BLACK SASH
MAKING HUMAN RIGHTS REAL

SOCIAL CHANGE ASSISTANCE TRUST

# Mpumalanga CMAP Healthcare Report

August 2011 – April 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 Mpumalanga.

| | |
|---|---|
| • Bohlabela Resource and Advice Centre<br>• Daggakraal Advice Centre<br>• Ensalabosho Orphans and Disable<br>• Jeppes Reef Home Based Care<br>• Lend a Hand Home Based Care<br>• Qedusizi<br>• Zimiseleni Dots Home Based Care | • Chief JM Dlamini Cheshire Home<br>• Dientjie Advice and Resource Centre<br>• Hope for Life Home Based Care<br>• Leandra Community Centre<br>• Nsikazi Advice and Resource Office<br>• Senzokhuhle Home Based Care |


Map of areas monitored August 2011 – April Jan 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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# Contents

# 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.

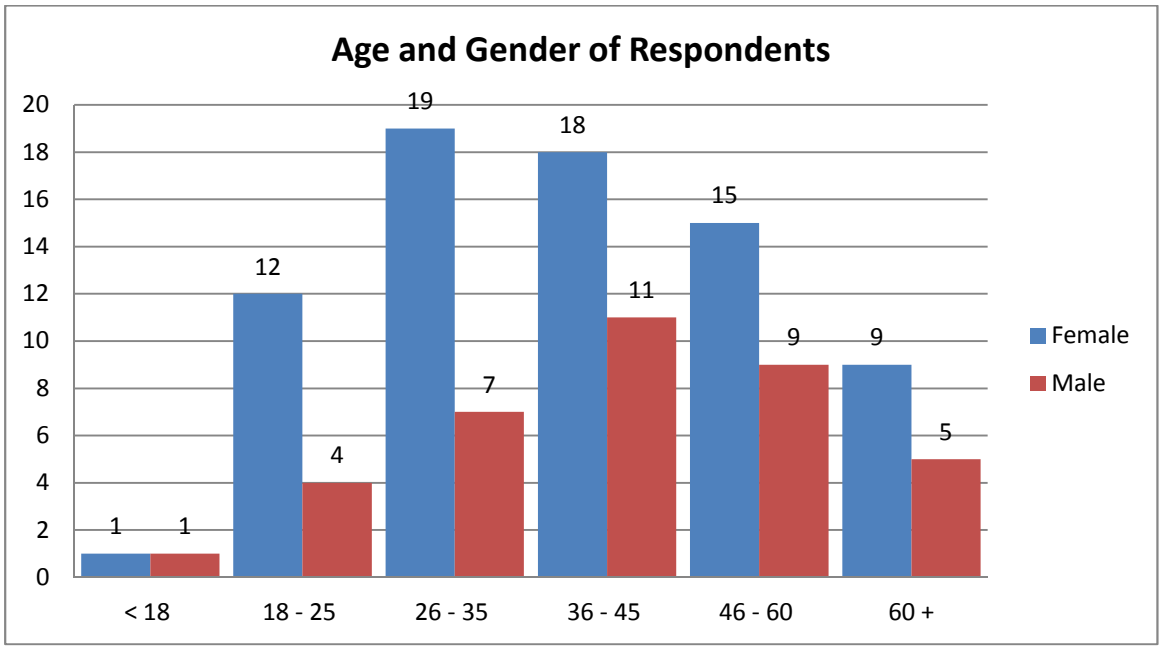
Monitors are selected by civil society networks; community based organisations and faith-based organisations and then trained to monitor selected public services using the monitoring tools. Each of these organisations have a CMAP memorandum of understanding with Black Sash to ensure mutual accountability 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 **Mpumalanga** has been monitored according to the following standardised entities: **time & venue**; **healthcare processing**; and **language & communication**. The monitoring took place during the period of **3 August 2011** to **26 April 2012**. The findings presented in this report takes into account the experiences and opinions of **115 respondents** from **30 clinics** in **3 districts** across **Mpumalanga**. The districts in which monitoring took place were: **Ehlanzeni (76.5%), Gert Sibande (20.9%),** and **Nkangala (2.6%)**. Please note that the percentages provided here are rounded off to the first decimal point.

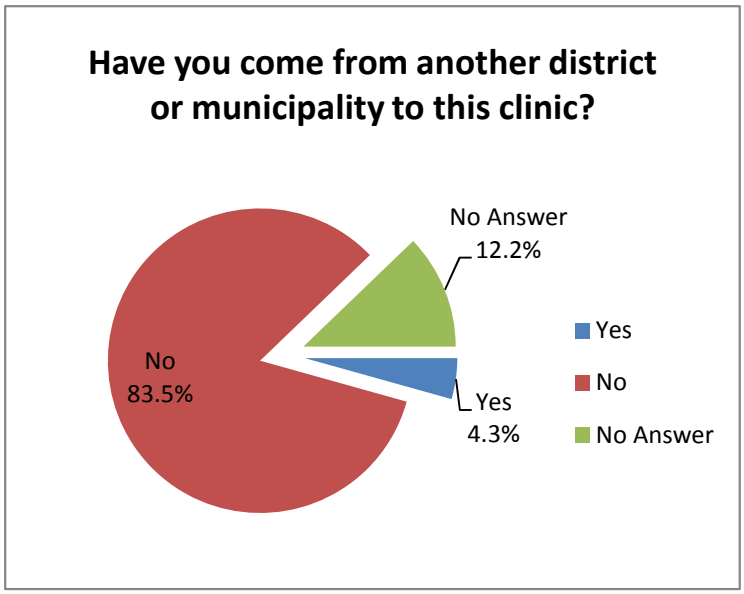



The majority of the respondents were South African citizens (86.1%), with asylum seekers being 1.7%, foreign nationals (5.2%) and permanent residents being 0.9%. The majority of respondents were female (64.3%) and in the age group 36 – 45 years old (25.2%). One respondent came from Namancha, Mozambique "because [she] thinks South Africa's medicine is the best".

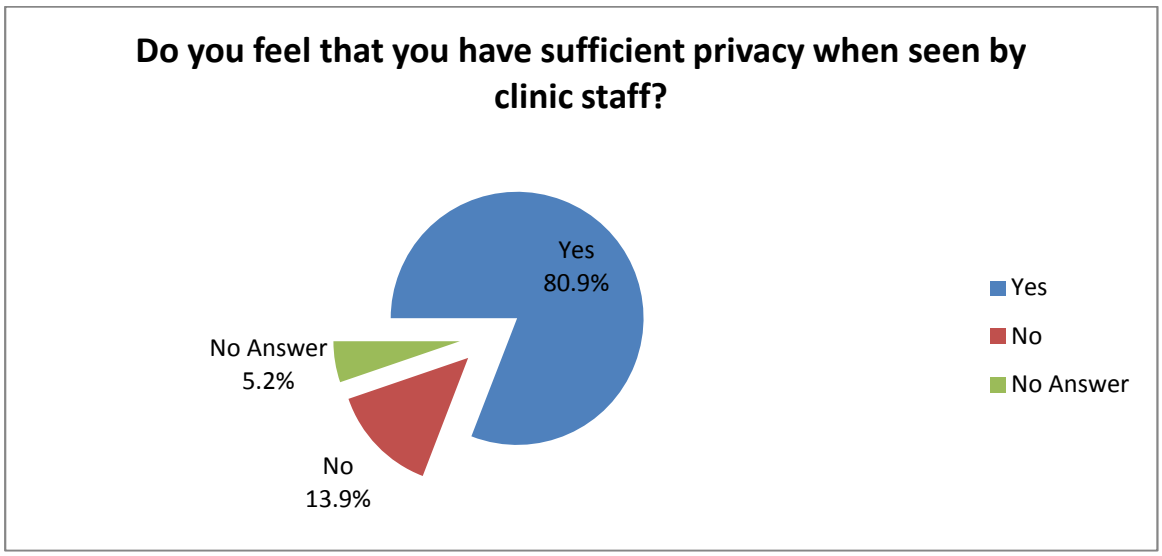
## Time & Venue

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** | 06:00 | 24 hours |
| **Closing Times of Clinics** | 13:45 | 24 hours |
| **Time taken to Travel to Clinics** | 1 min | 210 min |
| **Cost of Travel to Clinics** | R0.00 | R50.00 |
| **Time Waiting to be Serviced after Arrival** | 1 min | 180 min |
| **Number of Days per Week that the clinic operates from the venue** | 5 days | 7 days |

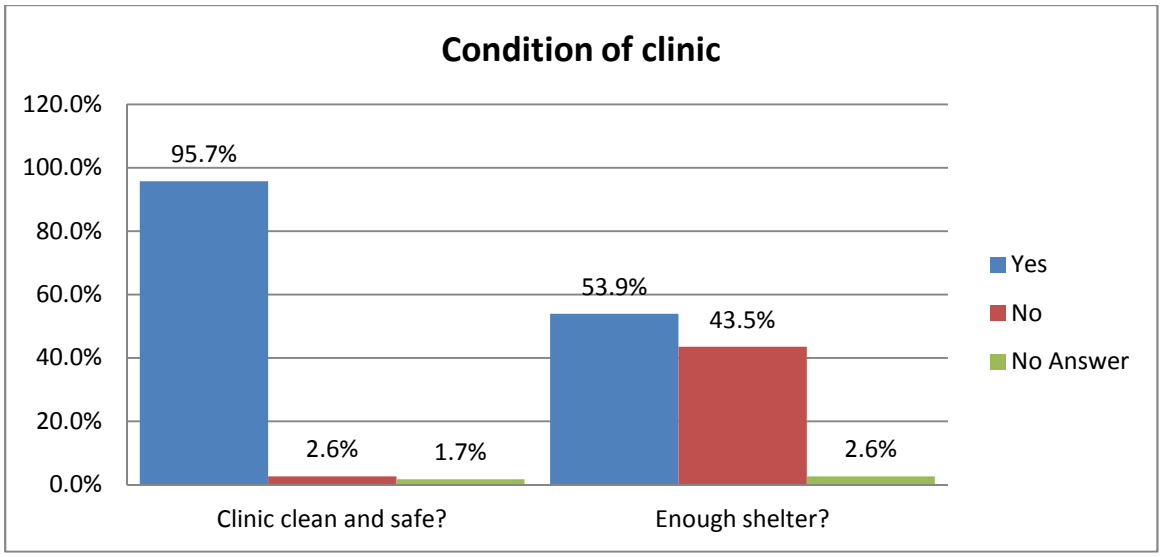



Most of the clinics opened at 07:00 and closed at 16:00. Most of the respondents said that the clinics were open five days per week. Most of the respondents took approximately 30 minutes to reach the clinic. However, there was a respondent at the Mbuzini in the Ehlanzeni district who said that it took her two and a half hours (210 minutes) to reach the clinic. The cost of travel ranged from R0.00 to R50.00, with most of the respondents not having expenses related to travel to the clinics.




The majority of the respondents (80.9%) felt that they had sufficient privacy when seen by clinic staff. The 16 respondents who felt that there was not sufficient privacy when they were seen by clinic staff were from the following clinics; Ka-Bokwani HBC, Maviljan, Mbangwane, Sibuyile, Tonga

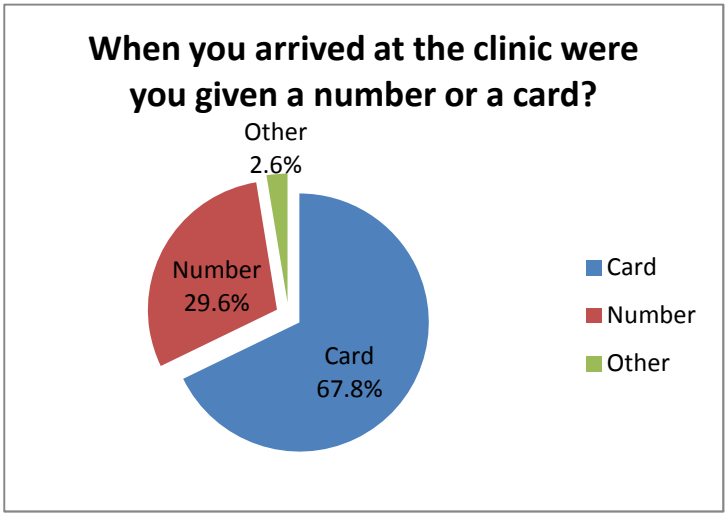
and Zwelisha clinics in Ehlanzeni; the Leandra Community Health Centre in Gert Sibande; and the Tweefontein C clinic in Nkangala.




The majority of the respondents (95.7%) 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 53.9% feeling that there was enough shelter. It should be noted that 43.5% felt that there was NOT enough shelter.

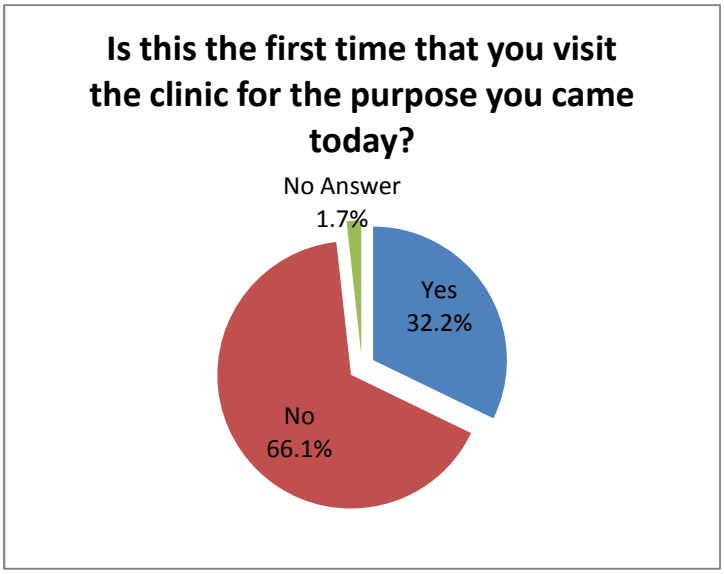
## Healthcare Processing

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

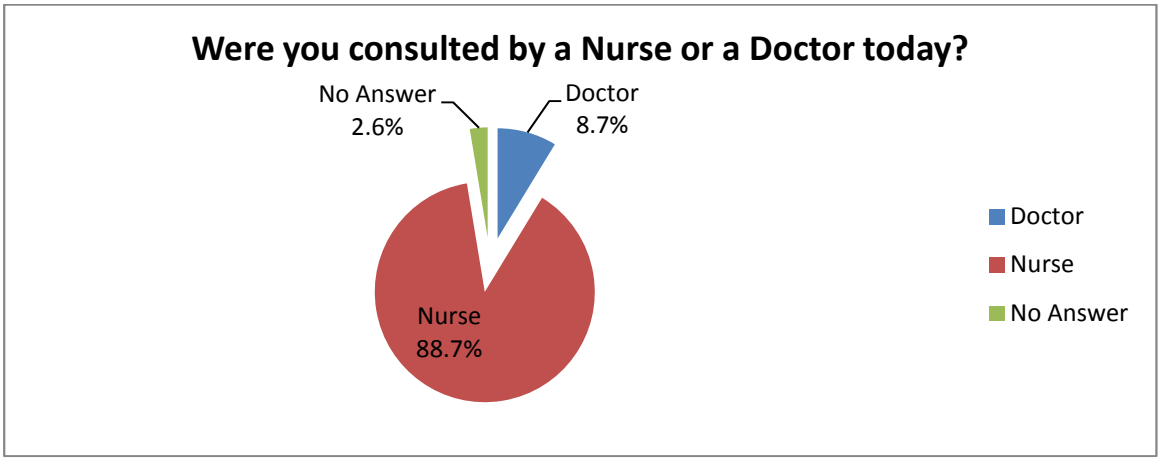



The respondents who were not given a number or card said that they had to wait in queue. For respondents who received a card, the monitors asked whether the card was a different colour than the cards of other patients at the clinic. 42.3% of the respondents said that this was indeed true for them. This 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.

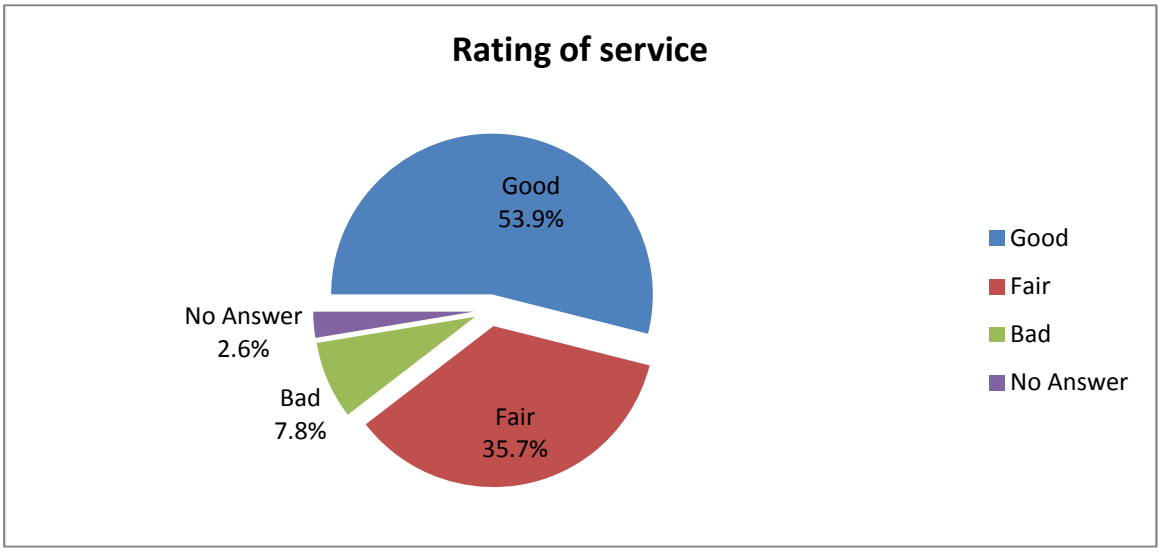
Approximately a third of the respondents (66.1%) were at the clinic for a return visit. Three respondents stated that they stated that they had to return 10 times. They were all in the Ehlanzeni district. Two of these respondents were there because there was a reoccurring of what was affecting them. The other was collecting anti-retroviral drugs.



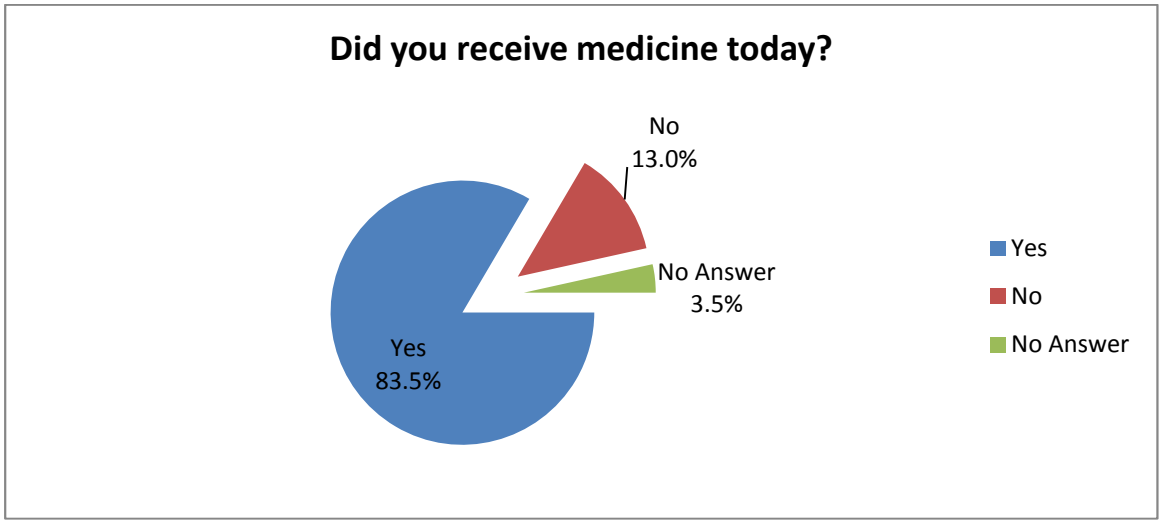

Some of the other reasons that the patients returning to the clinic include that they were there for a check-up and treatment. A large percentage of respondents had to pick up prescription medication. Contraception, family planning and pregnancy monitoring was also stated for a reason for returning. One respondent had to return because the doctor was not there on his previous visit. A respondent at Masibekela Clinic in Ehlanzeni said, "I like their service".



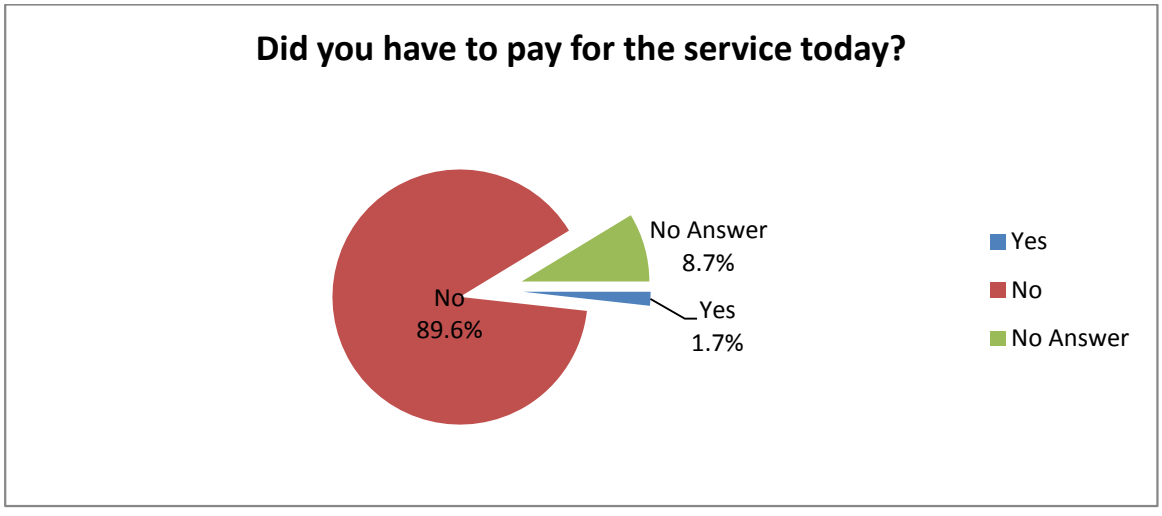

The majority of the respondents (88.7%) were consulted by a nurse. 52.2% of the respondents were seen by the same nurse or doctor that they had previously seen. The respondents were also asked if the consultation was in private. Most (91.3%) said that this was the case, but 7.0% said that they were not 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. The respondents who rated the service as fair said that they had to wait a long time. Also, they complained that there were a lack of medication and only 10 patients were seen. There were also complaints about nurses' attitudes and a lack of privacy. The main reason for rating the services as bad was because of the attitudes of the doctors or nurses. There were also complaints about the length of time that they had to wait and the lack of privacy. One respondent at Sibuyile clinic in Ehlanzeni stated that "Every time they give me a date to come back and collect my ARV they say they don't have".




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 shorted period that a patient had to wait was 1 minute, the longest being 3 hours (180 minutes). The latter was a respondent at the Clau-Clau clinic in Ehlanzeni.




Only two of the 72 respondents said that they had to pay for the services that they had received. The one respondent was at the Eerstehoek clinic, Gert Sibande district and the other was at the

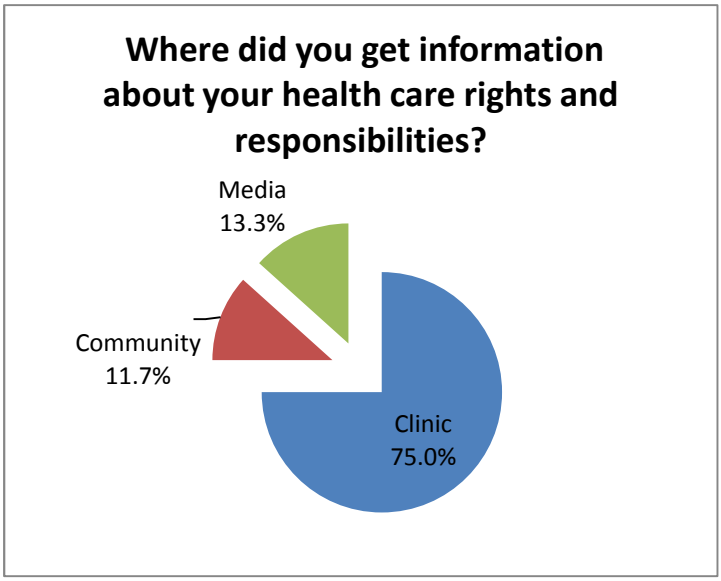
Malekutu clinic, Ehlanzeni. The respondents were also asked if they were aware of the costs before receiving the service. The answer was 'no' for 35.7% of the respondents, 18.3% of the respondent were aware of the cost and 46.1% did not answer the question.

## 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?** | 68.7% |
| **Did you know that you may refuse treatment (verbally or in writing) provided that this does not endanger the health of others?** | 53.0% |
| **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?** | 58.3% |
| **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?** | 53.0% |
| **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?** | 50.4% |
| **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?** | 53.9% |

The majority of the respondents in Mpumalanga were aware of the rights, although in all cases this was barely above 50%. Only 38.3% of the respondents have ever been asked their view on how to improve health services.




For three quarters (75.0%) of the respondents they received information about their health care rights and responsibilities from clinics. The media informed 13.3% and the community the remaining 11.7% The respondents were asked whether they received the information in their mother tongue, or a language which they were comfortable with. For 75.7% of the respondents, they did indeed receive the information in their spoken language.

| 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** | 44.3% |
| • **To comply with the prescribed treatment and/or rehabilitation procedures** | 49.6% |
| • **To enquire about the related costs of treatment and/or rehabilitation and to arrange for payment** | 43.5% |

| | |
|---|---|
| • **To take care of health records in your possession** | 63.5% |
| • **To take care of your health** | 68.7% |
| • **To care for and protect the environment** | 70.4% |
| • **To respect the rights of other patients and health providers** | 71.3% |
| • **To utilise the health care system properly and not abuse it** | 71.3% |
| • **To know your local health services and what they offer** | 61.7% |
| • **To provide health care providers with the relevant and accurate information for diagnostic, treatment, rehabilitation or counselling purposes** | 64.3% |

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

- To advise the healthcare providers on their wishes with regard to their death.
- To comply with the prescribed treatment and/or rehabilitation procedures.
- 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**:

- "Nurses cry with work load because of staff shortage"
- "Shortage of staff (nurses) because it's in a rural community of Nkomazi."
- "Shortage of nursing staff because it's next to RSA and Mozambique border."
- "At the maternity ward there was a shortage of staff and the patients wait for long to be serviced. There was only one nurse who attended to them at the PMTCT (Prevention of Mother to Child Transmission), they were not sure about the times of working at the clinic and some of them did not know about their rights to complain and how to complain because they only focused to be helped and go back home."
- "Lack of nurses cause people to sit long because lot of people come to the clinic for their health problems. Lack of information and most of the medicine is written in English and some people they don't know how to read and may be they took the medicines in a wrong way."
- "Long queues. The shelter is small."

Monitors also noted that there was a **shortage of particular types of personal**:

- "Pharmacists are in demand."
- "No dietician."
- "No social worker."

There was also a **lack of equipment and facilities** are certain clinics in Mpumalanga:

- "Admin clerk has no computers for data capturing."
- "Administrators have no computers for data filing."
- "Poor administration because no computers for data capturing."
- "Buildings must be renovated to accommodate more people. Shortage of medication. Improve ambulance services. The pharmacy is too small. Cards are different colours. All the staff takes

lunch at the same time leaving the patients waiting. The patients are not satisfied. Waiting a long time to see doctor/nurse to help them."

- "No toilet facilities to serve the disabled."
- "There is a shortage of shelter, small shelter. Shortage of medication. Service can be improved by the ambulance service. HBC should visit the farms more often as clinics are reaching these areas as often as they should. The toilets are unhygienic. They used without toilet papers. The toilets smell. The patients have to wait a long time to be served. Shortage of computers. The doctor comes one day per week and can't see all the patients. There was a serious fact that HBC are not funded for their voluntary work."
- "The patient was free and happy about the monitoring and the only problem is that he said there is no structure for them. They sat outside during rainy days and sunny days. No chairs to sit for them. When they must consult they use the structure where it is not safe. It is broken and those who are taking TB treatment they use the building where it was supposed to be the toilets."

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

- "Need health promoter for Health Education and Awareness."
- "There is a need for health promoter who shall assist with educating our community."
- "Community people need access. Information on health care information. Workshop is very important to the health people to know much more about health information and health status."
- "The information on the board must be written in different languages because some people they don't know to read other languages. There are some people coming from other countries. People coming from Maputo because here we are next to the Maputo Gate."
- "They must have a way people can know their rights especially rights of patient because some of the people they don't know about their rights."

Some monitors noted that **home based carers were not receiving any funding**:

- "HBC don't have stipend"
- "HBC have no funds."

The **distance that both the patients and the nurses need to travel to reach the clinic is quite far**:

- "Nurses Home is needed because they travelling more than 100km to and from work because they don't have accommodation., because they wish to work more hours but are paid and no accommodation at night."
- "Transport for people coming from the farming areas are a very big problem. Transport is not easily available. Shortage of medication. Waiting a long time to see doctor/nurse to help them."

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

- "All in all services are good."
- "At Gutshwa all the nurses were ready to start with their work and my client was open to talk and proud about the work that they do in the clinic. They start on time and also give lessons to their patients and the clinic was clean and it was safe for them to consult in each room."
- "Everything was in a good condition and the patient was attended to very well."
- "Nurse helpful and was treated with respect. Give good medication to treat disease."
- "Patients are satisfied with the cleanliness and hygiene of the facility and their accommodation. Waiting times and queues are managed."
- "Professional nurse give medicines prescribed according to treatment guidelines and patients are educated to understand."
- "The clinic at 07:00, all the officials were on time. I arrived at 07:16 we waited until 4 patients arrived then we start to pray and start working. One professional gave the health education to

the patient then she introduced me to them. Chairs were used for them to queue, not standing. The gate was kept close and the fence around the clinic. There is a security at the gate. Most patients arrived very late and by that time the professional finished the lecturing and was not going to repeat herself."

- "The clinic is a 24 hour clinic and it opens early at 6 'o clock. At first they pray and one of the staff teach the patients before they go to the consulting rooms. Their service is excellent, only there is a problem behind the clinic. The patients who collect the ARV'S got no proper structure, the shelter is broken and the secretary wrote a letter to the MEC of Health asking about the structure but he says that there is no budget. The people are queuing outside in the sunny days and rainy days. There is no shelter for them when they sit outside."
- "There are four waiting rooms for the patients. No patients have to queue outside. All four rooms have chairs. There is enough staff. E.g: 2 professional nurses, professional staff nurses, 2 auxiliary nurses, 1 cleaner, 2 security guards, 1 doctor that visits once a month."
- "You don't have to wait to get medicine because they give you immediately right after consultation."

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

- "At the clinic people were standing in some queues Voluntary Counselling and Testing (VCT) for children and those who are sick and the health professionals were at the meeting so people started to complain about time. Some says they woke up early but it took to long for them to be attended. At the VCT one of the patients complained that one nurse did ask her that if she did told her husband with her status in public. So there is no privacy that patients run away from their local clinic and go to the other clinics."
- "I was ashamed and worried about what they told me because I was sending my child to the clinic for such illness and instead of helping me or just say something they told me that there is nothing to give me for the child. I must go and buy a remedy for the child more especially if you bring a child with fever you get nothing. They are going to tell you that you are getting a grant for the child, go and buy a remedy for a child, that what they can tell you."
- "It was in the morning I wait and see that there is something wrong that day. At that moment people go outside and started singing songs that they do not want the manager of the clinic because the service is very poor. Sometimes they do not get their treatment on the same day they visit the clinic. They say it's a week now and still there is no ARV'S treatment at the clinic. So they suggested that the manager must go because she does not do her work properly."
- "The patient complained about medication and card for different colours from other patients."

"The patient supposed to start ARV's but when they give her the date to come and collect she don't get them. She even lose hope on starting them because her main concern is what if she has already started to drink them and only to find out when she is going to collect them, she can't get them. She is scared that she would die because if you default, you going to die."

"The staff was having breakfast during consultation period. One of the clients complained that the staff also come late at work and if they go for lunch or meeting they make them to wait too long at about hours. It is true because they were in their shelter while patients wait for them. Some of them were waiting outside with their children. There was no helping them at about an hour I stood inside where they were sitting and talk to one of the nurses about their work is where they start to work. The service is very poor."

## Recommendations from the Black Sash

The results of this report is 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.