

# Report on an isolated disadvantaged rural community



## Curriculum Vitae

Dr Eliz. Ann Ralston qualified as a general practitioner from the University of Cape Town Medical School in 1976. In 1978, she joined the (then) Day Hospitals' Organisation, and worked in Guguletu as well as teaching in the newly developed night school at Langa. She transferred to the Oncology Department at Groote Schuur Hospital during 1980, as a medical officer, and returned to the Day Hospitals in the middle of 1983. Between 1987-1992 she was based at Vincent Pallotti Hospital, in Cape Town, caring for the community of nuns and involved in the transition of the hospital from religious to secular management. During this time, she obtained the M Fam Med degree at Stellenbosch University; this report is one of the fruits of that study. She is now back with the Day Hospitals (renamed Community Health Centres) and works in one of the big squatter camps near Cape Town. She is interested in community development and enjoys teaching. She has developed a programme for human development (alias sex education), using interdependent creative learning methods, and has given several workshops for teachers and parents, as well as working with teenagers in the school setting. She loves to read eclectically, enjoys working with computers, is learning to cook, has taken up the study of oceanography, likes exploring mountain walks and listening to music. She is a fan of Colombo and has a cat called Tickie.

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## Summary

From May 1991 to November 1992, the living conditions were surveyed in an isolated, medically deprived rural community in the Langkloof area of the South-Western Cape. Attention was given to demographic, socio-economic, health, educational and attitudinal parameters. Home-remedies in use were identified and some assistance towards community development was given. Certain recommendations are made as a result of the observations documented.

## Introduction

"Equitable, universal access to health care is recognised as a basic human right, not (simply) a privilege."<sup>1</sup>

However, there are many small, disadvantaged rural communities scattered throughout South Africa. They are in urgent need of all-round improvement of the quality of their lives. In particular, they themselves need to be enabled to begin to change their own circumstances and to take charge, at every level, of their own future.

## Methodology

a) The following universal principles guided the members of the research team:

- \* consistently open and honest communication;
- \* sincere respect of all persons involved, both as individuals and as a community;<sup>2-5</sup> and
- \* feedback and analysis of results with repeated evaluation of the changing situation, as the study evolved.

This study was planned as a straightforward research exercise, intended to

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## KEYWORDS

Physicians, family;

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Socio-environmental

therapy;

Rural population.



*The landscape.*

Recognising the goal and beginning to move is half the battle.

establish the needs of a medically deprived rural community, its ordinary state of health and its means of managing illness. However, during the first contact, it was made clear that the residents wanted us to assist them with community development. Therefore, the project was modified to include the initiation of community development.

b) Practical instruments of research:

Information was obtained by:

- \* personal interviews, using simple questionnaires
- \* A bathroom scale, tape-measure, haemoglobinometer and aneroid sphygmomanometer were used for the basic physical examination (height, weight, haemoglobin, blood pressure (where applicable)). The instruments were standardised by comparing the same observations made on one of the team members with the results obtained from a reputable pathology laboratory.
- \* Data were assessed taking the sub-

jective as well as the objective experiences of the team members into account. The local residents also took part in these assessments.

**Constraints include:**

- \* habitual negative methods of coping with stress eg. alcohol and violence;
- \* time needed to move from theoretical insight to practical application eg. agreeing that vegetable gardening is good only led much later to actually planting such a garden;
- \* need for repeated, frequent positive reinforcement of learning experiences;
- \* indicators, only, are offered regarding the health and other needs of this and similar communities as the results apply to this unique community and cannot be generalised; and
- \* the people have the physical build of Koi-koi ancestry. This complicated the physical measurements as no standards of comparison were

Health care workers need to encourage this group and give them better hope for the future.

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found in the literature researched.

## Phases

### *Introductory phase (May 1991):*

Initial contact was made with the community, and the aim and purpose of the study discussed.

## Results

The priorities that the community initially wanted to address were established:

- \* Alcoholism
- \* Health education
- \* Health care
- \* Housing and sanitation
- \* Joblessness and lack of adequate pensions
- \* Social activities
- \* Spiritual care
- \* Transport
- \* Youth care and teenage pregnancies
- \* Wages
- \* Water

### *Phase I (June 1991 - August 1991):*

Monthly visits (two days at a time) took place. Regular contacts were made with each family. The local farmers were visited. A community committee was started. Initial health education was requested by the community, and therefore undertaken. Basic medical assistance was given.

## Results

### \* *Involvement of other residents of the area:*

Working relationships with the local farmers, religious ministers and health officers were established.

### \* **Review of priorities:**

After the first six months, the team and community reviewed the priorities initially listed. The following summary emerged:

- \* **A representative committee** was needed and should be trained in leadership. Therefore, possible leaders were identified by the commu-

nity so that they could be nurtured.

- \* **Local community health workers** were needed who would be especially involved in giving first aid, teaching personal and environmental hygiene, caring for the sick, liaising between the community and the local health authority
- \* **Intervention was needed in social problems**, particularly relational ones within families, and between employers and employees.
- \* **Revised action:**
- \* From this point on, the visiting team involved the committee members in planning and carrying out further interventions. Methods of training were researched.
- \* Basic health-care training was given to several interested women.
- \* Some training was given in dry gardening, water purification and toilet construction.

### *Phase II (September 1991 - September 1992):*

A formal survey week initiated this phase. During this time, the demographic, socio-economic and health status of the community was assessed. Work begun in Phase I was continued. Further assistance in community development was given, including basic leadership training, health education and garden development.

## Results

### *Demography:*

#### \* **Population:**

Adult males – 37  
Adult females – 37  
Adolescent males – 07  
Adolescent females – 09  
Prepubertal males – 16  
Prepubertal females – 09  
Total: 74

These were divided into 14 families, two of which were headed by the mother only.

- \* Intermarrying in an undetermined

Toilets were not perceived as a priority.

Malnutrition was very common.

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degree takes place between all the families. A number of children are informally fostered, including those born of teenage pregnancy.

- \* There is continuous migration in and out of the community, due to drought and social problems. Young men move to nearby towns, young women marry away. There is little job stability. Teenagers have to live at hostels in towns, if they are to obtain satisfactory education.
- \* Physical ageing appeared to occur more rapidly than in affluent urban communities. Only two members of the community were over 60 years old. Both have since died.

## Socioeconomic parameters

### Work-sources and accommodation:

Two families were employed by Spoornet at the small railway station, which has since been closed. They lived in reasonably good housing, provided by Spoornet. One of these hou-

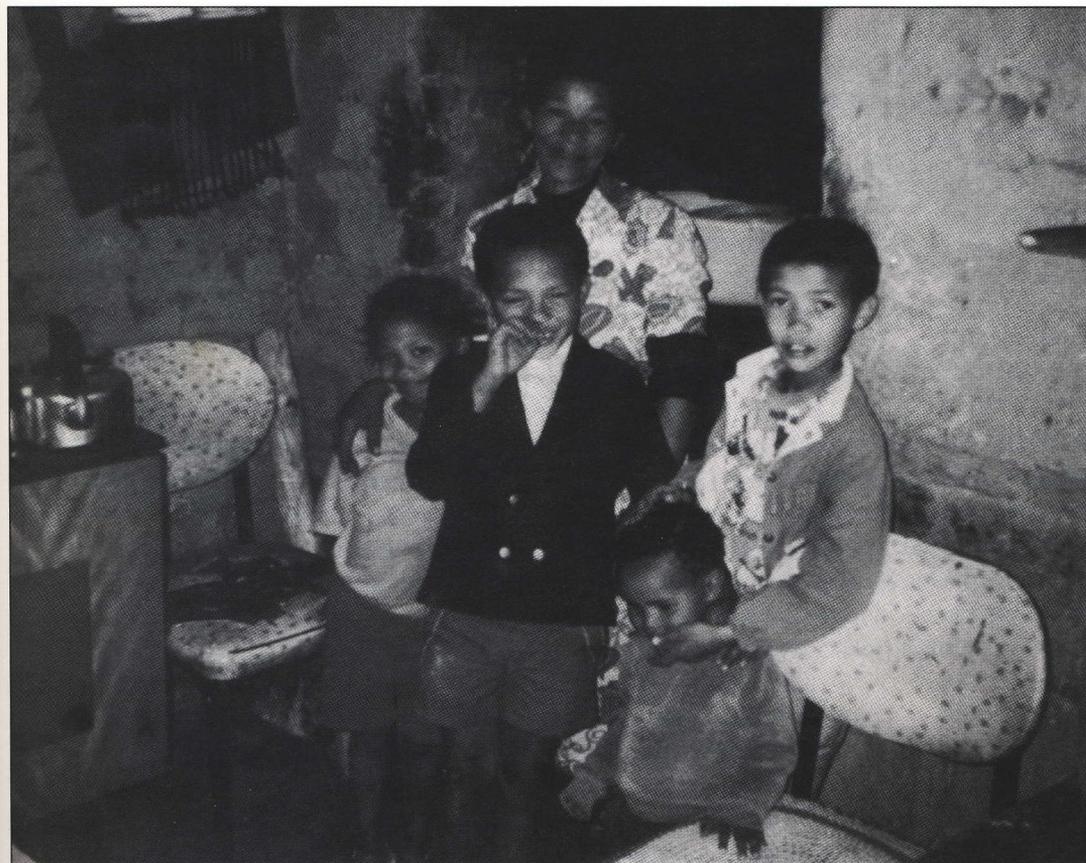
ses had a pit toilet, and one a flush toilet. One family was employed by the House of Representatives, Dept. of Education. They lived in a well-built house on the school property. This had a bucket toilet.

The other working adults were employed as labourers and domestic helpers, on the four local farms. They were accommodated on property belonging to the farmers. These houses were small and poorly built of mud-and-brick. Only one had a bucket toilet, constructed by the tenant. The others had no sanitation, and people simply used the bush. The labourers had no incentive to improve their accommodation, as they did not own it.

### Wages:

The school-teachers were paid according to the scales set by the House of Representatives. The Spoornet employees were earning approximately R1079.00 and R811.00 per month respectively. One farm labourer earned

Only two adults had progressed beyond Standard 6.



*In a home.*

Towards the end they reported a better self-awareness and self-respect.

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R360.00 per month, and the others averaged R150.00 per month, well below the poverty datum line. The minimum earned was as little as R32.00 per month. Hours worked were not limited and there were no regular days-off or yearly holidays.

(One needs to understand this in context. This area was in the throes of a five-year drought and all inhabitants, farmers and labourers alike, were struggling to make ends meet).

## **Nutrition and water-supply:**

It was difficult to maintain reasonable standards. Most people had a good idea of the kinds of food needed to stay healthy. However, access to food was a problem, due to the poverty and isolation of the area.

Only two families had vegetable gardens. Water was supplied from boreholes (Spoornet) and a nearby hot spring. The spring-water was rationed between the farmers in the area, and it could not be kept clean. Several families had to fetch water from drums, which were supplied by rubber pipes from a dam.

## **Energy sources:**

Brushwood was the main energy source. Time is needed to collect it, and when burning, it fills the houses with acrid smoke.

Paraffin was also used sometimes, but is expensive and difficult to obtain. Electricity would have been readily obtainable as an Eskom line terminated in the middle of the area, and supplied the farmers. However, the farmers were not able to afford the initial cost of electrifying each home. (A direct result of this is that water is not consistently boiled. Gastro-enteritis linked to dirty water, and asthma linked to excessive wood-smoke, are common complaints).

## **Health parameters:**

\* **A district professional nurse** and two assistants visited the area quarterly. They undertook family-plan-

ning, child-care education and immunisation, and follow-up of persons with STD and TB.

- \* **A dentist** visited from time to time, for tooth extractions only. Dental caries was commonplace, and many of the community were edentulous.
- \* **The district surgeon** lived in a town 70km away. Transport depended on the farmers and on two individuals who owned a car. These offered transport at a price.
- \* **General health** of the community carried a high rate of chronic morbidity (coughs, colds, worms, skin infections, bites, burns, farm injuries, dental caries, otitis, respiratory problems etc.).
- \* **Body-Mass Index** indicated the smallness of the people, but was also clearly related to the poor nutritional standard. Nearly all the children were at or below the 50th centile. Clinical protein calorie malnutrition was common. Haemoglobin levels were unusually high and could not be used as a nutritional indicator. This was possibly due to the fact that iron cooking pots were often used.<sup>6,7</sup>
- \* **Hypertension** was established in a small number of persons. These were reasonably well-controlled on medication received from the district surgeon.
- \* **Family planning** was well supervised, but there was no consistent counselling service offered to help families with marital problems.
- \* **Herbal remedies** are an integral part of the culture of this rural community. The uses to which the herbs are put accords well with both the traditional uses in other parts of the country and the small amount of research that has been done into the pharmacological properties of indigenous South African plants (Cf. personal communication from Dr T G Fourie, Noristan laboratories, Oct.1991).

## **Educational levels:**

Only two members of the whole community were older than 60 years.

Haemoglobin levels were unusually high.



*The people.*

Ownership of land and adequate housing was a basic need.

The adults considered it to be very important for the children to attend school for as long as possible. However, a number of these children were in low standards compared with equivalently aged children from urban communities. Only two adults had progressed beyond Std VI, although almost all were literate.

Several adults stated that they wanted their children to have a better chance in life than they had. The people were well aware of their need to develop a better quality of life, but they were hard put to it to find practical ways to do so.

### **Phase III (October 1992 - December 1992):**

Ten days' intensive work in the community initiated this phase. Preparation was begun for withdrawal from regular visiting in the community. A final community meeting was held at

the end of November 1992. During this, the team reported its survey results back to the community and both parties undertook evaluation of the whole experience. The community then reassessed its priorities.

### **Results**

#### **General:**

- \* The community members judged that they had gained in self-awareness and self-respect.
- \* They were learning to work together more consistently on combined projects and were developing a greater hope for their future.

#### **The following basic needs were pinpointed:**

- \* personal ownership of land and adequate housing
- \* provision of reasonably paid and meaningful work

- \* a more focussed effort to develop appropriate home-industries;
- \* a focussed effort to keep families together;
- \* ways of addressing **in cooperation with the community**, life-style linked diseases;
- \* nutritional know-how **and** access;
- \* health education; and
- \* involvement of the local community in the making available of clean water and basic sanitation eg. by undertaking simple spring protection.

## Different areas of responsibility were identified:

- \* **Employers** need to ensure adequate living conditions for their employees
- \* **Individuals** are responsible for combating substance abuse, developing vegetable gardens, encouraging partnership in family life.
- \* **Community** must identify its own leaders, encourage its members, ensure education for the children, and develop recreational facilities.
- \* **The State** must provide adequate preventive and curative services, appropriate transport, on-site education, nutritional supplementation, and subsidies for house and land ownership.
- \* **Religious bodies** should encourage ongoing personal and spiritual development, self-respect and creative life goals.
- \* **Urgent questions were raised by the team members:**
- \* How can we offer appropriate formation to enable people to make truly free choices?
- \* How can we address the problem of unemployment in rural areas?
- \* How can we prevent substance abuse?
- \* How do we solve the question of land ownership equitably?
- \* How do we assist healthy families to protect themselves from being drawn into the stream of "consumerism", human devaluation, violence?

- \* How can each of us, and all of us together, take creative and appropriate responsibility for adequate health-care in a fruitful, mutually enriching way?

## Conclusion and recommendation

Health issues are clearly linked to the need for community development and the provision of basic necessities in the field of primary preventive, promotive and curative services.

We need to encourage one another and offer practical grounds for hope that things can and will change. One of our colleagues has said: "Much work needs to be done to translate our aspirations into practical goals, but recognising the goal and beginning to move in this direction are half the battle."<sup>8</sup>

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