Setting new standards for health communication in South Africa

S Verwey and A Crystal
Department of Communication
Rand Afrikaans University
Johannesburg
Email: sve@lw.rau.ac.za and acr@lw.rau.ac.za

Abstract

Prior to the 1994 election, health care was a privilege enjoyed only by some sectors of the community. After the election health care was entrenched in the constitution through section 27(1) that states that everyone has a right to have access to health services.

The challenge the ANC led government faces is to balance the maintenance of tertiary care service with the simultaneous upgrading of primary care services. The strategy adopted by the Department of Health is to regulate the industry and educate the public. Although this strategic approach is designed to promote and provide healthcare to all South Africans, it appears to be failing. According to the Economist Intelligence Unit the health status of South Africa is the poorest of all 27 countries measured. During the first two years of the new health care system many crises occurred. According to the Director General of Health, some of the crises were the result of the long neglect of apartheid while other crises relate directly to the lack of skill in communication.

This article argues that improved communication at all levels is a necessary prerequisite if South Africa is to improve the health status of our population.

Introduction

"The state of the art of health communication is embryonic, to say the least ... By applying communication theory and research as well as interpersonal and group skills, communication specialists can enhance interactions in medicine, health care delivery systems, and health care in general" (Cassata, 1991:583). Health communication arose as a response particularly to the growing pragmatic and policy interest in health promotion and disease prevention, especially in developing countries like South Africa. According to the United Nation's classification, South Africa can be categorised as a developing country. Like other developing

countries, South Africa has limited manpower and financial resources and many inhabitants live in Third World conditions (Goosen, 1988:3).

Statistics highlight the challenges that face health care providers in developing countries. The World Health Report (1996) indicates that of all the births in 1995, almost 16 million were in the developed world, almost 25 million in least developed countries, and over 98 million in other developing countries. Of the more than 11 million deaths amongst children under 5, in the developing world about 9 million were attributed to infectious diseases, 25% of them preventable through vaccination. According to Statistics of the World Bank and World Health Organisation, child and infant mortality amongst black South Africans is twelve times higher than amongst white South Africans. This mortality rate is three times higher when compared to other countries who spend as much per capita on health care as South Africa. More children in South Africa suffer from malnutrition than in many other poorer countries; the tuberculosis rate is the highest in the world and our population growth in rural areas is higher than Kenya and Ethiopia respectively. Also, more children die of preventable diseases such as measles and dehydration than any other country that spends as much per capita on health care (Hudson, 1997:12).

It is little wonder that the Economist Intelligence Unit rates the health status of South Africans as the poorest out of 27 countries rated. Even countries who spend much less on health care provision are rated much higher. This is despite the fact that money spent on health care within the private sector has risen from 6,3% of GNP in 1982 to 17,3% in 1992, according to the 1995/6 *South African Health Review* (Hudson, 1997:12). The distribution of health services and manpower between the private sector and public sector is unequal in all respects. Almost 80% of the countries people rely on the state to provide for their health care needs, at little or no cost.

Only 15,8% of the white population rely on public health services (Shisana, 1996). Public health care is delivered to millions of people by 42% of doctors and specialists, and 86% of nurses in South Africa. More than 2000 doctors posts in the rural areas are vacant, of which 700 are deemed to be critically needed.

These are some of the more evident problems facing health care provision in South Africa. Prior to the 1994 election, health care was a privilege enjoyed by some South Africans. The challenge is to prevent crises in order to increase the proper management of health services. In line with global trends this entails that the causes of ill health need to be tackled through preventative rather than curative health care. The ANC led government has acknowledged that primary health care must be integrated with population development strategies that are aimed at improving the social and economic status of the whole population. Health forms the basis for social upliftment, but good health care is not sufficient if not combined with better living standards (Goosen, 1988:8). Even in developed

countries like the United States, this fact is now also being acknowledged as increasing emphasis is being placed on prevention rather than cure as a strategy for managing health care crises (Ratzan, 1994: 224).

The ANC led government faces a challenge to improve the two main factors which contribute to the health status of a country namely the general level of development and prosperity.

The approach of the ANC led government to improving the standard of health care in South Africa

According to Shisana (1993:2) planning health services for populations with diverse expectations poses major challenges to even the most experienced planners. During the change from apartheid to a democratic form of government there were varied expectations:

- Those who were deprived under the previous dispensation and who are expecting dramatic changes in the improvement of the quality of their lives.
- Those who benefited from the previous order and are divided into three groups:
  i. Those who benefited from the previous dispensation but genuinely want to see the needs of those previously deprived met.
  ii. beneficiaries of the previous dispensation who are willing to see deprived groups benefit but not at their expense.
  iii. those who benefited from the previous dispensation and want this to continue under the new government.

According to Shisana (1996:3) the ANC led government identified five burning issues where a natural tension existed due to the transition from apartheid health services to democratic health services. These are:

- cost containment
- resource allocation
- improvement in standards in health care
- protecting the health of the public and
- bringing health care closer to people.

Cost containment

By international standards South Africa spends too much on health care. The inequitable distribution of the resources between public and private sector contributes to this wastage. The tension in resource distribution between the public and the private sector and its resultant problems in health service delivery needs to be managed through the following measures:

- drug policy aimed at reducing the cost of medicine

- sharing resources between the private and pubic sector
- improved salaries of public health care workers.

Resource allocation

The ANC has introduced fiscal equalization to reduce inequalities between provinces and has adopted health care financing policies that promote equity of access of health services amongst all South Africans.

Improving in the standards of health care

Standards of health care will be improved through the adoption of the following measures:

- Vocational training through an additional two year supervised training in the public health sector for doctors.
- Dispensing of medicines which entails re-regulation with regard to dispensing practices through licensing.
- Review of maternal deaths with a view to investigate every maternal death and identifying the conditions which led to the deaths.
- Termination of Pregnancy Bill which aims to make the termination of pregnancy safe.
- TB control which is aimed at tackling the most common cause of ill health in South Africa.

Protecting the health of the public

To promote health, prevent disease and protect the public from hazardous environments, reregulation of the tobacco industry is required in order to protect and educate non-smokers, especially children.

Bringing health care closer to the people

The new constitution (Section 27(1)) states that everyone has the right to access health services, including reproductive health care, sufficient food and water.

This means that the basic health needs of all South Africans must be met. It is hoped that this will be achieved through free health care access to all pregnant women and children under six years of age, in all public health care facilities, and through the provision of health care to all South Africans at primary health care facilities.

These five issues need to be dealt with effectively if the aims of the ANC's National Health Plan for South Africa are to be realized. According to the ANC's National Health Plan (1994:7) that was introduced in May 1994, all legislation and

health care providers will have to be reviewed in order to achieve the following aims:

- emphasizing health care not just health services
- redressing the negative impact of apartheid on health care provision
- encouraging and developing comprehensive health care practices that are in line with international norms, ethics and standards
- providing all health care workers with equally important role, thereby ensuring that teamwork forms a central component of the health care system
- recognising that the most important component of the health care system is the community, and providing mechanisms that will ensure effective community participation, involvement and control
- the provision of management practices that will be conducive to effective humane health service delivery
- respect for human rights and accountability to the consumer of health services and the public in general and
- reduction of the burden and danger of illnesses that threaten the health of all South Africans.

Within this National Health Plan every individual's right to be healthy is strongly emphasized. This right will be met through equal social and economic development for all citizens. Health care for all is the main purpose of the plan (Snyman, 1994:45).

The primary health care approach incorporates a preventative orientation and education respectively, as a means to planning, delivering, controlling and monitoring of health services. It's aim is to maximize the participation of the community in aforementioned activities. Democratically elected representatives will play an important role in the structuring of health services, by appointing personnel and controlling budgets.

This will facilitate a greater degree of local control and responsibility over health issues. Furthermore, a primary health care approach will bring about a change in the medical culture. Previously, the community (the patients) were regarded as passive recipients of health services that were provided by health care personal in a very linear, one directional manner. Primary health care espouses the belief that all parties involved in the process are responsible for health care practices. According to the ANC (1994a:43) the sources of health problems are diverse and complex, thus attempts to solve problems associated with it, will require a multi-sector approach. For example, those sectors responsible for providing clean water, sanitation, housing etc. can have an even greater effect on health issues than health services *per se*. It is the responsibility of the health sector, to ensure that the policies, programs and plans of other sectors take health issues into account.

The President and Cabinet must ensure that this holistic health intervention philosophy is implemented as part of the Reconstruction and Development program. The Director of Health must ensure that the necessary mechanisms for effective communication, integration and co-operation between the various health activities are promoted and evaluated.

The principles contained in the policy deal with a variety of issues, *inter alia* emergency services; technology; the aged; environmental health; combating infectious diseases; AIDS and other STD's; mental and dental health; labour health etc. Furthermore, these policy issues are prioritized, for example priorities include *inter alia* providing women and children under the age of 16 respectively, with free health care and the improvement of pre-natal and post-natal care.

According to Snyman (1996:7), one of the first steps that will be taken in the development of a new national health system (NHS) is to install the national health authorities on a central level. Here, policy issues and central co-ordination will take place.

Each province will be divided into different health districts to enable the decentralization of the NHS to take place. Communities will play a very important role in allowing health services to filter down to grass roots level. Furthermore, the plan suggests that private doctors, especially GP's should play a greater role in the providing of these services. The ANC hopes to increase accessibility to health services through their increased involvement as they are found in most communities. Private doctors will further be encouraged to spend time in public clinics, centres and hospitals. Government hospitals will be streamlined so that certain services will only be available at selected facilities.

As seen in the previous section, many aspects of the plan have already been implemented. However, a perception exists that many of the programs that have flowed out of this plan can be regarded as ineffective. This is partly due to very public, thus visible, media exposure of communication failures such as:

- the Beedle plan which proposed that compulsory managed health insurance be implemented
- the Sarafina II debacle
- the Virodene incident
- the 2 year compulsory medical service announcements.

Dr. Sishana (1996:4) herself is quoted as saying that during the first 2 years " .....we have had crises. Some of the crises were a result of long neglect of apartheid while other crises relate to a lack of skill in communication." According to Kreps (1988) effective health care and health promotion are guided by relevant health communication. Communication is thus clearly the primary process used in health care to disseminate and gather health information. Communication is essential in the provision of social support (by health care provides, participants in

formal and informal support groups, family and friends). Communication is also fundamental in co-ordinating health care treatment and activities of various inter-dependent providers and consumers (Krepps, O'Hare and Clowers, 1994:249).

Communication strategies between health care professionals, patients, and their support groups play a key role in determining and assessing health outcomes. According to Kroger (1994:218) the leading causes of preventable disease, disability and premature deaths are primarily associated with lifestyle and behaviours. Future advances in health are likely to come from the social and behavioural sciences rather than from the biomedical, and health communication can play an integral role in shaping these advances.

The role of health communication

Health Communication can be defined as the art and technique of informing, influencing and motivating institutional and public audiences about important health issues. It's scope includes disease prevention, health promotion, health care policy, business as well as the enhancement of the quality of life and health of individuals within the community (Ratzan, Stearns, Payne, Amato, Liebergott and Madoff, 1994:362). What is required is an understanding and appreciation of the basic issues underlying health communication. According to Kroger (1994:218) these are:

(i) professionalism
(ii) systemism
(iii) consumerism

Professionalism

According to Paisley (1990) social scientists point to three principal avenues for influencing social change : education engineering and enforcement. Kroger (1994:218) maintains that educators influence through instruction and persuasion. A trend in professional education has been defining competencies for professional practice of health communication (Maibach, Parrott, Long and Salmon, 1994:352). A study conducted by Maibach *et al.* (1994:353) list the competencies required by professional health communicators to include the following:

- ability to apply relevant theories to program and development efforts at both the individual and societal level
- conduct program planning and implementation which requires knowledge of the full range of health communication goals
- good knowledge of the mass media and of its communication tools and
- ability to evaluate at all levels of strategy development and implementation.

Professional health communicators therefore need foundational competencies in order to gain an understanding of a broad base of human behaviour. Foundational

competencies suggested by Maibach *et al.* (1994:356) include an individual and societal understanding of behavioural theories, functions of the mass media, media production processes and technology, rhetoric and environmental scanning, previous health campaigns and corporate consumer marketing practices. Appropriate prepatory grounds for advanced training as health communication professionals include journalism, health education and public health, psychology, education, public policy, city planning and marketing communication. Applied competencies is demonstrated in the ability to perform a set of tasks. Individual applied competencies include the ability to collect and interpret formative data, synthesize relevant primary and secondary research findings, and reach action oriented recommendations. At societal level applied competencies demonstrate the importance of the health communicator's ability to define public health problems from multiple perspectives and levels of analysis. These perspectives broadly include policymakers, businesses and the general public. The foundational and applied competencies specified foster reflexive competency.

Reflexive competencies are fostered through providing a full range of understanding and skills required in health communications, thereby enabling professional health communicators to demonstrate and connect health communication outcomes to an understanding of their performance so that actions can be adapted to changes and unforeseen circumstances. In order to equip professional health communicators with these competencies, training institutions must provide graduate training programs to foster a full range of understanding and skills required in health communication. According to Rogers (1994:210) the growth of health communication rests fundamentally on the development of university centers of excellence that engage in scholarly but applied research that trains future generations of health communication experts. The general trend toward prevention in health programs and policies is one reason for the increasing recognition of health communication (Rogers, 1994:211).

Systemism

Kroger (1994:219) contends that a systems approach to disease or disability prevention requires intervention specialists to think holistically. Conscientious health communicators have to examine their roles within a bigger context. Green and Kreuter (1991) have distinguished between interventions in communities versus community interventions. Community interventions call for multiple strategies designed to influence environmental forces and behavioural patterns at several levels within a community. This requires networking and co-operation between all parties involved not just those within the health system per se. Effective health communication entails being aware of activities on the multiple microlevels of action. The individual is no longer the focus of behaviour change strategies, proving that public debate on policy issues is. Health communicators must therefore not only look at developing and deploying messages in a creative manner, but also at issues of distribution.

Consumerism

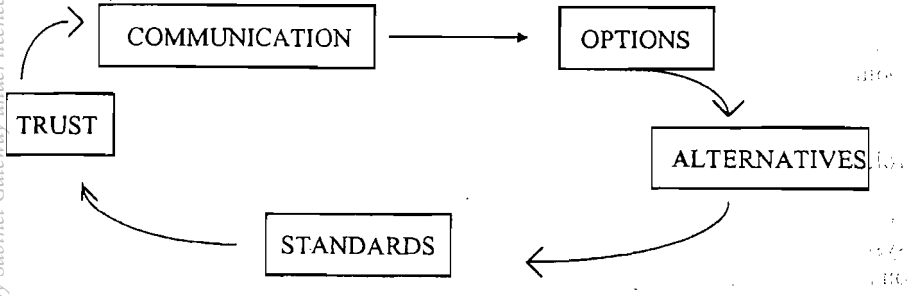
Consumerism has to do with the notion that a consumer orientation is more productive than a product orientation. This implies that the consumer's wants, needs, perceptions, preferences and tastes should determine the strategies and execution of the integrated marketing communication aimed at the consumer. Therefore, PHC must fit the requirements of particular local circumstances as well as the development of a customer orientation in the rendering of service. This entails that the community must be recognized as clients and treated as such with regard to the delivery of PHC services. This entails maintaining a clear vision for prioritizing resource allocations and the strengthening of your ability to communicate internally and externally. Community consultation enables the identification of short term priorities for addressing health care provision problems and on the long term it establishes a reaffirmation of the mandate by conferring public consent. The number and variety of people and associations to consult with, will be determined by health care issues and problems and the size and nature of the community. Community consultation is an ongoing process that promotes two way communication at all times. In essence PHC represents a broadening of the focus, in that the focus shifts from a curative approval to a preventative one.

According to Ratzan (1994:224) the motivation for the shift to preventative medicine has been heightened by the fact that Aids is incurable thus the emphasis has out of necessity shifted to preventative medicine. According to Hornik (1996:12) the substantial efforts in public health communication are founded in a recognition that much of health status reflects human behaviour rather than medical treatment, prevention and not cure. Ratzan *et al.* (1994:363) states that what is required is an understanding and appreciation of both the principles of health and health communication, thus implying that communication competency becomes a central aspect of the health care equation. Hornik (1996:12) postulates that this is why much attention is being focused on understanding why it is that people comply or don't comply with particular behaviours and the development of models of health behaviour choice. According to Kreps, O'Hair and Clovers (1994:248) the deployment of increased resources in health care becomes meaningless unless effective communication throughout the health care delivery process takes place continuously. According to Hornik (1996:11), failure to do this, means that the model of influence that comes from a social communication point of view is not respected, thus the quality of communication is not considered.

What is needed, is public health communication founded in the recognition of the role of health communication, in affecting secular trends in health behaviours, including both deliberate communication interventions as well as public health communication in general. Only then can public health communication be systematically used to influence secular health behaviour, so that there is a change on a scale that can be regarded as meaningful (Hornik, 1996:14).

Workable integrated negotiated health communication

The basis of the workable integrated negotiated (WIN) perspective is fostering democratic discourse that originates with the initial communication act (Ratzan, 1994:226). Given this perspective the individual must be empowered to communicate and effectively negotiate to render decisions that affect his/her well-being. According to Ratzan (1994:228) the WIN approach has the potential to significantly affect various levels of education and curriculum of health care professionals, and to contribute to informed citizenry. Furthermore, WIN can improve the quality and delivery of health care, as well as broaden the attitudes and beliefs of health care providers and consumers. In this health communication negotiation model, the individual is the recipient that is targeted to deliberate on the appropriate decision. The result, in part, is dependent on credible agents who make up his/her primary familial group. A secondary, yet important objective is for receivers of such information to become sources in the transactional process to others within the community. In addition to enhancing satisfaction, as well as optimizing successful outcomes, increased patient participation using negotiation concepts in the dyadic health encounter is beneficial for third parties such as insurance companies and other members of the health polity (Ratzan, 1994:233). WIN operates at the individual level and is realised through communication, options, alternatives standards and trust (COAST). The promise of implementing WIN within the extrinsic layers of society centers on a parsimonious model for effective decision making. COAST suggests an active participation by the individual in implementing self-determinism to effect his/her overall health and well-being. COAST originates with the initial communication act between individuals, defining interests, establish agendas, identifying cultural nuances, and developing effective listening habits. As the negotiation develops further, options are brainstormed, presented, and discussed along with appropriate alternatives. This important communication act occurs within the context of mutually agreed upon objective standards, thereby imbuing the process with trust. The COAST method inspires and empowers individuals within a similar group to work towards the common interests of quality health, which they collectively define and agree on. The COAST model can be depicted as follows:



The COAST negotiation approach to the health encounter is communication centered, incorporating essential elements of traditional communication models. COAST points to a dialectical approach with the opportunity to replace unidirectional flow and power relationships between health care provider and client practiced widely today, with a co-active encounter increasing the clients locus of control, and based on trust and free flow of information. According to Ratzan (1994:230) the key element of this strategy is the development of a dialogue which encourages individuals to select between alternatives. Essential to this approach is trust, the transactional product of open and honest sharing of information and credible feedback among the involved parties. Research reveals that the degree of trust within the health encounter can be positively correlated with the degree of compliance and overall satisfaction of the parties involved. According to Ratzan (1994:245) the challenge is to be involved dialectically in the communication process from its inception with in this transactional, holistic approach to health communication.

Health communication in South Africa: *Quo Vadis*?

Communication as foundational competence

According to Hill (1997:17) Western trained professionals have been taught to recognise pathology only. Completely excluded from their education has been any ability to recognise the more important culturally conditioned concepts of illness and wellness and how to treat either of these (Bayne-Smith,1996). Hill (1997) adds that communication competency is an important vehicle for care givers as it functions to overcome threats to one's standing and helps to define the care givers role. For care recipients, communication is extremely important for understanding problems and solutions for positive health outcomes. According to Long (in Hill, 1997:3) health communication is a significant and universal component of the medical encounter. The complex communication in medical settings gives rise to serious barriers. Thornton and Kreps (1993:34) list these barriers as follows:

- differences in knowledge
- power differentials
- social status differentials
- lack of mutual accommodation
- ambiguity of language and jargon
- pressures of time and
- cultural differences.

These findings were confirmed by market research conducted amongst South African patients into the needs and expectations that they had in their dealing with family practitioners. 82% agreed that "doctors can leave patients confused" and 59% felt that "consultations tend to be rushed" (Anon A., 1993:18). In a list of

what irritates patients most (Anon A., 1993:20) one of the factors mentioned was the use of medical and technical terminology. Similarly, when asked why they would change to another general practitioner one of the reasons cited (Anon A., 1993:18) was due to the unfriendly and disinterested attitude of the general practitioner. The article stated further, that "most of all, patients want to know that their doctor is accessible. He should be available after hours if necessary, to speak to patients on the telephone without giving the impression that they are being a nuisance or wasting his time."

For many South Africans patients, consultation of a medical doctor takes place in a multi-cultural clinical setting as doctor and patient do not necessarily share the same frames of reference regarding health care. De Villiers (1993:9) states that these differences in frames of reference pertain to different ideas and beliefs about the causes, treatment and prognosis of ill-health. For example, Uys (1994:6) refers to the fact that decision-making in some rural areas is linked to the tribal system, where the social hierarchy makes decisions for the people. The patient is dependent on the group or extended family and intrusion in the decision-making process can lead to withdrawal from health programs. The statistics that she provides shows that as many as 25% of rural patients absconded from a renal program in order to consult their traditional opinion leaders. She therefore suggests that the medical assessment of the patient should include a cultural assessment as well. Hill (1997:3) reiterates Uys' view and states that to understand and deliver culturally congruent care, health providers need to demonstrate sensitivity to the recipient's general worldview and philosophy of life.

Unfortunately this is not usually the case. Shaver's (1997:20) findings supports research that notes that societal perceptions about the roles of women, particularly indigent women of colour, are barriers to good health care and that stereotypical assumptions by health providers about women, their roles in society, and their "normal" states of wellness and illness are detrimental to health diagnosis and care. According to Shaver, (1996:15) studies pertaining to patient-physician encounters show that patients names were not often used. Although the doctor was called by his title, older women were often called by their first name or by a term of endearment such as sweety, dear, etc. Shaver (1997:15) believes that this demonstrates the doctors continued unreachability, and shows to what degree the doctor is separated from the patient by gender, status, culture and organisational power.

Research also indicates that physician's attitudes toward homosexuality are negative since negative attitudes towards gay, lesbian and bisexual patients were held by about half of physicians and physicians in training studied (Chaimonwitz, 1991; McGrory, McDowell and Muskin, 1990; Bidol, 1997). According to Bidol (1997:7) this large proportion of negative attitudes may result from a number of factors including general socialisation, lack of professional training and information on sexual orientation.

As early as 1976 Machanic concluded that communication is an essential component of these interpersonal transactions between doctor and patient and by implication suggested that there should be a high correlation between satisfaction with physician - patient communication and compliance. Later studies (Bidol, 1997:3) clearly point to the fact that interaction between physicians and patients have effects on patients satisfaction outcomes and on the expectations physicians and patients have of one another for future interaction. According to Cockerham (1993) recognition of this has resulted in a shift from a strictly biological approach to medicine towards a more psychosocial approach which depends an open mutual communication.

For the traditional physician the primary objectives of medical consultation are:

- determination of diagnosis or definition of possible diagnoses
- development of an evaluation and a treatment plan
- communication of the plans to the patient and
- development of relational rapport with the patient (Yallman, Yoels and Clair, 1993). According to Bidol (1997:4) the development of the relationship with the patient should be most salient in the medical consultation, in which the physician and patient are strangers to one another and guided by generalized expectations of one another. Conventional physician centered care tends to discourage the patient from speaking and limits the information the patient can provide - a critical problem in family planning and other health settings (Kim, Odallo, Thuo and Kols, 1997:2).

Parson (1951) described five expectations held in US Society about the physician role. These are that the physician is:

- technically competent
- universalistic toward patients, rather than preferential toward patients with certain characteristics
- functionally specific using acquired patient information only for the purpose of medical care
- effectively neutral, not emotionally involved with patients, not allowing the degree of liking to influence their treatment and
- collectively oriented, placing service to his/her patient above personal goals.

According to McGuire, Fairbarn and Fletcher (1989) new physicians are being advised increasingly to be professional but not bereft of warmth and empathy in their interactions with patients. New medical school curricula that focus more on patients' expectations and concerns, are being proposed and adopted hopefully resulting in more patient-sensitive, humanistic health professionals (Evans, Stanley and Burrows, 1992; Frankel and Beckman, 1993; Schofield and Arntson 1989; Todd 1989 in Bidol 1997:5). Research also indicates that greater patient participation leads to increased confidence in the decision made during the consultation and greater commitment to

follow through on that decision (Kaplan, Greenfield and Ware, 1989). According to Kim *et al.* (1997:25) training programs could teach health providers how to encourage client participation and become more responsive. Studies in the United States and Europe have shown that special courses can teach a more patient-centred style of communication (Gask *et al.* 1988; Levinson and Roter, 1993; Roter and Hall, 1992 in Kim *et al.* 1997:25).

However, Bruce (1990) cautions that training can succeed only if managers reinforce the new behaviours for example, by evaluating and rewarding providers on the quality of the interactions rather than the number of clients seen.

Unfortunately in the South African context the same emphasis is not being placed on either improved physician-patient communication or a patient centred style of communication training for physicians and health care providers. According to Pinkney-Atkinson, Head of Quality Care, Masa (Anon C., 1996:22) the vast majority of complaints received are communication or fee related problems. The Medical Ombudsman, Prof. Olliver Ransome, is reported to be concerned by the gradual deterioration of the doctor's public image which is due in part to the poor communication between doctors and patients (Anon C., 1996:26).

A survey of the medical schools at South African Universities reveals an alarming lack of emphasis and acknowledgment of the pivotal role that communication plays in health care delivery. Of the six institutions surveyed, only one included a six month course called medical communication into the training curriculum of aspirant physicians, namely the University of the Orange Free State. This course deals with doctor-patient communication and is offered by their Department of Communication. The responses of the other training institutions can be summarised as follows:

- University of Cape Town offer a course called medical communication within the subject Health care and Society. It is offered at first year level and appears to deal with communication superficially.
- Medical University of South Africa does not include communication in their training curriculum. The reason stated was that they do not have a Department of Communication and could therefore not include communication training into the curriculum.
- University of Pretoria have revised their curriculum and the new curriculum includes aspects pertaining to communication. However, there appears to be a recognition of the importance of including communication in their training.
- University of Stellenbosch offer a subject called Behavioural Science but do not offer any subject called or pertaining to communication.
- University of the Witwatersrand offer a subject called Human Behavioural Science, but no communication per se.

Enquiries to the Medical and Dental Council indicates that there is no official requirements pertaining to the inclusion of communication as either a separate subject, or a module in terms of content, into the training curriculums of medical training

institutions Failure to include communication training as part of the foundational competency training base of medical practitioners is in sharp contrast to international trends. In places like the United States training programs are addressing the importance of communication training through the development of dual training programs between departments of health communication and medical schools. Apart from incumbents who pursue careers as health communication professionals, these health communication courses are viewed as valuable supplements to students in the fields of medical practice such as medical doctors, dentists, nurses, veterinary surgeons, public health officials and public health policy makers. It also entails the creation of partnerships between medical schools and training institutions who offer health communication which enables the sharing of resources at these levels to become possible.

It would therefore appear as if South Africans health care providers are taught only to recognise pathology and that excluded from their education is the ability to recognise that health care is culturally bound and impacted by communication, or that the relationship between care givers and providers depends on the quality of health information rather than the quantity. The traditional health care provider, the physician, now shares in the information flow, leading to decision making between patient and provider rather than the traditional undirectional format with the physician as the sole focal point of information (Ratzan, 1994:225). Today the major goal of the health care professional is prevention as well as the treatment of the patient's illness. The new cornerstones of effective health communication are disease prevention, health promotion and maximizing one's well-being (Ratzan, 1994:225).

Options

The underlying philosophy of the National Health care system for the re-compilation of health services in South Africa is the Primary Health Care system. This entails a shift away form first world technological curative health care system towards a system of developmental health programs aimed at the prevention of disease. Unfortunately the implementation of this health strategy is limited by political expediency and bureaucratic delays, as is evident from personal interviews with members of Gauteng's Department of Health (1997). In response to Dr. Zuma's statements regarding the fact that South Africa cannot afford the duplication of high technology care centres, and that tertiary care will have to be rationalised, medical practitioners have expressed fears that reducing funding to academic and specialised hospitals will lead to the demise of health care in South Africa (St. Leger, 1994:5). The general sentiment expressed is that primary health care should be a priority but not at the expense of specialised care. The reduction in funding of academic hospitals could lead to the demise of primary health care since the effect of this will be that less health care professionals will be trained and academic hospitals will be forced to reduce the number of patients that are referred to them through the primary health care system (St. Leger, 1994:5). From the personal interviews conducted with Gauteng Department of Health officials, it is evident that although the philosophy of primary

health care is sound, the existing health care system is not geared for the implementation of primary health care because of existing shortages with regard to resources and staffing. Consequently the new system leads to further complications in health care service delivery. After the announcement of free health care to pregnant women and children under the age of six the number of children treated at the emergency unit of the Johannesburg General Hospital since the 1st of June 1994 rose with 150% and the number of babies delivered doubled (Marais, 1994a:7). According to Dr. Chimen Lalla there was a 19% growth in the number of children treated from July 1993 to July 1994 at the Chris-Hani Baragwanath hospital, (Anderson, 1994:S4). Clearly the lack of infra-structure and the immediacy of implementation of the primary health care strategy meant that the care providers and structures were not empowered to ensure successful implementation. Although the need for primary health care service delivery was correctly identified, the process of implementation has compromised the credibility of the system for a variety of stakeholders. One such an example is the implementation of the Termination of Pregnancy Bill. According to a spokesperson only four provinces have implemented the provisions of the bill which ensures a woman's right to termination of pregnancy. This means that this service is not delivered equitably, overburdening those hospitals that do provide the facility. Furthermore, the right to legal termination of pregnancy is compromised because the backlog in service delivery results in an inability of the system to provide termination before the 12 week cut-off period.

The health budgeting process is largely a paper exercise and renders the participation of both parliamentarians and provincial structures in the decision making process of limited value (Strachan, 1997). Parliament simply does not have the comparative information to make decisions about the appropriateness of budgets, and to know whether money is being spent appropriately. Strachan (1997) further states that of more concern is the lack of a systematic framework for achieving new health objectives, such as the absence of budgetary guidelines for the new district health system. The essential problem is poor budgeting and financial planning. According to a spokesperson for Gauteng's Department of Health what is needed is longer planning cycles that will take into account the implications of the new district health system. The possibility for provinces to manage finances more effectively lies not in "lack of capacity" by provinces, as is often stated, but in poor budgetary allocations of existing resources. However, decisions regarding health care priorities which implicate budgetary constraints with regard to where and how money is spent, it determined centrally by the Department of Health. Consequently it is not possible at provincial level to budget and allocate resources based on regional needs. According to Strachan (1997) the lack of provincial capacity is the result of an absence of financial planning at central level, that would reflect the new priorities set by the Department of Health. Quite simply, provinces are not fully empowered to make their own budget allocations.

Alternatives

In order to succeed in a consumer orientated environment, every organisation, including non-profit making services need to consider how to cooperate with compliments and competitors in order to deliver superior value. Casslione (1996:4) refer to this process as coopetition. The basis of coopetition is alliancing as a business philosophy which recognises the interdependence of all role players. For example, in America the American Cancer Society, the American Heart Association and the American Lung Association are already linked to one another through various bulletin boards and electronic mail systems to instantly activate appropriate actions and reactions to the tobacco industry's efforts (Kroger, 1994:221). Health communicators thus need to examine their roles within the context of the bigger picture on both the macro level and on the multiple micro levels of actions. This encompasses all the aspects pertaining to the health care system mentioned earlier.

However, in South Africa no cross budgeting exists and thus no sharing of resources takes place. Systemism is therefore not a priority despite the importance thereof. To quote from Hornik (1997:12) "...they are doing communication like it was a pill and not like a social process". Public health communication should be founded in the recognition that much of health status reflects human behaviour, rather than medical treatment, prevention and not cure. A greater emphasis needs to be placed on understanding human behaviour in a holistic manner. This has implications on at least two levels. Firstly, communication with (not to) the health recipient can no longer be reductionistic in character. The WIN orientation needs to be implemented, for example the recipient must actively be involved in selecting methods of treatment. Secondly, multiple strategies are required to influence environmental forces and behavioural patterns that have direct and indirect implications on people's health conditions.

Interdepartmental teams need to be assembled that deal with societal issues as a whole, with health comprising only one component thereof. Interviews with members of Gauteng's Department of Health indicate that this department has the intention of putting such project teams together that will consists of expertise from a variety of fields such as communication, media graphic design, adult education and health care. However, at present cross departmental structures are not yet in place.

Furthermore, there needs to be better utilization of existing infra-structure. This includes expanding the responsibilities of municipal clinics to encompass more activities than they currently take responsibility for, and to upgrade existing infra-structure instead of building new infra-structures The utilisation of existing and new infrastructure should be done in collaboration with other government departments with a view to multi-functional utilisation. This will facilitate redirecting of funding to areas where it is most needed. At present funding is largely utilized in a predisposed manner to maintain existing priorities, making it virtually impossible to address new health care priorities. Where health care projects have been based on community

needs, they have been successfully implemented such as the life skills training program. The success of this program can also be ascribed to the fact that it was offered in collaboration with non-governmental organisations which ensured appropriate resourcing thereof.

According to Sadie *et al.* (1994:65) the success of primary health care is dependent on health care interventions that take into account the whole system. An epidemiologist from Egypt, Prof. Amal Ibrahim, cautioned that the unnecessary scaling down of tertiary health care in favour of primary health care can create a medical crises in South Africa (Marais, 1994b: 6-9). He further proposes that national health care policy must take the whole system into account and maintain a balance with regard to the various levels of health care service delivery (Marais, 1994b:9). Dr. Zuma has been criticised for formulating National Health Care policy from behind her desk instead of visiting public hospitals to ascertain herself of the problems and demands being placed on these structures (Kruger, 1995:5). It appears as though the National Health Policy has not been appropriately communicated with or to the structures that are responsible for the implementation thereof (Clear, 1995:45).

According to Froneman (1994:5) the sweeping changes proposed by the Government at all levels needs to be addressed and effective communication channels need to be created within government departments, if effective internal and external communication of revised national policy directions is to be made possible.

Standards

The following information is based on personal interviews conducted with members of the Gauteng's Department of Health. Within the Department of Health on both a national and provincial level there is a lack of recognition of the importance of and the role of communication. Unfortunately, communication is seen as nothing more extensive than public relations in general and media liaison in particular. It is therefore quite clear that communication is underdeveloped and underutilized on all levels.

The primary reason for this situation is because only some of the Directors have a communication orientation. This could be due to the fact that communication does not appear in their formal job description. Therefore role clarity and recognition of role boundaries do not exist. The outlook is thus one where communication is not seen as part of their tasking. The question that was posed, is how does one develop and provide a philosophy pertaining to the importance of communication if at management level a positive predisposition towards communication does not exist? It was cited that a possible reason for this attitude towards communication was due to insecurities experienced amongst managers due to the lack of confidence relating to their own communication skills. It was suggested that communication with management needs to increase in order to convince them of the necessity of effective communication with both internal and external publics. Managers are responsible for

activities that they feel they don't posses the necessary authority to implement. This lack of communication in a climate that involves change upon change (internally and externally) simply serves to further compound the health situation.

Communication needs to be perceived as more than merely having a suitable in-house newspaper. All communicators need some form of expertise whether this be created by in-house training or/and more formal education. At present this is not the situation as many of those responsible for communication activities are not empowered to carry out their functions. For example many of those who work with the field of communication within the Gauteng's Department of Health come from a social worker background.

Furthermore, the Department is reliant on the former family planning motivators for the successful implementation of their various campaigns. These are non-professionals, most of whom possess a standard 6, and are now suddenly expected to fulfill the role of communication change agents. They have undergone training courses relating to primary health care but their orientation remains didactic in nature. Empowerment of employees who work at grass roots level and are often the first exposure that the public has of the Department, is lacking. Furthermore, it was stated that the Department at national level has moved away from an arrogant approach (associated with the former government's style of health communication) to a paternalistic one. Moreover communication is often characterised as being bureaucratic.

From the above, it is clear that there is a shortage of skilled communicators. It was mentioned that this shortage was not necessarily salary related.

Trust

According to Hill (1997:10) traditional health providers have historically been seen as representatives of the larger bureaucratic system that is not to be trusted. Brown (1996) states that because social interaction in medial settings is fundamental to health care in society, the recognition of the larger social structures and how these function to frame the relationship between care providers and care recipients is essential - after all, the encounter is influenced by the larger context - including issues of professional, institutional, socio-cultural and economic factors. As stated previously, within the WIN approach establishing agendas and identifying cultural nuances forms the basis for negotiating appropriate alternatives within the context of mutually agreed upon objective standards, thereby imbuing the process with trust.

Due to the disparity in health care service delivery as a consequence of the previous political dispensation, the new Department of Health was faced with a situation in which common interest with regard to the quality to health care service delivery is virtually impossible to negotiate given the tension that exist amongst those groups who have benefited almost exclusively from the previous dispensation.

The successful transformation of the health care system is dependent on credible agents and increased participation in the transformation process by all. The failure of president Clinton's health care program is amongst other factors attributed to the fact that grassroots support for the program from ordinary citizens was not obtained, and all the planning was done behind closed doors. This approach implied that the ordinary American's opinion of the proposed health care plan was not important. Failure to launch a pro-active communication strategy also contributed to the failure of the proposed plan (Lewton, 1994:29). According to Lewton (1994:29) all drastic reform processes must start with determining the vested interests of all stakeholders, and addressing these through a process of negotiation and consultation, if such a reform is to be successful.

According to Ratzan (1994:231) research reveals the degree of trust within the health care encounter to be a positive correlation with the degree of compliance and overall satisfaction of parties involved. At macro level the government commands an important position and responsibility to protect and inform civil society. Ratzan (1994:242) sees the government's role in the health care system to include the prompt discussion, deliberation and cogent debate on a variety of ethical and philosophical issues concerning the delivery of health care service. The democratisation of health care service delivery is based on a bottom up approach rather than a top down approach.

Since Dr. Zuma became Minister of Health in 1994, several communication failures due to a lack of consultation can be highlighted. In January 1995 sharp criticism was expressed towards her proposed implementation of the Beedle plan aimed at providing affordable health insurance to all South Africans. This criticism forced her to rethink the plan and appoint a committee to find an affordable alternative. According to De Villiers (1995:1) the implementation of the proposed Beedle plan would not have been brought to the public's attention if the financial committee responsible for it's implementation had not brought it to their attention. Other equally public communication failures include the proposed two year compulsory community service by graduating doctors which resulted in the withdrawal and review of the proposal due to the fact that there had not been proper consultation with all stakeholders concerned. However, resistance to the proposals is still attributed by Dr. Zuma to unpatriotic attitudes of white doctors, rather than communication failure on the part of the Health Department (Anon B., 1997:3). However, no single incident eroded the credibility of the Health Department and Dr. Zuma personally, as much the media debacle resulting from the Sarafina Aids Play. The continued approach appears to be top down as is also manifested in the recruitment of Cuban doctors, but even less well known is the fact that the Health Department had also concluded a contract with German doctors. It would appear as though the responsibility to protect and inform civil society is not taken seriously. This may be due to the fact that pressure from the new constituents to deliver did not allow enough time and opportunity for proper consultation. The tempo

of transformation appears to be too much and too quick for those responsible for implementing the changes.

However, Dr. Zuma, was able to meet the 100 day deadline set by Pres. Mandela for the delivery of free primary health care, and has succeeded in building and upgrading 300 new clinics mainly in rural areas. These successes have contributed to her popularity and broad support amongst members of the black community who could for the first time enjoy the benefits of health care. This is in sharp contrast with the public image portrayed by the media.

It is therefore evident that the degree to which trust exists between parties - derived in part from the frequency and quality of individual interaction(s) and subsequent development of reciprocal images of character, credibility and trustworthiness, serves as both as an indicator of overall satisfaction with the encounter and as a potential predictor of advocated attitude and behaviour change.

Conclusion

As stated previously the ANC led government faces a challenge to improve the two main factors that contribute to the health status of a country, namely the general level of development and prosperity. The primary health care program is aimed at promoting health status through prevention of disease and education. However development can not be limited to the individual level as it also needs to be viewed within a broader context. Health and health status in developing countries is typically characterised by poverty, malnutrition disease and a lack of resources.

A shift toward primary health care entails a strategic approach within which the focus shifts away from curative care toward health development programs aimed at ensuring the participation of the whole community. Unfortunately the implementation of the primary health care approach has not taken account of the basic principles of community development. According to Skinner (1996:1), participation is an important part of individual empowerment, allowing individuals to make enlightened decisions about issues pertaining to their health development. In the implementation of the Primary Health Care program empowerment of the individual failed to realise at two levels:

1. At grassroots level where service delivery occurs, empowerment did not occur due to lack of information, knowledge and experience that brings confidence in own abilities.
2. At macro-level where failure to empower the health service deliver system, meant that the developmental principle of release was not attained because actions did not succeed in freeing the community from its circumstances and transforming the lot of the community.

Successful implementation of developmental strategies relies on the following five key elements:

- consultation
- adaptation
- mobilisation
- accountability
- focus.

The perception created around the development of the ANC led government's Policy is that it is built on lack of consultation. The previous government was sharply criticized by the ANC because of its approach that tended to force decisions onto stakeholders, rather than to consult with them as partners in the development of workable alternatives. This paper has cited many instances where failure to consult properly with stakeholders has occured. None illustrated more clearly this lack of consultation than the Beedle Plan which according to De Villiers (1995:1) was planned more or less in secret despite repeated warnings and calls for greater transparency and cogent debate, and which Dr. Zuma planned to implement almost overnight.

As regards adaptation, the health care delivery system could not be adapted timeously to meet the goals set by the PHC strategy. An example of this is the inability to implement the Termination of Pregnancy Bill, and the inability of the existing resources to deliver efficient health care. What has occured is a change in the philosophy towards health care service delivery but this philosophy can not be realised because the resource allocation and service culture do not support the philosophy. This means that that quantity of service delivery was increased (more accessible) but the quality of service delivery was compromised. A development principle that was not adhered to was thus that bigger does not necessarily imply better. Thus delivery of primary health care to more people with resultant increased expenditure, did not lead to better health care service delivery. This is also evident from comparisons with other countries who spend less on health care but achieve better health status than South Africa.

With regard to mobilisation of resources, there seems to be very little if any coopetition on inter-departmental level with regard to resource allocation and training: One of the reasons why primary health car service delivery failed under the previous government was because an integrated approach to primary health care service delivery could not be established (Verwey, Crystal and Bessin, 1994:63). At grassroots level this entails providing a tangible service to the community through personal ownership, accountability and action. Much of the criticism against the previous government's health care policy centered on the fact that specific goals were not set or met. According to Shisana (1993:50) the absence of health goals makes it difficult to assess the impact of actions taken. In the Declaration known as the Alma-Ata Declaration and signed by 134 countries, health is defined as a social goal and it should therefore be approach as a factor that

is involved in all aspects of national and community development (Ferrinho, 1993:37). According to Ferrinho (1993:37) primary health care should be undertaken in interdisciplinary teams that address not only health issues but health related issues. What is implied is that not only are political imperatives required, but also relevant interdisciplinary skills if primary health care is to succeed as a developmental interaction.

Accountability refers to the obligation to exercise power in accordance with the views of the citizenry who are represented through a democratic process in government. Increased accountability leads to increased legitimacy. Dr. Zuma's public image, in particular, has created the perception that she is not accountable to the ordinary citizens. This was manifested clearly by the Sarafina debacle in which she refused to accept her public accountability. Thus the accountability of the Health Department to the public at large is apparently under threat, resulting in a lack of trust in Dr. Zuma's abilities. This has negative consequences on the legitimacy of provincial structures.

The focus of primary health care has shifted from a preventative approach to a curative approach. This entails a broadening of the health care focus to include community development and principles such as universality, equitability and participation. Such a community based approach to health care service delivery entails increased empowerment through information knowledge and experience and actions aimed at transforming the health care status of the whole community. With regard to the primary health care strategy, partial success has been achieved through the building of 300 new clinics that have brought health care service delivery to sections of the population who desperately needed it. However, communication as a process has not been transformed from a top-down approach to a bottom-up approach. This adversely affects the level of comprehension of the strategy amongst the system levels that have to ensure good practice and quality of service delivery in the system. Because the systems are not empowered through communication there is no coherence within the system with regard to the realisation of the vision. Thus, strategy has not been translated into action at each level of service delivery. Kreps, *et al.* (1994:255) contend that communication clearly fulfills an important function at organisational level of health care where members of modern health care systems share relevant information to coordinate the use of different organisational resources, personnel and technologies to provide health care service. This may be the result of too much emphasis on quantity of service delivery as opposed to quality of service delivery. Nel (1997) refers to this as the distinction between efficiency and effectiveness. Efficiency is doing things properly while effectiveness is doing proper things. It would appear as if the implementation of primary health care is focusing on attaining efficiency rather than effectiveness.

The essence of this paper can be summarised in the following quote:

"Health promotion and maintenance are the primary goals of the modern health care system and an enormous amount of time, energy and financial resources have been devoted to promoting and maintaining individual and public health in society. Major medical centres have been built and staffed; powerful new health care facilities have been built and staffed; powerful new health care therapies, technologies and pharmacological agents have been developed and applied, and a wide range of different health care providers have received intensive specialised training to advance goals of health promotion and maintenance. Yet we contend that all of these potent health care resources are of limited utility if the providers and consumers of health care do not communicate effectively in the health care delivery process" (Kreps et al, 1994: 248).

References

ANC. 1994a. *The reconstruction and development programme.* Johannesburg: Umanyano Publications.

ANC National Health Bill. 1994. *Fifty facts from the World Health Report.* 1996. http://www.who.ch/whr/1996/50facts.htm.

Anderson, E. 1994. Stormloop na gratis sorg verby. *Sake-Beeld.* 26 September.

Anon, A. 1993. Your patients' expectations. *S.A. practice management,* Vol. 14(2).

Anon, B. 1997. Zuma tells white medics to show more patriotism. *The Star.*

Anon, C. 1996. Phone the medical ombudsman.

Bidol, H.F. 1997. *Effects of expectancies and physician verbal messages on gay/lesbian/bisexual patients' satisfaction.* A paper presented at the 47th annual conference of the International Communication Association. May 22-26. Montreal, Canada.

Cassata, D.N. 1991. Health communication theory and research: a definitional overview. *Communication Yearbook 4.* New Jersey : Transaction books.

Casslione, J. 1996. The new marketing imperatives in the 21st Century. *Top Management forum.* 23-24 October. Johannesburg.

Clear, A. 1995. *Die opleiding van die skakelpraktisyn in beroepsgerigte spesialiseringsrigting: die mediese skakelpraktisyn as toepassing.* Unpublished Masters dissertation, RAU.

De Villiers, S. 1993. Perceptions in anthropological context, with specific reference to health care. *S.A. Journal Ethnology,* Vol. 16(1).

Ferrinho, P. 1993. Development of health. *Journal of Comprehensive Health,* Vol. 4(2):35-38.

Froneman, J. 1994. Tweerigting-benadering is nodig in S.A. Kommunikasie. *Beeld.* 18 May.

Goosen, H. 1988. Primary health care and disease prevention. *South African Panorama,* Vol. 33(7).

Hill, P.S. 1997. *African-American women: conflict in the clinic.* A paper presented as part of a panel "Mining a new data base" at the 47th annual conference of the International Communication Association. May 22-26. Montreal, Canada.

Hornik, R. 1996. Public Health contradictions : Making sense of contradictory evidence. A paper presented at the 47th annual conference of the International Communication Association. May 22-26. Montreal, Canada.

Hudson, M. 1997. S.A. Gesondheidsdienste erg olik. *Insig.* May.

Kim, Y.M.; Odallo, D.; Thuo, M. and Kols, A. 1997. Client communication and the quality of family planning counseling : Interaction analysis in Kenya. A paper presented at the 47th annual conference of the International Communication Association. May 22-26. Montreal, Canada.

Kroger, F. 1994. Toward a healthy public. *American behavioural scientist.* Vol. 38(2). November.

Kroger, E.M. 1994. The field of health communication today. *American Behavioural Scientist,* Vol. 38(2). November.

Kreps, G.L.; O'Hair, D. and Clowers, M. 1994. The influence of human communication on health outcomes. *American Behavioural Scientist.* Vol. 38(2). November.

Kruger, J. 1995. Chaos in morsige staatshospitale. *Rapport.* 22 January.

Lewton, K.L. 1994. The death of health care reform. *Public Relations tactics.* December:13.

Maibach, E.; Parrott, R.L.; Long, D.M. and Salmon, C.T. 1994. Competencies for the health communication specialist of the 21st Century. *American Behavioural Scientist,* Vol. 38(2). November.

Marais, M. 1994a. 'n Gratis donderslag, uiters chaotiese toestande by staatsklinieke wurg dokters en werkers. *Beeld.* 29 June:7.

Marais, M. 1994b. 'n Balans is nodig in mediese sorg. *Beeld.* 9 Augustus:9.

Marais, M. 1995. 'n Valbyl oor topdienste by die hospitale. *Beeld.* 1 Februarie:11.

Nel. C. 1997. *Translating, entrenching and communicating strategy : a multi-level approach to roles and accountabilities.* A paper presented at a conference on Modern trends in the prediction of occupational success. Johannesburg.

Paisely, W. 1990. *Public communication campaigns: the American experience.* In Atkin, C. & Rice, R. eds. *Public communication campaigns.* Newbury Park, CA: Sage.

Personal interviews . 1997. Employees Department of Health, Gauteng.

Personal interviews. 1997. Representatives of the various medical schools in South Africa.

Ratzan, S.C. 1994. Health communication as negotiation. *American Behavioural Scientist,* Vol. 38(2). November.

Ratzan, S.C., Stearns, N.S., Payne, J.G., Amato, P.P., Liebergott, J.W. & Madoff, M.A. 1994. Education for the health communication professional. *American Behavioural Scientist,* Vol. 38(2).

Rogers, E.M. 1994. The field of health communication today. *American Behavioural Scientists.* Vol. 38(2). November.

Sadie, Y., van Aardt, M. & Verwey, S. 1994. Public policy formulation and implementation as political communication : The case of AIDS in South Africa. *Communicare,* Vol. 1.

Shaver, L.D. 1997. *A taxonomy of the doctor/patient visit.* A paper presented as part of a panel "Mining a new data base" at the 47th annual conference of the International Communication Association. May 22-26. Montreal, Canada.

Shisana, O. 1993. The process of developing and monitoring national health objectives in S.A. *Journal of Comprehensive Health.* Vol. 4(2):50.

Shisana, O. 1996. Challenges of managing a health system in transition. *Top management forum.* 23-24 October. Johannesburg.

Skinner, J.C. 1996. *Community capacity building. Theoretical and practical guidelines.* J.C.S. Associates: Durban.

Snyman, R. 1994. Pasiënte moenie stille ontvangers wees nie. *Beeld.* 27 May.

Strachan, B. 1997. Health care expenditure and health status in South Africa. *Sunday Times - Business Times.* July.

St. Leger, C. 1994. Doctors warn of outbacks in services and standars. *Sunday Times.* 26 June.

Thornton, B.C. and Kreps, G.L. 1993. *Perspectives on health communication.* Prospect Heights, I.L : Waveland.

Uys, H. 1994. Cultural diversity in rural care: an African paradigm. *EDTNA-ERCA,* Vol. (1).