

State of Provincial Healthcare System Spotlight on Limpopo May 2018

Background

The Limpopo health system is plagued with severe staff shortages and a huge loss of experienced senior staff who have been seduced by better pay and working conditions in private hospitals. There are regular reports of theft of medicines, equipment that is aged, missing or broken, and ambulances that are reduced to mortuary vans because they take forever to arrive, if they arrive at all. Facilities are dangerously overcrowded. There are too few doctors and nurses. Inferior filing systems mean people wait an excessive number of hours to be seen, at times with fatal consequences. Ongoing medicine stockouts and shortages persist. Public health buildings are in disrepair, and some lack safe running water. When local clinics prove to be under-resourced, public healthcare users are referred to facilities in bigger towns. For a province where 80% of people live in rural settings, this means travelling long distances, at significant expense, to try to access treatment and care.

According to the provincial health department's budget speech, Limpopo has the lowest expenditure per capita on primary healthcare in South Africa. Worryingly, between the 2015/16 financial year and the 2016/17 financial year, this even spend dropped by 3.8%. It is particularly low in Mopani, Vhembe and Capricorn. In contrast, instead of paying for frontline services, there is high spending on district management in Waterberg, Mopani, and Vhembe.

The reality is that the health system in Limpopo is broken. It is failing hundreds of thousands of the country's most vulnerable people who rely on free healthcare that does not deliver. Each day we hear reports of collapse, pain, indignity, loss, shock and grief. Our peoples' Constitutional right to healthcare is being violated. We have received numerous complaints and reports of systems failure which has dire consequences for patients.

The Treatment Action Campaign (TAC) has been working in Limpopo since early 2000s and continues to represent users of the public healthcare system and campaign on critical issues related to the quality of and access to healthcare. We currently have a network of 24 branches in two districts in the province, Mopani and Vhembe. 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.

Our own monitoring in recent months at facilities across the Mopani and Vhembe districts confirm the extent of the provincial health crisis. In Limpopo, each TAC branch has adopted a primary healthcare facility local to them and have been monitoring the state of services at these facilities since November 2017. The results highlight a number of critical concerns with regard to the state of services at clinics and community healthcare centres. A summary of the results of data collected in March 2018 is provided within our analysis below. The full data set is captured in appendix 1.

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

The data collected by our branches corresponds to the worrying picture of our public healthcare system painted by reports published last year by the OHSC¹. According to the OHSC report, facilities should score at

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

least 80% to claim an acceptable level of care – yet in Limpopo of 59 clinics inspected by the OHSC (not necessarily the same facilities as monitored by TAC) only 3% of the clinics are performing at 50% or above and none above 60%:

# facilities	Rate
0	clinic performed below 20%.
12	clinics performed between 20-29%.
29	clinics performed between 30-39%.
16	clinics performed between 40-49%.
2	clinics performed between 50-59% score.
0	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.

In November 2017, TAC Limpopo marched to the provincial Department of Health in Polokwane to raise our deep concerns over the dysfunction in the health system that is claiming lives, leading to widespread suffering, and means the dignity of poor people is being trampled upon every day. A memorandum was issued to MEC Phophi Ramathuba^{2 3}, yet to date we still await a written response on our demands.

While we initially welcomed the appointment of MEC Ramathuba⁴ – especially for her open approach and serious engagement with activists⁵ – more recently, her empty promises and foot dragging make it seem as if she is becoming indifferent to the suffering of poor people.

This report reiterates our concerns and outlines a set of detailed demands. The MEC of Health, Premier and provincial health department must take this seriously. We request a written response on these issues by 15 June 2018. If the MEC does not take our demands seriously, we will be back to the provincial Department of Health in our numbers. The province has a long way to go and it is critical for all parties to work together to improve the situation. It is time for the Department of Health to deliver on its Constitutional mandate, or face the consequences.

Key concerns and demands

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

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

² TAC memorandum to MEC Ramathuba, November 2017. Available at: <https://tac.org.za/files/Limpopo-report-and-full-memorandum-2-November-2017-FINAL.pdf>

³ TAC statement, November 2017. Available at: <https://tac.org.za/news/detailed-report-on-state-of-limpopo-health-system/>

⁴ Spotlight, September 2017: “Spotlight on Health MECs”. Available at: <https://www.spotlightnsp.co.za/2017/09/20/spotlight-health-mecs-phophi-ramathuba/>

⁵ TAC, September 2015: “TAC Limpopo salutes MEC of Health Ramathuba”. Available at: <https://tac.org.za/news/treatment-action-campaign-tac-in-limpopo-salute-mec-of-health-ramathuba/>

However, instead of filling vacant posts and ensuring that there are enough people to properly deliver our healthcare, posts are being frozen in many areas. While many doctors and nurses remain unemployed, there are not enough open positions to employ them. The problem is only exacerbated for rural communities who struggle to attract specialists and senior doctors. According to the National Department of Health, there are currently over 44 000 funded posts in Limpopo. Of these only 35 450 are filled leaving almost 10 000 vacant posts in the province. This translates into almost 25% of the workforce.

Human resource shortages cause long waiting times, patients being turned away from facilities, longer hospital stays, higher risk of deaths, and increased pressure on the few staff in place. The overburdening of staff is a major contributor to the worsening of staff attitudes. One of the major causes of medicine stockouts and shortages are a result of staff being too busy to place orders in time. The result of all of this is that patients do not access quality healthcare services as required by the Constitution.

In addition, there are reported challenges with the Cuban doctor programme that runs into millions. Cuban doctors are firmly entrenched in Limpopo – this, even as their inability to understand local languages and local conditions is a cause of deep frustration for local patients⁶.

We recognise that since our November meeting with the provincial Department of Health, a number of vacancies have been advertised including 1071 ward attendants, 23 cleaners and 368 grounds men. However, as of yet the department has not shared the Human Resources for Health strategy to outline the turnaround plan to deal with personal gaps with TAC Limpopo as previously requested.

Long waiting times due to a shortage of staff to adequately deliver healthcare was the most prominent issue found in a fact-finding mission in several hospitals in the province in November. On subsequent investigations at these hospitals up until this month the same challenges were documented:

- In Malamulele Hospital people queued that day from 5.30am. Security began at 7am. Within the Hospital around 200 people were waiting to be attended by two doctors;
- In Tshilidzini Hospital around 75 patients were waiting for files. Those we spoke to had been waiting for files for over five hours. Once files were found patients entered the next phase of waiting to be attended to;
- In Elim Hospital patients waited for files for around 5 hours. After collecting files, they entered the queue to be attended to. In a corridor around 100 metres long, patients filled the entire hall waiting to be seen. One man had been admitted six hours prior but still remained on a trolley in the corridor.
- In Nkhensani Hospital, patients had been queuing since 5am. While they had received files, they were still waiting for a doctor to arrive at 10am.
- In Van Velden Hospital patients had been waiting more than five hours to be seen. They sat patiently whilst the doctors went on lunchbreak.

According to the South African Medical Association (SAMA) in the province:

- Pietersburg Hospital continues to exist with only one operating theatre on weekends, public holidays and afterhours due to understaffing of nursing personnel in the hospital. This has resulted in patients not being operated timeously and ultimately resulting in morbidity and in worst-case scenarios, mortality.
- Nkhensani Hospital continues to struggle without both a Senior Clinical Manager and a Chief Executive Officer, leaving the hospital rudderless.
- Medical practitioners continue to go beyond their contractual overtime without compensation in hospitals such as W.F Knobel, Seshego, Nkhensani and Donald Frazer. This leads to frustrations within the workforce and manifests in a worsening of staff attitudes – ultimately affecting patients seeking services.

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

⁶ Spotlight, October 2017: "Building health infrastructure and brand Phophi". Available at: <https://www.spotlightnsp.co.za/wp-content/uploads/2017/10/spotlight-3-v2.pdf>

Staffing: 22.6% (7/31) of facilities were classified as not having enough staff and 77.4% (24/31) facilities as having enough. At the very least, this finding shows that people in a number of facilities dependent on the public healthcare system perceive them as being understaffed. This is an improvement from our November survey following the rotation of nurses out of Polokwane Hospital and into primary healthcare facilities. TAC Limpopo will continue to monitor the situation.

Staff attitudes: At 83.9% of facilities (26/31) staff were generally considered to be friendly, at 6.5% (2/31) staff were classified as sometimes friendly, and at 9.7% (3/31) staff were generally considered not to be friendly. While mainly positive, bad staff attitudes – witnessed in all cadres in the health workforce – affect patients’ ability to access healthcare in those facilities.

Waiting times: Our survey found that at 41.9% (13/31) of facilities people had to wait for more than an hour to be seen and at 3.2% (1/31) of facilities the wait was more than two hours which is hugely disruptive for people. Though generally poor, waiting times were variable. At 48.4% (15/31) of facilities the waiting time was between 30 to 60 minutes. 6.5% (2/31) of facilities saw people in less than 30 minutes.

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.

2. Dire state of emergency medical services

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

In terms of absolute numbers, there is a major shortage of ambulances in service in the province. According to the Department of Health’s standards there should be 1 ambulance to 10,000 people. In a population of nearly 6 million that amounts to the minimum of 595 ambulances as outlined below.

District	Population (2018 estimates Stats SA)	# of ambulances required at 1:10 000
Capricorn District Municipality	1 335 951	134
Mopani District Municipality	1 222 202	122
Sekhukhune District Municipality	1 229 286	123
Vhembe District Municipality	1 451 836	145

Waterberg District Municipality	712 724	71
Limpopo	5 951 999	595

While the department has purchased over 250 EMS vehicles with the aim of curbing gaps in service provision of emergency medical services, this is not enough to ensure sufficient service delivery. In addition, these services are poorly managed. Many EMS personnel are not fully qualified, possessing only a Basic Ambulance assistance certificate. Out of the total 2024 EMS personnel, only 26 are advanced life supporters, and 1200 are only basic ambulance assistants.

In addition, our understanding is that the Limpopo Department of Health is acting in contravention of Supreme Court of Appeal judgment from 10 November 2017, which ordered the reinstatement of the South African Red Cross Air Mercy Service (AMS) as per the national tender. The province’s refusal to abide by this judgment is highly suspicious. We are also reliably informed that a political decision has been taken in the province that one of Mr. Buthelezi’s companies (including Buthelezi EMS CC, Buthelezi EMS (PTY) LTD, B EMS CC, Buthelezi HEMS CC, Buthelezi Helicopter EMS (PTY) LTD, Buthelezi One Stop Emergency Medical Services CC) must be paid.

Our demands:

- a. We demand at least 595 functional ambulances be in service in the province in order to meet the national norm of 1 ambulance to 10 000 – this should be seen as a minimum.
- b. We demand the provincial Department of Health reviews its Planned Patient Transport programme to ensure that patients have access to transport to and from health facilities to prevent unnecessary out-of-pocket payments. This will also help to strengthen service at the district level and ensure the referral system between facilities is accessible to patients thereby effectively operationalising the primary health care approach.
- c. We demand the provincial Department of Health takes the necessary steps to address the shortage in emergency medical personnel by filling all vacant posts.
- d. We demand that all EMS personnel must be sufficiently trained to ensure they have good medical skills, provide quality medical care while patients are in transit, are compassionate to patients and have good attitudes, 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 an independent forensic investigation into all contracts between the Limpopo Department of Health and Buthelezi companies (Buthelezi EMS CC, Buthelezi EMS (PTY) LTD, B EMS CC, Buthelezi HEMS CC, Buthelezi Helicopter EMS (PTY) LTD, Buthelezi One Stop Emergency Medical Services CC).

3. Broken, aged and inadequate infrastructure and equipment

Health facilities infrastructure in Limpopo is often aged and run down, dysfunctional or unsuitable to the needs of patients. Most of the facilities outside the NHI pilot district area were built many years ago with little renovation since. Certain facilities are facing ongoing water shortages which affect the functionality of the facility.

The following 17 facilities are noted as needing urgent renovation. These structures are either aged, broken, or too small to ensure quality healthcare services: Mapayeni Clinic, Thomo Clinic, Vyeboom Clinic, Khakhala Hlomela Clinic, Nkuri Clinic, Dzumeri Health Centre, Zava Clinic, Hlaneki Clinic, Malamulele Hospital, Manavela Clinic, Tshimo Clinic, Tshimbupfe Clinic, Davana Clinic, Tshilidzini Hospital, CN Mpathudi Hospital, Dan Clinic, and Elim Hospital.

While there has been some progress, there continues to be no adequate waiting area for visitors at Tshilidzini and Nkhensani Hospitals. People wait in the open in the grounds for visiting hours to begin, which is especially problematic in winter months.

According to the South African Medical Association (SAMA) in the province:

- The procurement of basic equipment (i.e. Casualty ventilators, ABG machines, anaesthetic machines & many others) moves at a slow pace which leads to rising morbidity and mortality from preventable conditions in regional hospitals. In addition, regional hospitals continue to exist without functional high care units.
- Tshilidzini hospital, which takes care of the whole of Vhembe district has to function with no high care and an ICU that has only four beds.
- While new equipment has been delivered at both Pietersburg and Mankweng Hospital, more must be done to prevent morbidity and mortality.

Waiting areas: 90.3% (28/31) of facilities had enough room in the waiting area and 9.7% (3/31) did not. Waiting areas in 87.1% (27/31) of facilities were classified as clean while waiting areas at 12.9% (4/31) of facilities were classified as not being clean.

Toilets: Of the 31 facilities, 64.5% (20/31) of facilities did not have clean functional toilets, and 35.5% (11/31) of facilities were rated as clean and with toilet paper.

There is R500 million in the conditional grant, and a further R143 million in the budget, to ensure revitalisation of infrastructure.

In terms of equipment, while the department has reportedly recently spent ZAR 12 million on equipment for primary healthcare facilities and a further ZAR 28 million for upgrading equipment at district and regional hospitals, TAC Limpopo continues to monitor the situation as this improvement has not yet been felt in many of the facilities we work with.

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 spent effectively.
- b. 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.

4. Red alert on provincial HIV and TB response

Limpopo continues to face major HIV and TB epidemics – Capricorn and Mopani face a high HIV burden, and Sekhukhune and Waterberg face a high TB burden⁷. According to the Thembisa model, in mid 2016, HIV prevalence across all ages in the province was at 8.0% (445 000 people). In 15 – 49 year olds this increased to 13.2%. There were 18 000 new HIV infections between mid 2015 to mid 2016. HIV related deaths mid 2015 to mid 2016 were at 4 800.

ART coverage in the province in mid 2016 was at 60.5%. Based on these figures nearly 175 775 people in Limpopo who could benefit from treatment, are not on it. Of those on treatment 67.5% were virally suppressed⁸. 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). According to the department currently 319 174

⁷ 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

⁸ Thembisa Model. Available at: <https://www.thembisa.org/content/downloadPage/Provinces2017>

people are currently on treatment in the province, even by these figures more than 125 000 people are still not on treatment.

This table below outlines the number of people living with HIV per district, and the ART coverage based on figures from both the District Health Barometer and PEPFAR (where they work in the province). By these figures, the total ART coverage in 2017 was 68.62%. 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 districts 2018)	ART coverage by DHB figures	ART coverage by PEPFAR figures
Capricorn	1 335 951	1 330 436	107 728	8.1	44 194	64 432	45.8	70 376	59,81%	65,33%
Mopani	1 222 202	1 159 188	114 449	9.9	67 908	80 829	19.0	86 265	70,62%	75,37%
Sekhukhune	1 229 286	1 169 761	81 708	7.0	40 629	55 014	35.4	n/a	67,33%	n/a
Vhembe	1 451 836	1 393 952	74 704	5.4	47 188	59 800	26.7	n/a	80,05%	n/a
Waterberg	712 724	745 758	66 508	8.9	32 587	45 346	39.2	n/a	68,18%	n/a
Limpopo	5 951 999	5 799 095	445 097	7,7	232 506	305 421	31.4	156 641	68,62%	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 Vhembe as part of NHI, this must be urgently rolled out to all other districts to ensure maximum impact. TAC Limpopo has been requesting an audit report into the rollout of NHI (which would include the functionality of the adherence clubs) for many months, yet no report has been provided that would outline the impact of the clubs.

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

In April 2018, the MEC publicly stated her intention to shut down HIV and TB treatment and care services at the Ndlovu Care Group. Community members were dismayed at this decision, some had been collecting medicines and receiving support there for a number of years. The MEC intends to absorb these people into the public healthcare system instead. It is reported that there is no operational plan on how to transfer the 3 700 people. To transfer patients in such a rushed manner, without an adequate handover plan, is irresponsible. It does not put patients' rights and health first. The question also remains whether the public health system will be able to provide the same quality of services as at Ndlovu Care Group in the long term. TAC Limpopo will continue to monitor this situation. The rights and lives of people living with HIV and TB cannot be put in jeopardy.

In terms of TB, the province continues to face a shortage of money to address the scale of the challenge in the province. The death rate of people with drug sensitive TB (11.9%) and drug resistant TB (16.4%) remains higher than targets of 5% and 12% respectively. The provincial department needs to investigate the reasons for the high death rates and develop interventions to address this. In terms of addressing the loss to follow up rate, this will require an aggressive active case finding and contact tracing campaign linked to the government CHW programme. In Limpopo, according to the District Health Barometer, the loss to follow up rate was at 6.1%, above the national target of 5.4%. The XPRES study concluded that active tracing and intensified case finding by healthcare workers should be scaled-up to reduce loss to follow up rates. 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 treatment⁹. While we know the department has expanded the number of DR-TB decentralised sites, much more needs to be done to address the current loss to follow up rate.

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 Limpopo Department of Health must launch an aggressive, and fully funded, TB contact tracing and active-case-finding campaign. This campaign must be linked to 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 Limpopo 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 Limpopo 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 Limpopo 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.

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

- f. By end 2019, the Limpopo 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 Limpopo Department of Health must investigate why a significant number of people in the province are dying while on TB and DR-TB treatment. A set of targeted interventions based on this evidence must be developed to address the death rate that is far higher than national targets.

5. Crisis in TB infection control

TB remains the leading reported cause of death in South Africa with over 33 063 deaths (8.4% of natural deaths) in the country in 2015¹⁰. The rate of new cases of active TB in South Africa remains extremely high at around 438 000 in 2016¹¹. 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 2007¹².

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 Limpopo assessed the state of TB infection control in 31 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 31 facilities assessed in March 2018, 20 were found to be in a “RED” state with very poor infection control measures in place. 11 were found to be in an “ORANGE” state, and none were found to be in a “GREEN” state with good TB infection control measures in place. If we wish to make progress against TB, GREEN ratings should be the norm in the public healthcare system, instead they are non-existent in the facilities surveyed in Limpopo.

The good: Facilities surveyed performed well in terms of ensuring windows were kept open (only 1 out of 31 facilities did not open the windows), and the size and space of the waiting rooms (3 out of 31 facilities did not have enough room).

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 (8 out of 31 facilities did not have posters), screening for TB symptoms (17 out of 31 facilities did not screen), and in offering tissues or masks to people who cough a lot (15 out of 31 facilities did not offer tissues or masks).

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

The ugly: Facilities surveyed performed extremely poorly in terms of the length of waiting times (29 out of 31 facilities failed to see people within 30 minutes), and separating those who were coughing a lot from those who were not coughing (21 out of 31 facilities did not separate people).

The full results in the province are outlined on the following page. While the survey has some limitations, and is by no means an exhaustive survey of facilities in Limpopo, 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 Limpopo 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
Basani Clinic	Yes	No	Yes	Yes	Yes	Yes	Yes	1	ORANGE
Bungeni CHC	Yes	No	Yes	No	No	No	No	5	RED
Dan Clinic	Yes	No	Yes	No	No	No	No	5	RED
Davhana Clinic	Yes	No	Yes	No	No	No	No	5	RED
DR Hugo Nkabinde Clinic	No	No	Yes	Yes	Yes	No	Yes	3	RED
Dzumeri CHC	Yes	No	Yes	Yes	No	No	Yes	3	RED
Giyani CHC	Yes	No	Yes	Yes	Yes	Yes	Yes	1	ORANGE
Hlaneki Clinic	Yes	No	Yes	Yes	Yes	Yes	Yes	1	ORANGE
Khakhala-Hlomela Clinic	Yes	No	Yes	Yes	No	Yes	No	3	RED
Khujwana Clinic	Yes	No	No	Yes	No	No	No	5	RED
Kulani Clinic	Yes	No	Yes	Yes	Yes	Yes	Yes	1	ORANGE
Mapayeni Clinic	Yes	No	Yes	Yes	Yes	Yes	Yes	1	ORANGE
Mariveni Clinic	Yes	No	Yes	Yes	Yes	No	No	3	RED
Marseilles Clinic	Yes	No	Yes	Yes	Yes	Yes	Yes	1	ORANGE
Mohlaba Clinic	Yes	Yes	Yes	No	No	No	Yes	3	RED
Moime Clinic	Yes	No	Yes	Yes	No	No	No	4	RED
Mpheni Clinic	Yes	No	Yes	Yes	Yes	Yes	Yes	1	ORANGE
Grace Mugodeni CHC	Yes	No	Yes	Yes	Yes	No	Yes	2	ORANGE
Mukhomi Clinic	No	No	Yes	No	No	No	No	6	RED
Nkhensani Clinic	Yes	No	Yes	Yes	Yes	Yes	Yes	1	ORANGE
Nkowankowa Clinic	No	No	Yes	Yes	No	No	No	5	RED
Nkuri Clinic	Yes	No	Yes	Yes	Yes	No	Yes	2	ORANGE
Phalaborwa Clinic	Yes	No	Yes	Yes	No	No	No	4	RED
Ratanang Clinic	Yes	No	Yes	Yes	No	No	No	4	RED
Shayandima Clinic	Yes	No	Yes	No	No	No	No	5	RED
Shivulani Clinic	Yes	No	Yes	Yes	No	No	Yes	3	RED
Thomo Clinic	Yes	No	Yes	Yes	No	No	Yes	3	RED
Tlangelani Clinic	Yes	No	Yes	No	No	No	No	5	RED

Vyeboom Clinic	Yes	Yes	Yes	No	No	No	No	4	RED
Waterval Clinic	Yes	No	Yes	Yes	Yes	No	No	3	RED
Nkhensani Gateway Clinic	Yes	No	Yes	Yes	Yes	Yes	Yes	1	ORANGE

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

The following questions were asked:

1. Is there a TB ward at the hospital?
2. Does the TB ward have proper ventilation?
3. Are there enough beds at the hospital in the TB ward?
4. Where are the TB patients kept if there is no TB ward?
5. Are people with DS-TB separated from those with DR-TB?
6. 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)	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
Elim Hospital	Yes	Yes	Yes	n/a	Yes	Yes	Yes	Yes	No	1
Kgapane District Hospital	Yes	Yes	Yes	n/a	Yes	Yes	Yes	No	Yes	1
Malamulele Hospital	Yes	Yes	Yes	n/a	Yes	Yes	Yes	No	No	2
Tshildzini Hospital	Yes	Yes	Yes	n/a	Yes	Yes	Yes	No	Yes	1

While not an exhaustive analysis into the state of TB related services, or hospitals in Limpopo, this snap survey highlights the challenges related to certain aspects of TB management in the province. Half the facilities had lost patients to follow up. This is a very worrying picture. People lost to follow up who do not finish their treatment course can potentially develop resistance to TB treatment, further spread TB to those around them, and ultimately potentially die without being cured. In addition, 3 facilities failed to provide masks to visitors to the ward, creating a further transmission risk.

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

Our demands:

- a. We demand that by end July 2018 the provincial Department of Health carries out their own full audit of all public health facilities in the province to assess whether sufficient TB infection control measures are in place. The audit will involve the health department assessing the state of TB infection control at each facility based upon WHO guidelines. After which the Department must develop a plan based upon the infrastructural, human resource or behavioural challenges found in order to improve TB infection control. The Department must publish the audit results.
- b. We demand that masks and TB posters are distributed to all public health facilities by end June 2018. Spot-checks should be undertaken to ensure these are utilised effectively.
- c. We demand that by end June 2018 a circular is sent to all facilities to ensure that:
 - All windows to be kept open;

- TB infection control posters to be displayed in visible places in the waiting area;
 - Patients to be screened for TB symptoms upon arrival;
 - People coughing or with TB symptoms to be seen first to reduce the risk of transmission;
 - People who are coughing to be separated from those who are not while waiting; and
 - People who cough a lot or who may have TB to be given tissues or TB masks.
- d. Where infrastructural issues mean that public facilities create a TB risk factor (e.g. too 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. Inadequate mental healthcare services that fail the people who need them

In terms of mental health, it is critical that the Limpopo 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 Limpopo, mental health does not receive the recognition and attention it requires.

According to SASOP, Limpopo (together with Eastern Cape) 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. 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.

There are currently three psychiatric hospitals in Limpopo. However, the majority of users of these hospitals are not people with mental illnesses, but rather mostly people with learning and intellectual disabilities. These people should not be in these establishments however there are few other care or support services in the province. There are enormous waiting lists for Pfunanani Special School for children with intellectual disability in Giyani. People with learning disabilities then end up institutionalised in these hospitals forever, despite not needing to be. This is deplorable. Furthermore, where people do get discharged, there is no halfway house to rehabilitate them. They are sent immediately back to their families without support.

Our demands:

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

7. Urgent improvement needed in access to cancer prevention, treatment and care services

In terms of cancer and oncology Limpopo faces a number of challenges. At a TAC dialogue on HPV, complaints were made that women faced extremely long waiting times to get the results of pap smears. Further they complained that nurses at a primary healthcare level lacked understanding on the prevention and diagnosis of cancers – and worse in certain facilities nurses demanded patients to only get pap smears in the mornings as they were not hygienic in the afternoon. In terms of treatment, while Polokwane Hospital provides certain

chemotherapy, other forms of chemotherapy, radiotherapy and certain cancer treatments are not accessible within the province. Oncology patients are transported to Steve Biko Hospital in Pretoria.

In this regard we have the following questions of the Limpopo Department of Health:

- a. Are patients provided with planned patient transport to and from Steve Biko Hospital?
- b. Are patients provided with overnight sleeping facilities in the relevant Limpopo facility before and after transport to Steve Biko Hospital?
- c. Is there sufficient budget for chemotherapy and cancer treatments in the Department's budget? How much is allocated to this?
- d. How many mammography machines are available in the province and in which facilities?
- e. Is there plans to provide training to nurses at a primary healthcare level to ensure better diagnosis of cancers?

8. Dysfunctional accountability structures

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

Section 42 of the National Health Act 61 of 2003 requires provinces to provide for clinic committees and hospital boards and ensure their functioning. However, to our knowledge Limpopo 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 31 clinics surveyed in March 2018, 7 (23%) had no clinic committee, and of those with a clinic committee, only 7 can be said to be functioning.

Many AIDS councils in Limpopo at provincial, district and local levels across the country are not functioning effectively. These structures should be driving the implementation of the NSP as well as monitoring progress, but most often this is not happening. 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. 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 July 2018.
- b. We demand that all clinic committees and hospital boards are capacitated on their roles and responsibilities by end July 2018, and that an annual review takes place of the functionality of each structure by the Limpopo Department of Health.
- c. We demand that all AIDS Councils at local, ward, district and provincial levels meet quarterly in order to provide a space for discussions and reflections 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.

Conclusion

This report highlights the persistent and severe challenges faced by people who try to access free public healthcare in Limpopo. Often these services are dysfunctional and fail those they are meant to serve. We need an urgent turnaround strategy in the province to ensure quality and dignified healthcare for all. The MEC of Health, Premier and provincial health department must take this seriously. It is a Constitutional obligation. If our demands are not taken seriously, we will be forced to escalate our campaign. The province has a long way to go and it is critical for all parties to work together to improve the situation.

TAC will continue to monitor the state of healthcare services 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 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.
- 2a. We demand at least 595 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.
- 2b. We demand the provincial Department of Health reviews its Planned Patient Transport programme to ensure that patients have access to transport to and from health facilities to prevent unnecessary out-of-pocket payments. This will also help to strengthen service at the district level and ensure the referral system between facilities is accessible to patients thereby effectively operationalising the primary health care approach.
- 2c. We demand the provincial Department of Health takes the necessary steps to address the shortage in emergency medical personnel by filling all vacant posts.
- 2d. 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.

2e. We demand an independent forensic investigation into all contracts between the Limpopo Department of Health and Buthelezi companies (Buthelezi EMS CC, Buthelezi EMS (PTY) LTD, B EMS CC, Buthelezi HEMS CC, Buthelezi Helicopter EMS (PTY) LTD, Buthelezi One Stop Emergency Medical Services CC).

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

3b. 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.

3c. 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.

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

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

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

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

4f. By end 2019, the Limpopo 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.

4g. By end July 2018, the Limpopo Department of Health must investigate why a significant number of people in the province are dying while on TB and DR-TB treatment. A set of targeted interventions based on this evidence must be developed to address the death rate that is far higher than national targets.

5a. We demand that by end July 2018 the provincial Department of Health carries out their own full audit of all public health facilities in the province to assess whether sufficient TB infection control measures are in place.

The audit will involve the health department assessing the state of TB infection control at each facility based upon WHO guidelines. After which the Department must develop a plan based upon the infrastructural, human resource or behavioural challenges found in order to improve TB infection control. The Department must publish the audit results.

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

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

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

5d. Where infrastructural issues mean that public facilities create a TB risk factor (e.g. too 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 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.

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

7a. In regard to cancer, we have the following questions of the Limpopo Department of Health:

- a. Are patients provided with planned patient transport to and from Steve Biko Hospital?
- b. Are patients provided with overnight sleeping facilities in the relevant Limpopo facility before and after transport to Steve Biko Hospital?
- c. Is there sufficient budget for chemotherapy and cancer treatments in the Department's budget? How much is allocated to this?
- d. How many mammography machines are available in the province and in which facilities?
- e. Is there plans to provide training to nurses at a primary healthcare level to ensure better diagnosis of cancers?

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

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

8c. We demand that all AIDS Councils at local, ward, district and provincial levels meet quarterly in order to provide a space for discussions and reflections 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.