Maternal health services in South Africa

During the 10th anniversary of the WHO 'Safe Motherhood' initiative

S Fonn, M Xaba, K Tint, D Conco, S Varkey

The tenth anniversary of the World Health Organisation's 'Safe Motherhood' initiative is being celebrated this year and the organisation is using the opportunity to assess critically its gains, its strengths and its weaknesses. South Africa has taken some bold steps to address maternal health services, specifically introducing free health care for pregnant women and children under 5. In this paper we explore what further steps are necessary to ensure improved health outcome for pregnant women. South African health care administrations are, in some cases, engaged in broad health systems interventions at provincial level. This approach to improving health services is nonetheless frustrated by programme-specific initiatives, such as the introduction of female condoms or other piecemeal additions. We argue that making the systems function is the essential, primary step in the success of any intervention. The case of maternal health is explored in this paper.


The context within which we are working locally, nationally and globally is a significant determinant of what is achievable. The context of this South African case study is a South Africa which, since 1994, has been engaged in a general societal transformation aimed at decreasing inequity. This makes it unique. However, the situation from which the health service staff treat patients.

Women's Health Project, Department of Community Health, University of the Witswatersrand, Johannesburg

S Fonn, MB BCH, FFCH, PhD
M Xaba, BCom
K Tint, MB BS, MMedSc, MPH
D Conco, BCom, BA Hons
S Varkey, BCom, MA (Soc Work)
not want me to have more quickly'; and 'he may encourage me to use contraceptives'. The exception was in the case of teenagers, one of whom said: 'A man will tell you in front of his friends when drunk that this and this happened. I prefer to go alone.'

With regard to antenatal clinic staff, women want 'them to help me have a live baby'.

'I want to be properly checked out, not just asked how I feel.'

'They must tell us things not just test urine and weigh us.' Most women wanted a choice of times to come to the clinic. One woman also spoke of the need for abortion services when appropriate. 'They won't separate you even if you are ill; they leave you to suffer the whole 9 months and you get a rotten baby.'

Expectations of delivery services included that 'the nurse should be next to you' and 'they must check the baby's heart' and 'tell me how my labour is progressing' with 'not too many people, as they shout and confuse you'. In every focus group women complained that they were very hungry when appropriate. 'They won't separate you even if you are ill; they leave you to suffer the whole 9 months and you get a rotten baby.'

Patients spend 54 hours receiving care. For example, patients spend 54 hours receiving care. For example, patients spend 54
Table II. Women's prioritisation of required reproductive health services

<table>
<thead>
<tr>
<th>Priority level</th>
<th>Peri-urban group</th>
<th>Rural group</th>
<th>Youth group</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Contraception</td>
<td>ANC and delivery care</td>
<td>Safe abortion</td>
</tr>
<tr>
<td>2</td>
<td>STD treatment</td>
<td>STD treatment</td>
<td>STD treatment</td>
</tr>
<tr>
<td>3</td>
<td>Delivery care</td>
<td>Safe abortion</td>
<td>Delivery care</td>
</tr>
<tr>
<td>4</td>
<td>Infertility investigation</td>
<td>Cervical cancer screen</td>
<td>Contraception</td>
</tr>
<tr>
<td>5</td>
<td>Safe abortion</td>
<td>Sexuality education</td>
<td>Sexuality education</td>
</tr>
<tr>
<td>6</td>
<td>Sexuality education</td>
<td>Contraception</td>
<td>Infertility investigation</td>
</tr>
<tr>
<td>7</td>
<td>Menopause services</td>
<td>Infertility investigation</td>
<td>Menopause services</td>
</tr>
<tr>
<td>8</td>
<td>Cervical cancer screen</td>
<td>Menopause services</td>
<td>Cervical cancer screen</td>
</tr>
</tbody>
</table>

Table III. Time in clinic and time receiving care in the Northern Cape and North West

<table>
<thead>
<tr>
<th>Service</th>
<th>Mean total time in clinic (range)</th>
<th>Mean time receiving care (range)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Northern Cape</td>
<td>North West</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>54 m (8 m - 2 h 22 m)</td>
<td>10 m (2 m - 32 m)</td>
</tr>
<tr>
<td>Curative care</td>
<td>3 h 11 m (13 m - 6 h 16 m)</td>
<td>1 h 24 m (1 m - 6 h 20 m)</td>
</tr>
<tr>
<td>Child care</td>
<td>1 h 40 m (2 m - 4 h 24 m)</td>
<td>1 h (1 m - 5 h 21 m)</td>
</tr>
<tr>
<td>Family planning</td>
<td>50 m (1 m - 2 h 46 m)</td>
<td>58 m (6 m - 3 h)</td>
</tr>
</tbody>
</table>

Fig.1. Time spent in clinic waiting and receiving care by service

minutes waiting for 10 minutes of care from tuberculosis services; 3 hours and 11 minutes for 7 minutes of care from curative services; 1 hour and 40 minutes for 17 minutes of care (in group format) for child health services and 5 minutes of care for an average of 7 minutes of care from family planning services. The outliers in the findings are also of interest. The long period of time spent with some patients in family planning services at both clinics (46 and 58 minutes) was due to the patients' requesting treatment for vaginal discharge. As it was not 'STD day' at the clinic, significant extra time was taken up fetching the appropriate equipment, treatment and referral forms. Had these been readily available, the delay for these patients and the increased average waiting time of all other patients would have been decreased. The finding that over 60% of all patients who attend services have been treated and have left the clinic by 13h30 indicates some of the reason for the long waiting times. All patients arrive early in the morning and then wait to be seen. An appointment system, which is what women were requesting, would decrease patient waiting time and decrease the number of people waiting at any one time; this would also decrease the sense of pressure that clinic staff describe. The interventions here are obvious and possible, and could be implemented if senior clinic staff members were trained and given authority to manage clinics.

Facility checklists were sent to all clinics via the regional managers and were filled in by the person in charge of the clinic. Six broad categories of facility adequacy were evaluated: infrastructure, access, management of resources, patient environment, community participation and equipment for reproductive health services. Data were categorised so that facilities could be graded as desirable, acceptable or unacceptable (Table IV). For a significant number of clinics, basic infrastructure does not meet acceptable standards and in two provinces 50% or more of the clinics are in need of major repair. Poor electrification and inadequate or unreliable water supply mean that sterilisation of equipment can be problematic and that deliveries at night have to be conducted in suboptimal lighting. In this context only 30% of Northern Province clinics have special spotlights for deliveries. For example, in Northern Province, while 63% of clinics do have a drug supply system, only 27% of clinics have no problem with drug supplies. On average, 69% of clinics do have a drug supply system, only 27% of clinics have no problem with drug supplies. On average, 69% of clinics do have a drug supply system, only 27% of clinics have no problem with drug supplies. On average, 69% of clinics do have a drug supply system, only 27% of clinics have no problem with drug supplies. On average, 69% of clinics do have a drug supply system, only 27% of clinics have no problem with drug supplies. On average, 69% of clinics do have a drug supply system, only 27% of clinics have no problem with drug supplies. On average, 69% of clinics do have a drug supply system, only 27% of clinics have no problem with drug supplies. On average, 69% of clinics do have a drug supply system, only 27% of clinics have no problem with drug supplies.
Table IV. Infrastructural adequacy of 157 (52%) Northern Province, 136 (45%) North West and 85 (52%) Northern Cape clinics

<table>
<thead>
<tr>
<th>Facility</th>
<th>% Unacceptable NP</th>
<th>% Unacceptable NW</th>
<th>% Unacceptable NC</th>
<th>% Acceptable NP</th>
<th>% Acceptable NW</th>
<th>% Acceptable NC</th>
<th>% Desirable NP</th>
<th>% Desirable NW</th>
<th>% Desirable NC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Water</td>
<td>42</td>
<td>36</td>
<td>10</td>
<td>13</td>
<td>10</td>
<td>8</td>
<td>42</td>
<td>52</td>
<td>81</td>
</tr>
<tr>
<td>Electricity</td>
<td>48</td>
<td>56</td>
<td>20</td>
<td>18</td>
<td>12</td>
<td>29</td>
<td>31</td>
<td>28</td>
<td>46</td>
</tr>
<tr>
<td>Building structure</td>
<td>54</td>
<td>59</td>
<td>14</td>
<td>30</td>
<td>27</td>
<td>45</td>
<td>15</td>
<td>10</td>
<td>39</td>
</tr>
<tr>
<td>Toilet</td>
<td>27</td>
<td>24</td>
<td>15</td>
<td>18</td>
<td>12</td>
<td>8</td>
<td>48</td>
<td>57</td>
<td>73</td>
</tr>
<tr>
<td>Communication</td>
<td>41</td>
<td>51</td>
<td>13</td>
<td>29</td>
<td>38</td>
<td>14</td>
<td>19</td>
<td>5</td>
<td>71</td>
</tr>
<tr>
<td>Washing facility</td>
<td>47</td>
<td>55</td>
<td>24</td>
<td>13</td>
<td>9</td>
<td>13</td>
<td>36</td>
<td>32</td>
<td>59</td>
</tr>
<tr>
<td>Refrigerator</td>
<td>4</td>
<td>10</td>
<td>6</td>
<td>13</td>
<td>19</td>
<td>0</td>
<td>80</td>
<td>69</td>
<td>93</td>
</tr>
<tr>
<td>Patient privacy</td>
<td>12</td>
<td>25</td>
<td>8</td>
<td>35</td>
<td>32</td>
<td>32</td>
<td>49</td>
<td>40</td>
<td>58</td>
</tr>
</tbody>
</table>

NP = Northern Province, NW = North West, NC = Northern Cape.

Table V. Primary health care workers' listing and ranking of obstacles to quality services

<table>
<thead>
<tr>
<th>Problem identified</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of resources</td>
<td>216</td>
</tr>
<tr>
<td>Poor health sector management</td>
<td>180</td>
</tr>
<tr>
<td>Low salaries</td>
<td>114</td>
</tr>
<tr>
<td>Staff shortages</td>
<td>102</td>
</tr>
<tr>
<td>Poor interpersonal relations among clinic staff</td>
<td>50</td>
</tr>
<tr>
<td>Lack of certain staff categories (clerks)</td>
<td>28</td>
</tr>
<tr>
<td>Lack of study opportunities for staff</td>
<td>21</td>
</tr>
<tr>
<td>Poor clinic security</td>
<td>17</td>
</tr>
<tr>
<td>Insensitivity to language and cultural diversity</td>
<td>16</td>
</tr>
<tr>
<td>Lack of knowledge and skills</td>
<td>11</td>
</tr>
<tr>
<td>Staff duties outside of scope of practice</td>
<td>9</td>
</tr>
<tr>
<td>Nepotism</td>
<td>4</td>
</tr>
</tbody>
</table>

These findings illustrate clearly that health system functioning, with regard to resources and management issues, rates highly in health care workers' understanding of obstacles to quality health service provision, even above issues such as salary and inadequate staffing. What this ranking does not reflect is that health care workers did admit that many of the factors which determined how they relate to clients are the consequence of prejudice and unequal power relations based on class, sex and race. While they said that if they were not so stressed at work they might take more time and care with illiterate women, they also acknowledged that often they could not be bothered as such women are unlikely to complain. They also acknowledged that their lack of gender sensitivity, in spite of being women themselves, made them judgemental. 'We grow up in the same society as everyone else, we are socialised to see women in a certain way and we do.' The range of solutions that staff came up with does illustrate this understanding — primary care staff described interventions which they themselves could implement as well as those that others in the system are responsible for. What needs to be done? Health workers were asked to develop practical solutions to the problems of poor health services for women. The principle underlying these solutions is that all levels of the health system need to be involved in the process of change. The 820 participants in these
workshops listed a solution for each of the major problems identified.

Problems with the existing style of management within the health system were the need for management to develop policies and activities encouraging: (i) an open-door environment; (ii) participatory forms of functioning encouraging team-building and inter-departmental collaboration; (iii) two-way communication channels; (iv) training for managers in supervision skills; and (v) development of a jointly agreed code of conduct to be used to assess staff and determine promotion and disciplinary practices.

Management should ensure: (i) effective checks and controls, like supervisory visits; (ii) that regional and district managers know details of each service site (names of staff, condition of clinic); (iii) circulars, bulletins and meetings to disseminate information to staff; (iv) installation of telephones and timely payment of accounts; (v) that compensatory allowances or leave for overtime worked are allowed for; (vi) incentives such as free tea and meals during overtime hours; (vii) accommodation and uniform allowances; (viii) special incentives for people working in rural/remote areas; (ix) that achievement and good performance are acknowledged through promotion and merit schemes; and (x) that staff receive written information about job descriptions and performance. Health workers should: (i) follow the right channels of communication; (ii) be open and respect each other; (iii) conduct meetings to share information with each other at clinic level; (iv) collectively demand and ensure transparency between themselves and among their seniors; and (v) discuss problems with supervisors, failing which they should resort to unions, personnel associations or bargaining chambers.

For lack of resources like drugs, equipment, transport facilities and clinic conditions, management should: (i) increase budgets; (ii) introduce a regular maintenance system; (iii) update dispensary and store management systems; (iv) provide generators/solar power where electricity is frequently interrupted; and (v) distribute drugs according to clinic needs, not a standard list. Health workers should use drugs before they expire and prescribe appropriately.

To build staff capacity, management should: (i) identify staff potential; (ii) develop rational staff development plans; (iii) create more training opportunities; (iv) give bursaries and leave to staff interested in further studies; and (v) place staff appropriately after training. Health workers should make use of existing opportunities, participate actively in training sessions/workshops and use information taught during in-service education sessions.

To increase the quality of care given to patients, management should: (i) ensure the provision of a wider range of services, including abortion services; (ii) plan to provide reasonable 24-hour coverage; (iii) involve the community to ensure quality; (iv) do spot checks on clinics; (v) provide quality training for staff; (vi) include interpersonal skills as part of in-service training (in addition to technical skills); and (vii) plan open days when members of the community (including men) are invited into the clinic for general health information.

Health workers should: (i) have a written code of conduct and, if not applied, disciplinary actions should be taken; (ii) maintain patients' right to privacy; (iii) treat all patients equally; (iv) explain procedures, give information, refer patients; and (v) adopt systems like scheduling appointments and also see very sick patients first.

None of these ideas is new or revolutionary but they come from health workers themselves, and express a willingness to change and invite self-criticism. What is significant is that technical skills and knowledge, while important, are not first on the list. Almost all of these suggestions and the problems identified in the review of health services are elements of the functioning of the overall health system. These findings are not unique to South Africa. Very similar priorities and the same need to focus on health systems were found in two World Health Organisation multicentre studies in Africa from Uganda, Mozambique, Senegal, Zambia, Tanzania, Kenya, Ghana and Nigeria (for further details: Dr S Fonn, SAIMR, PO Box 1038, Johannesburg, 2000).

Conclusion

What is being suggested is a creative, focused rejuvenation of the public health sector. When women are asked about their maternal health needs and expectations they say, in summary, that they want a functioning health system. When health workers are asked about problems at work in providing services for women clients, they identify the need for a functioning health system. The latest World Development Report urges that we move away from extremist views on the role of the State. Development requires an effective State. Women of low economic status do not have the force to demand services, and do not have the monetary capability to attract alternative providers. It is in relation to maternal mortality that the State must take up its responsibility to decrease inequality. It is one of the core public activities that are crucial to development. It is this sector of the State that needs to be invigorated.

The ideas to improve health system functioning suggested by health workers are compatible with basic management principles in respect of efficiency and accountability. Introducing these processes, such as supervision of staff, equipment maintenance and transparency with regard to promotion criteria into the public sector, cannot be done within one component such as maternal health services. It is a sector-wide intervention.

Much of contemporary interest in reproductive health is in increasing the range of services (such as another method of contraception) under the guise of increasing choice. Yet what women want first and foremost is better quality of existing services, or that services be provided where none exist. The piecemeal, single-issue focus allows researchers, agencies, NGOs and governments to continue as before, maintaining their narrow specialist interests or services. If we want to make a difference to the health of women and want to decrease maternal mortality and morbidity we have to get the systems that exist functioning better, improve the quality of the existing services, take the staff who work in the system seriously and then move on to increasing the range of services. Investing in making existing services work well and as an integrated whole is the essential first step to increasing the range of services.

While South Africa has the commitment to maternal health and has a constitution which firmly establishes the rights of
women, it does not mean that there is good access to safe motherhood. ‘Safe Motherhood’ advocacy is essential and it is true that it is an indictment on any society that for half the population the consequence of sex may be death. Yet what is not working is the system. You don’t get morphine into clinics or transport for referrals because you are worried about the differential in maternal mortality between east and west or north and south. You do it because you can manage a system, because your drug order forms work and because you are doing it not only for a woman in labour but for a man with typhoid or a dehydrated child with diarrhoea.

The rationale for investing in safe motherhood is incontestable. The lessons learned are that advocacy is only the first step and that unifocal activities will not address the fundamentals that make safe motherhood possible. It appears that the best strategies are to make investments in the health system itself. To turn concern into improved maternal survival we have a systems approach. This demands that governments and multilateral and bilateral donators direct funding towards rejuvenating the health system. Funding exclusively for AIDS, maternal health or family planning distracts from rather than sets in place the fabric which would allow health service providers to meet the legitimate needs of women — both those using the health service and those who work in it.

The authors thank all the staff in Northern Cape, Northern Province and North West who supported this project and gave of their time, including staff at the various nursing institutions. Specifically we want to thank the heads of the MCWH section, Ms C Madikane, Ms E Mabitsela and Ms P Chueu, Ms N Manzini, head of PHC and District Health in Northern Province, the facilitators of the workshops, and the provincial coordinators, Ms T Mazibuko, Ms S Mokoala and Ms N Mothlaping.

REFERENCES

2. Rispel L, Cabral J, Marawa N, Xaba M, Fonn S. The Integration of Primary Health Care Services at the District Level Using Upington as a Case Study (Technical report). Johannesberg: Centre for Health Policy, Department of Community Health, University of the Witwatersrand, 1995.

Accepted 6 Sep 1997.

Haematology outreach clinics in the Free State and Northern Cape

Marius J Coetzee, Philip N Badenhorst, Engela P le Loux, Mathys J Doman

Objective. Evaluation of haematology outreach clinics in the Northern Cape and Free State.


Setting. Central South Africa is sparsely populated. Consultants from Bloemfontein held outpatient clinics in hospitals (with laboratories) in Bethlehem, Kimberley and Kroonstad.

Subjects. 117 patients with suspected haematological disease.

Main outcome measures. Input measures (population, number of clinics and costs), process measures (patient numbers, patients per clinic, new consultations per clinic, patients’ domicile, how they were referred, types of diagnoses and number of patients with non-haematological disorders) and output measures (attrition, changes in attendance and savings).

Main results. The 84 clinics that were held, with 636 consultations, did not cost the State anything. Only 6% of the 117 patients had no haematological problem. Sixty-eight per cent had chronic haematological neoplasms. In Kimberley most of the patients came from Kimberley Hospital, while most of the patients at the other clinics were referred via Bloemfontein. There was only a 10% attrition rate and only one-third of patients were referred to Bloemfontein. We saved paying patients an estimated R21 260 in transport costs, while saving the State R172 992 by seeing patients at secondary, instead of tertiary, hospitals.

Conclusions. It is cheaper to send a doctor to an outreach clinic than to refer patients to a central facility, provided there is enough work for a doctor at the clinic. It costs the State much less for patients to be seen at a secondary than a tertiary hospital. Positive spin-offs include academic stimulation of doctors and laboratories in the periphery, with more appropriate referrals to teaching hospitals. Weaknesses include poor availability of expensive drugs at the clinics and lack of standardised