BLACK SASH
MAKING HUMAN RIGHTS REAL

SOCIAL CHANGE
ASSISTANCE TRUST

Free State CMAP Healthcare Report

February 2012 – March 2012

*The Black Sash - **in partnership with the Social Change Assistance Trust or 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

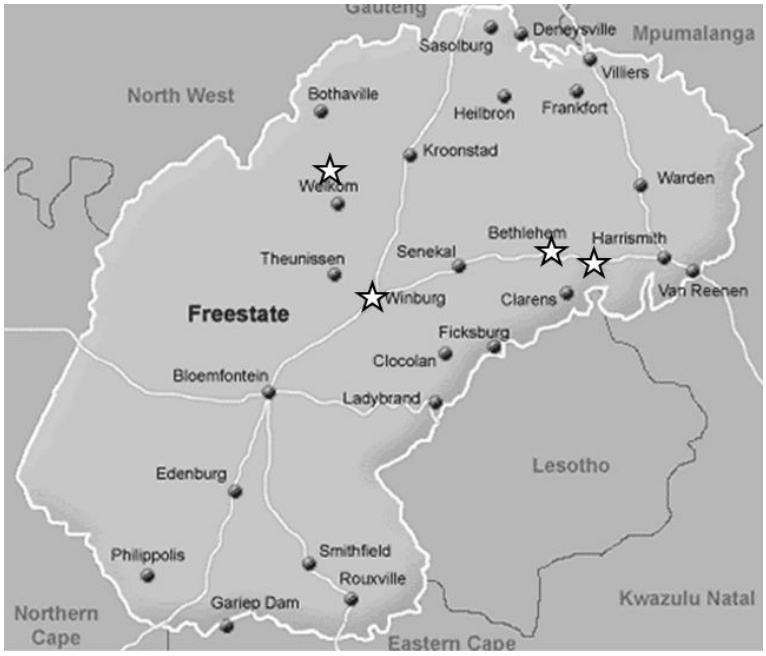
** "This document has been produced with the financial assistance of the European Union. The contents of this document are the sole responsibility of the Black Sash and can under no circumstances be regarded as reflecting the position of the European Union."*

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 Free State.

• **Dihlabeng Development Initiative** • **Susanna** • **Sekwele Centre for Social Reflection**	• **SACBC Justice and Peace – Kroonstad Diocese** • **Tlholong Socio Legal Advice Centre**

Map of areas monitored Feb/March 2012 (stars):



In addition we also wish to thank the various clinics and the Free State 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.

Open Society Foundation of South Africa

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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

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.

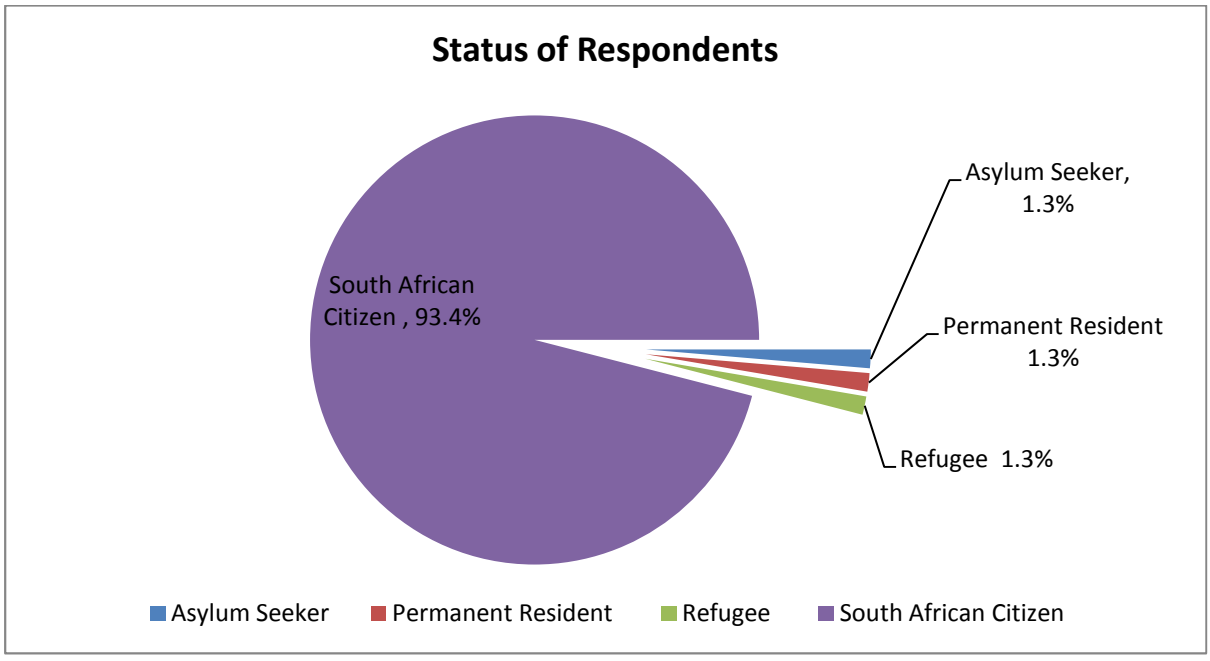
Monitors are selected by civil society networks; community based organisations and faith-based organisations and then trained to monitor selected public services using the monitoring tools. Each of these organisations have a CMAP memorandum of understanding with Black Sash to ensure mutual accountability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

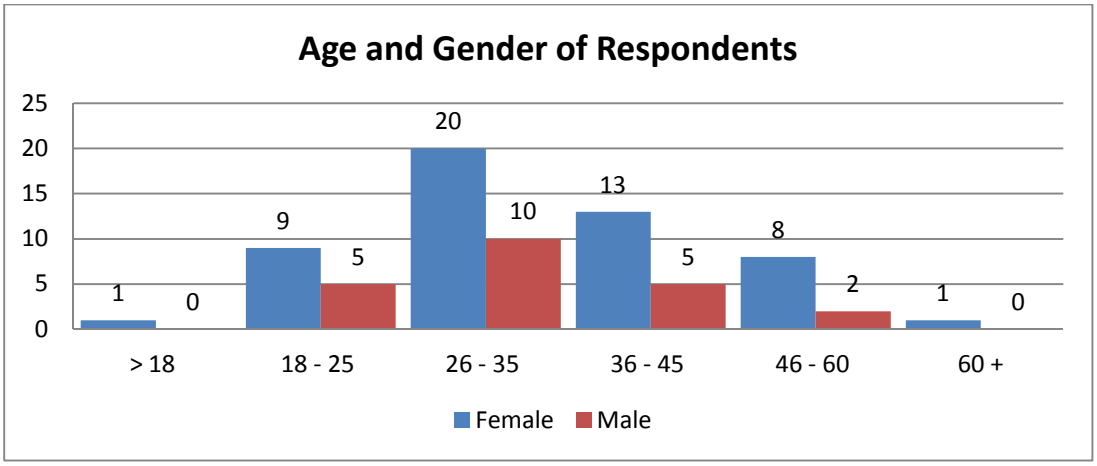
It is important to note that CMAP monitors undertake the monitoring in the areas where they live or work and that the selection of sites to monitor, depends either on where the monitoring organisation is located or where the monitor resides. No scientific formulation is used to select the geographic 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 Free State has been monitored according to the following standardised entities: **time & venue**; **healthcare processing**; and **language & communication**. The monitoring took place during the period of **21 February 2012** to **18 March 2012**. The findings presented in this report takes into account the experiences and opinions of **76 respondents** from **13 clinics** in **2 districts** across **the Free State**. The districts in which monitoring took place were: **Lejweleputswa (67.1%)** and **Thabo Mofutsanyana (32.9%)**. Please note that the percentages provided here are rounded off to the first decimal point.



The majority of the respondents were South African citizens (93.4%), with asylum seekers, permanent residents and refugees being 1.3% each.

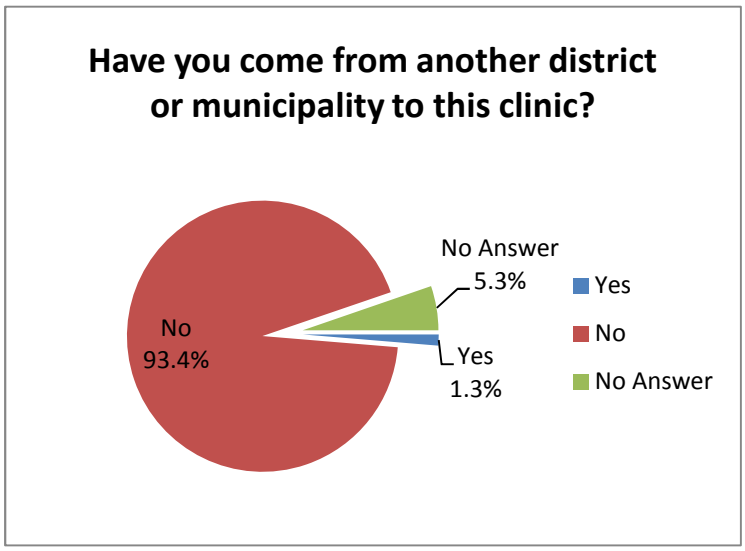


The majority of respondents were female (69.7%) and in the age group 26 – 35 years old (39.5%).

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	07:00	08:00
Closing Times of Clinics	15:30	16:30
Time taken to Travel to Clinics	3 min	120 min
Cost of Travel to Clinics	R10.00	R14.00
Time Waiting to be Serviced after Arrival	10 min	360 min
Number of Days per Week that the clinic operates from the venue	5 days	5 days



Most of the clinics opened 07:30 and closed at 16:00. All of the respondents, except one, stated that the clinics were open 5 days a week. One respondent stated that he was not sure how many days a week the clinic was open. No clinics were reported to be open for 24 hours – as noted in other provinces.

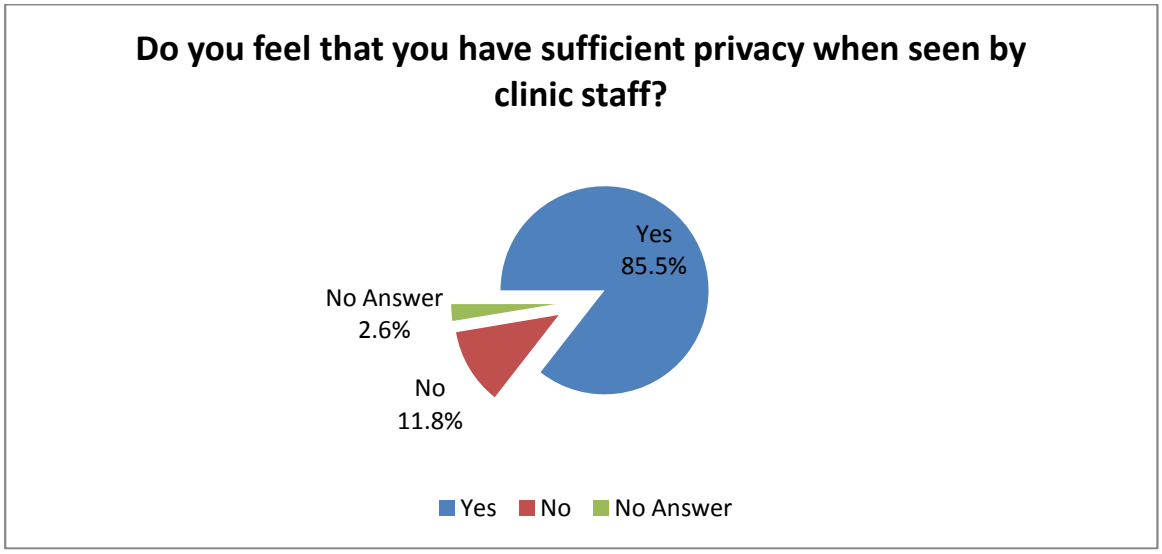
There were two respondents who had to travel up to 2 hours (120 minutes) to the clinic.

Both were from the Lejweleputswa district. One patient visited the Geneva clinic and the other, the Kamohelo clinic. Most of the respondents did not state how much the cost of travel to and from the

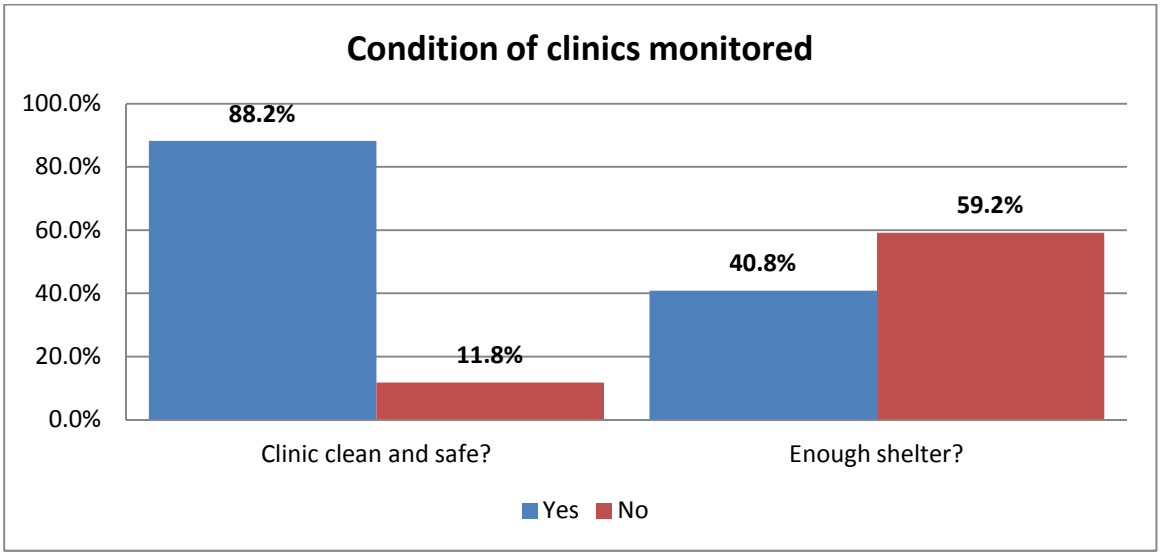
clinic amounted to. However, those who did answer this question, said that the cost of travel ranged from R10.00 to R14.00.

One respondent at the Mphohadi clinic in the Thabo Mofutsanyana district waited 360 minutes (6 hours) to be attended to after he had arrived.

The 1.3% of the respondents who came from another district were asked where specifically they came from. The respondent, a female that was younger than 18 years old, said that she came from a farm to the Kamohelo clinic in Lejweleputswa. It took her 120 minutes (2 hours) to reach the clinic.

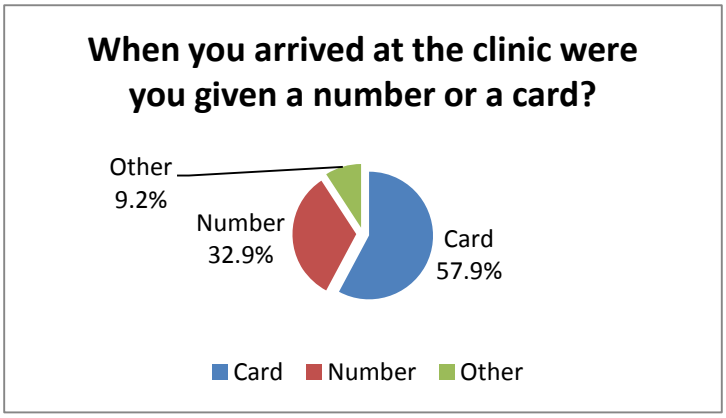


The majority of the respondents (85.5%) felt that they had sufficient privacy when seen by clinic staff. The nine respondents who felt that there was not sufficient privacy when they were seen by clinic staff were from the following clinic viz. the Bohlokong and Mphohadi clinics in the Thabo Mofutsanyana district; and the Bophelong, Geneva, and Kamohelo, all clinics in the Lejweleputswa district.



The majority of the respondents (88.2%) thought that the service in the clinic was provided in a clean and safe place; however, this was not the case in terms of shelter. For 59.2% of the respondents there was not enough shelter.

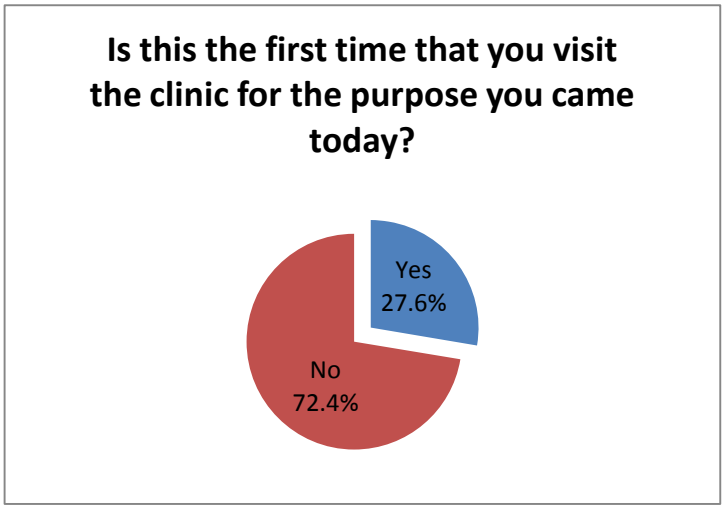
Healthcare Processing



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

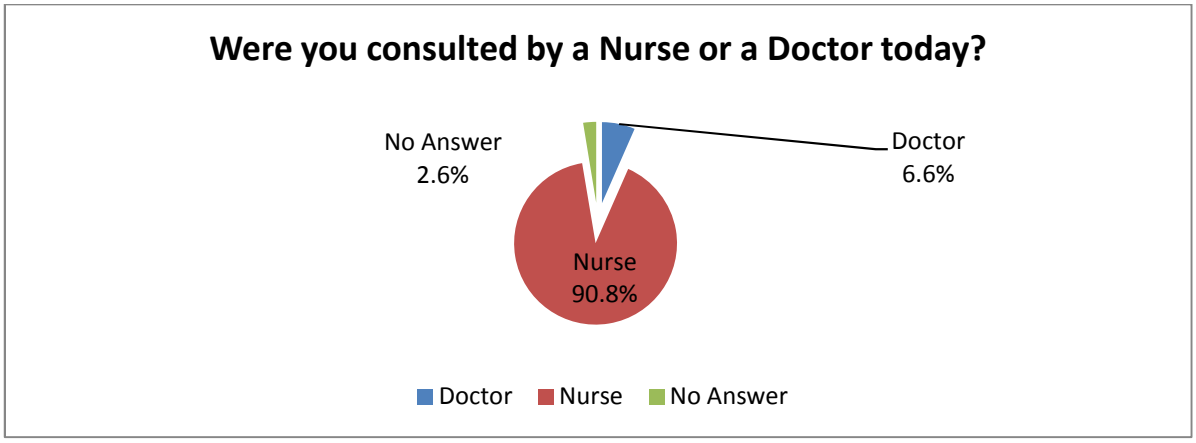
The respondents who not given a number or card told monitors that the clinic had opened files for them and that these were utilised. A respondent at the Mphohadi clinic in the Thabo Mofutsanyana district told monitors that they had "previously opened a file [for her] and [she] takes it on regular visits."

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. 38.6% 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.

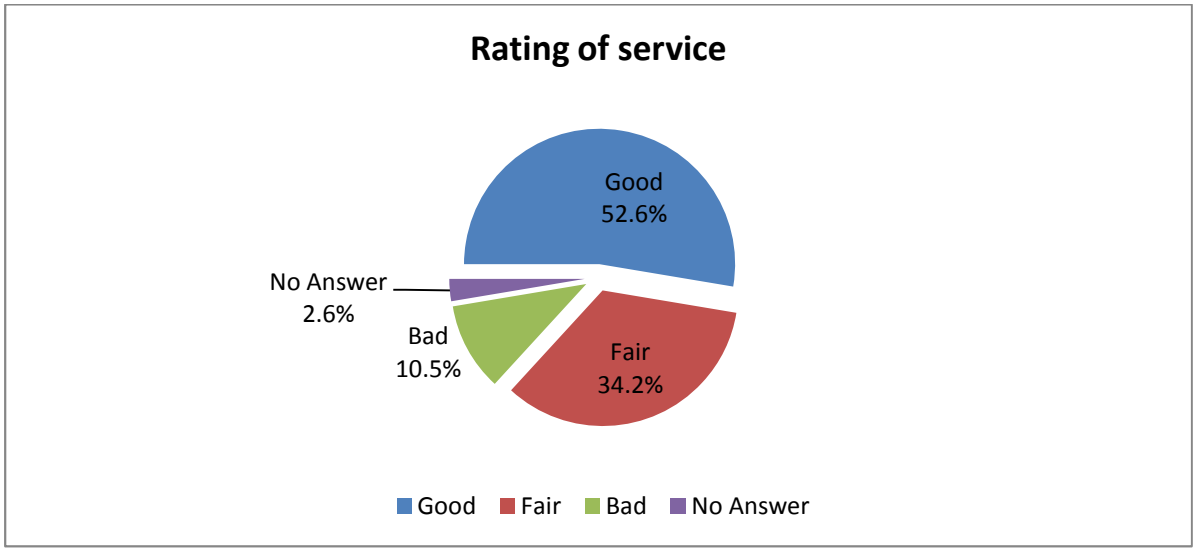


More than two thirds (72.4%) of the respondents were at the clinic for a return visit. Most of the respondents had to return three times for the same reason. However there was a respondent who had returned 15 – 17 times. This was a 36 – 45 year old female who was at the Kopanong clinic in the Thabo Mofutsanyana district. She complained that she "did not get medicine that helped" her and 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, especially for tuberculosis. A large percentage of respondents had to pick up prescription medication. Many mothers had to bring their children to be weighed and to receive their immunisations. A few of the women interviewed were there for pregnancy monitoring and contraceptive purposes. Many people had to return because they were not able to see a doctor or nurse on their previous visit, mainly due to a high number of patients waiting at the clinic. One respondent, 26 – 35 year old woman from the Kamohelo clinic in Lejweleputswa, said that return was because her health has not improved since the previous visit.



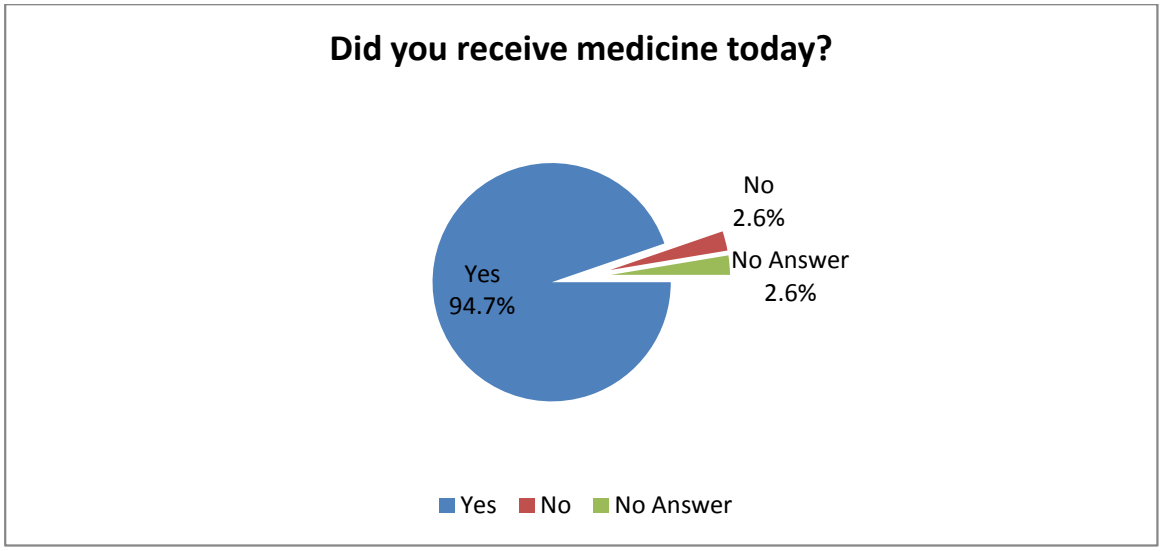
The majority of the respondents (90.8%) were consulted by a nurse. Only 21.1% of the respondents were seen by the same nurse or doctor that they had previously seen. The respondents were also asked if the consultation was in private. Most (94.7%) said that this was the case, but 3.9% said that they were not consulted in private.



After being asked to rate the service received, the respondents were asked why they rated it in this manner.

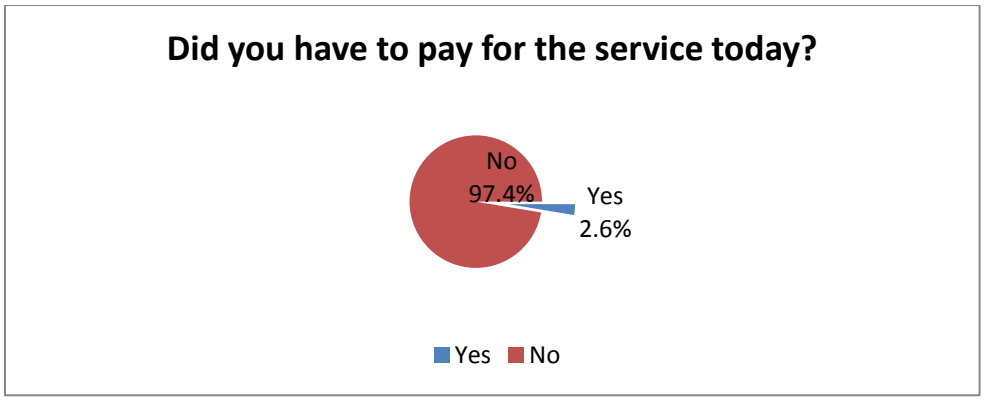
Amongst the main reasons why respondents felt that the service was “good” was because the Batho Pele (People First) principles were applied and that they were treated with respect despite the slow service due to staff shortages.

Other explanations include that they feel better after receiving treatment and that communication and explanations are good. The respondents who rated the services as fair said the reason for this was because the doctor/nurse was in a hurry because of the number of patients waiting. Other reasons were that they did not receive their medication or that they had to return. The long waiting period and the small size of the clinics were also a hindrance. Some complained of the doctor/nurses’ attitudes. The respondents who rated the service as bad said this was because they had to wait a long time to be seen, for their medication and even referral letters. Others complained about the manner in which the nurses treated them. One respondent at the Phedisanong Clinic in Lejweleputswa said that she returned without being attended to.



The respondents who did not receive their medication was asked why this was the case. Some of the respondents were there for test, and others did not come for their medication. One respondent at the Mphohadi clinic in the Thabo Mofutsanyana districts had not been attended to yet and therefore had not received his medication.

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 3 minutes, the longest being 3 hours (180 minutes). The latter was a female patient at the Winburg Clinic in Lejweleputswa.



Only two of the 76 respondents said that they had to pay for the services that they had received. One these respondents said that she had to pay R10.00 at the Phedisanong clinic in Lejweleputswa.

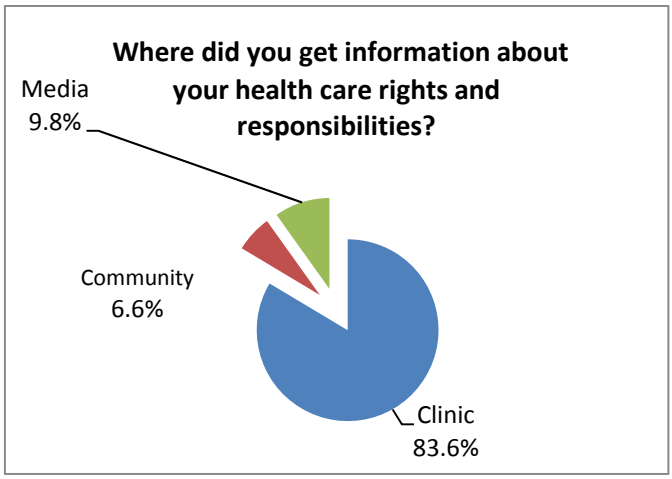
In answer to the question "were you aware of the costs before receiving the service?" the answer was 'no' for 44.7% of the respondents. None of the respondents (0%) were aware of the costs, and 55.3% did not answer the question. It is not clear why such a large percentage did not answer – **and we will investigate the reasons for this.**

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?	82.9%
Did you know that you may refuse treatment (verbally or in writing) provided that this does not endanger the health of others?	55.3%
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?	71.1%
Have you ever been asked your view on how to make health services better?	36.8%
Do you know that you have the right to be referred for a second opinion to a health provider of your choice?	60.5%
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?	71.1%
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?	81.6%

The above table shows that, in certain aspects of patient health rights knowledge, patients are well informed. Examples are their right to be treated by a named Health Professional (82.9%); their right to be given full and accurate information about the nature of their illness and the proposed treatment and the costs involved (71.1%); that they should not be abandoned by a health care professional or facility that initially took responsibility for their health (71.1%); and, that they have the right to complain and that their complaints should be investigated (81.6%).



There are rights of which patients in the Free State are less well informed. These include that they may refuse treatment if it does not endanger the health of others (55.35); and, their right to be referred for a second opinion to a health provider of their choice (60.5%). Low percentages (36.8%) of the respondents at clinics in the Free State have been asked their view on how to make health services better.

The respondents were asked whether they received the information in their mother tongue, or a language which they were comfortable with. For 89.5% of the respondents, they did indeed receive the information in their spoken language. However, 6.6% did not. There were respondents who did not answer this question (3.9%).

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**	61.8%
• **To comply with the prescribed treatment and/or rehabilitation procedures**	78.9%
• **To enquire about the related costs of treatment and/or rehabilitation and to arrange for payment**	43.4%
• **To take care of health records in your possession**	77.6%
• **To take care of your health**	82.9%
• **To care for and protect the environment**	88.2%
• **To respect the rights of other patients and health providers**	86.8%

• **To utilise the health care system properly and not abuse it**	86.8%
• **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**	82.9%

In terms of their responsibilities, patients generally know what their responsibilities are. However, the one responsibility where patients were not as well informed was their responsibility to enquire about the related costs of treatment and/or rehabilitation and to arrange for payment.

Monitors' Observations

Besides interviewing beneficiaries and monitoring service sites, the monitors recorded their own observations. One of the major concerns raised by monitors was the **long wait that patients had to endure**. Many of the **patients had to travel far** to reach the clinic. There were also an inordinate number of repeat visits in some health districts. A **shortage of staff** is one of the contributing factors to this:

- "All patients are complaining about the long wait."
- "Clinic staff and volunteers need to always inform patients about reasons for delay of service."
- "I as a monitor, I observed that this patient like the services of clinic and the way she get treated, privacy that she needs, but the problem is time. She has to wait a long before she got help or services."
- "I have observed that you even had to queue for a referral letter to another hospital and they say you must be at the clinic at 5 'o clock in order to be picked up by an ambulance and it is not safe for the distance they travel."
- "I observe that every Wednesday, children come to clinic for immunisation. But the children get restless because of the long wait."
- "Patients wait very long hours (4-6) before they can be serviced due to the fact that nurses were capacitating community health workers. Some patients know their rights and responsibilities concerning health facilities but others don't."
- "Patients waited in the queue between four to six hours before they can be serviced due to the nurses' orientation of community health workers."
- "Shortage of staff and high number of people using these clinics might be the cause of the delay."

There were patients and monitors who **praised the services provided at clinics in the Free State**, despite some shortcomings:

- "Gogo here claims to understand everything. She is happy of the service she received today and in the past."
- "I as a monitor, I observed that this patient like the services of the clinic and the way she get treated but the biggest issue/problem is all about time that she have to wait until she get help or services."
- "This young guy is very well informed of his rights and responsibilities. Clearly these nurses are doing their jobs properly."

The monitors felt that **there were patients who were informed about their health rights and responsibilities**:

- "I feel that the above mentioned information given to me (responses to the questionnaire) shows that he is informed of his health rights and responsibilities."
- "It's clear to me that this person is satisfied of the service he received from this clinic and he fully understands his rights and responsibilities."

There were, however, patients who were **not aware of their health rights and responsibilities**:

- "I have observed that he only come in the morning for his treatment and go home. He knows nothing about his rights as a patient."
- "Patients waited in long queues and hours before they can be serviced. Some patients know their rights while others don't."
- "Some patients are not aware of their health rights."

There was **some criticism of the service provided by the health services in the Free State**"

- "Service delivery is poor."
- "Sometimes is it like there is favouritism in the clinic due to some people are not treated equally."
- "The clinic is not doing enough to ensure TB patients' right to privacy is protected."
- "Today is a day that all mothers bring their children to clinic for immunisation. There is not enough space for all people to sit inside so others decided to sit outside."

Recommendations from the Black Sash

The above 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.