State of Provincial Healthcare System
Spotlight on Free State
May 2018

Background

The Free State public healthcare system has been in a state of dysfunction for many years. We hear endless stories of ambulances that do not arrive leaving family members cradling their dying loved ones without medical assistance. Too many reports of stockouts, not just as empty clinic cupboards, but of people resorting to rationing their medicines or spending pensions or grants to pay for these lifesaving treatments. Countless testimonies of people reluctant to use clinics and hospitals because of how they have been disrespected and ridiculed by nurses and doctors. The pilot of National Health Insurance (NHI), an effort to ensure healthcare is equal and accessible to all, has been a disaster in the Thabo Mofutsanyane. The repeated evidence of trauma, loss and injury in the province has been mounting for too long.

The Treatment Action Campaign (TAC) has been working in the Free State since 2009 and continues to represent users of the public healthcare system and campaign on critical issues related to the quality of and access to healthcare. We currently have a network of 24 branches in four districts in the province including Lejweleputswa, Mangaung, Fezile Dabi and Thabo Mofutsanyane. 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.

We see first-hand the impact the broken public healthcare system has on the communities in which we work. Investigations made by both the South African Human Rights Commission in 2007 and the Integrated Support Team in 2009 initially highlighted the severe challenges in the Free State. In 2015, the People's Commission of Inquiry into the Free State Health System raised the stakes in enabling public healthcare users to tell their own stories of this dysfunction. The Commissioners found that little had changed since those early investigations, and that it was plausible the situation had gotten even worse.

At the time, our attempts to engage constructively with former MEC of Health Malakoane were all rejected – and the province continued to limp from crisis to crisis. His removal gave new hope of turning the dire situation in the province's public healthcare system around. However, despite more open engagement with recently reshuffled MEC of Health Butana Komphela, the situation remains in crisis. The health department remains under provincial administration[1]. We need new MEC of Health Montsheng Tsiu to show real leadership and accountability in addressing the crisis. We need an urgent turnaround strategy and plan on implementation to ensure everyone can access the dignified and quality healthcare they deserve and that is enshrined in the Constitution of South Africa.

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.

[1] "Heading for the rocks". Spotlight, December 2017. Available at: https://www.spotlightnsp.co.za/2017/12/05/heading-for-the-rocks/

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[2]. According to the OHSC report, facilities should score at least 80% to claim an acceptable level of care – yet in Free State of 53 clinics inspected by the OHSC (not necessarily the same facilities as monitored by TAC) only 9% of the clinics are performing at 50% or above and none above 70%:

# facilities	Rate
1	clinic performed below 20%.
6	clinics performed between 20-29%.
24	clinics performed between 30-39%.
17	clinics performed between 40-49%.
3	clinics performed between 50-59% score.
2	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 Free State remains at code red. Persistent challenges continue to plague the provincial health system that require urgent improvement by the Free State Department of Health. We outline our concerns and demands in order to improve the situation below. The MEC of Health and Premier must take these demands seriously. We require a written response from the department by 1 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 Free State. 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 21 521 funded posts in the Free State. Of these only 17 420 were filled, leaving a shortfall of 4 101 vacant posts in the province. This translates into more than 19% of the provincial workforce. However, instead of filling vacant posts and ensuring that there are enough people to properly deliver our healthcare, some posts are instead being frozen. While many doctors and nurses remain unemployed, there are not enough open positions to employ them.

In 2016, we heard desperate pleas in the media from newly qualified yet unemployed nurses in the province – nurses who the Free State Department of Health had failed to hire after awarding them bursaries requiring that they work for the province's health department before they can seek work elsewhere[3]. Two years later, and many of these nurses remain unemployed. In 2014/15 the province lost a quarter of its public-sector

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2 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

3 Daily Maverick. Available at: https://www.dailymaverick.co.za/article/2016-05-24-groundup-in-free-state-no-jobs-for-newly-qualified-nurses/#.WqkxK5NuY0o

doctors. This followed 'call-for-help' letters sent to the national Minister of Health and an open letter published by whistle-blower doctors.

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

Staffing: Two thirds of facilities were considered to have insufficient staff. 74% (28/38) of facilities were classified as not having enough staff and 26% (10/38) 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.

The following primary healthcare facilities were found to have human resources shortages: A.M. Kruger Clinic, Allanridge Clinic, Bloemsprit Clinic, Boithusong Clinic, Bophelong Clinic, Bothaville Clinic, Bronville Clinic, D A Maleho Clinic, Dinane Clinic, Gaolenngwe Clinic, Intabazwe Clinic, Itumeleng Clinic, K. Maile Clinic, Kgothalang Clinic, Kgotsong Clinic, Kopanong Clinic, Leratong Clinic, Lusaka Clinic, Mafani Clinic, Meloding Clinic, Monontsha Clinic, Phahameng Clinic, Phedisanang Clinic, Rheederspark Clinic, Sedibeng SA Bophelo Clinic, Steynsrus Clinic, Tshepong Clinic, and Welkom Clinic.

Staff attitudes: At 42% of facilities (16/38) staff were generally considered to be friendly, at 45% (17/38) staff were classified as sometimes friendly, and at 13% (5/38) 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 53% (20/38) of facilities people had to wait for more than an hour to be seen and at 22% (8/38) of facilities the wait was more than two hours which is hugely disruptive for people. Though generally poor, waiting times were variable. At 24% (9/38) of facilities the waiting time was between 30 to 60 minutes. 3% (1/38) of facilities saw people in less than 30 minutes.

Furthermore, issues related to shortages of staff have also been raised to TAC by community members who use the following hospitals: Bongani Hospital, Pelonomi Hospital, Moroka Hospital, Manapo Hospital, and Dihlabeng Hospital. At Dihlabeng Hospital, the shortage of orthopaedic specialists is leading to overly long waiting times and further complications for patients. Furthermore, the non-payment of overtime for doctors, nurses and community healthcare workers (CHWs) has been an issue of ongoing concern that needs to be urgently rectified. At Manapo Hospital, a recent fact-finding mission found that the shortage of cleaners is leading to poor cleanliness and a lack of hygiene, putting patients at risk of infections.

Another lingering issue is the reinstatement of CHWs in the province. There remains a black mark against the department for its shameful handling of the protests by a group of CHWs. The so-called #BopheloHouse94 – a group of mostly elderly women – were arrested, prosecuted and convicted after taking part in a peaceful night vigil in June 2014 to protest their unfair dismissal by former MEC of Health Benny Malakoane. Their convictions were eventually overturned on appeal in 2016, in the Bloemfontein High Court – setting an important legal precedent regarding the right to protest. However, the plight of the CHWs remains an ongoing concern.

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 6 756 in total in Free State. In 2016 there were 1 637 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 Free State needing 75% more CHWs in post in order to meet the target.

Further issues regarding different CHWs being paid different amounts in the province – and the possibility of more contracts ending in May 2018 – also remain.

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
Fezile Dabi District Municipality	840	323	517	61,55%
Lejweleputswa District Municipality	1 114	271	843	75,67%
Mangaung Metropolitan Municipality	1 319	323	996	75,51%
Thabo Mofutsanyane District Municipality	1 319	526	793	60,13%
Xhariep District Municipality	2 164	194	1 970	91,04%
Free State	6 756	1637	5 119	75,77%

Our demands:

a. We demand the release of the provinces Human Resources for Health (HRH) plan before end June 2018. This plan should include a comprehensive list of current vacancies.
b. We demand that all vacant posts be filled in the next financial year and that the employment of nurses and doctors is prioritised in the 2018/19 financial year.
c. 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 5 119 in or before the 2019/20 FY to ensure that there are 1:600 CHWs in the provincial health system.
f. We demand that all CHWs are treated fairly with access to the equipment they need, and employed in a dignified and equal manner.

2. Health facilities in disrepair and equipment broken or unavailable.

Healthcare facilities in the Free State are often in disrepair, at times without running water or proper sanitation, too often with small waiting areas that do not fulfil the needs of the community, without fences or proper security, and toilets that are either dysfunctional or unclean. Furthermore, equipment is often broken or unavailable. The results of TAC Free State's monthly monitoring in March 2018 shows the following in relation to infrastructural issues:

Waiting areas: 53% (20/38) of facilities had enough room in the waiting area and 47% (18/38) did not. Waiting areas in 74% (28/38) of facilities were classified as clean while waiting areas at 26% (10/38) of facilities were classified as not being clean.

Infrastructure & toilets: 66% (25/38) of facilities were rated as being in good condition, 34% (13/38) of facilities were not. Of the 38 facilities, 45% (17/38) of facilities did not have clean functional toilets, and 55% (21/38) of facilities were rated as clean and with toilet paper. 1 facility had no toilet at all.

The following facilities were found to have infrastructure in disrepair: Boithusong Clinic, Bophelong Clinic, Bothaville Clinic, Bronville Clinic, Dinane Clinic, Eva Mota Clinic, Intabazwe Clinic, K. Maile Clinic, Kgothalang Clinic, Kgotsong Clinic, Lusaka Clinic, Meloding Clinic, Rheederspark Clinic, and Tshepong Clinic. Further analysis shows the following at a selection of clinics and hospitals:

PHC facility	
Boithusong Clinic	The structure is too small.
Bongani Hospital	There is poor maintenance of the infrastructure.
Dinane Clinic	The structure is too small. Patients wait outside regardless of the weather conditions.
Intabazwe Clinic	The structure is too small and in disrepair.
Khothalang Clinic	The structure is too small. There is no running water.
Kopanong Clinic	A robbery meant that much of the equipment at this facility such as computers and certain medication is missing.
Manapo Hospital	The hospital infrastructure is in disrepair. Further the ventilation pipe to the surgical theatre is reportedly not functioning, resulting in people's surgeries being delayed.
Meloding Clinic	The structure is too small.
Moroka Hospital	The infrastructure is run down and in disrepair.
Pelonomi Hospital	The infrastructure is in disrepair.
Thusanong Hospital	Poor maintenance of the already old and run-down infrastructure is leaving it in further disrepair.
Tshepong Clinic	Despite being an Ideal Clinic, it has poor infrastructure.

Allegedly, according to one hospital CEO, local clinics borrow equipment from nearby hospitals ahead of OHSC spot checks in order for them to improve their ratings by the agency. This is of particular concern given that Free State clinics already performed extremely poorly in the OHSC report. The accurate reflection would therefore result in even worse performance by the province.

At Pelonomi Hospital, sources claim that there is a general pattern of poor maintenance and of sub-standard equipment being acquired, as reported in Spotlight (TAC and SECTION27's joint publication). This is potentially most harmful in theatre, where sub-standard operating tables and theatre lighting have allegedly been acquired and where new sub-standard and incomplete anaesthetic machines remain unused. In addition, at the end of 2017, the air conditioning in the theatre was not functioning. This is concerning given the anaesthetic risks for patients with overheating during anaesthesia is high and sepsis rates are also then very high.

Manapo Hospital has been in a state of disrepair and dysfunction for many years[4]. A recent fact-finding mission discovered a number of issues related to poor maintenance and a lack of cleanliness and hygiene. The

[4] Nightmare at Manapo Hospital, TAC, 2016. Available here: https://tac.org.za/news/nightmare-at-manapo-hospital/

ventilation system for the entire hospital is not functioning, this is affecting the enclosed areas of the hospital worst such as the intensive care unit and the surgical theatres. This has resulted in a number of surgeries being cancelled. The lights in the toilets in the maternity ward have not been working for three years, putting pregnant women and new mothers at risk, relieving themselves in darkness. There is no clean linen in the maternity ward and women are being asked if they are willing to lie on dirty beds. The lifts in the hospital were not working on our last fact-finding mission, forcing patients, staff and visitors to use the stairs. During this visit, we watched four patients on crutches struggle down and up the stairs.

Our demands:

a. We demand an urgent, fully-funded, plan to address infrastructural issues at the facilities identified above. We demand to see this plan before the end of June 2018. We expect the MEC and the Premier to make this a priority and to ensure the funds are made available.
b. In line with the recommendations made by the South African Human Right Commission (SAHRC) in 2007[5], and the People's Commission of Inquiry into the Free State Healthcare System in 2016[6], the 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 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. Emergency medical services in shambles

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

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

The province is facing the ongoing issue of the use of the private ambulance company Buthelezi EMS, despite the tender granted to the company being irregular, a pattern of overcharging for services emerging, and the services being slammed for their dysfunctionality and ineffectiveness. Doctors and nurses in the Free State have accused Buthelezi EMS of operating like a minibus taxi. They accuse the company of providing limited medical support and expertise during transport, leaving the desperately sick and injured, including babies, unassisted and putting people's lives at risk[7].

In a recent Spotlight expose[8], health workers revealed a litany of failures, some life threatening, with common complaints extreme waiting times of up to six hours (even when patients, often babies, are critical), overcrowded ambulances (sometimes transporting as many as five patients at a time, while billing for five

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[5] "Public Inquiry: Access to Health Care Services", South African Human Rights Commission, 2007. Available here: http://www.sahrc.org.za/home/21/fles/Health%20Report.pdf

[6] People's Commission of Inquiry into the Free State Health Crisis, October 2015: "Free State in Chains". Available at: https://tac.org.za/files/free20state20in20chains20-20report20of20peoples20commission20of20inquiry.pdf

[7] Spotlight, April 2018: "Buthelezi Ambulance running a taxi service, not an ambulance service". Available at: https://www.spotlightnsp.co.za/2018/04/23/health4sale-part-4-buthelezi-ems-running-taxi-service-not-ambulance-service-doctors-nurses/

[8] Spotlight, April 2018: "Controversial private ambulance company in line for new tender". Available at: https://www.spotlightnsp.co.za/2018/04/24/health4sale-part-5-controversial-private-ambulance-company-line-new-free-state-tender/

different trips), ambulances waiting to fill up before transporting even very sick patients between facilities, poor staff attitudes, poorly equipped staff on the ambulances and in the call centres, call centre staff not understanding standard emergency medical terms as well as not knowing areas well leading to ambulances not finding patients, lack of equipment, extremely poor medical skills, no medical care while patients are in transit and a lack of compassion for patients.

Despite these failings, Buthelezi EMS continues to be paid on a month by month basis by the Free State Department of Health and they are frontrunners to secure a lucrative new three-year tender for Emergency Medical Services in the Free State.

While the National Minister of Health has asked Treasury to investigate the Free State contract – and is not in favour of outsourcing ambulance services to private companies – the Free State Department of Health states that the award of the tender for outsourced ambulance services is going ahead. MEC of Health Komphela previously said he does not want to re-appoint Buthelezi EMS, but he has not given any indication that the new tender will not be awarded[9].

Prior to Buthelezi's arrival, the Free State was doing remarkably well with their government-run inter-facility transfer service. In August 2013 Professor Martiens Schoon reported in the South African Medical Journal[10] that maternal mortality in the province decreased from 279/100 000 live births during 2011 to 152/100 000 live births during 2012. The improvement was mainly ascribed to the department procuring 48 new vehicles (18 dedicated to maternity care) and the use of these vehicles to transport women with pregnancy complications. For a while, this state-run programme was held up as an example for other provinces.

However, since 2013 when the province outsourced its inter-facility transfer ambulance service to Buthelezi EMS, and scaled down its own capacity building efforts in relation to EMS, this has all changed. Instead there is ballooning expenditure and a decline in the quality of services.

In February 2018, the Free State Department of Health stated that the department had paid a total of R613-million to Buthelezi EMS since the 2013/2014 financial year, with substantial year on year increases[11]. Internal Free State government figures, exposed by Spotlight, indicate extreme overspending on the province's emergency medical services budget:

- In 2015/2016 the department spent R152 million on EMS, overspending their budget by R88 million.
- In 2016/2017 the department spent R163 million on EMS, overspending their budget by R86 million.
- By the time the figures were generated, the EMS expenditure for the 2017/2018 financial year up to that point was R161, already overspending the budget by R117 million.

In terms of absolute numbers, according to the Department of Health's standards there should be 1 ambulance to 10,000 people. In a population of more than 4 million that amounts to the minimum of 405 ambulances as outlined below.

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[9] Spotlight, April 2018: "Motsoaledi asks treasury to investigate Buthelezi EMS". Available at: https://www.spotlightnsp.co.za/2018/04/20/health4sale-motsoaledi-asks-treasury-investigate-buthelezi-ems/

[10] South African Medical Journal. "Impact of inter-facility transport on maternal mortality in the Free State Province". Available at: http://www.samj.org.za/index.php/samj/article/view/6828/5286

[11] *Spotlight* reports that the breakdown given was as follows:

- 2013/2014 R4 million
- 2014/2015 R99 million
- 2015/2016 R159 million
- 2016/2017 R204 million
- 2017/2018 R147 million (Not yet full-year figures)

District	Population (2018 estimates Stats SA)	# of ambulances required at 1:10 000
Fezile Dabi District Municipality	504 058	50
Lejweleputswa District Municipality	668 413	67
Mangaung Metropolitan Municipality	791 490	79
Thabo Mofutsanyane District Municipality	791 490	79
Xhariep District Municipality	1 298 412	130
Free State	4 053 863	405

Our demands:

a. We demand at least 405 functional ambulances be in service in the province in order to meet the national norm of 1 ambulance to 10 000 – this should be seen as a minimum. These must be an insourced, and run through a state programme.
b. We demand the provincial Department of Health reviews its Planned Patient Transport programme to ensure that patients have access to transport to and from health facilities to prevent unnecessary out-of-pocket payments. This will also help to strengthen service at the district level and ensure the referral system between facilities is accessible to patients thereby effectively operationalising the primary healthcare approach.
c. We demand the provincial Department of Health takes the necessary steps to address the shortage in emergency medical personnel by filling all vacant posts.
d. We demand that all EMS personnel must be sufficiently trained to ensure they have good medical skills, provide quality medical care while patients are in transit, are compassionate to patients and have good attitudes, understand emergency medical terminology, understand the locations of the province to ensure ambulances can find patients easily – especially those in rural settings.
e. We demand that ambulances are not over filled in order to ensure timely delivery of patients to health facilities in a dignified manner.
f. We demand that the current tender process underway is not awarded to controversial private company Buthelezi EMS or any other private company, and instead the provincial department insources EMS services as per national policy and guidance from the Minister of Health.

4. Long waiting lists leading to crisis in orthopaedic services

At the end of last year Spotlight reported patients with broken legs, arms and other serious orthopaedic conditions being sent home because the provincial health system was unable to cope with the numbers[12]. More than 40 patients were sent home without being operated on, despite assurances that their surgeries were imminent. The domino effect of long waiting lists for orthopaedic services is further complications, septic bed sores for the elderly, children left disabled and adults losing their jobs.

According to the department, in December 2017 the orthopaedic backlog in Pelanomi Hospital alone stood at 72 hospitalised patients and 110 patients outside the hospital. However, the situation is reportedly much worse. On average 1 200 patients are admitted per month to the hospital[13]. Whistleblowers explained that Pelonomi is facing increasing pressure as peripheral hospitals no longer have skilled specialists to do orthopaedic surgeries. Further, the hospital is also taking in referrals from the Northern Cape and Lesotho. Sources allege that the hospital CEO, Ms Ramadula (a nursing sister) is not disclosing the current state of affairs to the provincial government for fear of reprisals. While some temporary locums have been brought in to address the backlog, we need a permanent solution to ensure that people are able to access these services in a timely manner and not cause further health issues.

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12 Spotlight, December 2017: "Orthopaedic nightmare in Free State". Available at: https://www.spotlightnsp.co.za/2017/12/01/orthopaedic-nightmare-free-state/

13 Spotlight, December 2017: "Deepening crisis at Pelonomi Hospital". Available at: https://www.spotlightnsp.co.za/2017/12/15/deepening-crisis-pelonomi-hospital/

At the same time as facing this orthopaedic backlog, last year millions were spent on a dodgy, illegal stem cell practice in the Pelonomi orthopaedics department. In 2016, Spotlight exposed an illegal stem cell experimental treatment that was being provided at Pelonomi Hospital, a state hospital in Bloemfontein[14]. The issue was also investigated by Carte Blanche who produced an insert[15]. Shortly after SECTION27 and TAC brought details of the Regenesis project to the attention of the national Director-General of Health Precious Matsoso, the Medicines Control Council (MCC) suspended the unlawful stem cell experimentation at Pelonomi. At the same time the Free State Department of Health cancelled its contract with the stem cell company, ReGenesis Biotechnologies which initially was set to add up to R30-million per year and R90-million over the three years of the contract.

However, it shows us that the provincial Department of Health was willing to spend millions on this illegal research, but not spend a fraction of that on improving orthopaedic services.

Our demands:

a. By end June 2018, we demand a plan to ensure that there is sufficient full-time capacity for orthopaedic surgeries in the province and that those people must have the right quality equipment to be able to carry this out.

5. HIV and TB response falling short

Free State continues to face major HIV and TB epidemics – Thabo Mofutsanyane faces a high HIV burden, Mangaung Metro faces a high TB burden, and Lejweleputswa faces a high dual burden of both HIV and TB[16].

According to the Thembisa model, in mid 2016, HIV prevalence across all ages in the province was at 12.6% (364 000 people). In 15 – 49 year olds this increased to 19.7%. There were 14 000 new HIV infections between mid 2015 to mid 2016. HIV related deaths mid 2015 to mid 2016 were at 4 900.

ART coverage in the province in mid 2016 was at 59.9%. Based on these figures nearly 146 000 people in the Free State who could benefit from treatment, are not on it. Of those on treatment 80.1% were virally suppressed[17]. 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 had dropped slightly to 58.65%. This is significantly far from the 81% ART coverage that the NSP is aiming for in 2020 (90% of all people with an HIV diagnosis receiving ART).

District	Population (2018 estimates Stats SA)	Total population (District Health Barometer)	Total PLHIV (District Health Barometer)	HIV prevalence (%) (DHB)	Total on ART 2015 (DHB)	Total on ART 2017 (DHB)	% increase in ART coverage	People currently receiving ART 2017 (PEPFAR based figures 2018)	ART coverage by DHB figures	ART coverage by PEPFAR figures
Fezile Dabi	504 058	494 778	53 436	10.8	27 355	35 007	28.0	n/a	65,51%	n/a
Lejweleputswa	668 413	646 920	102 689	15.9	44 841	52 136	16.3	52 035	50,77%	50,67%
Mangaung	791 490	787 803	80 226	10.2	41 080	46 342	12.8	n/a	57,76%	n/a

14 Spotlight, October 2016: "Illegal experiment scandal rocks Free State health". Available here: https://www.spotlightnsp.co.za/2016/10/02/illegal-experiment-scandal-rocks-free-state-health/

15 Carte Blanche. Available here: https://vimeo.com/198302755

16 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

17 Thembisa Model. Available at: https://www.thembisa.org/content/downloadPage/Provinces2017

Thabo Mofutsanyane	791 490	779 328	114 722	14.7	45 870	68 322	48.9	74 135	59,55%	64,62%
Xhariep	1 298 412	125 883	14 063	11.2	9 731	12 344	26.9	n/a	87,78%	n/a

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

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

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

Adherence clubs: Adherence clubs are a way for people living with HIV and adhering properly to treatment, to collect their ARVs outside of their local clinic. Instead they join an adherence club where they can collect their medication and join discussions about issues of treatment adherence. This is a much friendlier, simpler and quicker system than waiting in long clinic queues. Not only do the clubs promote better adherence but they also relieve the burden on health facilities that are already stretched to capacity. Given the increasing uptake of HIV treatment through "test and treat" this burden will only grow. While the adherence club model has been piloted in Thabo Mofutsanyane, the clubs are not functional. Clubs must be fully functional and 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 rural communities where people have to walk several kilometres to collect HIV treatment. The province should implement at least one fast track individual ART refill collection system and at least one group simplified model of care in every clinic.

In terms of TB, the National Strategic Plan for HIV, TB and STIs 2017–2022 aims to ensure that by 2020 treatment success is achieved for least 90% of all people diagnosed with TB. Currently in Free State, the death rate was above the national average at 10.5%, with one district, Fezile Dabi, reporting a death rate of 15.4%. The provincial department must identify which TB patients are dying and investigate why. Targeted interventions to address these issues must then be developed and implemented.

In terms of TB loss to follow up, addressing the loss to follow up rate will require an aggressive active case finding and contact tracing campaign linked to the government CHW programme. The XPRES study concluded that active tracing and intensified case finding by healthcare workers should be scaled-up. The study found that it was human resources rather than diagnostics that seemed to make the difference in reducing TB mortality. The study suggested that outreach to identify TB and to improve retention in care are more important than diagnostics like Gene Xpert in reducing the risk of death after starting antiretroviral treatment[18].

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.

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

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

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

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

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

6. Poor TB infection control at 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[19]. The rate of new cases of active TB in South Africa remains extremely high at around 438 000 in 2016[20]. 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[21].

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 Free State assessed the state of TB infection control in 34 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?

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19 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

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

21 Ibid

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 34 facilities assessed in March 2018, 31 were found to be in a "RED" state with very poor infection control measures in place. 3 were found to be in an "ORANGE" state, and none were found to be in a "GREEN" state with good TB infection control measures in place. Worryingly the Free State achieved the worst results of TAC's survey with the highest number of RED facilities. If we wish to make progress against TB, GREEN ratings should be the norm in the public healthcare system, instead they are non-existent.

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 34 facilities did not have posters), and the size and space of the waiting rooms (16 out of 34 facilities did not have enough room).

The ugly: Facilities surveyed performed extremely poorly in terms of the length of waiting times (33 out of 34 facilities did not see people within 30 minutes), screening for TB symptoms (23 out of 34 facilities did not screen), separating those who were coughing a lot from those who were not coughing (32 out of 34 facilities did not separate people), and in offering tissues or masks to people who cough a lot (28 out of 34 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 Free State, 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 Free State health system, where overstretched nurses at understaffed clinics lack the capacity and resources to engage effectively in TB infection control measures.

TAC
TREATMENT ACTION CAMPAIGN

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
A.M. Kruger Clinic	Yes	No	Yes	Yes	No	No	No	4	RED
Allanridge Clinic	No	No	Yes	Yes	No	No	No	5	RED
Batho Clinic	Yes	No	Yes	Yes	Yes	No	No	3	RED
Bloemspruit Clinic	No	No	Yes	Yes	No	No	No	5	RED
Bluegumbush Clinic	Yes	No	Yes	Yes	Yes	No	No	3	RED
Boithusong Clinic	Yes	No	Yes	Yes	No	No	No	4	RED
Bophelong Clinic	No	No	Yes	Yes	No	No	No	5	RED
Bothaville Clinic	No	Yes	No	Yes	No	No	No	5	RED
Bronville Clinic	Yes	No	Yes	Yes	Yes	No	No	3	RED
Dinane Clinic	No	No	Yes	Yes	Yes	No	No	4	RED
Eva Mota Clinic	Yes	No	Yes	Yes	No	No	No	4	RED
Gaolenngwe Clinic	Yes	No	Yes	Yes	Yes	No	Yes	2	ORANGE
Intabazwe Clinic	No	No	Yes	Yes	Yes	No	Yes	3	RED
K. Maile Clinic	No	No	Yes	Yes	No	No	No	5	RED
Kgothalang Clinic	No	No	Yes	No	No	No	No	6	RED
Kgotsong Clinic	No	No	Yes	Yes	No	No	No	5	RED
Kopanong Clinic	Yes	No	Yes	Yes	No	No	Yes	3	RED
Leratong Clinic	No	No	Yes	Yes	No	No	No	5	RED
Mafani Clinic	No	No	Yes	Yes	Yes	No	Yes	3	RED
Malesaoana Clinic	Yes	No	Yes	Yes	No	No	No	4	RED
Meloding Clinic	No	No	Yes	No	No	No	No	6	RED
Monontsha Clinic	Yes	No	Yes	Yes	No	No	No	4	RED
Mphohadi Clinic	Yes	No	Yes	Yes	Yes	No	No	3	RED
Nthabiseng Clinic	Yes	No	Yes	Yes	No	No	No	4	RED
OR Tambo Clinic	Yes	No	Yes	No	No	No	No	5	RED
Petsana Clinic	Yes	No	Yes	Yes	Yes	Yes	Yes	1	ORANGE
Phedisanang Clinic	Yes	No	Yes	Yes	No	No	No	4	RED
Phomolong Clinic	Yes	No	Yes	Yes	Yes	Yes	Yes	1	ORANGE
Rheederspark Clinic	No	No	Yes	No	No	No	No	6	RED
Sedibeng SA Bophelo Clinic	No	No	Yes	Yes	No	No	No	5	RED
Steynsrus Clinic	No	No	Yes	Yes	No	No	No	5	RED
Thaba Nchu Clinic	Yes	No	Yes	Yes	Yes	No	No	3	RED
Tshepong Clinic	No	No	Yes	No	No	No	No	6	RED
Welkom Clinic	Yes	No	Yes	Yes	No	No	No	4	RED

In addition to the primary healthcare facility survey, TAC Free State carried out a snap survey into the state of TB services and infection control at 15 hospitals in the province. While we recognise that many other indicators could have been tracked, these specific questions do reflect on the general state of TB services being provided at the hospitals monitored.

The following questions were asked:

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

Name of Hospital	Is there a TB ward at the hospital?	Does the TB ward have proper ventilation ?	Are there enough beds at the hospital in the TB ward?	Where are the TB patients kept if there is no TB ward?	Are people with DS-TB separated from those with DR-TB?	Are TB and DR-TB medicines available at the hospital? (i.e. no stockouts)	If no, which?	Are TB ward staff protected from contracting TB?	Are masks offered to relatives visiting people with TB?	Do all TB patients complete treatmen t? (i.e. no loss to follow up)	SCORE
Pelonomi Hospital	Yes	No	Yes	n/a	Yes	Yes	n/a	No	Yes	No	3
Thebe District Hospital	No	n/a	n/a	In separate rooms	Yes	Yes	n/a	Yes	Yes	Yes	1
National Hospital	No	n/a	n/a	With all other patients	Yes	Yes	n/a	No	No	?	3
Phekolong Hospital	Yes	Yes	Yes	n/a	Yes	Yes	n/a	Yes	Yes	?	0
Dihlabeng Hospital	No	n/a	n/a	With all other patients	Yes	Yes	n/a	Yes	No	?	2
Photholoha Hospital	No	n/a	n/a	With all other patients	Yes	Yes	n/a	Yes	No	?	2
Bongani Regional Hospital	Yes	Yes	Yes	n/a	Yes	Yes	n/a	Yes	Yes	Yes	0
Kopano Regional Hospital	Yes	Yes	Yes	n/a	Yes	Yes	n/a	Yes	Yes	Yes	0
Thusanong District Hospital	Yes	Yes	Yes	n/a	Yes	Yes	n/a	No	No	No	3
Nala District Hospital	No	n/a	n/a	With all other patients	Yes	Yes	n/a	No	No	No	4
Manapo Hospital	No	n/a	n/a	Mixed in surgical wards	No	Yes	n/a	Yes	No	?	3
Elizabeth Roos District Hospital	No	n/a	n/a	Mixed in surgical wards	No	Yes	n/a	No	No	?	4
Nketoana District Hospital	No	n/a	n/a	TB patients transfered to Dihlabeng Hospital	No	Yes	n/a	Yes	No	?	3
Moroka Hospital	Yes	Yes	Yes	n/a	Yes	No	Rifafour	Yes	No	Yes	2
Botshabelo Hospital	Yes	Yes	Yes	n/a	Yes	No	Raphina, rifafour	Yes	Yes	Yes	1

While not exhaustive of TB related services, this snap survey has shown that all except 2 hospitals (Bongani, Kopano) have failed, or have unknown inidcators, in certain aspects of TB management. Particularly we draw attention to Pelonomi, National, Dihlabeng, Photholoha, Thusanong, Nala, Manapo, Elizabeth Roos, Nketoana, and Moroka Hospital that performed especially poorly. Of the 15 hospitals, 3 were found to have lost patients to follow up, with 7 that were unknown. This is a very worrying picture. People lost to follow up who do not

finish their treatment course can potentially develop resistance to TB treatment, further spread TB to those around them, and ultimately potentially die without being cured.

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

Our demands:

a. We demand that by end June 2018 the provincial Department of Health carries out their own full audit of all public health facilities in the province to assess whether sufficient TB infection control measures are in place. The audit will involve the health department assessing the state of TB infection control at each facility based upon WHO guidelines. After which the Department must develop a plan based upon the infrastructural, human resource or 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 April 2018. Spot-checks should be undertaken to ensure these are utilised effectively.

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

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

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

7. 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 Free State 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 38 clinics surveyed in March 2018, 8 (22%) had no clinic committee, and of those with a clinic committee, few can be said to be functioning.

In addition, TAC Free State also has concerns over SANAC structures at a ward, district and provincial level. Often, these structures do not properly understand their function, HIV and TB issues, or what they are meant to achieve. These AIDS councils are meant to give civil society a way to have a say in South Africa's HIV and TB response. However, in the Free State AIDS councils are sometimes dormant or dysfunctional. AIDS Councils must be functional and responsive to the realities we face in our communities in order to ensure an appropriate HIV and TB response that meets people's needs. AIDS Council meetings should be used to ensure we get an effective response to HIV, TB and STIs in our provinces or districts. In order to be functional, discussions and reflections in these structures should focus on the state of the epidemic in the area, which interventions are working and which are not, and where interventions must be strengthened or modified to improve the response. Sufficient resources should be committed to ensuring the NSP can be implemented at each level. Officials in relevant departments should engage in these structures and be held accountable where failings occur. Currently however, these critical discussions are not occurring in most cases.

Our demands:

a. We demand an audit report of the functionality of clinic committees and hospital boards by end June 2018.
b. We demand that all clinic committees and hospital boards are capacitated on their roles and responsibilities by end June 2018, and that an annual review takes place of the functionality of each structure by the Free State Department of Health.
c. By end June 2018, we demand that all local and district AIDS councils be meeting quarterly, chaired by Mayors/Councilors, and providing space for discussions and reflections on the state of the epidemic in the relevant area.
d. We demand that the PLHIV, sex worker, and LGBTI sectors at all levels are revived by the end of the 2018-19 financial year.

8. Violence and killings of women and LGBTQIA+ community members

TAC Free State is outraged and distressed by the violent killing of Nonki Smous and a long list of other women in the recent past. A report released last year from Stats SA echoes this alarming trend of abuse in our society – stating that one in five women experience physical violence in their lives, rising to one in three for the poorest households.

23 years after the onset of democracy, women and LGBTQIA+ community members in South Africa continue to face disturbing levels of oppression, violence and injustice. The South African Constitution guarantees equality and freedom for all regardless of sex, gender, or sexual orientation – however across the country reports of murder, rape – including spousal rape and the so called 'corrective rape' of lesbians, harassment, domestic violence and sexual violence is worryingly prevalent. The reality of these Constitutional guarantees remains only on paper for the vast majority of women in our country.

Unfortunately, the rape and murder of women is nothing new in South Africa. TAC, the Social Justice Coalition, Sonke Gender Justice, and a number of other organisations have worked over more than a decade to improve the criminal justice system and to change gender norms in society. We recognise that the problem of patriarchy, homophobia and violence against women in our society is complex, deeply entrenched and has no quick solutions. But that is no excuse for inaction. We do not need to reinvent the wheel. We must learn from the important work of the Khayelitsha Commission of Inquiry that has already examined many of these issues[22]. The Free State government must use the recommendations as a template for the province. This must include more equitable distribution of police resources and a commitment to progressive reform of the criminal justice system.

Our demands:

[22] Khayelitsha Commission of Inquiry. Available here: http://www.khayelitshacommission.org.za/images/towards_khaye_docs/Khayelitsha_Commission_Report_WEB_FULL_TEXT_C.pdf

a. Premier Ntombela must show concrete leadership in ensuring meaningful equality for women and LGBTQIA+ people in all spheres of our society including through using the recommendations of the Khayelitsha Commission of Inquiry as a template for implementation in the Free State.
b. All SAPS members must attend a Domestic Violence training course. In addition, they must attend a sensitivity training on LGBTQIA+ issues in order to ensure there is no discrimination or stigma for LGBTQIA people requiring police assistance.

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 Free State remains at code red 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 1 June 2018. After which, the timeframes outlined in the individual demands must be adhered to.

For more information contact:

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Provincial Manager | Mpho Matobaka | mpho@tac.org.za | 072 806 7948
(National enquires) Campaign Manager | Lotti Rutter | lotti.rutter@tac.org.za | 072 225 9675

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

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

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

1c. 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 5,119 in or before the 2019/20 FY to ensure that there are 1:600 CHWs in the provincial health system.

1f. We demand that all CHWs are treated fairly with access to the equipment they need and employed in a dignified and equal manner.

2a. We demand an urgent, fully-funded, plan to address infrastructural issues at the facilities identified above. We demand to see this plan before the end of June 2018. We expect the MEC and the Premier to make this a priority and to ensure the funds are made available.

2b. In line with the recommendations made by the South African Human Right Commission (SAHRC) in 2007[23], and the People's Commission of Inquiry into the Free State Healthcare System in 2016[24], the 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 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. We demand at least 405 functional ambulances be in service in the province in order to meet the national norm of 1 ambulance to 10 000 – this should be seen as a minimum. These must be an insourced, and run through a state programme.

3b. We demand the provincial Department of Health reviews its Planned Patient Transport programme to ensure that patients have access to transport to and from health facilities to prevent unnecessary out-of-pocket payments. This will also help to strengthen service at the district level and ensure the referral system between facilities is accessible to patients thereby effectively operationalising the primary healthcare approach.

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

3d. We demand that all EMS personnel must be sufficiently trained to ensure they have good medical skills, provide quality medical care while patients are in transit, are compassionate to patients and have good attitudes, understand emergency medical terminology, understand the locations of the province to ensure ambulances can find patients easily – especially those in rural settings.

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

3f. We demand that the current tender process underway is not awarded to controversial private company Buthelezi EMS or any other private company, and instead the provincial department insources EMS services as per national policy and guidance from the Minister of Health.

4a. By end June 2018, we demand a plan to ensure that there is sufficient full-time capacity for orthopaedic surgeries in the province and that those people must have the right quality equipment to be able to carry this out.

5a. By end December 2018, 100% of primary health facilities across the province must have differentiated models of care including functional adherence clubs, support groups, and fast track (CCMDD) models of care for people living with HIV linked to all primary health facilities across the province to improve treatment adherence rates in the province.

5b. By June 2018, the Free State 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

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[23] "Public Inquiry: Access to Health Care Services", South African Human Rights Commission, 2007. Available here: http://www.sahrc.org.za/home/21/fles/Health%20Report.pdf

[24] People's Commission of Inquiry into the Free State Health Crisis, October 2015: "Free State in Chains". Available at: https://tac.org.za/files/free20state20in20chains20-20report20of20peoples20commission20of20inquiry.pdf

monitoring of progress and tracking of investments in staff, logistics and supplies clearly documented each month.

5c. By June 2018, the Free State Department of Health must begin a provincial TB awareness, education, and social mobilisation campaign to educate people about HIV and TB and encourage the uptake of HIV and TB services. This must include treatment and prevention literacy information in order to improve TB infection control, reduce risky sexual behaviour, encourage screening and testing for HIV and TB, and encourage treatment initiation. This education, awareness, and social mobilisation campaign must take place both inside public health facilities and outside.

5d. In 2018, and in every year after that, the Free State Department of Health must ensure that every person receiving antiretroviral therapy in the public sector receives at least one viral load test per year. Clinics must be held accountable for offering enhanced adherence support, and following clinical algorithms to switch patients in a timely manner for those with detectable viral loads.

5e. By end 2018, the Free State Department of Health must ensure that all clinics in the province are offering rapid ART initiation and rapid provision of TB treatment to all clinically eligible patients, with treatment start times reduced to under 7 days. In the case of DR-TB, this requires decentralisation of DR-TB care to all primary healthcare facilities in all high-burden districts.

5f. By end 2019, the Free State Department of Health must ensure that all people living with HIV have been screened for TB, and if eligible (they do not have TB and are not on TB treatment) are offered the option of taking TB preventative therapy (isoniazid) in order to reduce the risk of contracting TB.

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

6a. We demand that by end June 2018 the provincial Department of Health carries out their own full audit of all public health facilities in the province to assess whether sufficient TB infection control measures are in place. The audit will involve the health department assessing the state of TB infection control at each facility based upon WHO guidelines. After which the Department must develop a plan based upon the infrastructural, human resource or other challenges found in order to improve TB infection control. The Department must publish the audit results.

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

6c. We demand that by end April 2018 a circular is sent to all facilities to ensure that:

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

6d. Where infrastructural issues mean that public facilities create a TB risk factor (e.g. to small, or poor ventilation), an urgent, fully-funded turnaround strategy must be developed to outline how these challenges will be rectified. The strategy must be released by end of May 2018.

6e. We demand the release of the provinces Human Resources for Health (HRH) plan before end May 2018. This plan should include a comprehensive list of current vacancies. Adequate human resources are essential for addressing long waiting times, and in this instance, the prolonging of exposure to potential TB infection. All facilities that have highlighted a waiting time of more than 30 minutes should be prioritised for additional human resources in this financial year. We expect the MEC and the Premier to make this a priority and to ensure the funds are made available.

7a. We demand an audit report of the functionality of clinic committees and hospital boards by end June 2018.
7b. We demand that all clinic committees and hospital boards are capacitated on their roles and responsibilities by end June 2018, and that an annual review takes place of the functionality of each structure by the Free State Department of Health.

7c. By end June 2018, we demand that all local and district AIDS councils be meeting quarterly, chaired by Mayors/Councilors, and providing space for discussions and reflections on the state of the epidemic in the relevant area.

7d. We demand that the PLHIV, sex worker, and LGBTI sectors at all levels are revived by the end of the 2018-19 financial year.

8a. Premier Ntombela must show concrete leadership in ensuring meaningful equality for women and LGBTQIA+ people in all spheres of our society including through using the recommendations of the Khayelitsha Commission of Inquiry as a template for implementation in the Free State.

8b. All SAPS members must attend a Domestic Violence training course. In addition, they must attend a sensitivity training on LGBTQIA+ issues in order to ensure there is no discrimination or stigma for LGBTQIA people requiring police assistance.