

instrument: the measurement of both 'attitude' and 'practices' fails in terms of construct validity and content validity; measurement of 'listenership to Radio Zibonele' is crude and unreliable. The backbone of the study therefore falls short of acceptable methodological standards, rendering all conclusions invalid and unreliable.

The only measure of association that warrants attention is the one between 'knowledge' and 'presenting with gastro'. The other 'noteworthy trends in the data' and 'striking consistency of results' are unfounded. All references to measures of association between 'listenership to Radio Zibonele health programmes' and 'knowledge', 'attitude' and 'practices' remain unsubstantiated. Unfortunately, even the reported positive impact of community radio on knowledge of the community is invalid in the context of the study.

Where does this leave us as far as researching community radio is concerned? After 4 years of MTC's involvement in community radio in South Africa, we have ample 'everyday' experiences confirming its positive impact on primary health care and community development. Despite this, there is a strong need to conduct research as a formalised, systematic process that investigates these everyday experiences in an objective, reliable and valid manner. The mere commitment to conducting research (within a praxis framework) is not enough, however; it needs to be backed up by quality output. The whole sector (researchers and users of research — especially community radio stations) is responsible for ensuring that this happens. Researchers need to be held accountable for their methodology and reporting, and users of research need to become informed enough to ask critical questions. For this to happen, research needs to be a demystified, transparent process for everybody — a starting point that mirrors one of the characteristic values in community radio.

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## **Effective asthma control — time for physician and pharmacist to join forces**

**To the Editor:** We have seen a concerted and successful effort by the National Asthma Education Programme (NAEP) to increase both doctor and patient awareness of asthma. However, the greatest challenge facing asthma care-givers is not lack of patient awareness, but a pervasive non-compliance that occurs universally with inhaled 'preventer' medication.

For optimal asthma control, prolonged and consistent anti-inflammatory therapy is required even in the absence of symptoms. To achieve consistent medication usage, doctors will actively have to enrol the assistance of the community pharmacist. Use of the pharmacist as a medication supervisor and an asthma educator will greatly improve adherence to inhaler medication regimens.

Physicians tend to assume that their 'obedient' patients will automatically comply, and greatly overestimate adherence to medication regimens. Studies<sup>1</sup> show that only about 50% of patients take their medication in the dosages prescribed. The reasons for this are varied and complex, and numerous efforts to improve patient compliance have been disappointing. Unless community pharmacists are actively encouraged to play a greater supervisory role, asthma prevention programmes are doomed to fail. Even the Royal Pharmaceutical Society considers the subject of non-adherence a priority issue and has recommended that the term 'compliance' be substituted with the less autocratic term 'concordance'. It hopes that this will lead to a greater spirit of negotiation and co-operation between care-giver and patient.<sup>2</sup>

A recent study<sup>3</sup> in the USA on compliance with regard to long-term inhaled corticosteroids in asthma showed that despite patients having a good understanding of the inflammatory nature of asthma and diligently filling in diary cards, non-adherence was extremely high. In the study, 95.4% of patients claimed to be taking their inhalers on a regular twice-daily basis, while actual use, determined by an electronic monitor, was only 58.4%. An interesting observation was that the more poorly controlled asthma sufferers who required 'rescue' oral steroids or hospitalisation had even worse compliance data. In this subgroup, only 13.7% took their inhaled corticosteroids regularly as prescribed. This study has far-reaching implications when one considers the financial impact of wasted medication, unnecessary hospitalisation for exacerbations, and worsening long-term morbidity due to uncontrolled illness.

It is imperative that physicians and pharmacists bury old animosities and work together as 'educators', so as to increase the awareness of non-compliance and find ways of combating it via mutual co-operation.

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## **Migrancy and HIV/STDs in South Africa — a rural perspective**

**To the Editor:** Williams and Campbell<sup>1</sup> raise the important issue of the role of migration in the spread of HIV/STDs in their discussion of a proposed intervention around a mining centre near Johannesburg. Recognising that an intervention aimed solely at mineworkers would be futile, they argue that interventions must be targeted not only at mineworkers 'but also at members of the broader communities surrounding the goldmines, in which mineworkers live out their social and sexual lives while they are away from home'.

This represents an important strategy, but could go further. The vast majority of mineworkers are migrant

labourers from rural areas. Interventions must therefore also be aimed at rural partners of migrants who themselves may be at increased risk for HIV/STD infection because their partners are migrants.

The link between migration and HIV/STD has been documented in the few studies that have been done.<sup>2-6</sup> These studies suggest that 'migration of poor, rural and young sexually active individuals to urban areas . . . played a prominent role in the dissemination of HIV globally'.<sup>4</sup> In South Africa, the system of migrant labour has been shown anecdotally to exacerbate the spread of tuberculosis,<sup>7</sup> HIV<sup>8</sup> and other STDs.<sup>9</sup> However, with few exceptions, all these studies have examined the relationship between HIV/STD and migration from the perspective of *urban* migrants at their workplace. Consequently, they fail to document the impact of — and implications for — migrants' return to rural areas.

To that end, we are currently studying the social and epidemiological consequences of migration at the household level in the Hlabisa district of KwaZulu-Natal. Formative research has been underway since May 1996 and is aimed at understanding the patterns of migration into and out of the district, knowledge and awareness of HIV/STDs, local health beliefs and health-seeking behaviours, and patterns of sexual networking. A variety of qualitative research methods are being used, including the establishment of more than 20 key-informant households which are serving as long-term case studies, ongoing work with school students who are keeping daily logs of the composition of their households, observations at local taxi ranks, and interviews with traditional healers. The second phase of the research, due to begin in June 1997, will be a cross-sectional study aimed at testing the hypothesis that migrants and their rural partners are at increased risk for contracting HIV/STDs compared with non-migrants and their partners.

Our preliminary research suggests that nearly two-thirds of households in the district include a male who is a migrant. While nearly one-third of male migrants from Hlabisa work in the Johannesburg area, 48% work in towns scattered along the northern Natal coastline (within a 2-hour drive of Hlabisa) and 18% are in Durban (a 3½-hour drive from Hlabisa). These findings challenge the stereotype that migration is generally long-distance and long-term.

Our research also challenges the commonly held assumption that it is only men who migrate. While we have not yet measured the prevalence of migration among women, we do know that women who migrate tend to stay much closer to home than their male counterparts do. Of the women migrants we have identified, none works in Johannesburg and the majority work within a 1 - 2-hour drive from Hlabisa.

Patterns of migration in South Africa did not simply arise by chance. On the contrary, a myriad of laws under apartheid prohibited black South Africans from settling permanently in 'whites-only' areas. Migration patterns in South Africa, although incompletely documented, tend to be 'oscillatory' or circular, with migrant men and women maintaining close links to their rural homesteads. These patterns, however, are clearly in flux and these changes may bring with them important implications for the spread — and control — of HIV-STDs. In the past, for example, migrants

who went from Hlabisa to work in Johannesburg could return home only once a year. Now, however, with the lifting of restrictive laws, improvements in the transportation systems and more flexible work contracts, men from Hlabisa working in Johannesburg are able to return home much more often — on average about once every 2 - 3 months. One impact of this change in migration patterns may well be that rural partners are more frequently exposed to potential infections, and are therefore more likely to be infected with HIV and other STDs.

The work that Williams and Campbell and their colleagues propose around the goldmines is important indeed. At the same time, there is a need to understand migration from both ends of the spectrum. Appropriate HIV/STD treatment and prevention programmes must be targeted to migrants — both at their place of work and at home. They must also be targeted to rural partners of migrants if the epidemic is to be curtailed.

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#### Sarafina III?

**To the Editor:** As an intern, I would like to share some of my objections and those of my colleagues to the proposed plan of community service. When we embarked on a career in medicine we did not enter into any contract with the Department of Health or Dr Zuma with regard to our conscription.

It enrages us that we have neither been consulted nor given the opportunity to voice our opinions. Is it not arrogant and misinformed to presume that individuals enter the medical fraternity purely for altruistic reasons?

Another of the many unaddressed issues is why one profession is being targeted. Why not force accountants to