SECOND CARNEGIE INQUIRY INTO POVERTY

AND DEVELOPMENT IN SOUTHERN AFRICA

Mobile clinics - What can they do and achieve?

by

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PREFACE

Gazankulu is one of South Africa's so-called "black states". The Nhala 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 Nhala'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 Nhala

   a. Health and Health Care in Nhala : an overview.
   b. The Nutritional Status of Children 1 - 5 years.

2. A Critique of Some Health Service Interventions in Nhala

   a. Community Health Workers in Nhala : 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 Nhala 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 Nhala, 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 Backenroos, Eric Buch, Rob Collins, Cedric de Beer, Clive Evian, Vic Gordeuk, Merryl Hammond, Thoko Maluleka, Shirley Maswanganyi, Sanilesiwe Mtetwa, Dipuo Mosoue, Robert Waugh and Merrick Zwarenstein.

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MOBILE CLINICS - WHAT CAN AND DO THEY ACHIEVE?

Eric Buch

WHAT ARE MOBILE CLINICS?

Mobile clinics are health services that use transport to reach villages on a weekly or monthly schedule. A fixed clinic works from a building and provides care on a daily basis.

Services delivered may vary, but should cover preventive, promotive, curative, and rehabilitative tasks. Mobile clinics can care for acutely and chronically ill patients, and provide child health, ante-natal, family planning, screening, and care of the aged services.

Mobile clinics should have a frequent visiting schedule; enough trained staff; and adequate drugs, equipment, records, transport, and facilities. Organisational efficiency is needed to ensure that the ratio of service to travel and preparation time is optimal. The support system at the hospital (e.g the transport section and pharmacy) should be efficient in their support of the mobile clinic. The service should aim for true community participation. There should be a system for determining policy and evaluating the service.

WHAT ARE THE LIMITATIONS OF MOBILE CLINICS?

Because mobile clinics visit a village weekly or less they cannot provide a continuous service. This limitation is particularly important for acute illnesses. For example, the three major child killers (diarrhoea, pneumonia and measles) all need immediate care. This limitation can be partially overcome through the development of a village health worker programme. This development is in itself not free of problems (see paper entitled "Community Health Workers in Mhala: 2nd Class Care for the Poor?")

The mobile clinic does not reach the whole community. As fixed clinic staff live in the village and are there every day, they are theoretically able to move into the community and develop closer relationships. Mobile clinics can improve their community links if staffing is constant and if a specific effort is made to move into the community. But these efforts are unlikely to get beyond the odd home visit unless there is a suitable organisation in the village for the mobile clinic to link up with.

THE TINTSWALO MOBILE CLINIC - WHAT DOES IT ACHIEVE?

The earlier description of what a mobile clinic can do provides us with a standard against which to compare our service.

Services provided:

The service provides only curative care in two villages, and curative and ante-natal care in a third. No child health, family planning, care of the aged, or screening services are provided.

An average of only 26 ill patients are cared for per visit. The staff cost of these services is R1,65 per patient - 3 ¼ times the clinic and double the hospital outpatient costs. Vehicle expenses add further to the question of whether the service is cost-effective.

Visiting schedule:

The mobile clinic visits 3 villages weekly. It never misses out.

Staffing:

The service has five staff members; a registered nurse, staff nurse, nursing assistant, clerk and driver. This is more than adequate to meet current commitments, but skills and job descriptions are inadequate. Before the recent introduction of a primary health care nurse to the service, no staff member was trained to diagnose and treat illnesses. The job descriptions of the driver and clerk need to be expanded as they only drive and accept payment. Together they contribute very little to the service.

The support system:

The support system for a mobile clinic has many components. Each one has problems.

The service uses one of the hospital ambulances as it does not have its own vehicle. This leads inter alia to delays in leaving and the need to unpack and repack drugs each day.

The service used to have a limited drug list but now has what it needs. It is still short on equipment.

The record system is based on slips of paper which are thrown away after each visit.

A doctor visits to see referred cases. As few cases are referred it is not cost-effective to use a doctor's time and a vehicle in this way. Doctor's visits were stopped when a primary health care nurse was allocated to the service.

Organisational efficiency:

Organisational efficiency is poor. Preparations to leave begin at 7.30 a.m. Departure time is after 10.00. This means preparation and travel takes 5¼ hours out of each day, leaving only 2¼ hours for patient care. Some responsibility for the delay lies in the inefficiency of the hospital support system e.g the transport section, pharmacy, and kitchen.

Community participation:

There is no community participation.

WHAT DO WE DO NOW?

We believe that the information that we have presented shows that our mobile clinic service is neither satisfactory nor cost-effective. We need to ask ourselves two questions; firstly, are mobile clinics an appropriate method of delivering care, and if they are, how do we improve ours?

Is the mobile clinic an appropriate method of delivering care?

There are only ten clinics and one health centre to serve the 57 villages of Mhala. Additional clinics will only be added slowly. Therefore, although a mobile clinic has limitations we will need its services for a long time yet.

How do we plan to improve the mobile clinic service?

Services provided

Services will be expanded to include care of chronic disease and child health, ante-natal, family planning, screening, and care of the aged services. Because of our limited resources we will only add one at a time. If it is feasible we will also start to reach out into the community.

Staffing

We will continue to allocate a primary health care nurse to the service. We have started training programmes for the other staff members and hope that with time they will become more motivated and better skilled. We have yet to decide whether to replace the clerk and driver, or to train them to take an active part in the service.

Visiting schedule

The mobile clinic will continue to visit weekly. It will work five days a week rather than the current three.

The support system

We have received outside funding to replace the borrowed ambulance with a custom built vehicle. Amongst other benefits drugs will be stored in the vehicle, obviating the need for daily packing and unpacking.

A standard drug list has been drawn up and a standard equipment list and patient care guidelines are being developed. The equipment will include a freezer box for transporting vaccine.

A patient-kept record system will be established. This will obviate the need for the clinic to store records. It will also give patients the benefit of having all their health care information available to them wherever they seek care.

Organisational efficiency

The mobile clinic team will be trained to improve their organisational efficiency and steps will be taken to improve the hospital based support services. The departure time of the mobile clinic will be monitored, and reasons for delay sorted out.

WHAT LIMITATIONS WILL REMAIN?

We have stated that we believe that mobile clinics are an appropriate service at this point in time, and have explained how we plan to improve the service. However, we recognise that even if these improvements are successful, limitations will remain. These relate to the need for better coverage, care of acute illnesses, and community participation.

Coverage

Thirty six villages need mobile clinic services because they are more than 3 km from their nearest fixed clinic. A mobile clinic that provides comprehensive care can only reach one village a day. The hospital simply does not have the resources to run the 7 mobile clinics needed. The whole service has only 10 vehicles, and there are only 7 registered nurses in all our fixed clinics.

Care of acute illness

The mobile clinic cannot provide day to day care. Developing a village health worker programme to overcome this is fraught with obstacles, (see paper entitled "Community Health Workers in Mhala : 2nd Class Care for the Poor?")

Community participation

Communities should be involved in planning, implementing and evaluating their mobile clinic service. It has been suggested that mobile clinic committees should be established in the villages to do this. However, our experience is that these undemocratic bodies do not represent or adequately express the feelings of the poor. This is because they are made up of the elite, who protect their own interests.

Unfortunately, we are not in a position to develop alternatives. However, if effective community organisations do emerge, our mobile clinics could provide a base for supporting and encouraging their activities; if requested to do so.

CONCLUSION

Mobile clinics are not an end point, but an interim step that help to buy the time needed to develop comprehensive primary health care services. They are not an end point, because of their inability to provide continuous care and to be effective in community work. However, because we are a poor service mobile clinics that provide an adequate range of good quality care will be an appropriate interim component of our health services.

We are however faced with two very significant obstacles to the appropriate use of mobile clinics.

1. We do not have the resources to deliver enough mobile services to meet the need.
2. Under current constraints development of comprehensive primary health care services will take so long, that instead of mobile clinics being an interim step, they will become a permanent part of the health service.

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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