

Free State  
Department of Health  
**5-YEAR STRATEGIC PLAN**  
2010/11 to 2014/15



**health**

Department of  
Health  
FREE STATE PROVINCE



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## 1. INTRODUCTION

In order for an organisation to be successful there needs to be a roadmap for success. An organisation that has little idea where it is headed will wonder aimlessly with priorities changing constantly and employees confused about the purpose of their jobs. This means that each organisation needs to have a strategic plan that helps provide direction and focus for all employees. This strategic plan specifies goals for the organisation as whole and strategic objectives for each main service delivery area. All this applies to the Department of Health: Free State.

The department is faced with service delivery challenges which need to be comprehensively addressed. These include:

- Health outcomes:
- High maternal mortality rate which is currently at 256 per 100 000 live births,
- The under 5 child mortality rate is 68.2 per 1000 and the infant mortality rate is 48.1 per 1000
- The high prevalence of chronic infectious diseases like Tuberculosis and HIV & AIDS have significantly contributed to the increasing burden of disease increasing deaths in the province. It is estimated that 33,5% of the Free State antenatal population is HIV positive. It is true that this figure is not representative of the whole community, however it does indicate the dire situation we find ourselves in. 25,428 new cases of TB were reported in 2008. Accepting that this is just the tip of the iceberg implores The department to double efforts to prevent the spread of TB by implementing measures to detect, confirm and effectively treat patients with TB early.
- High cost of medication, blood products and lab services.
- A costly staff establishment.

This document serves as a blue print for the priority strategic goal and objectives that the department will strive to achieve over the 2010/2011 – 2014/15.

**Part A** provides a strategic overview of the Free State Department of Health and specifies the strategic goals it aims to achieve over the next five-years.

**Part B** provides targets and more detailed plans on the individual programmes and sub-programmes and specifies measurable objectives where relevant.

**Part C** presents the linkages with other plans of the department, especially the long-term infrastructure plan, etc.

The five year plan for the Free State Department of Health establishes the main focus during the term of office of the honourable MEC for health Me ES Mabe.

This document serves as a blueprint for the priority strategic goals and objectives that the department will strive to achieve over the 2010/11 to 2014/15 period.

These goals and objectives lay the foundation for the development of the Annual Performance Plan for 2010/11 to 2013/14

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## 4.1. OFFICIAL SIGN OFF OF THE STRATEGIC PLAN

### 4.1.1. FOREWORD BY THE EXECUTIVE AUTHORITY (HEALTH MEC)

At the initial stages of the current term of office, an array of health service delivery challenges were discerned that necessitate political interventions and identification of priorities for the department of Health for the 5 year term of office of the current government.

It is for these reasons that this 5 year Strategic Plan as well as the Annual Performance Plan is aligned with the integration of the political and strategic direction as derived from the following:

- Government Programme of Action
- State of the Nation Address
- State of the Province Address
- Premier's Injunctions
- Provincial Extended Lekgotla Resolutions
- National Health 10 Point Plan

Health has been identified as one of the five key priorities for government in the next five years. The proposed approach builds on the gains that have been achieved by government over the past fifteen years, whilst it addressed the shortfalls in the current health system. To this extent, the following ten health priorities have been identified as part of government's plan of action:

- Implement the national health insurance plan
- Improve quality of health services
- Overhaul management system
- Improved human resource management
- Physical infrastructure revitalization
- Accelerate implementation of the HIV and AIDS and STI plans
- Attaining better health for the population
- Social mobilization for better health
- Drug policy review
- Research and development

The above injunctions and mandates are what the Free State Department of Health under my leadership pledges to deliver to the people of the Free State with the resources placed at our disposal.



**Me ES Mabe: MEC for Health**  
**8 March 2010**

#### 4.1.3. STATEMENT OF THE ACTING HEAD OF DEPARTMENT

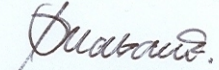
The Free State Department of Health has the following 7 strategic goals which are aligned with the strategic intent of the government:

1. Provision of strategic leadership and creation of social compact for better health outcomes
2. Improve the quality of health care services
3. Reduce the burden of disease.
4. Revitalisation of physical infrastructure
5. Improved Human Resource Management.
6. Overhaul the health care system and improve its management.
7. Research and development

These strategic goals are aligned to the key mandates of the Department as outlined by the Member of the Executive Council for Health.

It is important to note that this 5year Strategic Plan is developed with a full understanding of the limitation of available resources. There is therefore a deliberate intention to phase-in the costly medium to long term interventions, whilst ensuring that interventions that are immediate in nature are fully funded for immediate implementation. The resources that will be placed at the disposal of this department will focused on addressing the above interventions as outlined.

I hereby commit the department within the availability of resources to achieve the long term intentions of the plan over the 5 year period.

  
**Dr S Kabane: Acting Head of Health**  
Date: ..... 08 March 2010 .....

#### 4.1.3. OFFICIAL SIGN OFF: CHIEF FINANCIAL OFFICER)

The budget allocation has decreased over the past 3 years due to decreased population caused by among other things migration. However the burden of disease has increased.

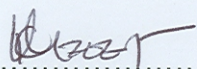
This has a detrimental effect on the ability to deliver health services.

The Service Transformation Plan (STP) is being reviewed to take into consideration the financial situation. The whole platform must take account of the availability (and ability to train) appropriate staff and packages of services. Local consolidation of services at district level will create an appropriate service platform while promoting the efficient use of resources.

#### Key issues in this regard include:

- Allocation and efficient management of adequate resources for implementation of the various mandates of the department
- Provision for the redistribution of resources
- Enabling management by efficient delegations

By means of cost effective management of the envelope of available resources the department will strive to deliver health services to the community



.....

**Mrs K Mzozoyana**  
**Chief Financial Officer**  
08/08/2010

#### 4.1.4. OFFICIAL SIGN OFF: HEAD OF STRATEGIC PLANNING

Strategic direction is derived from political imperatives contained in the Government Programme of Action.

The Free State provincial government developed Operation Hlasele from these priorities.

Health sector imperatives derive from the National Health Sector Strategic Plan 2009 to 2014. Various international agreements such as the Millennium Development Goals further inform the plan. The health summit informed the turnaround strategy of the department.

This 5 year plan was developed during a process of extensive consultation within and between clusters.

A series of 3 workshops attended by top management, extended top management and the office of the MEC.

Three different task teams also worked on the document. These task teams comprised of representatives of each of the executive management clusters. Information, analysis and content is derived from inputs from the various information systems and service delivery components of the department.

During January and February the plans were again reviewed to ensure alignment between the Government Programme of Action, the 5 year Strategic Plan and the Annual Performance Plan

The final document was approved by the by the Acting HOD and the MEC.

The Service Transformation Plan is being reviewed in the light of changing resources and mandates. This will establish the service platform over the longer term.

This plan is linked to the various plans and business cases which direct service delivery in the department including:

- POA of Free State Legislature
- District Health Plans
- Conditional grants
- STP and others

Implementation of this plan is linked to the allocation and efficient management of the available resources

  
JE MACKENZIE

DIRECTORATE STRATEGIC, INFORMATION AND RISK MANAGEMENT  
8 MARCH 2010

## **PART A: STRATEGIC OVERVIEW**

### **4.2.1. VISION, MISSION AND VALUES**

#### **Vision**

The vision of the department is:

“A healthy and self reliant Free State Community”

#### **Mission**

The Free State Department of Health:

- Provides quality, accessible and comprehensive health services to the Free State community
- Optimally utilizes resources to provide caring and compassionate services
- Empowers and develops all personnel and stakeholders

#### **Values**

The key determinants of relationships within the department are:

- Accountability
- Batho Pele
- Botho
- Commitment
- Integrity
- Respect
- Transparency
- Trust
- Discipline

#### **Key enablers**

- Support
- Team approach.
- Government Cluster approach and inter-sectoral collaboration.
- Monitoring and Evaluation
- Timely Corrective Actions
- Interdependence

### **4.2.2. LEGISLATIVE AND OTHER MANDATES**

**The Free State Department of Health derives its mandate from the following legislation:**

- Constitution of the Republic of South Africa, 1996 (Act No. 108 of 1996)
- National Health Act, 1977 (Act No. 63 of 1977)
- National Health Act, 2003 (Act No. 61 of 2003)
- Free State Hospitals Act, 1996 (Act No.13 of 1996)
- Free State Health Act, 1999 (Act No. 8 of 2000)
- Free State School Health Services Act, 1998 (Act No. 11 of 1998)
- Free State Nursing Education Act, 1998 (Act No. 15 of 1998)

**The Department functions within the provisions of all applicable legislation including:**

- Public Finance Management Act, 1999 (Act No. 1 of 1999)
- Public Service Act, 1994, (Proclamation 103 of 1994)
- Labour Relations Act, 1995 (Act No. 66 of 1995)
- Basic Conditions of Employment Act, 1997 (Act No 75 of 1997)
- Treasury Regulations issued in terms of the PFMA
- Free State Provincial Revenue Act, 1998 (Act 12 of 1998)
- Preferential Procurement Policy Framework Act, 2000 (Act 5 of 2000)
- Division of Revenue Act, 2007 (Act 1 of 2007)
- Free State Appropriation Act, 2005 (Act 1 of 2005)
- Free State Adjustment Appropriation Act, 2005 (Act 9 of 2005)
- Provincial Health Act, (Act 3 of 2009)
- Appropriation Act, 2008 (Act 1 of 2008)
- Adjustment of Appropriation, 2008 (Act 4 of 2008)

**Health Sector Legislation:**

- Mental Health Care Act, 2002 (Act No. 17 of 2002)
- Medicine and Related Substance Act, 1965 (Act No. 101 of 1965)
- Human Tissue Act, 1983 (Act No. 65 of 1983)
- Pharmacy Act, 1974 (Act No. 53 of 1974)
- Health Professions Act, 1974 (Act No. 56 of 1974)
- Health Laws Amendment Act, 1977 (Act No. 36 of 1977)
- Nursing Act, 2005 (Act 33 of 2005)
- Dental Technicians Act, 1979 (Act No. 19 of 1979)
- Prevention and Treatment of Drug Dependency Act, 1992 (Act No. 20 of 1992)
- Choice on Termination of Pregnancy Act, 1996 (Act No. 92 of 1996)
- Sterilisation Act, 1998 (Act No. 44 of 1998)
- National Health Laboratory Service Act, 2000 (Act No. 37 of 2000)
- Traditional Health Practitioners Act, 2004 (Act No. 35 of 2004)
- Free State Initiation School Health Act, 2004 (Act 1 of 2004)
- Atmospheric Pollution Prevention Act, 1965 (Act No. 45 of 1965)
- Hazardous Substance Act, 1973 (Act No. 15 of 1973)
- Health and Welfare Matters Second Amendment Act, 1993 (Act No.180 of 199)

#### 4.2.3. SITUATION ANALYSIS

##### **Performance (service delivery) environment**

The department has for the past several years experienced an increased patient load due among other things to the high and increasing burden of disease while the resources to meet this demand have not increased at the same pace.

The Health Sector as a whole is under pressure for increased funding. The result has been noted in the increasing incidents of medicines running out. Most significantly the personnel within the department in various sections are working under conditions of being severely under staffed. The resultant adverse incidents in the health institutions bear testimony to inadequate human resources employed. In spite of this the department has been consistently over spending on allocated funding for compensation of employees.

The department has also gained a negative reputation emanating from its efficacy in the provision of emergency medical services and emergency transportation of patients between institutions. It is a well known fact that there are over 20 000 individuals with adequate qualifications to be employed within the Emergency Medical Services in spite of the continuing high vacancy rates of this category of personnel in Free State Provincial Health Services.

This situation has been compounded by concurrent shortages of medical personnel in the out-lying areas of the province, away from major centres. Due to the lack of medical personnel, referral of patients to the next level of care has of necessity increased. This has the effect of increasing demands at higher levels of care and decreased utilisation of the primary levels. The result is increased cost of care.

Against this background the department has embarked on a mission to overhaul its systems and areas of emphasis. In the immediate future the primary health care will receive a much boosted prominence and prioritization, however it cannot be said that this will happen even if tertiary health care is compromised as this service is just as essential for the community of the Free State province.

Over the last few years the department has deliberated on the ways and means of overhauling and revamping the service. Towards this end the Service Transformation Plan has been developed. It is a fact that this plan has not been implemented for various reasons least of which is not the lack of necessary funding for the plan and the lack of requisite support from the political sphere for such implementation.

This service transformation plan specifically attempts to address the legacies of the past. As an example duplicated institutions of health care that were the order of the day during the Apartheid era, are still in existence and spreading personnel very thinly in institutions that were in certain instances not even necessary to continue in operation. This example also illustrates the difficulties that the implementation of the plan has faced and will still face when communities comfortable with having their own hospital or own ambulance were to suddenly be told that they would have to use the hospital in the next town and rely only on a clinic for the minor ailments.

The arrival of a new cycle for planning for service delivery affords the Free State Health department an opportunity to rethink the strategies employed in the past. This coming from the strategic goals outlined above put us in a situation where we can say:

“The health system will be overhauled in 3 to 5 years. This will be underpinned by improved quality of health care, well managed resources, a community engaged in their health care and documented improvement in health outcomes”

## **Maintenance of facilities, machinery and equipment**

### **Financial management:**

The distribution and allocation of resources has not necessarily been assisting the department to meet its priority mandates. The periodic unavailability of anti-retroviral medicine and other essential medicaments is a stark example of this malady. It is therefore of paramount importance that in this planning phase the department considers developing and implementing a finance model that is responsive to the priorities and mandates of the department.

The prevailing economic situation of the world has had its influence on the departmental financial performance. It is possible that the systems of the department also contributed more to the challenge of non-compliance with standards set in relation to payment of creditors and service providers.

Currently the department has nearly 16 000 employees and it is incredible to note that they have procured what the service delivery needed even though there has not been an induction program for procurement within the department. The knowledge has to date been transferred from one person to the other.

The requirements for proper asset management have not consistently been realised. This was manifested by significant differences of estimated value of assets in possession by the department as opposed to the assessments done by the auditor general.

Identification of assets especially in relation to their location has been a particular challenge due to lack of appropriate systems of keeping track of assets.

The Logis Systems currently utilized to keep record of assets in possession by the department has not been optimum due to the number of staff it requires for full implementation. In support of this system a mechanism of utilizing barcodes to identify assets was implemented. The interface between these two systems (Logis and Bar coding) is currently a challenge.

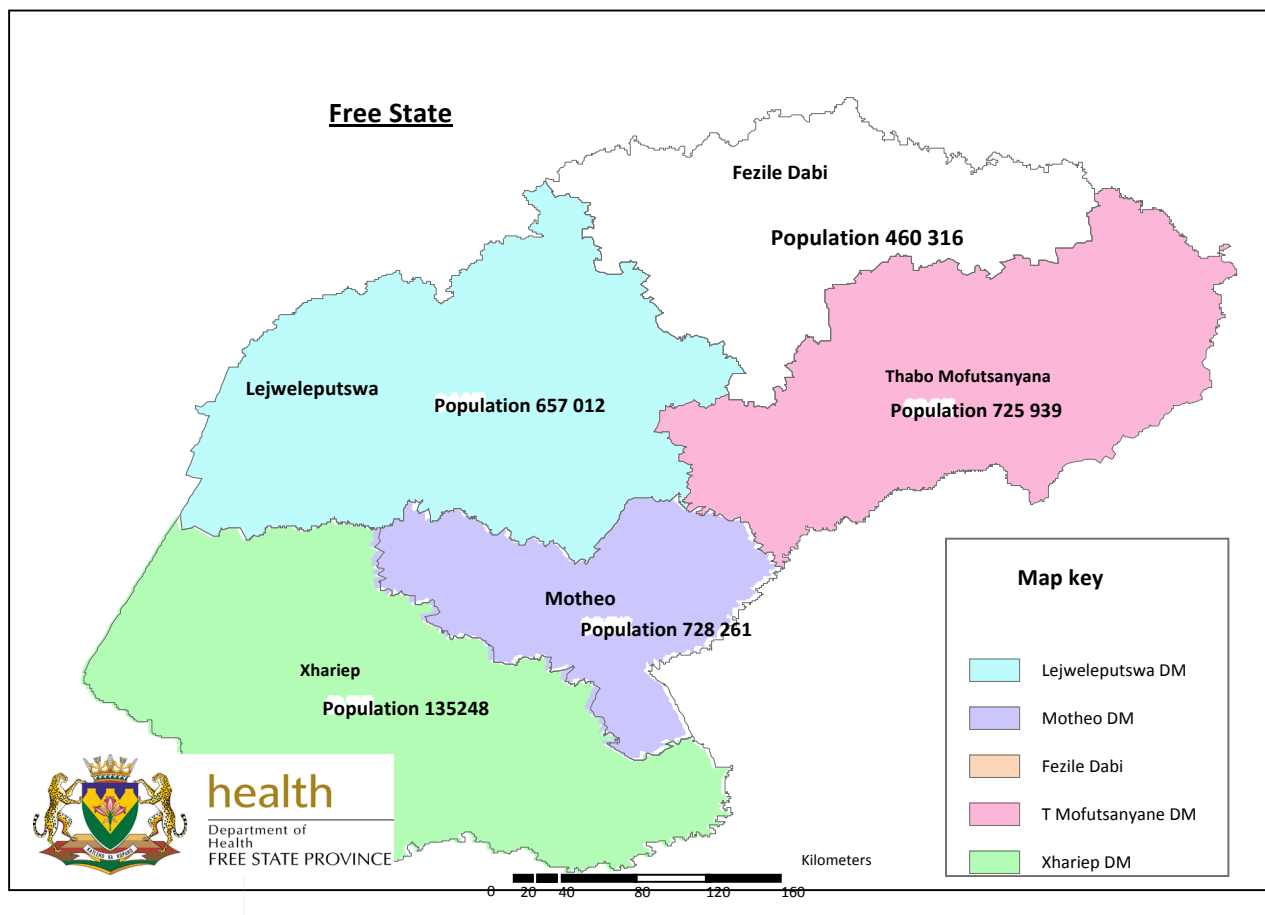
In collaboration with national treasury integrated planning is underway to develop a much improved asset registering system. In the short term the department is establishing service hubs in the five districts. The attempts to optimise the number of personnel currently responsible for logistics including asset management.

## **DEMOGRAPHIC PROFILE**

The Free State is divided into 5 districts namely, Xhariep, Motheo, Lejweleputswa, Thabo Mofutsanyana and Fezile Dabi. The districts are further subdivided into 20 local areas.

### **Districts of the FS with populations (Statistics SA., 2007b)**





### Population.

The FS Province has the second smallest population of the provinces representing (5.9%) 6.2% of the population of South Africa, occupying 11% of the country's land area at 129 480 km<sup>2</sup>. The population density was recorded as 20,9 per km<sup>2</sup> in 2001 and has changed very little since 1996 when it was recorded at 20,3 per km<sup>2</sup> as shown in Table 3.4 (Statistics SA., 2006), and Figure 3 (Statistics SA., 2004). (Mid – year population estimates 2009)

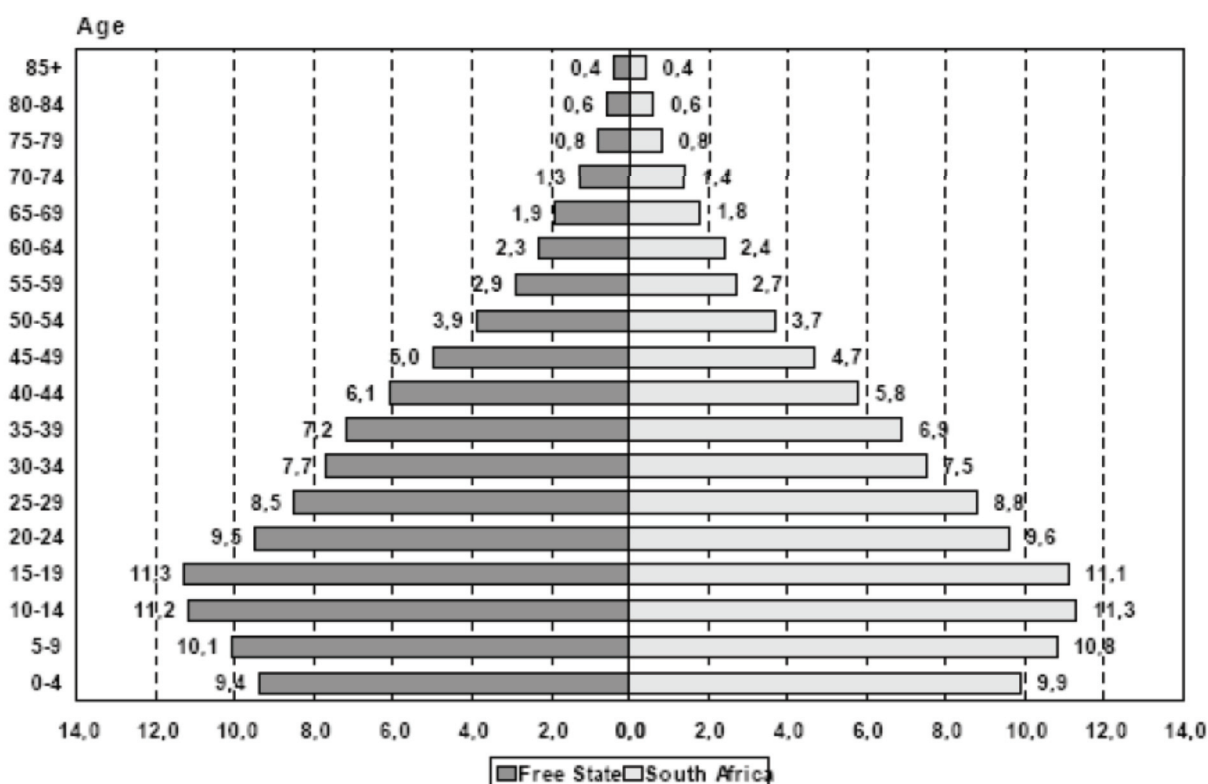
### Urbanisation

The province is large and sparsely populated with seventy six percent (76%) of the overall population living in urban areas. The Motheo district in which Bloemfontein is located, has the highest level of urbanisation (81,1%), followed by Fezile Dabi (76,0%) and Lejweleputswa (68,4%). Thabo Mofutsanyana in the east had the highest non-urban population (59,8%), followed by Xhariep (51,6%) (Statistics SA., 2007a).

Whilst the Free State has a population of 2,9 million people (Statistics SA., 2007), the population served by Universitas Academic Hospital is the larger area of Central SA with a population estimated at 4.3 million.

Data from the census of 2001 published in August 2005, revealed that (42.0%) 30% of the Free State population was under the age of 15 – 19 years, and (2.3%) 7.3% were over the age of 60 years as shown in below. Half are female, and 16% of all people over the age of 20 years have had no education.

## Age distribution of population in RSA and Central SA. (Statistics SA., 2004).



Both age group pyramids show a young population of similar age distribution in keeping with what one would expect in a developing country. The highest portion of the population for the Free State was in the 15 – 19 year age group. The figure above shows that 86% of the population of both the Free State and SA as a whole, are under the age of 49 years.

### Economy

Forty three percent (43%) of the group between 15 and 64 years of age in the FS, are Unemployed (Statistics SA., 2005b), which is double the unemployment figure for SA as a whole. The overall unemployment rate for the FS in 2003 and 2004 was 38.8% and 28.8% respectively (Statistics SA., 2007b).

In 2004, the FS contributed approximately 5, 5% to the economy of South Africa. Its average annual economic growth rate was 2,0%.

### Public Health Infrastructure in Central SA.

There are 34 hospitals in the FS providing 5513 beds to the population of 2.9 million people. However the estimated size of the population served by the FS health facilities is estimated at 4.3 million people when all the catchment areas of central SA are taken into consideration.

Related to the population size, the FS has a ratio of 104 919 people to each state hospital, or put in another way, 536 people per state bed, or 761 people per bed when the actual referral population to FS hospitals is considered. The ratio of state hospitals to population number per province is shown in the table below.

**Ratio of state hospitals to population by province**

Province	Population	State Hospitals	Ratio hospitals to population
KwaZulu-Natal	9 371 800	73	1 : 128 388
Gauteng	9 211 200	31	1 : 297 135
Eastern Cape	7 051 500	94	1 : 75 015
Limpopo	5 670 800	47	1 : 120 655
Western Cape	4 745 500	54	1 : 87 879
North West	3 858 200	26	1 : 148 392
Mpumalanga	3 252 500	27	1 : 120 462
Free State	2 958 800	34	1 : 104 919
Northern Cape	910 500	27	1 : 33 722
<b>SA TOTAL</b>	<b>47 390 900</b>	<b>410</b>	<b>1 : 115 587</b>

**State Hospitals in the FS**

Type of Hospital	No of hospitals	Number of Beds
District	27	2012
Regional/ Provincial	5	1930
Tertiary (Universitas)	1	647
<b>Total</b>	<b>33</b>	<b>4649</b>
Psychiatric	1	864
<b>Totals</b>	<b>34</b>	<b>5513</b>

There are 5 regional hospitals which receive referrals from the 27 district hospitals, the clinics and directly from the public. The current designated regional hospitals are:

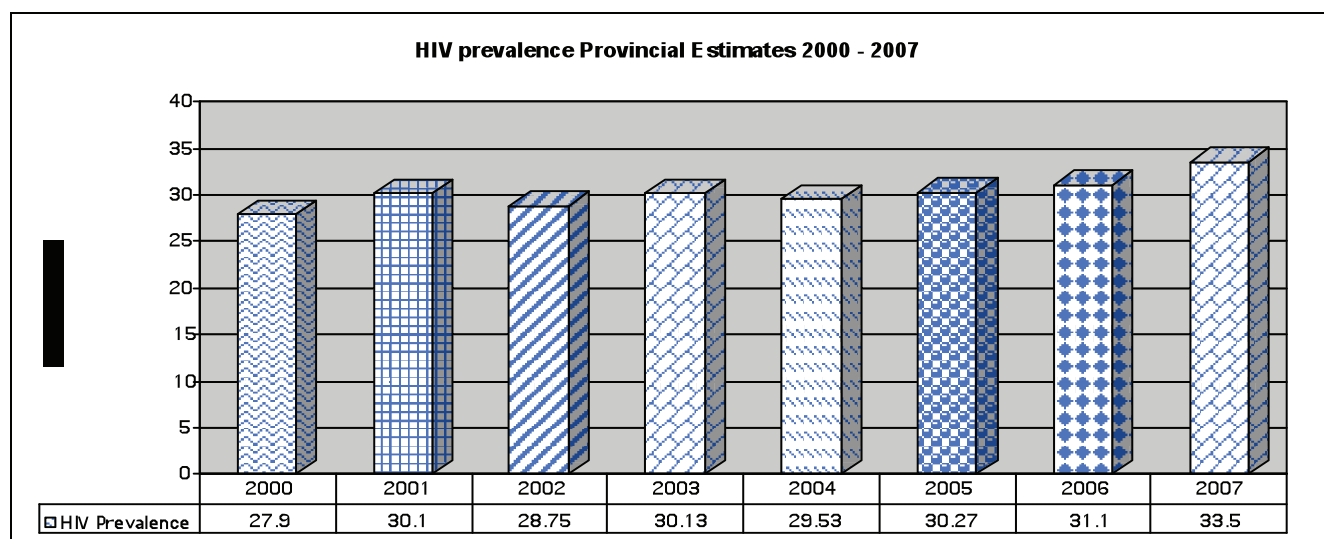
- Manapo Hospital in Qwa-Qwa
- Dihlabeng Hospital in Bethlehem
- Boitumelo Hospital in Kroonstad
- Bongani Hospital in Welkom
- Pelonomi Hospital in Bloemfontein.

Kimberley Academic Hospital is located in Kimberley in the Northern Cape Province just over the provincial border, but is included within the referral area of Central SA, as it uses Universitas Hospital as its tertiary level referral centre. Pelonomi hospital is also providing tertiary services to trauma, burns, infectious diseases and spinal surgery. The geographical locations of the hospitals are shown in the figure below.

**HIV AND AIDS****Epidemiological Information**

According to the 2007 National HIV Antenatal Prevalence Survey, the overall HIV prevalence estimates among first time antenatal care attendees in South Africa, is 28.0%. The Free State province is ranked second highest in the country with an HIV prevalence of 33.5% followed by Mpumalanga at 32% and Gauteng at 30.3%.

The Free State at 33.5% represents a 5.6% increase in HIV prevalence when compared to the 27.9% in 2000. Syphilis prevalence among the antenatal attendees in the same period, remained at 2.2% in 2007.



Source: Free State Province report of the national HIV and syphilis sero prevalence survey of women attending public antenatal clinics in South Africa – 2006 and HIV Antenatal Prevalence Survey 2007

## Tuberculosis Management

### Case Findings

A total of 24,428 TB cases, of which 20,848 were new Pulmonary TB cases, were reported in 2008. This translates to an incidence of 857/100 000 cases and places the Free State fourth in the country with the highest incidence of TB cases.

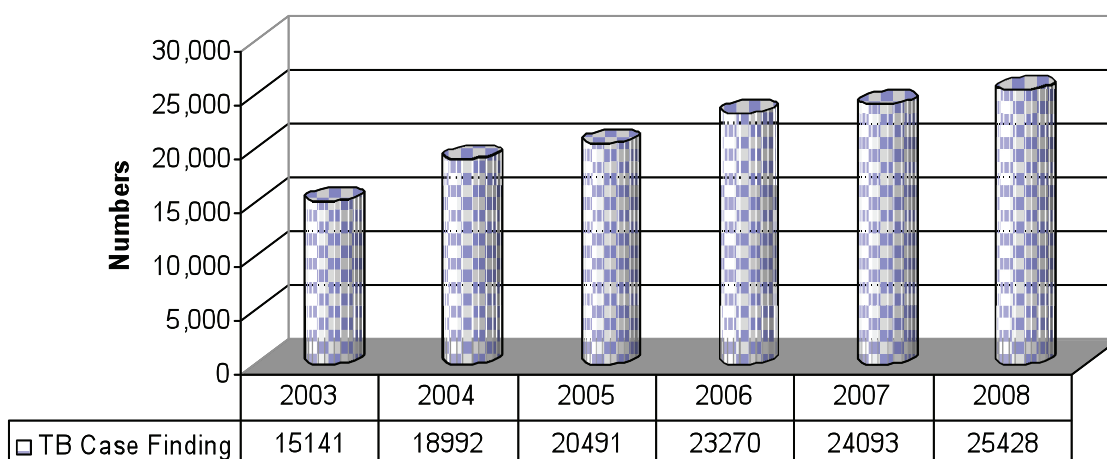
### Breakdown of all TB case incidence per100 000 per district for 2008

Lejweleputswa	1080,2
Motheo	913,8
Thabo Mofutsanyana	701,7
Fezile Dabi	626,8
Xhariep	1021,3

The district with the highest incidence and TB case load is Lejweleputswa. This is due to the gold mining industry in the district. This industry predisposes its employees to TB and most of its employees are resident or interact with the communities of this area. The cure rate of new smear positive cases is 71.4% (2007 cohort) and treatment interruption rate of new smear positive cases for the same period is at 4.7%.

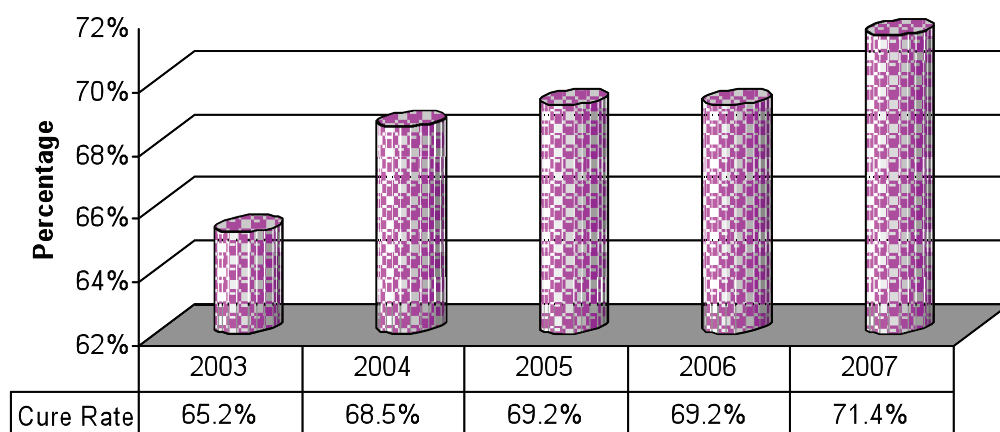
The death rate of all patients on TB treatment remains a concern at 13.6% for the 2007 cohort. This could be due to co-infection with both TB and HIV. TB and HIV collaborative activities have been strengthened including efforts to increase VCT uptake amongst TB patients as well as intensified TB screening among HIV positive patients. The incidence of MDR-TB is 1.12% of the total TB cases in the province for 2008. In the Free State, 15 cases of extensively drug resistance TB (XDR-TB) were identified up to 2008. The province has strengthened its efforts to detect MDR and XDR-TB patients.

### Free State Tuberculosis Case Finding for 2003 till 2008



Source: Free State TB Electronic Patient Database (ETR.Net) accessed 21/01/2010

### Free State Tuberculosis Cure Rate 2003 till 2007



Source: Free State TB Electronic Patient Database (ETR.Net) accessed 21/01/2010

## Maternal Health

The Annual Provincial Maternal Deaths Report for the 2006 calendar year reveals that a total of 189 maternal deaths were reported in the Free State, compared to 165 in the 2007 calendar year which brings the maternal mortality ratio to 288/100 000 live births.

### Maternal deaths per year

Year	Number reported FS	% deaths in SA	Deliveries FS*	MMR FS
1998	94	13.9		
1999	79	9.8		
2000	96	9.3		
2001	119	12	38859	306.2
2002	100	9.9	47546	210.3
2003	171	14	50190	340.7
2004	161	13.7	55939	287.8
2005	150	11.9	58357	257.0
2006	170	11.7	57976	293.2
2007	164	12	56670	289.4

Source: Saving Mothers 2005-2007 Report, NCCEMD

Analysis of the delivery patterns in the province show that the bulk of deliveries (75%) are done at primary health care level (CHC and district hospitals). Only 1 % of deliveries occur at tertiary level confirming a critical shortage of beds at that level. Of concern is the high number of deaths (38%) occurring at district hospital level suggesting problems in referring patients to specialist level

Deliveries and deaths at public institutions* 2005-2007					
	Deliveries	%	Deaths	%	MMR
PHC	28 087	18	1	0.2	3.6
Level 1	88 059	56.5	177	37.9	201
Level 2	38 160	24.5	247	52.9	647
Level 3	1 573	1	42	9	2 670
<b>Total</b>	<b>155 879</b>	<b>100</b>	<b>467</b>	<b>100</b>	<b>299</b>

Source: DHIS Information FSDOH

### A comparison of primary obstetric causes of death between 2005-2007 and 2002-2004 Free State province

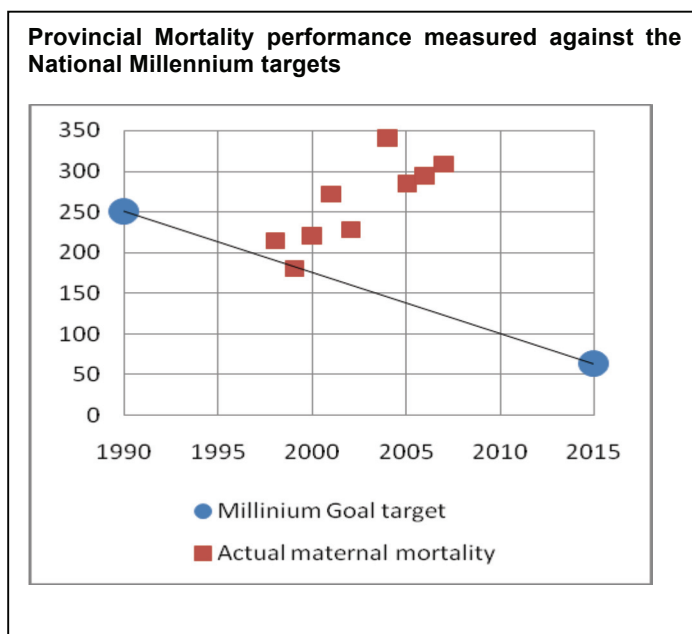
Primary Obstetric Cause	2005 - 2007		2002 - 2004	
	N	%	N	%
Direct	236	49.4	232	54.5
Hypertension	91	19.0	100	23.5
PPH	51	10.7	29	6.8
APH	15	3.1	14	3.3
Ectopic Pregnancy	5	1.0	6	1.4
Abortion	17	3.6	17	4.0
Pregnancy Related Sepsis	25	5.2	27	6.3
Anaesthetic related	22	4.6	18	4.2
Embolism	3	0.6		
Acute coll.	7	1.5	21	4.9
Indirect	216	45.2	182	42.7
Non Preg. Infect.	199	41.6	161	37.8
AIDS	113			
Pre-exist Med Dis	17	3.6	21	4.9
Unknown	26	5.4	12	2.8
<b>Total</b>	<b>478</b>	<b>100.0</b>	<b>426</b>	<b>100.0</b>

Source: Saving Mothers report 2005-2007, NCCEMD

Non pregnancy related infections is a major contributor to deaths in the province and highlights the need for access to antiretroviral treatment for pregnant women. Obstetric haemorrhage is the most important avoidable factor contributing to deaths in the province.

Maternal deaths in the province are not improving and the province is continuously struggling to achieve the Millennium Development Goals target. Posts for community specialist for obstetrics, paediatrics and anaesthesia have been created to address the issue of maternal deaths in the province, but could not be filled to date due to the financial situation in the province.

The available information clearly indicates that the Free State Department of Health needs to seriously prioritise the implementation of the recommendations of the national task team



## Child Health

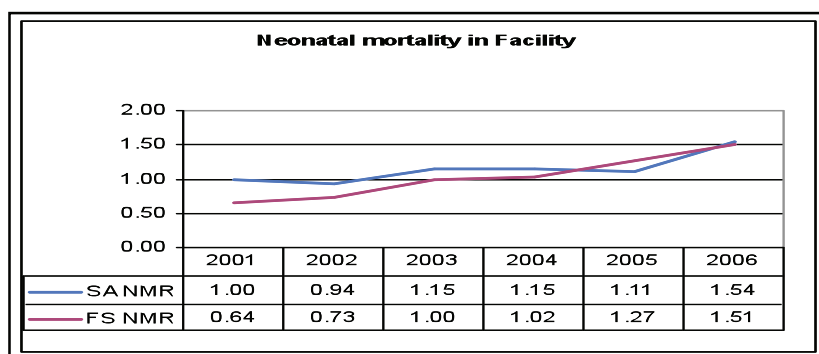
The provincial infant mortality rate of 66.1 per 1000 population under one year in 2005 decreased to 62.0 per 1000 for 2006. The under five mortality rate decreased from 18.4 (population under 5 years) in 2005 to 17.2 per 1000 in 2006. Amongst many other factors, the decrease may be attributed to the child survival strategies that are in place.

The goal of child survival strategies is to reduce child and infant mortality by 0.5% annually. The strategies implemented in this regard include the Integrated Management of Childhood Illnesses (IMCI), the Expanded Programme on Immunisation (EPI) and the Vitamin A Supplementation Programme.

## Perinatal and Neonatal Health

The fifth "Saving Babies" Report for the period 2003-2005 was published in July 2007 by the Medical Research Council (MRC). This report covers the Perinatal (0-7 days), stillbirth and neonatal (0-1 month) death rates. Five national recommendations were adopted for implementation in 2008/09. The recommendations are aimed at reducing the incidence of avoidable factors that cause death. Copies

of the report were disseminated in the province to ensure implementation of the five national recommendations. The quality of implementation is being monitored



Source: DHIS Data 2001- 2007

### ***Integrated Management of Childhood Illness (IMCI)***

Specialised staff trained to manage childhood illnesses and to fast track referrals of problems to appropriate levels proved to be effective and should be maintained. More specialised nurses need to be trained in IMCI principles. Community assessment and access should be improved through use of dedicated staff with the help of non governmental organisations

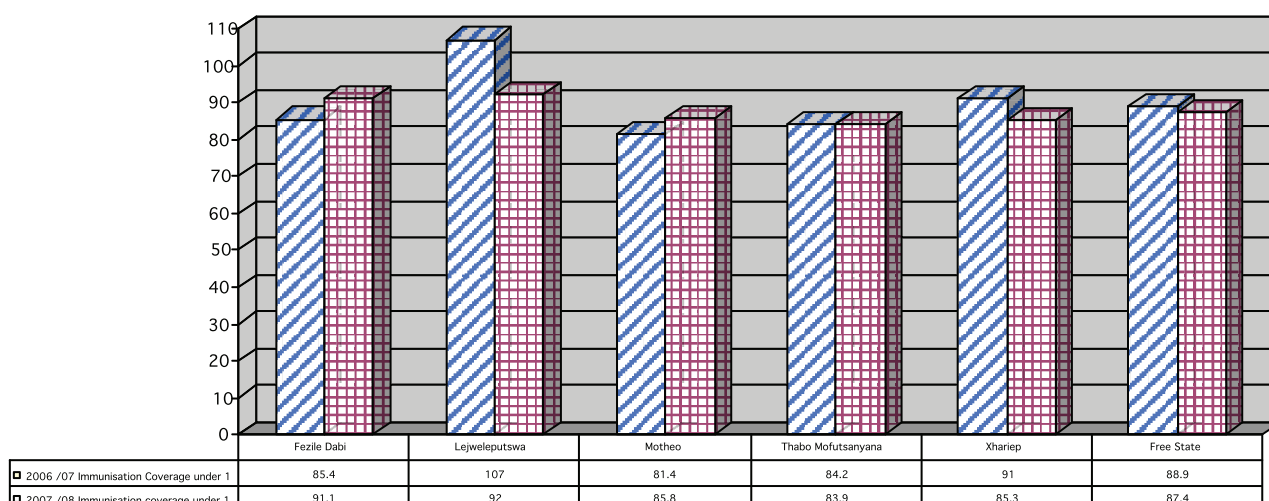
75% of PHC services have 60% saturation of IMCI trained personnel. All five districts and 15 sub districts are implementing the household and community IMCI component.

### ***Expanded Programme on Immunisation***

The immunisation coverage for children under one year has dropped from 88.9% in 2006 to 87.4% in 2007. To improve child survival, there is a special focus on measles coverage. The measles coverage under one year, increased from 89.2 in 2006 to 89.6 in 2007. The measles elimination strategy has been strengthened by the implementation of the Reach Every District (RED) strategy in all 5 districts and sub districts with low immunization coverage



Children fully immunised (under 1 year) per district - 2006/07 and 2007/08



Source: DHIS Data 2006 - 2007

## KEY SERVICE DELIVERY ISSUES

### Notes:

- Source Census in brief 2001 unless indicated otherwise.
- STATSSA is designated by the Statistician General as the custodian of official statistics.
- The health sector makes universal use of these sources and baseline markers of the same period to enable meaningful comparison across the sector.
- The identified sources of information are conducted at designated intervals. For example census is conducted every 10 years, with annual midterm estimates of key population markers.
- The SA Demographic and Household Surveys are conducted every 5 years.
- This enables consistent long term tracking of trends in key social and economic indicators over time.
- The data presented here does not fall within the mandate of the department and does not have a direct impact on decisions regarding health, but has an obvious impact on the health of the population and on the demand for health services.

### Dwelling Type per Household

Structure	Xhariep		Motheo		Lejwele-putswa		Thabo Mofut-sanyana		Fezile Dabi	
	2001	1996	2001	1996	2001	1996	2001	1996	2001	1996
Formal	31 267	24 555	147762	119638	110848	94601	110570	85981	86903	65552
Informal	6 136	4 951	48 038	38646	67849	58369	39698	28888	29466	31859
Traditional	1 386	853	9 963	11103	5104	5302	32425	40312	3799	6411
Other	89	293	598	619	669	2128	358	474	375	355

- Source: Census in brief 2001
- 2089 households do not live in a structure which provides "adequate" shelter

### Household Size

Household Size	Xhariep	Motheo	Lejweleputswa	Thabo Mofutsanyana	Fezile Dabi
	2001	2001	2001	2001	2001
1	7605	38114	33369	27252	125660
2	8196	42607	36936	30432	141939
3	6694	37033	32228	31167	128487
4	6187	34892	30129	30459	122421
5	4075	23223	20796	23345	85779
6	2610	13407	13007	15925	53631
7	1461	7620	7483	9912	31850

- Source: Census in brief 2001
- Average household size in the Free State is 3.6.

### Level of service per District Municipality in the Free State

District Municipality	Level of Service			Total households without adequate sanitation
	Urban		Farms	
	Buckets	None or unimproved pit	None or unimproved pit	
Lejweleputswa	41,928	6,406	15,180	63,514
Thabo Mofutsanyana	34,090	14,996	16,528	65,614
Motheo	31,744	31,001	8,702	71,447
Xhariep	3,077	3,455	10,140	16,672
Fezile Dabi	20,398	1,318	15,010	36,726
<b>Total</b>	<b>131,237</b>	<b>57,176</b>	<b>65,560</b>	<b>253,973</b>

Source: Census in brief 2001

### Health challenges related to use of the bucket system

It occurs that buckets are not emptied frequently enough and that spillage can occur. The resultant pollution exposes the surrounding communities to bacterial infections and attracts flies, rats and infections.

### Refuse removal in the Free State

Category of refuse removal	Number of households	% of total
Removed at least weekly by local authority	429 474	58%
Removed less than weekly by local authority	23 334	10%
Communal refuse dump	26 057	4%
Own refuse dump	184 555	25%
No rubbish disposal	69 880	3%
<b>Total</b>	<b>733 302</b>	<b>100%</b>

- Source: Census in brief 2001
- Excludes all collective living quarters

### Management of medical waste

The department has outsourced the management of medical waste for 31 hospitals, 222 clinics, 10 Community Health Centres, Laundries and Mortuaries to Compass Waste Services. The company collects, treat and dispose medical waste at approved sites.

### Safe drinking water

- 95.64% of the Free State population has access to relatively safe drinking water (piped water in dwelling, piped water inside yard, piped water on community stand more and less than 200 meter away).
- 4.3% of the population has access to water from not necessarily safe sources (borehole, spring, rainwater tank, dam/ pool /stagnant water, river/ stream, water vendor, other). The implications for this group are the risks they experience in terms of waterborne disease.
- At present waterborne diseases do not occur in significant ratios in the province.

## SOCIO ECONOMIC PROFILE

(Source Stats SA Census in brief 2001 unless stated otherwise)

### Employment

483 205 of the economically active population in the Free State found employment within the formal sector in 2001.

### Income

The Free State population is relatively poor. In 2001, 64.5% of households earned less than R30 000 per year. Poverty is predominantly rural, affecting mainly Africans and to a lesser extent Coloureds.

Approximately 22 254 million people in South Africa live in absolute poverty during 2001. In the Free State alone, approximately 1,544 million people lived in poverty, the majority (97%: 1 503 million) of them are Africans.

### Livelihood security

The proportion of people living in poverty in the Free State is 63.6%.

### Overview of the District Municipalities in the Free State

District Economies (2002)	Population	GDP	Unemployment	People living in poverty	Growth p.a. ('90-'02)
Motheo	26,0%	30,9%	41,1%	61%	1,3%
Lejweleputswa	26,9	26,5	36,6	66	-2,3
Thabo Mofutsanyana	26,3	14,0	34,1	72	0,3
Fezile Dabi	16,3	25,5	38,3	62	0,4
Xhariep	4,5	3,1	38,3	57	0,9
<b>Total</b>	<b>100,0</b>	<b>100,0</b>	<b>38,9</b>	<b>63.6 %</b>	<b>-0,1</b>

Source Stats SA census in brief

## ALTERNATIVE SERVICE DELIVERY OPTIONS

The Free State Department of Health entered into a 16.5-year concession agreement (later extended to 21 years) with Community Hospital Management (PTY) Ltd in 2002. This agreement was entered into through the guidance of the department of Public-Private Partnerships of National Treasury. Under this agreement (that commenced in September 2003), known as Universitas/ Pelonomi Co-location PPP project, the private partner Community Hospital Management (CHM) injected capital into the upgrading of 116 general beds and 11 intensive care unit beds and three exclusive use operating theatres at the Universitas Hospital, 127 general beds and 16 intensive care unit beds and two exclusive use operating theatres at the Pelonomi Hospital and a total of 10 theatres at Pelonomi Hospital to the tune of R20 million. In return CHM was allowed to operate private hospitals at both Universitas and Pelonomi, using state buildings, which buildings represented redundant capacity. In addition to the R20 million capital injection the state is getting a certain percentage of the turnover generated by the private hospital, as well as retains ownership of the buildings.

The private sector partner utilises both exclusive and joint facilities on a commercial basis. Service Level Agreements direct shared services as follows:

- Provision of utilities and air-conditioning to CHM by Universitas Academic (UAH) and Pelonomi hospitals. (PH)
- Maintenance of physical facilities – concession area
- Delivering of diagnostic radiology services at both sites
- Shared services:
  - UAH and PH
    - Diagnostic Radiology

- UAH
  - Gastro-enterology unit – share unit with designated areas
  - Renal dialysis unit – public and private units sharing resources
  - Adult and pediatric Cathlabs – CHM hire the facility if needed
  - Cardiothoracic theatres - CHM hire the facility if needed

### Milestones achieved to date

The planned investment of each partner is detailed below:

#### Free State Department of Health investment

Facility Upgrades	Cost in R million
Upgrade of Lifts at Universitas Hospital	2.5 complete and lift service has improved.
Concession payment in terms of Pelonomi Practical Completion	1.693
Concession payment in terms of total completion Universitas	5.780 amount has been paid.
Patient Transfer building at Universitas	0.25 Building complete and is being used as consultation rooms and admin offices for CHM

#### Private Partner Investment: Universitas and Pelonomi Construction

Facility Upgrades	Cost R million	Number of beds
Final phase of upgrading Pelonomi Private facility	R25 million	143 beds
Upgrade of UAH wards 9A and 9B and 8A		116 beds
Patient Drop off area at UAH		
Upgrading of Renal Unit at Universitas	R3 million	The facility was renovated to provide UAH with 13 dialysis points and National Renal Care with 8 points that is utilized separately with the use of shared sterile water resources.

The PPP is currently being reviewed, Transaction advisors were appointed to do a comprehensive review of the contract and to provide an exposition and examination of options for the FSDOH.

### Overview of the performance of the Free State Department of Health during 2004-2009

The department has for the past several years experienced an increased patient load due among other things to the high and increasing burden of disease while the resources to meet this demand have not increased at the same pace.

The Health Sector as a whole is under funded. Various avenues are being explored to obtain additional funding.

In order to ensure that resources (financial, personnel, infrastructure etc) are available to meet the demand at all levels of care the department is addressing the restructuring of the service platform over the longer term. This includes among other measures:

- Creation of service Hubs per district which will share scarce skills and resources like Supply Chain, financial management and other support and administrative services instead of duplicating all these scarce skills and assets at each institution and the district office.
- Finalisation and implementation of the Service Transformation Plan including:
  - Decrease in the number of clinics and a concomitant increase in the number of Community Health Centres.
  - Reconfiguration of identified District Hospitals which will operate as Community Health Centres.
  - Management and development of personnel will be updated by for example review of the skills mix and adoption of models from other sectors.
  - Decentralisation of EMS
  - Academic Health Services platform
  - Review of DHC module

- Alternative sources of funding and management models for funding must be found to enable the proposed transformation.
- Overhaul pharmaceutical services including the medical depot
- Creation of jobs via in-sourcing of services
- Ensure clean audits 2014
- Improve the management of Strategic Planning , information management and monitoring and evaluation

The shortage of funding for the OSD for nurses, increased inflation and higher health inflation, hamper the rendering of the full complement of health services. If the funding for OSD for all health professional categories is not provided, the fund shortages would be compounded.

It is projected that the Department will run out of cash towards December.

With limited funds available, the department has to prioritise the implementation of the plan. In many instances Institutions struggle to fulfill their mandate. Stringency measures have been implemented during each of the last four years in the department with various levels of impact on the performance of the department

The ultimate goals of any health system are:

- Improved Health Outcomes
- Financial Risk Protection
- Responsiveness to the health needs of the population it serves
- Emphasis on preventative and promotive health care

It is important that any analysis of the impact of the stringency measures is aimed at determining this impact on the health system as a whole. It should also determine the extent to which it affects the ability of the health system to achieve each of its ultimate goals.

It is important to note that the stringency measures have been applied over the past four years without fail, and therefore the impact of these measures can already be felt by the health system even allowing for their “lag effect”. In other words some of the system failures we are currently experiencing are a result of the implementation of the stringency measures some four years ago.

A quick analysis of the Free State Provincial health system will indicate that it has the following features, which are alarming and indicate poor performance:

***Impact of the financial situation on the performance of the department***

- Long and increasing waiting times for services
- High and increasing maternal mortality rate
- High and increasing infant and child mortality rates
- Increasing deaths due to TB, HIV and AIDS
- Increasing incidence and prevalence of non-communicable diseases

The departmental turnaround plan consists of the decisions reached at the Health Summit.. The implementation of the annual cost containment measures will further inform the final draft of each of the Annual Performance Plans as necessary.

It is crucial that the critical under funding of health services in the country be addressed as a matter of urgency to minimise the undesirable consequences of some of the cost containment measures which have become unavoidable.

In some cases, additional funding is necessary to establish the required means of cost containment. In the longer term, savings are anticipated to result from these measures.

### **Key service delivery issues (including social determinants of health)**

Among the consequences of the issues discussed elsewhere, the following concerns need to be addressed during the planning time frame:

- Health Outcomes
- Community and client satisfaction
- Personnel shortages and high turnover rates
- Inappropriately placed facilities
- Too many hospitals and clinics.
- Insufficient CHCs
- Insufficient EMS personnel and vehicles(158/279)
- Appropriate and accessible service platform and referral system
- Prioritisation of service delivery needs within the available resources
- Stagnant Outreach and Telemedicine Services
- Costly medication, blood products and lab services
- Costly staff establishments
- Purification of levels of service at the expense of good health outcomes

#### 4.2.5. ACCELERATING PROGRESS TOWARDS THE MILLENNIUM DEVELOPMENT GOALS (MDGs)

##### 4.2.5.1. REVIEW OF PROGRESS TOWARDS THE HEALTH-RELATED MILLENNIUM DEVELOPMENT GOALS (MDGs) AND PROGRESS REQUIRED BY THE UNITED NATIONS IN 2015

MDG GOAL	TARGET	INDICATOR	SOUTH AFRICA'S PROGRESS IN 2004-2009	FREE STATE 2007 UNLESS OTHERWISE INDICATED	SOURCE OF DATA	SOUTH AFRICA'S REQUIRED PROGRESS BY 2015
<b>Goal 1: Eradicate Extreme Poverty And Hunger</b>	Halve, between 1990 and 2015, the proportion of people who suffer from hunger.	Prevalence of underweight children (under five years).	29 165 children suffered from malnutrition in 2007.	956 severely malnourished under 5	Development Indicators Mid-term Review, published by the Presidency, RSA, 2008.	Not more than 14, 582 children presenting to health facilities with severe Malnutrition.
		Under-five mortality rate.	58 per 1000	68.2 per 1000 (SADHS 2003)	South Africa Demographic and Health Survey (SADHS) 2003	19,7 per 1000 (or less)
<b>Goal 4: Reduce Child Mortality</b>	Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	Infant mortality rate.	43 per 1000	48.1 (SADHS 2003)		14,3 per 1000 (or less)
		Proportion of one year old children immunized against measles	85,8% in 2007	Measles coverage under 1 year 87.4% (DHIS)	District Health Information System (DHIS), National DoH, 2007.	100%
<b>Goal 5: Improve Maternal Health</b>	Reduce by three-quarters, between 1990 and 2015, the maternal mortality rate	Maternal mortality ratio.	147 per 100 000	288 per 100 000 (MCWH)	National Confidential Enquiries into Maternal Deaths, 2002-2004	36,8 per 100 000 (or less)
		Proportion of births attended by skilled health personnel.	92%	90% (DHIS) (to use SADHS)	South Africa Demographic and Health Survey (SADHS) 2003	100%



MDG GOAL	TARGET	INDICATOR	SOUTH AFRICA'S PROGRESS IN 2004-2009	FREE STATE 2007 UNLESS OTHERWISE INDICATED	SOURCE OF DATA	SOUTH AFRICA'S REQUIRED PROGRESS BY 2015
Goal 6: Combat HIV and AIDS, malaria and other diseases	Have halted by 2015, and begin to reverse the spread of HIV and AIDS.	HIV prevalence among 15- to 24-year-old pregnant women.	12,9% (amongst 15-19 year old)	31.5% (National HIV and Syphilis Prevalence Survey of SA 2007)	National HIV and Syphilis Prevalence Survey of South Africa 2007	9.5 (or less) 50% reduction in prevalence
			28,1% (amongst 15-19 year old)		National HIV and Syphilis Prevalence Survey of South Africa 2007	9.5 (or less) 50% reduction in prevalence
	Have halted by 2015, and begin to reverse the spread of HIV and AIDS.	Contraceptive prevalence rate 65%	65%	11 condoms per male per month DHIS	South Africa Demographic and Health Survey (SADHS) 2003	85%
	Have halted by 2015, and begin to reverse the incidence of malaria and other major diseases.	Proportion of tuberculosis cases detected and cured under directly observed treatment, short-course (DOTS).	64%	71.3% (ETR:Net)	DHS	85%

**Note:** The mortality rates were previously calculated based on population numbers in the denominator. For planning purposes going forward the SADHS figures will be used for standardization. It is necessary to establish systems which will be able to measure this annually. In the meantime facility data can be used as an annual measure in the Annual Performance Plan.



#### 4.2.4. STRATEGIC GOALS OF THE DEPARTMENT

STRATEGIC GOAL	GOAL STATEMENT	RATIONALE	EXPECTED OUTCOMES
1. Provision of strategic leadership and creation of social compact for better health outcomes	Integrated planning.	Integrated planning pools (leverages) all resources directed towards effective service delivery	<ul style="list-style-type: none"> <li>Strong governance structures</li> <li>Strong collaboration with all stakeholders including patients</li> <li>Shared responsibility for good health outcomes.</li> </ul>
	Strengthen collaboration with stakeholders		
	Strengthen governance structures		
2. Improve the quality of health services.	Promote of holistic patient care	Improvement of patient and other stakeholder satisfaction	<ul style="list-style-type: none"> <li>The health services of acceptable standards are delivered.</li> <li>The services are rendered in a transparent manner to ensure clean audits.</li> </ul>
	Implement comprehensive health services		
	Improve information management		
	Improve implementation of quality improvement strategies		
3. Reduce the burden of disease	Promote healthy life styles	Realization of macroeconomic benefits.	Quality of life in the general community is improved
	Increase utilisation of preventative measures		
	Increase utilisation of effective interventions		
	Improve turnaround times		
4. Revitalization of physical infrastructure	Improve the maintenance and upgrading of facilities.	Delivery of health care services performed in safe and accessible facilities that have appropriate equipment and machinery.	The quality of health care services is improved.
	Ensure availability of appropriate technology		
	Improve management of assets.		
	Implementation of a comprehensive Human Resources Plan.		
5. Improved Human Resource Management.	Improve skills of personnel	Enhancement of performance of personnel for improved quality of health care services and social upliftment.	Sustainable health service delivery
	promote employability		
	Promote provision of comprehensive health services		
	Strengthen Governance structures		
6. Overhaul the health care system and improve its management.	Improve financial management	Turn around the recent trend of unresolved challenges and negative audits.	Clean audits
	Improve availability of Medicines and consumables		

STRATEGIC GOAL	GOAL STATEMENT	RATIONALE	EXPECTED OUTCOMES
7. Research and Development	Conduct or commission research studies into: <ul style="list-style-type: none"> <li>▪ Accurately quantify infant mortality</li> <li>▪ Support for research</li> <li>▪ Health and nutrition survey linked to social determinants of health</li> <li>▪ Medicines</li> <li>▪ Promotion of indigenous knowledge systems and use of appropriate traditional medicines</li> </ul>	Generate key information for health planning, health service delivery and monitoring.  Establish partnerships with relevant research institutions.	Informed managerial decisions.

### Climate and general morale of personnel.

#### *Organisational environment*

The department currently has a staff complement of just over 16000 having shrunk from over 17000 in the last quarter of 2008. The decrease in the number has been a deliberate measure to right size the staff according to available financial resources. The contradiction to this is the fact that there is a telling shortage of skilled personnel in the department.

There is a departmental retention strategy in place that aims to retain within the department, people with scarce skills. The success of this strategy needs to be evaluated at the beginning of this new planning phase. The reasons for the review are manifested in the notably high turnover and vacancy rates at the critical areas of service delivery. There are various vacancies that could be blamed on inadequate coaching and mentoring of personnel.

In an attempt to improve human resources the department has also spent significant amounts of money on offering bursaries to promising students. Most unfortunately the current situation of lack of adequate financial resources has resulted in the department being unable to employ many of those who qualified.

The management of the department had in the past called regular meetings with all personnel in the form of "Staff Indaba". Did these serve to improve climate? The authors believe this should remain a question to be answered by the current administration.

In general the verdict on the organizational environment is not a positive one and the department still needs to make huge strides just to come to par with the expectations of its community.

#### 74.2.5.2. HEALTH RELATED MDGS AND KEY PROVINCIAL ACTIVITIES TO ACCELERATE PROGRESS

MDG GOALS	INDICATORS	KEY ACTIVITIES	TARGETS FOR 2015 (OUTPUTS)	OUTCOMES (IMPACT)
<b>Goal 1:</b> Eradicate extreme poverty and hunger.  <b>Target 2:</b> Halve, between 1990 and 2015, the proportion of people who suffer from hunger.	<b>National:</b> Prevalence of underweight children (under five years)  <b>Free State:</b> Incidence of severe malnutrition under five years.	Implement the food supplementation programme.	Reduce severe malnutrition to 5 per 1000 population under 5 years.  (Baseline : 956 severely malnourished under 5 – DHIS 2007).	Extreme poverty and hunger reduced.
	Proportion of the population below minimum level of dietary consumption.	Implement the food supplementation programme.	100 000 people receiving food supplementation programme.	Reduced proportion of population below minimum level of dietary consumption.
<b>Goal 4:</b> Reduce child mortality  <b>Target 5:</b> Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.	Under-five mortality rate	Implement IMCI Strategy	28 per 1000 Under-five years (SADHS baseline 68,2 in 2003)	Reduction of Child Mortality Rates.
	Infant mortality rate.	Implement PPPIP task recommendations.		
		Strengthen expanded programme on immunization.	20 per 1000 under 1year	
		PMTCT Dual Therapy.	(SADHS baseline 48,1 in 2003)	
	Measles coverage under 1 year.	Immunization against measles.	94% of one year old children immunized against measles.	

MDG GOALS	INDICATORS	KEY ACTIVITIES	TARGETS FOR 2014 (OUTPUTS)	OUTCOMES (IMPACT)
<b>Goal 5: Improve maternal health</b>  <b>Target 6:</b> Reduce by three-quarters, between 1990 and 2015, the maternal mortality rate.	Maternal mortality ratio.	Effective antenatal care.	Less than 208 per 100 000 live births. (288 per 100 000 in 2007) (Baseline 372,2 per 100 000 Stats SA 2006)	Reduction of Maternal Mortality Rate
		Antiretroviral therapy for pregnant HIV positive women.		
		Prioritise interventions to address the preventable causes of maternal deaths.		
	Proportion of births attended by skilled health personnel.	ESMOEE training (Essential steps in the management of obstetric emergencies).  Accreditation of facilities based on skills level of personnel according to defined standards.	95% of births attended by skilled health personnel	

MDG Goal	INDICATORS	KEY ACTIVITIES	TARGETS FOR 2014 (OUTPUTS)	OUTCOMES (IMPACT)
Goal 6: Combat HIV and AIDS, malaria and other diseases.	HIV prevalence among 15- to 24-year-old pregnant women	Implementation of the National Strategic Plan for HIV and AIDS	100% of health facilities offering a complete package of contraceptive methods	Reduction of HIV prevalence.
			5% reduction in prevalence of HIV among 15 to 24 year old pregnant women	
Target 7: Have halted by 2015, and begin to reverse the spread of HIV and AIDS .	Number of children orphaned by HIV and AIDS	Multisectoral approach to care and support of children orphaned by HIV and AIDS	No baseline	Decreased level of children orphaned by HIV and AIDS

MDG Goal	INDICATORS	KEY ACTIVITIES	TARGETS FOR 2014 (OUTPUTS)	OUTCOMES (IMPACT)
<b>Goal 6:</b> Combat HIV and AIDS, malaria and other diseases.  <b>Target 7:</b> Have halted by 2015, and begin to reverse the spread of HIV and AIDS .	Prevalence and death rates associated with malaria.	Strengthen Travel Medicine Services:  Monitor Travel Medicine services.  Increase awareness through Health Promotion campaigns.	All Travel Medicine Service Providers registered.  Strategic Health programmes and Medical Support cluster  Please provide	Communicable diseases contained
	Proportion of the population in malaria-risk areas using effective malaria prevention and treatment measures.  Prevalence and death rates associated with tuberculosis.	(Free State is not a malaria endemic area)  Strengthen management of co-infected patients.  Facilitate implementation of Isoniazid Preventive Therapy.	Less than 5% death rate amongst notified TB patients.	Reduced mortality due to TB.

MDG GOALS	INDICATORS	KEY ACTIVITIES	TARGETS FOR 2014 (OUTPUTS)	OUTCOMES (IMPACT)
<p><b>Goal 6:</b> Combat HIV and AIDS, malaria and other diseases.</p> <p><b>Target 8:</b> Have halted by 2015, and begin to reverse the incidence of malaria and other major diseases.</p>	Proportion of tuberculosis cases detected and cured under directly observed treatment, short-course (DOTS).	Implement the National TB Strategic Plan.	85% cure rate (conditional on implementation of IPT). (current: 71,4%)	Reduced incidence of drug resistant TB.
<p><b>Goal 8:</b> Develop a global partnership for development</p> <p><b>Table 1 Target 17:</b> In cooperation with pharmaceutical companies, provide access to affordable drugs in developing countries.</p>	Proportion of the population with access to affordable essential drugs.	Review and strengthen Drug Supply mechanisms.	A standardised drug supply system established.	Efficient and effective drug availability.

4.2.6. IMPLEMENTATION OF NATIONAL HEALTH SYSTEMS (NHS) PRIORITIES 2009-2014				
	NHS PRIORITY (STRATEGIC OBJECTIVES)	KEY ACTIVITIES	TARGETS FOR 2014 (OUTPUTS)	OUTCOMES (IMPACT)
01	Provision of Strategic leadership and creation of Social compact for better health outcomes	Provide strategic leadership.	Implementation of the political strategic direction in the Free State Department of Health.	5 Year Plan and Annual Performance Plan aligned to the national health and political strategic imperatives.
		Mobilize leadership structures of society and communities.	Number (actual) of functional governance structures: <ul style="list-style-type: none"> <li>Provincial health councils 1</li> <li>District health councils 5</li> <li>Mental health review boards 3</li> <li>Hospital boards 19</li> </ul>	Align the Hospital Boards and Mental Health Review boards with Mental Health Care Act and National Health Act
		Communicate policy to promote buy in to support government programmes.	Provincial Consultative Health Forum established Provincial Communication Strategy Published	All plans aligned with government Programme of Action
		Review of policies to achieve NHS and MDG goals.	Implementation of stated policies monitored	Annual progress report submitted to NDoH on implementation of NHS priorities
02	Implementation of the National Health Insurance	Impact assessment and programme evaluation	5 year evaluation on performance commission	5 year evaluation on performance
		Conduct accreditation of health facilities based on quality of care provided	Implement appropriate and functional service platform.	STP reviewed and implemented



	NHS PRIORITY (STRATEGIC OBJECTIVES)	KEY ACTIVITIES	TARGETS FOR 2014 (OUTPUTS)	OUTCOMES (IMPACT)
03	Improving the Quality of Health Services	Focus on Maluti a Phofung Sub District as one of 18 Health districts by implementing a quality improvement plan which focuses on the following key service delivery indicators: TB Cure Rate HIV Prevalence Maternal Mortality Rate Infant Mortality Rate Child Mortality Rate	Quality Improvement Plan implemented and monitored in Maluti a Phofung Sub District.	Improving the quality of health services in Maluti-a-Phofung against stated indicators
		Refining and scale up the detailed plan on the improvement of Quality of services and directing its immediate implementation	262 facilities having Quality Improvement Plans	Increased service users satisfaction with services rendered Compliance with Universal Precautions for Infection Prevention and Control f
		Measure public and private health facilities performance against national core standards.	80 public and 26 private health facilities with performance assessment report in terms of national core standards	At least 60 % compliance with national core standards
		Improve financial audit outcomes	Strengthen Financial Management Systems Work towards a clean audit	Unqualified Audit / Improved Audit Outcomes
04	Overhauling the health care system and improve its management	Development of a decentralised operational model, including new governance arrangements	District Management Teams established in all districts District Health Plans aligned with Annual Performance Plan	Integrated planning
		Training managers in leadership, management and governance	Hospital CEOs qualified in Hospital Management.	Hospital management equipped for their task
		Asses skills, competencies and qualifications of hospital managers	Conduct a skills audit	
		Decentralisation of management	Support the provision of financial, HR and SCM delegations to hospital CEOs	

	NHS PRIORITY (STRATEGIC OBJECTIVES)	KEY ACTIVITIES	TARGETS FOR 2014 (OUTPUTS)	OUTCOMES (IMPACT)
05	Improvement of Human Resources	Refinement of the HR for health plan in line with national and provincial processes	Annual HR plan aligned with requirements and needs for service	HR planning aligned to enable the supply to meet the demand for employee This will ensure effective integrated plans
		Re-opening of nursing schools and colleges.	5 nursing schools and 1 campus	Increased supply of nurses and improved service delivery
			Train different categories of nurses	
			Implementation of nursing strategy	
		Recruitment and retention of professionals, including urgent collaboration with countries that have excess of these professionals.	Implementation of comprehensive Human Resources plan	Increased supply of health professionals and improved health service delivery
			Implementation of OSD	
			Implementation of the skills mix nursing model	
		Specify staff shortages and training targets for the next 5 years.	Retention of bursary holders	
			Implementation of targets for training and production of health professionals in various categories	

	NHS PRIORITY (STRATEGIC OBJECTIVES)	KEY ACTIVITIES	TARGETS FOR 2014 (OUTPUTS)	OUTCOMES (IMPACT)
06	Revitalization of infrastructure.	Urgent implementation of a clean-up, refurbishment and preventative maintenance of all health facilities	Improve maintenance and upgrading of health facilities.	Planned preventive maintenance of health infrastructure to improve services and safety and to extend the useful life of facilities
			Implement Infrastructure Master Plan.	Better planning and prioritization of infrastructure projects
				Minimization of duplication
				Provision of adequate facilities
		Assess progress on revitalization and submit progress reports	6 projects under revitalization Annual progress reports	6 projects are ongoing and 4 projects are in planning

	NHS PRIORITY (STRATEGIC OBJECTIVES)	KEY ACTIVITIES	TARGETS FOR 2014 (OUTPUTS)	OUTCOMES (IMPACT)
07	Accelerated implementation of the HIV and AIDS strategic plan and the increased focus on TB and other communicable diseases.	Decrease the incidence of HIV	1% of ART patients treated for new STI reduced by 100 % of ANC clients tested for HIV	Reduction of incidence of HIV by 2015
		Implement PMTCT, Paediatric Treatment guidelines.	PMTCT and Pediatric Care according to treatment guidelines at all relevant facilities.	Reduced morbidity and mortality
		Implement HIV and AIDS Adult Treatment Guideline	All PHC facilities implementing the integrated model of care.	
		Urgently strengthen programmes against TB, MDR-TB and XDR-TB	85% TB cure rate <5% treatment interruption rate	
08	Mass mobilisation for the better health for the population.	Intensify health promotion programmes	All five districts implementing the Healthy Lifestyle Strategy	Positive change in health seeking behavior.
		Decrease the maternal mortality ratio through diverse interventions	Reduce MMR to 220 per 100 000 live births	Reduction of the maternal mortality rate
			Reduce MMR due to obstetric related causes to 18%	
		Reduce child mortality through diverse interventions	Reduce Child Mortality to 48 per 1000 population under 5	Reduction of the child mortality rate
			Reduce Infant Mortality to 27 per 10000 population under 1 year	
			New immunisation protocol implemented	
		Increase the life expectancy of all South Africans through diverse interventions	98 817 of adult patients initiated on ART 12 078 of child patients initiated on ART	Expand access to ART for people living with HIV and AIDS
		Place more focus on: non-communicable diseases and patient's rights, quality and provide accountability	Implement a model of care for prioritized for chronic conditions	Focused services for Non Communicable Diseases

	NHS PRIORITY (STRATEGIC OBJECTIVES)	KEY ACTIVITIES	TARGETS FOR 2014 (OUTPUTS)	OUTCOMES (IMPACT)
09	Review of drug policy.	Complete and submit proposals and a strategy, with the involvement of various stakeholders	95% availability of essential drugs Extend the use of existing electronic system to all facilities	Continuous availability of medical supplies and consumables at institutions
10	Research and Development	Coordinate research conducted in health services	Research registers available	Improved management of research toward integrated planning

## 4.3. PART B: STRATEGIC OBJECTIVES

### PROGRAMME 1: ADMINISTRATION

#### PROGRAMME PURPOSE

**Programme 1 has the following sub programmes:**

- Office of the MEC
- Management

#### **Office of the MEC**

The Office of the MEC delivers a support service to the MEC.

#### **Provincial Management**

The sub programmes funds the offices of the executive management of the department.

#### **Information Communication Technology**

This component ensures that all ICT needs are met within the annual allocated budget. The main areas include: managing networks and hardware support and repairs; web-development, software management and data warehousing. Technical and operational standards are established for the department.

#### **Health Technology and Imaging Services**

Both sub-directorates support all health institutions in terms of policies, guidelines and technical advice on medical equipment.

#### **Risk Management**

The PFMA requires the department to have and maintain effective, efficient and transparent systems of financial and risk management and internal control. Risk management is the process of identifying risk, assessing the consequence and likelihood, planning a response, monitoring and evaluation. The strategy followed by the department focuses on the identification of risk and managing risk to acceptable levels. A risk management section was established in 2009 and is currently holding workshops at institutions throughout the department at which risk management training is provided, a risk awareness culture is fostered and a risk register is developed which reflects the risk profile of the institution.

#### **The top strategic risks for the Department are as follows:**

Inability to provide the quantity and quality of healthcare services through our system in line with the population needs and expectations due to:

1. Inadequate quantity and quality of personnel
2. Inadequate medication and medical consumables
3. Inadequate and poorly maintained equipment
4. Inappropriate and poorly maintained facilities
5. Inability to improve healthcare quality and patient safety due resource constraints.
6. Inability to supply essential medication and consumables due to budgetary, supply and logistics failures.
7. Inability to provide sufficient ARV's due to budgetary constraints and an increased demand for the service.
8. Inability to attract, recruit and retain key personnel despite the implementation of OSD.

9. Inability to deliver an unqualified report despite a clear understanding of issues to be addressed.
10. Inability to prevent fraudulent and criminal activities.
11. Inabilities to appropriately plan, implement, monitor and evaluate our services and programmes.
12. Inability to optimize the synergies between district and programmes leading to poor health outcomes.
13. Inability to provide consistent and quality leadership in the healthcare services management.

The Process Framework (as indicated in the Risk Management Strategy for the Free State Department of Health) was followed during the Strategic Risk Assessment engagement:

# **PROGRAMME 1. STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES FOR 2010-2014**

STRATEGIC GOAL (Strategic objective)	GOAL STATEMENT (Not in prescribed format shows link to APP)	OBJECTIVE STATEMENT	RATIONALE	BASELINE		INDICATOR	EXPECTED OUTCOMES (TARGETS)
Provision of strategic leadership and creation of social compact for better health outcomes.	Integrated planning	Implementation of the political strategic direction of the Free State Department of Health.	Ensure alignment of plans	Full participation of the Department in the inter-departmental clusters.		Report on alignment of corporate plans within the mandate of the department.	Full participation of the Department in the inter-departmental clusters.
				No comprehensive equipment plan for different levels.	No standardized equipment list at different levels.	2 new facilities are equipped at 50%	Comprehensive equipment plans for all levels of care.
Standardized equipment lists at all levels.							
Aging ICT infrastructure (networks and hardware).	20 health institutions ICT replaced, 14 ICT upgraded.	Improved availability and accuracy of patient information.					
	Improve information communication technology systems.	Enable delivery of comprehensive integrated health services,	Draft comprehensive ICT plan aligned to Service Delivery Plan.		Approved ICT comprehensive Plan	Improved availability and accuracy of patient information.	
Strengthen Telemedicine.			Clinical support for regional, district and PHC services in the Free State	Telemedicine not fully implemented.		Number of health care facilities benefiting from Telemedicine.	Telemedicine intervention strengthened.
	Improve the quality of health Services.	Ensure availability of appropriate technology					



STRATEGIC OBJECTIVE	GOAL STATEMENT (Not in prescribed format shows link to APP)	OBJECTIVE STATEMENT	RATIONALE	BASELINE	INDICATOR	EXPECTED OUTCOMES (TARGETS)
Improve the quality of health Services	Implement comprehensive health services	Ensure compliance of pharmacy facilities with legislation to enhance service delivery.	Good pharmaceutical practices	31 facilities fully compliant with South African Pharmacy Council (SAPC)	No of facilities fully compliant with SAPC requirements.	84 facilities fully compliant with SAPC requirements.
Improved Human Resource Management and Development	Implementation of a comprehensive Human Resources Plan.	Implement a comprehensive Human Resource Plan for the Department.	Appropriate and adequate staff for service delivery.	44 % critical posts filled.	Number of critical posts filled.	30% .critical vacant posts filled.
Overhaul the Health Care System and improve its management.	Improve financial management	Implementation of the Public Finance Management Act (PFMA).	To ensure that the department comply with the Public Finance Management Act.	Monthly compliance certificate submitted.	Compliance to all requirements of the PFMA with regard to reports, statements, certificates, regulations and directives.	Full implementation and compliance to PFMA. to achieve a clean audit
		Implementation of the Supply Chain Management (SCM) in line with policy prescripts.		80% compliance to 2006 Treasury analysis	Compliance to Supply Chain Management Policies.	Full implementation of Supply Chain Management.
Overhaul the Health Care System and improve its management.	Improve financial management	Implementation of Risk Management in line with legislation.		All policies required by Risk Management legislation, approved. Risk committee approved and implemented.	Compliance with Risk Management legislation.	Full implementation of Risk Management.

## RESOURCE CONSIDERATIONS

The Free State Department of Health has for some years been under increasing pressure to stay within budget in terms of the annual financial allocation without reducing the quality level of Health services rendered.

The Department of Health regularly informed Treasury since the first quarter of the 2008 financial year that the Department will overspend in 2009 because of various circumstances.

The shortage of funding for the OSD for nurses, increased inflation and higher health inflation, added to unfunded mandates hamper the rendering of the full complement of health services.

Various presentations were made to Provincial and National Treasury where the deteriorating financial position of the Free State Department of Health was confirmed. It was mentioned throughout that the whole Sector is in financial difficulty and that the Provincial Department would not be able to escape its part of the burden.

The implication of this projection is that the Department will run out of cash towards December 2009. In order to keep rendering services, shifting of funds between various programmes and economic items is non negotiable. In many instances Institutions struggle to fulfill their mandate. Stringency measures have been implemented during each of the last five years in the department with various levels of impact on the performance of the department

The ultimate goals of any health system are:

- Improved Health Outcomes
- Financial Risk Protection
- Responsiveness to the health needs of the population it serves

It is important that any analysis of the impact of the stringency measures is aimed at determining this impact on the health system as a whole. It should also determine the extent to which it affects the ability of the health system to achieve each of its ultimate goals.

It is important to note that the stringency measures have been applied over the past five years without fail, and therefore the impact of these measures can already be felt by the health system even allowing for their "lag effect". In other words some of the system failures we are currently experiencing are a result of the implementation of the stringency measures some five years ago.

A quick analysis of the Free State provincial health system will indicate that it has the following features, which are alarming and indicate poor performance:

### ***Impact of the financial situation on the performance of the department***

- High and increasing maternal mortality rate
- High and increasing infant and child mortality rate
- Increasing deaths due to TB, HIV and AIDS
- Increasing incidence and prevalence of non-communicable diseases
- Increasing complaints about the quality of the services

The departmental turnaround plan is being finalised. The decisions are summarised in the Government Programme of Action and the Health Summit Resolutions.

It is crucial that the critical under funding of health services in the country, be addressed as a matter of urgency to minimize the undesirable consequences of some of the cost containment

measures which have become unavoidable. Initially additional funding will be required to achieve the required cost containment measures. In the longer term, savings should result from these measures.

Recruitment and retention of scarce health and other professionals remains a challenge. The Human Resource Plan should be able deal with this providing it is linked to the reviewed Service Transformation Plan. Additional funding will be required for the initial implementation

The actual financial implications can only be calculated once the Service Transformation Plan has been reviewed and approved. Currently the majority of the critical vacancies are unfunded and cannot be filled

The increased demand for services in the Employee Health and Wellness Programme is expected to have a financial impact.

## RISK MANAGEMENT

<b>Risk Description:</b>	<b>Measures to mitigate impact:</b>
Management of resources of the department to implement stated objectives.	Implementation of the Risk Management Component in line with Legislation
Timeous completion and implementation of the Service Transformation Plan	The Service Transformation Plan will give direct guidelines to the Human Resource Plan on where services are needed, and which skills gaps there are. It is proposed that the Service Transformation Plan be completed as soon as possible. Alternatively the Human Resource Plan should be revised on the current staff establishment structure.
Implementation of the occupational salary dispensation [OSD] for health professionals.	The implementation of the OSD will assist and support in the retention of certain scarce skills.
Non-filling of critical vacancies	Due to the cost containment measures, certain critical posts might not be filled, since it is not funded. The relevant funding must be set aside in the MTEF.

## **PROGRAMME 2: DISTRICT HEALTH SERVICES**

### **PROGRAMME PURPOSE**

The purpose of the District Health Services (DHS) is to render Level 1 services at the Primary Health Care, Clinics and the District Hospitals.

#### **Programme 2 has the following sub-programmes:**

- District Management
- Community Health Clinics
- Community Health Centres
- District Hospitals
- Community Based Services
- Other Community Services
- Coroner Services (Forensic Pathology Services)
- HIV and AIDS
- Nutrition (includes Maternal, Child and Women's Health)
- Disease Prevention and Control

### **SITUATION ANALYSIS**

#### **Progress Towards Equity**

Annual budgets are based on PDE's per hospital and amount of clinic visits per population member. This does not take into consideration distances and topography which places additional demands in terms of the provision of health care in sparsely populated areas. .

Rural Health Services are rendered from 109 mobiles in all towns in the Free State on a 4 - 6 weekly basis. Maluti -a- Phofung in Thabo Mofutsanyana is part of the 18 priority districts project

All 5 districts have District Health Plans which are developed in consultation with stakeholders on a yearly basis. These plans are monitored on a quarterly basis.

#### **Governance Structures**

Governance Structures are fully functional both at both clinic and district hospital levels. A total of 73 clinic committees have been established in all five districts in the Free State.

## PROGRAMME 2: SPECIFICATION OF STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES FOR 2010-2015

STRATEGIC OBJECTIVE	GOAL STATEMENT (Not in prescribed format shows link to APP)	OBJECTIVE STATEMENT	RATIONALE	BASELINE	INDICATOR	EXPECTED OUTCOMES (TARGETS)
Improve the quality of health services	Improve implementation of quality improvement strategies	Implement Batho Pele Revitalization Programme	Enhance Customer Satisfaction.	30 out of 262 institutions implementing Batho Pele Revitalisation Programme.	Number of institutions complying with Batho Pele Revitalisation Programme.	All institutions implementing Batho Pele Revitalisation Programme (improved Service Delivery).
		Measure public and private health facilities performance against national core standards	To enhance the quality of health services received by the community.	Two hospitals with performance assessment reports.	Number of health establishments with performance assessment reports.	All 262 Public and 24 Private Health Establishments with performance assessment reports
Improve quality of health services.	Increase utilisation of effective interventions  Improve comprehensive health services	Strengthen "National 18 Priority District Project" at Thabo Mofutsanyana i.e Maluti -A-Phofung.	Improve health outcomes in Maluti- A-Phofung.	Non-compliance to MDG 4,5 + 6 indicators	Compliance to MDG 4,5 + 6 indicators	Effective and efficient health services in Maluti-A-Phofung.
		Improve accessibility of services at Primary Health Care facilities and District hospitals.	Accessible services at Primary Health Care and District Hospitals	<ul style="list-style-type: none"> <li>Partial compliance to the service packages for PHC services</li> <li>0 Clinics and 7 district Hospitals are rendering a full package of service.</li> <li>10 CHC 's render full package of service</li> </ul>	Number of facilities implementing the full PHC and District Hospital packages.	222 PHC, 24 District Hospitals and 10 CHC Facilities rendering the full PHC package Effective and improved accessibility to PHC services and district hospitals.
		Strengthen Rural Health Strategy.	Access PHC care services in rural areas.	Partial compliance to Rural health strategy.  3 500 farms visited by a mobile every six weeks.	Number of farms visited by a mobile every 6 weeks.	Improved Access of PHC services at rural areas.  5000 farms visited by a mobile every six weeks.

STRATEGIC OBJECTIVE	GOAL STATEMENT (Not in prescribed format shows link to APP)	OBJECTIVE STATEMENT	RATIONALE	BASELINE	INDICATOR	EXPECTED OUTCOMES (TARGETS)
Improve quality of health services.	Improve implementation of quality improvement strategies	Ensure continuous medicine and medical consumables availability	To improve the availability of medication and consumables for continued patient care	Inconsistent availability of medication and medical consumables	% of medication and consumables available	90 % of medication and consumables available (6 week buffer stock).
Reduce the burden of disease	Improve utilisation if effective interventions	Reduce the incidence of drug resistant TB.		1.4	Proportion of MDR TB amongst TB patients	1%
		Rate of new HIV infections.	Control the spread of the HIV in the community	6.3%	Proportion of XDR TB amongst MDR TB patients	0.5%
		Provide appropriate packages of support, care and treatment to HIV positive people and their families.		Indicator not measured	All designated facilities offering aspects of the prevention package i.e. VCCT, PMTCT, IEC, STIs, PEP and Condom Distribution.	All designated facilities offering all aspects of the prevention package.
			To promote positive healthy living	27000	Number of HIV positive people receiving treatment, care and support.	60 000 people receiving support
		Comprehensive Care, Management and Treatment Plan for HIV and AIDS (CCMT).	Reduce infant mortality	Not in plan	Percentage of antenatal care facilities implementing revised therapy for PMTCT. % of HIV exposed infants receiving Dual Therapy.	100% of facilities where antenatal care is delivered implementing the revised PMTCT therapy 100%
					Rate of VCT among TB patients.	90% of TB patients tested for HIV

STRATEGIC OBJECTIVE	GOAL STATEMENT (Not in prescribed format shows link to APP)	OBJECTIVE STATEMENT	RATIONALE	BASELINE	INDICATOR	EXPECTED OUTCOMES (TARGETS)
Reduce the burden of disease	Improve utilisation of effective interventions	Comprehensive Care, Management and Treatment Plan for HIV and AIDS (CCMT).			% of Eligible co-infected patients initiated on treatment.	100 %
		Reduce infant and under 5 child morbidity and mortality.	Improve child health	(68.2 SADHS 2003)	Rate of TB testing among HIV positive patients.	100% of HIV patients tested for TB.
				(48.1 SADHS 2003)	Reduce the under 5 mortality rate.	28/1000 population
				93% 2008/2009	Reduce the infant mortality rate.	20/1000 population
					Immunization coverage	
		Reduce maternal mortality and morbidity.	Improve maternal health	256 per 100000 live births (2008 calendar year)	Maternal mortality ratio (MMR) per calendar year (overall).	208 per 100 000 live births
				28%	Maternal mortality ratio per calendar year (obstetric related).	Reduce MMR due to obstetric related causes to 18%
		Early detection and rapid response to disease outbreaks to reduce morbidity and mortality.		1 day	Outbreak responded to within 24 hours	All outbreaks responded to timeously
		Strengthen surveillance on priority communicable diseases.		0%	Malaria fatality rate (annual )	
				0%	Cholera fatality rate (annual)	

STRATEGIC OBJECTIVE	GOAL STATEMENT (Not in prescribed format shows link to APP)	OBJECTIVE STATEMENT	RATIONALE	BASELINE	INDICATOR	EXPECTED OUTCOMES (TARGETS)
Overhaul the health care system and improve its management.	Integrated planning	Strengthen the District Management Teams.	Effective Management.	District Management teams not standardized.	Micro Structure implemented.	Effective Management at District level.
		Reconfiguration of services.	Transform services.	Access to health care.	Improved access	Efficient services delivery.
		Capacity building for managers	Effective health system management.	6 MPH Course	Number of Managers trained.	Improved management of health care services.
				1 Oliver Tambo Programme		



## RESOURCE CONSIDERATIONS

### DISTRICT HEALTH SERVICES

#### Expenditure trends in the DHS Programme during the MTEF period 2007/08 – 2009/10

TOTAL ALLOCATION	2007/08			2008/09			2009/10
	Budget R'000	Actual R'000	Variance %	Budget R'000	Actual R'000	Variance %	Budget R'000
Economic classification	1,384,519	1,408,370	102%	1,591,717	1,648,500	104%	1,862,863
Compensation of employees	844,019	897,543	106%	1,097,632	1,176,568	107%	1,210,547
Goods and services	424,475	425,657	100%	399,596	399,596	100%	569,392
Transfers and subsidies	38,828	40,618	105%	49,971	45,961	92%	54,168
Payments for capital Assets	77,197	44,552	58%	44,517	26,374	59%	28,756
<b>Total</b>	<b>1,384,519</b>	<b>1,408,370</b>	<b>102%</b>	<b>1,591,717</b>	<b>1,648,500</b>	<b>104%</b>	<b>1,862,863</b>

### Unfunded Priorities

The following are the priorities that were not budgeted due to the availability of funds:

- Kopano MDR Unit;
- Implementation of the new vaccines
- Approved Micro-structure

### Trends in the supply of key categories of health personnel

There is a significant decrease in the filling of clinical posts. Most of the institutions rely on the use of outsourced nursing and doctor services, due to the lowest nursing and medical officer staff turnover. Below is the statistics of posts vacated during the period 01 September 2008 and 30 June 2009:

#### Posts vacated during 01 September 2008 to 30 June 2009

Directorate	No of posts vacated	Financial implications
Xhariep district	31	R4,316,325
Motheo District	60	R6,921,453
Lejweleputswa district	66	R8,848,732
Fezile Dabi district	41	R4,505,676
Thabo Mofutsanyana	71	R8,777,779
<b>TOTAL</b>	<b>269</b>	<b>R33,369,965</b>

## Key categories of health personnel

Post	No. of posts vacated
Chief Executive Officers	2
Medical Officers	13
Professional Nurses	69
Nursing Assistants	28
Occupational Therapists	4
Physiotherapists	4
Pharmacists	7
Dentists	3
Dieticians	4
Social Worker	1
Hygienist	1
Radiographers	5
Environmental Health Officer	1
<b>Total clinical posts</b>	<b>142</b>

**Other support staff** **127**  
**Total number of posts vacated** **269**

## RISK MANAGEMENT

### DISTRICT HEALTH SERVICES

Risk	Mitigating factors
Shortage of personnel due to high turnover of health personnel.	The retention strategy will be revisited to determine how best we can attract and retain the scarce skills.
Constant supply of medicines and consumables.	Improve communication with the depot; Improved monitoring and evaluation.
Insufficient financial resources.	Service Transformation Plan
Shortage of space at the facilities, mobiles and poor maintenance of facilities.	Infrastructure programmes.
Adherence to the legislation and prescripts due to the limited resources.	Monitor compliance and develop improvement plans to close the gaps.

## **PROGRAMME 3: EMERGENCY MEDICAL (AND RESCUE) SERVICES**

### **PROGRAMME PURPOSE**

**Programme 3 has the following sub-programmes**

- Emergency Transport
- Planned Patient Transport

The Emergency Medical Services provide the key to the constitutional imperative of access to emergency medical treatment. The Emergency Medical Services provide access to emergency medical treatment through the following functions within the Free State province:

- Emergency Communications Call Taking and Dispatch and incident management;
- Basic, Intermediate and Advanced Life Support Ambulance based Emergency Care throughout the Province;
- Rescue from entrapments in motor vehicles including heavy vehicle rescue;
- Industrial rescue from entrapments in industrial and agricultural machinery;
- Urban Search and Rescue of patients entrapped by building collapse;
- Swift water rescue including rescue diving
- Special events standbys and medical management at major events;
- Disaster mass casualty incident management;
- Emergency radio communication and
- Non Emergency Patient Transport.

Emergency Medical Services in the Free State consists of the following components:

- Pre-hospital Emergency Care
  - Response and Rescue Services
  - Emergency Patient Transport (Ambulance)
  - Control Centre (Communications)
- Planned Patient Transport (Commuter Service)
- Disaster Risk Management
- Administration and Finance

Each district is currently headed by an Assistant Manager. The Chief Divisional Officer (CDO) is responsible for EMS Operations in the District. With the approval of the Macro Structure, EMS will be headed by a Senior Manager, three Managers, viz, Manager Operations, Manager Logistics and Manager Clinical Governance (Vacant) and Assistant Managers (Motheo Vacant) in the districts. The new staff establishment in the districts was reviewed and has been approved and will be filled in a phased in approach with additional funding. The high vacancy rate of 54% within EMS requires additional funding in order to maintain the national norms of response times within fifteen and forty minutes in urban and rural areas respectively.

**PROGRAMME 3: SPECIFICATION OF STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES FOR 2010-2015.**

STRATEGIC OBJECTIVE	GOAL STATEMENT (Not in prescribed format shows link to APP)	OBJECTIVE STATEMENT	RATIONALE	BASELINE	INDICATOR	EXPECTED OUTCOMES (TARGETS)
Improve the Quality of Health Services.	Implement comprehensive services	Provide an efficient pre hospital and Inter hospital patient transport service.	Provision of 1 ambulance per 10000 people in the Free State.	77 ambulances operational out of 270.	Number of ambulances per 10000 people.	1 ambulance per 10000 people in the Free State.
			Response times within national norms of 15 minutes and 40 minutes	Rural : 35% Urban : 60%	% Of calls within national urban and rural targets (Urban 15 minutes, Rural 40 minutes).	Response times within national norms.
			% of ambulance that are fully operational and available for operational purposes.	45%	% Of ambulances with less than 500 000 km on the odometer.	% of ambulance that is fully operational.
		Provide an efficient preparedness and response plan to disaster in Free State Province.	Number of patients transported to the next level of higher care.	601 000	Number of patients transported by planned patient transport service.	Number of patients transported to the next level of care.
			Preparedness of the Department to respond to disasters.	2 per District	Number of disaster exercise / drills done per district.	Preparedness to respond to disasters.

## RESOURCE CONSIDERATIONS

**Expenditure trends in the EMS Programme during the MTEF period 2007/08-2009/10 and how these are expected to evolve over the 5-year period 2010/11-2014;**

Budget 2008/9 R220million  
Budget 2009/10 R257million

The funding is inadequate. The vacancy rate is 54% that requires an additional R105 million pa for staff. Additional funding is required for 2010.

### Unfunded priorities

- Confederations and Soccer World Cup

### Trends in the supply of key categories of health personnel

- Funding for personnel, EMS currently has a vacancy rate of 54%.
- The establishment of the College of Emergency Care to train and develop EMS personnel.

### Intervention required to address national priorities

- Need more funding to appoint personnel and to procure emergency vehicles in preparation of the 2010 World Cup. The vacancy rate of EMS is at 54%. Additional personnel are required for the ambulances in order to achieve the national response time norms. (The department does not comply to the National Norm at present: Urban 15 min, Rural 40 min).
- The National norm prescribes 1 ambulance for every 10 000 population. Which means that The Free State needs 270 ambulances for a population of 2,7 million. At present there are personnel for 77 ambulances, which indicates a 38,8% efficiency level .
- Additional funding is needed for the maintenance and repair of emergency vehicles and also due to the high increase in the price of diesel which has a marked financial implication for the EMS Budget.

## RISK MANAGEMENT

Risk	MEASURES TO MITIGATE IMPACT
Non compliance with National norms of response times resulting to high mortality rates.	Obtain additional funding
Insufficient resources will compromise the hosting of the soccer world cup and service delivery to the community.	

## PROGRAMME 4: PROVINCIAL HOSPITAL SERVICES

### PROGRAMME PURPOSE

The purpose of Provincial Hospital Services programme is to provide level 2 Hospital Services or Specialist Hospital Services. In the Free State the level 2 services are provided in 5 Regional Hospitals and 1 Psychiatric Hospital.

### Programme 4 has the following sub-programmes

General (regional) Hospitals

Psychiatric Hospitals

The 5 Regional hospitals and 1 Psychiatric Hospital in the Free State are:-

NAME OF HOSPITAL	DISTRICT	NUMBER OF BEDS
Pelonomi Regional	Motheo & Xhariep	720
Bongani Regional	Lejweleputswa	460
Boitumelo Regional	Fezile Dabi	340
Dihlabeng Regional	Thabo Mofutsanyana	150
Mofumahadi Manapo Mopedi Regional	Thabo Mofutsanyana	300
Free State Psychiatric Complex	Motheo	877



# **PROGRAMME 4. SPECIFICATION OF STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES FOR 2010-2015.**

STRATEGIC OBJECTIVE	OBJECTIVE STATEMENT	RATIONALE	BASELINE	INDICATOR	EXPECTED OUTCOMES (TARGETS)
Provision of Strategic leadership and creation of social compact for better health outcomes.	Align the Hospital Boards and Mental Health Review Boards with Mental Health Care Act and National Health Act	Well functioning Hospital Boards and Mental Health Review Boards	Hospital Boards not aligned to National Health Act.	Number of Hospital Boards aligned to National Health Act.	6 Hospital Boards
	Fill vacant executive management posts with appropriately qualified personnel	Ensure that executive management teams and CEOs have appropriate qualifications to run hospitals.	Hospital CEOs are studying Masters in Public Health (MPH) in Hospital Management. Not all Executive management posts are filled.	Number of Mental Health Review Boards functioning according to legislation.	3 Mental Health Review Boards.
	Support the provision of financial, HR and SCM delegations to hospital CEOs	Appropriate authority delegated to the hospital CEOs to execute hospital management responsibilities	Delegations centralized	Number of Hospital Executive management teams and CEOs qualified in Hospital Management.	6 provincial hospitals.
	Ensure adherence to service level agreements with strategic partners.	Management of relations with PPP, local Private Health sector, NGO's and integrated infrastructure planning with other Government Departments.	Fragmented Public and Private Health Services.	Hospital management authority delegated to CEOs	100% of hospitals
				% of compliance with PPP service level agreements and co-operative relations with local Private Health sector, NGO's and integrated infrastructure planning with other Government Departments.	100% Provincial Hospitals sustaining strategic partnerships and intersectoral collaboration.

STRATEGIC OBJECTIVE	OBJECTIVE STATEMENT	RATIONALE	BASELINE	INDICATOR	EXPECTED OUTCOMES (TARGETS)
Improve quality of Health Services.	Ensure provision of a full package of Regional Hospitals and comprehensive Psychiatric Services.	Improved service delivery.	Only Pelsonomi Regional Hospital has the full complement of full time specialists.	Number of Level 2 disciplines and comprehensive psychiatric services available.	9 Disciplines in Regional Hospitals.
	Provide outreach services to lower levels of care	Increased accessibility of all clinical disciplines for the community	Not all disciplines available at all the hospitals in the province	Number of clinical disciplines conducting outreach	1 comprehensive psychiatric service in FSPC.
	Implement quality management programme, Batho Pele and Patient Rights Charter.	Improvement of quality Service Standards	Inability to implement National Core Standards in the hospitals.	Number of hospitals implementing National Core Standards.	5 clinical disciplines per regional hospital
	Provide appropriate equipment.	Improved availability of equipment.	Obsolete and shortage of equipment.	% of planned equipment procured.	All (6) Hospitals implementing National Core Standards.
	Ensure good hygienic standards in hospitals	Improved image of hospitals and reduced risk of hospital acquired infections	Poor public image due to poor cleanliness	Cleanliness score of ≥80%	95% of planned equipment procured.
				No of dirty areas reported to the dedicated internal call centre	100 of provincial hospitals with Cleanliness score of ≥80%
	Implement the infection prevention and control programme per hospital	Safe patient care environment	Infection Control Coordinators available per hospital Infection Control plan available per hospital	Infection control Plan available per hospital in line with National policy	1% of dirty areas reported to the call centre
				Nosocomial infection control rate	6 provincial hospitals
	Ensure waiting times according to national core standards	Improved patient satisfaction and safety of care	Long waiting times	Patient waiting times in Admissions, OPD, Casualty and Pharmacy are in line with National Core Standards.	Nosocomial infection rate +/- 5%.
				% of staff wearing identity tags	Waiting times as indicated in core standards
				Patient satisfaction rate	100% of staff
	Ensure that patients are treated with dignity and respect		Staff attitude to patients is generally negative		≥80% staff satisfaction rate

STRATEGIC OBJECTIVE	OBJECTIVE STATEMENT	RATIONALE	BASELINE	INDICATOR	EXPECTED OUTCOMES (TARGETS)
Improve quality of Health Services	Improve patient safety and security	Safe and secure environment for patients	Inconsistent provision of safety and security to patients.	% of SAC 1 & 2 (Fatal and very serious adverse incidents) in relation to all adverse events.	Less than 3%
	Improve availability of medication and medical consumables in hospitals.	Improved availability of medication and medical consumables for patients.	Interrupted supplies of medication and medical consumables	% of medication available.	90% availability of medication.
				% of medical consumables	90% availability of medical consumables
Accelerated implementation of HIV and AIDS strategic plan and increased focus on TB and other communicable diseases.	Implement strategies for integration of management of TB and HIV and AIDS in hospitals.	Improvement of the quality of the management of the conditions.	Poorly integrated management of TB and HIV and AIDS in Provincial Hospitals.	Number of TB Focal points available in hospitals.	HIV/Aids and TB management fully integrated in Hospitals.
				National and Provincial TB and HIV and AIDS policies implemented in hospitals.	
				Number of Hospitals with TB and HIV and AIDS coordinators.	
	Implement HCT in hospitals including voluntary testing	Improve access to testing facilities	Testing is not available to all hospitals.	Testing site available in all hospitals	6 hospitals
Overhaul the health care system and improve its management.	Conduct Health Promotion activities in hospitals.	Prevention of diseases.	Health Promotion strategy not implemented.	Number of Health Promotion activities conducted.	All 6 hospitals implementing Health Promotion strategy.
	Provide Service Delivery model for Regional Hospital aligned to S.T.P. (Service Transformation Plan)	Ensure effective and efficient management of hospitals resources.	Duplication and inefficiencies in service delivery with current model.	% of STP implementation	100% STP implementation in Hospitals.
	Implement quality improvement programmes to support the implementation of National Health Insurance (NHI).	Provide Quality Health Services.	14.8 % of population have access to medical insurance.	% of compliance with quality standards.	80% compliance

STRATEGIC OBJECTIVE	OBJECTIVE STATEMENT	RATIONALE	BASELINE	INDICATOR	EXPECTED OUTCOMES (TARGETS)
Improved Human Resource Management	Implement Skill Mix Nursing Model.	Improve the total nursing care in hospitals.	Incorrect Skills Mix of nurses in hospitals.	100% of Skill Mix Nursing model implementation in Hospitals.	100% implementation.
	Fill critical posts	Improve service delivery	High vacancy rate in hospitals	% of posts filled	80% of posts filled.
Research and development	Coordinate research conducted in hospitals.	Use research results to improve service delivery.	Research not coordinated in hospitals.	Research registers available in Hospitals.	Increased evidence based health care.

## RESOURCE CONSIDERATIONS

### Unfunded priorities

- The OSD for nurses was implemented in 2007/08. The department did not receive full compensation for the resultant costs. This has led to overspending on salaries of employees. As a result vacant funded critical posts could not be filled.
- Critical posts have remained vacant causing staff shortages and a negative impact on the capacity to render services.
- Some critical equipment has not been procured due to inadequate funding. This continues to hamper accessibility, quality of services and patient safety.
- Major maintenance (Floors, fence, lifts, etc) cannot be attended to.
- Specialized oral health services are not available in Regional hospitals.
- Outreach meetings need strengthening.

### Trends in the supply of key categories of health personnel

- Shortage of health professionals, particularly medical officers, nurses and pharmacists have progressively worsened over the past 5 to 10 years.
- Due to the rollout in 2009 of 2-year medical internship, there was a decrease in the availability of medical officers. The situation is expected to improve slightly during 2010 when the first 2-year group begins community service.
- The availability of the lower categories of nurses will improve in the latter part of the 5-year period, provided that the nursing schools in 4 regional hospitals will be able to continue with such training and the envisaged nursing skills mix is implemented.

## RISK MANAGEMENT

RISK	MEASURES TO MITIGATE IMPACT
Inadequate Funding	<ul style="list-style-type: none"><li>• Review service delivery model.</li><li>• Cost cutting measures implementation in line with the STP.</li><li>• Reduce losses in facilities.</li></ul>
Implement S.T.P.	<ul style="list-style-type: none"><li>• Political support for STP implementation.</li><li>• Task Team to manage implementation.</li></ul>
Centralized delegations	<ul style="list-style-type: none"><li>• Decentralize delegations to CEO's.</li></ul>
Security	<ul style="list-style-type: none"><li>• Put security systems in all hospitals.</li></ul>
Bio-hazard Infections	<ul style="list-style-type: none"><li>• Appropriate placement of staff.</li><li>• Improved hygiene in workplace e.g. Proper ventilation, extractor fans and UV lights.</li></ul>

## **PROGRAMME 5: CENTRAL HOSPITAL SERVICES**

### **PROGRAMME PURPOSE**

The purpose of Programme 5 is to provide tertiary and central hospital services to the central part of South Africa.

#### **Programme 5 has only 1 sub programme**

Central Hospital

**PROGRAMME 5: SPECIFICATION OF STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES FOR 2010-2015.**

STRATEGIC OBJECTIVE	GOAL STATEMENT	OBJECTIVE STATEMENT	RATIONALE	BASELINE	INDICATOR	EXPECTED OUTCOMES (TARGETS)
Provision of strategic leadership and creation of social compact for better health outcomes.	Strengthen strategic alliances	Strengthen collaboration with UFS, CUT and FSSoN, 3MIL and private training institutions to increase output of health professionals in areas of critical skills shortage.	Increase the availability of critical skills for the rendering of Health Services at UAH	>10%	% of departments experiencing a shortage of health workers who possess critical skills	<3%
Improve the Quality of Health care services.	Improve implementation of quality improvement strategies	Ensure implementation of Batho Pele Program at AHC	Improve patient satisfaction	Patient satisfaction rate > 90%	Patient satisfaction rate (established through questionnaires and rate of complaints)	Patient satisfaction rate > 95%
		Implement Clinical Governance Programme.	Provide evidence based care through effective clinical governance programmes	Clinical Governance Programmes in place at UAH (no evidence available)	Clinical Governance Programme Implemented in AHC (M&M meeting, Clinical audits, Protocols and guidelines being followed, Peer review and Retrospective Medical Document Review in place).	Improved Clinical Governance Programmes with evidence for all aspects in all academic clinical departments
		Improve Patient Safety	Patient safety is an important determinant of health care outcome	Keep SAC 1+2 <25%	% of SAC 1 and 2 (fatal and very serious adverse incidents per month).	Keep SAC 1+2 at UAH <25%
				3% of Admissions	% Incidents reported per admission.	UAH 4%
				UAH 100%	Incident completion rate.	UAH 100%
				UAH < 7 % of total admissions	Nosocomial Infection Rate as a % of total admissions	UAH < 10 % of total admissions
				< 10 % of PDEs	Adverse Event Rate as a % of PDEs	< 5 % of PDEs

STRATEGIC OBJECTIVE	GOAL STATEMENT	OBJECTIVE STATEMENT	RATIONALE	BASELINE	INDICATOR	EXPECTED OUTCOMES (TARGETS)
Improve the Quality of Health care services.	Improve implementation of quality improvement strategies	Maintain Quality Standards of AHC.	To maintain the quality of care at UAH	COHSASA accreditation for 3 years (2008) >85% measured against COHSASA standards	% QA score against National core standards	>80% against national core standards
		Implement Quality Improvement Plans	To improve the quality of care at AHC	All quality aspects in place (COHSASA accredited) but improvements can still be achieved	% departments with 1 new quality improvement plan per annum, covering for example: patient safety; infection prevention and control; availability of medicines; waiting times and positive and caring attitudes among staff	AHC have a new detailed Quality Improvement Plan on Quality of Care in place per annum and achieved in more than 70% of departments
Reduce Burden of Disease	Increase the Utilisation of Effective Interventions	Reduce backlogs of tertiary service package to be rendered by the AHC	Tertiary services should be rendered to all patients referred to AHC from FS, NC, EC and Lesotho for T1 and T2 care	On average 30% of annual tertiary service packages volumes per discipline not rendered due to unavailability of resources	% of annual expected tertiary service volumes per discipline that cannot be rendered (% of annual patients not treated – on the waiting lists)	Average 10% AHC package volumes not handled at AHC
Revitalisation of physical Infrastructure	Improve the maintenance and upgrading of facilities	Annual upgrading/ replacement of UAH equipment	Revitalise UAH equipment as part of the MTS initiative	7.5% of UAH equipment value is replaced	% of UAH equipment value replaced (Equipment value is estimated at R800)	50% of UAH equipment replaced
Improve Human Resource Management	Improve Skills of Personnel	Development and Implementation of Professional Skills Mix Model (PSMM).	Scarce Skills available and optimized in all departments	Discrepancies in the availability and utilisation of scarce skills between tertiary service components	Percentage roll out of the PSMM Plan	All professional groups evaluated and redistributed according to PSMM and optimal utilization maintained



STRATEGIC OBJECTIVE	GOAL STATEMENT	OBJECTIVE STATEMENT	RATIONALE	BASELINE	INDICATOR	EXPECTED OUTCOMES (TARGETS)
Overhaul the health care system and improve its management	Improve Implementation of Quality Improvement Strategies	Strengthen Outreach to Regional Hospitals	Outreach services strengthen training and capacity building and facilitate decentralized service rendering	Bongani: 16 Dhlabeng: 12, MMM :11, Boitumelo: 11	Number of outreach visits per regional hospital per annum	Bongani: 26 Dhlabeng: 22 MMM :22 Boitumelo: 22
			Reduction of advanced pathology by improving early detection of chronic and degenerative diseases	Bongani: 4, Dhlabeng: 4 MMM: 4, Boitumelo: 4	Number of departments involved per regional hospital	Bongani: 13 Dhlabeng:13 MMM: 13 Boitumelo: 13
			Offering ESMOE and similar training to MOs in FS hospitals and districts	4 ESMOE training sessions	% advanced cases seen at AHC	Less than 20%
		Roll Telemedicine out to Regional Hospitals	Telemedicine strengthens training and capacity building and facilitate decentralized service rendering	No telemedicine encounters between AHC and regional hospitals	Number of ESMOE training sessions offered in collaboration with institutions of higher education to support basic skills of Medical Officers and other professional categories	12 training sessions offered annually
				2	Number of telemedicine encounters between UAH and regional hospitals	At least 4 monthly telemedicine encounters between all regional hospitals and AHC;
					Number of active tele-radiology links between UAH and regional hospitals	5

## RESOURCE CONSIDERATIONS

The focus of the MTEF was to restore the current staff establishment to full capacity without increasing the gaps in professional staff in service.

UAH experienced increasing budget shortfalls for the MTEF period 2007/08-2009/10. These were on Compensation and on Goods and Services. As a result annual stringency measures had the following effects:

### ***Service Rendering***

- Patients are not receiving the health care they need, with the following results:
  - Delayed or non identification of pathology at peripheral facilities
  - Late referral to higher level facilities
  - Patients are faced with long waiting lists at regional and tertiary institutions for clinic visits as well as for theatre procedures
  - Pathology becoming more advanced as complications set in while on the waiting lists
  - Patients die on the waiting lists or due to complications
  - Cost structure of tertiary care become more expensive as sicker patients with more complications need to be treated with more expensive treatment modalities
  - Patients are not receiving medication from district hospitals and clinics, therefore need to come back to UAH for medication at increased cost to the system
- Health workers suffer from “burn out” due to constantly working under difficult circumstances as a result of out of stock situations and lack of staff.
- The medico-legal risk increases as patients and health workers are subject to unacceptable and unsafe conditions of health care delivery.
- Risk of serious adverse events increases, resulting in litigation against the department
- The ethical dilemma for health workers becomes unbearable as they are forced to compromise standards of care due to financial reasons.
- The morale of health workers becomes so low that UAH loses key professionals that cannot easily be replaced.
- The equipment and facilities are left to deteriorate to such an extent that service delivery becomes compromised to the extent that certain services will need to be terminated.

### ***Training***

- Training opportunities for pre- and post graduates become limited due to a dwindling in numbers of patients and treatment modalities offered due to unavailability of stock, equipment or staff
- Departments are not able to complete their curriculums for post graduates
- Pre-graduate and postgraduate training is compromised as out-of-stock situations make it impossible to maintain evidence based care and to provide quality services
- Accreditation as training facility becomes endangered due to lack of facilities, equipment, staff, stock or working conditions conducive for training
- The danger is there for the Free State to lose the academic health complex as a unique national asset due to a number of circumstances that may endanger its existence

### **Unfunded priorities:**

**Services: The following required costs could not be included in current MTEF projections**

- Specialised Paediatric and Child Health
- Tertiary obstetrics beds (currently only 1% of provincial deliveries v.s 11% in other provinces. There is a need to increase maternity beds substantially.
- Specialised Oral Health: The required increase in the staff establishment.
- Paediatric Oncology could not be included in current MTEF projections
- Paediatric Surgery in the fields of Urology, Neurosurgery, Plastic and Reconstructive Surgery, ENT and Ophthalmology
- Specialised Surgery in the fields of Head and Neck Surgery, Gastro-enterology and Mamma
- Adult and Paediatric Cathlab procedures
- Vascular Cathlab procedures done in Diagnostic Radiology
- Allied Health consultations for tertiary treatment
- Infrastructure Revitalisation
- Lack of appropriate facilities and equipment

### **RISK MANAGEMENT**

<b>RISK</b>	<b>MEASURES TO MITIGATE IMPACT</b>
Shortage of funds due to lack of ring-fenced allocation of NTSG/voted funds.	Commission a health systems review on the funding needs for the AHC.
Lack of accountable governance structures for the AHC	

## **PROGRAMME 6: HEALTH SCIENCES AND TRAINING**

### **PROGRAMME PURPOSE**

**Programme 6 has the following sub programmes:**

- Nurse Training Colleges
- Bursaries
- Primary Health Care Training
- EMS Training College
- Other Training

# **PROGRAMME 6 : SPECIFICATION OF STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES FOR 2010-2015.**

STRATEGIC OBJECTIVE	GOAL STATEMENT (Not in prescribed format shows link to APP)	OBJECTIVE STATEMENT	RATIONALE	BASELINE	INDICATOR	EXPECTED OUTCOMES (TARGETS)
Improved Human Resource Management.	Improve skills of personnel	Increase the number of nursing training facilities	Improvement of service delivery and performance enhancement (efficient and effective service delivery).	7 hospitals nursing schools and 3 campuses operational.	Number of new nursing schools and campus opened.	12 Schools and 4 campuses.
		Train different categories of nurses.		Oversupply of PNs and under supply of ENA, EN, midwives and auxiliary midwives.	Number of nurses per category	Produce 500 nurses of all categories per annum.
		Train different categories of employees.	Improvement of service delivery and performance enhancement (efficient and effective service delivery).	Few training opportunities to level 5 and below employees	Number of different categories trained	Train 5450 employees in various categories per year with emphasis on the lower level categories. (support from all clusters)
				College of Emergency Care not fully functional.	Fully functional College of Emergency Care	1 College of Emergency Care to be accredited and fully functional.
				40 EMS personnel are receiving training.	Number of EMS personnel trained in various courses.	225 EMS personnel to be trained.

STRATEGIC OBJECTIVE	GOAL STATEMENT (Not in prescribed format shows link to APP)	OBJECTIVE STATEMENT	RATIONALE	BASELINE	INDICATOR	EXPECTED OUTCOMES (TARGETS)
Improved Human Resource Management.	Promote employability	Improve educational level of lower categories (Level 1-3).	Improve the literacy level of the lower categories.	300 employees enrolled in the ABET training programme	Number of employees enrolled in the ABET training programme	Train at least 300 employees on ABET annually
		Promote employability and sustainable livelihood through skills development.	Reduce the level of unemployment.	100 learnerships granted.	Number of 18.2 learnerships.	250 new 18.2 learnerships granted.
				100 learnerships granted.	Number of non health care professionals trained (CHCW)	100 (NQF Level 1 – 50, NQF Level 3 – 20, NQF Level 4 – 30)
Revitalisation of physical infrastructure	Improve the maintenance and upgrading of facilities	Establish a fully functional College of Emergency Care	Improvement of EMS service delivery.	College of Emergency Care working towards accreditation.	College of Emergency Care accredited	1 College of Emergency Care accredited

## RESOURCE CONSIDERATIONS

**Expenditure trends in the Health Sciences and Training Programme during the MTEF period 2007/08-2009/10, and how these are expected to evolve over the 5-year period 2010/11-2014;**

	2007/2008	2008/2009	2009/2010
<b>Total</b>	98,728	122,541	142,267
<b>Total per person</b>	40,47	42,88	49,78
<b>Total per uninsured person</b>	47,50	50,32	58,43
<b>Total capital</b>	5,108	326	354

### Unfunded priorities

#### Expanded Public Works Programme (EPWP)

EPWP is a short to medium term measure to mitigate the adverse social political and economic consequences of high and growing levels of unemployment. It focuses on training of volunteers as community care givers at NQF level 1,2 and 3.

#### Project 3535 (Data Capturer Project)

Project 3535 is a National priority which is aimed at improving the quality of health information. Data captures are training on the management of health information and this project goes beyond training and putting a data capturer in every health facility.

#### Establishment of the College of Emergency Care

This college has to be established in order to achieve the targets for 2010 in relation to the level of emergency care that needs to be delivered in the province and in order to implement the emergency care technician programme.

## **PROGRAMME 7: HEALTH CARE SUPPORT SERVICES**

### **PROGRAMME PURPOSE**

**Programme 7 has the following sub-programmes**

- **Laundries**

A laundry service aims to comprehensively manage all linen related issues across the province to ensure standardization. Amongst others it ensures that linen purchased by health institutions meet minimum standards to prevent cross infection and durability. The major function is to ensure that linen is collected and delivered from various health institutions at agreed intervals.

- **Orthotic and prosthetic services**

- **Trading account for the medical depot**



**PROGRAMME 7: SPECIFICATION OF STRATEGIC OBJECTIVES AND EXPECTED OUTCOMES FOR 2010-2015.**

STRATEGIC OBJECTIVE	OBJECTIVE STATEMENT	RATIONALE	BASELINE	INDICATOR	EXPECTED OUTCOMES (TARGETS)
Improve the quality of health care	Improve management of laundry services.	To improve the management and supply of hospital linen.	50% of required laundry equipment is available.	Percentage of laundry equipment replaced and upgraded.	80% of clean linen available to all healthcare facilities.
			28% of required linen for health institutions is available.	% increase of linen available	80% linen replaced.
Reduce the burden of disease	Improve accessibility to Orthotic and Prosthetic Services	To promote efficient rehabilitation	3 Medical Orthotic and Prosthetic outreach programmes	Number of Medical Orthotic and Prosthetic Outreach programmes increased.	Accessible Orthotic and Prosthetic Services.
			10 000 patients per year	Number of users per year	

## **PROGRAMME 8: HEALTH FACILITIES MANAGEMENT**

### **PROGRAMME PURPOSE**

The Health Facilities Management programme funds the major infrastructure projects of the department

### **Programme 8 has the following sub-programmes**

- Community Health Facilities
- Emergency Medical Services
- District Hospitals
- Provincial Hospitals
- Central Hospitals
- Other facilities

The purpose of health facility management (infrastructure management) is mainly to support all clusters in:

- Planning of infrastructure projects;
- Monitoring and support during the project implementation;
- Assist health institutions with technical advice and support for physical infrastructure needs;
- Advise on the management on infrastructure priorities annually.

**PROGRAMME 8: HEALTH FACILITIES MANAGEMENT**

<b>STRATEGIC OBJECTIVE</b>	<b>OBJECTIVE STATEMENT</b>	<b>RATIONALE</b>	<b>BASELINE</b>	<b>INDICATOR</b>	<b>EXPECTED OUTCOMES (TARGETS)</b>
Revitalization of physical infrastructure	Improve maintenance and upgrading of health facilities.	Improve physical status of the health institutions.	10% of facilities maintained.	31 hospitals, 232 clinics and CHCs, 4 x Colleges Emergency Care, 6 x Forensic mortuaries and 5 x Laundries (Includes day to day minor maintenance).	Facilities are: functional, safe, fit for purpose, low maintenance and operational costs
	Develop and implement Infrastructure Master Plan.	Improve access to health care.	No comprehensive long-term maintenance and upgrading plan.	Developed and approved comprehensive long-term maintenance and upgrading plan.	Well maintained and safe health facilities.
			There is no Infrastructure Master Plan.	Approved Infrastructure Master Plan.	Functional, safe, fit for purpose and accessible health facilities.

## 5. PART C: LINKS TO OTHER PLANS

Linkages between the Strategic Plan and the Free State Department of Health long-term infrastructure and capital plans. Projects entailed in the long-term capital investment plan of the Department are reflected;

PROJECT NAME	PROGRA MME	MUNICI PALITY	PROJECT DESCRIPTION/TYPE OF STRUCTURE	OUTPUTS	ESTIMATED PROJECT COSTS	EXPENDITURE TO DATE (IF ANY)	PROJECT DURATION
Boitumelo	8	Moghaka	Hospital	1	R546 214 124	R301 823 268.72	5
Pelononi	8	Mangaung	Hospital	1	R90 972 877	R63 248 008.42	4
Trompsburg	8	Kopanong	Hospital	1	R329 019 549	R12 910 867.83	4
Free State Psychiatric Complex	8	Mangaung	Hospital	1	R 612,864,000	R15 903 331.67	5
Dihlabeng Hospital (Floors & OPD)	8	Dihlabeng	Hospital	1	R114 000 000	R0	2
Ladybrand Hospital	8	Mantsopa	Hospital	1	R 288 498 640	R 13 247 075.17	3
Mangaung Hospital	8	Mangaung	Hospital	1	R201 383 000	R0	4
EMS Control Room	8	Maluti-A-Phofung	Emergency Medical Service Facility	1	R 2 000 000	R0	3
Mafube Hospital	8	Mafube	Hospital	1	R3 500 000	R0	3
Winburg Hospital	8		Hospital	1	R3 500 000	R0	3
Palliative Care	8	Mangaung	Hospital	1	R3 000 000.00	R0	
MANCOFS	8	Mangaung	Hospital	1	R 9 311 022.24	R 16 226 323.61	
Bloemfontein Forensic Mortuary	8	Mangaung	Mortuary	1	R63 481 957.19	R76 694 934.47	4
PROJECT NAME	PROGRA MME	MUNICI PALITY	PROJECT DESCRIPTION/TYPE OF STRUCTURE	OUTPUTS	ESTIMATED PROJECT COSTS	EXPENDITURE TO DATE (IF ANY)	PROJECT DURATION
EMS College Structure	8	Mangaung	College	1	R 24 000 000	R0	Will continue
Elizabeth Ross	8	Maluti-A-Phofung	Hospital	1	R67 284 073.89	R57 226 664.86	2
Thebe Hospital	8	Maluti-A-Phofung	Hospital	1	R59 745 946.57	R51 524 479.80	3
Tokollo Hospital	8	Mafube	Hospital	1	R45 923 146.45	R55 730 597.50	2
Bultfontein Clinic	8		Hospital	1	R5 810 000	R 8 627 837.2	2

## 6. CONDITIONAL GRANTS

NAME OF CONDITIONAL GRANT	PURPOSE OF THE GRANT	PERFORMANCE INDICATORS	CONTINUATION/ DISCONTINUATION OVER THE NEXT 5-YEARS	MOTIVATION FOR CONTINUATION/ DISCONTINUATION
HIV and AIDS	Implement the NSP	Level of utilisation of the conditional grant. Compliance with the DORA conditions.	CCMT programs implemented at health facilities	
Forensic Pathology Services	Transfer the forensic pathology services from the SAPS to Provincial Health and strengthen the service.	Level of utilisation of the conditional grant Compliance with the DORA conditions.	3 functional Mortuaries and 9 holding facilities to service the whole province	
National Tertiary Services Grant	The grant funds the rendering of tertiary service in the Free State for compensation, goods and services and capital expenses	Achievement of Service delivery outcomes and progress made against set objectives and outcomes, in order to determine how effective the monitoring of the NTSG has been approached, and how the funds are managed by the provinces.	Ongoing grant to fund the tertiary service for up to 70% on total expenditure in the province	The grant needs to continue to enable the department to meet its obligations towards the rendering of tertiary service, including the upgrade/ replacement of capital equipment
Hospital Revitalisation Grant	Provide funding to enable provinces to plan, manage, modernise, rationalise and transform the infrastructure, health technology, monitoring and evaluation of hospitals in line with national policy objectives Transform hospital management and improve quality of care in line with national policy	Level of utilization of the conditional grant. Compliance with the DORA conditions.	Continuation	The grant will continue to provide funding to enable the department to address Infrastructure backlog within the department. The full realization of this is a process which will take more years to accomplish, thus the Grant will continue for more than 5 years to come.
Infrastructure Grant to Provinces	To improve and address Infrastructure backlog including maintenance and refurbishment	Level of utilization of the conditional grant. Compliance with the DORA conditions.	Continuation	The grant will continue to provide funding to enable the department to address Infrastructure backlog within the department. The full realization of this is a process which will take more years to accomplish, thus the Grant will continue for more than 5 years to come.

NAME OF CONDITIONAL GRANT	PURPOSE OF THE GRANT	PERFORMANCE INDICATORS	CONTINUATION/ DISCONTINUATION OVER THE NEXT 5-YEARS	MOTIVATION FOR CONTINUATION/ DISCONTINUATION
Infrastructure Enhancement Allocation	To fund miscellaneous infrastructure related activities.	Comply with the Public Finance Management Act.	Continuation	It increases the capacity of the department to deliver on certain Infrastructure needs.
Health Professional Training and Development Grant	Cover expenditure related to training of health professionals.	Number of health professionals funded.	Continuation.	Specialists are needed for health services. It is important to fund their training and education.

#### 7. PUBLIC ENTITIES

NAME OF PUBLIC ENTITY	MANDATE	OUTPUTS	CURRENT ANNUAL BUDGET (R'THOUSAND)	DATE OF NEXT EVALUATION
NHLS as established according to the NHLS Act 37 of 2000.	To provide health laboratory services to the Free State Department of Health as contained in the SLA	Provide cost effective laboratory services	Total for all outputs R163 000 000	Quarterly October 2009
		Support HIV and AIDS program		
		Support TB Programme		
		Support Cervical Cancer programme		
		Comply with SLA		

#### 8. PUBLIC-PRIVATE PARTNERSHIPS (PPPs)

NAME OF PPP	PURPOSE	OUTPUTS	CURRENT ANNUAL BUDGET (R'THOUSAND)	DATE OF NEXT EVALUATION

<b>1. BOT PPP between FSDH &amp; CHM as private partners on Co-Location of health services at both Pelonomi and Universitas Hospitals</b>	1. Utilisation of excess capacity 2. Affordability of health services on private health services to the community. 3. Transfer of risk from the public sector to the private partners. 4. Refurbishment and upgrading of existing health facilities at the designated hospitals. 5. Transfer of equipment and other resources to the public sector at the end of the Contract.	(Number of clients accessing health care) (Transfer of skills and expertise) Financial gains to the public sector State of the art machinery. Upgraded facilities	R0	To be decided by the Head of Department and Provincial Treasury
	<b>CHM and DOH: Free State</b>	Hospital Improved service delivery	No budget	

