BLACK SASH
MAKING HUMAN RIGHTS REAL

SOCIAL CHANGE
ASSISTANCE TRUST

Limpopo CMAP Healthcare Report

April 2011 – May 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

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• Centre for Research and Development • Kabosadi Disability • Kopermyn Advice Office • Lusaka Ahipfunaneni Shipingwana • United People Against Crime (UNPAC)	• Ditenteng Advice Office • Khari-Gude • Lotavha Advice Office • Relemogile Advice Office

Map of areas monitored April 2011 – May 2012 (stars):

In addition we also wish to thank the 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

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.

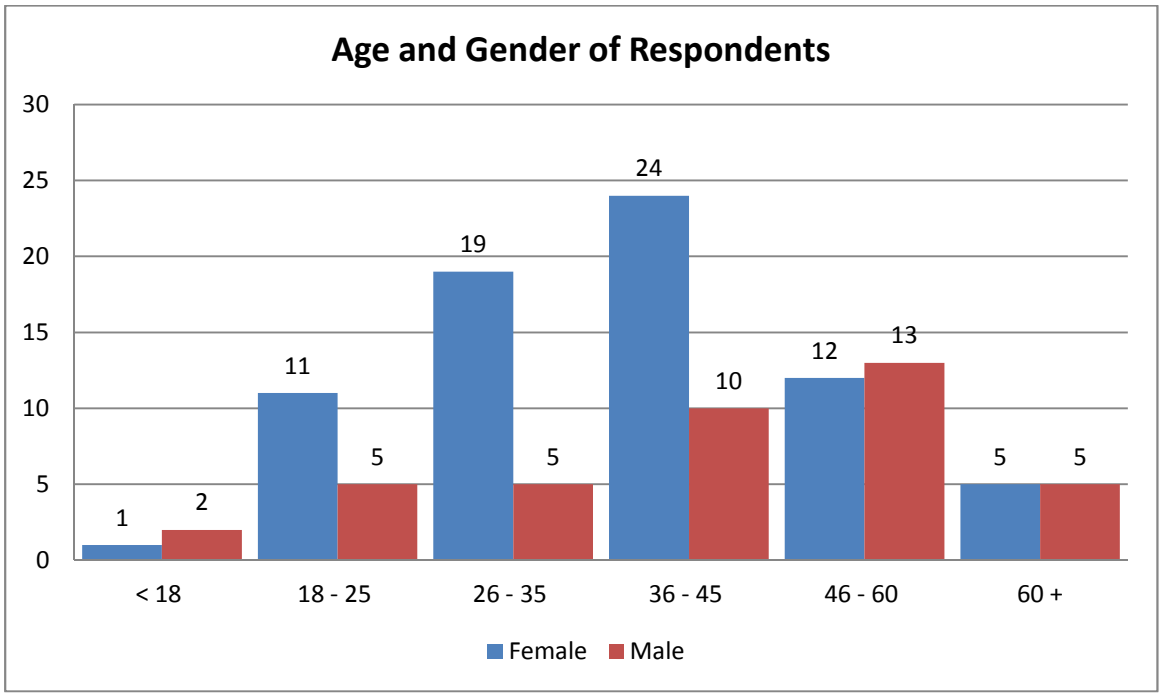
Monitors are selected by civil society networks; community based organisations and faith-based organisations and then trained to monitor selected public services using the monitoring tools. Each of these organisations have a CMAP memorandum of understanding with Black Sash to ensure mutual accountability 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 **Limpopo** has been monitored according to the following standardised entities: **time & venue**; **healthcare processing**; and **language & communication**. The monitoring took place during the period of **20 April 2011** to **21 May 2012**. The findings presented in this report takes into account the experiences and opinions of **115 respondents** from **18 clinics** in **four districts** across **Limpopo**. The districts in which monitoring took place were: **Capricorn (36.5%), Mopani (45.2%), Sekhukhune (2.6%),** and **Vhembe (15.7%)**. Please note that the percentages provided here are rounded off to the first decimal point.

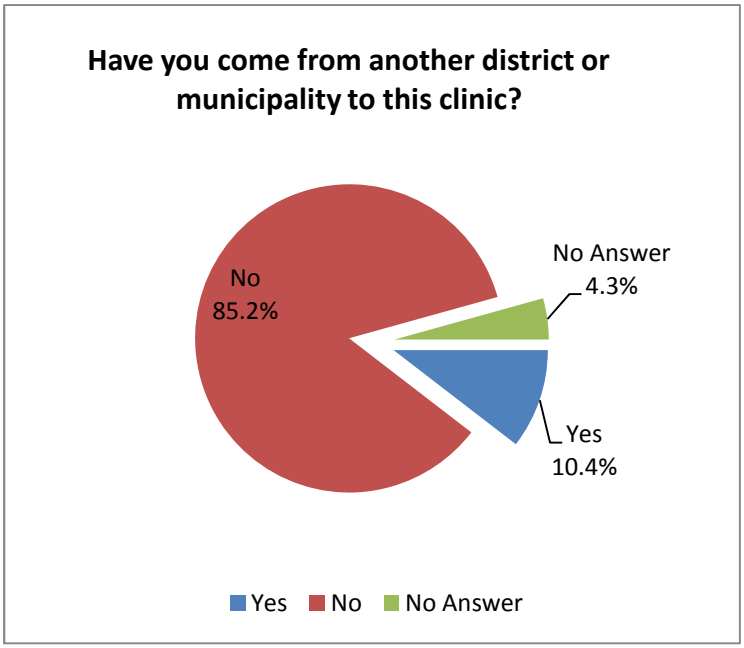


The majority of the respondents were South African citizens (93.9%), with asylum seekers being 0.9% and refugees being 2.6%. The majority of respondents were female (63.5%) and in the age group 36 – 45 years old (29.6%).

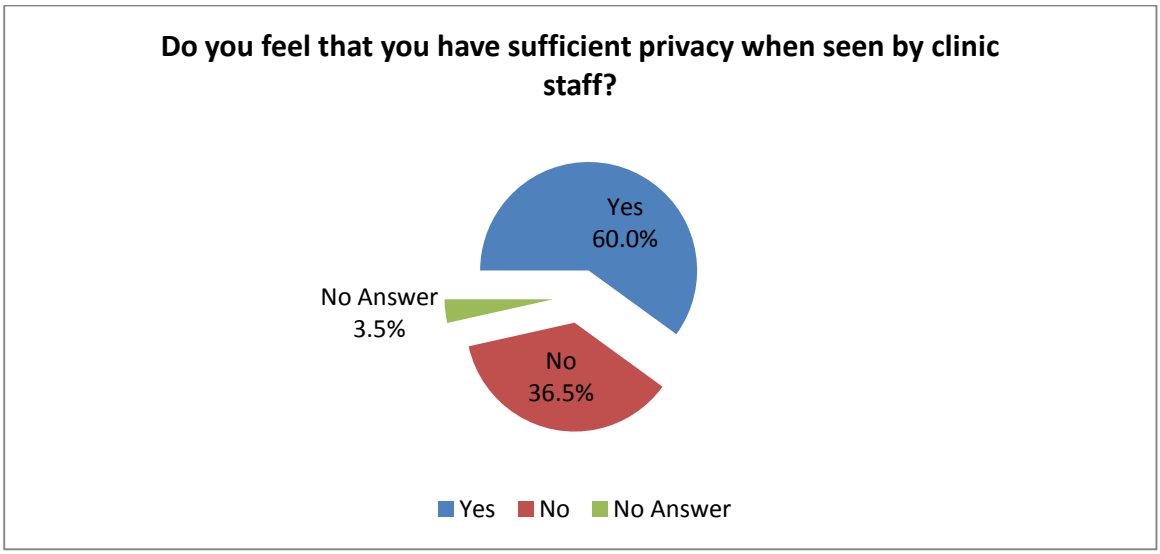
Time & Venue

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.

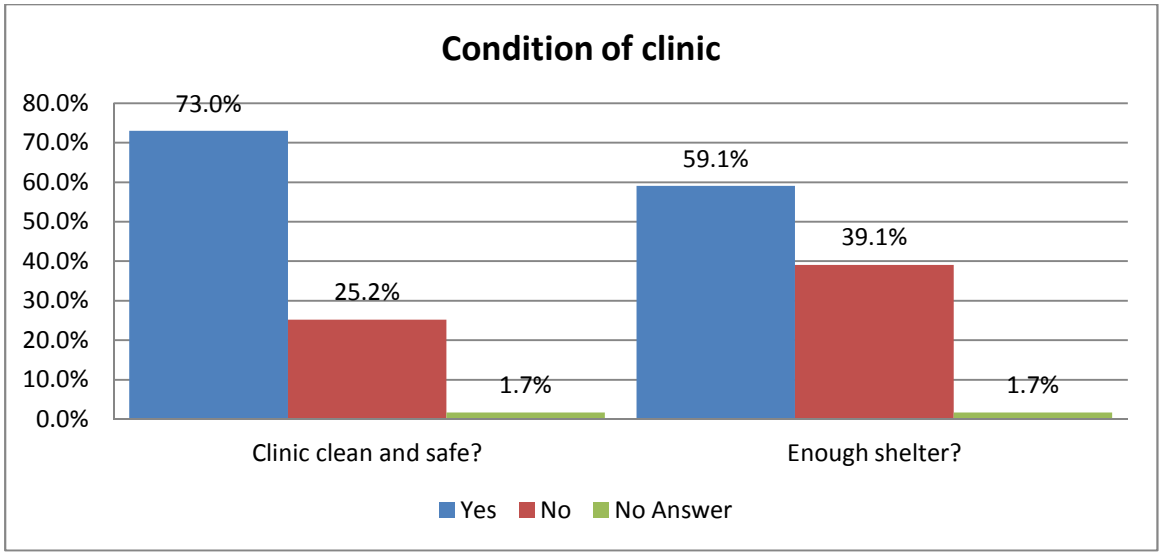
	Minimum	Maximum
Opening Times of Clinics	04:00	24 hours
Closing Times of Clinics	11:00	24 hours
Time taken to Travel to Clinics	1 min	420 min
Cost of Travel to Clinics	R0.00	R500.00
Time Waiting to be Serviced after Arrival	0 min	480 min
Number of Days per Week that the clinic operates from the venue	5 days	7 days



Most of the respondents said that the clinics were open seven days per week. Most of the respondents took approximately 30 minutes to reach the clinic. However, there was a respondent at the Manamela Clinic in the Capricorn district who said that it took him seven hours (420 minutes) to reach the clinic. The cost of travel ranged from R0.00 to R500.00, with most of the respondents not having expenses related to travel to the clinics. The respondent who paid R500.00 attended the Maja Clinic in Capricorn.



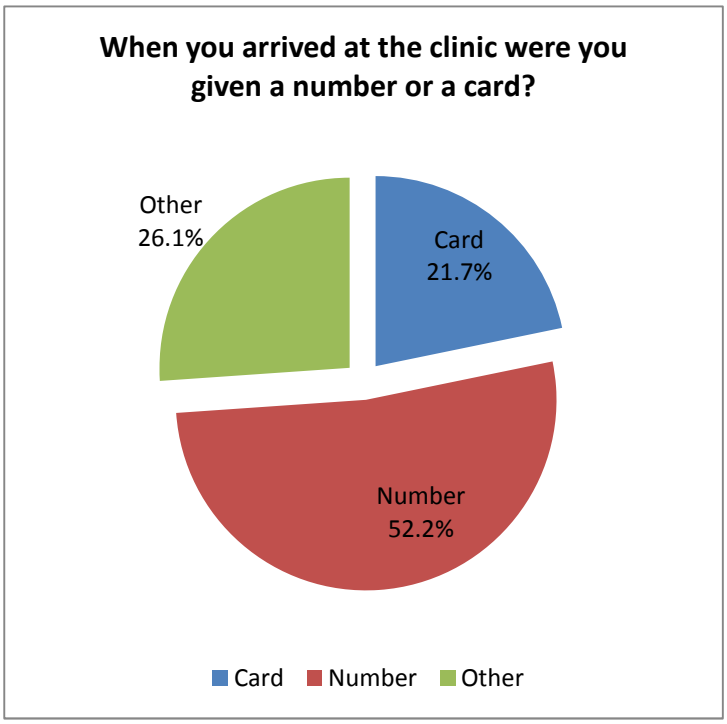
The majority of the respondents (60.0%) felt that they had sufficient privacy when seen by clinic staff. However, 36.5% of the respondents said that they did not have sufficient privacy.



The majority of the respondents (73.0%) thought that the service in the clinic was provided in a clean and safe place, this was also the case in terms of shelter with 59.1% feeling that there was enough shelter.

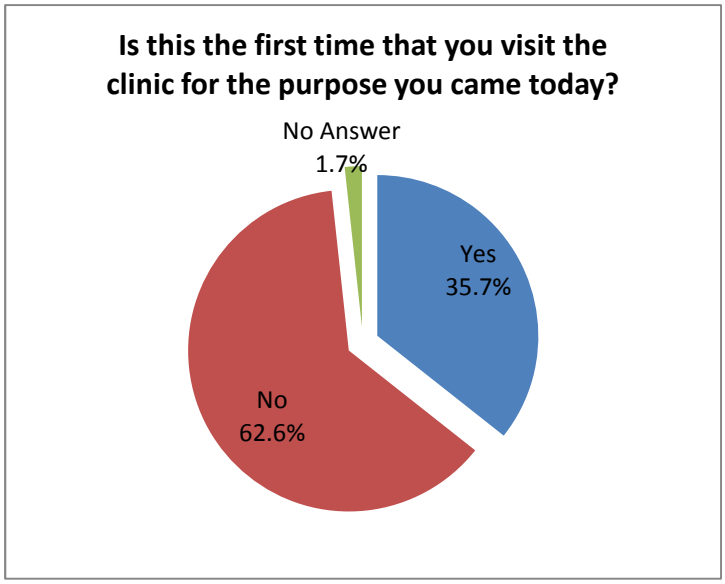
Healthcare Processing

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

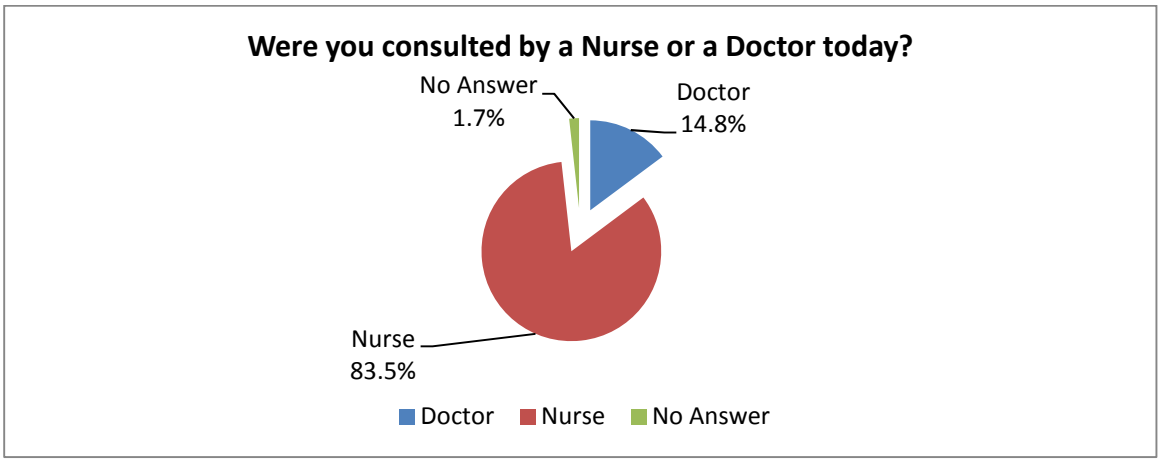


The respondents who were not given a number or card said that they had to wait in queue. Respondents also said that they had to bring a small book with their patient information. The respondents who had to bring their own books were at the Manamela Clinic in the Capricorn district. For respondents who received a card, the monitors asked whether the card was a different colour than the cards of other patients at the clinic. 36.0% 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.

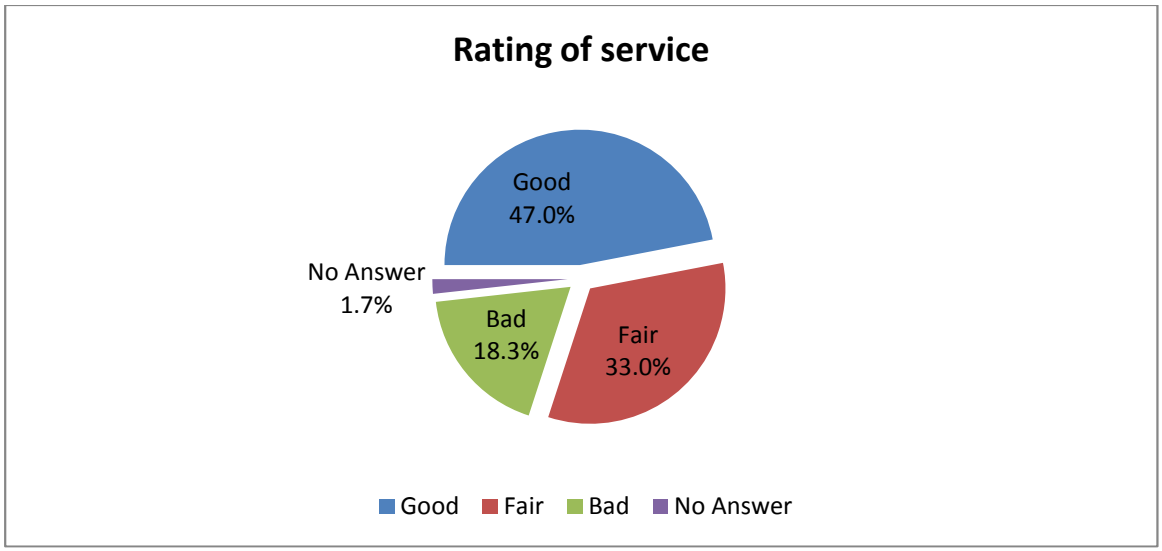
Approximately two thirds of the respondents (62.6%) were at the clinic for a return visit. One respondent said that he had to return twice a month to the Manamela Clinic in Capricorn for treatment.



Some of the other reasons that the patients have for returning to the clinic include that they were there for a check-up or treatment. A large percentage of respondents had to pick up prescription medication. Some said that that they did not receive medication on their previous visit, either because there was not enough or because the queues were too long. Many complained that medication was not available. Family planning and pregnancy monitoring were also stated as reasons for returning.



The majority of the respondents (83.5%) were consulted by a nurse. Only 43.5% 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 (93.9%) said that this was the case, but 5.2% said that they were not consulted in private.

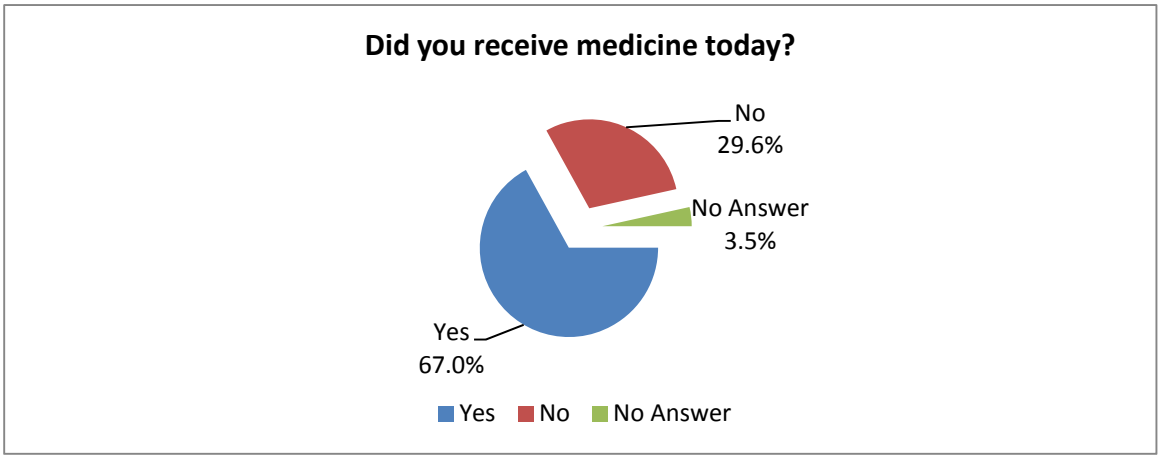


After being asked to rate the service received, the respondent were asked why they rated it in this manner.

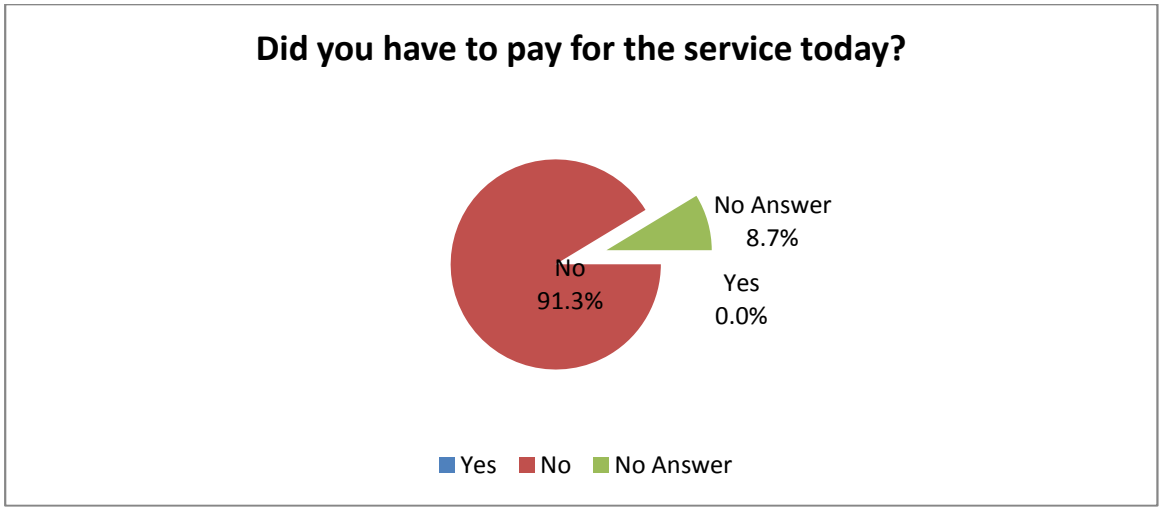
The main reason for respondents rating the service as **good** was because they were treated with respect and they got the assistance and medication that they required. Furthermore, they were consulted in private. They also praised the nurses for communicating with them in their own language or that a translator was available.

The respondents who rated the service as **fair** complained about the small size and the conditions of the clinics. They said that they had to wait a long time because the nurses worked at a slow pace. They also complained that there was a lack of medication.

The main reason for rating the services as **bad** was because of the attitudes of the doctors or nurses. Some respondents complained that the nurses did not really listen to them. There were also complaints about the length of time that they had to wait and the lack of privacy. Some respondents complained about a lack of medication and doctors. A respondent at the Dan Clinic in Mopani said "My treatment was not available for the last few months". One respondent, an asylum seeker, interviewed at the Tzaneen Bus Terminal in Mopani said, "I should not be denied my health consultation for being a foreigner." Other foreigners also complained about not being assisted.



The respondents who did not receive their medication was asked why this was the case. Most of the respondents said that the reason that they did not get medication was because there was a shortage. 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 immediately, the longest being 8 hours (480 minutes). The latter was a respondent at the Jane Furse Hospital in Sekhukhune.



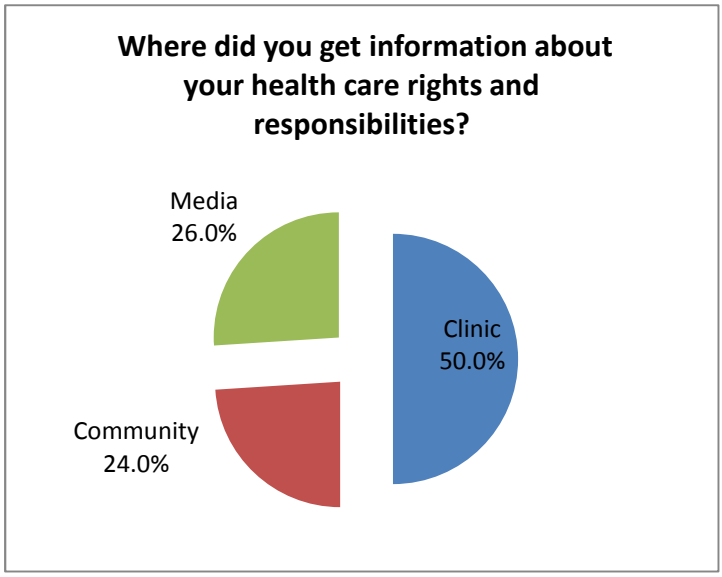
None of the respondents had to pay for the services that they had received. The respondents were also asked if they were aware of the costs before receiving the service. The answer was 'no' for 26.1% of the respondents, 6.1% of the respondent were aware of the cost and 67.8% did not answer the question.

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?	61.7%
Did you know that you may refuse treatment (verbally or in writing) provided that this does not endanger the health of others?	45.2%
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?	59.1%
Have you ever been asked your view on how to make health services better?	38.3%
Do you know that you have the right to be referred for a second opinion to a health provider of your choice?	46.1%
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?	33.9%
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?	54.8%

In general, the respondents in Limpopo were not well aware of their rights. This is especially true for right not to be abandoned by a health care professional worker or a health facility that initially took responsibility for their health.



50.0% of the respondents said that they received information about their health care rights and responsibilities from clinics. The media informed 26.0% and the community the remaining 24.0%. The respondents were also asked whether they received the information in their mother tongue, or a language which they were comfortable with. For 69.6% of the respondents, they did indeed receive the information in their spoken language. However, 21.7% 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**	40.9%
• **To comply with the prescribed treatment and/or rehabilitation procedures**	71.3%
• **To enquire about the related costs of treatment and/or rehabilitation and to arrange for payment**	45.2%
• **To take care of health records in your possession**	54.8%
• **To take care of your health**	73.0%
• **To care for and protect the environment**	73.9%
• **To respect the rights of other patients and health providers**	79.1%
• **To utilise the health care system properly and not abuse it**	74.8%
• **To know your local health services and what they offer**	62.6%
• **To provide health care providers with the relevant and accurate information for diagnostic, treatment, rehabilitation or counselling purposes**	70.4%

Generally the respondents in Limpopo are aware of their healthcare responsibilities. However, for the following responsibilities the percentages are low:

- To advise the healthcare providers on their wishes with regard to their death.
- 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.

Monitors noted that there were **long queues** due to the fact that there was a **shortage of staff**. There were also many patients who **arrived very early** so that they could be helped first:

- "According to my observations there is a shortage of staff at the clinic. There is no doctor at the clinic and no visit at any doctor during the year. There is no special arrangement for old people, seriously ill people and disabled people. The seriously ill older people are also spending more time in queues."
- "All patients are told to wait in the queue regardless of age or how ill they are. First come, first served."
- "Here is a lack of staff as the clinic is filled with patients."
- "Sometimes patients take the whole day waiting for services. They told them that they are in a meeting."
- "The clinic is very small and highly overcrowded as many people come from different areas of Greater Tzaneen and Letaba come for services."
- "The clinic is very small and with no space to accommodate more than 20 people."
- "The clinic needs more staff as they are filled with patients that wait for hours."
- "The clinic operates 24 hours. However, it's experiencing a shortage of staff."
- "There is shortage of nurses in this clinic. The doctor comes once a week and stay there for only three hours. If the government can give each clinic a doctor who can work every day and 24 hours so that the people must be attended every day without waiting the day the doctor can come. This is the problem."

There was also a **lack of equipment and facilities** in certain clinics. There is also a **lack of medication**:

- "I think the service is poor because people are leaving without medication as the clinic has a lack of it."
- "The clinic is running short of medicine. The clinic has a constant late delivery of medicine for chronic patients (TB, HIV/AIDS, sugar, blood etc.)."
- "The clinic is very small to accommodate people who consulted on daily basis. It is not well fenced. Consulting rooms are very small, no air conditioners. Everything is very small."
- "The lack of consistency of delivery of medicine from the Letaba Provincial Hospital is inconvenient. The patients' lives are being endangered due to a failure to provide treatments regularly."

Some monitors also highlighted that **health education and awareness is needed**:

- "Because of our presence the services are nice. It depend on nurses who are on duty, some are not harsh while others are. It differs daily. People are not aware of their rights because nobody explained to them."
- "If workshops are done, different strategies may be used to let the patients know their rights and responsibilities."
- "More need for people to understand their rights as patients. Doctors are making good job for coming to clinics. Our people do not travel to hospitals in order to get treatment."
- "Most of the patients need to be informed about their rights in the clinic. People do not know the Batho Pele principles."

- “Patients do not know all of their rights and responsibilities. Patients need to be taught about their rights and responsibilities.”
- “Patients know most of their rights but they do not apply them (do not know how to apply them and when to apply them).”
- “People need to be taught about their rights. The staff are working hard because of our presence. The patients are treated quickly today.”
- “The community is not aware of their rights and responsibilities.”
- “The need for patients to be informed about their rights and to be provided with information on Batho Pele principles.”
- “The patient does not know their rights and the nurse refuse them letter or referrals to hospitals. There is no good communication between the nurse and the patients. The nurse does not respect the rights of the patients and the patients get assisted after a long time. No special arrangements to emergency patients. The patients spend more time in queues.”

There was also **praises** for the services provided at clinics in:

- “Doctors come once a month. He treated the patients with respect. He was wearing a uniform and a name tag.”
- “Nurses advise patients to eat the relevant food, to drink the tablet on time and not overdose.”
- “Nurses greet their patients and the patients right constitutionally.”
- “Patients are satisfied with their nurses.”
- “Patients feel happy because they know their nurses. They wear their name tags. They receive information in their spoken language. They help critical patients quickly.”
- “The clinic is secure because you pass through security as you enter.”
- “The provision of chronic treatment for the patients is constantly delivered.”
- “The service is good but people complain about the long lines that they need to stand in.”
- “The sister in charge opens with a prayer everyday so that their patient s feels at home. Patients feel happy. They can ask their nurses to change tablets or medicine if they feel like doing so. They work hand to hand with the nurses.”
- “This clinic is clean and it has toilet for everyone and shelter. The people who work at this clinic they use Batho Pele and they always on duty. The problem which we have in this clinic is the shortage of medicine but it's not the problem of staff, it's the problem of our government. Please government may you take into consideration with medicine.”
- “This clinic is very secure, has extra security in place.”
- “This clinic, people are helped on time. It has only one problem of shortage of medicine. Government must produce medicine in time so that the staff can assist their patients. It's not good for patient to leave the clinic without medicine.”

There were some **complaints** about the conditions at the clinics:

- “Ambulance delay to help a patient. Nurses are not wearing their name tags. The information box was checked by the sister in charge. After that she selected the other information and burnt them.”
- Ambulance take time to come and help patient.
- “Asylum seekers are being denied health services by the department. The matrons in some clinics gave instructions to the security gate personnel to only allow those documented to enter the premises.”
- “Nurses take a long time for breakfast. They don't care about critical patients.”
- “Patients are often denied transfer letters to Letaba Provincial (office) hospital for further observation or treatment.”

- “Pregnant woman was complaining about a nurse who pushed her roughly as she was pregnant. Sister in charge call all nurses to solve that problem and nurses ask for forgiveness from that woman.”
- “The clinic is a small building serving community from Mariveni "A", Mariveni "B" and Nkowankowa "C". The clinic has no medicine.”
- “The clinic is dirty. The nurses are not wearing name tags. One of the nurses was not in uniform. An incident of verbal abuse took place in my presence by a nurse in my presence.”
- “The clinic is under staffed. There are no health facilities accessible after 17:00 for the 6 villages which utilize the facility.”
- “The refugees are being denied health care due to unavailability of identity books and permits. The space of the clinic is very small without enough seats to accommodate the high influx of patients visiting the centre.”
- “There is a shortage of doctors and utilising one doctor for more than 300 patients a day. The doctor who was working 14/07/2011 refused to give this patient the required medicine. The patient refused the same medicine that received from the clinic. One nurse decided to ignore the option of the doctor and offer the patient a proper medicine that manage to give the patient power and the patient is now healed. She was not eating but thereafter, she ate.”

The monitors also noted that there was a **lack of privacy**:

- “No confidentiality at the clinic, they open the door and check the patients.”
- “No confidentiality that day from the nurses. Patients complain about it.”

The following **suggestions** were also made by the monitors:

- “Clinic committee requests the hospital board to help them when doing the campaign of teenage pregnancy.”

Recommendations from the Black Sash

In particular, we want to underscore the need for privacy at some clinics in Limpopo province, since this was brought to our attention by more than one monitor. Please note that privacy can defined as not only being attended to in a private setting, but one in which their sense of privacy was also respected. For example, a door may be left open whilst being examined, or staff may enter and leave a room where someone is being examined.

Through the CMAP work, we were able to monitor health care – as envisaged at the end of our Final NHI synthesis Report and now will begin disseminating these findings in the public domain. We now aim to continue engaging more intently with health authorities at a national, provincial, and where appropriate, local level.

The results are therefore 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.