State of Provincial Healthcare System
Spotlight on Eastern Cape
May 2018

Background

For years the healthcare system of the Eastern Cape province has been teetering on the edge of complete collapse. Horror stories abound of dysfunctional hospitals, run down clinics, over stretched nurses, medicine shortages and stockouts, and ambulances that never arrive. The healthcare system is not functioning in a way that is ordinarily understood as operational – all at the expense of people's rights, dignity and lives.

TAC has been active in the Eastern Cape 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 26 branches in 5 districts in the Eastern Cape including Buffalo City, Chris Hani, Nelson Mandela Bay, OR Tambo, and Sarah Baartman. 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 recent years TAC, together with SECTION27, have been the driving force behind the Eastern Cape Health Crisis Action Coalition (ECHCAC) – a coalition of over 20 partner organisations including doctors, unions and patient groups. The coalition's work has led to direct interventions from the National Department of Health and contributed to the removal of former MEC for Health Sicelo Gqobana. We also litigated in relation to the infamous Village Clinic in Lusikisiki and helped set the stage for the 2015 Human Rights Commission investigation into emergency medical services in the province. Unfortunately, nothing much has changed in the dire state of the health system in the province since these interventions

At a local level, each of our branches has adopted a primary healthcare facility local to them and have been monitoring the state of services at these 26 facilities since November 2017. The results highlight a litany of critical concerns with regard to the state of service delivery at clinics and community healthcare centres across the province. 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.

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 Eastern Cape of 100 clinics inspected by the OHSC (not necessarily the same facilities as monitored by TAC) only 12% were performing at 50% or above and none above 70%:

# clinics	Rating by OHSC
1	clinic performed below 20%.
18	clinics performed between 20-29%.
37	clinics performed between 30-39%.
32	clinics performed between 40-49%.
11	clinics performed between 50-59% score.

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

1	clinic performed between 60-69%.
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.

Despite ongoing interventions, the situation in the Eastern Cape remains critical. Many persistent challenges plague the provincial health system that require an urgent and comprehensive turnaround strategy by the Eastern Cape Department of Health. We outline our concerns below and demands in order to improve the situation. The MEC of Health and Premier must take these demands seriously. We require a written response from the department by 15 June 2018.

Key concerns and demands

1. **Critical shortage of human resources including doctors, nurses and community healthcare workers**

The shortage of human resources is a major issue in the Eastern 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.

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. This problem is only exacerbated for the majority of rural communities in the Eastern Cape who struggle to attract specialists and senior doctors.

According to the National Department of Health, there are currently over 46,298 funded posts in the Eastern Cape. Of these only 39,293 are filled leaving almost 7,005 vacant posts in the province. This translates into more than 15% of the workforce.

These shortages lead to 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. The result of all of this is that patients do not access quality healthcare services as required by the Constitution. The results of TAC Eastern Cape's monthly monitoring in March 2018 shows the following in relation to human resources for health:

Staffing: Two thirds of facilities, 67% (18/27), were considered to have insufficient staff and 33% (9/27) facilities as having enough. At the very least, this finding shows that a substantial number of people dependent on the public healthcare system perceive facilities as being understaffed.

Staff attitudes: At 51% of facilities (14/27) staff were generally considered to be friendly, at 41% (11/27) staff were classified as sometimes friendly, and at 7% (2/27) 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.

Waiting times: Our survey found that at 19% (5/27) of facilities people had to wait for more than an hour to be seen and at 33% (9/24) of facilities the wait was more than two hours which is hugely disruptive for people. Though generally poor, waiting times were variable. At 19% (5/27) of facilities the waiting time was between 30 to 60 minutes. 30% (8/27) of facilities saw people in less than 30 minutes.

More detailed analysis can be taken from TAC branch lead fact finding at a number of hospitals and primary health facilities outlined below:

Hospitals	
Butterworth Hospital	The hospital operates with a budget for 250 000 patients but caters for a further 150 000. According to the Hospital organogram, there should be 12 doctors in service (consulting around 50 patients per 12-hour cycle). However, practically, there are only around 6 to 8 doctors per day shift (consulting around 200 patients daily), this highlights a major shortage.
Canzibe Hospital	There are insufficient medical doctors, (no dentists or physiotherapists), though five doctors were employed in July after TAC and RHAP intervened. Nurses are scarce, especially those working night shifts. General workers are a major hurdle to accessing health. There are no senior administrators for HR issues. There are shortages of EMS workers and complaints of poor attitudes among them. There are not enough pharmacists at the hospital which results in patients waiting too long for prescriptions. Overall there are very long waiting times at the hospital.
Holy Cross Hospital	There are ongoing shortages of doctors that results in long waiting times. Furthermore, questions have been raised over the sustainability of the Hospital CEO.
Isilimela Hospital	There are insufficient numbers of doctors and physiotherapists in service at the hospital.
St Elizabeth Hospital	Staff at OPD do not wear name tags. On weekends health workers are not available to assist patients on arrival, as a result security guards assist in administering patients into the system. There are substantial staff shortages, as a result the hospital operates with a skeleton staff. This leads to extremely long waiting times.

PHC facility	
Bodweni Clinic	No pharmacy assistants, nurses screen and dispense.
Eluxolweni Clinic	No pharmacy assistants, nurses screen and dispense.
Jabavu Clinic	No pharmacy assistant, shortage of staff. The security guard dispenses medicines.
Lizo Ngcana Clinic	No pharmacist, as a result one security guard dispenses medication
Machibini Clinic	No security during the day, no pharmacist
Mpoza Clinic	No pharmacist
Palmerton Clinic	No pharmacy assistant
Port St John's Health Centre	No pharmacy assistants, nurses screen and dispense.
Xurana Clinic	No pharmacy assistants, nurses screen and dispense.

In addition to doctors, nurses and pharmacists, there is also a 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 number of CHWs to be employed, the Brazilian best practice puts a ratio of 1 CHW to 600 people in the population (1:600) – this amounts to 12,027 in total in the Eastern Cape. In 2016, there were 3,368 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.

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
Alfred Nzo District Municipality	1 444	411	1 033	71,55%
Amathole District Municipality	1 620	426	1 194	73,71%
Buffalo City Metropolitan Municipality	1 457	198	1 259	86,41%
Chris Hani District Municipality	1 365	499	866	63,44%
Joe Gqabi District Municipality	619	311	308	49,74%
Nelson Mandela Bay Metropolitan	2 164	364	1 800	83,18%
OR Tambo District Municipality	2 487	816	1 671	67,19%
Sarah Baartman District Municipality	871	343	528	60,63%
Eastern Cape	**12 027**	**3 368**	**8 659**	**72,00%**

Our demands:

a. We demand the release of the provinces Human Resources for Health (HRH) plan before end July 2018. This plan should include a comprehensive list of current vacancies.
b. We demand that all vacant posts be filled in the next financial year and that the employment of nurses and doctors is prioritised in the 2018/19 financial year.
c. We demand the provincial health department fills the gap in community healthcare workers by adding 5 000 in the 2018/19 FY and 3 659 in the 2019/20 FY to ensure that there are 1:600 CHWs in the provincial health system.
d. 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.
e. Often staff do not treat people properly due to stress, exhaustion, and burn out as a result of the malfunction in the health system including, lack of time, tools, equipment or medicines. Better staff support systems should be put in place by the provincial Department of Health in order to ensure staff wellness and support.

2. Poor facility infrastructure & poor equipment

Often the infrastructure of health facilities in the Eastern Cape is in disrepair. Facilities are small, aged, and run down leading to issues of overcrowding, a lack of dignity and privacy, and impacting on the effectiveness of TB infection control measures. At times facilities face water shortages and no electricity. The results of our March 2018 survey found:

Waiting areas: 41% (11/27) of facilities had enough room in the waiting area and 59% (16/27) did not. Waiting areas in 85% (23/27) of facilities were classified as clean while waiting areas at 15% (4/27) of facilities were classified as not being clean.

Infrastructure & toilets: 63% (17/27) of facilities were rated as being in good condition, 33% (9/27) of facilities were not. 1 facility was excluded from the analysis due to a lack of data. Of the 27 facilities, 67% (18/27) of

facilities did not have clean functional toilets, and 33% (9/27) of facilities were rated as clean and with toilet paper.

Hospital	
Bedford Hospital	There is a shortage of beds at the hospital. Old linen is being used.
Butterworth Hospital	The hospital experiences ongoing water shortages, at times family members are forced to bring water for patients admitted in the hospital. The infrastructure is old and worn. There were reports in late 2017 of an infestation of rats and mice, and rats biting patients. These issues were raised in a meeting between TAC and the hospital CEO on 17 October 2017. They have yet to be fully rectified.
Canzibe Hospital	The hospital structure is very old and the building leaks. The mortuary is tiny and only accommodates six corpses, leading to challenges in storage of people who have passed away. Additionally, there are reports of shortages and stockouts of medicines.
Holy Cross Hospital	The hospital faces persistent water shortages resulting in patients having to collect water from a nearby stream. In addition, there are ongoing medicine shortages.
Isilimela Hospital	The hospital infrastructure is old. There are no wheelchairs or crutches available. The x-ray machines are not functional. There is no privacy at the OPD when doctors are consulting patients. A computerised Patients Administration System is not available (administration is using a manual paper system which leads to delays in patients receiving files). The Hospital Call Centre is not operating after hours or during weekends, as result there is poor communication between the hospital and community during these times.
St Elizabeth Hospital	The infrastructure renovations and building of an additional unit came to a stand-still in 2012. There are reports of shortages of gloves, aprons, dressing equipment, cleaning equipment.

PHC facility	
Eluxolweni Clinic	This facility has a small structure and is built on a slope. There is one toilet for everyone to share, with no door and a leaking sink. There are no urine jars for urine samples.
Flagstaff Clinic	There is no electricity, as a result nurses use a torch to carry out pap smear screening. The building is small, as result there is not enough space and patients wait outside the small structure. There is no dignity or privacy for pregnant women (they have to take urine jars and go outside the clinic in an open space to urinate for samples). There is extremely poor TB infection control – the windows are locked others seem not to have been opened for some time. The toilets are dysfunctional. The clinic is dirty. There are no medical clinic cards.
Jabavu Clinic	There is no TB consulting room, as result patients are consulted in the cloak room. At times, there is no electricity. There are no telephones.
Machibini Clinic	The facility has a small infrastructure. The waiting area accommodates about 30 patients. HIV voluntary counselling and testing takes places in the kitchen. Medicines are stored in the caretaker's room. During the doctor's visit, patients must wait outside the structure.
Magwa Clinic	There is no electricity, nurses carry out pap smears by torch. Immunizations and blood samples are kept in a cooler box. There is no long-term plan for water supply which faces persistent shortages. The site is not secure, as there is no fence, risking staff and patients' safety.
Mondile Clinic	The facility infrastructure is too small, this results in patients waiting outside for more than two hours.
Philani Clinic	The facility infrastructure is too small, people queue outside when the waiting area is full regardless of weather conditions.
Port St John's Health Centre	The x-ray machine is not working.
Xurana Clinic	The toilets are not finished, they use buckets for toilets. The roof leaks in all consulting rooms. The structure needs urgent renovation.

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. We demand that all broken, inadequate and missing equipment and medical supplies be replaced or provided to health facilities to ensure the proper and improved functionality of these services by end August 2018.

3. Dire state of emergency medical services & planned patient transport

The provincial emergency medical services (EMS) and planned patient transport (PPT) systems in the Eastern 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. Response times are unacceptable, ambulances take hours to arrive or they never arrive at all. People in the Eastern Cape, specifically in rural communities have lost trust in the EMS system.

The current failure of the EMS and PPT system impacts disproportionally on the most vulnerable and especially on those in poor and rural settings. The majority of people in the Eastern Cape live in rural communities who have a particularly difficult time accessing healthcare services at all – only made worse when transport is not available. Often EMS vehicles are unable to travel on the terrain to reach those in need of urgent medical attention. In rural areas, many people must walk long distances to clinics and hospitals. This negatively impacts HIV treatment adherence and TB treatment completion rates.

National Department of Health guidelines specify that nobody should live more than 5 kilometres from their nearest clinic, however the reality in rural communities is that this distance is at times much further as people must get around rivers and other impassable terrain. This also fails to take into account the reduced mobility of people who are sick or have a disability.

Poor or unavailable EMS and PPT mean many people are forced to make substantial out-of-pocket payments to access health services at facilities. This is particularly problematic in the Eastern Cape that faces the largest official unemployment rate at 35.1% in December 2017[2]. For instance, to hire a car from Khohlo or Majola in Port St John's to Isilimela Hospital costs R800. To hire a car from Tombo to Isilimela Hospital costs R350, and from Qandu costs R450. To hire a car from Gwexintaba-Magwa location in Lusikisiki to St Elizabeth Hospital it costs R400 during the day and R500 during the night. For those who are unable to pay for these services, they have no option than to wait for an ambulance which either take hours to arrive, or does not arrive at all.

The reality is that in the Eastern Cape there is a major shortage of ambulances. According to the Department of Health's standards there should be 1 ambulance to 10,000 people. In a population of more than 7.2 million that amounts to the minimum of 722 ambulances. Note this ratio does not factor in different geographical requirements that should be taken into consideration. Yet according to media reports at the end of 2017, there were just over 200 ambulances and planned patient transport vehicles in service in the province[3]. Reports earlier in the year suggested that out of 400 ambulances, half of the fleet was out of order[4].

District	Population (2018 estimates Stats SA)	# of ambulances required at 1:10 000
Alfred Nzo	866 646	87
Amathole	972 188	97
Buffalo City	874 199	87
Chris Hani	818 915	82
Joe Gqabi	371 240	37
Nelson Mandela Bay	1 298 412	130
OR Tambo	1 492 014	149
Sarah Baartman	522 720	52
Eastern Cape	**7 216 334**	**722**

[2] Quarterly Labour Force Survey - Quarter 4 2017, Stats SA. Available at: http://www.statssa.gov.za/publications/P0211/P02114thQuarter2017.pdf

[3] Daily Dispatch, December 2017. Available at: https://www.pressreader.com/south-africa/daily-dispatch/20171204/281724089877874

[4] Daily Dispatch, May 2017. Available at: https://www.google.co.za/amp/www.dispatchlive.co.za/news/2017/05/11/simple-repairs-cripple-half-ecs-ambulances/amp/

In the Eastern Cape communities reported the lack of ambulances to the South African Human Rights Commission (SAHRC) at a public hearing in March of 2015. At the hearing, the SAHRC heard from various community members and officials from the Eastern Cape Department of Health regarding challenges to EMS in the province. On 2 October 2015, the SAHRC launched its report into EMS that found substantial failings in the system and provided numerous recommendations to the Eastern Cape Department of Health[5].

Furthermore, there have also been complaints made to TAC with regard to bad attitudes of certain EMS personnel including call centre operators, drivers, and paramedics. At times it is reported that there is inappropriate and poor service where ambulances assistants ride in the front and leave patients alone in the back of the ambulance. This is not appropriate for people in need of emergency and other medical services.

Our demands:

a. We demand that the provincial Department of Health address the recommendations of the South African Human Rights Commission EMS Hearing Report from 24 & 25 March 2015.
b. We demand at least 722 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.
c. 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.
d. We demand the provincial Department of Health takes the necessary steps to address the shortage in emergency medical personnel by filling all vacant posts.
e. We demand that staff members who are working in EMS must be sufficiently trained, including basic ambulance drivers and call centre staff members to ensure appropriate service and better staff attitudes at all levels;
f. The provincial Department of Health must ensure that it has the suitable types of ambulances for all kinds of terrain including 4x4 vehicles in rural areas.

4. HIV and TB response falling short

Eastern Cape continues to face major HIV and TB epidemics – Amathole and Alfred Nzo face a high HIV burden, Nelson Mandela Metro and Sarah Baartman face a high TB burden, and OR Tambo, Chris Hani, and Buffalo City all face a high dual burden of both HIV and TB[6].

In terms of HIV, in mid 2016, HIV prevalence across all ages in the province was at 11.8% (768 000 people). In 15 – 49 year olds this increased to 19.2%. Between mid 2015 and 2016, the rate of new HIV infections remained stubbornly high at 35 000. HIV related deaths mid 2015 to mid 2016 were at 11 100.

According to the Thembisa Model, ART coverage in the province in mid 2016 was at 52.3%. Based on these figures, more than 360 000 people in the Eastern Cape who could benefit from treatment were not on treatment. Of those on treatment, only 73.4% were virally suppressed indicating that we need to do much more to improve adherence levels[7].

The below table 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 at 53.81%. This is still significantly far from the 81% that the government is aiming for by 2020, as outlined in the National Strategic Plan on HIV, TB, and STIs 2017 – 2022.

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5 Access to Emergency Medical Services in the Eastern Cape Hearing Report, South African Human Rights Commission. Available at: https://www.sahrc.org.za/home/21/files/SAHRC%20Report%20on%20Access%20to%20Emergency%20Medical%20Services%20in%20the%20Eastern%20Cape....pdf

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

According the Eastern Cape Department of Health, 74 909 people with TB were lost to follow up in the 2016/17 financial year.

District	Population (2018 estimates Stats SA)	Total population (District Health Barometer-DHB)	Total PLHIV (DHB)	HIV prevalence (%) (DHB)	Total on ART 2015 (DHB)	Total on ART 2017 (DHB)	% increase in ART coverage (DHB)	Total on ART 2017 (PEPFAR)	ART coverage by DHB figures	ART coverage by PEPFAR figures
Alfred Nzo	866646	867 863	103 224	11.9	41591	60023	44.3	57 576	58,15%	55,78%
Amathole	972188	880 790	96 786	11.0	40281	54608	35.6	51 478	56,42%	53,19%
Buffalo City	874199	834 998	103 173	12.4	40359	50707	25.6	58 582	49,15%	56,78%
Chris Hani	818915	840 055	100 575	12.0	39436	49327	25.1	51 404	49,04%	51,11%
Joe Gqabi	371240	372 913	42 641	11.4	17805	23317	31.0	n/a	54,68%	n/a
Nelson Mandela Bay	1298412	1 263 049	106 070	8.4	44604	56462	26.6	n/a	53,23%	n/a
OR Tambo	1492014	1 457 386	178 204	12.2	76645	96052	25.3	99 181	53,90%	55,66%
Sarah Baartman	522720	479 920	40 030	8.3	19341	24237	25.3	n/a	60,55%	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 Eastern Cape’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 piloted in OR Tambo as part of NHI, this must be urgently rolled out to all other districts to ensure maximum impact.

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 a rural province like the Eastern Cape 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 addition, the province must prioritise decentralising the broader Centralised Chronic Medicines Dispensing and Distribution (CCMDD) programme for people taking all chronic medicines, in order to make chronic medication collection simpler, faster and more accessible to people across the province. The provincial department has been delaying this process, which must be urgently expedited.

In terms of TB, according to available figures, in 2016 only 66.3% of people diagnosed with TB in the province were initiated onto treatment (the national average is 72.8%), and close to one in three people with drug resistant TB died whilst on treatment in 2014[8]. This is particularly worrying and indicates a broad crisis in TB management that needs to be urgently addressed in the province.

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].

Overall in the province there is a lack of education and awareness on HIV and TB resulting in people not knowing their status or seeking testing services, and lower rates of treatment initiation and completion than required. A mass awareness, education, and social mobilisation campaign needs to take place in the province in order to create demand and uptake of these services.

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 Eastern 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 Eastern 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 Eastern 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 August 2018, the Eastern Cape Department of Health must decentralise the Centralised Chronic Medicines Dispensing and Distribution (CCMDD) programme to accessible locations across the province to improve chronic medication collection for all public health users. In addition, we recommend the piloting of "pharmacy ATMs" as showcased in Gauteng within this fast track model for chronic conditions.

f. By end 2018, the Eastern 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.

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[8] District Health Barometer 2016/17. Available at: http://www.hst.org.za/publications/District%20Health%20Barometers/District%20Health%20Barometer%202016-2017.pdf

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

g. By end 2019, the Eastern 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.

5. Red alert on TB infection control at primary health facilities

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 Eastern Cape assessed the state of TB infection control in 28 public primary health facilities across the province. The following questions were answered by TAC members from local branches linked to each facility assessed:

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

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

Of 28 facilities assessed in March 2018, 20 were found to be in a “RED” state with very poor infection control measures in place. 6 were found to be in an “ORANGE” state, and 2 were found to be in a “GREEN” state with good TB infection control measures in place.

We commend the two GREEN facilities, Goso Forest Clinic and Rhodes Clinic. The Eastern Cape was the only province to have any facilities ranked GREEN. Our local branches linked to the 2 facilities will award them with certificates and urge them to remain at this level. However, if we wish to make progress against TB, GREEN ratings should be the norm in the public healthcare system, not the exception.

The good: Facilities surveyed performed well in ensuring windows were kept open (only 1 facility was reported to have closed windows).

The bad: There were mixed results in terms of posters being visible on the walls telling people to cover their mouths when coughing or sneezing (5 out of 28 facilities did not have posters).

The ugly: Facilities surveyed performed extremely poorly in terms of the size and space of the waiting rooms (17 out of 28 facilities did not have enough room), the length of waiting times (20 out of 28 facilities did not see people within 30 minutes), screening for TB symptoms (15 out of 28 facilities did not screen), separating those who were coughing a lot from those who were not coughing (15 out of 28 facilities did not separate

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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

people), and in offering tissues or masks to people who cough a lot (18 out of 28 facilities did not offer tissues or masks).

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 Eastern Cape, it nevertheless provides compelling evidence that we have an infection control problem at a number of public sector facilities. Given that poor infection control at health facilities may be a significant contributor to TB transmission in South Africa, this is a red flag that should be taken seriously. The problems highlighted in TB infection control through the audit are indicative of the wider crisis within the Eastern Cape 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
Bodweni Clinic	No	Yes	Yes	Yes	Yes	Yes	Yes	1	ORANGE
Braelyn Clinic	Yes	No	Yes	Yes	Yes	No	Yes	2	ORANGE
Eluxolweni Clinic	No	No	Yes	Yes	No	No	No	5	RED
Flagstaff Clinic	No	No	No	No	No	No	No	7	RED
Goso Forest Clinic	Yes	Yes	Yes	Yes	Yes	Yes	Yes	0	GREEN
Jabavu Clinic	Yes	No	Yes	Yes	No	Yes	No	3	RED
Joza Clinic	No	No	Yes	Yes	No	No	No	5	RED
Laetitia Bam CHC	No	No	Yes	Yes	Yes	Yes	No	3	RED
Lizo Ngcana Clinic	Yes	Yes	Yes	Yes	No	No	No	3	RED
Mabandla Clinic	No	No	Yes	Yes	No	No	No	5	RED
Machibini Clinic	No	Yes	Yes	Yes	No	No	No	4	RED
Magwa Clinic	No	No	Yes	No	Yes	Yes	No	4	RED
Malangeni Clinic	Yes	Yes	Yes	No	Yes	Yes	No	2	ORANGE
Mantlaneni Clinic	No	No	Yes	Yes	Yes	Yes	No	3	RED
Mondile Clinic	No	No	Yes	Yes	No	No	Yes	4	RED
Mpoza Clinic	No	Yes	Yes	Yes	Yes	Yes	Yes	1	ORANGE
N.G Dlukulu Clinic	No	No	Yes	Yes	No	No	Yes	4	RED
Nomzamo Clinic	Yes	No	Yes	Yes	No	No	No	4	RED
Palmerton Clinic	No	No	Yes	Yes	Yes	Yes	No	3	RED
Philani Clinic	No	No	Yes	Yes	No	No	No	5	RED
Port St Johns CHC	No	No	Yes	No	No	No	No	6	RED
Qaukeni Clinic	Yes	Yes	Yes	No	No	No	No	4	RED
Raglan Road Clinic	No	No	Yes	Yes	No	No	Yes	4	RED
Rhodes Clinic	Yes	Yes	Yes	Yes	Yes	Yes	Yes	0	GREEN
Rossdale Clinic	Yes	No	Yes	Yes	Yes	Yes	Yes	1	ORANGE
Siyaphilisa Clinic	Yes	No	Yes	Yes	No	No	No	4	RED
Village Clinic	No	No	Yes	Yes	Yes	Yes	No	3	RED
Xurana Clinic	Yes	No	Yes	Yes	Yes	Yes	Yes	1	ORANGE

In addition to the primary healthcare facility survey, TAC Eastern Cape carried out a snap survey into the state of TB services and infection control at 3 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 or shortages)	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
Settlers Hospital	No	n/a	n/a	DS-TB patients transferred to Temba Hospital, DR-TB patients transferred to Marjorie Parish Hospital	No	Yes	Yes	Yes	Yes	2
Temba TB Hospital	Yes	Yes	Yes	n/a	No	Yes	Yes	Yes	Yes	1
Fort England Tertiary Hospital	Yes	Yes	Yes	n/a	No	Yes	Yes	Yes	Yes	1

While not exhaustive research into the state of TB related services, or hospitals in the Eastern Cape, this snap survey has shown that each hospital has failed in certain aspects of TB management. Particularly we draw attention to Settlers Hospital that performed especially poorly.

<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 other 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 June 2018. This plan should include a comprehensive list of current vacancies. Adequate human resources are essential for addressing long waiting times, and in this instance, the prolonging of exposure to potential TB infection. All facilities that have highlighted a waiting time of more than 30 minutes should be prioritised for additional human resources in this financial year. We expect the MEC and the Premier to make this a priority and to ensure the funds are made available.

6. Poor and undignified treatment of people with mental health problems

In terms of mental health, it is critical that the Eastern Cape Department of Health ensures that people's dignity and right to access mental healthcare services is prioritised. The tragic and devastating loss of life in the Life Esidimeni tragedies cannot be allowed to happen again. Yet across South Africa, including Eastern Cape, mental health does not receive the recognition and attention it requires.

According to SASOP, the Eastern Cape (together with Limpopo) suffers the most from a lack of resources when it comes to mental health. Child and adolescent psychiatric care is non-existent in the province, and psychiatrists must admit children and adolescents unlawfully into adult psychiatry wards. No province currently has an organised community-based psychiatric service. The Eastern Cape is also struggling with a lack of general hospital beds to accommodate acute psychiatric admissions. The inability to deal with aggressive behaviour by severely mentally ill people has resulted in long waiting lists for forensic psychiatric services. Following the report by the Health Ombud, there was hope that there would be an overhaul of the mental healthcare system to ensure it includes resourced, developed community- based primary and specialist multidisciplinary teams. The reality however is that the health system still does not cater adequately for the thousands of people who continue to live with mental illness within the community.

In particular, recent media reports[13] have raised serious concerns over the treatment of patients at Tower Psychiatric Hospital in Fort Beaufort. This includes allegations of death registers and files being amended or disappearing, poor food quality, patients being held in solitary confinement as punishments – and one man setting himself on fire during this time, patients wearing tattered and old clothing, and patients having to pay a levy charge to access the money their families send them.

An independent TAC investigation at the facility confirmed a number of concerns including:

- The death register in the facility disappeared in November 2017 – when found 6 pages (pages 5, 8, 9, 10, 13, 14) were missing from it;
- Single rooms are used as solitary confinement for aggressive patients and those who do not want to be included at the commune because of the noise. Further, that staff put patients in these single rooms for up to 7 days instead of the recommended 2 hours, with no close monitoring because the rooms are too far from the nursing station;
- There is poor communication between clinicians and hospital management, meaning that some stable patients are discharged without alerting their families;
- The infrastructure of the facility is old and run down. The single (solitary) rooms are dirty and not in condition to accommodate anyone. There are no toilets in these single rooms and patients must use a bucket to relieve themselves inside.

<u>Our demands:</u>

a. We demand an immediate intervention at Tower Psychiatric Hospital with evidence of this intervention by end June 2018. This intervention must urgently address our concerns around the poor quality services provided, lack of cleanliness of the facility, lack of dignity for patients, and unethical behaviour of staff.

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[13] News24, 4 March 2018. Available here: https://www.news24.com/SouthAfrica/News/eastern-capes-ticking-psychiatric-time-bomb-20180304-2

b. We demand that the province provides us with a detailed list of all mental health facilities in the province and a report on the human resource and infrastructural state of these facilities. We demand to see this report by end July 2018.
c. We demand the development of specialist care centres that provide dignified care and support services to people with mental illness and learning disabilities.

Conclusion

Overall, the persistent and severe challenges outlined in this report result in people who depend on the public healthcare system receiving inadequate, poor quality and undignified healthcare. The government is failing in its Constitutional obligation to provide decent and quality health services to its people. This dysfunction impacts disproportionately on the poorest and those in rural communities. The broken health system also impedes on the success of the provincial HIV and TB response.

The situation in the Eastern Cape remains critical and 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 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. We demand the provincial health department fills the gap in community healthcare workers by adding 5,000 in the 2018/19 FY and 3 659 in the 2019/20 FY to ensure that there are 1:600 CHWs in the provincial health system.

1d. 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.

1e. Often staff do not treat people properly due to stress, exhaustion, and burn out as a result of the malfunction in the health system including, lack of time, tools, equipment or medicines. Better staff support systems should be put in place by the provincial Department of Health in order to ensure staff wellness and support.

2a. 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. We demand that all broken, inadequate and missing equipment and medical supplies be replaced or provided to health facilities to ensure the proper and improved functionality of these services by end August 2018.

3a. We demand that the provincial Department of Health address the recommendations of the South African Human Rights Commission EMS Hearing Report from 24 & 25 March 2015.

3b. We demand at least 722 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.

3c. 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.

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

3e. We demand that staff members who are working in EMS must be sufficiently trained, including basic ambulance drivers and call centre staff members to ensure appropriate service and better staff attitudes at all levels;

3f. The provincial Department of Health must ensure that it has the suitable types of ambulances for all kinds of terrain including 4x4 vehicles in rural areas.

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

4b. By end July 2018, the Eastern 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.

4c. By end July 2018, the Eastern 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.

4d. In 2018, and in every year after that, the Eastern 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.

4e. By end August 2018, the Eastern Cape Department of Health must decentralise the Centralised Chronic Medicines Dispensing and Distribution (CCMDD) programme to accessible locations across the province to improve chronic medication collection for all public health users. In addition, we recommend the piloting of "pharmacy ATMs" as showcased in Gauteng within this fast track model for chronic conditions.

4f. By end 2018, the Eastern 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.

4g. By end 2019, the Eastern 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.

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

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

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

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

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

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

6a. We demand an immediate intervention at Tower Psychiatric Hospital with evidence of this intervention by end June 2018. This intervention must urgently address our concerns around the poor quality services provided, lack of cleanliness of the facility, lack of dignity for patients, and unethical behaviour of staff.

6b. We demand that the province provides us with a detailed list of all mental health facilities in the province and a report on the human resource and infrastructural state of these facilities. We demand to see this report by end July 2018.

6c. We demand the development of specialist care centres that provide dignified care and support services to people with mental illness and learning disabilities.