

THE EFFECT OF CIVIL UNREST ON
NURSING PERSONNEL AND NURSING SERVICES
IN THE CAPE PENINSULA DURING 1986

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for the degree of
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by

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ABSTRACT

Civil unrest has become a feature of South African society and has resulted in varying degrees of social disruption. Health services, particularly those located in residential areas, have been affected. As nurses constitute the largest group of health care professionals in South Africa, and often live in the communities in which they work, they serve as useful indicators both of community dynamics and the health services.

This study describes the effect of civil unrest on nursing personnel and determines the short term and long term effects on health and nursing services.

A self-administered questionnaire was distributed to all community based nurses working in two major health services in the Cape Peninsula in 1986. In addition, routinely available health data directly related to nursing services were collected on a monthly basis for the period 1984-1988 (inclusive).

For purpose of analysis the Cape Peninsula was classified into areas of high, medium and low impact violence evident in 1986.

The nursing questionnaire had a response rate of 76.9%. Problems associated with civil violence that were identified were the need for nurses to ensure the safety of their own children; transportation to and from work; identification as nurses; security; curtailment of nursing services (particularly home visits); disruption of ancillary services; employer attitudes; political and police activity.

Health data relating directly to nursing services revealed disrupted antenatal clinics, an increase in the number of women booking antenatally following a time of disrupted booking clinics, an increase in deliveries associated with interrupted family planning clinics, a decrease in treatment of ophthalmia neonatorum and umbilical sepsis associated with curtailed home visits.

The study indicated that nurses were not adequately equipped to cope with the changing demands mad1:1 upon them during periods of political instability; that civil unrest negatively affects nursing personnel and nursing services; and further, that disruption of a service impacted other services.

It is recommended that in areas of violence it is essential to have a single management team co-ordinating all health services; education and in-service training must address the needs of nurses and health care in situations of civil violence; nurses must strive to be accepted as universal carers and be committed to justice and peace; and the professional association must be proactive in providing guidelines to nurses who are affected by civil unrest.

TO MY PARENTS

JEAN AND GORDON

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(x)

DEFINITIONS

- accessibility (to work) - the physical ability to reach work, e.g. with reference to transport, roadblocks
- civil unrest - community disruption resulting from security force/sectarian clashes which forms one portion of the spiral of violence (see political violence, below). It may be ill-defined, intermittent, of varying intensity and unpredictable. The term is used interchangeably with civil violence.
- civil violence - see civil unrest
- domestic situation - information regarding household occupants especially elderly relatives, infants and scholars who might require the attention of the nurse-member of the household
- effect - any deviation from the normal pattern
- ethical dilemma - a discrepancy between personal/professional code of conduct and conduct/information required by the law
- long-term - a 2-year period following documented heightened civil unrest
- needs - the solution to any factor which impedes the nurse's ability to fulfil her role
- nurse - any nurse registered or enrolled with the South African Nursing Council in terms of the Nursing Act No. 50 of 1978. As the majority of nurses in South Africa are female, the feminine personal pronoun is used for nurses throughout this dissertation.
- nursing personnel - see "nurse" above
- political violence - refers to discriminatory legislation, which adversely affects the lives of certain groups of people, and leads to violent reaction, repression and counterviolence viz spiral of violence
- professional nurse - a nurse registered with the South African Nursing Council following completion of a three or four year nursing programme
- short-term - the time of the documented heightened civil unrest, i.e. May - July 1986

- standard of care - as defined in the Conduct of Midwives R1886, 1974 and with reference to the Scope of Practice R2598 of the Nursing Act No 50 of 1978.

- subprofessional nurse - a nurse enrolled with the South African Nursing Council following completion of a two year or six month nursing programme

ABBREVIATIONS

BBA	:	(Babies) Born Before Arrival
CERSA	:	Centre for Epidemiological Research in South Africa
CTCC	:	Cape Town City Council
DIVCO	:	Divisional Council (of the Cape)
IMR	:	Infant Mortality Rate
MASA	:	Medical Association of South Africa
MOH	:	Medical Officer of Health
MOU	:	Midwife Obstetric Unit
oph. neonatorum	:	ophthalmia neonatorum
PMNS	:	Peninsula Maternal & Neonatal Service
PNMR	:	Perinatal Mortality Rate
RSA	:	Republic of South Africa
RSC	:	(Western Province) Regional Services Council (previously Divisional Council of the Cape)
RXH	:	Red Cross War Memorial Children's Hospital
SAIRR	:	South African Institute of Race Relations
SANA	:	South African Nursing Association
SANC	:	South African Nursing Council
SHAWCO	:	Students' Health and Welfare Community Organisation
STD	:	Sexually Transmitted Disease
TB	:	Tuberculosis
UCT	:	University of Cape Town

CHAPTER 1 INTRODUCTION

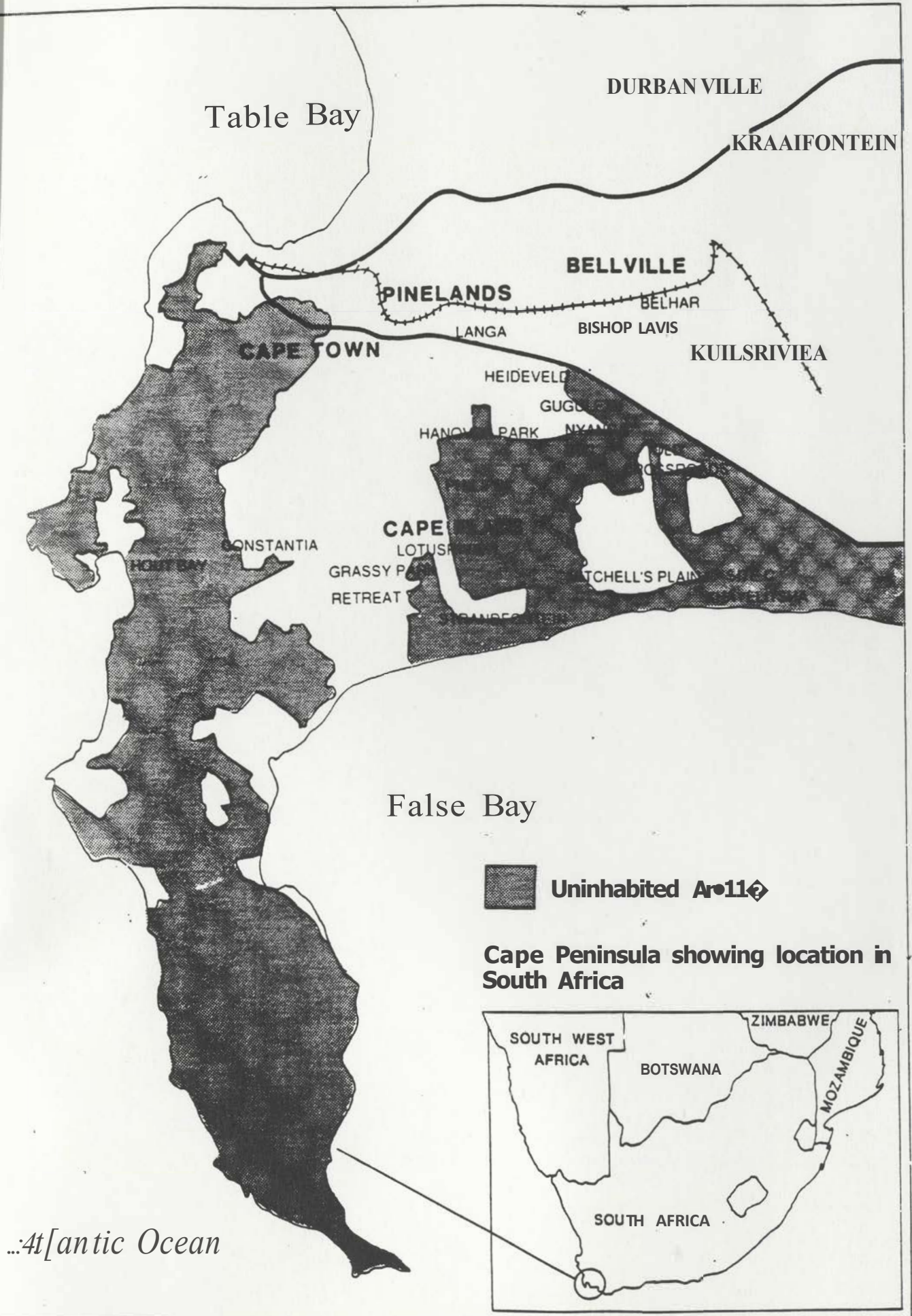
Civil violence has become a characteristic of South African society and has resulted in varying degrees of social disruption. Although some of the violence can be blamed on criminal elements which are present in any society, the roots of the endemic violence can be found in the political violence which is widespread in South Africa. Such violence, whether overtly militaristic or occurring in the less obvious forms of control through repression, torture and disenfranchisement, provokes a violent response from its victims. This in turn is answered with further repressive violence and counterviolence of the oppressed. The term, "spiral of violence" (Camara, 1971) is apt and indicates the potential for ever increasing conflict, which is apparent in South Africa today.

In some areas of the country, the impact of civil violence has resulted in devastation on the scale of a natural disaster but it has an added dimension for the victims - that of the adversaries' intent to harm (Logue et al, 1981). "The health impact of political violence can be measured by deaths, disabilities and injuries. The indirect effects include the destruction of communities and their displacement (to areas which may be impoverished, lacking infrastructure, food and supplies) disruption of services and economic stresses resulting from disproportionately high military expenditure" (Zwi and Ugalde, 1989).

Over a period of time ever increasing levels of violence, from oppressors and the oppressed alike, become accepted, although not acceptable, as the norm. Armenian considers war a disease at the societal level and thus an important problem that needs to be addressed by epidemiologists (Armenian, 1986). The civil violence present in various areas of South Africa today, and specifically in the Cape Peninsula in 1986, (Map 1) has had effects akin to those of civil war, seriously affecting all aspects of health. It thus requires to be studied so that the impact on health and health services can be minimized and ultimately the "anti-health" forces supporting the violence are eliminated (Hindson, 1985).

This is the responsibility of the state. "Everyone without distinction as to race, colour or ethnic origin, has the right to security of person and protection by the State against violence or bodily harm, whether inflicted by government officials or by any individual, group or institution" (Centre for Human Rights, 1988).

It might not be without significance that since the promulgation in 1984 of the Republic of South Africa Constitution Act No 110 of 1983, which must be considered non-neutral with regard to government policy, there has been an escalation, and in some areas almost continuous state, of civil unrest. In any society when changes take place there is a degree of uncertainty and feeling of insecurity which may be expressed violently. This has been apparent in Eastern Europe in the past twelve months as well as in South Africa in 1990.



MAP OF THE CAPE PENINSULA SHOWING ITS LOCATION IN SOUTH AFRICA AND INDICATING UNINHABITED AREAS

This chapter will introduce the subject of this dissertation by presenting an overview of the factors contributing to the civil unrest in the Cape Peninsula in 1986. In addition, the responsibility for the provision of health services in this region is discussed and the necessity for such a study to be undertaken is motivated.

1.1 Background to the civil unrest in the Cape Peninsula in 1986

In spite of The Black (Urban Areas) Consolidation Act No 25 of 1945 which restricted the movement and settlement of blacks in areas close to cities, many people, when faced with the accelerating impoverishment of the area of their birth, sought their fortunes in the cities. For some this meant moving to the mining centre of the country. Others, particularly from the Transkei and Ciskei, moved south to the metropolitan area of Cape Town. Initially it was the men who sought work and in terms of the provisions of The Black (Urban Areas) Consolidation Act No 25 of 1945, referred to as The Influx Control Act, they were required to renew their contract annually.

Against this background, it was not long before their wives and families tried to move nearer to them. The existing hostels for male migrants, particularly in Nyanga (a suburb of Cape Town), were not able to accommodate the number of people immigrating to Cape Town. In 1975 Old Crossroads was established as a "temporary" settlement by these women and squatters from other parts of the Peninsula, and in 1978

limited basic services were provided. The continued existence of these residents was precarious as they were considered to be residing illegally in terms of the Influx Control Act. Three groupings emerged in the community but the threat of removal from their homes forged an alliance. They made various attempts to secure rights for all Crossroads residents to remain in Cape Town. However, the government policy was to allow only as many Black people in the Cape Town metropolitan area as necessary to fulfil labour requirements (Dewar et al, 1990). The government attempted to relocate thousands of people to their respective homelands¹ and proposed reform initiatives that excluded many of those living in Crossroads. When the community resisted these measures, the state unleashed its repressive potential by conducting frequent raids in the area, deporting "illegal residents", detaining community leaders, and destroying large numbers of dwellings (Cole, 1987). In 1980 the first families moved to the housing that was built at New Crossroads. There was some resistance to this because of high rentals, and a number of these families who had had "lodgers" in their homes at Old Crossroads were no longer able to accommodate them. Thus the former lodgers set up their own dwellings at Old Crossroads occupying space earmarked for "development".

¹ Homelands: "Traditional settlement areas of the different South African Black ethnic groups. The ten comprise six self-governing areas while four are fully independent, viz Transkei, Bophutatswana, Venda and Ciskei" (IBVC countries) (Department of Health and Population Development, 1988). All these areas are financially dependent on the Republic of South Africa.

The population was highly mobile and continued to grow. Eventually the struggle for power and control in the Crossroads community led to division. The victorious leadership exerted their control along traditional "chieftain" lines, changing the nature of Crossroads from a community that defied and resisted removal into a "mini-Bantustan" (Cole, 1986). This, coupled with the unfulfilled promises of the government, resulted in a loss of credibility among many residents. After the repeal of the Influx Control Act in 1985 and the adoption of The Black Communities Development Act No 4 of 1984, there was a huge inflow of people and large numbers set up informal dwellings at Old Crossroads. However, the plan of the government was to relocate squatters to a new township, Khayelitsha, ±30 km from Cape Town. This divided the community further as distinctions were made between those entitled to be in Cape Town, and those who were not.

With increasing pressure on space and facilities, the simmering violence that had erupted in 1984, which was later fuelled by the education and shop boycotts in 1985, and by dissatisfaction with the activities of those in positions of power in the community, erupted into violent clashes in 1986. The lines were drawn generally between the more recent and younger residents, "comrades", and the more established residents, vigilantes or "witdoeke" (white scarves), who were supported by the security forces (Cole, 1987). Destruction of property, arson and the dislocation of an estimated 60 000 people characterised the

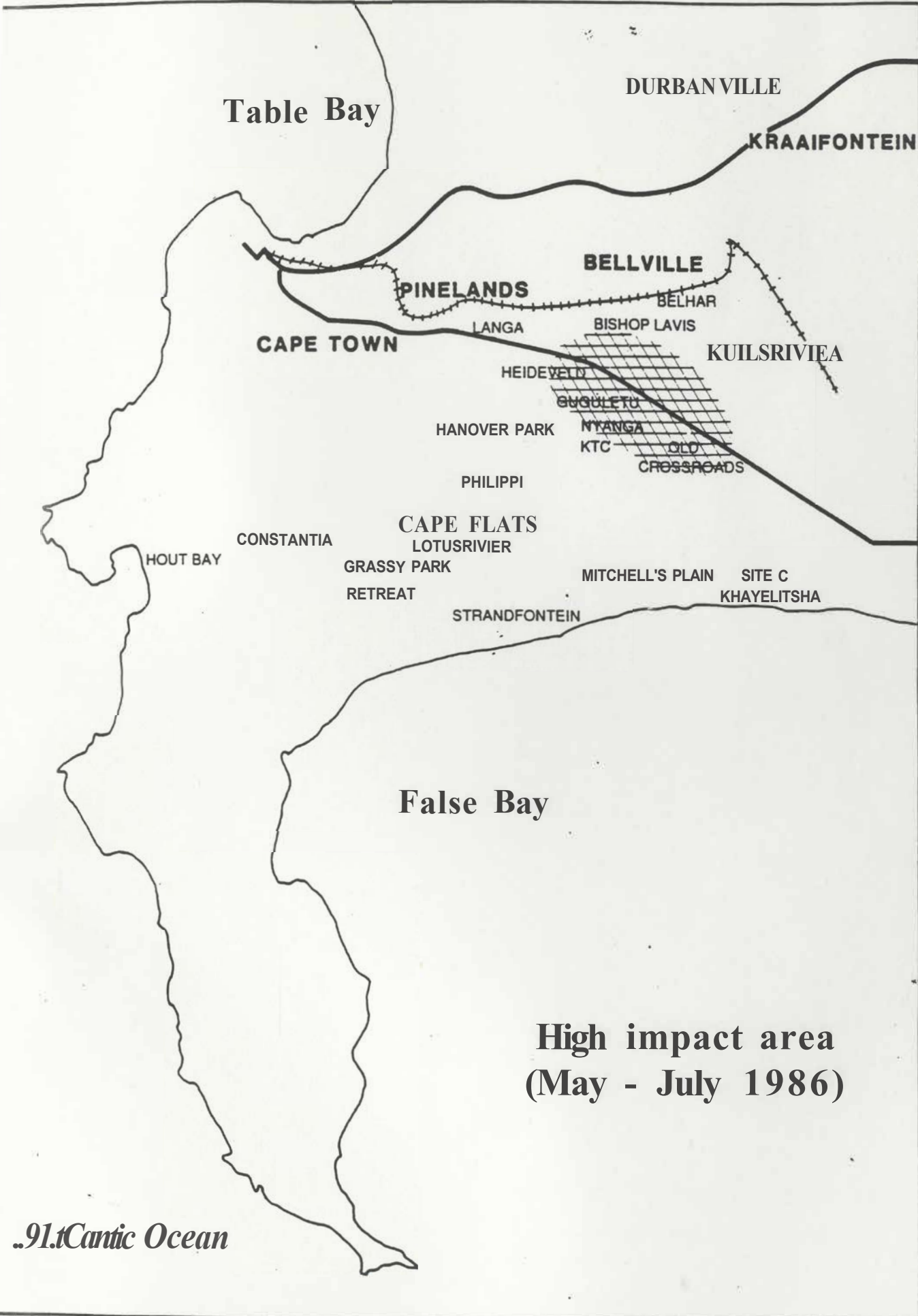
May - July 1986, which prompted a State of Emergency to be declared on 12 June 1986 (Yach, 1987). This State of Emergency which was renewed in 1987, 1988 and 1989 was finally lifted in February 1990 in most areas of South Africa, excluding the Natal/Kwazulu region. During this time major restrictions on information were imposed, but it was clear from the official unrest reports issued by the South African Police that high levels of violence and police/defence force activity were present in many areas, including the Cape Peninsula.

The focus of the violence therefore was Crossroads, with a spillover effect into the neighbouring black residential areas of Nyanga, KTC and Guguletu {Map 2}.

1.2 Organisation of Health Services in the Cape Peninsula

Health services in the Cape Peninsula are offered by a number of authorities. Prior to the implementation of The Republic of South Africa Constitution Act No 110 of 1983 (referred to as The Constitution Act) the following levels of care were identifiable:

- (i) local authorities, i.e. Cape Town City Council and the Divisional Council of the Cape, were responsible for preventive and promotive health which includes personal & environmental services, and for ambulance services delegated by the provincial authority.
- (ii) provincial authorities, i.e. Cape Provincial Administration, had the responsibility for personal public sector hospitals, curative clinics
(e.g. Day Hospitals and the Peninsula Maternal and Neonatal Service): and ambulance services



**High impact area
(May - July 1986)**

Atlantic Ocean

MAP OF THE CAPE PENINSULA ILLUSTRATING LOCATION OF THE VIOLENCE AND ITS INTENSITY

- (iii) central authority, i.e. Department of Health and Welfare, was responsible for activities not covered by the other two levels, although where there was a local authority, central government often delegated these functions which it subsidized and supervised. These included chronic psychiatric services, medico-legal services, infectious diseases control, and the provision of various services to areas not served by a municipal authority (de Beer, 1988).
- (iv) Other services delivering health care elsewhere in the country include the mining houses, South African Defence Force, self-governing states, the private sector, and voluntary organisations.

The contribution of (iii) and (iv) to health care in the areas of the Cape Peninsula affected by the civil violence are minimal and so further discussion will be limited to (i) and (ii) above.

The implications for health of The Constitution Act No 110 of 1983 were elucidated by a new health policy announced in August 1986. This did not change the status of local authorities.

- (i) Regional Authorities - A new concept of Regional Services Council, which would provide a multi-racial tier of government embracing the various own affairs.¹

¹ Own Affairs:

- 14) Matters which specially or differentially affect a population group in relation to the maintenance of its identity and the upholding and furtherance of its way of life, culture, traditions and customs are own affairs in relation to such population group. e.g. health, education (Department of Foreign Affairs and Information, 1983).

local authorities, was introduced. The previously named Divisional Council of the Cape, which had been unique, metamorphosed into the new Western Cape Regional Services Council. There was little change in the type of health service offered, but now ambulance services fell under the control of the Emergency Health Services directorate of the Provincial Administration which in turn delegates the function to the local authority.

- (ii) Provincial Authorities - The intention was for this level of government to disappear. The elected councillors were replaced by officers appointed by the State President. They continue to administer hospitals on behalf of •own affairs• and •general affairs•.¹ Departments of Health and have been given the additional responsibility for certain psychiatric and tuberculosis hospitals. The impact of this in the area of this study is that the previously existing Day Hospitals' Organisation which provided a network of outpatient-based curative care clinics (Smith, 1981), was fragmented and became subject to a number of •own affairs• authorities. The Peninsula Maternal and Neonatal Service which consists of five midwife obstetric units, three base hospitals and one referral hospital, by virtue of its link to Groote Schuur academic hospital (i.e. general affair), continued to be managed as previously. The Red Cross War Memorial Children's Hospital (general affair) was

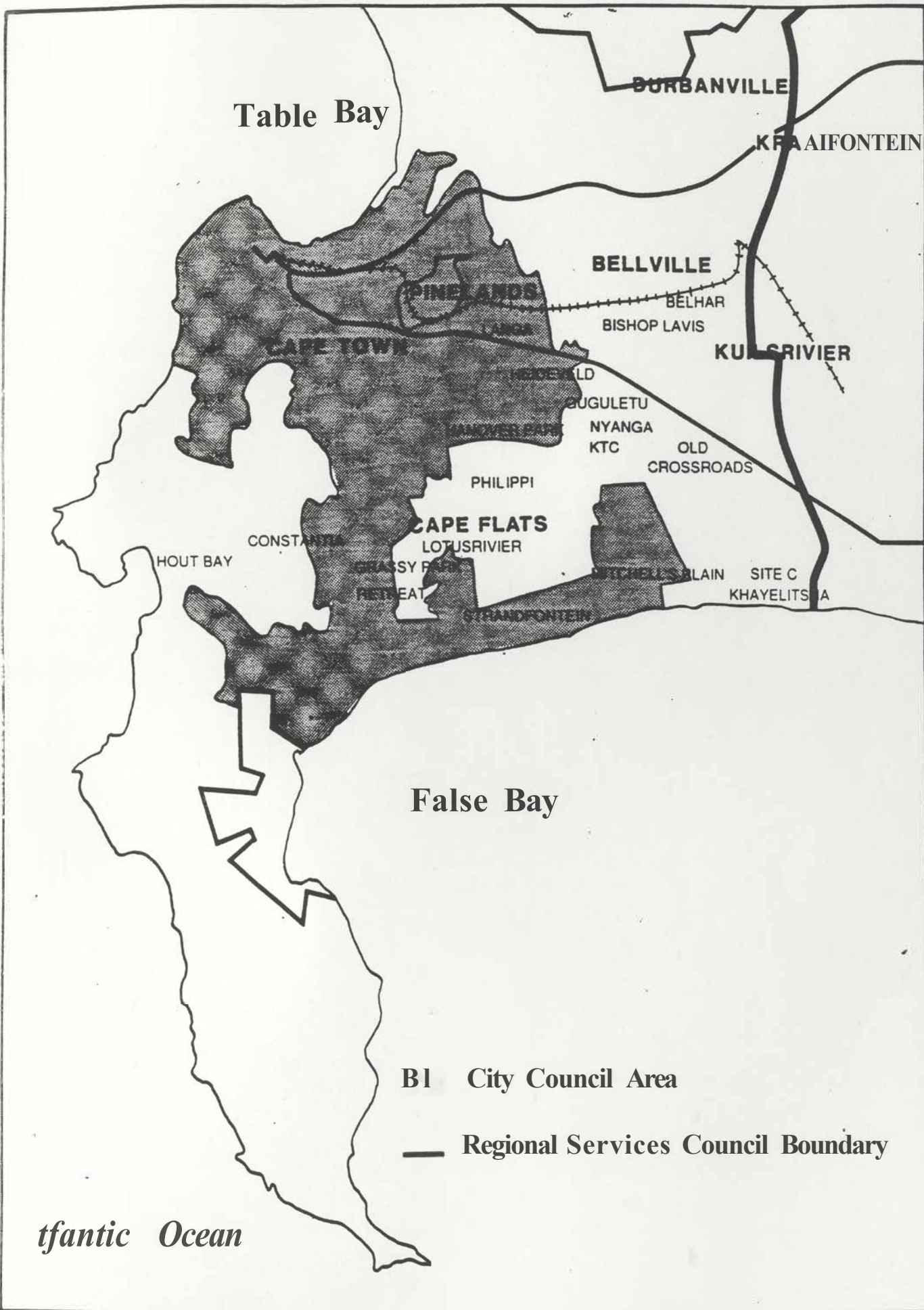
¹ General Affairs:

"15) Matters which are not own affairs of a population group in terms of section 14 are general affairs".
(Department of Foreign Affairs and Information, 1983)

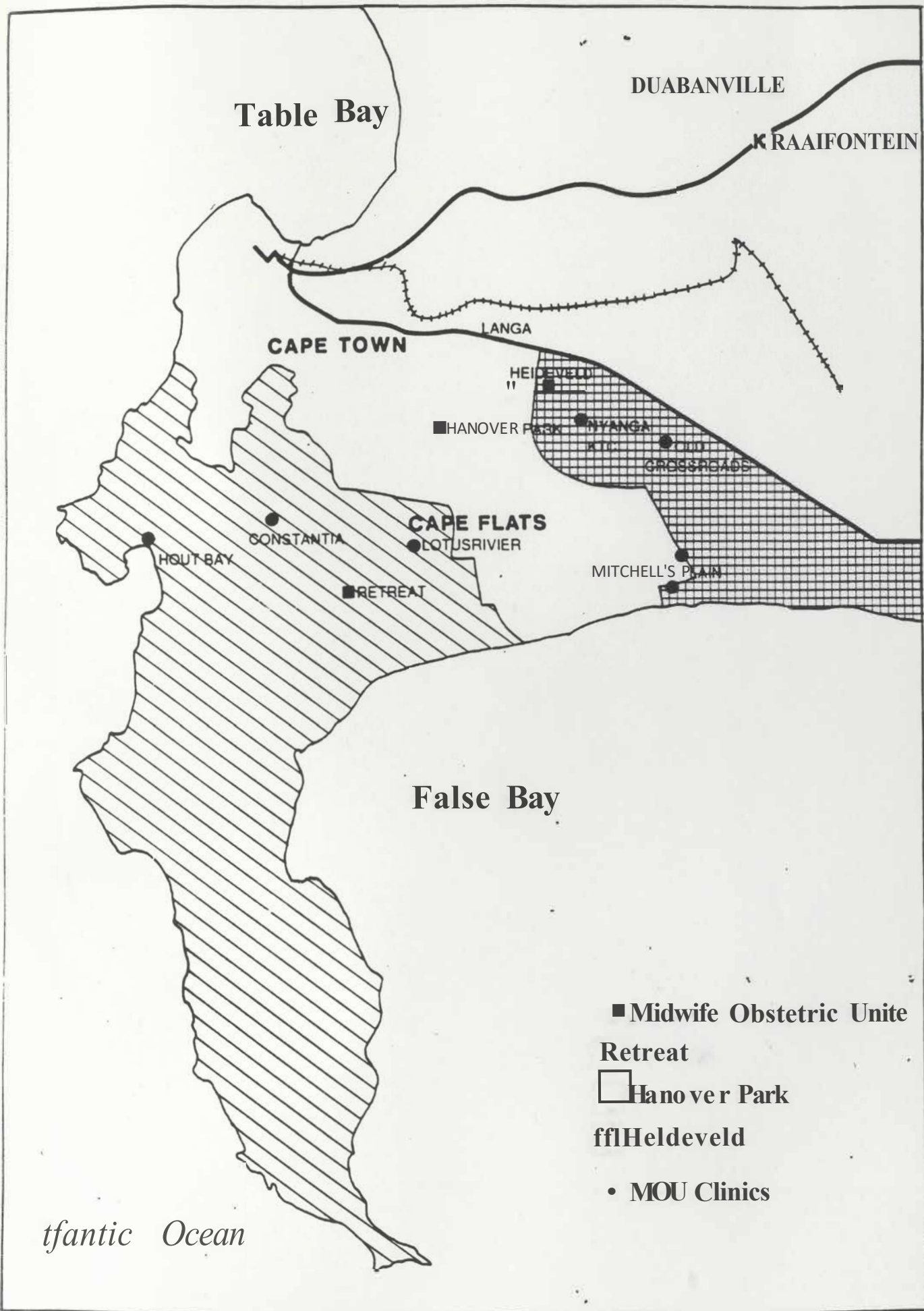
originally planned to provide tertiary paediatric care. However, in the past decade escalating numbers of children requiring basic attention have stretched the resources available to the limit as primary, secondary and tertiary levels of medical, surgical and nursing care are needed (Red Cross Hospital Annual Report, 1989).

Map 3 indicates the boundaries of the services supplied by Cape Town City Council and the Western Cape Regional Services' Council (formerly the Divisional Council of the Cape). Their clinics, which are staffed by nurses and sessional medical officers, offer a comprehensive health service which includes screening for, and treatment of tuberculosis, screening for, and treatment of sexually transmitted diseases, child health assessment and immunization, family planning, geriatric services and home visits.

Map 4 indicates the boundaries of the midwife obstetric units (MOU) within the Peninsula Maternal and Neonatal Service. These units are staffed by registered midwives who provide an antenatal clinic service, care during labour, birth and the first 6 hours after delivery, and a home visiting service for the 7 days following delivery. Some units have satellite clinics attached to them, e.g. Retreat MOU - Lotus River clinic, Heideveld MOU - Nyanga (NY3) clinic. These clinics offer an antenatal clinic service only. Pregnant women have access to medical care as



MAP OF THE CAPE PENINSULA INDICATING CAPE TOWN CITY COUNCIL AND WESTERN CAPE REGIONAL SERVICES COUNCIL (FORMERLY DIVISIONAL COUNCIL OF THE CAPE) SERVICE BOUNDARIES



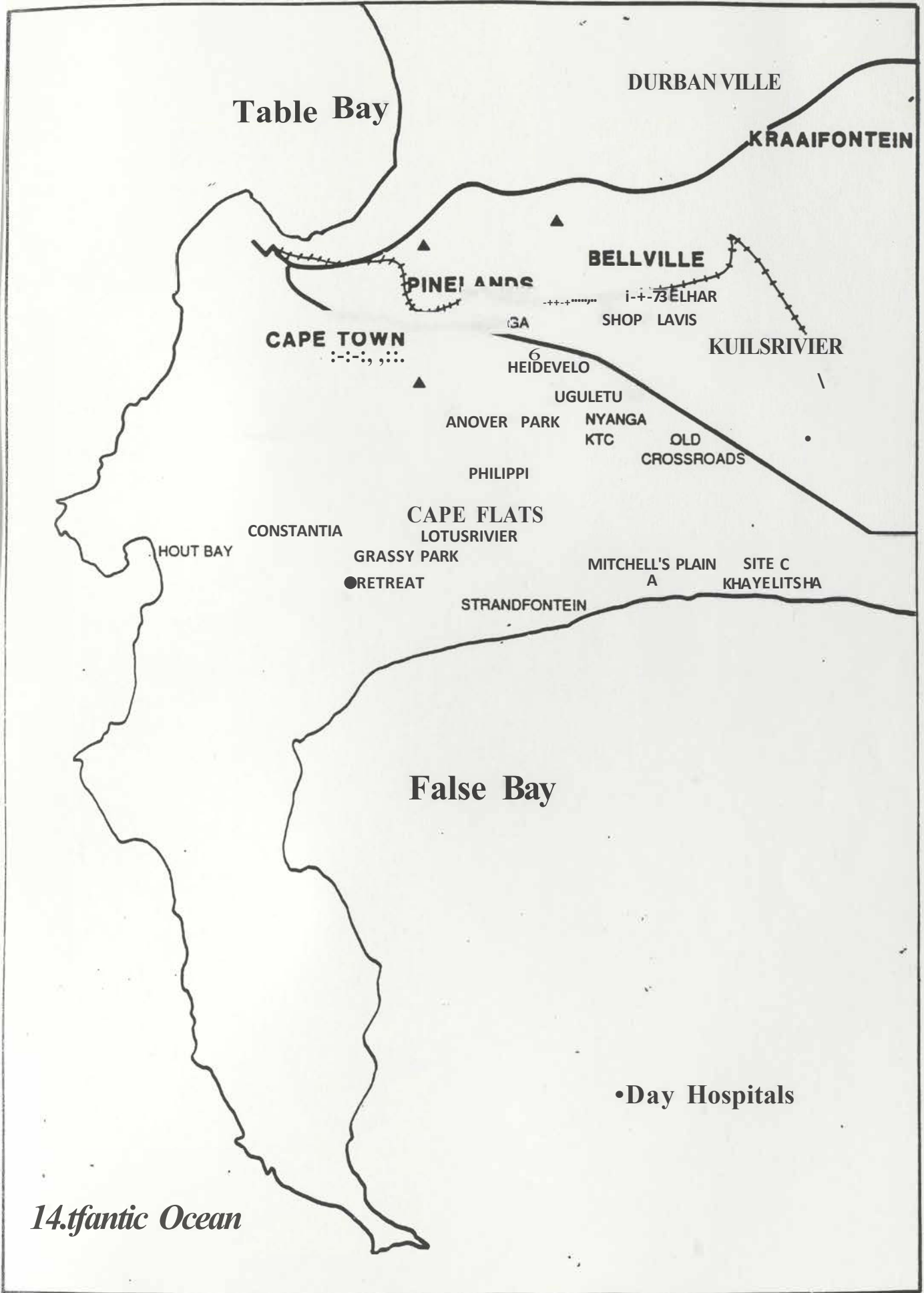
MAP OF THE CAPE PENINSULA INDICATING MIDWIFE OBSTETRIC UNIT BOUNDARIES WITHIN THE PENINSULA MATERNAL AND NEONATAL SERVICE

medical officers are available for certain sessions. In the case of abnormalities arising in the pregnancy or difficulties being experienced during labour, the midwife must refer her patient to the base hospital to which her unit is attached (SANC, 1974 : 12). Likewise, neonates at risk must be transferred via the obstetric and neonatal flying squad to a referral hospital.

Map 5 shows the locations of the Day Hospitals in the Cape Peninsula which were included in the 1986 study. These offer routine curative services for acute and chronic disease conditions, e.g. hypertension, diabetes mellitus; and basic casualty and trauma services with minor surgery, e.g. vasectomy/tubal ligation at limited centres. Pharmacy and radiography services exist and physiotherapy services are available at certain day hospitals. Most day hospitals are open on weekdays between 08:00 and 17:00, but two offer a 24-hour service.

Emergency services, as mentioned earlier, are administered by a directorate of the provincial administration. This assumes responsibility for the planning and training of paramedical personnel by the Medical Emergency Treatment and Rescue Operation (METRO) unit, and provides a control centre for ambulances in the Cape Peninsula.

Each local authority should have a civil defence service which is answerable to the provincial administrator, and whose actions fall under the provisions of the Civil Defence Act No 67 of 1977.



MAP OF THE CAPE PENINSULA WITH THE LOCATIONS OF THE DAY HOSPITALS

Voluntary organisations, e.g. St John Ambulance Brigade and the Red Cross Society are able to assist in providing First Aid and relief in disaster situations.

There is, however, no apparent mechanism available to co-ordinate the functions of the various agencies involved in health care in the case of large scale disruption as was experienced in the Cape Peninsula in 1986. Prior to the adoption of the present Civil Defence Act, in the case of a disaster being declared, authority was given to the army to mobilize whatever help was necessary. However, since the implementation of the Civil Defence Act No 67 of 1977, this co-ordinating function is no longer defined.

1.3 The need for this study

Nurses constitute the largest group of health professionals in South Africa. At 31 December 1989 there were 70 118 nurses on the register of the South African Nursing Council (professional category) and 74 346 nurses on the rolls (subprofessional category) (**SANC**, 1990). At the same date there were 22 260 medical doctors on the register of the South African Medical and Dental Council¹ (**SAMDC**, 1990).

¹ This does not exclude those doctors who have emigrated or who do not practise in South Africa. Therefore, the ratio of doctor:population should be considered to be at the maximum possible level.

This represents a ratio of 1:430 registered nurse:population, 1:209 nurse (all categories):population, and 1:1 356 doctor:population. Nurses are more available not only numerically, but also by their geographical distribution. They are predominantly responsible for the health services that are located in the community, but are also required to fill in for the shortages due to the maldistribution of other health professions (de Villiers, 1984). Unlike doctors in the public sector who tend not to live in the communities in which they work, nurses often live and work in the same community. Nurses, therefore, serve as a good indicator of community dynamics.

During periods of civil disruption a different pattern of health needs may emerge. Other health professionals who do not reside in these areas are likely to withdraw or be withdrawn (Halbert et al, 1988), leaving nurses to cope with additional responsibilities and possibly an increase in the number of patients requiring a greater diversity of treatment. It is also possible that the demands for the services they routinely offer are diminished in the face of the population's difficulty in reaching the clinics, and replaced with demands of an entirely different nature.

The short-term effects of the political violence in the Cape Peninsula during 1986 have been documented by Yach, who states in his conclusions that "further studies are urgently required to aid health planners in their decisions

regarding adaptations required to routine health services during or following outbreaks of political violence" (Yach, 1987). To provide such guidelines for health planners it is necessary to consider not only the short term effects of civil disruption but also the long-term implications of disrupted health services.

Although current negotiations between the South African government and the African National Congress offer some hope for peace in South Africa, it is anticipated that civil violence may continue to be a feature of this society for some time. Further outbreaks in the Cape Peninsula occurred in September/October 1989 shortly before the parliamentary elections and in August 1990, while in the Natal/Kwazulu area on the outskirts of Pietermaritzburg there exists a war-like situation between rival political groups of Inkatha supporters and members of the African National Congress/United Democratic Front/Congress of South African Trade Unions alliance, compounded by a vicious criminal element.

As nurses working in close geographical location to each other may be employed by one of at least four health authorities, it is believed that more efficient use of available professional and other resources could be achieved if a co-ordinated policy for health service provision were implemented. This is especially important during periods of civil conflict.

Therefore this project proposes to:

1. describe the effect of civil unrest on nursing personnel employed in community health services in the Cape Peninsula
 - 1.1 ascertain their domestic situations in relation to their ability to continue attending work
 - 1.2 describe their accessibility to **work**
 - 1.3 determine the presence/absence of intimidation/violence
2. describe the short-term effects of civil unrest on nursing services in relation to:
 - 2.1 the continuity/curtailment of services
 - 2.2 the nurses' assessments of the standard of care
3. determine the needs of nurses for maintaining existing services and offering emergency care during periods of civil unrest
4. describe the potential long-term effects of civil unrest on nursing services and health care
5. make recommendations for managing a community-based primary nursing care service during periods of civil unrest
6. examine the role of the professional association in assisting nurses during periods of civil unrest
7. discuss the ethical and moral dilemmas confronting nurse practitioners during periods of civil unrest.

CHAPTER 2 LITERATURE REVIEW

A review of the literature pertinent to this study will be presented in this chapter. The relationship between political violence and disaster is considered and the effects of political violence on physical, psycho-emotional, social and spiritual aspects of health are discussed. In addition the effects of political violence on health services and health professionals are presented. Existing models for nursing practice are considered in relation to political violence, but are found to be inadequate. A new conceptual framework is proposed. A model for the organisation of epidemiologic action in wartime is presented.

2.1 Political Violence

2.1.1 Political Violence and Disaster

The concept of a "disaster" may be understood by people in many different ways. Skeet gives a broad definition "... an occurrence of such magnitude as to create a situation in which the normal patterns of life within a community are suddenly disrupted and people are plunged into helplessness and suffering, and as a result, may urgently need food, shelter, clothing, medical attention, protection and other life-sustaining requirements" (Skeet, 1977:1). It is possible to consider the impact of both natural disasters, e.g. meteorological, topological,

telluric/tectonic and biological, and man-made disasters, e.g. accidents, civil disturbance, warfare and refugees, in this context.

Unlike other forms of disaster which are specific and localised in relation to time and space, political violence is usually chronic and ill-defined in nature, with intermittent periods of heightened intensity. It reflects the political, social and economic climate (Gibson, 1989), there is often a high level of personal involvement, and victims may experience an adversary's intent to harm (Logue et al, 1981). It differs from conventional warfare in that civilians, including children, may be involved in direct violent activity (Fraser 1974; Chikane, 1986).

In South Africa, repression of groups of people by statute has occurred regularly since the late 19th century, but since 1948 the policy of separate development has become entrenched in every statute. However, detentions without trial, bannings of people and organisations, censorship of news and publications became more widespread with the introduction of the first State of Emergency in July 1985. Violent clashes between groups of black people of differing persuasions is termed "black on black violence and implies that it is not connected to the actions of the State. However, in the Cape

Peninsula in 1986 there was a perception of collusion between the security forces and the vigilantes (Cole, 1987; CERSA, 1990) and in Pietermaritzburg in 1988 between the security forces and Inkatha (Aitchison, 1989).

In both these societies people have become socialised into an acceptance of violence, a phenomenon where a certain level of violence becomes the norm (Zwi and Ugalde, 1989; Armenian, 1989). This can be seen in the local newspapers which publish daily "unrest" reports supplied by the police (Cape Times, 1990).

2.1.2 Political Violence and the Health of the Population

Health patterns amongst the major racial groupings in South Africa vary considerably. Using the 1984 mid-year population estimates Bradshaw et al (1987) project the life expectancy for males and females as follows:

		Male	Female
White	1	66.6	74.2 years
"Asian "	2	62.3	68.4 years
"Coloured"	3	54.3	62.6 years

-
1. White: people of European descent
 2. Asian: people mainly of Indian descent
 3. Coloured: people of mixed parentage

Due to the maldistribution of health resources, it is necessary to consider the health parameters of the different population groups. A further important factor in the distribution of health resources is that of the place of residence, viz. urban, peri-urban, rural.

Due to the lack of reliability of the 1980 census information for Black people life expectancies have not been published, however, Bradshaw et al suggest that these lie between 50-55 years for males and 55-60 years for females.

During the period 1981 - 1985 the average Infant Mortality Rate (IMR) (per 1000 live births) was:

White	12.3
"Asian"	17.9
"Colour" ^d	12.4 ²
Black	

(Bradshaw et al, 1987:34)

During the same period the average IMR for black infants in ten urban areas was between 27/1000 and 83.3/1000 (Yach, 1988) with the exception of Grahamstown (203.7/1000) which borders on Ciskei.

While these figures may compare favourably with the rest of Africa, they do highlight the inequality of health that is experienced by the various groups of people in South Africa. The impact of political violence on health will be discussed under four broad categories - physical, social, psycho-emotional and spiritual.

1 Black: Indigenous African people

2 Excludes black people living in the "independent" states of Transkei, Bophutatswana, Venda and Ciskei, and includes black people living in "self-governing" states.

1. Physical health. Hoffman et al (1986) labelled 'unrest' as a vital community health issue and highlighted the six-fold increase in the number of patients admitted to the Groote Schuur Hospital Trauma Unit between August and November 1985 many of whom were children. Injuries from birdshot, used in crowd control, and from plastic bullets, used in riot control are reported (Hill & Peart, 1986; Cohen, 1985).

The South African Institute of Race Relations reported 128 people killed as a result of political violence in the Cape Peninsula and Boland areas during 1985 (SAIRR, 1986). This included civilians killed by security forces, security force personnel killed by civilians, and civilians killed by civilians. Also in 1985 a study of ninety-three deaths from gunshot injuries as a result of security force action reported that six were due to routine law enforcement and eighty-seven occurred during civil unrest situations (Duflo, 1986). By February 1986, nationally over 1 000 people were estimated to have died in the unrest (Haysom cited in Cole, 1987 : 103).

The impact on physical health is not limited to incidents of trauma. Patients on long term medication, e.g. for hypertension and tuberculosis will be affected (Hoffman et al, 1986). Disruption of ancillary services, e.g. water, sanitation and distribution of food could have a negative impact, particularly on

children. In a study on the endemic war in West Beirut, although attention was focussed on notifiable diseases, a surveillance of hospitals and dispensaries revealed that the most common medical conditions treated were gastroenteritis (30%), respiratory infections (18%) and tonsillitis (8%) (Armenian, 1989). The same author reports that, although typhoid is an endemic disease in Lebanon, the number of cases in 1982 (during massive disruption due to the Israeli invasion) was surprisingly lower than in 1980 despite interrupted fuel and water supply and sanitation. These reports suggest that unanticipated health effects may become evident due to the highly volatile nature of endemic war.

2. Social health. Social bonds that weave the fabric of society may be destroyed in times of civil unrest. Children cope better with stress when the family environment is harmonious and supportive (Garmezy, 1983; Robertson, 1990). Heskin's work in Northern Ireland suggests that the increase in anti-social behaviour amongst the youth is more closely related to deteriorating social conditions associated with political violence than with the violence per se (Heskin, 1980). In their study of mothers and children in Beirut, Bryce et al (1989) found that mothers with low levels of education and income reported more life experiences with a greater negative impact, than mothers with a higher level of education. These women

in turn exhibited higher levels of symptoms of depression. It should be remembered that war related events do not occur in isolation, but as a part of ongoing everyday life. This leads to overloading the resources of the individual and the society, and inevitably these resources decrease as the war continues.

Violence outside a country's borders may also impact on social health. The civil war in Chad has resulted in more than 500 000 refugees seeking safety in Nigeria. Not only have they brought communicable diseases, but as victims of violence they threaten the social stability and disrupt the economies of the receiving countries (Ogba, 1989).

3. Psycho-emotional health. The term "Post traumatic stress disorder" has been applied to many veterans of the Vietnam war, yet Straker suggests that a more appropriate term for South African children exposed to political violence is "continuous traumatic stress syndrome" (Straker, 1987). She describes this as the exposure to a series of stressful events occurring within the context of violence in the community.

Acute reactions to stress may be marked by shock accompanied by anxiety which may last a few days, whereas chronic reactions may present with more debilitating symptoms lasting for a longer period of

time. In the child these would include age-appropriate symptoms of stress whereas the adult may show characteristics of the post traumatic stress syndrome. Events which may become foci for psychological responses include the assault or witnessing of an assault, the detention of a family member and accompanying family dysfunction. Gibson (1989) suggests that children may incorporate certain experiences into a general political understanding of the event and similarly McWhirter (1983) hypothesizes that children are able to maintain a distinction between violence for a just cause and that which is perceived as unjust.

4. Spiritual health. "Crisis situations bring one face-to-face with the ultimate issues in life - the limitations of one's humanness, the loss of personal and environmental control, and the meaning of pain and suffering in the overall purpose of life. The questions of why and when events occur raise the issue of a God who does or does not exist and is or is not involved with one's life" (Stoll, 1979 : 1575). Crisis can be an opportunity for growth in faith and an ability to live fully.

Friedlander (1964) defines spirituality as "the life principle that pervades a person's entire being, including volitional, emotional, moral-ethical, intellectual and physical dimensions and generates a

capacity for transcendent values. The spiritual dimension of a person integrates and transcends biological and psychological nature, giving access to the non-physical realms of prophecy, artistic inspiration, love and healing actions".

But what, or who, is the focus of this faith? It is necessary to acknowledge a person's concept of a higher being, their perceived relationship to this being and the way in which a person believes that this higher being affects his/her life. Jourard states that "man needs reasons for living and if there are none, he begins to die ... man is incurably religious. What varies about men is what they are religious about." Whatever a person acknowledges to be the highest value in life can be regarded as his God, "the focus and purpose of his time and life" (Jourard, 1974 : 305-7).

However, although all people possess a spirituality, that spirituality may not be founded on a belief in a higher being. "Every man needs a purpose in order to give his life meaning, and meaning is a personally perceived phenomenon, whether it is related to a personal relationship with God or a nontheistic activating force" (Ellis, 1980 : 8). Although Martha Rogers defined nursing as a humanistic science she acknowledges that human behaviour reflects the merging of physical, biological, psychological, social, cultural and spiritual attributes into an indivisible

whole (Rogers, 1970). Lingley, in reviewing nurse theorists' perspectives, found that while some directly addressed the spiritual dimension, others did not deny the truth that man is a spiritual being and none of the models would inhibit spiritual care (Lingley, 1984a).

When addressing the spiritual dimension of health, Kiening (1978) defines spiritual needs as "the thinking, feeling, motivating forces which influence us • in our search for meaning and our inner strivings toward these goals in life which hold the deepest values for us".

It is clear that these authors consider spirituality as divisible from religion. For some people their spirituality may be expressed through their faith in a deity, e.g. the Judea-Christian God, but for others that which gives meaning to their lives may be power, social status, or material wealth, among others.

Many parts of South African society are in crisis, and other sectors of the community are facing the inevitability of change which might become a critical issue for that community. People who live in a society that is experiencing crisis and change may find that the focus of their spirituality is threatened. This may lead to alterations in spiritual health as defined by the National Committee for Classification of Nursing Diagnoses and O'Brien. Examples include:

Etiology

Defining characteristics

Spiritual concerns
anticipated role changes
concerned about relationship with God
search for more meaning or purpose in existence

verbalises inner conflicts about beliefs
questions meaning for own existence
mild anxiety, bewildered

Spiritual distress
anger towards God
disrupted spiritual trust
sense of meaninglessness, purposelessness

disturbance in concepts or perception of God or belief system
moderate to severe anxiety
depression, preoccupation
psychosomatic manifestations
expression of anger/guilt

(Lingley, 1984 b)

Spiritual pain
discomfort/suffering related to one's human/transcendent relationships as well as one's transcendent values and beliefs

lack of spiritual fulfilment
inability to come to terms with one's reason for existing
discomfort with relationship to God, fellow human beings and/or transcendent values and beliefs

Spiritual loss
feeling of having lost hold of those aspects of life which give ultimate and transcendent meaning and purpose

expressions of fear that one's faith in a spiritual being has been misplaced
listlessness with regard to things that previously were meaningful

(O'Brien, 1982; Labun, 1988)

In South Africa, where the majority of the population are disenfranchised, social status may be achieved by involvement in local community politics or through membership of a gang. When it is this power that integrates one's life, vocation and relationships and gives meaning to what is important (Stoll, 1979), violence, intimidation and corruption may follow in order to retain the power that accompanies this status.

It is therefore quite possible to consider the violence in South Africa in a spiritual dimension. The quest for power has led to structural violence, repression and torture, all of which accelerate the spiral of violence. One can blame structures and systems, but these were created and maintained by people (Boesak, 1979). St Paul, in his letter to the Ephesians, states: "For we wrestle not against flesh and blood, but against principalities, against powers, against the rulers of the darkness of this world, against spiritual wickedness in high places" (Holy Bible). To ignore the impact of spiritual ill health in South African society is to ignore a major contributor to the spiral of violence.

2.1.3 Political Violence and Health Services

Ityavyar and Ogba (1989) examined the impact of incessant violence and political conflicts on the development of health services in Africa and conclude that in wartime, health policies of

African states become narrow and unidimensional e.g. both the rural and the urban poor are ignored or given only very basic services while soldiers and members of the privileged classes have greater access to better services. This causes further isolation of the disenfranchised people, thus fuelling the fire of further conflict.

The withdrawal of health services may also be used as a weapon of control by government in the case of civil war. Volunteer medical movements such as three Paris-based organisations - Medecins sans Frontieres (MSF), Medecins du Monde (MOM), and Aide Medicale Internationale (AMI) - believe that medical care should be placed above affairs of state. They insist that when diplomacy fails and government backing is not given to an organisation like the International Red Cross, they have an obligation to bypass official channels and bring medical assistance to those in need (Johnson, 1989).

When the conflict subsides the response of governments to health care have not necessarily redressed the imbalances of access to adequate health care. For example, following the civil war in Nigeria in 1970, the health policy during the reconstruction and reconciliation phase concentrated on the renovation of hospitals and

clinics. It was only after 1975 that the Basic Health Services Schemes, targetting the health needs of the rural and urban poor, was introduced (Ityavyar and Ogba, 1989). Had it not been for the political conflict, community based health policies encompassing immunization, health education including oral rehydration, and training of community health workers could have been introduced far sooner.

Woolhandler and Himmelstein (1985) show a strong correlation between infant mortality rates and the proportion of the gross national product spent on defence. These authors suggest that the emphasis on military spending diverts attention from social and development projects. Opportunities for socio-economic and health advancement of the general population are minimized and thus the most vulnerable of the population - the children - are placed at risk.

During the 1988/89 financial year 15.2% of the national budget of South Africa was allocated to defence and 4,3% to health¹ (SAIRR, 1989).

1. The budget for the Department of National Health and Population Development includes welfare and pensions. Additional funding for health comes from the budgets of the Administrations of the three parliamentary houses, viz Assembly, Delegates and Representatives, i.e. "own affairs" and from the budget of the Commission for Administration.

In addition, although 5.7% of the gross national product (GNP) was spent on health in 1988, the proportion spent on white people was equivalent to 13-14% of the GNP while that spent on black people was equivalent to 3-3.5% GNP - well below the World Health Organisation target of 5% (McIntyre and Dorrington, 1990). The infant mortality rates presented earlier suggest that the findings of Woolhandler and Himmelstein are true for the majority of South Africans.

The percentage increase in military expenditure in selected African countries experiencing civil war compared to the increase in health expenditure for the period 1972-1978 is revealing, e.g.

<u>State</u>	<u>Defence</u>	<u>Health</u>
Chad	28.2	3.9
Ethiopia	42.6	4.2
Nigeria	14.6	2.0
Somalia	17.9	5.3

(Ityavyar & Ogba, 1989)

In South Africa during the 1988/89 financial year the percentage increase in the defence and health budgets over the previous year was 23% and 5% respectively (SAIRR, 1989).

The ability to render a service during civil unrest

may be called into question. In times of peace the traditional three-tier system of referral allows efficient use of the scarce human and other resources, but in times of conflict this system is vulnerable. Base hospitals are easily isolated, transport and communication to more remote areas is dangerous or discontinued, and lower level health workers unused to taking responsibility and using their initiative are ill-prepared and unable to function effectively (Halbert et al, 1988). Skilled and professional personnel often emigrate from unstable regions (Halbert et al, 1988, Summerfield, 1988) causing paralysis of direct health care delivery and further collapse of health service management .

As a result, specific strategies have to be developed to meet the emerging demands on a health service. In Nicaragua a greater emphasis was placed on primary levels of care when the Sandanista party came to power in 1979. However, when military activity increased in 1982 in response to the 'contra army', the increased demand for surgical intervention due to war injuries ensured that a greater proportion of the health budget was allocated to curative, physician-centred health care from 1983. Three ongoing health campaigns have been developed to reduce the harmful effects of war, e.g. first aid training of 25 000 volunteers from the

population, the building of refuges to provide protection against attack, and fire control education to reduce the damage caused by sabotage or attack. In addition there has been a reorganisation of clinical services and referral systems with the army taking greater responsibility for health services in war zones (Garfield, 1989).

As a result of the civil war in Mozambique different health service needs have emerged, notably rehabilitation (and access to prosthetic limbs) and control of epidemics, e.g. polio, cholera, neonatal tetanus (Summerfield, 1988), while in Central America measles, malaria and polio require control in the areas of conflict (Garfield et al, 1987).

In order to make rational decisions for health care delivery and plan for the future, rapid and valid information is necessary. With his experience in Lebanon, Armenian suggests that one needs to look beyond the usual war related research, and conduct active surveillance of health conditions, monitor disease control programmes, and assess the utilization of services, as well as institute epidemiologic systems in the affected areas (Armenian, 1989). He describes the development of a surveillance programme which was designed to supply information on major health problems in the community to international agencies and local public

health authorities so that appropriate and timely intervention and assistance could be given. Armenian also emphasises the necessity for documenting the work of disaster relief agencies. As a result of such documentation it was evident that one of the major problems encountered was that of adequately managing both vertical and horizontal communication (Armenian, 1989).

2.1.4 Political Violence and the Health Professional

The destruction of health facilities and the victimisation of health personnel is a particularly vindictive form of terrorism. Despite this there is evidence that in many countries health workers and health facilities are specifically targeted for destruction, e.g. Chile, Guatemala (Zwi and Ugalde, 1989), Afghanistan (Halbert et al, 1988), Nicaragua (Garfield et al, 1987), Honduras and El Salvador (World Council of Churches, 1989), Mozambique (Summerfield, 1988). A physician in Nicaragua, later to become governor of North Zelaya stated

"In a poor country like Nicaragua, to better the level of life of the people you can't talk too much about housing. It is too expensive. We are trying to improve transportation, but that also is not so easy. A road to Managua was opened in 1982, but because of the war you cannot travel safely. But health is something you can do in every village. It is a way for the revolution to get to everybody, every village, anywhere in Nicaragua. That's why the health personnel are targets of the contras"

(Garfield, 1989 : 669).

Health professionals may face situations for which they are not adequately prepared which will require creative responses (Johnson, 1989; Waddy, 1986; Halbert et al, 1988).

An issue of specific import to researchers who are clinicians is raised by Gibson. She questions the value of research as opposed to the value which could be offered by a clinician who intervenes in a crisis situation particularly in the context of psychological and emotional disturbance (Gibson, 1989). However, the work of a researcher ought to be directed towards the removal of the origin of crisis, whereas by addressing only the individual's need, the researcher/clinician would send such an individual back into the environment that precipitated the crisis.

Epidemiologists undertaking research into the area of political violence are faced with a number of problems. Personal factors include anxiety about personal safety and security while carrying out the field work, maintaining a scientific detachment, and being confronted with strong political polarization (Armenian, 1989). The motivation for undertaking research should be carefully examined and answers to the following questions sought. Is it useful to focus on this subject? Will it assist

the society or will it further the aims of those perpetrating the violence by legitimizing their action? Will the research findings be readily accessible, in presentation and location, to those who need to use them or will they be dressed in academic respectability that accentuates the gulf between the researcher and those who experience the conditions being researched? (Gibson, 1989).

In addition to the personal problems associated with the provision of health care in civil unrest, there are specific methodological problems unique in the field of political violence:

- 1) the time lapse between the disaster impact and the implementation of the research (Logue et al, 1981);
- 2) political and military sensitivities associated with data collected during wartime;
- 3) the lack of centralized power which causes difficulty in obtaining permission to undertake research;
- 4) the dynamic nature of the population, or the absence of a reliable census resulting in unreliable denominators (Armenian, 1989).

How can health related individuals and groups respond to violence? Zwi and Ugalde answer their own question by suggesting that one could educate the general community by raising awareness and

encouraging governments and the media to focus attention on political violence and its ill effects (Zwi and Ugalde, 1989). Armenian recognizes the possible dilemmas facing the epidemiologist including the need for scientific objectivity. He notes the fact that the individual in his or her personal capacity may be politically active. He highlights the following as options for action in wartime:

	Relief Action	
	+	-
Political Action +	A	B
-	C	D

- A Combines political action with relief
- B Involvement in political action with no participation in relief operations
- C Providing relief with no involvement in political action
- D No involvement in the problem of war

Further, Armenian states that:

"considering that war is a disease at the societal level affecting the health of millions of individuals every year, it behoves us, as public health professionals to be activists rather than bureaucrats. We should be concerned as much with prevention as with relief in dealing with this problem" (Armenian, 1989 : 646).

Bryce and associates reiterate this sentiment by suggesting that all research relating to the consequences of war should be directed towards the goal of peace (Bryce et al, 1989).

A number of writers campaign strongly for more than palliative action. Paul Hindson, in his presidential address to the World Health conference on Health Education in 1985, stated that in order for all peoples of the world to attain a level of health to permit them to lead a socially and economically productive life, health professionals should support the strategies for health adopted at Alma Ata.

However, he emphasised that one also needed to "eliminate certain aspects of our world civilisation which will always stand in the way of health for all" viz war, suppression - which is intrinsically evil and begets violence - poverty, dehumanization (Hindson, 1985 : 8).

2.2 Conceptual models

2.2.1 Nursing Practice

Although Florence Nightingale and Virginia Henderson were pioneers of modern nursing, the development of nursing models only emerged in the 1960's. Some of the earliest of these were the Johnson Behavioural System (Johnson, 1961), Peplau's Developmental Model (Peplau, 1952), and the patient-centred approach (Abdellah et al, 1960).

The need for nurses to develop their practice beyond

the reflexive or responsive reactions within the medical model led to the generation of conceptual models for nursing practice. These were systematically constructed, scientifically based, and logically relate a set of concepts which identify the essential components of nursing practice together with the theoretical bases for these concepts and the values required in their use by the practitioner (Riehl and Roy, 1980). Further impetus was gained when the National League for Nursing set accreditation criteria requiring nursing programmes to be based on a conceptual framework.

Ultimately the criteria of a model's usefulness are whether it stimulates new observations and insights, and generates predictions of relevant events that are subsequently confirmed (Berthold, 1968). Thus the impact of such models should be felt in education, service and research.

Two of the conceptual models taught and implemented most commonly in North America - Orem's Self-care and Peplau's Developmental (Riehl, 1980) - will be considered in relation to nursing in the context of political violence.

In the Orem self-care model, nursing is defined as "the giving of direct assistance to a person when

he¹ is unable to meet his own self-care needs. Requirements for nursing are modified and eventually eliminated when there is progressive favourable change in the state of health of the individual, or when he learns to be self-directing in daily self-care. The nurse (i) works directly with the needs of the patient in close relation to his total living situation; (ii) provides for the direct need fulfilment - physiologic, interpersonal and socio-cultural - insofar as the patient is incapable of self-care; and (iii) functions on a basis of a holistic philosophy in assessing the areas of need, identifying and utilizing resources for need fulfilment" (Caley et al, 1980).

'Therapeutic self-care demand' is a set of requirements which will assist an individual to maintain the present state of well-being or progress towards a more desirable health status. 'Therapeutic self-care demand' is subdivided further into universal self-care, which includes the essentials for daily living, and health deviation self-care, which is required only in the event of injury, illness and disease (Coleman, 1980).

After assessing the patient's health status, the nursing system employed may be wholly compensatory, partly compensatory or educative-developmental.

1. The masculine personal pronoun is used in relation to a patient or client throughout this dissertation. The feminine personal pronoun is used in relation to a nurse, as the majority of nurses are female.

It must be acknowledged that this model is designed for nursing at the level of the individual. Health and well-being are also discussed at this level (Orem, 1985). This makes it difficult to translate Orem's model in terms of a community, although aspects of universal self-care at a community level would hold, e.g. adequate air, water, food; care related to excrements; prevention of hazards to life and well-being. If one were to measure the usefulness of the Orem self-care model against Berthold's criteria, viz stimulates new observations and insights and generates predictions of relevant events that are subsequently confirmed, its usefulness would be limited to nursing at the level of the individual patient and not at the level of communities in turmoil due to political violence.

The Peplau Model introduced in 1952 focuses on the developmental potential of man (Blake, 1980).

Nursing is regarded as an interpersonal process which focuses on support processes, or self-repair and self renewal which ultimately will result in growth (defined as the learning of more positive behaviours) of the patient and the nurse. The goals, therefore, are to meet the physiological and interpersonal needs of the organism (i.e. man) within the context of the individual, family or community. Peplau suggests that the role adopted by the patient (and therefore the

nurse) is dependent on the patient's maturity in coping with tension (i.e. illness). For example, he may exhibit behaviour characteristic of a child even though prior to the tension he appeared to be a fully functional adult. The nurse would then adopt an attitude of unconditional acceptance or a mother role.

The planned outcomes of Peplau's model are (i) the positive use of the energy created by the person in stress in order that change and self-actualisation may occur, and (ii) the increase of potential for intervention as knowledge about change is increased (Peplau, 1952). In her discussion of Peplau's model, Blake highlights the unintended outcomes of the model as (i) its indistinct mission for nursing, and (ii) the dependency of the goals of action on value systems (Blake, 1980).

The model recognises the growth potential for both the patient and the nurse, emphasising relationships and personality development.

In attempting to establish the applicability of Peplau's model to nursing during political violence, the following should be considered:

- 1) It may be possible to shift the focus of this model from the individual to the community. One would then need to assess the growth potential of the community.

- 2) Professional closeness could then be redefined as "...involvement with a [community] that requires the nurse to observe the [community] and her own participation in the situation - the end result being a clinical judgement that would most likely benefit the [community] (my own substitution of community in place of patient in the definition given by Peplau).
- 3) The context within which this model was developed was the hospital setting at primary, secondary and tertiary levels of care, the emphasis being on primary care. There is, therefore, no structure in the model which could accommodate non-health forces that would impinge on health care.
- 4) Practice within this conceptual framework is dependent on the value systems of the players, and where these are not shared or understood, as in the case of civil unrest, the progress towards resolution will probably be slow.
- 5) The usefulness of the model in predicting behaviour is minimal, due to the non-specific nature of behavioural outcomes.

The South African Nursing Council adopted the Scientific Process of Nursing (referred to as the nursing process) in 1979 and requires that this be taught in all nursing education programmes and utilized in clinical practice. In Riehl's survey of conceptual models taught in baccalaureate programmes,

the nursing process was found to be taught in theory by ten percent of nursing schools, used in clinical practice by seven percent and used by ten percent of academic nurses. However, Orem and Peplau discussed above, as well as many other proponents of nursing models, support the methodology of the Nursing Process, which is primarily a problem-solving process (Riehl & Roy, 1980). Orem views nursing as a process of actions related to nursing goals. This series of actions is the nursing process, but the goals are determined by the model employed which, in the case of Orem, relate to universal self-care and health-deviation self-care.

It can be seen that the conceptual models discussed also incorporate aspects of the systems model. These have been found to be deficient when applied to nursing during civil unrest. The systems model has been found to have application in the physical and the social sciences and so it would be useful to consider key features which would enable one to design a model that would describe, explain and predict community and nursing actions in times of civil stress.

A system consists of a number of components which are interdependent and interact with one another. A boundary defines the system or subsystem under scrutiny. Tension will occur as a result of variables reacting differently to change and may result in

conflict. A system is assumed to tend towards balance - either equilibrium (balance at a fixed point) or steady state (balance independent of a fixed point). Feedback refers to input and output across the boundary, and transformation within the boundary (Chin, 1980 : 23-28).

A simple system focussing on the individual could be diagrammatically represented thus:

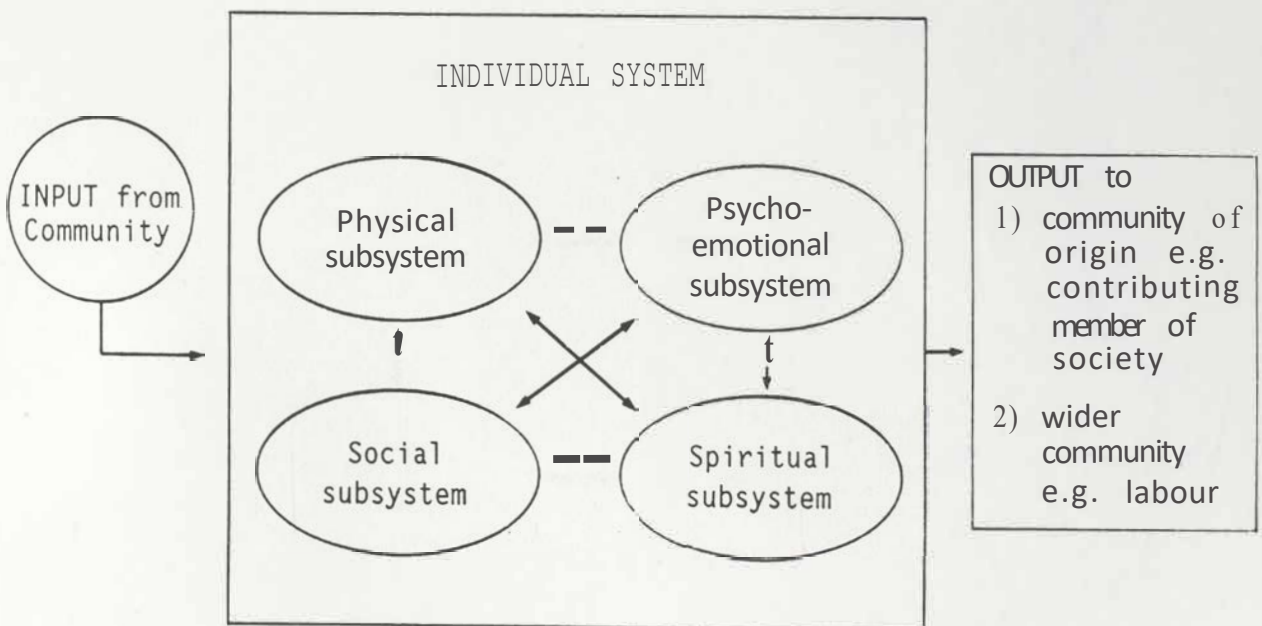


DIAGRAM 1 : THE INDIVIDUAL SYSTEM

The individual functions in an open system which impacts on him, and in turn can be affected by him. However, this ignores the impact of other forces. Buchele represents an organisational system in this way.

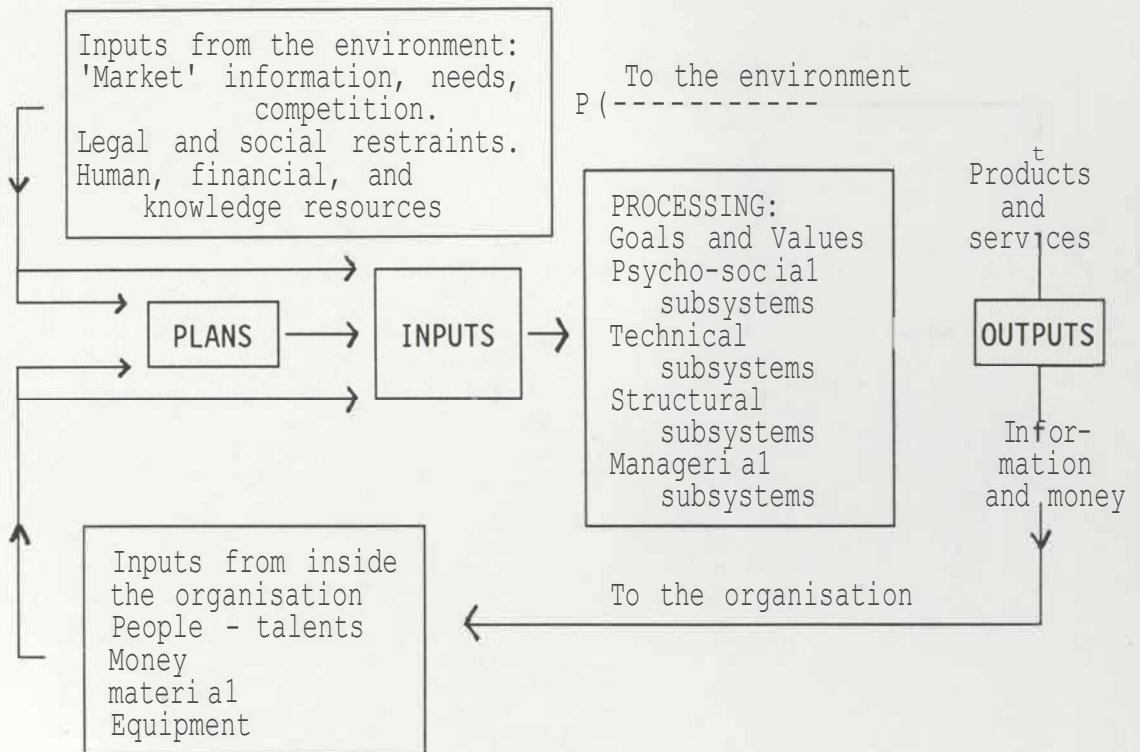


DIAGRAM 2 : AN ORGANISATIONAL SYSTEM (Buchele, 1977 : 29)

In relating Buchele's model to an individual, the organisation could refer to the immediate community in which the individual functions, and the environment would be the wider society and the controls placed on societal functioning e.g. legislation. Thus far one can describe and define the individual's relationships with the society in which he functions. The health of the individual is implied by the inclusion of the four components of health (discussed previously) as subsystems i.e. physical, psycho-emotional, social and spiritual.

However, the relationship between the individual and the health care service is not apparent. This service in itself is a system, and will have greater or lesser impact on the community and the individual depending on the individual's health status. It is inadequate to regard this as one of the component parts designated "input", and it needs to be accommodated as a system with a number of subsystems, e.g. human resources, management, education, non-human resources.

It is possible to develop this further as an Intersystem model. This enables one to "examine the interdependent dynamics of interaction both within and between the units and provides a tool for diagnosis that retains the virtues of system analysis, adds the advantage of clarity, and furthers our diagnosis of the influence of various connectives, conjunctive and disjunctive on the two systems" (Chin, 1980 : 29). Chin postulates that this model is applicable to problems of leadership, power, communication, and conflict in organisations, intergroup relations and international relations. It would appear that this framework could be helpful in the context of nursing and political violence.

By combining the attributes of the frameworks of Buchele and Chin, the Intersystems Framework is proposed (Diagram 3).

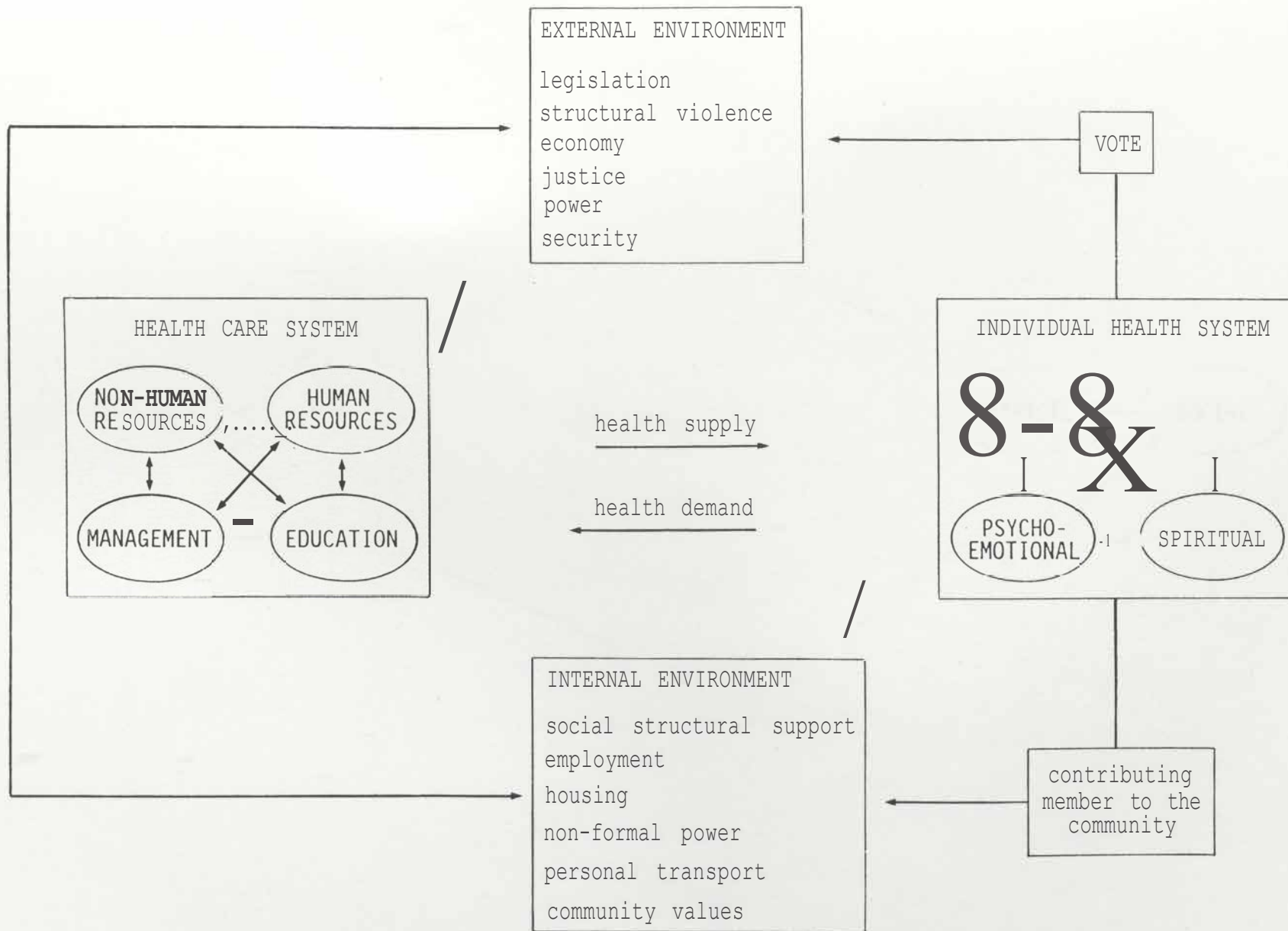


DIAGRAM 3 : INT[RSYSTEMS FRAMEWORK FOR NURSING IN SITUATIONS OF POLITICAL VIOLENCE

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It has been named "Intersystems" as opposed to "Intersystem" because not only is the relationship defined between the two focal systems, viz. the individual, and the health care system (as described by Chin), but it also acknowledges the effect of the external and internal environmental factors on the individual and on the health care system.

This framework also acknowledges factors that might lead to civil violence, e.g. legislation, justice and differing values, which may impact on individual and health care systems alike. In fact it would be possible for each of the focal systems to stand clear of each other while retaining their relationships with the internal and external environments. This would still explain those factors initiating and maintaining political violence in relation to each focal system.

In attempting to explain factors that affect an individual's ability to receive health care in a society characterized by political violence, it is also necessary to study the relationship that exists between the individual system and the health care system. This is indicated in the Intersystems framework by two connectives named 'health supply' and 'health demand'. It is suggested that the strength of the connectives will be related to the individual's perception of his health. The strength of the relationship between the

individual and health care systems is determined by the level of the health demand, e.g. any deterioration in the individual's system will strengthen the health demand connective. Similarly, any improvement in the health care system will strengthen the health supply connective.

Orem states that the goal of health care service is the health and well-being of individuals, families and communities (Orem, 1985 : 184) and so the major output from the health care system is directed at the individual who in turn will impact on the internal environment system, viz. the local community. The health care system also has a direct output to the community in the form of setting acceptable standards of health care practice through management, education, and human resources in the form of health professions including nursing. The output of the individual to the internal environment is as a contributing member to his community and his output to the external environment is effected by his exercising his right to vote. The fact that Black people in South Africa have no voting power in parliamentary elections (and that this right was only extended to "Asian" and "Coloured" people in 1984 after the implementation of the Constitution Act of 1983) indicates that this is a weak feedback mechanism. This has meant that changes in the external environment, and ultimately the internal environment, have not been responsive to individuals.

Using Berthold's criteria regarding a [framework's] usefulness, this framework does stimulate new observations and insights, and generates predictions of the effects of change by focussing on the relationships that exist. This conceptual framework, therefore, is used in this study.

Further analysis is required in two major areas:

- 1) analysis of the connectives between the individual system and the health care system - their nature in the beginning, how they change and how they are terminated.
- 2) at the operational level of interaction between the change agent (e.g. nurse) and the client (e.g. individual) a theory of change is necessary. In previous discussion some theories have been found wanting because they do not translate well to the community level, but their application at this level would be appropriate and realistic, e.g. Orem.

2.2.2. Disaster Dynamics

In order to minimise the effect of a disaster, it is useful to be able to predict the probable development of the situation, and then plan to minimise its consequences. When considering the impact and effect of disasters there are two models that are useful. The temporal model is characterised by the following phases:

1. stable
2. warning
3. impact
4. isolation
5. salvage and rescue
6. rehabilitation

(de Villiers, 1980)

Similar stages are suggested by Powell and Rayner (Logue et al, 1981) and could be applied to meteorological and topological disasters, e.g. hurricane, earthquake, volcanic eruption.

The second model is the spatial model advanced by Wallace (de Villiers, 1980) which describes a disaster geographically in five concentric rings extending from the zone of greatest impact outwards. These are the:-

1. total impact zone
2. marginal zone
3. filtration zone
4. organised community zone
5. organised national and international zone

and could be applied to a bomb blast, declared war, nuclear accident.

These both offer well-defined, recognisable stages which progress sequentially, either temporally or geographically, towards an ultimate resolution or conclusion. The temporal model has an impact phase which is acute, and a final rehabilitation phase which may vary from weeks to years before the community is restored. On the other hand the spatial model also has an impact phase that is finite, but its effects diminish towards the

periphery. In some disaster situations both models may be applied in order to identify possible problem areas and to intervene timeously so that the effects can be minimized, e.g. hurricane leading to floods.

Some disasters that may be caused by political violence, e.g. bomb blast in a high density area, relocation/migration of refugees, may be described by the spatial model. The initial two phases of the temporal model may not be as easily identifiable, but the impact phase and post impact phases would be valid in a situation of massive damage to property, as was the case in the Cape Peninsula in 1986. Although aspects of disasters as a result of political violence can be explained in these ways, there are traits which are unique and this is not covered by these models.

Political violence is often insidious in nature, taking place over prolonged periods with no progress towards resolution, e.g. the South African migratory labour system. Neither of these models is able to accommodate the chronic nature of political violence and so their value is limited to specific incidents.

2.2.3 Epidemiologic Action

When considering the needs of epidemiologists in wartime, it is necessary to have a framework so that epidemiologic action can take place rapidly and in the most effective way. Armenian proposes a conceptual model of a three-dimensional matrix to assist in organising epidemiologic action.

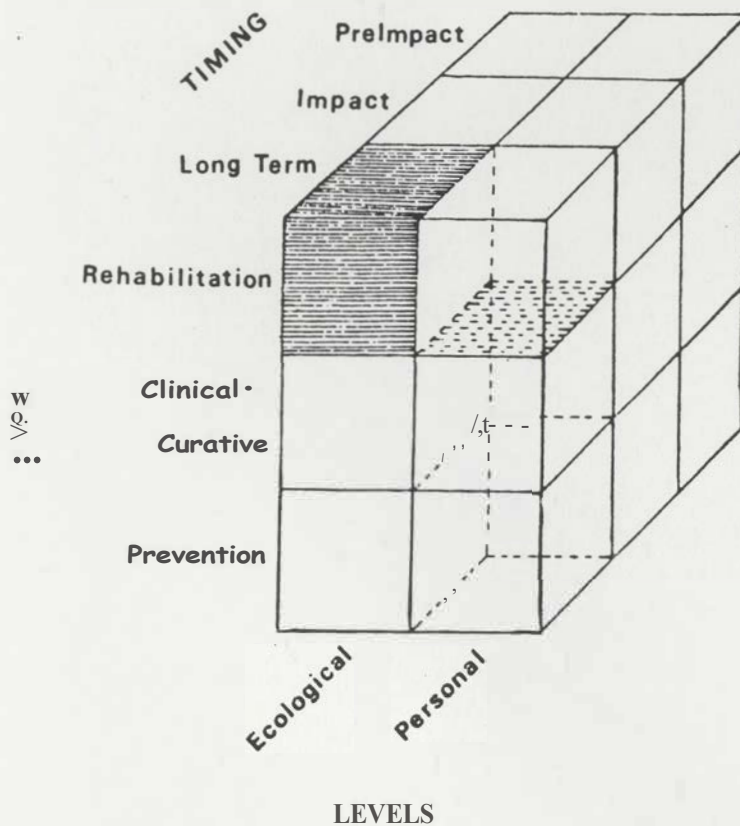


DIAGRAM 4 : CONCEPTUAL MODEL FOR THE ORGANISATION OF
EPIDEMIOLOGIC ACTION IN WARTIME

(Armenian, 1986 : 31)

1. The level of action
 - ecologic - efforts should be made to change policy and influence government action
 - personal - concern for prevention and rehabilitation
2. Type of action - prevention, clinical-curative and rehabilitation all require attention in wartime.
3. Timing of action - the three phase approach is a modification of the temporal model reported by de Villiers (1980) and presented by Power and Rayner (Logue et al, 1981) as it includes only the impact, post-impact and long term time frame. Armenian suggests it should also include a pre-impact phase for prevention (Armenian, 1986).

The type of action chosen by the epidemiologist is dependent on the nature of the war, e.g. formally declared, guerilla attacks, its progress vis-a-vis timing, and the country in which it occurs, and so this framework does not indicate the direction the research should take.

This framework is helpful in orientating an epidemiologist, or preferably a multi-disciplinary team, to the nature of the work. As has been stated in Chapter 2.2.2 the effects of political violence do not necessarily follow a sequential pattern and therefore the orientation offered by this model is most useful to apply in the context of political violence.

CHAPTER 3 METHODOLOGY

The methodology for the three phases of this study is presented, i.e. literature review, nurses' survey (1986), and health data (1984-1988).

3.1 Literature Search

A number of literature searches were done with the assistance of the Biomedical Communication Unit at the Medical Research Council, Parow, using the Medline Database and through the University of Cape Town Library Service using the Social Sciences Citation Index, Sociological Abstracts, and Nursing and Allied Health Databases. As there is very little published literature specific to this subject, access to literature across disciplines in Medicine, Law, Arts, Social Sciences and Humanities was sought.

The inter-library loan facility locally and internationally, as well as the assistance of the Document Supply Centre in the United Kingdom, was invaluable in tracing literature required.

3.2 Nurses' Survey

Originally this study formed part of a wider study by the Medical Research Council (MRC) which investigated the impact of political violence on health and health services

in Cape Town in 1986 (Yach, 1987). The protocol for the overall study was approved by the Ethics Committee of the Medical Faculty of the University of Cape Town. Permission was also obtained from the Medical Superintendent and Chief Nursing Service Manager of the Peninsula Maternal and Neonatal Service (PMNS), the Day Hospitals Organisation (OHO), the National Cancer Association, the St John Ambulance and the Students' Health and Welfare Centres Organisation (SHAWCO) to survey all nurses working in these organisations.

In order to ascertain the degree of disruption that occurred in communities in the Cape Peninsula, press reports and officially published police reports relating to each area were studied and an overall view of the unrest activity obtained.

The most directly affected areas, Old Crossroads and KTC, were identified as high impact areas. Although Guguletu is a neighbouring township, for the purposes of this study it was regarded as a high impact area because the day hospital is directly opposite KTC store which gives its name to one area of high impact violence. Other areas, although experiencing high levels of police/defence force activity/presence, were less affected, e.g. Retreat and Mitchell's Plain, and were defined as low impact regions (Map 2).

All nurses working in Midwife Obstetric Units (MOUs), Day

Hospitals and voluntary organisations in affected **areas** of the Cape Peninsula during 1986, and whose employing authority had granted permission, were included in the survey. Any nurse who had not been employed as a community based nurse in the Cape Peninsula at this time was excluded.

When this survey was conducted in November 1986 there were three MOUs in the Peninsula at Heideveld, Hanover Park and Retreat. Heideveld and Hanover Park were in the affected areas. Retreat was the only MOU unaffected by the unrest, and it was therefore used as a control. The Retreat and Mitchell's Plain Day Hospitals acted as control Day Hospitals.

It was decided that the most appropriate method of data collection for this potentially sensitive subject of study would be a self-administered questionnaire. This method facilitated complete anonymity of the participants, which was an important consideration at a time of social tension. A self-administered questionnaire is far more efficient with regard to time and personnel resources than is an interview, and it reduces the risk of bias that may be introduced by an interviewer.

Prior to formulating the questionnaire, unstructured interviews were conducted with various individuals who had been present in the unrest-affected areas during the course of their work or everyday life, i.e. voluntary

workers, health motivators, educators and lay people; none were nurses and none were involved in the survey. In attempting to ensure that the questionnaire was as comprehensive as possible, contact was made with various nurse managers in Port Elizabeth and the Eastern Cape, an area that had had recent experience of heightened civil unrest, to obtain information relating to the experience of nurses in those areas.

The questionnaire covered the following broad categories: access to work, presence/absence of intimidation/violence, continuity/curtailment of services and nurses' assessments of the standard of care during the unrest (Appendix A). In order to reduce error, and increase the validity and the reliability of the questionnaire, questions were short and covered single concepts. Clear instructions were given regarding which portions of the questionnaire should be omitted. Most questions were direct but space was also available for qualifying answers which allowed for the collection of both quantitative and qualitative data.

A pilot study was conducted at the Hanover Park Day Hospital. This clinic was selected as it was in an area of high impact unrest and, because it borders the Hanover Park MOU, similar information would be forthcoming in the survey and would not be lost because of the pilot study. As there were only three MOUs in the survey, it was unreasonable to conduct the pilot study at an MOU and diminish the surveyed population further.

The questionnaire included an introduction to the survey and assured the respondent that permission to administer the questionnaire had been obtained from their employing authority and that the individual responses would be anonymous. An envelope which could be sealed after the questionnaire had been completed was supplied with each questionnaire. This was then placed in a locked cabinet until collection.

The questionnaires were distributed over a period of four days and suitable times for their collection were arranged with the sister-in-charge after consulting the off-duty roster. The interval was usually 3-4 days. In order to ensure as high a response rate as possible, repeated visits were made if the questionnaires were not all available at the arranged time. In one instance (Guguletu Day Hospital) 5 extra visits were made until it was established that no more questionnaires were forthcoming.

The data were coded manually and this was checked. Comparisons were made between the experiences of nurses in control and affected clinics within both services as well as across the services.

3.3 Health Data

Following the completion of the nurses' survey for the MRC project, it was decided to examine the short and long term implications for health when nursing services have been

disrupted, thus expanding this section of the project, and to submit the dissertation for the degree of MSc (Nursing). A revised protocol was submitted to the Ethics and Higher Degrees Committees of the Medical Faculty of the University of Cape Town and permission was granted to continue with the expanded study.

Permission for access to unpublished but available health and health service data was sought and obtained from

- The Nursing Ethics Committee - Groote Schuur Hospital
- Professor H A van C de Groot, Department Community Obstetrics and Gynaecology, University of Cape Town
- Miss L J du Preez, Deputy Director: Nursing, Groote Schuur Hospital Region
- Dr R O Simpson, Chief Medical Superintendent, Red Cross War Memorial Children's Hospital
- Professor C Karabus, Department of Child Health and Paediatrics, University of Cape Town
- Dr S Fisher, Acting Medical Officer of Health, Regional Services Council
- Permission was sought from Dr M Popkiss, Medical Officer of Health, Cape Town City Council, but this was withheld.

The annual reports of the Medical Officer of Health of the Cape Town City Council, the Medical Officer of Health of the Divisional Council of the Cape (and later the Western Cape Regional Services Council), the Red Cross War

Memorial Children's Hospital and the Department of Obstetrics and Gynaecology, University of Cape Town, for the period 1984-1988 inclusive were used. This time period was chosen so that the health data of two complete years before and after the unrest of mid-1986 could be scrutinised and baseline patterns identified.

Health data relating directly to services offered almost exclusively by nurses or midwives were selected so that the impact of nurses' activities on health could be assessed. As doctors are actively involved in the service offered by the Day Hospitals, it was not appropriate to include these data even though the nurses in that organisation had participated in the initial survey of nurses.

The following monthly data for the period 1984-1988 were collected:

- Midwife Obstetric Units - antenatal booking and clinic attendance
- babies born before arrival
 - deliveries
 - perinatal deaths
 - home visits
 - infants requiring phototherapy

The number of women booking antenatally each month is included in the total antenatal clinic attendance figures for each month. This is also reflected as a fraction of the total antenatal clinic attendance data.

The perinatal mortality rate for each MOU was calculated as follows

$$\frac{\text{number of stillbirths and early neonatal deaths} \times 1000}{\text{total number of deliveries}} \quad 1$$

where stillbirth is defined according to the World Health Organisation viz. a mass of 1000g or more (WHO, 1974). (This contradicts the definition of stillbirth in the Births, Marriages and Deaths Registration Act No 18 of 1963 which defines stillbirth as "viable but showed no signs of life after complete birth" and viability as "at least six months of intrauterine existence" (Taitz & Clow, 1988), but does allow for information to be more readily compared internationally). Stillbirths that occurred after the mother was transferred to the base hospital are excluded. Early neonatal death is defined as death occurring in the first week of life.

It was planned to collect weekly data on home visits and deliveries during the periods of major disruption, but this information was not available as it was destroyed after being collated.

It was possible to check the reliability of the MOU data as records are kept by both midwifery and medical personnel.

Data were collected from each MOU and considered in relation to the level of violence in that community. Trends over the five year period were observed. When necessary, clarification was obtained from nursing,

obstetric or paediatric records, or in discussion with appropriate maternity service personnel, for any significant alteration in the pattern.

Community Services

- TB notifications and clinic attendance
- STD clinic attendance
- family planning
- home visits
- well baby clinic attendance (includes immunization)

Home visits included all aspects of the service that took place outside the clinic, i.e. TB domiciliary treatment, TB contact follow up, STD contact follow up, services delivered from mobile vehicles on farm runs. Well baby clinic attendance figures include physical assessment, immunizations and creche visits.

Data on children up to the age of 5 years were included as the health of these children is monitored by the "well baby" clinic service and any disruption of these services might be reflected in an altered pattern of health data.

Data relating to the community health clinic services of the Western Cape Regional Services Council were collected from seven clinics. These serve an area to the south of the Bellville South (industrial) railway line (Map 3), which approximates the area studied in the nurses' survey and the service boundaries of the MOUs in the Peninsula Maternal and Neonatal Service. Trends were observed over

the five year period and related to the level of violence in that community.

The data of these comprehensive health clinics and of the midwife obstetric units were compared in order to establish if effects in one service were reflected in the other service.

Red Cross Hospital - neonatal jaundice) outpatient
- ophthalmia neonatorum) and admission
- umbilical sepsis) figures

Data regarding infants requiring phototherapy were collected from Red Cross Hospital and from the community neonatologist in the PMNS, in order to present a comprehensive picture.

The data on Ophthalmia Neonatorum and Umbilical Sepsis were expressed as rates in relation to the total number of births in the PMNS each month, i.e. MOUs and referral hospital births included.

Neonatal data from the Red Cross Children's Hospital were considered in relation to the MOU health visiting data as the majority of neonatal problems are usually referred to Red Cross Children's Hospital from the MOUs when midwives do follow up home visits in the seven days after birth.

The areas defined earlier as high and low impact in the nurses' survey were retained in this section of the study.

CHAPTER 4 FINDINGS

4.1 Nurses' Survey 1986

4.1.1 Response

226 questionnaires were distributed and 174 returned - an overall response rate of 76.9%. Of these, thirteen nurses were unable to complete the forms because they were newly employed in the Cape Peninsula. The analysis is, therefore, based on a total of 161 respondents.

Since the questionnaire was anonymous it was impossible to establish which individual nurses were non-responders. Information regarding response is given in Table 1. The response rate for the MOUs (95.7%) was higher than that obtained in the Day Hospitals (68.4%). Figure 1 indicates the responders' locations by service and impact area. Further detailed information about non-responders is contained in Appendix B.

4.1.2 Domestic Characteristics of Nurses

131 nurses were mothers who had their children living with them. Of these, fifty-two had children of preschool age (i.e. less than 5 years old) and ninety-nine had school-going children. This information is summarized in Table 2.

Of the fifty-two mothers of pre-school children, twelve (23%) required alternative arrangements to be made for their children's care in 1986. As these alternative arrangements were made throughout the year and cannot be linked to civil disruption, it is considered to be not significant to this study.

Of the ninety-nine others with school-going children twenty-two had a total of thirty-five children who were unable to get to school during 1986. Twenty-six of the thirty-five children did not attend school because their mothers perceived that there was a danger due to unrest, while four children were at schools involved in the schools' boycott. Illness accounted for most of the remaining five children who were unable to get to school during months other than May and June 1986.

4.1.3 Travel Factors

Twenty-five (15%) respondents stated that they had had to make alternative travel arrangements during 1986. Seven of these were unrelated to unrest. The remainder stated that the need for these arrangements occurred in May, June or July. Table 3 indicates that most nurses requiring alternative arrangements worked at Heideveld/Hanover Park MOU or Guguletu Day Hospital.

The information gathered regarding normal modes of transport to work is most interesting. (Figure 2) 40% use their own car and 37.7% walk at least part of the way. A total of 28.2% are normally reliant on public transport. When personal safety is endangered and normal modes of transportation are unreliable during periods of civil disruption, the journey to work might be undertaken with great difficulty.

One respondent stated that because there was no transport available from her place of residence to place of work, she had gone to work at the clinic nearest to her home.

Of the twenty-two nurses who had stated that they had been discouraged from going to work during 1986, four were from the Retreat centres. Further questioning regarding safety at work revealed that only the MOU staff of Hanover Park and Heideveld were unanimous in stating that they felt safe at work.

It is noteworthy that twelve of the twenty-two respondents discouraged from attending work felt either unsafe or very unsafe both on the way to work and at work. Of the remainder more felt a greater degree of safety at work than on the journey to work. Only three felt safe in both situations. The information is summarised in Table 4.

Comments regarding nurses' perception of their safety en route to work can be found in Appendix C.

4.1.4 Personal Factors

Only those nurses working in voluntary organisations such as St. John Ambulance and SHAWCO had provided care from home. Two of the four respondents had given help with first aid and nursing a sick person at home.

Following the pilot study it was felt that there might be specific health problems related to the civil disruption which might affect an individual's ability to cope with their work. When asked, nine respondents (5.5%) said that there had been a reason, other than personal illness, that made them stay away from work. However, no temporal pattern could be established as the months stated were scattered throughout the year, and five reported the illness of their child being the reason for staying away.

Nurses are easily recognisable by their uniform. Given the fact that there was a stayaway proposal in June 1986, the nurses were asked if they ever felt it was necessary not to wear their uniform. Ten nurses, all from Heideveld/Hanover Park or Guguletu, gave positive answers indicating that this decision

was made during June and July. The reasons given were intimidation during stayaway (6), identification as government workers (3), while one nurse supported the stayaway.

Twenty-two (13%) recorded that they were discouraged from going to work during the year. Of these, seventeen stated that this occurred during June. Most were from Heideveld/Hanover Park or Guguletu.

4.1.5 Work Factors

Having given information regarding the effect of civil unrest on nursing personnel at home and en route to work, the respondents were asked questions pertaining to their situation at work.

Of the eleven (7%) respondents who answered that there were difficulties entering the place of work during 1986, most referred to difficulties in getting to work, e.g. transport limited, burning tyres blocking the roads.

4.1.6 Disruption to Nursing Services

The questionnaire established which services were offered by the various organisations. Some offered more than one service and the details are recorded in Table 5.

Twenty-eight (17%) nurses reported some aspect of their nursing services was stopped during 1986 with home visiting being the most affected. The reason for this was the situation prevailing in the residential areas, as other services offered from the clinic or MOU were able to continue.

Sixteen of these twenty-eight respondents stated that June had been the month when services were curtailed and with the exception of two nurses, all were satisfied with the decision made by the employing authority to stop services. The NY3 satellite antenatal clinic in Nyanga (serviced by staff of this MOU) was closed during periods in May and June 1986 and therefore those patients were seen at the MOU. Four of the ten respondents from Guguletu Day Hospital reported that clinics and well-baby clinics were stopped, and one stated that the sexually transmitted diseases clinic service had been curtailed.

It was also important to ascertain if additional work pressures were placed on the nurses who maintained services throughout the period of heightened unrest. As nurses in the employ of the local authorities (Cape Town City Council and the Divisional Council) were precluded from participating in this study, information about disruption of these services was obtained from nurses working in proximity to them.

At Retreat MOU, five nurses answered that other health services had been curtailed. Two of these referred to other services offered by the MOU. The other three stated that clinics and well-baby clinics were curtailed for short periods and the impact on the MOU was that of having to provide care outside the normal service offered by the MOU. This was borne out by the comments of the nurses at the Retreat Day Hospital. One respondent pointed out that they had to "treat patients who were on daily tuberculosis regime."

The responses from Heideveld MOU were similar to those from Retreat MOU.

It was possible to establish the level of functioning of the Cape Town City Health Department and Divisional Council of the Cape Health Department when the annual reports became available. Details of Divisional Council clinic function can be found in Chapter 4.2. The Cape Town City Council Medical Officer of Health, in his 1986 annual report, stated "The first 6 months of 1986 was a turbulent period with civil unrest continuing until June, when the State of Emergency (which had been lifted) was declared anew. No clinic sessions were ever abandoned (my emphasis), however, though sometimes steps had to be taken to protect life and property." (Cape Town City Council Medical Officer of Health, 1986)

4.1.7 Ancillary Services

Certain services are essential to the smooth functioning of a built-up area whether residential or industrial. **Were** any of these interrupted during the year? At Retreat, **where** there was minimal civil disruption, four nurses at the MOU reported electricity cuts during August and September. One nurse at the Day Hospital reported disruption of the refuse removal and ambulance services, but gave no details. The information regarding curtailed services is summarized in Table 6 Heideveld/ Hanover Park MOUs and the Guguletu Day Hospital experienced the most disruption to a range of ancillary services particularly during June and July.

4.1.8 Nurses' Assessments

With curtailment of essential services, difficulties relating to their home situations, personal danger en route to and at work, and an increased and unexpected workload, were the nurses able to maintain their usual standard of care? 115 of the 161 respondents (71 %) said that they were able to do so.

Superficially this appears to be a satisfactory situation. However, forty-seven respondents (29%)

felt they were unable to maintain their usual standard of care. Of these, twenty-five (53%) were from the midwives' obstetric units (Figure 3). Undoubtedly this was due to the fact that nurses were unable to fulfil their normal duties, i.e. home visits to new mothers and neonates - duties which are perceived by the midwives to be a vital service.

The four nurses from Retreat MOU who confirmed that clients were prevented from attending the service, referred to the incomplete home visiting programme following discharge of the mother and infant after delivery. The only nurse from the Day Hospital at Retreat to respond similarly was a senior member of staff who stated, "During May, June and July 1986 patients were too scared to leave their homes to come to work" (sic). Of the nineteen respondents from Heideveld/Hanover Park MOUs (high impact area) who stated that this had been the case, twelve were from Heideveld closest to the violence. Three respondents of the ten from Guguletu Day Hospital confirmed that patients were prevented from attending the service.

(Detailed information regarding MOU home visits can be found in Chapter 4.2.)

Of the remaining Day Hospitals' respondents, eleven stated that patients had been prevented from

attending the service offered, and of these, eight stated that June was the affected month.

Figure 3 records the responses of nurses to the quality of service offered during this time.

4.1.9 General Comments

Suggestions made by nurses regarding measures that could facilitate their work, should the unrest situation occur again, were made by 70.4% of respondents. They range from the very practical to the idealistic dream of peace.

Quotes that are taken directly from the questionnaire are recorded in Appendix D. They pertain to Emergency Planning/ Facilities, Security and Transport, Identification, Commitment/ Communication, Political and Police Activity, First Aid, Employer Attitudes.

4.2 Health Data 1984-1988

4.2.1 Midwife Obstetric Units

Low impact area - Retreat

The antenatal clinic attendance pattern (Figure 4) illustrates the protocol for antenatal clinic

attendance introduced in October 1985 (Chapter 5.2.1; Appendix E). The booking rate remained unchanged while the total attendances pattern took several months to re-establish an equilibrium.

The number of deliveries (Figure 5) decreased over the 5 year period from 130 - 110 per month. There were regular peaks in August/September of each year. This corresponds to (i) a nine month gestation following the end of year holidays and (ii) the significantly lowered attendance at the related RSC family planning clinics of Constantia (Figure 35), Hout Bay (Figure 37) and Grassy Park (Figure 41) in December (this is in part due to the number of public holidays in December when clinics would be closed). The proportion of infants born before arrival (BBA) in relation to the total deliveries is constant (Figure 6).

Midwives are expected to attend women for seven days following the birth (SANC, 1974). One would, therefore, expect the number of home visits to be proportional to the number of deliveries. However, patients delivered in a base or referral hospital would be discharged to the MOU for postnatal follow-up until the completion of the 7 days. Therefore, the rise in home visits (Figure 7) in the face of a constant delivery rate, i.e. March, June, September 1984 is not notable. However, the

opposite pattern evidenced in September 1985, July - August 1986 and February - April 1987 requires explanation.

The perinatal mortality rate illustrated in Figure 8 is not unexpected. In view of the small denominator (between 110 and 170) a change of 1 or 2 deaths in the numerator would result in a large change in this rate as can be seen in June and December 1987.

High impact area - Hanover Park

The antenatal clinic attendance pattern (Figure 9) illustrates the amended attendance protocol, but a stable baseline is not established prior to the opening of Mitchell's Plain MOU in November 1986. Decreased attendances in January and September 1985 and a sustained low level July - October 1986 are noteworthy. When one considers the growth of the Mitchell's Plain MOU service (Figure 10) it appears that a functional baseline is established by June 1987. When viewing the combined operations of Hanover Park and Mitchell's Plain (Figure 11), this is confirmed.

The number of deliveries (Figure 12) remained constant between 250-300 per month. However, the largest number occurred between June and August 1986. This may be explained by the particularly low

attendance at the related RSC family planning clinic at Philippi in September 1985 and the following two months (Figure 52). The number of babies born before arrival (Figure 13) remained relatively constant with minor increases in April and September 1985.

When considering postnatal home visits in relation to deliveries (Figure 14), there is a dramatic drop in home visits September - November 1985. This was due to the fact that the Peninsula Maternal and Neonatal Service (PMNS) management decided to stop home visits for large portions of this time due to unrest and the perceived danger to midwives. During May - July 1986, there is a constant level in the number of home visits in the face of a small increase in deliveries. It was not possible to get any further details of the number of visits each week as those records were no longer in existence.

The perinatal mortality rate is of little value for the same reasons as discussed previously and no major change is apparent over the 5 year period (Figure 15).

High impact area - Heideveld

The impact of the revised antenatal protocol is less obvious here than at the other two centres.

However, the baseline for attendances in 1987 is lower than in preceding years and in 1988 a further lowering due to the opening of Khayelitsha can be seen (Figure 16). The number of bookings has some variation, but is reasonably constant. However, there is one three month period where the bookings are depressed, May - July 1986. In the three months following there is an associated increase, a "catch-up" effect on bookings. Other months indicating low levels of booking relate to the end of year holiday period and closure of clinics, i.e. December 1984-1987 inclusive. This is also apparent in the antenatal visits - December 1984, 1986, 1988 (December 1987 is confounded by the opening of Khayelitsha MOU in November 1987.)

There is a marked decrease in antenatal attendance (in spite of constant booking levels) in July 1984 and August 1985. In July 1984, both population groups served by this MOU had a decrease in attendance of 50%. This was at the MOU itself and not at the satellite clinics (Figure 17a). In August 1985 the decrease was apparent at each centre and was due to the fact that the clinics were closed. In June and July 1986 there was a sustained low level of antenatal attenders seen - this was evident at all three centres in June (Guguletu was closed for periods, as was Crossroads) and at the MOU itself in July. The population distribution

shows that only 20% of the monthly average of Black women attended at this time. Unlike booking visits, it is not possible to "catch-up" antenatal visits which have been lost due to curtailed services. The drop in the number of women attending the antenatal clinic in November and December 1987 (Figure 17b) relates to the transfer of women in the Khayelitsha MOU in November 1987 who had previously attended at Heideveld MOU. The antenatal clinic attendance figures soon increased when a satellite clinic was commenced at Langa and a similar number of women attended this as had attended the Khayelitsha clinic offered at Heideveld.

The delivery data (Figure 18) show a marked drop in deliveries from November 1987 which corresponds with the opening of Khayelitsha MOU. The anticipated peaks in September 1984 and 1985 are apparent, but in October and November 1986 and February 1987 there is a distinct drop in deliveries which cannot be accounted for. The low attendance at the related RSC family planning clinic at Crossroads in March 1984 (Figure 65) may explain the unusual peak in deliveries in December 1984 and January 1985.

The pattern of babies born before arrival (Figure 19) fluctuates throughout the five year period. Any major change could be significant - a greater proportion than usual would be anticipated when

transport and access to the MOU is difficult. A lower number coupled with a fall in deliveries might indicate that babies are being born at home and then not being brought to the MOU. October 1985, September and October 1986 might indicate problems existing in the community.

By contrast, the home visits undertaken by the midwives at Heideveld MOU show major decreases in July 1984, August - October 1985, June - August 1986 and March - April 1987 (Figure 20). In July 1984 both population groups served by this clinic had a drop of 40% in home visits. In 1985 (despite the seasonal peak in deliveries) visits to "Coloured" women were slightly increased and visits to Black women were reduced by 20% in August; in September visits to "Coloured" women decreased by 70% and visits to Black women by 80% and in October visits to both groups were 50% below the average. The nursing records indicate that during each of these periods home visits were restricted due to the level of violence in these areas.

The Perinatal Mortality Rate (Figure 21) is reasonably constant 1984-1987, but illustrates an increase in 1988. In this case the denominator decreased as women moved to Khayelitsha MOU for their deliveries but the same number of perinatal deaths were occurring at Heideveld MOU resulting in the increase in the perinatal mortality rate.

Units commissioned since 1986 survey

Mitchell's Plain

This unit relieved Hanover Park MOU of a large population which was geographically far removed from Hanover Park.

The antenatal clinic became established quickly and has exhibited a consistent and stable booking attendance (Figure 10). When viewing the number of patients delivered each month alongside the deliveries undertaken by Hanover Park, it can be seen that there was no period when patients were "lost" (Figure 22). The seasonal peaks (August - September 1987 and 1988) are present (Figure 23), but an unexpected slump occurred in April 1988 and can also be found in the antenatal attendances. There is no corresponding health data available to this study as Mitchell's Plain falls under the jurisdiction of the Cape Town City Health Department. Home visits follow delivery rates in a logical and appropriate manner.

Khayelitsha

This unit relieved the Heideveld MOU of patients who had previously had to travel long distances to obtain midwifery care. Like Mitchell's Plain MOU the previous year, this unit was soon operating a busy

service. April 1988 showed a marked drop in antenatal clinic attendances (Figure 24) as did the figures for Mitchell's Plain. Deliveries initially complemented the data of the Heideveld MOU (Figure 25), but within a year of opening, both units were delivering a similar number of babies each month. The expected peak in September 1988 occurred (Figure 26).

4.2.2 Red Cross Hospital

Neonatal jaundice

Data were collected on neonates whose condition required phototherapy treatment. Until the end of 1986, this was offered exclusively by Red Cross Hospital. From Figure 27 it can be seen that there was a sustained decrease in the number of infants receiving phototherapy at Red Cross Hospital, particularly from October 1985 onwards.

In January 1987 Hanover Park and Mitchell's Plain MOUs commenced a phototherapy service, and a similar service was started at Khayelitsha MOU when it was commissioned in November 1987, which accounts for the reduced demand on Red Cross Hospital.

Ophthalmia Neonatorum

Prior to 1986 the diagnosis coding system for

outpatients was broad (refer to Chapter 5.2.1) and was therefore excluded for the purpose of this study. Hence the changed pattern for ophthalmia neonatorum from January 1986 can be noted (Figure 29a) when the same coding system was used, and both inpatient and outpatient data were included. There are 2 peaks in the number of patients seen with this condition (February/March and August 1986) and there is generally a greater number in 1986 than in the following two years. This pattern is also apparent in Figure 29b which illustrates the rate of ophthalmia neonatorum per 1000 neonates. The rate is particularly increased in August 1986 following a lower level in June and July than normal. Such a low level was not evident until a year later at a time when the baseline was moving downwards.

A noticeable drop can be seen during June and July 1986 of patients admitted to hospital and those treated in the outpatient department (Figure 29a). More detailed information regarding the type of ophthalmia neonatorum (gonococcal or non-gonococcal) is available in Figures 30 and 31. The apparent inversion of the figures of the two types in the data for outpatients in 1988 is partially explained by the introduction of improved transport media resulting in an increase in diagnosis of gonococcal over non-gonococcal ophthalmia neonatorum.

Umbilical Sepsis

Outpatient data is recorded from 1986 (Figure 32a) and shows a slight downward trend throughout 1986, with the exception of June and August when significantly fewer infants were treated for umbilical sepsis in the outpatient department. There was no corresponding change in the pattern of admissions for this condition during the same time period.

During 1987 and 1988 the numbers of infants requiring treatment was lower than in 1986, and a new feature is that a number of months show no admissions for treatment, only outpatient treatment. The data indicate that fewer than five infants received outpatient treatment for umbilical sepsis during February 1987 (this coincides with curtailed home visits from two MOUs) and September 1987 as well as January and October 1988, for which no relationship to the MOU service can be established.

The same features are found in the rate of umbilical sepsis (Figure 32b). Months during which lower rates are evident, i.e. January/February, June, August 1986 and February 1987 are followed by a sharp increase in March, July, September/October 1986 and March 1987, and correspond to months when the level of civil violence was high and home visits were curtailed.

The variation in rates from the end of 1987 through 1988 are less extreme.

4.2.3 Community Services

In order to maintain a pattern in the way data are presented, particularly for readers unfamiliar with the Cape Town area, community services' data will be presented to approximate the areas serviced by the Midwife Obstetric Units, with due regard for those experiencing high impact or low impact violence.

Low Impact Area

The area covered by the Retreat Midwife Obstetric Unit encompasses the Regional Services Council clinics of Constantia, Hout Bay and Grassy Park.

In December there are three public holidays resulting in decreased clinic activities. This pattern is shown classically at Constantia - TB, child health, family planning (Figures 33-35), Hout Bay - TB, child health, family planning (Figures 36-38), Grassy Park - TB, child health, family planning (Figures 39-41). The exception is the child health clinic attendance at Hout Bay which does not exhibit this pattern in 1987 and 1988.

Generally TB notifications are relatively low,

particularly in view of the fact that the Western Cape has one of the highest incidences of TB in the country (RSC MOH 1987). No significant pattern emerges from these three clinics (Figures 42-44).

A pattern of peaks in TB attendances is noted at Constantia for May 1984, 1985 and 1986 and at Grassy Park in May 1985 and 1986. At Hout Bay there is generally a higher attendance between May 1985 and October 1986, than at other times during the period under review. Grassy Park shows TB attendance to be gradually increasing.

Child health attendances (which include immunization and creche visits) do not reveal a consistent pattern. Grassy Park reveals a slight increase over the five year period. Hout Bay shows a marked drop in attendances between December 1987 and October 1988. Constantia also exhibits a decrease over the same period, although the pattern is not as marked as Hout Bay.

Family planning attendances remained fairly constant at Constantia and Hout Bay, but there was a marked decrease at Grassy Park during the period August 1985 - August 1987. A drop in attendances in December of each year was noted at each centre and had an impact on the delivery pattern at Retreat MOU (refer to Chapter 4.2.1). Attendance at the Sexually

Transmitted Disease clinic is relatively low and the data are non-contributory.

Home visits include follow-up visits for TB and STD contacts, domiciliary TB treatment, mobile farm runs and newborn visits. There is no correlation between home visits from Retreat MOU (Figure 45) and those co-ordinated by the three clinics in this area (Figure 46-48). Unlike MOU visits which are structured in relation to deliveries, these home visits are of a more dynamic nature. "Farm run" routes change from time to time resulting in changes in attendances. No pattern emerges from the figures collected for these three clinics which would indicate strategic events.

High Impact Area

The area served by Hanover Park Midwife Obstetric Unit includes that of the Regional Services Council Philippi clinic. The area of the most intense political violence affected the north eastern parts of Hanover Park whereas Philippi falls into the south eastern corner of the Hanover Park MOU area (Map 4). The Heideveld Midwife Obstetric Unit serves the area of Nyanga, Crossroads and Khayelitsha. The two areas will be discussed separately to enable comparisons to be made with MOU data.

Philippi

Over the 5 year period TB notifications (Figure 49) generally remained between 5 and 15 per month. There is a dip in each December which is not unexpected. TB attendances (Figure 50) show a tendency to peak in midyear. Although this occurs in July 1986 there is a marked decrease in attendances in June 1986 as well as in September 1984.

From August 1984 the baseline for child health attendances lowered (Figure 51) to a new level in 1988. Apart from the dips in December each year, low levels of attendance were recorded in September 1985 and June 1986. Family planning figures (Figure 52) show some fluctuations - a generally low level from September 1985 to August 1987 followed by an upward movement of the baseline. Apart from the increase in deliveries at Hanover Park MOU between June and August 1986 (Figure 12) due to the low level of family planning clinic attendances in September 1985, the generally low level of attendances does not appear to have had any major impact on the number of deliveries.

Nyanga, Crossroads and Khayelitsha

From March 1985 - December 1986 TB notifications in Nyanga (Figure 55) exhibit a "see-saw" pattern within

the range of 60-90 per month with some exceptions, and thereafter fluctuates. Months during which there were fewer notifications were June, July and September 1985, June 1986 and July 1987. These coincide with periods of civil disruption. The expected drop in December occurred in 1985, 1986 and 1987.

TB attendances (Figure 56) were depressed from August 1985 - February 1987, particularly August - November 1985 which coincides with the drop in TB notifications.

Child Health attendances (Figure 57) exhibit the opposite with a sustained rise May 1985 - February 1987. Slightly depressed figures evident in each December are not unexpected. The attendance figures of May - August 1986 are noteworthy as being depressed within a normally high level. These coincide with the period of increased violence in 1986.

Family planning clinic attendances (Figure 58), although reasonably constant, show fluctuations during the disrupted period March - September 1986 with marked slumps in March, June, August and September. The effects of this can be seen in the number of deliveries at Heideveld MOU nine months later (Figure 18).

The record of STD clinic attendances (Figure 59), exhibits an extraordinary fluctuation with no pattern being evident. Slumps are apparent in December 1984, 1985, 1987 and 1988. Other months that show a sudden drop in attendance are September 1985 and June 1986 which correspond to the periods of major violent disruption. Although it is not possible to indicate such a direct relationship between STD clinic attendance and ophthalmia neonatorum as one can between family planning clinic attendance and the number of infants delivered, two of the three peaks in neonates requiring treatment for ophthalmia neonatorum occurred in February/March and August 1986 (Figure 28) and may bear some relationship to the decreased attendances mentioned above.

Home visits in the Nyanga area (Figure 60) do not display a recognisable pattern. However, the number done during 1985 and 1986 are low particularly during September 1985 - January 1986 and June 1986. As home visits include the follow-up of TB contacts which would lead to TB notification, these depressed figures for September 1985 and June 1986 correlate with the decrease in TB notifications.

As at Nyanga, the TB notifications at Crossroads (Figure 61) are very low during 1984. Thereafter no specific trend can be identified, but there was a sustained drop from April - August 1986. From

January 1984 - April 1986 the TB clinic attendance (Figure 62) showed a gradual increase except for the three month period July - September 1985. The attendance during May, June and July 1986 was diminished and from January 1987 a new baseline is established showing an increase in 1988. Civil violence and major relocation of people could account for these changes. The solitary peak in December (unusual) may be due to an influx of visitors to the area, but this is not borne out by other parameters measured.

Child health attendances (Figure 63) exhibit the usual December drops. Generally the levels are depressed from February 1985 - January 1988. This can be explained by the establishment of health services at Khayelitsha, particularly child health services (Figure 64). However, at Crossroads the leanest periods in terms of child health clinic attendance were June 1986 and May 1987. One is aware of the dynamics in the community during June 1986, however in May 1987 there was a period of one week when there was a lot of "activity" in the Guguletu area bordering Crossroads, and public transport was nil (RSC records unpublished). Although new settlers moved into the area during 1987 (RSC MOH, 1987) their use of services is not apparent until 1988 (Figures 62 and 63). This would indicate that it takes time for settlers to become orientated to the services available and to become users.

The pattern exhibited by the family planning figures (Figure 65) is the opposite of any other figures emanating from Crossroads. There are minor dips in December of each year and a sustained decrease June - September 1986 which is consistent with other findings. It matches that of Nyanga (Figure 58) and also supports the effect on the Heideveld MOU deliveries (Figure 19). The marked increase in Figure 65 from January 1987 onwards is remarkable.

The Sexually Transmitted Diseases clinic attendance at Crossroads (Figure 66) shows a dramatic drop June - September 1986 and thereafter establishes a new baseline. Civil disruption and relocation could account for these changes. The STD clinic attendance at Khayelitsha (Figure 67) is complementary. One should also note the decrease in STD clinic attendances at Crossroads for the period July - October 1985 which would reflect the previous period of disruption and, as suggested when considering figures from Nyanga, may contribute to the increased need for treatment of infants with ophthalmia neonatorum.

Home visits did not form a major part of the work at Crossroads (Figure 68). It was noted in the Annual Report for the Divisional Council of the Cape (1986:136) that it was difficult to trace TB or STD contacts because of the destruction of homes and the fleeing population.

Although one would expect an overall increase in attendances in Khayelitsha once people had moved there, this is not the case in STD or TB clinic attendances (Figures 67 and 69) although child health attendances (Figure 64) did increase. One needs to consider factors of orientation and trauma due to the nature of relocation. Although the clinics continued operating in Khayelitsha throughout this time, nurses reported that they had to get out and tell the community that the services were being offered (Figure 70) (RSC unpublished). A combination of fear and ignorance probably led to the inconsistencies in the levels of clinic attendance.

4.2.4 Summary of Findings

The goal has been to describe the effects of civil violence on nursing services and in accordance with the definition this means any alteration from the normal pattern.

A summary of the data presented above is set out in Table 7. This isolates the indicators of a disrupted service in each area with reasons for the disruption where possible. This information has been taken from nurses' reports. The effect of this disruption on health is also given with cross-references to the text and the data.

TABLE 7 : SUMMARY OF THE EFFECTS OF DISRUPTED COMMUNITY NURSING SERVICES DURING CIVIL UNREST

TIME	PLACE	REASON	INDICATOR	REFERENCE/ FIGURE	EFFECT	REFERENCE/ FIGURE
Dec 84-88	Constantia Hout Bay RSC Grassy Park	Public holidays	1family planning	4.2.3/35-37	1 deliveries R MOU Aug/Sept 85-88	4.2.1/5
Dec 84,85,87,88 84,86 85,86,88	Crossroads Nyanga RSC Khayelitsha	Public holidays	ifamily planning	4.2.3/65,58,71	'tdeliveries HV MOU Sept 85,87, Jul-Sept 88 K MOU Sept 88	4.2.1/19 4.2.1/26
Dec 86	Philippi RSC	Public holidays	tfamily planning	4.2.3/52	1 deliveries HP MOU Aug-Oct 87	4.2.1/12
Dec 84,86,88	Heideveld MOU	Public holidays	iantenatal attendance	4.2.1/17		
<u>1984</u>						
March	Crossroads RSC		i family planning	4.2.3/58	1 deliveries HV MOU Dec 84/Jan 85	4.2.1/19
July	Heideveld MOU		i antenatal attendances (MOU)	4.2.1/18		
			l home visits	4.2.1/72		
September	Philippi RSC		i TB attendance	4.2.3/50		

TIME	PLACE	REASON	INDICATOR	REFERENCE/ FIGURE	EFFECT	REFERENCE/ FIGURE
<u>1985</u>						
January	Hanover Park MOU		1antenata l attendance	4.2.1/9		
June	Nyanga RSC		1TB notifications	4.2.3/55	1 TB notifications "catch-up" Oct 85	4.2.3/55
July	Nyanga RSC		!TB notifications	4.2.3/55	1 TB notifications "catch-up" Oct 85	4.2.3/55
	Crossroads RSC		i TB attendance !STD attendance	4.2.3/62 4.2.3/66	t oph neonatorum Feb/March 86	4.2.2/28
August	Nyanga RSC Crossroads RSC	TB screening facilities unavailable emergencies only transported to distant clinic	! TB attendance i TB attendance	4.2.3/56 4.2.3/62		
			i STD attendance	4.2.3/66	t oph neonatorum March 86	4.2.2/28
	Hanover Park MOU	civil strife - clinics closed - visits restricted	J.antenatal attendance home visits	4.2.1/17 4.2.1/72		
	Heideveld MOU	civil unrest - clinics closed	antenatal attendances	4.2.1/17		

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TIME	PLACE	REASON	INDICATOR	REFERENCE/FIGURE	EFFECT	REFERENCE/ FIGURE
<u>1985</u> (continued)						
September	Philippi RSC	Threats to property - roads closed	J, family pJanning	4.2.3/52	'ideliveries HP MOU June-Aug 86	4.2.1/12
			i child health	4.2.3/51		
	Retreat MOU	boycotts [school and consumer]	i home visits	4.2.1/45		
	Nyanga RSC	facilities unavailable emergencies only trans- ported to distant clinic. transport difficult stone throwing - no bus service	iTB notifications	4.2.3/55	t TB notifications "catch up" Oct 85	4.2.3/55
					i TB attendance Sept-Nov 85	4.2.3/56
			TB attendance	4.2.3/56		
			J,STD attendance	4.2.3/59	l oph neonatorum Feb/March 86	4.2.2/28
		Clinic vandalised	home visits	4.2.3/60	J TB notifications Sept 85	4.2.3/55
	Crossroads RSC	Transport difficult - stone throwing	i TB attendance	4.2.3/62		
			J,STD attendance	4.2.3/66	'toph neonatorum Feb/March 86	4.2.2/28
Hanover Park MOU	civil violence ban on home visits	l antenatal attendance	4.2.1/9			
		i home visits	4.2.1/73			
Heideveld MOU	civil violence home visits restricted	i home visits	4.2.1/72			
October	Heideveld MOU		i BBA	4.2.1/19		
			J,home visits	4.2.1/72		
	Nyanga RSC	Facilities unavailable Transport to distant clinic	1 TB attendance	4.2.3/56		
	Transport difficult Clinic closed 23/10	i home visits	4.2.3/60			

TIME	PLACE	REASON	INDICATOR	REFERENCE/FIGURE	EFFECT	REFERENCE/FIGURE
<u>1985</u> (continued)						
October (continued)	Crossroads RSC	No staff, few patients no transport, area "on fire" 8/10	t STD attendances	4.2.3/66	f oph neonatorum Feb/March 86	4.2.2/28
	Hanover Park MOU	Civil violence - ban on home visits	lhome visits	4.2.1/73		
November	Hanover Park MOU	Civil violence - ● ban on home visits	lhome visits	4.2.1/73		
	Nyanga RSC	Facilities unavailable - transport to distant clinic ● lolc , ,odallsed - no thoroughfare Funeral marches	i TB attendances ! home visits	4.2.3/56 4.2.3/60		
December		Mobile clinics targetted	lhome visits	4.2.3/60		

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TIME	PLACE	REASON	INDICATOR	REFERENCE/ FIGURE	EFFECT	REFERENCE/ FIGURE
<u>1986</u>						
January	Nyanga RSC	District service curtailed end January	thane visits	4.2.3/60	t oph neonatorum Feb/Mar & Aug 86	4.2.2/28
March	Nyanga RSC	Situation tense	lfamily planning	4.2.3/65		
April	Crossroads RSC	Public transport unsafe District service curtailed	}TB notifications	4.2.3/61	tTB attendance May 86	4.2.3/62
May	Crossroads RSC	Shooting in Crossroads staff sent home Closed for various periods during this month. No clients Staff to help at Red Cross tents	iTB notifications	4.2.3/61		
			iTB attendance	4.2.3/62		
	Nyanga RSC	Public transport unsafe Youths continue fighting through clinic. Curative service required	ichi ld health	4.2.3/57		
	Hanover Park MOU		lhane visits	4.2.1/73	tumbilical sepsis June 86	4.2.2/32
	Heideveld MOU		ibooking visits	4.2.1/16	j booking visits "catch-up"Aug-Oct 86	4.2.1/16
June	Heideveld MOU	f Only 20% of the ,,,al Black wanen attenders - suggesting trouble in residential areas	hooking visits	4.2.1/16	i booking visits "catch-up"Aug-Oct 86	4.2.1/16
			iantenatal attendance	4.2.1/17		
			ihane visits	4.2.1/72	l oph neonatorum June/July 86	4.2.2/28
			iTB attendances in spite of usual mid-year (May-Sept) increase	4.2.3/50		
	Philippi RSC		i Child health	4.2.3/51		

TIME	PLACE	REASON	INDICATOR	REFERENCE/ FIGURE	EFFECT	REFERENCE/ FIGURE
<u>1986</u> (continued)						
June (continued)	Nyanga RSC	Few patients arrive. staff had to vacate clinic on various occasions	! TB notifications i Child health ♦ Family planning	4.2.3/55 4.2.3/57 4.2.3/58	1 TB notifications 'catch-up' July 86 1 deliveries HV MOU March-Aug 87	4.2.3/55 4.2.1/19
			!srn I home visits	4.2.3/59 4.2.3/60	1 oph neonatorum Aug 86 I TB notifications	4.2.2/28 4.2.3/55
	Crossroads RSC	Very few patients arrive & staff sent home early on various occasions Staff stopped in Council car and searched by "Witdoeke"	i TB notifications i TB attendance i child health I family planning hrn	4.2.3/61 4.2.3/62 4.2.3/63 4.2.3/65 4.2.3/66	i TB attendance June/July 86 deliveries HV MOU Mar-Aug 87	4.2.3/62 4.2.1/19
July	Hanover Park MOU	Major disruption throughout the month (Cole, 1987)	♦ home visits in the face of a rise in deliveries	4.2.1/73	i oph neonatorum July 86	4.2.2/28
	Heldeveld MOU		.,antenatal attendance	4.2.1/9	f booking 'catch-up' Aug-Oct86	
			i booking visits	4.2.1/17	1 oph neonatorum Jul 86	4.2.2/26
			antenatal attendance	4.2.1/17	t umbilical sepsis Aug 86	4.2.2/32
			home visits	4.2.1/72		
	Crossroads RSC		♦ family planning	4.2.3/65	1 deliveries HV MOU Mar-Aug 87	4.2.1/19
			!srn	4.2.3/66		
			! TB notifications	4.2.3/61	i TB attendance Jul 86	4.2.3/62
			TB attendance	4.2.3/62		
	Nyanga RSC		J Child health	4.2.3/57		
	Retreat MOU		} home visits	4.2.1/45	i oph neonatorum Jul 86 + umbilical sepsis Aug 86	4.2.2/28 4.2.2/32

TIME	PLACE	REASON	INDICATOR	REFERENCE/ FIGURE	EFFECT	REFERENCE/ FIGURE
<u>1986</u> (continued)						
August	Retreat MOU		l hane visits	4.2.1/45	t umbilical sepsis Aug 86 1 oph neonatorum Aug 86	4.2.2/32 4.2.2/28
	Nyanga RSC		i child health i family planning	4.2.3/57 4.2.3/58	1 deliveries Heideveld MOU Mar-Aug 87	4.2.1/19
	Crossroads RSC		i TB notifications i family planning	4.2.3/61 4.2.3/65	't deliveries HV MOU Mar-Aug 87	4.2.1/19
			hrn	4.2.3/66		
	Hanover Park MOU Heideveld MOU		i antenatal attendance i hane visits	4.2.1/9 4.2.1/72	l umbilical sepsis Aug 86 i oph neonatorum Aug 86	4.2.2/32 4.2.2/28
September	Nyanga RSC		Jfami ly planning	4.2.3/58	1 deliveries HV MOU Mar-Aug 86	4.2.1/19
	Crossroads RSC		ifamily planning	4.2.3/65	1 deliveries HV MOU Mar-Aug 86	
			i STD	4.2.3/66		
	Heideveld MOU	t booking visits May-July 86	l booking visits "catch-up"	4.2.1/16		
	Hanover Park MOU		i SBA i antenatal attendance	4.2.1/19 4.2.1/9		
October	Hanover Park MOU Heideveld MOU		t antenatal attendance deliveries	4.2.1/9 4.2.1/19		
		i booking visits May-July 86	t booking visits "catch-up"	4.2.1/16		
November			BBA	4.2.1/19		
	Heideveld MOU		} deliveries	4.2.1/19		

TIME	PLACE	REASON	INDICATOR	REFERENCE/ FIGURE	EFFECT	REFERENCE/ FIGURE
<u>1987</u>						
February	Heideveld MOU		t deliveries	4.2.1/19	lhane visits Mar 87	4.2.1/72
	Mitchell's Plain MOU		t home visits	4.2.1/74	umbilical sepsis Feb 87	4.2.2/32
	Retreat MOU		i home visits	4.2.1/45	umbilical sepsis Feb 87	4.2.2/32
March	Retreat MOU		i home visits	4.2.1/72		
	Heideveld MOU		i home visits	4.2.1/72		
April	Heideveld MOU		i home visits	4.2.1/72		
	Retreat MOU		} home visits	4.2.1/45		
May	Crossroads RSC	civil violence - no public transport	ichild health	4.2.3/63		
<u>1988</u>						
	Mitchell's Plain MOU		deliveries	4.2.1/23		
			i antenatal attendances	4.2.1/10		
	Khaye litsha MOU		t antenatal attendances	4.2.1/24		

CHAPTER 5 DISCUSSION

In this chapter the methodological problems, limitations and implications of the findings are discussed in relation to the 1986 Nurses' Survey, and the health data collection of 1984-1988, which reflects the functioning of the nursing services.

5.1 Nurses' Survey 1986

5.1.1 Methodological Problems and Limitations

This survey aimed to gather information from all nurses employed on a regular basis in the Cape Peninsula. Those who had been called upon to work in a relief capacity were, in some cases, interviewed while the questionnaire was being formulated. However, it was felt that their experiences would not translate adequately in terms of the "normal" situation that had prevailed prior to the socially disruptive events of 1986. These nurses were therefore not included in the survey.

In view of the target population envisaged, it was unfortunate that the Medical Officers of Health for the Cape Town City Council and the Divisional Council of the Cape withheld permission for their nurses to be surveyed. The reason given was that it was felt that participation by their staff in such a

study could jeopardise their safety in the future. Furthermore, the Department of National Health and Population Development considered it unnecessary to participate as they had information available to facilitate the co-ordinated functioning of their nursing services during this period of civil unrest.

In spite of this non-participation the survey was able to cover the same affected geographical areas as are serviced by all health authorities (Maps 3, 4 and 5).

Due to the sensitive nature of this survey, and the tension that existed in many areas of the Cape Peninsula at the end of 1986, it was necessary to implement this study rapidly. There was therefore limited time in which to establish sophisticated measures of validity and reliability. In addition to the attempts made in this regard mentioned in Chapter 3.2, the following should be considered:-

- 1) content validity was established by ensuring that the concepts being investigated were defined and that the information gathered was relevant to these. The pilot study demonstrated that the questionnaire was reliable and valid at this level.
- 2) criterion validity was more difficult to establish as there was not a known valid instrument against which to measure the concepts under scrutiny. However, although multiple measurement has not occurred, trends could be identified within and

between centres involved in the study as well as between the pilot study and the survey.

- 3) In the original project co-ordinated by the Medical Research Council, a community survey was conducted. This is not included in the methodology of this study, but it is possible to ascertain that information submitted by the nurses was often repeated by the householders who were included in the community survey (Yach, 1987). This establishes a measure of reliability.

It is acknowledged that the value of this study would be enhanced with greater attention to these aspects of the methodology. However, the urgency surrounding the implementation of this study precluded this. A repeat survey was considered at the end of 1989, but study leave and year-end vacations of nursing staff would have resulted in a diminished population. The benefits of establishing criterion validity and reliability would have been outweighed by the unavoidably small population.

Later on, during the study of health data, records of the Western Cape Regional Services Council (formerly Divisional Council of the Cape) were made available detailing periods of civil violence that had disrupted nursing services. This information is included in the summary of health data (Table 7, page 98).

The very reason for this survey imposed a limitation. In certain areas there was pressure to conform to the community mores and subsequent pressure on individuals who continued working. Participating in this survey might have been viewed as "informing" against the community and so in a real sense some nurses might have felt vulnerable. The level of response from the nurses working at the Guguletu Day Hospital supports this explanation as this centre was in the area most seriously affected for prolonged periods in 1986.

Since there were repeated reminders to staff to complete and return the questionnaires and repeated visits to each centre, it is unreasonable to assume that forgetfulness contributed to the low response rate from Guguletu Day Hospital.

Many of the respondents from the MOUs did not make use of the anonymous nature of the data collection and left their envelopes unsealed. It is possible that this high response rate from the MOUs (96%) was because the person who distributed the questionnaires to these centres had established professional relationships with many of these staff and a measure of enthusiasm for this study resulted in this trusting response.

For reasons of confidentiality the study could not include a longitudinal survey to assess reliability or validity in the same nurses.

It is apparent that the disruption due to the schools' boycott and the more diffuse civil unrest prevented a few children from attending school. This affected all areas in this study including the "control" groups at Retreat as the schools' boycott was more widespread than was the civil unrest.

It can be seen that the special problems facing epidemiologists during endemic war as discussed by Armenian (1989), viz. difficulty in maintaining detached professionalism, the logistical and methodological problems and dealing with political polarization, were also features of this study.

5.1.2 Implications of Findings

5.1.2.1 Work factors

Home visits were the aspect of services most often affected by the unrest.

Midwives who were forced to curtail this particular service expressed great concern for the welfare of the mothers and babies who had been delivered at MOUs and whom they were unable to follow up and care for once they had been discharged (\pm six hours after delivery). The South African Nursing Council Regulations regarding the practice

of midwives state that a midwife "shall nurse a mother and her infant for seven days following the birth." (SANC, 1974). This is a crucial time for the mother, the infant and the family in establishing emotional bonds and for fulfilling basic physical needs, and the midwife's facilitating and caring role as well as her role as a primary (i.e. first contact) health practitioner are of great importance.

5.1.2.2 Ancillary service

The disruption of these services is disquieting. All are necessary for the smooth functioning of a clinic or health service - a service that is already trying to cope with an unexpected increase in work. Bearing in mind the fact that 10 staff members from Guguletu Day Hospital responded, the replies are noteworthy. Most of the respondents stated June and July to be the months of disruption.

Telephone disruption was mentioned by twelve respondents from all areas. This communication link was essential to summon help or advice to cope with the situation.

There was no explanation as to why it was curtailed.

Eleven of the fourteen nurses who reported ambulance service disruption were working at Heideveld and a number of them mentioned the problems encountered by the ambulance getting into the Black residential areas.

Many ambulance crews were encouraged to accept police escorts when entering unrest areas. Verbal communication with ambulance crews at that time gives the impression that escorts made the ambulances more vulnerable to stone throwing and attack.

The data represented under Hanover Park/Heideveld MOUs mainly refers to Heideveld although answers regarding water, electricity and sanitation were equally distributed. It is worth noting that in spite of the major damage at Heideveld as a result of a burst water pipe (April 1986), the respondents do not mention this as a problem with respect to water supply.

5.1.2.3 Nurses' Assessments of the Services Offered

There was anxiety on the part of nurses that patients/clients were prevented from attending the nursing services offered. The reasons given for patient stayaway from Heideveld/Hanover Park MOJ were lack of transport, fighting in the area, intimidation, (especially on so-called "stay-away" days) and unavailability of the service (NY3 antenatal clinic was closed). Most stated that May, June and July were the problem months and they also confirmed that the ambulance service had tried to ease the transport problem by ferrying patients requiring help, out of the problem areas by bus.

In view of what has been stated earlier regarding the low response from Guguletu Day Hospital nurses, cognisance must be taken of their replies regarding patients not seeking assistance. [Patients were] "afraid of being shot", "would tell you that they were scared of coming to the clinics", "not prevented, but had to give priority to the unrest victims and sometimes [clients] could not be attended at all."

5.1.2.4 Nurses' suggestions for future situations

As one assimilates all the information contained in this questionnaire one can appreciate the difficulties faced by authorities attempting to be responsible employers. Some centres perceive the immediate solutions differently from others and so, in formulating an overall plan for the Cape Peninsula, there would need to be consultation with nurses in each centre in order to achieve consensus.

Some nurses found it difficult to make suggestions and others defy categorisation. It is quite clear that some experienced a terrible ordeal and have expressed a desperate plea for healing in the community.

"I really don't know." [Retreat]

"I hope there will be no need to start again with the unrest." [Heideveld]

"Everything possible was done." [Heideveld]

"I wish that such a thing should never happen again as I felt it's unnecessary and should not be allowed to happen again. We should listen to the Almighty and try and go along with it. It was a terrible experience."

"I think it's difficult for me to suggest in this situation because this affects us in the non-white areas. So whatever you tell your employers at above or top they don't know what you are talking about. They don't feel the pain. Not experiencing what you experience. Because they can 'phone the police to scare while you are at work forgetting that you stay with these people in the location so you are not safe at all. (sic) The only thing I can say the employers must understand."

One is struck by the intensity of feelings of these people, who have had to withstand enormous pressures from several directions both at home and at work. Many expressed their satisfaction verbally when told of this survey.

Nurses made several suggestions as to how they and their work during civil disruption, might be assisted and they were delighted that their opinions were sought. These suggestions are summarised in Appendix D.

5.2 Health Data 1984 - 1988

5.2.1 Methodological Problems and Limitations

Health data included in this project had to meet one criterion, i.e. which specific health parameters might have been affected if nursing services were curtailed? For this reason mortality rates (infant and adult) were not collected as the causes of death are many and do not reflect the specific impact of nurses. Therefore, most of the data is taken from community services, but neonatal figures for Red Cross Hospital are included as these could reflect an impact from curtailed MOU, health clinic and day hospital services.

It has been mentioned in Chapter 3.3 that the definitions of high and low impact violence areas in 1986 were retained for the purposes of the longitudinal study of health data. This has the potential for confounding results as patterns of violence may change in certain areas over time e.g. Philippi (RSC) is served by the Hanover Park MOU. Although the MOU is geographically close to the high impact violence areas and services areas directly affected by the violence, Philippi is far removed to the south-east. The results obtained from Philippi lead one to conclude that it is mainly a rural area with a large amount of health care being delivered

from mobile clinics at farms. Therefore civil disruption resulting from schools or shop boycotts is not likely to have had the same effect on nursing services as an area closer to these facilities might have had. There does not appear to have been a major impact from this area on the midwifery service offered at Hanover Park MOU.

Routinely collected South African health data often lacks reliability. Only registered births and deaths can be used. In addition classification of diagnoses may be incomplete as may be the classification of the cause of death, and the system of classification may change. In order to calculate rates, information is required from the census (Bradsaw et al, 1987). Population figures for the Cape Town Metropolitan area differ by up to 400 000 people! (Dewar et al, 1990). A variety of contradicting population estimates for the Crossroads settlement have been announced over the years (Cole, 1987).

The problems associated with the data used for this study are as follows.

General

The population census figures for the wider metropolitan area of Cape Town are regarded as being

conservative estimates (Dewar et al, 1990 : 6). In addition, the following recent historical events further confound the establishment of workable baseline data.

- (i) While the Influx Control Act remained on the statute books, only "legal" Black urban residents, i.e. those who had attained urban residential privilege through the provisions of Section 10 of the Act, could be included in any census.
- (ii) With the removal of the Influx Control Act in 1985, previously "illegal" Black urban residents were now included in population estimates. In addition, many inhabitants of rural areas and "independent states" joined the exodus to the cities. Various estimates of the impact on Cape Town have been made. (Dewar et al, 1990:9-11).
- (iii) The dormitory township of Khayelitsha was established in 1984. However, as there was an inadequate infrastructure at this time, residents made use of services in other areas, e.g. Khayelitsha women were assigned certain days for clinic attendance at Heideveld MOU prior to the Khayelitsha MOU being commissioned. In 1986, when an estimated

60 000 people were displaced from the informal Crossroads settlement, a second wave of people were relocated to Khayelitsha (Yach, 1987; Cole, 1987).

Midwife Obstetric Units

- (i) Prior to November 1986, there were three midwife obstetric units - at Retreat (established 1978), Hanover Park (1980, although this service was first offered at Mains Avenue in 1974), and Heideveld (1974). In 1980 these facilities were incorporated into the Peninsula Maternal and Neonatal Service (PMNS) which is jointly administered by the Cape Provincial Administration and the Department of Obstetrics and Gynaecology at the University of Cape Town. Taking into consideration the increasing workload on these units, and the large new residential areas being established, two more units were commissioned - at Mitchell's Plain (November 1986) and Khayelitsha (November 1987). These serve women who previously would have attended at Hanover Park and Heideveld MOU respectively.

- (ii) The policy regarding antenatal clinic attendances changed during the period under

review. Previously the frequency of visits followed the protocol suggested by the Ministry of Health in Great Britain in 1929 and adopted by the South African Nursing Council. i.e. once a month until 28 weeks, once a fortnight until 36 weeks and weekly thereafter (SANC, 1974). The revised policy (Appendix E) introduced by the Department of Obstetrics and Gynaecology in 1985, resulted in fewer antenatal clinic attendances despite an ever-increasing number of pregnant patients seen, i.e. a decrease in the average number of attendances per pregnant patient.

Red Cross Hospital

- (i) The introduction of phototherapy treatment at two MCUs in January 1986 and at a third MCU in November of the same year led to a reduction in the number of infants treated at Red Cross Hospital. In addition, the vigorous follow-up of neonates in the community resulted in increased detection and treatment of neonatal jaundice being undertaken at the MCU. This was possible due to the appointment of a community neonatologist (in addition to the neonatology medical officer) as well as increasing use being made of registered midwives with advanced diplomas in midwifery or the certificate in neonatal nursing.

- (ii) Prior to 1986 outpatients seen at Red Cross Hospital had their diagnoses coded according to an internal coding system. As the categories were very broad it was not possible to equate these with the International Classification of Diseases, Version 9 (ICD-9) system introduced at Red Cross Hospital in 1986. It was decided not to include the data prior to 1986 as the results would not be sufficiently reliable to draw any conclusions.
- (iii) It would have been interesting to have data on diagnoses related to geographic areas. The limitations, however, outweigh any anticipated usefulness because:
- a) postal codes may be entered incorrectly at reception and are not validated prior to storing the patient record;
 - b) the most recent postal code is the only one that is stored, e.g. a child who lived in Crossroads in 1986 and moved to Khayelitsha in 1987, will have records reflecting only the Khayelisha code.
- (iv) In order to try and establish a causal link between curtailed MOU home visits and ophthalmia neonatorum and umbilical sepsis it was planned to check the place of origin of the affected infant. However, as has been

elucidated in (iii) above, this information would not be sufficiently accurate to verify this link.

- (v) Although it would appear that conclusions are being made on the evidence of a small data base, it must be remembered that the three parameters in this section of health data, i.e. neonatal jaundice, ophthalmia neonatorum and umbilical sepsis are specific to the neonatal phase. This, therefore, limits the population to infants within the first month of life.

Community

- (i) It was planned to collect health data from both the Cape Town City Council Health Department and the Western Cape Regional Services Council Health Department. Unfortunately permission was withheld from the Cape Town City Council to use any of its data. However, for purposes of this study this has not resulted in a major deficit as most of the violence under scrutiny took place in areas serviced by the Western Cape Regional Services Council, with the exception of Guguletu (see Map 3). All areas south of the Bellville (South Industrial) rail route were included in the data collection.

(ii) During the period under review the residential area of Khayelitsha was being established. Although Khayelitsha itself was not a centre of civil violence in 1986, many of the new residents had been relocated there from the chaos of Crossroads. Some health facilities were initially offered at Crossroads to Khayelitsha residents, and the Heideveld MOU service extended as far as Khayelitsha until a new MOU was opened there in November 1987. Thus the people remained sensitive indicators after their move from Crossroads. Only at the end of the period of data collection is a baseline established. Until that time the data need to be considered in relation to those of Crossroads and Nyanga. They can also be viewed in tandem with the data collected from the Khayelitsha MOU.

(iii) Data were not available in the format required. Once these were obtained there was found to be an unexplained drop in all areas for all services for a 3 month period, October - December 1987. As a result of this study the gap in the database was found and corrected before the original records were destroyed.

5.2.2 Implications of the Findings

It is clear from the information summarized in Table 7 that community nursing services which promote health and seek to prevent illness have been affected during the violence which reached its height in mid 1986. An attempt has been made to indicate associations between health data, health service functioning and the prevailing level of civil violence. In some instances lag times are apparent, e.g. a woman infected with gonococcus who is prevented from attending an STD clinic because it is closed, might deliver a baby with ophthalmia neonatorum some months later. A causal relationship is difficult to prove using routine data, but an association of this nature exists on more than one occasion in the five year period. More sophisticated epidemiological studies are needed to quantify the true impact of the violence. Periods of violence have only been recorded in this table when such information was available in nursing records or in Cole's monograph (Cole, 1987). Although the data illustrate high levels of disrupted health services due to violence at Crossroads, Nyanga and Heideveld, it is also clear that over the five year period other areas also experienced some degree of violence, e.g. Retreat/Philippi - September 1985, and this does confound clear analysis.

All aspects of the services offered at the Midwife Obstetric Units and Regional Services Council clinics were disrupted at various times during the period under review. This often had a later effect within the service, e.g. a decrease in Regional Council Services home visits was often associated with a decrease in TB notifications which in turn resulted in a "catch up" period for notifications. In addition, some areas exhibited very depressed levels of TB clinic attendance e.g. Nyanga (Figure 56). This is of great concern and has implications both for the workload of the clinic staff and for the control of this disease, particularly in view of the fact that the incidence of TB in the Western Cape is the highest in South Africa (RSC MOH, 1987).

The disruption of one service often had its effect felt in another service, e.g. an increase in the number of deliveries was associated with a decrease in family planning attendances at the corresponding Regional Services Council clinics nine months before. This could have long term implications for the community and nation for which the birth rate is greater than 22.5/1000 in three of the four population groups (SAIRR, 1989). Altered patterns are also apparent in the Red Cross Hospital data. e.g. The phototherapy service offered by the three MOUs has reduced the demand on Red Cross Hospital,

but it is apparent that a greater number of infants are receiving treatment than previously. This indicates that, in this aspect of treatment, the appropriate use of the peripheral (MOU) service has reduced the load on the tertiary centre, i.e. Red Cross Hospital. There is no dramatic change in 1986 that would indicate a clear relationship to the civil violence. However, given the increasing numbers of infants receiving treatment in the community since 1987, it is fair to assume that any future disruption of community midwifery services would result in decreased detection and treatment of affected infants.

The dramatic peak in August 1986 of infants with ophthalmia neonatorum may be attributed to a "catch-up" effect with both admissions to hospital and outpatient attendance increasing sharply. This would appear to be directly attributable to disrupted community midwifery services, particularly home visits (see Chapter 4.2.1 -all MOUs), and partly attributable to the increased population in this area following the abolition of the Influx Control Act. The places of origin do not provide good preventative disease cover (Yach, Coetzer et al, 1990) and with disruptions in the STD clinic services, the pool of sexually transmittable organisms would have increased, resulting in neonatal eye infections.

In some instances existing services were required to fulfil a different function from usual, e.g. a curative/trauma unit function at Nyanga antenatal clinic in May 1986. During the nurses' survey the opposite example was given, i.e. routine TB medications usually administered by the Regional Services Council service had to be administered by the staff of the Guguletu Day Hospital when Nyanga clinic was closed due to security problems.

This information has implications for the management of health services with regard to the delivery of health care and the efficient use of staff.

The demand for curative health care, particularly those aspects which are violence-related, e.g. trauma, may increase dramatically in the short-term, but would be expected to resolve quite quickly once the level of civil disruption had diminished. However, the disruption of health services which aim to prevent disease and promote health will have long-term implications for the health of the community and the health services. It is necessary for managers of health services to be acquainted with the extent of actual disruption of their services so that an immediate redressing of the problem can be made, if possible, e.g. TB notification "catch up" campaign or measles immunization "blitz".

The individuals most vulnerable to a disruption of the community nursing service will be the low birth weight infants, non-immunized children and people with tuberculosis and their close relatives. Classically these people are severely socio-economically disadvantaged, and it is within this community that the seeds of discontent are sown which bear the fruit of civil violence. This in turn leads to further impairment of health care delivery and deterioration of the health of individuals, and ultimately of the community.

Aspects which forced the service to be curtailed, e.g. security, transport and identification, are similar to the problem areas identified in the nurses' survey, and obviously require special attention from the managers of services (see Chapter 7.1).

CHAPTER 6

FURTHER IMPLICATIONS AND CONSIDERATIONS

6.1 Ethical Considerations

When considering the ethics of nursing practice during times of civil unrest, the nurse is faced with a number of conflicting obligations, which are evident in the Intersystems Conceptual Framework proposed in Chapter 2.2 as the nurse occupies roles in both the individual and health care systems. These obligations are:

- to the state
- to her employing body (which also may be a state or para-statal organisation)
- to her community (and/or society at large)
- to her patient(s)
- to herself as a professional and a citizen

Which of these is primary and how does an individual arrive at this conclusion? Neither this dissertation nor any other authority can dictate to a professional what her decision will be in any given situation. It is for her to decide on her course of action, but in order to reach a decision about the appropriate conduct she has to weigh one moral principle against another - a major task of moral reasoning (Beauchamp, 1985). In doing so she must be able to justify why she arrived at her conclusion rather than stating what her conclusion was, she should not be dependent on a positive outcome to justify her action.

A working knowledge of the nursing and allied health professionals' codes is required to guide her practice.

Most nursing codes express the following:

"I pledge myself to the service of humanity"

(South African Nursing Association) (Vlok, 1983:5)

These codes may be expanded to incorporate the responsibilities of the nurse:

"to promote health, prevent illness, to restore health and to alleviate suffering"

(International Council of Nurses, 1973) and

"the nurse should participate and share with other citizens the responsibility for initiating and supporting action to meet health and social needs"

(International Council of Nurses, 1973).

How might these be achieved? In considering the first two clauses above, the undertaking "to promote health" would possibly assume greater importance during peacetime than during strife and the undertaking "to prevent illness" or harm and "restore healing" would possibly have a higher priority during times of strife.

In addition it is helpful to study international agreements on human rights and medical/health practice. Some of these (Geneva Conventions I - IV) have been signed by South Africa, and yet those in which South Africa does not participate (e.g. Geneva Protocols I & II) offer useful guidelines for health personnel working in areas experiencing armed conflict.

However, many aspects of practice are not specifically covered by these codes and so one must invoke moral, ethical and philosophical principles to reach just, moral and defensible conclusions. Common principles in ethical decision making are those of: autonomy, non-maleficence, beneficence and justice.

Autonomy, or the principle of respect for persons, is regarded as the primary moral principle by some philosophers, taking precedence over all other moral considerations, whereas others consider it to be merely one important principle among others (Beauchamp, 1985).

To respect the autonomy of an individual means that "they must be accorded the moral right to have their own opinions and act upon them, as long as those actions produce no serious harm to others." (my emphasis) (Beauchamp 1985:215). According to Gillon there may be certain circumstances in which the respect for autonomy of the patient is not the central moral issue, e.g. when confidentiality may conflict with respect for the autonomy of others (Gillon, 1986). If this is the case one can weigh these circumstances in the balance of moral obligation. The principles of confidentiality, privacy and truth arise from autonomy.

Individuals who seek assistance and care from nurses (and any other health personnel) need to know that they can be trusted to give the best care possible without divulging

personal details to others.

"I will hold in confidence all personal matters coming to my knowledge" (South African Nursing Association) (Vlok, 1983:5)

"The nurse safeguards the client's right to privacy by judiciously protecting information of a confidential nature" (American Nurses Association, 1976).

This is a basic tenet of the client-practitioner contractual relationship. Is this absolutely inviolable and if not, in what circumstances may it be infringed?

Firstly, what information is confidential?

In the ethical tradition, confidentiality rests on three premises:

- a) individual autonomy in the control of personal information;
- b) respect for the intimate content of personal relationships;
- c) the importance of keeping one's promises.

(Auster, 1985 : 341)

The roots of this tradition may be found in the Hippocratic school of thought which demands an all-encompassing obligation of confidentiality.

"What I may see or hear in the course of treatment or even outside of the treatment in regard to the life of men, which on no account must be spread abroad, I will keep to myself holding such things shameful to be spoken about."
(Auster, 1985 : 341),

Centuries after Hippocrates, Percival, who published in 1803 what is generally accepted as the first formal code of ethics in Anglo-American medicine, limited the obligation for confidentiality:

"...Secrecy and delicacy, when required by peculiar circumstances, should be strictly observed. And the familiar and confidential intercourse, to which the faculty are admitted in their professional visits, should be used with discretion and with the most scrupulous regard to fidelity and honour." (Auster, 1985 : 342)

Secondly, who may decide what the boundaries of confidentiality are? An appreciation of ethical codes and the oath taken on entering professional practice will serve as a guide to the nurse. However, some codes may allow a discretionary clause, which is congruent for an independent practice, but this forces the practitioner to take the responsibility for her decision(s) and action(s). The subprofessional category of nurse in South Africa makes no ethical declaration prior to commencing practice and so the responsibility for her respecting the confidential information of her patients would rest with her supervising professional nurse.

There is another aspect of limit-setting on confidentiality and that is the legal constraint. -In South African law a relationship of privilege is recognised between attorney and client, and between spouses. However, a court can insist on information, regarded by a health professional to be confidential, being admitted in court. Rule 16 in the guidelines for practice issued by the South African Medical

and Dental Council states that this should only be done after registering protest (Schultz, 1987).

Addressing the issue of confidentiality the General Medical Council (United Kingdom) states the following exceptions: "... e) when there are statutory requirements to disclose confidential medical information; f) when a judge or equivalent legal authority directs a doctor to disclose confidential medical information; g) when the public interest overrides the duty of confidentiality such as, for example, investigation by the police of a grave or very serious crime." (British Medical Association 1984:12).

Thirdly, in what way may civil unrest affect confidentiality?

As a result of the violence which escalated in various parts of the country from 1984, a State of Emergency was declared in the Republic of South Africa on 12 June 1986. This was renewed annually on three occasions and was only lifted in 1990. This gave wide-ranging powers to members of the police force whose priorities for law enforcement were often in conflict with the priorities of health professionals for treatment. An example of this was reported in an editorial in the American Journal of Public Health relating to an incident that occurred at a clinic in Alexandra township outside Johannesburg in 1986. By force of intimidation the police obtained the medical records of over 300 patients in order to get the names of gunshot

victims. The records were returned within two hours and so it is more likely that the purpose was to intimidate the health care workers than to obtain details of the large number of gunshot victims.

The Geneva Protocols I & II signed in 1977, to which South Africa was not a signatory, are additional to the Geneva Conventions I - IV of 1949, and apply to international and non-international armed conflict respectively. Chapter 16 (Protocol I) and Chapter 10 (Protocol II) refer to the protection of medical personnel and share the same Paragraphs 1 & 2:

- "1. Under no circumstance shall any person be punished for carrying out medical activities compatible with medical ethics, regardless of the person benefitting therefrom.
- "2. Persons engaged in medical activities shall not be compelled to perform acts or to carry out work contrary to the rules of medical ethics or to other rules designed for the benefit of the wounded and sick or to the provisions of the Conventions or of this Protocol, or to refrain from performing acts or carrying out work required by those rules and provisions."
(Marriott 1978 : 571).

These give very clear directions to those involved in health care regarding their obligations to those requiring their attention. They also give notice to law enforcement agencies that health care workers have an internationally acknowledged responsibility to their patients, and therefore the support of international law in carrying out these responsibilities.

Paragraphs 3 and 4 of Protocol II (non-international armed conflict) refer specifically to the protection of information.

Paragraph 4 has particular significance as it refers to "no person engaged in medical activities". This would include all subprofessional nurses (who in many cases form the backbone of the service in the community, e.g. MOUs) all ancillary workers, clerical staff, etc. and would mean that none of them could be penalised for refusing to give information. It is worth noting that paragraph 3 (Protocol I - International Conflict) from which these two paragraphs arose, includes the provisions:

"[information could be withheld if], in his opinion, [disclosure could] be harmful to the patients concerned or for their families" (my emphasis); and "Regulations for the compulsory notification of communicable disease shall, however, be respected." (Marriott 1978 : 571).

However, although one might use these as guidelines, the words "subject to national law" in Protocol II would render these paragraphs impotent in the face of the Emergency Regulations (RSA Regulation Gazette, 1985) even if South Africa was a signatory to these Protocols.

The Declaration of Havana, of which MASA is a signatory, sets out rules and regulations covering the care of the sick and wounded in times of conflict:

Regulation 4 "In emergencies the physician must always give the required care impartially and without

consideration of sex, race, nationality, religion, political affiliation or any other similar criterion. Such medical assistance must be continued as long as necessary and practicable."

Regulation 5 "Medical confidentiality must be preserved by the physician in the practice of his profession."

Rule 2.3 "The fulfilment of medical duties and responsibilities shall in no circumstances be considered an offence. The physician must never be prosecuted for observing professional secrecy."

(Medical Association of South Africa 1984:33)

An area of confusion is that of the reporting of all gunshot (or similar) wounds to the police. South African law does not require this, but the requirements of common law must be acknowledged. If it is believed that an individual who has received a gunshot wound in a conflict situation has committed an offence, then the withholding of this information may incriminate the treating professional as an accessory after the fact (Gluckman, 1985). Although it may seem from the history, taken by the health practitioner, that no offence had been committed, it may be extremely difficult during a period of civil unrest (and during a State of Emergency) to determine whether the patient is an innocent victim of unrest or a criminal who has committed armed robbery or murder under cover of the

prevailing confusion. It should be borne in mind that individuals may sustain gunshot wounds as a result of security force action (Ouflo, 1986), and disclosure of information regarding such wounds would result in suspicion that the patient may have been engaged in an activity of an unlawful nature. For this reason many people requiring treatment may be reluctant to seek assistance from the formal health service for fear of being detained as police have often detained people who report to health services with gunshot wounds (Yach, 1988).

Disclosure of information which is received in the course of one's professional activities is a serious breach of trust between patient and health professional. It is this trust which undergirds the relationship between patient and professional and any breaches of this trust should be made only in exceptional circumstances. To answer the question posed regarding the nature of confidentiality and in what circumstances, if any, it may be infringed, the ICN Code for Nurses gives useful guidance: "The nurse holds in confidence personal information and uses judgement in sharing this information" (my emphasis) (ICN, 1973). Therefore a good understanding of the bases of ethical thought, and the ability to apply them in the local situation, enables an individual to make a responsible decision within a considered framework rather than an arbitrary one in a circumstantially biased context.

Non-maleficence - the principle of not inflicting evil or

ham - has specific application for nurses working in a climate of civil strife. This moral principle is a corollary of the principle of beneficence, which includes the prevention of evil or harm, the removal of evil or harm, and the promotion of good. It is the nurse's task to weigh the risks and benefits accruing from these two principles when determining her course of action.

When one considers the powers of the police under security legislation in South Africa, a potential conflict of interests arises, e.g. A senior commissioned police officer, who has reasonable grounds for suspecting the presence of an individual thought to have committed a serious offence in terms of the Internal Security Act, is empowered to enter any premises at any time and arrest that individual (RSA Statute, 1982). This includes a clinic, operating theatre and casualty. Therefore, a policeman may remove a patient from direct health care and to prevent this would entail breaking the law.

Gluckman, in an editorial in the South African Medical Journal, suggested that a physician could protest in the strongest terms against such removal, and that should removal occur, a letter of referral should be addressed to the District Surgeon detailing care given and the intentions for further care (Gluckman, 1985). In this way health care is responsibly transferred to another professional practitioner who will have access to the patient. Although the editorial is written for medical

practitioners, such actions would be entirely appropriate for nursing personnel confronted with a comparable situation.

The principle of justice requires that equals be treated equally. Concepts of neutrality and impartiality would flow from this principle. Practically this would deny support to any form of discrimination - religious, political, racial, economic etc.

This sentiment is contained in various nursing codes (SANA-Vlok, 1983; ICN, 1973; RCN, 1976; ANA, 1976), but the focus is usually the individual. It is vital that nurses recognise that if an individual, by virtue of being classified as a member of a particular group (as is the case in South Africa with the Population Registration Act) is prevented from equal access to resources that influence health, e.g. water, sanitation, food, finance, education, health care, that individual is being denied the right to be treated with justice.

The withdrawal of health and ancillary services as a method of exerting control has been discussed in Chapter 2.1. It is therefore necessary for health service managers to question rigorously and carefully the need for withdrawing services lest they breach this moral principle of justice.

Although it may be difficult to be politically unbiased, nurses should strive to promote an understanding of

impartiality. There have been very disturbing reports of violations of neutrality of medical institutions from El Salvador (Public Health Commission, 1981). Since the adoption of the Geneva Conventions, doctors and nurses as well as the sick and wounded have been regarded as neutrals. However, the Public Health Commission to El Salvador reports that: "traditional protection has been increasingly ignored as military and para-military gangs have assassinated, tortured and threatened health workers military and para-military personnel have flagrantly entered hospitals and shot down patients in cold blood..... Consequently health workers have been afraid to render services to patients who are or could be considered 'oppositionists', and inevitably this has resulted in some patients requiring surgical or medical attention not receiving it" (Public Health Commission 1981 : 329-33).

If a climate of civil strife continues in South Africa and if the State of Emergency is extended, this ghastly scenario may be one that nurses in this country will have to face. To maintain their integrity and to be loyal to their pledge of service, they must be adequately prepared to manage such a situation, and they need the strong support of their professional colleagues and employing authorities (see Chapters 6.2 and 7.2).

When considering the second qualification of duty to one's patient, i.e. "the nurse should participate and share with other citizens the responsibility for initiating and

supporting action to meet health and social needs" (ICN, 1973), it is clear that nurses must confront the broader nature of their commitment to health. This does not only refer to localised initiatives in community health, but embraces issues that may impinge on the health of a community or nation. This is endorsed in the Code for Nurses prepared by the American Nurses' Association "The nurse collaborates with members of the health professions and other citizens in promoting community and national efforts to meet the health needs of the public" (ANA, 1976). The Royal College of Nursing Code of Professional Conduct (1976) addresses this as it states that nurses as citizens and as private individuals should ... "actively pursue those moral values to which their profession is committed namely parity of treatment and the pursuit of health". This implies that nurses should be concerned with political and social issues particularly when these are relevant to the prevention of disease or the delivery of health care.

Firstly, the antecedents of armed conflict are social disease and disruption which ultimately lead to loss of life. Such a climate undermines the noble aspirations of health professionals, particularly nurses. Healthier conditions of life are delayed or deteriorate (especially in developing communities), and advances in practice and research are impeded. (Lancet 1952 : 258)

Secondly, it is clear from McEwan's discussion on areas of

morality, i.e. personal, social, professional, that there is an interrelationship between these (McEwan, 1973). Therefore, it is not possible to endorse the sentiment expressed in a letter to the South African Medical Journal, "medical ethics has to do with the circumscribed situation in which an individual chooses to seek our professional advice and trusts us to do a good job" (Shulman, 1982). This appears to be a narrow interpretation and ignores one's responsibilities for health.

Another view is that of Cousins who recognises the apathy of the professional when individual or social morality supercedes professional morality and moral judgement is suspended, when the term "national security" is invoked - a common phrase in South Africa today. He comments further that the training of physicians "should make them highly responsive to all questions involving public health and safety"; and "if physicians are to regard themselves as a vital part of the life-sustaining process and not as mechanical attendants on an assembly belt of human breakdown, can they avoid moral decisions with implications for the health of the total community?" (Cousins, 1979 : 271-12). These comments are equally pertinent for all nurses.

There are various ways in which nurses may pursue this commitment. It may be to press for implementation of key strategies for health as identified in the Alma-Ata Declaration of 1978 i.e. GOBI - FFF (Growth monitoring,

Oral rehydration, Breastfeeding, Immunization, Food supplementation, Family spacing, Female literacy), or to campaign actively for peace and use negotiation and mediating skills at community level. This need not, indeed should not, be identifiable as a political affiliation, but commitment to the promotion of health in its widest context.

It is not easy to do this in isolation and therefore the conduct of the professional association is critically important.

6.2 Role of the Profession

When appraising the role of the profession during times of civil unrest, it is necessary first to consider what is central to nursing. The emphasis on practice has changed and developed dramatically since the turn of the century (Gabrielson, 1976; Collins, 1981) and although the role of the nurse differs according to the patient setting, the essential element of caring has always been present. Indeed the role of the nurse must always be closely related to the needs of the patients.

In 1922 the President of the American Nurses' Association (ANA), Clara Noyes observed: "...The work of nursing touches the child in the home and in the school; it is concerned not only with the care of the sick in the home and institution, but is concerned with the great questions

of causation and prevention of disease, and therefore touches the work of other groups, the physician, the nutritional worker, the teacher, the social worker. Its interests are interwoven in the very fabric of civilization" (Gabrielson 1976 : 270).

The role of nursing in the health care system is vital and particularly so when nurses constitute the largest cadre of health professionals in South Africa.

Therefore the profession has major responsibilities to the public and to its members. These are recognised in law and upheld by the South African Nursing Council (SANC) which is a statutory body in terms of the Nursing Act No 50 of 1978. Of its thirty members, at least seventeen (57%), with a possible maximum of twenty-five (83%), must be registered nurses. The objects of the Council include the promotion of health standards and the control of all matters affecting the education and practice of nurses, as well as advising the Minister of National Health and Population Development on any matter within the scope of the Nursing Act (Government Gazette, 1978). Thus the South African Nursing Council is clearly a participant in the management, education and human resources subsystems of the health care system in the Intersystems Conceptual Framework proposed in Chapter 2.2, as well as having a responsibility for input into the external environment.

It was, therefore, most appropriate that the SANC prepared

a policy document entitled "A nurses' responsibility in conflict situations" (SANC, 1988a) (Appendix F). The following point is clearly made "..... the nurse must maintain a position of trust and impartiality and at all times have respect for the rights of the patient. The protection of the rights of a patient is inextricably linked to the duties and responsibility of the nurse to such a patient."

If it is accepted that situations arising from civil unrest do not contribute to a healthy environment, the profession should use all means at its disposal to prevent or minimise the impact of these.

As has been described before, the impact of civil unrest may be diffuse, ill-defined and sporadic, and in some regions, e.g. Pietermaritzburg and Western Cape, it is approaching a chronic scenario. In promoting health, the community nurse pays attention to the dynamics in families and communities. When the community is exposed to civil unrest, widespread social pathology is evident, e.g. families fragmented through detention and death, escalating fear of gatherings even if these be for scholars at schools or adults attending community centres, increasing distrust of friends, strangers and those in uniform.

If nurses are to fulfil their obligation to the community, i.e. to prevent illness, to restore health, to alleviate suffering and to promote health, they cannot afford to be

guilty of the charge that "apartheid means separate development for South Africa's race and applies in full to nursing" (Watson, 1986 : 18).

How then should the nursing profession respond to a situation in which it is unable to offer its optimal service?

Firstly it is acknowledged that nurses' scope in health care is being limited because services are being curtailed due to the nursing shortage in South Africa at present. There are many reasons for this, which are beyond the scope of this dissertation, but the profession has to address those aspects affecting recruitment and retention, if its aim is to offer an optimal service.

Secondly, nurses must realise that decisions regarding the distribution of health care facilities involves political thought and decisions. In South Africa, the medical profession is regarded as being the powerful health profession as it dominates policy-making, administration and research while nursing, which forms the backbone of health services, is regarded as occupying a subservient role. This is understandable when nursing in South Africa is seldom seen to take the initiative in matters relating to health, but rather is seen to defend or react to situations.

In the matter of health care those most in need have the

least power to effect the necessary changes. Therefore, nurses must develop abilities in the critical analysis of present day health service problems (Schrock, 1977), be sensitive to consumer needs and demands for health care, and be active in conducting research in these areas.

The nursing profession has an exemplary model for this action in that early nursing pioneer, Florence Nightingale. During her sojourn at Scutari during the Crimean War, she had to overcome great resistance from the military authorities. They resented the fact that her authority was independent of the armed services, that she was a civilian, and that she was a woman (Donahue, 1985). She was immortalized by Longfellow as the "Lady with a Lamp" in his poem "Santa Filomena" written in 1857 (Longfellow), but it was her use of data that led to major reforms in military and civilian hospitals. Cohen lauds her as "a pioneer in the use of social statistics and in their graphical representation" (Cohen, 1984 : 98) and these were her strongest arguments to the policy makers and administrators which led to the massive reform in British health care in the second half of the nineteenth century.

Thirdly, the profession must recognise the need for it to be viewed as non-discriminatory and committed to the health of all, and then must encourage nurses to promote this in all interactions. In this regard, the suggestions of two respondents to the questionnaire are very pertinent:

"To continue my service whether during the unrest and to work with the public so as to show teach (sic) the public that our duty is to treat enemy and friend."

"Build a good relationship between you and the community by providing a good service. Always treat people with respect. Try to solve problems in a professional way. Stay open during crisis."

Nurses need to be regarded and trusted as universal carers giving preference to no one. Although this identification will not come overnight, nurses need to promote this role actively and ensure that their behaviour as residents and care-givers in a community is consistent with this.

Therefore, the undertaking of the nursing profession during times of civil violence is twofold:

- 1) to the profession
 - in setting and maintaining standards of practice appropriate to a society experiencing political change
 - in developing standards of education to meet these requirements
 - in offering guidelines for practice
- 2) to the public
 - in working for equality in accessibility and standards of health care for all
 - in nurturing an attitude of impartiality
 - in equipping the profession to intervene or react appropriately to the health needs which arise from civil unrest.

There is a need for nurses to achieve a greater understanding of the social, economic and political context in which nursing operates (Schrock, 1977). Nurses must be equal to the accolade of Dorothy Cornelius who in her presidential address to the ICN in 1970 stated: "Nursing is the conscience of the health care system. Through the years nursing has taken leadership among the professions to secure the rights of human beings to receive adequate health care. Many times nursing has stood alone to support the principle that health care is a right not a privilege" (Gabrielson, 1976 : 271).

That should be the goal of the profession even in times of civil unrest.

CHAPTER 7 RECOMMENDATIONS

The recommendations will be discussed under the broad categories of management, education, the role of the professional association and the direction for future research.

7.1 Management

Taking into account the endemic nature of civil violence in many areas of South Africa, people charged with the responsibility of managing health services must identify its impact, or potential impact, on their service. Escalation of violence may be rapid and unpredictable and so those with the responsibility for administering a service must be prepared to act within both an immediate and a long-term time frame.

The Intersystems conceptual framework discussed in Chapter 2.2 highlights the relationships between the Individual's system and that of the Health Care system, as well as the external factors impacting on these. It can be seen that management as a subsystem of Health Care has a close direct relationship with human and non-human resources as well as education.

As a result of the situation experienced in the greater Cape Town area the following recommendations are made:

7.1.1 Immediate arrangements

Immediate arrangements need to be made for nursing staff during times of conflict. In addition the security of health service resources, e.g. property and equipment, must be considered and maintained.

An obvious omission in this set of priorities is that of the needs of patients. This is deliberate because the following discussion highlights the decisions facing nursing staff, one subject being safety, which includes that of patients. Other aspects affecting the patients' access to health care are discussed in Chapter 7.1.2.

7.1.1.1 Human Resources

From the responses given by nurses from various areas there can be no single plan that will be universally acceptable. Therefore close consultation with each group of nurses must be carried out to formulate the most appropriate measures.

Factors that need to be considered include:

Identification. It may be desirable in some areas for nurses to travel to and from **work** in civilian clothes while in other areas a nurses' uniform may afford more protection.

Transport. Transport in these localities is often unreliable, even during periods of calm. The nurses, however, displayed resourcefulness in getting to work, often incurring great expense by using taxis.

During periods of civil disruption it may be helpful to have certain "pick-up points" from where staff could be transported to work. The type of transport provided would have to be negotiated because in some areas a provincial authority car may have untroubled access whereas in other areas it might be the target of violence.

Another suggestion which occurred frequently and should be considered in relation to transportation, is the advantage of working close to home. In such a period of unrest a co-ordinating group could authorize nursing personnel to report to the nearest clinic or hospital. From there they could be utilized wherever their service was required.

Security. Most of the concerns regarding security were expressed in relation to travelling to and from work. Decisions regarding security precautions at work need

to be devolved to the local level. Such decisions could be made by consultation between the sister-in-charge and senior medical officer.

Compensation. A number of staff appeared to have been working under great stress. Financial compensation would be appropriate when extra duties have been necessary. In addition it is important that these staff be compensated for time. They need to be withdrawn from the stressful working environment, especially when the unrest assumes a chronic rather than an acute nature, so that ultimately they can continue to work over a longer period of time.

7.1.1.2 Non-human Resources

Security of health service property and equipment should be ensured following careful advance planning (see Chapter 7.1.2.2).

7.1.2 Advance Planning

Management practices have shifted from being rigid and authoritarian in nature, to being more flexible

and consultative with various levels within an organisation's structure. In South African society, where the disenfranchised are stamping their authority on many situations particularly in the work place and where mass support has often attracted the attention of security forces as a result of or resulting in violent clashes, it would be particularly appropriate for the top management of health services to consult closely with those interfacing directly with the violence. Co-operation, support and creative strategies for functioning in disturbed circumstances can be gained by building a strong two-way communication and decision-making process rather than utilizing a passive top-down system of management.

This could be strengthened further by establishing community liaison committees for each health centre. Their functions could include crisis intervention co-ordination and they could be valuable in building a close relationship with the community. This could result in the positive identification of that centre as "belonging" to the community which, in the long term, might have a positive impact on the health of that community. The need for a strong commitment to, and a closer relationship with, the community they serve was highlighted by a number of nurses in the survey, when they were invited to make comments (Appendix D).

The Intersystems Framework proposed in Chapter 2.2 acknowledges the impact of the local community (internal environment system) on the health care system, and a co-operative relationship would enhance the functioning of both systems.

7.1.2.1 Clinic Staff Development

Clinic staff who form part of the human resources subsystem need to be utilized in the most efficient way. A number appeared to be ill-prepared to deal with the range of care and responsibility required in such a crisis situation. Recognizing that during periods of civil violence nursing personnel may feel vulnerable and be expected to perform duties beyond their normal scope, and perhaps capability, it is necessary that appropriate staff preparation, training and development be a joint priority for clinic staff and management.

Inservice Training

Recognizing the existing fragmentation of services due to the replication of political structures, and the increased

specialization within the services, nurses need to be exposed to new trends in nursing and have regular updating of current practices. Nurses will be able to identify areas in which they require further teaching. It is obvious from the data that any programme should include first aid, resuscitation and suturing. This would not be as crucial for the Day Hospital Staff who already offer a casualty service. However, it might be useful for these nurses to have a midwifery update, particularly for those situations which require emergency care.

Stress Management

There are a number of factors that contribute to the stressful situation in which nurses find themselves, one of which is the prevailing nursing shortage. Another major problem is clearly identified by the Intersystems Framework. The nurse as a member of a subsystem of the health care system should not become completely a part of the client system. In his discussion of intersystem analysis, Chin states that the change agent, e.g. nurse, must remain separate to some extent, create

and maintain some distance between herself and the client, thus standing apart in another system from which she re-relates (Chin, 1980 : 27).

However, as the nurse is often a member of the community in which she works she also occupies the place of the individual system. This may lead to role identification problems between herself and the internal environment system e.g. her professional role as a universal carer and her individual/civilian role with a certain political affiliation. This may result in tension, particularly within her psycho-emotional, social and spiritual subsystems. The additional stress of different demands and increased workload due to civil violence compounds this situation. This may lead to "burn out" which would also include effects of a physical nature.

This breakdown in the health of an individual who, as a nurse, also occupies a place in the human resource subsystem of the health care system, will impact on the health care system. The nurse impacts on the Intersystems not only as a careseeker

via the health demand connective, but also by withdrawing as a caregiver. This will have implications on the human resources and management subsystems. It is therefore essential that nurses are assisted in acquiring necessary stress reduction and management skills. They should be encouraged to form support groups which would enable them to evaluate their experiences and to plan alternative ways of managing future situations.

Management Skills

Although many nurses were satisfied with decisions taken by management on their behalf, e.g. to close the service, senior nursing staff expressed reservations - "authorities should be flexible", and "you should be treated as adults and not ordered about by people not aware of the situation you are in".

Although the senior clinic staff will be aware of the situation in their area, they may not have access to other information that might influence responsible decision-making. Equally those in management may not have insight into the

local situation, e.g. "nobody interferes with the Day Hospital because they know they got help from this clinic." (Guguletu - Appendix D).

It is suggested that the senior staff at clinics be given more scope for exercising their leadership. However, decisions cannot be made in a vacuum. It would, therefore, be appropriate for these staff members to have training in management skills specific to their needs. In addition protocols for decision-making could be negotiated and agreed upon by staff and management. This would lead to responsible and supported decisions being made during critical times when the established authorities are unable to assess the situation personally. This is particularly pertinent when one recalls that the telephone service was one ancillary service adversely affected during 1986 (Table 6).

Communication Skills

Not only is it important that clinic staff be able to communicate adequately with those responsible for the management of their service, but it is even more

important that they be able to communicate skillfully with patients and the wider community. The not unlikely situation of rival groups being confronted by each other in a clinic (Public Health Commission to El Salvador 1981:329) would require strong and competent negotiating skills on the part of nursing staff. It would be valuable for nurses to be equipped with conflict resolution and formal mediation skills. These could be incorporated into the in-service training programme, so that over a period of time, all nurses would have an opportunity to learn these skills.

Community Support

In the long-term it would be desirable for the nurses to have universal acceptance in the communities they serve. Effective communication in therapeutic situations, as well as wider education for involving people in the care of their families, will be key to attaining this goal.

"Patients and relatives should be educated as how to (sic) care for the sick" (Appendix D). This comment from a nurse at Mitchel's Plain is most perceptive. Many

families could cope well with nursing ill or infirm relatives at home if they were given adequate guidance and were confident of receiving help when it was required. This approach could lead to empowering the community to participate in the care of the ill and lead to truly "community-based" care rather than the present system which is more "non-hospital based" care.

It is nearly a century since Lillian Wald wrote "nurses have an organic relationship with the neighbourhood - in no sense is nursing an isolated undertaking" (Bergman, 1984 : 28). Nurses must demonstrate that this is true. This refers not only to curative care but also to the role of the nurse as disease preventer, e.g. immunization service, and health promoter. This is not readily appreciated by the public.

In the same way as the nurse has a responsibility to promote health, the community should have the responsibility for its own healthy living practices. This cannot always be done in isolation as the provision of certain services which are necessary for the achievement of a healthy

environment e.g. refuse removal, provision of water, are dependent on local authorities. However, one of the major points of the Alma Ata declaration of 1978 is that "people have the right and duty to participate in the planning and implementation of their health care" (Bergman, 1984 : 28). Nurses are in the ideal position to promote this idea and to encourage community participation in health care.

Time invested by nurses in the community in such actions could prove to be very worthwhile.

7.1.2.2 Management Responsibilities

Human Resources

It is clear from the foregoing discussion that there are various areas in which community nurses need to develop skills. Some aspects translate into action mainly in the community situation while others, e.g. inservice training and management skills, should be effected in conjunction with those holding authority in the health service.

The nature of the management, therefore, merits attention. It is suggested that the following functions are key - those of initiator, facilitator and even creator.

Initiation of new systems, e.g. type of management structure, involvement of senior clinic staff in policy and decision making.

Initiation of staff development programmes where these do not exist.

Facilitation of staff functioning during the orientation phase of new systems.

Creation of opportunities, e.g. communication skills workshops.

Creation of posts where staffing is inadequate or creation of a reserve of staff who could be utilized in emergency situations.

Non-human Resources

When health centres are planned, consideration should be given to what might be required in a situation of civil strife. Additional accommodation may be needed and so advance planning for appropriating other buildings or extending existing facilities, e.g. by using awnings, should be made. Attention to the incendiary capacity of the

accommodation is important - one nurse suggested that as her clinic was a pre-fabricated building it constituted a fire hazard.

As the scope of care required may be very different from the usual functions performed at a particular centre, certain equipment and stock, e.g. first aid and resuscitation packs, would be necessary. These could be stored at various key areas and made available to the most appropriate location.

It appears that disaster planning is non-existent in some centres. Formulation of such plans by the staff would need to take account of local situations e.g. size of clinic, structure of building - pre-fab (fire hazard) or brick - staff complement, access routes, the need for emergency resources anticipated, communication systems. It would also be valuable for staff of neighbouring clinics who work in different services, to be involved in co-ordinating their proposals so that the most effective use could be made of all resources available. Ultimately these plans should form part of a Peninsula-wide co-ordinated disaster plan.

Part of disaster planning would have to include an understanding of the concept of triage, and an appreciation of the circumstances which would make this concept applicable, i.e. when the demand on resources outstrips their availability (MacMahon, 1986). In the context of this study the constraints would probably occur in respect of personnel with various levels of skill, equipment, treatment and ambulance transport.

During major civil disruption communication is indispensable - to assist in decision-making, to seek assistance or equipment, and to summon emergency services, e.g. ambulance. In some areas the only means of communication was by telephone and this was cut off. A back-up system organised in connection with the post office, or an alternative system, e.g. radio should be investigated. This system is now in place in certain centres.

All resources, whether material or human, are precious and therefore attention to security is important. Nurses gave differing points of view as to how they would establish security (Appendix D).

This area would need sensitive negotiation between clinic staff, management, the police and security consultants.

Health Service

Arising from the nurses' survey, it is clear that it is difficult to continue rendering an efficient service during periods of civil disruption. It is also apparent from the health data and supporting information from the respective divisions of health, that the health needs of the affected communities changed. Definite trends have been identified showing that the disruption of one service does have effects on other services.

Using established parameters for assessing the health of a community, one can determine the long-term and short-term needs. These can be categorized into those that are essential or of primary importance and those that provide supplementary health benefits and are of secondary importance. The criteria for this categorization would be to take into account the possible long-term health and economic effects if a certain service was withheld.

It is suggested that immunization, family planning, TB screening and follow-up treatment, screening of sexually transmitted diseases and follow-up treatment and maternal and child health services would be regarded as priorities for health. If such programmes are curtailed the repercussions could be evident into the succeeding generation.

From the data presented in Chapters 4.1 and 4.2 and the ensuing discussion in Chapters 5.1 and 5.2 it is clear which aspects of health care were adversely affected and thus specific strategies should be formulated to counteract these.

This does not mean that the existing services for these would necessarily continue in the same manner as during periods of calm, but having established the priorities for care, one could then accommodate a service within the limitations of available staff and resources. e.g. Mobile services such as those operated by SHAWCO could relieve the client load on some centres. Routine and non-pivotal services could be deflected from the centres during times of crisis.

It is therefore recommended that, as long as responsibility for health care delivery is vested in a number of different services within the same geographic area, the managers of services should judge the extent of disruption of their own services and inform colleagues of the possible implications on their services. Thus nursing service managers would be better able to plan to accommodate the altered pattern by allocating staff and resources rationally.

Research

Any service should collect data that will facilitate future planning by identifying health patterns.

As has been highlighted in Chapter 2.1.3, Armenian suggests that in addition to the information usually collected for war-related research (Armenian, 1986), the following should be considered: active surveillance of health conditions; disease control programmes; assessment of the utilization of services; and efforts directed at the long-term institutional development of epidemiologic systems where these exist within the war affected areas (Armenian, 1989).

7.1.3 Co-ordination Across Health Services

Thus far discussion has centred on strategies for management within one health service authority. To leave the argument at this point would be to beg the question.

The number of authorities involved in providing health services in the Cape Peninsula is discussed in Chapter 1.2. Not only do some services offer similar health care, e.g. Cape Town City Council and Western Cape Regional Services Council, but some services cut across the boundaries of others, e.g. Peninsula Maternal and Neonatal Service covers areas served by the two local authorities named above.

Such a myriad of authorities is not only wasteful of personnel and financial resources, but also cannot make rational decisions for the whole Peninsula because too many aspects of care fall outside their individual jurisdictions. At present there seems to be no plan for dealing with a huge human emergency of the nature that affected the greater Cape Town area in 1986. It is suggested that the time has arrived for all services to be co-ordinated in such a way as to maximise resources available to them during such an emergency. With reference to the Intersystems Framework discussed in Chapter 2.2, the present situation could be represented with the four

existing health services as components in the management subsystem. Unless these work together, enormous tension is generated within the management subsystem resulting in fragmentation in the health care system.

"What is clear is that the historical layering of diffuse and fragmented structures has produced an enormously complex conglomeration of health systems. It is now the conventional wisdom that this complexity results in ineffective, wasteful and unjust delivery of health care." (de Beer, 1988:71).

The experiences of nurses working in other strife-torn communities, e.g. Beirut, have suggested that optimum use of medical personnel and services has been made in West Beirut because of the co-ordinating role played by the Christian Aid Team (Weir, 1982).

De Beer outlines certain functions of co-ordination, namely: co-ordination between component parts; developing standards and policies within an overall plan; ensuring the efficient and effective use of limited resources; data collection and monitoring the functioning of the system (de Beer, 1988).

It would seem logical for the nursing and medical managers of health services in the Cape Peninsula

and the Metro Emergency Service to form such a management group to plan for co-ordinated health care in an emergency situation. There are a number of community organisations, e.g. SHAWCO, SACLA (South African Christian Leadership Assembly); and private agencies, e.g. St John Ambulance, St Luke's Hospice, The National Cancer Association, and the South African Red Cross Society, that employ nurses in the Peninsula and it would be helpful if these organisations chose to be involved with this group.

Although the recommendations of this dissertation are focussed on the local situation, such functions are equally applicable for a national health plan. If it is acknowledged that the best way of ensuring optimum health provision to all residents in the Cape Peninsula during a time of crisis can be achieved through co-ordinated action, then why should this system be abandoned once the critical phase has passed?

It is vital that the decisions made for long-term planning and actual implementation are pertinent to providing the best health service for the needs that present themselves at this time, rather than idealistic in implementing a health policy which takes no cognisance of extraordinary circumstances. This is as pertinent at national level as it is at the local level.

In discussing guidelines for a national health system, Klekzcowski et al (1984) support the concept of decentralization. "Much decision making authority, related to both planning and implementation, is vested in the lower echelons, sometimes within broadly defined guidelines from the central authority."

One of the features of decentralization that de Beer highlights is that there should be a clear definition of the tasks and responsibility at each level (de Beer, 1988). This has been seen to be necessary within the individual services (Chapter 7.1.2.2) and this feature could become common throughout all levels of the health service.

Rebecca Bergman (1984 : 30) in addressing the challenge of primary health care for nurses and nursing states: "It is a challenge for us to take stock of ourselves as nurses and of the health care in our countries, to be objective to be resourceful and creative." Nurses must be bold to claim the best possible health care for all and should take note that Florence Nightingale is "reputed to have spent much more of her time in political activity directed at the civil service mandarins of the British War Office, than in giving direct tender loving care to wounded soldiers". (Journal of Advanced Nursing, 1981 : 163).

"What we have to maintain is Miss Nightingale's firm sense of purpose allied to contemporary scientific knowledge." (Skeet, 1980).

7.2 Education

It is clear from the discussion in Chapter 2 that although the effects of political violence may be similar to the effects of other disasters, the distinguishing features are those of social disruption before and after impact, suspicion and distrust. It is also clear that although there is a climate of change in South Africa at present, the uncertainty that this engenders may result in violence from different sources.

This is the milieu for which nursing students must be prepared, and which educators must understand in order to enable the students to meet the challenge of providing health care in a climate of profound socio-political change. The Intersystems Framework proposed in Chapter 2.2 illustrates that education must be responsive to the human resources subsystem, viz. the students and the profession, as well as to the needs identified by the management subsystem. This will ensure that its output through the profession to the individual and community is appropriate for the demands made on the health care system.

The most common form of preparation for nurse registration in South Africa is a four year diploma which leads to

registration as a nurse (general, psychiatric and community) and midwife, with the South African Nursing Council. This programme was implemented nationally in 1986. Prior to this nurses undertook a three year diploma in general nursing and could then do a one year diploma in a specialty of their choice. 8,9% of student nurses prepare for registration through a baccalaureate degree programme (Thompson, 1988). In 1986 when the comprehensive diploma course was implemented nationally, 80% of nurses registered with the South African Nursing Council had a midwifery qualification. Only 11,7% of registered nurses were formally equipped for a psychiatric nursing practice and 8.6% for community health practice (Thompson, 1988). Nurses who wish to specialise in a specific area following registration may study for a post-basic diploma, a post-basic baccalaureate degree or a post-graduate degree. Recommendations for nursing education programmes will be proposed and will include discussion of the educator's role.

As the first students of the four year programme only graduated in 1989, it will be assumed that most students undertaking post-basic courses have not had the benefits of the integrated programme. The subject matter will therefore be the same, but the level of application required would be different depending on the maturity of the student. Since 1988 all post-basic nursing diploma courses whether in a clinical field, education or management have consisted of a common core curriculum (A)

and the specific discipline curriculum (B) (SANC, 1988b). It is suggested that the general understanding, attitudes and skills required by nurses in times of political violence should be integrated in the core curriculum because many nurses have not been exposed to the pervasiveness of political violence and its impact on health.

7.2.1 Basic Diploma or Degree and Post-Basic Diploma

It is not possible to prepare a nurse for every situation that she will encounter throughout her career. It is, therefore, important that critical skills of assessment and problem-solving be fostered during her nurse education programme. This approach can be introduced in the first year curriculum, and initially need not be specific to nursing, but can build on the common life experiences of the students. In the senior years greater degrees of insight and sophistication would be expected. This approach requires active participation of the student and a flexibility in the educator which will encourage a wide range of thought on the part of the student to some of the problems presented. The application of these skills is not limited to nursing during times of disaster, but can be used in all clinical areas as well as in management situations.

It would be indulgent of the profession to admit only those students who have the ability to cope with critical situations particularly in view of the serious shortage of nurses in the public sector today. However it is necessary to ensure that students who enter nursing programmes have their potential abilities recognised and developed so that growth can occur. The philosophy of the South African Nursing Council regarding education in nursing, viz "... the development of the nurse on personal and professional levels ..." and "... the development of the ability for analytical, critical, evaluative and creative thinking and the stimulation of the exercise of independent judgement ..." (SANC, 1984) encourages this in all basic nursing education programmes. At post-basic level, however, it should be possible to screen nurses to assess their suitability for a particular field of nursing.

Students should be given the opportunity to consider the development of a personal philosophy and relate this to their professional commitment. As one tests the validity of assumptions and challenges values which are positively regarded, one is forced to consider the framework within which decisions are made. Seminars, discussions and group work encourage all students to participate so that all are involved in teaching each other and in assisting in the formation of attitudes. In this way one is

able to appreciate the basis for ethical decision-making. It is clear from the discussion in Chapter 6.1 that a good understanding of these ethical principles is needed when faced with unique and complex situations which may present during periods of civil violence.

The aspect of political violence that distinguishes this situation from other disasters is the socio-political one. The South African Nursing Council document regarding minimum requirements for education in relation to Community Nursing Science includes: "c) Factors which influence the physical, social and economic welfare of the community" (SANC, 1984). In relation to Social Sciences the following is stated:

" c) Basic social processes, social interaction, socializing, institutionalising, social stratification and mobility, social change and conflict ..." (my emphasis) (SANC, 1984). The minimum requirements for General Nursing Science include "d) Disaster Nursing" (SANC, 1984).

While it is acknowledged that these are minimum requirements which serve as guidelines, political influences on health and health care provision are omitted entirely from this document. It is necessary at this time in the development of South Africa, for nurses to be aware of the overt and subtle

influences of political activity on health. Input from policy makers, health service administrators, opinion makers, non-governmental health organisations as well as possibly lawyers, psychologists, spiritual advisers and social workers could foster a broad knowledge base. A greater appreciation of the effects of political violence on individuals and communities could be developed through the use of film footage of specific incidents and role-playing situations which are everyday occurrences in the lives of many people. Students, however, need to be exposed to the reality of the effects of political violence on health. Much theory can be learnt in the classroom, but the real understanding only comes if the person has been able to live some of that experience. Clinical placements during community health modules could have some of these facets built into family study or community profile projects.

This would lead to a better understanding of the dynamics in a community where political violence manifests itself, thereby assisting the nurse to act, or react, in an informed, and hopefully wise, manner when conducting her professional life.

Having enabled the student to formulate frameworks within which to work, attention should be paid to clinical skills. Clearly the focus of the nurses'

work will alter according to the situation presenting and so a basic comprehensive/all-round competence is important. Skills related to trauma care are necessary as this became apparent during the review of literature. A knowledge of triage management (as discussed in Chapter 7.1) would be useful in the case of mass casualties. Additional clinical and management skills are probably beyond the scope of the basically prepared nurse, but should be considered in a post-basic programme.

As all students in basic programmes complete an introductory course in psychiatric nursing, it is presumed that skills for counselling, crisis intervention and conflict resolution at an individual level will have been introduced and practised. These would need to be developed into the post-basic programmes. At every level it is essential that the students are evaluated on their understanding and ability. This could be done by testing specific clinical skills, simulating situations in which the nurse has to intervene, setting up a debating session, building into written assignments a section which requires critical analysis and interpretation. These methods can be used for many situations and serve only as initial suggestions on which educators could build.

Certain curricula B (i.e. specific discipline in the

post-basic diploma programme) would require further input in order to equip nurses in specific clinical specialty areas to cope with political violence, e.g. community health, child health, midwifery, psychiatry, trauma and emergency. From the nurses' survey and the health data presented in Chapters 4.1 and 4.2, it is clear that demands on the health services, and thus on the nurses, altered during periods of high levels of violence which demanded different responses both in the short-term and the long-term. Nurses suggested that it would be appropriate to prepare the community to give basic nursing care to relatives at home and also to train people to cope with civil unrest, e.g. building of shelters, evacuation plans, emergency communication. This devolves responsibility to the most immediate level of care and although it probably would not be appropriate for nurses to implement all schemes, the nurse would require skills to motivate the community and facilitate the implementation of these programmes, thus fulfilling her role in primary health care.

Being aware of health needs of children, women and communities during periods of civil disruption discussed in Chapter 2.1 (Bryce et al, 1989; Gibson, 1989; Armenian, 1989; Heskin, 1980; Garmezy, 1983; Straker, 1987; McWhirter, 1983), nurses undertaking post-basic clinical courses should be prepared to accommodate these changing needs within the service for which they are responsible.

Some specific suggestions for each of the courses mentioned above include:

community health -

learn management skills including triage;

gain a thorough understanding of the philosophy of primary health care;

develop skills that can be used to empower a community;

acquire the ability to recognise the needs of those who are vulnerable so that appropriate intervention takes place, e.g. strengthen coping mechanisms particularly among women with low levels of education and income;

learn radio communication skills;

child health -

be able to identify the effects of disrupted health or ancillary services so that these might be minimised;

develop skills in order to foster supportive family and community structures in order to enable children to cope better with stressful situations.

midwifery -

learn how to identify families under stress;

develop motivation skills to encourage women in their role as nurturer;

practice skills related to resuscitation and emergencies;

trauma and emergency -

be able to cope with large scale casualties

particularly gun shot and blunt instrument wounds;
learn how to manage emergency maternity care;
know and practise advanced triage; learn radio
communication skills;

psychiatry -

understand and be able to recognise post-traumatic
stress syndrome;
be able to anticipate the level of depression in
affected communities and know how to recognise and
treat appropriately;
develop an appreciation of the impact of assault
and detention of a close relative.

This list is not exhaustive, but highlights aspects
that have presented in the literature and in this
study. Using Armenian's model (Chapter 2.2.3) many of
these suggestions can be located in the persona1 -
clinical/curative - impact dimension. Some may be
located in the long-term rehabilitation or prevention
dimensions. However, as discussed in Chapters 2, 6
and 7, there is a place for nurses to be more active
in the ecological - prevention - pre-impact dimension.

Nurses undertaking post-basic studies in nursing
education and management should also be challenged by
the presence of political violence in their society.

The foregoing discussion illustrates the need for
nurse educators to have a broad view of health so that

the guidelines for nursing curricula laid down by the South African Nursing Council can be interpreted creatively for nurse education programmes. Their major task is to facilitate students' growth, which will result in professional nurses enabling the patients or clients they serve.

In some cases nurse educators will feel ill-equipped to handle this subject. It is suggested that they could include community health nurses who have first-hand experience of trying to care for people during times of civil disruption. Members of these communities could also be involved in such a programme. If nurses are to respond to the health needs of the community they must listen first. If the community were to become involved in aspects of the learning experiences of nurses, patterns of co-operation would be established which could be continued throughout a nurses' professional life. This would then confirm that the direct relationship between the community and the health care system shown in the Intersystems Framework is valid and necessary.

A nurse manager who has responsibility for a health service that is affected directly by civil disruption needs to be multi-talented. Not only must she manage the service itself, but she needs to enable subordinate colleagues to take responsibility for their defined area of practice. It follows that many

of the skills required by a nurse educator could well be utilized by a nurse manager and thus a programme for preparing individuals for this role should include these aspects. She would also need to be well-versed in progressive labour practices including mediation skills and conflict resolution not only for her service, but also for application to situations in the community.

All nurses undertaking post basic or postgraduate study need to be equipped with research skills as well as skills relating to policy development and administration. If nurses develop in these areas they will be able not only to identify problems and ask pertinent questions, but will be equipped to find answers to the questions and initiate any necessary changes.

7.2.2 Postgraduate degree programme

A number of postgraduate degree programmes are offered in university nursing departments in South Africa (Thompson, 1988). These may lead to professional registration with the South African Nursing Council in one or more disciplines, and cognisance should then be paid to the relevant area discussed in Chapter 7.2.1 above. Postgraduate programmes that offer academic advancement only, have a responsibility to develop the body of

nursing knowledge, and thus may encompass research in the area of political violence and its impact on health.

7.2.3 Education for enrolled nurse categories

There are two options available for aspirant nurses who did not possess the equivalent of a matriculation certificate - a two year enrolled nurse programme or until recently, a six month enrolled nursing assistant course. The latter is no longer available but a one year enrolled nursing assistant course has taken its place. There are 74 346 nurses who have completed one of these programmes, and they constitute 51.47% of all nurses registered or enrolled with the South African Nursing Council (SANC, 1989). Nurses who are enrolled at either level, however, may only work under the direct or indirect supervision of a registered nurse. It is recommended that responsibility for a specific direction to their practice, vis-a-vis civil disruption, should be planned by the management of the service which employs them, by means of ongoing in-service training which is discussed in Chapter 7.1.2.1.

7.3 Role of the Professional Association

The South African Nursing Association (SANA) to which all nurses are required to belong by law states in its objects the following:

- "1.2.1 promote the development of an adequate, efficient and effective nursing and midwifery service in the Republic of South Africa;
- "1.2.2 raise the status, maintain the integrity and promote the interests of the profession of nursing and midwifery" (SANA, 1986)

This clearly makes an undertaking to the profession and to the public concerning the service offered by the profession.

In addition SANA states,

- "1.2.3 consider and deal with any matters concerning or affecting the profession of nursing and midwifery" (SANA, 1986), and
- "1.2.4 safeguard and promote the dignity, rights, interests and socio-economic status of the individual member
- "1.2.5 perform any act necessary for or incidental to the attainment of the foregoing objects" (SANA, 1989).

This implies an undertaking to monitor constantly all events that impinge on, or influence, nursing and nurses.

How can the professional association meet its objectives in relation to civil unrest?

Firstly, the constitution of an organisation indicates its intention. The SANA has, until 1989, fragmented its membership and leadership by race, and in so doing, has not been able to convince the wider community of its commitment to the dignity of individuals, while its constitution has reflected the current government policy of separate development. (This is underlined by the fact that as an organisation defined in the Nursing Act No 50 of 1978, it is necessary for the Minister of National Health and Population Development to approve any amendment to the constitution.) At a constitutional congress of SANA in August 1989, it was resolved that there should be no reference to race in the constitution (SANA 1989). While this is a positive development, it will be some time before the implications are realised and understood by the public and before the wounds of the divisions in the profession are healed.

Secondly, the organisation must speak on behalf of nurses on matters of health organisation which lead to inequality and inaccessibility of care. This has been discussed in Chapter 6.2 as a responsibility of the profession, but it is also the responsibility of the professional association by virtue of its objectives stated above. In addition this will ensure that its actions are congruent with the undertakings embodied in the South African Nursing Association's Nurses' Pledge of Service, viz

"... will not permit considerations of religion, nationality, race or social standing to intervene between my duty and my patient" (Vlok, 1983 : 5).

As SANA withdrew from the International Council of Nurses (ICN) in 1973 (Harrison, 1973), it cannot expect to enjoy the support of the international community of nurses. However, it would be possible for SANA to indicate its stand in relation to resolutions made by the ICN, e.g. The nurse's role in safeguarding human rights, Health Care and Quality of Life, The Nurse's Role in Society (ICN, 1988).

Thirdly, any organisation that represents a profession has an enormous responsibility in assisting the professional development of its members. Through leadership it must offer guidelines for practice and resolving ethical dilemmas.

The National Medical and Dental Association (NAMDA) communicated with its members through the regular media (Cole, 1987), while the Medical Association of South Africa (MASA) provided leadership by reminding its members of its adherence to the World Medical Association's Declarations of Havana and Tokyo, and the Geneva Conventions (Editorial, 1986). It also advised members how to deal with situations occurring during the State of Emergency e.g. torture of detainees/prisoners and the confidentiality of medical records (MASA Bulletin, 1986). In addition it repeatedly made public the position of the profession to political violence and its negative impact on health and health care.

Regrettably it took the SANA almost a year before advising nurses of their duties and obligations during periods of civil unrest (SANA, 1987) (Appendix G).

Fourthly, it is incumbent on the association to support colleagues who are at the interface of civil unrest and health, in particular by wise management and safeguard[ing] ... the interests ... of the individual [nurse]" (SANA, 1989).

It is not known how many nurses have been affected by civil unrest in South Africa whether in their personal or professional lives. However, it is clear from this study that at least 161 nurses were affected, and they need to receive the benefit of support from the association of which they are members.

It is only when nurses have concrete and constructive ideas presented to them by their professional organisation that they will support the organisation to the extent which will give it the power to achieve its aims.

7.4 Future research

The responsibility of nurses, as defined by the International Council of Nurses, is to promote health, prevent illness, to restore health, and alleviate suffering and to that end the nurse should participate and share with other citizens the responsibility for initiating and supporting action to meet health and social needs" (ICN, 1973).

The emphasis in this study on the effects of political

violence on health has been on physical health. This should not be regarded as the only aspect of health that is affected because, as has been illustrated in the literature review (Chapter 2.1), all four aspects of health may be negatively affected. Although some community health nurses are involved in encouraging the formation of support groups within communities, the impact of these on social and psycho-emotional health has not been measured. The only data available regarding nursing services relate to the physical dimension of health.

As can be seen in the conceptual framework proposed in Chapter 2.2 the nurse has a direct relationship with the individual. However, when that individual's total health is jeopardised by the situation in the local or wider community, the nurse has a responsibility to take action. Armenian's conceptual framework outlines what actions might be appropriate. Within this context nurses need to identify areas that require their attention - not only in the physical dimension, but also in the psycho-emotional, social and spiritual dimensions - by conducting needs analyses and then evaluating the impact of the programmes implemented in response to these analyses.

Any evaluation of this kind should have its results communicated to the nurses concerned, so that they can use any recommendations made to improve their service and ultimately the health of the community. Nurses at the operational level are involved in compiling monthly reports

on the activities in their service and in collecting data for various researchers, but complain that they seldom receive any feedback (Personal communication, 1986). When invited to participate in the Nurses' Survey in 1986 they responded positively - as evidenced by the response rate of over 75% - and expressed their gratitude when each participating centre received a summary of the findings and recommendations. An interim report was sent to the nurse managers of these services in early 1987. Since that time the second phase of the study has been undertaken. Interaction with nurse managers has been positive and it is planned to present the completed study to all community health and related organisations in the Cape Peninsula, with a view to encouraging the implementation of the recommendations.

One of the limiting factors in this study was the necessity for implementing the research rapidly where no epidemiologic system existed. The long term institutional development of such systems, discussed by de Ville and Goyet (Armenian, 1989), could be a task of the co-ordinating team proposed in Chapter 7.1. Ongoing active surveillance of health conditions, disease control programmes and assessment of the utilisation of services, would form a part of the database, and a critical analysis would assist health services to respond timeously and appropriately.

CHAPTER 8 CONCLUSION

The study has shown that nurses have an important role to play in the health of the community by preventing illness and promoting health. When their services are curtailed, there are measurable effects which are to the detriment of health.

However, the reasons behind curtailed services may have an impact on the service itself and the staff. In the case of civil unrest the impact may be profound as has been documented in this study. This touches individual lives and safety, the ability to function in one's professional capacity, and a fundamental loss of trust between various sections of the community, leaving jagged wounds of a physical, psycho-emotional, social and spiritual nature which may take a long time to heal.

Collectors of data may observe trends returning to statistically acceptable norms but the reality is that Old Crossroads, KTC and parts of Nyanga are "no-go" areas for nurses. The reality is that as South African society is faced with the challenge of change, the dynamic of the civil violence may change, but its presence is likely to persist in the foreseeable future.

Nurses, at all levels, must be prepared to meet the situation - as clinicians, educators, managers and professional leaders. Health professionals with the responsibility of running a health service must communicate with colleagues particularly while

fragmentation of health services exist. As individuals and as a profession they must strive to remove all factors which interfere with the health of the community adhering strictly at all times to an acknowledged code of ethics.

CHAPTER 9 EPILOGUE

During his address at the opening of Parliament on 2 February 1990, President F W de Klerk declared that the time had come for 'a new South Africa'.

On that day he lifted the State of Emergency, which had originally been declared on 12 June 1986, in all parts of the country excluding the Natal/Kwazulu region. Forty-one proclamations of the Internal Security Act No 74 of 1982 were withdrawn, some of which had been introduced as far back as 1952. A further twenty-three government notices were withdrawn (RSA Government Gazette, 1990). This effectively unbanned people and organisations and paved the way for normal political activity. Nine days later - 11 February 1990 - Nelson Mandela, a leader of the African National Congress who had been sentenced to life imprisonment in 1963, was released.

These developments were greeted with euphoria, dismay or incredulity. Since then pre-negotiation talks have been held between the Pretoria government and the African National Congress, the Separate Amenities Act has been repealed, the State of Emergency was finally lifted in Natal/Kwazulu on 18 October 1990 and many changes are taking place. Do these circumstances render this study obsolete?

Changes may be viewed as too fast, too slow or cosmetic, depending on one's political affiliation. In 1989 there were fifty-three hunger strikes involving 1487 people (Human Rights

Commission, 1990a). In 1990 there have been two hunger strikes involving three people labelled as "right wing terrorists" (Human Rights Commission, 1990b).

Changes are going to have a profound impact on the socio-economic fabric of society, and so the insecurity and uncertainty that this time brings may herald further violence. We have witnessed this happening in Germany in the past twelve months.

Political events may herald an upsurge in violence. In a recent study conducted in the area around Durban in Natal, the five most violent days in February 1990 (defined by reports in the press) followed major political events (Karim & Andelman) and resulted in an increased utilization of tertiary hospital emergency surgical services. In a recent Human Rights Commission document it was reported that between 2 February and 30 September 1990, 214 people were killed and 2521 injured in direct or indirect police action (Human Rights Commission, 1990b).

However, much of the legislation that has led to political violence remains on the statute books - the Population Registration Act which is central to the policy of separate development, the Group Areas Act, the Aliens Act which was used to remove Crossroads residents to the Transkei in 1981 (Cole, 1987), and the Internal Security Act which includes the mechanism for detaining or banning people and organisations.

Until these laws are scrapped (as opposed to being reformed in a different guise), party policy is distanced from the statutes,

and the judicial system is freed to administer justice, political violence and its effects on the population will continue.

This study, therefore, is not obsolete. Regardless of the cause of the political violence, the recommendations outlined in Chapter 7 still apply and there is greater reason for their being considered carefully and implemented in various areas. Nurses, and other health professionals, must act with courage and commitment to fulfil their responsibilities for promoting the health of all people.

TABLE 1 RESPONSE RATE BY LOCATION

ORGANISATION	LOCATION	NO. QUESTIONNAIRES DISTRIBUTED	NO. QUESTIONNAIRES RETURNED	RESPONSE RATE (PERCENTAGE)	NO. RESPONDERS AFTER EXCLUSION
MOU	Retreat	18	17		15
	Heideveld	29	29		26
	Hanover Park	22	20		17
	SUBTOTAL	69	66	95.7	58
Day Hospital	Retreat	15	14		13
	Heideveld	17	11		10
	Guguletu	25	10		10
	Mitchell's Plain	20	8		7
	Athlone (Dr Abdurahman)	20	12		11
	Bishop Lavis	15	14		13
	Elsies River	18	16		15
	Kensington	5	5		5
	Langa	13	10		10
	Ruyterwacht	4	4		4
	SUBTOTAL	152	104	68.4	99
Voluntary Organisations	SHAWGO	2	2		2
	National Cancer Association	1	1		1
	St John's Ambulance	2	1		1
	SUBTOTAL	5	4	80	4
TOTAL		226	174	76.9	161

TABLE 2 DOMESTIC CHARACTERISTICS OF NURSES SURVEYED IN 1986

	MOU		DAY HOSPITAL		
	RETREAT	HEIDEVELD/ HANOVER PARK	RETREAT/ MITCHELL'S PLAIN	GUGULETU	OTHER
Total nurses (161)	15	43	20	10	73
Median age of nurses	40 (23)	35 (18)	41 (14)	44 (13)	39 (15)
Pre-school children	3	10	13	3	32
School-going children	20	39	21	13	84
Total children	23	49	34	16	116
Children:nurse ratio	1.5	1.1	1.7	1.5	1.6
Median (interquartile range)					

TABLE 3 DIFFICULTIES EXPERIENCED BY NURSES DURING 1986

	MOU		DAY HOSPITAL		
	RETREAT	HEIDEVELD/ HANOVER PARK	RETREAT/ MITCHELL'S PLAIN	GUGULETU	OTHER
Nurses (161)	15	43	20	10	73
Number of nurses who made alternative arrangements in 1986 for:					
- their children	8	3	0	3	8
- their transport	1	9	4	5	6
- wearing uniform	0	7	0	3	0
- entering workplace	1	6	0	3	1
Discouraged from attending work	1	9	3	7	2
Reported own services stopped	5	16	1	2	5
Not able to maintain usual standard of care May - June 1986	8	17	3	3	16

TABLE 4 RESPONSES REGARDING SAFETY

		Safety at work			
		Felt safe	Unaware of any danger	Felt unsafe	Felt very unsafe
Safety en route to work	Felt safe	3	0	0	0
	Felt unsafe	1	2	9	0
	Felt very unsafe	1	1	2	3

TABLE 5 SERVICES OFFERED BY NURSES IN VARIOUS HEALTH AUTHORITIES, 1986

	%
Clinics	37.2
Home visits	33.5
Maternity delivery	29.3
Well baby clinic	2.4
Casualty/Outpatients	33.5

n = 161

TABLE 6 THE NUMBER OF NURSES REPORTING DISRUPTED ANCILLARY SERVICES DURING 1986

	MOU		DAY HOSPITAL		
	RETREAT	HEIDEVELD/ HANOVER PARK	RETREAT/ MITCHELL'S PLAIN	GUGULETU	OTHER
Water	0	2	0	0	3
Electricity	4	5	0	5	1
Telephone	0	4	0	3	5
Refuse removal	0	7	1	7	6
Sanitation	0	3	0	1	2
Ambulance	0	14	1	6	11
n = 161	15	43	20	10	73

NURSES 1986

LOCATION BY SERVICE/IMPACT AREA

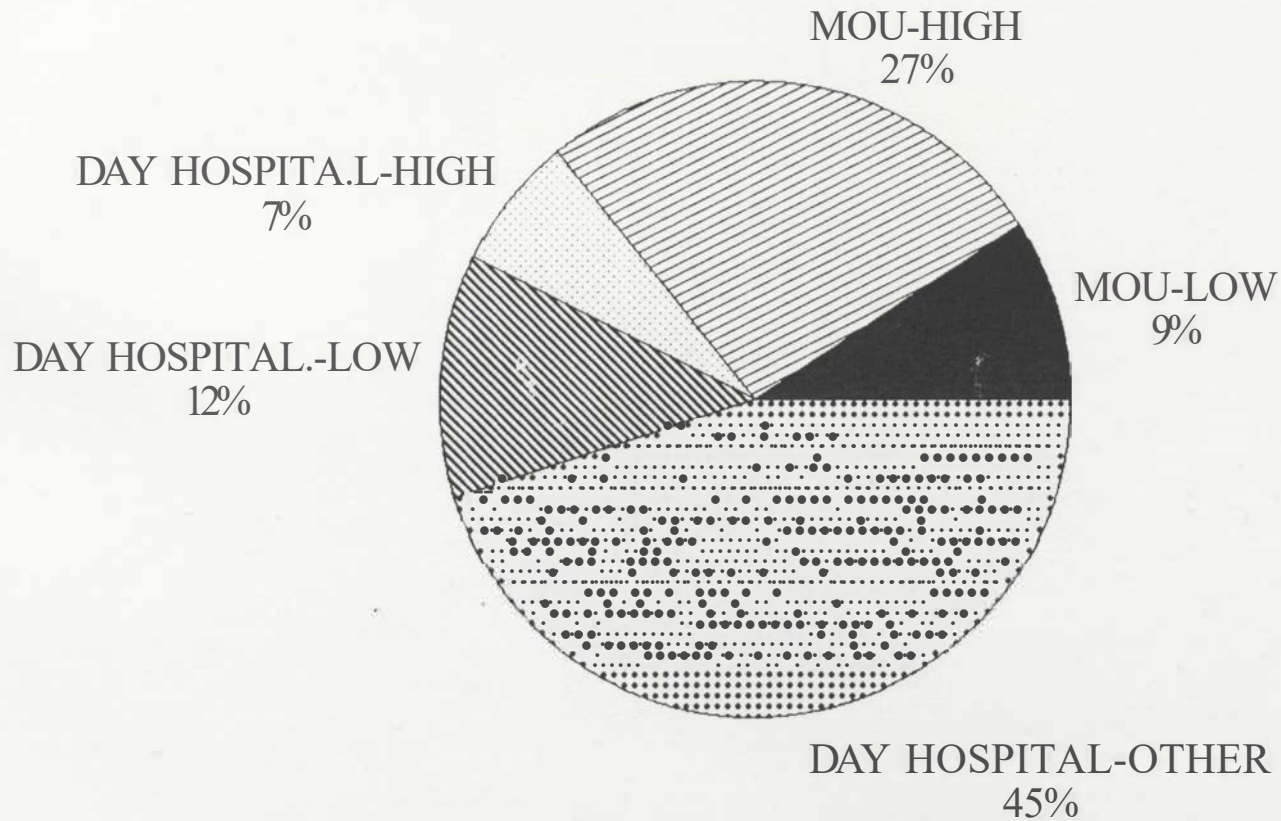


FIGURE 1 n=161

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USUAL TRANSPORT TO WORK

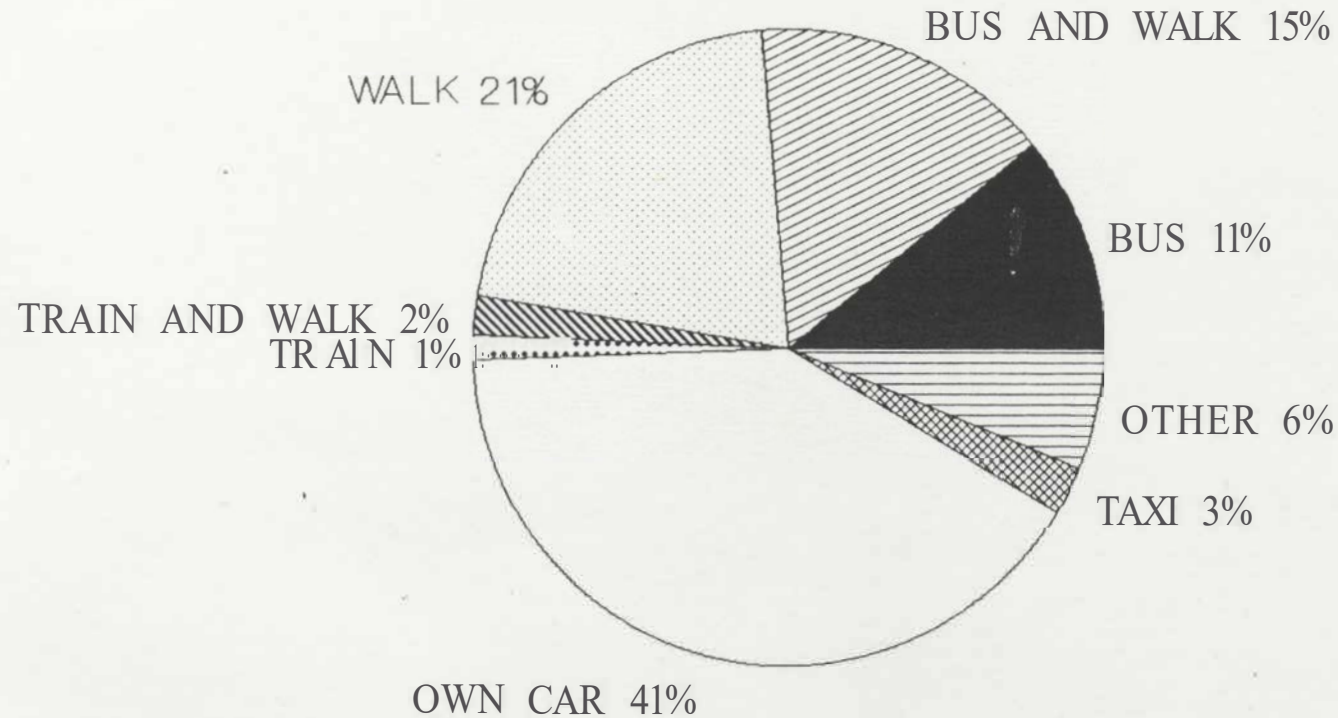
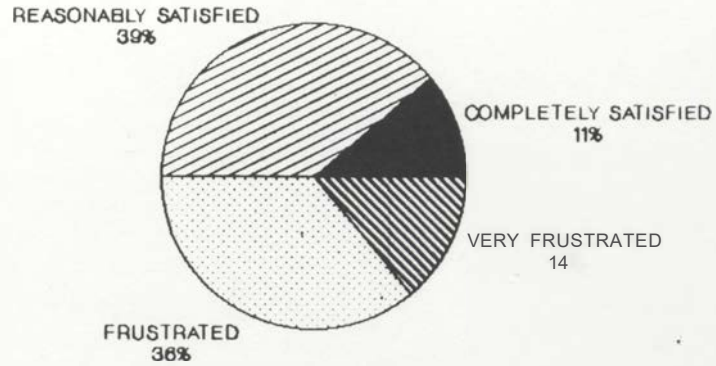


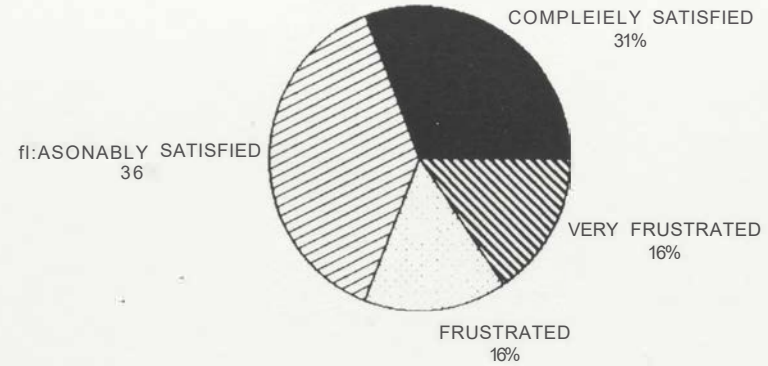
FIGURE 2 n•161

HIGH IMPACT MOU



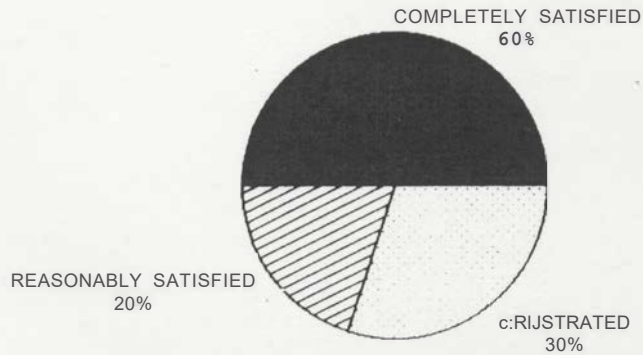
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LOW IMPACT MOU



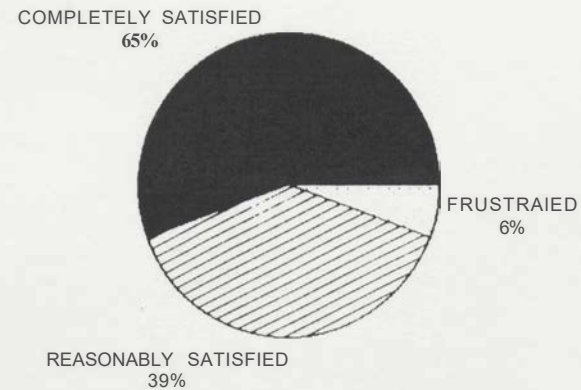
n=13

HIGH IMPACT DAY HOSPITAL



n=10

LOW IMPACT DAY HOSPITAL



n=18

FIGURE 3: NURSES' ASSESSMENTS OF SERVICE

n=77

RETREAT MOU ANTENATAL CLINIC

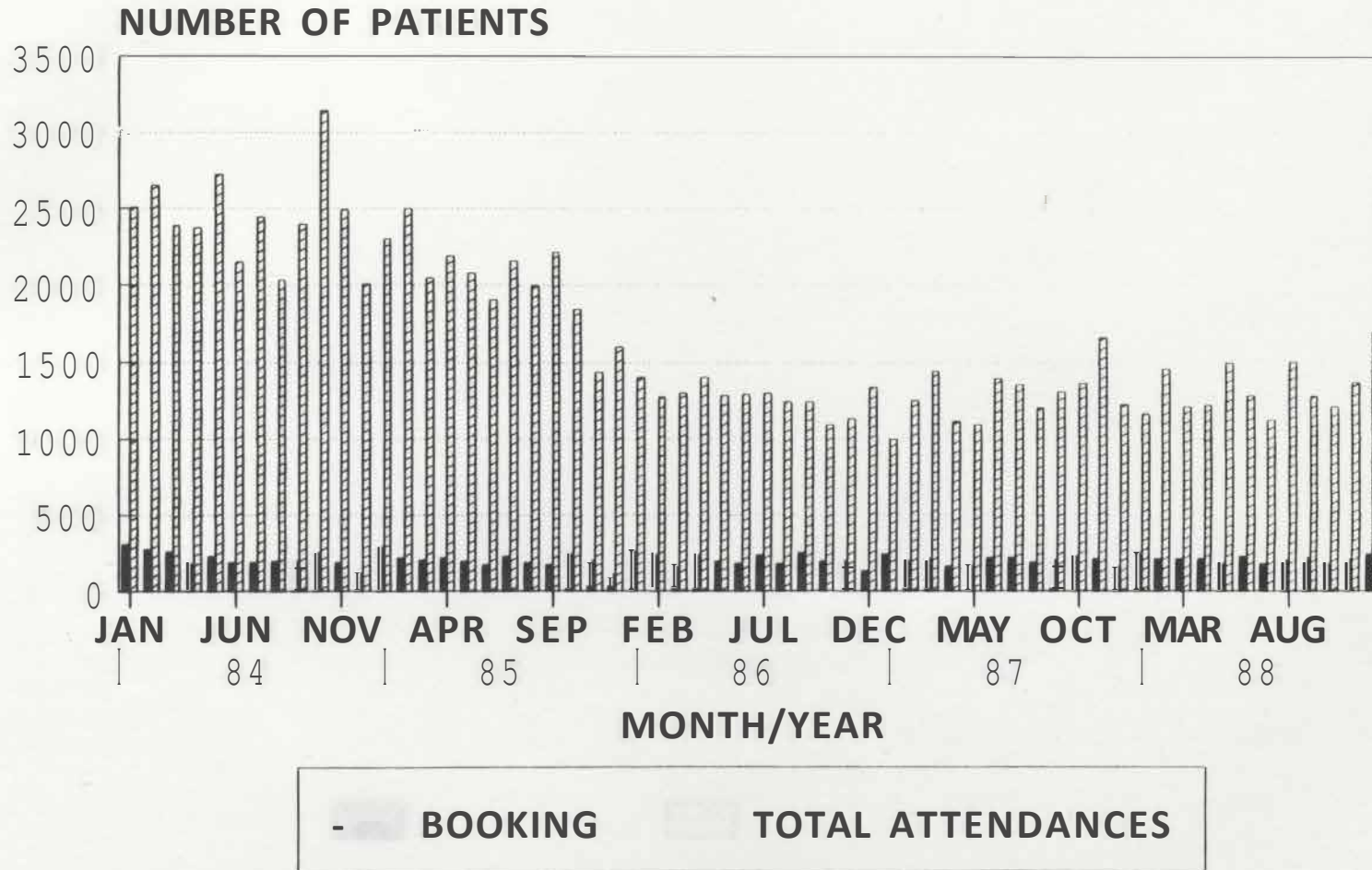


FIGURE 4

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RETREAT MOU DELIVERIES

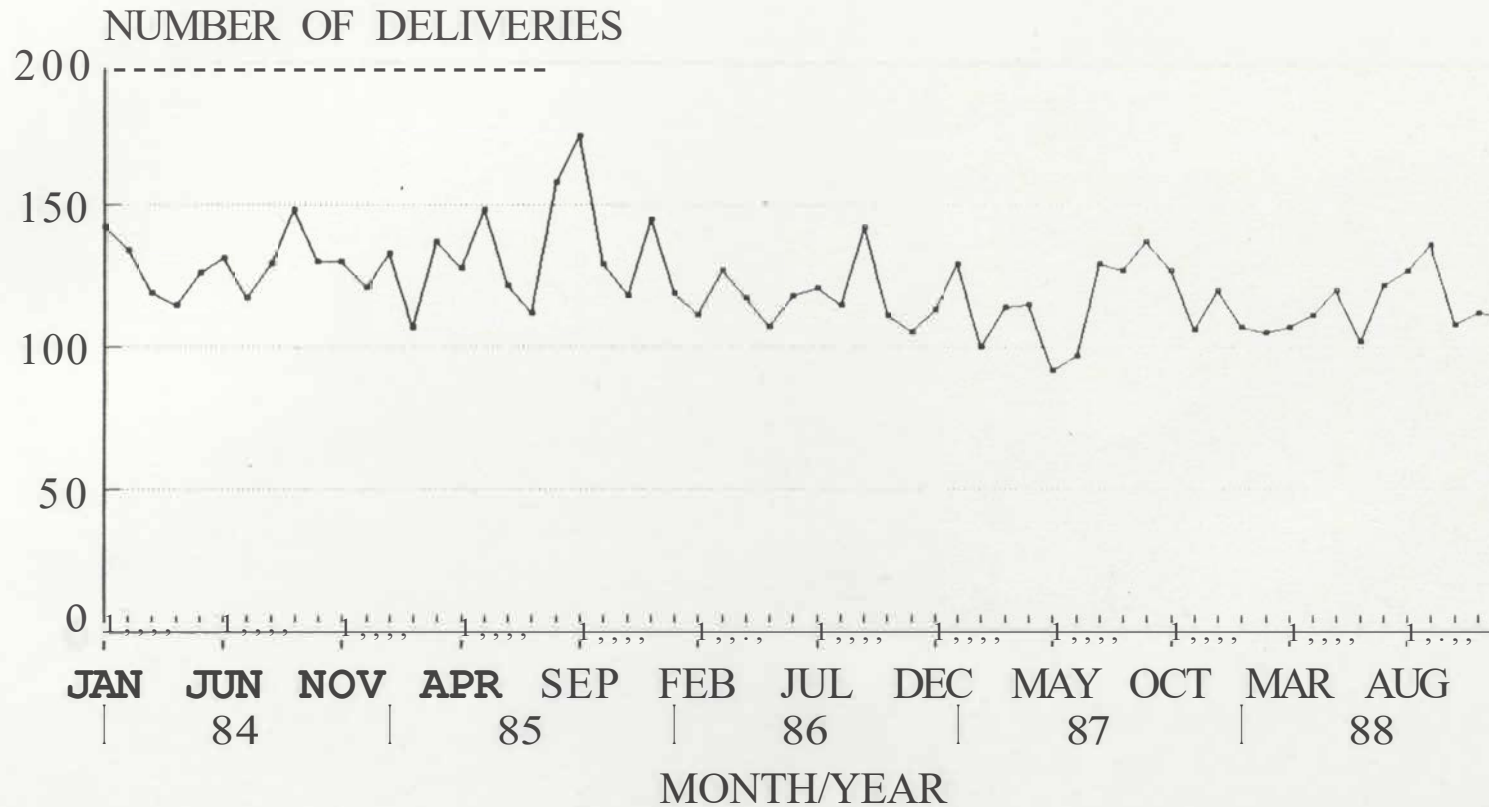


FIGURE 5

RETREAT MOU DELIVERIES

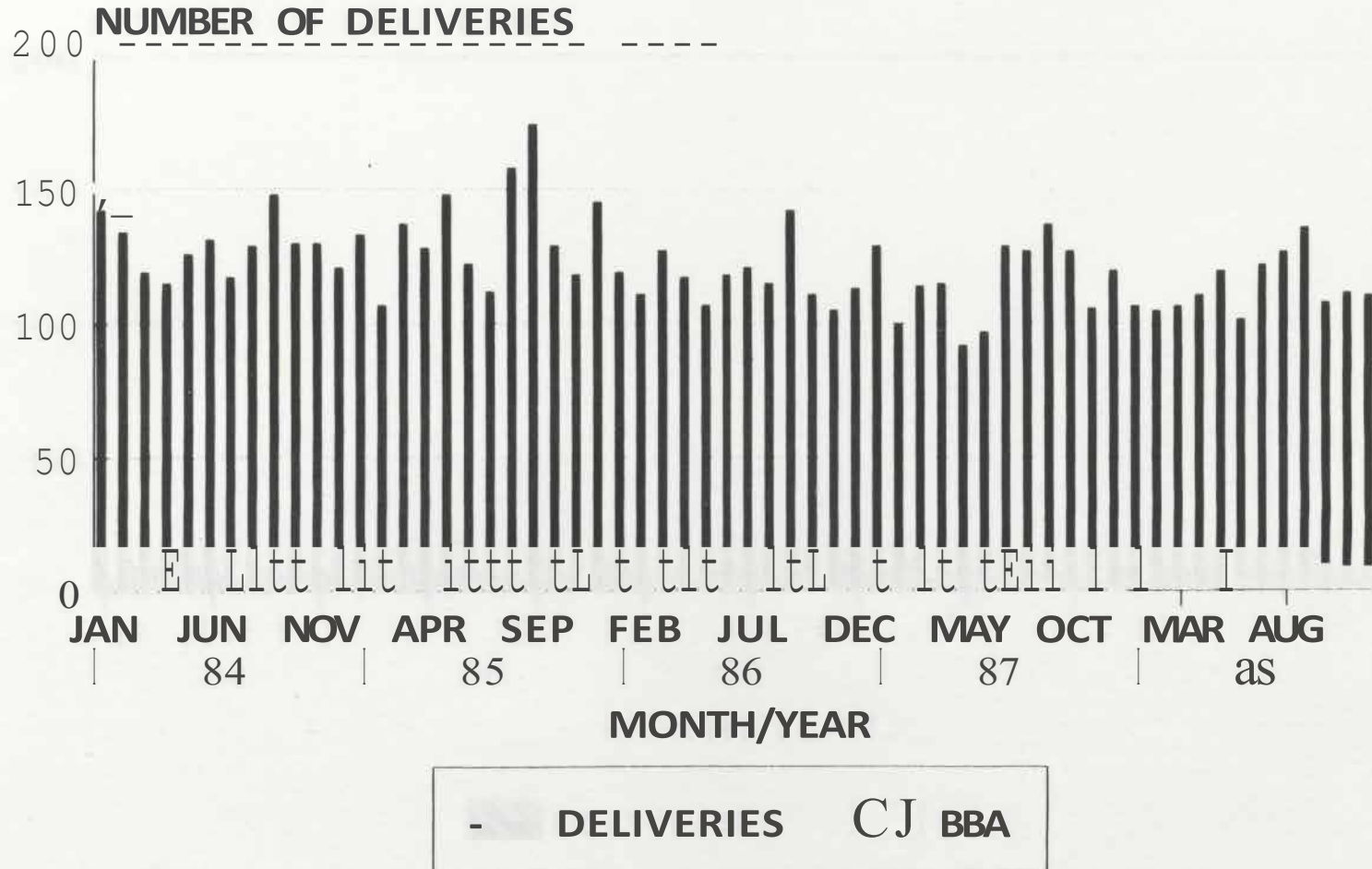


FIGURE 6

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RETREAT MOU DELIVERIES/HOME VISITS

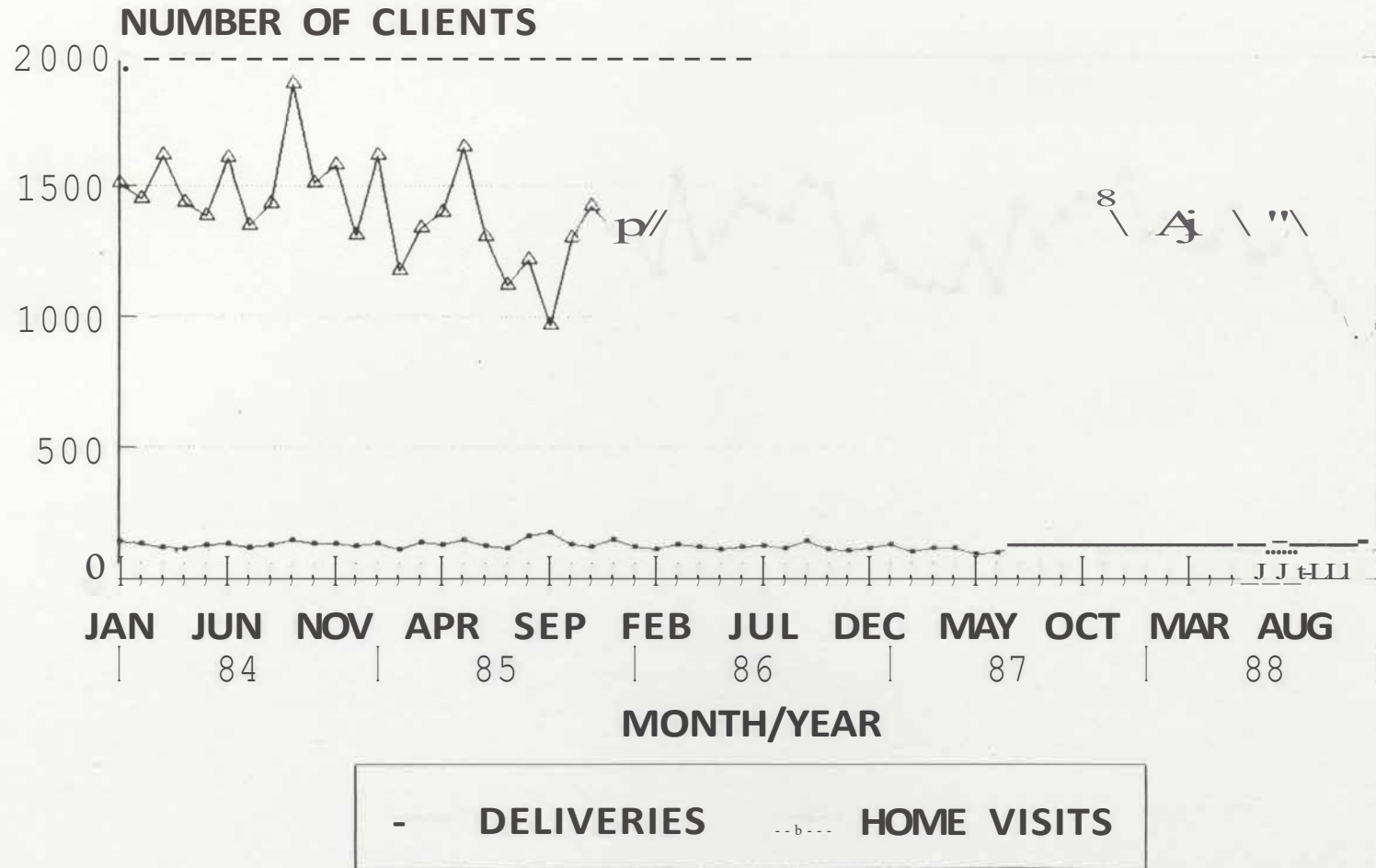


FIGURE 7

RETREAT MOU PERINATAL MORTALITY RATE

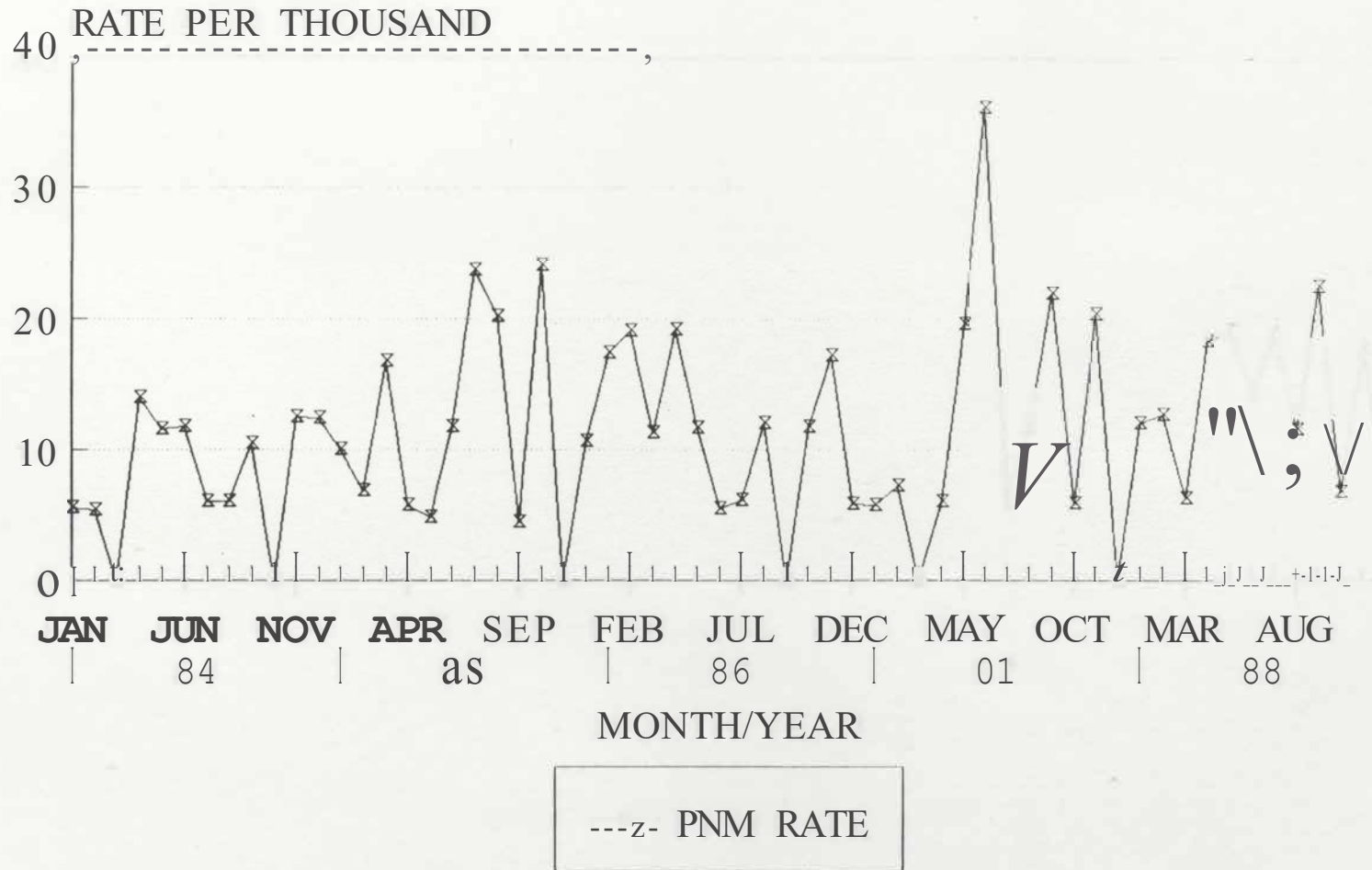


FIGURE 8

HANOVER PARK MOU ANTENATAL CLINIC

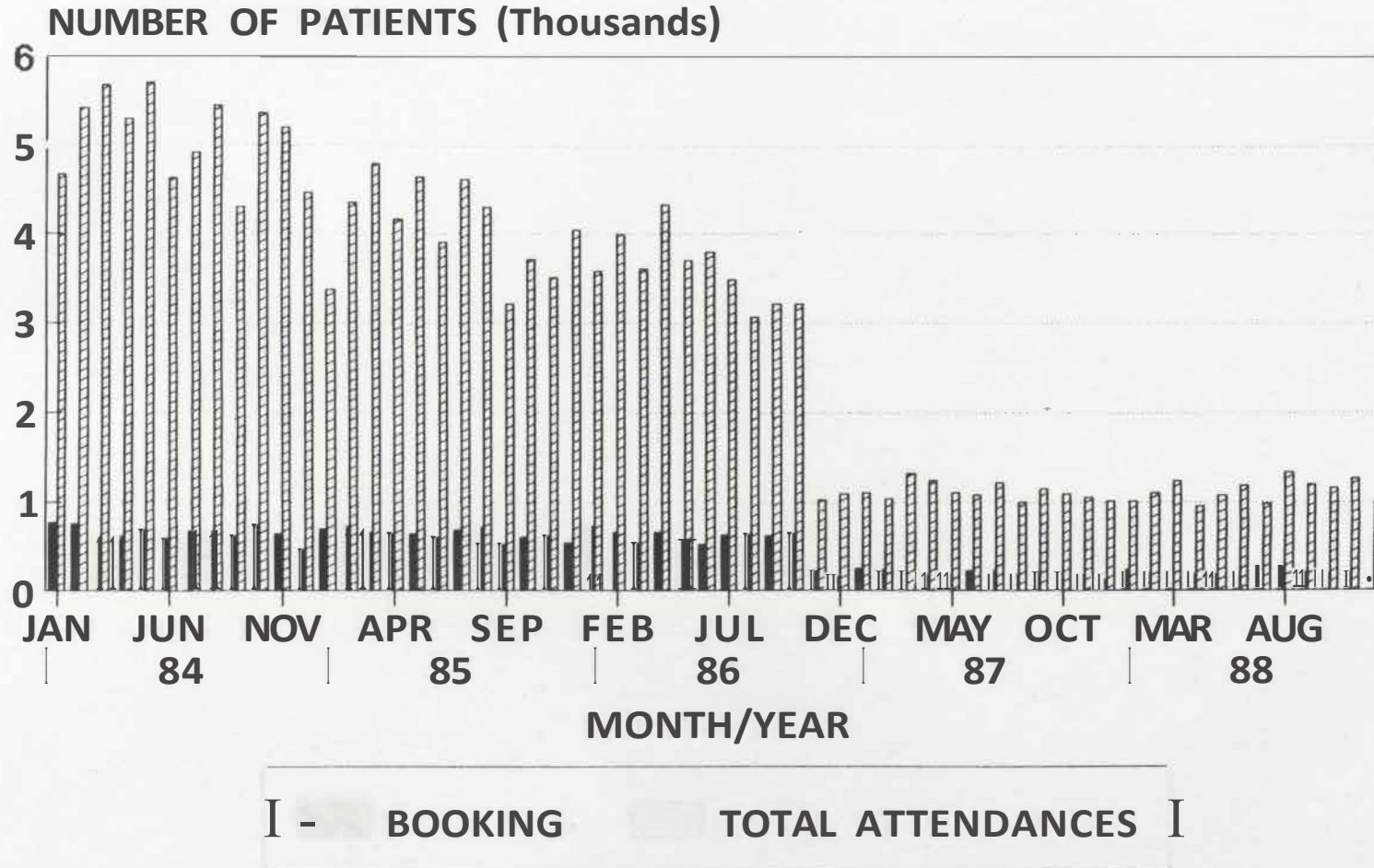


FIGURE 9

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MITCHELL'S PLAIN MOU ANTENATACLINIC

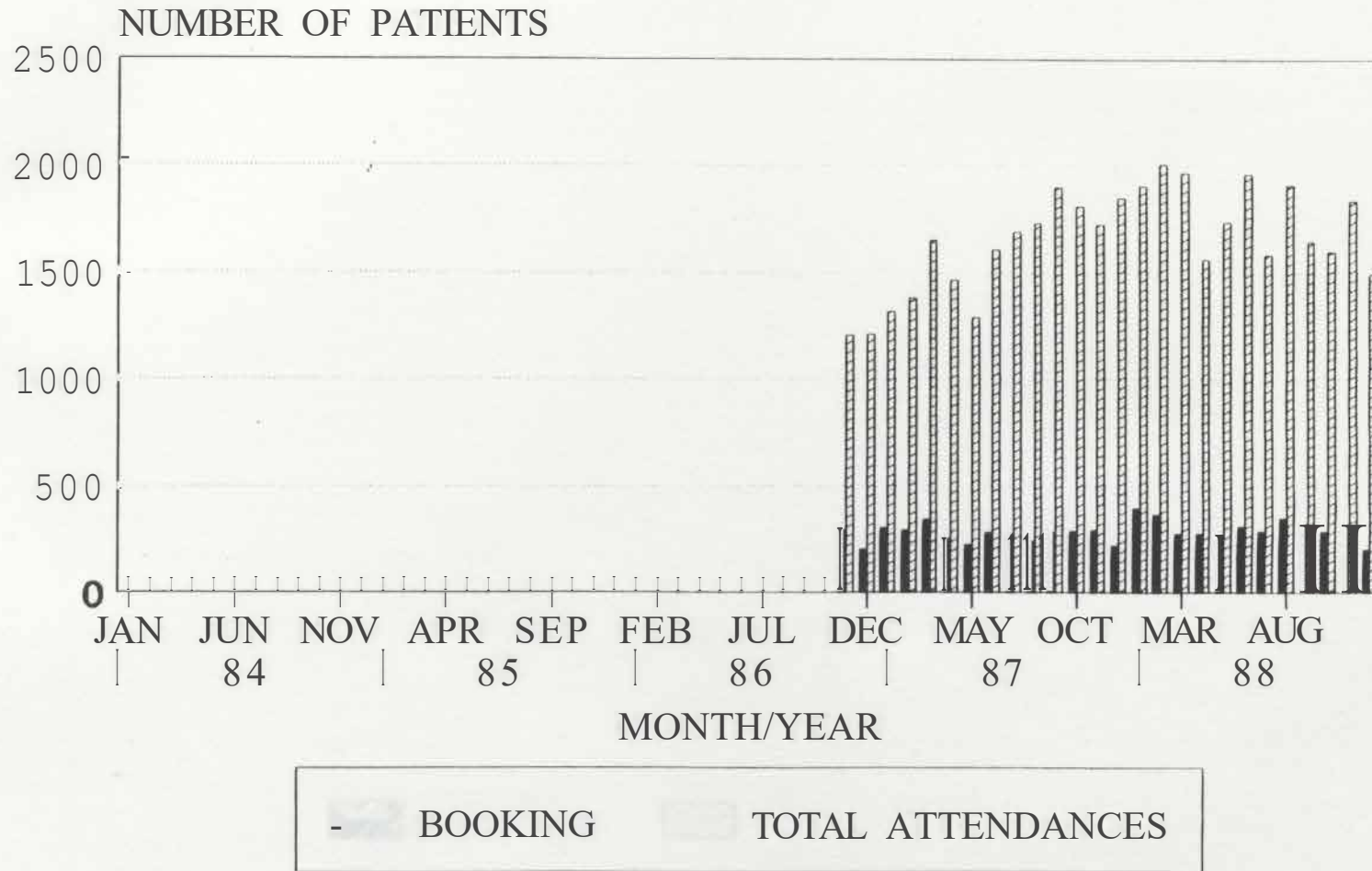
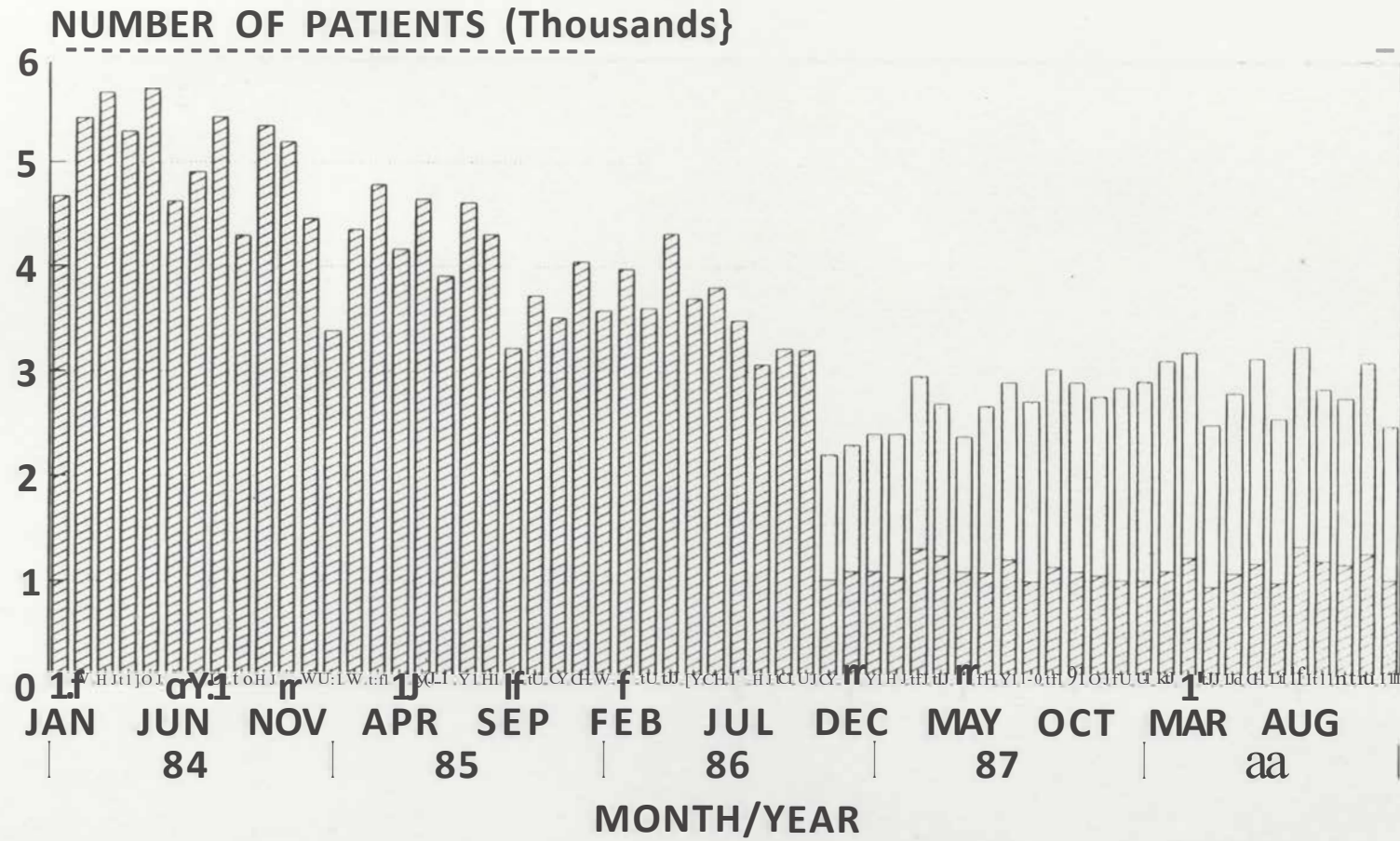


FIGURE 10

ANTENATAL CLINIC



HANOVER PARK

 CJ MITCHELL'S PLAIN

FIGURE 11

HANOVER PARK MOU DELIVERIES

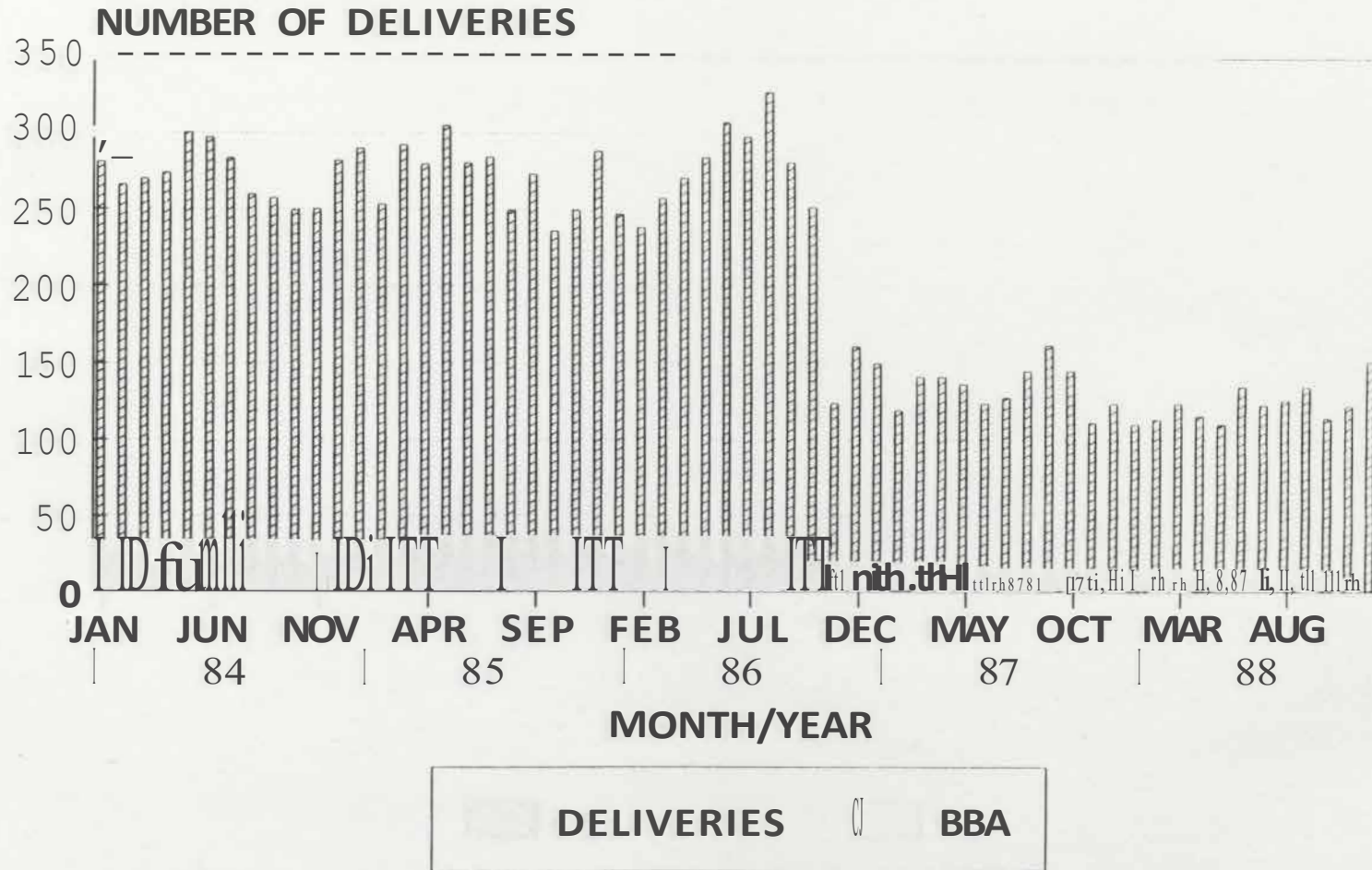


FIGURE 13

HANOVER PARK MOU DELIVERIES/HOME VISITS

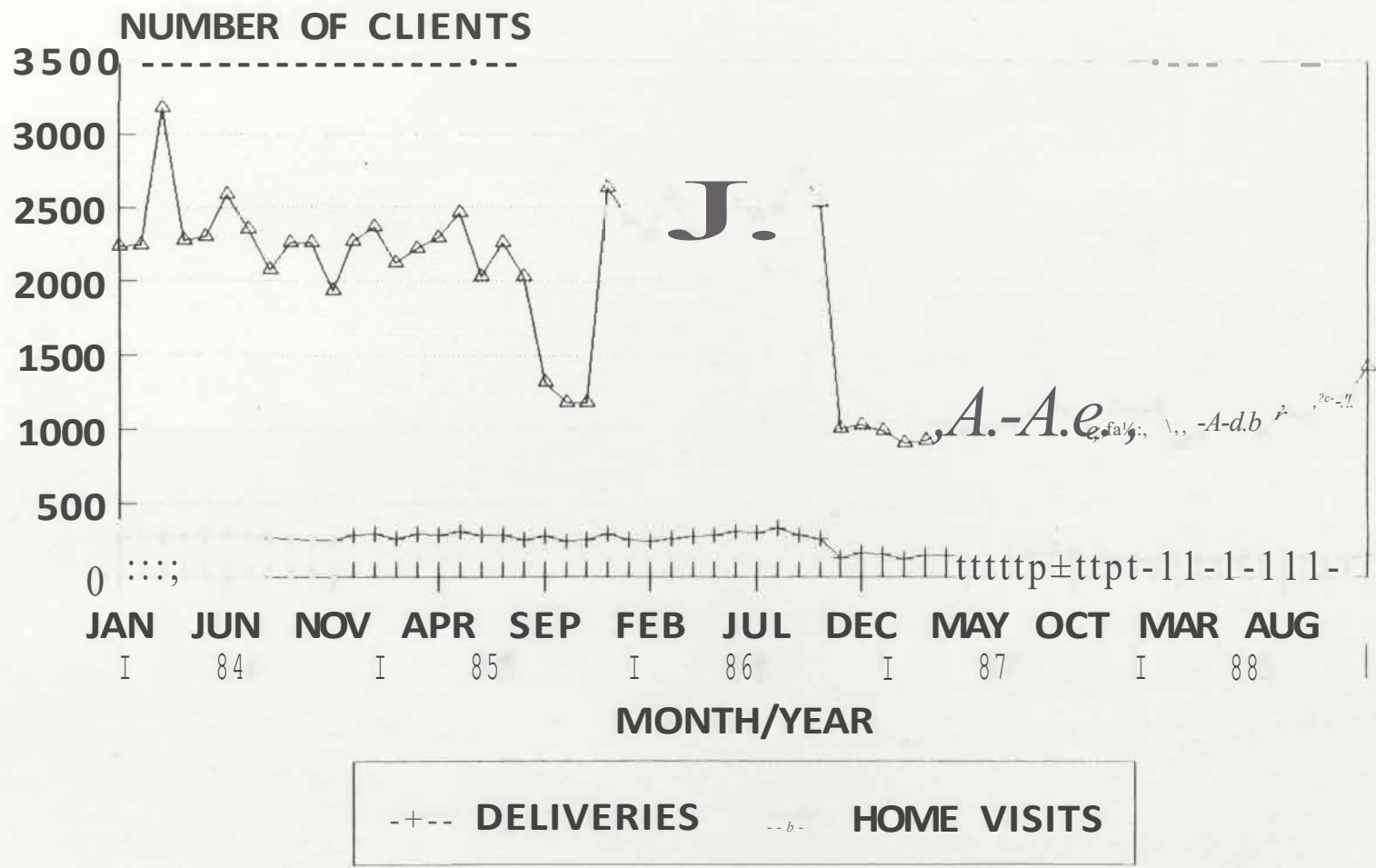


FIGURE 14

HANOVER PARK MOU PERINATAL MORTALITY RATE

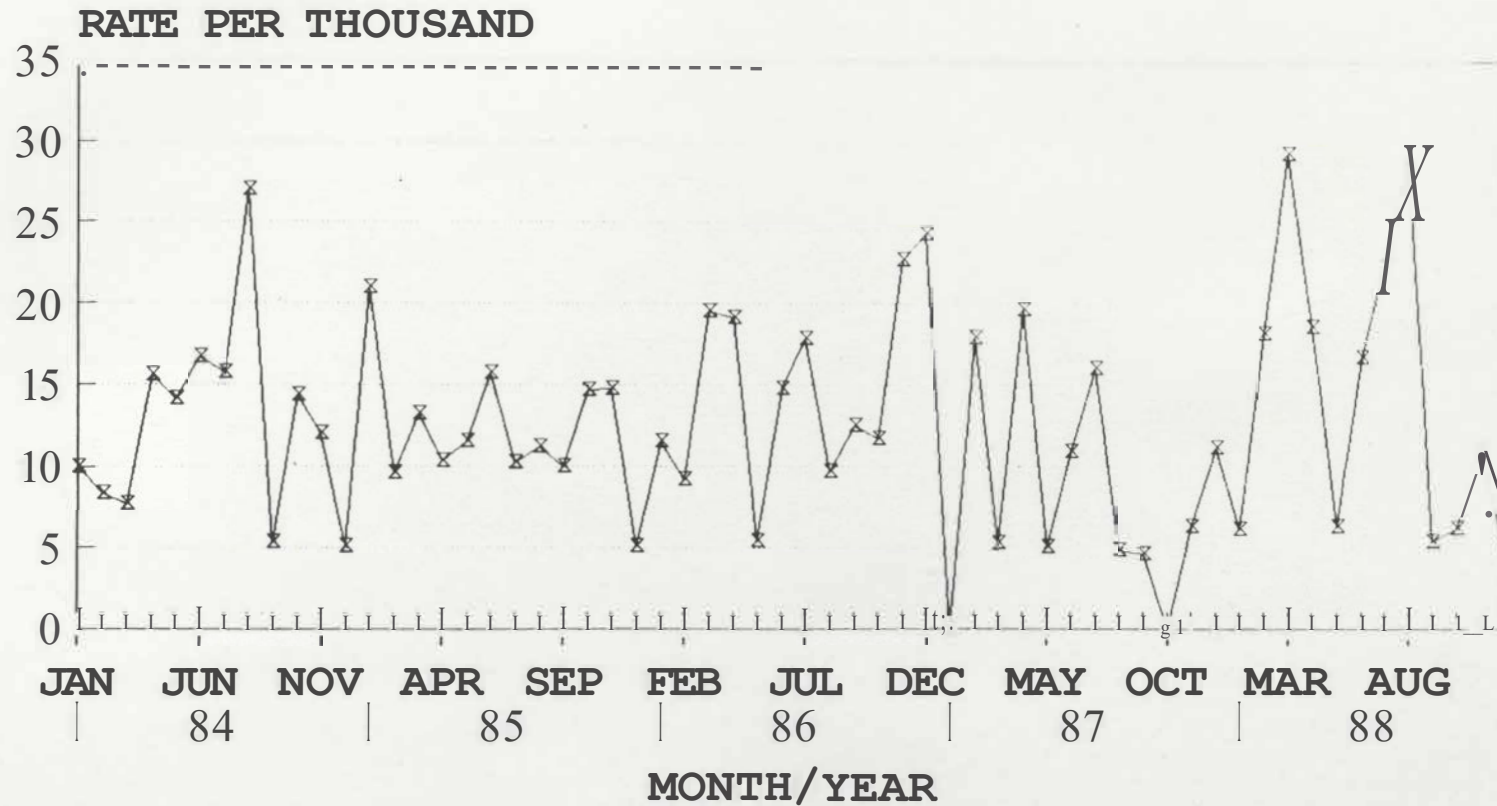


FIGURE 16

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HEIDEVELD MOU ANTENATAL CLINIC

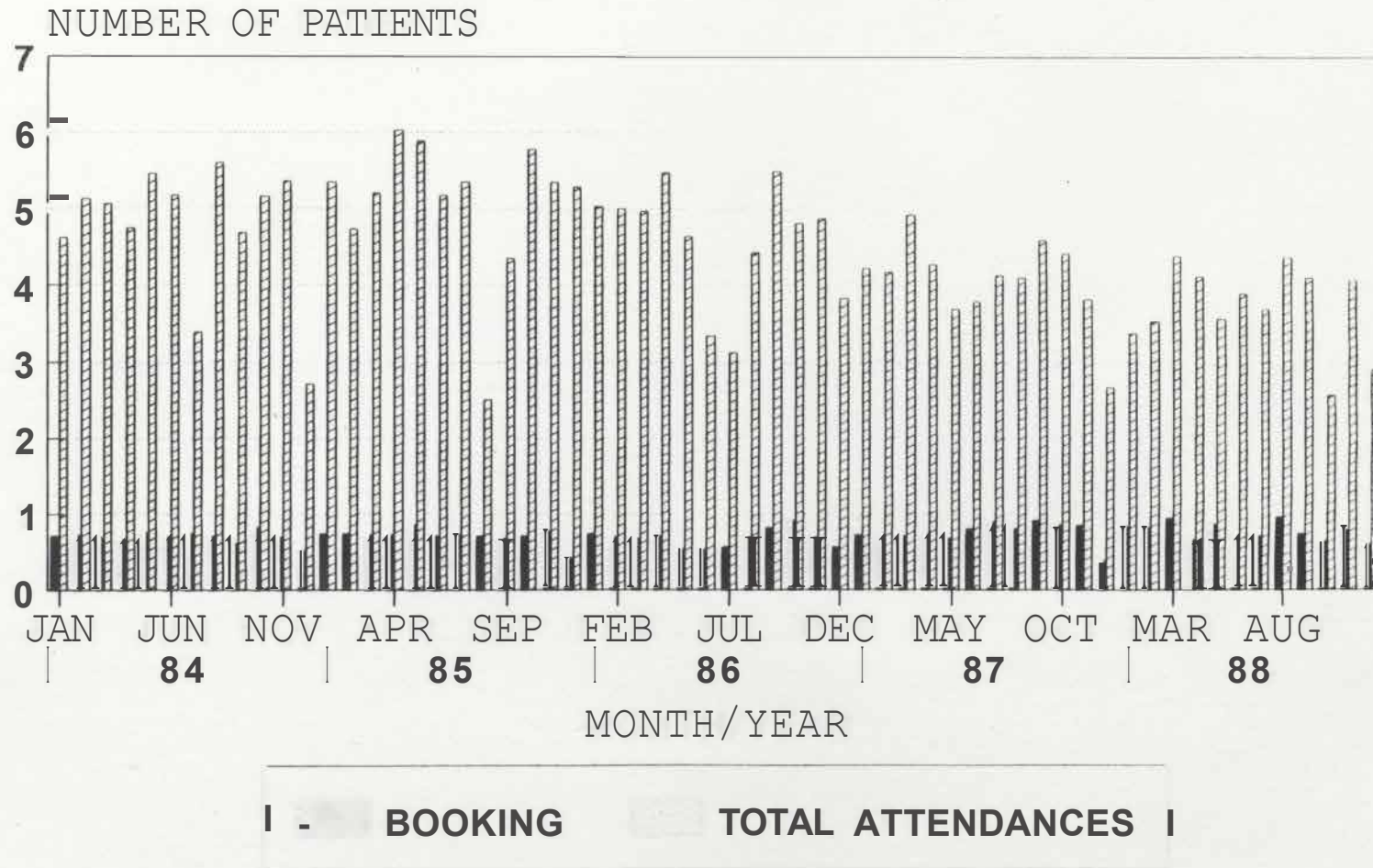


FIGURE 16

HEIDEVELD MOU ANTENATAL CLINIC

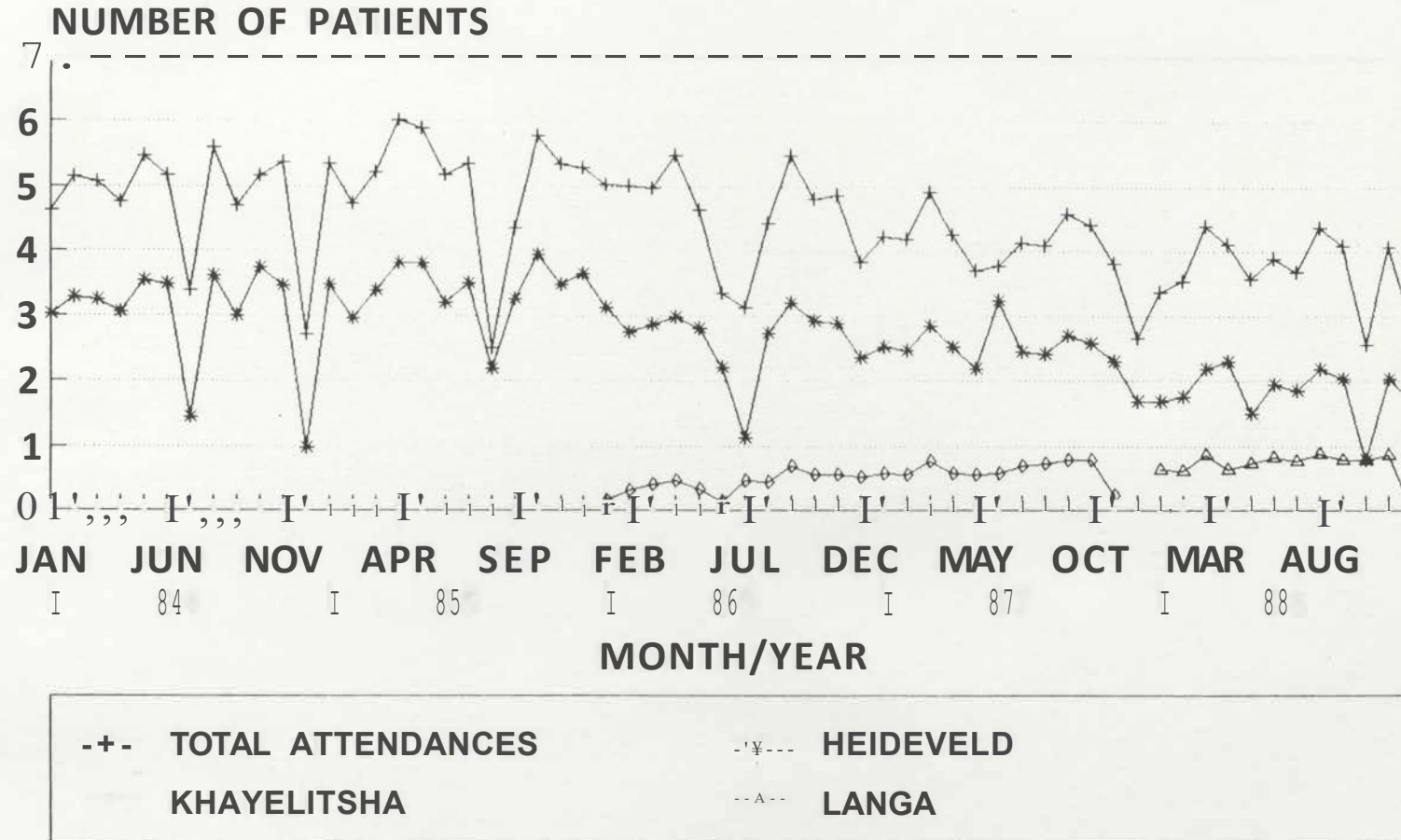


FIGURE 17b

HEIDEVELD MOU DELIVERIES

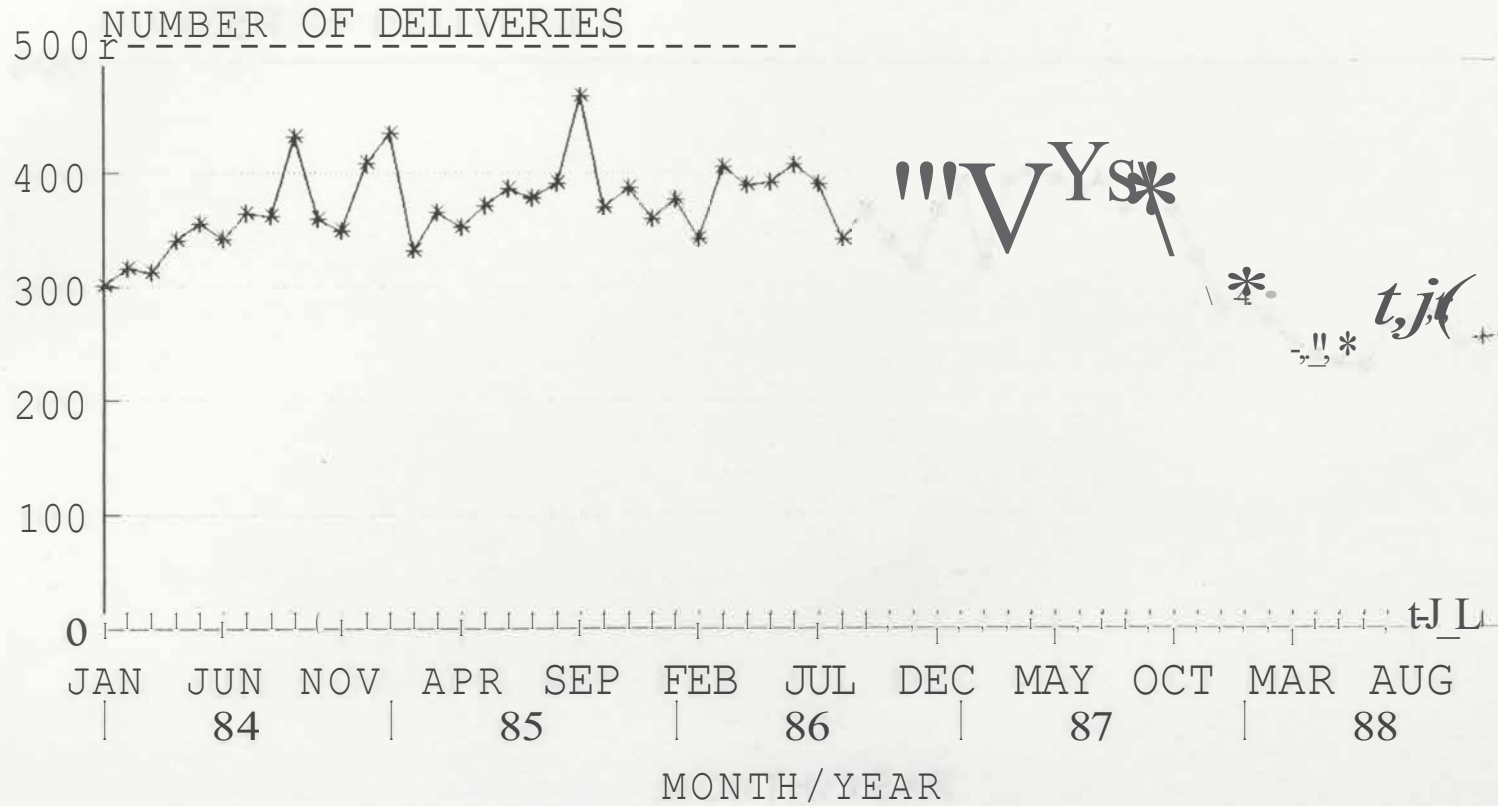
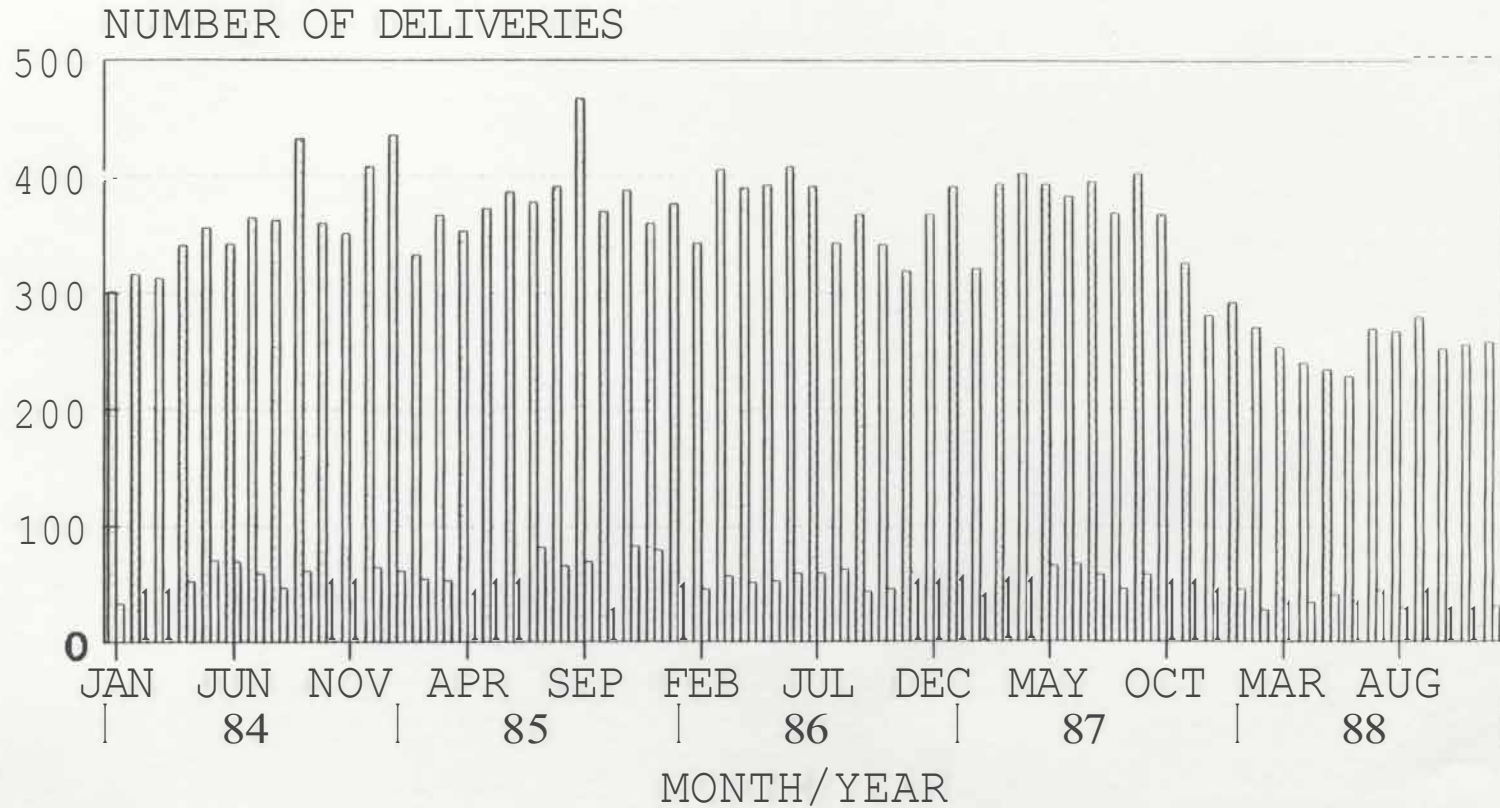


FIGURE 18

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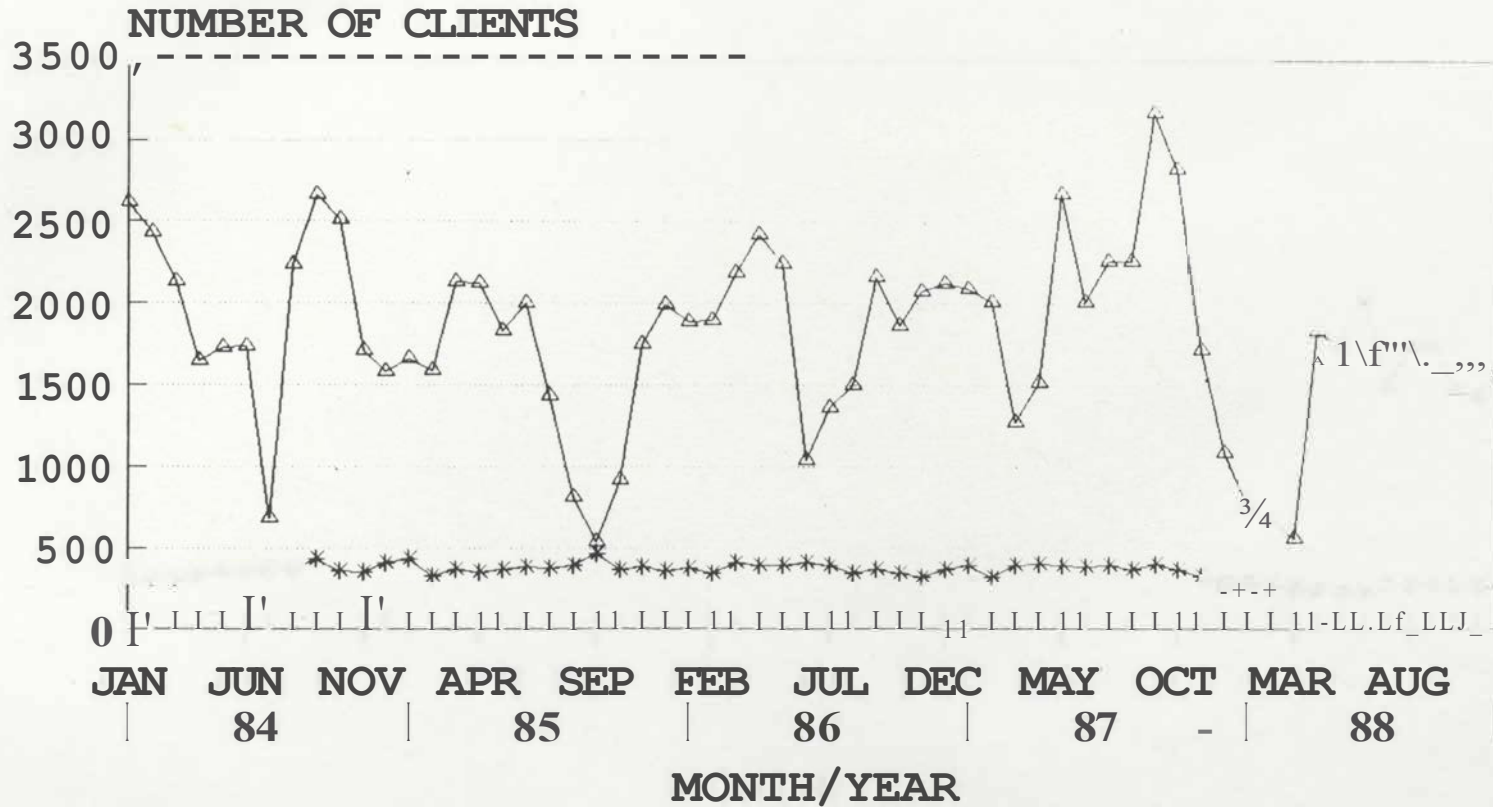
HEIDEVELD MOU DELIVERIES



[D DELIVERIES D BBA]

FIGURE 19

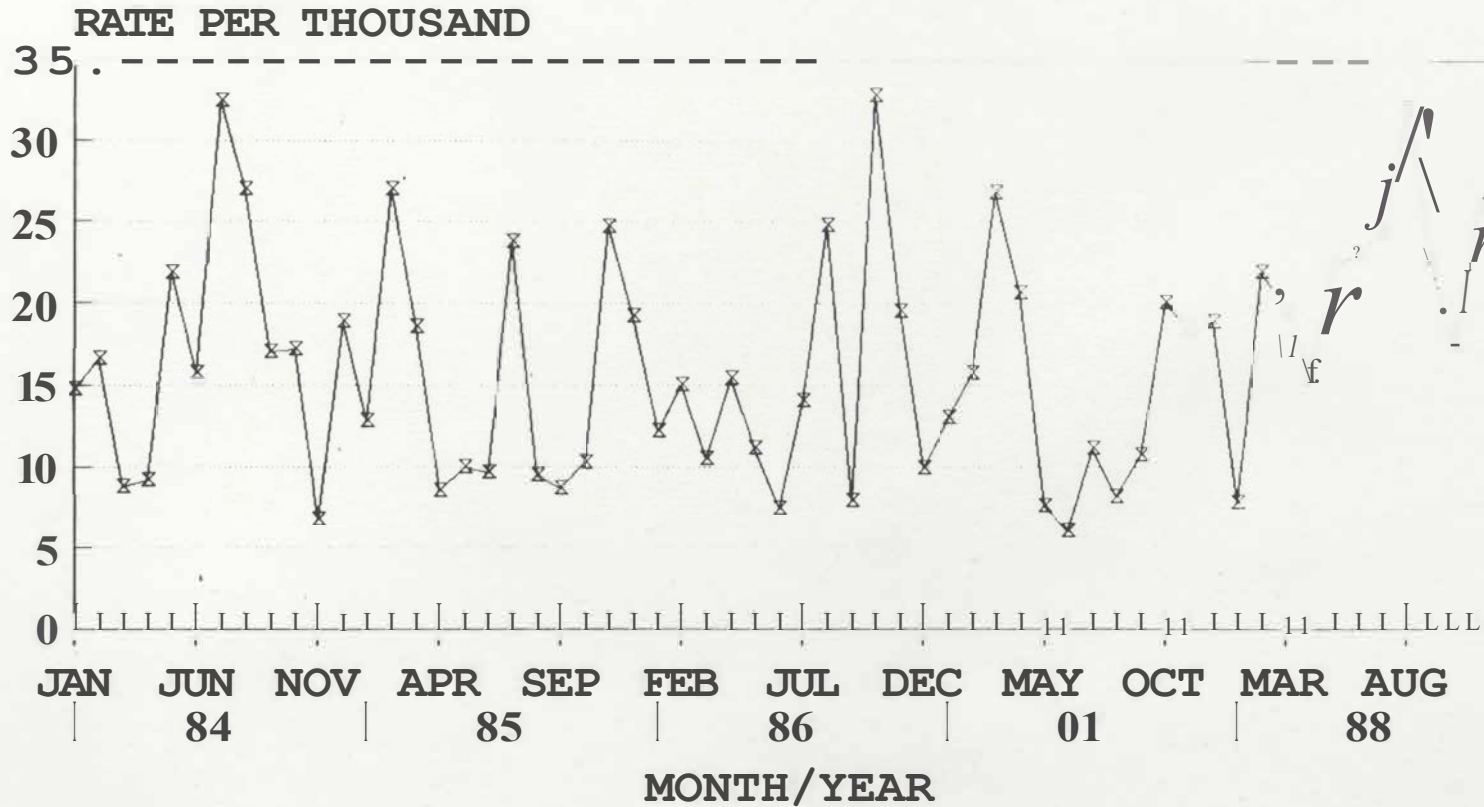
HEIDEVELD MOU DELIVERIES/HOME VISITS



---△--- DELIVERIES ---*--- HOME VISITS

FIGURE 20

-HEIDEVELD MOU PERINATAL MOR.TALITY RATE

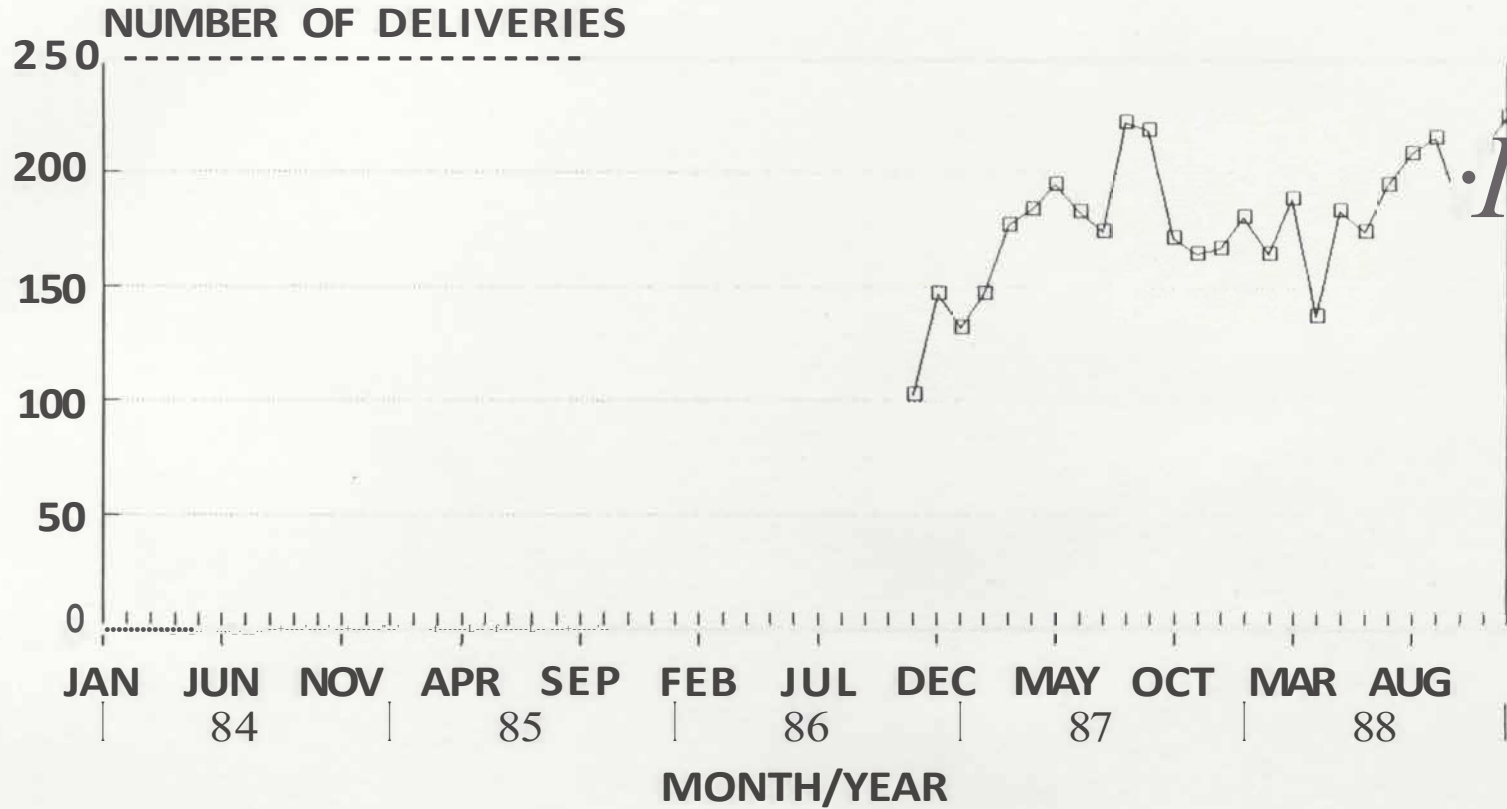


- f - PNM RATE

FIGURE 21

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MITCHELL'S PLAIN DELIVERIES



- 9 - MITCHELL'S PLAIN

FIGURE 23

KHAYELITSHA ANTENATAL CLINIC

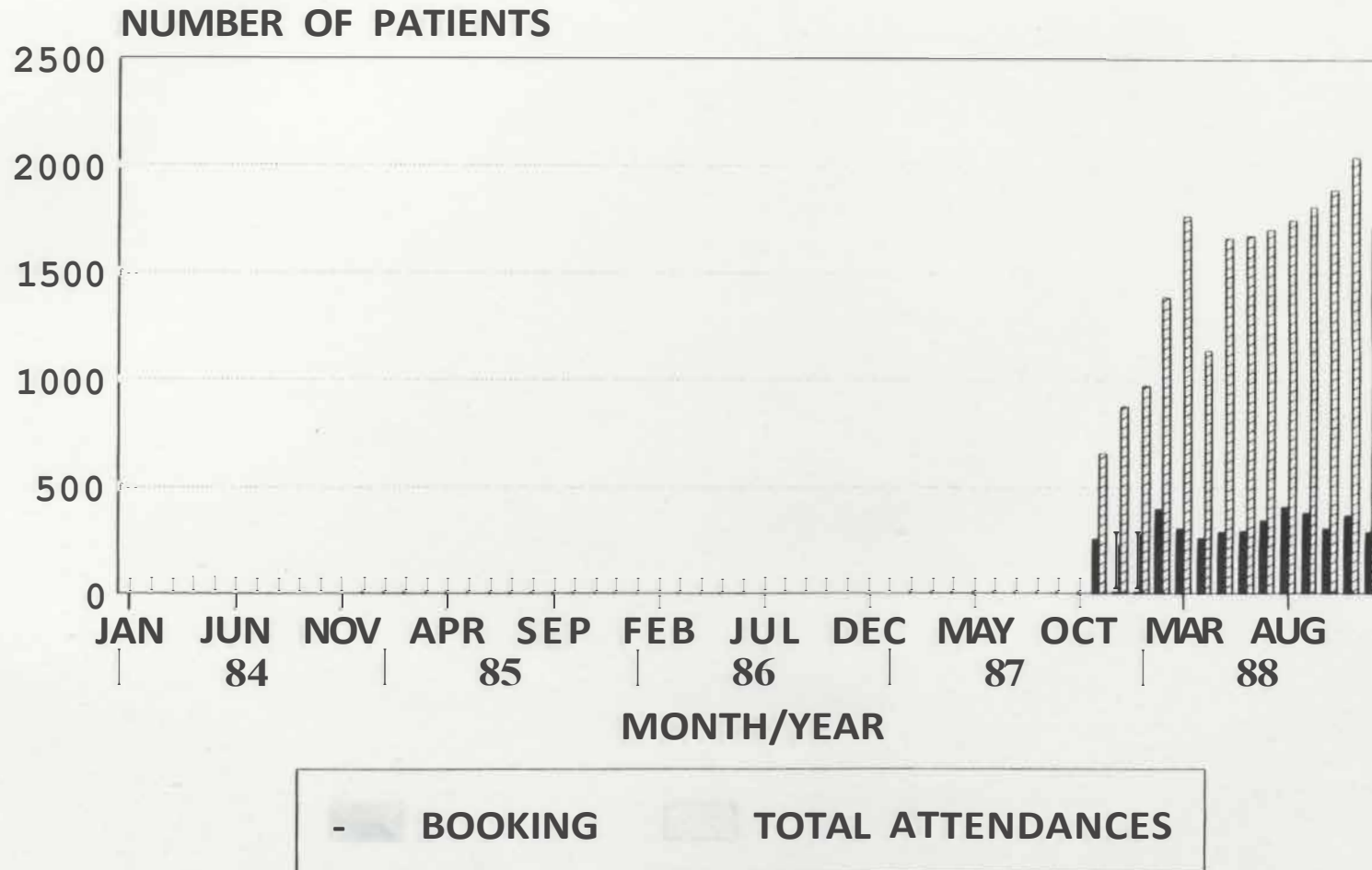
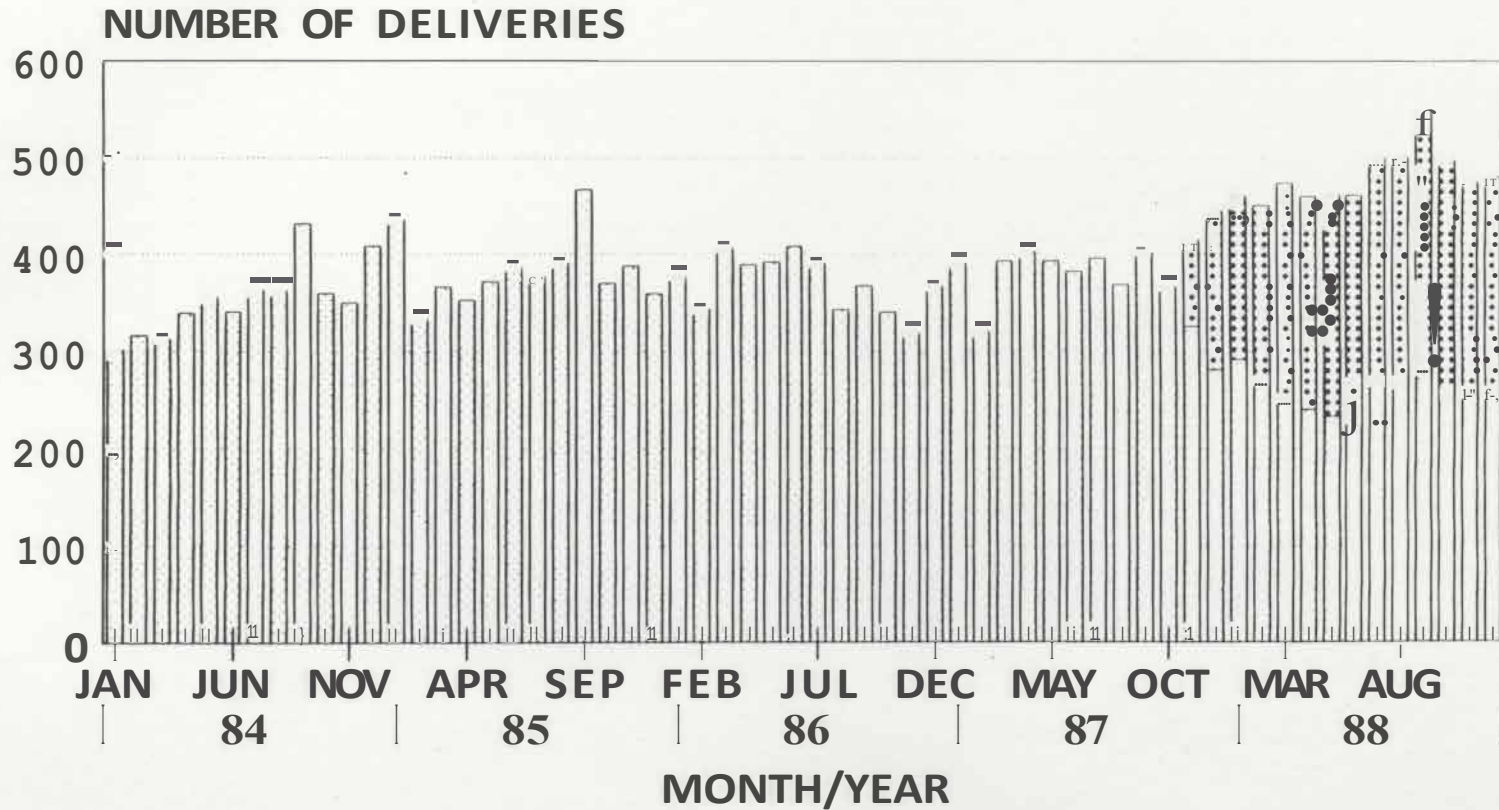


FIGURE 24

DELIVERIES HEIDEVELD/KHAYELITSHA



D HEIDEVELD **mmmm** KHAYELITSHA

FIGURE 26

KHAYELITSHA MOU DELIVERIES

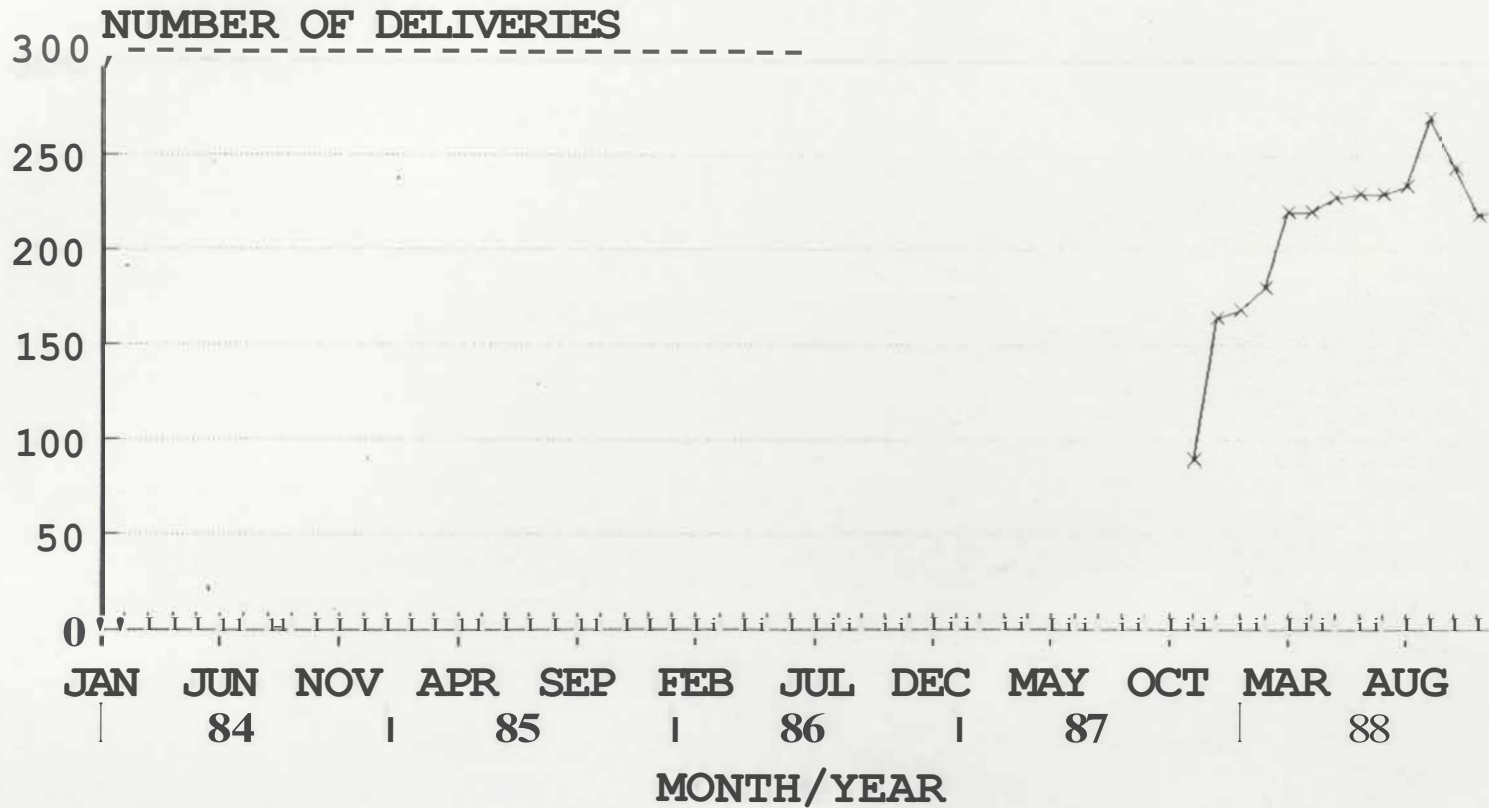


FIGURE 26

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NEONATAL JAUNDICE INFANTS REQUIRING PHOTOTHERAPY

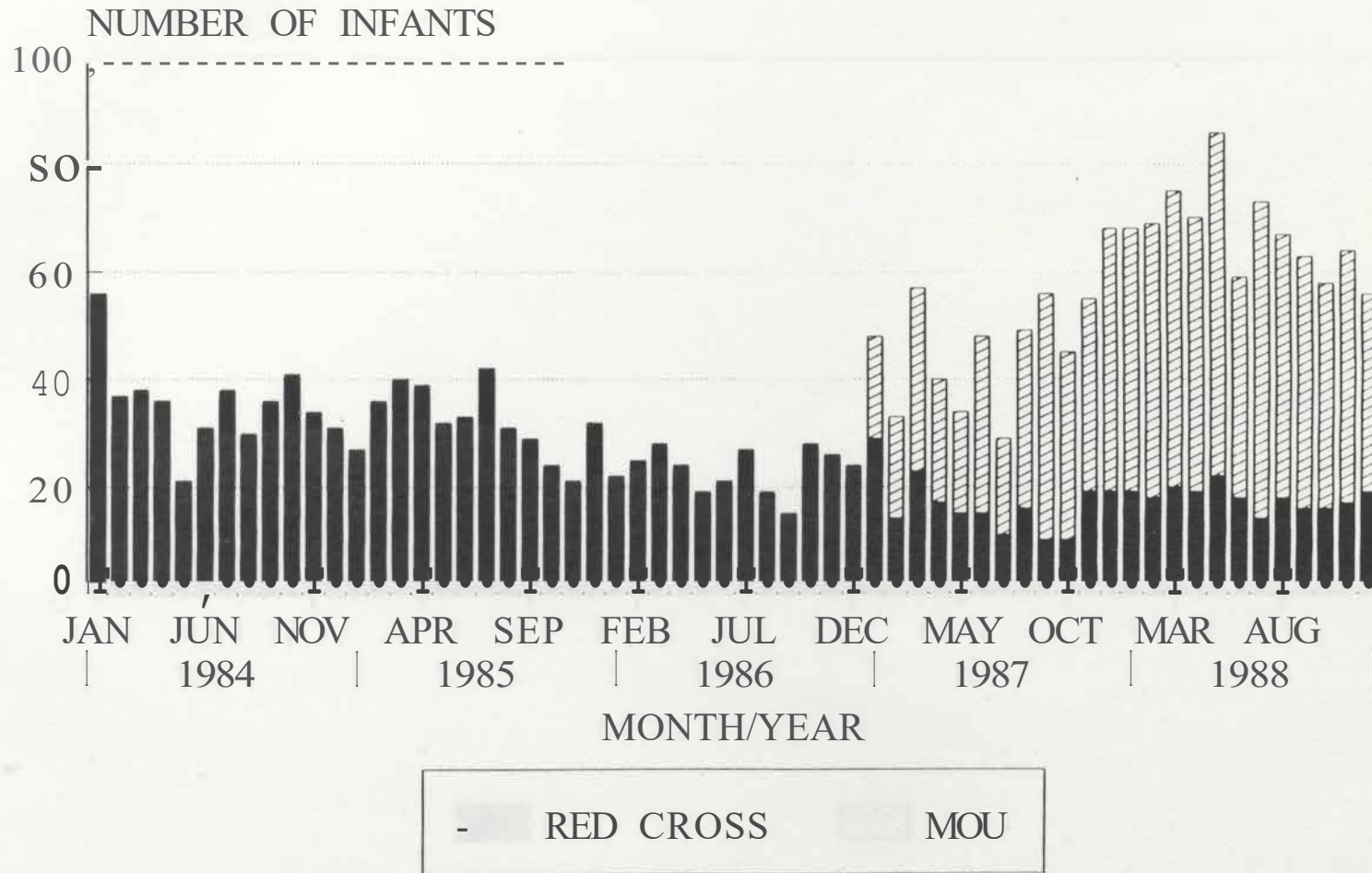


FIGURE 27

RED CROSS HOSPITAL OPHTHALMIA NEONATORUM

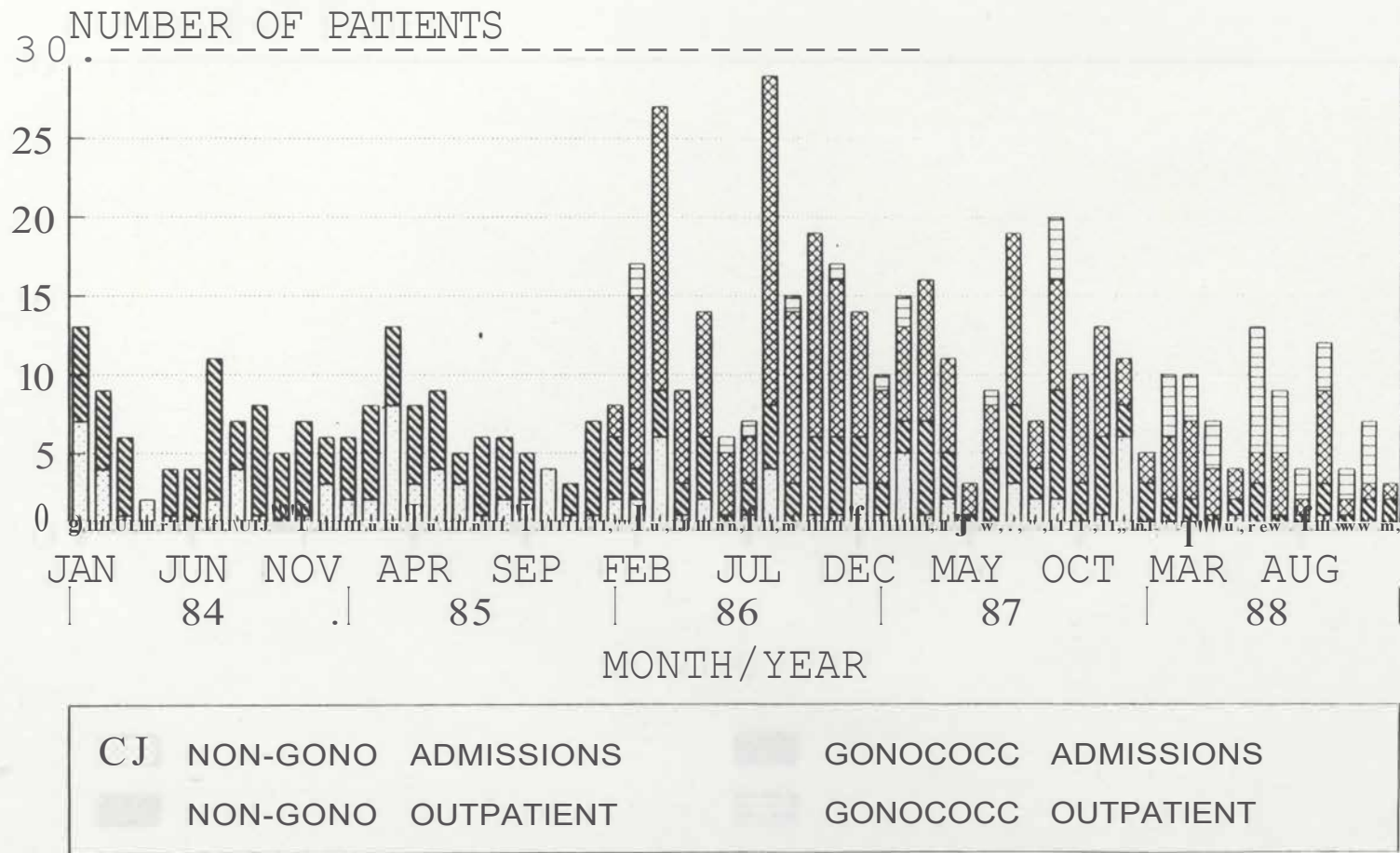
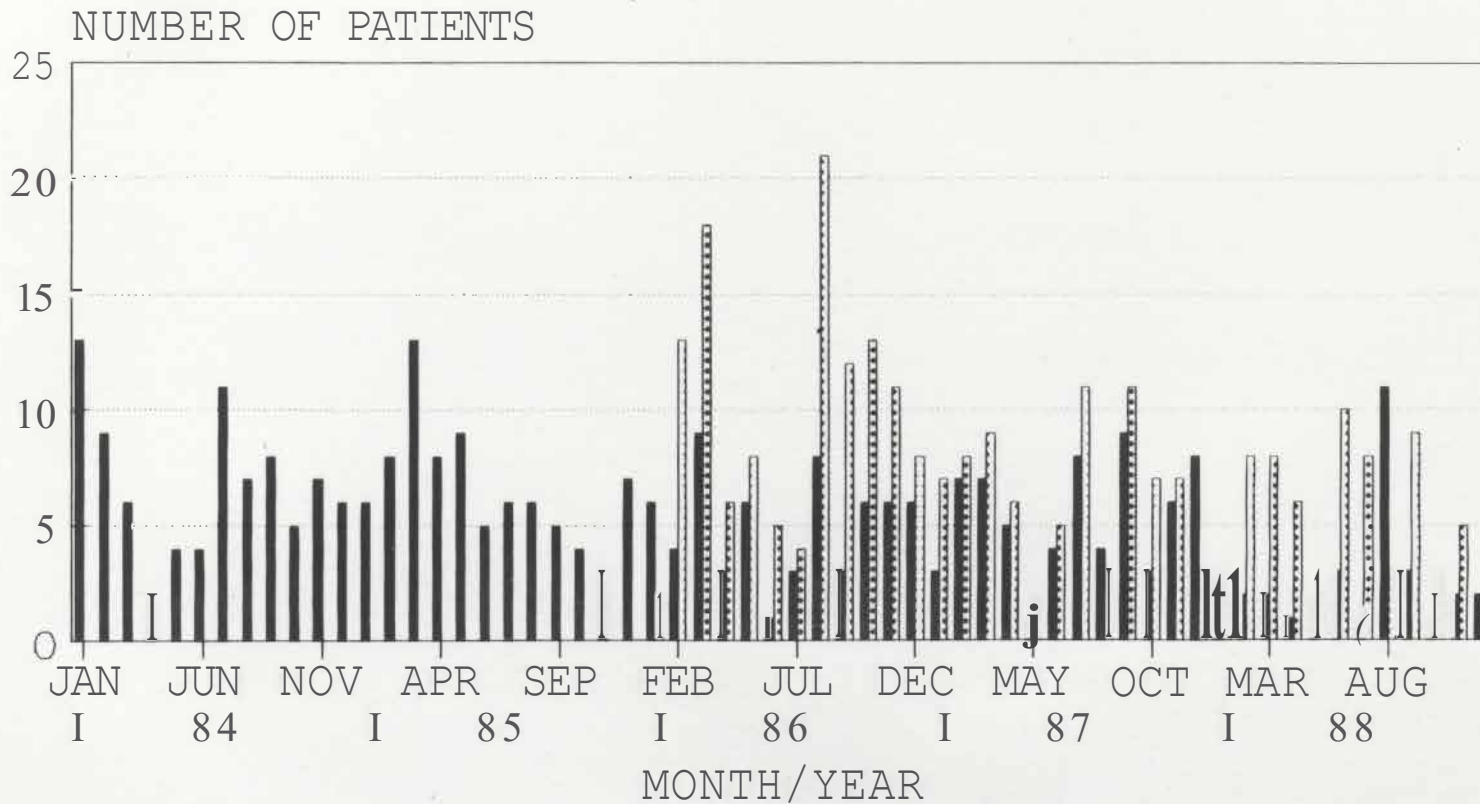


FIGURE 28

RED CROSS HOSPITAL OPHTHALMIA NEONATORUM



I - ADMISSIONS § OUTPUT PATIENTS I

FIGURE 29a

RATE OF OPH. NEONATORUM

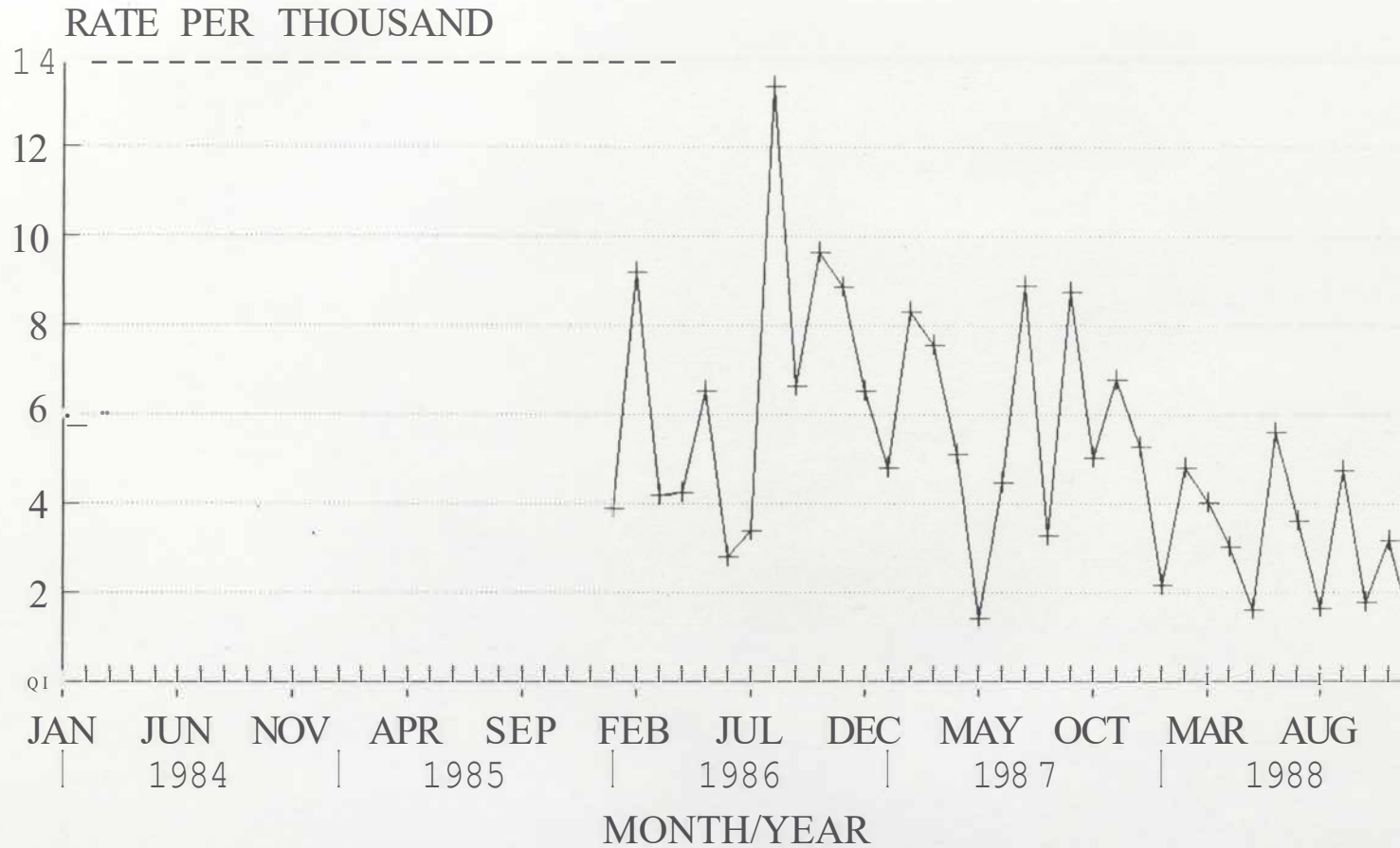


FIGURE 29b

RED CROSS HOSPITAL OPHTHALMIA NEONATORUM

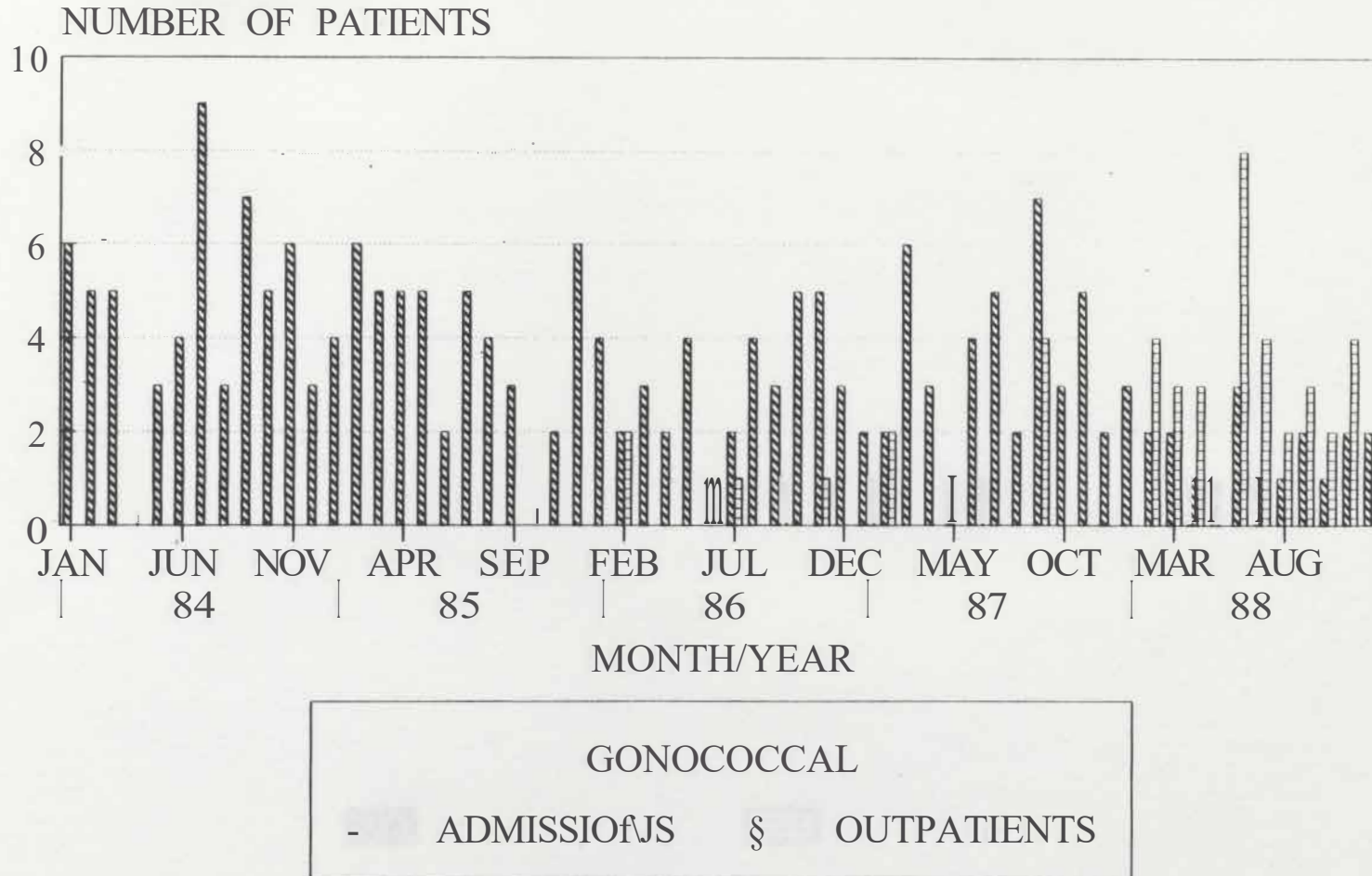


FIGURE 30

RED CROSS HOSPITAL OPHTHALMIA NEONATORUM

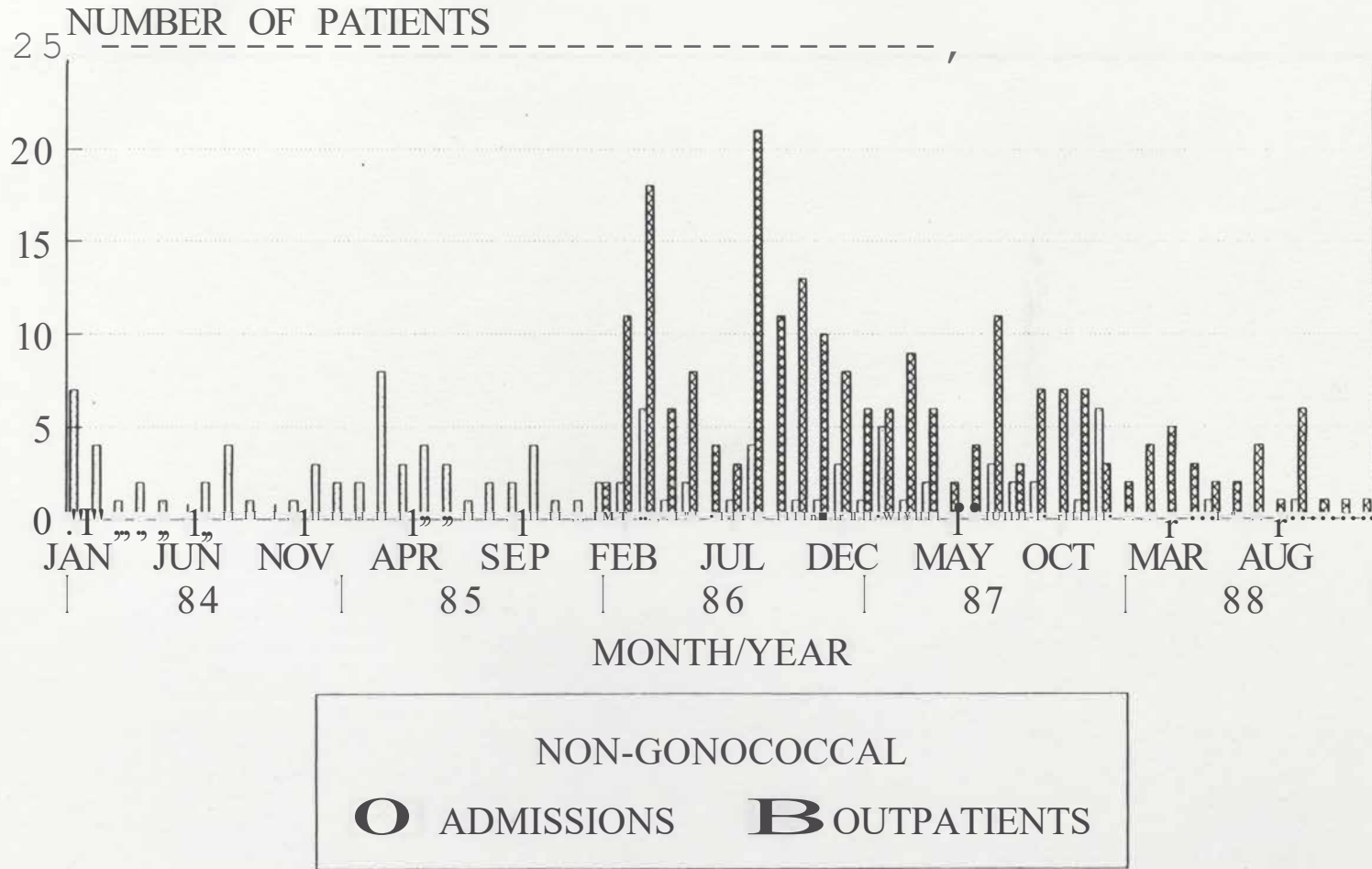


FIGURE 31

RED CROSS HOSPITAL UMBILICAL SEPSIS

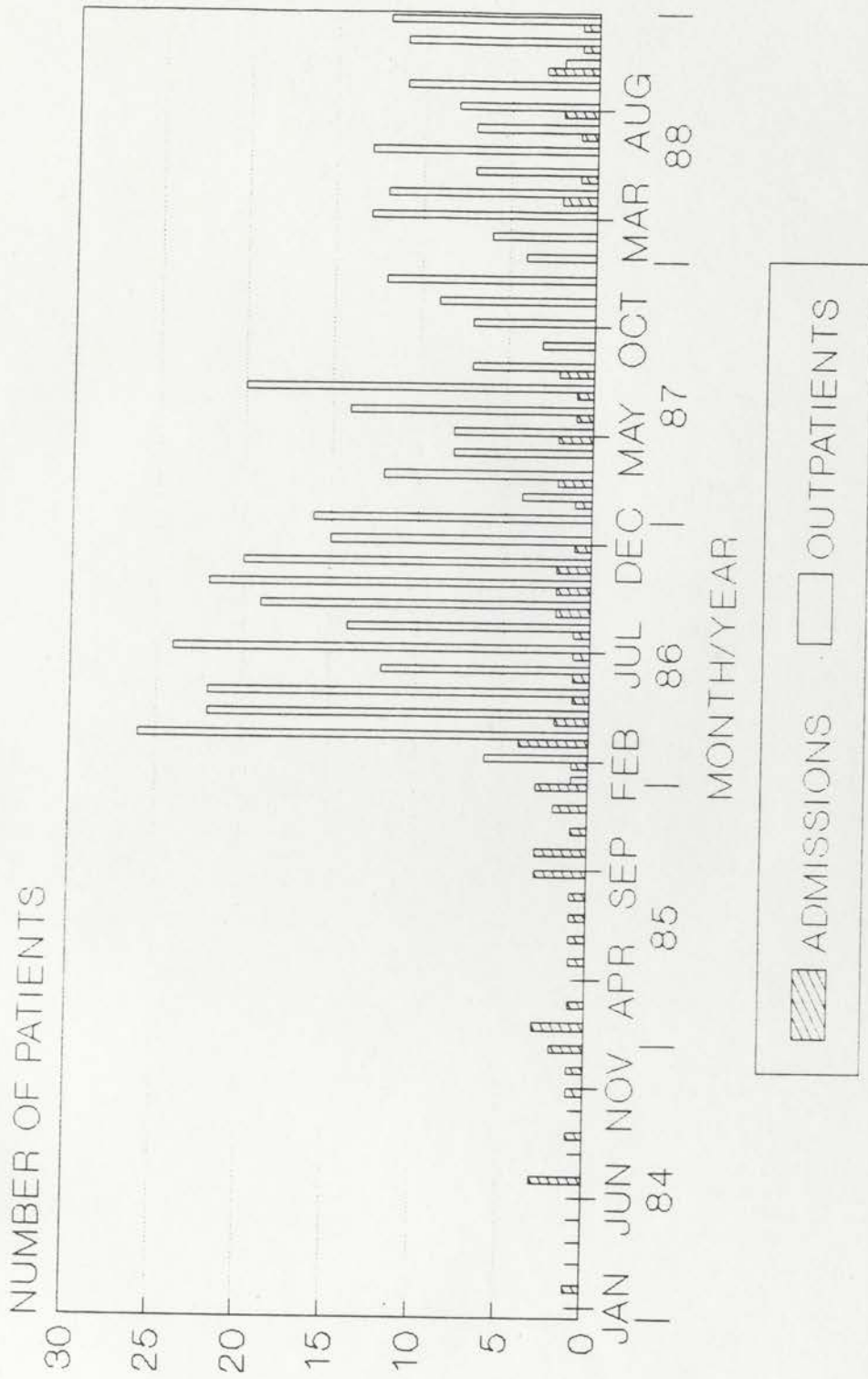


FIGURE 32a

RATE OF UMBILICAL SEPSIS

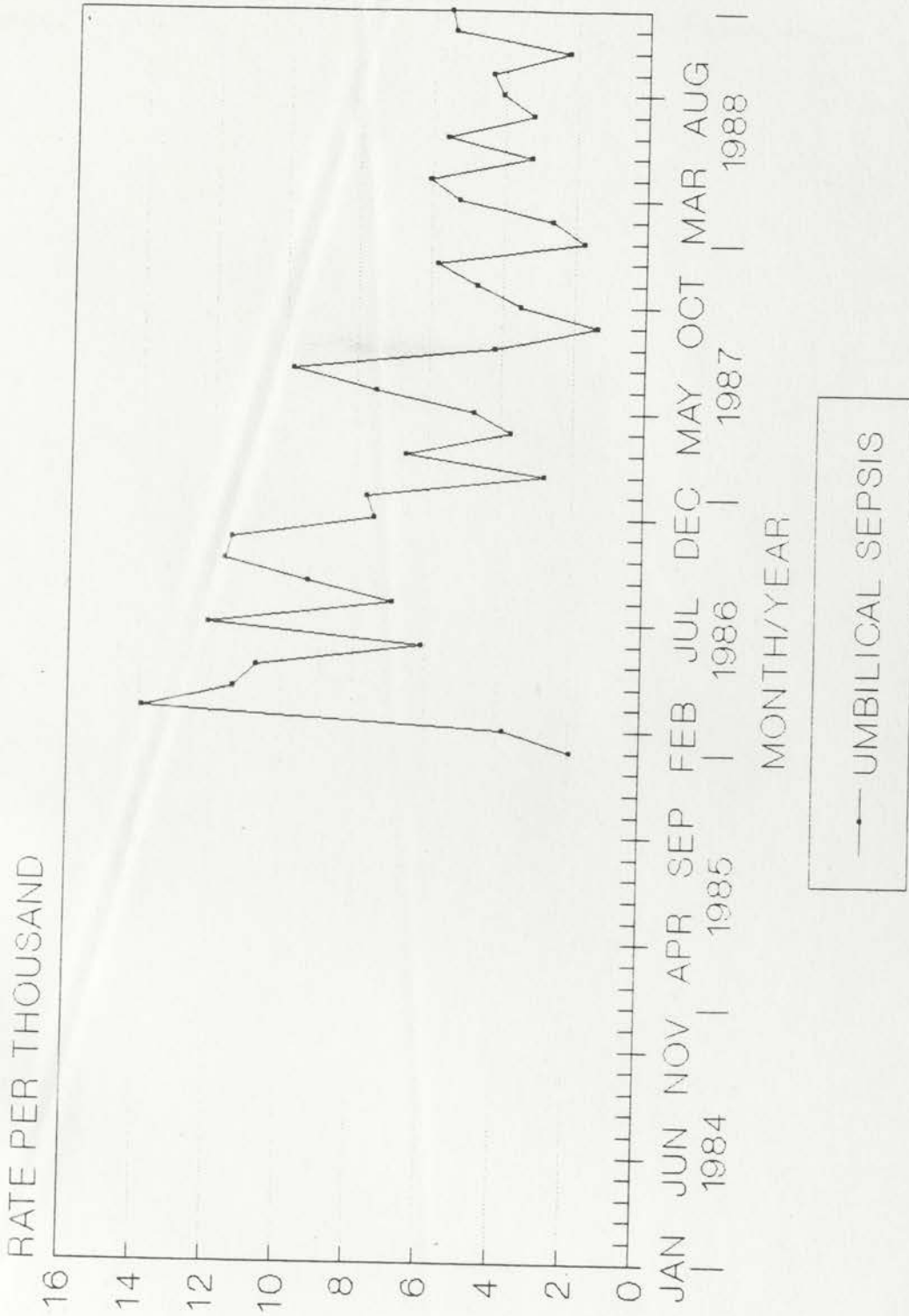


FIGURE 32B

FIGURE 32b

CONSTANTIA

FIGURE 33

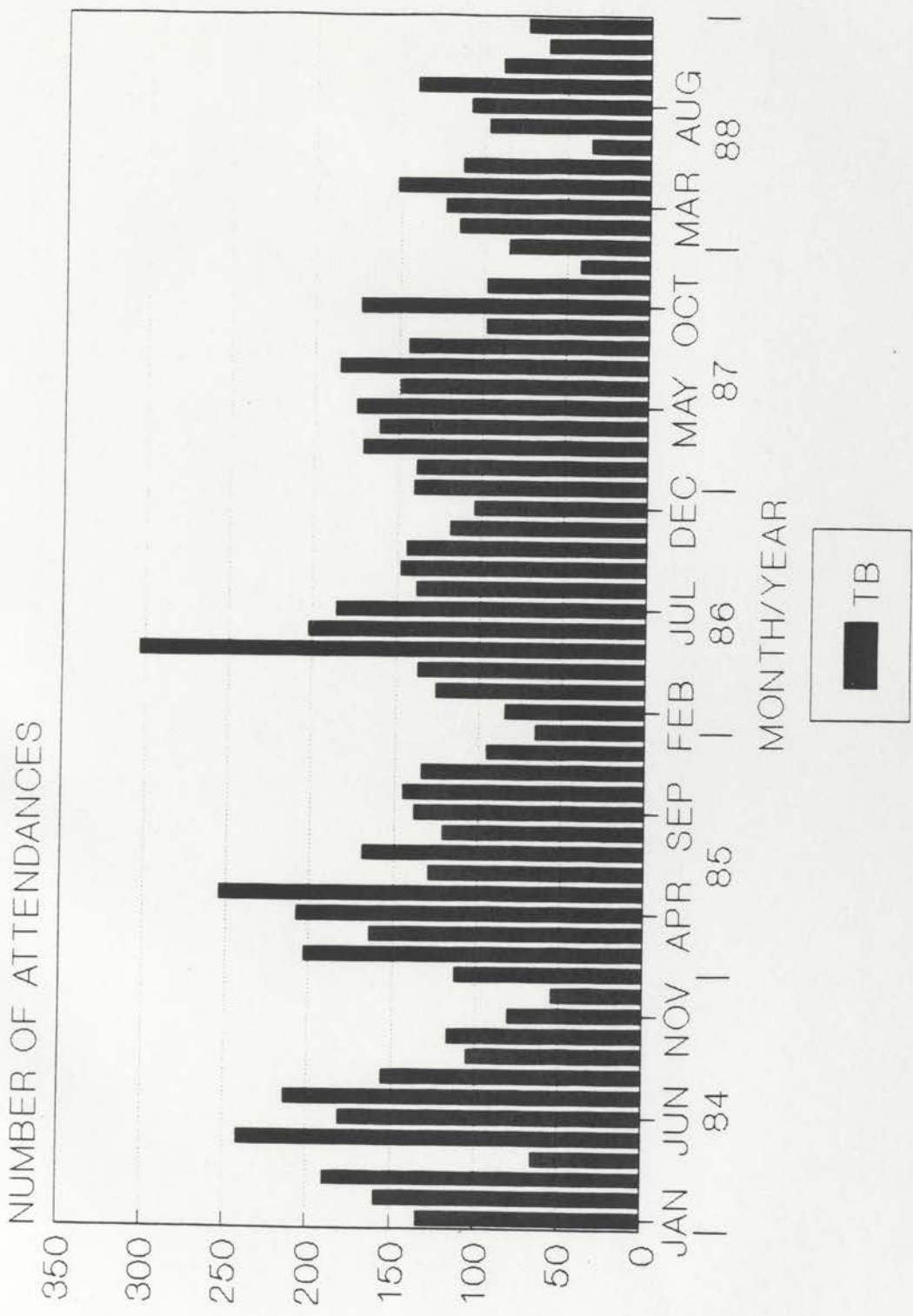


FIGURE 33

CONSTANTIA

FIGURE 34

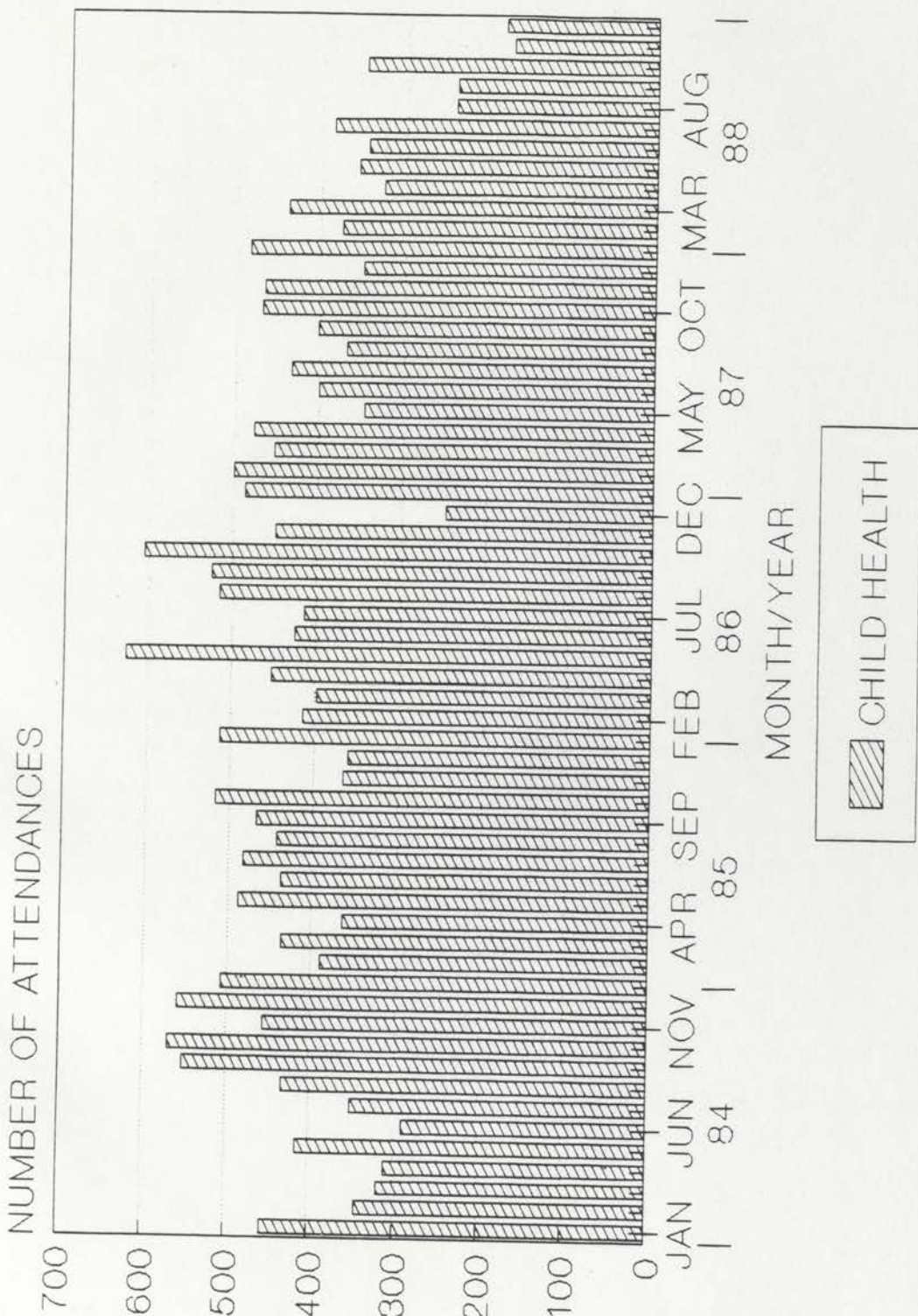


FIGURE 34

CONSTANTIA

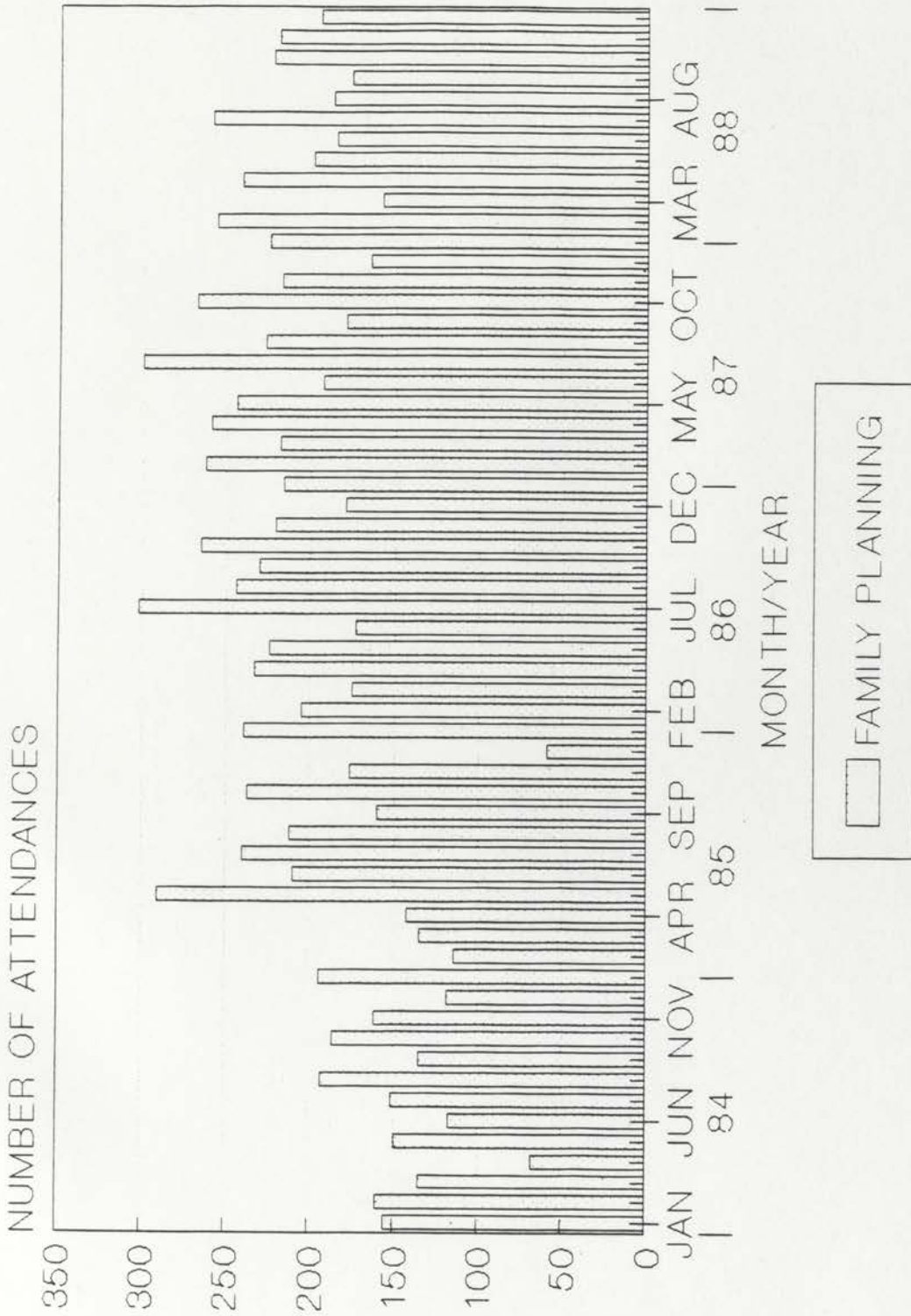


FIGURE 35

FIGURE 35

HOUT BAY

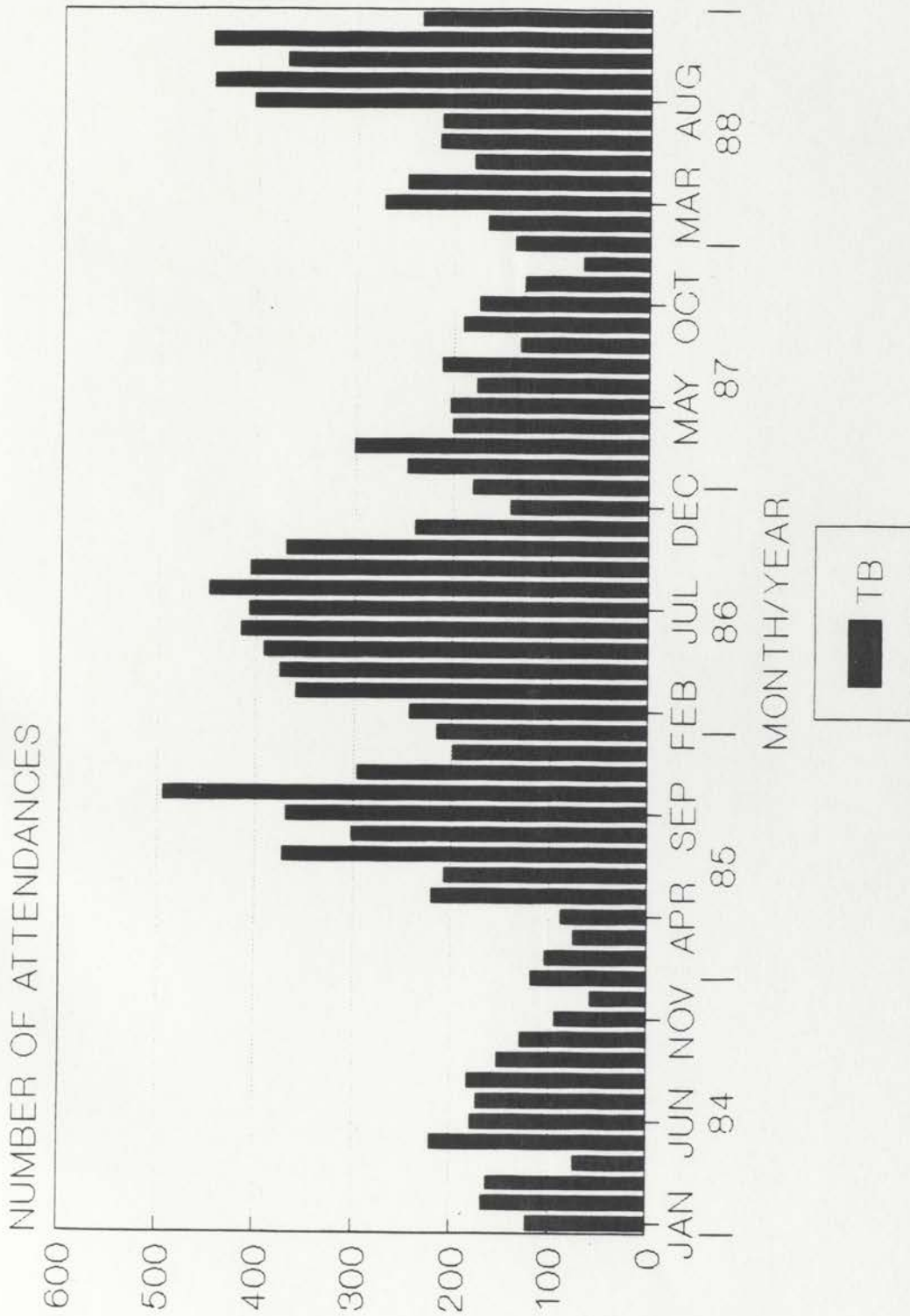


FIGURE 36

HOUT BAY

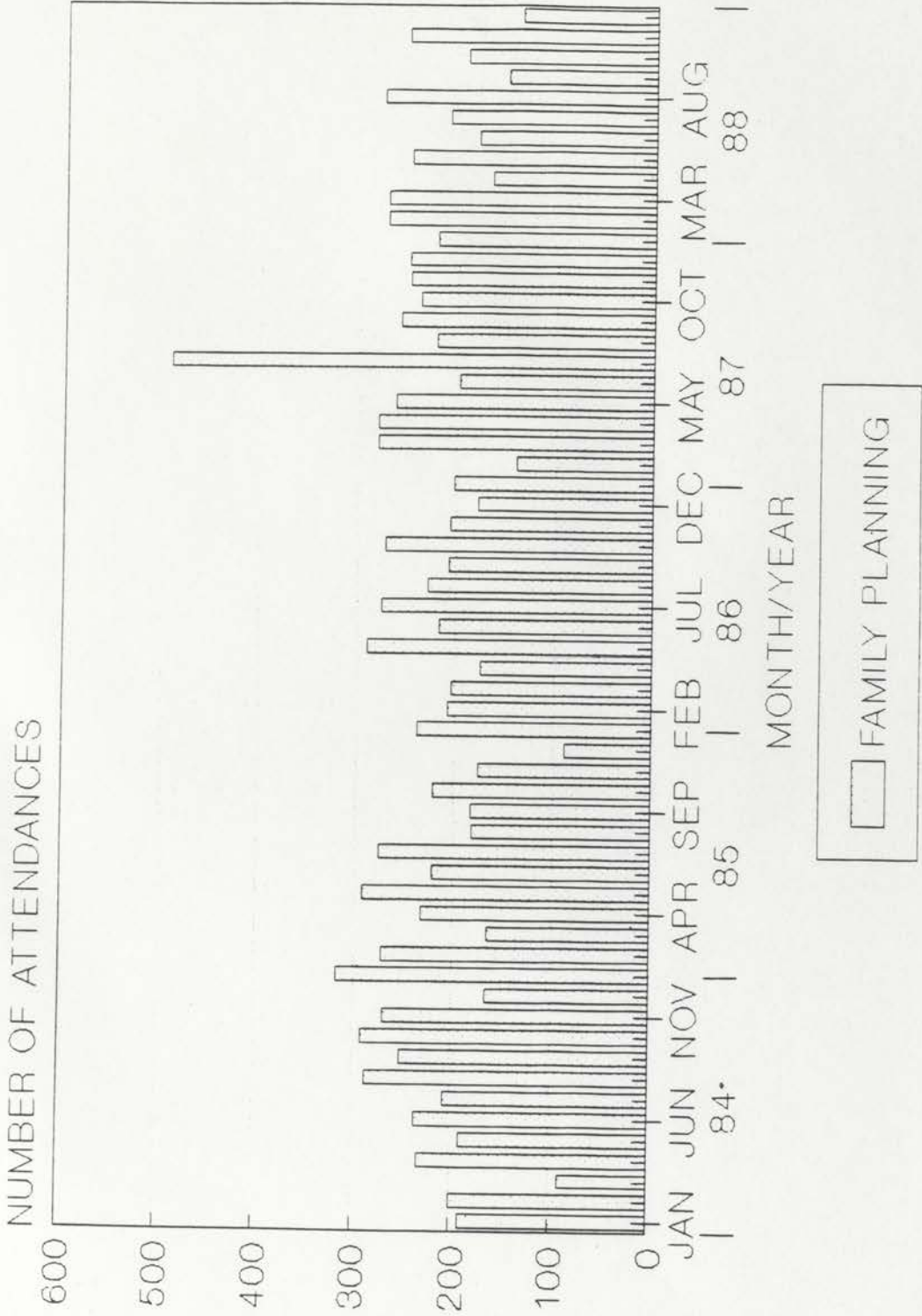


FIGURE 37

FIGURE 37

HOUT BAY

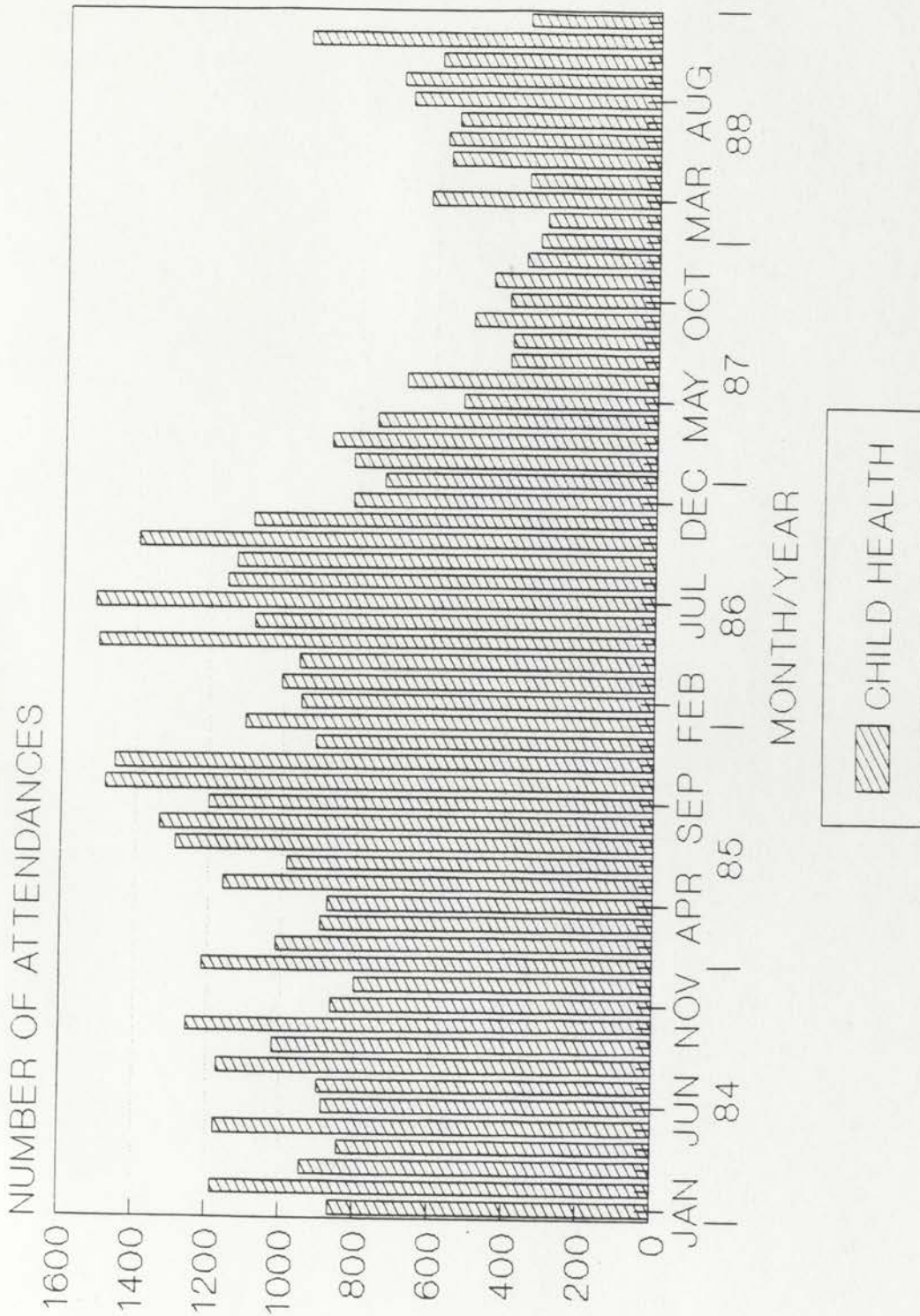


FIGURE 38

FIGURE 38

GRASSY PARK

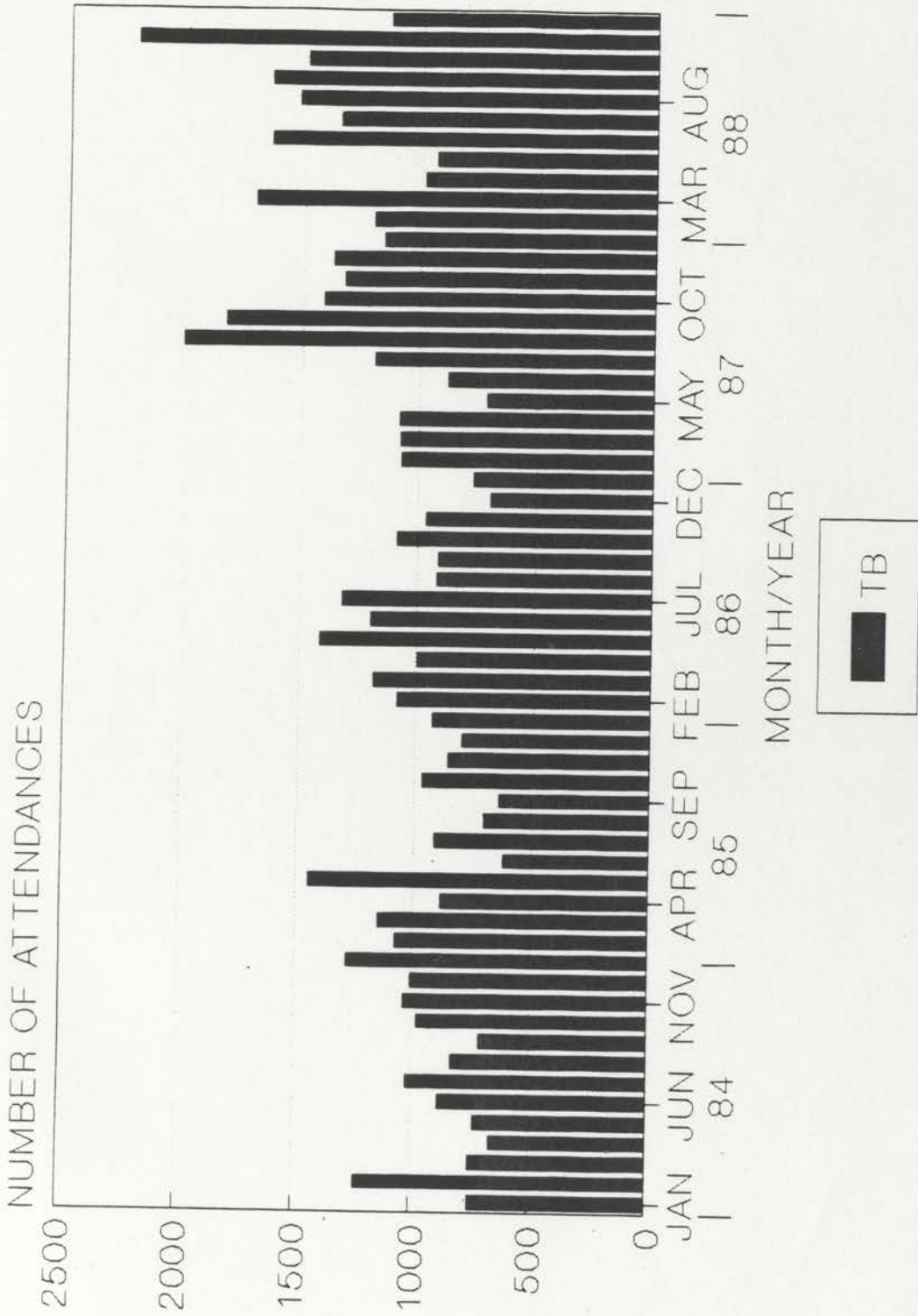


FIGURE 39

FIGURE 39

GRASSY PARK

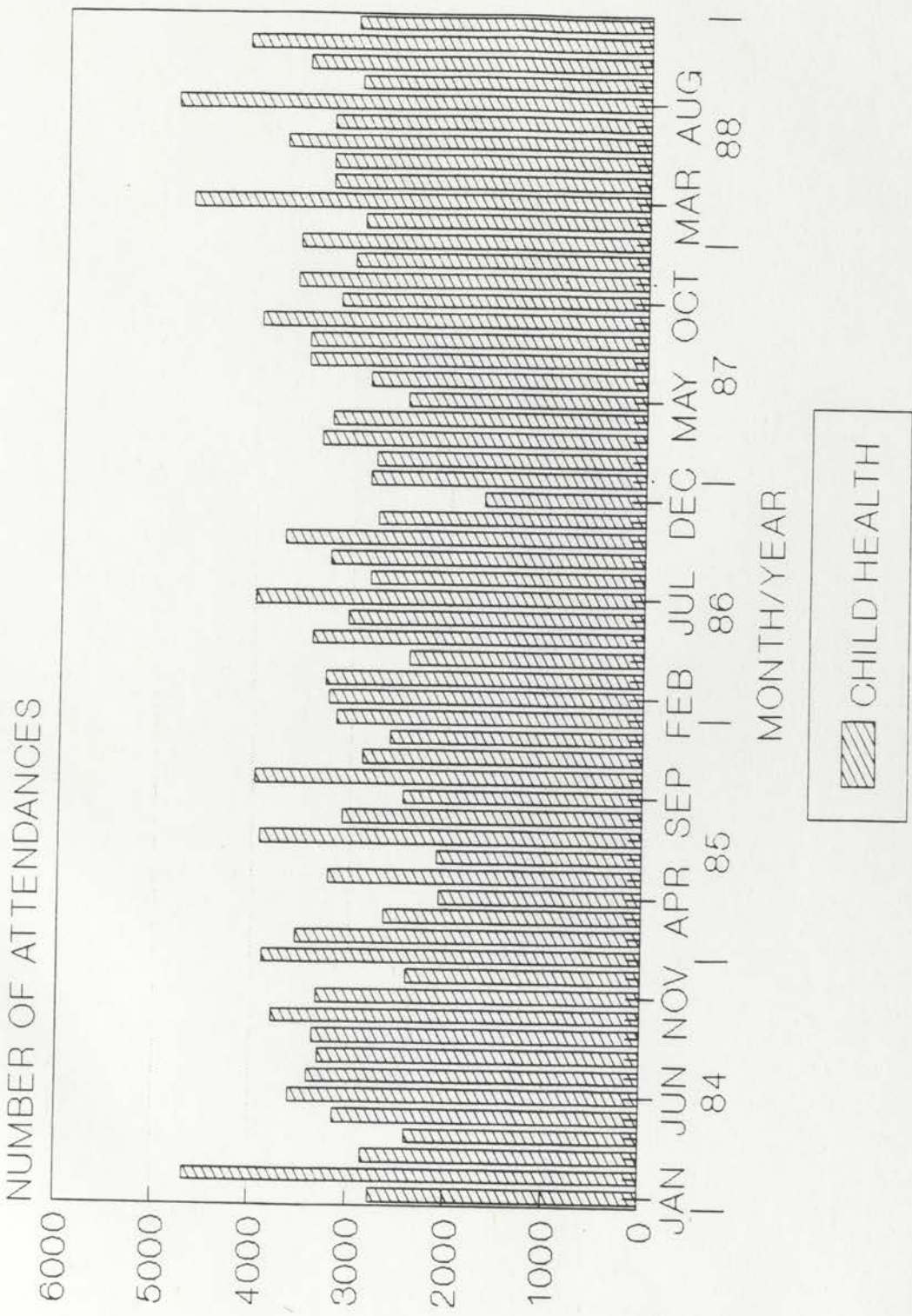


FIGURE 40

FIGURE 40

GRASSY PARK

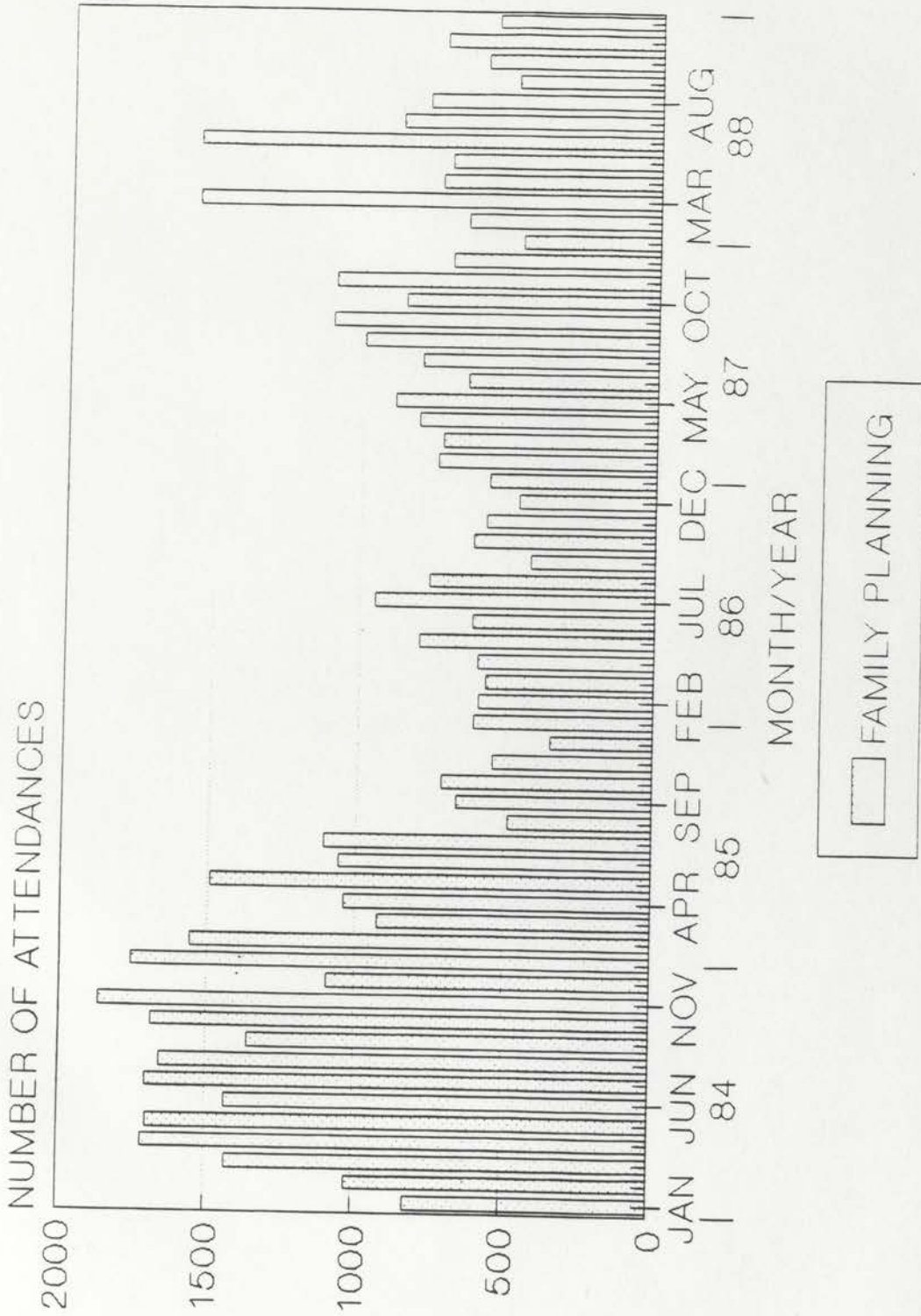


FIGURE 41

FIGURE 41

CONSTANTIA

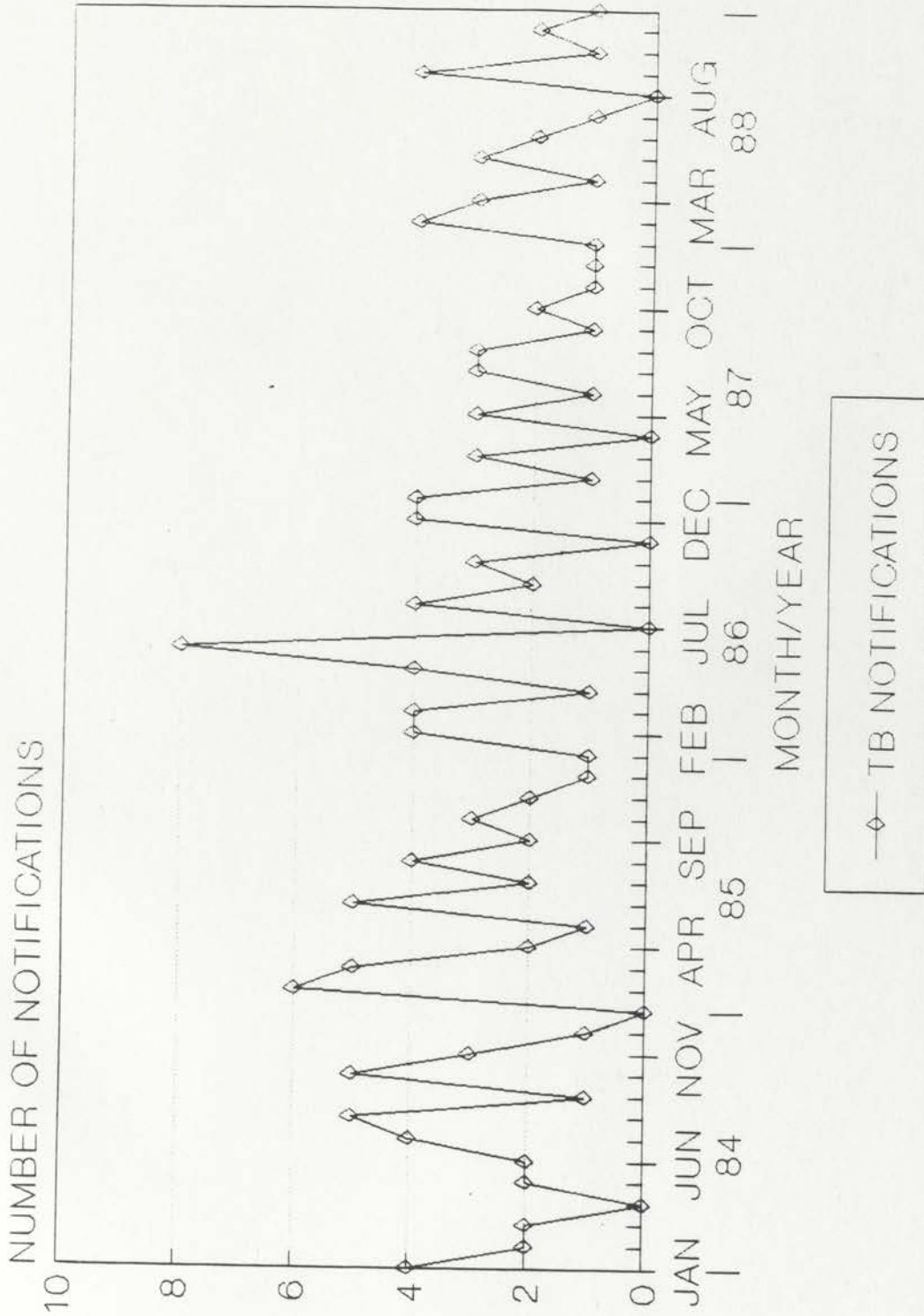


FIGURE 42

FIGURE 42

HOUT BAY

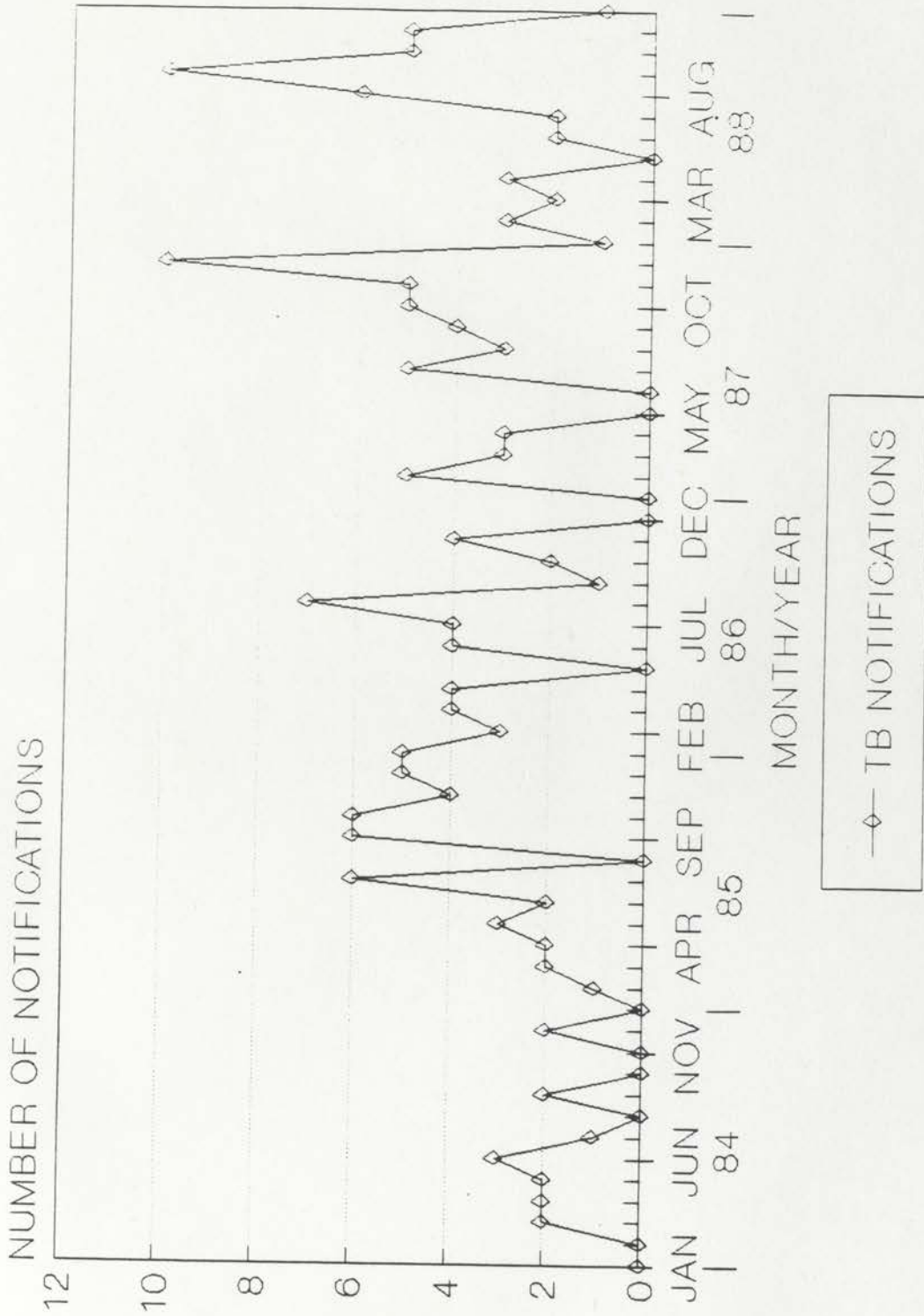


FIGURE 43

FIGURE 43

GRASSY PARK

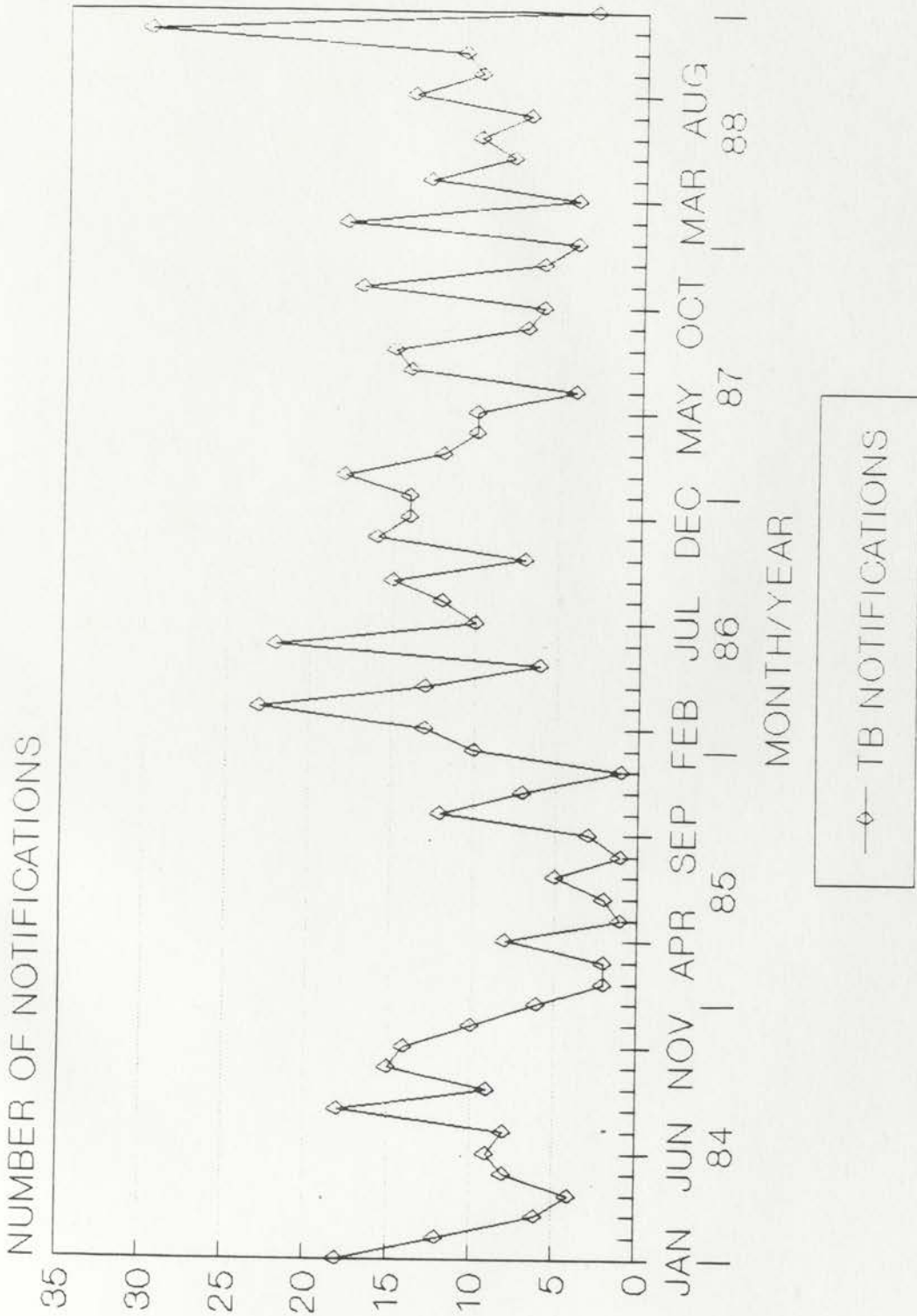


FIGURE 44

FIGURE 44

RETREAT MOU

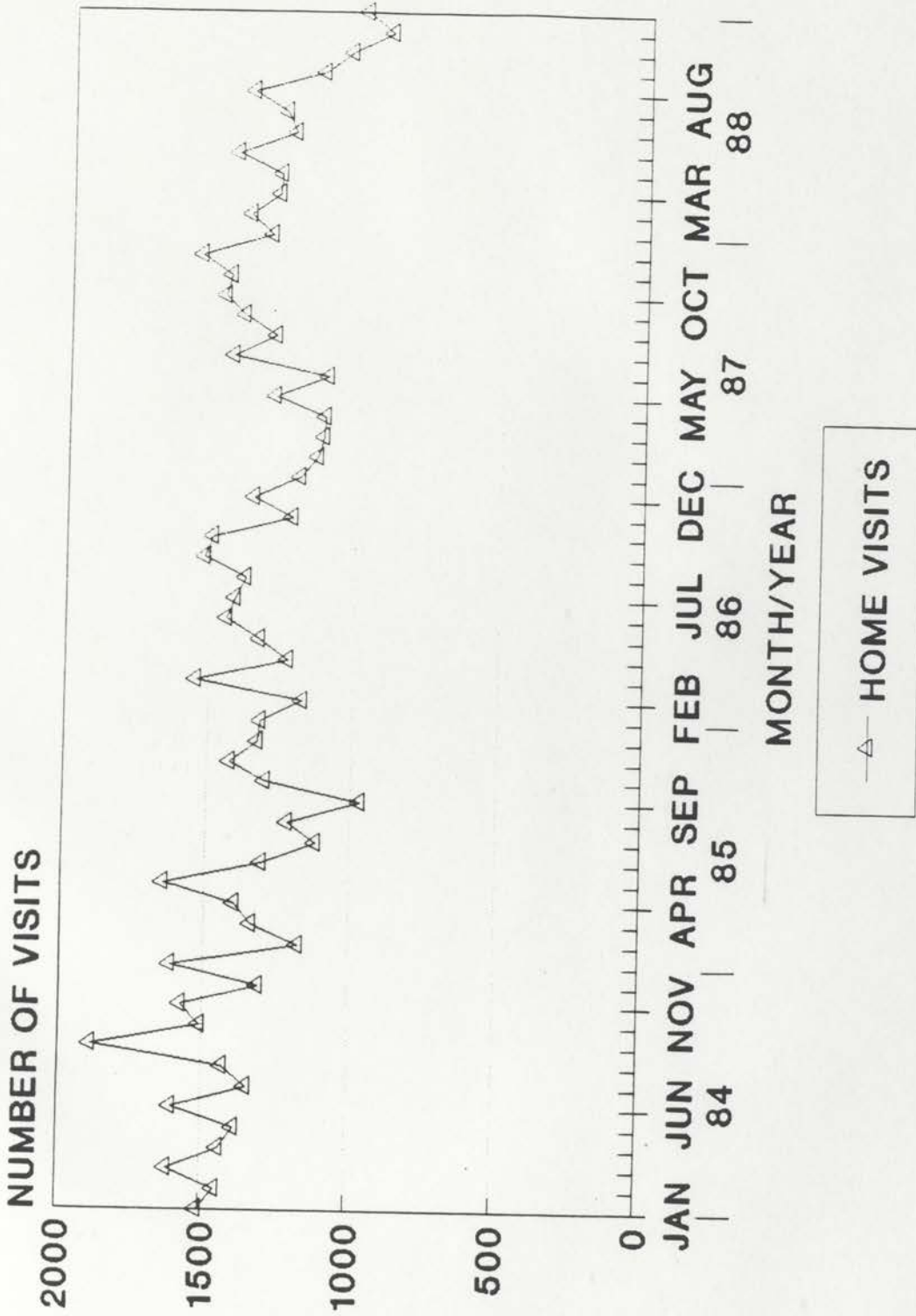


FIGURE 45

FIGURE 46

CONSTANTIA

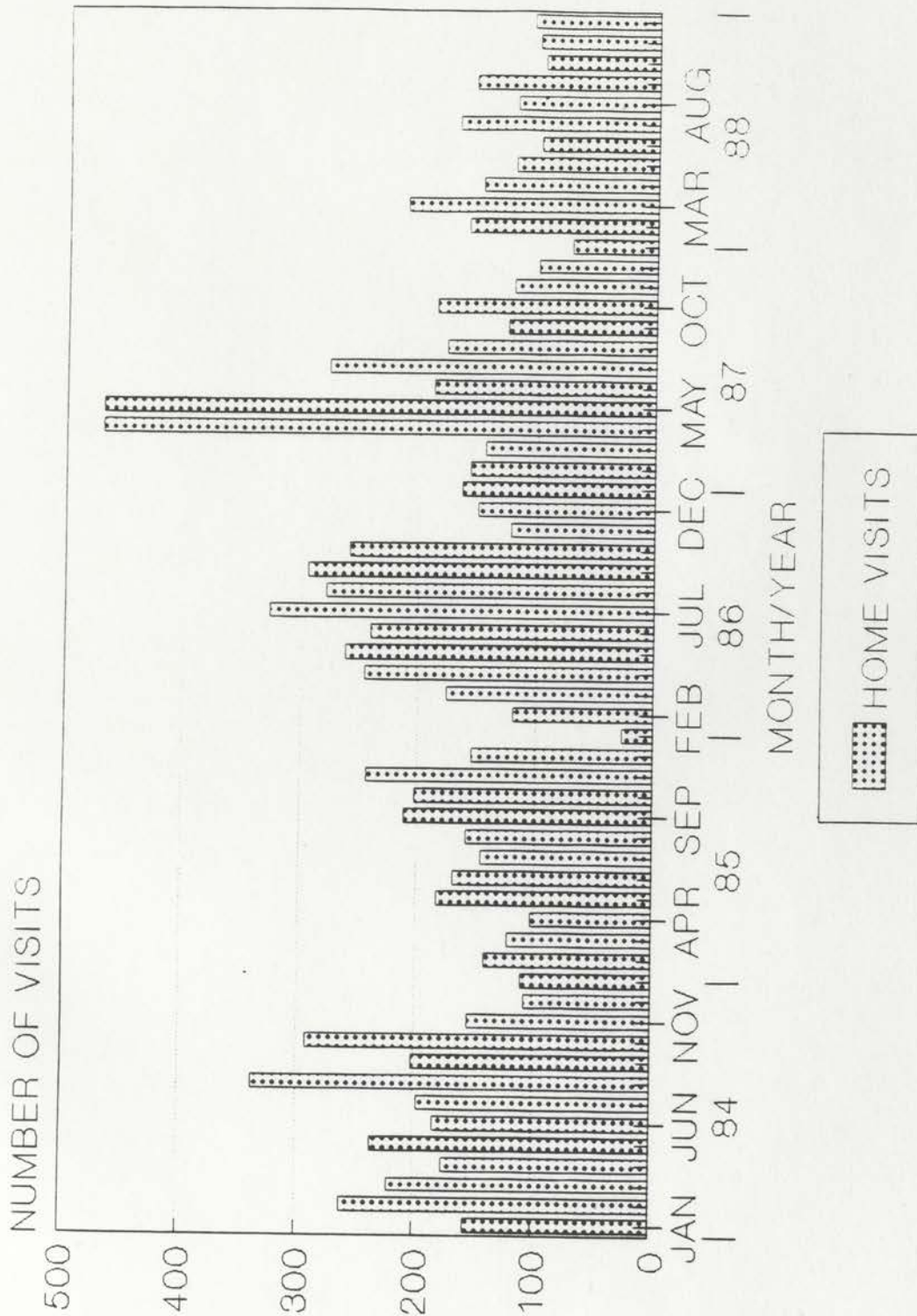


FIGURE 46

FIGURE 46

HOUT BAY

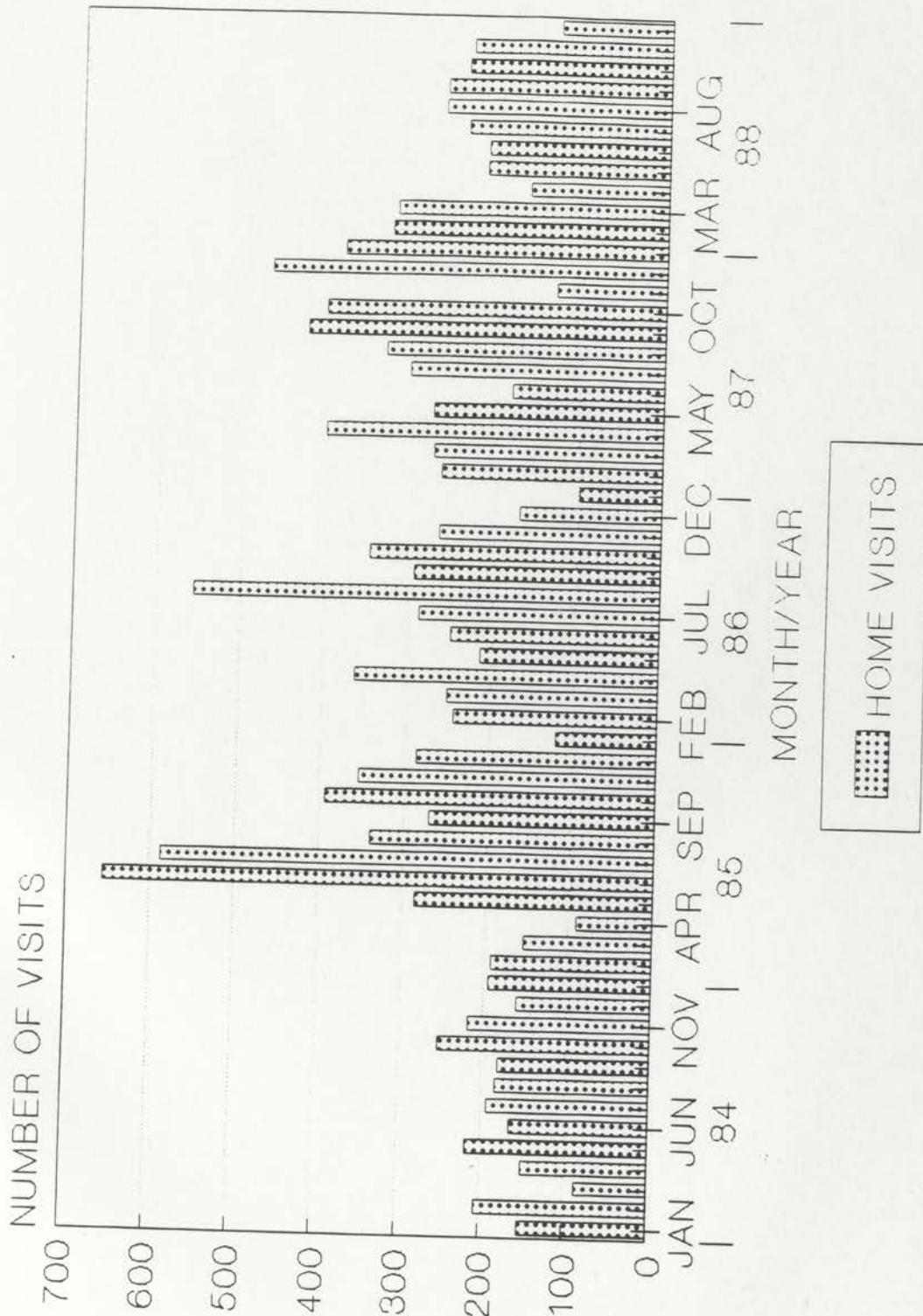


FIGURE 47

FIGURE 47

GRASSY PARK

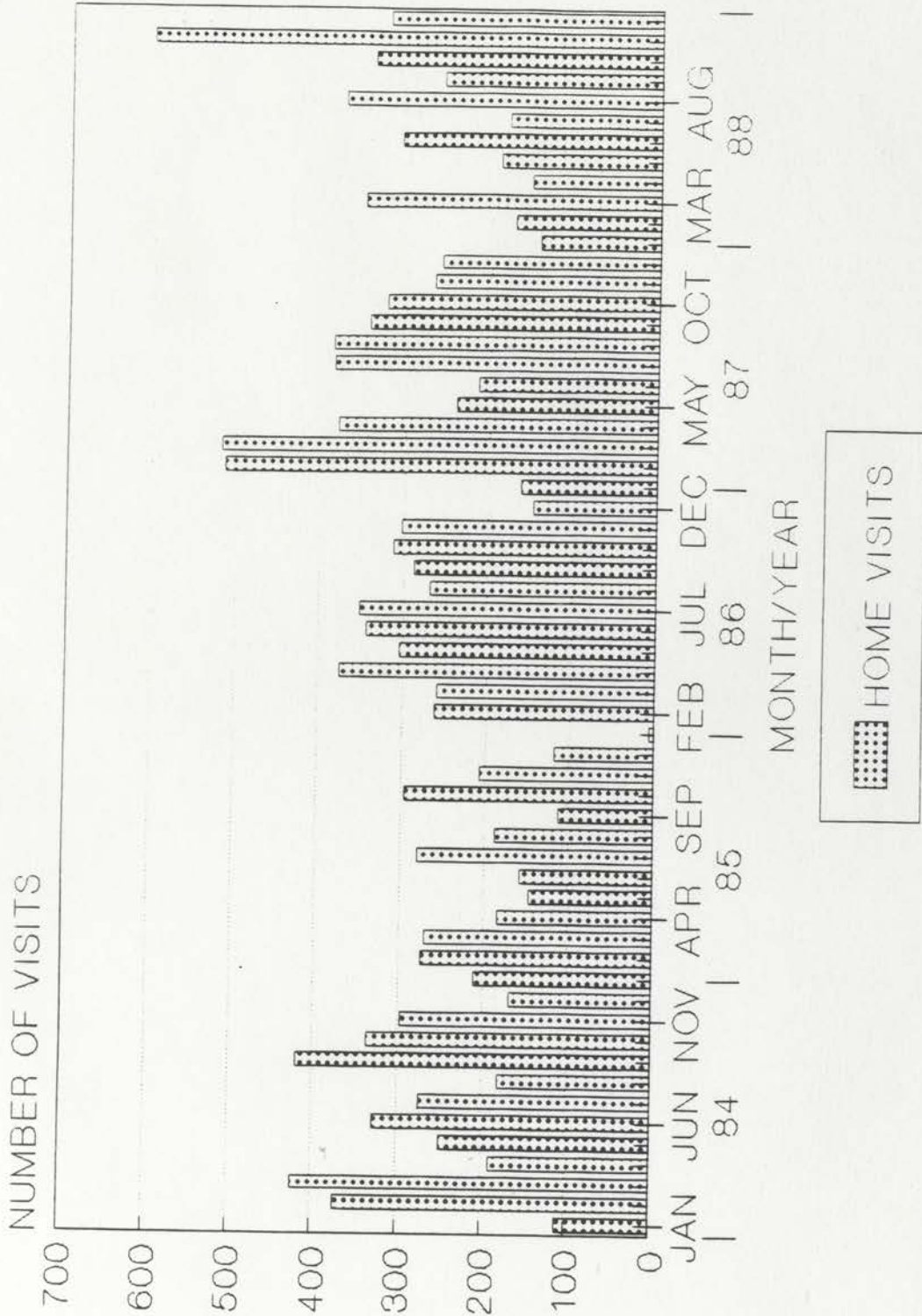


FIGURE 48

FIGURE 48

PHILLIPPI

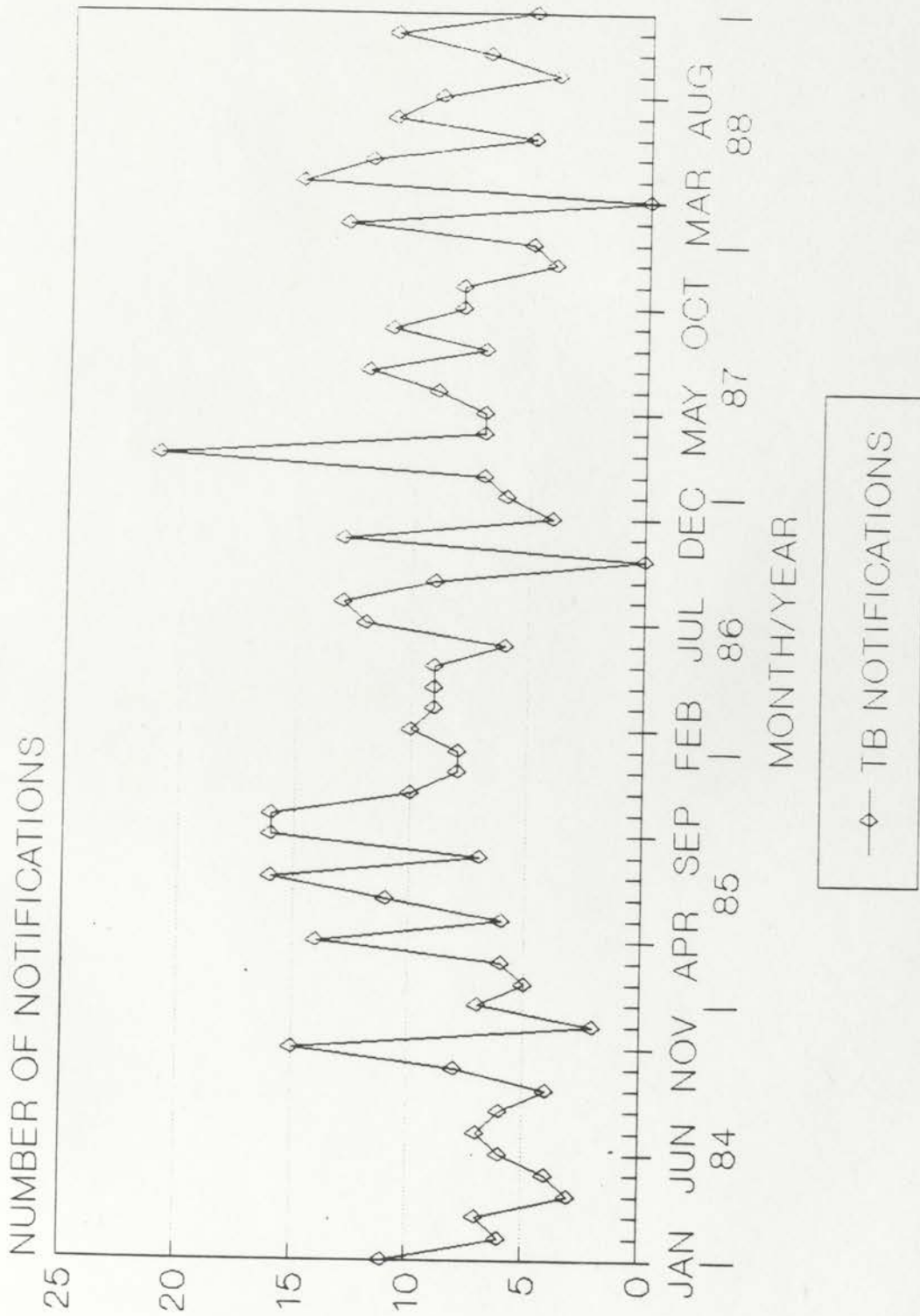


FIGURE 49

FIGURE 49

PHILLIPPI

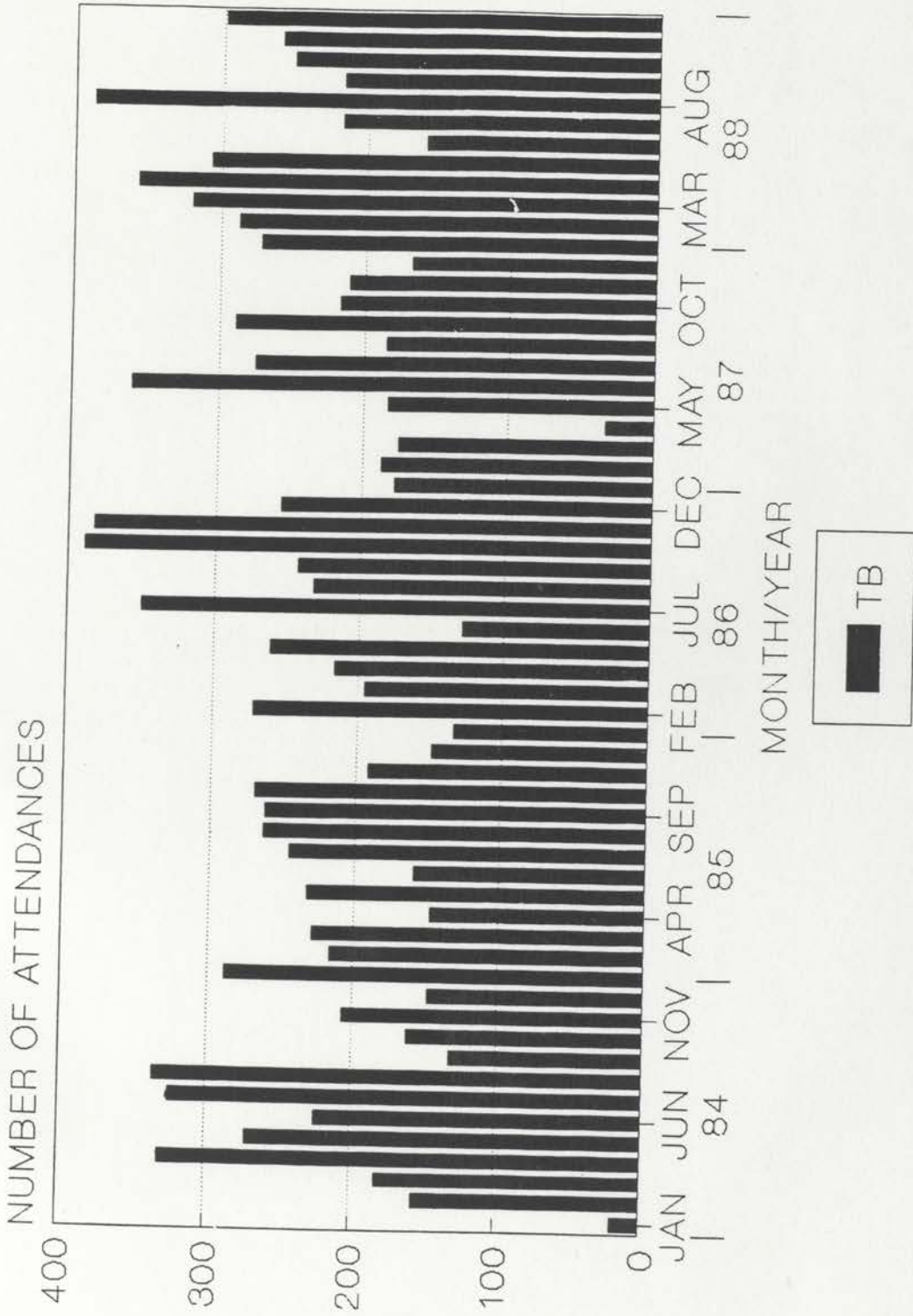


FIGURE 50

FIGURE 50

PHILLIPPI

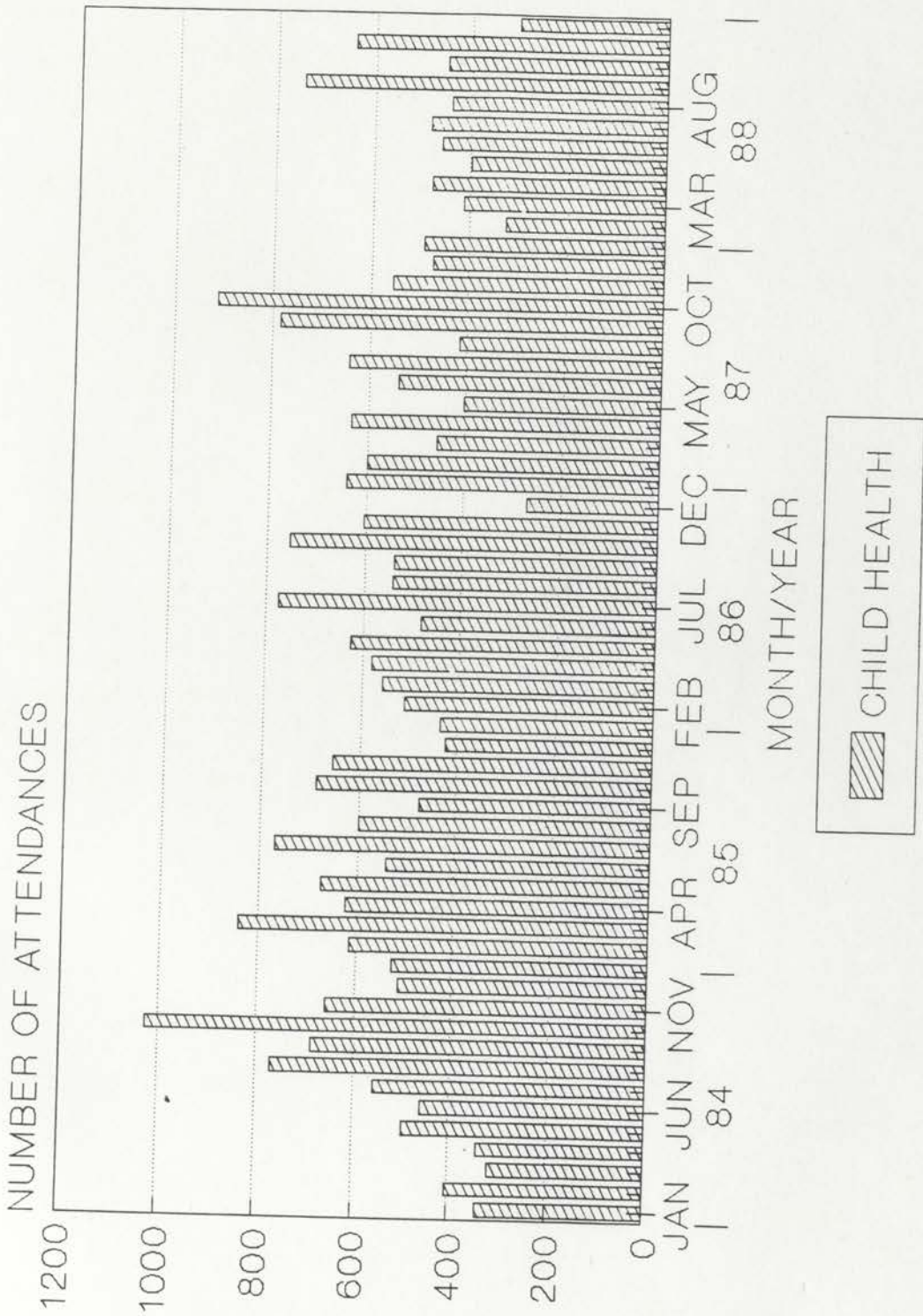


FIGURE 51

FIGURE 51

PHILLIPPI

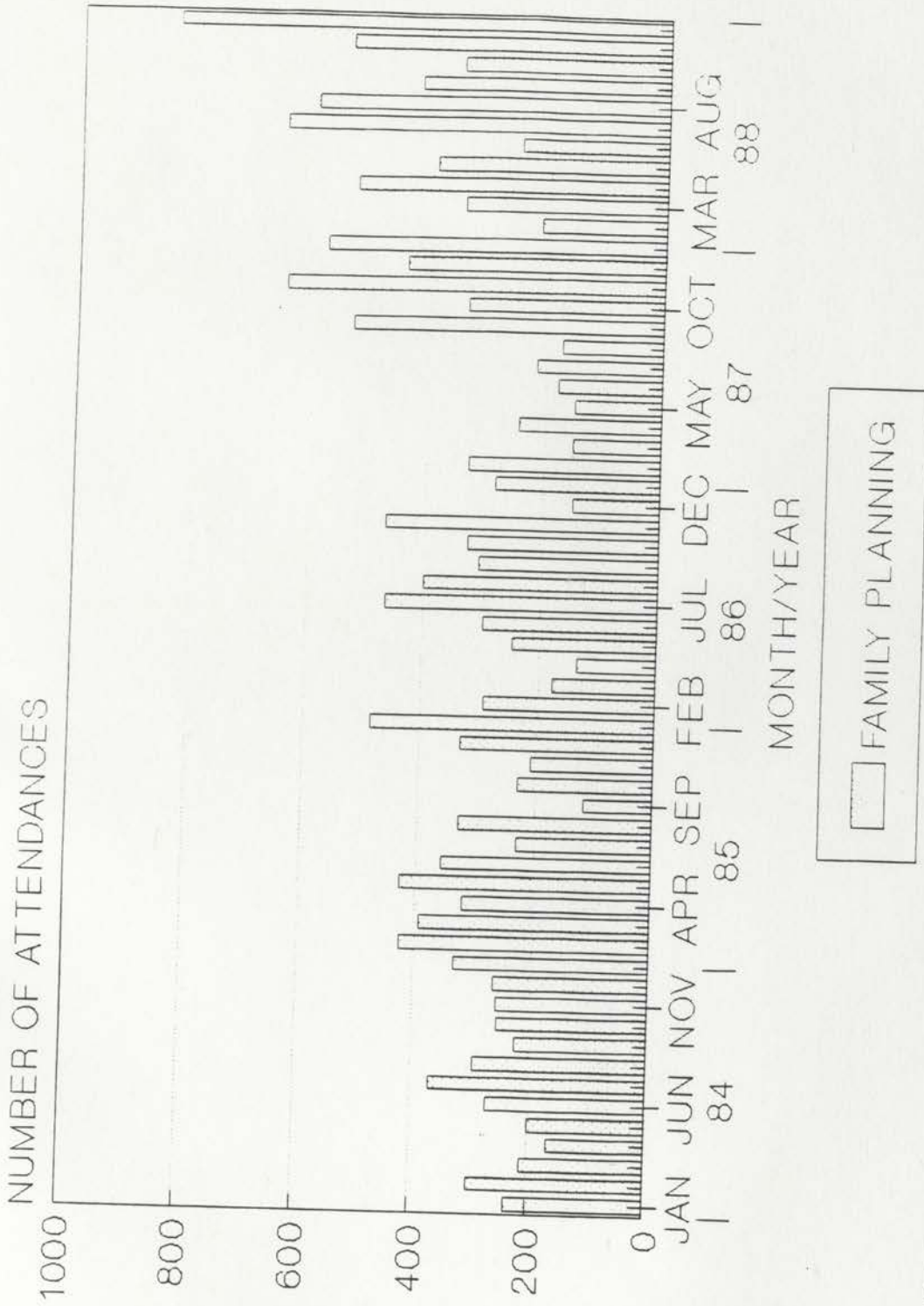


FIGURE 52

FIGURE 52

PHILLIPPI

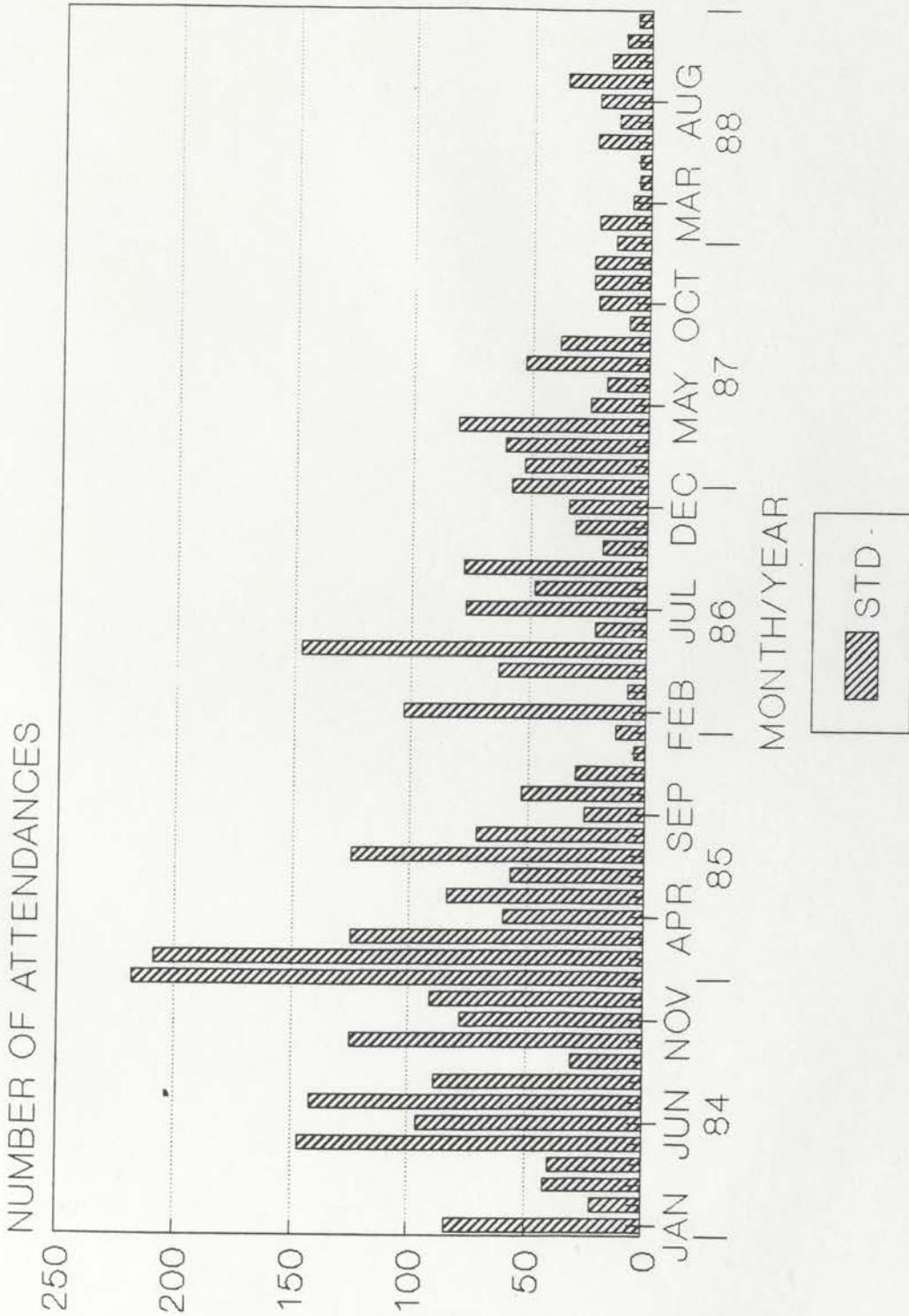


FIGURE 53

FIGURE 53

PHILLIPPI

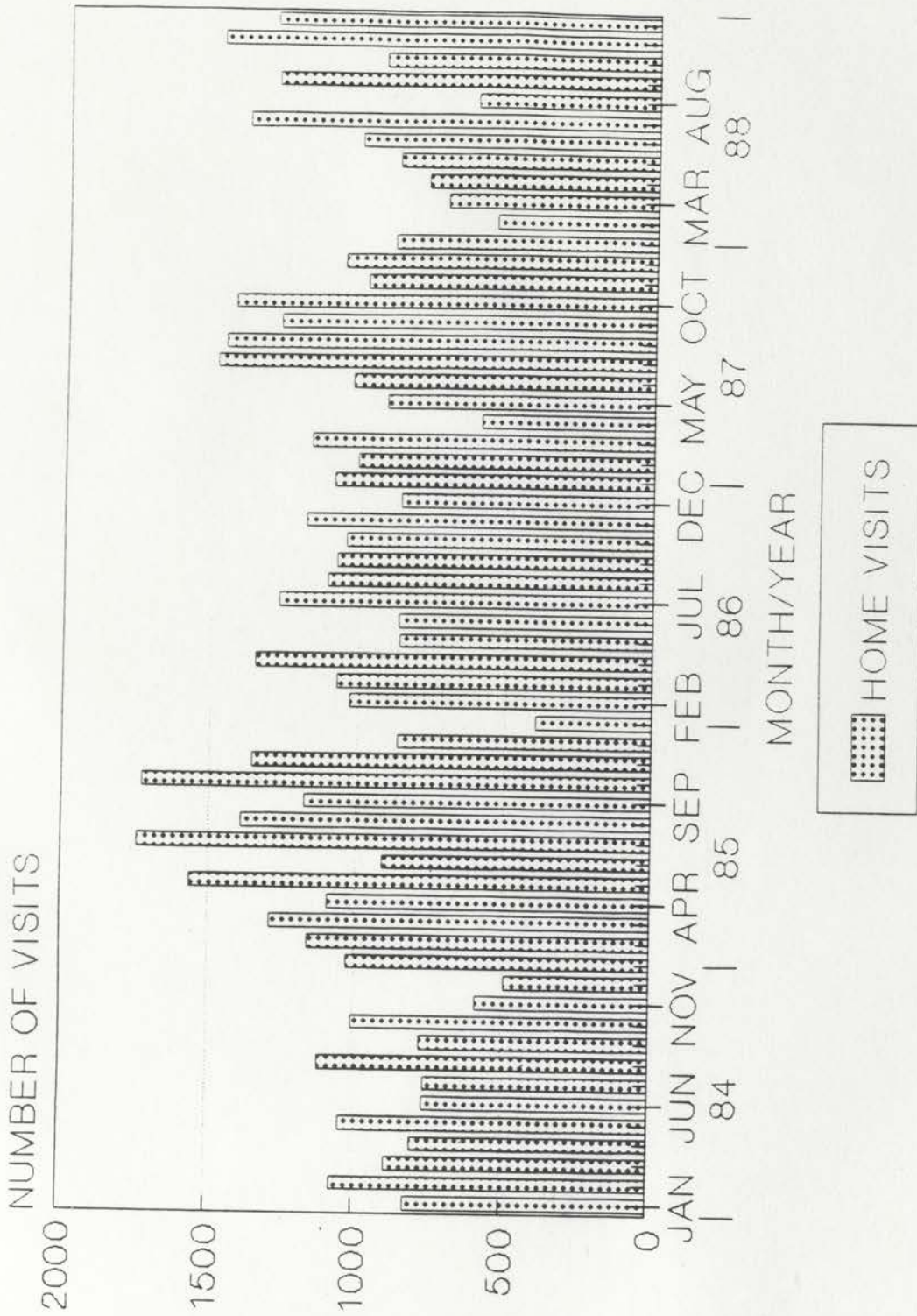


FIGURE 54

FIGURE 54

NYANGA

INCLUDES NEW CROSSROADS' RESIDENTS

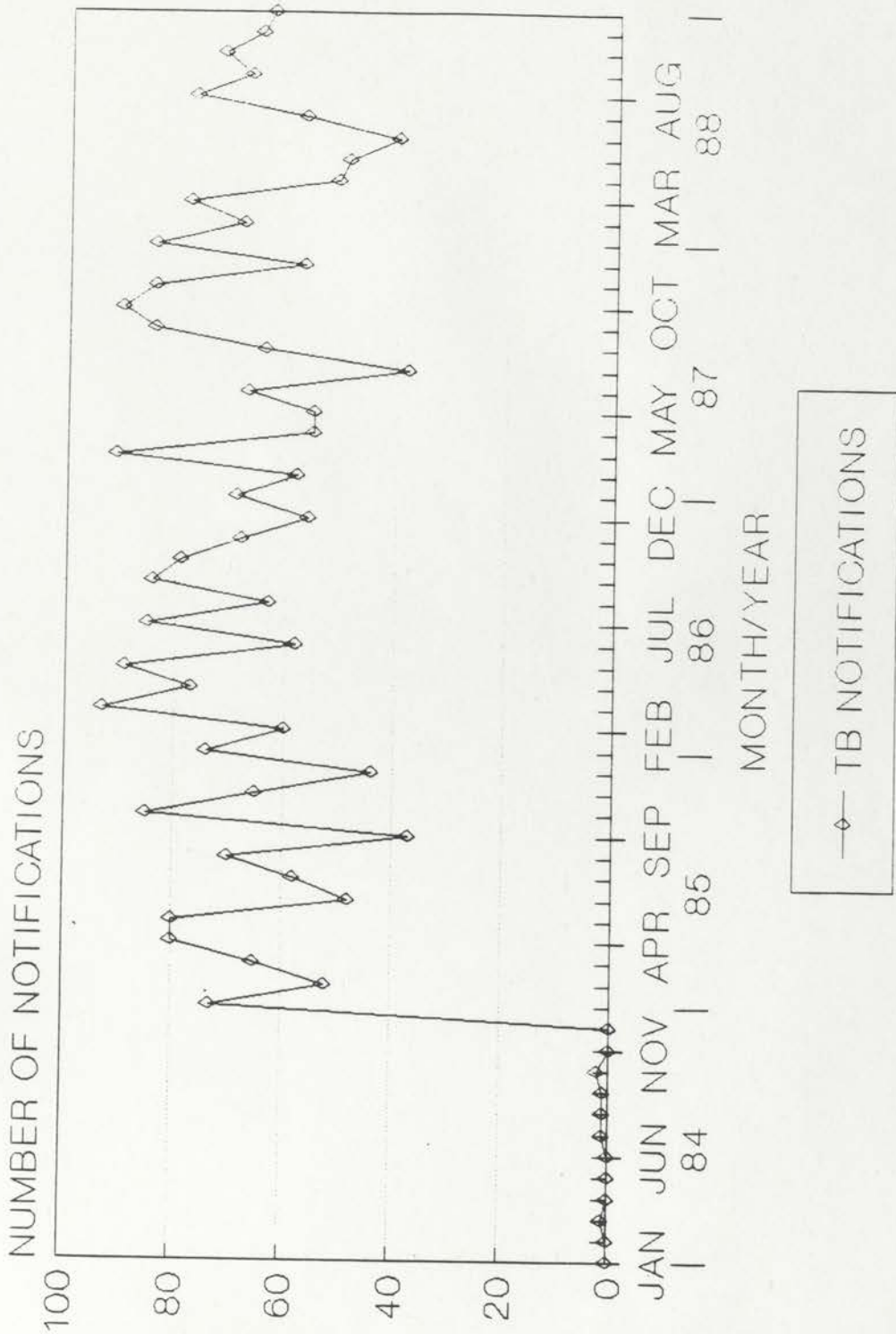


FIGURE 55

FIGURE 55

NYANGA

INCLUDES NEW CROSSROADS' RESIDENTS

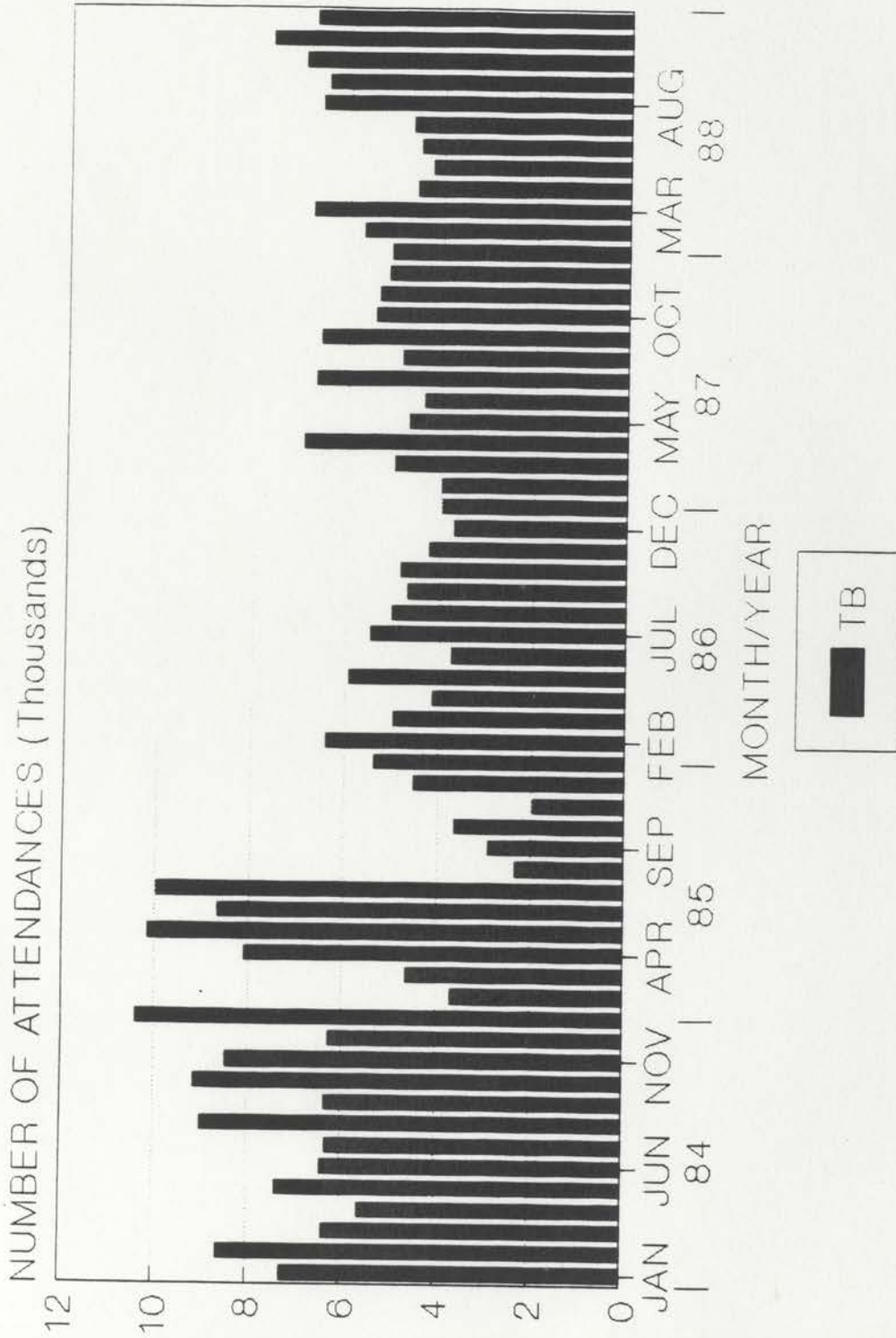


FIGURE 56

NYANGA

INCLUDES NEW CROSSROADS' RESIDENTS

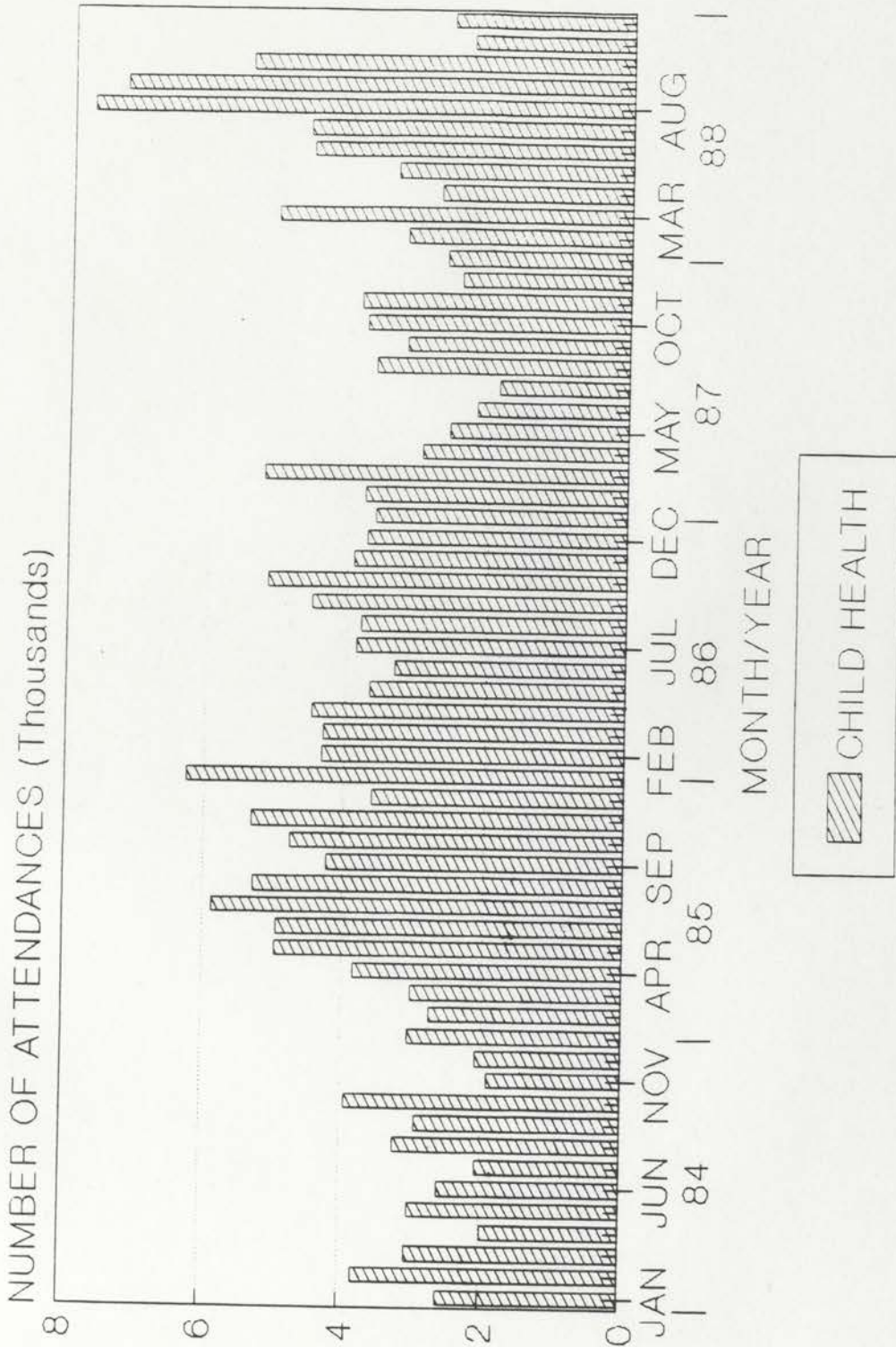


FIGURE 57

FIGURE 57

NYANGA

INCLUDES NEW CROSSROADS' RESIDENTS

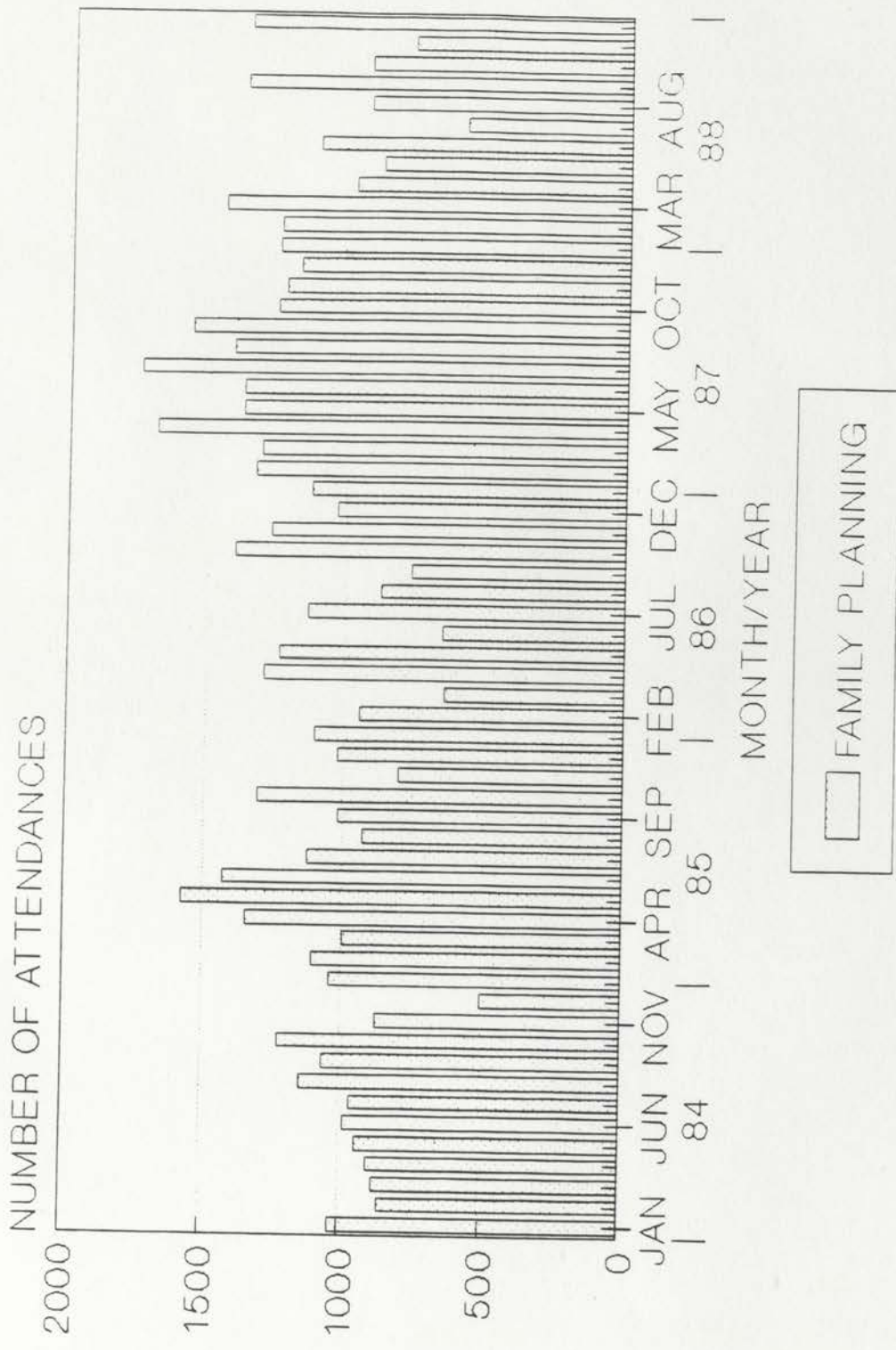


FIGURE 58

FIGURE 58

NYANGA

INCLUDES NEW CROSSROADS' RESIDENTS

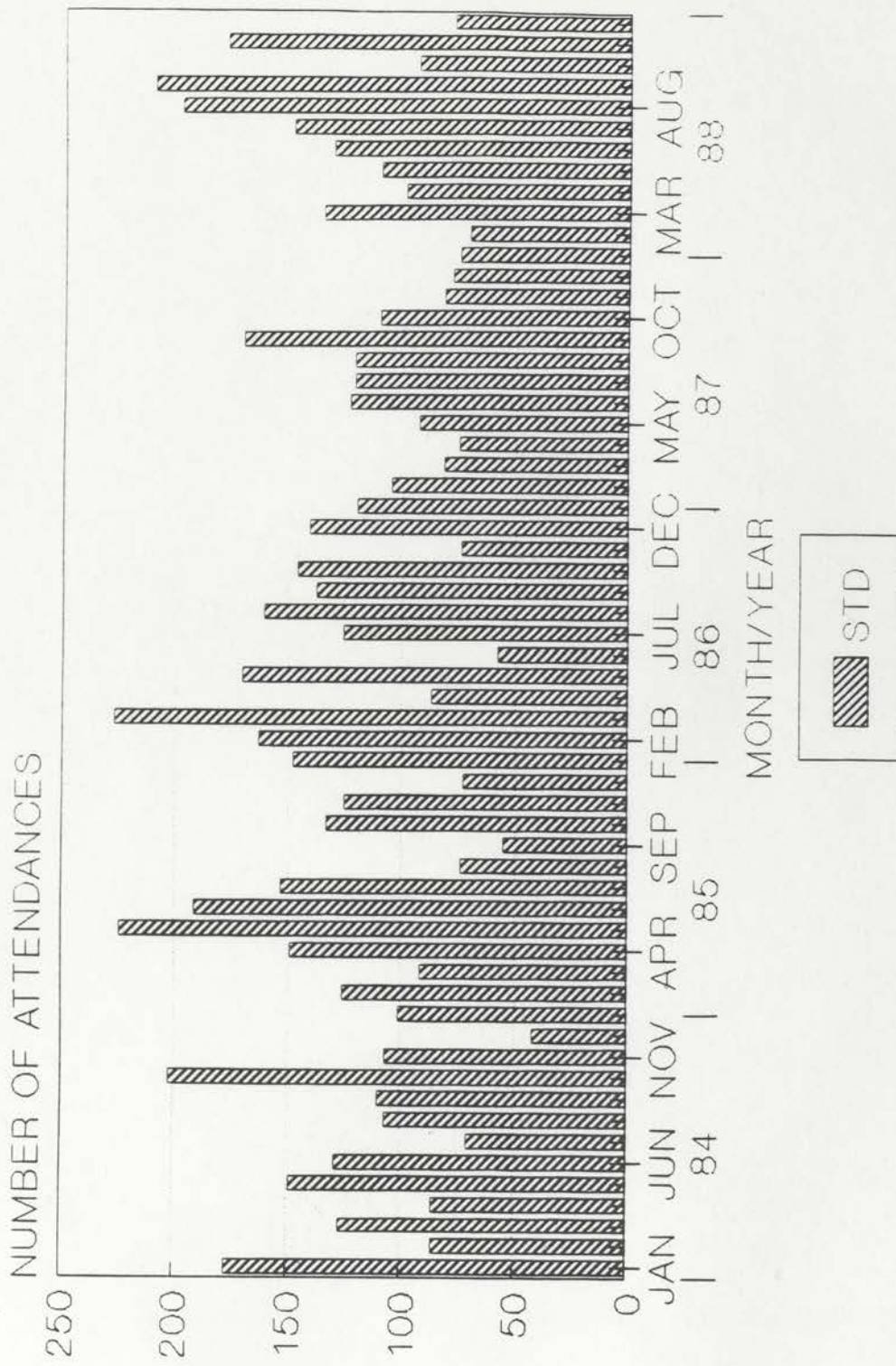


FIGURE 59

FIGURE 59

NYANGA

INCLUDES NEW CROSSROADS' RESIDENTS

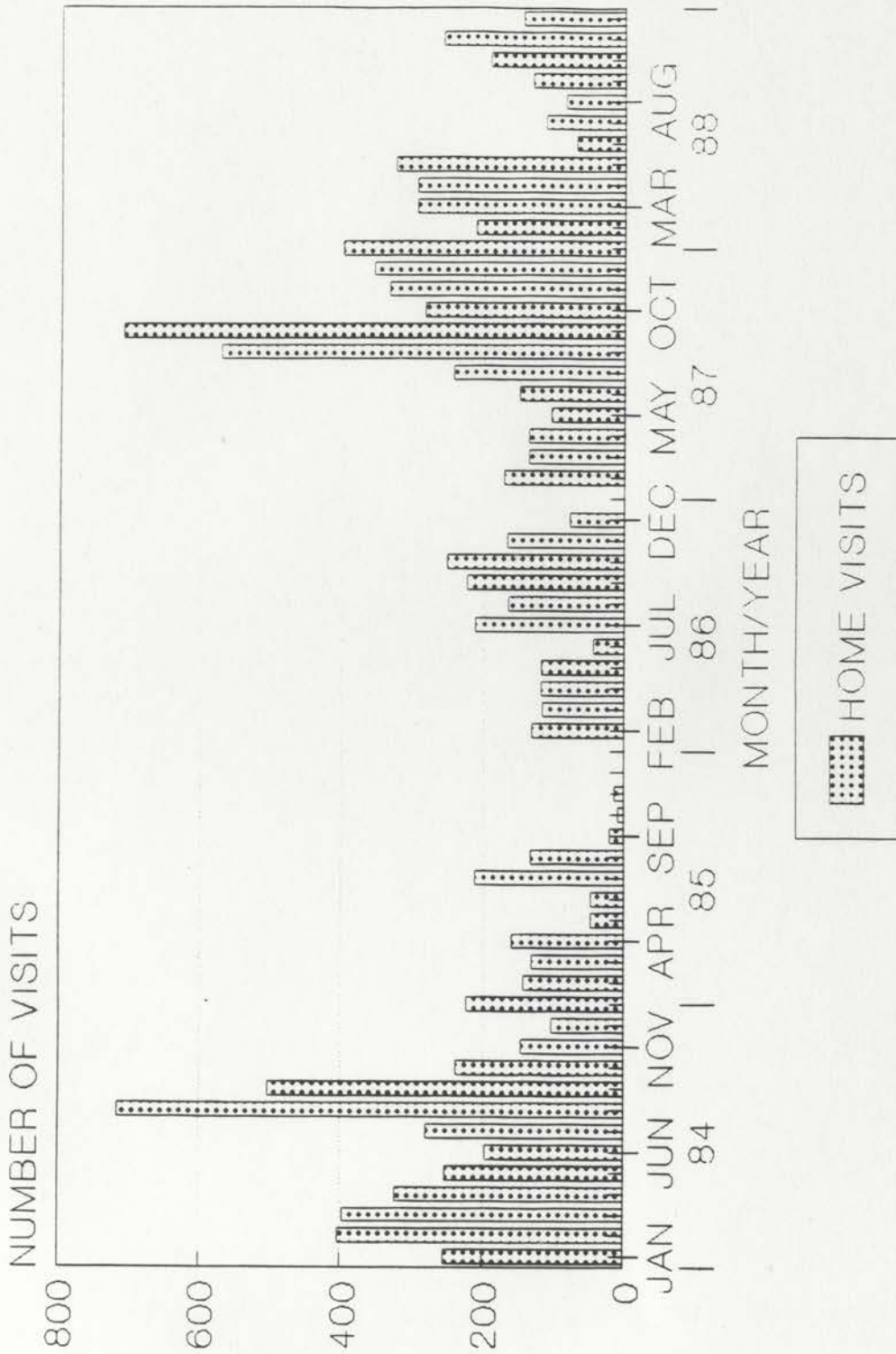


FIGURE 60

FIGURE 60

CROSSROADS

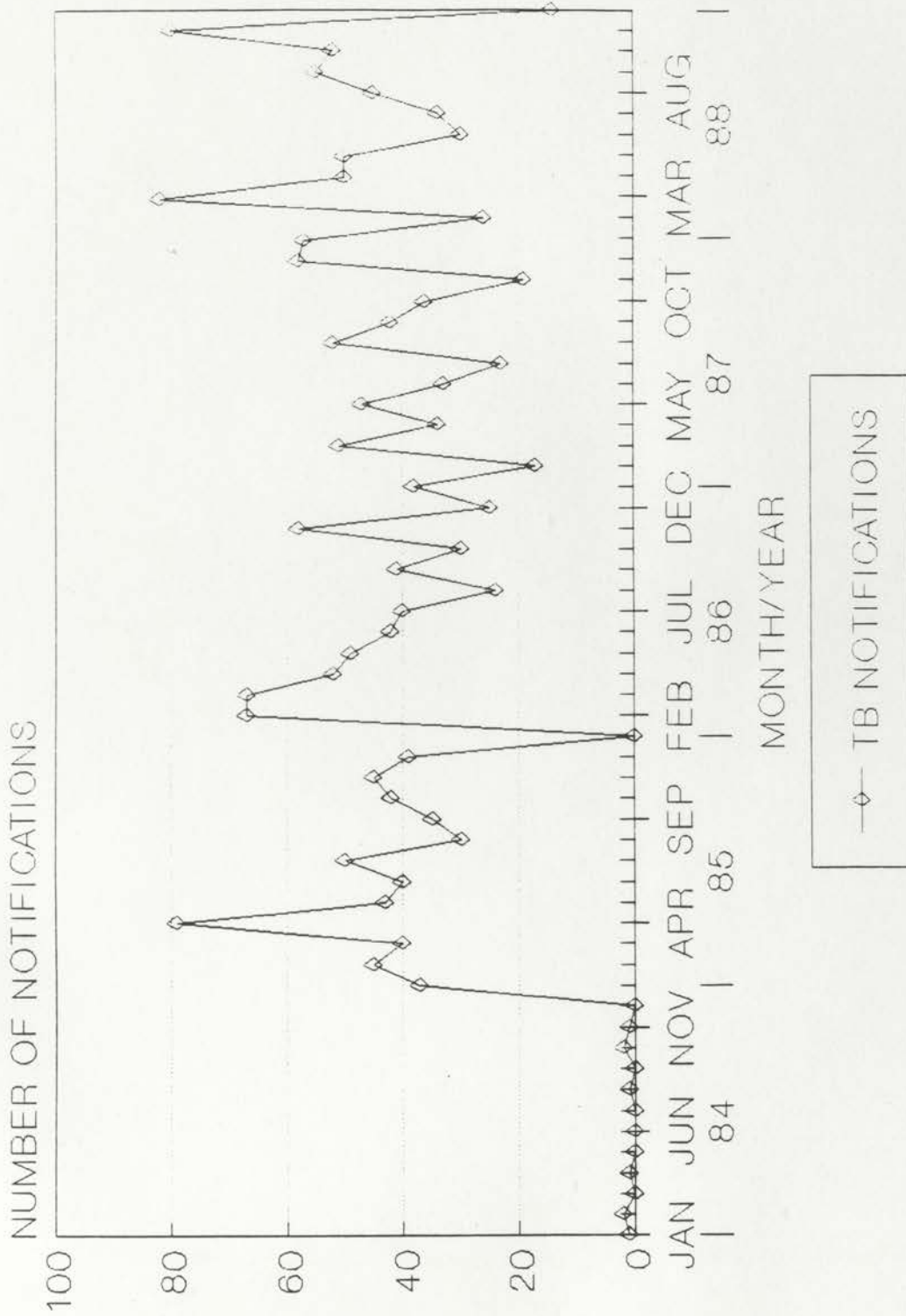


FIGURE 61

FIGURE 61

CROSSROADS

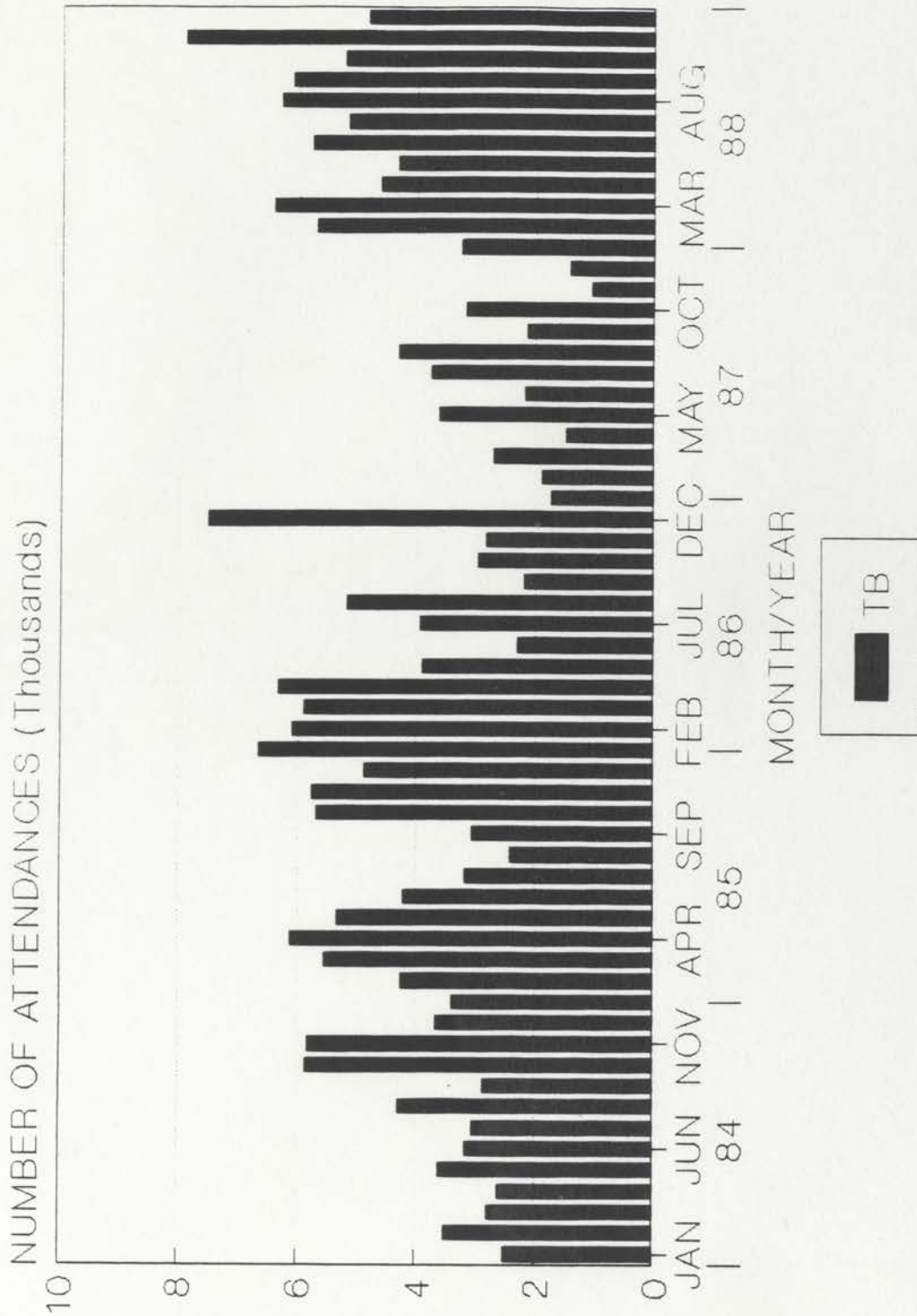


FIGURE 62

CROSSROADS

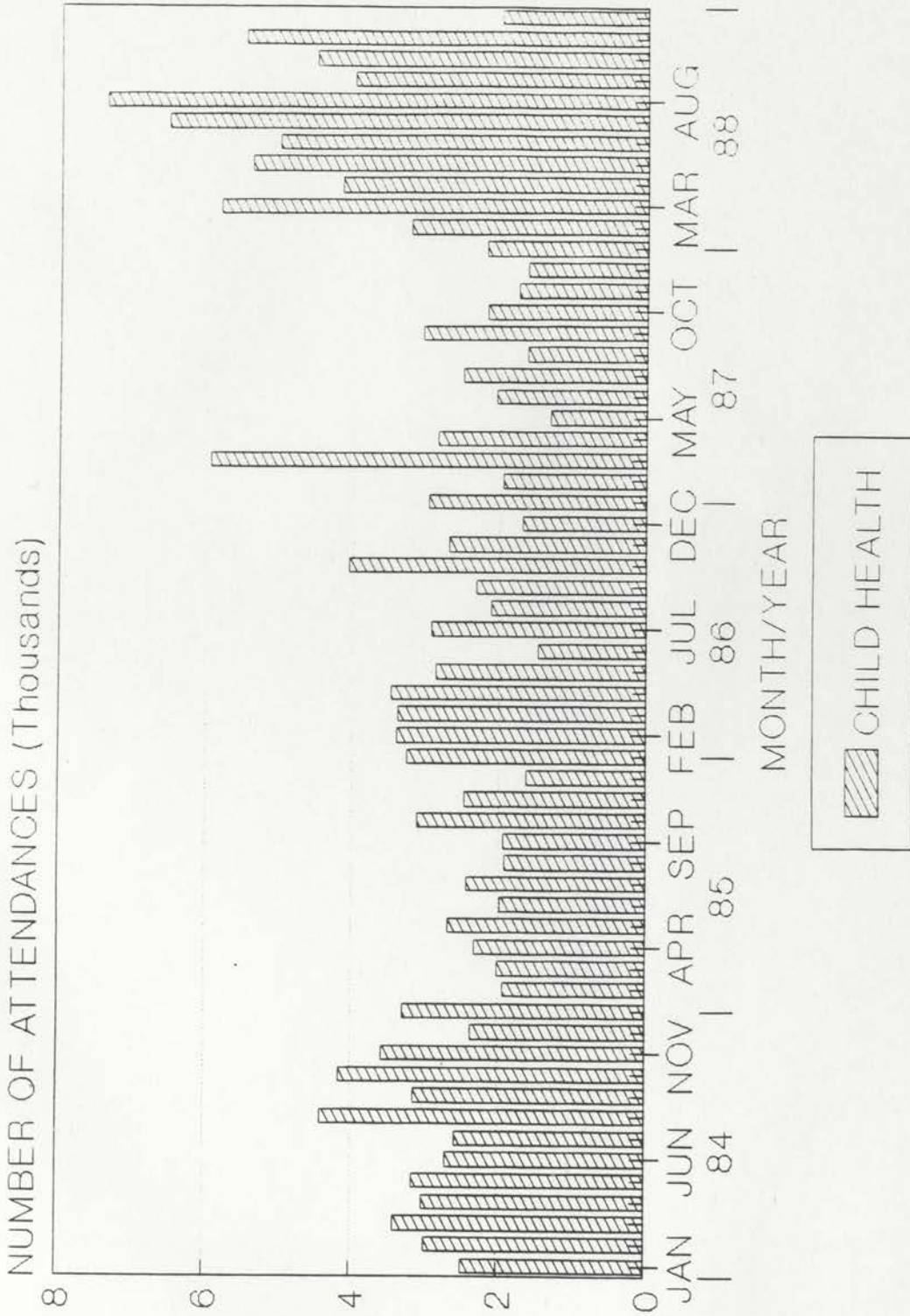


FIGURE 63

FIGURE 63

KHAYELITSHA

INCLUDES NOLUNGILE/DRIFTSANDS

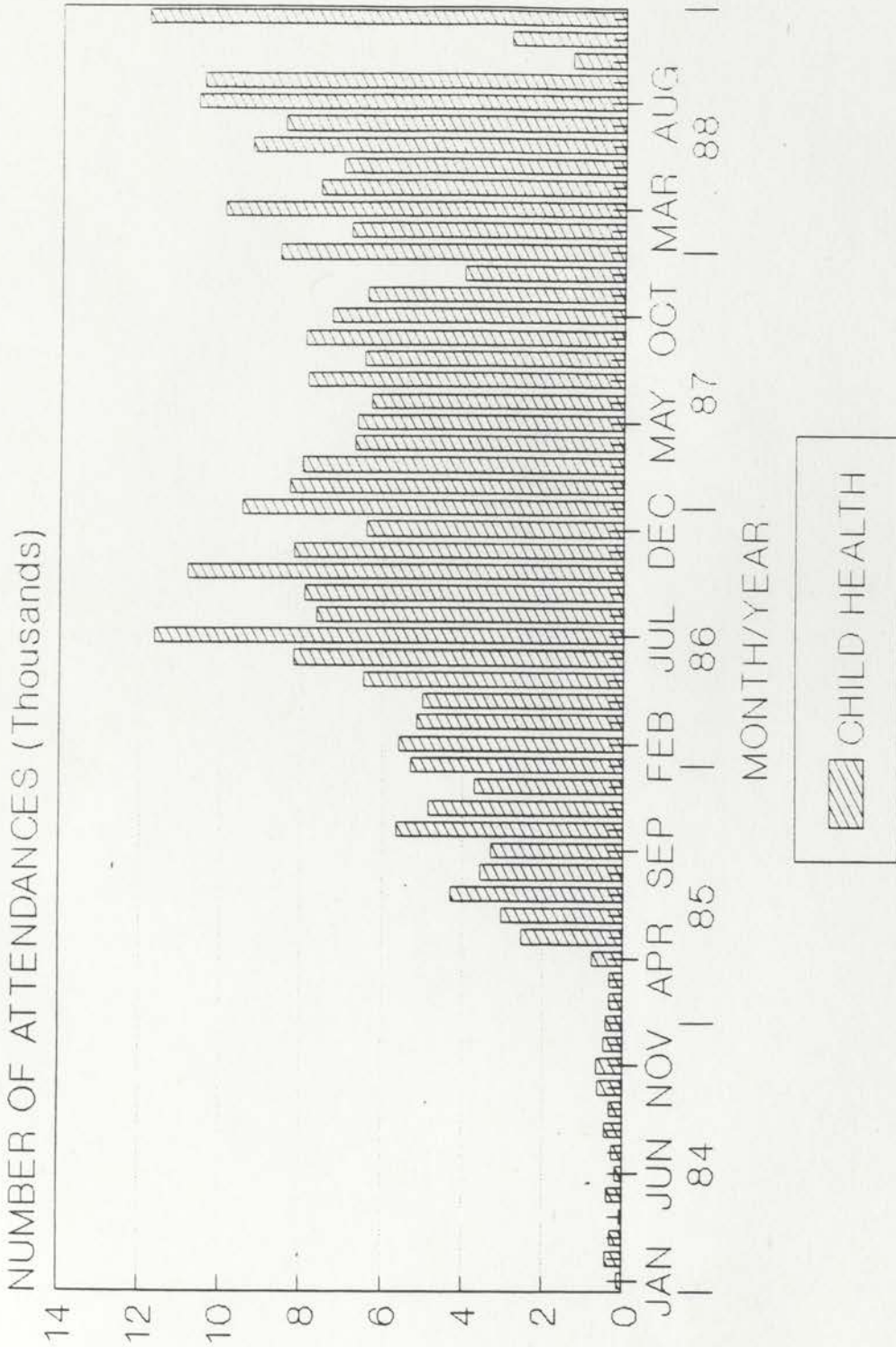


FIGURE 64

FIGURE 64

CROSSROADS

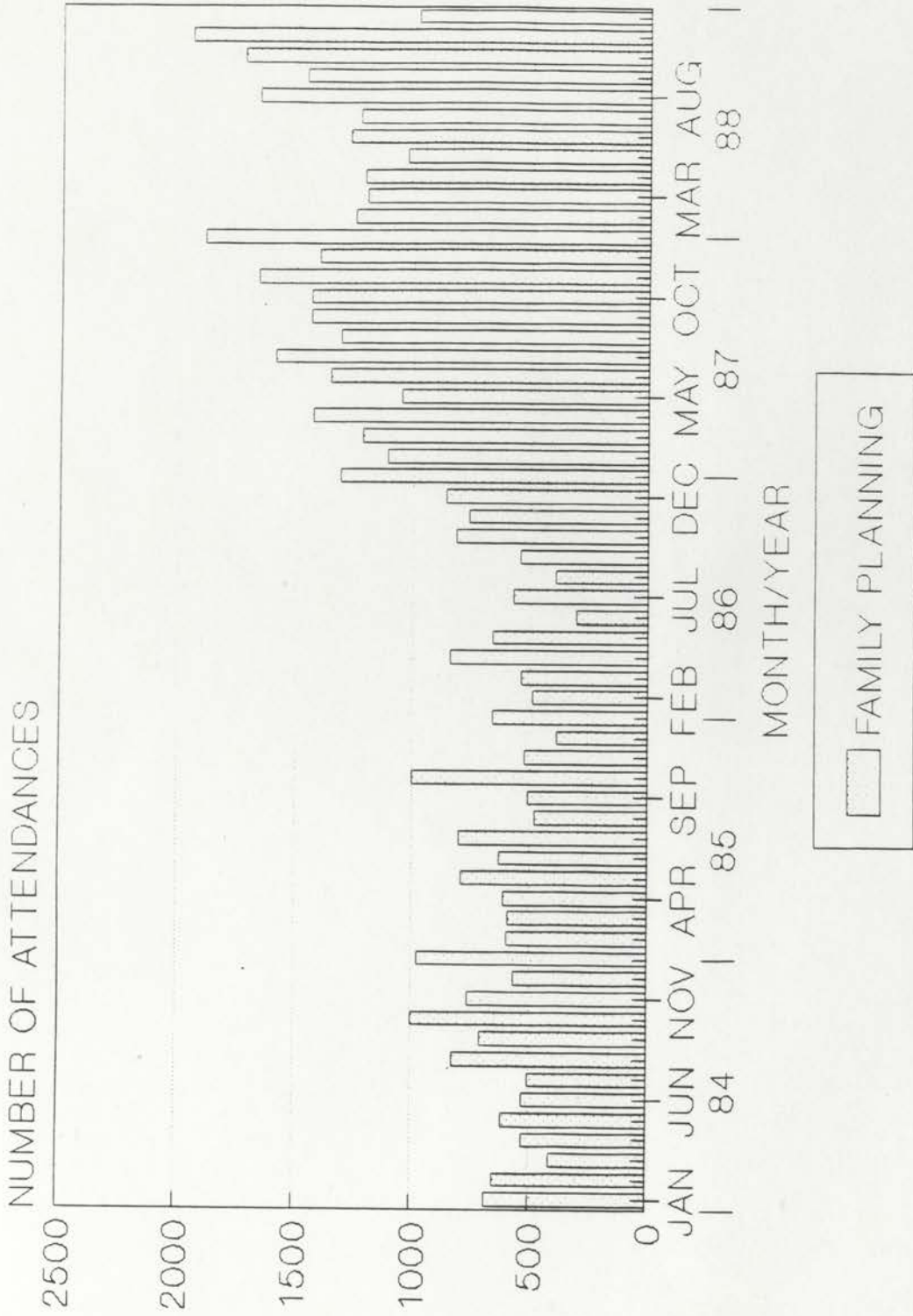


FIGURE 65

FIGURE 65

CROSSROADS

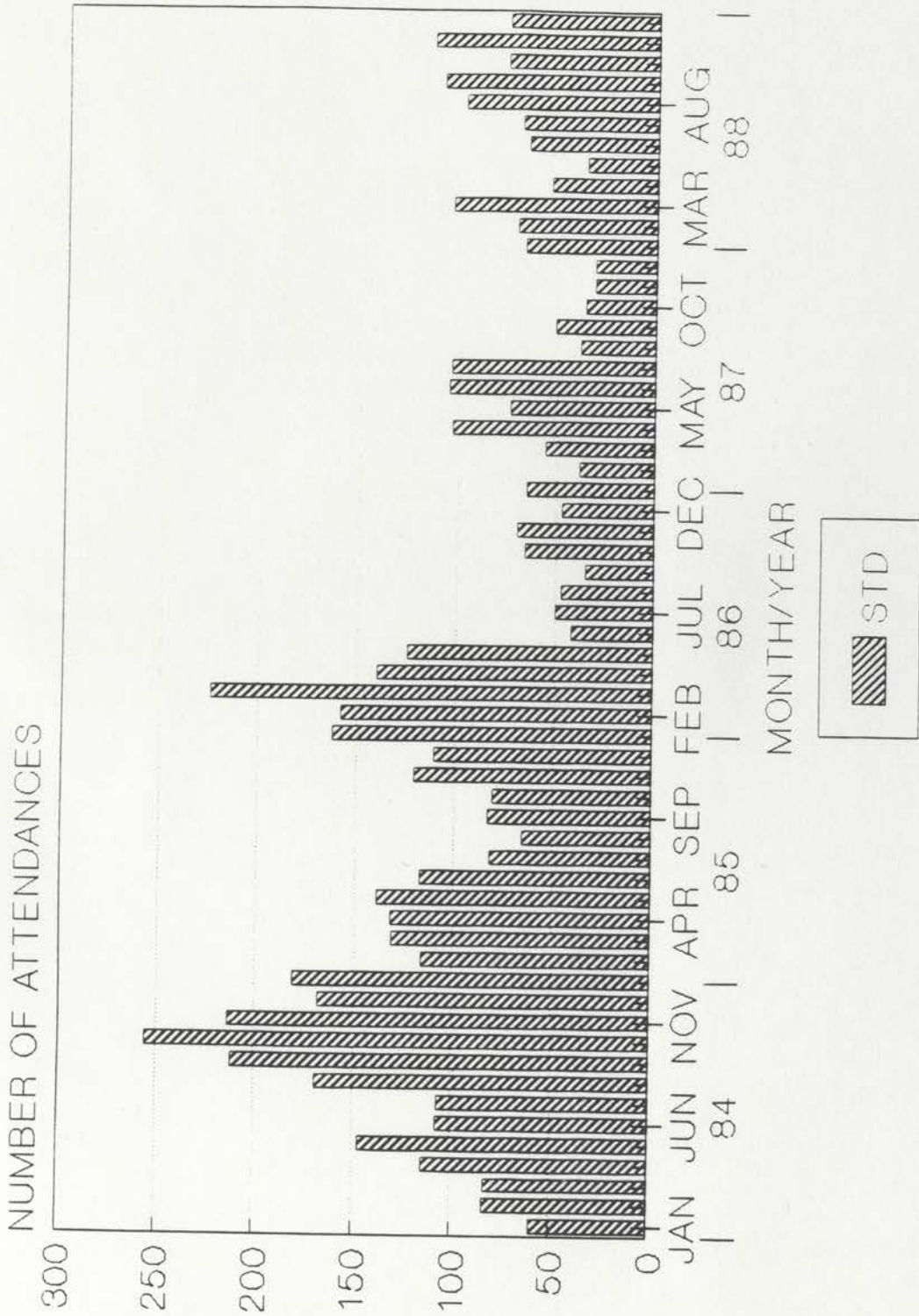


FIGURE 66

KHAYELITSHA

INCLUDES NOLUNGILE/DRIFTSANDS

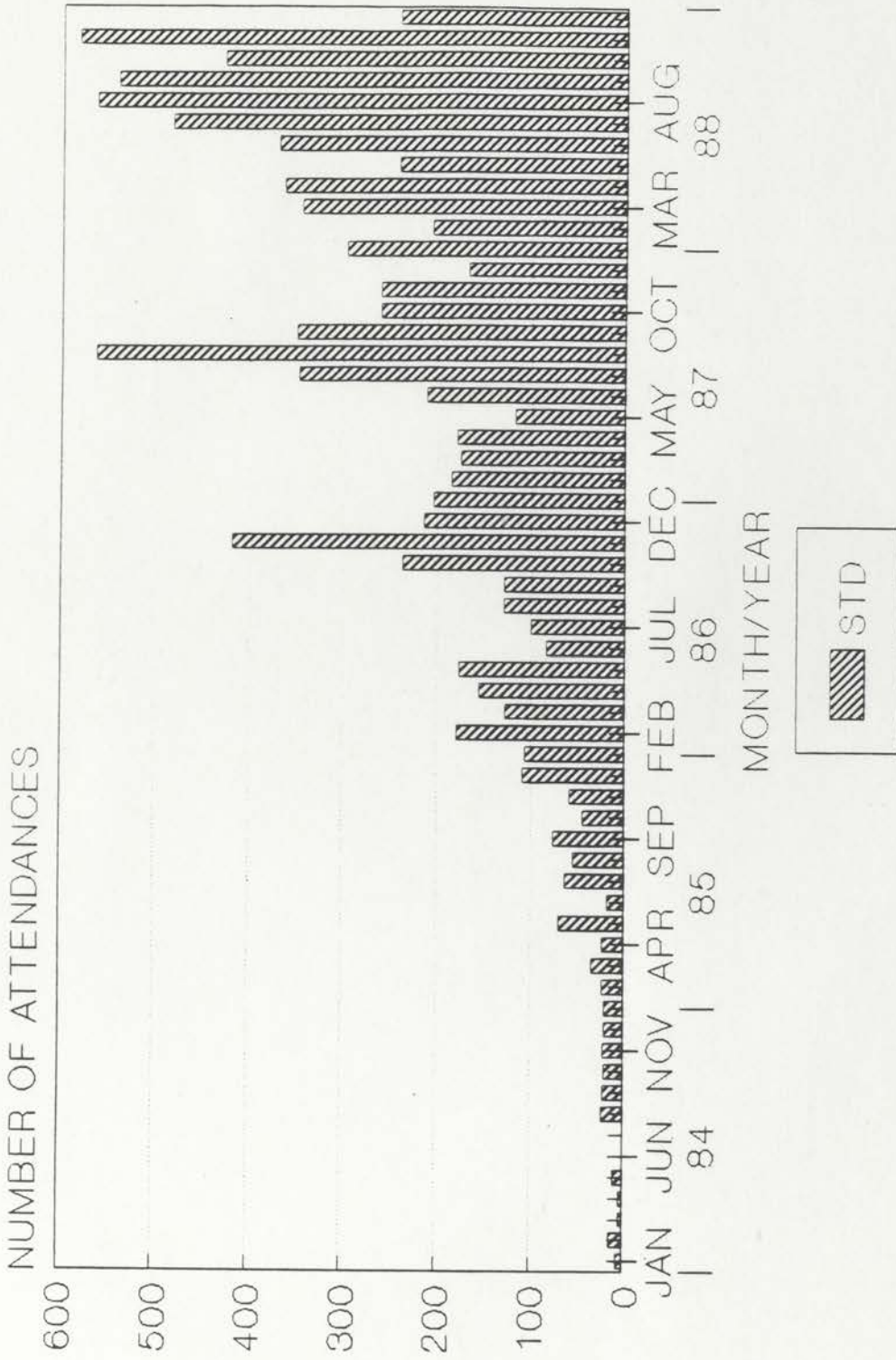


FIGURE 67

FIGURE 67

CROSSROADS

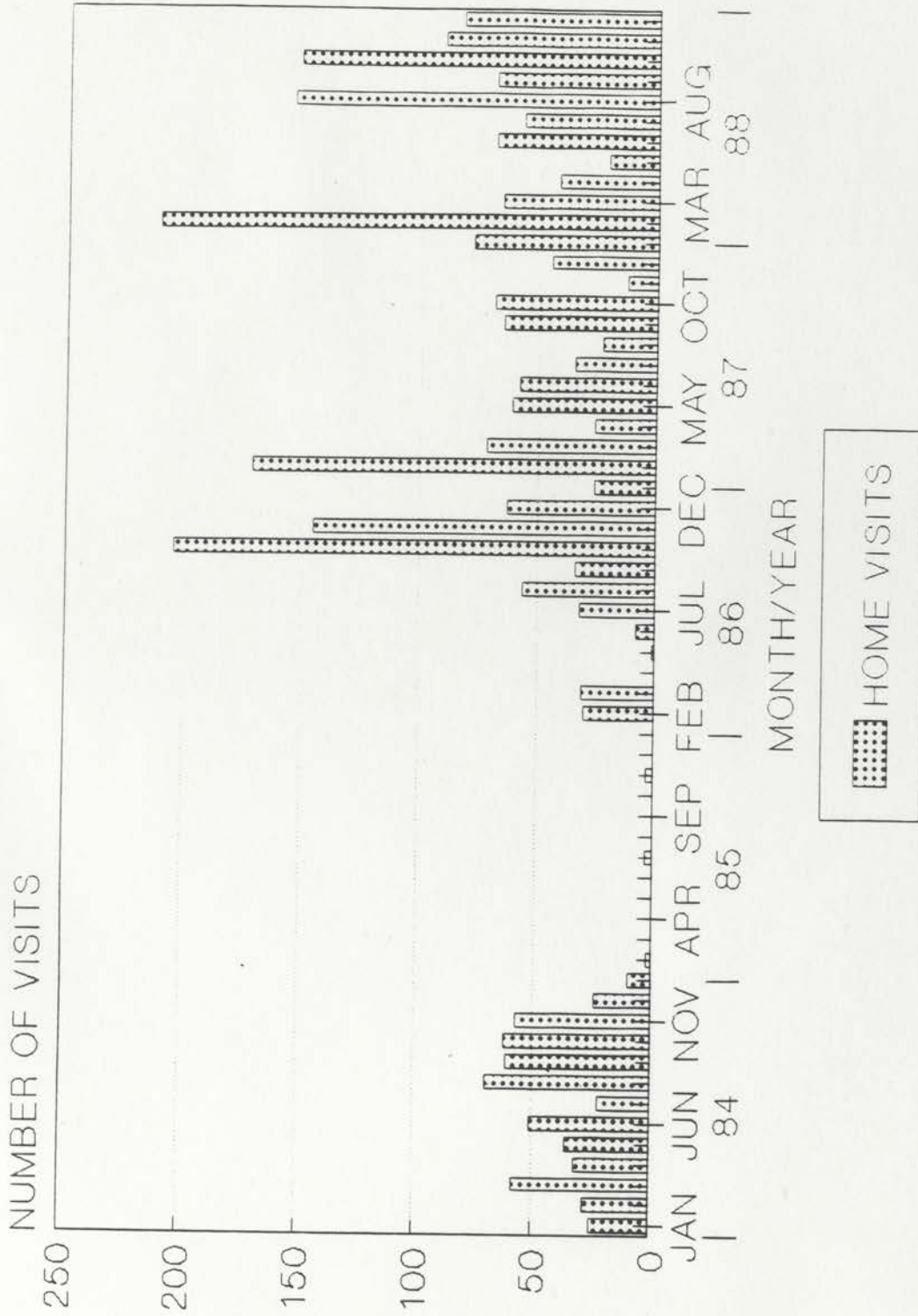


FIGURE 68

FIGURE 68

KHAYELITSHA

INCLUDES NOLUNGILE/DRIFTSANDS

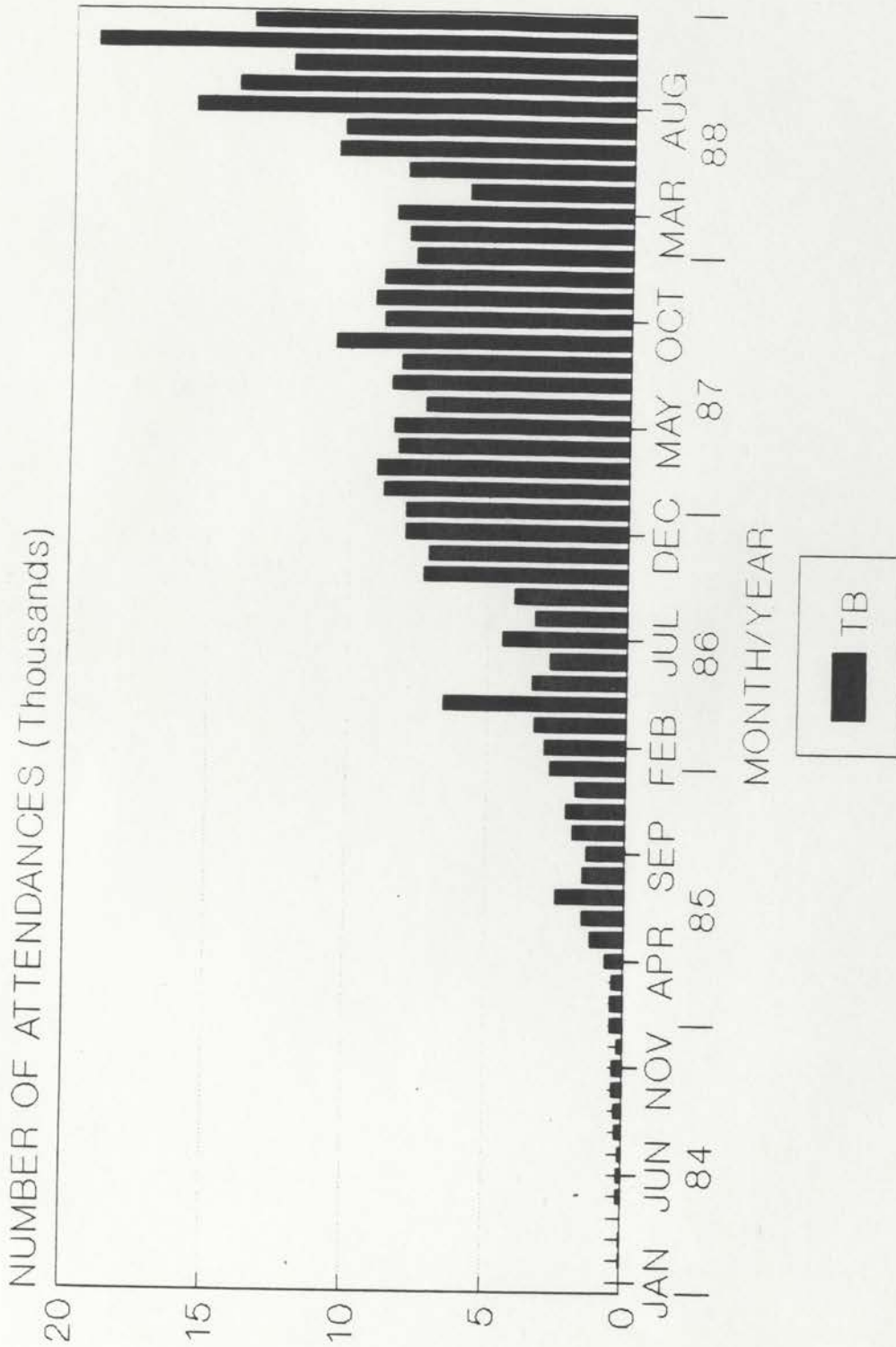


FIGURE 69

FIGURE 69

KHAYELITSHA

INCLUDES NOLUNGILE/DRIFTSANDS

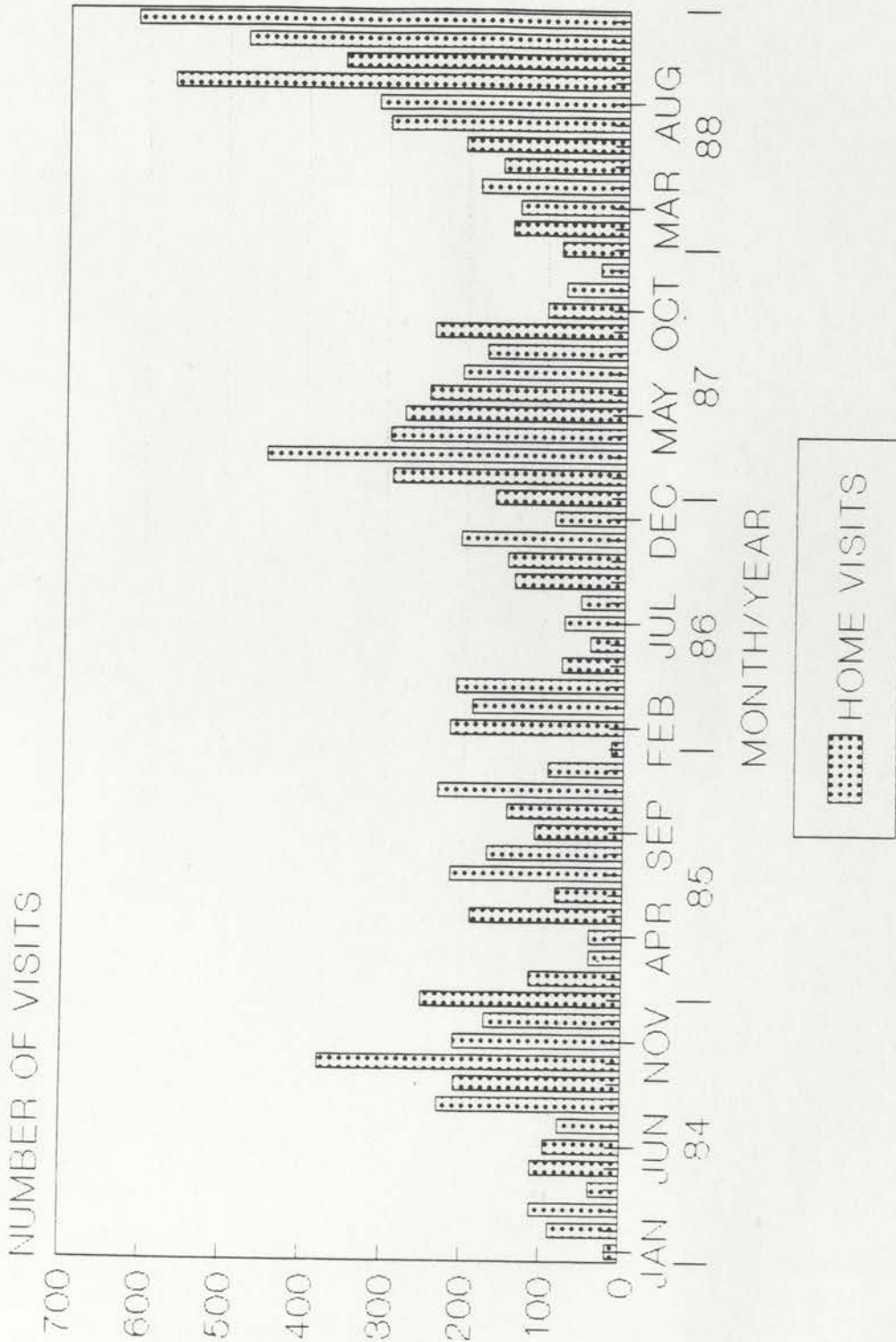


FIGURE 70

FIGURE 70

KHAYELITSHA

INCLUDES NOLUNGILE/DRIFTSANDS

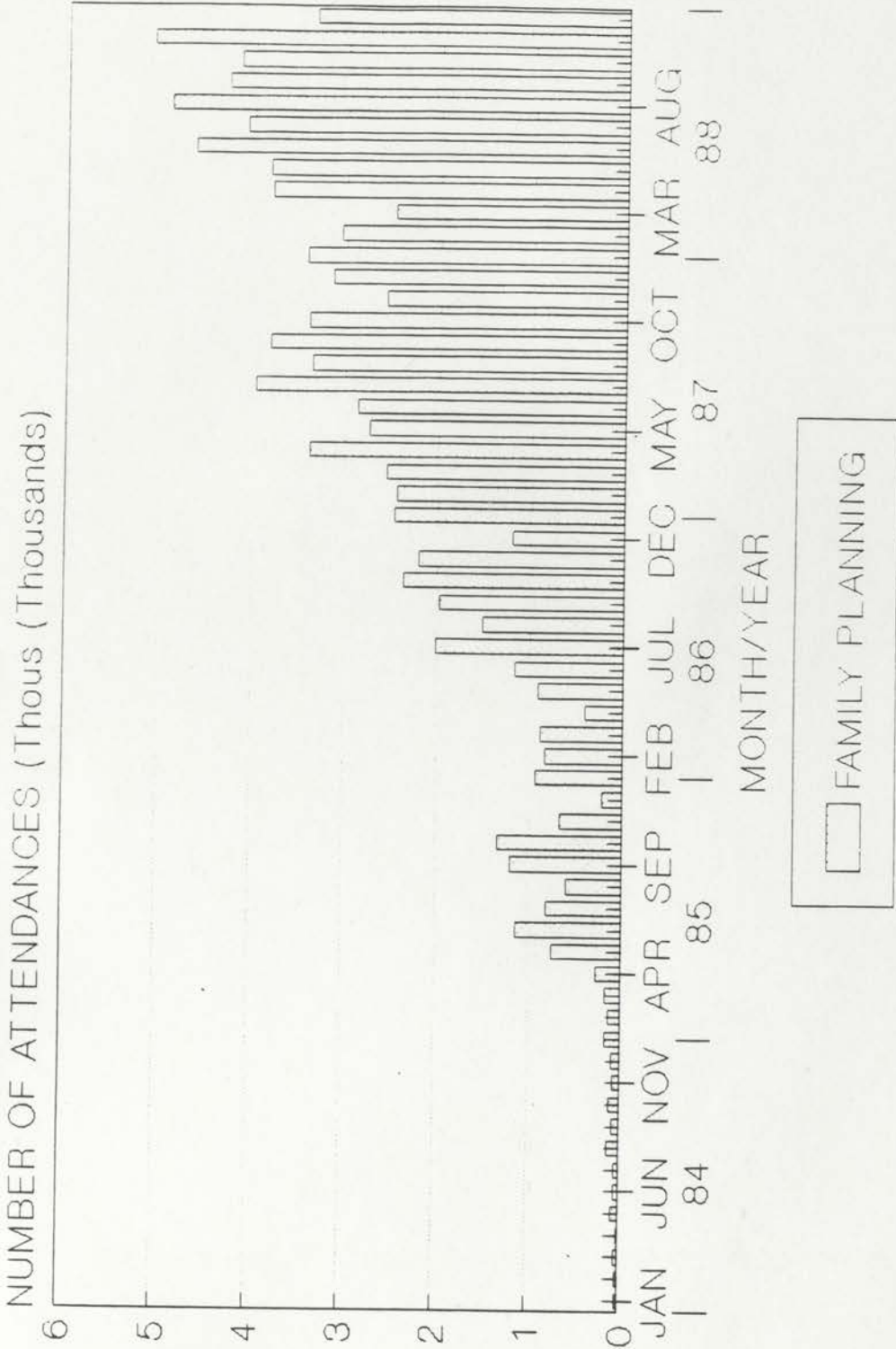


FIGURE 71

FIGURE 71

HEIDEVELD MOU

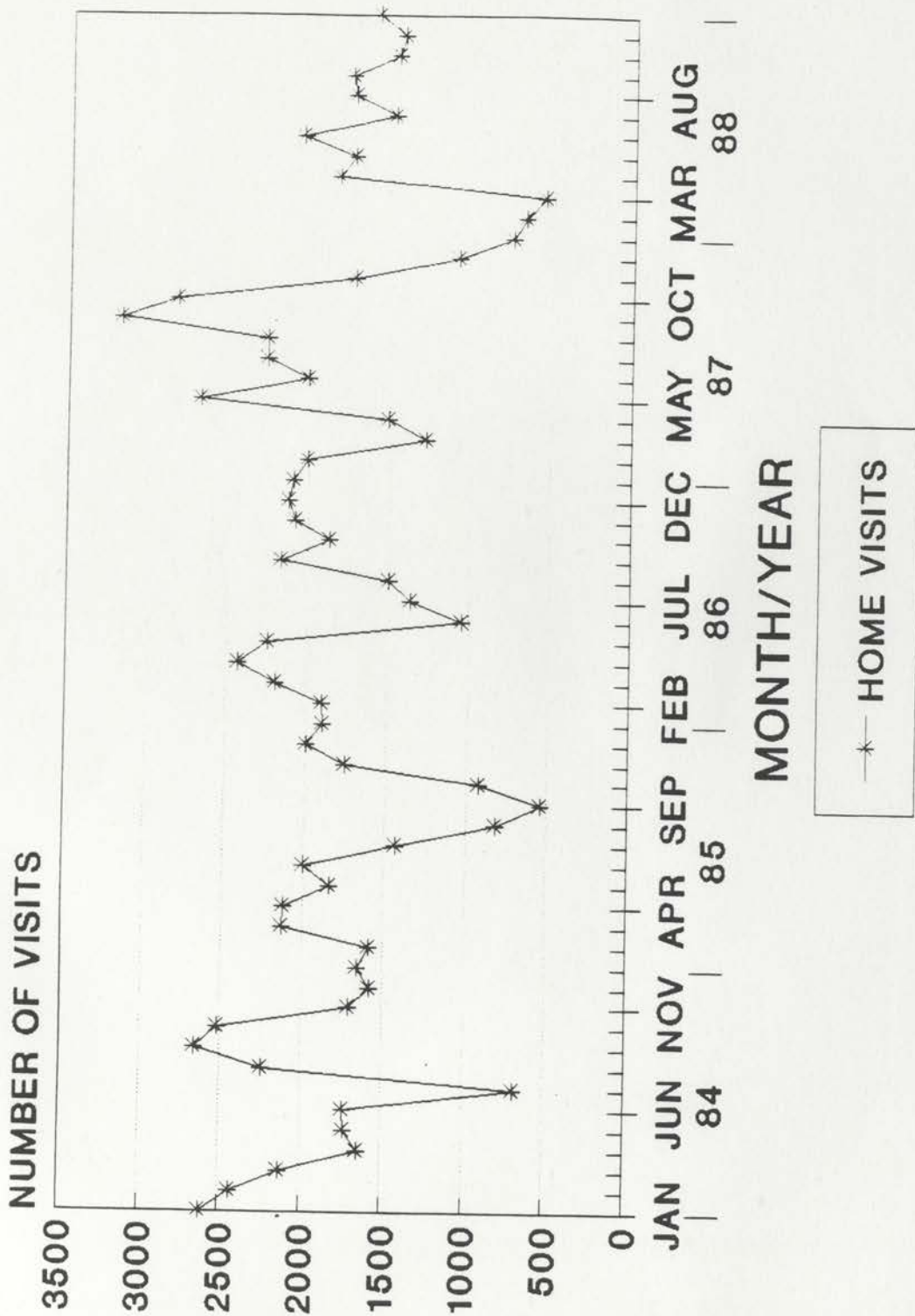


FIGURE 72

HOME VISITS

HANOVER PARK MOU

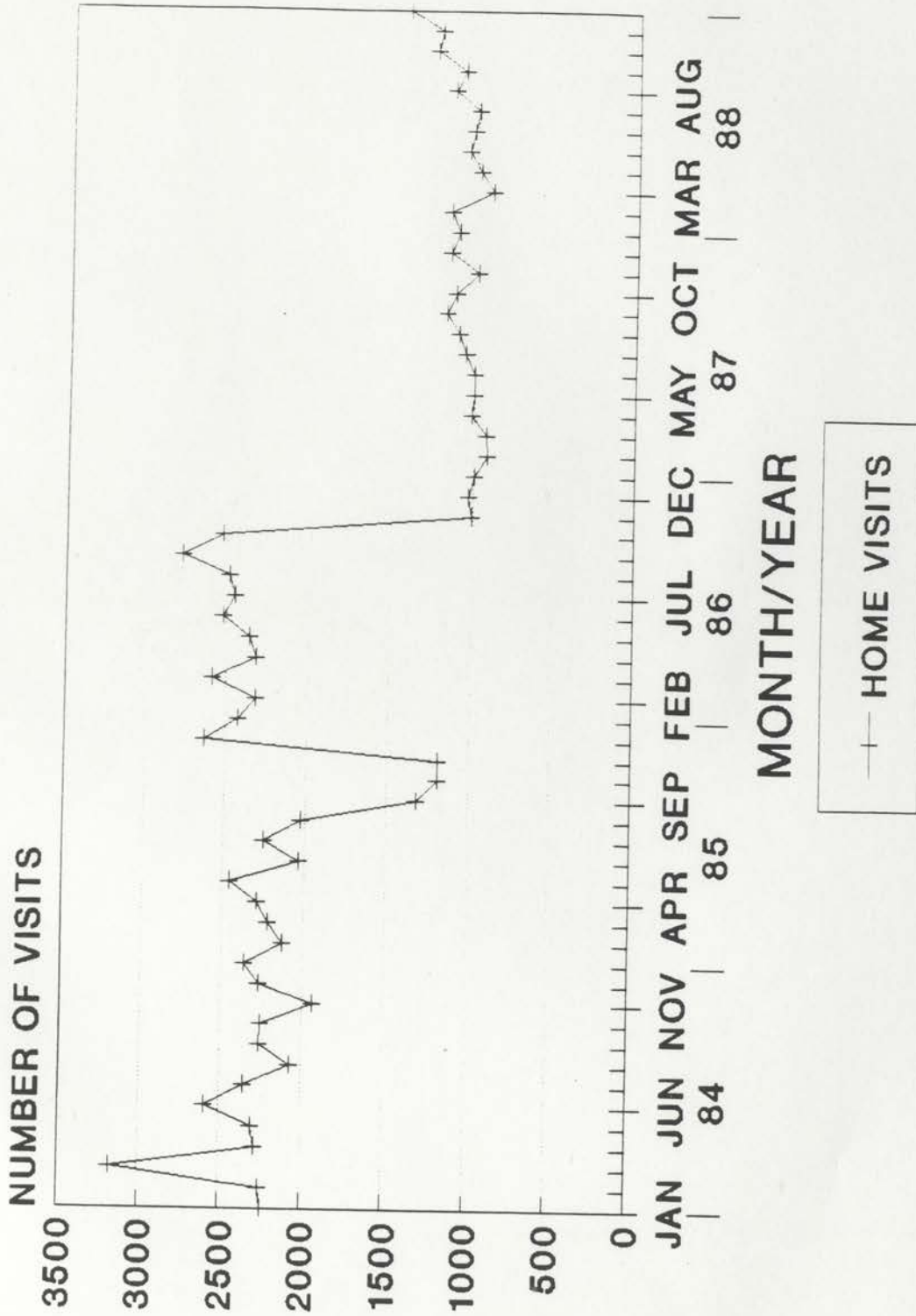


FIGURE 73

FIGURE 73

MITCHELL'S PLAIN MOU

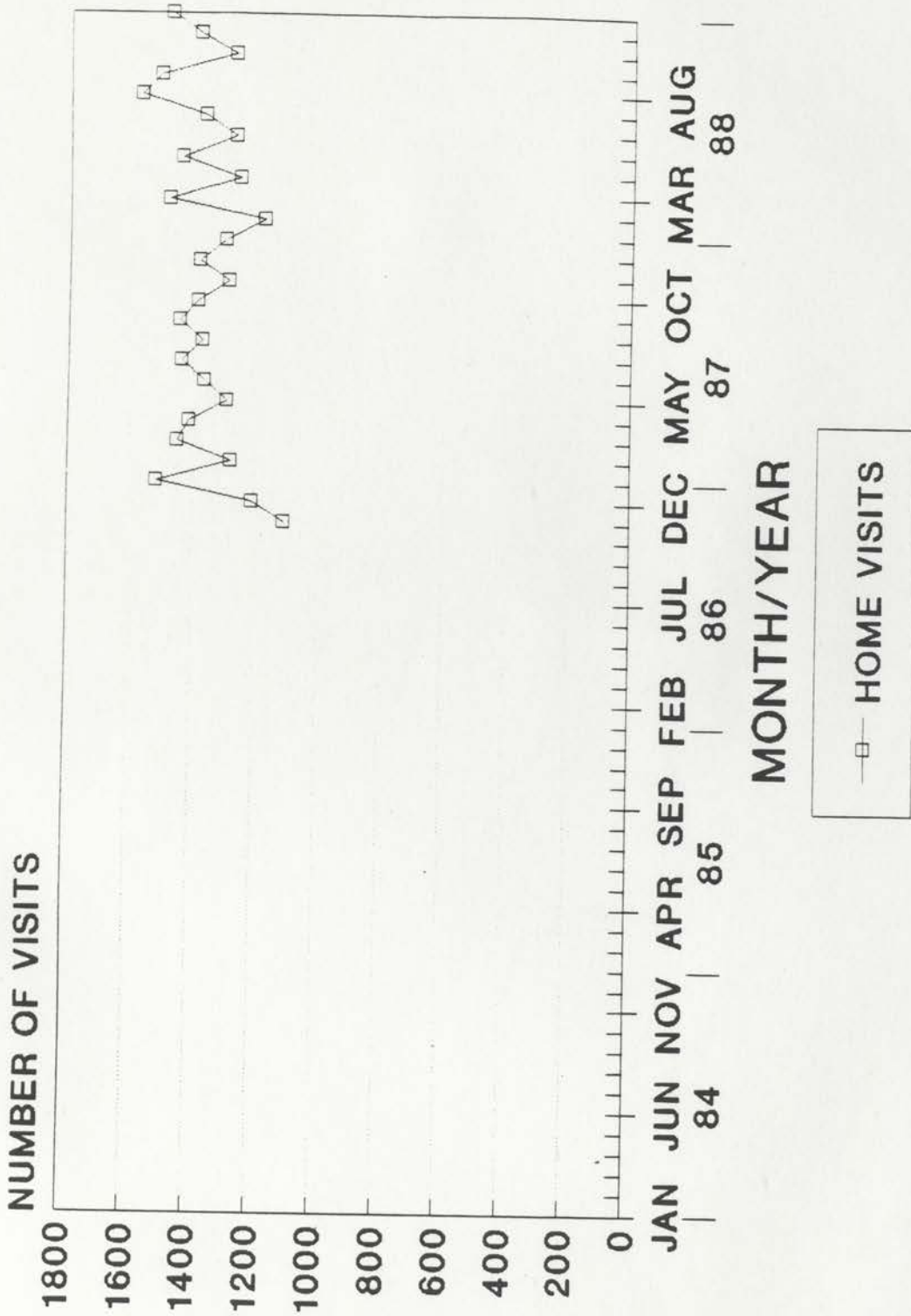


FIGURE 74

FIGURE 74

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APPENDIX A

MEDICAL RESEARCH COUNCIL - DEPARTMENT OF NURSING, U.C.T.

Dear Colleague

The Medical Research Council is currently investigating health services in the Cape Peninsula in the past two years and has approached the Nursing Department at the University of Cape Town to obtain information regarding nursing services this year.

We need to know if you or your service have been affected by events of the past year. If this is the case we need the opinions of as many nurses in the Peninsula as possible.

Permission to administer this questionnaire has been obtained from your employing authority. HOWEVER, all information is anonymous and no one outside the research team will have access to anything you have said.

I urge you to complete this questionnaire as fully and as accurately as possible. Once it is complete please seal it inside the attached envelope to ensure that no one else reads it. You can then hand it to the sister-in-charge of your unit who will keep it safely until it is collected.

IF YOU WOULD LIKE MORE INFORMATION PLEASE
PHONE SHEILA CLOW AT 47 1250 EXT 410
(DEPARTMENT OF NURSING, UNIVERSITY OF CAPE TOWN)

Thank you for your assistance.

SURVEY OF HEALTH SERVICES IN THE CAPE PENINSULA

FOR OFFICE USE

1 Card no

2

5

1. Where do you work at present? _____

2. a) Were you working at this place during May - July this year?

Mark the appropriate block

YES NO

If yes, go to Question 3.

b) If no, were you working in another part of the Cape Peninsula during May - July?

Mark the appropriate block

YES NO

c) If yes to 2 (b), where was this?

If no to 2 (a) and 2 (b) do not continue.

→ 3. What is your position? Mark the appropriate block.

Senior Professional Nurse

Professional Nurse

Enrolled Nurse

Enrolled Nursing Assistant

9

4. Please state your age in years. _____

5. In which suburb do you live? _____

12

6. Who lives with you? Mark appropriate block(s).

Spouse

Children

Older relative(s)

Other (specify)

Relative(s)

If no children, go to Question 12.

7. How many children do you have of pre-school age?

14

If no pre-school children go to Question 10.
If yes, answer Questions 8 and 9.

8. Who usually looks after them while you are at work?
Mark appropriate block.

Household member

Neighbour

Crèche

Other, please specify _____

<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>

9. Did you have to make alternative arrangements for your children at any time this year?

YES	NO
-----	----

If yes,

a) at what time of year? State month(s) _____

b) why did you need to? _____

c) What were these alternative arrangements?
Mark appropriate block.

Household member

Neighbour

Crèche

Other, please specify _____

<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>

10. How many children do you have of school-going age? _____

17

21

If no school-going children, go to Question 12.

11. Was there any time during 1986 that they were unable to get to school?

YES	NO
-----	----

If yes,

<p>a) at what time of year? State months(s)</p> <p>_____</p> <p>b) why was this? _____</p> <p>_____</p> <p>_____</p>
--

FOR OFFICE USE

22

<input type="checkbox"/>	<input type="checkbox"/>
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12. During 1986, were you ever asked to give care to people from your home? Mark appropriate block.

YES	NO
-----	----

If yes,

<p>a) at what time of year? State month(s)</p> <p>_____</p> <p>b) what type of service was required?</p> <p>_____</p> <p>_____</p> <p>_____</p>

26

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

13. Was there any time during 1986 when you personally required medical care or medication? Mark appropriate block.

YES	NO
-----	----

If yes,

<p>a) at what time of year? State month(s)</p> <p>_____</p> <p>b) what type of care was this? _____</p> <p>_____</p> <p>c) was this work-related? <table border="1"><tr><td>YES</td><td>NO</td></tr></table></p>	YES	NO
YES	NO	

30

<input type="checkbox"/>	<input type="checkbox"/>
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34

FOR OFFICE USE

14. How do you normally get to work? Mark appropriate block. (Only give most frequent method)

Walk	<input type="checkbox"/>	Bicycle	<input type="checkbox"/>
Bus	<input type="checkbox"/>	Own car	<input type="checkbox"/>
Bus & Walk	<input type="checkbox"/>	Taxi	<input type="checkbox"/>
Train	<input type="checkbox"/>	Other, specify	<input type="checkbox"/>
Train & Walk	<input type="checkbox"/>		<input type="checkbox"/>

1 2 Card no

15. Did you have to make alternative transport arrangements to get to work at any time this year?

Mark appropriate block

YES	NO
-----	----

If yes,

a) at what time of year? State month(s)

b) why did you need to? _____

c) what were these alternative arrangements? Mark appropriate block.

Walk	<input type="checkbox"/>	Bicycle	<input type="checkbox"/>
Bus	<input type="checkbox"/>	Own car	<input type="checkbox"/>
Bus & Walk	<input type="checkbox"/>	Taxi	<input type="checkbox"/>
Train	<input type="checkbox"/>	Other, specify	<input type="checkbox"/>
Train & Walk	<input type="checkbox"/>		<input type="checkbox"/>

4

7

16. Have you been discouraged from going to work at any time this year?

Mark appropriate block.

YES	NO
-----	----

8

If yes,



a) at what time of year? State month(s).

b) i) how did you regard your safety on your way to work?

felt very safe	<input type="checkbox"/>
felt safe	<input type="checkbox"/>
unaware of any danger	<input type="checkbox"/>
felt unsafe	<input type="checkbox"/>
felt very unsafe	<input type="checkbox"/>

ii) why did you feel that way during that/ those month(s)?

c) i) how did you regard your safety at work?

felt very safe	<input type="checkbox"/>
felt safe	<input type="checkbox"/>
unaware of any danger	<input type="checkbox"/>
felt unsafe	<input type="checkbox"/>
felt very unsafe	<input type="checkbox"/>

ii) why did you feel that way during that/ those month(s)?

14

17. Was there ever any reason other than personal illness that made you stay away from work this year?

YES NO

If yes,

a) at what time of year. State month(s)
b) what was this reason?
c) could this have been prevented? YES NO
Comment

15

20

18. Did you feel it necessary to stop wearing your nurses' uniform at any time this year?

Mark appropriate block

YES NO

If yes,

a) at what time of year. State month(s)
b) why did you feel this?

19. Did you have any difficulties entering your place of work at any time this year?

YES NO

If yes,

a) at what time of year. State month(s)
b) what was this difficulty?

25

28

20. What services do you offer? Mark appropriate block.

	YES	NO
Clinics		
Home Visits		
Maternity-delivery		
Well-baby clinics		
Casualty/Outpatients		
Other, please specify		

20

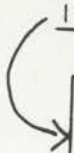
21. Were any of your services stopped during 1986?

YES	NO
-----	----

35

--

If yes,



a) which ones? Mark appropriate block.

Clinics	
Home Visits	
Maternity-Delivery	
Well-baby clinics	
Casualty/Outpatients	
Other, please specify	

b) at what time of year? State month(s)

c) who decided to stop these services? Mark appropriate block.

Staff members	
Employing authority	
Community	
Other, please specify	

d) Was this decision acceptable to you? Mark appropriate block.

YES	NO
-----	----

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--	--

--

40

--

24. Was there any time during 1986 when your patients/clients were prevented from attending your service?
Mark appropriate block.

YES	NO
-----	----

59

If yes,

<p>a) at what time of year? State month(s)</p> <p>_____</p> <p>b) in what way? _____</p> <p>_____</p>

25. Were you able to maintain your usual standard of care between May and July 1986?

Mark appropriate block

YES	NO
-----	----

63

26. How did you feel about the service you were able to offer between May and July 1986?
Mark most appropriate block.

Completely satisfied

Reasonably satisfied

Frustrated

Very frustrated

<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>

27. What suggestions can you make that would facilitate your work should the unrest situation occur again?

67

PLEASE CHECK THAT ALL QUESTIONS HAVE BEEN ANSWERED. THANK YOU.

Hierdie vraelys is ook in Afrikaans verkrybaar.

APPENDIX B : NURSES' SURVEY 1986 - NON-RESPONSE

MIDWIFE OBSTETRIC UNITS

1 of the 3 non-responders (Hanover Park) was absent on extended sick leave and at the time of the survey had just been discharged from hospital following surgery. She was not well enough to give information at that time.

DAY HOSPITALS

Athlone (Dr Abdurahman Hospital) had 8 non-responders.

The reasons were:

Sick Leave	4
Annual Leave	1
New	1
Unwilling	2

(Unwillingness to respond only constituted 25% of this 40%, i.e. the response rate (10%) was in the same range as the other centres.)

Bishop Lavis had 1 non-responder who was unwilling to give information.

Elsies River had 2 non-responders - both were unwilling to give information.

Langa had 3 non-responders. They did not wish to fill in the questionnaire or return them.

Heideveld had 6 non-responders. 4 were on leave or sick leave. The remaining 2 did not wish to return the forms.

Retreat had 3 non-responders. There is no information available as to why they failed to return their forms.

The remaining 2 day hospitals with non-responders are the 2 with the highest non-response rate - Guguletu and Mitchell's Plain, 60% and 65% respectively. These are significant in that these rates are much higher than at any other.

APPENDIX C : RESPONDENTS' REASONS FOR FEELING UNSAFE ON THE WAY TO WORK

Guquletu Day Hospital Responses

"Felt unsafe - the condition was tense, stone-throwing, teargas and shooting."

"Felt safe from rioters because they dared not hurt the nurses (whose) help they needed, but felt unsafe from the Caspirs - could shoot anybody when Crossroads was burning."

"Felt very unsafe - people were being killed or stoned or harassed."

"During September felt very unsafe - bus thrown with stones, taxi man and pirates fighting - burning of buses."

14 of the 29 (48%) Heideveld M.O.U. respondents commented on their feelings of safety this year.

"16th and 17th June felt unsafe - during the stay-away people in the location were threatened and some stones thrown."

"May - August - felt very unsafe - because they would say you're a sell-out when you go against their rules and either burn your house or kill you."

"June and July - felt unsafe - since there is throwing of handbombs."

"felt very unsafe - scarcity of transport."

2 had comments of a more general application

"(no month stated) - felt unsafe - because I have to walk and wait at bus stop for a bus. Very few people at bus stop."

"(no month stated) - felt unsafe - it is never safe to walk. I had my bag snatched on way to work."

APPENDIX D : SUGGESTIONS MADE BY NURSES REGARDING MEASURES THAT COULD FACILITATE THEIR WORK SHOULD THE UNREST SITUATION OCCUR AGAIN

1. Emergency Planning/Facilities

"To have enough equipment; enough staff - doctors and nurses; emergency room bigger, dressing room - enough facilities; emergency room - big and fully equipped; physiotherapist very much needed; more radiographers; psychiatrist; mobile health services to help the Guguletu community in need."
GUGULETU

"Day Hospital is a pre-fab and could be a fire hazard if petrol bombs were used."
ATHLONE

"We should have a backyard gate for escape, should have first aid points around the troubled areas, transport for critical cases, standby doctors, hot soup kitchens with stimulants."
LANGA

This last quote highlights a number of factors that were suggestions common to all areas.

2. Security and Transport

"Staff to be safeguarded to and from work. Offer places to sleep nearer work."
HEIDEVELD

"See to safety of staff because we render service to victims." ATHLONE

"Security arrangements at place of work until closing time" KENSINGTON

"Our clinic must have securities."
GUGULETU

"My employing body should please make arrangement for transportation.. as it is done by City Council and Divisional Council."
HEIDEVELD

"Transport is unsafe."
HANOVER PARK

"The blacks were far worse off than us - they were threatened if they went to work."
ATHLONE

Every area in the survey mentioned transport as a problem.

Solutions included:

a) transport organised by the employing authority:

"Transportation must be arranged to fetch us from home to work not a PA car. CA registration and sticker for hospital services."
GUGULETU

"Suggest staff relying on public transport should be transported in provincial cars operated by our 3 district sisters as a safety measure."
ATHLONE

b) being employed close to home

"One must work at the clinic nearest to where we live."
"Staff to report to the nearest hospital in area."
GUGULETU
ATHLONE

3. Identification

The problem of being identified as belonging to any particular group has been recognised earlier when discussing the wearing of uniform to and from work where a number of respondents replied that this identified them as government workers.

"Certain people feel unsure/not safe wearing uniforms - any (other) form of identity should be provided."

"Medical services are not commonly interfered with."

GUGULETU

"All nurses should wear luminous or display a luminous cross on the car to make people aware that you are attached to the nursing profession. They do allow you to pass them without harming you."

ATHLONE

4. Commitment/Communication

"Build a good relationship between you and the community by providing a good service. Always treat people with respect. Try to solve problems in a professional way. Stay open during crisis."

BISHOP LAVIS

"I wish we would have guaranteed security and trust from the communities we are serving."

LANGA

"Nobody interferes with the Day Hospital because they know they got help from this Clinic."

GUGULETU

"Work harder at building a better community. Improve communication with the community. Get to know the real community leaders and not only those appointed by the State. Ensure that the community knows you are there to see to their health needs and that no victim will be handed to the police."

BISHOP LAVIS

"Closing clinics and day hospitals as they do not really tend to people who require urgent medical attention."

ELSIES RIVER

"Health services should not be interrupted during unrest situation."

LANGA

"Have essential services continue, e.g. maternity delivery."

HANOVER PARK

"To continue my services whether during the unrest and to work with the public so as to show/teach the public that our duty is to treat enemy and friend."

5. Political and Police Activity

"I appeal to authorities to talk to people and stop these events."

GUGULETU

"The police force keep a low profile because their presence at times excites the hooligan element."

LANGA

"Remove police and SADF immediately. Their presence in the area only makes matters worse."

RETREAT

5. Political and Police Activity (continued)

"Police not to interfere with our work."

ST JOHN'S

"More security measures and less provocation by police. Stop pamphlets and writing on walls. Keep children busy during holidays."

BISHOP LAVIS

"As far as possible let every group stay in their own area."

RUYTERWACHT

These opinions and suggestions all deal with background, long-term problems. There were some valuable comments made regarding what nurses themselves need to do during such a time of civil disruption.

6. Nurses' Responses

"The work must go on. If we nurses give up our work, what will happen to our patients."

RETREAT

"Employ more nursing staff at all hospitals in the Peninsula so that in times of unrest staff can be drawn to where most needed."

HEIDEVELD

"We were inundated, as a result we had to do night duty and work Sundays and help Saturdays. I am quite sure that more staff can help because we did have help from other organisations. What frustrated us was to see the number of patients injured, the way they suffered and numbers that died, and can only say the system must change."

GUGULETU

"Payment for overtime and days off to rest."

GUGULETU

"Patients and relatives should be educated as how to care for the sick."

MITCHELL'S PLAIN

"Patients with newborn babies should not be discharged, but after care should be given at a place where delivery took place."

RETREAT

"Offer community training for coping with civil unrest."

SHAWCO

7. Employer Attitudes

"Authorities to be flexible during times of crisis."

ST JOHN'S

"The co-operation of authorities if a staff member needs to leave unexpectedly."

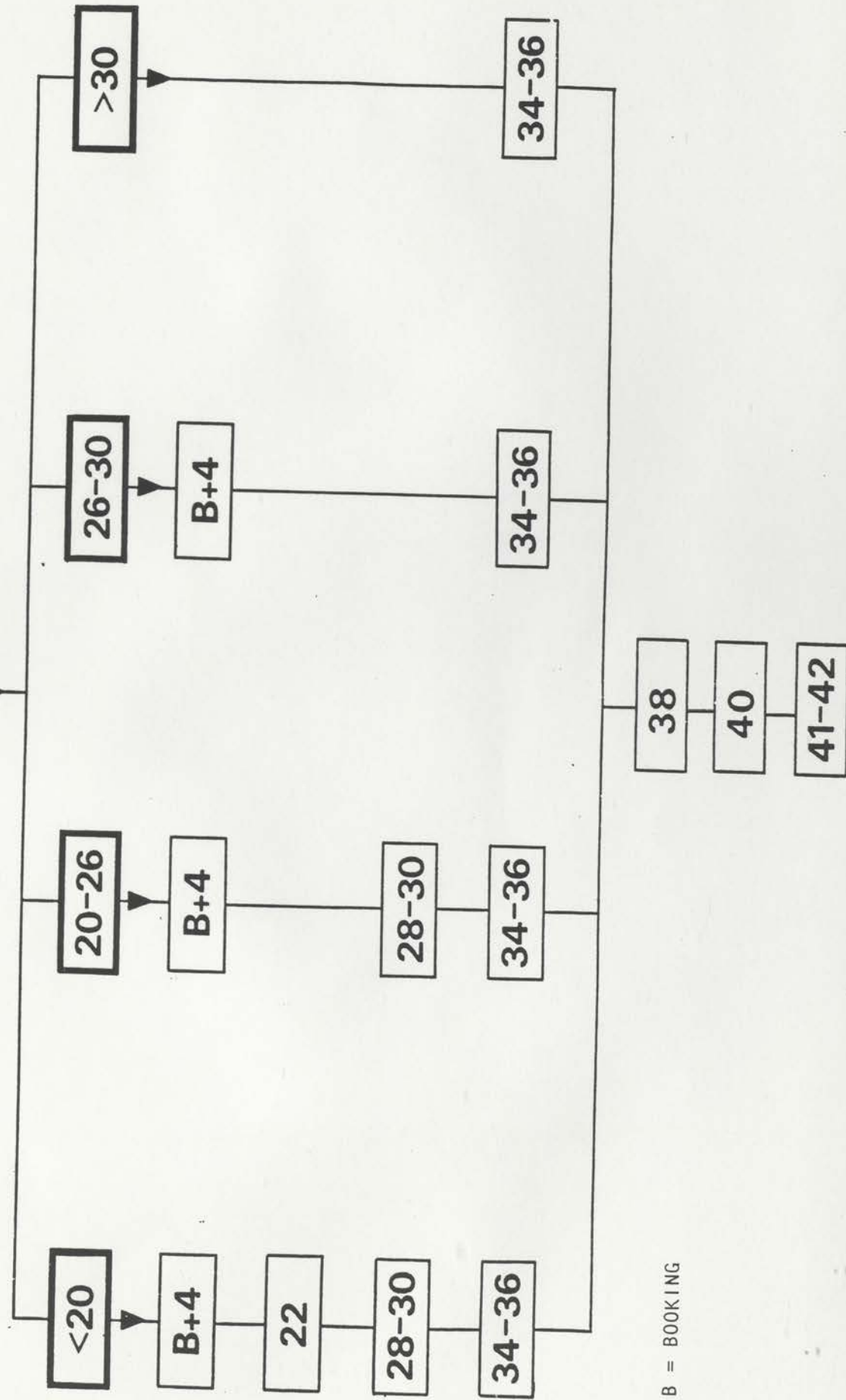
RETREAT

"You should be treated as adults and not ordered about by people not aware of the situation you are in."

PENINSULA MATERNAL & NEONATAL SERVICE

ANTENATAL ATTENDANCE SCHEDULE

GESTATIONAL AGE AT BOOKING



THE SOUTH AFRICAN NURSING COUNCILPOLICY DOCUMENT ON A NURSE'S RESPONSIBILITY IN CONFLICT SITUATIONS

In the light of possible uncertainty which could arise among members of the nursing profession regarding the attitude that should be taken when dealing with patients in various conflict situations, the Council has resolved to issue a policy statement setting out its viewpoints on the professional ethical responsibilities of a nurse in such situations.

The nurse is today being placed under increasing pressure in circumstances where complex ethical decisions are demanded and where such issues as professional responsibility are not always clearcut. Examples of such conflict situations are labour and civil unrest, insurgency and terrorism and the treatment of detainees and prisoners.

In all of these examples, the nurse must maintain a position of trust and impartiality and at all times have respect for the rights of the patient. The protection of the rights of a patient is inextricably linked to the duties and responsibility of the nurse to such a patient.

The "Rules setting out the acts or omissions in respect of which the Council may take disciplinary steps," published under Government Notice R387 of 15 February 1985, as amended, have a direct bearing on this matter. In particular, the acts or omissions referred to in rules 3, 4 and 5 are extremely relevant. They read as follows:

- "3. Wilful or negligent omission to carry out such acts in respect of the diagnosing, treatment, care, prescribing, collaborating, referral, co-ordinating and patient advocacy as the scope of his profession permits.
4. Wilful or negligent omission to maintain the health status of a patient under his care or charge, and to protect the name, person and possession of such a patient, through -
 - (a) correct patient identification;
 - (b) determining the health status of the patient and the physiological responses of the body to disease conditions, trauma and stress;
 - (c) the correct administration of treatment, medication and care;
 - (d) the prevention of accidents, injury or other trauma;
 - (e) the prevention of the spread of infection;
 - (f) the checking of all forms of diagnostic and therapeutic interventions for the individual;
 - (g) specific care and treatment of the very ill, the disturbed, the confused, the aged, infants and children, the unconscious patient, the patient with communication problems and the vulnerable and high-risk patient; and
 - (h) the monitoring of all the vital signs of the patient concerned.

5. Wilful or negligent omission to keep clear and accurate records of all actions which he performs in connection with a patient."

With the foregoing in mind, the duty and responsibility of a nurse in the situation referred to in paragraph 2 can be summarised as follows:

- (a) It is the professional obligation of a nurse to provide life-saving care and alleviation of pain to a suspected terrorist or insurgent if he should seek such help.
- (b) A nurse who is charged with the nursing care of prisoners and detainees has a duty to provide them with the same standard of protection of their physical and mental health and whatever treatment is needed, as would be afforded to any other patient.
- (c) A nurse may not be involved in any professional relationship with prisoners or detainees which has any other purpose than to evaluate, protect or improve their physical and mental health.
- (d) A nurse may not participate in any procedure for restraining a prisoner or detainee unless such procedure is determined in accordance with purely medical criteria as being necessary for the protection of the physical or mental health or the safety of the prisoner or detainee himself, or of his fellow prisoners or detainees.

It must be borne in mind that the nurse also has responsibilities and duties as an ordinary citizen and that she is at all times subject to whatever other legislation may be applicable to the particular situation in which she finds herself, e.g. the reporting of a suspected terrorist or any ill-treatment of a detainee or prisoner.

1988-06-20

APPENDIX G : THE SOUTH AFRICAN NURSING ASSOCIATION POSITION PAPER: THE RESPONSIBILITY OF THE PROFESSIONAL NURSE IN TIMES OF CIVIL UNREST

Introduction

The South African Nursing Association believes that it is the responsibility of the professional nurse to promote health, prevent illness, restore health and alleviate suffering. She has a further primary responsibility to render high quality patient care to those who require it, without consideration of religion, nationality, race, social standing, political opinions or other considerations. Her practice is further regulated by the Nursing Act (Act 50 of 1978), and the rules and regulations pertaining thereto, in particular the regulations relating to her scope of practice and the rules setting out the acts or omissions in respect of which the South African Nursing Council may take disciplinary steps. The nurse's behaviour should at all times reflect credit upon the profession. Neglect to maintain the health status of a patient under her care, or to protect the name, person and possessions of such a patient, be it wilful or through negligence, may lead to disciplinary steps by the South African Nursing Council. Furthermore, a nurse may not divulge any personal information concerning a patient which has become known to her in her professional capacity, except in certain circumstances, e.g. in acts of terrorism where silence may be regarded as abetting.

POLICY

In view of the above the South African Nursing Association:

1. REAFFIRMS that the nurse's first responsibility is towards her patients.
2. CONDEMNS any act of violence, such as torture, mutilation, cruel treatment or murder, and any humiliating or degrading treatment which affronts personal dignity.
3. UPHOLDS the principles that during times of national or international unrest, all persons, whether involved in the hostilities or not, and regardless of religion, race, nationality, social standing, political opinion or other considerations:
 - (a) shall receive the necessary protection and care if wounded or ill;
 - (b) shall not be subjected to physical or psychological abuse or experimentation;
 - (c) shall be protected as far as possible from health hazards which may arise from the hostilities.

4. RESOLVES that nurses acquiring knowledge of physical or mental ill-treatment of detainees and prisoners shall take the necessary action which may include reporting the matter through the appropriate channels.
5. CONFIRMS the right of the professional nurse to hold in confidence all personal information divulged to her by her patients, except where instructed thereto by a court of law or where a nurse is otherwise lawfully bound thereto.
6. RESOLVES that the right of access to any health facility be upheld. This means, inter alia:
 - (a) that access by police can only be allowed when in possession of appropriate documentation or when otherwise authorised by law;
 - (b) that anyone who is deemed to be a threat to the patient's safety, can be refused admission.
7. BELIEVES that despite the nurses' acceptance of the professional ethic that she should place the interest of her patient before self-interest, she has rights as a human being and as a citizen.