State of Provincial Healthcare System
Spotlight on Western Cape
May 2018

Background

The Western Cape health system is failing the people who rely on it. People dread to attend overcrowded and under-resourced clinics. They wait for hours or days to be seen by a nurse or doctor. Sometimes without any privacy from others waiting. People without appointments are turned away. Pregnant women are shouted at to stop pushing while in labour, causing long term health complications or the death of their babies. State of the art hospitals look impressive on the outside, yet on the inside patients lie without dignity on the floor. Overstretched nurses get security guards to give out patient files. Ambulances are delayed, too afraid to respond without police presence, or they never arrive at all. This is the reality facing people who depend on free health services in the Western Cape.

20 years ago, the first TAC branch was born in Khayelitsha. We began campaigning to ensure access to HIV treatment for all. Today, TAC Western Cape continues to fight for the rights of the poor and marginalised. Now as well as people living with HIV and TB, we represent all people who use the public healthcare system. We campaign on critical issues related to the quality of and access to healthcare. There are now 36 branches across the province in Cape Town Metro, Eden, Overberg, and West Coast. 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 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 the Western Cape of 65 clinics inspected by the OHSC (not necessarily the same facilities as monitored by TAC) only 22% of the clinics are performing at 50% or above, only 4% of the clinics at 60% and above, and none above 70%:

# facilities	Rate
0	clinic performed below 20%.
7	clinics performed between 20-29%.
23	clinics performed between 30-39%.
21	clinics performed between 40-49%.
12	clinics performed between 50-59% score.
2	clinic performed between 60-69%.

[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

0	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.

TAC Western Cape 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 15 June 2018. We urge the MEC of Health Nomafrench Mbombo, Premier Helen Zille, and the 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 and community healthcare workers**

The shortage of human resources is an issue in the Western Cape. 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 33 468 funded posts in the Western Cape. Of these 32 040 were filled, leaving a shortfall of 1 428 vacant posts in the province. 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. 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. These shortages are only worsened as a result of staff who reportedly should be at facilities, at times not being there. The result of all of this is that patients do not access quality healthcare services as required by the Constitution.

1a. Primary healthcare

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

Staffing: Nearly three quarters of facilities were considered to have insufficient staff. 73.1% (19/26) of facilities were classified as not having enough staff and 23.1% (6/26) facilities as having enough. 1 facility was excluded from the 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.

Staff attitudes: While at most facilities, 84.6% (22/26), staff were generally considered to be friendly, at 15.4% (4/26) staff were only classified as sometimes friendly. Bad staff attitudes – witnessed in all cadres in the health workforce – affect patients' ability to access healthcare in these facilities. Individual testimonies and complaints speak to a number of cases of bad staff attitudes including from doctors, nurses and even security guards that lead to a worsening of health outcomes.

Waiting times: Our survey found that at 7.7% (2/26) of facilities people had to wait for more than an hour to be seen and at 80.8% (21/26) of facilities the wait was more than two hours which is hugely disruptive for people in the Western Cape. At only 7.7% (2/26) of facilities the waiting time was between 30 to 60 minutes. 3.8% (1/26) of facilities saw people in less than 30 minutes.

Further, we have major concerns over the appointment system in place at all primary healthcare facilities. The appointment system was designed for chronic patients in order to set dates to collect medicines, get blood tests, and to get health check-ups. However, the system is now making it difficult for emergency patients and those who feel ill but do not have a chronic condition, to access healthcare. Patients who are critical, or feel ill, must wait until after all the patients with an appointment have been seen, or get turned away without being seen at all. This is not a functional system and must be reviewed to ensure patients are not detrimentally affected. In addition, we receive numerous complaints about lost files at a number of facilities we monitor.

1b. Hospital level

TAC Western Cape also receives ongoing complaints about the state of services provided at Khayelitsha District Hospital. Complaints to TAC and fact finding shows that patients wait many hours or even days to be seen due to severe human resource shortages that contribute to extremely lengthy waiting times. Some people report waiting for as long as three days before being attended to. Patients sit in gowns with drips in the waiting area in order to see one of the few doctors. Further there have been a number of complaints regarding bad staff attitudes, of both nurses, doctors, and security guards.

1c. Community healthcare workers

In addition to a shortage of doctors and nurses, 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. 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 10 819 in total in Western Cape. In 2016 there were 3 534 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 Western Cape needing over 67% more CHWs in post in order to meet the target.

In addition to a shortage of CHWs, we also have concerns over the CHW programme being run by NGOs instead of directly by the provincial health department. There are reports that CHWs at times do not have the right equipment to carry out their work. In addition, there is a lack of monitoring, supervision, and accountability among the NGO funded CHW programme. To be effective CHWs must be linked and integrated

with specific primary health facilities. This will ensure better integration and re-entry into health services for patients. CHWs must be well trained and capacitated, with appropriate supervision and accountability structures, and have access to all relevant tools of trade, in order to ensure they are able to carry out their duties effectively. In addition they should have a standardised salary above the living wage.

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
Cape Town Metropolitan Municipality	6 878	2 010	4 868	70,78%
Cape Winelands District Municipality	1 520	424	1 096	72,11%
Central Karoo District Municipality	128	78	50	38,93%
Eden District Municipality	1 044	474	570	54,62%
Overberg District Municipality	487	255	232	47,62%
West Coast District Municipality	762	293	469	61,54%
Western Cape	**10 819**	**3 534**	**7 285**	**67,34%**

There is a further issue with regard to security personnel in certain facilities in the Western Cape. It has been reported that at Khayelitsha Site B Trauma Clinic, security guards at times are seen doing certain functions of nurses, for example giving out files and coding patients. In addition, there have been a number of security challenges reported at Site B Youth Clinic, Site B Male Clinic, and Kuyasa Clinic – where robberies took place towards the end of 2017. Medication, fridges, and testing equipment is amongst the reported stolen items. These facilities do not have adequate security to ensure the safety of the property.

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. 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.
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 7,285 in or before the 2019/20 FY to ensure that there are 1:600 CHWs in the provincial health system.
f. We demand additional and adequate numbers of security personnel to ensure the safety and security of health facilities and public healthcare users in the province.

2. Overcrowded facilities

Healthcare facilities in the Western Cape are often too small and therefore overcrowded. Due to structural issues, some facilities lack proper infection control and put patients at risk of contracting TB. We hear reports of consulting rooms at certain facilities that have no doors, meaning patients have no privacy when talking about their health problems. In some facilities patients are forced to use dirty toilets that are not stocked with toilet paper. The results of our survey in March 2018 found that:

Waiting areas: 73.1% (19/26) of facilities had enough room in the waiting area and 26.9% (7/26) did not. The 7 facilities that are overcrowded are: Crossroad Clinic, Ivan Toms Community Healthcare Centre, Kuyasa Clinic, Micheal Maphongwana Clinic, Matthew Goniwe Clinic, Mfuleni Clinic and St Helena Bay Clinic. Waiting areas in 92.3% (24/26) of facilities were classified as clean while waiting areas at 7.7% (2/26) of facilities were classified as not being clean.

Infrastructure & toilets: 76.9% (20/26) of facilities were rated as being in good condition, 19.2% (5/26) of facilities were not. 1 facility was excluded from the analysis due to a lack of data. Of the 26 facilities, 11.5% (3/26) of facilities did not have clean functional toilets, and 84.6% (22/26) of facilities were rated as clean and with toilet paper. 1 facility was excluded from the analysis due to a lack of data.

At Khayelitsha District Hospital there is a shortage of beds. During spot checks, patients who should be admitted and in beds, are often found in the main waiting areas with drips or sleeping on the floors.

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 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.

3. HIV and TB response falls short

Western Cape continues to face significant HIV and TB epidemics – West Coast faces a high TB burden, and the City of Cape Town faces a high dual burden of both HIV and TB[2]. According to the Thembisa model, in mid 2016, HIV prevalence across all ages in the province was at 6.3% (413,000 people). In 15 – 49 year olds this increased to 9.6%. There were 19 000 new HIV infections between mid 2015 to mid 2016. HIV related deaths mid 2015 to mid 2016 were at 4 800.

ART coverage in the province in mid 2016 was at 52.0%. Based on these figures nearly 198 240 people in Western Cape who could benefit from treatment, are not on it. Of those on treatment 84.8% were virally suppressed[3]. This 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 and PEPFAR (where they work in the province). By these figures, the total ART coverage in 2017 was 54.76%. 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).

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2 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

3 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
Cape Town	4 127 040	4 005 016	300 424	7.5	131 177	162 704	24.0	163 530	54,16%	54,43%
Cape Winelands	912 107	866 001	48 348	5.6	19 615	27 162	38.5	n/a	56,18%	n/a
Central Karoo	76 634	74 245	1 842	2.5	1 418	1 631	15.0	n/a	88,55%	n/a
Eden	626 685	611 282	38 886	6.4	14 805	20 127	35.9	n/a	51,76%	n/a
Overberg	292 077	286 785	12 569	4.4	7 233	10 397	43.7	n/a	82,72%	n/a
West Coast	457 068	436 400	19 683	4.5	6 521	8 910	36.6	n/a	45,27%	n/a
Western Cape	**6 491 611**	**6 279 729**	**421 752**	**6,7**	**180 769**	**230 931**	**27.7**	**163 530**	**54,76%**	**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.

There are also “Risk of Treatment Failure” Clubs at many facilities across the province. However, instead of providing support and guidance to those who have defaulted, or are at risk of defaulting, these clubs often act as a punishment, blaming people part of them and making them wait long hours to access the services. Instead of motivating adherence, this is pushing people away from accessing HIV services altogether. In contrast, TAC and Médecins Sans Frontières (MSF) have been running a Welcome Back Service Clinic to provide a comprehensive treatment, care and support – without judgement or punishment – to people who have defaulted addressing any issues and ensuring they restart treatment.

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.

Adherence Clubs were piloted by TAC and MSF in clinics and communities across Khayelitsha in 2007. 514 patients were enrolled in clubs while 2288 patients remained on the current system. The outcomes after 40 months showed that 97.14% of patients enrolled in clubs adhered to treatment, while a lower rate of 87.18% of those attending clinics adhered. Since then the programme was expanded to over 55 clubs across Khayelitsha. In 2013, the provincial health department took over management of the clubs. However, since this take over, people living with HIV using the clubs report common challenges, where club counsellors often

arrive late without appropriate equipment, lengthening the time taken at clubs, thus defeating the purpose of them.

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.

Access to prevention methods such as Pre-Exposure Prophylaxis (PrEP) and Post Exposure Prophylaxis (PEP) also falls short in the province. PrEP is not widely available in facilities, despite demand for it. PEP is only available to people who can prove they are rape survivors, which inherently causes huge difficulty in accessing it for those in need.

In terms of TB, the drug resistant TB death rate in the province was at 17.8%, above the national target of 12%. The provincial government needs to investigate why these deaths are happening, and put in place interventions to address this. In terms of 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 loss to follow up rate in Western Cape was at 10.5%, almost double the 5.4% target. The XPRES study concluded that active tracing and intensified case finding by healthcare workers should be scaled-up to address loss to follow 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[4].

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 Western Cape 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 Western Cape 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 Western Cape 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 Western Cape 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.

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

f. By end 2019, the Western Cape 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.

4. Red alert on TB infection control in the province

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[5]. The rate of new cases of active TB in South Africa remains extremely high at around 438 000 in 2016[6]. 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[7].

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 Western Cape assessed the state of TB infection control in 27 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 27 facilities assessed in March 2018, 19 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. Not one facility was found to be in a “GREEN” state with good TB infection control measures in place. This is extremely worrying for the province.

The good: Facilities surveyed performed well in ensuring windows were kept open (no facilities were reported to have closed windows, 1 facility was excluded due to a lack of data), and in offering tissues or masks to people who cough a lot (only 1 facility out of 27 did not offer tissues or masks).

The bad: There were mixed results in terms of the size and space of the waiting rooms (7 out of 27 facilities did not have enough room), and posters being visible on the walls telling people to cover their mouths when coughing or sneezing (5 out of 27 facilities did not have posters).

The ugly: Facilities surveyed performed extremely poorly in the length of waiting times (25 out of 27 facilities did not see people within 30 minutes), screening for TB symptoms (19 out of 27 facilities did not screen), and separating those who were coughing a lot from those who were not coughing (26 out of 27 facilities did not separate people).

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 Western Cape, it nevertheless provides compelling

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5 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

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

7 Ibid

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 Free State 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
Crossroads Clinic	No	No	Yes	Yes	Yes	No	Yes	3	RED
Gugulethu Clinic	Yes	No	Yes	Yes	Yes	No	Yes	2	ORANGE
Inzame-Zabantu Clinic	Yes	No	Yes	Yes	Yes	No	Yes	2	ORANGE
Ivan Toms Clinic	No	No	Yes	Yes	No	No	Yes	4	RED
Khayelitsha MOU CHC	Yes	No	Yes	Yes	Yes	No	Yes	2	ORANGE
Khayelitsha Site B Day Hospital	Yes	No	Yes	Yes	Yes	Yes	Yes	1	ORANGE
Khwezi Clinic	Yes	No	Yes	Yes	No	No	Yes	3	RED
Kuyasa Clinic	No	No	Yes	Yes	No	No	Yes	4	RED
Kuyasa Male Clinic	Yes	No	Yes	Yes	No	No	Yes	3	RED
Kwanokuthula Clinic	Yes	No	Yes	Yes	No	No	Yes	3	RED
Laingville Clinic	Yes	No	Yes	Yes	No	No	Yes	3	RED
Micheal Maphongwana Clinic	No	No	Yes	No	No	No	Yes	5	RED
Matthew Goniwe Clinic	No	No	Yes	Yes	No	No	Yes	4	RED
Mayenzeke Clinic	Yes	No	Yes	Yes	No	No	Yes	3	RED
Mfuleni Clinic	No	No	?	No	No	No	Yes	5	RED
Mzamomhle Clinic	Yes	No	Yes	Yes	Yes	No	Yes	2	ORANGE
New Horizen Clinic	Yes	No	Yes	Yes	No	No	Yes	3	RED
Nolungile Clinic	Yes	No	Yes	Yes	No	No	Yes	3	RED
Plattenberg Bay Clinic	Yes	No	Yes	Yes	Yes	No	Yes	2	ORANGE
Site B Male Clinic	Yes	No	Yes	No	No	No	Yes	4	RED
Site B Youth Clinic	Yes	No	Yes	Yes	No	No	Yes	3	RED
Site C Hub 2 Clinic	Yes	No	Yes	No	No	No	Yes	4	RED
Site C Youth Clinic	Yes	Yes	Yes	Yes	Yes	No	Yes	1	ORANGE
St Helena Bay Clinic	No	No	Yes	No	No	No	Yes	5	RED
Town 2 Clinic	Yes	No	Yes	Yes	No	No	Yes	3	RED
Ubuntu Clinic	Yes	No	Yes	Yes	No	Yes	Yes	2	ORANGE
Zwelihle CHC	Yes	No	Yes	Yes	No	No	No	4	RED

In addition to the primary healthcare facility survey, TAC Western Cape carried out a snap survey into the state of TB services and infection control at four 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. Have there been any reports of TB medicine stockouts or shortages?
7. Are there any reports that the TB ward staff have contracted TB?
8. Are masks offered to relatives visiting people with TB?
9. Have there been any reports of people with TB lost 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)	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
Khayelitsha District Hospital	Yes	Yes	No	n/a	Yes	Yes	No	Yes	Yes	2
Mitchells Plain Hospital	Yes	Yes	Yes	n/a	Yes	Yes	Yes	No	Yes	1
Vreendberg Hospital	Yes	Yes	No	n/a	No	Yes	Yes	Yes	No	3
Kwezi Day Hospital	No	n/a	n/a	With all other patients	No	Yes	Yes	Yes	No	3

While not exhaustive of TB related services, this snap survey has shown that each hospital has failed in certain areas in terms of TB management. Particularly we draw attention to Kwezi Day Hospital, and Vreendberg Hospital that performed especially poorly. Half the hospitals surveyed were found to have lost patients to follow up. 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.

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

<u>Our demands:</u>

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.

5. Extremely poor quality maternal healthcare

TAC Western Cape has been highlighting serious problems in maternity and obstetrics units (MOUs) in the provincial healthcare system since 2015. Numerous shocking cases have been reported to TAC over the years, of women who faced undignified and traumatic conditions while in labour, that resulted in health complications for them and their babies, and at times their infants dying. Often there are no doctors available and women are faced with bad attitudes from nurses. From being told to mop up after their waters break, to being shouted at to stop pushing even when they are in labour[8]. This is unacceptable and violates the rights of pregnant women.

While TAC Western Cape marched to the provincial Department of Health in 2015[9], handing over a detailed memorandum[10], to date many of the same problems persist. While certain changes have been made, for instance the extension of Micheal Mapongwana Clinic, the facility remains overcrowded and women are forced to wait outside, or are told to return at a later point, despite being in labour. Much more needs to be done to protect the rights and health of women and their children.

While it is hard to know the full extent of the problem, the number of cases and the nature of the cases warrants a serious and urgent investigation by the provincial Department of Health.

Our demands:

a. We demand an urgent investigation into the state of services provided at MOUs in the province, including human resources and infrastructural and equipment issues that impact upon overcrowding. A clear strategy for turnaround should then be developed based on the findings. This report should be made available by end July 2018.
b. We demand steps to be taken to ensure that all MOUs have sufficient space in their waiting room areas. In these waiting room areas mothers must be monitored closely by a professional healthcare worker. We believe that these two measures will decrease the number of babies that will be born outside of MOUs.
c. Urgent steps must be taken to improve the quality of the education and counselling sessions preparing mothers for pregnancy, childbirth and beyond. Many of the mothers we spoke to did not receive proper counselling.
d. We demand an urgent increase in the number of professional healthcare workers who are placed in MOUs, especially doctors. The shortage of doctors causes delays in the referrals of mothers to tertiary health facilities. Such delays can have serious consequences for mothers and their babies.
e. A system must be implemented that will promote early bookings and early diagnostics to avoid mothers giving birth at home.
f. We demand that urgent steps be taken to ensure women are treated with dignity and respect at all health facilities across the province. Many of the cases reported to us involve serious infringements on the dignity of pregnant mothers.

[8] NSP Review (now known as Spotlight), October 2015 "Poor Maternal and Obstetric Care in Western Cape". Available at: https://www.spotlightnsp.co.za/wp-content/uploads/2015/10/NSPreview13-web-1.pdf

[9] TAC, August 2015: "Why are our babies dying and being born with disabilities". Available at: https://tac.org.za/news/why-are-our-babies-dying-and-being-born-with-disabilities/

[10] TAC memorandum, August 2015. Available at: https://tac.org.za/files/memorandum20-2027th20august20march20to20provincial20parliament.pdf

6. Ensuring youth friendly services & promotion of HIV prevention among young people

Every week in South Africa over 2 500 young people acquire HIV – that is over 350 every day. Young women and adolescent girls alone represent 100,000 of the 270,000 new infections every year[11]. Rates of teenage pregnancy remain high with one third of teenage girls getting pregnant before the age of 20[12]. Whether older people like it or not, the fact is that many young people – including learners at schools – are sexually active.

Yet despite this, clinics and other primary health facilities are often inconvenient, unfriendly, and even unsafe places for learners and young people to try to access services. Clinic opening hours restrict access to learners, as it is too late to go after school. Where they are able to seen, it has been widely reported that older healthcare workers can at times judge them, reprimand them, and even deny access to HIV testing or contraception. Some young people have decided to stay away from clinics altogether, putting them more at risk of getting HIV or becoming pregnant. Young people need youth friendly health services including sexual and reproductive health and HIV prevention that are approachable, accessible and safe.

In an attempt to better ensure access for young people in Khayelitsha, a number of youth clinics were established (at Nolungile Clinic in 2007, at Khayelitsha Site B Clinic in 2010, and at Micheal Maphongwana Youth Clinic in 2017). While this initiative was a very positive step forward, in only covered Khayelitsha. In addition, there remain a number of challenges in terms of re-integrating young people into adult health services. As young people approach 25 years (the cut off age for using these facilities), little preparation occurs for absorbing them into the main clinic. No file history is passed along and young people report having to start new files with no medical history. While the services in the youth clinic run more smoothly, young people also then face the dysfunction of the public health system – ultimately discouraging some from continuing to access healthcare.

Preventing HIV infection in adolescent girls and young women could change the course of the epidemic and reverse the current poor global progress in HIV prevention. However, access to condoms and PrEP remain out of reach to youth. A Department of Basic Education policy released last year seeks to address these issues and allows for the distribution of condoms in the schools, albeit under a confusing description that it should be "discreet" and "dependent only on age of consent, inquiry or need." However, this policy is not being progressively rolled out. We know already that in some clinics, healthcare professionals do not provide young people with HIV tests or contraceptives and that condoms are not truly available in many schools. To be truly effective male and female condoms should be easily available to all – meaning for example availability in toilets at schools.

Comprehensive annual sexual and reproductive health services should be made available in schools, during which learners can test for HIV, get screened for TB and STIs, take a pregnancy test, access to PrEP, access and to get referral to family planning, VMMC, TOP, or other health services (e.g. to care for sexual violence). There should be an HIV focal point in all schools—life orientation educator or learner support agent or school nurse, that can provide referral and support on a year-round basis to learners.

The alarming pregnancy rates in higher education institutions indicates low use of condoms and other family planning methods. Access to oral tenofovir, alone or in combination with emtricitabine (PrEP) could be a way to address new HIV infections. PrEP is the only woman-initiated prevention technology that does not require partner knowledge or co-operation. We cannot afford not to make this prevention option available to young women. However, PrEP is not yet widely accessible in the public sector in the Western Cape.

Our demands:

a. The Western Cape Department of Health should ensure the roll out of youth clinics across the province, raising the cut off age to 30, that are effective in reintegrating those people back into adult health services. Where it is not possible to establish a youth clinic, services at the main clinic should

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[11] 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

[12] 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

be made more youth friendly. Staff should be better trained to provide health, SRHR and HIV services in a non-judgmental way to young people.

b. The Western Cape Department of Health should work together with Department of Education in the province to ensure comprehensive sexual and reproductive health services be made available in schools, and ensure the rollout of easy to access condoms in schools.
c. The Western Cape Department of Health should ensure that all young people who want to, are able to access PrEP in the province.

7. Dire state of emergency medical services

The provincial emergency medical services (EMS) and planned patient transport (PPT) systems in the Western Cape 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. 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 nearly 6.5 million that amounts to the minimum of 649 ambulances as outlined below.

District	Population (2018 estimates Stats SA)	# of ambulances required at 1:10 000
Cape Town Metropolitan Municipality	4 127 040	413
Cape Winelands District Municipality	912 107	91
Central Karoo District Municipality	76 634	8
Eden District Municipality	626 685	63
Overberg District Municipality	292 077	29
West Coast District Municipality	457 068	46
Western Cape	**6 491 611**	**649**

The situation has been worsened due to a spate of robberies, where thieves posing as patients have been reported to hold up ambulances at gun point. EMS personnel are now, unsurprisingly, fearful of their own safety to enter certain areas. In Khayelitsha, people who call ambulances in the Phillipi and Nyanga areas are instructed to wait at the nearest fire station. Ambulances are then escorted into the location by police. This leads to major delays in accessing EMS services as well as inconvenience, difficulty, and cost implications for patients in need of medical care to transport themselves to a different location.

Our demands:

a. We demand at least 649 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 health care 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.
e. We demand the provincial Department of Health, together with the SAPS, investigate the safety issues in Khayelitsha, and develop a strategy for ensuring that EMS services can properly resume to ensure patients can be collected in a timely manner, where they are.

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 the Western Cape 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 26 clinics surveyed in March 2018, 5 (19%) had no clinic committee at all (1 facility had no data). Of those with a clinic committee, none can be said to be functioning. They have currently all been disbanded and structures that remain are only interim and lack proper community representation. It is critical that

In addition, TAC Western Cape also has concerns over the state of the Provincial AIDS Council. The Provincial AIDS council is meant to give civil society a way to have a say in South Africa's HIV and TB response. However, in the Western Cape, it is not functioning in a way that is responsive to the realities we face in our communities. All Provincial AIDS Councils must be chaired by the Premiers of each province however even this is not happening yet in the Western Cape. It is critical that AIDS Councils are functional in order to ensure an appropriate HIV and TB response that meets people's needs.

<u>Our demands:</u>

a. We demand an audit report of the functionality of all clinic committees and hospital boards by end July 2018.
b. We demand that by end June 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. These structures must have proper community representation.
c. 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 Mpumalanga Department of Health.
d. The Western Cape Premier must chair the Provincial AIDS Council from the next meeting and going forward in order to ensure accountability and progress on the AIDS and TB response in the province.

Conclusion

In the Western Cape, the healthcare system is not functioning in the way that it should. People who depend on free health services often receive sub-standard, undignified, and at times even life threatening healthcare. The

provincial government is obligated by the Constitution of South Africa to provide decent healthcare to its people. Yet on this matter, it is failing. The gap in healthcare between the rich and the poor is extreme. The dysfunction in the provincial healthcare system also impedes on the success of the HIV and TB response, a response that is delivered locally through our primary health system. The Premier, MEC of Health and provincial Department of Health must urgently prioritise improving the quality of and access to healthcare services in the province.

TAC will continue to monitor the state of healthcare delivery in the Western Cape 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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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. 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.

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 7,285 in or before the 2019/20 FY to ensure that there are 1:600 CHWs in the provincial health system.

1f. We demand additional and adequate numbers of security personnel to ensure the safety and security of health facilities and public healthcare users in the province.

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 July 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 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.

3a. 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.

3b. By July 2018, the Western Cape 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.

3c. By July 2018, the Western Cape 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.

3d. In 2018, and in every year after that, the Western Cape 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.

3e. By end 2018, the Western Cape 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.

3f. By end 2019, the Western Cape 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.

4a. 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.

4b. 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.

4c. 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.

4d. 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.

4e. 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.

5a. We demand an urgent investigation into the state of services provided at MOUs in the province, including human resources and infrastructural and equipment issues that impact upon overcrowding. A clear strategy for turnaround should then be developed based on the findings. This report should be made available by end July 2018.

5b. We demand steps to be taken to ensure that all MOUs have sufficient space in their waiting room areas. In these waiting room areas mothers must be monitored closely by a professional healthcare worker. We believe that these two measures will decrease the number of babies that will be born outside of MOUs.

5c. Urgent steps must be taken to improve the quality of the education and counselling sessions preparing mothers for pregnancy, childbirth and beyond. Many of the mothers we spoke to did not receive proper counselling.

5d. We demand an urgent increase in the number of professional healthcare workers who are placed in MOUs, especially doctors. The shortage of doctors causes delays in the referrals of mothers to tertiary health facilities. Such delays can have serious consequences for mothers and their babies.

5e. A system must be implemented that will promote early bookings and early diagnostics to avoid mothers giving birth at home.

5f. We demand that urgent steps be taken to ensure women are treated with dignity and respect at all health facilities across the province. Many of the cases reported to us involve serious infringements on the dignity of pregnant mothers.

6a. The Western Cape Department of Health should ensure the roll out of youth clinics across the province, raising the cut off age to 30, that are effective in reintegrating those people back into adult health services. Where it is not possible to establish a youth clinic, services at the main clinic should be made more youth friendly. Staff should be better trained to provide health, SRHR and HIV services in a non-judgmental way to young people.

6b. The Western Cape Department of Health should work together with Department of Education in the province to ensure comprehensive sexual and reproductive health services be made available in schools, and ensure the rollout of easy to access condoms in schools.

6c. The Western Cape Department of Health should ensure that all young people who want to, are able to access PrEP in the province.

7a. We demand at least 649 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.

7b. 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 health care approach.

7c. We demand the provincial Department of Health takes the necessary steps to address the shortage in emergency medical personnel by filling all vacant posts.

7d. 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.

7e. We demand the provincial Department of Health, together with the SAPS, investigate the safety issues in Khayelitsha, and develop a strategy for ensuring that EMS services can properly resume to ensure patients can be collected in a timely manner, where they are.

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

8b. We demand that by end June 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. These structures must have proper community representation.

8c. 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 Mpumalanga Department of Health.

8d. The Western Cape Premier must chair the Provincial AIDS Council from the next meeting and going forward in order to ensure accountability and progress on the AIDS and TB response in the province.