State of Provincial Healthcare System
Spotlight on KwaZulu-Natal
May 2018

Each day in KwaZulu-Natal we hear reports of health system failures. Shortages of doctors, nurses and specialists that mean people wait hours, days or months for critical services. Broken equipment that mean cancer diagnostics and treatment are unavailable. Countless incidents of medical negligence. Pregnant women recount the fear and indignity they felt while giving birth in public hospitals. Healthcare workers without proper equipment get TB again and again. In emergencies people struggle to pay for private cars, knowing the ambulance will never arrive. Nurses shouting at vulnerable patients. Dirty, run down and broken infrastructure. The outcomes are clear – people are suffering and dying. We cannot turn a blind eye.

While the KwaZulu-Natal Department of Health is taking certain positive steps in addressing the HIV pandemic in the province, much more needs to be done to ensure everyone living with HIV gets on treatment, to reduce new HIV infections, to stop people getting TB and ensuring those who do are cured, and importantly to strengthen the public health system so that everyone can access decent free healthcare.

The Treatment Action Campaign (TAC) has been working in KwaZulu-Natal since the early 2000s and continues to represent users of the public healthcare system and campaign on critical issues related to the quality of and access to healthcare. We currently have a network of 44 branches in four districts in the province including eThekwini, King Cetshwayo, iLembe, and uMgungundlovu. Through these branches we monitor service delivery at a number of clinics and hospitals. Our members are the people who need the public health system to work, so they are the first to notice when it does not.

Each of our branches in the province has adopted a primary healthcare facility local to them and have been monitoring the state of services at these facilities since November 2017. The results highlight a number of critical concerns with regard to the state of services at clinics and community healthcare centres. A summary of the results of data collected in March 2018 is provided within our analysis below. The full data set for November 2017, March 2018, April 2018 is captured in appendix 1.

The monitoring tool used has 24 questions based on the services and quality of service that a primary healthcare facility should offer. The questions, developed in consultation with TAC members, are designed to address the key concerns for users of the public healthcare system – and as such should be seen as complimentary to the more systematic and operational monitoring conducted by the Office of Health Standards Compliance (OHSC). The monitoring was conducted by TAC members trained in the use of the tool. In addition to monitoring facilities, TAC branches engage with members of the community to understand the challenges and collect testimonies and complaints that relate to these concerns.

The data collected by our branches corresponds to the worrying picture of our public healthcare system painted by reports published last year by the OHSC[1]. According to the OHSC report, facilities should score at least 80% to claim an acceptable level of care – yet in KwaZulu-Natal of 53 clinics inspected by the OHSC (not necessarily the same facilities as monitored by TAC) only 22.64% of the clinics are performing at 60% or above and 11.34% above 70%:

# facilities	Rate
1	clinic performed below 20%.
0	clinics performed between 20-29%.
17	clinics performed between 30-39%.
3	clinics performed between 40-49%.
20	clinics performed between 50-59% score.

[1] Annual Inspection Report 2015/16. Office of Health Standards and Compliance. Available at: http://us-cdn.creamermedia.co.za/assets/articles/attachments/68604_ohsc_annual_inspection_report_draft_4_20170318.pdf

6	clinic performed between 60-69%.
4	clinics performed between 70-79%
2	clinics performed above the required standards to claim an acceptable level of care.

In addition to monitoring facilities, TAC branches engage with members of the community to understand the challenges and collect testimonies and complaints that relate to these concerns. We also conduct ongoing investigations into the state of a number of hospitals in the province, the results of which are shared in our analysis below.

Fixing the health system in KwaZulu-Natal is an emergency. The many persistent challenges that plague the provincial health system require an urgent and comprehensive turnaround strategy by the provincial Department of Health. We outline our concerns and demands below in order to improve the situation. MEC of Health Dr Sibongiseni Dhlomo and Premier Willies Mchunu must take these demands seriously. We require a written response from the department by 15 June 2018.

Key concerns and demands

1. **Critical human resource shortages including nurses, doctors, specialists and CHWs**

The shortage of human resources is a major issue in KwaZulu-Natal. Ensuring access to quality healthcare services and ensuring everyone living with HIV and TB get access to treatment and care depends largely on having enough qualified and committed staff – including doctors, nurses, pharmacists, pharmacy assistants, community healthcare workers (CHWs), lay counsellors, peer-educators, security guards, porters and cleaners.

We note the large number of vacancies that remain unfilled in the province. Looking at available data from the National Department of Health in February 2017, there were over 79 038 funded posts in KwaZulu-Natal. Of these 70 134 were filled, leaving a shortfall of 8 904 vacant posts in the province. This translates into more than 11% of the provincial workforce. However, instead of filling vacant posts and ensuring that there are enough people to properly deliver our healthcare, some posts are instead being frozen. While many doctors and nurses remain unemployed, there are not enough open positions to employ them.

Human resource shortages cause long waiting times, patients being turned away from facilities, longer hospital stays, higher risk of deaths, and increased pressure on the few staff in place. Staff are exhausted, stressed, under-resourced and overburdened contributing to the worsening of attitudes and a lack of compassion shown towards patients seeking care. A major cause of medicine stockouts and shortages are a result of staff being too busy to place orders in time. Some health workers are even being lured to the private sector for better working conditions, job satisfaction and pay. Medical KZN spent more than 240 million in legal claims because of medical negligence, which lead to adverse incidences. The result of all of this is that patients do not access quality healthcare services as required by the Constitution.

The results of TAC KwaZulu-Natal's monthly monitoring in March 2018 shows the following in relation to human resources for health:

Staffing: Two thirds of facilities were considered to have insufficient staff. 35.7% (10/28) of facilities were classified as not having enough staff and 64.3% (18/28) facilities as having enough. At the very least, this finding shows that a substantial number of people dependent on the public healthcare system perceive facilities as being understaffed.

Staff attitudes: At 64.3% of facilities (18/28) staff were generally considered to be friendly, at 32.1% (9/28) staff were classified as sometimes friendly, and at 0% (0/28) staff were generally considered not to be friendly. Bad staff attitudes – witnessed in all cadres in the health workforce – affect patients' ability to access healthcare in these facilities. 1 facility was excluded from the analysis due to a lack of data. Further engagement with communities shows a lack of compassion among many nurses.

Waiting times: Our survey found that at 32.1% (9/28) of facilities people had to wait for more than an hour to be seen and at 17.9% (5/28) of facilities the wait was more than two hours which is hugely disruptive for people. Though generally poor, waiting times were variable. At 32.1% (9/28) of facilities the waiting time was between 30 to 60 minutes. 14.3% (4/28) of facilities saw people in less than 30 minutes. 1 facility was excluded from the analysis due to a lack of data.

In May 2016, shocking details were shared with TAC and SECTION27[2] from health workers highlighting a crisis in healthcare within oncology, urology, general surgery, obstetrics, psychiatry, orthopaedics, trauma surgery, intensive or critical care, forensic pathology services, cardiothoracic surgery, paediatrics, cardiology and ENT. The South African Medical Association (SAMA) in KwaZulu-Natal's memorandum[3] outlined the following issues:

- Despite the huge shortage of doctors, many young doctors are unemployed because there are insufficient community service, intern and even medical officer posts;
  There are not enough specialists and senior doctors to train young, inexperienced staff;
  A huge shortage of nurses has led to longer hospital stays for patients, higher numbers of deaths and increased pressure on doctors and remaining nurses;
- There is a shortage of anaesthetists across the province;
- Hospital management is not functioning and there is no accountability when things go wrong;
  Human resources management is poor at all levels despite heavily staffed human resource departments.

In terms of the widely reported cancer crisis in the province, while some action has been taken, much more needs to be done to address the ongoing challenges and ensure all people with cancer are able to access adequate treatment and care. In terms of human resources, a public private partnership has been entered into with the Wits Consortium in providing three private sector oncologists on a temporary basis to deal with the backlog of cancer patients. However, one issue arising is that patients may be forced to see different oncologists on different visits, leading to communication challenges. In addition, this temporary measure will not help new cancer patients, who will still have to wait. Oncology services need to be placed inside the public sector on a permanent basis in order to ensure there are sufficient staff to treat all cancer patients.

In addition to doctors, nurses and specialists, there is also a major shortage of community healthcare workers (CHWs) in the province. CHWs have long been recognised to be an important part of a primary healthcare system. They have the potential to bring the community closer to health services, and health services closer to the community. Disease prevention, health promotion, and linkage to care are at the core of CHW programmes the world over. The efficacy of CHWs depends on the effectiveness of the healthcare system as a whole. They are not a panacea for a weak system and cannot replace facility-based healthcare services. What they can do is offer certain services to otherwise underserved communities, and provide preventative and health promotion services that are not otherwise adequately available within the health system. Evidence suggests that CHWs can bridge the gap between the community and the healthcare system and can facilitate patient re-entry into healthcare services after a negative experience.

CHWs can also reduce the burden on already overstretched primary healthcare services by providing services outside the facility setting that traditionally happen at a clinic level. This includes providing treatment literacy, counselling and support services, providing HIV testing and offering information to help reduce risky behaviour, providing alternate ART collection methods including direct delivery to people's homes or via adherence clubs, providing prevention information and even distributing condoms. This reduces the burden on clinic staff that often leads to other problems that worsen the HIV and TB response. For instance, one of the major causes of facility level medicine stockouts and shortages which directly impacts treatment adherence, is that overstretched clinic staff sometimes fail to order medicine stock in a timely manner given that they prioritise attending to endless long queues of patients who require care. Additionally, TAC research in 27 facilities (outlined below), shows very poor levels of TB infection control at a primary healthcare level.

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[2] TAC & SECTION27, May 2017: "KZN Healthcare System in Crisis". Available at: https://tac.org.za/news/kzn-healthcare-system-crisis/

[3] SAMA memorandum, May 2017. Available at: http://section27.org.za/wp-content/uploads/2017/05/SAMA-Memo.pdf

Alleviating the burden on clinics through the CHW programme would provide time to, for example, screen patients for TB and to provide tissues and masks to those coughing.

In terms of the absolute number of CHWs needed to be employed in the province, the Brazilian best practice puts a ratio of 1 CHW to 600 people in the population (1:600) – this amounts to 18 966 in total in KwaZulu-Natal. In 2016 there were 9 684 in post in the province. Based on these figures it is clear that there is a major gap in the number of CHWs in the province to effectively respond to HIV, TB and non-communicable diseases, with KwaZulu-Natal needing over 48% more CHWs in post in order to meet the target.

District	Total CHWs required by 1:600 ratio	Actual CHWs in post (DHIS 2016)	Additional CHWs who should be in post in 2018	% of additional CHWs needed in 2018
Amajuba District Municipality	959	925	34	3,52%
eThekwini Metropolitan Municipality	6 267	1 663	4 604	73,47%
Harry Gwala District Municipality	856	639	217	25,32%
iLembe District Municipality	1 170	960	210	17,97%
King Cetshwayo District Municipality	1 659	1 030	629	37,92%
Ugu District Municipality	1 301	795	506	38,90%
uMgungundlovu District Municipality	1 923	894	1 029	53,51%
uMkhanyakude District Municipality	1 156	830	326	28,23%
uMzinyathi District Municipality	953	396	557	58,44%
uThukela District Municipality	1 260	391	869	68,96%
Zululand District Municipality	1 462	1 161	301	20,60%
KwaZulu-Natal	**18 966**	**9 684**	**9 282**	**48,94%**

Our demands:

a. We demand the release of the provinces Human Resources for Health (HRH) plan before end July 2018. This plan should include a comprehensive list of current vacancies.
b. We demand that all vacant posts be filled in the next financial year and that the employment of nurses and doctors is prioritised in the 2018/19 financial year.
c. We demand the provincial health department fills the gap in community healthcare workers by adding 9 282 in or before the 2019/20 FY to ensure that there are 1:600 CHWs in the provincial health system.
d. By end July 2018 we demand a plan to ensure there is sufficient full-time oncology capacity within the public health sector and those people have the right quality equipment to treat and care for all cancer patients.
e. The provincial Department of Health must carry out investigations into all allegations made with regard to health personnel failures – including neglect and bad attitudes – and that following this investigation disciplinary action be taken where appropriate and compensation be paid out to victims of neglect or ill-treatment.
f. 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. Better staff support systems should be put in place by the provincial Department of Health in order to ensure staff wellness and support.

2. Inaccessible healthcare in rural communities

One major challenge in the province is that in rural communities, primary healthcare services are not provided close enough to where the people who need them live and work. The National Health Act requirement of 10,000 people for a clinic to be established is failing people in KwaZulu-Natal. Instead of a permanent clinic, many communities are serviced by infrequent and inadequate mobile clinics that do not offer the full range of

health services patients may need. Often, they are reported to arrive without enough medicines for those using them. If people get sick between mobile clinic visits, or need a service or medicine that is not available in the mobile clinic, they are forced to travel up to 13 kilometres to the closest clinic – either by walking or by paying out of pocket for transport to those areas. In certain cases, mobile clinics act as a diagnostic unit only, and send people to the nearest clinic for medicines afterwards, defeating the object of them. This is highly inconvenient and costly to people who are poor or unemployed, and even life-threatening where health conditions are left untreated. It is clear that the current mobile clinic system is inadequate and does not reach people often enough. It is critical that a better service is put in place for the people who live in areas without a clinic.

Our demands:

a. Where mobile clinics are used, they should provide a complete package of primary healthcare services including diagnosis, treatment and care for HIV, TB, mental health, diabetes etc.
b. Where mobile clinics are used they should attend to the community on a frequent basis so that people are able to access health services when they need them.
c. By end August 2018 we demand a clear strategy on how mobile clinics and Ward Based Outreach Teams (CHWs) will work together to ensure that people in areas without clinics can receive the healthcare services they need and deserve.

3. Overcrowding, infrastructure in disrepair, and broken or missing equipment

Healthcare facilities in KwaZulu-Natal are often overcrowded and at times in a state of disrepair. Nearly 40% of the facilities we monitor do not have enough room in the waiting area. In hospitals, people are seen sleeping in corridors on stretchers waiting to be admitted for hours or even days. Some facilities are at times without running water and sometimes the toilets are dysfunctional and dirty.

Critical medical equipment is often in short supply, broken or missing altogether. The provincial Department fails to maintain and repair high-tech and even day-to-day equipment. Medical record keeping is in shambles and patient files, with essential medical histories, are regularly lost. Air-conditioning machines are not being repaired resulting in surgeries being cancelled or hospital infections.

Cancer services stalled because there was no access to appropriate radiology and chemotherapy equipment. While the situation has been improved marginally, much more needs to done to ensure appropriate treatment and care of people with cancer. Currently there are only three oncology machines. The radiotherapy machine has been moved to Albert Luthuli Hospital so all patients in need of radiotherapy now must attend there. The chemotherapy machines are at Addington, meaning all patients in need of chemotherapy must go there.

The results of TAC KwaZulu-Natal monthly monitoring in March 2018 shows the following in relation to infrastructural issues:

Waiting areas: 57.1% (16/28) of facilities had enough room in the waiting area, while 39.3% (11/28) did not have enough room. 1 facility was excluded from the analysis due to a lack of data. This month, waiting areas in 100% (28/28) of the facilities were classified as clean. However, the same cannot be said for Prince Mshiyeni Hospital, which was not found to be in a clean or functional state at a spot check In April 2018.

Infrastructure & toilets: 92.9% (26/28) of facilities were rated as being in good condition. 2 facilities were excluded from the analysis due to a lack of data. Of the 28 facilities, 17.9% (5/28) of facilities did not have clean functional toilets, and 82.1% (23/28) of facilities were rated as clean and with toilet paper. Again, Prince Mshiyeni Hospital this month was found with many infrastructural issues. Doors, windows and burglar bars that are broken, Rubbish in the passageways. Floors with uneven and broken surfaces. Toilets without access to taps or water.

Our demands:

a. We demand an urgent, fully-funded, plan to address infrastructural issues at the facilities identified above. We demand to see this plan before the end of July 2018. We expect the MEC and the Premier to make this a priority and to ensure the funds are made available.

b. The provincial Department must ensure that there is adequate funding and personnel to ensure that health facilities are maintained, fitted with the appropriate technology (medical equipment, ICT equipment, access to internet etc.) in order to address the compromised ability of facilities to provide both an adequate environment to staff and to healthcare users.
c. The provincial Department in conjunction with the Department of Public Works must strengthen the Infrastructure Unit (engineers, maintenance crew, quantity surveyors, quality control) to address backlog maintenance, routine maintenance and the building of new health facilities and to prevent any unnecessary under expenditure of the Health Infrastructure Grant.
d. The provincial Department must ensure that they are enough chemotherapy, radiotherapy, and other oncology equipment across hospitals in order to treat all people with cancer in the province.

4. HIV and TB response falls short

KwaZulu-Natal continues to face major HIV and TB epidemics – Umgungundlovu, Uthungulu, Zululand, Ugu, uThukela and Harry Gwala face a high HIV burden, and eThekwini faces a high dual burden of both HIV and TB[4]. According to the Thembisa model, in mid 2016, HIV prevalence across all ages in the province was at 18.0% (1,937,000 people). In 15 – 49 year olds this increased to 27.1%. There were 71 000 new HIV infections between mid 2015 to mid 2016. HIV related deaths mid 2015 to mid 2016 were at 22 200.

ART coverage in the province in mid 2016 was at 61.2%. Based on these figures nearly 751 556 people in KwaZulu-Natal who could benefit from treatment, are not on it. Of those on treatment 84.2% were virally suppressed[5]. While higher than some other provinces, this indicates that there is still a need to improve adherence levels in the province in order to reach the 90% viral suppression target by 2020 as outlined by UNAIDS in the 90-90-90 targets – and reiterated by the National Strategic Plan on HIV, TB, and STIs 2017 – 2022 (NSP).

This table below outlines the number of people living with HIV per district, and the ART coverage based on figures from both the District Health Barometer (DHB) and PEPFAR (in the districts in which they work in the province). By these figures, the total ART coverage in 2017 was 61.29%. This is significantly far from the 81% ART coverage that the NSP is aiming for in 2020 (90% of all people with an HIV diagnosis receiving ART).

District	Population (2018 estimates Stats SA)	Total population (District Health Barometer)	Total PLHIV (District Health Barometer)	HIV prevalence (%) (DHB)	Total on ART 2015 (DHB)	Total on ART 2017 (DHB)	% increase in ART coverage	People currently receiving ART 2017 (PEPFAR based figures 2018)	ART coverage by DHB figures	ART coverage by PEPFAR figures
Amajuba	575 265	531 325	86 354	16.3	41 272	53 646	30.0	n/a	62,12%	n/a
eThekwini	3 760 409	3 702 232	621 411	16.8	305 567	379 833	24.3	388 566	61,12%	62,53%
Harry Gwala	513 362	510 868	87 579	17.1	41 540	49 519	19.2	46 780	56,54%	53,41%
iLembe	702 222	657 611	105 906	16.1	51 406	66 904	30.1	n/a	63,17%	n/a
King Cetshwayo	995 462	971 133	172 960	17.8	91 013	105 433	15.8	103 040	60,96%	59,57%
Ugu	780 676	753 337	139 233	18.5	67 432	86 388	28.1	86 098	62,05%	61,84%
uMgungundlovu	1 153 896	1 095 861	226 236	20.6	109 066	135 654	24.4	112 157	59,96%	49,58%
uMkhanyakude	693 899	689 086	115 688	16.8	66 386	84 506	27.3	87 366	73,05%	75,52%
uMzinyathi	571 650	554 883	93 166	16.8	44 602	54 593	22.4	n/a	58,60%	n/a
uThukela	755 749	706 589	118 150	16.7	55 767	70 052	25.6	71 375	59,29%	60,41%

[4] National Strategic Plan on HIV, TB and STIs 2017 – 2022. SANAC. Available at: http://sanac.org.za/wp-content/uploads/2017/05/NSP_FullDocument_FINAL.pdf

[5] Thembisa Model. Available at: https://www.thembisa.org/content/downloadPage/Provinces2017

Zululand	877 285	892 309	171 640	19.2	77 411	101 471	31.1	100 499	59,12%	58,55%
KwaZulu-Natal	**11 379 875**	**11 065 234**	**1 938 323**	**17,5**	**951 462**	**1 187 999**	**24.9**	**995 881**	**61,29%**	**n/a**

Overall, the province must do much more to reach the 90-90-90 targets by 2020 - 90% of all people living with HIV knowing their HIV status; 90% of all people with an HIV diagnosis receiving sustained antiretroviral therapy; and 90% of all people receiving antiretroviral therapy achieving viral suppression.

The Thembisa model found that for the purposes of reducing new HIV infections the "most important epidemiological parameter to target will be the infectiousness of patients receiving ART". They explained that this will mean "promoting adherence interventions such as adherence clubs, patient supporters, and SMS contact". In other words, the most important intervention for reducing new infections is helping people already on treatment to stay on treatment and become and remain virally suppressed.

Support groups: Support groups linked to each public health facility are critical to provide counselling and support services to people prior to testing, post testing, pre-treatment, and those struggling on treatment. There continues to be a high number of people lost to follow up. Even within the PLHIV community and TAC's own membership of mainly people living with HIV, there have been a number of losses in the past few years of people becoming treatment fatigued, stopping ARVs, and passing away. Much more needs to be done to provide counselling and mental health services to prevent this "pill fatigue" from taking place.

Adherence clubs: Adherence clubs are a way for people living with HIV and adhering properly to treatment, to collect their ARVs outside of their local clinic. Instead they join an adherence club where they can collect their medication and join discussions about issues of treatment adherence. This is a much friendlier, simpler and quicker system than waiting in long clinic queues. Not only do the clubs promote better adherence but they also relieve the burden on health facilities that are already stretched to capacity. Given the increasing uptake of HIV treatment through "test and treat" this burden will only grow. While the adherence club model has been established in certain areas by community groups, the provincial health department is instead developing "Chronic Clubs" that incorporate people facing any chronic condition. This is problematic in that people living with HIV are forced to disclose their status to all in the clubs and there is no HIV specific discussion or support during the sessions which is one of the reasons to establish an adherence club. As such these chronic clubs are not effective.

Fast track model: For people who are stable on ART, there should be an option to utilise a fast track model of treatment collection at a community level. The decentralisation of ART collection is especially important in rural communities where people have to walk several kilometres to collect HIV treatment. The province should implement at least one fast track individual ART refill collection system and at least one group simplified model of care in every clinic.

We also note challenges regarding the CCMDD programme in the province, where patients report to TAC being given incorrect medicines at time through the programme.

TAC KwaZulu-Natal welcomed the announcement that the University of Zululand would provide HIV treatment to students and staff on campus[6]. If implemented effectively, this should provide an easier and quicker system for people to collect their ARVs and therefore ensure better treatment adherence. It is important that this intervention to improve treatment accessibility is coupled with counselling and adherence support on campus. We urge other campuses to follow this trend, and make ARVs and HIV prevention options accessible to their own students and staff.

One issue in the province is related to organisations carrying out voluntary male medical circumcision (VMMC) services in KwaDukuza as alarming adverse events have been noted. This behavior is leading to a lower uptake of VMMC among men.

In terms of TB, addressing the loss to follow up rate will require an aggressive active case finding and contact tracing campaign linked to the government CHW programme. The XPRES study concluded that active tracing

[6] TAC, July 2017 "TAC welcomes ARVs on campus". Available at: https://tac.org.za/news/tac-welcomes-arvs-on-campus/

and intensified case finding by healthcare workers should be scaled-up. The study found that it was human resources rather than diagnostics that seemed to make the difference in reducing TB mortality. The study suggested that outreach to identify TB and to improve retention in care are more important than diagnostics like Gene Xpert in reducing the risk of death after starting antiretroviral treatment[7].

Our demands:

a. By end December 2018, 100% of primary health facilities across the province must have differentiated models of care including functional adherence clubs, support groups, and fast track (CCMDD) models of care for people living with HIV linked to all primary health facilities across the province to improve treatment adherence rates in the province.

b. By July 2018, the KwaZulu-Natal Department of Health must launch an aggressive, and fully funded, TB contact tracing and active-case-finding campaign. This campaign must be linked the provincial government CHW programme. A specific programme needs to be implemented to 'find the missing cases,' with specific monitoring of progress and tracking of investments in staff, logistics and supplies clearly documented each month.

c. By July 2018, the KwaZulu-Natal Department of Health must begin a provincial TB awareness, education, and social mobilisation campaign to educate people about HIV and TB and encourage the uptake of HIV and TB services. This must include treatment and prevention literacy information in order to improve TB infection control, reduce risky sexual behaviour, encourage screening and testing for HIV and TB, and encourage treatment initiation. This education, awareness, and social mobilisation campaign must take place both inside public health facilities and outside.

d. In 2018, and in every year after that, the KwaZulu-Natal Department of Health must ensure that every person receiving antiretroviral therapy in the public sector receives at least one viral load test per year. Clinics must be held accountable for offering enhanced adherence support and following clinical algorithms to switch patients in a timely manner for those with detectable viral loads.

e. By end 2018, the KwaZulu-Natal Department of Health must ensure that all clinics in the province are offering rapid ART initiation and rapid provision of TB treatment to all clinically eligible patients, with treatment start times reduced to under 7 days. In the case of DR-TB, this requires decentralisation of DR-TB care to all primary healthcare facilities in all high-burden districts.

f. By end 2019, the KwaZulu-Natal Department of Health must ensure that all people living with HIV have been screened for TB, and if eligible (they do not have TB and are not on TB treatment) are offered the option of taking TB preventative therapy (isoniazid) in order to reduce the risk of contracting TB.

5. Red alert on TB infection control

TB remains the leading reported cause of death in South Africa with over 33 063 deaths (8.4% of natural deaths) in the country in 2015[8]. The rate of new cases of active TB in South Africa remains extremely high at around 438 000 in 2016[9]. While total TB rates do appear to be slowly declining (down from 250 000 in 2015), multi-drug resistant TB (MDR-TB) and extreme drug resistant TB (XDR-TB) rates are increasing. The World Health Organization (WHO) estimates 19 000 cases in 2016 up from 7 350 in 2007[10].

TB can be spread through the air when people with active TB disease cough or sneeze. However, various infection control measures can be taken to reduce the risk of TB transmission.

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7 XPRES Study. Available at: http://www.aidsmap.com/New-TB-screening-methods-cut-deaths-in-people-with-HIV/page/3221271/

8 National Strategic Plan on HIV, TB and STIs 2017 – 2022. SANAC. Available at: http://sanac.org.za/wp-content/uploads/2017/05/NSP_FullDocument_FINAL.pdf

9 Global Tuberculosis Report, WHO. Available at: http://apps.who.int/iris/bitstream/10665/259366/1/9789241565516-eng.pdf?ua=1

10 Ibid

In the run-up to World Tuberculosis (TB) Day in March 2018, TAC KwaZulu-Natal assessed the state of TB infection control in 24 public primary health facilities across the province. The following questions were answered by TAC members from local branches linked to each facility assessed:

1. Is there enough room in the waiting area?
2. Are you seen within 30 minutes of arriving at the facility?
3. Are the windows open?
4. Are there posters telling you to cover your mouth when coughing or sneezing?
5. Are people in the facility waiting area asked if they have TB symptoms?
6. Are people who are coughing separated from those who are not?
7. Are people who cough a lot or who may have TB given tissues or TB masks?

Based on the answers to these seven questions facilities were ranked RED (3+ questions answered "no"), ORANGE (1-2 questions answered "no"), or GREEN (0 questions answered "no").

Of 28 facilities assessed in March 2018, 11 were found to be in a "RED" state with very poor infection control measures in place. 15 were found to be in an "ORANGE" state, and none were found to be in a "GREEN" state with good TB infection control measures in place. 2 were inconclusive and unable to be ranked due to missing data. If we wish to make progress against TB, GREEN ratings should be the norm in the public healthcare system, instead they are non-existent in the facilities surveyed in KwaZulu-Natal.

The good: Facilities surveyed performed well in terms of ensuring windows were kept open (only 1 out of 28 facilities did not open the windows), and posters being visible on the walls telling people to cover their mouths when coughing or sneezing (again only 1 out of 28 facilities did not have posters).

The bad: There were mixed results in terms of, the size and space of the waiting rooms (11 out of 28 facilities did not have enough room, 1 was excluded due to missing data), screening for TB symptoms (8 out of 28 facilities did not screen), separating those who were coughing a lot from those who were not coughing (14 out of 28 facilities did not separate people), and in offering tissues or masks to people who cough a lot (9 out of 28 facilities did not offer tissues or masks).

The ugly: Facilities surveyed performed extremely poorly in terms of the length of waiting times (23 out of 28 facilities failed to see people within 30 minutes).

The full results in the province are outlined on the following page. While the survey has some limitations, and is by no means an exhaustive survey of facilities in the KwaZulu-Natal, it nevertheless provides compelling evidence that we have an infection control problem at a number of public sector facilities. Given that poor infection control at health facilities may be a significant contributor to TB transmission in South Africa, this is a red flag that should be taken seriously. The problems highlighted in TB infection control through the audit are indicative of the wider crisis within the KwaZulu-Natal health system, where overstretched nurses at understaffed clinics lack the capacity and resources to engage effectively in TB infection control measures.

Name of facility	Is there enough room in the waiting area for everyone?	Are you seen within 30 minutes	Are the windows in the facility open?	Are there posters telling you to cover your mouth when coughing or sneezing?	Are people in the facility waiting area asked if they have TB symptoms?	Are people who are coughing separated from those who are not?	Are people who are coughing a lot or may have TB given TB masks or tissues?	SCORE	RANK
AA Clinic	No	No	No	No	No	No	No	7	RED
Ashdown Clinic	No	No	Yes	Yes	Yes	No	Yes	3	RED
Balgowan Clinic	Yes	No	Yes	Yes	Yes	Yes	Yes	1	ORANGE
Caluza Clinic	Yes	Yes	Yes	Yes	Yes	No	Yes	1	ORANGE
Cinci Clinic	No	No	Yes	Yes	Yes	Yes	Yes	2	ORANGE
Cramond Clinic	No	No	Yes	Yes	No	No	No	5	RED

Dondotha Clinic	No	No	Yes	Yes	Yes	Yes	Yes	2	ORANGE
Empangeni Clinic	Yes	No	Yes	Yes	Yes	Yes	Yes	1	ORANGE
Howick Clinic	Yes	No	Yes	Yes	No	Yes	Yes	2	ORANGE
Inanda Clinic	No	No	Yes	Yes	No	No	No	5	RED
K Clinic	Yes	Yes	Yes	Yes	No	No	No	3	RED
Kearsney Clinic	No	No	Yes	Yes	No	No	No	5	RED
Link Clinic	No	No	Yes	Yes	Yes	Yes	Yes	2	ORANGE
Mafakatini Clinic	No	No	Yes	Yes	Yes	No	Yes	3	RED
Mbalenhle CHC	Yes	Yes	Yes	Yes	Yes	?	?	0	?
Mbhekaphansi Clinic	Yes	No	Yes	Yes	Yes	Yes	Yes	1	ORANGE
Molokohlo Clinic	Yes	No	Yes	Yes	Yes	Yes	Yes	1	ORANGE
Mpophomeni Clinic	Yes	No	Yes	Yes	Yes	Yes	Yes	1	ORANGE
Mpumuza Clinic	?	?	Yes	Yes	?	No	No	2	?
Mvutshini Clinic	Yes	No	Yes	Yes	Yes	Yes	Yes	1	ORANGE
Ntumeni Clinic	Yes	Yes	Yes	Yes	Yes	No	No	2	ORANGE
Ocilwane Clinic	Yes	No	Yes	Yes	Yes	Yes	Yes	1	ORANGE
Phaphamani CHC	Yes	No	Yes	Yes	Yes	Yes	Yes	1	ORANGE
Sobantu Clinic	Yes	No	Yes	Yes	Yes	No	No	3	RED
Songonzima Clinic	Yes	No	Yes	Yes	No	No	Yes	3	RED
Talyors Halt Clinic	No	No	Yes	Yes	Yes	No	Yes	3	RED
Thokozani Clinic	Yes	No	Yes	Yes	Yes	Yes	Yes	1	ORANGE
Willowfontein Clinic	No	No	Yes	Yes	No	No	No	5	RED

In addition to the primary healthcare facility survey, TAC KwaZulu-Natal carried out a snap survey into the state of TB services and infection control at 11 hospitals in the province. While we recognise that many other indicators could have been tracked, these specific questions do reflect on the general state of TB services being provided at the hospitals monitored.

The following questions were asked:

1. Is there a TB ward at the hospital?
2. Does the TB ward have proper ventilation?
3. Are there enough beds at the hospital in the TB ward?
4. Where are the TB patients kept if there is no TB ward?
5. Are people with DS-TB separated from those with DR-TB?
6. Are TB medicines available at the hospital (i.e. no stockouts or shortages)?
7. Are TB ward staff protected from contracting TB?
8. Are masks offered to relatives visiting people with TB?
9. Do all TB patients complete treatment (i.e. no loss to follow up)?

Name of Hospital	Is there a TB ward at the hospital?	Does the TB ward have proper ventilation?	Are there enough beds at the hospital in the TB ward?	Where are the TB patients kept if there is no TB ward?	Are people with DS-TB separated from those with DR-TB?	Are TB and DR-TB medicines available at the hospital? (i.e. no stockouts)	If no, which?	Are TB ward staff protected from contracting TB?	Are masks offered to relatives visiting people with TB?	Do all TB patients complete treatment? (i.e. no loss to follow up)	SCORE
Edendale Hospital	No	n/a	n/a	Transferred to Doris Goodwin Hospital (TB Hospital) or Edendale Hospital (no TB ward).	No	Yes	n/a	Yes	Yes	Yes	2
Northdale Hospital	No	n/a	n/a	Transferred	No	Yes	n/a	Yes	Yes	Yes	2
Greys Hospital	No	n/a	n/a	In TB hospitals in the District	Yes	Yes	n/a	Yes	No	Yes	2
Doris Goodwin Hospital	Yes	Yes	No	n/a	Yes	Yes	n/a	Yes	Yes	Yes	1
Mbongolwane Hospital	Yes	Yes	No	n/a	?	Yes	n/a	Yes	Yes	Yes	1
Eshowe Hospital	Yes	Yes	?		Yes	Yes	n/a	Yes	Yes	Yes	0
Prince Mshiyeni Hospital	No	n/a	n/a	Isolated from other patients, side ward	No	Yes	n/a	Yes	Yes	Yes	2
King Dinizulu Hospital	Yes	Yes	Yes	n/a	Yes	Yes	n/a	Yes	Yes	Yes	0
Richmond Hospital (TB Hospital)	Yes	Yes	Yes	n/a	Yes	Yes	n/a	Yes	Yes	Yes	0
Addington Hospital	No	n/a	n/a	Try to isolate TB patients	No	Yes	n/a	Yes	Yes	Yes	2
King Edward Hospital	Yes	Yes	Yes	n/a	Yes	No	BCG	Yes	Yes	?	1

While not exhaustive of TB related services, or hospitals in KwaZulu-Natal, this snap survey has shown that 8 hospitals failed in certain aspects of TB management. Particularly we draw attention to Edendale, Northdale, Greys, Prince Mshiyeni, and Addington. Many of which do not have a TB ward, and all of which fail in a number of indicators.

Based on this evidence and analysis we therefore demand the following:

Our demands:

a. We demand that by end July 2018 the provincial Department of Health carries out their own full audit of all public health facilities in the province to assess whether sufficient TB infection control measures are in place. The audit will involve the health department assessing the state of TB infection control at each facility based upon WHO guidelines. After which the Department must develop a plan based upon the infrastructural, human resource or behavioural challenges found in order to improve TB infection control. The Department must publish the audit results.

b. We demand that masks and TB posters are distributed to all public health facilities by end June 2018. Spot-checks should be undertaken to ensure these are utilised effectively.

c. We demand that by end June 2018 a circular is sent to all facilities to ensure that:
   - All windows to be kept open;
   - TB infection control posters to be displayed in visible places in the waiting area;
   - Patients to be screened for TB symptoms upon arrival;
   - People coughing or with TB symptoms to be seen first to reduce the risk of transmission;
   - People who are coughing to be separated from those who are not while waiting; and

- People who cough a lot or who may have TB to be given tissues or TB masks.

d. Where infrastructural issues mean that public facilities create a TB risk factor (e.g. to small, or poor ventilation), an urgent, fully-funded turnaround strategy must be developed to outline how these challenges will be rectified. The strategy must be released by end of July 2018.

e. We demand the release of the provinces Human Resources for Health (HRH) plan before end July 2018. This plan should include a comprehensive list of current vacancies. Adequate human resources are essential for addressing long waiting times, and in this instance, the prolonging of exposure to potential TB infection. All facilities that have highlighted a waiting time of more than 30 minutes should be prioritised for additional human resources in this financial year. We expect the MEC and the Premier to make this a priority and to ensure the funds are made available.

6. Dire state of emergency medical services

The provincial emergency medical services (EMS) and planned patient transport (PPT) systems in KwaZulu-Natal are characterised by long waiting times, a lack of reliability, and indignity—all experienced in the most vulnerable and frightening moments of life for people who depend on these services.

The current failure of the EMS system impacts disproportionally on the most vulnerable and especially on those in poor and rural settings. The unavailability of ambulances either in emergencies or for planned patient transport means that many people are forced to make substantial out-of-pocket payments to access health services at facilities. For those who are unable to pay for these services, they have no option than to wait for an ambulance which often take hours to arrive, or does not arrive at all.

In terms of absolute numbers, there is a major shortage of ambulances in service in the province. According to the Department of Health's standards there should be 1 ambulance to 10,000 people. In a population of more than 11 million that amounts to the minimum of 1 138 ambulances as outlined below.

District	Population (2018 estimates Stats SA)	# of ambulances required at 1:10 000
Amajuba District Municipality	575 265	58
eThekwini Metropolitan Municipality	3 760 409	376
Harry Gwala District Municipality	513 362	51
iLembe District Municipality	702 222	70
King Cetshwayo District Municipality	995 462	100
Ugu District Municipality	780 676	78
uMgungundlovu District Municipality	1 153 896	115
uMkhanyakude District Municipality	693 899	69
uMzinyathi District Municipality	571 650	57
uThukela District Municipality	755 749	76
Zululand District Municipality	877 285	88
KwaZulu-Natal	**11 379 875**	**1 138**

Our demands:

a. We demand at least 1 138 functional ambulances be in service in the province in order to meet the national norm of 1 ambulance to 10 000 – this should be seen as a minimum.
b. We demand the provincial Department of Health reviews its Planned Patient Transport programme to ensure that patients have access to transport to and from health facilities to prevent unnecessary

out-of-pocket payments. This will also help to strengthen service at the district level and ensure the referral system between facilities is accessible to patients thereby effectively operationalising the primary healthcare approach.

c. We demand the provincial Department of Health takes the necessary steps to address the shortage in emergency medical personnel by filling all vacant posts.
d. We demand that all EMS personnel must be sufficiently trained to ensure they have good medical skills, provide quality medical care while patients are in transit, are compassionate to patients and have good attitudes, and understand emergency medical terminology.

7. Poorly functioning accountability structures

In South Africa, governance structures in the form of clinic committees and hospital boards are intended to ensure community participation at a local and district level. They are provided for in South African law and are key to ensuring accountability and a successful AIDS and TB response. They are the forums through which public healthcare users are meant to engage and take ownership over the health system, raise concerns and ensure accountability at local, district, and provincial levels. They should input and feedback into the planning, delivery and organisation of health services and play an oversight role in the development and implementation of health policies and provision of equitable health services. The committees are made up of a combination of community and civil society representatives and health professionals of each area. They allow community concerns to be elevated through the structures from local to district to provincial and finally to national level.

Section 42 of the National Health Act 61 of 2003 requires provinces to provide for clinic committees and hospital boards and ensure their functioning. However, to our knowledge KwaZulu-Natal has not implemented this legislation - and it cannot be claimed that clinic committees or hospital boards function effectively across the province. Too many lack a clear understanding of their role and responsibility and no financial resources are allocated to improve this situation. In certain cases, reports show that community members' complaints brought before the committees are ignored. TAC is attempting to capacitate certain clinic committees aiming to improve functionality to the benefit of public healthcare users, however TAC does not work in all clinics across the province. Of the 28 clinics surveyed in March 2018, 3 had no clinic committee, however of those with a clinic committee, very few can be said to be functioning.

Many AIDS councils at ward and local levels are dysfunctional. These structures should be driving the implementation of the NSP as well as monitoring progress, but most often this is not happening. They should be chaired by Ward Councillors, but many are not. They should meet at least once a quarter – but many do not. AIDS Council meetings should be used to ensure we get an effective response to HIV, TB and STIs. In order to be functional, discussions and reflections in these structures should focus on the state of the epidemic in the area, which interventions are working and which are not, and where interventions must be strengthened or modified to improve the response.

<u>Our demands:</u>

a. We demand an audit report of the functionality of clinic committees and hospital boards by end July 2018.
b. We demand that all clinic committees and hospital boards are capacitated on their roles and responsibilities by end August 2018, and that an annual review takes place of the functionality of each structure by the KwaZulu-Natal Department of Health
c. We demand the convening of a commission to investigate the functionality of Ward AIDS Councils. This commission should consist of members of civil society, the Provincial AIDS Council Secretariat, representatives of the Office of the Premier, representatives of the Office MEC of Health. Operation Sukuma Sakhe vehicles should be used for this investigation. No individual should receive any payment for taking part in the commission's investigation.
d. All individuals sitting in AIDS Councils at all levels must represent a specific organisation or constituency.

Conclusion

The KwaZulu-Natal health system is broken. Poor people who depend on free public health services are being failed – often receiving inadequate, poor quality and undignified healthcare. As we speak to community members we hear a litany of stories of medical negligence that impact upon people's lives forever. The provincial government is obligated by the Constitution of South Africa to provide decent and quality healthcare services to the people of KwaZulu-Natal. Instead we see severe dysfunction, that hits poor and rural communities hardest, costing people their dignity and at times their lives.

TAC will continue to monitor the state of healthcare delivery in KwaZulu-Natal and to seek solutions through all the means at our disposal. We request a written acknowledgement of the concerns and demands outlined in this report by 15 June 2018. After which, the timeframes outlined in the individual demands must be adhered to.

For more information contact:

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(National enquires) Campaign Manager | Lotti Rutter | lotti.rutter@tac.org.za | 072 225 9675

For ease of reference we again list all our demands below:

1a. We demand the release of the provinces Human Resources for Health (HRH) plan before end July 2018. This plan should include a comprehensive list of current vacancies.

1b. We demand that all vacant posts be filled in the next financial year and that the employment of nurses and doctors is prioritised in the 2018/19 financial year.

1c. We demand the provincial health department fills the gap in community healthcare workers by adding 9 282 in or before the 2019/20 FY to ensure that there are 1:600 CHWs in the provincial health system.

1d. By end July 2018 we demand a plan to ensure there is sufficient full-time oncology capacity within the public health sector and those people have the right quality equipment to treat and care for all cancer patients.

1e. The provincial Department of Health must carry out investigations into all allegations made with regard to health personnel failures – including neglect and bad attitudes – and that following this investigation disciplinary action be taken where appropriate and compensation be paid out to victims of neglect or ill-treatment.

1f. 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. Better staff support systems should be put in place by the provincial Department of Health in order to ensure staff wellness and support.

2a. Where mobile clinics are used, they should provide a complete package of primary healthcare services including diagnosis, treatment and care for HIV, TB, mental health, diabetes etc.

2b. Where mobile clinics are used they should attend to the community on a frequent basis so that people are able to access health services when they need them.

2c. By end August 2018 we demand a clear strategy on how mobile clinics and Ward Based Outreach Teams (CHWs) will work together to ensure that people in areas without clinics can receive the healthcare services they need and deserve.

3a. We demand an urgent, fully-funded, plan to address infrastructural issues at the facilities identified above. We demand to see this plan before the end of July 2018. We expect the MEC and the Premier to make this a priority and to ensure the funds are made available.

3b. The provincial Department must ensure that there is adequate funding and personnel to ensure that health facilities are maintained, fitted with the appropriate technology (medical equipment, ICT equipment, access to internet etc.) in order to address the compromised ability of facilities to provide both an adequate environment to staff and to healthcare users.

3c. The provincial Department in conjunction with the Department of Public Works must strengthen the Infrastructure Unit (engineers, maintenance crew, quantity surveyors, quality control) to address backlog maintenance, routine maintenance and the building of new health facilities and to prevent any unnecessary under expenditure of the Health Infrastructure Grant.

3d. The provincial Department must ensure that they are enough chemotherapy, radiotherapy, and other oncology equipment across hospitals in order to treat all people with cancer in the province.

4a. By end December 2018, 100% of primary health facilities across the province must have differentiated models of care including functional adherence clubs, support groups, and fast track (CCMDD) models of care for people living with HIV linked to all primary health facilities across the province to improve treatment adherence rates in the province.

4b. By July 2018, the KwaZulu-Natal Department of Health must launch an aggressive, and fully funded, TB contact tracing and active-case-finding campaign. This campaign must be linked the provincial government CHW programme. A specific programme needs to be implemented to 'find the missing cases,' with specific monitoring of progress and tracking of investments in staff, logistics and supplies clearly documented each month.

4c. By July 2018, the KwaZulu-Natal Department of Health must begin a provincial TB awareness, education, and social mobilisation campaign to educate people about HIV and TB and encourage the uptake of HIV and TB services. This must include treatment and prevention literacy information in order to improve TB infection control, reduce risky sexual behaviour, encourage screening and testing for HIV and TB, and encourage treatment initiation. This education, awareness, and social mobilisation campaign must take place both inside public health facilities and outside.

4d. In 2018, and in every year after that, the KwaZulu-Natal Department of Health must ensure that every person receiving antiretroviral therapy in the public sector receives at least one viral load test per year. Clinics must be held accountable for offering enhanced adherence support and following clinical algorithms to switch patients in a timely manner for those with detectable viral loads.

4e. By end 2018, the KwaZulu-Natal Department of Health must ensure that all clinics in the province are offering rapid ART initiation and rapid provision of TB treatment to all clinically eligible patients, with treatment start times reduced to under 7 days. In the case of DR-TB, this requires decentralisation of DR-TB care to all primary healthcare facilities in all high-burden districts.

4f. By end 2019, the KwaZulu-Natal Department of Health must ensure that all people living with HIV have been screened for TB, and if eligible (they do not have TB and are not on TB treatment) are offered the option of taking TB preventative therapy (isoniazid) in order to reduce the risk of contracting TB.

5a. We demand that by end July 2018 the provincial Department of Health carries out their own full audit of all public health facilities in the province to assess whether sufficient TB infection control measures are in place. The audit will involve the health department assessing the state of TB infection control at each facility based upon WHO guidelines. After which the Department must develop a plan based upon the infrastructural, human resource or behavioural challenges found in order to improve TB infection control. The Department must publish the audit results.

5b. We demand that masks and TB posters are distributed to all public health facilities by end June 2018. Spot-checks should be undertaken to ensure these are utilised effectively.

5c. We demand that by end June 2018 a circular is sent to all facilities to ensure that:

- All windows to be kept open;
- TB infection control posters to be displayed in visible places in the waiting area;
- Patients to be screened for TB symptoms upon arrival;
- People coughing or with TB symptoms to be seen first to reduce the risk of transmission;
- People who are coughing to be separated from those who are not while waiting; and
- People who cough a lot or who may have TB to be given tissues or TB masks.

5d. Where infrastructural issues mean that public facilities create a TB risk factor (e.g. to small, or poor ventilation), an urgent, fully-funded turnaround strategy must be developed to outline how these challenges will be rectified. The strategy must be released by end of July 2018.

5e. We demand the release of the provinces Human Resources for Health (HRH) plan before end July 2018. This plan should include a comprehensive list of current vacancies. Adequate human resources are essential for addressing long waiting times, and in this instance, the prolonging of exposure to potential TB infection. All facilities that have highlighted a waiting time of more than 30 minutes should be prioritised for additional human resources in this financial year. We expect the MEC and the Premier to make this a priority and to ensure the funds are made available.

6a. We demand at least 1 138 functional ambulances be in service in the province in order to meet the national norm of 1 ambulance to 10 000 – this should be seen as a minimum.

6b. We demand the provincial Department of Health reviews its Planned Patient Transport programme to ensure that patients have access to transport to and from health facilities to prevent unnecessary out-of-pocket payments. This will also help to strengthen service at the district level and ensure the referral system between facilities is accessible to patients thereby effectively operationalising the primary healthcare approach.

6c. We demand the provincial Department of Health takes the necessary steps to address the shortage in emergency medical personnel by filling all vacant posts.

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7a. We demand an audit report of the functionality of clinic committees and hospital boards by end July 2018.

7b. We demand that all clinic committees and hospital boards are capacitated on their roles and responsibilities by end August 2018, and that an annual review takes place of the functionality of each structure by the KwaZulu-Natal Department of Health

7c. We demand the convening of a commission to investigate the functionality of Ward AIDS Councils. This commission should consist of members of civil society, the Provincial AIDS Council Secretariat, representatives of the Office of the Premier, representatives of the Office MEC of Health. Operation Sukuma Sakhe vehicles should be used for this investigation. No individual should receive any payment for taking part in the commission's investigation.

7d. All individuals sitting in AIDS Councils at all levels must represent a specific organisation or constituency.