# "No, we can't": what will it take to change the "lack of" chant?

The paper by Schoeman et al published in this issue of the SAJCN makes for bleak reading. The picture presented is of under-resourced rural clinics, lacking basic facilities such as water and toilets (never-mind telephones), with poorly trained staff who considered themselves overworked, and who believed that the solution to many of the prevalent childhood conditions was caregiver education, but evidently expended little effort offering any. The population of parents and caregivers served consisted largely of poor, single unemployed women claiming limited home food security, yet almost half were overweight or obese. Although the study is dated (conducted in 2003), many of its findings are likely to be as valid today.

This scenario would be very familiar to most South African health practitioners, and there is little in the paper that surprises or shocks. While most urban primary health care settings would have better basic amenities, the dysfunctional state of equipment or indifference to completing disease registers, together with the other documented deficiencies described in the paper, are pervasive at health centres around the country.

The study attempts to link the state of primary health care services in the area to the anthropometric status of the children and their caregivers attending these clinics. It found no major differences in malnutrition indices in the two regions compared to the findings of two earlier national surveys. One would have expected to find higher rates of malnutrition in these more resource-constrained study settings. However, the data needs to be interpreted with some caution: the overall sample size was relatively small (< 2000 children) with no confidence intervals offered for the various anthropometric statistics, sample sizes were particularly small in some age sub-categories, the study excluded sick children (those with fever, breathing difficulties, vomiting or diarrhoea) and the reliability of measurements is uncertain (153 children were excluded from analysis because of "missing" or "erratic" measurements).

The study offers some interesting statistics though, warranting further reflection. The high home birth rate, particularly in the Eastern Cape clinics (45%), differs markedly from the national average (<5%), probably reflecting the restricted access and/or quality of care offered to pregnant women in the areas the study was conducted. More than 13% of under-5 deaths were attributed to witchcraft in KwaZulu-Natal. This is a manifestation of the caregiver's world view, but also an indicator of the failure of the education and health system to adequately educate parents and caregivers about the causes of death, particularly in children. It is hard to explain why such a high number of caregivers subscribed to such beliefs in a country where just 10% of under 20s have had no schooling.[1] It is also intriguing that over a quarter of caregivers indicated that the reason for bringing the child to the clinic was the need for "food-aid or nutrition support". In the absence of further detail, one wonders if these caregivers were requesting, or actually receiving food. The availability and provision of food supplements to children who are failing to thrive by even a quarter of clinics could be considered remarkable and cause for a minor celebration, as few primary health care centres are currently offering this service, despite this activity being a cornerstone of the Integrated Nutrition Programme (INP). Indeed, the provision of this service has disappeared even in major metropolitan areas such as the City of Johannesburg in recent years.[2]

The authors, similar to most citizens throughout the country, appear to buy into the "lack of" philosophy as the primary explanation for this dismal state of affairs. Thus, for example, the authors argue that to improve breastfeeding practices, "nurses' capacity needs to be strengthened and constraints in human resources addressed" or that the failure of implementation of the INP at a clinic level is because it "is a huge burden for nurses". Here the accepted "lack" is that of human resources. Indeed, more than 80% of nurses interviewed in both provinces claimed staff shortages. The evidence presented within the paper, however, suggests otherwise. The mean number of nurses at a clinic was 3.1 in the Eastern Cape and 3.6 in KwaZulu-Natal, with an average of 30 or 25 patients, respectively, per nurse per day. These are no different from the norms elsewhere in the province and country.[3] This translates into nurses consulting a maximum of four patients per hour and having 15–20 minutes per patient. This would certainly be enough time to complete a full child consultation using the Integrated Management of Childhood Illness (IMCI) approach, to offer comprehensive counselling, preventive and promotive care to the caregiver and child, and to complete the required child and clinic records and registers.[2] To excuse or condone nurses' suboptimal practices as a simple lack of time or training, is feeding into the South African "culture" of blaming others and externalising solutions, rather than viewing oneself as the primary agent of change, and assuming responsibility.

This does not mean that health professionals were not working under trying circumstances. Is it acceptable to expect health professionals to function in a setting without a toilet or electricity? Of course not, and district and provincial health managers are completely liable for allowing this situation to continue. They in turn are as likely to recite the same "lack of" chant – money, human resources, or whatever

– in short, anything other than assuming personal or collective responsibility for the situation. Is the real issue not a lack of insight, accountability, self-criticism, initiative and self-reliance? Who then should be held accountable? One cannot but wonder who was responsible for the study's finding that half of the 14 facilities that were built or renovated after 1994 were in a "bad" condition. Was this the consequence of bad workmanship or wanton neglect? Were health professionals completely powerless to mount an appropriate response and to mobilise citizens and communities to assist them in doing this?

The authors attribute the nurses' failure to implement INP activities to a lack of training – essentially "neglect or gaps in pre-service and in-service-training, as well as basic, ongoing and specialised training". Limited evidence is provided to support this assertion. Interviewees self-reported exposure to INP training varied markedly in the two provinces, but more than half the Eastern Cape nurses were trained in all the assessed components. Again, in reality, the deficit is less likely to be inadequate exposure to any training and more likely the inability or lack of motivation to apply the lessons learnt during regular training, on return to the work situation. Over 10 000 health professionals have had IMCI training in South Africa (many attending 11 full days of training), yet it is estimated that fewer than a fifth of trainees are using the IMCI methodology in their daily practice.[2] The real "lack of" here may be the motivation and opportunity for individuals to change their own practice rather than the absence of training per se.

Schoeman et al's conclusion is that shortcomings in "the quality of services should firstly be addressed before a difference in the health and nutritional status of vulnerable groups in South Africa can be expected". The need for primary health care services to improve and to be more responsive to patients needs is well recognised by all. Similarly, the importance of addressing child undernutrition is attracting renewed global interest. However, Schoeman et al may have got the temporal relationship wrong. Most of the recent available evidence favours removing the primary responsibility for growth monitoring and promotion away from clinics and re-assigning it to the community setting, primarily through the use of community health promoters (workers). We truly do not need lots more clinics, infrastructure, nurses, scales, or whatever else is "lacking" to start to make a difference to children's health. Instead, let's focus on what matters – the right food offered in the correct frequency and amounts, for example – and ensure that all children get this, even while health professionals and others continue to chant the "lack of" mantra.

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