BLACK SASH
MAKING HUMAN RIGHTS REAL

North West CMAP Healthcare Report Localised Study

June Wednesday 13th 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.*

This localised study was conducted at the Jouberton Clinic and Letsopa Clinic facilities in the Districts of Kenneth Kaunda and Dr Ruth Segmotsi Mompati over a 3 day period. The following data and methodology is inteneded to act as a guide to local advocacy networks who campaign for improved service delivery at a District level.

"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 North West.

- **Ben Kolojane** - Letsopa Advice Centre (North West)
- **Elroy Paulus and Monique Warden** – Black Sash Trust
- **Mr Jerry Sebothe** - Tshwaraganang HIV/AIDS (North West)
- **Eddie Mongala** – CMAP North West Province Fieldworker - Mafikeng

In addition we also wish to thank the local clinics and 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.

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.

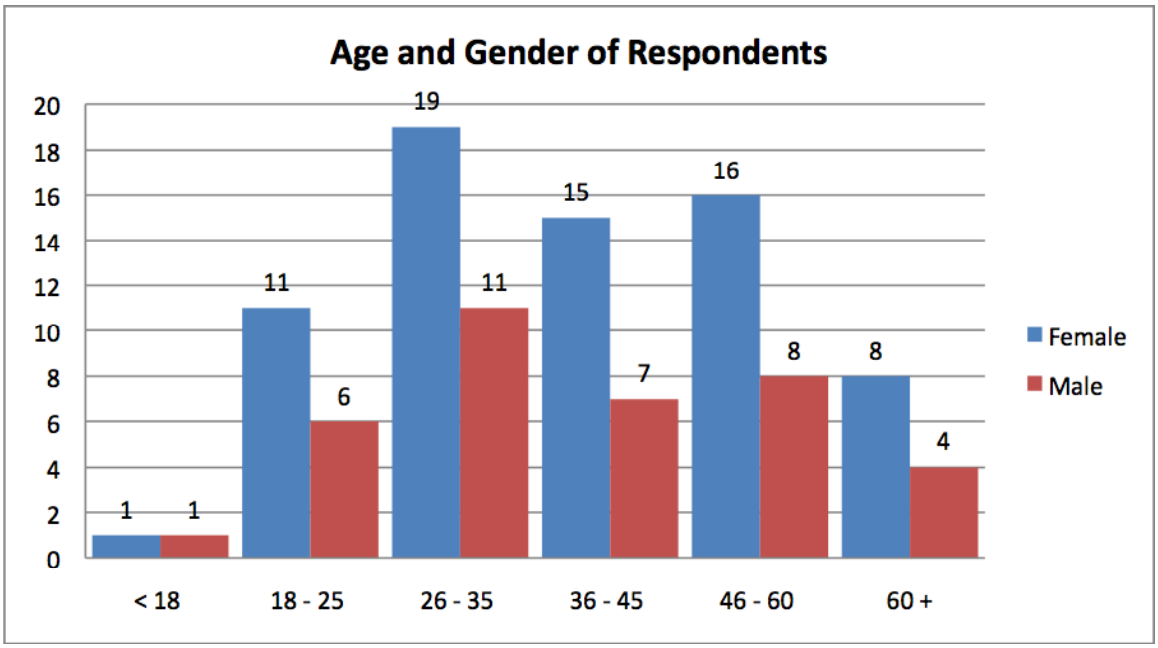
Monitors are selected by civil society networks; community based organisations and faith-based organisations and then trained to monitor selected public services using the monitoring tools. Each of these organisations have a CMAP memorandum of understanding with Black Sash to ensure mutual accountability 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 **Jouberton Clinic and Letsopa Clinic (City of Matlosana)** in the **Dr. Kenneth Kaunda District** and **in the Tswaing Local Municipality, within the Ngaka Modiri Molema District** has been monitored according to the following standardised entities: **time & venue**; **healthcare processing**; and **language & communication**. The monitoring took place during the period of **13th to 15th June 2012**. The findings presented in this report takes into account the experiences and opinions of **15 respondents** from **2 clinics** in **these districts**, at the Jouberton Clinic (10 respondents) and at the Letsopa Clinic (5 respondents).

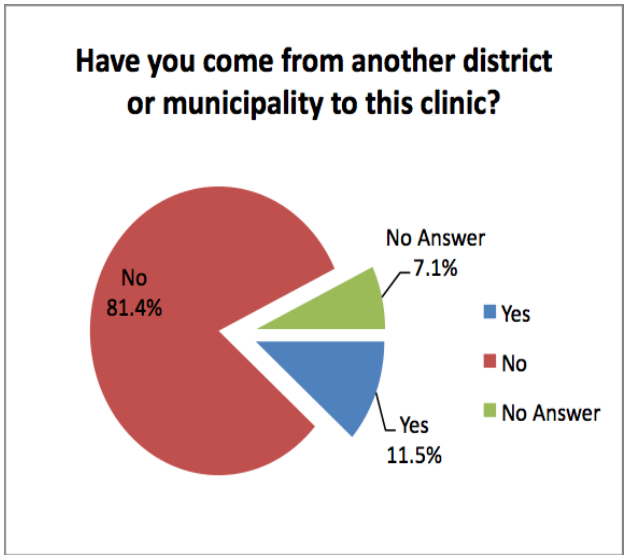


(above numbers are %'s – show numbers instead) . All of the respondents were South African citizens. The majority of respondents were female (53.3%) and in the age group 46-60 years old (33.3%).

Time & Venue

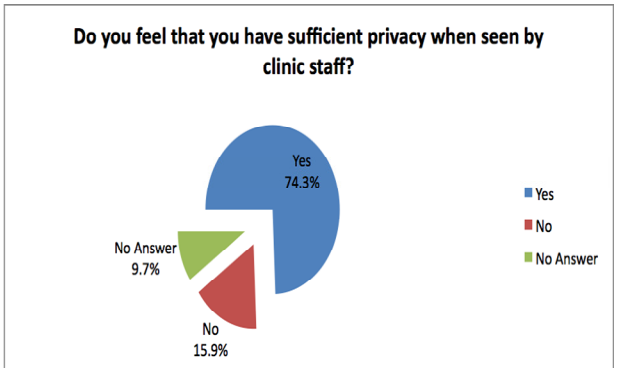
We looked at the opening and closing times of the clinics. The time and cost of travel to the clinics was also assessed. The venues that were monitored were also looked at in terms of privacy, cleanliness and facilities.

	Minimum	Maximum
Opening Times of Clinics	07:00	24 hours
Closing Times of Clinics	16:00	24 hours
Time taken to Travel to Clinics	10 min	120 min
Cost of Travel to Clinics	R0.00	R14.00
Time Waiting to be Serviced after Arrival	60 min	480 min (8 hours)
Number of Days per Week that the clinic operates from the venue	5 days	7 days



A large percentage of the interviewees (4 respondents) came from another municipality to access the clinics. (Some of them may have come from farms and a mine outside of Jouberton).

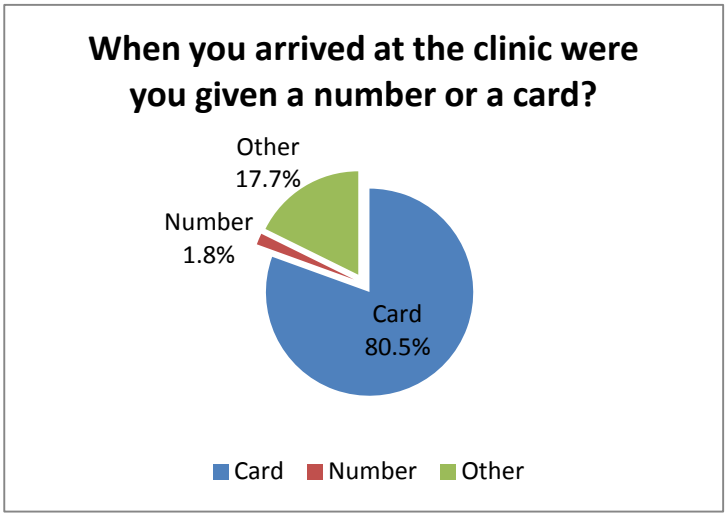
The majority of the respondents (73.3%) felt that they had sufficient privacy when seen by clinic staff. There were 4 respondents who felt that there was not sufficient privacy. These persons were seen by clinic staff that worked at both the Jouberton and Letsopa clinics. One of the respondents was a 60+year old female.



The majority of the respondents (73.3%) thought that the service in the clinic was provided in a clean and safe place, whilst slightly more respondents were satisfied with the amount of shelter, with 86.7% feeling that there was enough shelter.

Healthcare Processing

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



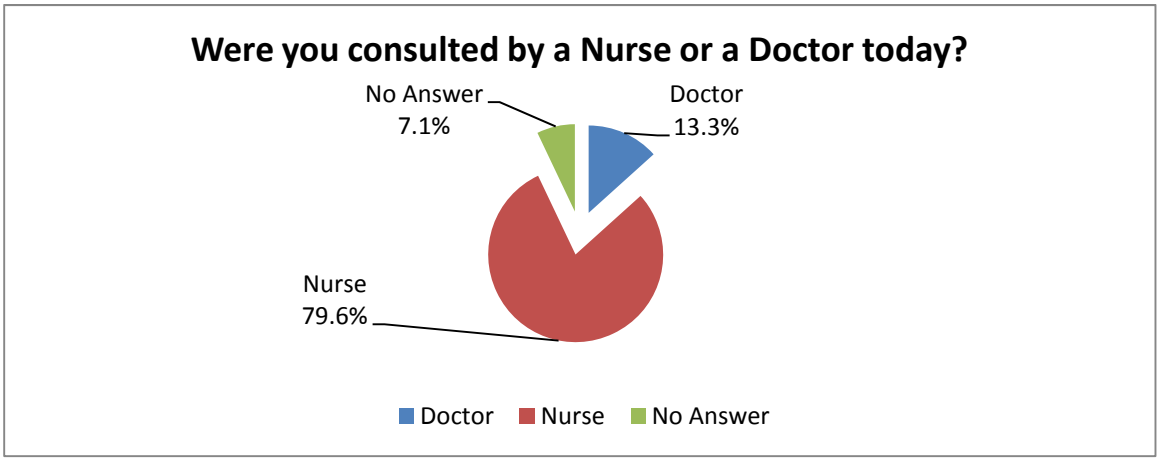
86.7% of respondents were given a card when they arrived at the clinic (Importantly, the other 13.3% were 2 non-answers).

The monitors asked whether the card was a different colour than the cards of other patients at the clinic, only 1 respondent answered that they had a different colour card but this was because she used her own book. This question is linked to issues of privacy and confidentiality. At the Jouberton clinic – we found and spoke to several patients who were instructed to purchase a book, which required to be brought along with them at every clinic visit.

A colour coded system could mean that other patients are aware of the medical reason for the visit to the clinic. But that does not seem to be a problem in this set of responses.

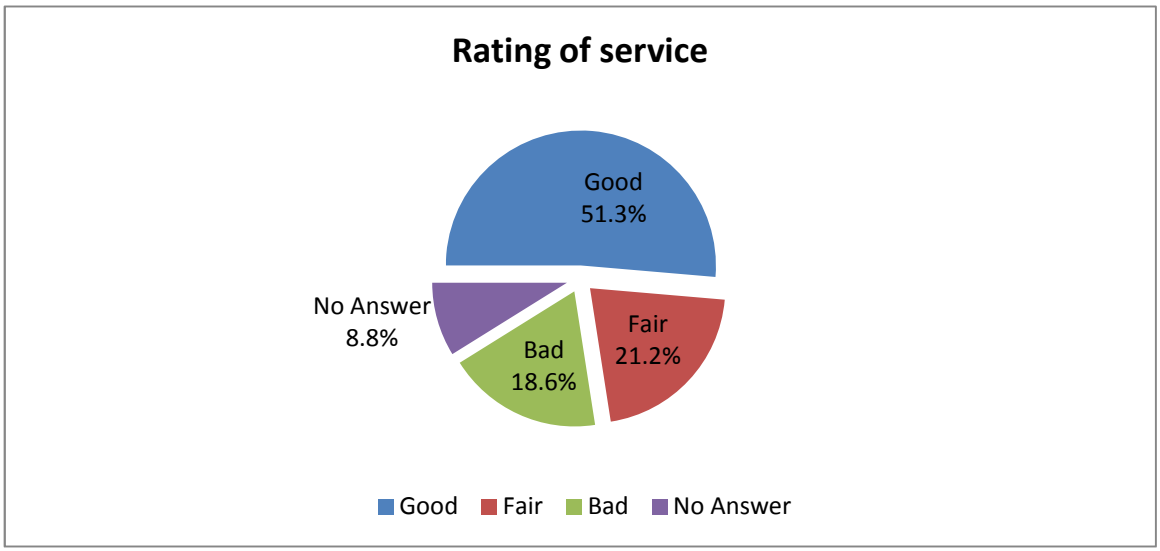
Approximately two-thirds of the respondents (66.7%) were at the clinic for a return visit. Of these, only 3 respondents gave a reason, one had returned 6 times, one answered "many times' and the third returned on a monthly basis. The reasons for needing to return included:

- a failure to get medication at the previous visit,
- one respondent returned to get test results, and
- in 5 cases respondents returned for treatment.
- One respondent returned for a TB check up.



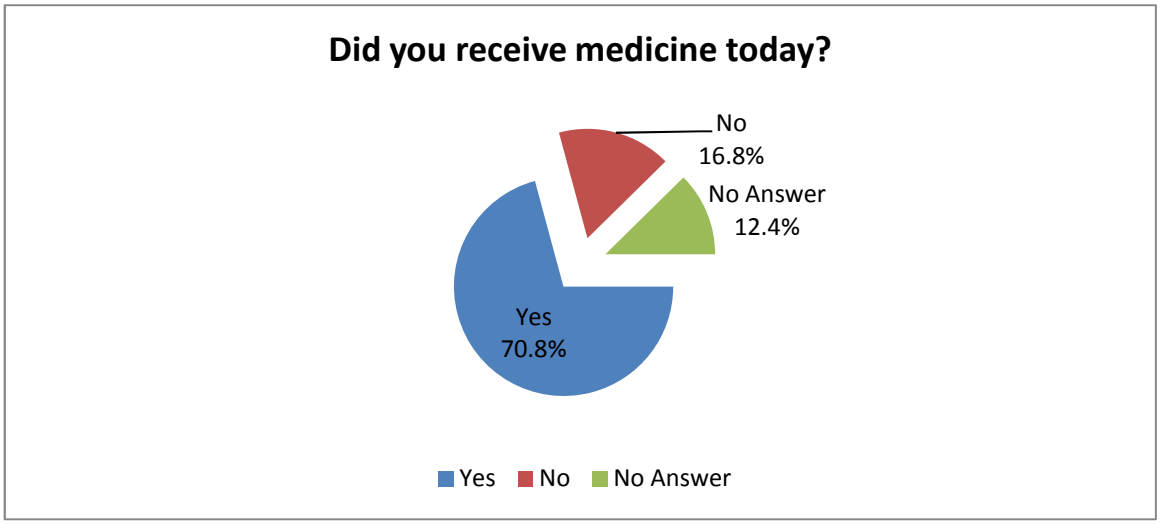
The majority of the respondents (66.7%) were consulted by a nurse. 86.7% of the respondents were seen by the same nurse or doctor that they had previously seen. The respondents were also asked if

the consultation was in private. Most (80%) said that this was the case, but 13.3% (2 respondents) said that they were not consulted in private.



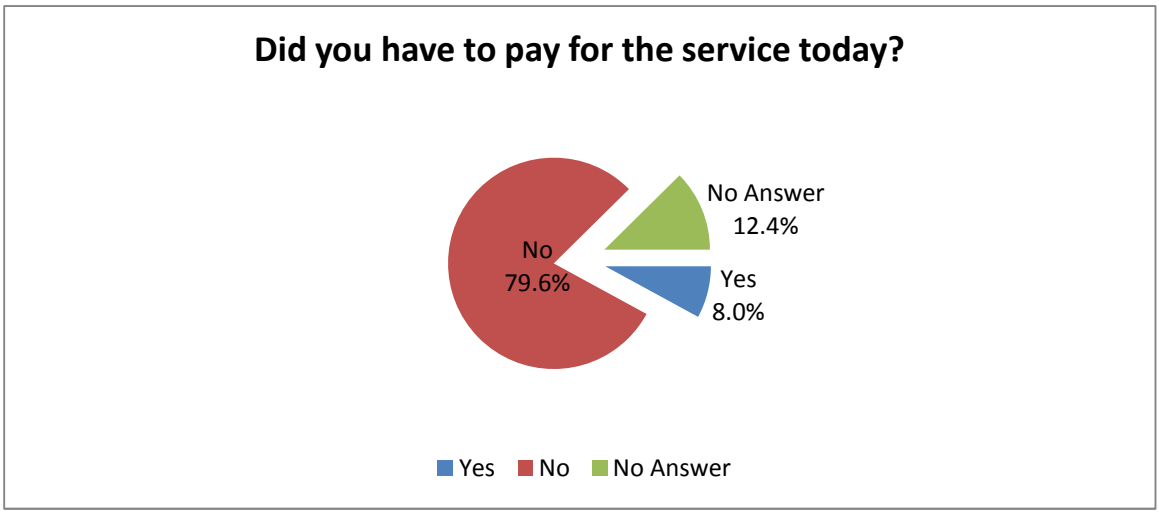
After being asked to rate the service received, the respondents were asked why they rated it in this manner. Those who rated the service as 'Bad' commented on the manner of nurses: "*The service we get is bad. Bad behaviour of some nurses"; They shout at us"; "Lost my file so no treatment"; "My privacy was violated."*

One further unsatisfied respondent noted that the *"Treatment sometimes don't do good in my body."* In contrast, those who felt they had received a good service commented on the respectful or positive way they were treated, and on the effectiveness of the treatment they were given. Those who rated the service as 'Fair' noted that the staff members were always in a hurry and another felt the medication was not effective enough as sometimes it did not work.



The respondents who did not receive their medication were asked why this was the case, and they were all still in a queue waiting for it. One respondent noted that while they had received their medication they had not received their results. 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, whilst the longest was an entire day (8hours)! Respondents noted, when they were asked about waiting times, that the total time they had to wait at the clinic including waiting for a consultation and then waiting for medication or that the waiting was excessive. One waited in total for over 300 minutes, another for 480 minutes and a third for 420 minutes. One respondent was still waiting at 12:05pm having arrived at the clinic at 06:30am.



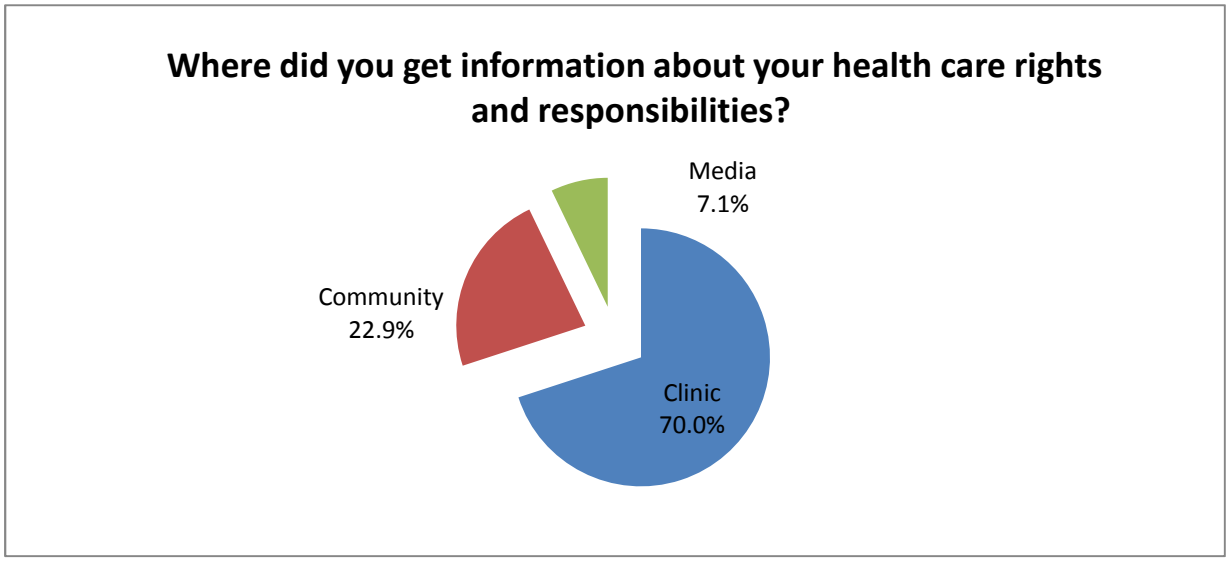
None of the respondents stated that they had to pay for the services that they had received. The respondents were also asked if they were aware of the costs before receiving the service.

Language & Communication

This looks at whether or not the official languages are spoken by the clinic staff. 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?	73.3%
Did you know that you may refuse treatment (verbally or in writing) provided that this does not endanger the health of others?	60%
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?	73.3%
Have you ever been asked your view on how to make health services better?	46.7%
Do you know that you have the right to be referred for a second opinion to a health provider of your choice?	46.7%
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?	46.7%
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?	53.3%

The majority of the respondents at these clinics were aware of some of their rights as patients, although on some aspects, in particular around referrals and feedback on the quality of the services provided, was barely above 50%.



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	46.7%
• To comply with the prescribed treatment and/or rehabilitation procedures	73.3%
• To enquire about the related costs of treatment and/or rehabilitation and to arrange for payment	40%
• To take care of health records in your possession	66.7%
• To take care of your health	80%
• To care for and protect the environment	80%
• To respect the rights of other patients and health providers	86.7%
• To utilise the health care system properly and not abuse it	80%
• To know your local health services and what they offer	80%
• To provide health care providers with the relevant and accurate information for diagnostic, treatment, rehabilitation or counselling purposes	73.3%

Generally the respondents were aware of their healthcare responsibilites. However, for the following rights 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

"Patients others complain that they pay for clinic books they should buy themselves.
Some patients say they sometimes shout at them. Other patients say they sometimes leave her and assist other patients or just left them there, later come not telling her the reason for not leaving her there."

"A patient complains the doctor see after six months. They always been sent back to come for treatment they don't have. Most information as a patient I only have received from Tshepong hospital not at this clinic."

"In an conversation with the NW Department of Health's transporter team we saw and learnt of queue education where these staff were encouraging people not to abuse ambulances – that are for emergencies, but use patient transport facilities instead." However there was just one such vehicle.

Language was a real problem in some interviews. In some interviews where this was a problem, it was facilitated by a Tswana speaking CMAP monitor.

We learnt of some "shortcoming in the questionnaire. It does not have questions with regards to special arrangements for children, disabled, pregnant women and senior citizens."

"Often in winter there is a long line. Patients have to wait outside in the cold, no chairs.

We noted that the "Interviewee once put a suggestion in the suggestion box, the reaction was not good and they complained that they were treated badly."

Some interviewees say that the "treatment is ok but the problem is that we wait too long to be examined by the doctor and too long to wait for our medications".

Patients are being treated by various doctors and there are translators for Xhosa, Zulu and Tswana.

A patient did not feel free to give relevant/adequate information – i.e. did not feel free to speak freely inside the clinic..

We sensed that some patients were scared. It appeared that some patients must be encouraged before they go or get examined by the doctor. Sometimes people go home without being seen by the doctor.

On a positive note, others felt that the children section and the person who are consulted alone worked better.

One monitor spoke to a person "who was giving me information as an employee. He did not want people to be suspicious. The time nurses saw him talking to me, he then suddenly he went to assist patients. We did not finish our conversation."

Some patients had to buy books and doctors and nurses to write in when patients come to be seen.

For cards, we learnt that a blue card was for Epilepsy; a white card = from /for hospital

The idea of a 24 hour service was questioned. It became clear that Monday to Fridays included services for patients that need treatment, but that Saturdays and Sundays were only for patients who are stabbed or in accidents.

Some felt that the "service is bad in this main clinic. Patients no longer come to this clinic. Instead they go to other local clinics. They open at 07h00 but nurses started to work on 08h30."

Another patient said the clinic opens 24 hours for pregnant women, not for other illnesses.

In most cases, patients who speak English received better treatment from Dr ___. However, he got annoyed when nurses interpret for him.

One monitor felt that "The majority of patients do not know their rights because most of them where there is no problem when they are regularly treated. They need to be sensitized about their rights. According to this patient only a few nurses are following Batho Pele principles.
Another monitor said "You have to come early for chairs."

Others reported that patients "use the same card but the difference is HIV/AIDS consulting room is called a secret room. It is easy for you to detect people who are HIV and AIDS and those of sugar diabetes, HBP and other diseases".

People reported that "In winter people had to stay outside,…. disabled and elderly people".

On the issue of privacy, because the door was open and patients on the line could hear everything.

A monitor reported that "Patients came from 05h00 in the morning to avoid long queue. But it does not work. There are some patients who should be seen by doctor. It is alleged that "at 15h50 nurses will tell them the doctor is sleeping". We don't know when he is coming back home and the doctor comes back the next morning – and the patient is told" to come back on a future date.

Recommendations from the Black Sash

The Black Sash will make recommendations based on perusal of the provincial report. We do hope however that the issues raised in this very specific report will be addressed. General recommendations (as per the NW Report) are included below:

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.