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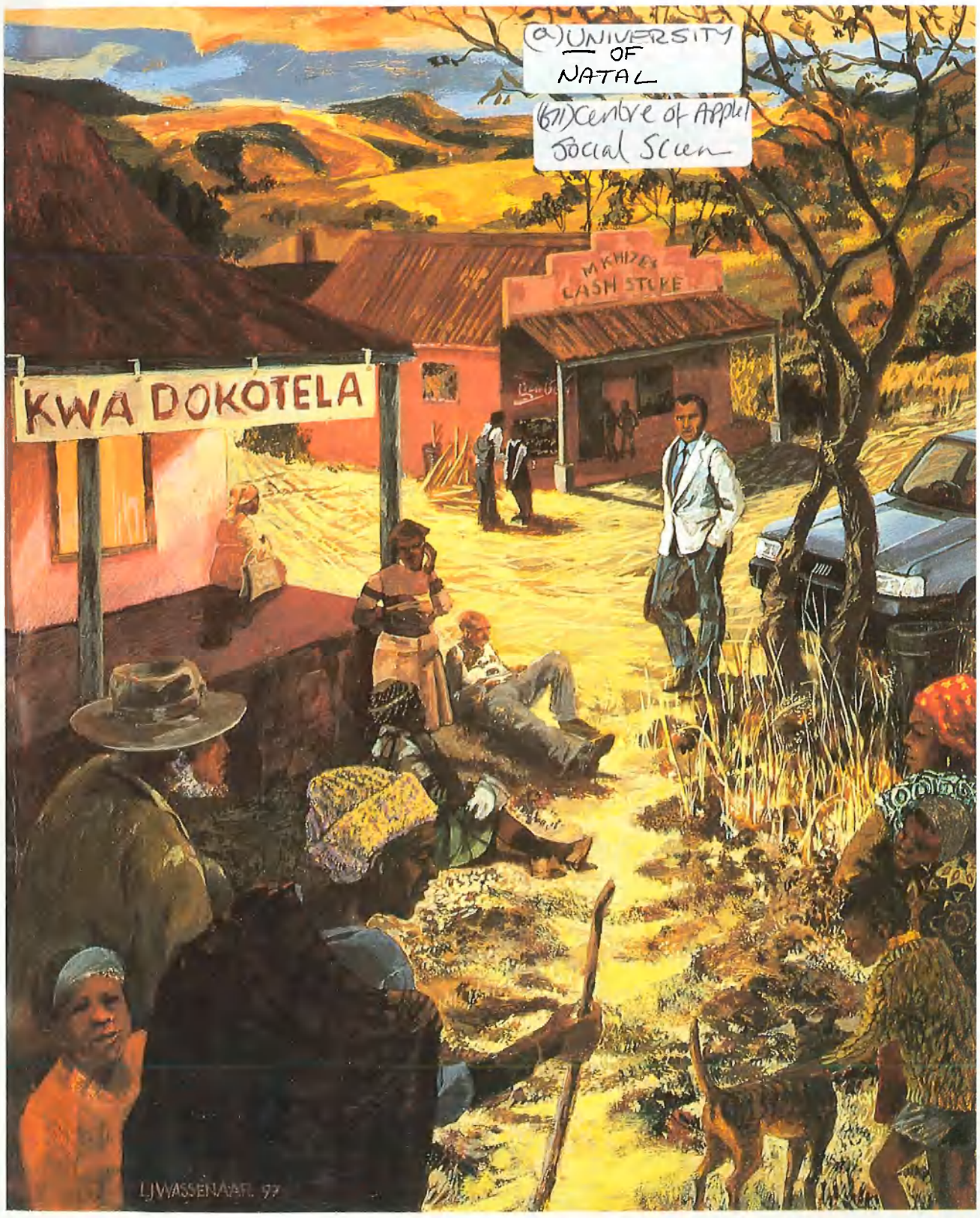

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INDICATOR SOUTH AFRICA
Quarterly Report

SUMMER 1997

VOLUME 14 NUMBER 1

Editorial

Probably the most infamous – and potentially the most expensive – blunder of the African National Congress government thus far, has been the Sarafina II scandal. The tale of how the Ministry of Health allocated – without following correct tender procedures – over R14 million to a play in the name of AIDS education, has for months been the subject of comedy, cartoons and more seriously, analysis and investigation.

Although inadequate, it seems South Africans will have to rely on satirists to extract a measure of accountability in this case. An internal investigation recently charged a senior Health Department official with misconduct. But the denials of the Minister at the time, the President's outright support before the facts were known, and the overwhelming sense of mismanagement in the Ministry, render this belated conclusion to a costly 'oversight', somewhat dissatisfying.

Indicator SA starts the year with a focus on health policy issues. Although not part of the line up, the memory of Sarafina II is never far off when considering two crucial elements in the delivery of health services: the health workers (in this issue in particular, the doctors) and the costs of health care.

The Government's primary health care policy itself is not at issue – indeed critics believe the policy is a good one. But a good policy is not enough. Without adequate planning, education, training and management of human resources in the health sector, the right kinds and numbers of people will simply not be there to operationalise the policy.

The Ministry of Health has alienated medical students and doctors with proposals for compulsory 'vocational training' and insinuations of disloyalty and greed. But until the lack of incentives and of infrastructural and staff support in the rural and peri urban areas where services are needed, are addressed – Government's only option will be coercion. Added to an overstretched budget, the cost to patients and the health sector of disgruntled doctors, is one the system cannot afford.

The health sector is not alone in its need for attention to human resources reform. Another case is that of the South African Police Service. The SAPS has undergone more transformation than any of the criminal justice system agencies. But a solid plan for restructuring its human resources component and for training, is still far off. Detectives and those in middle management in particular, need training. But the human component generally needs urgent attention: the cost to those in need of dissatisfied, demotivated police officers is as dire as that of disgruntled doctors.

Antoinette Louw, Editor

CONTENTS

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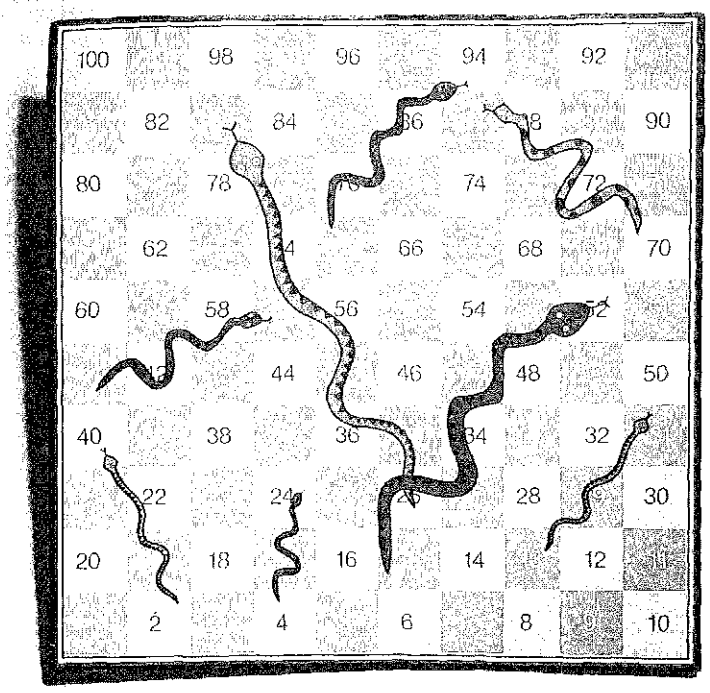
Categories of personnel	Western Cape	Nthern Cape	Free State	Eastern Cape	KwaZulu -Natal	Mpum -alanga	Nthern Prov	Gauteng	North West	South Africa
Nurses (All)	**35.7**	**26.5**	**27.3**	**28.2**	**31.4**	**14.8**	**21.7**	**37.9**	**26.8**	**29.1**
Public	26.9	21.2	24.1	26.2	28.1	13.3	21.2	28.4	23.3	25.1
Private	8.7	2.3	3.2	1.9	3.2	1.5	0.3	9.5	2.4	4.2
Pharmacists (All)	**7.5**	**2.7**	**3.6**	**1.8**	**2.5**	**2.1**	**0.7**	**9.5**	**2.1**	**3.8**
Public	0.5	0.4	0.2	0.1	0.2	0.2	0.1	0.4	0.2	0.2
Private	7.1	2.3	3.4	1.7	2.2	1.9	0.6	9.2	1.9	3.4
Dentists (All)	**2.3**	**0.8**	**0.5**	**0.3**	**0.6**	**0.4**	**0.2**	**2.5**	**0.3**	**0.9**
Public	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.1	0.1
Private	2.2	0.8	0.5	0.3	0.4	0.4	0.1	2.2	0.2	0.8
GPs (All)	**7.7**	**3.9**	**3.5**	**2.4**	**4.4**	**2.1**	**0.9**	**9.1**	**1.9**	**4.2**
Public	3.4	1.5	1.1	1.0	1.4	0.7	0.5	4.3	1.1	1.8
Private	4.3	2.5	2.5	1.4	2.7	1.5	0.4	4.9	0.8	2.4
Specialists (All)	3.8	0.7	1.3	0.6	1.4	0.3	0.2	3.7	0.4	1.5
Public	1.6	0.1	0.7	0.2	0.8	0.1	0.1	1.4	0.1	0.7
Private	2.2	0.5	0.6	0.4	0.7	0.2	0.1	2.3	0.3	0.9

Source: *South African Health Review 1996,* published by the Health Systems Trust and the Henry J Kaiser Family Foundation, October 1996



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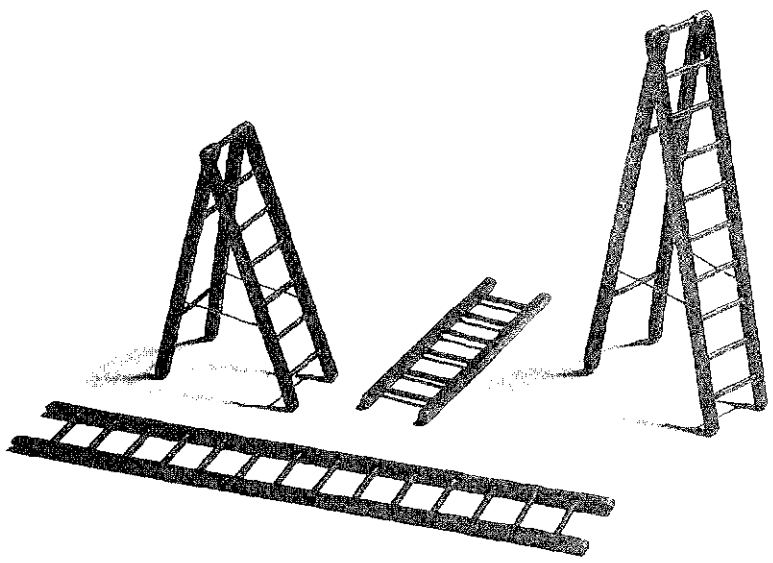

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No Rest without the Wicked

Assessing the Truth Commission

By André du Toit
Department of Politics, University of Cape Town

Half way through its term, the Truth and Reconciliation Commission has achieved much given its complex task. The TRC's uniquely public and democratic nature accounts for some strengths but also many weaknesses. Dealings with victims have been successful. But if substantial numbers of perpetrators, particularly prominent security force and ANC figures, do not apply for amnesty, the TRC will have failed in one of its main objectives.

A novel and controversial experiment in public political morality, many questions remain about the Truth and Reconciliation Commission (TRC). How has it set about defining its task? What content is being given to 'truth' and 'reconciliation'? Can it possibly achieve its *daunting objectives? It is a measure both of* the scope and the complexity of the TRC project that these questions remain as perplexing and elusive now as when the idea of a truth commission was first debated.

The TRC has not been slow off the mark. The Commission itself was appointed in December 1995 and by April 1996 was already staging its first public hearings. During the second half of the year it sustained a weekly schedule of concurrent hearings in urban centres as well as rural towns around the country – and these were only one part of its activities (TRC *Interim Report*, June 1996).

This is impressive, if only in organisational and logistical terms. The general political significance should also not be underestimated. Prior to its launch, fears were expressed that the resulting individual hurts and collective passions would be difficult to control. Even sympathetic critics saw the TRC as a high risk operation that could endanger South Africa's fragile democratic transition. It is significant that so far, these fears have proved entirely groundless.

Despite their highly volatile and controversial subject matter, few if any, hearings have been marked by public protests or visible opposition. At most, opponents have sought court injunctions to block the TRC's proceedings. This amounts to a general – and quite remarkable – acceptance of process far beyond earlier expectations.

Having achieved this impressive record of performance and a basic legitimacy, why is there still so much uncertainty regarding the main tasks and objectives of the TRC? This is partly because the process must still run its course: it is not easy to gain a proper perspective while being swept along the roller-coaster ride of new disclosures, on the one hand, and continuing cover-ups and stonewalling on the other.

But it is also a matter of the TRC's simultaneous pursuit of several different tasks and objectives which are difficult to balance and may even conflict with one another. An interim assessment requires taking stock of the process in a larger historical and comparative perspective.

Even sympathetic critics saw the TRC as a high risk operation that could endanger South Africa's fragile democratic transition

Uniquely in the comparative international experience, the TRC is essentially a public and democratic enterprise

There is also a need to disaggregate the tasks and objectives of the TRC and gauge its progress, or lack thereof, with respect to different issues.

Democratic process?

The South African Truth Commission was able to build on a range of comparable efforts and the architects of the TRC consciously set out to learn from these precedents. Eventually it was the Chilean model which influenced South African thinking most. But the TRC is actually unique.

Like the Chilean model, and unlike for example its Argentinean counterpart, the TRC does not seek criminal prosecutions for perpetrators: instead it is committed to amnesty for the sake of national reconciliation. Again like the Chilean model, the TRC sets out to balance amnesty for perpetrators with discovering and acknowledging the truth about the fate of the victims as a means of restoring their human and civic dignity.

The TRC has to operate as a quasi-political agency interacting with a range of other forces

But unlike the Chilean model, and uniquely in the comparative international experience, the TRC is essentially a public and democratic enterprise. This accounts for some of its strengths and also many of its greatest problems. The TRC is not, like many of its counterparts elsewhere, a Presidential Commission or even an international tribunal, but a parliamentary commission.

Not only was the establishment of the TRC uniquely preceded by an extended public debate concerning its objectives, but its specific terms of reference were fashioned through parliamentary hearings and debates with the participation of all major political parties. Even the appointment of the Commissioners themselves was subject to a similar process of hearings and public scrutiny.

Setting the TRC up as a parliamentary rather than a presidential commission provided an opportunity to tie the major political parties into the process

Moreover, this democratic character has been sustained in the TRC's proceedings which, to an unusual degree, are happening in public. The Chilean commission also held public hearings, but crucially, without ongoing media coverage. The dramatic impact of the Chilean TRC's report, as of the Argentinean and Brazilian *Nunca Mas* reports, had largely to do with the public presentation of authoritative and well defined finished products. The Latin American models only went public once they were ready to do so.

More generally the TRC largely fashioned its own agenda through a process of highly publicised negotiations. The issue of amnesty is a case in point. The TRC has not been charged with investigating the cases of a predefined set of alleged perpetrators. Since amnesty is only granted on individual application conditional on full disclosure, the TRC has to persuade reluctant perpetrators to avail themselves of this opportunity – much of which is being played out in full public view.

All parties are aware that this is likely to be a self-reinforcing process: if some key perpetrators apply for amnesty, their disclosures may set off a domino effect. Effectively this means that the TRC has to operate as a quasi-political agency interacting with a range of other forces – depending on alliances with some while having to demonstrate to others that it is a force to be reckoned with. In a sense this is the stuff of democratic politics; but for the TRC it is also a high stakes game of which the outcome is by no means assured.

Moreover, the TRC is not necessarily of a single mind itself. Indeed, it is possible to trace how – as different actors became involved – its character and objectives changed. To begin with it was bound up with the negotiated settlement reached at Kempton Park in late 1993 to clear the way for democratic transition. As the 'post-amble' to the Interim Constitution spelled out, national reconciliation was the highest priority which meant the issue of amnesty had to be settled, at least in principle.

It was left to human rights NGO's and others from civil society to develop the idea of a truth commission as a means of 'dealing with the past'. This was taken up by Minister of Justice Dullah Omar who, charged with giving effect to the amnesty provision, saw that if combined with the notion of a truth commission, the focus would shift from the perpetrators only, to acknowledgement of the victims as well.

Setting the TRC up as a parliamentary rather than a presidential commission provided an opportunity to tie the major political parties into the process. Finally, the appointment of the Commission, with Archbishop Tutu as chairperson and other religious leaders and members of the legal and counselling

professions, saw another change of actors leading to a new and increasing stress on a religious discourse and symbolism of 'healing' and 'reconciliation'.

Victims focus

The Commission set about getting its work under way, leaving the more theoretical issues concerning its main objectives – truth or justice, amnesty and reconciliation – for later. The TRC was also determined to see its tasks not only in human rights terms but rather in a developmental and representative context: priority was given to affirmative action appointments of support staff at every level possible.

The Commission's initial focus was around victims, in the form of the Human Rights Violations Committee's public hearings. The one part of the TRC process which, so far, has had the greatest public impact is undoubtedly the hearings at which victims could tell their own stories. The Commission created a sympathetic and caring setting for the bereaved – quite different from the adversarial procedures of a court of law, with assistants on hand to comfort those in distress. In this way a diverse range of individual testimonies could be taken up in a general discourse of forgiveness and reconciliation.

How much truth did these hearings uncover? In the more high profile cases, such as that of Goniwe or the 'Pebco three', and where there had been previous inquests, the hearings probably did not offer much new evidence. Their 'truth' function was essentially different – it was a matter of public and official acknowledgement of the victims' own stories and of the many atrocities which had so long been denied.

Still, the impact of the hearings lay primarily in the numbers who came forward, demonstrating the sheer scope and impact of political atrocities which occurred over the past decades. The cumulative effect as witness followed witness, was not so much to add insight about how and why all these terrible things had happened. On the one hand it was not possible to provide the full context for each story. On the other, the different stories did not add up to a single main narrative. It remains to be seen how the Commission will eventually incorporate all this into its final report.

In the mean time, however, the ongoing process of hearings has established a new historical benchmark in terms of public knowledge: in whatever way they may still be interpreted or explained, the sheer number and gravity of political atrocities in our recent past can no longer be doubted or ignored. This is already a historical achievement for the TRC.

The sheer number and gravity of political atrocities in our recent past can no longer be doubted or ignored

Amnesty

Although the public hearings dominated the early stages of the TRC's work, this relates to only one part of its official brief. By the latter part of 1996 the TRC began to shift the focus of attention away from the victims. Here its record is mixed and its aims still unclear.

Little has been heard of the Reparation and Rehabilitation Committee, which is responsible for recommending appropriate means of restitution to victims. The Amnesty Committee too, has been much slower off the mark. This committee has a complex relation to the TRC: in some ways it is semi-autonomous, reporting directly to the President, while its judges are not themselves Commissioners.

Little has been heard of the Reparation and Rehabilitation Committee

Its procedures are more formal. Compared to the caring discourse of the victims' hearings, the Amnesty Committee is closer to the adversarial approach of criminal trials, while the judges also had some difficulty coming to terms with media coverage. It was only in October 1996 that the first major cases of former police officers applying for amnesty were brought before the Amnesty Committee.

Although the deadline for such applications has been extended to early this year, it is still an open question whether substantial numbers of perpetrators – and in particular prominent security force and ANC figures – will in fact apply for amnesty. If not, the TRC will have failed in one of its main objectives.

Compared to the caring discourse of the victims' hearings, the Amnesty Committee is closer to the adversarial approach of criminal trials

If the TRC was established to deal with amnesty and with the participation of all the political parties, why is this issue still unresolved? Part of the answer lies in the complex history of amnesty negotiations preceding the TRC. At one stage –

Ironically, the litany of atrocities presented to the Human Rights Violations Committee can only strengthen the call for justice, not amnesty

following the breakdown of Codesa, and in the context of the bilateral rapprochement between the ANC and National Party (NP) leaderships which resulted in the Record of Agreement of September 1992 – the idea of a mutual bilateral amnesty was apparently mooted and some implicit understanding reached.

Arguably it was this that the NP representatives and the security forces had in mind when they pressed for inclusion of amnesty in the Interim Constitution. From their perspective it is contrary to this earlier agreement that the TRC Act made amnesty conditional on individual application and on the Norgaard criteria for political offences. On the ANC side too, serious reservations remain regarding the TRC as the vehicle for amnesty.

Many in the ANC dispute the need for alleged perpetrators of atrocities in the course of the anti-apartheid struggle to apply for amnesty

Many would prefer to see the perpetrators – both the operatives and their political masters – be prosecuted in the criminal courts. Ironically, the litany of atrocities presented to the Human Rights Violations Committee can only strengthen the call for justice, not amnesty. Moreover, many in the ANC dispute the need for alleged perpetrators of atrocities in the course of the anti-apartheid struggle to apply for amnesty. Whatever the history of the TRC's establishment, it cannot count on the key perpetrators from both sides coming forward with individual applications for amnesty.

Legal inducement

The main inducement for perpetrators to apply for amnesty is the prospect that they might otherwise be prosecuted in court – or, in the case of those on the side of the ANC, that civil actions might be brought against them. However, as the case of former Defence Minister, Magnus Malan has shown, the odds may favour those prepared to take their chances in court rather than applying for amnesty.

It is by no means clear that the TRC is in any better position than the courts to mount 'prosecutions' of suspected perpetrators on an adversarial basis

In court the onus of proof – beyond a reasonable doubt – is on the prosecution. The granting of amnesty by the TRC by contrast, is conditional on full disclosure by the applicants themselves. There can be little doubt that the acquittal of all the accused in the KwaMakhutha-Malan trial will weigh heavily with any security force agents who must decide whether or not to apply for amnesty.

Public proof of this was provided by the content and tenor of the submission made on behalf of the former South African Defence Force (SADF). The military was clearly closing ranks; did not see the need to apply for amnesty and was not proposing to volunteer any disclosures. Dr Boraine and other Commissioners expressed their ire over this approach and indicated that the TRC would use its powers to subpoena and investigate alleged perpetrators.

However, it is by no means clear that the TRC – faced with persistent stonewalling and legalistic manoeuvres – is in any better position than the courts to mount 'prosecutions' of suspected perpetrators on an adversarial basis.

It is thus clear why Tutu threatened to resign in November 1996 unless both the ANC and NP together with its former allies in the security forces, assist with the amnesty process – meaning that perpetrators from both sides submit their individual applications and volunteer disclosures. If this does not happen on a substantial scale, the TRC will not be able to resolve the amnesty issue. And if a different 'political' solution may have to be found, there are certain to be those on both sides who will press, once more, for a general bilateral amnesty.

Courts vs amnesty

But the TRC's role in amnesty may yet be different. On the same day that the military so blandly declined to make any real disclosures, the police took a very different approach. The former Commissioner of Police, General van der Merwe, testified before the Amnesty Committee on behalf of six senior police officers who had actually applied for amnesty. For several reasons this was significant.

First, Van der Merwe had previously played a leading role in presenting a united front on behalf of the security forces in their dealings with the TRC – one clearly designed to prevent individuals making amnesty applications. The six officers had done just that, but instead of disowning them, he appeared on their behalf, announced that he would be applying for amnesty himself, and even volunteered the disclosure that he had been involved in a 'dirty tricks' operation.

Second, at one stage there were efforts to prepare a joint submission by the NP and the security forces. But there must have been a parting of ways, as in August FW de Klerk

presented the NP's disappointingly thin submission, while Van der Merwe went on record to implicate his political masters, even pointing to PW Botha as responsible for such outrages as the bombing of Khotso House. Evidently these police generals had concluded that the politicians could not be trusted to take co-responsibility with those who had carried out their policies in fighting a 'dirty war'.

If this surprising change of tack by the police constitutes the breakthrough on the amnesty issue needed by the TRC, then no doubt it can also be explained as an attempt to pre-empt the threat of imminent prosecution. Gauteng Attorney General D'Oliveira – following the conviction of Eugene de Kock for atrocities committed in the course of the Vlakplaas operations – was preparing further prosecutions against De Kock's superiors, such as general Basie Smit and others close to Van der Merwe.

If this points to a double track strategy, with the threat of prosecutions aiding the TRC in getting perpetrators to apply for amnesty, then it also indicates ways in which the two processes could interfere with each other. On the one hand, the prosecution of some perpetrators requires dispensing indemnity to others whose cooperation is needed as state witnesses. Some of the key individuals whose disclosures the TRC needs to get further applications for amnesty might choose indemnity in exchange for turning state witnesses in a criminal prosecution.

Conversely, the chances of an Attorney General mounting a successful prosecution may be scuppered by key state witnesses opting to apply for amnesty. In theory the two tracks could and should be coordinated in the interests of both justice and amnesty. In practice, it may well lead to battles over terrain and prerogatives between the TRC and the Attorneys General, providing opportunities for the targeted perpetrators to play them off against each other. For the time being it remains unclear whether the TRC will be able to resolve the amnesty issue satisfactorily.

Reconciliation

The TRC must be considering how its final report should present its findings. The Act charges it to prepare a 'comprehensive report' of political atrocities from 1960 to the end of 1993, which should include the perspectives of victims and the motives and views of perpetrators.

In one sense the public nature of the hearings means there is no strong separation between process and product as with other truth commissions. In telling their stories, the victims have already put their perspectives on record in ways which will have to be accommodated by the eventual report. On the other hand, the diverse stories do not readily combine in a common narrative of reconciliation. And as long as the perpetrators are not coming forward, an essential part of that larger narrative remains outstanding (Krog 1996).

A critical issue is the relevant senses of 'truth' as the commission goes from the stories told by victims and perpetrators towards its own report. Inevitably it must be concerned with the factual truth of any statements and develop appropriate procedures for corroborating these. However, there is a danger that in reducing individual stories to manageable 'cases' based on verifiable statements, the personal and narrative truth crucial to these stories will be lost.

Some observers have already been critical of how individuals' stories are framed by the TRC, and how subtle yet significant nuances are lost in translation; sub-texts ignored and dissenting voices silenced. All this is bound to apply even more to the bald factual case summaries which might result from the information management process set up by the TRC (Research Department, TRC 1996). Case summaries alone – however well corroborated for their factual truth – will not generate the larger narrative of reconciliation.

More generally, the TRC still seems surprisingly uncertain regarding its basic conceptual framework. Public statements by some commissioners as well as TRC study documents remain remarkably open ended and sometimes even sceptical on such fundamental issues as the TRC's commitment to justice and/or truth and the tensions between amnesty and prosecution (Villa-Vicensio and Verwoerd).

The commission seems so overwhelmed by the sheer practical details of getting the

Some of the key individuals whose disclosures the TRC needs, might choose indemnity in exchange for turning state witnesses in a criminal prosecution

The chances of an Attorney General mounting a successful prosecution may be scuppered by key state witnesses opting to apply for amnesty

The commission has not reflected and reached consensus on the basic moral and political issues at stake

The representatives of political parties could not be expected to make disclosures which could damage their political interests

public hearings under way, together with the complications of its other diverse tasks, that it has not reflected and reached consensus on the basic moral and political issues at stake. This may be due to the democratic character of the TRC as suggested above, and the extent to which it conducts its business in public. Even so, the problem has been compounded by the invitation to political parties to make formal submissions to the TRC in August 1996.

These submissions were disappointing and the political parties were variously blamed for this. But such blame is misdirected. The representatives of political parties could not realistically be expected to make disclosures which could be damaging to their own political interests. If the idea was that the parties should assist the TRC in developing a conceptual framework for its task of national reconciliation, then this also backfired. Almost inevitably all parties were concerned not with the mandate of the TRC, but rather with how best to protect their own interests in relation to the TRC.

'Just war' doctrines

It is a basic tenet of just war theory to distinguish between the justice of war as against justice in war

The ANC in particular proposed an approach which is in serious tension with the TRC's own mandate. Invoking traditional just war theories, the ANC essentially argued that its armed struggle against the apartheid government had been in a just cause and thus could not be equated with the gross violations of human rights committed in defence of an unjust order.

But this confuses the traditional just war doctrines: it is a basic tenet of just war theory to distinguish between the justice *of* war as against justice *in* war. Crucially it does not follow that if your cause is just, the rules of justice in war do not apply. The principles of justice in war – such as the rule that noncombatants may not be killed – apply equally to those fighting in a just cause as to those fighting in an unjust cause (see Adam in this issue). This is a cardinal principle for any criterion which the TRC develops to deal with gross violations of human rights.

This unresolved issue of how the TRC's basic normative framework applies to the main protagonists in the earlier political conflicts is closely connected to the contested issue of an implicit agreement on the amnesty issue. An enormous amount of work awaits the TRC in its final year – but in a broad political sense, these remain the key challenges on which its overall success or failure will depend. IPEM

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AFRICA'S NAZIS:

APARTHEID AS HOLOCAUST?

By Heribert Adam
Graduate School of Business, University of Cape Town

The old controversy about the nature of apartheid in comparison with Nazism has been refuelled with the publication of Kader Asmal, Louise Asmal, and Ronald Suresh Robert's Reconciliation through Truth. A Reckoning of Apartheid's Criminal Governance. *This article challenges this notion, and that of 'just war'. Apartheid was not genocide and a disregard for nuances and differentiations, and ahistorical labelling and false analogies hardly contribute to an understanding of events.*

It would be a mistake to dismiss Asmal *et al's* book *Reconciliation through Truth. A Reckoning of Apartheid's Criminal Governance* as mere propaganda because Kader Asmal is a well known cabinet minister. Precisely because the African National Congress's chief ethics commissioner and widely respected legal expert and human rights advocate articulates controversial opinions forthrightly, his account has to be taken seriously and engaged with.

The authors' powerful polemic aims at reminding South Africans of the atrocities committed by a 'criminal regime' – it indicts forcefully, records the well known racial laws and exhorts apartheid's beneficiaries to take collective responsibility. It denies that defenders and resisters can be placed 'on an equivalent legal footing'. Asmal seems to side with those in the ANC who incited Tutu's ire because they argued they fought a 'just war' and therefore do not need to appear before the Truth Commission (see Du Toit in this issue).

Asmal *et al* admit comparatively few or 'scattered human rights infringements' on the part of the ANC. They are called mere 'lapses' of an 'underresourced' organisation under stress – never condoned but actually forbidden. If that is the case, why the initial reluctance to appear before the Commission by leading ANC members?

In their eagerness to establish that resisters and defenders of apartheid inhabit 'fundamentally incompatible, moral universes', the authors ignore the classical philosophical distinction between a 'just war' and 'justice in war'. Nobody doubts that the anti-apartheid movement fought a just cause.

The complementary principle of 'justice in war' insists that even in such cases, conventions of justice have to be followed. The just party must be held accountable if it does not do so – for instance killing prisoners of war, or unnecessarily harming civilians – regardless of the moral evil of the opponent. The oppressed too are bound into rules. Tutu, to his credit, brought this principle home.

Nazi analogies

Asmal *et al*'s indictment becomes problematic in its constant references to the Nazis of Africa in order to justify calling apartheid a 'form of genocide'. The Nazi analogies are supposed to sweep the reader into outrage: South Africa resembles an open house concentration camp. Indeed, it is generally known that many leading apartheid ideologues sympathised with the Nazis in the 1940s, but that was mainly in the context of anti-war mobilisation on the side of the British.

It is unclear in Asmal's account whether they adopted this attitude because of

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The comparison ignores that apartheid tolerated an outspoken white opposition in contrast to Hitler's totalitarian control of the population

similar racist and anti-semitic beliefs or perhaps more for reasons of anti-British sentiment. Nowhere in the book is it mentioned that a leading Nazi, such as Prime Minister Vorster, later visited Jerusalem's holocaust memorial, and that Israel – more than any other independent state – collaborated with the Nazis of Africa. While Israel also collaborated with other unsavoury regimes, the real Nazis would not have been able to collaborate with Jews (and vice versa) even out of necessity or expediency.

Constant labelling, such as 'Verwoerd's ideological klansman Adolf Hitler', and frequent comparisons between the Nuremberg Laws against Jews and apartheid laws, miss the different sociological contexts behind the anti-black and anti-semitic racism. For example, a statement that apartheid "was a principle around which large numbers of people actively rallied, as they rallied around anti-semitism in Nazi Germany" (Asmal *et al* 1996: 149) suggests similar reasons for their support. In fact, the historical reasons for Afrikaner and German nationalism differed substantially.

Asmal et al *rightly point to the neglected collaboration of many business tycoons with apartheid*

The comparison ignores that apartheid tolerated an outspoken white opposition in contrast to Hitler's totalitarian control of the population. That made support for apartheid actually worse in the presence of clear alternatives. False analogies abound such as:

> *"The Broederbond was remodelled on the lines of Hitler's Nazi Party with secret cells and a secret membership."* (Asmal *et al* 1996: 33)

In fact, the Nazi Party was an open mass party, hardly comparable with the 15 000 carefully selected members of the Broederbond. The Broederbond initially formed an employment agency for Afrikaner professionals and later served more as a political thinktank. As an elite organisation, it could at the most be compared to the Nazi SS without uniforms and military functions.

Unlike the fictious conflict between Germans and Jews, in South Africa a real civil war took place with self declared opponents on each side

Asmal *et al* rightly point to the neglected collaboration of many business tycoons with apartheid, just as the Krupp, IG Farben and other beneficiaries of the German war machine went along quietly with the Nazi policy. In seeming contradiction, however, the authors also assert:

> *"Thus, for apartheid's functionaries as for the Nazis, international capital and its most bitter opponents (Communists) were one and the same."* (Asmal *et al* 1996: 83)

This simplistic conclusion from the well know stereotyping of 'Jewish financiers as agents of communism' overlooks that the apartheid advocates extended great efforts and resources to woo international capital. In contrast, the German Nazis despised international capital as controlled by Jews. Apartheid always presented itself as a bastion against communism which needed the help of the West to fend off sanctions and secure South Africa for free enterprise. Ironically, the abolition of apartheid achieved this goal far more successfully than its worried advocates could have dreamed of.

In South Africa, a monitory regime fought 'by all means possible' the seizure of power by the majority. In doing so, it tortured, killed and disregarded human rights conventions as it pleased. In Germany on the other hand, a Nazi majority set out to eliminate – systematically – designated minorities who had no political ambitions and were therefore no threat to the ruling group, except in the fantasy of the rulers who constructed them as the major enemy.

Unlike the fictious conflict between Germans and Jews, in South Africa a real civil war took place with self declared opponents on each side. In Germany, a struggle existed only in the imagination of the anti-semite. No Jews ever dreamt of overthrowing a German government before the pogroms started. Even then, many Jews foolishly did not realise the impending threat and believed in the false security of real assimilation.

This different constellation does not absolve the apartheid executioners of their crimes. However, it locates their deeds differently, requiring more nuanced explanations to comprehend the motives of perpetrators.

UN standards

Most of Asmal *et al's* text utilises United Nations (UN) resolutions to substantiate their perspective of apartheid as genocide. While the UN played a strategic role in giving international prominence to injustices under apartheid, the language used hardly serves to further our understanding of the phenomenon.

The quest for the elimination of racial inequality calls for nothing less than a scrupulously honest deconstruction of the

underlying theoretical underpinnings of racial ideologies and the personal motivations of its beneficiaries. Neither of these aims is met through the uncritical use of hyperbolic descriptions, though it may have had its strategic value at certain historic junctures.

Nor is a distinction between types of oppression intended to trivialise the experience of victims of each kind of racialised situation or give moral support to the former oppressors, as Asmal hints his critics do when the try 'to preserve a semblance of morality' underneath apartheid.

The authors call this 'our own brand of holocaust denial'. Steven Friedman (*Business Day*, 11 November 1996) has drawn attention to another danger of this partisan denouncement of all critics as willing or unwilling allies of apartheid: those who fought the moral evil of apartheid in the ANC place themselves beyond reproach. With their moral credentials, they now claim 'a licence for them to govern in whichever way they please', because they need not be judged by the same standard.

If all criticism of liberation policies is automatically tainted by the suspicion of apartheid support, the new rulers have delegitimised all opposition and given themselves a free hand. To rely solely on UN resolutions to discern the nature of a regime can be misleading. One only has to be reminded of the ill considered 'Zionism is racism' verdict, later rescinded.

The so called international community in the form of national government representatives with their own self interested agendas, functions as a poor forum for reliable moral judgements. Yet taking its rationale from a UN sub-committee, Asmal and his co-authors insist that apartheid as genocide is not hyperbole but "an understatement" (Asmal *et al* 1996: 201).

Genocide?

It is always a macabre undertaking to discern degrees of oppression. One dissenter harassed is too many. It is also a futile exercise akin to a theological debate, to argue about whether apartheid constitutes a crime against humanity or something worse or less offensive, as has been the controversy in the South African press. The fact that the notion of crime against humanity has been pushed by states allied with the Soviet Union in a Cold War climate and resisted by Western democracies is equally irrelevant for the truth or correctness of the verdict, which must be found independent of sponsors.

However, if words have any meaning, apartheid did not amount to genocide, even if the term is stretched to include any harm done to the life chances of ethnic or racial collectivities. Profound legal discrimination and genocide still remain two distinct events.

Apartheid robbed the South African majority of dignity and countless opportunities. It deprived the disenfranchised of land, jobs and equal pay, of the right to family life, equality of education, and tried to make them foreigners in the land of their birth. It terrorised those who resisted and in the process maimed and killed some of the best and bravest. But genocide it was not.

Otherwise, the number of blacks, both absolute and relative to the ruling group, would not have increased steadily – higher child mortality and lower life expectancy of Africans notwithstanding. Ironically, the authors themselves seem to confirm this unwittingly when they compare the thousandfold more people killed on the mines than by the police torturers: "throughout the entire apartheid period, 68 political prisoners died in police detention". This could be an average figure of Jews killed in a month in a small Ukrainian town by the German occupiers and their auxiliaries.

In short, if anything and everything amounts to fascism and genocide, then nothing is fascism and genocide. The propagandistic inflation of serious accusations cheapens the fate of the real victims of fascism. By being blind to nuances and necessary differentiations, by ahistorical labelling and false analogies, well intended polemicists may be able to incite passion – even combat dangerous historical amnesia – but hardly contribute to political literacy.

If Daniel Goldhagen's central thesis in his much discussed *Hitler's Willing Executioners* is correct, far more ordinary German soldiers and prison guards than generally believed, voluntarily

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Under apartheid, the vastly outnumbered ruling group could not aim at eliminating, but only controlling the majority

participated in the Nazi atrocities. They were keen to act out their own deficiencies on dehumanised objects. Under apartheid, however, a different constellation prevailed.

The vastly outnumbered ruling group could not aim at eliminating, but only controlling the majority. This required the active participation of willing members of the discriminated. At the height of apartheid during the 1970s and 1980s, about two thirds of the South African police were already black. Far from being reluctant co-optees in their own subjugation, the black police personnel – on the whole – had fully internalised the official doctrine of fighting terrorism. They frequently outperformed their white masters. The latter, in turn, prided themselves on fighting a common enemy together.

No Nazi official would have accepted Jewish co-defenders in their rank. This dependence of the apartheid regime on their 'others' – not only in assuring security but at all levels of life, from economic survival to administrative capacity – also acquired a general perception of the subordinates that differed from the generalised demonisation of Jews by the Nazis. Apartheid advocates could only afford selective reprisals against suspected activists, not the indiscriminate terror of the Nazis against all members of the outgroup, regardless of their political outlook.

Apartheid's 'willing executioners' were constrained by legal authority which Hitler's followers never encountered

Legal authority

At the same time, comprehensive legal control in South Africa discouraged private unofficial violence. KKK vigilante activity occurred relatively rarely. The phenomenon of a 'Third Force' of policemen killing on their own with the tacit or explicit approval of politicians escalated in a phase when the regime was already losing control. However, even during this transitional era, the apartheid government had to pretend that policemen complied with 'the law'.

In contrast, Nazi Germany explicitly placed Jews outside the law and thereby legitimised arbitrary terrorism. Had apartheid Pretoria pursued a similar strategy, it would have incited massive upheavals. The appearance of legality and impartial justice was a necessary instrument of minority domination.

Apartheid's 'willing executioners' were thereby constrained by legal authority which Hitler's followers never encountered. In the German case, the will of the leader reigned supreme – in the setting of settler colonialism, far more complex factors intervened to make it both easier and more difficult to combat oppression.

The struggle against apartheid suffered from the flexible and pragmatic manipulation of the opposition, from co-optation to sophisticated concessions alternating with outright repression. In Hitler's case, only repression prevailed as a matter of principle. The anti-apartheid struggle, however, was also facilitated by circumstances that were not allowed to surface in Germany: the victims in South Africa could expect to find some influential allies in the ruling group itself.

Any expression of empathy or support for Jews in Nazi Germany was considered an act of treason that threatened heavy penalties. While some heroic whites from Braam Fisher to Neil Aggett paid this price in South Africa as well, far more people sympathised actively or passively with the black cause in a variety of ways and for a multitude of reasons. Whether out of pragmatic self interest or moral qualms, by openly appealing to the better sense of the rulers, the apartheid opposition strengthened itself immensely.

Recipe for repression

It was the split in the ruling group, the cleavage between 'softliners' and 'hardliners' – *verligte* and *verkrampte* – that ultimately allowed for the negotiated revolution when the more far sighted Afrikaner majority backed then President De Klerk's strategy of compromise. In the absence of such a public discourse about a group's self concept, the Hitler opposition could not work politically in a totalitarian environment that silenced all dissent.

By contrast, in the authoritarian South African state, despite censorship and emergency laws, sufficient articulation of the alternative order exposed the bankruptcy of apartheid, undermined the moral certainty of its upholders and ultimately forged a new hegemony of negotiated co-existence. Thus an old lesson is again confirmed by the dialectic of repression: it has to be self sufficient, total and ruthless in order to succeed for a while. Any concession for whatever reason bears the seeds of an accelerating collapse of repression. IPEG

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Politics of Change

Swaziland's future in the balance

By Kuseni Dlamini
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Over the past five years, commissions set up by Swaziland's King have not accommodated views of political parties and progressive organisations. Instead they have tried to wish political parties away. It is not yet evident that a genuine reform process is underway.

The establishment of a Constitutional Review Commission (CRC) and the appointment of a new prime minister – widely perceived to be a liberal – by Swaziland's King Mswati III in July 1996 marked a watershed in the politics of change in the mountain kingdom. It appeared to put an end to a long period of uncertainty about the country's political destiny. The new prime minister, Sibusiso Dlamini, replaced the hard-core traditionalist and conservative, Prince Mbilini, who was fired by Mswati in May.

The King's recent political moves marked the first ever admission by the powers that be that the current system of government based on *Tinkhundla* – traditional councils with no provisions for political parties – is undemocratic. It is also the King's first concrete and official reaction to the mounting pressure for democratic change, led by an alliance of banned political organisations and the country's militant trade unions affiliated to the Swaziland Federation of Trade Unions (SFTU).

The appointment of members of the CRC was preceded by the establishment of an advisory committee – the Swazi National Council (SNC) – to replace the controversial and secretive Central Committee (CC). Also a controversial body, the SNC was ostensibly formed to 'advise the *Ngwenyama* (king) on all matters regulated by Swazi law and custom and connected with Swazi tradition and culture', and on all matters 'referred to it from time to time by the King'.

The SNC caused outrage and controversy when it summoned leaders of the teachers' union to the palace during the teachers' strike. It is rumoured that the SNC also chose the current prime minister and gave him a directive to deal 'accordingly' with elements violating the country's laws. The King's credibility internationally was compromised by the appointment of an ultra-conservative body to advise on constitutional reform.

Composition

The 31 person CRC initially comprised only four (mainly conservative) women, the president of the banned People's United Democratic Movement (PUDEMO), and the vice president of SFTU – all appointed as ordinary citizens.

Mario Masuku of PUDEMO pulled out in January 1997, arguing that 'it will be a treasonable offence to the people of Swaziland and the international democratic community if we are seen to be part of the process which is nothing but a miscarriage of democracy'. It is widely believed that SFTU's vice-president will also soon pull out of the CRC process.

The terms of reference of the CRC provide, among other things, that no one may represent anyone or be represented in any capacity while making submissions to

The King's recent political moves marked the first ever admission that the current system of government is undemocratic

Hand picked by the King and his advisors, the majority of CRC members are not only pro-establishment but are princes, chiefs, or are related to the royal family in some way

the commission. In practice, this means that political parties, trade unions, youth organisations, the church, environmental and women's organisations cannot make submissions.

Only three women and one member of the right-wing Swaziland Federation of Labour (SFL) were appointed to the 21 person SNC. Both structures are chaired by members of the royal family. Hand picked by the King and his advisors, the majority of members of the CRC are not only pro-establishment but are princes, chiefs, or are related to the royal family in some way. While the selection criteria remain largely unknown, most of those appointed have little commitment to or understanding of democratic principles.

The terms of reference were also not a subject of negotiation between the major stakeholders, and social and political formations were not invited to make contributions. The banned People's United Democratic Movement (PUDEMO), SFTU and the Swaziland Democratic Alliance (SDA) have been vocal in their call for an all inclusive, transparent and democratically constituted convention where all the organised social formations will be fairly represented.

A widely criticised clause of the CRC provides that no person may insult, disparage or belittle any member of the commission

Meanwhile, government sources insist that there is no point in the king negotiating with illegal organisations which violate the country's law, because by so doing he will be according them some degree of recognition.

CRC mandate

The CRC, established in terms of the controversial King's Proclamation of 1973, has been mandated by King Mswati III to 'draft a new constitution suitable for the Kingdom of Swaziland'. In doing so it shall:

Swaziland is the only country in southern Africa which still prohibits its people from forming and joining political parties of their own choice

- ❑ Compile and document the current constitutional framework and circulate it to all *Tinkhundla* centres.
- ❑ Review any legislation, degree or proclamation which has a bearing on constitutional and human rights matters.
- ❑ Consider the constitutions of other countries which the commission may consider appropriate for the purpose of obtaining any information, guidelines or principles.
- ❑ Receive oral submissions, representations, and information from members of the general public, and for this purpose visit all *Tinkhundla* centres to access such members as well as consider the 1992 *Tinkhundla Review Commission Report*.

In addition to the above, the CRC has also been ordered to 'consider and provide for appropriate provisions and entrenchments on the monarchy and other Swazi traditional institutions ...'. This clause is a source of much of the confusion and controversy surrounding the commission and its real intentions, and has caused many people to be sceptical about its real intentions.

Another widely criticised clause provides that 'no person may insult, disparage or belittle any member of the commission, or obstruct, interrupt, hinder or prejudice an officer, member of the commission or the commission in the performance of its functions'. Contravention of the clause may result in a maximum fine of R5 000 or five years' imprisonment or both.

This clause has been criticised by the banned political parties, the labour movement, human rights organisations and the press as a ploy to intimidate people who might wish to raise issues in a critical manner. It can also muzzle the press, as journalists and newspapers are not exempted from its application. In a society such as Swaziland, it's usually not clear what is an insult and what is not, as a cultural interpretation of an innocent act may render it insulting to *labadzala* – the nation's elders.

Opposition response

Swaziland is the only country in southern Africa which still prohibits its people from forming and joining political parties of their own choice. As a result, it has over the last four years, been rocked by a series of pro-democracy strikes, mass protests and rallies led by PUDEMO and the militant Swaziland Federation of Trade Unions. During 1996 there was an intensification of the campaign for multi-party democracy, with PUDEMO vowing to make the country ungovernable until the 23 year old ban on political parties and free political activity was lifted.

Mswati's reform programme according to PUDEMO, SFTU and the SDA is flawed for a number of reasons. First, it does not

guarantee a genuine and meaningful negotiation process. Second, the process is not guided by the principles of freedom, co-determination and shared responsibility.

PUDEMO also argues that the process is the preserve of a select few. It insists on its long standing call for a properly constituted and representative constitutional forum that will bring together all organs of civil society, registered and unregistered, to chart the way forward for Swaziland.

The party has put together 'fundamental pre-conditions for effective broad based participation'. These include the levelling of the political playing field through the following measures:

- Repealing the King's Proclamation of 1973 which banned political parties and free political activity.
- Developing a broad based, all inclusive constitution making process.

PUDEMO also calls for an independent judiciary, freedom of the press, time frames covering the various stages in the process, a clear agenda for negotiations and a mechanism for the appointment of an independent chairperson.

Broadly speaking, there are two different and conflicting perspectives that have informed the opposition's response to the reforms announced by Mswati. The first one sees the current reform process as a deliberate strategy pursued by the regime aimed at refining the Tinkhundla system by eliminating its dysfunctional aspects and replacing them with mechanisms which allow it to be maintained more efficiently. In terms of this perspective, reform is seen as part of a coherent strategy which has a significant potential to impede far reaching structural reform.

While the second view also attributes considerable coherence to reform, it suggests that the government has begun a plan aimed at dismantling the *Tinkhundla* system of government at a gradual pace in order to allay the fears of traditionalists and conservatives who feel threatened by change. In terms of this view, a gradual process of change is necessary to acclimatise *labadzala* (the elders) to a new democratic order.

Both views imply a particular course of action as far as the reform process is concerned. The first suggests that reform should be resisted and the struggle to make the country ungovernable intensified until the regime gives in to popular demands. The second suggests that reform be embraced, as it will eventually result in a democratic order. The democratic movement in Swaziland currently finds itself split between those who reject participation and those who favour it.

Alternative view

Current state reform strategies in Swaziland may be neither a conscious attempt to dismantle the *Tinkhundla* system, nor a coherent and potentially successful strategy to refine and strengthen the system. Instead, they can be seen as a desperate response by the regime to accommodate – in a very superficial way – structural changes which have rendered specific politics and laws unworkable. They are not an attempt to initiate and implement far reaching political changes but are aimed at seizing control of the pace and content of the process of change from the democratic movement which has been in the forefront of the process.

The reform process, by its very nature, is an attempt to reformulate policies, practices and laws which are unworkable. This inevitably opens up new space for fundamental changes to be instituted. Thus, opposition forces in Swaziland need to view reform not as an obstacle to structural change nor a guarantee of such change, but as an opportunity which, if tactically handled, may create the necessary conditions for change.

SADC intervention

An emergency consultative meeting of southern African leaders was held in Maputo in July 1996 to discuss the political crisis in Swaziland. The meeting was, however, 'boycotted' by King Mswati III. Indications are that the king pulled out because he did not want his announcement of the impending constitutional reform measures to be interpreted as a sign that he was bowing to foreign pressure from his Southern African Development Community (SADC) counterparts.

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Current state reform strategies can be seen as a desperate response by the regime to accommodate structural changes which have rendered politics and laws unworkable

Opposition forces in Swaziland need to view reform not as an obstacle to structural change but as an opportunity which may create the necessary conditions for change

In May 1996, the then chairman of the SADC said that the SADC would not meddle in Swaziland's affairs

The July meeting in Maputo was the first of its kind to be held by SADC leaders on the crisis in Swaziland, and followed the launching of a new SADC Organ on Politics, Defence and Security.

Speaking at *Ludzidzini* royal kraal in May 1996, Ketumile Masire, president of Botswana and the then chairman of the SADC, said that change was inevitable, and that it would benefit both the SADC and Swaziland to find the proper way forward. He, however, stated the SADC would not meddle in Swaziland's affairs.

Southern Africans and the rest of the world expect the SADC to play a prominent role in diffusing regional conflicts through preventive diplomacy and other means. The end of the Cold War has meant, among other things, the decline in strategic significance of most of sub-Saharan Africa. This should be seen as an opportunity for these countries to determine their affairs and show the rest of the world that Africa can solve its own problems.

Mandela is believed to have taken an immense personal interest in helping Swaziland resolve its political crisis

It remains to be seen whether the SADC will demonstrate the will and commitment to facilitate the democratisation of Swaziland and ensure the observance of fundamental human rights.

Diplomacy

It is widely believed that President Mandela favours secret discussions with King Mswati III. Mandela is believed to have taken an immense personal interest in helping Swaziland resolve its political crisis, which came to a head in January 1996 when virtually the entire workforce embarked on a general strike, demanding a return to constitutional rule.

However, Mandela's behind-the-scenes diplomatic approach to the Swaziland question has been criticised as reminiscent of Pretoria's approach to the Nigerian situation, which ended up being a foreign policy blunder. Mandela has also been criticised for having taken an active personal stance against the Nigerian military junta for executing Ken Saro Wiwa, while not taking an equally tough line against undemocratic rule in a neighbouring country.

Mandela is trying hard to avoid being seen as the 'bully-boy' in sub-Saharan African affairs

Speaking in Pretoria after the SADC meeting held to discuss the political crisis in Swaziland, Mandela said:

> *"I believe that His Majesty on his own is already taking this role (as a democratic reformer). For that reason we are convinced the way forward that he mapped out is one that, in due course, will mirror the aspirations of the people of Swaziland."*

It seems that Mandela is trying hard to avoid being seen as the 'bully-boy' in sub-Saharan African affairs – pressure from Western capitals and expectations from the region notwithstanding.

The 'Sugar War'

Future relations between South Africa and Swaziland will be shaped by two other issues: claims of lost territories by the latter and competition between the two countries' sugar industries. Pretoria has angered Swaziland by rejecting its longstanding claim for a substantial part of adjoining South African territory. Mpumalanga premier Matthews Phosa urged Swaziland to drop the border adjustment issue because South Africa has decided not to tamper with colonial boundaries.

The 'sugar war' between the two countries has resulted in sanctions being imposed on Swaziland by South Africa. This development is the product of a longstanding disagreement between the two countries over sugar trading. Unlike other commodities, the movement of sugar and sugar products across the Swaziland-South Africa border has been regulated by a separate agreement between the two countries.

The last agreement expired on April 30 1993, and no new deal could be reached on its further extension. Thereafter, the governments of the two countries asked their respective sugar associations to meet and work towards free trade in a relatively short period. The South African Sugar Association (SASA) wanted adjustment time to prepare for free trade. It demanded a 12 year period leading not to free trade but to Swaziland being allocated a 20% market share based on its share of total joint production.

The Swaziland Sugar Association (SSA) proposed a four year adjustment period leading to free trade in the fifth year. The SSA found SASA's position unacceptable, and went ahead with exporting to South Africa on an unrestricted basis.

South Africa responded by imposing sanctions on Swaziland by denying it access to: the sugar terminal at Durban harbour, new varieties and new strains of cane from the Mount Edgecombe Experimental Station north of Durban, the industrial training centre at Mount Edgecombe, and the Sugar Milling Research Institute in Durban.

The first of these sanctions takes effect as of April 1 1997, when the current agreement regarding Swaziland's use of the sugar terminal expires – the others have already been applied. In addition, SASA has ordered the refinery at Malelane in Mpumalanga province to stop refining Swaziland's brown sugar.

Sanctions will worsen Swaziland's already crisis ridden economy, where sugar accounts for 67% of agricultural production, 23% of GDP and 57% of foreign exchange earnings. This will be further exacerbated by South Africa's free trade agreement (FTA) currently being negotiated. A European Research Office study of the effect of a free trade agreement between the EU and SA on African countries, says that the FTA could profoundly jeopardise Swaziland's sugar industry, which exports nearly half of its sugar to South Africa.

Whither Swaziland?

In view of the above developments, it is worth asking the following questions about the government's current reform strategies:

- Are they a mere side show or a sign of potential movements towards a more democratic system?
- Do they suggest that the ongoing conflict which has marked Swaziland's politics since the early 1990s might by broken or that it will persist indefinitely?
- Are they aimed at bringing about democracy or disguising the control and power still wielded by the monarchy?

The proposition that the regime is currently pursuing a genuine reform process is not yet self evident. Over the past five years, the regime has been seen embarking on a non-stop process of setting up commissions, giving the world and the general populace the impression that something is being done to bring democracy to Swaziland.

Despite being responses to popular demands for political pluralism, the King's commissions have not accommodated views of political parties and progressive organisations. Instead, they have tried to wish political parties away, not only by ignoring them and their views, but also by vilifying them and calling them 'un-Swazi' and 'communist'.

The success or failure of the CRC will, among other things, be determined by the extent to which it comes to terms with the existence of competing political tendencies espousing a different political world view from that of the royalist establishment. If Swaziland is to be democratic and maintain stability, it must adapt its political institutions to ensure democratic governance, greater transparency, accountability and popular participation.

The country faces the challenges of striking an appropriate balance between competing thrusts of political culture. It is first necessary to eliminate barriers to popular participation in the reform process and recognise political parties and other organs of civil society as legitimate partners. Second, there is a need to cultivate partnerships and move towards political pluralism. This may require the regime to share power and political parties and their leaders to assume greater levels of responsibility.

Swaziland urgently requires a political system and culture that can resolve the intense conflicts of interest. The challenge for both the government and the banned opposition is to move towards the politics of consensus and common ground. To do this, the right forums with the right objectives need to be created.

Both parties need to participate actively in measures geared towards ensuring, among other things, a democratic system of governance, a vibrant civil society, a free press and a multi-party political system. Swaziland's future success and stability depends on the extent to which it comes to terms with the critical political and macro-economic choices it has to make. IPSA

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Sanctions will worsen Swaziland's already crisis ridden economy, where sugar accounts for 67% of agricultural production, 23% of GDP and 57% of foreign exchange earnings

Over the past five years, the regime has been seen embarking on a non-stop process of setting up commissions

Saving the System

Making Primary Health Care Work

By David Harrison
Director, Initiative for Sub-District Support, Health Systems Trust

Servicing primary health needs has been accepted as the foundation for health care. Progress towards this goal has mostly been good. While a commitment to primary health care favours the poor in the short term, it is the most logical long term survival strategy for both the public and private health sectors.

Providing primary health care (PHC) is seen by Government as the starting point for developing a system which addresses people's health needs – from the most basic to increasingly advanced forms of health care. The notion of PHC as the antithesis of sophisticated or specialised medical care is misguided: it is not a case of either PHC or sophisticated services, but the necessity of both.

The challenge for the government, academics and the private sector is to expand and improve primary level services while consolidating and sustaining South Africa's hospital infrastructure at all levels. This article puts forward the case for a PHC approach. The critical factors for implementation will be discussed and the progress to date, assessed.

Justifying primary care

There are four compelling reasons for improving and extending primary health care services in South Africa:

- From a human rights perspective: if equity is our goal, then meeting basic needs is a priority. In South Africa, African children under five years are eight times more likely to die than their white counterparts (Yach and Harrison 1994). Building more hospitals will not change this. Providing good, accessible primary health care will help to ease the 'burden of disease' from the most poor and vulnerable.

It is not a case of either primary health care or sophisticated services, but the necessity of both

- From the health perspective: infectious diseases, maternal and perinatal mortality represent an 'unfinished agenda' in which diseases of the poor persist, despite South Africa's relative wealth (Bradshaw and Buthelezi 1996).

- Together, perinatal causes, diarrhoea, acute respiratory infections, malnutrition, and tuberculosis account for 47,5% of potential years of life lost (PYLL) in people under 65 years of age (Bradshaw *et al* 1995). With the partial exception of perinatal problems, generally none of the above require sophisticated medical cure. But all require a systematic, comprehensive strategy of primary prevention and disease management.

- From the health service perspective: hospitals in South Africa face the twin dilemmas of having to care for people who should be treated at a lower level of care and having to manage more and more people with chronic diseases. The development of appropriate primary level services is crucial if higher level services are to run efficiently, both through better use of hospital services and greater prevention of chronic disease.

- From an economic perspective: treating predominantly post-transitional health problems like hypertension, ischaemic heart disease, cancer and strokes is becoming increasingly expensive. Costs of treatment in the private sector are spiralling, while the public health sector is forced to ration more severely (McIntyre 1995). Unless explicit

emphasis is placed on primary and secondary prevention strategies, medical care will become impossibly expensive and eat voraciously into the profits of industry.

So, while a commitment to primary health care does favour the poor in the short term, it represents the most logical long term survival strategy for both the public and private sectors.

Conditions for success

There are seven essential ingredients for effective primary health care delivery. These will be outlined and the progress towards putting these ingredients in place, assessed.

❑ Interaction with communities

A limited sense of community ownership may lead to inappropriate provision or use of health services. The conveyor belt approach of many health facilities often means that patients leave the health service with little understanding of their illness, and their own role in preventing or managing problems. This results in poor compliance and continued risk taking behaviour.

Deliberate processes of support need to be created to ensure community participation in the governance, management, provision and monitoring of health services. Non-government organisations involved in aspects of health care delivery need to be strengthened in their ability to manage, implement and evaluate their progress just as efforts are needed to strengthen public health services.

In general, creating effective relationships with community members and organisations has often been given the lowest priority by newly appointed and hard pressed health managers. In Mpumalanga and North West provinces, however, significant progress has been made in creating functional community and clinic committees.

In an innovative guide for district managers, Mpumalanga has outlined structures for community participation within districts and their respective functions (Mpumalanga Department of Health 1996). In the North West, certain districts have taken the lead in creating functional community and clinic committees (North West Department of Health 1996).

At national level, it is understood that the Health Act currently being drafted makes provision for mechanisms of community participation at national, district and facility level. The latter two mechanisms are likely to reflect those outlined in a national policy document on district development, but ironically, the draft Act is not yet available for public scrutiny (Owen 1995).

❑ Easy access to services

There are several facets to the accessibility of health services: physical accessibility remains a considerable problem especially in rural areas where many people live well outside the 10 km radii of health facilities. Approximately one third of Africans in rural areas travel more than one hour to reach their closest point of health care (CASE 1995).

In addition, language barriers, transport costs and poor organisation of services all constrain access. For example, many facilities only open during regular office hours, and provide services such as child health and family planning only on designated days.

The National Clinic Building Programme was one of the Reconstruction and Development Programme (RDP) Presidential lead projects. Since 1994, a total of 60 new clinics have been built and 47 existing clinics upgraded. The Department of Health projects that by the end of 1997, 301 new clinics will have been built and a 100 existing clinics improved (Doherty *et al* 1996). Given the rural and peri-urban location of most of these facilities, this undoubtedly constitutes significant progress towards greater accessibility for poor people.

The introduction of free health care in all primary level facilities has been criticised by many health workers as contributing to overutilisation of services, overcrowding and the low morale of personnel. However, an evaluation of the introduction of free care to pregnant women and children under six years demonstrated clear benefits.

For example, while there was a marked increase in attendance at almost all health

In Mpumalanga and North West provinces, significant progress has been made in creating functional community and clinic committees

Approximately one third of Africans in rural areas travel more than one hour to reach their closest point of health care

Since 1994, a total of 60 new clinics have been built and 47 existing clinics upgraded

Often health service users feel the brunt of unhappy working conditions and the low morale of health workers

facilities, the proportion of women who 'booked' for antenatal care increased, as did the number and proportion of referrals from clinics to higher levels of care (McCoy 1996). Nevertheless, it remains to be seen whether adequate provision will be made for this increased utilisation, or whether the effect in the medium or longer term may be to undermine the viability of service provision.

Facilities' hours of opening and organisational arrangements continue to constrain access. However, the MEC for Health in Mpumalanga, Candith Moshego, has announced that all primary facilities should remain open from 7h00 to 19h00. There is also evidence of slow but sure integration of preventive and curative services in many provinces.

❑ Well equipped personnel

The majority of health workers are based in urban areas and, with the exception of nurses, most work within the private sector

The adequacy of human resources relates not only to numbers of personnel, but also to their competence, range of skills, attitudes and systems of support (see Brookman Amissah in this issue). Adequate provision will also depend on the degree to which all health care providers – public, private, non-government and traditional – work together in addressing the health problems of their district.

Effective service provision relies on sound clinical, community outreach and administrative skills among health workers. Fragmentation of health services often meant that primary level personnel developed a limited range of skills, depending on whether they worked for provincial administrations or local authorities. Those working for the province generally learnt how to dispense medicines, while the duties of local authority employees were primarily preventative.

With service integration, personnel are expected to render a comprehensive, one-stop service. But improved delivery will not just happen. It will only be brought about by a sustained process of in-service support for local health workers which enables them to address and resolve problems – whether public health, clinical or logistical.

A feather in the cap of the Department of Health has been its efforts in ensuring management and primary health care training

But in addition to service related skills, health workers require continuing backup and support. Often health service users feel the brunt of unhappy working conditions and the low morale of health workers. One of the common complaints of health workers is a sense of isolation – of 'working in a vacuum'. Health workers need access to information to continue their education, understand policy decisions better, or seek advice or clarity. Personnel expenditure accounts for about two thirds of recurrent public sector health expenditure (McIntyre, Bloom *et al* 1995). It makes economic sense to invest effort in improving the quality of their service delivery.

The maldistribution of personnel needs to be tackled on three fronts. The majority of health workers are based in urban areas and, with the exception of nurses, most work within the private sector. In addition, the majority of health workers are based in hospitals (Mametja 1996).

Given the fact that there are over 200 000 nurses and more than 25 000 doctors in South Africa, it will take years to reverse these trends.

A number of options have been mooted or implemented, such as the introduction of foreign doctors as a stop-gap measure, vocational training for new graduates and contracting of accredited private general practitioners (see Begg and Bekker in this issue). The controversy surrounding these options is largely due to the fact that they have not been seen as part of a clear strategy.

A feather in the cap of the Department of Health has been its efforts in ensuring management and primary health care training. Decentralisation of health care and a greater commitment to PHC have necessitated new training initiatives nationwide. While some have been critical of the limited coordination of training efforts, the end result has been substantive skills development at lower levels of management and for primary health providers (Power and Robbins 1996).

❑ Physical and financial resources

Years of neglect have left a legacy of dilapidated services in parts of the country, particularly in some former 'homelands' (see Crisp in this issue). Restoring and developing services in these areas requires a multi-pronged strategy which includes physical renovation, but also decentralisation of management, better communication between head office and peripheral areas, and improved stock management systems (Eastern Cape Portfolio Committee Report 1995).

The success of the clinic building programme has already been discussed. Changes in the presentation of the budget between the 1995/6 and 1996/7 financial years make an evaluation of the shift towards primary care services difficult. The Department's commitment to strengthening PHC services is evidenced in the Medium Term Expenditure Framework, which recommends an annual real budgetary increase for PHC services of 9%, as opposed to real increases of 1,3%, 2,1% and 3% for academic, provincial and district hospitals respectively.

Sustaining support for hospital services, while developing PHC services, is recognised as important if hospitals are to keep up with the likely increase in demand for referral services. At present, roughly the same amount is being spent in the public sector on academic hospitals and primary care services.

Given the need to maintain the hospital infrastructure, it is unlikely that much funding for PHC will be liberated from within the health sector. The National Portfolio Committee on Health has recommended an additional R1,96 billion for PHC services in 1997/8 from sources outside of the present health budget (Makan *et al* 1996).

One of the most important aspects of health reform was the introduction of the South African Drugs Action Programme (SADAP), aimed at improving the supply of pharmaceuticals in the public sector and regulating the cost of medicines in the private sector.

An essential element of SADAP is the introduction of an essential drugs list of about 300 medicines, which will serve as the basic stock in all public sector primary care facilities. Although too early to assess impact, this list should improve the distribution and availability of essential medicines – provided that it is accompanied by a programme of training in rational drug use and stock management (*HST Update*, April 1996).

❑ Management

Improved PHC delivery depends on more efficient organisational and management systems at the site of delivery as well as between service delivery sites and the district office.

Within primary level facilities there is still often little prioritisation or triage of patients resulting, for example, in critically ill children waiting for hours in queues.

In many facilities, preventive and curative services are still rendered separately, and health worker skills are inappropriately used. Administrative procedures are cumbersome, and the volumes of paperwork completed by health workers have little meaning.

The main vehicle through which Government hopes to dramatically improve the primary health care system is the health district. Decentralised systems of information, financial and pharmaceutical management are to be created to support local health care delivery. In most provinces, district structures which will facilitate PHC are beginning to take shape. Boundaries have been delineated, district managers are being appointed, and different administrative authorities are being integrated (*HST Update,* July 1996).

There is little evidence yet of improved organisational and management systems, either at district or facility level. But fairness dictates that judgement be reserved until new managers have had an opportunity to develop district systems better. The energy with which many provincial administrations are seeking to implement district based care is in itself encouraging, and a far cry from the air of stagnation which previously wafted over public health services.

There are one or two provinces, like KwaZulu-Natal and the Western Cape, which have not kept pace with the others in district development. Time will tell whether the peculiar constraints facing these provinces can be satisfactorily overcome.

❑ Communication

Poor communication, particularly in rural areas, is a major cause of frustration and isolation for health workers. A simple, yet reliable means of communication is crucial for improving health care delivery.

Electronic mail now provides an opportunity to improve communication

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The Health Systems Trust has introduced a store-and-forward e-mail system in over 500 sites in Northern Province, Free State, Eastern Cape and KwaZulu-Natal

channels between health workers and supervisors, among health workers themselves, between the public and private sector, and between health and other sectors.

In conjunction with the Department of Health, the Health Systems Trust has introduced a store-and-forward e-mail system in over 500 sites in Northern Province, Free State, Eastern Cape and KwaZulu-Natal.

The emphasis is on developing *HealthLink* as an instrument for health service management, communication and information support for health personnel. Although exciting uses have been developed, much of *HealthLink*'s potential has yet to be realised through a triple strategy of technical support and training, applications development, and nurturing the use of computers and electronic mail among health workers.

❑ Partnerships

Although intersectoral collaboration is an explicit strategy of district systems development, there is little real evidence of its application

At present, most primary health facilities are geared towards dealing with the immediate health problem which presents at the door. There is little assessment of the degree to which health services are responding to health problems and little effort to develop a joint response with other sectors. The management of acute diarrhoeal disease in children, usually caused by contaminated water, is a case in point.

Although intersectoral collaboration is an explicit strategy of district systems development, there is little real evidence of its application. In provinces in which health and welfare are combined under a single department (all except Gauteng and KwaZulu-Natal), collaboration within districts has been facilitated to a greater degree. However, management structures are still in a state of flux and in fact, Free State has recently separated health and welfare functions.

The ultimate intention of delegating all district health functions to local authorities may encourage joint planning among service sectors. At present, almost all provinces have opted to retain district responsibility, and it is difficult to see them relinquishing this further down the line.

The bottom line

The Government's emphasis on primary health care makes humanitarian, health, health service and economic sense. The factors critical to the successful extension and improvement of health care delivery go way beyond simply ensuring that there are enough clinics, enough nurses, and enough drugs.

The Health Department's greatest shortcoming probably lies in its failure to present a systematic and concrete plan for addressing the skewed distribution of health workers towards urban areas, the private sector and higher level hospitals. Its greatest achievement must be the fact that it has pointed the juggernaut of health care toward district based services, and that the creaking wheels of government are gaining ever increasing momentum towards that goal. PSM

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South African Health Review 1996 has been heralded as the most comprehensive collation of health information in South Africa. It is published jointly by the Health Systems Trust and the Henry J Kaiser Foundation (USA). It may be obtained from: Health System Trust,
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Policy At A Price

Primary Health Care Dilemmas

By Ivan McCusker
Chairman, Health Policy Committee
Medical Association of South Africa (MASA)

There is agreement that primary health care is essential for meeting the health needs of many South Africans who have been deprived in the past. But a good policy is not enough. The creation of an effective system is being threatened by inefficient recruitment of health care workers, questionable budgetary allocations, and the Ministry of Health's alienation of doctors, particularly in the private sector.

Extreme poverty has a significant negative impact on the health of large sectors of the South African community. The provision of safe drinking water, environmentally safe sanitation, an adequate diet, secure housing, basic education and income generating opportunities, however, fall outside the scope and budget of the Department of Health.

Access to, and the provision of, adequate health care should be an urgent priority of health authorities. And while our national conscience dictates our responsibility to provide health care to the indigent and to achieve equity in the delivery of health services – the budget imposes restraint.

Hospital based medicine

Arguing why primary health care services should be extended and improved, Harris (in this issue) points out that diseases of the poor persist despite South Africa's relative wealth, which generally do not require sophisticated medical cure. In addition, developing appropriate primary level services is crucial if higher level services are to run efficiently.

It is, however, important to accept that primary health care will prevent some disease but identify other that require treatment at primary, secondary or tertiary levels and would require additional expenditure. There should be no reduction in funding or staffing of hospital based medicine until and unless the system of primary health care reduces the number of people requiring these services. Tertiary hospital services should not be restricted until secondary hospitals are functioning efficiently.

In practical terms, bureaucracy must not be allowed to outstrip in number or relative costs, the provision of trained health care workers accessible to the population. While the building of clinics is indeed required, the essential basic unit is the health care worker with an adequate supply of materials from essential drug lists and access to an efficient upward referral system in the health care hierarchy where indicated.

In terms of the cost implications, the Medical Association of South Africa (MASA) also has no objection to primary care being free to everyone in the country,

While the building of clinics is indeed required, the essential basic unit is the health care worker

As yet, there is no structured incentive programme in place to attract doctors to the rural primary care system

provided that the private health sector remains as an alternative to those who can afford and wish to utilise it.

Recruitment of workers

Several other problems are important to consider in this debate. Recruitment of health care workers is inefficient. The government cannot blame health care workers for lack of cooperation and for being maldistributed throughout the country when there is no advertising campaign for vacant post which are available and coupled to finance for salaries, drugs and equipment.

In respect of medical practitioners, the *South African Medical Journal* is sent to all identifiable practising doctors and not just to members of MASA. It is therefore the logical place for doctors to seek employment opportunities. The cost of reaching 18 000 doctors is less than 25% of the equivalent space in the largest national Sunday newspaper, excluding a 50% special discount in the rural appointments column.

The budget estimates in respect of primary health care are probably too low

An investigation of issues in 1996 reveals that of the job or career related advertisements, 51% related to overseas placements, 36% to opportunities outside the government sector in South Africa, 8% to urban academic appointments in the public sector and only 2% could be related to primary health care employment opportunities.

The contribution of doctors on a part time and solo basis are an essential and logical component to provide services in inaccessible areas and should be nurtured and expanded, not restricted as proposed in the policy documents of the Department of Health. Importing foreign doctors is probably not cost effective and avoiding loss of doctors trained within this country would achieve more in improving our national health.

Coupled to primary health care planning, the Ministry of Health needs to retain and regain the loyalty of alienated and emigrated doctors

As yet, there is no structured incentive programme in place to attract doctors to the rural primary care system, other than a R19 000,00 annual allowance allocated to hospital doctors in the most remote and inhospitable areas.

Budgetary problems

The budget estimates in respect of primary health care are probably too low. This should not be allowed to derail the programme or be used as a basis of criticism. The whole primary health care system cannot be created in a single financial year and the country is involved in a learning process. Further expansion may well dictate additional allocation of finance. Experience will assist in utilising funds effectively.

Proposals whereby taxation initiatives can reside within the Department of Health should be resisted as they would remove the financial control of the national budget from the fiscus and place it within the grasp of the Ministry of Health. Central control and a visible and fair distribution between all departments is an essential component of equitable government management. Irresponsible or inefficient departments may then be effectively controlled.

The loss of tax abatements in respect of medical aid contributions and health care expenditure seem negative as the more people who avail themselves of alternative services, the less the load would be on the Department of Health.

Public before private

The Ministry needs to concentrate on improving the provision of health in the public sector to reach standards adequate and acceptable for South Africa's mixed and emerging economy, before allowing its efforts to stray into the private sector which results in the further alienation of health care workers.

The gap in health care provision needs to be narrowed by improving care to the indigent, not restricting care to the insured or wealthy segments of the population to disguise the inadequacy of the public sector. The fact that managed health care initiatives may allow more people access to the private sector should ease the load of people dependent entirely on a very restricted national health budget (see Tuft in this issue).

Coupled to primary health care planning, the Ministry of Health needs to retain and regain the loyalty of alienated and emigrated doctors. Inefficiency and delays in implementing revised salary scales and even longer delays and confusion in respect of overtime remuneration, coupled with the perceived and unjustified and restrictions proposed on dispensing by doctors and the imposition of compulsory community service under the guise of vocational training, do little to bolster the image of a department. All attempts should be aimed at cooperation between the various sectors to ensure better overall community health. DPBA

1995/1996 AND 1996/1997 BUDGETS AND PROVINCIAL ALLOCATIONS

Provinces	1995/1996 (thousand Rands)	% of Total	1995/1996 Per Capita Public Sector Health Care Budget (Rands)	1996/1997 (thousand Rands)	% of Total	1996/1997 Per Capita Public Sector Health Care Budget (Rands)
Eastern Cape	1 974 219	12.79	301	2 502 666	14.55	366
Northern Cape	262 306	1.70	366	289 176	1.68	376
Western Cape	1 893 317	12.26	513	2 120 160	12.33	576
KwaZulu-Natal	2 907 793	18.84	334	3 130 742	18.20	356
Free State	1 060 189	6.87	383	1 230 879	7.16	432
Mpumalanga	604 707	3.92	203	783 590	4.56	268
Northern Province	1 444 376	9.36	271	1 594 712	9.27	300
North West	917 737	5.94	271	1 109 637	6.45	307
Gauteng	3 241 925	21.00	458	3 726 193	21.66	537
Sub-total	14 306 569	92.67	-	16 487 755	95.86	-
National	1 131 103	7.33	-	711 699	4.14	-
Total	**15 437 672**	**100.0**	**347**	**17 199 454**	**100.0**	**421**

Note: Some sources have used preliminary budget estimates which may account for slight differences in provincial allocations

Source: *South African Health Review* 1996, published jointly by the Health Systems Trust and the Henry J Kaiser Family Foundation, October 1996

The Health Business

Assessing Managed Health Care

By Richard Tuft
Chair, Private Practice Committee
Medical Association of South Africa

Managed health care should reduce costs without compromising quality, but the medical profession is resisting. One contentious area involves the review of doctor's decisions about how to treat their patients. Opposing managed care with knee jerk responses will leave the health system in a funding wilderness. Alternative funding methods may be less palatable to the private sector.

Managed care, simply defined, is the application of business principles to the provision of health care. Why then does the mere mention of it threaten and polarise the medical profession? Does South Africa need managed care and will it benefit either doctors or their patients? Is managed care just a method of cutting the cost of care, compromising quality and boosting the profits of health care insurers, or can it really reduce cost and enhance quality? Can managed care reduce cost, improve access and improve the quality of health care in South Africa? To answer these questions the problem and the proposed solution need to be analysed.

Health care policy must be targeted to understand doctor's behaviour and to provide incentives to modify this behaviour to achieve policy

Spiraling costs

South Africa's private health care industry is in a parlous state. The cost of health care is spiraling upwards and the increase in medical aid subscriptions regularly exceeds the CPI. Patients and employers are reeling under the financial strain and the medical profession is seeing a real drop in its income.

Approximately R30 billion or 8,5% of South Africa's Gross National Product (GNP), is spent on health care annually. The private sector absorbs 61% of this but only provides health care to 22% of the population. In the private sector there is an abnormally high percentage spend on pharmaceuticals: 32% in South Africa, compared to only 8% in the United States of America.

The spend on doctors in South Africa is only 25% of the total, but it is accepted that doctors decisions are directly responsible for more than 70% of health spending. Health care policy must be targeted to understand doctor's behaviour and to provide incentives to modify this behaviour to achieve policy goals.

Total health care costs are simply the product of unit price and volume. Both these components have increased. The price of medical services has for the private medical and hospital industry been controlled by the Representative Association of Medical Schemes (RAMS) – a statutory body until 1994. RAMS issues an annual scale of benefits, which it is at great pains to point out, is a benefit and not a fee.

However, since a guarantee of direct payment has been linked to the charging of the scale of benefits, the distinction is in many cases academic, with the medical profession being forced to charge the scale of benefits to ensure reasonable cash flow. The scale of benefits have lagged behind inflation and are approximately 50% below

the recommended fees of the Medical Association of South Africa (MASA). There is enormous patient resistance to the charging of any fee above the scale of benefits.

Medical aid system

There is different legislation for the medical schemes and the insurance industry. Since deregulation, the insurance industry has been able to offer risk based cover at lower premiums to the young and healthy. The medical aid industry has provided cover on a community rating with cross subsidisation of the sick and old by the young and healthy.

The lower premiums offered by the insurance industry have left the medical aids with the older and higher cost patients. The medical aid industry is financially unsound, largely funding claims out of current income, with virtually no pre-funding. It has been estimated that the industry has an actuarial deficit of R30 billion with reserves of only R1 billion.

Until recently, the medical aid industry has had no incentive to control costs. The medical aid administrators collect their fees in relation to turnover in the schemes. Vast profits have been made by the administrators. At the same time there has been no expenditure on the information systems needed to identify and control the cost drivers in the system. There has been neither the will nor the ability to control the volumes, and systems are not available to monitor and control fraud and abuse.

For doctors and private hospitals, the payment mechanism has been the major cost driver. There are several payment mechanisms in managed care which will be discussed later. In conventional indemnity insurance (medical aid cover), there is only one significant method of payment: fee for service. This is the best possible payment method for the profession and private hospitals – rather like having a book full of blank cheques.

The doctor or hospital decides which procedure is necessary and gets paid for it without any checks or controls or clinical audit. The account is submitted to the medical aid and if the coding is correct, the account is paid. The system works well in the majority of cases, but is wide open to manipulation and abuse. There is no assessment of the quality of the care, its appropriateness and the clinical outcome. The doctor's clinical judgement and decision making processes are rarely challenged.

From the patient's point of view the existing system, if affordable, is also ideal. The patient can choose his or her own doctor and all the treatment is paid for. A culture of 'free' health care has thus developed and in some cases benefits are used purely because they are available.

There has been no control of the perverse incentives provided by doctor ownership of health facilities and diagnostic modalities and the ability to dispense for profit. Doctor ownership of health facilities, in itself, is acceptable as long as it does not effect the admitting behaviour of it shareholders.

Managed health care

Managed care uses new terminology: anybody who provides a service such as doctors or hospitals, become 'service providers' and those who pay for the service are 'funders'. Managed care attempts to cut costs by controlling access to and use of health facilities without compromising the quality of care. It does this by several mechanisms: accreditation of service providers and health facilities, pre-authorisation of procedures and hospital admissions and physician profiling.

There may be built in disincentives to use services in the form of deductibles, where a patient pays for treatment up to a specified limit and the funder pays once this limit has been reached. The funder may also require a fixed co-payment for each item of service. Both deductibles and co-payments have been shown to reduce service volumes in the USA managed care environment.

Managed care uses different payment mechanisms which include: conventional fee for service, discounted fee for service, per diem rates, and payment for diagnostic related groups of procedures and capitation. Capitation is a payment method where the doctor or hospital is paid a fixed monthly amount in advance per patient under or potentially under his care. There is a progressive transfer of risk from the

The medical aid system works well in the majority of cases, but is wide open to manipulation and abuse

A culture of 'free' health care has developed and in some cases benefits are used purely because they are available

Managed care attempts to cut costs by controlling access to and use of health facilities without compromising the quality of care

Data and 'covered lives' will become the most important tradeable currencies in health care

funder to the service provider (doctor) in these payment methods. The service provider carries no risk with fee for service payments, but all the risk with capitation.

The gathering of data and turning it into useful information is also a cornerstone of managed health care. Data and 'covered lives' will become the most important tradeable currencies in health care. This is one of major differences between the conventional indemnity funders (medical aids) and the new emerging managed care organisations.

The medical aids have not invested in the information systems to allow them to collect, collate and use data, while the new managed care funders are investing millions of rands in computer systems. Access to information may require a breach of the traditional confidentiality between doctor and patient.

There is a huge information inequality between the doctor and his patient, and doctors have far more market influence than sellers of most other goods and services

Managed care tends to limit the providers who are able to offer services to patients. Networks of doctors and hospitals are formed and the patients are only allowed to seek medical services within the network. Patients are of course allowed to seek health care wherever they wish, but benefits are usually limited if care is sought outside the network. This necessitates a contractual relationship between patients and the doctor or hospital. The contract may be between an individual provider or a group of providers in a formal structure, or a group of providers in a group practice.

Doctor resistance

Given the stated aim of managed care to reduce the cost of health care without compromising access or quality, why is there such resistance from the medical profession? It does not appear to be the quantum of the fees offered, which for most disciplines are higher than the current scale of benefits offered by the medical aids. The contentious areas are having to sign a contract, access to patient's confidential records, pre-authorisation and utilisation review which implies that the doctor may not be the best judge of the correct treatment for his patient.

There is significant resistance by doctors to having to request authorisation of procedures from lesser qualified health care workers

The most important difference between health care and other industries is that there is a huge information inequality between the doctor and his patient, and doctors have far more market influence than sellers of most other goods and services. In other words, patients are in most cases unable to assess the quality of, or the necessity for, treatment given.

Also of importance is that the medical profession is conservative and generally resistant to change. Doctors are used to independent thought and are not trained to expect their clinical decisions to be questioned. Furthermore, doctors are not usually managers. There is no constant relationship between the cost of treatment and the beneficial outcome of treatment.

Utilisation review – which includes certifying cases before they can be admitted to hospital, or both specialist referrals and hospital admissions, and physician profiling which tracks the practice patterns of individual doctors – is perceived as a threat to the clinical independence of doctors and a source of increased administrative burden.

There is significant resistance to having to request authorisation of procedures from lesser qualified health care workers employed by the managed care companies. But it should be remembered that the authorising nurses are using protocols designed by the practitioners peers and ideally approved by the doctor's own professional group or association. It may be a bitter pill for the profession to swallow, but it will only encourage good practice through clinical audit and outcome measurement.

The old adage in the computer industry of 'junk in, junk out' applies to medical data and information systems. A new procedural coding system, CPT4 owned and published by the American Medical Association, will be introduced as the standard coding system. The Medical Association of South Africa (MASA) has negotiated the right to publish a South African Compendium to CPT4 in which the codes will be modified for South African conditions. A diagnostic coding system, ICD10 will be introduced at the same time. These two coding systems will link the medical diagnosis and the treatment – a vital link missing at the moment and essential to profile physicians.

Contracts

Contracts are an important part of any business arrangement. MASA has accepted that managed care will form an important part of health care funding in South Africa.

The Association has commissioned American legal experts, with verifiable expertise in the field of managed care contracting, to produce a *pro forma* managed care contract for the South African environment.

After extensive negotiations with Southern HealthCare JV and Sanlam Health – the first two funders in the market – the initial contracts presented by these organisations have been extensively modified and approved by MASA as generic managed care contracts. The decision whether or not to sign the contracts has been passed down to the individual doctor advised by his or her specialist or special interest group.

This signifies an important trend. In the past it has not been possible to negotiate satisfactory reimbursement from the medical aids and hence the large discrepancy between the scale of benefits and the MASA fee. The failure was due to the difficulty of one organisation being able to negotiate globally for widely different general practice and specialist interests, and the inability of the medical aids to control costs to allow adequate funding for professional benefits.

MASA's role will change and move away from financial negotiations. These will be done by the specialist groups, special interest groups and the professional management companies, increasingly on a regional rather than a national basis. MASA will have an important role in controlling the coding system and bench marking the tariffs, and will coordinate and publish treatment protocols and guidelines.

Out-patient treatment

With the introduction of managed care the role of the hospital will change, becoming a place for treating the very sick. There will be a move to out-patient treatment and minimally invasive and out-patient surgical procedures. Rehabilitation and post acute centres will be increasingly used and there will be a marked reduction in the 'bed days' seen in the insured population. Hospital groups who have national coverage and are able to discount their rates and negotiate fixed fees will survive. Smaller hospitals, including many doctor owned hospitals, may not.

Tariff negotiations on a regional level will be done by the new doctor groupings and vertical and horizontal integration of general practitioner and specialist groups in group practices. The demise of some of the existing medical aid schemes will almost certainly follow. The profit motive will also be taken out of dispensing and more doctors will become employees.

Managed health care is needed in South Africa. There are, however, certain provisos: there must be a demonstrable effect on outcome and quality of care and a high percentage of the premium income must go to health care. Managed health care needs good doctors. South Africa, unlike the USA, does not have an oversupply of doctors and good doctors will have to be paid well for their services. The challenge for the profession is to work with the new funders to provide good products and broaden access to private health care for the benefit of the profession and their patients.

Change is difficult. The success of the higher income managed schemes will encourage the development of new products to benefit the presently uninsured. Opposing managed care with knee jerk responses will leave the health system in a funding wilderness and may facilitate the introduction of alternative methods of funding health care which may be less palatable to the private sector.

The role of the hospital will change, becoming a place for treating the very sick

The profit motive will also be taken out of dispensing and more doctors will become employees

INDUSTRIAL MONITOR

ALLOCATION OF 1995/96 HEALTH BUDGET ACCORDING TO SERVICE CATEGORY (THOUSAND RANDS)

Service Category	Current	Capital	Total	% of Total
Nurse training	165 047	5 412	170 459	1.06
Academic hospitals	4 240 098	19 785	4 437 883	27.52
Regional hospitals	1 856 481	113 532	1 970 013	12.22
Community hospitals	3 403 445	194 637	3 598 082	22.32
PHC (Personal)	2 261 503	167 056	2 428 559	15.06
PHC (Non personal)	586 847	12 897	599 744	3.72
Psychiatric hospitals	575 184	23 233	598 417	3.71
TB hospitals	403 318	14 378	417 696	2.59
Emergency services	422 149	53 540	475 689	2.95
Administration	1 221 795	205 527	1 427 322	8.85
Total	**15 135 867**	**987 997**	**16 123 864**	**100.00**

Note: The totals differ slightly from those presented in the Table on the Economic Monitor cover due to the inclusion of RDP allocations in this Table and other small adjustments. These totals differ from those in the Portfolio Committee's report due to errors identified in the source document's calculation of totals.

Source: *South African Health Review 1996*, published by the Health Systems Trust and the Henry J Kaiser Family Foundation, October 1996

Examining the Doctors

By Oliver Ransome, Medical Ombudsman

Complaints about medical treatment can now be directed to the recently established medical ombudsman. While the ombudsman has limited powers, the position is filling an important need. During the first six months of operation, the overwhelming impression was that patients were not well informed by their doctors.

The only power afforded to the ombudsman is that of negotiation

In an enlightened move, the Medical Association of South Africa (MASA) established a national medical ombudsman in March 1996. The increasingly sophisticated and costly modes of investigation and treatment of disease, together with the political emancipation of the country in 1994, made it inevitable that people would increasingly question the service provided for them by their doctors. Furthermore, South Africa is hopefully moving into an era of transparency and accountability, and there is no reason why the medical profession should be exempt.

The South African Medical and Dental Council – now known as the Interim National Medical and Dental Council (INMDC) – has been available to investigate complaints about doctors from the public for many years. However, largely because of the nature of its statutory obligations, the SAMDC has not been perceived as 'user friendly'.

The problems with both peer review and the INMDC is that both these avenues are perceived by the public to be dominated by doctors who 'look after their own'

It is also unfortunately true that the public's regard for the medical profession has declined over the last few decades – the reasons for this are merely speculative. Hopefully the efforts of the ombudsman, with the resulting increased transparency and attention to consumer demands, will help to reverse this trend.

Method of operation

The ombudsman is almost universally accessible by means of a toll free telephone number. The only power afforded this position is that of negotiation and it is therefore important that all concerned are convinced that the ombudsman has carefully listened to (or read) what the complainant has said (or written). The story is then paraphrased back to the complainant to ensure that no important details have been left out.

The next step is to contact the doctor to convey the complainant's perception of the problem and to obtain his or her version of the events. Having heard this, a conclusion must be reached about how to proceed and to convey this to the complainant. The vast majority of complainants are dealt with over the telephone; a small number through the post and a minority via fax transmission.

Possible outcomes

Contacting the ombudsman presents a limited number of possible outcomes:

- ❑ Reconciliation between the complainant and the respondent.
- ❑ Realisation on the part of the complainant that he or she does not have a valid complaint.
- ❑ Referral to the local Branch Council of MASA for peer review.
- ❑ To lay a complaint before the INMDC.
- ❑ Litigation through the courts.

The problems with both peer review and the INMDC is that both these avenues are perceived by the public to be dominated by

doctors who 'look after their own'. The costs involved virtually exclude the vast majority of the population from going the litigation route, which is made more difficult by the fact that doctors are often unwilling to take the stand as expert witness against a colleague.

Findings

In the first six months, approximately 1 000 telephone calls were made and received per month; 750 calls were entered into a computerised database and many more were taken that were inappropriate to computerise.

It was difficult to define accurately and compartmentalise the problems raised by complainants and there was, as a result, a good deal of overlap. Table 1, however, provides an idea of the issues which were brought to the ombudsman's attention. It must be emphasised that these problems were classified according to the complainant's perception and not the final outcome.

It is worrying that the service does not appear to be meeting the needs of those who prefer to communicate in an African language. It is estimated that less than 10% of the complainants were black. The ombudsman's task was also made more difficult by not being fluent in an African language. Clearly, this is an area which must be urgently addressed.

Table 1: Problems encountered as perceived by complainants

Problems	Number
Negligence	144
Fees and costs of treatment	127
Communication with the doctor	46
Mal-practice	46
Medical aid claims	44
Incompetence	40
Unsatisfactory medical result	40
Provincial hospital /clinic	39
Attitude of the doctor	36
Private hospital / clinic	26
Incorrect certification	25
Delay in filling out forms	18
Unprofessional conduct	12
Information only	11
Medical insurance	7
Fraud	5
Reception attitude	5
Workmen's compensation	5
Appointments, e.g. not keeping	3
Prison health	3
Racism	1

Table 2: Outcomes

Outcomes	Number
Complainant convinced that they had no case	440
Successful mediation (fees/medical aid)	94
Referred to INMDC	67
Referred for MASA branch peer review	55
Suggested litigations	38
Referred to provincial health authority	25
Negotiated with medical aid society	20
Referred to RAMS*	6
Reconciliation	2

It was similarly difficult to categorise the precise outcome in every instance. Table 2, however, provides a reasonably accurate picture of the outcomes.

As could be expected, the vast majority of complainants were from the densely populated Southern Gauteng and Western Cape areas (234 and 116 respectively), with smaller numbers from Northern Gauteng (95), KwaZulu-Natal (62), Eastern Gauteng (39), Tygerberg-Boland (30) and very small numbers from the rest of the country.

The vast majority of complainants thus far have been members of the public who heard about the service through the media or the various Help Lines. Significant numbers have, however, also been referred by the INMDC and the various medical aid societies. A small number of queries also came from the private hospital sector.

The INMDC has referred complainants because it realised that the ombudsman has the ability to deal with, and usually finalise, complaints with a minimum of formality. The INMDC is statutorily obliged to follow a lengthy procedure of about two and a half years. It would be interesting to quantify the trend in the number of formal complaints laid before the INMDC since the inception of the ombudsman's position.

Very few doctors have reacted aggressively to telephone calls from the ombudsman. The vast majority have realised the advantages of an informed, impartial person mediating between them

In the first six months, approximately 1 000 telephone calls were made and received per month

It is estimated that less than 10% of the complainants were black

The vast majority of complainants were from the densely populated Southern Gauteng and Western Cape areas

Many members of the public expect all interventions to be successful and regarded failure as negligence

and an aggrieved patient and that success in this process will probably save them from having to explain their actions formally to the INMDC.

The establishment of an ombudsman was initially a pilot project for which MASA carries the entire funding. MASA is in turn primarily funded by the subscriptions of its members. Currently about 13 000 medical practitioners of a total of 21 000 practising doctors (excluding interns) are members of MASA. It is unfair that the burden of funding should be restricted solely to the Association and since the public are benefiting primarily from the service, the state – probably the Department of Health, the INMDC and the other stake-holders – should make significant contributions.

Perceived negligence

There is no doubt that the establishment of the ombudsman has filled an enormous need in South Africa as judged by the response of the public. In many instances all that was necessary was to allow the complainant unlimited time to tell their story, after which it was almost unnecessary to explain, for instance, that perceived negligence was in fact an unforeseeable and unavoidable complication of an intervention.

Many members of the public expect all interventions to be successful and regarded failure as negligence. It was frequently necessary to define negligence as the failure to act in the way that anyone else with similar training and experience would have acted under similar circumstances, and that this would have to be proved before a case against a doctor would succeed.

Although it must be emphasised that the number of respondent doctors represents a small percentage of the total number of doctors in the country, the overwhelming impression was that patients were often not fully informed. This lack of information ranged from details concerning the illness and planned intervention, to fees and expected costs of treatment. On several occasions medical aid societies were also guilty of failing to inform their members of rules or rule changes, often resulting in successful mediation on their behalf.

Lack of information ranged from details concerning the illness and planned intervention, to fees and expected costs of treatment

The numbers of the various disciplines involved (Table 3) reflects firstly the relative number of practitioners in that field – specialists constitute approximately 24% of doctors – as well as the risk of the discipline involved. Thus the number of complaints involving Obstetrics and Orthopaedics are relatively high because of the high risks in these fields.

The very small numbers of cases (2) where reconciliation was effected (Table 2) was due to the fact that once a patient decides to

Table 3: Disciplines involved

Discipline	Number	Comment
General practice	173	
General surgery	61	
Obstetrics & Gynaecology	58	
Orthopaedics	56	
Anaesthetics	34	
Internal medicine	27	Includes Cardiology, Gastro-enterology
Neurosurgery	22	
Ophthalmology	19	
Psychiatry	16	
Neurology	12	
Radiology	11	
Ear, Nose, Throat	10	
Paediatrics	9	
Urology	8	
Dermatology	7	
Pathology	7	
Oncology	4	
Thoracic surgery	4	
Traditional healer	3	Includes one Chiropractor
Maxillo-facial surgery	2	Usually goes to the Dental Ombudsman

It is important to foster a culture where neither patients nor doctors are threatened by dealing with perceived problems with quality

report his or her doctor to a third party, the doctor-patient relationship has invariably broken down irretrievably. Most people intuitively realise that this relationship is, of itself, therapeutic. It is important to foster a culture where neither patients nor doctors are threatened by dealing with perceived problems with quality.

With a few exceptions, correspondence with provincial health authorities was unrewarding – either unanswered or very defensive. It certainly appears that the new ethos of transparency and accountability has yet to take hold in these quarters. This is distressing in that the many of complaints about provincial health services involved indigent people with no access to expensive legal help.

Rights and obligations

There needs to be a concerted campaign to inform the public of their rights concerning medical management. In a nutshell, these are:

- The right of access to efficient, informed and well trained health care deliveries.
- The right to information concerning all aspects of the problem that has been raised, including the grounds for making a diagnosis, the rationale for special investigations, the prognosis, the rationale, details, expected success rate and risks of suggested interventions and the costs involved.

Finally, and probably most importantly, patients have the right to expect empathy.

Rights always carry responsibilities. These are that the patient should: be completely open and frank with his or her doctor; be compliant concerning medication, diet, habit modification etc.; and realise that the doctor must be paid for his or her services.

The obstacles mentioned above, raised by imperfections of the INMDC and MASA Peer Review system and the inhibitive costs of litigation, may be alleviated in the near future. The implementation of Consumer Affairs (Harmful Business Practices) Bills by the Provincial Legislatures, recently enacted in Gauteng and, no doubt, soon to be enacted in the other Provinces, should put justice within the reach of all citizens.

Clearly, the Consumer Protectors created by these Bills will have to draw up a *modus operandi* with the professions in order to tap their expertise. A significant advantage, in terms of consumer satisfaction, will be the presence of lay people on reviewing boards. Hopefully MASA will manage to be pro-active in this respect.

The medical ombudsman is undoubtedly filling an important need. This function, however, needs to be expanded and the appointment of at least one associate to the ombudsman fluent in a widely spoken African language is an urgent necessity. The question of powers of investigation also needs to be addressed and the cooperation between the ombudsman and the Consumer Protectors will also have to be defined. Funding of the operation will have to be addressed to secure a firm footing for the future.

With a few exceptions, correspondence with provincial health authorities was unrewarding

The implementation of Consumer Affairs Bills by the Provincial Legislatures, should put justice within the reach of all citizens

The Medical Ombudsman's toll free number is: 0800 119 820

Healing An Industry

The Mine Health And Safety Act

By Fleur Plimmer, Health and Safety Coordinator
National Union of Mineworkers

The South African mining industry is at a turning point. Under the new Mine Health and Safety Act the management of health and safety has become essential for any business plan. Managers are required to proactively prevent accidents and ill health in the workplace – an important element of which is improved worker training.

The Mine Health and Safety Act is in the process of being promulgated and implemented. It is the product of both extensive and intensive tripartite negotiations: the Government, represented by the Department of Minerals and Energy, the employers and labour have jointly produced a quality piece of legislation which, if implemented and enforced properly, should introduce a positive trend in the health and safety record of the mining industry.

The new Mine Health and Safety Act is also a product of the history of the mining industry. In its darkest days, the mining industry was essential to the apartheid government – it represented the microcosm of all that was bad about apartheid.

In its darkest days, the mining industry represented the microcosm of all that was bad about apartheid

A decade's progress

An historical analogy between the 1986 Kinross gold mine disaster and the 1995 Vaal Reefs gold mine disaster highlights how far the mining industry has had to travel. In September 1986, 177 mineworkers lost their lives as a result of an underground fire at the Gencor owned Kinross gold mine in Evander. The fire was a result of polyurethane burning and the deaths were due to asphyxiation from the fire's noxious thick gas.

The majority union in the mining industry, the National Union of Mineworkers (NUM) was excluded from the investigation into the accident. At the government led accident inquiry, the union was not considered an interested party and was therefore not allowed to cross examine witnesses. This was despite many of the deceased being members of the union. NUM eventually had to take the Government Mining Engineer to the Supreme Court to win the right to act as an interested party.

The bodies of the dead black mineworkers were sent to the 'blacks only' mortuaries around Evander. The mortuaries were ill equipped to deal with the quantity and as the ultimate degradation, the bodies were piled on top of each other outside the buildings in the sun. Due to a lack of medical equipment, bolt-cutters had to be used to cut open the corpses. The thousands of mineworkers who attended the memorial service were taking part in an illegal gathering and the apartheid government sent tanks and riot police lest the mourning mineworkers riot.

The dangers of using polyurethane underground were well known in mining industries around the world. Both the United Kingdom and America had banned the use of the substance on mines in the mid to late sixties following several accidents and many fatalities. The Chamber of Mines of South Africa has always had strong links with the international mining community and knew of the banning. Yet the South African

mining industry continued to use the deadly substance which kept water chilled in insulated pipes underground.

A plate-welder who was eventually blamed for causing the accident and found guilty of contravening regulations, received a fine of R200. That valued the life of each dead mineworker at less than one rand. The company was not found negligent, and by the time the use of polyurethane was banned a few years after the Kinross accident, related accidents had claimed even more lives.

The Vaal Reefs gold mine accident resulted in the death of 104 mineworkers in May 1995 when a cage carrying mineworkers was crushed at the bottom of a mine shaft. In this case, NUM was involved in the accident investigation from the start.

President Mandela visited the mine and expressed shock and sadness over the tragic loss of life. The sombre and dignified memorial service for the dead was attended by the Oppenheimer's and the chairman of Anglo American Corporation. This was the first time in the tragic history of the mining industry that such senior corporate representatives were there to comfort the families that had lost their loved ones and their breadwinners.

The joint inquiry into the mining disaster was headed by a judge and extensive legal and technical evidence was lead at the hearings. Expert testimony was heard from a variety of sources regarding every conceivable technical angle. Several persons were eventually found guilty of culpable homicide. The mine manager and the company as a whole, were found guilty of negligence – an outcome very different from the Kinross tragedy. The Union felt vindicated by the judge's findings.

Leon Commission

Perhaps it is because the Vaal Reefs tragedy occurred in a newly democratised South Africa that it received such a response and widespread media interest. Perhaps the Union participation in the accident investigation was ensured because of the damning findings of the Leon Commission into mining health and safety. Whatever the multitude of reasons for such contrasts between Vaal Reefs and Kinross, the worm had turned.

The Judicial Commission of Inquiry into Mining Health and Safety headed by Justice Leon in 1994 was the starting point of the new legislation. The report of the Leon Commission was an indictment of the mining industry, criticising both the mining groups and the government for not properly managing health and safety.

Criticisms centred around the poor health and safety record of the mining industry at that time and the lack of action by employers and mining inspectors alike to safeguard the safety of employees. The Commissioners were adamant that change had to occur in the form of a restructured mining inspectorate and a legislative framework for health and safety on mines.

The next milestone was the International Labour Organisation (ILO) conference in Geneva in June 1995. The three stakeholders from the South African mining industry played a significant role in the negotiations of the ILO Convention and Recommendation on Mine Health and Safety. The Convention was adopted by the overwhelming majority of member countries and enshrines international occupational health and safety standards and practices.

A small tripartite committee in South Africa then began drafting a new Mine Health and Safety Act, using the ILO Convention as the foundation. Their work was completed in two months and a tripartite negotiating process to refine the Bill commenced through the Mining Regulations Advisory Committee (MRAC). The three parties had never engaged in such an exercise before.

International standards

The Mine Health and Safety Act is an eclectic piece of legislation. It has borrowed good occupational health and safety legislation from the United Kingdom, British Columbia and Australia and strives to enact the best international practices at mine level.

Managers are required to proactively prevent accidents and ill health in the workplace. Each mine has to develop a health and safety system to effectively control and manage risks to employees and those who may be affected by mining activities. The Act calls for a process of hazard identification and risk assessment

The Judicial Commission of Inquiry into Mining Health and Safety headed by Justice Leon in 1994 was the starting point of the new legislation

The Leon Commission criticised both the mining groups and the government for not properly managing health and safety

The Mine Health and Safety Act has borrowed good occupational health and safety legislation from the United Kingdom, British Columbia and Australia

Good health and safety at the mine is now good business

to be carried out regularly and systematically. This safety system must be part of broader worker participation and training.

The manager is required to conduct a risk assessment process as part of an overall risk management programme. This programme can no longer be separated from other aspects of running the business – good health and safety at the mine is now good business. The management of health and safety should be seen as an essential component of any business plan.

The Act requires the manager to identity all safety and health hazards to employees. The risks associated with the hazards must then be assessed so that information is gained on the risk profile of the workplace and the risks to employees. Systems to control the risks must be designed.

The average black mine worker has less than a standard five education and many are defined as functionally illiterate

As far as is reasonably practicable, the manager must eliminate, control and minimise the risks to employees. This is in line with the European Union Recommendation on risk management and conforms to best international practice regarding occupational health and safety. Indeed, this system is practised by employers in Canada, Australia and Western Europe.

As a first step risks must be eliminated, starting with the major ones. If this is not possible, systems must be designed to control the risk at source using engineering solutions. In so far as the risk cannot be totally controlled at source, it must be mitigated and reduced to the lowest level possible. Should the risks remain, workers must be issued with personal protective equipment.

Mineworkers will now be able to enjoy the four health and safety rights: the rights to representation and participation, the right to information, the right to education and training and the right to withdraw from dangerous situation. Every employee will have the right to elect a health and safety representative and each mine with more than 200 employees will have a joint health and safety committee which will enable employees to participate in addressing health and safety problems in their workplace.

Training has to be systematic and ongoing – induction training on return from leave will no longer suffice

This committee will comprise equal numbers of employees and managers. The management representatives must have the authority to implement health and safety policy on the mine. The health and safety representatives will elect the employee representatives to the committee.

New training

The new legislation requires that the training of employees be extensively restructured. It is widely accepted that current training for both workers and supervisors is inadequate in terms of safety and health: the industry has traditionally trained workers to complete their tasks as quickly as possible. The aim now is to ensure that workers and supervisors are trained to work safely and efficiently.

In the face of increased international competition, it is essential to have a well trained and skilled workplace. The mining industry more than any other has been at the receiving end of 'bantu education': the average black mine worker has less than a standard five education and many are defined as functionally illiterate. The Mine Health and Safety Act seeks to address this problem on the basis that the root causes of many accidents are ill trained workers who have not been formally taught to identify hazards in the workplace.

The new legislation requires managers to train workers to perform safely and without risks to health as part of the risk management programme. Workers must be capable of identifying and addressing risks either through remedial measures or by calling for the assistance of a supervisor.

Training has to be systematic and ongoing – induction training on return from leave will no longer suffice. The programme must be at intervals that are determined to be necessary according to the risks assessment programme and should also occur when new risks come to light or a major risk is identified that requires attention.

Tripartite negotiations

These legislative changes will occur within a boarder context of tripartite participation and negotiation. Several tripartite institutions have been established to deal with health and safety issues: the two most important centralised committees are the Mining Qualifications Authority (MQA) and the Mine Health and Safety Council (MHSC).

The MQA will be linked to the South African Qualifications Authority (SAQA)

and oversee the restructuring of training for the mining industry. The MQA will be a standard setting body. The MHSC will make recommendations to the Minister of Minerals and Energy on all health and safety matters.

Due to the nature of tripartism, the employers and trade unions and associations have had to form power blocks to ensure that they have united positions. The employers have formed their own high level working party which is coordinated by the Chancellor of Mines. The trade unions and associations in the mining industry have found a labour caucus to deal with the requirements of tripartite participation. The labour caucus represents over 80% of employees in the mining industry and has adopted a formal constitution.

The MHSC has three permanent committees: the Safety in Mines Research Advisory Committee (SIMRAC), the Mining Regulations Advisory Committee (MRAC) and the Mining Occupational Health Advisory Committee (MOHAC). These committees deal with health and safety research, mining health and safety legislation, and occupational health respectively.

Health focus

Health will also receive far greater attention under the Act. The mines will be required to keep data on both occupational hygiene and occupational health trends. These two data sets have to be linked to draw together exposure in the workplace and the manifestation of occupational disease.

Every mine will be required to have both an occupational health medical practitioner and an occupational hygienist, who will have to work closely together. A system of occupational hygiene surveillance must be established which continuously monitors workers health. The inspectorate will also have a health arm to enforce this legislation.

Each employee will have the right to appeal if found to be medically unfit to perform a certain job. On leaving the mining industry furthermore, workers should be issued with an exit certificate. The medical record of each employee must be kept for the entire life of that employee and stored at the mine until the employee leaves, and thereafter with the Department of Minerals and Energy until the ex-employee passes away.

The mining industry has come a long way – an example of this is the mining group Gencor. It is ironic that Kinross is owned by Gencor which is spearheading commitment at the highest level to improving health and safety. In a bold move, Gencor's board of directors established a sub-committee to advise them on health, safety and the environment. The sub-committee must look into health, safety and environmental matters for the operations of Ingwe Coal Corporation, SAMANCOR, Impala Platinum, Alusaf and Gengold.

This sub-committee is chaired by the chairman of Engen, and Gencor's chairman attends the committee's meetings. The committee has as its members two internationally recognised mining safety experts, a health expert and a labour representative. Hopefully the committee will provide the industry with an example of a social partnership on occupational health and safety.

Partnerships

Ingwe Coal Corporation is another example of a social partnership being forged between labour and employers. This company has established forums at mine level on health and safety that feed into a national forum. The board of directors has established a health and safety advisory committee with representatives of both labour and government.

The implementation of the new Mine Health and Safety Act will be the end of a new chapter in mining health and safety. Hard work lies ahead in implementing the Act in a proactive manner that allows for meaningful input from all stakeholders. It is also important that there is a well equipped and well resourced inspector of mines to enforce and to monitor the implementation of the Act.

It has been said that the history of apartheid is written on the bodies of mineworkers. The challenge lies in the parties forming a social partnership that will stop the senseless deaths, maiming and disease that have been an inherent part of the South African mining industry. IPSA

The mines will be required to keep data on both occupational hygiene and occupational health trends

Every mine will be required to have both an occupational health medical practitioner and an occupational hygienist

It is important that there is a well equipped and well resourced inspector of mines to enforce and to monitor the implementation of the Act

REGIONAL MONITOR

PERCENTAGE OF CLINICS AND HEALTH CENTRES WITHOUT BASIC AMENITIES

	Northern Province	KwaZulu-Natal	North West	Eastern Cape	Free State	Northern Cape
Total Number (Clinics, clinic satellites and health centres)	333	407	300	645	281	134
% no adequate water supply	30	20	30	46	7	7
% no telephone	23	15	43	38	10	13
% no grid electricity	23	11	42	52	9	12

FACILITY GUIDELINES FOR DIFFERENT AREAS

Type of PHC	Type of area facility	Population per km²	Catchment population	Maxium catchment radius
Mobile clinic	Dense metropolitan	>10 000	5 000 per visiting point	0,33km for each visiting point
	Large urban	1 000-2 000	3 000-6 000 per visiting point	1km for each visiting point
	Smaller urban	200-400	600-5 000 per visiting point	1-2km for each visiting point
	Deep rural or semi desert	5-40	250-2 000 per visiting point	4km at each visiting point
Medium sized clinic or health centre	Dense metropolitan	>10 000	80 000	1,4km
	Large urban	1 000-2 000	50 000	2,8-4km
	Smaller urban	200-400	10 000-20 000	4km
	Deep rural or semi desert	5-40	-	-
Major 24 hour health centre	Dense metropolitan	>10 000	80 000 for general care 180 000 for specialised and 24 hour services	1,4km 2km
	Large urban	1 000-2 000	50 000 for general care 180 000 for specialised and 25 hour services	2,8-4km 5,4-7,6km
	Smaller urban	200-400	100 000-180 000	9,9-15,9km
	Deep rural or semi desert	5-40	-	-

Source: *South African Health Review* 1996, published jointly by the Health Systems Trust and the Henry J Kaiser Family Foundation, October 1996

Standards, Sophistication and Quality

The Health Balancing Act

By Nicholas Crisp
Head, Department of Health and Welfare
Northern Province

It is at last possible for Northern Province to prevent tetanus and measles, treat first stage cancers and deliver babies in a safe environment. Given the Third World conditions prevailing in this province, a tug-of-war between 'equity' and 'excellence' must be avoided. These goals are not mutually incompatible – indeed, they are absolutely interdependent.

South Africa post apartheid is coming to terms with the realities of its complex past. Despite appearances, the country is in fairly serious debt, wrought with a legacy of social evils and torn between a highly developed and technologically advanced world and a severely disadvantaged, underdeveloped and culturally traditional world.

Many privileged South Africans continue to deny the extent of these divergent worlds and fail to acknowledge the existence of the Third World in the country. Part of the denial is the result of anxiety around losing familiar and comfortable 'standards'. This is extremely prevalent in the medical world.

The public in Northern Province have developed an extremely high tolerance for illness and suffering

Professionals, trained mostly in high technology environments, confuse standards with sophistication and quality of care. It is almost inconceivable that a doctor cannot recognise that the collective aim of decreasing morbidity and mortality (including human suffering) cannot be correlated with increasing sophistication technology.

The standards of simple interventions have often been so bad that children still fall prey to measles, tetanus and diarrhoeal disease. The professionals will sooner equate the ventilation of a newborn baby suffering from tetanus as good standards than accept the absolute failure inherent in the mere occurrence of the disease.

Third World

Northern Province is one example of South Africa's Third World. It is a 'new' province which was previously administered by various apartheid regimes. The independent state of Venda and self-governing territories of Lebowa and Gazankulu were scattered across the province in 22 pieces, surrounded by part of the then Transvaal Province. Almost 95% of the 5,3 million people live in these former territories – which cover only half of the surface area. There are only 13

formal urban centres which accommodate 8% of the population, extended to 12% if the informal peri-urban areas are included.

Black South Africans comprise 97% of the population. Almost 60% of the population is under 18 years of age and adult unemployment is around 50%. The economy is fragile, largely dependent on an extensive informal sector – which handles 30% of the GGP – and the public service which constitutes 22% of GGP. People are poor. Social security is an important contributor to the R2 500 per capita yearly gross income.

Infant mortality is around 60 to per 1 000 live births with frequent maternal deaths still occurring too. Most of these are preventable deaths, as is much of the morbidity. The public have developed an extremely high tolerance for illness and suffering. People consult traditional healers first in most instances and present their problems to the 'western system' very late. End stage breast, cervix and lung cancers are still seen at first contact consultations.

The service infrastructure was mostly developed by missionaries. Douglas Smit Hospital was established over 110 years ago and Elim is 98 years old. The hospitals were taken over by the government in the 1970's and managed by the homelands. With only a few exceptions, these facilities have gradually deteriorated. In many cases forced removals and resettlement by the apartheid regime have rendered these hospitals poorly situated and kept them marginalised.

Most professionals – except nurses – are imported and have been extremely difficult to recruit. At the time of the April 1994 elections there were around 200 full time doctors in the province – for 43 hospitals with 12 500 beds – supported by a private sector of about 180 doctors. This produces average ratios of between 1:15 000 and 1:17 500 doctors to population with isolated areas rising to 1:65 000 or more. Several doctors have worked alone with only the nursing staff to assist them. Telecommunications and professional support have been very poor and professionals are highly demoralised.

One of the results was a one-way traffic of referrals to Gauteng, notably to GaRankuwa, HF Verwoerd and Baragwanath Hospitals. Patients – often critically ill – were raced along poor roads for seven hours or more by converted kombies under supervision of an untrained driver and an assistant nurse. Many of these vehicles had travelled 300 000 kilometres or more and several had fatal accidents which made staff very hesitant to accompany patients on trips.

Because over 90% of doctors are foreign graduates and the turnover of doctors is high, the treatment modalities and equipment were frequently changed. This left a lot of expired medicines and disused, expensive equipment all over store rooms in the province.

Budgets were limited – and frequently wasted. The tendency was to centralise spending in hospitals and clinics, while outreach services were neglected. The consumption cycle was a vicious one which ended with self-defeating morbidity management instead of simple prevention. With the 1994 elections and the disbanding of the homelands, came the vision – and commitment – to equity within a unified national health care system.

Critical changes in vision included:

- ❑ Identification of primary health care and deliberate funding of the community health services.
- ❑ Equitable allocation of funds with a progressive shift over a very short time frame.
- ❑ Planned rationing of services rather than leaving it to 'market forces', technological possibility or individual desire.

New opportunities

For the newborn Northern Province this created opportunities for dramatic improvement in services. The historical inheritance had to be dismantled and replaced by a new service entirely. It was recognised that the window of opportunity is likely to be small and that ad hoc enthusiasm could be as destructive as the old system. The 'battle plan' was to avoid too many 'contacts' or 'conflicts' at one time.

Most professionals – except nurses – are imported and have been extremely difficult to recruit

Average ratios are between 1:15 000 and 1:17 500 doctors to population with isolated areas rising to 1:65 000 or more

Several facilities were beyond repair and a few were blatant violations of human rights. Patients were moved and these facilities closed

The budget was built from zero into cost centres with a uniform project and programmatic structure

❑ Structural and organisational changes

The period from 1994 to 1995 was devoted to restructuring and reorganising systems. The geographical reorganisation of command was a high priority. It ensured shorter lines of communication and created significant savings. The hierarchical reorganisation of referrals and support was next.

This created much anxiety around entrenched interests. Two hospitals were designated as a 'tertiary complex', five others as regional referral (secondary) centres and the others as district or community hospitals. A system of central health centres with peripheral clinics and outreach services completes the hierarchy in health services.

Posts and equipment were moved and structural changes planned to accommodate the new roles. Several facilities were beyond repair and a few were blatant violations of human rights. Patients were moved and these facilities closed. Where necessary, replacement facilities have been planned. In some instances this was an ideal opportunity to rationalise apartheid's expansive duplication strategy, both on racial and ethnic grounds.

There are about 90 more doctors in Northern Province's health service than at the time of the 1994 elections – an increase of 50%

❑ Capacity development

The latter half of 1995 saw the beginning of a range of capacity enhancement interventions. This is a long and ongoing requirement and some of the important initial actions include:

- Developing information technology. Phase one of an extensive network of LANs has been installed. Training in the operation of the systems commenced immediately.

Over 14% of the budget was committed to purchasing 'real' ambulances, other vehicles suitable for rural roads, medical equipment and upgrading facilities

- Human resource development. There was virtually no plan for individual performance improvement nor career movement. The first actions were a skills audit, a resource database and management and organisational development skills programmes.

- Financial management. A decision was taken to decentralise control of finances. The many budgets of former administrations had to be amalgamated into a totally different structure. The budget was built from zero into cost centres with a uniform project and programmatic structure. It will take many years to fully implement the vision but significant strides have been made.

- Health care. Nursing staff and allied medical professionals bear the brunt of clinical care because doctors are so scarce. Primary health care nursing courses, district management, ambulance assistance, radiography, laboratory and pharmacy courses have been pursued with excellent academic results. A new bursary system is being implemented. Many doctors have been for specific clinical short courses.

- Increasing numbers. 'Right-sizing' is a buzzword. In the case of professionals it means increasing numbers. Recruitment campaigns are beginning to bear fruit. There are about 90 more doctors in our service than at the time of the 1994 elections, an increase of 50%.

- Facilities and equipment. All savings and increases were focused on capital improvements in the first instance. A full facilities structural audit has enabled clearly planned targeting for expenditure. Over 14% of the budget was committed to purchasing 'real' ambulances, other vehicles suitable for rural roads, medical equipment and upgrading facilities. In the first year (1995/96) it was purely to repair existing buildings. In the second (1996/97) it has been used to extend where necessary and create new facilities in certain instances.

❑ Service delivery

Between 1996 and 1997 the battle plan has moved into its third phase with the focus on quality of service delivery. Here the human element is very intense. Morale was extremely low during the transition period of restructuring and absorption – or rationalisation – from the old administrations into the new. Public perceptions and expectations grew with the local government elections in November 1995. The major areas of emphasis were:

- To clearly define tasks, a process was embarked upon for every unit in the whole department to develop clear operational plans with objectives and

targets; with quality measurements included.

- A clinical quality assurance programme was developed and is being implemented.
- Joint programmes have been developed with MEDUNSA and others to establish sustainable clinical quality assurance development.
- Private companies in commerce and industry have sponsored trophies for various areas in a campaign for 'Excellence and Endeavour' in the department.
- Intersectoral cooperation with departments of public works, public transport, education, and safety and security have been established with specific focus areas.
- A policy for public–private mix has been developed and several examples of cooperation are already being implemented.

Future goals

Corporate reengineering on the scale required to transform government is likely to take many years and to create its fair share of complications. The challenge is to remain focused on the goal – in our case health care, measured by a handful of indications of morbidity and mortality. Second, it is critical to remember that the province's districts are not islands. The collective impact for the country is more important than 'excellence' in one local area.

Third, we must be constantly reminded that this is Africa, not America or Europe. Standards will be the same but the sophistication of the care environment depends on a very different set of imperatives. Fourth, quality is relative. If prevention is really better than cure then surely quality of prevention services is as important as quality of curative service?

The reality is that rationing is unavoidable. It has to be spread and it has to be deliberate. Tough decisions must be taken. Our collective wisdom as health professionals and care providers must now refocus on motivating that health care is an investment in human potential. This can only be proved if there is a national improvement in quality life expectancy and a decrease in disability adjusted life years. A tug-of-war between 'equity' and 'excellence' must be avoided – they are not mutually incompatible. Indeed, they are mutually and absolutely interdependent.

For Northern Province the opportunity to prevent tetanus and measles, to treat first stage cancers and to deliver babies in a safe environment is at last a possibility. There is little doubt that this will make a significant impact on the health status of the country as a whole. IPSA

If prevention is really better than cure then surely quality of prevention services is as important as quality of curative service?

The collective impact for the country is more important than 'excellence' in one local area

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Diversity Within Regularity

Energy Use in Durban

By Robert Aitken and Sean Jones
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A qualitative longitudinal study in Cato Manor, Durban provides people-sensitive perspectives on domestic energy use which may have been obscured by previous surveys. This research method usefully informs planning and policy by showing how social differences correlate with quite different attitudes towards energy sources and appliances.

South African industry has enjoyed one of the world's cheapest supplies of electricity for most of this century. During the years of Nationalist Party rule, government intervention in the energy sector ensured provision of subsidised electricity to industry with the intention of invigorating the mining, transport and manufacturing sectors of the economy. South Africa would certainly not be the industrial state it is today were it not for this cheap supply of electrical energy.

Yet despite – and arguably because of – the importance of cheap electricity for industrial growth, approximately 50% of South African households were unelectrified at the end of 1995. These households are forced to rely on 'transitional' fuels such as paraffin, gas and candles, supplemented in some cases by wood and coal.

Approximately 50% of South African households were unelectrified at the end of 1995

Since transitional fuels can be less cost efficient than electricity – depending on how and for what purposes they are used – poor households may carry a greater 'energy burden' (the cost of energy as a proportion of income) than industry and more privileged households. To compound matters, South Africa is one of the few industrialised countries that has yet to formulate a coherent national energy policy.

A new vision

In 1994, the Department of Minerals and Energy (DME) instituted a longitudinal study of energy use in low income households in the metropolitan areas of Johannesburg, Cape Town, East London and Durban. The emphasis is on the social and economic determinants of energy use patterns in poor households, and it is envisaged that these studies will enhance government's capacity to produce an equitable national energy policy.

This energy research is distinct in its focus on qualitative research techniques. By adopting a longitudinal approach, combined with a research method which prioritises close daily interaction with informants in their home environments, the DME expects the programme to reveal people-sensitive perspectives on domestic energy use. These may have been obscured by the short term surveys that have predominated thus far.

Longitudinal qualitative research invariably requires very small samples of informants. This is because it is impossible, using a large sample, for researchers to achieve the desired level of insight. Instead, this style of research involves learning as much as possible about the minutiae of people's lives

through regular interaction and observing their activities.

Through intimate knowledge of individuals, researchers can discern their choices, aspirations and the rationale underlying these. Although samples are generally too small to be statistically representative, one of the advantages of in-depth qualitative research is that it reveals the particularities of regular behaviour, enabling a richer understanding. It is also useful in understanding seemingly irregular and unpredictable behaviour.

The longitudinal aspect of the research has advantages of its own. Whereas surveys certainly have value, they fail to capture fully the processes of social and economic life and the changes that constantly occur within it. The longitudinal approach enables researchers to observe and document the vicissitudes of domestic life over time. These findings can later be tested by surveying a larger sample.

It is this kind of approach which the DME favours in developing a national energy policy which is sensitive to the needs of poor households. This article attempts to demonstrate the utility of such an approach by focusing on one aspect of the research being conducted in Durban.

Cato Manor project

The bulk of the research for the Durban project is being conducted in the broader Cato Manor region. Some 2 000 hectares in extent, Cato Manor is located approximately six kilometres from central Durban. It is enclosed by middle class suburbs and relatively close to the light industrial areas of Mayville and Overport. Cato Manor contains a number of extremely dense settlements, most of which comprise unplanned shacks or low cost planned housing.

A significant proportion of the land however remains vacant, although the Cato Manor Development Association (CMDA) recently published plans to develop the entire area. The CMDA envisages the construction of around 30 000 houses accommodating some 150 000 people by the year 2000. These plans may not be without hindrance, however, since the existence of this large tract of undeveloped land so close to the city is a result of forced removals during apartheid. The Land Claims Commission is presently considering applications by evictees for return of their land.

In 1995/96 – the project's first year – qualitative work was conducted within 50 households in Cato Manor. A further 15 were selected, but research in these homes had to be delayed. Of the initial 50, the principal members of 30 households are people of rural origin who have only recently moved to an urban area. Fourteen of the households of rural origin are lodged in backyard shacks in Chesterville, the oldest and most established settlement in Cato Manor. The remaining 16 are located in Old Dunbar, an unplanned settlement which was established in the early 1990s.

At face value, all the households of rural origin occupy much the same market niche in terms of energy use and supply. All live in dwellings that are not connected to the electricity grid. A few backyard shacks are supplied with makeshift electric lighting from the main houses in Chesterville, but none have plug points. Thus all rely on other sources of energy for cooking, water heating, entertainment appliances and other domestic purposes. Paraffin is by far the most common of these alternative fuels, while candles are used by most for illumination at night.

The households also appear to be fairly uniform in social and economic terms. Most household heads are between twenty and forty years, and most moved to an urban area for the first time within the past three to four years. Employed household members are all low paid blue-collar, menial or domestic workers, and most householders have minor dependants who either live with them, or are supported by them but live with relatives in a rural home.

The majority of the households have per capita incomes of between R200 and R300 per month. These households of rural origin would therefore appear to be part of a common 'socio-fuel set' – that is, they have broadly the same biographical, social, economic and fuel use characteristics.

Differing aspirations

During the course of the fieldwork it became clear that, despite their apparent

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Despite their apparent uniformity, households of rural origin can in fact be divided into two markedly distinct consumer sets

uniformity, households of rural origin can in fact be divided into two markedly distinct consumer sets. First, there are those who have homes in the countryside and are determined to maintain and invest in these homes. None of these people professes to want a permanent urban home – indeed all state quite the opposite. To paraphrase the sentiments of many of the informants: 'This place is not home'.

This apparently single minded commitment to the countryside is evident in a variety of ways. All who deny any desire to settle permanently in the urban context visit their rural homes regularly, in some cases every weekend. For the most part, they are scrupulous about saving money and spend precious little on improving their living circumstances in the urban setting.

This pecuniary strategy is clearly related to their goal of maintaining a primary home in the countryside: they are in the urban setting to support and earn money to invest in their rural homes. Another marker of these people's commitment to rural society is their noticeable avoidance of establishing anything but the most superficial relations with immediate neighbours and others in the vicinity. Since their intent is not to become integrated into township or urban life, they prefer to avoid developing strong social ties.

Oscillating migrants do not aspire to dwelling ownership and permanent residence in the urban area

The other category of people of rural origin are characterised in entirely contrary terms. Unlike their counterparts described above, these people do aspire to urban settlement and their actions and personal strategies are clearly oriented towards achieving this. They generally no longer have primary homes in the countryside.

Admittedly, many claim to have secondary places of affiliation elsewhere, but there they have informal rights to reside – usually by virtue of kinship ties – but which are not their homes per se. Since most do not have primary homes elsewhere, their overriding intention is to establish permanent homes for themselves and their families in Cato Manor.

Among aspirant urban settlers, only one household did not own a television set, hi-fi system or transistor radio

The urban orientations of this second category is also reflected in family and household structure. Whereas those who remain committed to the countryside commonly leave their children, and sometimes spouses, at the rural home, most of the aspirant urban settlers live in Cato Manor with their families. They are also more given to developing strong support networks where they live, and to involving themselves in local level political and civic affairs. Together these features clearly signal an intent to remain, if at all possible, where they are.

On the basis of their articulated goals and observable strategies, the householders of rural origin can therefore be divided into two fairly discrete categories. On the one hand are those who might loosely be termed oscillating or circular migrants. These are folk who claim to have primary homes in the countryside and who do not aspire to dwelling ownership and permanent residence in the urban area. On the other hand, there are those who are committed to creating urban homes for themselves largely because they lack primary homes elsewhere.

Different appliance usage

These distinctions in terms of aspirations and strategies correlate with quite different attitudes towards energy sources and appliances among people who, on the surface, appear to have much in common. While all of the households rely on transitional fuels such as paraffin, gas and candles, there are differences in the area of entertainment appliances.

Within the category of aspirant urban settlers, there is only one household which does not own a television set, hi-fi system or transistor radio. The remainder own at least one of these appliances, operated using dry cell or car batteries. In contrast, less than half of the migrants own such appliances.

This distinction between the two categories in terms of entertainment appliances is hardly major. Nonetheless, it demonstrates how social differences may impact on energy related behaviour. Many of the migrants live alone or as couples and most eschew close relations with others in the immediate neighbourhood. In these circumstances, they might be expected to prioritise entertainment appliances. In the absence of family and other company, their spare time could be greatly enhanced by radio, recorded music or television.

Given also that mean household per capita income is slightly higher among the migrants, entertainment appliances and the energy they consume are theoretically more affordable to them than the aspirant urban

settler category. Yet almost all of the urban settlers – who have company and can least afford it – own and use entertainment appliances.

This difference is easily understood against the background of the varying goals and aspirations of the two categories. The aspirant urban settlers are concerned to consolidate urban homes for themselves, part of which involves creating a homely environment even under impoverished circumstances. In contrast, the migrants would rather direct the largest proportion of their resources to their rural homes and will economise in any way possible to achieve this.

Policy implications

The implications of these different outlooks for energy policy extend far beyond entertainment appliances. The aspirant urban settlers are extremely enthusiastic about the prospect of electrification and will if possible, invest in electrical appliances when their homes are electrified. The migrants on the other hand, are unlikely to embrace electrification of their urban dwellings with anything like the same vigour.

Informal discussions lead to the distinct impression that they would eschew large scale investment in electrical appliances. This does not derive from an aversion to electricity: the migrants have little doubt that it would greatly enhance the quality of their lives. Along with virtually all others who are confined to paraffin, gas and other transitional fuels in the domestic environment, they also complain about these fuels, citing the high cost to their health and safety related implications.

The migrants' conservatism regarding electrical appliances is instead related to their current goals. Investment in electricity and electrical appliances entails committing resources to an urban lifestyle which, for them, is simply a means to an end. Full conversion to electricity is an extravagance that is incompatible with the pecuniary values associated with their goals.

The implications of this for energy planning are obvious. Although all the households desire electricity, those who are resolute in their intention to settle permanently in the urban area wish to make extensive use of electrical appliances. In contrast, those who remain committed to rural homes desire electricity primarily for illumination and are therefore unlikely to become major consumers in the short to medium terms.

This does not mean that electricity providers should prioritise electrification among people who are committed to urban residence, nor that urbanites of rural origin should be last in line for electrification because they are a risky category of consumer in terms of investment returns. Whether people are likely to use electricity primarily for lighting, or whether they are likely to use it to meet all their energy related needs, electrification is – or should be regarded as – a basic right.

These findings do indicate that the transition to electricity will be more expeditious among some categories of household than others and that demand for transitional fuels and associated appliances will not necessarily diminish entirely. Thus, the need remains to render these alternative fuels and appliances safer, cheaper and more cost efficient. These are matters that the emerging national energy policy will have to address.

Policy research

This article has attempted to demonstrate how longitudinal qualitative research may usefully inform planning and policy. In Cato Manor there are two categories of 'residents' of rural origin. This distinction emerged through close engagement with informants over a prolonged period of research.

The value of longitudinal qualitative research is that it permits perspectives on the diversity which inevitably exists within regularity, rather than just perspectives on regularity itself.

This is not to suggest that survey methods are incapable of achieving this kind of insight. Surveys are the most efficient and cost effective means of gleaning information about large segments of the population. It is also possible to obtain fine distinctions of this order provided that the survey design process is informed by the most relevant markers. Quite simply, a survey must know what to look for. In-depth qualitative research among a small sample of informants, is of value in this regard. IPSA

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Those who remain committed to rural homes desire electricity primarily for illumination

Acknowledgement

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A Better Life For All

Views of Development in KwaZulu-Natal

By Valerie Møller
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A pilot project to identify the indicators which best capture the needs and aspirations of KwaZulu-Natal's population produced useful insights on how people assess current and future development efforts as well as their quality of life. Subjective indicators of development priorities and satisfaction with living conditions are being incorporated into a comprehensive survey of households in the province.

The KZN Household Survey includes more details on households and living conditions than the census and covers a larger number of households than the October Household Survey

When it took office in 1994, the Government of National Unity promised a better life for all the people of South Africa. In the years ahead, it is envisaged that the Reconstruction and Development Programme (RDP) will bring improvements to the lives of ordinary people. In KwaZulu-Natal, an ambitious research programme is underway to produce baseline data against which progress made in achieving development can be measured.

The KwaZulu-Natal Interdepartmental Indicator Initiative, which includes all provincial government departments and feeds into the province's good governance programme, has launched a large scale household survey to monitor the impact of development on life chances of citizens.

About 6 500 households will participate to collate information on household characteristics including health, income and employment, access to services, living standards, development priorities and satisfaction with life and living conditions. The survey is planned as a tool to aid government and development agents to initiate development programmes for which there is community support and to monitor progress.

The KwaZulu-Natal (KZN) Household Survey covers different ground than national household surveys such as Census '96 and the Central Statistical Service's October Household Survey, and is designed to aid planning at the district level. The KZN Household Survey includes more details on households and living conditions than the census and covers a larger number of households in the province than the October Household Survey.

A distinctive feature of the KZN Household Survey is the inclusion of subjective development indicators. The subjective indicators – measures of popular perceptions of development needs and quality of life – are designed to complement conventional objective indicators based on hard facts.

Pilot study

A pilot study to develop a set of subjective indicators was planned well in advance of the KZN Household Survey. The task was to identify the indicators which best capture the divergent needs and aspirations of people in the province. The most powerful subjective indicators identified in this way are replicated in the KZN Household Survey.

A joint project by the Economic Affairs and Tourism Department, the KwaZulu-Natal Human Sciences Research Council and University of Natal's Quality of Life & RDP

Monitoring Unit, the pilot study was conducted in late 1995 among 678 households. The sample was a small but carefully selected one which represented the diversity of people in the province and their living conditions.

Although designed as a forerunner to the larger survey, the pilot study also produced useful insights into how people in the province assess current and future development efforts and their quality of life. The following article taken from *Perceptions of Development in KwaZulu-Natal: a subjective indicator study*, published by Indicator Press, summarises popular views of the province's development prospects.

The pilot study addressed three facets of development – popular development priorities, social climate for development and perceived quality of life. Specific questions which guided the research were:

- Do government and people agree on development priorities?
- How knowledgeable are citizens of the Reconstruction and Development Programme?
- Who is seen to benefit from development programmes in the province?
- How satisfied are citizens generally and with their living conditions?

Development priorities

Survey participants identified violence, crime and unemployment as the major problems in KwaZulu-Natal. Violence and crime were perceived as more pressing problems in the province than in the rest of South Africa, and were seen to be overshadowing other development issues (Figure 1 and 2). Jobs, better wages, water, housing, peace and security were at the top of the list of recommendations for the government to assist households in KwaZulu-Natal to improve their living standards (Figure 3).

Figure 1
Most pressing problems in KwaZulu-Natal

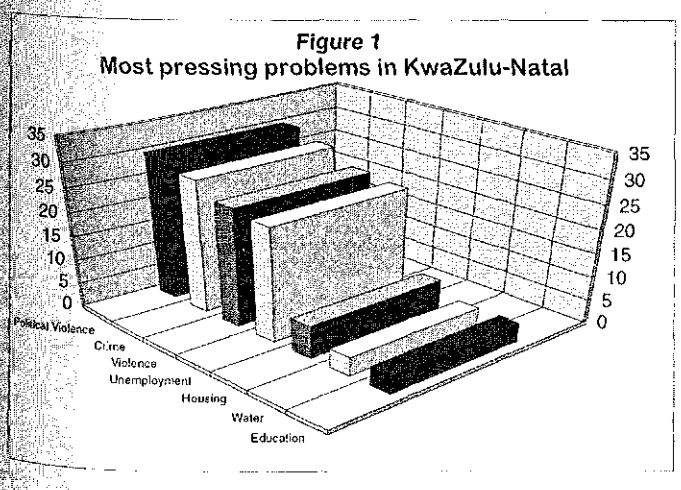
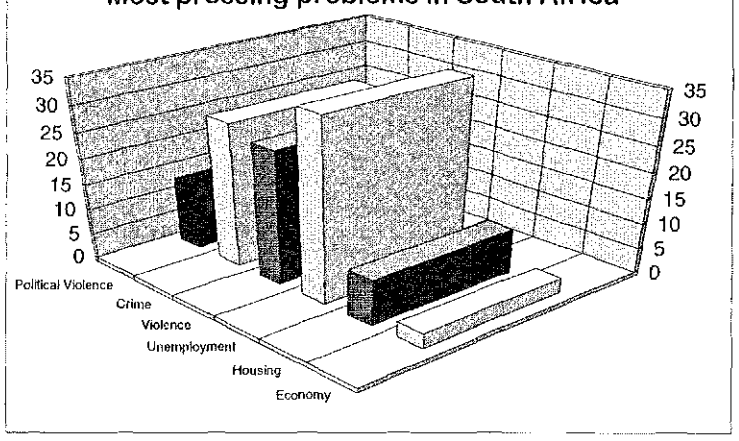


Figure 2
Most pressing problems in South Africa



Only 39% of respondents could recall any positive developments underway in their residential area in the past year to improve living standards. Improvements included infrastructure, electricity, roads, schools and health care. Over 60% remembered events in the past year which had deterred development in their communities. Crime was the most prominent negative event.

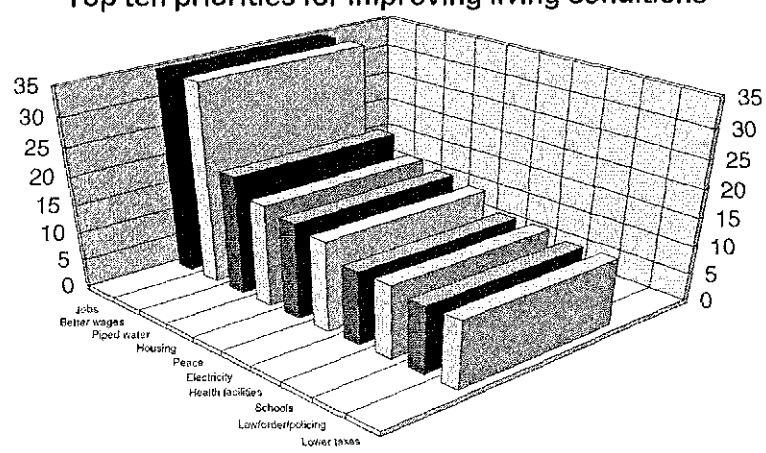
Over four in five had heard of the Reconstruction and Development Programme and three quarters could define RDP goals. The RDP was mainly associated with improvements to the standard of living, in particular jobs, housing and infrastructure development.

A popular viewpoint was that the RDP should be nurtured in a peaceful environment and required a concerted effort from all citizens. While survey participants were adamant that election promises should be acted on and infrastructure development could not be deferred, results also suggested that people were concerned about the costs of development. Some respondents questioned whether the poor would be able

Survey participants identified violence, crime and unemployment as the major problems in KwaZulu-Natal

Over 60% remembered events in the past year which had deterred development in their communities

Figure 3
Top ten priorities for improving living conditions



to afford the services put in place by the RDP (Table 1).

On average, 30% of people questioned in the survey identified themselves as current beneficiaries of development

On average, 30% of people questioned in the survey identified themselves as current beneficiaries of development programmes. Just over one in two (53%) expected to become future beneficiaries. Current beneficiaries among rural dwellers and poorer households earning less than R829 per month exceeded 37%, while 72% of the small group of shack dwellers surveyed saw themselves as having benefited. Expectations of future benefits exceeded 72% among rural and shack dwellers.

Development budgets

The study tested popular views of development priorities for the province. Respondents were invited to rank order 28 line function development goals identified as important by government departments in advance of the study. The rank ordering exercise was designed to probe the match between government and popularly defined development priorities.

Top priority goals for the respondents included education, safety, security issues, health care, clean water and affordable housing

Top priority goals for the respondents included education, safety and security issues, health deliverables (including primary health care), clean water and affordable housing. Intermediate priorities were nutrition, sanitation, electricity, literacy and good governance.

Longer term goals such as environmental protection and balancing population pressure and natural resources also featured as intermediate goals. Although the development of roads, transport and security of tenure issues were lower priority issues overall, they were more important for rural than urban dwellers.

The match between government and popularly defined development priorities was generally satisfactory. The only point of disagreement concerned the removal of the welfare security net, with less than one in two respondents agreeing that reducing welfare and dependency was currently a feasible development goal for the province. A revised set of development priorities based on these findings will be put to the people in the larger household survey currently underway.

Approximately 70% of survey respondents in the pilot study were in a position to propose a community development project for their area. The most popular types of community development projects were income-generating ones, including infrastructure and skills development. Skills development projects were seen as the first step to access or create jobs.

Living conditions

Life satisfaction measures are known to be relatively stable over time. They are also sensitive to changes in life circumstances and conditions. In most Western and democratic societies around the world, the majority of the

Table 1: Popular perceptions of the Reconstruction and Development Programme (RDP)

Percentage agreement	%
Will succeed if all play their part	80
Needs peace and security to succeed	76
Opportunities for the disadvantaged of the past	71
Services for the poor	70
People shaping their own future	65
Increased economic output	63
Paid for with higher taxes	61
Eliminates injustices of the past	61
A non-starter in KwaZulu-Natal	60
Less inequalities between provinces	57
South Africa is doomed if RDP falls	51
Won't benefit white people	48

(Items shortened and paraphrased)

population – usually at least 70% – express satisfaction overall with their lives.

It is estimated that over the past 15 years about one in two South Africans have been satisfied with their lives. An exception was when 79% of South Africans stated satisfaction after voting in the country's first non-racial elections in April 1994. However, post-election euphoria was short lived and 18 months later the number of South Africans content with life had dropped again to 45% (Møller 1995).

In the pilot study, satisfaction was measured at the personal level ('how satisfied are you with your life on the whole?') and household level ('how satisfied are you and members of this household with the way you live?'). Survey participants also stated how satisfied they were with 20 aspects of life.

Dissatisfaction with life and living conditions was prevalent, with the majority reporting dissatisfaction with their lives overall, as well as with 20 aspects of living, including housing, infrastructure and services. Only 40% of respondents reported that members of their household were satisfied with living conditions generally, and 34% indicated personal satisfaction with their lives overall.

Most South Africans are familiar with objective statistics that document the backlog of provision of services to the rural areas. The pilot study provided subjective indicators to match hard facts. Only 24% of rural compared to 57% of urban respondents reported that members of their household were satisfied with living conditions.

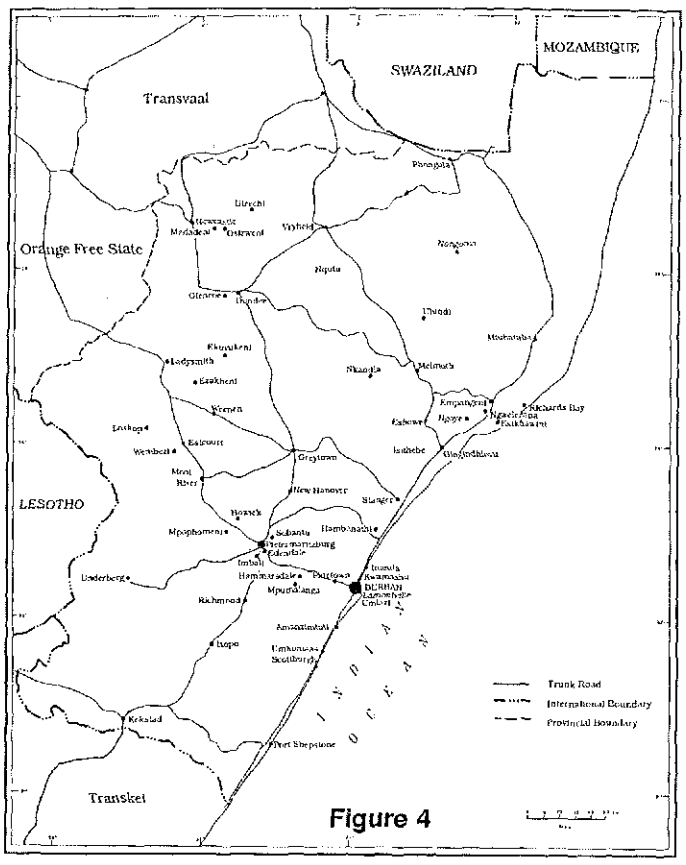
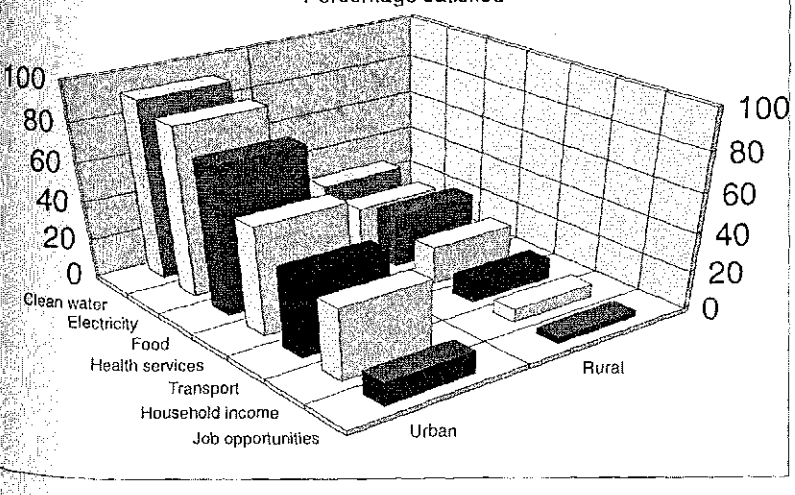


Figure 4

Satisfaction with aspects of living was also consistently lower in rural than in urban areas. Examples are the low levels of satisfaction among rural dwellers with regard to clean water and electricity supply in the home. The percentages satisfied were 27% rural and 92% urban for water; 23% rural and 87% urban for electricity (Figure 5).

Figure 5 Satisfaction indicators for rural and urban areas

Percentage satisfied



Approximately one third of respondents felt that their security situation had improved in the past year and 28% felt it had deteriorated. The security risk was perceived to be greater for crime than political violence. Better off households felt more threatened than others less well off.

In most Western and democratic societies at least 70% of the population express satisfaction with their lives

Crime and violence were seen to be more critical problems in the region than in South Africa as a whole

The pilot study found that satisfaction with health services, income and social security made the greatest impact on personal satisfaction. Satisfaction with a clean and safe residential area, good quality housing and food security contributed most to household satisfaction.

Jobs and security

A common theme in the responses to the survey was the need for greater job opportunities to combat crime. Survey respondents thought crime and violence retarded development in the province. Crime and violence were seen to be more critical problems in the region than in South Africa as a whole. Three quarters of the people surveyed thought that the RDP could only deliver if peace and security were brought to the province.

In late 1995, popular knowledge of the RDP programme exceeded by far the researchers' expectations

The need for peace and security ranked alongside the need for jobs and income security on lists of problems and wish lists for government intervention to improve living standards. Expectations were that RDP projects would improve living conditions by creating jobs. Satisfaction with income security and protection from crime were also indicative of higher levels of personal and household satisfaction.

Rural-urban divide

In KwaZulu-Natal, the rural-urban divide is essentially a division between the rich and the poor. Survey results confirmed that rural people represent the most disadvantaged sector of the population in terms of access to income and basic needs and services. Survey categories for the disadvantaged, comprising women, the less educated, households with lower than average income, and black people, are overrepresented in the rural areas.

The divide between urban and rural was apparent in development priorities. Access to basic needs such as water and food, security, roads, transport and land issues were of greater importance for rural than urban people.

A popular viewpoint was that the sheer scale of the development undertaking would slow down service delivery

Future optimism

According to the pilot study, in spite of widespread dissatisfaction in the rural areas, optimism still prevailed. The relatively small number of RDP projects – apart from the Presidential Lead projects in primary health care and nutrition – underway in the province at the time of the survey appeared to be reaching mainly disadvantaged groups, including people in remote areas.

Rural people seemed to be confident – more so than urban people – that they would reap future benefits from the Reconstruction and Development Programme. Income generating projects were eagerly awaited.

The population of KwaZulu-Natal is receptive to growth and development efforts and supportive of government programmes to improve standards of living in the province. In late 1995, popular knowledge of the RDP programme exceeded by far the researchers' expectations (Table 2).

The goals attributed to the programme of an improved standard of living matched perfectly the popular definition of development needs for the province. The RDP was mainly associated with a better standard of living, fulfilment of the election promises to provide houses, jobs, and infrastructure, and nation building.

Attitudes to the RDP suggest that respondents were trusting rather than cynical about the development process underway in the province. The majority – 80% – believed that the RDP would succeed only if everybody played their part. Slow delivery was not seen as being due to poor government performance. A popular viewpoint was that the sheer scale of the development undertaking would slow down service delivery. The statement 'too many people need housing, jobs, water, electricity' was endorsed by 90% of survey respondents.

Communities appeared to be receptive to emergent RDP benefits and were also confident that further benefits would be forthcoming. Reactions to the low key activities of local development committees – only 15% were aware of a committee in their area – showed a constructive attitude to local development and a keen interest in progress.

The main recommendations were that the committees should engage local people in order to achieve joint aims, and attract financial support from government and the community.

Monitoring in future

The signs of constructive support for development in the survey response have

implications not only for the focus and pace of delivery of services, but also for monitoring the impact of delivery. The rationale for testing popular development priorities and applying social indicators is precisely that efforts by government to carry out development do not always attract popular support.

People who have gained better houses, electricity, schools and jobs do not necessarily register greater contentment or support for their government or its agents of development. Rising expectations and critical attitudes to agents of development may thwart even the best government efforts to uplift living conditions and quality of life.

Preliminary results from the pilot study suggest that the people of KwaZulu-Natal are appreciative of good living conditions. Comparisons between objective and subjective indicators showed that better living conditions consistently registered higher levels of satisfaction among respondents. Preliminary analysis indicated that a clean, safe and healthy living environment might go a long way towards improving perceived quality of life across the rural-urban divide.

The pilot study confirmed that satisfaction with living conditions is a powerful indicator of positive gains in development and quality of life. Personal life satisfaction and household satisfaction with living conditions emerged as the ideal addition to any set of development indicators of the objective variety.

The application of satisfaction indicators will assist in testing whether development projects targeting specific communities also have positive spillover effects on neighbouring ones.

If enhanced quality of life results from development projects, higher levels of household satisfaction will be measured in both target and neighbouring communities. Alternatively, feelings of relative deprivation might lower the satisfaction levels of the neighbouring community relative to that of the target community.

Conclusion

The pilot study demonstrates that it is possible to measure perceived quality of life. Satisfaction measures are useful tools for monitoring popular assessment of development gains. The KwaZulu-Natal Household Survey, which uses a larger and more fully representative sample, will incorporate the indicators of development priorities and satisfaction with living conditions tested in the pilot study.

From a practical viewpoint, the preliminary report concludes that the people of KwaZulu-Natal are responding positively to development efforts underway in the province against a backdrop of crime, violence and unemployment. Levels of perceived quality of life were generally depressed, especially in the rural areas.

However, the levels of satisfaction recorded under improved living conditions were above average. The challenge to government and development agents will be to improve the basic needs of people to uplift living standards and quality of life throughout the province.

Table 2: Community awareness of the Reconstruction and Development Programme in KwaZulu-Natal October 1995

Heard of the RDP	86%
Can describe RDP goals	74%
Self has benefited	19%
Local people have benefited	17%
Local RDP project exists	9%
Has worked on a RDP project	1%
Expects future RDP benefits	50%
Identifies need for a local RDP project	70%

Better living conditions consistently registered higher levels of satisfaction among respondents

People who have gained better houses, electricity, schools and jobs do not necessarily register greater contentment or support for their government

ACKNOWLEDGEMENT

This article is based on Perceptions of Development in KwaZulu-Natal: a subjective indicator study by Valerie Møller, with contributions by Fikile Kuhlase, Errol Moloi, Brian O'Leary, Edmund Pillay, Craig Schwabe, Baby Ndlovu and Boris Vusakovic.

Published by Indicator Press, University of Natal, Durban, 1996. The full report is available from Indicator South Africa and the Human Sciences Research Council, KwaZulu-Natal Office, at a nominal cost.

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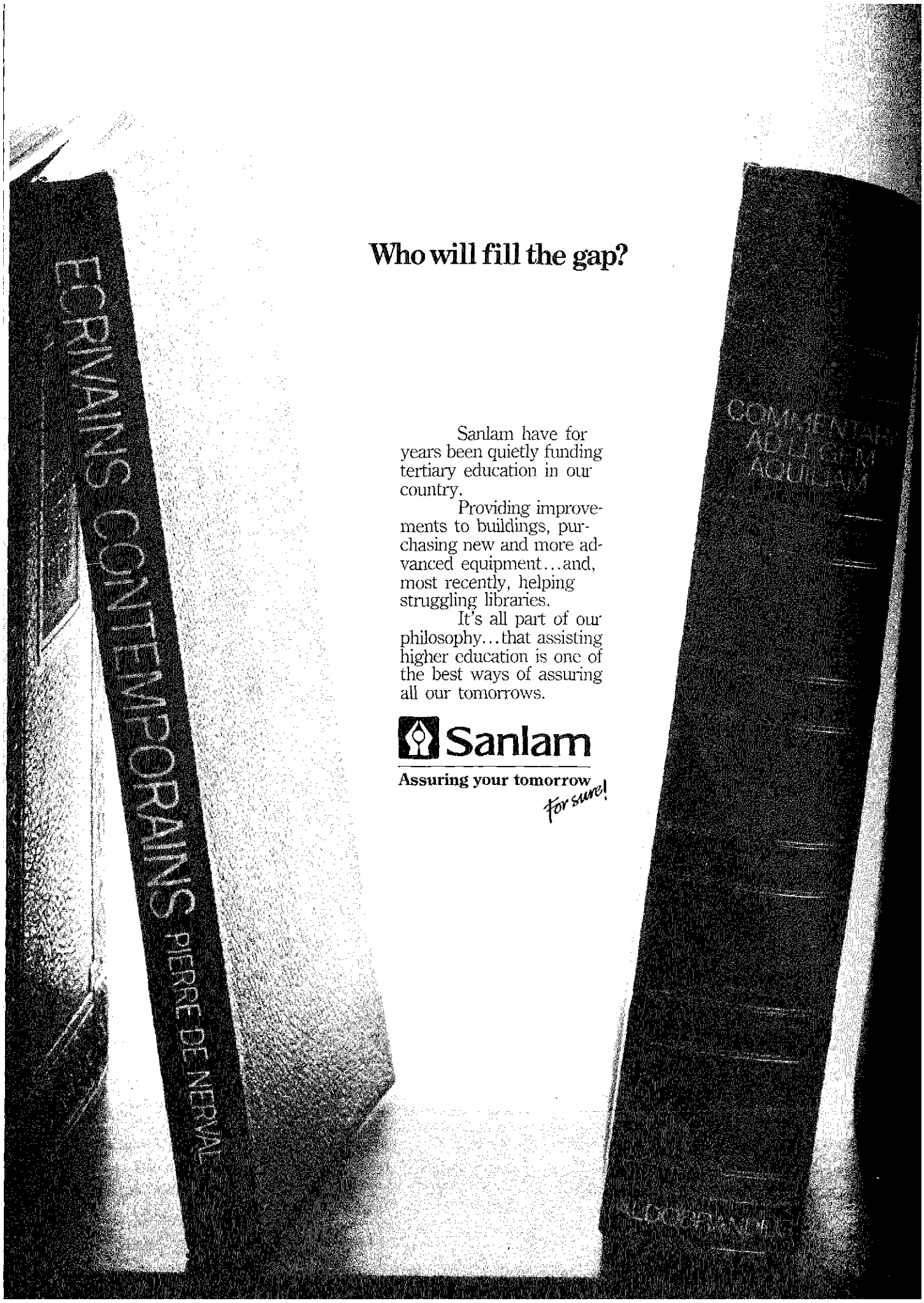

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University	1991	1995	% Change
Cape Town	64 682 000	39 064 360	-40
Durban-Westville	11 791 000	15 656 482	33
Fort Hare	*	9 469 983	
Medunsa	9 693 000	11898 035	23
Natal	57 895 000	36 456 559	-37
North	3 359 000	18 002 132	436
North West	*	13 106 084	
Orange Free State	46 354 000	22 794 003	-51
Port Elizabeth	11 833 000	9 920 702	-16
Potchefstroom	20 215 000	16 550 427	-18
Pretoria	76 598 000	54 192 430	-29
Rau	42 295 000	20 569 774	-51
Rhodes	14 667 000	9 909 823	-32
Stellenbosch	52 175 000	33 662 419	-35
Transkei	*	14 593 375	
Unisa	34 135 000	42 686 202	25
Venda	*	6 389 616	
Vista	8 361 000	16 591 943	98
Western Cape	9 779 000	17 007 143	74
Witwatersrand	77 023 000	46 943 527	-39
Zululand	3 920 000	7 846 390	101
Total	**544 775 000**	**463 329 409**	**-15**

*Former Homeland allocation was from the Department of Foreign Affairs and not the Department of Education

Source: *South African Health Review* 1996, published jointly by the Health Systems Trust and the Henry J Kaiser Family Foundation, October 1996

AGAINST ALL ODDS
WOMEN IN MEDICINE

By Jocelyne Kane-Berman
Chief Director, Department of Health,
Provincial Administration of the Western Cape
and Hannah Reeve Sanders

Women outnumber men in most undergraduate disciplines and some post-graduate groups at many medical schools. But less than a quarter train to become specialists. While the problems women encounter have been recognised, little has been done in South Africa to address them, with potentially dire consequences for health services.

At the World Medical Association's annual assembly in Cape Province in October 1996, one of the issues discussed was human resources strategies for health. Attention was drawn to the need for planning in terms of need, skills mix, multidisciplinary teams and the medical brain drain from developing to developed countries.

Dr Eunice Brookman Amissah, Ghanaian Minister of Health, said that 50% of that country's annual output of 100 medical graduates leave Ghana to work and remain in other countries. Reporting on research into the European medical workforce, Dr Jesper Poulsens – President of the Permanent Working Group of European Junior Hospital Doctors – projected an absolute shortage of doctors in Europe by 2010 despite the fact that 60 000 medical practitioners are currently underemployed or unemployed in many European countries.

Women comprise the majority of health care workers in South Africa except in the medical profession

Many unanswered questions were subsequently posed about the impact of increasing numbers of women medical graduates on the delivery and economics of health care in the next 20 years – and the effect on women in medicine of the issues raised above.

Problems facing women

There is a substantial international body of literature which addresses the problems women face during their training and their post-graduate careers. Relatively little research has, however, been done in this regard in South Africa. Several facts are relevant:

- Women comprise the majority of health care workers in South Africa except in the medical profession.
- Increasing numbers of women are now being accepted as medical students by all the faculties of medicine in this country.
- Women outnumber men in most undergraduate disciplines and some post-graduate groups at many medical schools. The striking exception is in post-graduate medical training, where women generally number less than 25% of the total.

Several studies have shown that many women find it difficult to combine a full time productive career in the health services with marriage and motherhood. This is particularly where medical practice demands night and weekend work as well as on call availability, in addition to a 40 hour working week (Sanders *et al* 1990; Ulstad 1993: Warren and Wakeford 1989).

Research has shown that many married women doctors tend to work part time for

between 10 and 15 years after bearing children before returning to full time practice. Some practice part time for their entire careers. Those who attempt to return to full time practice find it difficult to re-enter the profession and to update their skills and knowledge.

Barriers to specialisation

Women who wish to train as specialists encounter resistance to part time training, a reluctance to make concessions for maternal responsibilities and apparent discrimination which inhibits access to higher level positions. In the past, women doctors did not easily obtain appointment to positions of authority and had limited access to policy and decision making fora. Changes have taken place in recent years but women are still underrepresented in many arenas.

Women doctors who are pregnant or have young children also have problems with regard to specialist training:

- It is inadvisable for pregnant women to be exposed to anaesthetic gases or irradiation. This interferes with training in anaesthesiology or radiology.
- Part time specialist training is possible, but only for a portion of the training, and training post structures in most teaching hospitals do not make provision for part time training.
- Most teaching hospitals do not provide adequate child care facilities to enable medical women with small children to work long unsociable hours.
- The culture of most societies, although changing, still expects mothers rather than fathers to be child rearers and carers.

While women comprise the minority of medical graduates, their problems have been recognised. Little has, however, been done in South Africa to address these problems. As the number of women graduates increases, it becomes imperative to find solutions or the detrimental impact on health services as a whole will be significant.

There are also economic consequences: unsatisfactory returns on the individual's and the country's investment in medical training and an underutilisation or wastage of a costly resource. It is clear that this is not a women doctors' problem but one which the employing authorities, the Universities, and the profession as a whole must address.

Research

A small workgroup has recently been constituted under the auspices of the Medical Association of South Africa to assess the extent of the problem in this country and to identify interventions which will minimise the obstacles or enhance beneficial factors.

Several research questions have been posed:

- What factors impede or facilitate doctor's training and career development. Do these factors affect women to a greater or lesser extent than men?
- Do cultural and racial factors either facilitate or impede women doctors' training and career development to a greater extent than their male colleagues?
- Are women doctors discriminated against in professional associations and other bodies? Why are they so poorly represented on the Councils of these organisations?
- What impact do these detrimental or beneficial factors have on the optimal utilisation of both male and female doctors?
- What interventions have been successfully introduced in other countries?
- What additional interventions can be devised and at what cost?

When answers to these questions have been found it will be necessary to ensure that the decision makers and other stakeholders are persuaded of the need for change. Proposals have already been made for the appointment of a Ministerial taskforce to address not only issues relating to medical women, but also to women generally in the health services. There is much work to be done. DPSA

Many married women doctors tend to work part time for between 10 and 15 years after bearing children before returning to full time practice

Most teaching hospitals do not provide adequate child care facilities

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PAWNS OR PARTICIPANTS?
COMPULSORY COMMUNITY SERVICE

By Kerrin Begg, Chairperson
Junior Doctors Association of South Africa

Junior doctors should participate in uplifting health care. But conscriptive medical labour or 'vocational training' is unpalatable, particularly since there are no properly funded and planned training schemes. Communities and doctors would benefit far more from a voluntary, incentive driven system in which doctors go to areas they have freely chosen.

Compulsory community service has been extremely contentious since it was first debated in 1989

It is an undisputed fact that the Government of National Unity has inherited a health care system completely fragmented by the legacy of apartheid. With 14 different departments of health, public health services could not but become inadequate, inaccessible and unaffordable to meet the requirements of most South Africans – especially those in rural and peri-urban communities.

One aspect that contributed to this situation was the maldistribution of medical practitioners both between the private and public sectors, within the public sector, and between rural and urban areas. In addition, medical education was split along racial lines (see Khosa in this issue), which affected funding and orientation of training – of specialists versus generalists – creating the perception that 'white English' medical schools were training doctors for export, and 'black' medical schools were training doctors for rural areas.

Compulsory community service, as one alternative to alleviate the maldistribution of health services in underserved rural areas, has been debated since April 1989, when the South African Medical and Dental Council (SAMDC) resolved to approve and further investigate national community service. The issue was extremely contentious, particularly in view of strong objections to military conscription of white males at the time, and was not supported by the majority of stakeholders.

Arguments against the concept included:

- That it did not address the reasons why doctors are reluctant to work in the underserved areas, namely appalling working conditions, inadequate facilities, equipment and medications, poor supervision by senior colleagues, lack of back-up facilities and irregular payment of salaries, among others.
- That it was discriminatory in view of the fact that only the medical profession was targeted, and other professions who could make an important contribution to improving primary health care were ignored – such as engineers, plumbers, artisans, teachers, and lawyers.

Shortly after the elections in April 1994, the issue of compulsory community service was again brought to the fore with the appointment of Dr Nkosasana Zuma as Minister of Health. Zuma indicated her strong support for the concept, which she perceived to be a real solution to right the wrongs of the past.

In addition, the Health Finance Committee recommended early in 1995 that junior doctors be compelled to perform community service in view of the massive government subsidy toward their undergraduate training – mooted at anything between R400 000 and R750 000. This despite the fact that all tertiary education is subsidised and the medical curriculum is one of only a few with

a service component as part of training, which is unpaid.

The Junior Doctors Association of South Africa (JUDASA), representing medical students, interns and junior doctors, was extremely concerned about the implications of such a system. At the same time, however, JUDASA wanted to address the imbalances of the past and strive towards finding the solution for an ideal health system.

Community service

The arguments for compulsory community service are simple. There is a shortage of doctors where there is a desperate need – in rural and peri-urban communities. Sufficient graduates are being produced by the country's medical schools, but doctors prefer the comparatively lucrative world of private practice or greener pastures in other countries. These 'self-seeking' doctors should thus be forced to fulfil their responsibilities in the 'needy' areas, thereby giving the country something in return for their state sponsored medical education.

Compulsory community service, as envisaged by the Department of Health, is not a solution to stem the tide of emigrating doctors because it does not address the reasons behind doctors' eagerness to work abroad and their reluctance to work in rural areas. Research has shown that the 'debt factor' was the prime motivation influencing particularly junior doctors to leave the country.

Graduates at the end of their sixth year of study have amassed a student loan debt of up to R80 000. In 1994, a study analysing the financial position of graduates indicated that over 70% had loans with an average of R40 300, and that over 10% had loans exceeding R60 000. Taking inflation and increased fees into account, R80 000 is a conservative estimate for 1996.

When faced with repayment over the following six years in relatively poorly paid positions in the state service in South Africa versus repayment over six months in a far more favourable currency – the latter option is easily the most attractive.

Prior to July 1996, the starting salary of a doctor as an intern was R28 000 per annum. Since July the salary has been increased to R50 500 per annum. A policy of compulsory community service would only serve as a catalyst to encourage mass emigration of highly trained South African doctors.

Logistical concerns with implementing compulsory service include:

- Newly qualified doctors do not have sufficient clinical experience to enable optimal health care provision in remote areas without adequate guidance and supervision.
- Structures are not yet in place in primary health care settings to receive doctors performing community service.
- It does not address the issues of shortages in secondary level hospitals, shortages of specialists in the public sector per se, selection of medical students, and the specialist orientation of the present undergraduate curriculum.

More philosophically, the compulsory component amounts to conscription, which contravenes the individual's rights enshrined in the Constitution, namely:

- Equality – since the medical profession is the only profession singled out.
- Freedom from slavery, servitude and forced labour – community service constitutes compulsory labour, especially if the period of time required is longer than one year, and if students are not notified well in advance, that is prior to commencing their studies.
- Freedom of movement and residence – an individual is required by the state to work in a particular area.
- Freedom of trade, occupation and profession – an individual would earn a salary which compares unfavourably with that which they would otherwise have been able to secure.

The Bill of Rights, however, recognises that access to health care is a basic human right, which provides the state with a strong argument for using compulsory public service to meet this requirement.

But the Constitution does require that 'less restrictive means to achieve the purpose'

Compulsory community service does not address doctors' eagerness to work abroad and their reluctance to work in rural areas

Newly qualified doctors do not have sufficient clinical experience to enable optimal health care provision in remote areas without adequate guidance and supervision

The compulsory component amounts to conscription, which contravenes the individual's rights enshrined in the Constitution

Before making a rural post attractive, it needs to be made workable and liveable

be considered. One example could include a voluntary incentive-based scheme which encourages rather than forces doctors to work in the periphery.

Incentives

Before making a rural post attractive, however, it needs to be made workable and liveable. Thus working conditions need to be acceptable, physical security guaranteed, health facilities and infrastructure improved, and referral networks established. Remuneration must also be adequate and regular as a prerequisite for introducing any community service, whether voluntary or compulsory.

Some of the proposals for incentives have included:

In July 1996 the Interim National Medical and Dental Council of South Africa (INMDCSA) passed a resolution to introduce a period of two years post-graduate training from January 1998

- Support for continuing medical education since most doctors fear not being able to keep up with the latest developments in a rapidly changing medical environment. Examples include linking peripheral hospitals to an academic health complex thereby providing back-up and supervision; library and journal facilities; and study leave.

- Additional allowances such as relocation expenses, recruitment allowance, and inhospitability allowance – dependent on the hospitability factor according to which the particular area was graded.

- Other remunerative rewards such as repayment of study loans – payment of R2 000 per month directly into the student loan account would pay off a loan of R50 000 in approximately two to three years; and scholarship facilities for children to attend appropriate schools.

- Preferential admission to specialisation programmes for time spent at peripheral hospitals. Another option is that of large scale re-introduction of state bursaries, with the students contractually bound prior to commencing their studies to a year-for-year service agreement in return for fees being paid by the state.

Vocational training seems to have replaced the concept of compulsory community service

One major advantage of a voluntary incentive driven system is that doctors would feel positive going to an area which they have freely chosen, as opposed to feeling resentful about being 'punished' under a compulsory system. This attitude of goodwill would increase the benefit to the community.

Goalposts shifted

In July 1996 the Interim National Medical and Dental Council of South Africa (INMDCSA) passed a resolution to introduce a period of two years post-graduate training, or 'vocational training', from 1 January 1998 as a pre-requisite for medical practitioners to enter private practice.

INMDCSA – a supposedly autonomous body regulating the medical profession and safe guarding the public – claims one of the primary aims is 'to ensure that adequate standards of education and training of health care professionals are in place'. This raises several critical questions:

- Why did the concept of 'vocational training' originate from the Department of Health as early as February 1996, when a document was released proposing that all doctors undergo a period of at least two years post-graduate training after internship 'to meet the increasing complexity of modern medicine and to ensure that doctors have had sufficient experience before they start to practice independently'?

- Why does the wording of this echo familiarity with another document released by the Department of Health – the official policy document on *Restructuring the National Health System for Universal Primary Health Care?* The discordant note comes, however, in proposals to attract and retain full time medical staff in the public sector: 'implementation of a policy requiring new medical and other health professional graduates to spend a defined period working in the public sector, under limited registration, prior to being allowed to enter private practice, with full registration.

- If the protests that the term 'vocational training' has not simply been substituted for 'compulsory community service' are to be believed, why has the Department of Health dropped all initiative and impetus for the concept of 'compulsory community service' ?

Vocational training

There are few who would argue against the concept of vocational training *per se*. The demands of medicine are such that newly qualified doctors need all the training they can get before beginning their chosen profession. A majority of doctors remain in the public sector in training positions after completing internship, indicating a self identified need for additional training and experience.

But the proposal may not truly be for vocational training, but a thin and unconvincing excuse to disguise what is in reality medical conscription.
The constituency that this policy affects most – present medical students – are convinced that though the terminology has changed, the end result remains the same: conscriptive or forced labour. It is interesting that South African graduates are in demand for their clinical excellence world wide. This questions the assumption that they are now deemed to be in need of additional training.

INMDCSA has been unable to produce any evidence indicating that medical graduates lack essential knowledge or skills. If graduates are indeed as inadequately prepared as is being suggested, the first place to start correcting the deficiencies should be the present undergraduate curriculum – rather than attempting 'corrective surgery' after graduation.

In addition, the medical Council cannot justify imposing a further two years of training on individuals nearing the end of their studies, prolonging expectations of a seven year training period to nine years.

More practically, over 2 000 posts would be required to employ the 'vocational trainees'. Of these posts that are available in the country at present, the majority are in rural areas, or primary care facilities. At present most 'supervisors' are in secondary or tertiary facilities, and thus not where the available posts exist.

In addition, medical schools are struggling to find sufficient supervisors for undergraduate tuition – as senior consultant specialists are also leaving the public sector in droves because of dissatisfaction – let alone those needed for post-graduate supervision. To ensure that the concept is in fact 'training' and not 'service', supervision must be guaranteed. A curriculum, methods of evaluation and certification all need to be established before calling the process 'training'. And working conditions and facilities need to be of a sufficiently high standard to warrant being given status as a training post.

Conclusion

It is understandable that a government committed to bringing health care to the underprivileged majority of South Africans will attempt to use all the resources available to fulfil its obligations. It is also recognised that the intent of community service is to ensure adequate health delivery by doctors in the public sector in terms of quality and quantity.

However, the imposition of conscriptive medical labour is unpalatable, particularly given the conspicuous absence of a properly motivated, funded and well planned vocational training scheme. Junior doctors do have a responsibility to participate in the upliftment of health care in all communities – by being effective roleplayers in the provision of appropriate, accessible health services.

But is the best solution via compulsory community service, or are there 'less restrictive means available' to achieve the same result? Thus, the principle of redistribution of human resources is agreed upon, but the method of implementation is of greatest concern.

"It is an old adage in the Armed Forces that one volunteer is worth ten pressed men, and disgruntled doctors do not make good doctors. The beginning of a medical career should be characterised by optimistic and pleasurable anticipation of a worthwhile and fulfilling professional life – a frame of mind hardly likely to be fostered by treating junior colleagues as cheap, directable labour." (Lee 1996) IPSA

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That South African graduates are in demand for their clinical excellence world wide questions the assumption that they are now deemed to be in need of additional training

Junior doctors do have a responsibility to participate in the upliftment of health care in all communities

To ensure that the concept is in fact 'training' and not 'service', supervision must be guaranteed

Public Service for Specialists?

By Linda Gail Bekker
Registrars Association, Medical Association of South Africa

The acceptable world wide ratio of general practitioner to specialist is 4:1. Although this is South Africa's ratio, the present system is believed to encourage specialist urban private practice with its attendant financial rewards, at the cost of service to the majority of people, particularly those in rural and periurban areas. There is also an apparent imbalance of white males working in these urban areas.

To counter these problems, it has been suggested that there be a requirement of public service before registration as a specialist. Another proposal is for selection committees to appoint more blacks, women and candidates of rural origin.

Current training

Specialist training involves both financial and personal sacrifice on the part of the registrar, often against a backdrop of debts incurred during undergraduate training. In addition, workloads in the academic and tertiary institutions have become such that the service load detracts considerably from formal theoretical training.

Many registrars are working far in excess of the 56 hour week for which they are paid.

The Interim National Medical and Dental Council's (INMDC) requirements for specialist registration is one year of post internship general medicine followed by 48 months in a recognised registrar post with either the College of Medicine or MMed Higher Degree.

The registrar post is only recognised if the trainer to trainee ratio in that facility is 1:2 – one specialist consultant for every two trainee specialists or registrars.

Subspecialisation requires a further two years in a recognised unit such as cardiac, respiratory, renal, etc. Again, ratios should be at least 2:1 and preferably 1:1. The continuing loss of trained and experienced consultants from the public sector will obviously have implications for this ratio and subsequently the numbers of registrars trained in the future.

Limited registration?

One of the proposals recently put forward is a three year post specialisation limited registration period whereby the newly qualified doctor will only be eligible to practice in the public sector at level two and three hospitals. There would also be greater emphasis on general specialists and very few posts for subspecialisation. The Registrars Association in South Africa believes some of these issues should be addressed.

An independent document proposes the role of registrars in health care delivery to the South African community. This proposal has been encompassed in the report of the combined Medical Association of South Africa (MASA), Ministry of Health Ministers Work Group addressing issues regarding public sector medical practitioners.

In essence, the document proposes that the needs of the community be properly defined, and the involvement of the academic health complexes at all levels of health care delivery ensured.

Registrars can be very instrumental in this process by rotating their community facilities for short periods of time as organised by their academic departments during their registrar training period.

Provision has been made by the Medical and Dental Council for registrars to spend one year in non-academic centres under partial supervision.

Community service that is not voluntary, incentive driven and agreed to after dialogue between the main roleplayers is doomed to failure. It will contribute to a disincentive to specialise, increase the brain drain, increase social and economic upheaval in a discriminatory fashion and may not assist the equalisation of imbalances in recruitment of these registrars, particularly in terms of gender.

At the University of Cape Town (UCT) the undergraduate classes are approximately half female to male, yet less than 25% of registrar posts are female.

A task force within MASA in conjunction with UCT is currently looking at where women are in medicine in South Africa and how the system assists or obstructs their career pathways.

It is possible that additional training, albeit in the community, may make specialisation impossible for the woman doctor who wishes also to have a family.

Urgent research and investigation is needed to ensure that the numbers and types of registrars that are trained will address the health needs of the country.

This is both in terms of rural health needs, but also continued standards in tertiary care, teaching and research. This will ensure equal access to excellence rather than mediocrity and deficit for all the people of our country.

Race and Gender in Medical Schools

A Snapshot of 1994

By Meshack Khosa
Centre for African Research and Transformation
University of Natal

Health personnel development must be an integral part of health national development. Predictions are that numbers of health workers in South Africa have to be doubled over the next three decades. This daunting task represents an opportunity for countering the effects that racial and gender discrimination have had on our medical schools. While changes have occurred since 1994 in some universities, this article provides a snapshot of gender and race representation in medical schools in 1994.

Until the early 1980s, there was a 'policy of racial exclusion' in tertiary education. Some institutions were reserved only for whites, and other race groups were not allowed access to those facilities without ministerial permission. This mindset largely continued throughout the 1980s and 1990s despite the repeal of the discriminatory legislation.

In general terms, this created two types of medical schools at South African universities. Those which were the stronghold of whites including: the Universities of Cape Town, Orange Free State, Pretoria and Stellenbosch. The others were set up for black people, like the University of Natal Medical School, Medunsa and the University of the Transkei.

The era of negotiations started by then President FW de Klerk in 1989 had reformist ramifications throughout society. The new tendency was away from racial – and to some extent gender – discrimination in white dominated institutions. However, the normalisation of medical departments so that they accurately reflect the proportions of society is hardly nearing completion.

This article is based on a study carried out for the Department of Health between July and December 1994. At issue is the representativeness – in terms of race and gender – of students and staff in faculties of medicine at Universities in South Africa.

Statistics were requested from each university. For students, first and final year proportions are used on the assumption that the statistics for final year students represent the intake conditions in the late 1980s.

For staff, gender and race were also examined where these data were supplied. Information received was varied and sometimes incomplete and considerable data refining was necessary to make the information compatible across universities. The term 'race' is based on the categories defined during apartheid: Africans, Indians, coloureds and whites, since it is according to those categories that discrimination has occurred.

UCT

❑ Students

In 1994 the Faculty of Medicine at the University of Cape Town had a student

In UCT's medical school, the proportion of Africans increased to about half the number of whites among first years in 1994

The composition of staff at UCT fared considerably worse than the students, both in terms of race and gender

body which was white dominated. However, the proportion of Africans – about a ninth of the size of the white students in the final year class – increased to about half the number of whites among first years in 1994. The proportion of coloureds and Indians also increased, although not by as much. The position of female medical students has considerably improved, from a male to female ratio of around 60% to 30% in the final year class to close on half-half on the first year intake.

❑ Staff

The composition of staff at UCT fared considerably worse than the students, both in terms of race and gender. The number of whites far outstripped that of other race groups, both at the University and at the Groote Schuur Hospital. As many as 95% of the University staff and 88,5% of the Hospital staff were white, indicating a strong entrenchment of whites in the medical education institutions.

Coloureds occupied only two of the 81 staff positions and 41 of the 739 medically qualified Groote Schuur staff

It is possible that the low showing of Indians – 2,3% of staff – relates to the significant distance from KwaZulu-Natal where the majority of Indians live. However, the same can not be said for coloureds who are most concentrated in the Cape. Despite this they occupied only two of the 81 staff positions and 41 of the 739 medically qualified Groote Schuur staff in 1994. Africans similarly were poorly represented. All three black groups collectively made up little more than 10% of the staff for both the University and the Hospital.

In terms of gender, males were in the majority, holding close to four fifths of the positions. There were a total of 542 males and 156 females at the University and the Hospital, placing males at over three quarters of the total staff complement. In the lecturing department specifically, in 1994 there was only one woman out of the 40 professors, associate professors and senior lecturers. This imbalance is tremendous and far from society's proportional norm of approximately half the numbers of males to females.

Medunsa

❑ Students

In the group due to graduate from Natal University at the end of 1994, 56,3% were Indian thus making up the majority

Medunsa's history as a 'black university' explains the strong bias towards African students. In 1994's final year class, African students were in the majority. Indian students made up 4,3% of the class. The 1994 intake was quite different with 62,5% of the class being African and 35,6% Indian. The seven white students represented only 2% of the total first year class.

Males were equally dominant in both the first and final years and in all race groups. In the first year group, 68% of the students were male – although this figure is more representative than the final year group, it is still greater than two thirds of the student body.

University of Natal

❑ Students

The University of Natal's Medical School was established for the express purpose of producing qualified black medical practitioners. There were consequently no white students in either the intake or in the final year class in 1994. White students were, however, admitted to the medical school for the first time in 1995.

In the group due to graduate at the end of 1994, 56,3% were Indian thus making up the majority. The next largest group was Africans, with only two coloured final year students. For the 1994 intake, the proportion of coloureds had almost doubled to 4%. African first year students were by this stage in a slight majority over the formerly dominant Indians, now making up 43,5%.

The gender statistics demonstrate that although males were still in the majority, female numbers have increased from less than half of the final year class to almost the same in the 1994 intake.

❑ Staff

Racial proportions among staff demonstrate that most of the 229 posts were held by Indian staff in 1994. The next largest group of staff were whites, while Africans held only 6,7% and coloureds just over 1% of posts.

This can only be described as surprising in a department which has overwhelmingly trained black students for four decades. The important question is where African graduates have gone and why they do not join the academic staff. Further, the majority of academic staff positions are occupied by Indian and white males.

Orange Free State

❑ Students

The overwhelming dominance of white students is evident in Table 1. In the final year there was a single Indian male student. The 1994 student intake represented only a marginal improvement. There were two Africans and nine Indians in the first year class of 140 – together making up just 7,8% of the total 1994 intake.

The complete shift from a male dominated to a female dominated student body is, however, noteworthy. In the final year class, 29,5% of the students were female, compared with an increase to 56% in the 1994 intake. This was only true, however, for the whites. The minimal number of coloureds and Africans were still dominated by males.

❑ Staff

Every member of the 322 strong staff in 1994 was white. Whereas most establishments in the new South Africa had by this time responded positively to democratisation, the University of the Orange Free State's medical faculty remained largely unaffected.

University of Pretoria

❑ Students

At the University of Pretoria's Faculty of Medicine – where approximately 20% of South Africa's medical graduates are produced – the majority of the students in 1994 were white. In the final year class, there were only two black (Indian) students. *The Sunday Times* (4 December 1994) announced that the two black students 'Zaheer Ismal, 23, and Priya Soma-Pillay, 23, became the first persons of colour to complete the medical degree course at the Afrikaans university (Tukkies)'.

However, in the article, the Dean of the faculty, Professor Jan van der Merwe, said 'Tukkies had been open to local people of colour since 1988'. Is it coincidence then that black people have not gone to this university? While poor schooling for black students was a factor, the language of education – Afrikaans – was also important.

In the first year class of 1994 the proportion of whites dropped to 88%. The remaining 12% comprised 2,9% coloured, 4,1% African and 5% Indian students. Although there were more males in both the final and first year classes, the differences were marginal.

University of Stellenbosch

❑ Students

At the University of Stellenbosch, white students and staff were in the majority. There were no African students registered in either the first year or the final year class. One Indian and 17 coloured students were in the final year class of 173, with whites completely dominating the student population. In the new 1994 intake, the white dominance actually increased by 5% points.

The University supplied the acceptance rates for 1994, revealing that 'only' 11% of whites who applied were accepted. By comparison 38% of African applicants and 6% of Indians and 38% of coloureds were accepted. This may paint an 'affirmative picture' but absolute numbers tell a different story: there were 946 white applicants and only 37 African applicants.

A slight gender bias toward male students in the graduating class of 1994 was largely overcome in the new intake, with an almost 50/50 ratio.

❑ Staff

Staff at the University of Stellenbosch were overwhelmingly white with a definite male domination.

University of Transkei

❑ Students

There were only African and Indian students at the Transkei University's Department of Community Health. Whereas there were equal numbers of *Indians and Africans in the class to* graduate in 1994, over three quarters of the new intake were African. In terms of gender, proportions were fairly even, with a slight bias towards males in 1994's intake.

❑ Staff

There were no coloured staff members at Transkei, with slightly more African than

At Natal University, the important question is where African graduates have gone and why they do not join the academic staff

In O.F.S. medical school's 1994 intake, there were two Africans and nine Indians in the first year class of 140

At O.F.S. the complete shift from a male dominated to a female dominated student body in 1994 is noteworthy

Every member of the 322 strong staff at O.F.S. in 1994 was white

The University of Pretoria – where about 20% of South Africa's medical graduates are produced – was also white dominated in 1994

At Pretoria, while poor schooling for black students was a factor, the lanuage of education – Afrikaans – was also important

Table 1: Collective tabulation of the race and gender breakdown of staff and students at South African universities

Table showing numbers of first and final year students in each race group and gender class at Medical Schools

University	Class	Africans	Indians	Coloureds	Whites	Male	Female	Total
Cape Town	first year	43	25	32	88	98	90	188
	final year	13	12	23	119	101	66	167
Medusa	first year	230	131	00	7	250	118	368
	final year	113	5	0	0	86	32	118
Natal	first year	65	54	5	0	64	60	124
	final year	39	53	2	0	64	30	94
O.F.S.	first year	2	0	9	129	61	79	140
	final year	0	0	1	87	62	26	88
Pretoria	first year	10	12	7	213	134	108	242
	final year	0	2	0	163	90	76	165
Stellenbosch	first year	0	2	8	147	81	76	157
	final year	0	1	17	155	81	76	173
Transkei	first year	32	9	0	0	22	19	41
	final year	9	9	0	0	9	9	18
WITS	first year	30	71	4	104			209
	final year	20	46	10	124			200
TOTAL		**606**	**432**	**118**	**1336**	**1236**	**849**	**2492**

Table showing numbers of joint establishment of staff at Medical Schools according to race group and gender class

University	African	Indian	Coloured	White	Male	Female	Total
Cape Town	27	19	43	731	156	542	698
Medusa						392	
Natal	16	115	3	95	164	65	229
O.F.S.	0	0	0	95	229	93	322
Pretoria							656
Stellenbosch (JS)	4	7	4	343	164	38	358
Transkei	34	32	0	13	64	15	79
TOTAL	**81**	**173**	**50**	**1182**	**613**	**53**	**2849**

Please Note: These statistics are based on information provided by the University Medical Schools and Faculties themselves. In some cases they were provisional. In certain areas, the required breakdown was not provided. This accounts for discrepancies between totals.

Indian staff members. There were many more males than females at a ratio of more than 5 to 1.

WITS

The historically white university pattern was repeated at the University of Witwatersrand Medical School. There were far more white students in both the first and final years, although the proportion decreased for the 1994 intake. In that year, Indians tended to be in greater numbers than Africans, and coloureds were the least represented. Information on staff composition according to race and gender was not available.

Divided medical schools

In all formerly white medical schools, the majority of staff and students were white and male. Although in each 'white' university the 1994 intake is noticeably more representative than the proportions of race groups in the final year class, they are not significantly more representative.

Also, the propensity for historically white institutions to be opened up to other race groups seems greater than the enrolment of whites, and to a lesser extent coloureds and Indians, into African medical schools. This could be an indication of the quality – real or imagined – of facilities offered by the two types, the favoured facilities being those of white institutions.

This could indicate previous over catering for white students and under catering for African, coloured and Indian students. The current inflow into the previously white institutions represents therefore, the overflow of students interested in becoming medical practitioners but who have not been given the opportunity.

In the past, racial exclusion meant that Africans, Indians and coloureds were not adequately represented in the compositions of universities. Instead, positions and opportunities were racially reserved at the level of each institution.

Drastic action

The conservative progress in terms of redressing racial and gender imbalances among staff represented the extreme of the trend already demonstrated among students. It is possibly among the staff that the most drastic action is needed to redress imbalances. Staff statistics also demonstrate that the notion of 'black' universities is a misnomer, since they often have high white, and non-African percentages.

Predictions have been made that various categories of health workers in South Africa have to be doubled over the next three decades in order to cope with natural loss as well as increased population and economic growth. This task, although daunting, represents an opportunity for countering the effects racial and gender discrimination continue to have on our medical schools.

Evidence provided by the Department of Health's academic chief directorate suggests that since 1994 the composition of students in medical schools has changed and there is progress in some institutions. The major challenge now is to attract African, Indian and coloured staff.

Health personnel development must be an integral part of health and national development. However, affirmative action and equal opportunity programs must go beyond the mission statements of universities. Historical, racial and gender imbalances must be urgently addressed. Training and research should make use of appropriate teaching methods and technology in community based settings. Medical schools and nursing colleges will have to equip their graduates with knowledge, attitudes and skills needed for implementing a new health policy. [illegible]

ACKNOWLEDGEMENT

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At WITS, Indians tended to outnumber the black student group and coloureds were the least represented

Various categories of health workers in South Africa have to be doubled over the next three decades in order to cope with natural loss as well as increased population and economic growth

Aspiring Doctors: Hurdles To Entry

By JP deV Van Niekerk
Dean, Faculty of Medicine, University of Cape Town

The University of Cape Town was the first to establish a medical school in Africa south of the Sahara. Its first doctors graduated in 1992. The University of the Witwatersrand followed shortly afterwards. Today there are eight medical schools in South Africa, the newest, Unitra, having been established in Umtata during the period of independence of the Transkei.

More doctors?

With the hullabaloo about Cuban and other doctors with foreign qualifications invading the country, the first question is why we do not train more. There is certainly a maldistribution of doctors but given our population of over 40 million people – over 25 000 doctors on the South African Medical and Dental Council's register and an annual supply of just over 1 000 new doctors from all the medical schools – South Africa is probably correctly catering for its present needs and for what it can afford.

The eight medical schools in the country are all in a process of change. However, their historical backgrounds are very different.

Language and race

They were divided by language and by racial classification. The Universities of Cape Town and the Witwatersrand are English speaking and mixed race although they were prevented from accepting black African students until the mid 1980's. The Universities of Pretoria, Stellenbosch and Bloemfontein were white and Afrikaans speaking.

The Universities of Durban and Medunsa were established as black medical schools and are English. Unitra is the newest and also teaches in English. All medical schools have now adopted policies of becoming more representative of the population of the country.

Since most Africans – who are in the majority – matriculate with English as their second language, the former Afrikaans medical schools now also teach in English.

Changes in the undergraduate composition by racial classification in the medical schools shows substantial improvements over the past few years (Figure 1). White students are over represented compared with their proportion of the population and Indian students even more so.

Changes in the demographic profile of students according to gender have been equally dramatic. Until the 1970's the proportion of women in medical classes in South Africa was roughly 10%. More women have since entered medical school and women now comprise just under 50% students in first year classes.

Selection

All medical schools rely largely or completely on academic criteria as measured by matriculation, university or equivalent results in offering places to applicants. Some also use biographical data to help in their selections.

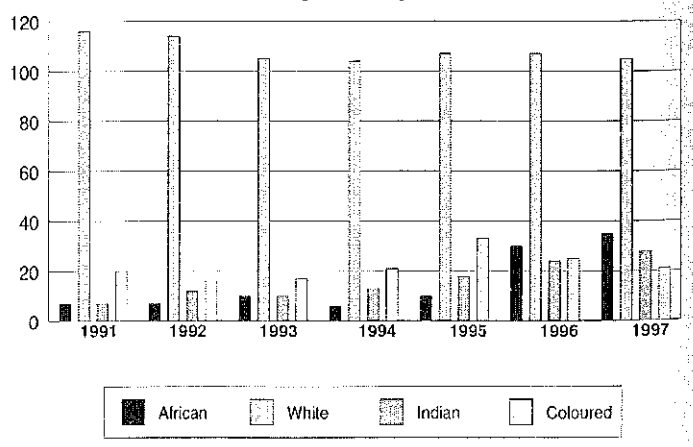
How then do they deal with the very varied student applications from the different former matriculation authorities? In particular, the poorly resourced former Department of Education and Training and Transkei schooling offered only on a very small percentage of students the option of taking mathematics and science which are pre-requisites for medicine.

The University of Cape Town found that students from the latter educational authorities fared very poorly because they were underprepared. UCT Medical Faculty then introduced an Academic Support Programme in which approximately 40 matriculants from these examinationauthorities are admitted as a special category. They take the same subjects as other students but receive the benefit of special tuition and fewer subjects to start with – completing the first three years in a structural four year programme. This project has proved effective and has resulted in a dramatic change in the student profile (Figure 1).

The ability of students to meet their financial commitments is another cause of considerable concern. This is of course not limited to medical students and has been a flashpoint in several tertiary educational institutions recently. It is, however, more severe in medicine because of the higher costs and longer courses.

Furthermore, support courses as described further lengthen courses for those students who can least afford the costs. External donors, including the most successful organisation, MESAB (Medical Education for South African Blacks), provide only part support. More sustainable long term solutions are urgently required.

Figure 1: New admissions to MBChB1
University of Cape Town



Brick By Brick

Low Cost Housing Developers

By Rod MacKinnon and Sharon Lewis
Settlement Dynamics

Delivering low cost housing remains one of the state's most important tools for achieving its socio-economic objectives. While some structural and regulatory adjustments are still being made, the housing delivery sector does appear to be knuckling down to the task of building houses. This article examines the activities of developers in the industry.

The sluggish start to housing delivery has caused of a series of high profile slanging matches and buck-passing exercises. National government has been blamed for implementing obstructive policy and financial institutions have been slated for their rigid lending criteria. The private sector too has been reprimanded for its slow response to the subsidy opportunities, and local authorities have been represented as being apathetic, disorganised and in an incurable state of flux.

Who then is creating the 538 481 housing units that are estimated to be in the delivery chain? The Housing Monitor (November 1996) lists 855 active low cost housing projects, an increase of 19% over the previous year. Housing units in this analysis consist of all low cost housing products. This includes serviced sites, serviced sites with a wet-core, and serviced sites with a substantial top structure.

Low cost housing in turn, is defined here as having an upper price limit of R150 000. But the most important defining factor is that the housing is intended for low income consumers. In other words, the analysis excludes sectional title and 'gash' – good address, small house – housing.

Table 1: Number of active low cost housing projects listed in *The Housing Monitor* (1989 - 1996)

	Transvaal	Cape	KwaZulu -Natal	Free State	Total
NOV 89	173	162	33	25	393
MAY 90	285	170	86	51	592
NOV 90	244	101	127	53	525
MAY 91	271	110	217	66	664
APR 92	233	115	148	58	554
NOV 92	335	115	182	62	694
AUG 93	182	107	138	69	496
APR 94	157	107	134	50	448
NOV 94	185	106	164	47	502
MAY 95	168	211	194	66	639
NOV 95	239	235	159	84	717
APR 96	227	264	192	88	771
NOV 96	270	301	191	93	855

There may be slight distortions of the regional figure represented after 1993 when the new regional boundaries were implemented. To retain comparative value, the current analysis is presented in four areas: KwaZulu-Natal, the Free State, Transvaal (consisting of Gauteng, the Northern Province and Mpumalanga), and the Cape (consisting of the Western Cape, Eastern Cape, Northern Cape and North West).

With more projects being initiated and fewer housing units being completed, projects are taking longer to reach fruition

According to Table 1 the predictions that the rate of activity in the low cost sector is increasing, are borne out. However, the rate of delivery is not quite so impressive. In the last six months, 19 projects have been completed nationwide, accounting for only 12 032 units. This decrease in real housing delivery is affirmed by the drop in the number of units sold during the last 12 months (Table 2). The last 12 months saw about 40% greater delivery than two years ago, but roughly 20% less than last year.

Table 2: Estimate of affordable housing sales (1993-1996)

	Estimated sales / year
1993	56 500
1994	46 000
1995	83 000
1996	65 500

There are currently 465 developers in South Africa who have active housing projects on the go

The reasons for the slowed rate of delivery are difficult to pinpoint. What is evident, however, is that with more projects being initiated and fewer housing units being completed, projects are taking longer to reach fruition.

The delivery drop off indicates in part that the reserve of easy-to-deliver land and partly planned projects is almost exhausted – having been introduced into the Independent Development Trust (IDT) and subsidy schemes. Project cycles are now likely to become longer. It also illustrates the impact of the project cycle, which is discussed below.

In the following analysis 436 (presently active) subsidy scheme projects are considered. The discussion below considers all delivery in the sub-R150 000 market, and takes a closer look at the important subsidy suitor.

Table 3: How the cake is cut (Nov 1996)

	No of Projects	%	No of units	%	Ave size of projects
Private developers	463	54	283 201	53	612
Public developers	268	31	186 332	35	695
Joint Ventures	82	10	43 049	8	525
Parastatals	42	5	43 862	8	1 044
Total	855		538 481		630

Note: the four private and public developer groups are combined into two.

Developers

There are currently 465 developers in South Africa who have active housing projects on the go. These are all projects which are in the delivery pipeline, from planned projects, to those which are in final construction stages. In 1991 by comparison, there were 256, so the industry has almost doubled the number of participants in that period. The types of developers have also expanded, and today there are six broad groups (Table 3):

- Local public developers comprise local authorities.
- Provincial public developers are housing or development corporations which handle housing delivery on a provincial basis such as Free State Development and North West Housing Corporation.
- Private developers are companies which operate for gain such as Stocks & Stocks and Grinaker Housing, as well as Section 21, non-profit, companies like NewHco and Comhousing.
- Unusual private developers include companies responding to a need for housing within an organisation such as Transnet Housing, as well as development trusts, associations and organisations which are established for the development of a specific project, like Cato Manor Development Association.
- Parastatals comprise developers which are partly funded by the state, but are also expected to raise financing within the private sector. The most notable being the SA Housing Trust (SAHT) which dominates this group.
- Joint ventures are a growing group, with the majority being between the public and private sector, for example, between local authorities and private firms. The degree to which identified joint venture partners share risk and profit on developments is not known, and will be the subject of future research.

The increased diversification in the industry is welcomed in most quarters because it provides a national capacity to respond to varying local opportunities.

It is useful to distinguish between the number of active projects and the number of

sites in delivery. The different groups of developers exhibit distinct trends.

Who's developing

The parastatals are active in projects which are of the largest average size (Table 3). Approximately 90% of the activity in this group is in the hands of the SAHT, which is largely involved in 'historical' development, with most of these projects having been active for longer than five years.

They reflect historical funding mechanisms, are generally selling at slow rates, and are unlikely to be repeated in their current form. The large sizes reflect the significant land holdings of the SAHT, which were acquired at a time when holding risks were not perceived in the same way as they are today.

The public sector developers are second ranked in terms of both average project size and overall activity, although there are significant provincial variations – from an average size of 1 542 sites to 90 as derived from Tables 3 and 4.

The largest public sector projects are found in Gauteng, Mpumalanga and Northern Province. The general size of these projects probably reflect public ownership of land and therefore reduced holding costs and/or risks.

These may also be older projects, having been approved when the provincial housing boards (PHB's) were funding larger projects. It is unlikely that this size trend will continue as PHB's tend now to approve large projects in phases rather than in toto.

The joint venture developers reflect the smallest average project size, although this figure disguises a range from 2 000 (in KwaZulu-Natal) to 184 (in Free State). Joint ventures dominate project activity in the Free State (Table 4), while private developers produce twice as many units per project in that province.

Joint venture partnerships are playing an increasingly important role, and in most cases, are between small local authorities and private sector groups. This indicates that the former do not have the capacity, knowledge or resources to handle housing development themselves.

Recently some joint ventures have been established between large private developers and financial institutions – and in Gauteng and Mpumalanga, the provincial Departments of Housing. These vehicles may overcome delays in the delivery process by involving key roleplayers directly in the development process. Their performance relative to the other groups in future bears watching because they are likely to face the same obstacles as others in terms of land identification and release.

The private developers account for the majority of both project and unit activity nationally, although projects tend to be smaller than those of public developers. Again the figure in Table 3 disguises a significant range – from 168 in Northern Cape to 2 235 in Western Cape. The largest private projects – of an average 1 000 sites – are found in Western Cape, North West, Northern Province and KwaZulu-Natal. Private developers significantly dominate delivery activities in both Gauteng and KwaZulu-Natal (Table 4).

Parastatals are active in projects which are of the largest average size

Joint venture partnerships in most cases, are between small local authorities and private sector groups

Table 4: Number of projects by developer category by province

	Nation-wide	E Cape	Free State	Gauteng	KwaZ -Natal	Mpum -alanga	N West	N Cape	N Prov	W Cape
Total	855	105	93	178	191	55	48	36	37	112
Local public developers	223	41	16	48	57	7	5	18	4	27
Provincial public developers	44	9	2	1	13	0	10	2	7	0
Private developers	400	37	31	105	98	30	17	9	22	47
Unusual private developers	64	18	4	6	19	2	2	6	0	7
Parastatals	42	0	5	18	0	9	5	1	0	4
Joint ventures	82	0	35	0	4	7	9	0	4	27

Table 5: Number of units by developer category by province

	Nation-wide	E Cape	Free State	Gaut -eng	Kwa -Natal	Mpum -alanga	N West	N Cape	N Prov
Total	538 481	53 989	31 685	178 404	95 376	50 178	39 620	5 486	39 858
Local public developers	139 208	19 441	4 410	71 327	19 293	10 794	3 081	2 433	4 976
Provincial public developers	47 124	3 291	2 138	2 114	5 900	0	8 085	180	7 481
Private developers	217 399	13 196	11 359	85 078	40 912	16 227	13 493	1 511	25 721
Unusual private developers	65 802	18 061	1 809	1 922	21 271	3 550	2 480	1 030	0
Parastatals	43 862	0	5 526	17 963	0	7 146	5 473	332	0
Joint ventures	43 049	0	6 443	0	8 000	12 461	7 008	0	1 680

Local authority activity

The growth in the number of active projects in the last couple of years is largely made up by developers active in one or two projects

The forthcoming Housing Act seeks to reinforce the involvement of local authorities in delivery. They are currently active as developers in 26% of projects with 26% of units in the delivery chain. This has risen from less than 2% of projects six years ago; and approximately 11% in late 1994.

Our records indicate that local government started to reflect as developers in 1993 as the IDT's programme gained momentum, and that the arrival of the subsidy scheme spurred activity in 1994. In that year local authorities in KwaZulu-Natal were in the majority of this group, running 21 of the 54 identified projects.

Table 4 shows that KwaZulu-Natal still has the most active local authorities, although some of the other provinces are closing the gap, namely Gauteng, Eastern Cape and Free State – including the joint venture projects in the latter. According to Table 4, 223 projects are being run by 197 local authorities. This means there are 358 Transitional Local Council's not presently active.

Table 6: Levels of developer activity

	No of Projects	No of Units	No of Developers
10+ Projects	189	138 982	8
7-10 Projects	50	30 015	18
5-7 Projects	59	37 112	11
3-4 Projects	92	55 500	70
1-2 Projects	465	276 872	358
Totals	855	538 481	465

These figures present useful bench ma evaluate in some measure the impacts Housing Act on future levels of activit local government.

Extent of the industry

These figures have shown that the diff groups of developers display general characteristics that reflect the scale of activities. It should not come as a surp therefore, to see that the industry is no homogeneous in the levels of activity individual developers. Table 6 and Fig illustrate the numbers of projects that developers are active in.

There is a very skewed relationship bet the number of projects per developer an number of units in delivery. Roughly 77 developers who are active in one or two projects are delivering 51% of the units, the 2% who are working with more than projects are delivering 26% of the units.

This suggests a number of conclusions:

- The growth in the number of activ projects in the last couple of years (Table 1) is largely made up by developers active in one or two pr
- As newcomers their relative performance against the establishe activity developers is seen to be les effective, when measured in terms units in delivery.
- The majority of delivery is being managed by newcomers to the ind who may yet be developing efficie and capacities.

- These developers should be encouraged and enabled to remain in the industry to complete their present projects so that their growing experience adds to the overall capacity of the industry – it will not be to the housing sector's advantage if the majority of production continues to rest in less experienced hands with high turnovers of participants.

- The small number of larger players are responsible for a significant proportion of national delivery. Should the industry become unstable, the exit of a few of these developers would have considerable impact on delivery whereas the exit of the same number of smaller players may not be noticed.

- There would be structural advantages in expanding the delivery capacity of the 'middle order batsmen'.

Eight of the developers in the top 10 list are private organisations – their rankings are a reflection of their national scope of activities, which the public bodies are not able to match.

The subsidy sector

The general characteristics of the industry as reflected in Table 3 are mirrored in the subsidy market, although the joint venture developers reflect a better ratio of units to projects, and the public developers show a worse ratio (Table 8). The parastatals are conducting a much lower proportion of their business in this market – about 30% – than each of the other groups of developers, who are at about 50%.

It is evident that the private developers have made more progress in delivery. There were few public developers active in 1994; the explanation for the skewed completion profile therefore lies partly in the different ages of the projects. This is also partly attributable to higher delivery effectiveness among private developers, which are reflected in the top 10 rankings in Table 7.

Delivery cycle

It is useful to be aware of the length of the housing delivery project cycle. At a time when there are very high expectations of delivery (meaning completion), all of those with an interest should understand the realities of project timing. As a rule of thumb, a three year cycle can be used for planning and programming. There are a range of factors which may adjust the reality either way; but if land can be

Figure 1: Levels of developer activity

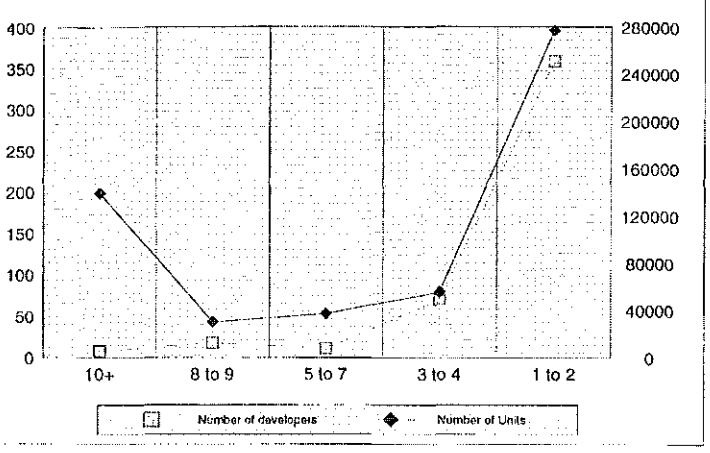


Table 7: Developers Top Ten

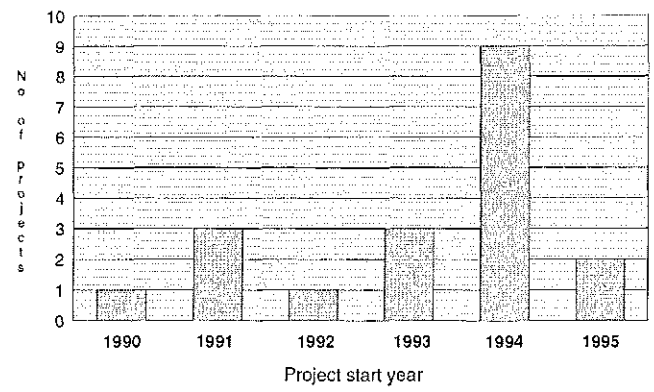
Organisation	Developer Group	No of Units	Unit Ranking	No of Projects	Project Ranking
SA Housing Trust	Parastatal	44 449	1	39	2
NewHco	Private	35 083	2	51	1
Comhousing	Private	13 077	3	22	3
Condev	Private	12 640	4	16	4
Stocks & Stocks	Private	12 345	5	13	5
North West Housing Corporation	Public	8 085	6	10	6
Safrich Group (Pty)Ltd	Private	4 462	7	7	8
National Builders	Private	4 358	8	6	10
Sarkumphakathi Developers	Private	2 273	9	7	9
Habicon Group	Private	2 130	10	6	-
Minrav International	Private	1 149	-	10	7

Note: The various sub-structures of the Durban Metropolitan Council are involved in a large number of projects (ranked 6th for number of units) many of which are insitu upgrades. They have therefore been excluded from this analysis.

Table 8: Subsidy Sector Slices

	No of Subsidised Projects	%	No of subsidised units	%	No of subsidised completed units	%
Private Developers	241	55	138 793	50	23 098	75
Public Developers	138	32	63 151	23	3 375	11
Joint Ventures	44	10	59 049	21	1 432	4
Parastatals	13	3	15 202	6	3 085	10

Figure 2: Start dates for projects completed in the six months to November 1996



On present actual performance the three year rule of thumb may be optimistic for almost half of the projects being started

relatively painlessly identified and released, and if township establishment can proceed without too many obstructions, then a project of average size which is initiated early in 1997 may complete late in 1999.

The subsidy projects have not yet been active long enough to test them against the proposition, although there have been a number of completions. Approximately 25% of subsidy projects started in 1994, and the balance are equally split between 1995 and 1996. We should therefore expect a good rise in project completions this year as the 1994 projects and some of the 1995 ones are completed.

Figure 2 indicates the start year of the 19 projects that completed in the second half of 1996. There are two small projects which have been completed in up to two years. Almost half have taken three years, with the balance being longer. On present actual performance, therefore, the three year rule of thumb may be optimistic for almost half of the projects being started.

Local authorities will be advised to set realistic programmes of delivery when preparing their land development objectives

A further indication of the three year cycle period is the drop off in completions referred to in Table 2. In addition to the various substantive factors referred to, there are structural factors that make lower delivery inevitable. Table 1 indicates a sharp decline in project start ups in late 1993 and early 1994 from a peak in 1992.

Table 2 indicates that the 1992 peak worked through to a peak of completions in 1995 – reinforced by pre-construction signalling of 'sales' in subsidy projects due to administrative procedures – and in 1996 the impacts of industry uncertainty and changes related to the birth of the new South Africa were being experienced.

There can be no better illustration of how much water passes under the bridge while structural change works through the housing delivery chain. A steady increase in completions can therefore be expected to reflect the subsequent trends of Table 1. However, the increased number of inexperienced developers may flatten the curve in the short term.

Local authorities will be advised to set realistic programmes of delivery when preparing their land development objectives. Those set on wishful thinking rather than present industry experience will be set up to fail from the start. DPSA

About The Housing Monitor

The Housing Monitor was first published in November 1989 in response to a demand for information on the availability and location of affordable housing – housing units priced at less than R150 000. The publication has evolved through the years and now provides more than just a listing of housing projects.

Detailed information – on building materials, financing mechanisms, engineering services and developer activities – has been added over the years. Information is gathered at a number of levels, the most important sources being the Provincial Housing Boards, every local authority in the country and the developers themselves.

There are two levels of detail reflected in *The Housing Monitor*. All active affordable housing projects are listed in the primary index for each region, and project details are supplied for as many of these projects as possible. The number of detailed projects that appear in the publication depends upon the number of responses received from the developers. Since the first edition, *The Housing Monitor* has consistently managed to provide a detailed survey of more than 25% of all affordable housing projects.

The history of *The Housing Monitor*, and the level of detail it covers, means that the publication can be used to identify and track a number of interesting trends and developments in the affordable housing sector in South Africa.

The Housing Monitor is researched and published by Settlement Dynamics, consultants in housing, planning and development.

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COMPARATIVE MONITOR

HEALTH STATUS OF PROVINCES

	Eastern Cape	Mpuma -langa	Gauteng	KwaZulu -Natal	Nthern Cape	Nthern Prov	North West	Free State	Western Cape	South Africa Total/Ave
MORTALITY										
Infant mortality rate 1990	44.7	45.1	32.3	44.9	42.9	52.9	40.1	45.8	24.4	40.2
Neonatal deaths per 1 000 public hospital deliveries (1995)	15.0	-	-	7.0	9.8	14.7	9.8	12.2	-	-
Child mortality rate 1990	19.4	14.8	13.1	14.3	19.6	8.3	24.7	23.3	12.3	-
Maternal mortality rate	-	-	-	-	-	-		-	-	32
1994	63	-	-	44	-	52.8	70	61	-	-
Still born per 1 000 deliveries	22	-	-	19	-	17.3	26.5	21.3	-	-
Potential years of life lost 1990	1 039 876	191 076	778 771	638 198	139 750	231 919	635 889	383 383	385 045	-
Trauma related deaths excluding MVA (%) 1990	-	-	1.2	-	1.8	-	1.1	-	1.6	-
Life expectancy at birth M/F (1990)	61/68	63/69	63/69	62/69	60/65	62/68	64/70	61/66	63/68	62/68
MORBIDITY										
Communicable Diseases										
Incidence of TB 1993	280.6	84.2	191.9	115.3	417.2	53.2	83.0	472.0	702.6	224.9
Incidence of measles 1992	51.7	93.4	69.0	44.5	115.5	47.8	27.8	105.5	40.2	57.2
Incidence of typhoid 1993	3.0	7.7	2.4	5.2	0.3	11.4	0.2	0.9	0.6	-
Incidence of malaria 1993	0.1	131.0	9.0	45.1	2.9	42.7	4.4	0.5	0.5	27.5
Incidence of congenital syphilis1992	4.8	0.4	1.9	0.4	2.4	0.9	0.2	0.2	7.0	2.0
HIV (antenatal) (%) 1994	4.5	12.2	6.4	14.4	1.8	3.0	6.7	9.2	1.2	7.6

Source: *South African Health Review* 1996, published jointly by the Health Systems Trust and the Henry J Kaiser Family Foundation, October 1996

Humane Wars?

Campaigning Against Anti-Personnel Landmines

By Jakkie Cilliers
Director, Institute for Security Studies

Anti-personnel mines are intended to maim enemy soldiers. This saps morale and strains support systems and combat capabilities. The international community now believes that mines are no longer a security issue, but a humanitarian issue of global proportions. South Africa has steadily moved towards a total prohibition on the use of these mines.

Both anti-personnel (AP) and anti-tank landmines have been used extensively for generations. Hundreds of thousands of mines were planted in wars during and since the Second World War. But the international humanitarian community's first real contact with the challenge presented by their widespread use was in Afghanistan during the 1980s. The international peacekeeping operation in Cambodia and the situation in Kuwait following Operation Desert Storm underlined the disproportionate effect that mines have on innocent civilians years after a conflict has ended.

Despite clear guidelines and control, mine warfare has always been a dirty affair

The debate around AP mines is chiefly concerned with the humanitarian threat posed by these devices. This article considers this issue, as well as international initiatives to ban these landmines and related South African policy.

Tactical uses

The doctrine of professional armed forces on landmine use is clear: they are intended to protect military bases and key installations as well as hinder and deter the enemy. Mines are also used to protect open flanks, deny routes and strategic positions, restrict the ability of opponents to manoeuvre, and force them to deploy in areas where they are most vulnerable or least likely to attack with success.

AP mines are generally used to protect anti-tank mines, but have an added deliberate intention to maim and wound enemy soldiers. This saps morale and places additional strain on support systems – such as medical and transport systems – as well as combat capabilities.

Conventional armed forces have dedicated specialists (engineers) who are trained in the use of mines. Laid according to set patterns, minefields are clearly demarcated to enable their subsequent lifting or safe passage for friendly forces. All combat forces receive general mine awareness training. Despite these clear guidelines and control, mine warfare has always been a dirty affair, even during so-called 'conventional operations' between the armed forces of countries 'formally' at war.

The indiscriminate use of AP mines is, however, a fairly recent phenomenon, dating from the war in Indochina in the sixties and seventies when the US used so-called 'bombies'. Following the 1979 invasion of Afghanistan, Red Army forces dropped vast quantities of 'butterfly' AP mines over areas controlled or thought to be frequented by the guerrillas.

In these campaigns, conventional armed forces moved to the indiscriminate use of AP mines against both their enemy and civilians. This is particularly problematic, as mines leave a legacy long after the conflict has ended.

The practice in irregular wars such as those fought in much of Africa is even worse. Most recent wars involve non-conventional combatants, variously called insurgents, partisans, terrorists, guerrillas, freedom fighters or *muhaheddin*. Regular armies fighting against them carry out 'counter insurgency' campaigns, stability or emergency operations.

In such conflicts both sides may make extensive use of mines, often in a random and unrecorded manner as has been the case in countries such as Angola, Zimbabwe and Mozambique. Part of the problem is that not all 'users' are governments (such as UNITA and RENAMO), not all governments are responsible and legitimate (for example North Korea and Burundi) and certain countries – such as Israel, South Korea and India – have legitimate security concerns within which they argue that AP mines play an important defensive role.

Technological developments have also complicated the traditional uses of mines, which can now be mechanically delivered in their thousands by vehicle, aircraft and rocket artillery. 'Deep strike' or 'cut-off' deployment of mines is aimed at blocking an advancing force from in front, behind, or both. As a result, mines have become part of an offensive strategy if employed as part of a fluid battlefield – although some of these systems are only available to first world militaries.

To compound matters, many modern mines are non-detectable through the use of non-metallic materials. In addition, many anti-tank mines have anti-handling devices, making mine clearance particularly hazardous and blurring the distinction between anti-personnel and anti-tank mines.

At the other end of the technological spectrum, rudimentary AP mines can literally be manufactured in the backyard of a house or in the bush. These homemade devices are often crude, unstable and hard to detect, since they are mostly made of non-metallic materials. As a result, AP mines are qualitatively different from most other types of weapons which the international community has sought to ban in recent decades. They are not strategic weapons and do not have global reach as do intercontinental missiles.

Effects of mines

The statistics which relate the effects of landmines are daunting, although perhaps not always reliable. On average, every year an additional one to two million landmines are planted, while less than 100 000 are lifted in the same period. Therefore more than a million landmines are added every year to the estimated 85 to 100 million mines already planted in some 69 countries.

In Africa, the continent most severely affected by landmines, an Organisation of African Unity (OAU) study has found that:

> *"More than 18 African countries face, in varying degrees, the scourge of anti-personnel mines. Angola (9 to 15 million), Mozambique (2 million), the Sudan (1 250 000), Somalia (1 million), Eritrea (1 million), Ethiopia (500 000) are particularly affected. Without the same magnitude, other countries are also faced with relatively alarming situations: Rwanda (80 000), Chad (70 000), Namibia (50 000), Liberia (18 250)."*

The commitment to lift mines is equally depressing. In 1995, pledges announced for mine clearance amounted to around US$100 million of the estimated US$33 billion required to clear all mines currently in place. Based on the unit price of a mine – from US$3 to US$75 – it costs on average between US$300 and US$1 000 to lift that mine. Only in the aftermath of Operation Desert Storm in Kuwait was the international community able to commit significant resources – US$800 million – in a concerted military campaign.

Not all 'users' are governments and not all governments are responsible and legitimate

Based on the unit price of a mine, it costs on average between US$300 and US$1 000 to lift that mine

In reaction to the growing abhorrence at the effects of AP mines on civilians, the defence industries developed 'smart' mines

According to the International Committee of the Red Cross, of the roughly 1 million AP landmine victims since 1975, in excess of 80% were

In reaction to the growing abhorrence at the effects of AP mines on civilians, the defence industries developed 'smart' mines. The most secure of these have a self destruct timer and a limited battery life. In other words, if the self destruct timer fails, the mine becomes dormant and therefore harmless after a certain period.

Technically, this solves the problem for the armed forces who could afford to acquire such expensive mines or replace their existing stocks of mines. However, most mines are planted during internal and irregular conflicts by armed forces who do not apply the Queensbury rules. Similarly, the estimated 100 million 'dumb' mines that are in stockpiles around the world would not realistically all be replaced by smart mines.

Military vs humanitarian

AP mines force people to re-experience the horrors of war one victim at a time and impede the work of relief organisations

The limited military utility of AP mines has come up squarely against the humanitarian, post-conflict costs of such mines. The findings of several human rights organisations' studies into the utility of AP mines on the battlefield, point to the obvious fact that mines have some utility as part of a wider defence system. This utility is, however, not crucial to armed forces or to defence except within very limited parameters. Clearly, AP mines are not 'essential' weapons.

Whether AP mines are indiscriminate and/or excessively injurious relates to both military and civilian casualties. On the surface there is doubt that AP mines cause indiscriminate civilian casualties of an excessively injurious nature. According to the International Committee of the Red Cross (ICRC), of the roughly 1 million AP landmine victims since 1975, in excess of 80% were civilians.

The horrible effects of these weapons are further evident from the ratio of amputees to the total population: 1:236 in Cambodia, 1:470 in Angola, 1:650 in North Somalia; 1:1 100 in Uganda and 1:1 682 in Mozambique. This is in comparison to a ratio of 1:22 000 in an unaffected country such as the USA.

AP mines are in the same category as poison gas, blinding lasers and dumdum bullets

Yet statistics relay little of the suffering and costs involved to children. The prosthesis for a child with an amputated limb has to be changed every six months, and every three to five years in the case of an adult. In low income developing countries this means that a non-adult mine victim has to use crutches. In 1995 alone, the ICRC's 33 prosthetics programs fitted nearly 8 000 amputees and manufactured some 11 000 prostheses. In the preceding 10 years the ICRC had treated over 30 000 mine victims and cooperated with local and national medical personnel to assist many times that number.

According to some estimates, AP mines kill or injure 500 people per week. In the process they terrorise and impoverish entire communities, burden developing countries with the costly needs of victim assistance, force people to re-experience the horrors of war one victim at a time and impede the work of relief organisations and UN peacekeepers.

It is also a common practice to lay mines around key economic installations such as electric power stations, high voltage lines, water treatment plants and major roads – all of which are essential for post-conflict economic growth.

A strong argument can also be made that AP mines cause unnecessary suffering and maiming of soldiers. Article 35 of Protocol 1 additional to the Geneva Conventions of 1949 re-states a long standing customary rule of humanitarian law: "It is prohibited to employ weapons ... of a nature to cause superfluous injury or unnecessary suffering". This rule is intended to protect combatants and prohibit the intentional infliction of more injury than is needed to take a soldier out of combat. The President of the ICRC presents a graphic description of the effects of AP mines:

> *"If a person steps on a buried anti-personnel mine, his or her foot or leg is blown off. The force of the blasts drives earth, grass, the vaporised mine case and portions of the victim's shoe and foot upwards into the tissues of the other leg, buttocks, genitals, arms and sometimes the eyes. ... if the wounded person gets to a hospital with the necessary facilities and expertise ... he or she will require several operations. Awaiting the survivor is permanent and severe disability with all the social, psychological and economic implications of being an amputee. Mines are* designed *to produce these effects".*

It is these characteristics that place AP mines in the same category as poison gas, blinding lasers and dumdum bullets. For the

international community AP mines are no longer a military or a security issue, but a humanitarian issue of global proportions. The future of mines should, therefore, not be negotiated within the confines of arms control issues, but in terms of humanitarian law.

International campaign

An important component of any campaign against landmines is that their use, either by government, guerrilla or any other organisation, should be stigmatised to the extent that the associated political and other costs of employment outweigh the potential military advantage. This requires the ongoing mobilisation by civil society as has happened with nuclear weapons since the 1970s.

During the review of the restrictions on using certain conventional weapons – the CCW Convention – of August 1994, Sweden was the first country to formally propose a total ban on AP mines. At the time, the Swedish proposal was met with scepticism and even surprise by many governments. Today, an international ban on AP mines is being formulated and is within reach.

The landmine issue has been driven by a remarkable coalition of non-governmental organisations (NGO's), which formed the International Campaign to Ban Landmines, along with the ICRC which has thrown its considerable weight behind the campaign. The momentum that has built up during the last few years is extraordinary: in October 1995, only 14 governments were in favour of a ban. By May 1996 this had grown to 39 governments and the recent conference in Ottawa was attended by 50 states.

To date, the only legally binding international agreement regulating the use of AP mines is an instrument of humanitarian law – Protocol II of the CCW Convention. The many shortcomings of this protocol and the international community's failure to restrict the use of these mines led the secretary-general of the United Nations to convene a Review Conference in 1996 to propose amendments to Protocol II.

Despite the impressive list of technical issues, it was clear that this conference had failed to produce real improvements capable of having a significant impact on the global AP mine problem. Cornelio Sommaruga, the President of the ICRC was scathing in his criticism, calling the new limitations on the use of anti-personnel mines 'weak and overly complex'.

South African policy

Until 1993, South Africa had no coherent policy on landmines. In 1994, shortly before the April elections, the National Party government announced a moratorium on the marketing, export and transit of all types of landmines. Subsequently South Africa, in the past a large producer of landmines, has made significant policy changes. South Africa became a State Party to the CCW Convention in March 1996 – one of only six African countries to have done so.

At the CCW Review Conference in 1995, South Africa announced its intention to discontinue using 'long-life' AP mines and instead, to develop 'smart' mines. This concept met with international condemnation, captured in the slogan 'Smart mines, dumb idea'.

During the second resumed session of the CCW in 1996, South Africa's position had changed with the Government's decision to unilaterally suspend the operational use of anti-personnel landmines. Yet South Africa was uncomfortable about being too far ahead of its Southern African Development Community (SADC) partners.

On 20 February 1997 the Government announced that it will ban the use, development, production and stockpiling of AP mines with immediate effect. A limited number will be retained for training military personnel in demining techniques and for research into demining. In this process, South Africa has again assumed – in Africa – a leadership position on a crucial humanitarian issue.

Canadian initiative

By mid-1996, the international campaign to ban AP-mines had gained substantial international momentum, but the CCW negotiations had been disappointing. During October 1996 the Canadian Government sponsored an international strategy conference 'Towards a Global

Sweden was the first country to formally propose a total ban on AP mines

The only legally binding international agreement regulating the use of AP mines is an instrument of humanitarian law

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It is not necessary to wait for an international ban

Ban on Anti-Personnel Mines'. It brought together 50 governments that had pledged support for a total ban on AP mines, as well as 24 observer states and a host of NGO's.

The scope of human and economic devastation of AP mines and the extensive resources required to clear mines was leading a growing number of countries to support a total ban. In a decisive move, Canada's foreign minister committed that country to preparing a treaty that could be signed by December 1997 and implemented by the year 2000. In doing so, tortuous negotiations through the Conference on Disarmament in Geneva had been circumvented.

Worldwide ban

It is, of course, not necessary to wait for an international ban. Many governments such as Belgium, Norway, Germany, the Philippines, Sweden and Switzerland have taken unilateral steps. These and others have already embarked on the complete or partial destruction of their stockpiles, and 47 governments have agreed to stop all exports.

A few countries, such as Norway, have already completed the total destruction of all AP mine stockpiles

The European Parliament has called on all member states to ban the production and use of AP mines and to destroy stocks. Over 20 governments have stated that they will not produce landmines. A few countries, such as Norway, have already completed the total destruction of all AP mine stockpiles.

There is a perception that there should be a 'global ban' on AP mines. While there are no global arms control treaties, strategic weapons arguably require such treaties. But landmines are tactical weapons. Therefore there is no compelling reason why South African should not ban landmines if China does not. In fact, a country whose neighbour deploys landmines technically only has a legitimate concern if it harbours hostile intentions against that neighbour.

Most countries that have banned AP mines state that they retain the right to use the mines

Another problem area relates to the scope of agreements. The present definition of what constitutes AP mines categorises mines according to their primary intention – one which NGO's would like to see expanded. But most armed forces will balk at the inclusion of anti-tank mines in a worldwide ban. The argument that these mines are excessively injurious and indiscriminate weapons will be difficult to sustain.

Clearly, an international agreement to ban anti-personnel landmines will not be 100% effective. In fact, most countries that have banned AP mines state that they retain the right to use the mines. Controlling the use of AP mines has either been moved higher up in the military hierarchy or shifted to the political level. Furthermore, the armed forces argue that they require continued training on AP mines since potential enemies may still have these weapons.

Conclusion

The South African Minister of Defence, Joe Modise, stated in May 1996 that the SANDF had a total of 311 179 landmines in stock, of which 261 423 were anti-personnel mines. The larger portion of the latter will now be destroyed in a process which will underscore South Africa's support for a world wide ban on AP mines.

South Africa has also offered bilateral assistance and assistance through the United Nations to other states to help solve their landmine problem. For example:

- In July 1995, South Africa pledged assistance to the UN Stand-By Capacity for mine clearance for training programs up to the value of R600 000.
- In 1995 South Africa signed a Declaration of Intent with the Government of Mozambique to cooperate in demining efforts in Mozambique. South Africa is also assisting the Angolan Demining Institute with training. Mechem, a South African company, is also involved in demining activities in Angola in cooperation with the United Nations.

The heart of the issue is simple: stop the manufacture and destroy the existing stockpiles of AP mines, demine or mop up the mines that are already planted, and provide support to the victims of landmine explosions.

Based on humanitarian considerations, the South African government should continue to participate actively in international efforts to ban anti-personnel landmines. **IDEA**

Heading for disaster?
Southern Africa's ills

By Johan Smith and Liza Niedermeier
Department of Economics, University of South Africa

Southern Africa's health picture looks gloomy. Governments of less developed countries have been hesitant to implement health care projects because their benefits are intangible. The health profiles of Malawi, Swaziland and Zimbabwe are discussed, and some comparisons made with the situation in South Africa.

Health is defined by the World Health Organisation (WHO) as 'a state of complete physical, social and mental well being', with preventative, curative and rehabilitative aspects. In most less developed countries (LCD's) where an increase in the gross domestic product has been the traditional means of measuring development, health has been accorded a low priority in development plans. Where health has been of concern, the curative aspects have received the most attention, with little emphasis being placed on the preventative or rehabilitative aspects.

The United Nations (UN) Human Development Report introduces qualitative variables as means of determining the level of development of a country. It stresses the human dimension rather than merely providing the macroeconomic indices of development. The report suggests that the level of development should be based on three criteria: life expectancy at birth, knowledge measured by the literacy rate, and the standard of living measured by the per capita income.

At a conference held at Alma Ata in 1978, the member states of the World Health Organisation stressed the importance of health as a universal human right by issuing the idealistic declaration, 'Health for all in the year 2000'. Can this objective be achieved in southern Africa, or are these countries heading for disaster?

Health and development

The Organisation for Economic Cooperation and Development (OECD) views health as an important element in:

- Improving productivity by improving the mental and physical capacity of workers by reducing the incidence of absenteeism and increasing their energy levels, stamina, strength and mental ability.
- Improving the living standards of the mass of the population, thus leading to an increase in life expectancy and a longer productive lifespan.
- Being able to reduce the rate of population growth because of an increase in the availability of family planning information and services, as well as a reduction in the rate of infant mortality and a concomitant reduction in the number of births.

The health-development relationship is generally a reciprocal one. For example, as a country develops and as the level of education improves, there is increasing knowledge about the benefits of health care. This leads to an improvement in the health status of individuals.

Health in LDCs

The percentage of LDC inhabitants living in urban areas has increased considerably

As a country develops and as the level of education improves, there is increasing knowledge about the benefits of health care

In inner city areas, poor living conditions and occupational hazards have resulted in an increase in the number of diseases associated with poverty

in recent years. It is estimated that by the year 2000 the percentage of the urbanised LDC population will have increased to 45%. The rapid rate of urbanisation has caused problems in inner city areas, where poor living conditions and occupational hazards have resulted in an increase in the number of diseases associated with poverty. These include measles and nutritional diseases, trauma – caused by car accidents and violence, for example – and other modern diseases which accompany unhealthy lifestyles.

The rural areas, which house 70% of sub-Saharan Africa's population, have suffered a worse fate than the urban areas as far as the health status of the population is concerned. The cross-regional migrations that accompany modernisation have led to the spread of endemic diseases and AIDS, making transportation routes that pass through rural communities transmission mechanisms for diseases in LDCs.

The development of new irrigation schemes has increased the exposure to bilharzia and

TABLE 1: HEALTH PROFILES OF THREE SOUTHERN AFRICAN COUNTRIES

	MALAWI	SWAZILAND	ZIMBABWE
Life expectancy at birth			
1960	37,8	40,2	45,3
1992	44	57	60
Infant mortality (per 1 000 live births)			
1960	207	157	110
1992	142	108	47
Daily calorie supply (as % of requirements)			
1965	91%	-	87%
1988-1990	88%	-	94%
Population with access to:			
Health services (1987-1990)	80%	55%	71%
Safe water (1988-1990)	53%	30%	36%
Sanitation (1988-1990)	32%	-	42%
Population without access to (millions)			
Health services (1991)	2	0,3	3
Safe water (1991)	4,7	0,5	6,6
Sanitation (1991)	-	0,5	6
Under-five mortality rate (per 1 000 live births)			
1990	253	167	87
Pregnant women with prenatal care			
1988-1990	76%	76%	83%
Births attended by health personnel			
1988-1990	41%	67%	65%
One-year-olds immunised			
1989-1991	84%	90%	71%
Population per doctor			
1992	11 340	18 820	7 180
Population per nurse			
1992	3 110	-	1 000

Diseases associated with poverty include measles and nutritional diseases and trauma caused by car accidents and violence

The rural areas, which house 70% of sub-Saharan Africa's population, have suffered a worse fate than the urban areas

other vector borne diseases. Consequently, advances in health care that have accompanied development in some areas have been counteracted by an increase in the incidence of disease in others.

It is argued that the reason why LDC governments have been hesitant in implementing health care projects is because the benefits of such projects are intangible, often yielding results only after a number of years. On the other hand, when investing in projects which have GDP growth or employment creation as their main objective, the benefits are immediately visible. This increases their chances of being approved by aid agencies and government officials.

Where investments in health projects have been undertaken they have been in projects where the benefits could be measured in the short term, such as the establishment of clinics and the initiation of vaccine coverage. Health care investment can be seen as a trade off for other growth promoting projects in the short term, although the long term benefits of investment in human capital are obvious.

Health profiles

In an attempt to provide a general picture of the health situation in southern Africa, the health profiles of the three countries which provide the most reliable statistics, namely Malawi, Swaziland and Zimbabwe, are discussed.

❑ Malawi

Malawi is committed to a policy of primary health care. A 1991 UN Population Fund Report estimated that 80% of the population had access to primary health services. The quality of these services, however, is low due to inadequate government funding.

Table 1 shows that while health conditions in Malawi have improved over the years, there are still enormous backlogs that need to be addressed. The infant mortality rate and the under-five mortality rate of 142 and 253 per 1 000 live births respectively are significantly higher than the 71 and 104 respectively for all developing countries.

People without access to health services and safe water totalled 2 million and 4,7 million respectively in 1991. Only 41% of all births in Malawi are attended by health personnel, compared with 66% in all developing countries. The population per doctor is 11 340 and the population per nurse 3 110. The respective figures for all developing countries are 5 080 and 1 870. About 8 million people are living in absolute poverty, showing the desperate need for an improvement in health services in Malawi.

In 1993 the government declared that Malawi was facing an HIV and AIDS epidemic, estimating a total of 20 000 registered AIDS patients and 600 000 HIV-infected people. Major international organisations are now working on the assumption that 700 000 adults and 300 000 children will develop AIDS-related illnesses by the end of the decade.

In March 1994, Malawi officials and Western aid agencies said that up to 11,7% of Malawi's 9,7 million people – that is 1,13 million people – were infected with HIV. The country's AIDS secretariat estimates that in 1998 there will be at least 25 new HIV infections, 13 new AIDS cases and 12 deaths per hour in Malawi.

❑ Swaziland

A survey conducted in 1989 found that 60% of households in Swaziland were undernourished, with one fifth of the families having an inadequate protein intake. More than 40% of children in Swaziland below the age of two are stunted, and the major cause of infant death is malnutrition.

There have been definite improvements in health conditions in Swaziland from 1960 to the 1990s. This can be attributed to an above average public spending as percentage of GNP on health of 5,8%. This figure is 3,7% for the developing world and 3,1% for sub-Saharan Africa.

Alarming however, is the fact that hundreds of thousands of people do not have access to safe drinking water and sanitation. Adverse health conditions associated with a lack of water have already been noted in rural areas, including diarrheal diseases and skin infections such as scabies and conjunctivitis.

The development of new irrigation schemes has increased the exposure to bilharzia and other vector borne diseases

Only 41% of all births in Malawi are attended by health personnel, compared with 66% in all developing countries

There is a distinct shortage of medical personnel in Swaziland with one doctor for every 18 820 people

Births attended by health personnel in Zimbabwe increased from 49% in 1982 to 65% in 1990

There is a distinct shortage of medical personnel, as can be seen when looking at the rate of one doctor for every 18 820 people. The same figure for the developing world is 5 080. There are also serious shortages of laboratory staff, radiographers and physiotherapists.

In December 1993, the Ministry of Health revealed the results of a survey conducted in Swaziland which indicated that more than one fifth of the population aged above 15 years tested HIVpositive. In some areas the rate was as high as one in three. The ministry said that some 90 000 people were infected, and estimated that by the year 2000 the figure would stabilise at about 180 000. In 1993 at least 400 people died of AIDS in Swaziland. By the end of the century this figure will probably have reached 17 000 per annum.

❑ Zimbabwe

A major problem in Zimbabwe is that millions of people do not have access to health services, safe water and sanitation

Government funding of health services in Zimbabwe grew substantially after independence. However, as the economy deteriorated it became increasingly difficult to sustain the initial momentum in health delivery and some projects have in fact been disbanded. In the mid- and late-1980s the total and per capita allocation to the health sector continued to grow, although at a much slower rate than in the early period. After substantial initial improvements, the mid-1980s saw the stagnation and erosion of inputs to health.

The vast improvements in the health sector can be seen clearly in Table 1. Life expectancy improved from 45,3 in 1960 to 59,6 in 1990, the infant mortality rate decreased from 110 in 1960 to 61 per 1 000 live births in 1991 and the under-five mortality rate – which was 134 per 1 000 live births in 1980 – came down to 87 in 1990. In 1982, 73% of women received prenatal care. This figure increased to 83% in 1990. Furthermore, births attended by health personnel increased from 49% in 1982 to 65% in 1990.

South Africans are worse off than Zimbabweans in terms of infant mortality and the under-five mortality rate

A major problem in Zimbabwe is that millions of people do not have access to health services, safe water and sanitation – 3 million, 6,6 million and 6 million respectively in 1990. These alarming figures exist despite the fact that there are water and sanitation projects in 28 districts. Between 1984 and 1989 a total of 4 796 new water points and a few hundred pit latrines were constructed.

The population per doctor is 7 180 and population per nurse is 1 000. This compares favourably with the 24 380 and 2 400 respectively for sub-Saharan Africa and the 22 590 and 4 620 respectively for the least developed countries of the world.

30 000 new cases of AIDS were reported in 1993 – twice the entire total for the 1987-1992 period. Government officials estimate that the actual total for 1993 was 90 000. Officials estimate that nearly 600 000 Zimbabweans are HIVpositive. Mortality statistics prove that something alarming is happening. Before 1985, employed men aged between 40 and 44 years died at a stable yearly rate of about 3,6 per thousand. By 1990 the death rate had reached 7,5 per thousand. The government has set up an AIDS education programme with financial help from the World Bank.

❑ South Africa

In terms of life expectancy, South Africa compares favourably, with a life expectancy at birth of 63 years. South Africans are, however, worse off than Zimbabweans in terms of infant mortality and the under-five mortality rate, which were 53 per thousand and 94 respectively in 1993.

Policy implications

From the above, it is clear that the objective of 'health for all in the year 2000' is far from being realised. The following possible policy implications must, therefore, be given serious consideration by the authorities in the countries of southern Africa.

❑ Population growth

In most countries of southern Africa, population growth has taken on the proportions of a population explosion. Contraceptive prevalence rates in all countries of southern Africa are unacceptably low. All these countries have a fragile resource base, and continuing high population growth puts further strain on the carrying capacity of the land.

Furthermore, rapid population growth also puts strain on the social infrastructure of a country – especially the health and education sectors. Facilities are too few and most hospitals and clinics are understaffed.

An explicit population policy is therefore needed in South Africa and in every country in Africa.

❑ Rural health services

Rural clinics form the backbone of the primary health care infrastructure in the least developed countries of the world. Isolated, badly understaffed and poorly equipped, they are too thinly spread to be effective. They are thus unable to meet the needs of the communities they serve.

❑ Feeding programmes

It is known that malnutrition can permanently affect a child's intelligence and future productivity. The principal victims of malnutrition are the very poor, especially the rural poor. Health clinics, schools and pre-schools can serve as information centres as well as providing food and direct nutritional supplements. Feeding programmes in schools should therefore be part and parcel of South Africa's health policy.

❑ Safe water and sanitation

Households in urban areas rely mostly on piped water and have access to either a flush toilet or a pit latrine. In rural areas millions of people do not have access to safe water or sanitation. A programme of expanding and upgrading water supplies and sanitation in southern Africa is needed urgently.

❑ Personnel shortages

The training and maintaining of doctors and health personnel in South Africa should be a high priority. Doctors and health personnel are overworked and cannot cope with the serious health problems inside these countries.

❑ AIDS prevention

AIDS, together with a desperate need for development funding, is already posing a significant social and economic cost to the countries of southern Africa. AIDS education programmes, AIDS prevention and control programmes, AIDS task forces and AIDS committees should be established in every country. These projects need foreign financial support as well as the support of their own governments. Furthermore, the media should be at their disposal to spread information on AIDS and its serious consequences.

Conclusion

South Africa's new political dispensation has led to an increased influx of migrants from neighbouring countries. However, the ability of the South African health system to handle this influx and the resulting pressure on health resources is questionable. The picture with regard to health in South and southern Africa looks gloomy. There are still prospects, but action is needed now. If the above policy implications are taken seriously and can be implemented as soon as possible with the help of foreign aid, the southern African health situation need not end in disaster.

Malnutrition can permanently affect a child's intelligence and future productivity

The ability of the South African health system to handle the influx of immigrants from neighbouring countries and the resulting pressure on health resources is questionable

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Servicing the Future

Developing Health Care Workers

By Eunice Brookman Amissah
Minister of Health, Ghana

Strategies for producing and managing doctors and other health workers are gradually being recognised as crucial for delivering health services – some controversial South African debates are covered in this issue. Based on Ghana's experiences, this article discusses future health systems challenges and how human resources need to be developed accordingly. There are many lessons for South Africa's struggling health sector.

With the 21st century approaching, a human resources strategy is needed for health care. The time has come to radically rethink the key components of this strategy, and the many stakeholders' roles in the health sector. Before considering these strategies, some perspective is needed on the challenges and future realities of health care delivery.

These challenges, as well as the limitations of current human resources strategies and the key elements of a more appropriate approach, are covered here. Some of Ghana's experiences in fashioning a new programme for health care workers are also presented. Since 1992, the health sector in Ghana has been pursuing several radical reforms – a critical one being creating a Ghana Health Service. This has forced the Ministry of Health to carefully examine human resources development.

This article borrows heavily from the Ghanaian experience. There are wide variations in the way health care is provided, in culture and attitudes, work style, technology and skills among countries. While direct comparisons can be inappropriate, it is also true that Ghana and South Africa share surprisingly many similarities. Furthermore, many of the issues raised here are true at least for a large number of low income countries.

Ghana and South Africa share surprisingly many similarities in health issues

Future challenges

In future, health care delivery systems will increasingly be judged by the extent to which they respond to the:

- Needs of the population.
- Need for essential preventative, promotive, curative and rehabilitative services.
- Quality of care provided.
- Degree of equity in the system.

- Efficiency with which resources used contribute to improving health status.

The population will continue to age, with more absolute numbers of older people. This alteration in demographic structure will be associated with more chronic non-communicable diseases. Communicable diseases both old and new will, however, remain major causes of disease, suffering and death for the vast majority of the world's population.

With more people becoming better educated, expectations and demands for health will be raised. People will want services as close to their homes as possible and for a wide range of needs to be met through an integrated set of general health services. More specialist services closer to homes will also be expected. Greater community involvement, citizen empowerment and health promotion will sharpen the focus on needs as well as the responsibility of individuals for their own health.

The general population will become increasingly critical of the performance of health systems and professional health standards. More economical services will be demanded and expectations about quality and responsiveness are likely to rise (see Ransome in this issue). This will be fuelled by media interest in health services and in all matters related to health. Increased travel, better communications and information, and increased links with the world will also introduce more people to standards and expectations taken for granted elsewhere.

In terms of social factors, the breakdown of the family and community structures will leave many people isolated and unsupported, leading probably to more neuropshychiatric disorders. Crime, violence, smoking and substance abuse among the youth and the appearance of new groups of deprived communities like street children, will continue to pose new challenges to the health system.

On the technological front, new and emerging technologies will allow more to be done and in new ways. As a result, the proportion of both elective and emergency surgery carried out as day cases will rise considerably. Distance consultation using computer and video images will become more common. The use of endoscopy (cameras for internal examination) and lasers will increase the proportion of minimal access surgery. These advances in medicine and nursing care will bring in their wake serious ethical issues and an escalation of medical costs.

Most importantly, resources will continue to be limited and scarce. Countries will be constantly under pressure to scrutinise national priorities and reassess government's role in providing social services (see McCusker in this issue). Cost containment and value for money concerns will consequently feature prominently on the national agenda. The introduction of 'business and economic values' will increase (see Tuft in this issue). In this environment, contracting, competition and the search for mechanisms to reward efficient providers will become fashionable.

Health care implications

The implications of these changes are enormous. Health care systems will be expected to have the capacity and competence to:

- Assess patients' total health care needs with an integrated promotive-preventative-curative and rehabilitative approach.
- Promote healthy lifestyles through public information and education and the empowerment of individuals and groups for their own protection.
- Increasingly work with other health related sectors like education, social welfare, urban planning, information, housing, water, sewerage.
- Do more with less resources and make optimal use of new technologies, bearing in mind the ethical and financial considerations and the ultimate benefit of the consumer.

Meeting future human resources challenges will require two broad strategies. One is to produce the appropriate numbers and type of health care workers. The second is to manage health care workers to ensure they are retained in the health sector and deliver care to their best ability.

The general population will become increasingly critical of the performance of health systems and professional health standards

The breakdown of the family and community structures will leave many people isolated and unsupported

Advances in medicine and nursing care will bring in their wake serious ethical issues and an escalation of medical costs

It is not uncommon to see future projections of surgeons without the concomitant planning exercise for anaesthetists or theatre nurses

Current status

❑ Human resource planning

Health workers include people of many disciplines and a multiplicity of skill levels. Traditionally, most attention has tended to be focused on those providing services directly to people – doctors, nurses, pharmacists and paramedics – as opposed to administrative and support staff.
In recent years, attention is increasingly being directed at managerial and administrative staff and non-health professionals who together make up anything from 30% to 70% of the total workforce. In most countries health human resource development strategies have focused solely and perhaps naively, on production – particularly training.

Training in developing countries tended to occur abroad in industrialised countries of North America and Europe. This has had mind broadening benefits, provided cross cultural experience and served as an important vehicle for acquiring special skills, including a foreign language. But there are also drawbacks: it is expensive, and individuals overseas for extended periods tend to acquire a second culture making assimilation back home difficult and chances of a brain drain higher.

Health workers are expected to work together as a team, yet are hardly ever trained together

More training is now being provided locally, with many countries establishing their own training institutions. This has in many cases allowed for more custom tailoring of curriculum and has reduced costs. Specialised and advanced training has, however, proved more difficult to localise.

In most cases, there have been no clear policies about how many medical workers to produce each year, and in several cases, schools are established according to political considerations rather than need. In some countries, almost every province wants a medical school and the numbers of graduates are based more on institutional capacity than on the health service's needs.

Coordination between education and training institutions and policies of recruitment is often poor

And where the numbers have been worked out, staff projections have tended to be based on 'ideal' standards – so called staff-population ratios and norms. Many of these are borrowed from industrialised countries with very little adaptation to suite the economic realities and organisational structures of low income countries.

These projections are also usually cadre-specific and issues of staff complementarity and staff mix are not considered. It is not uncommon to see future projections of surgeons without the concomitant planning exercise for anaesthetists or theatre nurses. Projections also almost invariably ignore the private sector. There is practically universal resistance to involving communities and the private sector in health human resources policy development and planning.

Furthermore, in many low income countries there is no planning infrastructure. This is usually a reflection of the general shortage in the availability of policy and planning specialists in government as a whole and in the health sector. There is also a lack of reliable data information systems on human resources at country level to assist planning.

❑ Training health workers

Curricula, especially at the pre-service level, have tended to be conservative. The training methodology has changed very little and review of innovations in training has mostly been at the postgraduate level.

The system also tends to attract the cream of the bright youth, but the intensive and competitive nature of most programmes virtually turn extra curricula activities into luxuries. Teaching institutions thus turn out graduates who are highly trained, but who are sometimes ignorant about arts, culture, fashion, politics and sports.

Health workers are also expected to work together as a team, yet are hardly ever trained together. Regular evaluation and review of training institutions and methodologies also do not receive the attention they deserve.

❑ Management

Compared to production strategies, plans for management of health care workers have received very little attention. Coordination between education and training institutions and policies of recruitment is often poor, resulting in heavy over production of certain staff types and under production in other areas.

In most developing countries, employment policies have changed very little and mirror those of colonial periods. Understandably these were based on centralised control and

automatic employment of all trainees. Employment practices are also often nationally determined with the health sector having little ability to modify these practices. In Ghana, all appointments are handled by the Head of Civil Service and the Public Service Commission. Procedures for recruitment are thus tedious and bureaucratic.

Job descriptions are virtually non-existent and those that exist are vague and do not lend themselves to performance appraisals. Staff distribution also tends to be biased towards urban areas and there are usually no incentives for health professionals to work in rural areas (see Begg in this issue). There is usually a clear urban-rural divide in staff distribution with very little effort at exploring more flexible use of human resources.

There are usually no incentives for good performance and no disincentives for bad performance either. Career development is personalised and career counselling is absent in most cases. Even though salaries and benefits constitute up to 70% of the health sector's recurrent costs, conditions of service for health workers are deplorable. Many are demoralised because of low salaries, lack of fringe benefits and poor living and working conditions. Health workers tend to undertake industrial actions to enjoy marginal change to conditions of service.

The capacity for human resource management tends to be limited. Managerial control therefore tends to be highly centralised and sometimes dominated by people with little idea about their expected roles. Modern personnel management practices have hardly permeated the health sector.

Ghana's experiences

Ghana has developed a framework for health development which sets priorities and provides a programme of work for the health sector. Human resource development is recognised as more than training: the former Training Division has been elevated into a Human Resources Directorate with units for planning, training and management in this field.

Management decentralisation within the health sector is being actively pursued. Individual health institutions have been designated management centres and have more decision making responsibilities. Tertiary institutions have also been granted self governing status.

Specific guidelines have also been developed on service delivery using Reproductive Health as a prototype to outline the various skills and competencies required. Long term (20 year) projections for human resources requirements for key health professionals have been developed, and a nation wide inventory of health training institutions has been conducted. This has shown that there are far too many nursing training institutions.

In terms of training, a School for Allied Professions is in the process of being established to train middle level health technicians like laboratory technologists, physio and radiotherapists and health information technicians. In collaboration with the Nurses and Midwives Council, the curricula for training these professions is being reviewed to conform to the new policy guidelines and modern trends.

Policy and clear procedures for awarding fellowships have also been designated. A high powered committee has been set up to review and streamline post graduate medical education and a local school of Public Health has been established to train public health professionals. The school admits doctors, pharmacists and others.

In-service training is also being institutionalised by setting up units in each region. Regional managers are being encouraged to develop annual in-service training plans based on training needs assessments. The required budget has been decentralised to regional level to facilitate implementation. This training also increasingly adopts the team approach in line with the Ministry's policies of building multifunctional teams of health workers to provide a broader spectrum of service.

Perhaps the broadest and most far reaching reform is the establishment of the Ghana Health Service as an executive agency of the Ministry of Health. This Service will remain part of the public service but not the civil service. Managers will therefore have the flexibility to adopt employment policies and conditions of service that are different from that of the civil service. Hopefully this will offer

In Ghana, long term (20 year) projections have shown that there are far too many nursing training institutions

Regional managers are being encouraged to develop annual in-service training plans based on training needs assessments

The broadest and most far reaching reform is the establishment of the Ghana Health Service as an executive agency of the Ministry of Health

Reforming health care workers is a highly political endeavour fraught with difficulties

Ghana the opportunity to change employment practices, job descriptions, personnel policies and salary incentive packages.

Lessons

There are a number of lessons to be learned from the Ghanaian experience. Human resources development is a complex area of health development. Awareness about human resources issues in the health sector is very limited and the skills to develop the position and profile of health care workers are woefully inadequate.

Reforming this sector is also a highly political endeavour fraught with difficulties. The key institutional reform Ghana has undertaken is saddled with a number of risks. One concerns the willingness of the Ministry of Finance, Office of the Controller and Account General and Public Services Commission to liberalise controls and give health service managers greater autonomy.

Support for capacity building remains limited to training, at the expense of developing viable management structures and systems

A second concern is the fact that despite the rhetoric, support for capacity building remains limited to training, at the expense of developing viable management structures and systems. Perhaps the greatest lesson of all is that while institutional reform is necessary, it is not sufficient to guarantee sustained improvements in the performance of the health sector.

Overall resources to the health sector need to be increased: the per capita health expenditure in Ghana is less then $10. Managers at institutional and district level must therefore have greater authority and dexterity in the allocation and use of meagre financial and human resources.

If the proposed changes are to be acceptable, a common vision must be developed, which must be communicated to all staff and professional groups. The difficulties in achieving the vision must be acknowledged and overcome, and a realistic timetable must be adopted with clearly assigned responsibilities for action.

Those who anticipate and prepare for change will often lead it. Those who are overtaken by change are often swept away in the storm and may have very little influence on events thereafter. Human resources development must be pushed high on the international agenda, but charity begins at home. The time has come for us to review our strategies for producing and managing doctors. IPEM

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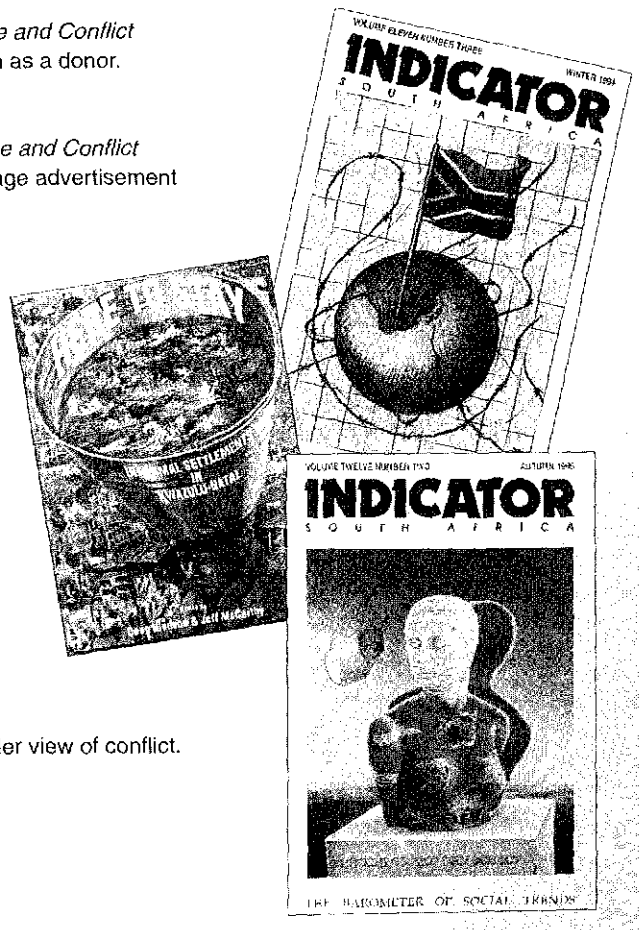

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