LIMPOPO

PROVINCIAL GOVERNMENT

REPUBLIC OF SOUTH AFRICA

HEALTH – VOTE 7
STRATEGIC PLAN
2020-2025

FINAL

Date of Tabling:

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Executive Authority Statement

Every financial year, the Department strives to achieve both its short and long-term objectives. The next five years will not be any exception.

This strategic document will be a guiding lodestar of what we seek to achieve as a Department in the sixth administration. We are able to reflect with pride and considerable humility at the strides we have made in the previous administration and the admirable work done to effect meaningful change to the lives of ordinary residents of our beautiful Province.

We look back with immeasurable pride at the work done in the past five years and our deliberate efforts to improve the health of our population and expand access to quality public health. We have done coupled with the provision of high, quality medication.

We have also expanded access to healthcare facilities, including opening our clinics for 24 hours. We can say without being justly contradicted that the healthcare machinery has been properly oiled to serve our people with great and unmatched distinction.

In the next five years we aim to increase our commitment to the delivery of health services to our people. The next five years will see us continue with our deliberate investment in infrastructure delivery, improve the inhabitability of existing buildings and procuring modern day technology to enhance service delivery.

Again, in the next five years we should be able to have tangible outcomes with regards to the policy framework, including achieving the strategic objectives of the Limpopo Development Plan, the National Development Plan and the Sustainable Development Goals.

We should join the global community in the effort to bring about Universal Healthcare Coverage.

I present this document as a calculated service delivery mechanism intended at monitoring and assessing the rate of performance in our execution of the electoral mandate bestowed upon us by the people. Today is indeed better than yesterday, and tomorrow will surely be better than today. We have made quantum leaps since we took over government in 1994.

Let's grow Limpopo together!

Dr Ramathuba P.C

Member of the Executive Council

Accounting Officer Statement

The Strategic Plan 2020-2025 sets a direction the department will undertake in the sixth administration of government. Embarking into the medium-term, the department is mindful of the socio-economic factors government is faced with in entering the 'New Dawn' *inter alia* unemployment in particular among youth, poverty, inequality and gender-based challenges. In dipping into the aforementioned socio-economic factors, the Department with this Strategic Plan aims to action among the Limpopo community the health related objectives contained in both the National Development Plan (NDP) and the Limpopo Development Plan (LDP). Consequently, we ensured that this Strategic Plan is community oriented and that the plan outlines implicitly relevant contributions the department will make towards the seven government priorities, which include:

- **Priority 1:** Building a capable, ethical and developmental state;
- **Priority 2:** Economic Transformation and job creation;
- **Priority 3:** ***Education, skills and health;***
- **Priority 4:** Consolidating the social image through reliable and quality basic services;
- **Priority 5:** Spatial integration, human settlements and local government;
- **Priority 6:** Social cohesion and safe communities; and
- **Priority 7:** A better Africa and World.

Therefore, the plan demonstrates that the department aims towards making contributions in addressing youth development, gender equity in senior leadership positions and promoting access to those living with disability to both health services and job opportunities.

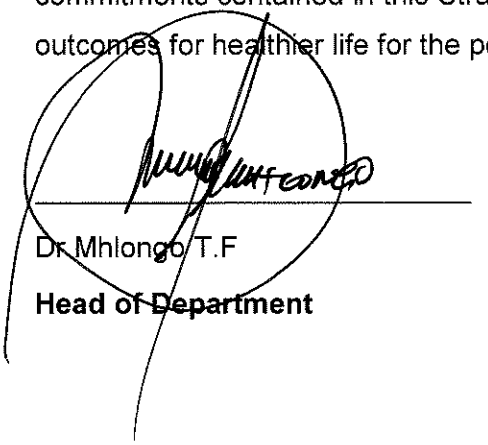
In aligning itself to *'Priority 3: Education, skills and Health'*, the department has set the impact and outcomes in the plan which aim at achieving the four goals in the sector NDP Implementation Plan 2019-2024, which are:

- **Increase Life Expectancy;**
- **Promote health to prevent diseases;**
- **Implement NHI, and**
- **Quality improvement in the provision of care.**

Over the five-years the department is committed to being ready for the NHI roll-out in the province as well as seeing the dream of the academic hospital being realised. In terms of the NHI, the department will monitor the implementation of the ten year infrastructure plan pertaining health facilities that need major refurbishment or replacement.

Therefore, this plan will serve as a guideline and a barometer over the next five years for the department to evaluate and measure its impact as well as outcomes. By implementing

commitments contained in this Strategic Plan 2020-2025, the Department envisages positive outcomes for healthier life for the people in Limpopo.



Dr Mhlongo T.F

Head of Department

Official Sign-off

It is hereby certified that this Strategic Plan:

- Was developed by the management of the Limpopo Province Department of Health under the guidance of Dr Ramathuba P.C.
- Takes into account all the relevant policies, legislation and other mandates for which the Limpopo Province is responsible for.
- Accurately reflects the Impact, Outcomes and Outputs which the Limpopo Province Department of Health will endeavor to achieve over the period 2020 - 2025.

Mr Mawasha Z Signature: _____

Manager Programme 1: Administration

Dr Dombo M Signature: _____

Manager Programme 2: District Health Services

Mr Kruger P Signature: _____

Manager Programme 3: Emergency Medical Services

Dr Ndwamato N Signature: _____

Manager Programme 4: General (Regional) Hospitals

Dr Ndwamato N Signature: _____

Manager Programme 5: Tertiary and Central Hospitals

Dr Ndwamato N Signature: _____

Manager Programme 6: Health Science and Training

Mr Kruger P Signature: _____

Manager Programme 7: Health Care Support

Ms Mogadime M Signature: _____

Manager Programme 8: Health Facilities Management

Mr Mudau J Signature: _____

Chief Financial Officer

Mr Molokwane J Signature: _____

Integrated Planning

Dr Pinkoane T Signature: _____

Head Official responsible for Planning

Dr Mhlongo T Signature: _____

Accounting Officer

Approved by:

Dr Ramathuba P Signature: _____

Executive Authority

Part A: Our Mandate

1. Constitutional Mandate

In terms of the Constitutional provisions, the Department is guided by the following sections and schedules, among others:

The Constitution of the Republic of South Africa, 1996, places obligations on the state to progressively realise socio-economic rights, including access to *(affordable and quality)* health care.

Schedule 4 of the Constitution reflects health services as a concurrent national and provincial legislative competence

Section 9 of the Constitution states that everyone has the right to equality, including access to health care services. This means that individuals should not be unfairly excluded in the provision of health care.

- People also have the right to access information if it is required for the exercise or protection of a right;
- This may arise in relation to accessing one's own medical records from a health facility for the purposes of lodging a complaint or for giving consent for medical treatment; and
- This right also enables people to exercise their autonomy in decisions related to their own health, an important part of the right to human dignity and bodily integrity in terms of sections 9 and 12 of the Constitutions respectively

Section 27 of the Constitution states as follows: with regards to Health care, food, water, and social security:

(1) Everyone has the right to have access to:
  (a) Health care services, including reproductive health care;
  (b) Sufficient food and water; and
  (c) Social security, including, if they are unable to support themselves and their dependents, appropriate social assistance.
(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights; and
(3) No one may be refused emergency medical treatment.

Section 28 of the Constitution provides that every child has the right to 'basic nutrition, shelter, basic health care services and social services.

2. Legislative and Policy Mandates

2.1 Legislation falling under the Department of Health's Portfolio

National Health Act, 2003 (Act No. 61 of 2003)

Provides a framework for a structured health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services. The objectives of the National Health Act (NHA) are to:

- unite the various elements of the national health system in a common goal to actively promote and improve the national health system in South Africa;

- provide for a system of co-operative governance and management of health services, within national guidelines, norms and standards, in which each province, municipality and health district must deliver quality health care services;
- establish a health system based on decentralised management, principles of equity, efficiency, sound governance, internationally recognized standards of research and a spirit of enquiry and advocacy which encourage participation;
- promote a spirit of co-operation and shared responsibility among public and private health professionals and providers and other relevant sectors within the context of national, provincial and district health plans; and
- create the foundation of the health care system, and understood alongside other laws and policies which relate to health in South Africa.

Medicines and Related Substances Act, 1965 (Act No. 101 of 1965) - Provides for the registration of medicines and other medicinal products to ensure their safety, quality and efficacy, and also provides for transparency in the pricing of medicines.

Hazardous Substances Act, 1973 (Act No. 15 of 1973) - Provides for the control of hazardous substances, in particular those emitting radiation.

Occupational Diseases in Mines and Works Act, 1973 (Act No. 78 of 1973) - Provides for medical examinations on persons suspected of having contracted occupational diseases, especially in mines, and for compensation in respect of those diseases.

Pharmacy Act, 1974 (Act No. 53 of 1974) - Provides for the regulation of the pharmacy profession, including community service by pharmacists

Health Professions Act, 1974 (Act No. 56 of 1974) - Provides for the regulation of health professions, in particular medical practitioners, dentists, psychologists and other related health professions, including community service by these professionals.

Dental Technicians Act, 1979 (Act No.19 of 1979) - Provides for the regulation of dental technicians and for the establishment of a council to regulate the profession.

Allied Health Professions Act, 1982 (Act No. 63 of 1982) - Provides for the regulation of health practitioners such as chiropractors, homeopaths, etc., and for the establishment of a council to regulate these professions.

SA Medical Research Council Act, 1991 (Act No. 58 of 1991) - Provides for the establishment of the South African Medical Research Council and its role in relation to health Research.

Academic Health Centres Act, 86 of 1993 - Provides for the establishment, management and operation of academic health centres.

Choice on Termination of Pregnancy Act, 196 (Act No. 92 of 1996) - Provides a legal framework for the termination of pregnancies based on choice under certain circumstances.

Sterilisation Act, 1998 (Act No. 44 of 1998) - Provides a legal framework for sterilisations, including for persons with mental health challenges.

Medical Schemes Act, 1998 (Act No.131 of 1998) - Provides for the regulation of the medical schemes industry to ensure consonance with national health objectives.

Council for Medical Schemes Levy Act, 2000 (Act 58 of 2000) - Provides a legal framework for the Council to charge medical schemes certain fees.

Tobacco Products Control Amendment Act, 1999 (Act No 12 of 1999) - Provides for the control of tobacco products, prohibition of smoking in public places and advertisements of tobacco products, as well as the sponsoring of events by the tobacco industry.

Mental Health Care 2002 (Act No. 17 of 2002) - Provides a legal framework for mental health in the Republic and in particular the admission and discharge of mental health patients in mental health institutions with an emphasis on human rights for mentally ill patients.

National Health Laboratory Service Act, 2000 (Act No. 37 of 2000) - Provides for a statutory body that offers laboratory services to the public health sector.

Nursing Act, 2005 (Act No. 33 of 2005) - Provides for the regulation of the nursing profession.

Traditional Health Practitioners Act, 2007 (Act No. 22 of 2007) - Provides for the establishment of the Interim Traditional Health Practitioners Council, and registration, training and practices of traditional health practitioners in the Republic.

Foodstuffs, Cosmetics and Disinfectants Act, 1972 (Act No. 54 of 1972) - Provides for the regulation of foodstuffs, cosmetics and disinfectants, in particular quality standards that must be complied with by manufacturers, as well as the importation and exportation of these items.

2.2 Other legislation applicable to the Department

Criminal Procedure Act, 1977 (Act No.51 of 1977), Sections 212 4(a) and 212 8(a) - Provides for establishing the cause of non-natural deaths.

Children's Act, 2005 (Act No. 38 of 2005) - The Act gives effect to certain rights of children as contained in the Constitution; to set out principles relating to the care and protection of children, to define parental responsibilities and rights, to make further provision regarding children's court.

Occupational Health and Safety Act, 1993 (Act No.85 of 1993) - Provides for the requirements that employers must comply with in order to create a safe working environment for employees in the workplace.

Compensation for Occupational Injuries and Diseases Act, 1993 (Act No.130 of 1993) - Provides for compensation for disablement caused by occupational injuries or diseases sustained or contracted by employees in the course of their employment, and for death resulting from such injuries or disease.

National Roads Traffic Act, 1996 (Act No.93 of 1996) - Provides for the testing and analysis of drunk drivers.

Employment Equity Act, 1998 (Act No.55 of 1998) - Provides for the measures that must be put into operation in the workplace in order to eliminate discrimination and promote affirmative action.

State Information Technology Act, 1998 (Act No.88 of 1998) - Provides for the creation and administration of an institution responsible for the state's information technology system.

Skills Development Act, 1998 (Act No 97of 1998) - Provides for the measures that employers are required to take to improve the levels of skills of employees in workplaces.

Public Finance Management Act, 1999 (Act No. 1 of 1999) - Provides for the administration of state funds by functionaries, their responsibilities and incidental matters.

Promotion of Access to Information Act, 2000 (Act No.2 of 2000) - Amplifies the constitutional provision pertaining to accessing information under the control of various bodies.

Promotion of Administrative Justice Act, 2000 (Act No.3 of 2000) - Amplifies the constitutional provisions pertaining to administrative law by codifying it.

Promotion of Equality and the Prevention of Unfair Discrimination Act, 2000 (Act No.4 of 2000)

Provides for the further amplification of the constitutional principles of equality and elimination of unfair discrimination.

Division of Revenue Act, (Act No 7 of 2003) - Provides for the manner in which revenue generated may be disbursed.

Broad-based Black Economic Empowerment Act, 2003 (Act No.53 of 2003) - Provides for the promotion of black economic empowerment in the manner that the state awards contracts for services to be rendered, and incidental matters.

Labour Relations Act, 1995 (Act No. 66 of 1995) - Establishes a framework to regulate key aspects of relationship between employer and employee at individual and collective level.

Basic Conditions of Employment Act, 1997 (Act No.75 of 1997) - Prescribes the basic or minimum conditions of employment that an employer must provide for employees covered by the Act.

3. Health Sector Policies and Strategies over the five year planning period

3.1 National Health Insurance Bill

South Africa is at the brink of effecting significant and much needed changes to its health system financing mechanisms. The changes are based on the principles of ensuring the right to health for all, entrenching equity, social solidarity, and efficiency and effectiveness in the health system in order to realise Universal Health Coverage. To achieve Universal Health Coverage, institutional and organisational reforms are required to address structural inefficiencies; ensure accountability for the quality of the health services rendered and

ultimately to improve health outcomes particularly focusing on the poor, vulnerable and disadvantaged groups.

In many countries, effective Universal Health Coverage has been shown to contribute to improvements in key indicators such as life expectancy through reductions in morbidity, premature mortality (especially maternal and child mortality) and disability. An increasing life expectancy is both an indicator and a proxy outcome of any country's progress towards Universal Health Coverage. The phased implementation of NHI is intended to ensure integrated health financing mechanisms that draw on the capacity of the public and private sectors to the benefit of all South Africans. The policy objective of NHI is to ensure that everyone has access to appropriate, efficient, affordable and quality health services.

An external evaluation of the first phase of National Health Insurance was published in July 2019. Phase 2 of the NHI Programme commenced during 2017, with official gazetting of the National Health Insurance as the Policy of South Africa. The National Department of Health drafted and published the National Health Insurance Bill for public comments on 21 June 2018. During August 2019, the National Department of Health sent the National Health Insurance Bill to Parliament for public consultation.

3.2 National Development Plan: Vision 2030

The National Development Plan (Chapter 10) has outlined 9 goals for the health system that it must reach by 2030 (refer to Figure 1). The **NDP goals are best described using conventional public health logic framework**. The **overarching goal** that measures impact is "Average male and female life expectancy at birth increases to at least 70 years". The **next 4 goals measure health outcomes**, requiring the health system to **reduce premature mortality and morbidity**. Last **4 goals are tracking the health system that essentially measure inputs and processes** to derive outcomes

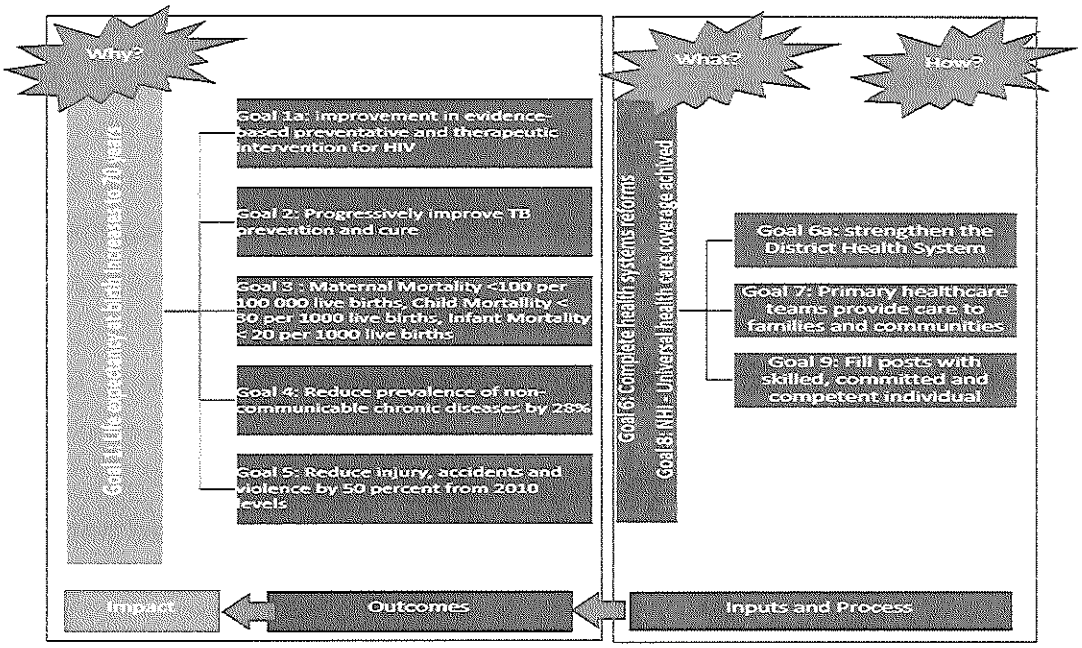


Figure 1. NDP Goals

3.3 Sustainable Development Goals

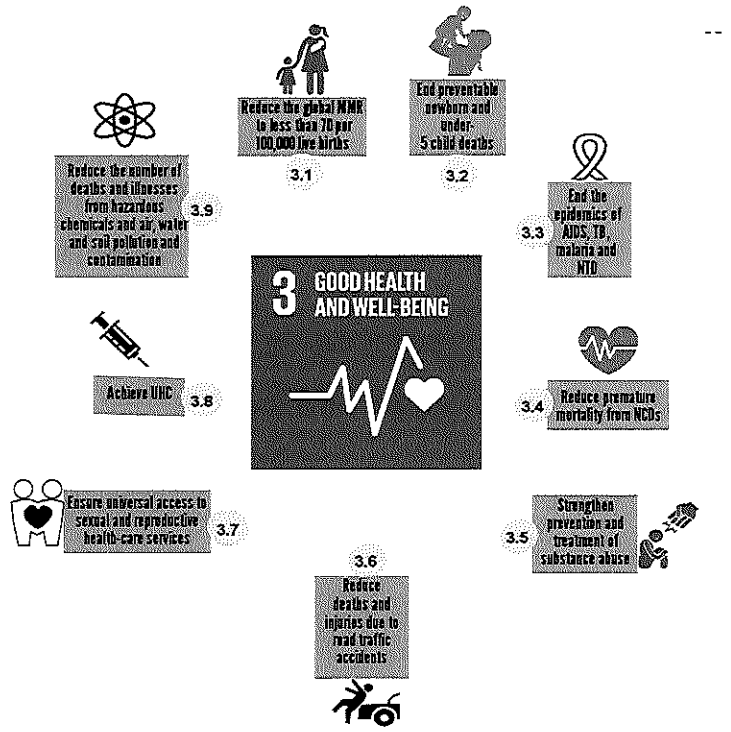


Figure 2. SDGs Goals

Goal 3. Ensure healthy lives and promote well-being for all at all ages

(1) 3.1 - By 2030, reduce the global maternal **mortality ratio to less than 70 per 100,000 live births**

(2) 3.2 - By 2030, end **preventable deaths of new-borns and children under 5 years of age**, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births

(3) 3.3 - By 2030, **end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases** and combat hepatitis, water-borne diseases and other communicable diseases

(4) 3.4 - By 2030, **reduce by one third premature mortality from non-communicable diseases** through prevention and treatment and promote mental health and well-being

(5) 3.5 - Strengthen the **prevention and treatment of substance abuse,** including narcotic drug abuse and harmful use of alcohol

(6) 3.6 - By 2020, **halve the number of global deaths and injuries from road traffic accidents**

(7) 3.7 - By 2030, **ensure universal access to sexual and reproductive health-care services**, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

(8) 3.8 - Achieve **universal health coverage, including financial risk protection**, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all

(9) 3.9 - By **2030, substantially reduce the number of deaths and illnesses from hazardous chemicals** and air, water and soil pollution and contamination

(10) 3.a - Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate

(11) 3.b - **Support the research and development of vaccines and medicines** for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all

(12) 3.c - Substantially **increase health financing and the recruitment, development, training and retention of the health workforce** in developing

countries, especially in least developed countries and small island developing States

(13) Strengthen the capacity of all countries, in particular developing countries, for **early warning, risk reduction and management of national and global health risks**

3.4 Medium Term Strategic Framework and NDP Implementation Plan 2019-2024

The plan comprehensively responds to the priorities identified by cabinet of 6th administration of democratic South Africa, which are embodied in the Medium-Term Strategic Framework (MTSF) for period 2019-2024. It is aimed at eliminating avoidable and preventable deaths (***survive***); promoting wellness, and preventing and managing illness (***thrive***); and transforming health systems, the patient experience of care, and mitigating social factors determining ill health (***transform***), in line with the United Nation's three broad objectives of the Sustainable Development Goals (SDGs) for health.

Over the next 5 years, the Provincial Department of Health's response is structured into 4 goals and 10 sector strategies (see Table 1 below). These goals and strategic objectives are well aligned to the Pillars of the Presidential Health Summit compact, as outlined in the table below.

Table 1. Health Sector Goals

	MTSF 2019-2024 Impacts	Health sector's strategy 2019-2024		Presidential Health Summit Compact Pillars
Survive and Thrive	Life expectancy of South Africans improved to 70 years by 2030	Goal 1: Increase Life Expectancy improve Health and Prevent Disease	1. *Improve health outcomes by responding to the quadruple burden of disease of South Africa* 2. *Inter sectoral collaboration to address social determinants of health*	*N/A*
Transform	Universal Health Coverage for all South Africans achieved and all citizens protected from the catastrophic financial impact of seeking health care	Goal 2: Achieve UHC by Implement NHI	3. *Progressively achieve Universal Health Coverage through NHI*	*Pillar 4: Engage the private sector in improving the access, coverage and quality of health services; and* *Pillar 6: Improve the efficiency of public sector financial management systems and processes*
		Goal 3: Quality Improvement in the Provision of care	4. *Improve quality and safety of care*	*Pillar 5: Improve the quality, safety and quantity of health services provided with a focus on to primary health care.*
			5. *Provide leadership and enhance governance in the health sector*	*Pillar 7: Strengthen Governance and Leadership to improve*

	MTSF 2019-2024 Impacts	Health sector's strategy 2019-2024		Presidential Health Summit Compact Pillars
	by 2030		*for improved quality of care*	*oversight, accountability and health system performance at all levels*
			6. *Improve community engagement and reorient the system towards Primary Health Care through Community based health Programmes to promote health*	*Pillar 8: Engage and empower the community to ensure adequate and appropriate community based care*
			7. *Improve equity, training and enhance management of Human Resources for Health*	*Pillar 1: Augment Human Resources for Health Operational Plan*
			8. *Improving availability to medical products, and equipment*	*Pillar 2: Ensure improved access to essential medicines, vaccines and medical products through better management of supply chain equipment and machinery* *Pillar 6: Improve the efficiency of public sector financial management systems and processes*
			9. *Robust and effective health information systems to automate business processes and improve evidence based decision making*	*Pillar 9: Develop an Information System that will guide the health system policies, strategies and investments*
		Goal 4: Build Health Infrastructure for effective service delivery	10. *Execute the infrastructure plan to ensure adequate, appropriately distributed and well maintained health facilities*	*Pillar 3: Execute the infrastructure plan to ensure adequate, appropriately distributed and well-maintained health facilities*

4. Medico-Legal Challenge

Medico legal case reached a point of concern leading to the former Minister Dr Motsoaledi calling a medico legal summit on the 9 and 10 March 2015. The summit culminated in Paper 33 and declaration of medico legal. Patient safety, law reform and capping of claims were amongst the issues that were identified. Limpopo department of health is equally affected by cases of medico legal litigation. The contingency liability amount is growing on a daily bases as cases get registered. Cases of medico legal litigation are twofold. There is the medical part and the legal arm. Both arms need to be mitigated and managed. The medical arm entails of the issues of litigation to do with service delivery. Service provision encompasses among others of the place of service delivery; the personnel providing the service; the time it takes to provide the service and the overall outcome post service

provision. The quality of health provided by the department has psychosocial impact on the community at large. It is thus of paramount importance that systems are put in place to provide services in terms of National Patient Safety Policy and or National Core Standards. Litigation costs for the previous four financial years are depicted below:

Financial year	Amount paid
2015/2016	R6 883 452,99
2016/2017	R74 174 281,15
2017/2018	R8 229 135,00
2018/2019	R9 015 000,00

To this end the cases in the liability register are 1099 at an amount up to R 939 788 4068.00. In a short term, the department intends to use internal specialist to review cases; ensure that all litigation files have appropriate information; and triage litigation cases and manage them accordingly. In the medium term, there will be review of management of court cases while waiting for finalisation of the Liability Amendment Bill to come into effect.

Part B: Our Strategic Focus

5. Vision

A long and healthy life for people in Limpopo.

6. Mission

The Department is committed to provide quality health care service that is accessible, comprehensive, integrated, sustainable and affordable.

7. Values

The department adheres to the following values and ethics that uphold the Constitution of the Republic of South Africa through:

- Honesty
- Integrity
- Fairness
- Equity
- Respect
- Dignity
- Caring

8. Stakeholder analysis

Internal Stakeholders				
Stakeholder	**Characteristics**	**Influence**	**Interest**	**Linkages with other stakeholders**
Executive management	Key point of accountability on overall departmental performance	High	High	Strong linkages of accountability with both internal and external stakeholders
Programme managers	Highly knowledgeable on subject matter in line with areas of responsibility	High	High	Accountable to the executive management on performance matters
District offices	Key drivers of policy and strategy implementation	Low	High	Closely relates with the beneficiaries or service users
Internal control	Ensure compliance to	Low	High	A link between department and both internal and external auditors

	audit standards			including other oversight bodies (i.e. audit committee and SCOPA)
Trade unions	Politically inclined and represent employees	Low	High	Advocate for employees and drives
External Stakeholders				
Stakeholder	**Characteristics**	**Influence**	**Interest**	**Linkages with other stakeholders**
Oversight bodies (Portfolio committee on health, audit committee, SCOPA, AGSA etc.)	-Politically oriented -Experts in areas of study -Strongly opinionated	High	High	Serves as a linkage between department and the community on health service delivery matters
Treasury	Plays an oversight role for departmental accountability on financial management and performance issues	Low	High	Link with oversight bodies in particular audit committee on departmental financial and performance issues
Beneficiaries (communities)	Strongly advocates for their interests	Low	High	Links with portfolio committee on matters of community interest in the department
National Department of Health	Policy development driven	High	High	Direct link with AGSA
Office of health standards compliance	Interested in ensuring that facilities comply to legislated norms and standards	Low	Low	Link with NDoH and provincial health departments

9. Situational Analysis

9.1 Overview of the Province

Limpopo, South Africa's northernmost province, borders onto Mozambique, Zimbabwe and Botswana. It also borders the Mpumalanga, Gauteng and North West provinces. Named after the Limpopo River, which flows along its northern border, it is a region of contrasts, from true Bushveld country to majestic mountains, primeval indigenous forests, unspoiled wilderness and patchworks of farmland. In the eastern region lies the northern half of the magnificent Kruger National Park.

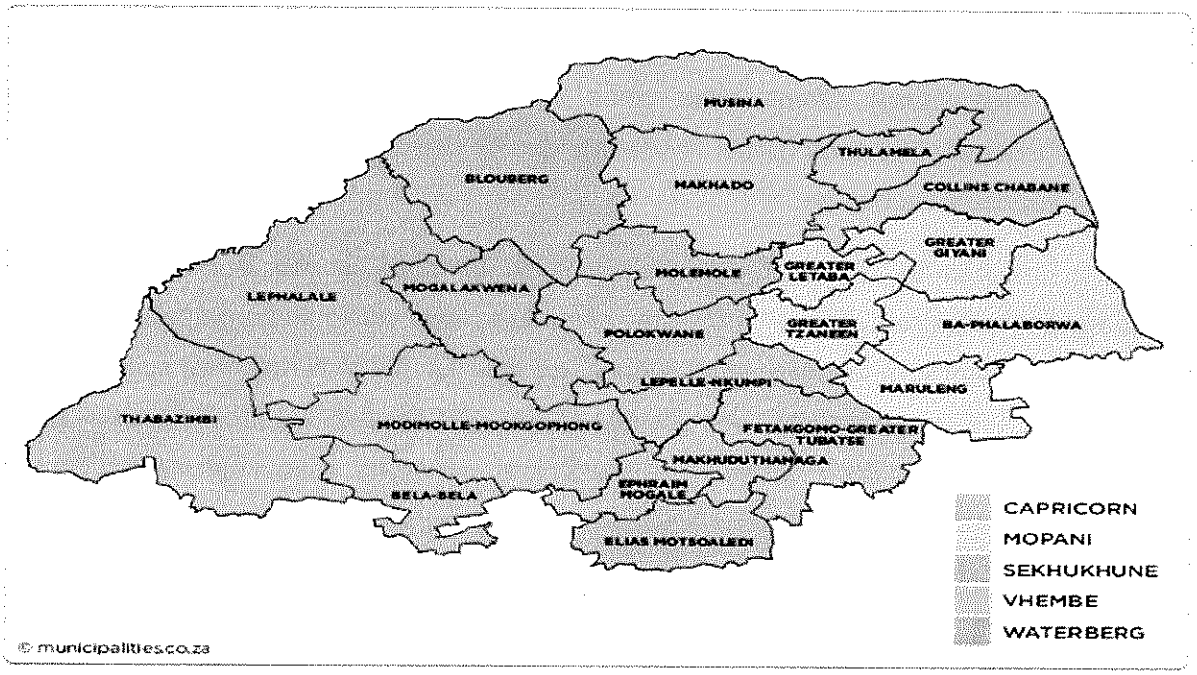
Limpopo ranks fifth in South Africa in both surface area and population, covering an area of 125 754km² and being home to a population of 5 951 999. The capital is Polokwane (previously Pietersburg). Other major cities and towns include Bela-Bela (Warmbad), Lephalale (Ellisras), Makhado (Louis Trichardt), Musina (Messina), Thabazimbi and Tzaneen (see the Limpopo map below).

Mining is the primary driver of economic activity. Limpopo is rich in mineral deposits, including platinum-group metals, iron ore, chromium, high and middle-grade coking coal, diamonds, antimony, phosphate and copper, as well as mineral reserves such as gold, emeralds, scheelite, magnetite, vermiculite, silicon and mica. The province is a typical developing area, exporting primary products and importing manufactured goods and services.

The climatic conditions in the province allow for double harvesting seasons, which results in it being the largest producer of various crops in the agricultural market. Sunflowers, cotton, maize and peanuts are cultivated in the Bela-Bela–Modimolle area. Bananas, litchis, pineapples, mangoes and pawpaws, as well as a variety of nuts, are grown in the Tzaneen and Makhado areas. Extensive tea and coffee plantations create many employment opportunities in the Tzaneen area. The Bushveld is cattle country, where controlled hunting is often combined with ranching.

Limpopo is divided into five district municipalities, which are further subdivided into 22 local municipalities.

Demographic Data	LP	Unit of Measure
Geographical area	125,754	Km2
Total population SA Mid-year estimates 2018	5,951,999	Number
Population density (SA Mid-year estimates 2018)	286	Per Km^2
Percentage of population with medical insurance (StatSA)	8.2	%

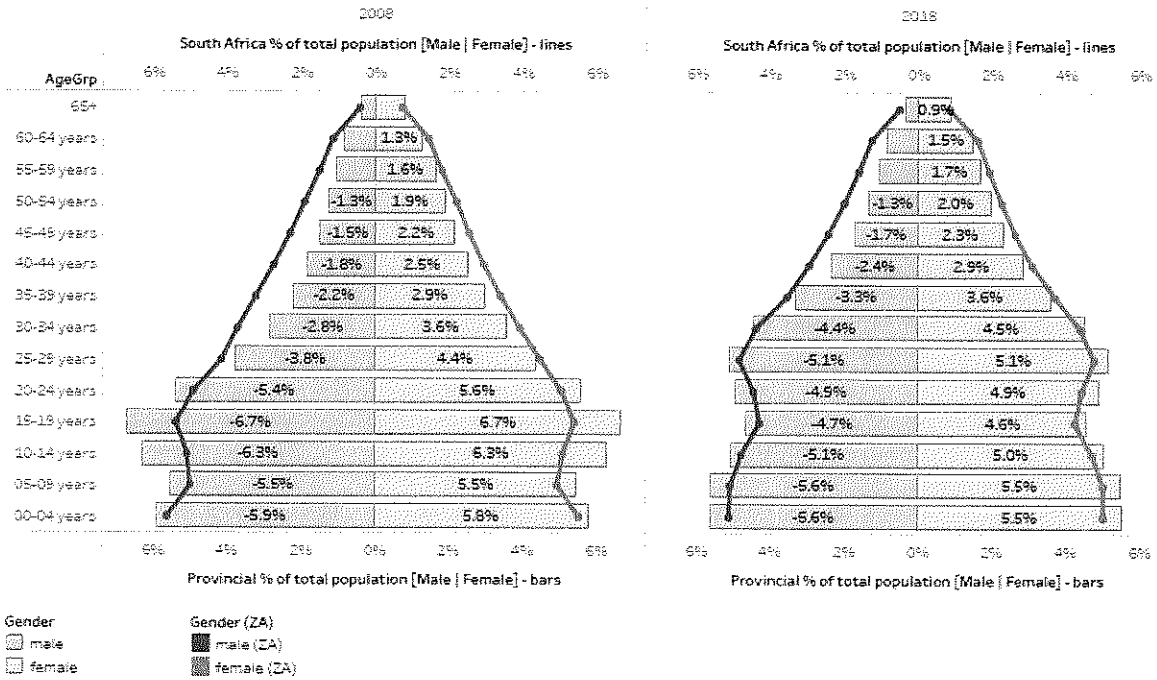


9.2 External Environmental Analysis

9.2.1 Demography

Provincial % population by age-gender group compared to South Africa

LP



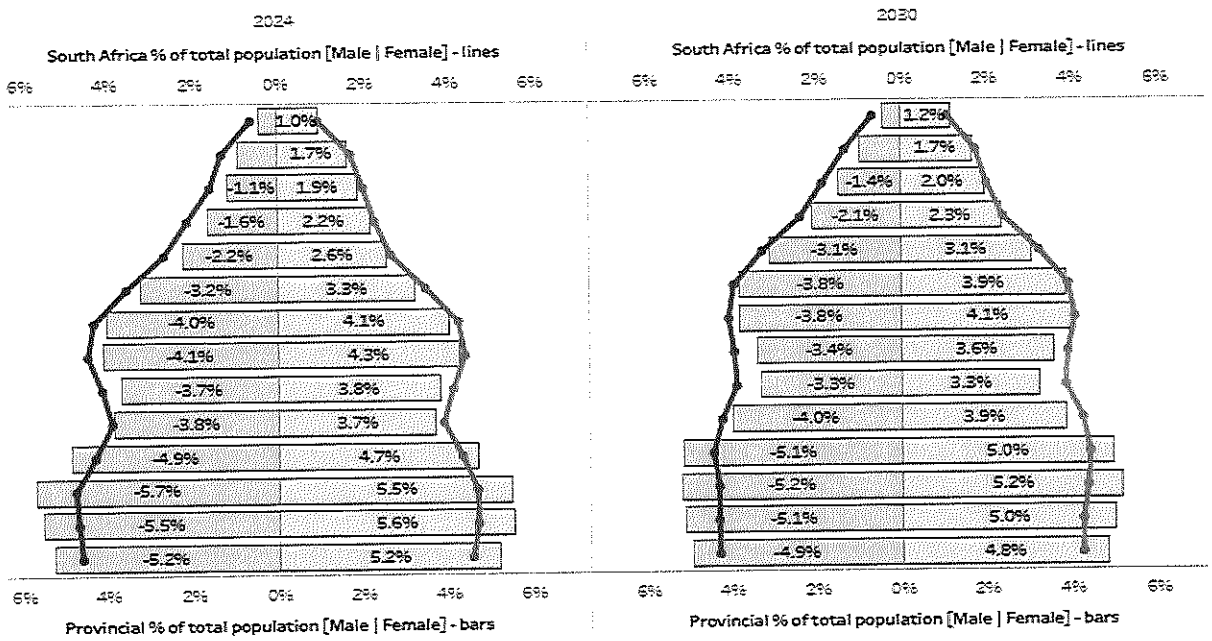


Figure 3. Population Pyramids 2008-2030

Despite a drop in the birth rate, Limpopo maintains a high birth rate than the country through to 2030 (see Figure 3). Comparatively, the age-sex distribution shows that the Limpopo population below 19 years remains higher than the country estimation. This makes Limpopo to be a youthful province.

In the medium to long term (cf 2024 and 2030 graphics as in Figure 3), the provincial age-group between 15 and 35 years as compared to the country, is depicted to be narrowing to below the national estimation. With key focus on ages 15 – 24, there is a significant reduction from current to future trends which might be attributed to death as a result of road injuries and interpersonal violence for males and HIV(AIDS) and TB for females. The age-group 40 – 54 years graphics shows an increase in population growth. In the same period, the graphics depict an expanding ageing population in the 55 years and above.

Implications on health

1. A decreasing birth rate is supported by the high couple-year protection rate of 70.5%, which is above the country average (DHB 2017/18).
2. A trend between 20 to 39 years reveals the deaths of more males than females. The cause these deaths is mainly attributed to violence and injuries requiring intensified intersectoral collaboration.
3. The current interventions (e.g. high couple year protection rate) seem to result in negative population growth rate in the long term

The interventions put in place by the department are strengthening of inter-sectoral collaboration as well as health promotion, education, and prevention. Worth noting, In terms

of provision of healthcare, the increased life expectancy comes with a burden on the already constrained healthcare system. For an example, living longer (or ageing population) often results in increased number of people with non-communicable diseases requiring healthcare services.

8.2.2 Social Determinants of Health for Province and Districts

Globally, it is recognized that health and health outcomes are not only affected by healthcare or access to health services. They result from multidimensional and complex factors linked to the social determinants of health which include a range of social, political, economic, environmental, and cultural factors, including human rights and gender equality.

Health is influenced by the environment in which people live and work as well as societal risk conditions such as polluted environments, inadequate housing, poor sanitation, unemployment, poverty, racial and gender discrimination, destruction and violence*

Table 2. Provincial and districts social determinants of health

	Limpopo		Ip Capricorn District Municipality	Ip Mopani District Municipality	Ip Sekhukhune District Municipality	Ip Vhembe District Municipality	Ip Waterberg District Municipality
	Census 2011	CS 2016	CS 2016	CS 2016	CS 2016	CS 2016	CS 2016
Female Headed Household	50,1%	58,4%	58,2%	59,1%	61,5%	58,7%	52,2%
Child headed household	1,4%	0,8%	0,7%	1,1%	0,6%	1,1%	0,6%
Household head older than 65 years	16,9%	18,3%	2,9%	1,6%	4,8%	2,4%	9,5%
Informal dwelling	5,1%	3,8%	1,7%	6,2%	5,0%	9,9%	1,0%
Traditional dwelling	4,4%	5,2%	20,8%	16,4%	22,1%	16,3%	15,9%
Household with no access to piped (tap) water	14,0%	13,8%	14,1%	23,3%	32,0%	16,4%	15,8%
Household with no electricity for lighting	13,3%	5,5%	3,7%	4,1%	7,9%	4,0%	9,7%
Household with no flush toilet connected to sewerage	80,0%	82,8%	77,1%	87,5%	95,9%	86,7%	58,0%
Household with no access to refuse removal	78,0%	79,6%	72,7%	85,3%	91,8%	85,2%	53,5%
No schooling	10,0%	19,3%	18,5%	20,4%	19,8%	20,0%	16,8%
Matric	14,8%	15,1%	17,3%	14,6%	13,8%	14,0%	16,3%
Higher education	3,1%	5,0%	6,4%	4,6%	3,5%	5,2%	5,1%

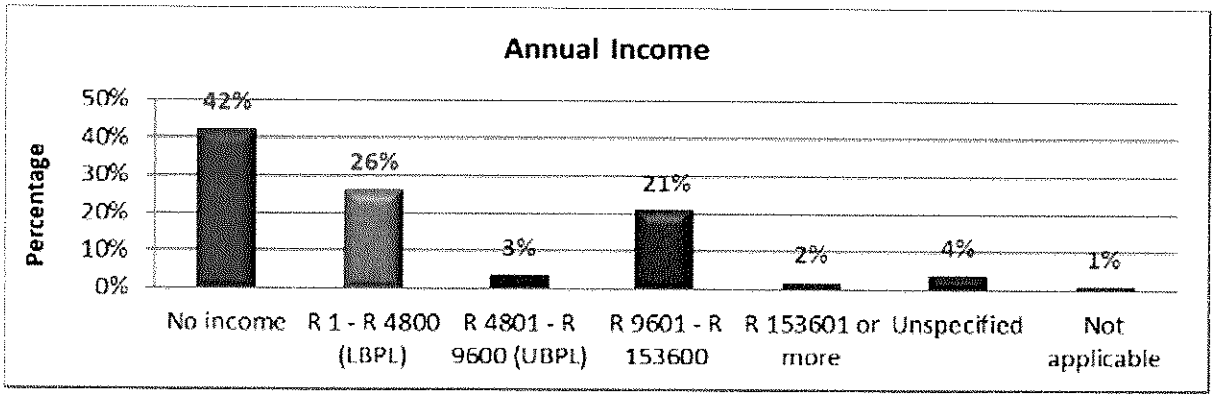


Figure 4. Limpopo annual income distribution

The province has shown an improvement in some of the social determinants of health in the period between 2011 and 2016 *inter alia* child headed household and household with no electricity for lighting has declined. However, performance of some of the social determinants of health has not improved including household with no flush toilet connected to sewerage, household with no access to waste removal, and number of persons with no schooling. For an example the four districts except Capricorn district have high household with no access to piped water (as demonstrated in Table 3), with Sekhukhune (32%) and Mopani (23.3%) respectively as the worst performing districts. As a result, diarrhoea case fatality rate under five in both Sekhukhune and Mopani is demonstrated to be higher than the national average.

Pertaining to annual income (as in Figure 4), 42% of the population does not have income, with 26% (>R4800) being below the lower bound poverty line (LBPL). The above, may be associated to factors including no schooling, matric and higher education performance (refer to Table 2 and StatSA, General Household Survey of 2016). The implications of provincial annual income disparities is an indication of the poverty levels experienced in Limpopo. The increased poverty levels attributes to performance of indicators such as incidences of sever acute malnutrition (SAM), diarrhoea, prevalence of HIV (AIDS). Furthermore, these multi-dimensional factors of poverty further constrain the resources of the department in delivering services.

Through the cluster approach, the province aims at addressing the social determinants of health. Among others, the department participates in the IDP review meetings as well as development and implementation of the district development model in all districts.

8.2.3 Epidemiology and Quadruple Burden of Disease

Epidemiologically South Africa is confronted with a quadruple BOD because of HIV and TB, high maternal and child morbidity and mortality, rising non-communicable diseases and high levels of violence and trauma.

8.2.3.1 Leading causes of Death

Leading causes of death by age group (Broad cause & Single causes), 2013 - 2015: LP

Average number of deaths per year, % of total and [rank] per age group

	Broad cause				Single causes													
AgeGroup (NDoH)	Non-communicable	Comm/Mat/Peri/Nutr	HIV/AIDS and TB	Injuries	HIV/AIDS	Lower respiratory infections	Tuberculosis	Cerebrovascular disease	Diarrhoeal diseases	Diabetes mellitus	Hypertensive heart disease	Road injuries	Meningitis/encephalitis	Accidental threats to breathing	Preterm birth complications	Protein-energy malnutrition	Birth asphyxia
<1 year	305 9.6% [2]	2 476 80.0% [1]	180 5.8% [3]	135 4.4% [4]		635 20.5% [1]			618 20.0% [2]						436 14.1% [3]	144 4.7% [5]	275 8.9% [4]
1-4	160 13.1% [2]	898 65.0% [1]	132 9.6% [4]	170 12.3% [3]	87 6.3% [4]	255 18.5% [2]			334 24.2% [1]				54 3.9% [5]			192 13.9% [3]	
5-14	178 21.5% [3]	297 35.9% [1]	156 18.9% [4]	197 23.8% [2]	85 10.3% [3]	100 12.1% [2]	71 8.6% [5]		103 12.5% [1]			79 9.6% [4]					
15-24	357 20.1% [4]	397 22.4% [3]	400 22.5% [2]	620 34.9% [1]	235 13.3% [2]	140 7.9% [5]	165 9.3% [3]					243 13.7% [1]		154 8.7% [4]			
25-49	3 122 22.8% [2]	3 061 22.3% [3]	5 737 41.9% [1]	1 781 13.0% [4]	3 512 25.6% [1]	1 364 10.0% [3]	2 225 16.2% [2]		907 6.6% [4]			854 6.2% [5]					
50+	16 610 65.1% [1]	5 125 20.1% [2]	2 803 11.0% [3]	967 3.8% [4]		2 525 9.9% [2]	1 503 5.9% [5]	3 529 13.8% [1]		2 377 9.3% [3]	2 092 8.2% [4]						

Deaths per year: 54 – 5 000 – 10 000 – 16 610

% of Total Deaths: 3.8% – 80.0%

Figure 5. Leading causes of death

Narrative:

In the province, communicable diseases and preterm-related causes of death is a leading factor amongst the under five year olds, followed by non-communicable diseases (as in Figure 5). Even though communicable diseases remain a leading cause of death amongst the 5 – 14 year olds, deaths due to injuries is the number two cause of death in the same age-group. Amongst the 15 – 24 year olds, mortalities are mainly caused by violence and injury related factors followed by HIV/AIDS and TB. Noteworthy, the HIV/AIDS and TB followed by non-communicable diseases are amongst the top leading causes of death in the age group 25 – 49 years. Non-communicable as well as communicable diseases other than HIV/AIDS and TB are the leading causes of death among the population above 50 years. The department is implementing health system strengthening initiatives such as ward-based primary healthcare outreach teams (WBPHCOT) and recruitment of health professionals.

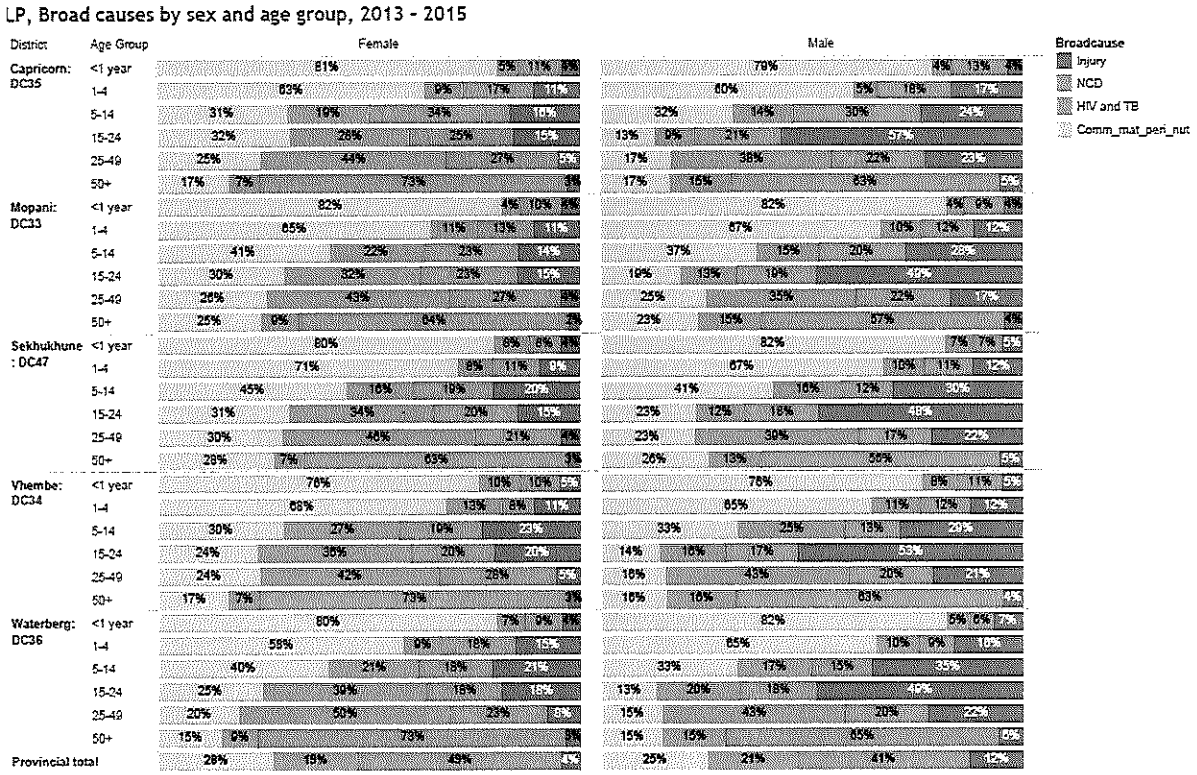


Figure 6. Leading causes of death by district. Source: Adapted from District Health Barometer 2017/18

Narrative:

Cutting across the five districts, amongst the population less than 5 years, maternal/communicable and preterm related conditions as well HIV/AIDS and TB are the leading causes of mortality for both males and females (refer to Figure 6). Between the ages 5 – 14 years, non-communicable diseases increase with Capricorn district mostly affected amongst both genders. However, it is noted that females in the age group 5 – 14 years across the five districts are mostly dying of non-communicable diseases as compared to their male counterparts. One the one hand, in the age group 15 – 24 years, in particular females, are mostly dying as a result of HIV/AIDS and TB related causes in all the five districts. On the other, males in the same age group in all the five districts are dying as a result of injuries and violence.

It is observed that among the age group 25 – 49 years, HIV/AIDS and TB in all the five districts is a leading cause of death affecting mostly females. Although the 50 years and above are mostly dying from NCDs, the trend of causes of death due to NCDs start rising from as early as the age of 1 year. In a nutshell, amongst the quadruple burden of diseases, NCDs were the leading causes of death in the five districts of Limpopo.

9.3 Internal Environmental Analysis

9.3.1 Service Delivery Platform/Public Health Facilities

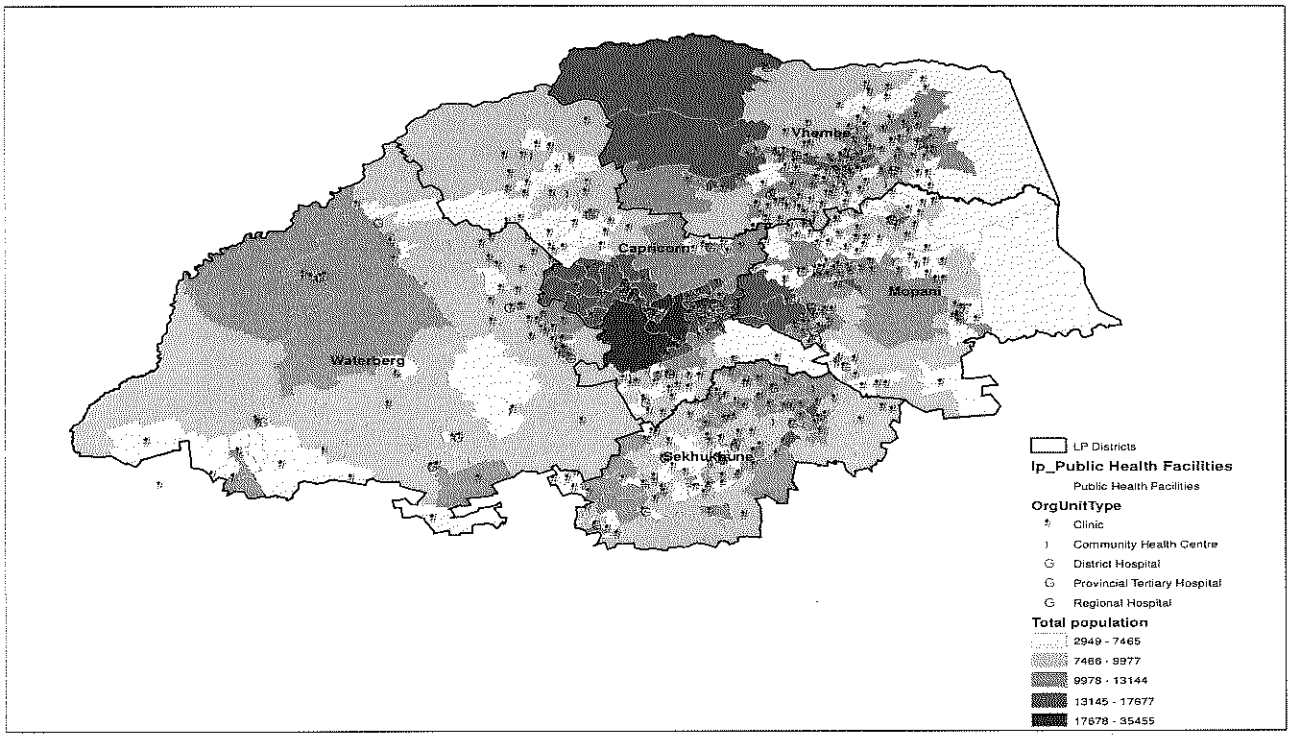


Table 3. Distribution of health facilities per district

	lp Capricorn District Municipality	lp Mopani District Municipality	lp Sekhukhune District Municipality	lp Vhembe District Municipality	lp Waterberg District Municipality	Grand Total
Clinic	98	97	86	115	60	454
Community Health Centre	4	8	3	8	3	26
District Hospital	6	6	5	6	7	30
EMS Station	12	10	13	10	12	57
Provincial Tertiary Hospital	2	0	0	0	0	2
Regional Hospital	0	1	2	1	1	5
Specialised Hospital	1	1	0	1	1	4
Grand Total	**123**	**123**	**109**	**141**	**84**	**578**

Narrative:

Capricorn district is the only district in the province that hosts two tertiary hospitals and has no regional hospital. District hospitals within Capricorn district refer directly to the tertiary hospitals. The two tertiary hospitals further receive referrals from hospitals in the four other districts. Concomitantly, that leaves the tertiary hospitals overburdened which is evident in

Capricorn being the highest in maternal mortality nationally. Central to the overburdening of tertiary hospitals is the regional and district hospitals not providing health services optimally according to their service packages. The department is in the process of finalizing plans for development of a central hospital to stabilize the service platform.

In terms of primary healthcare facilities Sekhukhune, Waterberg and Capricorn have the lowest number of community healthcare centres. For an example, the number of CHCs in Capricorn is against the population size of the district in light of the district being the second largest in the province. The department is in the process of building primary healthcare facilities including CHCs while refurbishing and maintaining the old ones in compliance with ideal clinic status.

9.3.2 Universal Health Coverage (Population and Service Coverage)

9.3.2.1 Community Health Workers Programme

WBPHCOTs are linked to a PHC facility and consist of CHWs lead by a nurse. CHWs assess the health status of individuals and households and provide health education and promotion service. They identify and refer those in need of preventive, curative or rehabilitative services to relevant PHC facilities*

Outreach Visits

Support visit types monitor the different types of basic health care provided to households as proportion of total number households visited by the WBPHCOT. Most of the household visits are for child health and adherence support.

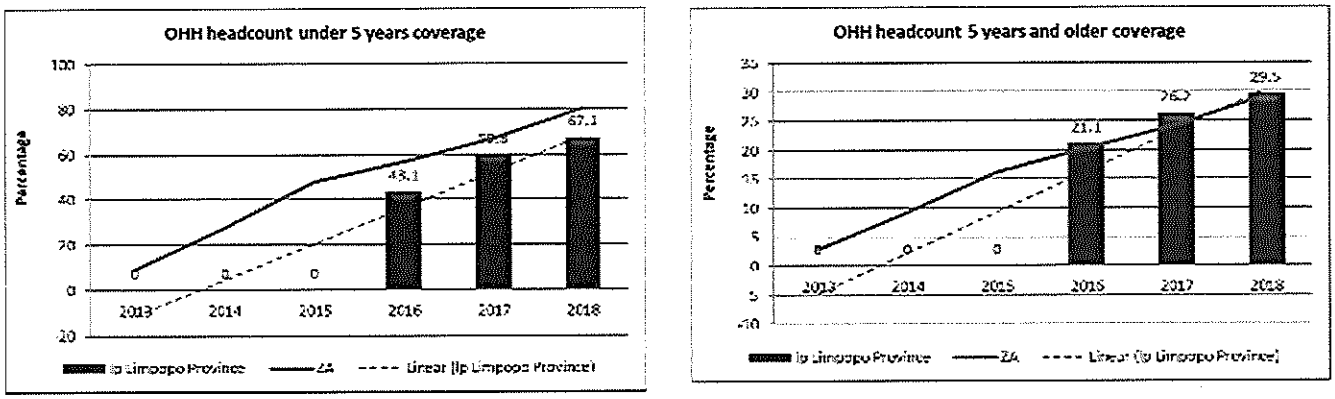


Figure 7. OHH headcount under years & under years and older coverage. Source: DHIS

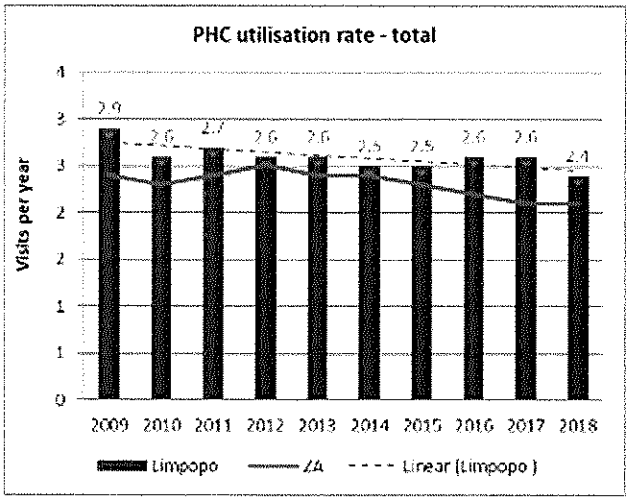
Narrative:

According to Figure 7, outreach household headcount coverage under five years shows a growing trend but still remain below the national average. The picture changes with the 5 years and older, where the coverage is growing in tandem with the national trend. Despite

the under five year olds being below the national, the percentage coverage is higher compared to the coverage for the five years and above.

9.3.2.2 PHC Utilization Rate

The primary health care (PHC) utilisation rate indicators measures the average number of PHC visits per person per year to a public PHC facility. It is calculated by dividing the PHC total annual headcount by the total catchment population*



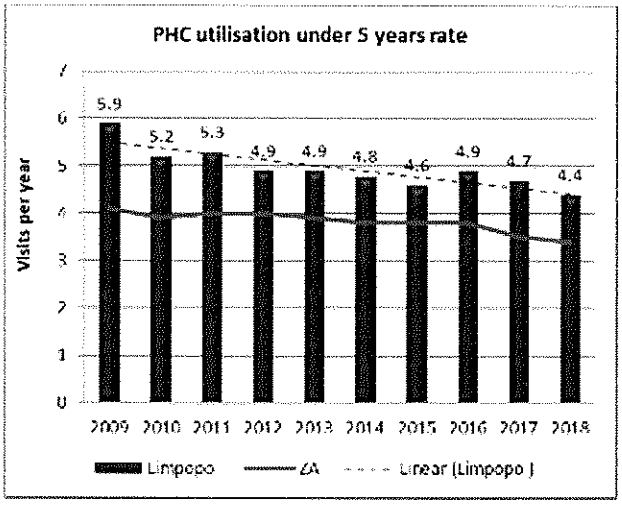


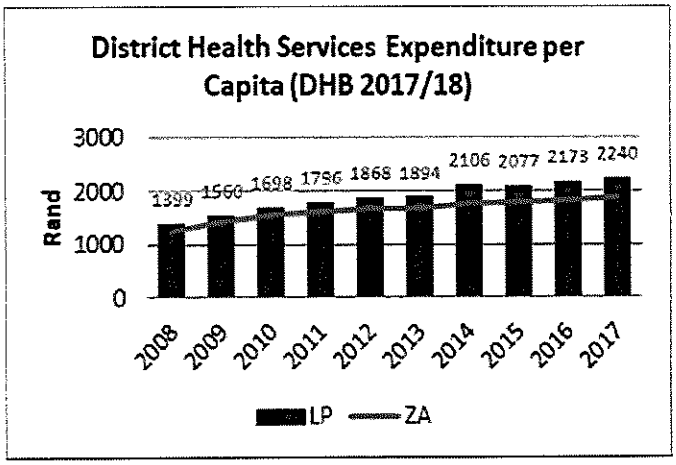
Figure 8. PHC utilisation and under 5 years utilisation

Narrative:

The trend shows a decline in PHC utilisation rate (in terms of the total and under five years) even though the graph depicts a performance above the national average (as depicted in Figure 8). It is worth to note that this performance is below the national target of 3.2. Even though the decline in utilisation is noted on both graphs, there is still a high rate of under five year olds using the PHC facilities.

9.3.2.3 PHC Expenditure

While PHC expenditure per capita can provide insight into equity in resource distribution and the prioritization of PHC across districts, looking at how much was spent per headcount/visit might be a better measure to evaluate efficiency.



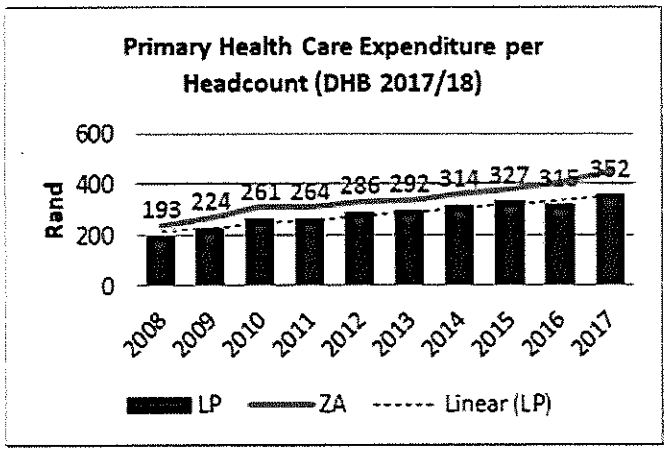


Figure 9. District and PHC expenditure trends

The numerator PHC expenditure per headcount is the same as in the previous indicator (community health clinics, community health centres, community-based services, other community services, HIV AIDS, nutrition and LG PHC expenditure) while the denominator is the number of primary health care headcounts.

Narrative:

In terms of Figure 9, the expenditure per capita in the District Health Services and expenditure per headcount in the PHC are both on an upward trend. The DHS expenditure was at par with the national average except from 2011 when it went above it, with the gap becoming more pronounced from 2014. But for PHC expenditure per headcount, the expenditure has been below the national average since 2008. The expenditure per headcount at PHC shows inequitable distribution of resources. Implying that resource allocation is more skewed to district hospitals than PHC facilities.

9.3.2.4 Hospital Care

OPD new client not referred rate is new OPD clients not referred as a proportion of total OPD new clients and does not include OPD follow-up and emergency clients in the denominator. The indicator monitors utilisation trends of client's by-passing PHC facilities and the effect of PHC re-engineering on OPD utilisation. A high OPD new client not referred rate value could indicate overburdened PHC facilities or a sub-optimal referral system. In light of the National Health Insurance Policy, a PHC level is the first point of contact with the health system and therefore key to ensure health system sustainability. If PHC works well and the referral system is seamless, it will result in fewer visits to specialists in referral hospitals and emergency rooms.

Table 4. Hospital efficiency indicators trends

lp Limpopo Province	OPD new client not referred rate			Average length of stay - total			Inpatient bed utilisation rate		
Hospital Type	2016/17	2017/18	2018/19	2016/17	2017/18	2018/19	2016/17	2017/18	2018/19
District Hospital	75.3	72.4	73.6	4.3	4.3	4.3	69.6	72.7	73.1
Regional Hospital	60.4	72.1	62.7	4.9	4.4	4.4	72.3	74.9	71.9
Provincial Tertiary Hospital	12	14.7	13.9	7.3	7.6	7.5	75.5	79.9	82.3

lp Limpopo Province	Inpatient crude death rate			Delivery by Caesarean section rate		
Hospital Type	2016/17	2017/18	2018/19	2016/17	2017/18	2018/19
District Hospital	5	4.6	4.6	22.4	22.3	22.1
Regional Hospital	5	4.8	4.9	24.2	23.5	24.5
Provincial Tertiary Hospital	6.1	6.3	6	35.4	33.3	35.7

Narrative:

According to Table 4, out-patient department (OPD) new client not referred rate in both district and regional hospitals is high. In particular for district hospitals, the rate is on a rise and above the national average of 60.4% by 13.2%. The average length of stay and inpatient bed utilisation rate at the three levels of care are within normal ranges. The inpatient crude death rate and Caesarean section rate is within normal ranges across all the three levels.

Hospital Efficiency Indicators

Table 5. Efficiency indicators for regional and tertiary hospitals. Source: DHIS

		OPD new client not referred rate			Average length of stay - total			Inpatient bed utilisation rate		
Referral Hospitals		2016/17	2017/18	2018/19	2016/17	2017/18	2018/19	2016/17	2017/18	2018/19
Regional Hospital	lp Letaba Hospital	46.7	52.1	53.5	4.9	4.5	4.7	65	82.3	71.2
	lp Mokopane Hospital	81.1	81.6	86.2	5.3	6.3	5.6	62.2	77.1	73.3
	lp Philadelphia Hospital	46.1	86.4	41.5	6.6	4.8	4.2	102	74.9	69.8
	lp St Rita's Hospital	75	72.8	73.9	3.7	3.6	4.3	56.1	65.1	70
	lp Tshilidzini Hospital	72.3	25.1	25.5	4.5	4	3.9	75.4	76	74.5
Provincial Tertiary Hospital	lp Mankweng Hospital	0.05	0	0	6.5	6.6	6.5	78.4	80	82.7
	lp Pietersburg Hospital	24.8	25	22.5	8.4	8.9	9.1	72.7	79.8	81.8

Narrative:

Among regional hospitals, Mokopane followed by St Ritas are the institutions with the highest OPD new client not referred (as shown in Table 5). In terms of length of stay St Ritas is having a low ALOS. However, this ALOS could be attributed to the facility functioning at the level of a district hospital as supported by a low inpatient bed utilisation rate. The inpatient bed utilisation rate for provincial tertiary hospitals is within the normal range.

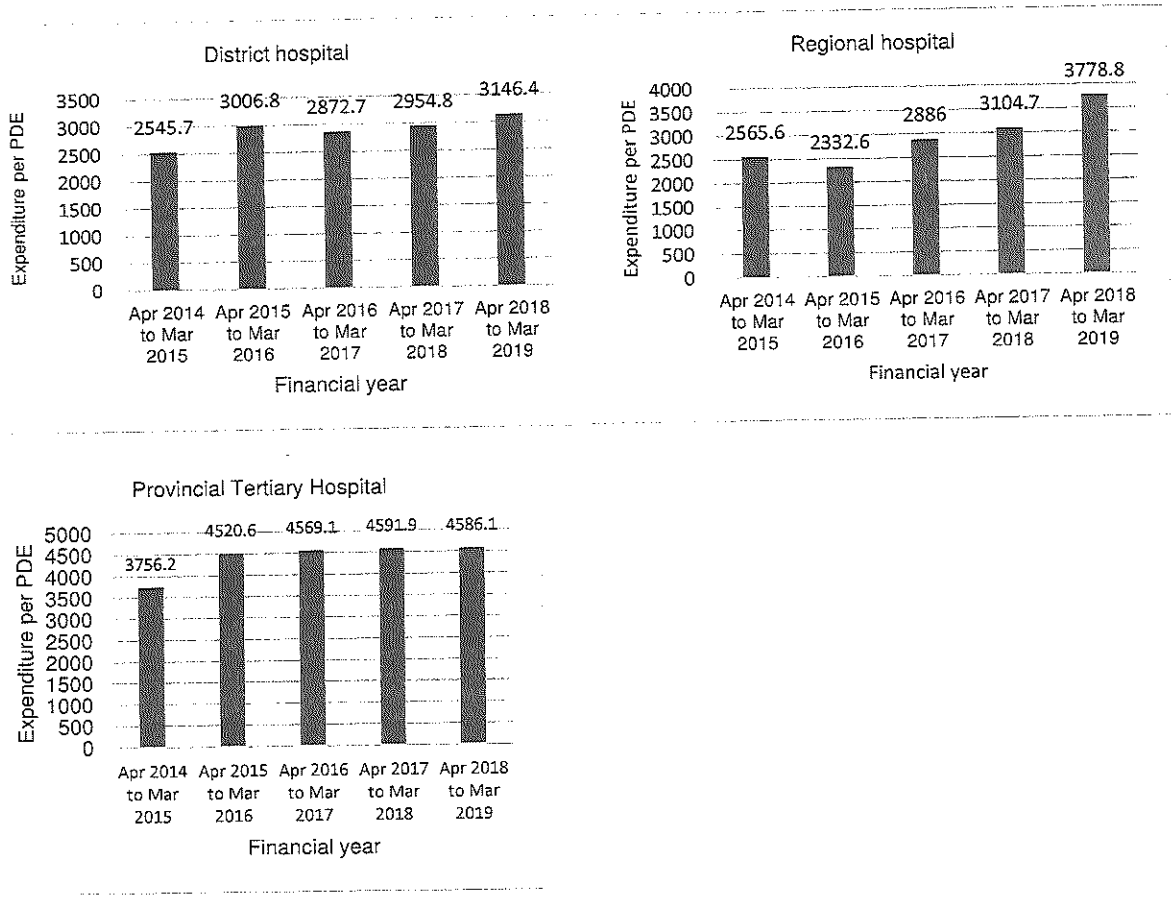


Figure 10. Expenditure per PDE for all levels of hospitals

Narrative:

According to Figure 10, expenditure per PDE across the three levels of care is above the national average. This is due to financial inefficiencies.

Hospital Case Management Indicators

Table 6. Hospital case management trends. Source: DHIS

		Inpatient crude death rate			Delivery by Caesarean section rate		
Referral Hospitals		2016/17	2017/18	2018/19	2016/17	2017/18	2018/19
Regional Hospital	Ip Letaba Hospital	6.4	5.2	5.2	31.8	31.4	29
	Ip Mokopane Hospital	4.6	4.8	5.1	28.1	26.6	27.8
	Ip Philadelphia Hospital	4.7	5.3	5.3	21.4	18.6	20
	Ip St Rita's Hospital	4.2	3.9	4.8	16.6	18.4	21.9
	Ip Tshilidzini Hospital	5.2	4.8	4.4	25.8	24.1	25.4
Provincial Tertiary Hospital	Ip Mankweng Hospital	5.7	5.7	5.3	25.6	26.2	29.3
	Ip Pietersburg Hospital	6.7	7.1	7.1	61.5	51.3	50.3

Narrative:

In terms of the inpatient crude death rate and Caesarean section rate, both the regional and provincial tertiary levels of care show consistent performance throughout the years with the exception of Pietersburg hospital.

9.3.3 Maternal and Women's Health

Maternal death is death occurring during pregnancy, childbirth and the puerperium of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy and irrespective of the cause of death (obstetric and non-obstetric) per 100,000 live births in facility. The maternal mortality in facility ratio is a proxy indicator for the population based maternal mortality ratio, aimed at monitoring trends in health facilities between official surveys.

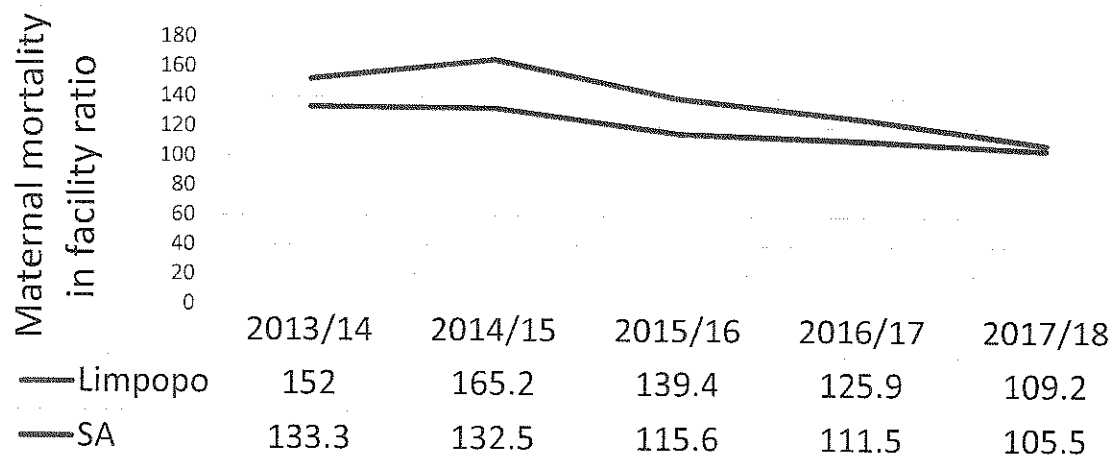


Figure 11. Maternal mortality 2013/14 - 2017/18

Narrative:

The maternal mortality in facility ratio has shown a significant decline from 152 in 2013/14 to 109 in 2017/18 (as depicted in Figure 11). However, it remains higher than the national average (105.5). According to the Limpopo Saving Mothers 2017, the main causes of maternal mortality are obstetric haemorrhage, hypertensive disease in pregnancy and non-pregnancy related infections.

Maternal and Women's Health Trends

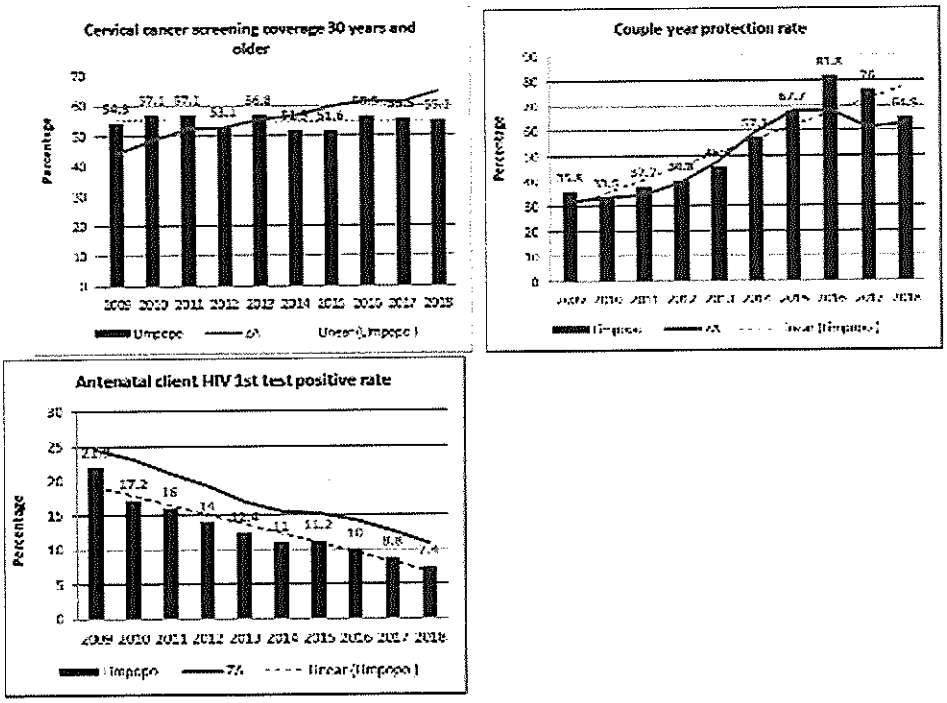


Figure 12. Women health indicator trends

Narrative:

Cervical cancer screening (see Figure 12)

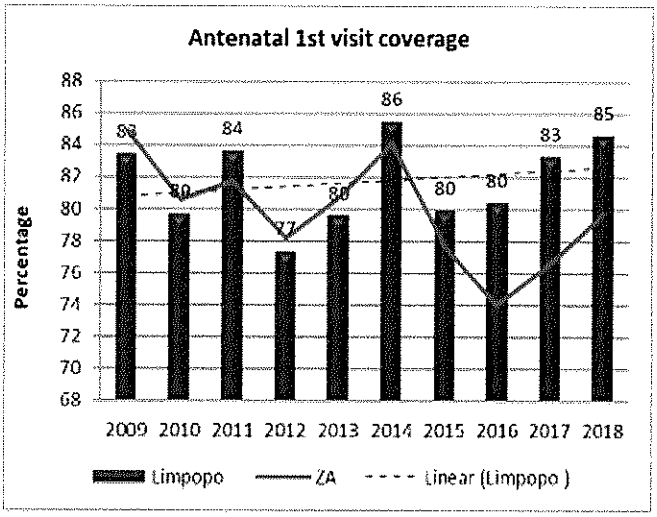
From 2014, the province is performing below the national average.

Couple-year protection

An upward trend was realised peaking in 2016. The decline thereafter was attributed to a shortage of preferred contraceptives.

Antenatal client HIV 1st test positive rate

Expanded HIV Testing Services (HTS) has led to high testing rates in the community. Hence the ANC client HIV 1st test positive rate has been on a steady decline since 2009 because there is few new clients testing positive.



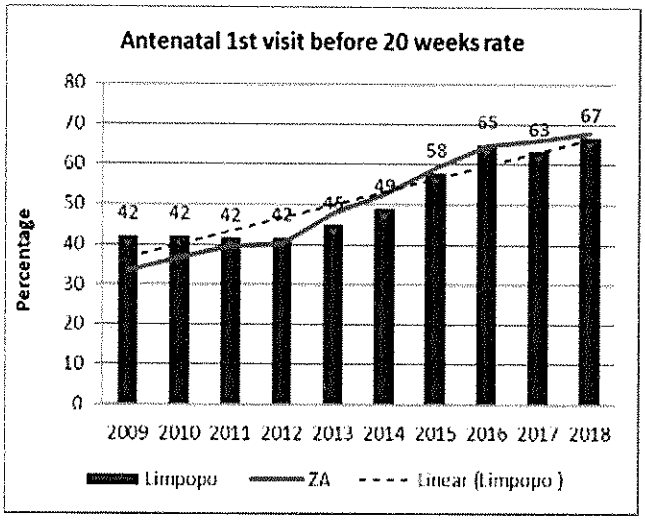
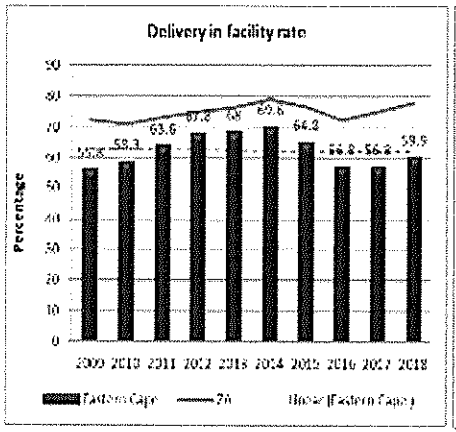
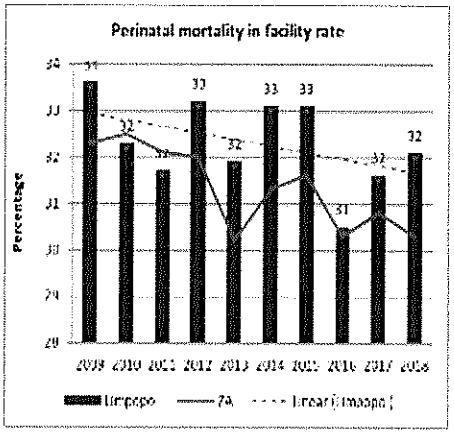


Figure 13. ANC 1st visit coverage and before 20 weeks. Source: District Health Barometer 2017/18

Narrative:

In terms of Figure 13, Antenatal 1st visit coverage has remained high over a period of time. While, Antenatal 1st visit before 20 weeks rate is depicted to be on a rise from 2009 to 2018. As demonstrated by Figure (Maternal mortality), it could be deduced that the rise in first visit before 20 weeks has resulted in reduced maternal mortality.





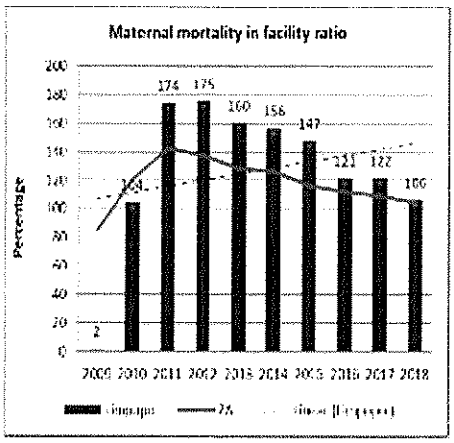


Figure 14. In facility delivery, perinatal & maternal mortality. Source: District Health Barometer 2017/18

Narrative:

Delivery in facility rate (refer to Figure 14)

Our delivery in facility is above the national average.

Perinatal mortality in facility rate

The perinatal mortality in facility rate has seen minor fluctuations over the years but remain above the national average.

Women and Maternal Health

				Country	Province	District				
				ZA	LP	DC33	DC34	DC35	DC36	DC47
				South Africa	Limpopo	Mopani DM	Vhembe DM	Capricorn DM	Waterberg DM	Sekhukhune DM
Maternal mortality in facility ratio (per100K)	DEInd	Impact	2018/19	105.9	111.6	107.4	81.5	196.7	97.1	66.8
Maternal death in facility (No)	DE		2018/19	1 065	143	28	25	57	15	18
Live birth in facility (No)	DE		2018/19	959 720	123 990	25 333	29 944	28 043	14 893	25 777
Delivery in 10 to 19 years in facility rate (%)	DEInd	Outcome	2018/19	12.9	13.4	13.1	15.8	12.4	13.5	11.7
Delivery 10-19 years in facility (No)	DE		2018/19	124 628	16 587	3 312	4 703	3 489	2 032	3 051
Delivery in facility - total (No)	DE		2018/19	964 209	124 236	25 314	29 794	28 134	14 998	25 996
Antenatal client initiated on ART rate (%)	DEInd	Outcome	2018/19	95.8	97.7	97.5	98.4	99.1	97.6	95.8
Antenatal client start on ART (No)	DE		2018/19	109 900	10 557	2 254	1 965	2 188	1 991	2 159
Antenatal client known HIV positive but NOT on ART ..	DE		2018/19	18 005	1 823	518	278	320	388	319
Mother postnatal visit within 6 days rate (%)	DEInd	Output	2018/19	75.3	98.2	123.9	98.7	81.9	99.4	89.5
Mother postnatal visit within 6 days after delivery (..	DE		2018/19	725 586	121 975	31 356	29 402	23 043	14 905	23 269
Antenatal 1st visit before 20 weeks rate (%)	DEInd	Output	2018/19	68.1	67.2	71.5	69.7	62.2	67.6	65.1
Antenatal 1st visit before 20 weeks (No)	DE		2018/19	729 259	84 930	18 541	20 819	17 039	11 240	17 291
Antenatal 1st visit - total (No)	DE		2018/19	1 071 081	126 379	25 933	29 880	27 388	16 618	26 560
Couple year protection rate (%)	DEInd	Output	2018/19	61	63.3	67.5	59.3	69.6	78	49.9
Contraceptive years dispensed (No)	DE		2018/19	7 247 868	793 206	174 324	183 032	192 761	109 578	133 510
Cervical cancer screening coverage (%)	DEInd	Output	2018/19	65.1	52.3	62.9	54.4	38.1	54	54.9
Cervical cancer screening 30 years and older (No)	DE		2018/19	861 893	69 228	17 925	17 307	11 671	8 277	14 048

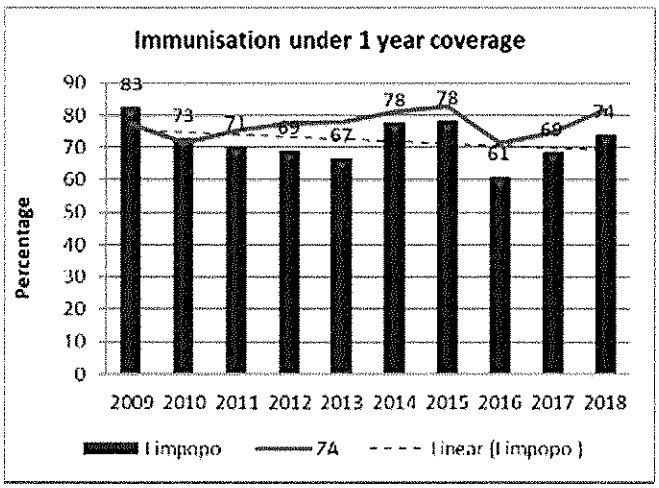
Other
Worst 10 DM

Figure 15. Women health indicator trends

Narrative:

According to Figure 15, maternal mortality in the Capricorn District is the highest among the other districts in Limpopo Province. That is mainly due to the two tertiary hospitals and the lack of a regional hospital in the Capricorn District. The two tertiary hospitals in Capricorn absorb maternal cases from all districts resulting in Capricorn accounting for the maternal mortalities. Capricorn District is the lowest among the other districts in the province in terms of antenatal first visit bookings and cervical cancer screening. This is attributed to the reluctance of women thirty years and older to be screened. Even though Limpopo is performing above national average on couple year protection Sekhukhune District is the lowest followed by Vhembe District. The performance in both districts is due to women being reluctant to usage of modern contraceptives as well as shortage of injectable and oral contraceptives.

9.3.4 Child Health



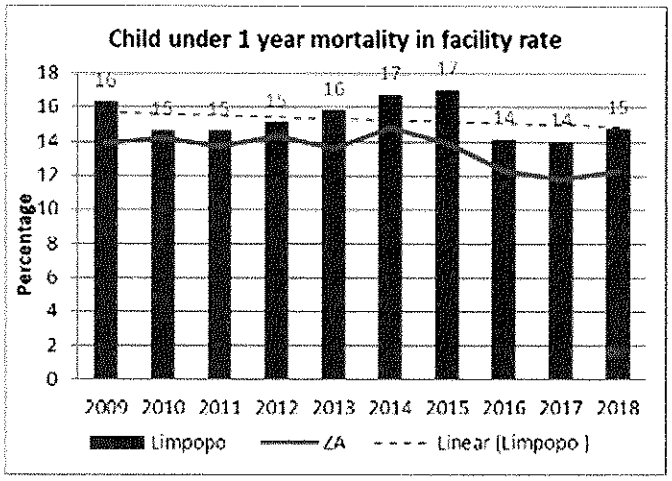


Figure 16. Under 1 year immunisation and in facility mortality

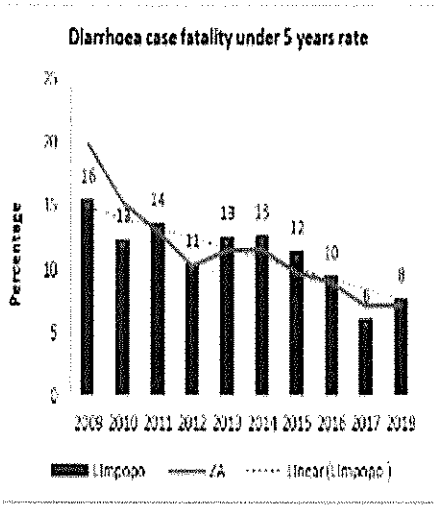
Narrative:

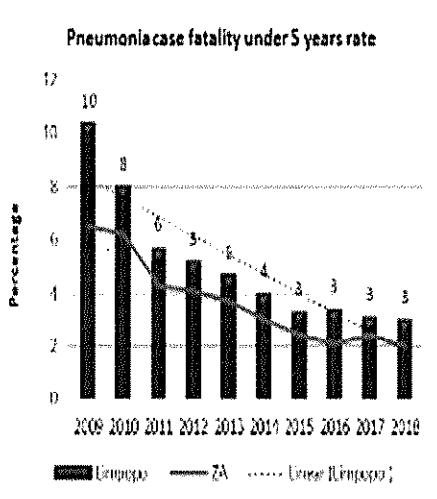
Immunisation under 1 year (as demonstrated in Figure 16)

The trend of immunisation coverage for under one year in Limpopo mirrors that of the national coverage. However the provincial performance is consistently below that of national.

Under 1 year mortality

The under I year mortality is consistently above average. For immunisation to have a significant impact (herd immunity) on mortality, the coverage should be sustained at 90% and above. Other significant contributions to mortality in under one year are prematurity, birth asphyxia and congenital abnormalities.





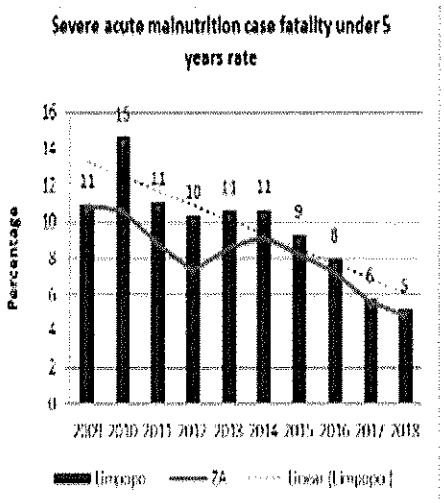


Figure 17. Under 5 years mortalities per type

Narrative

According to Figure 17, there is a decline in case fatality rates for diarrhoea, pneumonia and severe acute malnutrition (SAM). However, the decline in pneumonia case fatality rate is persistently above the national average. This could be attributed to poor case management. In terms of SAM, the provincial poverty headcount could be a major contributor as it is the third highest in the country.

Child Health

			Country ZA South Africa	Province LP Limpopo	District DC33 Mopani DM	DC34 Waterberg DM	DC35 Capricorn DM	DC36 Waterberg DM	DC47 Sekhukhune DM
Death in facility under 1 year rate (%)	Impact	2018/19	7.5	9.9	12.5	9	9	9.1	10.9
Death in facility under 1 year (No)		2018/19	14 841	2 001	404	367	630	219	381
Death in facility under 5 years rate (%)	Impact	2018/19	4.8	5.9	6.9	4.4	6.3	5.2	6.7
Death in facility under 5 years (No)		2018/19	16 844	2 291	473	425	726	242	424
Diarrhoea case fatality under 5 years rate (%)	Impact	2018/19	1.9	2.2	3.8	0.91	2.8	0.74	3.2
Diarrhoea death under 5 years (No)		2018/19	679	111	42	17	22	4	26
Diarrhoea separation under 5 years (No)		2018/19	36 009	5 098	1 092	1 861	776	540	819
Early neonatal death in facility rate (per1K)	Impact	2018/19	9.8	11.7	12.4	8.7	15.1	11.3	11.1
Death in facility 0-7 days (No)		2018/19	9 431	1 450	313	260	423	169	285
Live birth in facility (No)		2018/19	959 720	123 990	25 333	29 944	28 043	14 893	25 777
Neonatal death in facility rate (per1K)	Impact	2018/19	12.1	13.2	13.4	10.1	17.2	12.6	12.8
Death in facility 8-28 days (No)		2018/19	2 212	192	27	43	58	18	46
Pneumonia case fatality under 5 years rate (%)	Impact	2018/19	1.9	3.3	5.1	2.3	8.2	1.8	2.1
Pneumonia death under 5 years (No)		2018/19	962	178	39	47	66	9	17
Pneumonia separation under 5 years (No)		2018/19	50 212	5 435	1 244	2 008	789	696	698
Severe acute malnutrition case fatality under 5 years rate ...	Impact	2018/19	7.1	6.2	3.6	10.4	4.4	6.6	15.1
Severe acute malnutrition death under 5 years (No)		2018/19	806	125	30	32	17	19	27
Severe acute malnutrition inpatient under 5 years (No)		2018/19	11 280	1 997	825	307	387	289	179
Infant PCR test positive around 10 weeks rate (%)	Outcome	2018/19	0.74	0.73	0.85	0.72	0.72	0.66	0.7
Infant PCR test positive around 10 weeks (No)		2018/19	1 371	118	20	21	28	18	22
Infant PCR test around 10 weeks (No)		2018/19	185 318	16 113	3 428	2 905	3 902	2 722	3 156
Immunisation under 1 year coverage (%)	Output	2018/19	81.9	71	66.6	74.3	69.6	81.2	65.6
Immunised fully under 1 year now (No)		2018/19	944 650	91 038	18 454	24 424	18 996	11 123	15 041
Infant exclusively breastfed at DTaP-IPV-Hib-HBV 3rd dose..	Output	2018/19	49.5	43	35.4	39.1	50.3	49.5	43.7
Infant exclusively breastfed at DTaP-IPV-Hib-HBV (Hexaval.. DTaP-IPV-Hib-HBV (Hexavalent) 3rd dose (No)		2018/19	477 984	50 523	8 404	11 564	13 117	6 589	10 849
Measles 2nd dose coverage (%)	Output	2018/19	966 387	117 506	23 751	29 547	26 055	13 309	24 844
Measles 2nd dose (No)		2018/19	76.5	80.5	78.9	79.8	87.7	79.8	76.2
School Grade 1 screening coverage (%)	Output	2018/19	890 235	106 023	21 676	26 812	24 301	11 328	21 906
School Grade 1 - learners screened (No)		2018/19	17.7	46.7	26.7	20.3	48.1	34.2	24.2
School Grade 1 - learners total (No)		2018/19	281 110	65 239	13 150	18 016	12 836	10 179	11 058
School Grade 8 screening coverage (%)	Output	2018/19	1 166 792	139 580	28 413	31 752	31 502	15 877	32 036
School Grade 8 - learners screened (No)		2018/19	13.1	66.2	18.4	15.2	30.3	11.6	9.9
School Grade 8 - learners Total (No)		2018/19	196 461	30 650	6 605	11 318	7 239	4 978	510
Vitamin A dose 12-59 months coverage (%)	Output	2018/19	889 304	105 309	20 814	26 032	23 665	12 610	22 188
HIV test around 18 months (No)		2018/19	56.6	42.2	45.2	44.1	41.5	46.8	35.5
Live birth to HIV positive woman (No)		2018/19	238 392	19 551	4 158	3 340	6 779	2 436	2 838
		2018/19	267 329	25 462	5 522	4 586	5 719	4 156	5 477

Performance
Other
Best 10 DM
Worst 10 DM

Figure 18. Child health indicator trends

Narrative

Immunisation of under 1 year old remains a challenge in the province with none of the districts performing at the acceptable 90% coverage standard (see Figure18). The worst performing districts in the province are Mopani, Capricorn and Sekhukhune. Partially blame on the performance is attributed to inconsistent stock levels of vaccines as well as budgetary constraints. As a result, child health from birth gets compromised. Key to note is the high under five pneumonia fatality rate across all the five districts in the province. That makes the province to perform higher than the national average as a result of children being brought to facilities already having complications. Sekhukhune district is the mostly hit district in terms of severe acute malnutrition (SAM). That can be attributed to poverty levels in the Sekhukhune district.

9.3.5 HIV and AIDS
Provincial Perspective

Narrative:

According to Figure 19, Limpopo is currently at 93-67-77 in terms of performance against 90-90-90 across its total population. Results for each of the sub-populations vary, with adult females at 94-71-80, adult males at 91-59-74, and children at 78-60-54. For adult males and females, focus must be placed not only on initiation onto ART, but also on ensuring that clients are retained in care. There is a growing number of adults who have been previously diagnosed, but are not on ART.

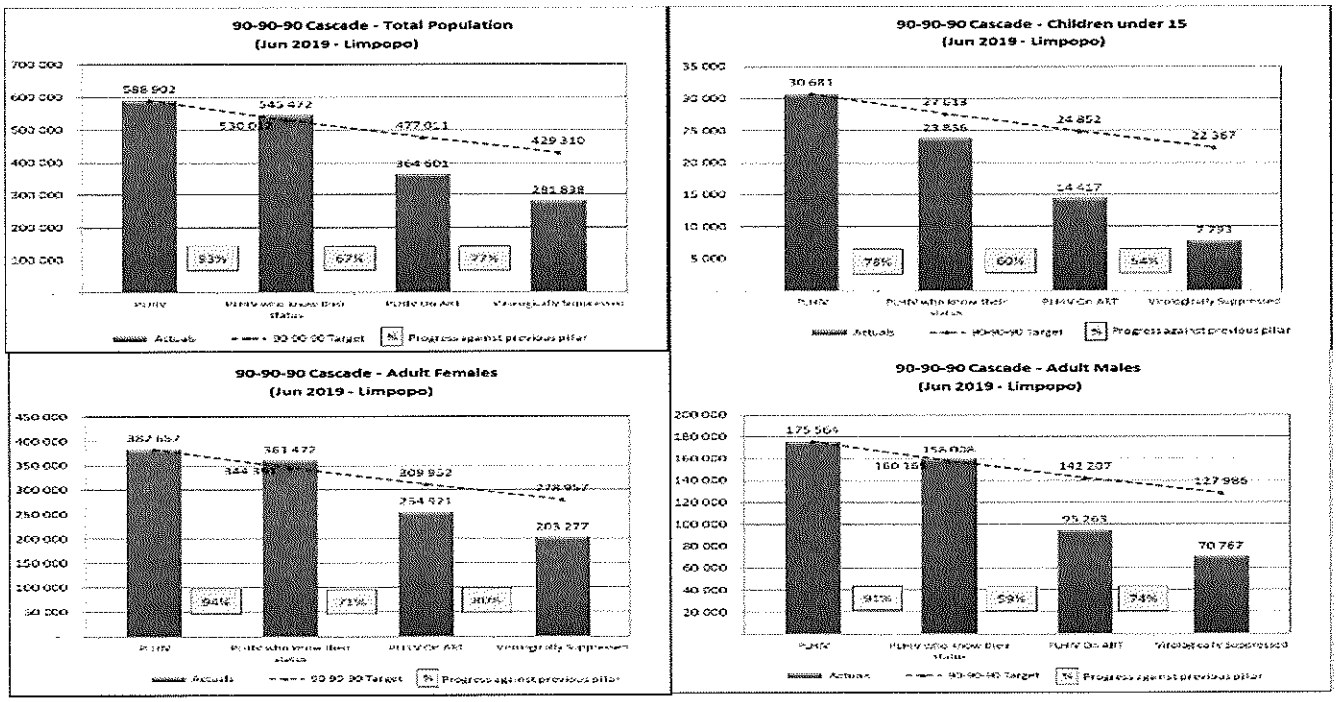


Figure 19. Provincial 90-90-90 cascades

This includes those who had started ART and defaulted, as well as those who were never initiated. The results do show that for women who remain on ART, suppression rates are higher. There are gaps across the cascade for children under 15 years. Case finding, ART initiation and retention have all underperformed and should be addressed through focused interventions. To achieve 90-90-90 targets, the province must increase the number of adult men on ART by 46944, the number of adult women on ART by 55031, and the number of children on ART, by 10435, by December 2020. Across the province, Mopani and Sekhukhune are the closest to attaining 90-90-90 based on preliminary data collected.

Capricorn

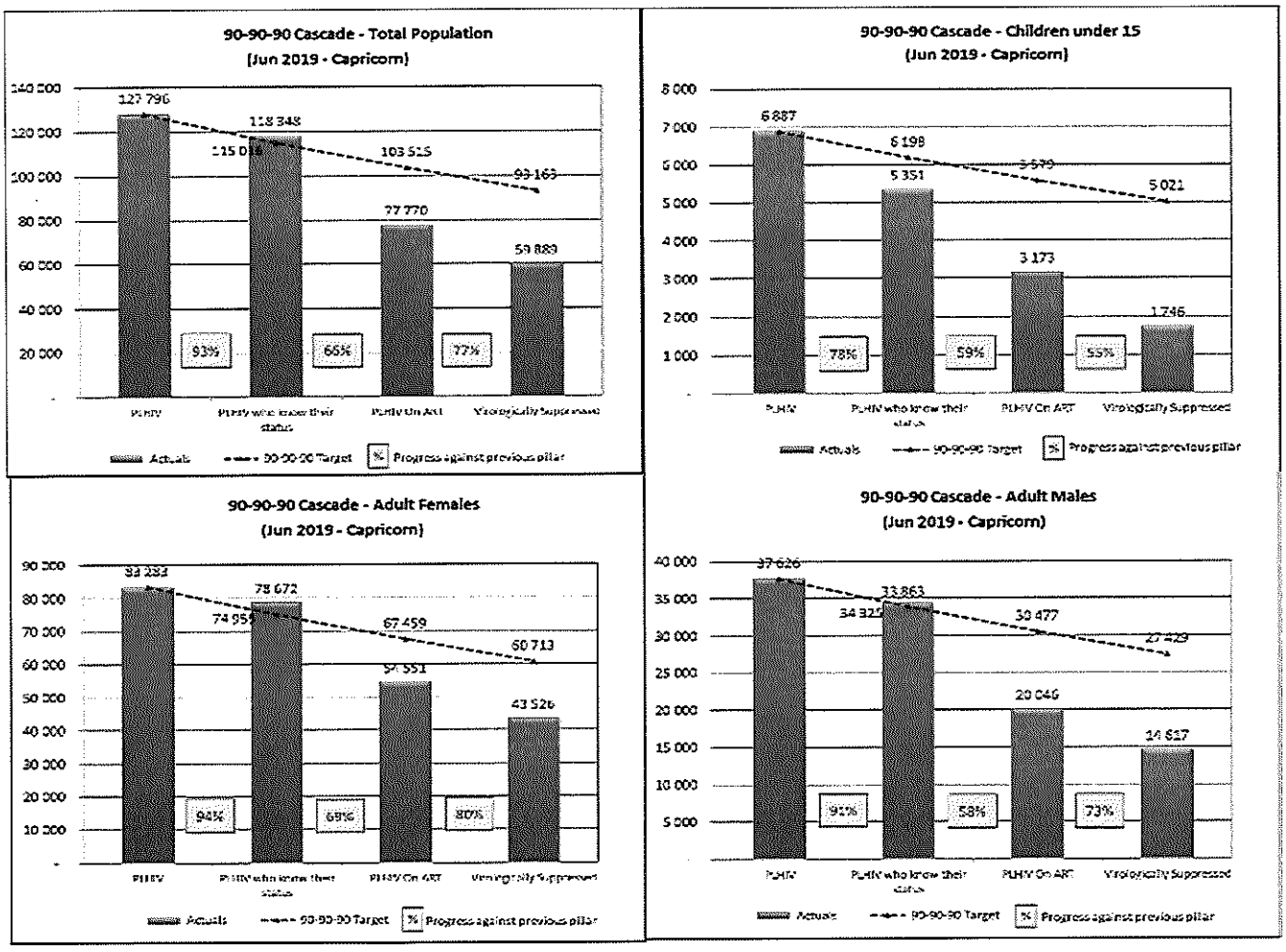


Figure 20. Capricorn 90-90-90 cascades

Narrative:

Figure 20 above shows that, Capricorn is currently at 93-66-77 in terms of performance against 90-90-90 across its total population. The District is ranked 4th out of the 5 districts in the province against 90-90-90. Results for each of the sub-populations vary, with adult females at 94-69-80, adult males at 91-58-73, and children at 78-59-55. For adult males and females, focus must be placed not only on initiation onto ART, but also on ensuring that clients are retained in care. There is a growing number of adults who have been previously diagnosed, but are not on ART. This includes those who had started ART and defaulted, as well as those who were never initiated. The results do show, that for women who remain on ART, suppression rates are higher. There are gaps across the cascade for children under 15 years. Case finding, ART initiation and retention have all underperformed and should be addressed through focused interventions. To achieve 90-90-90 targets, the district must

increase the number of adult men on ART by 10431, the number of adult women on ART by 12909, and the number of children on ART, by 2406, by December 2020.

Mopani

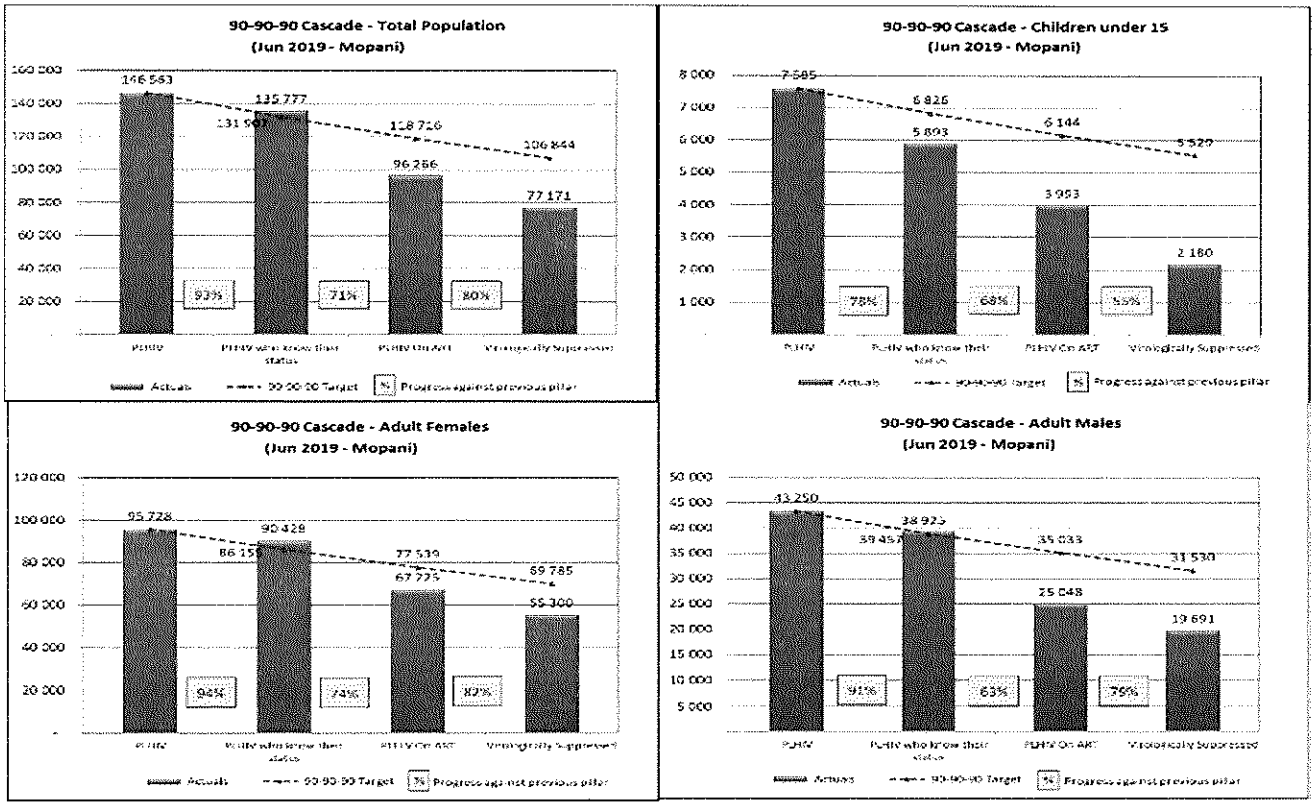


Figure 21. Mopani 90-90-90 cascades

Narrative:

Mopani is currently at 93-71-80 in terms of performance against 90-90-90 across its total population (as demonstrated in Figure 21). The District is ranked 1st out of the 5 districts in the province against 90-90-90. Results for each of the sub-populations vary, with adult females at 94-74-82, adult males at 91-63-79, and children at 78-68-55. For adult males and females, focus must be placed not only on initiation onto ART, but also on ensuring that clients are retained in care. There is a growing number of adults who have been previously diagnosed, but are not on ART. This includes those who had started ART and defaulted, as well as those who were never initiated. The results do show, that for women who remain on ART, suppression rates are higher. There are gaps across the cascade for children under 15 years. Case finding, ART initiation and retention have all underperformed and should be addressed through focused interventions. To achieve 90-90-90 targets, the district must increase the number of adult men on ART by 9984, the number of adult women on ART by 10315, and the number of children on ART, by 2151, by December 2020.

Sekhukhune

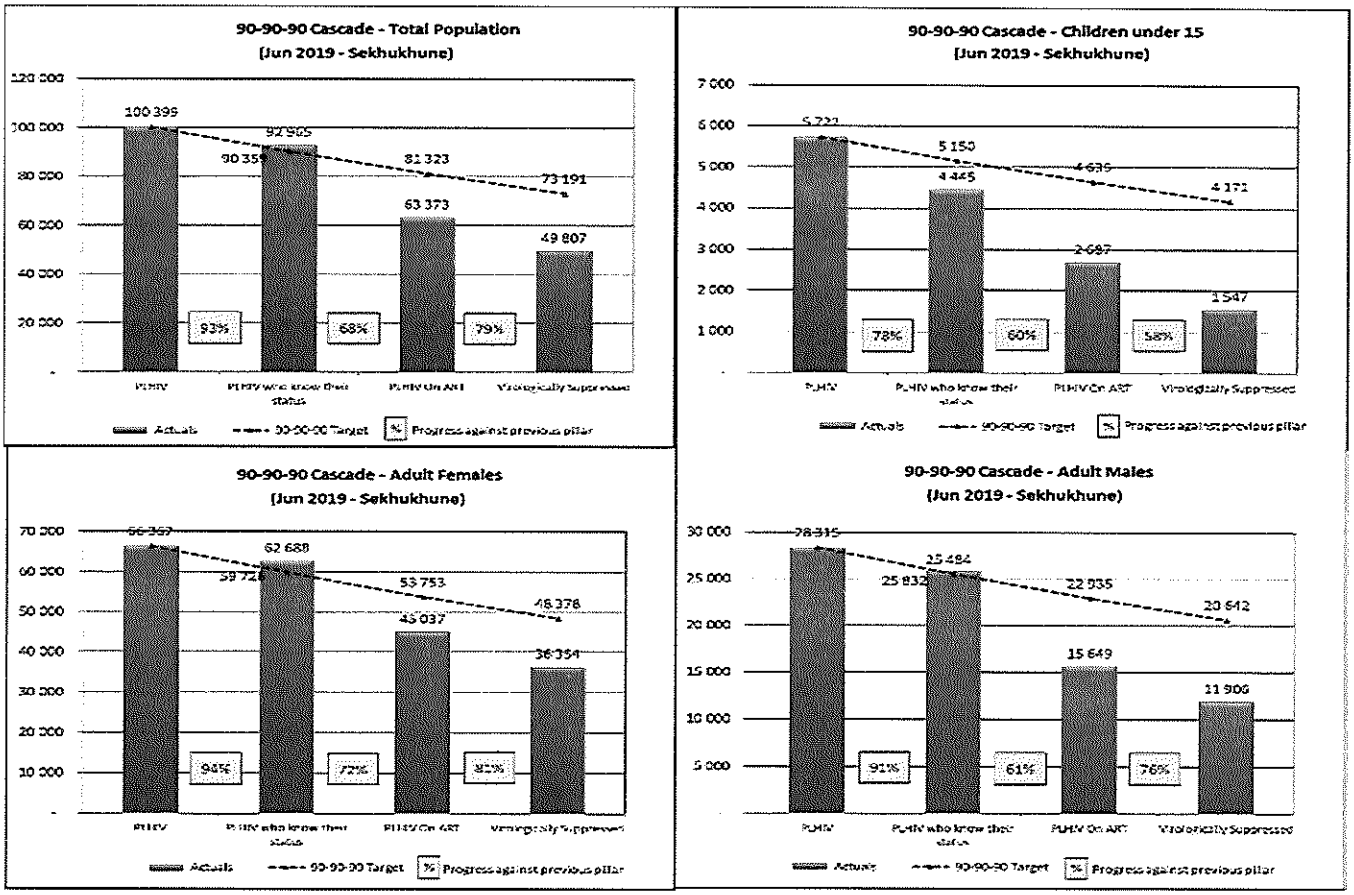


Figure 22. Sekhukhune 90-90-90 cascades

Narrative:

In terms of Figure 22, Sekhukhune is currently at 93-68-79 in terms of performance against 90-90-90 across its total population. The District is ranked 2nd out of the 5 districts in the province against 90-90-90. Results for each of the sub-populations vary, with adult females at 94-72-81, adult males at 91-61-76, and children at 78-60-58. For adult males and females, focus must be placed not only on initiation onto ART, but also on ensuring that clients are retained in care. There is a growing number of adults who have been previously diagnosed, but are not on ART. This includes those who had started ART and defaulted, as well as those who were never initiated. The results do show, that for women who remain on ART, suppression rates are higher. There are gaps across the cascade for children under 15 years. Case finding, ART initiation and retention have all underperformed and should be addressed through focused interventions. To achieve 90-90-90 targets, the district must increase the number of adult men on ART by 7286, the number of adult women on ART by 8717, and the number of children on ART, by 1948, by December 2020.

Vhembe

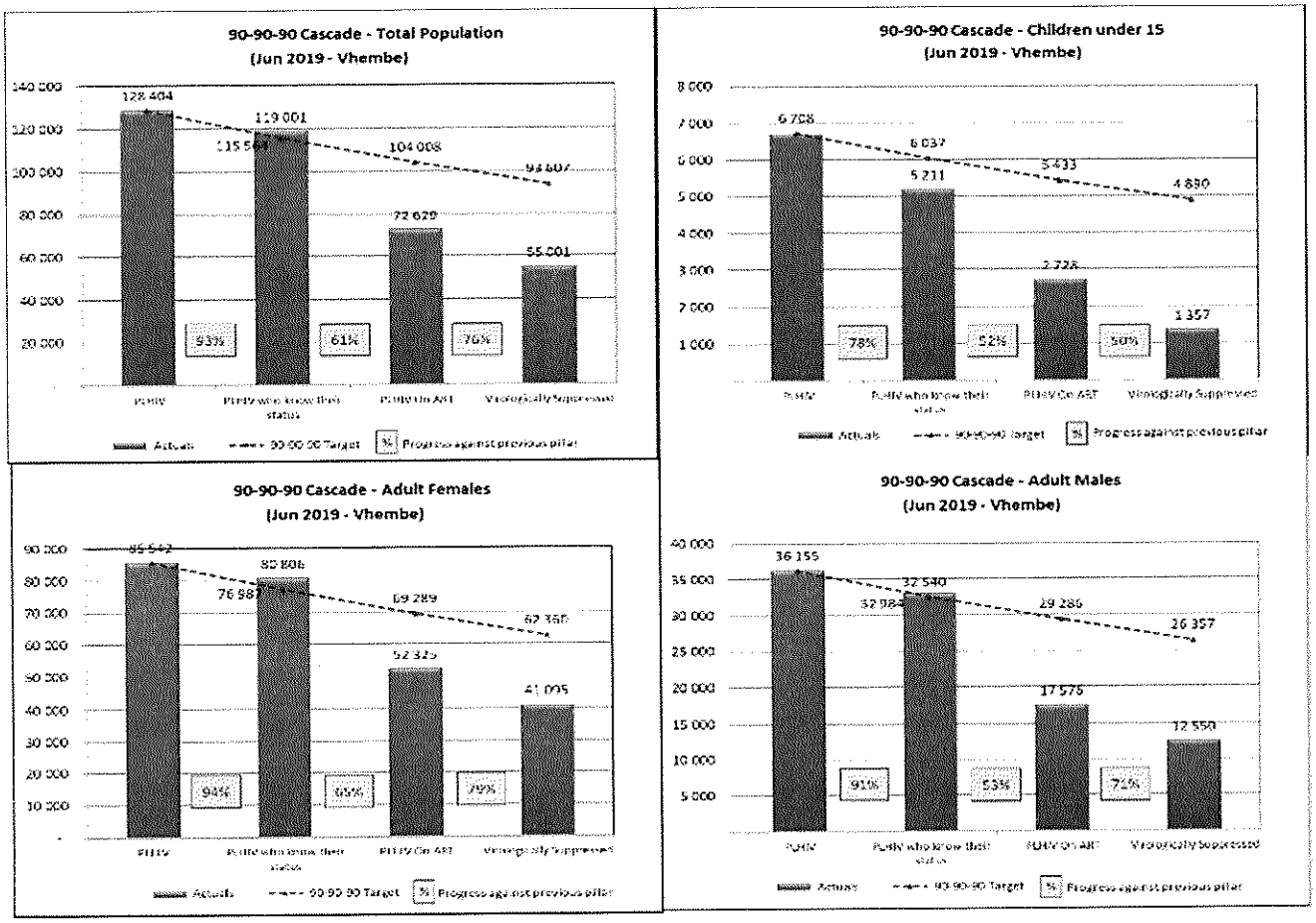


Figure 23. Vhembe 90-90-90 cascades

Narrative:

Vhembe is currently at 93-61-76 in terms of performance against 90-90-90 across its total population (refer to Figure 23). The District is ranked 5th out of the 5 districts in the province against 90-90-90. Results for each of the sub-populations vary, with adult females at 94-65-79, adult males at 91-53-71, and children at 78-52-50. For adult males and females, focus must be placed not only on initiation onto ART, but also on ensuring that clients are retained in care. There is a growing number of adults who have been previously diagnosed, but are not on ART. This includes those who had started ART and defaulted, as well as those who were never initiated. The results do show, that for women who remain on ART, suppression rates are higher. There are gaps across the cascade for children under 15 years. Case finding, ART initiation and retention have all underperformed and should be addressed through focused interventions. To achieve 90-90-90 targets, the district must increase the number of adult men on ART by 11710, the number of adult women on ART by 16963, and the number of children on ART, by 2705, by December 2020.

Waterberg

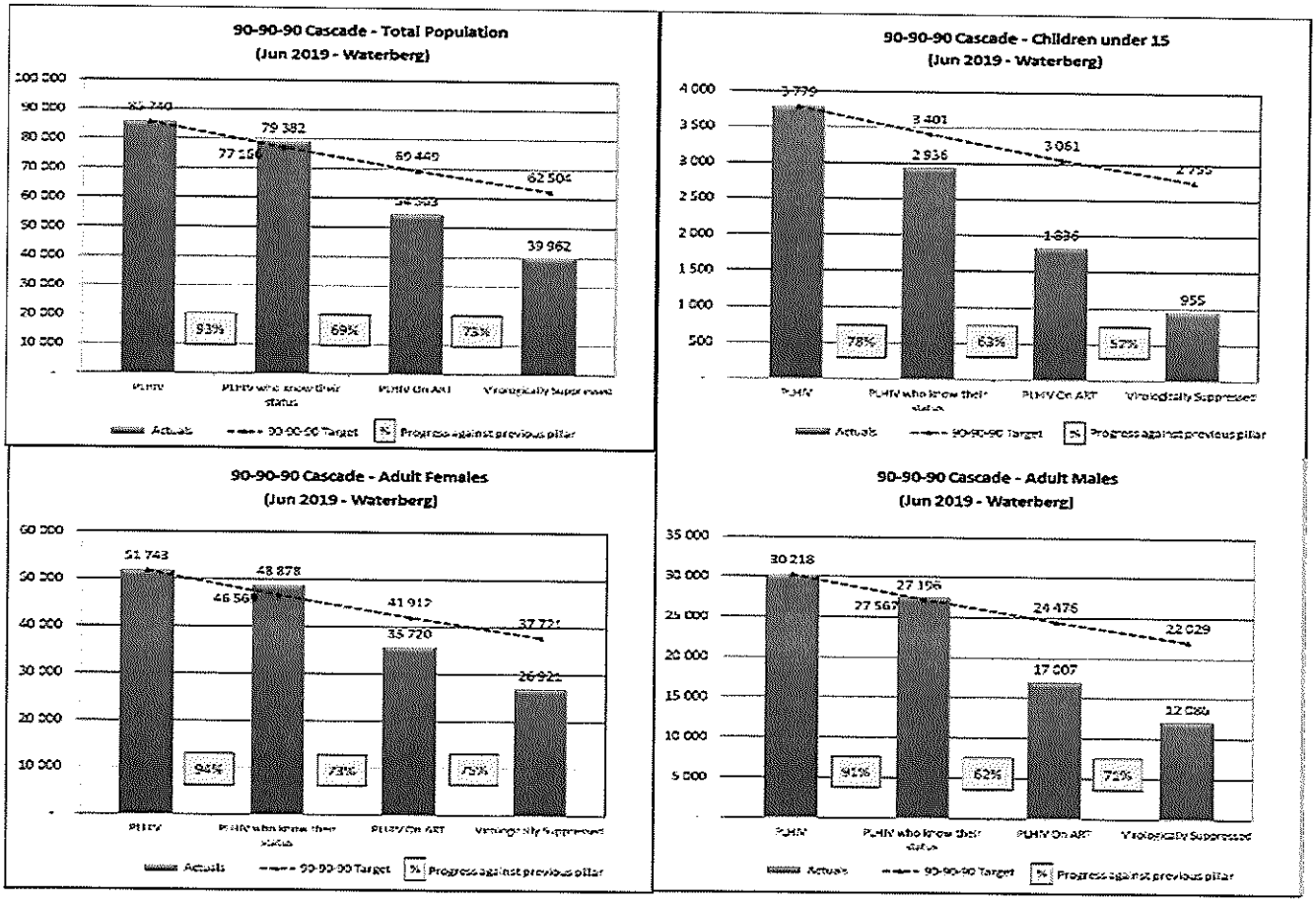


Figure 24. Waterberg 90-90-90 cascades

Narrative:

As demonstrated in Figure 24, Waterberg is currently at 93-69-73 in terms of performance against 90-90-90 across its total population. The District is ranked 3rd out of the 5 districts in the province against 90-90-90. Results for each of the sub-populations vary, with adult females at 94-73-75, adult males at 91-62-71, and children at 78-63-52. For adult males and females, focus must be placed not only on initiation onto ART, but also on ensuring that clients are retained in care. There is a growing number of adults who have been previously diagnosed, but are not on ART. This includes those who had started ART and defaulted, as well as those who were never initiated. The results do show, that for women who remain on ART, suppression rates are higher. There are gaps across the cascade for children under 15 years. Case finding, ART initiation and retention have all underperformed and should be addressed through focused interventions. To achieve 90-90-90 targets, the district must increase the number of adult men on ART by 7470, the number of adult women on ART by 6191, and the number of children on ART, by 1225, by December 2020.

9.3.6 Tuberculosis

TB Treatment Trends

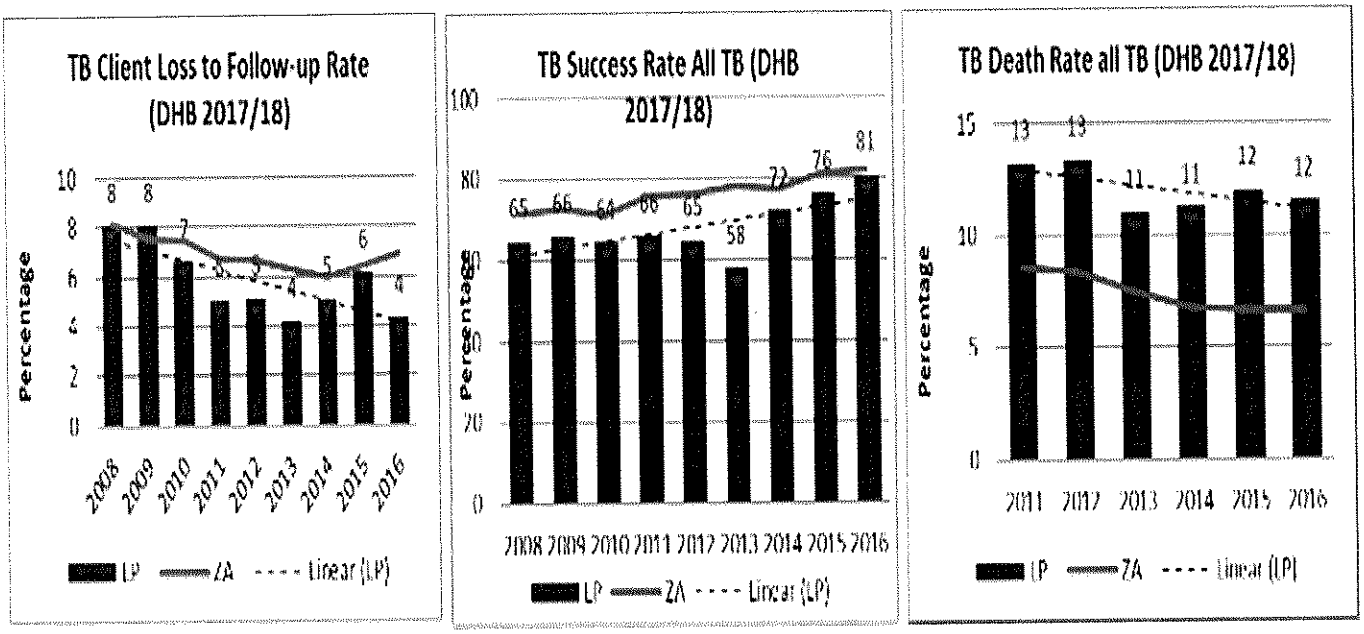


Figure 25. TB treatment trends

Narrative

According to Figure 25, TB Client loss to follow-up rate is on a decline. While the TB success rate is continuously improving it is still below the national average. The province consistently performs below the national average in terms of TB death rate. The death rate can be attributed due to migration patterns, comorbidities and late presentation.

TB

				Country	Province	District				
				ZA	LP	DC33	DC34	DC35	DC36	DC47
				South Africa	Limpopo	Mopani DM	Vhembe DM	Capricorn DM	Waterberg DM	Sekhukhune DM
TB DS death rate (%)		Impact	2017	6.5	9.3	10.1	5.7	9.6	11.2	10.4
DS TB patients who died (No)			2017	16 133	1 237	254	174	265	328	216
All DS TB patients in cohort (No)			2018	225 553	12 709	2 585	2 228	2 753	2 957	2 196
TB DS client lost to follow up rate (%)		Outcome	2017	8	5.7	5.3	5.1	5.2	6.4	7
DS TB patients who were lost to follow up (No)			2017	19 761	764	133	157	143	187	144
TB DS treatment success rate (%)		Outcome	2017	76.3	81.2	82.6	84	81.9	77.9	79.1
DS TB patients who completed treatment or were cured			2017	188 352	10 829	2 084	2 585	2 253	2 271	1 636
TB MDR client death rate (%)	long regimen	Impact	2018	20.8	19	30	22.8	23.9	15.5	20
	short regimen	Impact	2017	17.3	20.4	12.9	25	16.4	20.7	24.4
TB MDR client loss to follow up rate (%)	long regimen	Outcome	2016	19.6	10.8	0	3.5	18.2	10.9	7.5
	short regimen	Outcome	2017	14.6	7	6.5	8.9	8.2	6.7	4.4
TB MDR treatment success rate (%)	long regimen	Outcome	2016	53.9	65.5	70	70.2	54.5	70	57.5
	short regimen	Outcome	2017	49.6	42.4	64.5	28.6	38.1	46.7	40
TB XDR client death rate (%)	long regimen	Impact	2016	21.3	0				0	
	short regimen	Impact	2017	20.7	50				66.7	0
TB XDR client loss to follow up rate (%)	long regimen	Outcome	2016	11.3	0			0	0	
	short regimen	Outcome	2017	7.7	0				0	0
TB XDR treatment success rate (%)	long regimen	Outcome	2016	58.1	0			0	0	
	short regimen	Outcome	2017	31.3	25				0	
TB symptom 5 years and older screened in facility rate		Process	2018/19	83.7	91.6	94.4	83.5	99.4	96.6	88.5
Screen for TB symptoms 5 years and older (No)			2016/19	82 929 115	10 456 360	2 481 691	2 590 241	2 334 139	1 226 304	1 823 985
PHC headcount 5 years and older (No)			2018/19	99 082 287	11 409 321	2 629 724	3 100 694	2 349 187	1 269 852	2 059 864
TB symptom child under 5 years screened in facility rate		Process	2016/19	81.7	80.8	78.9	72.3	93	92.9	77.4
Screen for TB symptoms under 5 years (No)			2018/19	16 547 063	2 365 672	539 751	591 996	495 418	288 169	450 338
PHC headcount under 5 years (No)			2018/19	20 264 739	2 926 909	683 922	818 381	532 925	310 168	581 513
TB/HIV co-infected client on ART rate (ETR.Net) (%)		Outcome	2017	89.1	93.4	95.6	91.8	95.3	92.5	90.9
HIV-positive TB cases who are on ART (No)			2018	108 481	6 726	1 514	1 131	1 450	1 589	1 042
HIV-positive TB cases (No)			2018	125 222	7 630	1 634	1 281	1 648	1 838	1 229

Other
Best 10 DM
Worst 10 DM

Figure 26. TB indicators performance

Narrative

Whilst the province is performing higher than the national average on TB treatment success rate, Waterberg and Sekhukhune districts are pulling the performance down (see Figure 26). Due to the mining activities happening in the two districts, loss to follow-up remains is also higher than the other three districts. That impacts negatively on the attempts to reduction of the TB death rate which is still high in the province.

9.3.7 Human Resources for Health

9.3.7.1 Current deployment of staff

In terms of the current approved organizational structure, the Department has a total number of **63 460** posts including both core and support. Based on this structure, the total number of filled posts is **32 456.** The number of vacant posts is **31 886** which gives a vacancy rate of **49.56%.** In the terms of outcome 12, all government departments are expected to implement the Persal Clean-up project and one of the outputs of the project is to abolish all unfunded vacant posts from the Persal system. Post status after Persal Clean –up project is reflected as follows: Total number of approved posts: **36856**; filled posts: **32456** Vacant posts: **4400**; and vacancy rate is at **11, 94**.

9.3.7.2 Accuracy of staff establishment at all level against service requirements

The current institutional staff establishment at various levels of health care services such as Primary Health Care (PHC), District Hospital, Regional Hospital and Tertiary Hospitals are appropriately aligned with service needs.

9.3.7.3 Staff recruitment and retention systems and challenges

Recruitment and retention of human resources for health in the Department remains a challenge and this is manifested by the following challenges, to mention a few:

- Lack of opportunities for career-pathing;
- Inadequate infrastructure;
- Inadequate and non-functional equipment; and
- Poor working conditions

In response to these challenges, the Department had a Recruitment and Retention Strategy 2016/2019 which was partially implemented due to financial constraints. However, the Department has finalised conducting and analysing staff satisfaction survey which will culminate into reviewing of the current Recruitment and Retention Strategy for 2019/2022 based on the identified challenges.

Additionally, a succession plan framework has been developed with the aim of retaining required skills within the Department. The National Department of Health is in the process of developing the Human Resources strategy for Health which will address issues of attracting and retention of Human Resources for Health nationwide – the department await to benefit from this strategy. In the meanwhile, the Department is currently training Medical Officers (Registrars) towards in key specialty areas to close the shortage of the necessary skills required to improve health outcomes in the province.

9.3.7.4 Absenteeism

Absenteeism is analysed from the following types of leaves, vacation, sick leave, responsibility leave, and unauthorized leave and any other form of absenteeism. According to the absenteeism and staff turnover report of 2015/16 and also the resent report of 2018 there is high workload and in the Department which is influenced by the high vacancy rates of health workers and this contribute to burn out resulting in absenteeism and negative staff turnover. Absenteeism also contribute to increased overtime expenditure.

Absenteeism due to sick and disability leave impact negatively on health service delivery. The department is currently strengthening the application of employee health and wellness programme in order to create an enabling platform for employees to have their issues addressed professionally.

9.3.8 Financial management (AGSA 2018/19 key audit findings and strategies)

Item	Area of concern	Strategy to address the concerns
Regulatory Audit (asset management)	Fair valuation of assets not aligned to the Modified Cash Standard(MCS)	• Check all asset values in the historical asset register and reconcile with invoices/supporting documents. • Prepare a fair value price listing which will be updated by all institutions for consistence. • Reconciliation between BAS and asset register amounts to be enforced on a monthly basis. • Continuously scrutinise the asset register for out of range values.
Audit of predetermined Objective (AOPO)	Reconciliation between DHIS and registers materially misstated	Intensify awareness campaigns in all districts on the new reconciliation approach and all stakeholders will be reoriented on the DHMIS Policy and SOPs.
Audit of compliance with legislation	• Effective and appropriate steps not taken to prevent irregular expenditure amounting to R50 243 000, as disclosed in note 31 of the annual financial statements, as required by	• A compliance checklist will be developed. • Assign quality checklist compliance teams to ensure adherence with financial regulatory prescripts.

	Section 38(1)(c)(ii) of the PFMA and Treasury Regulation 9.1.1. • Fruitless and wasteful expenditures identified at the different institutions were not recorded in the fruitless and wasteful expenditure register resulting in an understatement of the current year fruitless and wasteful expenditure.	• Strengthen discussion of findings and recommendation with end-users. • Assign a team to investigate all unwanted expenditures and then subject them to regularization.

9.3.9 Limpopo Central Hospital

The need for strengthened tertiary health care capacity has been identified for many years. Since 1994 the province has been developing this capacity in Pietersburg and Mankweng hospitals (different disciplines in each). In the late 1990s Pietersburg Hospital was partly refurbished to replace some inadequate wards that were part of the apartheid split of 'Black' and 'White' hospitals on the same campus. The new casualty was also built and later a bunker and linear accelerator installed. Over time there have been piecemeal additions to the technology and service capacity of the hospital, but the infrastructure has not kept up with the evolution of services. Very little has been done to improve the capacity of Mankweng Hospital infrastructure.

Consultants were appointed to develop options for the establishment of what was referred to as the Limpopo Academic Hospital (LAH). The process has been ongoing for many years but has regained impetus and this megaproject has finally been accepted as a government priority. The total tertiary bed requirement has been calculated at 688 beds. Options on the table include a new 488 bed facility on a new site with 200 beds in existing hospitals providing the remaining capacity, and refurbishment and repurposing of the Pietersburg Hospital. The creation of this capacity has become urgent and is a strategic priority for Limpopo Department of Health. The recurrent costs associated with the chosen option will need to be funded from PES and conditional grants (HPTDG and NTSG).

Part C: Measuring Our Performance

Institutional Programme Performance Information

Impact Statements

Impact A	Life expectancy of South Africans improved to 70 years by 2030
Impact B	Universal Health Coverage for all South Africans achieved and all citizens protected from the catastrophic financial impact of seeking health care by 2030

Measuring Outcomes

MTSF Priority 3: Education, Skills and Health												
MTSF Intervention	**Outcome**	**Outcome Indicator**	**Data Source**	**South Africa**		**Provincial**		**District Five Year Targets (2024/25)**				
				Baseline (2018/19)	**Five Year Target (2024/25)**	**Baseline (2018/19)**	**Five Year Target (2024/25)**	**District Capricorn**	**District Mopani**	**District Sekhukhune**	**District Vhembe**	**District Waterberg**
Improve access to maternal health services; Improve the Integrated Management of Childhood Diseases services Protect children against vaccine preventable	Maternal, Neonatal, and Child Mortality reduced	1. Maternal mortality in facility ratio	DHIS	129 per 100 000 live births	<100 per 100 000 live births	111.6 per 100 000 live births	<100 per 100 000 live births	<100 per 100 000 live births	<100 per 100 000 live births	<100 per 100 000 live births	<100 per 100 000 live births	<100 per 100 000 live births
		2. Neonatal death in facility rate	DHIS	12 per 1 000 live births [1]	0 per 1,000 live births	11.5 per 1,000 live births	<8.5 per 1,000 live births	<8.5 per 1,000 live births	<8.5 per 1,000 live births	<8.5 per 1,000 live births	<8.5 per 1,000 live births	<8.5 per 1,000 live births
		3. Death under 5 years against live birth rate	DHIS	32 per 1,000 live Births [1]	25 per 1,000 live births	28.8 per 1000 live births	<26 per 1,000 live births	<26 per 1,000 live births	<26 per 1,000 live births	<26 per 1,000 live births	<26 per 1,000 live births	<26 per 1,000 live births

MTSF Priority 3: Education, Skills and Health												
MTSF Intervention	Outcome	Outcome Indicator	Data Source	South Africa		Provincial		District Five Year Targets (2024/25)				
				Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	District Capricorn	District Mopani	District Sekhukhune	District Vhembe	District Waterberg
diseases		4. Children <5 who are stunted	SADHS	27%	23%	No baseline	20%	20%	20%	20%	20%	20%
Provide prompt treatment of HIV and other sexually transmitted infections	Morbidity and Premature mortality due to Communicable diseases (HIV, TB and Malaria) reduced	5. HIV positive 15-24 years (excl ANC) rate	Survey DHIS	-	-	No baseline	7%	7%	7%	7%	7%	7%
		6. ART death rate	DHIS (Tier.net)	-	-	3.5%	3%	3%	3%	3%	3%	3%
		7. ART client remain on ART end of month – total	ART register; TIER.Net; DHIS	-	-	356 915	545 608	120 708	138 286	92 896	115 149	78 669
		8. All DS-TB client death rate	Tier.Net	29 513 [4] (2016)	8 510	10.1%	7%	7.5%	7.2%	7.5%	5.2%	7.1%
		9. Malaria case fatality rate	DHIS	70 / 581 700	Malaria eliminated by 2023	0.51%	<0.5%	<0.5%	<0.5%	<0.5%	<0.5%	<0.5%
Drive national health wellness and healthy lifestyle campaigns to reduce the burden of disease and ill	Morbidity and Premature mortality due to Non-Communicable diseases reduced by 10%	10. Overweight or obese child under 5 years incidences	SADHS	13%	10%	14.2%	10%	10%	10%	10%	10%	10%
		11. School learner overweight rate	DHIS	-	-	0.65%	0.35%	0.35%	0.35%	0.35%	0.35%	0.35%

MTSF Priority 3: Education, Skills and Health												
MTSF Intervention	Outcome	Outcome Indicator	Data Source	South Africa		Provincial		District Five Year Targets (2024/25)				
				Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	District Capricorn	District Mopani	District Sekhukhune	District Vhembe	District Waterberg
health		12. Men and Women 15 years and older with hypertension[2]	SADHS	-	-	No baseline	263 045	-	-	-	-	-
		13. Men and Women 15 years and older with diabetes[2]	SADHS	-	-	No baseline	119 000	-	-	-	-	-
	Package of services available to the population is expanded with priority given to equity and most cost-effective services	14. UHC service Index [5]	SAHR	68%	75%	No baseline	75%	75%	75%	75%	75%	75%
Roll-out a quality health improvement programme in public health facilities to ensure that they meet the quality standards required for certification and accreditation for	Quality of health services in public health facilities improved	15. Percentage of patients satisfied with their experience of care in public health facilities	Patient surveys	76.5%	85%	No baseline	85%	85%	85%	85%	85%	85%
		16. Ideal clinic status obtained rate	Ideal Health Facility software	56% (1920 / 3400)	100%	34.4%	90%	90%	90%	90%	90%	90%

MTSF Priority 3: Education, Skills and Health												
MTSF Intervention	Outcome	Outcome Indicator	Data Source	South Africa		Provincial		District Five Year Targets (2024/25)				
				Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	District Capricorn	District Mopani	District Sekhukhune	District Vhembe	District Waterberg
NHI; Improved quality of primary healthcare services through expansion of the Ideal Clinic Programme												
Mitigate the risks related to medical litigation	Contingent liability of medico-legal cases reduced by 80%	17. Contingent liability of medico-legal cases	Medico-legal case management system	R 90 bn	R 18 bn	R9 bn	R1.8 bn	-	-	-	-	-
	Management of patient safety incidents improved	18. Patient Safety Incident (PSI) case closure rate	PSI Software	-	-	No baseline	100%	100%	100%	100%	100%	100%
Roll-out a quality health improvement programme in public health facilities to ensure that they meet the quality standards required for certification and	Leadership and governance in the health sector enhanced to improve quality of care	19. Number of Districts with Quality Improvement; monitoring and Response Forums formalized and convened quarterly	Terms of Reference of Monitoring and Response Forums	-	52 Districts	No baseline	5	1	1	1	1	1

MTSF Priority 3: Education, Skills and Health												
MTSF Intervention	Outcome	Outcome Indicator	Data Source	South Africa		Provincial		District Five Year Targets (2024/25)				
				Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	District Capricorn	District Mopani	District Sekhukhune	District Vhembe	District Waterberg
accreditation for NHI;		20. Percentage of PHC facilities with functional Clinic committees	Attendance registers of meetings of clinic committees	Baseline to be determined	-	100% (480/480)	100% (480/480)	100%	100%	100%	100%	100%
		21. Percentage of Hospitals with functional hospital boards	Attendance registers of meetings of hospital boards	Baseline to be determined	-	100% (41/41)	100% (41/41)	100%	100%	100%	100%	100%
	Co-coordinating health services across the care continuum, re-orienting the health system towards primary health	22. EMS P1 rural and urban response time	DHIS	-	-	49.5%	80%	80%	80%	80%	80%	80%
Public health facilities supplied with adequate ICT infrastructure to implement the Digital Health Strategy 2019-2024 of South Africa	Robust and effective health information systems to automate business processes and improve evidence based	23. Percentage of health facilities electronically recordings clinical codes for their patient visits [7]	(TBC)	-	50%	No baseline	100% (41/41)	100%	100%	100%	100%	100%

MTSF Priority 3: Education, Skills and Health												
MTSF Intervention	Outcome	Outcome Indicator	Data Source	South Africa		Provincial		District Five Year Targets (2024/25)				
				Baseline (2018/19)	Five Year Target (2024/25)	Baseline (2018/19)	Five Year Target (2024/25)	District Capricorn	District Mopani	District Sekhukhune	District Vhembe	District Waterberg
	decision making											
Not Applicable	Improve financial management	24. Audit opinion of Provincial DoH	Annual Reports	Unqualified	Clean Audit	Qualified Audit Opinion	Unqualified Audit Opinion	N/A	N/A	N/A	N/A	N/A
Implement the costed infrastructure plan to improve efficiency and effectiveness of health services delivery	Infrastructure maintained and back log reduced	25. Percentage of Health facilities with major refurbishment or rebuild	Project management Information Systems (PMIS)	10-year infrastructure plan drafted	80%	No baseline	16.3% (100/614)	-	-	-	-	-

[2] Diabetes and Hypertension Prevalence measured by SADHS 2016

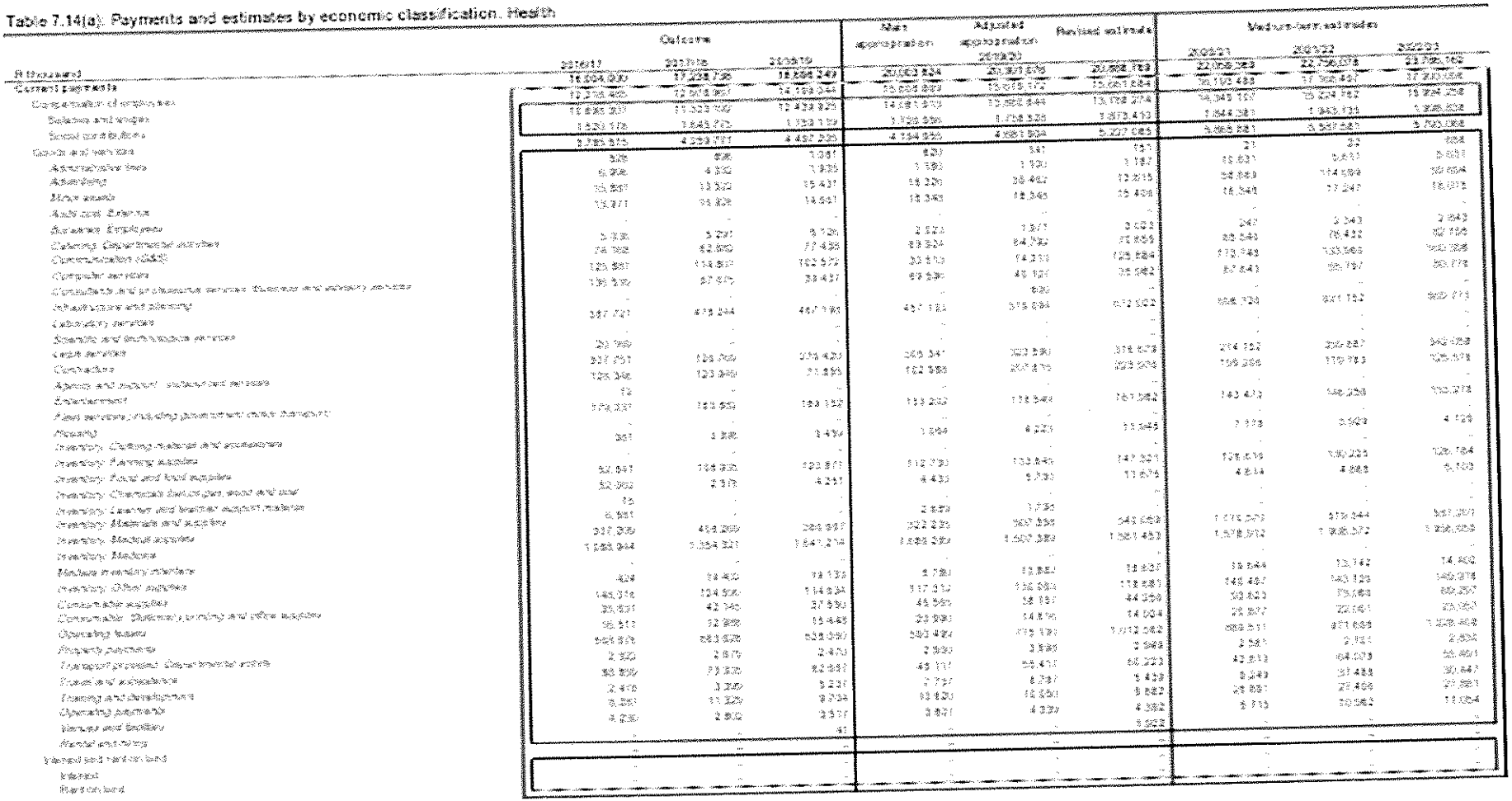
[1] Rapid Mortality Surveillance 2017, MRC 2019 (published 2019)

3 NCCEMD, 2018

[4] Leading causes of Mortality in South Africa 2016, StatsSA 2018

Resource Considerations

Table 7.14(a): Payments and estimates by economic classification: Health



Explanation of the Planned Performance over the Five Year Planning Period:

a) The outcomes contributes to healthy long-life outcome by addressing the quadruple burden of diseases through adoption of people centred health systems. In addition, these outcomes support the vision of Universal Health Coverage by ensuring health facilities readiness for National Health Insurance.

b) The rationale for the outcomes emanates from the burden of diseases in the province as well as the social determinants of health (cf. situational analysis). In contributing towards improved life expectancy the above outcome indicators are essential measures towards improved health outcomes. Measuring institutional mortalities will aid in the disaggregation of maternal and child mortalities to facilities in order to attach the accountability of mortalities to referring institutions rather than pointing accountability only to the Tertiary Hospitals.

c) In health facilities, the department will strengthen its collaboration with SAPS and community stakeholders in order to reduce the security incidents in the PHC facilities. Pertaining reduction mortalities due to TB and HIV, the department will among others intensify patients tracing through community health workers (CHW) and stakeholders as well as implementation of Finding Missing TB Patients strategy. The department will as well as strengthen implementation of the Direct Observed Treatment (DOT) strategy for all TB patients. In addition, the department will ascertain the effective roll-out of U-LAM at Primary Healthcare facilities. In terms of reducing maternal, neonatal, infants and child under five mortalities, the department will continue creating awareness among communities on management of childhood illness and increase access to reproductive health services. Furthermore, the department will conduct awareness campaigns on the prevention of unplanned and unwanted pregnancies including the use of family planning methods. Among staff, the departments will continue implementing key interventions such as ESMOE and IMCI trainings. In managing NCDs, The department will continue with health education and promotion and advocacy for exercising among the community and staff members. The department will implement a Computerised Assisted Call Tracking & Dispatch system to ensure that ambulances' response to the scene of call are improved. In improving personnel capacity, the department will continue to attract and recruitment of Advance Life Support Paramedics, to improve personnel availability to respond to priority (critical) calls. The department will ensure that the reporting system on breakdowns in facilities is functioning effectively in order to ensure minimal service disruptions as well as prompt repairs in the facilities in case of any unplanned maintenance.

d) The contribution of the outcome indicators to the impact is by ensuring that systems of governance including clinical governance are in place to in order to improve patient safety and satisfaction. Furthermore, the outcomes contribute to the impact by envisaging an improved management of women and child health. In reforming the health infrastructure in the province, improving quality standards required for health infrastructure is critical in getting facilities ready for NHI roll-out.

Key Risks

Outcome	Key Risk	Risk Mitigation
Maternal, Neonatal, Infant and Child Mortality reduced	Lack of capacity to manage women and child health (e.g. medical equipment, infrastructure not fit for purpose, inadequate skills mix)	• Procure the necessary medical equipment • Skills capacity building among health professionals • Accelerate deliverance of the centre of excellence
Morbidity and Premature mortality due to Communicable diseases (HIV, TB and Malaria) reduced	Ineffective communicable diseases management Diseases Outbreak (e.g. Malaria and Collera)	• Intensify implementation of the universal test and treat intervention • Strengthen interdepartmental meetings with COGSTA, Water and Sanitation and Department of Agriculture • Provincial Public Health to participate in the development of early warning system for infectious diseases (iDEWS) with National Institute of Communicable disease Control (NICC) • Intensify fumigation
Morbidity and Premature mortality due to Non-Communicable diseases reduced by 10%	Risky lifestyle among community members	Conduct community lifestyle awareness campaigns
Package of services available to the population is expanded with priority given to equity and most cost-effective services	Old and dilapidated infrastructure (infrastructure not fit for purpose)	Conduct refurbishment (minor or major) including rebuild to accommodate health services expansion
Quality of health services in public health facilities	Failure to manage key health priorities (e.g. long	Encourage proactive management than reactive

improved	queues, medicine stock-outs, governance and leadership, staff attitudes, cleanliness)	management
Contingent liability of medico-legal cases reduced by 80%	Increased litigations due to medical negligence	• Mortality and morbidity reviews and training • Provisioning of training for clinical managers and medical doctors on ethics and general management • Reduction of medico-legal expenditure through alternate dispute resolution (ADR) • Reduction of medico-legal expenditure through defence • Make representation to the Ministerial Task Team (MTT) to reduce the quantum of cases lost
Management of patient safety incidents improved	Prevalence of clinical and non-clinical risks in health facilities	• Monitor patient experience of care satisfaction to remedy factors raised by healthcare users • Intensify adherence to good clinical governance while encouraging monitoring and clinical audit periodically
Leadership and governance in the health sector enhanced to improve quality of care	Unclear terms of reference	Draw clear terms of reference on monitoring quality improvement by the district forums
Co-coordinating health services across the care continuum, re-orienting the health system towards primary health	Ineffective emergency medical service	• Migration from Analogue to Digital system • Attract and retain appropriately qualified EMS staff • In-service training of EMS personnel

Robust and effective health information systems to automate business processes and improve evidence based decision making	Ineffective Information Communication Technology (**ICT**) system	• Replacement of the obsolete ICT infrastructure (networks and computers) • Enhancement of the network security • Procurement and contracting of the service provider for the replacement current health information system
Improve financial management	Ineffective procurement processes	• Implementation of procurement plan • Revisiting of the processing of procuring emergency goods and services
	Unwanted expenditures (Irregular and unauthorised expenditures)	• Request adequate funding • Conduct training on financial management • Apply corrective measures for non-compliance
	Inadequate asset management	• Take action for non-compliance • Monitoring the effective implementation of BAUD system • Provide awareness on assets management procedure manuals
	Abuse of overtime	• Enforce compliance to departmental policies • Improve supervisory mechanism • Apply corrective measures for non-compliance
Infrastructure maintained and back log reduced	Unsafe and dilapidated infrastructure	• Building of new infrastructure • Refurbishment and maintenance of health facilities

Public Entities (*Department does not have public entities*)

Name of Public Entity	Mandate	Outcomes	Current Annual Budget (R thousand

Part D: Technical Indicator Description (TID) for Strategic Plan

Indicator Title	Definition	Source of data	Method of Calculation / Assessment	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Reporting Cycle	Desired performance	Indicator Responsibility
1.Maternal mortality in facility ratio	Maternal death is death occurring during pregnancy, childbirth and the puerperium of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy and irrespective of the cause of death (obstetric and non-obstetric) per 100,000 live births in facility	Maternity register, DHIS	**Numerator:** Maternal death in facility **Denominator:** Live birth known to facility	Conduction of ESMOE is key to reduction of maternal mortalities. Strengthened HIV/AIDS management	Females	All districts	Annual progress against the five year target	Lower institutional maternal mortality is desired	MNCWH programme manager
2. Neonatal death in facility rate	Infants 0-28 days who died during their stay in the facility per 1000 five births in facility	Delivery register, Midnight report	**Numerator:** Neonatal deaths (under 28 days) in facility **Denominator:** Live birth in facility	Implementing Limpopo Initiative for Newborn Care	Not applicable	All districts	Annual progress against the five year target	Lower neonatal mortality rate is desired	MNCWH Programme manager
3. Death under five years against live birth rate	Children under 5 years who died during their stay in the facility as a proportion of all live births	Delivery/maternity/midnight report	**Numerator:** Death in facility under five years total **Denominator:** Live birth in facility	Implementing integrated management of childhood illness	Children	All districts	Annual progress against the five year target	Lower children mortality rate is desired	MCWHN Programme manager
4. Children <5 who are stunted	Percentage of stunted (moderate and severe) children aged 0-9 months (moderate = height-for-age below -2 standard deviations from the WHO child growth standards median; severe = height-for-age below -3 standard deviation from the	South African Demographic and Health Survey 2016	Not applicable	The main limitation of this indicator is that length or height can be difficult to obtain thus leading to problems of validity	Children	All districts	Annual progress against the five year target		MNCWH Programme Manager

Indicator Title	Definition	Source of data	Method of Calculation / Assessment	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Reporting Cycle	Desired performance	Indicator Responsibility
	WHO child growth standards median)								
5. HIV positive 15-24 years (excl. ANC) rate	Adolescent and youth 15 to 24 years who tested positive as a proportion of those were tested for HIV in this age group	PHC comprehe nsive tick register; HTS register (HIV testing services), TIER.Net, DHIS	**Numerator:** HIV positive 15-24 years (excl. ANC) **Denominator:** HIV test 15-24 years (excl. ANC)	All systems for monitoring HIV/TB epidemic are in place and functional	Youth	All districts	Annual progress against the five year target	Low	HIV/AIDS Programme Manager
6. ART death rate	ART cumulative death – total as a proportion of ART start minus cumulative	ART register;Ti er.net; DHIS	**Numerator:** ART cumulative death – total **Denominator:** ART start minus cumulative transfer out	Universal test and treat strategy is been implemented in the department	Not applicable	All districts	Annual progress against the five year target	Reduced deaths as a result of AIDS	HIV/AIDS Programme Manager
7. ART client remain on ART end of month - total	Total clients remaining on ART (TROA) are the sum of the following: -Any client on treatment in the reporting month -Any client without an outcome reported in the reporting month Clients reaming on ART equals [new starts (naïve) + experienced (Exp) + transfer in (TFI) + restart] minus [died (RIP) + loss to follow-up (LTF) + transfer out (TF)]	ART register; TIER.Net; DHIS	ART adult and child under 15 years remaining on ART end of month	All systems for monitoring HIV/TB epidemic are in place and functional	Not applicable	All districts	Annual progress against the five year target	Higher	HIV/AIDS programme manager

Indicator Title	Definition	Source of data	Method of Calculation / Assessment	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Reporting Cycle	Desired performance	Indicator Responsibility
8. All DS-TB Death Rate	TB clients who started drug-susceptible tuberculosis (DS-TB) treatment and who subsequently died as a proportion of all those in the treatment cohort	TB register, ETR.Net	**Numerator:** Al DS-TB client dead **Denominator:** All DS-Tb patients in treatment outcome cohort	All systems for monitoring TB epidemic are in place and functional	Children and adults	All districts	Annual progress against the five year target	Low	TB Programme Manager
9. Malaria case fatality rate	Malaria deaths in hospitals as a proportion of confirmed malaria cases for those admitted for malaria	Malaria Informatio n System	**Numerator:** Malaria deaths reported **Denominator:** Malaria new cases reported	Strengthened indoor residual spraying and surveillance	Not applicable	All districts	Annual progress against the five year target	Lower percentage indicates a decreasing burden of malaria	Communicable Diseases Programme Manager
10.Overweight or obese child under 5 years incidence	Child under 5 years newly diagnosis with overweight and/obesity per 1000 children under 5 years In the population	South African Demograp hic and Health Survey	Not applicable (Survey data)	Accuracy dependent on quality of data submitted by health facilities	Children	All districts	Annual progress against the five year target	Lower	MCWH&N programme
11.School learner overweight rate	Proportion of learners screened by a nurse in line with the ISHP services package diagnosed as overweight (above +25D)	DHIS	**Numerator:** School learner overweight **Denominator:** Population under 5 years	Not applicable	Children	All districts	Annual progress against the five year target	Lower	MCWH&N programme
12. Men and women 15 years and older with hypertension	An individual is classified as having hypertension with a systolic blood pressure of 140 mmHg or above or a diastolic blood pressure of 90 mmHg or above at the time of the survey, or was currently	South African Demograp hic and Health Survey	Not applicable	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All districts	Annual progress against the five year target	Lower	Non-communicable diseases Programme Manager

Indicator Title	Definition	Source of data	Method of Calculation / Assessment	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Reporting Cycle	Desired performance	Indicator Responsibility
	taking antihypertensive medication to control blood pressure								
13.Men and women 15 years and older with diabetes	An individual is classified as having diabetes with HbA1c above or equal 6.5%	South African Demographic and Health Survey	Not applicable	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All districts	Annual progress against the five year target	Lower	Non-communicable diseases Programme Manager
14.UHC services index	Universal services coverage is a measurement of coverage of essential services health services and is calculated as the product of reproductive , maternal, newborn and child health coverage, infectious diseases control; non-communicable diseases and service capacity and access	South African Demographic and Health Survey	Not applicable	Not applicable	Not applicable	All districts	Annual progress against the five year target	Higher	DHS manager
15. Percentage of patients satisfied with their experience of care in public health facilities	Total number of satisfied responses as a proportion of all responses from patient experience of care survey questionnaires	Patient experience of care surveys	**Numerator:** Patient Experience of Care survey satisfied responses **Denominator:** Patient Experience of Care survey total responses	Standardised data collection tools have been developed and used to conduct the surveys	Not applicable	All districts	Annual progress against the five year target	Higher	Quality Assurance
16. Ideal Clinics status obtained rate	Fixed PHC health facilities that obtained Ideal Clinic status (bronze, silver, gold) as a proportion of fixed PHC clinics and CHCs/CDCs	Ideal Health Facility software	**Numerator:** Fixed PHC health facilities have obtained Ideal Clinic status **Denominator:**	Teams (PPTICRM) and district coordinators for ICRM are available conduct assessments and monitor implementation of	Not applicable	All districts	Annual progress against the five year target	Higher	Quality Assurance

Indicator Title	Definition	Source of data	Method of Calculation / Assessment	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Reporting Cycle	Desired performance	Indicator Responsibility
			Fixed PHC clinics or fixed CHCs and or CDCs	quality improvement plans National support					
17. Contingent liability of medico-legal cases	Total rand value of the medico-legal cases that were on the case register as at March 31, 2019	Medico-legal cases management system	Total rand value of the medico-legal claims for all backlog cases that were on the register as at March 31, 2019	Medico-legal team is in place to manage medico-legal system	Not applicable	All districts	Annual progress against the five year target	Lower	Legal services
18. Patient safety incidents (PSI) case closure rate	Patient Safety Incident (PSI) case closed in the reporting month as a proportion of Patient Safety Incident (PSI) cases reported in the reporting month	Patient Safety Incident Software	**Numerator:** Patient Safety Incident (PSI) case closed **Denominator:** Patient Safety Incident (PSI) case reported	Quality assurance teams are in place in districts	Not applicable	All districts	Annual progress against the five year target	Higher	Quality Assurance
19. Number of districts with quality improvement, monitoring and response forums formalized and convened quarterly	Districts with quality improvement; monitoring and response forum formalization that convene quarterly with clinical governance responsibility	Terms of reference for response forums	Number of districts with quality improvement, monitoring and response forums formalized and convened quarterly	The districts have in place the districts management teams	Not applicable	All districts	Annual progress against the five year target	Higher	Quality assurance DHS manager
20. Percentage of PHC facilities with functional Clinic committees	Improve quality of services at PHC facilities conducting regular meetings with functional clinic committees	Attendance registers of meetings of clinic committees	**Numerator:** Number of functional clinic committees **Denominator:** Number of PHC facilities	Existence of transformation and transversal unit to coordinate the appointment functioning committees	Not applicable	All districts	Annual progress against the five year target	Higher	Transformation and transversal Directorate Communications programme in districts
21. Percentage of Hospitals with functional hospital boards	Improve quality of services at hospitals conducting regular meetings with functional hospital boards	Attendance registers of meetings of hospital boards	**Numerator:** Number of functional hospital boards	Existence of transformation and transversal unit to coordinate the appointment and functioning of	Not applicable	All districts	Annual progress against the five year target	Higher	Transformation and transversal Directorate Communications programme in

Indicator Title	Definition	Source of data	Method of Calculation / Assessment	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Reporting Cycle	Desired performance	Indicator Responsibility
			Denominator: Number of hospitals	the boards					districts
22. EMS P1 rural and urban response time	Emergency P1 responses in rural/urban locations with response times as a proportion of EMS P1 urban calls. Response time is calculated from the time the call is received to the time that the first dispatched medical resource arrives on scene	DHIS, institutional EMS registers OR DHIS, patient and vehicle report.	**Numerator:** SUM([EMS P1 rural/urban response]) **Denominator:** SUM([EMS P1 rural responses])	Availability of operational ambulances and paramedics	Not applicable	All districts	Annual progress against the five year target	Higher	EMS Manager
23. Percentage of health facilities electronically recording clinical codes for their patient visits	Health facilities electronically recording clinical codes for their patient visits	Project report	**Numerator:** Hospitals electronically recording clinical codes for patient visits **Denominator:** Total number of hospitals	Reliable connectivity in health facilities	Not applicable	All districts	Annual progress against the five year target	Higher	ICT unit
24. Audit opinion from AGSA	Audit opinion for Provincial Departments of Health for financial performance	Documented Evidence: Annual Report Auditor General's Report	Categorical	Department is implementing an audit action plan to improve the audit outcomes	Not applicable	All districts	Annual progress against the five year target	Unqualified opinion	Chief Financial Officers of Provincial Departments of Health
25. Percentage of Health facilities with major refurbishment or rebuild	Number of existing health facilities where capital, have been completed (excluding new and replacement	Project management information	**Numerator:** Total number of health facilities with completed	The department has support from department of public works and	Not applicable	Norms are utilised to facilitate decision making with respect to spatial location of health facilities	Annual progress against the five year	Higher	Infrastructure Chief Directorate

Indicator Title	Definition	Source of data	Method of Calculation / Assessment	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Reporting Cycle	Desired performance	Indicator Responsibility
	facilities). Rebuild is considered where refurbishment cost is >70% of estimated replacement value scheduled maintenance or professional day-to-day maintenance projects (The indicator is for projects classified under 3 nature of investment i.e. upgrade & additions, new/replacement and renovations & refurbishments).	n systems (PMIS)	refurbishment or rebuild **Denominator:** Total number of health facilities on the 10 year infrastructure plan that needed major refurbishment or replacement	DBSA to address infrastructure needs. The department has infrastructure personnel to manage the infrastructure planning.			target		

Annexure A: District Development Model

#	Project / Programme Name	Municipality / Region	District	Latitude	Longitude	2020 - 2025
1	Mopudu/Spitzkop Clinic: Enviroloo and related services	Polokwane	Capricorn			1 900,00
2	Blouberg CHC: Replacement or Refurbishment of Stand By Generators & Related Infrastructure	Blouberg	Capricorn	-23,142483	29,008283	4 000,00
3	Byldrift Clinic: Enviroloo and related services	Lepelle Nkumpi	Capricorn	-24,545833	29,503694	1 700,00
4	Nthabiseng Clinic: New clinic	Molemole	Capricorn	-23,484590	29,912800	200,00
5	Phuti Clinic: Enviroloo and related services	Polokwane	Capricorn	-23,955861	29,706944	1 700,00
6	Slypsteen clinic: Alternative back up power supply & Related Infrastructure for Ideal Clinic Program	Lepelle Nkumpi	Capricorn	-24,452000	29,403306	200,00
7	Chuene Clinic: Alternative back up power supply & Related Infrastructure for Ideal Clinic Programme	Polokwane	Capricorn	-24.208611	29.494444	400,00
8	Slypsteen Clinic: Enviroloo and related services	Lepelle Nkumpi	Capricorn	-24,452000	29,403306	1 700,00
9	Seshego Hospital: Upgrade neonatal facilities (Phase B)	Polokwane	Capricorn	-23,846167	29,391278	12 000,00
10	Chuene Clinic: Enviroloo and related services	Polokwane	Capricorn	-24,1914167	29,4859722	2 170,00
11	Sello Moloto clinic: Alternative back up power supply & Related Infrastructure for Ideal Clinic Program	Aganang	Capricorn	-23,625390	29,246030	200,00
12	Mashashane Clinic: Enviroloo and related services	Aganang	Capricorn	-23.930000	29.133056	1 720,00
13	Grootdraai clinic: Alternative back up power supply & Related Infrastructure for Ideal Clinic Program	Blouberg	Capricorn	-23,117750	28,707778	200,00
14	Helene Franz Hospital: Upgrade and repairs to chiller plant	Molemole	Capricorn	-23,285133	29,111650	200,00

15	Lebowakgomo EMS station: Upgrade EMS station	Lepelle Nkumpi	Capricorn	-24,2955000	29,5285000	500,00
16	Lebowakgomo Hospital: Upgrade NeoNatal facilities. MCCE Phase B	Lepelle Nkumpi	Capricorn	-24.295500	29.528500	15 300,00
17	Lebowakgomo Unit B Clinic: New Clinic	Polokwane	Capricorn	-24.295500	29.528500	100,00
18	Mankweng hospital: Upgrade boundary wall & security	Polokwane	Capricorn	-23,879444	29,725000	2 000,00
19	Mankweng Hospital: Upgrade Hospital Laundry electro-mechanical repairs	Polokwane	Capricorn	-23,879444	29,725000	800,00
20	Mankweng Hospital: Upgrade Laundry Building	Polokwane	Capricorn	-23,879444	29,725000	200,00
21	Seshego Hospital: Upgrade of the existing Hospital Mortuary & Health Support	Polokwane	Capricorn	-23,856667	29,395833	8 900,00
22	Matlala EMS Station:		Capricorn			7 500,00
23	Matlala Hospital - Enabling Works Program: Upgrade Health Support, OPD, X-Ray, Casualty & Pharmacy;	Aganang (not plotted)	Capricorn	-24,832000	29,503500	240,00
24	Pietersburg hospital: Rehabilitate cardio theatre	Polokwane	Capricorn	-23,858330	29,465278	15 000,00
25	Pietersburg Hospital: Repairs & Maintenance to MCCE and neonatal facilities (Phase A)	Polokwane	Capricorn	-23,858330	29,465278	2 000,00
26	Pietersburg Hospital: Upgrade Central Mini-Hub Laundry	Polokwane	Capricorn	-23,858330	29,465278	18 367,39
27	Dithabaneng Clinic: Enviroloo and related services	Lepelle Nkumpi	Capricorn	-24,370444	29,577722	1 907,90
28	Pietersburg Hospital: Upgrade Electrical System and provide Certificate of Compliance	Polokwane	Capricorn	-23,858330	29,465278	1 600,00
29	Pietersburg Hospital: Upgrade Hospital Laundry electro-mechanical repairs	Polokwane	Capricorn	-23,88984	29,46128	9 300,00
30	Soetfontein Clinic: Replacement of existing on a new site	Polokwane	Capricorn	-24,086944	29,597806	2 000,00
31	Pietersburg hospital : Upgrade MCCE facilities. Phase B	Polokwane	Capricorn	29,46128	-23,88984	71 900,00

32	Mogoto clinic: Alternative back up power supply & Related Infrastructure for Ideal Clinic Programme	Lepelle Nkumpi	Capricorn	-24,348361	29,264889	200,00
33	Mafefe clinic: Alternative back up power supply & Related Infrastructure for Ideal Clinic Programme	Lepelle Nkumpi	Capricorn	-24,195250	30,099889	500,00
34	Pietersburg Hospital: Upgrade Hospital Laundry equipment	Polokwane	Capricorn	-23,88984	29,46128	24 300,00
35	Provincial head office: Provision of Mobile Standby Generators & Related Infrastructure Units	Polokwane	Capricorn	-23,8922582	29,4560838	200,00
36	Ramokgopa Clinic: Alternative back up power supply & Related Infrastructure for Ideal Clinic Program	Molemole	Capricorn	-23,466528	29,815917	300,00
37	Ratshaatshaa Health Center:Staff Accommodation; 2x 10 single rooms blocks	Blouberg	Capricorn			11 000,00
38	Schoongezicht Clinic: Replace existing clinic on a new site	Blouberg	Capricorn	-23,336444	29,043194	200,00
39	Schoonoord Clinic: Enviroloo and related services	Makhuduthamang	Capricorn	-24.754833	30.002667	1 900,00
40	Seakamela Clinic: Enviroloo and related services	Blouberg	Capricorn	-23,140861	29,101500	1 700,00
41	Seshego zone 4 clinic: Alternative back up power supply & Related Infrastructure for Ideal Clinic Pr	Polokwane	Capricorn	-23,841306	29,386139	200,00
42	Sovenga Nursing College Campus : Student Nurses residential accommodation	Polokwane	Capricorn	-23,87548	29,72543	10 800,00
43	Thabamoopo Hospital: Medical & Geriatric Wards & Upgrading of steam reticulation system; LDPW-B/0705	Lepele-Nkumpi	Capricorn			2 000,00
44	Mahale Clinic	Polokwane	Capricorn	30,96836	-23,69461	7 000,00

45	Moletjie Clinic: Alternative back up power supply & Related Infrastructure for Ideal Clinic Programm	Polokwane	Capricorn	-23,737472	29,302472	1 000,00
46	Thabamoopo Hospital: New Health Care Support Facility	Lepele-Nkumpi	Capricorn			11 000,00
47	Thabamoopo Hosp: Complete Service Platform					9 000,00
48	Thabamoopo Hospital: Central Mini-Hub Laundry and Linen Bank.					7 000,00
49	Thabamoopo Hospital: Residential Accommodation, Half Way House, Pharmacy & Kiosk	Lepele-Nkumpi	Capricorn			600,00
50	WF Knobel Hospital: Staff Accommodation - 10 single rooms' block	Blouberg (LIM351)	Capricorn	-23,631944	29,120000	2 000,00
51	WF Knobel Hospital: Upgrade Electrical System and provide Certificate of Compliance	Aganang	Capricorn	-23,631944	29,120000	200,00
52	Pietersburg Hospital: Mass water storage tanks	Polokwane	Capricorn	-23,858330	29,465278	59 000,00
53	Moletlane Clinic: Alternative back up power supply & Related Infrastructure for Ideal Clinic Progra	Lepelle Nkumpi	Capricorn	-24,363056	29,335694	600,00
54	Matoks Clinic: Alternative back up power supply & Related Infrastructure for Ideal Clinic Programme	Molemole	Capricorn	-23,477850	29,713850	200,00
55	Zebediela Hospital: Staff Accommodation -10 single rooms' block	Lepelle Nkumpi	Capricorn	-24,325444	29,298472	7 000,00
	Mankweng Hospital: New Mankweng Forensic Laboratory and Upgrade of Existing Hospital Mortuary: 2nd	Polokwane	Capricorn	-23,879444	29,725000	23 183,00
56	Mankweng Hospital: Laundry Machines	Polokwane	Capricorn	-23,879444	29,725000	28 000,00