State of Provincial Healthcare System
Spotlight on Mpumalanga
May 2018

Background

Mpumalanga's ailing healthcare system is plagued with serious issues. You wait hours to see a doctor, even in emergencies. Overstretched nurses take out their frustrations on the patients waiting for services. Facilities have not been properly maintained, and face shortages of supplies or medicines even for basic procedures. Ambulances take hours to arrive, or never arrive at all. Poverty and a lack of opportunity are widespread in the province. Almost a quarter of households survive without any income at all. Mining is growing in the province, giving rise to increasing rates of tuberculosis. In Mpumalanga, many vulnerable people rely on free public healthcare, but the reality is that the health system is failing them.

The Treatment Action Campaign (TAC) has been working in Mpumalanga 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 24 branches in all districts in the province – Ehlanzeni, Gert Sibande and Nkangala. 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.

In 2011, the Gert Sibande District in Mpumalanga was put forward as an NHI pilot district. It was envisaged that the NHI piloting would revive the broken healthcare system in the district that was marred by medicine stockouts, inadequate infrastructure and a shortage of human resources. We hoped that the primary healthcare system would undergo a complete overhaul.

In 2013, TAC and SECTION27 started monitoring the implementation of the NHI programme in the district, by visiting various healthcare facilities across the district and speaking to healthcare practitioners and patients to get a sense of what the new NHI policy meant for ordinary citizens on the ground. It was clear that the piloting process had shown very limited success, although there have been some improvements in infrastructure at so called "ideal clinics" – however until now, the infrastructural, human resources and governance weaknesses in the district are far from resolved. It is clear that much more needs to be done to ensure that people can access to quality healthcare.

In Mpumalanga, each TAC branch 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 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 Mpumalanga of 57 clinics inspected by the OHSC (not

[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

necessarily the same facilities as monitored by TAC) only 14% of the clinics are performing at 60% or above, only 2% above 70% and none above 80%:

# facilities	Rate
0	clinic performed below 20%.
3	clinics performed between 20-29%.
8	clinics performed between 30-39%.
26	clinics performed between 40-49%.
12	clinics performed between 50-59% score.
7	clinic performed between 60-69%.
1	clinics performed between 70-79%
0	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.

Overall, the severe challenges outlined in this report result in people dependent on the public healthcare system receiving inadequate and poor-quality healthcare services. These challenges also directly impact the success of the HIV and TB response in the province.

It is also evident that less and less people – whether health workers or patients – are willing to speak out and take a stand as they fear for their safety, the security of their jobs, or their access to health services.

TAC Mpumalanga demands provincial leadership and accountability in order to develop a turnaround strategy to address the crisis in the province's broken public health system. This report outlines a set of detailed concerns and demands. We request a written response on these issues by 25 May 2018. We urge the MEC of Health Gillion Mashego, Premier Refilwe Mtshweni and provincial Department of Health to deliver on your Constitutional mandate and to urgently address these issues with the seriousness they deserve.

Key concerns and demands

1. **Critical human resource shortages including doctors, nurses, specialists and community healthcare workers.**

The shortage of human resources is a major issue in Mpumalanga. 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, and security guards, porters and cleaners.

However, instead of filling vacant posts and ensuring that there are enough people to properly deliver our healthcare, posts are being frozen in many areas. While many doctors and nurses remain unemployed, there are not enough open positions to employ them. The problem is only exacerbated for rural communities who struggle to attract specialists and senior doctors. According to the National Department of Health, there are currently over 23,156 funded posts in Mpumalanga. Of these only 20,359 are filled leaving almost 2,797 vacant posts in the province. This translates into more than 12% of the workforce. In our engagement with the District Health Directors in both Gert Sibande and Nkangala, as well as with Hospital CEOs at Ermelo Hospital, Rob Ferreira Hospital and Sabie Hospital – a shortage of specialists including radiologists, general practitioners, and ultrasonographers (who are often outsourced) was confirmed.

a. Primary health

At a primary health facility level, the shortage of staff is at times exacerbated by poor management. At times nurses are sent to attend external workshops (including those for technical assistance programmes via FDP and other PEPFAR sourced programmes) for days or weeks at a time. This causes there to be too few staff remaining at the facility who are unable to deal with the unmanageable workload.

Staffing: In one of the most notable findings, over half of primary health facilities monitored by TAC Mpumalanga in March 2018 were considered to have insufficient staff. 57.1% (20/35) of facilities were classified as not having enough staff and 40.0% (14/35) facilities as having enough. 1 facility was excluded from this analysis due to a lack of data. At the very least, this finding shows that a substantial number of people dependent on the public healthcare system perceive facilities as being understaffed.

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. The overburdening of staff is a major contributor to the worsening of staff attitudes. One of the major causes of medicine stockouts and shortages are a result of staff being too busy to place orders in time. The result of all of this is that patients do not access quality healthcare services as required by the Constitution. Our survey in March found the following with regard to staff attitudes and waiting times:

Staff attitudes: At 31.4% of facilities (11/35) staff were generally considered to be friendly, at 57.1% (20/35) staff were classified as sometimes friendly, and at 8.6% (3/35) 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.

Waiting times: Our survey found that at 25.7% (9/35) of facilities people had to wait for more than an hour to be seen and at 51.4% (18/35) of facilities the wait was more than two hours which is hugely disruptive for people. Though generally poor, waiting times were variable. At 22.9% (8/35) of facilities the waiting time was between 30 to 60 minutes, however 0% (0/35) of facilities saw people in less than 30 minutes. Due to these long waiting times, it is reported that sometimes patients are turned away without being seen at all. In particular at the following facilities it is reported that patients are turned away by 14h00, with varying reasons given by staff: Mtonjeni Clinic, Kameelpoortnek Clinic, Goerdereheerder Clinic, and Boekenhouthook Clinic.

There is also a challenge of long waiting lists and a long turnaround time for receiving test results. Pap smears results often take more than 6 weeks to be returned. At Amsterdam CHC results can take up to 9 weeks and are reportedly sometimes lost. Furthermore, nurses wait for a doctor to attend the clinic in order to interpret results which is only every 3 months. Lost files at Thusi Clinic, MN Cindi Clinic, Phola Park CHC, and KwaMhlanga Hospital also cause further delays in patients being able to access healthcare.

In a meeting between TAC and the Head of Department (Mpumalanga Department of Health) in early 2017 the issues of shortages of nurses at a primary health level were raised. However, the issue was denied. It was claimed that there was misplacement of staff leading to either too few or too many healthcare workers per facility. We have yet to see evidence of this being addressed to ensure sufficient numbers per clinic.

b. Hospitals

Long waiting times due to a shortage of staff to adequately deliver healthcare is also a prominent issue found at hospitals monitored in the province.

KwaMhlanga Hospital: there are insufficient human resources that prevent the fulfilment of the right of access to healthcare services. According to the State of the Province Address in 2016/17, there were more than 50% of vacancies in the hospital. According to the Hospital CEO in a meeting on 28 February 2018, of 969 positions in the organogram, only 369 are filled, leaving 600 positions vacant. This translates to more than 61% of the workforce. This is the major cause of long waiting times – at times reportedly more than 8 hours. In addition, there have been a number of complaints regarding medical negligence. Furthermore, sometimes staff are reported to not wear name tags, complicating the laying of complaints.

Themba Hospital: there is a major shortage of staff (including doctors and nurses) that severely impacts on long waiting times and worsens staff attitudes to patients using the facility. Health workers of all cadres recently shut down the hospital in a strike action demanding an increase in human resources and better working conditions at the hospital. TAC Mpumalanga supports these calls that will ensure more timely healthcare provision at the hospital and will reduce the burden on overstretched workers, thus improving the level of care and staff attitudes. However, we disagree with the way in which the strike was conducted by shutting down services that threatened people's health and lives by restricting services[2].

Elsie Ballot Hospital: relatives of admitted patients had been asked to come to the hospital in order to feed them. Hospital management blamed this need on a shortage of nurses to be able to care for patients themselves.

c. Community healthcare workers

It is not only doctors, nurses and specialists that are lacking – there is also a shortage of community healthcare workers 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. 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 7 413 in total in Free State. In 2016 there were only 3 348 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 Mpumalanga needing 55% 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
Ehlanzeni District Municipality	2 887	1 137	1 750	61%
Gert Sibande District Municipality	1 986	907	1 079	54%
Nkangala District Municipality	2 540	1 304	1 236	49%

[2] TAC, April 2018: "TAC calls for urgent intervention at Themba Hospital". Available at: https://tac.org.za/news/tac-calls-for-urgent-government-intervention-at-themba-hospital/

Mpumalanga	**7 413**	**3 348**	**4 065**	**55%**

Our demands:

a. We demand the release of the provinces Human Resources for Health (HRH) plan before end June 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. All staff must wear name tags at all times – and the complaints register must be visible and accessible to patients. The 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.
d. 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.
e. We demand the provincial health department fills the gap in community healthcare workers by adding 4 065 in or before the 2019/20 FY to ensure that there are 1:600 CHWs in the provincial health system.

2. Health facility infrastructure in disrepair, with inadequate and missing equipment

Healthcare facilities in Mpumalanga are often in disrepair, at times without running water or proper sanitation, too often with small waiting areas that do not fulfil the needs of the community and lead to overcrowding, and without fences or proper security. Furthermore, equipment is often broken or unavailable. Although there has been some improvement in certain facilities – where temporary park home structures have been erected (e.g. Fernie 2 Clinic, Matsulu CHC, Kanyamazane CHC, Diepdale Clinic, Town 2 Clinic, Khumbula Clinic) – the process is very slow and many affected areas are not prioritised. Many facilities do not have proper sanitation and utilise dirty pit latrine toilets with or without doors, and toilet paper is commonly missing. The results of our survey in March 2018 found that:

Waiting areas: 57.1% (20/35) of facilities had enough room in the waiting area and 42.9% (15/35) did not. Waiting areas in 100% (35/35) of facilities were classified as clean.

Infrastructure & toilets: 82.9% (29/35) of facilities were rated as being in good condition, 17.1% (6/35) of facilities were not. Of the 35 facilities, 28.6% (10/35) of facilities did not have clean functional toilets, and 71.4% (25/35) of facilities were rated as clean and with toilet paper.

KwaMhlanga Hospital: the infrastructure lacks adequate space required for people to wait, which exacerbates the issue of overcrowding. People line the corridors of the hospital waiting to be seen for many hours. On one fact finding mission, a number of wheelchair users were found squashed together with knees pressing into the back of each other's chairs. The maternity ward is majorly overcrowded with too few beds – after giving birth women are rotated out of the few maternity ward beds and made to sit on a hard chair for 6 hours for observation before being sent home. The Intensive Care Unit is not functioning at all and has no equipment. The overcrowding at the hospital will only exacerbate the issue of poor TB and drug resistant-TB infection control.

Themba Hospital: an ongoing water shortage at the hospital that is causing the toilets to be blocked and very dirty; forcing patients to bath in small amounts of cold water and having to request family members to bring additional water for them; and meaning infants are being born and sent home without being washed. Many windows, tiles and chairs are broken in the OPD, waiting area and other areas. Some laundry machines are broken leading to the costly outsourcing of laundry services and in some cases patients wearing dirty gowns and sleeping in unclean beds for several days. Doctors are unable to operate because they cannot sterilise equipment. The food supply is inadequate, patients have been fed tinned fish and beans only for almost a

month. The facility heating system is faulty, forcing amongst other things patients to bath with cold water. The refrigerators in the mortuary are not functioning, despite media reports that this issue has been rectified.

Patients consistently tell us that the quality of food is poor at hospitals in the province. Healthcare workers report that equipment is often sub-standard and does not get repaired. This brings into question how tenders to provide food and other services were granted, as those who currently have them are incapable of providing a sufficient service.

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 June 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 provincial Department of Public Works 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 of Health must ensure that there is adequate funding to ensure that KwaMhlanga Hospital and Themba Hospital are maintained properly and fitted with the appropriate equipment in order to ensure that they are able to ensure all services and procedures can take place, and to provide both an adequate environment to staff and to healthcare users. The maternity ward at KwaMhlanga Hospital must be enlarged with adequate number of beds to ensure that women have access to quality maternal health services during the time they give birth.

3. Dire state of emergency medical services

The provincial emergency medical services (EMS) and planned patient transport (PPT) systems in Mpumalanga 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 and privatisation of the EMS system impacts disproportionally on the most vulnerable and especially on those in poor and rural settings. The unavailability or delay 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 particular we note the following broad challenges across the province:

Slow servicing out of order vehicles: Often the ambulances that do exist are in bad condition or are not functioning. Yet, delays in approval mean that they remain out of service for longer than necessary, further putting a burden on the few in operation. For example, currently 7 ambulances service the Thembisile Hani municipality that needs 31 – of the 7, 4 are functional and 3 are out of service (1 is broken, 1 has a gearbox problem, 1 has an engine issue) – all those that are not functioning are waiting for the provincial Head of Department of Health to approve fixing.

System challenges: In Mpumalanga, the EMS system is centralised per district such that calls made to a district call operator need to then be transferred to the correct municipality. Often people face long calls including being put on hold – all at the expense of their own airtime which negatively impacts the poorest. Sometimes people are asked to rather wait at the clinic for the ambulance. This system only worsens the length of waiting times for ambulances which can be six hours or more.

Infrastructure and safety: Poor quality road infrastructure, lack of street names, and safety concerns all detrimentally impact the ability of ambulances to collect people in need of urgent medical attention. This particularly affects poor people living in rural areas. People are often asked to wait at the nearest main road to

find the ambulance or even to take the person to the clinic to be collected instead – which is often not feasible and dangerous for critical patients.

Transporting multiple patients: At times, it is reported that ambulances transport more than one patient with various conditions from primary health facilities to the hospital in one vehicle. This can deprive patients of their dignity and privacy, as well as cause infection control issues.

User fees: Notably in the Mkhondo municipality, as well as others, patients must pay R25 in order to access ambulance services. This again detrimentally affects the poorest who cannot afford such payments (remembering that around 23% of households in the province survive with no source of income at all).

EMS staff issues: Alleged improper and rough driving by certain EMS drivers is reportedly leading to an increased need for servicing of vehicles more regularly which leads to vehicles being off the road. In addition, there are allegations of EMS drivers utilising ambulances for private reasons.

In terms of absolute numbers, according to the Department of Health's standards there should be 1 ambulance to 10,000 people. In a population of nearly 4.5 million that amounts to the minimum of 445 ambulances as outlined below. Note this ratio does not factor in different geographical requirements that should be taken into consideration. At a meeting on May 6th 2017, the MEC estimated that 400 additional ambulances were needed in the province, yet only 40 had been received.

District	Population (2018 estimates Stats SA)	# of ambulances required at 1:10 000
Ehlanzeni District Municipality	1 732 249	173
Gert Sibande District Municipality	1 191 707	119
Nkangala District Municipality	1 523 787	152
Mpumalanga	**4 447 743**	**445**

In addition, it has been reported by Spotlight that the Mpumalanga Department of Health has defied guidance from its provincial treasury and acted in contravention of the Public Finance Management Act (PFMA) in awarding a three-year contract to Buthelezi HEMS, a joint venture between a controversial private ambulance company called Buthelezi EMS[3] and HALO Aviation[4]. Buthelezi EMS has been widely reported as being an inefficient, costly and dysfunctional service, that provides limited medical support and expertise during transport, leaving the desperately sick and injured, including babies, unassisted and putting people's lives at risk.

Up until June 2016 aeromedical services in Mpumalanga were provided by the South African Red Cross Air Mercy Service (AMS), a non-profit. In June 2016, this tender was cancelled by treasury due to a technicality. Rather than continuing with AMS, Mpumalanga opted to switch to Buthelezi HEMS within days of the cancelling. This is despite the fact that Buthelezi HEMS did not have an aeromedical presence in the province that caused a gap in service. The switch to Buthelezi HEMS took place through an irregular process without any companies bidding for a tender, instead the department piggy backed on the Free State tender, something that is not allowed under the PFMA.

[3] *Spotlight* has previously reported on complaints about the quality of service provided by Buthelezi EMS's ground ambulances. Presently, contracts between Buthelezi EMS and the North West Department of Health is being investigated by the Hawks and as part of a "forensic investigation" launched by North West Premier Supra Mahumapelo.

[4] Spotlight, April 2018: "Mpumalanga Department of Health broke rules hiring controversial ambulance company". Available at: https://www.spotlightnsp.co.za/2018/04/20/mpumalanga-department-health-broke-rules-controversial-ambulance-company/

It has also since emerged that despite the appeal court judgment in November 2017 and an instruction from National Treasury in December 2017, both ordering that the original tender should be reinstated – meaning AMS should be reinstated as the provider – the Mpumalanga Department of Health has not yet done so.

Our demands:

a. We demand at least 445 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. These must be an insourced, and run through a state programme.
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, understand emergency medical terminology, understand the locations of the province to ensure ambulances can find patients easily – especially those in rural settings.
e. We demand that ambulances are not over filled in order to ensure timely delivery of patients to health facilities in a dignified manner.
f. We demand that all vehicles that are out of service, are urgently fixed and put back into service by end May 2018.
g. We demand that the provincial Treasury investigates the contract with Buthelezi HEMS and into the fact that a three-year contract was awarded against the advice of treasury.
h. We demand that the province complies with the judgment of the Supreme Court of Appeal on 10 November 2017 ordering the reinstatement of the previous service provider.

4. Stockouts and shortages of medicines & medical supplies

Stockouts and shortages of essential medicines place the health of TAC members and people in our communities at risk. TAC is committed to continuing to monitor stockouts and advocating for systemic solutions to stockouts. While stockouts and shortages of ARVs have mostly been addressed because of the interventions of TAC and the Stop Stockouts Project, medicines for many other conditions continue to be regularly out of stock or in short supply. While we recognise the improvement in the provision of medicines through the CCMDD programme, there are still cases where people are forced to buy medicines using their own money or to go without. Often people wait at the facility for several hours only to be told there are no medicines available – thereby discouraging them from attending the clinic in the future.

The local facility survey showed that in November (on the day of being surveyed), 21% of facilities (8 out of 38) were facing a stockout or shortage of medicine and patients were sent home empty handed. In March 2018, 9% of facilities (3 out of 35) were facing a stockout or shortage of medicines.

Stockouts and shortages of medicines and medical supplies in Mpumalanga can be attributed to poor management including: not ordering on time, lack of stock checking, a lack of internet to ensure the procurement system is effective, and shortages of staff including a lack of pharmacists or pharmacy assistants.

Some facilities do not have suitable infrastructure to store medicines leading to a lack of supplies. This currently includes facilities in the following municipalities: Goven Mbeki, Thembisilie Hani, Msukwakaligwa, Chief Albert Luthuli, and Dr JS Moroka. In September 2016, more than ZAR 5 million worth of medicines such as antiretrovirals and antibiotics, and medication for diabetes, high blood pressure and tuberculosis were destroyed by the provincial health department following their expiration[5]. Reasons cited by the department included poor infrastructure and shortages of storage space.

[5] Sowetan, September 2016. Available at: http://www.sowetanlive.co.za/news/2016/09/20/medicine-worth-r5m-dumped

There are continuing reports of shortages of supplies for people with disabilities such as crutches, wheelchairs, special shoes, and prosthesis. Often people who are unable to buy their own equipment and supplies are forced to wait for seven or more years to get this necessary equipment through the public health system.

Mobile Clinics in the province often do not have the required medication. Rural communities including but not limited to Donkirok, Goba, Vezunyawo, Emsinyane must spend as much as R60 per return trip to access a clinic. The majority of these communities are made up of poor and elderly people – choosing between a meal and a taxi is not an option. This results in patients defaulting on ARVs and/or TB and other medication. Ensuring closer and easier access to medicines would reduce the suffering of these communities.

In terms of equipment we note the following challenges at a hospital level:

- At KwaMhlanga Hospital, there is no functional ICU facility – the space allocated to the ICU sits empty with no beds or equipment.
- At Ermelo Hospital, the lifts are broken – given the ICU is on the second floor this renders it unusable.

Our demands:

a. We demand an urgent provincial strategy by no later than end June 2018 to address the continued and ongoing stockouts and shortages of medicines and other medical tools and supplies – this plan must address the impact of human resource shortages, poor management, and infrastructure where these impact on the ability of facilities to order and store supplies.
b. We demand closer pick up points for medication for communities serviced by mobile clinics. This should be available within walking distance for elderly patients.
c. Urgent interventions before end June 2018 to ensure that the ICU in KwaMhlanga Hospital is fully functional and the elevators and ICU in Ermelo Hospital are fully functional.

5. HIV and TB response falls short

Mpumalanga continues to face major HIV and TB epidemics – Gert Sibande and Nkangala face a high HIV burden, and Ehlanzeni faces a high dual burden of both HIV and TB[6]. According to the Thembisa model, in mid 2016, HIV prevalence across all ages in the province was at 14.8% (662 000 people). In 15 – 49 year olds this increased to 22.7%. There were 29 000 new HIV infections between mid 2015 to mid 2016. HIV related deaths mid 2015 to mid 2016 were at 9 900.

ART coverage in the province in mid 2016 was at 53.0%. Based on these figures nearly 311 140 people in Mpumalanga who could benefit from treatment, are not on it. Of those on treatment 68.2% were virally suppressed[7], as compared to around 85% in KwaZulu-Natal, North West and Western Cape. This is a cause for concern and indicates that there is 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 (where they work in the province). By these figures, the total ART coverage in 2017 was 56.73%. 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).

[6] 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

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

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
Ehlanzeni	1 732 249	1 754 930	307 654	17.5	144 279	186 606	29.3	196 806	60,65%	63,97%
Gert Sibande	1 191 707	1 135 410	196 950	17.3	77 411	104 641	35.2	100 505	53,13%	51,03%
Nkangala	1 523 787	1 445 624	160 437	11.1	63 294	86 041	35.9	99 107	53,63%	61,77%
Mpumalanga	**4 447 743**	**4 335 964**	**665 041**	**15,3**	**284 984**	**377 288**	**32.4**	**396 418**	**56,73%**	**59,61%**

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 rolled out across the province, it is not yet functioning effectively as it should. TAC receives reports that people referred into clubs have not received adequate counselling meaning they are reluctant to join as they believe they will no longer receive proper care. It is critical that adequate counselling takes place to ensure a smooth transition and ensure maximum impact of the clubs.

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.

In terms of TB, the National Strategic Plan for HIV, TB and STIs 2017–2022 aims to ensure that by 2020 treatment success is achieved for least 90% of all people diagnosed with TB. Currently in Mpumalanga, the death rate for people with drug resistant TB was at 27.1%, far above the national target of 12%. The provincial department must identify which TB patients are dying and investigate why. Targeted interventions to address these issues must then be developed and implemented. As outlined in the South African Tuberculosis Drug Resistance Survey, between 2012 – 2014 Mpumalanga faced the highest prevalence of multi-drug resistant TB at 5.1% (the national average being 2.8%)[8].

[8] NICD, "South African Tuberculosis Drug Resistance Survey". Available at: http://www.nicd.ac.za/assets/files/K-12750%20NICD%20National%20Survey%20Report_Dev_V11-LR.pdf

In terms of TB loss to follow up, 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 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[9].

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. Adequate counselling services must take place when referring people between different models.

b. By June 2018, the Mpumalanga 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 June 2018, the Mpumalanga 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 Mpumalanga 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 Mpumalanga 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 Mpumalanga 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.

g. By end July 2018, the Mpumalanga Department of Health must investigate why people in the province are dying while on TB treatment. A set of targeted interventions based on this evidence must be developed to address the above average death rate.

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

6. 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[10]. The rate of new cases of active TB in South Africa remains extremely high at around 438 000 in 2016[11]. 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[12].

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.

In the run-up to World Tuberculosis (TB) Day in March 2018, TAC Mpumalanga assessed the state of TB infection control in 35 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 35 facilities assessed in March 2018, 27 were found to be in a "RED" state with very poor infection control measures in place. 8 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. 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 Mpumalanga.

The good: Facilities surveyed performed well in terms of ensuring windows were kept open (only 1 out of 35 facilities did not open the windows).

The bad: There were mixed results in terms of the size and space of the waiting rooms (15 out of 35 facilities did not have enough room), and posters being visible on the walls telling people to cover their mouths when coughing or sneezing (9 out of 35 facilities did not have posters).

The ugly: Facilities surveyed performed extremely poorly in terms of screening for TB symptoms (26 out of 35 facilities did not screen), separating those who were coughing a lot from those who were not coughing (20 out of 35 facilities did not separate people), and in offering tissues or masks to people who cough a lot (27 out of 35 facilities did not offer tissues or masks). Of particular concern is the length of waiting times, 35 out of 35 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 Mpumalanga, 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

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[10] 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

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

[12] Ibid

indicative of the wider crisis within the Mpumalanga 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
Amsterdam CHC	Yes	No	Yes	Yes	No	?	No	3	RED
Engincourt Clinic	Yes	No	Yes	Yes	No	Yes	No	3	RED
Buffelspruit CHC	Yes	No	Yes	Yes	No	No	No	4	RED
Daggakraal CHC	Yes	No	Yes	Yes	No	Yes	No	3	RED
Derby Clinic	No	No	Yes	Yes	No	Yes	No	4	RED
Diepdal Clinic	Yes	No	Yes	Yes	Yes	Yes	No	2	ORANGE
Driefontein CHC	Yes	No	Yes	Yes	No	No	No	4	RED
Embalenhle Ext 4 Clinic	Yes	No	Yes	Yes	Yes	Yes	Yes	1	ORANGE
Ext 14 CHC	Yes	No	Yes	Yes	No	Yes	No	3	RED
Eziweni Clinic	No	No	Yes	No	No	No	No	6	RED
Fernie Clinic	Yes	No	Yes	Yes	No	No	No	4	RED
Goedereherde Clinic	No	No	Yes	No	No	No	No	6	RED
Iswepe CHC	Yes	No	Yes	Yes	No	No	No	4	RED
Kameelportnek Clinic	No	No	Yes	No	No	No	No	6	RED
Kameelriver B Clinic	No	No	Yes	No	No	No	No	6	RED
Kanyamazane Clinic	Yes	No	Yes	Yes	No	No	No	4	RED
Khumbula Clinic	No	No	Yes	Yes	Yes	Yes	No	3	RED
Kwagga A Clinic	Yes	No	Yes	No	No	No	No	5	RED
Kwagga CHC	Yes	No	Yes	No	No	No	No	5	RED
Matsulu CHC	No	No	Yes	Yes	No	No	No	5	RED
Mayflower CHC	Yes	No	Yes	Yes	No	No	Yes	3	RED
MN Mcindi Clinic	No	No	Yes	Yes	No	No	No	5	RED
Morgenzone Clinic	No	No	Yes	Yes	Yes	Yes	Yes	2	ORANGE
Mzinti Clinic	Yes	No	Yes	Yes	No	No	No	4	RED
Phola Park Clinic	Yes	No	Yes	Yes	No	Yes	No	3	RED
Sakhile Clinic	Yes	No	Yes	Yes	Yes	Yes	Yes	1	ORANGE
Sead Clinic	Yes	No	Yes	Yes	Yes	Yes	Yes	1	ORANGE
Shatale Clinic	No	No	Yes	Yes	No	No	No	5	RED
Esilobela Clinic	Yes	No	Yes	Yes	Yes	Yes	Yes	1	ORANGE
Siyabuswa CHC	Yes	No	Yes	Yes	No	No	No	4	RED

Thuthukani Mobile Clinic	No	No	No	No	No	No	No	7	RED
Tweefontein B2 Clinic	No	No	Yes	No	No	No	No	6	RED
Tweefontein C Clinic	No	No	Yes	No	No	No	No	6	RED
Vukuzakhe Clinic	No	No	Yes	Yes	Yes	Yes	Yes	2	ORANGE
Zamokuhle Clinic	No	No	Yes	Yes	Yes	Yes	Yes	2	ORANGE

In addition to the primary healthcare facility survey, TAC Mpumalanga carried out a snap survey into the state of TB services and infection control at 5 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, what medicines?	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
Bethal District Hospital	Yes	Yes	Yes	n/a	No	Yes	n/a	Yes	Yes	No	2
Ermelo TB Hospital	Yes	Yes	Yes	n/a	No	No	Bactrim	Yes	Yes	No	3
Mapulanen g District Hospital	Yes	Yes	Yes	n/a	No	Yes	n/a	Yes	Yes	No	2
Rob Ferrera District Hospital	No	n/a	n/a	Isolated from other patients, Ward 7	Yes	Yes	n/a	Yes	Yes	?	1
Themba District Hospital	Yes	No	Yes	n/a	Yes	Yes	n/a	Yes	Yes	?	1

While not exhaustive research into the state of TB related services, or hospitals in Mpumalanga, this snap survey highlights challenges related to certain aspects of TB management. Of the 5 hospitals, 3 were found to have seen patients lost to follow up, with 2 that were unknown. This is a very worrying picture. People lost to follow up who do not finish their treatment course can potentially develop resistance to TB treatment, further spread TB to those around them, and ultimately potentially die without being cured. In addition, 3 facilities do not separate those with normal (drug sensitive TB) and drug resistant TB.

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

Our demands:

a. We demand that by end June 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 April 2018. Spot-checks should be undertaken to ensure these are utilised effectively.

c. We demand that by end April 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 May 2018.

e. We demand the release of the provinces Human Resources for Health (HRH) plan before end May 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.

7. Ensuring access to healthcare for marginalised groups and key populations

Many people report difficulties in accessing healthcare due to discrimination, stigma, and inappropriate and hard to reach services including LGBTQIA+ people, young women, sex workers, mineworkers and people living with disabilities.

Bad and discriminatory staff attitudes towards LGBTQIA+ people, young women, and sex workers are very common. Staff are known to use religious beliefs as an excuse not to provide services, or they make patients feel discriminated against or uncomfortable due to how they are spoken to and treated. Further there is a lack of understanding regarding the unique needs of these various groups in terms of sexual and reproductive health services. This leads to people often not even attempting to access services again.

While comprehensive sexuality education is critically important, it is only half the battle. South Africa responded to its HIV epidemic with a rapid expansion of its condom distribution programme. However, condoms, especially female condoms, often remain out of reach to the most at risk group – young people and in particular, young women.

Additionally, services remain unfriendly to young people and difficult to access after school hours. After 3pm many young people requiring SRHR services and tools are turned away and told to return the following day. Some healthcare providers deny young people access to abortion services due to religious beliefs. While this situation has improved following TAC's intervention at several facilities, many others remain too difficult to access for learners.

Whether we like it or not, the fact is that many young people – including learners in schools – are sexually active. Every week in South Africa over 2 500 young people acquire HIV – that is over 350 every day. It is a moral imperative, and quite likely a Constitutional obligation, that we provide these young people with all the tools they need to protect themselves from getting HIV and to prevent unwanted pregnancies. For this reason, we need condoms to be made easily available in schools and in communities.

Another major issue is young girls missing school because of not being able to access sanitary wear during their periods. No girls should be disadvantaged to miss school because they can't afford to buy pads or tampons. The government should ensure all girls are able to access free sanitary pads at schools to protect their Constitutional right to access education.

In terms of mineworkers – there are a number of mines in Mpumalanga. Mineworkers are at high risk of contracting TB. South Africa already has one of the highest rates of TB in the world—yet the TB rate among miners is 10 times higher. There are 242 mines in the province. Only 85 are supported by provincial development partners according to the National Department of Health. As a result, those working in non-supported mines often face significant barriers to accessing healthcare leading to defaulting on ARVs or TB and other chronic medication.

Our demands:

a. We demand that all people who access healthcare services do so with dignity and respect – proper training and information must be given to healthcare providers and clinic committees around the needs of sex workers, the LGBTQIA+ community, young people and people with disabilities.
b. We demand that complaints regarding discrimination at facilities be addressed and where necessary disciplinary measures take place.
c. We demand access to comprehensive sexuality education in all schools across the province.
d. We demand easy access to male and female condoms in schools – these should be made available without request and in privacy.

8. Dysfunctional 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 Mpumalanga 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. Further there is political interference in the structures in the province and a prioritisation of funding to structures in ANC wards.

TAC is attempting to capacitate certain clinic committees aiming to improve functionality to the benefit of public healthcare users, however TAC has only adopted 33 clinics across Mpumalanga, and there are 288 primary health facilities in total. Even in those we have adopted and monitor, there is no clinic committee at all in four including: Kwagga A Clinic, Mayflower CHC, Tweefontein C Clinic, and Tweefontein B2 Clinic. Of the 29 others (minus one that is a mobile clinic), none can be said to be functioning properly.

In addition, there are two further issues that reduce accountability in our health facilities. Staff in certain healthcare facilities including KwaMhlanga Hospital, Ezweni Clinic, Kanyamazane Clinic, Matsulu Clinic, Buffelspruit Clinic reportedly either do not wear name tags or turn them around – rendering the laying of

complaints impossible. According to staff at some of these facilities the machine to make the name tags is broken; and there are no complaints register at certain health facilities or they are kept with the Operational Manager or Sister in Charge and out of easy access of patients – especially in the Goven Mbeki municipality and across Nkangala.

In addition, TAC Mpumalanga also has concerns over SANAC structures at a ward and district level. Often, these structures do not properly understand their function, and they do not have any financing to be able to do what they are meant to achieve. These AIDS councils are meant to give civil society a way to have a say in South Africa's HIV and TB response. However, in the Mpumalanga AIDS councils are sometimes dormant or dysfunctional. Further they are not all being chaired by Mayors for instance Ehlanzeni District AIDS Council, and several Local AIDS Councils. AIDS Councils must be functional and responsive to the realities we face in our communities in order to ensure an appropriate HIV and TB response that meets people's needs.

Our demands:

a. We demand an audit report of the functionality of all clinic committees and hospital boards by end June 2018.
b. We demand that by end March 2018 a circular is sent out to all healthcare facilities in the province ordering the establishment of clinic committees and hospital boards at all facilities (as required in law) and providing ongoing guidance to facilities on the correct and lawful operation of these critically important structures.
c. We demand that all clinic committees and hospital boards are capacitated on their roles and responsibilities by end June 2018, and that an annual review takes place of the functionality of each structure by the Mpumalanga Department of Health.
d. We demand that, where currently not, all AIDS councils are chaired by Mayors at the local and district level.

Conclusion

As TAC Mpumalanga, we understand that the underlying cause of much of this dysfunction is political. For years corruption, tenderprenuership, mismanagement in the province has chipped away at the fabric of our public service and the morale of public servants. Political deployment in Mpumalanga has often put uncommitted and unskilled people in positions of responsibility. We will not be able to turn around the fundamental decline of our public health system without a major political intervention. Such a political intervention will have to include a clear and unambiguous anti-corruption campaign that is driven by Premier Mtshweni and MEC Mashego who must commit to serving the public interest ahead of private or party interests.

TAC will continue to monitor it 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 25 May 2018. After which, the timeframes outlined in the individual demands must be adhered to.

For more information contact:

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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 June 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. All staff must wear name tags at all times – and the complaints register must be visible and accessible to patients. The 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.

1d. 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.

1e. We demand the provincial health department fills the gap in community healthcare workers by adding 4 065 in or before the 2019/20 FY to ensure that there are 1:600 CHWs in the provincial health system.

2a. 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 June 2018. We expect the MEC and the Premier to make this a priority and to ensure the funds are made available.

2b. 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.

2c. The provincial Department in conjunction with the provincial Department of Public Works 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.

2d. The provincial Department of Health must ensure that there is adequate funding to ensure that KwaMhlanga Hospital and Themba Hospital are maintained properly and fitted with the appropriate equipment in order to ensure that they are able to ensure all services and procedures can take place, and to provide both an adequate environment to staff and to healthcare users. The maternity ward at KwaMhlanga Hospital must be enlarged with adequate number of beds to ensure that women have access to quality maternal health services during the time they give birth.

3a. We demand at least 445 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. These must be an insourced, and run through a state programme.

3b. 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.

3c. We demand the provincial Department of Health takes the necessary steps to address the shortage in emergency medical personnel by filling all vacant posts.

3d. 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, understand emergency medical terminology, understand the locations of the province to ensure ambulances can find patients easily – especially those in rural settings.

3e. We demand that ambulances are not over filled in order to ensure timely delivery of patients to health facilities in a dignified manner.

3f. We demand that all vehicles that are out of service, are urgently fixed and put back into service by end May 2018.

3g. We demand that the provincial Treasury investigates the contract with Buthelezi HEMS and into the fact that a three-year contract was awarded against the advice of treasury.

3h. We demand that the province complies with the judgment of the Supreme Court of Appeal on 10 November 2017 ordering the reinstatement of the previous service provider.

4a. We demand an urgent provincial strategy by no later than end June 2018 to address the continued and ongoing stockouts and shortages of medicines and other medical tools and supplies – this plan must address the impact of human resource shortages, poor management, and infrastructure where these impact on the ability of facilities to order and store supplies.

4b. We demand closer pick up points for medication for communities serviced by mobile clinics. This should be available within walking distance for elderly patients.

4c. Urgent interventions before end June 2018 to ensure that the ICU in KwaMhlanga Hospital is fully functional and the elevators and ICU in Ermelo Hospital are fully functional.

5a. 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. Adequate counselling services must take place when referring people between different models.

5b. By June 2018, the Mpumalanga 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.

5c. By June 2018, the Mpumalanga 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.

5d. In 2018, and in every year after that, the Mpumalanga 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.

5e. By end 2018, the Mpumalanga 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.

5f. By end 2019, the Mpumalanga 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.

5g. By end July 2018, the Mpumalanga Department of Health must investigate why people in the province are dying while on TB treatment. A set of targeted interventions based on this evidence must be developed to address the above average death rate.

6a. We demand that by end June 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.

6b. We demand that masks and TB posters are distributed to all public health facilities by end April 2018. Spot-checks should be undertaken to ensure these are utilised effectively.

6c. We demand that by end April 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.

6d. 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 May 2018.

6e. We demand the release of the provinces Human Resources for Health (HRH) plan before end May 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.

7a. We demand that all people who access healthcare services do so with dignity and respect – proper training and information must be given to healthcare providers and clinic committees around the needs of sex workers, the LGBTQIA+ community, young people and people with disabilities.

7b. We demand that complaints regarding discrimination at facilities be addressed and where necessary disciplinary measures take place.

7c. We demand access to comprehensive sexuality education in all schools across the province.

7d. We demand easy access to male and female condoms in schools – these should be made available without request and in privacy.

8a. We demand an audit report of the functionality of all clinic committees and hospital boards by end June 2018.

8b. We demand that by end March 2018 a circular is sent out to all healthcare facilities in the province ordering the establishment of clinic committees and hospital boards at all facilities (as required in law) and providing ongoing guidance to facilities on the correct and lawful operation of these critically important structures.

8c. We demand that all clinic committees and hospital boards are capacitated on their roles and responsibilities by end June 2018, and that an annual review takes place of the functionality of each structure by the Mpumalanga Department of Health.

8d. We demand that, where currently not, all AIDS councils are chaired by Mayors at the local and district level.