LIMPOPO

PROVINCIAL GOVERNMENT

REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT

HEALTH: VOTE 7

ANNUAL PERFORMANCE PLAN 2007/08 TO 2009/10

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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 Revitalisation, 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 stabilising 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 aforementioned 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 2007/08 financial year will see the Department putting more focus into, over and above our Strategic Objectives, the implementation of the National Health System's Priorities for 2007/8 financial year. namely:

- Development and implementation of service transformation plan
- Strengthening of human resources
- Strengthening physical infrastructure development
- Improving quality of care and

- Priority health programmes (promoting healthy lifestyles, TB crisis management plan and HIV prevention)
- Maternal and Child Health (reach every district strategy EPI, implement the recommendations of the confidential enquiry report.

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 have naturally brought about opportunities, challenges and implications that 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 outcome of this plan is to ensure a comprehensive, efficient, effective and quality health service delivery system that contributes to a self – reliant society in line with the Provincial Growth and Development Strategy Objectives.

It is therefore my pleasure to present this Annual Performance 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 Annual Performance Plan (Health - Vote 7) of the Department of Health and Social Development as presented hereunder.

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

PART A: OVERVIEW AND ANNUAL PERFORMANCE PLAN UPDATE

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

The second decade of democracy brings with it, amongst others the challenge of improved and accelerated service delivery within the public sec
decade progress on management and service delivery was characterized by milestones that included transformation and rationalization of health
fragmented institution based to comprehensive and community based services accessed by the entire population in the province. In pursuit of ou
and legislative obligations, the Department has delivered programmes intended to address problems of morbidity, mortality and poverty for a 5.2 mi
that is predominantly rural. We applaud these successes and are now, more than ever aware of the milestones we still have to achieve as th
Southern Africa". We have to date recorded significant success in the following programme areas:

Limpopo is served by 40 hospitals and 28 health centres. Fixed clinics and visiting points have increased from 302 in 1994/95 to 415 in 2005/06
were built while 63 existing clinics were up-graded. The increase in the number of PHC facilities is an attempt to demonstrate our commitment
Health Care approach aimed at increasing access to Health Care. This is evidence by increase in utilization and coverage rates. Antenatal Care c
at 93% while Immunization coverage is over 82%. 35 of the hospitals are now baby friendly, offering programmes such as the kangaroo moth
children with low birth weight are given specialized care. In pursuit for poverty alleviation and promotion of good nutritional habits we have laun
greenery projects in the communities of Limpopo. Our Comprehensive HIV & AIDS Care, Management, Treatment & Support Response has se
prevalence rate stabilize with an average annual increase of 1.1% leading to an insignificant increase in the prevalence rate of 19.3 % in 2004 to 2
To support the provision of Primary Health Care, we have put special programmes in place which are aimed at improving the quality of service i
programmes includes the hospital revitalization, development of hospitals as centres of excellence and modemisation of tertiary services. To i
capacity to render quality services we have had an intake of over 750 enrolled nurses in our hospital nursing schools and have put over 70 profess
advanced courses.

Organizational Development and general management of resources have improved over the years. The implementation of the job evaluations ar
management system assist us to improve performance efficiency and accountability across the organization. The introduction of a risk manageme
implementation of a fraud prevention and risk management plan has helped us to make inroads in financial management to achieve the desire
outcome i.e. value for money. Chief Executive officers have been appointed for well over 90 % of our hospitals.

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

- Shortage and difficulty in recruiting and retaining Health Professionals
- Addressing the backlog of our infrastructure development

- Curbing the burden of HIV & AIDS, TB and Malaria..
- Training enough nurses and other health professionals to meet the needs

We will continue to invest more resources and pay attention to the strategic priorities of the National Department of Health and those adopted Health System for the 2007/8 Financial year. They are:-

- Development and implementation of service transformation plan
- Strengthening of human resources
- Strengthening physical infrastructure development
- Improving quality of care and
- Priority health programmes (promoting healthy lifestyles, TB crisis management plan and HIV prevention)
- Maternal and Child Health (reach every district strategy EPI, implement the recommendations of the confidential enquiry report.

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 inte 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 Health and Social Development Annual Performance Plan (Health- Vote 7) as presented hereunder.

Dr. J. Dlamini
HEAD OF DEAPRTMENT (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

- We commit ourselves to serve the community with honesty and integrity.
- Fairness and equity will be adhered to at all times.
- Every person will be treated with respect and dignity.
- We commit ourselves to render services effectively, efficiently and economically
- We will adhere to professional ethics.
- Teamwork and partnerships will be promoted at all times.
- All our services will be transparent.
- We will encourage innovation and quality in service delivery
- We will uphold the Constitution of the Republic of South Africa

5 Sectoral Situation Analysis

Demography

Background

Limpopo province is the most northern province of South Africa. The province shares borders with Gauteng province in the south, the Republic of Mozambique in the east through the Kruger National Park (a world conservation icon), Zimbabwe in the north and Botswana in the west. Recent political changes resulted in the phasing out of cross border - districts, with Limpopo province currently consisting of five districts. These changes have resulted into some districts particularly Mopani, having substantial population increases contrary to what the situation would have been in the absence of the demarcation changes. Without the demarcation changes, the population of Limpopo Province is estimated at clos to 5.7 million in 2006, but drops to 5.4 million when the demarcation changes are taken into consideration. Table 2 provides a summary of the estimated population of Limpopo Province by district and sex.

Table 2: Estimated population for Limpopo province by district and sex, 2006

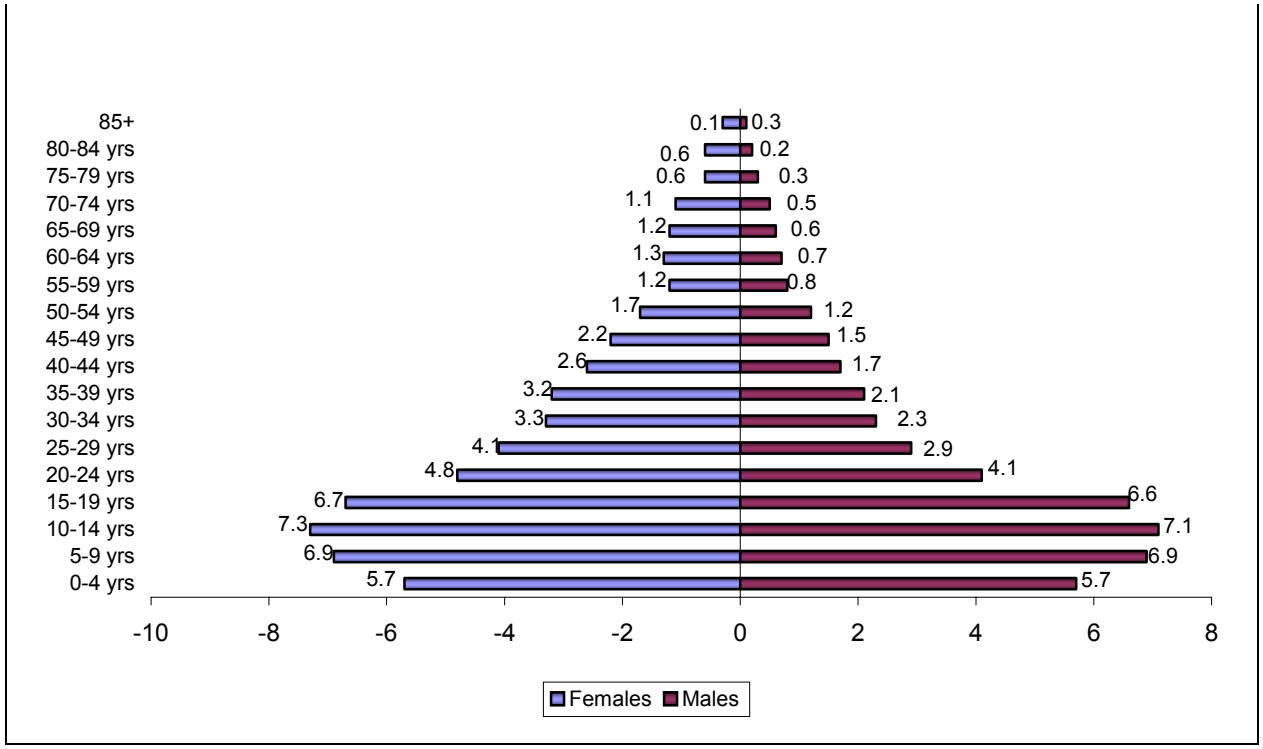
District	Males		Females		Total	
	Number	% of male population	Number	% of female population	Number	% of total population
Capricorn	597 718	23.2	666 004	23.0	1 263 722	**23.1**
Vhembe	608 807	23.5	704 145	24.3	1 312 952	**24.0**
Waterberg	338 273	13.1	341 454	11.8	679 727	**12.4**
Mopani	549 840	21.3	616 508	21.3	1 166 348	**21.3**
Sekhukhune	485 127	18.8	571 715	19.7	1 056 842	**19.3**
Total	**2 579 765**	**100**	**2 899 826**	**100**	**5 479 591**	**100**

NB. Details regarding estimation of provincial population by district are available in the Mid – Year population estimates - 2006

Information in Table 1 and Figure 1 shows that the age structure of Limpopo province has not changed substantially from the structure in 2001 - when the latest census was conducted - albeit demographic and political changes. The effect of the latter [political changes] however, has had a recognizable impact on the population size of Sekhukhune and Mopani Districts where particular local municipalities were incorporated into the two districts. Maruleng local municipality was incorporated into Mopani District while Moutse West was incorporated into Sekhukhune District.

Bushbuckridge was incorporated into Mpumalanga province. 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 1. Limpopo therefore remains the 4th highest populated province in South Africa as per both the 1996 and 2001 census. See Diagram 1

Figure 1: Percentage (%) Of Limpopo Population by Age Group and Gender 2001



Source: Census in brief 2001

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 the African population in the whole country. Whites in Limpopo exhibits a very different age pattern, typical of industrialized societies – proportionally with fewer children and more elderly people. A younger population requires more educational, recreational and health facilities.

Limpopo has the highest female population in the country (54.6%). Females tend to account for a larger proportion of the population than males in all provinces except for Gauteng. (F=49% vs. M=51%).

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.

6 Sectoral Situational Analysis

Based on the National mid-year estimate for 2004 Limpopo population has more than 5.5 million people, approximately 11.9% of the total population of South Africa. The province covers 123 910 km^2, with a population density of 41.7% which makes Limpopo to be the fourth most populated province in SA. (State of the Province Report: 2005)

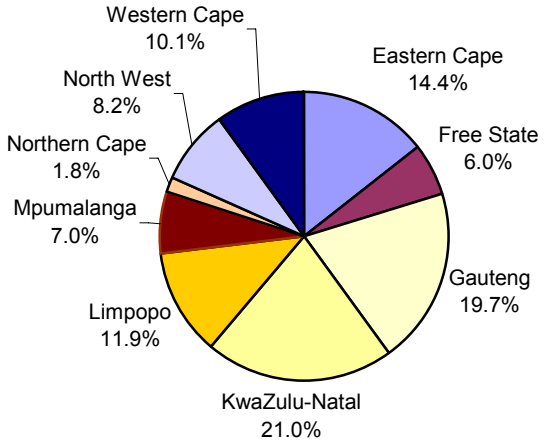
Limpopo remains the 4^{th} highest populated province in South Africa as per both the 1996 and 2001 census. See Diagram 1.

Poverty indicators

Percentage of households with access to piped water is 78% 6.5% less than the National (84.5%) in 2001 whilst households with no toilet is 10% (23.3%.) less than the national (13.6).

The average number of people per household is 4, with two out of ten households made of traditional material. National is 3.8 and 15 households respectively (Stats SA: 2001).

Diagram 1: Population of South Africa by Province



Source: Census in brief 2001

Land area distribution by Province in SA

Province	EC	FS	GP	KZN	MP	NC	LP	NW	WC	SA
KM^2	169 580	129 480	17 010	92 100	79 490	361 830	123 910	116 320	129 370	1 219 090
%	13.9	10.6	1.4	7.6	6.5	29.7	10.2	9.5	10.6	100

Source: Stats SA 2001

Racial distribution

Compared to the SA, the majority of the citizens in Limpopo are African (96.7%) followed by whites (2.4%) and the remainders are Coloureds, Indians/Asians and unspecified. (NW=91%, MP=89%, EC=87%, FS=84%) Most Coloureds, Indians and Whites live in urban areas with better provision of services and infrastructure.

Population distribution by racial groups in Limpopo

Racial group	%
Africans	97.2
Whites	2.4
Coloured	0.2
Indians/Asians	0.2
TOTAL	100

Source: Stats SA census 2001

Socio-economic profile

The Limpopo Province has a labour force of approximately 1. 1 million people, which accounts for 7,7 % of the total South African labour force.

The unemployment rate (expanded def) for the province in 2001 was 36.2 % compared to 29.5% for the rest of South Africa. *(SAHR 2001).* The unemployment rate is higher amongst black South Africans as compared to Whites in Limpopo, and highest in Black African women vs. African males. In Limpopo unemployment rate is higher in rural areas (45%) than in urban areas (24%). The urban rural unemployment rate pattern is the same in the SA. 41% of the unemployed males are aged between 25 to 34 years of age, whilst 29% are younger than 25% of the unemployed males are aged between 25 to 34 years of age, whilst 29% are younger than 25yrs of age. *(Stats SA 2001).*

Unemployment rate is highest among those who had no education at all (51%). Those who have some education including standard 10 experience slightly lower levels of unemployment (40-47%). A much lower unemployment rate (12%) is experienced by those with post school qualification.

The type of work done by the employed people in Limpopo varies by race and gender. 28% of African males and 48% of African females work in elementary occupations such as cleaning, garbage collecting and agricultural labour. Operator and assembler type of work occupies 14% of

African males, whilst 15% are involved in crafts and related trades. 1 in 5 African females are in semi-professional occupations such as nursing assistants. 5% of African males and 2% of African females are in managerial posts. This pattern is seen throughout the country. *(OHS 1995).*

A different picture is seen when looking at occupations by whites in Limpopo. They tend to be in occupations requiring higher levels of competence. A third of them (36%) work as artisans and craft workers, 14% are technicians and associate semi-professionals. White males are slightly more likely to be in managerial positions (12%) that the white females (8%). Nationally, a larger proportion of white males are in management positions.

Both nationally and in the province, 33% and 31% respectively are earning on average R999 or less per month. Among females, however a large proportion (41%) are earning on average R999 or les per month compared to the national figure (31%). *(OHS1995).*

The province has the highest age-dependency ratio of 91.7% vs.64.6% nationally. Medical Aid covers 7.6% of Limpopo population vs. 16.4% nationally.

Amongst the primary environmental health concerns occurring in the province are lack of access to sufficient quantities of safe water supply, good sanitation facilities, waste services, unsafe food preparation facilities and the prevalence of diseases caused by vectors such as rodents and insects. (SARH 2000)

Major causes of illness and death

The disparity between population groups is narrowing. Based on child mortality rates, the risk of dying for Africans was twice high as for Whites in 1995 (African=2.0 vs. Whites 1.0) compared with 4 times higher in 1990 (Africans=3.9 vs. Whites1.0)

The correlation of HIV prevalence and Child mortality rates as observed in various provinces and may be due to Mother Child Vertical transmission of HIV.

The crude deaths rates in Limpopo increased from 2.6% in 1994 to 12.8% in 2001. This pattern is observed in all the provinces and correlates to the HIV epidemic.

Understanding the causes of death is important in order to reduce the child mortality. Age-specific variations in the causes of death illustrate the following pattern:

- Under 5's die from diarrhoeal diseases, nutritional deficiencies and respiratory infections
- 5-14 yrs of age die from trauma (both road traffic as well as domestic)

- Young adults die from trauma, Tuberculosis, lower respiratory infections
- Over 45 yrs of age die from Tuberculosis, trauma, stroke

MAJOR CAUSES OF DEATH

CAUSES OF DEATH	FREQUENCY %
Ill-defined (All natural)	23.5
Undetermined injuries	9.1
Cardiovascular disease	7.4
Stroke	5.9
Tuberculosis	5.6
Lower Respiratory Infections	4.8
Diarrhoeal Disease	3.9
Diabetic Mellitus	3.1
Ischemic Heart Disease	3
Road accidents	1.8

(Source= Stats 2001)

MAJOR HEALTH SERVICE PROVISION 2005

MATERNAL AND CHILD HEALTH	
Termination of Pregnancy - No. of institutions - Total no. performed o <12weeks of gestation o <18 years of age	 38 4612 12% 9%
NUTRITIONAL STATUS	
Stunting	23.1%
Wasting	7.5%
Underweight	15.0%

(Sources: DHIS 2005, SA Health Review 2005)

NOTIFIABLE MEDICAL CONDITIONS

The highest notifiable medical condition in Limpopo and across all provinces is TB. 86.2/100 000 population with case fatality rate (CFR) of 8% in 2005 followed by Malaria with a case fatality rate 0f 0.8% in 2005 compared to 1.2% in 2004.

EPIDEMIC PRONE DISEASES reported 2005

Condition	No. Cases	CFR (%)
Food poisoning	**20**	**5**
Hepatitis A	**23**	**21.4**
Typhoid	**17**	**11.7**
Hepatitis B	**17**	**5.8**
Malaria	**3 716**	**0.83**
Meningococcal Meningitis	**26**	**15.3**
Organophosphate Poisoning	**9**	**0**
Human Rabies	**8**	**100**
Haemophilus Influenza Type B	**1**	**100**
Bilharzia	**256**	**0**

Source: Provincial Notification System (2005)

Trends in key provincial mortality indicators

Mortality Rates	Limpopo		Eastern Cape		SA	
	1998	2003	1998	2003	1998	2003
Infant Mortality Rate/1000 live births	37.2	34.1	61.2	68.3	45.5	42.5
U5 mortality Rate/1000 live births	53	43.9	80.5	79.1	59.4	58
Child Mortality Rate/1000 live births	15.7	10.1	20.5	11.6	15.4	15.8

Source: SADHS 1998 & 2003

HIV &AIDS/STI/TB

The result from the annual Antenatal HIV Seroprevalence survey indicates that 21.5% of pregnant women attending public health facilities were infected with HIV. The highest HIV prevalence rate is recorded amongst women aged 25-29 years (30.5%). Whilst there is a slight increase in the HIV prevalence, there is a decline in the syphilis prevalence from 2.1% in 2003 to 0.9% in 2004.

The average provincial smear conversion rate (SCR) is at 63.1% with Sekhukhune the lowest at 47.1%. The cure rate improved from 53.9% in 2003 to 68.8%, in 2004, with Sekhukhune the lowest at 53.6%.

Figure 2: Limpopo v/s National HIV Prevalence Trends

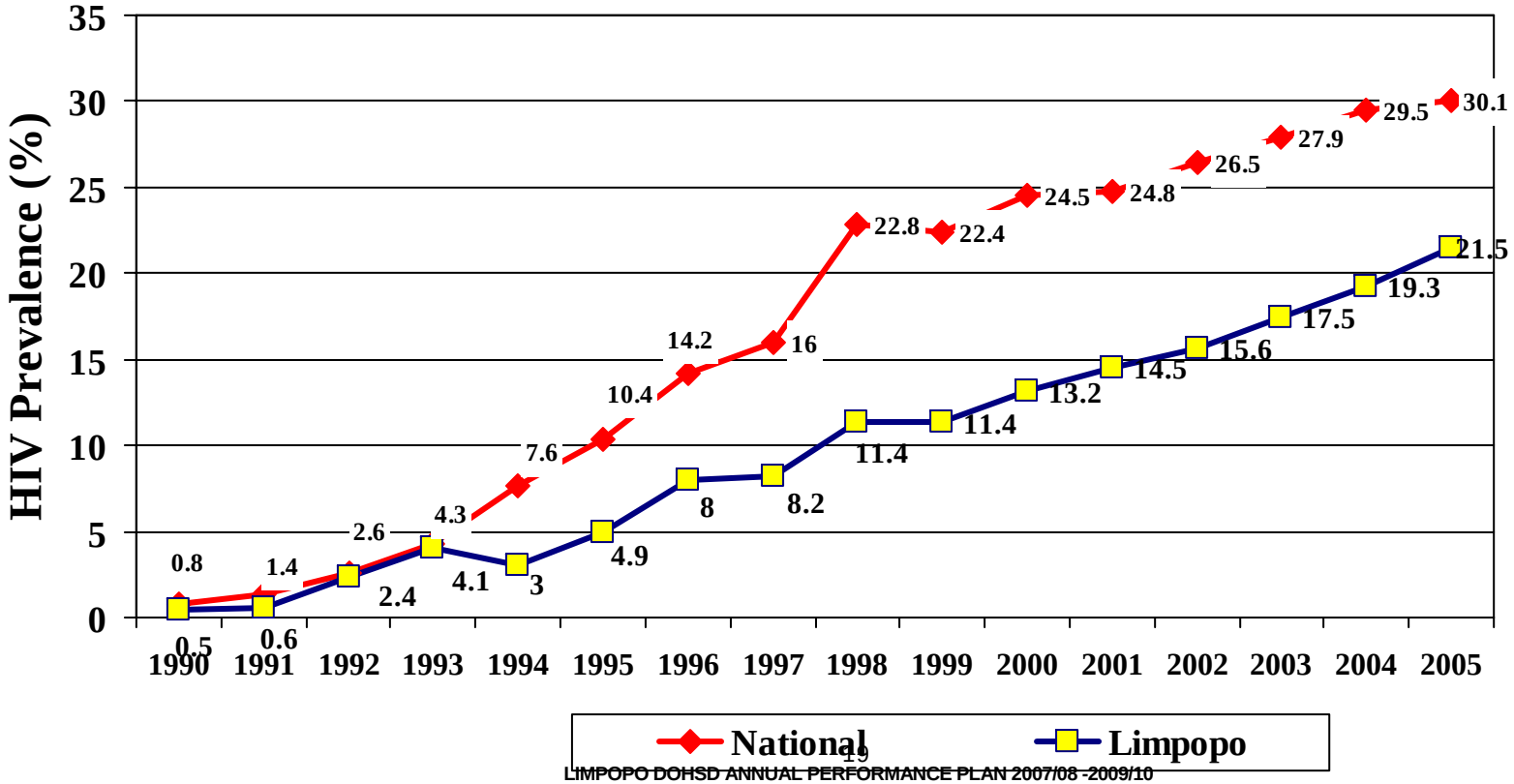
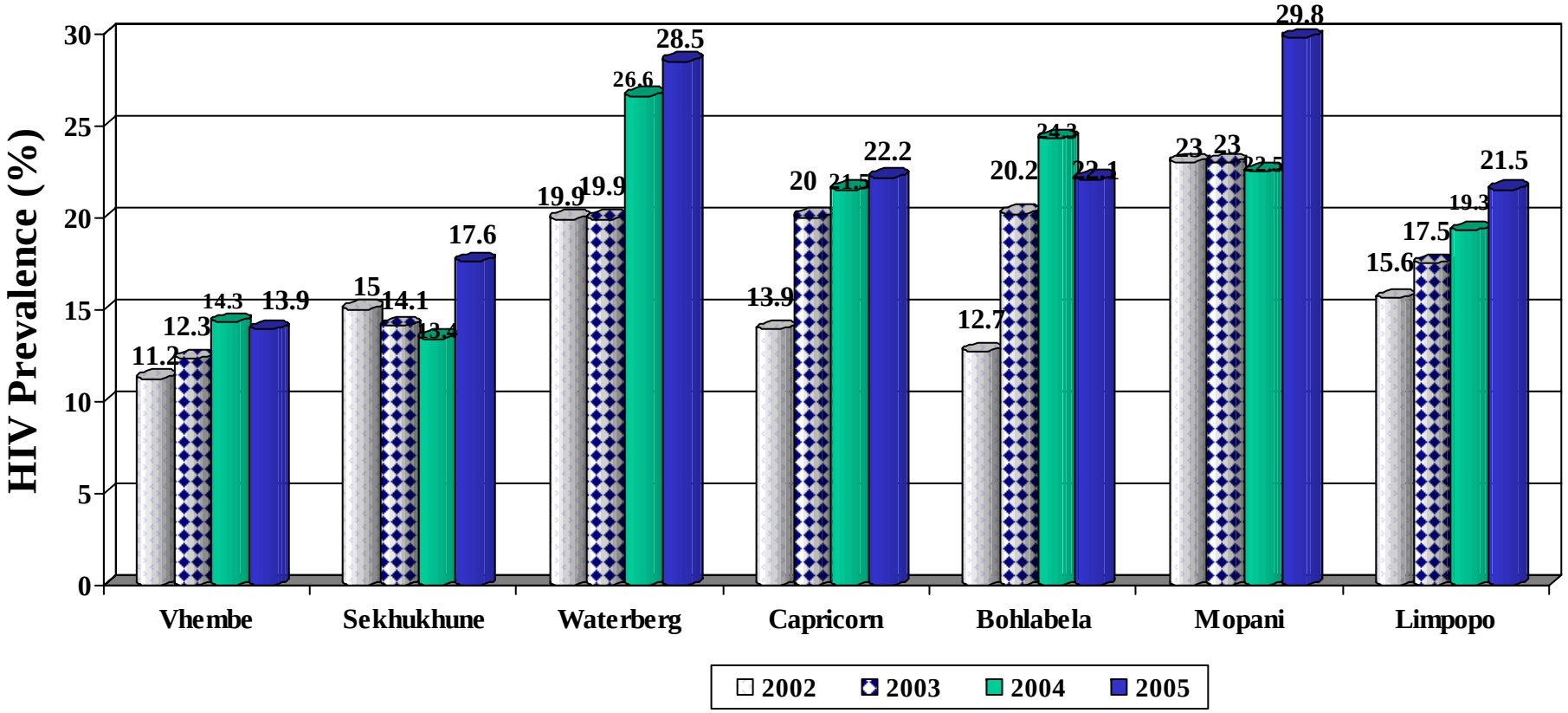


Figure 3: HIV prevalence by district for 2002/2005



Major health service challenges and progress made since 2001/02:

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.

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.

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.

Quality of care improvements

The major challenges include unavailability of health professionals and the hospital infrastructure (both buildings and essential health technology) is grossly inadequate.

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 the NGO's need to be capacitated

Resource trends: funding and sustainability of health services based on the IHPF, including the resource implications of current trends in service volumes

Broad policies

The mandates that dictate the Annual Performance Plans for the delivery of health services emanate from the following:

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-sect oral 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.

National Health Act (Act 61 of 2003):

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

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

b) 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)

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

The World Health Organisation Sector Strategies in Poverty Alleviation

The Millennium Development Goals

NEPAD Health Sector Strategy

The National Department of Health Strategic Priorities 2004-9

The Northern Province Health Act of 1998

The Provincial Priorities as in PGDS

The Health Strategic Plan 2004- 2009

The State of the Nation Address

The State of the Province Address

Priorities and strategic goals

Five Priorities adopted by the National Health System for the Financial Year 2007/8 :

- .Development and implementation of service transformation plan
- Strengthening of human resources
- Strengthening physical infrastructure development
- Improving quality of care and
- Priority health programmes (promoting healthy lifestyles, TB crisis management plan and HIV prevention)
- Maternal and Child Health (reach every district strategy EPI, implement the recommendations of the confidential enquiry report.

The Limpopo DOH&SD has adopted the following National Department of Health priorities with an addition of the development of tertiary services (Medical School) for 2007/8.

1. Improve governance and management of NHS
2. Promote healthy lifestyles
3. Contribute towards human dignity by improving quality of care
4. Improve the management of communicable diseases and non communicable illnesses
5. Strengthen PHC, EMS and hospital services delivery systems
6. Strengthen support services
7. Human resource planning , development and management
8. Planning, budgeting and monitoring and evaluation
9. Strengthen international relations
10. Tertiary services development including the establishment of the Medical School

Provincial focus areas

- Attainment of Millennium Development Goals targets
  - Child health, maternal health, HIV and AIDS,TB, Malaria
- Roll out of HIV/AIDS programme to remaining health facilities
- Revitalization of remaining hospitals
- Improvement of EMS response time
- Improvement of availability of drugs in the clinics

- Establishment of nursing colleges and schools
- Districts Health services and Primary Health Care services

7 PART B: Specification of measurable objectives and performance indicators

Table ADMIN1: Provincial objectives and performance indicators for Administration

Strategic. Objective	Measurable objective	Performance indicators	ACTUAL 2004/05				
				ACTUAL 2005/06	ESTIMATE 2006/07	BUDGET 2007/08	TARGET 2008/09
To develop, promote and maintain supply chain management (SCM) system	SCM system implemented	% of periodic contracts renewed prior to expiry	No baseline	No baseline	100%	100%	100%
		% of bids awarded to HDI owned companies	No baseline	No baseline	78 %	82 %	90 %
		% of bids awarded to companies owned by	No baseline	No baseline			
		women,			47 %	54 %	62 %
		disabled,			3 %	3 %	4 %
		youths			35 %	37 %	40 %
		locality			30 %	45 %	55 %
		SMME			95 %	95 %	96 %
To provide effective and efficient Stores Management	Stock taking at institutions monitored	% of institutions that conducted Annual stock taking as per PFMA	65%	80%	100%	100%	100%
		% of quality stock take report submitted by institutions	No baseline	No baseline	80%	100%	100%

Strategic. Objective	Measurable objective	Performance indicators	ACTUAL 2004/05	ACTUAL 2005/06	ESTIMATE 2006/07	BUDGET 2007/08	TARGET 2008/09
		Reduced matters of emphasis	No baseline	No baseline	30%	50%	70%
To manage audit queries	Management letters responded to within the given time	% audit queries responded to within the given time	No baseline	No baseline	100%	100%	100%
To provide effective and efficient Asset Management	Electronic asset register developed and maintained	Availability of updated electronic asset register	None	None	100%	100%	100%
		% of assets captured in the system	10%	75%	100%	100%	100%
		% of institutions that conduct asset verification	No baseline	None	100%	100%	100%
To manage financial systems and process	Book Keeping and Bank Reconciliation functions Provided	Monthly closure of books	92 %	92 %	92 %	92 %	100 %
		Annual financial statement completed and submitted as per the PFMA and the audit opinion to be unqualified	31 May 05 and qualified	31 May 06 and unqualified	31 May 07 and unqualified	31 May 08 and unqualified	31 May 09 an unqualified

Strategic. Objective	Measurable objective	Performance indicators	ACTUAL 2004/05	ACTUAL 2005/06	ESTIMATE 2006/07	BUDGET 2007/08	TARGET 2008/09
To co-ordinate the development and management of public private partnership (PPP)	PPP Projects managed and coordinated	Number of PPP Projects approved and successfully implemented	PPP projects initiated	o Renal dialysis o Concession of Hospitals o Staff accommodation o Laundry services o EMS	o Renal dialysis o Concession of Hospitals o Staff accommodation o Laundry services o EMS	o Renal dialysis o Concession of Hospitals o Staff accommodation o Laundry services o EMS	o Renal dialy o Concessio of Hospital o Staff accommod on o Laundry services o EMS
To provide Legal Services	Relevant Legislation drafted	Limpopo Health Services Bill finalised and submitted to the Provincial Legislature	Legislative drafting team established.	First draft of Limpopo Health Services Bill available	Final draft of the Limpopo Health Services Bill approved by the Premier	Limpopo Health Services Bill tabled in the Legislature	Limpopo Heal Services Act assented to b the Premier
		Limpopo Health Services Act Regulations proclaimed	No baseline	No baseline	No baseline	Limpopo Health Services Act Regulations finalised	Limpopo Heal Services Act Regulations proclaimed
		Rationalised Provincial Legislation	None	None	Complete collation of provincial legislation	Review process in progress	Completion of the review process

Strategic. Objective	Measurable objective	Performance indicators	ACTUAL 2004/05	ACTUAL 2005/06	ESTIMATE 2006/07	BUDGET 2007/08	TARGET 2008/09
	Sound legal opinions provided	% of written legal opinions provided within 10 days of receipt of instructions	41%	70%	90%	100%	100%
		Legal Advice Manual available	None	None	Legal Advice Manual finalised.	Legal Advice Manual in operation	Legal Advice Manual in operation
	Service Level Agreements (SLA's) drafted	% of Service Level Agreements (SLA's) finalised within 45 days	No Baseline		70% of SLA's finalised within 20 days of receipt of instructions	80% of SLA's finalised within 20 days of receipt of instructions	90% of SLA's finalised within 20 days of receipt of instructions
	Drafting of other contracts (MOA's& MOU's) including lease agreements	% of contracts finalised within 20 days	No Baseline		80% of contracts finalised within 20 days of receipt of instructions	90 of contracts finalised within 20 days of receipt of instructions	100% of contracts finalised within 20 days of receipt of instructions
	Management of litigations	% of consultations and instructions issued within 5 days of receipt of court processes	None	None	70%	80%	90%

Strategic. Objective	Measurable objective	Performance indicators	ACTUAL 2004/05				
				ACTUAL 2005/06	ESTIMATE 2006/07	BUDGET 2007/08	TARGET 2008/09
To provide Human Resources Management and Development	Human Resources Management and Development Provided	100% signed performance agreements and work plans annually	76%	100%	100%	100%	100%
	Staff recruited and retained	Reduction of vacancy rate to 15%	31%	31%	30%	25%	20%
	To promote equity in the workplace promoted	Compliance with employment equity	(a) 35:30:5:0 (b) 1-12 40:45:14:1	13-16 45:45:8:2 1-12	(a) 13-16 48:48:2:2 (b) 1-12 48:48:2:2	(a) 13-16 48:48:2:2 (b) 1-12 48:48:2:2	(a) 13-16 48:48:2:2 (b) 1-12 48:48:2:2
	HR plan developed	Integrated HR Plan developed and implemented	No baseline	First draft HR plan developed	2nd draft HR plan developed	Integrated HR Plan developed and implemented	Integrated HR Plan reviewed and implemented
	Staff trained and developed	% of work force trained and skilled	20%	22%	22%	25%	30%
	Learnership programmes provided	% of participants on learnership of the total staff establishment	1.2%	2%	3%	5%	5%
	Bursary awards provided	No of bursaries for various fields awarded per year	228	625	416	420	425
	Effective and efficient fleet	% of vehicle availability	75%	79%	85%	80-95%	80-95%

Strategic. Objective	Measurable objective	Performance indicators	ACTUAL 2004/05	ACTUAL 2005/06	ESTIMATE 2006/07	BUDGET 2007/08	TARGET 2008/09
	management services provided	% of vehicle utilization	60%	60%	85%	60-80%	60-80%
To manage Labour Relations	Labour Relation Services provided	% Of cases finalised in respect of the following	90% finalised cases	90% finalised cases	97% finalised cases	96% cases to be finalised	96% of cases recorded finalised
		(a) Misconduct cases	97%	96%	100%	100%	100%
		(b) Grievance cases	47.4%	62%	100%	100%	100%
		(c) Dispute cases	52%	49%	100%	100%	100%
To manage and coordinate strategic planning processes	The development of Annual Performance Plan managed and coordinated	Annual Performance Plan approved	Annual Performance Plan approved	Annual Performance plan approved and in place	Annual Performance plan approved and in place	Annual Performance plan approved and in place	Annual Performance plan approved and in place
	The implementation of Departmental strategic plans monitored	Quarterly reports	Quarterly progress reports produced in July and November 2004 and in January and April 2005	Quarterly progress reports produced in July and November 2005 and in January and April 2006	Quarterly progress reports produced in July and November 2006 and in January and April 2007	Quarterly progress reports produced in July and November 2007 and in January and April 2008	Quarterly progress repo produced in Ju and Novembe 2008 and in January and April 2009

Strategic. Objective	Measurable objective	Performance indicators	ACTUAL 2004/05	ACTUAL 2005/06	ESTIMATE 2006/07	BUDGET 2007/08	TARGET 2008/09
	The development of the Annual Report coordinated and supported	Annual report available as per mandate and within prescribed time frames	Annual report available as per mandate and within prescribed time frames	Annual report available as per mandate and within prescribed time frames	Annual report available as per mandate and within prescribed time frames	Annual report available as per mandate and within prescribed time frames	Annual report available as p mandate and within prescribed tim frames
	Departmental Strategic Plans aligned to the PGDS and IDPs	Alignment progress reports available	No baseline	Alignment progress reports available	Alignment progress reports available	Alignment progress reports available	Alignment progress repo available
	Policy development strengthened and supported	Number of analytical reports on proposed policies	Number of analytical reports on proposed policies	Number of analytical reports on proposed policies	Number of analytical reports on proposed policies	Number of analytical reports on proposed policies	Number of analytical reports on proposed policies
	Policies developed and implemented	% of polices formulated and implemented	100% of policies identified and developed	100% policies identified and developed	100% of new identified policies implemented	100% for implementation policies monitored	100% of identified policies reviewed and implemented
		% of national polices aligned and implemented	100% of polices implemented	100% of policies implemented	100% of policies implemented	100% of policies implemented	100% of polici implemented

Strategic. Objective	Measurable objective	Performance indicators	ACTUAL 2004/05	ACTUAL 2005/06	ESTIMATE 2006/07	BUDGET 2007/08	TARGET 2008/09
To provide monitoring and evaluation	Provide monitoring and evaluation framework and reports provided	Monitoring and evaluation framework and analytical reports available	No baseline	No baseline	Draft M & E Framework available	M & E framework and analytical reports available	M & E framework an analytical reports availal
To manage and coordinate transformation of programmes	Transformation programs and Governance structures facilitated and provided	Number of Batho Pele Service standards and service excellence	No baseline	No baseline	All institutions	All intuitions	All institutions
		% of institutions with developed, reviewed and implemented service standards	100%	100%	100%	100%	100%
		% of institutions with developed, reviewed services delivery improvement plans	100%	100%	100%	100%	100%
To promote intergovernmental relations	IGR Services Coordinated	% of trips outside SA coordinated through IGR office	None	100 %	100 %	100 %	100 %
		% of services rendered outside SA with SLA / MOU signed	None	100 %	100 %	100 %	100 %

Strategic. Objective	Measurable objective	Performance indicators	ACTUAL 2004/05	ACTUAL 2005/06	ESTIMATE 2006/07	BUDGET 2007/08	TARGET 2008/09
To provide risk management and security services	Risk management services strengthened and supported	Departmental risk management strategy in place	No baseline	No baseline	Draft risk management strategy available	Risk management strategy in place	Risk management strategy in pla
	Security services managed and coordinated	% of facilities with security services.	80%	80%	95%	100%.	100%.
To manage Information resources	Information management services provided	A central data base available	No baseline	40 % baseline	60%	100%	100%
	IT Support Services provided	% of facilities with IT infrastructure	No baseline	No baseline	70 %	100%	100%
To manage records and archives.	Records and archives Managed	% of facilities managing paper and electronic records in line with Archives and records legislation	No baseline	50 %	60 %	70%	90%
To provide effective communication services	Internal communication managed	Internal communications satisfaction survey	No baseline	No baseline	Conduct internal communication survey	■ Improve baseline by 20%	■ Improve baseline by 50%

Strategic. Objective	Measurable objective	Performance indicators	ACTUAL 2004/05	ACTUAL 2005/06	ESTIMATE 2006/07	BUDGET 2007/08	TARGET 2008/09
	Public Participation Improved	Number of Imbizo`s	9 Imbizo`s	6 Imbizo`s	■ Two Imbizos per district	■ Three Imbizos per district	■ Four Imbizos per district
		% Health and Social development campaigns supported and coordinated	100 %	100 %	100 %	100 %	100%
		Media relation coordinated and monitored	None	■ Increased 85% of positive media coverage	■ Increased 95% of positive media coverage	■ Increased 100% of positive media coverage	■ Maintain 100 of positive media covera
	Healthy lifestyles promoted	Initiate and maintain Healthy lifestyle campaigns	None	■ 5 campaigns per district	■ 10 campaigns per district	■ 20 campaigns per district	■ 30 campaigns per district
	■ The establishment and implementation of Health promoting schools facilitated	■ Number of schools implementing the Health promotion school programme	None	■ 5 schools per district	■ 10 schools per district	■ 30 schools per district	■ 50 schools pe district
Establishment of departmental information resource centre	Departmental information resource centre established	Well equipped and fully functional departmental resource centre	■ Resource centre available equipped with necessary resources	■ Resource centre marketed to clients	■ Continuous management and improvement of the resource centre	■ Resource centre fully functional	■ Resource centre fully functional

Strategic. Objective	Measurable objective	Performance indicators	ACTUAL 2004/05	ACTUAL 2005/06	ESTIMATE 2006/07	BUDGET 2007/08	TARGET 2008/09
Ensure Availability of IT resources and IT delivery mechanisms	■ IT resources and IT delivery mechanism available	% of Health Facilities with functional network Infrastructure	None	■ Hospitals: 99% ■ CHC's: 25% ■ Clinics: 0% ■ Other: 100%	■ Hospitals: 100% ■ CHC's: 35% ■ Clinics: 0% ■ Other: 100%	■ Hospitals: 100% ■ CHC's: 100% ■ Clinics: 5% ■ Other: 100%	■ Hospitals: 100 ■ CHC's: 100% ■ Clinics: 10% ■ Other: 100%
		% of Health facilities with fully functional Provincial Health Info System (PHIS)	Not Measured	■ Hospitals: 95% ■ CHC's: 0% ■ Clinics: 0% ■ Other: 25%	■ Hospitals: 95% ■ CHC's: 0% ■ Clinics: 0% ■ Other: 50%	■ Hospitals: 100% ■ CHC's: 25% ■ Clinics: 0% ■ Other: 60%	■ Hospitals: 100 ■ CHC's: 50% ■ Clinics: 5% ■ Other: 100%
To monitor quality assurance	Quality assurance Monitoring and Evaluation tool developed and implemented	Available quality assurance Monitoring and Evaluation reports	Nil	Nil	Nil	Nil	Develop Quali Assurance Evaluation and Monitoring Too based on the Service Delive Model and Policy on Financial Awards Draft impleme the M& E Tool Consultations Evaluation and Monitoring Too implemented

Past expenditure trends and reconciliation of MTEF projections with plan

The table below provide an account of the spending trends of previous years and their relationship between the MTEF projections and the strategic plan

Table ADMIN2: Trends in provincial public health expenditure for Administration (R million)

Expenditure	2004/05 (actual)	2005/06 (actual)	2006/7 (estimate)	2007/08 (MTEF projection)	2008/09	2009/10	2009/10 (MTEF projection)
Current prices1							
Total2	310	305	288	302	317	353	372
Total per person	60	60	55	60	61	68	72
Total per uninsured person	62	61	58	60	63	71	74
Total capital2	51	13	41	39	39	36	39
Constant (2004/05) prices3							
Total2	1036	1168	988	1315	1390	951	999
Total per person	199	224	190	253	267	183	192
Total per uninsured person	207	234	198	263	278	190	200
Total capital2	204	52	164	195	195	108	117

ANNEXURE 1 – DISTRICT HEALTH SERVICES

Situation analysis

Integrated Primary Health Care

The development and delivery of Primary Health Care services to a population of about 5.2 million people in a predominantly rural province is quite a challenge. Primary Health Care services in this province are provincial function in line with the National Health Act of 2003, with a few local municipalities delivering some services.

The understanding of District Health System in this province is all health services that are rendered within a defined health district. They include primary health care, district hospitals services and EMS although considered a vertical programme. This approach ensure a comprehensive health service based on the principles of equity, and participation of al stakeholders in addressing the expectation and needs of the communities

In the last twelve months we have seen strengthening of relationships between Provincial and Local Government officials through joint planning at district and municipal levels. The District Health Plans are included in the Integrated Development plans of each district. It is quite evident that the strengthening of collaboration with Local Government will enhance service delivery and immensely contribute towards service integration.

81% of the PHC package is being implemented in Primary Health Care Facilities province wide.

Access to health care facilities is made difficult in the deep rural areas due to the topography of our province, poor road infrastructure, poverty and cultural factors .Other factors such as poor staff attitude, shortage of staff and inadequate skill mix affect access to the services as well. Efforts to improve access of basic health services include development of Mobile Teams; Home based care, Care groups and workshops on health workers for change among others. There is an urgent need to improve transportation of patients to hospitals to facilitate the development of the Referral system

About sixty percent of primary health care facilities render twenty four hour services.

Table DHS1: District health service facilities by health district

Health district[1]	Facility type	No.	Population[2,5]	Population per PHC facility[5] or per hospital bed	Per capita utilization
Waterberg District	Mobile clinics (Non fixed clinics)[3]	1177	679727	1,7	2.7
	Fixed Clinics[4]	48			
	CHCs	1			
	Sub-total clinics + CHCs	1224			
	District hospitals	6			
Capricorn District	Mobile clinics (Non fixed clinics)	641	1263722	,7	2.9
	Fixed Clinics[4]	80			
	CHCs	4			
	Sub-total clinics + CHCs	731			
	District hospitals	6			
Vhembe District	Mobile clinics (non fixed clinics)[3]	1255	1312952	,6	4.2
	Fixed Clinics[4]	107			
	CHCs	8			
	Sub-total clinics + CHCs	1137			
	District hospitals	6	1166348	2,8	3.5
Mopani District	Mobile clinics (Non-fixed)	909			
	Fixed	85			
	CHC	7			
	Sub-Total clinics and CHC	92			
	District Hospitals	7			
Sekhukhune District (Nodal)	Mobile Clinics (Non-fixed)	326	1056842	1,7	2.1
	Fixed	76			
	CHC	2			
	Sub-Total CHC and Clinics	78			
	District Hospitals	5			
Province	Non fixed clinics[3]	3977	5 479 591	2,3	3.08
	Fixed Clinics[4]	396			
	CHCs	22			
	Sub-total clinics + CHCs	418			
	District hospitals	34			

Table DHS2: Personnel in district health services by health district

Health district	Personnel category1	Posts filled	Posts approved	Vacancy rate (%)	Number in post per 1000 uninsured people
District Vhembe	**PHC facilities**				
	Medical officers	0	0	0	4.8
	Professional nurses	486	486	0	2.6
	Pharmacists	1	1	0	
	Community health workers				
	District hospitals				
	Medical officers	101	263	61.5	0.7
	Professional nurses	936	1817	4%	25.1
	Pharmacists	48	51	3	
District Capricorn	**PHC facilities**				
	Medical officers	0	0	0	
	Professional nurses	522	608	15%	1.89
	Pharmacists	1	1	0	
	Community health workers	0	0	0	
	District hospitals				
	Medical officers	68	191	64.3	6
	Professional nurses	440	569	23%	2
	Pharmacists	13	25	5%2	46
Waterberg					
Province	**PHC facilities**				
	Medical officers	0	0	0	
	Professional nurses	247	394	37.3%	1.7
	Pharmacists	1	1	0	
	Community health workers	0	0	0	
	District hospitals				
	Medical officers	92	301	69%	2.2
	Professional nurses	344	483	29%	1.3
	Pharmacists	19	27	29.6%	24.9
District Mopani					
Province	**PHC facilities**				
	Medical officers	0	0	0	
	Professional nurses	500	589	15%	1.6

Health district	Personnel category1	Posts filled	Posts approved	Vacancy rate (%)	Number in post per 1000 uninsured people
	Pharmacists	1	1	0	
	Community health workers				
	District hospitals				
	Medical officers	51	158	67.7%	6.3
	Professional nurses	517	736		1.3
	Pharmacists	22	40	18	24.9
	Professional nurses	619	698	11%	1.0
	Pharmacists	1	1	0	
	Community health workers				
	District hospitals				
	Medical officers	52	163	68%	4.6
	Professional nurses	384	471	13%	1.6
	Pharmacists	18	26	30.7%	29.4

TableDHS3: Situational analysis indicators for district health services

Indicator[1]	Type	Province wide value 2005/06	Province wide value 2006/07	Province wide value 2007/08	Province wide value 2008/09	Capricorn District 2005/06	Vhembe District 2005/06	Mopane District 2005/06	Sekhukhune District	Waterbe g Distric
Input										
1. Uninsured population served per fixed public PHC facility	No	60 000	60 000	60 300	60 600	60 900	6 1 200	61 500	61 800	62 100
2. Provincial PHC expenditure per uninsured person	R	460	460	470	490	**230**	160	150	380	260
3. Local government PHC expenditure per uninsured person	R									
4. PHC expenditure (provincial plus local government) per uninsured person	R	460	460	470	490	**230**	160	150	380	260
5. Professional nurses in fixed PHC facilities per 100,000 uninsured person	No	7	7	10	10	25	30	25	30	30
6. Sub-districts offering full package of PHC services	%	85	85	90	90	80	95	98	55	57
7. EHS expenditure (provincial plus local govt) per uninsured person	R	6	5	5	5	5	5	5	5	5
Process										
8. Health districts with appointed manager	%	100	100	100	100	100	100	100	100	100
9. Health districts with plan as per DHP guidelines	%									
10. Fixed PHC facilities with functioning community participation structure	%	75%	80	80	80	80	80	80	80	80
11. Facility data timeliness rate for all PHC facilities	%	80 %	80 %	80 %	80 %	80 %	80 %	80 %	80 %	80 %
Output										
12. PHC total headcount	No									
13. Utilisation rate – PHC	No	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00
14. Utilisation rate - PHC under 5 years	No	3.25	3.25	3.25	3.25	3.25	3.25	3.25	3.25	3.25
Quality										
15. Supervision rate	%	80	80	80	80	80	80	80	80	80
16. Fixed PHC facilities supported by a doctor at least once a week	%	75.5	80	80	85	75	81	95	78	75
Outcome										
19. Health districts with a single provider of PHC services	%	2	2	0	0	0	0	0	2	0

Policies, priorities and strategic goals

Policies

- National Health Act 2003
- District Hospital Service 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 ;
- Partnerships (UNDP; Belgium Government EU/SA Agreement of July 2002

Priorities

- Strengthen Integrated Primary Health Care services
- Promoting Healthy Lifestyles
- Improvement of governance and management of District Health Systems and Devolution
- Improvement of Communicable diseases and non-communicable illness control
- Strengthening of Partnerships with NGO's
- Strengthening monitoring and evaluation
- Increase access to health care services
- Take over and establishment of Forensic Pathology Mortuaries.
- Improving the quality of care;
    - Patient waiting time.
    - Referral system.
- Improvement in hospital efficiencies;
    - Sub-acute beds.
    - Management capacity e.g. Finance.
- Development of the Service Transformation Plan
- Promotion of healthy lifestyles.
- Provide adequate, appropriately skilled, and motivated staff
- Improve governance and management within the District Health System.

Analysis of constraints and measures planned to overcome them

Constraints	Measures
Access to services	Implement PHC and district hospitals packages Revitalization of PHC services.
	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
Poor PHC services	Strengthen referral system Address recruitment and retention issues Accelerate the promotion of healthy life styles
Lack of capacity in the implementation of district health information systems	Capacity building of staff.
Demotivated staff and poor staff attitudes	Address staff accommodation Strengthen PHC training Implement Performance Management system Align with the National Human Resource Strategy.
Shortage of Health professionals.	Accelerate recruitment drive: Devolve recruitment delegations
Old infrastructure.	Accelerate upgrading and maintenance programme:
Cumbersome procurement process and insufficient delegations.	Capacity building:- numbers and skills: systems review and redesign Increase delegations to R200 000 to Chief Executive Officers
Lack of capacity in head office office/district to monitor and mentor PHC facility managers. (inappropriate staff establishment)	Review staff establishment and fill vacancies with appropriately skilled staff.
Staff accommodation.	Provide accommodation for locally identified needs.
Poor governance and management within the District Health System	Ensure establishment of functional governance structures Implement quarterly reporting system Implement management structures at all levels Strengthen participation in District Planning process Alignment of District Health Plans to Integrated Development Plans through active participation of all stakeholders.

Strategic Objective	Measurable Objective	Performance measure /indicator	ACTUAL 2004/05	ACTUAL 2005/2006	ESTIMATE 2006/07	BUDGET 2007/08	TARGET 2008/09	TAR 200
To provide comprehensive PHC package at all PHC facilities	PHC service delivery system strengthened	% of PHC facilities implementing PHC service package.	100%	100%	100%	100%	100%	100
		% of full PHC package implemented	70%	81%	83%	85%	90%	100
		% of PHC facilities visited by doctors once a month	30%	56%	70%	80%	90%	100
		% of clinic visited by clinical Support once a month	23%	47%	60%	75%	80%	100
		% of PHC facilities with at least 90% stock levels with essential drugs	80%	85.75%	88%	92%	100%	100
		% of facilities implementing guidelines and protocol on priority Chronic diseases	75%	80%	85%	90%	100%	100
	Access to PHC services Improved	PHC utilization rate	2.5 visits / person /annum	2.7 visits / person /annum	3.0	3.2	3.5	3.8
		% of facilities providing 24 hrs services.	73%	80%	85%	90%	95%	100
	Healthy lifestyle promoted	% of facilities with chronic diseases campaigns including mental health once per month.	40%	45%	75%	80%	85%	100
	Non communicable diseases managed	% of facilities implementing guidelines and protocols on priority chronic diseases	75%	80%	85%	90%	100%	100
Implement legislation	Mental Health Care Act Implemented	% of designated facilities implementing the provisions of the Act	No baseline	40%	83%	100%	100%	100

Strategic Objective	Measurable Objective	Performance measure /indicator	ACTUAL 2004/05	ACTUAL 2005/2006	ESTIMATE 2006/07	BUDGET 2007/08	TARGET 2008/09	TAR 200
		% of facilities integrating Mental Health policy guidelines & protocols into the Primary Health Care	No baseline	10%	20%	50%	70%	80%
		% of clinics conducting patient satisfaction survey	50%	56%	65%	70%	75%	80%
Strengthen primary health care service delivery systems	Functional health districts with special reference to rural nodes developed	No of health districts with district health plans using the provincial strategic Plan DHIS module	No baseline	None	6	6	6	6
		No of health districts reporting quarterly using DPRF formats	No baseline	None	6	6	6	6
		No of Districts implementing National District Health Planning Guidelines.	No baseline	None	6	6	6	6
	PHC programme development and implementation strengthened	No of DHPs aligned to IDPs.	No baseline	None	6	6	6	6

SUB-PROGRAMME: DHS & DEVOLUTION		Strategic Goal: Integration of the District Health Systems						
Strategic Objective	**Measurable Objective**	**Performance measure /indicator**	**2004/2005 Actual**	**2005/2006 Actual**	**2006/2007 Estimate**	**2007/2008 Budget**	**2008/09 Target**	**200 Targ**
To facilitate transfer of Municipal health and Primary Health Care Services	Transfer and devolution of municipal health and PHC services coordinated	% of municipal health services assets transferred	No baseline	25%	50%	100 %	100%	100
		% of PHC assets transferred	No baseline	25%	50%	100 %	100%	100
		% of Municipal Health Service Personnel transferred	No baseline	25%	50%	100 %	100%	100
		% of PHC personnel transferred	No baseline	25%	50%	100 %	100%	100
To Align District Health Plans To IDP's	Alignment of DHP's to IDP's coordinated	No of DHP's aligned to IDP Plans	No baseline	6	6	6	6	6

Table DHS6: Performance indicators for district health services

Indicator[1]	**Type**	**2004/05**	**2005/06**	**2006/07**	**2007/08**	**2008/09**	**2009/10**	**Nation target**
Input								
1. Uninsured population served per fixed public PHC facility	No	64601	64601	65 894	67 212	64 523	65 813	<10
2. Provincial PHC expenditure per uninsured person	R	460	460	470	490	517	545	N
3. PHC expenditure (provincial plus local government) per uninsured person	R	460	460	470	490	517	545	2
4. Professional nurses in fixed PHC facilities per 100 000 uninsured person	No	0.02	0.02	3.3	3.3	3.3	3.3	1

Indicator[1]	Type	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	Nation target
Input								
5. Sub-districts offering full package of PHC services	%	79%	81%	85%	90%	95%	100%	1
6. EHS expenditure (provincial plus local govt) per uninsured person	R	5	5	5	5	5	6	
Process								
7. Health districts with appointed manager	%	100%	100%	100%	100%	100%	100%	1
8. Health districts with plan as per DHP guidelines	%	100%	100%	100%	100%	100%	100%	1
9. Fixed PHC facilities with functioning community participation structure	%	85%	75%	80%	85%	100%	100%	1
Output								

1 'Fixed' means clinics plus community health centres. 'Public' means provincial plus local government facilities.

SUB-Programme: PDPHCP(Community based health services delivery)								
Strategic Objective	Measurable Objective	Performance measure indicator	2004/2005 ACTUAL	2005/2006 ACTUAL	2006/2007 ESTIMATE	2007/2008 BUDGET	2008/09 TARGET	2009/1 TARGE
To strengthen delivery of PHC through partnerships with NPO's.	Access to PHC enhanced.	% of wards using health services provided by NPO's	40%	5%	40%	60%	80%	100%
		% of NPO's providing standardized community health service packages.	No baseline	5%	50%	75%	80%	100%
	Quality community based health services (PHC) services to communities provided	% of NPO's trained in standardized training programme	No baseline	10%	50%	80%	100%	100%
		Number of carers trained towards Community Health workers qualification (Level 1,2,3)	No baseline	None	1800	3000	5000	6000

Table DHS7: Performance indicators for district hospitals sub-programme

Indicator	Type	2005/06	2006/07	2007/08	2008/09	2009/10	Na t 20
Input							
1. Expenditure on hospital staff as % of district hospital expenditure	%	94.6	94	93	91	90	
2. Expenditure on drugs for hospital use as % of district hospital expend	%	17.3	15	13	11	10	
Process							
3. District hospitals with operational hospital board	%	86	90	95	100	100	
4. District hospitals with appointed (not acting) CEO in post	%	86	96	96	100	100	
5. Facility data timeliness rate for district hospitals	%	100	100	100	100	100	
Output							
6. Caesarean section rate for district hospitals	%	14.1	13.5	13	12.5	12	
Quality							
7. District hospitals with patient satisfaction survey using DoH template	%	100	100	100	100	100	
8. District hospitals with clinical audit (M and M) meetings every month	%	80	96	100	100	100	
Efficiency							
9. Average length of stay in district hospitals	Days	4.86	5	5	5	5	
10.Bed utilisation rate (based on usable beds) in district hospitals	%	67.8	75	78	78	78	
11. Expenditure per patient day equivalent in district hospitals	R	R 1 021.4	R 1 000	R 990	R 980	R 980	8 20 p
Outcome							
12. Case fatality rate in district hospitals for surgery separations	%	2.6	2.5	2.4	2.4	2.4	

Service level agreements and transfers to municipalities and non-government organisations

Table DHS8: Transfers[1] to municipalities and non-government organisations (R '000)

Municipalities	Purpose of transfer	Base year 2005/06 (estimate)	Year 1 2006/07 MTEF projection)	Year 2 2007/08 (MTEF projection)	Year 3 2008/09 (MTEF projection
Municipality 1	Regional services levies	7 731	9 178	0	0
Total municipalities		**7 731**			
Non-government organisations					
NGO 1	Integrated Nutrition Programme	0	3 782	0	0
NGO 2	Community Based Home Care	21 160	23 210	50 614	53 148
Total NGOs		**28 894**	**36 170**	**50 614**	**53 148**

SUB-PROGRAMME 2.7 : DISTRICT HOSPITALS		**Strategic goal:** Improvement of Service Delivery					
Strategic Objective	**Measurable Objective**	**Performance measure indicator**	**2005/2006 Actual**	**2006/2007 Estimate**	**2007/2008 Target**	**2008/2009 Target**	**2009/20 Target**
Improvement of Quality of Care	Hospital efficiency improved	Average length of stay	4.8	4.5	4.0	4.0	4.0
		Usable bed utilization rate	67.8%	80%	80%	80%	80%
		Patient waiting time	4hrs14 min	3hrs30min	3hrs 15min	3hrs	2hrs 45r
		Caesarean section rate	No baseline	15%	13%	13%	13%
		Case fatality rate for surgery	No baseline	0.1%	0.1%	0.1%	0.1%
		Cost/PDE	R916	R900	R900	R890	R880
		Income/PDE	R25	R30	R30	R35	R35
		Number of hospital with sub-acute beds	20	30	30	30	30

SUB-PROGRAMME 2.7 : DISTRICT HOSPITALS		Strategic goal: Improvement of Service Delivery					
Strategic Objective	**Measurable Objective**	**Performance measure indicator**	**2005/2006 Actual**	**2006/2007 Estimate**	**2007/2008 Target**	**2008/2009 Target**	**2009/20 Target**
	Primary Health Care supported	Number of hospitals visiting clinics weekly	21	21	30	30	30
	Peer reviews strengthened	Number of hospitals conducting peer review	21	30	30	30	30
	Patient satisfaction improved	% of hospitals with patient satisfaction surveys conducted during 1st & 3rd qrt	100%	100%	100%	100%	100%
		Client satisfaction rate	70%	75%	80%	85%	90%
	Compliance with national norms and standards adhered to.	% compliance to National Norms & Standards according to standardize tool	77.35%	80%	85%	90%	100%
		% Hospitals monitoring compliance of National norms & standards	100%	100%	100%	100%	100%
	Complaint management strengthened	% Hospitals addressing complaints within 60days	100%	100%	100%	100%	100%
	Hotel services program(HSP) implemented	Number of hospitals implementing(HSP)	20	30	30	30	30
To improve infrastructure/capital facilities (DISTRICT HOSPITALS)	Infrastructure development/improvement programme implemented	% Of hospitals with equipment maintenance plan available	No baseline	100%	100%	100%	100%
	Hotel Services in Hospitals implemented	Number of hospitals Implementing 50% of hotel service program – phase 1	No baseline	30	30	30	30

SUB-PROGRAMME 2.7 : DISTRICT HOSPITALS		Strategic goal: Improvement of Service Delivery					
Strategic Objective	**Measurable Objective**	**Performance measure indicator**	**2005/2006 Actual**	**2006/2007 Estimate**	**2007/2008 Target**	**2008/2009 Target**	**2009/20 Target**
	Sub Acute Care unit established	No. of Hospitals with Sub - Acute Care	No baseline	5	10	18	20
		Number of hospital with Uni-care(electronic Hospitals Information) system	28	28	30	30	30
		% of facilities reporting on all indicators as adopted by the Province	100%	100%	100%	100%	100%
Decentralisation of hospitals management (DISTRICT HOSPITALS)	Management of hospitals at a strategic level improved	% of hospitals with functional boards (HB)	100%	100%	100%	100%	100%
		% Of hospitals with 100% PI's signed	100%	100%	100%	100%	100%
		% Of hospitals with 100% personnel evaluated	100%	100%	100%	100%	100%
		% Of hospitals with approved business plans	100%	100%	100%	100%	100%
		% of hospitals implementing 100% of business plan	100%	100%	100%	100%	100%
		% of hospitals with CEO's appointed	94%	100%	100%	100%	100%
		% of hospitals with full complement of CEO support staff	66%	100%	100%	100%	100%
Use of HIS for planning, monitoring and evaluation	Health information management strengthened	% of district hospitals that use HIS for management & planning	100%	100%	100%	100%	100%
		% of hospital with electronic Hospitals Information system	100%	100%	100%	100%	100%

SUB-PROGRAMME 2.7 : DISTRICT HOSPITALS		Strategic goal: Improvement of Service Delivery					
Strategic Objective	**Measurable Objective**	**Performance measure indicator**	**2005/2006 Actual**	**2006/2007 Estimate**	**2007/2008 Target**	**2008/2009 Target**	**2009/20 Target**
		% of hospitals compliant with National archives guidelines	No baseline	No baseline	100%	100%	100%
To coordinate HR Development & Training	Workplace skills plan improved and implemented	% of hospitals implementing workplace skills plans	100%	100%	100%	100%	100%
	Continuing Medical education training programme implemented	% of hospitals with accredited CPD programs	70.8%	100%	100%	100%	100%
	ABET programme strengthened	% of Hospitals with ABET programme	97.3%	100%	100%	100%	100%
Improvement of risk management	Risk management programmes supported and strengthened	% of hospitals with risk management plan	100%	100%	100%	100%	100%
		% of hospitals conducting risk awareness campaigns	No baseline	Establish baseline	100%	100%	100%
		% of hospitals implementing 100% risk management plan	100%	100%	100%	100%	100%
		% of hospitals with disaster management plan	No baseline	Establish baseline	100%	100%	100%
		% of hospitals conducting disaster drills	No baseline	Establish baseline	100%	100%	100%
		% of hospitals compliant with Occupational Health and Safety Act	No baseline	Establish baseline	100%	100%	100%
Strengthen workplace discipline	Disciplinary management structures functional in hospitals	% of hospitals implementing workplace discipline	No baseline	100%	100%	100%	100%
		% of hospitals with 100% disciplinary cases finalised	No baseline	No baseline	100%	100%	100%

SUB-PROGRAMME 2.7 : DISTRICT HOSPITALS		Strategic goal: Improvement of Service Delivery					
Strategic Objective	**Measurable Objective**	**Performance measure indicator**	**2005/2006 Actual**	**2006/2007 Estimate**	**2007/2008 Target**	**2008/2009 Target**	**2009/20 Target**
To develop and promote sound financial management systems and processes	Procurement management strengthened	% of hospitals with weekly bid and cash flow committee meeting	100%	100%	100%	100%	100%
	Asset management improved	% of hospitals with functional electronic asset management programme	80%	100%	100%	100%	100%
		% of hospitals with updated manual asset registers	100%	100%	100%	100%	100%
		% of hospitals with quarterly Board of Surveys meetings	30. 76%	100%	100%	100%	100%
		% hospitals conducting assets verification bi- annually	100%	100%	100%	100%	100%
	Stores management improved	No of hospitals conducting of stocktaking-Annual	30	30	30	30	30
	Revenue generation improved	% of hospitals attaining revenue target	97.2	100%	100%	100%	100%
		% of hospitals with DSPN beds	19	25	25	26	28
	Contract management improved	% of hospitals monitoring SLA's (contract management)	100%	100%	100%	100%	100%
	Expenditure management improved	% of hospitals submitting monthly in-year monitoring reports	100%	100%	100%	100%	100%
		% of hospitals paying all creditors within 30 days	66%	100%	100%	100%	100%
	Budget management strengthened	% of hospitals with monthly budget committees meetings	70.5%	100%	100%	100%	100%

Past expenditure trends and reconciliation of MTEF projections with plan

Table DHS9: Trends in provincial public health expenditure for district health services (R million)

Expenditure	2005/06 (actual)	2006/7 (estimate)	2007/08 (MTEF projection)	2008/09 (MTEF projection)	2009/10 (MT projection)
Current prices1					
Total2	2,366	2917	3012	3517	4075
Total per person	450	500	520	580	530
Total per uninsured person	490	540	600	630	580
Total capital2	162	166	131	137	1293
Constant (2004/05) prices3					
Total2	8 816	11004	14405	16900	8346
Total per person	1 695	2 116	2770	3 250	1 605
Total per uninsured person	1 763	2 201	2 881	3 380	1 669
Total capital2	648	664	655	685	3879

ANNEXURE 2 – HIV & AIDS, STI & TB CONTROL

Situation analysis

- **HIV & AIDS, STI**

The National Department of Health adopted a comprehensive approach to the management of HIV and AIDS, STI s and TB. The intention was to ensure, that those who are HIV negative, stay negative. The approach also emphasizes the prevention of infection, treatment for those already infected and care and support for those infected and affected by HIV. At the same time aims to alleviate poverty and to enhancement the nutritional status of the individual.

The result from the 2004 annual Antenatal HIV Sero -prevalence survey indicates that 19, 3% of pregnant women attending public health facilities were infected with HIV. The highest HIV prevalence rate is recorded among women aged 25 -29 years (30, 5%). Whilst there is a slight increase in the HIV prevalence there is a decline in the syphilis prevalence from 2, 1% in 2003 to 0, and 9% in 2004.

Prevention remains the cornerstone of the Comprehensive Plan HIV and AIDS Care, Management and treatment. By end of December 2005 all health facilities were providing Mother to Child Transmission (PMTCT) with 41, 3% acceptance rate. On going prevention efforts such as an increasing condom distribution (14condoms/male < 15 years/annum) and supply, STI partner treatment increased from 23,6 in 2004 to 25 % in 2005 and access Voluntary Counselling and Testing facilities increase from 94% facilities in 2004 to 100% in 2005.

- **TB CONTROL**

TB management and control remains a challenge. The average provincial smear conversion rate (SCR) is at 63.1% with Bohlabela being the highest at 80.4% and Sekhukhune the lowest at 47.1%.
The provincial cure rate is 62%, in 2004, compared to 53.9% in 2003, with Bohlabela at 74.3% and Sekhukhune the lowest at 49.6%.. Both are part of Rural Nodes. The November 2000 meeting in Cairo gave birth to the Medium Term Development Plan (MTDP) 2002 -2005. The targets to be reached were identified as follows: 70% detection rate, 85% cure rates, less than 5% defaulter rate and less than 1% MDR TB rate. Limpopo developed its own MTDP based on the National MTDP; however its implementation was hampered by lack of sufficient human resources.

On 25 August 2005, TB was declared an emergency in Africa by the 46 Ministers of Health at their meeting in Maputo, Republic of Mozambique. Recognizing the deep concern about the gravity of the epidemic, the resolution warned that unless "urgent extraordinary actions" are in place, the situation will worsen and the 2015 Millennium Development Goal TB targets will not be met.

This declaration called for specific actions to be undertaken by the African countries, namely:

- Develop and implement, with immediate effect, emergency strategies and plans to control the worsening tuberculosis epidemic.
- Improve quantity and quality of staff involved in TB Control
- Rapidly improve TB case detection and treatment success rates with expanded DOT coverage at national and district levels
- Reduce TB default and transfer out rates to 10% or less.
- Scale up interventions to manage TB and HIV together (access to Antiretroviral for TB pts co-infected with HIV & chemoprophylaxis against TB for people with HIV)
- Expand national TB partnerships, public-private collaboration and community participation in TB control activities.
- Mobilize additional resources for TB Control.

Priorities, Policies and Strategic Goals:

- **Comprehensive Plan for HIV and AIDS Care, Management and Treatment.**
  Implementation of comprehensive plan
  Continued roll-out and strengthening of ART
  Monitoring and evaluation of ART

- **Home-based Care**
  Contribute towards human dignity by providing treatment care and support services
  Implement an integrated Home-Based Care Programme
  Development of a data base for Home Based carers

- **High Transmission area interventions**
  Strengthening of programme for prevention and treatment of STIs
  Expansion of services in High transmission areas

- **Post Exposure Prophylaxis (PEP)**
  Strengthening of the Post Exposure Prophylaxis programme
  Provide facilities with adequately trained staff with the skill to mange these occurrences

- **Prevention of mother to child transmission (PMTCT)**
  Reduce the incidence of Mother to Child Transmission of HIV
  Provide single dose Nevirapine regime to mother and baby
  Implement and maintain a continual improvement of a comprehensive programme for the prevention of mother to chid transmission of HIV
  Integrate follow up into child health-babies will be tested at child health clinics
  Development of integrated monitoring and evaluation of the success of the PMTCT programme

- **Programme management strengthening**
  Provision of adequate staffing for programme management
  Ensure effective programme management capacity and skill
  To form coordinate, manage, monitor and evaluate partnerships for the planning management and implementation by focussing on the various levels of the DOH and external stakeholders
  Ensure availability and accessibility of quality, comprehensive HIV and AIDS services

- **Step down care**

- Voluntary Counselling and Testing
- Addressing TB-HIV and MDR
- Health System Strengthening
- Engaging all care providers
- Relevant Operational Research
- Prioritising the poor and Vulnerable

Analysis of constraints and measures to overcome them

- Co-ordination of community based HIV and AIDS initiative is also a challenge. A number of volunteers and community based health workers perform uncoordinated activities.
- Stipends or grants for volunteers are not standardised
- Rational and effective management of budgets from conditional grant and donor grants are a challenge
- Monitoring and evaluation is a major challenge particularly monitoring of outcomes and impact

Sub-programme 2.6: HIV/AIDS, STI & TB								
Strategic Objective	**Measurable Objective**	**Performance measure indicator**	**2004/2005 Actual**	**2005/2006 Actual**	**2006/07 Estimate**	**2007/08 Budget**	**2008/2009 Target**	**2009/ Targe**
To accelerate the implementation of the comprehensive plan for HIV & AIDS	Interventions to deal with the HIV and AIDS epidemic improved	Proportion of ANC clients tested for HIV	None	36%	41.6%	70%	80%	90%
		% PHC facilities offering PMTCT	None	70%	80%	90%	95%	100%
		% Public health facilities offering voluntary counselling and testing (VCT)	None	92%	98%	100%	100%	100%
		% Of health facilities where condoms are freely available	None	100%	100%	100%	100%	100%
		STI partner treatment rate	None	24.%	25%	35%	40%	45%
		% Facilities offering Syndromic management of STIs	30%	50%	80%	90%	100%	100%
		% hospitals offering PEP	None	None	80%	100%	100%	100%

SUB-Programme: TB								
Strategic Objective	**Measurable Objective**	**Performance measure indicator**	**2004/2005 Actual**	**2005/2006 Actual**	**2006/2007 Estimate**	**2007/2008 Budget**	**2008/09 Target**	**2009/ Targe**
To reduce mortality and morbidity due to TB	The cure rate of new smear positive TB cases at first attempt increased	% of new smear positive TB cases cured at first attempt.	67.8%	69%	71%	77%	80%	85%
		% of new smear converted positive to negative at 2 months	58.9%	60%	65%	75%	80%	85%
		% of TB patients on DOTS	60%	70%	75%	80%	85%	90%

SUB-Programme: TB								
Strategic Objective	**Measurable Objective**	**Performance measure indicator**	**2004/2005 Actual**	**2005/2006 Actual**	**2006/2007 Estimate**	**2007/2008 Budget**	**2008/09 Target**	**2009/ Targe**
		% of new smear positive pulmonary TB	7.8%	7.6%	7.4%	7%	6.8%	6%
	The TB treatment interruption rate to <5%.reduced	% of patients who have interrupted treatment for more than 2 months within one year	3.9%	4%	4%	4%	4%	3.5%
	Improved smear result turn –around- time	% of health facilities with turn-around time of 48hrs or less	No baseline	34%	40%	60%	70%	80%
		Number of new MDR TB cases reported.	17	24	30	40	50	60
	Improved interventions to reduce the burden of HIV in TB infected patients	Number of sub-districts implementing and reporting TB and HIV activities	8	11	18	22	25	25

Past expenditure trends and reconciliation of MTEF projections with plan

Table HIV4: Trends in provincial public health expenditure for HIV & AIDS conditional grant (R million)

Expenditure	**2004/05 (actual)**	**2005/06 (actual)**	**2006/7 (estimate)**	**2007/08 (MTEF projection)**	**2008/09 (MTEF projection)**	**2009/10 (MTE projection)**
Current prices1						
Total	77	103	212	190	205	222
Total per person	15	20	41	37	39	43
Total per uninsured person	15	21	42	30	41	44
Constant (2004/05) prices2						
Total	308	412	848	950	1 025	666
Total per person	59	79	163	183	205	133
Total per uninsured person	62	82	170	190	213	133

ANNEXURE 3 – MCWH & NUTRITION

Situation analysis

Maternal, Child, Women and Youth Health & Nutrition

All hospitals are implementing Perinatal Problem Identification Program (PPIP) and birth defects policy. Eight hospitals are implementing Baby friendly initiative, 90% of facilities offer Integrated Management of childhood Illness (IMCI) programme. Incidence of pneumonia in children less than 5 years is 5.4 per thousand. Incidence of diarrhoea in children less than 5 years increased 15.4 per thousand. Facility perinatal mortality rate is 5.5% and neonatal mortality rate of 1.8%. Delivery rate of women less than 18 years increased from 9.4% in 2004 to 11% in 2005.

40 hospitals and 28 community health centres are designated to perform CTOP. 70% of the designated hospitals and four Community health centres are providing first trimester terminations. All methods of contraception are available in all our facilities. Youth friendly services are provided in 40 % of our primary health care facilities. 45 700 women have been screened for cervical cancer since the implementation of the programme in 2004. The micro-nutrients available in all facilities and Vitamin A is given to both under 1 year children and lactating women. The uptake on the screening programme is low. 100 % of districts are providing school health services but only 150 schools (4%) are receiving school health services. There is lack of second trimester terminations in designated hospitals. Maternal mortality is increasing, presently at 253/100 000 due to lack of proper management of pregnant women health. There is also low utilization of contraception services by the community. The women year protection rate is at 40 %.

Table MCWH1: Situation analysis indicators for MCWH & N

Indicator	Type	Province wide value actual 2005/2006	Province wide value 2006/07	Province wide value 2007/08	Province wide value 2008/2009	Province wide value 2009/10	National ta 2003/4
Incidence							
Hospitals offering CTOP services	%	75%	77%	95%	95%	95%	100
CHCs offering CTOP services	%	26%	50%	100%	100%	100%	50
Output							

Indicator	Type	Province wide value actual 2005/2006	Province wide value 2006/07	Province wide value 2007/08	Province wide value 2008/2009	Province wide value 2009/10	National ta 2003/4
District at which phase 1 school health services are being rendered	%	100%	100%	100%	100%	100%	
Antenatal coverage	%						80%
6.Vitamin A coverage under 1 years	%	113%	100%	100%	100%	100%	80%
7.Vitamin A coverage under 1 - 4years	%	22.9%	40%	50%	70%	100%	80%
Cervical cancer screening coverage	%	2.1%	10%	20%	30%	40%	15
Quality							
Facilities certified as baby friendly	No	32	35	38	41	43	20
Fixed PHC facilities certified as youth friendly	%	24.6%	30%	40%	50%	60%	20
Fixed PHC facilities implementing IMCI	%	95%	100%	100%	100%	100%	
Outcome							
Institutional delivery rate for women under 18 years	%	12.8%	11.5%	11%	10.5%	10%	13
Not gaining weight under 5 years	%	0.9%	0.8%	0.7%	0.5%	0.5%	

Priorities, Policies, and strategic objectives
Nutrition

The key focus areas are as follows:

- Disease Specific Nutrition Support Specific for chronic Diseases

Intervention is the management of malnutrition in health facilities

- Growth Monitoring and promotion

Provision and distribution of tools to support growth monitoring and promotion

- Nutrition promotion education and advocacy

Intervention is participation in nutrition promotion activities

- Micronutrient malnutrition

Vit A supplementation

- Promotion, protection and support of breast feeding

Baby friendly hospital initiative, influencing maternity health facilities to adhere to sound infant feeding practices

Maternal, Child and Women's Health

1. Child and Youth Health
2. Expanded Programme of immunisation
3. Maternal Health

- Reduce maternal mortality and morbidity
- Reduce morbidity and mortality of women

Priorities:

1. Expanded programme of immunisation

Delivery of a safe potent vaccine to each child
Maintain surveillance

2. Maternal Health

- Reduce maternal deaths from avoidable factors and advocate for as many pregnant mothers who need ARVs during pregnancy and in the postnatal period to access the treatment care and support for AIDS as required
- Develop a postnatal care system at all levels of service
- Reduce perinatal deaths from avoidable factors through skills development, identification of best practices and retention.
- Limit neonatal morbidity, especially low birth weight babies using Kangaroo Mother care

Genetic services

- Development of Provincial Genetic services and commencement of planning for introduction of Province based courses on human genetics
- Policy development: ANC and PNC care and Child Health care including immunisation

Specification of measurable objectives and performance indicators

Table MCWH2: Provincial objectives and performance indicators for MCWH & N

Strategic Objective	Measurable Objective	Performance measure indicator	2004/05 ACTUAL	2005/2006 ACTUAL	2006/2007 ESTIMATE	2007/2008 BUDGET	2008/2009 TARGET	2009/ TARG
To improve the management of children under the age of 5 years presenting with diarrhoea, malaria, Pneumonia, HIV and other communicable diseases.	Reduced infant and child morbidity and mortality rate.	% facilities implementing IMCI strategy	71%	95%	100%	100%	100%	100%
		% of districts with 60% IMCI saturation	No baseline	40%	60%	100%	100%	100%
		% of facilities implementing the household and community IMCI	No baseline	6%	24%	40%	50%	70%
		% of hospitals implementing the program on management of children with malnutrition	No baseline	95%	100%	100%	95%	100%
		% of Baby-friendly hospitals	54%	77%	90%	100%	100%	100%
		Infant mortality rate	36/1000 live births	36 /1000 live births	30/1000 live births	20/1000 live births	15/1000 live births	10/10 births
		Child mortality rate	<5yrs 50/1000 live births	<5yrs 49/1000 live births,	<5yrs 40/1000 live births	<5yrs 35/1000 live births	<5yrs 30/1000 live births	<5yrs 25/10 births
To improve adolescence and youth health services	Improved access to youth health services	% of Schools receiving phase 1 of school health services	10%	15%	20%	30%	50%	100%
		% of PHC facilities implementing youth friendly health services	9%	27%	30%	50%	80%	100%

Strategic Objective	Measurable Objective	Performance measure indicator	2004/05 ACTUAL	2005/2006 ACTUAL	2006/2007 ESTIMATE	2007/2008 BUDGET	2008/2009 TARGET	2009/ TARG
To strengthen programmes on women and maternal health	Improved women's health and reduce maternal and neonatal mortality and morbidity.	% of women screened for cervical cancer.	No baseline	1.7%	15%	25%	50%	75%
		% of hospitals approved and providing CTOP	95%	95%	100%	100%	100%	100%
		Number of CHC facilities offering CTOP services	1	4	6	10	15	20
		% of facilities implementing 80 % recommendations from Saving Mothers Report	No baseline	50%	50%	50%	70%	100%
		% of facilities implementing 80% recommendations from Saving Babies Report	No baseline	50%	50%	50%	70%	100%
		% of facilities providing genetic service	No baseline	20%	40%	60%	80% %	100%
		Maternal mortality rate	No baseline	156/100 000	140/100 000	130/100 000	120/100 000	100/1
		% of first Antenatal Care attended before 13 weeks	No baseline	No baseline	23%	50%	70%	100%
	Food service management policy in all the facilities implemented	Number of hospitals implementing food service management policy	None	22	43	43	43	43
	Vit A supplementation to children under 5 and postpartum	% of Vit A coverage in under five.	10%	14% for 1-5 years	50%	60%	70%	80%
			80 %	107% for 0-6 months	100%	100%	100%	100%

Strategic Objective	Measurable Objective	Performance measure indicator	2004/05 ACTUAL	2005/2006 ACTUAL	2006/2007 ESTIMATE	2007/2008 BUDGET	2008/2009 TARGET	2009/ TARG
	mothers provided	% of Vit A coverage in postpartum mothers	40%	47.5%	60%	100%	100%	100%

Table MCWH3: Performance indicators for MCWH & N

Indicator	Type	2005/06	2006/07	2007/08	2008/09	2009/10	Nat ta 200
Incidence							
1. Incidence of severe malnutrition under 5 years	%	15%	14%	13%	12%	11%	
2. Incidence of pneumonia under 5 years	%	4%	3%	3%	3 %	3%	
3. Incidence of diarrhoea with dehydration under 5 years	%	15%	14%	13%	12%	11%	
Input							
4. Hospitals offering TOP services	%	75%	80%	90%	95%	100%	
5. CHCs offering TOP services	%	22.2%	30%	40%	50%	60%	
Output							
6. Districts at which phase 1 health services are being rendered	%	99%	100%	100%	100%	100%	
7. Vitamin A coverage under 1 year	%	113%	100%	100%	100%	100%	
8. Cervical cancer screening coverage	%	2,1%	12,1%	22,1%	32,1%	42,1%	
Quality							
9. Facilities certified as baby friendly	%	32	35	38	41	43	
10. Fixed PHC facilities certified as youth friendly	%	24.6%	30%	40%	50%	60%	
11. Fixed PHC facilities implementing IMCI	%	95%	100	100%	100%	100%	
Outcome							
12. Not gaining weight under 5 years	%	0.9%	0.8%	0.7%	0.6%	0.5%	

ANNEXURE 4– DISEASE PREVENTION & CONTROL

Malaria Programme

- This Province has three Malaria risk areas. These areas are prone to frequent explosive epidemics during the summer rainy season. Seasonal outbreaks continue to result in a high number of malaria deaths. The province experienced a case fatality rate of 0.87% in the 2005/2006 financial year. The major strategies used in the malaria control programme are indoor residual spraying of structures, epidemic management and health promotion. The indoor residual spraying programme operates 42 spray teams that are able to achieve 89% coverage of the targeted 1 000 000 structures. Health education expanded in all risk districts involving community health workers and teachers. Malaria Case Fatality Rate reduced from 1.2% to 0.83% (3 716 cases & 31 deaths)

  Challenges:
  - Delay health seeking behavior care for Malaria;
  - Movement of parasite carriers into the province from endemic areas outside the provincial and country borders
  - Seasonal outbreaks
  - Break down of control measures across our borders with Zimbabwe and Mozambique
  - Poor management of Malaria cases by health professionals

Communicable Diseases Control & Non – Personal Health Programmes

Scale up epidemic preparedness and response

Strategies to reduce morbidity and mortality through rapid detection (within 5 days) and outbreaks response (within 2 hours) to epidemic prone diseases are implemented. Epidemic preparedness and response teams have been established in all municipalities. 90 health officials have been trained in Epidemic Management and Surveillance systems.

The decline in the rain fall led to drying of water sources and forced majority of communities to use heavily polluted water leading to increase in water and food related diseases such as diarrhoeal diseases, Typhoid, Hepatitis A, and food poisoning. During October to December 2005, weekly diarrhoeal surveillance was conducted with 12 018 total number of cases. 180 deaths (CFR: 1.5%) reported. Of the reported cases 47% (5 648) were under the age of 5 years.

Table 12: EPIDEMIC PRONE DISEASES reported 2005

Condition	No. Cases	CFR (%)
Food poisoning	**20**	**5**
Hepatitis A	**23**	**21.4**
Typhoid	**17**	**11.7**
Hepatitis B	**17**	**5.8**
Malaria	**3716**	**0,83%**
Meningococcal Meningitis	**26**	**15.3**
Organophosphate Poisoning	**9**	**0**
Rabies Contacts	**38**	**5.2***
Haemophilus Influenza Type B	**1**	**100**
Bilharzia	**256**	**0**

NB: * = 2 deaths of Rabies contacts (1 confirmed death and 1 possible death based on exposure and clinical pictures)

Improving Immunization Coverage

An average of 92% immunization coverage for children less than 1 year was reached, with only one district below 80%.

The surveillance of AFP has improved significantly with all hospitals being active surveillance sites. A total of 34 cases were (1.6 detection rate), all non-Polio. And a stool adequacy rate of 93%

Sixty two suspected Measles cases were reported and only two were Measles IgM positive and rest were Rubella.

Strengthening health monitoring and evaluation

Tender for management of Health Care Risk Waste (HCRW) has been awarded. HCRW strategy has been implemented in all hospitals. Staff dealing with HCRW trained.

Occupational Health and Safety strategy is implemented in all facilities. Hospital CEOs appointed as Health and Safety officers in terms of Section 16.2 of Occupational Health and Safety Act 85 of 1993. Health and Safety Representatives appointed. Occupational Health and Safety Officers and committees trained.

Port health services are activated in three out of eight border posts.

Challenges:

- Late and under reporting due to uncoordinated different diseases surveillance system
- Sustainability of the functional (EPR) teams, {active only during outbreaks}
- Expansion of HCRW in Community Health Centres and clinics
- Implementation of the recommendations of the audit
- Activation of the remaining five border posts
- Allocation of resources to port of entry, i.e. Human resources, office space, furniture etc

Table PREV1: Situation analysis indicators for disease prevention and control

Indicator	Type	2005/06	2006/07	2007/08	2008/09	2009/10	National tar 2003/04
Output							
1. Health districts with health care waste management plan implemented	No	no	no	No	no	no	N/A
2. Hospitals providing occupational health programmes	%	0	0	100%	100%	100%	80
3. Schools implementing Health Promoting Schools Programme (HPSP) DISTRICT	%	6	5	5	5	5	
4. Integrated epidemic preparedness and response plans implemented	Y/N	Y	Y	Y	Y	Y	Yes
5. Integrated communicable disease control plans implemented	Y/N	Y	Y	Y	Y	Y	Yes
Quality							
6. Schools complying with quality index requirements for HPSP	%	N/A					
7. Outbreak response time	Days	1	1	1	1	1	2
Outcome							
8. Dental extraction to restoration rate	No						0.5
9. Malaria fatality rate	No	1,1	1	0,9	0,8	0,7	0,6
10. Cholera fatality rate	No	0.25%	0.4%	<1%	<1%	<1%	1
11. Cataract surgery rate	No	95%	98%	98%	98%	98%	950
12. Trauma centres for victims of violence	No	N/A					N/A

Specification of measurable objectives and performance indicators

Table PREV2: Provincial objectives and performance indicators for disease prevention and control

SUB-Programme: Malaria PROGRAMME								
Strategic Objective	**Measurable Objective**	**Performance measure indicator**	**2004/2005 ACTUAL**	**2005/2006 ACTUAL**	**2006/2007 ESTIMATE**	**2007/2008 BUDGET**	**2008/09 TARGET**	**2009/1 TARGI**
To Reduce Malaria incidence	Protection of communities against malaria through indoor residual spraying improved	Number of dwellings sprayed	950 000	1.1 million	1.15 million	1.20 million	1.25 million	1.3 mil
To reduce malaria case fatality rate	Reduced case fatality rate	% reduction in case fatality rate	1.2%	1.1%	1%	0.9	0.75%	0.5%

Sub-programme : Public Health Programme								
Strategic Objective	**Measurable Objective**	**Performance Measure Indicator**	**2004/2005 ACTUAL**	**2005/2006 ACTUAL**	**2006/2007 ESTIMATE**	**200720/08 BUDGET**	**2008/2009 TARGET**	**2009/2 TARGI**
To improve immunization coverage of under 1yr	Improved immunization coverage of children under 1 yr	% of fully immunized children under 1yr	86%	87%	88%	90%	100%	100%
		% of health district with more than 90% full immunization coverage	84%	84%	100%	100%	100%	100%
		No. of AFP cases /100 000 children under 15yrs detected and investigated	52	25	44	44	44	44

Sub-programme : Public Health Programme								
Strategic Objective	**Measurable Objective**	**Performance Measure Indicator**	**2004/2005 ACTUAL**	**2005/2006 ACTUAL**	**2006/2007 ESTIMATE**	**200720/08 BUDGET**	**2008/2009 TARGET**	**2009/2 TARG**
		% of measles 1st dose coverage of children under 1yr	88%	89%	90%	90%	90%	90%
		No. of NNT cases/1000 live births detected	Less than 1	Less than 1	Less than 1	Less than 1	Less than 1	Less than 1
To improve management of communicable diseases	Scaled up epidemic preparedness and response	% of districts implementing EPR policy guidelines	100%	100%	100%	100%	100%	100%
To reduce environmental and occupational health related risks	Improved Management of Health care Risk Waste	% of hospital in implementing Health Care Risk Waste Strategy	100%	100%	100%	100%	100%	100%
	Developed Health Care Risk waste strategy for District Health Services	HCRW strategy in DHS in place	None	None	HCRW strategy in DHS in place	HCRW strategy in DHS in place	HCRW strategy in DHS in place	HCRW strateg DHS in place
	Promoted occupational health and safety in Public Health facilities	% of facilities implementing Occupational Health and Safety Act	100%	100%	100%	100%	100%	100%
To improve provision of Port Health services	Port health services provided	No. of border posts providing Port health Services	3	3	3	8	8	8

ANNEXURE 5 – EMERGENCY MEDICAL & PATIENT TRANSPORT SERVICES

SITUATIONAL ANALYSIS

Emergency Medical Services in the province has once again 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. The increase in demand for EMS services has also been noticed with the number of events taking place in the province that require our service. Identification of new EMS stations has also taken place, so that we are able to improve our response time/ access to all emergency calls in the province. The need to render Rescue Services as a specialized service with the aim of improving our "Early Access" after our arrival on scenes was identified. Provision was made to acquire 11 Rescue vehicles with an estimated value of about R 700 000.00/ vehicle, which is fully equipped. More emphasis was put on the training of Advanced Life Support personnel with the aim of improving patient care in the pre hospital setting.

POLICIES, PRIORITIES AND STRATEGIC OBJECTIVES

Policies

- The National Health Act of 2003(Act no 61 0f 2003)

Priorities

- Training of all frontline manager on various management skills
- The province participated in the study my NEMS committee to develop norms and standard for the country with the aim of having foundation and backing to request appropriate funding and resource allocation for the programme nationally by Treasury.
- The department also identified the need to set up a new call centre since the current one is unable to cope with the work load.

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

Specification of measurable objectives and performance indicators

Table EMS2: Provincial objectives and performance indicators for EMS and patient transport

Str. Objective	Measurable objective	Performance indicators	Actual 2004	Estimates				
				Target 2005	2006/07	2007/08	2008/09	2009
To provide quality Emergency Medical Services	Appropriately equipped ambulances	% of ambulances equipped as per National standards	**70%**	100%	100%	100%	100%	100%
	Improved response to calls within National norms	% of response to calls within the norm	**45%**	53%	60 %	70%	80%	90%
	Ambulance per population improved	The ratio of ambulance per population	**1:45 000**	1:45 000	1;35 000	1;25 000	1;15 000	1:10 00

Table EMS3: Performance indicators for the EMS and patient transport

Indicator	Type	2005/06	2006/07	2007/08	2008/09	2009/10	National 2007/
Input							
Rostered Ambulances per 1000 people	No	0,015	0,02	0,035	0,05	0,1	0.3
2. Hospitals with patient transporters	%	0	0	50	75	100	100
Process							
3. Kilometres travelled per ambulance (per annum)	Kms	107625	108000	108000	108000	108000	
4. Locally based staff with training in BLS	%	385	680	1200	1800	2200	100
5. Locally based staff with training in ILS	%	150	200	600	800	2400	
6. Locally based staff with training in ALS	%	10	15	30	100	200	
Quality							
7. Response times within national urban target (15 mins)	%	53	60	70	70	80	100
8. Response times within national rural target	%	53	60	70	70	80	100

Indicator	Type	2005/06	2006/07	2007/08	2008/09	2009/10	National 2007/
9. Call outs serviced by a single person crew	%	0	0	0	0	0	0
Efficiency							
10 Ambulance journeys used for hospital transfers	%	3	5	10	10	10	30
11.Green code patients transported by ambulance	%	75	75	70	70	70	
12.Cost per patient transported by ambulance	R	1106	700	700	700	700	
13. Ambulances with less than 500,000 Kms	%	136	216	300	420	550	100
Output							
14.Patients transported (by PTS) per 1,000 separations	No	Currently	done	By	Hospitals		5

Table EMS4: Trends in provincial public health expenditure for EMS and patient transport (R million)

Expenditure	2005/06 (actual) '000	2006/7 (estimate) '000	2007/08 (MTEF projection '000	2008/09 (MTEF projection '000	2009/10 (MTEF projec '000
Total[2]	115	259	284	282	257
Total per person	0.02	0.05	0.06	0.05	0.05
Total per uninsured person	0.02	0.05	0.06	0.06	0.05
Total capital[2]	5	82	84	83	87
Constant (2004/05) prices[3]					
Total[2]	485	1,165	1,391	1,623	8,521
Total per person	0.09	0.24	0.26	0.32	1.62
Total per uninsured person	0.10	0.24	0.30	0.34	1.76
Total capital[2]	26	370	412	481	505

ANNEXURE 6 – PROVINCIAL HOSPITALS

SITUATION ANALYSIS

Regional Hospital Performance

There is a wide diversity in regional hospital performance. Warm baths Hospital appears to be the most efficient of regional hospitals with an admission rate of 150 per 1000 population and ALOS of 4.7 days .Mokopane Hospital has the cost per PDE R1168 and UBUR of 77%, ST Ritas has UBUR of 70% and ALOS of 5days and cost per PDE of R 908.40.

In 1996 the National Hospital Strategy Project recommended that 2.3 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 3 beds (1.3 level 1, 0.5 level 2, 0.1 level 3, and 0.4 chronic) as opposed to the WHO norm of 2,6 beds per 1000 population. The suggested IHPF norm of 1.4 beds per population means closure of 2000 beds. The province has adopted the MTS planning norm to ensure adequate access to hospital services.

An assessment of current hospital utilisation and efficiency in the Limpopo 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.
.Bed provision levels are currently lower for all acute levels of care than recommended.

- ⇨ 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, 2 mil) 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 six regional hospitals in the province that are also illustrated visually on the attached GIS maps of health facilities per district, are distributed as follows:

- **Waterberg District –**Mokopane Hospital and Warm bath Hospital
- **Vhembe District -**Tshilidzini Hospital
- **Mopani District -**Letaba Hospital
- **Sekhukhune District** -St Ritas' Hospital. If the demarcation of the boundary between Sekhukhune District and Mpumalanga Province is considered, then there will be two regional Hospitals in Sekhukhune District as Philadelphia Hospital is also a regional hospital.
- **The Capricorn District** has no regional hospital but has two secondary/tertiary hospitals, Polokwane/Mankweng Hospital Complex.

Movement of patients should be dictated by the referral criteria. Patients should only be transferred to a hospital with higher capability in terms of skills and technology appropriate for the management of their problems. If the next level does not justify transfer due to the above, the referring doctor should select another hospital with a higher level of care for the patient. In such circumstances, bypassing of the next **designated** level is justified. It is the responsibility of the superintendent of hospital to acquaint all new staff with this provincial referral policy.

Districts have to refer patients for level II care to the regional hospitals in their respective districts. This is not possible in Capricorn District, which has no regional hospital. For this reason district hospitals in Capricorn refer their patients to Polokwane/ Mankweng Hospitals. Level I patients are also directly referred to Polokwane and Mankweng Hospitals as there is no district hospital in the Polokwane urban area. Some district hospitals refer patients directly to Dr G Mukhari Hospital in Gauteng Province.

Regional hospitals are supposed to refer patients for tertiary care to Polokwane and Mankweng Hospitals. In practice some patients from regional hospitals such as Tshilidzini Hospital are referred passed Polokwane/Mankweng Hospitals to Dr G Mukhari Hospital. Polokwane/ Mankweng Hospital Complex refers a number of patients to Dr G Mukhari Hospital because they do not have the capacity to render the highly specialised services.

Services Offered

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 TB Care at FH Odendaal Hospital
- Acute psychiatric care at:
  - ⇨ Tintswalo Hospital
  - ⇨ Siloam Hospital
  - ⇨ Donald Fraser Hospital
  - ⇨ Jane Furse, and
  - ⇨ Nkhensani Hospital.

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
- Psychiatry
- Family Medicine

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

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	10,844	2.2	361,715		2,698,810		

Table PHS1: Public hospitals by hospital type

Hospital type	Number of hospitals	Number of beds	Beds per 1000 uninsured people1		
			Provincial average	Highest district (include name)	Lowest district (include name)
District	34	6031	1.22	66.6 Vhembe	42.6 Waterberg
General (regional)	5	1951	0.35	194.2 Tshilidzini	284.5 Letaba
Central Tertiary	2	841	0.05	70.9 Tertiary	N/A
Tuberculosis2	1	804	0.16		---
Psychiatric[2]	3	1364	0.42	N/A	---
Total public	45	10223	2,2		
Private sector	8	458	4.1%	N/A	Mopani
* NA. Institutions serve the Province and beyond the Provincial borders					

Table PHS2: Public hospitals by level of care

Hospital type	Number of hospitals providing level of care	Number of beds	Beds per 1000 uninsured people[1]
			Provincial average
Level 1	31	6031	1.22
Level 2	5	1977	0.35
Level 3	1	1122	0.05
All acute levels	37		

POLICIES, PRIORITIES AND STRATEGIC OBJECTIVES

Policies

- National Health Act (Act no 63 of 2003)
- 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

Priorities

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

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.

Specification of measurable objectives and performance indicators

Str. Objective	Measurable Objective	Performance Measure	2004/05 ACTUAL	2005/06 ACTUAL	2006/07 ESTIMATE	2007/08 BUDGET	2008/09 TARGET	2009/10 TARGET
To develop secondary level services	Referrals to tertiary level reduced	% decrease in referrals	No baseline	3%	10%	10%	10%	10%
	Outreach programme conducted	% of hospitals with outreach programmes	74%	77%	100%	100%	100%	100%
To improve the quality of care	Improved efficiencies	ALOS	6.5days	5.5	5	5	5	5
		UBUR	68 %	70%	7%5	80%	80%	85%
		Waiting time	5.5hrs	4.5	4	4	3	3
	Improved client satisfaction	% client satisfaction	No baseline	No baseline	No baseline	40%	60%	70%
	Peer review conducted in hospitals	% of hospitals with peer review programmes	100%	100%	100%	100%	100%	100%
To improve health technology	Technology aligned with level of service	% of hospitals with technology aligned with level of service	No baseline	No baseline	No baseline	50%	100%	100%
To improve hospital infrastructure	CAPEX plan prioritised	% of hospitals with prioritised CAPEX plans	87%	87%	100%	100%	100%	100%

Str. Objective	Measurable Objective	Performance Measure	2004/05 ACTUAL	2005/06 ACTUAL	2006/07 ESTIMATE	2007/08 BUDGET	2008/09 TARGET	2009/10 TARGET
	Health Facilities Maintained according to plans	% of hospitals that implement the maintenance programmes	87%	87%	100%	100%	100%	100%
To decentralise hospital management	Governance structures established	% hospitals with functional hospital boards (HB)	75%	75%	100%	100%	100%	100%
	Staff establishment appropriate	% of hospitals with appropriate staff establishments	0%	0%	100%	100%	100%	100%
To improve access to mental health care	Outreach programme conducted	% of hospitals with outreach programmes	74%	77%	100%	100%	100%	100%
To improve the quality of mental health care	Improved efficiencies	ALOS	No baseline	59 days	59 days	60 days	60 days	60 days
		UBUR	68 %	70%	75%	80%	80%	85%
	Peer reviews conducted in the hospitals	% of hospitals with peer review programmes	100%	100%	100%	100%	100%	100%
To improve health technology	Technology aligned with level of service	% of hospitals with technology aligned with level of service	No baseline	No baseline	No baseline	50%	100%	100%
To improve hospital infrastructure	CAPEX plan prioritised	% of hospitals with prioritised CAPEX plans	87%	87%	100%	100%	100%	100%
To decentralise hospital management	Governance structures established	% hospitals with functional hospital boards (HB)	75%	75%	100%	100%	100%	100%

Str. Objective	Measurable Objective	Performance Measure	2004/05 ACTUAL	2005/06 ACTUAL	2006/07 ESTIMATE	2007/08 BUDGET	2008/09 TARGET	2009/10 TARGET
	Staff establishment appropriate	% of hospitals with appropriate staff establishments	0%	0%	100%	100%	100%	100%

Table PHS5: Performance indicators for general (regional) hospitals

Indicator	Type	2005/06	2006/07	2007/08	2008/09	2009/10	Natio target 2007/
Input							
Expenditure on hospital staff as % of regional hospital expenditure	%	82%	83%	83%	82%	82%	66
Expenditure on drugs for hospital use as % of regional hospital expend	%	10	11	11	12	12	12
Process							
Regional hospitals with operational hospital board	%	100	100	100	100	100	100
Regional hospitals with appointed (not acting) CEO in post	%	66	100	100	100	100	100
Facility data timeliness rate for regional hospitals	%	100	100	100	100	100	100
Output							
Caesarean section rate for regional hospitals	%	20.8	20.5	20	19.5	19	18
Quality							
Regional hospitals with patient satisfaction survey using DoH template	%	100	100	100	100	100	100
Regional hospitals with clinical audit (M&M) meetings every month	%	100	100	100	100	100	100
Efficiency							
Average length of stay in regional hospitals	Days	6	6	6	6	6	4.1
Bed utilisation rate (based on usable beds) in regional hospitals	%	74	74.5	75	75.5	76	75

Indicator	Type	2005/06	2006/07	2007/08	2008/09	2009/10	Natio target 2007/
Expenditure per patient day equivalent in regional hospitals	R	936	950	980	1000	1100	1,128
Outcome							
Case fatality rate in regional hospitals for surgery separations	%	4.1	3.6	3.3	3	2.5	2.0

Past expenditure trends and reconciliation of MTEF projections with plan

An account should be given of how the spending trends of previous years have transpired and how MTEF projections correspond to strategic plan objectives. The table below refers to regional hospitals. However, the table should also be separately completed for each specific sub-programme (principally TB and mental health hospitals).

Table PHS6: Trends in provincial public health expenditure for general (regional) hospitals (R million)

Expenditure	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/7 (estimate)	2007/08 (MTEF projection)	2008/09 (MTEF projection)	2009 (MTE projec
Current prices[1]							
Total[2]	474	593	620	578	612	562,478	513,8
Total per person	0.72	0.62	0.66	0.69	0.72	0.76	0.7
Total per uninsured person	0.78	0.62	0.66	0.69	0.72	0.76	0.8
Total capital[2]	4	9	6	7	8	8	8
Constant (2004/05) prices[3]							
Total[2]	2,340	2,605	2,863	2,910	3,055	3,208	2,33
Total per person	2.95	2.62	2.7	3	3	3	2.9
Total per uninsured person	3.21	2.85	3.0	3	3	3	3.2
Total capital[2]	153	396	413	432	453	474	153

ANNEXURE 7 CENTRAL & TERTIARY HOSPITALS

SITUATIONAL ANALYSIS

Central Hospital Services

Level 3 beds (tertiary) at 0.05 are 50% less than the recommended norm of 0.1 beds per 1000 population.

Table : 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

Numbers of beds in central hospitals by level of care[1]

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

Summary of Service Delivery Environment & Challenges

Staff mix and provision of care**:** The Complex has a staff compliment of 3359 broken down as follows**:**

Category	Approved posts	Filled	Vacant
Medical officers	148	148	0
Specialists	112	53	59
Nursing	1364	939	425

Category	Approved posts	Filled	Vacant
Allied	202	98	104
Artisan, technicians & technologists	73	41	32
Admin & general	1460	1151	309
TOTAL	3359	2430	929

Problems in referral chain:

- Patients' by-pass PHC facilities and other hospitals and demand to be attended to at the Tertiary level (PMHC).
- Private Practitioners refer non-tertiary patients directly to PMHC, bypassing District and Regional Hospitals.
- District and Regional Hospitals refer inappropriate cases, which can be attended to at their level of care.
- Patients are referred late and therefore present with complications.
- Senior personnel in all Provincial Departments refer their relatives directly to PMHC.
- The facilities of the PMHC are a positive problem, as patients of all levels refer themselves to the facility.
- Planned patient transport from other institutions delay in picking up discharged patients from PMHC, or inappropriate transport is brought along e.g. stretcher patients in a non modified vehicle.
- Planned patient transport is inadequate and inappropriate for the Complex.
- Transport for patients who require Quaternary level of care that is not catered for in PMHC is inadequate and inappropriate.
- EMS is inadequately equipped in terms of personnel and equipment or to deal with transport of patients from accidents scene or for inter-institutional transfers.
- The by-pass fee charges have not yet been implemented.
- Chronic patients usually come to Casualty after hours for the medication they should have collected at clinics.
- The peripheral hospitals often "dump" their patients whom are collected after a struggle.
- Imbalanced allocation of required vehicles.

Infrastructure development:

Plans are in progress to establish a new academic hospital

Quality of care improvement issues:
All service delivery points develop service delivery improvements plans according to the identified gaps. Activities that are undertaken to address the identified gaps include training and retraining, monitoring and evaluation of services rendered.

		Locality	Population served		Staff Mix									
		Local Municipality	Population served (Sources: 2001 Census Data & 2014 Projections - IHPF, 2005)		Medical Officer	Medical Specialist	Dentist	Dental Specialist	Pharmacists	Prof Nurse	Staff Nurse	Nursing Assistant	Manager, administrators & Logistical support	T N
	Hospital name		2005 IHPF Projection-uninsured	2014 Projections	2014 Projections									
	Pietesburg / Mankweng Level 2		**1,087,143**	**1,250,887**	450	197	27	10	86	467	209	316	80	

Public Private Interactions Issues:

The Complex contracts doctors in Private Practice on sessional basis. Maintenance of sophisticated equipment is outsourced**.** We are currently busy with the PPP on Renal Dialysis.

Summary of Organisational environment and challenges

- ☐ **Management capacity:** Middle managers from level 9 and clinical staff from level 9 to 14 need development on Planning, Project Management and Leadership
- ☐ **Information Technology and Management:**
  Improvements on Telemedicine continue. More clinical disciplines intend utilising the Telemedicine facility.

Table CHS1: Numbers of beds in hospitals by level of care

Central /tertiary hospital (or complex)	Level 3 and 4 beds	Level 1 and 2 beds	Total beds
Pietersburg Hospital	70%	30%	438
Mankweng Hospital	50%	50%	403
etc.			

POLICIES, PRIORITIES AND STRATEGIC OBJECTIVES

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

Priorities

- Improve quality of care
- Strengthening human resources
- Strengthen Planning, budgeting and monitoring and evaluation
- To develop cost centres in the Complex
- To develop a Medical School: A definite decision is urgently required regarding the major capital developments relating to the establishment of a medical school e.g. a new tertiary hospital or extension of existing hospital(s).
- Recruitment and retention of specialists and the middle cadre in clinical services
- To maximise filling of governance and registrar cadre
- Strengthening management [To optimise Hospital Board participation in the management of the Complex]
- To establish office and housing accommodation

ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

Constraints	Measures to overcome constraints
Lack of appropriate staff establishment	Approval of the proposed structure
Lack of Provincial RWOPS policy	Develop and approve the proposed one with delegations to the CEOs

Constraints	Measures to overcome constraints
Lack of office accommodation	Build administrative block
Shortage of specialists and the middle cadre	Improve management of available conditions of service and accommodation
Delays with the effective establishment of UNILIMPOPO and problems with cooperation with the Medunsa Campus	Proposed appointment of consultants to facilitate these processes.

Table CHS3: Provincial objectives and performance indicators

SUB-PROGRAMME 5. CENTRAL HOSPITAL SERVICES		Strategic goal: Provide tertiary and secondary hospital services					
Strategic Objective	**Measurable Objective**	**Performance measure indicator**	**Actual 2004/2005**	**Actual 2005/2006**	**Estimate 2006/2007**	**Target 2007/2008**	**Targe 2008/**
To improve efficiencies in the complex	Reduced ALOS	Average Length of stay	6.5	6.3	6.0	5.5	5.0
	Increased bed utilisation	Usable bed utilisation	70 %	74 %	78 %	80 %	84%
Development to develop Tertiary services	Increased % of tertiary patients services	% of tertiary patients seen in the complex	65 %	70 %	73 %	75 %	77 %
Implementation of "developing" tertiary services package (MTS)	Increased proportion of developed tertiary services	Proportion of developed tertiary services offered at the complex	9/16	12/16 Rad Ren Neo	13/16 Burns Paed.Surg & ICU	13/16 Human Genetics Dept	13/16 Stroke Spina
Strengthen hospital management systems	Establishment of hospital board of the Complex	Functional hospital board (HB)	No baseline	Appointment of HB	100% functional	Monitor impact	Monito

Table CHS2: Situation analysis indicators for each central/ tertiary hospital

Indicator	Type	2005/06	2006/07	2007/08	2008/09	2009/10	Na ta 20
Input							
1. Expenditure on hospital staff as % of hospital expenditure	%	77.5	78	80	80	80	
2. Expenditure on drugs for hospital use as % of hospital expenditure	%	35.1	34	33	32	31	
Process							
3. Operational hospital board	Y/N	Y	Y	Y	Y	Y	Y
4. Appointed (not acting) CEO in place	Y/N	Y	Y	Y	Y	Y	Y
5. Individual hospital data timeliness rate	Mnth	Y	Y	Y	Y	Y	Y
Output							
6. Caesarean section rate	%	25	25	25	25	25	
Quality							
7. Patient satisfaction survey using DoH template	Y/N	Y	Y	Y	Y	Y	Y
8. Clinical audit (M&M) meetings at least once a month	Y/N	Y	Y	Y	Y	Y	Y
Efficiency							
9. Average length of stay	Days	6.9	6.8	6.7	6.6	6.5	
10. Bed utilisation rate (based on usable beds)	%	76.6	76.4	76.3	76.2	76	
Outcome							
11. Case fatality rate for surgery separations	%	3.5	3.4	3.3	3.2	3.1	

Table CHS5: Trends in provincial public health expenditure for central hospitals (R million)

Expenditure	2004/05 (actual)	2005/06 (actual)	2006/7 (estimate)	2007/08 (MTEF projection)	2008/09 (MTEF projection)	2009/10 (M projectio
Current prices[1]						
Total[2]	419	431	493	515	541	568
Total per person	1.22	1.24	1.42	1.50	1.57	1.65

Expenditure	2004/05 (actual)	2005/06 (actual)	2006/7 (estimate)	2007/08 (MTEF projection)	2008/09 (MTEF projection)	2009/10 (M projectio
Total per uninsured person	1.32	1.35	1.55	1.63	1.71	1.79
Total capital[2]	31	32	57	54	55	50
Constant (2004/05) prices[3]						
Total[2]	1718	1810	2122	2310	2706	2841
Total per person	4.99	5.23	6.12	6.43	6.75	7.09
Total per uninsured person	5.43	5.68	6.66	6.99	7.34	7.71
Total capital[2]	121	134	254	266	314	330

ANNEXURE 8 – HEALTH CARE SUPPORT SERVICES

SITUATION ANALYSIS

- The number of pharmacists employed in the province is 60 and the number of posts is 167. Number of posts should be 277.
- Number of pharmacists per population should be 1: 15 000 and is currently 1: 93 000.
- Pharmacists are leaving the province for higher remuneration packages in private sector and other provinces.
- 9 hospital pharmacies are without pharmacists and community service pharmacists leaving in December 2002 manage a further 11.
- Hospital pharmacies are experiencing problems in obtaining transport to deliver medicines to clinics.
- Medicine availability at clinics serviced by hospitals without pharmacists is wer than those with pharmacists.
- Medicine availability at periphery is lower than at Depot and hospitals.
- Pharmacy support personnel are not trained in pharmacy

POLICIES, PRIORITIES AND STRATEGIC OBJECTIVES

Policies

- Medicines and related substance control Act
- Pharmacy Act as amended (2000)
- SA medicines and medical devices Act (1965)

Priorities

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

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

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 report

Specification of measurable objectives and performance indicators

Table SUP1: Provincial objectives and performance indicators for support services

SUB – PROGRAMME : NURSING EDUCATION								
Str. Objective To provide nursing education in the Limpopo	Measurable objective	Performance indicator(indicators)	Actual 2004/5	Target				
				2005/6 ACTUAL	2006/7 ESTIMATE	2007/8 BUDGET	2008/9 TARGET	2009/1 TARGE
To provide post basic diploma nurse training	Post basic diploma nursing program offered	% of operational programmes	46% operational	46%	75%	75%	100%	100%
To provide post basic certificate programs	Post basic Certificate programs offered	% of operational post basic certificate programs	0	0%	5%	15%	25%	50%
To provide basic diploma nurse training (comprehensive programme)	Basic diploma programs offered	% of comprehensive student passed	76%	76%	80%	90%	98%	98%

Str. Objective	Measurable Objective.	Performance Indicators.	2004/05 (Actual).				
				2005/2006(Actual)	2006/2007 Estimate	2007/2008 Budget	2008/2 Target
To increase the drug availability at the depot and health facilities.	Medicines available.	% drug availability at the Depot	95%	95%	95%	95%	95
		% drug availability at Hospitals	90%	90%	90%	95%	95
		% drug availability at PHC facilities	75%	80%	85%	90%	92

Str. Objective	Measurable Objective.	Performance Indicators.	2004/05 (Actual).				
				2005/2006(Actual)	2006/2007 Estimate	2007/2008 Budget	2008/2 Target
To manage pharmaceutical services budget	Expenditure within budget.	% expenditure within budget.	No baseline	86%	100%	100%	10
	Functional DTC in place	% Functional DTC at all institutions.	50%	75%	85%	95%	100%
To train relevant Health Professionals to comply with Pharmacy Act.	Trained Personnel.	% relevant health professionals trained	No baseline	No baseline	100%	100%	100%

SUB-PROGRAMME: CLINICAL SUPPORT SERVICES							
Strategic Objective	Measurable Objective	Performance measure indicator	2004/2005 Actual	2005/2006 Actual	2006/2007 Estimate	2007/2008 Budget	2008/2 Target
To improve access to clinical support services.	Facilities with full complement clinical support services.	% of facilities with full complement clinical support services.	26%	46%	55%	65%	80%
	Outreach teams functional	% of facilities with functional outreach teams	26%	33%	42%	53%	67%

Past expenditure trends and reconciliation of MTEF projections with plan

Table SUP2: Trends in provincial public health expenditure for support services (R million)

Expenditure	2005/06 (actual)	2006/7 (estimate)	2007/08 (MTEF projection)	2008/09 (MTEF proje
Current prices[1]				
Total	366	420	419	4
Total per person	0.07	0.08	0.08	0.08

Expenditure	2005/06 (actual)	2006/7 (estimate)	2007/08 (MTEF projection)	2008/09 (MTEF proje
Total per uninsured person	0.07	0.08	0.08	0.07
Constant (2004/05) prices[2]				
Total	1536	1807	1885	2079970
Total per person	0.29	0.34	0.36	0.39
Total per uninsured person	0.29	0.36	0.36	0.43

ANNEXURE 9 – HUMAN RESOURCES

SITUATIONAL ANALYSIS

The effectiveness and outcomes of Health and Social Development systems are influenced by the correct number of workforce, skills mix, working environment and availability of financial resources. The department has developed policy guideline on human resource planning with the main aim of facilitating the development of an appropriate and responsive human resource needs for health and social development services in Limpopo.

The department also developed recruitment and retention strategies to reinforce the capacity of the human resources that is required for service delivery programme. The approach to the APP in respect to the human resources is to determine the current human resources in terms of staff establishment at all levels of the system.

Current staff establishment at all levels of the system compared to service requirements

Post Designation	Level	No. of posts	Posts Filled	Posts Vacant	Vacancy Rat
Head Of Department	16	1	1	0	
Senior General Manager	15	4	2	2	
Chief Financial Officer	15	1	0	1	
General Manager	14	14	9	5	
Chief Specialist	14	18	4	14	
Principal Specialist	13	70	34	36	
Senior Manager	13	54	32	22	
Chief Executive Officer	13	8	6	2	
Managers	12	25	25	0	
Chief Executive Officer	12	29	19	10	
Principal Clinical Psychologist	12	23	9	14	
Clinical Manager	12	6	6	0	
Chief Medical Officer	12	159	66	93	
Chief Clinical Psychologist	12	11	5	6	
Snr Specialist	12	15	11	4	
Clinical Manager	11	28	15	13	
Specialist	11	183	57	126	
Medico Legal Manager	11	1	0	1	
Principal Medical Officer	11	194	95	99	
Managers	11	154	124	30	

Post Designation	Level	No. of posts	Posts Filled	Posts Vacant	Vacancy Rat
Chief Pharmacist	11	13	8	5	
Chief Industrial Technician	11	1	0	1	
Principal Artisan Foreman	11	1	1	0	
Principal Artisan Superintendent	11	1	1	0	
Principal Pharmacist	10	30	26	4	
Principal Artisan Superintendent	10	5	2	3	
Deputy Manager	10	44	36	8	
Senior Medical Officer	10	289	70	219	
Senior Clinical Psychologist	9	17	7	10	
Senior Artisan Superintendent	9	10	6	4	
Registrar	9	84	6	78	
Medical Officer	9	678	326	352	
Engineer	9	2	0	2	
Deputy Manager	9	364	258	108	
Dentist	9	87	67	20	
Control Medical Technologist	9	2	0	2	
Control Med Orthotist & Prosthetist	9	1	0	1	
Control Industrial Technician	9	2	0	2	
Control Environ Health Practitioner	9	7	7	0	
Control Clinical Technologist	9	8	1	7	
Legal Admin Officer	9	1	1	0	
Chief Information Officer	9	10	4	6	
Senior Workstudy Officer	8	49	15	34	
Chief Vocational Councellor	8	3	0	3	
Senior Administration Officer	8	228	146	82	
Senior Provisioning Admin. Officer	8	79	44	35	
Chief Divisinal Officer	8	7	7	0	
Senior Personnel Practitioner	8	91	58	33	
Senior State Accountant	8	61	45	16	
Senior Training Officer	8	6	2	4	
Senior Personnel Officer	8	171	100	71	
Senior Information Officer	8	6	0	6	
Personal Assistant	8	98	47	51	
Principal Dietican	8	47	9	38	
Pharmacist	8	117	71	46	

Post Designation	Level	No. of posts	Posts Filled	Posts Vacant	Vacancy Rat
Clinical Psychologist	8	97	32	65	
Chief Social Worker	8	4	1	3	
Chief Network Controller	8	6	0	6	
Chief Professional Nurse	8	729	444	285	
Chief Personnel Officer	8	17	13	4	
Chief Med Orthotist & Prosthetist	8	1	1	0	
Chief Health Therapist	8	196	57	139	
Chief Community Liaison Officer	8	43	41	2	
Chief Environmental Health Practioner	8	67	64	3	
Chief Clinical Technologist	8	4	0	4	
Artisan Superintendent	8	6	4	2	
Household Manager	8	7	3	4	
Labour Relations Practitioner	8	6	3	3	
Forensic Control Dissector	7	13	0	13	
Work study Officer	7	22	4	18	
State Accountant	7	162	60	102	
Social worker	7	215	110	105	
Senior Professional Nurse	7	2725	2530	195	
Senior Optometrist	7	1	0	1	
Senior Librarian	7	2	2	0	
Senior Food Service Manager	7	20	8	12	
Procurement Admin Officer	7	29	13	16	
Provisioning Administration Officer	7	95	48	47	
Principal Telecom Operator	7	35	34	1	
Principal Personnel Officer	7	106	50	56	
Divisional Officer	7	78	44	34	
Personnel Practictioner	7	202	103	99	
Medical Natural Scientist	7	5	0	5	
Medical Physist	7	2	0	2	
Medical Intern	7	44	40	4	
Deputy Household Manager	7	1	1	0	
Chief Typist	7	32	5	27	
Chief Registry Clerk	7	98	20	78	
Chief Provisioning Admin Clerk	7	72	14	58	
Chief Administration Clerk	7	176	70	106	

Post Designation	Level	No. of posts	Posts Filled	Posts Vacant	Vacancy Rat
Chief Accounting Clerk	7	36	13	23	
Chief Revenue Clerk	7	38	3	35	
Artisan Foreman	7	127	54	73	
Administrative Officer	7	277	119	158	
Information Officer	7	39	6	33	
Chief Auxiliary Services Officer	7	2	1	1	
Emergency Care Practitioner	6	541	461	80	
Environmental Health Practitioner	6	122	108	14	
Senior Accounting Clerk	6	8	3	5	
Forensic Dissector	6	21	0	21	
Professional Nurse	6	4003	3265	738	
Principal Laundry Manager	6	10	4	6	
Optometrist	6	82	2	80	
Medical Technologist	6	31	0	31	
Medical Orthotist and Prosthetist	6	16	2	14	
Horticultrist	6	46	4	42	
Health Therapist	6	739	271	468	
Food Service Manager	6	36	18	18	
Health Therapist (dental)	6	2	0	2	
Health Therapist (oral)	6	2	0	2	
Health Therapist Radiography	6	4	0	4	
Clinical Technologist	6	2	0	2	
Dietician	6	91	39	52	
Dental Technician	6	2	0	2	
Chief Auxiliary Services Officer	6	14	11	3	
Assistant Household Manager	6	1	1	0	
Medical Natural Scientist	6	1	1	0	
Librarian	6	3	2	1	
Industrial Technician	6	6	2	4	
Medical Physist	6	6	1	5	
Statistical Advisor	6	1	1	0	
Senior Staff Nurse	6	712	316	396	
Chauffer	5	1	1	0	
Senior Admin Clerk	5	1	0	1	
Principal Typist	5	4	0	4	

Post Designation	Level	No. of posts	Posts Filled	Posts Vacant	Vacancy Rat
Principal linen Supervisor	5	2	0	2	
Principal Food Service Supervisor	5	16	2	14	
Principal Food Service Manager	5	2	0	2	
Principal Housekeeping Supervisor	5	8	0	8	
Principal Food Service Supervisor	5	8	0	8	
Orthopaedic Shoemaker	5	7	0	7	
Artisan	5	412	118	294	
Supplementary Diagn. Radiographer	4	185	36	149	
Senior Nursing Assistant	4	618	403	215	
Senior Laundry Supervisor	4	3	1	2	
Senior Housekeeping Supervisor	4	65	32	33	
Senior Administration clerk	4	311	276	35	
Senior Foreman Grounds	4	13	6	7	
Principal Operator	4	38	8	30	
Network Controller	4	2	0	2	
Laundry Manager	4	42	1	41	
Computer Operator	4	3	0	3	
Staff Nurse	4	2760	1907	853	
Principal Messenger	3	2	0	2	
Specialised ASO	3	423	104	319	
Senior Seamstress	3	4	4	0	
Senior Linen Supervisor	3	11	7	4	
Library Assistant	3	9	0	9	
Personnel Officer	3	197	110	87	
Linen Supervisor	3	67	18	49	
Laundry Supervisor	3	59	27	32	
Housekeeping Supervisor	3	147	73	74	
Foreman	3	69	11	58	
Food Services Supervisor	3	70	29	41	
Administration Clerk Grade I	3	1566	1075	491	
Accounting Clerk	3	254	88	166	
Nursing Assistant	3	3879	2729	1150	
Registry Clerk	3	319	97	222	
Revenue Clerk	3	52	33	19	
Provisioning Administration Clerk	3	219	133	86	

Post Designation	Level	No. of posts	Posts Filled	Posts Vacant	Vacancy Rat
Typist	3	180	62	118	
Auxiliary Services Officer	3	663	582	81	
SASO	3	14	14	0	
Telecom Operator	3	186	164	22	
Photocopier Operator	3	3	3	0	
Tradesman Aid II	2	313	299	14	
Senior Porter	2	114	104	10	
Senior Messenger	2	4	3	1	
Seamstress I	2	188	178	10	
Principal Porter	2	40	12	28	
Laundery Aid II	2	516	440	76	
Household Aid II	2	138	111	27	
Groundsman II	2	341	311	30	
General Worker II	2	168	162	6	
General Store Assistant	2	75	38	37	
Food Service Aid II	2	698	634	64	
Driver	2	495	331	164	
Tractor Driver	2	41	30	11	
Cleaner II	2	1175	1090	85	
Tradesman Aid I	1	77	49	28	
Porter	1	458	423	35	
Operator	1	444	427	17	
Messenger	1	116	91	25	
Linen Stores Assistant I	1	159	140	19	
Laundry Aid I	1	113	76	37	
Household Aid	1	25	25	0	
Groundsman	1	400	359	41	
General Worker I	1	63	54	9	
Security Guard	1	938	323	615	
Food Sevices Aid I	1	670	134	536	
Labourer	1	459	300	159	
Cleaner I	1	2608	2070	538	
TOTAL		**39687**	**26786**	**12901**	

Post Designation	Level	No. of posts	Posts Filled	Posts Vacant	Vacancy Rat
TOTAL NUMBER OF POSTS		**39687**			
TOTAL POSTS FILLED		**26786**			
TOTAL VACANT POSTS		**12901**			
VACANCY RATE		**32**			

- **Staff recruitment and retention system and challenges**

The department has developed guidelines on recruitment that indicate the process of recruitment and based on the National retention strategy the departmental policy on the retention strategies was developed.

The following challenges were identified:

- Poor infrastructures remained a challenge.
- Training and development
- Working conditions

HUMAN RESOURCES AS SUGGESTED BY THE INTEGRATED HUMAN RESOURCE FRAMEWORK (IHPF MODEL)

As the IHPF model operates on the principle of population based planning, as a core driver of equitable resource allocation, we chose the **Shosholoza** option out of the four master Presidential Growth Scenarios[i]. This choice was based upon the following assumptions and considerations:

- With the mining boom experienced over the recent past, the external environment is likely to remain supportive, with investment expected to create expansion in the industrial sector;
- The ensuing economic growth, coupled with the current low crime rate, is likely to bring about a cohesiveness of the social fabric through wealth creation and distribution;
- Access and resources, though limited, will be made available to the poor through social grants and other social development initiatives;
- Efforts are undertaken to make drugs and equipment affordable and distributed at all levels of care;
- There is a steady indication that the implementation of priority health programmes (malaria, HIV, maternal health, etc…) have started to have an impact on the quality of life of the inhabitants of the Province (this is not easy to quantify in the absence of a systematic review);
- Although there is no strong evidence that our health promotion around HIV/AIDS have induced a drastic change in sexual behaviour, the Provincial HIV prevalence rate remains among the lowest in the Country,;
- The general socio-economic growth and the improvement in the health status of the population are good predictors of a high population growth.

IHPF 2014 PROJECTED STAFF MIX:

Category	Level of Care					
	L1/Load Per 1000 inhabitants	L2/Load Per 1000 inhabitants	L3/Load Per 1000 inhabitants	TB/Load Per 1000 inhabitants	Psy/Load Per 1000 inhabitants	Total Lo V
Medical Officer	0.166	0.028	0.029	0.001	0.001	1
Medical Specialist	0.012	0.022	0.032	0.001	0.012	
Dentist	0.010	0.003	0.001	0.000	0.000	
Dental Specialist	0.002	0.001	0.000	0.000	0.000	
Medical assistants	0.005	0.000	0.000	0.000	0.000	
Prof Nurse	0.713	0.128	0.106	0.066	0.033	5
Staff Nurse	0.295	0.059	0.043	0.021	0.012	2
Nursing Assistant	0.362	0.075	0.043	0.065	0.054	5
Student nurses	0.025	0.000	0.000	0.003	0.003	
Total Nurses						**13**
Allied Health Prof & Technical Staff	0.192	0.064	0.021	0.008	0.008	1
Pharmacists	0.032	0.007	0.006	0.001	0.001	
Managers, administrators & logistical Support	0.815	0.243	0.211	0.065	0.065	7
Total	2.629	0.613	0.468	0.178	0.178	25

Categories	Number employed	% of total employed	Number per 1000 people[2]	Number per 1000 uninsured people[2]	Number per 100 000 people	Vacancy rate[5]	% of total personnel budget	Annual cost per staff member	National average	
									% of total employed	Number 1000 uninsured people
Medical officers[3]	557	64%	1232	867	50	36%	6%	R200 235		
Medical specialists	75	53%	304	175	0.3	57%	2.3%	R394 554		
Dentists[3]	67	67%	79	87	0.08	23%	0,5	R200 235		
Dental specialists	0	0	17	0	0.07	0%	0	0		
Professional nurses	3265	84%	5895	4003	0.58	18%	16%	R122 841		
Staff nurses	1907	69%	2440	2760	0.28	35%	6%	R64 143		
Nursing assistants	3132	70%	5111	3879	0.38	30%	6%	R46 200		
Student nurses	0	0	175	0	0.17	0%	0	0		
Pharmacists[3]	105	90%	265	117	0.26	10%	0.4%	R122 841		
Health therapist	328	35%	348	739	0.34	65%	2%	R79 407		
Number of psychologists	53	42%	348	125	0.34	58%	1%	R286 203		
Number of radiographers	106	66%	348	160	0.34	44%	0.5%	R98 916		
Number of dieticians	68	63%	348	108	0.34	28%%	0.3%	R98 916		
Total		100				%	100		100	

ANNEXURE 10 – HEALTH FACILITIES MANAGEMENT

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. Recently, a Facility Audit and Condition Assessment of all health and social development institution was conducted in 2005. This audit provides a basis for a review of the health facilities' performance, the capital needs and upgrade and furthermore, provides a basis to holistically plan the capital works and maintenance program of the entire Department.

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 grants like hospital revitalization, provincial infrastructure and forensic and pathological services' mortuary grants. The implementing agents for the major part of capital works is the Department of Public Works with a portion through the Independent Development Trust.

The CSIR is through a memorandum of agreement with the Department, providing technical support and programme implementation for the maintenance programme starting with the Facility Audits, specifications and maintenance term contracts.

POLICIES, PRIORITIES AND STRATEGIC OBJECTIVES

Policies

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

Priorities

- Upgrade and Building of PHC facilities (Clinics and Health Centres)

- Clinic Electrification
- Clinic Sanitation
- Clinic Water
- Upgrade of District, Provincial and Specialized Hospitals
- Building of New EMS Stations
- Upgrading and building of Nursing Colleges
- Upgrading and building of Forensic Pathological Services' Mortuaries
- Upgrading and building of Central Laundries
- Upgrade and building of Corporate Office Accommodation
- Maintenance of Health Facilities

Strategic objectives

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 a reliable source of water at health facilities
	8.1.3 To provide appropriate sanitation at health facilities
	8.1.4 To provide reliable electricity supply
	8.1.5. To maintain Health Facilities in a serviceable condition

11.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

Constraints	Measures
Staff not proportional to increasing number of projects	Recruit and appoint more staff at both Provincial and District levels t enhance quality control and monitoring
Environmental Impact Assessment (EIA) Process possibility to lengthen the construction period and also escalate construction costs. Impact on staffing requirements internally and number of consultants to be engaged per project site	Sites to be identified and secured earlier (as is planning) so as to all time for EIA processes. Recruit EIA officer solely to deal with sites / land issues, soil investig and EIA process.
Site Acquisition inconsistency amongst municipalities that is donation from municipality and pressure on DoHSD to purchase land from municipalities	Engage municipalities, Local Government and Housing and Public W an effort to resolve land acquisition, re-zoning and transfer
Donor funded clinics and other facilities which do not address the	Develop guidelines for donor funded facilities and communicate infor

Constraints	Measures
comprehensive DoHSD's building package. Donor funded facilities that do not meet the requirements and no communication with DoHSD until project completion	through DoHSD stakeholder forums and Imbizos
The apparent fine line between renovations and maintenance co-ordinated through Logistics and those through Physical Facilities Planning & Co-ordination	Develop a flow of communication and clear communication lines to g role players
Implementing Agencies' Performance in relation to targets, time lines, quality control and impact on client's under-expenditure and service delivery targets (Public Works and IDT)	Review and finalize service level agreements (SLA's) that are more demanding (water-tight) on the Implementing Agents Recruit and appoint more staff at both Provincial and District levels t enhance quality control and monitoring

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
- Recruitment and retention of staff
- Improve inter-governmental collaborations and relation building (IDP)

(2) Service delivery improvement plan

- Batho – Pele
- The implementation of service standards and Citizen's report
- Strengthen on site project monitoring and evaluation

(3) Health Technology

- Utilization of Health Information System for planning and projections

(4) Physical facilities management

- Maintenance
- Development of an immovable asset register

(5) Monitoring and Evaluation

- Compile cash flow projections per project
- Strengthen on site project monitoring and evaluation
- Evaluate projects' physical progress against cash flow projections
- Compile Weekly, Monthly, Quarterly and Annual reports

Table : Objectives and performance indicators for Health Facilities Management

Strategic Objective	Measurable Objective	Indicator	2004/05 (actual)	2005/06 (actual)	2006/07 (estimate)	2007/08 (Budget)	2008/09 (target)	
To render capital planning and development of infrastructure	Health facilities upgraded	% progress in the upgrading of Pietersburg/Mankweng Hospital Complex	95%	95%	95%	95.5%	96%	9
		% progress in upgrading of the targeted Regional Hospitals	Letaba at 40%	Letaba at 40%	65%	85%	95%	1 5 **P**
			None	None	100% (ablution facilities at Philadelphia)	100% re-organization of OPD & Casualty at Philadelphia	None	N
		% progress in upgrading of the targeted specialized hospitals	Thabamoopo at 60%	Thabamoopo at 60%	70%	80%	90%	1 5 **E**

Strategic Objective	Measurable Objective	Indicator	2004/05 (actual)	2005/06 (actual)	2006/07 (estimate)	2007/08 (Budget)	2008/09 (target)	
		Number of District Hospitals upgraded	4: Lebowakgomo Jane Furse Dilokong Nkhensani	4: Lebowakgomo Jane Furse Dilokong Nkhensani	4: Lebowakgomo Jane Furse Dilokong Nkhensani	5: Dilokong Nkhensani **Musina Thabazimbi Maphutha Malatjie**	3: Musina Thabazimbi Maphutha Malatjie	4 M T M M **W**
		% progress in upgrading Lebowakgomo	o Phase 4: 100% o Phase 5: 25%	Phase 5: 95%	Phase 5: 100%	None	None	N
		% progress in upgrading Jane Furse	o Phase 3: 100% o Phase 4: 37%	Phase 4: 97%	Phase 4: 100%	None	None	N
		% progress in upgrading Dilokong	o Phase 3: 100%	Phases 4 & 5: 35%	Phases 4 & 5: 98%	Phases 4 & 5: 100%	None	N
		% progress in upgrading Nkhensani	Phase 2: 100%	Phase 3: 30%	Phase 3: 95%	Phase 3: 100%	None	N
		% progress in upgrading Musina	None	None	None	20%	70%	1
To render capital planning and development of infrastructure	Health facilities upgraded	% progress in upgrading Thabazimbi	None	None	None	20%	80%	1
		% progress in upgrading Maphutha Malatjie	None	None	None	10%	60%	1

Strategic Objective	Measurable Objective	Indicator	2004/05 (actual)	2005/06 (actual)	2006/07 (estimate)	2007/08 (Budget)	2008/09 (target)	
		% progress in upgrading W.F. Knobel & George Masebe boilers	None	None	80%	100%	None	N
		Number of clinics upgraded	20	33	20	15	30	3
		% progress in upgrading clinics	85%	94% (20) 49% (33)	100% (20) 98% (33) 70% (20)	100% (33 + 20) 25% (15)	100%	1
To render capital planning and development of infrastructure	Health facilities developed	Number of Emergency Medical Services (EMS) Stations developed	None	None	5	6	6	6
		% progress in developing EMS Stations	None	None	95%	100%	100%	1
		Number of Nursing Campuses developed (phased development)	None	None	2: Sekhukhune Waterberg	2: Sekhukhune Waterberg	2: Sekhukhune Waterberg	2 S W
		% progress in developing Nursing Campuses	None	None	100% (100 students' per campus: Park Homes)	30%	90%	1

Strategic Objective	Measurable Objective	Indicator	2004/05 (actual)	2005/06 (actual)	2006/07 (estimate)	2007/08 (Budget)	2008/09 (target)	
		% progress in developing Thaba Leshoba Health Centre	None	Planning	30%	80%	100%	N
		% progress in developing H.C. Boshoff Health Centre	None	None	5%	50%	80%	1
		% progress in developing Whitoc-Cum-Provincial Office	None	None	30%	90%	100%	N
To render capital planning and development of infrastructure	Health facilities developed	Number of staff accommodation units developed	None	279 Units	51 Units	224 Units	53 Units	5
		% progress in developing staff accommodation	None	100%	100% including additional services to the 330 units (279 + 51)	100%	100%	1
		% progress in developing central laundries	None	None	100% Planning	60% Sekhukhune Laundry	100% Sekhukhune Laundry 50% Vhembe Laundry	1 V L

Strategic Objective	Measurable Objective	Indicator	2004/05 (actual)	2005/06 (actual)	2006/07 (estimate)	2007/08 (Budget)	2008/09 (target)	
		Number of Forensic Pathological Services Laboratories (Forensic Mortuaries) developed	None	6: Polokwane Lephalale Mokopane Warmbath M.L. Malatji Mapulaneng	2: Musina Tshilidzini (in total 8 sites)	1: Thabazimbi (the 9th site)	None	N
		% progress in developing Forensic Mortuaries	None	12%	80%	100%	None	N
To provide a reliable source of water at health facilities	Health facilities provided with water	% of health facilities provided with a reliable source of water	100% (39 clinics)	100% (49 clinics)	100% (50)	100% (50)	100% (50)	1
To provide appropriate sanitation at health facilities	Health facilities provided with appropriate sanitation	% of health facilities with appropriate sanitation	100% (76 clinics)	100% (40 clinics)	100% (110)	100% (70)	100% (40)	1
To provide reliable electricity supply	Health facilities provided with reliable electricity.	% of health facilities provided with reliable electricity	100% (23 Clinics with no electricity)	100% (26 Clinics with no electricity)	100% (25 Clinics with unreliable electricity- single phase)	100% (25)	100% (25)	1
To maintain Health Facilities in a serviceable condition	Health facilities maintained	% health facilities maintained	59.3%	59.6%	60%	61%	62%	6

Table : Programme budget by sub-programme (R million)[1]

Sub-programme	Year - 2 2003/04 (actual)	Year - 1 2004/05 (actual)	Base year 2005/06 (estimate)	Average annual change (%)[2]	Year 1 2006/07 (budget)	Year 2 2007/08 (MTEF projection)	Year 3 2008/09 (MTEF projection)	Ave cl
1. Community Health Facilites	22	102	121	-9.5	125	185	194	
2. District Hospital Services	221	118	227	-41.25	108	136	143	
3. Provincial Hospital Services	15	8	16	10.99	15	61	64	
4.Tertiary Hospitls	3	13	25	1.31	24	41	43	
5. Other Facilities		45	90	-8.52	69	285	299	
Total programme	**261**	**286**	**508**	**-21.81**	**331**	**708**	**743**	

CAPITAL INVESTMENT, MAINTENANCE AND ASSET MANAGEMENT

Since 1996, the Department developed a policy to maintain its assets. Funds have been set aside in the various Districts, specifically for maintenance. Budget allocations have increased steadily over the last few years.

Each facility has maintenance staff employed by Health and Social Development.

Public Works staff assists on request and where they are unable to provide direct service, external service providers / contractors are called in with Public Works offering technical advice.

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)

Table HFM1: Historic and planned capital expenditure by type[2] (R' million)

	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/7 (estimate)	2007/08 (MTEF projection)	2008/09 (MTEF projection)	2009/1 proje
Major capital[3]	227	236	226	221	493	585	
Minor capital[4]							
Maintenance	34	50	151	45	47	50	
Equipment	0	0.11	236	19	23	78	
Equip maintenance							
Total capital[1]		286	401	340	403	463	

Table HFM2: Summary of sources of funding for capital expenditure

	2003/04 (actual)	2004/05 (actual)	2005/06 (actual))	2006/7 (estimate)	2007/08 (MTEF projection)	2008/09 (MTEF projection)	2009/1 proje
Infrastructure grant	58	83	61	102	106	129	
Equitable share	107	97	188	190	239	240	
Revitalisation grant[1]	96	106	152	48	148	216	
Donor funding							
Other (Maintenance)	34	50	151	45	47	50	
Total capital	295	336	552	395	541	635	

Table HFM3: Historic and planned major project completions by type

	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/7 (estimate)	2007/08 (MTEF projection)	2008/09 (MTEF projection)	200 (MTEF p
New hospitals	-	-	-	-	-	-	-
New clinics / CHC's	-	-	6	6	-	5	5
Upgraded hospitals		4	4	4	3	2	1
Upgraded clinics / CHC's	21	20	33	20	15	30	30

Table HFM4: Total projected long term capital demand for health facilities management (R milion)[2]

Programme	Province wide total	Planning horizon (years)	Province total annualised[4]	Annualised				
				Waterberg	Mopani	Vhembe	Sekhukhune	
Programme 1								
MECs office and Administration[1]	6	10	1	-	-	-	-	
Programme 2								
Clinics and CHC's	129	10	17					
Mortuaries	12	3	4	1	-	2	-	
District hospitals	31	10	2	1	-	1	-	
Programme 3								
EMS infrastructure[1]	37	10	6	2	1	1	1	
Programme 4								
Regional Hospitals	6	10	1	-	1	-	1	
Psychiatric hospitals[1]	3	10	1	-	-	-	-	
TB hospitals[1]	-	-	-	-	-	-	-	
MDR	1	10	-	-	-	-	-	
Programme 5								
Provincial tertiary	2	3	2	-	-	-	-	
Central Teaching Hospital	1	10	1	-	-	-	-	
Other programmes[1,3]								
Nursing colleges	5	10	2	1	-	-	1	
Laundries	5	10	1	-	-	-	1	
Staff Accommodation	607	3	224	58	43	44	42	
Total all programmes								

Table HFM7: Performance indicators for health facilities management

Indicator	Type	2005/06	2006/07	2007/08	2008/09	2009/10	National ta 2007/08
Input							
1. Equitable share capital programme as % of total health expenditure	%	3.48	4.03	4.46	4.46	4.46	2.5
2. Hospitals funded on revitalisation programme	%	14	0.1	0.1	0.1	0.1	25
3. Expenditure on facility maintenance as % of total health expenditure	%	1.83	2.04	1.92	1.92	1.92	4
4. Expenditure on equipment maintenance as % of total health expenditure	%	18	29	29	27	27	4
Process							
5. Hospitals with up to date asset register	%	100	100	100	100	100	100
6. Health districts with up to date PHC asset register (excl hospitals)	No	5	5	5	5	5	All
Quality							
7. Fixed PHC facilities with access to piped water	%	78	80	100	100	100	100
8. Fixed PHC facilities with access to mains electricity	%	70	75	100	100	100	100
9. Fixed PHC facilities with access to fixed line telephone	%	80	80	100	100	100	100
10. Average backlog of service platform in fixed PHC facilities	R milion	20	21	22	23	25	15
11. Average backlog of service platform in district hospitals	R milion						15
12. Average backlog of service platform in regional hospitals	Rmilion	1	1	1	1	1	15
13. Average backlog of service platform in specialised hospitals	Rm	1	1	1	1	1	15
14. Average backlog of service platform in tertiary and central hospitals	Rm	0	0	0	0	0	15
15. Average backlog of service platform in provincially aided hospitals	R	0	0	0	0	0	15
Outcome							
16. Level 1 beds per 1000 uninsured population	No	1.3	1.3	1.3	1.3	1.3	90
17. Level 2 beds per 1000 uninsured population	No	0.5	0.5	0.5	0.5	0.5	60

Indicator	Type	2005/06	2006/07	2007/08	2008/09	2009/10	National ta 2007/08
18. Level 3	N	0.1	0.1	0.1	0.1	0.1	
19. Population within 5km of fixed PHC facility	%						95

2 Summarised from provincial Integrated Health Planning Framework (IHPF) model

Table HFM8: Trends in provincial public health expenditure for health facilities management (R million)

Expenditure[1]	2005/06 (actual)	2006/7 (estimate)	2007/08 (MTEF projection)	2008/09 (MTEF projection)	2009/10 (MTEF projection)
Current prices[2]					
Total	1684	1462	1813	2316	2432
Total per person	0.32	0.28	0.34	0.44	0.46
Total per uninsured person	0.35	0.30	0.39	0.48	0.50
Constant (2004/05) prices[3]					
Total	1684	1462	1813	2316	2432
Total per person	0.32	0.28	0.34	0.44	0.46
Total per uninsured person	0.35	0.30	0.39	0.48	0.50