Same silos, different grains: Legacy, Reconciliation and South African health care

Dr. I. Cassimjee
Exercise
Answer yes/no

• Do you have a means to negotiate sector wide salaries?
• Are there opportunities for skills development from your employer?
• Are there measures of health care quality evaluation in place?
• Do multidisciplinary teams meet regularly?
• Are there adequate rehabilitation services post discharge?
• Are consultations private?
• Is the WHO essential drug list available?
• Do you rarely run out of basic equipment and supplies?
• Do you communicate with your patients in their mother tongue?
The triple burden

• Poverty-related illness
• Trauma
• HIV

CRIME IN SOUTH AFRICA

MURDER: 44 PER DAY
SEXUAL OFFENCES: 181 PER DAY
ATTEMPTED MURDER: 44 PER DAY
ASSAULT GBH: 509 PER DAY
COMMON ASSAULT: 473 PER DAY
AGGRAVATED ROBBERY: 290 PER DAY

509 ASSAULT GBH
181 SEXUAL OFFENCES
473 COMMON ASSAULT
290 AGGRAVATED ROBBERY
44 MURDER

Asylum claims in South Africa | 2002-2012

Fig. 01

HIV Prevalence Rates

Women

Men

Age

15-19
20-24
25-29
30-34
35-39
40-44
45-49
50-54

0
5
10
15
20
25
30
35

Zimbabweans
non-Zimbabweans
Chris-Hani Baragwanath
Surgical Training

Resuscitation Area

Cubicles / Triage Area in Disaster

UNIVERSITY OF THE WITWATERSRAND
Johannesburg
Baragwanath in crisis
Anele Ka-Nene  12 Nov 2003 16:13

Dead Bara patient left in ward for 3 days
2015-02-19 19:37

Baragwanath hospital emergency theatre generator fails

Almost 5,000 awaiting surgery at Chris Hani Baragwanath Hospital
by Ayanda Mkhwanazi on April 7, 2015 in Health Management, Public Health & Health Systems

Chris Hani Baragwanath Academic Hospital will begin scheduling surgeries on Saturday to attempt to address the almost 5,000 patients awaiting surgeries.
Where did it all go wrong?

(Post 1994)
Historical context of training in South Africa

Bantu Education Act 1953

The implementing of this Act meant that people of different races received different educations.
Medical Training

• Required permission from the government and a permit to travel
• No post-mortem or dissections on white bodies
• Black students could only see black patients
• No mentorship (57% failure rate)
Medical practice

• Non-whites did internship in non-white hospitals
• Minimal opportunities for specialist training
• Coloureds and Indians were paid 70% of white doctors and blacks 63%
• Up to 2/3rds of non-white doctors emigrated
Nurse training and practice

• Universities generally trained whites
• Conditions in ‘black’ hospitals were poor
• Salaries were a fraction of white colleagues
• Limited career progression
• Lack of respect for their qualification
“I was shocked by the conditions they had to work under – there were patients in bed, under the bed, down the passages. It was appalling. I had never experienced something like it. I felt sorry for the nurses; they actually couldn’t nurse, it was just first aid. They had never known normal nursing conditions. They were in fact trained in abnormal nursing. For example, they ignored aseptic technique, they were never able to apply it, so they never learnt it. There was a lack of facilities for washing hands – one basin at the front of the ward. If you were at the back attending to the 67th patient in a 48 bed ward, there was no way to the front to wash at the basin before attending to the 68th patient. So the crisis became the standard, the norm”

- A highly qualified and experienced white nursing manager

K Holdt. South African post apartheid bureaucracy: inner workings, contradictory rationales and the developmental state
Post qualification

• Separate entrances
• Separate canteens
• Separate toilets (often no toilets)
• Separate living quarters (far away)
• Race based power hierarchy (Matrons white, Professors white)
BLANKES WHITES

NIE—BLANKES NON—WHITES
Post 1994 – Silos
Remedies

- Emphasis is placed on systems and infrastructure development

- What about integration of teams and interprofessional development?
The challenge

To integrate professionals from

– Different backgrounds
– Different hierarchies of power
– Differing training standards
– Different gender stereotypes
– Different aspirations
– Lots of social antagonism
Who’s responsibility is it?
Post-conflict interprofessional development

• Governments

• Universities

• NGO/CSO/Multilateral Organisations

• Professional bodies
What would it entail?

• Historical context (without blame/shame/victim mentality)

• Or is it better to move on building bridges without reenacting the past

• Acknowledgement of the past and a commitment to address past injustices
What can we learn?

• Post conflict integration in healthcare teams requires active intervention
  – (similar to TRC)

• Values, in societies that are fractured and denigrated, are pervasive in all aspects of society – including health care delivery
Today
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