ANNUAL PERFORMANCE PLAN

2023/2024

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

GGT2030
GROWING GAUTENG TOGETHER

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The Annual Performance Plan for the Gauteng Department of Health is available on:
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Gauteng Department of Health
Annual Performance Plan
2023/24

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

I. FOREWORD BY THE EXECUTIVE AUTHORITY

We are in the business of improving the quality of life, measured through a variety of indices, of which health and wellness is central. As life expectancy improves this should at the same time, impact positively on the experience of the end users of our services.

The World Health Organization defines quality of life as an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards, and concerns.

We are at that point in Government planning cycle where we are supposed to crystallise our service actions into a performance matrix against which our work, for the remainder of this term of office, can be measured. This we proudly do as a necessary tool for accountability and measurement of progress.

The overarching intonation of our government is to be a responsive, value-based and deliver a people-centred healthcare system which is predicted on values of integrity, respect and accountability which must permeate the manner in which we deliver care to communities.

Our work individually and collectively as Team Health, is grounded in the principles underpinned by a belief that no staff and stakeholders must be left behind during delivery of health care services. People are therefore the integral pillars of the health care delivery in Gauteng.

We ended our year on a very sad note with the catastrophic Boksburg explosion in which 41 lives were lost in the tragedy of which 12 were our own health care workers and colleagues. This explosion and its impact, also resulted in serious structural damages to our facility, Tambo Memorial Hospital, but we have since restored both the building and services of that hospital.

We remain committed to honour the memory of those who lost their lives in the traffic incident by ensuring that our health facilities reman places of care that are safe for both communities and the health workers. To this end, the Department is forging ahead with the commitment to accelerate the roll out of the refurbishment and rehabilitation of health infrastructure to ensure compliance with Occupational Health and Safety requirements in our facilities.

I have initiated engagements with other Departments to explore available options to de-bureaucratise operational maintenance and the decentralisation of some of the supply chain management functions to service delivery points in order to accelerate our responsiveness and accountability when it comes to the delivery of health care services on the ground.

This performance planning and management matrix will be incomplete if it does not prioritise the strengthening of the fight against crime, corruption, vandalism, and lawlessness which has impacted on our health infrastructure and thus putting the lives of health care users at risk.

To this end, our strategy of taking health care services to the doorstep of communities including wellness programmes is in line with the commitment made by the Premier to ensure quality health care services are provided in an equitable manner without putting any huge financial burden on poor and vulnerable users.
We are steadfast in our resolve to re-imagine a comprehensive health care system that is primary healthcare centric

in which a doctor and nursing staff can be available in a cluster of municipal wards and within the reach of the most vulnerable and the poor in communities. This model of health care delivery has proven successful in countries such as Cuba and with some reconfiguration, taking into consideration the most efficient, effective, and sustainable approaches, it can also work in Gauteng.

The mental health care programme will receive our outmost priority in the planning, resourcing and execution and included in this consideration is the wellbeing of our staff and those that are vulnerable in our communities. In this regard, the mental health strategy and the wellness programme of the Department will remain central to our delivery programme and it is our deliberate intention to expand the coverage of our mental health care services.

Today cancer is the second leading cause of death globally, the department and its partners cannot treat the situation as business as usual since the burden of cancer as it grows also sees the growth in the demand for services. The Department will be expanding on its service provision with the construction of bunkers to ensure oncology services are provided at all our central services including brachytherapy.

We are cognizant of the fact that management sets the tone of any organisation and accordingly, we have made an undertaking to ensure that all leadership positions in the Department are filled with competent leaders and technical people. No hospital should run without a CEO. Our recruitment processes will be improved to ensure that they become much more efficient so that no post must remain vacant for more than 3 months and once recruitment commences the turnaround must not be more than two months before the post is filled.

The work of implementing a comprehensive health information system will receive dedicated commitment to ensure that the vision of one patient one record is realised within this term of office. We are committed to fast track the implementation of the queue management system to ensure that no patient stands in queues waiting for services beyond acceptable timeframes.

To this end, the 2023/24 Annual Performance Plan we put forward here outlines key performance areas for the Department, which are informed by the GGT 2030, the GDoH Strategic Plan 2020/21-2024/25, and the Premier's priorities.

The success of this plan must be measured against tangible improvements in patients' experience care at our facilities, especially in townships, informal settlements and hostels (TISH communities). The achievement of the key performance areas outlined in the plan requires a leadership and staff committed to building a healthcare system that is responsive, patient-centred and stakeholder driven. It is through staff commitment and stakeholder collaboration that the quality of health care services in Gauteng will improve.

Ms Nomantu Nkomo-Ralehoko (MEC)
Executive Authority
Gauteng MEC for Health and Wellness

II. STATEMENT BY THE ACCOUNTING OFFICER

The Strategic Plan of the Gauteng Department of Health 2020/21 – 2024/25, outlines six priorities to be implemented during the 6th Administration to improve the quality of health care in the Province. The six priorities are:

1) Implementation of the National Health Insurance (NHI);
2) Improving patients' experience of care;
3) Improving clinical services;
4) Health education and health promotion;
5) Governance and leadership; and
6) Job creation and economic growth.

These priorities serve as a yardstick against which the performance and effectiveness of the public health care system in Gauteng is measured.

Although progress has been made towards the implementation of the priorities set out in the Strategic Plan, the public health care system in Gauteng is still plagued by challenges which negatively impact on the overall performance of the Department. The challenges facing the health system in Gauteng Province have been identified by various stakeholders, including oversight bodies and staff members. These include among others, budget constraints, non-compliance to Supply Chain Management (SCM) prescripts, incidents of vandalism and theft at health facilities, ageing health infrastructure, poorly maintained machinery resulting in prolonged downtimes, ageing technology infrastructure, outdated IT programmes, outdated health information systems, low staff morale, inefficient human resource management, misalignment of the organisational structure with the values and strategic objectives of the Department, congested maternal offerings, delayed performance of caesarean sections, limited availability of mental health beds and high amounts of medical litigations.

Urgent interventions have been developed to address the challenges facing the health care system and expedite the implementation of the six priorities outlined in the strategic plan. As a result, the Department has developed a comprehensive Implementation Plan on Priority Support and Clinical Services, titled: *"Turning the Tide: Implementation Plan to Reclaim the Jewel of Public Health".* The Turning the Tide Implementation Plan addresses various support and clinical services through identifying high impact activities, which if successfully implemented, would result in significant improvements in the attainment of health outcomes. The Plan focuses on services that have been identified as critical through the Department's midterm strategic review sessions and by the Provincial Strategic Support Teams (PSST), namely, financial management, corporate services, safety and security, infrastructure, laundry services, pharmaceutical services, health information, medico-legal services and selected clinical services. The implementation of the Turning the Tide Plan will continue during the 2023/24 financial year to accelerate the attainment of the six priorities outlined in the Strategic Plan.

The Premier of Gauteng Province has also identified key service delivery interventions to expedite the implementation of the priorities of the 6th Administration. The Premier's service delivery priorities to which the Gauteng Department of Health contributes are:

1) Implementation of wellness programmes;
2) Introduce a regulatory arm that will focus on eliminating fake food circulating in our shops;
3) Reduce queues at medical facilities;
4) Mental health;
5) Rehabilitation of individuals addicted to drugs;
6) Improving health services in townships;
7) Infrastructure delivery: Accelerated delivery of smart public infrastructure; and
8) Cross cutting commitments.

The Department has made positive strides towards the implementation of the Premier's service delivery priorities. To this end, to roll out a comprehensive Health and Wellness Programme in the Province, a service provider has been procured to provide extensive Life Course Health and Wellness campaigns. A Wellness Wednesday Programme was launched in Sebokeng to promote positive health outcomes by encouraging healthy lifestyles and literacy. The Wellness Wednesday Programme entails:

1) Physical activity;
2) Screening for non-communicable diseases and communicable diseases such as TB and HIV and AIDS;
3) Establishment of food gardens in health facilities;
4) Actively engaging with the Gauteng Department of Agriculture and Rural Development (GDARD) towards the establishment of food gardens;
5) Facilities with land for food gardens have been identified in Tshwane (21), Ekurhuleni (4), Sedibeng (4) and Johannesburg Districts (17). The West Rand District has one (1) facility with a food garden, which will be supported by GDARD.
6) Soil testing for food garden sites has been conducted by GDARD; and
7) Local communities are involved in the food gardens projects

Progress made towards the implementation of the Wellness Wednesday campaign include:

1) The establishment of two physical activity programmes in two Districts, namely, Ekurhuleni and West Rand Health Districts;
2) A total of 2045 people were reached through various healthy lifestyle activities of the wellness programme;
3) 570 community members and employees including executive managers participated in physical exercises such as aerobics and a 5km walk;
4) A Walk Against Cancer was held in October 2022;
5) The World Diabetes Day was commemorated in November 2022;
6) The World Aids Day commemoration was held in Mamelodi on the 1st December 2022; and
7) A total of 4 442 people were reached through the measles campaign in December 2022 and January 2023, which communicated integrated services and wellness messages

Improving health services in townships will be prioritised in 2023/24. In this regard, 27 mobile clinics will be deployed in 20 identified townships. 6 hospitals will receive first phase OHS upgrade and 37 hospitals will be OHS compliant by March 2024. The delivery of smart public health infrastructure will be accelerated. To this end, 9 PHC facilities will be upgraded and refurbished by March 2024. Two infrastructure projects are scheduled for completion and hand over to the Department by March 2024.

Fake food sold in shops continue to pose a great health concern. A regulatory arm will be established to focus on eliminating fake foods in our shops. Consultations with municipalities and other relevant stakeholders in this regard, are underway.

Long waiting times at public health are a source of frustration for patients. Reducing queues at health facilities is amongst the key interventions to improve the quality of public health care in the Province. As a result, a queue management system will be implemented at 37 hospitals by March 2024. An electronic health record system will also be implemented at 37 hospitals by March 2024 to reduce waiting times.

The provision of mental health services will be strengthened and prioritised. 206 additional mental health acute beds will be available by March 2024. District mental health teams will be established in all Districts, with all vacant posts filled by March 2024. Vacant mental health posts at Central Office will also be filled by March 2024. Training will be provided to 468 non-specialist nurses and doctors working in 72hours assessments.

The excessive use of psychoactive drugs, which can lead to physical, social and emotional harm, continues to plague communities in the Province. Services to individuals addicted to drugs will be prioritised. As a result, baseline medical assessment reports will be processed through identified Primary Health Care facilities. A dual diagnosis substance abuse treatment will also be provided. Patients will be referred to the Department of Social Development for rehabilitation.

The positive media coverage that the Wellness Wednesday campaign has received, has enabled the Department to communicate messages of healthy lifestyles and wellness to the larger population of the Province.

Fake food circulating in shops pose a health risk to communities. Inspections are regularly conducted to curb the circulation of fake food, especially in townships, informal settlements and hostels. 2 182 informal and 13 661 formal food premises have been inspected. 32 formal and 13 informal food premises have been issued with prohibition notices for contravening food safety regulations. 178 formal and 1 informal food premises were issued with fines.

A Food Control Committee which will focus on eliminating fake food circulating in shops, was established on 14 December 2022. The Committee will comprise of stakeholders from various Departments and entities, namely:

1) Municipal Health Services Managers;
2) GPGDED: Consumer Affairs and Business Compliance;
3) Consumer Group Council of South Africa: Food Safety and Sustainability Initiatives;
4) National Health Department: Food Control Directorate;
5) GDARDE: Veterinary Public Health and Agriculture and Agro-processing; and
6) Department of Trade and Industry

Consultations with the identified stakeholders will be held to gather essential information and intelligence for the purposes of establishing a regulatory arm to eliminate the circulation of fake food in shops. Consultations will also be used to finalise the terms of reference for the Food Control Committee. This will be followed by consultations with the Provincial Health Council, Local Government and Office of the Premier.

Waiting times at health facilities contribute towards patients experience of care. To eliminate long queues at health facilities, a queue management system is being implemented at priority hospitals. Six hospitals are currently implementing a queue management system. All 37 hospitals will be implementing a queue management system by March 2024. An electronic health record system will also be implemented in all 37 hospitals by March 2024 to reduce waiting times at health facilities. 11 hospitals are currently implementing the electronic health record system.

Increasing bed capacity for mental health care users is key to the provision of mental health services in the Province. In this regard, 83 additional mental health acute beds are currently available. Pholosong Hospital has increased the bed capacity to 9 mental health acute beds. Bertha Gxowa Hospital has increased the bed capacity to 20 mental health acute male beds. 206 additional mental health acute beds will be available by March 2024. Tembisa Hospital has increased the bed capacity from 30 to 44 mental health acute beds. Dr Yusuf Dadoo Hospital has 10 beds which are being utilised for 72-hour assessments in a medical ward.

The scourge of substance abuse continues to afflict communities in the Province. Medical assessment and diagnosis are essential to the rehabilitation of substance users. Although all PHC facilities can complete medical assessments of substance users referred by the Department of Social Development, specific facilities have been identified for such assessments. The Department has set a target of 300 medical assessments to be processed through identified Primary Health Care facilities by March 2023. 156 of the 300 targeted medical assessments have been completed. 2100 medical assessments will be completed by March 2024.

30 individuals are currently on the dual diagnosis substance abuse programme. 210 individuals will be on the dual diagnosis substance programme by March 2024. 3 out of 5 Districts, namely, Johannesburg, West Rand and Tshwane Districts, are currently running structured DDU programs. A total of 23 dual diagnosis were rendered at Sterkfontein Hospital, which resulted in 8 admissions. 315 individuals were seen at Chris Hani Baragwanath Academic Hospital DDU out-patients department. Hospitals and clinics refer substance users to inpatient and outpatient substance rehabilitation. 25 patients have been referred from hospitals and clinics to DSD for rehabilitation.

The Premier has called for the accelerated delivery of smart public infrastructure to improve service delivery. Infrastructure plays a crucial role in the delivery of health care services. The Department continues to upgrade health infrastructure to improve service delivery, especially in townships. Oncology bunkers will be built at Chris Hani Baragwanath and Dr George Mukhari Academic Hospitals to expand access to oncology services. Kopanong and Thelle Mogoarane Hospitals will have upgraded wellness centres by March 2024. Minor maintenance has been undertaken at 100 health facilities. By the end of March 2024, 450 health facilities would have received minor maintenance. Various health facilities have been refurbished, opened and handed over. Among these are:

1) 13 newly upgraded units at Dr George Mukhari Academic Hospital;
2) Refurbished and re-constructed trauma unit at Chris Hani Baragwanath Academic Hospital; and
3) Launch of the Sedibeng mobile dental units

210 facilities are targeted for technology linked upgrades by March 2024. The upgrades will include the installation of solar powered day-night switches and movement sensors. The first phase upgrades will be undertaken at six hospitals to ensure that they are OHS compliant by March 2024. 19 hospitals are 50% compliant with the Occupational Health and Safety Act and regulations. All 37 hospitals will be compliant with OHS legal requirements by March 2024.

The 2023/24 Annual Performance Plan outlines the performance indicators and targets geared towards accelerating the implementation of the priorities outlined in the Strategic Plan of the Gauteng Department of Health 2020/21-2024/25. Emphasis will be put on improving the delivery of services in townships, informal settlements and hostel dwelling through fast-tracking the implementation of the priority interventions identified by the Premier.

The successful implementation of this Annual Performance Plan requires a concerted effort from all stakeholders. The support of the Executive Management team and staff in the Department will therefore play a pivotal in ensuring that the plan is successfully implemented.

Mr L. A. Malotana
Head of Department (Acting)

III. ABBREVIATIONS AND ACRONYMS

ANHPRS	Health Patient Registration System
AG	Auditor General
A&E	Accident and Emergency
AET	Adult Education and Training
AIDS	Acquired Immune Deficiency Syndrome
ALOS	Average Length of Stay
ANC	Antenatal Care
AOP	Annual Operational Plan
APP	Annual Performance Plan
ART/ARV	Antiretroviral Treatment
ASELPH	Albertina Sisulu Executive Leadership Programme in Health
BOD	Burden of Diseases
BOR	Bed Occupancy Rate
BUR	Bed Utilisation Rate
CCMDD	Central Chronic Medicine Dispensing and Distribution
CCMT	Comprehensive Care, Management and Treatment
CEO	Chief Executive Officer
CFM	Clinical Forensic Medical Services
CFO	Chief Financial Officer
CHC	Community Health Centre
CHW	Community Health Worker
CMR	Child Mortality Rate
COE	Compensation of Employees
CPD	Continuing Professional Development
CUPS	Contracting Unit for PHC Services
DCST	District Clinical Specialist Teams
DHB	District Health Barometer
DHIS	District Health Information System
DHMO	District Health Management Office
DHS	District Health System
DID	Department of Infrastructure Development
DoH	Department of Health
DPME	Department of Planning, Monitoring and Evaluation
DR – TB	Drug Resistant TB
DS – TB	Drug Susceptible TB
ECE	Estimates of Capital Expenditure
EHWP	Employee Health and Wellness Programme
EML	Essential Medicine List
EMS	Emergency Medical Services
EPI	Expanded Programme on Immunisation
EPWP	Expanded Public Works Programme
EVP	Employee Value Proposition
GAS	Gauteng Audit Service
GCR	Gauteng City Region
GCRA	Gauteng City Region Academy
GDoH	Gauteng Department of Health
GGT	Growing Gauteng Together
GHS	General Household Survey
GIAMA	Government Immovable Asset Management Act
GIFA	Gauteng Infrastructure Financing Agency
GRPBMEAF	Gender Responsive Planning, Budgeting, Monitoring, Evaluation and Auditing Framework
GSDF	Gauteng Spatial Development Framework
HAART	Highly Active Antiretroviral Treatment
HAST	HIV, AIDS, STIs and TB
HIE	Health Information Exchange
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HOD	Head of Department
HNSF	Health Normative Standards Framework
HPRS	Health Patient Registration System
HR	Human Resources

HWSETA	Health & Welfare Sector Education and Training Authority
JHB	Johannesburg
CD10	International Classification Diseases version
ICT	Information & Communication Technology
ICU	Intensive Care Unit
IDMS	Infrastructure Delivery Management System
IGR	Intergovernmental Relations
IMCI	Integrated Management of Childhood Illnesses
MM	Metropolitan Municipality
MMR	Maternal Mortality Rate
MOU	Memorandum of Understanding
Metro	Metropolitan
MPET	Management Practice Enhancement Tool
MSD	Medical Supplies Depot
MTEF	Medium-Term Expenditure Framework
MYE	Midyear Population Estimates
NCDs	Non-communicable diseases
NDOH	National Department of Health
NDP	National Development Plan
NHI	National Health Insurance
OHSC	Office of Health Standards Compliance
OPD	Outpatient Department
OSD	Occupation Specific Dispensation
PACS	Picture Archiving and Communication System
PBC	Premier's Budget Committee
PDE	Patient Day Equivalent
PEP	Post-exposure Prophylaxis
PHC	Primary Health Care
PHSDSC	Public Health Social Development Sector Bargaining Chamber
PMDS	Performance Management Development System
PPP	Public-Private Partnership
PPR	Preferential Procurement Regulations
PReP	Pre-exposure prophylaxis
PWD	People with disabilities
QA	Quality Assurance
SADHS	South African Demographic and Health Survey
SAHR	South African Health Review
SANAC	South African National AIDS Council
SAP	System Analysis Programme
SAPS	South African Police Service
SDGs	Sustainable Development Goals
SDH	Social Determinants of Health
SOP	Standard Operation Procedures
StatsSA	Statistics South Africa
TB	Tuberculosis
TER	Township Economic Revitalisation
TISH	Townships, Informal Settlements and Hostels
TMR	Transformation, Modernisation and Re-Industrialisation
TVET	Technical and Vocational Education and Training
UHC	Universal Health Coverage
UNCRPD	United Nations Commission on the Rights of Persons with Disabilities
WEGE	Women Empowerment and Gender Equality
WHO	World Health Organization
WISN	Workforce Indicators of Staffing needs
XDR TB	Extreme Drug Resistant Tuberculosis

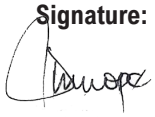
IV. OFFICIAL SIGN-OFF

It is hereby certified that this Annual Performance Plan:

1. 1. Was developed by the management of the Gauteng Department of Health under the guidance of MEC Ms Nomantu Nkomo-Ralehoko
2. 2. Takes Into account all relevant policies, legislation and other mandates for which the Gauteng Department of Health is responsible.
3. 3. Accurately reflects the outcomes and outputs which the Gauteng Department of Health will endeavour to achieve over the period of 2023/24.

Recommended by:

Ms. N. Mmope (Acting)
Chief Operations Officer
Signature:



Dr. S. Mankupane (Acting)
Deputy Director General:
Clinical Services
Signature:

Ms. B. Baloyi
Deputy Director General:
Corporate Services
Signature:

Mr. S. Khobo (Acting)
Head of Infrastructure
Signature:

Mr. M. Ndima (Acting)
Chief Financial Officer
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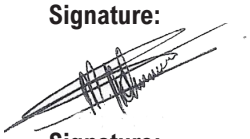


Ms. T. Adelekan
Head Official Responsible for Planning
Signature:

Mr. L. A. Malotana (Acting)
Head of Department
Signature:

Approved by:

Ms. N. Nkomo-Ralehoko
Executive Authority
Signature:

CONTENTS

PART A: GAUTENG DEPARTMENT OF HEALTH MANDATE

The Gauteng Department of Health (GDoH) core mandate is to improve the health status of the population, improve health services, secure better value for money, ensure effective organisation, provide integrated services and programmes that promote and protect health as well as assist in forging good quality and sustainable livelihoods for the poor, vulnerable and marginalised groups in the broader society.

In contemplation to fulfil its mandate, the GDoH five-year Strategic Plan 2020/21-2024/25 is underpinned by a base of guiding legislative and policy frameworks. In responding to the strategic plan and the need for quality health care services the department developed the 2023/2024 Annual Performance Plans (APP). The APP would as well direct the department towards meeting the requirements of sections 27(4), 40(3) and 55(2) of the Public Finance Management Act (PFMA) and contain measurable objectives for each directorate within the department vote for accountability. The provision of health care in GDoH is revered by the Constitution of the Republic of South Africa, Act 108 of 1996., with the following sections and guidelines among others:

1. Constitutional Mandate

Along with others, the Constitution of the Republic of South Africa, Act 108 of 1996 gives a statutory mandate for GDoH to render health services through the following sections and schedules:

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

- **Schedule 4 of the Constitution** reflects health services as a concurrent national and provincial legislative competence.
- **Section 9 of the Constitution** states that everyone has the right to equality, including access to health care services. This means that individuals should not be unfairly excluded in the provision of health care.
    - People also have the right to access information if it is required for the exercise or protection of a right;
    - This may arise in relation to accessing one's own medical records from a health facility for the purposes of lodging a complaint or for giving consent for medical treatment; and
    - This right also enables people to exercise their autonomy in decisions related to their own health, an important part of the right to human dignity and bodily integrity in terms of sections 9 and 12 of the Constitution respectively.
    - **Section 27 of the Constitution states as follows: with regards to health care, food, water, and social security:**
        1. Everyone has the right to have access to:
           (a) Health care services, including reproductive health care;
           (b) Sufficient food and water; and
           (c) Social security, including, if they are unable to support themselves and their dependents, appropriate social assistance.
        2. The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights; and
        3. No one may be refused emergency medical treatment.

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

2. Legislative and Policy Mandates (National Health Act, and other Legislation)

2.1 Legislation falling under the Department of Health & Wellness Portfolio

The GDoH service delivery operations are performed as guided by the fundamentals in the following legislations:

National Health Act, 61 of 2003	Provides a framework for a structured health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services. The objectives of the National Health Act (NHA) are to: 1) unite the various elements of the national health system in a common goal to actively promote and improve the national health system in South Africa; 2) provide for a system of cooperative governance and management of health services, within national guidelines, norms and standards, in which each province, municipality and health district must deliver quality health care services; 3) establish a health system based on decentralized- management, principles of equity, efficiency, sound governance, internationally recognized standards of research and a spirit of enquiry and advocacy which encourages participation. 4) promote a spirit of cooperation and shared responsibility among public and private health professionals, and providers and other relevant sectors within the context of national, provincial and district health plans; and 5) create the foundation of the health care system and understood alongside other laws and policies which relate to health in South Africa.
Medicines and Related Substances Act, 101 of 1965	Provides for the control of hazardous substances, those emitting radiation.
Occupational Diseases in Mines and Works Act, 78 of 1973	Provides for medical examinations on persons suspected of having contracted occupational diseases, especially in mines, and for compensation in respect of those diseases.
Pharmacy Act, 53 of 1974	Provides for the regulation of the pharmacy profession, including community service by pharmacists.
Health Professions Act, 56 of 1974	Provides for the regulation of the health professions, in particular medical practitioners, dentists, psychologists and other related health professions, including community service by these professionals.
Dental Technicians Act, 19 of 1979	Provides for the regulation of dental technicians and for the establishment of a council to regulate the profession.
Allied Health Professions Act, 63 of 1982	Provides for the regulation of health practitioners, such as chiropractors, homeopaths, etc., and for the establishment of a council to regulate these professions.
SA Medical Research Council Act, 58 of 1991	Provides for the establishment of the South African Research Council and its role in relation to health research.
Academic Health Centres Act, 86 of 1993	Provides for the establishment, management and operation of academic health centres.
Choice on Termination of Pregnancy Act, 92 of 1996	Provides a legal framework for the termination of pregnancies based on choice under certain circumstances.
Sterilization Act, 44 of 1998	Provides a legal framework for sterilisations, including for persons with mental health challenges.
Medical Schemes Act, 131 of 1998	Provides for the regulation of the medical schemes industry to ensure consonance with national health objectives.
Tobacco Products Control Amendment Act, 12 of 1999	Provides for the control of tobacco products, the prohibition of smoking in public places and of advertisement of tobacco products, as well as sponsoring of events by tobacco companies.
National Health Laboratory Service Act, 37 of 2000	Provides for a statutory body that offers laboratory services to the public health sector.
Council for Medical Schemes Levy Act, 58 of 2000	Provides a legal framework for the Council to charge medical schemes certain fees.
Mental Health Care Act, 17 of 2002	Provides a legal framework for mental health in the Republic and the admission and discharge of mental health patients in mental health institutions, with an emphasis on human rights for mentally ill patients.
Nursing Act, 33 of 2005	Provides for the regulation of the nursing profession.
Traditional Health Practitioners Act, 22 of 2007	Provides for the establishment of the Interim Traditional Health Practitioners Council, and registration, training, and practices of traditional health practitioners in the Republic.

Foodstuffs, Cosmetics and Disinfectants Act, 54 of 1972	Provides for the regulation of foodstuffs, cosmetics, and disinfectants, in particular quality standards that must be complied with by manufacturers, as well as the importation and exportation of these items.

2.2 Other legislation applicable to the department

Criminal Procedure Act, 51 of 1977, Sections 212 4(a) and 212 8(a)	Provides for establishing the cause of non-natural deaths.
Children's Act, 2005 (Act No. 38 of 2005)	The Act gives effect to certain rights of children as contained in the Constitution; to set out principles relating to the care and protection of children, to define parental responsibilities and rights, to make further provision regarding children's court.
Occupational Health and Safety Act, 85 of 1993	Provides for the requirements that employers must comply with in order to create a safe working environment for employees in the workplace.
Compensation for Occupational Injuries and Diseases Act, 130 of 1993	Provides for compensation for disablement caused by occupational injuries or diseases sustained or contracted by employees in the course of their employment, and for death resulting from such injuries or disease.
National Roads Traffic Act, 93 of 1996	Provides for the testing and analysis of drunk drivers.
Employment Equity Act, 55 of 1998	Provides for the measures that must be put into operation in the workplace in order to eliminate discrimination and promote affirmative action.
State Information Technology Act, 88 of 1998	Provides for the creation and administration of an institution responsible for the state's information technology system.
Skills Development Act, 97of 1998	Provides for the measures that employers are required to take to improve the levels of skills of employees in workplaces.
Public Finance Management Act, 1 of 1999	Provides for the administration of state funds by functionaries, their responsibilities, and incidental matters.
Promotion of Access to Information Act, 2 of 2000	Amplifies the constitutional provision pertaining to accessing information under the control of various bodies
Promotion of Administrative Justice Act, 3 of 2000	Amplifies the constitutional provisions pertaining to administrative law by codifying it.
Promotion of Equality and the Prevention of Unfair Discrimination Act, 4 of 2000	Provides for the further amplification of the constitutional principles of equality and elimination of unfair discrimination.
Division of Revenue Act, 7 of 2003	Provides for the manner in which revenue generated may be disbursed
Broad-based Black Economic Empowerment Act, 53 of 2003	Provides for the promotion of black economic empowerment in the manner that the state awards contracts for services to be rendered, and incidental matters.
Labour Relations Act, 66 of 1995	Establishes a framework to regulate key aspects of relationship between employer and employee at individual and collective level.
Basic Conditions of Employment Act, 75 of 1997	Prescribes the basic or minimum conditions of employment that an employer must provide for employees covered by the Act.
Spatial Planning and Land Use Management Act, 16 of 2013	Provide the framework for Spatial Planning and Land Use Management

The above-mentioned legislation and acts are not exhaustive, and it is recognised that the GDoH must comply with all national and provincial legislation and regulations, and all municipal by-laws, applicable to its functions or the areas in which it operates.

3. Health Sector Policies and Strategies over the 5-year planning period review

The above-mentioned legislation and regulations state the scope and directive to regulate how the GDoH shall implement, various national and provincial health policy and strategy frameworks with clear command on the priorities and focus areas of GDoH for the 2020-2025 period of this Strategy Plan.

3.1 National Health Insurance Bill

There are significant health system changes being implemented in South Africa with the introduction of a phased in approach of the National Health Insurance (NHI) which is a social solidarity tool for quality of health care for all. The phased-in implementation of NHI is intended towards an integrated health financing mechanism that draws on the capacity of the public and private sectors to the benefit of all South Africans. The NHI deeply aspires to provide consumers of health services in SA with a health financing model that will assist in the realisation of Universal Health Coverage (UHC). The UHC takes into consideration the basic principles of the right to health for all, entrenching equity, social solidarity, efficiency and effectiveness and appropriate health service delivery.

In order to achieve UHC, institutional and organisation rectifications and redress are required to address structural inefficiencies; ensure accountability for the quality of the health services rendered and ultimately to improve health outcomes particularly focusing on the poor, vulnerable and disadvantaged groups. The NHI policy objective is to ensure that everyone has access to appropriate, efficient, affordable and quality health services.

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

In an interview with the GDoH NHI coordinator, it is stated that the National Health Portfolio Committee undertook roadshows in provinces to discuss the NHI Bill, from October 2019. As a result of ongoing debates held, various stakeholders have been submitting inputs to NDoH, the Bill will be discussed at provincial legislature. Following NHI programme progression, the NDoH has advertised fourty four (44) NHI positions. A technical working group on NHI in a form of a National Health Council was appointed following provinces invitations.

3.2 National Development Plan (NDP): Vision 2030

The NDP aims to eliminate poverty and reduce inequality by 2030. South Africa is currently in a process of implementing NHI in order to achieve an integrated response to the country's health challenges requiring all government structures to work together. The NDP 2030 spells out specific health goals and outcomes for the health system, described as follows: The overarching outcome that measures impact is "Average male and female life expectancy at birth increases to at least 70 years". The next 4 outcomes measure health outcomes, requiring the health system to reduce premature mortality and morbidity. Last 4 outcomes are tracking the health system that essentially measure inputs and processes to derive outcomes.

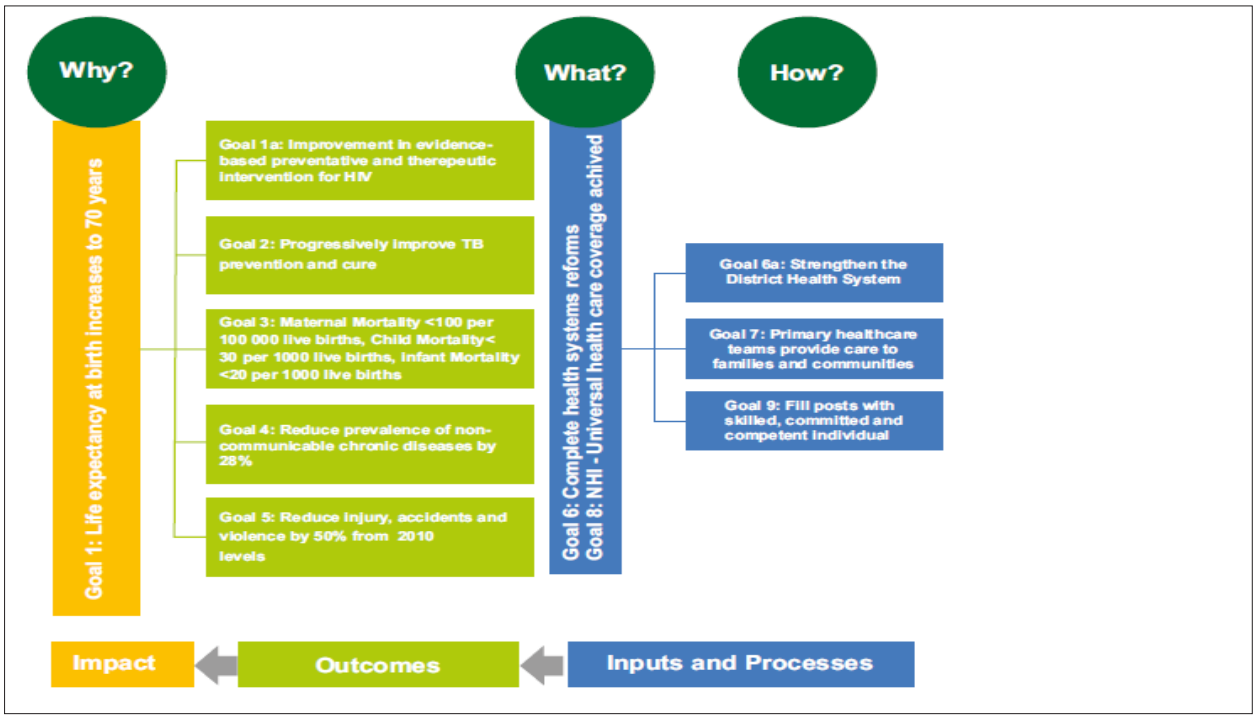


Figure 1: Summary of National Development Plan: Vision 2030

3.3. Sustainable Development Goals (SDGs)

The 2030 Agenda for Sustainable Development, 2015 (Goal 3) is a shared blueprint for peace and prosperity for people and the planet and consists of 17 SDGs[1]. The department is committed to achieving Goal 3, Good Health and Wellbeing with a particular focus in the next 5 years. South Africa currently has data on the SDG 3 targets in their national policies.[2,3]

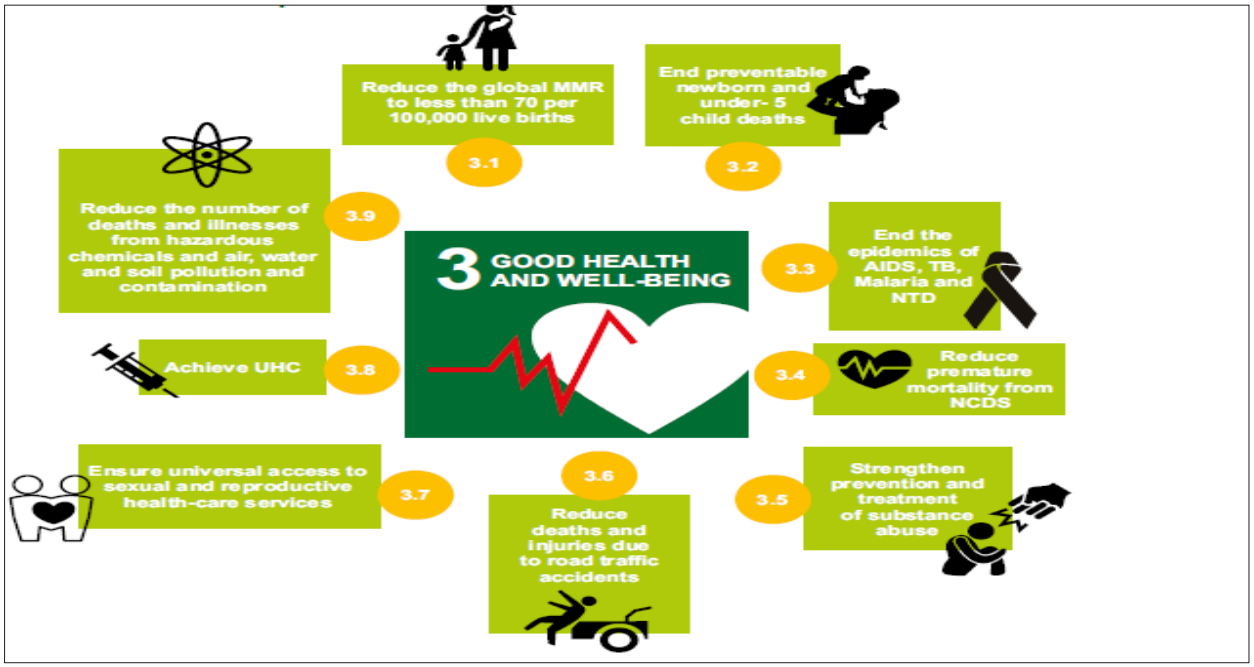


Figure 2: SDG 3: Ensure healthy lives and promote wellbeing for all at all ages.

1 World Health Organization, Sustainable Development Goals. 2023. Available: https://www.who.int/europe/about-us/our-work/sustainable-development-goals
2 Statistics South Africa. 2019. Sustainable Development Goals. Country R-eport 2019. Available: http://www.statssa.gov.za/MDG/SDGs_Country_Report_2019_South_Africa.pdf
3 National Development Plan 2030, Our future -make it work. Available: https://www.nationalplanningcommission.org.za/assets/Documents/ndp-2030-our-future-make-it-work.pdf

Table 1: Targets of SDG 3 to ensure healthy lives and promote well-being for all at all ages.[4]

SDG 3 targets	Description
3.1. Maternal mortality	By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.
3.2. Neonatal and child mortality	By 2030, end preventable deaths of new-borns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.
3.3. Infectious diseases	By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases, and other communicable diseases.
3.4. Noncommunicable diseases	By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.
3.5. Substance abuse	Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.
3.6. Road traffic	By 2020, halve the number of global deaths and injuries from road traffic accidents.
3.7. Sexual and reproductive health	By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.
3.8. Universal health coverage	Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.
3.9. Environmental health	By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination.

3.4. Medium Term Strategic Framework (MTSF) and NDP Implementation 2019-2024

This APP acknowledges and comprehensively responds to the priorities set by cabinet of the sixth administration of the democratic South Africa, within the MTSF for period 2019-2024. It is aimed at eliminating avoidable and preventable deaths ***(survive);*** promoting wellness and preventing and managing illness ***(thrive***); and transforming health systems, the patient experience of care, and mitigating social factors determining ill health (thrive), in line with the United Nation's (UN) three broad outcomes of the SDGs for health. The GDoH response is structured into 2 impacts, 4 outcomes and 12 outputs which are aligned to the Pillars of the Presidential Health Summit compact, as outlined in the table 1 below.

3.5 Provincial Policy Context

The Gauteng Provincial Government continues to implement the Growing Gauteng Together 2030 plan with key provincial policies informing the focus and work of the Gauteng Department of Health as follows:

4 World Health Organisation, Targets of Sustainable Development Goal 3, 2023. Available: https://www.who.int/europe/about-us/our-work/sustainable-development-goals/targets-of-sustainable-development-goal-3

Table 2: Provincial Policy Framework Implication

Provincial Policy Framework Implication	
Plan for the 6th Administration – "Growing Gauteng Together: Our Roadmap to 2030" (GGT:2030) **The provincial MTSF**	The 6th Gauteng Provincial Administration will focus on the following six priorities: • Economy, jobs and infrastructure; • Education, skills revolution and health; • Integrated human settlements and land release; • Safety, social cohesion and food security; • Building a capable, ethical and developmental state; • A better Africa and world. Flagship programmes will continue, including the Township Economy Revitalisation (TER), Tshepo 1 Million, and Ntirhisano. Specifically, under the GGT 2030 outcome of "universal access to good quality health care for all South Africans achieved", the 2025 target is to: "implement the enabling legislative framework and create institutional capacity for NHI by 2024 to achieve universal health coverage for all South Africans by 2030". For the provincial health portfolio, specific commitments and priorities arising from the GGT 2030 are discussed in section 3 below.
Other relevant provincial policies and strategies	• The Gauteng Accelerated Social Transformation Strategy; • The Gauteng Spatial Development Framework (GSDF) 2030; • The GCR Integrated Infrastructure Master Plan (GIIMP); • Gauteng Township Economy Revitalisation Strategy; • GCR Governance and Planning Roadmap; • Gauteng Anti-Corruption Strategy; • Gauteng City Region Youth Development Strategy; • Procurement Strategy in Support of the Township Economy Revitalisation; • Gauteng E-Governance and ICT Strategy; • Gauteng Safety Strategy; and • COGTA Back to Basics Strategy.

Where the above sections reflect the GDoH broad alignment to legislation and the national and provincial policy stance for the 6th Administration, the specific policy and strategy trajectory of the GDoH, as it informs the 2020-2025 Strategic Plan, is outlined below.

3.6 The Gauteng Department of Health Policy and Strategy Focus for 2020-2025

In response to the national and provincial policy and strategy priorities outlined above, the MEC has outlined 6 priorities for the GDoH for the period 2020 to 2025, fully aligned to both the national and provincial policy context, as follows:

Figure 3: GDoH 2021/20-2025 provincial priorities and outcomes

3.6.1. Gauteng Department of Health institutional capacity to deliver on its mandate

Turning the Tide Implementation plan

The functionality of a public health system is measured against the ability to achieve its mission and outcomes.[5] The GDoH strategic plan 2020/21 – 2024/25 sets out strategic priorities that determines the functionality of the public health system for Gauteng Province in terms of performance against set outcomes. For the period 2021/22 the departmental annual report shows the departments overall performance was 51% this is below the 80% set target. This underperformance prompted the Premier of the Province to mandate the GDoH MEC and HOD to develop a six months intervention plan to address the root causes of underperformance per programme and develop key interventions to expedite the implementation of the 6th Administration key priorities. The areas identified in the plan are as follows:

- Failure to pay undisputed supplier invoices on time
- Failure to meet the set target of 30% spend on township enterprises against identified commodities
- Poor contract management
- Escalating contingent liability which is around R20bn
- Security breaches at health facilities
- Non-compliance to vetting requirements for SMS members and officials in SCM, Finance and Human Resource Management
- Low compliance with financial disclosure requirements by employees below SMS level
- Outdated organisational structure
- Leadership instability
- Poor enforcement of Remuneration Work Outside the Public Service (RWOPS) and commuted overtime policies
- Non-implementation of ICT projects due to delays SCM processes
- Failure to implement planned infrastructure projects on time

The Turning the Tide implementation plan seeks to address challenges relating to support and clinical services through identifying high impact activities that must be implemented in Financial Management, Corporate Services, Safety and Security, Infrastructure, Pharmaceutical Services, Health Information, Medico Legal Services and selected Clinical Services, the same challenges were identified during the departmental strategic review and planning session held on 07-08 October 2022. It is envisaged that the successful implementation of the activities contained in the six months intervention plan will enable the department to escalate performance and attain the health outcomes contained in the

5 Handler, A,. Issel, M., Turnock. 2001. A Conceptual Framework to Measure Performance of the Public Health System. Available: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1446752/

2020/21 – 2024/25 Strategic Plan. The Turning the Tide Plan advocates for the implementation of the following key interventions to improve performance:

- Improving governance and management systems for better leadership and compliance with the legislative prescripts
- Addressing the safety and security of health care users and employees through a compliant health infrastructure and physical security
- Review of the organisational structure to ensure that it is relevant and fit for purpose
- Improving business processes through the implementation of modern technologies and tightening internal controls

Operational plans have been developed and costed to ensure that the outputs contained in the Turning the Tide Plan are achieved, through specific activities which must be implemented within the allocated timeframes.

Economy, Jobs and Infrastructure

Economy, job creation and infrastructure are one of the 6th administration priorities that are core to Re-igniting Gauteng Economy. The department is expected to attain and contribute on these priorities by addressing socio-economic challenges such as poverty, unemployment and inequality. To improve the socio-economic conditions of people living in Gauteng's townships, informal settlements and hostel dwellings the Premier of Gauteng Province has called for acceleration of implementation of the 6th administration priorities. The roll out of health infrastructure is one of the strategies used by the department to contribute towards economic growth and job creation in the Province. The 2021/22 department annual report show that the planned infrastructure projects targets were not during the FY 2021/22, the non-achievement of the set infrastructure targets impacts negatively to the Provincial Government's plan to grow the economy and create jobs.

Township Economy Revitalisation (TER)

Small and medium enterprises are major contributors to job creation and economic development, they are crucial in alleviating developmental challenges faced by African countries of which South Africa is faced with developmental challenges such as poverty, unemployment and inequality.[6] The economic disparities among social classes in South Africa exacerbates social instability for example the July 2021 civil unrest that the country experienced in Gauteng and KwaZulu-Natal therefore, it is essential for the government to play an active role in addressing the developmental challenges facing the country to prevent social unrest.

During FY 2021/22 period, the department set aside 30% of its procurement budget to spend on township enterprises. This is one of the strategies undertaken by the department to grow the township economy and create jobs through supporting Small, Medium and Micro Enterprises (SMMEs) in townships. This intervention resonates with the Premier's call to improve the living conditions of people in townships, informal settlements and hostel dwellings. The department did not achieve the 30% set target it only spent 8.5% of its procurement budget on township enterprises[7] this target non achievement limits the department's contribution towards economic growth and job creation in the Province therefore, plans to improve procurement of goods and services from township enterprises must be developed and vigorously implemented to improve performance.

Payment of suppliers within 30 days

The treasury regulation section 8.2.3 states, "unless determined otherwise in a contract or other agreement, all payments due to creditors must be settled within 30 days from receipt of an invoice or in the case of civil claims, from the date of settlement or court judgement". Based on the above statement, the department has a statutory obligation to pay supplier invoices within the prescribed timeframe.

The department has persistently underperformed on the set target of paying undisputed supplier invoices within 30 days. During 2021/22, only 27.2% of invoices were paid within 30 days, against the set target of 70%. The sustainability of SMMEs is dependent on payment of their invoices on time to avoid cashflow challenges that might result in businesses closure. Failure to pay supplier invoices on time also hinders job creation, as some businesses may be forced to lay off employees in order to stay afloat. The department needs to develop a plan to ensure that all undisputed supplier invoices are paid on time.

6 Fatoki, O. 2014. The Role of Small and Medium Enterprises in Alleviating the Development Challenges Facing South Africa. Available: https://www.researchgate.net/publication/280781859_The_Role_of_Small_and_Medium_Enterprises_in_Alleviating_the_Development_Challenges_Facing_South_Africa

7 Gauteng Department of Health. 2022. Annual Report financial year 2021/2022.

Table 3: Alignment MTSF, Health Strategy and Health Summit Pillars

	MTSF 2019-2024 Impacts	Health sector's strategy 2019-2024		Presidential Health Summit Compact Pillars
Survive and	Life expectancy of South Africans improved to 70 years by 2030	Outcome 1: Increase Life Expectancy improve Health and Prevent Disease	• Improve health outcomes by responding to the quadruple burden of disease of South Africa. • • Inter sectoral collaboration to address social determinants of health	N/A
Transform	Universal Health Coverage for all South Africans achieved, and all citizens protected from the catastrophic financial impact of seeking health care by 2030	Outcome 2: Achieve UHC by Implement NHI	• Progressively achieve Universal Health Coverage through NHI	Pillar 4: Engage the private sector in improving the access, coverage, and quality of health services; and. Pillar 6: Improve the efficiency of public sector financial management systems and processes
		Outcome 3: Quality Improvement in the Provision of care	• Improve quality and safety of care	Pillar 5: Improve the quality, safety and quantity of health services provided with a focus on to primary health care.
			• Provide leadership and enhance governance in the health sector for improved quality of care	Pillar 7: Strengthen Governance and Leadership to improve oversight, accountability, and health system performance at all levels
			• Improve community engagement and reorient the system towards Primary Health Care through Community based health Programmes to promote health	Pillar 8: Engage and empower the community to ensure adequate and appropriate community-based care
			• Improve equity, training and enhance management of Human Resources for Health	Pillar 1: Augment Human Resources for Health Operational Plan
			• Improving availability to medical products, and equipment	Pillar 2: Ensure improved access to essential medicines, vaccines and medical products through better management of supply chain equipment and machinery
			• Robust and effective health information systems to automate business processes and improve evidence-based decision making	Pillar 9: Develop an Information System that will guide the health system policies, strategies and investments
		Outcome 4: Build Health Infrastructure for effective service delivery	• Execute the infrastructure plan to ensure adequate, appropriately distributed and well-maintained health facilities	Pillar 3: Execute the infrastructure plan to ensure adequate, appropriately distributed and well-maintained. health facilities

Table 4: Alignment MTSF 2019-2024, GGT2030 and Premier's Elevated Priorities:

MTSF priority 2: Education, Skills, and Health MTSF Impact Statement: Total life expectancy of South Africans improved to 70 years by 2030		GGT2030 priority 2: Education, Skills Revolution and Health GGT2030 Outcome Statement: Universal access to good quality health care for all South Africans achieved	Health Sector Priorities	Premier's Elevated Priorities
MTSF 2019-2024 outcome	**MTSF 2019-2024 Interventions**	**GGT 2030 Interventions**		**Interventions to End of Term**
1. Achieve UHC by implementing NHI	• Roll-out a quality health improvement plan in public health facilities to ensure that they meet the quality standards required for certification and accreditation for NHI. • Develop comprehensive policy and legislative framework to mitigate the risks related to medical litigation. • Improved quality of primary healthcare services through expansion of the Ideal Clinic Programme. • Develop and implement a comprehensive HRH strategy 2030 and an HRH plan 2020/212024/25 to address the human resources requirements, including filling critical vacant posts for full implementation of universal healthcare. • Establish provincial nursing colleges with satellite campuses in all 9 provinces. • Expand the primary healthcare system by integrating over 50 000 community health workers into the public health system. • Drive national health wellness and healthy lifestyle campaigns to reduce the burden of disease and ill-health. • Provide good quality antenatal care. • Protect children against vaccine preventable diseases. • Improve the management of childhood diseases services.	• Transform public health care experience in Gauteng. • Greater access to quality healthcare for all, with delivery supported via the roll out of the NHI within the province, technology, and the involvement of other role-players such as non-profit organisations (NPOs). • Facilities open on time, are patient-friendly and safe, and are supported by adequate medicine supplies and clean equipment of which 90% of clinics, community health centres, districts and regional hospitals meet the ideal clinic standards within 5 years. • 24-hour services provided across all 32 community health centres. • Eleven new primary health care centres fully constructed and operational, and construction of one new district hospital completed. • Empowerment of health care facility management teams with resources and decision-making authority to serve patients and fast-track delivery, without bureaucratic delays. • Results from citizen satisfaction surveys undertaken across all province-wide health care facilities highlighting positive experiences of the care received – with respondents indicating an overarching sense that all who work within the sector are focused on delivering a professional service and supporting the well-being of all health care users • Delivery on HIV and TB 90:90:90 targets (90% of patients knowing their status; 90% of patients receiving treatment; 90% of patients with viral load suppressed). • Expand screening of users of public health services for priority non-communicable diseases. • Quality mental health and rehabilitation services integrated into all public health care facilities, supported by the necessary training and support of health professionals, and effective delivery of community awareness campaigns on issues of mental health. • Strengthen maternal health programmes to reduce maternal mortality. • Delivery on the SDG target of <8.5/1000 neonatal mortality rate, with significant progress towards the achievement of SDG targets relating to the mortality rate for infants and children under five years. • Implement intersectoral action to improve food security and nutrition and reduce stunting.	National Sector Outcome 2: Achieve UHC by implementing NHI	Improving health services in townships Implementation of wellness programmes Reducing queues at our medical facilities Mental Health Rehabilitation of individuals addicted to drugs
2. Increase life expectancy improve health and prevent Disease			National Sector Outcome 4: Build health infrastructure for effective service delivery. Gauteng Priority 1: Improved patient experience of care	Infrastructure Delivery: Accelerated delivery of smart public infrastructure Reducing queues at our medical facilities
			National Sector Outcome 1: Increase life expectancy, improve health and prevent disease. Gauteng Priority 2: Improved clinical services.	Improving health services in townships Implementation of wellness programmes Mental Health
			National Sector Outcome 1: Increase life expectancy, improve health and prevent diseases. Gauteng Priority 2: Improved clinical services	Improving health services in townships Implementation of wellness programmes Mental Health

4. Relevant Court Rulings

There are no new court rulings that have a significant, ongoing impact on operations or service delivery obligations of the Department.

PART B: OUR STRATEGIC FOCUS

1. Vision

A responsive, value based, and people centred health care system in Gauteng.

2. Mission

Transforming the health care system, Improving the quality, safety and coverage of health services provided, focusing on primary health care strengthening public health education and health promotion, and ensuring a responsive, innovative and digitally enabled health system.

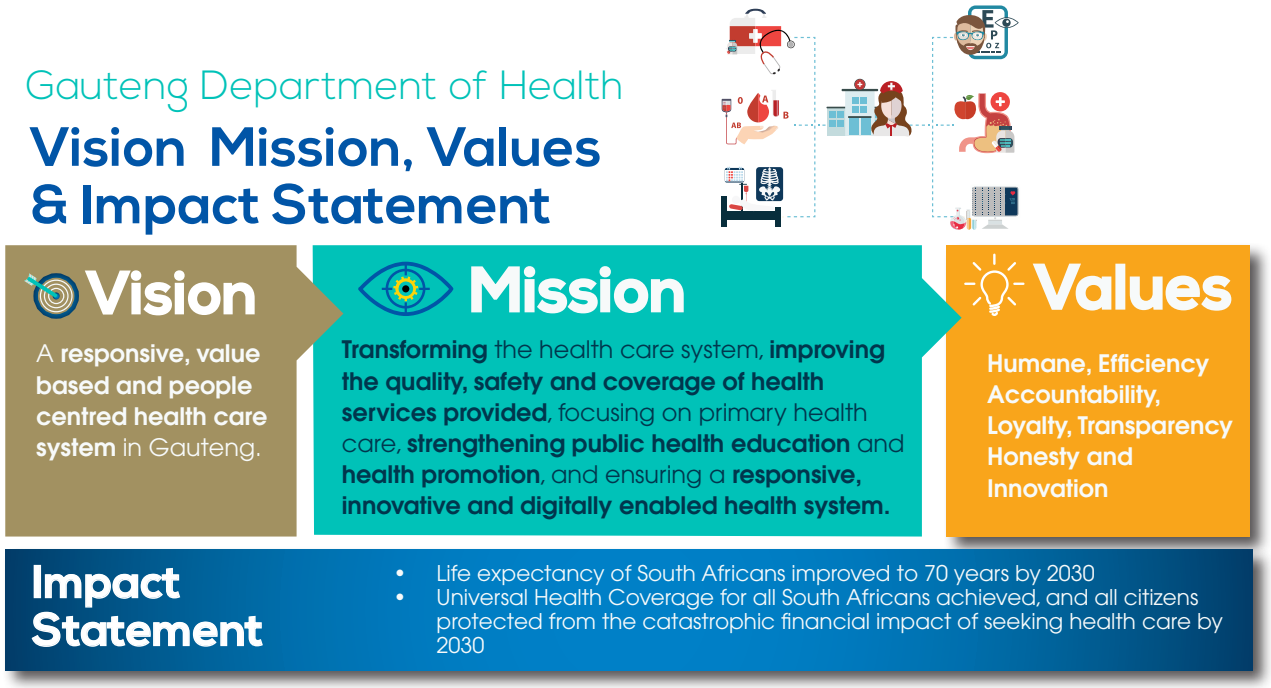


Figure 4: GDoH vision, mission, values & impact statement

3. Values

Humane, efficiency, accountability, loyalty, transparency, honesty an innovation.

Table 5: GDoH values in line with Batho Pele Principles

Value		Description
H	Humane	The value system is entrenched in Batho Pele principles, with patient focused activities benefitting all the consumers of health care services
E	Efficiency	GDOH works efficiently, effectively, and professionally, optimising the benefits based on the available resources and ensuring that the people receive quality services.
A	Accountability	Good governance is executed by the different health providers within GDOH, holding all colleagues accountable towards achieving the desired health outcomes
L	Loyalty	We will consistently seek to do the right thing as we believe in the organisation, where it is going and what must be done to get there. We care about the organisation, about its stakeholders and about its mission – we are working for something greater than just ourselves.
T	Transparency	We are open to scrutiny and will consult and inform stakeholders about the level and quality of public services they will receive so that they are aware of what to expect. We will ensure all citizens have equal access to the services to which they are entitled; and will providing more and better information about our services.
H	Honesty	We conduct our business with integrity, in an honest, truthful, consistent and ethical manner, to ensure we foster trust among our employees, stakeholders.
I	Innovation	We conduct our business in a way that focuses on cutting-edge, best in class and “outside the box” approaches and solutions. We seek to listen to and understand the needs of our stakeholders, to inform us in creating new approaches to what we do.

4. Situational Analysis

Overview of the province

Gauteng (figure 5) with a population of 16 098 571 people approximately 16 million, is the smallest in land size but it is a densely populated province, followed by KwaZulu-Natal (11 million) and Western Cape (7 million). It stretches over an area of 18 178 km² or approximately 1.4% of the total surface area of South Africa, bordered by the Free State, North-West, Limpopo and Mpumalanga provinces. It is situated on the highveld and comprises of 5 districts i.e. three metropolitan municipalities and two district municipalities populated as follows: Sedibeng (966 230), West Rand (969 545), City of Ekurhuleni (4 080 699), Johannesburg (6 121 323) and Tshwane (3 860 013). Gauteng renders health care services to 84% of the population in the public sector and 16% in the private sector.

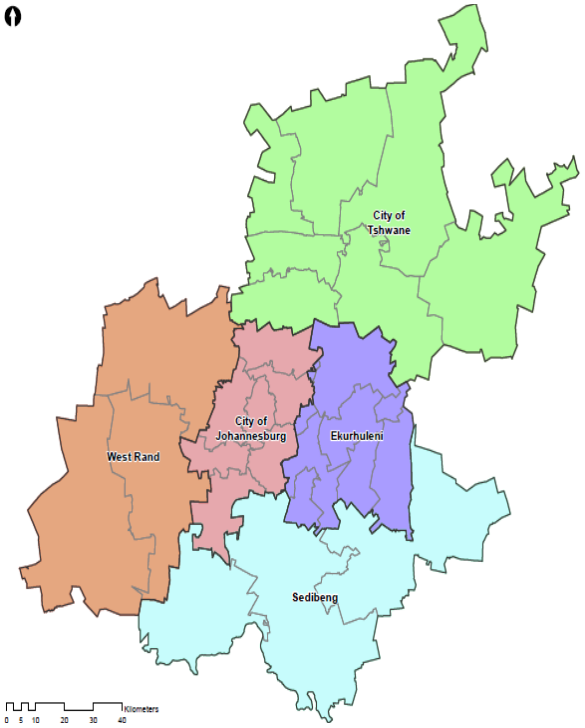


Figure 5: Map of Gauteng Province, source DHIS, 2023

Gauteng is considered the economic hub, wealthiest and highly urbanised province in the country. It is the financial hub of not only South Africa but the entire African continent. It contributes more than 35% to South Africa's Gross Domestic Product (GDP), the provincial economy grew by 7.4% in the first half of 2021 compared to the same period last year. It is home to the Johannesburg Stock Exchange, the largest stock exchange in Africa. Some of the largest companies in Africa and abroad are based in Gauteng, it also includes Pretoria, the administrative capital. It contributes heavily in the financial, manufacturing, transport, technology, and telecommunications sectors, among others. It also plays host to a large number of overseas companies requiring a commercial base in and gateway to Africa.

4.1. External Environmental Analysis

4.1.1. Demography

Mid-year population estimates

Stats SA estimates the mid-year population table 1 of Gauteng at approximately 16 098 571 (16 million) people in 2022 which is 26.6% of South Africa's population. Approximately 51,1% 8 047 327 (8 million) of the population are females, about 24% (3 785 878) of the population in Gauteng is below the age of 15, and 10.4% (1 391 406) of the population is 60 years and older[8].

8 Gauteng total population figures, District Health Information System, 2023. Available: https://za.dhis.dhmis.org/dhis-web-dashboard/#/

Table 6: Gauteng mid-year population estimates by age and sex, 2022

Age	Gauteng		
	Male	Female	Total
0-4	658 878	643 920	1 302 798
5-9	634 673	619 994	1 254 667
10-14	618 669	609 744	1 228 413
15-19	578 621	581 609	1 160 230
20-24	665 510	663 826	1 329 336
25-29	810 361	820 939	1 631 300
30-34	870 738	857 612	1 728 349
35-39	776 360	756 989	1 533 349
40-44	607 712	590 407	1 198 120
45-49	504 557	455 602	960 160
50-54	393 601	366 034	759 636
55-59	306 374	314 433	620 807
60-64	237 857	263 055	500 912
65-69	172 987	205 638	378 624
70-74	116 037	147 330	263 367
75-79	64 405	91 313	155 718
80+	33 904	58 881	92 785
Total	8 051 244	8 047 327	16 098 571

Source: StatsSA, 2023

Total fertility rate

Statistics South Africa (Stats SA) mid-year population figure shows Gauteng fertility estimates for the periods 2001–2006; 2006–2011; 2011–2016, 2016–2021 and 2021-–2026[9] In the period 2006–2011, there is a general rise in total fertility rate (TFR), giving shape to the Census 2011 provincial population structure. However, for the period 2011–2026 there is an overall decline in TFR over time. The average fertility rate in the province is estimated to decline from 2,10 to 1,89 between the periods 2011-2016 and 2016-2021. About 70 per cent of the population are in the economically active age groups.

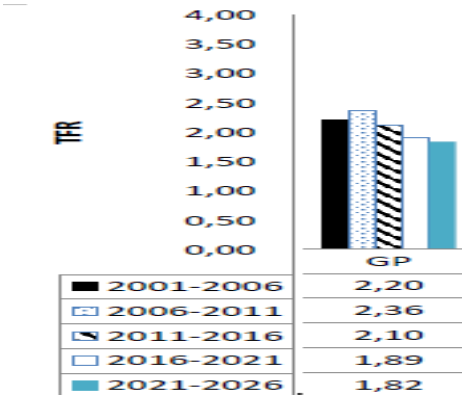


Figure 6: Gauteng average total fertility rate over time, 2001–2022, NICD, 2021

Life expectancy

Life expectancy at birth reflects the overall mortality level of a population. Figures 6 shows Gauteng's average life expectancy at birth for males and females for the 5-year periods 2001–2006; 2006–2011; 2011–2016 and 2016–2021. The life expectancy increased incrementally for each period across the province but more significantly in the period 2011–2016 due to the uptake of antiretroviral therapy over time in the country.

9 Statistics South Africa. 2022. statistical release P0302, Mid-year population estimates. Available: https://www.statssa.gov.za/publications/P0302/P03022022.pdf

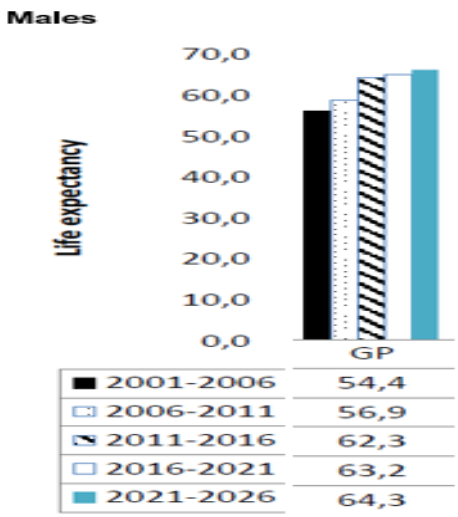


Figure:7 Gauteng average life expectancy at birth (males), 2001–2026, NICD 2021

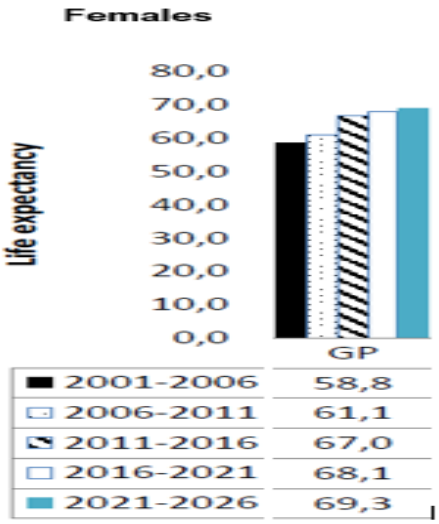


Figure 8: Gauteng average life expectancy at birth (females), 2001–2026, NICD 2021

There has been a great variability in the COVID-19 related morality rates occurring across the province predominantly affecting the elderly population, resulting in a declining growth rate. Behavioural factors affecting the spread, population age and sex structure of the province as well as varying health capacity across provinces, amongst others, played a determining role in mortality rates across the province in the last 2 years[10]. The impact of COVID-19 deaths occurring since March 2020 to end of June 2022 have been incorporated into the provincial estimation and slowed down the improvement in life expectancy (LE) over the 5-year period.

Migration

The inter-provincial migration assumptions by sex have not been revised due to the COVID-19 pandemic in the period March 2020–June 2022. Gauteng attracts international migrants as well as domestic migrants from rural provinces such as Limpopo, KwaZulu-Natal and Eastern Cape it has an in-migration of 1 559 881 and a net migration of 986 527. This in-migration is significant, not only demographically it forms the "push" or "pull" factors categorised as politically, economically, socially and cultural or environmental. Movement made during lockdown constitutes a temporary one in majority of cases whilst inter-provincial migration constitutes a more permanent move. The assumptions figure 3 indicate that Gauteng and Western Cape received the highest number of in-migrants for all periods[11].

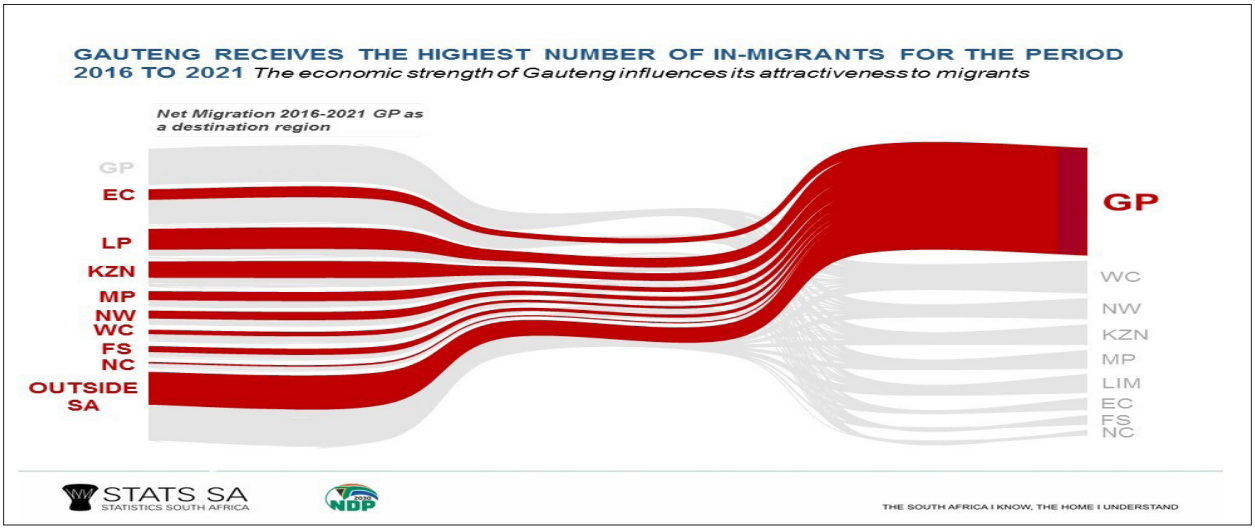


Figure 9: Migration patterns into Gauteng Province

10 National Institute for Communicable Disease (NICD) (2021(b)) Quarterly COVID-19 in children Surveillance report. Available: www.nicd.ac.za

11 Kyle H. O'Brien, Social determinants of health: the how, who, and where screenings are occurring; a systematic review. 2019. Available: https://www.statssa.gov.za/wp-content/uploads/2018/07/pic1.jpg

4.1.2. Social determinants of health for province and districts

There is a link to several factors of social determinants of health in South Africa, and Gauteng is prone to these factors. Social determinants operate at different levels (global, national, and local) it influences one's health, mental health, and access to care. [12] Health is influenced by the environment in which people live and work as well as societal risk conditions social factors such as include poverty, unemployment, racial and gender discrimination, poor water and sanitation, health literacy, social support, trauma, violence food insecurity, high levels of alcohol, substance abuse, inadequate health-system and inadequate housing.

Education is one of the most important social determinants of health it shapes individual's health developmental outcomes as compared to individuals and communities in poverty-stricken conditions that are subjected to overcrowding, poorly ventilated structures, poor quality of early childhood care and lack of education.[13] Intersectoral collaboration (ISC) is key to addressing social determinants of health, laid out in the SDGs as the interlinked challenges of poverty, inequality and climate change, among others.

District Development Model (DDM)

The DDM is a bilateral and multilateral cooperation within and among the three spheres of government under the auspices of department of corporate government. The different government sectors, metros and districts table their planned budgeted projects as part of the One Plan planning together in collaboration with multidisciplinary stakeholder whereby all health-related SDGs goals outputs are prioritised into municipal Integrated Development Planning (IDPs). The GDoH is engaging on cross cutting issues to ensure an Integrated Intergovernmental Relations (IGR) plan across the province see (annexure C) for the departments planned infrastructure projects.

GDoH is structured into five districts across Gauteng in line with National Health Act, each district is further divided into subdistricts. Each sub district has defined levels of care i.e. hospitals, PHC and CHCs. Amongst the planned infrastructure projects the department is implementing the WBOTs a PHC reengineering programme by taking services to the people in preparation for UHC and NHI.

Events impacting on service delivery

1. Eskom load shedding

The current daily load shedding with areas experiencing power outages lasting two to four hours as a result of the country's electricity demand that exceeds its production ability has resulted in a national energy crisis. During 2022, the country experienced the highest numbers of load shedding hours averaging over 1 500 hours this has impacted severely on the quality of public healthcare across the nation.

Government run hospitals nationwide care for >80% of the population but only 77 of 400 hospitals and clinics are exempt from load shedding nationwide, while the rest are still burning fuel to provide healthcare service. The impact of load shedding[14] on the health system has been felt on the intensive care units (ICU) which utilise electronic machinery to keep patients alive whereby multiple technologies involved in critical care are unable to function without power and water supply, which leaves numerous healthcare workers forced to do tasks manually in an already short-staffed system where there is only 1 doctor per 3 198 citizen.

Another major impact is on the surgical departments, for example it is reported that Chris Hani Baragwanath Hospital, the largest hospital in Africa, has more than 11,000 surgery backlogs with a waiting list purported to be running up till December 2026[15]. Also, there were events where doctors had to resort to torches during surgery of which poor lighting in procedures is associated with a higher error rate and increased postoperative complications. More importantly, the inability to carry out emergency procedures and scans causes untimely deaths and emotional trauma for all involved.

12 O Brein, K. 2019. Social determinants of health: the how, who, and where screenings are occurring; a systematic review. Available: https://www.tandfonline.com/doi/abs/10.1080/00981389.2019.1645795

13 South African Health Review 2020, Health, and Related Indicators. Available: https://www.hst.org.za/publications/South%20African%20Health%20Reviews/Chapter29_Indicators_SAHR21_04022022_OD.pdf

14 Malange, D. Load shedding and healthcare: Salt in the wound. South African Medical Journal 2023. Available: https://doi.org/10.7196/SAMJ.2023.v113i2.431

15 Business Day. 2022. Available:.https://www.businesslive.co.za/bd/national/2022-12-12-only-77-of-400-hospitals-and-clinics-exempt-from-load-shedding-says-sa-medical-association/

2. Attacks on Emergency Medical Services (EMS) and Vandalism/Theft at health institutions

The Gauteng EMS has reported that between September 2021 and August 2022 there were 23 attacks and robberies on the Green Angels. The Gauteng EMS is now being escorted by police to prevent incidents and is in the process of introducing panic buttons. The rollout of safety and security equipment on personnel and vehicles is at the final stages. The rollout of panic button devices linked to the emergency communication centre in all ambulances and response cars linked to security services in identified areas is being finalized.

The Gauteng Department of Health experienced misfortunes, which had a potential to negatively impact on the delivery of care at some of the institutions namely, Chris Hani Baragwanath Academic Hospital,
Tambo Memorial Hospital, Tembisa Hospital and Charlotte Maxeke Hospital. The latest trends of community members targeting health facilities wherein diesel gets stolen, tampering with water supply (e.g Chiawelo, Walkerville and Soshanguve) are amongst emerging trends that were observed at facilities. Such events put patients' lives at risks and cannot be tolerated.

Most of the incidents of vandalism and theft, especially of copper and electrical cables are allegedly committed by private security personnel in collusion with some officials, sometimes acting independently (e.g Charlotte Maxeke). Thus, technology and the screening of contracted security personnel is key, including backup on CCTV surveillance. The process of reviewing all contracts in the dept including SLAs, MOUs and related agreements is underway and close partnerships with the Law enforcement agencies, especially the Provincial SAPS Commissioner and team will be key.

Employment status

COVID-19 mortality contributed to the rising unemployment rate in the country mortality.[16] StatsSA Quarterly Labour Force Survey (QLFS) – Q2:2022 shows unemployed persons increased by 132 000 to 8,0 million in the second quarter of 2022 compared to the first quarter of which Gauteng (down by 3,3 percentage points) with major job losses in manufacturing (73 000) and transport (54 000). The total number of persons employed was 15,6 million in the second quarter of 2022 the biggest job gains were recorded in community and social services (276 000), trade (169 000), finance (128 000) and construction (104 000). [17]

Employees, Youth and Senior Citizens

Majority of South Africans with disabilities particularly those who are historically disadvantaged, face significant challenges in accessing employment or opportunities for their livelihood development. The department continues with advancement of people with disabilities, currently there are 1 274 permanent employees with disabilities out of 83 049 (100%) departmental employees against a target of 2% (1 166) for PWD employed. In the first quarter of the 2021/22, 92 youth with disabilities participated in departmental developmental programmes, which makes up 7.6%. The department has an environment that is accommodative and sensitive to the senior citizens of the province with continuous health promotion drives, elders are given awareness around COVID-19 and other chronic illnesses that senior citizens are prone to. The department has made measures to reduce waiting times for senior citizens when they visit healthcare institutions.

Mainstreaming women, youth and persons with disabilities (WYPD)

The department of women, youth and persons with disabilities (DWYPD) is mandated to regulate, lead and coordinate the fulfilment of South Africa's mandate to realise gender equality and the empowerment of women, girls, youth and persons with disabilities and their full and equal enjoyment to all human rights and fundamental rights. Therefore, all governments departments, provinces, public entities etc, are mandated to deliver on women's emancipation and gender equality, youth development and the rights of persons with disabilities.

SA is ranked number 12 in the world in terms of women's representation in parliament, although at local levels women's representation remains low. South Africa has made important gender, youth and disability advances in areas such as legislation, policies, representation of women in political and some decision-making levels, health, education and economic advances as it is a prerequisite for sustainable development even though progress is slow. Women continue to lag behind men in access to decision making and leadership in public and private sectors. Women are also

16 Rajib, P., Ahmed, A., Kamana, P. & Subhanwita, G. 2021. The Association of Social Determinants of Health With COVID□19 Mortality in Rural and Urban Counties. 2021. Available: https://pubmed.ncbi.nlm.nih.gov/33619746/

17 StatsSA, Quarterly Labour Force Survey (QLFS) – Q2:2022. Available: https://www.statssa.gov.za/publications/P0211/Presentation%20QLFS%20Q2%202022.pdf

still more likely to work part-time or in unskilled and semi-skilled jobs and for lower pay.

Gender Responsive Planning, Budgeting, Monitoring, Evaluation and Auditing (GRPBMEA) Framework

The GRPBMEAF was approved by cabinet on 27th March 2019 for implementation across the country it entails mainstreaming WYPD in government planning processes through WYPD responsive planning, budgeting, monitoring, evaluation and auditing. The development of the framework on GRPBMEA was a renewed means in the country to address the challenges related to:

- Poor accountability for Women Empowerment and Gender Equality (WEGE)'s performance across state sector.
- Outdated key WEGE policies and systems.
- Weak institutionalisation of gender mainstreaming.
- Lack of coherent gender responsive policy, research, planning, budgeting, monitoring and evaluation and gender auditing, policies, programmes and systems.
- Genderblind/silent policies.
- Poverty, inequality and unemployment with greater direct negative effect on women.

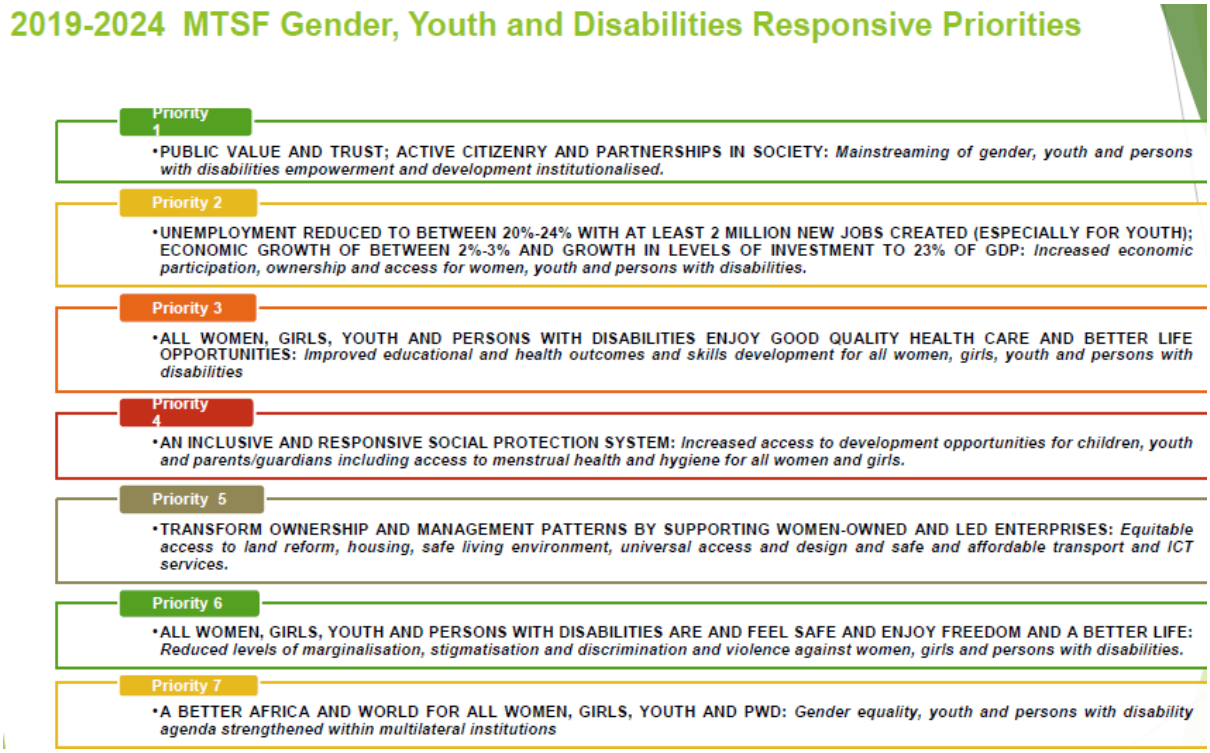


Figure 10: MTSF 2014-2024 gender priorities

The implementation of GRPBMEA in Gauteng is the responsibility of the Office of the Premier in partnership with Treasury, through usage of the budget system to enable the estimation, monitoring and tracking of that expenditure. MTSF 2024/25 must be stronger on WPYD interventions. The GDoH annual performance plan acknowledges the priorities and pillars of the GRPBMEAF.

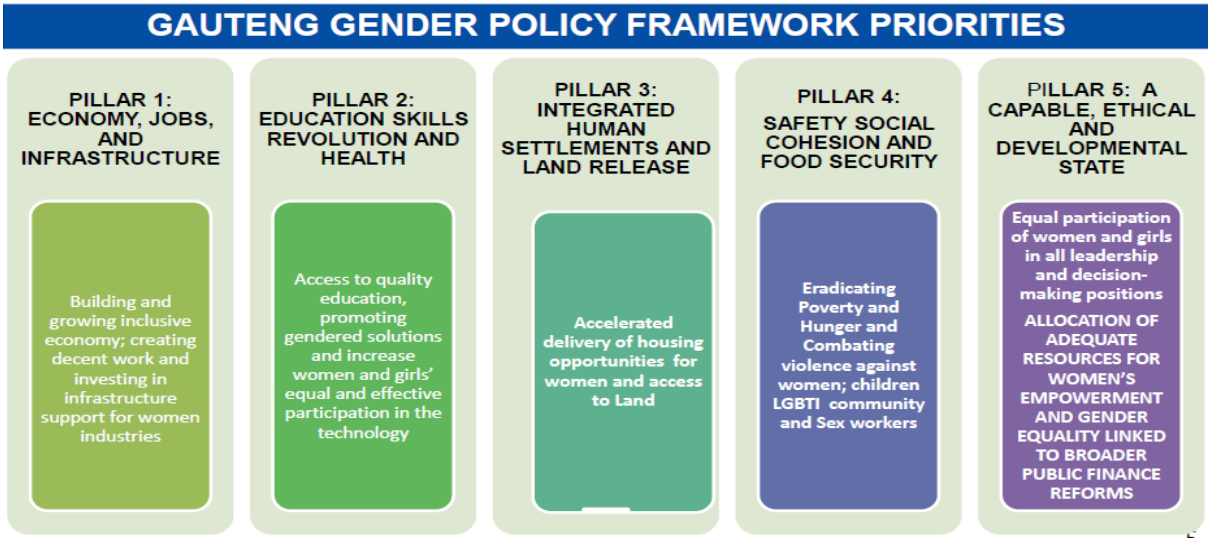


Figure 11: Gauteng gender policy priorities

Disability

South Africa is a signatory to United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), to achieve UHC equitable access to healthcare for persons with disabilities is needed. Globally there is an increased prevalence of persons with disabilities mainly notable in areas where populations are growing older leading to a higher incidence of diabetes, cardiovascular diseases, and mental disorders.[18] The South African government legislation and policies consider participation and inclusion of persons with disabilities.

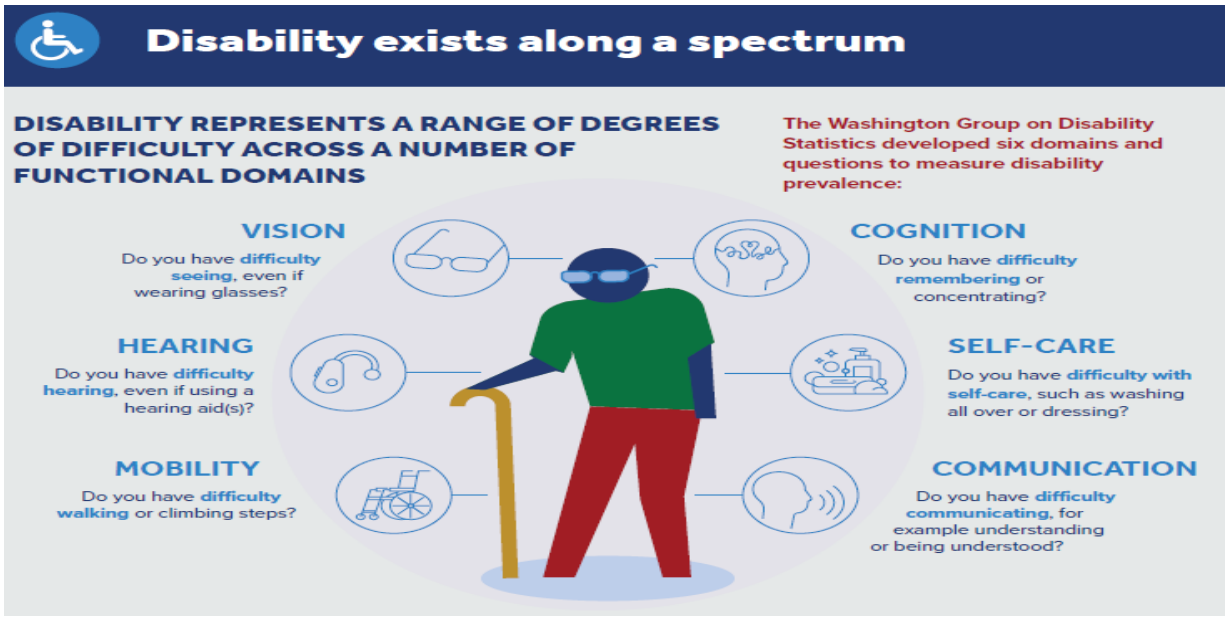


Figure 12: Disability spectrum, SAHR, 2020

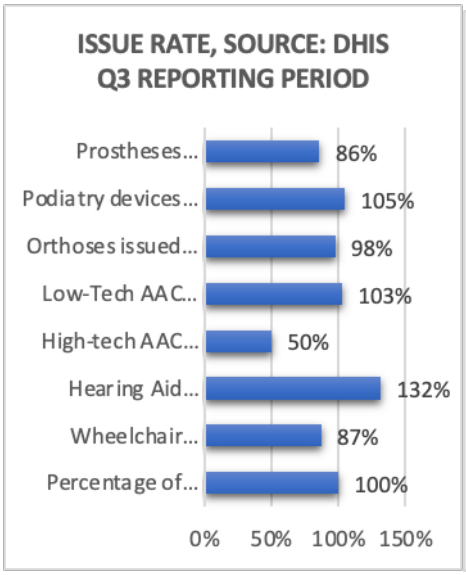
The Gauteng Health Department supports improvements in the quality of life for individuals and their integration back into the society through its rehabilitation programmes offered across all its institutions and also through community outreach programmes. Provision of assistive devices to ensure realisation of integration into communities will be pursued including support of Non-Government Organisations in participating in the health economy of fixing wheelchairs.

18 South African Health Review 2020, Health, and Related Indicators. https://www.hst.org.za/publications/South%20African%20Health%20Reviews/Chapter29_Indicators_SAHR21_04022022_OD.pdf

i. Assistive Devices Programme

The collective assistive devices issue rate target of 85,0% for 2022/24 financial year was exceeded with an actual issue rate of 100%. Wheelchair issue rate and Hearing aid issue rate were 100% and prostheses were 86%. However, the programme is concerned about the waiting period for assistive devices hearing aids where patients wait for more than 120 days for devices on average and would like to see the waiting period reduced to 60 days. New indicators have been added to monitor the waiting period to issuing of the hearing aids, wheelchairs, and prostheses. 14% of PWDs were issued with prosthesis within 90 days from prescription date, the average waiting period for issue hearing aids is 56days and for wheelchair is 13days hearing aids issue. Both wheelchair and hearing aids are within the set standard of 3 month (90days). These assistive devices performance indicate the availability of assistive devices, financial support which ensure the availability of assistive devices

The programme has not yet adopted the priority assistive products list in line with the World Health Organisation 50 Assistive Products list. This will be the priority for the GDoH Rehab 2030 Call for Action. However, the programme added Augmentative and Alternative Communication (AAC) devices both high tech & low tech (figure 13) for clients with speech or language impairment to communicate, and assistive devices for visual impaired (figure 14.) which had been neglected. A total of 137 visual impaired assistive devices were issued. There is a need to capacitate staff on advance training for AAC and on the types of AAC high tech devices available on tender. ICT resources for creation of low-tech devices must be made available at all institutions.



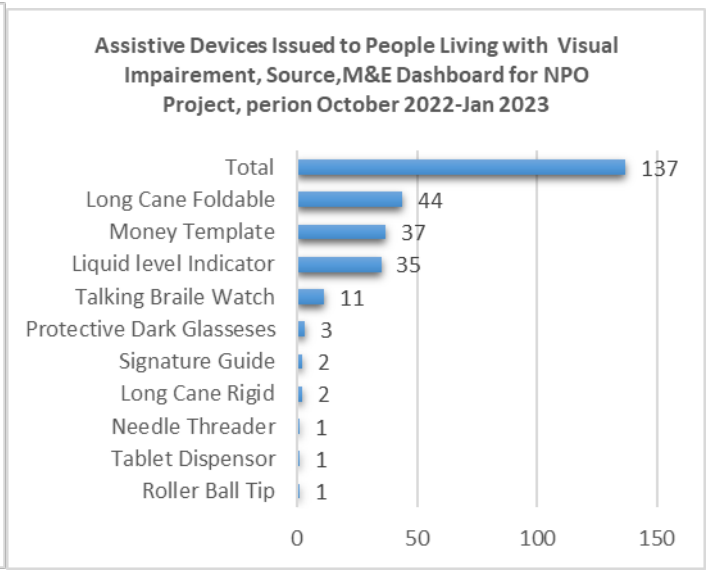


Fig 13 Issue rate of the assistive devices per category Fig 14-Assitive Devices issued to Visual Impaired client

ii. Cochlear (CHABAH) Implant Programme

The Chris Hani Baragwanath Academic Hospital Cochlear (CHABAH) Implant Programme was initiated in September 2006, and there have been 140 patients implanted by this programme over the past 14 years. It is currently the largest state-funded programme in South Africa and the Gauteng provincial center for cochlear implants in the public sector. Cochlear Implant Programme recipients include young children who were born deaf as well as children, teenagers and adults who lost their hearing later in life due to conditions such as meningitis, MDR-TB ototoxicity. The cochlear implant recipients are able to hear soft speech, improving employment possibilities for adults, and speech and language, as well as educational access, for children.

There are currently 62 patients on the waiting list, some of whom have been waiting for 2 years. Delayed surgery results in young children missing the critical language learning period, in teenagers being unable to return to school and in adults unable to maintain their employment and support their families. Funding has been approved at CHBAH for 50 cochlear implants per year. However, the role of the audiologist in managing cochlear implants patients is time consuming. Each patient requires a minimum of 15 hours of audiological management prior to implantation and a minimum of 40 hours of contact in the first 6 months post-cochlear implant.

Steve Biko Academic Hospital (SBAH) initiating their cochlear implant (CI) program in 2022. The required cochlear implant mapping and rehabilitation audiology certification was completed by 2 SBAH audiologists in 2021. SBAH has provided funding for 5 Cochlear implants on Adult patients for the 2022-23 financial year.

As noted above the time required for both Audiological as well as Aural Rehabilitation is important. Staffing challenges exist for both speech therapy and audiology and will need to be addressed by outreach from facilities within the cluster in the short term, and improvement of the post establishment structures in the long term (consideration must be taken to the split Audiology and speech degree).

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iii. Integration of Rehabilitation services within all level of care

Rehabilitation is required at all levels, for identification of needs and for an effective continuum of care throughout a person's recovery. Standardized referral pathways and other coordination mechanisms between levels help to ensure good transition of care for optimal outcomes (WHO, 2017). Rehabilitation personnel are therefore available at all levels of care to render integrated and patient centred rehabilitation services within a multi-disciplinary context. However, 92 % of district hospitals have full rehab services (OT/PT/STA), no speech therapy services at Pretoria West hospital, and Lenasia South district hospital is utilizing primary health care rehabilitation personnel. At Carletonville hospital no permanent physiotherapist and occupational therapist whereas no permanent occupational therapist at Dr Yusuf Dadoo. The plan is to improve the availability of full complement rehabilitation personnel at District Hospitals from 92% to 100% by

iv. Blindness and vision impairment Programme

The rehabilitation services were expanded to include rehabilitation services for the blind in partnership with Non-Profit Organisations (NPO) with capacity to provide Orientation and Mobility services from 2012. The blind people are rehabilitated to become independent in their own living environment, to move safely from one place to another, to use public transport, to go shopping, to recognize coins and paper money, etc. The patients are also provided with assistive devices such as white folding canes, money templates, talking watches, liquid level indicators, etc. to enhance their independence and according to their needs. Two non-governmental organizations were contracted by government to deliver Orientation & Mobility rehabilitation to visual impaired patients. A total of 70 clients (fig. 15) , of which 56% were males and 44% females were integrated with the community from ctober 2022/23-Jan 2022/2023 year. Of Visual Impairment client integrate in the community, 83% were people with blindness and 17%.

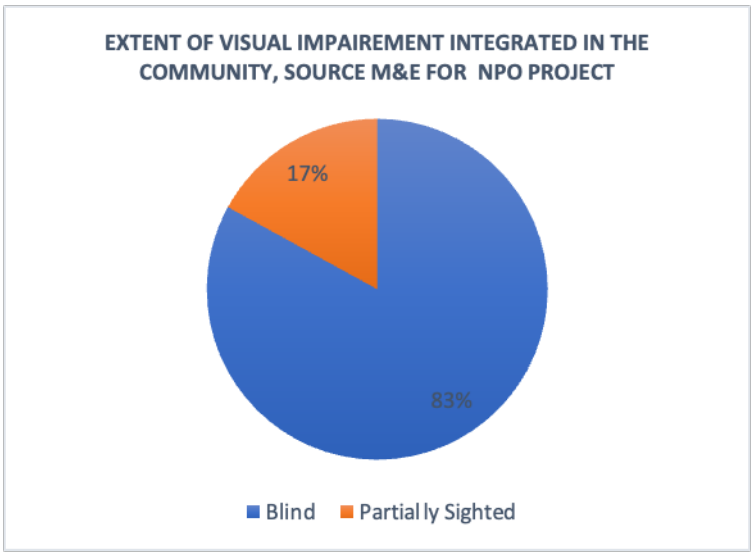


Fig 15: Extent of the Visual Impairment integrated with the Community

The appointment of the NPO(s) during the 2023/24 financial year will ensure continued access to rehabilitation services for the blind (which includes orientation and mobility) at community level. Although there is no formal data on the number of patients certified blind from eye care services, this number is expected to increase as more people become aware. The disability sector had advocated for inclusion of orientation and mobility practitioners in the Human Resource for Health (HRH) plan from NDOH as a strategy for inclusion of disability within the Gauteng Health Care System and NHI package of care.

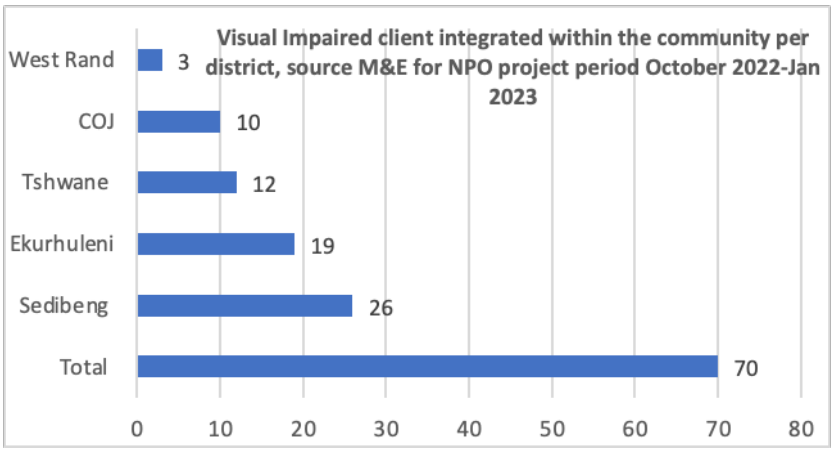


Fig 16. Visual Impaired client per district.

v. Improving Service for Children with Special Needs & their Families.

As part of reclaiming the 'JEWEL' of health services, GDoH seeks to improve the quality of services provided to children special needs and their families. A Cerebral Palsy (CP) Steering Committee and district operational task teams has been established to establish a comprehensive and cohesive system for children with special needs and their family needs which is community-based system. Cerebral Palsy(CP) Medico-legal litigation against the Gauteng Department of Health (GDoH) continues to increase. Concerns regarding the mounting CP litigation liability and its impact on the health care financial resources abounds. This project of establishing a Comprehensive & Cohesive system for all children with special needs & the families is a milestone of establishing centers of excellence (COE) for CP. In addition,the COE will further enhance Public Health Defence i.e court orders in favour of the Department on payment of future medical expenses in kind.

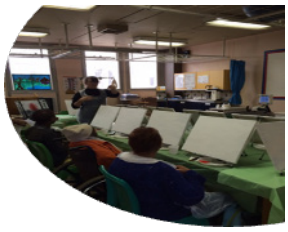
vi. Early Childhood Intervention Programme.

The Rehabilitation programme seeks to strengthen integrated early childhood intervention (ECI) services to ensure that all children under 5 years of age, who at risk of developmental delay/disabilities have access to rehabilitation services at all levels of care. The introduction of screening of children under 5 years for disabilities and / or developmental delays as well as to monitor their access to early rehabilitation intervention and support has been ongoing with all the District Health services performing well. Early detection of hearing is a continued priority as the department strives to ensure 100% of new-borns are assessed for hearing impairments. Ideally, all neonates and infants must be screened for signs and / or risks of developmental delays from birth and referred for early intervention and monitoring to minimize the effects later in their lives.

vii. Vocational Rehabilitation Programme

The key priority of vocational rehabilitation is to empower people with disabilities to participate actively in the economy by either going back to their previous employment where they worked before injury / illness or participate in any income-generating project within their communities.

In 2022/24, 156 newly diagnosed people with the disabilities entered into a vocational rehabilitation program and 95 people with disabilities were successfully re-integrated to their work environment. This has been achieved through different vocational sub-programme such as (1) Siyasebenza program concentrated on work skills and hardening program (2) trained in basic computer skills; (3) Cooking with Gadgets program; (4) Painting project; (5) Bake Me Better project, (6) Christmas Decoration and Basket Making, etc. Unfortunately, some of these projects have been negatively affected by the increase attrition rate in occupational therapy departments. Furthermore, the department is busy with the process of contracting 5 non-governmental organizations for people with disabilities to repair and service manual wheelchairs.



Basic computer training for PWD ***Painting project*** ***Sensory Mobility Bake Me Better Project***

Fig.17: Vocational Rehabilitation programme

Gender Based Violence (GBV), Violence and Trauma

GBV is a public health challenge that paralyses women and girls from enjoying their fundamental human rights, the National Strategic Plan (NSP) on Gender-Based Violence & Femicide (GBVF) 2020 – 2030 provides a cohesive strategic framework to guide the national response to GBV[19]. GBV is aggravated by socio economic factors and cultural dynamics among other things.[20] Women who are victims of abuse are vulnerable, as in many cases they are economically dependent on the perpetrators for survival, which results in the withdrawal of criminal cases.

The GDoH provides services to survivors of gender-based violence and trauma are provided through 26 centres, 7 of which are Thuthuzela Care Centres. A full spectrum of services is provided, which include trauma containment, HIV testing services for non-occupational PEP, PrEP and linkage to lifelong ART, clinical and forensic management, psychosocial support services and follow-up care for survivors of GBV, closing the loop with forensic management of alleged perpetrators, medical assessments for placements in shelters or foster care and prevention interventions from primary to tertiary prevention through campaigns. The Department is currently in the process of developing a framework for the prevention for the prevention of injuries that lead to non-natural deaths. Internal and external stakeholder management will be strengthened for collaborative implementation of GBV prevention, curative and rehabilitation services. The Diepsloot CFM Centre is under development through funding received from the First for Women Foundation with the support of Networking HIV and AIDS Communities of Southern Africa (NACOSA)

4.1.3. Epidemiology and Quadruple Burden of Disease

Leading causes of deaths

Mortality and Morbidity

The South African Medical Research 2019 & 2020 Rapid Mortality Surveillance report[21] shows an increase in number of deaths. In 2020 there were 493 602 deaths as compared to 441 996 in 2091.

The trends in figure 9, shows an increase in the number of natural and unnatural deaths from the national population register (NPR) mainly in adult natural deaths over 60 years in 2020 attributed to the COVID-19 pandemic. For children under 15 the number of natural deaths declined in 2020. Also noticeable is a decline in the number of unnatural deaths in 2020 for adults aged 15-59.

19 Republic of South Africa, Department of Women, Youth and Persons with Disabilities. 2020. National Strategic Plan on Gender-Based Violence & Femicide Human Dignity and Healing, Safety, Freedom & Equality in our Lifetime. Available: https://www.justice.gov.za/vg/gbv/nsp-gbvf-final-doc-04-05.pdf

20 Kudakwashe Gracious Zinyemba. Men's conceptualization of gender-based violence directed to women in Alexandra Township, Johannesburg, South Africa. 2022. Available: https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-022-14616-5

21 South African Medical Research Council, Rapid Mortality Surveillance report 2019 & 2020. Available: https://www.samrc.ac.za/sites/default/files/files/2021-11-25/Rapid%20Mortality%20Surveillance%20Report%202019%262020.pdf

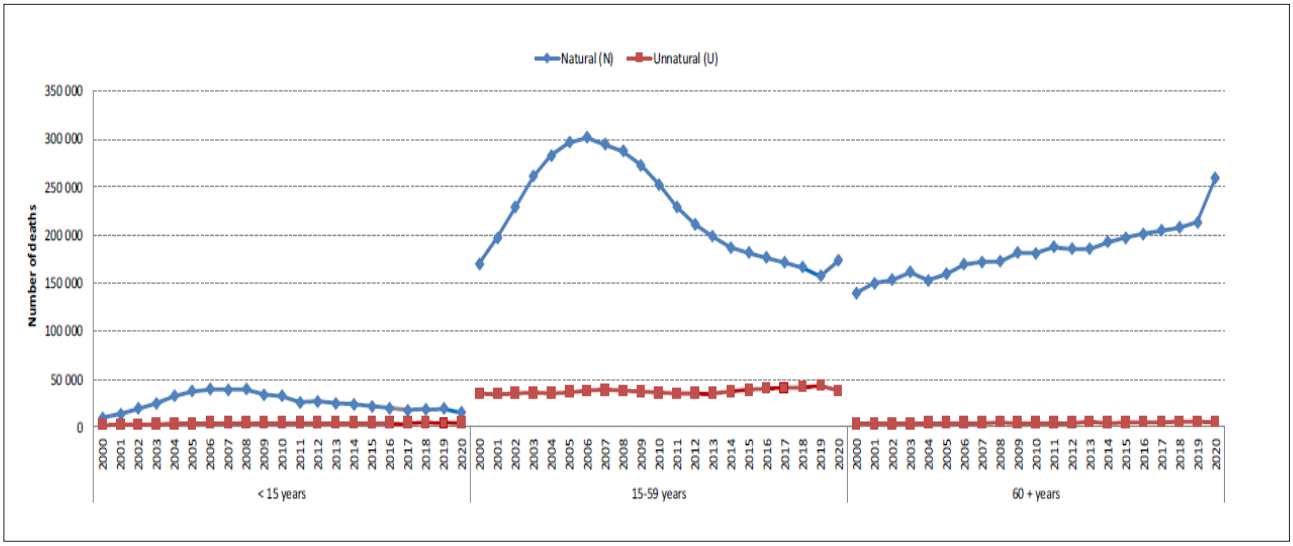


Figure 18: Trend in the number of natural (N), unnatural (U) by broad age group, NPR 2000-2020

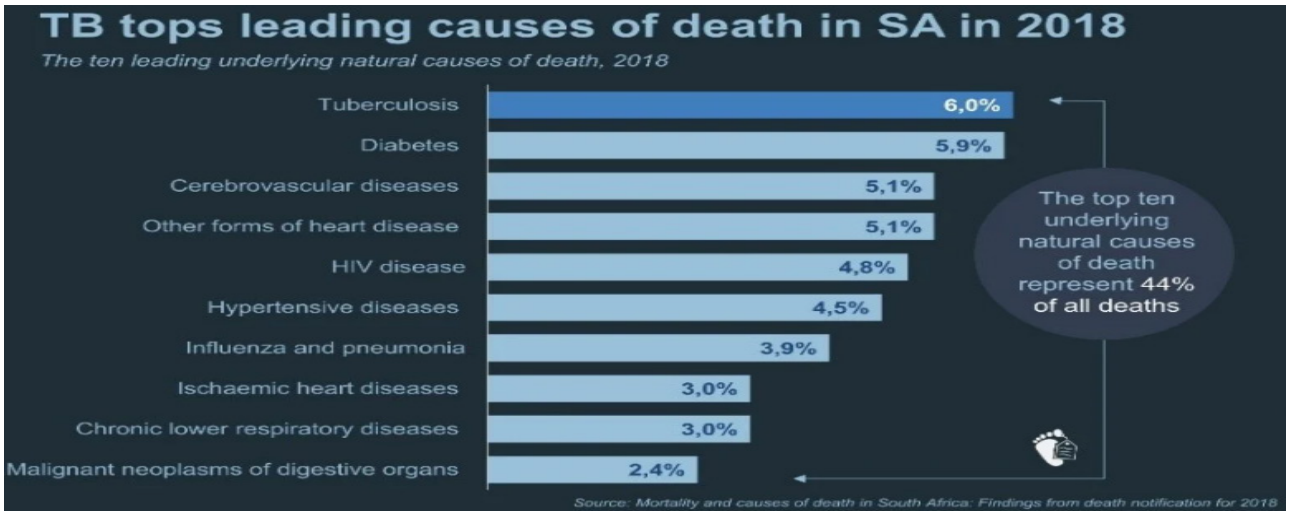


Figure 19: Causes of deaths in South Africa, 2018

Deaths due to violence and injury

Injuries and violence are a significant cause of death and burden of disease in all countries, males are prone to be killed than females due to injuries and violence[22]. Injuries result from road traffic crashes, falls, drowning, burns, poisoning and acts of violence against oneself or others, among other causes.

Gauteng provincial government EMS had a total of 18 719 deaths for FY 2022/23 (Q1-Q3) while for the same period FY 2021/22 (Q1-Q3) there were 19 284 deaths recorded and for FY 2020/21 a total of 12 384 deaths were recorded by the EMS. These deaths comprise of trauma (gunshots, assaults, stabbing), suicide (hanging, slit wrist) and accident amongst other things.

22 World Health Organization, Injuries and violence key facts. 2023. Available: https://www.who.int/news-room/fact-sheets/detail/injuries-and-violence

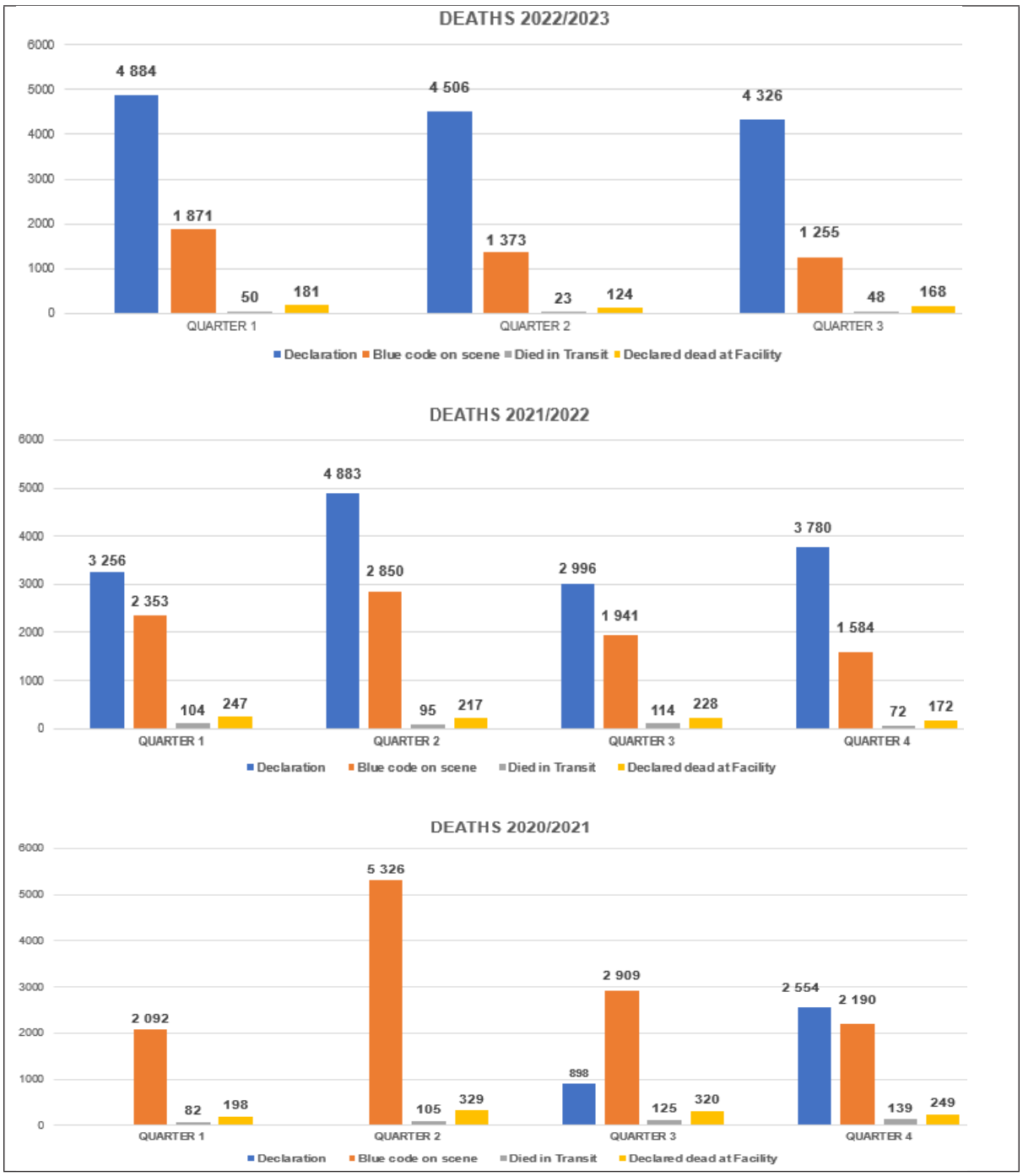


Figure 20: Gauteng violence and injury deaths, 2020-2022.

Malaria

Gauteng is a malaria non-endemic province majority of its cases are imported meaning the cases come from other provinces and countries. Gauteng mainly experiences malaria season between September and March, figure 12 shows cases for the period January- December 2022 of which there was a total of 14 malaria deaths out of 1 256 reported malaria cases.

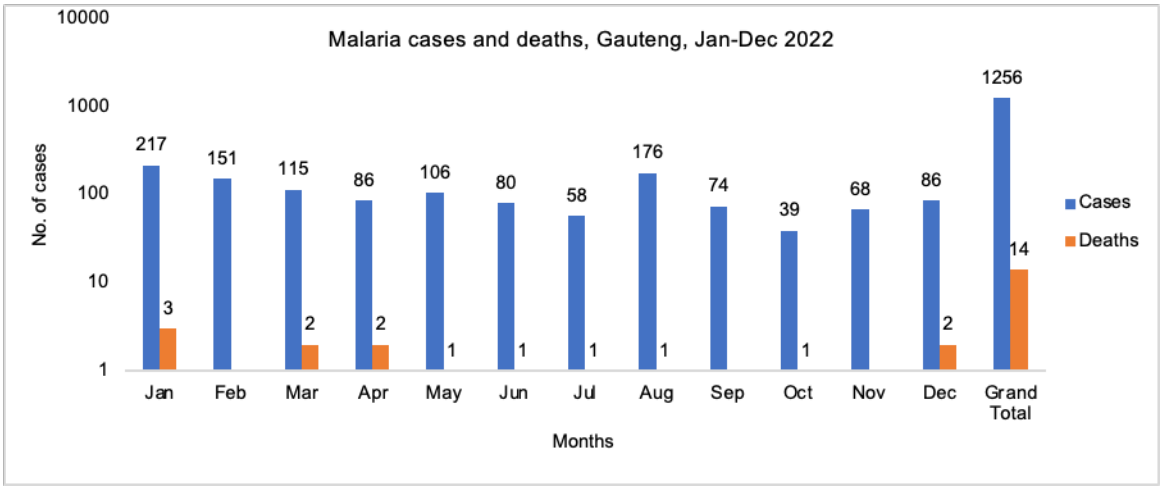


Figure 21: Gauteng malaria cases and deaths, January 2022-December 2022

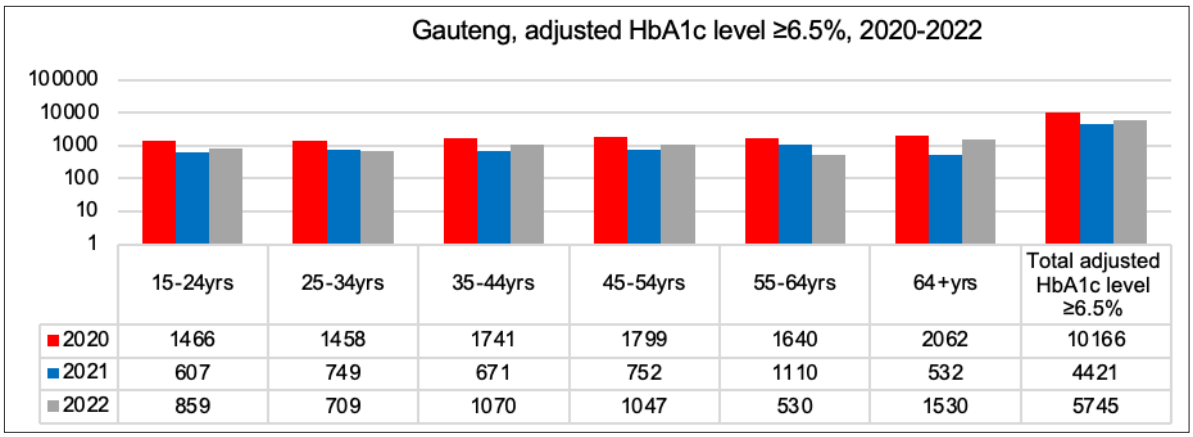
All malaria cases in Gauteng are investigated by Environmental Health Practitioners (EHP's) and the malaria deaths in the districts are audited by the malaria death audit committee (district and provincial team). To mitigate malaria incidences, malaria campaigns are conducted mostly during holiday seasons due to majority of people travel to malaria endemic provinces and countries in this period. As part of preventative measures health education and promotion is conducted at bus stations, taxi ranks and prophylaxis are issued according to national guideline for malaria treatment, 2019 to commuter's travelling to malaria endemic areas.

Non-Communicable Diseases (NCDs)

According to WHO[23], 80% of the priority NCDs known as chronic diseases i.e. cardiovascular disease (*heart attacks and stroke*), cancer, diabetes and chronic respiratory diseases are avoidable. These preventable health conditions are a results of risk factors such as alcohol use, physical inactivity, unhealthy diet and air pollution just to name a few. There has been an increase in deaths and disability due to NCDs compared to communicable diseases, injury and trauma, also an increase in co and multi-morbidities between NCDs, HIV/AIDS and TB has been observed over the period 1997–2017.[24]

Diabetes and hypertension

The SADHS 2016[25], figure 12 shows the prevalence of diabetes (adjusted HbA1c level ≥6.5%) generally increases with age reaching a peak of 30% among women age 65 or older and 23% among men age 55-64. The SADHS,2016 reports that in Gauteng women have a lower prevalence 9% of diabetes (adjusted HbA1c level ≥6.5%). The SADHS, 2016 reports that since 1998 the prevalence of hypertension has nearly doubled, from 25% to 46% among women and from 23% to 44% among men.



	15-24yrs	25-34yrs	35-44yrs	45-54yrs	55-64yrs	64+yrs	Total adjusted HbA1c level ≥6.5%
2020	1466	1458	1741	1799	1640	2062	10166
2021	607	749	671	752	1110	532	4421
2022	859	709	1070	1047	530	1530	5745

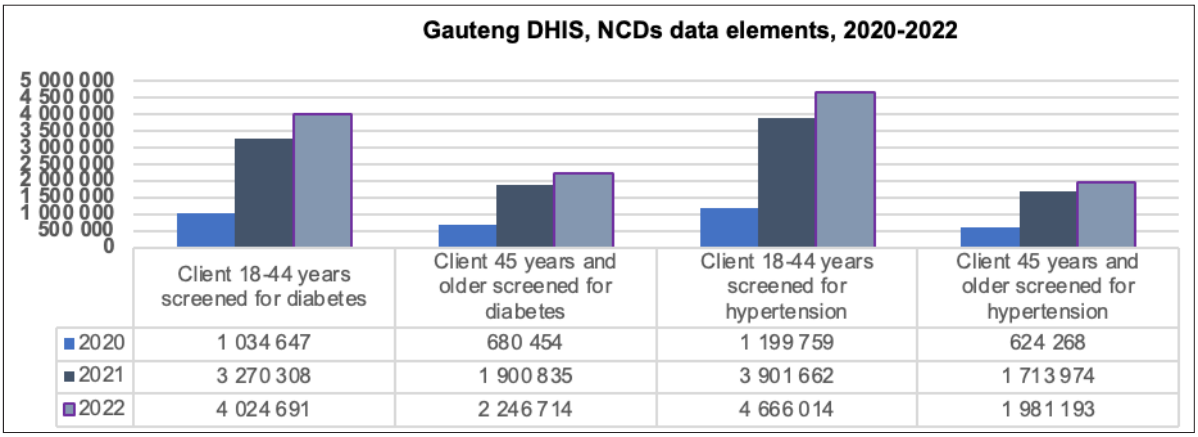
Figure 22: adjusted HbA1c level ≥6.5%, DHIS, 2023

23 World Health Organization, Noncommunicable diseases, key facts. 2023. Available: https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases

24 Stein, D. Integrating mental health with other non-communicable diseases, BMJ, 2019. Available: https://www.bmj.com/content/364/bmj.l295

25 South Africa Demographic and Health Survey (SADHS). 2016 .Available: http://www.statssa.gov.za

The district health information system (DHIS) figure 13 shows an increase in screening for diabetes and hypertension between the period 2021-2022. Diabetes type 2 prevalence increases with age those over 45 years are at an increased risk this becomes a major public health concern considering the significant rise in aging population projected in South Africa.



	Client 18-44 years screened for diabetes	Client 45 years and older screened for diabetes	Client 18-44 years screened for hypertension	Client 45 years and older screened for hypertension
2020	1 034 647	680 454	1 199 759	624 268
2021	3 270 308	1 900 835	3 901 662	1 713 974
2022	4 024 691	2 246 714	4 666 014	1 981 193

Figure 23: DHIS, NCD data elements, 2020-2022.

Cancer

The National Cancer Registry (NCR) 2019 data shows the top 5 most common invasive cancers reported in South Africa for female cancers is breast (377), cervix (49), colorectal (59), uterus (50) and Non-Hodgkin's Lymphoma (33). while for males it is prostate (379), colorectal (92), lung (52), Non-Hodgkin's Lymphoma (37) and melanoma (11). [26]

Mental Health

Mental health contributes significantly to the burden of diseases and mortality, a notable number of mental health cases is being noted with depression taking the lead resulting in disability with suicide being ranked the fourth leading cause of death among 15-29-year-olds. [27] A survey on COVID-19[28] found that the pandemic had a significant impact on mental health illness in the entire country whereby the loss of employment during lock down levels is associated with an increase in depressive symptoms 72.2% among 18-35-year olds affecting male workers more than females. The study also assessed the emotional well-being among youth, one third of the youth reported feeling "depressed", "fearful", "restless", or "lonely".

In Gauteng there has been an increase in the number of mental health patients, the DHIS[29] data shows for FY 2022/23 Q1-Q3 there was a total of 10 337 PHC treated mental disorder new patients as compared to FY 2021/22 Q1-Q3 with a total of 8 091 this shows that there has been an additional increase of .2 246 patients treated for mental health disorders. The increase in mental health patients can be attributed to the ripple effects of COVID-19 that gave an outcome of increased unemployment, substance abuse, poverty, crime and suicides. The Gauteng Province mental health strategy and action plan 2019- 2023 outline a recovery roadmap for the management of mental healthcare delivery in Gauteng to enable provincial mental health focus areas general objectives and health outcomes of the department as reflected in the Strategic Plan to be achieved.

COVID-19 Epidemic

The COVID-19 a severe acute respiratory syndrome was first identified in Wuhan, Hubei province in China on December 2019, due to its epidemiology and pathogenicity the WHO declared the outbreak a global emergency on the 30th January 2020. The virus has rapidly spread around the world, reaching South African shores on 5 March 2020. Gauteng reported its first case on 7 March 2020. On 15 March 2020 the President declared a National State of Disaster and South Africa went into lockdown on 26 March 2020.

To curb the spread of the disease non-pharmaceutical interventions such as travel restrictions, social distancing, large

26 National Health Laboratory Service, Summary statistics of cancer diagnosed histologically in 2019. Available: https://cansa.org.za/files/2022/03/NCR_Path_2019_Full_Report_8dec2021.pdf
27 World Health Organization, Mental health. 2023. Available: https://www.who.int/health-topics/mental-health#tab=tab_1
28 Oyenubi, A. & Kollamparambil, U. (2020). Covid-19 and Depressive Symptoms in South Africa. National Income Dynamics Study (NIDS) – Coronavirus Rapid Mobile Survey (CRAM). Available: https://cramsurvey.org/wp-content/uploads/2020/09/12.-Oyenubi-A.-_-Kollamparambil-U.-2020-COVID-19-and-depressive-symptoms-in-South-Africa.pdf
29 DHIS 2023. Available: https://za.dhis.dhmis.org/dhis-web-data-visualizer/#/cekuEbwkLQG

scale testing and contact tracing were practiced. Since the start of the pandemic as of 18 December 2022, there had been 1 344 593 confirmed cases of COVID-19 Gauteng province, and 21 148 reported deaths (table 6). The pandemic displays wave-like periods of high rates of infection and prevalence of active cases, and hospitalizations spread with periods of low levels of infection.

Table 6: Cumulative number of cases as of 18 December 2022

	Daily		Cumulative						
	Confirmed	%	Confirmed	%	Deaths	CFR (%)	Recovered	Recovery Rate (%)	Active cases
Gauteng	494	100%	1 3 44 593	100%	21 148	1.6	1 323 228	98%	217
JHB	235	47.6%	536 544	39.9%	6 032	1.1	530 401	99%	111
TSH	126	25.5%	38 550	28.7%	6 563	1.7	378 890	98%	51
EKU	91	18.4%	265 975	19.8%	5 020	1.9	260 917	98%	38
SED	17	3.4%	75 761	5.6%	1 637	2.2	74 116	98%	8
WR	16	3.2%	70 008	5.2%	1 815	2.6	68 187	97%	6
unallocated	0	0.0%	919	0.1%	81	8.8	838	91%	0
Address outside Gauteng	9	1.8%	9 882	0.7%	0	0.0	9879	100%	3

A national vaccine roll out campaign commenced mid May 2021, comprising of either Pfizer vaccine which consists of 2 doses apart or a Johnson and Johnson (J&J) single dose vaccine. Health workers were the first group to participate using J&J. Gauteng has the largest number of vaccines administered at close to 9 million. Nationally females in all population groups are the ones with high vaccination coverage at 56.66% compared to males at 43.45%. The 60+ population is currently the highest vaccinated at 67.51% with lower coverages among 50-59; 35-49 and 18-34 being experienced.

Resurgence Plan for COVID-19

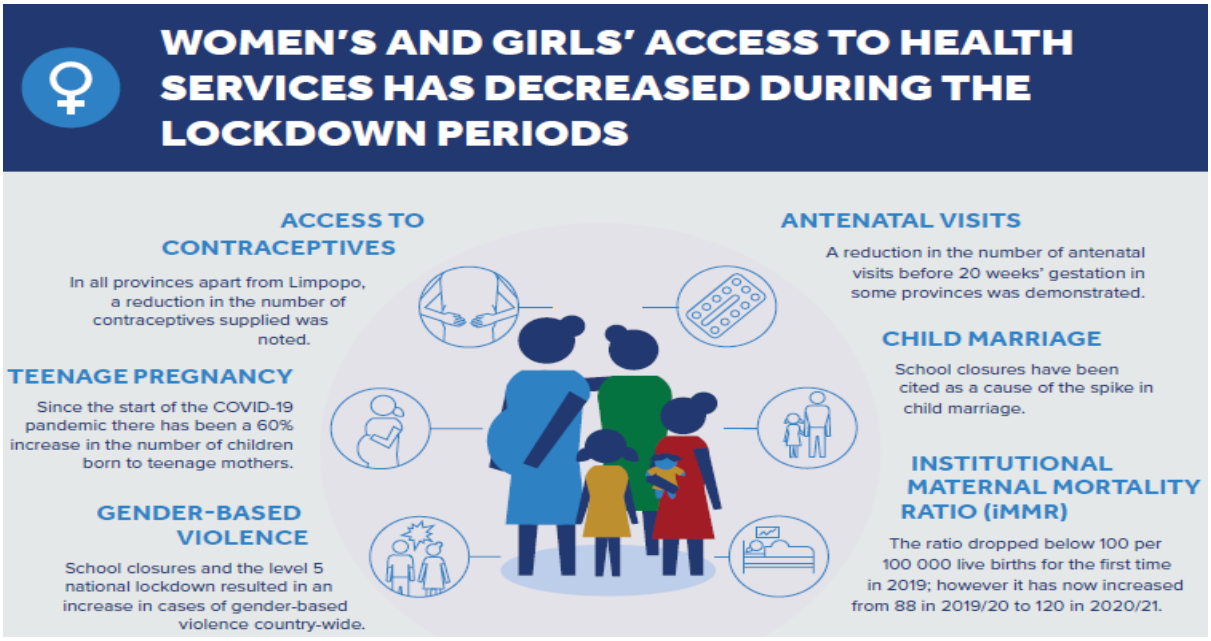
The GDoH public health resurgence plan defines COVID-19 resurgence as an increase in incidence after a period of lower transmission. The plan is a practical guide to mitigate and plan for a possible resurgence of the pandemic applicable at all levels of health care. It details several key resurgence indicators to monitor the adequate action of each phase either under control and alert, or response action, based on the data monitored at all levels. The plan further details governance, leadership and coordination of intervention areas, risk communication and community engagement and vaccination work streams with detailed toolkits for each intervention area to follow, including procedures for medical supplies, port and environmental health.

Epidemiology and Surveillance for Gauteng

The GDoH public health is mandated by WHO standards and National Health Act, 2003, Regulations: Surveillance and control of notifiable medical conditions to control and manage communicable diseases by conducting active surveillance whereby weekly surveillance line list and reports are collated by district surveillance officers then send to provincial office. Passive surveillance: Notifiable Medical Conditions (NMC) districts line list are merged monthly for data verification (duplication, harmonization).

Maternal and reproductive health

Women's ability to make decisions regarding their reproductive health has important implications for their health and well-being, the health of women and girls in many societies is disadvantaged by discrimination rooted in sociocultural factors, for example, women and girls face increased vulnerability to HIV/AIDS.[30] The SDGs goals 3, 4 and 5 and its 2030 targets aim for improved health, education and gender equality, this depends on improvements in sexual and reproductive health and satisfying people's needs for modern contraception, reducing maternal and newborn deaths, and ending the HIV epidemic.[31]



Source: SAHR, 2021

To achieve these targets and reach the most disadvantaged populations, the SDGs calls for countries to attain UHC ensuring that quality services are accessible and affordable to everyone, these calls reflect the aims of other global initiatives, such as the UN's Global Strategy for Women's, Children's and Adolescents' Health.[32]

Maternal mortality

Improving maternal health is one of the thirteen targets for the SDG goal 3 on health, the target 3.1, commits countries to end preventable maternal mortality and to reach a global maternal mortality ratio (MMR) of less than 70 deaths per 100 000 live birth due women die as a result of complications during pregnancy, childbirth and postpartum. Most of these complications develop during pregnancy other complications may exist before pregnancy but are worsened during pregnancy. The major complications that account for 80% of all maternal deaths are (5): a). severe bleeding (mostly bleeding after childbirth), b). infections (usually after childbirth), c). high blood pressure during pregnancy (preeclampsia and eclampsia), d). unsafe abortion and e). indirect maternal deaths (pregnancy aggravated by another condition or disease such as malaria, diabetes, or heart disease).[33]

Based on the DHIS data figure 14, an increase in maternal deaths in Gauteng is been observed during 2021/22. The MMR actual performance was 129.3 (309/238 933) against a set target of <90 deaths per 100 000 live birth as compared to 2019/2020 with an actual performance of 118.7 (294/247 755). The increase in maternal deaths is aggravated by eclampsia, COVID-19, pneumonia, cardiac arrest, sepsis meningitis, multiple organ failure, liver failure, post-partum haemorrhage, pulmonary embolism and cerebral haemorrhage[34]. The department still makes strides in

30 Darteh, E.K., Dickson, K.S., Doku, D.T. 2019. Women's reproductive health decision-making: A multi-country analysis of demographic and health surveys in sub-Saharan Africa. Available: https://doi.org/10.1371/journal.pone.0209985

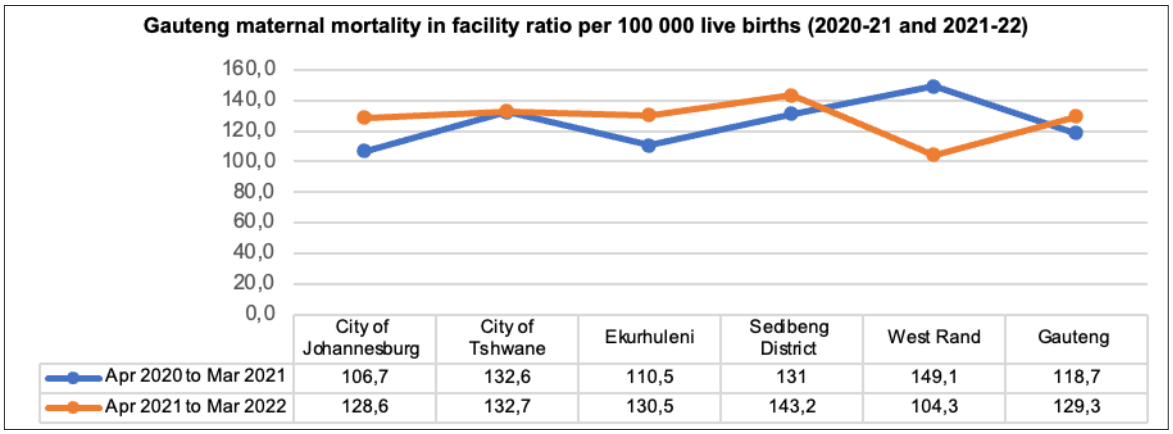
31 Sully,A., Biddlecom, A Darroch, E, Riley, T., Ashford, L., Lince-Deroche, N., Lauren Firestein, L., Murro, R. 2020. Adding It Up: Investing in Sexual and Reproductive Health 2019. Available: https://www.guttmacher.org/report/adding-it-up-investing-in-sexual-reproductive-health 2019?utm_source=Guttmacher+Email+Alerts&utm_campaign=f2f2c89da2AIU2020+GUpdate+no+usintlonly&utm_medium=email&utm_term=0_9ac83dc920-f2f2c89da2-244263581

32 United Nations Population Fund. 2023. Sexual & reproductive health. Available: https://www.unfpa.org/sexual-reproductive-health

33 World Health Organization, Maternal mortality Evidence Brief. 2019. Available: https://apps.who.int/iris/bitstream/handle/10665/329886/WHO-RHR-19.20-eng.pdf

34 Gauteng Department of Health, Annual report. FY 2019/20 & 2021/2022.

improving the performance by implementation of interventions such as the Basic Antenatal Care Plus (BANC) Plus Model for early identification of hypertensive disorders in pregnancy, maternal deaths review meetings implementation of safe delivery standards and ESMOE training will continue.

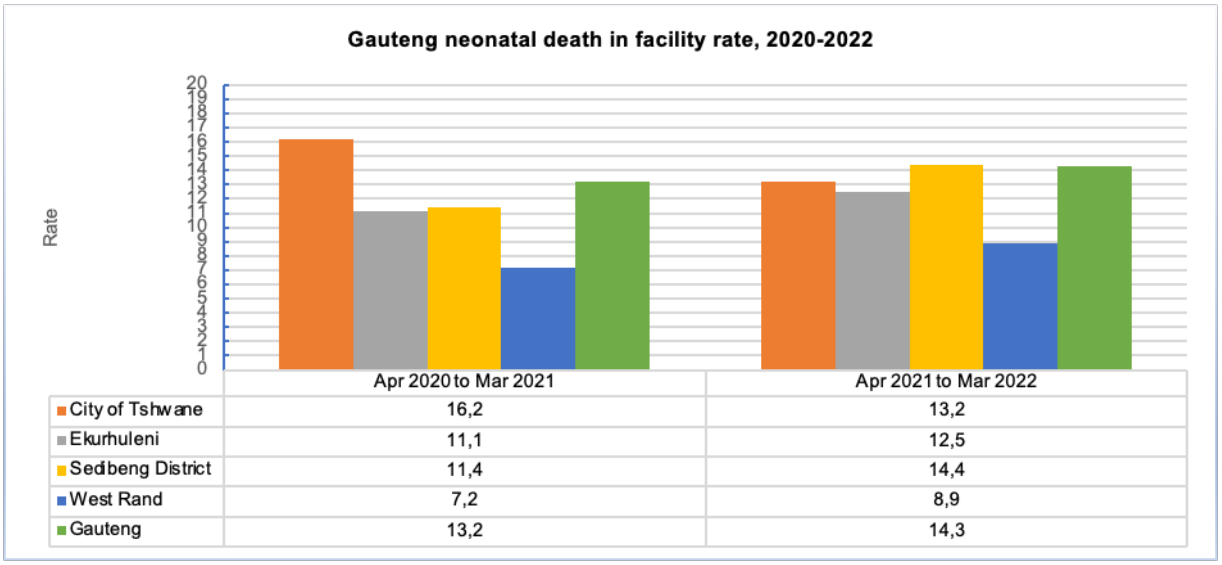


	City of Johannesburg	City of Tshwane	Ekurhuleni	Sedibeng District	West Rand	Gauteng
Apr 2020 to Mar 2021	106,7	132,6	110,5	131	149,1	118,7
Apr 2021 to Mar 2022	128,6	132,7	130,5	143,2	104,3	129,3

Figure 24: Maternal Mortality Ratio per 100 000 live births (2020-21 and 2021-22, DHIS

Neonatal mortality

Maternal health and newborn health are closely linked, nearly 2.5 million children die worldwide in the 1st month of life every year, and an additional 2.6 million babies are stillborn. In Gauteng for FY 2021/22 the performance for neonatal death in facility rate was 14.3 (3 283/229 179) as compared to FY 2019/2020 whereby the performance was at 13.2 (3 161/238 749). A rise in neonatal deaths is noted, most of these deaths occurred within 0-6 days of birth.



	Apr 2020 to Mar 2021	Apr 2021 to Mar 2022
City of Tshwane	16,2	13,2
Ekurhuleni	11,1	12,5
Sedibeng District	11,4	14,4
West Rand	7,2	8,9
Gauteng	13,2	14,3

Figure 25: Neonatal mortality ratio per 100 000 live births (2020-21 and 2021-22), DHIS

Despite stresses and constrains caused by the outbreak of the COVID-19 pandemic the department is still strengthening the prevention of neonatal deaths by continuous training of clinicians on helping babies breath, Essential Steps in the Management of Obstetric Emergencies (ESMOE) and management of sick and small new-borns amongst other things. The department needs to refocus on the WHO six building blocks[35] for example investing on human resources by hiring maternal specialists, health financing, electronic registers to limit the stumbling block of patients taking files home.

35 World Health Organization. Everybody's Business: Strengthening health systems to improve health outcomes—WHO's Framework for Action. Geneva: WHO, 2007, page 3.)

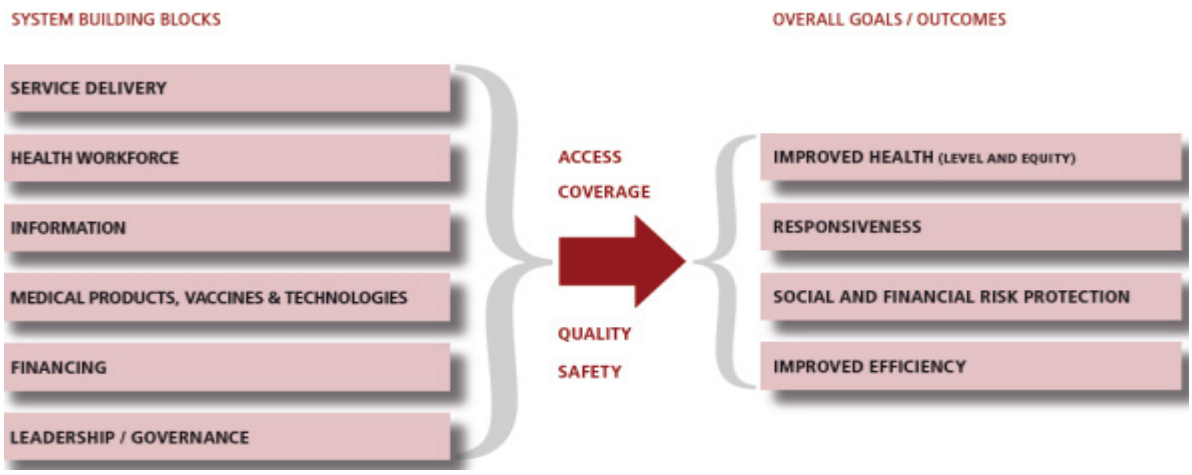


Figure 26: The WHO health system framework six building blocks

Couple year protection (CYP)

Couple year protection rate serves as a proxy for the Contraceptive Prevalence Rate (CPR). CYPR is defined as women protected against pregnancy by using modern contraceptive methods, including sterilisation. The measure includes all contraceptive methods (modern and traditional).

The average CYPR for the province has increased from 26.7% in Q2 Jul-Sep 2022 to 36.3% in Q3 Jul-Sep 2022 as depicted in the below figure. In responding to unplanned/ unwanted pregnancies the province is introducing strategies that will strengthen provision of long-acting reversable contraceptive which includes implants, intra uterine devices (IUD) the department is in the process of introducing patches and vaginal rings.

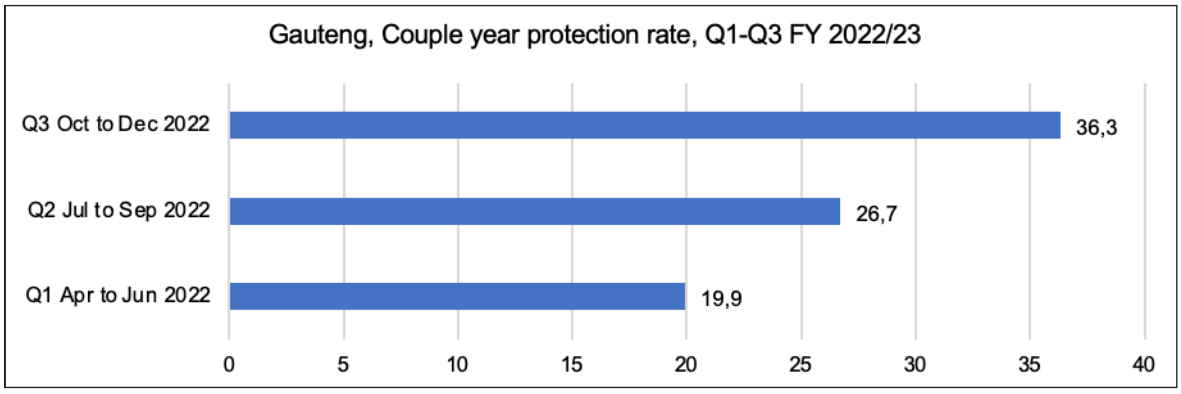


Figure 27: Gauteng couple year protection rate, DHIS

Cervical cancer

The global strategy to accelerate the elimination of cervical cancer proposes a vision of a world where cervical cancer is eliminated as a public health problem by achieving the 90-70-90 targets that must be met by 2030 as follows:

- 90% of girls fully vaccinated with HPV vaccine by age 15 years.
- 70% of women are screened with a high-performance test by 35 years of age and again by 45 years of age
- 90% of women identified with cervical disease receive treatment (90% of women with precancer treated, and 90% of women with invasive cancer managed).

The department will be implementing the WHO global strategy to accelerate the elimination of cervical by 2030, In South Africa and the Gauteng province, cervical screening is conducted in 10 years intervals. Even though the WHO vaccination coverage is 90%, the department has set its HPV vaccination coverage target at 80%. DHIS data shows that for September 2022-October 2022 the HPV coverage is at 80.4% (70 618/87 790) for girls in public schools who

are 9 years and older.

Some of the experienced challenges are due to absenteeism, lack of signed consent forms, contra-indications (for example if a child is ill) and some learners are repeating class and are already fully immunised.

In order to achieve the 70% cervical screening, target the department ensures that uninsured women who are 35 years and above have three pap smears in their lifetime at a 10-year interval by using colposcopy instrument to screen. The department's DHIS data figure 28 shows the 2022 provincial coverage is at 31.4%, this shows that the province is still far from achieving the 70% screening target. For the 90% target on cancer treatment the province has received Large Loop Excision of the Transformation Zone (LLETZ) machines used to treat cervical cell changes (abnormal cells) or early-stage cervical cancer by conducting surgery that removes a small part of the cervix, as well as to diagnose cervical cancer.

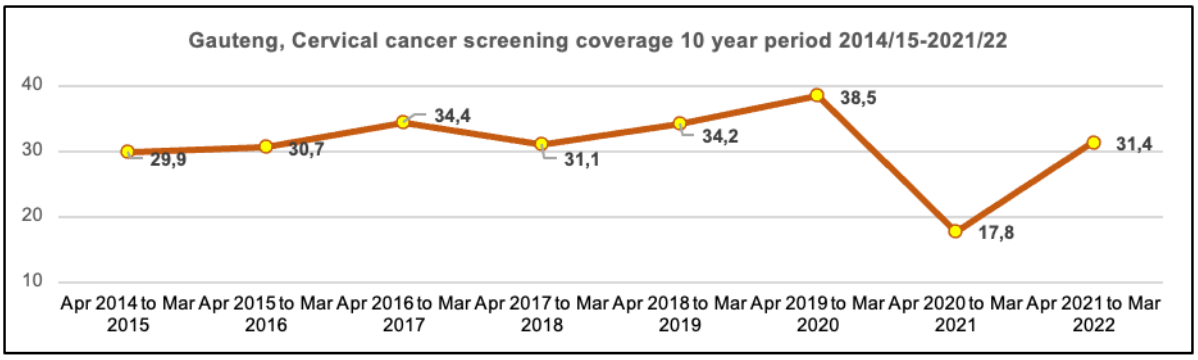


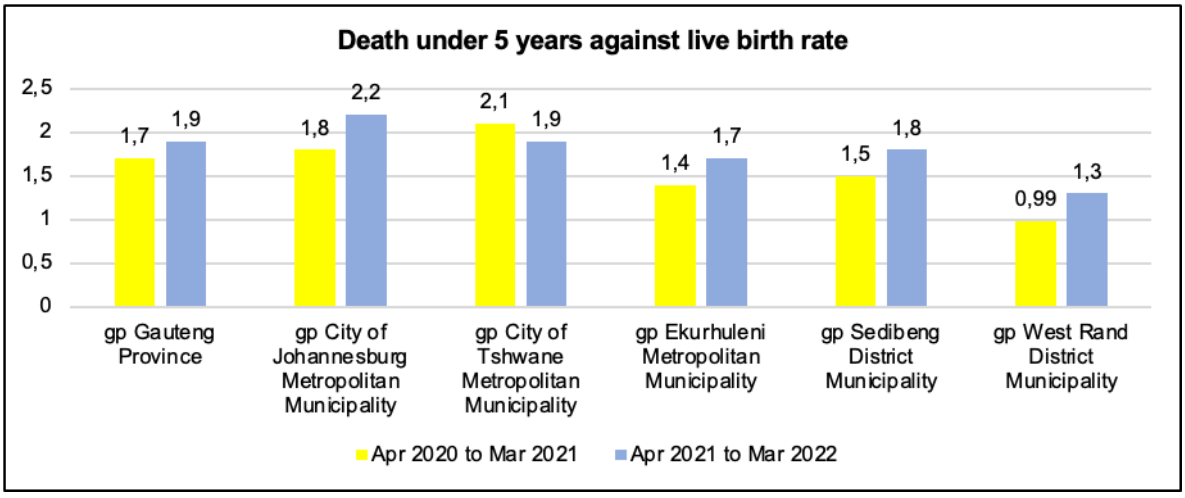
Figure 28: Gauteng cervical cancer screening coverage, DHIS

Child Health

Death under 5 years against live birth rate

The under-five mortality rate refers to the probability a new-born would die before reaching exactly 5 years of age, expressed per 1,000 live births. In 2021, UNICEF data shows that 5 million children under 5 years of age died globally, primarily from infectious diseases, including pneumonia, diarrhoea and malaria these diseases remain a leading cause of under-five deaths, along with preterm birth and intrapartum-related complications. [36]

Gauteng is at 1.9 death under 5 years for the 2021/22 figure. This is a slight increase from 2020/21 with a performance of 1.7. There has been an increasing under 5 years deaths in CoJ for the period 2021/22 it was at 2.2 as compared to 2020/21 at 1.8, Tshwane has shown to have had a decrease in under 5 years deaths from 2,1 in 2020/21 to 1.9 in 2021/22. The health system's efforts are confined to immunization in ensuring infants are protected against vaccine preventable diseases (VPDs) and improving case management of diarrhoea, pneumonia, and severe acute malnutrition (SAM) in hospitals. Most of the child health indicators performance across the districts figure has improved.



36 UNICEF, Under-five mortality. 2023. Available: https://data.unicef.org/topic/child-survival/under-five-mortality/

Figure 29: Gauteng province child under 5 years against live birth rate, DHIS

Gauteng case fatality under 5 years rate

Child under 5 years diarrhoea case fatality rate (CFR)

Child under 5 years diarrhoea case fatality rate (CFR) refers to the proportion of all children under 5 years admitted to hospital with diarrhoeal disease who die during admissions. Diarrhoea is a leading cause of morbidity and mortality among children under 5 years in low- and middle-income countries, accounting for about 9% of all child under-5 deaths. The risk factors for diarrhoea include HIV, poverty, undernutrition, poor hygiene, underprivileged household conditions, and poor access to appropriate care.

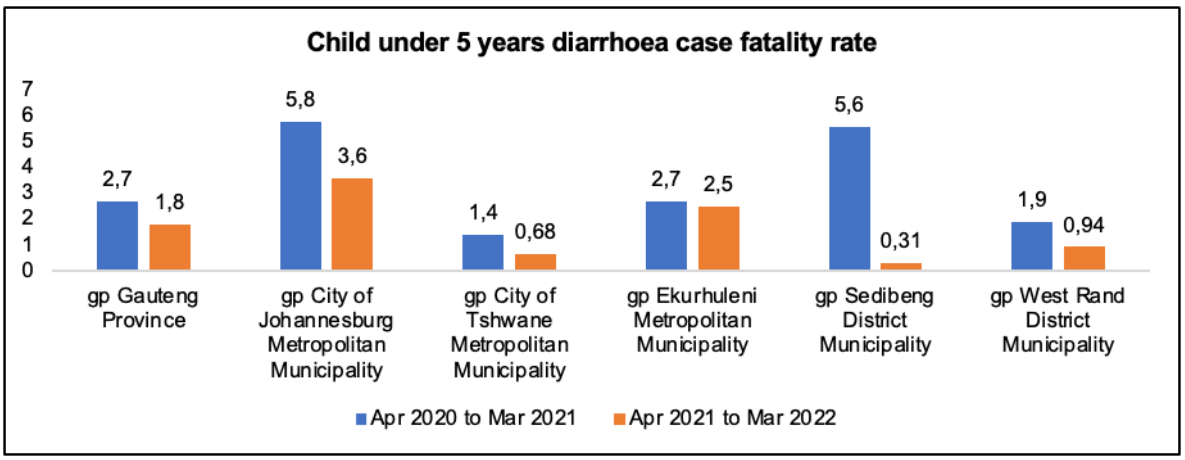


Figure 30: Gauteng province child under 5 years diarrhoea case fatality rate, DHIS

Child under 5 years pneumonia case fatality rate

The indicator 'child under 5 years pneumonia case fatality rate' measures the number of children who died from pneumonia as a proportion of the number of children who were admitted with pneumonia.

Globally, pneumonia kills nearly 1 million children under the age of 5 years annually, causing more deaths than HIV and AIDS, diarrhoea and malaria combined. Mortality due to childhood pneumonia is strongly linked to poverty-related factors such as undernutrition, lack of safe water and sanitation, indoor air pollution and inadequate access to health care. Thus, pneumonia can be prevented by means of immunisation, adequate nutrition and by addressing environmental factors.

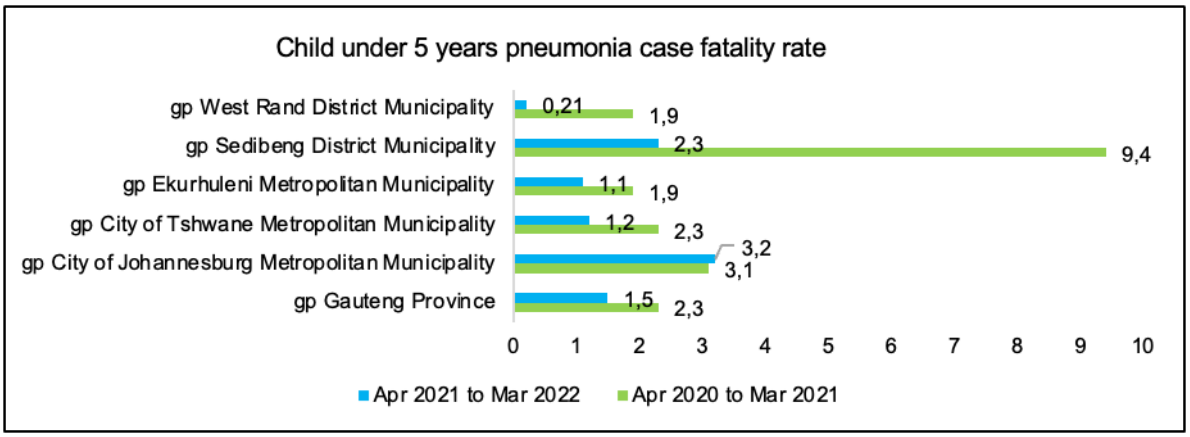


Figure 31: Gauteng province child under 5 years pneumonia case fatality rate, DHIS

Severe acute malnutrition death under 5 years rate

Severe acute malnutrition is defined as severe wasting (a weight-for-height below two standard deviations from the mean, or a mid-upper arm circumference (MUAC) less than 11.5 cm), or the presence of nutritional oedema. High

CFRs reflect poor case management of children with SAM. High CFRs may also be due to late identification of the condition or late presentation of children with SAM to health facilities. Conversely, a declining CFR suggests better management of children with SAM who present to health facilities, and/or earlier presentation, i.e. children are less ill at the time of presentation and therefore more likely to respond to standard treatment.

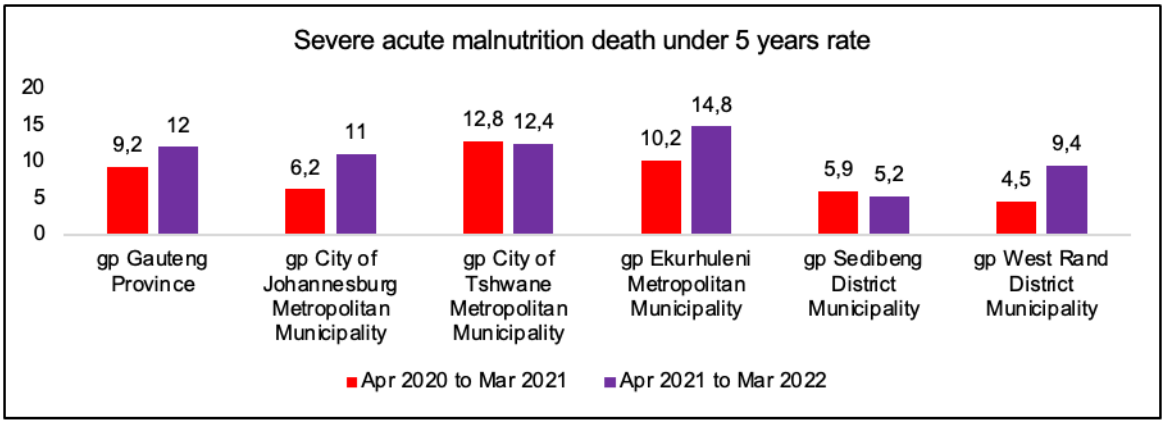
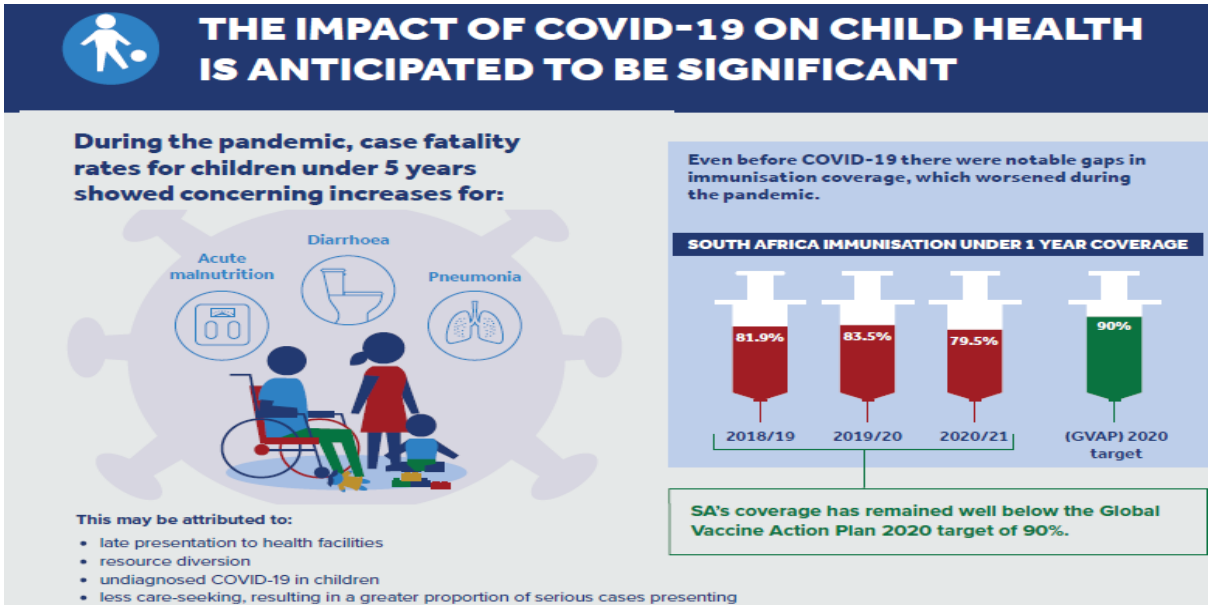


Figure 32: Gauteng province child under 5 years severe acute malnutrition rate, DHIS

The effect of COVID-19 pandemic has been greatly felt, the above DHIS data shows most of the child health indicators were affected when comparing the financial years. Gauteng province experienced four waves of infection which resulted in constraints on delivery of health care services whereby mothers and caregivers had to miss their children's immunization appointments and other provisions of healthcare services in facilities.



Source: SAHR, 2021

Under five years interventions

Immunisation under 1 year coverage

Immunisation coverage under 1 year measures the percentage of children under 1 year of age who have received all the following immunisations: at birth: OPVa (0), BCGb, 6 weeks: OPV (1), DTaP-IPV/Hibc (1), Hep Bd (1), PCVe (1), RVf (1), 10 weeks: DTaP-IPV/Hib (2), Hep B (2), 14 weeks: DTaP-IPV/Hib (3), Hep B (3), (3), PCV (2) RV (2), 9 months: Measles vaccine (1), PCV (3).

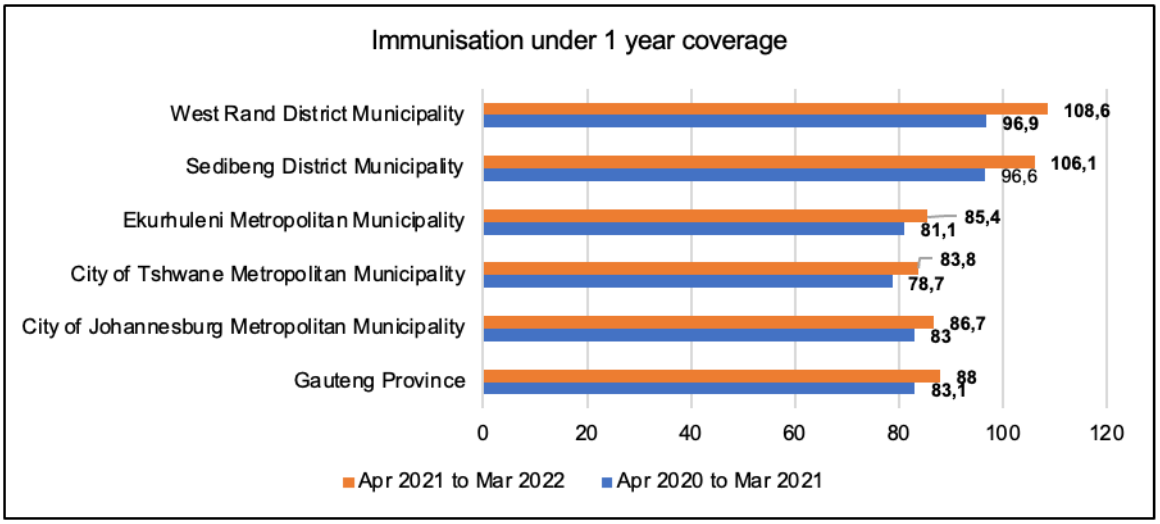


Figure 33: Gauteng immunisation under 1 year coverage, DHIS

Measles 2nd dose 1 year coverage

Measles 2nd dose 1 year coverage measures the proportion of children aged 1 year (12–23 months) who received measles 2nd dose coverage, normally at 18 months.

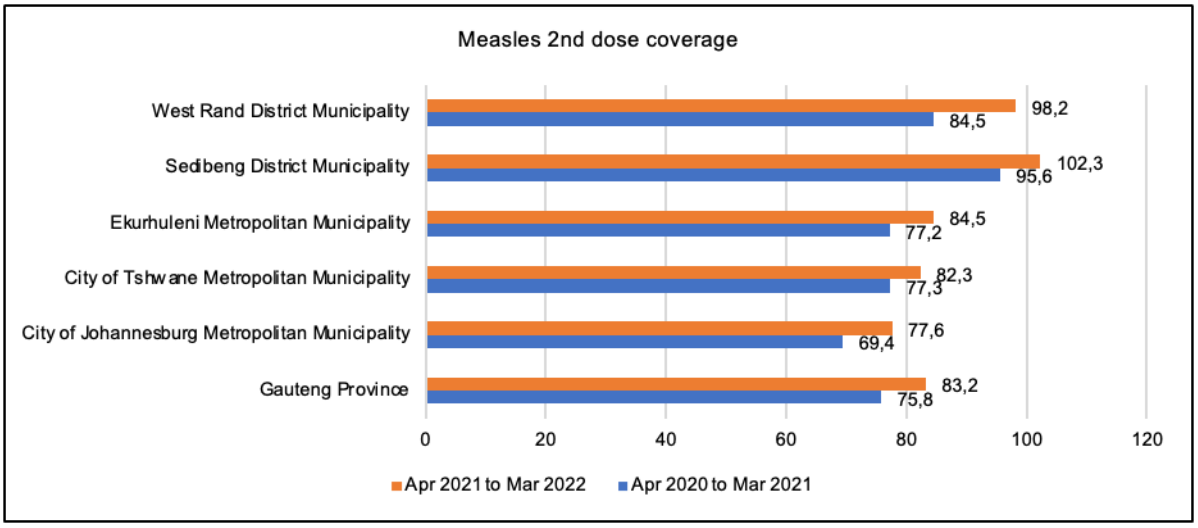


Figure 34: Gauteng measles second dose coverage, DHIS

Vitamin A coverage 12–59 months

Vitamin A coverage 12–59 months is defined as the proportion of children in the 12–59-month age group who receive their full quota of two doses of oral vitamin A supplementation at 4–6-month intervals each year. This indicator provides useful information on preventive child health intervention coverage and acts as a proxy indicator for access to preventive health services among 12–59-month-old children.

As part of childhood disease prevention Gauteng is continuously administering Vitamin A supplementation in the age group 12-59 months. The Vitamin A reduces the incidences of diarrhoea and measles in children and prevents blindness and hearing loss. Most importantly, Vitamin A supplementation can improve a child's chance of survival by 12 to 24 per cent. [37]

37 UNICEF Vitamin A Supplementation: A statistical snapshot. 2016. Available: https://data.unicef.org/resources/vitamin-supplementation-statistical-snapshot/

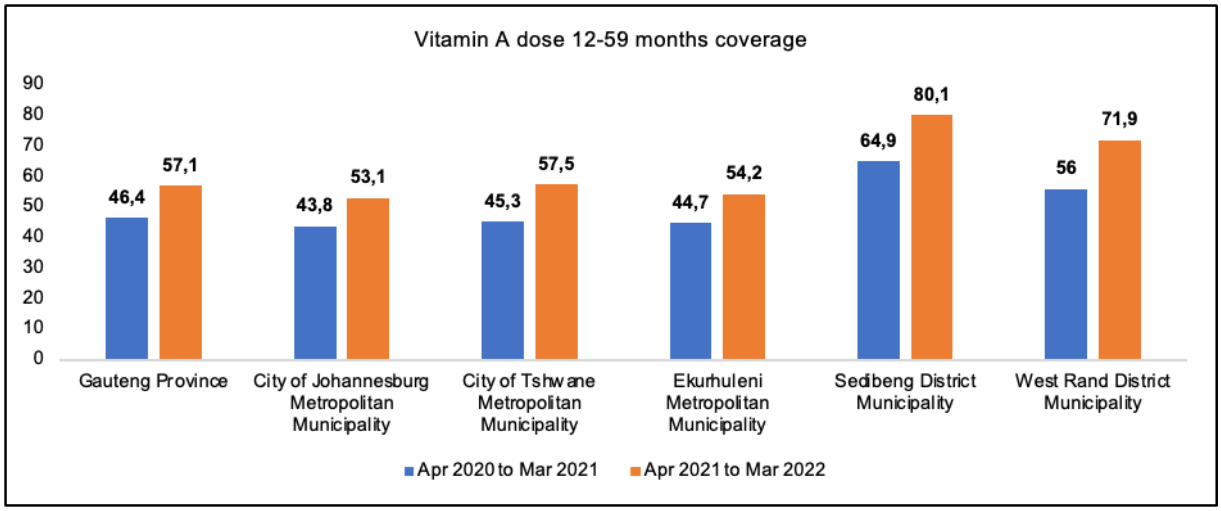


Figure 35: Gauteng Vitamin A dose 12-59 months coverage, DHIS

Communicable diseases

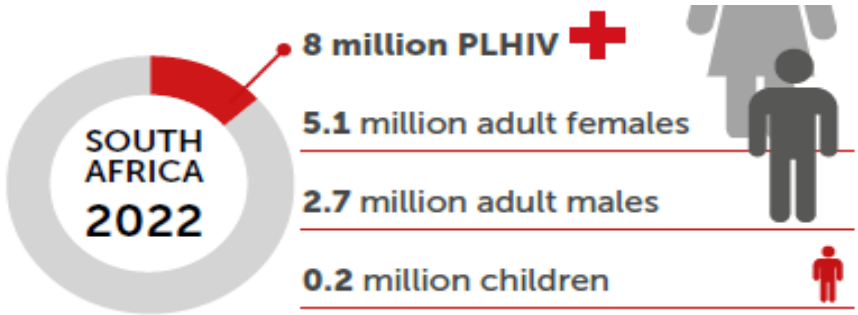
HIV and AIDS

South Africa adopted the UNAIDS 90, 90, 90 targets for HIV in 2014, which aim to ensure that by 2020:

- 90% of all people living with HIV will know their HIV status
- 90% of all people with diagnosed HIV infection will receive sustained anti-retroviral therapy
- 90% of all people receiving anti-retroviral therapy will have viral suppression.

HIV prevalence in South Africa

The proportion of people living with HIV (PLHIV) in South Africa was 13.5% in 2022, which equates to approximately 8 million PLHIV, out of this adult females were 5.1 million, 2.7 million were adult males and 0.2 million were children with adolescent girls and young women having a higher prevalence than their male counterparts (8.8% versus 3.7%). [38] Gauteng with a prevalence of 21.8% and KwaZulu-Natal 17.6% contribute almost half of the total burden of HIV in the country. The top 12 districts with the highest prevalence of HIV are found in KwaZulu-Natal and Mpumalanga provinces while those with the least HIV prevalence are in the Western Cape and Northern Cape.



Source: NSP 2023-2028

HIV incidence in South Africa

HIV incidence is highest in Gauteng (21%), followed by KZN (19%) and Eastern Cape provinces (16%) the top five provinces (Gauteng, Eastern Cape, Mpumalanga, KwaZulu- Natal, and Limpopo provinces) constitute almost 80% of all new infections.

38 National Strategic Plan for HIV,TB & STIs. 2023-2028

Gauteng 90-90-90 cascade

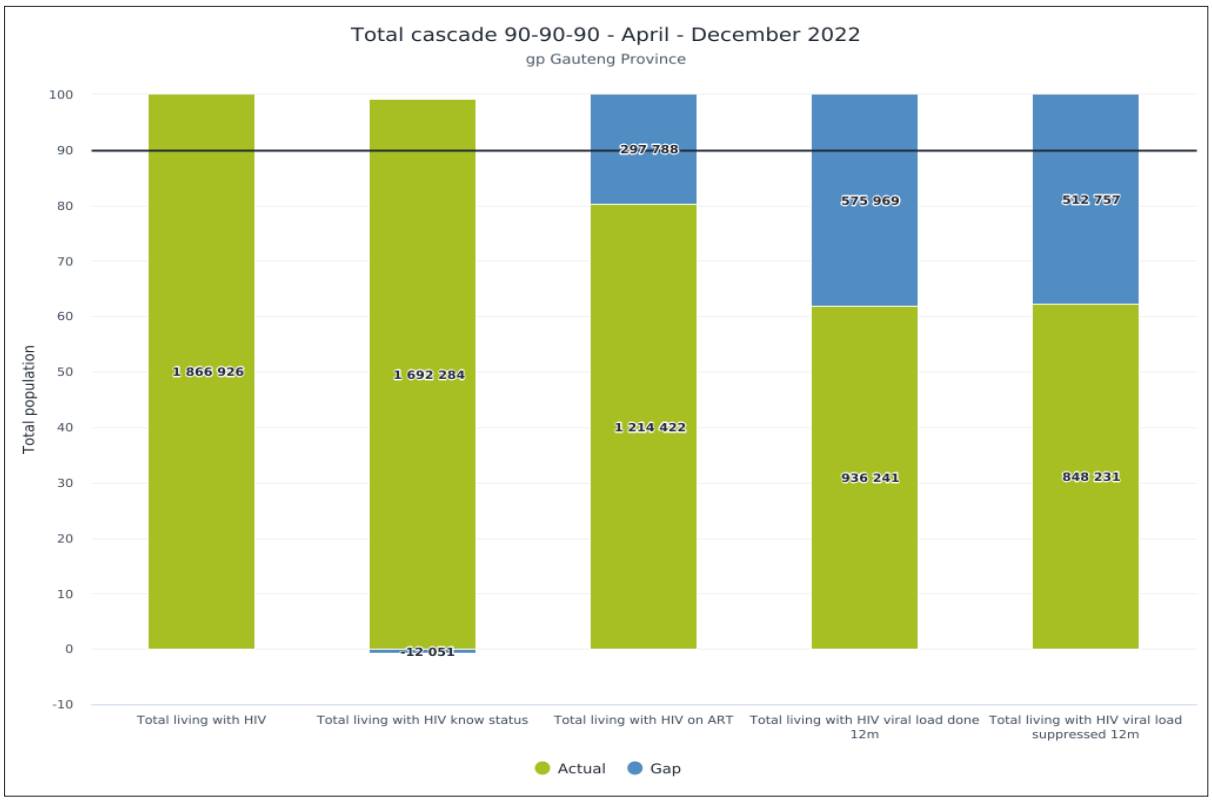


Figure 36: Gauteng province 90-90-90 cascade, April-December 2022, DHIS

Gauteng is progressively moving towards attaining the 90-90-90 targets. DHIS data figure 17 shows for the period April 2022 -December 2022 the first 90 of the USAID targets is been achieved 90.6% (1 692 284/1 866 926). For the second 90 target, the province is at 71.8% (1 214 422/1 692 284) this indicates that there are some PLHIV who are not initiated on ART. The last 90 target is also performing below target at 70% (848 211/1 214 244). South Africa has the largest number of people enrolled on ART programme in the world. [39] The COVID-19 pandemic to some extent interrupted HIV prevention and treatment programmes in Gauteng and countrywide the case fatality rate (CFR) was higher for HIV infected persons (20,9%) when compared to non-HIV infected persons (18,9%).[40]

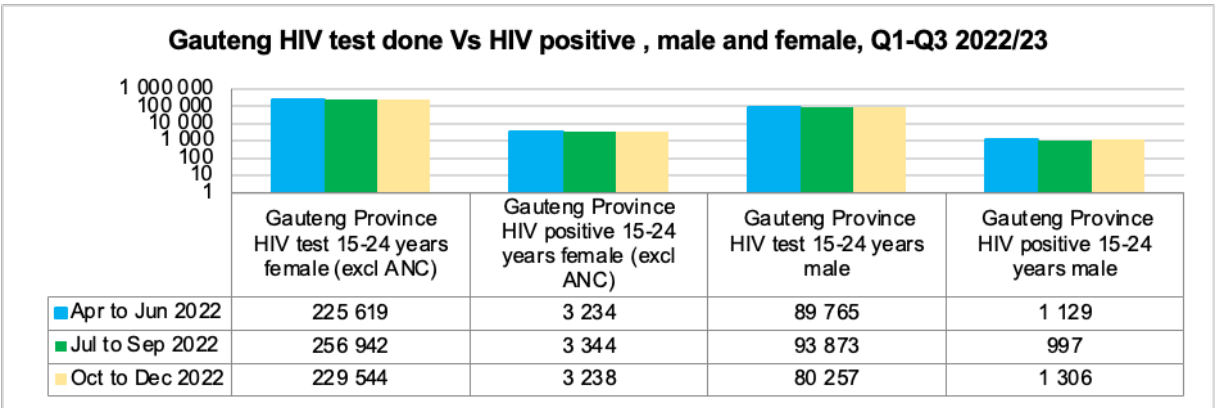
HIV key populations

The NSP 2023-2028 focuses on HIV Key and other priority populations as follows: 57.9% HIV prevalence in female sex workers, followed by transgender people with 51.9%, and 29.9% men having sex with men (MSM), 21.8% people who inject drugs (PWID) and people in prisons report 17.5%.

39 StatsSA, mid year population estimates. 2022.

40 National Institute for Communicable Disease (NICD) (2021 (a)) COVID-19 Hospital Surveillance Update, Week 14. Available: www.nicd.ac.za

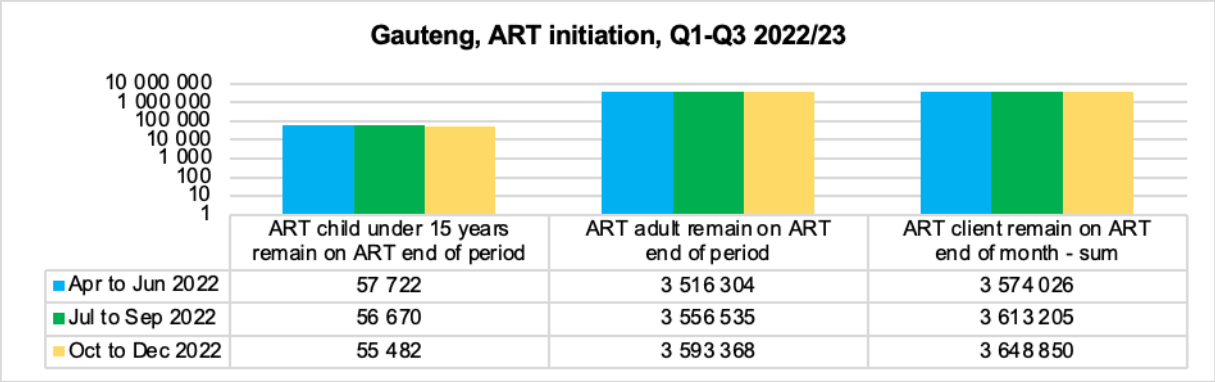
1st 90



	Gauteng Province HIV test 15-24 years female (excl ANC)	Gauteng Province HIV positive 15-24 years female (excl ANC)	Gauteng Province HIV test 15-24 years male	Gauteng Province HIV positive 15-24 years male
Apr to Jun 2022	225 619	3 234	89 765	1 129
Jul to Sep 2022	256 942	3 344	93 873	997
Oct to Dec 2022	229 544	3 238	80 257	1 306

Figure 37: HIV tests done and HIV positive cases amongst 15-24 years females and males, DHIS

2nd 90



	ART child under 15 years remain on ART end of period	ART adult remain on ART end of period	ART client remain on ART end of month - sum
Apr to Jun 2022	57 722	3 516 304	3 574 026
Jul to Sep 2022	56 670	3 556 535	3 613 205
Oct to Dec 2022	55 482	3 593 368	3 648 850

Figure 38: Gauteng ART Initiation children under 15 years and adults, DHIS

3rd 90

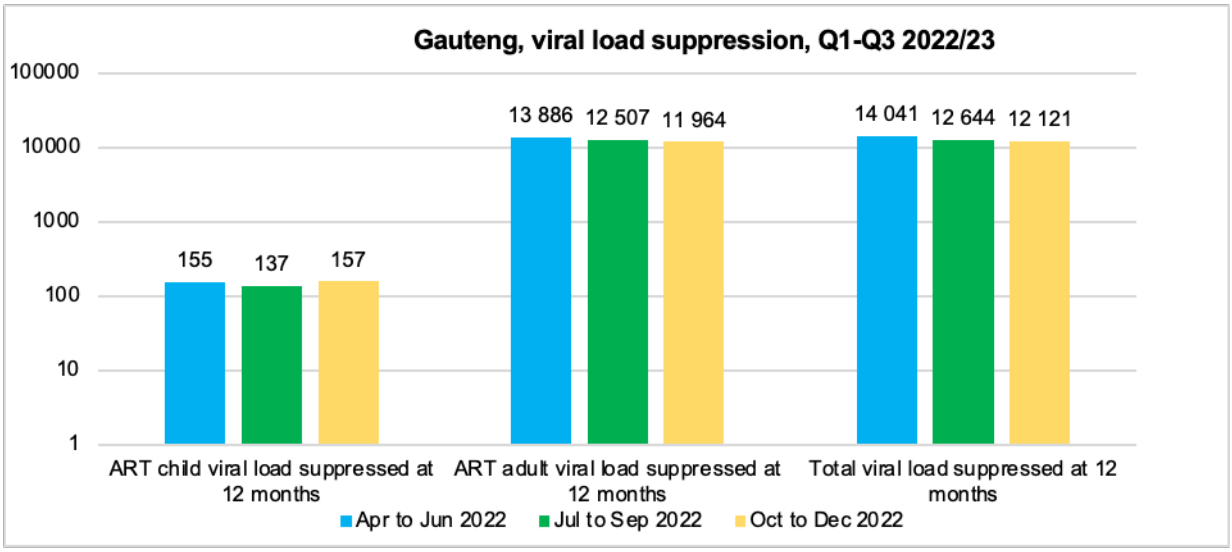


Figure 34: Gauteng viral load suppression among children and adults, DHIS

1ST 90 Test done vs test positive by district

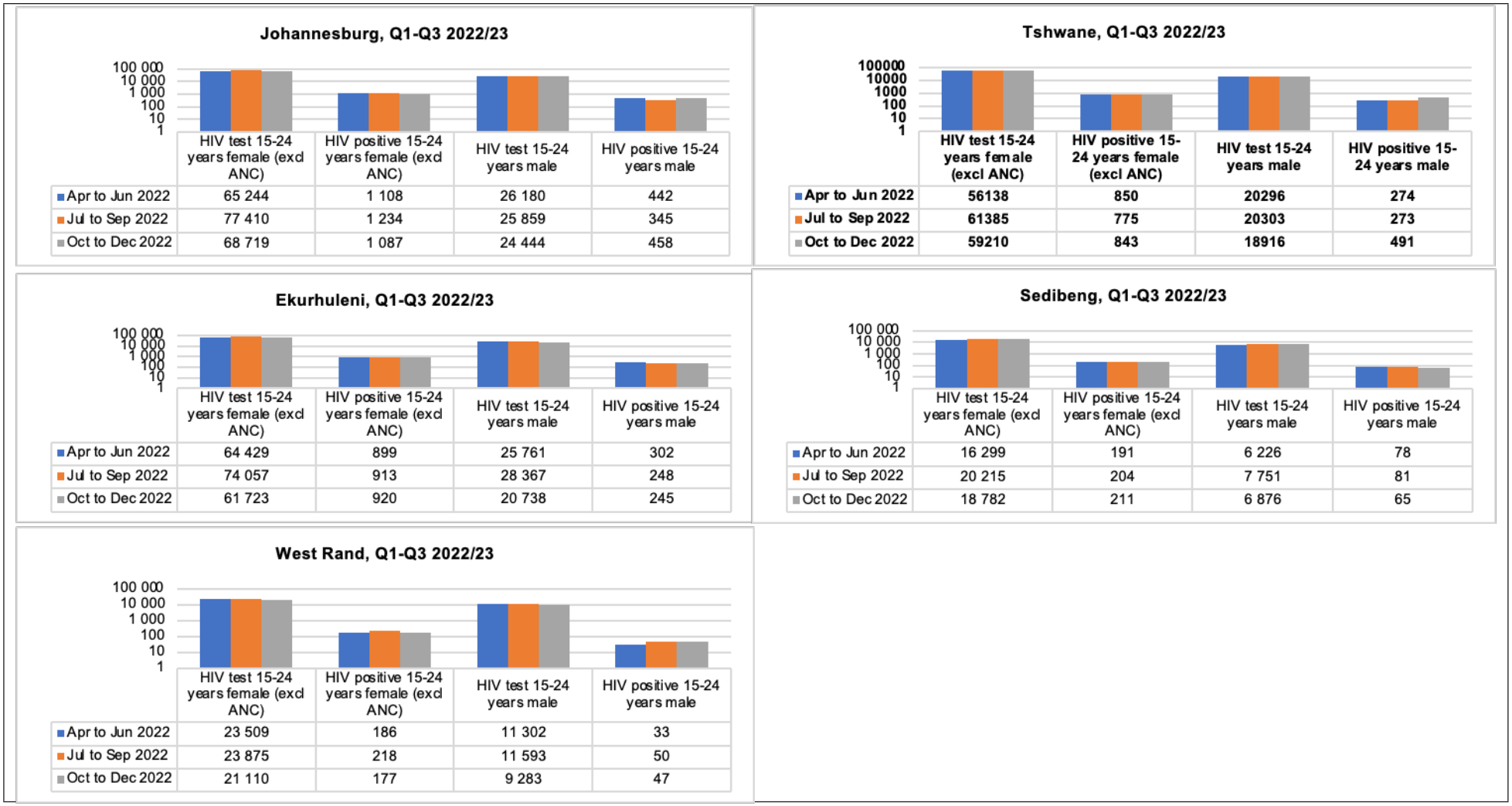
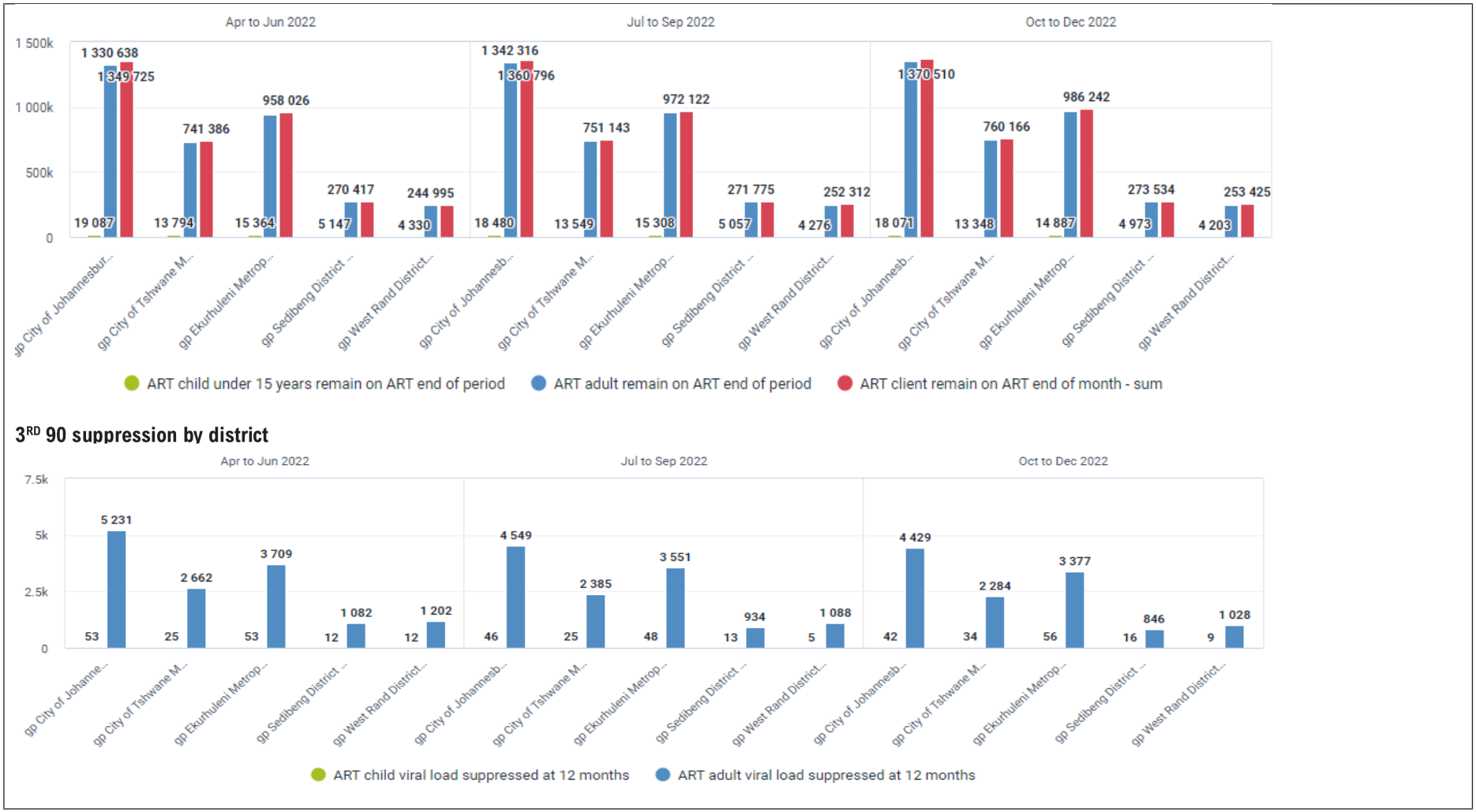


Figure: 39 DHIS, Gauteng district ART indicators, April 2022- December 2022

2ND 90 ART remain by district



3RD 90 suppression by district

Figure 40: Gauteng, ART remain in ART and viral load suppression among children and adults as per Districts, DHIS

Challenges

Despite disruptions caused by COVID-19 pandemic in rendering healthcare services, implementation strategies for HID/AIDS activities were not fully realised. Loss to follow up whereby the programming losing contact with clients who are on ART treatment and unsuccessful tracing efforts due to incorrect addresses, relocations, unavailable contact numbers and failure to honour scheduled appointments at still remains a hurdle the programme should be overcome.

Interventions to achieve 90-90-90 target

Objective 2.4 Ensure that 95% of PLHIV, especially key populations, and other priority populations, know their status and 95% of them are on treatment and 95% of those on treatment are retained in care and achieve long-term viral suppression. NSP

GDoH continues to implement the UNAIDS 90-0-90 strategy whereby 90% of people living with HIV know their HIV status, 90% of people who know their status are receiving treatment and 90% of people on HIV treatment have a suppressed viral load so their immune system remains strong and the likelihood of their infection being passed on is greatly reduced. The Siyenza and Operation Phuthuma play vital roles in ensuring attainment of the HIV/AIDS targets. The GDoH strives on strengthening HIV counselling and testing campaigns targeting high risk population. The antiretroviral (ARV) roll out is intensified by the department in order to improve ART initiation including viral loads and adherence strategy implementation. The HIV and TB services are continuously integrated with COVI-D19 screening, testing and contact tracing.

Tuberculosis (TB)

South Africa TB prevalence and incidence

South Africa is on the top 10 countries in the world with highest TB burden. The South African TB prevalence survey that was conducted during 2017-2019, showed that SA TB prevalence was 852 cases per 100 000 this is above the global average of 127 per 100 000. Amongst the people diagnosed with TB, 3.3% (6 784 cases) had MDR/rifampicin-resistant (RR)-TB and 0.4% (733 cases) had pre-extensively drug-resistant (XDR)-TB3. TB is also the leading cause of death in PLHIV accounting for almost half of deaths. In South Africa, the TB burden is driven by poverty, socio-economic inequalities, and delayed or limited access to screening, TB investigations and treatment. There is a strong link between both undernutrition and low income and TB incident rate.

TB key populations

Key populations are vulnerable to infections due to social barriers related to their behaviours.

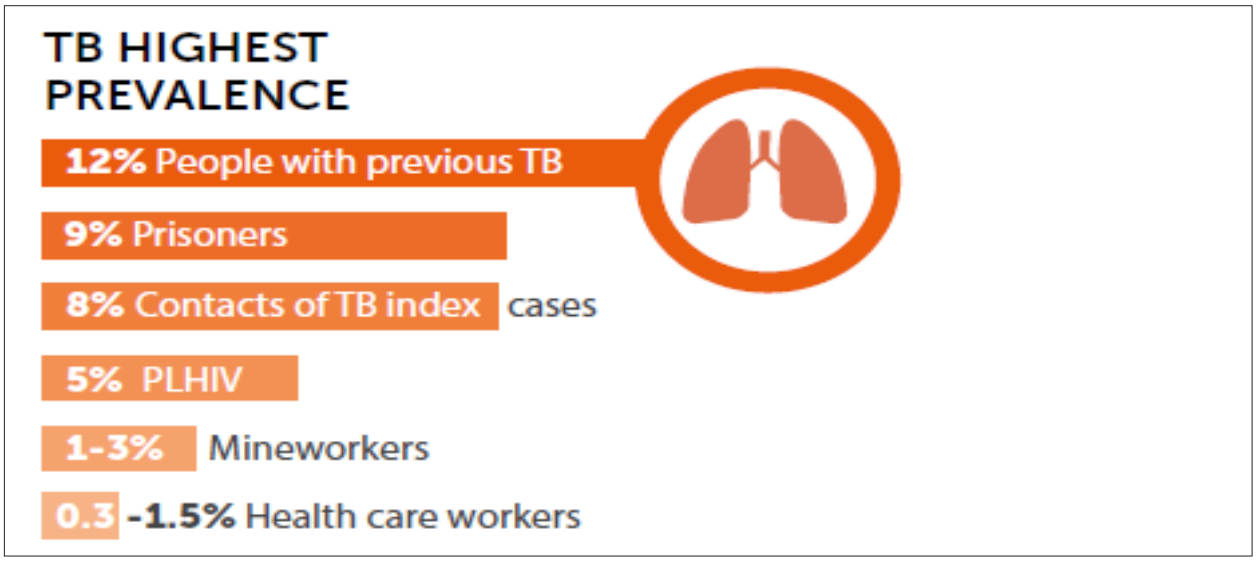
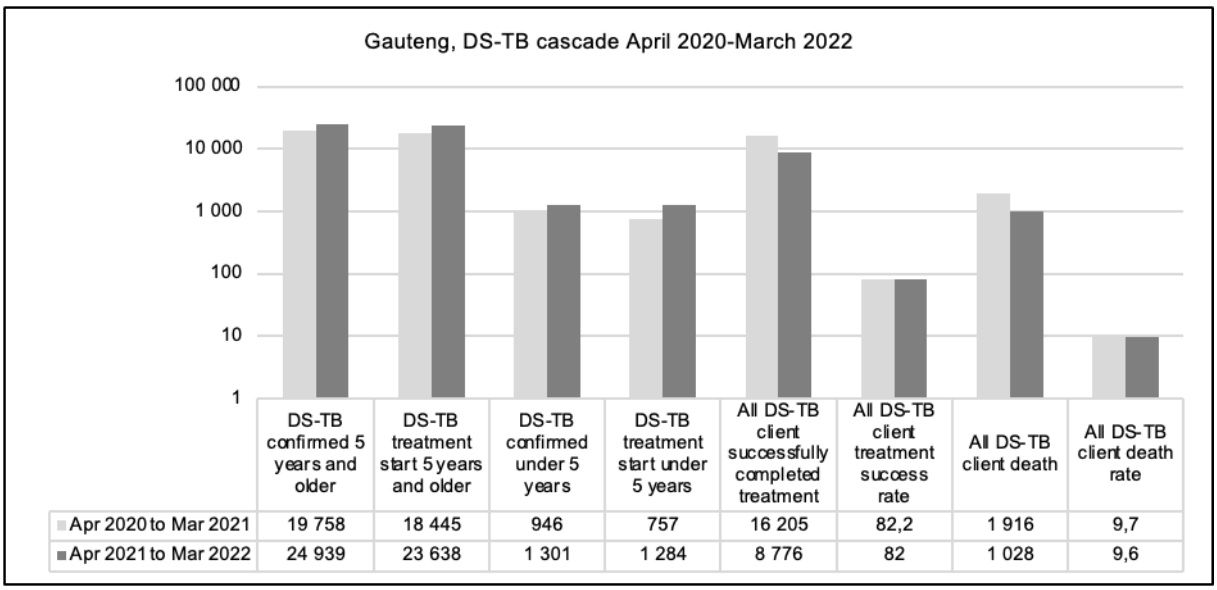


Figure 41: TB Highest Prevalence
Source: National Strategic Plan

Provincial data

In Gauteng 26 240 DS-TB people were confirmed/ notified in the FY 2021/22, the 5 years and older constituted 24 939 people and the under 5 years were 1 301. The treatment success rate was 84% (4 154) and thus falling short of the 90% target for DS-TB. West Rand is progressively moving towards the 90% with a performance of 89.5% for treatment success rate. There were 529 DS-TB client death with a rate of 10.4% for the province Sedibeng was the worst hit with a rate of 18.8%.



	DS-TB confirmed 5 years and older	DS-TB treatment start 5 years and older	DS-TB confirmed under 5 years	DS-TB treatment start under 5 years	All DS-TB client successfully completed treatment	All DS-TB client treatment success rate	All DS-TB client death	All DS-TB client death rate
Apr 2020 to Mar 2021	19 758	18 445	946	757	16 205	82,2	1 916	9,7
Apr 2021 to Mar 2022	24 939	23 638	1 301	1 284	8 776	82	1 028	9,6

Figure 42: DHIS, DS-TB data elements, April 2021 to March 2022.

TB cascade

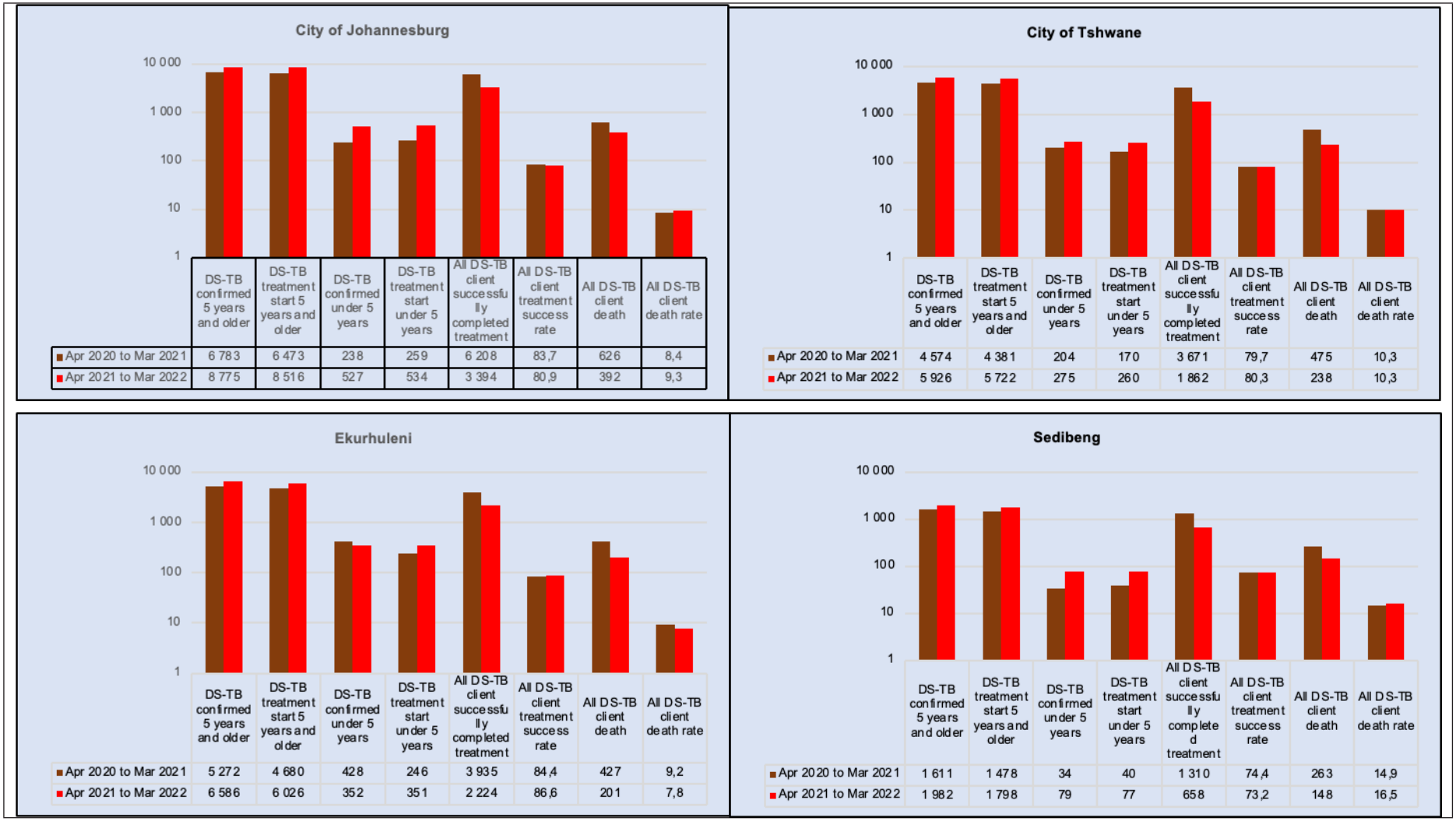


Figure 43: TB Cascade Report per Districts, DHIS

Challenges

The increased lost-to-follow-up and high death rates negatively impact TB treatment success, the COVID-19 pandemic also impacted negatively on the efforts made in reducing the TB disease burden. Late presentation by TB clients at health facilities due to seeking alternative non-medical interventions as their first level of contact also contributes to the high TB death rate. Undernutrition weakens the body's immune system and is therefore an important risk factor for active TB disease. In addition, living and working in crowded areas also increases the risk of acquiring TB.

Interventions to achieve 90-90-90 target

Amid the COVID-19 interruptions the department is making to achieve the USAIDS targets a number of interventions are made such as fast accelerating the adherence strategy and improving source and quality of data management to prevent the loss of TB clients by conducting loss to follow up. Integration of TB screening in COVID-19 screening, testing and contact tracing. The number of people acquiring infection and developing disease (and in turn the number of deaths caused by TB) can also be reduced through multisectoral action to address TB determinants such as poverty, undernourishment, HIV infection, smoking and diabetes.

4.2. Internal Environmental Analysis

Situational Analysis: Internal Environment Analysis

Service Platforms

The Department renders health care services through its service platforms, which are 24 CHCs, 332 PHCs, 6 CDCs, 3 Satellite Clinics, 4 Central, 3 Tertiary, 9 Regional, 12 District, 4 Specialised Psychiatric and 5 Specialised Rehabilitation hospitals. These facilities are supported by 5 District Offices in which they are located, namely, City of Johannesburg, Tshwane, Ekurhuleni, Sedibeng and West Rand Districts. The Provincial Office is responsible for developing policy, providing strategic direction and support. Service platforms are at the coal face of service delivery and play a critical role in the implementation of health outcomes outlined in the Strategic Plan of the Gauteng Department 2019/20 – 2024/25. Although the public health system in Gauteng is plagued by a myriad of challenges, services continue to be rendered through the service platforms and challenges are continuously identified and interventions to address them developed.

Table 9: Gauteng number and type of health facilities

Facility level	COJ	Tshwane	Ekurhuleni	Sedibeng	West Rand	GP Total
CHC	12	8	7	4	3	**34**
PHC	105	66	84	30	47	**332**
CDC	0	0	2	4	0	**6**
Total fixed facilities	**117**	**74**	**93**	**38**	**50**	**372**
Satellite Clinics	1	1	0	0	1	**3**
Grand Total	**118**	**75**	**93**	**38**	**51**	**375**

Hospital Type	COJ	Tshwane	Ekurhuleni	Sedibeng	WR	GP Tot
National Central Hospital	2	2				4
Provincial Tertiary Hospital	1	1	1			3
Regional Hospital	2	1	4	1	1	9
District Hospital	2	4	1	2	2	12
Specialised Psychiatric Health Service	1	2			1	4
Specialised Rehab Health Services	1	4				5
Totals	**9**	**14**	**6**	**3**	**4**	**37**

Strategic Review

The Department held a midterm strategic review session in October 2022 to reflect on progress towards the implementation of the outcomes outlined in the Strategic Plan. It emerged from the strategic review session that although progress has been made towards the implementation of the outcomes set out in the strategic plan, the pace of implementation has been slow and needs to be accelerated to improve performance. The slow pace of implementation

is reflected in the Department's quarter 3 performance report, which shows that the overall performance has declined from 69% in quarter 2 of 2022/23 to 61% in quarter 3 of the same financial year. A set of interventions to improve performance were developed during the strategic review session and they include: the digitisation of health services, improving maternal and neonatal services, addressing surgical backlogs, improving oncology services, adherence to the National Core Standards, improving forensic pathology services on autopsy turnaround times and responsiveness to gender based violence, maximising the functionality of 24 hours CHCs, improving mental health care delivery, reducing waiting times at health facilities, improving health education and literacy, maintenance and refurbishments and improving occupational health and safety. These interventions are being implemented across all service platforms.

Turnaround Plan

The Department has developed a turnaround plan called, "Turning the tide: Implementation to reclaim the jewel of public health". The plan seeks to address challenges facing the public health system in Gauteng, which have been identified through the Department's midterm strategic review sessions and by the Provincial Strategic Support Teams (PSSTs). These challenges constitute the underlying reasons for the Department's under-performance on strategic priorities. The plan addresses various support and clinical services challenges through identifying high impact activities, which, if successfully implemented, would result in significant improvements in the attainment of health outcomes. The areas of intervention are financial management, corporate services, safety and security, infrastructure, laundry services, pharmaceutical services, health information, medico-legal services and selected clinical services. The implementation of the turnaround plan is monitored through the submission of weekly progress to the HOD.

Financial Management

The inability to comply with the Treasury Regulations due to non-adherence to supply chain management (SCM) processes, budget constraints, inadequate systems support, non-implementation of audit action plans and human resource deficiencies are some of the challenges that negatively impact negative on financial management. Failure to address these challenges may result in financial over commitments and poor service delivery. The identified challenges are being addressed through the review of supply chain management processes and governance systems, improving the payment of suppliers within 30 days, reducing irregular expenditure and decentralisation of functions to health facilities.

The Department plans to spend 30% of its budget on township enterprises to contribute towards the revitalisation of the township economy. However, the spend on township enterprises declined by 72% from R10.37 million in Q2 of 2022/23 to R2.95 million in Q3 of 2022/23, due to the inability to enforce the 30% sub-contracting, as a result of the Preferential Procurement Regulations (PPR) 22 which no longer supports the 30% sub-contracting.

The review and improvements in SCM processes are expected to assist with the attainment of the 30% budget spend on township enterprises by March 2024. The resolution of web cycles within 15 days from receipt of an invoice is being implemented to improve the payment of invoices within 30 days. The payment of undisputed service provider invoices within 30 days is also expected to improve to 100% by March 2024.

Corporate Services

The turnaround plan identifies inefficient human resource management, misalignment of the organisational culture with the values and strategic objectives of the Department, aging technology infrastructure, outdated IT programmes, as well as poor management of stakeholder expectations, as some of the challenges impacting negatively on the functioning of the Department. The organisational structure has been reviewed to ensure that it is aligned to the strategic objectives of the Department and is pending approval. A draft Human Resource Plan informed by the burden of disease and the population of the Province, has also been developed. The Human Resource Plan is expected to be finalised by March 2023. Plans are underway to address the aging technology infrastructure and outdated IT programmes through the acquisition of appropriate digital applications and infrastructure to improve the provision of health services for patients and health workers.

Clinical Services

Congested maternal health offerings and delayed performance of caesarean sections are some of the challenges afflicting the provision of clinical services and may result in increased morbidity and mortality of mothers and babies.

Congested maternal health offerings and delayed performance of caesarean sections have also been identified as leading causes of escalating medico-legal claims against the Department. In order to address these challenges, the Department has established zonal caesarean hubs to prevent delays in the performance of caesarean sections. The implementation of minimum standards for caesarean delivery is being enforced at all hospitals providing maternity services. This will assist with the reduction of the contingent liability of medico-legal cases against the Department by 50% over the MTEF period.

Inadequate human resources and poor access to technology result in long waiting times for medical oncology and radiation therapy, which may lead to high rates of morbidity and mortality due to cancer. The Department plans to improve access to radiology services through the commissioning of radiation oncology services at two additional hospitals providing quaternary care, namely, Chris Hani Baragwanath Academic Hospital (CHBAH) and Dr George Mukhari Academic Hospital (DGMAH). Two linear accelerator machines have already been purchased at CHBAH and one at DGMAH. The enrolment of cancer patients for radiation therapy at CHBAH and DGMAH will result in a minimum of 100 oncology service patients benefitting. This will improve access to oncology services in the townships, as these hospitals are township based, servicing the greater part of Soweto and Ga-Rankuwa respectively. Radiation oncology services capacity will also be improved at Steve Biko Academic Hospital (SBAH) through increasing the human resource capacity to fully operate all 5 linear accelerator machines at the institution.

Mental health is a growing non-communicable disease, which has been compounded by the Covid-19 pandemic. Access and availability of mental health services have been constrained by the limited availability of mental health beds. Since the implementation of the Mental Health Act, the strengthening and integration of district mental health services has been prioritized. There is a need to increase mental health beds and to integrate mental health care services by all primary health services at district level. Failure to address this will lead to the increasing burden of mental illness and poor economic productivity. The Department is expanding access to mental health services through the provision of 83 additional acute ill mental health beds at Bertha Gxowa (20), Pholosong (9), Tembisa (44) and Yusuf Dadoo (10) hospitals. 8.6% of beds in District hospitals will be available for acute ill mental health patients by March 2024 to improve access to mental health services.

Medico-Legal Litigations

The high amounts of medical litigations paid towards court judgments in medico-legal cases against the department is a threat to the provision of health services and fiscal sustainability of the Department. Payments are made based court judgments which are sometimes not honored due to budgetary constraints. These amounts are paid from the department's revenue and goods and services budget, out crowding the financial resources for the Department to fulfil its constitutional obligation. The rising litigation bill threatens the delivery of quality health care services and promotes defensive medicine practices.

The rand value of medico-legal claims declined by 3% from R20.9bn at the end of September 2022/23 to R20.2bn at the end of October 2022/23 due to the verifications done by CAJV. The Department is in the process of appointing additional human resources to strengthen the capacity of the Litigation Directorate to manage medico-legal claims. Claims against the Department are being settled by means of mediation. Forensic investigations into suspected irregularities pertaining to medico-legal claims are also conducted on an ongoing basis. These interventions will enable the Department to reduce the contingent liability of medico-legal claims by R2.1bn during the 2023/24.

Health Information Management

The availability of timely and accurate health information, based on quality data to support performance management and accountability remains a challenge, due to limited technical human resource capacity and organisational structure design. This is exacerbated by the implementation of multiple paper records, outdated information systems and management information systems that do not provide comprehensive health information.

The Department is in the process of automating business processes to improve evidence-based decision making. The digitisation of health records will form an integral part of the automation of business processes, which will involve the scanning of patient paper records. This will assist in reducing waiting times and ensuring that the medical details of patients are readily available when they consult with health facilities. The capabilities of the existing systems to automate business transactions will be assessed in collaboration with e-Government, in order to minimise the use of manual systems. Change management will be implemented to prepare staff for the automation of business processes.

An integrated Health Information System (HIS) is being rolled out at 31 CHCs and 29 hospitals to improve the quality of health information at health facilities. The implementation of HIS at these facilities will enable the digitisation of patient records. By the end of March 2024, HIS will be rolled out at all 40 CHCs and 37 hospitals. A five-year support and maintenance on the SAP application will be delivered by Gijima to ensure continuous functionality of system. The implementation of HIS will assist with bed management and alleviating pressure at health facilities, whilst reducing queues and waiting times.

Infrastructure Management

Health infrastructure plays a vital role in the provision of health care services. Some of the challenges that impact on health care provision include, ageing infrastructure, misaligned organisational structure that does not support business delivery, limited technical capacity, skills mismatch, poor oversight of Professional Service Providers (PSP), causing delays in the planning and execution of projects, including failure to timely, proactively and adequately maintain health infrastructure. These challenges impact negatively on the quality of care provided and user experience. To address infrastructure challenges, the Department is reviewing the Service Delivery Agreement (SDA) with the implementing agent, to include key performance areas for the implementing agent. This will enable the Department to enforce the implementation of the SDA, to ensure that health projects are delivered on time and within the allocated funds. Infrastructure staffing norms and standards prescribed by the National Treasury in the Health Facilities Revitilisation Grant (HFRG) are being implemented to build the technical capacity of the Infrastructure Management Unit in the Department. 07 hospitals are planned for infrastructure rehabilitation and maintenance. Infrastructure projects that were put on hold due to budgetary constraints, have been handed over to the Gauteng Infrastructure Financing Agency (GIFA) for PPP funding.

Occupational Health and Safety

OHS projects are being implemented to improve OHS compliance at all priority hospitals and linked CHCs. 20 of the 37 hospitals are currently compliant with OHS regulations, namely, Bheki Mlangeni, Chris Hani Bara, Charlotte Maxeke, Dr George Mukhari Academic, Jubilee Hospital, Weskoppies Hospital, Tambo Memorial Hospital, Tembisa Hospital, Sebokeng Hospital, Kopanong Hospital, Sterkfontein Hospital, Carletonville Hospital, Rahima Moosa Mother and Child Hospital, Steve Biko Academic Hospital, Kalafong Provincial Tertiary Hospital, Helen Joseph Tertiary Hospital, Thelle Mogoarane, Cullinan Care Rehab, and Pretoria West Hospital and South Rand Hospital. All 37 hospitals will be OHS compliant by March 2024.

Premiers' Elevated Priorities

The Premier has identified five service delivery priorities to accelerate the implementation of the non-negotiable areas and the GGT2030. The service delivery priorities outlined below are aimed at improving the provision of services, especially to communities in the Townships, Informal Settlements and Hostels (TISH):

Priority 1: Accelerate economic recovery;
Priority 2: Strengthen the battle against crime, corruption, vandalism and lawlessness;
Priority 3: Improve living conditions in townships, informal settlements and hostels (TISH);
Priority 4: Strengthen the capacity of the state to deliver services; and
Priority 5: Effectively communicate the government's programmes and progress

The Gauteng Department of Health's contribution towards the attainment of the elevated priorities include: (1) Readily available medical details of citizens when they consult with medical facilities; (2) Introduce Information Management, which will assist with bed management and alleviating pressure from our health system; (3) Reducing queues at our medical facilities; (4) Introducing a regulatory arm that will focus on eliminating fake food circulating in our shops thereby improving food safety; (5) Incorporating a Wellness Programme in our education system to teach children on health literacy and health promotion; and (6) Improve health service offerings in Hospitals in townships, and address the negative attitude of some of our employees towards patients

The Department played a leading role in the launch of the Wellness Wednesday and Asibe Healthy campaigns to promote healthy lifestyles in communities. The MEC for Health and Wellness has taken a lead in promoting health and wellness

in the Province through participating in sports activities such as the Soweto Marathon, regular walks and hiking. This has communicated to internal and external stakeholders, a positive message of a participatory and caring leadership, whilst igniting further interest into other programmes of the Department, as evidenced by the decrease in negative media coverage and increase in social media following. The Health and Wellness Programme will be strengthened through the implementation of the Extensive Life Course Health and Wellness campaigns, which will reach 120 000 people by March 2024. Physical activities programmes will also be rolled out at 20 TISH sites by March 2024.

A queue management system is being implemented at 10 priority hospitals, namely, Sebokeng, Dr George Mukhari, Edenvale, Tembisa, Jubilee, Kopanong, Mamelodi, Bheki Mlangeni, Tambo Memorial and Thelle Mogoerane hospitals, to reduce long queues at health facilities. This involves a ticket system, which captures the patient's waiting times from entry into a health facility, the duration through a point of care and exiting the facility. This system will enable us to know who visited the facility, the time of arrival, reason for the visit, time spent and time of leaving the facility. All 37 public hospitals will be implementing the queue management system by the end of March 2024.

4.2.1. Universal Health Coverage (UHC) (Population and Service Coverage)

UHC is viewed as fundamental for achieving SDGs not only for health and wellbeing but also to eradicate poverty, ensuring quality education, achieving gender equality and women's empowerment, providing decent work and economic growth, reducing inequalities, ensuring just, peaceful and inclusive societies and fostering partnerships. The SDG 3 target 3.8 aims to achieve UHC, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all. Provincial Policy Framework Implication, Plan for the 6th Administration – "Growing Gauteng Together: Our Roadmap to 2030" (GGT:2030). under the GGT 2030 outcome of "universal access to good quality health care for all South Africans achieved", the 2025 target is to: "implement the enabling legislative framework and create institutional capacity for NHI by 2024 to achieve universal health coverage for all South Africans by 2030".

The GDoH provincial policy framework implication, plan for the 6th administration GGT:2030 outcome aims to achieve universal access to good quality health care for all South Africans by implementing enabling legislative framework and create institutional capacity for NHI by 2024 to achieve UHC for all South Africans by 2030. To ensure attainment of UHC through the NHI financing models several health reforms are being implemented that integrate prevention, treatment, care and support ensuring that all people have equal access to services irrespective of geographical location and race. This include PHC reengineering, Integrated Scholl Health programmes, Ideal Clinic and Ideal hospital programme. Implementation of the NHI to prepare the health care system by improving patient care, clinical outcomes, achieving ideal clinic status and ideal hospital status. PHC reengineering will see provision of 24hour x-rays services in CHCs to avoid transfer of patients to hospital for simple x-rays that can be at PHC level. One of the key lessons SA learned from its fight against COVID-19 is the equitable distribution of health care workers across public and private services.

Community Health Workers (CHWs) Programme

Based on the MTSF priority 2: Education, Skills and Health the MTSF 2019-2024 interventions are to expand the primary healthcare system by integrating over 50 000 community health workers into the public health system. Health Promoters and Community Health Workers continue to engage the communities emphasizing the importance of adhering to non-pharmaceutical interventions.

The CHWs current status quo for GDoH reflects a total of 5 734 CHWs are based in various health facilities their main responsibility is health promotion and health education in communities and household and referrals to facilities by identifying clients in communities for example they identify pregnant women and refer them for ANC visits. There are 812 ward based primary healthcare outreach teams (WBOTs) out of this 812 teams, 499 are fully functional. Only 657 teams have enrolled nurses/ professional nurses as teams leaders. In July 2020 the GDoH permanently employed CHWs in the department. Budgetary constraints and high cost of permanent employment remains a stumbling block in realising the set objectives for the programme.

As at end of Q3 September2022-December 2022 a total of 1 049 000 (approximately 1 million) household visits were conducted and referrals were done accordingly. Various mobile devices have been introduced amongst CHWs to support loss to follow up tracing for both HIV and TB clients. The COVID 19 household tracing response is integrated onto the existing TB and HIV screening services. Lastly CHWs skills are improved through education and training by implementing the Health Officer Promotion qualification for Community Health workers.

PHC Utilization Rate

The PHC utilisation rate indicator measures the average number of PHC visits per person per year to a public PHC facility. It is calculated by dividing the PHC total annual headcount by the total catchment population. The average number of PHC visits for a population determines the health seeking behaviour of a person. The average number of PHC visits for individuals is 2.5, the under 5 years should at least be accessing PHC 5 times a year, adults should be 3 times in a year this is done to measure community access to PHC in year. The average PHC utilisation rate for Gauteng during the period 0ct 2022-Dec 2022 was 1.1.

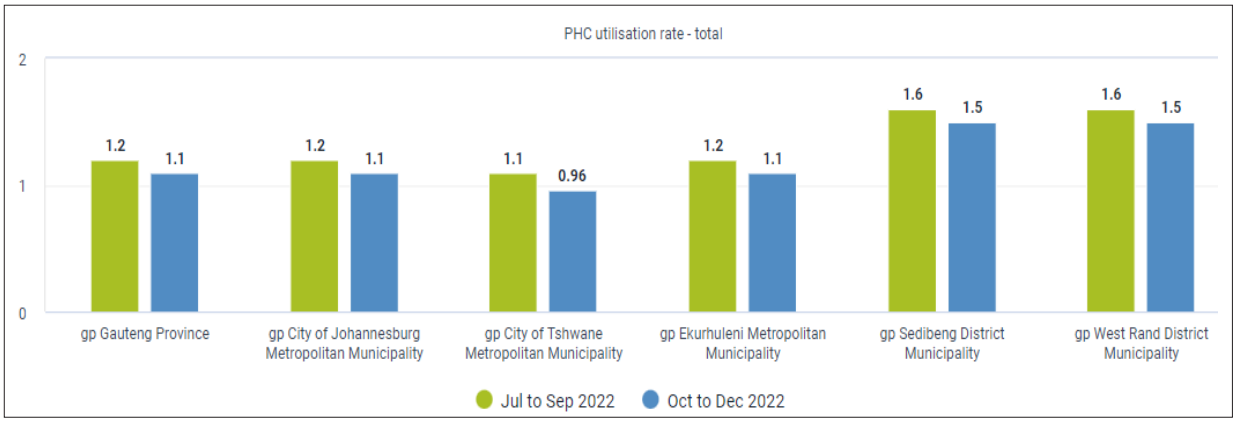
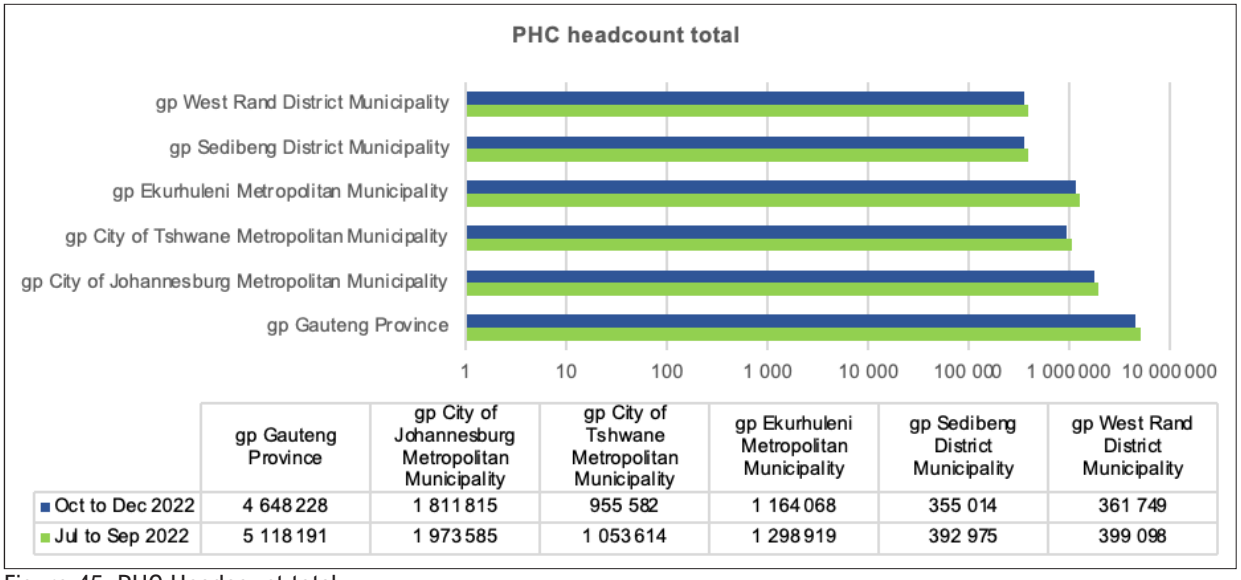


Figure 44: Total PHC Utilisation rate

Source: DHIS

The total PHC headcount for Gauteng for the period Oct 2022-Dececember 2022 was 4 648 228 as compared to Q2 (Apr 2022-June 2022) at 5 118 191 this indicates a drop of 469 963 clients see below figure. Tshwane is the worst affected in Q2 it was at 1 053 614 however in Q3 it dropped to 955 582. Generally, for all districts there is a drop in PHC utilisation rate.



	gp Gauteng Province	gp City of Johannesburg Metropolitan Municipality	gp City of Tshwane Metropolitan Municipality	gp Ekurhuleni Metropolitan Municipality	gp Sedibeng District Municipality	gp West Rand District Municipality
Oct to Dec 2022	4 648 228	1 811 815	955 582	1 164 068	355 014	361 749
Jul to Sep 2022	5 118 191	1 973 585	1 053 614	1 298 919	392 975	399 098

Figure 45: PHC Headcount total

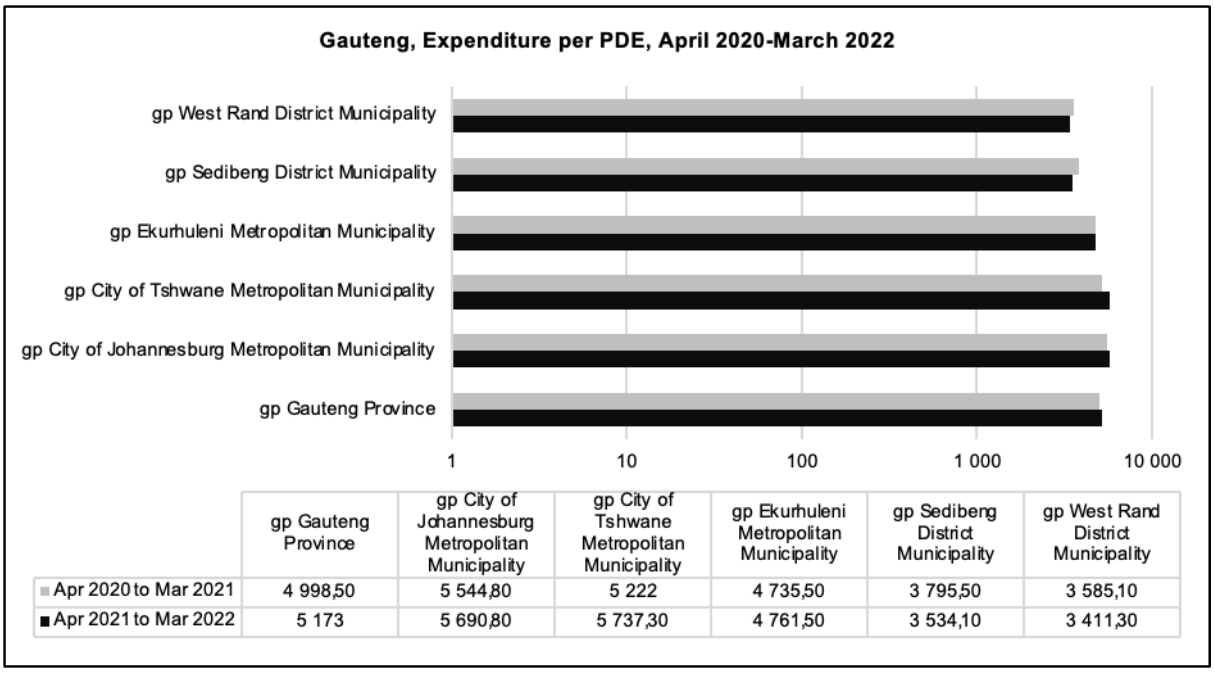
Source: DHIS

Challenges

Because of the booking systems, patients that are decanted/ home visits are not counted as facility head count.

Expenditure per patient day equivalent (PDE) (district hospitals)

Expenditure per patient day equivalent is a composite process indicator that connects financial data with service-related data from the hospital admissions and outpatient records. The indicator measures the average cost per PDE at a district hospital, and is expressed as Rand per PDE, this indicator measures how the resources available to the hospital are being spent and is a marker of efficiency. The figure below shows the provincial and district expenditure per PDE trends from 2020/21 to 2021/22 as expected, there has been an increase in expenditure per PDE over the two financial years surprisingly, Sedibeng district shows a decrease in expenditure per PDE during 2020/21 it was at R 3 795.50 then it decreased to R 3 537.10 during 2021/22.



	gp Gauteng Province	gp City of Johannesburg Metropolitan Municipality	gp City of Tshwane Metropolitan Municipality	gp Ekurhuleni Metropolitan Municipality	gp Sedibeng District Municipality	gp West Rand District Municipality
Apr 2020 to Mar 2021	4 998,50	5 544,80	5 222	4 735,50	3 795,50	3 585,10
Apr 2021 to Mar 2022	5 173	5 690,80	5 737,30	4 761,50	3 534,10	3 411,30

Figure 46: Gauteng, Expenditure per PDE, April 2020 – March 2022
Source: DHIS

Hospital care

Outpatient department (OPD) new client not referred rate

Outpatient department new client not referred rate refers to the percentage of new outpatient clients who enter a hospital without a referral letter. The OPD new client not referred rate monitors the utilisation trends of clients who bypass PHC facilities. A high OPD new client not referred rate value could indicate overburdened PHC facilities or a lack of referral systems. In light of the NHI Policy[41], the PHC level is the first point of contact with the health system and therefore key to ensure health system sustainability. If it works well and the referral system is seamless, it is associated with fewer visits to specialists and to emergency rooms. The below graphs depict the trends for Gauteng province and district OPD new client not referred rate.

The below figure shows that generally there is decreasing trend in the rate over the quarters however Tshwane and West Rand show an increase between July 2022- Sept 2022 and Oct 2022- Dec 2022 as compared to the other districts. In Sedibeng there is a sharp decrease from 43.4 in Q2 July-Sept 2022 to 9.2 in Oct 2022-Dec 2022 from 48.

41 National Health Act, 2003 National Health Insurance Policy Towards Universal Health Coverage. Available https://www.gov.za/sites/default/files/gcis_document/201707/40955gon627.pdf

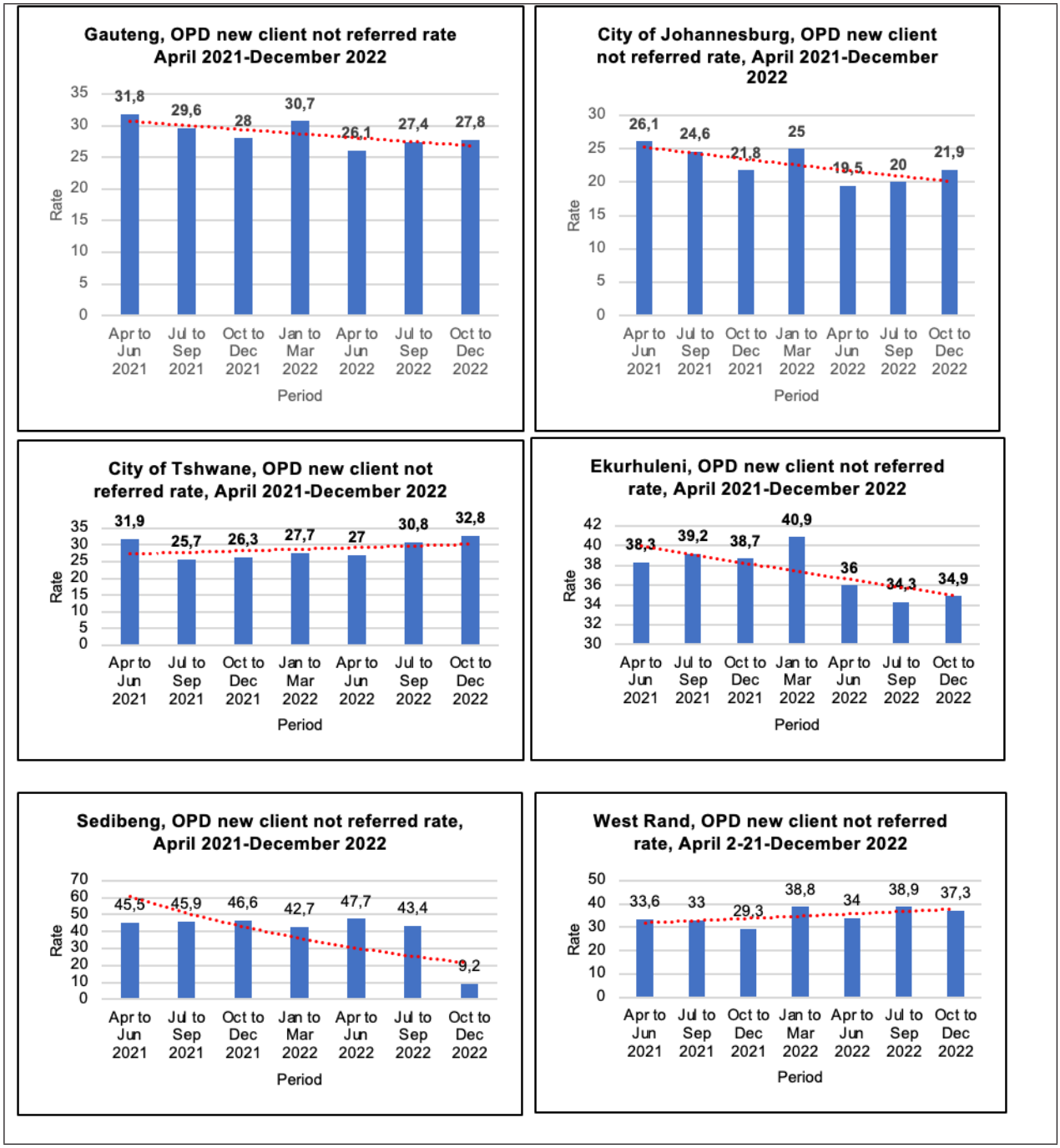


Figure 47: OPD new client not referred rate, April 2021-December 2022

Source: DHIS

Inpatient bed utilisation rate (District hospitals)

The IBUR measures the occupancy of available beds and therefore indicates how efficiently a hospital is using its available capacity, bed utilisation is expressed as a percentage. There below figure indicates that for Gauteng there is a decline in usable beds from 95% in 2020/21 to 74.6 in 2021/22 this could be indicative of the COVID-19 pandemic whereby during the period 2020/21 there was a spike in COVID-19 hospitalizations. However, for Sedibeng district an increase in usable beds in observed from 80.6% during 2020/21 to 96.9% in 2021/22.

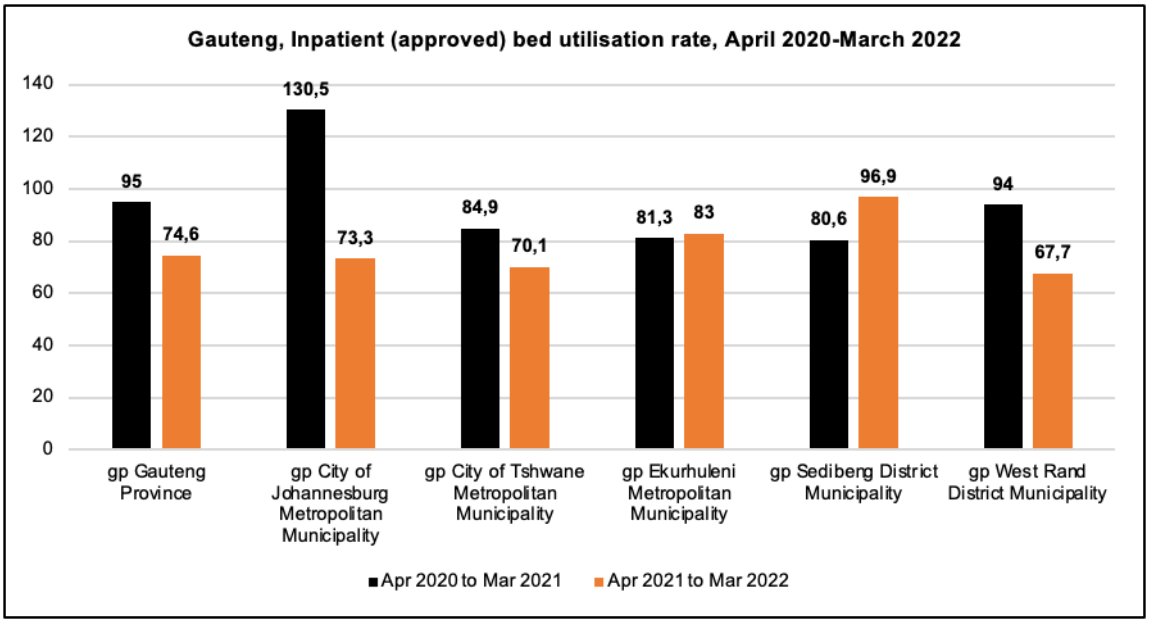


Figure 48: Gauteng, Inpatient (approved) bed utilisation rate, April 2020-March 2022
Source: DHIS

Hospital case management

Inpatient crude death rate (ICDR) (all hospitals

The inpatient crude death rate (ICDR) is an impact indicator that refers to the proportion of all inpatient separations due to death. Inpatient separations include inpatient transfers out, deaths, and inpatient discharges. The indicator therefore includes deaths from all causes that occur in a health facility.

Figure 17 below shows that there has been a slight decline of almost one percentage point in the inpatient crude death rate for 2020/21 to 2021/22. Sedibeng has the greatest decline from 7.4 in 2020/21 to 6.5 in 2021/22 while Ekurhuleni increased slightly from 5.9 in 2020/21 to 6 in 2021/22.

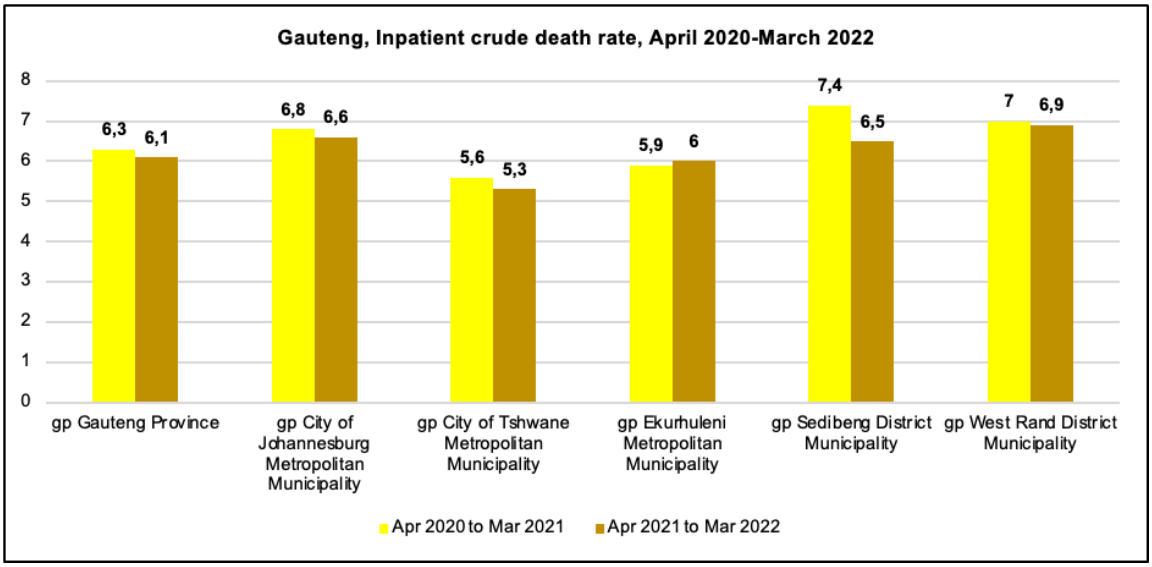


Figure 49: Gauteng, Inpatient crude death rate, April 2020-March 2022
Source: DHIS

7.4. Expenditure trends and budgets of the Gauteng DoH

Table 10: Summary of Payments and Estimates: Health

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	2019/20	2020/21	2021/22		2022/23		2023/24	2024/25	2025/26
1. Administration	1 481 446	3 695 016	2 173 192	1 444 146	1 456 146	1 639 568	1 489 406	1 681 783	1 755 961
2. District Health Services	15 895 452	17 959 247	19 251 444	20 341 822	21 087 151	21 055 858	20 137 498	20 855 393	21 473 306
3. Emergency Medical Services	1 539 781	1 680 801	1 431 691	1 629 684	1 795 100	2 069 598	1 778 114	1 826 339	1 853 982
4. Provincial Hospital Services	9 224 458	9 905 850	10 697 214	10 986 544	11 286 458	11 323 950	11 357 425	11 790 469	12 310 924
5. Central Hospital Services	19 064 441	19 254 052	20 331 658	21 068 239	21 978 884	22 043 641	21 762 135	22 715 959	23 810 477
6. Health Sciences And Training	1 045 256	787 210	706 868	1 106 493	1 090 663	988 779	1 196 718	1 226 932	1 232 035
7. Health Care Support Services	368 944	388 844	388 833	412 718	432 966	438 912	453 930	468 434	487 851
8. Health Facilities Management	2 053 885	4 041 357	2 068 235	2 436 752	2 224 049	2 224 049	1 918 309	2 162 797	2 096 473
Total payments and estimates	**50 673 663**	**57 712 377**	**57 049 135**	**59 426 398**	**61 351 417**	**61 784 355**	**60 093 535**	**62 728 106**	**65 021 009**

Table 11: Summary of Provincial Payments and Estimates by economic classification: Health

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	2019/20	2020/21	2021/22		2022/23		2023/24	2024/25	2025/26
Current payments	**46 323 290**	**51 508 233**	**53 337 343**	**54 811 436**	**56 829 971**	**57 109 632**	**56 010 461**	**58 411 810**	**60 716 105**
Compensation of employees	29 203 076	31 474 850	35 463 853	35 743 691	36 750 691	36 604 656	35 665 552	37 245 518	38 307 478
Goods and services	17 117 833	20 031 799	17 872 343	19 067 745	20 079 280	20 504 976	20 344 909	21 166 292	22 408 627
Interest and rent on land	2 381	1 584	1 147						
Transfers and subsidies to:	**2 310 826**	**1 787 316**	**1 687 029**	**1 706 932**	**1 727 049**	**2 038 141**	**1 806 571**	**1 838 586**	**1 884 168**
Provinces and municipalities	705 394	520 489	441 595	490 515	517 164	517 164	512 480	512 480	535 440
Departmental agencies and accounts	22 135	23 352	24 636	25 819	25 819	25 819	26 955	26 955	27 354
Higher education institutions	1 488	12 871	7 867	17 092	4 039	4 039	10 844	10 844	10 844
Non-profit institutions	672 292	602 710	630 704	719 860	728 078	728 078	772 718	790 524	811 200
Households	909 517	627 894	582 227	453 646	451 949	763 041	483 574	497 783	499 330
Payments for capital assets	**2 035 549**	**4 416 802**	**2 023 091**	**2 908 030**	**2 794 397**	**2 630 882**	**2 276 503**	**2 477 710**	**2 420 736**
Buildings and other fixed structures	451 786	2 419 098	735 593	1 335 920	936 434	936 434	694 546	957 909	866 840
Machinery and equipment	1 583 763	1 997 704	1 287 091	1 572 110	1 857 963	1 694 448	1 581 957	1 519 801	1 553 896
Software and other intangible assets			407						
Payments for financial assets	**3 998**	**26**	**1 672**			**5 700**			
Total economic classification	**50 673 663**	**57 712 377**	**57 049 135**	**59 426 398**	**61 351 417**	**61 784 355**	**60 093 535**	**62 728 106**	**65 021 009**

7.3.6 Expenditure trends related to specific goals

The budget allocated to Programme 1: Administration remains constant within the R1.4 billion margin from 2022/23 financial year to the 2023/24 financial year. The administration programme also makes provision for, amongst others, the application of the Policy and Procedure on Incapacity Leave and Ill Health and Retirement, payment of revenue collecting agencies for the department to benefit from the Revenue Incentive Scheme and investment in an integrated health information system.

Programme 2: District Health Services decreases slightly from a main appropriation of R20.3 billion in 2022/23 to R20.1 billion in the 2023/24 financial year. Over the 2023 MTEF, funding is earmarked for accelerating the provision and improvement of PHC services through ward-based outreach teams, district clinical specialist teams and integrated school health services. Existing funds within the baseline are made available to broaden access to quality public healthcare by implementing the 24-hour extension of services within CHCs. Furthermore, strengthening of district mental healthcare services has been allocated funds to implement the three types of mental health teams: district specialist mental healthcare, clinical community psychiatric and NGO governance compliance teams. The South African Cuban doctor programme is integrated within the programme to enhance the primary health care services.

The budget allocated to Programme 3: Emergency Medical Services (EMS) increases from a main appropriation of R1.62 billion in 2022/23 to R1.77 billion in the 2023/24 financial year. The final phase of the provincialisation of EMS was completed during the 2020/21 financial year.

Over the four-year period 2022/23 to 2025/26, the budget of Programme 4: Provincial Hospital Services increases by R1.3 billion. The increase is because of the increased allocation for the Mental Health Contracted beds. Additional funding was made available to increase acute bed capacity for persons with severe and/or profound intellectual disability and mental illness. Further increases are made to accommodate the improvement in conditions of services as a result of the 3% wage provision for public servants.

The budget in Programme 5: Central Hospital Services increases from a main appropriation of R21.7 billion in 2023/24 to R23.8 billion in the 2025/26 financial year. The programme is also funding the Nelson Mandela Children's Hospital that provides specialised paediatric services to the country and the Southern African Development Community (SADC) region. These specialised services are being introduced through a phased approach. The hospital is funded through the National Tertiary Services grant and has not been spared the effects of fiscal consolidation. An amount R250 million for reduction of radiation oncology has been centralised to the Central Hospital Services programme to be managed through a cluster model.

Over the 2023 MTEF, the budget of Programme 6: Health Science and Training increases by R35.3 million to support employee bursary holders and to support the South African Cuban Doctor programme which is aimed at addressing the shortage of doctors in the country. Funds are allocated to align and to comply with the implementation of the newly introduced nursing curriculum, to fill new posts and to procure stimulation training and development equipment as well as additional learning and teaching material.

The budget of Programme 7: Health Care Support Services increases by R33.9 million from 2023/24 to 2025/26 to provide for laundry and pre-packed food services. The effects of increased food price inflation have over the years been adding pressure on the adequacy of the allocation within this programme.

Programme 8: Health Facilities Management is funded through the equitable share and the Health Facility Revitalisation Grant and is geared towards improving and maintaining health infrastructure. This programme's budget decreases slightly over the 2023 MTEF.

The compensation of employees' budget decreases from R35.7 billion in 2022/23 to R35.6 billion in the 2023/24 financial year due to R1.1 billion made available during the 2022/23 as compared to R600 million made in the 2023/24 financial year for retention of COVID-19 capacity. Priorities continue to include provision for the extension of 24-hour services and strengthening of mental health care.
The allocation for goods and services increases from R19.0 billion in 2022/23 to R20.3 billion in the 2023/24 financial year, an increase of 6.7 per cent. The increase is attributable to amongst others funding allocated for the re-engineering of PHC and additional funding for the Health Revenue Incentive Scheme. The increase will assist with strengthening mental healthcare services through increasing contracted bed capacity. Further increases were made to augment the non-negotiable items including but not limited to medical supplies, medicine, inventory food and food supplies, laboratory services, consumables supplies and property payments.

The budget for transfer payments decreases from a main appropriation of R1.7 billion in 2022/23 to R1.8 billion in the 2023/24 financial year. The budget for transfers to provinces and municipalities increases from R490.5 million in 2022/23 to R512.4 million in the 2023/24 financial year. Transfers to departmental agencies and accounts increases from R26.9 million in 2023/24 to R27.3 million in the 2025/26 financial year because of payments to the Health and Welfare Sector Training Authority (HW-SETA) for skills development and training of health professionals on behalf

of the department. Transfers to households includes provision for bursaries in relation to the South African Cuban doctor programme and increases from R453.6 million in 2022/23 to R483.5 million in 2023/24 due to reduced intake of students and funds are for the expected last batch of students who will be completing their studies.

The machinery and equipment has a marginal budget increase within the R1.5 billion mark in the 2022/23 to 2023/24 financial year. The allocation is to accommodate the revised National Tertiary Services grant business plan. Through this budget, the department will be enabled to continue its investment in the recapitalisation and replacement of ambulances for the purpose of improving response times. The budget for machinery and equipment also caters for replacement and procurement of oncology and radiology equipment at central and tertiary hospitals.

Broad Based Black Economic Empowerment (BBBEE) Status of the Department

"Broad Based Black Economic Empowerment Act No. 46 of 2013 implementation Section 13G (1) of Broad Based Black Economic Empowerment Act, 2013 (Act No. 46 of 2013) indicates that all spheres of government, public entities and organs of state must report on their compliance with Broad-Based Black Economic Empowerment (BBBEE) in their audited annual financial statements and annual reports required under 40 the Public Finance Management Act, 1999 (Act No. 1 of 1999). The Department will ensure that it complies with the Act by ensuring that it gets its BBBEE status verified annually. Furthermore, the Department will continue to have its status verified on an annual basis and strive to improve its score".

Human Resources for Health

The departments' organisational structure is not finalised, the delays need to be addressed. Once finalised, implementation of the structure will be aligned to the departmental strategy. The department still needs to finalise the organisational structure for all the health programmes, hospitals and PHC clinics.

Organisational Structure

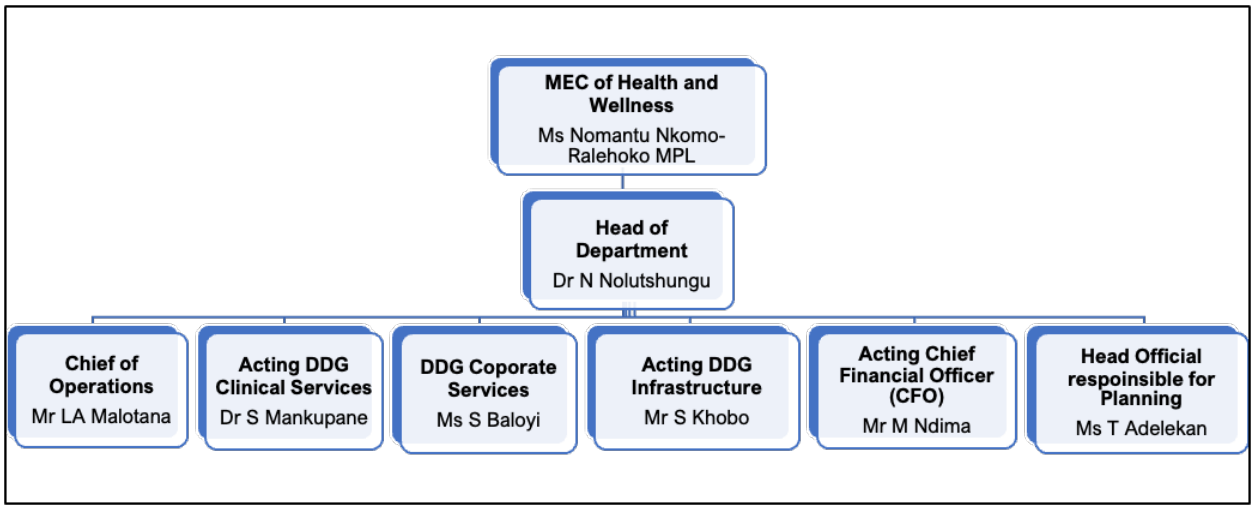


Figure 50: GDoH organisational structure

The province's commitment to attaining universal coverage requires capable human resources for health sector reforms to flourish. The human resource unit in the department has in the year under review put measures in place to ensure movement towards attaining reforms which include development of a comprehensive human resource for health strategy amongst other initiatives to ensure that retention of talent and filling of leadership positions continues.

It has also ensured that policy directives are implemented. These include early retirement without penalisation introduced in 2019 by the Minister of Finance. The goal of the framework was to curb the budget deficit by targeting retiring employees aged 53 to 59 who qualified for early retirement. To this end, the department managed to retire a total of 213 employees. The employees were released in phases; in the first phase, 122 employees were released on 31 December 2021 and in the second phase 91 employees were released on 31 March 2022.

The department has signed a contract with independent service provider Pro-Active Health Solutions for the current sick leave cycle (2022 till 2024). This is for the purpose of assessing and recommending policy and procedure on incapacity and ill health retirement (PILIR) applications. 29 employees retired during the 2021/2022 financial year due to ill-health.

To address leadership instability and closing gaps in the management echelons, the department managed to fill 17 SMS critical posts including that of Chief Executive Officers of hospitals. With the continuation of the pandemic and its negative effects on the economy, budgets relating to compensation of employees were cut. The budget cuts resulted in most institutions projecting an over-expenditure by middle of the financial year. It was problematic to replace and fill some of the critical posts. There were also some outstanding payments of staff such as incentive bonuses and pay progression which were paid well after they were due. The department still needs to work hard towards finalising the organisational structure of all the health programmes, hospitals and PHC clinics.

7.3. Personnel

Table 12: Vote personnel numbers and costs by salary level and programme

Salary band	Personnel expenditure (R'000)	% of total personnel cost	No. of employees	Average personnel cost per employee (R'000)
Lower skilled (levels 1-2)	1 855 775	8,18%	17074	109
Skilled (level 3-5)	3 625 282	15,97%	21701	167
Highly skilled production (levels 6-8)	4 765 491	21,00%	17823	267
Highly skilled supervision (levels 9-12)	8 840 773	38,95%	13087	676
Senior and Top management (levels 13-16)	104 180	0,46%	88	1 184
Contract (level 1-2)	79 262	0,35%	758	105
Contract (level 3-5)	235 019	1,04%	1483	158
Contract (level 6-8)	425 831	1,88%	1698	251
Contract (level 9-12)	2 735 675	12,05%	3980	687
Contract (level 13-16)	30 679	0,14%	23	1 334
Periodical Remuneration	0	0,00%	707	0
Abnormal Appointment	0	0,00%	2235	0
Total	**22 697 966**	**100,00%**	**80657**	**281**

Source: Persal System

Gender

The Leadership, Management and Skills Development Sub Directorate, plays an integral part in contributing strategically towards building human capital for high performance and enhance service delivery. This is done to achieve the Human Resource Development Strategic Framework, by providing strategic leadership management and skills development. These skills are targeted to programmes for senior, middle, emerging and foundational managers, including hospital CEO's, facility managers, supervisors and all other levels of employees to improve health system efficiency. The following programmes were offered in 2021/22 financial year: Quarter 3 (Oct – Dec 2021): 368 Managers were trained on various leadership and management development programmes such as, PSC Ethical Leadership webinar for SMS, SMS Strategic planning & management, SMS Financial Budget Planning & Management, SMS Leading change, Introduction to Policy Formulation and Implementation, Operations Management Framework etc.

During the 2021/22 financial year, a total of 677 employees were provided various trainings to enhance their knowledge, skills and improve efficiency. In addition, a total of 856 employees were trained on specialised programmes for improved Human Resource for Health (HRH). These specialised trainings included Introduction to Strategic Human Resource Management, Ethics for Auditors, Code of Conduct & Ethics Training, Human Resource Policies, Recruitment & Selection processes, Employment Equity Policy & process, Policy on reasonable accommodation and assistive devises. In this regard, a total of 1 919 staff were trained on specialised programmes for improved Financial Management and Supply Chain Management. Senior Management Services training was also provided including Supply

Chain Management process, Demand Management, Introduction to Financial Management and Budgeting, Generally Recognised Accounting Practice (GRAP) and these trainings were provided to 197 staff members.

Youth

To address the issue of unemployed youth in the province, the GDoH contributes to Tshepo 1 million (one of the provincial strategies for job creation and empowerment of unemployed youth) by proving job opportunities to unemployed youth in a form of access to internship and learnership programmes. These programmes create a platform for relevant work experience by empowering youth in becoming employable in the labour market, and in some instances, direct employment within the host site.

The department also assists student interns to complete their work integrated learning programme, which is an academic requirement by the TVET colleges for students to meet the graduation criteria. Due to the departmental recruitment policy which supports an open competition for posts, interns are considered for entry level posts and encouraged to apply should they meet the requirements of the post. Interns that are placed in GDoH have access to training opportunities offered by the department. At the end of quarter 1 of 2021, 656 internship participants, 514 learnership participants, and 30 bursary participants were recorded by the department. In terms of gender disaggregation, these participants comprise of 857 females and 343 males.

Persons with disabilities

The department continues with advancement of people with disabilities, in the third quarter of FY2021/22 five (5) institutions were workshopped on priorities of Reasonable Accommodation, Assistive Devices (PRAAD) Policy. Currently, the department reflects 1 274 permanent employees with disabilities reported on persal against a target of 2% (166) of the overall total of 83 049 (100%) employees in the department.

Youth programmes on disability

The total of active youth participants in developmental programmes in the first quarter of the 2021/22 financial year is 1200 and 92 of this number consist of people with disabilities, which makes up 7.6%. The annual target for youth disability for developmental programmes is 5%. The department has exceeded the target.

PART C: MEASURING OUR PERFORMANCE (PER BUDGET PROGRAMME)

5. Institutional Programme Performance Information

5.1. Budget Programme 1: Administration

Programme Purpose:

The purpose of this programme is to conduct strategic management and overall administration of the Department of Health through the Sub-programmes: In Office of the MEC: rendering of advisory, secretarial, and office support services; (including, administrative, public relations / communication and parliamentary support) through the sub-programmes:

I. Office of the MEC: rendering of advisory, secretarial, and office support services; (including, administrative, public relations / communication and parliamentary support)

II. Management: Policy formulation, overall management and administration support of the Department and the respective regions and institutions within the Department

5.1.1. PROGRAMME 1: ADMINISTRATION PROGRAMME OUTCOMES, OUTPUTS, OUTPUT INDICATORS AND TARGETS

Outcome (as per SP 2020/21- 2024/25)	Outputs	Output Indicator	Audited/Actual Performance			Estimated Performance	MTEF Targets					
			2019/20	2020/21	2021/22	2022/23	2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
Leadership and governance in the health sector enhanced to improve quality of care	Township economy in local communities promoted	Percentage of budget spent on Township enterprises against identified commodities	23%	13.2%	8.5%	30%	30%	Annual			30%	30%	30%
		Numerator (Rands)	#	#	5 221 589.96	27 000 000	30 000 000				30 000 000	33 000 000	35 000 000
		Denominator (Rands)	#	#	61 420 800.00	90 000 000	100 000 000				100 000 000	110 000 000	115 000 000
Improved financial management	Increased economy of local communities including township businesses and SMMEs	Percentage of service providers invoices without dispute paid within 30 days	66%	#	27.2%	80%	100%	Annual			100%	100%	100%
		Numerator	#	#	32 936	82 641	399 197				399 197	429 137	429 137
		Denominator	#	#	121 113	103 301	399 197				399 197	429 137	429 137
Leadership and governance in the health sector enhanced to improve quality of care	Women employed in senior management positions increased	Percentage of women in senior management posts	44%	#	44.1%	49%	50%	Annual			50%	50%	50%
		Numerator	50	#	49	57	59				59	59	59
		Denominator	113	#	111	117	117				117	117	117
Improved financial management	Unqualified audit opinion	Audit opinion of Provincial DOH	Unqualified	N/A	Unqualified			Annual				Clean	Clean
Quality of health services in public health facilities improved	Health facilities are compliant with Occupational Health and Safety	Percentage of hospitals compliant with occupational health and safety regulations	#	85%	51.4%	51.4%	100%	Annual			100%	100%	100%
		Numerator	#	#	19	19	37				37	37	37
		Denominator	#	#	37	37	37				37	37	37
	Lean Management System implemented in public priority health facilities	Number of priority hospitals and clinics implementing Lean Management System	10/37	5	9	16	20	Annual			20	20	20
Quality of health services in public health facilities improved	Contingent liability of medico- legal cases reduced by 50% over the MTEF	Rand value of medico-legal claims	#	R16.7bn	R24bn	R15.5bn	R2.1bn	Annual			R20bn	R16bn	R13bn

Outcome (as per SP 2020/21- 2024/25)	Outputs	Output Indicator	Audited/Actual Performance			Estimated Performance	MTEF Targets						
			2019/20	2020/21	2021/22	2022/23	2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
Robust and effective health information systems to automate business and improve evidence-based decision making	Quality of patient information in health facilities improved	Percentage of CHCs implementing PACS	#	0%	0%	100%	100%	Annual			100%	100%	100%
		Numerator	#	0	0	38	40				40	40	40
		Denominator	#	33	33	38	40				40	40	40
		Percentage of CHC's with Integrated Health Information systems	#	12%	18.2%	100%	100%	Annual			100%	100%	100%
		Numerator	#	4	6	38	40				40	40	40
		Denominator	#	33	33	38	40				40	40	40
		Percentage of hospitals with Integrated Health Information systems	0%	10%	5.4%	100%	100%	Annual			100%	100%	100%
		Numerator	#	4	2	37	37				37	37	37
		Denominator	#	37	37	37	37				37	37	37
	Quality of patient information in health facilities improved	Percentage of facilities implementing Forensic Pathology Management Information Systems	#	0%	0%	100%	100%	Annual			100%	100%	100%
		Numerator	#	#	0	11	11				11	11	11
		Denominator	#	#	11	11	11				11	11	11
Quality of health services in public health facilities improved	Reduce queues in health facilities	Number of hospitals implementing the Queue Management System	#	#	#	#	37	Annual			37	37	37

5.1.2. Explanation of Planned Performance over the Medium-Term Period

The department has developed interventions to respond to identified inefficiencies in the business environment and ensure the successful implementation of the Premier's priorities. The interventions include the finalisation of the review of the organisational structure, improving financial management, preparing district and regional hospitals for decentralisation of administrative processes, digitization of health care services by automating the health care system's key business processes, review of internal processes and controls to minimise potential for litigation, improve staff morale through strengthening the Employee Value Proposition (EVP), implement medical surveillance for health workers, implement lean management at hospitals and CHCs and strengthen committee systems for improved governance.

1) Organisational structure: The Department has commenced with the alignment of the organisational structure to the Strategic Plan for the review period 2020-2025. The process involved all the Senior Managers of Branches, the Chief Directorates and Directorates. The Executive Management Committee (EMC) Tech has approved the final draft which has been be presented to the MEC at the EMC for approval. The structure once approved by the EMC will be sent for concurrence to DPSA. It is envisaged that the whole process will be finalised by the end of the financial year. A draft Human Resource Plan has been developed and is expected to be approved by end of March 2023.

2) Financial management: The funding model from Treasury needs review, and recalibration of the budget in view of in- migration is also an urgent priority. Treasury allocates and continues to fund the GDOH on earmarked funding that addresses some of the key funding pressures such as Mental Health beds and posts, OHS posts, M&E data capturers, 24-hour service expansion. Eliminating fraud and corruption in the system, whilst building capacity and strengthening internal controls are key to better financial management. All undisputed supplier invoices will be paid within 30 days. The structure of the Supply Chain Management Unit structure to be reconfigured so that it is responsive to the needs of the Department. Provide SCM with skills and build capacity at district level for Contracting Unit for PHC Services (CUPS). A contract management system to be developed to improve efficiency and prevent irregular expenditure. SCM processes to be automated. The Department will ensure improvement in the achievement of targets for women owned enterprises through:

- Identifying specific projects to increase spend on women owned companies.
- Specific drive to increase the number of contracts.
- Conducting SCM training to upskill SCM officials and building SCM capacity within the department.
- Full rollout of SAP Inventory Management within the Department to replace manual Inventory Management system.

3) Decentralisation of administrative processes: Improve financial controls and systems inclusive of PFMA controls. Up-skill managers, to increase financial delegations from R 500 000 to R2 million. SCM processes be managed at facility level. Comprehensive policy on result-based performance management and accountability will be developed and implemented. In the longer-term, the implementation of an electronic tool to facilitate operational plans and organisational performance, and automation of management decisions and an MPET framework for governance structures is recommended.

4) Digitalisation of health services: Optimising business of the health care system by automating key business processes to enable collection of pertinent data for evidence driven decision making. In a period of one hundred (100) days, the Department will automate business processes in ten (10) priority hospitals which are servicing townships, informal settlements and hostels, namely, Sebokeng, Dr George Mukhari, Edenvale, Tembisa, Jubilee, Kopanong, Mamelodi, Bheki Mlangeni, Tambo Memorial and Thelle Mogoarane. This will ensure that the necessary medical details of citizens are readily available when they consult with medical facilities and also assist with bed management system. An integrated and interoperable Provincial Health Information System will be implemented at the ten (10) priority hospitals within six months. This will among other things enable the automation of the current manual filing system. The Department has planned to implement an Integrated Health Information System at all health facilities during the 2023/24 financial year. To reduce waiting times, a queue management system will be implemented at four (4) of the priority hospitals within six months, namely, Tembisa, Mamelodi, Edenvale and Dr George Mukhari. A physical network infrastructure and broadband connectivity for priority digital health applications and services will be rolled out at ten (10) priority hospitals within six (6) months to improve access to health services. A tele-health policy to be developed and implemented.

5) Digitization of medical records is another critical intervention to prevent limitation of scope and ensure that patient records are availed on a cloud for continuity of care. This intervention will also go a long way in supporting the gaps on medical litigation.

6) Automating the patient journey from household level to the hospital level importance has also been put sharply to the fore by COVID-19. This programme will be accelerated commencing with automating ward-based outreach teams and linking that level of care and its associated data collection processes with Primary Health Care Facilities, hospital and back to community level. This programme is closely linked to the establishment of the Health Observatory which would enable monitoring of population health and impact of the health systems policy interventions. A comprehensive data management strategy to be developed and implemented within twelve (12) months. The capacity of the workforce to support and implement digital health will be enhanced.

7) Medicolegal: Continuous engagement with the National Department of Health as medico-legal litigation is a national challenge faced by all provinces. Interventions have been developed to reduce the contingent liability of medico-legal claims, with a target of R2.1bn set for the 2023/24 financial year. The contingent liability of medico-legal claims will be reduced by R10.1bn over the MTEF period.

Specialised services required

- The National Department of Health (NDoH) followed a competitive bidding process by means of tender number NDOH 29-2018/2019 to procure service providers to provide expert and strategic support including forensic, special and other investigations in the management of medico-legal matters for a period of 3 years to the following provinces: Kwa-Zulu Natal, Northern Cape, Eastern Cape, Free State, Gauteng, Mpumalanga, Limpopo, and North-West with the exception of the Western Cape.

- CAJV was appointed to render services to Gauteng, Mpumalanga, Limpopo, and North-West for the 3-year period from 10 June 2019 to 9 June 2022. CAJV rendered services to the GDH in terms of the contract until the end of the 2020/2021 financial year, where after they ceased to render services as the NDoH stopped to pay CAJV's invoices due to budgetary constraints.

- It is imperative to note that the Legal Unit is structured and capacitated to render legal and support services. The Legal Unit is neither structured nor capacitated to render expert and strategic support services including forensic, special and other investigations related to the management of medico-legal matters.

- CAJV assisted the department by rendering data analytics and monetary verification of medico-legal claims against the department, thereby ensuring the veracity of the GDH's reported contingent liability by means of reports and portfolios of evidence that comply with audit standards and requirements of, without limitation, the AGSA and SCOPA.

- This was one of the reasons for National to enter into the SLA with CAJV on behalf of not only Gauteng but other Provinces as well. This service is critical for data analytics and monetary verification of medico-legal claims against the department in order to ensure the veracity of the GDH's reported contingent liability by means of reports and portfolios of evidence. Whilst external support is being pursued, other interventions such as Mediation strategies to curb the medical litigation bill are being pursued including reviving the State Liability Bill, 2018. The bill will ensure that a person who suffers damages as a result of negligent medical treatment claims compensation for damages in terms of the common law "once and for all" rule. A plaintiff must therefore claim damages once for all damages already sustained or expected in future.

- The Bill aims to amend the principal act to provide for inter alia structured settlements for the payment of claims against the state as a result of wrongful medical treatment of persons by servants of the state.

- Forensic investigations into suspected irregular medico-legal claims will be conducted on an ongoing basis
- **Employment Equity:** 50% target of women in decision making levels of the Department and Job Access for People with Disabilities to achieve the 3% target: The Department is committed to redressing the imbalances of the past and ensuring that the provisions of the Employment Equity Act 55 of 1998 are complied with and it has made progress in redressing the imbalances of the past. The number of women in decision making levels was at 44.1% in 2021/22. The gains that were experienced were offset by natural attrition. The number of people with disabilities decreased from 1492 in December 2020 to 1274 in December 2022. The decline was due to natural attrition,

- To achieve the targets set, vacant funded posts should be treated as Affirmative Action positions for Women Candidates. Senior Management Service adverts will state that only women applicants will be considered (fair discrimination) for positions advertised, to enable the Department to reach the stipulated targets. A pool of Middle Managers should be mentored and coached to take up Senior Management positions when opportunities arise.

- All positions vacated by females at SMS Levels should be replaced by female candidates to maintain the numbers of females at SMS levels, unless it can be demonstrated that there is no suitable female candidate who could fill the position from middle management levels. In terms of People with disabilities the Department will continue with the disability declaration campaign to encourage employees to declare their disability status.

- **Staff morale:** Overhaul ineffective HR processes and standardise prescripts and policies, ensuring consistent application. Clean Persal System as a precursor to filling critical posts. Develop and implement a succession planning framework. Introduce Employee Value Proposition (EVP) and implement an employee care framework, exploring non-financial and hygiene incentives to encourage staff, as well as youth development opportunities for linking young staff with leaders.

- **Lean management:** For the 6th administration the implementation of lean with be focusing on meeting the contractual agreement between the Gauteng Premier and the Gauteng Health MEC. This focuses on implementing Lean in 10 priority Hospitals and the CHC's that are linked in terms of the referral system. The contracts states that all these facilities must be implementing Lean in the following area MOPD, Pharmacy, Patients registrations a, Radiography and X-ray. The 10 priority facilities are: DGMAH; Tembisa; Edenvale; Mamelodi; Sebokeng; Tambo; Thelle Mogoerane; Bheki Mlangeni; Jubilee; Kopanong. Although lean management is a critical intervention, its current location, scope and championing need to be revisited to improve the effectiveness of the programme

- **Strategic governance and leadership:** Further strengthening of the Governance system through the management committee system to support health systems effectiveness, will be the focus of the administration. Ensuring improved accountability through approved Governance Framework of the Committee system and implementation of the resolution tracking system, implementation of e-submissions and corporate calendar. Completion of the Governance system to influence key changes will also be fast tracked and will be used to guide Hospital and Clinic Boards Management information dashboards for accountability purposes. In the advent of COVID-19, the department COVID-19 operations have been enhanced through a functional project management structure led by the COO. The project structure accounts daily with defined metrics. An operational plan guiding the implementation with operational risks forms part of the operations.

- **Medical surveillance for Health Workers:** The Department has established protocols on the management of ill and Covid-19 exposed employees, medical surveillance tool for baseline and routine surveillance for application in the public and private sector. The medical surveillance will inform the future risk assessments; information and training; monitoring of exposure at the work- place; record keeping; controls of exposure to SARS Cov-2 causing COVID-19 and proper and rational utilisation of respiratory protection including fit testing of PPE through information, instruction, training and supervision on the use of PPE.

- The GDoH will establish management systems associated with COVID-19 response by implementing plans for certification on ISO-45 000 for occupational health and safety; ISO 14 000 Environmental Management and ISO 14 000 Quality Management by 30 March 2024. The GDOH will also for the first time implement the regulations on ergonomics to guide the return to work and ergonomic changes in the workplace to ensure social distancing. Healthwise Methodology will be used to change work processes Medical Surveillance, standardisation, respiratory protection including fit testing implementation of HealthWise will require major investment in HR for OHS and Wellness including Occupational Medical specialists and practitioners; Occupational Health Nurses; Occupational Hygienists, Ergonomist; Epidemiologist; Clinical and Industrial Psychologists; EAP Practitioners and Coaches.

- The OHS compliance of GDoH buildings to be improved through completing OHS projects in 37 hospitals.

5.1.3. PROGRAMME RESOURCE CONSIDERATIONS/ BUDGET ALLOCATION

Reconciling performance targets with expenditure trends and budgets table admin 3: expenditure estimates: administration.

TABLE 13: SUMMARY OF PAYMENTS AND ESTIMATES: ADMINISTRATION

	Outcome			Main	Adjusted	Revised estimate	Medium-term estimates		
R thousand	2019/20	2020/21	2021/22		2022/23		2023/24	2024/25	2025/26
1. Office Of The MEC	17 051	16 068	16 392	24 693	24 693	16 806	25 075	26 106	26 637
2. Management	1 464 395	3 678 948	2 156 800	1 419 453	1 431 453	1 622 762	1 464 331	1 655 677	1 729 324
Total payments and estimates	**1 481 446**	**3 695 016**	**2 173 192**	**1 444 146**	**1 456 146**	**1 639 568**	**1 489 406**	**1 681 783**	**1 755 961**

TABLE 14: SUMMARY OF PROVINCIAL PAYMENTS AND ESTIMATES BY ECONOMIC CLASSIFICATION: ADMINISTRATION

	Outcome			Main	Adjusted	Revised estimate	Medium-term estimates		
R thousand	2019/20	2020/21	2021/22		2022/23		2023/24	2024/25	2025/26
Current payments	**997 922**	**2 940 737**	**1 649 055**	**1 431 053**	**1 431 053**	**1 308 734**	**1 475 930**	**1 668 114**	**1 741 679**
Compensation of employees	429 366	442 839	463 885	559 963	559 963	463 085	561 788	600 969	627 252
Goods and services	567 539	2 496 314	1 184 072	871 090	871 090	845 649	914 142	1 067 145	1 114 427
Interest and rent on land	1 017	1 584	1 098						
Transfers and subsidies to:	**470 415**	**395 238**	**371 718**	**3 595**	**3 595**	**309 248**	**3 651**	**3 753**	**3 921**
Provinces and municipalities									
Non-profit institutions									
Households	470 415	395 238	371 718	3 595	3 595	309 248	3 651	3 753	3 921
Payments for capital assets	**13 002**	**359 034**	**152 410**	**9 498**	**21 498**	**21 498**	**9 825**	**9 916**	**10 361**
Buildings and other fixed structures									
Machinery and equipment	13 002	359 034	152 410	9 498	21 498	21 498	9 825	9 916	10 361
Payments for financial assets	**107**	**7**	**9**			**88**			
Total economic classification	**1 481 446**	**3 695 016**	**2 173 192**	**1 444 146**	**1 456 146**	**1 639 568**	**1 489 406**	**1 681 783**	**1 755 961**

Expenditure in the programme decreases from R3.6 billion in 2020/21 to R2.1 billion in the 2021/22 financial year. The on-going administrative support provided to the entire department including the modernisation of the health information system and the centralisation payment of medico-legal claims contributed to the growth in the expenditure.

The budget of the programme increases marginally at R1.4 billion in 2022/23 to the 2023/24 financial year. Funds are allocated to pay revenue collecting agencies and are earmarked for the planned investment in an integrated health information system.

5.1.4 RISKS AND MITIGATING FACTORS

Outcome	Risk	Mitigating factors
Robust and effective health information systems to automate business processes and improve evidence-based decision making	Inadequate and vulnerable ICT system and infrastructure to support health needs.	• The implementation of the ICT Strategy (Digital Strategy) of the department. • Motivate for additional funding - to implement the Digital Strategy • Review and align the SLA between e-Gov and GDoH, in terms of the implementation of the Digital Strategy • Aging health ICT infrastructure- Development ICT infrastructure plan • implementation of a ICT infrastructure plan
Robust and effective health information systems to automate business processes and improve evidence-based decision making	Inaccurate and compromised reporting of departmental performance (Poor and unreliable data)	• Full implementation of COBIT 5
Leadership and governance in the health sector enhanced to improve quality of care	Instability at leadership and management echelon/level	• Approval of Departmental Organisational Structure • Re-issuing of amended delegations in line with the new approved Organisational Structure • Monitor the implementation of the new structure for potential resourcing and Post Filling Plan • Monitor the implementation of the GDoH Leadership and Management Framework and Strategy
Improved financial management	Inefficient SCM processes and procurement irregularities	• Review the Supply Chain Management processes • Filling of vacant positions • Train officials on how to draft specifications. • Re-alignment of the Supply Chain Management establishment to the needs of the Department • Perform only instructions that is in writing as per of DPSA awareness instruction circular. • Implement consequence management. • Awareness and training on emergency processes • Review and update Supply Chain Management & financial delegation • Implementation of a Check list on Procurement for Supply Chain Management Practitioners • Conducting awareness workshops on bid-rigging, cover quoting, fronting, contravention of the PFMA and National Treasury Irregular Expenditure Framework • Certification declaration in terms of RWOPS and doing business with the state. • Investigations on procurement irregularities: Due Date: As and when the need arises
Quality of health services in public health facilities improved	Costly legal claims against the Department (Contingency Liability)	• Digitalization of record keeping over a period of 2-3 years. • Scanning of medical records into the system • Creation of record keeping Lockable areas and scanning of medical records. • Drafting the Gauteng Medical Litigation and Mediation Bill to provide a legislative mechanism for among others, the provision of future medical treatment and related health care requirements at state facilities instead of paying a lump sum to a successful plaintiff and periodic rather than once off payments of any monies due to a successful plaintiff in terms of a court order. • Engagement with the Gauteng Provincial Treasury to ensure their compliance with section 3(11) of the State Liability Act by developing a budget for the payment of final court orders against the department. • Addressing the root cause of medico-legal litigation (negligence at clinical level) to ensure patient health and safety and prevent causes for medico-legal claims
	Failure to recover critical health functions, following a disaster or any material disruptive event (1)	• Follow-up with HR on the review of the organisational structure to inform the risk governance structure of the department. • Review, communicate and implement a comprehensive business continuity policy for the department. • Establish and develop capacity for the business continuity needs of the department. • Migrations of new systems to the cloud and engage SITA to migrate the historical legacy systems to the fully managed data centre. • Development and implementation of the ICT DR in line with the provincial approved Cloud policy (Migration to CLOUD)

5.2. Budget Programme 2: District Health Services (DHS)

Programme Purpose

The purpose of the programme is to render Primary Health Care Services and District Hospital Services.

i. District Management: Planning and administration of services, managing personnel - and financial administration and the coordinating and management of the Day Hospital Organisation and Community Health Services rendered by Local Authorities and Non- Governmental Organisations within the Metro and determining working methods and procedures and exercising district control.

ii. Community health clinics: Rendering a nurse driven primary health care service at clinic level including visiting points, mobile- and local authority clinics.

iii. Community health centres: Rendering a primary health service with full-time medical officers in respect of mother and child, health promotion, geriatrics, occupational therapy, physiotherapy, psychiatry, speech therapy, communicable diseases, mental health, etc.

iv. Community based services: Rendering a community-based health service at non –health facilities in respect of home-based care, abuse victims, mental- and chronic care, school health, etc.

v. Other community services: Rendering environmental, port health and part-time district surgeon services, etc.

vi. HIV and AIDS: Rendering a Primary Health Care Service in respect of HIV and AIDS campaigns and Special Projects

vii. Nutrition: Rendering a nutrition service aimed at specific target groups and combines direct and indirect nutrition interventions to address malnutrition.

viii. Coroner Services: Rendering forensic and medico legal services in order to establish the circumstances and causes surrounding unnatural death.

ix. Hospital Care: Coordination and management of District and Regional Hospitals.

5.2.1. PROGRAMME 2: DISTRICT HEALTH SERVICES (DHS) PROGRAMME OUTCOMES, OUTPUTS, OUTPUT INDICATORS AND TARGETS

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual Performance			Estimated Performance	MTEF Targets					
			2019/20	2020/21	2021/22	2022/23	2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
Quality of health services in public health facilities improved	Positive experience of care of health care users improved	Patients experience of care satisfaction rate	84%	92.5%	92.4%	95.2%	92.4%	Annual			92.4%	92.4%	92.4%
		Numerator	#	#	#	95 226	843 888				843 888	843 888	843 888
		Denominator	#	#	#	100 000	913 699				913 699	913 699	913 699
Quality of health services in public health facilities improved	Management of patient safety incidents improved to reduce new medico-legal cases	Severity assessment code (SAC) 1 incident reported within 24 hours rate	#	94.7%	86.9%	95.3%	95%	95%	95%	95%	95%	95%	95%
		Numerator	#	161	233	162	548	137	137	137	137	548	548
		Denominator	#	170	268	170	576	144	144	144	144	576	576
		Patient Safety Incident (PSI) case closure rate	#	91.8%	95.7%	92%	95%	95%	95%	95%	95%	95%	95%
		Numerator	#	235	331	231	300	75	75	75	75	300	300
		Denominator	#	256	346	250	316	79	79	79	79	316	316
Quality of health services in public health facilities improved	All submitted complaints resolved within 25 working days	Complaints resolution within 25 working days rate	98%	95%	97.5%	95%	95%	95%	95%	95%	95%	95%	95%
		Numerator	#	707	998	707	712	178	178	178	178	712	712
		Denominator	#	744	1 024	747	748	187	187	187	187	748	748

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual Performance			Estimated Performance	MTEF Targets						
			2019/20	2020/21	2021/22	2022/23	2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
Package of services available to the population with priority given to equity and most cost-effective services	PHC facilities provide integrated quality healthcare service	Ideal Clinic status obtained rate	93.0%	89%	92.4%	90.5%	92%	Annual			92%	93%	89%
		Numerator	334	#	341	333	338				338	334	#
		Denominator	359	#	369	368	368				368	359	#
Leadership and governance in the health sector enhanced to improve quality of care	Functional governance structures in PHC facilities	Percentage of PHC facilities with functional clinic committees	80%	80%	23.6%	100%	100%	Annual			100%	100%	100%
		Numerator	#	298	87	369	368				368	368	368
		Denominator	#	372	369	369	368				368	368	368
Package of services available to the population with priority given to equity and most cost-effective services	All CHC'S provide 24-hour full service	Number of facilities providing 24-hour emergency services	#	#	#	#	40	Annual			40	40	40

5.2.2. Explanation of Planned Performance over the Medium-Term Period

The commitment to patient centered care continues in the 6th administration with the elevated areas to end of term being improving patient experience of care, intersectoral collaboration to address social determinants of health, promoting equity through expansion of the service platforms in order to reduce mortality and morbidity across the different population groups to improve the life expectancy for service users, monitoring of the Ideal Clinic and Ideal Hospital programmes to ensure continuous improvement of the quality of health care services , readiness for NHI certification and reducing waiting times at points of service . In this regard, the following are prioritized for implementation:

1. Reorientation towards disease prevention: A reorientation towards disease prevention and health promotion is necessary, linking and strengthening the referral pathways between CHCs, district and regional hospitals. Implementation of a health and wellness programme through health literacy, health promotion and healthy lifestyle campaigns. Improve utilisation of WBOTs for home visits.

Demographic details of household beneficiaries captured during COVID to be used to strengthen the process of household registrations and capturing the health needs already implemented in all most deprived wards. Collection of data at household level, supports the NHI implementation with a targeted approach.

2. Partnerships and intersectoral Collaboration: Engaging various stakeholders in the delivery of health care is critical to address structural and socio-economic determinants of health. This includes engagements of other government departments on their contributions to addressing health outcomes and also private sector to ensure optimal utilization of health care beds in an equitable manner within the available legislative frameworks.

3. Increased community participation: Community participation and active involvement of users in the delivery of care and in managing their own health remains critical in improving life expectancy. Community participation to be strengthened through improved patient communication, functional hospital boards and clinic committees, improvement of the HCW environment, staff training and inter-sectorial initiatives to promote mental, social and physical wellbeing. Advocacy, social mobilisation, side to side campaigns, road to health booklets, Upscale Mom-Connect and increase mother and child advocacy to inform patients of entry points to health services to avoid influx to central hospitals. Revision of Service Charters, partnership compacts, health in all policies, and stakeholder engagement framework.

4. Optimising care: Expanding of health care service platforms and service coverage to reduce mortality and morbidity through the following:

- Provision of 24-hour X-ray services, 24-hour emergency medical care, MoU's.
- Facilitate intersectoral approach in preventing, managing and rehabilitation in addressing substance abuse.
- Upgrading of physical infrastructure in line with Ideal Clinic standards for service delivery.
- Up-skill the medical practitioners in obstetrics, so that they are the first point of referral to midwives and provide staff to strengthen maternity services in hospitals.
- The longer-term should see an increase in the number of CHC's, through conversion of clinics with MoU's, and clinics in strategic areas without access to CHC's, facilitating the full implementation of the CHC service package.
- Continuous support visits to ensure compliance to Ideal Hospital framework by all health facilities who have and had to conducting self-assessments that are meant to align Regulated Norms and Standards with the framework Customer complaints are regarded as a good yardsticks for checking institutional performance, therefore activities that will be looked into will be geared towards reducing patients' complaints.
- Monitoring of Patient Safety Incidents will also be of prime importance and continuous support via the Provincial Office will be offered to all institutions to make sure that Patient Safety is regarded as the primary focus of the Dept.
- All the institutions that are still to be registered on Ideal Hospital Framework will be registered to ensure that all institutions are reporting timeously.

5. Reorganise health service in compliance to the NHI prescripts:

- Governance Structures: District Management Structures with fully-fledged and functional Sub-District structures: Reorganise current non-utilised paediatrics beds and space. Emphasis will be on the roles, responsibilities and relationships with the health facilities. Managers need to be adequately prepared for decentralised systems with full delegations, and hospital boards must be purposefully selected and appropriately skilled to manage the transition to NHI.

- NHI will have to be presented as a partnership between private and public sector, enabling best practices to be learnt from each other.
- Modification of service delivery models to ensure use of m-health applications in self-help and accessing of other health care services in the department will be prioritised to ensure continuous decongesting of health facilities.
- Self-assessment results as well as OHSC results and all other governance bodies like Gauteng Health Accreditation Committee (GHAC) are playing a major role in preparation for better results to see implementation of NHI being a success, and therefore close observation of facilities performance in the assessment results will be of crucial importance.
- Due to COVID, the National Department of Health could not proceed with the intended Quality Improvement initiatives, but had to change to introduction of Quality Learning Centres, which process is still underway, and once fully understood will be implemented across the province
- Facilitate ideal clinic and Regulated Norms and Standards (NCS).
- Prioritize Re-engineering of Primary Health Care Services
- Human Resource Planning: A Clinical Excellence Academy needs to be established to ensure ongoing up- skilling on protocols, maintaining quality levels attained and improving accessibility to quality health care services.

5.2.3. UPDATED RISKS AND MITIGATING FACTORS FROM THE SP

Outcome	Risk	Mitigating factors
Leadership and governance in the health sector enhanced to improve quality of care	Inability to provide effective mental health services	• Implementation of the mental health strategic plan • Train specialised mental health nurses and doctors
Quality of health services in public health facilities improved	Failure to implement the National Quality Learning Centre approach	• Implementation of Quality Learning Centres using the Cluster approach
Quality of health services in public health facilities improved	Failure to implement the National Quality Learning Centre approach	• Implementation of Quality Learning Centres using the Cluster approach

5.2.4. EXPLANATION OF PLANNED PERFORMANCE OVER THE MEDIUM-TERM PERIOD

Primary Health Care as the foundation for Universal health coverage will continue to strive to ensure that:

- Provision of 24-hour maternity service in all CHCs and district hospitals continues to ensure that services for safe deliveries of babies more accessible. Through accessible services, the deaths of both mothers and babies will decrease.
- Continuation of monitoring of Ideal Clinic and Ideal Hospital programmes to ensure continuous improvement of quality of health care facilities and readiness for NHI certification. Improving patient's experience: Measured through timely commencement of all health services; adequate availability of medicines, sundry and medical equipment; cleanliness and availability of cleaning materials; be patient friendly and patient feel and are safe.
- Waiting times are to be reduced at all points of service and or delays managed and communicated to end users. The focus of this MTEF period is to ensure that all hospitals (from 11 hospitals to 12) have all processes and systems in place to maintain waiting times below agreed benchmark of 180 minutes. This will be tracked at operational plan level.

5.2.5. UPDATED KEY RISKS AND MITIGATING FACTORS FROM THE SP

Outcome	Risk	Mitigating factors
Quality of health services in public health facilities improved	Increasing morbidity and mortality	• Implementation of the RWOPS processes and provisions. Consequent management to be implemented as and when contraventions on RWOPS occur. • Increase the number of specialists trained in clinical specialties.
	Increasing morbidity and mortality	• Finalisation and implementation of the Health Education, Promotion and Happiness plan. • Train educators and health promoters up to specialist's level.
Quality of health services in public health facilities improved	Failure to implement the National Quality Learning Centre approach	• Implementation of Quality Learning Centres using the Cluster approach
Quality of health services in public health facilities improved	Failure to provide quality care services	• Analysis of the data to reduce the waiting times and implement the identified deficiencies. • Training of Queue Marshals • Development and implementation of a waiting times measuring tool. • Assessment and monitoring of adverse events in all facilities. • Pilot assessment using the Ideal Hospital Electronic Tool and Development of a quality improvement plan on the remedial action emanating from the plan. • Automation of collection of chronic medication at medication through Telemedicine and E-Health • Implementation of Covid-19 Memorandum of Understanding for enabling public patients to access beds at private hospitals at an agreed fee • Implementation of the PMDS and the recruitment, retention of critical skills. • Review of the Delegation Framework
Morbidity and premature mortality due to non- communicable diseases reduced by 10%.	Inability to manage and curb communicable/non- communicable diseases	• Utilisation of funds given to procure equipment (renal dialysis machines, radiation oncology equipment) to address the demand in the burden of disease
Quality of health services in public health facilities improved	Costly legal claims against the Department (Contingency Liability)	• Refer cases of negligence to the Health Professional Council of South Africa for action to be instituted against the member/ employee. • Digitalization of record keeping over a period of 2-3 years. • Creation of record keeping lockable areas and scanning of medical records. • Full implementation of the clinical modules • Continue scanning of the paper-based records • Assigned Integrated Forensic Accounting Services ("IFAS") and CAJV the investigation of the top law firms that are litigating against the State (for the respective Provinces) on medico-legal matters • Implementation of onsite-midwife birthing units • Strengthening of District Health Services • Establish Seizure Hubs to clear the backlog of long theatre lists • Conduct training on reading of CTGs by District Clinic Teams • Resuscitations of the Provincial Patient Safety and Medico Legal committee.
Quality of health services in public health facilities improved	Increased morbidity due to mental health instability	• Implementation of the mental health strategic plan • Accreditation from SANC/DHET for the Gauteng College of Nursing GCON to train nurses on the new curriculum • Training of nurses once the accreditation is received from SANC/DHET • Enhancement of the current mental health strategic plan to incorporate an integrated approach to the management of mental health.

5.3. Sub-Programme: District Hospitals

5.3.1 Programme Purpose

- Provide basic non - specialised health care services including minor surgeries and serve as a gateway to Regional, Tertiary and Central Hospitals.

5.3.2. DISTRICT HOSPITALS OUTCOMES, OUTPUTS, OUTPUT INDICATORS AND TARGETS

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual Performance			Estimated	MTEF Targets						
			2019/20	2020/21	2021/22	2022/23	2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
Maternal, neonatal, infant and child mortality reduced	Number of women who die in health facilities reduced	Maternal mortality in facility ratio	#	69.8	63	53.8	53.7	53.7	53.7	53.7	53.7	53.6	51
		Numerator	#	32	29	24	24	6	6	6	6	24	23
		Denominator	#	45 814	46 034	44 600	44 700	11 175	11 175	11 175	11 175	44 800	44 900
	Less children under 5 years dying from diarrheal diseases	Child under 5 years diarrhoea case fatality rate	#	2%	1.1%	2.2%	2,2%	2.2%	2.2%	2.2%	2.2%	2.2%	2.1%
		Numerator	#	10	16	29	28	7	7	7	7	28	27
		Denominator	#	503	1 471	1 300	1 292	323	323	323	323	1 280	1 270
Maternal, neonatal, infant and child mortality reduced	Less children under 5 years dying from pneumonia	Child under 5 years pneumonia case fatality rate	#	1.8%	0.91%	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%	1,2%
		Numerator	#	9	11	12	12	3	3	3	3	12	11
		Denominator	#	511	1 210	900	900	225	225	225	225	900	950
	Stunting among children reduced less	Child under 5 years severe acute malnutrition case fatality rate	#	#	#	#	8%	8%	8%	8%	8%	7,8%	7,8%
		Numerator	#	#	#	#	24	6	6	6	6	25	25
		Denominator	#	#	#	#	300	75	75	75	75	320	320
	Number of children who die in health facilities reduced	Death under 5 years against live birth rate	#	0.74%	0.88%	0.7%	0.7%	0.7%	0.7%	0.7%	0.7%	0.7%	0.7%
		Numerator	#	330	391	312	320	80	80	80	80	315	310
		Denominator	#	44 522	44 577	44 600	44 700	11 175	11 175	11 175	11 175	44 800	44 900
Quality of health services in public health facilities improved	Patients report positive experience of care	Patients experience of care satisfaction rate	80%	90.2%	89.6%	90.4%	90%	Annual				90%	90%	90%
		Numerator	#	65 341	37 917	66 000	38 140					38 140	38 140	38 140
		Denominator	#	73 151	42 334	73 000	42 334					42 334	42 334	42 334

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual Performance			Estimated	MTEF Targets					
			2019/20	2020/21	2021/22	2022/23	2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
Quality of health services in public health facilities improved	Hospitals ready to deliver quality health care	Ideal hospital status obtained rate	#	16.7%	83.3%	66.7%	100%	Annual			100%	100%	100%
		Numerator	#	2	10	8	12				12	12	12
		Denominator	#	12	12	12	12				12	12	12
Quality of health services in public health facilities improved	Management of patient safety incidents improved to reduce new medico-legal cases	Severity assessment code (SAC) 1 incident reported within 24 hours rate	#	72.7%	93.3%	70%	95.1%	95.1%	95.1%	95.1%	95.1%	95.1%	95.1%
		Numerator	#	290	499	280	548	137	137	137	137	548	548
		Denominator	#	399	535	400	576	144	144	144	144	576	576
		Patient Safety Incident (PSI) case closure rate	#	74.4%	92.9%	75%	93%	93%	93%	93%	93%	93%	93%
		Numerator	#	468	722	300	744	186	186	186	186	744	744
		Denominator	#	629	777	400	800	200	200	200	200	800	800
Quality of health services in public health facilities improved	All submitted complaints resolved within 25 working days	Complaints resolution within 25 working days rate	97.8%	92.2%	97.7%	95%	95%	95%	95%	95%	95%	95%	96%
		Numerator	500	320	301	508	508	127	127	127	127	508	514
		Denominator	511	347	308	536	536	134	134	134	134	536	536
Leadership and governance in the health sector enhanced to improve quality of care	Functional governance structures in hospitals	Percentage of hospitals with functional hospital boards	#	66.7%	58.3%	100%	100%	100%	100%	100%	100%	100%	100%
		Numerator	#	8	7	12	12	12	12	12	12	12	12
		Denominator	#	12	12	12	12	12	12	12	12	12	12
Quality of health services in public health facilities improved	Integration of mental health into mental health services	Percentage of beds in district hospitals offering acute ill mental health care users (72hrs assessment)	#	5.6%	7.4%	7.4%	8.6%	Annual			8.6%	10%	10%
		Numerator	#	165	225	222	250				250	300	300
		Denominator	#	2 901	3 048	3 000	2 901				2 901	3 000	3 000

5.3.3. EXPLANATION OF PLANNED PERFORMANCE OVER THE MEDIUM-TERM PERIOD

- 24-hour maternity service in all CHCs and district hospitals.
- Increase the District Hospitals from 12 to 13
- Quality of health care services: Facilitate ideal hospitals and Regulated Norms and Standards (NCS, and District Hospitals will be scheduled accordingly to ensure that they are assessed on time.
- Improving patient's experience: Measured through timely commencement of all health services; adequate availability of medicines, sundry and medical equipment; cleanliness and availability of cleaning materials; be patient friendly and patient feel and are safe.

Waiting times are to be reduced at all points of service and or delays managed and communicated to end users. The focus of this MTEF period is to ensure that all hospitals (from 11 hospitals to 12) have all processes and systems in place to maintain waiting times below agreed benchmark of 180 minutes. This will be tracked at operational plan level.

5.3.4. UPDATED KEY RISKS AND MITIGATING FACTORS FROM THE SP

Outcome	Risk	Mitigating factors
Quality of health services in public health facilities improved	Increasing morbidity and mortality	• Implementation of the RWOPS processes and provisions. • Consequent management to be implemented as and when contraventions on RWOPS occur. • Increase the number of specialists trained in clinical specialties
	Increasing morbidity and mortality	• Finalisation and implementation of the Health Education, Promotion and Happiness plan • Train educators and health promoters up to specialist level.
Quality of health services in public health facilities improved	Failure to implement the National Quality Learning Centre approach	• Implementation of Quality Learning Centres using the Cluster approach
Quality of health services in public health facilities improved	Failure to provide quality care services	• Analysis of the data to reduce the waiting times and implement the identified deficiencies. • Training of Queue Marshals • Development and implementation of a waiting times measuring tool. • Assessment and monitoring of adverse events in all facilities. • Pilot assessment using the Ideal Hospital Electronic Tool and Development of a quality improvement plan on the remedial action emanating from the plan. • Automation of collection of chronic medication at medication through Telemedicine and E-Health • Implementation of Covid-19 Memorandum of Understanding for enabling public patients to access beds at private hospitals at an agreed fee • Implementation of the PMDS and the recruitment, retention of critical skills • Review of the Delegation Framework
Morbidity and premature mortality due to non-communicable diseases reduced by 10%.	Inability to manage and curb communicable/ non-communicable diseases	• Utilisation of funds given to procure equipment (renal dialysis machines, radiation oncology equipment) to address the demand in the burden of disease.
Quality of health services in public health facilities improved	Costly legal claims against the Department (Contingency Liability)	• Refer cases of negligence to the Health Professional Council of South Africa for action to be instituted against the member/employee. • Digitalization of record keeping over a period of 2-3 years. • Creation of record keeping lockable areas and scanning of medical records. • Full implementation of the clinical modules • Continue scanning of the paper-based records • Assigned Integrated Forensic Accounting Services ("IFAS") and CAJV the investigation of the top law firms that are litigating against the State (for the respective Provinces) on medico-legal matters • Implementation of onsite-midwife birthing units • Strengthening of District Health Services • Establish Seizure Hubs to clear the backlog of long theatre lists • Conduct training on reading of CTGs by District Clinic Teams • Resuscitations of the Provincial Patient Safety and Medico Legal committee

5.4. Sub-Programme: HIV and AIDS, STI & TB Control (HAST)

5.4.1 Programme Purpose

- To decrease the burden of disease related to the HIV and Tuberculosis epidemics.
- To reduce maternal and child mortality and morbidity; and
- To optimise good health for children, adolescents and women Programme by rendering comprehensive HIV, TB and STI Programmes mainly focusing at District Health Services platform, using Primary Health Care Services as a vehicle as well as in Hospital Services with Special Projects and or campaigns.
- Rendering a primary health care service in respect of HIV and AIDS campaigns and Special Projects.

5.4.2. HIV AND AIDS, STI & TB CONTROL (HAST) PROGRAMME OUTCOMES, OUTPUTS, OUTPUT INDICATORS AND TARGETS

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual Performance			Estimated Performance	MTEF Targets						
			2019/20	2020/21	2021/22	2022/23	2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
Morbidity and premature mortality due to communicable diseases reduced	People living with HIV are tested, initiated on treatment, and retained on care	HIV positive 15-24 years (excl ANC) rate	#	2.9%	1.7%	4.5%	3%	3%	3%	3%	3%	2.8%	2.8%
		Numerator	#	22 715	20 735	100 363	67 000	16 750	16 750	16 750	16 750	63 363	63 363
		Denominator	#	795 984	1 217 412	2 237 930	2 226 036	556 509	556 509	556 509	556 509	2 226 034	2 226 034
	HIV test positive under 5 years (NDoH)	HIV Test positive around 18 months rate	#	#	#	#	0.75%	0.75%	0.75%	0.75%	0.75%	0.75%	0.75%
		Numerator	#	#	#	#	252	63	63	63	63	236	222
		Denominator	#	#	#	#	33 516	8 379	8 379	8 379	8 379	31 504	29 614
	People living with HIV are tested, initiated on treatment, and retained on care	HIV test done-sum	5 174 748	4 355 221	5 014 704	4 629 388	4 857 196	1 214 299	2 428 598	3 642 897	4 857 196	4 629 388	4 208 536
		ART adults remain in care rate (12 months)	#	#	#	90%	90%	90%	90%	90%	90%	90%	90%
		Numerator	#	#	#	56 836	70 488	17 622	17 622	17 622	17 622	77 690	77 690
		Denominator	#	#	#	63 100	78 292	19 573	19 573	19 573	19 573	86 221	86 221
		ART child remain in care rate (12 months)	#	#	#	90%	90%	90%	90%	90%	90%	90%	90%
		Numerator	#	#	#	488	492	123	123	123	123	590	685
		Denominator	#	#	#	544	544	136	136	136	136	655	760

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual Performance			Estimated Performance	MTEF Targets						
			2019/20	2020/21	2021/22	2022/23	2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
		ART Adult viral load suppressed rate (12 months)	#	88.1%	90.8%	90%	95%	95%	95%	95%	95%	95%	95%
		Numerator	#	156 945	57 696	180 958	210 956	52 739	52 739	52 739	52 739	230 959	230 959
		Denominator	#	178 222	63 511	201 064	221 172	55 293	55 293	55 293	55 293	243 287	243 287
		ART Child viral load suppressed rate (12 months)	#	66.7%	64.6%	90%	90%	90%	90%	90%	90%	90%	90%
		Numerator	#	1 955	698	4 988	4 992	1 248	1 248	1 248	1 248	5 420	5 420
		Denominator	#	2 934	1 080	5 544	5 544	1 386	1 386	1 386	1 386	6 000	6 000
Morbidity and premature mortality due to communicable diseases reduced	TB cases are detected and successfully treated	All DS-TB client lost to follow-up rate	9.4%	8.7%	8.3%	5.5%	5.5%	5.5%	5.5%	5.5%	5.5%	5.5%	5.5%
		Numerator	3 216	2 736	1 853	1 928	1 928	482	482	482	482	1 727	1 727
		Denominator	34 101	31 366	22 327	34 800	34 800	8 700	8 700	8 700	8 700	31 352	31 352
		All DS-TB Client Treatment Success Rate	81.6%	83.5%	82.1%	90%	90%	90%	90%	90%	90%	90%	90%
		Numerator	27 955	26 184	18 328	31 324	34 456	8 614	8 614	8 614	8 614	37 902	37 902
		Denominator	34 101	31 366	22 327	34 800	38 280	9 570	9 570	9 570	9 570	42 108	42 108
		All DS-TB client death rate	7.1%	7.4%	#	5.5%	5.5%	5.5%	5.5%	5.5%	5.5%	5.5%	5.5%
		Numerator	2 400	2 312	#	1 412	1 916	479	479	479	479	1 916	1 970
		Denominator	34 101	31 366	#	25 492	34 800	8 700	8 700	8 700	8 700	34 800	35 800

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual Performance			Estimated Performance	MTEF Targets						
			2019/20	2020/21	2021/22	2022/23	2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
Morbidity and premature mortality due to communicable diseases reduced	Rifampicin resistant/ Multidrug - Resistant treatment success	Rifampicin resistant/ Multidrug - Resistant treatment success rate	#	#	#	#	62%	62%	62%	62%	62%	64%	65%
		Numerator	#	#	#	#	472	118	118	118	118	490	495
		Denominator	#	#	#	#	764	191	191	191	191	767	767
	TB Rifampicin resistant/ Multidrug - Resistant lost to follow-up	TB Rifampicin resistant/Multidrug - Resistant lost to follow-up rate	#	#	#	#	16%	16%	16%	16%	16%	15%	14%
		Numerator	#	#	#	#	124	31	31	31	31	118	111
		Denominator	#	#	#	#	776	194	194	194	194	767	767
	TB Pre-XDR treatment success	TB Pre-XDR treatment success rate	#	#	#	#	64%	64%	64%	64%	64%	65%	65%
		Numerator	#	#	#	#	28	7	7	7	7	28	28
		Denominator	#	#	#	#	44	11	11	11	11	43	43
	TB Pre-XDR loss to follow up	TB Pre-XDR loss to follow up rate	#	#	#	#	10%	10%	10%	10%	10%	8%	8%
		Numerator	#	#	#	#	4	1	1	1	1	4	4
		Denominator	#	#	#	#	40	10	10	10	10	52	52

5.4.3. EXPLANATION OF PLANNED PERFORMANCE OVER THE MEDIUM-TERM PERIOD

To reduce burden of HIV/AIDS and TB, the Department will continue to focus on Implementation of the UNAIDS 90-90-90 strategy for HIV, TB and Non-Communicable Diseases. The critical aspects of the strategy will be customized to include the following interventions whose aim is to curb HIV and TB related mortality and morbidity:

- Revitalization of the HCT campaign through our fixed health facilities and use of 113 contracted NPO's who will support the provision of HCT services, focusing on highest risk key populations namely Sex Workers, Drug Users, LGBTIQ community and vulnerable populations (Children, pregnant women, mine workers, truck drivers, adolescent and young women and men). During these HCT campaigns, targeted testing and TB screening will also be conducted to identify people with HIV and TB who need treatment. Index testing has also been introduced with the aim to expand access of care for the potentially infected contacts. Self-testing packs have also been introduced to improve status awareness.
- We will continue to conduct universal test and treat with the aim to intensify ARV rollout to initiate more people on ART treatment
- Adherence to treatment will be encouraged through enrolment of stable clients on the CMDD programme and adherence clubs thereby decongesting health facilities and those who are not stable on treatment will access fast queues at health facilities including the welcome back strategy for those lost to follow-up
- Interventions related to viral load suppression for children includes implementation of the paediatric and adolescent matrix through integration of HIV, Maternal and District health services to ensure that every child accessing care can be screened for HIV upon consent by the caregiver and support of those that are already on treatment.
- For every tested client diagnosed with TB, they shall be placed on treatment. The Department has appointed 48 Nurses and TB Caucus was launched in March 2022 to lead the TB response and curb loss to follow-up by Legislators. The TB Health Check is being used for TB self-screening. TB recovery plan was developed to fast tract and close the gaps caused by Covid19 and further improve TB performance.
- Various mobile devices have been introduced amongst community health workers to support loss to follow-up tracing for both HIV and TB clients. The Covid 19 household tracing response shall be integrated onto the existing TB and HIV screening services
- Various programme evaluations will be introduced to assess effectiveness of the interventions and adjust where required.

5.4.4. UPDATED KEY RISKS AND MITIGATING FACTORS FROM THE SP

Outcome	Risk	Mitigating factors
Morbidity and Premature mortality due to Communicable diseases reduced	Inability to manage and curb communicable/non-communicable diseases	• Implementation of health behaviour change strategies to prevent diseases and promote healthy lifestyle • Provide health education programmes on the importance of medication adherence • Implement guidelines on TB and HIV • Conduct tracing for loss to follow-up. • Conduct training/ Workshop to traditional health practitioners and faith-based leaders on the consequence late presentation of patients to the hospital.

5.5. Sub-Programme: Maternal, Child and Women's Health & Nutrition (MCWH&N)

Purpose of the Programme: To protect and promote the health of mothers, children, adolescents and women in the province through free healthcare for pregnant women and children, reduction of morbidity and mortality from preventable diseases,

- Including implementation of comprehensive immunisation programme, integrated school health programme, improved nutrition, health education for priority issues, increased and enhanced reproductive health services, development of comprehensive women' health services,
- Including prevention of breast and cervical cancers and provision of contraceptive and fertility planning and termination of pregnancy services, effective measures against HIV and AIDS and sexually transmitted infections and redirected training and education for health workers and rendering a nutrition services aimed at specific target groups through combining direct and indirect interventions to address malnutrition, including obesity.

5.5.1. MATERNAL, CHILD AND WOMEN'S HEALTH & NUTRITION (MCWH&N) PROGRAMME OUTCOMES, OUTPUTS, OUTPUT INDICATORS AND TARGETS

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual Performance			Estimated Performance	MTEF Targets						
			2019/20	2020/21	2021/22	2022/23	2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
Maternal, neonatal, infant and child Mortality Reduced	Coverage of Family planning services increased	Couple year protection rate	44%	45.3%	37.8%	42%	43%	43%	43%	43%	43%	45%	44%
		Numerator	175 352	1 825 479	1 766 617	176 565	180 772	45 193	45 193	45 193	45 193	189 177	186 000
		Denominator	397 208	4 028 597	4 669 276	420 393	420 396	105 099	105 099	105 099	105 099	420 393	420 393
	Teenage pregnancy managed at appropriate level of care	Delivery in 10 to 19 years in facility rate	7.5%	8.9%	9.1%	10%	10%	10%	10%	10%	10%	10%	10%
		Numerator	15 882	20 250	20 877	22 663	22 664	5 666	5 666	5 666	5 666	22 100	22 100
		Denominator	210 544	226 633	230 102	226 633	226 636	56 659	56 659	56 659	56 659	226 633	226 633
	Antenatal care visits before 20 weeks increased	Antenatal 1st visit before 20 weeks rate	66.5%	63.3%	66.8%	68%	70%	70%	70%	70%	70%	70%	70%
		Numerator	180 229	164 576	167 110	176 750	180 948	45 237	45 237	45 237	45 237	182 346	182 346
		Denominator	271 224	259 926	250 160	259 926	259 928	64 982	64 982	64 982	64 982	259 926	259 926
	Institutional Maternal Mortality Ratio reduced	Maternal Mortality in facility ratio	102.9 /100 000 live births	118.7	129.3	116	116	Annual			116	113	113
		Numerator	#	294	309	278	278				278	270	270
		Denominator	#	247 755	238 933	238 749	238 749				238 749	238 749	238 749

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual Performance			Estimated Performance	MTEF Targets						
			2019/20	2020/21	2021/22	2022/23	2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
Maternal, neonatal, infant and child Mortality Reduced	Improved management of neonates	Live birth under 2500g in facility rate	#	13%	14%	12.5%	12.5%	12.5%	12.5%	12.5%	12.5%	12%	11.5%
		Numerator	#	31 005	32 010	29 844	29 844	7 461	7 461	7 461	7 461	7 162	27 456
		Denominator	#	238 749	229 179	238 748	238 748	59 687	59 687	59 687	59 687	59 687	238 749
	Postnatal care coverage increased	Mother postnatal visit within 6 days rate	85.5%	75%	74.7%	80%	80%	80%	80%	80%	80%	81%	87%
		Numerator	180 000	169 959	171 907	181 308	181 308	45 327	45 327	45 327	45 327	184 000	197 171
		Denominator	210 544	226 633	230 102	226 632	226 636	56 659	56 659	56 659	56 659	226 633	226 633
	Neonatal death reduced	Neonatal death in facility rate	12.4 1 000 live births	13.2	14.3	12	12	Annual			12	11	11
		Numerator	#	3 161	3 283	2 865	2 865				2 865	2626	2626
		Denominator	#	238 749	229 179	238 749	238 749				238 749	238 749	238 749
	Infant PCR test positive under 5 years	Infant PCR test positive around 6 months rate	#	#	#	#	0.75%	0.75%	0.75%	0.75%	0.75%	0.75%	0.75%
		Numerator	#	#	#	#	252	63	63	63	63	236	222
		Denominator	#	#	#	#	33 516	8 379	8 379	8 379	8 379	31 504	29 614
	Epidemics / occurrences of communicable diseases reduced	Immunisation under 1 year coverage	88.5%	85%	88%	90%	90%	90%	90%	90%	90%	95%	95%
		Numerator	227 222	217 717	232 031	235 176	235 176	58 794	58 794	58 794	58 794	248 405	248 405
		Denominator	256 733	255 530	263 761	261 310	261 312	65 328	65 328	65 328	65 328	261 310	261 310
		Measles 2nd dose 1 year coverage	79.9%	77.8%	83.2%	88%	92%	92%	92%	92%	92%	92%	92%
		Numerator	205 414	198 630	219 008	230 112	240 408	60 102	60 102	60 102	60 102	241 000	241 000
		Denominator	256 733	254 832	263 306	261 312	261 312	65 328	65 328	65 328	65 328	261 310	261 310

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual Performance			Estimated Performance	MTEF Targets						
			2019/20	2020/21	2021/22	2022/23	2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
Maternal, neonatal, infant and child Mortality Reduced	Child under 5 years mortality reduced	Child under 5 years diarrhoea case fatality rate	1.7%	2.7%	1.8%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.3%	2.3%
		Numerator:	88	70	102	64	64	16	16	16	16	60	60
		Denominator:	5 191	2 603	5 521	2 604	2 604	651	651	651	651	2 603	2 603
		Child under 5 years pneumonia case fatality rate	1.8%	2.3%	1.5%	2.2%	2.2%	2.2%	2.2%	2.2%	2.2%	2%	2%
		Numerator:	116	98	98	94	96	24	24	24	24	86	86
		Denominator:	6 532	4 269	6 634	4 268	4 268	1 067	1 067	1 067	1 067	4 269	4 269
	Severely malnourished children managed per prescribed treatment protocols on care	Child under 5 years Severe acute malnutrition case fatality rate	#	#	#	7%	7%	7%	7%	7%	7%	7%	7%
		Numerator:	#	#	#	68	68	17	17	17	17	69	69
		Denominator:	#	#	#	980	980	245	245	245	245	980	980
Maternal, neonatal, infant and child Mortality Reduced	Under 5 deaths reduced	Death under 5 against live birth rate	#	1.7%	1.9%	1.6%	1.6%	1.6%	1.6%	1.6%	1.6%	1.4%	1.4%
		Numerator:	#	3 979	4 293	3 688	3 688	922	922	922	922	3 320	3 320
		Denominator:	#	238 749	229 179	230 416	230 416	57 604	57 604	57 604	57 604	230 417	230 417
	Nutritional needs of children under 5 taken care of	Vitamin A dose 12–59 months coverage	52.6%	47.5%	57.1%	53%	55%	55%	55%	55%	55%	57%	57%
		Numerator:	1 067 632	961 292	1 195 043	1 070 876	1 111 288	277 822	277 822	277 822	277 822	1 151 698	1 151 698
		Denominator:	2 026 062	1 010 832*2	2 091 512	2 020 520	2 020 520	505 130	505 130	505 130	505 130	2 020 520	2 020 520
Morbidity and Premature mortality due to non-Communicable diseases reduced by 10%	School Grade 1 and 8 learners screened	School Grade 1 learners screened	74 222	17 922	54 561	40 000	50 000	Annual			50 000	60 000	60 000
		School Grade 8 learners screened	54 357	4 944	35 305	20 000	25 000	Annual			25 000	30 000	30 000

5.5.2 EXPLANATION OF PLANNED PERFORMANCE OVER THE MEDIUM-TERM PERIOD

I. Increased community participation in sexual reproductive health and rights (including reduction in partner violence in pregnancy) mother and child advocacy to inform healthcare users / patients of Primary Health Care clinics as entry points to health services to avoid influx to Tertiary Hospitals through:

1. Ward-based Meetings.
2. Community and National Radio slots.
3. Thursday Women Church Services – Health Committees.
4. Upscale of MomConnect.

ii. Provide 24-hour maternity service in all Community Health Centres / Midwife-Obstetric Units and District Hospitals;

iii. Provide Onsite Maternity Birthing Units (OMBU) in selected hospitals

iv. Health Promotion by encouraging population to know own health status, identify and prevent childhood obesity, disease, and non-communicable disease prevention and rehabilitation.

v. Subsidize Early Childhood Development Centres with the aim of reducing hunger and prevention of Severe Acute Malnutrition and strengthen partnership with Gauteng Department of Social Development, Gauteng Department of Education, Gauteng Department of Agriculture and SASSA.

vi. Standardisation of healthcare through treatment protocols, skilled personnel, appropriate equipment and health technology.

vii. Reduce child and women mortality and morbidity including those with disability by fostering the environment that enable healthy choices and achieve universal health coverage, taking Soft-Cross-Border threats into consideration.

viii. Provision of sexual reproductive health and rights (including maternity services) that is responsive to the needs of people living with disability.

ix. Monitoring of the impact of COVID-19 in the provision of services and reduction of morbidity and mortality relating to Maternal, Neonatal and Child Health, Human Genetic Services, Integrated School Health Programme, Expanded Programme on Immunisation, Surveillance of Vaccine Preventable Diseases, Adolescent, Youth, Woman's Health and Nutrition; and

x. Improvement to contraception and fertility planning services in the context of current COVID-19 restrictions and regulations.

5.5.3. UPDATED KEY RISKS AND MITIGATING FACTORS FROM THE SP

Outcome	Risk	Mitigating factors
Maternal, neonatal, infant and child mortality reduced	Inability to provide effective Maternal and child healthcare access	• Roll out training and development of nurses in midwifery. • Development of business case for modelling health service needs in accordance with population growth. • Enforce referral pathway through Cluster system communication.
Morbidity and premature mortality due to non-communicable diseases reduced by 10%.	Increasing morbidity and mortality	• To embark on HIV, STI, TB and Malaria awareness programmes using various media platforms. Workshop Traditional Health Practitioners and Faith Based Leaders • Train educators and health promoters on morbidity and mortality • Register the request with HRD to increase the number of specialists trained in • clinical specialities.

5.6. Sub-Programme: Disease Prevention and Control

Programme Purpose

- The sub-programme focuses on disease prevention and reduction of morbidity and mortality associated with communicable as well as non-communicable diseases.
- Disease prevention activities are aimed at creating awareness about the disease, education to emphasise disease control, training of health professionals for improved disease management and surveillance to prevent and reduce disease outbreak.

5.6.1. SUB-PROGRAMME: DISEASE PREVENTION AND CONTROL OUTCOMES, OUTPUTS, OUTPUT INDICATORS AND TARGETS

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual Performance			Estimated Performance	MTEF Targets						
			2019/20	2020/21	2021/22	2022/23	2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
Morbidity and premature mortality due to non – communicable diseases reduced by 10%	Eliminate malaria by 2023	Malaria case fatality rate	1.3%	1.2%	1.4%	0.8%	2.3%	0%	1.5%	2%	2.3%	2.3%	2.3%
		Numerator	22	5	13	8	3	0	1	2	3	12	12
		Denominator	1 757	425	941	960	130	33	66	99	130	520	520
Morbidity and premature mortality due to non – communicable diseases reduced by 10%	Diabetes prevalence managed	Normal haemoglobin A1c (HbA1c) test with result ≤ 8% rate	#	#	60%	50%	50%	50%	50%	50%	50%	51%	51%
		Numerator	#	#	175 345	880 000	880 000	220 000	220 000	220 000	220 000	900 000	900 000
		Denominator	#	#	292 623	1 760 000	1 760 000	440 000	440 000	440 000	440 000	1 780 000	1 780 000
	Diabetes prevalence managed	Clients 18-44 years screened for diabetes	#	#	3 522 311	2 670 132	2 937 144	734 286	1 468 572	2 202 858	2 937 144	3 230 857	3 230 857
		Clients 45 and older screened for diabetes	#	#	1 983 685	1 800 000	1 980 000	495 000	990 000	1 485 000	1 980 000	2 178 000	2 178 000
	Hypertension prevalence managed	Clients 18-44 years screened for hypertension	#	#	4 175 071	1 594 539	1 753 992	438 498	876 996	1 315 494	1 753 992	1 929 392	1 929 392
		Clients 45 and older screened for hypertension	#	#	1 791 027	1 600 000	1 760 000	440 000	880 000	1 320 000	1 760 000	1 936 000	1 936 000

Refers to new indicators where baseline data is not collected in that financial year

5.6.2. EXPLANATION OF PLANNED PERFORMANCE OVER THE MEDIUM-TERM PERIOD

The Gauteng Premier has identified key priorities to be implemented by the Department during the remaining term of the sixth administration. Amongst the key priority areas that are service oriented is the need to reduce service queues at medical facilities, introduction of a regulatory arm that will focus on eliminating fake food that is circulating in the shops, incorporation of a Wellness Programme in the Education System and improvement of hospitals in townships and improvement of employee attitudes. The following are amongst other interventions to be implemented:

a. Provide public health response on diagnosis and investigation of health problems and health hazards in the community with focus on the disease prevention and reduction of morbidity and mortality associated with communicable as well as non-communicable diseases.
b. Manage Communicable Diseases and prevent the further spread of communicable diseases including outbreaks.
c. Reduce the prevalence and complications of Non-Communicable Diseases and improving the health and wellbeing of the Older Persons through active aging programmes.
d. Improve quality of life for patients with chronic obstructive airway diseases and implement the Prevention of blindness Programme
e. Strengthen disease surveillance through collection, collation, analysis, interpretation, feedback and action/response mechanism to improve decision making.
f. Strengthen public literacy and health promotion through implementation of health wellness programme, integrated school health and education.
g. Provide community health awareness and wellness programmes in partnership with strategic stakeholders.
h. h. Drive health wellness and healthy lifestyle campaigns to reduce the burden of disease and ill health.
i. Improve mental health through re-prioritisation of mental health services within district health services; and adoption of an intersectoral approach, which involves civil society, business, labour and other sectors to respond to mental health epidemic;
j. Develop policies, Standard Operation Procedures and plans that support individual and community health efforts and
k. Conducting Malaria campaigns within the communities.

5.6.3. PROGRAMME RESOURCE CONSIDERATIONS / BUDGET ALLOCATION

The Budget Allocation for programme and sub-programmes and explanation of the contribution of resources towards achievement of outputs as per EPRE will be submitted with the final 2022/23 Annual Performance Plan as EPRE is still being developed.

TABLE 15: SUMMARY OF PAYMENTS AND ESTIMATES: DISTRICT HEALTH SERVICES

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	2019/20	2020/21	2021/22		2022/23		2023/24	2024/25	2025/26
1. District Management	676 273	826 373	1 226 765	1 191 267	1 054 885	997 381	1 106 118	1 086 251	1 103 930
2. Community Health Clinics	2 365 449	2 475 289	2 559 621	2 724 179	2 856 426	2 808 399	2 810 322	2 876 451	2 932 626
3. Community Health Centres	1 970 765	2 064 122	2 211 791	2 436 121	2 479 863	2 430 740	2 524 083	2 610 644	2 650 464
4. Community Based Services	2 191 503	2 445 328	2 583 098	2 521 215	2 742 671	3 060 483	2 734 575	2 849 132	2 898 571
5. Hiv, Aids	4 862 623	5 986 583	5 995 932	6 530 874	6 886 474	6 886 474	6 039 240	6 375 895	6 657 100
6. Nutrition	58 586	4 591	49 495	72 117	80 335	80 335	75 290	75 290	78 663
7. Coroner Services	245 116	263 857	274 106	329 631	335 720	316 047	328 711	340 410	345 866
8. District Hospitals	3 525 137	3 893 104	4 350 636	4 536 418	4 650 777	4 475 999	4 519 159	4 641 320	4 806 086
Total payments and estimates	**15 895 452**	**17 959 247**	**19 251 444**	**20 341 822**	**21 087 151**	**21 055 858**	**20 137 498**	**20 855 393**	**21 473 306**

TABLE 16: SUMMARY OF PAYMENTS AND ESTIMATES BY ECONOMIC CLASSIFICATION: DISTRICT HEALTH SERVICES

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	2019/20	2020/21	2021/22		2022/23		2023/24	2024/25	2025/26
Current payments	**14 958 811**	**16 896 832**	**18 266 704**	**19 087 097**	**19 792 234**	**19 818 414**	**18 857 530**	**19 567 672**	**20 129 861**
Compensation of employees	8 789 007	10 019 369	11 938 291	11 335 683	11 691 494	12 097 851	11 298 450	11 394 400	11 631 843
Goods and services	6 169 804	6 877 463	6 328 413	7 751 414	8 100 740	7 720 563	7 559 080	8 173 272	8 498 018
Interest and rent on land									
Transfers and subsidies to:	**808 032**	**760 127**	**821 714**	**942 120**	**977 187**	**979 399**	**1 002 772**	**1 010 532**	**1 054 168**
Provinces and municipalities	404 259	445 569	441 595	490 515	517 164	517 164	512 480	512 480	535 440
Departmental agencies and accounts									
Non-profit institutions	372 292	285 710	348 704	420 860	429 078	429 078	457 718	461 524	482 200
Households	31 481	28 848	31 415	30 745	30 945	33 157	32 574	36 528	36 528
Payments for capital assets	**127 266**	**302 272**	**162 347**	**312 605**	**317 730**	**255 702**	**277 196**	**277 189**	**289 277**
Buildings and other fixed structures									
Machinery and equipment	127 266	302 272	162 347	312 605	317 730	255 702	277 196	277 189	289 277
Software and other intangible assets									
Payments for financial assets	**1 343**	**16**	**679**			**2 343**			
Total economic classification	**15 895 452**	**17 959 247**	**19 251 444**	**20 341 822**	**21 087 151**	**21 055 858**	**20 137 498**	**20 855 393**	**21 473 306**

The total budget of the programme decreases slightly by R204.3 million from a main appropriation of R20.3 billion in 2022/23 to R20.1 billion in the 2023/24 financial year. The programme is funded through allocation of the District Health Programmes grant which has two components: the District Health component and the Comprehensive HIV/AIDS component. The Community Outreach Programme and the Human Papillomavirus programme have been merged and renamed the District Health component from the 2022/23 financial year and funding for COVID-19 programme has been discontinued. The HIV/AIDS programme and the Tuberculosis programme were merged and renamed the Comprehensive HIV/AIDS component. An overall R501.9 million decrease is realised in the 2023/24 financial year on the District Health Programmes grant. The Health Professions Contracting and Mental Health Services were merged and renamed National Health Insurance.

Increases within the Community Health Centres and Community Based Services sub-programmes are due to additional funds made available to enable broadening of access to quality public healthcare by implementing the 24-hour extension of services within the community health centres. Strengthening of district mental healthcare services has been allocated additional funds to implement the three types of mental health teams: district specialist mental healthcare, clinical community psychiatric and NGO governance compliance teams.

The baseline allocation still prioritises implementation of the 24-hour extension of community health services as well as strengthening mental healthcare services.

Over the 2023 MTEF, the allocation for goods and services decreases slightly from R7.7 billion in 2022/23 to R7.5 billion in the 2023/24 financial year. This allocation is earmarked for, amongst others, purchasing of medicine, medical supplies, and laboratory services. This programme will embark on public education aimed at promoting the utilisation of primary healthcare facilities as a measure to decongest hospitals which offer higher levels of care. The public will through this programme be encouraged to consult clinics and community health centres before going to hospitals.

5.6.4. UPDATED KEY RISKS AND MITIGATING FACTORS FROM THE SP

Outcome	Risk	Mitigating factors
Morbidity and premature mortality due to non-communicable diseases reduced by 10%.	Inability to manage and curb communicable/non-communicable diseases leading to Increasing morbidity and mortality	• Implement health behaviour change strategies (health education, promotion, happiness, health communication, healthy lifestyle adherence) • Motivate for funding and filling of vacant positions and train educators and health promoters up to specialist level • To increase the number of patients accessing services from the adherence club and from external pick-up points • Embark on awareness programme using various media platforms • Procure equipment (renal dialysis machines, radiation oncology equipment) to address the demand in the burden of disease aligned with available funds • Provide health education programmes on the importance of medication adherence
	Unpredictable torrential rain and flush flooding	• Provide continuous Malaria risk communication messages
Morbidity and Premature mortality due to Communicable diseases reduced COVID 19	COVID 19 Prolongation of the pandemic	• Preparations and continuous planning for a sustained pandemic

5.7. Budget Programme 3: Emergency Medical Services (EMS)

Programme Purpose

- To render pre-hospital Emergency Medical Services, including Inter-Hospital Transfers and Planned Patient Transport services.
- The program is divided into two categories which are 3a (emergency Service Transport and 3b (Planned Patient Transport)

Emergency Service Transport (EST)

- Rendering Emergency Medical Services including Special Operations, Communications and Air Ambulance services.

This entails the following service delivery units that are used to render emergency services.

- Emergency Ambulances
- Primary Response vehicles
- Medical Rescue vehicles
- Disaster Management and Special Operations
- Emergency Communication Centre
- Events Management

Planned Patient Transport (PPT)

Rendering Planned Patient Transport including Scheduled Emergency Transport for Outpatient Transport (within the boundaries of a given town or local area), Inter-City/Town Outpatient Transport (Into referral centres) and between health facilities.

This entails the following service delivery units that are used to render emergency services.

- Planned Patient Transport
- Gauteng Scheduled Emergency Transport
- Inter Facility Transport
- Intensive Care Transport

The program performance and effectiveness is measured by using the response times as a guide.

The response times are defined as follows: the time when the caller started to call the emergency communication centre until the time an emergency services vehicle arrives on scene.

5.7.1. EMERGENCY MEDICAL CERVICES (EMS) OUTCOMES, OUTPUTS, OUTPUT INDICATORS AND TARGETS

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual Performance			Estimated Performance	MTEF Targets						
			2019/20	2020/21	2021/22	2022/23	2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
Coordinating health services across the care continuum, re-orientating the health system towards primary health care	EMS response time improved	EMS P1 urban response under 30 minutes rate	82.8%	95.8%	83%	84%	85%	85%	85%	85%	85%	85%	85%
		Numerator:	#	7 570	10 450	1 532	6 852	1 713	1 713	1 713	1 713	6 849	6 849
		Denominator:	#	7 903	12 594	1 832	8 060	2 015	2 015	2 015	2 015	8 058	8 058
		EMS P1 rural response under 60 minutes rate	100%	94.4	94.6%	100%	100%	100%	100%	100%	100%	100%	100%
		Numerator:	#	118	106	205	300	75	75	75	75	300	400
		Denominator:	#	125	112	205	300	75	75	75	75	300	400
		EMS P1 urban inter-facility transfer (IFT) under 30 minutes rate	#	#	#	#	85%	85%	85%	85%	85%	85%	86%
		Numerator:	#	#	#	#	1 532	383	383	383	383	1 532	1 632
		Denominator:	#	#	#	#	1 812	453	453	453	453	1 800	1 900
		EMS P1 rural inter-facility transfer (IFT) under 60 minutes rate	#	#	#	#	100%	100%	100%	100%	100%	100%	100%
		Numerator:	#	#	#	#	300	75	75	75	75	300	400
		Denominator:	#	#	#	#	300	75	75	75	75	300	400
		EMS all calls with response under 60 minutes rate	#	#	#	#	98%	98%	98%	98%	98%	97%	97%
		Numerator:	#	#	#	#	566 440	141 610	283 220	424 830	566 440	593 333	593 333
		Denominator:	#	#	#	#	580 284	145 071	290 142	435 213	580 284	611 982	611 982

5.7.2. EXPLANATION OF PLANNED PERFORMANCE OVER THE MEDIUM-TERM PERIOD

- Investment in intensive care ambulances and specialized equipment to deal with complicated critical cases in the prehospital environment.
- Establish a 'Health Uber' to improve Planned Patient Transport, as well as telemedicine consultations.
  - Improve EMS infra-structure standards: o Along with Department of Infrastructure Development (DID) construct purpose-built EMS stations as per statutory legislation i.e., Occupational Health and Safety and other applicable legislative acts and regulations, EMS Regulations, and Ideal EMS Framework (IEF).
  - Along with Department of Infrastructure Development (DID) improve condition of current EMS stations as per statutory legislation i.e., Occupational Health and Safety and other applicable legislative acts and regulations, EMS Regulations, and Ideal EMS Framework (IEF).

- Improve EMS Standards: Recruitment, retention and investment in skilled human resource capital.
  - Promote proactive programmes related to Public Information Education and Relations by ensuring prevention and awareness through targeted training of Primary, Secondary, Leaners and Educators, in schools across the province.
  - Improve education and training of EMS staff through the Provincial EMS College, by transforming the EMS operational staff skills mix and qualifications, in line with NECET policy, viz: Emergency Care Assistant (ECA) Diploma in Emergency Care (DEC).
  - Invest in versatile ambulances and special operations vehicles and resources, i.e. all terrain ambulances and specialised special operations vehicles and equipment that will enable continuity of service delivery for special operations

- Finalise integration of vehicle tracking and the roll-out of electronic Care Report (ePCR), with Revenue Management Billing, Inventory Management and real-time Data Management.
- Finalise Private Ambulance Service tender for Aeromedical
  - Body Warn Cameras
  - Under safety garments
  - Tactical Medicine Unit
  - Installation of surveillance equipment in EMS vehicles
  - Community buy-in through PIER

- Improve and review infectious diseases standard operating procedures (SOP's) related mobility and mortality through:
  - Ongoing review of available EMS capacity to meet growing demand for pre-hospital services.
  - Ongoing review of available EMS capacity to meet growing demand for pre-hospital services.

5.7.3. PROGRAMME RESOURCE CONSIDERATIONS / BUDGET ALLOCATION

TABLE 17: SUMMARY OF PAYMENTS AND ESTIMATES: EMERGENCY MEDICAL SERVICES

	Outcome			Main appropriation	Adjusted	Revised estimate	Medium-term estimates		
R thousand	2019/20	2020/21	2021/22		2022/23		2023/24	2024/25	2025/26
1. Emergency Transport	1 424 067	1 531 680	1 151 058	1 352 912	1 501 919	1 796 755	1 470 724	1 511 795	1 529 048
2. Planned Patient Transport	115 714	149 121	280 633	276 772	293 181	272 843	307 390	314 544	324 934
Total payments and estimates	**1 539 781**	**1 680 801**	**1 431 691**	**1 629 684**	**1 795 100**	**2 069 598**	**1 778 114**	**1 826 339**	**1 853 982**

TABLE 18: SUMMARY OF PAYMENTS AND ESTIMATES BY ECONOMIC CLASSIFICATION: EMERGENCY MEDICAL SERVICES

	Outcome			Main	Adjusted	Revised estimate	Medium-term estimates		
R thousand	2019/20	2020/21	2021/22		2022/23		2023/24	2024/25	2025/26
Current payments	**845 924**	**1 006 360**	**1 135 040**	**1 383 193**	**1 501 354**	**1 469 883**	**1 459 711**	**1 507 936**	**1 530 614**
Compensation of employees	620 939	757 890	899 602	900 147	1 003 544	1 015 981	1 006 480	1 049 705	1 070 825
Goods and services	223 621	248 470	235 389	483 046	497 810	453 902	453 231	458 231	459 789
Interest and rent on land	1 364		49						
Transfers and subsidies to:	**303 244**	**76 019**	**1 515**	**3 805**	**3 805**	**3 991**	**8 403**	**8 403**	**8 780**
Provinces and municipalities	301 135	74 920							
Non-profit institutions									
Households	2 109	1 099	1 515	3 805	3 805	3 991	8 403	8 403	8 780
Payments for capital assets	**390 540**	**598 422**	**295 113**	**242 686**	**289 941**	**595 620**	**310 000**	**310 000**	**314 588**
Buildings and other fixed structures		478							
Machinery and equipment	390 540	597 944	295 113	242 686	289 941	595 620	310 000	310 000	314 588
Payments for financial assets	**73**		**23**			**104**			
Total economic classification	**1 539 781**	**1 680 801**	**1 431 691**	**1 629 684**	**1 795 100**	**2 069 598**	**1 778 114**	**1 826 339**	**1 853 982**

The personnel budget increases by R18.7 million from the main appropriation of R900.1 million in 2022/23 to R1.0 billion in the 2023/24 financial year. The increase is aimed at filling critical EMS posts because of the conclusion of the EMS provincialisation process, the absorption of emergency care technicians trained at Lebone College and to sustain the 3% wage provision made to public servants.

The department will continue to invest in the recapitalisation and replacement of ambulances with the aim of improving response times. Over the medium term, the department will ensure that there is reach and coverage in the areas that were not covered such as Sedibeng, Metsweding, and Rand West. While there is coverage in the suburban areas due to the presence of private ambulances, this programme will spread its reach towards the most vulnerable and deprived locations throughout the province. Therefore, machinery and equipment have an appropriation of R242.6 million in 2022/23 which increases marginally to R310.0 million in the 2023/24 financial year.

5.7.4 UPDATED KEY RISKS AND MITIGATING FACTORS FROM THE SP

Outcome	Risk	Mitigating factors
Quality of health services in public health facilities improved	EMS Regulations – Operational License	To fully comply with EMS Regulations, additional funding will be needed for ensuring EMS Stations compliance EMS Regulations.
	Inadequate capacity at Head Office and District level on Quality Assurance.	Temporary secondment of staff on an ad hoc basis to ensure continuity and optimum functionality of the unit.
	Staff Attrition-Terminations of Advanced Life Support personnel.	Upskilling of current employees on Diploma in Emergency Care. Continuous recruitment of skilled qualified EMS officials in line with EMS Regulations
	Procuring of EMS Head Office and Communications Centre building	Procuring of EMS Head Office and Communications Centre building
	Poor Customer Care skills	Poor Customer Care skills
	Attack on Paramedics	Introduce systems that will assist law enforcement agencies to identify and arrest criminals that attack Paramedics

5.8. Budget Programme 4: Provincial Hospitals

Programme Purpose

Delivery of hospital services, which are accessible, appropriate, effective and provide general specialist services, including a specialized rehabilitation service, as well as a platform for training health professionals and research.

General (Regional) hospitals

- Rendering of hospital services at a general specialist level and a platform for training of health workers and research.

Tuberculosis hospitals

- Convert present Tuberculosis hospitals into strategically placed decentralised sites in which a small percentage of patients may undergo hospitalisation under conditions, which allow for isolation during the intensive level of treatment, as well as the application of the standardized multi-drug resistant (MDR) protocols.

Psychiatric / Mental Hospitals

- Rendering a specialist psychiatric hospital service for people with mental illness and intellectual disability and providing a platform for the training of health workers and research

Sub-acute, Step down and Chronic Medical Hospitals

- These hospitals provide medium to long term care to patients who require rehabilitation and/or a minimum degree of active medical care but cannot be sent home. These patients are often unable to access ambulatory care at our services or their socio-economic or family circumstances do not allow for them to be cared for at home.

Dental Training Hospitals

- Rendering an affordable and comprehensive oral health service and training, based on the primary health care approach.

5.8.1. SUB-PROGRAMME: REGIONAL HOSPITALS OUTCOMES, OUTPUTS, OUTPUT INDICATORS AND TARGETS

Outcome (as per SP 2020/21- 2024/25)	Outputs	Output Indicator	Audited/Actual Performance			Estimated Performance	MTEF Targets					
			2019/20	2020/21	2021/22	2022/23	2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
Maternal, neonatal, infant and child mortality Reduced	Number of women who die in health facilities is reduced	Maternal mortality in facility	#	105	117	100	96	24	48	72	96	95	95
	Death of children under 5 years from diarrheal diseases is reduced	Child under 5 years diarrhoea case fatality rate	#	2.7%	1.6%	2.4%	2.3%	2.3%	2.3%	2.3%	2.3%	2%	2%
		Numerator	#	23	32	24	20	5	5	5	5	21	21
		Denominator	#	851	1 943	1 000	872	218	218	218	218	1 100	1 100
	Death of children under 5 years from pneumonia is reduced	Child under 5 years pneumonia case fatality rate	#	2%	1.1%	2.3%	2.3%	2.3%	2.3%	2.3%	2.3%	2.2%	2.2%
		Numerator	#	34	29	62	64	16	16	16	16	60	60
		Denominator	#	1 667	2 734	2 704	2 752	688	688	688	688	2 740	2 740
	Death of children under 5 years from malnutrition is reduced	Child under 5 years severe acute malnutrition case fatality rate	#	#	#	12%	12%	12%	12%	12%	12%	12%	12%
		Numerator	#	#	#	46	48	12	12	12	12	44	44
		Denominator	#	#	#	390	400	100	100	100	100	380	380
	Death of children under 5 years in health facilities is reduced	[Number of] Death in facility under 5 years	#	1 451	1 614	1 460	1 472	368	736	1 104	1 472	1 480	1 480

Outcome (as per SP 2020/21- 2024/25)	Outputs	Output Indicator	Audited/Actual Performance			Estimated Performance	MTEF Targets					
			2019/20	2020/21	2021/22	2022/23	2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
Quality of health services in public health facilities improved	Patients report positive experience of care	Patients experience of care satisfaction rate	76%	85.69%	84.2%	85.7%	86%	Annual			86%	86%	87%
		Numerator	#	53 029	36 160	53 029	53 320				53 320	53 029	49 800
		Denominator	#	61 880	42 936	61 880	62 000				62 000	61 880	57 244
	Hospitals are ready to deliver quality health care and obtain ideal status	Ideal hospital status obtained rate	0	22.2%	100%	66.7%	66.7%	Annual			66.7%	100%	100%
		Numerator	#	2	9	6	6				6	9	9
		Denominator	#	9	9	9	9				9	9	9
	Adverse events and incidents reported within 24 hours	Severity assessment code (SAC) 1 incident reported within 24 hours rate	#	74.1%	88.6%	60%	95.1%	95.1%	95.1%	95.1%	95.1%	95.1%	95.1%
		Numerator	#	519	728	346	544	136	136	136	136	544	544
		Denominator	#	700	822	573	572	143	143	143	143	572	572
	Patient safety incidents reported and managed timeously	Patient Safety Incident (PSI) case closure rate	50%	74%	81%	65.5%	81.3%	81.3%	81.3%	81.3%	81.3%	81.3%	81.3%
		Numerator	#	917	1 212	720	1 220	305	305	305	305	1 220	1 220
		Denominator	#	1 242	1 497	1 100	1 500	375	375	375	375	1 500	1 500
	All submitted complaints resolved within 25 working days	Complaints resolution within 25 working days rate	#	#	97.1%	96%	95%	95%	95%	95%	95%	95%	95%
		Numerator	#	#	633	628	628	157	157	157	157	628	628
		Denominator	#	#	652	656	664	166	166	166	166	664	664

Outcome (as per SP 2020/21- 2024/25)	Outputs	Output Indicator	Audited/Actual Performance			Estimated Performance	MTEF Targets					
			2019/20	2020/21	2021/22	2022/23	2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
Quality of health services in public health facilities improved	Integration of mental health into mental health services	Percentage of beds in regional hospitals offering acute ill mental health care users (72hrs assessment)	#	1.8%	4.6%	5%	5%	Annual			5%	5%	5%
		Numerator	#	82	207	228	228				228	228	228
		Denominator	#	4 547	4 505	4 547	4 547				4 547	4 547	4 547
Leadership and governance in the health sector enhanced to improve quality of care	Functional governance structures in hospitals	Percentage of hospitals with functional hospital boards	#	0%	75%	100%	100%	100%	100%	100%	100%	100%	100%
		Numerator	#	0	6	9	9	9	9	9	9	9	9
		Denominator	#	7	8	9	9	9	9	9	9	9	9

Refers to new indicators where baseline data is not collected in that financial year

* Refers to numerators and denominated not reflected in Annual Reports

5.8.2. SUB-PROGRAMME: SPECIALISED HOSPITALS OUTCOMES, OUTPUTS, OUTPUT INDICATORS AND TARGETS

Outcome (as per SP 2020/21- 2024/25)	Outputs	Output Indicator	Audited/Actual Performance			Estimated Performance	MTEF Targets					
			2019/20	2020/21	2021/22	2022/23	2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
Quality of health services in public health facilities improved	Patients report positive experience of care	Patients experience of care satisfaction rate	77%	94.6%	92.6%	95.5%	96%	Annual			96%	96%	96%
		Numerator	#	6 326	4 840	6 300	6 304				6 304	6 304	6 304
		Denominator	#	6 683	5 226	6 600	6 600				6 600	6 600	6 600
	Hospitals ready to deliver quality health care	Ideal hospital status obtained rate	#	22.2%	55.6%	77.8%	77.8%	Annual			77.8%	100%	100%
		Numerator	#	2	5	7	7				7	9	9
		Denominator	#	9	9	9	9				9	9	9
	Prompt response to adverse events	Severity assessment code (SAC) 1 incident reported within 24 hours rate	#	66.7%	87.8%	80%	95%	95%	95%	95%	95%	95%	95%
		Numerator	#	12	36	12	76	19	19	19	19	76	76
		Denominator	#	18	41	15	80	20	20	20	20	80	80
	Incidence of harm managed and reduced	Patient Safety Incident (PSI) case closure rate	#	92.5%	98.4%	95%	95%	95%	95%	95%	95%	95%	95%
		Numerator	#	422	551	348	380	95	95	95	95	380	380
		Denominator	#	456	560	368	400	100	100	100	100	400	400
	All submitted complaints resolved within 25 working days	Complaints resolution within 25 working days rate	#	#	94.4%	100%	95%	95%	95%	95%	95%	95%	95%
		Numerator	#	#	84	30	76	19	19	19	19	76	76
		Denominator	#	#	89	30	80	20	20	20	20	80	80
Leadership and governance in the health sector enhanced to improve quality of care	Functional governance structures in hospitals	Percentage of hospitals with functional hospital boards	#	0%	#	100%	100%	100%	100%	100%	100%	100%	100%
		Numerator	#	0	#	6	6	6	6	6	6	6	6
		Denominator	#	6	#	6	6	6	6	6	6	6	6

Refers to new indicators where baseline data is not collected in that financial year
* Refers to numerators and denominated not reflected in Annual Reports

5.8.3. EXPLANATION OF PLANNED PERFORMANCE OVER THE MEDIUM-TERM PERIOD

- Assess the internal performance of health facilities.
- Improve performance of the Regulated Norms and Standards (NCS) and ideal health facilities (addressing staff attitudes, waiting times, staff morale and minimize litigations).
  - Improve accident and emergency services.
  - Improve surgical services through reduction.
  - Set aside 5% of regional hospitals beds acute ill for mental care users; and
- Patient's experience of care: Positive experience of care will be monitored The focus this year is to ensure that hospitals have systems and processes in place to treat patients within agreed waiting times benchmarks All regional hospitals will be adhering to average waiting time of 160 minutes for P2- patients; average waiting time of 160 minutes for P3 - average waiting time of 160 minutes for P3 – for all patients with acute injuries and pain; the OPD average treatment waiting times below agreed benchmark of 180 minutes. All these hospitals will be monitored through the operational plans to ensure compliance to these benchmarks.

5.8.4 PROGRAMME RESOURCE CONSIDERATIONS / BUDGET ALLOCATION

TABLE 19: SUMMARY OF PAYMENTS AND ESTIMATES: PROVINCIAL HOSPITAL SERVICES

	Outcome			Main	Adjusted	Revised estimate	Medium-term estimates		
R thousand	2019/20	2020/21	2021/22		2022/23		2023/24	2024/25	2025/26
1. General Hospitals	6 735 022	7 414 991	7 998 877	7 960 518	8 105 370	8 195 495	8 199 417	8 533 042	8 911 733
2. Tuberculosis Hospitals	310 335	305 465	321 495	372 917	372 086	369 039	390 450	404 027	422 126
3. Psychiatric/Mental Hospital	1 531 428	1 523 443	1 669 528	1 894 381	2 020 517	1 970 604	1 985 866	2 041 917	2 129 977
4. Dental Training Hospitals	551 622	563 679	603 093	649 930	676 651	676 701	667 965	693 440	723 825
5. Other Specialised Hospitals	96 051	98 272	104 221	108 798	111 834	112 111	113 727	118 043	123 263
Total payments and estimates	**9 224 458**	**9 905 850**	**10 697 214**	**10 986 544**	**11 286 458**	**11 323 950**	**11 357 425**	**11 790 469**	**12 310 924**

TABLE 20: SUMMARY OF PAYMENTS AND ESTIMATES BY ECONOMIC CLASSIFICATION: PROVINCIAL HOSPITAL SERVICES

	Outcome			Main	Adjusted	Revised estimate	Medium-term estimates		
R thousand	2019/20	2020/21	2021/22		2022/23		2023/24	2024/25	2025/26
Current payments	**9 067 916**	**9 719 813**	**10 536 389**	**10 822 675**	**11 099 919**	**11 150 353**	**11 142 090**	**11 588 417**	**12 104 366**
Compensation of employees	6 792 486	7 125 491	7 914 479	8 111 578	8 187 238	8 099 473	7 966 504	8 329 308	8 675 270
Goods and services	2 275 430	2 594 322	2 621 910	2 711 097	2 912 681	3 050 880	3 175 586	3 259 109	3 429 096
Interest and rent on land									
Transfers and subsidies to:	**24 267**	**25 768**	**26 171**	**17 864**	**17 864**	**20 872**	**21 690**	**19 069**	**19 924**
Departmental agencies and accounts									
Non-profit institutions									
Households	24 267	25 768	26 171	17 864	17 864	20 872	21 690	19 069	19 924
Payments for capital assets	**131 708**	**160 269**	**134 144**	**146 005**	**168 675**	**151 412**	**193 645**	**182 983**	**186 634**
Buildings and other fixed structures									
Machinery and equipment	131 708	160 269	133 737	146 005	168 675	151 412	193 645	182 983	186 634
Software and other intangible assets			407						
Payments for financial assets	**567**		**510**			**1 313**			
Total economic classification	**9 224 458**	**9 905 850**	**10 697 214**	**10 986 544**	**11 286 458**	**11 323 950**	**11 357 425**	**11 790 469**	**12 310 924**

This programme received the third largest share of the total departmental budget. The programme budget increases slightly from a main appropriation of R10.9 billion in 2022/23 to R11.3 billion in the 2023/24 financial year. The programme is mainly funded through the equitable share, the National Tertiary Services grant and the Human Resources and Training grant. An amount of R454 million is allocated in the current financial year to sustain and continue with the mental health human resources and mental health contracted beds.

5.8.5. UPDATED RISKS AND MITIGATING FACTORS FROM THE SP

Outcome	Risk	Mitigating factors
Maternal, neonatal, infant and child Mortality Reduced	Maternal, neonatal, infant and child Mortality Reduced	• Roll out training and development of nurses in midwifery. • Development of business case for modelling health service needs in accordance with population growth. • Enforce referral pathway through Cluster system communication.
Quality of health services in public health facilities improved	Failure to implement the National Quality Learning Centre approach	• Implementation of Quality Learning Centres using the Cluster approach
Quality of health services in public health facilities improved	Increasing morbidity and mortality	Increase the number of specialists trained in clinical specialities
Morbidity and premature mortality due to non-communicable diseases reduced by 10%.	Inability to manage and curb communicable/non-communicable diseases	• Utilisation of funds given to procure equipment (renal dialysis machines, radiation oncology equipment) to address the demand in the burden of disease.
Quality of health services in public health facilities improved	Costly legal claims against the Department (Contingency Liability)	• Refer cases of negligence to the Health Professional Council of South Africa for action to be instituted against the member/employee. • Digitalization of record keeping over a period of 2-3 years. • Creation of record keeping lockable areas and scanning of medical records. • Full implementation of the clinical modules • Continue scanning of the paper-based records. • Assigned Integrated Forensic Accounting Services (“IFAS”) and CAJV the investigation of the top law firms that are litigating against the State (for the respective Provinces) on medico-legal matters. • Implementation of onsite-midwife birthing units • Strengthening of District Health Services • Establish Seizure Hubs to clear the backlog of long theatre lists • Conduct training on reading of CTGs by District Clinic Teams • Resuscitations of the Provincial Patient Safety and Medico Legal committee

5.9. Budget Programme 5: Central Hospital Services

Programme Purpose

To provide tertiary health services and creates a platform for the training of health workers through sub- programmes Tertiary and Central hospitals.

Provincial Tertiary hospital services sub-programme

- Render general specialist and tertiary health services on a national basis and maintaining a platform for the training of health workers and research.

Central hospitals sub-programme

- Render a highly specialised medical health and quaternary services on a national basis and a platform for the training of health workers and research.

5.9.1. CENTRAL HOSPITALS PROGRAMME OUTCOMES, OUTPUTS, OUTPUT INDICATORS AND TARGETS

Outcome (as per SP 2020/21- 2024/25)	Outputs	Output Indicator	Audited/Actual Performance			Estimated	MTEF Targets					
			2019/20	2020/21	2021/22	2022/23	2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
Maternal, neonatal, infant and child mortality reduced	Number of women who die in health facilities reduced	Maternal mortality in facility	#	109	106	96	88	22	44	66	88	86	86
	Less children under 5 years dying from diarrheal diseases	Child under 5 years diarrhoea case fatality rate	#	3.1%	2.8%	2.9%	2.8%	2.8%	2.8%	2.8%	2.8%	2.6%	2.6%
		Numerator:	#	26	42	36	32	8	8	8	8	31	31
		Denominator:	#	838	1 483	1 260	1 144	286	286	286	286	1 192	1 192
	Less children under 5 years dying from pneumonia	Child under 5 years pneumonia case fatality rate	#	2.7%	2.5%	3.3%	2.9%	2.9%	2.9%	2.9%	2.9%	2.7%	2.7%
		Numerator:	#	40	48	56	48	12	12	12	12	43	43
		Denominator:	#	1 480	1 926	1 696	1 652	413	413	413	413	1 612	1 612
	Less children dying from malnutrition	Child under 5 years severe acute malnutrition case fatality rate	#	#	#	8%	7.6%	7.6%	7.6%	7.6%	7.6%	7.5%	7.5%
		Numerator:	#	#	#	32	32	8	8	8	8	29	29
		Denominator:	#	#	#	404	420	105	105	105	105	386	386

Outcome (as per SP 2020/21- 2024/25)	Outputs	Output Indicator	Audited/Actual Performance			Estimated	MTEF Targets					
			2019/20	2020/21	2021/22	2022/23	2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
Maternal, neonatal, infant and child mortality reduced	Number of children who die in health facilities reduced	[Number of] Death in facility under 5 years	#	1 646	1 495	1 712	1 732	433	866	1 299	1 732	1 670	1 670
Quality of health services in public health facilities improved	Patients report positive experience of care	Patients experience of care satisfaction rate	75%	84%	86.5%	86.3%	86.5%	Annual			86.5%	86.5%	86.5%
		Numerator:	#	81 424	24 694	85 000	24 694				24 694	24 694	24 694
		Denominator:	#	96 892	28 538	98 500	28 538				28 538	28 538	28 538
Quality of health services in public health facilities improved	Hospitals ready to deliver quality health care	Ideal hospital status obtained rate	#	25%	75%	75%	75%	Annual			75%	100%	100%
		Numerator	#	1	3	3	3				3	4	4
		Denominator	#	4	4	4	4				4	4	4
	All submitted complaints resolved within 25 working days	Complaints resolution within 25 working days rate	#	#	96.1%	95%	95.5%	95.5%	95.5%	95.5%	95.5%	95.5%	95.5%
		Numerator	#	#	618	500	504	126	126	126	126	504	504
		Denominator	#	#	643	528	528	132	132	132	132	528	528
	Prompt response to adverse events	Severity assessment code (SAC) 1 incident reported within 24 hours rate	#	95%	93.4%	95%	95%	95%	95%	95%	95%	95%	95%
		Numerator	#	819	397	740	380	95	95	95	95	380	380
		Denominator	#	862	425	780	400	100	100	100	100	400	400
	Incidence of harm managed and reduced	Patient Safety Incident (PSI) case closure rate	#	67.2%	78.8%	71%	80.5%	80.5%	80.5%	80.5%	80.5%	80.5%	80.5%
		Numerator	#	1 190	1 470	1 020	1 272	318	318	318	318	1 272	1 272
		Denominator	#	1 770	1 865	1 428	1 580	395	395	395	395	1 580	1 580
Leadership and governance in public health facilities enhanced to improve quality of care	Functional governance structure	Percentage of hospitals with functional hospital boards	#	75%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Numerator:	#	3	4	4	4	4	4	4	4	4	4
		Denominator	#	4	4	4	4	4	4	4	4	4	4

5.9.2 CHRIS HANI BARAGWANATH ACADEMIC HOSPITAL PROGRAMME OUTCOMES, OUTPUT INDICATORS AND TARGETS

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual Performance			Estimated Performance	MTEF Targets						
			2019/20	2020/21	2021/22	2022/23	2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
Maternal, neonatal, infant and child mortality reduced	Number of women who die in health facilities reduced	Maternal mortality in facility	#	34	48	30	28	7	14	21	28	27	27
Maternal, neonatal, infant and child mortality reduced	Less children under 5 years dying from diarrheal diseases	Child under 5 years diarrhoea case fatality rate	#	8.4%	6.3%	2.2%	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%
		Numerator	#	16	35	16	12	3	3	3	3	12	12
		Denominator	#	191	560	736	640	160	160	160	160	638	638
	Less children under 5 years dying from pneumonia	Child under 5 years' pneumonia case fatality rate	#	4.4 %	5.5%	3.8%	2%	2%	2%	2%	2%	1.6%	1.6%
		Numerator:	#	11	28	8	4	1	1	1	1	4	4
		Denominator:	#	252	507	212	200	50	50	50	50	252	452
Maternal, neonatal, infant and child mortality reduced	Less children dying from malnutrition	Child under 5 years severe acute malnutrition case fatality rate	#	#	#	16%	16%	16%	16%	16%	16%	13%	13%
		Numerator:	#	#	#	12	12	3	3	3	3	12	12
		Denominator:	#	#	#	76	76	19	19	19	19	92	92
	Number of children who die in health facilities reduced	[Number of] Death in facility under 5 years	#	676	693	560	552	138	276	414	552	550	550
Quality of health services in public health facilities improved	Patients report positive experience of care	Patients experience of care satisfaction rate	67%	83.7%	82.5%	85.1%	85%	Annual			85%	85%	85%
		Numerator:	#	#	8 070	31 500	31 500				31 500	31 500	31 500
		Denominator:	#	#	9 778	37 000	37 000				37 000	37 000	37 000
	All submitted complaints resolved within 25 working days	Complaints resolution within 25 working days rate	#	#	95.9%	95%	95%	95%	95%	95%	95%	95%	95%
		Numerator:	#	#	302	220	220	55	55	55	55	220	220
		Denominator:	#	#	315	232	232	58	58	58	58	232	232

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual Performance			Estimated Performance	MTEF Targets					
			2019/20	2020/21	2021/22	2022/23	2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
Quality of health services in public health facilities improved	Prompt response to adverse events	Severity assessment code (SAC) 1 incident reported within 24 hours' rate	#	100%	82.1%	100%	95%	95%	95%	95%	95%	95%	95%
		Numerator:	#	48	23	48	76	19	19	19	19	76	80
		Denominator:	#	48	28	48	80	20	20	20	20	80	84
Quality of health services in public health facilities improved	Incidence of harm managed and reduced	Patient Safety Incident (PSI) case closure rate	#	99%	87.6%	95.8%	95%	95%	95%	95%	95%	95%	95%
		Numerator:	#	410	750	368	496	124	124	124	124	496	496
		Denominator:	#	414	856	384	520	130	130	130	130	520	520
	Hospitals ready to deliver quality health care	Ideal hospitals status obtained rate	#	0%	N/A	100%	100%	Annual			100%	100%	100%
		Numerator:	#	0	N/A	1	1				1	1	1
		Denominator:	#	1	N/A	1	1				1	1	1
Leadership and governance in public health facilities enhanced to improve quality of care	Functional governance structure	Percentage of hospitals with functional hospital boards	#	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Numerator:	#	1	1	1	1	1	1	1	1	1	1
		Denominator:	#	1	1	1	1	1	1	1	1	1	1

5.9.3. CHARLOTTE MAXEKE JOHANNESBURG ACADEMIC HOSPITAL: PROGRAMME OUTCOMES, OUTPUTS AND TARGETS

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual Performance			Estimated Performance	MTEF Targets					
			2019/20	2020/21	2021/22	2022/23	2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
Maternal, neonatal, infant and child mortality reduced	Number of women who die in health facilities reduced	Maternal mortality in facility	#	27	15	20	16	4	8	12	16	16	16
Maternal, neonatal, infant and child mortality reduced	Less children under 5 years dying from diarrheal diseases	Child under 5 years diarrhoea case fatality rate	#	4.1%	3.4%	4.00%	4%	4%	4%	4%	4%	4%	4%
		Numerator:	#	6	4	4	4	1	1	1	1	4	4
		Denominator:	#	146	118	100	100	25	25	25	25	100	100
	Less children under 5 years dying from pneumonia	Child under 5 years' pneumonia case fatality rate	#	1.2%	2.1%	4.42%	4%	4%	4%	4%	4%	3.98%	3.98%
		Numerator:	#	3	2	20	16	4	4	4	4	18	18
		Denominator:	#	256	96	452	452	113	113	113	113	452	452
	Less children dying from malnutrition	Child under 5 years severe acute malnutrition case fatality rate	#	#	#	5%	5%	5%	5%	5%	5%	5%	5%
		Numerator:	#	#	#	4	4	1	1	1	1	4	4
		Denominator:	#	#	#	80	80	20	20	20	20	80	80
	Number of children who die in health facilities reduced	[Number of] Death in facility under 5 years	#	323	278	552	552	138	276	414	552	600	500
Quality of health services in public health facilities improved	Patients report positive experience of care	Patients experience of care satisfaction rate	69%	77.6%	N/A	81.4%	80%	Annual			80%	80%	80%
		Numerator:	#	16 513	N/A	17 500	17 200				17 200	17 200	17 200
		Denominator:	#	20 73	N/A	21 500	21 500				21 500	21 500	21 500
	All submitted complaints resolved within 25 working days	Complaints resolution within 25 working days rate	#	#	92.6%	96%	95%	95%	95%	95%	95%	95%	95%
		Numerator:	#	#	75	96	84	21	21	21	21	95	95
		Denominator:	#	#	81	100	88	22	22	22	22	100	100

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual Performance			Estimated Performance	MTEF Targets						
			2019/20	2020/21	2021/22	2022/23	2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
Quality of health services in public health facilities improved	Prompt response to adverse events	Severity assessment code (SAC) 1 incident reported within 24 hours rate	60%	53%	88.5%	60%	95%	95%	95%	95%	95%	95%	95%
		Numerator:	#	64	46	60	76	19	19	19	19	76	80
		Denominator:	#	122	52	100	80	20	20	20	20	80	84
Quality of health services in public health facilities improved	Incidence of harm managed and reduced	Patient Safety Incident (PSI) case closure rate	#	18.4%	77.2%	60%	75%	75%	75%	75%	75%	75%	76%
		Numerator:	#	75	166	120	156	39	39	39	39	165	185
		Denominator:	#	408	215	200	208	52	52	52	52	220	245
Leadership and governance in public health facilities enhanced to improve quality of care	Functional governance structure	Percentage of hospitals with functional hospital boards	#	0%	100%	0%	100%	100%	100%	100%	100%	100%	100%
		Numerator:	#	0	1	0	1	1	1	1	1	1	1
		Denominator:	#	1	1	1	1	1	1	1	1	1	1

5.9.4. STEVE BIKO ACADEMIC HOSPITAL: PROGRAMME OUTCOMES, OUTPUTS, OUTPUT INDICATORS AND TARGETS

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual Performance				MTEF Targets						
			2019/20	2020/21	2021/22	2022/23	2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
Maternal, neonatal, infant and child mortality reduced	Number of women who die in health facilities reduced	Maternal mortality in facility	#	11	18	10	12	3	6	9	12	10	10
Maternal, neonatal, infant and child mortality reduced	Less children under 5 years dying from diarrheal diseases	Child under 5 years diarrhoea case fatality rate	#	0	0.32%	3%	3%	3%	3%	3%	3%	3%	3%
		Numerator:	#	0	1	4	4	1	1	1	1	4	4
		Denominator:	#	208	312	126	128	32	32	32	32	150	150
	Less children under 5 years dying from pneumonia	Child under 5 years' pneumonia case fatality rate	#	2.3%	1.8%	2.9%	2.9%	2.9%	2.9%	2.9%	2.9%	2.1%	2.1%
		Numerator:	#	14	12	16	16	4	4	4	4	10	10
		Denominator:	#	604	659	552	552	138	138	138	138	480	480
Maternal, neonatal, infant and child mortality reduced	Less children dying from malnutrition	Child under 5 years severe acute malnutrition case fatality rate	#	#	#	4.8%	3.8%	3.8%	3.8%	3.8%	3.8%	3.3%	3.3%
		Numerator:	#	#	#	8	8	2	2	2	i2	5	5
		Denominator:	#	#	#	168	212	53	53	53	53	150	150
	Number of children who die in health facilities reduced	[Number of] Death in facility under 5 years	#	236	233	200	160	40	80	120	160	110	110

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual Performance				MTEF Targets						
			2019/20	2020/21	2021/22	2022/23	2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
Quality of health services in public health facilities improved	Patients report positive experience of care	Patients experience of care satisfaction rate	84%	91.1%	92.6%	93.3%	93%	Annual			93%	93%	93%
		Numerator:	#	27 126	8 475	28 000	28 000				28 000	28 000	28 000
		Denominator:	#	29 756	9 156	30 000	30 000				30 000	30 000	30 000
	All submitted complaints resolved within 25 working days	Complaints resolution within 25 working days rate	#	#	95.1%	100%	95%	95%	95%	95%	95%	95%	96%
		Numerator:	#	#	97	30	84	21	21	21	21	95	24
		Denominator	#	#	102	30	88	22	22	22	22	100	25
Quality of health services in public health facilities improved	Prompt response to adverse events	Severity assessment code (SAC) 1 incident reported within 24 hours rate	60%	85.7%	76.5%	60%	95%	95%	95%	95%	95%	95%	95%
		Numerator:	#	12	52	12	76	19	19	19	19	76	80
		Denominator:	#	14	68	20	80	20	20	20	20	80	84
Quality of health services in public health facilities improved	Incidence of harm managed and reduced	Patient Safety Incident (PSI) case closure rate	50%	17.8%	31.1%	60%	75%	75%	75%	75%	75%	75%	75%
		Numerator:	#	42	106	120	180	45	45	45	45	180	188
		Denominator:	#	236	341	200	240	60	60	60	60	240	250
Quality of health services in public health facilities improved	Hospitals ready to deliver quality health care	Ideal hospitals status obtained rate	#	100%	N/A	100%	100%	Annual			100%	100%	100%
		Numerator:	#	#	N/A	1	1				1	1	1
		Denominator:	#	#	N/A	1	1				1	1	1
Leadership and governance in public health facilities enhanced to improve quality of care	Functional governance structure	Percentage of Hospitals with functional hospital boards	#	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Numerator:	#	1	1	1	1	1	1	1	1	1	1
		Denominator:	#	1	1	1	1	1	1	1	1	1	1

5.9.5. DR GEORGE MUKHARI ACADEMIC HOSPITAL: PROGRAMME OUTCOMES, OUTPUTS AND TARGETS

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual Performance			Estimated	MTEF Targets					
			2019/20	2020/21	2021/22	2022/23	2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
Maternal, neonatal, infant and child mortality reduced	Number of women who die in health facilities reduced	Maternal mortality in facility	#	37	25	36	32	8	16	24	32	30	30
Maternal, neonatal, infant and child mortality reduced	Less children under 5 years dying from diarrheal diseases	Child under 5 years diarrhoea case fatality rate	#	1.4%	0.41%	2.4%	2.4%	2.4%	2.4%	2.4%	2.4%	2.4%	2.4%
		Numerator:	#	4	2	12	12	3	3	3	3	12	12
		Denominator:	#	293	493	500	504	126	126	126	126	500	500
	Less children under 5 years dying from pneumonia	Child under 5 years' pneumonia case fatality rate	#	3.3%	0.9%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
		Numerator:	#	12	6	12	12	3	3	3	3	12	12
		Denominator:	#	368	664	480	480	120	120	120	120	480	480
Maternal, neonatal, infant and child mortality reduced	Less children dying from malnutrition	Child under 5 years severe acute malnutrition case fatality	#	#	#	10%	10%	10%	10%	10%	10%	10%	10%
		Numerator:	#	#	#	8	8	2	2	2	2	8	8
		Denominator:	#	#	#	80	80	20	20	20	20	80	80
	Number of children who die in health facilities reduced	[Number of] Death in facility under 5 years	#	411	291	400	420	105	210	315	420	410	410
Quality of health services in public health facilities improved	Patients report positive experience of care	Patients experience of care satisfaction rate	80%	75.5%	87.7%	80%	85%	Annual			85%	85%	85%
		Numerator:	#	8 575	8 420	8 000	8 500				8 500	8 500	8 500
		Denominator:	#	11 354	9 601	10 000	10 000				10 000	10 000	10 000
	Hospitals ready to deliver quality health care	Ideal hospital status obtained rate	#	0%	100%	100%	100%	Annual			100%	100%	100%
		Numerator:	#	#	1	1	1				1	1	1
		Denominator:	#	#	1	1	1				1	1	1

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual Performance			Estimated	MTEF Targets						
			2019/20	2020/21	2021/22	2022/23	2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
Quality of health services in public health facilities improved	Prompt response to adverse events	Severity assessment code (SAC) 1 incident reported within 24 hours' rate	60%	97.5%	99.6%	98%	98%	98%	98%	98%	98%	95%	95%
		Numerator:	#	664	276	600	776	194	194	196	196	800	820
		Denominator:	#	681	277	612	792	198	198	198	198	840	860
Quality of health services in public health facilities improved	Incidence of harm managed and reduced	Patient Safety Incident (PSI) case closure rate	40%	96.9%	98.9%	97%	75%	75%	75%	75%	75%	76%	76%
		Numerator:	#	690	448	624	640	160	160	160	160	662	682
		Denominator:	#	712	453	644	850	212	212	212	213	875	900
	All submitted complaints resolved within 25 working days	Complaints resolution within 25 working days rate	#	#	99.3%	95%	95%	95%	95%	95%	95%	95%	95%
		Numerator:	#	#	144	160	160	40	40	40	40	160	160
		Denominator:	#	#	145	168	168	42	42	42	42	168	168
Leadership and governance in public health facilities enhanced to improve quality of care	Community involved and taking responsibility for the delivery of health services	Percentage of hospitals with functional hospital boards	#	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Numerator:	#	1	1	1	1	1	1	1	1	1	1
		Denominator:	#	1	1	1	1	1	1	1	1	1	1

5.9.6. TERTIARY HOSPITALS PROGRAMME OUTCOMES, OUTPUTS, OUTPUT INDICATORS AND TARGETS

Outcome (as per SP 2020/21 2024/25)	Outputs	Output Indicator	Audited/Actual Performance			Estimated	MTEF Targets						
			2019/20	2020/21	2021/22	2022/23	2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
Maternal, neonatal, infant and child mortality reduced	Number of women who die in health facilities reduced	Maternal mortality in facility	#	42	53	32	52	13	26	39	52	50	50
Maternal, neonatal, infant and child mortality reduced	Less children under 5 years dying from diarrheal diseases	Child under 5 years diarrhoea case fatality rate	#	2.7%	1.9%	2.4%	2.4%	2.4%	2.4%	2.4%	2.4%	2.2%	2%
		Numerator:	#	11	12	20	16	4	4	4	4	16	16
		Denominator:	#	411	624	848	668	167	167	167	167	728	800
	Less children under 5 years dying from pneumonia	Child under 5 years' pneumonia case fatality rate	#	2.5%	1.3%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1%	1%
		Numerator:	#	15	10	4	12	3	3	3	3	2	2
		Denominator:	#	611	764	260	800	200	200	200	200	200	200
Maternal, neonatal, infant and child mortality reduced	Less children dying from malnutrition	Child under 5 years severe acute malnutrition case fatality rate	#	#	#	7%	7%	7%	7%	7%	7%	7%	7%
		Numerator	#	#	#	8	12	3	3	3	3	8	8
		Denominator	#	#	#	116	168	42	42	42	42	116	116
	Number of children who die in health facilities reduced	[Number of] Death in facility under 5 years	#	481	524	600	560	140	280	420	560	552	552

Outcome (as per SP 2020/21 2024/25)	Outputs	Output Indicator	Audited/Actual Performance			Estimated	MTEF Targets						
			2019/20	2020/21	2021/22	2022/23	2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
Quality of health services in public health facilities improved	Patients report positive experience of care	Patients experience of care satisfaction rate	74%	83.9%	90.6%	85.5%	90.6%	Annual			90.6%	90.6%	90.6%
		Numerator:	#	23 824	15 496	24 264	15 496				15 496	15 496	15 496
		Denominator:	#	28 389	17 098	28 382	17 098				17 098	17 098	17 098
	Hospitals ready to deliver quality health care	Ideal hospital status obtained rate	#	33.3%	66.6%	100%	100%	Annual			100%	100%	100%
		Numerator:	#	1	2	3	3				3	3	3
		Denominator:	#	3	3	3	3				3	3	3
	All submitted complaints resolved within 25 working days	Complaints resolution within 25 working days rate	#	#	84%	95%	95%	95%	95%	95%	95%	95%	95%
		Numerator:	#	#	442	380	380	95	95	95	95	380	380
		Denominator:	#	#	526	400	400	100	100	100	100	400	400
Quality of health services in public health facilities improved	Prompt response to adverse events	Severity assessment code (SAC) 1 incident reported within 24 hours' rate	#	64.1%	67.6%	64%	95%	95%	95%	95%	95%	95%	95%
		Numerator:	#	270	477	268	380	95	95	95	95	380	380
		Denominator:	#	421	706	420	400	100	100	100	100	400	400
Quality of health services in public health facilities improved	Incidence of harm managed and reduced	Patient Safety Incident (PSI) case closure rate	#	66.9%	76.5%	70%	80%	80%	80%	80%	80%	80%	80%
		Numerator:	#	852	1 712	700	752	188	188	188	188	752	752
		Denominator:	#	1 274	2 237	1 000	940	235	235	235	235	940	940
Leadership and governance in public health facilities enhanced to improve quality of care	Functional governance structures in hospitals	Percentage of hospitals with functional hospital boards	#	66.6%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Numerator:	#	2	3	3	3	3	3	3	3	3	3
		Denominator:	#	3	3	3	3	3	3	3	3	3	3

5.9.7. Explanation of Planned Performance over the Medium-Term Period

- Improve patient experience of care in the public sector through upholding patient's rights, ensuring patient's safety, Occupational Health and Safety compliance and improvement of clinical care; and assess the internal performance of health facilities.
- Patient's experience of care: Positive experience of care will be monitored. If COVID-19 period remains as challenging, continuation with DPOS measure of experience of care will be revisited.
- All tertiary hospitals will be adhering to average waiting time of 160 minutes for P2- patients; average waiting time of 160 minutes for P3 - average waiting time of 160 minutes for P3 – for all patients with acute injuries and pain; the OPD average treatment waiting times below agreed benchmark of 180 minutes. All these hospitals will be monitored through the operational plans to ensure compliance to these benchmarks as well as individualised facility visits.
- All tertiary hospitals will be adhering to average waiting time of 160 minutes for P2- patients; average waiting time of 160 minutes for P3 - average waiting time of 160 minutes for P3 – for all patients with acute injuries and pain; the OPD average treatment waiting times below agreed benchmark of 180 minutes. All these hospitals will be monitored through the operational plans to ensure compliance to these benchmarks as well as individualised facility visits.
- Improve performance of the Regulated Norms and Standards (NCS) and ideal health facilities (addressing staff attitudes, waiting times (Accident and Emergency Departments (A&E) and the Outpatient Department (OPD) treatment waiting times across all hospitals); staff morale and minimize litigations).
- Improve surgical services through reduction of surgical backlog and waiting times for surgical waiting list and oncology by increasing theatre utilisation and limit cancellations; and strengthen cooperation between cluster hospitals, appropriate facilities and maintenance at cluster hospitals.

5.9.8. PROGRAMME RESOURCE CONSIDERATIONS / BUDGET ALLOCATION

TABLE 21: SUMMARY OF PAYMENTS AND ESTIMATES: CENTRAL HOSPITAL SERVICES

	Outcome			Main	Adjusted	Revised estimate	Medium-term estimates		
R thousand	2019/20	2020/21	2021/22		2022/23		2023/24	2024/25	2025/26
1. Central Hospital Services	14 603 682	14 208 556	14 919 462	16 255 479	16 903 002	16 290 099	16 929 989	17 639 804	18 404 730
2. Provincial Tertiary Hospital Services	4 460 759	5 045 496	5 412 196	4 812 760	5 075 882	5 753 542	4 832 146	5 076 155	5 405 747
Total payments and estimates	**19 064 441**	**19 254 052**	**20 331 658**	**21 068 239**	**21 978 884**	**22 043 641**	**21 762 135**	**22 715 959**	**23 810 477**

TABLE 22: SUMMARY OF PAYMENTS AND ESTIMATED BY ECONOMIC CLASSIFICATION: CENTRAL HOSPITAL SERVICE

	Outcome			Main	Adjusted	Revised estimate	Medium-term estimates		
R thousand	2019/20	2020/21	2021/22		2022/23		2023/24	2024/25	2025/26
Current payments	**17 775 367**	**18 315 272**	**19 505 923**	**19 902 956**	**20 586 198**	**21 039 464**	**20 673 771**	**21 600 821**	**22 681 489**
Compensation of employees	11 681 989	12 331 230	13 476 463	13 940 507	14 408 721	14 131 164	13 876 645	14 873 383	15 292 666
Goods and services	6 093 378	5 984 042	6 029 460	5 962 449	6 177 477	6 908 300	6 797 126	6 727 438	7 388 823
Interest and rent on land									
Transfers and subsidies to:	**381 490**	**369 149**	**335 981**	**349 344**	**349 344**	**349 344**	**363 749**	**390 523**	**390 523**
Departmental agencies and accounts									
Non-profit institutions	300 000	317 000	282 000	299 000	299 000	299 000	315 000	329 000	329 000
Households	81 490	52 149	53 981	50 344	50 344	50 344	48 749	61 523	61 523
Payments for capital assets	**906 391**	**569 631**	**489 322**	**815 939**	**1 043 342**	**653 439**	**724 615**	**724 615**	**738 465**
Buildings and other fixed structures									
Machinery and equipment	906 391	569 631	489 322	815 939	1 043 342	653 439	724 615	724 615	738 465
Software and other intangible assets									
Payments for financial assets	**1 193**		**432**			**1 394**			
Total economic classification	**19 064 441**	**19 254 052**	**20 331 658**	**21 068 239**	**21 978 884**	**22 043 641**	**21 762 135**	**22 715 959**	**23 810 477**

This programme receives the largest share of the total departmental budget as it caters for the largest hospitals in the country whose related budget for operations is significant. The programme budget increases from a main appropriation of R21.0 billion in 2023/24 to R21.7 billion in the 2023/24 financial year. The programme is mainly funded through the National Tertiary Services conditional grant and the Human Resources and Training and Grant.

The compensation of employees' budget in the programme decreases from R13.9 billion in 2022/23 to R13.8 billion in the 2023/24 financial year because of reduced retention of existing COVID-19 human resource capacity.

Goods and services show an increase from the R5.9 billion in 2022/23 to R6.7 billion in 2023/24; the increase is attributable to funding to augment medical supplies, medicine and consumable supplies. Further allocation was made towards reduction of radiation (oncology) backlog in facilities.

5.9.9. UPDATED KEY RISKS AND MITIGATING FACTORS FROM THE SP

Outcome	Risk	Mitigating factors
Quality of health services in public health facilities improved	Failure to provide quality care services	• Analysis of the data to reduce the waiting times and implement the identified deficiencies. • Training of Queue Marshals • Development and implementation of a waiting times measuring tool. • Assessment and monitoring of adverse events in all facilities. • Pilot assessment using the Ideal Hospital Electronic Tool and Development of a quality improvement plan on the remedial action emanating from the plan. • Automation of collection of chronic medication at medication through Telemedicine and E-Health. • Implementation of Covid-19 Memorandum of Understanding for enabling public patients to access beds at private hospitals at an agreed fee. • Revive the hospital cluster system managed by the Central hospital. • Implementation of the PMDS and the recruitment, retention of critical skills. • Establishment of Cost Centres and Functional Business Units. • Review of the Delegation Framework.
Quality of health services in public health facilities improved	Increasing morbidity and mortality	• Increase the number of specialists trained in clinical specialties.
Maternal, neonatal, infant and child mortality reduced	Inability to provide effective Maternal and child healthcare access. (MCWH	• Roll out training and development of nurses in midwifery. • Development of business case for modelling health service needs in accordance with population growth. • Enforce referral pathway through Cluster system communication.
Morbidity and premature mortality due to non-communicable diseases reduced by 10%.	Inability to manage and curb communicable/non-communicable. diseases	• Utilisation of funds given to procure equipment (renal dialysis machines, radiation oncology equipment) to address the demand in the burden of disease.
Quality of health services in public health facilities improved	Costly legal claims against the Department (Contingency Liability)	• Digitalization of record keeping over a period of 2-3 years. • Scanning of medical records into the system • Creation of record keeping Lockable areas and scanning of medical records. • Drafting the Gauteng Medical Litigation and Mediation Bill to provide a legislative mechanism for among others, the provision of future medical treatment and related health care requirements at state facilities instead of paying a lump sum to a successful plaintiff and periodic rather than once off payments of any monies due to a successful plaintiff in terms of a court order. • Engagement with the Gauteng Provincial Treasury to ensure their compliance with section 3(11) of the State Liability Act by developing a budget for the payment of final court orders against the department. • Addressing the root cause of medico-legal litigation (negligence at clinical level) to ensure patient health and safety and prevent causes for medico-legal claims.
	Failure to recover critical health functions, following a disaster or any material disruptive event (1)	• Follow-up with HR on the review of the organisational structure to inform the risk governance structure of the department. • Review, communicate and implement a comprehensive business continuity policy for the department. • Establish and develop capacity for the business continuity needs of the department. • Migrations of new systems to the cloud and engage SITA to migrate the historical legacy systems to the fully managed data centre. • Development and implementation of the ICT DR in line with the • provincial approved Cloud policy (Migration to CLOUD)

5.10. Budget Programme 6: Health Sciences and Training (HST)

Programme Purpose

Rendering of training and development opportunities for actual and potential employees of the Department of Health through sub-programmes:

- Gauteng College of Nursing (GCON): Training of nurses at undergraduate and post graduate level. Target group includes actual and potential employees.
- Emergency medical services: (EMS) training college: Training of rescue and ambulance personnel. Target group includes actual and potential employees.
- Bursaries: Provision of bursaries for health science training programmes at undergraduate and postgraduate levels. Target group includes actual and potential employees.
- Primary Health Care (PHC) training: Provision of PHC related training for personnel, provided by Regional Training Centre; and Nurse training college (Gauteng College of Nursing - GCON)
- Training (other): Provision of skills development interventions for all occupational categories in the Department. Target group includes actual and potential employees.
- Gauteng Nursing College (GCON) has been accredited by Council on Higher Education (CHE) and South African Nursing Council (SANC) to offer new qualifications aligned to Higher Education Qualifications Sub Framework (HEQSF) in accordance with National Qualifications Framework Act, 2008 (Act 67 of 2008), Higher Education Act, 1997 (Act 101 of 1997 as amended) and Nursing Act, 2005 (Act 33 of 2005).
- Implement Districts Regional Training Centres and maintain the accreditation status of Tshwane Centre

5.10.1. HEALTH SCIENCES AND TRAINING (HST) PROGRAMME OUTCOMES, OUTPUTS, OUTPUT INDICATORS AND TARGETS

Outcome (as per SP 2020/21- 2024/25)	Outputs	Output Indicator	Audited/Actual Performance			Estimated	MTEF Targets						
			2019/20	2020/21	2021/22	2022/23	2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
Quality of health services in public health facilities improved	Positive employee experience	Employee satisfaction rate	54%	59%	61.7%	60%	60%	Annual			60%	60%	60%
		Numerator:	#	#	74	5 565	5 624				5 624	5 683	5 683
		Denominator:	#	#	120	9 275	9 374				9 374	9 473	9 473
Leadership and governance in the health sector enhanced to improve quality of care	Enrolment of students in the new undergraduate qualifications program	Number of nursing students enrolled	#	#	#	550	800	Annual			800	800	800
		Number of emergency medical care students enrolled	#	#	#	#	60				60	60	60

5.10.2. EXPLANATION OF PLANNED PERFORMANCE OVER THE MEDIUM-TERM PERIOD

Staff morale

- Employee satisfaction improved from 59% in 2020/21 to 61.7% in 2021/22. A comprehensive employee strategy and programme to address wellness has been developed, including counselling for frontline/clinical staff.
- There has been an increase in the incidence of mental health problems, prompting a call for regular mental health assessments for employees.
- Longer-term goals include advocating for DPSA staffing norms, capacitating staff through collaboration with institutions of higher learning, and the overall creation of a conducive work environment for personnel.

Improved Skills through Education and Training

- Nursing college and six satellite campuses will be conditionally accredited and new curriculum institutionalised.
- Accreditation of nursing colleges to offer post-graduate diploma programs.
- Implement districts regional training centres and maintain the accreditation status of Tshwane Centre.
- Implement and accredit district Basic Life Support (BLS) training sites.
- Conduct Advance Cardiac Life Support (ACLS) training as per the AHA guidelines and standards at Lebone College.
- Application of accreditation for emergency medical care undergraduate programmes at Lebone College as standalone higher education institution.
- Implement the health officer promotion qualification for community health workers.
- Capacity development programmes for hospital CEOs and clinical managers.
- Specialised training for technical skills on financial management and supply chain management.
- Specialised training for technical skills on human resource and labour relations.

5.10.3. PROGRAMME RESOURCE CONSIDERATIONS / BUDGET ALLOCATION

TABLE 23: SUMMARY OF PAYMENTS AND ESTIMATES: HEALTH SCIENCES AND TRAINING

	Outcome			Main	Adjusted	Revised estimate	Medium-term estimates		
R thousand	2019/20	2020/21	2021/22		2022/23		2023/24	2024/25	2025/26
1. Nurse Training Colleges	693 034	556 647	515 496	652 396	629 343	531 174	696 496	723 190	724 243
2. Ems Training Colleges	29 123	36 495	37 357	43 397	50 301	50 561	56 156	57 386	59 955
3. Bursaries	263 503	129 244	78 178	321 123	321 123	321 123	341 974	341 974	341 974
4. Other Training	59 596	64 824	75 837	89 577	89 896	85 921	102 092	104 382	105 863
Total payments and estimates	**1 045 256**	**787 210**	**706 868**	**1 106 493**	**1 090 663**	**988 779**	**1 196 718**	**1 226 932**	**1 232 035**

TABLE 24: SUMMARY OF PAYMENTS AND ESTIMATES BY ECONOMIC CLASSIFICATION: HEALTH SCIENCES AND TRAINING

	Outcome			Main	Adjusted	Revised estimate	Medium-term estimates		
R thousand	2019/20	2020/21	2021/22		2022/23		2023/24	2024/25	2025/26
Current payments	**717 915**	**619 303**	**573 526**	**707 620**	**704 640**	**602 325**	**779 797**	**810 011**	**814 093**
Compensation of employees	654 671	556 097	521 237	619 075	616 298	513 669	680 814	711 028	712 646
Goods and services	63 244	63 206	52 289	88 545	88 342	88 656	98 983	98 983	101 447
Interest and rent on land									
Transfers and subsidies to:	**321 931**	**159 908**	**129 212**	**389 623**	**374 673**	**374 706**	**405 775**	**405 775**	**406 297**
Departmental agencies and accounts	22 135	23 352	24 636	25 819	25 819	25 819	26 955	26 955	27 354
Higher education institutions	1 488	12 871	7 867	17 092	4 039	4 039	10 844	10 844	10 844
Households	298 308	123 685	96 709	346 712	344 815	344 848	367 976	367 976	368 099
Payments for capital assets	**4 726**	**7 996**	**4 128**	**9 250**	**11 350**	**11 350**	**11 146**	**11 146**	**11 645**
Buildings and other fixed structures									
Machinery and equipment	4 726	7 996	4 128	9 250	11 350	11 350	11 146	11 146	11 645
Software and other intangible assets									
Payments for financial assets	**684**	**3**	**2**			**398**			
Total economic classification	**1 045 256**	**787 210**	**706 868**	**1 106 493**	**1 090 663**	**988 779**	**1 196 718**	**1 226 932**	**1 232 035**

The overall budget for compensation of employees increases from R619.0 million in 2022/23 to R680.8 million in the 2023/24 financial year to comply with the implementation of the newly introduced nursing curriculum, to fill new posts and to accommodate a 3% wage provision for public servants.

The goods and services allocation remains constant increases to R98 million in 2023/24 financial year from R88 million in 2022/23 to align and comply with implementation of the newly introduced nursing curriculum in 2020/21 and to fund the newly established Gauteng College of Nursing (GCON) Unit. Furthermore, provision has been made to procure additional learning and teaching material because of the newly introduced curriculum and procure simulation training and development equipment.

5.10.4. UPDATED RISKS AND MITIGATING FACTORS FROM THE SP

Outcome	Risk	Mitigating factors
Morbidity and premature mortality due to non – communicable diseases reduced by 10%	Increasing morbidity and mortality	• Train health care workers and health promoters on the management of non-communicable diseases. • Increase number of Community Health Workers trained on 1 year Health Promotion Officer qualification. • Conducts in-service trainings and short skills programs to clinicians
Quality of health services in public health facilities improved	Increasing morbidity and mortality	• Increase the number of professionals trained in various clinical specialty programs
Quality of health services in public health facilities improved	Inability to provide effective mental health services	• Train health nurses and doctors on specialised mental health care skills programs • Increase annual enrolments of the one year post basic mental health qualification

5.11. Budget Programme 7: Health Care Support Services (HCSS)

Programme Purpose

The purpose of this programme is to render support services required by the Department to realise its aims through sub-programmes:

- Laundry services: Rendering a laundry service to hospitals, care and rehabilitation centres and certain local authorities; and
- Medical trading account (Medical Supplies Depot): Managing the supply of pharmaceuticals to hospitals, community health centres and local authorities.

5.11.1 HEALTH CARE SUPPORT SERVICES (HCSS) PROGRAMME OUTCOMES, OUTPUTS, OUTPUT INDICATORS AND TARGETS

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual Performance			Estimated	MTEF Targets						
			2019/20	2020/21	2021/22	2022/23	2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
Quality of health services in public health facilities improved	Vital medical products, and equipment available at health facilities	Percentage vital medicine availability at health facilities	95.56%	97%	96%	96%	96%	96%	96%	96%	96%	96%	96%
		Numerator:	#	428	424	424	424	106	106	106	106	424	424
		Denominator:	#	441	441	441	440	110	110	110	110	441	441
	Essential medical products, and equipment available at health facilities	Percentage essential medicine availability at health facilities	95.73%	95%	96%	96%	96%	96%	96%	96%	96%	96%	96%
		Numerator:	#	528	424	534	536	134	134	134	134	534	534
		Denominator:	#	556	441	556	556	139	139	139	139	556	556
Quality of health services in public health facilities improved	Waiting times in health facilities reduced as Patients voluntarily collect chronic medication at identified pick-up points.	Number of patients enrolled on Centralized chronic medicine dispensing and distribution programme (Cumulative)	721 350	1 022 840	1 085 232	1 100 000	1 200 000	Annual			1 200 000	1 300 000	1 500 000

5.11.2 EXPLANATIONS OF PLANNED PERFORMANCE OVER THE MEDIUM- TERM PERIOD

CCMDD PROGRAMME

- Advocacy for the CCMDD programme, especially at hospital level to decongest the facility during the COVID-19 pandemic.
- Phased in approach to include adolescents and paediatric patients who are stable on chronic medications and do not require regular clinical review of their treatment onto the programme.
- Increase the number of patients that are serviced by external pick-up points, to ensure that medicines access becomes a reality.
- Continuously engage the CCMDD Service provider to ensure the availability of medicines to ensure continuous supply to patients enrolled on the programme.

Medicine availability

The following initiatives will be implemented to ensure medicine availability close as possible to the target of 96% within the province, which include:
Monitoring of the Medicine Supply Chain:

- Monitor medicine availability weekly at health facilities to serve as an early warning system for urgent intervention.
- Escalation of the out of stocks to the National Department of Health and contract managers for intervention;
- regular follow up on outstanding orders
- Inclusion of the administrative lead-time into the buffer quantity especially for the buy-out orders;
- Identification of alternatives, including therapeutic alternatives to procure in the case of long standing out of stocks item.

5.11.3 PROGRAMME RESOURCE CONSIDERATIONS / BUDGET ALLOCATION

TABLE 25: SUMMARY OF PAYMENTS AND ESTIMATES: HEALTH CARE SUPPORT SERVICES

	Outcome			Main	Adjusted	Revised estimate	Medium-term estimates		
R thousand	2019/20	2020/21	2021/22		2022/23		2023/24	2024/25	2025/26
1. Laundries	287 581	294 625	315 450	300 971	318 394	335 117	338 339	351 474	365 653
2. Food Supply Services	81 363	94 219	73 383	111 746	114 571	103 794	115 590	116 959	122 197
3. Medicine Trading Account				1	1	1	1	1	1
Total payments and estimates	**368 944**	**388 844**	**388 833**	**412 718**	**432 966**	**438 912**	**453 930**	**468 434**	**487 851**

TABLE 26: SUMMARY OF PAYMENTS AND ESTIMATES BY ECONOMIC CLASSIFICATION: HEALTH CARE SUPPORT SERVICES

	Outcome			Main	Adjusted	Revised estimate	Medium-term estimates		
R thousand	2019/20	2020/21	2021/22		2022/23		2023/24	2024/25	2025/26
Current payments	**367 066**	**387 500**	**386 858**	**410 010**	**429 458**	**435 344**	**451 021**	**465 525**	**484 812**
Compensation of employees	197 050	201 582	209 814	216 725	223 420	223 420	219 313	228 817	239 068
Goods and services	170 016	185 918	177 044	193 285	206 038	211 924	231 708	236 708	245 744
Interest and rent on land									
Transfers and subsidies to:	**1 254**	**975**	**682**	**581**	**581**	**581**	**531**	**531**	**555**
Provinces and municipalities									
Departmental agencies and accounts									
Non-profit institutions									
Households	1 254	975	682	581	581	581	531	531	555
Payments for capital assets	**593**	**369**	**1 289**	**2 127**	**2 927**	**2 927**	**2 378**	**2 378**	**2 484**
Buildings and other fixed structures									
Machinery and equipment	593	369	1 289	2 127	2 927	2 927	2 378	2 378	2 484
Payments for financial assets	**31**		**4**			**60**			
Total economic classification	**368 944**	**388 844**	**388 833**	**412 718**	**432 966**	**438 912**	**453 930**	**468 434**	**487 851**

The budget of this programme is allocated to the five laundries throughout the province that provide cleaning services and purchase linen for health facilities. The department also allocates budget for the Masakhane Cook-freeze which provides pre-packed food service supplies to health facilities. The budget increases from the main allocation of R412.7 million in 2022/23 to R453.9 million in the 2023/24 financial year to sustain the provision of the abovementioned services.

The compensation of employees' budget increased slightly from R216.7 million in 2022/23 to R219.3 million in 2023/24 financial years. In the outer year of the 2023 MTEF, the personnel budget grows to R239 million to make provision for the appointment of critical staff.

To continue to provide cleaning services to health institutions and replace linen, the goods and services budget in the programme increases from a main allocation of R193.2 million in 2022/23 to R231.7 million in the 2023/24 financial year due to revised gas contract rates. Lastly, R2.3 million is allocated for procurement of machinery and equipment in the 2023/24 financial year to ensure that laundries are equipped with machines to provide clean linen to health facilities. The bulk of the machinery and equipment is funded through Programme 8: Health Facilities Management.

5.11.4. UPDATED RISKS AND MITIGATING FACTORS FROM THE SP

Outcome	Risk	Mitigating factors
Quality of health services in public health facilities improved	Inability to keep and maintain the required minimum stock levels of 96%	• Achieve quarterly resolution on switch over of products that are on contract by the Gauteng Pharmaceutical and Therapeutically Committee • Implement the provision of section 21 - engagement with National Department of Health • Apply to SAPHRA for section 21 in the event that there is no supplier that has stock of a required medicine and identify alternate medicines • Contract to have multiple awards-multiple suppliers for the supply of the same Product-Business Continuity will be built into contracts. • Purchasing on quotations. Engage National Dept. of Health to intervene as large companies who are sole suppliers of certain products do not respond to national tenders but opt for price quotations at an exorbitant price
	Failure to provide quality care services	• Automated collection of chronic medication (Access medication at mall for example). Telemedicine and E-Health • Weekly monitoring of the average percentage of vital and essential medicines at pharmacies and PHC facilities as an early warning signal for intervention when necessary (Stock levels to be 96%). Early warning trigger is at 94%)-intervention is required immediately • Gauteng Pharmacy and Therapeutics Committee meets quarterly to address the shortage of medicines.

5.12. Budget Programme 8: Health Facilities Management (HFM)

Programme Purpose
Provision of new health facilities and the refurbishment, upgrading and maintenance of existing facilities

Community Health Facilities: Construction of new and refurbishment, upgrading and maintenance of existing Community Health Centres, Primary Health Care clinics and facilities.

Emergency Medical Rescue Services: Construction of new and refurbishment, upgrading and maintenance of existing EMS facilities.

District Hospital Services: Construction of new and refurbishment, upgrading and maintenance of existing District Hospitals.

Provincial Hospital Services: Construction of new and refurbishment, upgrading and maintenance of existing Provincial/Regional Hospitals and Specialised Hospitals.

Central Hospital Services: Construction of new and refurbishment, upgrading and maintenance of existing Tertiary and Central Hospitals.

Other Facilities: Construction of new and refurbishment, upgrading and maintenance of other health facilities including forensic pathology facilities and nursing colleges and schools.

5.12.1 HEALTH FACILITIES MANAGEMENT (HFM) PROGRAMME OUTCOMES, OUTPUTS, OUTPUT INDICATORS AND TARGETS

Outcome (as per SP 2020/21-2024/25)	Outputs	Output Indicator	Audited/Actual Performance			Estimated	MTEF Targets						
			2019/20	2020/21	2021/22	2022/23	2023/24	2023/24 Quarterly Targets				2024/25	2025/26
								Q1	Q2	Q3	Q4		
Financing and Delivery of Infrastructure projects improved	Refurbished and maintained health facilities	Percentage of Health facilities with completed capital infrastructure projects	#	N/A	0%	15.6%	21.9%	Annual			21.9%	21.9%	21.9%
		Numerator:	#	N/A	0	5	7				7	7	7
		Denominator:	#	#	32	32	32				32	32	32
	Functional PHC facilities	Number of new Primary Health Care Centres completed	#	#	1	10	11	Annual			11	11	11

5.12.2. EXPLANATION OF PLANNED PERFORMANCE OVER THE MEDIUM-TERM PERIOD

OHS ON 32 Hospitals

The program is structured into 13 priorities for 2020/23 and the remaining 20 for 2024/27. The scope is structural repairs, system upgrade; layout and additions to achieve IUSS benchmarks; architectural works to submit drawings for approval by Municipalities; Acquisition of land that is not vested under GDID; Application for appropriate Zoning; Submitting As – Built Drawings in terms of Municipal Submission Requirements. Funding Requirements: Professional Fee Structure goes beyond the determination (12%) set by Treasury. The works to achieve compliance goes beyond only repairs but ensuring that requirements of bylaws are met. All professional works (Town Planning, Architectural, Fire Safety have to be paid). It is anticipated that 30% - 40% of annual ECE (Estimated Capital Expenditure) allocation will be utilised over the 2022/23 MTEF.

Expanding Access to PHC

The Gauteng Province has prioritised PHC access to communities. This includes expansion of services on existing facilities – resulting in requirements for replacements and extensions; the development of Community Health Facilities in identified areas to enable provision of 24 hours access to healthcare. Scope: Completion of projects at hand; putting into tender and appointment of contractors to construct approved prioritised projects and acquisition of land and development rights in critically underserviced area (Sedibeng, City of Tshwane (Rural Districts).

Expansion of Bed Capacity

The Province needs additional hospital beds to cope with demand in the public sector. The province beds demand is placed around 22 000. Prior to COVID-19 pandemic, GDOH had 17 518 hospital beds, which was a shortfall of 4 482 from the target of 22 000 beds based on the estimates against the Gauteng population studies. With establishment of 2 117 Covid-19 beds in 2021/22, the beds count is now at 19 635. The awarding of Khayalami, Lillian Ngoyi, Hillbrow, Tshwane Rehab Hospital, Tembisa & Thelle Mogoerane Mother & Child, Daveyton Hospital can assist the province to bridge the gap (2 365) within the current Administration. Because of fiscal constraints, there are private funding options being investigated through the assistance of GIFA – Although this will not necessarily affect the MTEF baseline, it would change the strategy of managing cashflow from Capital to Current should the PPP options be successful.

Packaging of Health Care Service

While we have identified a gap of 2365: It remains critical to re-package the healthcare offering to consider the following: Beds required for mental health; Beds required at Tertiary level; Beds required at District level; Beds required at Regional Level. Through adequate packaging and motivation (health care business cases), the Province can access Grants to finance development of the other hospitals from National. However, the challenge that still remains include that of acquisition of appropriate land (accessible / owned by the GPG / Zoned properly).

Continuous Maintenance

GDOH has identified Maintenance as the critical area for service offering to the institutions: To streamline control and oversight, GDOH has introduced the following: Maintenance Policy to regulate the decision making process at facilities level; Standardized Service Level Agreement to regulate the conduct of service providers appointed for repairs and maintenance in facilities; Approval of planned maintenance services is now being centralized at Central Office – where scope of works & budgets are presented for evaluation and approval. As part of transferring payments to budget holder, process for issuing Purchase Orders for maintenance works has been approved and has support from Treasury – Implementation is still a challenge. We are also building capacity and capabilities to oversee Electro Mech programme to ensure that value for money is achieved in this area of specialization.

Horticulture

The upkeep of 32 hospital grounds and gardens is identified as a key facilities management program. The Program for bush and grass trimming, tree felling, removal of alien species, maintenance of fire breaks, planting new plants where required. On incremental basis, it will include turning hospital facilities as centauries for preservation of indigenous

fauna & flora. Key to this program is to use it a development program for young people around local to where the facilities are located. This could be through development contracts of 18 months to 36 months with an exits plan being a qualification in Horticulture, Should we receive sponsorships, this should include capital resources for starting own business (individually or as co-operatives) Because it is a program that includes services and development, we are looking at accessing funding at Sector Education Training Authority.

Local Contractor Development

Local Contractor Development is an option that GDOH sees as critical for economic participation for marginalised categories of persons. One of GDOH strategic key objective and outcome is economic participation of Women, and its building program. Central to this objective is structured development initiatives. This will ensure skills development, and localisation. We are looking at enabling skilling of young people across various trades, while equipping them to start their own enterprises. Apart from Construction based Sector, we are also looking at Property Management Sector – where we can appoint emerging Property Practitioners opportunities to manage GDOH facilities for income generation – as a mitigating program against illegal occupation. GDOH is in the development phase of policies that would enable us to achieve these Infrastructure (Real Estate) linked initiatives within SCM regulations. To achieve all this GDID will have to play a critical supporting and advisory roles henceforth as the Custodian of Real Estate Assets in the Province.

5.12.3. PROGRAMME RESOURCE CONSIDERATIONS / BUDGET ALLOCATION

TABLE 27: SUMMARY OF PAYMENTS AND ESTIMATES: HEALTH FACILITIES MANAGEMENT

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
R thousand	2019/20	2020/21	2021/22		2022/23		2023/24	2024/25	2025/26
1. Community Health Facilities	421 683	526 523	311 696	419 817	386 053	386 053	293 782	507 508	640 829
2. Emergency Medical Rescue Services	6 813	19 933	8 561	27 242	24 600	24 600	15 420	56 179	69 875
3. District Hospital Services	242 631	631 525	131 976	355 696	191 237	191 237	215 536	279 856	277 796
4. Provincial Hospital Services	377 035	353 929	247 403	496 104	332 058	332 058	419 696	470 468	350 312
5. Central Hospital Services	604 556	1 520 597	837 714	628 259	678 289	678 289	581 370	509 926	414 927
6. Other Facilities	401 167	988 850	530 885	509 634	611 812	611 812	392 505	338 860	342 734
Total payments and estimates	**2 053 885**	**4 041 357**	**2 068 235**	**2 436 752**	**2 224 049**	**2 224 049**	**1 918 309**	**2 162 797**	**2 096 473**

TABLE 28: SUMMARY OF PAYMENTS AND ESTIMATES BY ECONOMIC CLASSIFICATION: HEALTH FACILITIES MANAGEMENT

	Outcome			Main	Adjusted	Revised estimate	Medium-term estimates		
R thousand	2019/20	2020/21	2021/22		2022/23		2023/24	2024/25	2025/26
Current payments	**1 592 369**	**1 622 416**	**1 283 848**	**1 066 832**	**1 285 115**	**1 285 115**	**1 170 611**	**1 203 314**	**1 229 191**
Compensation of employees	37 568	40 352	40 082	60 013	60 013	60 013	55 558	57 908	57 908
Goods and services	1 554 801	1 582 064	1 243 766	1 006 819	1 225 102	1 225 102	1 115 053	1 145 406	1 171 283
Interest and rent on land									
Transfers and subsidies to:	**193**	**132**	**36**						
Provinces and municipalities									
Households	193	132	36						
Payments for capital assets	**461 323**	**2 418 809**	**784 338**	**1 369 920**	**938 934**	**938 934**	**747 698**	**959 483**	**867 282**
Buildings and other fixed structures	451 786	2 418 620	735 593	1 335 920	936 434	936 434	694 546	957 909	866 840
Machinery and equipment	9 537	189	48 745	34 000	2 500	2 500	53 152	1 574	442
Payments for financial assets			**13**						
Total economic classification	**2 053 885**	**4 041 357**	**2 068 235**	**2 436 752**	**2 224 049**	**2 224 049**	**1 918 309**	**2 162 797**	**2 096 473**

The bulk of the budget is transferred to the Gauteng Department of Infrastructure Development for major capital works programmes performed on behalf of the Department. This includes construction of new facilities and rehabilitation, upgrading and maintenance of existing facilities. The main allocation decreases from R2.4 billion in the 2022/23 to R1.9 billion in the 2023/24 financial year.

The compensation of employees' budget in the programme decreases from the main allocation of R60 million in 2022/23 to R55.5 million in the 2023/24 financial year.

5.12.4. UPDATED KEY RISKS AND MITIGATING FACTORS FROM THE SP

Outcome	Risk	Mitigating factors
Infrastructure maintained and backlog reduced	Unauthorised access to information (electronic/ physical)	• Implement the encryption of passwords Monitor compliance to the ICT policies • Implementation of the first phase of the Health Information System and scanning of documents • Continuous updating of security patches on the system. • Update the policies and monitor compliance • Implementation and monitoring of the user-access monitoring tool • Update the Records Management Policy • Implementation of the Digital Strategy
Infrastructure maintained and backlog reduced	Sub-standard health infrastructure quality and management	• Initiative to enhance compliance to OHS Act (Theatres, psychiatric areas, emergency areas, paediatric wards, ICU and electro-mechanical elements) • Filling of vacant positions-Health facilities revitalisation grant.
Infrastructure maintained and backlog reduced	Compromised health service delivery. Compromised health and safety of staff and patients	• Initiative to enhance compliance to OHS Act (Theatres, psychiatric areas, emergency areas, paediatric wards, ICU and electro-mechanical elements-Boilers, Generators, etc.)-Certificate of compliance to be in place • Development of a Maintenance Management System-procure the SAP maintenance Module. (This could take between 12-18 months • Motivate for the Procurement of a Condition Monitoring System- Real Time Data providing an early warning system for critical equipment. • Conduct maintenance as per the Maintenance Schedule (Intensified Maintenance Programme). • Filling of vacant positions-Health facilities revitalisation grant.

6. Infrastructure Projects

No	Project Name	Programme	Project Description	Outputs	Project Construction Start Date	Project Construction Completion Date	Total Estimated Cost	Current Year Expenditure
1	Charlotte Maxeke Academic Hospital	OHS, Refurbishment, Security Infrastructure and Landscaping	Planned, statutory and preventative maintenance	Well maintained facility	Feb 2021	April 2024	R 393 944 763.68	R 0.00
2	Chris Hani Baragwaneth Academic Hospital	OHS, Refurbishment, Security Infrastructure and Landscaping	Planned, statutory and preventative maintenance	Well maintained facility	Feb 2021	Feb 2025	R 809 759 197.55	R 0.00
3	Helen Joseph District Hospital	OHS, Refurbishment, Security Infrastructure and Landscaping	Planned, statutory and preventative maintenance	Well maintained facility	Feb 2021	April 2024	R 378 995 750	R 0.00
4	South Rand District Hospital	OHS, Refurbishment, Security Infrastructure and Landscaping	Planned, statutory and preventative maintenance	Well maintained facility	May 2021	April 2023	R 187 108 444.49	R 0.00
5	Sizwe Tropical Disease Hospital	OHS, Refurbishment, Security Infrastructure and Landscaping	Planned, statutory and preventative maintenance	Well maintained facility	May 2021	April 2024	R 261 789 054.81	R 0.00
6	Edenvale Hospital	OHS, Refurbishment, Security Infrastructure and Landscaping	Planned, statutory and preventative maintenance	Well maintained facility	Oct 2020	April 2024	R 278 359 213.56	R 0.00
7	Rahima Moosa Mother and Child Hospital	OHS, Refurbishment, Security Infrastructure and Landscaping	Planned, statutory and preventative maintenance	Well maintained facility	May 2021	April 20234	R 11 963 682.41	R 0.00
8	Tara Moross Centre Hospital	OHS, Refurbishment, Security Infrastructure and Landscaping	Planned, statutory and preventative maintenance	Well maintained facility	May 2021	April 2024	R 96 752 422.95	R 0.00
9	Bertha Gxowa District Hospital	OHS, Refurbishment, Security Infrastructure and Landscaping	Planned, statutory and preventative maintenance	Well maintained facility	May 2021	April 2023	R 94 279 968	R 0.00
10	Tembisa District Hospital	OHS, Refurbishment, Security Infrastructure and Landscaping	Planned, statutory and preventative maintenance	Well maintained facility	Oct 2020	April 2023	R 221 821 506.33	R 0.00
11	Pholosong Hospital	OHS, Refurbishment, Security Infrastructure nand Landscaping	Planned, statutory and preventative maintenance	Well maintained facility	May 2021	April 2023	R 125 252 846	R 0.00
12	Tambo Memorial Hospital	OHS, Refurbishment, Security Infrastructure and Landscaping	Planned, statutory and preventative maintenance	Well maintained facility	Oct 2020	April 2023	R 199 741 819.31	R 0.00
13	Far East Rand Hospital (To Be Renamed)	OHS, Refurbishment, Security Infrastructure and Landscaping	Planned, statutory and preventative maintenance	Well maintained facility	May 2021	April 2024	R 184 184 502	R 0.00
14	Dr George Mukhari Academic Hospital	OHS, Refurbishment, Security Infrastructure and Landscaping	Planned, statutory and preventative maintenance	Well maintained facility	Sep 2020	Dec2023	R 246 409 416.10	R 2,405,865.47
15	Steve Biko Tertiary Hospital	OHS, Refurbishment, Security Infrastructure and Landscaping	Planned, statutory and preventative maintenance	Well maintained facility	May 2020	April 2023	R 85 468 931.41	R 0.00
16	Weskoppies Psychiatric Hospital	OHS, Refurbishment, Security Infrastructure and Landscaping	Planned, statutory and preventative maintenance	Well maintained facility	May 2022	April 2024	R 184 474 343.24	R 0.00
17	Mamelodi Hospital	OHS, Refurbishment, Security Infrastructure and Landscaping	Planned, statutory and preventative maintenance	Well maintained facility	Sep 2020	April 2023	R 41 209 896.63	R 0.00
18	Steve Biko Tertiary Hospital	OHS, Refurbishment, Security Infrastructure and Landscaping	Planned, statutory and preventative maintenance	Well maintained facility	May 2020	April 2023	R 85 468 931.41	R 0.00
19	Weskoppies Psychiatric Hospital	OHS, Refurbishment, Security Infrastructure and Landscaping	Planned, statutory and preventative maintenance	Well maintained facility	May 2022	April 2024	R 184 474 343.24	R 0.00
20	Mamelodi Hospital	OHS, Refurbishment, Security Infrastructure and Landscaping	Planned, statutory and preventative maintenance	Well maintained facility	Sep 2020	April 2023	R 41 209 896.63	R 0.00
21	Jubilee Hospital	OHS, Refurbishment, Security Infrastructure and Landscaping	Planned, statutory and preventative maintenance	Well maintained facility	Sep 2020	April 2024	R 218 721 399.74	R 0.00
22	Kalafong Hospital	OHS, Refurbishment, Security Infrastructure and Landscaping	Planned, statutory and preventative maintenance	Well maintained facility	May 2021	April 2024	R 267 167 589.74	R 5,653,000.00

No	Project Name	Programme	Project Description	Outputs	Project Construction Start Date	Project Construction Completion Date	Total Estimated Cost	Current Year Expenditure
23	Odi Hospital	OHS, Refurbishment, Security Infrastructure and Landscaping	Planned, statutory and preventative maintenance	Well maintained facility	May 2021	April 2023	R 186 525 232.01	R 2,230,841.77
24	Pretoria West Hospital	OHS, Refurbishment, Security Infrastructure and Landscaping	Planned, statutory and preventative maintenance	Well maintained facility	May 2021	April 2023	R 102 339 363.65	R 1,040,000.00
25	Tshwane District Hospital	OHS, Refurbishment, Security Infrastructure and Landscaping	Planned, statutory and preventative maintenance	Well maintained facility	May 2021	April 2023	R 46 774 068.13	R 0.00
26	Cullinan C&R Hospital	OHS, Refurbishment, Security Infrastructure and Landscaping	Planned, statutory and preventative maintenance	Well maintained facility	May 2021	April 2023	R49 288 515.53	R 0.00
29	Bronkhorstspruit Hospital	OHS, Refurbishment, Security Infrastructure and Landscaping	Planned, statutory and preventative maintenance	Well maintained facility	May 2021	April 2023	R 44 403 969.48	R 0.00
30	Sterkfontein Psychiatric Hospital	OHS, Refurbishment, Security Infrastructure and Landscaping	Planned, statutory and preventative maintenance	Well maintained facility	July 2020	April 2023	R 207 705 929.58	R 0.00
31	Dr Yusuf Dadoo Hospital	OHS, Refurbishment, Security Infrastructure and Landscaping	Planned, statutory and preventative maintenance	Well maintained facility	Jul 2020	April 2023	R 166 170 887.97	R 0.00
32	Carletonville Hospital	OHS, Refurbishment, Security Infrastructure and Landscaping	Planned, statutory and preventative maintenance	Well maintained facility	Jul 2020	April 2023	R 180 671 497.53	R 0.00
33	Leratong Hospital	OHS, Refurbishment, Security Infrastructure and Landscaping	Planned, statutory and preventative maintenance	Well maintained facility	Jul 2020	April 2023	R 217 232 412.27	R 0.00
34	Sebokeng District Hospital	OHS, Refurbishment, Security Infrastructure and Landscaping	Planned, statutory and preventative maintenance	Well maintained facility	Oct 2020	April 2023	R 176 611 400.04	R 2,001,765.22
35	Heidelberg Hospital	OHS, Refurbishment, Security Infrastructure and Landscaping	Planned, statutory and preventative maintenance	Well maintained facility	May 2021	April 2023	R 62 075 000.00	R 0.00
36	Kopanong Hospital	OHS, Refurbishment, Security Infrastructure and Landscaping	Planned, statutory and preventative maintenance	Well maintained facility	Oct 2020	April 2023	R 228 935 500.00	R 2,677,000.00
37	Bheki Mlangeni Hospital	OHS, Refurbishment, Security Infrastructure and Landscaping	Planned, statutory and preventative maintenance	Well maintained facility	Oct 2020	April 2023	R 101 070 486.43	R 0.00
38	Telle Mogoerane	OHS, Refurbishment, Security Infrastructure and Landscaping	Planned, statutory and preventative maintenance	Well maintained facility	May 2022	April 2024	TBC	R 0.00

7. Private Public Partnerships (PPPs)

PPP Name	Purpose	Outputs	Current Value of Agreement	End Date of Agreement
N/A	N/A	N/A	N/A	N/A

PART D: Technical Indicator Description (TID)

The Technical Indicator Descriptions have been aligned with the approved National Data Set and outcome indicators in the approved Departmental Strategic Plan.

Indicator Title	Definition	Source of Data	Method of Calculation/ Assessment		Means of Verification	Assumptions	Disaggregation of beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative (year- end); cumulative (year-to-date) or non-cumulative	Reporting cycle	Desired	Indicator Responsibility	Budget Programme Number
			Numerator	Denominator									
Percentage of budget spent on Township enterprises against identified commodities	Percentage of budget spent on township enterprises against identified commodities against	BAS Spent Report / financial records	Total budget spent on township enterprises against identified commodities	Total SCM budget	BAS / financial records	Data quality is reliant on compliant tendering processes, contracts, invoices and	Not applicable	All districts and hospitals	Non - Cumulative	Annual	Higher	Chief Director: SCM	1
Percentage of service providers' invoices without dispute paid within 30 days	Total number of service providers' invoices (without dispute) paid within 30 days as a proportion/ percentage of invoice received from service providers submitted by service providers	BAS/SAP	Total number of services providers' invoices without dispute paid within 30 days	Total invoices (without dispute) paid	BAS/SAP reports	Payments dependent on availability of funds	Not applicable	All districts, hospitals, head office and nursing colleges	Non-cumulative	Annual	Higher	Chief Director: Financial Accounting	1
Percentage of women in senior management posts	The number of women in senior management as a percentage of the total number of senior positions. senior positions start from level13 to level16	Personnel Salary System (PERSAL)	Total number of funded senior women management posts filled	Total number of senior management posts.	Personnel Salary System (PERSAL)	Dependent on accuracy of and completeness of Persal data at end of the reporting period	Women	All districts	Not Applicable	Annual	Higher	Cooperate Service DDG	1
Audit opinion of Provincial DoH	Audit opinion for Provincial Departments of Health for financial performance	Auditor General Report Management report	Audit outcome for regulatory audit expressed by AGSA for the financial year	Not Applicable	AGSA Audit Report	Audit cycle completed on time	Not Applicable	All Districts	Not Applicable	Annual	Unqualified Audit Opinion	Chief Financial Officers of Provincial Departments of Health	

Indicator Title	Definition	Source of Data	Method of Calculation/ Assessment		Means of Verification	Assumptions	Disaggregation of beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative (year- end); cumulative (year-to-date) or non-cumulative	Reporting cycle	Desired	Indicator Responsibility	Budget Programme Number
			Numerator	Denominator									
Percentage of hospitals compliant with Occupational Health and Safety regulations	Total number of hospitals compliant to the Health and Safety Standards as a proportion of all hospitals	Hospitals Occupational Health and Safety Reports	Total number of hospitals compliant to the health and safety regulations	Total number of all hospitals	Hospitals Occupational Health and Safety Reports based on Integrated OHS tool	Accuracy dependent on quality of data submitted by reporting hospital	Not Applicable	All hospitals	Not Applicable	Annual	Higher	Chief Director: EHP&W (OHS Manager)	1
Number of priority hospitals and clinics implementing Lean Management System	Total number of priority hospitals and clinics implementing (Outpatients journey, starting at Patients registrations, Clinic and Pharmacy) Lean Management System (Lean with A3 tool and visual management systems in place)	Lean management reporting tool	Total of all priority hospitals and clinics with Lean Management System implemented (Lean with A3 tool and visual management systems in place)	Not Applicable	Lean Management reports	Accuracy dependent on quality of data submitted by reporting priority hospitals and clinics	Not Applicable	All 10 priority hospitals and 10 priority clinics	Not Applicable	Annual	Higher	Lean Management Manager	1
Rand value of medico-legal claims	Total rand value of the medico legal claims for all backlog cases that were on the case register as of 31 March 2019	Medico-legal case management system	Total rand value of the medico legal claims for all backlog cases that were on the case register as of 31 March 2019	Not Applicable	Not applicable	Accuracy dependent on data from reporting facility	Not applicable	All institutions	Not Applicable	Annual	Lower rand value	Chief Director: Legal services	1
Percentage of CHCs implementing PACS	Total number of Community Health Centres where Patient Archiving Communication system (PACS) is deployed and operational as a percentage of total Community Health Centres	CHCs records	Sum of total Community Health Centres s with operational PACS solution	Total number of Community Health Centres	CHCs Usage Report Signoff certificate of acceptance	Accuracy dependent on the quality of data from reporting facilities	Not applicable	All CHCs	Not Applicable	Annual	Higher	CIO	1
Percentage of CHCs with integrated Health Information System	Total number of CHCs with integrated health Information System implemented as a percentage of all CHCs	Certificate of acceptance	Total number of CHCs with integrated health information system implemented	Total number of CHCs	CHC certificate of acceptance	Not applicable	Not applicable	All CHCs	Not Applicable	Annual	Higher	CIO	1

Indicator Title	Definition	Source of Data	Method of Calculation/ Assessment		Means of Verification	Assumptions	Disaggregation of beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative (year- end); cumulative (year-to-date) or non-cumulative	Reporting cycle	Desired	Indicator Responsibility	Budget Programme Number
			Numerator	Denominator									
Percentage of hospitals with integrated Health Information System	Total number of hospitals with integrated health Information System implemented as a percentage of all hospitals	Hospital certificate of acceptance	Total number hospitals with integrated health information system implemented	Total number of hospitals	Hospital certificate of acceptance Usage Report	Not applicable	Not applicable	All hospitals	Not Applicable	Annual	Higher	CIO	1
Percentage of Forensic Pathology Management Information Systems implemented	Total number of Forensic Pathology Management Information Systems (signoff) certificate of acceptance) as a percentage of all Forensic Pathology Management Information Systems	Forensic Pathology Management Information Systems certificate of acceptance	Total number of Forensic Pathology Management Information Systems implemented	Total number of Forensic Pathology Management Information Systems	Forensic Pathology Management Information Systems certificate of acceptance	Not applicable	Not applicable	All districts	Not Applicable	Annual	Higher	CIO	1
Number of Hospitals implementing the Queue Management System	The Queue Management System will be implemented in hospitals to reduce patient waiting times and increase efficiency in facilities		Total of all hospitals implementing the Queue Management System	Not Applicable		Accuracy dependent on quality of data submitted by reporting priority hospitals	Not Applicable	All 37 Hospitals	Not Applicable	Annual	Higher	CIO	1
Patient Experience of Care satisfaction rate	Total number of Satisfied responses as a proportion of all responses from Patient Experience of Care survey questionnaires (in Fixed PHC clinics/ fixed CHCs/CDCs and public hospitals)	Patient Surveys	Sum of Patient Experience of Care responses reflecting satisfaction	Patient Experience of Care survey total responses	Patient Survey questionnaire and the PEC spreadsheet download	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Not Applicable	Annual	Higher	Director: Quality Assurance Managers	2,4,5
Severity assessment code (SAC) 1 incident reported within 24 hours rate	Severity assessment code (SAC) 1 incidents reported within 24 hours as a proportion of Severity assessment code (SAC) 1 incident reported	Ideal health monitoring tool	Severity assessment code 1 incidents reported within 24 hours	Severity assessment code 1 incidents reported	Ideal health monitoring tool -PSI register	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Cumulative (year-end)	Quarterly	Higher	Director: Quality Assurance	2,4,5

Indicator Title	Definition	Source of Data	Method of Calculation/ Assessment		Means of Verification	Assumptions	Disaggregation of beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative (year- end); cumulative (year-to-date) or non-cumulative	Reporting cycle	Desired	Indicator Responsibility	Budget Programme Number
			Numerator	Denominator									
Patient Safety Incident (PSI) case closure rate	Patient Safety Incident (PSI) case closed in the reporting month as a proportion of Patient Safety Incident (PSI) cases reported in the reporting month	Ideal health monitoring tool	Patient Safety Incident (PSI) case closed	Patient Safety Incident (PSI) case reported	Ideal health monitoring tool -PSI register	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Cumulative (year-end)	Quarterly	Higher	Director: Quality Assurance	2,4,5
Complaints resolution within 25 working days rate	Complaints resolved within 25 working days (including public holidays) as a proportion of all complaints resolved	Ideal clinic monitoring tool- Complaints register	Complaint resolved within 25 working days (SUM)	Complaint resolved (SUM)	Ideal clinic monitoring tool-Complaints register	Accuracy dependent on the quality of data from reporting facility	Not applicable	All Districts	Cumulative (year-end)	Quarterly	Higher	Director Quality Assurance	2,4 and 5
Ideal clinic status obtained rate	Fixed PHC health facilities that obtained Ideal Clinic status (bronze, silver, gold) as a proportion of fixed PHC clinics and CHCs and or CDCs	Fixed PHC clinics or fixed CHCs and or CDCs	Fixed PHC health facilities have obtained Ideal Clinic status	Fixed PHC clinics or fixed CHCs and or CDCs	Ideal Health Facility software	Accuracy dependent of reporting of data into the system	Not Applicable	All Districts clinics	Cumulative Year to date	Annual	Higher	Chief Director: District Health Services	2
Ideal hospital status obtained rate	A health facility with good infrastructure, efficient patient administrative processes, adequate managed	Ideal Hospital Framework	Hospitals that obtained Ideal Hospital status	Total number of hospitals	Ideal Hospital Framework	Accuracy dependant on the quality of data from reporting facility	Not applicable	All Hospitals	Cumulative Year to date	Annual	Ideal hospital status obtained	Director: Quality Assurance	2,4 and 5
Percentage of PHC facilities with functional Clinic committees	Improve quality of services at PHC facilities conducting scheduled meetings with functional Clinic Committees	Attendance Registers of meetings of Clinic committees and minutes of committee	Number of clinics with functional clinic committees (functional clinic committee is composed of 3 to 5 members)	Total Number of PHC Facilities	Attendance Registers	Attendance Registers are accurately kept including minutes	Not Applicable	All Districts	Non-cumulative	Annual	Higher	MEC's office	2
Percentage of hospitals with functional hospital boards	Improve quality of services at hospitals conducting scheduled meetings with functional Hospital Boards	Attendance Registers of meetings of hospital boards	Number of hospitals with functional Hospital Boards	Number of Hospitals	Attendance registers and minutes of meetings	Attendance Registers are accurately kept	Not Applicable	All Hospitals	Non-cumulative	Quarterly	Higher	MEC's office	2,4,5

Indicator Title	Definition	Source of Data	Method of Calculation/ Assessment		Means of Verification	Assumptions	Disaggregation of beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative (year- end); cumulative (year-to-date) or non-cumulative	Reporting cycle	Desired	Indicator Responsibility	Budget Programme Number
			Numerator	Denominator									
Number of facilities providing 24- hour emergency services	Total number of facilities with 24-hour emergency services	DHS standardised reporting tool	Sum of total facilities opened and providing 24 hours emergency	Not applicable	Facility reports	Accuracy dependant on the quality of data from reporting facility	Not applicable	All districts clinics	Non-Cumulative	Annual	Higher	Chief Director: DHS	2
Maternal Mortality in facility Ratio	Maternal death is death occurring during pregnancy, childbirth and the puerperium of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy and irrespective of the cause of death (obstetric and non- obstetric) per 100,000 live births in facility	Maternal death register, Delivery Register Deaths Review Forms M&M Minutes Maternity case records Patient folders PPIP	Maternal death in facility [in DHS and Referral Hospitals]	Live births known to facility (Live birth in facility plus born alive before arrival at facility) [in r DHS and Referral Hospitals]	Maternal death register, Delivery Register	Accuracy dependent on quality of data submitted by health facilities	Females	All Districts	Cumulative (year- to-date)	Annual (MCWH&N Programme) Quarterly (District Hospitals)	Lower	Director: MCWH&N Programme and DHS Managers	2 (Subprogram 2.2 and 2.4)

Indicator Title	Definition	Source of Data	Method of Calculation/ Assessment		Means of Verification	Assumptions	Disaggregation of beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative (year- end); cumulative (year-to-date) or non-cumulative	Reporting cycle	Desired	Indicator Responsibility	Budget Programme Number
			Numerator	Denominator									
Maternal Mortality in facility	Maternal death (In Regional and Tertiary Hospitals) are deaths occurring during pregnancy, childbirth and the puerperium of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy and irrespective of the cause of death (obstetric and non-obstetric)	Maternal death register, Delivery Register Deaths Review Forms M&M Minutes Maternity case records Patient folders PPIP	Maternal death in facility [in Regional and Tertiary/Central Hospitals]	Not Applicable	DHIS report on MMR Maternal Deaths Review Forms M&M Minutes	Accuracy dependent on quality of data submitted by health facilities	Females	Only Regional and Tertiary/ Central Hospitals	Cumulative (year-to-date)	Quarterly	Lower deaths	CEOs of Hospitals/DDG Clinical Services	4, 5
Child under 5 years diarrhoea case fatality rate	Diarrhoea deaths in children under 5 years as a proportion of diarrhoea separations under 5 years in health facilities	DHIS report Child PPIP Paediatric Ward register TPH21 TPH 57 Road to health card Patient folder Monthly input forms	Diarrhoea death under 5 years	Diarrhoea separation under 5 years	DHIS report Child PPIP	Accuracy dependent on quality of data submitted by health facilities	Children under 5-years	All Districts	Cumulative (year-end)	Quarterly	Lower	Director: MCWH&N Programme and Hospital CEOs, DHS, CEOs of Hospitals/DDG Clinical Services	2,4,5

Indicator Title	Definition	Source of Data	Method of Calculation/ Assessment		Means of Verification	Assumptions	Disaggregation of beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative (year- end); cumulative (year-to-date) or non-cumulative	Reporting cycle	Desired	Indicator Responsibility	Budget Programme Number
			Numerator	Denominator									
Child under 5 years pneumonia case fatality rate	Pneumonia deaths in children under 5 years as a proportion of pneumonia separations under 5 years in health facilities	DHIS report Child PPIP Paediatric Ward register TPH21 (hospital) TPH 57(hospital) Road to health card Patient folder PHC tick register (PHC) Death review forms Monthly input forms	Pneumonia death under 5 years	Pneumonia separation under 5 years	DHIS report Child PPIP	Accuracy dependent on quality of data submitted by health facilities	Children under 5-years	All Districts	Cumulative (year-end)	Quarterly	Lower	Director: MCWH&N Programme and Hospital CEOs, DHS, CEOs of Hospitals/DDG Clinical Services	2,4,5

Indicator Title	Definition	Source of Data	Method of Calculation/ Assessment		Means of Verification	Assumptions	Disaggregation of beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative (year- end); cumulative (year-to-date) or non-cumulative	Reporting cycle	Desired	Indicator Responsibility	Budget Programme Number
			Numerator	Denominator									
Child under 5 years severe acute malnutrition case fatality rate	Severe acute malnutrition deaths in children under 5 years as a proportion of Severe Acute Malnutrition (SAM) under 5 years in health facilities	DHIS report Child PPIP Paediatric Ward register TPH21 (hospital) TPH 57(hospital) Road to health card Patient folder PHC tick register (PHC) SAM deaths review forms Monthly input forms	Severe acute malnutrition (SAM) death under 5 Years	Severe acute malnutrition (SAM) inpatient under 5 years	DHIS, Paediatric Ward register, Child PPIP and SAM deaths review forms	Accuracy dependent on quality of data submitted by	Children under 5-years	All Districts	Cumulative (year-end)	Quarterly	Lower	Director: MCWH&N Programme and Hospital CEOs, DHS, CEOs of Hospitals/DDG Clinical Services	2,4,5
Death under 5 years against live birth rate	Children under 5 years who died during their stay in the facility as a proportion of all live births		Death in facility under 5 years total [in DHS and Referral Hospitals]	Live birth in facility [in DHS and Referral Hospitals]	DHIS, Midnight Report	Accuracy dependent on quality of data submitted by health facilities	Children under 5-years	All Districts	Cumulative (year- to-date)	Quarterly (MCWH&N Programme and District Hospitals)	Lower	Director: MCWH&N Programme, Chief Director: DHS (for District Hospitals)	2
[Number of] Death in facility under 5 years #	Children under 5 years who died during their stay in the facility as a proportion of all live births		Death in facility under 5 years total [in Regional and Tertiary/Central Hospitals]	Not Applicable	Midnight Report DHIS Child PPIP, SAM death review form, neonatal death report	Accuracy dependent on quality of data submitted by health facilities	Children	All Districts	Cumulative (year-to-date)	Quarterly (Regional, Central and Tertiary Hospitals)	Lower	Chief Director: DHS, CEOs of Regional and Tertiary/Central Hospitals, DDG Clinical Services	4,5

Indicator Title	Definition	Source of Data	Method of Calculation/ Assessment		Means of Verification	Assumptions	Disaggregation of beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative (year- end); cumulative (year-to-date) or non-cumulative	Reporting cycle	Desired	Indicator Responsibility	Budget Programme Number
			Numerator	Denominator									
Percentage of beds in district and regional hospitals offering acute ill mental health care users (72hrs assessment)	Total number of usable beds in districts and regional hospitals offering acutely ill mental health care users (72hrs assessment) as a proportion of total beds in usable beds	DHIS And Hospital reports	Sum of beds in district and regional hospitals offering acutely ill mental health care users (72hrs assessment)	Sum of all usable beds in district and regional hospitals	DHIS	Accuracy dependant on the quality of data from reporting facilities and DHIS and hospital reports	Not applicable	All district and regional hospitals	Not Applicable	Annual	Higher	Chief Director: DHS	2 and 4
HIV positive 15-24 years (excl ANC) rate	Adolescents and youth 15 to 24 years who tested HIV positive as a proportion of children who were tested for HIV in this age group	HTS Register (HIV Testing Services) or HTS module in TIER.Net DHIS Consent form Clinical stationery	HIV positive 15-24 years (excl ANC)	HIV test 15-24 years (excl ANC)	HTS Register (HIV Testing Services) or HTS module in TIER.Net, DHIS	Accuracy dependent on quality of data submitted by health facilities	Youth	All Districts	Not Applicable	Annual	Lower	Director: HAST, HIV/AIDS Programme Manager	2
HIV Test positive around 18 months rate #	Children who tested HIV positive using rapid antibody test around 18 months	Tick Register	HIV test positive around 18 months	HIV tests done around 18 months	Tick Register DHIS Patient File	Accuracy dependent on quality of data submitted by health facilities	Children at 18 months	All Districts	Cumulative (year-end)	Quarterly	Lower	Director: HAST HIV/AIDS Programme Manager	2

Indicator Title	Definition	Source of Data	Method of Calculation/ Assessment		Means of Verification	Assumptions	Disaggregation of beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative (year- end); cumulative (year-to-date) or non-cumulative	Reporting cycle	Desired	Indicator Responsibility	Budget Programme Number
			Numerator	Denominator									
HIV tests done - sum	The total number of HIV tests done in all age groups	PHC	HIV test done - Sum SUM {Antenatal HIV 1st test}+{Antenatal client HIV re-test}+{HIV test 19-59 months}+{HIV test 5-14 years (excl ANC)}+{HIV test 15 years and older (excl ANC)} + {HIV test 15-24 years female (excl ANC)} + {HIV test 15-24 years male} + {HIV test 25-49 years (excl ANC)} + {HIV test 50 years and older}	N/A	PHC Comprehensive Tick Register; HTS Register (HIV Testing Services) or HCT module in TIER.Net, DHIS	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	Cumulative (year-to-date)	Quarterly	Higher	Director: HAST HIV/AIDS Programme Manager	2
ART adult remain in care rate (12 months)	ART adult remain in care - total as a proportion of ART adult start minus cumulative transfer out	DHIS Tier.Net	ART adult remain in care - total	ART adult start minus cumulative transfer out	DHIS Tier.Net Patient file	Accuracy dependent on quality of data submitted by health facilities	Adults	All District	Cumulative (Year to-date)	Quarterly	Higher	Director: HAST	2
ART child remain in care rate (12 months)	ART child remain in care - total as a proportion of ART child start minus cumulative transfer out	DHIS Tier.Net Tier.net NHLS report	ART child remain in care – total	ART child start minus cumulative transfer out	DHIS Tier.Net Patient file	Accuracy dependent on quality of data submitted by health facilities	Children under 15 years	All Districts	Cumulative (Year to-date)	Quarterly	Higher	Director: HAST HIV/AIDS Programme Manager	2

Indicator Title	Definition	Source of Data	Method of Calculation/ Assessment		Means of Verification	Assumptions	Disaggregation of beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative (year- end); cumulative (year-to-date) or non-cumulative	Reporting cycle	Desired	Indicator Responsibility	Budget Programme Number
			Numerator	Denominator									
ART Adult viral load suppressed rate (12 months)	ART adult viral load under 50 as a proportion of ART adult viral load done Provincial Specific extended Definition (Reported based on 12 Months Cohort as per App framework)	DHIS Tier.net Tier.net NHLS report	ART adult viral load under 50	ART adult viral load done	Web-DHIS Tier.Net Patient file	Accuracy dependent on quality of data submitted by health facilities	Adult clients	All Districts	Cumulative (year-end)	Quarterly	Higher	Director: HAST HIV/AIDS Programme Manager	2
ART child viral load suppressed rate (12 Months)	ART child viral load under 50 as a proportion of ART child viral load done Provincial Specific extended Definition (Reported based on 12 Months Cohort as per App framework)	Tier.Net DHIS Tier.net NHLS report	ART child viral load under 50	ART child viral load done	Web-DHIS Tier.Net Patient file	Accuracy dependent on quality of data submitted by health facilities	Children and adolescent	All Districts	Cumulative (year-end)	Quarterly	Higher	Director: HAST HIV/AIDS Programme Manager	2
All DS-TB client lost to follow-up rate	TB clients who started drug-susceptible tuberculosis (DS-TB) treatment and who subsequently became lost to follow-up as a proportion of all those in the treatment outcome cohort	Tier.Net DHIS Tier.net NHLS report	All DS-TB client loss to follow-up	All DS-TB treatment start	Web-DHIS Tier.net Patient file	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Cumulative (year- end)	Quarterly	Lower	Director: HAST TB Programme Manager	2
All DS-TB client treatment success rate	TB clients who started drug-susceptible tuberculosis (DS-TB) treatment and who subsequently successfully completed treatment as a proportion of all those in the treatment outcome cohort	DHIS	All DS-TB client successfully completed treatment	All DS- TB treatment start	Web-DHIS Tier.Net Patient file	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Cumulative (year-end)	Quarterly	Higher	Director: HAST TB Programme Manager	2

Indicator Title	Definition	Source of Data	Method of Calculation/ Assessment		Means of Verification	Assumptions	Disaggregation of beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative (year- end); cumulative (year-to-date) or non-cumulative	Reporting cycle	Desired	Indicator Responsibility	Budget Programme Number
			Numerator	Denominator									
All DS-TB client death rate	TB clients who started drug-susceptible tuberculosis (DS-TB) treatment and who subsequently died as a proportion of all those in the treatment outcome cohort	DHIS	All DS-TB client died	All DS-TB treatment start	Web- DHIS Tier.net Patient file	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Cumulative (year-end)	Quarterly	Lower	Director: HAST TB Programme Manager	2
Rifampicin resistant/ Multidrug - Resistant treatment success rate #	TB Clients confirmed with RR/MDR TB with or without resistance to Isoniazid who successfully completed treatment	EDRWeb	TB Rifampicin resistant/ Multidrug Resistant successfully completed treatment	TB Rifampicin Resistant/ Multidrug Resistant client started on treatment	Patient folder EDRWeb	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Cumulative (year-end)	Quarterly	Higher	Director: HAST TB Programme Manager	2
TB Rifampicin resistant/Multidrug - Resistant lost to follow-up rate #	TB client with Rifampicin Resistant (RR)/ Multidrug Resistant (MDR) TB who are loss to follow up	EDRWeb	TB Rifampicin Resistant/ Multidrug Resistant client loss to follow-up	TB Rifampicin Resistant/ Multidrug Resistant client started on treatment	Patient folder EDRWeb	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Cumulative (year-end)	Quarterly	Lower	Director: HAST TB Programme Manager	2
TB Pre-XDR treatment success rate #	TB client with Rifampicin Resistant (RR)/ Multidrug Resistant (MDR) TB and resistant to a fluoroquinolone who successfully completed treatment	EDRWeb	TB Pre-XDR client who successfully completed treatment	TB Pre-XDR client started on treatment	Patient folder EDRWeb	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Cumulative (year-end)	Quarterly	Higher	Director: HAST TB Programme Manager	2
TB Pre-XDR loss to follow up rate #	TB client with Rifampicin Resistant (RR)/ Multidrug Resistant (MDR) TB and resistant to a fluoroquinolone who are loss to follow up	EDRWeb	TB Pre-XDR clients who are loss to follow up	TB Pre-XDR clients started on treatment	Patient folder EDRWeb	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Cumulative (year-end)	Quarterly	Lower	Director: HAST TB Programme Manager	2

Indicator Title	Definition	Source of Data	Method of Calculation/ Assessment		Means of Verification	Assumptions	Disaggregation of beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative (year- end); cumulative (year-to-date) or non-cumulative	Reporting cycle	Desired	Indicator Responsibility	Budget Programme Number
			Numerator	Denominator									
Couple year protection rate	Women protected against pregnancy by using modern contraceptive methods, including sterilisations, as proportion of female population 15-49 year. Couple year protection are the total of (Oral pill cycles / 15) +	PHC	Couple year protection (of (Oral pill cycles / 15) +	Population 15-49 years female	PHC Comprehensive Tick Register Birth Register, Labour, Combined and Postnatal ward Health Facility Register, DHIS Denominator: StatsSA	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	Cumulative (year-end)	Quarterly	Higher	Director: MCWH&N Programme	2
Delivery in 10 - 19 years in facility rate	Deliveries to women under the age of 20 years as proportion of total deliveries in health facilities	Health Facility Register, DHIS Birth register Maternity case record	Delivery 10-19 years in facility (Delivery 10 – 14 years in facility) + (delivery 15 – 19 years in facility)	Delivery in facility - total	Health Facility Register, DHIS	Accuracy dependent on quality of data submitted by health facilities	Females	All Districts	Cumulative (year-end)	Quarterly	Lower	Director: MCWH&N Programme	2
Antenatal 1st visits before 20 weeks rate	Women who have a first visit before they are 20 weeks into their pregnancy as proportion of all antenatal 1st visits	PHC/CHC	Antenatal 1st visits before 20 weeks	Antenatal 1st visit - total	PHC/CHC Comprehensive Tick Register	Accuracy dependent on quality of data submitted by health facilities	Females	All Districts	Cumulative (year-end)	Quarterly	Higher	Director: MCWH&N Programme	2
Live birth under 2500g in facility rate	Infants born alive weighing less than 2500g as proportion of total Infants born alive in health facilities (Low birth weight)	Delivery register, Midnight report DHIS Monthly input forms	Live birth under 2500g in facility	Live birth in facility	Delivery register, Midnight report, DHIS	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Cumulative (year-end)	Quarterly	Lower	Director: MCWH&N Programme	2
Mother postnatal visit within 6 days rate	Mothers who received postnatal care within 6 days after delivery as proportion of deliveries in health facilities	PHC/CHC	Mother postnatal visit within 6 days after delivery	Delivery in facility-total	PHC Comprehensive Tick Register Birth Register, Labour, Combined and Postnatal ward Health Facility Register, DHIS	Accuracy dependent on quality of data submitted by health facilities	Females	All Districts	Cumulative (year-end)	Quarterly	Higher	Director: MCWH&N Programme	2

Indicator Title	Definition	Source of Data	Method of Calculation/ Assessment		Means of Verification	Assumptions	Disaggregation of beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative (year- end); cumulative (year-to-date) or non-cumulative	Reporting cycle	Desired	Indicator Responsibility	Budget Programme Number
			Numerator	Denominator									
Neonatal death in facility rate	Infants 0-28 days who died during their stay in the facility per 1000 live births in facility	Delivery register, Midnight Report Child PPIP Pediatric Ward register TPH21 (hospital) TPH 57(hospital) Road to health card Patient folder PHC tick register (PHC)	Neonatal deaths (< 28 days) in facility	Live birth in facility	Delivery register, Midnight report	Accuracy dependent on quality of data submitted by health facilities	Children under 28 days	All Districts	Not Applicable	Annual	Lower	Director: MCWH&N Programme	2[42]
Infant PCR test positive around 6 months rate #	Infants tested PCR positive for follow-up test as a proportion of infants PCR tested around 6 weeks	PHC	Infant PCR test positive around 6 months	Infant PCR test around 6 months	PHC Comprehensive Tick Register	Accuracy dependent on quality of data submitted by health facilities	Children	All Districts	Cumulative (year-end)	Quarterly	Lower	Director: MCWH&N Programme	2
Immunisation under 1-year coverage	Children under 1 year who completed their primary course of immunisation as a proportion of population under 1 year	PHC	Immunised fully under 1 year	Population under 1 year	PHC Comprehensive Tick Register (Numerator Data) StatsSA (Denominator Data)	Accuracy dependent on quality of data submitted by health facilities	Children	All Districts	Cumulative (year-end)	Quarterly	Higher	Director: MCWH&N Programme	2

42 Neonatal deaths in facility rate and MMR in facility ratio are measured Annually in contrast with the National Framework and NIDS framework for the following reasons in Gauteng province:
These are new indicators and the definition for these indicators will be finalized once the NIDS are finalized

Indicator Title	Definition	Source of Data	Method of Calculation/ Assessment		Means of Verification	Assumptions	Disaggregation of beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative (year- end); cumulative (year-to-date) or non-cumulative	Reporting cycle	Desired	Indicator Responsibility	Budget Programme Number
			Numerator	Denominator									
Measles 2nd dose 1 year coverage	Children 1 year (12 months) who received measles 2nd dose, as a proportion of the 1-year population.		Measles 2nd dose	Target population 1 year	Numerator: PHC Comprehensive Tick Register Denominator: StatsSA DHIS	Accuracy dependent on quality of data submitted by health facilities	Children	All Districts	Cumulative (year-end)	Quarterly	Higher	Director: MCWH&N Programme	2
Vitamin A dose 12-59 months coverage	Children 12-59 months who received Vitamin A 200,000 units, every six months as a proportion of population 12-59 months.	PHC	Vitamin A dose 12-59 months (Vit A dose 12-59 months + COS Vitamin A dose 12-59 months)	Target population 12-59 months * 2	PHC Comprehensive Tick Register, Outreach register	PHC register is not designed to collect longitudinal record of patients. The assumption is that the calculation proportion of children would have received two doses based on this calculation	Children	All Districts	Cumulative (year-end)	Quarterly	Higher	Director: MCWH&N Programme	2
School Grade 1 learners screened	Number of Grade 1 learners that received at least one type of screening by a nurse in the ISHP service package. This excludes follow-up visits and referrals and each learner must be counted only once per school year (Quintile 1 to 5 Public primary schools)	School Health data collection forms	School Grade 1 - learners screened. (Sum)	N/A	School Health data collection forms	Accuracy dependent on quality of data submitted by School health services	Not applicable	All districts	Cumulative	Annual	Higher	Director: MCWH&N Programme	2
School Grade 8 learners screened	Number of Grade 8 learners that received at least one type of screening by a nurse the ISHP service package (Quintile 1 to 5 Public primary and secondary schools)	School Health data collection forms	School Grade 8 - learners screened (SUM)	N/A	School Health data collection forms	Accuracy dependent on quality of data submitted by School health services	Not applicable	All districts	Cumulative	Annual	Higher	Director: MCWH&N Programme-Manager	2

Indicator Title	Definition	Source of Data	Method of Calculation/ Assessment		Means of Verification	Assumptions	Disaggregation of beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative (year- end); cumulative (year-to-date) or non-cumulative	Reporting cycle	Desired	Indicator Responsibility	Budget Programme Number
			Numerator	Denominator									
Malaria case fatality rate	Malaria deaths reported in South Africa. The death resulting from primary malaria diagnosis at the time of death	Notifiable Medical Conditions information system	Malaria deaths reported	Malaria new cases reported	Notifiable Medical Conditions information system	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Cumulative year-to-date	Quarterly	Lower	Director: Public Health, Communicable Diseases Manager	2
Normal Haemoglobin A1c (HbA1c) test with result ≤8% rate	Total number of diabetic clients with HbA1C test with a result less than ≤8%	NHLS Laboratory results	Total Number of diabetic clients with HbA1C test less than or equal 8%	Total number of diabetic clients with HbA1c tests conducted	NHLS data	Accuracy dependent on quality of data submitted by NHLS	Not applicable	All districts	Cumulative (Year-end)	Quarterly	Higher	Director: Public Health	2
Clients 18-44 years screened for Diabetes	Client 18-44 years, not diagnosed with diabetes, screened for diabetes in the facility	DHIS Tick register Monthly input forms	Client screened diabetes 18 -44 years	None	DHIS	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	Cumulative year to date	Quarterly	Higher	Director: Public Health	2
Clients 45 and older screened for Diabetes	Client 45 years and older, not diagnosed with diabetes, screened for diabetes in the facility	DHIS Tick register Monthly input forms	Clients screened for diabetes 45 years and older	None	DHIS	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	Cumulative year to date	Quarterly	Higher	Director: Public Health	2
Clients 18-44 years screened for Hypertension	Client 18-44 years, not diagnosed with hypertension, screened for hypertension in the facility	DHIS Tick register Monthly input forms	Clients screened for hypertension 18 - 44 years	None	DHIS	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	Cumulative year to date	Quarterly	Higher	Director: Public Health	2
Clients 45 and older screened for Hypertension	Client 45 years and older, not diagnosed with hypertension, screened for hypertension in the facility	DHIS Tick register Monthly input forms	Clients screened for hypertension 45 years and older	None	DHIS	Accuracy dependent on quality of data submitted by health facilities	Applicable	All Districts	Cumulative year to date	Quarterly	Higher	Director: Public Health	2
EMS P1 urban response under 30 minutes rate	EMS P1 calls in urban locations with response times under 30 minutes as a proportion of EMS P1 urban responses	DHIS, institutional EMS registers, EMS input forms	EMS P1 urban response under 30 minutes	EMS P1 urban responses	DHIS, institutional EMS registers OR DHIS, patient and vehicle report	Accuracy dependent on quality of data from reporting EMS station	Not Applicable	Not Applicable	Cumulative year end	Quarterly	Higher	Director: EMS	3

Indicator Title	Definition	Source of Data	Method of Calculation/ Assessment		Means of Verification	Assumptions	Disaggregation of beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative (year- end); cumulative (year-to-date) or non-cumulative	Reporting cycle	Desired	Indicator Responsibility	Budget Programme Number
			Numerator	Denominator									
EMS P1 rural response under 60 minutes rate	EMS P1 calls in rural locations with response times under 60 minutes as a proportion of EMS P1 rural responses	DHIS, institutional EMS registers OR DHIS, patient and vehicle report	EMS P1 rural response under 60 minutes	EMS P1 urban responses	DHIS, institutional EMS registers OR DHIS, patient and vehicle report.	Accuracy dependent on quality of data from reporting EMS station	Not Applicable	Not Applicable	Cumulative year end	Quarterly	Higher	Director: EMS	3
EMS P1 urban inter-facility transfer (IFT) under 30 minutes rate	EMS P1 inter-facility transfers response times under 30 minutes as a proportion of EMS urban inter-facility transfers	Patient report form and	EMS P1 urban inter-facility transfers under 30 minutes	EMS P1 urban inter-facility transfers	Patient Report Forms	None	N/A	N/A	Cumulative	Monthly Quarterly Annually	Higher	Director: EMS	3
EMS P1 rural inter-facility transfer (IFT) under 60 minutes rate	EMS P1 inter-facility transfers response times under 60 minutes as a proportion of EMS rural inter-facility transfers	Patient report form and	EMS P1 rural inter-facility transfer (IFT) under 60 minutes rate	EMS P1 rural inter-facility transfers	Patient Report Forms	None	N/A	N/A	Cumulative	Quarterly	Higher	Director: EMS	3
EMS all calls with response under 60 minutes rate	EMS all calls in urban and rural locations with response times under 60 minutes as a proportion of EMS all response total. Response time is calculated from the time the call is received to the time that the first dispatched medical resource arrives on scene	Patient report form and	EMS all calls with response under 60 minutes	EMS all calls response - total	Patient Report Forms	None	N/A	N/A	Cumulative	Quarterly	Higher	Director: EMS	3
Employee satisfaction rate	The percentage of employees who participated in the employee satisfaction survey who were satisfied with the work environment	Survey reports	Total number of employees satisfied with the service in the Department	Total number of employees that took part in the employee satisfaction survey	Survey reports	Accuracy dependant on the quality of data from reporting health facilities	Not Applicable	All Districts	Not applicable	Annual	Higher	Chief Director: EH&WP	6

Indicator Title	Definition	Source of Data	Method of Calculation/ Assessment		Means of Verification	Assumptions	Disaggregation of beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative (year- end); cumulative (year-to-date) or non-cumulative	Reporting cycle	Desired	Indicator Responsibility	Budget Programme Number
			Numerator	Denominator									
Number of nursing students enrolled	Number of students enrolled in the nursing programme	Learner Management Information System	Number of students that have been enrolled in the nursing programme	N/A	Learner Management Information System (LMIS)/ enrolment databases from Nursing Colleges	Accuracy dependent on the accuracy of data in LMIS	Not Applicable	Not Applicable	Not applicable	Annual	Higher	Chief Director Nursing and Principal of GCON	6
Number of emergency medical care students enrolled (Intake of 60 students)	The NQF Aligned programmes which provides excellent, quality education experience to students, considering the needs of the Department of Health and related role players: Diploma NQF 6 Higher Certificate NQF 5	Students' administration report Form	Number of Emergency Medical Care students enrolled.	N/A	Students' administration report Form	None	N/A	N/A	Cumulative	Annual	Higher	EMS Training and Development Director: EMS	3, 6
Percentage vital medicine availability at health facilities	Total number of drugs available in the essential medicines list against total essential medicine list at health facilities	RxSolution the current inventory management system at hospital and district pharmacies	Total number of available medicines	Total essential medicine list x100	RxSolution inventory management system at hospitals and districts	Accuracy dependant on the quality of data from reporting health facilities	Not Applicable	All Districts	Cumulative year end	Quarterly	Higher	Chief Director: Pharmaceutical services	7
Percentage essential medicine availability at health facilities	Total number of drugs available in the essential medicines list against total essential medicine list at health facilities	Rx Solution the current inventory management system at hospital and district pharmacies	Total number of available medicines	Total essential medicine list x100	Rx Solution, inventory management system at hospitals and district pharmacies	Accuracy dependent on the quality of data from reporting health facilities	Not Applicable	All Districts	Cumulative year end	Quarterly	Higher	Chief Director: Pharmaceutical services	7

Indicator Title	Definition	Source of Data	Method of Calculation/ Assessment		Means of Verification	Assumptions	Disaggregation of beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative (year- end); cumulative (year-to-date) or non-cumulative	Reporting cycle	Desired	Indicator Responsibility	Budget Programme Number
			Numerator	Denominator									
Number of patients enrolled on centralized chronic medicine dispensing and distribution programme (Cumulative)	Total number of patients enrolled on centralized chronic medicine dispensing and distribution programme	CCMDD service provider reports and district pharmacies	Sum (total of patients enrolled on centralized chronic medicine dispensing and distribution programme)	N/A	CCMDD service provider reports	Accuracy dependent on the quality of data from reporting health facilities	Not Applicable	All Districts	Cumulative	Annual	Higher	District Manager and Chief Director: Pharmaceutical services	7
Percentage of Health facilities with completed capital infrastructure projects	Number of health facilities with completed capital infrastructure projects (i.e. Practical Completion or equivalent achieved for projects categorised as New & Replacement, Upgrade & Additions or Rehabilitation, Renovations & Refurbishments) expressed as a percentage of the number of health facilities planned to have completed capital infrastructure projects. the total SCM budget	Project management Information Systems (PMIS)	Total number of health facilities with completed capital infrastructure projects i.e. Practical Completion Certificate (or equivalent) issued	Total number of health facilities planned to have completed capital infrastructure projects i.e. Practical Completion Certificate (or equivalent) planned to be issued	Project list (B5) and Practical Completion Certificates (or equivalent)	Accuracy dependent on quality of data from PMIS is subjective as it depends on the honesty of vendors FR fronting issues etc.)	Not Applicable	All Districts	Cumulative (year- to-date)	Annual	Higher	Head of Infrastructure	8
Number of new Primary Health Care Centres completed	Number of Primary Health include Day Clinic, and Community Health Centres to be constructed as new or as replacement of	Project management Information Systems (PMIS)	Total number of new PHC facilities completed and handed over	NA	Project management Information Systems (PMIS)	Accuracy dependent on quality of data from PMIS	Not Applicable	All Districts	Non-cumulative	Annual		Head of Infrastructure	8

Annexures

Annexure A: Trading Entities

The Gauteng Department of Health does not have a Public Entity; the Medical Supplies Depot (MSD), is a trading entity, falls under the oversight and control of the MEC as described below.

Name of Trading Entity	Mandate	Output	Current Annual Budget (R'000)
Medical Supplies Depot (MSD)	Registered as 'The Central Medical Trading Account' since 1 April 1992 under the Exchequer Act, Act 1 of 1976. The depot charges a levy of 5% on stock supplied to the provincial health care facilities.	Timely testing of medicines by laboratory Availability of EML medicine improved Effective distribution of essential medicines to health facilities Fully functional ordering system	5% of the Department's Medicine budget

Annexure B: Changes to the five-year strategic plan

Original Outcome	Changes to the Outcome	Original Outcome Indicator	Changes to the Outcome Indicator	Original 5-year target (2024/25)	Changes to the Original 5-year target	Reasons for the Change
Morbidity and Premature mortality due to Communicable diseases (HIV, TB, and Malaria) reduced		All TB Client death rate	All DS-TB Client death rate	<4%	5%	Indicator naming changed to realign with National Indicators Definitions (NIDS) The 5-year term target was amended due to Covid-19 pandemic that brought about delays in implementation of interventions.
	Morbidity and premature mortality due to non-communicable diseases reduced by 10%	Malaria case fatality rate		<1%	2%	The Malaria indicator was previously misclassified erroneously under the communicable disease outcome instead of under the non-communicable disease outcome Realignment with the outcome indicators and outcome in the 5-year strategic plan section of Explanation of planned performance over the next five years
						Alignment with the outcome in the Annual Performance Plan
						The 5-year end of term target was adjusted from <1% to 2% due to the emergence of Covid-19 pandemic
		School learners who are overweight		<10%	None	
		Men and Women 18 years and older with hypertension		31.6%%	31.6%	Correction through the removal of the repeated % symbol
		Men and Women 18 years and older with diabetes		6.3%	None	None
		Maternal in facility mortality ratio		<60 per 100 000 live births	113 per 100 000 live births	The end of term target was changed due to the emergence of Covid-19 pandemic
		Neonatal (<28 days) dearth in facility mortality ratio	Neonatal death in facility rate	<10 per 1 000 live births	11 per 1 000 live births	The end of term target was changed due to the emergence of Covid-19 pandemic. The changes to the indicator nomenclature were due to alignment of the original indicator with NIDS
		ART client remain on ART end of the month Total		2 475 331	1 349 345 (children and adults	Changes made to the target due to effect of Covid on retention on treatment
		Employee satisfaction rate		75%	60%	The 5-year target was changed from 75% employee satisfaction rate to 60% because 75% is no longer realistic given that in the past three years we were below 60% on performance due to a number of reasons such as Life Esidimeni issues, BOL building fire eruptions and emergence of Covid-19 pandemic. The above-mentioned affects the mental health of employees, also demotivates, and demoralizes them. Hence, it is difficult to get the full participation of employees in completing the Staff Survey. Another reason is the non-compliance by CEO in institutions that are not participating in the survey

Original Outcome	Changes to the Outcome	Original Outcome Indicator	Changes to the Outcome Indicator	Original 5-year target (2024/25)	Changes to the Original 5-year target	Reasons for the Change
		Contingent liability of medico-legal cases	Rand value of medico-legal claims			Further refinement of the original indicator to make it more specific and quantifiable
Package of services available to the population is expanded with priority given to equity and most cost-effective services	Quality of health services in public health facilities improved removal. Co-coordinating health services across the care continuum, re-orienting the health system towards primary health	EMS P1 rural and urban response time				Alignment of outcome indicator EMS P1 rural and urban response time with outcome in the APP and NDOH APP framework
		Death in facility under 5 years rate	Death under 5 years against live birth rate	<3 per 1000 live births	1.4%	Indicator amended to align with the NIDS and also change in method of calculation
Not in the Strategic Plan	Coordinating health services across the care continuum, re-orientating the health system towards primary health care					Added in the APP after the approval of Strategic Plan hence the number of outcomes is no longer aligning between the Strat Plan and the APP. Outcome disclosed for adding to the Original Strat plan in order to align with NODH planning framework
		Percentage of health facilities electronically recording clinical codes for their patient visits	Not included in the APP			The measurement removed because it's a Lag indicator and can only be tracked following the roll-out of the HIS system
		Percentage of health facilities with major refurbishment or rebuild	Percentage of Health facilities with completed capital infrastructure projects			The indicator was changed to align with the National framework

Annexure C: District Development Model (Gauteng city region (GCR) – Urban Renewal Programme (URP)

Areas of Intervention (examples)	Medium Term (3-year MTEF)						
	Project description		District Municipality	Location: GPS coordinates		Project leader	Social partners
				Latitude	Longitude		
Health Infrastructure	Alexandra CHC	Upgrading of the existing CHC	COJ Municipality	-26,105703	28,090638	Head of Infrastructure	Municipality; Project Steering Committees; Local Councillors
Health Infrastructure	New Alexandra District Hospital	Construction of new District Hospital	COJ Municipality	N/A	N/A	Head of Infrastructure	Municipality; Project Steering Committees;Local Councillors
Health Infrastructure	Kliptown Clinic	Rehabilitation, Renovation and Refurbishment	COJ Municipality	-26,2902	27,89538	Head of Infrastructure	Municipality; Project Steering Committees; Local Councillors
Health Infrastructure	New Eldorado CHC	Construction of new CHC	COJ Municipality	26.286262	27.907176	Head of Infrastructure	Municipality; Project Steering Committees; Local Councillors
Health Infrastructure	Bekkersdal West CHC	Rehabilitation, Renovation and Refurbishment	Rand West City Local Municipality	GIS Coordinates to be updated	GIS Coordinates to be updated	Head of Infrastructure	Municipality; Project Steering Committees; Local Councillors
Health Infrastructure	New Borwa Clinic	Construction of new Clinic	Rand West City Local Municipality	N/A	N/A	Head of Infrastructure	Municipality; Project Steering Committees; Local Councillors
Health Infrastructure	Levai Mbatha CHC	Upgrading of the existing structure.	Sedibeng District	GIS Coordinates to be updated	GIS Coordinates to be updated	Head of Infrastructure	Municipality; Project Steering Committees; Local Councillors
Health Infrastructure	Dr. Helga Kuhn Clinic	Upgrading of the existing structure & Addition.	(Emfuleni Local Municipality	GIS Coordinates to be updated	GIS Coordinates to be updated	Head of Infrastructure	Municipality; Project Steering Committees; Local Councillors
Health Infrastructure	Evaton Main Clinic	Upgrading of existing structure.	Sedibeng District	GIS Coordinates to be updated	GIS Coordinates to be updated	Head of Infrastructure	Municipality; Project Steering Committees; Local Councillors
Health Infrastructure	Beverly Hills Clinic	Upgrading of existing structure & Addition.	(Emfuleni Local Municipality	GIS Coordinates to be updated	GIS Coordinates to be updated	Head of Infrastructure	Municipality; Project Steering Committees; Local Councillors
Health Infrastructure	Mpumelelo Clinic	Upgrade & Addition of existing structure	Sedibeng District	GIS Coordinates to be updated	GIS Coordinates to be updated	Head of Infrastructure	Municipality; Project Steering Committees; Local Councillors
Health Infrastructure	New Kgabo CHC	Construction of new CHC	City of Tshwane	25.470825	28.058184	Head of Infrastructure	Municipality; Project Steering Committees; Local Councillors

Annexure D: Conditional Grant

Name of Grant	Purpose	Outputs	Current Annual Budget	Period of Grant
Comprehensive HIV AIDS conditional grant	Enable the health sector to develop an effective response to HIV and AIDS including universal access to HIV Counselling and Testing. Support the implementation of the National operational plan for comprehensive HIV and AIDS treatment and care. Subsidise in-part funding for the antiretroviral treatment plan	• Clients tested for HIV. • Adults remain in care. • children remain in care. • Adult viral load suppressed rate. • ART Child viral load suppressed rate. • All DS – TB Client Treatment Success Rate.		1 year 2022/23
National tertiary services grant	Ensure provision of tertiary health services for all south African citizens. Compensate tertiary facilities for the costs associated with provision of these services includi ng cross border patients	• Day patient separations • Inpatient days • Inpatient separations • Outpatient first attendances • Outpatients follow up attendances		1 year 2022/23
Health profession training and development grant (HPTDG)	Support provinces to fund service costs associated with training of health science trainees on the public service platform.	• Number of posts funded • specialists • registrars • medical officers • clinical supervisors • Grant managers		1 year 2022/23
Health facilities revitalisation grant	Help accelerate construction, maintenance, upgrading and rehabilitation of new and existing infrastructure in health including health technology, organisational design (OD) systems and quality assurance (QA), Supplement expenditure on health infrastructure delivered through public-private partnerships, Enhance capacity to deliver health infrastructure.	• (DRAFT) • 2 Clinics Completed. • JHB Forensic Pathology Services Building to be completed • Hillbrow Hospital will be on tender by last quarter of 2022/23 • 2 Clinics, and 2 CHC's will be on • Construction	R 965 871 000	1 year 2022/23
Human papilloma virus (HPV)	Enable the health sector to prevent cervical cancer by making available HPV vaccination for grade four schoolgirls in all public and special schools	• Grade 5 schoolgirls aged 9 years and above vaccinated for HPV. • School with grade 5 schoolgirls reached by the HPV vaccination team.		1 year 2022/23
National health insurance (NHI) personal services component-subcomponent of health practitioner contracting	Expand the health services benefits through the strategic purchasing services from health care providers	• Health professionals contracted (total and by discipline)		1 year 2022/23

Annexure E: Long term population projections 2019-2023 (calendar year)

The long-term population projections 2019-2030 (calendar year) is too big and comprehensive to be included as an annexure. The projection will be made available to managers and oversight bodies if requested. StatsSA 2022 Projections.

	MALES					FEMALES				
Age	Sedibeng District Municipality (DC42)	West Rand DM (DC48)	Ekurhuleni Metropolitan Municipality	City of Johannesburg Metropolitan Municipality	City of Tshwane Metropolitan Municipality	Sedibeng District Municipality (DC42)	West Rand DM (DC48)	Ekurhuleni Metropolitan Municipality	City of Johannesburg Metropolitan Municipality	City of Tshwane Metropolitan Municipality
0	7556	7706	34970	49799	32573	7298	7410	34209	48794	31681
1.	7612	7570	34516	50347	33306	7332	7299	33807	49391	32459
2.	7629	7727	34571	50264	32951	7303	7472	33867	49350	32180
3.	7649	7909	34699	49960	32392	7274	7668	33996	49091	31691
4.	7685	8043	34781	49596	31920	7262	7811	34066	48749	31248
5.	7715	8109	34722	49051	31444	7255	7894	34032	48273	30813
6.	7739	8120	34545	48364	30969	7238	7911	33839	47599	30324
7.	7761	8092	34292	47596	30509	7213	7880	33538	46803	29813
8.	7812	8048	34058	46931	30206	7215	7828	33238	46084	29428
9.	7885	7960	33751	46300	30047	7273	7769	33008	45588	29294
10.	7974	7839	33373	45709	30011	7338	7666	32660	45060	29228
11.	8101	7733	33130	45356	30166	7469	7606	32566	44950	29463
12.	8292	7669	33178	45399	30600	7651	7581	32719	45201	29945
13.	8338	7527	32656	44804	30525	7733	7504	32444	45029	30090
14.	8320	7450	31919	44160	30239	7731	7458	31846	44698	30000
15.	8296	7474	31249	43787	29970	7679	7460	31125	44426	29823
16.	8199	7450	30391	43176	29502	7561	7413	30215	43942	29473
17.	8083	7410	29481	42527	29033	7438	7356	29297	43495	29162
18.	7989	7405	29025	42296	28694	7318	7330	28751	43423	28970
19.	7844	7367	29001	42240	28208	7126	7272	28523	43445	28605
20.	8033	7652	30678	44322	28966	7218	7534	29901	45616	29482
21.	8465	8183	33417	47899	30644	7519	8033	32272	49291	31271
22.	8879	8713	36209	51536	32278	7789	8519	34613	52931	32976
23.	9231	9189	38758	54897	33875	8013	8944	36796	56451	34683
24.	9333	9403	40078	56704	34881	8039	9095	37970	58678	35839
25.	9524	9691	41599	58968	36491	8152	9295	39444	61595	37640

MALES						FEMALES				
Age	Sedibeng District Municipality (DC42)	West Rand DM (DC48)	Ekurhuleni Metropolitan Municipality	City of Johannesburg Metropolitan Municipality	City of Tshwane Metropolitan Municipality	Sedibeng District Municipality (DC42)	West Rand DM (DC48)	Ekurhuleni Metropolitan Municipality	City of Johannesburg Metropolitan Municipality	City of Tshwane Metropolitan Municipality
26.	9798	10060	43503	61795	38510	8328	9559	41273	65112	39851
27.	9915	10271	44781	63725	39987	8366	9665	42512	67719	41506
28.	9971	10401	45680	65209	41132	8342	9687	43259	69585	42688
29.	10050	10527	46487	66714	42134	8333	9708	43685	70973	43505
30.	10067	10563	46838	67683	42659	8276	9657	43512	71404	43665
31.	10032	10536	46894	68273	42931	8186	9560	43083	71416	43562
32.	10022	10525	47003	68986	43278	8125	9482	42718	71531	43526
33.	9956	10445	46828	69262	43359	8033	9365	42173	71304	43287
34.	9730	10184	45912	68365	42734	7827	9118	41095	70109	42469
35.	9424	9827	44627	66870	41740	7571	8812	39794	68478	41381
36.	9139	9486	43401	65475	40783	7337	8526	38558	66911	40330
37.	8490	8769	40416	61393	38155	6834	7923	35849	62711	37721
38.	8042	8247	38297	58682	36260	6471	7475	33802	59586	35670
39.	7777	7891	36913	57229	34933	6240	7175	32371	57474	34051
40.	7421	7435	35003	55002	33003	6057	6924	31126	55602	32465
41.	7121	7045	33341	53078	31294	5827	6619	29614	53170	30583
42.	6657	6502	30896	49817	28872	5458	6157	27381	49393	27979
43.	6247	6055	28806	46889	26733	5194	5818	25726	46441	25993
44.	6012	5842	27700	45238	25415	5019	5579	24574	44074	24551
45.	5820	5718	26917	43861	24337	4903	5407	23753	42056	23480
46.	5637	5614	26170	42470	23295	4808	5258	23025	40147	22508
47.	5487	5547	25564	41276	22367	4670	5057	22088	37844	21313
48.	5321	5467	24804	39777	21438	4586	4924	21358	35964	20438
49.	5186	5416	24042	38221	20763	4541	4850	20702	34358	19848
50.	5033	5345	23072	36291	20107	4429	4717	19668	32258	19060
51.	4768	5156	21570	33508	19015	4364	4633	18841	30513	18496
52.	4443	4896	19815	30335	17703	4346	4598	18214	29095	18155
53.	4233	4758	18565	27972	16768	4358	4577	17729	27912	17874
54.	4107	4714	17669	26199	16005	4376	4531	17317	26840	17470
55.	4052	4750	17069	24911	15391	4400	4463	16973	25886	16973
56.	4015	4799	16528	23720	14828	4418	4384	16612	24937	16448

MALES						FEMALES				
Age	Sedibeng District Municipality (DC42)	West Rand DM (DC48)	Ekurhuleni Metropolitan Municipality	City of Johannesburg Metropolitan Municipality	City of Tshwane Metropolitan Municipality	Sedibeng District Municipality (DC42)	West Rand DM (DC48)	Ekurhuleni Metropolitan Municipality	City of Johannesburg Metropolitan Municipality	City of Tshwane Metropolitan Municipality
57.	3965	4827	15928	22443	14218	4426	4292	16217	23967	15894
58.	3911	4829	15319	21225	13632	4415	4176	15766	23008	15329
59.	3857	4794	14716	20144	13122	4413	4065	15371	22280	14919
60.	3771	4687	14016	19038	12578	4398	3939	14946	21641	14564
61.	3684	4565	13329	17994	12047	4278	3721	14196	20576	13895
62.	3585	4422	12618	16948	11485	4192	3539	13604	19765	13377
63.	3473	4242	11907	15930	10905	4130	3380	13107	19127	12941
64.	3346	4012	11205	14931	10296	4045	3208	12541	18415	12411
65.	3214	3749	10532	13980	9681	3895	2990	11785	17440	11671
66.	3076	3472	9870	13067	9073	3778	2804	11155	16668	11060
67.	2933	3185	9214	12181	8474	3662	2622	10547	15943	10476
68.	2782	2895	8567	11337	7873	3524	2438	9927	15178	9894
69.	2617	2612	7937	10547	7267	3306	2220	9155	14125	9181
70.	2468	2362	7394	9898	6729	3113	2038	8519	13231	8621
71.	2292	2092	6794	9174	6141	2918	1862	7900	12346	8075
72.	2106	1821	6183	8431	5553	2716	1689	7279	11444	7525
73.	1924	1568	5600	7718	4998	2514	1525	6682	10554	6995
74.	1739	1328	5022	7000	4462	2312	1369	6106	9669	6483
75.	1556	1109	4460	6282	3954	2107	1220	5449	8768	5972
76.	1391	920	3942	5581	3522	1912	1077	4977	7878	5441
77.	1239	759	3451	4867	3148	1745	951	4466	7074	4939
78.	1097	623	2978	4131	2820	1597	837	3989	6313	4453
79.	967	515	2523	3368	2542	1454	728	3514	5544	3943
80+	4569	869	8451	13124	9626	8210	2360	14671	25809	19257
Total	501479	506487	2126114	3099553	1950475	467520	476266	2038996	3195519	1999743

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