Special Article

Maternal health services in South Africa

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

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

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The context within which we are working locally, nationally and globally is a significant determinant of what is achievable. The context of this South African case study is a South Africa which, since 1994, has been engaged in a general societal transformation aimed at decreasing inequity. This makes it unique. However, the situation from which the health sector is trying to move is similar to that in many other countries in Africa and further afield. South Africa's starting point is one of disorganised services, low morale in the health sector, poor people, low literacy levels, especially among rural women, and inadequate infrastructure (roads, transport, water and electricity supply). The South African transition, while well intentioned, is limited by national and global economic imperatives as well as by the capacity of a new government to transform a society built upon inequity.

The data on which this paper is based come from two research projects undertaken by the Women's Health Project. The first is a comprehensive review of maternal health services[1] in the most populous province of the country. This included 13 focus group discussions with women who use public sector maternal health services (and the majority of women do) about their experiences, opinions and expectations of maternal health services.

The rest of the data are drawn from a research and implementation project undertaken in conjunction with three provincial health services: the Northern Cape, North West and Northern Province. These three provinces are among the poorest in South Africa, are rural in character and include one province with a low population density but a large land mass as well as the province with the highest population growth rate, the highest teenage pregnancy rate, the lowest per capita income and a high rate of male migrancy. The Reproductive Health Transformation Project (RHTP) was a wide-ranging multifaceted project aimed at improving the range and quality of reproductive health services and further integrating these services into the developing district-based primary health care service. The design of the intervention recognised that service providers have to be mindful of the context in which the service users live in order to provide appropriate services. In other words who are we trying to provide services for, what is their reality, their needs and how do we meet them? This may seem elementary but, in fact, few services are developed with this in mind. The RHTP aimed to reorient services to become more user-sensitive and user-friendly.

In the course of this research project we undertook a review of the capacity of the existing health sector to provide and train people for comprehensive, integrated, reproductive health care services. The project also aimed to investigate the attitudinal issues that influence service quality. The project collected data by various means, both quantitative and qualitative; these are summarised in Table I.

This extensive data collection exercise was characterised by participatory methods of working and included a significant degree of local capacity-building (F Lund — mid-term review of the RHTP, 1997). This allowed us, in conjunction with provincial health staff, to develop a comprehensive view of problems and possibilities associated with meeting the health needs of South African women.

What do women want? By far the most common aspect of maternal health services commented on is the way in which health service staff treat patients.

'Nurses instigate each other to scold and insult you.'

'Mothers deliver without assistance; they leave us alone and go to sleep.'

'I choose to give birth at home because at the hospital or clinic we teenagers they treat us very bad, they hit us and insult us so it is better at home because my mother won't scold me.'

Women were asked to describe what their expectation of services is. The most common request, after wanting to be treated with dignity and respect, was for their partners to accompany them during the delivery. The most common reasons for this were 'so that he can see my pain'; 'he will

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Table I. Data collected during the RHTP

Data collection tool	Target	Information collected	Number reached
Key informant interviews	Senior health managers	Opinions on service development	76 managers
Self-administered questionnaire	Staff of primary care clinics	Views on reproductive health services and requirements for delivery of these	1 481 primary care staff
Change management workshops 'Health workers for change'	Primary care staff	Open up discussion on role that providers can play to impact on quality of care	270 3-day workshops reaching 820 primary care staff
Facility checklists	Primary care clinics	Adequacy of infrastructure and supplies	378 clinics
Focus group discussions	Community women	Community opinion of services	7 groups
Time flow and workload studies	Primary care clinics	Assess workload and patient waiting time	1 pilot clinic per province
Self-administered questionnaires	Nurse tutors	To assess tutors' understanding of reproductive health	128 tutors
Focus group discussions	Nurse tutors	To assess tutors' understanding of gender	7 groups — 58 tutors
Focus group discussion	Nursing students	To document their opinions on teaching methods	83 students
Interactive questionnaire	Nursing students	Students' understanding of reproductive health and gender	425 students
Observation of classroom teaching	Nursing teaching institutions	Methods of teaching	20 classes
Review nursing curricula	Nursing teaching institutions	Content of curricula	7 institutions
Key informant interviews	Heads of nursing teaching institutions	To document their understanding of how gender could be incorporated into the nursing curriculum	46 heads of sections
Gender and health workshops	Primary care staff	Expand understanding of gender and health and discuss how this impacts on quality of care and service provision	52 2-day workshops reaching 779 primary care staff

not want me to have more quickly'; and 'he may encourage me to use contraceptives'. The exception was in the case of teenagers, one of whom said: 'A man will tell you in front of his friends when drunk that this and this happened. I prefer to go alone.'

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

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

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

Expectations of delivery services included that 'the nurse should be next to you' and 'they must check the baby's heart' and 'tell me how my labour is progressing' with 'not too many people, as they shout and confuse you'. In every focus group women complained that they were very hungry after delivery, that food is rationed and comes at specific times, not when needed. One woman told us: 'They don't give you enough pads; then when you stand up after delivery a clot can fall out. They shout at you to clean up and when you have finished the food trolley is gone.'

These data are rich and extensive. In summary, most women in the groups interviewed had had negative experiences of childbirth. Specifically, their sense of dignity was offended. Overall, with the exception of the desire to have ultrasound examinations, their expectations of acceptable services are reasonable and minimalist. Women want to feel attended to, to be treated with care and respect, to deliver in a safe, clean environment and to know that the service can deal with complications. Many problems cited relate to poor communication between health workers and their patients.

The more limited focus group discussions with community women as part of the Reproductive Health Transformation Project echoed many of these sentiments. The most common complaint was about how patients are treated when they come to clinics. This was tempered by an appreciation of the skills that health service providers do have. Long waiting time at clinics and the inability of clinics to provide a combination of services on a single day were listed among the important problems. Women also wanted a range of services and they listed and prioritised what reproductive health services should be available. The results from this small sample are summarised in Table II. What is of interest about this prioritisation is that, in spite of the groups' having a wide age range and being generally conservative, abortion services were included within the first five priorities of all age groups. In addition, an understanding of the whole life cycle of women, including menopause and cervical cancer as reproductive health issues, was evident.

Community opinion of services was triangulated with the data from the various other data tools used to evaluate services in the three provinces and they were mutually reinforcing.

Waiting time is, in fact, long when compared with the actual contact time with service providers. Fig. 1 illustrates this. Table III compares the mean total time with the time spent receiving care. For example, patients spend 54

Table II. Women's prioritisation of required reproductive health services

Priority level	Peri-urban group	Rural group	Youth group
1	Contraception	ANC and delivery care	Safe abortion
2	STD treatment	STD treatment	STD treatment
3	Delivery care	Safe abortion	Delivery care
4	Infertility investigation	Cervical cancer screen	Contraception
5	Safe abortion	Sexuality education	Sexuality education
6	Sexuality education	Contraception	Infertility investigation
7	Menopause services	Infertility investigation	Menopause services
8	Cervical cancer screen	Menopause services	Cervical cancer screen

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

	Mean total time in clinic (range)		Mean time receiving care (range)	
Service	Northern Cape	North West	Northern Cape	North West
Tuberculosis	54 m (8 m - 2 h 22 m)		10 m (2 m - 32 m)	
Curative care	3 h 11 m (13 m - 6 h 16 m)	1 h 24 m (1 m - 6 h 20 m)	7 m (5 m - 15 m)	4 m (2 m - 7 m)
Child care	1 h 40 m (2 m - 4 h 24 m)	1 h (1 m - 5 h 21 m)	17 m (5 m - 30 m)	12 m (1 m - 35 m)
Family planning	50 m (1 m - 2 h 46 m)	58 m (6 m - 3 h)	7 m (1 m - 58 m)	5 m (1 m - 46 m)

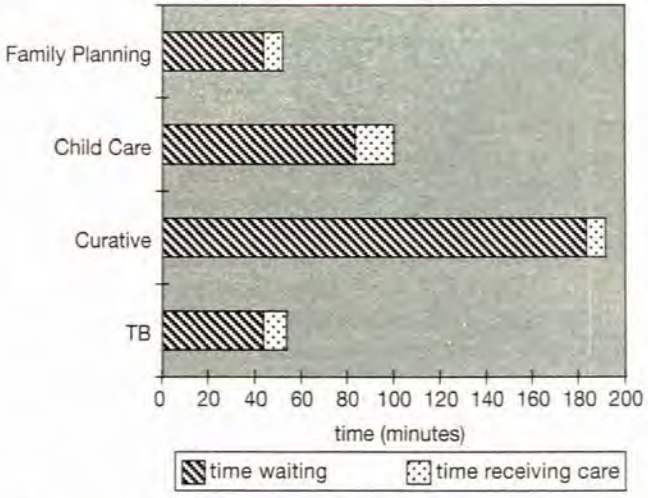

Fig.1. Time spent in clinic waiting and receiving care by service

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

Facility checklists[2] were sent to all clinics via the regional managers and were filled in by the person in charge of the clinic. Six broad categories of facility adequacy were evaluated: infrastructure, access, management of resources, patient environment, community participation and equipment for reproductive health services. Data were categorised so that facilities could be graded as desirable, acceptable or unacceptable (Table IV).[3]

For a significant number of clinics, basic infrastructure does not meet acceptable standards and in two provinces 50% or more of the clinics are in need of major repair. Poor electrification and inadequate or unreliable water supply mean that sterilisation of equipment can be problematic and that deliveries at night have to be conducted in suboptimal lighting. In this context only 30% of Northern Province clinics have special spotlights for deliveries. For example, in Northern Province, while 63% of clinics do have a drug supply system, only 27% of clinics have no problem with drug supplies. On average, 69% of clinics do not have oxytoxics (95% of clinics in North West do not have an adequate supply of oxytoxics). Pethidine (which is the drug of choice for pain relief during labour in South Africa and which midwives are licensed to prescribe) is available at only 5% of facilities surveyed.

Equipment supplies, while better, are still not adequate. The vast majority of clinics have baumanometers but not all are in working order and the turn-around time for repair of

Table IV. Infrastructural adequacy of 157 (52%) Northern Province, 136 (45%) North West and 85 (52%) Northern Cape clinics

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

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

equipment is reported to range from 2 weeks to months, with equipment often getting lost in the system and not being returned at all.

At least 35% of clinics cannot test urine and more than one-third cannot measure haemoglobin levels to screen for anaemia. This is in the context of a country where the major causes of maternal mortality are related to high blood pressure in pregnancy and haemorrhage followed by sepsis and obstructed labour. Perhaps the biggest inadequacy is the absence of reliable communication systems, both verbal and physical; this undermines the ability of the service to deal adequately with obstetric emergencies. Seventy-seven per cent of clinics have no transport available for referral purposes.

Contraceptives are available, though limited in range, and this probably reflects the political commitment of the previous regime in South Africa to decreasing black fertility. Reviews of the quality of family planning services have found that while contraceptives are widely available, the service is nonetheless inadequate.[4]

There are various other data which relate to adequacy of services and other aspects of women's health, beyond maternal health which is the focus of this paper.

What do health workers think? In the self-administered questionnaire completed by staff at primary care clinics, 34% rated lack of equipment, and inadequate facilities and drugs as the worst thing about their jobs. This problem rated higher than lack of staff (18%) and was followed by problems with transport (14%). Seventy-five per cent of staff indicated that change is required; the reasons are to improve the quality of the service (18%), to meet community needs (16%) and to improve staff morale (15%).

Staff opinion on service development and problems was further investigated through qualitative research techniques using Health Workers for Change.[5] During this process, health care providers are asked to reflect on their work from various points of view and to isolate obstacles to providing quality care. Significantly, health workers themselves believe that they deliver suboptimal care to clients. They describe themselves as rude, uncaring, insensitive, and note that they treat clients selectively, providing better treatment to educated and well-off women and to men and worse treatment to illiterate or poor women. It is in understanding the reasons why they do this that solutions can be found for improving health services, health service utilisation and contributing to improving health status indicators such as maternal mortality.

Obstacles to providing quality care were listed and prioritised throughout the three provinces. A system of scoring was developed which allowed staff to indicate numerically how big the problems were in relation to each other. The findings are set out in Table V.

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

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

These findings illustrate clearly that health system functioning, with regard to resources and management issues, rates highly in health care workers' understanding of obstacles to quality health service provision, even above issues such as salary and inadequate staffing. What this ranking does not reflect is that health care workers did admit that many of the factors which determined how they relate to clients are the consequence of prejudice and unequal power relations based on class, sex and race. While they said that if they were not so stressed at work they might take more time and care with illiterate women, they also acknowledged that often they could not be bothered as such women are unlikely to complain. They also acknowledged that their lack of gender sensitivity, in spite of being women themselves, made them judgemental. 'We grow up in the same society as everyone else, we are socialised to see women in a certain way and we do.'

The range of solutions that staff came up with does illustrate this understanding — primary care staff described interventions which they themselves could implement as well as those that others in the system are responsible for.

What needs to be done? Health workers were asked to develop practical solutions to the problems of poor health services for women. The principle underlying these solutions is that all levels of the health system need to be involved in the process of change. The 820 participants in these

workshops listed a solution for each of the major problems identified.

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

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

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

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

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

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

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

Conclusion

What is being suggested is a creative, focused rejuvenation of the public health sector. When women are asked about their maternal health needs and expectations they say, in summary, that they want a functioning health system. When health workers are asked about problems at work in providing services for women clients, they identify the need for a functioning health system. The latest World Development Report[6] urges that we move away from extremist views on the role of the State. Development requires an effective State. Women of low economic status do not have the force to demand services, and do not have the monetary capability to attract alternative providers. It is in relation to maternal mortality that the State must take up its responsibility to decrease inequality. It is one of the core public activities that are crucial to development. It is this sector of the State that needs to be invigorated.

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

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

While South Africa has the commitment to maternal health and has a constitution which firmly establishes the rights of

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

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

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