Agenda: Empowering women for gender equity

Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/ragn20

Young women from informal settlements report on their experiences of accessing sexual and reproductive and other health services from clinics
Melissa O'Reilly & Laura Washington

To cite this article: Melissa O'Reilly & Laura Washington (2012): Young women from informal settlements report on their experiences of accessing sexual and reproductive and other health services from clinics, Agenda: Empowering women for gender equity, 26:2, 126-138
To link to this article: http://dx.doi.org/10.1080/10130950.2012.708621

PLEASE SCROLL DOWN FOR ARTICLE

Full terms and conditions of use: http://www.tandfonline.com/page/terms-and-conditions

This article may be used for research, teaching, and private study purposes. Any substantial or systematic reproduction, redistribution, reselling, loan, sub-licensing, systematic supply, or distribution in any form to anyone is expressly forbidden.

The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to date. The accuracy of any instructions, formulae, and drug doses should be independently verified with primary sources. The publisher shall not be liable for any loss, actions, claims, proceedings, demand, or costs or damages whatsoever or howsoever caused arising directly or indirectly in connection with or arising out of the use of this material.
Young women from informal settlements report on their experiences of accessing sexual and reproductive and other health services from clinics

Melissa O’Reilly and Laura Washington

abstract

Project Empower is a Durban based non-governmental organisation (NGO) working with young women in a programme aimed at increasing their ability to defend their sexual and reproductive rights as a strategy to support their efforts to avoid primary and secondary HIV infection. Project Empower has worked with up to 80 young women from Durban shack settlements and has become aware of the struggles faced by young women in accessing sexual and reproductive health services. The research reported in the Briefing shows that young women shack-dwellers perceive that they frequently face inadequate and sometimes harmful service provision. Some of these are well known and documented such as long queues, delayed test results and drug stock-outs. Less known is the prejudice and discrimination experienced by young women from health care providers, reported by women in the research to frequently hold anti-poor, sexist and ageist attitudes. The Briefing argues that these experiences discourage young women from returning for follow-up services, often with long-term negative consequences for their health. This Briefing is based on focus group discussions with young women participating in our programme and outlines their experiences of accessing sexual and reproductive health care. It also compares these experiences with the Department of Health’s own policy document ‘Sexual and Reproductive Health and Rights: Fulfilling our Commitments 2011-2021 and Beyond’ (published in May 2011) and presents the young women’s demands for how the services can be transformed.

keywords

Young women, informal settlements, sexual and reproductive health and rights, HIV/AIDS, rights violations

Introduction: HIV in South Africa and young women in informal settlements

HIV prevalence in South Africa continues to impact negatively on individual wellbeing as well as on national development prospects (Dept of Health - DoH, 2011b). HIV prevalence is around 17.9% in the adult population but is distributed unequally in South African society, with gender, poverty and residential location influencing risk of
infection (*ibid*). The province of KwaZulu-Natal has a much higher HIV prevalence level, at 24.9%, than other provinces and these levels have increased since 2008 (DoH, 2011b:4). Young women between the ages of 15 and 24 years are four times more likely to be HIV-positive than young men in the same age group (SANAC, 2011:25). Furthermore, people aged between 15 and 49 years who live in informal settlements have the highest HIV prevalence of all people in South Africa based on residential type (Shisana *et al.*, 2005:xxvi).

The heightened risk faced by young, poor women living in informal settlements is recognised in the current National Strategic Plan (NSP) on HIV, STIs and TB 2012 – 2016 (SANAC, 2011) which identifies 14 key populations who are most at risk of HIV infection. Young women living in informal settlements can be included in the following four of these key population categories:

- Young women between the ages of 15 and 24
- People living in informal settlements
- Young people not attending school
- People with the lowest socio-economic status

Clearly young women living in informal settlements face a crisis, not only with regards to HIV infection, but also with associated infections such as tuberculosis (TB), Sexually Transmitted Infections (STIs), and related issues such as unplanned pregnancy and gender-based violence.

Existing literature has already identified the need to ensure young women’s access to quality health services, in general, and sexual and reproductive health services, in particular, as well as the difficulties they face in accessing these services in the context of the sub-Saharan African HIV pandemic. For instance, Klepp, Fischer and Kaaya (2008:7) hold that:

“despite being at the centre of the HIV epidemic in terms of transmission, vulnerability and impact, the majority of adolescents encounter significant barriers to maintaining their sexual and reproductive health, such as stigma and discrimination, lack of access to youth friendly services, critical information, and programmes which are designed to equip them with the skills and services they need for prevention, treatment and care.”

South African health policies addressing sexual and reproductive rights

The South African government has produced many policy and strategy documents on women’s sexual and reproductive rights and also aims to address the needs of young women and advance patients’ rights. Key amongst these are:

- The current NSP for HIV, TB and STIs (SANAC, 2011);
- The document outlining the Department’s commitment to sexual and reproductive health and rights (DoH, 2011a);
- The Health Professions Council’s National Patient Rights Charter (Health Professions Council of South Africa, 2008);
- The Batho Pele Principles (KZN Department of Transport, undated), which addresses the rights of recipients of government services in general.

The latest NSP specifically addresses the centrality of sexual and reproductive health as an HIV prevention strategy in its prevention objectives, which is:

“The delivery of an integrated package of SRH [Sexual and Reproductive Health] services as part of the PHC [Primary Health Care] approach within the district health system, with a focus on key populations [see above]. The package should include fertility management services (including termination of pregnancy services, contraception counselling and dual contraceptive method use). This is essential to reduce unintended pregnancies (especially teenage pregnancy) and to improve planning for safe and desired pregnancies. The range of contraceptive methods available to all women should be increased. Appropriate contraception should be offered to all HIV-positive women and men at every opportunity,
and contraceptive services should be integrated into ART [antiretroviral treatment] services” (SANAC, 2011:41).

“Women and young girls must also be supported and enabled to access a comprehensive package of services including sexual and reproductive health services” (SANAC, 2011:53).

The South African Department of Health’s vision statement says that all people in South Africa are entitled to sexual and reproductive health information, education and treatment, free from discrimination due to age, sex, ethnicity, gender, sexuality, HIV status or any other factors (DoH, 2011a). The ‘Sexual and Reproductive Health and Rights: Fulfilling our Commitments 2011–2021 and Beyond’ (DoH, 2011a) policy was created in order to clarify the responsibilities of health service providers and to ensure the provision of a high level of customer service with regard to sexual and reproductive health services. In addition, the Department of Health employs the National Patient’s Rights Charter and the Batho Pele Principles as the framework for determining what constitutes appropriate healthcare and as the guidelines for the acceptable treatment of patients.

little attention is paid by health managers to ensuring that services received by patients, especially young women, meet policy requirements.

The Health Professions Council of South Africa (HPCSA) formulated the National Patient’s Rights Charter to specify its expectations of health care workers. This document consists of regulations regarding the patient’s rights to a healthy and safe environment, participation in decision making, access to health care, treatment by a named health care provider, confidentiality and privacy, informed consent, refusal of treatment and complaints about health services.

The Batho Pele Principles are guidelines for the provision of customer service to all those accessing government services. These principles encompass eight topics with two additional topics specific to KwaZulu-Natal. The areas are consultation, service standards, courtesy, access, information, openness and transparency, dealing with complaints, giving best value, encouraging innovation and rewarding excellence and customer impact. ‘Sexual and Reproductive Health and Rights: Fulfilling our Commitments 2011–2021 and Beyond’ specifies the level of care required from local clinics. It is expected that clinics will provide patients with appropriate sexual and reproductive health information, education and counseling as well as contraception, fertility planning and safe termination of pregnancy, antenatal and postnatal care, treatment of STIs and the testing and antiretroviral treatment of HIV and AIDS amongst other services.

The literature on women’s health services

It is expected that local clinics will implement and abide by these policies. However, evidence suggests that these policies are frequently overlooked, and little attention is paid by health managers to ensuring that services received by patients, especially young women, meet policy requirements.

Some issues are well known and documented such as long queues, delayed test results and health facilities running out of drug stocks (see for example, Anso Thom, ‘Matsoso tackles rude staff and dirty clinics’, Health-e News Service March 7, 2011 and Miriam Mannak, ‘Communities draft health map to push for better services’, Inter Press Service, April 24, 2009). The most recent and comprehensive indictment of the South African services was published by Human Rights Watch in August 2011 in their report ‘Stop Making Excuses’ which documented a continuum of negligence and abuse faced by pregnant women in the Eastern Cape. While Jewkes et al (1998) and Campbell (2003) note health service provider abuses directed particularly at young women, little attention has been paid over the past 13 years by the health system to remediating the abuses which are commonly experienced by this group of women, as this report shows.
Background to the research

This Briefing, based on questionnaires and focus group discussions administered by Project Empower with young women participating in our programme, outlines young women’s experiences of accessing sexual and reproductive health care and compares these experiences with the Department of Health’s own policy document ‘Sexual and Reproductive Health and Rights: Fulfilling our Commitments 2011-2021 and Beyond’ which was published in May 2011 and presents young women’s demands for how the services can be transformed. While the sample size of the research is small and cannot be generalised, the research was conducted to provide a platform for marginalised and vulnerable young women to share their experiences of inaccessible sexual and reproductive health services and to contrast these experiences with policy which has been put in place to improve access to quality, non-discriminatory treatment and care.

The research was conducted in January 2012, after a growing realisation from Project Empower that sexual and reproductive health services were inaccessible for young women participants in our programme. Participants in the research were women between the ages of 18 and 26 who lived in various informal settlements in eThekwini Municipality. The research aimed to understand satisfaction levels with health services, and the nature and causes of any possible dissatisfaction. Questionnaires were completed by 66 young women between the ages of 15 and 35, with a mean age of 23 and a mode (the age occurring most often) of 18. The questionnaire consisted of nine questions and took about 15 minutes to complete. It asked for basic demographic information, information regarding the nature of services used at clinics, whether respondents were satisfied with the services received and if not, the nature of their complaints. The focus group discussion with 20 participants probed participants’ experiences of poor service. Participants gave consent for their experiences to be recorded and reported on.

Informal settlements in Durban generally consist of small clusters of shacks located on marginal land on the peripheries of formal settlements. They seldom house more than a few thousand people, and do not have dedicated public health services. Instead residents of informal settlements use local public health facilities that are also used by residents of formal settlements. It is not uncommon therefore to find users of public health facilities coming from a range of socioeconomic backgrounds.

A comparatively high percentage of these female shack-dwellers expressed dissatisfaction with the health services they had received.

Participants in this study were drawn from four informal communities in the Durban area and their comments relate to both the clinics closest to their homes as well as other clinics and health facilities which they use.

Findings

Reasons for using clinics

It was found that the main reasons for using a clinic within the last three years were for baby and child health, family planning and contraception, pregnancy and childbirth, HIV testing, STI treatment and common respiratory infections such as colds and flu. It was also found that only 28 out of the 66 women (42%) who completed the questionnaire were happy with the services they had received at clinics. A comparatively high percentage of these female shack-dwellers expressed dissatisfaction with the health services they had received: an HSRC survey which surveyed the opinions of 3,000 health survey users found that 58% were happy with the service delivery they had received at clinics (Anso Thom, ‘Matsoso tackles rude staff and dirty clinics’, Health-e News Service March 7, 2011; Miriam Mannak, ‘Communities draft health map to push for better services’, Inter Press Service, April 24). Project Empower’s questionnaire found that the young women’s levels of dissatisfaction were so severe that 20 out of 66 (30%) of them opted to use clinics further away from their houses where they received somewhat better service, despite incurring higher transport costs. We also discovered that 18 out of the 66 (27%) of the participants had had experiences where health care workers had denied them treatment altogether.
Policy implementation in terms of courtesy and respecting patients’ dignity

The findings of this research project also demonstrate that there are numerous sections of the Batho Pele Principles (KwaZulu-Natal Dept of Transport, undated) and the National Patient’s Rights Charter (HPCSA, 2008) which are not being adhered to by health workers at public health facilities. These include patients’ rights to be treated with dignity and courtesy as well as to be free from physical violence and discrimination when receiving care. The research also demonstrates that the following aspects of these charters are frequently violated:

- The right to access and have freedom of choice regarding contraception;
- The right to patient-provider confidentiality;
- The right to receive timely health care, appropriate medical treatment, advice and medication;
- The right to demand accountability for poor service provision through recognised complaints procedures.

The ‘Fulfilling our Commitments 2011–2021 and Beyond’ (DoH, 2011a) policy insists that a human rights approach should be adopted in terms of customer service, confidentiality and the ethical treatment of patients, and to do so, Batho Pele and the Patient’s Rights Charter should be abided by. The Batho Pele Principles highlight the importance of courtesy in the delivery of customer service in government departments. Batho Pele establishes that courtesy involves acting in a friendly and helpful manner and treating all customers with dignity and respect. It also stresses that these aspects should be monitored in line with a code of conduct and staff provided with further training when required. The other important policy document, the National Patient’s Rights Charter (HPCSA, 2008), also encourages health care providers to possess a positive attitude and to treat patients with courtesy, empathy, dignity, patience, and tolerance.

It is therefore of concern that 25 out of 66 (37%) young women who completed the questionnaire reported that they were not happy with the service they received at clinics as the staff were rude. Some of the women reported that they had been shouted at by nurses and that they had discussed their HIV statuses so loudly that others could overhear. Nurses were described as being impatient and unfriendly, often swearing and using vulgar language with the patients. Some women said that they dreaded going to clinics because of difficulties telling the nurses what was wrong with them in a way which would satisfy the nurses. They reported having been frequently berated with senseless and tedious questions and asked how they could possibly know what is wrong with them. One young woman mentioned that she had attended a clinic while she was pregnant. Despite having undergone a number of tests and scans at the same clinic which confirmed that she was pregnant, the nurse was unable to hear the baby’s heartbeats and proceeded to tell the young woman she was not pregnant. The nurse repeatedly asked her who had told her she was pregnant and called her crazy. She then forced the patient to undergo a further pregnancy test which again was positive.

Another woman in the focus groups reported having taken her son to a clinic for attention. She said that she was then accosted by a nurse who asked her whose child he was and when she responded that he was her child she was told to “stop lying” and to “tell her who the real mother of the child was”. Others have reported receiving long lectures about “how disgusting” they are. Some women reported that the nurses were only nice when there were special events or visitors. On these occasions they would put up charts, make the place look nice and act kindly to patients in order to impress official visitors.

Policy implementation in terms of confidentiality and trust

As well as courtesy, the National Patient’s Health Charter (HPCSA, 2008) stresses the importance of confidentiality and mutual trust in relationships between patients and health care workers. Privacy and discretion are of paramount importance when dealing with information regarding patients’ health and the treatment they receive and the National Patient’s Health Charter (HPCSA, 2008) states that this information cannot be disclosed without informed consent.
or a court order. Despite this, it has been reported that health care workers often possess little discretion when discussing patients’ health.

Nineteen of the 66 (28%) young women who completed the questionnaire reported feeling dissatisfied with the treatment they had received because they had overheard staff at health facilities gossip about patients’ health. Women reported breaches of confidentiality as among the most significant reasons why they did not attend the clinics in their local areas. Another young woman reported that having had a miscarriage, nurses inaccurately informed both her and her parents that she had an abortion. Consequently, she is no longer on good terms with her parents.

Policy implementation in terms of nondiscriminatory service-provision

The ‘Fulfilling our Commitments 2011–2021 and Beyond’ (DoH, 2011a) policy states that all people have the right to access sexual and reproductive health care without discrimination based on race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language or birth. Regardless of this policy, many young women have reported experiencing discrimination, specifically based on age, class, sex and ethnicity.

Some women have reported waiting for up to nine hours in clinics to obtain treatment. They note that often those of non-African race groups are not subject to the same lengthy delays. These women report having witnessed those of non-African descent skipping queues and receiving treatment quickly, regardless of when they arrived at the clinics. It is possible that these differences in the provision of treatment are a result of the health care workers stereotyping those of non-African descent as more highly educated and therefore more capable of following complaints procedures. It was perceived that perhaps it is these stereotypes that entice health care workers to avoid any repercussions or complaints by providing those of other ethnicities with more timely, superior treatment.

A further issue which emerged is that some young women reported that they had experienced prejudice as a result of their age. The ‘Fulfilling our Commitments 2011–2021 and Beyond’ policy (DoH, 2011a) has included a life cycle approach to ensure that irrespective of age - clients’ specific sexual and reproductive health and rights needs are met.

Despite this, young women are often not provided with age-appropriate sexual health education. Some of the young women also reported being told that they were too young to have sex or to be sexually active. Others also said that they had been denied access to the contraceptive pill as they were deemed too unreliable to take it consistently. In these cases contraceptive options such as the intra-uterine device or female condoms are frequently not even offered to young women from informal settlements. Instead, they have often been forced into using contraceptive injections.

Policy implementation in terms of informed consent

The ‘Fulfilling our Commitments 2011–2021 and Beyond’ (DoH, 2011a) policy states that health services should meet the needs of all South Africans, including those from marginalised or vulnerable populations and those living with HIV. The National Patient’s Health Charter affirms that a person has the right to decline treatment, providing that the health of others is not endangered (HPCSA, 2008). Furthermore, the ‘Fulfilling our Commitments 2011–2021 and Beyond’ (DoH, 2011a) policy states that all people have the right to make decisions concerning their sexual and reproductive health, including the right to informed consent and to not be subjected to medical experiments or research without their full agreement and understanding or knowledge. Despite these policies, some young women reported instances in which they had been forced to obtain HIV tests to obtain treatment for any medical condition, as health care workers otherwise threatened to withhold treatment.
Several of the women reported instances where health workers had refused to examine them if they had not been tested for HIV. Eighteen out of 66 (27%) young women involved in this study reported having been denied treatment on these grounds. One young woman reported that a clinic nurse forced her baby to undergo HIV testing as they believed her baby had the symptoms of HIV infection. She said that when the test results came back as negative they still did not provide her baby with treatment. Another young woman provided the following story of a similar experience she had:

“I went to the clinic because I had thrush and my baby had flu. The nurse refused to touch me because she wanted me to go for an HIV test before she attended to me. I told her that I had tested for HIV at the same clinic whilst I was pregnant. She demanded my results. I told her that I left them at home. I had no choice because I wanted to get treatment for me and my daughter. I went to the Infection Control department and was tested for HIV and my results again came back negative. She still did not do any proper check-ups. She said my thrush was a result of unprotected sex. I told her I use condoms at all times and she told me that I was lying. I told her to help me with the baby as she had flu too. She instructed me to buy honey and painkillers.”

Clinics are believed to have target figures to meet regarding HIV testing and as such are perceived by some patients to be over zealous in the attempt to meet targets. However, it is against the National Patient Health Charter (HPCSA, 2008) to compel anyone to obtain unwanted testing or treatment. It appears that young black women are stereotyped due to their class, race and gender and are assumed to be HIV positive as well as assumed to be less able to resist HIV. One young woman reported that “the nurses assume whatever you come to the clinic for is HIV/AIDS related, even if it is not”.

Policy implementation in terms of freedom from violence at facilities

A further concerning issue relates to physical violence. The ‘Fulfilling our Commitments 2011–2012 and Beyond’ policy affirms that all people have the right to have their sexual health protected without coercion, discrimination or violence. The policy also observes the guarantee in the South African Constitution (Section 12) that all South Africans have the right to be “free from all forms of violence from either public or private sources and not to be treated or punished in a cruel, inhuman or degrading way”. In terms of this policy’s implementation, it is deeply disturbing that, four out of 66 women interviewed reported having been physically abused (‘slapped’ or ‘hit’) by a nurse while seeking medical treatment.

Policy implementation in terms of women’s rights to choose contraceptive options

The ‘Fulfilling our Commitments 2011–2021 and Beyond’ policy (DoH, 2011a) confirms that all South Africans have the right to access contraception that is firstly, safe, affordable, effective and acceptable and secondly, that is of their choosing, and to safe termination of pregnancy. The National Patient’s Rights Charter (HPCSA, 2008) also reinforces this ideal, stating that all South Africans have the right to make their own decisions regarding their own health. Women are afforded the option to decide if, when and how often they wish to reproduce and to be well informed regarding these rights. The Sexual and Reproductive Health and Rights policy includes guidelines (DoH, 2011a) that go as far as detailing the types of contraception which women are permitted to access, including intra-uterine devices, hormonal contraception, male and female condoms and emergency contraception, or referral for sterilisation. Although the policy documents promote women’s autonomy in sexual and reproductive health decision making, the research shows that the subject demographic are rarely allowed these freedoms.

Some women who participated in the study reported that they had experienced a general lack of courtesy as well as inferior treatment at clinics, regardless of what they are seeking treatment for. Participants reported these problems had been more pronounced when they had tried to access treatment for STIs, to obtain contraceptives or antenatal care. Despite the policy stating...
women have the right to contraception of their choice, some women described not being allowed to change from a three-month injection (depo provera) to a two-month injection (nuristerate). It was reported that generally women prefer the nuristerate injection over the depo provera injection, presumably because it has fewer side effects. One young woman reported gaining weight as a result of the depo provera injection and requested to change. Her request was denied. As a result this young woman said that she ceased using any type of contraceptive. Another young woman reported having her period for more than two weeks due to a contraceptive injection. Despite the side-effect, she said that the health care workers she had consulted had refused to change her medication. One young woman recounted the following story:

“A friend of mine was on a three month injection. She was never happy with it because it created a lot of problems for her. She reported the problems at the clinic and requested to change to the two-month injection. But the nurse refused to change her. She is sick from it and she has severe lower abdominal pains and she bleeds but the reasons were not good enough for the health care workers. They said she will be alright. She even got pregnant while on the injection and the father’s family members do not believe that she is on an injection, they just tell her she is irresponsible.”

Some women described being refused contraceptive pills because health care workers say they are too irresponsible to take them properly. Another woman stated that female condoms were not provided at clinics like male condoms and that women had to specifically request them. Even on request, each woman was reportedly given a maximum of three female condoms. Other women also reported feeling unable to request contraceptives as they had often received long and degrading lectures from the staff regarding their sexuality. This research indicates that although there are policies in place to allow women access to contraception of their choice, they are often not adhered to.

Policy implementation in terms of receiving necessary health care

It is not only in terms of contraception that these young women receive inadequate health care. The National Patient’s Health Charter (HCPSA, 2008) insists that all people are entitled to necessary health care, including accurate information regarding diagnostic procedures and treatment. Many of the study’s participants reported instances where they had received inadequate treatment and incorrect medication.

Some examples of this lack of care and attention that the women reported included being given incorrect medication for illnesses. Twelve out of 66 (18%) of women reported that when they had visited the clinics, they had been out of stock of necessary medication – as in the case of one woman who said she had attended a clinic with her child who was suffering from a very itchy rash and was told to return to the clinic two weeks later as they had no medication in stock. As well as issues with lack of stock, many women also reported being provided the wrong prescriptions. Two women mentioned that they had attended a clinic with a rash and given the wrong medicines: one was given medication for shingles and the other was given sleeping pills instead. Another woman told us that she had had an obvious and very uncomfortable STI and had not been provided with a diagnosis or any form of treatment, and had merely been sent home with painkillers and the advice to use condoms in future. She recounted that instead she had to attend a pharmacy by herself and pay R120 for the correct treatment. One woman reported that even when she had been provided medication, the health care workers she had seen had not fully explained its purpose or how to take it and she had been left to decipher this herself. This woman expressed the legitimate concern that people who are illiterate would be unable to do this.

A woman described her experience in attempting to obtain the correct dosage of ARVs:

“Health care workers are ignorant, even if you go for regular treatment they always make mistakes. I collect my ARVs at a local clinic. I know my medication and the dosage. But every time I go to collect my
medication, I have to fight for the correct medication. They advise me to change the dosage and they give me a smaller supply. I have refused to accept what they give and I have told them that I was referred by a doctor to this clinic who gave me a script to give them, and until my doctor tells me that the routine is changing I will not take their advice. I am concerned about people who cannot speak up for themselves and who do not know their medication that well, and the fact that most people think that if the nurse tells you something, you should not object. They trust that they know what they are doing when they actually don’t.”

The seriousness of these concerns becomes apparent in the story of another young woman, who claimed that a friend of hers had lost her baby when it was given ARVs for adults instead of those for children.

The study found that 6 out of 66 of the young women who completed the questionnaire said that they had been told that their medical test results had been lost.

Policy implementation in terms of the timely provision of emergency care

Even when women receive medical attention, it can take a substantial amount of time which they feel is unnecessary. The National Patient’s Rights Charter (HCPSA, 2008) specifies that all people have the right to receive timely emergency care at any health care facility, regardless of whether that person can afford it. The ‘Fulfilling our Commitments 2011–2021 and Beyond’ (DoH, 2011a) policy states that all people should have access to appropriate health care at the time they seek it. The research obtained showed that time delays were a significant barrier in the ability to obtain medical treatment. We heard numerous accounts of long queues at health clinics. Several women reported that they had often had to spend the whole day at the clinic, at times without having obtained the assistance they needed. Many of the women said that they had spent as long as six to nine hours waiting at a clinic. Forty five out of 66 (68%) women who completed the questionnaires said that they were dissatisfied with the care they had received at clinics because of the long wait entailed for treatment.

One woman said that she had taken her baby to a clinic when she was very sick and had been denied help by nurses as they had told her it was their lunch time and that they needed to eat. Nurses have been reported as frequently taking extended breaks. Some women reported that they had been told to go home if they had arrived at the clinic after midday, whilst others said that regardless of the time they had arrived at the clinic they could be forced to wait the entire day. There have also been instances of people passing away whilst waiting for treatment. One woman told us that:

“My mom was very sick so I took her to the clinic. She was so weak that she couldn’t walk. They didn’t attend to us until my mom died right there in my arms on the clinic benches and it took even longer for them to take her body away.”

Another patient reported a similar history of waiting for treatment in a ward when a patient passed away. She claimed that the body had remained in the ward for more than three hours before it had been removed, with little regard for the other patients waiting in the same ward.

Policy implementation in terms of the right to complain

Even when these young women receive substandard care and attention, they frequently find that it is difficult to lodge complaints. The National Patient Right’s Charter (HCPSA, 2008) states that all people are allowed to complain about the services they have received and to expect that each complaint will be investigated and responded to. The ‘Fulfilling our Commitments 2011–2021 and Beyond’ (DoH, 2011a) policy states that patients should be educated about their rights to complain and also to be aware of the quality of care they can expect. The Department of Health is expected to monitor the quality of care provided and to ensure accountability to patients. The Batho Pele Principles also highlight the importance of redress and accountability. These principles state that it should be simple to lodge complaints regarding the quality of health care services and that these complaints should be dealt with in a helpful and cour-
teous manner: in principle, mistakes should be apologised for and rectified as quickly and as effectively as possible (KwaZulu-Natal Dept of Transport, undated).

It is difficult to lodge a complaint when the health care worker involved is not identifiable. The National Patient’s Health Charter (HCPSA, 2008) states that patients have the right to know who is treating them and that they should only be attended to by clearly identified health care workers. Despite this, the young women interviewed described numerous instances of health care workers not wearing name tags. One young woman reported having attended a clinic for antenatal care. After disputes and further testing as the nurse would not believe that she was pregnant, the nurse reportedly left for the day without having provided the patient with any proper care. This young woman said that she was then required to wait for over an hour before she was able to consult with someone, at which point she was seen by a doctor who was surprised by the treatment she had received. Although the doctor said he was inclined to follow up the matter, he claimed that he was unable to do so without the name of the nurse. The young woman said she was unsure of the nurse’s name as she had not been wearing a name tag. The doctor apparently recommended that she always obtain the name of the health care worker in future, however he did not explain how to do this if the health care workers do not wish to be identified.

Although these health care policies stress the importance of a transparent complaints system, many young women reported not understanding it or having difficulties using it. We uncovered that women experience difficulties in making complaints in the following areas:

- Lack of accountability;
- Requests for bribes;
- Refusal of health care workers to accept complaints;
- Denial of accusations;
- Logistical difficulties in reporting complaints.

Our research indicated that information regarding complaints procedures was often not accessible and that most young women were unaware of how to file a complaint.

One young woman shared the story of her father whose family members had taken him to a clinic as he had a fever. Although he had experienced chest problems previously, the clinic staff did not offer this woman a chance to explain this. Her father was apparently taken to an isolation room and put on an oxygen mask for the whole day. The young woman said that she had checked on him and found that he was unattended, short of air and sweating. She took him home with her and he died early the next morning. She explained her anger at the lack of treatment he received from the hospital but she was unable to lodge a complaint as she was unaware of the process. She also said that she believed that lodging a complaint would be a futile endeavour as the clinic staff always protected their colleagues.

Logistically, many women reported that the offices of management were frequently not clearly marked and as a result it was difficult to locate someone who could take their complaints. They said that the offices often had old names on the doors and that patients frequently wasted time attempting to locate old staff. Another problem the women said that they had experienced was in getting to the manager’s office, as to do so they usually had to explain to security, nurses and many other people what they are doing before they are allowed to see the facility’s head. Many women noted that if these intermediate people did not feel their complaint was worthy of the manager, or if the complaint was not in the facility’s best interest, they would deny them access to its most senior employee.

Even when young women were able to overcome these hurdles in order to report a complaint, some said that they had had difficulties in having them recorded in line with the relevant policies. One young woman offered the following account of the difficulties she had experienced in lodging a complaint:

“Upon attending a clinic, prior to being asked what was wrong, I was forced to have an HIV test. After the test I was able to report the lower abdominal pains I was experiencing as well as what felt like a small lump in my lower abdomen. I was not asked any further questions and was just given pills to take for five days.
Each time I took the medication I became dizzy and nauseous. I went back to the clinic and reported my case. The other nurse asked who gave me this medication and told me I had been given the wrong type. When the clinic manager heard this, he requested that I didn’t talk about it. I was with a friend who was very angry about this and told the clinic manager that we were going to go public with the story. The manager said I should not do that and promised to give me R1000 if I agreed to keep quiet. I was tempted to take the R1000 but my friend stopped me. I then got a referral letter to go to the hospital and have proper treatment. The doctor who treated me was very angry about this and followed it up with the clinic, but they denied giving me the medication and claimed I had fabricated the story. My friend tried to back me up but they got away with denying everything that happened.”

Discussion: What is the problem?
It is difficult to explain what lies behind the actions of these health care workers. Some argue that this behaviour is a result of the health care system itself—that nurses are overworked, underpaid and therefore experience stress and difficulties in providing appropriate medical care. Whilst one must acknowledge the conditions in which health care workers practice, these conditions do not explain all of the experiences of this demographic group. The frequently discourteous treatment meted out to young, poor and black women is a chosen behaviour which our study suggests may also be linked to the underlying prejudice of health workers against this demographic group, as opposed to difficulties within the health care system.

women are afraid to seek diagnoses and treatment for STIs and HIV as they fear the verbal and physical abuse

Breaches of confidentiality, physical abuse, refusing to provide appropriate medical care and discrimination are not solely a result of lack resources or pressure on the health care system but are also significantly shaped by the health care workers’ attitudes, which this study suggests are frequently negative in relation to women who are young, poor and black.

Perhaps our most important finding was that young, poor black African women’s perception that they receive worse treatment at health facilities sometimes deters them from obtaining treatment or seeking follow up services, which can have negative implications for their health. Some women reported ceasing contraceptives as they were not provided the most suitable kind for their needs, which can result in higher instances of unwanted pregnancies. The lack of access to female condoms and the difficulties these women encounter in attempting to obtain condoms can result in higher instances of STIs and HIV. When this occurs, women are afraid to seek diagnoses and treatment for STIs and HIV as they fear the verbal and physical abuse, as well as the lack of confidentiality. Young women who believe that they have experienced abuse at the hands of the health care system are given no opportunity to seek remedy but are forced to endure what they perceive to be negative behaviour, refuse care, or seek alternative treatment at their own expense elsewhere.

Participants’ recommendations
The young women who participated in the study made numerous recommendations in terms of improvements to the health care system. Although it is policy that health care workers be identifiable, this is rarely enforced. To assist with accountability and complaints, it was recommended that health care workers be required to wear name tags at all times. Nurses should be required to introduce themselves to patients and it would be helpful for the nurses to write their names next to any notes they write in patient’s files so complaints may be lodged if necessary. It was suggested that a complaints department be created separately to the clinics to make it easier for patients to lodge complaints without being stopped by other health care workers. Participants also proposed that clinics have posters, in many different languages that are understandable, which detail the complaints procedures to ensure patients’ awareness. It was also noted that whilst suggestion boxes are sometimes present in clinics, the suggestions must be taken into consideration. It is expected that if health
care workers become more accountable for their treatment of patients, the provision of better service and more attentive treatment would ensue.

In terms of the quality of medical care and issues with lengthy delays, it was recommended that health care workers take reasonable and staggered breaks and not provide particular racial groups with preferential treatment. The young women believed that the clinics should be friendly and welcoming and that health care workers should refrain from judging and discriminating, or subjecting the young women to verbal and physical abuse.

The National Patient’s Rights Charter and the Batho Pele Principles encourage a human rights approach to sexual and reproductive health care. Despite this, many young women shack-dwellers think that the health care workers, who they depend upon for health services and care, hold views that are sexist, racist anti-youth and anti-poor that are neither acceptable nor justified. We believe that these simple recommendations could assist in improving the health care system and encourage more young women to seek and receive medical attention, especially in terms of the sexual and reproductive health services that they require.

References
LAURA WASHINGTON works at Project Empower with Nompumelelo Mbatha, Ntokozo Madlala and Busisiwe Ntshangase. Email: laura@projectempower.co.za