B4 | CONTEXUALIZING THE STRUGGLE OF HEALTH WORKERS IN SOUTH AFRICA

Public health in South Africa in the 1930s and 1940s

In the late 1930s and early 1940s progressive new thinking around public health, community medicine and family practice emerged in South Africa. Pioneering doctors, notably Sidney and Emily Kark, understood the social, economic and environmental roots of ill health and disease and the importance of active community participation and inter-sectoral coordination in health promotion.

At Pholela, a rural setting where the migrant labour system forced local men to work on the distant mines, the Karks employed and trained local community health workers (health assistants) who compiled detailed maps drawn from the local population. These became the foundation for the first population census in the area, which compiled information from 887 inhabitants of the 130 homes adjacent to the health centre. Its report highlighted the need for village planning in basic sanitation, soil erosion and nutrition.

The geographic area of work was expanded annually, and a yearly household health census administered by the health assistants was introduced. Health and agricultural workers worked closely together to reduce malnutrition and improve the soil (Yach and Tollman, 1993, pp. 1043–50). They called this community-oriented primary healthcare (COPHC). COPHC linked community development with primary medical care, with community epidemiology as its base.

The home visit, and not the clinic, became the basis for activity. Health assistants compiled detailed records of home visits. Preventive and curative healthcare merged into ”a more comprehensive outlook best described by the title of social medicine” (Digby, 2008, pp. 485–502). The results were remarkable: crude mortality rate decreased from 38.3 per 1,000 in 1942 to 13.6 per 1,000 in 1950; infant mortality dropped from 275 to 100 per 1,000; and the incidence of severe malnutrition fell. These improvements were accompanied by increasing interest and active cooperation on the part of the people served by the project (Kark and Cassel, 1952).

In 1942, the government established the National Health Services Commission (NHSC) with Sydney Kark as technical adviser (Yach and Tollman, 1993,pp. 1043–50). The NHSC's mandate was to make recommendations for an organized health service to ensure "adequate medical, dental, nursing and hospital services to all sections of the people" (Jeeves, 2005, pp. 87–107).

Two years later, the NHSC report declared that the health of the people was "far below what it should be and could be". It blamed this upon poverty and on primitive health and educational facilities. It proposed a single national health service (NHS) for all, funded by progressive taxation. Healthcare delivery was to be done by teams of doctors, nurses and auxiliary personnel mandated to preserve and promote health, moving away from reliance on curative medicine. Furthermore, it was held that the reform of the health system alone would achieve little if the country did not address the underlying social causes of disease (ibid., p.91).

The 'basic unit' of the system would be the community health centre rather than more hospitals, providing personal health services for all the people "as a citizen's right…according to needs rather than means". Four hundred centres were proposed under twenty regional health authorities, each covering roughly 25,000 people. The pioneering Pholela project served as a model (Digby, 2008, pp. 485–502).

The NHSC's idea of a single national health system, based on community health centres, challenged the existing thinking in both South Africa and Britain. It came up against a range of powerful vested interests. Powerful provincial health departments insisted on control over large central hospitals; the Medical Association of South Africa insisted on the right to private practice. The government resisted drafting legislation necessary to establish the system. Health centres that were established never received enough resources to realize their potential and remained marginal. The window of opportunity to establish a national health service closed when the racist National Party won the 1948 election on an Apartheid ticket.

Health civil society during apartheid and in the 1990s

By the mid-1980s the apartheid health system had established 14 very patchy official Departments of Health (DoH) across the country. Under the divide and rule policies of apartheid, each so-called 'independent homeland' (*bantustan*) had its own puppet government with its own DoH. In addition, the rest of the country (the 'main' South Africa) needed three separate governance structures and health departments – one for each defined racial group without a homeland: Whites, Coloureds and Asians. The health centres established after the NHSC report had been "reduced to a cheap option for black health care" (Marks, 1997, pp. 452–59).

Growth and achievements of health civil society during apartheid The 1980s spawned massive internal civil society resistance to apartheid. This included the rise of a progressive health and social services movement representing both professional groupings and community-based projects. Though the organizations were united in opposition to apartheid, there were intense ideological debates among them. For example, the National Medical and Dental Associa-

tion (NAMDA), established by doctors and dentists to oppose the collabora-tionist Medical and Dental Associations of South Africa, was seen by other oppositionist health worker organizations as elitist and perpetuating divisions between professionals and non-professionals (Picket et al., 2012, pp. 403–05).

Through the 1980s and into the 1990s, the focus of struggle shifted from opposition to apartheid towards developing health policy for the future. Though there was an expressed commitment to the broad developmental inter-sectoral PHC approach among all the organizations, there were tensions between those who favoured a centralist, top-down approach and those committed to a community-based bottom-up approach.

In 1990, the apartheid government revoked its ban on the African National Congress (ANC) and released Mandela and his comrades from prison. As the ANC prepared itself to govern, it incorporated the core of the health policy work of the anti-apartheid health movement into its 1994 Health Plan. Meanwhile, the labour movement under the Congress of South African Trade Unions (COSATU) pressurized the ANC to adopt the broad Reconstruction and Development Programme (RDP) "to meet the basic needs of people: jobs, land, housing, water, electricity, telecommunications, transport, a clean and healthy environment, nutrition, health care, and social welfare".

After a landslide victory in the 1994 election, the ANC formed the first democratic government with a human rights–based constitution. Health activists looked forward to a new health system based on PHC, while the RDP would take care of the social determinants of health. Many key activists moved from civil society into government.

The current South African health crisis

This optimism proved to be short-lived. Twenty-three years later, seven decades after the birth of COPHC, South Africa is in the midst of a major health crisis. For an upper middle-income country, health outcomes are a long way from where they could, and should, be. Figure B4.1 shows health (as life expectancy) in relation to wealth (GDP per capita) for most of the world's countries in 2013. In general, population health is better in rich than in poor countries – most fall on a band running from bottom left (poor and unhealthy) to top right (rich and healthy). South Africa does not fall within that health–wealth band: for example, poorer countries like Bangladesh, Kenya, Ghana and Rwanda – countries poorer than South Africa – have better health outcomes. It should be noted that average numbers like these hide inequality, a major cause of poor health. South Africans experience a massive quadruple burden of disease attributable to four categories of disease:

- HIV/AIDS, tuberculosis and other infections
- high maternal and child mortality
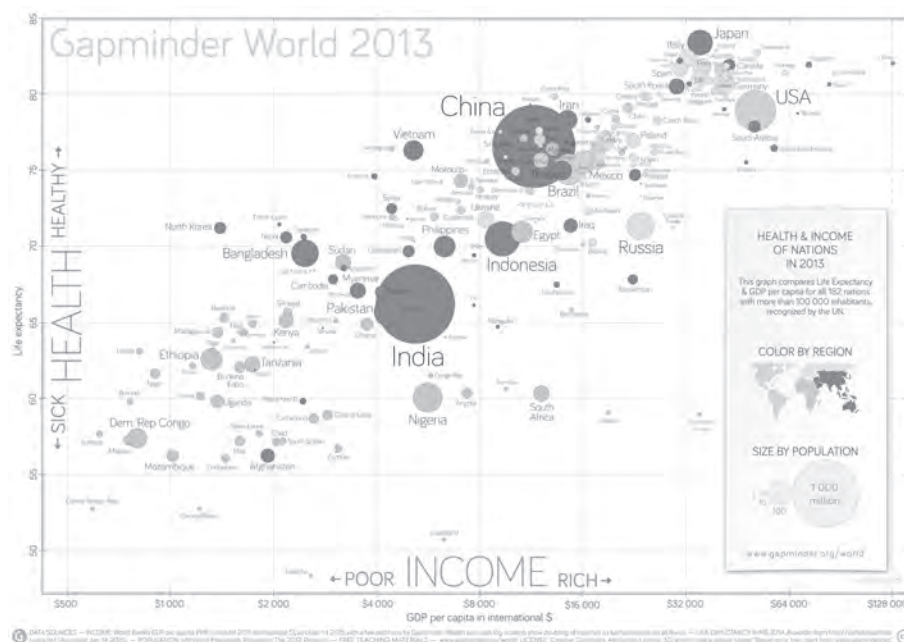- high levels of violence and injuries

Figure B4.1: Health life expectancy vs wealth (per capita GDP)
Source: Based on a free chart from www.gapminder.org (Gapminder, 2015)

- escalating non-communicable (lifestyle) diseases such as obesity, heart disease, diabetes and cancer.

The social determinants of health (SDH) – adequate sanitation and housing, decent and safe work, clean environment and a healthy food environment – remain highly stratified by race and class. Income inequality is among the highest in the world, with a Gini coefficient of 0.7.

How South Africa got here is a dismal testament to the devastating and dehumanizing legacy of apartheid and the prevailing power of vested interests and opportunists, the malignant, insidious influence of rampant corruption, the abandonment of the RDP in 1996 in favour of a neoliberal macroeconomic policy ironically termed the Growth, Employment and Redistribution (GEAR) programme, as well as the marginalization of active, informed citizenship following the deliberate disbanding of the vibrant civil society networks.

The HIV epidemic and developments in health civil society

After a promising start under President Mandela, the presidency of Thabo Mbeki between 1999 and 2008 was characterized by AIDS denialism and the refusal by his health minister, Manto Tshabalala-Msimang, to develop and implement anti-retroviral (ARV) treatment programmes in the public

sector. A key study indicates that more than 330,000 lives or approximately 2.2 million person-years were lost as a result. Thirty-five thousand children were born with HIV by not implementing a mother-to-child transmission prophylaxis program with nevirapine, resulting in an additional 1.6 million lost person-years. The total lost benefits of ARVs (anti-retroviral medicines) are at least 3.8 million person-years for the period 2000 to 2005 (Chigwedere et al., 2008, pp. 410–15).

Developments in civil society The Mandela era marked the marginalization of progressive civil society, including social movements in health, as many activists moved into government and others felt that the struggle had been won and was over.

The AIDS denialism of the Mbeki era sparked the re-awakening of social movements in health with the launch of the Treatment Action Campaign (TAC) in 1998 to "campaign for access to treatment for all South Africans by raising public awareness and understanding about the availability, affordability and use of HIV treatments". Though initiated by a small group of activists, the TAC soon established chapters in many regions of the country. Though its membership consisted mainly of black and poor people with HIV, it included many others, including academics, professionals and faith groups, who joined because they were social activists and identified with the cause. The TAC's campaign methodology included civil disobedience, street demonstrations, literacy programmes, publications and court action.

Image B4.1 March to Parliament by TAC in 2003 (Louis Reynolds)

The TAC had several victories by combining mass mobilization and litigation. In April 2001 it and its overseas allies, particularly the AIDS Coalition to Unleash Power (ACT UP) in the USA, pressured the Pharmaceutical Manufacturer's Association (PMA) and its supporters in the US government to withdraw a lawsuit against the South African government for importing cheaper generic ARVs. In 2002, the TAC won recognition for the right of pregnant women to access an anti-retroviral drug, nevirapine, at all public health facilities capable of providing a PMTCT (prevention of mother-to-child transmission) service.

Finally, after more than a decade of denialism, the government agreed to a plan to distribute ARVs to people living with HIV/AIDS in late 2003. There is no doubt that TAC's multi-strategy campaigning had a pivotal role in this about-face.

The ARV treatment roll-out started in April 2004, and it is now the largest ARV programme in the world, with more than 20 million people tested and almost 4 million on treatment. The rapid improvement in both under-five mortality and life expectancy since 2005 is largely attributable to this programme, since neither the improvements in the SDH nor in the general quality of care can account for this (Figure B4.2).
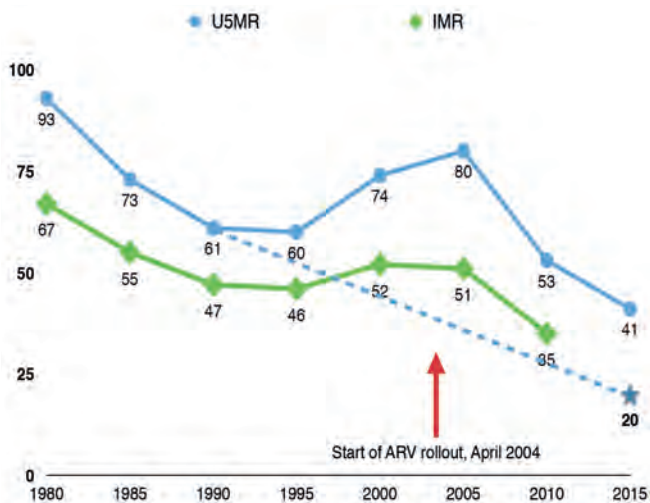

Figure B4.2: Trends for U5MR and IMR in South Africa between 1980 and 2015

Source: CHERG/WHO/UNICEF for distribution of causes of neonatal and under-five deaths (Liu et al., 2014). An updated version is available in Liu et al. (2016, pp. 2151–61)

Notes:
UM5R = under-five mortality rate
IMR = infant mortality rate
The dotted blue line shows the approximate trajectory the country should have followed to meet the U5MR target of 20 (indicated by the blue star); the solid blue line shows the trajectory that was followed instead. The red arrow shows when the anti-retroviral programme started

The rise and success of the TAC campaign occurred in a period when influential external donors – notably the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the US President's Emergency Plan for AIDS Relief (PEPFAR) – started funding HIV/AIDS activities undertaken by a range of 'service delivery' non-governmental organizations (NGOs), which have come to dominate the health civil society in the past 15 years. Such NGOs employed large numbers of lay health workers known variously as treatment/adherence supporters, counsellors, home-based carers and so on, who now collectively make up the approximately 70,000 community care workers (CCWs) in the country.

This NGO-ization of health civil society is not confined to South Africa. It reflects the changed nature of donor funding under neoliberalism – namely, the directing of substantial funding through private and non-government recipients in a climate of cuts in public spending by the state under austerity.

The National Health Insurance project

The current health system mirrors inequalities in society, with a modern, urban-based and specialist-dominated private sector accounting for 50 per cent of total spending, and with approximately 50 per cent of general practitioners and over 70 per cent of medical specialists serving about 16 per cent of the population.

In December 2007, the ruling ANC resolved to establish a National Health Insurance (NHI) scheme to achieve universal health coverage (UHC) and realize the state's constitutional obligation to deliver healthcare with financial protection to all. The proposed National Health Insurance Fund (NHIF), financed predominantly from progressive taxation, will purchase healthcare for all from "accredited public and private providers".

In preparing for the NHI, the health department has attempted to strengthen the public health sector through the implementation of a policy termed the Re-engineering of Primary Health Care (RPHC). The RPHC comprises three streams: Ward-based Outreach Teams (WBOTs) based on community health workers (CHWs) to strengthen community-based services; a school health stream; and District Clinical Specialist Teams with a focus on maternal and child health. The RPHC has initially been implemented at 11 pilot sites to test the model.

The WBOTs are key to achieving improved coverage of households and ensuring basic PHC activities, including addressing local SDH. Success depends crucially on recognition and affirmation, by both the health authorities and local health professionals, of the central role of the CHWs in achieving health for all.

Community care workers and community health workers The NHI provides an opportunity to integrate the current 70,000 CCWs into the formal health

Image B4.2 Community health workers at a workshop organised by PHM (Louis Reynolds)

system as community health workers or as part-time workers operating at the household level. They represent an important health resource for providing and extending key but simple health interventions to vulnerable and underserved populations.

Yet in most of the pilot sites, the CCWs lack basic information about the NHI and are not included in consultation or integrated properly into programmes. In South Africa, there is currently no standardized training or employment of the CCWs. Despite this, thousands are working in vulnerable communities helping to address the need caused by South Africa's massive burden of disease and the failure of our ailing health system.

Many CCWs work as volunteers, others for a stipend from NGOs, a few through health departments. Where wages are paid, they range from ZAR800 to 2,000 per month (US$ 60 to 150). Payment is often erratic and dependent on the current budget of the employing organization, and most of the CCWs are employed through temporary annual contracts that may or may not be renewed. Because their work is not formally recognized, they have no associated benefits and almost no occupational health and safety training. In addition to the potential risk of communicable diseases, the CCWs are exposed to tremendous personal risk, including violent muggings, sexual assault and exposure to the domestic and community violence endemic to many South African communities. They often walk alone from house to house when they are called upon for help and have no protection and often little support from local health facilities.

In other countries, the CHWs perform a wide range of essential functions in the community management of important prevalent diseases like HIV and TB. Given appropriate training, support and recognition, they can recognize and start early treatment of life-threatening conditions like pneumonia, diarrhoea, acute malnutrition and malaria. They can also promote maternal, neonatal and child health.

The NHI plan grossly underestimates the number of CHWs that will be needed. Currently, each CHW is expected to cover 250 households. Given the burden of disease and given that many households are crowded, this is impossible and unsustainable. Furthermore, the scope of practice of the planned CHWs is confined to undertaking household registration and providing information and advice. The CCWs provide very basic home-based care.

The optimal arrangement, given South Africa's burden of disease and its size, would be a combination of CHWs who would undertake the more complex tasks of curative care and personal prevention, with CCWs performing the laborious and time-consuming home care of the sick and bed-ridden. Increasing the total number of community-based workers would have the additional advantage of creating employment for women, thereby promoting improved household income and health benefits, especially for children,

During the anti-apartheid struggle CHWs played a key role in community mobilization for improved social and environmental conditions as well as better medical care. To realize the potential for CHWs to lead actions to address SDH will require a radical shift in thinking. A truly democratic government should welcome and support this notion.

The broader health worker crisis The current austerity policies and tight limits to public spending under neoliberalism have led to inadequate allocation of financial resources to the public sector. A freeze on posts for health workers has led to shortages of professionals, excessive workloads, long shifts and intolerable working conditions, especially in rural areas.

This poses enormous risks to patients as well as health professionals themselves. Recently a 25-year-old doctor fell asleep and crashed while driving home after a long shift, killing herself and critically injuring two others, one of whom died later. This incident brought to light that young doctors face many risks due to austerity. The impact of such neoliberal policies is not confined to South Africa – austerity has also led to protracted doctors' strikes in Kenya and Zimbabwe resulting in much unnecessary suffering and even avoidable deaths.

A critical perspective on South Africa's health reforms

The possibility that South Africa will soon achieve health for all and universal health coverage appears bleak. On the one hand, the state is paralysed by strife within the ruling ANC and seems unable to make rapid progress towards

reducing inequality, addressing the social causes of ill-health and establishing an equitable health system. On the other, powerful vested interests in lucrative private healthcare are using this weakness to lobby for what amounts to a nationwide public–private partnership.

Evaluations conducted at the 11 NHI pilot sites to date are, on the whole, disappointing. Dysfunctional facilities, poor management and leadership, and inadequate human resources for health (HRH) are key problems. At a broader level, the risk of the NHIF being maladministered or looted is high in the current climate of rampant corruption and state capture by rich and powerful conglomerates.

The NHI risks aggravating urban-rural inequity. NHI accreditation will be less demanding for urban than rural facilities where HRH are scarce and government has not been able to address the situation. Furthermore, private providers are overwhelmingly urban.

This situation calls for active and informed citizenship on a massive scale to mobilize for health. Recently the People's Health Movement, the Treatment Action Campaign and Section 27 (a prominent advocacy organization focused on Section 27 of the Constitution, which entrenches relevant socioeconomic rights) hosted a National Health Assembly of civil society. Provincial Assemblies in all nine provinces have paved the way.

The aim of this coalition is to develop a broad social movement in civil society to campaign for the right to health for all. The central role that the TAC played in bringing sense to our approach to the HIVAIDS pandemic showed how citizen action can bring about change from below However, these problems could be overcome with powerful civil society mobilization to ensure greater investment, especially in more HRH, appropriate training and leadership, and ending corruption in both public and private sectors.

References

Chigwedere, P, Seage, GR III, Gruskin, S, Lee, T H & Essex, M 2008, 'Estimating the lost benefits of antiretroviral drug use in South Africa', *Journal of Acquired Immune Deficiency Syndrome*s, vol. 49, no. 4, pp. 410–15 http://journals.lww.com/jaids/Abstract/2008/12010/Estimating_the_Lost_Benefits_of_Antiretroviral.10.aspx

Digby, A 2008, 'Vision and vested interests: National Health Service reform in South Africa and Britain during the 1940s and beyond', *Social History of Medicine*, vol. 21, no. 3, pp. 485–502.

Gapminder 2015, *Gapminder World Poster 2013* https://www.gapminder.org/downloads/gapminder-world-poster-2013/

Jeeves, A 2005,'Delivering primary care in impoverished urban and rural communities: the Institute of Family and Community Health in the 1940s', in Dubow, S and Jeeves, A (eds), *South Africa's 1940s: worlds of possibilities*, Double Storey,Cape Town, pp. 87–107.

Kark S L, Cassel J 1952, The Pholela Health Centre: a progress report. South African medical journal, 1952

Liu, L, Johnson, HL, Cousens, S, Perin, J, Scott et al., 2016, 'Global, regional, and national causes of child mortality: an updated systematic analysis for 2010 with time trends since 2000', *The Lancet*, vol. 379, no.

9832, pp.2151–61, http://dx.doi.org/10.1016/
S0140-6736(12)60560-1

Marks, S 1997,'South Africa's early experiment
in social medicine: its pioneers and politics',
American Journal of Public Health, vol. 87,
pp. 452–59.

Pick, W, Claassen, J W B, Le Grange, CA
&Hussey, GD2012, 'Health activism in Cape
Town: a case study of the Health Workers
Society', *The South African Medical Journal*,
vol. 102, no. 6, pp. 403–05, viewed 10 April
2017, http://www.samj.org.za/index.php/saj/
article/view/5624/4208

Yach, D & Tollman, S M 1993,'Public health
initiatives in South Africa in the 1940s and
1950s: lessons for a post-apartheid era',
American Journal of Public Health, vol.
83,no. 7, pp. 1043–50.