

**SECOND CARNEGIE INQUIRY INTO POVERTY
AND DEVELOPMENT IN SOUTHERN AFRICA**

How well do our rural
clinics function?

by

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PREFACE

Gazankulu is one of South Africa's so-called "black states". The Mhala district is an isolated island midway between Nelspruit and Tzaneen. It is typical bushveld with limited water and poor agricultural potential. 152,000 people live in Mhala's 57 villages which vary in size and infrastructure. Health services are underdeveloped and comprise one 280-bed hospital (Tintswalo), one health centre, ten clinics and a mobile clinic.

Why did Wits Medical School become involved here? It was by both design and fate. At Wits we had people interested in rural health and a benefactor (Anglo American Chairman's Fund) prepared to sponsor rural health work. The government has encouraged the various medical schools to become involved in rural health care and has designated schools to particular "homelands".

So we became involved in Gazankulu and the Health Services Development Unit (HSDU), a project of the Wits Department of Community Health, was established. The objectives of the Unit are the training of appropriate health service staff, the expansion and development of clinic services and the creation of a health service which is community supportive and responsive to local needs. To succeed we need the goodwill, support and respect of the community and the wholehearted backing of the existing health service.

This paper and the others of the HSDU are reflections, analyses, recommendations and ideas and are the product of our first two years' experience. Opinions expressed are based on the critical analysis of hard data on the one hand and on personal impressions on the other. Whatever the opinion, it has been acquired by first hand and sustained personal experience.

The papers cover three aspects of our experience:

1. The State of Health and Health Care in Mhala
 - a. Health and Health Care in Mhala : an overview.
 - b. The Nutritional Status of Children 1 - 5 years.
2. A Critique of Some Health Service Interventions in Mhala
 - a. Community Health Workers in Mhala : Perversion of a Progressive Concept?
 - b. How well do our Rural Clinics Function?
 - c. Reviewing the Health Centre Policy.
 - d. Mobile Clinics : What can and do they Achieve?
3. Health Service Interventions by the Wits HSDU
 - a. Do Primary Health Care Nurses in Gazankulu provide Second Class Cheap Care to the Poor?
 - b. Can good Tuberculosis Services be provided in the Face of Poverty?
 - c. School Health Services : Problems and Prospects.
 - d. Mass Immunisation Campaigns - The Tintswalo Experience.

The message is that:

- Health care in Mhala is inadequate.
- This care can be improved without preceding changes in the present economic and political systems.
- Such improvement is limited by social, economic and political constraints which are the root cause of much illness.
- It is worth working in "homeland" health services because of what can be achieved.

In acknowledging all who have worked in or with HSDU it must be remembered that health service development is a team effort. Many of the people of Mhala, the hospital staff, primarily Dave Stephenson as superintendent and the community health nurses, Dr Erica Sutter and the superintendents and staff of Gazankulu's other hospitals, the health department led by Dr Roos and, more recently, Dr Robert, and the Chief Minister of Gazankulu have all contributed to the establishment and development of the Unit. The Chairman's Fund of Anglo American and the University of the Witwatersrand have provided the infrastructure.

The action has come from Anita and Bob Backentose, Eric Such, Rob Collins, Cedric de Beer, Clive Evian, Vic Gordeuk, Merryl Hammond, Theko Maluleka, Shirley Maswanganyi, Semlesine Mtswa, Dipuo Moseue, Robert Waugh and Merrick Zwarenstein.

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HOW WELL DO OUR RURAL CLINICS FUNCTION?

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INTRODUCTION

There are 10 clinics in the Mhala district of Gazankulu. Together with Tintswalo hospital and Agincourt Health Centre they serve 152 000 people living in 57 villages spread over 1 204 sq km.

Clinics have an important role to play in the delivery of health services in rural areas. There is more to a clinic service than a building with a nurse in it. It should provide adequate primary health care for the community that it serves. The primary health care approach, based on the W.H.O definition of primary health care adopted at Alma Ata, recognises six basic criteria that a health service, and hence a clinic service, should match. (1) These are that:

- a. Essential care of a high quality is provided.
- b. Services are well supported by the base hospital.
- c. Services are accessible to the community.
- d. The health care team approach is used.
- e. The community participates in the service.
- f. The health service provides more than just medical care.

Each of these will be considered in more detail later. For now, let us say that a service that does not match these criteria is providing second class care. If this inadequate service is provided for some citizens of a country, while others get better care; this amounts to "second class care for second class citizens". (2)

With these six criteria in mind we set out to review our clinic services.

HOW WELL DO OUR RURAL CLINICS FUNCTION?

DO OUR CLINICS PROVIDE ESSENTIAL CARE OF A HIGH QUALITY:

The declaration of Alma Ata defined a number of essential areas of care. (1) Clinics contribute to this by providing appropriate treatment of disease and good ante-natal, child health and family planning services at the clinic. The clinic staff should also move beyond the confines of their clinic building to promote food supply and proper nutrition, an adequate supply of safe water, basic sanitation, and control of locally endemic diseases.

Not only should clinics be active in these areas, but their work should be of a high quality.

Care provided within the clinic

Treatment of common diseases

The clinics see an average of 22 ill people per day. No staff member has ever been trained to diagnose and treat illnesses. They are unable to examine patients, and there are no guidelines for treatment. Most treatment is a response to the patient's main symptom. For example, coughs get cough mixture and diarrhoeas diarrhoea mixture. As these symptoms have many causes, each needing their own treatment, this is not satisfactory. This approach has been called "hit and miss" care - the nurse tries to hit, but often misses.

The registered nurse does better than the nursing assistant, whose hospital based training equips her for menial tasks only such as taking temperatures, feeding patients and carrying bedpans. These nursing assistants are often responsible for diagnosis and treatment, as the registered nurse is away from her clinic at least 135 days each year (for days off, leave, illness, etc).

Appropriate treatment is further limited by clinics running out of drugs and not having adequate equipment. These factors will be considered further later.

As a result of all these problems, many patients remain without the treatment they need.

Child health, ante-natal and family planning services

Our mother and child health services have many gaps.

Child health clinics have become a meaningless routine where processes are mechanically carried out. This is not appropriate as child health clinics are supposed to find and respond to problems, and build good relationships with mothers. Relationship problems are considered later under 'alienation'.

Weighing is practiced as a ritual from which mothers are excluded. Weights are read behind the scale and then charted on to a graph which mothers can't read. Inadequate growth leads to no response from the health service except maybe a scolding for the mother. Screening for disease does not check for all the problems that it should. What is done, is done poorly, and so problems are missed. The educational component of the service is based on a single lecture to all the mothers. The nurse imparts information to passive listeners. Concentration is poor, as many cannot hear, few teaching aids are used and no questions are asked. In the end, the child has really only gained an immunisation, and this only if he was due for one and the vaccine was still good.

Ante-natal clinics have similar problems. Those related to education and relationships between staff and patients are similar to those at the child health clinics and don't need repetition. There are no written guidelines for action to take if problems are found on screening. Necessary laboratory tests, such as those for anaemia and syphilis, are not done. The service is out of touch with the reality that its patients face. For example, most mothers will deliver at home without the assistance of a health worker, but the health service does not teach mothers how to prepare for or carry out an adequate home delivery.

Family planning services are run on Thursdays only. As family planning is still a controversial subject some women have expressed concern about being seen going to the clinic on this day. Women who do go will not receive adequate advice. One result is that depopovera injections, even in young women, remain the most commonly used contraceptive.

Care in the community

Besides the odd lecture at child health services, our clinics are not involved in promoting food supply, proper nutrition, an adequate supply of safe water, basic sanitation or control of locally endemic diseases.

ARE THE SERVICES WELL SUPPORTED BY THE BASE HOSPITAL?

To function effectively clinics need good support from their base hospital. There should be adequate communication, transport and referral systems. Supervision from doctors and senior nurses should improve workers motivation and job performance. Continuing education programmes are needed for each staff category. A sound ordering and distributing system is needed to ensure that clinics receive adequate drugs and equipment.

Communication, transport and referral systems

Until recently communication with Tintswalo was based on a slow telephone service that was often out of order. One of the results was that nurses could not request advice or an ambulance in emergencies. Communication has recently been improved by the installation of radios.

Tintswalo only has 10 vehicles. As few of these are available for clinic related work, supplies are delayed and supervisory visits blocked. There is no transport for clinic staff to do community work.

Referral of patients is hampered by these communication and transport problems, and also by hospital staff not giving feedback on referred patients.

Supervision

There is too little supervision because of the public health nurses' enormous workload. The supervision that there is, is inadequate because of its "policeman-like" nature, where the objective is to "catch out" the subordinates, rather than to try to help and motivate them. Advice on improving the quality of care, eliminating wasted time, and simplifying work remains an unmet need. There is inadequate emotional support, understanding of difficulties and recognition of good work. "Specialist" support is provided by visits from doctors and psychiatric nurses. Unfortunately our only ophthalmic nurse is hospital based.

Continuing education

Until recently when we started a monthly in service course for clinic sisters there had been no continuing education for more than a year. There is still none for nursing assistants or "cleaners".

Drugs and equipment

Patients may not get the drugs they need. This is because clinics do not have an adequate range of drugs or guidelines for their appropriate use, and because there are problems with the supply system. (More than half our clinics run out of drugs each month).

Clinics have a fair range of equipment, but there is no standard list and there are shortages. Shortages are particularly serious when they involve essential equipment such as that needed for resuscitation of newborn babies.

The absence of adequate maintenance and repair systems also leads to equipment problems. For example, in January 3 fridges were broken (and not fixed for the whole month) and another 3 clinics were without gas for their fridges for more than two weeks. When this happens the clinic's vaccine gets hot and becomes ineffective. (Polio vaccine collected from six of our clinics during the polio epidemic had less than the number of living viruses necessary for it to be effective).

ARE CLINIC SERVICES ACCESSIBLE TO THE COMMUNITY?

A service that is accessible to people will be less than 5 km from them, and will provide care at all times and at a cost within their means. Staff behaviour will not alienate people from the service.

Unfortunately, problems related to distance, time, cost, and alienation tend to restrict access. Let us consider each in turn.

Distance

Distance has an impact on attendance because more than half the people of Mhala live further than 5 km from their nearest clinic, and transport services are inadequate and expensive. There is no bus service. Taxi fares range from 40c to R5.00 for a return trip to the nearest clinic.

Distance affects attendance for both curative and preventive care. Most ill patients come from the village that the clinic is in, and attendance decreases as the villages get further away. Preventive services are worse affected, because there is no urgent reason to attend. Why should a mother understand the need to walk 10 or 20 km with her child to get an injection (immunisation) when the child is well. She is probably not even aware of the need, as our health education programme does not reach into the villages.

Time

We see far fewer patients at night than we estimate need care because the very high costs of night transport (R10.00 - R20.00 a trip) and the 5 p.m. closing time inhibit access to the clinics. If the nurse is not available patients face the further expense of reaching the hospital (R10.00 to R80.00 a trip).

Cost

The drop in clinic attendance when fees were raised (Table I) and the finding that attendance in the first week of the month is double that of the other weeks shows that the cost of care is beyond the means of our community.

TABLE I
CLINIC ATTENDANCE IN THE YEAR BEFORE AND AFTER THE FEE INCREASE
IN OCTOBER 1982

Category of care	Cost before increase	Cost after increase	Attendance	Comments
Ill patients	80	R2.00	- 26,0%	-
Ante-natal care	R4.00	R8.00	- 1,4%	The drop is less than expected as most clinics did not increase their fees.
Child health clinic	Free	Free	+ 1,2%	In spite of 3 mass immunisation campaigns.
Family Planning	Free	Free	+ 34,5%	-

The 26,0% drop in attendance by ill patients is of special concern. It cannot be explained by changing disease patterns and therefore indicates that our community cannot afford the increase. In contrast, attendance at free services grew.

Illness is not more prevalent in the first week of every month. The double attendance in the first week is explained by people having more money early in the month, and then don't even have enough money left to buy health care.

Alienation

If patients feel alienated from the clinics less people will seek care. To prevent alienation clinic staff should ensure that they have a good relationship with their patients, that they inform them adequately, that traditional beliefs are respected, and that there is no elitism in their behaviour. Unfortunately, our clinic staff tend to behave in a way that increases alienation, (see Table II below). Their behaviour is particularly harmful because it leads to a systematic exclusion of the illiterate and the poor from the health service.

TABLE II
THE IMPACT OF CLINIC STAFF BEHAVIOUR ON PATIENT ALIENATION

Category	Lessens Alienation	Increases Alienation
<p>Relationship between health worker and patient.</p> <p>Nurses information to patients.</p>	<p>Patients welcomed and thanked for coming.</p> <p>Patients feel comfortable and free to ask questions</p> <p>Patients show emotion.</p> <p>Patients like the nurse.</p> <p>Gives extensive information to patients.</p> <p>Uses simple words.</p> <p>Explains what is wrong, why medicines are needed, and how they will work.</p> <p>Explains what she is doing.</p>	<p>Patients treated as another unwelcome addition to the day's burden.</p> <p>Patients feel insecure and ill at ease.</p> <p>Patients hold their emotion back.</p> <p>Patients do not like the nurse.</p> <p>Does not inform patients.</p> <p>Uses big words.</p> <p>Told to take the medicine.</p> <p>Makes patients feel that what she is doing is above their ability to understand.</p>
<p>Traditional beliefs.</p>	<p>Respects customs and beliefs.</p> <p>Encourages helpful customs and beliefs, while respectfully discouraging harmful ones.</p>	<p>Thinks traditional customs and beliefs are backwards.</p> <p>Discourages all customs and beliefs, often rudely and mockingly.</p>
<p>Elitism</p>	<p>All patients wait their turn.</p> <p>Relates to patients as equals.</p> <p>Recognises the obstacles that face the poor, and tries to help.</p>	<p>Powerful people don't queue.</p> <p>Relates to patients as if they were inferior.</p> <p>Scolds mothers e.g. those whose children are malnourished, without considering their problems</p>

The proportion of need met

The problems of distance, time, cost and alienation from the service result in only a small percentage of the need for care being met (Table III below). Of particular concern is that these problems hit those who need health services most, the hardest - the poor.

TABLE III
PERCENTAGE OF NEED MET BY CLINICS IN MHALA

Category of care	Needs estimate based on	Need in Mhala	Total care delivered	% of need met
Ill patients	3 visits per person per annum	456 000	72 800	16,0
Ante-natal clinics	8 visits per pregnant woman	36 000	21 070	58,5
Deliveries	Number of births	4 500	570	12,8
Family planning	1 in 2 women of childbearing age attending 4 times per annum	60 000	3 540	5,9
Child health clinics	6 visits per under 5 child per annum	240 000	53 930	22,5
Home visits	1 visit per household per annum	50 600	1 580	3,1

It is important to recognise that the need for care is real and also that it is a fallacy that "rural people don't want our care". If steps are taken to overcome the accessibility barriers, then attendance will increase significantly. This was shown by the mass immunisation campaign when more than the official number of children were immunised. This service was accessible because free care became available in every village and some of the alienation was overcome by informing people well.

IS THE HEALTH CARE TEAM APPROACH FOLLOWED?

The health care team approach requires more than just amicable relationships between co-workers. A true health care team will have enough skilled workers who are appropriately selected, trained and supported. They will work together towards the same goals; with reasonable work conditions and with job satisfaction. Unfortunately, we are far from matching these criteria. Let us consider each in turn.

Enough skilled workers

Data presented earlier under "Do our clinics provide essential care of a high quality" showed that we do not have enough workers and that those that we do have are inadequately skilled. One further point. We only have 7 registered nurses working in our clinics. Our current need is for 20.

Appropriate selection and training and adequate support

Selection and training are inappropriate and support inadequate. Staff selection should be undertaken by the community, in conjunction with the health service. In practice, neither have much say because there are not enough candidates. Few nurses are willing to work in the clinics. (The reasons will be considered later).

The clinic staff are not trained for their job. The registered nurse has a hospital based training in "carrying out doctors' instructions". Her job in the clinic is very different - she must diagnose and treat illnesses and take decisions on her own. The nursing assistant, who often does registered nurses' work, is worse off. Her hospital based training only taught her to perform menial tasks such as carrying bedpans and feeding patients. Because of the workload on nursing staff the "cleaner" performs a number of nursing tasks. She could perform these well, if only she had been trained.

Support from Tintswalo for the clinics has already been extensively considered and shown to be inadequate.

Working together towards the same goals

Relationships in the clinic are usually amicable, but the registered nurse remains on top, and makes all the decisions. No goals are set, and there are no meetings to discuss the service.

Work conditions

Work conditions are poor. Housing is absent or inadequate, there is no overtime pay and the nurses are isolated. As a result of their isolation they miss out on peer support and continuing education, and maybe even promotion.

Job satisfaction

If we consider the clinic staffs workload, their lack of skill and support, and their work conditions, it is not surprising that job satisfaction is low. Little wonder that matrons complain that they have to push nurses to the clinics, rather than being able to select from people eager for these posts.

DOES THE COMMUNITY PARTICIPATE IN THE CLINIC SERVICE?

Communities, or their democratically elected representatives, should participate in planning, implementing and evaluating the clinics that serve them. This would ensure that their priorities are respected and their needs met.

Community participation

Community participation is limited to unelected tribal authorities and the few clinic committees that exist. Their role is limited, but when they do participate they may have a negative impact. This is borne out by a recent experience. A decision had to be made on the siting of the next health centre. Our Superintendent advised building it at Calcutta because it is far from any hospital and has the greatest need. The committee decided that the health centre should go to Thulamahashi; a township of the elite. Thulamahashi is much closer to the hospital and is the only place in Mhala with electricity and running water.

If people in Thulamahashi need care they simply get into their cars, or take one of the many taxis to the hospital.

We believe that communities should participate actively in the health service, but, unfortunately, the hierarchical social structures in Mhala are likely to inhibit appropriate forms of community participation for a long time yet.

ARE THE CLINICS PROVIDING MORE THAN JUST MEDICAL CARE?

Medical care alone will not result in good health in Mhala because the major diseases are those of poverty. Water, food, land, income, and employment are the main problems. The health service should therefore play its part in overcoming these causes of ill health.

Moving beyond medical care

As public servants clinic staff will not be able to tackle the social, economic and political factors at the root of ill health. However, there are still many contributions they can make. For example, they could help by pushing for repairs on broken water supplies, help people build pit latrines, set up buying co-operatives, and help people understand the causes of ill health.

The clinic staff are not active in these areas. They may give the odd lecture on good food or on how to chlorinate water, but lectures do not change the availability of either.

It is hardly surprising that clinic staff are only involved in medical care - this is how their role has been interpreted. Furthermore, their workload is already too large, and they have not been trained for the task.

CONCLUSION

We can conclude that our clinics do not function at all well because:

- a. They do not provide essential care and the care that is provided is not of high quality.
- b. Poor support from the hospital leads to inadequate referral and supervision, and shortages of drugs and equipment.
- c. Problems of distance, cost, time, and alienation make services inaccessible.
- d. Our workers are not functioning satisfactorily as the health care team approach is not practiced.
- e. The community participation that exists is probably of more harm than good.
- f. Clinics do not play their part in overcoming the basic causes of ill health.

We realise that this situation is very unsatisfactory and have started to improve things. A clinic sister training programme has begun, child health and ante-natal clinics are being upgraded, drug supply has been looked into, and radio communication has been installed. Primary health care nurses have started working in the clinics.

Unfortunately, improvements are an uphill battle. Our biggest problem is that we do not have the resources - manpower, money, or materials (e.g. transport, equipment) to develop our clinic services to the full. We are thus faced with the reality of too few clinics, and of clinics unable to provide the range and quality of care that they should. We are also faced with the problem that as we improve our services we will increase our patient numbers and our workload. This will put even more strain on our staff, our funds and our support system, and will in itself lead to a decrease in the quality of care.

In spite of the obstacles, we believe that it is important to continue building our clinic services, as they are the most appropriate facility from which to develop primary health care services for our area.

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These papers constitute the preliminary findings of the Second Carnegie Inquiry into Poverty and Development in Southern Africa, and were prepared for presentation at a Conference at the University of Cape Town from 13-19 April, 1984.

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Quoting (in context) from these preliminary papers with due acknowledgement is of course allowed, but for permission to reprint any material, or for further information about the Inquiry, please write to:

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