Limpopo

DEPARTMENT OF HEALTH & SOCIAL DEVELOPMENT

10 YEARS OF FREEDOM
South Africa 1994 - 2004

Health (Vote 7) Strategic Plan for 2005/06 –2009/10

FOREWORD BY THE EXECUTIVE AUTHORITY (MEC)

As we celebrated our ten years of democracy, we noted with pride, great strides we have made in redressing the historical imbalances in the delivery of Health care services in the Province. Progress made in the past decade is characterised by landmarks that include transformation and rationalisation of health services from fragmented institution – based to universal and comprehensive services accessed by the entire population in the province. The overwhelming election results we received from the citizens of Limpopo are a vote of confidence in our government and a renewed mandate to offer services of high quality.

We are now beginning to see and feel the impact of our interventions as in reduction in malnutrition, morbidity and mortality rates. The Department successfully managed to implement policies and programmes that were focused on increasing access to Primary Health Care, Devolution of District Health Services to Municipalities, Hospital Revatilisation, Organisational Development and Resource Management and consequently succeeding in offering our communities greater access to and better quality of services. Key areas of success include integrated nutrition programme, 24 hour clinic services, quality improvement programmes, Voluntary Counselling and Testing, Prevention of Mother to Child Transmission of HIV and ADS and Community Home Based care. District and Hospital Management have improved significantly while the HIV & AIDS Prevalence is stabalising gradually.

The implementation of the job evaluation and performance management system intended to improve performance efficiency, is in motion. The introduction of a Risk Management Unit and the implementation of a Fraud Prevention and Risk Management plan saw us making significant improvement in financial management to achieve overall value for money. All the afore going successes resulted in a positive impact on the lives of all citizens of Limpopo. Without the active participation of our communities, the successful implementation of these programmes would not have been realized.

Much as we are registering significant success in contributing to the improvement of the quality of life for our citizens, we still face challenges related to limited resources, inadequate human resource capacity and inefficient management of available resources. We will continue to strive towards reducing morbidity and mortality arising from communicable diseases, immunisable childhood diseases (EPI), diseases of life style, HIV & AIDS and TB, trauma and violence against women and children so that we are able to successfully push back the frontiers of ill-health and poverty. Organisational and Leadership Development, Revitalisation of Health Facilities and District Health Development will serve as key strategies for Quality service Improvement Plans and good governance.

The creation of the South African Social Security Agency (SASSA) as a public entity and the reconfiguration of the Department as Health and Social Development will naturally bring about opportunities, challenges and implications that will need to be managed effectively and efficiently. Inevitably, Social Development will need to redefine its roles and priorities in the light of the social security policy shift. As we continuously explore new methods and tools to match these challenges, we are confident that we will ultimately manage to bridge the gap between available resources and the needs of communities in our Province.

The intended outcomes of this plan is to ensure a comprehensive, efficient, effective and quality health service delivery system that contributes to a self – reliant society.

It is therefore my pleasure to present this Strategic Plan which serves as a Social Contract between my Department and the people it serves.

Taking the above into account, I hereby declare that my Office will give oversight to this Strategic Plan (Health - Vote 7) of the Department of Health and Social Development as presented hereunder.

Mr S.C Sekwati
HONOURABLE MEC FOR HEALTH & SOCIAL DEVELOPMENT

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PART A – STRATEGIC OVERVIEW

1. INTRODUCTION AND SIGN OFF BY THE ACCOUNTING OFFICER (HOD)

The past decade progress on management and service delivery is characterized by milestones that include transformation and rationalization of health services from fragmented institution based to comprehensive and community based services accessed by the entire population in the province. In pursuit of our constitutional and legislative obligations, the Department has delivered programmes intended to address problems of morbidity, mortality and poverty for a 5.2 million population that is predominantly rural. We recorded significant success in the following programme areas:

Limpopo is served by 43 hospitals and 22 health centres. Fixed clinics and visiting points have increased from 302 in 1994/95 to 479 in 2004/05. 127 new clinics were built while 63 existing clinics were up-grated. The increase in the number of PHC facilities is an attempt to demonstrate our commitment to the Primary Health Care approach aimed at increasing access to Health Care. This is evidenced by increase in utilisation and coverage rates. Antenatal Care coverage stands at 93% while Immunisation coverage is 82%. This means that more pregnant women, mothers and children are now utilising our PHC services than a decade ago. Our Comprehensive HIV & AIDS Care, Management, Treatment & Support Response has seen HIV & AIDS prevalence rate stabilise with an average annual increase of 1.1% leading to an insignificant increase of the prevalence rate of 14.5% in 2002 to 17.5% in 2003. Along with our focus in Primary Health Care, we have put special programmes in place which are aimed at improving the quality of services. Progress includes the hospital revitalization, development of hospitals as centres of excellence and modernisation of tertiary services.

Organisational Development and general management of resources have improved. The implementation of the job evaluation and performance management system assist us to improve performance efficiency and accountability across the organisation. The introduction of a Risk Management Unit and the implementation of a Fraud Prevention and Risk Management plan help us to make inroads in financial management to achieve the desired management outcome i.e. value for money. Chief Executive Officers have been appointed for well over 90% of our Hospitals. A policy to outsource non – core functions such as Laundry and Linen services, Staff accommodation, etc. is being implemented to strengthen our PPP Initiatives.

Much as we have made significant progress in improving access to and quality of health services there are still greater challenges facing us.

In response to the pressing needs of our communities we found ourselves extending free health care to the disabled with no additional resources.

While we spend 53% of our total budget on District Health Services the major portion of this goes to district hospitals, leaving Primary Health Care with only 14% of the total budget. Additional funds are expended on Primary Health Care in the form of Capital Upgrading and Pharmaceuticals.

While we have a vacancy rate at 36 %, the personnel expenditure is increasing and non-personnel expenditure declining. We will be moving at greater speed to finalise and implement our Human Resource Plan to ensure that we are able recruit, retain and develop an efficient and effective cadre of personnel.

We will continue to invest more resources and attention to the following strategic priorities in line with the National DoH Ten Points Plan:

HIV and AIDS, STIs & TB, other Communicable and Diseases of Lifestyle;
Districts Health services and Primary Health Care services;
Emergency Medical services
Logistical support services (including pharmaceuticals)
Infrastructure development (including hospital revitalization, clinic upgrading and maintenance);
Legislation, Governance, Organisational Development and Quality Improvement;
Human Resources Development and Management;
Communication, collaboration and participation;
Tertiary service development; and
Revenue generation.

We view this strategic plan as a tool to assist in managing the above mentioned challenges. The drawing up of this plan has been an interactive process involving managers at all levels as a foundation for decentralized management, good governance and accountability.

All factors considered, I hereby declare that my office will provide the necessary management oversight for the implementation of the Limpopo Department of Health and Social Development Strategic Plan (Health – Vote 7) as presented hereunder.

DR H.N MANZINI
HEAD OF DEPARTMENT (HEALTH & SOCIAL DEVELOPMENT)

2. VISION

A health promoting and developmental service to the people of Limpopo.

3. MISSION

The department is committed to providing sustainable health and developmental services of high quality through a comprehensive and integrated system.

4. VALUES AND ETHICS

The Department is committed to uphold the following values:	The Department and its staff are committed to uphold the following ethical principles:
Humanity Honesty Respect Empathy Compassion Courtesy Fairness Dignity Humility	Professional Ethics Competence Information Accessibility Equity Partnership Dedication Transparency Cost Effectiveness

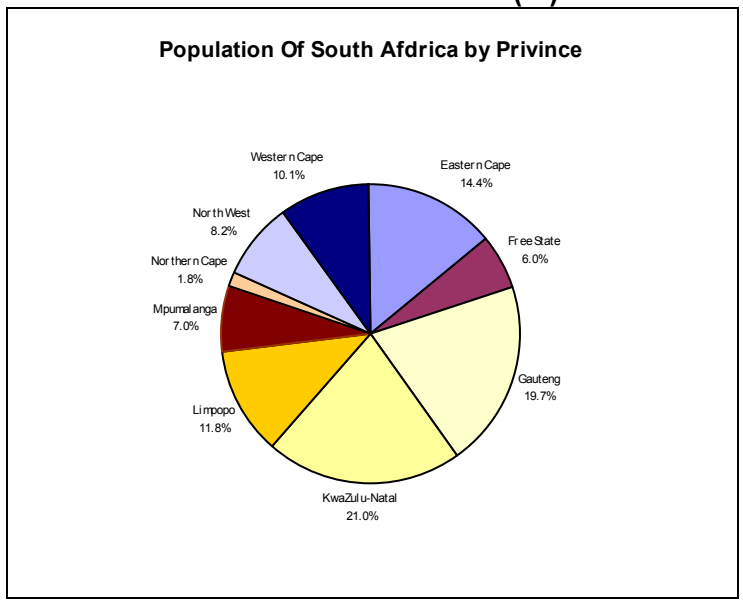
5. SECTORAL SITUATIONAL ANALYSIS

Demography

Background

The Limpopo province is the most northern province of South Africa. The province shares borders with the Gauteng province in the south, Mpumalanga and Mozambique in the east through the Kruger National Park (a world conservation icon), Zimbabwe in the north and North West and Botswana in the west According to the 2001 population census, Statistics South Africa has estimated the size of the population in Limpopo to be 5 273 642 (5.2 million), which is 11.8% of the total population of the country. This shows a 7 % increase from 4.9 in 1996 to 5.2 million in 2001. Females account for 54,6% of the population, a 0.3% increase to that of the 1996 census. See Diagram 2. Limpopo therefore remains the 4th highest populated province in South Africa as per both the 1996 and 2001 census. (See Diagram 1).

DIAGRAM 1: POPULATION (%) BY PROVINCE



Source: Census in brief, 2001

The estimated fertility rate decreased from 5.8 % in 1991 to 3.9 % in 1998. It is estimated that by 2011 the fertility rate will decrease to 3.0 % (high estimate) or 2.6 % (low estimate).The average household decreased from 4.9 % in 1996 to 4.3 % in 2001. This is higher than the national average of 3.8 % in 2001.

Population distribution by Age and Gender

The age distribution of the population in Limpopo resembles the typical broad base pyramid of developing countries, with a large portion in the younger age groups and a steadily decreasing proportion in the older age groups. This distribution shows that Limpopo population is somewhat younger than in the whole country. A younger population requires more educational, recreational and health facilities thus adding more pressure to the limited provincial fiscal resources.

Children between 0-4 years: 11.4%

Children between 5-9 years: 13.8%

Children between 10-14 years: 14.4%

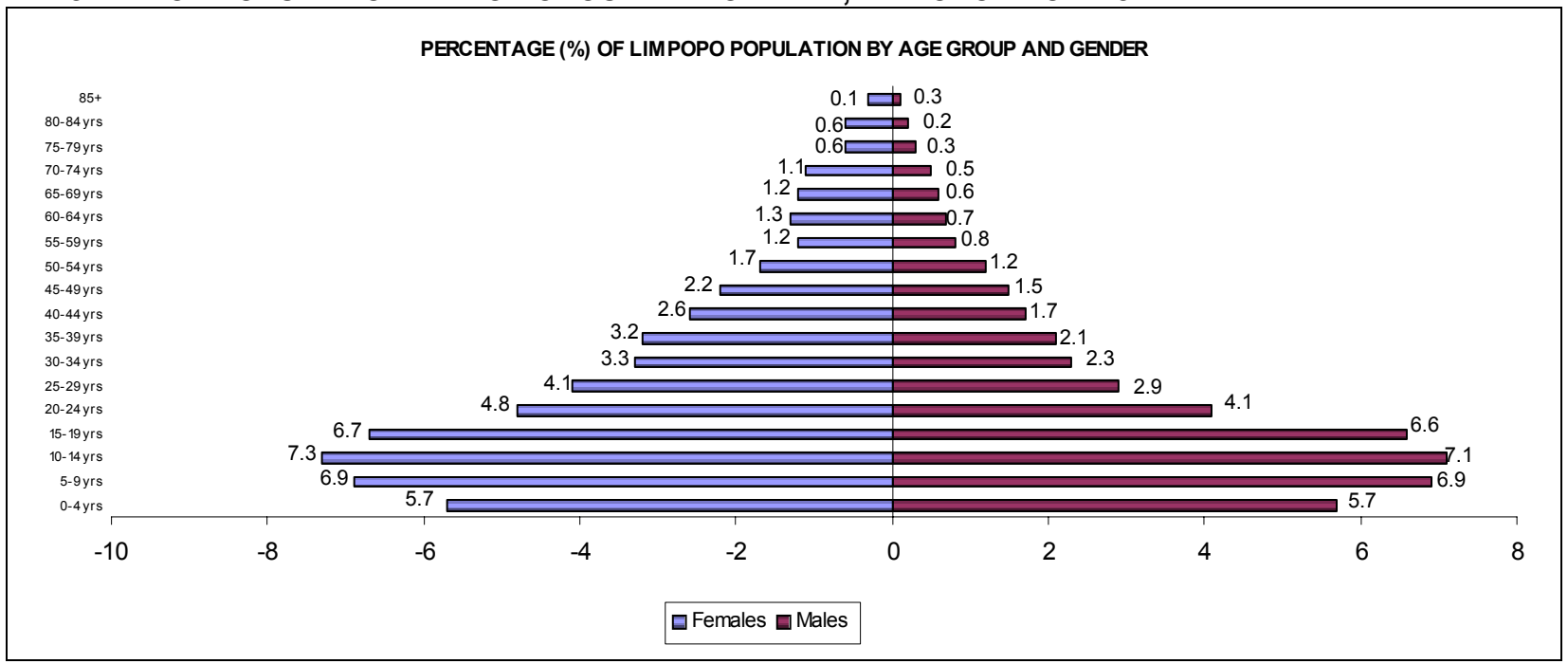
Female Population 15-19 years: 6.7%

Females 15-44 years: 24.7%
(an increase of 1.01% from 23.69% of the 1996 census)

Persons 65 years and older: 5.5%
(an increase of 1.21% from 4.29% of the 1996 census)

Limpopo has the highest female population in the country 54.6% compared to the national average of 52.2%. Females tend to account for a larger proportion of the population than males in all provinces except for Gauteng. (F=49.7% vs. M=50.3%)There is a fast decline in proportion of males between the age groups 15-19 and 25-29 compared to that of females in the same age groups.

DIAGRAM 2:
PERCENTAGE POPULATION BY AGE GROUP AND GENDER, LIMPOPO PROVINCE



Source: StatsSA-Census 2001

Females tend to account for a larger proportion of the population than males.
Females 54.6% an increase of 0.3% from 54.3% of the 1996 census
Males 45.4% an increase of 0.1% from the 45.3 of the 1996 census

Table 1 Distribution of the population of Limpopo by District

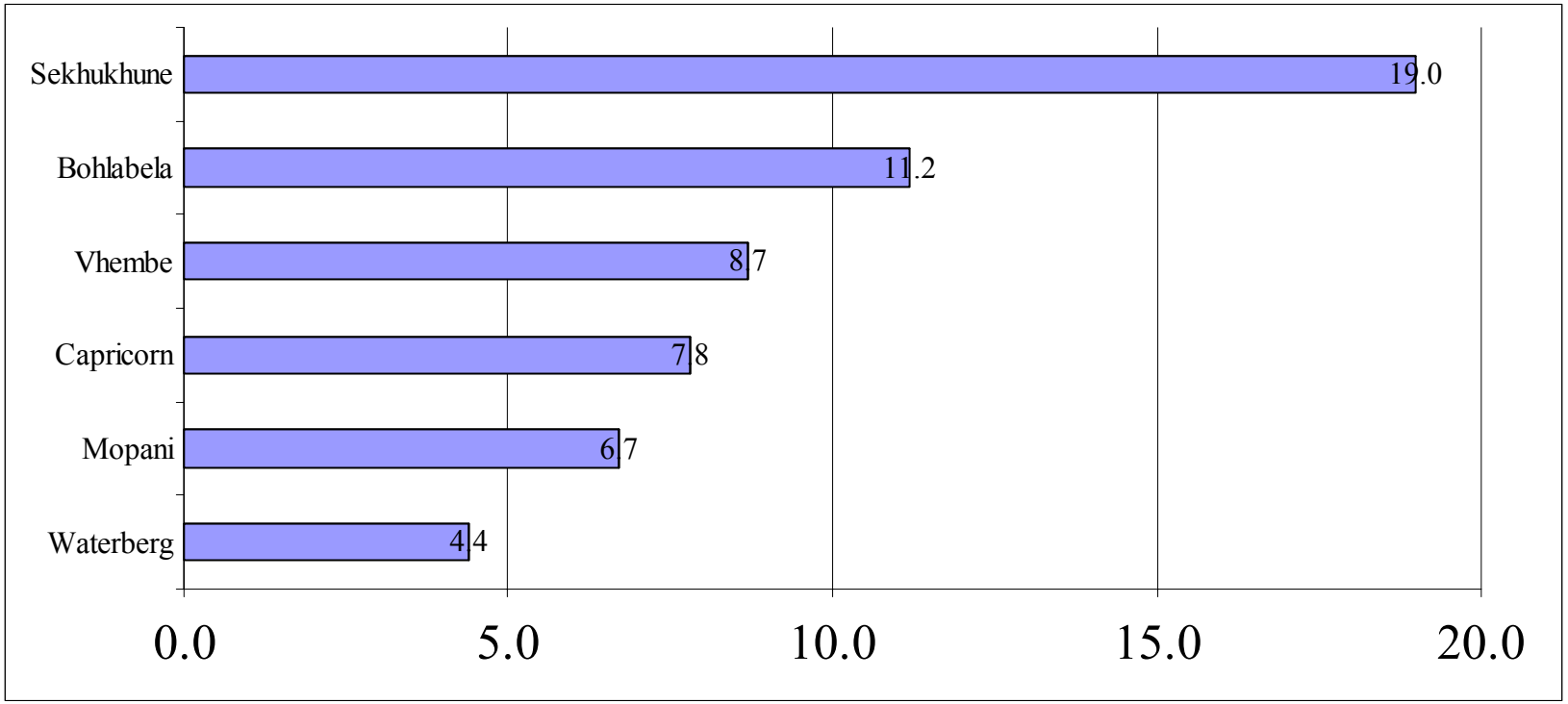
DISTRICT	1996	2001	Average annual growth rate (%)
Bohlabela	632,859	595,203	-1.20
Capricorn	1,063,179	1,154,690	1.66
Mopani	872,179	964,230	2.03
Sekhukhune	717,650	745,568	0.76
Vhembe	1,097,630	1,199,880	1,79
Waterberg	548,673	614,158	2.28
Total	4,932,164	5,273,630	1.30

Source: Development Index Framework: Limpopo (2001)

The total population does not take into account cross – border inflows of patients from neighbouring countries as Limpopo shares borders with the Gauteng province in the south, Mozambique in the east through the Kruger National Zimbabwe in the north and Botswana in the west. Patients crossing from Zimbabwe, Mozambique and Botswana pose a challenge to the already scarce healthcare resources.

Over 90% of the province is rural and poor; this has an impact on the service delivery and accessibility to service points. Despite improvement in the economic growth of the province, the poverty levels remain high at 60%, particularly in Bohlabela and Sekhukhune districts where the dependency ratio are at 1: 11 and 1: 19 respectively. (ref. Provincial Growth and Development Strategy) The challenge is to establish sustainable projects to address poverty issues. (ref. Provincial Growth and Development Strategy)

Figure 1 Limpopo dependency ratio per district: 2001



Source: Development Index Framework: Limpopo (2003).

Table 2 Level of employment by district: 2003

Item	Year	Capricorn	Bohlabela	Mopani	Sekhukhune	Vhembe	Waterberg	Province
Economically active population (number)	1998	219167	144410	214298	124303	271454	187933	1161565
	2003	277590	183 759	270004	157 591	343649	235505	146 8098
Employment (number)	1998	118380	45673	129871	27459	123271	135804	580457
	2003	128818	57863	150274	34075	134466	169595	675092
Unemployment (%) (expanded)	1998	46	55.7	39.6	68.1	49.3	30.1	46.6
	2003	50.7	56.9	41.8	69.4	53.1	31.2	49.3

Source: Development Index Framework: Limpopo. (2003)

Table 3 Number of people in poverty: 1998 and 2003a

District	1998	%	2003	%
Capricorn	588 345	60.9	680 216	65.3
Bohlabela	490 526	66.5	448 503	56.5
Mopani	554 706	61.4	537 757	55.5
Sekhukhune	534 206	70.4	545 362	67.2
Vhembe	720 434	60.9	786 842	62.0
Waterberg	380 348	55.4	373 800	50.8
Province	3 268 566	62.4	3 372 479	60.0

Source: Global Insight Southern Africa: 2004

The number of people in poverty represents the percentage of people living in households with an income less than the poverty income. The poverty income is defined as the minimum monthly income needed to sustain a household and varies according to household size, the larger the household the larger the income required to keep its members out of poverty (BMR report no. 235, Minimum and Supplemented Living Levels in the main and other selected urban areas of RSA.)
According to the Actuarial Society of South Africa, life expectancy in Limpopo declined from 58 years in 2000 to 52 years in 2003 and is anticipated to decline even further to 42 years by 2010 (quoted in SAIRR's South African Survey 2003/2004). This decline is attributable to a combination of the impact of HIV & AIDS and other burden of diseases. Underdevelopment, malnutrition and chronic diseases, such as tuberculosis and respiratory diseases, aggravate the condition since they reduce the body's resilience and increase the patients' vulnerability to the affects of HIV& AIDS. Government 's response is geared towards curbing further decline in life expectancy.

Figure 2 : Limpopo v/s National HIV prevalence trends

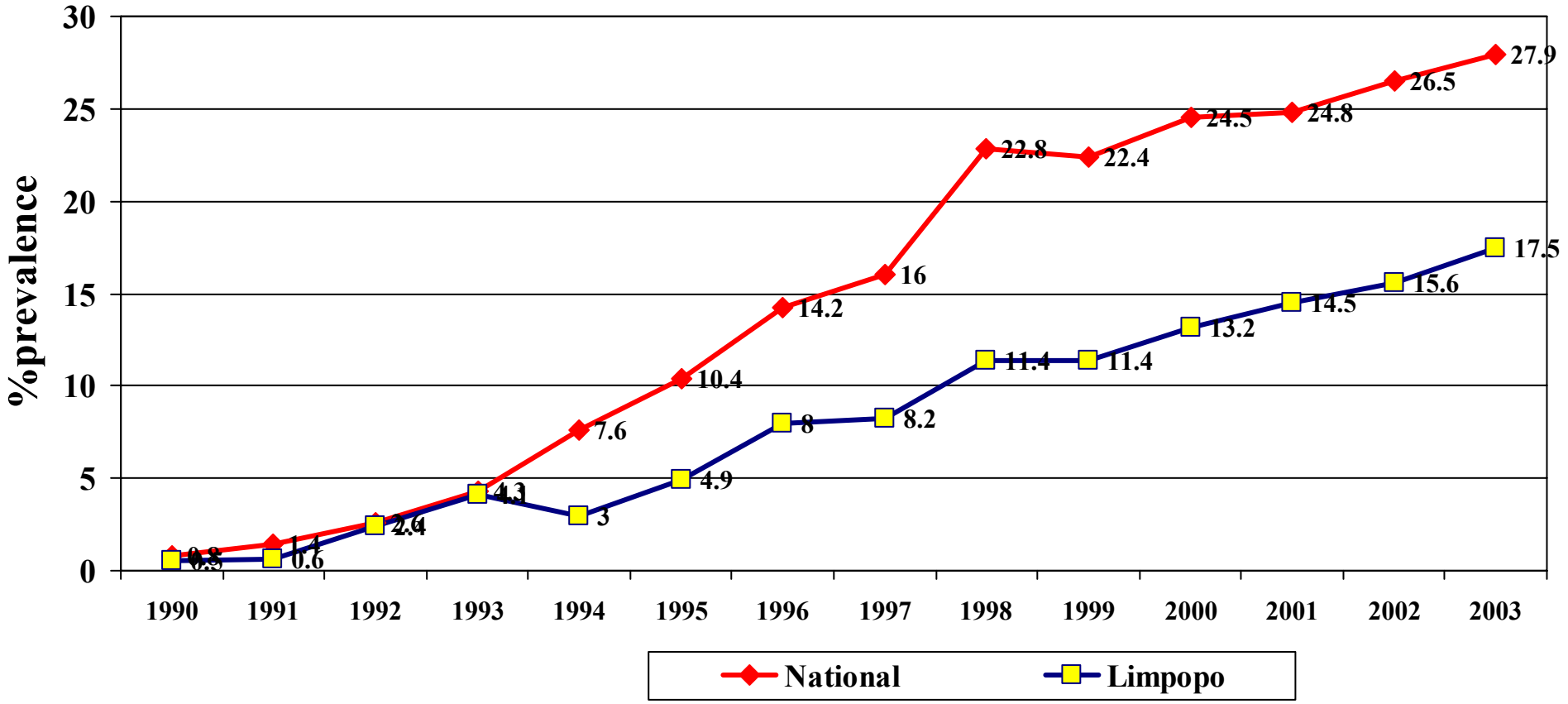


Figure 3:Limpopo HIV Prevalence by district 2001 - 2003

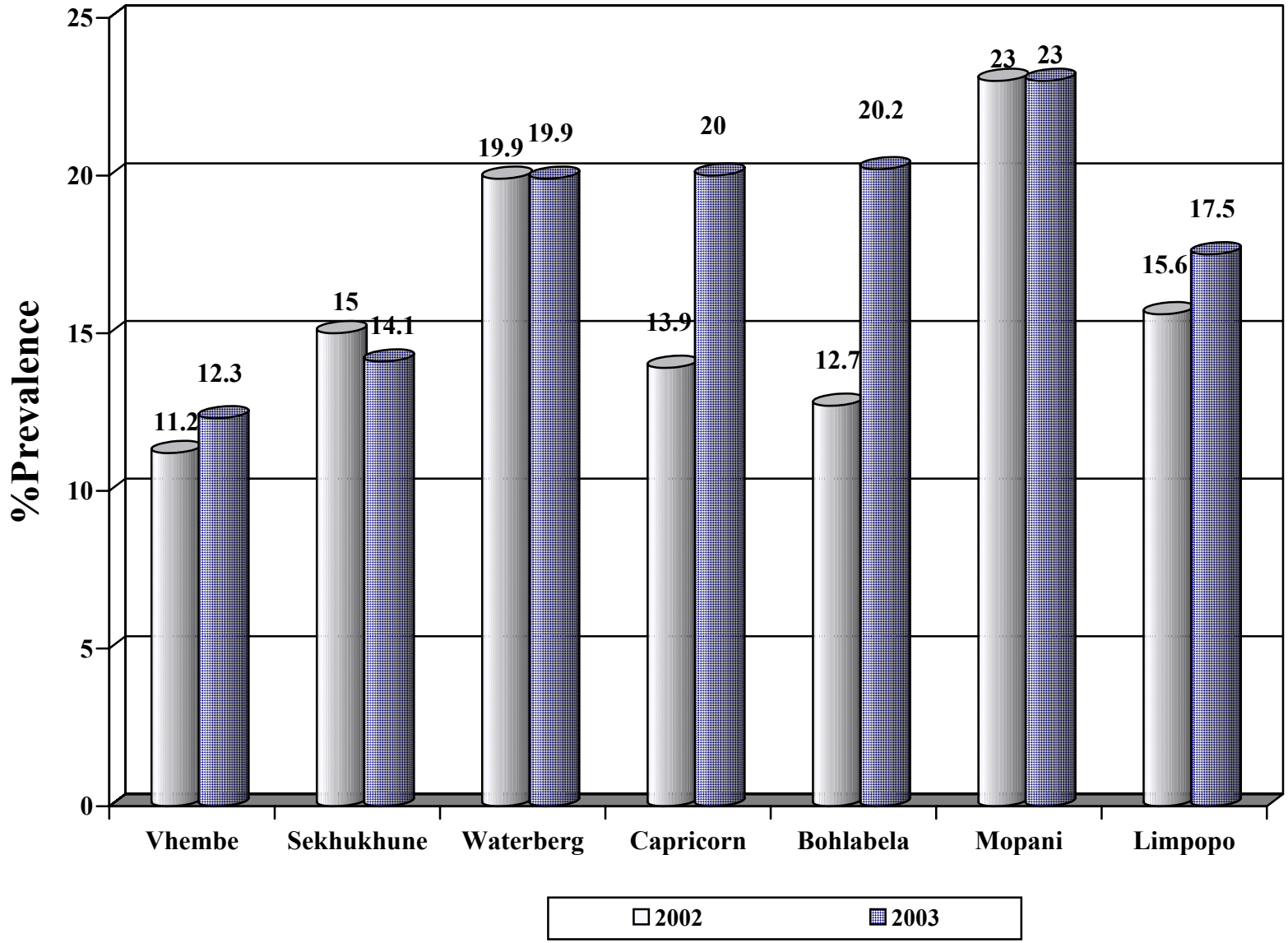


Table 4: HIV prevalence by province for 2001 - 2003

Provinces	YEAR		
	2001	2002	2003
WC	8.6	12.4	13.1
NC	15.8	15.1	16.7
LP	14.5	15.6	17.5
EC	21.7	23.6	27.1
NW	25.2	26.2	29.9
FS	30.1	28.8	30.1
GP	29.4	31.6	29.6
MP	29.4	28.6	32.6
KZN	33.5	36.5	37.5

While our goal for 2002/03 was to translate the marginal stabilisation in HIV infection rate achieved during 1999 - 2001 into actual reduction in new infections, the 2002 survey of pregnant women shows an increase of about 1.1% (14.5 – 15.57 %) in new HIV infections for Limpopo. National HIV Prevalence rose from 26.5% in 2002 to 27.9% in 2003 (a 1.1% increase). Limpopo had remained third from the bottom in the past three years having registered an insignificant increase from 15.6% in 2002 to 17.5% in 2003.

The escalations in new infections pose a challenge for Government and the population of the province to play an active role in combating the scourge of HIV & AIDS.

5.1 Summary of service Delivery Environment and Challenges

Health service challenges
Imbalances in service structure:

In line with national policy, province is putting more resources to primary health care. The devolution of municipal health services to local government will be a challenge for the next few years. Developing the tertiary services is in process. A lot has been achieved but significantly more is required before the Province is self sufficient.

Staff mix and provision of care:
Despite the introduction of the rural service incentives, it is still difficult to attract professionals needed. Strengthening of physical security measures at all clinics remains a significant problem impacting on the ability to provide full 24 hour services.

The Burden of Disease
The single biggest challenge of all remains the management of HIV and AIDS, TB and STI.

Problems in referral chain:
The provision of emergency medical services and other patient transport still remains a challenge at all levels. Due to the phased development of regional hospitals all the necessary services can not be provided at the nearest point, therefore requiring additional transport. Some services are not yet provided in the province.

Infrastructure development

(a) Hospital revitalisation:
The major problem is that due to under funding there is not enough finances to deal with the backlog of R1, 334 billion rand (with 5 % escalation) needed for facility development. The under funding also affects the ability to address maintenance back lock. Appropriate health technology is affected by this as well.

(b) Clinic Upgrading
The program is ongoing with large backlogs mostly in the rural areas.

Management capacity
The level of capacity in administrative areas is also a problem. With the implementation of the PFMA it has become apparent that a lot of capacity development in terms of financing and human resource management and planning needs to take place.

Quality of care improvements:
The Batho Pele initiatives have improved the quality of care. However, there is still room for improvement especially with regards to health workers attitude and implementation of Patients' Rights Charter.

Public Private Interactions:
A lot of NGO's work with government in delivering services to the public, especially in the areas of home based care for HIV and AIDS patients. Some of these need to be capacitated.

Information Technology and Management
This is still a huge challenge within the Department, particularly the Hospital Information System. In addition the wide area network infrastructure still needs to be developed and improved in some institutions.

Public Private Partnerships (PPP's):
The capacity to manage the PPP Plan aimed at outsourcing the Non – core functions such as Laundry, etc. still remains a challenge.

Implementing the Department's fraud prevention plan
The implementation of this plan is underway but full compliance with the PFMA remains a challenge.

5.2 Summary of Organisational environment and challenges

Key issues impacting on Health services

There are key issues which impact on the capacity of the Department of Health to deliver quality services and improve health outcomes of the population of this province. These are:

During the decade, Health in Limpopo used to be the least funded and the most disadvantaged province in terms of funding for health. The per capita funding of the Limpopo was 25% less than the equitable share of the national budget. This did not take into account the tertiary service conditional grant which favours the better resourced provinces. The net effect was that this had a most fundamental impact on the capacity of the DoHSD to deliver on its priorities and meet health needs. However, Treasury is now attending to this budgetary anomaly which should see the provincial resource budget improving.

Due to historical lack of development of services, the population of the province is under serviced with one of the lowest admission rates in the country (65/1000 for non-Aids acute admissions).

Access to health facilities remains a challenge to utilisation of health services. Unsuitability and poor condition of physical facilities impact negatively on the quality of care.

The migration of labour as reflected by migration of Health Professionals to the private sector, other countries and provinces drains local expertise and skills. Recruitment and retention of appropriate staff to all Health care settings remains a challenge.

The study of Burden of Disease will assist in proper Public Health Planning, monitoring, evaluation and accurate reporting.

The re-configuration of the Department as Health and Social Development brings with it opportunities and challenges that need to be managed efficiently and effectively. The establishment of the South African Social Security Agency (SASSA) would naturally necessitate the re-organisation of our Provincial Organogram and Health and Social Development Services in order to carryout the new mandates for the next five year strategic period.

6. LEGISLATIVE AND OTHER MANDATES

1) The Constitution of RSA, Act 108 of 1996
2) National Health Act 61 of 2003
3) Chiroparactors, Homeopaths and Allied Health Professions Amendment Act 6 of 2000
4) Chiroparactors, Homeopaths and Allied Health Professions Second amendment Act 50 of 2000
5) Council for Medical Schemes levies Act 58 of 2000
6) National Health Laboratory Services Act, Act 37 of 2000
7) Foodstuffs, Cosmetics and Disinfectants Act, Act 54 of 1972
8) Pharmacy Act, Act 53 of 1974 as amended by no 1 of 2000
9) Hazardous Substances Act, Act 15 of 1973
10) Medicines and Related Substances Control Act, Act 90 of 1997 amended
11) SA Medicines & Medical Devices Act, Act 101 of 1965
12) Compensation for Occupational Injuries and Diseases Act, Act 130 of 1993.
13) Tobacco Products Control Act, Act 12 of 1999
14) Allied Health Professions Act, Act 63 of 1982
15) Dental Technicians Act, Act 43 of 1997
16) Health Professionals Act, Act 25 of 2002
17) South African Nursing Act, Act 5 of 1995
18) S.A. Medical Research Council Act, Act 58 of 1991
19) Sterilization Act, Act 44 of 1998
20) Choice on Termination of Pregnancy Act, Act 92 of 1996
21) Mental Health Act, Act 17 of 2002
22) Northern Province Health Services Act, Act 6 of 1998
23) Limpopo College of Nursing Act, of 2003
24) P.F.M.A., Act 1 of 1999 as amended by act 29 of 1999
25) Treasury regulations 2002
26) Public Service Act Proclamation 103 of 1994
27) Public Service Regulations, 2001
28) Labour Relation Act, Act 12 of 2002
29) Skills Levy Act, Act 9 of 1999
30) Employment Equity Act, Act 55 of 1998

31) Skills Development Act, Act 97 of 1998
32) Basic Conditions of Employment Act, Act 75 of 1997
33) SAQA' Act 4 October 1995
34) Human Sciences Research Act, Act 23 of 1968
35) White paper on Transformation of the Public Service
36) Occupational Health and Safety Act 85 of 1993
37) Traditional Health Practitioners Bill
38) Promotion of Access to Information Act
39) Higher Education Act

7. BROAD POLICIES, PRIORITIES AND STRATEGIC OBJECTIVES

The Priorities for the National Health System for the next Five year strategic period 2004-2009 as approved by the Health MINMEC are listed below:

7.1.1 Improve Governance and management of the NHS/Provincial Health System
7.1.2 Promote healthy lifestyles
7.1.3 Contribute towards human dignity by improving quality of care
7.1.4 Improve the management of communicable diseases and non-communicable illnesses
7.1.5 Strengthen Primary Health care, EMS and Hospital service delivery systems
7.1.6 Strengthen support services
7.1.7 Human Resource Planning, Development and Management
7.1.8 Planning, Budgeting and Monitoring and Evaluation
7.1.9 Prepare and implement legislation
Strengthen International Relations

7.2 Broad Policies

7.2.1 Constitution, (1996):

The Constitution guarantees everyone the right to health care services and security. Those who are unable to support themselves and their dependants are guaranteed appropriate social assistance.

The state is required to take legislative and other measures within its available resources, to achieve the progressive realisation of these rights.

Further, no one may be refused emergency medical treatment.

Special mention is made of the rights of children. They must be provided with appropriate care when removed from their families. They also have the right to basic nutrition, shelter, basic health care social services and to be protected from maltreatment, neglect, abuse or degradation.

All members of the public have right to participation and empowerment, inter-sectoral collaboration, cost-effective care and the integration of preventative, promotive, curative and rehabilitation services. Thus the core function of the department is to render health and related services, which have been assigned to the Province in terms of the Constitution.

7.2.2 National Health Act (Act 61 of 2003):

Section 2: The Object of the Act is to regulate national health & to provide uniformity in respect of health services across the nation by:

Establishing a national health system which –
encompasses public & private providers of health services
Provide in an equitable manner the population of the Republic with the best possible health services that available resources can afford

Setting out the rights & duties of health care providers, health workers, health establishments and users

Section 3: The Responsibility for Health is to provide for the realisation of the Bill of Rights as enshrined in Sections 7 (2); 27 (2); 27 (3) and 28 (1) (c) of the Constitution of RSA.

Section 4: Eligibility for Free Health services in Public Health Establishments:

(a) Pregnant and lactating women & children below the age of six years who are not members or beneficiaries of Medical Aid Schemes
(b) All persons, except members of the medical aid schemes & their dependants and persons receiving compensation for compensable occupational;

- Patients Rights (Consent, Confidentiality, Promotion of Access to Information Act (2000); etc.)

- District Health System (Chapter 5): requires formation of Governance Structures to manage healthcare panning and services

- Certificates of Needs (Sections 36 - 40):

- Inspectorate for Health Establishments and Office of Standards Compliance (Sections 77 - 89)

7.2.3 The October 2003 Cabinet Decision on the Provision of the Comprehensive HIV & AIDS Care, Management, Treatment & Support:

7.2.4 National PPP Framework
7.2.6 Supply Chain Management Policy:

7.2.7 Transport Policy:

7.2.8 Minimum Information Security Standards

7.2.9 The promotion of Access to Information Act (No. 3 of 2000)

7.2.10 The electronic communication and transactions Act (No. 25 of 2002)

7.2.11 The National Archives and Record Services Act (No. 43 of 1996 as amended)

7.2.12 Control and Access to Public Premises and Vehicle Act (No 53 of 1985)

8 CORE FUNCTIONS

- To provide Regional and specialized Hospital services as well as academic Health services, where relevant;
- To render and co-ordinate Medical Emergency services (including ambulance services);
- To render Medico-legal services;
- To render health services to those detained, arrested or charged;
- To screen applications for licensing and inspection of Private Hospital facilities.
- Quality control of all health services and facilities.
- Formulate and implement Provincial Health policies, norms, standards and Legislation.
- Inter-Provincial and Inter-Sectoral co-ordination and collaboration.
- Co-ordinate the funding and financial management (budgetary process) of the District Health services.
- Provide technical and logistical support to Health Districts.
- Render specific Provincial services programmes, e.g., TB programme.
- Provide non-personal Health services.
- Provide and maintain equipment, vehicles and health care services.
- Effective consultation on health matters at the local level.
- Provide occupational health services.
- Research on, and planning, co-ordination, monitoring and evaluation of health services rendered in the Province.
- Ensure that functions delegated by the National level are carried out, including providing primary health care services (until they are devolved) and district hospital services.

8.1 PROVINCIAL STRATEGIC GOALS

- HIV and AIDS,TB,STI & other communicable diseases
- Districts Health services and Primary Health Care services
- Emergency Medical services
- Logistical support services (including pharmaceuticals)
- Infrastructure development (including hospital revitalization, clinic upgrading and maintenance)
- Human Resources management issues
- Human Resource development

- Communication, collaboration and participation
- Tertiary service development
- Revenue generation

8.2 MAIN SERVICE/FOCUS AREAS

- Prevent and control the spread of HIV and AIDS, STI & TB
- Integrated Mother, Child, Women Health services
- Improving nutritional status
- Integrated Primary Health Care
- EMS across the province
- Equitable access to health care services
- Quality patient care
- Tertiary services
- Training of health professionals
- Developing & implement capital upgrade and building programmes for health facilities.
- Provision of good financial, administrative, Human resource(management, planning, development, labour relations), and operational support
- Devolution of District Health Services
- Occupational Health-related conditions
- Prevention and Control of Communicable Diseases
- Oral health services
- Services to the Aged and people with chronic diseases
- Mental Health

INFORMATION SYSTEMS TO MONITOR PROGRESS

8.3 Financial information systems

- The Department uses transaction processing systems that have been adopted by Limpopo.
- The FINEST system is used for the issuing of orders, capturing of invoices, Asset and Revenue Management.
- The BAS System is used for reporting of financial information that is used in all reports on financial performance and payment of vouchers.

8.4 Operational information systems

- The Hospital Information System (HIS) is used for the capturing of all data in respect of patients administration. This system cannot interface with the financial system, PERSAL and other transversal information systems.
- District Health Information Systems is a system that functions on the MS Access based system. The system is used to capture hospital and primary health care data. This is the system that is used to capture early warning system
- The pharmaceutical Distribution system is used to monitor medicine content at the different depots in the province.

DESCRIPTION OF THE STRATEGIC PLANNING PROCESS

10.1 Staff involvement

Planning starts at the cost centre level to enable Managers to bring inputs to a central planning event. The department then holds consultative and review workshops annually with members of the senior management, Heads of institutions and programme managers.

10.2 Stakeholders Involvement

The National Departments of Health and Social Development guides this process through facilitation and development of guidelines, frameworks and in – year monitoring tools such as the quarterly reporting formats and guidelines. The three spheres of Government also interface through the National Spatial Development Perspective from the office of the Presidency, the Provincial Growth and Development Strategy, Provincial Cluster Committees, the GIS, and the Municipalities IDPs. For future planning the department will be consulting with provincial and district health councils, Hospital boards, clinic committees, Portfolio committee, etc.

PART B: PROGRAMMES AND SUB-PROGRAMME PLANS

11 PROGRAMME 1: ADMINISTRATION

To provide the overall strategic management and support services in the following areas:

- Political and legislative interface between Government, Civil Society and the relevant stakeholders.
- Policy interpretation and strategic direction.
- Service Delivery
- Corporate services.
- Infrastructure and technology.
- Demographic and health data for planning and information.
- Develop and manage Heath Information System.
- Transformation of Health Services through service delivery improvement plan.
- Human resource development and management.

11.1 Situational Analysis

The per capita expenditure in Limpopo is R 968, which is the lowest in the country.

The Department was the second lowest funded, until two financial years ago when Mpumalanga's budget was increased and thus we became the lowest funded.

The national treasury formula for social cluster, Department and other funding is not adhered to and disadvantage the Department of Health because the Lion's share goes to Department of Education.

Key Challenges over a strategic plan period

Population Dynamics (size of population, cross border patients flow vs limited resources)

Factual knowledge of the Burden of Disease to assist in planning and service improvement and delivery;

Development and Implementation of HR Strategy;

Alignment of the Provincial Health legislation to the National Health Act;

Full Implementation of Fraud Prevention and Risk Management Plan in line with the provisions of the PFMA;

Management of total security functions within the Department in terms of (MISS) Minimum Information Security Standards and departmental security policy.

Management Information Systems.

11.2 Specific programme Policies, Priorities and Strategic Objectives

11.2.1 Policies

- National Health Act (61 of 2003)
- Comprehensive HIV & AIDS care management treatment and support strategy
- PFMA
- Health Technology policy
- NP Health services act
- Supply Chain Management Act
- Promotion of Access to information Act (2000)

11.2.2. Priorities

- Improve governance and the management of the Provincial Health System (PHS)
- Strengthen Admin support services
- Human resource planning development and management
- Planning, budgeting and monitoring and evaluation

- Prepare & implement legislation
- Implementation of Fraud Prevention and Risk Management Plan;
- Management of Records and Information Systems
- Strengthen Communication

11.2.3 Strategic Objectives

TABLE 5: STRATEGIC GOALS AND OBJECTIVES FOR PROGAMME 1.

STRATEGIC GOALS	STRATEGIC OBJECTIVES
MEC OFFICE Commitment by the MEC to national and provincial policies.	Ensure fulfillment of statutory obligations (executive and political mandates)
HOD OFFICE Management of the department	Ensure that the responsibilities assigned by all applicable acts of parliament are adhered to. Provision of strategic leadership and management oversight for the department
1.3 CFO OFFICE Management of finance and Supply - Chain Management	To develop and promote sound financial management systems and processes
	1.3.2 To develop , promote and maintain an effective, efficient, economical, transparent provisioning and contract management system
	1.3.3 To co-ordinate the development and management of public private partnerships
	1.3.4 To provide capital infrastructure
	1.3.5 To provide and coordinate effective and efficient fleet and logistics management
1.4 CORPORATE SERVICES OFFICES Management of Corporate Services	1.4.2 To develop and promote human resource systems and processes including labour Relations
	1.4.3 To co-ordinate and provide strategic management oversight
	1.4.4 To coordinate and provide transformatory, inter-governmental and quality improvement oversight

1.5 Health Care Office Management of health care services	1.5.1 To coordinate, integrate and implement Health services in the department 1.5.2 To establish and maintain partnerships for service delivery
1.6 G I TO Management of risk, information and records as well as information technology resources.	1.6.2 To provide and implement departmental wide risk management systems and Processes
	To develop and maintain reliable information systems for the Department
	To manage records and archives for the department.

11.3 Analysis of constraints and measures planned to overcome them

Constraints	Measures to overcome constraints
Departmental vacancy rate of 36%.	Development and Implementation of HR Plan
Rural and scarce skills allowances not covering all staff members	Ongoing lobbying with treasury and other stakeholders
Absence of the Burden of Disease (BoD) study	A Provincial Study on BoD is underway

11.4 Description of planned quality improvement measures

The quality of service will be improved through, amongst others; the following measures:

(1)Organisational Development
Effective implementation of performance management systems
Capacity building programmes
On-going review and re-engineering of institutional systems and structures
Skills audit

(2)Service delivery improvement plan
Batho – Pele
Patient Rights Charter
The coordination of service standards and Citizen's report

3) Health Technology
Health Information System
Tele-Health

(4) Physical facilities management

Planning
Maintenance

(5) Monitoring and Evaluation
Quarterly, Half yearly and annual reports

12. PROGRAMME 2: DISTRICT HEALTH SERVICES

12.1 Situation analysis

12.1.1.1Integrated Primary Health Care

- The Limpopo Strategic Position Statement proposes province needs about 97 new clinics (Capricorn needs 39; Bohlabela = 14; Mopani = 2; Sekhukhune = 38; Vhembe = 6 and Waterberg needs 2 clinics). Some clinics are in need of general upgrading, water and electricity supply while some need communication systems such as radio and telephones (see Programme 8 at the back
- 24 Hour Service is still low in some areas;
- There is a need for Mobile Clinics throughout province;
- Staff : Client Ratios still inadequate in some areas;
- Staff Skill Mix: need more PHC Nurses;
- Staff Attitudes can still improve more:
- Accelerate Change of mindset e.g. from Curative to Preventive Care;
- Management of Drugs – shortages at some clinics;
- Collaboration with Traditional and Faith Healers need to improve;
- Referral System: Patient Transport need better management by the Districts;
- Staff Attrition & Turnover Rates are still areas needing better management;

12.1.2 District Health & Devolution of Services

- The Devolution Strategy has been developed and is being implemented: Municipal Health Services (Environmental Health Services) have been transferred to the District Municipalities;
- The process of finalising transfer of clinics from Municipalities to province is underway;
- Districts Health Councils are being established;
- The Plan to delegate PHC Services to District Municipalities is unfolding.
- Challenges: EHS Personnel and assets have not yet transferred due to disparities in Conditions of Employments between the Department and Municipalities.

12.1.3 Communicable Diseases Control & Non – Personal Health Programmes

- Programmes for Reduce morbidity and mortality through rapid detection (within 5days) and response to outbreaks of Cholera, Meningococcal meningitis, Typhoid fever food-borne diseases and others are being undertaken;
- Currently, of the 1509 Notifiable Medical 84% of the cases are TB, Typhoid 11% and 0.4% and food poisoning accounted for 0.4%;
- Fully immunized children under one year of age is 79. %:

Routine Coverage's:

Measles =82.7%
DPT-HIB3 = 89.3%
Polio = 85%

Immunization campaign coverage's:

Polio first round =99.%
Polio 2nd round = 84%
Measles coverage=84%

- Detection and investigation of at least 1 Acute Flaccid Paralysis (AFP) case per 100 000 children under 15 years of age (Limpopo expected to detect 25 cases per yr):

- Active AFP surveillance is continuing in all institutions. 90% of the sites submit their monthly reports including zero reports.

- An Audit conducted in 92% of the health facilities to assess compliance with the Occupational Health & Safety Act of 1993

- Measures to implement a Plan for a comprehensive management of Health Care Waste are being finalized
- Challenges:
- Under and late reporting due to lack of dedicated personnel;
    - Non –compliance by some health facilities.

12.1.4 Maternal, Child, Women and Youth Health & Nutrition

- 90% of facilities offer Integrated Management of childhood Illness programme;
- % of all live births have low birth weight;
- The incidence of pneumonia in children less than 5 years reduced from 5.46 quarter to 4.10per thousand children under one year of age in 2004;
- The incidence of diarrhoea with dehydration in children less than 5 years increased from 1.28 in the previous quarter to 1.54 per thousand children under one year of age;
- The incidence of diarrhoea without dehydration in children less than 5 years increased from 11.63 in the previous quarter to 12.57 per thousand children under one year of age
- Delivery rate of girls aged less than 18 years is 9.18%;

12.1.5 Maternal Health:

- PHC facilities are designated to provided the CTOP service by the National Department of Health
- 818 CTOP performed at designated institutions. 93% performed in less than 12 weeks of gestation
- 32% performed in women aged less than 18years of age
- Curriculum on abortion care presented to the South African Nursing Council
- Debriefing workshop with service providers held:
    - Antenatal coverage is 93.97%
    - Antenatal visits per client is 4
    - Antenatal less than 20 weeks rate is 32.75%
    - Tetanus Toxoid for antenatal clients is 75.79%
- Challenges: No abortion care trainer at college; Shortage of staff and transport to implement School Health services and need to prevent maternal deaths.

12.1.6 Malaria Programme

- Malaria Case Fatality Rate reduced from 1.1% to 0.6% (1115 cases & 7 deaths)
- 730 (target=700) structures were sprayed during the 2004/05 period;

Challenges:

- Delay in patients seeking health care for malaria;
- Poor management of complicated malaria cases by Health Care practitioners.
- Late notification of Malaria related death

12.1.7 HIV & AIDS, STIs & TB

- Incidence of STIs is 0.63 per 1000 population above 15yrs of age; STI slips issued rate is 84.2%; Contact tracing rate is 28.07% and STI partner treatment rate is 23.64% AND Male Condom usage rate is 11.04;
- 323 NPOs are providing Community Home – Based Care services to about 45 000 people.
- 8 sites are rendering the Comprehensive HIV & AIDS Care, Management, Treatment & Support services:
- 497 patients were on treatment by end of Nov 2004;
- Nutritional supplements delivered to all sites;
- weeks for ARV module, 4 days ARV module and ART adherence Training running concurrently up to Jan 2004;
- 60% sites personnel appointed;
- All facilities offer VCT services; VCT counselling rate is 96.46% and VCT testing rate is 58.76%;
- Multi – Drug Resistance (MDR) TB is still posing a challenge for our efforts to manage Tuberculosis. The MDR Clinic established at Polokwane/Mankweng Health Complex is receiving and treating patients referred from peripheral hospitals. Plans are underway to open a provincial MDR Specialised ward in Modimolle. Non – compliance by affected individuals contribute significantly to the development of Multi – Drug Resistance TB and thus there is a big need for communities to participate in Directly Observed Treatment Support (DOTS) groups to ensure compliance to appropriate treatment regimens.

12.1.8 District Hospitals

According the Strategic Position Statement (SPS bed provision levels are currently lower for all acute levels of care than recommended.
L 1 beds at 1.22 beds per 1000 population are 6% less than the recommended norm of 1.3 beds per 1000 population.
District hospitals provide mainly level 1 care (which is care provided by general medical practitioners). Medico-legal services are rendered at the majority of district hospitals and (TB) patients are treated in a number of district hospitals. Some districts hospitals provides specialised services as well:

- Ophthalmology at Elim Hospital.

- MDR Care at FH Odendaal Hospital
- Acute psychiatric care at:
  - Tintswalo Hospital
  - Siloam Hospital
  - Donald Fraser Hospital
  - Groothoek Hospital, and
  - Nkhensani Hospital.

Table 6 : Bed Distribution

Hospitals	No. of level 2 beds	No. of levels 1 beds	Total no. of beds
District Hospitals		6020	6020
Total		6020	6020

Table 7 : Summary of hospital bed distribution and efficiency by level of care

Level of Care	Current beds	Bed / 1000 population	Admission / year	Admission rates	Inpatient Days	ALOS	% Occupancy
Level I	6,020	1.22	274,480	44	1,317,285	4,8	60
TOTAL	6,020	1.22	274,480	44	1,317,285	4,8	60

- A Quality Improvement Plan is being implemented in all District Hospitals. The average Patient waiting time is estimated at 4.27 hours; 28 Medical Practitioners visits clinics at least monthly; four hospitals have sub-acute beds that are functioning well.
- A Hospital revitalisation plan is underway and achievements include: 66.7% with 60% equipments according to the District health package; 93.3% have maintenance plans; 100 % hospitals with approved business plans; 30 Hospitals conducted peer review on morbidity and mortality; 100% of district hospitals have conducted Patient satisfaction survey and Client satisfaction rate is 87.8%.
- Average length of Stay is 5.2 days is and 72% of Usable Bed Utilization rate has been achieved
- Challenges:
  - Incapacity in patient administration;
  - In adequate outreach programs to clinics and Health Centres;
  - Shortage of Medical Practitioners and Allied Health Professionals;
  - Shortage of transport

12.1.8 Partnership for the Delivery of PHC, HIV & AIDS Services (PDPHC)

- The overall programme goal is to strengthen District Health Service delivery through Primary Health Care for the poorest communities in Bohlabela and Sekhukhune District by formalising partnerships between the Department and NPOs with more focus on PHC and HIV & AIDS Services.
- Provincial Programme Management Unit (PMU) has been established and is operational;
- District Programme Management Units for Sekhukhune districts have been established and are functioning;
- A Tool for district needs analysis has been developed assist with baseline evaluations needed for planning partnerships programmes;
- National DoH has developed a Tool to profile NPOs/NGOs and work has started in this regard;
- A Plan is underway to review Packages for HIV & AIDS Continuum of Care.
- **Challenges:**
    - Lack of human and other material resources to fast track implementation of the programme;
    - Programme started late in provinces in relation to EU – RSA contractual time scales;
    - Poor conceptualisation of the programme and inadequate mechanisms for easy integration of the programme with conventional PHC and HIV & AIDS Services at the Districts make implementation slower than it should.

Table 8 Personnel in district health services by health district1

Health district	Personnel category	Number employed	Number per 1000 people3
Waterberg District	Medical officers	75	0.01
	Professional nurses	664	0.13
	Staff Nurses	284	0.05
	Assistant Nurses	378	0.07
	Pharmacists	15	0.002
	Allied Health Professionals	66	0.01
Sekhukhune District	Medical officers	30	0.005
	Professional nurses	672	0.13
	Staff Nurses	281	0.05
	Assistant Nurses	243	0.05
	Pharmacists	8	0.001

	Allied Health Professionals	58	0.01
Capricorn District	Medical Officers	39	0.01
	Professional Nurses	956	0.18
	Staff Nurses	348	0.06
	Assistant Nurses	502	0.09
	Pharmacists	10	0.001
	Allied Health Professionals	151	0.03
Mopani District	Medical Officers	60	0.01
	Professional Nurses	927	0.18
	Staff Nurses	478	0.09
	Assistant Nurses	387	0.07
	Pharmacists	12	0.002
	Allied Health Professionals	87	0.02
Vhembe District	Medical Officers	38	0.01
	Professional Nurses	1 539	0.29
	Staff Nurses	892	0.17
	Assistant Nurses	750	0.14
	Pharmacists	12	0.002
	Allied Health Professionals	69	0.01
Bohlabela District	Medical Officers	52	0.01
	Professional Nurses	464	0.09
	Staff Nurses	262	0.05
	Assistant Nurses	304	0.06
	Pharmacists	0	0
	Allied Health Professionals	79	0.01

12.2 POLICIES, PRIORITIES AND STRATEGIC OBJECTIVES

12.2.1 Policies

- Chapter 5 of the National Health Act
- Free Primary Health Care package
- District Hospital package
- Comprehensive HIV & AIDS care, management, treatment and support plan
- Free health for Pregnant Women, children under 6, disabled and the aged
- Choice of Termination of Pregnancy policy ;
- EU/SA Agreement of July 2002;
- Treasury PPP Policy Document

12.2.2 Priorities

- Integrated Primary Health Care
- District Health Services and Devolution
- Communicable Disease Control
- Malaria programme
- HIV & AIDS, STIs & TB
- Decentralization of Hospital Management
- Strengthening of Partnerships with NPOs

12.2.3 Strategic Objectives

TABLE:9 STRATEGIC GOALS AND OBJECTIVES FOR PROGAMME 2.

STRATEGIC GOALS	STRATEGIC OBJECTIVES
2.1 Integrated Primary Health Care Full implementation of Primary Health Care (PHC) packages at all PHC facilities	2.1.1 To provide comprehensive PHC packages at all PHC facilities
	2.1.2 To improve Access to PHC services

2.2 DHS AND DEVOLUTION Implementation of Devolution Strategy to improved the Integration of IDPS and the Mobilisation of Stakeholders on Devolution of PHC and Environmental Health Services.	2.2. To develop and manage the implementation of the DHS devolution strategy
2.3 COMMUNICABLE DISEASE CONTROL Effective and efficient management of the expanded programme on immunization . Improve the management of communicable and non diseases	2.3.1 To increase immunization coverage of children under 1yr
	2.3.2 To reduce mortality and morbidity through rapid response to outbreaks of disease
	2.3.3 To improve the health care waste management
2.4 Maternal Child women and youth health and Nutrition	2.4.1 To reduce morbidity and mortality in women and children
	2.4.2 Improved youth and adolescent health
	2.4.3 Improved nutritional status of the vulnerable population
	2.4.4 To increase access to CTOP services
	2.4.5 To improve the nutritional status of children under 5 years of age through the Integrated Nutrition Programme (INP)
2.5 Malaria Programme Protection against malaria and awareness to the risk of malaria	2.5. To reduce malaria incidence and fatality rates
2.6 HIV & AIDS,STIs and TB Reduced HIV & AIDS prevalence Increased TB cure rate	2.6.1 Increase access to comprehensive care, management, Treatment & Support
	2.6.2 Reduce mortality and morbidity due to TB
	2.6.3 Promote community participation and partnership
2.7 District hospitals Improvement of quality of Services Improvement in Hospital efficiencies	2.7.1 To improve quality of care
	2.7.2 To improve health technology in health facilities
	2.7.3 to improve infrastructure/capital of health facilities
	2.7.4 Decentralisation of hospitals management
	2.7.5 To coordinate HR Development & Training

2.8 EU PDPHC & HIV & AIDS Implementation of partnerships with NPOs for the delivery of PHC including HIV & AIDS services within the Districts.	2.8.1 Establishment and strengthening of the delivery of PHC services through partnerships with NPOs
	2.8.2 To formalize partnerships between NPOs and government within the Districts
	2.8.3 To align NPOs and Governance Structures functioning within government policies and strategies

12.3 Analysis of constraints and measures planned to overcome them

Constraints	Measures
Access to services	Make PHC and district hospitals packages available in the relevant institutions.
	Recruitment and retention of appropriately trained staff.
	Improve security at health facilities.
	Improvement of staff attitude.
	Improve provision of 24 hrs service
	Improving mobile services
Lack of capacity in the implementation of district health information systems	Capacity building of staff.

12.4 Description of planned quality improvement measures

The quality of service will be improved through, amongst others; the following measures:

(1) Organisational Development
Effective implementation of performance management systems

Capacity building programmes
On-going review and re-engineering of institutional systems and structures

(2) Service delivery improvement plan
Batho – Pele
Patient Rights Charter
The implementation of service standards and Citizen's report

(3) Health Technology
Utilization of Health Information System and Tele-Health

(4) Physical facilities management
Maintenance

(5) Monitoring and Evaluation
Quarterly, Half yearly and annual reports

13 PROGRAMME 3 – EMERGENCY MEDICAL SERVICES

13.1 Situational Analysis

- Emergency Medical Services in the province has showed an increase in the number of emergency cases that required the services of the programme by an estimated 10% as compared to the previous years.
- Identification of new EMS services has also taken place, so that we are able to improve our response time/ access to all emergency calls in the province.
- More emphasis was put on the training of Advanced Life Support personnel with the aim of improving patient care in the pre hospital setting.
- Aero – medical services are provided through a Private Public Initiative (PPI)

13.2 Policies, priorities and strategic objectives

13..2.1 Policies
The National Health Act of 2003

13.2.2 Priorities
- HR development

- Improve access to EMS services

13.2.3 Strategic Goals

TABLE 10 : STRATEGIC GOALS AND OBJECTIVES FOR PROGAMME 3.

STRATEGIC GOAL	STRATEGIC OBJECTIVES
EMERGENCY MEDICAL SERVICES Provision of quality Emergency Medical Services	3.1.1 To improve access to emergency medical service (EMS)
	3.1.2 To provide EMS in line with National norms
	3.1.3 To provide training of Emergency care practitioners

13.3 Analysis of constraints and measures planned to overcome them

Constraints	Measures to overcome constraints
Obsolete communication system	To replace the Obsolete communication system
Inadequate Emergency Care Practitioners	To recruit and retain personnel
Inadequate transport	To implement full maintenance lease through PPP
Inadequate number of Ambulance stations in the province	To provide and improve an ambulance station for each district

13.4 Description of planned quality improvement measures

The quality of service will be improved through, amongst others; the following measures:

(1) Organisational Development
Effective implementation of performance management systems
Capacity building and training programmes
On-going review and re-engineering of institutional systems and structures

(2)Service delivery improvement plan
Batho – Pele
Patient Rights Charter

The implementation of service standards and Citizen's report

(3) Health Technology
Utilization of Health Information System and Tele-Health

(4) Physical facilities management
Maintenance

(5) Monitoring and Evaluation
Monthly, Quarterly, Half yearly and annual reports

14. PROGRAMME 4 – PROVINCIAL HOSPITALS SERVICES

14.1 Situation analysis

Hospital Performance
There is a wide diversity in regional hospital performance. Warmbaths Hospital appears to be the most efficient of regional hospitals with an admission rate of 200 per 1000 population, 93 % bed occupancy and ALOS of 5 days. In contrast Mapulaneng Hospital has an admission rate of 55 per 1000, 86 % bed occupancy but ALOS of 8, 3 days.

In 1996 the National Hospital Strategy Project recommended that 3.7 beds per 1000 population was required to deliver hospital services in the Public Sector. This was subsequently reviewed by a task team of the PHRC and revised to 2.3 beds (1.3 level 1, 0.5 level 2, 0.1 level 3, and 0.4 chronic)

An assessment of current hospital utilisation and efficiency in the Limpopo Province suggests (SPS 2001):

Overall bed provision of between 1.86 and 2.2 beds per 1000 population is lower than the recommended level of 2.3 beds per 1000 population.

L2 beds at 0.35 are 30% less than the recommended norm of 0.5 beds per 1000 population.
Chronic (Psychiatric and TB) bed provision of 0.57 is 42.5% higher than the recommended norm of 0.4 beds per 1000 population.

Most of the beds used for TB are in acute hospitals and if considered L 1 and L2 beds then the overall bed occupancy for acute beds is 62%, which is 18% lower than the recommended level of 80%.

If the current population served by facilities (5,832,913) as indicated in the province is considered then the overall public bed provision is 1.86 bed per 1000 population.

ALOS (5.2 days) for all acute services is in line with recommendations by the HSP (between 5 and 8 days) overall acute admission rate of 62 is considerably less than 85/1000 recommended by the Hospital Strategy Project (HSP). This suggests a gross under-utilisation and / or non- availability of services resulting in patients being treated elsewhere.

Referral Patterns
The regional hospitals are distributed as follows:

Waterberg District –Mokopane Hospital and Warmbath Hospital
Vhembe District -Tshilidzini Hospital
Mopani District -Letaba Hospital
Bohlabela District -Mapulaneng Hospital
Sekhukhune District - St Rita's' Hospital.
The Capricorn District - Polokwane/Mankweng Hospital Complex.

Regional hospitals refer patients for tertiary care to Polokwane and Mankweng Hospitals. Polokwane/ Mankweng Hospital Complex refer a number of patients to Dr. George Mukhari Hospital because they do not have the capacity to render some of the highly specialised services.

Services Offered

Regional hospitals provide level 1 and level 2 care that include the following clinical disciplines:

Internal medicine
General surgery
Orthopaedics
Paediatrics
Obstetrics and Gynaecology
Anaesthetics
Intensive care,

Table 11 Chronic psychiatric inpatients are treated at Evuxakeni Hospital, Thabamoopo Hospital and Hayani Hospital which also has a forensic unit.

Hospitals	No. of level 2 beds	No. of levels 1 beds	Total no. of beds
Regional Hospital	751	1128	1879
Total	751	1128	1879

Table 12: Summary of hospital bed distribution and efficiency by level of care

Level of Care	Current beds	Bed / 1000 population	Admission / year	Admission rates	Inpatient Days	ALOS	% Occupancy
Level II	1,734	0.35	66,430	17	421,210	6,3	67
Psychiatry (acute)	2,052	0.42	1,825		703,720	N/A	N/A
Chronic TB	769	0.16	10,585	2	183,230	17,3	65
TOTAL	4,555	0.93	78.84	19	1,308,16	23,6	

Table 13 : Hospital Performance Indicators as at December 2004

HOSPITAL PERFORMANCE INDICATOR	PROGRESS REPORT
OUTPATIENT VISITS	17 450
ALOS	6
UBUR	68%

COST PER PDE	849
COST PER SEPARATION	7 791

14.2 Policies, Priorities and Strategic Objectives

14.2.1 Policies

- National Health Act
- Secondary Hospital package
- Comprehensive HIV & AIDS care, management, treatment and support plan
- Free health for Pregnant Women, children under 6, disabled and the aged
- Choice of termination of pregnancy policy
- Modernisation of Tertiary Services
- National Health Laboratory Services Act

14.2.2 Priorities

- Revitalization of Hospitals
- Implementation of Secondary Hospital Package
- Decentralisation of Hospital management
- Specialised Hospital Services
- Accreditation of facilities for teaching purposes

14.2.4 Strategic Objectives

Table 12 : Strategic Objectives – Programme 4

STRATEGIC GOALS	STRATEGIC OBJECTIVES
4.1 REGIONAL and SPECIALISED HOSPITALS SERVICES Provision of Secondary Hospital services Provision of training platform	4.1.1 To improve Hospital Infrastructure
	4.1.2 To improve health technology in all provincial hospitals
	4.1.3 Decentralization of management
	4.1.4 Transformation of Nursing Services

	4.1.5 To train & develop staff
	4.1.6 To build Management and Leadership capacity
	4.1.7 To improve Health Technologies at facilities
	4.1.8 To improve efficiency in health facilities
	4.1.9 To improve q Quality of Service
	4.1.10 To implement a maintenance policy
4.2 Coordination of Laboratory Health Services	4.2.1 To implement the Service Level Agreement s and monitoring of laboratory

14.3 Analysis of Constraints and Measures planned to overcome them

Constraints	Measures
Access to services	Make Secondary Hospital package available.
	Recruitment and retention of appropriately trained staff.
	Improvement of staff attitude.

14.4 Description of planned quality improvement measures

The quality of service will be improved through, amongst others; the following measures:

(1)Organisational Development
Effective implementation of performance management systems
Capacity building and training programmes
On-going review and re-engineering of institutional systems and structures

(2)Service delivery improvement plan
Batho – Pele
Patient Rights Charter
The implementation of service standards and Citizen's report

(3) Health Technology
Utilization of Health Information System and Tele-Health

(4) Physical facilities management
Maintenance

(5) Monitoring and Evaluation
Monthly, Quarterly, Half yearly and annual reports

15. PROGRAMME: 5 CENTRAL HOSPITALS AND PROVINCIAL TERTIARY SERVICES

15.1 Situational Analysis

Central Hospital Services
L3 beds (tertiary) at 0.05 is 50% less than the recommended norm of 0.1 beds per 1000 population.

Table 13: Summary of hospital bed distribution and efficiency by level of care

Level of Care	Current beds	Bed / 1000 population	Admission / year	Admission rates	Inpatient Days	ALOS	% Occupancy
Level III	269	0.005	8,395	17	73,365	8,9	75
TOTAL	269	0.005	8,395	17	73,365	8,9	75

Polokwane and Mankweng Hospitals provide secondary and tertiary level of care. The admission rates at these two hospitals are 45 and 49 per 1000 population respectively. Factors such as staffing, services offered, transport and drug availability may affect admission rates.

In addition to regional hospital services the following tertiary services are provided:

Cardiology

Urology
Paediatric surgery
Cardiothoracic surgery
Ophthalmology
ENT
Neonatology
Oncology
Radiology

A limited number of highly specialised services are provided at Polokwane and Mankweng Hospitals. This amounts to 6145 admissions and 26924 outpatient visits per year, which represents 1% and 2% respectively of the national figures.
These services include:

Clinical haematology
Endocrinology
Respiratory medicine
Nuclear medicine
Vascular surgery
Neurosurgery
Gastroenterology
CT scan
Burns and ICU
Renal Dialysis
Medical Resonance Imaging (MRI) outsourced

Table 14 : Numbers of beds in central hospitals by level of care1

Central hospital (or complex)	No. of level 3 beds	No. of levels 1 and 2 beds	Total no. of beds
Polokwane	317	105	422
Mankweng	240	240	480
Total	557	345	902

15.2 Policies, Priorities and Strategic Objectives

15.2.1 Policies

- National Health Act
- Tertiary Hospital package
- Specialised comprehensive HIV & AIDS care, management, treatment and support plan
- Free health for Pregnant Women, children under 6, disabled and the aged
- Choice of termination of pregnancy policy
- Modernisation of Tertiary Services
- National Health Laboratory Services Act

15.2.2 Priorities

- Revitalization of Hospitals
- Implementation of Tertiary Hospital Package
- Decentralisation of Hospital management
- Accreditation of facilities for teaching purposes
- Development of a medical school

15.2.3 Strategic Goals and Objectives

TABLE 15: provincial tertiary hospital

STRATEGIC GOALS	STRATEGIC OBJECTIVES
5.1 Provincial tertiary Hospital Provide Outreach Services and Tertiary Hospital Services	5.1.1 To improve efficiencies in health facilities
	5.1.2 Implementation of Outreach Programmes
	5.1.3 Develop Tertiary services
	5.1.4 Improvement of Financial Management Systems
	5.1.5 To provide an effective, efficient, economical and transparent procurement system
	5.1.6 Recruitment of adequate professional staff to provide tertiary health services
	5.1.7 Appropriate technology for delivery of health services in the complex and referring hospitals

	5.1.8 Improvement of infrastructure
	5.1.9. Decentralisation of hospital management systems
	5.1.5 Optimal revenue collection

15.3 Analysis of constraints and measures planned to overcome them

Constraints	Measures to overcome constraints
Under developed tertiary services	Make Tertiary Hospital package available.
	Recruitment and retention of appropriately trained staff.
	Improvement of staff attitude.
Partial accreditation	Recruit and retain training instructors
	Develop training facilities
Limited research capacity	Partner with MRC to develop the research capacity
	Implement twining agreements
Lack of management and Leadership skills	Capacitate managers and clinicians

15.4 Description of Planned Quality Improvement Measures

The quality of service will be improved through, amongst others; the following measures:

(1)Organisational Development
Effective implementation of performance management systems
Capacity building and training programmes
On-going review and re-engineering of institutional systems and structures
Build research capacity
Build management and leadership capacity

(2)Service delivery improvement plan
Batho – Pele
Patient Rights Charter
The implementation of service standards and Citizen's report

Increase and improve the number of specialised health services

(3) Health Technology
Utilization of Health Information System and Tele-Health

(4) Physical facilities management
Maintenance

(5) Monitoring and Evaluation
Monthly, Quarterly, Half yearly and annual reports

16. PROGRAMME 6 – HEALTH SCIENCES AND TRAINING

16.1 Situation Analysis

EMS Ambulance College

- 74 % of staff trained in BLS; 21 % of staff trained in ILS; 5 % of staff trained in ALS and 30 % of staff trained in defensive driving techniques
- College Accreditation suspended after successfully completion of one course and there is a shortage of training staff;
- Challenges: Allocation of more funds in order to reconstruct the College to the HPCSA required standards. Employ more training personnel

NURSING EDUCATION DIPLOMAS

- Provision of Diploma in ophthalmic nursing; currently 10 students are in training as this is dependent on study leave for trainees;

- Provision of Diploma in Nursing , Health Assessment, Treatment and Care: 71 students are in training against a target of 80;
- Decentralized Education Program in Advanced Midwifery and Neonatal Nursing Science (DEPAM); Study leaves approved

- Diploma in Clinical Nursing Science (OT, ICU, Orthopaedic, Paeds); Submission of request to use AFROX curriculum to SANC and Study leaves have been approved;

- Provision of Diploma in Midwifery: 148 students are in training against a target of 150;
- Provision 0f Diploma in General Nursing (community, psychiatric) and Midwifery Diploma in General Nursing (community, psychiatric) and Midwifery: Target has been met and a Total of 544 students are on training'
- Provision of r diploma in general nursing (bridging); 447 students are in training;
- Challenges: Inadequate residential accommodation and some training programmes dependent on approval of study leaves.

16.2 Policies, Priorities and Strategic Objectives

16.2.1 Policies

- SAQA
- SANC
- HRD Plan
- Work Skills Plan
- White Paper on the transformation of nursing education and training in South Africa, 1999
- White Paper on the transformation of health system in South Africa, 1997
- Nursing Act, 50 of 1978 as amended
- Skills Development Act

16.2.2 Priorities

- Conduct research in nursing
- Train mid level workers
- Train nurses
- Provide bursaries
- Train Emergency Care Practitioners

16.2.3 Strategic Goals and Objectives

TABLE 16: STRATEGIC GOALS AND OBJECTIVES FOR PROGAMME 6 – HEALTH SCIENCES AND TRAINING

STRATEGIC GOALS	STRATEGIC OBJECTIVES

6.1 Training of Nurses and Emergency Care Practitioners	6.1.1 To provide Nurse Training
	6.1.2 To provide technical and on –line support
	6.1.3 To initiate and implement partnerships with institutions of higher learning
	6.1.4 To provide training for Emergency Care Practitioners

16.3 Analysis of Constraints and Measures planned to overcome them

Constraints	Measures to overcome constraints
Inadequate training facilities	Negotiate for the utilisation of the under utilised nurses colleges in the province
	Upgrading of existing facilities
Failure to retain training personnel	Implement the recruitment and retention plan

16.4 Description of planned Quality Improvement Measures

The quality of service will be improved through, amongst others; the following measures:

(1)Organisational Development
Effective implementation of performance management systems
Capacity building and training programmes
On-going review and re-engineering of institutional systems and structures
Build nursing research capacity

(2)Service delivery improvement plan
Batho – Pele
The implementation of service standards and Citizen's report

(3) Health Technology
Utilization of Health Information System and Tele-Health

(4) Physical facilities management
Maintenance

(5) Monitoring and Evaluation
Monthly, Quarterly and Annual reports

17. PROGRAMME 7 - HEALTH CARE SUPPORT SERVICES

17.1 SITUATION ANALYSIS

Province has created a full directorate for pharmaceutical services. There is a shortage of pharmacist and a high turn over rate. Drug availability levels of medicine at the depot is 95 % and at the Hospital is at 85 %and the clinics are at 75 %.

17.2Policies, priorities and Strategic Objectives

17.2.1 Policies

- Medicines and related substance control Act
- Pharmacy Act as amended (2000)
- SA medicines and medical devices Act (1965)
- (check for more from the list in Part A)

17.2.2 Priorities

- Supply of medicines to health facilities
- Monitor rational utilisation of drugs;

- Inspectorate Services

17.2.3 Strategic Goals and Objectives

TABLE 17 : STRATEGIC GOALS AND OBJECTIVES FOR PROGAMME 7 HEALTH CARE SUPPORT SERVICES

STRATEGIC GOALS	STRATEGIC OBJECTIVES
7.1 HEALTH CARE SUPPORT SERVICES Provision of Pharmaceutical Services	7.1.1 To manage the supply of medicines to all health facilities
	7.1.2 To implement a drug policy in all health facilities in the province
	7.1.3 To train pharmacy support personnel in line with SA pharmacy council regulations

17.3 Analysis of constraints and measures planned to overcome them

Constraints	Measures to overcome constraints
Shortage of personnel	Recruitment and retention
Non compliance of pharmacies with regulations	Upgrade the dispensaries and pharmacies to be in line with the provisions of the Pharmacy Act

17.4 Description of planned Quality Improvement measures

The quality of service will be improved through, amongst others; the following measures:

(1) Organisational Development
Effective implementation of performance management systems
Capacity building and training programmes
On-going review and re-engineering of institutional systems and structures
Strengthen the repackaging unit

(2) Service delivery improvement plan
Batho – Pele
The implementation of service standards and Citizen's report

(3) Health Technology
Utilization of Health Information System and Tele-Health

(4) Physical facilities management
Maintenance

(5) Monitoring and Evaluation
Monthly, Quarterly and Annual reports

18. PROGRAMME 8 – HEALTH FACILITIES MANAGEMENT

18.1 Situation Analysis

The Department conducted a Hospital Facility Condition and Suitability Audits in 1995 and 1997. A similar audit for PHC facilities was conducted in 1997. These audits provided the base line information for the ten-year plan to upgrade and rebuild health facilities in the Province.

The equitable share budget for infra-structure has been shrinking over the years. The capital works and physical facility development is now sustained through conditional grant. The implementing agents for these projects are Department of Public Works and Independent Development Trust.

CAPITAL WORKS' PROJECTS FUNDING FROM 1995 TO DATE	
TOTAL NO OF CONTRACTS COMPLETE	954
VALUE OF PROJECTS IN DOCUMENT AND TENDER STAGE	R 86,829,000
VALUE OF ALL APPROVED PROJECTS	R 1, 433,195,908
EXPENDITURE FOR 2003/4 YEAR	R 219,539,795
TOTAL OF COMPLETED PROJECTS	R 1,433,195,908

18.2 Policies, Priorities and Strategic objectives

18.2.1 Policies

- Regulation 158
- Building Regulation
- Occupational Health and Safety Act
- Pharmacy Act
- Mental Health Act
- Fire Brigade Act
- Supply Chain Management Act
- Preferential procurement Act

18 2.2 Priorities

- Upgrade and Building of PHC facilities
- Hospital revitalisation
- Maintenance of Health Facilities

18.2.3 Strategic objectives

TABLE 18 : STRATEGIC GOALS AND OBJECTIVES FOR PROGAMME 8 – HEALTH FACILITIES MANAGEMENT

STRATEGIC GOALS	STRATEGIC OBJECTIVES
HEALTH FACILITIES MANAGEMENT To render Health facility planning and development	8.1.1. To render Capital Planning and Development of Infrastructure
	8.1.2. To provide water and sanitation at all health facilities
	8.1.3 To provide reliable electricity supply
	8.1.4. To maintain Health Facilities and retain them in a serviceable condition

18.3 Analysis of Constraints and measures planned to overcome them

Constraints	Measures
Lack of capacity	Recruitment and retention of skilled personnel
	Capacity building in contract management
	Training and re-skilling of personnel
Land ownership	Integrated Facility Development Plan
Access to facilities	To address compliance of facilities for the disabled persons

18.4 Description of Quality Improvement Measures

The quality of service will be improved through, amongst others; the following measures:

(1) Organisational Development
Effective implementation of performance management systems
Capacity building and training programmes
On-going review and re-engineering of institutional systems and structures
Improve inter-gorvemental collaborations and relation building (IDP)

(2) Service delivery improvement plan
Batho – Pele
The implementation of service standards and Citizen's report
(3) Health Technology
Utilization of Health Information System and Tele-Health

(4) Physical facilities management
Maintenance

(5) Monitoring and Evaluation
Monthly, Quarterly and Annual reports

Table 19: PHYSICAL CONDITION OF DISTRICT FACILITY NETWORK

Facility type CLINICS	No.	Average 1996 NHFA condition grading	Any later condition audit grading (with date)	Outline of major rehabilitation projects since last audit.
Mopani district	94	DPW AUDIT 95	IDT AUDIT 1997	Upgraded 64 clinics @ R81, 720, 041
Bohlabela district	52	DPW AUDIT 95	IDT AUDIT 1997	Upgraded 20 clinics @ R28, 062, 683
Sekhukhune district	67	DPW AUDIT 95	IDT AUDIT 1997	Upgraded 30 clinics @ R39, 667, 903
Vhembe district	120	DPW AUDIT 95	IDT AUDIT 1997	Upgraded 33 clinics @ R41, 742, 976
Capricorn district	85	DPW AUDIT 95	IDT AUDIT 1997	Upgraded 33 clinics @ R45, 857, 084
Waterberg district	53	DPW AUDIT 95	IDT AUDIT 1997	Upgraded 20 clinics @ R26, 305, 982
	TOTAL			200 clinics @ R263, 356, 669

Table 20: BASIC INFRASTRUCTURALSERVICES IN DISTRICTFACILITY NETWORK BY HEALTH DISTRICT.

Health district	Facility type	No.	No. (%) with electricity supply from grid	No (%) with piped water supply
Mopani district	Clinics	120	100%	90.85
Bohlabela district	Clinics	46	87%	69.5%
Sekhukhune district	Clinics	60	88.3%	69.5%
Vhembe district	Clinics	126	86.5%	93%
Capricorn district	Clinics	91	85.7%	74.7%
Waterberg district	Clinics	54	100%	96%
TOTALS		497	91,25%	82,5%

Table 21: PROJECTS COMPLETED

District Hospital Projects Completed	2004/05
Bohlabela	19,503,248
Waterberg	2,034,219
Capricorn	41,077,728
Vhembe	25,655,320
Mopani	36,701,323
Sekhukhune	93,368,319
Pietersburg Mankweng Complex	51,466,592
Clinics	17,021,852
Welfare	6,819,191
TOTAL LIMPOPO PROVINCE	293,647,792

Capital investment, maintenance and asset management

CO-ORDINATION, CO-OPERATION AND OUTSOURCING PLANS

Interdepartmental linkages

The department consists of two Votes namely Vote 7 (Health) and Vote 12 (Social Development). The two votes share common ground in the fight against HIV & AIDS and poverty. The burden of Infrastructure development and upgrading of facilities is jointly undertaken in conjunction with the Department of Public Works. Public Works is responsible for the contract management of the contractors that perform the work and ensure that Service Level Agreements are adhered to.

Local Government linkages

The devolution of District Health Services to the Municipalities and transfer of Environmental Health Services to the District Municipalities is being finalised.

Through the Health District plans, the department ensures that its pans are linked to processes of developing and implementing Integrated Development Plans (IDPs) in support of co-operative governance.

Public Private Partnerships, outsourcing, etc.

The department has employed the services of Transactional Advisors and feasibility studies have been undertaken.

The following PPP's are being considered; concession of Phalaborwa and Ellisras Hospitals, Renal Dialysis Unit, Laundry Services, Provision of Staff Accommodation and EMS fleet management.

The department has made use of outsourcing non core business that includes, Catering for patients, Gardening Services, and Security of Assets.

Departmental policy decision to outsource non core services as well as some of the core functions.

For the next five years the Department is planning to outsource the following services:

Laundry and Linen services

Staff accommodation

Concession of Hospitals

Renal dialysis

Departmental Transport and EMS

The rationale for outsourcing is informed by the following:

Insufficient budget

The department does not have the capacity to manage the services

Cost implications (costly and not efficient)

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