The struggle for healthcare services in Western Cape Townships

Table of Contents

1. Introduction........ 1

2. Research objectives 2

3. Methodology........ 2

3.1. Sampling........ 2

3.2. Data collection 2

3.3. Data management and analysis 3

4. Survey Results 3

4.1. Demographic characteristics........ 3

4.2. Access to healthcare........ 3

1.1. Challenges experienced by communities after the closure of clinics........ 7

5. Conclusion and Recommendations........ 10

5.1. Conclusions........ 10

5.2. Community Engagements........ 11

5.3. Recommendations 11

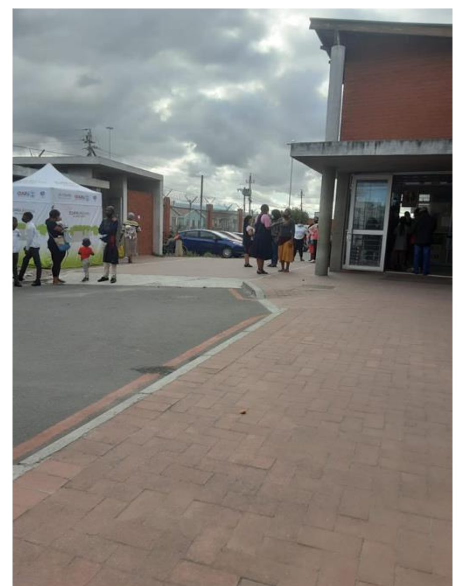
1. Introduction

The public healthcare system in the Western Cape is characterised by staff shortages, poor filing systems, shortage of space, and congestion in the clinics, all leading to delays in the delivery of quality care to clients. The recent closure of clinics like Zakhele, Lizwe Nobanda, and Welterveden clinics presents an added threat to the lives of the poor people in the Western Cape as they have to rely on the public sector for healthcare services, moreover, vulnerable populations may bear the risk of less health care access and poorer health care outcomes than the general population.

Ritshidze monitoring conducted across 13 facilities in the Western Cape point to the dysfunction among facilities in the province. During Q1 monitoring conducted by Ritshidze community led monitoring which is a systematic collection of data at the site of service delivery by community members that is compiled, analysed and then used by community organisations to generate solutions to problems found during data collection.

In Ritshidze, people living with HIV are empowered to monitor services provided at clinics, identify challenges, generate solutions that respond to the evidence collected, and make sure the solutions are implemented by duty bearers. Ritshidze monitoring takes place on a quarterly basis at more than 400 clinics and community healthcare centres across 29 districts in 8 provinces in South Africa — including 25 facilities across Western Cape (City of Cape Town Metropolitan.

Ritshidze data shows that only 58% of patients who visited facilities found the staff to be friendly and professional. Data collected in Western Cape reveal significant staff shortages are undermining the quality of services provided at health facilities. Ensuring access to quality healthcare services and ensuring everyone living with HIV and TB gets access to medicines and care depends mainly on having enough qualified and committed staff, the data shows that 30% of patients reported that there is always enough staff at the facility.



Long waiting times are a major challenge in Western Cape, where public healthcare users often spend hours at each visit to the facility.

This simply does not work well for most people — particularly working people and those in school. Having people living with HIV spend an extended time at a facility, simply to collect ART refills, increases the risk of that person disengaging from care. In Gauteng, public healthcare users reported that they spent an average of 4:46 hours waiting in the facility (including time before the facility opens), of which an average of 4:43 hours is waiting after the facility opens. With clinics closures such issues will only be exacerbated in the province and this needs urgent remediation.

The Treatment Action Campaign deployed a team from the national office to support the Western Cape team in the campaign to improve access to quality healthcare services in the province, including working with the department of health to resolve the problems associated with the closure of the clinics. TAC worked with the department of health in many instances.

This survey was done to assess the situation at the facilities and capture the experiences of affected communities. Getting an understanding of how communities are affected will help in the formulation of short-term and long-term solutions.

2. Research objectives

2.1. To assess how communities have been affected by the closure of the clinics

2.2. To analyse the experiences of the affected communities since their clinics closed

2.3. To determine whether patients can still get the healthcare services they need at alternative clinics they were referred to

3. Methodology

3.1. Sampling

The purposive sampling method was used, where specific communities are targeted for the research exercise. In this case, the study targeted communities surrounding the affected clinics and referral sites. This sampling method allows for the gathering of as much information as possible and to describe the impact of the findings on the communities. A total of 193 participants were selected for the survey from communities in Khayelitsha and Mitchells Plain districts.

3.2. Data collection

Data collection took place between the 19th and the 27th of January 2022. A structured survey questionnaire was used to collect the data, it was interviewer-administered. Participants had a choice to be interviewed in English or Xhosa. Confidentiality was essential in the data collection process.

3.3. Data management and analysis

The data was collected using a paper-based method, the questionnaire was printed on paper, responses were captured in excel and later transported to SPSS where it was analysed using descriptive statistics. The questionnaire also had open ended questions yielding qualitative data. After content analysis, this data was assigned into different categories and these were interpreted accordingly.

4. Survey Results

4.1. Demographic characteristics

Table 1: Distribution of respondents by gender and age group

	15-24	25-35	36-46	47-55	55+	Unidentified	Total
Females	15 (8%)	42 (22%)	35 (18%)	23 (12%)	20 (10%)	2 (1%)	137 (71%)
Males	7 (3.6%)	14 (7%)	12 (6%)	18 (9%)	5 (2.6%)	0	56 (29%)
Total	22	56	47	41	25	2	193

The majority of participants were females (71%, n=137). Women between the ages 25-35 had the largest proportion (22%, n=42), followed by the age group 36-46 (18%, n=35). More older men within the age group 47-55 participated in the study compared to the age group of 15-24 (3.6%) and 55+(2.6%).

Table 2: Distribution of respondents by area of residence

Area	Number of interviews	Percentage
Section A	45	23%
Site B, Taiwan, Blue downs, Boipatong	11	5,6%
Site C	13	7%
Samora	119	62%
Unidentified	5	2.6%
Total	193	100

A large proportion of the participants were from Samora in Mitchells Plain district (62%, n=119), the rest were interviewed in Khayelitsha district in areas including site B, Section A, Site C, and Taiwan.

4.2. Access to healthcare

Almost all the participants in the study (99%) make use of public healthcare facilities.

Figure 1: Percentage of participants using public healthcare facilities

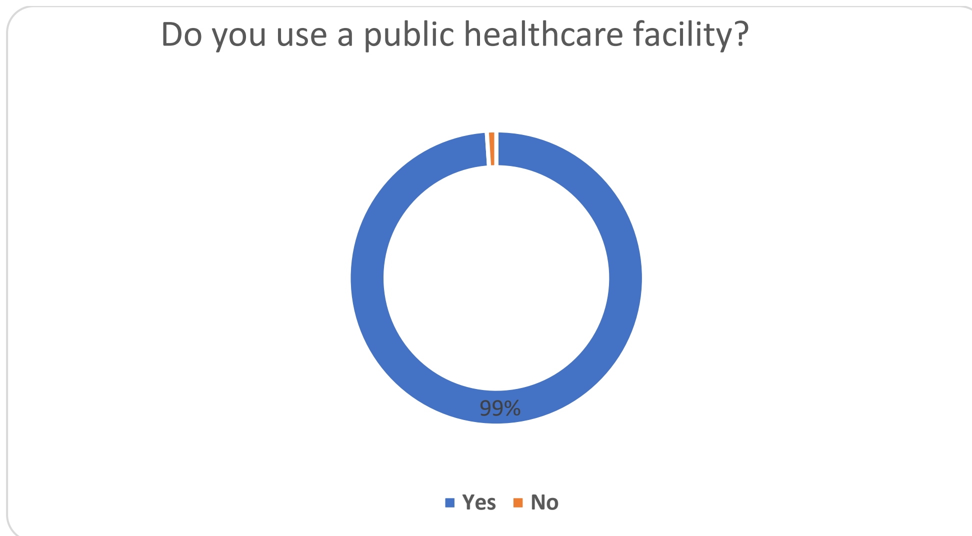
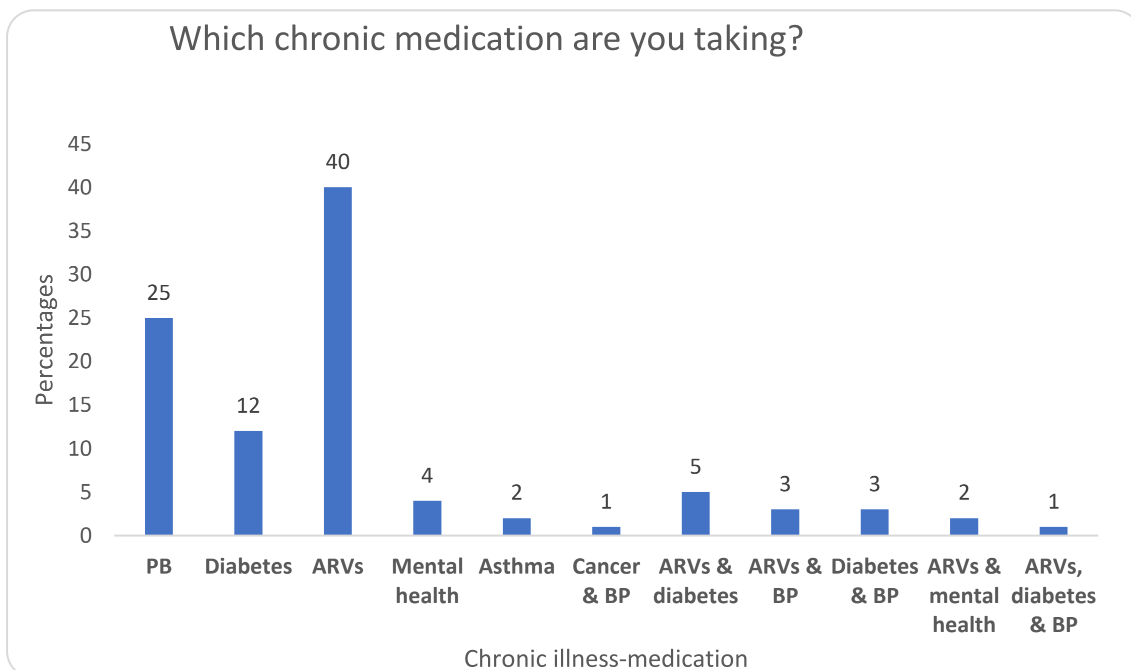


Table 3: Respondents on chronic medication

Of the 179 participants that responded to this question, 54% reported that they're on chronic medication.

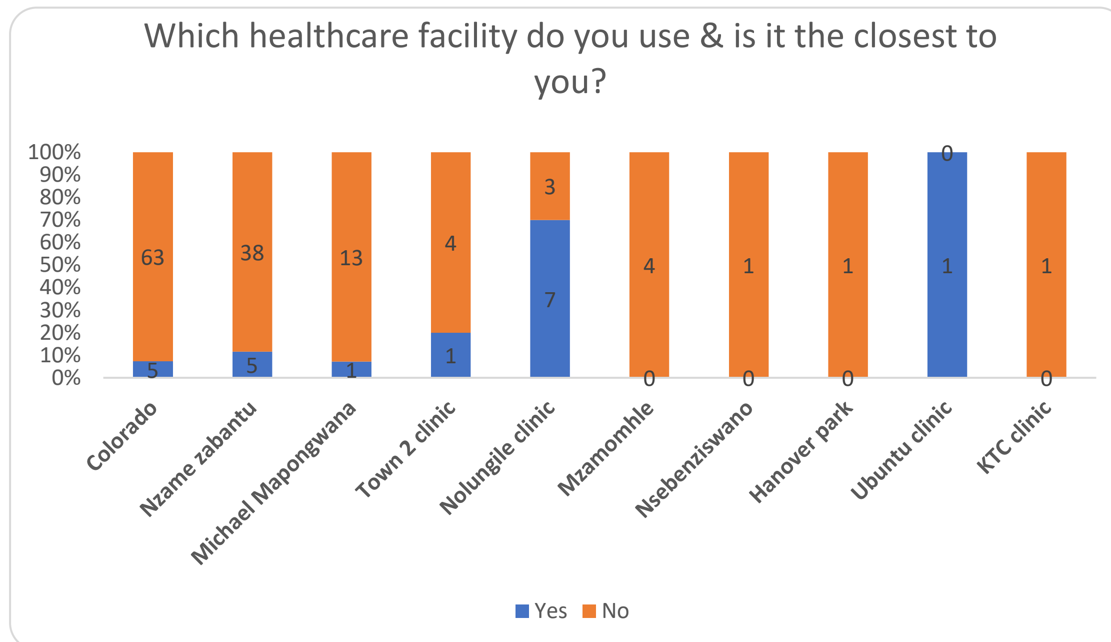
Are you on chronic medication?		Percentage
Yes	96	54%
No	83	46%
	179	100

Figure 2: Distribution of respondents by chronic medication



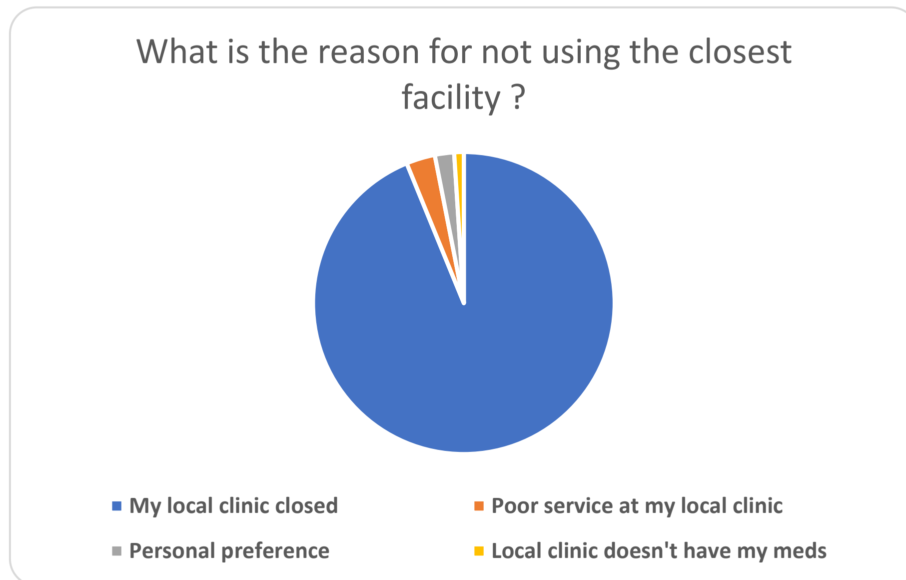
A high proportion of the respondents are on ARVs (40%), followed by BP medication and diabetes medication at 25.7% and 12.3% respectively. A small proportion takes more than one medication, like ARVs and BP medication (3%), ARVs and diabetes medication (5%), ARVs and mental health medicine (2%) and only one respondent reported being on ARVs, diabetes and BP medication.

Figure 3: Clinics used by the respondents



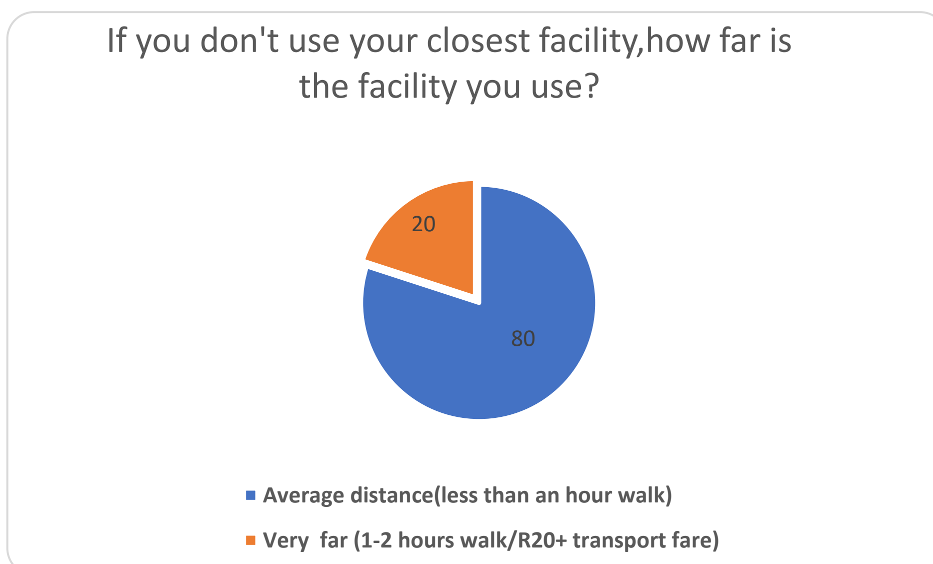
From figure 3 above, a huge proportion of clients interviewed are not using the closest facility, for example, only 5 out of 68(7%) patients reported that Colorado clinic was closest to them, the same figure was reported for Nzame Zabantu. Majority of the patients are forced to travel far for healthcare services, this is also demonstrated in figure 5 below.

Figure 4:Reasons for not using closest facility



A large proportion (94%) of the respondents are not using their closest facility because of facility closures. About 3% of the respondents don't use their closest facility because of poor service, 1% said the local clinic did not have their medication and 2% responded that they just preferred to go to the facility outside their community.

Figure 5: distance from healthcare facility used



About 80% of the respondents travel far to get to their alternative facility, they walk for 1 to 2 hours to get there.

4.3 Challenges experienced by communities after the closure of clinics

4.3.1 Crime

Several key challenges were cited by health care users. The most recurring theme is crime. Several respondents indicated that crime has been the number one deterrent from getting quality healthcare services at the nearby facility. Since the onset of the closures of their nearby facilities, community members voiced that:

"The problem is safety. There is violent crime on the way to the clinic since it's far from my area".

"[I] got robbed of my phone because of the crime, because of walking [a] long distance".

"I got mugged at the bridge when I decided to walk to the clinic".

"We get robbed because we don't have money to pay [for] public transport".

"I find it difficult to get to the clinic because when I don't have money to take a taxi I have to walk and it is very dangerous to cross the bridge on my way".

4.3.2 Transport costs

South Africa is currently facing high levels of unemployment, Stats SA estimates the unemployment rate to be about 35%. Clinic closures in most instances require community members to travel to neighboring clinics, which involves transport fare. A fare that many cannot afford and therefore end up not accessing health care facilities for life-saving treatments. Community members highlighted that:

"When it rains I can't go to the clinic because I don't have transport money, I live with a TB patient and she can't go to the clinic because of funds".

"Sometimes I miss my appointment because of not having transport money. The place is far and there are robbers".

"Missing my appointment due to not having transport money".

"Struggling with money for transport".

"It is difficult because I'm in a wheelchair and I have to pay people for transport so that I don't miss my appointment".

"I can't go there at Colorado. It's far for me".

4.3.3 Staff attitudes at alternative facilities

The data have shown that community members especially from Colorado, are facing challenges in terms of staff attitudes at the new facilities that they need to access. Community members explained that:

"It affects [me] because at the new facility they take time to assist me being told to go back home because I missed an appointment (sic)".

"I wake up early [and] stand in long queues and incur transport costs".

"I have experienced long queues and unhealthy treatment as a new patient".

"Their attitude is bad to us new patients".

"Slow services, poor services, and staff members are rude. I have not yet received my medication".

"I was chased away from the nearest clinic and was told to go to Michael Mapongwana (Clinic) because I am sick".

4.3.4 Overcrowding at facilities & Lost files

The consequence of closing facilities led to the overcrowding of facilities that are still running. This leads to health care workers being overworked and overburdened by patient volumes. Several community members have shared that there are extremely long queues at the facilities, which hinders patient care. Lost files are also cited as a challenge when accessing other health care facilities which lead to health care users defaulting on treatment or not accessing services at all. Several quotes from the data show that:

"There are long waiting times. I get hungry in the queue".

"Long queues, family planning not available, the clinic is very far and sometimes we don't have transport money. Walking is a risk as the crime is high".

"It's always packed and there are long queues. Medical records are not transferred properly and we often have to start afresh".

"My folder was not transferred so they don't have my history and can't assist me"

5. Conclusion and Recommendations

5.1. Conclusions

This report brings the voice of people in communities, their perspectives and experiences with the healthcare system and more specifically the challenges experienced as a result of the closure of some clinics in the two districts. While we have admittedly used a small sample size, it appears that patients of the closed clinics haven't been accessing healthcare consistently since their closure. Physical distance, safety concerns and poor staff attitudes are some of the hurdles preventing access.

Clinics are generally considered to be the centre of township health care systems. Not only are important health services based at these facilities, but many of a community's depend on these clinics to collect their medication an seek out medical care. With the province also dealing with the grappling effect of the Covid-19 pandemic on health in the province, the closure of facilities will be detrimental. Crime has been cited to be the main factor for some facilities closing in the province.

The data also highlights that patients from closed clinics haven't been accessing healthcare consistently since the closures. Access to healthcare is a basic human right, and governments should aim to provide universal and equitable access to high quality health care services, and adequate solutions should be put in place to ensure the safety of healthcare professionals in affected facilities as well as patients who are in need of healthcare services.

It is clear that physical distance, safety concerns, and poor staff attitudes are some of the hurdles preventing access. With more than 50% of the respondents on chronic medication, it is concerning that they're not able to access facilities at times, this could worsen their condition and undermine gains of the treatment programs. This could be detrimental to their health and to the country reaching the 95-95-95 targets. According to the National Department of Health, South Africa is sitting on 93-77-59, the Western Cape province is at 91 -66- 93, clearly indicating a serious adherence problem and such impediments continue undermining efforts.

Another key concern is access to contraception. Community members foresee an increase in teenage pregnancies since people decided to stop going to healthcare facilities because of the challenges.

5.2. Community Engagements

TAC engages in several community engagements within affected communities. The key message that came from these engagements were that the communities were never notified of the closure of facilities and no appropriate measures were taken to ensure they continue to access healthcare services smoothly.

5.3. Recommendations

What is critical at this point is for the people to have continuity of care whether the clinics stay closed or not. Provisions should be made for patients to continue accessing services in their specific contexts, for example, in the case of long distances to the referral sites, the city could make transport arrangements for chronic patients to be taken to the referral clinics through Planned Patient Transport. This will also solve the problem of crime where patients reported being attacked on the way to and from the clinics.

The renovation work at the closed facilities could be faster. It is recommended that the necessary work needed to render the clinics safe and ready to operate should be fast tracked in order for people to be able to access services without the inconvenience of travelling to the next community.

The province needs to zone in on issues around attitudes of staff members and put in place disciplinary measures. No patient who seeks out care should be turned away from facilities as this ultimately results in patients being lost to care. PLHIV lead complicated lives and may miss appointments and even miss taking some pills. When they do, meeting them with support when they return to the clinic, even if it is not their usual and regular clinic helps ensure long term adherence. But patients and PLHIV who return to the clinic and are treated badly, or who fear they will be, will often not come back. Often staff do not treat people properly due to stress, exhaustion, and burn out as a result of the malfunction in the health system including, lack of time, tools, equipment or medicines. This directly impacts our ability to reach the 2nd and 3rd 95 targets.

Understandably staff at clinics may be overburdened by the extra volume of patients flooding the facilities. It is necessary that the province hires extra staff in facilities where most referrals are occurring. Understaffed clinics mean healthcare workers are overburdened. This leads to longer waiting times, limited time to attend to public healthcare users and at times, bad attitudes.

Public healthcare users begin queuing early in the morning in an attempt to get seen more quickly — often so they can make it to work or to take care of their children. With imminent clinic closures, more patients will likely arrive early at facilities early this impacting on their risk of experience of crime. It is

therefore important to ensure that the appointment systems at these referral facilities are functional to avoid having patients spending too much time at the facility.

Full time policing

Small waiting areas can also lead to overcrowding and even before COVID-19, patients have been forced to wait outside in long queues at certain clinics. The lack of appropriate space for patients to wait, has a profound effect on the TB infection control at the site level

Inadequate space impacts patients in multiple ways. Lack of space for HIV counselling and testing can mean PLHIV are consulted, tested, or counselled in the same room as someone else. This lack of privacy and confidentiality can lead to individuals disengaging from care. With clinic closures occurring in the province this will lead to overcrowding in the facilities as well.

Another key recommendation to ensure that communities in the Western Cape get proper access to health care services is to ensure that clinic hours are extended (as per the NDoH circular from 5am to 7pm on Monday to Friday), this can ensure that People living with HIV and those collecting their other chronic medication will be able to pick up their medication.

TAC and Ritshidze will engage in broader community-led monitoring to further understand the challenges in the Western Cape, this will help point to needed interventions for prioritization and also provide detailed data for continuous quality improvement.

Communication and compassion are still key to improving a crumbling clinic system. The truth is public healthcare users do not expect the moon — just to be properly informed about their test results and the treatment they are receiving. They are only asking to be treated fairly and with dignity and professionalism. Yet we hear too many reports of people's anxiety of being treated poorly and left in the dark by clinic staff and of running out of options even as the public healthcare system deteriorates.

INDAWO YOLWAMKELO