Health has been considered a core component of South Africa’s transformation and development since the advent of democracy in 1994. More than twenty-two years later however, the provision of equitable and effective healthcare to all South Africans remains a critical challenge. A raft of progressive legislation by the current government has promised an overhaul of the health system with dramatic shifts in resource allocation but these have yet to be realised.

Rural communities, making up over 40% of South Africa’s population, continue to experience both the serious health risks of poverty and the disadvantages of a fragile and urban-centric health system (Gaede & Eagar 2013). Rural populations on average are poorer, less healthy, less educated, less often employed and with less access to opportunities, basic services and the means of a decent life, than their fellow citizens (Noble & Wright 2013). Labour migration to urban areas leaves a residual population of the elderly, the young and the sick or disabled in rural areas, increasing both their vulnerability and their health needs. The inverse care law applies here as nowhere else.

Rural health services face particular challenges in attracting and retaining good staff. The urban bias in the healthcare student demographic, the lack of resources, opportunities and decent accommodation in rural areas, the isolation and more frequent administrative challenges – all serve to limit the numbers of healthcare workers willing and able to serve in such areas, as well as their lifespan in such posts (Versteeg et al. 2013). This leaves rural services fragile and constantly vulnerable to shocks. Crises such as epidemics or budget cuts tend to affect the most precarious and least developed parts of the system first, so that nation-wide problems frequently have their most serious and immediate impact on already marginalised communities.

Human resources for health (HRH) has long been a serious challenge for the South African health system, and not only in rural areas (National Department of Health 2011). South Africa trains healthcare workers who are respected and sought after all over the world for their skills, knowledge and experience. Unfortunately, the majority of those trained (and invested in by the taxpayer) do not remain in the public sector but leave for private sector positions or for overseas. Innovative strategies such as the Cuban medical training program and community service for health science graduates have gone some way towards increasing access to healthcare for marginalised populations, but these are only short-term and partial measures. As things stand, vital services are withheld from thousands of citizens simply because there are not enough healthcare workers in the public sector to provide them.

But this is not only because healthcare workers choose to work elsewhere. Escalating health costs alongside a stagnant or shrinking budget for healthcare are placing increasing pressure on health officials, managers and frontline workers to ‘do more with less’. In 2016, this culminated in a crisis in human resources for health (HRH). A call by the Minister of Finance to contain Compensation of Employees (CoE) costs has resulted in drastic measures by provincial departments of health, many of which were already in significant financial difficulty. In spite of stipulations by the national government...
that “critical posts” (including front-line health workers) be protected from staffing cuts, this is exactly where the knife has fallen, whether officially or otherwise. Because of the difficulties in retaining existing staff, this has mainly taken the form of hiring freezes. Vacated posts are frozen, while existing unfilled posts (even those budgeted for) are likewise left unfilled. This has hit frontline posts the hardest, as healthcare workers are highly mobile compared to administrative and managerial staff, who have therefore seen far fewer post losses. Unfortunately, it is the most fragile health facilities and districts which are most likely to lose staff, due to difficult working conditions, high workloads and high rates of staff burnout. The failure to replace staff lost in such setting can set off a cascade of further losses, as the remaining staff strain to cope with the increased workload and in turn make the choice to leave.

There is no question that the cost of healthcare services must be contained, and choices made about the most efficient and effective use of existing resources. However, this must not be done at the expense of South Africa’s most vulnerable citizens. The purpose of this report is to unpack the situation for rural communities and their healthcare services, and understand at a human level what current HR challenges and choices mean. It is hoped that this in-depth investigation of the dynamics in one district in the Eastern Cape province will provide much-needed insight into the implications of HRH decisions and challenges, and point towards some potential ways to address the crisis.

The Eastern Cape is a predominantly rural province incorporating two of the former ‘homelands’, Ciskei and Transkei. The legacy of the Apartheid homeland policy was a severe neglect of local services, infrastructure and development in these regions, and the Eastern Cape has struggled for the past 22 years to redress the backlog, with limited success. The province faces a high burden of HIV and TB, with poor health outcomes and high rates of poverty-related disease. Its population is disproportionately poor, and the province includes two of the three most deprived districts in the country: OR Tambo and Alfred Nzo (Masyn et al. 2015). OR Tambo district, situated to the east of the province and including the city of Mthatha, has been chosen as the focus for this report. Not only does it encapsulate the problems of rurality, poverty and a fragile health system, but it has also been in the spotlight as a pilot site for Primary Healthcare Re-engineering (PHC-R) and the National Health Insurance (NHI). While the report will zero in on OR Tambo district, this area is seen as representative of other poor rural (especially former homeland) areas of the country, and represents perhaps the greatest challenges we face as a nation.

Methodology for the report

This report was compiled on behalf of the Rural Health Advocacy Project (RHAP) and its partners, with invaluable input from healthcare workers, health officials, community members, activists, researchers and others on the ground. Much of the data collection took place during a visit to OR Tambo district in November 2016, and built on the experience of the RHAP and partners in engaging with the HRH crisis in this area throughout the previous year. All case stories, including photographs and names, are used with the written consent of the individuals and families involved. The report also includes recent literature and available health data, as well as material from reports and presentations made by EC healthcare workers and their advocacy partners. It is dedicated to the people of OR Tambo district and the healthcare workers who serve them.
The launch of the report coincided with the formation of the Eastern Health Barometer (Massyn et al. 2015), OR Tambo district has the third highest rate of teen pregnancy (ages 18-34) make up 40.7% of the population. The average household size is relatively large at 4.6 and 43.6% live in traditional dwellings, although outside the city these numbers are greater. Less than 40% of households have access to piped water of any kind, and only 25% have the use of a flush toilet. Approximately 86.5% of households are connected to electricity of some kind, although many still use wood, paraffin and other fuel sources for lighting and cooking (Statistics South Africa 2016).

These living conditions constitute significant determinants of (ill) health. According to the District Health Barometer (Massyn et al. 2015), OR Tambo district has the third highest rate of teen pregnancy in the country, with 11.5% of deliveries in health facilities being to women under the age of eighteen (compared to the national average of 7.4%). This figure reflects poor levels of education and access to reproductive health services, and indicates risk of poor health outcomes for infants and children. The maternal mortality rate of 198 (per 100 000 live births) is also substantially higher than the national average (133), reflecting poor access to healthcare during pregnancy, birth and postpartum. This is reinforced by the fact that only 40.7% of mothers delivering in facility record a postnatal healthcare visit within six days of birth (Massyn et al. 2015).

Tuberculosis is rife in the district, with a reported incidence of 784 per 100 000 population, nearly 30% higher than the national rate of 593 per 100 000. Worse, the estimated incidence in the district is even higher at 860 per 100 000 (Massyn et al. 2015). This underreporting by possibly more than 10% is further evidence of a weak health system.

The district has a population of 1 364 943, of which 53.3% are female and 46.7% male. The youth (ages 18-34) make up 40.7% of the population. The average household size is relatively large at 4.6 and 43.6% live in traditional dwellings, although outside the city these numbers are greater. Less than 40% of households have access to piped water of any kind, and only 25% have the use of a flush toilet. Approximately 86.5% of households are connected to electricity of some kind, although many still use wood, paraffin and other fuel sources for lighting and cooking (Statistics South Africa 2016).

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The dire state of the Eastern Cape Department of Health was captured in a report released by SECTION27 and partners in 2013, entitled “Death and dying in the Eastern Cape” (Treatment Action Campaign & SECTION27 2013). The launch of the report coincided with the formation of the Eastern Cape Health Crisis Action Coalition (ECHCAC), made up of more than forty civil society organisations, including human rights lawyers, grassroots activists, trade unions, healthcare workers and faith-based organisations. The coalition has campaigned consistently over the past three years to address specific issues in the health system, with mixed success. Efforts targeting EMS failures culminated in a hearing by the South African Human Rights Commission in East London in March 2016, which produced a report with recommendations for the Department. Unfortunately, little change has been observed since that time with the exception of the Xhora Mouth community who advocated for their own EMS services and met with EMS personnel in Bhisho in September 2016, after which an ambulance was made available to the community1.

To understand the realities of healthcare access on the ground, this chapter offers a snapshot of one rural community in OR Tambo district, known as Mankosi.

Snapshot of rural healthcare access: the Mankosi community

About 70km from Mthatha lies Mankosi, situated in the Nyandeni subdistrict of OR Tambo. Mankosi is made up of eleven villages, with a population of around 8000 people. The majority live in traditional dwellings, with even more limited access to clean water and sanitation than in other parts of the district. Households subsist on government grants (92.8%) of income. (Statistics South Africa 2016), remittances from family members working in cities, and tourism-related activities such as guided walks, village-based accommodation services and selling craftwork. Fishing and mariculture also contribute to local livelihoods.

First contact care: getting to the clinic

The nearest healthcare facility for Mankosi residents is Pilani clinic, a nurse-run PHC service situated about 9km from the village. While this may not seem a significant distance, the route follows a poor gravel road with steep hills, difficult to navigate for the elderly, ill or disabled – i.e. those who most often need health services. NDoH guidelines stipulate that nobody should live more than 5 kilometres from their nearest clinic, but physical proximity alone does not assure access. For many rural communities, those 5 km may include a river which is impassable in the rainy season, or require walking over rough terrain, without the option of public transport. Neither does this take account of the reduced mobility of people who are ill or have a disability. A mobile clinic visits the Mankosi community once a month, but is unreliable and limited in the services offered.

Public transport is available on the route to the clinic in the form of a government-subsidised bus, which leaves Mankosi around 5.30 am, and one or two pick-ups, known as guru-guru’s, which also leave once a day and return in the afternoon. A guru-guru costs around R10 (one way) to the clinic, the bus slightly less. Neither is suited for anyone with mobility difficulties, either temporary (due to illness) or permanent, particularly as most people must walk some distance from their homes to the road where they can be accessed. The local terrain is rough and often steep, almost impossible to navigate with a wheelchair, and in the rainstorms of spring and summer can become impassable due to flooding rivers and thick mud, which may prevent public transport from running.

Even the seemingly negligible cost of a bus or taxi may be too much for some households, as evidenced by the many who choose to walk rather than catch transport to the clinic. For those with chronic health needs, the cumulative costs of fetching monthly medication can deplete resources for school uniforms, food and other household essentials. Despite the lack of user fees at point of care, PHC services in this area place a significant financial burden on poor households through the costs of transport.

Quality of services

Once at the clinic, the people of Mankosi are far from certain of receiving the treatment they need. Drug stock-outs are reported to be frequent, and it is not uncommon for patients to be told to visit clinics further afield to collect what they need, or even to travel to Mthatha to purchase their medication from a retail pharmacy. Anti-hypertensives, ARV’s, anti-epileptics and other essential drugs are included among the stock-outs mentioned by local community members, with serious consequences for this community:
Beyond basic PHC

The clinics in this area are nurse-run, and at Pilani clinic there is neither outreach by hospital-based doctors, nor contracted services by private GP’s. Given the clinic’s remote location, it is unlikely that any of the town-based private GP’s in the area would choose to work here, even if the district chose to fund this service. If someone from Mankosi needs to see a doctor therefore, she must visit the clinic first for a referral letter, and then go to the hospital.

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Access to state facilities further afield is near impossible. A bus to Mthatha costs around R70 return per person, while the same journey by taxi costs at least R92 (depending on route). Any hospital visit requires a referral from the clinic, which means another day’s travel. Although planned patient transport exists to take patients from Canzibe to the Mthatha hospital complex for specialist appointments, it remains an arduous and costly journey. On the day before the appointment, the patient must travel to Canzibe: a 6am start to catch bus or taxi, followed by a day and night spent on the benches of the outpatient waiting area. The transport leaves Canzibe for Mthatha before six in the morning, returning late in the afternoon. Another night must then be spent on the outpatient benches before a taxi can be caught home again.

In the past, doctors from Canzibe were able to conduct outreach visits to Pilani and other clinics, greatly reducing travel costs for those they treated there. These visits also allowed them to support the clinic nurses and consult on difficult cases. Significantly, this was the only opportunity for people on antiretroviral therapy (ARV’s) to be reviewed by a doctor, as the ARV program here is entirely run at clinic level. Today outreach is non-existent, because there are not enough doctors to cover even the hospital’s needs. Those who are unable to travel as far as the hospital are therefore without access to any but the most basic PHC. Those who do make the journey to Canzibe frequently incur financial costs they can ill afford, and may not receive the services they need after all.

These stories illustrate not only the difficulty and financial cost of accessing basic healthcare in this area, but also the lasting impact on the health and opportunities of these households. Preventable disability is ubiquitous, and in turn makes it even more difficult and expensive to access healthcare.

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Emergency medical services

The problem of transport to access healthcare is even more severe when the need is an emergency. Accidents, acute illnesses and women in labour may need after-hours care, and this is only available at the hospital. As public transport does not run at night or regularly on weekends, the only option is to hire a private vehicle, if one can be found and the cash raised to pay for it. Such private hires may cost up to R300 for a return trip to the clinic, while a ride to the hospital may cost R600 (daytime) and up to R1000 at night. If the household is unable to raise this cash at the time they may be able to negotiate credit, but will pay exorbitant interest on the debt.

Sibongile Masiso is a local man who offers emergency hospital transport for people from Mankosi area for only R150 a trip – less than half of the usual price – and he is called upon at least three or four times a week. But this is a service to the community rather than a business: because of the heavy toll on his vehicle from the poor roads, at this price he makes little or no profit.

Although ambulances are in theory available from Mthatha-based state contractor Metro, they are seldom if ever seen in these parts. The distance from the city and the bad state of the roads renders drivers unwilling to travel here, and the vehicles and staffing are in any case inadequate for the vast area they are meant to cover.

Stories abound of catastrophic health incidents due to lack of emergency transport.

Obstetric emergencies are also commonplace, especially where poor access to antenatal care means potential problems are not detected early. In another recent incident related by Mr Masiso, a woman from a village near Mankosi who was eight months pregnant began fitting during the night, probably due to undiagnosed high blood pressure. Her husband went searching in the village for transport, and managed to get a ride for her to Canzibe for R800. Again, Canzibe staff were unable to manage her at the hospital, and she was transferred several hours later to Nelson Mandela Hospital. Although the mother was saved, the baby died.

Disability and access to healthcare

The stories above demonstrate how easily healthcare failures may result, if not in death, in permanent and unnecessary disability for people living in rural areas. Disability should be understood as more than just an impairment of the individual: it is the combination of a person with a health condition and their physical and social environment, which either prevents or allows their functioning and participation in society (World Health Organisation 2001).

The rural environment is often far more difficult for people with impairments to navigate, compared to an urban environment. For example, a wheelchair user living in a town with tarred roads, paths and pavements might be able to move around quite independently, especially if the distances she needs to travel to get to school, work and local amenities are small. By contrast, someone with the same impairment living in a rural area may not even be able to leave her house without help. She would also need a very different kind of wheelchair to cope with the terrain.

Living with a disability is also much more expensive than life without any functional impairments. In Mankosi, public transport might cost between three and a hundred times as much for someone with a disability, or might be entirely inaccessible. With little access to piped water or electricity, daily survival tasks require serious physical effort. If one is unable to fetch water or wood, grow vegetables to eat or maintain one’s home, family members must take on these tasks or someone else must be paid to help. If there is no one at home who can help with self-care and daily living tasks such as preparing food, washing and getting to the toilet, these things too must be paid for. While the state disability grant is helpful, it is seldom even close to enough to cover the costs of living with a disability.

The cycle of poverty and disease or ill health is well known, as is the relationship between poverty and disability. However, the role of preventable disability in entrenching and exacerbating the poverty-illness cycle has not been widely acknowledged. Image 9 below depicts these processes.
The red outer arrows show the vicious cycle of poverty and disability: poor people are more likely to become disabled, and people with disabilities are more likely to become and stay poor (Yeo 2001; Mitr et al 2013).

The inner arrows demonstrate how ill health and poor access to healthcare (particularly pertinent in poor rural communities) lead to preventable disability. Disability in turn increases health needs and simultaneously obstructs access to healthcare even further. Expensive, inaccessible and poor quality healthcare clearly plays a central role in the cycle of poverty and disability, especially in rural areas.

Estimates of disability prevalence vary widely, depending on the type of measurement used. StatsSA reports a disability prevalence of 7.5% across South Africa and 9.6% in the Eastern Cape (Statistics South Africa 2014), while the WHO estimates the national prevalence to be close to 25% (based on burden of disease studies) (World Health Organisation 2011). The rise in non-communicable diseases, the advent of HAART for HIV and the gradual increase in life expectancy all contribute to more years of life lived with health conditions, many of which cause impairments over time. There is reason to believe the prevalence to be even higher in rural areas: migrant labour takes the majority of healthy adults of working age to the cities, leaving behind the young, the elderly and those unable to work due to illness or disability (Sherry 2015).

Even taking the conservative StatsSA estimate, one could expect Canzibe’s catchment area to include 9600 people with disabilities. At the time of writing however, not a single healthcare worker with disability expertise was employed in state health services in this subdistrict.

Rehabilitation: essential services overlooked

People with disabilities need the same health services as others, but are often at greater risk of illness. For example, a recent South African study found that a significantly higher proportion of people with disabilities are diagnosed with TB compared to their non-disabled peers (Moodley & Ross 2015). Healthcare workers who serve this group need to understand these risks, as well as the realities of life with a disability, in order to provide appropriate and effective healthcare. But alongside generalist healthcare, people with disabilities often require disability-specific support in the form of rehabilitation services.

Rehabilitation is a process which aims to enable people with disabilities to regain function and to participate in their communities and life roles. It includes a wide range of activities, from physical interventions to prevent or minimise impairments, to prescribing and fitting assistive devices (e.g. wheelchairs, hearing aids), to addressing environmental and social barriers to participation. Rehab requires a multi-disciplinary team, including physiotherapy, occupational therapy, audiology and speech and language therapy. Psychologists, social workers and mid-level rehabilitation workers also have important roles to play, and collaboration between these disability specialists and other members of the PHC team is imperative.

While listed as one of the five aspects of PHC (alongside prevention, health promotion, curative and palliative care), rehabilitation in fact includes elements of all three. Image 10 takes the example of an older man at risk of hypertension, and presents the health risks and interventions necessary at each stage of his health/illness trajectory. As can be seen, the generalist members of the PHC team (i.e. doctors, nurses and community health workers) are responsible for primary and some secondary prevention, but should these activities fail and the man suffer a stroke, the rehabilitation team is needed to prevent further illness and disability for himself and his family, and to promote their health and well-being.

Image 9: The vicious cycle of poverty, illness and disability (adapted from (Sherry 2015))

Image 10: The health/illness trajectory of an older man at risk of hypertension (adapted from (Sherry 2015))
Rehabilitation is most effective when provided as near as possible to where the person with a disability lives and works. It is included as a basic right in the UN Convention on the Rights of Persons with Disabilities (Article 26, United Nations 2006). Unfortunately, rehab is poorly understood and generally overlooked by healthcare officials and managers, tending to be considered a “non-essential” service, when in fact it is fundamental to the health and rights of a large proportion of our population.

The lack of rehabilitation services for people with disabilities in the Mankosi area is a major gap in healthcare. In the past, community service physiotherapists and occupational therapists (OT’s) have been placed at Canzibe hospital for a year at a time, but this has been sporadic, and the hospital’s urgent requests to the province for therapist posts over the past two years have been fruitless. People with disabilities are referred to Mthatha for rehabilitation, or to St Barnabas district hospital in the neighbouring subdistrict of Libode. St Barnabas itself is struggling for therapists, having lost all but one to more lucrative posts in the Department of Education in 2016. Without access to rehabilitation, people with disabilities have no opportunity to regain mobility and function, and the burden of care on their families is a heavy one. In addition, without therapists to conduct the necessary functional assessments, disability grant applications are no longer possible at Canzibe, removing yet another support from people with disabilities and their families.

Rehabilitation is a complex intervention, and requires sustained engagement over time, often with family members and other stakeholders as well as the person with a disability themselves. Certain aspects of rehab may only be possible in the person’s home, work or community environment, because they require direct contact with and intervention in those environments, whether physically (e.g. assessing the workplace for wheelchair access) or interpersonally (e.g. educating family and neighbours about the condition and needs of someone with a mental illness). This means that accessing rehabilitation in another district or at a central hospital is almost certainly very limited in its effectiveness and financially unsustainable.

Nonetheless, some families will work hard to access rehab despite these barriers. Boniswa Fish, another Mankosi resident, has a three-year-old daughter with cerebral palsy (CP), whom she manages to take to Zithulele Hospital for rehabilitation. The journey requires four taxi rides in each direction and costs R136 return each month, but Boniswa is fortunate because Ayanda is still small enough for her to carry and does not yet pay fares. The Zithulele therapists have also helped her obtain a family dependency grant, which was not possible at Canzibe because there were no therapists to complete the necessary functional assessment. Incidentally, Boniswa herself walks with a limp, due to burns she suffered to her legs as a child when her home caught alight (a fairly common occurrence in this region, where open flame cooking predominates and houses are often hatched). Had she had access to physiotherapy at the time, this lasting impairment could have been prevented.

At Zithulele, Boniswa meets with other mothers and caregivers of children with CP, to share concerns and learn from one another, as well as to receive input from the OT, physio and speech therapist. They are taught about feeding their children, helping them to communicate, encouraging them to use their hands and do things for themselves, and helping them to move on their own. Children with CP usually have multiple disabilities, and their needs are complex and changing over time. Preparation for school must begin early, for example by making sure the child is toilet trained and can communicate her needs, and if special school placement is required, starting the application process early enough to allow for long waiting lists. Assistive devices such as wheelchairs, walking aids and orthoses must be assessed for, prescribed and fitted, and both child and caregiver must be trained in their use and care. Together, these services form the basis for access to all other rights and opportunities for these children. Without such support, children with CP may develop serious secondary impairments and health problems (e.g. joint contractures, breathing and cardiac problems, malnutrition, aspiration pneumonia), and be unable to participate in family and community life. They are denied their right to education, all kinds of civil participation, and dignity. The burden on their families becomes severe, with the physical and emotional strain of caregiving, the financial costs of disability and social isolation all taking their toll on the entire household.

Only twenty years old herself, Boniswa is an orphan and lives with her extended family. No-one in the family is employed, and she is now pregnant with her second child. It is unlikely that she and Ayanda will be able to access rehab at Zithulele for much longer.

Cerebral palsy is not uncommon in this area, where antenatal and obstetric care are often inaccessible or of poor quality. Birth trauma due to complicated delivery or undetected health problems suffered by the mother in pregnancy can lead to neurological damage of the infant, resulting in CP. Another common cause is epilepsy, which is rife in this area due to endemic pork tapeworm. If the condition is not adequately controlled with medication, prolonged and repeated fitting can cause brain damage, resulting in both physical and mental impairments. Poor control of fits is most often due to inadequate medical attention (to monitor drug effectiveness and ensure optimal treatment) and medication stock-outs.
Philasanda Tonayi is a fifteen-year-old boy with epilepsy, who developed cerebral palsy as a result of uncontrolled fits at a young age. He is completely dependent on his grandmother and aunt for everything from feeding and dressing to toileting (he uses nappies). He cannot speak, and cannot sit by himself. Although he has a specialised buggy which he sits in in the day, it is no good for transport in the community because of the rough ground. Taxi drivers also refuse to carry the buggy, which takes up a great deal of space and is difficult to load, and so when Philasanda needs to go to the clinic or hospital, he is carried on his grandmother’s back. A petite woman in her sixties, the grandmother complains of swollen and painful knees from these trips, and worries about who will look after him when she is no longer able to do this. Philasanda’s mother is working in town, and his aunt is looking for work. Although he receives a care dependency grant, there are five other children to provide for in this household, and the money does not go far.

This granny’s greatest concern for Philasanda right now is that he has not been seen by a doctor in a long time. Although he should be reviewed every three months because of the medication he is taking, he has not had an appointment in over three years. She explains that she cannot simply take him to the hospital: first, she must go to the clinic to request a referral, and this means yet another gruelling day’s travel for her. She also knows that at Canzibe, they may or may not be attended to by a doctor. So far, the costs of this endeavour have outweighed its potential benefits in her mind.

She continues to collect his medication for him at the clinic by herself, and when it is not available, travels to town to buy it privately. She has tried taking Philasanda to the doctors at Nelson Mandela Hospital in Mthatha, but was turned away and told to go back to Canzibe. Unfortunately, most doctors have no training at all in CP or disability of any kind, and individuals like Philasanda are often dismissed as ‘beyond help’. Another concern right now is his severe constipation, a combined result of his lack of movement and the very limited soft diet she is able to feed him. His movement difficulties (which also affect his mouth) have made feeding a challenge from the beginning, but this is now much worse because of a side-effect of his epilepsy medication, which has caused overgrowth of his gums (gingival hyperplasia). This has pushed his teeth completely out of alignment and now makes it impossible for him to close his mouth, in turn making it very difficult for him to take food and to swallow. It is extremely difficult to get food into him at all, and only his grandmother and aunt are able to manage this (meaning also that he cannot be left with anyone else should these relatives need to be elsewhere – for example to seek healthcare for themselves). He is extremely underweight and malnourished as a result.

Philasanda’s medication should be changed as a matter of urgency, and he also needs to see a dentist, a speech therapist (for feeding techniques) and a dietician. Unfortunately, none of these services are available at Canzibe, even should his family be able to get him there.
Kwanda Blayi is a resident of Kind Sabata Dalindyabo (KSD) subdistrict, which borders on Nyandeni. He is another teenage with a disability, although of a different nature. Three years ago he was an ordinary, active thirteen-year-old, playing soccer and walking the long uphill road to school with his friends every morning, but today he is in a wheelchair, dependent on his family for everything and unable even to leave their house unless carried by his older brother. After complaining of back pain in 2013, Kwanda was taken to the clinic, then to Zithulele hospital in the neighbouring subdistrict, and eventually to Frere Hospital in East London, where he was diagnosed with a congenital scoliosis (unusual curving of the spine, which one is born with but only becomes obvious during the teenage years and tends to get worse over time). A year ago he lost the use of his legs, and then the control of his bladder and bowel, indicating serious and progressive damage to his spinal cord. A lengthy inpatient stay at Bedford Orthopaedic Hospital in Mthatha afforded him a wheelchair but nothing else. He is no longer able to go to school (over an hour’s walk away), or to attend physiotherapy at his nearest clinic. Ironically, accessing rehabilitation from Kwanda’s village requires being able to walk two hours up a steep gravel road to reach the nearest outreach site. This is also the nearest pick-up point for public transport to the hospital or to town. Private vehicle hire is financially out of the question for this family.

Fortunately for Kwanda, there happens to be a community disability worker (CDW) employed by the Jabulani Rural Health Foundation, an NPO operating in their area. When she hears of his problems, she talks with her manager who agrees to fetch him and take him to Zithulele hospital. Although this NPO cannot as a rule help with such transport needs (they would simply be overwhelmed by the demand), for Kwanda there is no other option. Once they reach the hospital, Kwanda, his family and the CDW will be able to work with the therapists to address the various difficulties and health risks they face. The CDW will subsequently serve as his link with the health and rehab team, and follow him up at home. Ideally he should be visited there by the therapists in future, but the hospital has neither the staff nor the transport to provide such a service.
Although just three years ago Kwanda was a normal, active teenager, today he cannot leave his home unless carried by his brother. Jabulani Foundation staff help Kwanda into their vehicle for his trip to the hospital. On arrival at Zithulele hospital, Kwanda is seen by a doctor. His X-ray shows a severe deformity in his vertebrae, characteristic of TB spine. In this area TB is common, but despite all his travels across the province to find healthcare, it seems that nobody has considered this diagnosis. Perhaps the initial diagnosis of congenital scoliosis was simply never questioned, or each service provider assumed another had assessed him and ruled out TB. Perhaps the X-ray service at his most recent hospital visits was out of commission (not infrequent given that the province’s failure to pay service providers often means that equipment goes unserviced). This is health service fragmentation at its most damaging: although Kwanda still needs this diagnosis confirmed and treated, it is too late to save his spine or his ability to walk.

One does not need to spend much time in OR Tambo district to hear story after story about the failures of local healthcare and their devastating impact on individuals and families. The Mankosi community is just one of hundreds in OR Tambo and the many other rural districts in the country. While details may differ, the overall pattern of a fragile rural health system, catastrophic healthcare costs and the poverty-driving effects of preventable ill health and disability are universal. Sadly, the stories told here are representative rather than exceptional.

Community action: the building of Mankosi clinic

While Mankosi community is far from alone in their experiences of poor access to basic PHC services, they have responded in way most rural communities have not: by building their own clinic. Mankosi clinic, built by the community themselves with the help of local NPO Transcape.
Mrs Nongezile Tshemese, a member of the Mankosi Clinic Committee, says:

“We saw that we have no clinic here. We wake up early to go to [Pilani] clinic, leaving home at 6am, arriving 6:30 or 7 before the clinic is open. They will open maybe 8 o’clock or 9, and you wait to be seen. Then you find there is no medication, and you have to walk home again. We sat down as the community and decided to collect the money to build a clinic.”

Despite the desperate poverty of most Mankosi residents, they have access to a surprising source of funds. Building contractors from the region visit this coastal area to collect sand, and although this activity is illegal, the community has no way of stopping it. They decided instead to charge a levy per truck-load, and with the help of local NPO Transcape, established the Mankosi Community Association (MCA) to manage the funds for the benefit of the community. In 2010, the MCA decided unanimously to put the money towards a clinic, and again enlisted the help of Transcape to secure further funds and manage the building process. Together they approached the Department of Health with the plan, and were told that although the state had no money to build the clinic, it would support them once it was built. After consultation with the Department of Public Works, plans were drawn up, and the clinic was completed in 2011, and signed off by Public Works as fit for use a few months later.

But despite repeated efforts by the MCA and their partners, Mankosi clinic has yet to serve a single patient.

“It is painful now, because people are discontinuing their treatment because there is nothing at the clinic. Most people have stopped going to Pilani clinic now because of the lack of services. Some people are having strokes, others epilepsy, others are fitting, but they are not taking treatment. Children also are fitting.”

“So it is the worst pain for us as the community, all these people. It was in our hearts to build the clinic to bring services closer to us, but we are so sad because still nothing is happening. The Department of Public Works has passed the clinic, but now it stops with the Department of Health.”

The Department of Health measures access by “the proportion of people living within 5km of a clinic”. As a result, at 9km from the nearest staffed clinic, it could be said that the Mankosi people have no reasonable access to primary health care.

Chapter 3: Healthcare worker perspectives: a tale of two hospitals

As shown in the stories above, the district hospital in a rural area forms something of a hub for healthcare in the district (LeRoux & Couper 2015). It may be the only 24-hour service available, and is often the base for all the available health professionals apart from PHC nurses. It is also the access point for more advanced services which may be required. Specialist care such as cardiology, ophthalmology or psychiatry requires a referral from a district hospital doctor, and healthcare workers also assist with social grant applications (especially disability grants), referrals to social services and access to special education for learners with disabilities, among other things. Ideally, the multidisciplinary team based at the district hospital plays a coordinating role for their patients, particularly those with complex and ongoing health needs (such as many people with disabilities). Without such coordination, the most vulnerable will be lost to follow-up, and may also incur vast unnecessary expenses through wasted healthcare visits.

A well-functioning district hospital is also essential in ensuring efficient use of resources. Without this, health costs are magnified and transferred in two directions: upwards in the health system, with costlier secondary and tertiary services being used inappropriately, and downwards, with the costs of unmet health needs and more expensive healthcare seeking being borne by the community itself.

This chapter will take a closer look at the challenges faced by rural district hospitals by comparing Canzibe hospital in Nyandeni subdistrict, with another district hospital in OR Tambo where the picture is very different: Zithulele hospital of KSD subdistrict.

Canzibe hospital

Canzibe hospital lies a mere 46km from Mthatha, but may as well be in another world. Twenty kilometres of rough gravel separate it from the tarred R62, and this is enough to discourage both an easy commute from the city (for staff and their families) and EMS drivers. The toll on vehicles from travelling such roads is substantial, and discourages public transport as well as private individuals and services.

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The hospital is as a small district hospital according to the Eastern Cape Department of Health, with 120 beds and services including general medical, paediatrics, maternity and a long-stay TB ward. It should be able to offer basic surgical procedures such as wound debridement, setting of fractures and caesarean sections (C-sections), but this is seriously limited by the shortage of doctors and trained theatre staff.

Like the majority of rural hospitals, Canzibe suffers from high staff turnover and difficulty recruiting and retaining healthcare workers. In 2016 Canzibe had 5 doctors (including the medical manager), but two were community service officers who stay for just one year. The learning curve for young doctors entering such an environment is a steep one; not only must they come to grips with the significant disease burden and its many complications in a rural environment, but they must learn to do this almost without support from senior colleagues. Unsurprisingly, few choose to stay on after their obligatory year, and the learning curve begins again with a new set of juniors the following year – it in fact the hospital is allocated these posts. At the time of writing, no community service doctors have been allocated to the hospital for 2017, in spite of persistent lobbying of province by the hospital manager.

Canzibe’s catchment population of 100 000 has no other access to 24-hour services, but because of the hospital’s skeleton staff, many emergency procedures cannot be conducted out of hours. Perhaps most significant of these are C-sections, which require three medical practitioners to be conducted safely; one to operate, one to manage the anaesthetic, and one to attend to the newborn (some guidelines recommend four doctors). At Canzibe, this is often impossible even in working hours, as the demands of the outpatient wards and the wards preclude pulling two doctors into theatre for an hour or more for a single patient.

After-hours services at Canzibe are limited to one doctor at a time, often a junior with little experience and minimal access to senior support, and the bulk of more complicated cases must be referred to Mthatha or to St Barnabas hospital in the neighbouring subdistrict. Both of these facilities are already overloaded, and the on-referral of patients who should be able to be treated at Canzibe is causing further strain on the system. The transfer of patients is challenging, from gaining permission from the doctor on duty at the referral centre to send the patient, to the logistics of getting her there. EMS services called by the hospital may take hours to arrive, or not come at all. Such vehicles are seldom equipped with paramedic support or basics such as oxygen. Planned patient transport from Canzibe is highly constrained by the availability of hospital vehicles. And as has been seen, few patients can afford transport themselves. In December 2015, Canzibe hospital saw two maternal deaths directly attributable to these issues. But it is doubtful whether the cause of death recorded on the certificates included “lack of rural healthcare workers.”

As mentioned in the previous chapter, the shortage of doctors at Canzibe has also meant the cutting of all outreach services to clinics such as Pilani, which has effectively meant the removal of doctors from the HAART program, which is entirely managed at clinic level. People living with HIV in Nyandeni therefore have technical access to these life-saving drugs, but without medical back-up may suffer toxic side-effects and treatment failure which renders them useless, if not dangerous.

Like most rural facilities, Canzibe hospital faces serious challenges in recruiting and retaining staff. The area boasts few amenities, and healthcare workers are housed on the hospital premises because no other suitable accommodation (for rental or purchase) is available in this impoverished community. Hospital accommodation is basic and somewhat haphazard: Department of Health planning for facilities does not seem to take account of the housing needs of its rural staff, and despite Canzibe’s staffing shortages, the available accommodation is inadequate.

Families of healthcare workers are difficult to accommodate, and there are few work opportunities for spouses here, or decent schooling options for children. The hospital managed with considerable effort to recruit and employ a Grade 3 medical officer in 2015, but she stayed only three months; the lack of schooling for her grandchild and the effect of the roads on her car were too much. When they advertised the post again, they had only one application – from a Zimbabwean doctor, whom Foreign Workforce Programme requirements make it next to impossible for them to employ.

Foreign qualified doctors (FQD’s) have historically been the backbone of the team at Canzibe, as at many rural hospitals where few South Africans choose to work. However, current regulations make the process of employing foreigners a laborious one, and the inefficiencies of the various state bodies involved make it still worse. Mrs Vatiswa Vapi, the hospital manager, bemoans these challenges: “Even if we have a foreign doctor who is willing to come here, we are required first to advertise the post in South Africa, and that can take some months. By then, maybe that doctor has found somewhere else to go.” The delays in advertising posts happen within the district and provincial offices, where much of the HR processing and decision-making takes place. At Canzibe itself, HR staff do not even have a data line to access PERSAL (the computerised HR and payroll system). When they need this, they must travel to St Barnabas or Mthatha, and wait for their turn when local staff are not busy.
Image 25: Nyandeni residents wait in outpatients. Only five doctors serve this population of 100,000, and there are no state-employed rehab professionals at all.

Image 26: “Photocopying machine isn’t working”: medical forms, maternity records and other key documents cannot be produced, rendering legal and clinical record-keeping requirements in the hospital almost impossible. A lack of basic equipment and supplies affects every aspect of patient care.

Whether or not a hiring moratorium is officially declared, Canzibe is experiencing a kind of HRH attrition by neglect. A number of hospital staff are now nearing retirement, and even with forewarning, Mrs. Vapi has a battle to fill their posts. **The problem is not only with clinical staff: in mid-2016, four general assistants retired, and only one was replaced by the province. As a result, a single person is now responsible for cleaning four out of the hospital’s five inpatient sections, posing serious hygiene risks to both patients and staff. Management staff have been known to don aprons and gloves and clean the wards themselves – an impressive show of dedication, but a woefully inefficient use of human resources.**

Image 27: Canzibe management and administration staff clean the hospital wards.

Image 28: Beds stand empty at Canzibe hospital, where lack of both staff and essential goods and services result in ongoing unofficial service cuts.

Image 29: Swallows nest beside empty light sockets in the ceiling of the female ward. Like other support services in the hospital, maintenance is hopelessly underequipped and understaffed.

Image 30: Without basic maintenance and care, existing hospital equipment goes to waste.
Procurement challenges

Human resources are not the only aspect of the health system to suffer under the budget crisis. In order to ‘save’ costs, the provincial department is known to delay payment of suppliers, shifting these debts from quarter to quarter as a rising stack of accruals. Not only is this financially unhelpful, it has a direct effect on healthcare. It is not unusual for Canzibe hospital kitchen to run out of meat and other groceries because suppliers have not been paid. Patients with special dietary needs are completely unprovided for.

The regional pharmaceutical depot in Mthatha is well known for its inefficiencies, and stock-outs of medication and surgical supplies (such as wound dressings and urinary catheters) are commonplace. At a hospital level, procurement problems and fluctuating pharmacy staffing create further complications. Staff find themselves working without the means of basic hygiene (e.g. gloves, hand sanitiser, face masks), placing both themselves and their patients at serious risk of infection. Essential drugs are out of stock for prolonged periods, resulting in enforced defaulting by people on HAART (highly active antiretroviral therapy), TB medication, and other treatments with a high risk of drug-resistance developing6. Here ‘cost saving’ backfires badly, as second- and third-line drugs are generally far more expensive, and the cost to the state of treating someone with drug-resistant disease is exponentially greater.

Zithulele: the success story next door

67km from Canzibe, still within the OR Tambo district, lies a district hospital where the picture is entirely different. Zithulele hospital has 146 beds and serves a catchment population similar to Canzibe’s. As of January 2017, the hospital has thirteen doctors, as well as ten rehabilitation therapists and two dieticians (as well as other allied health professionals). While these numbers may seem excessive, there is no question that each staff member will be working at maximum capacity to meet demand for services.

Zithulele offers a 24-hour C-section service (unbroken for almost eleven years) as well as other minor surgery. During the 2015/2016 financial year, 1855 women delivered at the hospital, on average 155 each month. The hospital recorded only one maternal death in 2015, and just two in 2016, and their peri-natal mortality rate (PNMR) currently sits at 22.6 per 1000 live births.

Given the picture at Canzibe just down the road, how is this possible?

Eleven years ago, the picture at Zithulele was very similar to Canzibe’s, if not a little worse. Three doctors staffed the hospital, two of whom were CSO’s and one had completed her community service the year before. There was no medical manager, no pharmacist and no rehabilitation team. Many staff didn’t even come to work on Fridays. But since mid-2005, the hospital has had a core of senior staff with long-term commitment to the area. Both clinically and managerially, systems have steadily been put in place, battles fought, and a critical mass of motivated, skilled staff built up. Slowly, a team has been forged, and relationships built between administration, managerial, nursing and other clinical staff. Today, new health sciences graduates are eager to work at Zithulele, knowing that they will learn from and be supported by experienced senior staff. Senior staff in turn have collegial support and are continually learning and improving their practice. Auxiliary support from a number of NGO’s fills gaps in state provision, from expanding staff accommodation to purchasing milk for the paediatric ward, to employing additional staff for the extensive anti-retroviral program. Perhaps most significantly, the team is multidisciplinary, including pharmacists, dieticians, audiologists, OT’s, physiotherapists, speech therapists and dentists. Despite the challenges of the district, Zithulele hospital offers a standard of healthcare comparable with some of the best in the country.

6 Adherence Guidelines for HIV, TB and NCD’s – Policy and service guidelines for linkage to care, adherence to treatment and retention in care (Nacosa) – February 2010
The impact of the hospital on its catchment population is reflected in its maternity statistics. In 2006, only 727 pregnant women came to the hospital to deliver, an estimated 50% of the total number in the catchment population (based on the known fertility rate for the area). By 2011, the number had climbed to 1778, roughly 90% of those estimated to have given birth (Dr B Gaunt, personal communication).

Why this growth in numbers? The estimated fertility rate for the region has not changed, and transport costs have not altered much. The change has also been a gradual one, not an overnight rise in response to increased staff numbers or new facilities available. What is different is that today, after more than ten years of gradual improvement, the community has come to trust in the quality of service at Zithulele. They are willing to spend the money and effort to get there, because they know they will be cared for. Increasingly, people are also coming here from other districts, willing to sacrifice for the additional costs in return for the relative certainty of help.

Service utilisation rates: the double bind

While Zithulele patient numbers continue to rise, at Canzibe they are steadily falling as fewer and fewer people are willing to invest in travelling to the hospital to be seen. There are two problems here. One is that the people of Nyandeni are not even close to getting the healthcare they need and are entitled to. The other is that in the eyes of the Department of Health, these unmet health needs, for all intents and purposes, do not actually exist.

Here is the logic: the need for health services of a given population is measured by the headcounts of people who actually use those services. In other words, utilisation rates are taken as a proxy for the level of health need. This assumes two things:

- That everyone who needs a given service is currently accessing it, and
- That all services which the population needs are already being adequately provided

The case of Mankosi community demonstrates clearly that neither is true – neither here, nor for the thousands of rural South Africans who live in similar conditions. The trouble is that staffing decisions currently being made by the Department of Health are based on those utilisation rates, which form the basis for the Workload Indicators of Staffing Need (WISN) HR methodology which the NDoH has adopted. This means facilities which already offer good services (through being able to attract and retain a strong healthcare team) are more likely to secure posts, based on high patient numbers. Facilities where faltering human resources result in unreliable services and falling patient numbers are deemed “low need”, and posts are lost.

While on paper it may seem more ‘efficient’ to direct resources to where the greatest number of health care users live and actually visit health services, the outcome is frighteningly regressive. Flourishing services are strengthened, while overstretched or failing services are weakened to the point of collapse. Any cost ‘saved’ by the Department of Health is transferred directly onto the community in the form of raised costs of healthcare access and greatly diminished health outcomes. The poorest and least visible pay.

This utilisation-based measure of need has further implications for services that currently do not exist at all at a given facility. For example at Canzibe, in the absence of an occupational therapy (OT) service, no headcounts for OT exist. In utilisation terms, this implies zero need for occupational therapy, and the service is therefore not factored into planning or budgets – and families like Philasanda’s must continue to suffer.

Mrs Vapi describes her struggles to secure posts for badly needed staff cadres, both clinical and non-clinical. Back in Mankosi community, the reasons for this downward shift are made clear. Transport costs are part of the picture, but are not different to some of the areas served by Zithulele. The crux lies in people’s perception of services: for many, it’s just not worth the investment to get themselves there. Medication stockouts frequently require patients either to travel further to other state facilities to see if what they need is available there, or go all the way to town and purchase it themselves from a private retail pharmacy. Service hours at clinics in particular can be erratic, with nurses delayed in returning from weekends at their homes in town, and sometimes being gone for days at a time to attend training.

When present, both clinic and hospital staff vary widely in the quality of service they offer. While some are dedicated, skilful and caring, others are neglectful and rude. Patient dignity and confidentiality are violated. This is not unique to this area: the same complaints are heard across the country.

Like many other struggling health facilities, Canzibe hospital is caught in a vicious cycle: lack of staff leads to poor quality services, low community trust and fewer people choosing to access care. Lower numbers are interpreted by the powers that be as lower need, and so staff numbers continue to shrink, and services have no hope of being turned around.

Lessons for HRH

This chapter has explored the ‘inside workings’ of the service quality experienced by the people of OR Tambo district. The Mankosi community’s situation is fairly typical for poor rural areas, and the root causes in system inefficiencies, procurement hassles and most importantly human resource challenges are widespread. The disproportionate impact of health system weaknesses on impoverished rural communities has been made clear.

Zithulele hospital offers a contrasting picture of what might be possible in this setting, and illustrates the central importance of a strong, consistent team for the overall quality and effectiveness of a service. Certain key principles can be drawn from this example which have a bearing on HRH planning across the (rural) board.

Firstly, the question of longevity or the retention of staff members over several years in one place cannot be overstated. It is not merely a question of healthcare worker numbers or level of experience at any given point, but also of the time each person has spent in that institution (or district). Relationships must be built and local knowledge gained before any team member reaches their full effectiveness. Value for money on any staff member increases dramatically after their first year of work, especially for juniors. The building of systems and protocols in a developing institution also takes time, and short-term staff can do very little in improving how a service runs. To build up a previously weak and neglected health service (as many rural facilities are) requires consistent investment by skilled and experienced staff over many years.

Not only are longer-term rural healthcare workers vital to improving efficiency and quality in services, but they create a stability and consistency within the team which makes it more likely that others will
choose to join them. *Critical mass* is a key principle in attracting and retaining rural healthcare workers, allowing a level of professional and personal support which is essential to overcome the isolation inherent in rural work. Below a certain number of staff, health teams disintegrate and become unworkable, and without a core of long-term members they are vulnerable to rapid fluctuations, which in turn create greater instability.

Retention and critical mass are not only important in ensuring maximum effectiveness from staff. Consistency of service quality over time is essential in building community trust in the healthcare service. Mere numbers of healthcare workers at any given time are not enough to ensure uptake of services by those who need them. If a service is not trusted, people are far less likely to invest money, time and effort in using it. The Zithulele maternity figures demonstrate this vividly. Trust is slow to build, and can very quickly be destroyed should service conditions change. As in the case of the Mankosi mobile clinic point, where provision is unreliable people quickly transfer to other options or withdraw from using services altogether. Both alternatives impose serious costs on the community, and greatly reduce the impact of service investments.

The composition of healthcare teams is another important principle. Adequate senior staff with advanced clinical skills and managerial ability are essential for quality services, especially where a service is new or in need of development. A *multi-disciplinary* healthcare team is also vital to service quality and comprehensiveness. Of particular note is the need for disability expertise, including mental health skills, given South Africa’s current burden of disease and particularly conditions in poor rural areas (as explained above).

Human Resources for Health cannot be understood without acknowledging health services as complex systems, where any single aspect has multiple effects throughout. The impact of stock-outs on healthcare functioning as a whole has been clearly demonstrated here. Inefficient procurement systems frequently have catastrophic effects on the health of individuals, as evidenced in the example of the diabetic woman without insulin needles, and the inpatients at Canzibe who go without food when suppliers have not been paid.

Similar issues in HR administration also have a serious impact on healthcare teams. Delays in filling vacant posts can create untenable working conditions for remaining staff, leading to further staff losses. Delays in appointing identified individuals for open posts can lead to candidates finding work elsewhere, because they cannot afford to wait. Late or incorrect salary payments can similarly drive committed rural healthcare workers into urban areas, other provinces or the private sector.

There is no question that simply keeping minimum numbers of nurses and doctors at the frontline is not enough to sustain rural healthcare. And with huge gaps in essential services yet to fill, simply sustaining current service levels is not an adequate or acceptable goal. Unfortunately, current fiscal realities in South Africa (as in many countries) pose serious threats to rural healthcare through the imperative to contain human resource costs. We turn now to examine the nature of the HRH crisis and current responses to it from both the national DOH, and the Eastern Cape province.

### Chapter 4: The HR crisis & impact of cuts

The need to contain health costs is a universal challenge. In South Africa, 2016 has seen a particular clamp-down on the Compensation of Employees (CoE) element of the health budget, which now represents up to 64% of the total budget.1 Above-inflation wage increases and the growth in managerial numbers have led to a now unmanageable wage bill. Many departments have dealt with this in the short-term by borrowing from other budgets, resulting in delayed payments for goods and services and a growing stack of accruals which must be settled at the beginning of each financial year, generally without having been budgeted for.2 The situation has now reached crisis point, and urgent and drastic action is needed to deal with deficits and find a sustainable way forward. Despite the widely known shortages of healthcare workers in the public sector already, provincial departments of health are seeking to restrict numbers still further in order to cope with rising costs. Unfortunately, the strategies currently on the table have serious and regressive implications for rural communities.

#### Post freezing

Most provinces have immediately reacted to the budget crisis with hiring moratoria or “post freezing”, whether officially adopted or by simply failing to appoint staff to existing posts. Vacant posts are blocked, and employees who leave are not replaced. Despite assurances by both national and provincial departments of health that frontline posts will not be affected by such measures, and that 'critical' posts will be protected, these measures are already hitting health service provision in rural areas hard.

Post freezing has its most immediate effect on hard-to-staff facilities where turnover is high. Staff who resign because of difficult working conditions leave gaps which only increase the load on their colleagues who remain. In fragile health teams, just one or two staff leaving can set off a cascade effect, quickly decimating a service. When one facility shuts down in this way, the load is shifted to clinics and hospitals in the neighbouring areas, and the rising pressure soon sets off the same effect there. Rural health services, characterised by serious staffing challenges at the best of times, are the first to go. Rural communities, who have the fewest healthcare alternatives, are doubly vulnerable to the effects of HRH cuts in their local services.

#### Utilisation-based approaches to HRH planning

Alongside this ad hoc, short-term response, both national and provincial departments are attempting a more rational and standardised approach to HRH planning. At national level, the Workload Indicators of Staffing Need (WISN) method has been adopted to develop evidence-based staffing norms for existing services. At provincial and district levels, health planners are also attempting to determine staffing needs based on available data. The data used to inform both national and local HRH planning is most often utilisation rates: patient headcounts, or the numbers of people currently using the services in question. As demonstrated in the previous chapter, utilisation rates as a proxy for health need are seriously flawed, being based on assumptions about healthcare uptake and existing services which are simply not true. In services like Canzibe, the use of utilisation rates for HRH planning has a highly regressive effect: the poorest quality services are least likely to secure posts, and the communities who rely on these struggling facilities must increasingly seek healthcare elsewhere or do without. In rural areas this bias against staffing underdeveloped and underperforming services compounds the existing challenges in attracting and retaining good staff.

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2 Available at: www.treasury.gov.za

Standardised organograms in the Eastern Cape

The Eastern Cape Department of Health (ECDOH) has undertaken to standardise and contain its HRH in another way as well. Set organograms have been developed which are to be applied to all healthcare facilities, depending on their classification of level and size. During 2016, facility managers were warned that they would need to select from their current staff those who will fill this restricted post structure, and that ‘superfluous’ workers, once identified, would be redeployed elsewhere in the province. An outcry from healthcare managers and workers, as well as from civil society organisations, led to further consultation by the ECDOH, and the organograms were still on track to be signed off for implementation in December 2016. However at the time of writing, no one has seen the final organograms and while at a meeting between the ECDOH and RHAP and its partners in September 2016, the SG promised that rural facilities will be protected, Canzibe has started off 2017 in a preventable crisis. It has been allocated zero conserve doctors, has zero allied health professionals employed nor posts available, the one vacant and advertised MO post has not been filled (despite a foreign doctor application) and the facility and communities are left with two filled MOs posts of which one is serving notice.

While the attempt to develop standard staffing norms is laudable, the organograms that were tabled mid-2016 by the ECDOH were worryingly out of sync with service needs and standards. As has been demonstrated at Canzibe, five doctors (not to mention the remaining 2 from February 2017) are insufficient to provide a 24-hour C-section service, not to mention offer medical services to people on HAART or conduct clinic outreach for patients unable to access the hospital. Should the draft 2016 organogram be approved, then the Zithulele team will have no choice but to cease a large proportion of the essential services they currently provide. From the current 22 midwives who are managing to provide obstetric services for the full number of pregnant women in the catchment, this staff complement will be shrunk to only four. With no other 24-hour maternity services in the subdistrict outside Mthatha, this means that only one in six women will have access to a skilled birth attendant. Not only is this an unlawful deterioration of current health services offered, it is in direct violation of the immediately realisable right to essential health services for pregnant women and children under six years.

Rationing and “non-essential services”

Which women should be left to deliver their babies alone, or with inadequate skilled assistance? Healthcare workers must take such decisions every day, as they are forced to ration scarce time and resources among a huge array of pressing health needs. The decision to cut staff is not simply one of taking away jobs: it is the decision not to provide essential health services to certain sections of the population. However these decisions are not made by health care workers at facility level, but it is made by officials who are far from the frontline and who need not face the life-and-death consequences of such a step.

Unfortunately, at present these circumstances remain unacknowledged by the officials who make staffing decisions. Healthcare workers continue to carry the responsibility for Department of Health programmes, and to come face to face every day with the people whose health needs they are prevented from meeting. At Canzibe, doctors must choose between a C-section for a single at-risk pregnant woman, and attending to eight or ten outpatients with anything from pneumonia to multi-drug resistant TB. But the pregnant woman must still be helped, so she is sent by ambulance to another hospital to be operated on. Unnecessary resources are used, unnecessary risks taken with her wellbeing, but the doctor on the ground has no other choice. Cost ‘saving’ produces only greater inefficiency.

Outreach services are among the first to be cut when district hospital staff are reduced. Unfortunately, the immediate effect is to raise the ‘barriers to entry’ for healthcare: if you cannot travel to the hospital, whether for financial, health or logistical reasons, you no longer have access. This cuts off the poorest, most remotely located and the most unwell, including many people with disabilities. The inverse care law is at work even among the poor themselves, and the ‘saved’ cost of additional hospital staff is transferred directly to those who can least afford it.

Rehabilitation services are another item readily cut by health managers when budgets shrink. Again, this is a regressive choice: people with disabilities frequently have greater and more complex health needs than their able-bodied peers, but without disability specialists on the team, they may never access the care they need. Where disability is the direct result of a health system failure, such as stockouts of essential medication, the exclusion is yet more cruel.

This section has unpacked the key responses of the ECDoH (along with other departments) to the current HRH crisis. While the need to contain CoE is a pressing one, it is clear that current strategies adopted by the province serve simply compound existing inequities, and transfer the cost to those citizens who can least afford it.

But this is not all. Another factor is at work in the provincial healthcare arena which may yet pose the greatest threat to healthcare for all, and which cannot be ignored in HRH planning: the rise of medico-legal claims by users of the public healthcare service.

Medico-legal implications

Maternity care has been used as an example throughout this report thus far, and it is not an incidental one. Not only is it a basic right entrenched in the Constitution with far-reaching implications for mother, child and society, but medical negligence claims in this area have skyrocketed over the past ten years. In the 2015/2016 financial year, the ECDOH faced claims amounting to 20% of their total budget. In the 2016/2017 financial year, this looks to be rising to almost one third (Daily Dispatch 2016).

The steep rise in medico-legal claims can be traced directly to increased solicitation by law firms, since changes to the Road Accident Fund claims process in 2009 excluded them from earning fees from this source. Whether claims are legitimate or not they are costly for the province to defend, and approximately half of the amounts claimed are awarded. In the first quarter of the 2015/2016 financial year, R154 million in awarded claims from the previous year were paid out, and outstanding claims against the ECDOH stood at R1,1 billion. To date, 98% of claims are related to obstetric incidents, the majority leading to permanent disabilities such as cerebral palsy, and 96% are from the Mthatha area (i.e. OR Tambo district) (Daily Dispatch 2015). The scale of the payouts reflects very real problems in maternity services, and it seems only a matter of time before claims spread to other aspects of health services and other parts of the province.

Thus far, the ECDOH has responded by laying blame at the feet of ‘negligent’ and inadequately skilled healthcare workers, as well as the unscrupulous lawyers who exploit the situation. Unfortunately, no connection seems to have been made by provincial managers between the medico-legal crisis and the widespread HRH shortages which produce these outcomes. Despite this avalanche of maternity- and disability-related litigation, the proposed HRH organograms seem set to cut these very services still further.
While maternity and neonatal services are the focus of these lawsuits, the costs of rehabilitation and support for a child with a disability play a significant role in determining settlements paid out to claimants. It stands to reason that the near-absence of disability services in the public sector will result in higher pay-outs by the Department of Health to cover the costs of private speech therapy, occupational therapy and any other services required. To their credit, the ECDoH have taken the initiative to strengthen rehabilitation services at Nelson Mandela Academic Hospital in Mthatha where certain claimants access healthcare, and this is understood to have a mitigating effect on the Department’s liability on these specific cases. Unfortunately, this has so far been confined to once-off training for existing staff, and has not carried over into broader HRH planning. And although the medicolegal process is now transferring the financial costs of disability directly onto the health service, the connection does not seem to have been made at all to the implementation of the NDoH’s own Framework and Strategy for Disability and Rehabilitation, launched in 2015 – either in the Eastern Cape or the rest of the country. For now, the ECDoH remains reactive and entirely short-term in their response to the problem, and only those who go to court will gain any help for their struggles.

According to the ECDoH’s proposed organograms, small district hospitals such as Canzibe and Zithulele will each have a single junior post for a rehabilitation therapist – either a physiotherapist or an occupational therapist – and speech therapy and audiology will only be available at larger hospitals. Choosing between the different rehabilitation cadres makes no more sense than choosing between a pharmacist and a dentist for a single post, and a junior therapist working in isolation and without supervision cannot be expected to develop or render an adequate service. Neither can rehabilitation services be centralised as medical specialists are: for reasons explained in the previous chapter, if these services are not available within close reach of where people live and work, they are in effect not available to those people at all.

To date, the vast majority of medico-legal claims have been in cities, but Zithulele hospital itself is facing litigation by a group of mothers of children with cerebral palsy who were born there before the improvements in the service. Under the staffing cuts proposed by the ECDoH, it is likely that those conditions will soon prevail once again, and this time those who suffer under the changes will be well aware of the litigation avenue – and ready to use it.

Chapter 5: Recommendations

This report has sought to show both the gravity and the complexity of the HRH crisis for rural communities in South Africa. While many of the challenges described affect health services at all levels and in urban and peri-urban areas as well, it is clear that rural South Africans are uniquely vulnerable to the effects of staffing cuts, and disproportionately affected by them. We have argued that poor access to healthcare for impoverished communities plays a critical role in the vicious cycle of illness and poverty. Disability has also been shown to play a rapidly increasing role in the (ill) health of our citizens, and it is imperative that health services are staffed and equipped to address this.

Based on these arguments, we now present recommendations for HRH which take account of both fiscal constraints and human rights imperatives.

1. Prioritise posts in rural PHC services

District HRH planning should take account of rural communities’ lack of service choice and the heavy burden of transport costs to reach facilities. Research should be conducted to quantify the costs transferred to the community by cutting remote services (including outreach), including both direct (transport) costs, and the indirect costs of failing to access services. These calculations should be used to inform distribution of resources between facilities and subdistricts.

HRH decision-making should also take account of the specific challenges in recruiting and retaining staff in rural areas, and seek to protect fragile health teams from across-the-board cuts. The increasing returns on investment in longer-term staff should be considered and retention prioritised.

2. Reconsider utilisation-based measures of need

The regressive impact of utilisation-based measures of need has been clearly demonstrated, as well as the false assumptions which underpin them. Such measures should be balanced against known prevalence rates for given conditions (for example the fertility rate to predict need for obstetric services) and against benchmarked utilisation rates in comparable well-functioning facilities.

HRH planning should also be informed by the package of services to be provided. The WISN method offers a rational approach to planning for staffing needs, calculating time requirements for tasks against workload and available working hours. Expecting staff to carry a workload disproportionate to the hours available to them can only lead to deteriorating quality of service and ultimately system collapse. Where HRH cuts beyond this point cannot be avoided, the state itself must take public responsibility for the cuts in essential services required, and not simply transfer rationing decisions to remaining staff.

3. Plan for HRH as part of a complex system

Healthcare worker posts cannot be planned for in isolation. Non-clinical support staff, hospital transport, drug supply and decent staff accommodation have all been shown to play critical roles in rural healthcare. Unless HRH is understood as part of a complex system, investments in frontline posts may be wasted.
For this to happen, HRH decision-making should be devolved as far as possible to facility level, so that detailed insight into local conditions can be brought to bear on post allocation.

4. Include rehabilitation and mental health workers as essential services at PHC level

The increasing significance of disability as a dimension of South Africa’s burden of disease, with all its health and economic impacts, must be recognised. Multidisciplinary PHC teams should include a full complement of rehabilitation professionals as far as possible. A mid-level rehabilitation worker cadre could offer the most cost-effective and sustainable route to ‘rehabilitation for all’, and could dovetail psychosocial rehabilitation with the needs of people with physical and sensory disabilities – in accordance with both the national Mental Health Strategic Framework, and the Framework and Strategy for Disability and Rehabilitation.

5. Consider the hidden costs

The costs to communities, the economy and ultimately South Africa itself of poorly functioning health services cannot be underestimated. Money is not ‘saved’ when service conditions result in deepening poverty and marginalisation of the sick and disabled. More easily quantifiable, medico-legal costs pose a monumental threat to the health system as a whole, and current cost-cutting measures will certainly drive claims yet higher. Radical approaches are needed to address this situation, and budgeting for healthcare must take account of these direct costs to the service of rendering inadequate care. Instead of the current short-sighted transfer of funds from service provision to medicolegal payouts, health planners need to invest in preventing incidents through ensuring the resources for decent healthcare.

Conclusion

While the Eastern Cape and OR Tambo district in particular represent perhaps the worst-case scenario in South Africa’s public healthcare, the stories in this report are far from unique. Across the nation, poor communities and otherwise vulnerable groups suffer greatly from the lack of decent healthcare. As has been illustrated here, living in a rural area exacerbates these effects on multiple levels. Furthermore, the DOH’s strategies to rationalise healthcare costs have a markedly regressive effect on these same communities, setting the stage for still worse rural health conditions in the near future.

The Mankosi community are unusual in having been able to take positive action to address their own healthcare needs, and yet the local DOH have still failed to meet them halfway. For rural South Africans, it remains a case of “out of sight, out of mind”. In the rest of the district, citizens are speaking out in the one avenue that seems to get response: through litigation. Despite the shady legal practices making this possible, one cannot blame these individuals for trying – given the realities of health costs both direct and indirect, the battle for survival for such families is a fierce one.

Meanwhile, healthcare workers are blamed for poor services rendered, but face impossible demands with woefully inadequate resources. Rural health services are hanging by a thread, and that thread is the nurses, managers, doctors, therapists and others who are prepared to go far, far beyond the call of duty to serve their communities. They are paying too: with their time, health, finances, quality of life and sometimes even their lives.

Where will it go from here? The South African public health system has never been nearer a full-scale collapse, and it is people living in rural areas and the healthcare workers who serve them who are paying.

To the health care workers who face struggle and adverse working conditions on a daily basis in rural and underserved communities:

“Our ordinary acts of love and hope point to the extraordinary promise that every human life is of inestimable value.” Desmond Tutu
References


