



Polokwane Integrated Medical Development Policy 2026

Reaga
Polokwane

"Polokwane shall be Limpopo's inclusive, resilient, and innovation-driven medical ecosystem — characterized by equitable access, environmental sustainability, and integrated healthcare delivery that effectively serves urban and rural populations alike."

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SECTION 1

Executive Summary



This policy framework positions Polokwane as Limpopo's integrated medical hub, blending spatial planning, healthcare infrastructure, and socioeconomic resilience. The municipality covers **1,978 km²** with a 2026 population projected at **519,000**, growing to over **573,000 by 2030**, driven by urbanization and migration dynamics (CAGR: 2.3–2.4%).

Baseline healthcare metrics reveal suboptimal bed density (**4.2 beds/1,000 residents**, below the WHO ideal of 5.0), inequitable rural access (**55%**), and low green energy adoption (**10%**), compounded by high unemployment at **28.2%** (Stats SA, 2025).

 CATALYTIC PROJECT — LIMPOPO CENTRAL HOSPITAL (LCH)

Central to this framework is the Limpopo Central Hospital — a **488-bed tertiary facility** with an **R5 billion investment**, projected for completion in **2028**. Strategic phased investments including over **R500 million municipal capital** and public-private partnerships (PPPs) aim to increase bed capacity to 2,240 (+5.2%), elevate rural access to 75%, achieve 50% green energy adoption through solar microgrids and rainwater harvesting, and generate over 5,000 health-related jobs.

Strategic Alignment



Three-Phase Implementation Approach



 SECTION 2

Introduction

2.1 Background and Context

Polokwane Municipality serves as Limpopo Province's administrative and healthcare nexus, interfacing with Capricorn District and beyond. Historically dependent on the Provincial Hospital and private facilities such as Pholoso Hospital (200 beds), the current healthcare system faces rising pressures due to demographic growth, epidemiological shifts, and infrastructural deficits (Department of Health, 2022).

The 2005 Medical Development Policy became inadequate in the wake of COVID-19, which exacerbated chronic disease burdens (HIV/TB/diabetes), supply chain disruptions, and digital health disparities (WHO, 2021). A comprehensive, forward-looking framework was therefore necessary to address these multidimensional challenges.

2.2 Policy Evolution and Rationale

This 2026 policy iteration consolidates fragmented strategies into a cohesive framework responsive to NHI Phase 3 preparatory funding (2023–26), rapid urbanization (2.3–2.4% annual growth), and a youthful demographic profile (median age ~25 years) with high maternal and child health needs (Statistics South Africa, 2025).

KEY POLICY DRIVERS

The Limpopo Central Hospital project — a key catalyst — addresses tertiary care shortfalls and stimulates precinct development, emphasizing integration of **public, private, and traditional health systems**. NHI Phase 3 readiness, digital health infrastructure, and SPLUMA-compliant spatial planning are foundational imperatives of this revision.

 SECTION 3

Problem Statement

Polokwane faces multifaceted healthcare challenges aggravated by socioeconomic pressures. Population growth from approximately 519,000 in 2026 to 573,000 by 2030 stresses existing infrastructure, reflected in a baseline of **2,129 hospital beds** (4.2 beds/1,000 residents), below the WHO recommended minimum of 5.0 (WHO, 2020). Urban cores experience overcrowding with 5.4 beds/1,000, whereas rural areas are severely underserved at **2.1 beds/1,000**, compounded by travel distances often exceeding 5 km and wait times over 5 hours (Department of Health, 2024).

3.1 DEMOGRAPHIC & EPIDEMIOLOGICAL TRENDS

Chronic non-communicable diseases (NCDs) such as hypertension and diabetes affect **35% of adults**, while mental health issues rose **20% post-COVID-19** (South African Medical Journal, 2023). The HIV/TB dual burden remains a persistent challenge requiring integrated treatment protocols.

3.2 HEALTHCARE INFRASTRUCTURE GAPS

Urban cores experience bed density of 5.4/1,000 but face increasing demand from population growth. Rural areas are severely underserved at **2.1 beds/1,000**, with travel distances frequently exceeding 5 km and average wait times exceeding 5 hours.

3.3 SOCIOECONOMIC AND ENVIRONMENTAL CHALLENGES

The provincial unemployment rate of **28.2%**, with youth unemployment exceeding **45%**, limits healthcare affordability and insurance uptake (Stats SA QLFS, 2025). Infrastructure backlogs and climate vulnerabilities — droughts impacting water and solar power viability — compound these risks and threaten equitable healthcare delivery.

 SECTION 4

Legal and Regulatory Foundations

The Polokwane Integrated Medical Development Policy Framework is anchored firmly within a comprehensive legal and regulatory environment that ensures enforceability, alignment with national development goals, and compliance with environmental and administrative standards.

4.1 National Legislation and Policies

CONSTITUTION 1996

Constitution of the Republic of South Africa

Section 27 enshrines the right to healthcare services. Subject to progressive realization within available resources, it compels government entities to develop policies promoting equitable access. The Constitution mandates spatial justice and non-discrimination, requiring efforts to redress historical inequalities in healthcare provisioning between urban and rural areas.

SPLUMA 2013

Spatial Planning and Land Use Management Act (Act 16 of 2013)

Provides the legislative framework to guide spatial planning and land use management. Incorporates five developmental principles: **Spatial Justice, Sustainability, Efficiency, Resilience,** and **Good Administration.** Designates Overlay Zone 5 for medical nodes, guiding rezoning and development controls in Polokwane.

NDP 2030

National Development Plan (NDP) 2030

Chapter 9 advocates for improved access, quality, and equity of healthcare services and explicitly supports the Limpopo Central Hospital to strengthen tertiary care capacity in underserved provinces.

NHI ACT 2019

National Health Insurance (NHI) Act

Establishes a framework for financing and delivering universal health coverage. Phase 3 (2023–2026) focuses on fund holder contracting and integrating private and public providers. Polokwane aligns by promoting PPPs, telehealth expansion, and infrastructure upgrades consistent with national contracting requirements.

NHA & NEMA

National Health Act (2003) & NEMA (1998)

NHA regulates health facility licensing, ensuring safety, quality standards, and patient rights. NEMA governs environmental impact assessments (EIAs) for developments exceeding 500 m², requiring sustainable design compliance including stormwater management, biodiversity conservation, and solar energy use.

MFMA 2003

Municipal Finance Management Act

Governs municipal financial planning and expenditure, ensuring transparent, accountable budgeting. Phased capital investments (R500 million+ over the MTREF) comply with MFMA requirements, ensuring fiscal prudence and sustainable funding.

THP ACT 2007

Traditional Health Practitioners Act (No. 22 of 2007)

Regulates the traditional health profession and establishes the Interim Traditional Health Practitioners Council of South Africa. The Polokwane framework integrates traditional medicine by designating specific **traditional medicine hubs** within medical precincts, ensuring cultural sensitivity and safety. It formalizes the role of registered traditional practitioners in the primary healthcare continuum.

SECTION 4 — LEGAL AND REGULATORY FOUNDATIONS (CONTINUED)

4.2 Provincial Level Frameworks

LIMPOPO DEV PLAN

Limpopo Development Plan (2022–2027)

Prioritizes the Limpopo Central Hospital as a catalytic project, situating Polokwane as the province's primary health node. Aligns infrastructure investment with provincial growth corridor strategies.

LIMPOPO SDF

Limpopo Spatial Development Framework

Designates Polokwane as a key urban node and promotes cluster-based growth, including the **R71 corridor** for urban-rural linkages and healthcare accessibility enhancement.

4.3 Municipal Level Instruments

Polokwane IDP and SDF (2025/26) outline health infrastructure development as **Key Performance Area 2**, emphasizing cluster-based planning across seven IDP clusters. The Polokwane Integrated Land Use Scheme (2022) codifies **Use Zone 10** (Institutional) and **Overlay Zone 5** (Medical Nodes). Clauses 36–37 allow development relaxations conditional upon public participation and environmental compliance.

4.4 Alignment and Integration Matrix

TABLE 4.1 — REGULATORY ALIGNMENT MATRIX

INSTRUMENT	KEY PROVISION	POLICY LINKAGE
Constitution (1996, s27)	Right to healthcare; progressive realization	Equitable access mandate
SPLUMA (2013, s5-8)	Spatial justice, sustainability, efficiency	Rural precinct prioritization; zoning overlays
NDP 2030	Universal health coverage; infrastructure-led growth	Infrastructure investment focus
NHI Act (2019)	Fund holder contracting; private integration	PPP contracting; 5,000+ job creation
THP Act (2007)	Registration and regulation of traditional healers	Integration of traditional medicine hubs; cultural sensitivity
NHA (2003) & NEMA (1998)	Facility licensing; EIAs for >500 m²	Environmental and health compliance
MFMA (2003)	Phased municipal budgeting	Sustainable finance management
Limpopo Development Plan	Central Hospital priority	Catalytic project designation
Polokwane IDP/SDF (2025/26)	Cluster-based health strategies	Functional health hierarchy
Polokwane Land Use Scheme	Overlay Zone 5; Clause 37 relaxations	Threshold controls; zoning flexibility

4.5 International Standards and Best Practice Alignment



WHO Guidelines

Targets WHO-recommended bed densities (5/1,000) and integrates telehealth and green infrastructure benchmarks consistent with WHO's Healthy Cities framework (WHO, 2020).



UN Sustainable Development Goals

Contributes toward SDG 3 (Good Health) and SDG 11 (Sustainable Cities), emphasizing equitable, sustainable, and resilient healthcare infrastructure (UN, 2015).

 SECTION 5

Vision, Mission, Principles & Objectives

Clear articulation of vision, mission, guiding principles, and strategic objectives is essential for steering the integrated medical development of Polokwane. These elements align stakeholders, guide implementation, and measure progress toward sustainable and equitable healthcare outcomes.

5.1 Vision Statement

OFFICIAL VISION — PIMD-PF 2026

"Polokwane shall be Limpopo's **inclusive, resilient, and innovation-driven** medical ecosystem — characterized by **equitable access, environmental sustainability, and integrated healthcare delivery** that effectively serves urban and rural populations alike."



INCLUSIVITY

No population group marginalized; special attention to rural and underserved areas with targeted investment.



RESILIENCE

Systems capable of withstanding epidemiological transitions, economic shocks, and climate variability.



INNOVATION

Leveraging telehealth, digital diagnostics, and green infrastructure for quality and efficiency gains.

5.2 Mission Statement

STRATEGIC MISSION

"To deliver **SPLUMA-optimized, precinct-based healthcare infrastructure** that integrates public, private, and traditional providers, ensuring **universal access** to quality health services across Polokwane through sustainable, equitable, and innovative approaches."



SPLUMA OPTIMIZATION

Embedding spatial justice, efficiency, and sustainability in land use planning for all health precincts.



UNIVERSAL ACCESS

Equitable healthcare availability irrespective of geography or socioeconomic status across all zones.



INTEGRATION OF PROVIDERS

Coordinated delivery among government clinics, private hospitals, traditional healers, and NPOs.

SECTION 5 — GUIDING PRINCIPLES & STRATEGIC OBJECTIVES (CONTINUED)

5.3 Guiding Principles

The policy framework is underpinned by six interrelated guiding principles, consistent with national legislation (SPLUMA, NDP), international best practices, and local needs assessments.



5.3.1 EQUITY

Prioritize healthcare access for rural, peri-urban, and historically underserved populations, redressing apartheid-era spatial imbalances per SPLUMA Section 5(a).

Target: 75% Rural Access Index by 2030



5.3.2 SUSTAINABILITY

Integrate environmentally responsible design and operations to minimize ecological footprint and ensure resource efficiency (NEMA compliance).

Target: 50% Green Energy Adoption



5.3.3 INTEGRATION

Foster mixed-use precincts combining health, residential, and commercial functions to enhance accessibility and reduce travel distances.

Target: 30% Commercial/Residential Mix



5.3.4 INNOVATION

Leverage digital health tools, telemedicine, AI, and data analytics to improve service delivery, especially in rural areas (WHO, 2021).

Target: 20% Outpatient Telehealth Shift



5.3.5 CULTURAL SENSITIVITY

Recognize and incorporate traditional medicine practices within the formal healthcare system, enhancing acceptability and holistic health approaches (DoH, 2023).

Action: Establish Traditional Medicine Hubs



5.3.6 RESILIENCE

Design facilities capable of withstanding shocks such as epidemics, floods, and power outages (WHO Health System Strengthening, 2020).

Target: 20% Surge Capacity; 100% Uptime

5.4 Strategic Objectives

-  **1. Environmental Protection & Green Precinct Development** — Implement NEMA-compliant green precincts with solar energy, rainwater harvesting, and biodiversity conservation. Minimum 30% open and green spaces within medical precincts.
-  **2. Enhancement of Development Corridors & Nodes** — Prioritize healthcare infrastructure along the R71 corridor. Promote densification in seven identified growth nodes.
-  **3. Promotion of Densification & Efficient Land Use** — Encourage vertical expansion with height relaxations up to 5 storeys. Reduce land consumption per hospital bed from 150 m² to 120 m².
-  **4. Leveraging Economic Opportunities through Job Creation** — Facilitate creation of 5,000+ health-related jobs through PPPs, NHI contracting and precinct-linked employment.
-  **5. Provision of Facilities Based on Functional Hierarchy** — Adhere to established bed density targets (4.44 beds/1,000 by 2030) differentiated by urban, peri-urban, and rural clusters.
-  **6. Optimization of Infrastructure & Central Hospital Synergies** — Integrate new investments with the Limpopo Central Hospital to improve referral pathways and deploy telehealth pods and mobile units.

5.5 Alignment with Broader Frameworks

TABLE 5.1 — FRAMEWORK ALIGNMENT SUMMARY

FRAMEWORK	RELEVANCE TO THIS POLICY
NDP 2030	Good Health and Sustainable Cities commitments embedded in all strategic objectives.
SDGs 3 & 11	Equitable access, environmental sustainability, and resilient infrastructure mandates.
IDP & SDF	Cluster-based, spatially coherent healthcare delivery across 7 IDP clusters.

 SECTION 6

Scope and Applicability

The scope delineates the geographic, sectoral, temporal, and stakeholder boundaries within which the framework operates, ensuring focused implementation and inclusivity of all key actors.

6.1 Geographic Scope

The policy applies comprehensively to the entire jurisdiction of Polokwane Local Municipality, covering approximately **1,978 km²** and encompassing seven IDP clusters.

TABLE 6.1 — GEOGRAPHIC ZONE DISTRIBUTION — 2026

ZONE	2026 POPULATION	HEALTHCARE ROLE
Urban Core (CBD)	~207,000	Primary tertiary healthcare hub — Limpopo Central Hospital anchor
Growth Nodes (Seshego/Mankweng)	~181,000	Rapid urbanization; emerging demands — district hospital level
Rural Areas	~98,000	Significant access challenges; mobile clinics and telehealth pods
Industrial & Agricultural Zones	~33,000	Specialized occupational health services and ambulance staging

6.2 Sectoral Scope



PRIMARY HEALTHCARE

Clinics, mobile units, CHCs, and traditional medicine hubs providing frontline services.



SECONDARY HEALTHCARE

District and regional hospitals offering specialist and inpatient services.



TERTIARY HEALTHCARE

Limpopo Central Hospital and other tertiary referral facilities delivering advanced care.



PRIVATE & NPO PROVIDERS

Entities participating in NHI contracting, community-based and faith-based service providers.

6.3 Temporal Scope

TABLE 6.2 — IMPLEMENTATION PHASES

PHASE	PERIOD	KEY ACTIVITIES
Phase 1	2026	EIAs, rezoning, LCH anchor integration, governance establishment and foundational infrastructure
Phase 2	2027–2028	Clinic upgrades, telehealth deployment, microgrid energy systems, mobile clinic network expansion
Phase 3	2029–2030	Bed capacity optimization, green infrastructure scaling, 50+ KPI reviews and adaptive management

6.4 Applicability to Stakeholders



Developers and Healthcare Providers

Must comply with the framework when seeking rezoning or land use permissions for all medical developments.



Municipal Authorities

Responsible for land use administration, development approvals, and compliance monitoring across all zones.



Provincial Departments

Including Health, Cooperative Governance, and Environmental Affairs in Limpopo Province.



Community and Civil Society

Engagement mechanisms ensure community voices are incorporated in planning; 21-day public notices mandatory.



PPP Entities

Must align joint venture projects with policy objectives, NHI contracting, and all regulatory standards.

6.5 Exclusions

⚠ The following categories are excluded from this framework: Pure research laboratories without direct healthcare delivery; non-medical noxious uses; hazardous industrial activities within medical zones; and non-healthcare land uses governed by existing regulations (unless within authorized mixed-use precincts).

SECTION 7

Contextual and Situational Analysis

An evidence-based understanding of Polokwane's demographic dynamics, socioeconomic conditions, health profile, and infrastructure baseline is critical for informed policy formulation and targeted healthcare interventions.

7.1 Demographic Profile

7.1.1 POPULATION SIZE AND GROWTH

Polokwane Municipality covers approximately **1,978 km²** with an estimated 2026 population of **519,000**, projected to increase to **573,000 by 2030** — a CAGR of 2.3–2.4%. Growth is driven by natural increase (~1.8%) and net migration (0.5–0.6%) attributable to Polokwane's status as a regional economic hub (Stats SA, 2025).

TABLE 7.1 — POPULATION PROJECTIONS BY ZONE (2026–2030)

YEAR	URBAN CORE	GROWTH NODES	RURAL	IND./AGRI.	TOTAL
2026	207,000	181,000	98,000	33,000	519,000
2028	227,000	198,000	96,000	31,000	552,000
2030	247,000	220,000	85,000	21,000	573,000

7.1.2 AGE STRUCTURE AND DEPENDENCY

Polokwane exhibits a youthful demographic profile, with approximately **60% of the population under 35**. The 2022 age distribution showed 28.1% under 15 years, 65.1% between 15–64 years, and 6.8% aged 65+. The high youth dependency ratio drives increased demand for maternal and child health services.

7.1.3 ETHNIC AND CULTURAL COMPOSITION

The population is predominantly Black African (~**93.5%**), primarily comprising Bapedi (Northern Sotho), Tsonga, and Venda ethnic groups, each with distinct cultural practices influencing health-seeking behaviors. White (~5%), Coloured and Indian/Asian (~1.5%).

7.2 Socioeconomic Context

28.2%

PROVINCIAL UNEMPLOYMENT RATE

45%+

YOUTH UNEMPLOYMENT (18–34)

16.8%

ADULTS WITH TERTIARY QUALIFICATIONS

7.2.1 EMPLOYMENT AND INCOME

High unemployment constrains household incomes, limiting access to private health insurance and increasing reliance on public services. Health sector GVA contributes roughly 8–10% of municipal GDP.

7.2.3 ACCESS TO BASIC SERVICES

⚡ Electricity Access (lighting)	95.0%
🚽 Flush Toilets (sewerage)	48.3%
💧 Piped Water inside Dwelling	41.4%

SECTION 7 — SITUATIONAL ANALYSIS (CONTINUED)

7.3 Health System Overview and Epidemiological Trends

7.3.1 HEALTHCARE INFRASTRUCTURE

Baseline: **2,129 hospital beds** — urban core (1,125), growth nodes (685), rural (241), other (78). Ambulance services: 45 vehicles at 85% operational status. Bed density averages **4.2 beds/1,000**, below the WHO ideal of 5.0 (WHO, 2020).

7.3.2 DISEASE BURDEN

Dual burden of disease: HIV/AIDS, TB, and diabetes prevalent. Adult hypertension and diabetes affecting **~35% of the population**. Post-COVID-19 mental health disorders surged **20%**. Severe acute malnutrition mortality: 12.4% (vs. 7.3% target) — critical concern.

7.4 Infrastructure and Services Assessment

7.4.1 ENERGY AND WATER

Only **10% green energy adoption**. Healthcare facilities rely on fossil fuel-dependent grid electricity. Water supply is vulnerable to drought-related disruptions. Solar microgrids and rainwater harvesting are key policy priorities.

7.4.2 TRANSPORT AND CONNECTIVITY

The **R71 corridor** is the critical arterial linking urban cores to rural clusters. Rural road conditions and public transport limitations hamper timely access, requiring mobile clinic deployment and telehealth expansion.

7.5 SWOT Analysis

STRENGTHS

- › Strategic hub status with Provincial and Central Hospitals
- › Well-defined SDF nodes and cluster planning framework
- › Limpopo Central Hospital under active development (488 beds)
- › Established private health anchors (Pholoso Hospital — 200 beds)

WEAKNESSES

- › Rural access gaps — >5 km travel for 45% rural residents
- › Workforce shortages compounded by 28.2% unemployment
- › Aging infrastructure at the Provincial Hospital
- › Low green energy adoption (only 10%)

OPPORTUNITIES

- › Expansion of NHI Phase 3 and PPP contracting pipelines
- › Telehealth and digital health technology deployment
- › Green jobs in solar energy and water sectors
- › Formal integration of traditional medicine systems

THREATS

- › Funding delays and inflation (>5% escalation risk)
- › Climate and drought-related water scarcity
- › Disease surges and post-COVID-19 burden
- › Rapid urbanization at 2.4% CAGR stressing infrastructure

7.6 Key Insights and Policy Implications

- › The youthful and growing population necessitates expansion of maternal, child, and chronic disease services.
- › Socioeconomic challenges limit private health coverage uptake and increase public sector reliance.
- › Infrastructure deficits in rural and peri-urban clusters require targeted investments in facility expansion, mobile clinics, and telehealth.
- › Environmental vulnerabilities demand incorporation of sustainable, resilient designs in all healthcare infrastructure.

 SECTION 8

Benchmarking with Best Practices

8.1 Local Best Practice Models

SA BEST PRACTICE

8.1.1 Ideal Clinics Programme (South Africa)

A national health systems strengthening initiative targeting infrastructure upgrades and patient-centered care standards (DoH, 2019). Polokwane clinics have achieved approximately **70% compliance**, approaching the national target of 85%. Key lessons: facility standards, improved waiting times, data-driven management, and performance feedback loops.

SA BEST PRACTICE

8.1.2 Presidential Health Compact & NHI Pillars

South Africa's Presidential Health Compact sets pillars for universal health coverage, emphasizing equitable access and quality improvement. Polokwane's PPP and precinct-based service models align with the Compact's goals to reduce service fragmentation in peri-urban and rural clusters.

SA MUNICIPAL MODEL

8.1.3 eThekweni Municipality's Health Precincts

eThekweni (Durban) pioneered mixed-use health precincts integrating clinics within Business 3 zoning areas, fostering accessibility and urban synergy (eThekweni Municipality, 2021). This model directly informs Polokwane's **Overlay Zone 5** strategy for reducing travel distances and promoting co-location of health and commercial uses.

8.2 International Benchmarking



WHO Global Benchmarking Tool

Recommends 4.44 beds/1,000 (SA-adjusted). Guides Polokwane's target of 2,240 beds by 2030, emphasizing quality assurance and digital health solutions (WHO, 2020).



Singapore Telehealth Hubs

40% of outpatient consultations delivered digitally, using AI diagnostics and remote monitoring (Singapore MoH, 2022). Polokwane targets a 20% shift to telehealth by 2030.



Rwanda One Health Drone Delivery

Drone technology delivers medical supplies to remote rural areas, overcoming geographic barriers (Drone Delivery Canada, 2021). Informs Polokwane's telehealth pod and mobile clinic strategy.



Cape Town Green Hospital Retrofits

Achieved 40% solar energy and 60% water recycling (Western Cape DoH, 2023). Informs Polokwane's 50% green energy target and rainwater harvesting mandate.

8.3 Comparative Adoption Table

TABLE 8.1 — INTERNATIONAL AND LOCAL BEST PRACTICE ADOPTION

PRACTICE / INNOVATION	SOURCE	POLOKWANE APPLICATION	KEY BENEFITS
WHO Global Benchmarking Tool	WHO (2020)	Bed density target: 4.44 beds/1,000	Standardized quality and capacity metrics
Ideal Clinics Programme	SA DoH (2019)	85% facility compliance target	Enhances quality and access at PHC level
Singapore Telehealth Model	Singapore MoH (2022)	20% outpatient telehealth shift	Expands access; reduces facility load
Rwanda Drone Delivery	Drone Delivery Canada (2021)	Telehealth pods in rural north/south	Overcomes geographic barriers

SECTION 9

SPLUMA Principles & Liveable Environments

SPLUMA (Act 16 of 2013) mandates five interrelated developmental principles underpinning all land use and planning decisions. This section explicates how these principles are embedded in the IMDPF, enabling healthcare precincts to foster equitable access and liveable environments.

9.1 Spatial Justice — Equitable Access and Redress

SPLUMA Section 5(a) requires spatial planning to redress historical inequalities, prioritizing rural and marginalized communities. In Polokwane, entrenched spatial disparities manifest through uneven facility distribution and access barriers in rural north and south clusters.

- Prioritization of Underserved Areas:** 40% of new beds and clinics allocated to growth nodes and rural precincts, including mobile health units in Agricultural Zone 16.
- Threshold Adjustments:** Minimum erf size for rural health posts lowered to 700 m², reducing development barriers.
- Quantitative Equity Targets:** Reduce health access Gini coefficient from 0.45 to 0.30 by 2030, measured through GIS-based spatial heatmaps.
- Monitoring Metrics:** Annual DHIS audits track rural bed density (target: 4.3 beds/1,000). GPS surveys monitor reduction of >5 km travel-time populations from 19% to 5%.

9.2 Spatial Sustainability — Environmental Protection and Resource Efficiency

SPLUMA Section 5(b) mandates sustainable land use integrating environmental conservation. Polokwane's semi-arid context necessitates sustainable practices to mitigate climate risks and conserve scarce water and energy resources.

- Green Precinct Mandates:** Solar microgrids (minimum 100 kWp capacity) mandatory for tertiary facilities. Rainwater harvesting must supply at least 50% of non-potable water needs.
- Zoning Linkages:** Overlay Zone 5 requires minimum 30% open green space. FAR relaxations (0.6 to 0.8) granted conditional on EIA certification.
- Biodiversity Conservation:** No net loss zones designated in agricultural and conservation areas; native species planting mandated for building setbacks (3–5 m).

TABLE 9.1 — SUSTAINABILITY PERFORMANCE TARGETS

Element	Scheme Control	2030 Target	SPLUMA Link
Green Energy %	Solar mandatory for tertiary facilities	50%	Section 5(b) Efficiency
Water Reuse	Rainwater harvesting systems required	50%	NEMA Integration
Open Space	Minimum 30% coverage in all precincts	40%	Livability Overlay

9.3 Efficiency — Optimized Land and Infrastructure Use

SPLUMA Section 5(c) promotes compact, efficient spatial development to maximize infrastructure utility and minimize urban sprawl, supporting cost-effective healthcare delivery.

TABLE 9.2 — EFFICIENCY TARGETS DASHBOARD

Metric	2026 Baseline	2030 Target	Gain
FAR Utilization	0.6	1.4	+133%

Land per Bed (m²)	150 m²	120 m²	-20%
Bed Occupancy	~65%	80%	+23%

SECTION 9 — SPATIAL RESILIENCE, GOOD ADMINISTRATION & LIVEABLE ENVIRONMENTS (CONTINUED)

9.4 Spatial Resilience — Adaptation to Shocks

SPLUMA Section 5(d) emphasizes resilience to climate variability, disease outbreaks, and other shocks, ensuring healthcare infrastructure continuity and surge capacity.

- **Surge Capacity:** Medical facilities must accommodate a 20% increase in beds for epidemic or disaster surges within 72 hours.
- **Flood-Resilient Design:** Buildings in flood-prone areas adhere to 1:100-year floodline setbacks with elevated floors.
- **Backup Power:** Solar-powered backup systems ensure 100% uptime during grid failures for life-saving equipment.
- **Telehealth and Ambulance Staging:** Priority deployment of telehealth pods in rural areas and ambulance staging zones in industrial clusters.

TABLE 9.3 — RESILIENCE INDICATORS AND CAPACITY TARGETS

RISK	CONTROL MEASURE	CAPACITY TARGET
Drought / Power Failure	Solar backup systems (50% share)	100% critical equipment uptime
Flood Inundation	5 m building setback; elevated floors	Zero inundation compliance
Epidemic Surge	Modular surge design in all new builds	+20% bed capacity within 72 hrs

9.5 Good Administration — Inclusive Governance

SPLUMA Section 5(e) requires transparent, participatory, and accountable administrative processes. Polokwane operationalizes this through:



PUBLIC PARTICIPATION

All rezoning applications undergo a minimum **21-day public notice period** and Municipal Planning Tribunal hearings.



STAKEHOLDER ENGAGEMENT

Annual IDP forums with over **500 attendees** ensure community inputs are incorporated into planning decisions.



DIGITAL PLATFORMS

Online portals facilitate access to planning documents, public comments, and compliance reporting to Council.

9.6 Liveable Environments — Beyond SPLUMA

Building on SPLUMA, the policy integrates UN-Habitat and WHO Healthy Cities frameworks to promote environments enhancing health, well-being, and social cohesion (UN-Habitat, 2020; WHO, 2017).



ACTIVE TRANSPORT

Bike lanes and pedestrian paths ensuring 80% coverage linking residential areas to health facilities.



GREENING

30% minimum open green space with tree canopies to mitigate urban heat islands and promote biodiversity.



SOCIAL SPACES

20% of precinct areas designated for public social interaction, promoting mental health and community resilience.

9.7 Integrated Compliance Framework

The framework institutionalizes a **SPLUMA Application Protocol** requiring:

- Pre-application consultations with municipal planning officials.
- Motivation Reports demonstrating adherence to all five SPLUMA principles.
- Post-approval monitoring via annual audits and EIA compliance reviews.



SECTION 10

Strategic Spatial Proposals & Implementation Framework

This section translates the integrated medical development vision into spatially explicit proposals and a structured implementation plan, organizing healthcare infrastructure into functional nodes and applying zoning and development controls.

10.1 Medical Node Classification and Hierarchy



PRIMARY NODE — URBAN CORE

Population: 200,000+. Role: Tertiary & Specialist Care. Example: Limpopo Central Hospital. Scale: 20+ ha. Service Radius: 30+ km region-wide.



SECONDARY NODE — GROWTH NODE

Population: 50,000–200,000. Role: District Hospital & CHC. Examples: Seshego, Mankweng. Service Radius: 10–30 km peri-urban.



TERTIARY NODE — RURAL/COMMUNITY

Population: 5,000–50,000. Role: Community/Mobile Clinic. Examples: Clinics, Telehealth Pods. Scale: 5–10 ha. Radius: up to 5 km.

10.2 Overlay Zoning and Development Controls

The Polokwane Integrated Land Use Scheme (2022) designates **Use Zone 10 (Institutional)** with **Overlay Zone 5 (Medical Nodes)** to regulate healthcare developments. The scheme permits mixed-use precincts with specific relaxations for densification and sustainability, contingent on environmental compliance under NEMA.

10.3 Phased Implementation Overview



PHASE 1

2026

Environmental and spatial planning, precinct rezoning, integration of the Limpopo Central Hospital within the urban core node, and establishment of foundational infrastructure and governance arrangements.



PHASE 2

2027–2028

Clinic upgrades, telehealth deployments, and renewable energy installations within growth and district nodes. Expanding accessibility and sustainability through solar microgrids and mobile clinic networks.



PHASE 3

2029–2030

Capacity scaling with bed expansions, green infrastructure optimization, and comprehensive performance evaluation via more than 50 Key Performance Indicators with adaptive management responses.

10.4 Spatial Prioritization Criteria and Node Delineation

Nodes are selected based on: population concentration and growth projections; existing healthcare infrastructure capacity and deficits; transport and accessibility corridors (especially the R71); and equity considerations targeting underserved rural and peri-urban zones. Boundaries use cadastral and satellite data with radial buffers (200–1,000 m) for future-proofing.

10.5 Risk Mitigation and Adaptive Management



DIVERSIFIED FUNDING

Municipal capital, PPPs, NHI resources, and grant mechanisms to reduce single-source dependency.



CLIMATE-RESILIENT DESIGN

Flood line setbacks, solar backups, and water harvesting integrated into all new facilities.



CONTINUOUS MONITORING

Annual audits of over 50 KPIs with adaptive management protocols and Council reporting.

 SECTION 11

Criteria for Evaluating Applications

All applications for medical facilities, rezoning, consent uses, or overlay zone permissions shall be evaluated using a transparent, consistent, multi-criteria assessment framework ensuring rigour, equity, and regulatory compliance.

11.1 Compliance with Zoning and Land Use Schemes

- › Compatibility with designated Use Zones (10, 12, 16) and Overlay Zone 5 under the Polokwane Land Use Scheme (2022).
- › Alignment with the Polokwane SDF, IDP cluster hierarchy, and medical node classification.
- › Compliance with development controls: height limits, FAR, coverage, setbacks, and parking standards as per Appendix B.
- › Demonstration that the proposal does not introduce incompatible uses prohibited within the designated zone.

11.2 Municipal By-laws and Health Standards Compliance

- › Full compliance with all relevant municipal by-laws, including Polokwane Health By-laws, Waste Management By-laws, and Environmental Health By-laws.
- › Adherence to national health standards under the National Health Act (2003): facility licensing, infection control, medical waste management (Category A, B & C), sanitation, ventilation, and patient safety.
- › Proof of registration and licensing with statutory bodies such as HPCSA, South African Pharmacy Council, and South African Nursing Council (where applicable).
- › Compliance with OHS Act 85 of 1993, fire safety regulations (SANS 10400), and emergency evacuation standards.
- › **Traditional Health Practice Compliance:** Any facility incorporating traditional medicine must provide proof of practitioner registration with the Interim Traditional Health Practitioners Council, adhering to the THP Act (No. 22 of 2007).

11.3 Potential Community Impact and Feedback

- › Assessment of socio-economic, traffic, noise, visual, and health impacts on surrounding communities.
- › Consideration of public participation outcomes from the mandatory 21-day public notification period and MPT hearings.
- › Demonstration of how the application addresses healthcare gaps in the IDP, particularly in underserved rural and peri-urban clusters.
- › Positive weighting for proposals generating employment (aligned with 5,000+ job target) and improving equitable access.
- › Community impact must reflect SPLUMA's spatial justice principle, ensuring benefits for historically disadvantaged and rural populations.

11.4 Infrastructure Feasibility and Environmental Considerations

- › Detailed Engineering Services Report confirming adequate capacity or funded upgrades for water, sewerage, electricity, stormwater, and roads.
- › NEMA compliance: EIA or Basic Assessment where the development exceeds 500 m² or is in a sensitive area.
- › Green infrastructure: solar PV systems, rainwater harvesting (minimum 30–50% of non-potable demand), and at least 30% open/green space.
- › Climate resilience measures including flood-line setbacks, backup power systems, and drought-resistant design.

- Medical waste management plan preventing contamination of groundwater or surrounding areas.

11.5 Parking, Ablution, and Subservient Facilities

11.5.1 PARKING REQUIREMENTS

TABLE 11.1 — PARKING STANDARDS BY FACILITY TYPE

FACILITY TYPE	PARKING STANDARD	ADDITIONAL REQUIREMENTS
General (consulting rooms)	4 bays per consulting room or 25 m² GLA	Higher of threshold table or this standard
Hospitals & Inpatient Facilities	1 bay per 3 patient beds + 6 bays per 100 m² public area	TIA mandatory for >5 rooms or 300 m²
Clinics & Outpatient Facilities	4 bays per consulting room + 1 bay per 50 m²	Screened from street with landscaping
RMOZ	Min 4 bays per room + 1 per 50 m² public area	Must not dominate front garden
Accessible Parking	Minimum 5% of total bays (min 1 bay)	SANS 10400 Part S compliance

11.5.2 ABLUTION (SANITATION) FACILITIES

- 1 toilet per 10 beds (inpatient) or 1 per 15 patients/staff (outpatient), whichever is greater.
- Separate male, female, and accessible toilets. At least 1 shower per 20 beds in overnight facilities.
- Minimum 1 unisex accessible toilet per floor or per 200 m² GLA, equipped with grab rails and emergency call systems.
- Dedicated staff ablutions separate from public use. Hands-free taps, antimicrobial surfaces, and proper ventilation are mandatory.
- Rural/mobile facilities: chemical or composting toilets permitted where municipal sewerage is unavailable, subject to environmental approval.

11.6 Weighted Scoring Matrix

TABLE 11.2 — EVALUATION CRITERIA: WEIGHTED SCORING MATRIX

CRITERION	MAX POINTS	MIN PASS (60%)	KEY FOCUS AREAS
Compliance with Zoning & Land Use Schemes	25	15	Alignment with SDF, zoning maps, node hierarchy, and Overlay Zones
Municipal By-laws & Health Standards	20	12	NHA (No. 61 of 2003) compliance; by-laws on waste, food safety, premises
Community Impact & Spatial Justice	20	12	Public hearings under SPLUMA; equitable access and socio-economic upliftment
Infrastructure Feasibility & Environmental	20	12	NEMA EIAs, bulk services, climate resilience, and green building standards
Parking, Ablution & Subservient Facilities	15	9	SANS 10400 standards for parking ratios, sanitation, and ancillary structures
TOTAL	100	60	No individual criterion may fall below 60% of its allocated points

All five criteria are mandatory. Failure to meet the 60% threshold in any single criterion results in automatic referral back regardless of total score.

APPENDIX Glossary of Terms

Ambulatory Surgical Centres (ASCs)

Licensed healthcare facilities specializing in outpatient surgical procedures where patients are admitted and discharged within 24 hours. ASCs focus on elective, low- to moderate-risk surgeries in controlled environments outside hospitals, emphasizing efficiency and quality outcomes.

Authorized Official

An official of the municipality authorized in terms of SPLUMA Section 35(2) to consider and decide on specific categories of land development and land use applications as delegated by the municipal council.

Birth Centres

Facilities dedicated to midwifery-led care for low-risk pregnancies, offering antenatal, labour, delivery, and postpartum services in a home-like, wellness-oriented environment promoting natural childbirth with cultural sensitivity and family involvement.

Blood Banks

Specialized units responsible for collection, testing, processing, storage, and distribution of blood and blood products, ensuring a safe and sufficient supply for transfusions adhering to national and international standards.

Clinics

Outpatient healthcare facilities providing preventive, diagnostic, therapeutic, and primary or specialized care without overnight stays, staffed by multidisciplinary healthcare workers focusing on accessible ambulatory care.

Community Health Centre (CHC)

Public health facilities offering comprehensive outpatient services with limited short-stay inpatient capacity (usually 48–72 hours), providing emergency care, maternal/child health, minor surgical procedures, and referrals.

Culturally-Based Health Practices

Traditional and indigenous health systems incorporating holistic approaches (spiritual, physical, and social) to health, recognized by WHO, including herbal remedies, spiritual rituals, and community healing practices.

Diabetes Education Centres

Specialized outpatient programs delivering structured education and support to diabetes patients for self-management, including blood glucose monitoring, nutrition, medication adherence, and complication prevention.

Dialysis Centres

Facilities providing renal replacement therapy (hemodialysis or peritoneal dialysis) for patients with kidney failure, staffed by specialized medical teams ensuring safe and effective treatment with monitoring and supportive care.

District Hospital

Public inpatient facilities (usually 50–600 beds) providing essential secondary-level care including emergency, medical, surgical, maternity, paediatrics, and basic diagnostics, serving defined district populations.

— APPENDIX A — GLOSSARY OF TERMS (CONTINUED)

Hospice Homes

Residential facilities offering specialized palliative and end-of-life care to terminally ill patients, focusing on pain and symptom management, emotional and spiritual support, and dignity during the final stages of life.

Hospitals

Licensed inpatient healthcare institutions equipped to provide comprehensive medical, surgical, and nursing care for acute and chronic illnesses, including emergency services, operating theatres, and intensive care.

Imaging and Radiology Centres

Outpatient facilities performing diagnostic and interventional imaging such as X-rays, CT scans, MRIs, and mammography, staffed by radiologists adhering to safety and quality standards.

Medical Consulting Rooms

Private consultation spaces within clinics or medical centres where healthcare professionals conduct patient examinations, diagnosis, and treatment planning, ensuring confidentiality and clinical functionality.

Mental Health and Addiction Treatment

Specialized inpatient, outpatient, or residential facilities providing psychiatric and addiction services through multidisciplinary teams, offering psychotherapy, medication, and rehabilitation.

Mobile / Outreach Clinic

Temporary or vehicle-based healthcare services delivering primary care, screenings, vaccinations, and treatment to remote or underserved communities, extending healthcare access beyond fixed facilities.

Municipal Planning Tribunal (MPT)

A body established by a municipality in terms of SPLUMA Section 35(1) to decide on land development and land use applications. Comprises municipal officials and external experts with knowledge in spatial planning, land use management, and law.

Nursing Homes

Long-term residential care facilities providing 24-hour nursing and personal care for individuals with chronic illnesses, disabilities, or rehabilitation needs, aimed at maintaining quality of life and safety.

Private Day Hospital / Sub-Acute Hospital

Short-stay facilities offering elective surgeries, minor procedures, infusions, and post-acute care without full acute hospital infrastructure, often part of private healthcare networks.

Regional Hospital

Larger public hospitals (200–800 beds) providing specialist secondary care across multiple disciplines, advanced diagnostics, theatres, and intensive care, serving as referral centres for district hospitals.

Rehabilitation Centres

Facilities offering multidisciplinary programs for restoring function and independence after injury, illness, or surgery, including physical, occupational, speech, and psychological therapies.

SPLUMA

Spatial Planning and Land Use Management Act (Act No. 16 of 2013), governing spatial planning, land use management, public participation, and development control to promote sustainable and equitable urban development in South Africa.

Telehealth

The delivery of healthcare services remotely using digital communication technologies, such as video consultations, remote monitoring, and mobile health applications, extending healthcare access beyond physical facilities.

Traditional / Spiritual Healer

A formally recognized practitioner registered under the Traditional Health Practitioners Act (2007) who uses indigenous knowledge, herbal remedies, and spiritual methods for healing, integrated within regulated health systems.

Unjani Clinic / Container-Based Clinic

Community-oriented private primary care facilities, often housed in converted shipping containers, providing affordable, accessible services with fixed-fee models and telehealth support, targeting underserved populations.

B

APPENDIX

Threshold Table: Zoning and Development Controls

This table governs medical facility developments under the Polokwane Integrated Land Use Scheme (2022), specifying zoning categories, permitted uses, population thresholds, dimensional controls, and regulatory requirements.

TABLE 12.1 — ZONING AND DEVELOPMENT CONTROLS: MEDICAL FACILITY HIERARCHY

Hierarchy Level	Zoning (2022 Scheme)	Permitted Uses	Pop. Threshold / Bed Density	Service Radius	Height / FAR	Coverage
Urban Core Node (Polokwane CBD)	Use Zone 10 (Institution); Overlay Zone 5; Business 5 (Mixed-Use)	Primary: Tertiary Hospitals, Specialist Centres Special Consent: Medical Consulting Rooms, Step-Down Written: Pharmacy ≤36 m² Prohibited: Noxious industries	1 tertiary / 500,000+ Bed density: 1.22–5.0/1,000 (2026: ~207,000)	30+ km region-wide	3–5 storeys / FAR 0.6–0.8	60–80% (Clause 37)
Growth Nodes (Seshego, Mankweng)	Use Zone 10; Use Zone 2–3 (Residential Overlay)	Primary: District Hospitals, CHCs, Clinics Special: Consulting Rooms, Nursing Homes Written: Telehealth Pods Prohibited: Full hospitals in pure residential zones	1 hospital / 50,000 Bed density: 1.22–3.5/1,000 (2026: ~181,000)	10–30 km peri-urban	2–5 storeys / FAR up to 1.4	70–85% (Clause 37)
Rural Settlements (Dispersed Villages)	Use Zone 16 (Agricultural, Conditional); Overlay Zone 5	Primary: Clinics, Health Posts Special: Small Community Hospitals, Nursing Homes Written: Mobile/Outreach Units, Traditional Medicine Centres Prohibited: Large Hospitals	1 clinic / 5,000–20,000 Bed density up to 4.3/1,000 (2026: ~98,000)	Up to 5 km scattered	2–3 storeys / FAR 0.6–1.4	Up to 70%
Industrial & Economic Areas	Use Zone 12 (Industrial); Overlay Zone 5	Primary: Occupational Health Clinics, First Aid Special: Trauma Stabilization, Worker Wellness Written: Ambulance Staging Prohibited: Full hospitals	Bed density ~3/1,000 Variable industrial workforce	Proximity to workforce	2–3 storeys / FAR 0.6–0.8	60–80%

Local & Neighbourhood Facilities	Use Zones 7–9 (Business 2/3); Use Zones 1–4 (Residential)	Primary: Medical Consulting Rooms (GPs, Dentists) Special: Large Practices, Telehealth, Nursing Homes Written: Social Refuge Centres Prohibited: Hospitals	Small: 1/2,000–10,000 Large: 1/50,000 urban	0.5–5 km mixed areas	2–5 storeys / FAR 1.2–1.8	70–85% (Clause 37 up to 30% relaxation)
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APPENDIX

Demographic and Health Data Tables

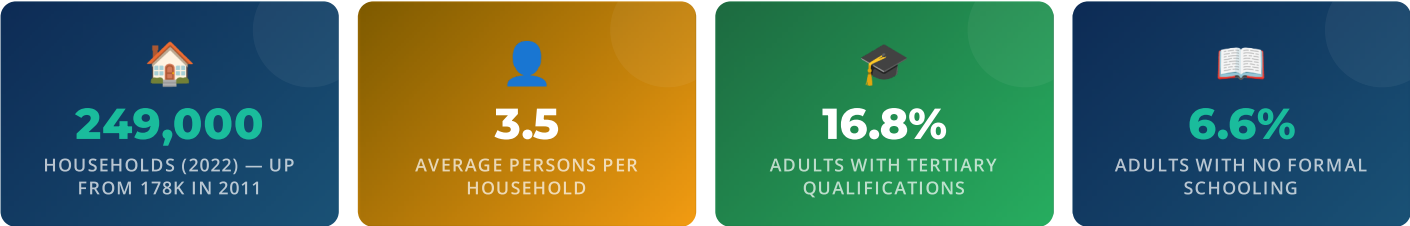
Polokwane is a rapidly growing urban centre and economic hub in Limpopo Province, displaying dynamic demographic trends that impact service delivery, urban planning, and health infrastructure development.

Population Size and Growth

TABLE 12.2 — POPULATION SIZE AND GROWTH TRENDS

YEAR	ESTIMATED POPULATION	GROWTH RATE	KEY DRIVERS
2011	~629,000	2.15% avg.	Natural increase and in-migration
2013	~656,000	~2.15%	Regional hub attraction
2024	~494,000 (municipal boundaries)	~3.0%	Accelerated urbanization
2026	~519,000	2.4%	Urban core & peri-urban growth
2030 (projected)	~573,000	2.3–2.4%	Policy target population

Household Dynamics and Composition



Age Distribution (2022)

TABLE 12.3 — AGE STRUCTURE AND HEALTH SERVICE IMPLICATIONS

AGE GROUP	SHARE (%)	IMPLICATION FOR HEALTH SERVICES
Under 15 years	28.1%	High demand for maternal and child health, immunization, and nutrition services
15–64 years (working age)	65.1%	Productivity potential; NCD prevention and occupational health priorities
65 years and older	6.8%	Growing demand for geriatric care, chronic disease management, and nursing homes

Health and Safety Indicators (2023/24)

TABLE 12.4 — KEY HEALTH PERFORMANCE INDICATORS

INDICATOR	MEASUREMENT	STATUS
Ideal Clinic Compliance (Limpopo)	42%	✓ Exceeds 20% national target
Patient Satisfaction Rate	85%	✓ Exceeds 82% target
Pneumonia Fatality Rate (under 5)	2.4%	✓ Meets target
Diarrhoea Fatality Rate (under 5)	1.6%	✓ Meets target

Severe Acute Malnutrition Mortality	12.4%	⚠️ Above 7.3% target — critical concern
Ambulance Fleet (province-wide)	500 new units procured	✅ Improving coverage and response times

Infrastructure Access Summary (2022/23)

TABLE 12.5 — HOUSEHOLD ACCESS TO BASIC SERVICES

Service	Household Access (%)	Policy Priority
⚡ Electricity (lighting)	~95.0%	Maintain; support solar microgrid transition
🚽 Flush toilets (sewerage)	~48.3%	Critical gap — expand sanitation infrastructure
💧 Piped water inside dwelling	~41.4%	Critical gap — rainwater harvesting and water expansion



APPENDIX

Residential Medical Overlay Zone (RMOZ)

Annexure to the Polokwane Integrated Land Use Scheme (2022) — Polokwane Integrated Medical Development Policy Framework 2026

1. Purpose and Legal Basis

This Annexure introduces the RMOZ as a special overlay applicable to **Use Zones 1–4 (Residential)**. The RMOZ permits medical uses — including full specialist medical practice — within existing and future residential areas while strictly maintaining the residential character, structural character, scale, and amenity of the neighbourhood. It operationalizes: SPLUMA Section 5 principles; Policy Framework Objectives 3, 5, and 9; and Section 10 Threshold Table (Local and Neighbourhood Facilities).

2. Application and Geographic Scope

The RMOZ applies *only* to erven or portions of erven zoned Residential 1–4 that fall within clearly demarcated Medical Nodes or Priority Residential Medical Areas as explicitly shown on the Polokwane SDF maps or as formally designated through Council resolution.

3. Permitted Uses (Medical-Related)



PRIMARY (AS-OF-RIGHT)

Medical Consulting Rooms for General Practitioners and Specialist Medical Specialists (cardiologists, paediatricians, gynaecologists, dermatologists, etc.). Allied health consulting (physiotherapy, OT) integrated with specialist rooms.



SPECIAL CONSENT (MPT REQUIRED)

Small-scale outpatient diagnostics (X-ray/ultrasound only); minor day procedures; diabetes education centres; telehealth pods. Pharmacy ≤36 m²; medical laboratory collection point.



PROHIBITED USES

Hospitals, inpatient wards, nursing homes, sub-acute/step-down facilities with overnight stays, ASCs with general anaesthesia, or any use generating high traffic, noise, or bio-hazard risk incompatible with residential character.

4. Development Controls (To Preserve Residential Character)

TABLE 12.6 — RMOZ DEVELOPMENT CONTROLS

CONTROL	REQUIREMENT	RATIONALE / ALIGNMENT
Maximum Height	2 storeys (max 8 m to eaves)	Maintains residential scale; Clause 37 relaxation NOT permitted
Coverage	Maximum 60% of erf area	Retains substantial open/residential garden area
Floor Area Ratio (FAR)	Maximum 1.2 (no further relaxation)	Prevents over-development altering residential feel
Building Lines	Street: 3 m (relaxable to 1 m for access only). Side/Rear: 2 m (relaxable to 1 m with neighbour consent)	Preserves privacy, light, and ventilation
Green / Open Space	Minimum 20% of site as landscaped garden with indigenous vegetation and tree canopy	Enhances livability, biodiversity, and SPLUMA spatial sustainability

**Architectural
Character**

Design must complement surrounding residential buildings (residential materials, pitched or low-profile roofs, no dominant commercial façade).
Signage limited to 2 m² discreet name plates only.

Strict protection of residential and structural character

 **Important:** Any structural alterations must be minimal and reversible. The building must retain the external appearance of a dwelling house or small residential complex at all times.

5. Parking Provision

Parking shall be provided on-site at the following standard ratio:

- › 4 parking bays per consulting room (or equivalent per 25 m² of gross medical floor area).
- › Plus 1 additional bay per 50 m² of public/waiting/reception area.
- › 5% of total bays must be accessible parking for persons with disabilities (minimum 1 bay).
- › Staff parking: minimum 2 bays per specialist practice.
- › Parking layout must be screened from the street with landscaping and not dominate the front garden.
- › Cash-in-lieu of parking is permitted only in exceptional cases (high-density nodes) with full municipal justification.
- › Traffic Impact Assessment (TIA) required for any proposal >5 consulting rooms or >300 m² GLA.

6. Services and Infrastructure Provision

All applications must include an **Engineering Services and Infrastructure Report** (prepared by a registered professional engineer) confirming:

- › Sufficient municipal capacity for water, sewerage, electricity, and stormwater (or on-site augmentation).
- › Rainwater harvesting system providing at least 30% of non-potable water demand.
- › Solar PV or alternative energy contribution where feasible (minimum 5 kWp for practices >200 m²).
- › Stormwater management that does not increase runoff onto neighbouring residential properties.
- › Waste management plan compliant with health regulations (separate clinical and domestic waste streams).
- › No additional load on residential roads beyond acceptable levels (peak-hour traffic <20 vehicle trips/hour).
- › NEMA EIA compliance if development >500 m² or in sensitive areas. Fire safety compliant with SANS 10400.

7. Operational Conditions (To Protect Residential Amenity)

OPERATIONAL CONDITIONS — RMOZ

CONDITION	REQUIREMENT
Hours of Operation	07:00–18:00 (Monday–Friday); 08:00–13:00 (Saturday). Extended hours by Special Consent only with neighbour consultation.
Noise, Odour & Light	Must be mitigated to residential standards. No audible equipment from neighbouring properties at any time.
Patient Management	Patient and visitor management plan required to minimise street parking and loitering near residential properties.
Compliance Certificate	Annual compliance certificate required from the Municipality confirming ongoing adherence to all conditions.

8. Application Process and Decision-Making



SMALL-SCALE (<200 M² GLA)

Written Consent with **30-day neighbour notification period** and basic motivation report.



LARGER / INTENSIVE USES

Special Consent via Municipal Planning Tribunal — **21-day public notice** plus site notice displayed on the property.



MOTIVATION REPORT

Must explicitly address: (i) maintenance of residential character; (ii) SPLUMA principles compliance; (iii) alignment with Policy Framework Sections 9 and 10.

Conditions of approval may include time-limited consent (reviewable every 5 years) and performance bonds for infrastructure upgrades.

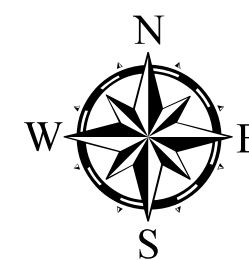
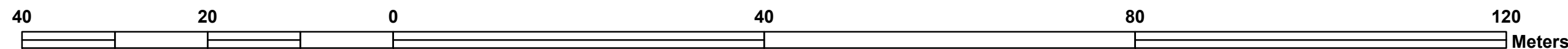
| 9. Monitoring, Enforcement, and Review

- › Municipal Town Planning Department to conduct **annual site audits** for all RMOZ approvals.
- › Non-compliance (e.g., conversion to non-medical use or breach of character controls) may result in withdrawal of consent and enforcement action under the Land Use Scheme.
- › This Annexure will be reviewed as part of the **5-year Land Use Scheme review** or earlier if NHI or IDP amendments require adjustment.

Bo-okelo Street Seshego A Extension 2

Legend

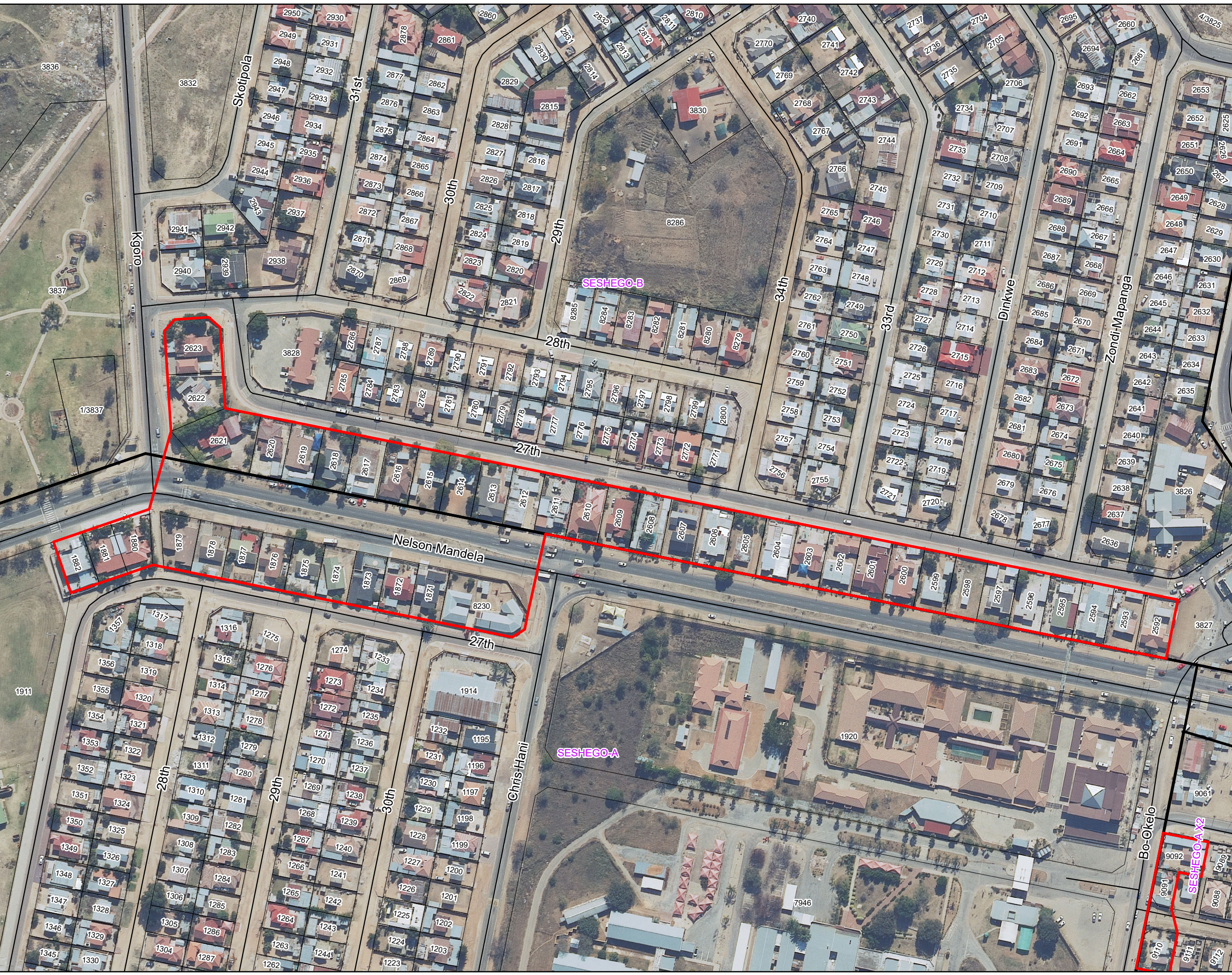
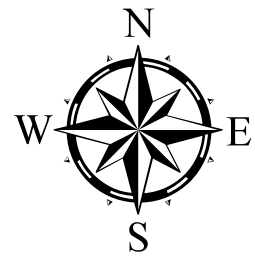
- Streets
- Specialist_Node_Bounadry
- Erven
- Townships



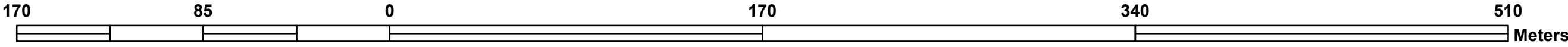
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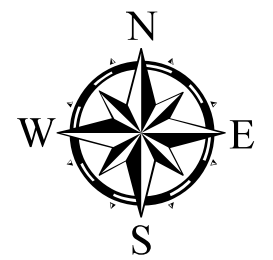
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- Specialist_Node_Bounadry
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- Townships



1 centimeter = 21 meters



 Streets
 Medical_Node_Boundary
 Erven
 Townships

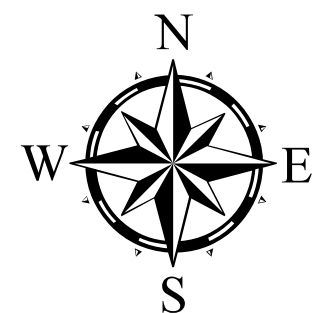


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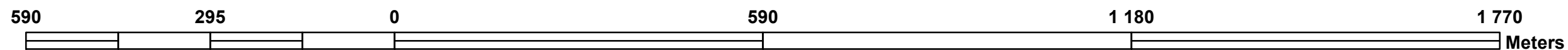
Polokwane Central Nodes

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-  Medical_Specialist Proposed
-  Medical_Specialist Existing
-  Streets
-  Erven
-  Townships



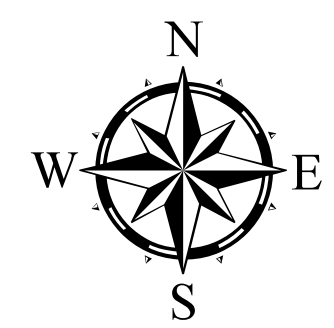
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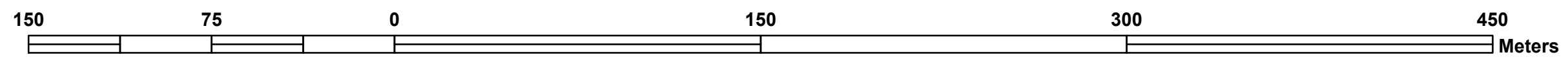
Pietersburg Ext 6 and 11 Nodes

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-  Medical_Specialist_Proposed
-  Streets
-  Erven
-  Townships



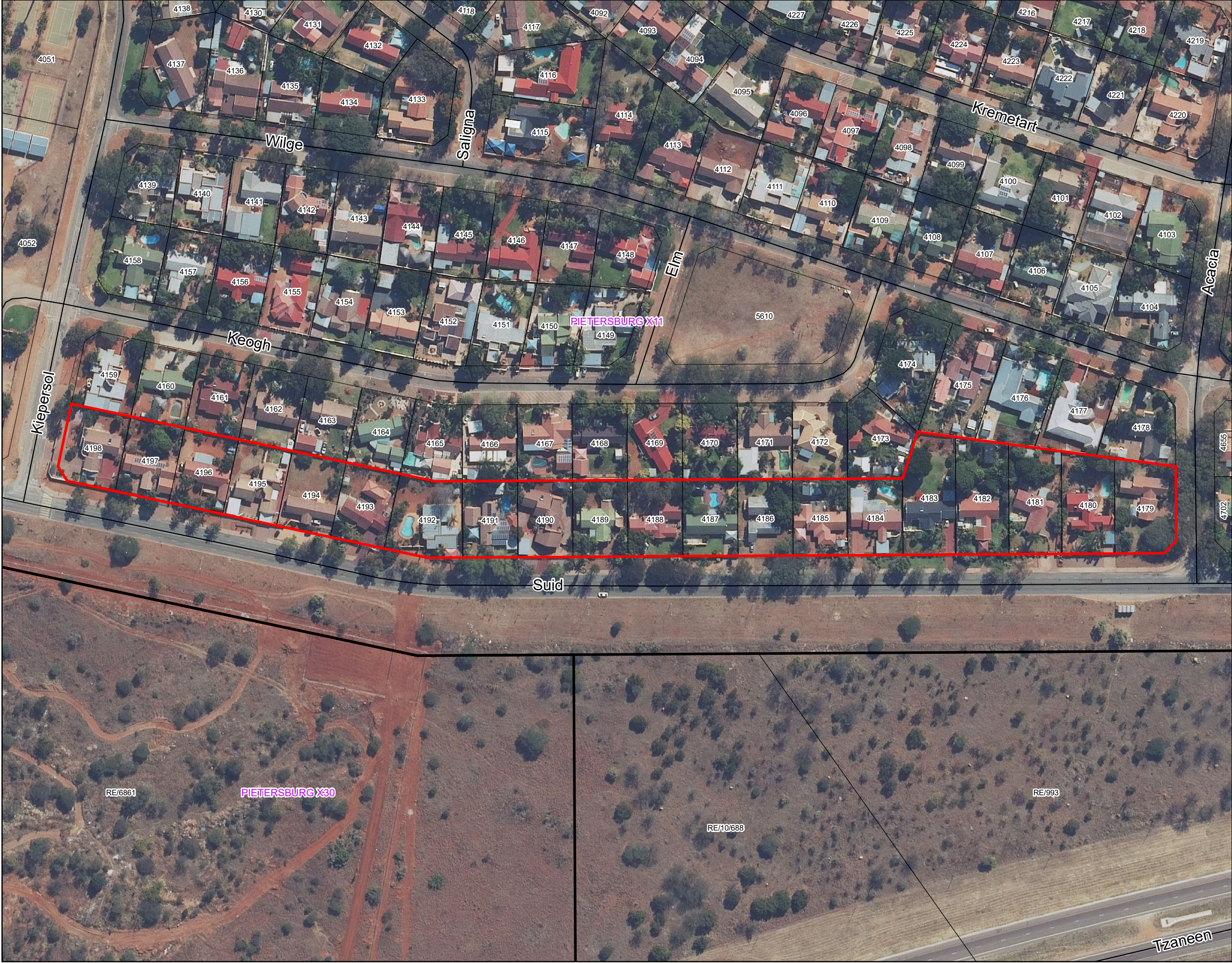
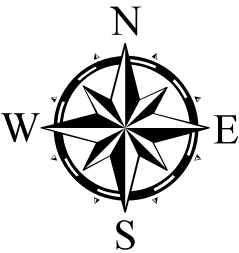
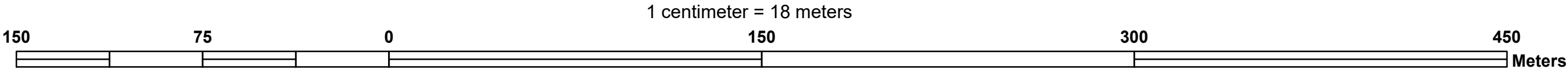
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Suid Street Flora Park

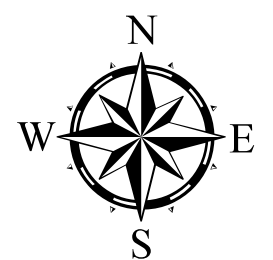
Legend

- Streets
- Specialist_Node_Bounadry
- Erven
- Townships



Legend

- Streets
- Medical_Node_Bounadry
- Erven
- Townships



1 centimeter = 52 meters

