BLACK SASH
MAKING HUMAN RIGHTS REAL

SOCIAL CHANGE ASSISTANCE TRUST

Eastern Cape CMAP Healthcare Report

October 2011 – March 2012

*The Black Sash - **in partnership with the Social Change Assistance Trust (SCAT)** - launched the national Community Monitoring and Advocacy Project or CMAP in 2010 in a bid to help **improve government service delivery**, with a particular focus on poor and vulnerable communities in South Africa.*

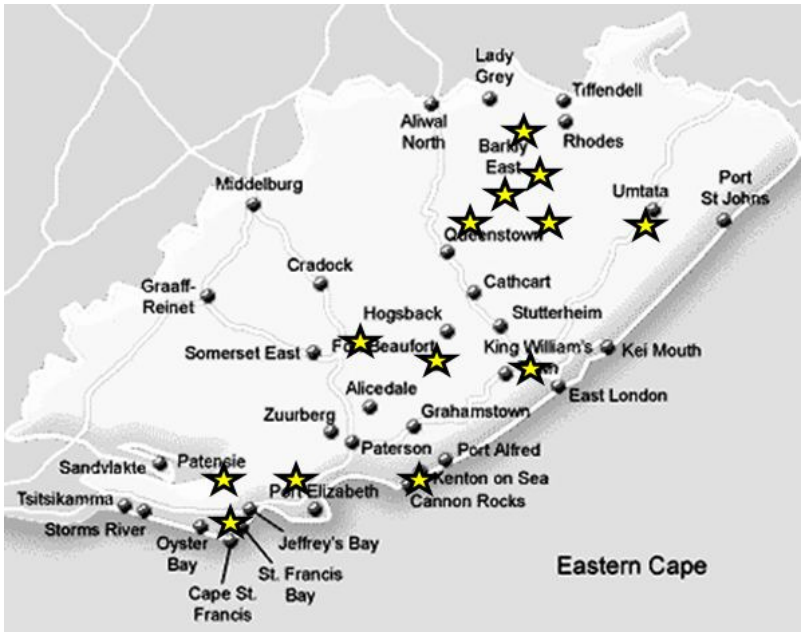
Open Society Foundation of South Africa

** "This document has been produced with the financial assistance of the European Union. The contents of this document are the sole responsibility of the Black Sash and can under no circumstances be regarded as reflecting the position of the European Union."*

Acknowledgements

The Black Sash would hereby wish to thank the following community monitors and their respective organisations who volunteered their time to monitor health services in the Eastern Cape.

• Barkly East Community Advice Office • Berlin Advice Office • Engcobo Community Legal Advice Centre • Indwe Legal Advice Office • Marselle/Bushmans Advice Office • Patensie Advice Office • Tshatshu Advice Office	• Bedford Advice Centre • Elliot Paralegal Advice Office • Fort Beaufort Advice Office • Interchurch Local Development Agency • Masiphakameni Advice Office • Qunu Community Advice Office



Map of areas monitored Oct 2011 - March 2012 (stars)

In addition we also wish to thank the National Department of Health for their collaboration and openness to facilitate our monitors' access. The Black Sash wishes to thank the following organisation for their financial commitment to the Community Monitoring and Advocacy Project.

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Introduction

The Black Sash, a human rights organisation active for the past 56 years in South Africa, works to alleviate poverty and inequality; and is committed to building a culture of rights-with-responsibilities in South Africa. We focus specifically on the socio-economic rights guaranteed by our Constitution to all living in South Africa. For more information see www.blacksash.org.za

The Social Change Assistance Trust (Scat) is a veteran independent fund-raising and grant-making development agency based in Cape Town. Scat was established in 1984 to channel resources to rural communities. Scat works in partnership to support local non-profit community-based-organisations in their human rights work. Scat's focus is on capacity development, human rights, gender equity, HIV and AIDS awareness and local economic development. For more information see www.scat.org.za.

Our premise is that quality service is a critical factor that our society should be able to tackle even at a time of economic recession and that we, as civil society, should hold our government responsible for fulfilling its mandate and promise, that includes providing affordable, appropriate, effective services, with dignity as is promised in policy frameworks, legislation, party manifestos and service delivery norms and standards. We argue that active citizens will be able to monitor service delivery as it is experienced by people receiving these services, and by constructively engaging with government at all levels to improve these services.

It is in this context, that the Black Sash's Community Monitoring and Advocacy Project (CMAP) was conceptualised and implemented, in collaboration with other civil society organisations and networks.

The objectives of the project are two-fold:

- To assess and report on the quality of service delivery in specified government departments and municipalities across South Africa as experienced by beneficiaries; and
- To develop a system for civil society organisations and community members to hold government accountable for the principles of Batho Pele (People First) as well as specific norms and standards that govern service delivery and promise excellence.

Working closely with our partners, the Black Sash:

- Ensures widespread, visible, standardised and regular monitoring of service delivery points by Community Monitors that are selected by civil society organisation (CSO)/community based organisation (CBO) networks;
- Co-ordinates the development of the monitoring instruments and the databases; collates and analyses the monitoring information; produces and distributes regular reports to our partners and the public;
- Presents reports to the appropriate government officials in order to affirm good practice and to work together to make improvements where required.

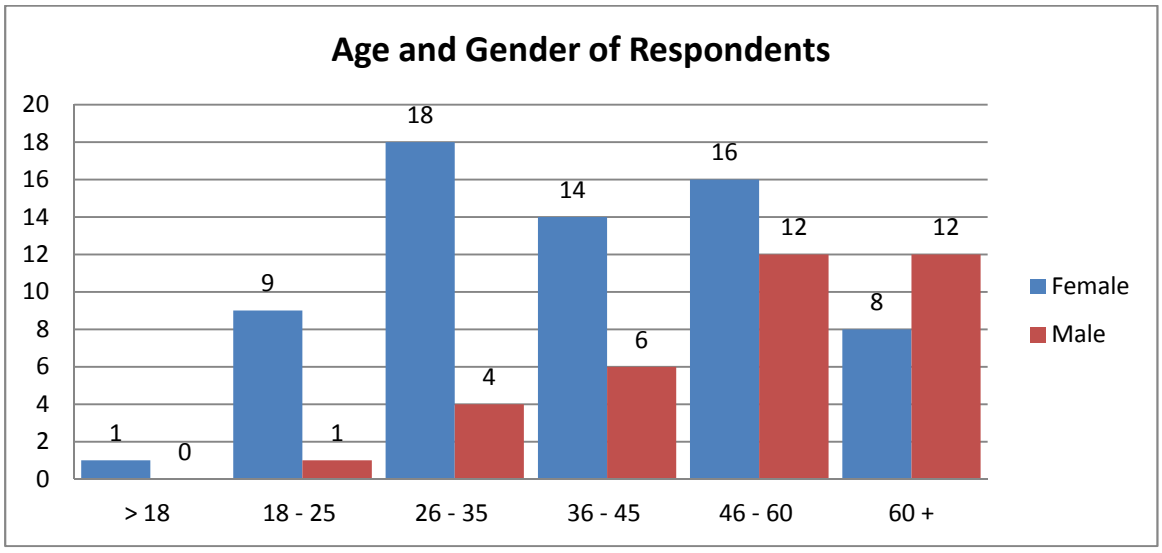
Monitors are selected by civil society networks; community based organisations and faith-based organisations and then trained to monitor selected public services using the monitoring tools. Each of these organisations have a CMAP memorandum of understanding with Black Sash to ensure

mutual accountability and to ensure that a normative framework of values and principles underpin this monitoring project. Prior to monitoring, they are also asked to sign a code of conduct. Each monitor identifies the day(s), within a specified timeframe, that they will monitor selected sites in the communities where they live or work. Once the site has been visited and assessed, the completed questionnaires are forwarded to the Black Sash for capturing and analysis. The reports developed as a result of this analysis are forwarded to the relevant government department for response within an agreed period, after which they are made available to the public.

It is important to note that CMAP monitors undertake the monitoring in the areas where they live or work and that the selection of sites to monitor, depends either on where the monitoring organisation is located or where the monitor resides. No scientific formulation is used to select the geographic spread; however, we do encourage organisations that have a diverse presence to participate in the project. However, the monitoring data analysed here is real, and a reflection and perspective of the beneficiaries interviewed at the service site on the particular date of the interview. We also try to ensure the data generated through CMAP does not reflect an urban bias.

Findings

The efficiency and quality of the service provided by the **Department of Health** in the Eastern Cape has been monitored according to the following standardised entities: **time & venue**; **healthcare processing**; and **language & communication**. The monitoring took place during the period of **28 October 2011** to **13 March 2012**. The findings presented in this report takes into account the experiences and opinions of **105 respondents** from **24 clinics** in **6 districts** across **the Eastern Cape**. The districts in which monitoring took place were: **Amathole (17.1%), Cacadu (19.0%), Chris Hani (38.1%), Joe Gqabi (9.5%), OR Tambo (9.5%)** and **Nelson Mandela Bay Metropolitan (5.7%)**. Please note that the percentages provided here are rounded off to the first decimal point.

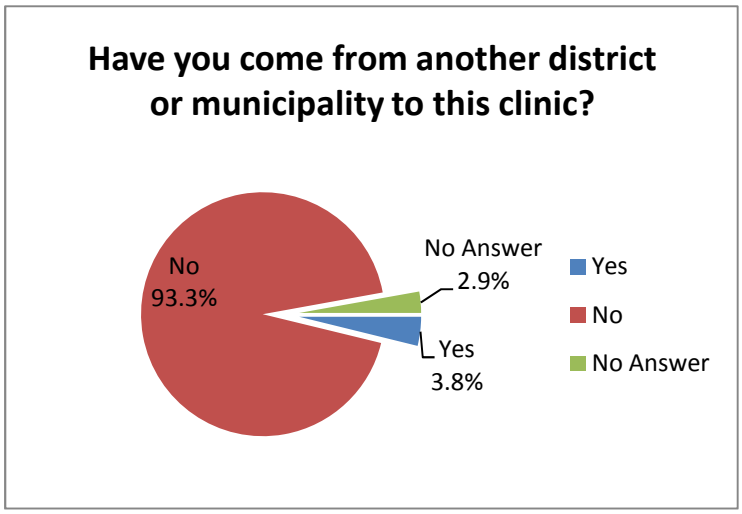


The majority of respondents were female (63.8%) and in the age group 46 – 60 years old (26.7%). All of the respondents were South African citizens. The majority of the male respondents were older than 45 years old.

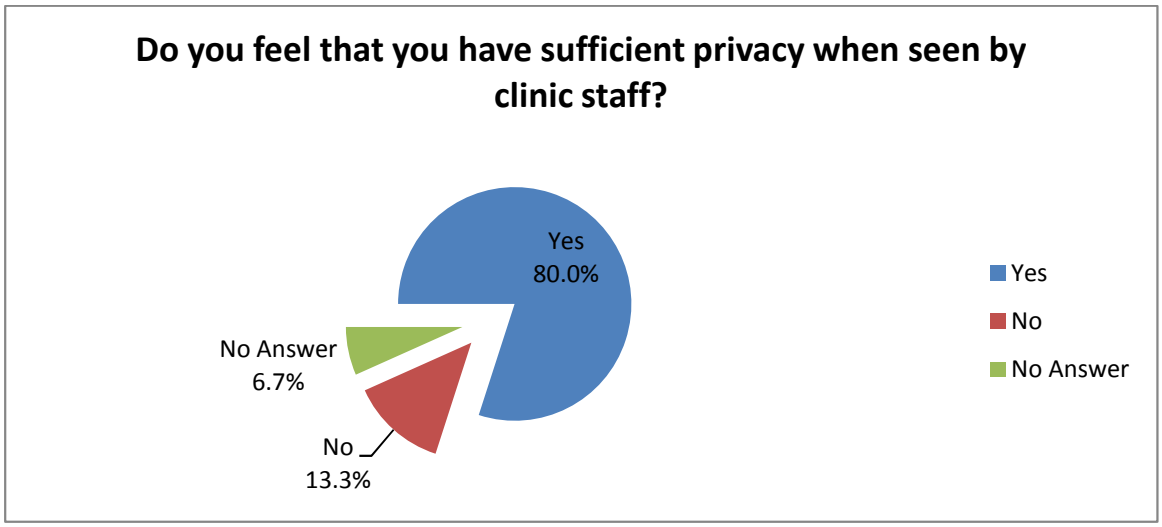
Time & Venue

We look at the opening and closing times of the clinics. The time and cost of travel to the clinics is also assessed. The venue is also looked at in terms of privacy, cleanliness and facilities.

	Minimum	Maximum
Opening Times of Clinics	06:30	10:00
Closing Times of Clinics	15:30	24 hours
Time taken to Travel to Clinics	10 min	300 min
Cost of Travel to Clinics	R0.00	R50.00
Time Waiting to be Serviced after Arrival	2 min	540 min
Number of Days per Week that the clinic operates from the venue	4 days	7days

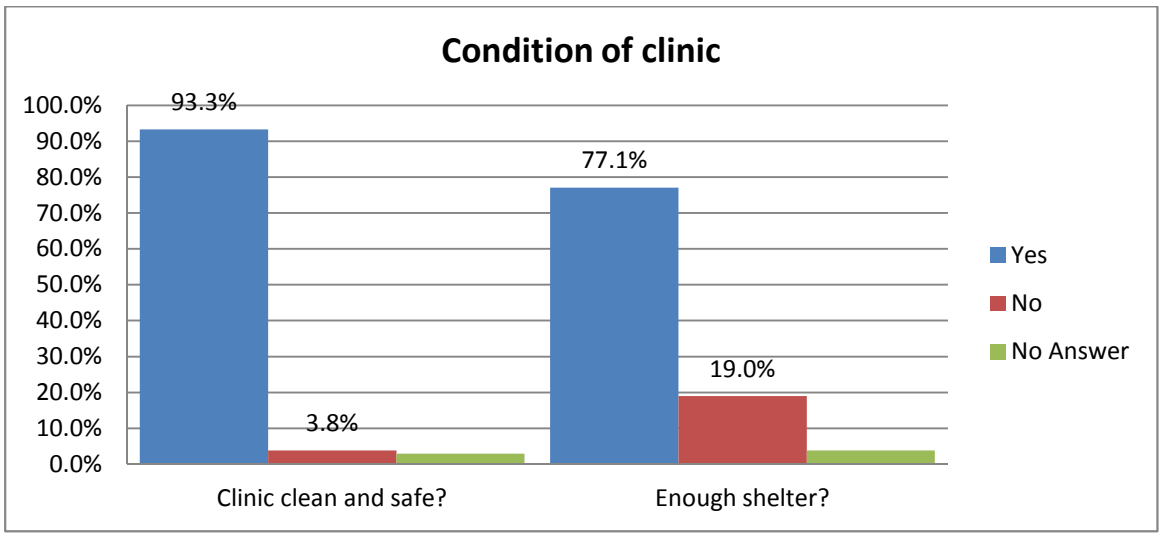


Most of the clinics opened at 08:00 and closed at 16:00. Most of the clinics were opened for 5 days per week. There were five respondents who had to travel up to 5 hours (300 minutes) to the clinic. All five went to the Mdeni Clinic in the Chris Hani district. The cost of travel ranged from R0.00 to R50.00. One respondent at the Mawzana clinic in the Chris Hani district waited 540 minutes (9 hours) to be attended to after she had arrived.



The majority of the respondents (80.0%) felt that they had sufficient privacy when seen by clinic staff. The fourteen respondents (13.3%) who felt that there was not sufficient privacy when they were seen by clinic staff were from the following clinics; the Gate Way and Mzamomhle clinics in the

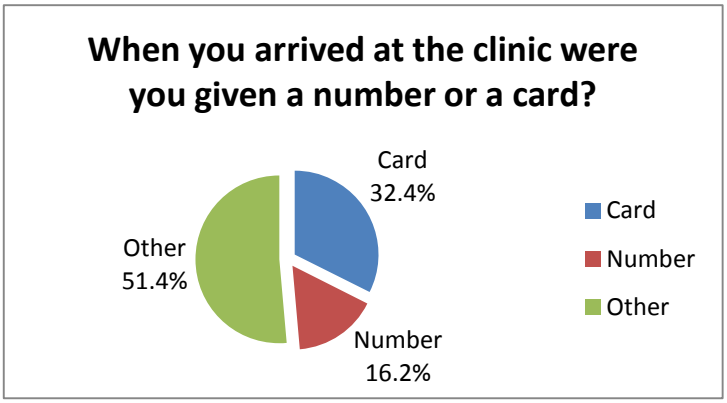
Amathole district; the Imizamo Yethu, and Marselle clinics in the Cacadu district; the All Saints, Mawzana, and Zwelakhe Dalasile clinics in the Chris Hani district, the Sonwabo Zandile clinic in the Joe Gqabi district; and the Qunu Health Care Centre, in the OR Tambo district.

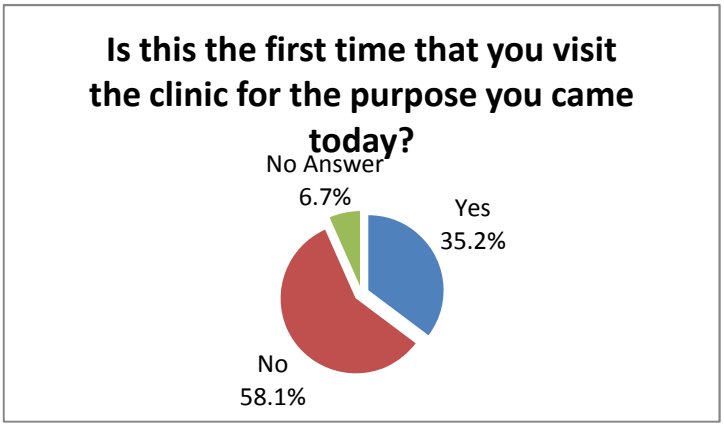


The majority of the respondents (93.3%) thought that the service in the clinic was provided in a clean and safe place; this was also the case in terms of shelter. For 77.1% of the respondents there was enough shelter.

Healthcare Processing

This section looks at the quality of the service provided by health care facilities.



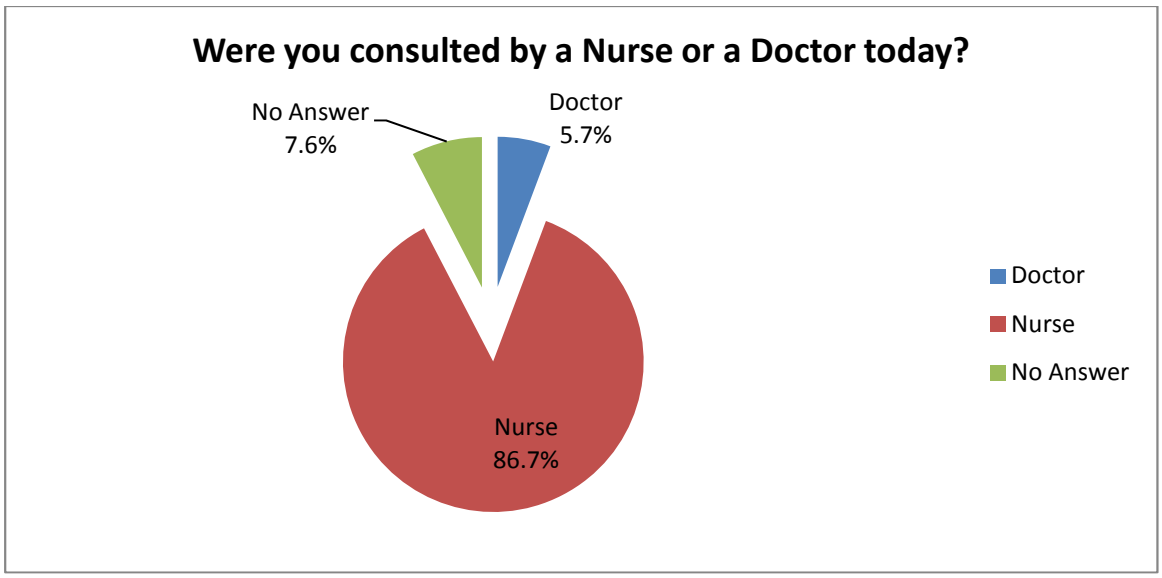


The respondents who were not given a number or card told monitors that they had to stand in a queue to be helped. Others said their names were written down in a book. For respondents who received a card, the monitors asked whether the card was a different colour than the cards of other patients at the clinic. 26.5% of the respondents said that this was indeed true for them. This question is linked to issues of privacy and confidentiality. A colour coded system could mean that other patients are aware of the medical reason for the visit to the clinic.

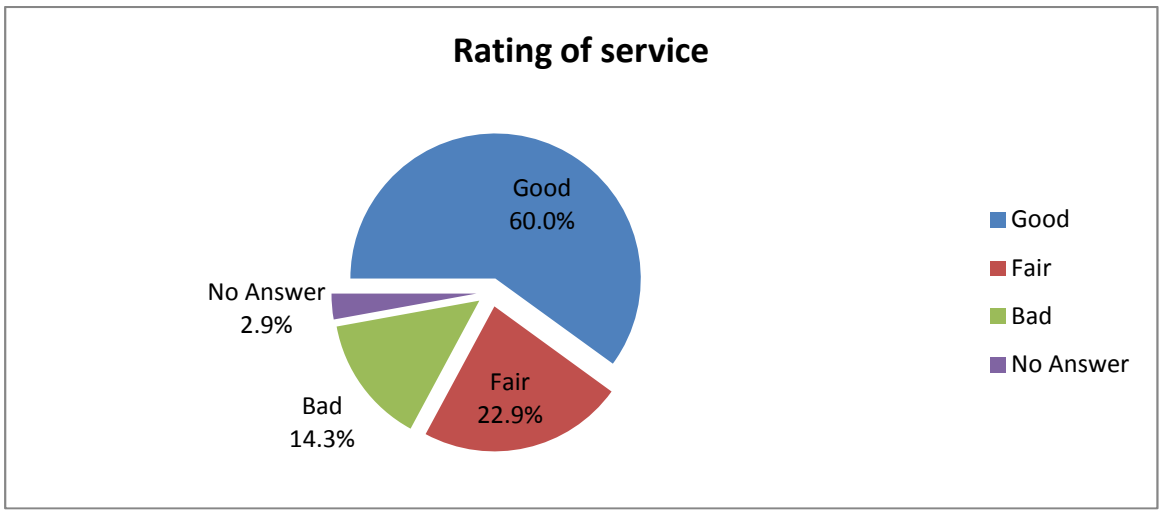
More than half (58.1%) of the respondents were at the clinic for a return visit. Most of the respondents had to return three times for the

same reason. However there was a respondent who had returned 12 times. This was a 26 – 35 year old female who was at the Gate Way clinic in the Amathole district. She had to return for her treatment.

Some of the other reasons that the patients returning to the clinic include that they were there for a check-up and treatment. A large percentage of respondents had to pick up prescription medication. A few of the woman were there for pregnancy monitoring, family planning and contraceptive purposes. Some returned because they did not see any improvement in their health since their previous visit. A few had to return because they were not able to see a doctor or nurse on their previous visit due to a high number of patients waiting at the clinic.

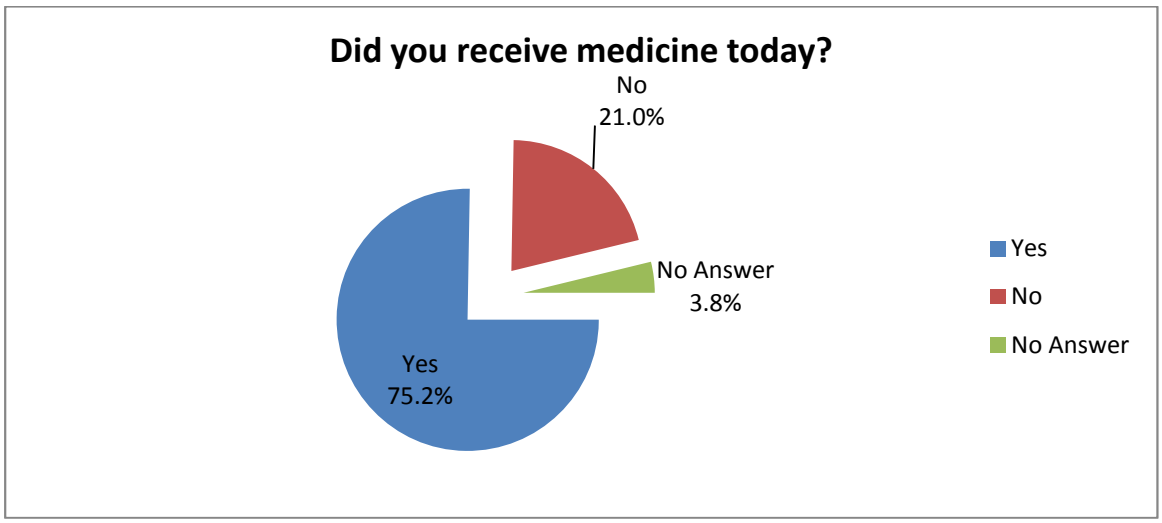


The majority of the respondents (86.7%) were consulted by a nurse. Only 41.0% of the respondents were seen by the same nurse or doctor that they had previously seen. The respondents were also asked if the consultation was in private. Most (87.6%) said that this was the case, but 8.6% said that they were not consulted in private.

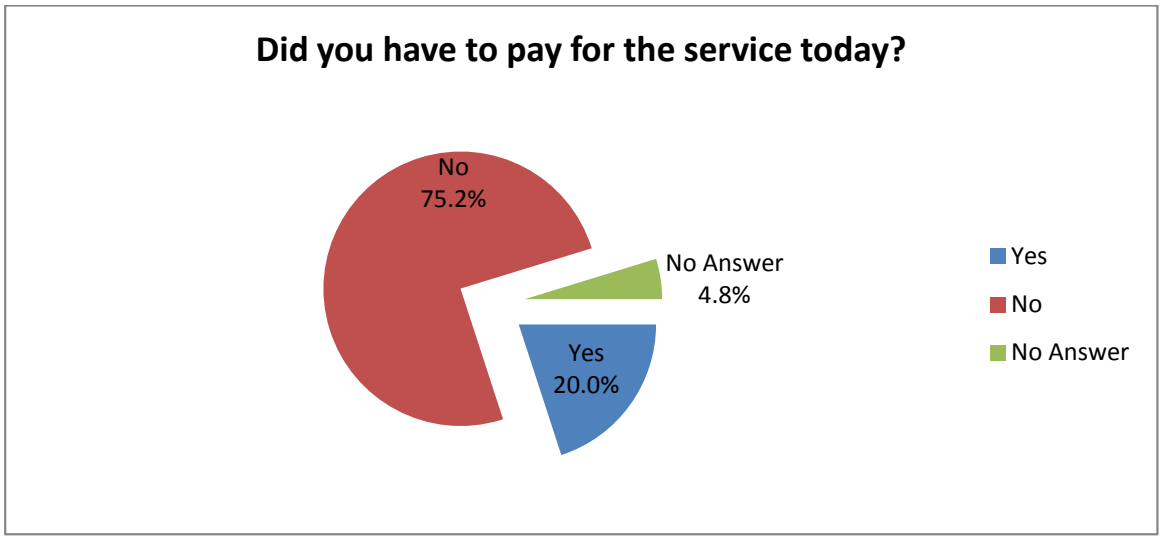


After being asked to rate the service received, the respondent were asked why they rated it in this manner. Some of the main reasons why respondents felt that the service was good because the

Batho Pele (People First) principles were applied and that they were treated with respect despite the slow service due to staff shortages. Other explanations include that they feel better after receiving treatment, they were treated in private and that communication and explanations are good. The respondents who rated the services as fair said the reason for this was because the service was slow, but they had to wait a long time. The respondents who rated the service as bad said this was because they had to wait a long time to be seen. Others complained about the manner in which the nurses treated them. There were complaints about the lack of medication and information. One respondent at the All Saints Clinic in Chris Hani complained that there was "no privacy, [and they used] insulting language".



The respondents who did not receive their medication were asked why this was the case. Most of the respondents stated that there was not enough medication because the clinic was under-stocked. The respondent who did receive their medication were asked how long they had to wait in a queue to get it. The shortest period that a patient had to wait was 1 minute, the longest being the entire day. The latter was a female patient at the Imizamo Yethu Clinic in Cacadu.



Twenty-one of the 105 respondents (20.0%) said that they had to pay for the services that they had received. The most that a respondent had to pay was R70.00. This was a respondent at the Zwelakhe Dalasile clinic in the Chris Hani district. The respondents were also asked if they were aware of the

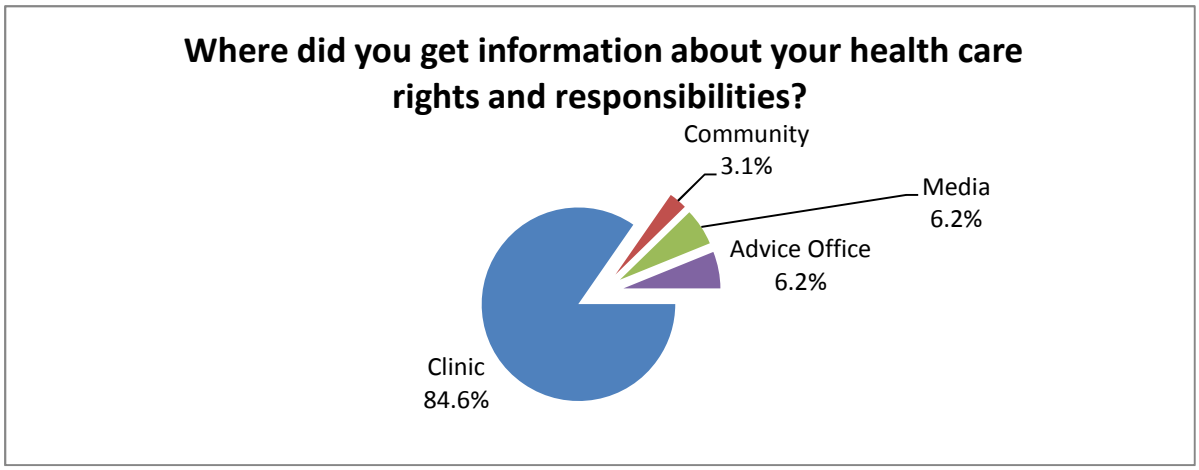
costs before receiving the service. The answer was 'no' for 51.4% of the respondents, 18.1% were aware of the costs, and 30.5% did not answer the question.

Language & Communication

This looks at whether or not the official languages are spoken. There is also a focus on how much people know about the about the health services provided by the Department of Health and where they received their information.

	Yes
Are you aware that you have the right to be treated by a named Health Professional?	61.9%
Did you know that you may refuse treatment (verbally or in writing) provided that this does not endanger the health of others?	37.1%
Do you know that you have the right to be given full and accurate information about the nature of your illness and the proposed treatment and the costs involved, for you to make a decision?	62.9%
Have you ever been asked your view on how to make health services better?	40.0%
Do you know that you have the right to be referred for a second opinion to a health provider of your choice?	55.2%
Do you know that you should not be abandoned by a health care professional worker or a health facility that initially took responsibility for your health?	58.1%
Do you know that you have the right to complain/comment about the health care service you receive and that it should be investigated and you should get feedback on the investigation?	61.0%

The above table shows that in certain areas patients are better informed than in others. The right which the respondents were not as well informed about was the right to refuse treatment provided that this does not endanger the health of others, where only 37.1% were aware of this. The other rights respondents were better informed about, but barely. More needs to be done to inform clinic patients in the Eastern Cape of their healthcare rights. There were also a low percentage of respondents who were asked their view on how to improve health services.



The respondents were asked whether they received the information in their mother tongue, or a language which they were comfortable with. For 80.0% of the respondents, they did indeed receive the information in their spoken language. However, 16.2% did not.

AS A PATIENT YOU HAVE THE FOLLOWING RESPONSIBILITIES, DID YOU KNOW THIS?	Yes
• **To advise the health care providers on your wishes with regard to your death**	24.8%
• **To comply with the prescribed treatment and/or rehabilitation procedures**	61.9%
• **To enquire about the related costs of treatment and/or rehabilitation and to arrange for payment**	38.1%
• **To take care of health records in your possession**	76.2%
• **To take care of your health**	81.9%
• **To care for and protect the environment**	83.8%
• **To respect the rights of other patients and health providers**	88.6%
• **To utilise the health care system properly and not abuse it**	86.7%
• **To know your local health services and what they offer**	82.9%
• **To provide health care providers with the relevant and accurate information for diagnostic, treatment, rehabilitation or counselling purposes**	77.1%

The table above shows that, generally, patients know what their responsibilities are. However, patients were not as well informed of their responsibility to enquire about the related costs of treatment and/or rehabilitation and to arrange for payment. They were also not aware that they had the responsibility to advise the healthcare providers on their wishes with regard to their death.

Monitors' Observations

Besides interviewing beneficiaries and monitoring service sites, the monitors recorded their own observations.

There are serious **shortages in the number of clinics, staff and facilities** in certain parts of the Eastern Cape:

- "All the surrounding villages are served by this Rodana clinic. Two professional nurses, two care givers, one security officer, one garden boy, one cleaner, six village health workers. No electricity in the clinic. Scarcity of ambulance. Shortage of medication and medical cards. No doctor. The patients referred to Glen Grey Hospital to be seen by the doctor. We have already written a letter to the hospital manager to request for the doctor."
- "Four village health workers worked for four years in the local clinic but they retrenched by a letter from the department of health."
- "Berlin clinic needs more health workers because more people come to this clinic. People from villages come to Berlin clinic. There are only two professional nurses in this Berlin clinic, government needs to employ more nurses. There is a lack of medicine."
- "Clinic is very far from the areas. No mobiles in far areas. No visiting doctor. Lack of professional nurses. Seats are available."
- "Distance from Klipfontein community brings up a problem for those who are very sick and aged people. They fetch taxi to clinic or hire a transport for more expenses. They wait outside the clinic gate from 3h00am for 8h00am, the opening time of the clinic. Clinic become full that result in not being able to consult everybody, whenever they are sick. The reason is the shortage of staff. Meaning government should open up vacancy for more nurses."

- “I see that the clinic needs more space and that it needs a place for counselling of TB and HIV/Aids patients.”
- “No toilets and special arrangements for disabled. No doctors. Scarcity of medication. Nurses did not start on time. People wait for a long time. All nurses go for their tea time at 10:30-11:00am.”
- “I've observed that the toilet facilities are at fault, not working (broken as from December 2011). No toilet paper every time we do visits.”
- “Rodana clinic is situated in a poor rural area called Tshatshu. No electricity. The clinic is too small because it was built with the renovation money. Two small consulting rooms, waiting room, small dispensary and one BP room. No labour room, no store room. It has small kitchen. It is under Emalahleni L.S.A BP machine is not working since September. Not enough medical cards for the patients as it is serve all surrounding villages.”

There is also a **shortage of medication** at certain clinics:

- “At times the clinic does not have sufficient medicine for patients. Patients have to travel and come back to check the medicine. They (nurses) stated that the department did not supply immediately when the medicine finished.”
- “Medicines are sometimes not available. Nurses send patients to chemist to buy themselves medicines or advise them about herbs from the bush. (Umhlonyane)”

Despite the shortcomings, there are **some praises** for the clinics in the Eastern Cape:

- “As a user of the local clinic I observed that that they are changing their strategies every now and then so that they can assist the clients faster. And they take turns for lunch.”
- “Good relationship. Information posts are available. Update communities about their service. Visited local areas and serve.”
- “Nurses are eager to help people, but due to shortage of staff it is difficult to do as you wish. At this clinic there were few nurses at the time I got there”
- “Patients feel very happy with manner in which they treated. But also feel that there is a need for extension of waiting rooms. Some patients must wait outside as there is not enough for communities.”
- “The clinic is in order and the nurses are working well with the patients.”
- “This date 01/11/2011 is the first day our clinic visited by the doctor. We wrote a letter to the health manager to request for the doctor. Our request was successful because we were visited by the doctor monthly. This application letter for the doctor took one month. We are happy for that because this rural area is far from the Glen Gary Hop in Lady Frere (60km)".

There were some **complaints about the way that nursing staff treated patients**:

- “Clinic is very clean and enough resources but the service is very poor. Nurses leave the patients for long time if they go to tea and lunch time and they used extra time. There is no respect to the patients”
- “No courtesy. No respect from nursing officials. Not given information about your problem. Official staff (cleaners), doctors have no name tags.”
- “No security for safety. Only collect money from patients. In the gate you didn't receive service from the clinic if you've got no fee of R2. No privacy for your own problems. Leave out patients.”
- “People wait for opening of the clinic hours, as they need to get first in the queue. Privacy is limited and causes them not to feel willing to disclose in the clinic, their volunteers are gossiping with the patient status. Also there is not enough staff like professional nurses. Doctors visit the clinic once a week and take such a certain number. There is also problem of ambulance taking time to arrive for emergency. They visit the clinic from 4h00am waiting outside whatever it is cold or raining and they become sicker.”

Some **patients needed to be informed about their health rights**:

- "From what I observed some old people don't have enough knowledge about their rights. Worst of all on their health rights. They just go to the clinic because they are sick and need help."
- "The client is not aware of other things as he is not given information. And is complaining that the reason why they don't get proper information is that they are told things in English of which sometimes English is difficult to understand. There are few Xhosa speaking nurses, maybe two or three."
- "The patient was not fully aware about his health status and was not given full information about how to take of his health and the surrounding environment. Above all he was not given all of his medication. The prescriptions on his medication are written in English and of which he is illiterate."

The monitors also **recommended that the operating hours of the clinics be extended** to accommodate all the patients at the clinic:

- "Ilitha clinic should be open for longer hours. Only two nurses that I have seen there and I stay more than 4 hours from 7 - 11. To improve the ambulance matter people wait too much at the clinic for ambulance. The security was okay. Nurse treats people with respect and care."
- "The clinic must open on weekends to help people who need help. It must close around 19:00 on week days and government must employ a security company to secure the clinic."
- "The clinic should open on weekends. Employ more nurses, you find that one nurse take care more than 10 people at one hour. There should be a doctor once a week. The clinic needs more security."

Recommendations from the Black Sash

These results are a real reflection of data acquired by our CMAP monitors, but are not weighted, indicative of trends, nor can any generalized inferences be made from these findings.

However – many of the content issues of the interviews strongly aligns to our CMAP SASSA paypoint - ; service point reports. Often the challenges raised in the reports that were developed have identified common social determinants of social protection (social security and health) – such as poor staff attitudes; poor intergovernmental relations; supply side management challenges; transportation challenges; food security - ; and lack of information or knowledge about rights and responsibilities.

Many of the recommendations from our reports and our NHI and Health System Reforms align with our CMAP findings and recommendations. As government moves towards the implementation of the National Health Insurance system – civil society organizations are concerned and keen to work alongside government to ensure the realization of its objectives in order to realize section 27 rights for all, the objects of the NHI and health system reform, and the attainment of MDG goals.

To this end, we have endorsed a submission by a civil society network of organizations – entitled Rural Now! – A Submission on the Green Paper on National Health Insurance (Rural Doctors' Association of Southern Africa, Rural Health Advocacy Project, Wits Centre for Rural Health; UKZN Centre for Rural Health, Ukwanda Centre for Rural Health; UCT: PHC Directorate – Africa Health Placements and Rural Rehab South Africa), in December 2011.

The submission underscores the interrelationship between so many factors that needs to be addressed, NOT ONLY by the Departments of Health, Social Development or those linked to the "Social Cluster'. Consider for example that:

- "24.2% of South Africans have at least one disability - making them SA's largest minority group

- 50% of disabilities are preventable and directly linked to poverty.

- 77.6% of HIV positive children have a physical delay, 63.5% a cognitive delay and 49.2% a language delay - this is lessened but not preventable by timeous initiation of ARVs.

- Half a million South Africans have a visual impairment, but 80% of blindness is avoidable.

The submission maintains that "As a result of previous disadvantage and current inequity in health status and access to health services affecting rural areas, as well as the relative lack of capacity to reverse the situation, a specific strategy is proposed to ensure that these inequities are not worsened in the future by the introduction of NHI, but instead are pro-actively addressed by weighting interventions in favour of those who are most disadvantaged.....Rural areas are characterized by a number of intrinsic disadvantages that have particular relevance to the ideal of universal coverage proposed by NHI: there is a higher burden of poverty; the social determinants of health have a more direct influence on health; the cost of accessing health services is higher; management capacity is relatively weak; and there is a relative paucity of private practitioners and specialists in rural areas."

The NHI consultations (and many of the issues raised by CMAP respondents that requires urgent intervention) – points to a strategy of progressive universalism – of service, access and affordability.

We therefore support interventions of progressive universalism that ensures that the poor gain at least as much as the rich from every intervention. Rural areas need to be prioritized to compensate for their access and HRH constraints and high levels of deprivation.

Priority areas (for intervention) include the abolition of User Fees Abolished and No Increase on VAT;

Reversing the existing Infrastructure/Inequality trap through needs-based budgeting; access to Health by addressing social determinants including transport; luring sufficient human resources to rural (and impoverished) areas, no to delegated management responsibility WITHOUT authority and accountability; and only *through*

consultation with communities, health workers and activists, should a wide-ranging PHC benefit package including Rehabilitation, Mental Health Care and Eye Care at all levels of care be implemented.