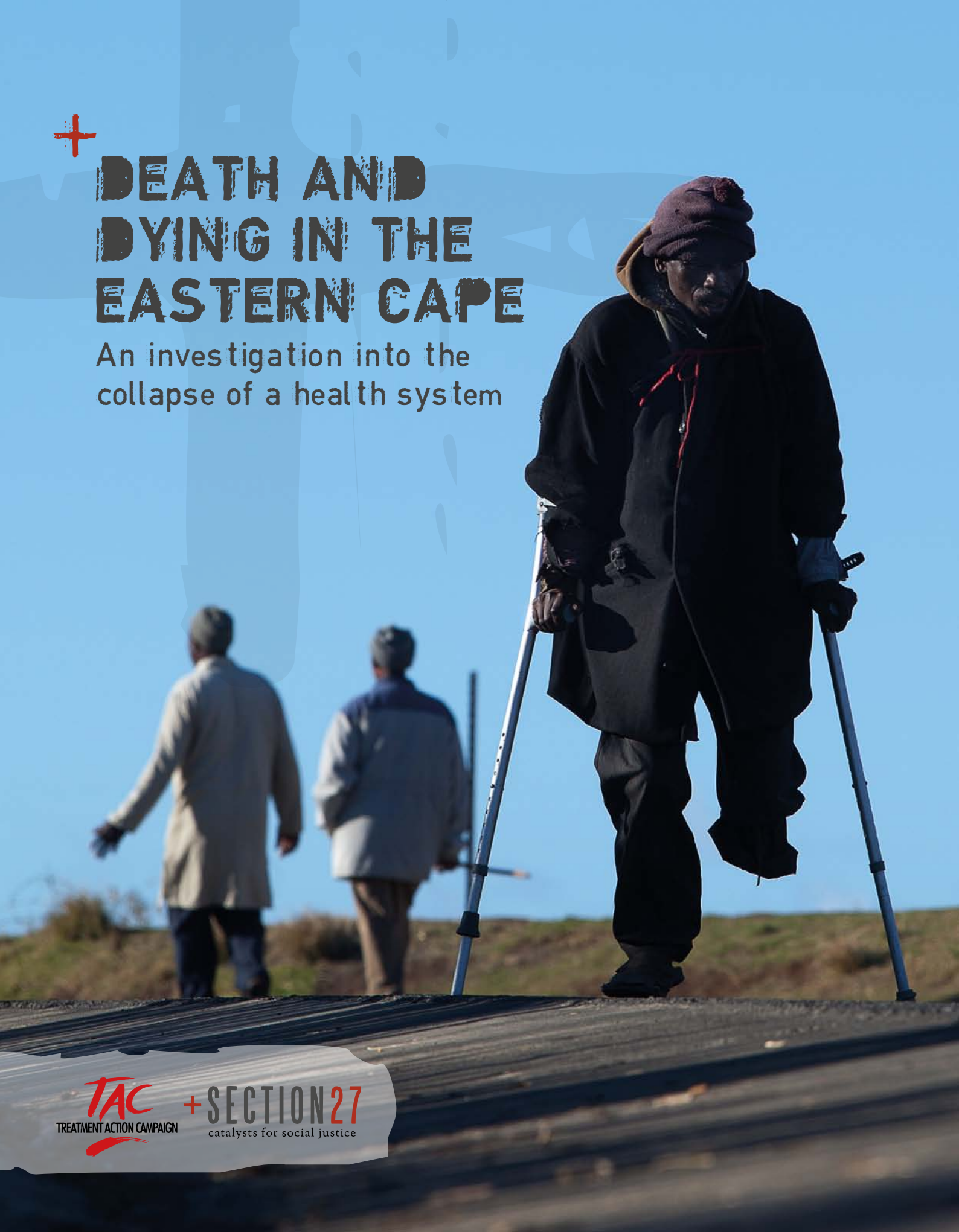
DEATH AND DYING IN THE EASTERN CAPE

An investigation into the collapse of a health system



TAC TREATMENT ACTION CAMPAIGN

+SECTION27 catalysts for social justice

This is Hamburg Clinic in the Amathole district between Port Alfred and East London. The clinic building is literally collapsing, but the patients needing healthcare have no option. This is their only health facility within reach. Health workers have alerted authorities to the state of collapse on numerous occasions over several years, but nothing has happened.

CONTENTS

Eastern Cape Health Crisis Action Coalition Memorandum 3

Leaders' Analysis

Mark Heywood, Executive Director, SECTION27
Health warning *2*

Anele Yawa, Treatment Action Campaign Provincial and National Chairperson
We have had enough! *10*

Sasha Stevenson and John Stephens, SECTION27
The power is with the people *12*

Marije Versteeg, Rural Health Advocacy Project
Usana olungakhali lufela embelekweni – a Tale of Rural Health *18*

Daygan Eagar, Rural Health Advocacy Project & Budget Analyst
When the solution compounds the problem *19*

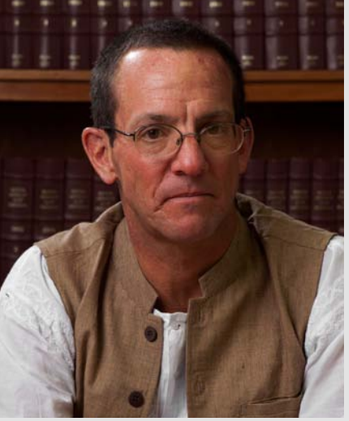
Kholiswa Tota, Provincal Secretary DENOSA Eastern Cape
Time to nurse the system back to health *26*

Dr Trudy Thomas, Eastern Cape Health MEC (1994-1999)
A blueprint for recovery *27*

Citizens' Reports

Of dignity and death *4*
Baby Ikho: he should have lived *6*
Fighting the odds *14*
"People are dying here!" *16*
A hospital crumbles *20*
A bridge too far *22*
The steep road to health *23*
Operating in the dark *24*

This is a special report of the TAC/SECTION27 NSP Review. It has been researched and written because throughout 2012 and 2013 we have become increasingly aware of the scale of the health system crisis in the Eastern Cape and its adverse impact on patients and health providers. This is not a report of statistics and numbers, but of people and their pictures. It aims to remind the reader that it is people who suffer the consequences of mismanagement, corruption and indifference. Through this report we aim to bring this matter to national attention – and to force improvements.
TAC and SECTION27 are both members of the Eastern Cape Health Crisis Action Coalition, which is driving the campaign to fix health systems. We acknowledge and thank our partners without whom the production of this report would not be possible.



+ LEADERS' ANALYSIS

HEALTH WARNING

Mark Heywood, Executive Director, SECTION27

Dear reader. A health warning should be attached to this report: its contents are upsetting and may sicken you.

This report is about rights and wrongs. The unnecessary death of one-year old baby Ikho is wrong. The suffering of Lindeka Gxala and the gross violations of her dignity and privacy are wrong.

The health care workers and patients who bravely have decided to report their stories have opened a window that allows you to see not only their suffering but also part of a much bigger picture of pain and indignity.

The report bears witness to, and provides an analysis of, the collapse of a provincial public health system on which over six million people depend. For over a decade this collapse has been overlooked, nay permitted, by a succession of politicians at both a provincial and national level who have abused public trust and become more interested in using their elected positions to line their own pockets, than to advance the public interest.

This is no polemical exaggeration for, as Daygan Eagar (p19) explains, an investigation by the Special Investigation Unit (SIU) has found that over an 18 month period R800m was stolen by public officials. As far as we know, no-one is in prison for this grand theft.

There are no excuses for what is described in the pages that follow. The crisis of the health system is not an apartheid-legacy, but a democratic failure. It is a crisis of management and political oversight. It is a crisis of the Constitutional promise. We say this because we know that there are financial and human resources available to provide health care in the Eastern Cape; there are committed nurses, doctors, community health care workers as well as other people who want to be trained to work in hospitals and clinics; there are systems which can be made to work to effectively distribute medicines, X-ray machines and other essentials to clinics.

This is the story of a political failure.

But it is not all a tale of gloom. The mere existence of this report bears witness to the fact that many health workers and ordinary people in the Eastern Cape have decided enough is enough. In the words of Anele Yawa (p10), the TAC's Provincial Chairperson, "It has to stop." In this respect, this report is not a mere journalistic expose, but part of a social mobilisation for the right to health that will only end when the problems it describes have been reversed.

But how can problems of such enormity be overcome?

As we all know, Nelson Mandela hails from Qunu, a town in the OR Tambo health district of the Eastern Cape, an area in which the blight of apartheid-inherited inequality in health care has tragically deepened. Fortunately because of Nelson Mandela, and other visionary leaders like Chris Hani, Oliver "OR" Tambo, Govan Mbeki who also originate from villages and towns in the Eastern Cape, South Africans have a Constitution to which they can turn when their fundamental rights are being violated, or as a means to have the government ordered to take measures to realise the rights for which they struggled. We plan to do this.

The fundamental right that bleeds from the heart of this report is found in section 27 of the Constitution; it is the right of "everyone to have access to health care services" and the duty on the government to "progressively realise" this right.

The overarching wrong, as described by Dr Trudy Thomas (p27), the first democratic MEC for Health in the Eastern Cape, is that for the last 15 years there has been a deterioration of health services in the Eastern Cape – the exact opposite of what the Constitution requires.

This has to stop and the people must have a remedy for this disaster.

The Eastern Cape Health Crisis Action Coalition (ECHCAC) was established in May 2013 for this purpose alone. It will campaign for justice for people like Baby Ikho and Lindeka Gxala; it will campaign to end corruption with impunity; it will campaign for the dignified employment of health care workers and the filling of vacant positions; it will campaign to ensure that democratic and effective clinic committees and hospital boards are established; and it will campaign for a plan, timetable and resources to turn around the crisis we describe. If you want to join or support the ECHCAC contact us at echealthcrisis@rhap.org.za or via www.ECHealthCrisis.org

+ EASTERN CAPE HEALTH CRISIS ACTION COALITION MEMORANDUM*

FIX THE EASTERN CAPE HEALTH SYSTEM!

The Eastern Cape Health Crisis Action Coalition has picked up the baton to bring meaningful transformation and urgent change to the province's public health system. The partners are driving a number of processes and activities, one being a march in Bisho where a coalition memorandum will be handed over to the Eastern Cape government.

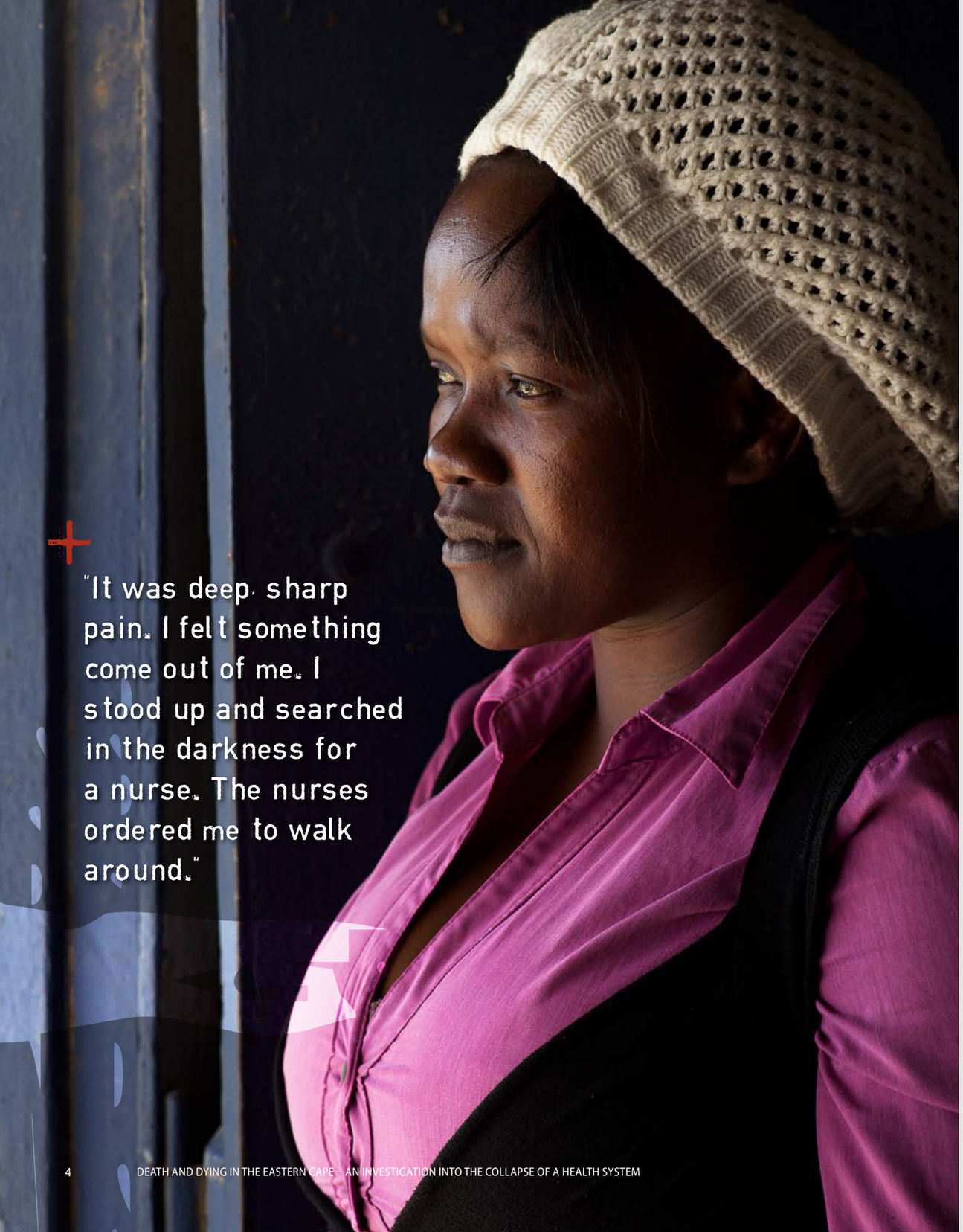
+ **Facilities** – The poor quality of many facilities hampers the delivery of health care. They often lack electricity and running water. Many are too small for the number of people served and some are literally falling apart.
+ **The availability of medication and supplies, and supply chain management** – Stock-outs and shortages of essential medicines and medical supplies continues across the province. The catastrophic situation at Mthatha Medical Depot has been allowed to continue. Supply chain management throughout the health care system in the Eastern Cape is in a state of chaos and this directly impacts patient care.
+ **Human Resources** – The combination of a high vacancy rate and an out of date Persal system has catastrophic consequences for the delivery of health care services. It frequently takes at least six months for an appointment to be confirmed, by which time candidates may well have found other jobs. It regularly takes three months from the date of commencement for an employee to be paid.
+ **Management** – There is no proper management and the day-to-day functioning of health facilities goes unattended. Clinical staff are not appointed or paid timeously and properly causing chronic under-staffing; facilities fall into disrepair; equipment goes unrepaired and new equipment cannot be obtained and staff are left without leadership.
+ **Patient Transport and Emergency Medical Services** – Patient transport and Emergency Medical Services are entirely absent in many places and insufficient in others. Patients can wait six hours for the arrival of an ambulance in some places; in others, the ambulance never comes.
+ **Equipment** – There are many reports of equipment shortages and faulty equipment. Reports of TB Hospitals without x-ray machines, busy clinics with only one blood pressure cuff are common.
+ **Staff accommodation** – Many facilities suffer from poor quality and insufficient staff accommodation. In some facilities there is no electricity or running water and the accommodation is filthy and run down. Some facilities have no accommodation. This dissuades health care workers from staying and contributes significantly to staff shortages and, in severe instances, violate the rights of health care workers to dignity.
+ **Rehabilitation, home based care and preventative services** – Some facilities have no budget with which rehabilitation departments can procure supplies, making preventative and home-based care near impossible. There is a minimum wait of 12 months for wheelchairs and other equipment in the OR Tambo District.
+ **Budgeting and expenditure** – Underpinning many of the challenges are the many chronic failures in the effective mobilisation of the health budget. There is little hope that the province could motivate for its fair share of revenue if it does not deal with endemic financial mismanagement that continues to contribute to the inefficient, ineffective and unaccountable use of public resources for health.

The problems identified above can be found to varying degrees across the province. The ongoing failure to address these issues leads to people going without health care, poor health outcomes and avoidable deaths. The ARV programme is being undermined by stock-outs and shortages, the TB programme is under threat, the neonatal mortality rate in facilities remains the highest in the country, and five of the eight districts in the province record under-5 mortality well above that of the national average with OR Tambo reporting the highest rate in the country.

The constitutional rights of health care service users and staff access to health care services, dignity and life are being violated. The rights of patients under the National Health Act 51 of 2003 are being undermined, and the obligations both in that Act and in numerous policies of the national and provincial departments of health are being breached. Failure by the Eastern Cape Department of Health to attend to these serious problems in the health care system is unlawful and contrary to its constitutional and legislative obligations.

The problems identified above require urgent attention. We call on the MEC for health to develop a plan with clear timeframes that includes components that address the items listed urgently to remedy the crisis in health in the Eastern Cape. We demand a response from the MEC to this memo, including the plan referred to above, by 11 October 2013.

** Please see the back page for a full list of current coalition partners. This is a condensed version of the memorandum.*



+ CITIZENS' REPORTS

OF DIGNITY AND DEATH

The story of Lindeka Gxala, a 33-year-old woman, who lost her baby when she was seven months pregnant, is a tough read.

Sadly and horrifically the story does not end with her loss, as she is forced to endure a painful and undignified abortion.

A receptionist at Mdumbi Backpackers in the breathtakingly beautiful Mankosi area, Gxala's tale starts at Pilani Clinic, where she was told in February 2013 that she was pregnant with her first baby.

'I was early in my pregnancy with my first child when I first walked to the clinic 10km from my home,' says Gxala. She waited the entire day to be seen at the busy clinic, which is run by a single nurse and an assistant.

Between February and May, Gxala made six visits to the clinic and only got to see the nurses on two occasions. On her sixth attempt, she says, 'I was six months' pregnant and I took the day off work to walk to the clinic. The nurse was again too busy to see me. My friend and I decided instead to go to Nelson Mandela Academic Hospital in Mthatha.

'The nurses at Pilani are kind and well regarded in the community. I can even call one of them on the phone if I have a serious problem, but they are simply too busy to attend to all the patients.'

When Gxala visited the hospital in Mthatha she learned that her unborn baby was dead. It was June 11 2013 and she was seven months' pregnant.

'The doctor assured me that there would be no pain when they removed her from me, and I was admitted and placed in a ward the following day.' There weren't enough beds and Gxala was forced to share a bed with another woman, who was already in labour.

'She was bleeding. The nurses told her to be still, but when the pain came she would thrash and the blood would spill onto the floor. She bled heavily and her blood pooled on the floor,' says Gxala.

Several hours later, the nurses provided Gxala with two tablets. It was never explained to her that these tablets would cause her to abort: 'I am not sure what the tablets were or what they were for.' Six hours after taking the drugs Gxala was still waiting for something to happen.

'The nurses gave me two more tablets. I became very thirsty and stood up to search for water. I went to the sink and it was full of vomit, I could not drink from it. The vomit blocked the sink and it could not drain.

'They brought me dinner, mincemeat and bread or rice, but I could not eat it because the place was filthy. There was blood all around me and people vomiting and the room was filled with the stench of blood and the vomit.'

The woman who was sharing a bed with Gxala warned her to get blankets before sunset, as the hospital would not be providing her with any.

'She was correct – the hospital did not provide me with a blanket.' A friend borrowed two blankets for Gxala. 'It was cold that night and I was glad for the blankets.'

Gxala recalls there being no electricity in the ward until one or two in the morning. 'When it became dark, the nurses attended to the women and delivered the babies by the light of their cell phones.'

Around midnight, 12 hours after taking the first tablets, Gxala experienced severe pain and cramps in her lower body.

'It was deep, sharp pain. I felt something come out of me. I stood up and searched in the darkness for a nurse. The nurses ordered me to walk around. I tried to tell them that something was coming out of me. They told me to walk around more. I kept telling them about the pain. By then my dead child had come out feet first and the head was stuck inside me. The baby hung from me as I walked around the ward and tried to plead with the nurses, to beg them for relief from the pain.

'I was still walking around when I collapsed from the pain. The nurses then removed another patient from her bed and put me in the bed. I stayed there until six in the morning without anyone helping me. I was in terrible pain the whole time.'

The nurses eventually took Gxala to the theatre. 'The nurses looked at my hospital card and commented that they had failed to give me an injectable anaesthetic for pain. I still do not know whether they had forgotten, or did not have the injection. Without giving me painkillers they then removed the dead baby while I was conscious. The pain was terrible. They eventually gave me something for the pain, but I had felt everything. I cried the whole time.'

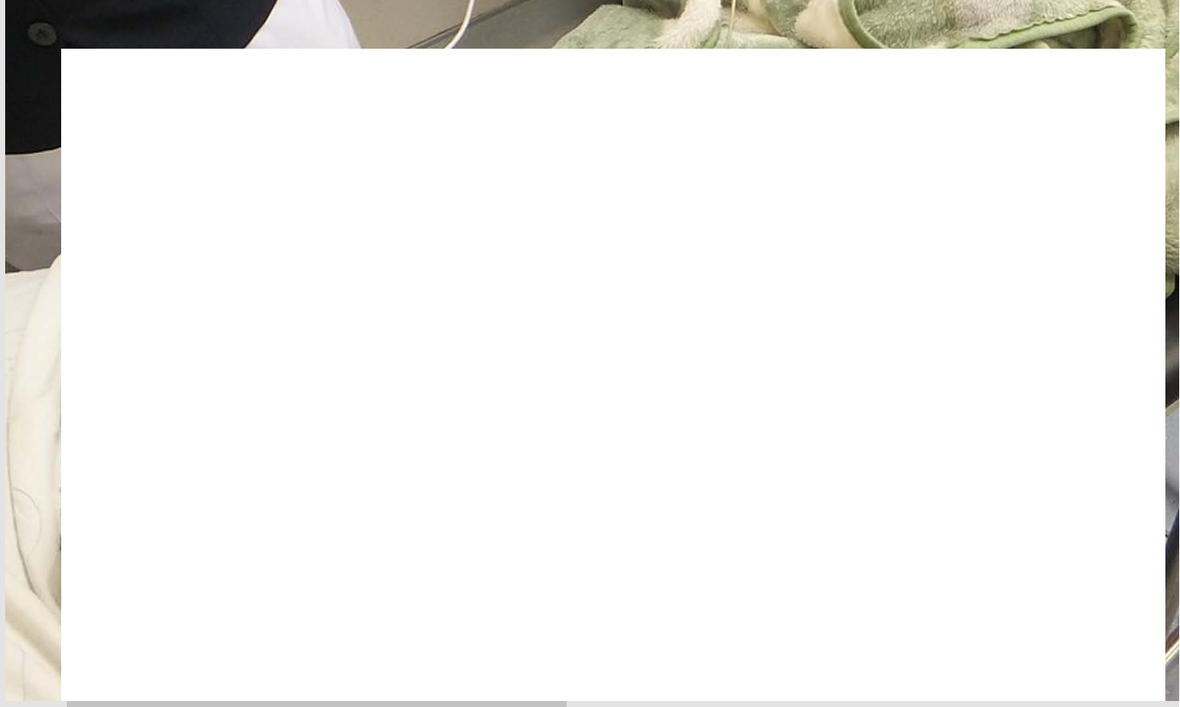
Lindeka Gxala was sent home the same day.

Her story speaks of a health system that fails its patients, and of some health workers who have no respect for them, leaving them stripped of their dignity.

+ CITIZENS' REPORTS

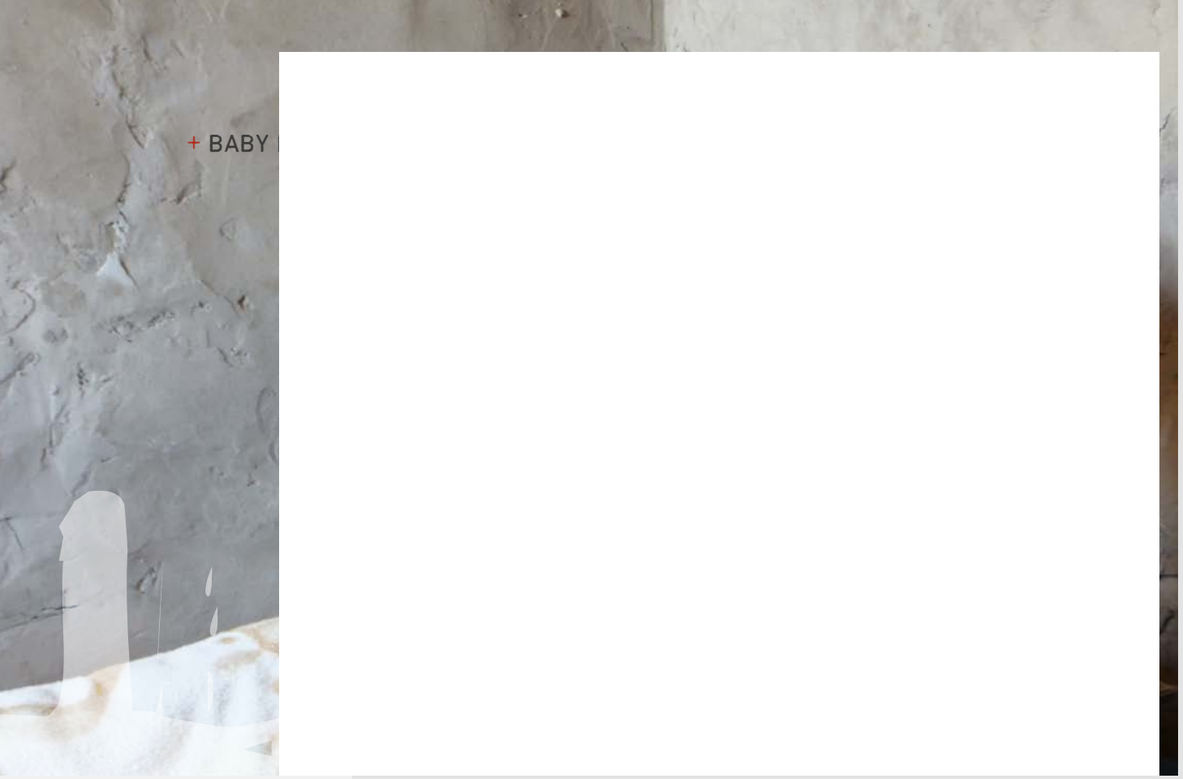
BABY IKHO: HE SHOULD HAVE LIVED

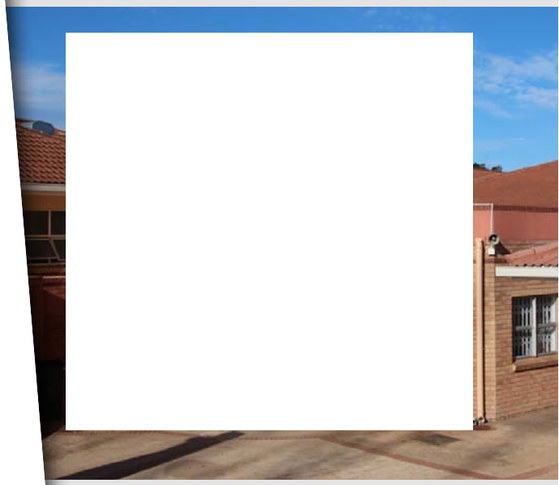
The Minister of Health and some doctors have expressed discomfort with the details contained in these pages. While the details were not disputed, we have redacted this article as an expression of good faith. The Minister has undertaken to urgently address the health system failings identified in the article.

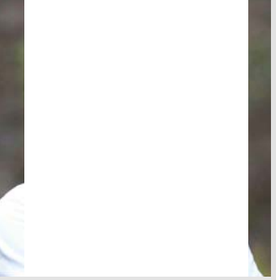


WHY did baby Ikho die?

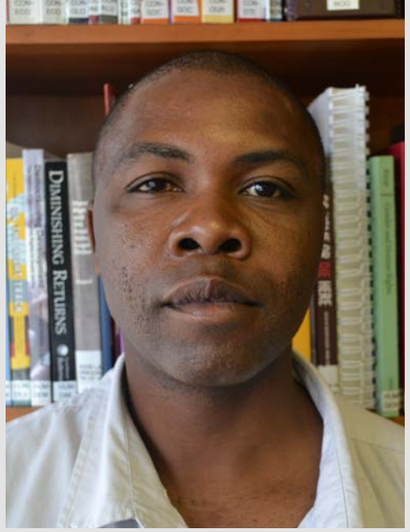
+ "Ikho, a healthy 12kg toddler, had celebrated his first birthday on August 15. By August 20 he was dead, failed a breathtaking number of times by a broken, inhumane and collapsed health system where accountability is non-existent."







+ BABY IKHO (continued)



+ LEADERS' ANALYSIS

WE HAVE HAD ENOUGH!

Anele Yawa – Treatment Action Campaign Provincial and National Chairperson

Tackling the health crisis in the Eastern Cape is one of the most important campaigns since activists took to the streets forcing our government to make antiretrovirals available in the public sector.

The Eastern Cape is one of the most beautiful places in South Africa. But stop at one of the clinics or hospitals and you are likely to be met by an inhumane situation of staff shortages, drug stock-outs and equipment failure.

There was a real effort to improve matters when Dr Siva Pillay was still the Head of Department at the ECDoH, but since his departure matters in the province have gone from bad to worse.

The Treatment Action Campaign (TAC) has driven a campaign in the Eastern Cape to strengthen the public health system. One of our focus areas has been the OR Tambo district, a vast rural area with high levels of poverty and unemployment.

Most of the residents rely on the public healthcare system. They are being failed. Our members in these areas report not receiving the antiretroviral medicines they need and having to stand in queues for hours to see a nurse.

In response to medicine stock-outs, the TAC has tried to sort out problems at the Mthatha depot. We deployed more than 20 volunteers to assist in packing and sending medicines to the various clinics and hospitals. These volunteers worked long hours at the depot and other facilities to ensure that the drugs reached the patients.

However, since the TAC's departure from the depot, matters have again deteriorated.

There are many such stories of mismanagement and dysfunction.

We have often tried to engage the provincial government on these and other issues, but the MEC keeps postponing meetings. We cannot accept this indifference to our suffering any longer.

- Our people's basic human rights are violated on a daily basis. It has to stop.
- Poor political leadership has contributed to the collapsing public health system, with cadre deployment resulting in high levels of corruption. It has to stop.
- Patients are increasingly using their last money to travel to a clinic or hospital only to be told they do not have the drugs they need. It has to stop.
- Too many times ill people are forced to wait overnight in long queues to see a health worker. It has to stop.
- Ambulances are almost never available. For many people this means they will die. It has to stop.
- Our health workers are not being paid what is due to them. It has to stop.
- Nurses and doctors are left to look patients in the eye and tell them they are unable to assist them because the equipment is not working. It has to stop.

The TAC is, again, ready to pick up the baton and to fight for quality healthcare services for all. We invite everyone to join this struggle for a more humane Eastern Cape.

Baby Ikho's name loosely translates into the English words "there is a man", indicating that the family were happy that he had arrived. How quickly that joy turned into grief. And it is here in our beloved province that we must start to demand better services, better provision and better healthcare for all…because it is possible. Ikho's death needs to be a clarion call to all of us, that the time to stand up is here.

+ "Patients are increasingly using their last money to travel to a clinic or hospital only to be told they do not have the drugs they need."

+ LEADERS' ANALYSIS

THE POWER IS WITH THE PEOPLE

Sasha Stevenson and John Stephens, SECTION27

Lusikisiki Village Clinic is one of many healthcare facilities in the Eastern Cape that has suffered because of the deterioration of the province's healthcare system. For now, the situation at the clinic is looking up, testament to the unique power held in the combination of social mobilisation and the use of the law; a power unknown to either tool individually.

This little clinic has a complex history. It began as a park home next to the Lusikisiki town hall. In the early 2000s Médecins Sans Frontières (MSF) added another park home next door as part of a pioneering antiretroviral treatment (ART) campaign. In 2005, both operations moved, into a building that had previously been used as a clinic by AngloGold Ashanti.

The building was ideal. It had private consultation rooms, a waiting area, bathrooms and a pharmacy. Moreover, the rent to TEBA, the company that owned the building, was only R8 800 per month by 2012. In 2006, MSF handed over operation of the ART programme, and the lease on the TEBA building, to the Eastern Cape Department of Health (ECDoH). From 2005 to December 2012, the clinic thrived in the location.

In 2012, the clinic provided primary health care to between 4 500 and 7 500 people every month, and ART to approximately 1 500. This in a health district known for poverty and rated the worst place to access healthcare services in the country.[1]

An HIV support group also thrived at the clinic, up to 30 people at a time crowded into its twice-weekly meetings. Local TAC member and organiser of the support group since 2005, Nozaliseko Ntwana, would say in an affidavit that the group: '[H]as been a great source of comfort and support to me personally and has enabled me to adhere to my treatment. The group provides education and creates a community in which people can find the support they need to live with HIV and adhere to treatment.'

Then, in December 2012, the ECDoH shocked the community by shutting down the Village Clinic.

It threw up a couple of tents and an old mobile home on a plot of dirt on the outskirts of town, dubbed it the new Village Clinic and walked away. The community, supported by the organising efforts of the local TAC (Treatment Action Campaign), responded forcefully. It held a series of protests and meetings with local authorities to try to understand the reasons for the move, and to address the abysmal conditions at the new clinic.

The situation did not improve. Indeed it got worse. One of the tents blew over in February and wasn't put back up for over a month. The single pit latrine filled and poured a stench over a considerable radius. Most people refused to use it and instead braved the bushes. Several women were mugged doing so.

The mobile unit, and the medication stored in it, baked in the sun. There was no electricity or running water. Bug bites spotted the legs of the nurses. People queued for hours in the hot sun, or the mud and rain. There was no privacy and nurses, unable to examine patients, diagnosed STIs on the basis of whispered descriptions of symptoms. People who could manage began to leave the clinic in droves. The support group shrivelled away.

The protests continued; sit-ins and pickets at the clinic were regular affairs. The ECDoH repeatedly promised, in writing, to fix the situation. But by May, the only progress it had made was to dig a big hole on the site, supposedly for a new pit latrine. The pit latrine never came.

In concert with its efforts to engage with the ECDoH, the TAC approached SECTION27 in February and asked it to get involved. SECTION27 initiated a chain of correspondence with the MEC that would prove to be fruitless.

The MEC gave increasingly contradictory and nonsensical explanations for his department's actions.

1. According to the 2013 District Health Barometer, published by the Health Systems Trust

Patients using Village Clinic queue up for vaccinations outside a tent. The tent is too small to accommodate all those waiting and they queue up in the open air, wind, rain, sun or cold. In the background patients, many elderly, stand in a queue for their chronic medication.

He complained that the ECDoH had been 'chased away' from the old location by TEBA; the company denied this under oath. The MEC then claimed that the Department had been unable to afford rent; TEBA provided emails attached to a sworn statement in which it told the ECDoH that it would put up with the Department using the building despite ongoing non-payment.

By May, the community and the TAC had lost faith in the power of organising tactics alone. The TAC helped dozens of community members to come forward to testify to their experiences at the clinic. They spoke of chronic drug shortages, children regularly turned away for vaccines, waiting in the mud on rainy days for hours, and other indignities.

The TAC filed a lawsuit against the ECDoH on 29 May 2013. The founding affidavit was supported by almost 30 affidavits from community members affected by the conditions at the clinic.

The TAC also named the National Minister of Health in the lawsuit due to his oversight role of provincial health departments. A SECTION27 staff member met the Minister and sat the thick application down in front of him. The Minister took one look at the pictures and was moved to action.

He advised the MEC that he would take over operations and tabled a plan immediately to provide a proper temporary structure by July 2013 and to build a large permanent clinic in the following eight to 12 months.

Construction of the temporary site began immediately and is now complete. It has, however, not yet opened because there is no furniture. The TAC and SECTION27 are currently engaging the DoH on this matter. The TAC has also instructed SECTION27 to make the Minister's plan an order of court.

The final outcome is still a work in progress, but it is work in which progress has been achieved. If the community and activists stay vigilant, their efforts will improve the lives of thousands for years to come.

Village Clinic is a story in which ordinary people came together to claim their human rights. People in other communities throughout the Eastern Cape hold the power to do the same; the conditions in their own 'Village Clinic' will depend on whether they organise and speak out.

+ CITIZENS' REPORTS

FIGHTING THE ODDS

Karen Galloway has made peace with the fact that working in a rural hospital means being prepared to fight for everything you need, be it a bandage or a wheelchair.

A physiotherapist at Zithulele Hospital (85km from Mthatha) for the past five years, Galloway says, 'I think we spend half our time fighting for transport or the items we need to do our jobs. Last year I made four efforts to procure and I was not successful.'

What did she try to order? 'Oh, consumables such as bandages, strapping, basic rehab equipment, stump bandages, a joint measuring device (that costs R100), all coming to about R6 000,' she says.

An outgoing personality, who chats easily with her patients in basic Xhosa over her cell phone, Galloway has learnt to find creative ways to beat the system, including 'smuggling' their patients to bigger centres in the Eastern Cape, where they have relatives, in the hope of getting services or treatment that are not available at Bedford Orthopaedic Hospital in Mthatha.

Cautious of being unfairly critical, Galloway says they have dealt with several cases from Bedford Hospital, where they had 'put in less than ideal metal work'.

The working conditions for the doctors at the hospital, who want to do a good job, are seriously adverse. The hospital does no knee or hip replacements, or ligament repairs. Several patients have been sent home with tendon repairs, with poor outcomes due to a lack of early referral to suitable rehab, or a complete absence of the protocols, which assist in guiding the physiotherapist in the rehab process, from surgeons.

Galloway describes the lives of those relying on the public sector as a lottery: 'Maybe you get surgery, maybe you don't. Maybe you get lucky, maybe you don't.'

She calls the wheelchair supply process and waiting time 'nonsensical', relying instead on funding from donors to buy the specialised wheelchairs or standing frames that enable her patients to enjoy some semblance of independence, and maintain their physical health.

But her frustration is evident in her account of a recent interaction with a young boy with a relatively 'minor' injury – a fracture to his ulnar and a dislocated radial head. The little boy is able to describe his injury: 'My bone moves out when I do this with my hand,' he explains while turning his hand to face downward. When we asked a consulting orthopaedic surgeon about this kind of injury, he confirmed that, while this kind of injury is a tricky problem to solve, it's worth an attempt.

Even though the boy was operated on (something rare in a hospital plagued by disrupted water and electricity supplies, a shortage of anaesthetists and surgeons, and a lack of metal work) they didn't fix the problem but merely removed a screw from another part of his body.

After returning repeatedly to the orthopaedic centre that initially saw him, and receiving no assistance for his (still) dislocated radius, the boy is trying to get referred to another centre. The problem is that the surgeons who have seen him have provided no notes explaining why his actual injury wasn't treated.

Although this is a 'minor' injury, he will struggle to straighten his arm for the rest of his life, and will live with it bent at the elbow. He will battle with many simple activities that will not only affect his quality of life, but could impact on his employment options, condemning him to a life with a disability that is avoidable with good, early orthopaedic management.

Galloway describes her decision to remain at Zithulele as simple: 'I love being here. I love the patients. I love not having to fight other therapists for patients. I love it that people don't slack off at work. Everyone here wants things to be better, it is incredibly satisfying work. You can be creative and find solutions,' she grins.

Why has Galloway opted to speak about the challenges?

'This is a really special place and it deserves better, our patients deserve better. I can find another job if they fire me for speaking out. I hate to see things happening, going wrong and not saying anything. It's not right.'

Challenging disabilities

Impeccably dressed in slacks and a black jacket, Lungile Maraqa (37) waits patiently next to the road for a taxi to stop.

Maraqa was working as a cashier at a shop on the Zithulele-Mthatha road, when he was shot and wounded during a robbery. 'When I came out of hospital I was in a wheelchair,' he says.

A single man, Maraqa now lives close to the main road with his three sisters, a brother, and their children.

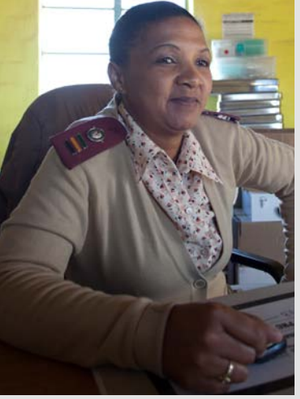
While hailing a taxi is no problem for an able-bodied person, Maraqa has to hope for a driver willing to transport him and his wheelchair.

'There are many challenges for disabled people and simply getting to Wilo Clinic is one of them,' he explains, adding that matters are made even worse when it is raining.

There are times when he makes the long and complicated trip to Wilo, only to be told they have no medication. Even getting painkillers is a challenge.

'Last week I had fever and lower back pain and they did not have drugs at the clinic. They sent me to Zithulele, but it is impossible for me to go from the clinic to the hospital on the same day, so I ended up going home and making the trip to hospital the next day.' A return trip to Wilo costs R18 and a return trip to Zithulele R60.

'I will go to Zithulele early in the morning and come back late in the evening,' he says.



+ CITIZENS' REPORTS

"PEOPLE ARE DYING HERE!"

Sister Sylvia Horner *(left)* looks up and smiles: 'Phone an ambulance? My dear, phoning an ambulance doesn't even cross my mind. In my seven years at Pilani Clinic I have never even seen an ambulance at this clinic.'

Dressed in her nurse's uniform, Horner is a striking figure amid the clutter and dust in the tattered rondawel that doubles up as her consulting room, and a storage room for drugs and files.

Before Horner arrived, the deep rural clinic, close to Ntshilini, had no nurses and wasn't functioning. Now, Horner and a nursing assistant, Selena Arends, see up to 1 800 patients a month, many of them in need of TB and HIV medication.

Horner has one of the toughest healthcare jobs in the country. She copes with constant drug stock-outs, vaccine shortages, no electricity, sporadic running water from an outside tap, zero emergency support, no option of transferring patients to Canzibe Hospital (unless they arrange their own transport), no staff accommodation, cramped and poorly maintained clinic buildings, and unreliable supply deliveries.

Why does she stay? 'Because of my people – they need us. If we leave, nobody else will come here. They were begging me for years to come here,' says the tall, upright woman, her hair swept back in a ponytail. 'I am the only registered nurse here, so many of the procedures can only be done by me. Arends joined me in 2011, but she is a nursing assistant and can only do some of the stuff. When I am not here or on leave, the patients are turned away,' explains Horner.

'We are serving a big community, our catchment area is huge and our patients are often very ill.'

Some of the coping strategies Horner has implemented include her walking the long and hilly dust road to the antiretroviral drug depot to collect their orders. She has devised her own system for providing long-distance patients with a three-month supply of their chronic drugs. A nearby shop owner allows them to store drugs and vaccines in the shop fridge; the daily supply for the clinic is kept in a cooler box. After sunset, when necessary, babies are delivered by cellphone light.

An angry Selena Arends walks in and slams her fist into the open palm of her hand: 'People are dying here and we have to say, "Sorry, we have no medicine." We are so far from everything here and we cannot turn people away. We are dealing with people's lives here.'

Quizzed on why they have opted to speak out despite the threat of being disciplined, both nurses smile. Arends responds: 'We are not killing anyone here. All we are asking for, on behalf of ourselves and our patients, is justice.'

What patients say...

'Recently, they did not have ARVs at Pilani, for three months. We ended up paying so the sister could get someone to go and fetch our drugs. The sister is so busy that even if you arrive at 6am you will only be seen in the afternoon, and we sit there hungry, because we do not have money to buy food. Two years ago, the sister referred me to Canzibe, but they did not admit me because they did not have beds. Only when I made a scene did they make a plan. They had no blankets and the food was terrible. It cost me R700 to travel to Canzibe.'
Boniwe Gxala

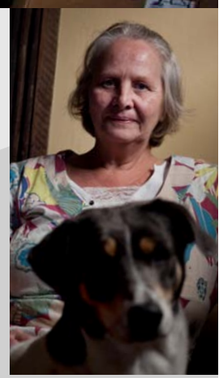
'When I went at 6am to deliver my baby at Canzibe, they first refused to admit me because I did not have a referral letter. Once they admitted me the nurses abused me by slapping me. When I need to go to Pilani, they often do not have drugs. They were out of stock of vaccinations when I had to take my child.'
Nonceba Gebengana

'Pilani does not have enough vaccinations. My baby is 11 months and has not had all his shots because they do not have stock. The toilets are also terrible, so we have to use the veld. There is also only one sister and there is too much work for her. Often they do not have drugs for HIV, children, high blood pressure, diabetes or pain. I am especially worried about the HIV drugs because people are defaulting on their treatment.'
Nolutha Hlohla

'Sometimes the security guard at the clinic says we must pay R2 because it goes to their salary. Last month I did not have the money to pay, so they said I can do so next time, but the problem is we often cannot afford to pay.'
Nothemsile Maqelana

Sisters Sylvia Horner and Selena Arends at work in Pilani Clinic.

"That's it"



Sharon-Anne Struckmeyer, a retired nurse, leans back into the couch and pats her dog: 'Healthcare services are virtually non-existent,' she says. 'The nurses at Pilani Clinic really do try, but they are fighting a losing battle.'

Struckmeyer, who is often called on to help nurse all kinds of ailments in the community, says it breaks her heart that 'Gogos walk 12km to the clinic and then they are told they do not have their blood pressure medication'.

'Yesterday I phoned and asked if they have painkillers for my elderly mother. Nothing. I am lucky; I am able to drive to Mthatha in a crisis, but for most of the people they have no alternatives.'

Struckmeyer has lived in the community for several years. She says she has no doubt that matters have worsened over the past couple of years.

'I am buying supplies with the little money I have, and we try to give transport money to those who are desperately ill, but my fear is that one night there will be someone I will not be able to help. Emergency transport is simply non-existent, so if you fall ill and you are unable to get to hospital, that's it.'

+ LEADERS' ANALYSIS

USANA OLUNGAKHALI LUFELA EMBELEKWENI

A TALE OF RURAL HEALTH

Marije Versteeg, Rural Health Advocacy Project

The failing healthcare system in the Eastern Cape affects everyone: urban communities, migrants from Gauteng and Cape Town (too sick to work or going home to retire) and healthcare workers who don't have the medicine, equipment or referral system to give the care their patients need.

But the greatest impact is undoubtedly felt among the 62 percent of people living in rural areas. Of the 10 most deprived districts in South Africa, three are rural districts based in the Eastern Cape: Chris Hani, OR Tambo and Alfred Nzo districts. A failing healthcare system compounds the many socio-economic hardships these communities face on a daily basis, such as high rates of unemployment, lack of clean water and sanitation, inadequate education, and poor nutrition.

What makes the failing healthcare system for all residents of the Eastern Cape a double disgrace for its rural people, are two fundamental barriers to care:

- The difficulties in accessing public health care in the first place, and the challenges to bring people back into the system after service failures have driven them away, and
- The lack of healthcare alternatives.

To illustrate: It takes two hours and a R30 taxi drive for Nozipho (60), living on a R1 260 monthly grant and carer of 1-year-old baby, Ayanda, to get to the clinic for her grandchild's vaccinations. After waiting a few hours, without access to sanitation or running water, she is told the vaccination is out stock and is asked to come back the following week when maybe – yes, only maybe – the vaccines would be there.

A recent study following up 478 babies born in the KSD sub-district of OR Tambo, found that 35 percent of mothers had similar experiences. By the age of three months, only 48.3 percent of children surveyed had received the immunisations that are due at birth, six weeks and 10 weeks.

At one clinic, vaccines are not kept in cold storage (as there is no fridge or electricity), yet the vaccines are given to unsuspecting mothers and children. This is more than a disgrace; this is indicative of a crisis that requires an urgent, immediate intervention.

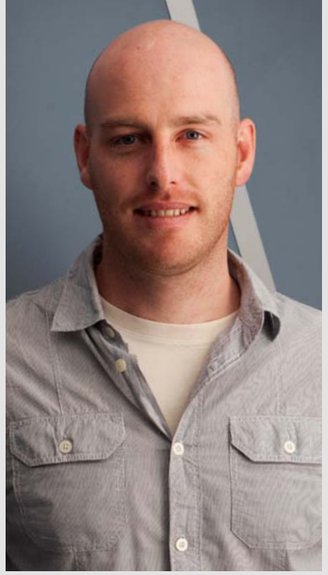
In another instance, many letters and calls regarding Komga Clinic seem to have fallen on deaf ears. Komga, where the mobile clinic to outlying farming communities is no longer operating; where half of their nurses have left, with no replacements in sight; where the dentist stopped coming; where there is no longer time to take preventative pap smears; where the treatment monitors, assisting the remaining nurses serving the 700 patients on ARVs, were told to go home; where the healthcare workers feel completely powerless.

There are many tales of frustrated health care workers soldiering on, or worse, deciding to leave the province. What happens when local leadership is poor, absent, disempowering, even using disciplinary tactics to silence competent doctors who want to fix the system, and who expose the health care failures? They are pushed out and poor management triumphs and carries on. And families continue losing their loved ones to preventable deaths.

Have these conditions become the accepted mode of practice in the Eastern Cape?

As RHAP (Rural Health Advocacy Project) and Coalition Members, we have tried to intervene in different ways, to no avail: supporting healthcare workers to report challenges to their superiors; writing and calling the Eastern Cape Department of Health to intervene; trying to set up meetings between role players and decision makers.

There is a saying in isiXhosa that goes 'Usana olungakhali lufela embelekweni' – 'A child who does not cry won't get help'. In this part of the world, the expectations of the healthcare system are so low, experiences with complaining so fruitless, that people have stopped crying for help. But health care is a human right. We need an outcry for the standards of care everyone deserves, but most of all for the rural communities, to rectify their historic neglect and today's failures.



+ LEADERS' ANALYSIS

WHEN THE SOLUTION COMPOUNDS THE PROBLEM

Daygan Eagar, Rural Health Advocacy Project & Budget Analyst

In April 2012, the Eastern Cape Department of Health (ECDoH) put in place a moratorium on the appointment of healthcare workers to vacant posts at facilities throughout the province. It was instituted to control the chronic overspending that was pushing it deeper into financial crisis each year.

The decision was based on the view that the bulk of the Department's budgetary shortfall of nearly R2-billion for the 2012/13 financial year, was caused by ballooning staffing costs that had to be controlled to prevent the collapse of service delivery.

In reality, the moratorium turned out to be a short-sighted attempt at austerity that pushed the already overstretched healthcare workers to breaking point.

A superficial assessment of the budget will show that overspending on staff appears to be the cause of its financial woes. In 2011/12, the Department overspent on its staffing budget by more than R1-billion because of higher than inflation increases to salaries and poorly managed employee benefits, such as the Occupational Specific Dispensation,.

But overspending on staffing is only a symptom of more complex and longstanding problems with the allocation and management of the health budget, which have persisted for more than a decade.

The Eastern Cape, one of the most rural and deprived provinces, has amongst the lowest per capita expenditure on primary health care in South Africa. The province is caught in an infrastructure inequality trap that is indicative of a budgetary system where decisions are based on crude assessments of absorptive capacity and historical spending and not on any measure of what is actually needed, to deliver services.

Yet, even if the budget more accurately reflected need, there is little reason to believe that, in a climate of entrenched inefficiency, financial mismanagement and corruption, this money would lead to significant improvements in health.

The Auditor General's annual audits of the Department's financial statements over the last decade revealed that tens of millions of rands are lost each year through a mix of deliberate fraud, improper financial oversight, and poorly managed supply chain systems.

In 2005, the 'Pillay Commission' of inquiry into maladministration, fraud and corruption in the province found that the centralisation of administrative functions and an inefficient bureaucracy significantly delayed the purchase and delivery of basic goods and services.

By 2009, little had changed and many of the commission's findings were repeated by the Integrated Support Team (IST) investigations into financial mismanagement within the ECDoH. The IST reported that a highly fragmented cadre of leadership responded to systemic challenges by using centralisation as a means of problem solving, compounding. the lack of cohesion between policy formulation, budgets, and the resources needed to implement the policies and planning.

The report highlighted that in trying to manage rather than confront financial management weaknesses, the Department has actually resorted to limiting service delivery and withholding payments to employees and providers as a means of managing overspending.

Broken systems of financial management and accountability have opened the door to endemic fraud and corruption. A Special Investigations Unit (SIU) investigation into corruption in the provincial department showed that in the 18 months between January 2009 and June 2010, officials and their associates pocketed more than R800-million.

Despite , all this evidence the Department denies that their financial management problems are dire, and they continue to placate everyone with promises of turnaround strategies, which never materialise.

As any good psychologist would tell you, for recovery to take place, you first have to admit that you have a problem, then be ready to ask for help and finally be willing to accept it. It is clear that the ECDoH remains unwilling to do any of this.

+ CITIZENS' REPORTS

A HOSPITAL CRUMBLES

Health care at Canzibe Hospital has all but collapsed as two foreign doctors desperately try to keep basic services going.

The road to Canzibe Hospital is dusty, mountainous and potholed. Turning off the gravel road from Mdumbi, it takes about two hours to travel the more than 20km from Coffee Bay. It's hard to imagine trying to survive this trip in the back of an ambulance or taxi when you are pregnant or ill. But this is the daily reality for the many patients who cannot be helped at Canzibe Hospital, a 140-bed district hospital that serves more than 150 000 people in the Ngqeleni sub-district.

The hospital is a collection of crumbling and collapsed buildings, with long grass and scattered rubbish everywhere. It has five inpatient wards, an outpatient department and a casualty section. The hospital also has any x-ray department, pharmacy and antiretroviral therapy unit.

While there are three doctors employed, the hospital essentially runs on the services of two Dutch doctors; the third doctor being mostly absent. Before the second Dutch doctor arrived this year, the hospital ran with one Dutch doctor for eight months.

The two doctors manage an outpatient department of between 80 and 100 patients daily, and are only able to attend to the seriously ill or injured patients. In addition, there are more than 80 inpatients that need to be attended to. The doctors work long hours with more overtime than should be allowed, an unsafe and unsustainable practice, with a high risk of burnout.

The hospital is unable to offer any outreach or preventative services to the 11 clinics it serves. This means patients often arrive at the hospital only when they are extremely ill, putting additional strain on the over-stretched staff and compromised services.

The litany of problems is extensive:

The doctor shortage means Caesarean sections are referred to other hospitals, as two doctors have to be present during surgery. The closest hospital is St Barnabas in Libode, more than an hour's drive away on bumpy, unsafe roads. The risks to pregnant women are exacerbated when they are forced to wait, often for hours, for transport to arrive. This situation compounds the problems at Canzibe: the hospital manager recently directed a doctor to accompany mothers to St Barnabas, which meant Canzibe was left with no doctor on the premises. The doctor refused. St Barnabas is also facing severe staff shortages and mothers are often referred on to Mthatha, between 90 minutes and two hours drive away. A hospital source said there is no doubt that some pregnant women and their unborn babies have died during the trip or after arriving at Mthatha.

Canzibe has a severe nursing shortage, no physiotherapist and no pharmacist. Staff members who work in the hospital pharmacy basically hand out drugs, but can offer no information on adverse side effects or drug combinations.

The x-ray machine has been due for its quarterly quality assurance test since October 2012, but management has failed to arrange the mandatory testing. The machine has been used nonetheless. It is now malfunctioning, and patients are referred to Mthatha for a simple x-ray test. A round trip to Mthatha by bus takes more than 12 hours, and suspected TB cases who are also sent to Mthatha for x-rays travel in the same bus as everyone else.

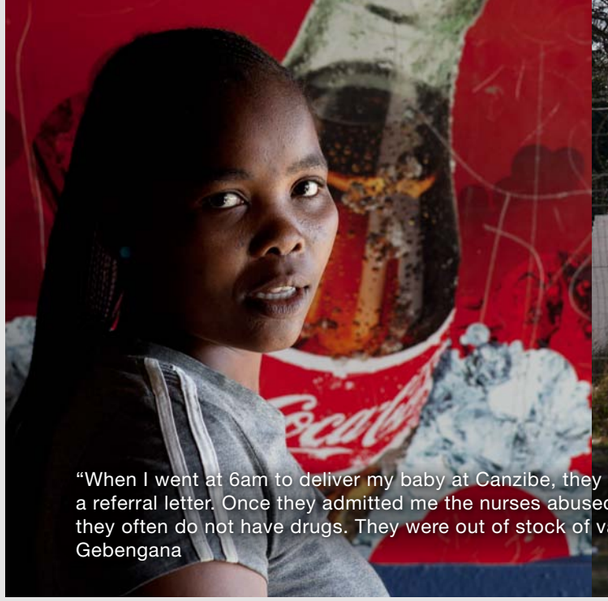
The hospital regularly runs out of oxygen. One source who spoke to SECTION27 was aware of at least one infant in respiratory distress who died because there was no oxygen supply.

A daily bus meant to transport patients between Canzibe and Mthatha does not operate every day, and is frequently used to transport supplies such as blood.

The hospital regularly runs out of medical supplies and drugs, including antibiotics.

Poor hospital management is identified as a major reason for the breakdown of services.

+ Canzibe Hospital is a 140-bed district hospital that serves more than 150 000 people in the Ngqeleni sub-district.



"When I went at 6am to deliver my baby at Canzibe, they first refused to admit me because I did not have a referral letter. Once they admitted me the nurses abused me by slapping me. When I need to go to Pilani, they often do not have drugs. They were out of stock of vaccinations when I had to take my child." Nonceba Gebengana

What workers & patients say...

'There is a poor management at the hospital, the broken x-ray machine being a prime example. The hospital grounds and buildings are totally neglected. Patients often sleep at the hospital as they wait to be seen. Transcape is now denied access to the hospital despite donors having invested hugely. Our malnutrition project was closed down by the hospital and the building is used for staff accommodation.'
Luzuko Bango – Transcape chair

'Our community depends on the Canzibe Gateway Clinic and Canzibe Hospital. There are no nurses and doctors, and people often wait long before being turned away. One nurse runs the clinic, which is on the same grounds as the hospital. The clinic and hospital often run out of medications and there is no ambulance, so we have to hire our own transport. If people do wait, they can wait for days before an ambulance takes them to Nelson Mandela Academic Hospital in Mthatha. The hospital grounds are in complete disrepair with overgrown bushes and grass. A patient was recently bitten by a snake on the hospital grounds. The toilet facilities are abysmal.'
Abigail Lamle – patient

'I have been a community health worker since 2008. My patients are regularly turned away from the clinic and hospital, without medication. Patients are sometimes told to go and buy their medication, or given painkillers for serious conditions. The patients are devastated as they often travel long distances. Young children and elderly patients are made to stand in long queues outside, in the sun. I have often waited the entire day with my patients without them seeing a doctor. Sometimes we sleep at the hospital in the hope of being seen the next day. Ambulances services are completely unreliable and mostly unavailable. Once an ambulance driver abandoned a minor patient in Mthatha and I had to reply on the goodwill of stranger to pay his taxi fare home. My salary payments are unreliable and I am not always paid.'
Nontandazo Mlilo – community health worker

'I have been a community health worker since 2008 and work for social services. The absence of ambulance services has caused great suffering. Mostly sickly patients have to pay for private transport and I have to loan them the money, even though I have very little. Canzibe has huge staff and medication shortages. Sometimes patients have to share ARVs because they do not get all their treatment. It really hurts me when my patients are in pain and I feel helpless. The clinic has now told us they will not be open on Fridays.'
Moyikwa Bottomane – community health worker

+ CITIZENS' REPORTS

A BRIDGE TOO FAR

There is a sparkle in Nozolile Zintoyinto's *(left)* eyes, but a frown clouds her face when quizzed about healthcare services in Nqileni Village.

The 82-year-old sangoma, who lives on a hill overlooking the magnificent Wild Coast and Xhora River, gestures wildly with her hands, her legs stretched out on the reed mat: 'It is very hard for us to reach our clinic, especially when it is raining. If we decide to walk, we have to first cross a river and to do so, we have to pay the man R6 to row us to the other side.'

Their closest clinic is Jalamba – a R15 one-way trip by taxi, operating only between 5am and 6.30am; those who miss the departure are stuck for the rest of the day. Zintoyinto says there are days when they use an ox sleigh to get sick villagers to the river and arrange for a car to meet them on the other side.

For after-hours emergencies, villagers pay hundreds of rands for transport to Madwaleni or Zithulele hospitals, or they call on the nearby Bulungula Lodge to transport desperately ill people in the middle of the night. 'Calling for an ambulance is a useless exercise. I have no doubt we would have had many more deaths if we were not able to rely on Bulungula during emergencies,' she says.

And when they get to the clinic, the prevailing conditions listed below mean they are still at risk:

- Jalamba Clinic had one professional nurse for seven months until another one arrived in February 2013. The clinic has no operational manager. The two nurses work long hours and struggle to take leave.
- There is no running water at the clinic and the only source is a rainwater tank. This means nurses rely on buckets of water to wash their hands.
- There is no proper fridge, only a freezer that is used to store vaccines.
- The clinic has seven consultation rooms, but only one blood pressure machine. There is no landline, fax machine or computer; staff members rely on their personal cell phones.
- Order forms have to be delivered personally and this means a long drive on a dirt road, using a taxi paid for by the personnel from their own pockets.
- The clinic frequently runs out of painkillers, TB medicine, antibiotics and vaccines. There are times when an entire month's supply does not arrive. The clinic vaccinates about 250 babies and children every month and regularly runs out of stock, forcing the clinic to turn patients away. Many of the patients who are turned away have walked long distances with babies and children. Some of them never return.

+ The closest clinic is Jalamba – a R15 one-way trip by taxi, operating only between 5am and 6:30am

+ CITIZENS' REPORTS

THE STEEP ROAD TO HEALTH

Manyadu Mpisekhaya *(right)* long ago stopped trying to remember how old he is. He gingerly negotiates an embankment, leaning on a stick, and lowers himself onto a rickety wooden bench, while a hen and her chicks peck around his feet. His blue overall pants and tracksuit top hide his thin frame; a blue beanie covers his grey hair.

'As older people, we are most affected by the poor health care in this province. We have no money, and when we find the money to get to the clinic, it is almost impossible to get transport,' he says, staring into the valley stretching out below Folokwe Village, towards the ocean.

Perched on a mountaintop, Folokwe can't be reached by car, leaving villagers with no option but to traverse the steep hills until they reach a road, and arrange private transport.

Mpisekhaya says he recently developed severe pain in his right leg and villagers had to carry him on their backs. Those who are severely ill, or have died, are transported to the road using ox and donkey sleighs.

'Two neighbours died from various illnesses because we could not get them transport. There has never been an ambulance that has agreed to meet us on the road; we always have to pay for private transport to get us to Zithulele Hospital or Jalamba Clinic,' says Mpisekhaya. Many women have confirmed that the going rate is R800 one-way if they are pregnant and need to urgently get to a hospital at night.

An epileptic, Mpisekhaya says he's often been told that they don't have his drugs at Jalamba Clinic. 'I make sure I go before my pills are finished as I know they often don't have it and I have to wait, or go to another clinic.'

A former miner at Buffelsfontein gold mine near Stilfontein in North West province, Mpisekhaya was sent packing by his employers after he was diagnosed with tuberculosis. 'I was paid R6 a month UIF,' he says.

Mpisekhaya now receives an old-age grant and lives with his wife, child and four grandchildren. His son died at home in 2011. 'It was an HIV-related disease; he did not want to take his medication,' he says.

Mpisekhaya says he fears the day he falls ill and is unable to make it up the hill to the road. 'If I fall sick at night, there will be no transport.'

+ "There has never been an ambulance that has agreed to meet us on the road: we always have to pay for private transport to get us to Zithulele Hospital or Jalamba Clinic."

"We speak about infection control, but speaking is all we can really do. We cannot possibly practice it properly."

OPERATING IN THE DARK

Sister Ethel Mhlekwa *(left)* of Kotyana Clinic is not asking for much. "Access to basic services such as electricity and water would go a long way to enabling us to meet standards which we should adhere to in the interests of our patients," says Mhlekwa.

A professional nurse, Mhlekwa is also the acting Operational Manager, an extra responsibility for which she is not compensated.

A nurse for the past 27 years, Mhlekwa arrived at Kotyana Clinic in 2009 although it was only officially opened a year later. She has been acting manager since it opened.

Although there are many problems at the clinic, there are four big challenges:

- the absence of electricity;
- staffing;
- staff accommodation; and
- the unavailability of water.

The clinic has solar panels, but they have not worked for approximately three years. This means the nurses rely on a gas fridge in the nurses' accommodation to store vaccines and the supply of gas is erratic and unreliable. In summer, the refrigerator is not sufficiently cold and in winter it gets too cold. The nurses also use the refrigerator to store their food.

No electricity presents huge challenges in emergencies after sunset. Recently, a baby was born at home and brought to the clinic in the evening. Mhlekwa had to check on the health of the mother and the baby by the light of a paraffin lamp. "It is not possible to perform this service properly under these conditions," she says.

As another example, in an emergency situation when a patient requires sutures in the evening, the nurses cannot attend to the patient because of the lack of light. They have to send the patient to Zithulele Hospital, which is approximately 10 kilometres from the clinic, but there is not an ambulance available and the patient have to hire a car, which is expensive. Similarly, mothers in labour are sent to Zithulele Hospital when it is dark.

There is also no telephone, fax machine or computer at the clinic. The staff's only means of communication is their personal cell phones. They charge their cell phones by turning on a car and using the car battery.

Nurses are also not keen to work at the Clinic because they know that the accommodation does not have electricity.

Kotyana has only two professional nurses, one nursing assistant, two lay counsellors and five community health workers (who are based at and report to the clinic but work in the community). The nursing assistant is furthering her studies this year and is away. This leaves the Clinic with just two nursing staff. They see between 1 200 and 1 500 patients every month and have serious difficulties providing care to patients due to the shortages of staff, working until after dark.

There is also no cleaner or caretaker appointed for the clinic. This means that the community health workers have to assist with the cleaning even though they are not paid to do so.

The grass around the clinic has not been mowed and there is no lawnmower.

When Mhlekwa applied for the post of Operational Manager in 2011 she was later told that the posts had been frozen and she could not be appointed to the position.

There are only three small rooms at the Clinic for staff accommodation. When the Clinic was opened, officials of the Eastern Cape Department of Health promised that a building near the Clinic would be renovated to provide more staff accommodation. This has never happened.

The clinic has five rainwater tanks. Three of the tanks are currently empty and the other two tanks are not full. The clinic has in the past run out of water when there is not enough rain.

There is a dam close to the clinic and there are pipes that run from the dam to provide the community around the clinic with water but the government has not installed pipes to get the water to the Clinic.

The lack of water is a problem for a number of reasons. It makes cleaning the Clinic difficult, limits the water available for patients to drink while waiting to receive services and limits the water available to nurses to wash their hands.

"We speak about infection control, but speaking is all we can really do. We cannot possibly practice it properly," says Mhlekwa.

The clinic orders medicine twice a month. The order is physically taken to the supervisor at Xhora office who then puts in a larger order and distributes the medication received to facilities. Nurses have to go in their own car or by taxi to the supervisor and pay for this out of their own money. This takes several hours and costs around R200 in a car or R60 by taxi.

+ LEADERS' ANALYSIS

TIME TO NURSE THE SYSTEM BACK TO HEALTH

Kholiswa Tota, Provincal Secretary DENOSA Eastern Cape

The Eastern Cape chapter of the Democratic Nursing Organisation of South Africa (DENOSA) feels strongly that the time has come to seriously tackle the healthcare challenges in our province.

As nurses, we are the people who have to look patients in the eye and tell them we have no drugs, we have to tell a pregnant mother that we can't take her to theatre for her Caesarean because there aren't enough nurses, and we have to turn our backs when distressed patients can't breathe and we have no oxygen.

There are a number of issues that need to be addressed urgently, but from Denosa's perspective the following are critical:

1. **Shortage of nurses:** Health facilities are operating with skeleton staff because of the failure to fill vacant posts, or the length of time it takes to do so, the freezing of posts that remain unfilled after several months, and the directive to only fill vacancies that arise in the current year. The situation is exacerbated by long working hours, and lack of management and community support, which lead to nurses burning out.
2. **Non-payment of salaries and benefits:** The delays and non-payment of salaries date back as far as 2007. Many nurses who should be considered for the Occupational Specific Dispensation (OSD), have not been paid, or do not receive their back pay.
3. **Failure to fill key positions:** Examples include Mthatha Academic Hospital, which has not had a Nursing Service Manager for six years, and Livingstone Tertiary Hospital and Port Elizabeth Provincial Hospital, where the posts of Nursing Service Manager have not been filled for the last three years. We are aware of nurses being victimised and forced to do these jobs without compensation. This flies in the face of the health department's own policies. The policy is clear when it comes to acting positions – incumbents must be paid the difference between their permanent salary and that of the acting position.
4. **Equipment and supplies shortages:** We know of facilities that don't have simple diagnostic equipment, and where broken equipment is never replaced. Slow delivery of medicines and other basic necessities compromises the quality of care. These shortages are most acutely felt in the rural areas. The Public Protector, who identified this problem when she visited Eastern Cape Hospitals, has also commented on these shortages.
5. **Education:** The staff shortage is the reason given for denying many nurses the opportunity for continuous development or study leave. For example, in 2012 nurses at SS Gida Hospital were denied study leave after they had been given permission to further their studies.
6. **Support and respect:** To enable nurses to supply quality health care, there has to be support from management, the community, and our clients. However, given the conditions under which they are required to work, nurses are increasingly reluctant to conduct certain procedures because they know they will be blamed when something goes wrong. This has reduced the trust between the patients and nurses.

The time has come to take the first steps on the road to better health services for the Eastern Cape.

+ "As nurses, we are the people who have to look patients in the eye."

+ LEADERS' ANALYSIS

A BLUEPRINT FOR RECOVERY

Dr Trudy Thomas – Eastern Cape Health MEC (1994-1999)

In my 77 years on this earth, I can hardly recall a time when I was not involved in health care in one form or another. In total, I have practised medicine for more than 35 years, the majority of which were spent in the Eastern Cape in both rural and urban areas.

In 1994, I became the first Member of the Executive Council (MEC) for the Eastern Cape Department of Health and Welfare (renamed the Eastern Cape Department of Health in 1997), a position I held until 1999.

Over the last 15 years, I have witnessed the progressive deterioration of the province's health department and the services it offers. This trend grew most acute in 2012 and has culminated in a full-blown catastrophe. The Eastern Cape is now threatened by a health crisis the likes of which I have never seen before.

The human resource crisis has, obviously and inevitably, resulted in the people of the Eastern Cape suffering. At the heart of this problem is the Department's failure to properly budget and manage finances and human resources.

A totally unpredictable twist in the progress of the health services in the Eastern Cape is that – except for the Transkei between the missionary and the Mandela days – all the services were good to excellent pre-1994, but have spectacularly crashed under the ANC regime.

When I took office, the Eastern Cape inherited three main administrations – the Eastern Province, Ciskei and Transkei. It also inherited their budgets; calculated at R250 per person in the Eastern Province, R70 in the Ciskei and a paltry R40 in the Transkei.

One of my first tasks was a survey of health services, which culminated in a report entitled *Urgent Additional Budgetary Needs—Transkei Health Services*. The report revealed a striking correlation between budgets and service quality in the three administrations.

Part of the investigation focused on the staff and health facilities, which included site visits to all hospitals. It showed that the western part of the province, which was mostly white, was short of some health professionals but otherwise its services were good to excellent. In the Ciskei – a black 'homeland' – some services were grossly overcrowded but its hospitals and clinics were mainly functional to good.

The conditions in these areas were in strong contrast to those in the Transkei. Twenty years earlier, mission hospitals in the area, founded on the principle that you found whatever funds you needed for the job, rather than doing only what you could with what you had, had been exemplary. Sadly, by 1994, they were collapsing.

The investigation showed that almost half (40 percent) of people lived between 20 and 60km from any health facility, with only one clinic for 18 000 people (the World Health Organization recommends one clinic for every 5 000 people).

The problems identified by the survey included: health facilities in poor repair and accommodated in makeshift structures, without adequate services or supplies; untenable and dangerous conditions for patients and staff; overcrowding was the norm; work and trauma loads were extraordinary; and already critical staff shortages were exacerbated by the high resignation rates of demoralised staff.

To turn this situation around, we devised a comprehensive plan that covered full staff accommodation, new health posts, new and upgraded clinics, and critical equipment and infrastructure improvements. Three years later, despite a tight budget, the 'patient' started showing signs of recovery and order began to emerge from the chaos. →

+ A BLUEPRINT FOR RECOVERY (continued)

We led the country in district development but, while all this was encouraging, it was not enough to reduce the apartheid backlogs in the Transkei to deliver basic health needs to all citizens of the province within a reasonable time frame.

In August 1997, in a document entitled *Determining the Backlog Factor in the Eastern Cape*, I tabulated and costed the backlog service and infrastructure needs of the health department, and distributed it widely. The report recommended that an extra R500 million annually for five years – under a separate, dedicated administration, used exclusively to close the service deficits in the Transkei – would lay the foundation for dignified, functional health services across the province.

Unfortunately, the proposal clashed with the National Treasury's decision, under advice from the World Bank, to avoid international borrowing to reduce the huge apartheid debt that South Africa had run up before 1994. Instead of an extra half a billion rands for five years, the already inadequate health service budget was sliced further.

This was catastrophic. By March 1999, at the end of the new government's first five years of office, there were escalating frequencies of medicine shortages, equipment failures, infrastructure deterioration, lack of transport, and huge staff vacancies.

Conditions in the Eastern Cape healthcare system are now at an all-time low. The decrease in budgets continues in a context where the Superintendent General for the health department reports a staff vacancy level of 46 percent, six hospitals condemned but still operating, 17 hospitals without water, more than 42 health facilities without electricity, 68 percent of hospitals without essential equipment, 16 percent of hospitals without telephones, and many clinics that are only physically accessible in good weather.

It is outrageous that, while conditions continue to decline, Treasury is proposing another budget cut.

The current budget is divorced from the reality of the health needs of the Eastern Cape's residents. We are on the path towards total service collapse.

While there are external reasons for the looming and inevitable collapse, many of the problems are of the province's own making.

My experience tells me it is possible to reverse the course and begin, once again, to improve the quality and availability of health services in the province.

The elements of the solution are basic, and should not take more than three months to establish:

- Appoint a tiny team of three to five *inspired, committed and sacrificial* people to conduct a quick-and-dirty situational analysis of the infrastructure, supplies, equipment and staffing of all Eastern Cape hospitals and clinics;
- Calculate the cost of bringing those facilities up to minimum acceptable standards; and
- Scan the financial landscape to source the necessary funds.

With the necessary information at hand, the team must establish the absolute minimum cost to supply the services, supplies and infrastructure necessary to provide reasonable access to healthcare services, and draw up a 'just-enough' budget for a three-year phased plan to achieve minimal, but real and respectful, functionality for the whole province. This is the minimum that government must provide.

But, note well, success is not measured only in monetary terms. Once there are nearly enough nurses in the clinics, and medicines in the pharmacy; when ARVs don't run out, and tuberculotics start fattening up; when dehydrated babies sit up and smile as a drip starts putting back life in their little shrunken bodies – then sulky, stolid nurses will start bustling and smiling, and injecting much more service into the system for the same money.

The principles and practice are really this simple. The Health and Finance ministers and their relevant subordinates know all these things. As do their managers. As do the Cabinet and Legislature.

There is just one option: They must take responsibility for the collapse of the system and take the steps necessary to fix it.

+ "The current budget is divorced from the reality of the health needs of the Eastern Cape's residents. We are on the path towards total service collapse."

Thank you to

+ The brave patients who trust us with their stories
+ The dogged health workers who are speaking out
+ Thandeka Vinjwa, Eastern Cape Treatment Action Campaign
+ The health activists who keep working at change

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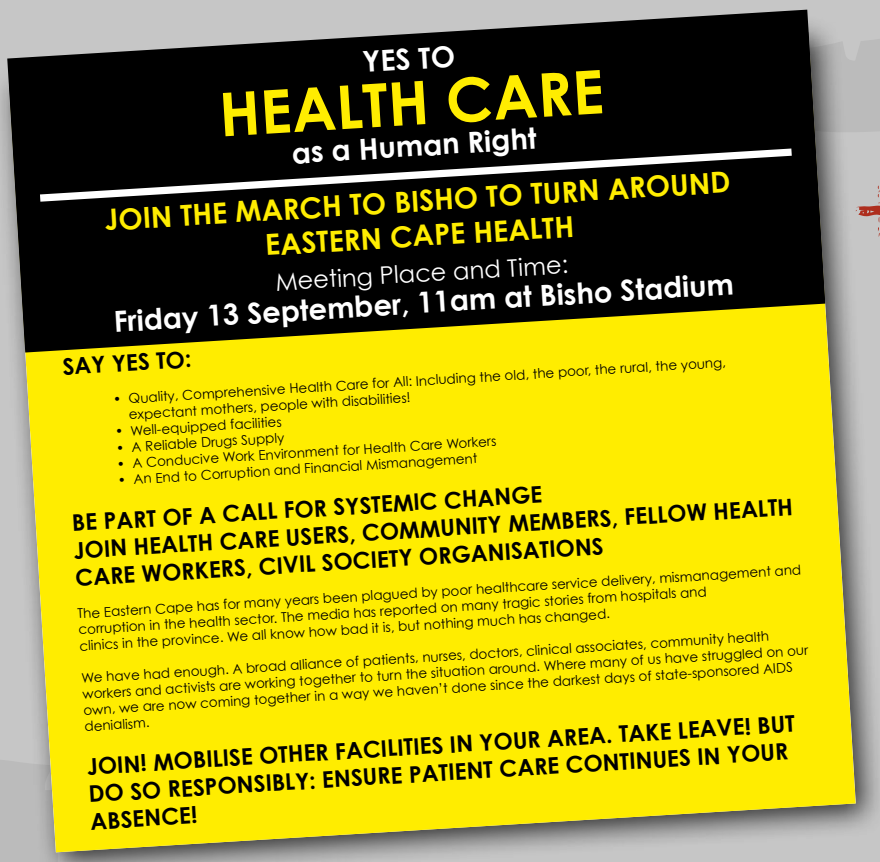

+ MARCH FOR HEALTH

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