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NAMDA

National Medical and Dental Association

NAMDA

Towards health for all

30 March 1989

The Evaluation and Planning Centre

The National Executive Committee of NAMDA endorses the establishment of the Evaluation and Planning Centre (EPC) in Durban, South Africa. We have long felt the need for such a facility to respond to both short term operational needs in this region and to contribute to our longer term strategic needs.

NAMDA is committed to the development of a unitary, non-racial and accessible health service based on the principles of the Alma-Ata Declaration and on a National Primary Health Care Strategy. In this regard the EPC will play a major role in strengthening our existing programmes, provide an opportunity to give practical expression to our committment and to make a contribution to the emergence of a non-racial democratic society in the post-Apartheid period.

Dr Diliza Mji
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TO WHOM IT MAY CONCERN

THE EVALUATION AND PLANNING CENTRE

This is to confirm that our Department agrees in principle to support the Evaluation and Planning Centre and that it will be located in the Department of Paediatrics and Child Health, University of Natal, Durban.

Our Department considers the establishment of such a centre as an important achievement for the forward-looking sector of our society and has no doubt that it will play a significant role in the promotion of health among the disadvantaged. Our experiences at the King Edward VIII Hospital and our Maternal and Child Health (MCH) programmes in the community, have long needed such support.

It is our hope that such a collaborative venture will strengthen MCH services in Natal in the short term, and will make a major contribution to the development of a National Health Service (NHS) in the long term. We have no hesitation in fully supporting the establishment of the centre.

H.M. COOVADIA
Professor and Acting Head

W.E.K. LOENING
Stella and Paul Loewenstein Professor of Maternal and Child Health

A BRIEF HISTORY OF THE NATIONAL MEDICAL AND DENTAL ASSOCIATION (NAMDA)

NAMDA was formally constituted during a humid summer afternoon on the 5th December 1982, on the tenth floor of the Teachers Association of South Africa (TASA) Building in Durban. It is not fortuitous that this was the beginning of the most significant decade in the history of resistance to apartheid. In 1982 the first stirrings of mass resistance were in the air. The progressive trade union movement had been growing rapidly since the Durban strikes in 1973 and was heading towards the formation of COSATU. A number of community based organisations were emerging in Cape Town, Durban and Johannesburg; these were founded on daily community issues such as housing, rents and local government. Student boycotts had reappeared after Soweto 1976 and were spreading through the land in African, Coloured and Indian Schools. Universities were the focal point of intense debate and student unrest. Youth, both inside and outside educational institutions, were getting organised. In a word, NAMDA was born in a period of burgeoning social dissent and challenge. Cracks in the monolithic State apparatus were widening: legislation allowed the unionization of Africans; influx control was being loosened; political institutions were being designed to accommodate Africans, Indians and Coloureds and petty apartheid was crumbling.

At this time a Health Workers Association was already in existence in the Transvaal. It was in Durban however that a group of doctors were able to take the first few steps to establishing the forerunner of NAMDA. It is not by chance that these events occurred early on in Durban: this city has the largest concentration of Indian, African and Coloured Doctors in the country; the University of Natal has the oldest and biggest black Medical Faculty; Doctors at the Medical School had the experience of an abortive strike over unequal salaries in 1968; This was the scene of the rise of Biko and Black Consciousness; Medical Students had lived through the South African Students Organisation and were more politicised than their colleagues in other campuses; Black private practitioners had an infrastructure of thriving Guilds and, most critically, a significant number of Doctors had been involved for many years in straightforward political work and community organising. This convergence of different factors created the objective and subjective conditions for NAMDA.

Two specific events acted as catalysts for bringing together health professionals to seek avenues for the expression of their discontent. These were the failure of MASA to take prompt and appropriate action against Drs Lang and Tucker who had been accused of unethical behaviour in their Medical Management of Steve Biko who died in detention in 1977, and the effects of detention without trial on health (especially the physical and mental deterioration produced by solitary confinement and torture). These made such a profound impact on the collective conscience of the Medical and Dental Fraternity that a wide range of individuals took up the struggle for a re-examination of Medical ethics and responsibilities in this country and for the

outlawing of unjust laws which had by then led to incalculable suffering and more then fifty (50) deaths in detention.

It was inevitable that professionals would react to the social consequences of apartheid which are so gross, so brutalising and so widely acknowledged and abhorred by the world. However, prior to the 1980's, this response by Health professionals had been isolated, fragmentary and individualised. No systematic examination of the nexus between apartheid and health had been undertaken by Doctors and Dentists; little was done on an organised basis and there were no programmes of action.

The impetus came, surprisingly, from the guilds (Durban North South and West Guilds, and Pietermaritzburg Doctors Guild). A decision was taken to hold a conference to go into the question of forming an alternative medical association. Representation was to be from as wide a group of Doctors as possible. An Interim Committee organised such a meeting on 15th November 1981 at the TASA Centre in Durban. About 150 Doctors from Natal and Transvaal attended.

The reasons formulated for a new medical association were the failure of MASA, the need for a forum for progressive Doctors to discuss the wider issues on health, the commitment to work for democratic change in health structures, services and education, the necessity to take up people's health issues and finally, to counter state propaganda by revealing the true conditions prevailing in health in South Africa to the world community. The alternative medical association was formed. This body further canvassed the views of doctors in Durban, Stanger, Port Shepstone, Pietermaritzburg, Newcastle, Port Elizabeth, Cape Town, and Johannesburg. There was considerable support for the new Association.

This mobilisation and consultation culminated in a National Conference held on 5th December 1982 at which NAMDA was named and formed. A Health Worker Organisation also appeared in Durban. NAMDA met the Health Worker Groups and despite optimistic expressions of agreement and unanimity on issues, there was considerable disagreements between it and NAMDA, These differences have decreased with time. Health Worker Organisations rallied health personnel across the Board whilst NAMDA concentrated on Dentists and Doctors. The fundamental differences in approach between these two types of organisations have been dealt with extensively in NAMDA Publications.

The goals of the organisation were enunciated for the first time and were broad and all-encompassing on Health. They are contained in the preamble to the constitution, accepting the World Health Organisation definition of Health, affirming the belief in health as a basic human right and, above all committing NAMDA to the establishment of just society as a precondition for optimum health. The aims and objectives extend in the most general way these goals and appear no different from similar expressions of other liberal bodies. In the light of the subsequent development of NAMDA, these aims and objectives appear particularly mild, if not bland. In terms of the repression prevailing in South Africa this avoidance of radical aims was probably a sensible approach. It is interesting that the latter directions of NAMDA into PPHC,

Detainees Care, CBME and ESG are related to the points made in aims and objectives, although no one could have predicted in 1982 the depth and extent of these involvements.

The guidelines for a programme of action drawn up at that time were primary concerned with building and strengthening the organisation on a broad and secure base. It was noted that "We have people in our ranks of different persuasions and we will have to accommodate as many interests as possible without compromising our fundamental goals... we will have to search out some common ground where such a diversity of talent can be satisfied and function effectively" Given the wide horizons pointed out in the goals , these sentiments would appear to be a contradiction, except that they most likely reflected the pragmatic approach adopted by the more radical and politically orientated members in leadership positions. It was suggested that such a programme would comprise a "General Programme" to have a Broad appeal and would contain academic and recreational activities, a "Strategic Programme" to address specific areas such as Primary Health Care, Education, Unemployment, Bantustans etc., and a "Monitoring Programme: on the continuing abuses of apartheid on Health. There was not much hint in these statements of the central role in health that NAMDA was to play in the rising surge of popular dissent in the 1980's

Full membership was restricted to registered medical practitioners and dentists. Associate membership was open to students and "concerned Health Professionals", this was later changed to "such other persons as determined by the association". This restricted membership was used by critics of NAMDA as a crucial weakness leading to control over Health matters by professional elites. The NAMDA argument is that the deep class division in South Africa prevent the organisation of all Health Workers into one body; The material needs of Health workers are best served by trade unions. There has been prolonged debate over the social location of nurses, are their interests promoted by unionisation or incorporation into professional bodies. The weight of argument tilts towards recognition of the proletarianization of nurses and therefore favour the former. Some of these debates have diminished in intensity and relevance with the formation of the trade union National Education Health and Allied Workers Union (NEHAWU).

A spirited public opposition by some NAMDA members to the idea that religious beliefs provided sufficient grounds for the establishment of a separate medical Association in South Africa laid the basis for an abrasive interaction with the Islamic Medical Association. Over the years, joint action, quiet diplomacy and a growing mutual tolerance and respect have led to cordial, and at times comradely, working relationships.

The dealings with MASA have deteriorated from suspicion and distrust to outright hostility. As alluded to above, the creation of NAMDA was in some measure, though not entirely, a reaction to the failure of MASA. It was inevitable that MASA's actions would be opposed as it was perceived by NAMDA as being closely aligned with the ideology and practices of the apartheid state. After criticisms of MASA on the handling of the Biko issue, contact between the two organisations bristled with suspicion .but was still subdued in relation to later events. NAMDA reaction to

the report of an Ad Hoc Committee of MASA (May, 1983) which had the Minister of Health on the Medical Care of Prisoners and detainees, was gentle if not muted. NAMDA supported MASA on its initiative and affirmed that the report was significant. However NAMDA believed that recommendations were limited and suggested that MASA improve their recommendations and "actively work for their implementation". Some of the reservations of NAMDA hinged on the dismal failure of the report to condemn the system of detention itself and demand its abolition and the right of access to detainees by an independent doctor of their choice.

The right wing and reactionary World Medical Association (WMA) had precipitated the breakaway of African, Scandinavian and British groups by its decisions to readmit MASA. In 1984 MASA planned to host the congress of the WMA in South Africa. The purpose of this would be to assist MASA in reducing the international outrage over its venal and degrading conduct on the Biko issue and to project an unrealistically favourable impression of health and disease in South Africa. NAMDA, Health Worker groups and Medical Students councils formed a coordinating body, the National Committee of Health Organisations (COHO) which spearheaded the opposition to this WMA congress. The campaign succeeded and the WMA congress was moved to Brussels. It was during this campaign that unity among health groups occurred in joint action and nascent international support was encouraged.

MASA continues to avoid meaningful action on crucial issues in health: effects of repressive state legislation, torture in jails, deaths in detention, the appalling detention and abuse of children, the emergencies, security branch harassment of NAMDA, non viable and corrupted bantustans, the disastrous fragmentation in health services accentuated by the new tricameral constitution, the terrible consequences of forced removals, the racist allocation of health resources, the crises in black housing and education, etc... MASA launched a scurrilous supplement to the SAMJ attacking a visit to the USA by the President of NAMDA, Diliza Mji. The accusations were based on distorted, tendentious, selective and occasionally false evidence. A basic principle of law - audi alteram partem - was violated by MASA when it refused to publish an in depth reply for NAMDA. A replay of these events occurred in DASA's Journal written by its Executive Director H. Heydt. The pages of the SAMJ are rarely open to NAMDA to respond to wild and baseless charges made against it by MASA members in its correspondence columns. The provocative and unethical approach of MASA is evident from the fact that some of the insinuations in these charges have the potential for vicious action from the security apparatus of the regime. In a police state it would be disingenuous to expect anything else.

Recently MASA branches have allowed the military intelligence service (known for its attempts at falsely discrediting the ECC) to malign NAMDA and make the most extreme and unfounded allegations against it.

It is clear that MASA is willing to allow, if not underhandedly encourage the repressive arm of the apartheid regime to smash NAMDA.

NAMDA has built a powerful support network at an international level. The WMA campaign served as the first entry point in this field. A number of solidarity groups and individuals have been set up in the past few years. Primum inter pares is the Committee for Health in South Africa (CHISA) in the USA which has grown and now has an identity and a presence which promotes the anti-apartheid struggle in health. A close, warm and trusting relationship exists between NAMDA and CHISA. A similar group "Health Watch" exists in Canada, and there are less formalised groups (but no less supportive) in the United Kingdom, Europe and Australia. NAMDA is a member of the international commission of Health Professionals and has informal Associations with UNICEF and other international agencies. In October 1986 a NAMDA delegation attended the Maseru conference of the Confederation of African Medical Association (CAMAS). NAMDA was accorded permanent observer status with this body. The CAMAS link established a precedent on the exchange with and support of academics in South Africa. The principle became "Support progressives engaged in anti-apartheid struggle, but isolate the cohorts and apologists of apartheid". NAMDA now regularly participates in international meetings, usually those concerned with human rights.

The theoretical, analytical and ideological framework of NAMDA has been enriched by experience gained in the field, in struggle, in work with the wider community and in mutually reinforcing international contacts. Paper at annual Conference were initially most concerned with the effects on health of the new constitution, detentions, relocations and occupation, The issues now being studied are being investigated at a much deeper level and more extensively. for example, the disproportional allocation of health services, the pyschological effects of detention, trends in health expenditure, PHC, Dental Manpower and Industrial Health have all been addressed with more insight and skills. The NAMDA annual conference proceedings has now attained wide recognition for the quality of its articles and the relevance of its subject. It is required reading for any interested in the struggle for health in South Africa.

The rising momentum of change in this country has created its own imperatives. While liberation may not be imminent, its appears realisable, For NAMDA this means planning for the future. Accordingly a number of Seminars, Publications and campaigns have addressed vital issues such as a nationalised health service, Primary Health Care (PHC), training of PHC workers, Doctors, Dentists and other Health Professionals for a post apartheid South Africa, traditional medicine, role of nurses, privatisation, role of drug companies, appropriate research etc... except for NHS recommendations in the Gluckman commission at the time of the 2nd world war, this is the first systematic inclusion of these issues and discussions on the future shape of this country health service.

The progressive direction taken by NAMDA was facilitated by leading members in its ranks with active involvement in political, community, youth, welfare and worker organisations. This ensured the sensitivity of NAMDA to popular struggles and the health related needs of organisations at the vanguard of the resistance movement. Up to this point, NAMDA has managed to balance the ability to provide leadership when necessary with the capacity to respond to the changing needs of people caught up in

daily struggle. Leadership qualities are especially relevant as health is not often perceived or articulated as a priority demand among communities immersed in the battle for survival. At the least, NAMDA has kept its members involved, its organisation intact and it has broadened the scope of its activities and strengthened its administration. This is an achievement in the context of a brutal racist regime and in the absence of any immediate material or other personal benefits accruing from NAMDA membership. The best evidence for the afore going paragraph is a short summary of NAMDA's major programmes.

The uprising in the Vaal triangle, which later spread throughout the country's Black Townships in 1984 increased requests for medical and psychological assistance. It was difficult for injured people to escape from townships ringed by a cordon of security forces and impossible for sympathetic outsiders to get in. A significant police presence was maintained at hospitals to arrest those seeking help for injuries. Access to doctors and clinics and even makeshift facilities at churches was limited. Furthermore the number of political detainees were increasing daily. Many thousands suffered the after effects of their detention and torture on being released from apartheid prisons. NAMDA brought together detainee support groups and a few other organisations to set up the Emergency Services Groups (ESG). This programme entails training local members of community organisations to deal with health related problems, especially surgical emergencies and crises, which occur during times of unrest. Counselling and rehabilitation of ex detainees is a major component of this project. This programme is now the largest health service provided by progressives to the community. While NAMDA maintains an abiding and important involvement in ESG, to a large extent the organisation functions independently.

NAMDA is committed to the building of a health system in a democratic South Africa based on a sound and secure primary health care services. Above this firm base of PHC will be constructed the intermediate and tertiary levels of health care. with priority of health needs determining allocation of resources. An imaginative move towards this medium term objectives was the convening of a conference by NAMDA of PHC workers in Cape Town during April, 1987. The minimum requirement we used for the invitation was a rejection of apartheid. From this meeting arose the Progressive Primary Health Care network (PPHC), which was formally launched in Johannesburg in September 1987. PPHC operates autonomously from NAMDA with its own projects, regional and national structures. NAMDA participates through its members elected onto PPHC committees.

Nurses comprise the largest group of health workers in South Africa. The organisation of nurses is therefore at the centre of any strategy for change in health services. The emergence of the national educations, health and allied workers Union (NEHAWU) is therefore critical for all health organisations. NAMDA has had extensive discussions with NEHAWU and Health Workers Association with regard to the organisation of health professionals into the Union. This area of NAMDA activity is likely to develop much further in the coming years. Health workers strikes in 1984 at King Edward VIII Hospital, Durban. were supported by NAMDA; similar assistance was provided during the nurses strike at Baragwanath Hospital.

The urgent need to match medical education and training with the major health problems of all South Africans has been clearly understood by NAMDA from its constitution, article 3.5 of which reads "To promote improved standards of teaching and training in health, medical and related professions, relevant to the needs of the majority of the people". It is an objective mentioned in all NAMDA brochures and discussed in virtually every annual meeting. With the experience of two senior members who had developed considerable expertise in this field of appropriate, medical education a special educational subcommittee of the National Council of NAMDA has been set up. Seminars on this subject have been given by NAMDA members in all the English speaking medical schools of South Africa. A delegation from NAMDA was invited to attend a conference held at the medical school of Newcastle, New South Wales, Australia. The conference was devoted to examining the experience of the Newcastle School in Innovative Medical Education. The December workshop at Wits is a launching pad for a serious initiative into Community Based Medical Education.

An entry into the field of occupational and industrial health has been made and NAMDA has offered a number of contributions to community based social and developmental programmes. If these are successful they could provide an entirely new thrust to NAMDA's work, overlapping to some extent with PPHC projects.

Research appropriate to NAMDA aims and objectives is a prominent activity. Many original papers have resulted from these efforts and provide the theoretical background to NAMDA programmes.

The membership has fluctuated in numbers, at best there were about 1000 members. The Annual Congress is the supreme policy and decision making body. It is comprised of mandated branch representatives. The Annual Congress elects a national council which manages the organisation. The National Executive Committee (NEC) is elected by the National Council. There are regional\provincial councils and local branches. There are at present 10 branches and\or regions.