

HEALTH BUSINESS PLAN

**for
2026/27 as of
8th**

May 2026

City Of Johannesburg

Health Department



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Executive Director: Health



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MMC: Health and Social Development

LIST OF ABBREVIATIONS	
AIDS	Acquired immune deficiency syndrome.
ANC	Antenatal care
ART	Anti-retroviral treatment
BMI	Body Mass Index
CAP	Climate Change Action Plan
CBP	Community Based Planning
CDL	Chronic diseases of lifestyle
CBSAC	Community Based Substance Abuse Centre
DHIS	District Health Information system
SABSSM V Fifth	South African National HIV Prevalence, Incidence, Behaviour, and Communication Survey
GDoH	Gauteng Department of Health
GLU	Government of Local Unity (GLU)
HAST	HIV AIDS and Tuberculosis
HDI	Human development index
HSRC	Human Sciences Research Council
IMMR	Institutional maternal mortality ratio
MSM	Men who have sex with men
NCD	Non communicable diseases
NDoH	National Department of Health
NDP	National Development Plan
NHI	National Health Insurance
PCR	Polymerase chain reaction
PHC	Primary health care
PLHIV	People living with HIV
QIP	Quality Improvement Plans

VTP	Vertical HIV transmission Prevention Programmes
SADHS	South African Demographic and Health Survey
SDH	Social determinants of Health
SLA	Service level agreement
Stats SA	Statistics South Africa
STIs	Sexually Transmitted Infection
SCU	Supply Chain Unit
TB	Tuberculosis
TROA	Trends in Clients Remaining on ART
YLL	Years of life lost

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1.EXECUTIVE SUMMARY

The Health Department is a cornerstone of the City of Johannesburg's mission to improve the health and well-being of its residents. Tasked with delivering essential services, the department operates as a key driver of **equitable access to healthcare**, addressing both **primary healthcare needs** and critical **environmental health concerns**.

The department's operations are guided by a robust business planning framework influenced by various legislations. This ensures strategic alignment with international, national and provincial health priorities, such as communicable diseases, improving maternal and child health, and addressing the underlying social determinants of health.

Business Planning in the City is a customer focussed plan which is guided by the Joburg 2040 Growth and Development Strategy (GDS 2040), the National Development Plan (NDP 2030), the Medium-Term Development Plan (MTDP 2024–2029), the Gauteng Growing Together (GGT 2030) Plan and the five-year Integrated Development Plan (IDP) which includes community and political inputs in line with the principle of community based planning.

By integrating these broader objectives, the department delivers a unified, effective approach to health planning and service delivery.

The 2026/27 Health Business Plan is **adaptable to complex environment in Johannesburg**. Through analysis, strategic planning, integration, inclusivity and community-based planning, the department support the City's two imperatives:

- The **developmental needs** of residents
- and the **strategic direction** of political leadership.

This balance is achieved through strategic, integrated, and community-based planning, as envisaged in Chapter 4 of the Municipal Systems Act, 2000 (MSA).

This involves:

- **Strategic Direction:** Setting clear, measurable objectives for the department.
- **Stakeholder Collaboration:** Partnering with community leaders, healthcare providers, non-governmental organizations, and provincial departments to foster an inclusive, participatory approach.
- **Resource Optimization:** Ensuring funds, infrastructure, and personnel are allocated efficiently to maximize impact.

- **Performance Management:** Establishing robust systems for monitoring, evaluation, and adaptive management to respond to evolving health needs.

2. STRATEGIC OVERVIEW

The City of Johannesburg Health Department is mandated to deliver **Primary Health Care (PHC)** and **Municipal Health Services (Environmental Health)** in line with the **National Health Act (2003)** and the City's **GDS2040**. These services are essential for safeguarding public health and promoting sustainable living conditions.

2.1 Vision

A long and healthy life for all.

2.2. Mission

To improve health, well-being, and life expectancy for Johannesburg residents in a resilient, liveable environment.

2.3 Values

- Establishment of a caring climate for service users.
- Creation of a positive work environment.
- Ensure effective and efficient use of public monies.
- Forge partnerships with others.
- Commitment to excellence.

2.4 Service Footprint

- **76 clinics** (75 fixed, 1 satellite) and **13 mobile units** delivering PHC.
- **Municipal Health Services** include:
 - **Water Quality Monitoring:** Surveillance of potable water and reticulation systems.
 - **Food Control:** Inspections, certification, and enforcement to ensure food safety.
 - **Waste Management:** Monitoring and compliance for refuse, hazardous, and healthcare waste.
 - **Health Surveillance of Premises:** Risk assessments, building plan reviews, and enforcement.
 - **Communicable Disease Surveillance:** Outbreak response and hygiene promotion.

- **Vector Control:** Integrated pest management for rodents and disease vectors.
- **Environmental Pollution Control:** Air, water, soil, and noise pollution monitoring.
- **Disposal of the Dead:** Compliance monitoring of undertakers, mortuaries, and cemeteries.
- **Chemical Safety:** Safe handling and disposal of hazardous substances.

2.5 Strategic Imperatives for 2026/27

- **Universal Health Coverage & NHI Readiness:** Accelerate compliance with Ideal Clinic standards and strengthen PHC systems.
- **Digital Transformation:** Implement Electronic Health Records and digital environmental health systems for efficiency and data-driven decision-making.
- **Infrastructure Resilience:** Upgrade facilities for climate adaptation and uninterrupted service delivery.
- **Community-Centric Health:** Expand outreach through mobile clinics, school health programs, and stakeholder partnerships.
- **Quadruple Burden Response:** Intensify interventions for HIV/TB, maternal and child health, non-communicable diseases, and violence/injury prevention.

3. DEPARTMENTAL CORE MANDATE

Departmental Core Mandate

The Health Department's mandate is twofold: delivering **personal primary healthcare services** and **environmental health services** that safeguard and promote the well-being of Johannesburg's residents. Personal primary healthcare services are provided under a Service Level Agreement with the Gauteng Department of Health, ensuring alignment with provincial and national priorities.

Primary healthcare focuses on

- Accessible, community-based services
- Maternal and child health
- Chronic disease management
- Immunization, and preventive care forming the foundation of a healthier population.

Environmental Health Services extend beyond clinical care to address the conditions in which people live and work. This includes **monitoring water quality**, enforcing **food safety standards**, **managing waste**, and **controlling vectors** that spread disease. It also involves **surveillance of premises**, **pollution control**, and ensuring **safe disposal of the dead**. These interventions are critical for **preventing outbreaks**, **reducing health risks**, and **creating sustainable, liveable environments**.

The city faces a high burden of non-communicable diseases (NCDs), as well as significant levels of trauma and violence, which place substantial pressure on the public health system. Six of the top ten natural causes of death were attributed to **non-communicable diseases** (NCDs), including strokes, diabetes, and respiratory conditions.

HIV remains a significant health concern. While the HIV prevalence in Johannesburg rose between 2011 and 2021, the growth has been gradual due to more residents living with HIV accessing antiretroviral treatment (ART) at the City's clinics.

Early identification and timely intervention both medical and non-medical along with the expansion of health promotion activities, can help reduce the morbidity and mortality associated with chronic diseases.

Together, these functions reflect the City's constitutional obligation to bring essential health services closer to communities. They also advance the national vision of **"A Healthy Life for All"** by reducing maternal and child mortality, combating communicable and non-communicable diseases, and strengthening local health systems. **Collaboration** with community organizations, private providers, and NGOs ensures **inclusivity** and shared responsibility for public health.

4. LEGISLATION AND POLICY ENVIRONMENT

The Health Department operates within a robust legislative and policy framework that ensures accountability, collaboration, and alignment with national, provincial, and municipal priorities. This framework provides the foundation for delivering equitable and sustainable health services.

4.1 Constitutional Mandate

The Constitution of South Africa (1996) establishes the principle of subsidiarity, requiring that matters best administered locally be assigned to municipalities with capacity. Section 156(4) empowers municipalities to deliver health services efficiently and closer to communities.

4.2 Legislative Framework

- National Health Act (2003): Formalizes the delegation of healthcare responsibilities to municipalities, ensuring integration with national health priorities.
- Municipal Systems Act (2000): Guides planning, monitoring, and evaluation for effective service delivery.
- Municipal Finance Management Act (MFMA, 2003): Provides a framework for sustainable financial management.

- White Paper on Local Government (1998): Promotes cooperative governance, integrated planning, and public participation.

4.3 Policy Framework

The Government-wide Monitoring and Evaluation System (GWMES, 2007) underpins governance and accountability across all spheres of government, ensuring continuous improvement in service delivery.

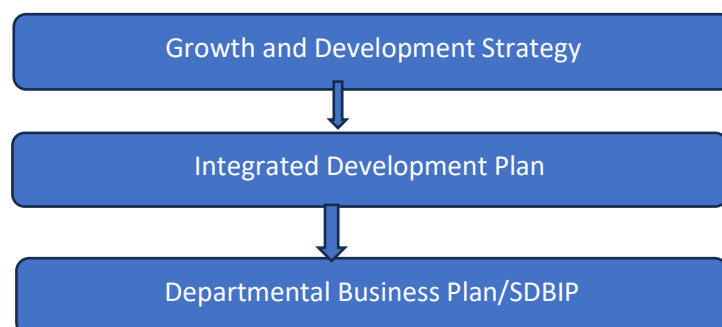
4.4 Service Level Agreement (SLA)

The operational relationship between the Gauteng Department of Health and the City of Johannesburg Health Department is governed by an SLA that:

- Defines roles and responsibilities for both parties.
- Establishes Key Performance Indicators (KPIs) for monitoring effectiveness.
- Ensures efficient allocation of resources—funding, personnel, and infrastructure.
- Provides mechanisms for issue resolution and annual review to adapt to emerging needs.

5. STRATEGIC ALIGNMENT

The Health Department aligns its programmes and objectives with the City's Joburg 2040 Growth and Development Strategy (GDS), Integrated Development Plan (IDP), and Service Delivery and Budget Implementation Plan (SDBIP). This section demonstrates strategic coherence through GDS outcomes, City priorities, the Theory of Change approach, collaboration mechanisms, and departmental objectives for 2026/27. **This is illustrated in the diagram below**



5.1 GDS 2040

The GDS provides the overarching framework that informs the IDP, the Service Delivery and Budget Implementation Plan (SDBIP).

The City of Johannesburg planning is an outcomes-led planning strategy. There are four overarching **outcomes** which define the Joburg 2040 GDS:

- **Outcome 1:** Improved quality of life and development-driven resilience for all.
- **Outcome 2:** Provide a resilient, liveable, and sustainable urban environment - underpinned by smart infrastructure supportive of a low-carbon economy.
- **Outcome 3:** An inclusive, job-intensive, resilient, competitive, and smart economy that harnesses the potential of citizens; and
- **Outcome 4:** A high-performing metropolitan government that pro-actively contributes to and builds a sustainable, socially inclusive, locally integrated, and globally competitive Gauteng City Region.

The **Health Programmes** outlined in this business plan are aligned to **Outcome 1 - Improved quality of life and development-driven resilience for all**; but responds to all 4 Outcomes.

5.2 Strategic Priorities

The **2025 Strategic Planning process** involved in-depth discussions that reaffirmed these priorities, ensuring they remain aligned with the City's vision. Additionally, the perspectives of residents were actively considered, helping to better tailor the City's plans to meet the community's needs and expectations.

The **Health Department's Business Plan** aligns with **eight** of the City's **eleven priorities**, as outlined in the table below. These strategic priorities will guide the department's medium- to short-term plans, acting as a roadmap toward achieving the City's long-term goals. By focusing on these priorities, the Health Department will contribute to the broader vision of the City's long-term strategy, ensuring that health services remain responsive and relevant to the needs of Johannesburg's residents.

No.	Priorities
1	Safer City
2	Sustainable Service Delivery
3	Energy Mix
4	Infrastructure Development and Refurbishment
5	Job Opportunity and Creation

6	Sustained Economic Growth
7	Green Economy
8	Good Governance
9	Financial Sustainability
10	Active and Engaged citizenry
11	Smart City

The city drives progress through **Operational Programmes**. This Business Plan is an **outcome and operationally focused developmental plan**. This business plan follows a Theory of Change method, which is an **outcomes-based approach** which is influenced by the Department of Planning, Monitoring and Evaluation's (DPME) Guide to the Outcomes

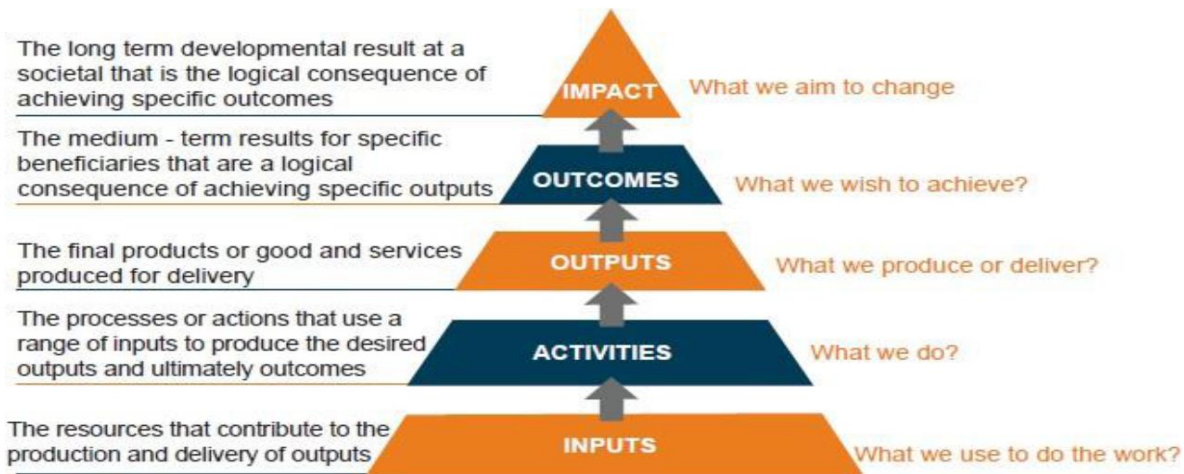
5.3 Outcome Led Planning

This Business Plan is an outcome and operationally focused developmental plan. Linked to the outcomes, are strategic interventions which will accelerate the City's developmental trajectory.



The **outcomes-based approach** enables the identification of a hierarchy of indicators and targets – defined in the context of impacts, outcomes, outputs, activities, and inputs. This sequence maps out the **logical sequence** of steps from inputs to impact.

The Results Chain



Result chain and performance measurement

GDS Outcomes (Impact)	GDS Strategic Outputs (Strategic Intervention areas/Deliverables)	Roadmap (Strategic Priorities) (Results)	Programmes/Activities (How)
Improved quality of life and development-driven resilience for all.	Reduce poverty Food security	Safer city	Ensuring food safety access to safe food Promote safe handling of food in respect of acceptable microbiological and chemical standards of all food for human consumption and optimal hygiene control throughout the food supply chain from the point of origin up to the point of consumption. routine inspection at food handling premises through: Developing and implementing food sampling programme Routine compliance Inspections at food handling premises

GDS Outcomes (Impact)	GDS Strategic Outputs (Strategic Intervention areas/Deliverables)	Roadmap (Strategic Priorities) (Results)	Programmes/Activities (How)
			Investigation of incidences of foodborne illnesses Key performance indicator: % inspections conducted at food premises to ensure that the premises adhere to food safety legislation
	Access to knowledge and lifelong learning		Awareness programmes conducted at Primary schools and High Schools on teenage pregnancy, substance abuse, and HIV/AIDS including Male Medical Circumcision. Awareness campaigns conducted in hostels to provide public education on the importance of healthy lifestyle choices including TISH Programmes. Distribution of Information, Education and Communication material (IEC) and female and male condoms. Key performance indicator: % knowledge increase of learners that are given health education on nutrition at schools
	A society characterised by healthy living for all		Immunisation Programme: Immunisation of children to safeguard against vaccine-preventable diseases and reduce child mortality.

GDS Outcomes (Impact)	GDS Strategic Outputs (Strategic Intervention areas/Deliverables)	Roadmap (Strategic Priorities) (Results)	Programmes/Activities (How)
			Tuberculosis (TB) screening and diagnostic testing enable early treatment for positive cases, helping to reduce the spread of the disease and encourage patients to complete treatment through adherence counselling and support. HIV initiation: Prompt initiation of HIV positive patients on ARV's to reduce HIV transmission and HIV related deaths. Key performance indicators: % of eligible children fully immunized by age 1 (One) Percentage all DS-TB treatment success rate. Percentage of HIV positive patients initiated on treatment
	A safe and secure city		Vector Control programme. Food Safety programme Ideal Standards Environmental Health Norms and Standards Key performance indicators: % Compliance in relation to the Ideal Clinic core standards in COJ health facilities in preparation for the NHI implementation Percentage achievement of service standards

GDS Outcomes (Impact)	GDS Strategic Outputs (Strategic Intervention areas/Deliverables)	Roadmap (Strategic Priorities) (Results)	Programmes/Activities (How)
	A city characterised by social inclusivity and enhanced social cohesion		Number of citizens participating in departmental events and engagements
Provide a resilient, liveable, sustainable urban environment – underpinned by smart infrastructure supportive of a low carbon economy	Sustainable and integrated delivery of water	Sustainable service delivery	Portable Water sampling for laboratory analysis
	Sustainable and integrated delivery of sanitation	Energy mix	
	Sustainable and integrated delivery of energy		
	Sustainable and integrated delivery of waste		
	Improved eco-mobility		
	Sustainable human settlements		
	Climate change resilience and environmental protection	Green Economy Infrastructure Development and Refurbishment	Early detection of diseases, rapid response, outbreak investigation and epidemic management and control at all levels. New facilities incorporating energy efficient designs, materials, and fittings, including natural light, insolation, renewable energy sources, rainwater harvesting and back-up water supply Key performance indicators: 100% notifiable medical conditions reported within three days % Of Identified hotspot areas where vector control measures are instituted
An inclusive, job-intensive,	Job-intensive economic growth	Job opportunity and creation	Recruitment of Jozi Ihlomile EPWP’s for the

GDS Outcomes (Impact)	GDS Strategic Outputs (Strategic Intervention areas/Deliverables)	Roadmap (Strategic Priorities) (Results)	Programmes/Activities (How)
resilient, competitive, and smart economy that harnesses the potential of citizens			implementation of door-to-door HIV/AIDS education programme. Key performance indicators: Number of EPWP job opportunities created (Jozi Ihlomile programme)
	Promotion and support to informal and micro businesses	Sustained economic growth	Educating, training, monitoring, and certification of informal traders
	Increased competitiveness of the economy		Public Health: Preventing Diseases and promoting quality of life. Key performance indicators: Number of individuals reached through the Jozi Ihlomile HIV/AIDS education door-to-door programme
	A spatially just and integrated city		Increase access to primary healthcare services, ensuring equitable distribution of services across the city's population Deploy Mobile clinics and temporary structures- in areas where there are no clinics to ensure that communities have access to health care
A high performing metropolitan government that proactively contributes to and builds a	Partnerships, intergovernmental & international relations	Good governance	Development of the demand plan to ensure that spending is according to planned activities. Sufficient systems in place to ensure compliance to the demand plan and budget authorisation.

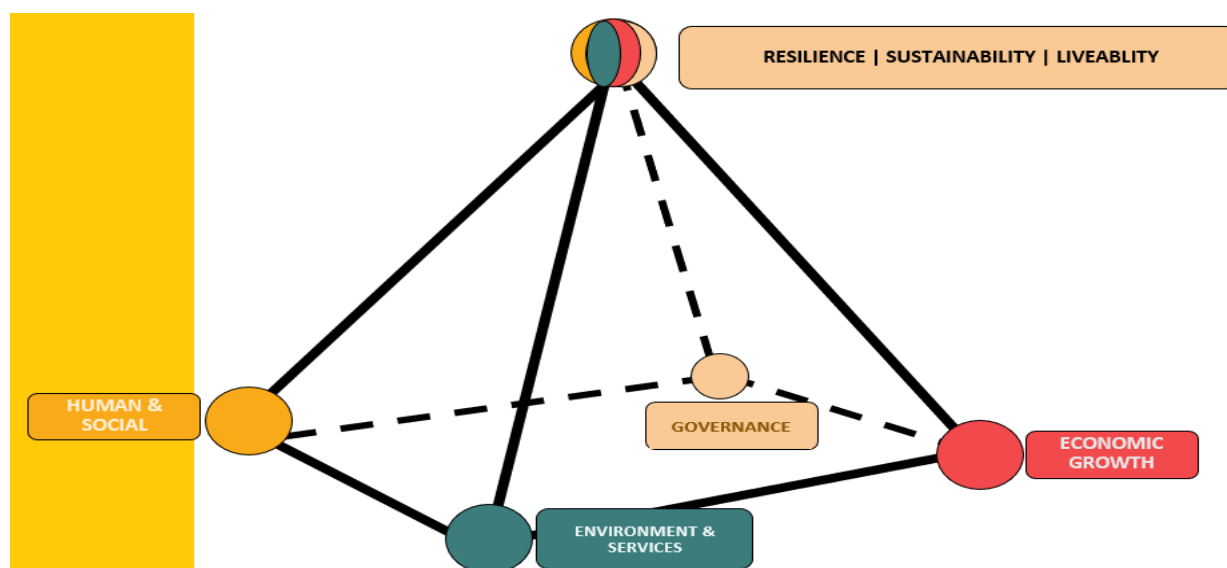
GDS Outcomes (Impact)	GDS Strategic Outputs (Strategic Intervention areas/Deliverables)	Roadmap (Strategic Priorities) (Results)	Programmes/Activities (How)
sustainable, socially inclusive, locally integrated, and globally competitive Gauteng City Region			All procurement is authorised by the Executive Director to prevent unauthorised expenditure. Risk management discussed by relevant stakeholders. Key performance indicators: 100% Percentage achievement of service standards of health facilities Delivery on cases of corruption Percentage resolution of AG findings % Compliance to acquisition of goods and services as per the approved demand plan Percentage implementation of the strategic risk management action plan findings resolved
	A responsive, accountable, efficient, and productive metropolitan government	Financial sustainability	Compilation of the departmental acquisition plan is done to prioritise spending on essential items Key performance indicators: % Compliance to acquisition of goods and services as per the approved demand plan 100% delivery on reported cases of corruption Percentage resolution of AG findings Percentage implementation of the strategic risk

GDS Outcomes (Impact)	GDS Strategic Outputs (Strategic Intervention areas/Deliverables)	Roadmap (Strategic Priorities) (Results)	Programmes/Activities (How)
			management action plan findings resolved
	Financially sustainable and resilient city		Development of the demand plan to ensure that spending is according to planned activities. Sufficient systems in place to ensure compliance to the demand plan and budget authorisation Key performance indicators: 100% delivery on reported cases of corruption Percentage resolution of AG findings Percentage implementation of the strategic risk management action plan findings resolved
	Meaningful citizen participation and empowerment	Active and engaged citizenry	Community participation is encouraged. The department respond to community needs raised during the Community Based Planning meetings. Stakeholder Management: A stakeholder matrix guides in prioritisation and response matters Health awareness programmes/ outreach campaigns at primary and high schools including the hostels. (substance abuse, teenage pregnancies, and HIV/AIDS programmes) Key performance indicators: Number of citizens participating in

GDS Outcomes (Impact)	GDS Strategic Outputs (Strategic Intervention areas/Deliverables)	Roadmap (Strategic Priorities) (Results)	Programmes/Activities (How)
			departmental events and engagements % knowledge increase of learners that are given health education on nutrition at school Number of awareness Programmes conducted at schools
	Guaranteed customer and citizen care and service		Amount of time spent by a patient visiting the facility, which is supposed to be below 2,5 hours as per Ideal clinic or Office of Standard and Compliance (DHSD) Key performance indicators: 100% of all complaints received by personal health to be attended to within 48 hours. (DHSD) 100% Percentage achievement of service standards of health facilities.
	A 'Smart' City of Johannesburg, that can deliver quality services to citizens in an efficient and reliable manner	Smart City	Development of Electronic Patient Health Record software Number of health facilities implementing Electronic Patient Health Record software % achieved in the development of the Digital Environmental Health System

5.4 Strategic collaboration

For better coordination of operations, the City of Johannesburg adopted a Cluster configuration to City Departments (JOBURG 2040 Paradigm). Through the cluster approach, the city intends to successfully coordinate organisational programmes around the Strategic Outcomes outlined in the 'Joburg 2040' Strategy. The Cluster approach will also assist the city to accelerate service delivery, create an enabling environment to stimulate economic growth, creating liveable urban spaces, creating an administration that is resilient and sustainable for future residents of the city.



Of the four identified Clusters, the Health Department belongs to the **Human and Social Development Clusters**.

5.5 Strategic Objectives

The Department has developed the following strategic **objectives** that are meant to assist the Department to achieve its goals:

1. **Promotion of Healthy Lifestyles:** Enhance the quality of life through the promotion of healthy lifestyles, encouraging behaviour change to prevent chronic diseases and improve overall well-being.
2. **Addressing the Quadruple Burden of Disease:** Tackle the Quadruple Burden of Disease through the prevention, management, and control of:

- Communicable diseases (e.g., HIV/AIDS, tuberculosis)
 - Non-communicable diseases (e.g., hypertension, diabetes)
 - Maternal and child mortality
 - Gender-based violence and related incidents
3. **Ensuring NHI Readiness:** Support National Health Insurance (NHI) readiness through the re-engineering of Primary Health Care (PHC), by strengthening the **District Health Systems** and improving PHC services across the city.
 4. **Promotion of Healthier Environments:** Improve public health by addressing environmental health stressors, such as foodborne illnesses, vector-borne diseases, and unsafe waste management practices (e.g., illegal dumping sites).
 5. **Improving Access to Primary Health Care:** Increase access to primary healthcare services, ensuring equitable distribution of services across the city's population.
 6. **Strengthening Governance and Financial Management:** Enhance good governance and ensure prudent financial management by adhering to existing legislation, protocols, and policies, ensuring accountability and transparency in all operations.
 7. **Digitalisation of the health Department:** Enhance operational efficiency, data management, promote collaboration and integration of systems and use digital technologies to make health care services more accessible

6. City Manager's Action Plan/Roadmap

The City Manager outlined a comprehensive roadmap identifying several critical interventions. These areas were integrated into the business plans. The interventions were designed to address pressing service delivery challenges and operational inefficiencies across the city. These include:

1. Improve Public Safety and Law Enforcement
2. Prioritize Repairs and Maintenance of Infrastructure
3. Deal Proactively with Bad Buildings in the Inner City
4. Increase Capital Spending Effectiveness
5. Enhance Financial Sustainability
6. Compliance with National Treasury Reforms

3 Years Project Action Plan

PROJECT 1– PROJECT 1 – Electronic Health Record System							
DESCRIPTION – The use Electronic Health Record System by All COJ Clinics							
LEAD – Health							
SUPPORT – Group Finance MTC, GICT							
Project	Budget (R'000)	Jan – Mar 26	Apr – Jun 26	Jul – Sep 26	Oct – Dec 26	Jan – Mar 27	Dependencies
E-Health Record System	R22m	Pilot to 3 facilities	Pilot to 14 facilities	Rolled out to 39/79 (49%) Ongoing upgrading of the system Ongoing training of users	Roll Out to 79/79 (100%)	100% Utilization and maintenance	MTC Katz Consulting Provincial and National department E-Health Record System Group Finance GICT
KPI: % Implementation of Electronic Patient Health Record software							

5 Years Project/Action Plan

PROJECT 4 - NHI Compliance and Readiness

DESCRIPTION – For the City of Johannesburg to be ready for the implementation of the NHI

LEAD – Health

SUPPORT – Gauteng provincial department of Community Safety, GCSS, SAPS, Forensic Services, GDOH and Office of the health Standard compliance

Project	Budget (R'000)	Jan – Mar 25	Apr – Jun 25	Jul – Sep 25	Oct – Dec 25	Jan – Mar 26	Dependencies
All clinics to be fully resourced with adequately skilled health personnel. All Clinics to be fully equipped with medical equipment's.	As per PFA R40m	Proactively filling out the approved vacant funded positions of Health professionals Continuous distribution of available procured medical equipment. Request for additional budget to finalize the Request for	Collaboratively as the department engages GCSS on the review of the departmental org structure. Regular audit to identify gaps (Where there is a need for maintenance/replacements of medical equipment) Establish a panel of service providers to procure and	Implementation of PFA Regular audits to identify gaps (Where there is a need for maintenance/replacements medical equipment)	Regular audits to identify gaps (Where there is a need for maintenance/replacements medical equipment) Motivate and facilitate a new panel of service providers, R&M	Comply with the schedule of GDOH. NDOH on Office of the Health Standard Compliance assessments GCSS	Provision of resources depends on the establishment and appointment of Bid Committees by finance department and availability of budget. Panel of contractors depends on JPC. OHSC assessments

Health Patient Register System (HPRS)		quotations through the midterm budget process. Audit of outstanding facilities to identify gaps. Engage GDOH/NDOH on the Roll out to outstanding facilities.	R&M of medical equipment.		including procurement of medical equipment.		depend on GDOH and NDOH schedules. processes .
		All health facilities to introduce (HPRS) system in collaboration with IPPR	All health facilities to introduce (HPRS) system in collaboration with IPPR	All health facilities to introduce (HPRS) system in collaboration with IPPR	All health facilities to introduce (HPRS) system in collaboration with IPPR	All health facilities to introduce (HPRS) system in collaboration with IPPR.	Health Patient Register System (HPRS) depends on the stable network system assisted by IPPR

KPI –% Compliance in relation to the Ideal Clinic core standards in COJ health facilities in preparation for the NHI implementation

5 Years Project/Action Plan

PROJECT 5 – Infrastructure							
DESCRIPTION – Planning and construction of new clinics, renewal and upgrading of existing facilities to improve the access to, and rendering of primary health care services							
LEAD – Health							
SUPPORT – Group Finance, Development Planning, JDA, JPC, PSP, Contractors, Community Development Department, CoJ Panel of Contractors							
Project	Budget (R'000)	Jan – Mar 26	Apr – Jun 26	Jul – Sep 26	Oct – Dec 26	Jan – Mar 27	Dependencies
Naledi Clinic Construction	R1.652m	Completion of construction and issuance of Permanent Occupational Certificate.	-	-	-	-	Merchant Payments JDA PSP (Professional service providers) Contractor
Hikhensile Clinic Phase 1 Construction	R14m	Final account for completion of Phase 1. Security the site.	Securing the site.	-	-	-	Merchant Payments JDA PSP (Professional service providers) Contractor
Hikhensile Phase 2 Construction	R72m <i>(only R32,6m approved)</i>	Security the site	Once confirmation is received that the R72m budget was approved over the next 2 years, construction may commence.	Construction	Construction	Construction	Budget Deficit Group Finance JDA PSP (Professional service providers) Contractor Development Planning Contractors Com Dev Dept.

Minor Upgrades - Minor works - Electrical works - Reticulated water backup systems - Air-cons	R18,576m	Construction ID of new upgrade projects. Line listing. Prioritizing projects.	Commitment of projects Construction and Completion ID of new upgrades is required. Line listing. Prioritizing projects.	Commitment of projects to be undertaken. ID of new upgrades. Line listing. Prioritizing projects.	Construction	Completion	Merchant Payments
KPI – % Capital budget spent (*) <i>* % Capital Budget spent also includes the project budgets related to Electronic Health Systems (Software and Hardware) and Operational Capital (Plant, equipment, furniture, tools of trade, etc.)</i>							

Key Dependencies

Note: for communication plan, timelines, accountability, strategic coordination internally and externally, establish points of contact....

NO	PROJECT / ACTION PLAN	DEPENDENCY AREAS	LEAD DEPARTMENT/ ENTITY	INTERNAL STAKEHOLDERS E.G. CITY DEPARTMENTS AND/OR ENTITIES	EXTERNAL STAKEHOLDERS E.G.
1.	PROJECT 1 – Electronic Health Record System	Funding Connectivity	MTC	Group Finance MTC GICT	Provincial and National Health department
2.	PROJECT 2 – NHI Compliance and Readiness	1. Security at Clinic facilities. 2. Grant Funding Assessments and Compliance	Health	JMPD	Wardens – Gauteng Provincial Department of Community Safety SAPS Forensic Services GDOH Office of the Health Standard Compliance
3.	PROJECT 3 – Infrastructure	Funding Payment of contractors Implementing Agents Contractors Com Dev Updated Priced Bill	Health	JDA Com Dev Dev Planning Budget Office Merchant Payments JPC Regional Health Management	Contractors Professional Service Providers
3.	PROJECT 3 – Electronic Health Record System	Funding Connectivity	MTC	Group Finance MTC GICT	

RISKS TO BE CONSIDERED

PROJECT NAME	RISK NAME	ACTIONS TO IMPROVE THE RISK
PROJECT 2 – Food Safety	Outbreak of food poisoning and food related illnesses and fatalities.	• Emphasis on integrated approach in addressing compliance by food premises. • Optimize clinical preparedness and readiness to contain the outbreak
PROJECT 3 – Electronic Health Record System	Lack of ability to integrate with existing systems. Inability to operate when offline	• Test the system to identify any gaps and address them. • To develop an action plan to address identified gaps and challenges
PROJECT 4 – NHI Compliance and Readiness	Inability to acquire NHI compliance and accreditation due to lack of resources	• Establish and develop the NHI Champions facility to ensure NHI compliance and accreditation. • Motivate for additional funding to address the gaps. (e.g. medical equipment's etc.)
PROJECT 5 – Infrastructure	Cash-flow challenges. Timeous payment of service providers. Inability of the implementing agent to deliver projects on time and within budget. Protracted project period. Project cost creep. Standing times. Increasing latent defects following construction. Inclement weather. Insufficient funding for upgrading or replacement of deteriorating fixed and movable assets. Adherence to Panel of Contractors prescripts. Outdated prices on Priced Bill. Competing projects vs scares resources.	• Holding the implementing agent accountable. • Improved project management required. • Improved project expenditure tracking and control. • Timeous consequence management of contractors and PSP by the implementing agent. • Request to increase budget provision for R&M and minor upgrades. • Timeous R&M to limit the deterioration and improve assets. • Adequate system to ensure contractor rotation. • Engage Com Dev on Priced Bill and follow procedures to address price challenges. • Prioritization model for choosing projects for implementation.

7. DEPARTMENTAL INSTITUTIONAL HISTORY AND APPLICABLE

7.1 Background issues

The Health Department has over the years developed a record of providing primary health care services with well-developed annual plans and good routine data reporting. This draft Health Department 2026/27 business plan continues this trend by identifying opportunities and further exploring the Department's potential to enhance primary health.

7.2 COJ Perspective

The plan is aligned to the GLU Priorities and priority programmes, as well as guidelines that have been provided by the Group Strategy Coordination and Relations Unit (GSPCR (Group Strategy, Policy Coordination and Relations)) for the COJ Departments to develop their Departmental Business Plans.

This Business Plan will also respond to issues related to the quadruple burden of diseases, which are as follows:

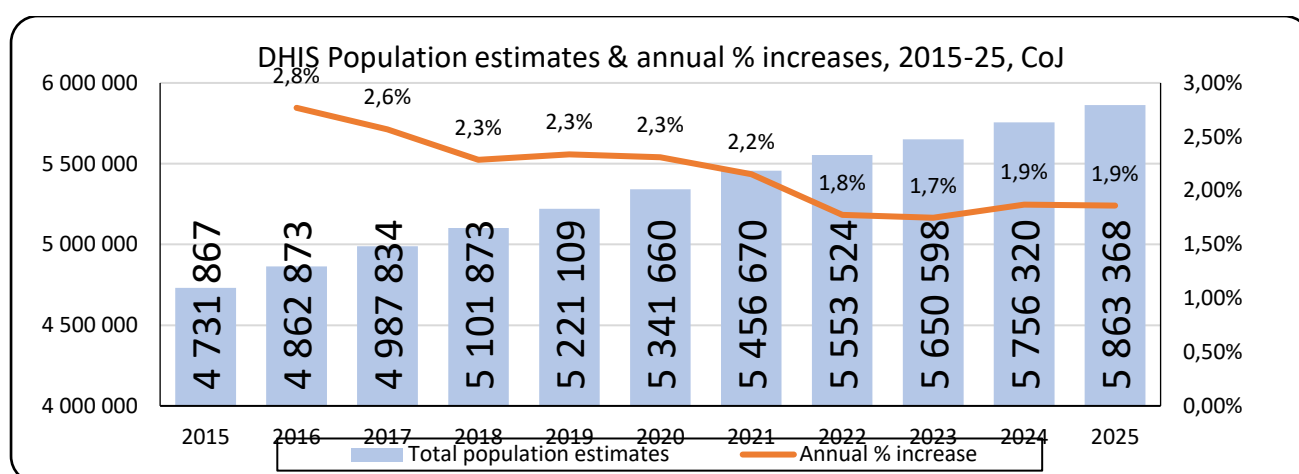
- **Maternal and child mortality:** Improving health outcomes of maternal and child health care services: prevalence of underweight amongst children < 24 months; % of women who attend antenatal care (ANC) before 20 weeks; % of births supervised by skilled attendants; promoting contraception methods (family planning); prevention of teenage pregnancy, successful interventions for vertical transmission prevention programmes of HIV and anti-retroviral treatment (ART) provision for HIV positive women and children.
- **Non-communicable diseases (NCDs):** Prevention through health literacy programmes to decrease modifiable risk factors, early identification, and prompt treatment of chronic diseases (e.g., Hypertension, Diabetes, Cancers, Heart disease).
- **Communicable disease (HIV/AIDS & TB):** Reducing HIV related morbidity and mortality, reduce new infections in children and adults, and reduce TB related mortality, by scaling up and improving the quality of key prevention and treatment programmes including male medical circumcision, successful interventions for vertical transmission prevention programmes of HIV & Communicable Infection, condom distribution and anti-retroviral treatment provision.

- **Violence, injuries, and trauma** – Related to the abuse of alcohol and drugs, prevention of accidents for children at home and in day-care centres, prevention of accidents in old age homes and day-care centres.

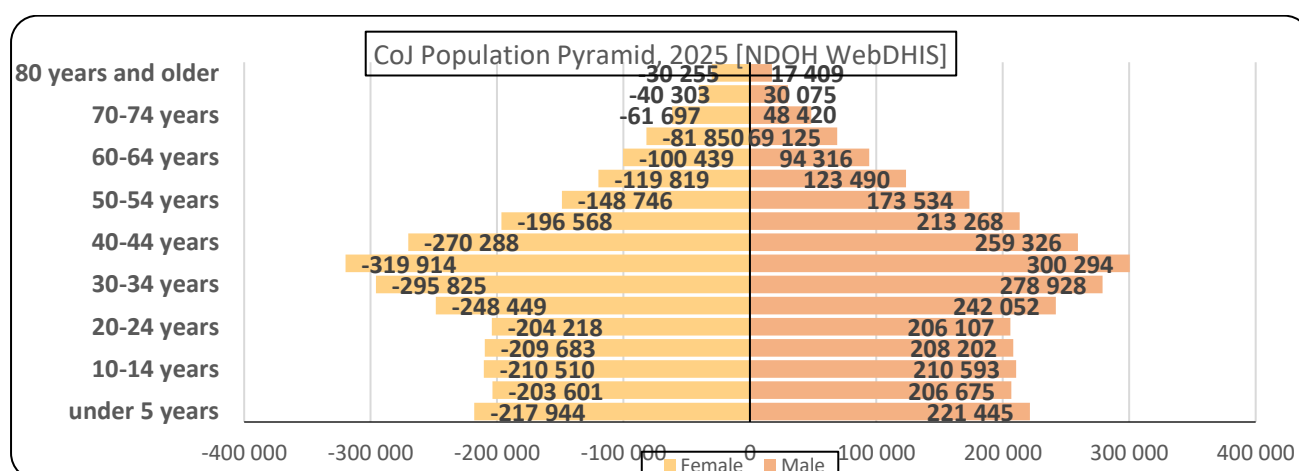
7.2.1 Socio-demographic profile of City of Johannesburg

The population of the city has increased from 4,7 million in 2015 to 5.9 million residents in 2025, as per the National Health Department's WebDHIS. In this period, the CoJ population grew by 1,9% from 2024 population size and places an additional burden on the City in the provision of basic services to the community.

Graph 1: DHIS Population Estimates, 2015 - 2025, CoJ.



Graph 2: Population Pyramid, 2025, CoJ (NDOH, WebDHIS)



The population pyramid above indicates that the CoJ population is young, due to migration from other parts of the country as young people seek jobs. CoJ is considered the economic hub and is thus the first choice of destination for job seekers across the country and from other countries.

In 2021, South Africa scored 0.71 in the Human Development Index (HDI), which indicated a high level of development. The country experienced a drop in the HDI score compared to the previous year, which was 0.73 (Table 1). The City of Johannesburg Human Development Index (HDI) was 0.72. The HDI is the index used by the United Nations to measure the progress of a country. The HDI provides a composite measure of three basic dimensions of human development:

- Life expectancy (health),
- Literacy (education) and
- Income.

In 2021, the high-income disparities in CoJ are reflected by the Gini Coefficient of 0.63 (SA: 0.64). Inequality in the City has shown a downward trend overtime, it has decreased over the period of more than 20 years.

Table 1: Developmental Indicators, Johannesburg, Gauteng & South Africa, 2022.

DEVELOPMENTAL Indicators			
	South Africa	Gauteng	Johannesburg
Human Development Index (HDI)*	0.71	0.73	0.72
Gini coefficient*	0.64	0.63	0.63
Share below the food poverty line	32.8%	24.1%	36.5%
Poverty gap rate (from upper poverty line)	31.7%	31.8%	51.0%
Functional literacy: age 15+, completed grade 7 or higher*	87.6%	93.3%	94.1%
Total Dependency Ratio (%) #	53.11%	40.68%	38.48%
Child Dependency Ratio (%) #	43.79%	33.13%	31.49%
Aged Dependency Ratio (%) #	9.32%	7.55%	6.99%

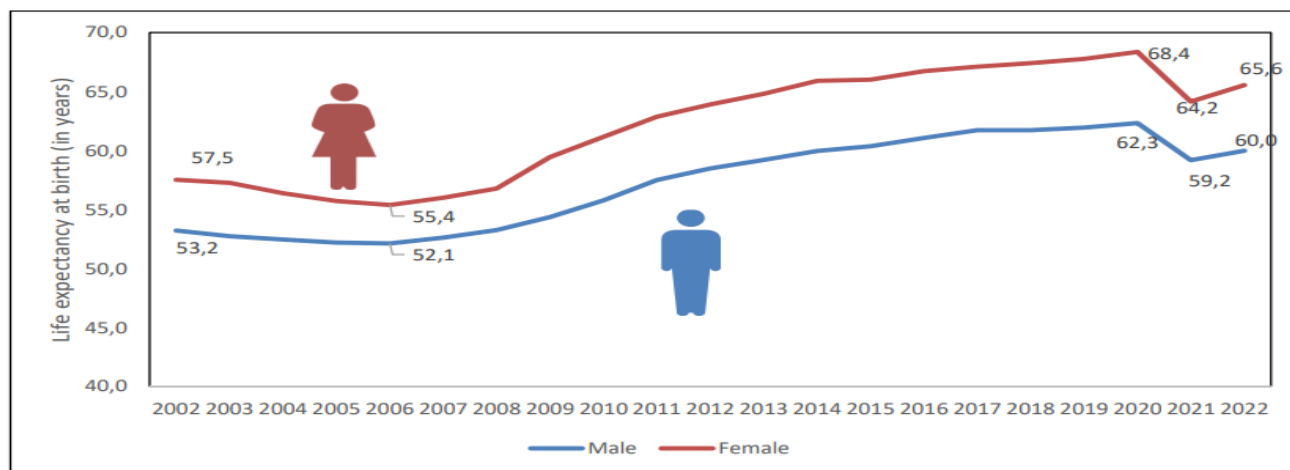
* Source: IHS Markit, 2022) *

7.3 Health status indicators

The national scale-up of ART services from 2005 has had a huge impact on the life expectancy and quality of life of HIV-infected individuals. Graph 3 below depicts the increase in life expectancy in South Africa from 57.5 in 2002 to 65.6 years in 2022 for females improved by 1.4% and 53.2 in 2002 to 60.0 years in 2022 for males improved by 0.8%.

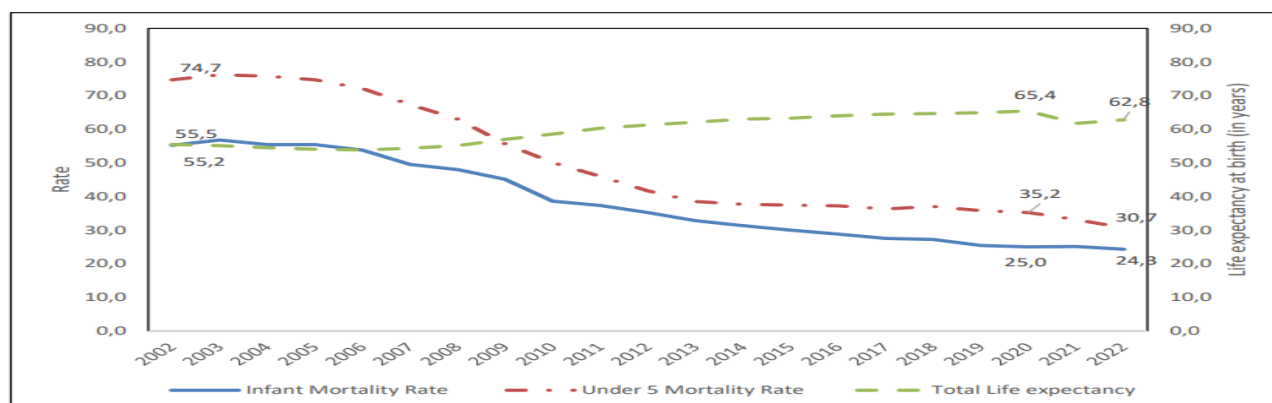
The infant mortality rate (IMR) has significantly declined from 55,2 per 1,000 live births in 2002 to 24,3 per 1,000 live births in 2022. Similarly, child mortality (under 5 years) has declined from 74,7 per 1,000 live births to 30,7 per 1,000 live births in 2022 (Graph 4)

Graph: 3 Life Expectancy at Birth by Sex over time 2002-2022, South Africa



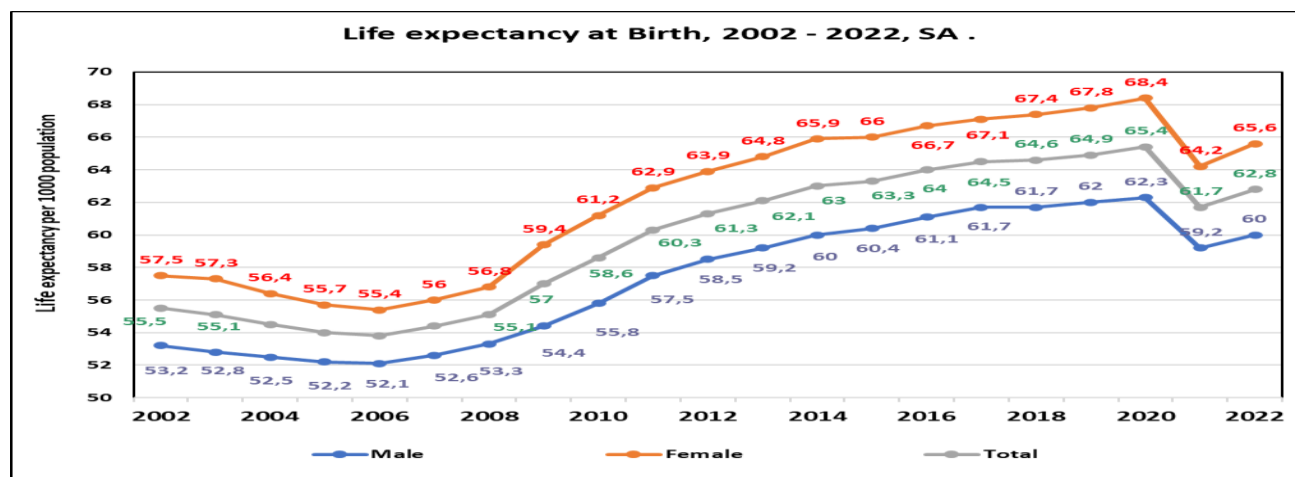
(Mid-Year Population Estimates, Stats SA, 2022)

Graph 4: Infant Mortality rate & Under 5 Mortality rate, 2002 – 2022, South Africa.

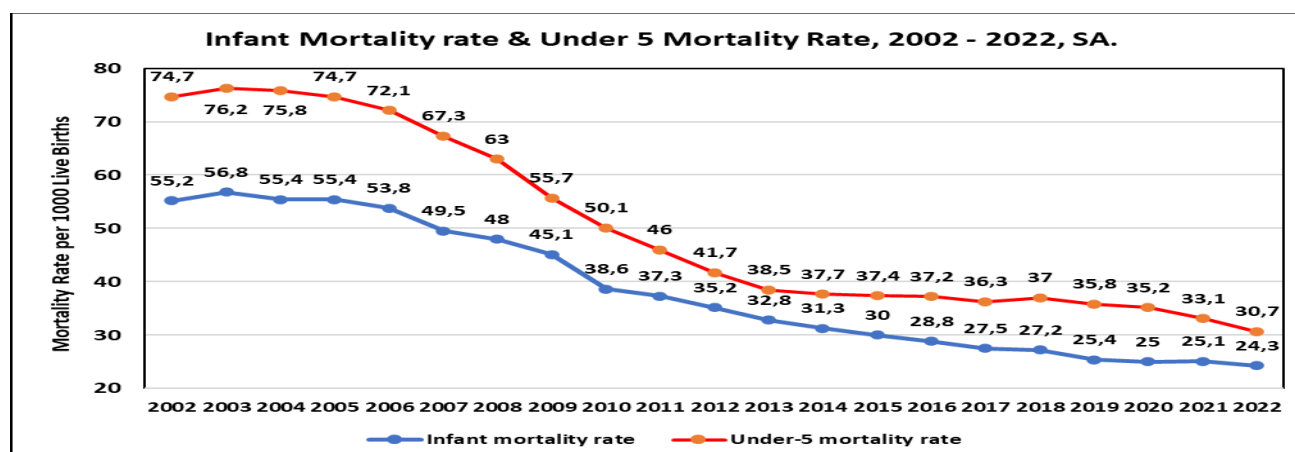


(Mid-Year Population Estimates, Stats SA, 2022)

Graph 3: Life Expectancy at Birth, 2002 – 2022, South Africa



Graph 4: Infant Mortality rate & Under 5 Mortality rate, 2002 – 2022, South Africa.



(Mid-Year Population Estimates, Stats SA, 2022)

Effective strategies for vertical transmission prevention programme (VTP) assisted in improving pregnant women's health through initiation of ART and minimised the number of babies born HIV positive to HIV positive mothers. It is estimated that VTP programme, when implemented exceptionally well, can reduce the rate of transmission of HIV infection in pregnancy, at birth, and while breastfeeding, from 25% – 45% to less than 2%.

The introduction of the Pneumococcal vaccine and Rotavirus vaccine in South Africa's routine immunisation programme has also assisted in decreasing vaccine preventable morbidity and mortality in children.

7.3.1 Burden of disease

South Africa (SA) faces a quadruple burden of disease, namely, HIV and AIDS, infectious diseases, trauma, and violence as well as non-communicable diseases. Trends between 2017 to 2019 show that eight of the ten leading natural underlying causes of death were the same since 2017. Diabetes mellitus was the leading cause of death in 2019, surpassing tuberculosis which was the leading cause of death in 2017 and 2018. Although diabetes mellitus ranked first, the proportion of deaths due to this cause declined to **5,7% in 2019 from 5,9% in 2018**.

There was an increase in the proportion of deaths due to non-communicable diseases; these were diabetes mellitus, cerebrovascular diseases, hypertensive diseases, ischaemic heart diseases, other forms of heart disease, chronic lower respiratory diseases, and malignant neoplasms of digestive organs. The 2019 Causes of Death report by Stats SA indicated that **Cerebrovascular diseases (3,6%) was the leading natural cause of death in CoJ (City of Johannesburg) (Table 2). Ischemic heart diseases (3,5%) and Tuberculosis (3,2%) were ranked 2nd and 3rd respectively in CoJ whilst in Gauteng “Diabetes Mellitus” was also the leading cause of death at 4,4%, Tuberculosis (4,0%) and other forms of heart diseases (3,9%).**

The report also showed that non-communicable diseases (NCDs) accounted for 18,4% of 29,8% of the top 10 causes of death in CoJ. Early detection and initiation of interventions (medical & non-medical) for these conditions can decrease the morbidity and mortality resulting from chronic diseases.

Table 2: The ten leading underlying natural causes of death in South Africa, Gauteng, & City of Johannesburg, 2019. (STATSSA)

Rank	South Africa	No. of deaths	%	Rank	Gauteng	No. of deaths	%	Rank	City of Johannesburg	No. of deaths	%
1	Diabetes mellitus (E10-E14)	26,191	5,7	1	Diabetes mellitus (E10-E14)	4,322	4,4	1	Cerebrovascular diseases (I60-I69)	1,026	3,6
2	Tuberculosis (A15-A19)	25,262	5,5	2	Tuberculosis (A15-A19)	3,936	4,0	2	Ischemic heart diseases (I20-I25)	1,002	3,5
3	Cerebrovascular diseases (I60-I69)	23,133	5,0	3	Other forms of heart disease (I30-I52)	3,829	3,9	3	Tuberculosis (A15-A19)	919	3,2
4	Human immunodeficiency virus [HIV] disease (B20-B24)	22,039	4,8	4	Cerebrovascular diseases (I60-I69)	3,824	3,9	4	Diabetes mellitus (E10-E14)	912	3,2
5	Hypertensive diseases (I10-I15)	20,492	4,4	5	Influenza and pneumonia (J09-J18)	3,621	3,7	5	Influenza and pneumonia (J09-J18)	910	3,2

6	Influenza and pneumonia (J09-J18)	17,294	3,8	6	Ischemic heart diseases (I20-I25)	3,597	3.7	6	Human immunodeficiency virus [HIV] disease (B20-B24)	860	3,0
7	Ischemic heart diseases (I20-I25)	15,904	3,4	7	Hypertensive diseases (I10-I15)	3,526	3.6	7	Other forms of heart disease (I30-I52)	849	3,0
8	Other forms of heart disease (I30-I52)	15,741	3,4	8	Human immunodeficiency virus [HIV] disease (B20-B24)	2,715	2,8	8	Malignant neoplasms of digestive organs (C15-C26)	789	2,8
9	Other viral diseases (B25_B34)	13,171	2,9	9	Other viral diseases (B25_B34)	2,671	2,7	9	Chronic lower respiratory diseases (J40-J47)	650	2,3
10	Chronic lower respiratory diseases (J40-J47)	12,309	2,7	10	Malignant neoplasms of digestive organs (C15-C26)	2,594	2.6	10	Other viral diseases (B25_B34)	577	2,0
	Other natural causes	212,308	46,1		Other natural causes	50,740	51.7		Other natural causes	16,242	56,8
	Non-natural causes	57,162	12,4		Non-natural causes	12,852	13.1		Non-natural causes	3,851	13,5
	All causes SA	461,006	100,0		All causes: Gauteng	98,227	100,0		All causes: CoJ	28,587	100,0

The burden of disease statistics can be derived from the death notifications that are routinely submitted to Stats SA. The relative proportion of the leading causes Years of Life Lost (YLLs) by broad cause groups is estimated.

The proportions of deaths and Years of Life Lost (YLLs) due to four broad cause groups were calculated for each district by the Medical Research Council. YLLs are a measure of premature mortality based on the age at death, and as such, highlight the causes of death that should be targeted for prevention.

In 2017, the proportion of Years of Life Lost (YLL) due to premature death caused by Other communicable diseases (excluding HIV & TB) & maternal, perinatal, and nutritional disorders was **16.5% (2015: 18.8%)**; **HIV/TB: 15.2% (2015: 19.4%)**. Non-communicable diseases (chronic **diseases of lifestyle**) were **49.8% (2015: 45.2%)**; **Injuries: 18.5% (2015: 16.6%)** for Johannesburg. Graph 5 below provides the burden of disease trends for the 4 broad groups for CoJ against the Tshwane, Ekurhuleni, Gauteng, and national average for the years 2015 to 2017.

Graph 5: Percentage Years of Life Lost due to Premature Mortality by broad causes, Districts / Gauteng / SA, 2015 to 2017. (District Health Barometer, 2019/20)

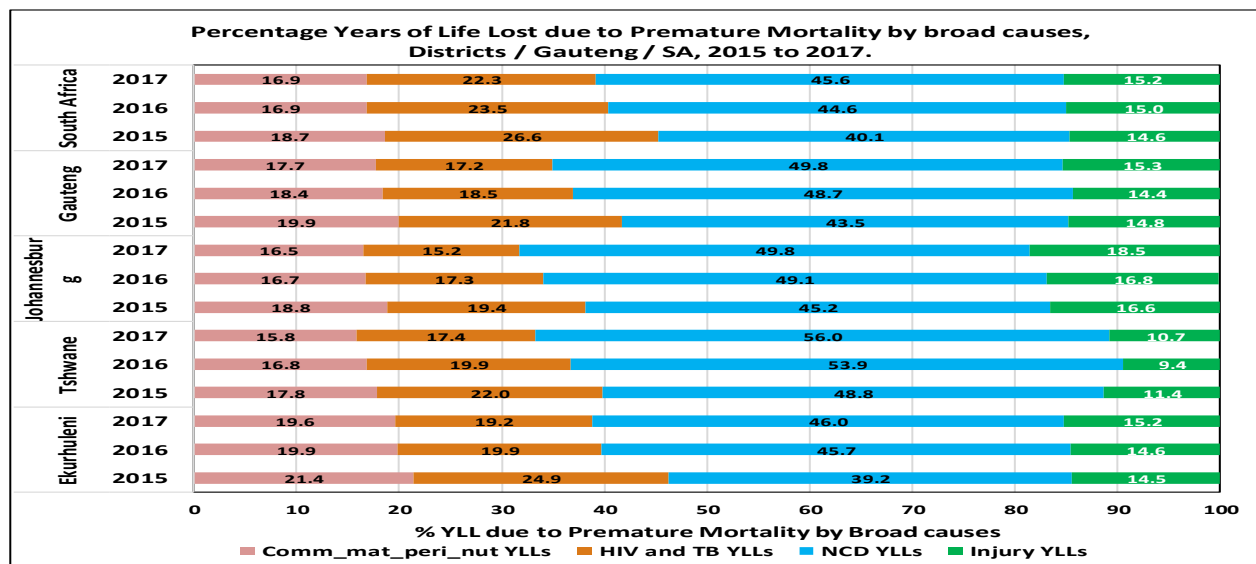


Table 3 shows the increasing burden due to non-communicable diseases from 33.4% in 2008 to 49.8% in 2017. The disease burden due to HIV and TB has decreased significantly from 26.4% in 2008 to 15.2% in 2017.

Table 3: Trends in % of Years of Life Lost due to Premature Mortality, CoJ, 2008 to 2017.

Trends in % of Years of Life Lost due to premature mortality, CoJ. *										
CoJ	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Other Communicable diseases (excluding HIV and TB) + Maternal, perinatal, and nutritional disorders	27.9	26.4	25.4	23.9	21.6	20.6	20.4	18.8	16.7	16.5
HIV and TB	26.4	25.9	25.6	23.7	24.4	22.5	21.7	19.4	17.3	15.2
Non-communicable diseases (NCDs)	33.3	36.0	37.1	40.2	41.1	43.3	43.6	45.2	49.1	49.8
Injuries	12.4	11.6	11.9	12.1	13.0	13.7	14.3	16.6	16.8	18.5

*District Health Barometer, 2019/20.

7.3.2 HIV / TB epidemic in South Africa

South Africa is at the epicentre of the global dual **HIV** and **tuberculosis (TB)** epidemic. In 2015, the country, along with other nations, endorsed the **Sustainable Development Goals (SDGs)**, which include a commitment to end the HIV and AIDS and TB epidemics by 2030.

To achieve this, the South African government adopted the **UNAIDS Fast-Track Strategy: Ending the HIV Epidemic by 2030** (95-95-95 strategy), which aims to significantly scale up the response to HIV and TB, with the goal of reducing new infections and deaths.

The original 2020 targets of the **90-90-90 strategy** were:

- 90% of people living with HIV know their HIV status.
- 90% of those diagnosed are on treatment.
- 90% of people on treatment achieve viral load suppression.

However, South Africa did not meet these targets by December 2020, largely due to having the largest and fastest-growing HIV epidemic globally, compounded by the **COVID-19 pandemic**, which led to job losses, migration, and fear of contracting the virus.

In response, the **National Department of Health** has revised the target to be achieved by 2028, in alignment with the updated **National Strategic Plan (NSP) on HIV, TB, and Sexually Transmitted Infections (STIs) 2023-2028**.

To expedite progress, South Africa has introduced **same-day antiretroviral therapy (ART) initiation** for newly diagnosed HIV-positive patients, aiming to improve treatment uptake and reduce transmission.

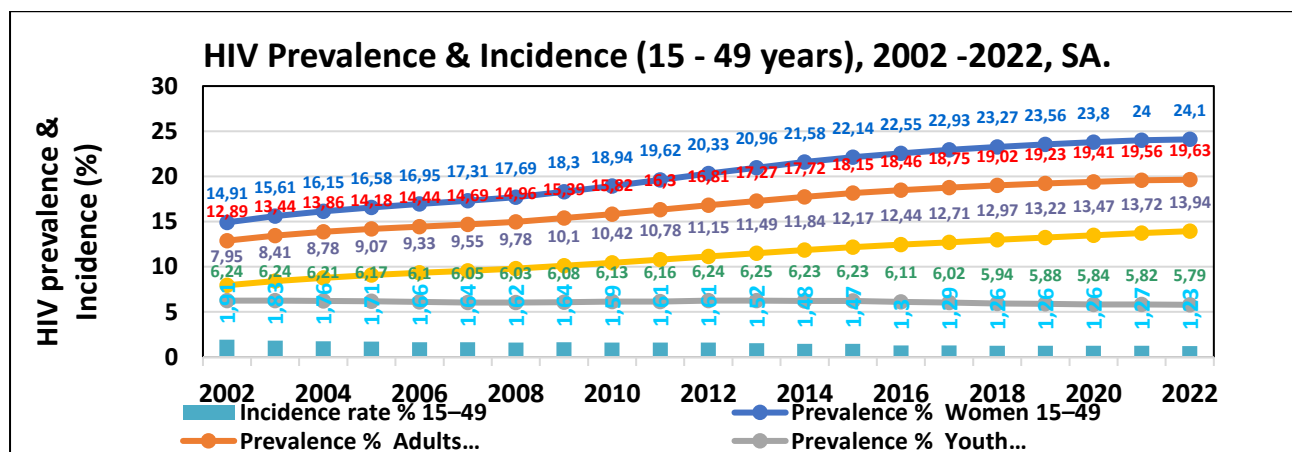
The **NSP 2023-2028** aims to put South Africa on track to eliminate HIV, TB, and STIs as public health threats by 2030.

The NSP 2023 – 2028 has the following 4 interlinked goals:

- Goal 1: Break down barriers to achieving outcomes for HIV, TB and STIs
- Goal 2: Maximise equitable and equal access to services and solutions for HIV, TB and STIs
- Goal 3: Build resilient systems for HIV, TB and STIs that are integrated into systems for health, social protection, and pandemic response.
- Goal 4: Fully resource and sustain an efficient NSP led by revitalised, inclusive, and accountable institutions.

According to STATS SA total HIV population is estimated to be 8.23 million people in South Africa in 2021 and for adults aged 15–49 years, an estimated 19.5% of the population is HIV positive. (<http://www.statssa.gov.za/> 2021 Mid-year population estimates/ 31st July 2021).

Graph 6: HIV Prevalence and Incidence estimates, 2002 – 2022, SA (Mid-Year Population Estimates, Stats SA, 2022)



The South African National HIV Prevalence, Incidence and Behaviour Survey, 2022. (HSRC)

The Human Sciences Research Council (HSRC), in collaboration with its partners, announced key findings from the Sixth South African National HIV Prevalence, Incidence, and Behaviour survey (SABSSM VI), which highlight progress toward ending HIV in South Africa – the country with the world’s largest HIV epidemic.

SABSSM VI found that the percentage of all people living with HIV in South Africa has decreased from **14.0% in 2017 to 12.7% in 2022**. This translates to approximately **7.8 million** people living with HIV in South Africa in 2022 compared to **7.9 million in 2017**.

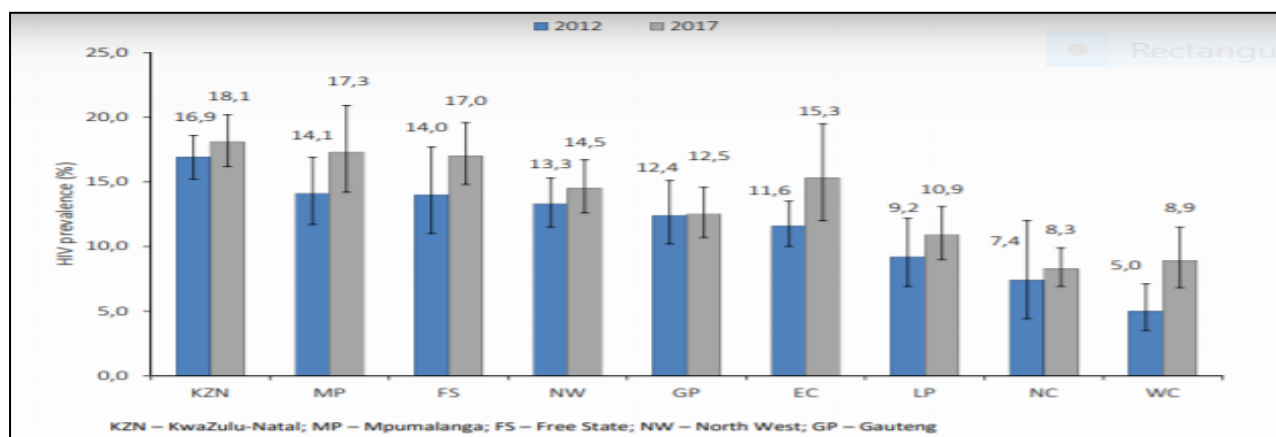
Several factors contribute to HIV prevalence, these factors include fewer people getting infected with HIV, more children born HIV-negative, AIDS-related mortality, and people aging and dying from natural causes. The increase in the population (birth of HIV-negative babies) would also increase the denominator of HIV-negative people in the country. The epidemic curve also shows an aging population of people living with HIV who are living longer as the epidemic stabilises.

The 2022 survey shows that South Africa has made significant progress toward the UNAIDS 95-95-95 targets – namely, that by 2025, 95% of all people living with HIV to be aware of their HIV status, 95% of those aware of their status to be on antiretroviral treatment (ART), and 95% of those on ART who also know that that they are living with HIV to achieve viral load suppression. SABSSM VI showed that among people aged 15 years and older living with HIV in South Africa **in 2022, 90% were aware of their status, 91% of those aware of their status were on ART, and 94% of those on ART were virally suppressed**.

SABSSM VI shows that **81% of people aged 15 years and older** living with HIV in South Africa were virally suppressed (less than 1000 copies /mL) in **2022 compared to 62% in 2017**. **Viral suppression was higher among women (83%) when compared to men (79%) and lower (70%) among younger adults aged 15–24 years**. The lowest percentage of viral load suppression (**66%**) was among men aged 25–34 years old.

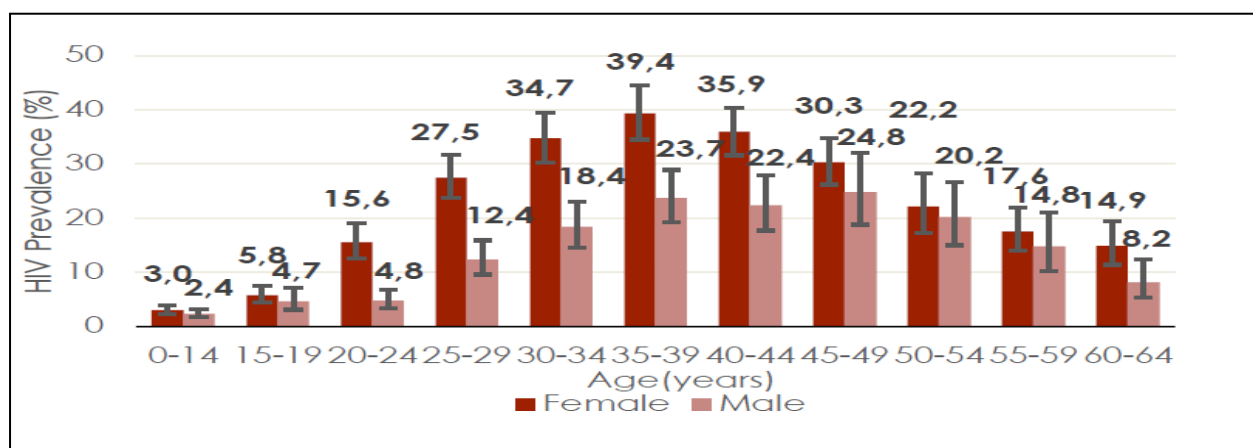
According to the survey, half of all young men **aged 15–24 years** were medically circumcised compared to **43% in 2017**. This is an important achievement as studies have shown that male circumcision can reduce the risk of heterosexual HIV transmission by approximately **60%**.

Graph 7: Comparative Provincial prevalence in 2012 and 2017 among South Africans (HSRC, SABSSM V 2017)



The HIV prevalence is the highest in females compared to their male counterpart as reflected in the Graph below. The National Department of Health has introduced the **“She Conquers”** campaign that aims to direct the focus to Adolescent girls and young women, with the aim to decrease new HIV, STI and TB infections in girls and young women with targeted messages and dialogues, decrease teen pregnancies, keep girls in school up to grade twelve, as well as to increase economic opportunities for young people. Graph 8 below depicts the high HIV prevalence rates in girls and young women.

Graph 8: HIV Prevalence by Age and Gender, South Africa. (HSRC, 2017)



The HIV prevalence for those that are less than **15 years of age was 1,7% (22,001)** ; for youth 15 to 24 years of age was 9,5% (69,781)¹ and for all those 15 years and above, the HIV prevalence **was 16,8% (638,683)**.

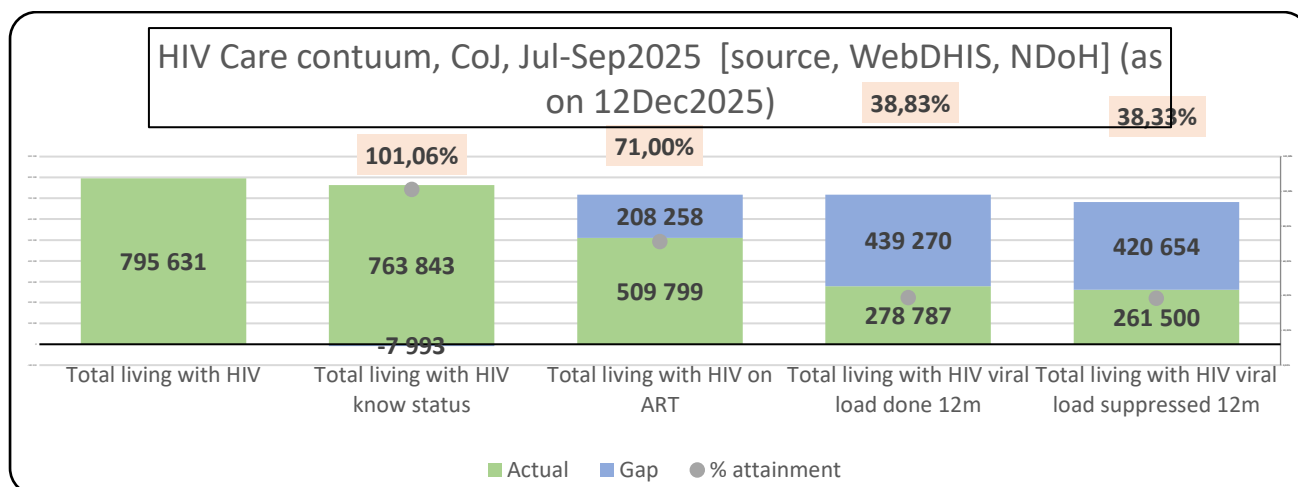
Johannesburg has a generalised HIV epidemic, with pockets of concentration amongst youth and key populations. According to the most recent available data, the overall HIV prevalence in Johannesburg **is 12,9%** , i.e. an estimated **702 754 people are HIV positive** in the district.

The prevalence of key and vulnerable populations, i.e. men who have sex with men, prisoners, sex workers and their clients, and injecting drug users and people with disabilities mirror the situation of other big cities in South Africa.

Progress is being made towards the UNAIDS 95-95-95 targets.

According to the NDoH WebDHIS 95-95-95 Treatment cascade Report for **July - Sep 2025 dated 12th December 2025**, it is estimated that there are **795,631 people living with HIV** in Johannesburg, **763,843 persons living with HIV know their status 101,06.%** of the 1st 95 target attained), **509,799 Persons** Living with HIV (PLHIV) has been placed on Anti-retroviral treatment (**ART**), **71.0%** of the 2nd 95 target attained, **as at the end of Sep 2025**. The Viral load blood test is done at 6 months, 12 months and thereafter annually and reflects viral suppression (limited ability to transmit the virus). Data as on the **12^{9th} of December 2025** indicates that **278,787** persons on ART have a recorded Viral load test done at 12 months (**38,83%**) and (**261,500**) (**38,3%**) **were virally suppressed as reflected in Graph 9**.

Graph 9: 95-95-95 HIV Care Continuum, Johannesburg Jul - Sept 2025.



HIV prevalence among Antenatal Women

The national Antenatal Sentinel HIV & Syphilis Prevalence Survey conducted in 2019 provides the latest estimates of HIV prevalence among antenatal women for districts, provinces, and South Africa. The HIV prevalence in antenatal women for CoJ was 25.5% and 30.0% for South Africa in 2019 (Table 4).

Table 4: HIV prevalence among Antenatal women, 2011 – 2015, 2017 & 2019.

	HIV prevalence among antenatal women ¹						
	2011	2012	2013	2014	2015	2017	2019
South Africa	29.5% (95% CI of 28.7% – 30.2%)	29.5% (95% CI of 28.8 – 30.2)	29.7% (95% CI of 28.9 – 30.2)	30.0% (95% CI of 29.2 – 30.8)	30.8% (95% CI of 30.0 – 31.8)	30.7% (95% CI: 30.1%– 31.3%)	30.0% (95% CI: 29.4% - 30.6%)
Gauteng	28.7% (95% CI of 27.3 – 30.1)	29.9% (95% CI of 28.3 – 31.5)	28.6% (95% CI of 27.0 – 30.3)	27.6% (95% CI of 26.2 – 29.0)	30.2% (95% CI of 28.5 – 32.0)	32.2% (95% CI of 30.7 – 33.6)	28.1% (95% CI 26.8% - 29.4%)
City of Joburg	28.9% (95% CI of 26.6 – 31.3)	29.6% (95% CI of 27.5 – 31.9)	27.3% (95% CI of 24.7 – 30.1)	27.3% (95% CI of 25.2 – 29.6)	29.6% (95% CI of 27.1 – 32.2)	30.9% (95% CI of 27.0 – 35.0)	25.5% (95% CI 22.3% – 28.8%)

¹ The 2019 National Antenatal Sentinel HIV & Syphilis Survey, South Africa, National Department of Health.

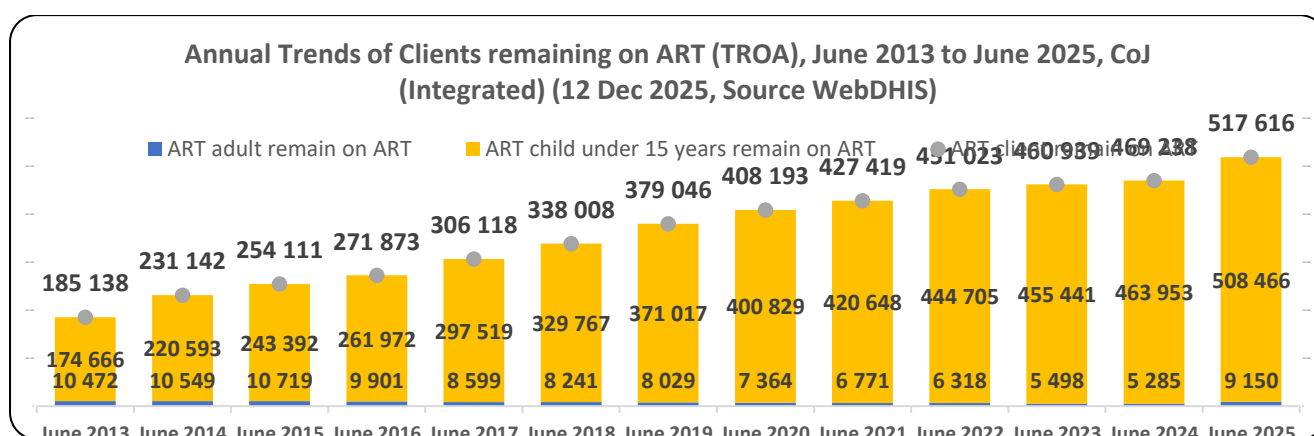
Vertical Transmission Prevention Programme (VTP)

With increased investments by the district, there have been significant results in VTP. In 2022/2023 there were 2,868 Antenatal HIV 1st test positive, 185 Antenatal HIV re-test positive, 171 antenatal clients were known HIV positive but **not on ART at 1st visit**, and therefore 3,224 were eligible for ART initiation. Of these **99,6% (3,212 of 3224)** antenatal clients were initiated on ART. The PCR (HIV test) positive rate at **10 weeks was 0.4% (66 of 18,286)**.

Expanding Access to Treatment

A total number of people that were initiated on ART treatment from July 2024 to June 2024 was 31,498 clients and 517,616 remained on HIV treatment as at June 2025 in the City of Johannesburg. The number of clients remaining on ART has increased from **469,238 as at June 2024 to 517,616 as at June 2025**.

Graph 10: Trends in Total Clients Remaining on ART (TROA), 2013 to 2025, CoJ.



The annual trends of clients remaining on ART has increased from **469,238 in June 2024 to 517,616 as at June 2025** (Table 5). There were 9,150 children less than **15 years and 508,466** adults (15 years and older) remaining on ART as of June 2025. It must be noted that the rollout of ART to all facilities began in 2010 in a phased manner.

Table 5: Annual Trends of Clients remaining on ART (TROA), June 2006 to June 2025, CoJ (Integrated) (as on 12th Dec 2025, Source DHIS)

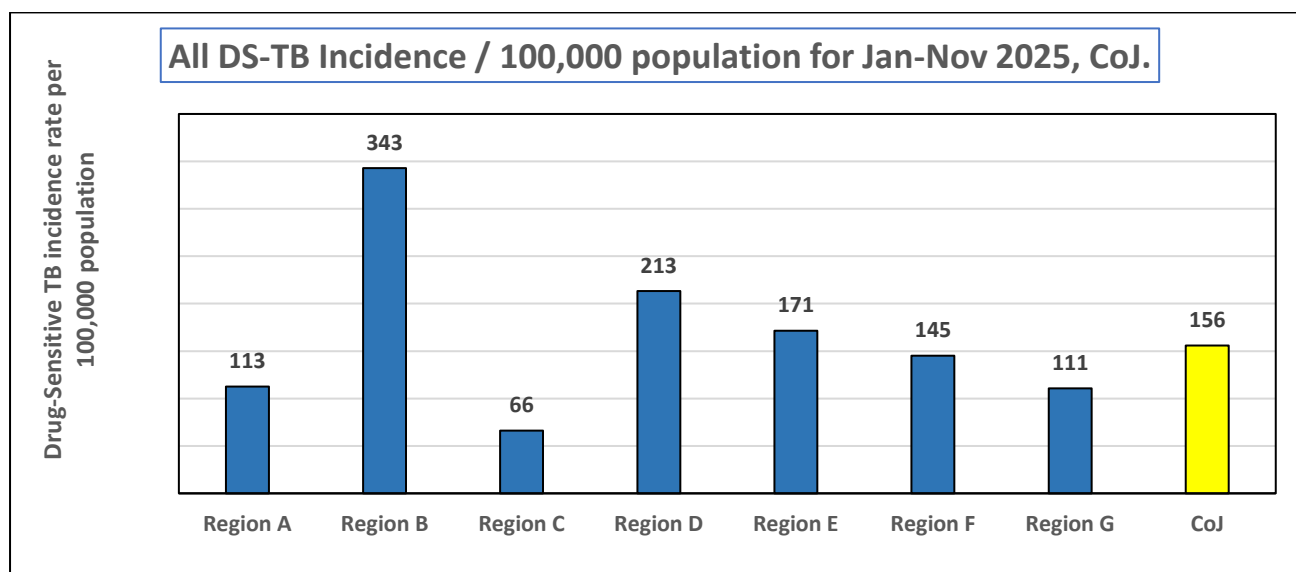
Month	ART adults remain on ART	ART children under 15 years remain on ART	ART clients remain on ART
June 2006	95	917	1,012
June 2007	82	1,097	1,179
June 2008	172	3,846	4,018
June 2009	159	10,628	10,787
June 2010	187	20,863	21,050
June 2011	146	39,695	39,841
June 2012	8,317	125,815	134,132
June 2013	10,472	174,666	185,138
June 2014	10,549	220,593	231,142
June 2015	10,719	243,392	254,111
June 2016	9,901	261,972	271,873
June 2017	8,599	297,519	306,118
June 2018	8,241	329,767	338,008
June 2019	8,029	371,017	379,046
June 2020	7,364	400,829	408,193
June 2021	6,771	420,648	427,419
June 2022	6,318	444,705	451,023
June 2023	5,498	455,441	460,939
June 2024	5,285	463,953	469,238
June 2025	9,150	508,466	517,616

7.3.3 Tuberculosis

South Africa is at the centre of the dual human immunodeficiency virus (HIV) and tuberculosis (TB) epidemics. The focus of the Tuberculosis Control Program (TBCP) is to strengthen the implementation of the TBCP by improving case detection of both TB and HIV infection, case holding and treatment outcomes whilst prioritising infection control.

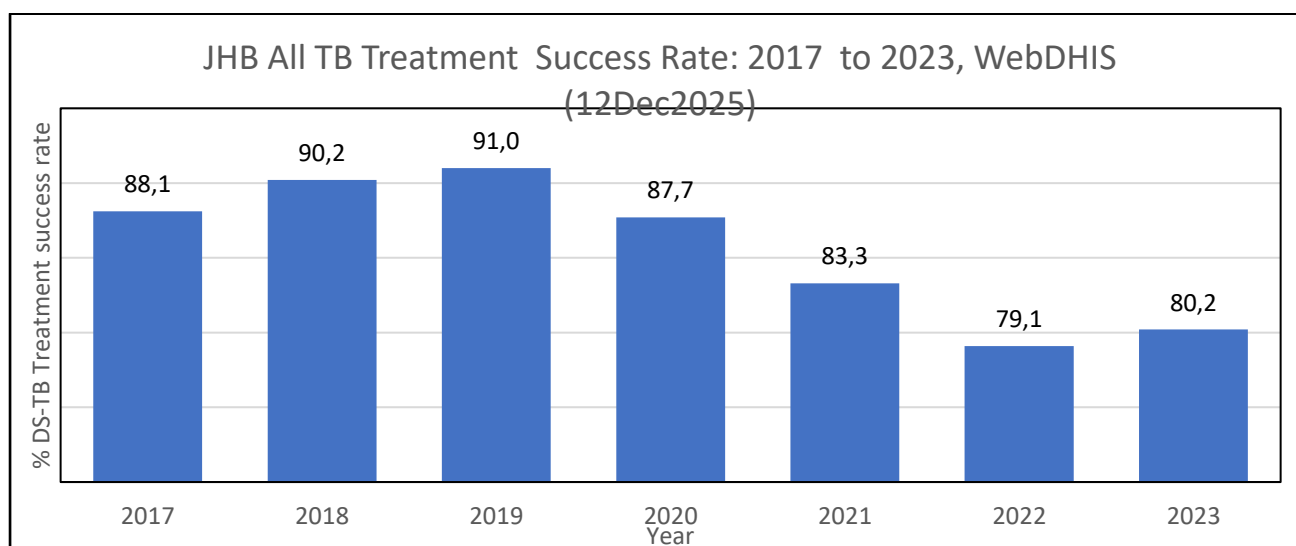
The Johannesburg Heath District TB incidence rate for 2025 has remained relatively the same from 157 per 100,000 population in 2024 to 156 per 100,000 population in Jan-Nov 2025 (Graph 11).

Graph 11: All Drug-sensitive TB Incidence (per 100 000 population), Jan – Nov 2025, JHB.



The integrated Treatment Success rate of All TB Cases has declined from **91.1% in 2013** to **79.1% in 2022** as shown in **Graph 12 below**. The trend has shown an **increase to 80,9%** in the Jan to June 2023 period. The monitoring of this outcome indicator is done via the NDoH mandated TB HIV Information System (THIS), also known as TIER.Net. The performance within Local government health facilities is slightly better at 88,1% during the year of 2022. The data is reported 15 months backwards to allow all the treatment regimen lengths to be completed

Graph 12: All TB Treatment Success Rate, 2019 – 2023, CoJ.



7.3.4 Maternal and Reproductive Health

MATERNAL MORTALITY RATIO (MMR):

The institutional maternal mortality ratio (iMMR) is the annual number of deaths of women from pregnancy-related causes or within 42 days of termination of pregnancy, per 100 000 live births. The maternal mortality ratio is an indicator of maternal health as well as the quality of the (obstetric) health services. It reflects poor care during pregnancy, inappropriately trained staff, inadequate facilities, and the lack of transport and means of communication.

The Saving Mothers 2021 Annual Report on Confidential Inquiries into Maternal Death in South Africa² highlights some positives and negatives. The corrected Maternal Mortality Ratio (MMR) was 145.0 maternal deaths per 100 000 live births, which is a further increase from 2020 (MMR 126.1) and a 47% increase in maternal deaths from 2019 (MDs 1022, iMMR 98.8). This shows that the steep decline from 2010 to 2019 was reversed in 2021 and 2020. The increased MMR from 2019, occurred in all provinces in South Africa. Deaths from Non-Pregnancy Related Infections (NPRI) accounted for 554 MDs in 2021 (37% of deaths) and have sharply increased from previous years. COVID-19 pneumonia and complications increased from 2020, accounting for 66.6% of NPRI deaths and 25.1% of all maternal deaths in 2021. Obstetric hemorrhage (OH) deaths (n=234) increased to become the second most common cause. Medical and surgical (M&S) disorders and Hypertensive disorders (HDP) were the third and fourth most common causes, respectively.

The reduction in iMMR seen in the previous triennium (2017-19) has been reversed even further in 2021 compared to 2020, due to the COVID-19 pandemic causing maternal deaths due to COVID-19 pneumonia, and due to the indirect effects on the management of other causes such as obstetric haemorrhage.

Table 6: Trends in Institutional Maternal Mortality Ratio (iMMR) [2011-2013]; [2014 – 2016] and 2017 and 2021.

	South Africa	Gauteng	CoJ
Institutional Maternal Mortality ratio (iMMR) (Number of maternal	2011 – 2013: 154.06 maternal deaths per 100,000 live births 2014 – 2016:	2011 – 2013: 135.24 maternal deaths per 100,000 live births	2014 – 2016: 121.99 maternal deaths per 100,000 live births

² Saving Mothers 2021: Annual report on Confidential enquiries into maternal death in South Africa: NDoH, South Africa.

deaths per 100,000 live births)	134.33 maternal deaths per 100,000 live births <u>2017:</u> 130.96 maternal deaths per 100,000 live births <u>2021:</u> 145.0 maternal deaths per 100,000 live births (Excl. Coincidental deaths)	<u>2014 – 2016:</u> 128.78 maternal deaths per 100,000 live births <u>2017:</u> 125.14 maternal deaths per 100,000 live births <u>2021:</u> 136.46 maternal deaths per 100,000 live births (Excl. Coincidental deaths)	<u>2017:</u> 78.59 maternal deaths per 100,000 live births <u>2021:</u> 128.6 maternal deaths per 100,000 live births (Excl. Coincidental deaths)
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In addition to the 2017 Annual report, the 2021 Annual report provides detailed interventions to be strengthened.

- Recommendations of the 2017-2019 Saving Mothers report are still relevant and need to be implemented.
- Functional Maternal and Newborn, and Sexual and Reproductive Health services must be maintained.
- During times of COVID-19 or similar future pandemics, and COVID-19 care for pregnant women must be integrated into maternity care services.
- Findings of E Motive trial for PPH to be implemented nationally.
- Disseminate and teach on new SA Maternity Care Guidelines.
- Update and continue with ESMOE training and drills.
- Provinces to address administrative / system issues arising from their reports in their annual operational plans.
- Maternal health needs to be prioritized at national level and appropriate investment and allocation of resources made to maternal health.

Graph 13: Comparison of iMMR per underlying condition per year (2017-2021), South Africa.

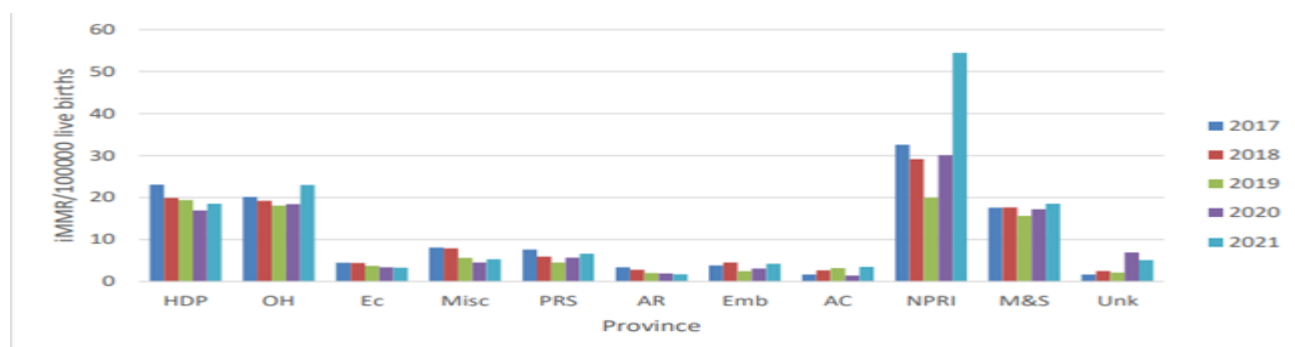


Table 7: Primary Obstetric cause of Maternal deaths and iMMR for 2021

Primary obstetric problem	Number MDs	%	iMMR
INDIRECT			
Medical and surgical disorders	188	12.6	18.5
Non-pregnancy-related infections*	554	37	54.5
DIRECT			
Ectopic pregnancy	33	2.2	3.2
Miscarriage	54	3.6	5.3
Pregnancy-related sepsis	67	4.5	6.6
Obstetric haemorrhage	234	15.6	23.0
Hypertension	187	12.5	18.4
Anaesthetic complications	17	1.1	1.7
Adverse drug reactions	5	0.3	0.5
Embolism	43	2.9	4.2
Acute collapse - cause unknown	36	2.4	3.5
Miscellaneous	3	0.2	0.3
Unknown	52	3.5	5.1
Total:	1473	100	145.0

Table 8: Comparison number and iMMR per underlying causes per year 2017 – 2021

Primary Obstetric Problem	2017	2018	2019	2020	2021
Hypertension	23.09	19.88	19.39	16.9	18.4
Obstetric haemorrhage	20.13	19.19	18.09	18.4	23.0
Ectopic pregnancy	4.46	4.4	3.75	3.4	3.3
Miscarriage	8.11	7.9	5.63	4.5	5.3
Pregnancy-related sepsis	7.62	5.95	4.52	5.7	6.6
Anaesthetic complications	3.4	2.79	2.02	1.9	1.7
Embolism	3.84	4.53	2.47	3.1	4.2
Acute collapse	1.68	2.64	3.21	1.4	3.5
Non-pregnancy related sepsis	32.59	29.15	19.95	30.1	54.5
Medical and surgical disorders	17.57	17.64	15.61	17.2	18.5
Unknown	1.66	2.52	2.12	6.9	5.1
iMMR for all maternal deaths (excluding coincidental deaths)	125.89	117.69	98.82	111.3	145.0

The 2021 Saving Mothers Report (Table 7) indicated that the four major causes of maternal death, accounting for 77.7% of maternal deaths were:

- Non-pregnancy related infections (NPRI): 37% (increased from 25.4% in 2017-2019) - resulting from meningitis, tuberculosis, GIT, appendicitis, malaria, pneumonia, and others.
- Complications of hypertension in pregnancy (12.5%).
- Obstetric haemorrhage (ante partum and postpartum haemorrhage (15.6%).
- Medical and surgical disorders (12.6%)

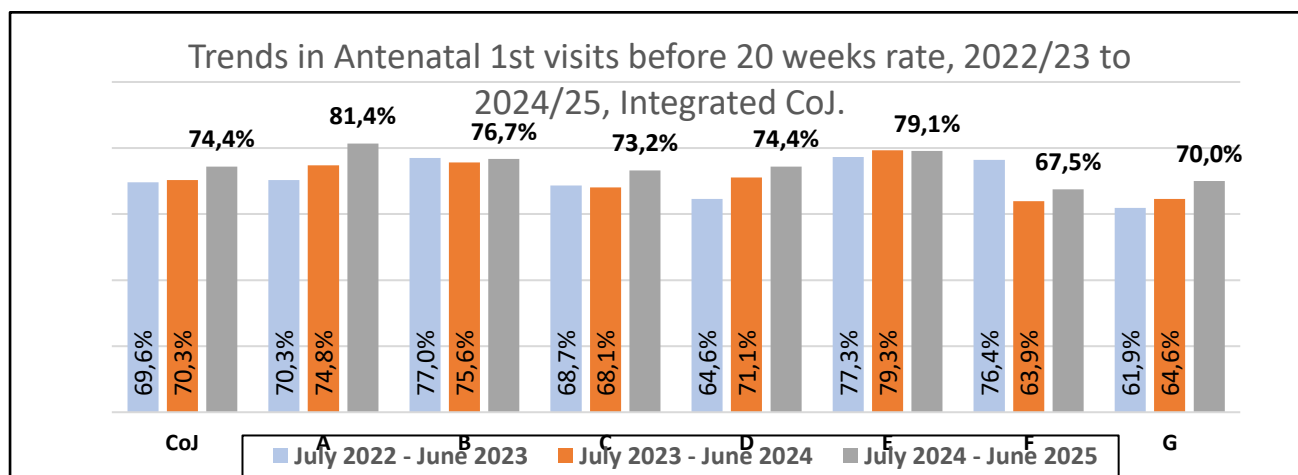
The most common health professional avoidable factors were identified as: poor clinical assessment, delays in referral, not following standard protocols and not responding to abnormalities when monitoring patients.

Unavailability and **poor access to antenatal services** have been identified as a contributory factor to causes of maternal deaths. (Women who did not attend antenatal care services had a four times increased risk of maternal death compared with the general pregnant population).

Antenatal care

The number of women attending CoJ health facilities (integrated) for antenatal care has decreased from **85,868 (1st ANC visits) in 2022/23 to 78,924 in 2024/25**. Early registration for antenatal care is crucial for pregnant women and affords them access into health care services, including PMTCT services. For the City (Integrated) the antenatal care 1st visits before 20 weeks (early booking) rate increased from **69.6% in 2022/23 to 74.4% in 2024/25** (Graph 14).

Graph 14: Trends in Antenatal 1st visits before 20 weeks rate, 2022/23 to 2024/25, Integrated CoJ.



The vertical Transmission Prevention (VTP) programme provides an opportunity to minimize the transmission of HIV from the HIV-infected pregnant mother to the child. All public health facilities provide this programme. The vertical transmission rate in the city (integrated) decreased from 0.6% in 2020/21 to 0.19% in 2023/24 (Infant PCR test positive around 10 weeks).

7.3.5 Child Health and Expanded Programme on Immunization (EPI)

The Sustainable Development Goals make a bold commitment to end the epidemics of AIDS, tuberculosis, malaria, and other communicable diseases by 2030. Sustainable Development Goal 3 focuses on Good Health and Wellbeing to ensure healthy lives and promote wellbeing for all ages.

The aim is to achieve universal health coverage as well as provide access to safe and affordable medicines and vaccines for all. Since 1990, substantial progress has been made in reducing childhood mortality rate. The total number of deaths under 5 worldwide has declined from 12.8 million in 1990 to 5 million in 2021. Therefore, the Under 5 mortality rates have dropped by 59%, from 93 deaths per 1000 live births in 1990 to 38 in 2021.

Despite this incredible progress, there are approximately 6 400 neonatal deaths daily, amounting to 47% of all child deaths under the age of 5 years (WHO). The common causes of death are attributable to six conditions: diarrhea, malaria, neonatal infection, pneumonia, preterm delivery, or birth asphyxia. Diarrhea and pneumonia are the commonest infective causes of death in children. These deaths can be avoided through prevention and treatment, education, and immunization campaigns (UNDP). Furthermore, the adoption and implementation of Integrated Management of Childhood illness (IMCI) strategy have been associated with a 15% reduction in child mortality, minimizing illnesses and disability, promoting growth and development in children under 5 years when activities were implemented at scale in health facilities and communities.

Immunization is one of the most effective health care interventions that prevent serious illnesses and death in young children. The World Bank also states that immunization is the most cost-effective health intervention after the provision of sanitation.

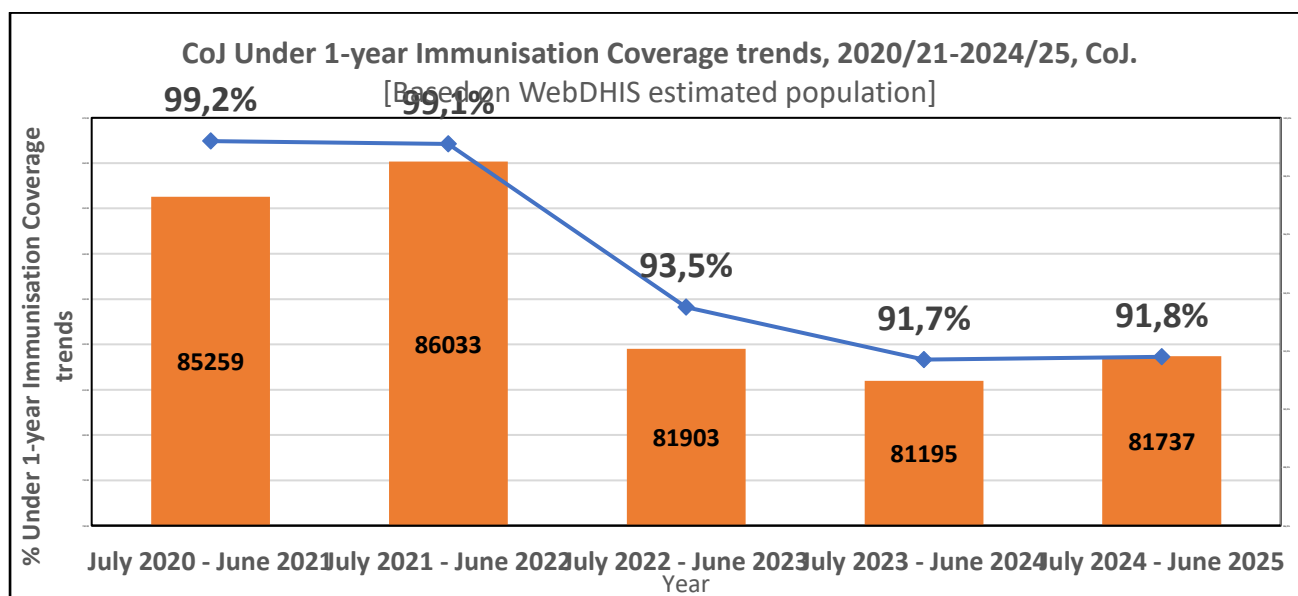
South Africa invested in immunization in recent years, most notably by the inclusion of pneumococcal and rotavirus immunization into the routine Expanded Programme on Immunization in 2009, as well as a transition from Td to Tdap vaccine in 2024. The pneumococcus, rotavirus and Tdap vaccines protect against the commonest causes of diarrhea, pneumonia, Tetanus and Diphtheria in children. Starting from 2014, a girl child who turns 9 years has been receiving Human Papilloma Virus (HPV) vaccine against cervical cancer as part of the Integrated School Health Programme (ISHP).

Immunization protects the individual vaccinated, and in addition, provides herd immunity and thus prevents disease outbreaks and epidemics, with immunization of a sufficient number of people in a community (usually > 90% coverage).

NDoH used DHIS 2.4 as one of the main data applications for routine health data. From 2016, Gauteng was moved to the WebDHIS. The mid-year population estimates are part of the datasets in the data application. Specific age-group population figures are used to calculate relevant health programme indicators. From August 2017, WebDHIS has an entire series of revised population estimates for the period 2007-2024.

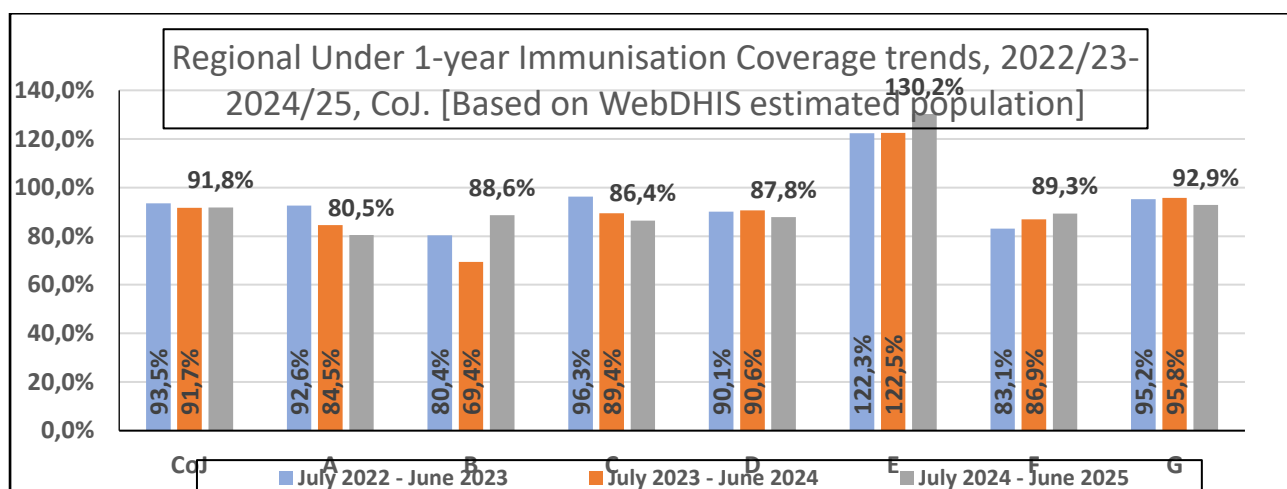
Therefore, the denominators for immunization coverage (i.e., under 1-year population) were revised according to the new population estimates and concomitantly, the annual trends in the immunization coverage of children under 1-year. The annual under 1-year immunization coverage trend for City of Johannesburg is shown in Graph 15 below, indicating an increase from 81.2% in 2019/20 to 87.1% in 2021/22, then decreasing to 82,7% in 2023/ 24. The number of children under 1 year that are fully immunized has decreased from 86 033 in 2021/22 to 80 734 in 2022/23.

Graph 15: Under 1-year Immunisation Coverage trends, 2020/21 - 2024/25, CoJ



The annual under 1-year immunization coverage trends for sub-districts (Regions) is shown in Graph 16 below.

Graph 16: Regional Under 1-year Immunisation Coverage trends, 2022/23 - 2024/25, CoJ.



The National Strategic Plan for the Prevention and Control of Non-Communicable Diseases 2022-2027

Non-communicable diseases (NCDs) and Mental health disorders are leading causes of mortality, morbidity, and disability in South Africa, and carry huge costs to patients, families, communities, the health system, and the economy at large.

This NSP aims to move South Africa closer to Sustainable Development Goal (SDG) 3.4: **To reduce, by one third, premature mortality from NCDs+ through prevention and treatment and promote Mental health and well-being by 2030** through the progressive improvement of wellness and reduction of premature morbidity, disability, and mortality from NCDs+.

A cascading strategy, like the 90-90-90 approach for HIV and AIDS, and TB defined and updated progressively to include other NCDs+. The proposed 90-60-50 cascade for diabetes and hypertension is the first step to improving early detection and treatment of NCDs+ and is as follows:

- 90% of all people over 18 will know whether they have raised blood pressure and/or raised blood glucose.
- 60% of people with raised blood pressure or blood glucose will receive intervention.
- 50% of people receiving interventions are controlled.

7.3.6 Non-communicable Diseases [Chronic diseases of lifestyle (CDL)]

Non-communicable diseases (NCD) are a group of diseases that share similar risk factors because of exposure over many decades to unhealthy diets, smoking, lack of exercise, and stress.

The **major risk factors** are high blood pressure, tobacco addiction, high blood cholesterol, diabetes, and obesity. These result in various long-term disease processes, culminating in high mortality rates attributable to stroke, heart attack, tobacco- and nutrition-induced cancers, chronic bronchitis, emphysema, renal failure, and many others. Internationally, these diseases are also known as 'non-communicable diseases' (NCDs) or 'degenerative diseases.' (SA Medical Research Council)

The 2016 South African Demographic and Health Survey (Table 8) indicate the obesity burden in South Africa and Gauteng. The mean body mass index (BMI) for **women 15 years and older was 29.2 (overweight) and 67.6% were either overweight or obese**. Thirty-one-point three percent (**31.3%**) of men were either overweight or obese.

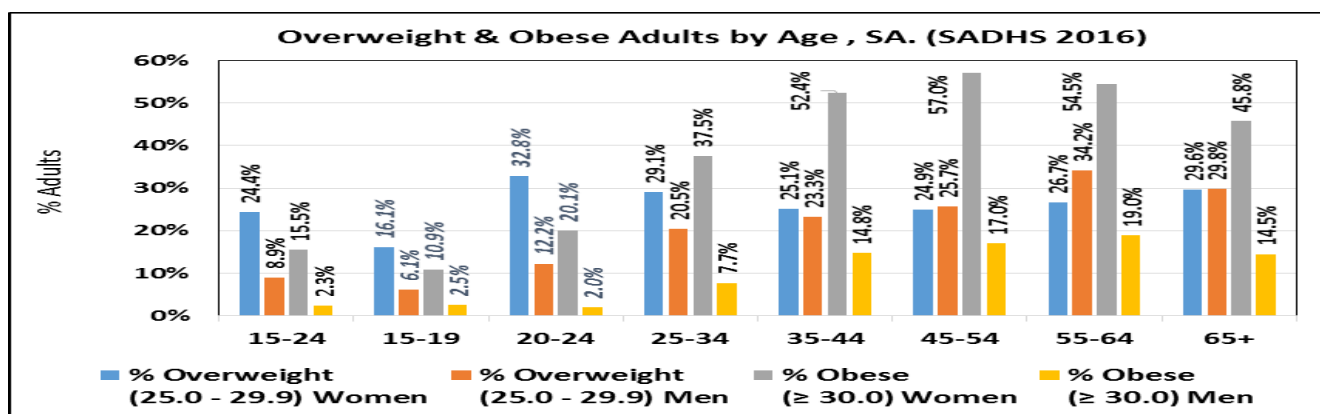
Table 8: Nutritional Status of Adults – BMI (SADHS* 2016 - Statistics SA)

			Mean BMI	Body Mass Index (BMI)			
				% Normal (18.5 - 24.9)	% Overweight (25.0 - 29.9)	% Obese (≥ 30.0)	% Severely Obese (≥ 35.0)
South Africa	Women	15 years & older	29.2	29.8%	26.6%	41.0%	20.30%
		15 - 49 years	28.3	34.7%	26.3%	35.9%	16.70%
	Men	15 years & older	23.6	59.2%	20.3%	11.0%	3.10%
		15 - 49 years	23.0	65.3%	17.2%	7.9%	2.40%
Gauteng	Women	15 years & older	29.2	32.8%	26.8%	39.0%	22.10%
	Men	15 years & older	23.8	58.10%	20.70%	12.80%	3.40%

- **SADHS: South African Demographic and Health Survey.**

Graph 17 below reflects the percentage overweight and obese adults by age group. Women in the age groups **25-34 years (37.5%) to 65 years and older (45.8%)** have very high obesity rates. Young women in the 20–24-year age group were found to have an **overweight rate of 32.8%**.

Graph 17: Overweight & Obese Adults by Age, SA. (SADHS 2016)



The major modifiable risk factors are unhealthy diet; tobacco use and physical inactivity.

The on-going management of these chronic conditions and their complications, once established, places a tremendous strain on health services. Therefore, health promotion targeting communities, to avoid these conditions from developing should be emphasized.

Four Risk Factors i.e., tobacco use, unhealthy diet, lack of physical activity and harmful use of alcohol contribute to four chronic diseases i.e., heart disease, type 2 diabetes, chronic lung disease and some cancers which, in turn, contribute to **more than 80%** of preventable deaths from non-communicable diseases in the world.

The 2018 Causes of Death report by Stats SA also showed that non-communicable diseases (NCDs) **accounted for 22.3% of 32.7% of the top 10 causes of death** in CoJ. Early detection and initiation of interventions (medical & non-medical) for these conditions can decrease the morbidity and mortality resulting from chronic diseases.

7.3.7 Diabetes Mellitus

Table 11 depicts the percentage of deaths attributed to diabetes mellitus in 2019. It was the fourth highest cause of death in **Johannesburg (3.2%)** and the first highest cause in South Africa (5.7%) and Gauteng (4.4%). It was also the leading cause of death for **females (7.5%) in South Africa**.

Table 11: Percentage Diabetes Mellitus deaths, CoJ, Gauteng, South Africa, 2019. (STATSSA 2019)

	All Sexes		Males		Females	
	Rank	%	Rank	%	Rank	%
South Africa	1	5.7%	4	4.1%	1	7.5%
Gauteng	1	4.4%	3	3.6%	1	5.4%
Johannesburg	4	3.2%				

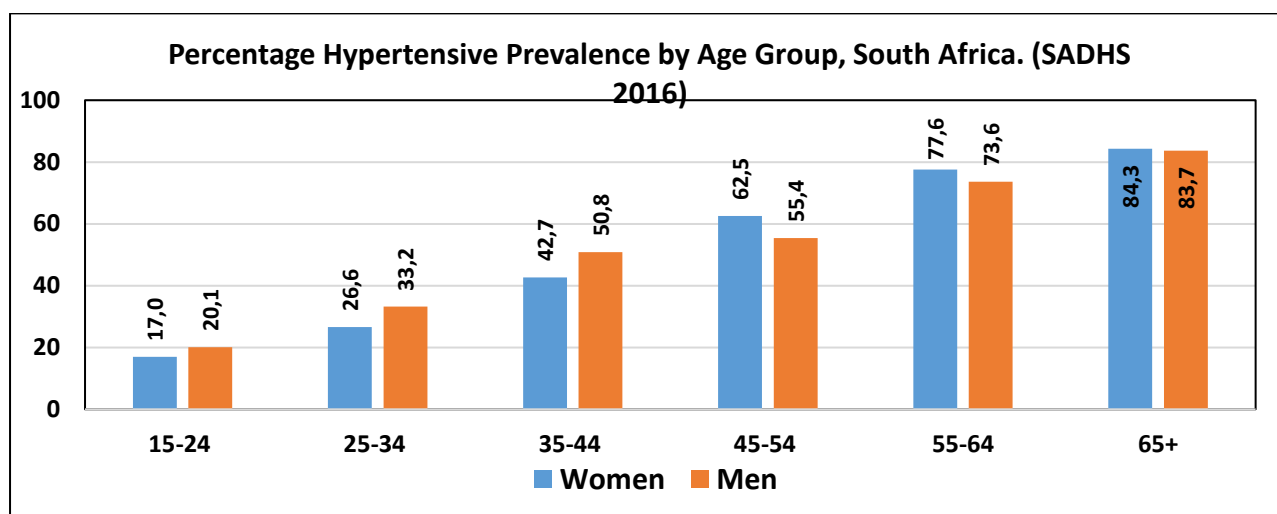
The 2016 South African Demographic and Health Survey also determined the prevalence of hypertension. The hypertensive prevalence the age group 15 years and older **was 45.5 for women and 43.7 for men in South Africa**. The Gauteng prevalence for the age group 15 years and older **was 42.3 for women and 39.5 for men** (Table 10 below).

Table 10: Prevalence of Hypertension, SA. (SADHS 2016)

Province	Hypertension Prevalence	
	Women	Men
Western Cape	51.6	58.7
Eastern Cape	49.8	47.3
Northern Cape	52.9	52.3
Free State	54.4	48.2
KwaZulu-Natal	48.1	47.5
Northwest	40.0	37
Gauteng	42.3	39.5
Mpumalanga	45.8	46.1
Limpopo	34.1	28.8
SA Total 15+	45.5	43.7
SA Total 15-49	30.6	33.7

Graph 18 shows the percentage hypertensive prevalence by age group. The hypertensive prevalence rate increases with older age groups. The hypertensive prevalence rate for 55-64 age group for women was 77.6% and 73.6% for men.

Graph 18: Hypertensive prevalence by Age, SA. (SADHS 2016)



7.4 Environmental Health Services (Municipal Health Services)

Environmental Health encompasses those aspects of human health, including quality of life, that are determined by physical, chemical, biological, social, and psychosocial factors in the environment. It also refers to the theory and practice of assessing, correcting, controlling, and preventing those factors in the environment that can potentially affect adversely the health of present and future generations.

Environmental Health is therefore in the forefront to protect the Environment and to safeguard the public from contracting communicable or non-communicable diseases from food, water, and other environmental impacts.

The Department provides environmental health services within the framework of various national, provincial, and municipal legislation, e.g. **The Constitution of the Republic of South Africa, Act 108 of 1996**, the **National Health Act, 61 of 2003** and the Regulations promulgated thereunder,

- Foodstuffs Cosmetics and Disinfectant Act, 54 of 1972 and the regulations
- Health Professions Act, 56 of 1974
- Gauteng Noise Control Regulations of 1999,
- City of Johannesburg Public Health By-laws of 2004.
- Moreover, the delivery of Environmental Health Services is aimed at addressing the Social Determinants³ of Health and attaining the Sustainable Development Goals such as poverty eradication; ensuring healthy living and promote wellbeing for all at all ages; ensuring the availability and sustainable

³ Conditions in which people are born, grow, live, work and age including the health system.

management of water and sanitation for all and strengthening partnerships for sustainable development goals.

Health services are essential to the well-being and sustainability of every community in South Africa. 'Municipal health services', in keeping with the developmental mandate of local government, are listed as a Schedule 4B function in the Constitution. It follows that local government has full executive and legislative authority over this function **Municipal Health**

Services are listed as:

7.4.1 Water quality monitoring

Water quality monitoring comprises the monitoring and surveillance of water quality and availability that is intended for human consumption, recreational, commercial, and industrial use. **It includes the following but is not limited to:**

- Complaint investigation
- Monitoring of water reticulation systems and other sources of water supply
- Ensuring that potable and an adequate supply of water is provided.
- Compliance monitoring in terms of legislative requirements and provisions and institute remedial and preventative measures.
- Law enforcement by serving compliance notices or if deemed necessary by issuing "summonses to appear in Court" notices (Sect 56 of Criminal Procedures Act 1977)
- Water sampling for bacteriological and chemical analysis

7.4.2 Food control

Food control is a mandatory regulatory activity with enforcement by national or local authorities to provide Consumer Protection and ensure that all foods during production, handling, storage, processing, and distribution are Safe, Wholesome and Fit for Human Consumption; conform to Quality and Safety requirements; and are honestly and accurately Labelled as prescribed by law.

In addition, food safety activities provide assurance that food will not cause harm to the consumer when it is prepared and/or eaten according to its intended use, that it does not contain biological (microbial agents), chemical (Naturally occurring toxins, pesticides, veterinary drugs, etc.) or physical contaminants (hair. stones, etc.), and to ensure high standards of production, processing, distribution, marketing, & preparation.

Food safety activities include the following but is not limited to:

- Issuing of Certificate of Acceptability
- Inspection of food premises (building, structure, stall, or other similar structure, and includes a caravan, vehicle stand, or place used for or in connection with the handling of food)
- Compliance monitoring in terms of legislative requirements and provisions and instituting remedial and preventative measures.
- Examination, sampling for microbiological or chemical analysis at the laboratory, detention, and seizure of foodstuffs
- Examination of food labels
- Investigation of food born related complaints
- Law enforcement by serving compliance notices or if deemed necessary by issuing “summonses to appear in Court” notices (Sect 56 of Criminal Procedures Act. 1977)
- Export control when requested.
- Health promotion and training
- Prohibition of food premises or facility the handling of food or any of the activities that relate to the handling of food.
- Monitoring the recall procedure and ensuring that all listed food stuffs are removed from the shelves.

7.4.3 Waste management.

Waste Management involves the monitoring of waste management systems, refuse, health care waste, hazardous waste, and sewage.

This includes the following but is not limited to:

- Complaint investigation
- Ensuring that waste is stored, collected, and disposed of properly and that proper facilities and containers are provided.
- Ensuring through monitoring that sewerage and industrial effluent or other liquid waste is disposed of in terms of legal requirements and that no blockages and spills occur and instituting remedial and preventative measures.
- Ensuring through monitoring the proper handling, storage, collection, treatment and disposal of health care and hazardous waste.
- Compliance monitoring of garden refuse sites, refuse transfer sites, landfill sites, incinerators, recycling sites, waste treatment plants and sites and sewerage works, and the processes associated with such premises and instituting remedial and preventative measures.
- Compliance monitoring in terms of legislative requirements and provisions and instituting remedial and preventative measures.

- Law enforcement by serving compliance notices or if deemed necessary by issuing “summonses to appear in Court” notices (Sect 56 of Criminal Procedures Act. 1977)

7.4.4 Health surveillance of premises

Health surveillance of premises concerns the identification, monitoring and evaluation of health risks, nuisances and hazards and instituting remedial and preventive measures.

This includes the following but is not limited to:

- Complaint investigation
- Giving advice on legal requirements, which includes comments on building plans, for the establishment of premises, as well as comments on Planning issues, as and when required.
- Compliance monitoring in terms of legislative requirements and provisions and institute remedial and preventative measures.
- Identification of health risks, nuisances and hazards and institute remedial and preventative measures.
- Monitoring indoor air quality, ventilation, lighting and dampness and instituting remedial and preventative measures.
- Enforcement of tobacco control legislation.
- Issuing Business licenses, permits, and certificates where applicable.
- Participation in the prevention of urban decay
- Law enforcement by serving compliance notices or if deemed necessary by issuing “summonses to appear in Court” notices (Sect 56 of Criminal Procedures Act. 1977)
- Ensuring the removal of health nuisances or hazards at the cost of the owner upon failure to comply with the requirements of compliance notices.
- Health promotion and training.

7.4.5 Surveillance and prevention of communicable diseases, excluding immunization.

The surveillance and prevention of communicable diseases entail health and hygiene promotion for the prevention of all environmentally induced diseases.

This includes the following but is not limited to:

- Complaint investigation.
- Case investigations and reporting. (Outbreak response)
- Taking samples for analysis and further action if deemed necessary.
- Institute remedial and preventative measures.

- Law enforcement by serving compliance notices or if deemed necessary by issuing “summonses to appear in Court” notices (Sect 56 of Criminal Procedures Act. 1977)
- Health promotion and training

7.4.6 Vector control.

Vector control is any method to limit or eradicate the mammals, birds, insects, or other arthropods (here collectively called "vectors") which transmit disease pathogens. The methods used are guided by the Integrated Pest Management approaches which are cultural, mechanical, biological, and chemical as a last resort.

Chemical used must be registered in terms of section 3 of the Fertilizers, Farm Feeds, Agricultural Remedies and Stock Remedies 36 of 1947 (as amended)

Vector control entails the monitoring, identification, evaluation, and prevention of vector related matters. In recent years rodents have become a major problem in Johannesburg, causing damage to property, eating and spoiling food reserves, and in certain cases even attacking humans. With residents mismanaging their household waste and litter they have created the ideal habitat for rodents to thrive.

This situation is challenging for the Council to apply effective rodent control measures. The increase in rodent attacks on humans bears proof that humans are living in closer proximity to rodents than before creating an opportunity for humans to be infected by rodent borne diseases such as plague, leptospirosis, toxoplasmosis, and rat bite infections which are four of the most relevant zoonotic infections associated with rodents.

This includes the following but is not limited to:

- Complaint investigation
- Compliance monitoring in terms of legislative requirements and provisions and instituting remedial and preventative measures.
- Identification of vectors, rodents and other insects, their habitats and breeding places and instituting remedial and preventative measures to eradicate vectors.
- Facilitate eradication measures such as spraying of premises, baiting, fumigation, application of pesticide, and placing out of traps.
- Collection of specimens for research purposes.
- Law enforcement by serving compliance notices or if deemed necessary by issuing “summonses to appear in Court” notices (Sect 56 of Criminal Procedures Act. 1977)
- Health promotion, campaigns, and training

7.4.7 Disposal of the dead

Disposal of the dead refers to compliance monitoring of funeral undertakers, mortuaries, embalmers, crematoria, graves, and cemeteries and to manage, control and monitor exhumations and reburial or disposal of human remains.

This includes the following but is not limited to:

- Complaint investigation.
- Monitor the treatment, storage, removal, or transportation of bodies.
- Law enforcement by serving compliance notices or if deemed necessary by issuing “summonses to appear in Court” notices (Sect 56 of Criminal Procedures Act. 1977)
- Compliance monitoring in terms of legislative requirements and provisions and instituting remedial and preventative measures.
- Input into the planning/establishment of cemeteries.
- Health promotion and training
- Referral of Occupational Health and Safety – as well as other violations to the appropriate authorities as far as practicable as well as inter-sectoral collaboration
- Facilitate Pauper burials if required.

7.4.8 Chemical safety

Chemical safety refers to the practice of safely using, handling, and disposing of chemical products. Various chemicals such as pesticides, are widely used in households, early childhood developments, food handling areas as a means of controlling rodents or other vectors. Ensuring that all pesticides used at various settings are registered in terms of section 3 of the Fertilizers, Farm Feeds, Agricultural Remedies and Stock Remedies 36 of 1947 (as amended), is key for protecting public health.

Chemical Safety includes the monitoring, identification, evaluation, and prevention of the risks of chemicals that are harmful to human health.

This includes the following but is not limited to:

- Complaint investigation.
- Monitoring safe disposal of chemical wastes
- Law enforcement by serving compliance notices or if deemed necessary by issuing “summonses to appear in Court” notices (Sect 56 of Criminal Procedures Act. 1977)

- Compliance monitoring in terms of legislative requirements and provisions and instituting remedial and preventative measures including the removal of chemical spillages.
- Health promotion and training
- Collaboration with other stakeholders such as the Department of Agriculture, Land Reform and Rural Development.

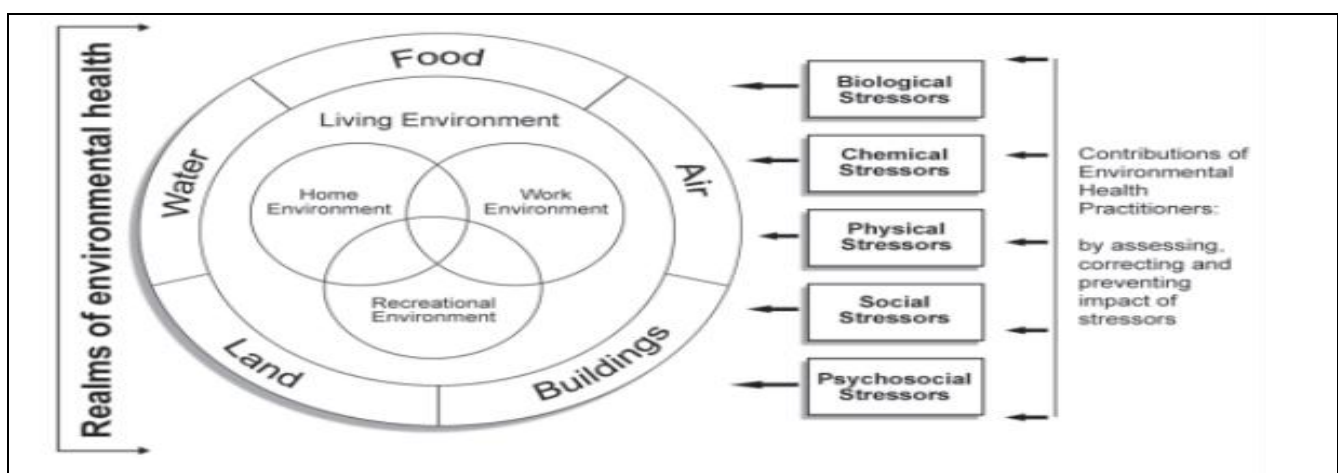
7.4.9 Environmental Pollution Control

Environmental pollution control relates to the identification, evaluation, monitoring, and prevention of land-, soil-, water-, noise- and air pollution.

This includes the following but is not limited to:

- Complaint investigation
- Identification and monitoring of sources of air pollution and instituting remedial or preventative measures.
- Identification of premises with poor indoor air quality and instituting remedial or preventative measures
- Identification and monitoring of sources of noise pollution and instituting remedial or preventative measures.
- Law enforcement by serving compliance notices or if deemed necessary by issuing “summonses to appear in Court” notices (Sect 56 of Criminal Procedures Act. 1977)
- Compliance monitoring in terms of legislative requirements and provisions and instituting remedial and preventative measures.
- Health promotion and training
- Input into Environmental Impact Assessments

REALMS OF ENVIRONMENTAL HEALTH



ENVIRONMENTAL HEALTH

Benefits of Environmental Health

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ENVIRONMENTAL HEALTH

In developing this Business Plan, the Department has considered the programmes and projects emanating from the international, National and Provincial perspectives.

8. ALIGNING LOCAL, PROVINCIAL, NATIONAL AND GLOBAL AGENDA

The City of Johannesburg Health Department's 2026/27 Business Plan is designed to ensure that local health interventions are fully aligned with global commitments, national policy frameworks, and provincial priorities. This alignment guarantees coherence, accountability, and impact across all spheres of government, while positioning Johannesburg as a leader in delivering equitable, sustainable health services.

8.1 International Perspective

The Health Department's strategic direction is informed by global health frameworks that emphasize universal access and equity. Central to this is the **Declaration of Alma Ata (1978)**, which identifies **Primary Health Care (PHC)** as the foundation for reducing health disparities. The Department also embraces the **United Nations Sustainable Development Goals (SDGs)**, particularly **Goal 3: Ensure healthy lives and promote well-being for all at all ages**, embedding these principles into local planning and service delivery.

Further, the Department applies the **World Health Organization’s Social Determinants of Health framework**, recognizing that health outcomes are shaped by socio-economic conditions such as housing, education, and income. Through the **Health in All Policies (HiAP)** approach, health considerations are integrated into municipal decision-making across sectors. This global alignment is reinforced by the **African Union Agenda 2063**, which calls for inclusive growth and expanded access to quality healthcare under **Aspiration 1: A prosperous Africa based on inclusive growth and sustainable development**.

8.2 National Perspective

At the national level, the Business Plan aligns with the **National Development Plan (NDP) Vision 2030** and the **National Department of Health’s Strategic Plan (2025–2030)**. These frameworks prioritize universal health coverage and the progressive implementation of **National Health Insurance (NHI)**. Key national objectives reflected in this plan include:

- **Advancing NHI readiness** to ensure equitable access to quality healthcare.
- **Reducing maternal, infant, and under-five mortality**, while improving life expectancy to 70 years.
- **Addressing the quadruple burden of disease** through integrated strategies for HIV/AIDS, TB, non-communicable diseases (NCDs), and injury prevention.
- **Strengthening Primary Health Care systems** and expanding community-based services.
- **Enhancing hospital infrastructure and clinical governance** to improve efficiency and patient experience.
- **Accelerating digital transformation**, including the rollout of electronic health records and integrated health information systems.
- **Building a resilient health workforce** through recruitment, training, and retention strategies.

These priorities underscore the Department’s commitment to national health goals and its role in operationalizing them at the city level.

8.3 Provincial Perspective

The Business Plan is also aligned with the **Gauteng Department of Health's 2025/26–2029/30 strategic priorities**, which focus on improving health outcomes and modernizing service delivery. Key provincial imperatives include:

- **Enhancing patient experience** and ensuring respectful, quality care across all facilities.
- **Reducing morbidity and mortality** from HIV, TB, NCDs, and maternal and child health conditions.
- **Expanding mental health services** and strengthening community-based interventions.
- **Achieving Ideal Clinic standards** and preparing facilities for NHI accreditation.
- **Investing in infrastructure development**, including new facilities and upgrades to meet compliance and capacity requirements.
- **Driving digital innovation** through the implementation of the Health Patient Registration System (HPRS) and automation of business processes.
- **Strengthening governance and accountability** to ensure efficient resource utilization and improved service delivery.

These priorities reflect a provincial commitment to integrated health systems, improved access, and technological modernization, which the City of Johannesburg Health Department fully supports.

8.4 Strategic Alignment and Impact

By aligning with global, national, and provincial agendas, the Health Department ensures that its interventions are not only locally relevant but also contribute to broader development objectives. This integrated approach enables:

- **Universal Health Coverage** through progressive NHI implementation.
- **Health System Resilience** to respond effectively to current and emerging health challenges.
- **Community-Centric Service Delivery**, fostering inclusivity and citizen empowerment.

- **Digital Transformation** for improved efficiency, transparency, and data-driven decision-making.

This alignment positions the City of Johannesburg as a proactive partner in achieving sustainable health outcomes and advancing the vision of a world-class African

9.DEPARTMENTAL RESPONSES TO:

9.1 IDP/Community issues

The following health related community issues were received by the Department:

Colour codes	
	Over 3 priority
	IGR Priorities
	Service Delivery Issue
	CBP priorities 2026/27

Ward	Region	CBP Priority	Motivation for Priority	Proposed Location	Dept / Entity	Departmental response
96	Region A	Construction of a new Clinic in Riverside view	According to the Ward Cllr and RD's Office from the session, the land has been identified. The community members further alluded that they are struggling to attend health services as other Clinics are far from Riverside.	Riverside View	Health	No budget allocation for this project in the current financial year.

Ward	Region	CBP Priority	Motivation for Priority	Proposed Location	Dept / Entity	Departmental response
79	Region A	Construction of a New Clinic to Supplement the Existing One	The current health facility serving the area is located more than 5 km away, creating significant challenges for residents—especially the elderly, people with disabilities, and parents with young children. The growing population within the ward has further strained the capacity of the existing clinic, which frequently turns away patients who are not residents of that specific ward. Community members have also raised safety concerns, as older residents with limited mobility struggle to travel such long distances and are vulnerable to crime when doing so. In light of these challenges, the community has requested the provision of a mobile clinic as an interim measure to improve accessibility to primary healthcare services while awaiting budget	Erf 18321 Ivory Park	Health	As previously reported the area has Thuthukani, Bophelong and Rabie Ridge clinics within the 5 km radius. Depending on the budget availability, the health department might need to consider a Mobile clinic to service the area in question.

Ward	Region	CBP Priority	Motivation for Priority	Proposed Location	Dept / Entity	Departmental response
			approval for the construction of a new permanent facility.			
87	Region B	Construction of a Day Clinic on Ward 87	Health department to investigate if there is an opportunity to open a day clinic at either 27 Boxes Melville, or Melville Boulevard which are COJ owner, privately leased properties. This would be of huge benefit to the residents / students in the area.	At either 27 Boxes Melville, or Melville Boulevard which are COJ owner, privately leased properties.	Health	Distance between 27 Boxes Melville and Sophiatown Clinic is 3.3km; between 27 Boxes Melville and Westbury Clinic is 4.6km. Distance between Boulevard Melville and Sophiatown clinic is 2.8km, while between Boulevard Melville and Westbury Clinic is 4.0km. Both places are in less than 5km radius from both Facilities, hence it is not feasible to open a clinic in those area.

Ward	Region	CBP Priority	Motivation for Priority	Proposed Location	Dept / Entity	Departmental response
134	Region C	Construction of a Clinic in Kya Sands	Important for vulnerable groups such as the elderly, children, and people with disabilities. Considering the inhabitants of the area. A mobile clinic does exist; however, it is only open once a week. Thus, the community requests for a clinic that will operate five days a week in Kya Sands	Kya Sands	Health	Kya sands fall under Region A. some community members are utilising the clinic, and some goes to the mobile clinic even though it is nearer the Cosmo city clinic which are within 5km radius.
44	Region C	Construction of a 'proper' Clinic at Braamfischerville			Health	Braamfischer clinic fall under province, i.e. Gauteng department of health. Closer to the community we have Solplatjie clinic and Itireleng clinics which are accessible. Department of health provincial will respond to the request.
49	Region C	Construction of the new clinic that will provide 24-hour services at Phase 3 Braamfisher	There is no clinic in the area. Residents have travel to Dobsonville or use a mobile clinic with limited services.	Phase 3 Braamfisher next to Siyabonga Secondary School	Health	Braamfischer clinic fall under province, i.e. Gauteng department of health. Closer to the

Ward	Region	CBP Priority	Motivation for Priority	Proposed Location	Dept / Entity	Departmental response
						community we have Solplatjie clinic and Itireleng clinics which are accessible. Department of health provincial will respond to the request.
83	Region C	REFURBISHMENT / Relocation of the Weltevreden park clinic	expansion and the removal of the asbestos roofing and ceilings which place the patients at risk, also more parking space for vehicles.		Health	The clinic is small indeed, but capex office is still looking for the site where the clinic can be built. Depending on the availability of funds, we hoping that the area might be considered.
100	Region C	Construction of a permanent clinic in Cosmo City.			Health	Cosmo city clinic falls under province Gauteng department of health. Closer to the community we have Zandspruit clinic and the mobile which clinic which are accessible. Department of health

Ward	Region	CBP Priority	Motivation for Priority	Proposed Location	Dept / Entity	Departmental response
						provincial will respond to the request.
70	Region C	Construction of a Clinic in Fleurhof:		According to the Community Land is available in the ward but needs to be rezoned - in Fleurhof	Health	There is Florida clinic which is within 5 km radius from Fleurhof. Mobile clinic is also servicing the area once a week.
135	Region D1	Construction of a Clinic (CHC).	Population has increased. Clinic needed and land has been identified.		Health	There is a mobile facility that services the Ward 135 area on Thursdays and Fridays at Protea Glen Fire Sation and Protea Glen Library, respectively in addition to the existing Protea Glen clinic. The Health Department has not budgeted for the construction of a new clinic for

Ward	Region	CBP Priority	Motivation for Priority	Proposed Location	Dept / Entity	Departmental response
						the next 03 year, from 2025/6.
15	Region D1	Extension of Senaone Clinic to Stand ERF No1956 Mabalane road.		Stand ERF No1956 Mabalane road.	Health	The stand belongs to JPC and currently the JPC has permitted the mechanical activities to take place. However, The Health Department also has not budget for any development for the next 03 years, since 2025/6.
16	Region D1	Clinic at Mabeane next to Seana-Marena Erf 2880 Pilane Street Mapetla.	request for the clinic is based on the demand that they have observed over the years. The current clinic in Senaoane is small and overstretched and is expected the community that is consistently growing. that is why the Senaoane Clinic is not able to cope with the current demand which is supplemented by a mobile	next to Seana-Marena Erf 2880 Pilane Street Mapetla.	Health	The stand is zoned institutional and belongs to provincial government. Therefore, the city is not able to construct any health facility at this stand without permission from

Ward	Region	CBP Priority	Motivation for Priority	Proposed Location	Dept / Entity	Departmental response
			clinic that regularly and/or weekly service ward 16. the request for the clinic in ward 16 according to the community will alleviate the current pressure on both Senaoane and Jabavu as it will not only serve ward 16 but will also service part of ward 33, Molapo and Moroka.			the province. There is a mobile clinic that services Mapetla area at Mapetla hall next to Merafe hostel, every Wednesday. There are also other facilities i.e. Senaoane and Tladi that are with 5 km radius. The Health Department also has not budget for the new construction of the clinic for the next 03 years, starting from 2025/06.
30	Region D2	Request for a Mobile Clinic at Nomzamo Park/Hall/No. 40 (Public Open Space)			Health	Currently the Region has one mobile, which services 06 areas. The Department of Health has

Ward	Region	CBP Priority	Motivation for Priority	Proposed Location	Dept / Entity	Departmental response
						motivated for an additional mobile clinic to cater for other areas including Nomzamo Park.
32	Region E	The completion of the Wellness Clinic in Klipfontein View	Project has been put on hold therefore the clinic is not yet completed	Klipfontein View	Health	The department is waiting for the project to resume. The budget for this project is not from the Health Capex budget. And there is no budget allocation from the health budget in the 2026/2027 financial year
81	Region E	Provision of a Mobile Clinic Bramley & Corlett Drive area			Health	River Park clinic and Orchard's clinic are within a 5 km radius for the provision of healthcare.
115	Region E	Construction of a CLINIC.	There is No clinic within a 5 km radius; the nearest is 8 km away. Overcrowding at		Health	There is no budget allocation for this project in

Ward	Region	CBP Priority	Motivation for Priority	Proposed Location	Dept / Entity	Departmental response
			existing clinics leads to long waiting times and delayed medical attention.			the 2026/2027 financial year.
118	Region F	Proposed Relocation and Expansion of Malvern Clinic	The current Malvern Clinic is too small to adequately cater to the growing population in the area. To address this challenge, it is proposed that the clinic be relocated to the Telkom Building, located on ERF 1972, corner of 10th Street and Jules. The building is currently vacant and belongs to the Provincial Government. Its size and layout make it suitable for the expansion of the clinic, allowing for improved service delivery and accessibility to healthcare for the Malvern community. Member of the Mayoral Committee (MMC) for Health have been in the facility and agreed to facilitate this relocation and ensure that the building can be	The proposed relocated area is the Telkom Building, located on ERF 1972, corner of 10th Street and Jules. The building is currently vacant and belongs to the Provincial Government. Its size and layout make it suitable for the expansion of the clinic.	Health	Planned relocation of Malvern Clinic has been suspended due to Budget.

Ward	Region	CBP Priority	Motivation for Priority	Proposed Location	Dept / Entity	Departmental response
			repurposed for healthcare use.			
125	Region F	Provision of a Mobile Clinic	Community members argued that their ward have lost of elderly people who have chronical illnesses and for them to travel to the then mentioned areas it's difficult as they must use two transport. Ormonde View/ Naturena /Meredale.	Ormonde view	Health	The Region has 1 mobile Clinic which has 4 dedicated sites they attend to weekly. As soon as we receive another allocation, we can consider more sites
55	Region F	Extension / upgrading of the clinic and the shelter needs to be extended in Belleville...Serous Street and Bellavista			Health	A request will be made for the new financial year 2026/2027
57	Region F	Covered Waiting Area at South Hills Clinic	The community has requested the provision of a covered shelter at the South Hills Clinic, as the current waiting area is too small to accommodate patients comfortably. A shelter would provide protection from weather conditions while		Health	A new request will be made in the new financial year 2026/2027

Ward	Region	CBP Priority	Motivation for Priority	Proposed Location	Dept / Entity	Departmental response
			patients wait for services. The Councillor has indicated that there were prior discussions about relocating the clinic. However, this process is currently stalled due to a legal dispute, as the land earmarked for the new clinic belongs to another party. The Councillor further noted that the development had already begun but has since been halted. At present, the Councillor has not been briefed on the status of the project or any proposed way forward.			
59	Region F	Clinic: Community members want a Clinic at Joubert Park, they want the old building to be refurbished.			Health	The community in Joubert Park is within the radius of 5km of Esselen Clinic & Hillbrow CHC, the proximity complies with WHO standards in terms

Ward	Region	CBP Priority	Motivation for Priority	Proposed Location	Dept / Entity	Departmental response
						accessibility to health services
60	Region F	The community is requesting for a mobile clinic inside Queen Elizabeth Park in Gwigwi and Simmonds Street.			Health	The Region has 1 mobile Clinic which has 4 dedicated sites they attend to weekly. As soon as we receive another allocation, we can consider more sites
61	Region F	Extension of operating hours for the Clinic:	Members of the community argued regarding the response from the department, they suggested that Clinic must be moved to the bigger space as the population of ward 61 is big, their biggest concern is pregnant women's who get labor pains at night and for them they feel Hillbrow is very far and majority of them they don't afford bolt and uber as they are not working, They want the	Identified area is corner Fox and Corrie Street, Jeppestown	Health	Additional infrastructure development and human resource will be required; this will also require additional budget. Therefore, a budget request will be made in the new financial year 2026/2027

Ward	Region	CBP Priority	Motivation for Priority	Proposed Location	Dept / Entity	Departmental response
			Clinic to operate 24/7 because in ward 61 they are over populated and too many injuries daily. Identified area is corner Fox and Corrie Street, Jeppestown			
63	Region F	Completion of the Essellen clinic	Apparently, the clinic only operates on the ground floor. two other floors way up not complete and if completed it can be used for other community activities. it is in Esselen corner Klein Street.	Located in Essellen corner Klein Street.	Health	The Provincial Health District Office has plans in place to develop Essellen Clinic into a CHC facility to be gate way to Hillbrow and South Rand Hospital. Follow-up will be made with District office
64	Region F	Provision of a Mobile Clinic	residents emphasised the mobile clinic in ward 64 at Hunter Street and Bertram Road in Bertram's, elderly people struggle to get medications for chronic as the Clinic is far away for them, the mobile Clinic must also do rounds in other parts	Hunter Street and Bertram's Road in Bertram's	Health	The community of Betram's is within the radius of 5km of Bezvalley Clinic the proximity complies with WHO standards in terms

Ward	Region	CBP Priority	Motivation for Priority	Proposed Location	Dept / Entity	Departmental response
			of ward 64 on different days. People in Bertram's lose their lives because they don't have Clinic around. Another suggestion is to extend Bezvalley Clinic to accommodate community members of ward 64 and extend working hours to 24/7 as the crime rate is very high, people who get injured at night lose their lives due to lack of assistance at night.			accessibility to health services
66	Region F	Provision of a fully fledged Mobile clinic	Mobile clinic that will be able to reach elders with chronic illnesses that get to be transferred to Hillbrow clinic and still return with no medication. It had for them to walk the distance and there's no transport. Mother miss immunization for their kids.	Three stops for the Mobile clinic have been Identified. Hofland Park on 5th Avenue and David Wester on 2nd Avenue and 2nd Street. Please ensure that is the Nurses that will be in the Mobile clinic not the Auxiliary Nurse.	Health	The Region has 1 mobile Clinic which has 4 dedicated sites they attend to weekly. As soon as we receive another allocation, we can consider more sites

Ward	Region	CBP Priority	Motivation for Priority	Proposed Location	Dept / Entity	Departmental response
1	Region G	Construction of a Health Care Facility (clinic), Stretford Ext. 8A	Residents of Ward 1 are urgently requesting the construction of a new healthcare centre between Anglican Primary School and Thamsanqa Secondary School. Currently, the community relies on a small satellite clinic, which operates from containers and cannot accommodate the entire population. This results in long queues, delays in consultations, and frequent shortages of medication. Many residents are sent home and told to return the following day because the clinic cannot attend to everyone. There is also no proper shelter for those waiting, exposing patients to harsh weather. The clinic is further overwhelmed as Ward 5 residents also use the facility, putting additional pressure on the limited	Stretford Ext. 8A between Anglican P School and Thamsanqa Sec School.	Health	Community Health centre is a competency of province not the municipality this issue will be escalated for action.

Ward	Region	CBP Priority	Motivation for Priority	Proposed Location	Dept / Entity	Departmental response
			space and resources. Chronic patients are particularly affected, as they struggle to receive their medication on time. While awaiting the new clinic, residents have requested the addition of a mobile clinic to provide healthcare services, especially for chronic patients, and to reduce long waiting times. The current administration is failing the residents, as the lack of proper facilities increases health risks. Patients waiting in long queues are exposed to other illnesses, which could worsen their conditions and affect the broader community. Constructing a new healthcare centre will ensure better access to medical services, reduce health risks, and improve the overall well-being of the community.			

Ward	Region	CBP Priority	Motivation for Priority	Proposed Location	Dept / Entity	Departmental response
5	Region G	Clinic Service Relocation with 24 hours operation	Poortjie area is part of ward 5 and is situated on isolation far from services. The community travels more than 20 km for services while area is dominated of unemployed people. Currently, there is a clinic that opens 12 to 3pm Monday to Friday and closed on weekend. Should you get sick weekend you must 26km travel to Lenasia. The close walking distance clinic is in Evaton, and they do not welcome Poortjie residence because of municipal boundaries. The identified space for relocation is to hospice in Poortjie as there is enough space that will accommodate extension of working/operational hours. The community of ward 5 is requesting that the existing clinic to be moved to hospice and where there is clinic to replace with Satellite Police	Poortjie area (part of ward 5)	Health	There is no budget to convert the hospice into a full package of primary healthcare facility, but the Poortjie community has access to Thula Mtwana clinic and Weiler's Farm clinic.

Ward	Region	CBP Priority	Motivation for Priority	Proposed Location	Dept / Entity	Departmental response
			station. The structures are enough for both spaces, and they are asking to be utilised. Moreover, they have indicated that the council will save a lot in building new structures from the ground as both spaces have infrastructure already. Furthermore, they have requested that the departments responsible to conduct site visit and check the two areas compliance before decision is made.			
6	Region G	Provision of a Mobile Clinic	The community of ward 6 in Finetown (Block 1) requested for mobile clinic in the area that will be able to service them. The current clinic is in Finetown on a block that is not within 5km, and which require transportation to get to the area. The population in the area increases always and the transportation is not reliable and that affect the community	ward 6 in Finetown (Block 1)	Health	Two mobile trucks allocated to the region are servicing far to reach areas in the region 5 days in a week, but the community request will be escalated for future consideration when budget is

Ward	Region	CBP Priority	Motivation for Priority	Proposed Location	Dept / Entity	Departmental response
						available to procure mobile truck for the region. In the interim Ward 6 community members can utilize Finetown clinic and Mid-Ennerdale clinic.
8	Region G	Re opening of a clinic in Lenasia Ext 10	The clinic was utilised for children with the clinic being closed, Thembelihle clinic is now being overcrowded as community from new informal settlements (Patsing and New York) are also using the clinic. The clinic was closed in 2018 and community request that it be reopened to assist with the overcrowding in Thembelihle clinic.	Lenasia Ext 10	Health	Thembelihle clinic is located within acceptable norms of 5 km radius to service the community. Facility is now under Johannesburg Property Company.
10	Region G	Construction of a new Clinic- Protea South between Quarry and Clark Crescent:	The community is facing challenges in accessing better healthcare services closer to home, as they are being turned away by	Protea South between Quarry and Clark Crescent:	Health	Construction of Protea South clinic is at advanced stage, awaiting

Ward	Region	CBP Priority	Motivation for Priority	Proposed Location	Dept / Entity	Departmental response
			Lenasia Ext 2 Clinic from other clinics and told to go to Lenasia South, which is too far and unaffordable for them. Having a local clinic would improve their access to healthcare. It will also reduce travel time to existing healthcare facilities. The clinic will benefit the community's health outcomes and quality of life. The mobile clinic comes occasionally, and people are sick due to the conditions of living in the ward, and due to no proper water and sanitation. The tanks provided do not have lids, and the water is easily exposed to dirt and other contaminants. The community needs their basic rights to access and services to any clinics in South Africa. The project has been approved, and the process of appointing the CLO has also			introduction of the contractor to start with the construction work.

Ward	Region	CBP Priority	Motivation for Priority	Proposed Location	Dept / Entity	Departmental response
			been finalized, Geo-technical studies were done. Therefore, the community needs the funds that were previously approved for the clinic so that the project can continue.			
10	Region G	Construction of a new Clinic- Protea South between Quarry and Clark Crescent:	The community is facing challenges in accessing better healthcare services closer to home, as they are being turned away by Lenasia Ext 2 Clinic from other clinics and told to go to Lenasia South, which is too far and unaffordable for them. Having a local clinic would improve their access to healthcare. It will also reduce travel time to existing healthcare facilities. The clinic will benefit the community's health outcomes and quality of life. The mobile clinic comes occasionally, and people are sick due to the conditions of living in the ward, and due to	Protea South between Quarry and Clark Crescent:	Health	Construction of Protea South clinic is at advanced stage, awaiting introduction of the contractor to start with the construction work.

Ward	Region	CBP Priority	Motivation for Priority	Proposed Location	Dept / Entity	Departmental response
			no proper water and sanitation. The tanks provided do not have lids, and the water is easily exposed to dirt and other contaminants. The community needs their basic rights to access and services to any clinics in South Africa. The project has been approved, and the process of appointing the CLO has also been finalized, Geo-technical studies were done. Therefore, the community needs the funds that were previously approved for the clinic so that the project can continue.			
121	Region G	Extension of Lawley extension 01 / Construction of a New clinic in Lawley Ext 1	Lawley Extension 01. Cnr Macrele & Barracude. Lawley 1 is a House clinic with 4 consultation rooms. Its catchment area has expanded they cater for Lawley 1, 2 and Lakeview informal Settlement, therefore there is a need for	Cnr Macrele & Barracude	Health	Lawley 1 clinic was undertaken by JOSCHO for design stages. The concept was developed including securing of Land from Human

Ward	Region	CBP Priority	Motivation for Priority	Proposed Location	Dept / Entity	Departmental response
			the project to be finalised as planning stage 1-3 are completed.			Settlement in Province. There is no budget in the current financial year to execute CAPEX projects, including the building of the Lawley 1 clinic.
131	Region G	Construction of a Clinic as ward 131 is being sent away when trying to access a neighbouring clinic	the one that is next to them doesn't accommodate them as they are referred to a far clinic. The Clinic next to them is serving only Orange Farm Ext 2 and they referred to Chris Hani (12 KM) and (Wildebessies (22 KM). All these clinics are provincial government clinic. They want a city owned clinic that will serve them.		Health	There is no budget allocated for CAPEX projects during this financial. The matter will be escalated to Provincial counterparts to assist community with access to Provincial facilities.
17	Region G	Conversion of Eldorado Park Ext. 8 Clinic into a 24-Hour Facility.	The community of ward 17 recommends that the Eldorado Park Ext. 8 Clinic be considered for conversion or expansion into a 24-hour facility. It is proposed that	Eldorado Park Ext. 8 Clinic into a 24-Hour Facility.	Health	Conversion of Primary Health Care facilities into Community Health Centres is a competency of

Ward	Region	CBP Priority	Motivation for Priority	Proposed Location	Dept / Entity	Departmental response
			this be implemented through a phased approach, with the possibility of transitioning to full 24-hour operations following an evaluation of the initial phase. This would: Improve access to healthcare services. Reduce the burden on nearby clinics. Enhance equity in service delivery; and better respond to the specific health needs of the local community.			provincial department, and the request will be escalated.
18	Region G	Upgrading of a Clinic in Eldorado Park, Extension 2		Eldorado Park extension 2	Health	The matter will be escalated for further consideration, but there is no budget allocation for CAPEX projects in this financial year.

9.2 Customer Satisfaction / Quality of Life Survey

Main reasons for customer dissatisfaction:

- Long waiting times at clinics.
- Occasional drug stock-outs and limited availability of certain medicines.
- Poor communication on service standards and patient rights.
- Inadequate infrastructure in some facilities (space constraints, ventilation).
- Staff shortages leading to rushed consultations and perceived poor service quality.

Response planned to improve satisfaction in 2026/27:

- Reduce waiting times by introducing appointment systems and extending service hours at high-volume clinics.
- Improve medicine availability through tighter stock management and collaboration with provincial supply chain.
- Enhance communication by displaying service standards in all facilities and using SMS reminders for appointments.
- Upgrade infrastructure via minor works (air-conditioning, water backup systems) and prioritizing compliance with Ideal Clinic standards.
- Staff development and retention: Continuous training on patient care and customer service; motivate for additional staffing budget.

Priority regions to target:

- Region B, D & G for infrastructure upgrades and water backup systems.
- Region D & F for intensified health awareness campaigns in hostels.
- Region A & G for Jozi Ihlomile HIV/AIDS outreach and school-based programmes.

9.3 Perception Management

a) Communicate milestones/journey to achievements:

- Share progress on Naledi Clinic completion and minor upgrades at Berario and Diepkloof clinics.
- Highlight rollout of Electronic Patient Health Record system (pilot completed, full implementation by Q4).
- Report on Ideal Clinic compliance improvements and NHI readiness.

b) Key actions and optics to change perception:

Visible improvements: grass cutting, clean clinic environments, signage updates.

Quick wins: repair broken equipment, ensure PPE availability, reduce queues.

c) Proactive communication strategies:

Quarterly good news stories (staff awards, successful outreach campaigns).
Monthly updates on service standards and health campaigns via social media and local radio.
Community engagement: invite ward councillors and clinic committees to progress briefings.

d) KPI for monitoring:

Number of positive sector-specific messages shared across CoJ communication platforms per quarter: Target = 4 per quarter.

GSPCR will review business plans against the 1-5 rating scale as per the below

1 = No reference to perception management
2 = Refers to perception management
3 = Actions to improve perceptions mentioned
4 = Targeted programmes or activities to improve perception included
5 = KPI aligned to improving perceptions included

10. INTERGOVERNMENTAL RELATIONS

Intergovernmental relations (IGR) play a crucial role in ensuring the effective delivery of public services across various levels of government. In the context of the City of Johannesburg Health Department, IGR refers to the collaborative and coordinated efforts between national, provincial, and local governments to promote health and well-being among citizens. These relations ensure alignment between the different tiers of government, optimizing resources and ensuring that the needs of the community are met effectively.

The South African government's structure, which includes national, provincial, and local spheres, necessitates a robust framework for intergovernmental relations to facilitate service delivery. These relations are particularly significant in the health sector, where collaboration between the Department of Health at national and provincial levels and local health authorities is vital for ensuring equitable access to health services, resource allocation, and policy implementation.

10.1 Legislative Framework

Legislation governing intergovernmental relations in South Africa includes key statutes such as the Constitution of the Republic of South Africa, 1996, which establishes the foundation for cooperative governance. The following key pieces of legislation regulate IGR within the health sector:

1. **The Constitution of the Republic of South Africa, 1996:** Section 41 outlines the principles of cooperative governance, emphasizing the need for collaboration between government spheres to deliver public services effectively.
2. **Intergovernmental Relations Framework Act, 2005:** This Act provides a framework for intergovernmental cooperation and coordination, aiming to enhance communication, reduce duplication, and facilitate better service delivery.
3. **National Health Act, 2003:** This Act establishes a national health system that integrates the roles of various levels of government in providing healthcare services.
4. **Municipal Systems Act, 2000:** This Act ensures that municipalities, including the City of Johannesburg, implement cooperative governance strategies in delivering services, including health services, in alignment with national and provincial priorities.

10.2 Departmental Intergovernmental Goals

The strategic goals for the City of Johannesburg Health Department, particularly in the context of intergovernmental relations focus on fostering collaboration, improving service delivery, and aligning health initiatives across all levels of government.

- Enhance Intergovernmental Collaboration and Coordination
- Improve Access to Quality Health Services
- Strengthen Resource Allocation and Management
- Facilitate Policy Alignment and Integration
- Promote Accountability and Transparency in Health Governance
- Enhance Capacity Building and Skills Development
- Advocate for Integrated Health Systems and Data Sharing

10.3 Stakeholder and partner identification

Key IGR stakeholders identified:

- **National Department of Health (NDoH)** – policy alignment, NHI implementation.
- **Gauteng Department of Health (GDoH)** – SLA for PHC services, resource allocation.
- **Office of Health Standards Compliance** – Ideal Clinic accreditation.
- **Provincial Departments** (Community Safety, Education) – security at clinics, school health programmes.
- **Municipal Entities** – JPC (infrastructure), JMPD (security), Joburg Water (sanitation). Roles and responsibilities are clearly articulated in the SLA and project action plans.

10.4 Collaboration and Engagement Mechanisms

Planned platforms:

- **Intergovernmental forums and task teams** for NHI readiness and Ideal Clinic compliance.
- **Joint working groups** with GDoH and NDoH for HIV/TB and maternal health programmes.
- **Cluster meetings** under the Human and Social Development Cluster for integrated service delivery.

Specific collaborative initiatives:

- **Electronic Health Record System rollout** – partnership with MTC, GICT, and provincial health.
- **Infrastructure upgrades** – collaboration with JDA, JPC, and provincial departments.
- **Community-based health campaigns** – joint efforts with Social Development and Education.

10.5 Departmental IGR Structure

- Dedicated IGR focal point at IPPR within the Health Department reporting to the Executive Director.
- Capacity supported by regional managers for operational coordination and unit Directors.
- Engagement tracked through quarterly reports and participation in provincial/national forums

Analysis Table

IGR Strategy Alignment Checklist for Departmental Business Plans	Status	Comments
1. Alignment with the IGR Strategy		
Has the department defined how its strategic goals support the City's IGR objectives and priorities?	Yes	Standard Operating Procedure has been developed
Are specific contributions toward integrated governance, collaborative service delivery, and sustainable community development clearly outlined?	Yes	Health and Social Development IGR Sub-Committee established
2. Stakeholder and Partner Identification		
Has the department identified key IGR stakeholders, including relevant government agencies, municipalities, and sector-specific institutions?	Yes	Stakeholders database with active strategic partners developed and updated
Are the roles and responsibilities of each identified partner clearly articulated?	Yes	Formal agreements are signed (MoU, MoAs, SLAs, Lol etc.)
Does the department explain how these partnerships will advance both departmental and citywide objectives?	Yes	Articulated in formal agreements
3. Compliance with Legislation and Policy		
Has the department identified key legislative and policy frameworks guiding	Yes	

its activities within an IGR context (e.g., Intergovernmental Relations Framework Act, relevant national or provincial policies)?		
4. Collaboration and Engagement Mechanisms		
Are planned collaboration platforms specified (e.g., intergovernmental forums, task teams, joint working groups)?	Yes	HSD IGR Sub-Committee, Citywide GEYODI Committee, DHCTC, NHI etc.
Has the department identified specific collaborative initiatives or programs where responsibilities, resources, and implementation plans will be shared with external stakeholders?	Yes	
5. Departmental IGR Structure		
Has the department outlined its capacity and any existing IGR structure?	Yes	

11. STRATEGIC ANALYSIS

11.1 Service delivery and infrastructure backlog and challenges

The key challenges for the Department include the increased demand for health services, lack of health facilities in newly developed areas, increasing staff workloads, inadequate basic infrastructure particularly in more remote areas and increased burglaries in health facilities.

SERVICE DELIVERY CHALLENGES

SERVICE DELIVERY BACKLOG	CHALLENGES	PAST EXPERIENCES	FUTURE OUTLOOK
Shortage of staff	The current staff population ratio is 1:37 000 and according to WHO and National Health is supposed to be. 1: 10 000	The current staff population ratio is 1:37 000 and according to WHO and National Health it is supposed to be 1: 10 000	Budget should be allocated to recruit staff
Water Shortages and Loadshedding/Load reduction	Provision of sustainable water and energy to facilities are hampered, impact health services delivery and poses unsafe, unhygienic, and compromised conditions	Provision of sustainable water and energy to facilities are hampered, impact health services delivery and poses unsafe, unhygienic, and compromised conditions	Budget allocation for • JoJo Tanks • Generators

Lack of Tools of Trade	Inadequate resources to carry out job function e.g. medical equipment's	Inadequate resources to carry out job function	Budget should be allocated to carry out tools of trade e.g. Sampling equipment, thermometers, etc.
Recruitment of staff according to their recognition level	Organograms are outdated not aligned to the additional package of services	Environmental Health Staff are not benched marked with other metros.	Environmental Health Professionals should be appointed and reimbursed in accordance with bench marking with other metros.
Lack of retention strategies for skilled employees	Unable to retain professionals due to competitive markets (e.g. competing with other metros)	The department is losing SKILLED staff to other metros because of higher remuneration, market related salaries and recognition of specialties.	Environmental Health Professionals should be appointed and reimbursed in accordance with benching marking with other metros. Nurses to be paid as per the benchmark of other related metros and speciality to be recognized.
Delayed processing of business certificates, licenses and permits	Lack of Departmental Collaboration	Delayed processing of certificates, licenses and permits	City to streamline and strengthen inter departmental collaboration

INFRASTRUCTURE BACKLOG	CHALLENGES	Past Performance	Outlook
Minor Upgrades inclusive of Minor Works, Electricity Upgrades, Air-cons and Reticulated Water Back-up Systems. Major Capital Projects, both new and renewals	• Insufficient capital budget and shrinking capital indicatives year on year. • The line-list of minor upgrade projects are growing exponentially against a shrinking capital budget allocation. • The rates as per the Rates Bill for the city-wide contractors panel appears not to be market related and is causing challenges with the implementation of projects. • R&M budget provision is a mere 2% against acceptable National Treasury standard of 8%. • Non-payment of contractors by city is resulting in increasing project cost. • Two projects in construction cannot be completed due to lack of budget provision. • Seven (7) major projects that cannot proceed to construction due to lack of funding (and impacting planning of future projects). • Protracted construction period for major projects i.e. Naledi Clinic project. It is taking double the expected construction period at double the cost. • Growing population and increasing demand for health services, but non-commensurate provision of new facilities. • Expanded basket of health care services with constrained facility capacity and no Opex and Capex to increase service delivery. • Poorest communities do not have access to Primary Health Care Services.	<u>MINOR UPGRADES:</u> July 2024 – June 2025 Achieved 100% expenditure. Full refurbishment of Diepkloof Clinic and space expansion at Berario Clinic. <u>MAJOR PROJECTS:</u> July 2024 – June 2025 Achieved 100% expenditure. Progress at Naledi Clinic enable the occupation of the building, although external works is ongoing. Hikhensile Clinic Phase I was completed.	Tireless efforts are made to expedite the commitment of funds on SAP and towards the implementation of minor upgrades. Additional funds are apportioned to minor upgrades in the adjustment from slow moving projects. Hikhensile Phase II implementation cannot proceed due to inadequate funding over the construction period of 15 to 18 months. R72m is required with only about 50% funded. This was captured on JSIP and will be motivated for at BSC. Sect. 79 Chair also communicated the committees concern in this regard to EM and MMC: HSD. JDA was requested to submit motivation for the funding to complete the Naledi Clinic project which has a shortfall of almost R10m.

	Non-compliant infrastructure and inadequate space against the standards for Ideal Clinics and the imminent implementation of NHI.		On advice from Health Finance, Senior Management took a decision not to apportion any additional funding to the project. The department's future approach is to only complete those major projects currently in construction, defer all others and focus on minor upgrades that would improve service delivery, ensure compliance, improve the working environment of health care workers, and improve the customer experience of patients visiting the city's clinics.

11.2 Environmental Analysis

This analysis considered the environmental trends, threats and opportunities that are likely to be a challenge to the Health Department. To analyse the environment, the Health Department conducted a SWOT analysis to analyse the internal environment and PESTEL analysis for analysis of the external factors which can influence the departmental performance. To mitigate against these factors, the Department developed strategic objectives, action plans and Key Performance Indicators for monitoring and tracking purposes.

11.2.1 SWOT Analysis

The SWOT analysis considered the Department's internal strengths and weaknesses in relation to the external opportunities and threats.

	Strengths	Weaknesses
Internal	- Established Infrastructure: Availability of clinics - Qualified Workforce: Skilled health professionals, nurses, and public health officers. - Existing Programs: Successful public health initiatives (e.g., vaccination campaigns, HIV/AIDS programs). - Strong community partnerships / collaborations. - Proactive management team - SLA with GDoH - PHC cash subsidy + HIV/AIDS grant. - Enabling Legislation and mandates, e.g., National Health Insurance policy framework. In Provision of the full scope of Municipal health services including comprehensive basket of services as per SLA with GDOH - Established support from Group corporate and shared	- Resource Constraints: Limited funding, outdated equipment, and inadequate supplies. - Workforce Challenges: Staff shortages in-ability to recruit and retain the skilled work force (professional) resulting in the shortage of professional staff, burnout, and high staff turnover rates. - Inability to cope with increased service demands due to budgetary constraints and increase in burden of diseases. - Space limitations due to old building being used as PHC clinics and population growth. - Inadequate security systems at health facilities - Unavailability of contracts for procurement of medical equipment and surgical sundries. - Department operating at 2013 organogram structure. - No active engagements with recruitment agencies to accommodate emerging epidemics.

	service (OD) on alignment of organogram	- Personal developments of health professionals are compromised due to the SUB-ed policy. - No offices to operate from due to OHS reports. - Poor communication regarding the state of progress regarding the offices.
External	Opportunities	Threats
	- Partnerships/collaborations with private organisations and communities to maximize resources and improve services. - Interdepartmental relations in addressing complex issues (e.g., response to the HIV (Human Immunodeficiency Virus), Covid-19 Pandemic, and by-law enforcement improvements.) - Working relationships with Gauteng Health Department, Gauteng Department of Department. - Admitted as a satellite for Rahima Moosa for training of PHC nurses for 2024. - Phased NHI implementation Region D being a pilot in all their facilities. - Phased NHI implementation. - Electronic Patient Health record and Digital Environmental Health system - Increased innovation/benchmarking	- Increasing demands on health services not accompanied by concomitant increase in resources. Disease Outbreaks, Epidemics/Pandemics: Risks from recurring infectious diseases e.g. COVID-19 or cholera outbreaks. Economic Challenges: Budget cuts or economic downturns affecting service delivery. - Inadequate security systems and ineffective security staff (due to lack of tools of trade) in the health facilities - Ongoing power outages (Load Shedding/Reduction) - Dependence on JMPD for Section 56 notices - Dependence on agencies like JDA (Johannesburg Development Agency). Environmental Risks: Pollution, water scarcity, or climate-related health challenge - Dependency on the use of generators due to loadshedding/load reduction and inadequate energy mix (Solar, Eskom and Generators) - Vandalism of infrastructure - Facility burglaries - Fuel costs. Urbanization: Rapid population growth in Johannesburg increasing the demand for healthcare services. - Inadequate subsidy from Provincial Government.

11.2.2 PESTEL

This analysis reflected on the political, economic, social, technological, legal and environment in which the department operates. A 'PESTEL analysis,' which reflects on current political, economic, social, technological, environmental, and legal challenges, was undertaken:

Political	Economic
• Unfunded mandates. • Social unrest • Government Policy: National Health Insurance (NHI) implementation and its impact on resource allocation and operations. • Municipal Priorities: Alignment with the City of Johannesburg's Integrated Development Plan (IDP). • Public Health Mandates: Compliance with directives from provincial and national health authorities.	• Budgetary allocation not proportional to service demands • Budget constraints at Provincial Health Department level and lack of PHC funding formula. • Budget rebasing that is not aligned to the demand plan. • Year on year shrinking of budget. • Load reduction and water shortages. • Healthcare Costs: Rising costs of medication, equipment, and staff remuneration. • Employment Rates: Unemployment influencing access to healthcare services and affordability
Social	Technological
• Quadruple burden of diseases • Population Growth: Increased demand for healthcare due to urbanization and migration. • Social determinants of health: poverty, unemployment, uncontrolled migration, • Increased mental health challenges due to drug abuse. • Increased teenage pregnancies. • Illegal foreigners saturating the facilities	• Ongoing delays on the implementation of the health information system • Unreliable WAN connectivity • Lack of improved infrastructure • Dependency on electricity/power supply and inadequate renewable energy sources at clinics. • Lack of awareness and promotion of available technology

Environmental	Legal
• Urban Pollution: Impact of air and water quality on public health, especially respiratory diseases. • Climate Change: Increased vector-borne diseases (e.g., malaria) and heat-related illnesses as well as emerging and re-emerging diseases. Infrastructure Resilience: Preparedness for environmental disasters (e.g., flooding, droughts) and above average precipitation/downpour affecting roofs and buildings	• NHI policy • Discussion document by DPSA: Single Public Service. • Protection of personal information Act (POPIA) • Working relationships with Gauteng Health Department, Gauteng Department of Education • Service Level Agreements with academic institutions and colleges. • National Health Act No 61 of 2003 as amended. • Regulatory Compliance: Adherence to South Africa's health laws and municipal regulations.

12. RISK ASSESSMENT

12.1 Risk Management Plan

The Health Department risk management is influenced by the City of Johannesburg's Group Risk Management Framework and the requirements of the Municipal Finance Management Act (MFMA). Group Risk and Assurance (GRAS) are custodians of risk management in the city. GRAS is a governance structure that has been established to exercise oversight and advise on the City's risk governance processes.

The Group Risk Management Framework provides a standard process to be followed by all departments in ensuring that there is an effective process of identification, management, and reporting of strategic, operational and project risks.

The Health Department's Strategic Risk identification/development is a collaborative effort during a risk workshop between GRAS, health management and regional health representatives. GRAS plays an advisory role and assists with guiding the process.

During development of the strategic risks, the team identify factors which might hinder the achievement of departmental objectives. These factors are then elevated and registered into the strategic risk register. Against the identified risks, root causes, current controls and existing plan of action together with timelines and risk owners are listed. Following the workshop, various units develop operational/physical and project risks.

On a quarterly basis, the risk owner's provides performance against the current controls. Management Support and Development Unit (MSD) is responsible for coordination of departmental performance reporting. The risk reporting forms part of the quarterly departmental performance.

MSD submit a consolidated risk report to GRAS for assessment of:

- Implementation of the action plans
- The effectiveness of the action plans on the identified risks
- Whether the risks identified are still relevant
- Emerging risks to be added to the register

2025/2026 Quarter 2 Risk performance

2025/26 strategic risk register that the Department developed, **6 risks were identified** for the department and mitigation measures put in place to reduce them to acceptable levels as shown below:

Table 1: Strategic Risks and Mitigation

Risk Ref	Risk	Residual Risk Rating				KPI linked to the risk	Action to improve management of risk	Due date	Progress on each action item as at end of Quarter 2
		Q1	Q2	Q3	Q4				
1	Inadequate provision of health service by the department	Very High					1.1 Filling of positions as approved by the strategic appointment panel 1.2. Explore PPP (Public Private Partnerships) 1.3. Motivate for additional budget	1. Ongoing depending on approval 2. 30 June 2026 3. As per Group finance Timelines	1.1 Some key strategic positions were approved and under process to be filled by HR including, PNs, Ens, ENAs, Admin assistants, and DD
						% of eligible children fully immunized	2.1. Maintaining functionality of existing external pick-up points. 2.2. Increase the number of facilities providing extended service hours	Quarterly	2.1 Functionality of all existing external pick-up points from the previous quarter has been maintained in all operational areas, ensuring uninterrupted access to medication for clients. Overall, service continuity and client access

Risk Ref	Risk	Residual Risk Rating				KPI linked to the risk	Action to improve management of risk	Due date	Progress on each action item as at end of Quarter 2
		Q1	Q2	Q3	Q4				
						by age 1 (One) ⁴	2.3. Monitoring the number of patients enrolled in the DMOC Programme. 2.4 Childhood immunization outreach done.		remained stable during quarter 2. 2.2 No additional facilities during Q2 due to staff shortages, budget constraints. 2.3 Ten (9) site visits to maintain monitoring of patient enrolment in the Differentiated Models of Care (DMOC) programme were conducted for the period of July-December 2025, and 262 412 clients were decongested for this period. 2.4 Outreach activities across the regions were conducted for measles-rubella. Thirty-two (32) outreaches done in Q2.

⁴ Immunization is happening throughout the City's clinics; the target is set at population estimate per facility as per the catchment area (Local Authority facilities only)

Risk Ref	Risk	Residual Risk Rating				KPI linked to the risk	Action to improve management of risk	Due date	Progress on each action item as at end of Quarter 2
		Q1	Q2	Q3	Q4				
						C88: Number of notifiable medical condition investigation following the prescribed protocols. Number of notifiable medical condition investigation following the prescribed protocols.	3.1. Compile the outbreak on call list regionally for outbreak preparedness and response. 3.2. Monitor the number of Notifiable Medical conditions 3.3. Monitor NMC turnaround time within three days	3.1 Quarterly 3.2. Quarterly 3.3 Quarterly	- On call list done for Q2 2025/26. On call list email sent to all regions on Friday of 9/01/2026 at 13:36 AM. (POE available) Q2 - Total of 240 NMC reported in Q2 Q2 - 2025 to 2026 Progress- 96 cases investigated out of 240 reported. 144 cases were not for investigation
							4.1. Plan and provide reticulated water backup systems to clinics 4.2. Plan and provide three-tiered power solutions to clinics	30 June 2026 30 June 2026	4.1 The implementation of reticulated water back-up systems is pending due to delays with the approval and activation of the city-wide panel of contractors. The roll-

Risk Ref	Risk	Residual Risk Rating				KPI linked to the risk	Action to improve management of risk	Due date	Progress on each action item as at end of Quarter 2
		Q1	Q2	Q3	Q4				
							4.3. Plan and provide maintenance plan for generators	31 December 2025	out is also limited due to budget that may only fund systems at about 12 clinics. 4.2 Due to extended use and insufficient funding to service generators, replacements are required. Thus, funding is channelled to generators and electrical works rather than systematically upgrade facilities to include solar as 1st level of a 3-tiered solution. 4.3 Maintenance plan done and submitted to JPC
						Development of Electronic Patient Health Record software	5.Implement eHealth	31 December 2025	Pilot in 3 clinics commenced Deployment to production server completed System changes have been implemented Weekly meetings with the service provider and national

Risk Ref	Risk	Residual Risk Rating				KPI linked to the risk	Action to improve management of risk	Due date	Progress on each action item as at end of Quarter 2
		Q1	Q2	Q3	Q4				
						Number of health facilities implementing Electronic Patient Health Record software			team are held to support system integration
2	Inadequate access to health care services	Very high				Percentage spent on capital budget against approved capital budget	2. Maintaining functionality of existing external pick-up points 2.2. Continue implementation of the existing funded capex projects	2. Quarterly 2.2 30 June 2026	2.1 pickup points are maintained 2.2 The implementation of funded major projects is extremely protracted as various challenges are experienced: 2.2.1 Insufficient funding 2.2.2 Late payments to contractors and professionals.

Risk Ref	Risk	Residual Risk Rating				KPI linked to the risk	Action to improve management of risk	Due date	Progress on each action item as at end of Quarter 2
		Q1	Q2	Q3	Q4				
									2.2.3 Additional requirements imposed by Entities ahead of works completion and issuing of OC. 2.2.4 Failure of Professionals to obtain, or failure of Entities to prescribe timeously, the desired requirements on a project affecting the issuing of a permanent OC. 2.2.5 Design challenges, mistakes and anomalies and mounting a claim against consultants. 2.2.6 Project scope creep and additional cost. 2.2.7 Delays caused by local SMME's. 2.2.8 Payment delays to contractors and Professionals.

Risk Ref	Risk	Residual Risk Rating				KPI linked to the risk	Action to improve management of risk	Due date	Progress on each action item as at end of Quarter 2
		Q1	Q2	Q3	Q4				
									2.2.9 JDA having to take the legal route to claim from contractors and consultants. 2.2.10 Delays with preparation and approvals of final accounts of 2 nd Naledi contractor, resulting in non-payment in 2023/24 & 2024/25 and now requiring additional budget in 2025/26.
3.	Inadequate addressing of municipal health services	Very high					1.Maintain and implement existing controls		Controls are being implemented
							2. Filling of the positions as per the approval strategic appointment panel	30 June 2026	Report submitted and approval for 8 EHP's and 1 manager.
							3.1Improve and increase the number of trainings	31 March 2026	To be reported in Q3

Risk Ref	Risk	Residual Risk Rating				KPI linked to the risk	Action to improve management of risk	Due date	Progress on each action item as at end of Quarter 2
		Q1	Q2	Q3	Q4				
							4.1. Conduct a regulated training for Pest controllers 4.2. Procure PPE 4.3 Develop SOP on the use of PPE	30 March 2026 30 March 2026 31 December 2025	To be done as per timeline as per timeline SOP developed and signed as per the deadline
4.	Failure to acquire the NHI accreditation	Very high				% Compliance in relation to the Ideal Clinic core standards in COJ health facilities in preparation for the NHI implementation	1.1 Develop a communication strategy for a successful buy-in for implementation. 1.2 Continuous engagement with the health officials and the community for the understanding of the National Health Insurance.	Ongoing 1. 2. Monthly	1.1 Through collaborated approach with the district office a multi-language pamphlet on frequently asked questions has been done and disseminated to all facilities to be given to the public during health education programmes 1.2 Monthly meetings are held with all regions to ascertain the progress per region

Risk Ref	Risk	Residual Risk Rating				KPI linked to the risk	Action to improve management of risk	Due date	Progress on each action item as at end of Quarter 2
		Q1	Q2	Q3	Q4				
							1.3 Continuous engagement with public and private stakeholders 1.4 Using Opex to improve NHI requirements adherence 1.4 Self Determination Assessments on Health Standards Compliance and PPTICRM 1.6 Develop Quality Improvement Plans	1.3. Quarterly 1.4 31 March 2026 1.5 Bi-annual as per NDoH schedule 1.6 As and when	1.3 Through a coordinate approach at district level programmes of engagements are happening 1.4 Budget constraints are hindering the process on Opex spending, however through innovation approach the department has resolved to seek for donations where possible 1.5 PPTICRM was conducted during the second quarter for all the facilities. 1.6 Continuous QIPs are shared and discussed on regular basis with all regions in collaboration with district counterparts.
5	Governance Failure	Very High					1. Engage SCM to improve the monitoring and evaluate the	31 March 2026	A monthly meeting on contract monitoring is being consistently held as

Risk Ref	Risk	Residual Risk Rating				KPI linked to the risk	Action to improve management of risk	Due date	Progress on each action item as at end of Quarter 2
		Q1	Q2	Q3	Q4				
							contracts and tenders to ensure suitable service providers		scheduled, providing a platform to review contract performance, compliance, and progress against set deliverables. These meetings ensure effective oversight, timely identification of challenges, and implementation of corrective actions where necessary. As a result, the key performance indicator (KPI) related to contract monitoring meetings is fully achieved.
							2. Engage Group Risk to conduct a contract risk assessment	31 March 2026	To be done in the third quarter
							3. Engage Group Internal Audit to conduct audit on tenders and contracts with the focus on duration of the awarding	31 March 2026	To be done in the third quarter

Risk Ref	Risk	Residual Risk Rating				KPI linked to the risk	Action to improve management of risk	Due date	Progress on each action item as at end of Quarter 2
		Q1	Q2	Q3	Q4				
							of the tenders and contracts		
							4.Ongoing Training of Officials from Assistant Director to Upwards on BID Committee and the implementation of contract	Ongoing	All officials ranging from Operational Managers to Directors will undergo mandatory training on Bid Committees upon completion of the ongoing vetting process in the first quarter. This initiative is aimed at ensuring that all designated officials possess the necessary knowledge and competency to effectively participate in bid evaluation and adjudication processes, in line with the Supply Chain Management policy and applicable legislative requirements.
6.	Lack of Digitalisation of the Department	Very High				% Development of Electronic Patient Health	1.1. Motivate for budget allocation 1.2. Expedite finalisation of insurance claims (of	Mid Term	1.1 Motivation Report for additional budget allocation. 1.2 Procurement of laptops and IT equipment initiated

Risk Ref	Risk	Residual Risk Rating				KPI linked to the risk	Action to improve management of risk	Due date	Progress on each action item as at end of Quarter 2
		Q1	Q2	Q3	Q4				
						Record software % achieved in the development of the Digital Environment al Health System	lost or damaged gadgets and IT equipment)		based on available budget of R400 000. Follow up of insurance claims for lost or damaged gadgets.
							2.Continuous engagement with MTC	Quarterly	Weekly Meetings are held with MTC and / or (SP) to ensure better service reliability.
							3.Continuous engagement with MTC	Quarterly	Weekly Meetings are held with MTC and / or (SP) to ensure better service reliability.
							4.Engaging with internal (MTC, GICT) and external stakeholders (national department)	Quarterly	For integration with HPRS, WEBDHIS, and NHLS, a formal letter was sent to Provincial Health and followed up.

Risk Ref	Risk	Residual Risk Rating				KPI linked to the risk	Action to improve management of risk	Due date	Progress on each action item as at end of Quarter 2
		Q1	Q2	Q3	Q4				
									However, no response has been received to date.
							5.Engaging with internal (MTC, GICT) and external stakeholders (national department)	Quarterly	A committee has been established with internal (MTC, GICT) and external stakeholders (national department) NHLS to facilitate broader system integration
							6.Continuous training of the users	Quarterly (after the acceptancy of the system)	End-user training sessions conducted (HPRS). Super-users identified and acknowledged to act as champions/examples. HPRS war room unestablished to address challenges related to uptake.
							7. Identifying and acknowledging super users and use them as the example		Super-users identified and acknowledged to act as champions/examples.

Risk Ref	Risk	Residual Risk Rating				KPI linked to the risk	Action to improve management of risk	Due date	Progress on each action item as at end of Quarter 2
		Q1	Q2	Q3	Q4				
									Approached NDOH to train super users for HPRS but have not reverted.
							8. Continuous testing, debug and corrections	Quarterly	Comprehensive system and user acceptance testing (UAT) completed. Continuous testing, debugging, and corrections are ongoing.
6.	Inability to reach out to the community	High					Motivate for additional resources e.g. mobile services and human resources	Quarterly	Request for additional budget was submitted

13 STRATEGIC RESPONSE - IMPLEMENTATION AND PERFORMANCE REVIEW

13.1 Key Performance areas

No.	Key Performance Areas
1	Life expectancy
2	Quadruple Burden of disease
3	COVID-19
4	National Health Insurance readiness
5	Integrated substance abuse
6	Food safety
7	Economic sustainability
8	Accountability and Good Governance
9	Procurement and Contract Management
10	Risk Management
11	Departmental Performance Management, monitoring, and reporting
12	Expenditure Management
13	Skills Development
14	People Management
15	Employee safety
16	Human Capital Management and Empowerment
17	Youth Development and Employment
18	Customer Satisfaction
19	Climate Change

13.2 PAST PERFORMANCE

This report provides progress on the performance of the Health Department for the fourth quarter period (April - June 2025) of the 2024/25 financial year in compliance with Section 41 of the Municipal Systems Act 32 of 2000.

The **Health Department SDBIP for 20224/25** consists of **38 key performance indicators**

divided into **26 Key Programmes** and **12 Day to Day indicators**.

The performance of the **38 Key Performance Indicators** is as follows:

- **3** out of the **26 Key Programmatic KPIs** were not achieved.
- **3** out of the **12 Day to Day KPIs** were not achieved.

In summary, **out of 38 key performance indicators, 6 (six) KPI's were not achieved against the set targets resulting in 84.2% achievement**

Progress made against the City Priorities

Progress made as per IDP programme.

The Health Department has three programmes on the IDP. The 2024/2025 Fourth Quarter performance of the Key Performance Indicators on the IDP is as follows:

Immunization Programme

KPI: The percentage of children under 1 year old immunization

The actual performance for Quarter 4 (April – June 2025, three months data) is 91.9% (13,447/14,628). Cumulative for the year (July 2024 – June 2025) is 93.0% which is 55,801 of 60,022 children under one year fully immunised against a target of 87.3%, for the period July 2024- June 2025, WebDHIS 17 June 2025. Target achieved.

HIV and AIDS Programme

KPI: Percentage of HIV positive patients initiated on treatment

The actual performance for Quarter 4 (April – June 2025 three months data) 98.2% (2,997 HIV positive patients initiated against a target of 3,051). Cumulative for the year (July 2024-June 2025), which is 96.9%, amounts to 13,627 HIV positive patients initiated

against a target of 14,058 (96.3%) of positive patients eligible to be initiated, based on WebDHIS 17 July 2025. The target has been achieved.

TB Programme

KPI: Percentage of TB patients initiated on treatment.

The actual performance for Quarter 4 (April – June 2025, three months of data) 95.8% (588 TB-positive patients initiated against a target of 614). Cumulative for the year July 2024-June 2025, which is 97.1%, amounts to 2,472 TB-positive patients initiated against a target of 2,545 (96.5%) of TB-positive patients eligible to be initiated on TB treatment, based on WebDHIS 17 July 2025. The target has been achieved.

13.3 Progress made in the implementation of the City Priorities

To ensure realisation of the GDS outcomes, the Integrated Development Plan (IDP) and the Service Delivery Budget Implementation Plan (SDBIP) Institutional the City identified eleven (11) Strategic Priorities. The Health Department **is aligned to 8 Of the City's 11 Priorities** as outlined on the below table. These priorities serve as a roadmap for the medium to short term plans towards the attainment of the long-term goals.

No.	Priorities	Achievement/Progress to date
1	Good Governance	- Some of the facilities have clinic committees appointed by the MEC. - Naledi Clinic had an engagement with community advising of participating in the Clinic Committee of the facility. - The health department jointly with Social Development hosted a fruitful "Gogo's Go Dancing Wellness Program on the 13th of March 2025 at East bank Hall, Alexandra Region E. 100% Percentage achievement of service standards of health facilities.
2	Financial Sustainability	The department is distributing resources to key priority programmes set by council.
		The rebasing of budget has forced the department to implement strict cost containment measures.
4	Sustainable Service Delivery	- There is continuous mobile service delivery in areas where there are no fixed facilities to ensure accessibility of basic services. - Personal Protective Equipment (PPE) reports are submitted

No.	Priorities	Achievement/Progress to date
		daily to the Provincial Office for compliance and control purposes. The Provincial Health Department supplies all the facilities with PPE. • Naledi Clinic was officially opened on the 19th of March 2025 to render a comprehensive basket of services. • The number of Nurses and Doctors trained in Community Based Substance Abuse during the fourth quarter (April to June 2025) is 30 nurses and 0 doctors. The accumulated number, including all other quarters, is 176 nurses.
5	Infrastructure Development and Refurbishment	Through a Service Level Agreement with the Johannesburg Property Company and utilizing their Panel of Contractors, the Health Department has successfully implemented the following minor upgrades projects through JPC: ○ Berario Clinic ○ Diepkloof clinic The department has a line-list of approved minor upgrade projects that are all urgent and important and would be implemented as soon as the department receives additional capital budget. These projects are, amongst others: ○ Reticulated water back-up systems at hot-spot clinics. Sustainability of water provision to clinics has become a service delivery emergency mostly in region B, D & G. ○ Generators and/or solar for identified facilities. ○ Electrical retrofitting of facilities ○ Air-conditioners for prioritized facilities ○ Space expansion at Bellavista clinic ○ Upgrading of Thuthukani clinic and replacement of asbestos roof ○ Upgrading of Shanty clinic and replacement of asbestos roof ○ Space expansion and upgrading of Randburg clinic. ○ Upgrading of Malvern clinic ○ Upgrading of Lenasia South clinic space expansion at Mountain view clinic The department has requested an additional budget during adjustment budget; however, the request was declined.
6	Job Opportunity and Creation	• Due to budget constraints, the Department of Health EPWP could not continue with the EPWP recruitment but managed to create 605 jobs through the Jozi Ihlomile programme funded. • The Health Department hosted a very successful Employee.

No.	Priorities	Achievement/Progress to date
		Award Ceremony on the 28th of February 2025. A total of 71 officials were awarded in different years categories.
7	Safer City	• 90,32% of formal premises inspected were compliant with food safety legislation. • 94% of public schools inspected were found compliant to environmental health legislation. All the health facilities are assessed by the Office of the health standards for regulatory compliance.
8	Active and Engaged Citizenry:	• Health department jointly with Social Development and Private partners of Disability are having monthly Alexander Local Drug Action meeting to discuss the challenges faced by the community and the mitigation strategies. • Awareness Programmes on teenage pregnancy, substance abuse, and HIV/AIDS including Male Medical Circumcision Awareness Programme conducted at 27 High schools and 90 primary schools, 02 colleges, 01 University, 01 Combined School. A total of 30 642 earners were reached, and 6 316 pamphlets were distributed. • 14 hostels were visited to conduct health awareness: eight (8) hostels in Region D, three (3) hostels in Region E and three (3) in Region F. • All facilities had built-up events commemorating World TB Day on the 24th of March 2025. The main event was in Region D Slovoville in partnership with Harmony Gold, • The City of Johannesburg Health departs, together with Pink Drive, hosted a World Cancer Day on the 4th of February 2025 at Slovoville. Dignitaries who were present were Deputy Minister of Health Dr Joe Phahla, MEC for Health and Wellness Ms Nomantu Nkomo-Ralehoko, and MMC for Health and Social Development Cllr Ennie Makhafola. • Awareness Programmes on teenage pregnancy, substance abuse, and HIV/AIDS including Male Medical Circumcision Awareness Programme conducted at 27 High schools and 90 primary schools, 02 colleges, 01 University, 01 Combined School. A total of 30 642 earners were reached, and 6 316 pamphlets were distributed. • HIV awareness campaign 1.1. Million closing the gap 16 May 2025 at Maponya mall, Region D • HIV awareness campaign 1.1. Million closing the gap 4 June 2025 at Phumlamqashi informal settlement, Region G • HIV awareness campaign 1.1. Million closing the gap 10 June 2025 at Diepsloot Sarafina Park, Region A

No.	Priorities	Achievement/Progress to date
		HIV awareness campaign 1.1. Million closing the gap 26 June 2025 at Riverlea Recreational Centre, Region B HIV awareness campaign 1.1. Million closing the gap 11 June 2025 at Orange Farm Ext 2 Taxi rank Region G. African Vaccination Week Launch 25 April 2025 Protea South Zone 1 Region G.
11	Smart City	The e-Health system has completed testing to identify inefficiencies and system gaps. Weekly meetings are held to align with agreed-upon deliverables, during which progress updates and ongoing system changes are discussed and communicated

13.3 INSTITUTIONAL SCORECARD

13.3.1 Table 1: Institutional SDBIP

GDS: Outcome 1: Improved quality of life and development-driven resilience for all																
MAYORAL PRIORITY: Safer city																
RELATED OUTPUT: A society characterized by healthy living for all																
No.	Key Project Performance Indicator	Baseline 2024/25	Target 2026/27	Target 2027/28	Target 2028/29	2026/27 QUARTERLY PERFORMANCE TARGETS				2026/27 BUDGET PER PROJECTS R 000						Evidence and means of verification
						Quarter 1	Quarter 2	Quarter 3	Quarter 4	Capex	Opex	Q1	Q2	Q3	Q4	
1	% of eligible children fully immunized by age 1 (One) ⁵	93.0%	87.5%	87.6%	87.6%	87.2%	87.3%	87.4%	87.5%	R0						Performance dashboard retrieved from DHIS and Quarterly Progress Reports.
2	Percentage of HIV positive patients initiated on treatment ⁶	96.9%	96.3%	96.3%	96.3%	96.0%	96.1%	96.2%	96.3%	R0						Performance dashboard retrieved from DHIS and ART initiation

⁵ Immunization is happening throughout the City's clinics; the target is set at population estimate per facility as per the catchment area ((Local Authority facilities only) Target set below baseline as first doses of vaccines or primary doses yield 85% of immunity for disease elimination according to vaccinator's manual "Immunisation That Works" 4th edition 4th Edition, January 2015.

⁶ Annual target aligned to the National Strategic Plan (NSP) 2023–2028 and UNAIDS 95-95-95 framework, which requires at least 95% ART initiation among diagnosed PLHIV. Based on that CoJ has already reached the upper threshold for target-setting by 1.3%, hence it remained at 96.3% for the current year and outer years.

GDS: Outcome 1: Improved quality of life and development-driven resilience for all MAYORAL PRIORITY: Safer city RELATED OUTPUT: A society characterized by healthy living for all																
No.	Key Project Performance Indicator	Baseline 2024/25	Target 2026/27	Target 2027/28	Target 2028/29	2026/27 QUARTERLY PERFORMANCE TARGETS				2026/27 BUDGET PER PROJECTS R 000						Evidence and means of verification
						Quarter 1	Quarter 2	Quarter 3	Quarter 4	Capex	Opex	Q1	Q2	Q3	Q4	
																Progress Reports
3	Percentage of all DS-TB treatment success rate ⁷	97.1%,	88.2%	88.3%	88.3%	85%	86%	87%	88.2%	R0						Performance dashboard retrieved from the DHIS and Progress Reports

⁷ Description: 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 Target across all spheres of government are as follows: National Dept of Health: 83%, Gauteng Department of Health (GDoH): 80% and City of Johannesburg (CoJ): 88% **(the highest target This clearly indicates that CoJ has already reached the upper threshold for target-setting. The 88.3% target therefore reflects a realistic and nationally consistent**

13.3.2 Department Scorecard

The Departmental key priority programmes that the Department will contribute to realise the Government of Local Unity (GLU) priorities follow here-under

GDS: Outcome 1: Improved quality of life and development-driven resilience for all MAYORAL PRIORITY: Safer city RELATED OUTPUT: A safe and secure city																
N O	KEY PERFORMANCE INDICATOR	BASELINE 2024/25	2026/27 TARGET	2027/28 TARGET	2028/29 TARGET	2026/27 QUARTERLY PERFORMANCE TARGETS				2026/27 BUDGET PER PROJECTS R 000						Evidence and MEANS OF VERIFICATION
						Q1	Q2	Q3	Q4	Capex	Opex	Q1	Q2	Q3	Q4	
4.	% Compliance to food safety legislation by formal food premises inspected	90,32%	90%	90%	90%	22,5%	45%	67%	90%	R0						Regional Environmental Health inspection registers and compliance checklists consolidated into the City-wide quarterly report

GDS: Outcome 1: Improved quality of life and development-driven resilience for all MAYORAL PRIORITY: Safer city RELATED OUTPUT: A safe and secure city																
N O	KEY PERFORMANCE INDICATOR	BASELINE 2024/25	2026/27 TARGET	2027/28 TARGET	2028/29 TARGET	2026/27 QUARTERLY PERFORMANCE TARGETS				2026/27 BUDGET PER PROJECTS R 000						Evidence and MEANS OF VERIFICATION
						Q1	Q2	Q3	Q4	Capex	Opex	Q1	Q2	Q3	Q4	
5.	% Compliance to food safety legislation by informal food premises inspected ⁸	90%	90%	90%	90%	22,5%	45%	67%	90%	R0						Regional Environmental Health inspection registers and compliance checklists consolidated into the City-wide quarterly report
6.	Percentage compliance to environmental health legislation for places of care, old-age facilities, schools etc.	90%	90%	90%	90%	85%	87%	89%	90%							EH inspection reports + Monitoring tool consolidated from 7 regions into a Quarterly progress report
7.	Percentage increase in	80%	80%	80%	80%	71%	73%	76%	80%							EH inspection reports +

⁸ Compliance to food safety legislation is aimed at protecting the public against food related illnesses including food poisoning. IT reflects the pivotal role of Environmental Health Practitioners in supporting informal food traders through continuous health education, on-site hygiene assessments, inspections, enforcement actions, and provision of compliance guidance.

GDS: Outcome 1: Improved quality of life and development-driven resilience for all

MAYORAL PRIORITY: Safer city

RELATED OUTPUT: A safe and secure city

N O	KEY PERFORMANCE INDICATOR	BASELINE 2024/25	2026/27 TARGET	2027/28 TARGET	2028/29 TARGET	2026/27 QUARTERLY PERFORMANCE				2026/27 BUDGET PER PROJECTS R 000						Evidence and MEANS OF VERIFICATION
						TARGETS										
						Q1	Q2	Q3	Q4	Capex	Opex	Q1	Q2	Q3	Q4	
	compliance of ECDs to regulations ⁹ (JSCC)															Monitoring tool consolidated from 7 regions into a Quarterly progress report
8.	% Compliance in relation to the Ideal Clinic core standards in COJ health facilities in preparation for the NHI implementation ¹⁰ (JSCC)	80%	80%	80%	80%	80%	80%	80%	80%	R0						Q1: Provincial PPTICRM Results Report Q2: Consolidated Quality Improvement Progress Report Q3: Facility Self-Assessment Reports Q4: Annual External Assessment

⁹ Environmental Health inspections of Early Childhood Development (ECD) centres are conducted in accordance with the National Health Act 61 of 2003 and the National Environmental Health Norms and Standards for Premises (2015), which mandate routine, risk-based surveillance of premises to ensure a safe and healthy environment

¹⁰ Planned perfect team for ideal clinic and realization maintenance (PPTICRM) is done once a year during the first quarter of the financial year and those results are kept and reported on for the year. In Quarter 3 self-assessments are done per facility So, 80% is the national target that must be achieved and improved on

GDS: Outcome 1: Improved quality of life and development-driven resilience for all																
MAYORAL PRIORITY: Safer city																
RELATED OUTPUT: A safe and secure city																
N O	KEY PERFORMANCE INDICATOR	BASELINE 2024/25	2026/27 TARGET	2027/28 TARGET	2028/29 TARGET	2026/27 QUARTERLY PERFORMANCE TARGETS				2026/27 BUDGET PER PROJECTS R 000						Evidence and MEANS OF VERIFICATION
						Q1	Q2	Q3	Q4	Capex	Opex	Q1	Q2	Q3	Q4	
																(Provincial/ND OH/OHSC)

GDS : Improved quality of life and development-driven resilience for all MAYORAL PRIORITY: A safer City RELATED OUTPUT: A society characterized by healthy living for all																
NO	KEY PERFORMANCE INDICATOR	BASELINE 2024/25	2026/27 TARGET	2027/28 TARGET		2026/27 QUARTERLY PERFORMANCE TARGETS				2026/27 BUDGET PER PROJECTS R 000						Evidence and MEANS OF VERIFICATION
						Q1	Q2	Q3	Q4	Capex	Opex	Q1	Q2	Q3	Q4	
9.	% of Children under 2 years underweight followed up ¹¹	100%	100%	100%	100%	100%	100%	100%	100%	R0						Malnutrition registers Quarterly Follow-up Consolidated Report.
10.	% Increase in the antenatal care (early booking rate ¹²)	75.8%	75,7%	75,7%	75,7%	75%	75.3%	75.5%	75.7%	R0						District Health Information System

¹¹ All children under 2 years old identified to be underweight for age at LG clinics will be followed up. Interventions like nutritional counselling and support; referral to hospital for further investigation to exclude underlying medical condition will be conducted.

¹² The antenatal care early booking rate target is lower than the baseline, however targets are set at 70% for the National Department of Health (NDoH), 70% for the Gauteng Provincial Department of Health (GDoH), and 75.7% for the City of Johannesburg (COJ), the highest among the three. This indicates that COJ has reached the upper threshold, making the 75.7% target acceptable, realistic, and consistent with national and provincial standards.

GDS: A high performing metropolitan government that proactively contributes to and builds a sustainable, socially inclusive, locally integrated and globally competitive Gauteng City Region

MAYORAL PRIORITY: Active citizenry

RELATED OUTPUT: Guaranteed customer and citizen care and service

NO	KEY PERFORMANCE INDICATOR	BASELINE 2024/25	2026/27 TARGET	2027/28 TARGET	2028/29 TARGET	2026/27 QUARTERLY PERFORMANCE TARGETS				2026/27 BUDGET PER PROJECTS R 000						Evidence and MEANS OF VERIFICATION
						Q1	Q2	Q3	Q4	Capex	Opex	Q1	Q2	Q3	Q4	
11.	Number of health awareness programmes conducted in COJ hostels ¹³	19 Health awareness programmes	1 health awareness programme per hostel per quarter	1 health awareness programme per hostel per quarter	1 health awareness programme per hostel per quarter	1 health awareness programme per hostel per quarter	1 health awareness programme per hostel per quarter	1 health awareness programme per hostel per quarter	1 health awareness programme per hostel per quarter	R0						List of hostels where health promotion was done. Quarterly consolidated report

¹³ CoJ has 13 hostels in total. Region D has 8 hostels: Dube, Diepkloof, Mzimhlophe Male, Mzimhlophe Female, Dobsonville, Jabulani Hostel, Nance field and Merafe Hostel x Region E has 3 hostels; Helen Joseph; Madala and Nobule; Region F has 2 hostels; George Gogh and Denver Hostel.

GDS: A high performing metropolitan government that proactively contributes to and builds a sustainable, socially inclusive, locally integrated and globally competitive Gauteng City Region MAYORAL PRIORITY: Active citizenry RELATED OUTPUT: Guaranteed customer and citizen care and service																
NO	KEY PERFORMANC E INDICATOR	BASELINE 2024/25	2026/27 TARGET	2027/28 TARGET	2028/2 9 TARGE T	2026/27 QUARTERLY PERFORMANCE TARGETS				2026/27 BUDGET PER PROJECTS R 000						Evidence and MEANS OF VERIFICATIO N
						Q1	Q2	Q3	Q4	Capex	Opex	Q1	Q2	Q3	Q4	
12.	% knowledge increase of learners that are given health education on nutrition at schools ¹⁴	New	60%	60%	70%	15%	30%	45%	60%	R0						List of schools Pretest Post test based on nutrition Attendance registers Photos

¹⁴ This education is given to prevent obesity which is a risk factor for the prevalence of type 2 diabetes, and address issues of Malnutrition (Obesity, underweight etc.). The schools selected in the seven regions of the City of Johannesburg. This is a new KPI introduced in 2026/27 to standardize measurement of behaviour change through pre- and post-test tools administered by Health Promotion during school-based nutrition education sessions

GDS: A high performing metropolitan government that proactively contributes to and builds a sustainable, socially inclusive, locally integrated and globally competitive Gauteng City Region

MAYORAL PRIORITY: Active citizenry

RELATED OUTPUT: Guaranteed customer and citizen care and service

NO	KEY PERFORMANCE INDICATOR	BASELINE 2024/25	2026/27 TARGET	2027/28 TARGET	2028/29 TARGET	2026/27 QUARTERLY PERFORMANCE TARGETS				2026/27 BUDGET PER PROJECTS R 000						Evidence and MEANS OF VERIFICATION
						Q1	Q2	Q3	Q4	Capex	Opex	Q1	Q2	Q3	Q4	
13.	Number of awareness programmes conducted at schools ¹⁵	19 Health awareness programmes	40 Health awareness programmes	40 Health awareness programmes	40 Health awareness programmes	10 health awareness per region	10 health awareness per region	10 health awareness per region	10 health awareness per region	R0						Signed report by DD- QA and Dir DHSD
14.	Percentage achievement of service standards	100%	85%	85%	85%	85%	85%	85%	85%	R0						Quarterly reports

¹⁵ Target are the quintile 1 schools with history of high pregnancy, substance abuse, depression and all the schools in the neighbouring. Also receiving invites from Private schools. awareness programmes on teenage pregnancy, substance abuse, and HIV & AIDS at schools

GDS: A high performing metropolitan government that proactively contributes to and builds a sustainable, socially inclusive, locally, globally competitive Gauteng City Region																integrated and
MAYORAL PRIORITY: Smart City																
RELATED OUTPUT: A 'Smart' City of Johannesburg, that can deliver quality services to citizens in an efficient and reliable manner (cross cutting output)																
NO	KEY PERFORMANC E INDICATOR	BASELINE 2024/25	2026/27 TARGET	2027/28 TARGET	2028/29	2026/27 QUARTERLY PERFORMANCE TARGETS				2026/27 BUDGET PER PROJECTS R 000						Evidence and MEANS OF VERIFICATION
						Q1	Q2	Q3	Q4	Cap ex	Opex	Q1	Q2	Q3	Q4	
15.	%Development of Electronic Patient Health Record software ¹⁶	60%	100% developm ent of the system	% 100 Utilisation and mainten ance	% 100 Utilisation and mainten ance	25%	50%	75%	100%		R 2,3418 83.64	R 5854 70.9 1	R 5854 70.9 1	R 585470 .91	R 5854 70.9 1	Milestone completion reports, deployment sign- off report project progress reports.
16.	Number of health facilities implementing Electronic Patient Health	New	40 clinics	39 Clinics	0	10 Clinics	20 Clinics	30 Clinics	40 Clinics			R 0.	R 0.	R 0.	R 0.	Utilization report Confirmation reports eHealth rollout reports

¹⁶ Measures the percentage completion of system development activities for the Electronic Patient Health Record software in line with the project plan and system development life cycle milestones. The 60% represents 108 out of 180 features completed System architecture designed and integration specifications with NHLS and other systems

GDS: A high performing metropolitan government that proactively contributes to and builds a sustainable, socially inclusive, locally, globally competitive Gauteng City Region																integrated and
MAYORAL PRIORITY: Smart City																
RELATED OUTPUT: A 'Smart' City of Johannesburg, that can deliver quality services to citizens in an efficient and reliable manner (cross cutting output)																
NO	KEY PERFORMANC E INDICATOR	BASELINE 2024/25	2026/27 TARGET	2027/28 TARGET	2028/29	2026/27 QUARTERLY PERFORMANCE TARGETS				2026/27 BUDGET PER PROJECTS R 000						Evidence and MEANS OF VERIFICATION
						Q1	Q2	Q3	Q4	Cap ex	Opex	Q1	Q2	Q3	Q4	
	Record software ¹⁷															
17.	% achieved in the development of the Digital Environmental Health System ¹⁸	New	100%	100%	100%	25%	50%	75%	100%	R20 00						System Development milestone report from GICT

¹⁷Counts the total number of COJ health facilities where the Electronic Patient Health Record system has been successfully rolled out, installed, configured, and is in active use

¹⁸ Climate change resilience and environmental protection

GDS: A high performing metropolitan government that proactively contributes to and builds a sustainable, socially inclusive, locally integrated and globally competitive Gauteng City Region

MAYORAL PRIORITY: Good governance

RELATED OUTPUT: A responsive, accountable, efficient, and productive metropolitan government

N O	KEY PERFORMANCE INDICATOR	BASELINE 2024/25	2026/27 TARGET	2027/28 TARGET	2028/2 9	2026/27 QUARTERLY PERFORMANCE TARGETS				2026/27 BUDGET PER PROJECTS R 000						Evidence and MEANS OF VERIFICATION
						Q1	Q2	Q3	Q4	Capex	Opex	Q1	Q2	Q3	Q4	
18	100% delivery on reported cases of corruption	100%	100%	100%	100%	100%	100%	100%	100%	R0						GFIS Recommendatio n reports Quarterly progress report
19	Percentage resolution of AG findings ¹⁹	100%	95%	95%	95%	95%	95%	95%	95%	38,547	1,787,361					AG Action Plan Progress Reports & Evidence Files
20	Percentage implementation of the strategic risk management action plan findings resolved	85%	85%	85%	85%	85%	85%	85%	85%	R0						Strategic Risk Register Quarterly Risk Report on GRAS Template

¹⁹ Quarter 1: 95% of the previous AG letter must be resolved.

Quarter 2: 95% of the previous AG findings must be resolved as we only getting a new AG letter in November every year while tracking the previous AG letter. Quarter 3: 50% of the Current/NEW AG letter finding must be resolved. Quarter 4: 95% of the AG findings must be resolved as the new AG letter would have been with management for period of + 6 months.

GDS: An inclusive, job-intensive, resilient, competitive, and smart economy that harnesses the potential of citizens.

MAYORAL PRIORITY: Job opportunity & creation

RELATED OUTPUT: Promotion and support to informal and micro businesses

N O	KEY PERFORMANCE INDICATOR	BASELINE 2024/25	2026/27 TARGET	2027/28 TARGET	2028/29	2026/27 QUARTERLY PERFORMANCE TARGETS				2026/27 BUDGET PER PROJECTS R 000						Evidence and MEANS OF VERIFICATIO N
						Q1	Q2	Q3	Q4	Capex	Opex	Q1	Q2	Q3	Q4	
21	Number of SMME's supported.	76	60	60	60	15	30	45	60							SMME Feedback report from Economic Development
22	Number of EPWP job opportunities created ²⁰	605 Jozi Ihlomile	323	350	400	0	0	0	323		R 0					Contracts, Database

²⁰ Target will depend on availability of budget. Achievement of the Jozi Ihlomile KPI is also considered as achievement for this KPI.

GDS: An inclusive, job-intensive, resilient, competitive, and smart economy that harnesses the potential of citizens.																
MAYORAL PRIORITY:		Energy Mix														
RELATED OUTPUT:		Climate change resilience and environmental protection														
NO	KEY PERFORMANCE INDICATOR	BASELINE 2024/25	2026/27 TARGET	2027/28 TARGET	2028/29	2026/27 QUARTERLY PERFORMANCE TARGETS				2026/27 BUDGET PER PROJECTS R 000						Evidence and means of verification
						Q1	Q2	Q3	Q4	Capex	Opex	Q1	Q2	Q3	Q4	
23.	% Of Identified hotspot areas where vector control measures are instituted	100%	100%	100%	100%	25%	50%	75%	100%	R0						Inspection records, premises registers

GDS: A high performing metropolitan government that proactively contributes to and builds a sustainable, socially inclusive, locally integrated and globally competitive Gauteng City Region MAYORAL PRIORITY: Financial sustainability RELATED OUTPUT: Financially sustainable and resilient city																
NO	KEY PERFORMANCE INDICATOR	BASELINE 2024/25	2026/27 TARGET	2027/28 TARGET	2027/28 TARGET	2026/27 QUARTERLY PERFORMANCE TARGETS				2026/27 BUDGET PER PROJECTS R 000						Evidence and MEANS OF VERIFICATION
						Q1	Q2	Q3	Q4	Cape x	Opex	Q1	Q2	Q3	Q4	
24.	Percentage spent on capital budget against approved capital budget ²¹	99%	95%	95%	95%	25%	50%	75%	95%		1,822,417					SAP Report
25.	Percentage spent on operating budget against approved operating budget	97%	100%	100%	100%	25%	50%	75%	100%	38,547	1,787,361					Operating Expenditure Report From SAP
26.	Percentage of spent on repairs and maintenance to property, plant, and equipment.	48.6%	8%	8%	8%	0%	4%	6.4%	8%		7,658					Operating Expenditure Report From SAP

²¹ although the 2024/25 baseline reflects a 99% capital budget spend, the 2026/27 target is set at 95% due to structural constraints affecting the Health Department's capital programme. Insufficient capital budget allocation, delays in major infrastructure projects (e.g., Naledi Clinic shortfall, Hikhensile Phase II requiring R72 million), reliance on minor upgrades due to budget rebasing, and systemic challenges in contractor performance, cash flow and procurement timelines. These external limitations make a sustained 99% expenditure rate unattainable in the medium term despite strong internal performance controls.

GDS: A high performing metropolitan government that proactively contributes to and builds a sustainable, socially inclusive, locally integrated and globally competitive Gauteng City Region MAYORAL PRIORITY: Financial sustainability RELATED OUTPUT: Financially sustainable and resilient city																
NO	KEY PERFORMANCE INDICATOR	BASELINE 2024/25	2026/27 TARGET	2027/28 TARGET	2027/28 TARGET	2026/27 QUARTERLY PERFORMANCE TARGETS				2026/27 BUDGET PER PROJECTS R 000						Evidence and MEANS OF VERIFICATION
						Q1	Q2	Q3	Q4	Cape x	Opex	Q1	Q2	Q3	Q4	
27.	Percentage reduction in unauthorized, irregular, fruitless, and wasteful (UIFW) expenditure incurred citywide.	100% reduction on	100%	100%	100%	40%	30%	20%	100%							UIFW report
28.	Percentage resolution of Internal Audit findings	85%	100%	100%	100%	100%	100%	100%	100%							Internal Audit Reports IA Findings Register Quarterly IA Resolution Progress Reports

13.3.3 Day to day operations

The daily operational programmes of the department that are core and have a supporting role in ensuring the department function appropriately.

GDS: Outcome 1: Improved quality of life and development-driven resilience for all																
MAYORAL PRIORITY: Safer city																
RELATED OUTPUT: A society characterized by healthy living for all																
NO	KEY PERFORMAN CE INDICATOR	BASELINE 2024/25	2026/27 TARGET	2027/28 TARGET	2028/29 TARGET	2026/27 QUARTERLY PERFORMANCE TARGETS				2026/27 BUDGET PER PROJECTS R 000						Evidence and MEANS OF VERIFICATION
						Q1	Q2	Q3	Q4	Capex	Opex	Q1	Q2	Q3	Q4	
1.	% Customer satisfaction level based on the National PEC (Patient Experience of Care) survey ²²	87%	80%	80%	80%	0	0	0	80%		32,132					approved Customer Satisfaction Survey Report level based on Customer Charter implementation in COJ health facilities

²² Customer Satisfaction is only measured annually through an approved survey conducted in Quarter 4. No customer satisfaction data is collected in Quarters 1 - 3; therefore, targets for Q1–Q3 are set at 0%

GDS: Outcome 1: Improved quality of life and development-driven resilience for all

MAYORAL PRIORITY: Safer city

RELATED OUTPUT: A society characterized by healthy living for all

NO	KEY PERFORMAN CE INDICATOR	BASELINE 2024/25	2026/27 TARGET	2027/28 TARGET	2028/29 TARGET	2026/27 QUARTERLY PERFORMANCE TARGETS				2026/27 BUDGET PER PROJECTS R 000						Evidence and MEANS OF VERIFICATION
						Q1	Q2	Q3	Q4	Capex	Opex	Q1	Q2	Q3	Q4	
2	Percentage increase in satisfaction levels ²³	1% decrease from the 2022/23 polling survey	1% increase	1% increase		0	0	0	1% increase							Data collection for GCRO's QoL survey
3	% Drug stock outs	5,43%	< 5% drug stock outs	< 5% drug stock outs	< 5%	< 5%	< 5%	< 5%	< 5%							Quarterly reports approved by the Director: DHSD
4	% Shrinkage of pharmaceuticals at PHC facilities	0.00%	< 5%	< 5%	< 5%	< 5%	< 5%	< 5%	< 5%							Quarterly reports approved by the Director: DHSD
5.	Percentage Antenatal client HIV 1st test rate (excluding clients with known status)	100.1%	98%	98%	98%	97,7%	97,8 %	97.9 %	98%		1,089,186					TIER. Net and WebDHIS Indicator Report

²³ Customer Satisfaction is only measured through the annual survey conducted in Q4. No measurement takes place in Q1–Q3

GDS: An inclusive, job-intensive, resilient, competitive, and smart economy that harnesses the potential of citizens.

MAYORAL PRIORITY: Active citizenry

RELATED OUTPUT: Increased competitiveness of the economy

Job intensive economic growth

NO	KEY PERFORMANCE INDICATOR	BASELINE 2024/25	2026/27 TARGET	2027/28 TARGET	2028/29 TARGET	2026/27 QUARTERLY PERFORMANCE TARGETS				2026/27 BUDGET PER PROJECTS R 000						Evidence and MEANS OF VERIFICATION
						Q1	Q2	Q3	Q4	Cape x	Opex	Q1	Q2	Q3	Q4	
6.	Number of individuals reached through the Jozi Ihlomile HIV/AIDS education door to door programme. ²⁴	3 426 549	3,000,000	3,000,000	3,000,000	750 000	1,500 000	2 250 000	3,000 000							Quarterly report verified by Director: PH

²⁴ Targets for the number of individuals reached through the Jozi Ihlomile HIV/AIDS door-to-door education programme are formally determined and communicated by the Gauteng Provincial Department of Health within the HIV and AIDS conditional grant funding agreement, after the publication of the Provincial Treasury Gazette for the relevant outer financial year, anticipated in April/May 2027. Targets depend on budget availability.

Table 3 Transversal Programme

ANNEXURE E1: TRANSVERSAL PROGRAMMES (External)

No	Dependency areas	Problem statement	Lead department/ Entity					External stakeholders e.g. National, Provincial Gov, Private Sector, NGO etc.
				Accountable (Business plan)	Responsible (Business plan)	Consult	Inform	
1.	Percentage children under 1 year immunization coverage	Dependence on GDoH for creation of cost Centres	Health	CoJ Health GDoH	CoJ Health GDoH	GDoH	GDoH	Private Providers NGO
2.	Most of the HIV Testing Services (HTS) counselors in Local Government health care facilities are employed by the District Support Partner (Anova Health Institute) and Gauteng Department of Health (GDoH).	Reliance on the GDoH and district Support Partners for the personnel capturing HIV/TB data	GDOH and Anova Health Institute	CoJ Health GDoH	CoJ Health GDoH	GDoH	GDoH	GDOH and Anova Health Institute
3.	Implementation of Jozi Ihlomile programme	Reliance of GDoH for grant funding		CoJ Health GDoH	CoJ Health GDoH			GDoH

KEY: Categories of Dependencies

Accountable	The buck stops here regardless of the output	✓
Responsible	This functional unit is <u>responsible</u> to complete actions as part of producing an output i.e. they are the "doers"	◇

Consulted	This functional unit must be <u>consulted</u> before decisions are taken which result in a fundamental change in the process	•
Informed	This functional unit must be <u>informed</u> immediately after decisions are taken which result in a fundamental change in the purpose	#

KPI	Lead department	2024/25 Target	Dependency		
			Implementing Department/ Entity	KPI	2024/25 Target

ANNEXURE E2: TRANSVERSAL PROGRAMMES (Internal)

No	Dependency areas	Problem statement	Lead department/ Entity					Internal stakeholders e.g. City Departments and/or Entities
				Accountable (Business plan)	Responsible (Business plan)	Consult	Inform	
1.	(% Request for services attended to: Land & Building Sanitation)	Illegal dumping of waste on open land as well as overgrown open land complaints are reported to Environmental Health in the regions	Health (Environmental Health)	Health	Health	Pikitup, JCPZ (Johannesburg City Parks and Zoo)		Pikitup, JCPZ (Johannesburg City Parks and Zoo)

2.	100% delivery on reported cases of corruption	The cases are reported anonymously directly to group forensic department thus health may not have an idea on the cases	GFIS	Health	Health implements recommendations	GFIS	GFIS	GFIS does the investigation and issues the report for implementation
3.	Percentage implementation of the strategic risk management action plan	GRAS (Group Risk and Assurance Service) does the assessment on the implementation of the risk register action plan	Health	Health	Health	GRAS	GRAS	GRAS
4.	% of business licence applications processed in terms of the Business Act	Applications for business license to trade in food and other areas regulated by the business act are made with the department of health	Health (Environment	Health	Health		Planning Dept and EMS Dept	Planning, EMS
5.	Request for services attended to: Water Quality Management	Water quality complaints and			Health		Joburg Water	Joburg Water

		request for services are reported to Environmental Health in the regions						
6.	% achieved in the development of the Digital Environmental Health System	Response to tenders	Health and MTC (GICT)	Health	Health	MTC	MTC	MTC
7.	% Development of Electronic Patient Health Record Software	Availability of resources Connectivity challenges	Health and MTC	Health	Health	MTC	MTC	MTC
8.	Number of EPWP job opportunities created.	Funding for programme	Economic Development	Health	Health	MTC	MTC	Economic Development

KEY: Categories of Dependencies

Accountable	The buck stops here regardless of the output	√
Responsible	This functional unit is <u>responsible</u> to complete actions as part of producing an output i.e. they are the “doers”	◇
Consulted	This functional unit must be <u>consulted</u> before decisions are taken which result in a fundamental change in the process	●
Informed	This functional unit must be <u>informed</u> immediately after decisions are taken which result in a fundamental change in the purpose	#

13.4 2026/27 Circular 88 Outcome Indicators

On an annual basis, the National Treasury provides indicators that form part of the planning and reporting requirements for Metropolitan Municipalities. Information regarding C88 is however subject to change as National Treasury continues to refine the C88 indicators as well as how they are implemented and reported. GSPCR will communicate any changes accordingly as soon as National Treasury communicates these changes.

Circular 88 Outcomes	No	IDP Performance Indicator (Outcomes)	Ref No.	Baseline (estimated Annual Performance 2024/25)	Target for (MTREF) (3 years)			Target for 2027/28	EVIDENCE	MEANS OF VERIFICATION
					2026/2027	2027/2028	2028/2029			
C102(ENV)		Number of incidents of improper disposal of medical waste responded to by the municipality		0					Quarterly consolidated report	Quarterly reports signed off by Director: Env Health
C103(ENV)		Number of notifiable medical condition investigations following the prescribed protocols		286 Cumulative 1382					Quarterly consolidated report	Quarterly report signed off by Director: Env Health

Circular 88 Outcomes	No	IDP Performance Indicator (Outcomes)	Ref No.	Baseline (estimated Annual Performance 2024/25)	Target for (MTREF) (3 years)			Target for 2027/28	EVIDENCE	MEANS OF VERIFICATION
					2026/2027	2027/2028	2028/2029			
C104(ENV)		Number of foodborne disease outbreak investigations following the prescribed protocols		14					Quarterly consolidated report	Quarterly reports signed off by Director: Env Health

13.4 TECHNICAL INDICATOR DESCRIPTIONS

KPI's DEFINITION

KPI No.	Key Performance Indicator	Short Definition	Purpose / Importance	Source / Collection of Data	Method of Calculation	Data Limitation	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
1	% of eligible children fully immunized by age 1 (One)	The indicator measures the immunization coverage rate for all children under 1 year old that are fully immunized for age.	The main objective of the Expanded Programme on Immunization in South Africa (EPI – SA) is to prevent death and reduce suffering from diseases of childhood that can be prevented by immunization of children.	Collected as part of routine data using - Standardized PHC Daily Tick registers. Collated into Clinic Monthly Input Forms. Electronically captured into webDHIS	Total number of children under 1 year old that are fully immunized is divided by the under 1 year old population estimate multiply by 100	Data quality at all levels of recording	Cumulative target	Quarterly	No	87.5%	Director: PH
2.	Percentage of HIV positive patients initiated on treatment	The indicator measures the percentage of HIV positive patients that have been initiated on Lifelong ART.	To ensure that HIV positive patients remain virally suppressed	Collected as part of routine data using Standardized HTS registers & ART Clinical Stationery for people initiated on ART. HIV positives collated into Clinic Monthly Input Forms, electronically captured into	Total number of HIV positive patients initiated on treatment divided by number of patients tested positive for HIV	Data quality at all levels of recording	Cumulative	Quarterly	No	96.3%	Director PH

KPI No.	Key Performance Indicator	Short Definition	Purpose / Importance	Source / Collection of Data	Method of Calculation	Data Limitation	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
				webDHIS at regional level and Initiated on ART processed electronically at the facility into Integrated TB/HIV Information System (TIER.Net data application). Facility Monthly TIER.Net generated report feeds into Clinic Monthly Input Form for Initiated on ART Electronically captured into web DHIS. (Selected facilities captures data daily)							
3.	Percentage of all DS-TB treatment	The clients successfully completed treatment (both cured	Monitors success of TB treatment for all types of Susceptible TB. This follows cohort analysis	TB patients identified collected as part of routine data	Percentage of all DS-TB treatment success rate = {All DS-TB client successfully	Data does not include patients transferred out to other facilities	Non-Cumulative	Quarterly	No	88.2%	Dir: Public Health

KPI No.	Key Performance Indicator	Short Definition	Purpose / Importance	Source / Collection of Data	Method of Calculation	Data Limitation	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
	success rate ²⁵	and completed) as a proportion of all Susceptible TB clients started on treatment. This applies to all TB clients (New, Retreatment, Other pulmonary and extra pulmonary)	therefore the clients would have been started on treatment at least 6 months prior.	using TB Case Identification Register. This is collated into Clinic Monthly Input Forms, electronically captured into WebDHIS. Initiated on TB treatment processed electronically at the facility into Integrated TB/HIV Information System (TIER.Net data application).	completed treatment} divided {All DS-TB client in treatment outcome cohort} multiply by 100 for rate						
4.	% Compliance to food safety legislation by formal food premises inspected	This indicator measures the compliance of formal food traders against the R638 regulations as assessed by	Food safety is a core public health issue. One of Council's statutory roles is to conduct routine food premises inspection to ensure compliance with legislation to	Monitoring tools document completed by the regions.	Number of formal food premises compliant with R638 out of the number premises inspected	Errors in completing the monitoring tool by regions	Cumulative	Quarterly	No	90%	Director: EH

²⁵ Description: 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

KPI No.	Key Performance Indicator	Short Definition	Purpose / Importance	Source / Collection of Data	Method of Calculation	Data Limitation	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
		the environmental health practitioners. This is measured as a percentage against the total formal food traders inspected.	minimize the risk of food poisoning occurring at food premises.								
5.	% Compliance to food safety legislation by informal food premises inspected ²⁶	This indicator measures the compliance of informal food traders against the R638 regulations as assessed by the environmental health practitioners. This is measured as a percentage against the total informal food traders inspected.	Food safety is a core public health issue. One of Council's statutory roles is to conduct routine food premises inspection to ensure compliance with legislation to minimize the risk of food poisoning occurring at food premises.	Monitoring tools document completed by the regions.	Number of informal food premises compliant with R638 out of the number premises inspected	Errors in completing the monitoring tool by regions	Cumulative	Quarterly	No	90%	Director: EH
6	Percentage compliance to environmental health legislation for	Regularly inspect healthcare, old-age	Health surveillance of premises is a core public health issue. One of Council's statutory roles is to	Monitoring tools document completed	Number of places of care compliant with public health bylaws out of the	Errors in completing the monitoring tool by regions	Cumulative	Quarterly	No	90%	Dir: EH

²⁶ Compliance to food safety legislation is aimed at protecting the public against food related illnesses including food poisoning.

KPI No.	Key Performance Indicator	Short Definition	Purpose / Importance	Source / Collection of Data	Method of Calculation	Data Limitation	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
	places of care, old-age facilities, schools etc.	facilities, schools, etc.	conduct routine inspection of places of care to ensure compliance with legislation.	by the regions.	number premises inspected						
7.	Percentage increase in compliance of ECDs to regulations	Ensure compliance and regulatory mechanisms on unregistered schools i.e.: • Town Planning and Building Control • Public Safety Environmental Health	Early childhood development inspection is a core public health issue. One of Council's statutory roles is to conduct routines at early childhood development centers to ensure compliance with legislation to minimize the risk of diseases spreading at these centers.	Monitoring tools document completed by the regions.	Number of Early childhood centers compliant with the public health bylaws inspected	Errors in completing the monitoring tool by regions	Cumulative	Quarterly	No	80%	Dir: EH
8.	% Compliance in relation to the Ideal Clinic core standards in COJ health facilities in preparation for the NHI implementation	This indicator measures the number of clinics found to be compliant with the Ideal Clinic core standards in line with predetermined criteria. This is measured as a percentage of the achievements of the clinics against these standards.	To improve health system to provide quality health services and prepare facilities for the National Health Insurance	Self-Assessment, PPTICRM, Peer Reviews and Peer Review update,	Proportion of elements that comply with the Ideal Clinic core standards in line with predetermined criteria.	The inclusion of some elements like National policies which are not yet available, disadvantage the facilities	Non-cumulative. Reflects status at time of assessment.	Quarterly as per GDOH and NDOH schedules	No	All the facilities to strive for platinum status. For a facility to be compliant, it must achieve either silver, gold, or platinum. 80%	Director DHSD

KPI No.	Key Performance Indicator	Short Definition	Purpose / Importance	Source / Collection of Data	Method of Calculation	Data Limitation	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
9.	% Of Children under 2 years underweight followed up ²⁷	This indicator measures the number of underweight children under 2 years old who are identified and followed up.	Assess the level of malnutrition in children under 2 years attending CoJ health facilities.	Clinic based Malnutrition Register.	Quarterly review utilizing the Malnutrition Register.	Tracing challenges due to incorrect addresses & mobility of communities.	Cumulative	Quarterly	No	100% of Children under 2 years underweight followed up	Director PH
10	% Increase in the antenatal care (early booking rate)	This indicator measures the increase in the number of pregnant women who book earlier than 20 weeks at COJ Clinics. This is measured as a percentage of additional pregnant women presenting early at COJ clinics in a specified period of the year	Early booking by pregnant women allows early identification of medical problems including HIV status. This can allow prompt initiation of ARTs (Anti-Retroviral Treatment) of those pregnant mothers who are HIV positive, so to minimize the risk of vertical transmission of HIV infection from mother to child.	Clinic data to DHIS	Proportion of pregnant women presenting before 20 weeks at COJ clinics divided by the total number of Antenatal first visits at Clinics.	Data quality at all levels of recording	Cumulative	Quarterly	No	75.7% (Regional or Facility Level (selected facilities that captures data daily) captured into Web DHIS).	
11.	Number of health awareness	The indicator measures the number of	Health surveillance of premises is one of the nine	Quarterly reports submitted	Number of awareness campaigns	Errors in completing the	Cumulative	Quarterly	No	1 health awareness programme	Director: EH

²⁷ All children under 2 years old identified to be underweight for age at LG clinics will be followed up. Interventions like nutritional counselling and support; referral to hospital for further investigation to exclude underlying medical condition will be conducted.

KPI No.	Key Performance Indicator	Short Definition	Purpose / Importance	Source / Collection of Data	Method of Calculation	Data Limitation	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
	programmes conducted in COJ hostels ²⁸	awareness Programmes undertaken quarterly at hostels focusing on waste management, other environmental health matters and personal health matters.	municipal health services to be provided by municipalities.	by the regions on awareness Programmes that have been conducted.	conducted at hostels in each quarter.	monitoring tool by regions				conducted per hostel per quarter.	
12.	% knowledge increase of learners that are given health education on nutrition at schools ²⁹	The indicator measures education given to Q1 - Q3 learners to increase their knowledge on healthy nutrition to prevent	To prevent the quadruple burden of disease and to increase the life expectancy rate.	GDE learner registers Pre-test and post test Attendance register	all pre-test scores from Quarter 1 to the current quarter are summed, as well as all post-test scores. The percentage knowledge	None	Cumulative	Quarterly	New	Percentage increase in knowledge	DHSD Director

²⁸ CoJ has 13 hostels in total. Region D has 8 hostels: Dube, Diepkloof, Mzimhlophe Male, Mzimhlophe Female, Dobsonville, Jabulani Hostel, Nancefield and Merafe Hostel 16.

Region E has 3 hostels; Helen Joseph; Madala and Nobule; Region F has 2 hostels; George Gogh and Denver Hostel.

²⁹ This education is given to prevent obesity which is a risk factor for the prevalence of type 2 diabetes, and address issues of Malnutrition (Obesity, underweight etc.). The schools selected are Q1 -Q3 in the seven regions of the City of Johannesburg.

KPI No.	Key Performance Indicator	Short Definition	Purpose / Importance	Source / Collection of Data	Method of Calculation	Data Limitation	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
		malnutrition including obesity which is a risk factor for the prevalence of type 2 diabetes.			increase is then calculated as: Sum of post-test-sum of pre-test divide by sum of pretest scores x 100						
13	Number of awareness programmes conducted at schools ³⁰	The indicator measures the number of awareness Programmes on teenage pregnancy, substance abuse and HIV/AIDS at schools in the COJ	The purpose of this indicator is to improve understanding of issues related to teenage pregnancy, HIV/TB & substance abuse amongst learners at both primary and high schools	Register of Schools where awareness Programmes are conducted.	The number of Primary & High schools where awareness Programmes are conducted.	Incomplete registers.	Cumulative	Quarterly	No	40 Health awareness programmes conducted at schools	Director: DHSD
14.	Percentage achievement of service standards ³¹	The percentage of Service Level Standards achieved of the total approved number of Service Level Standards									Directors : DHSD, PH and EH

³⁰ awareness programmes on teenage pregnancy, substance abuse, and HIV & AIDS at schools

³¹ The service standards are listed in the Service Standard Charter below. Refer to (Table 9.4 b) below (TID's FOR Service Standards)

KPI No.	Key Performance Indicator	Short Definition	Purpose / Importance	Source / Collection of Data	Method of Calculation	Data Limitation	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
		Refer to Table 13.6b) below (TID's FOR Service Standards)									
15.	Development of Electronic Patient Health Record software	Measures the percentage progress towards the integration and readiness for implementation of the Electronic Patient Health Record system based on approved system development milestones.	To have a single digitized health record for each patient treated by CoJ	Project progress reports, system development milestone reports and SLA deliverables from eHealth unit.	Percentage of completed system integration of milestones against the total planned milestones for the financial year.	Delays in system integration approvals, vendor dependency (SLA), procurement delays and technical system compatibility risks.	Cumulative	Quarterly	Yes	100% completion of Electronic Patient Health Record software development and readiness for implementation.	Director: IPPR
16.	Number of health facilities implementing Electronic Patient Health Record software	This indicator measures the number of clinics implementing the system	To utilize the system in all 79 CoJ health facilities	Signed facility go-live confirmation reports, system utilization reports and implementation	Count of health facilities that have officially gone live on the Electronic Patient Health Record system within the reporting period.	Network downtime, user resistance, training delays, system integration failures and infrastructure readiness challenges.	Cumulative	Quarterly	Yes	79 health facilities fully implementing and utilising the Electronic Patient Health Record system.	Director IPPR

KPI No.	Key Performance Indicator	Short Definition	Purpose / Importance	Source / Collection of Data	Method of Calculation	Data Limitation	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
				registers from eHealth unit.							
17.	% achieved in the development of the Digital Environmental Health System	This indicator measures the progress made on the development of the Electronic Environmental Health Record	To improve the efficiency and effectiveness of the Environmental Health Team	DHIS and DEHR	Measure progress based on the Digital Environmental Health Records System milestones provided on the System SLA	Availability of data and Network	Cumulative	Quarterly	Yes	% achieved in the development of the Digital Environmental Health System	Director: IPPR
18.	100% delivery on reported cases of corruption	The indicator measures the percentage of response to reported cases of corruption	To ensure zero levels of corruption in the department	GFIS reports	Quarterly GFIS reports	Dependency on GFIS for a report indicating the recommendation for implementation	Non-cumulative	Quarterly	No	Total zero cases of corruption	Director: MSD
19.	Percentage resolution of AG findings	It measures the number of audit findings resolved against the total number of audit findings issued by the AGSA (Auditor General of South Africa)	To avoid any form of deviation to legislation and protocols	Internal Audit Reports	Total number of Auditor General findings resolved/total number of Auditor General findings (excluding findings that are less than 60 days) *100	Dependency on agencies	Non-Cumulative	Quarterly dashboard/Annually	No	95% resolutions	Director Finance

KPI No.	Key Performance Indicator	Short Definition	Purpose / Importance	Source / Collection of Data	Method of Calculation	Data Limitation	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
20.	Percentage implementation of the strategic risk management action plan findings resolved	The percentage of strategic risk action plans implemented compared to total number of strategic risk action plans.	To mitigate, reduce or eradicate risks that have been identified by the Department	Units and Regional performance reports	Number of implemented strategic risk action plans divided by total number of strategic risk action plans multiplied by 100	Dependency on GRAS for assessment	non-cumulative	Quarterly	No	85%	Director: MSD
21..	Number of SMME's supported	The indicator measures the level of support the department gives to SMME's through the SCM processes	To ensure adherence to the MFMA quota requirements	Budget consumption report	Overall Departmental performance	Dependency on the Group SCM on procurement above R30 000	Cumulative	Quarterly reports	No		Director Finance
22.	Number of EPWP job opportunities created	The EPWP is a government short- to medium-term program aimed at reducing unemployment and thereby alleviating poverty through creating job opportunities.	The purpose is to enhance the ability of workers to earn an income after they leave the program. In addition, their skills are enhanced, and they are given work experience.	Contracts, C.V.'s, ID Copies, Proof of Residence, Database	Post availability minus Posts filled. (Identify the need, Availability of Budget, Applicants)	DED not giving a budget for EPWP appointments	Cumulative	Monthly Reporting to DED (Department of Economic Development) (Department of Economic Development) Office Quarterly to the	No	80% Participants receiving internal or external permanent employment	Director: IPPR

KPI No.	Key Performance Indicator	Short Definition	Purpose / Importance	Source / Collection of Data	Method of Calculation	Data Limitation	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
								Dept of Health			
23.	% of Identified hotspot areas where vector control measures are instituted	The indicator measures the total number of identified rodent hotspot areas where vector control measures have been instituted.	Vector control is one of the nine Municipal Health Services in terms of the national health act No. 61 of 2003.	Monitoring tools document completed by the regions.	Number of vector control measures instituted out of vector (rodent) hotspot areas identified.	Errors in completing the monitoring tool by regions.	Cumulative	Quarterly	No	100% of identified hotspot areas where vector control measures are instituted	Director: EH
24.	Percentage spent on capital budget against approved capital budget	The indicator measures the percentage of the allocated budget spent. (The Capex spent on projects against the approved budget. The objective is to improve, stabilize and sustain a positive financial position)	This is to ensure that as per the requirements of the MFMA over and under expenditure is avoided through tracking	Budget consumption report	Expenditure patterns as per the Budcon (Total Capex spent divided by the budget Capex spend* 100)	None	Cumulative	Weekly, monthly, and quarterly Budcon reports	No	95% expenditure	Director Finance
25.	Percentage spent on operating budget against approved	The indicator measures the percentage of the allocated budget spent by the Department	This is to ensure that as per the requirements of the MFMA over and under expenditure is avoided through tracking	Budget consumption report	Expenditure patterns as per the Budcon (Actual costs /Allocated budget *100)	None	Cumulative	Weekly, monthly, and quarterly Budcon reports	No	95% expenditure	Director Finance

KPI No.	Key Performance Indicator	Short Definition	Purpose / Importance	Source / Collection of Data	Method of Calculation	Data Limitation	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
	operating budget	against the allocated budget. The objective is to improve, stabilize and sustain a positive financial position									
26.	Percentage of spent on repairs and maintenance to property, plant, and equipment.	The indicator measures the percentage of the allocated budget spent on repairs and maintenance of facilities (It measures the level of Repairs & Maintenance to prevent breakdowns and interruptions to service delivery)	This is to ensure that as per the requirements of the MFMA over and under expenditure is avoided	Budget consumption report	Expenditure patterns as per the Budcon (Total Repairs and Maintenance Expenditure/ Property, Plant and Equipment and Investment Property (Carrying value) x 100)	None	Cumulative	Weekly, monthly, and quarterly Budcon reports	No	8% expenditure	Director Finance
27.	Percentage reduction in unauthorized, irregular, fruitless, and wasteful (UIFW) expenditure incurred citywide	This indicator measures the percentage reduction in the unauthorized expenditure. (Percentage reduction on UIFW	This is to ensure that as per the requirements of the MFMA unauthorized expenditure is prevented at all costs	Financial statements disclosure notes	Overall departmental performance (The UIFW Expenditure closing balance of the current financial year against (will be compared with)	Depending on the budget office	Cumulative	Quarterly	No	50% reduction in UIFW	Director Finance

KPI No.	Key Performance Indicator	Short Definition	Purpose / Importance	Source / Collection of Data	Method of Calculation	Data Limitation	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
		compared to the previous financial year AG finding)			the closing balance of the previous financial year)						
28.	Percentage resolution of Internal Audit findings	It measures the number of audit findings resolved against the total number of audit findings issued by the internal audit	To avoid any form of deviation to legislation and protocols	Internal audit assessment report	Total number of internal audit findings resolved/total number of internal audit findings (excluding findings that are less than 60 days) *100.	Dependency on agencies	Non - Cumulative	Quarterly	No	95% resolutions	Director Finance
Day to Day Programmes											
1.	% Customer satisfaction level based on the National PEC (Patient Experience of Care) survey	Yardstick to measure patient satisfaction level in a facility using the six ministerial domains (Staff attitude, access to health care, infection prevention and control, cleanliness, waiting time and	To measure the quality of health services rendered in the facility. To prepare our facilities for the National Health Insurance	Facility based survey data.	Web-based Gauteng Health Department application utilized for data collection and analysis.	The survey is conducted annually and reflects satisfaction levels of patients that visited the facility during a specific timeframe.	Non-cumulative Reflects satisfaction levels at time of survey.	Annual	No	All facilities to strive for at least 80%	Director: DHSD

KPI No.	Key Performance Indicator	Short Definition	Purpose / Importance	Source / Collection of Data	Method of Calculation	Data Limitation	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
		availability of medication).									
2.	Percentage increase in satisfaction levels	This indicator measures the percentage satisfaction of communities that are utilising the City's facilities.	To improve the quality of services and the community perception about health services.	Customer satisfaction survey	Interviews Field force interviewers Community consultation	Unsafe areas due to crime and drugs Theft of interviewers' tablets Schools are closed. Loadshedding	non-cumulative	2024	Yes	An increased in customers satisfaction.	Director DHSD done annually
3.	% Drug stock outs	This indicator measures the percentage stockouts (absence of the medicines at health facilities) in the customized EML per region.	To improve availability of essential medicines within the context of functioning health systems, in sufficient amounts, appropriate dosage forms and assured quality	Monitoring tools document completed by the regions.	Numerator: Number of items that are out of stock Denominator: Total number of medicine items on requisition list which has 354 items	None	non-cumulative	Quarterly	No	<5% drug stock outs	Director: DHSD
4.	% Shrinkage of pharmaceuticals at PHC facilities	% Shrinkage of pharmaceuticals at PHC facilities	This indicator measures the percentage reduction of stock. due to wastage/ breakage/ loss.	To reduce unnecessary and wasteful expenditure incurred by expired, broken and lost medicines	Reports of Expired/ broken Stock Returned to pharmacy	Numerator: The total cost of wasted stock per Region Denominator: Total Medicine expenditure per region	non-cumulative	Quarterly	No	<5% shrinkage	Director: DHSD
5	Percentage Antenatal client HIV 1st test rate (excluding clients with known status)	The proportion of pregnant women (1 st visit) with unknown HIV status who are tested for HIV.	This KPI is important for the early identification of HIV positive mothers so that Antiretroviral treatment is initiated to minimize the risk of	Clinic data to DHIS	Proportion of pregnant women presenting at COJ clinics (1 st visit) tested for HIV status (those whose HIV status	Data quality at all levels of recording.	Cumulative	Quarterly	No	98% Antenatal client HIV 1 st test rate	Dir: Public Health

KPI No.	Key Performance Indicator	Short Definition	Purpose / Importance	Source / Collection of Data	Method of Calculation	Data Limitation	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
			HIV transmission from mother to child.		is not known) divided by the total number of Antenatal first visits at Clinics.						
6.	Number of individuals reached through the Jozi Ihlomile HIV/AIDS education door to door programme.	The number of individuals educated through the Jozi Ihlomile HIV/AIDS education door to door programme.	To improve awareness on HIV / TB & STI infection and COVID-19. Encourage community members to know their HIV status.	Monitoring Tools completed by Jozi Ihlomile door to door educators.	Total number of individuals educated through the Jozi Ihlomile HIV/AIDS education door to door programme.	Quality of data collected by educators.	Cumulative	Quarterly	No	3 000 000 individuals reached through the Jozi Ihlomile	Dir: Public Health

C88 TECHNICAL INDICATOR DESCRIPTION

KPI No.	Key Performance Indicator	Short Definition	Purpose / Importance	Source / Collection of Data	Method of Calculation	Data Limitation	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
1	Number of incidents of improper disposal of medical waste responded to by the municipality	Counts all medical waste incidents attended and resolved.	To prevent environmental contamination and health hazards.	Environmental Health incident registers.	Number of incidents reported and resolved	Incomplete incident reporting.	Non-Cumulative	Quarterly	No	Reported incidents resolved	Dir: Env Health

KP I No.	Key Performance Indicator	Short Definition	Purpose / Importance	Source / Collection of Data	Method of Calculation	Data Limitation	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
2	100% Notifiable medical condition investigated within 3 days ³²	Counts all NMC cases investigated within the reporting period.	To reduce disease transmission through rapid response.	Regional outbreak reports.	Number of cases investigated	Delayed reporting from facilities and Region	Non-cumulative	Quarterly	No	Cases investigated within 3 days	Dir: PH
3.	Number of foodborne disease outbreak investigations following the prescribed protocols	Counts investigations completed following suspected foodborne outbreaks.	To protect communities against food safety risks.	Regional EH investigation reports.	Number of disease outbreaks for the reporting period	Laboratory result delays.	Non-cumulative	Quarterly	No	Cases investigated within 72hours	Dir: PH

³² Climate change resilience and environmental protection

13.5 SERVICE STANDARDS CHARTER

(Table with monthly targets)

Core Service	Reporting Period – 2026/2027											
	Service Level Standard monthly targets											
	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June
Average time spent by patients at the facility on monthly basis	Under 2.5 hours											
% of Complaint resolution at facility level within 25 days	100% complaints resolved within 25 days											
Percentage of complaints acknowledged within 72hrs	100% complaints received and acknowledged within 72 hours											
% of Notifiable medical conditions reported within 3 working days	100% Notifiable Medical conditions investigated within within 3 days											
Request for services attended by Environmental Health Services	100% of requests for services attended to, within 48 hours											
% of complaints received, investigated and routed to appropriate stakeholder for a service within 48hours												

9.5 b) TECHNICAL INDICATOR DESCRIPTIONS (KPI's DEFINITION FOR SERVICE STANDARDS)

KPI No.	Key Performance Indicator	Short Definition	Purpose / Importance	Source / Collection of Data	Method of Calculation	Data Limitation	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
Key Indicator: Percentage achievement of service standards `											
1	Average time spent by patients at the facility on monthly basis: Under 2.5 hours	Waiting times at clinics is the time interval for which one must wait after placing a request for an action or a service and before the action or service occurs. In health facilities it relates to time spent receiving services including health promotion and prevention messaging, clinical consultations, and the receiving of treatment.	The patient waiting time (PWT) highlights the bottlenecks or delays, it enables monitoring of the effectiveness of the health system's performance and assists in designing interventions to overcome these challenges.	Patients' records: Waiting time measuring form	Calculating time spend at the reception and time spend from vital area until consultation is completed	Inadequate human resource Challenges in submission due to loadshedding	Numerator and Denominator Sample size determination (240 patients). The headcount per day of each area and unit as follows: PHC Patient registration -240 patients per month i.e. collect and	Daily at facility and monthly submission	No	Expected minimum waiting times in service areas: Patient Registration = 30 minutes Vital Area until patient exit service = 180 minutes Ensure that patient does not spend more than 3 hours in the facility	Dir: DHSD

KP I No.	Key Performance Indicator	Short Definition	Purpose / Importance	Source / Collection of Data	Method of Calculation	Data Limitation	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
							capture 12 patients per day for 20 days. OPD (Acute, Mother Child, Chronic)- 240 patients per month i.e., 80 patients per month, per stream therefore, that means collecting and capturing 4 patients per day, per stream				
2	% of Complaint resolution at facility level within 25 days	A complaint is defined as the dissatisfaction, displeasure, disapproval, or discontent	To resolve problems and satisfy the concerns of the patients or their	Complaint form Telephonically E-mail Verbally	Number of complaints received, investigate, and resolved	Unable to reach a Complainant	Numerical	Monthly	Yes	Resolve all complaints	Dir: DHSD

KP I No.	Key Performance Indicator	Short Definition	Purpose / Importance	Source / Collection of Data	Method of Calculation	Data Limitation	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
		expressed verbally or in writing by any person about the specific health services being rendered and or care being provided within the health sector.	families/supporting. persons To avoid unnecessary litigation								
3.	Percentage of complaints acknowledged within 72hrs	A complaint is defined as the dissatisfaction, displeasure, disapproval, or discontent expressed verbally or in writing by any person about the specific health services being rendered and or care being provided within the health sector.	To resolve problems and satisfy the concerns of the patients or their families/supporting. persons To avoid unnecessary litigation	Complaint form Telephonically E-mail Verbally	Number of complaints received and acknowledged	Complainant not reachable	Numerical	Monthly		Acknowledge all complaints	Dir: DHSD
4	100% Notifiable Medical Conditions investigated within 3 days	▪Notifiable Medical Conditions are diseases that are of public health importance because they pose significant public health risks that can result in disease outbreaks	To provide scientifically proven and accurate information to detect and take steps to control the spread of infectious diseases such	Case notification form Notifiable medical condition Line listing	Number of conditions investigated and followed up within 3 days after being reported/ Number of conditions	Late reporting by health care facilities.	numerator and denominator	monthly and quarterly	NO	100% of cases to be followed up and investigated within 3 days after beginning reported	Public Health

KP I No.	Key Performance Indicator	Short Definition	Purpose / Importance	Source / Collection of Data	Method of Calculation	Data Limitation	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Indicator Responsibility
		or disease epidemics with high case morbidity and mortality rates both nationally and internationally. ▪ Notifiable Medical conditions are reported by Health facilities (Public and Private)	as epidemics. Additionally, to monitor and evaluate turnaround time of follow up and investigation of reported notifiable medical condition including rumour.	Outbreak response report.	investigated and followed up after 3 days						
5	Request for services attended by Environmental Health Services	This indicator measures the compliance to the Environmental health complaints policy	To ensure a safe Environment for the community at large.	Monitoring Tools completed by the Regions	A number of requests for services attended too.	Errors in completing the monitoring tool by regions	Cumulative	monthly and quarterly	NO	100% Request for services attended to	Dir: Environmental Health
6	% of complaints received, investigated and routed to appropriate stakeholder for a service within 48hours	This indicator measures the compliance to the Environmental health complaints policy	To ensure a safe Environment for the community at large.	Monitoring Tools completed by the Regions	A number of requests for services attended too.	Errors in completing the monitoring tool by regions	Cumulative	monthly and quarterly	NO	100% Request for services attended to	Dir: Environmental Health

SAFETY KPI'S

KPI No	Key Performance Indicator	Intervention	2024/25 Baseline	2026/27 Target	2027/28 Target	2028/29 Target	2026/27 Quarterly Performance Targets				2026/27 Budget per Project R 000						Means of Verification
							Q1	Q2	Q3	Q4	CAP EX	OPEX	Q1	Q2	Q3	Q4	
1 (IP# 3C1.4)	% Compliance in relation to the Ideal Clinic core standards in COJ health facilities in preparation for the NHI implementation	Provide access to an effective and re-engineered primary health care system which includes: • Providing access to quality health care facilities and efficient services • Promoting health and well-being of young people in City health care facilities	80%	80%	80%	80%	80%	80%	80%	80%							Annual Assessment Reports (Provincial). Outcome will be reported in Q4.

KPI No	Key Performance Indicator	Intervention	2024/25 Baseline	2026/27 Target	2027/28 Target	2028/29 Target	2026/27 Quarterly Performance Targets				2026/27 Budget per Project R 000						Means of Verification
							Q1	Q2	Q3	Q4	CAP EX	OPEX	Q1	Q2	Q3	Q4	
2 (IP# 3C1.5)	Percentage compliance to environmental health legislation for places of care, old-age facilities, schools etc.	Regularly inspect healthcare, old-age facilities, schools, etc.	90%	90%	90%	90%	87%	85%	87%	90%							Monitoring tool

KPI No	Key Performance Indicator	Intervention	2024/25 Baseline	2026/27 Target	2027/28 Target	2028/29 Target	2026/27 Quarterly Performance Targets				2026/27 Budget per Project R 000						Means of Verification
							Q1	Q2	Q3	Q4	CAP EX	OPEX	Q1	Q2	Q3	Q4	
3. (IP# 3C1.7)	Percentage increase in compliance of ECDs to regulation	Ensure compliance and regulatory mechanisms on unregistered schools i.e.: • Town Planning and Building Control • Public Safety Environmental Health	80%	80%	80%	80%	71%	73%	75%	80%							

KPI No	Key Performance Indicator	Intervention	2024/25 Baseline	2026/27 Target	2027/28 Target	2028/29 Target	2026/27 Quarterly Performance Targets				2026/27 Budget per Project R 000						Means of Verification
							Q1	Q2	Q3	Q4	CAP EX	OPEX	Q1	Q2	Q3	Q4	
4.	Percentage increase in level of satisfaction with supplementary services (to be applied to each service identified)	Address obstacles (eg lack of info, onerous documentation requirements / processes, limited / restricted operational hours, resource challenges, etc.) that relate to accessing supplementary services ³³ . This should include establishing and strengthening partnerships with civil organisations, NPOs, CPFs, CSFs, business, etc. for assistance	87%	80%	80%	80%	Annual Survey to be conducted in Q4	Annual Survey to be conducted in Q4	Annual Survey to be conducted in Q4	80% Quarterly Report on Customer satisfaction level based on the National PEC survey in COJ health facilities							Quarterly reports on customer satisfaction level based on Customer Charter implementation in COJ health facilities

³³ Supplementary services include but is not limited to: social safety nets; social service networks; community programmes run at recreation centres, libraries etc.; and healthcare facilities and services

14. Climate Action

As part of its corporate social responsibility, the city developed the Climate Action Plan as a contribution towards tackling the climate crises. Climate change is recognized as a crisis that must be tackled by the city.

14.1 Climate Action Plan

The city identified two Goals and Ten Themes identified under the Climate Action Plan:

Goal 1: Net Zero Emissions refers to city actions that are geared towards reduction in greenhouse gas emissions.

Goal 2: A Resilient City is about city actions that must be undertaken to protect the city against negative impacts of climate.

- Proper disposal of waste
- Contracted eligible private providers that will be registered for waste disposal at facilities.
- Hand washing campaigns are to be conducted every year, but the monitoring of the procedure is done daily to prevent cross-infection.

Summarised CAP themes (Under each theme are examples of measures or interventions)

MITIGATION Goal 1: NET ZERO EMISSIONS BY 2050 REDUCE THE SEVERITY OF CLIMATE CHANGE	ADAPTATION Goal 2: A CLIMATE RESILIENT CITY BY 2050 REDUCE THE IMPACT OF CLIMATE CHANGE
Affordable Clean Energy	Water Supply
Promote embedded and distributed generation (e.g., rooftop PV)	Improve water conservation and demand management
Increase share of renewable energy in the grid	Establish water recycling schemes
Eradicate energy poverty	Increase share of alternative, decentralise water sources
Improve energy efficiency and reduce share of fossil fuel use in industrial sector	Ensure water sensitive urban design
	Manage and monitor water quality
Optimised Energy Efficiency in Buildings	Resilient Human Settlement
Achieve net zero carbon, through efficiency and renewable, in all new public and private buildings built from 2030	Enhance community resilience through sustainable livelihoods programmes

Achieve net zero carbon in all existing buildings (through retrofits) by 2050	Develop safer settlements for vulnerable communities
Ensure all municipal operations and buildings are net zero carbon by 2030	Manage urban growth to decrease risk
	Promote sustainable and efficient land use
Green Transport	Flood and drought management
Enable mode shift towards public transport	Improve community and infrastructure resilience through land use and development planning
Promote non-motorised transport	Improve community infrastructure drought resilience through early warning systems and response planning
Enable fuel switching to cleaner fuels and electric vehicles	
Improve vehicle fuel efficiency	
Ensure transit-oriented development	
Alternative Waste Management	Resilient infrastructure
Reduce waste	Protect municipal infrastructure
Divert recyclables from landfill and incineration	
Optimise organic waste management	
Optimise waste collection and treatment	
Improved water supply and wastewater treatment	Healthy communities
Improved wastewater treatment (environmentally friendly)	Protection to heat related effects
Improve water pumping efficiency	Improve air quality
Water demand management	Improve resilience against disease
	Support local sustainable agriculture
	Establish early warning systems for climate hazards

Analysis Table

The Health Department responds to the following Climate Change:

CAP Theme	Departmental/Entity Strategic Objective	Departmental Programme/Projects/Activities
1.Affordable Clean Energy		Planned new and renewal clinics incorporates clean energy elements such as solar. Incrementally employ an energy mix in facilities where solar is the primary source, Eskom the secondary source, and generators are the tertiary source.
2.Optimized Energy Efficiency in Buildings		Planned new and renewal clinics incorporates energy efficient designs. The use of energy efficient construction methodology and materials.
4.Alternative Waste Management		
5.Improved Water Supply & Wastewater Treatment		Reticulated water back-up systems employed at clinics. Rainwater harvesting to boost supply to landscaped gardens, vegetable gardens and use around the clinic yard.
6. Water Security	Promotion of healthier environments to improve health by addressing environmental stress factors e.g., food poisoning, water quality, vector borne diseases and illegal dumping sites.	Water quality monitoring
7. Resilient Human Settlement		Provision of primary health care services in all human settlements through permanent buildings, temporary modular structures, porta-cabins and mobile clinics.

		Advocating for securing land parcels during township establishment processes for health-, social-, and community-facilities.
8. Flood & Drought Management		Observing 50- and 100-yr flood lines for building construction. Raising the concern for current facilities that are situated within flood lines.
9. Resilient Infrastructure		Land and building sanitation. Low maintenance building construction. Sustainability elements incorporated into buildings.
10. Healthy Communities	Promotion of healthier environments to improve health by addressing environmental stress factors e.g., food poisoning, vector borne diseases and illegal dumping sites.	Prevention of Vector borne diseases programme Illegal dumping Food safety surveillance
	Address the Quadruple Burden of disease through Prevention, management, and control of communicable (HIV/AIDS and Tuberculosis etc.), non-communicable diseases (Hypertension and diabetes etc.), maternal mortality, child mortality and gender-based incidences	Jozi Ihlomile programme Immunization programme Outbreak response teams in place in all regions for early identification of communicable diseases.
	Improving access to primary health care	5 Year Capital Plan. Regional motivations for infrastructure improvements. Line list of approved major and minor projects. Populating the JSIP System indicating the need for clinics.
	Ensuring NHI readiness through PHC re-engineering by strengthening the <u>District Health Systems</u> and improving Primary Health Care services in the city.	Ideal clinic programme. Compliance of facilities to Ideal Clinic prescripts.

The City of Johannesburg identified five interventions under the Healthy Communities CAP Theme. To ensure commitment to corporate social responsibility, the Health Department, responds to two out of the five Climate Change Action Plans. Linked to the Healthy Communities Themes, are activities which are monitored through Key Performance Indicators.

	HEALTH PROGRAMMES/ACTIVITIES	KEY PERFORMANCE INDICATORS
Protection to heat related effects		
Improve air quality	Promotion of healthier environments to improve health by addressing environmental stress factors e.g., air Quality. • Environmental health assessments	% Request for services attended to: Air Quality Management
Improve resilience against disease	Promotion of healthier environments to improve health by addressing environmental stress factors e.g., food poisoning, vector borne diseases and illegal dumping sites. • Health Promotion	Number of health awareness programmes conducted
Support local sustainable agriculture		Provision of space within clinic yards for a community food garden that may support the indigent and ill.
Establish early warning systems for climate hazards		Develop emergency response plans for clinics located in flood lines to ensure timeous response in time of crises.

15. FINANCIAL IMPACT

15.1 Budget and sources of funding

STRATEGIC INTERVENTIONS AND PROGRAMMES	IDP Code	Current year 2024/25			Medium-Term Budget 2025/26 - 2027/28			
		Approved Budget 2024/25	Adjustment 2024/25	Adjusted Budget 2024/25	Draft Budget 2025/26	Incr.	Draft Budget 2026/27	Draft Budget 2027/28
Food security that is both improved and safeguarded / Pest Control / Air Pollution	OT001	244 440	3 497	247 937	261 106	5,3%	274 979	290 624
Implementation of the City's Substance Abuse Strategy	OT002					0,0%		
Jozi Ihlomile Program	OT003	26 210	5 910	32 120	33 794	5,2%	35 554	37 515
Management Support / E-Health / Clean Audit	OT004	107 700	29 061	136 761	136 164	-0,4%	142 870	150 081
Maternal Health Care/Children Health Care/HIV and AIDS/ Communicable Disease	OT005	1 089 186	11 030	1 100 216	1 158 760	5,3%	1 220 413	1 290 059
Rollout of Mobile Clinics to increase access to primary health care	OT006	14 577	1 054	15 631	16 432	5,1%	17 276	18 205
TB / HIV and AIDS	OT007	2 617		2 617	2 756	5,3%	2 902	3 069
The expansion of extended hour libraries and clinics within the city	OT008	57 254	8 155	65 409	68 561	4,8%	71 866	75 367
Initiate and fund localised female dignity packs	OT009	31		31	32	3,2%	33	34
Day-to-day programme						0,0%		
TOTAL - DIRECT EXPENDITURE	----->	1 542 015	58 707	1 600 722	1 677 605	4,8%	1 765 893	1 864 954

KEY PRIORITIES	IDP Code	Current year 2024/25			Medium-Term Budget 2025/26 - 2027/28			
		Approved Budget 2024/25	Adjustment 2024/25	Adjusted Budget 2024/25	Draft Budget 2025/26	Incr.	Draft Budget 2026/27	Draft Budget 2027/28
Good governance	A	32 132	-68	32 064	33 666	5,0%	35 349	37 176
Financial sustainability	B	52 858	23 955	76 813	73 168	-4,7%	76 668	80 356
Sustainable service delivery	D	1 190 400	26 804	1 217 204	1 281 570	5,3%	1 349 335	1 425 599
Job opportunity and creation	F	5 616		5 616	5 916	5,3%	6 233	6 591
Safer city	G	244 440	3 497	247 937	261 106	5,3%	274 979	290 624
Smart city	K	16 569	4 519	21 088	22 179	5,2%	23 329	24 608
Day-to-day programme	DTD					0,0%		
TOTAL - DIRECT EXPENDITURE	----->	1 542 015	58 707	1 600 722	1 677 605	4,8%	1 765 893	1 864 954

Current year 2024/25	Medium-Term Budget 2025/26 - 2027/28
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GDS OUTPUTS	IDP Code	Approved Budget 2024/25	Adjustment 2024/25	Adjusted Budget 2024/25	Draft Budget 2025/26	Incr.	Draft Budget 2026/27	Draft Budget 2027/28
A society characterised by healthy living for all	A04	1 210 562	26 813	1 237 375	1 302 745	5,3%	1 371 562	1 448 965
A safe and secure city	A05	244 440	3 497	247 937	261 106	5,3%	274 979	290 624
A 'Smart' City of Johannesburg, that can deliver quality services to citizens in an efficient	C04	16 569	4 519	21 088	22 179	5,2%	23 329	24 608
A responsive, accountable, efficient, and productive metropolitan government	D02	17 586	-77	17 509	18 407	5,1%	19 355	20 401
Financially sustainable and resilient city	D03	52 858	23 955	76 813	73 168	-4,7%	76 668	80 356
Day-to-day programme						0,0%		
TOTAL - DIRECT EXPENDITURE	----->	1 542 015	58 707	1 600 722	1 677 605	4,8%	1 765 893	1 864 954

15.2 Operational Budget

The Health Department Operational Budget allocation for the coming years is listed below.

Health	2022/23	2023/24	2024/25	Current year 2025/26				Medium-Term Budget 2026/27 - 2028/29					
	Audited Outcome	Audited Outcome	Audited Outcome	Approved Budget	Budget Reallocation	Adjustment	Adjusted Budget	Draft Budget	Incr.	Draft Budget	Incr.	Draft Budget	Incr.
	R 000	R 000	R 000	2025/26 R 000	R 000	R 000	2025/26 R 000	2026/27 R 000	%	2027/28 R 000	%	2028/29 R 000	%
EXCHANGE REVENUE													
NON-EXCHANGE REVENUE													
Licences or permits	-1 807	-2 225	-2,105	-3 577			-3,743	-3,877	3.6%	-4,019	3.7%	-4,160	3.5%
Transfer and subsidies - Operational	-178 586	-179 391	-197,742	-207 233		516	-216,799	-224,604	3.6%	-232,914	3.7%	-241,066	3.5%
Operational Revenue	-561	-597							0,0%		0,0%		0,0%
DIRECT REVENUE	-180 954	-182 213	-199,847	-210 810		516	-220,542	-228,481	4,6%	-236,933	3,7%	-245,226	3,5%
Internal Transfers													
Costing - Internal Revenue				-403			-403		-100,0%		0,0%		0,0%
Total Internal Transfers				-403			-403		-100,0%		0,0%		0,0%
TOTAL REVENUE excluding capital grants/contr.	-180 954	-182 213	-182 293	-211 213			-211 213	-220 509	4,4%	-230 655	4,6%	-241 032	4,5%
EXPENDITURE by type													
Employee related costs	1 257 676	1 277 196	1,332,375	1 403 632	-10,153	197	1,510,247	1,581,954	3.6%	1,664,983	5.2%	1,752,369	5.2%
Inventory consumed	3 535	3 222	4,071	14 261	-1,109		12,266	12,707	3.6%	13,175	3.7%	13,634	3.5%
Depreciation and amortisation	43 492	61 704	51,941	51 941			64,083	66,376	3.6%	68,820	3.7%	71,218	3.5%
Interest									0,0%		0,0%		0,0%
Contracted services	9 743	10 966	23,702	11 578	2,171	10,400	25,888	26,825	3.6%	27,818	3.7%	28,792	3.5%
Transfers and subsidies	8 776	9 360	9,711	10 177	505		11,042	11,440	3.6%	11,863	3.7%	12,278	3.5%
Operational costs	78 034	85 705	83,353	50 426	8,586	-713	56,236	58,257	3.6%	60,413	3.7%	62,525	3.5%
Losses on disposal of Assets		1 130							0,0%		0,0%		0,0%
DIRECT EXPENDITURE	1 401 256	1 449 284	1,505,153	1 542 015		9,884	1,679,762	1,757,559	3.6%	1,847,072	5.1%	1 864 954	5.1%
Internal Transfers													
Operational costs - Inter-Company	237		1,923	2,011			2,011	2,104	4.6%	2,199	4.5%	2,298	4.5%
Costing - Internal Expenditure	66,506	66,591	110,191	115,472			115,472	120,763	4.6%	126,191	4,5%	131,864	4,5%
Total Internal Transfers	66,743	66,591	112,114	117,483					4.6%		4,5%		4,5%
TOTAL EXPENDITURE	1 465 720	1 516 027	1 522 659	1,566,303		9884	1,576,703	1,651,945	4,9%	1,738,529	5,2%	1,829,752	5,6%
OPERATING (SURPLUS) / DEFICIT	1 284 766	1 333 814	1 340 366	1,566,303		10,400	1,576,703	1,651,945		1,738,529		1,829,752	
Capital Transfers Recognised													
Transfers and subsidies - capital (monetary allocations)	-10 000		-72 915						4,6%		4,6%	-76 961	4,5%
OPERATING (SURPLUS) / DEFICIT	1 274 766	1 333 814	1 267 451	1,566,303		10,400	1,576,703	1,651,945		1,738,529		1,829,752	5,8%
Income Tax									0,0%		0,0%		0,0%
OPERATING (SURPLUS) / DEFICIT - after tax	1,274,766	1,333,814	1,298,596	1,566,303		10,400	1,576,703	1,651,945		1,738,529		1,829,752	

15.3 CAPITAL BUDGET

CITY OF JOHANNESBURG

DRAFT DETAIL MEDIUM-TERM CAPITAL BUDGET 2025/26 - 2027/28

Project Name	Project Number	TSR	Total Estimated Project Cost R 000	Budget 2025/26 R 000	Budget 2026/27 R 000	Budget 2027/28 R 000
Health						
Hikensile Clinic Renewal Clinic IVORY PARK EXT9 A Ward	2647		56,363	23,753	28,000	4,610
Operational Capital Spend for Health Renewal Operational Capex JOHANNESBURG F City Wide	2656		2,000			2,000
2660_00_MINOR WORKS at various clinics across the City Renewal Clinic JOHANNESBURG F City Wide	2660		15,289	5,289		10,000
Naledi clinic New Building NALEDI D	3059		1,354	1,354		
Elias Motsoaledi clinic Renewal Building DUBE EXT2 D	3060		41	41		
Rabie Ridge Clinic Renewal and Community Health Centre New RABIE RIDGE A	3068		41	41		
Freedom Park New Clinic DEVLAND EXT30 G Ward	3075		164	164		
AIRCONDITIONERS: Supply install and renew airconditioners in Health Facilities across the city New Clinic JOHANNESBURG F City Wide	3369		710		210	500
3370_00_Electricity Upgrades Solar Generators UPSs and Back-up Electricity for Health Facilities across the city New Clinic JOHANNESBURG F City Wide	3370		8,160	2,460	700	5,000
10_22684_WAN & LAN Upgrade	23550		3,000			3,000
03_22684_Hardware	23555		2,410	410		2,000
08_22684_Software for Environmental Health System	23570		16,200	4,100	2,100	10,000
Sustainable Reticulated Water Back-up Systems at Clinics City Wide	31228		2,596	246	350	2,000
Sub Total				37,858	31,360	39,110

<u>Insert all other and new capital project requests under this section</u>	Insert JSIP No.	Approved 3 yr MTB Increase (Decrease)	Approved Budget	Adjust-ment	Adjusted Budget	Approved Budget	Adjust-ment	Draft Budget	Approved Budget	Adjust-ment	Draft Budget	Draft Budget
Langlaagte Pharmacy Depot		2,000					1,000	1,000		1,000	1,000	30,000
Lawley Ext 1 Clinic Renewal Clinic LAWLEY G Regional		500					300	300		200	200	30,000
Marlboro Clinic Alexandra												1,000
Petervale Clinic												1,000
PRINCESS Renewal Clinic PRINCESS C Ward		500					300	300		200	200	40,000
Randburg Renewal Clinic BLAIRGOWRIE B Ward		2,000					1,000	1,000		1,000	1,000	5,000
Riverside Diepsloot New Clinic												1,000
Sandown Clinic												1,000
Senaoane Clinic												1,000
Sophia Town Clinic New Clinic TRIOMF B Ward												
Thuthukani Clinic		18,000					3,000	3,000		15,000	15,000	50,000
SIPHUMLILE Renewal Clinic ROODEPOORT C												1,000
Nokuphila Clinic												1,000
TPA Ivory Park Clinic												1,000
Retrofitting Electrical and Mechanical		6,000					2,000	2,000		4,000	4,000	6,000
Reticulated Water Back-up Systems		14,000		1,000	1,000		5,000	5,000		8,000	8,000	5,000
Shanty Clinic		4,000					1,000	1,000		3,000	3,000	30,000
Title Registration and Building plan submissions		100					100	100				
Total: Other and new capital project requests		47,100		1,000	1,000		13,700	13,700		32,400	32,400	204,000
GRAND TOTAL		509,431	57,928	35,519	93,447	53,743	196,700	250,443	47,688	277,212	324,900	544,500

16. MANAGEMENT AND ORGANISATIONAL STRUCTURE

The Health Department is responsible for ensuring that the residents of the COJ are provided with the opportunity for a long and healthy life. The Department is part of the Human & Social Development Cluster which also comprises the following other departments and entities:

- Public Safety
- Social Development
- Community Development (Sports & Recreation, Arts, Culture& Heritage, and Libraries)
- City Parks and Zoo
- City Theatres

16.1 Organisational structure

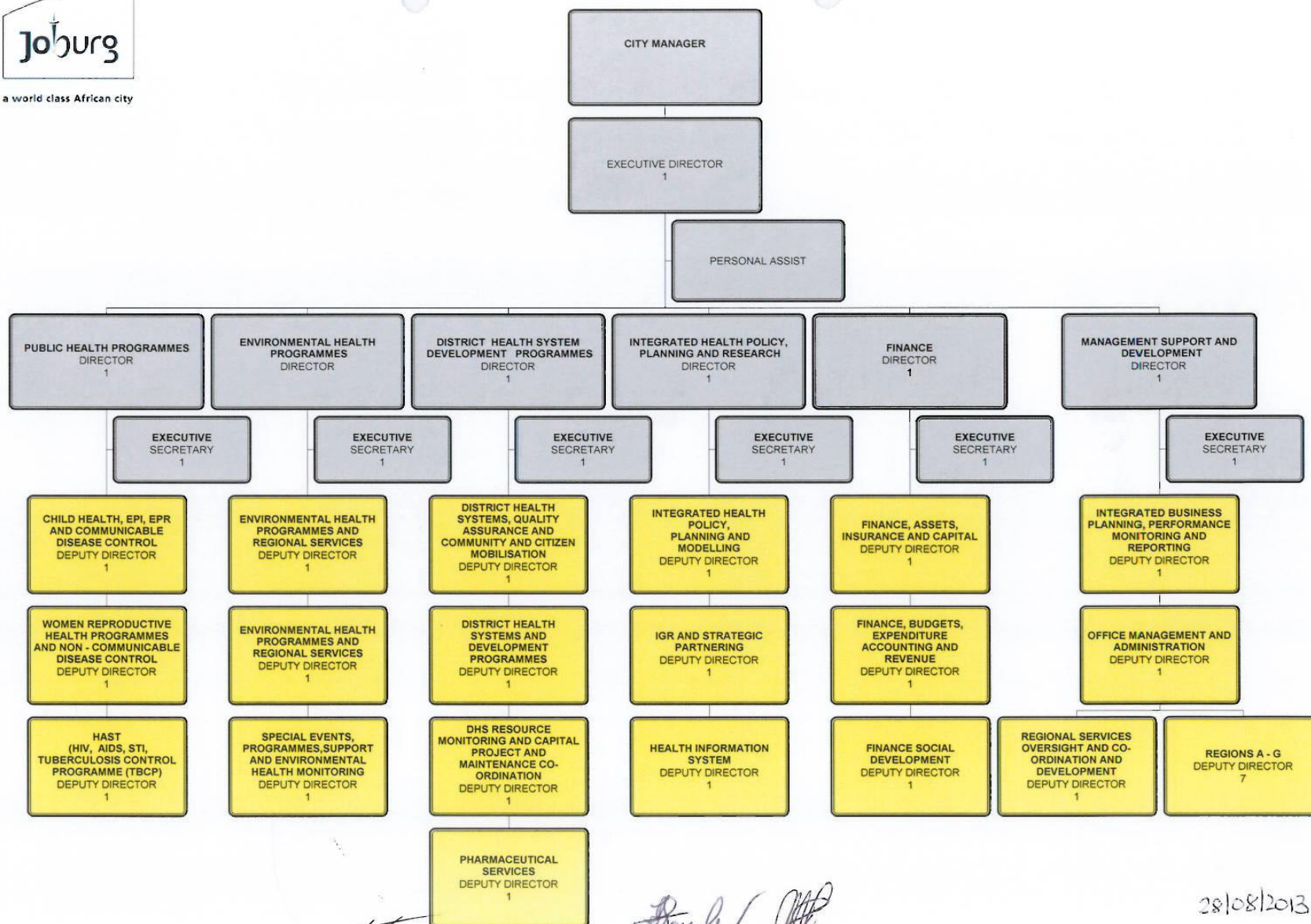
Health organisational structure sees below.



a world class African city

HEALTH DEPARTMENT - 2012

ANNEXURE C - P



APPROVED

GROUP EXECUTIVE DIRECTOR CITY MANAGER EXECUTIVE MAYOR

DATE

28/08/2013

16.2 Management Team

The department is organised into **six central units** headed by Directors (District Health Systems Development; Public health programmes, Finance, Environmental Health, Integrated Planning, Policy, and Research as well as Management Support and Development) headed by the **Executive Director responsible** for the delivery of all primary health services that are rendered as per the 7 service delivery Regions in the City.

The Department has a staff compliment of **3177**. The Department is affected in its mandate by its inability to recruit and retain the skilled work force that it requires due to competitive salary packages that are offered by the surrounding Metros and the Gauteng Health Department as well as the increased service demands including preparations towards the National Health Insurance implementation.

16.3 Capacity analysis

The Department has challenges in attracting professional nurses, medical doctors, and environmental health personnel. This has been worsened by surrounding Metros, Gauteng Health Department and the private sector that pays competitive salaries to those of the City of Johannesburg.

16.4 Employment equity

Row Labels	African	Asian	Coloured	Indian	White		African	Asian	Coloured	Indian	Others	White		
Health	2062	9	45	15	27	2158	964	1	30	4	1	14	1014	3172
A) Top Management	1					1								1
B) Snr Management	16	1			1	18	20				1	2	23	41
C) Profess & Mid Management	28		1		2	31	16					3	19	50
D) Skilled & Jnr Management	874	8	14	13	18	927	315	1	7	2		6	331	1258
E) Semi-skilled	507		11		6	524	418		16	2		2	438	962
F) Unskilled	120		15	2		137	92		5			1	98	235
G) Temp	33					33	5						5	38
H) EPWP	483		4			487	98		2				100	587

Foreigner					
	Female	Female Total	Male	Male Total	Grand Total
	African		African		
B) Snr Management			1	1	1
D) Skilled & Jnr Management	2	2	1	1	3

PWD's

Count of Employee Group	Column Labels								
	Female			Female Total	Male			Male Total	Grand Total
Row Labels	African	Coloured	White		African	Coloured	White		
D) Skilled & Jnr Management	5		1	6	6			6	12
E) Semi-skilled	4		2	6	2			2	8
F) Unskilled	3			3	1			1	4

17. COMMUNICATION AND STAKEHOLDER MANAGEMENT

17.1. Stakeholder engagement

The Department is focussed on changing perceptions and building trust among the communities that it serves. Various engagements are conducted throughout the city. These engagements interactions are aimed at fostering mutual understanding and building stronger relations between the city and its residents.

Annual meetings/Community Based Planning meetings are held at various Regions, where the Department SDBIP is presented. During these meetings, community members are afforded an opportunity to engage with health officials on various programmes offered by the department. Health representatives also attend the Community Based Planning meetings at various regions.

17.2 Stakeholder Matrix

Stakeholder	High Influence	High interest	Keep informed /Reporting/ Compliance
Political leadership	Yes	Yes	Keep informed
National Department of Health	Yes	Yes	Reporting
Gauteng Department of Health	Yes	Yes	Reporting
National Treasury	Yes	Yes	Compliance
Auditor General	Yes	Yes	Compliance
Community	No	Yes	Keep informed
NGO's	No	No	Keep informed
GSPCR	No	Yes	Reporting
Governance	No	Yes	Reporting
Group Finance	Yes	Yes	Reporting

17.3 Communication plan

(Key messages and success factors/Stakeholder Matrix)

The purpose of communication is to inform the community on the key health programmes that will be rolled out in their communities or any success stories that the department would like to share. Mass media of communication is used to for this purpose. Information is shared through the following platforms:

1. Multidisciplinary and multisectoral communication
2. Engage stakeholders for demand creation media.
3. Communication to the community members via social media platforms, local radio stations e.g., Jozi FM, Alex Radio, Eldo's FM, local newspaper Caxton newspaper
4. Develop News bulletin to update communities on health awareness plan.
5. Engage Civil Society Sectors (Traditional Health Practitioners etc (THPs), community leaders and hostel indunas.
6. Design and distribute a social mobilization and engagement strategy/demand plan and information awareness program.
7. Strategies include advocacy, communications, social mobilization, risk and safety communications, community engagement, and training to generate confidence, acceptance, and demand for services.
8. Ward based stakeholders' engagements, community education and mobilisation – clinic committee and ward health sector representatives, WHBOT and JI field workers.
 - WHBOT daily visiting of households.
 - Jozi Ihlomile: Door –Door education daily
 - COJ messages and Jozinet weekly and monthly calendar of events awareness messages
 - Health Promotion Social Mobilization Plan: weekly and monthly
 - Print pamphlets and Display posters.
 - Standardized message to be communicated during loud hailing, radio slots.
 - Engagements with Ward Councillors to encourage community members' participation and lead the ward-based activities.
 - Bulk mails to NGOs, FBOs, CBOs and other stakeholders
 - Bulk SMSs where possible to community members
 - Daily and continuous talks at facilities by health promoters to the relevant groups
 - Training/Orientation of field Workers: WHBOT, Jozi/ health sector reps. Community Policing Forum/ Social Development EPWP

Health events for the 2026/2027

Month	Health Event	Unit responsible	Medium of communication	Region
January	Cervical Cancer Awareness Month	PH in collaboration with Health promotion for mobilization	Word of Mouth, events, media, pamphlets etc.	All
February	Healthy Lifestyle Awareness Month	DHSD in collaboration with regions	Word of Mouth, events, media, pamphlets etc.	All regions
	Reproductive Health Month	PH in collaboration with Health promotion for community mobilization	Word of Mouth, events, media, pamphlets etc.	Central in collaboration with regions
	Environmental Health Awareness Month	EH with involvement of DHSD where mobilization is needed	Word of Mouth, events, media, pamphlets etc.	Regions, supported by central
March	TB Awareness Month	PH in collaboration with regions and health promotion support.	Word of Mouth, events, media, pamphlets etc.	Central and regions
April	Health Awareness Month	All Units in collaboration with Health promotion	Word of Mouth, events, media, pamphlets etc.	All Units and regions
	World Health Day	Environmental Health	Word of Mouth, events, media, pamphlets etc.	All regions
May	No Tobacco Awareness Month	Environmental Health in collaboration with health promotion for social mobilization	Word of Mouth, events, media, pamphlets etc.	ALL Regions supported by central
June	Men's Health Month	PH supported by regional health Programmes and health promotion		Central and regions

	World food safety day	EH	Word of Mouth, events, media, pamphlets etc.	Central and regions
July	Mental Illness Awareness Month	PH and regional health Programmes in conjunction with health promotion	Word of Mouth, events, media, pamphlets etc.	PH and regions
August	National Immunisation Awareness Month	PH in collaboration with Health promotion for mobilization	Word of Mouth, events, media, pamphlets etc.	All
	World Breastfeeding Week	PH in collaboration with Health promotion for mobilization	Word of Mouth, events, media, pamphlets etc.	All
September	Breast Cancer Awareness Month	PH and collaboration with regional Programmes	Word of Mouth, events, media, pamphlets etc.	Central PH and Regions
	Mental Health Awareness Month	PH and regional Programmes	Word of Mouth, events, media, pamphlets etc.	Central PH and regions
	World Environmental Health Day	Environmental Health	Word of Mouth, events, media, pamphlets etc.	All Regions
October	Lead Poisoning Prevention Week	EH in collaboration with health promotion	Word of Mouth, events, media, pamphlets etc.	Central EH and regions
	World Polio Day		Word of Mouth, events, media, pamphlets etc.	
	World food day		Environmental Health	All Regions
December	World AIDS Day	PH in collaboration with Province and national where possible. Health promotion for social mobilization		Central PH and regional health Programmes

19. Annexure A Risk Assessment

Risk Register- 2025/2026

Reference No.	Objectives	Risk Name	Root Causes	Consequences	Likelihood	Inherent Likelihood Rating	Inherent Risk Rating	Inherent Risk Exposure	Current controls	Control Effectiveness	Control Effectiveness Factor	Aggregate Control Effectiveness Factor	Residual risk Rating	Residual Risk Exposure	Risk Owner	Actions to improve management of the risk	Action Owner	Time scale
1	Address the Quadruple Burden of disease through Prevention, management, and control of communicable (HIV/AIDS and Tuberculosis etc.), non-communicable diseases	Inadequate provision of health service by the department	1. Inadequate resources: Resources (Human and skills) Medical equipment Financial Constraints (due to city's low revenue generation and budget rebasing)	1) High mortality and morbidity rate 2) Poor service delivery 3) Increasing cost incurred by health care system 4) Litigations 5) Increasing need for specialized health care workers 6) Increasing need for access to health care	Almost Certain	5	25	Very High	1.1. 2013 Approved organizational structure 1.2. Extended service hours 1.3. Jozi Ihlomile programme 1.4. Secondments of WBPHCOT (Ward based primary health care outreach teams) 1.5. Internship Programs 1.6. Inhouse training of nurses in primary care nursing 1.7. Training of environment practitioners	Partially Effective	40	56	14	High	Executive Director	1.1 Filling of positions as approved by the strategic appointment panel 1.2. Explore PPP (Public Private Partnerships) 1.3. Motivate for additional budget	1. Dir. MSD 2. Dir. IPPR 3. Dir. Finance	1. Ongoing depending on approval 2. 30 June 2026 3. As per finance Timelines

[illegible]

200

[illegible]

[illegible]

								where necessary.										
			4. Unsuitable structures for health service provision.					No control	None	100								
3	Promotion of healthier environments to improve health by addressing environmental stress factors e.g., food poisoning, vector borne diseases and illegal dumping sites.	Inadequate addressing of municipal health services	1. Losing experienced employees	1. Poor quality of work 2. lack an attention to details by staff 3. infrequent inspection of premises 4. poor customer service	Almost Certain	5	25	Very High	1.1. Paying staff at the midpoint of the salary bracket 1.2. Adjusted/increased car allowance provided to staff	Partially Effective	40	50	13	High	Executive Director	1. Maintain and implement existing controls		
			2. Staff shortfall according to the norms and standards					2.1. Continuous motivation for staffing budget submitted.	Ineffective	80						2. Filling the positions as per the approval strategic appointment panel	Director: Environmental Health	30 June 2026
			3. Inadequate Continuous development training					3.1. the department has availed subsidized education to all the staff members 3.2. develop internal training material for	Partially Effective	40						3.1 Improve and increase the number of trainings 3.2. Establishment	Director: Environmental Health	31 March 2026

			4. Unavailability of staff due to exposure to hazardous substances					staff 3.3. conduct in-service training 3.4 Training at development committee							of journal club for the training of practitioners		
			5. Personal safety and security of environmental health practitioners					4. Provide staff with PPE and conduct periodic medical surveillance of staff	Partially Effective	40					4.1. Conduct a regulated training course for Pest controllers 4.2. Procure PPE 4.3 Develop SOP on the use of PPE	Director: Environmental Health	4.1 30 March 2026 4.2 30 March 2026 31 December 2025
			6. Inadequate tools of trade e.g. pest controls vehicles in other regions					5.1. Provided with cell phones 5.2. Partnered with JMPD/SAPS to escort environmental health practitioners 5.3. Law enforcement forum	Partially Effective	40							
								6.1. Pest controls fleet 6.2. PPE provided	Less Effective	60							
4	Ensuring NHI readiness through PHC re-engineering by strengthening the District Health Systems and improving	Failure to acquire the NHI accreditation	1.Lack coordination amongst private and public healthcare stakeholders	Inadequate quality of care	Almost Certain	5	25	Very High 1.1. Assessments (NDoH and Office of Health Standards Compliance) of clinics in terms of National	Partially Effective	40	70	18	High	Executive Director	1.1 Develop a communication strategy for a successful buy-in for	Director: DHS D	1.1 30 September 2025 1. 2. Quarterly 2. Quarterly 3. 31 March 2026

																Health Standards Compliance and PPTICRM 4.2 Develop Quality Improvement Plans		
5	Strengthen good governance and prudent financial management by ensuring adherence to existing legislation, protocols, and policies	Governance Failure	1. Rebasing of the operational budget	1. Poor service delivery 2. Noncompliance to MFMA and other legal prescripts 3. Non achievement of set targets 4. inability to spend the allocated budget 5. Litigations	Almost Certain	5	25		1. Contract and tender register updated on a monthly basis 2. Report to senior management regarding the contract and tender management register 3. Inform user departments 9 months prior the contract ending to commence with the renewal of contracts and tenders 4. Performance management system in	Less Effective	60	60	15		Executive Director		Dir. MSD & Dir. Finance	
			2. ineffective and inefficient Internal controls							Less Effective	60					2. Engage SCM to improve monitoring and evaluate the contracts and tenders to ensure suitable service providers		30-Sep-25
										Less Effective	60					3. Engage Group Risk to conduct a contract risk		31-Dec-25

									place							assess ment		
									5. Monitor and evaluate the contracts and tenders with supply chain management							4. Engage Group Internal Audit to conduct audit on tenders and contract s with the focus on duration of the awardin g of the tenders and contract s		Dec-25
			3. Inadequate performance management							Less Effectiv e	60					5. Ongoin g Training of Officials from Assista nt Director to Upward s on BID Commit tee and the implem entation		Ongoing

																of contract		
			4. Inadequate supply chain and contract management processes															
6	1. Digitalization of the health Department: Enhance operational efficiency, data management, promote collaboration and integration of systems and use digital technologies to make health care services more accessible	Lack of Digitalization of the Department	1. Lack of resources (Financial and Equipment (such as gadgets)	Long waiting times Failure to acquire the NHI certification Poor records management High inefficiencies	Almost Certain	5	25	Very High	1.1 Desktops and Laptops 1.2 Procurement plan	Ineffective	80	58	14	High	Executive Director	1.1. Motivate for budget allocation 1.2. Expedite finalization of insurance claims (of lost or damaged gadgets and IT equipment)	Dir. IPPR	Mid Term
			2. Lack of offline capability,						1. SLA with MTC (regarding project development of the systems)	Less Effective	60					7.1 Continuous engagement with MTC	Dir. IPPR	Quarterly
			3. Implementing agency not adhering to TOR,						1. SLA with MTC (regarding project development	Less Effective	60					Continuous engagement	Dir. IPPR	Quarterly

4. System Reliability & Availability (network)	5. Lack of Interoperability & Integration	6. Poor Uptake appetite	of the systems) 2. Continuous meetings with MTC			with MTC	8.1 Engaging with internal (MTC, GICT) and external stakeholders (national department)	Dir. IPPR	Quarterly
			1. Fiber 2. Backup systems 2. Backup generators	Less Effective	60				
			1. SLA with MTC (regarding project development of the systems)	Less Effective	60				
			1. Training of the trainer 2. Training of the superusers	Partially Effective	40		1. Continuous training of the users 2. Identifying and acknowledging super users and use	Dir. IPPR	Quarterly (after the acceptance of the system)

																them as an example		
			7. Insufficient testing and debug					1. Terms of reference 2. Systems Designs	Partially Effective	40						1. Continuous testing, debug and corrections	Dir. IPPR	Quarterly
6	Promotion of healthy lifestyles to improve the quality of life	Inability to reach out to the community	1. Lack of transportation	High morbidity and mortality increasing burden of non-communicable diseases	Possible	3	15	High	1. Health promoters receive a locomotion allowance	Effective	20	20	3	Low	Executive Director	1. Maintain current controls		Quarterly
			2. Inadequate resources (Human)					2. Coordination of health promotion stakeholders	Effective	20								
			3. Safety and security of staff					3.1 Travelling in groups 3.2 Integrate with environmental health practitioners	Effective	20								
			4. Unavailability of IEC materials in different languages					4. Coordination of IEC material provided by province in limited languages	Partially Effective	40								