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REVIEW OF PROGRAMMES

INTRODUCTION

Broadly speaking a Health Programme is:

"An organised aggregate of activities directed towards the attainment of defined objectives and targets which are progressively more specific than the goals to which they contribute." (WHO)

Some characteristics of Health Programmes may be outlined as follows:

- They are specific; represent a component part of a strategy; they are delivered by a health system infrastructure.
- Each programme should have its specific objectives and targets, wherever possible quantified, that are consistent with those of the broad health strategy and national policy.
- Should set out clearly the requirements in health workers, physical facilities, technology, equipment and supplies, information and inter-communication, the methods of monitoring and evaluation, methods of timetables of activities, the ways of ensuring correction between its various elements and related programmes and a financial budget including running costs.

What we have to ask ourselves is whether or not our health programmes for our communities in exile, particularly those settled in the frontline states (rear base areas), are being adequately implemented. And, if not, what more should we do so that our programmes could be meaningful and effective for the development of health care services?

The Development of Health Programmes for our Communities in Exile

The main objective of our Health Care Services since the displacement of our people into exile in the early 60's and particularly since the Soweto Uprising in 1976, is to keep the movement's cadres in good health. To date this objective remains firmly rooted in the Health Policy and presents a challenge for the Health Department. With the development of the Department, health programmes underwent review and revision at opportune moments, Whilst at the same time being greatly influenced by factors such as the overall development of the movement at the time, the prevailing conditions, the accessibility to medical supplies, equipment, expertise, etc.

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Health care was made accessible to all our cadres in exile with the introduction of health care posts supervised by medical aides ("medical officers", as they were popularly known). Their activities were generally centred around the provision of curative services for our cadres which to date remains to be one of the main health programmes of the Department. Health education, as a programme, was virtually non-existent and environmental health services were severely hampered by the prevailing conditions. The distinct separation of our settlements initiated the era of on-the-job trainees for our department.

With the escalating struggle at home and the influx of our people into exile in 1976, greater responsibilities fell on the shoulders of the Health Department and necessitated the introduction of specific programmes for the development of health manpower to cater for our now much larger communities. A Medical Committee was established in August, 1977, and whose primary task was to supervise the activities of the regions. The priority programme for the Medical Committee was then to alleviate the severe manpower shortage. Nurses were organised to treat common medical problems, courses were arranged in medical assistance and First Aid. While at the same time links were established with solidarity organisations and international organisations (WHO). Following these developments the Medical Committee was renamed Health Committee.

By the early 1980's health care activities amongst our communities across the subcontinent had broadened sufficiently to warrant wide ranging health programmes. Furthermore, the establishment of an educational institution in Mazimbu, a development centre in Dakawa and links with a greater number of international organisations and solidarity groups made it possible to improve our health care facilities and initiate specific health programmes.

In 1982 the joint NLM/WHO Action Group that was set up following the International Conference on Apartheid and Health formulated a number of programmes to assist the victims of apartheid (see Annex 1).

In 1983 a Primary Health Care (PHC) Seminar was held in Lusaka for the ANC leadership to make the endorsement of PHC as the mode (approach) of health care delivery and the implementation of our health programmes (see Annex 2).

By this time in the development of the department there were beginning to emerge complaints of poor supervision of health care activities in the regions from both members of the community and the regional health teams themselves, and were directed against the now much reduced in number Health Committee.

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Following the decision taken at the National Consultative Council Meeting (CCM) in 1982, the Health Secretariat was established and Lusaka was declared the headquarters of the Health Department. Members of the Health Secretariat were allotted specific portfolios (Conference Document 3/HCM/11/86) and their tasks were to supervise, monitor and evaluate specific health programmes for the various regions. The success of these programmes has been minimal. Allegations of incompetent supervision, mismanagement and negligence were directed against the Health Secretariat by members of the community and members of the Regional Health Teams, particularly in East Africa. Meetings were held with members of the NEC and Commissions were appointed to investigate the problems affecting the smooth coordination of work within the Health Department. Council would do well to re-examine the infrastructure of the Department, seek ways to improve coordination at central level, between central and regional levels and with other sectors of the movement and finally to re-evaluate priority health programmes. The tragedy of the present status quo is that the Health Secretariat has lost control over health care activities in all regions.

Health Programmes for Consideration and Recommendations for their Implementation and Evaluation

From what has been said earlier, it can be deduced that:

a) Management of health care programmes at mid-level (regional) alone, without continuous supervision, direction and evaluation at central level is meaningless.

b) Management of health programmes at central level alone without the active involvement of regional structures is futile.

c) Efficient coordination of work is vitally important.

d) Cooperation with other sectors of the movement could be achieved if a health programme is shown to yield positive results. With the blatant lack of coordination that exists within our Department, little can be expected by way of positive input by other sectors of the movement.

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1. Programme on Mental Health

A burning issue that has gripped our communities is that our mentally ill comrades are left to occupy themselves without proper counselling by health workers. In my view this is not an emotional reaction, rather a practical situation which needs (demands) active and effective resolution. If acquiring our own facilities is difficult, perhaps more effort should be made to have our patients use the local facilities. In addition, our patients (especially in Zambia) should be supervised and cared for by our health wworkers alone and not be the responsibility of any other sector in the movement.

b. The active screening of our psychiatric patients into viable occupational therapy should be the collective responsibility of our own specialists/ specialising doctors. Three-monthly visits are far too infrequent; now more than ever before, as our struggle for national liberation unfolds. The reliance on regional responsibility falls far too short of effective and efficient monitoring and evaluation of progress of psychiatric care. There are few, if any, of our mentally ill comrades who are too advanced in their illness to be incorporated into some kind of useful occupation.

Isolation of our psychiatrically ill comrades, and in the absence of proper facilities, could hardly represent a "neighbourhood" rehabilitation centre nor community involvement. It serves rather as a means to prolong the "stigma" of inadequacy and runs contrary to the policy of our Health Department. What should be encouraged, both through active persuasion and community education campaigns, is great community involvement in psychiatric care. Needless to say, the family surrounding is probably the best therapy.

With the growing numbers of our mentally affected comrades, especially those who have undergone torture in detention, a study would aptly serve to create a link with those progressive organisations at home, which are presently dealing with this problem. Now that there exists a group of specialists studying the effects of torture in detention, we would do well to share experiences.

Integration into the work of the departments of the movement should be persistently encouraged. The incidents of this type of community participation (involvement) are few, but the results are most gratifying.

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2. Health Education Programmes

This portfolio in the Health Secretariat has been left devoid since the departure from the region of Comrade Kulukazi Mzamo. Equally disturbing is the fact that the evaluation and recommendations for a viable health education programme for Mazimbu, that was supposed to have been carried out in 1983, has not been brought to the attention of the Regional Health Teams. The programme should contain specific campaigns taking into account the diversity of activities in the various regions. Collaboration with local expertise and other departments/sectors of our movement would be vitally important. Simply written pamphlets, booklets, leaflets, both in the vernacular and English, popularising measures to deal with the harmful effects of a variety of wide ranging, common agents, should be a regular exercise undertaken with the full support and control of the Health Secretariat. Initiatives taken locally by the Regional Health Teams should be encouraged. A regular feature on health education in the future health bulletin is imperative.

3. Health Manpower Development and Rehabilitation Programmes

These programmes are well documented in the paper presented for Council. Sufficient proposals have been highlighted to stimulate discussion.

ANNEX / 1

JOINT NLM TECHNICAL COOPERATION PROGRAMME PROPOSAL

Programme	Duration	Support requested by NLM's
1. Mental Health	1983 - 1987	- STC psychiatrist - psychiatric drugs - training - joint NLM workshops - TCDC exchange of experiences between NLM's.
2. Health Manpower Development. (HMD)	1983 - 1987	- Study fellowships (10 fellows in the Health field). - Medicosocial delivery services (training) - Workshop/Seminars - Manpower development - Consultants - Study visits in the context of TCDC - Training materials - Audiovisual aids - Books
3. Essential drugs / equipment	1983 - 1987	

Programme	Duration	Support requested by NLM's
3. Rehabilitation	1983 - 1987	- Training of specific categories. - Study visits to specialized rehabilitation centres. - Workshop on occupational therapy - TCDC exchange of experiences between NLM's and front-line states. - Consultants (training/study). - Training of trainers in the use of rehabilitation equipment. - Study fellowships - - physiotherapits. - Equipment / drugs.
4. Environmental Health	1983 - 1987	- Workshops/seminars. - Case studies for refugee camps. - Implementation of IDWSSD for refugees. - Equipment / drugs - Consultants. - Exchanges of experience in the context of TCDC. - Training (engineers and technicians) as part of the IDWSSD.
5. Essential drugs/ equipment	1983 - 1987	- Essential drugs. - Materials/surgical equipment - Training of pharmacists. - Training of laboratory technicians.

RECOMMENDATION OF ANC PRIMARY HEALTH CARE WORKSHOP.

Lusaka 30/11/83.

The Apartheid system is incompatible with a healthy nation. Intrinsically, it constitutes a denial of the fundamental human right to health, especially as regards the Black Majority. The destruction of the Apartheid system and the transfer of all power to the people in a democratic South Africa is therefore a necessary and decisive condition for the implementation of a genuine Primary Health Care programme in South Africa.

Following from the contributions which were made both at Primary Sessions and during Group discussions, the Seminar arrived at certain conclusions and recommendations, which it wishes to place before the Movement for endorsement as guidelines for promoting Primary Health Care (PHC) programmes at home and abroad. The recommendations are particularly related to the ANC community abroad, and should also find relevance in a nation-wide programme in a liberated South Africa.

The findings are drawn along three broad areas corresponding to the three discussion groups, but a number of issues are inter-related and tend to overlap from one area to another.

The three main areas of discussion were : -

(a) Health Policy in Relation to PHC and the Strategy for its Implementation.

(b) Primary Health Care: The Programme Content.

(c) Intersectoral and Multi-disciplinary Approach to Health Problems.

(a) Health Policy in Relation to PHC .

- Primary Health Care should be in an integral part of State Policy on Health. This should be accompanied by political goodwill on the part of decision makers to promote its implementation.
- Health Policy should be geared towards PREVENTION of diseases rather than CURE. Such an approach is better investment of both financial and human resources.

1. Although the initial capital costs may appear exorbitant and prohibitive in the long run they prove more economical than the spending required to cure recurring preventable diseases;
2. Preventing diseases ensures a more stable work force, increased productivity of the population in their diverse occupations and a healthy nation.

- Primary Health Care must be accessible to the entire population. This should be a right all citizens who must be assisted realise their obligations for promoting PHC in their respective localities.

- Primary Health Care must be community-based, with direct participation of community members. It must seek to promote self-reliance and allow for a flexible approach by the Community in determining priorities of the local PHC programme within the context and scope of the National PHC objectives. This would strengthen community involvement, commitment and initiatives.

Strategy for Implementation .

- PHC education, as an on-going process, should begin at the earliest cognitive ages and institutions (creches, sunday schools, pioneers) and extend to Literacy and Adult Education programmes. PHC measures should be observed within the homes, at work places and throughout the territory of the Country.

- PHC programmes should be relevant to the socio-cultural conditions in the given community (urban or rural) and take into account the geographic situation and level of economic development of the country.

- The goal of promoting " Health for All " should go hand-in-hand with other nationwide developmental programmes which seek to minimize the disparities in the living conditions of the population.

- National PHC training programmes should maintain a balance in Health Personnel i.e: Nurses, Doctors, Health Inspectors, Medical Assistants, Auxilliaries. People must be educated to appreciate the role of the various categories of health workers and their interdependence and thus do away with defication of doctors and thus encourage the necessary corfidence not only in the doctor, but also in the other sectors of the medical personnel. On the other hand health personnel should be consciously discouraged from exploiting their profession or undermining their patients.

- Health training programme should be related to training programmes which take into consideration the intersectoral and multidisciplinary character of health problems. Thus training of health personnel should go hand-in-hand with the training of personnel in fields which are necessary for the servicing of health programmes e.g: food production, storage and preparation; construction and water works; socio-cultural activities etc.

- In acknowledgement that PHC depends on political commitment to the equitable distribution of resources, community participation and social justice, we would urge the ideological and political training to be a component of the training of health workers.

- Research should be conducted into traditional healing with the aim of discarding harmful practices and improving on the beneficial aspects.

- Realising that malaria, TB, diarrhoeal diseases and occupational diseases are the major health problems in our community, it was recommended that PHC based programmes to prevent and control these diseases be strengthened.

- Mental Health problems which are a result of the obnoxious system of apartheid and problems of exile should be managed, as much as possible, within the community.

- For the realisation of these broad objectives within the ANC Community, the seminar recommends:

1. That the NEC directs all missions and centres to facilitate and participate in the implementation of P.H.C. programmes.

2. That PHC courses be conducted in all regions and units of the ANC with regular survey to assess the execution of the PHC requirements.

- The Seminar appreciation of the involvement of the Health Department at the level of decision-making organs of the movement. This augurs well for the successful development of PHC programmes both within the ANC community and at broader national level.

3. That in order to meet the PHC needs in personnel, proper Career Guidance at ANC education institutions should include fields of study that cover the range of PHC-related skills and professions.

4. That deployment of Health Personnel should strive to ensure rational distribution of available Human Resources according to needs of the various ANC communities.

5. Manuals on the implementation of a PHC programme must be prepared and circulated to all ANC Communities.

PRIMARY HEALTH CARE : CONTENT OF PROGRAMME .

Having examined the various aspects of PHC, the Seminar recommended that :-

(a) PHC be at the core of the ANC's Health Policy, the adoption and implementation of which policy must be speeded up.

(b) That while we have the overall objective of a general programme for a free South Africa, PHC should hanceforth be our mode of health deliveries wherever we are.

(c) That the experience gained by Health Teams in different countries where we are, and that of SWAPO, be used in implementing our PHC programme.

EDUCATION :

- That the general education policy of the ANC must incorporate health education in all its aspects, and that this be initiated at nursery right up to the end of the school curriculum in all ANC Institutions.
- Parallel to the above process, communities should be given lectures on the importance of both environmental and personal hygiene as a means of preventing diseases. In this way good health will be both a right and an obligation to members of communities.
- The production of a programme being worked upon by the Programme Officer for Health Education must be speeded up. Further, once such a programme has been made available, all departments of the movement must ensure that it reaches all echelons of the movement, using all the available channels and units of the organisation, for instance : -
  (a) In the Charlottes.
  (b) In Women's unit meetings.
  (c) In branch meetings
  (d) To units working in creches and day-care centres.
- Training of health personnel of all categories and levels be stepped up, taking into consideration the priority areas.

FOOD AND NUTRITION .

- Medical teams must draft menu's for ANC Communities, including children and have a final say in this matter.
- Communities must be educated on Nutrition and the dangers of overcreating.
- ANC farms must be developed to become the main sources of our food requirements.

CLEAN AND ADEQUATE WATER :

- Problems of adequate and safe water supply are faced by all communities, both at home and in the host countries. The Seminar resolved that our Communities should, thrcugh community participation, learn to provide themselves with adequate and safe water.

SANITATION :

- Appropriate methods should be worked out in the spirit of the PHC programmes for the disposal of excretum and refuse.

MATERNAL AND CHILD HEALTH (CHILD SPACING ETC) :

- Most ANC Communities enjoy the MHC services of the countries in which they are. However, there is need for stressing Family Health Education, especially for our young generation, with the objective of avoiding unwanted and unplanned pregnancies.

- Lactating mothers must be be given time off from work to enable them to breastfeed their babies.

IMMUNISATION :

- Since we do not yet have the necessary facilities, mothers must be encouraged to take their children to local clinics for immunisation under the supervision of the Health Teams.

PREVENTION AND CONTROL OF DISEASES :

- Communities must have check-ups once in every 2 years.

- Realising that Malaria, TB, Diarrhoeal diseases and occupation diseases are the major health problems in our communities, it was recommended that PHC based programmes to prevent and control these diseases be strengthen.

- Mental Health problems, which are a result of the obnoxious system of Apartheid, and problems of exile, should be managed, as much as possible, within the Community.

ESSENTIAL DRUGS :

- Health Teams should, as far as possible, adhere to the essential drug lists of the host countries.

- In the implementation of the balanced health programme, legal and other active steps must be taken to prohibit the proliteration an distribution of dangerous drugs by Transnational Cooperations. In this regard, health personnel should be geared against such medicaments.

INTERSECTORAL AND MULTIDISCIPLINARY APPROACH :

The Seminar endorsed that Primary Health Care in conformity with the aspirations of our people as enshrined in the Freedom Charter. The Freedom Charter does in fact provide the base for the requisite political will for the implementations of a nation-wide PHC Programme.

- The Seminar acknowledged widespread lack of understanding of the concept of PHC. The sentiments of the participants were for the widest distribution of the findings and recommendations particularly when discussion reached the intersectoral and multidisciplinary approach to health problems. In fact with the problems which confront our health services. Thus such widely different issues like Policy, Administration, Political understanding, selection and Placement of both students and Qualified Cadres, Areas of study, Places of Study, Categories of ANC Members etc all become relevant under multisectoral and multidisciplinary coordination. Thus the concept of intersectoral and multidisciplinary approach was found to be in conformity with the concept of coordinated effort for over-all development.

- The Seminar came to realise the magnitude and interelationship of health to such areas as the supply of adequate, safe water, nutrition, housing, employment and working conditions, education etc.

- The Seminar found that it was imperative to intergrate the PHC concept within all the sectors and levels of our Movement using all the available structures and lines of Communication. Where necessary, appropriate structures and communication lines should be created to ensure the speedy solution of PHC problems in our communities. Intergration of PHC should both be vertical (National, Regional, District, Community) and horizontal i.e: among the various departments and sectors at each given level. It is absolutely imperative that these structures and lines of communication be known to the entire membership.

- There is need for the dissemination of information on PHC, both formally and informally in order to promote mutually-supportive solutions to health problems.

- The presence of the Department of Health at H.Q. should be strengthened and matters pertaining to health should be reffered to the Department for proper coordination.