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Letter from Johannesburg

PUBLIC HEALTH SITUATION 2000

The *South African Health Review 2000* has just been published (516 pages; 24 chapters). The publication of these annual reviews began in 1995. Those involved or interested in the health scenario in our constituent populations wonder whether any real progress has been made. Have we regressed in some respects? What are the outstanding problems?

In order to provide a proper perspective, before describing the changes that have taken place in South Africa, we need to consider whether affluent western nations have any serious problems in their national health scenes. They do indeed. In the USA, 'health care continues to fail the poor and the non-White races.' In the UK, a recent enquiry concluded that 'health of the nation deemed a failure' and urged the authorities 'to begin a serious assault on the gross inequalities that have emerged in Britain in the past two decades.' A further item, avers that 'one in three English hospital wards is filthy.' Notwithstanding the extent of the problems depicted, they pale in comparison with those faced by developing populations, such as those in sub-Saharan Africa, where one-tenth of the world’s population lives on 1% of the world’s total income.

In the South African report, among the positive findings listed, primarily in relation to the African population, substantial progress has been made in antenatal care. There have been moderate improvements in immunization, family planning and postnatal care, but only slight improvements in sexually transmitted diseases and in the care of patients with tuberculosis. The turnaround times of various laboratory tests have improved considerably. Home visits are being conducted by a relatively high percentage of clinics. Nationally, nurses at fixed clinics now have a substantially lower patient load than that in 1997. The updating of skills in the field of HIV/AIDS has improved. The availability of electricity at fixed clinics has increased markedly from 65% in 1997 to 92% in 2000, and in 5 of the 9 provinces, electricity is available in all the clinics. Condoms, oxygen, methyl dopa, oral rehydration solution, penicillin and oral contraceptives are more readily available than they were in 1998.

On the negative side, the availability of tests performed as part of primary health care (PHC) is unsatisfactory. Thus, the availability of HIV testing at fixed clinics remains low; indeed, 4 in every 10 clinics do not offer this extremely important test. Nationally, HIV tests are less available than those for syphilis. Only half the fixed and mobile clinics offer pregnancy tests. A quarter of the HIV tests are less available than those for syphilis. Only half the fixed and mobile clinics offer pregnancy tests. A quarter of the fixed and satellite facilities, and half of the mobile clinics, have no ambulances available for emergencies. Essential PHC equipment is not available at some fixed clinics. Although the availability of telephones at PHC facilities has increased substantially since 1998, the general situation is still unsatisfactory with no telephones in one-fifth of fixed clinics, and alternative means of communication in only 2 of 10 facilities. Despite the improvements in the availability of electricity, interruption of supply remains a major problem. In the month preceding the present survey, interruptions occurred at one-third of the clinics.

Poor water supply also remains a problem. At present, 12.5% of satellite clinics still depend on water delivered by a tanker; 5% of these obtain their water from a river or a dam; and 12.4% of fixed clinics rely on rainwater. Among the other drawbacks, one-third of mobile clinic health workers believe that their vehicles are unsuitable for the roads on which they travel. Iron tablets, doxycycline and erythromycin are less widely available than they were in 1998. The regularity of nurse supervisor visits to fixed facilities in the month preceding the survey has fallen substantially from 79% in 1997 to 67% in 2000; moreover, one-third of the facilities reported that they were ‘never’ visited. A preliminary investigation has shown that record-keeping of patients with tuberculosis is poor, especially in satellite clinics. Understandably, the above scenario varies considerably from province to province.

A recent enquiry in the Eastern Cape (perhaps the poorest of the
provinces) showed that more than half the population in the region were rural dwellers. In 8 of 17 clinics which serve 500,000 of the African population, there were faulty stethoscopes, broken or inaccurate blood pressure cuffs, incorrect weighing scales, no phones or electricity, and no usable two-way radio equipment. Refrigerators for drugs worked on gas, but only when the gas was delivered. ‘Nurses hitch-hike lifts with goods delivery vans and their working hours are regulated by this.’ Supervisory clinic inspections take place 3 times a year at best. Forty mobile health clinic stations around Umtata were not functioning because the buses had broken down. Only one-half to three-quarters of the operating theatres in tertiary hospitals were functioning because of a dire shortage of nurses. At the large Cecilia Makiwane Hospital in Mdantsane, a shortage of 148 nurses permits the use of only 900 of the 1200 available beds. Similarly, in Mount Frere Hospital, in the city of East London, only 690 of the 900 beds are occupied, because of a shortfall of 150 nurses. In this ‘very unhealthy province’, unemployment stands at 48%, and more than 18% of the population are believed to be HIV positive. Only 52% of children have been immunized (nationally: 62%-64%) and the infant mortality rate is 61 per 1000 live-births (nationally: 45 per 1000).

In South Africa as a whole, the general health situation in the year 2000 is better than that described in the review published in 1995. Of course, outstanding problems still exist. According to health managers, the retention of skilled staff, doctors and nurses, is a major challenge. One-third of the hospital facilities need replacement or repair. Yet, turning to vital statistics, in the populous African city of Soweto, adjacent to Johannesburg, the infant mortality rate has fallen to a mean of 20 per 1000 live-births. The survival of the national African population has reached a mean of 63 years (equal to that of some of the poorer populations in Europe).

Sadly, in South Africa as a whole, the disastrous HIV/AIDS epidemic, despite improvements, is likely to take its toll. The infant mortality rate is expected to rise soon, and survival is likely to drop to 40–45 years. It has been predicted that half of our African children are likely to die of HIV infection, and half the adults will die from related causes—a situation which already prevails in neighbouring Botswana. It has been estimated that should all the presently affected patients at Stages 3 and 4 be treated with triple antiviral therapy, the annual expense incurred by 2010 would be three times more than the annual total South African public health care budget. As has been stressed, restraining further rise in the HIV/AIDS epidemic will greatly depend on the level of response of individuals to ‘the Government’s “ABC” strategy—to abstain, be faithful, and to use condoms.’

REFERENCES
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**Letter from Chennai**

THE ETERNAL DEBATE: LAKSHMI VERSUS SARASWATHI

Mr Arcot N. Veeraswamy, Health Minister of Tamil Nadu, laid the foundation stone for yet another medical college, the Kanyakumari Medical College, on 12 March 2001. I have often referred in these letters to (i) the disparity between the views of the Planning Commission and the Government of Tamil Nadu on the number of medical colleges we need, (ii) the fact that the government keeps building new ones when it lacks adequate staff at its existing colleges to satisfy the requirements of the Medical Council of India, and (iii) the lack of adequate finances to keep the medical college buildings in good repair. The minister said that he expected a loan of Rs 6.5 billion from the World Bank, and, as soon as the money arrived, he would improve all the taluk hospitals in the state. He said the health care system in Tamil Nadu is the best in India. If that is true, the plight of poor Indians dependent on government medical facilities in other states is indeed pitiable.

I do not mean to go into that argument again. The minister casually slipped in what I thought was his most significant statement. He said that if a government order dated 9 March 2001, the government had permitted non-clinical doctors to do private practice. I understand that under the British Raj all doctors in administrative posts, were denied the right, and were given a non-