**4. REPORT OF THE PORTFOLIO COMMITTEE ON HEALTH ON OVERSIGHT VISIT TO MPUMALANGA PROVINCE FROM 22 TO 23 SEPTEMBER 2014, DATED 24 FEBRUARY 2016**

The Portfolio Committee on Health having undertaken an oversight visit to the Mpumalanga Province from 22 to 23 September 2014 report as follows:

1. **Objectives**

One of the functions of the Portfolio Committee on Health is to conduct oversight over the Department of Health and its entities. The Committee conducted its oversight visit in Mpumalanga Province from 22 to 23 September 2014.

The purpose of the visit was to:

* Assess public health services and challenges that the province is facing in delivering these services with specific emphasis on infrastructure, human resources, financial management and procurement.
* Assess Rob Ferreira Hospital’s state of readiness for Ebola Virus Diseases (EVD) cases.

1. **Delegation**

The delegation comprised of the following Members of Parliament:

Ms ML Dunjwa (ANC, Chairperson of the Committee)

Mr AF Mahlalela (ANC)

Dr P Maesela (ANC)

Mr I Mosala (ANC)

Ms CN Ncube-Ndaba (ANC)

Ms MA Scheepers (ANC)

Mr NS Matiase (EFF)

Mr NS ShaikEman (NFP)

Mr SM Jafta (AIC)

The following officials accompanied the delegation:

Ms Vuyokazi Majalamba (Committee Secretary)

Ms Nombali Magubane (Committee Assistant)

Mr Zubair Rahim (Committee Researcher)

Ms Lindokuhle Ngomane (Content Advisor)

1. **Site Visits:**

The Committee visited the following facilities; Rob Ferreira Tertiary Hospital, Nelspruit Community Health Centre, Kanyamazane Clinic and Themba Hospital.

## Rob Ferreira Tertiary Hospital

On the 22nd of September 2014, the Committee conducted its oversight visit at Rob Ferreira Tertiary Hospital. The Committee met the following delegation at the hospital:

Mr G Mashego (Member of the Executive Committee (MEC); Dr AM Morake (Head of Department); Mr H Maluka (Chief of Staff in the Office of the MEC); Ms IS Makwetla (Chief Director: Hospital Services); Ms P Ngobeni (Chairperson of the Provincial Committee on Health); Mr T Mawleng (Member of the Provincial Committee); and Mr Bongi Dlalisa (Acting Chief Executive Officer).

The MEC for Health of Mpumalanga Province delivered his welcoming statement and also gave a background on the health status of the province.

Dr Morake briefed the Committee on the profile and report of Rob Ferreira Hospital. He first outlined the vision of the hospital which aims at having a developed society in which all people of Ehlanzeni have equitable access to quality, humane and integrated health services. The mission is to provide and promote integrated quality health services in partnership with all stakeholders to ensure healthy lifestyles and reduce poverty in all communities of Mpumalanga.

The core values of the hospital are equity, human rights, honesty, dignity, integrity, collective accountability, efficiency and effectiveness and the Batho Pele Principles. The programme purpose of the hospital is to render tertiary health care services and to provide a platform for training of health care workers and to conduct research. The strategic goals are to increase life expectancy, reduce maternal and child mortality, management of HIV, TB, Communicable and Non-Communicable diseases and strengthen health system effectiveness. The strategic priority of the programme, is to overhaul the health care system by improving quality of care including the implementation of National Health Insurance.

The hospital has a total of 301 approved number of beds with 369 active beds, 87.7% bed occupancy and average length of stay of 7.3 days. Services rendered at the hospital are paediatrics, internal medicine, general surgery, orthopaedics, ophthalmology, radiology, obstetrics and gynaecology, neurosurgery, anaesthesia, trauma and critical care, dialysis (outsourced), pharmaceutical services, maxillofacial, urology and mental health.

In terms of staff establishment of the hospital, the Chief Executive Officer’s position was currently vacant. The hospital has a 46% vacancy rate of specialists, with high vacancy rates on allied health professionals such as pharmacists, pharmacy assistants, occupational therapists, optometrists, etc.

The allocated budget for the hospital on the equitable share for 2013/14 is R455 108 million, the expenditure was currently at R224 913 million (49%) of the available budget. With regard to the National Tertiary Services Grant, the hospital received R48 558 million and have spent R12 887 million (27%) of the allocation.

The following challenges the hospital faces were highlighted:

* High staff turnover on all categories of nursing.
* Turnaround time in supply chain management.
* Dialysis services and MRI (magnetic resonance imaging) services which have no contract or service level agreement between the two parties.
* There is no in-house laundry in the hospital.
* Absence of system to authenticate patient details in particular employment background and validity of medical aids schemes.
* Leaks on concrete roof of maternity theatre.
* Facade of the facility due to falling tiles.
* Old galvanised pipes that have rust and cause leakages in the sewerage system.
* Only 12 mortuary shelves which are insufficient.
* One boiler not functional.
* Two standby generators that are not functional.

The Committee took a walkabout at the hospital and visited the following areas:

## Outpatients Department (OPD)

While conducting the walkabout at the outpatients department, the Committee had an opportunity to interact with patients who informed the Committee on many issues they face when visiting the hospital including long waiting times, lack of doctors and the referral system. Patients complained that sometimes they sleep on the benches while waiting to be attended by a doctor and there is no catering provided by the hospital. The patients complained of the long waiting times which were sometimes up to six hours. They also informed the Committee that because the hospital was closer to their residential areas, they sometimes by-pass the clinic and come straight without a referral letter. Even those patients that were referred to the hospital from the clinics were complaining that they had to use their own transport.

## Resource Centre

The Committee had a walkabout at the resource centre and noted that the centre was finished but not operational. The centre has facilities such as the auditorium which can accommodate 240 people and a computer lab which will be equipped after the handover of the facility. The Committee was informed that there was a challenge on occupying the resource centre as the department was still waiting for the certification of occupation. This delay was due to the fact that the planning process did not happen at the initial stage. The construction of the building started without the approval of the plan.

## Accommodation for interns

The Committee also had a walkabout at the new accommodation for interns. There are 147 apartments which consists of bachelor and two bedroom units. The units are currently not occupied and the Committee was informed that there were items that needs to be finalised before the interns can occupy the building. There was no driveway that goes to the apartments which was being attended to.

* 1. **Isolation ward for Ebola cases**

The isolation rooms are allocated on the second floor in the short stay ward. Four rooms have been identified. In the event of more than four patients, the whole short stay ward will be used. The ward has a dedicated lift to transport suspected Ebola patients to the isolation ward. A total of 98 sets of personal protective equipment and 200 sets of disposable linen have been ordered. Training of health care workers has been conducted.

* 1. **Maternity unit**

In the maternity unit, there are four wards (maternity, antenatal, postnatal and neonatal). The antenatal ward consists of 15 beds, neonatal ward has 32 beds and 30 incubators. The Committee observed that infection control equipment in the unit were not functional. The ward manager mentioned that procurement system is very slow, taking months to procure items such as batteries.

## Nelspruit Community Health Centre (CHC)

The Committee visited Nelspruit CHC and was taken on a tour by Ms E Nkambule who is the operational manager. Members of the Committee noted that the CHC was clean. The Committee was informed that there were no patients’ registers at the CHC since 2013, this was a serious concern to the Committee. The Committee also noted that there were only two incubators within the CHC and were informed that the facility referrers to Rob Ferreira Hospital when they have more than two babies that need to be incubated. There are serious staff shortages in the CHC which sometimes results in staff not being able to take lunch breaks.

The Committee also visited an operating theatre which is not functional and was built in preparation for the 2010 FIFA World Cup. The theatre remains redundant because it did not comply with specifications.

## Kanyamazane Clinic

The Chairperson of the Clinic Committee addressed the Committee and mentioned that the clinic was built in 1971 and it used to be part of the Kruger National Park. Space is a challenge in this clinic and to address the space challenge, the clinic management is considering the option of buying a complex next to the clinic so that they can build a new clinic.

When conducting the walkabout at the clinic, the Committee noted that the clinic is clean. The clinic offers 24 hour services. There were no patients’ registers at the clinic hence they sometimes have to recycle registers. The sister in charge mentioned that this was due to challenges with procurement. The clinic also houses a victim empowerment centre which offers counselling to rape victims.

## Themba Hospital

The Committee had a meeting at Themba Hospital where the CEO of the Hospital briefed the Committee. He first gave a brief history of the hospital. The hospital was established in the 1930s by Missionaries of the Swedish Alliance Church as a small clinic in White River. It was moved to Kabokweni in 1974 due to the obnoxious system of apartheid. The hospital has been under various administrations including the then KaNgwane but is now currently under Mpumalanga Provincial Administration. The approved bed capacity is 623 with only 352 active beds. The hospital provides both level 1 and 2 services.

Challenges highlighted on infrastructure and maintenance includes underfunding, shortage of artisans and other staff, regular breakdowns of equipment resulting in a shortage of linen, cancellation of operations, old calorifiers and inadequate safety and security measures. On human resources, the challenges were related to difficulty to replace lost staff, particularly professional nurses, medical officers and specialists.

1. **Briefing by the MEC, Provincial Treasury and Provincial Department of Health**

**8.1 Briefing by Treasury**

Ms Nkamba (HOD, Provincial Treasury) briefed the Committee and gave a background of the status of health in the Mpumalanga Province. On her background Ms Nkamba informed the Committee that the Executive Council on 21 June 2014, directed the Provincial Treasury to intervene on the Provincial Department of Health. This was done in line with Section 18(2) (g) of the Public Finance Management Act (PFMA). The intervention commenced on 7 July 2014. Provincial Treasury has concluded a gap analysis and all weaknesses in the system have been identified. The fundamental challenge in the department was found to be in complete disregard of policies and legislative prescripts relating to the systems and controls particularly on financial and human resource management.

The provincial department is using a decentralised system. One of the issues that the intervention team identified as an urgent area for improvement was that the in-year monitoring report should be developed using information that was obtained from facilities. The major issues were accruals, where R473 million was disclosed in the 2013/14 annual financial statements for goods and services, transfers and subsidies as well as payments for capital assets. No disclosure for accruals was made on compensation of employees. To test the completeness of the amounts disclosed, the human resource, supply chain management and finance managers were invited on 2 September 2014 to bring all supporting documentation for amounts that were still due and payable. Some amounts dated as far back as 2007/08 financial year. The intervention team directed that none of these amounts should be paid as they were not part of the funds that were appropriated. The old outstanding amounts should first be declared to the Budget and Finance Committee before being paid so that they do not take away funds allocated for the deliverables of the annual performance plan.

There is high incidence of irregular expenditure where policy prescripts were deliberately violated. Accruals which are not conforming to the correct definition, fitted more in the definition of unauthorised expenditure. Non-disclosure of amounts outstanding (invoice) with some amounts dating as far back as 2007/08 financial year. Failure to pay for services within 30 days as stipulated in the Treasury Regulation 8.2.3 resulted in interest charged for late payment. The annual financial statements that were presented to the Office of the Auditor-General were incomplete as the amounts disclosed on accruals were grossly understated. The work embarked upon by the intervention team has been that of reconstruction of books of accounts from incomplete records for each institution.

The business processes are not responsive to the decentralised approach where documentation that has been submitted by various institutions are not attended to at the Head Office until they get lost. Cash flow challenges were on overtime, which accumulated and only paid between December 2013 and May 2014. A number of people were issued with appointment letters without indicating date for assumption of duty. Performance management system was not implemented correctly. Supply chain management was also a challenge in the department.

On financial management, all backlogs of orders/payment documents from 1 April 2014 to date for Head Office and the three district offices for the current financial year have been attended to in as far as these have been presented to the Financial Management Committee. Complete disregard of supply chain policies including failure to develop procurement plans with clear timelines, has impacted negatively on the procurement turn-around time. Some suppliers of medicine and medical equipment, both local and internationally are unable to supply on time due to the fact that the tenders are on a month to month basis. Some facilities do not order enough stock and do not order on time. From time to time there was a wide challenge of the non-availability of some vaccines, the most recent being Polio and BCG vaccines which are now in stock albeit late.

On human resources, an over expenditure on compensation of employees to the amount of R114 million was discovered, which on preliminary investigation revealed that the spending was emanating from appointments implemented mainly from April 2014. Source documents were requested from human resource management unit as supporting documents for each appointment and not all documents were made available from facilities/units.

The absence of source documents implied that:

* Normal recruitment processes were not followed, in that case source documents are non-existent.
* Not all facilities submitted documents to provincial office as requested. In this case a communique was issued again to District Managers and other responsible managers with a deadline of 15 September 2014 to submit any documents relating to the 1062 appointments.

In-year monitoring for four months which ended in July 2014 reflected a projected over-expenditure on compensation of employees amounting to R273.835 million. The process of validating all amounts owed by the department has resulted in an increase on the projected over-expenditure on compensation of employees. The Head of Department also informed the Committee that overtime incurred from 2012 was only paid from December 2013 to April 2014.

* 1. **National Health Insurance**

Dr Mohangi provided a progress report on the National Health Insurance implementation with an emphasis on Gert Sibande, the pilot district. She provided a background on NHI which seeks to ensure that everyone has access to appropriate, efficient, affordable and quality health services regardless of their socio-economic status. Major changes in the service delivery structures, administrative and management systems will bring reform that will improve service provision. To successfully implement a healthcare financing mechanism that covers the whole population such as the NHI, four key interventions as follows need to happen simultaneously:

* A complete transformation of healthcare service provision delivery
* The total overhaul of the entire healthcare system
* The radical change of administration and management
* The provision of a comprehensive package of care underpinned by a re-engineering of primary health care

The re-engineering of primary health care consist of five streams as follows:

* District Clinical Specialist Teams
* Ward-based primary health care outreach teams
* Strengthening of the integrated school health program
* Contracting of general practitioners for primary health care centres
* Establishment of ideal clinics
  + 1. **District Clinical Specialist Teams (DCSTs)**

The main function and aim of the DCSTs is to contribute to the reduction of maternal and child mortality through scaling up of skills on management of pregnant women and children and to improve quality of care in all health facilities. She noted that on progress made on implementation, all teams have conducted the baseline survey in all health facilities to determine the gaps in the provision of quality maternal and child health services. Action plans have been developed to address identified challenges. Some hospitals that will be prioritised includes, Lydenburg, Mapuleng, Tintswalo, Shongwe, Tonga, Matikwana, Bernice Samuel, Piet Retief, Evander, Standerton and Embhuleni.

Achievements highlighted were:

* All doctors and one midwife from the team were trained as ESMOE (Essential Steps in the Management of Obstetric Emergencies) facilitators.
* Paediatric dyad was conducted on neonatal resuscitation. Onsite training was also conducted in 33 PHC facilities on various child health related issues.
* PHC nurses have been trained at 27 facilities for early antenatal care booking and national formula for cervical cancer screening.

Challenges highlighted included, incomplete teams to effectively implement the strategy; unavailability of office space; and insufficient and unavailability of a dedicated budget to run the program; and unavailability of administration support to assist in the coordination of activities.

* + 1. **School Health Services**

The Integrated School Health Programme (ISHP) is a joint initiative between the Departments of Basic Education, Health and Social Development. The programme delivers a comprehensive package of both onsite health education and services to primary and secondary schools including special schools. Its aim is to identify the health barriers to learning and increase access to health services by learners who are economical and geographically challenged to access these services. The service is supposed to be provided by teams that are made up of a professional nurse, enrolled or auxiliary nurse and a health promoting practitioner (HPP). However, the province does not have sufficient HPP’s hence they are allocated to cover sub-districts and are being co-opted to join the teams when the teams visit their allocated areas.

Achievements highlighted included, Human Papilloma Virus (HPV) vaccine has been given to grade four learners reaching 91% learner coverage and 85% school coverage against the target of 80% for both indicators; managed to visit 97.8% of quintile 1 and 2 schools in 2012/13 financial year; and teams will be visiting all the schools and the scope has been increased to cover grade one, four, eight and ten.

Challenges noted included incomplete teams to render the complete package of care, insufficient teams to cover all the schools and insufficient budget to add more retired nurses.

* + 1. **Ward-based outreach teams (WBOTs)**

The ward-based outreach teams was introduced in 2011 with an emphasis of improving health outcomes. The function of the WBOT was to visit each and every household within the ward and compile household profile and update annually. The other function is to provide health information and education including psychosocial support to communities and households. Challenges highlighted on the WBOTs are delays in the recruitment process coupled with insufficient number of eligible applicants for professional nurses and high turnover of outreach team leaders especially in Gert Sibande making it difficult to roll out the programme as planned.

* + 1. **GP contracting**

Two orientation sessions on GP contracting were held in September 2013 and May 2014, however in both sessions the attendance was poor. To date, the province has managed to contract ten GPs with a number of GPs starting to show keen interest.

* + 1. **Ideal Clinic**

In Mpumalanga, Ntoroane in Dipaleseng Local Municipality and Breyten (Ubuhlebempilo) in Msukaligwa were identified as part of the Ideal Clinic initiative. The scores of the two facilities are still low, Ntoroane at 49% and Breyten (Ubuhlebempilo) at 56%. These two facilities have started with the central chronic medicines dispensing and distribution system. Currently, only patients on fixed-dose combination (FDC) therapy were enrolled on the system.

* 1. **The Head of Department, Dr A Morake tabled the following report**

## Socio-Economic Profile

Mpumalanga is ranked the third most rural province in South Africa with 66% of its population living in rural areas. The majority of the population resides in the former homelands of Kwa-Ndebele, KwaNgwane, Lebowa and Gazankulu areas that have historically lagged behind in terms of development and delivery of basic services such as health and education. Relative to other provinces, Mpumalanga’s population base exhibits low economic activity and the poverty rate (with an index of 50.5%) is higher than the national average. It is estimated that approximately 23% of households in the province have no regular source of income. Increased unemployment rates therefore translate directly into poverty. These poverty levels in the province places a high demand on public health resources.

On epidemiological profile, Mpumalanga Province like the rest of the country faces a quadruple burden of diseases. HIV and AIDS, Tuberculosis, high maternal and child mortality, non-communicable diseases and violence and injuries continue to take a toll on the province’s citizens. Mpumalanga is one of three provinces where malaria is endemic, and is progressively doing well on the management of the disease. The HOD highlighted that transmission of malaria normally occurs in October after the first rains with high peaks in January and February. An estimated population of 1 688 615 is at risk of contracting the disease locally in Ehlenzeni District.

Diet-related non-communicable ailments such as obesity, diabetes and cardiovascular diseases account for a large proportion of South Africa’s disease burden and that late detection of disease such as hypertension and diabetes results in increased costs, unnecessary suffering and increased risk of death. The department will continue to direct greater efforts and resources towards prevention, screening and early detection as well as effective management to improve life expectancy and quality of life.

The programme priorities are as follows:

* Universal coverage which will be progressively achieved through the implementation of National Health Insurance
* Improved quality of health care
* Implementation of the re-engineering of primary health care
* Reduced maternal, infant and child mortality
* Successful management of HIV and AIDS and Tuberculosis

The HIV epidemic is a complex and diverse epidemic and driven by many behavioural, social and biological factors that exacerbate and facilitate the spread of HIV although according to the 2012 antenatal sentinel HIV and syphilis prevalence survey, the HIV prevalence has decreased in Mpumalanga Province from 36.1% in 2011 to 35.5% in 2012. Gert Sibande showed a decrease from 46.1% in 2011 to 40.5% in 2012, Nkangala from 29.5% in 2011 to 32.1% in 2012 and Ehlanzeni from 35.8% in 2011 to 35.1% in 2012. The HOD was concerned though that the prevalence in the province remained a worrying factor as it is above 30% in all districts and the strengthening of the AIDS Councils at all levels cannot be delayed. Child mortality has also decreased with reported in-hospital mortality rate from 4.6% to 3.8% in January to June 2014.

Mpumalanga EMS requires a staffing level of 4040 personnel in order to render services effectively. There are only 777 employees currently employed within EMS leaving a shortfall of 3263. EMS currently has between 70 and 98 vehicles at any given time restored, leaving a shortfall of up to 306 vehicles. The shortage of personnel is supplemented with staff working overtime to fill the gaps.

On human resources, there are ten students that that have been approved for the 2014 Cuban programme and 32 have completed since the inception of the programme and are allocated in different hospitals in the province. A total of 19 registrars are at different levels of training at the University of Pretoria. The department has one nursing college accredited for an annual intake of 100 students for the four year diploma and for 2014 the intake is at 231. There are 15 nursing schools that offer the legacy courses including midwifery. Twenty two medical students are doing final year in the Cuban programme. Five hundred and eighty four (584) nurses have graduated.

The department has appointed 194 data capturers who are allocated in the various facilities. A further 83 will be trained and allocated to facilities based on the needs of the 33 hospitals.

Human resources challenges were as follows:

* Lack of capacity in the unit in terms of numbers and required skills
* Capacity of the implementing agents to manage the health portfolio

## Infrastructure and maintenance

Of the infrastructure budget, Ehlanzeni district received the bulk of the budget (47%), Gert Sibande received 34% and Nkangala (19%). A total R345 509 million was allocated on the Health Facilities Revitalisation Grant, by the end of August 2014, only 12% (R40 982 million) of the budget was spent.

## Planning related challenges were noted as follows:

* Alignment of strategic planning documents of the department.
* Input from clinical and service delivery sections of the department at projects initiation.
* Spatial planning linked to other service delivery departments.
* An agreed, documented and well known criteria for identification of projects.
* Formulation of clear and detailed project briefs before handover to the implementing agent by the Department of Health.
* An integrated approach for planning with all key stakeholders.
* Ensuring that national norms and standards related to infrastructure provision are adhered to for each level of facility that is being planned.
* Participation and input of Health Technology section throughout the lifecycle of the project.

## Implementation related challenges were highlighted as follows:

* Capacity constraints, in terms of implementing agents, professional teams, contractors, etc.
* Quality control and quality assurance on projects.
* Start and timeous completion of projects.
* Management of scope variations (process and validation).
* Proper closeout of projects.

## Monitoring and contract management challenges were reported as follows:

* Lack of monitoring from the client department.
* Quality and accuracy of reporting to stakeholders is compromised by reliance on IA (internal audit) information which is not 100% accurate.
* Contract management is left solely as a responsible of IAs.

## Maintenance and Repairs challenges were noted as follows:

* There is not enough investment on the maintenance of existing infrastructure stock
* Facilities are left to deteriorate to a level where they cannot be repaired. This is more costly to the province as the province has to do major upgrades or demolish and reconstruct

## Possible solutions suggested by the province:

* Proper capacitation of the Infrastructure Unit including built environment officials as well as health planners.
* There should be technical staff at Head Office, districts and facility levels.
* There should be built environment based facility managers starting with the big five hospitals in the province.
* There should be maintenance teams/hubs that could be district based or facility based depending on the size of the facility services.
* Participation of appropriately skilled personnel from the client department in the procurement committees of the IAs as required by DoRA to ensure that the functionality part of the process of appointing consultants and contractors is done properly.
* There should be increased and continued investment in maintenance of all facilities.

## General Findings

The following observations and findings were noted by the Committee following the visits to the different health facilities:

## Rob Ferreira Hospital

* The hospital does not offer critical services offered in a tertiary institution, such as dialysis and MRI services.
* The position of the Chief Executive Officer has been vacant for the past four years.
* The hospital does not have a laundry. Linen services are sent to neighbouring hospitals, in Themba and Barberton hospitals and also Barberton Correction services.
* Two standby generators are not functioning.
* There is insufficient mortuary shelves, only 12 shelves available.
* The hospital is faced with a shortage of medical professionals, this often leads to patients sleeping on benches waiting to be attended by a doctor.
* The hospital does not have data capturers and there was no indication from the hospital on when this will addressed.
* Patients complained of long waiting times which can be between four to six hours.
* There is no transport for patients who have been referred by clinics to the hospital.
* The Committee observed falling ceilings around the reception area.
* The Committee noticed that the hospital was very dirty.
* The Resource Centre that was not utilised was a concern to the Committee as this can lead to it being a white elephant.

## Nelspruit Community Health Centre

* There are no patient registers at the CHC since 2013
* There is staff shortages at the CHC which sometimes results in staff being unable to take lunch breaks.
* Patients complained about long waiting times.
* There are only two baby incubators at the CHC which result in babies being transferred to Rob Ferreira.
* The issue of the theatre which did not comply with specifications was a concern to the Committee as the theatre was not utilised since it was built in 2012.

## Kanyamazane Clinic

* There are no patients registers at the clinic.
* There is a lack of files for patients records.
* There are no chairs at the clinic.

## Overall findings and observations

The Committee made the following findings and observations:

* There is non-compliance to policies and legislative prescripts relating to internal controls particularly on financial and human resource management.
* Supply chain policies are not conformed to, including the failure to develop procurement plans with clear timelines which has impacted negatively on the procurement turn-around time.
* Accruals which can be described as unauthorised expenditure in some case dates back as far as 2007/08 financial year.
* Overtime which is not paid on time and it accumulates.
* Appointment letters that are issued without indicating date for assumption of duty and even those who reported for duty. It was discovered that recruitment processes were not followed, appointments were terminated with immediate effect.
* The provincial department has entered into contracts with service providers without making sure that they have appointment letters, banking details are in the system and have active tax clearance certificates.
* Most facilities in the province are not placing their orders on time or do not place enough stock which leads to non-availability of stock at facility level.
* A shortage of Emergency Services vehicles and personnel was also reported.
* There is a shortage of medical professionals.

## 11. Recommendations

The Mpumalanga Department of Health should ensure the following:

* Urgently address the issue of staff shortages, as staff shortages were identified in all health facilities visited.
* That human resources follow proper recruitment processes.
* That provincial officials comply with policies and legislative prescripts related to financial and human resource management. Actions should be taken for transgressions.
* That provincial officials conform to supply chain management policies. This will assist in improving procurement turn-around time.
* The province should put systems in place to ensure that all health facilities place their orders for stock on time and they order enough stock. This will ensure that stock is always available at facilities.
* That the provincial department follows proper contractual agreements with services providers.
* That the provincial department addresses the shortage of Emergency Services vehicles and personnel.
* That the issue of the operating theatre that is not operational at Nelspruit Community Health Centre is attended to as a matter of urgency.

**Report to be considered.**