From medical apartheid to siyazamile in the Eastern Cape province

A medical student's elective period in South Africa

Built in 1820, the Settlers' is a 300-bed hospital, serving a population of 9,000 whites, 13,000 coloureds and 80,000 blacks. Previously well staffed and equipped, it has provided a fairly high standard of health care to a small proportion of the community, demand always exceeding resources. Although the apartheid regime is no longer in place, its legacy remains. The segregation of blacks and whites continues: few blacks can afford private care; few whites cannot. As a result, the majority of my experience was with the black community. During my stay I witnessed a rapid deterioration in the medical care provided; this was for many reasons. To maintain confidentiality, the names in this report have been changed.

At the beginning of my visit, the medical team in the hospital consisted of six full-time doctors and five part-time medical officers. Specialists from larger hospitals held clinics monthly. The medical team was headed by the medical superintendent, who was the chief medical officer responsible for staffing, management and the running of the hospital. He suffered from a serious, debilitating chronic illness but ignored advice to retire.

Doctors spent the mornings on their allocated wards and in the afternoon attended casualty or outpatient clinics. For the first four weeks I worked with Dr Dimsdale, only qualified for three years, who covered a 40-bed paediatric ward. I learnt a great amount in the month. Respiratory disease such as tuberculosis and pneumonia was the most prevalent pathology among the children. Pneumonitis caused by paraffin ingestion was also common: consumption of paraffin oil stored in plastic drinks bottles was a frequent accident. Tuberculosis is endemic in the population. A TB hospital in the township tries to ensure that monitored treatment is given weekly for eight months. However, the stigma attached to the disease in the black community makes for low compliance, increasing the risk of development of resistant strains. Kwashiorkor and marasmus, diseases of malnutrition, were not uncommon. Many children with brain damage, a complication of meningitis, were abandoned in the hospital, accentuating the importance of recognising and treating the disease immediately. Rheumatic fever, now rarely seen in the West, was also prevalent.

The morning ward rounds were interrupted at 10 o'clock when all the doctors would meet for coffee and discuss patients or hospital politics. I was soon aware of a crisis brewing. With only five doctors—Dr Dimsdale covering the paediatric ward, Dr Ely the surgical ward and Drs March, Sweeting and Bretherton covering the obstetric and medical wards and casualty—night cover and supervision was impossible. The failing health of the medical superintendent was obvious, and his grip on hospital management was loosening. Efficiency fell: the queues in outpatients grew and patients would even sleep overnight in the hospital to be seen. The nurses were unhappy and complaints of malpractice accumulated.

In the afternoons I would join Dr Dimsdale in outpatients, an enormous general clinic, held in a cramped collection of examination rooms. Minor and severe conditions of all systems were seen on a 'first come first served' basis. The shortage of doctors meant that I had to take on the less complicated cases. Xhosa was the primary language, but the nurses were excellent interpreters; cultural differences were a greater barrier to communication. *Mutti*, the traditional tribal medicine, is widely practised in the rural communities, and distinguishing its effects from the signs and symptoms of disease is often difficult. Herbal enemas given to new-born babies often proved fatal. Another of the more primitive traditions was met in casualty at night. Seventeen-year old boys making the transition to adulthood would spend six months alone and self-supportive, far from the villages. At the end of this test the celebrations and rituals accompanying circumcision would take place. Ancient recipes from herbs and natural ingredients prevented complications in the majority of men, but occasionally infection or haemorrhage would require hospital attention. This was regarded as a failure of manliness and discretion was of great importance. Naked young men hidden under blankets would be brought in, having put off the visit for as long as possible.

The district surgeon, Dr Duran, worked most mornings at the hospital. He taught me to suture and to insert chest drains. Victims of domestic violence and car accidents filled casualty, so these were important procedures to learn. As the district surgeon, Dr Duran was responsible for the medical clinics held in the Gra-

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hamstown prison. The complaints invented in order to see the doctor were imaginative and colourful. The chance of a possible referral to hospital, a comfortable night's sleep, hot food and perhaps a chance to escape, was an opportunity to be seized. As far as genuine complaints were concerned, sexually transmitted diseases were rife. Homosexuality is illegal in South Africa, so condoms are not provided in the prisons. The implications for HIV infection are serious. My next encounter with the prison came unexpectedly one evening. One of the inmates had committed suicide and a doctor's death certificate was required. Accompanied by the warden we were shown to a solitary cell where a young man had hung himself by his clothing. There was little else to be done other than complete the paperwork.

The staffing crisis grew weekly and within a few weeks only one full-time doctor remained at the hospital. Dr Duran closed one of the medical wards, reorganised the duties of the remaining part-time doctors, and rallied support from the GPs in town. I was asked to cover the obstetrics ward and neonatal unit. With little alternative I began my final two weeks with much responsibility.

The labour ward was run by a generally efficient and experienced team of midwives, who were a great pleasure to work with. I began a ward round at 8 o'clock each morning with the senior midwife on duty. On most days the ailing medical superintendent would attend for half an hour to sign drug charts and to give advice. Otherwise decisions on management and treatment were made in consultation with the midwives.

Obstetric emergencies were common and blood was always in short supply. There was a high caesarean section rate, approximately 35%. Complicated deliveries were referred to Port Elizabeth Hospital, an hour away, if diagnosed in time. I delivered many babies, and was taught episiotomy and repair of vaginal tears. Pregnancy-induced hypertension was a common prenatal condition, requiring vigilant monitoring. The hospital was not equipped with an ultrasound machine, so assessment of the fetus was often difficult. History taking and clinical examination were especially important.

A role-model for development in community health care

One of the most inspiring experiences I had during my stay in South Africa was a health education open day inspired and organised by the black community of Bathurst. Long-standing and increasing neglect of health services and dwindling resources have resulted in self-motivated community action, a shining example of what can be done in the darkest hours.

The township of Bathurst is in the heart of the Eastern Cape's pineapple and chicory growing country. Forty kilometres from Grahamstown and 15 from the coast, it has a population of approximately 6,000. Due to male labour migration, 70% of this population are women and 50% are under 18, of whom 70% are illegitimate in civil and traditional terms. Like many of the rural communities in South Africa today, unemployment runs at above 80%, the average wage being only R120 (£24) per month. Ironically, the 20% of the male population who receive state pensions or grants make up the economic elite of the community.

Accessible health care resources are limited. Preventative and curative facilities are provided by a local clinic run by district nurses, some trained in primary health care and qualified to prescribe 'schedule 4' medications (eg antibiotics). Doctors hold weekly clinics. The ambulance service to the nearest hospital is sporadic and unreliable.

Concerned about the poor available health care, the rising number of teenage pregnancies, AIDS and TB, the Bathurst Community demanded a meeting with the health authorities in October 1993. As a result, the Siyazamile ('working together') Health Development Committee (SHDC) was formed. All the executive members were elected by and appointed from the community, with representatives from the central provisional administration (curative services), Bathurst municipality (preventative services) and from the Department of National Health and Population Development (DNHPD).

The committee's role is to act as a communication channel between the community and the health services. Specific objectives in its quest for improving health conditions include: identifying health needs in the community, conducting health education through workshops, training the Committee members in health topics, involving traditional midwives and healers, and addressing the needs of the aged.

The first project to be organised was the health education open day to which I was invited. It was a true community effort with medical staff keeping a low profile and providing assistance and resources only when asked. A beautifully rehearsed group of majorettes marched through the town, heading a large procession of young and old toward the community hall. In the presence of a large crowd, the day began with a prayer and an anthem. Five topics had been chosen, and health professionals were invited to speak for half an hour on each. There were lectures on tuberculosis, AIDS, childhood diseases, teenage pregnancies and sexually transmitted diseases. Three intervals ensured the continuing attention of almost all. During the first, teachers produced a play performed by the school children depicting the consequences of careless promiscuity, and highlighting the dangers of HIV infection. The only interruption of the smooth-running programme was the arrival of the monthly mobile pension office. The word spread quickly, as became obvious by the steady exodus of all the elderly in the audience during the second scene. In the second and third intervals, two traditional dances were performed by boys and girls in full costume. It was a high-spirited

and colourful performance, and the African rhythm was infectious.

The day was a great success in all areas. Its long-term impact on the health of the community will be difficult to assess, as statistical data are difficult to collect; however, nurses have reported a significant decrease in the number of severely dehydrated children brought to the clinic in recent months. It is possibly naive to expect significant improvements at this early stage, but one should recognise the day as a landmark in a developing health education programme and as an important achievement of individual efforts.

In addition to further workshops, the committee suggested that a video player and screen should be installed in the clinic. The DNHPD produces some excellent videos on a wide range of health issues. For these sorts of projects outside sponsorship is essential, and charitable organisations have an important role to play. The maximum use of resources, however, can be made only in conjunction with community consultation. Sister Snyman, a senior nurse at Settlers' Hospital and a representative on the Siyazamile Health Development Committee, is much encouraged by the community effort, and feels that the standard of health care in Bathurst will rise as long as local people are allowed to have a say in how it is run and to take part in its running.

Only by working in a country can one truly get to know it. As a doctor one is particularly well placed to learn at first hand about other people's culture, hardships and fortunes. I found a great deal of optimism and hope for the future.

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