ANNUAL PERFORMANCE PLAN 2026 - 2027

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

2030 NDP

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Department:
Health
REPUBLIC OF SOUTH AFRICA

ANNUAL
PERFORMANCE PLAN
2026 - 2027

STATEMENT BY THE MINISTER OF HEALTH

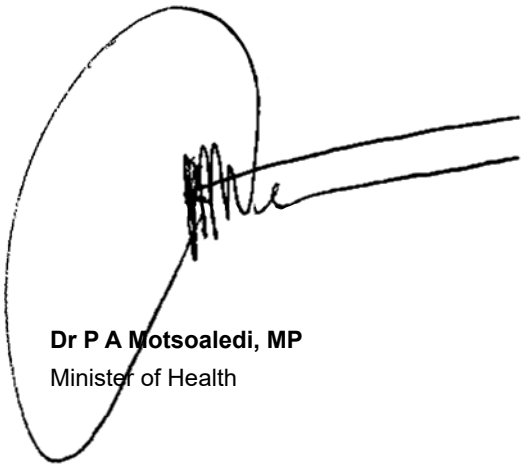
Dr P A Motsoaledi, MP
Minister of Health

Through the Medium-Term Development Plan 2024-2029, government has committed to reducing poverty and tackling the high cost of living, which can be achieved by addressing inequality, vulnerability and social ills. The department of health recommits to this endeavour as we transition to the 2026/2027 financial year.

Our response to the prevention and elimination of Human Immunodeficiency Virus (HIV) has been intensified by the introduction of Lenacapavir. In this financial year, this long-acting antiretroviral drug used for HIV prevention will be introduced in selected high-burden districts. Further expansion will target access for young people, rural communities and marginalized groups.

The country is actively accelerating towards cervical cancer elimination by 2030, targeting an incidence of less than 4 per 100,000 women. The elimination strategy focuses on the World Health Organisation 90-70-90 targets, which translates to 90% Human Papillomavirus Vaccination (HPV) coverage for girls under 15, 70% screening coverage using high-performance tests, and 90% treatment for identified cases. Furthermore, we are targeting an increased coverage of HPV screening for cervical cancer as well as increasing access to contraceptives and other Sexual and Reproductive Health services especially for young women and adolescent girls. The identified infrastructure projects outlined in this plan are crucial in addressing long-standing barriers to access health care in underserved population. These projects align with the National Infrastructure Plan 2050, ensuring that facilities are financially sustainable and capable of supporting South Africa's long-term healthcare needs.

The year 2030 is on the horizon, and this annual plan reaffirms our continued efforts to align with the National Development Plan's goal on achieving equitable access to quality health care through the National Health Insurance.



Dr P A Motsoaledi, MP
Minister of Health

STATEMENT BY THE DIRECTOR-GENERAL

Prof. N. Crisp
Acting Director-General: Health

I am pleased to present the National Department of Health's Annual Performance Plan for 2026/2027 financial year. Significant gains have been noted in the sector in the past year with life expectancy improving to 66,5 years in 2025. The interventions in place to address leading causes of mortality for expectant mothers and children are yielding positive results with Under-5 mortality rates decreasing to 28.6 deaths per 1 000 live births and institutional maternal mortality ratio also reduced to 105.5 deaths per 100 000 live births by March 2025.

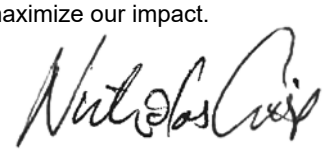
Through collaboration with the World Health Organization, the department has reinvigorated its pledge for its leadership directed at accelerating Universal Health Coverage aimed at promoting equitable access to quality healthcare for all without financial hardship. To this end, our interventions are aligned with strengthening Primary Health Care as well as intensifying strategies for the prevention and management of Non-Communicable Diseases.

The implementation of the Electronic Medical Record is a game-changer in the delivery of health care in our country because it will enable true portability of care. Significant progress has been made on this priority as marked by the development and rollout of the Health Patient Registration System (HPRS). The installation of the HPRS solution had been expanded to 3 266 health establishments and Automated Biometric Identification System (ABIS) rolled out in 82 PHC facilities by March 2025.

The health workforce is a critical component of our service delivery, and the department will continue to drive the implementation of the Human Resource Strategy for 2030 which seeks to address critical issues in Workforce Planning, Development and Sustainability.

As a sector, we are working collaboratively to improve the experience of care for our health service users. The feedback provided through surveys and complaints is used to identify areas for improvement and opportunities to engage and educate the users.

Efforts to strengthen and foster better coordination and collaboration with stakeholders are ongoing in addressing social determinants of health and to leverage resources to maximize our impact.



Prof. N. Crisp
Acting Director-General: Health

OFFICIAL SIGN OFF

It is hereby certified that this Annual Performance Plan:

- Was developed by the management of the National Department of Health under the guidance of Dr P.A. Motsoaledi
- Consider all the relevant policies, legislation and other mandates for which the National Department of Health is responsible
- Accurately reflects the Impact, Outcomes and Outputs which the National Department of Health will endeavor to achieve over the MTEF period 2026/27 - 2028/29

Ms Q. Gambu
Acting Manager Programme 1: Administration — Signature

Prof N. Crisp
Manager Programme 2: National Health Insurance — Signature:

Dr N Ndlovu
Manager Programme 3: HIV/AIDS, TB AND Maternal, Child and Women's Health — Signature

Ms J. Hunter
Manager Programme 4: Primary Health Care — Signature

Dr M. Mathebula
Acting Manager Programme 5: Hospital Systems — Signature:

Dr A. Pillay
Acting Manager Programme 6: Health System Governance and Human Resources — Signature:

Mr H. Nevhutalu
Acting Chief Financial Officer — Sign

Approved by:

Prof N. Crisp
Acting Director-General

Dr P.A. Motsoaledi, MP
Minister of Health

PART A
OUR MANDATE

OUR MANDATE

1. Constitutional Mandate

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

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

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

Section 9 of the Constitution states that everyone has the right to equality, including access to health care services. This means that individuals should not be unfairly excluded in the provision of health care. People also have the right to access information if it is required for the exercise or protection of a right. This may arise in relation to accessing one's own medical records from a health facility for the purpose of lodging a complaint or for giving consent for medical treatment; and this right also enables people to exercise their autonomy in decisions related to their own health, an important part of the right to human dignity and bodily integrity in terms of section 9 and 12 of the Constitutions respectively.

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

1) Everyone has the right to have access to: (a) Health care services, including reproductive health care; (b) Sufficient food and water; and (c) Social security, including, if they are unable to support themselves and their dependents, appropriate social assistance.

2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights; and

3) No one may be refused emergency medical treatment.

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

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

The Department of Health derives its mandate from the National Health Act (2003), which requires that the department provides a framework for a structured and uniform health system for South Africa. The act sets out the responsibilities of the three levels of government in the provision of health services. The department contributes towards Strategic Priority 2 of the Medium-Term Development Plan 2024-2029 which focus on the reducing poverty and tackling the high cost of living and the vision articulated in chapter 10 of the National Development Plan.

2.1 Legislative falling under the Department of Health's Portfolio

National Health Act, 2003 (Act No. 61 of 2003) Provides a framework for a structured health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services. The objectives of the National Health Act (NHA) are to:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2.2 Other legislation applicable to the Department

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

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

Child Justice Act, 2008 (Act No. 75 of 2008, Provides for criminal capacity assessment of children between the ages of 10 to under 14 years.

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

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

Criminal Law (Sexual Ofences and Related Matters) Amendment Act, 2007 (Act No. 32 of 2007), Provides for the management of Victims of Crime.

Criminal Procedure Act, 1977 (Act No.51 of 1977), Sections 77, 78, 79, 212 4 (a) and 212 B (a) - Provides for forensic psychiatric evaluations and establishing the cause of non-natural deaths.

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

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

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

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

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

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

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

Promotion of Equality and the Prevention of Unfair Discrimination Act, 2000 (Act No.4 of 2000) - Provides for the further amplification of the constitutional principles of equality and elimination of unfair discrimination.

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

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

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

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

3.1 National Development Plan: Vision 2030

The strategic intent of the National Development Plan (NDP) 2030 for the health sector is the achievement of a health system that is accessible, works for everyone and

produces positive health outcomes. The NDP vision is that by 2030 it is possible for South Africa to have (a) raised the life expectancy of South Africans to at least 70 years; (b) produced a generation of under-20-year-olds that is largely free of HIV;

c) reduced the burden of disease; (d) achieved an infant mortality rate of less than 20 deaths per thousand live births, including an under-5 year old mortality rate of less than 30mper thousand; (e) achieved a significant shift in equity, efficiency and quality of health service provision; (f) achieved universal coverage; and (g) significantly reduced the social determinants of disease and adverse ecological factors.

Chapter 10 of the NDP has outlined 9 goals for the health system that it must reach by 2030. The overarching goal that measures impact is “Average male and female life expectancy at birth increases to at least 70 years”. The next 4 goals measures health outcomes, requiring the health system to reduce premature mortality and morbi dity. The last 4 goals are tracking the health system that essentially measure inputs and processes to achieve outcomes.

3.2 Sustainable Development Goals

In 2015, all countries in the United Nations adopted the 2030 Agenda for Sustainable Development. Goal 3 ensures promotion of healthy lives and well-being for all, at all ages.

The following goals pertain to health, goal 3:

3.2.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births.

3.2.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1 000 live births and under 5 mortality to at least as low as 25 per 1 000 live births.

3.2.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.

3.2.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.

3.2.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol

3.2.6 By 2030, halve the number of global deaths and injuries from road traffic accidents.

3.2.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

3.2.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential.

3.2.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination.

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

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

3c. Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States.

3d. Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks.

3.3 Medium Term Development Plan 2024 – 2029

The Medium-Term Development Plan (MTDP), as the implementation plan of the National Development Plan (NDP) and align to the goals and objectives of the NDP and Programme of Priorities of the Government of National

Unity. MTDP has a greater emphasis on development outcomes and is framed as an economic plan to address existing socio economic challenges.

The Plan sets out 3 Strategic Priorities namely: Inclusive growth and job creation, Reduce Poverty and tackle the high cost of living as well as a capable, ethical and developmental state. The health sector's contribution towards the strategic outcome of reduction of poverty and tackling high cost of living will be implemented through 4 sector priorities outlined below:

3.3.1 Pursue achievement of universal health coverage through the implementation of the National Health Insurance to address inequity and financial hardship in accessing quality health care.

3.3.2 Improve the quality of health care at all levels of the health establishments, inclusive of private and public facilities.

3.3.3 Improve resource management by optimizing human resources and healthcare infrastructure and implementing a single electronic health record.

3.3.4 Strengthen the primary health care (PHC) system by ensuring that home and community-based services, as well as clinics and community health centres as well-resourced and appropriately staffed to provide the promotive, preventative, curative, rehabilitative and palliative.

3.4 National Health Insurance Act

The attainment of Universal Health Coverage (UHC) is one of the 17 Sustainable Development Goals (SDGs) 2030 to be achieved globally by 2030. The World Health Organi sation (WHO) asserts that UHC exists when: "all people have access to the health services they need, when and where they need them, without financial hardship. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care.

The implementation of the National Health Insurance (NHI) is the pathway that the Country has chosen to attain Universal Health Coverage. The NHI Act was signed into law in May 2024 to:

- establish the National Health Insurance Fund and set out its powers, functions and governance structure;
- provide Framework for the strategic purchasing of health care services by the Fund on behalf of users;
- create mechanisms for the equitable, effective and efficient utilization of the resources of the Fund to meet the health needs of the population; and
- preclude or limit undesirable, unethical and unlawful practice in relation to the Fund and its users.

3.5 Presidential Health Compact 2024 - 2029

The Presidential Health Compact (PHC) is an agreement and commitment by key stakeholders signed in July 2019, developed to identify primary focus areas towards establishing a unified, integrated and responsive health system. Partners committed themselves to a 5-year program of partnering with government in improving health care services in our Country. In 2024 the second Presidential Health Compact (2024 - 2029) was adopted.

Health compact is essential for ensuring collaboration and coordination the state and key stakeholders in achieving better health outcomes for the population; the State, as the main provider of health care services, needs the support of other stakeholders, including the labour, private sector, civil society organisations and communities.

Under the theme, Accelerating Health System Strengthening and National Health Insurance (NHI), the Health Compact Pillars outlined below:

Pillar 1: Augment Human Resources for Health Operational Plan.
Pillar 2: Better supply chain equipment and machinery management to ensure improved access to essential medicines, vaccines, and medical products.
Pillar 3: Execute the infrastructure plan to ensure adequate, appropriately distributed, well maintained health facilities.
Pillar 4: Engage the private sector in improving health services' access, coverage and quality.
Pillar 5: Improve health services' quality, safety, and quality, focusing on primary health care.
Pillar 6: Improve the efficiency of public sector financial management systems and processes.
Pillar 7: Strengthen Governance and Leadership to improve oversight, accountability and health system performance at all levels.
Pillar 8: Engage and empower the community to ensure adequate and appropriate community based care.
Pillar 9: Develop an information system to guide the health system's policies, strategies and investments.
Pillar 10: Pandemic Preparedness and Response

3.6 G20 Health Ministers' Declaration

The department remains committed to the realization of Universal Health Coverage (UHC) and played a central role in the G20 Health Working Group. Under the theme Accelerate Health Equity Solidary and Universal Coverage, with strengthening Primary Health Care as a pathway towards Universal Health Coverage and stemming the tide of Non-Communicable Diseases as some of the core priorities.

A significant milestone in 2025 in our country was the G20 Summit. World leaders discussed ways to promote solidarity, equality and sustainability as key pillars for inclusive growth. Various discussions under the leadership of the department culminated in South Africa's G20 Health Ministers' Declaration which was informed by negotiations with G20 members and invited countries.

The Summit recognized the importance of Health financing and investments in health as fundamental to drive of stability, growth and resilience and thus encouraging domestic public financing for health as the primary source for health. finance, complemented by international support. Furthermore, the critical importance of investing in the health and well-being of all, including women, children and adolescents as a foundation for sustainable development and call upon all partners to intensify coordinated action and efforts to accelerate progress towards UHC. The Summit reiterated the commitment to building more resilient, equitable, sustainable, and inclusive health systems for the provision of integrated people centred health services, including mental health, and to achieve Universal Health Coverage.

Figure 1. Theory of Change: Towards the 2030 goals and target

Theory of Change principle in the Health Sector

The Health Sector follows the Theory of Change (Result-based Framework) approach in determining the deliverables of health services for the sector based on the NDP and SDG goals. Factors, determining the inputs are related to the population (demography and epidemiology); social factors of the community (e.g. deprivation index; equity; disease burden) to prevent and prioritize illnesses and conditions that contribute to mortality and morbidity of the population. These interventions aim to reduce morbidity (Outcome) and reduce mortality (Impact) by increasing the life expectancy of the population. Interven tions are based on priority areas to reduce inequality, through an integrated patient centered approach, supported by adequate inter-departmental and inter-sectoral collaborations.

Table 1: Health Sector Long- and Medium-Term Priorities Alignment

NDP2030	MTDP 2024-2029		STRATEGIC OUTCOMES 2025-2030	PRESIDENTIAL HEALTH COMPACT 2024-2029
Vision 2030 ► A health system that works for everyone and produces positive health outcomes. ► By 2030, it possible to: • Raise the life expectancy of South Africans to at least 70 years; • Ensure that the generation of under-20s is largely free of HIV; • Significantly reduce the burden of disease; • Achieved an infant mortality rate of less than 20 deaths per thousand live births including an under-5 mortality rate of less than 30 per thousand • A National Health Insurance system needs to be implemented in phases.	1	Pursue achievement of Universal Health Coverage through the implementation of the National Health Insurance to address inequity and financial hardship in accessing quality health care	1. Financial Management strengthened in the health sector 2. Improved access to equitable healthcare services 3. National Health Insurance awareness improved 4. Governance of Public Entities strengthened	**Pillar 1:** Augment Human Resources for Health Operational Plan **Pillar 2:** Better supply chain equipment and machinery management to ensure improved access to essential medicines, vaccines, and medical products. **Pillar 4:** Engage the private sector in improving health services' access, coverage and quality. **Pillar 6:** Improve the efficiency of public sector financial management systems and processes.
	2	Strengthen the Primary Health Care (PHC) system by ensuring that home and community- based services, as well as clinics and community health centres are well resourced and appropriately staffed to provide the promotive, preventive, curative, rehabilitative and palliative care services required for South Africa's burden of disease	5. Improved responsiveness to community needs 6. Reduced burden of disease 7. HIV and AIDS related deaths reduced 8. TB Mortality reduced 9. Malaria related deaths reduced 10. Mortality due to Cervical Cancer reduced 11. Improved maternal and child health 12. Improved access to School health programme 13. Improved access to Youth health programme 14. Mental health care integrated in Primary Health Care 15. Early warning and integrated disease surveillance and response strengthened	**Pillar 5:** Improve health services' quality, safety, and quantity, focusing on primary health care. **Pillar 8:** Engage and empower the community to ensure adequate and appropriate community-based care
	3	Improve the Quality of Health Care at all levels of the health establishments, inclusive of private and public facilities.	16. Improved access to safe and quality healthcare 17. Enabling legislation for effective service delivery	**Pillar 5:** Improve health services' quality, safety, and quantity, focusing on primary health care. **Pillar 10:** Pandemic Preparedness and Response (cross-cutting)
	4	Improve Resource Management by optimizing human resources and healthcare infrastructure and implementing a single electronic health record	19. Equitable distribution of health professionals to health facilities 20. Integrated electronic health record 21. Health infrastructure optimised for delivery of care	**Pillar 1:** Augment Human Resources for Health Operational Plan (also in priority 1) **Pillar 3:** Execute the infrastructure plan to ensure adequate, appropriately distributed, well-maintained health facilities. **Pillar 7:** Strengthen Governance and Leadership to improve oversight, accountability and health system performanceat all levels (cross cutting) **Pillar 9:** Develop an information system to guide the health system's policies, strategies and investments.

PART B

OUR STRATEGIC FOCUS

4. Vision
A long and healthy life for all South Africans.

5. Mission
To improve the health status through the prevention of illness, disease, promotion of healthy lifestyles, and to consistently improve the health care delivery system by focusing on access, equity, efficiency, quality and sustainability.

6. Values
The Department subscribes to the Batho Pele principles and values:

Consultation: Citizens should be consulted about the level and quality of the public services they receive and, wherever possible, should be given a choice regarding the services offered;

Service Standards: Citizens should be told what level and quality of public service they will receive so that they are aware of what to expect;

Access: All citizens have equal access to the services to which they are entitled;

Courtesy: Citizens should be given full, accurate information about the public services to which they are entitled to;

Openness and transparency: Citizens should be told how national and provincial departments are run, how much they cost, and who is in charge;

Redress: If the promised standard of service is not delivered, citizens should be offered an apology, a full explanation and a speedy and effective remedy; and when complaints are made, citizens should receive a sympathetic , positive response; and

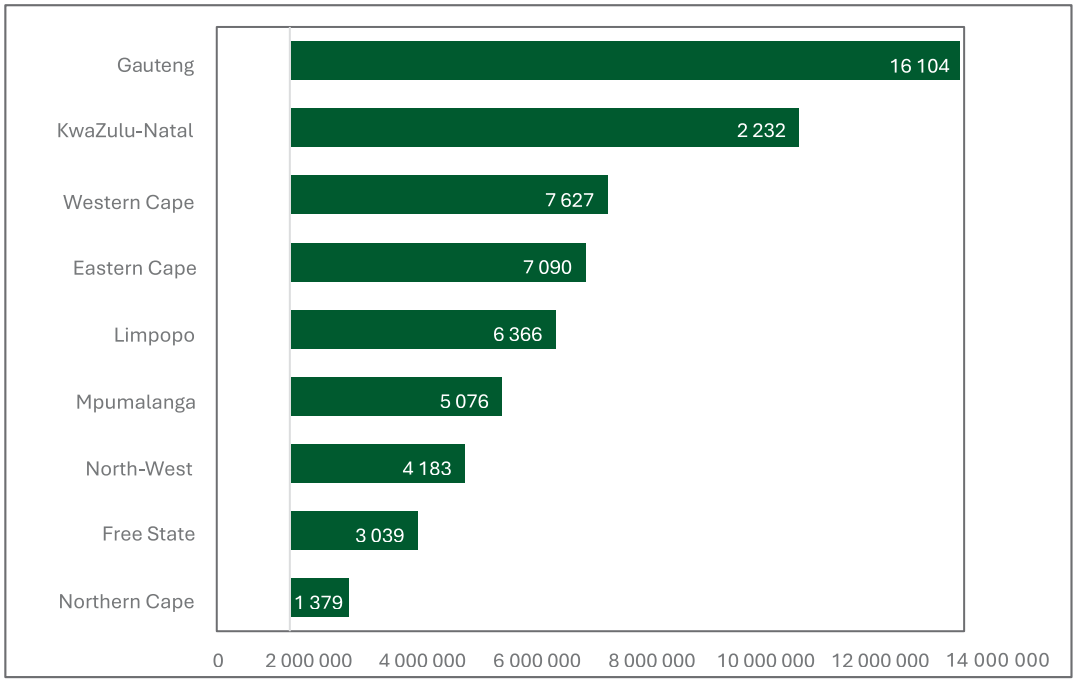
Value for Money: Public services should be provided economically and efficiently in order to give citizens the best value for money.

7. Situational Analysis

7.1 External Environment Analysis

7.1.1 Demography
Statistics South Africa (Stats SA) estimates the mid-year population at 63,10 million people. The female population accounts for 51,1% (approximately 32,23 million) of the population. [1]Population estimates by provinces shows that Gauteng province has the largest share of the population at 25.5% (approximately 16.10 million people) and Northern Cape remains the province with the smallest share of the population with 1.37 million (2.2%) people.

Figure 2: Mid-year population estimates for South Africa by province, 2025



Source: 2025 Mid-year population statistics, Stats SA

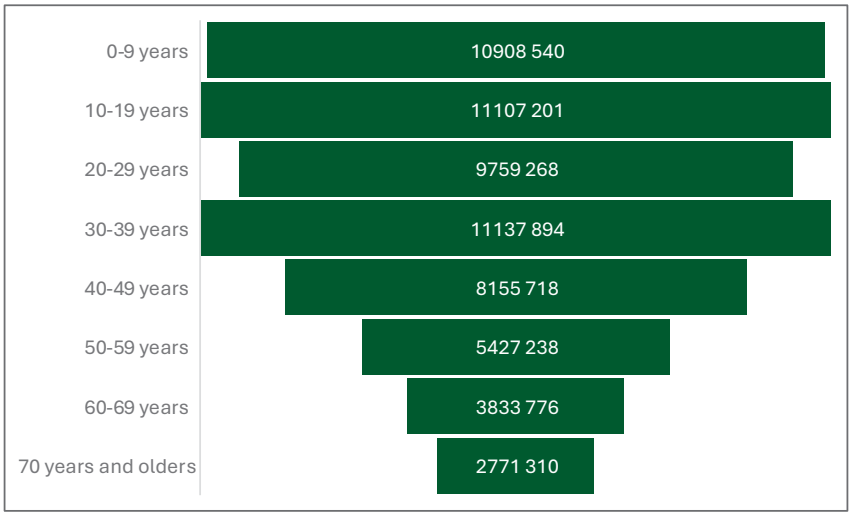
[1] Statistics South Africa, 2025 Mid-Year Population Estimates,
[2] WHO, Social Determinants of health, Website: https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1, accessed 28 Oct 2024.

Population race distribution

Black African make the majority of the population estimated at 81.8% followed by Coloureds (8.5%), Whites (7.1 %) and Indians (2.6%) . The figure below shows the breakdown of the population per province.

Population age distribution

Figure 3: Population estimates by age group



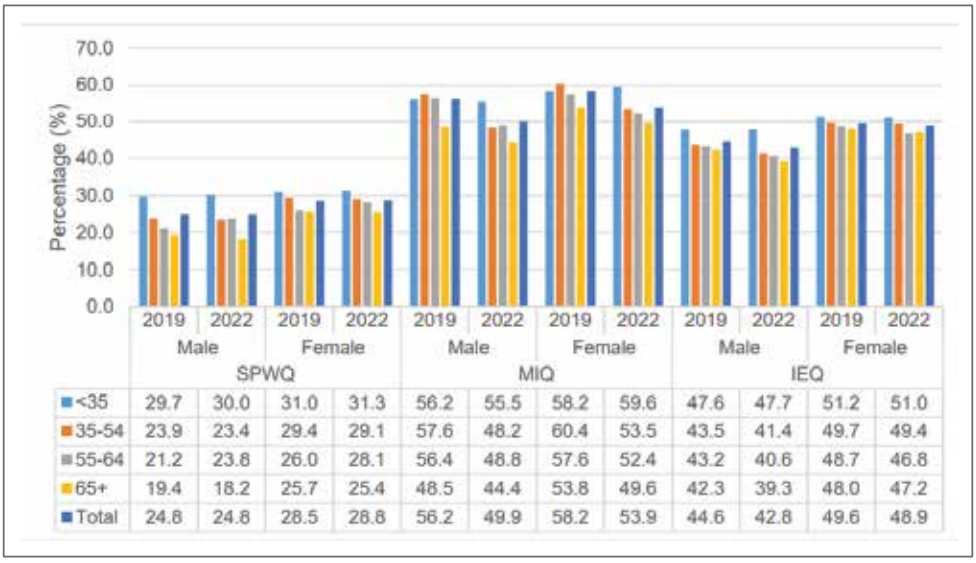
Source: 2025 Mid-year population statistics, Stats SA

The above figure depicts largest age group of 30-39 years at 11 137 894, followed by 10-19 years and 0-9 years at 11 107 201 and 10 908 540 respectively. The youth category between 20 and 35 years comprise of a population around 15 263 541 whilst the population of 60 years and above is estimated at 6 605 086.

Social Determinants of Health for South Africa

"The social determinants of health (SDH) are the non-medical factors that influence health outcomes" Health equity according to WHO, is striving for the highest possible standard of health for all people, giving specially attention to those most vulnerable populations in society. Social determinants of a country can be adversely affected by wars, poverty and epidemic outbreak of diseases, including decision-making processes, policies, social norms and structures that exist in society.

Figure 4: Poverty incidence by subjective poverty indicator and age and sex of the household head between 2019 and 2022



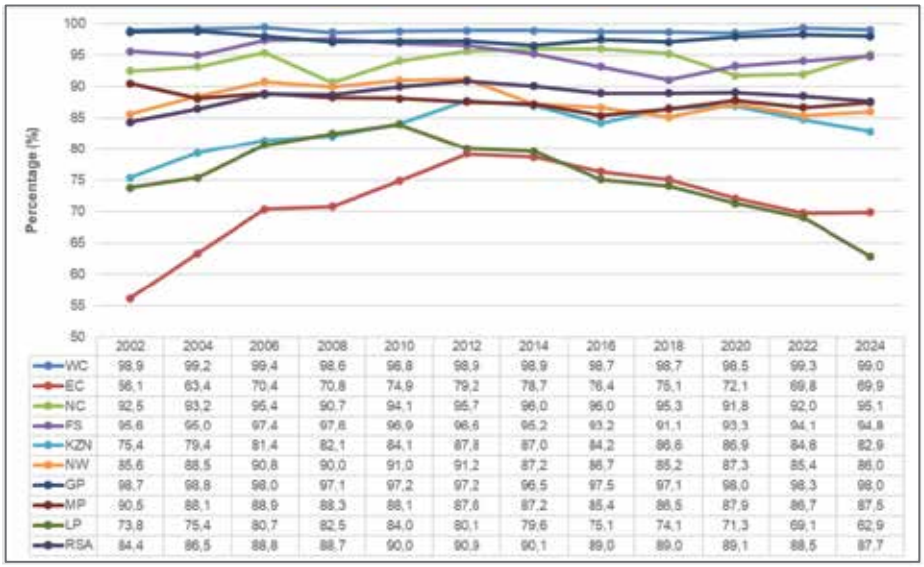
	SPWQ				MIQ				IEQ			
	Male		Female		Male		Female		Male		Female	
	2019	2022	2019	2022	2019	2022	2019	2022	2019	2022	2019	2022
<35	29.7	30.0	31.0	31.3	56.2	55.5	58.2	59.6	47.6	47.7	51.2	51.0
35-54	23.9	23.4	29.4	29.1	57.6	48.2	60.4	53.5	43.5	41.4	49.7	49.4
55-64	21.2	23.8	26.0	28.1	56.4	48.8	57.6	52.4	43.2	40.6	48.7	46.8
65+	19.4	18.2	25.7	25.4	48.5	44.4	53.8	49.6	42.3	39.3	48.0	47.2
Total	24.8	24.8	28.5	28.8	56.2	49.9	58.2	53.9	44.6	42.8	49.6	48.9

Source: Subjective Poverty in South Africa. Findings from The General Household Surveys 2019 And 2022, Stats SA

The figure above depicts the incidence of poverty in male and female-headed households according to the age cohort between 2019 and 2022. In 2022, across all the poverty measures and age groups, female- headed households consistently reported the highest incidence of poverty compared to their male counterparts. Across households headed by both sexes, the prevalence of poverty shows a declining pattern as you move up the age cohort hierarchy.

Access to safe drinking water is important for the health of the public and in the reduction of poverty.

Figure 5: Distribution of household with access to piped or tap water by province, 2002-2024



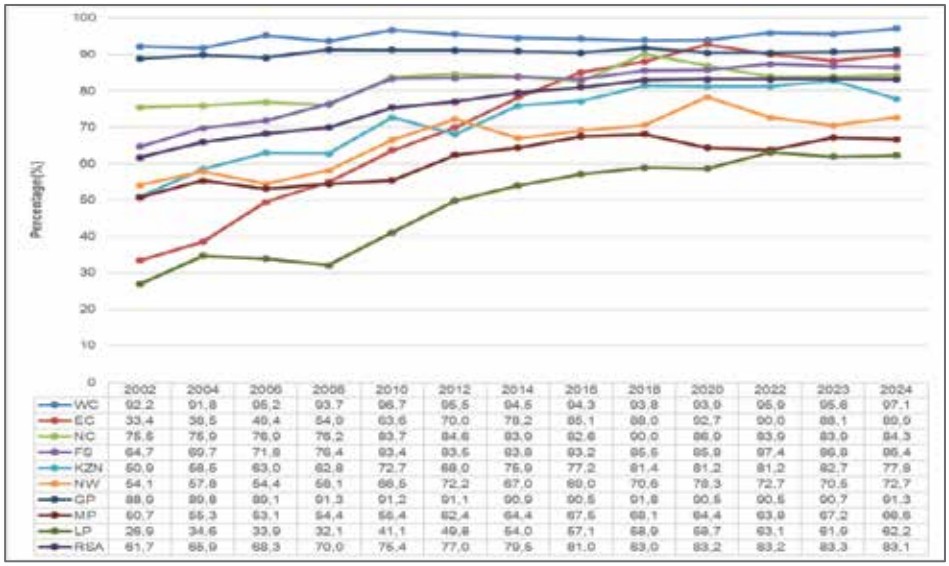
	2002	2004	2006	2008	2010	2012	2014	2016	2018	2020	2022	2024
WC	98,9	99,2	99,4	98,6	98,8	98,9	98,9	98,7	98,7	98,5	99,3	99,0
EC	56,1	63,4	70,4	70,8	74,9	79,2	78,7	76,4	75,1	72,1	69,8	69,9
NC	92,5	93,2	95,4	90,7	94,1	95,7	96,0	96,0	95,3	91,8	92,0	95,1
FS	95,6	95,0	97,4	97,6	96,9	96,6	95,2	93,2	91,1	93,3	94,1	94,8
KZN	75,4	79,4	81,4	82,1	84,1	87,8	87,0	84,2	86,6	86,9	84,8	82,9
NW	85,6	88,5	90,8	90,0	91,0	91,2	87,2	86,7	85,2	87,3	85,4	86,0
GP	98,7	98,8	98,0	97,1	97,2	97,2	96,5	97,5	97,1	98,0	98,3	98,0
MP	90,5	88,1	88,9	88,3	88,1	87,6	87,2	85,4	86,5	87,9	86,7	87,5
LP	73,8	75,4	80,7	82,5	84,0	80,1	79,6	75,1	74,1	71,3	69,1	62,9
RSA	84,4	86,5	88,8	88,7	90,0	90,9	90,1	89,0	89,0	89,1	88,5	87,7

Source: General Household Survey 2022, StatsSA, 2024

The figure above despicts majority of provinces have sustained the provision of drinking water at above 80% of the population over the years. Eastern Cape and Limpopo provinces have seen a sharp decline with reported access in 2024 at 70% and around 63% respectively.

Sanitation is a critical enabler for environmental hygiene which contributes to the prevention of diseases.

Figure 6: Distribution of households that have access to improved sanitation by province, 2002–2024



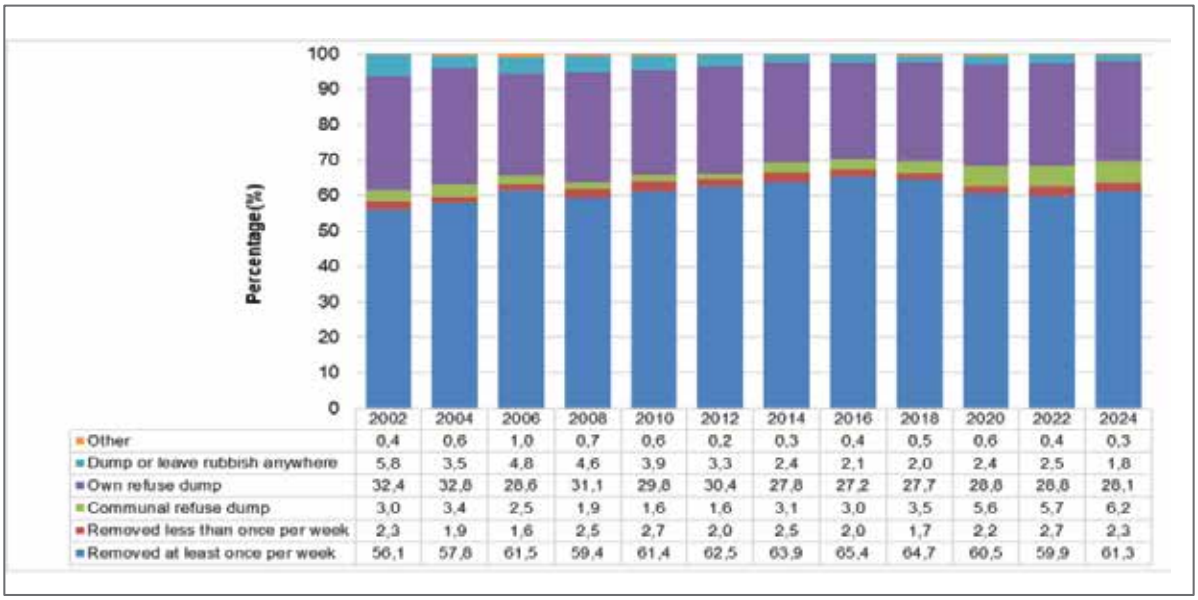
	2002	2004	2006	2008	2010	2012	2014	2016	2018	2020	2022	2023	2024
WC	92,2	91,8	95,2	93,7	96,7	95,5	94,5	94,3	93,8	93,9	95,9	95,6	97,1
EC	33,4	39,5	40,4	54,9	63,6	70,0	78,2	85,1	88,0	92,7	90,0	88,1	89,9
NC	75,6	76,9	76,9	76,2	83,7	84,6	83,9	82,6	90,0	86,9	83,9	83,9	84,3
FS	64,7	69,7	71,8	76,4	83,4	83,5	83,8	83,2	85,5	85,9	87,4	86,8	86,4
KZN	60,9	68,6	63,0	62,8	72,7	68,0	76,9	77,2	81,4	81,2	81,2	82,7	77,9
NW	54,1	57,8	54,4	58,1	66,5	72,2	67,0	69,0	70,6	78,3	72,7	70,5	72,7
GP	88,9	89,8	89,1	91,3	91,2	91,1	90,9	90,5	91,8	90,5	90,5	90,7	91,3
MP	50,7	55,3	53,1	54,4	56,4	62,4	64,4	67,5	68,1	64,4	63,9	67,2	66,8
LP	26,9	34,6	33,9	32,1	41,1	49,8	54,0	57,1	58,9	59,7	63,1	61,9	62,2
RSA	61,7	65,9	68,3	70,0	76,4	77,0	79,5	81,0	83,0	83,2	83,2	83,3	83,1

Source: General Household Survey 2022, StatsSA, 2024

Nationally, the percentage of households with access to improved sanitation increased from 61,7% in 2002 to 83,1% in 2024. Households' access to improved sanitation was highest in Western Cape (97,1%), Gauteng (91,3%) and Eastern Cape (89,9%), and most limited in Limpopo (62,2%) and Mpumalanga (66,6%)

Household Waste and refuse disposal is important to maintain environmental hygiene of the households' neighbourhoods.

Figure 7: Percentage (%) distribution of household refuse removal for even years between 2002 and 2024



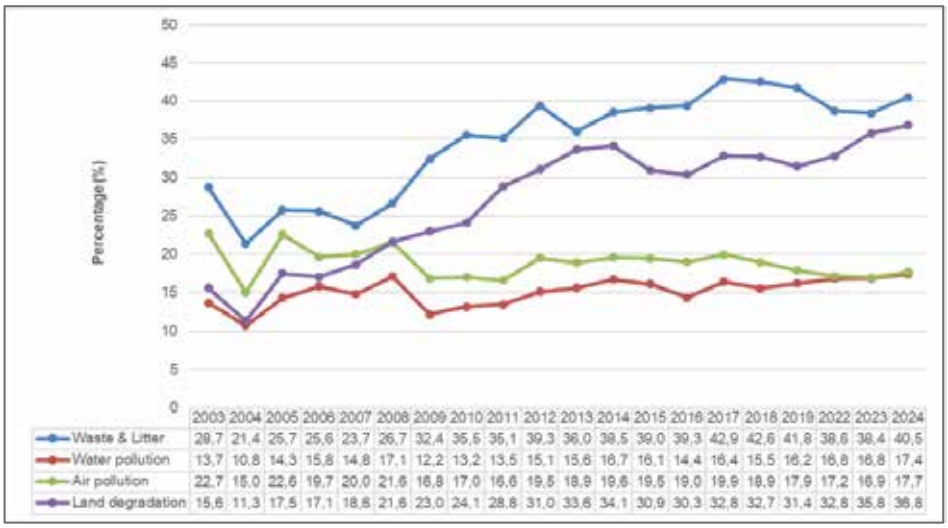
	2002	2004	2006	2008	2010	2012	2014	2016	2018	2020	2022	2024
Other	0,4	0,6	1,0	0,7	0,6	0,2	0,3	0,4	0,5	0,6	0,4	0,3
Dump or leave rubbish anywhere	5,8	3,5	4,8	4,6	3,9	3,3	2,4	2,1	2,0	2,4	2,5	1,8
Own refuse dump	32,4	32,8	28,6	31,1	29,8	30,4	27,8	27,2	27,7	28,8	28,8	28,1
Communal refuse dump	3,0	3,4	2,5	1,9	1,6	1,6	3,1	3,0	3,5	5,6	5,7	6,2
Removed less than once per week	2,3	1,9	1,6	2,5	2,7	2,0	2,5	2,0	1,7	2,2	2,7	2,3
Removed at least once per week	56,1	57,8	61,5	59,4	61,4	62,5	63,9	65,4	64,7	60,5	59,9	61,3

Source: General Household Survey 2022, StatsSA, 2024

Nationally, majority (61.3%) of household refuse was removed at least once per week (or less than once per week (2,3%). About 34,3% of households used communal or household refuse dumps, while 1,8% of households had no facilities at all.

Environmental problems as experienced by households

Figure 8: Distribution of households who experience specific kinds of environmental problems, 2003–2024



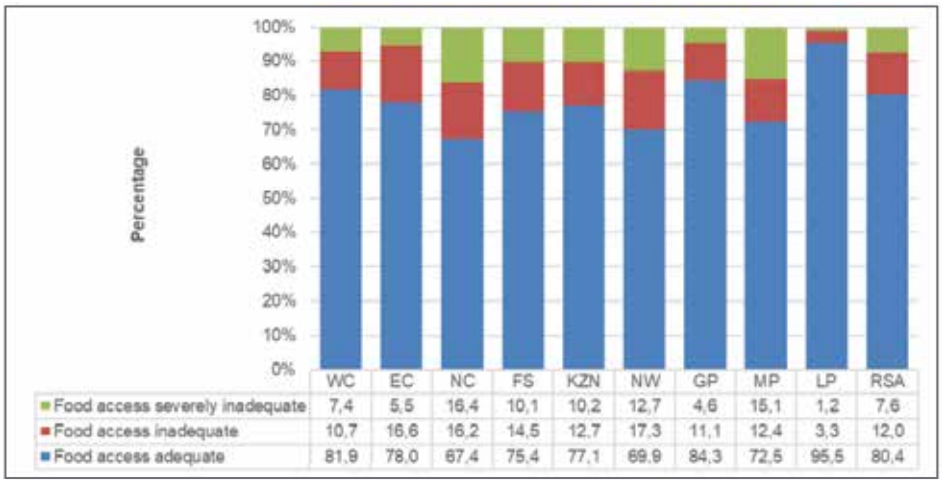
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2022	2023	2024
Waste & Litter	28,7	21,4	25,7	25,6	23,7	26,7	32,4	35,5	35,1	39,3	36,0	38,5	39,0	39,3	42,9	42,6	41,8	38,6	38,4	40,5
Water pollution	13,7	10,8	14,3	15,8	14,8	17,1	12,2	13,2	13,5	15,1	15,8	16,7	16,1	14,4	16,4	15,5	16,2	16,8	16,8	17,4
Air pollution	22,7	15,0	22,6	19,7	20,0	21,6	16,8	17,0	16,6	19,5	18,9	19,6	19,5	19,0	19,9	18,9	17,9	17,2	16,9	17,7
Land degradation	15,6	11,3	17,5	17,1	18,8	21,6	23,0	24,1	28,8	31,0	33,6	34,1	30,9	30,3	32,8	32,7	31,4	32,8	35,8	36,8

Source: General Household Survey 2022, StatsSA, 2024

The figure shows that households are becoming increasingly concerned about waste removal and littering as well as land degradation. Households' experiences of air pollution have fluctuated over the years with a steady decline notable in the recent years.

Food access is attributed to good nutrition which is key to general wellbeing and contributes to recovery during ill-health

Figure 9: Percentage distribution of households experiencing food adequacy or inadequacy by province, 2022



	WC	EC	NC	FS	KZN	NW	GP	MP	LP	RSA
Food access severely inadequate	7,4	5,5	16,4	10,1	10,2	12,7	4,6	15,1	1,2	7,6
Food access inadequate	10,7	16,6	16,2	14,5	12,7	17,3	11,1	12,4	3,3	12,0
Food access adequate	81,9	78,0	67,4	75,4	77,1	69,9	84,3	72,5	95,5	80,4

Source: General Household Survey 2022, StatsSA, 2024

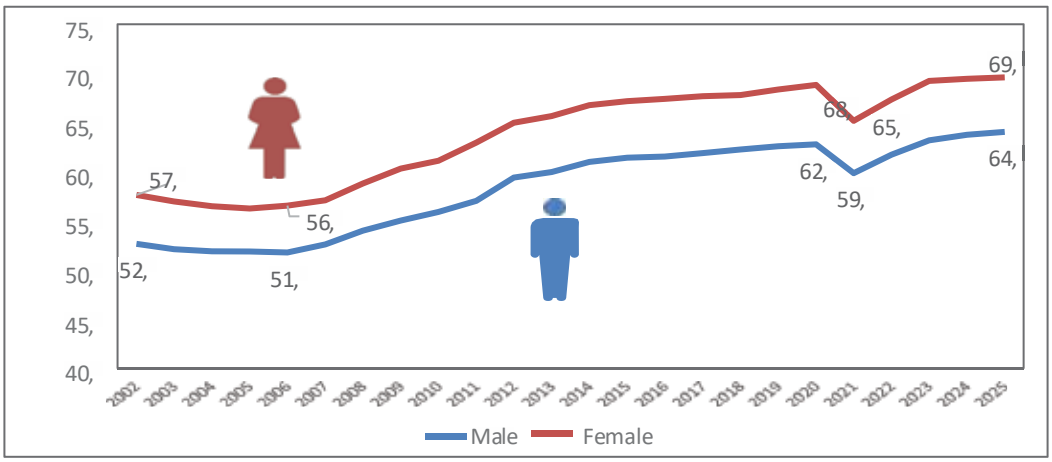
The figure above depicts tha 19,6% of households, nationally, considered their access to food as inadequate or severely inadequate. Food access problems were most common in Northern Cape (32,6%), and North West (30,1%).

7.1.2 Life Expectancy

The definition of life expectancy according to WHO is “the average number of years that a newborn could expect to live”.. Following the negative impact of COVID-19 on the life expectancy at birth in South Africa, there was a significant improvement of 1,9 years for males (61,7 years) and 2,2 years for females (67,4 years) in 2022. In 2025, life expectancy at birth for males is estimated at 64,0 years while for females the estimate is 69,6 years. Various health interventions such as access to HIV prevention and treatment, as well as other strides in health and living conditions, have played a significant role in these gains.

Additionally, the country has recorded a decline in infant mortality rate (IMR) from an estimated 61,9 infant deaths per 1 000 live births in 2002 to 23,1 infant deaths per 1 000 live births in 2025 and the under-five mortality rate (U5MR) declined from 79,9 child deaths per 1 000 live births to 26,1 child deaths per 1 000 live births between 2002 and 2025.

Figure 10: Life Expectancy at birth from 2002 – 2024.



Source: 2025 Mid-year population statistics, Stats SA

7.1.3 Epidemiology and Quadruple Burden of Disease

Disease Profile

South Africa disease profile is regarded as a "quadruple burden of disease" which includes communicable diseases (like HIV/AIDS and TB), non-communicable diseases (NCDs such as cardiovascular diseases, cancer, and diabetes), violence/trauma and injuries, as well as maternal and child health issues. There has been an epidemiological shift in the causes of death with Diabetes Mellitus taking the lead in 2022 from COVID-19 which was rated number 1 amongst 10 causes for 2020 and 2021.

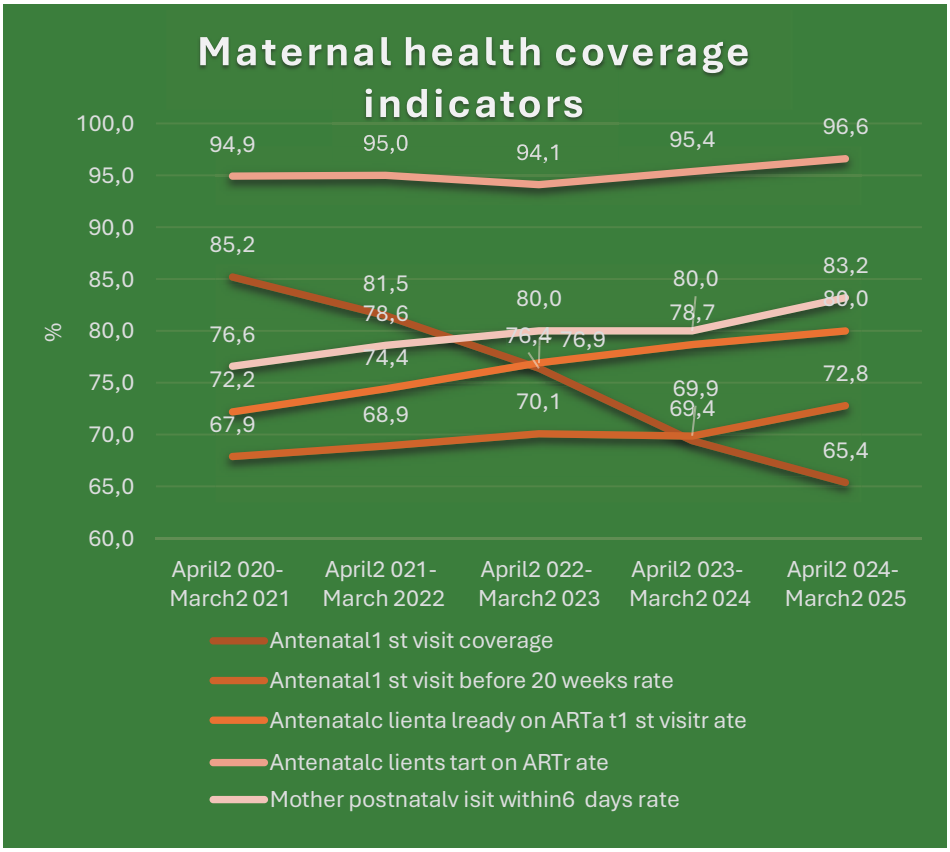
Maternal and Child Health

The recent national reports, including *NaPeMMCo, Saving Babies, the NCCEMD Saving Mothers, the STATSSA Recorded Live Births Report*, and the *Perinatal Mortality Report*, collectively provide a comprehensive picture of maternal, perinatal, and neonatal health outcomes in South Africa. The data show important shifts in birth and mortality trends. Total live births declined from over 998,000 in 2022 to 932,138 in 2023, with more than 80% of births now registered within 30 days, demonstrating notable progress in civil registration systems. However, perinatal deaths remain high, largely due to preterm labour, hypertensive disorders, obstetric haemorrhage, respiratory and perinatal care-related conditions.
Across the reports, more than half of maternal and perinatal deaths were deemed potentially preventable.

The most common avoidable factors include late antenatal booking, poor recognition of danger signs, and delays in seeking care. On the health system side, persistent challenges include overcrowded facilities, staff shortages, poor referral systems, limited neonatal intensive care capacity, inadequate monitoring during labour, and shortages of essential equipment. Data management weaknesses also hinder effective surveillance, with incomplete or inaccurate reporting and inconsistent use of tools such as the Perinatal Problem Identification Programme (PPIP) and the Maternal Morbidity and Mortality Audit System (MaMMAS).

The reduction of maternal in-facility mortality between 2020/21 and 2023/24 reflects improvements in antenatal ART and access to long-term contraceptives and TOP services. However, the recent uptick suggests challenges in sustaining gains, with contributing factors including declining antenatal first-visit coverage, delays in care-seeking, and resource constraints in facilities, particularly staffing and emergency readiness. Challenges identified include discrepancies in data management, as well as health system pressures such as overcrowding in hospitals or trained Health Care Workers.

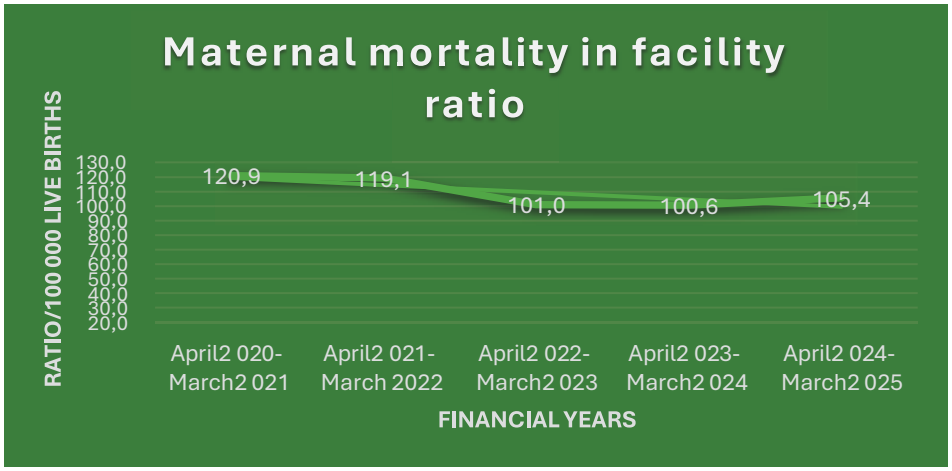
Figure 11: Maternal Health Coverage Indicators Trends (April 2020 – March 2025)



Maternal Mortality in Facility Ratio

Facility-based maternal mortality in South Africa remains a major challenge despite gradual progress. The ratio has shown an overall downward trend over the past five years, declining from 120.9 per 100,000 live births in 2020/21 to 100.6/100 00 live births in 2023/24. However, this progress was not sustained in 2024/25, when the ratio rose slightly to 105.4/100,000 live births, highlighting persistent vulnerabilities in the health system. However, a remarkable decline has been observed in the first quarter 2025/6, is 90/100 000 live births. While South Africa has made progress in improving birth registration, maternal and neonatal mortality remain above Sustainable Development Goal (SDG) targets. The high proportion of preventable deaths highlights the need for systemic improvements in health systems, clinical care, data surveillance, and community engagement. Accelerated action in these areas will be critical to achieving national and global commitments to end preventable maternal and neonatal deaths by 2030.

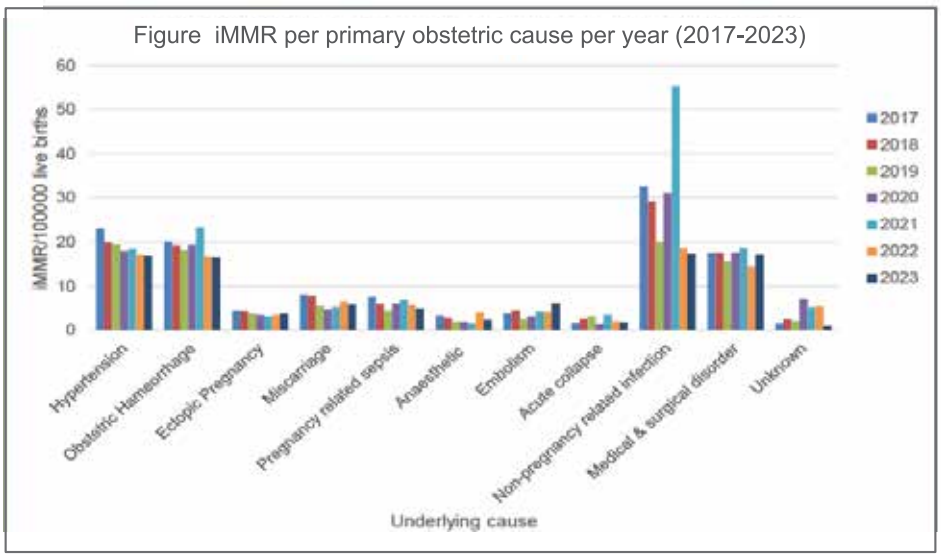
Figure 12: Maternal mortality in facility ratio



Source: DHIS

The leading causes of maternal deaths are hypertensive disorders, obstetric haemorrhage, sepsis, and non-pregnancy-related infections (particularly HIV and TB). These remain largely preventable through timely detection, quality intrapartum care, and effective referral systems. Other notable causes include embolism, miscarriage, and pregnancy-related sepsis. HIV remains a major driver of maternal mortality, though significant progress has been achieved through universal test-and-treat and high ART coverage rates (>95%). This has reduced the contribution of HIV-related complications to maternal deaths. However, indirect causes such as hypertension, obstetric haemorrhage, and sepsis remain leading contributors, reflecting persistent gaps in emergency obstetric care, referral pathways, and health system responsiveness. Postnatal follow-up within six days has improved, reaching 83.2% in 2024/25.

Figure 13: IMMR per primary obstetric cause per year (2017-2023)



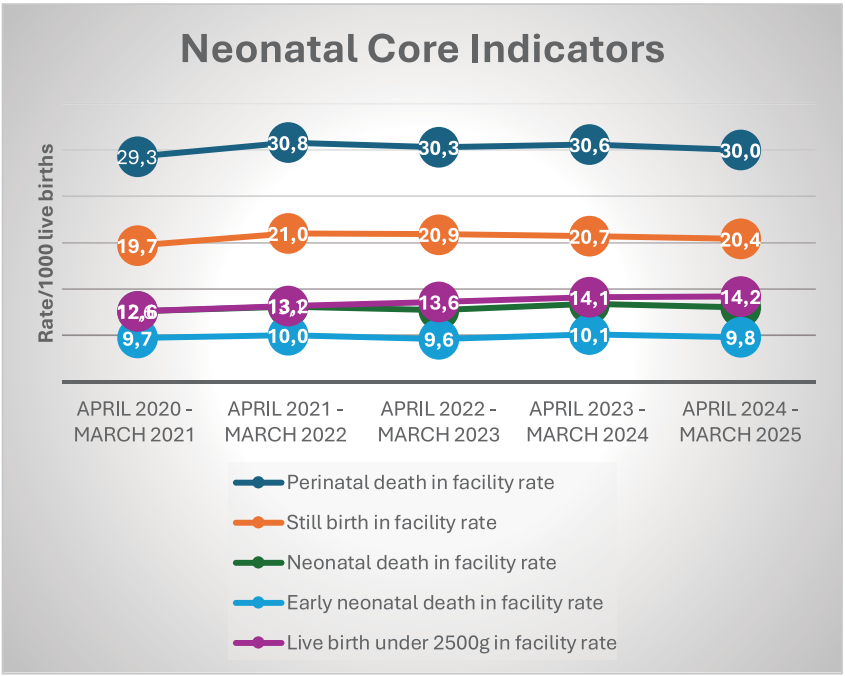
Priorities include reversing the decline in ANC coverage through community engagement, addressing access barriers, and expanding outreach services; sustaining HIV integration by ensuring ART initiation and continuity; and consolidating postnatal care gains through timely follow-up and home-based support. The overarching goal is to restore and expand service uptake while leveraging existing successes to reduce preventable maternal and neonatal deaths.

Neonatal Mortality

The Neonatal Mortality Rate (NMR) refers to the number of children aged from birth to 28 days who die in a given year per 1,000 live births within the same year. The Sustainable Development Goal (SDG) target is to reduce neonatal mortality to at least as low as 12 deaths per 1,000 live births. Within the health system, the neonatal mortality in facility ratio is used as a key indicator to monitor and track trends in neonatal deaths occurring in health facilities.

Neonatal mortality in facility ratio fluctuated slightly over recent years, declining from 13.4 to 12.2 per 1,000 live births in Q2 of FY 2025/26, before increasing marginally to 12.4. Despite this, the APP target was achieved. Deaths remain largely attributable to conditions arising in the perinatal period, including prematurity, hypoxia, and stillbirths (97.1%), with congenital malformations contributing around 4%.

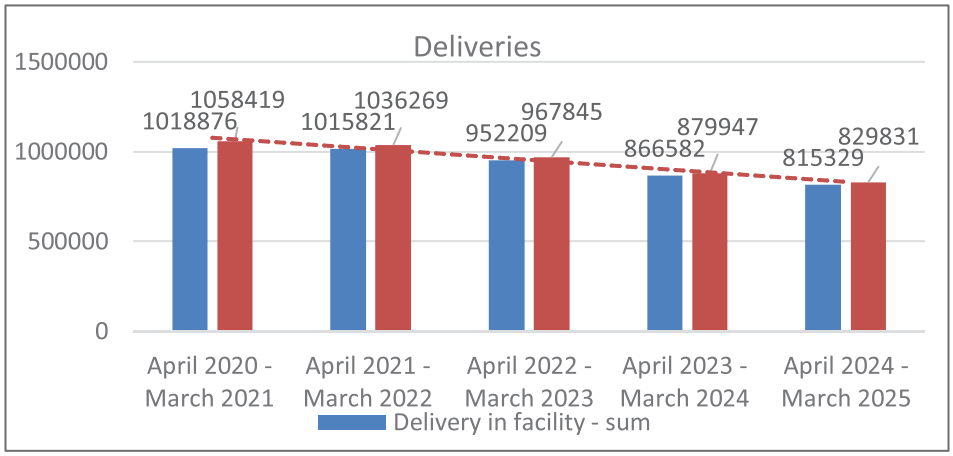
Figure 14: Neonatal core indicators



There has been a notable decline in both facility deliveries and total births in health facilities over the past five years. Facility deliveries decreased from 1,018,876 in 2020/2021 to 829,831 in 2024/2025**,** while total births in facilities declined from 1,058,419 to 815,329 over the same period.

Summary: The data highlights a decline in utilization of facility-based deliveries, alongside persistent clinical and systemic challenges that contribute to poor maternal and neonatal outcomes. Addressing these issues requires strengthening intrapartum care, enhancing obstetric surgical skills, improving infection control, and tackling maternal malnutrition.

Figure 15: Delivery in facility and Total delivery in facility



Source: DHIS

To address these, interventions focus on strengthening maternal nutrition, improving intrapartum and neonatal care, enhancing infection prevention, and expanding antenatal screening for high-risk pregnancies. Scaled-up Kangaroo Mother Care, neonatal resuscitation, and perinatal death audits (PPIP) are being prioritised to reduce preventable deaths and improve newborn survival.

Child Mortality

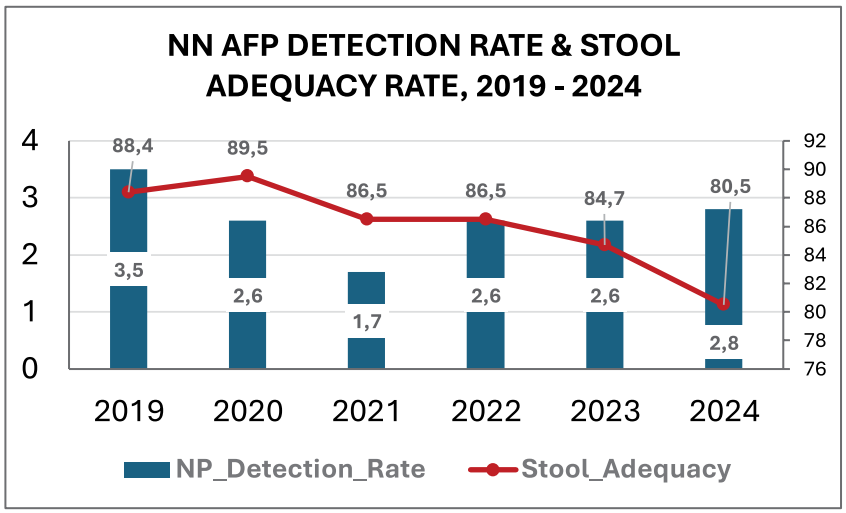
The under 5 mortality rate (U5MR) refers to the number of children under five years old who die in a year, per 1,000 live births in the same year. The SDG target for under 5 mortality is by 2030, at least as low as 25 deaths per 1,000 live births. The Under-5 mortality rate has been steadily declining since 2010 from 52.9 deaths per 1 000 live births, to 29.7 deaths per 1 000 live births by 2018.

- **Expanded programme on immunisation**

South Africa's EPI is guided by international and national frameworks, including IA2030, SDG 3, WHO's Polio Eradication Strategy, and national programmes such as the Maternal & Women health, Epidemiology & Surveillance, Communicable Disease Control, Integrated School Health Programme and the National Cancer Strategic Framework. These frameworks focus on maintaining population immunity, strengthening surveillance for vaccine-preventable diseases (VPDs), preventing outbreaks, and reducing morbidity and mortality from diseases like polio and cervical cancer.

For HPV vaccination, multi-disciplinary teams (MDTs) using school health platforms enhance coordination, support outreach planning, and address vaccine hesitancy, leading to improved vaccination uptake and faster case investigations where MDTs are functional. Challenges include uneven MDT distribution, staff shortages, and competing priorities. Solutions include phased MDT redistribution, task-shifting to nurses, and using digital systems (NMC & SVS) for real-time monitoring. Strengthening MDTs at district hospitals remains essential for sustaining AFP surveillance and HPV vaccination coverage.

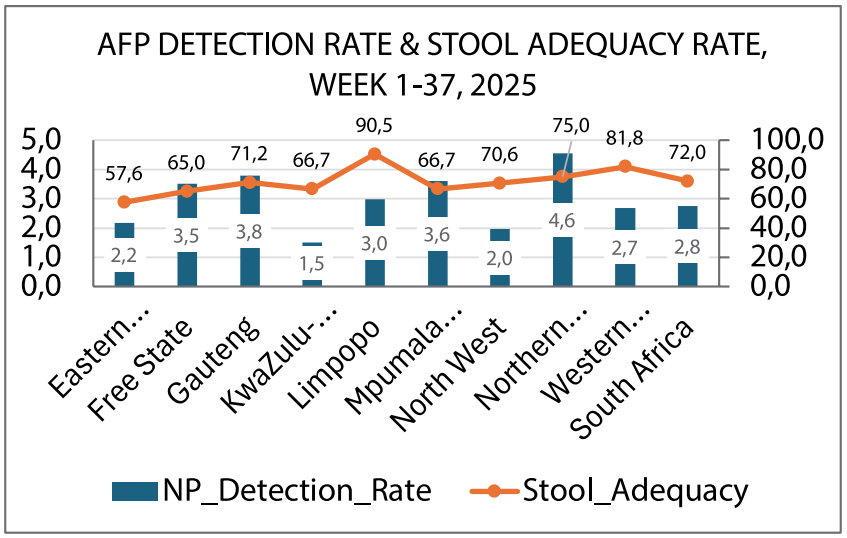
Figure 16: AFP performance indicators, Week 1-52 of 2019 - 2024



The data in the above figure reveals a decline in both non-polio AFP (NP-AFP) detection and stool adequacy. NP-AFP detection started strong in 2019 at 3.5 per 100,000 children under 15 years, well above the WHO target of 2.0, but dropped to a low of 1.7 in 2021. Although performance recovered somewhat to 2.6 in 2022–2023 and 2.8 in 2024, it has not returned to the robustness seen before 2020, indicating gaps in case finding and active surveillance.

Stool adequacy, which was 88.4% in 2019 and briefly rose to 89.5% in 2020, has consistently declined over the years, reaching only 80.5% in 2024. This downward trend highlights persistent weaknesses in specimen collection and timely transportation, reducing the system's capacity to confirm or rule out poliovirus. Combined with declining immunisation coverage, these surveillance gaps heighten the risk of delayed detection of poliovirus outbreaks and call for urgent strengthening of field surveillance and laboratory support.

Figure: 17 AFP performance indicators, week 1-37, 2025



Only Northern Cape reached the national operational target of 4/100000 population of under 15 years but did not meet the stool adequacy rate. KwaZulu-Natal is the only province which failed to reach both AFP indicator target. Limpopo reached the WHO targets in both indicators. Challenges include shortages of dedicated Infection Control staff in some hospitals, uneven distribution of MDTs across provinces, and competing priorities that stretch available human resources. Solutions being implemented include phased redistribution of MDTs to high-burden districts, task-shifting to trained professional nurses for stool collection and vaccination support, and leveraging digital systems (NMC & SVS) for real-time monitoring and feedback. Over the medium term, strengthening MDTs at district hospitals will remain a cornerstone for sustaining progress on AFP surveillance quality and HPV vaccination coverage, thereby advancing both national and global immunisation goals.

- **Vaccine preventable disease surveillance**

In line with the global agenda to eliminate and eradicate targeted vaccine-preventable diseases, South Africa conducts surveillance for neonatal tetanus, measles, rubella, and acute flaccid paralysis (AFP) for poliomyelitis detection. Surveillance is implemented through active and passive systems across all provinces and districts, supported by the NICD, a WHO regional reference laboratory. Environmental surveillance for poliovirus is also underway and expanding.

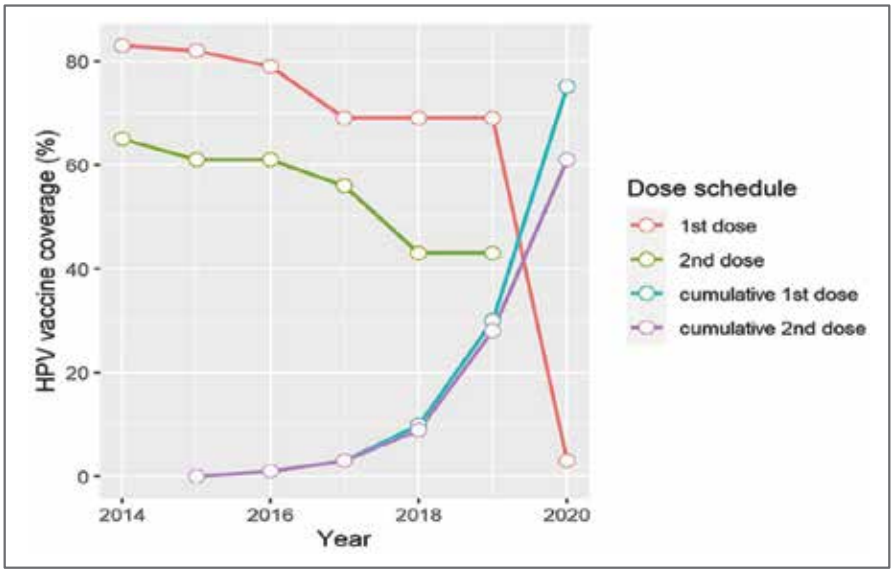
The last wild poliovirus case in the country was reported in 1989. South Africa was declared polio-free in 2006, but this status was rescinded in 2017 due to weak surveillance and low immunisation coverage. Following corrective measures, the country regained polio-free certification in 2019.

AFP surveillance has generally met the WHO-recommended detection rate of at least 2 cases per 100 000 children under 15 years for over a decade. However, the current rate is 1.9 per 100 000. children under 15 years, with persistent challenges in stool adequacy and case detection at district level.

- **Human Papillomavirus Vaccine (HPV) Vaccination**

The HPV vaccination programme in South Africa is a school-based intervention under the Expanded Programme on Immunisation (EPI). It targets learners in grades 5, 6 and 7 across both public and private schools, with vaccination provided through biannual campaigns. Following the 2024 recommendations of the National Advisory Group on Immunisation (NAGI), the schedule shifted to a single-dose regimen, enabling expansion to private schools and ensuring that learners previously excluded from vaccination over the past decade can now benefit from protection against HPV.

Figure 18: HPV Vaccine Coverage



The sector is working towards strengthening and expanding the HPV vaccination programme in order to vaccinate 90% of girls 9 – 15 years old. Since 2014, 7.16 million doses of HPV vaccination have been administered. Coverage of all girls 10 – 15 years is now estimated to be 73.5%.The first round of the HPV campaign has been completed.

Following the transition from a two to a one dose schedule, the second round will be used to provide vaccination to girl learners in private and independent schools. As of 2020, an estimated 75% of adolescent girls (9-14 years) received at least one dose of the HPV vaccine and 61% completed recommended two-dose schedule of the time.

Table 2: HPV Vaccine(1st dose) Coverage

Province	FY 2024/2025					
	HPV single dose Sept/Oct			Schools reached with HPV Single Dose, Sept/Oct		
	Grade 5 schoolgirl learners	Learners vaccinated	Coverage	No. of schools	Schools reached	Coverage
EC	63 992	60 022	94%	4066	3883	95%
FS	27035	24216	90%	624	619	99%
GP	93 724	82 137	88%	1 496	1 496	100%
KZN	100127	94300	94%	3965	3965	100%
LP	66 882	64 084	96%	2597	2475	95%
MP	41948	39124	93%	1109	1107	99.8%
NW	33 533	29 536	88%	1037	1037	100%
NC	11900	9334	78%	394	358	91%
WC	50474	36900	73%	1155	1155	100%
NATIONAL	489 615	430 319	88%	16443	16095	97%

At the national level, achieving 88% coverage demonstrates commendable progress but still falls short of the 90%+ benchmark set for school-based campaigns. This gap signals the need to strengthen strategies that address bottlenecks at the point of learner uptake, since school access is already high (97% of schools reached). For the APP, this means revisiting performance indicators to ensure they do not only track school outreach but also measure and incentivise improvements in learner coverage, with emphasis on strategies for reaching the “last mile” learners.

The provincial disparities highlighted in the data further emphasize where targeted interventions must be prioritised. Provinces like Northern Cape (78%) and Western Cape (73%) risk pulling down the national average and undermining equity in programme performance. For the APP review, these findings call for a sharper focus on context-specific barriers, such as parental consent, vaccine hesitancy, or operational challenges, that may hinder uptake despite school access being secured. Strengthening monitoring, resource allocation, and advocacy in low-performing provinces will be critical to align with national immunisation goals and to sustain progress toward broader health system priorities, including prevention of cervical cancer through equitable HPV vaccine delivery.

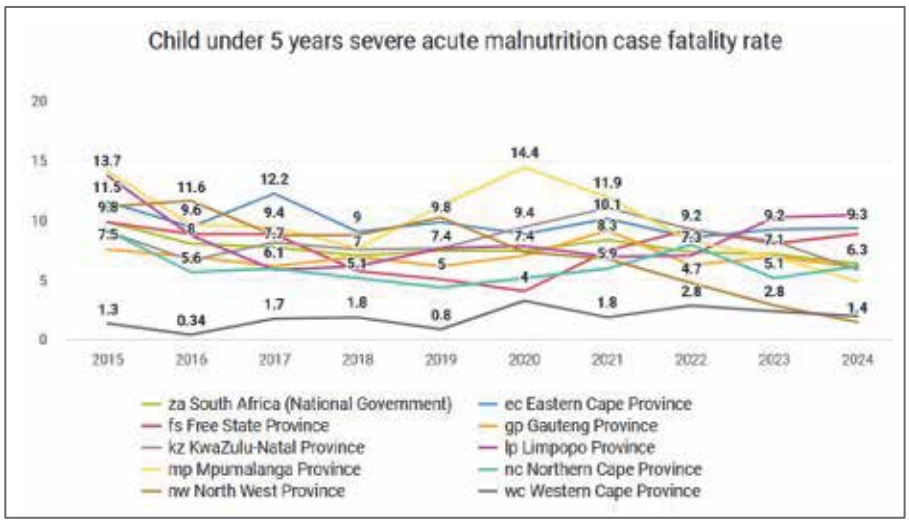
- **Maternal and Child Nutrition**

South Africa continues to face a triple burden of malnutrition, with undernutrition, micronutrient deficiencies, and overnutrition affecting women and children. The most recent national food and nutrition security survey indicates that among children under five years, 7.7% are underweight, 28.8% are stunted, 5.3% are wasted, and 22% are overweight. Stunting remains the most prevalent form of malnutrition, reflecting chronic undernutrition and poor dietary quality, while the rising rates of overweight and obesity signal a growing overnutrition challenge. Among women of reproductive age, anaemia affects 28%, with well-established links to poor maternal, foetal, and neonatal outcomes. Anaemia is increasingly recognized as a modifiable risk factor for postpartum haemorrhage, a leading cause of maternal morbidity and mortality. Additionally, overweight and obesity are highly prevalent, affecting approximately 68% of women, further contributing to maternal and child health risks.

Progress has been made in reducing deaths associated with severe acute malnutrition (SAM), with case fatality rates declining from 9.8% in 2015 to 6.3% in 2024. Despite this improvement, SAM remains a significant underlying cause of child mortality, accounting for 24% of in-hospital deaths among children under five. Severely malnourished children remain nine times more likely to die compared to well-nourished children.

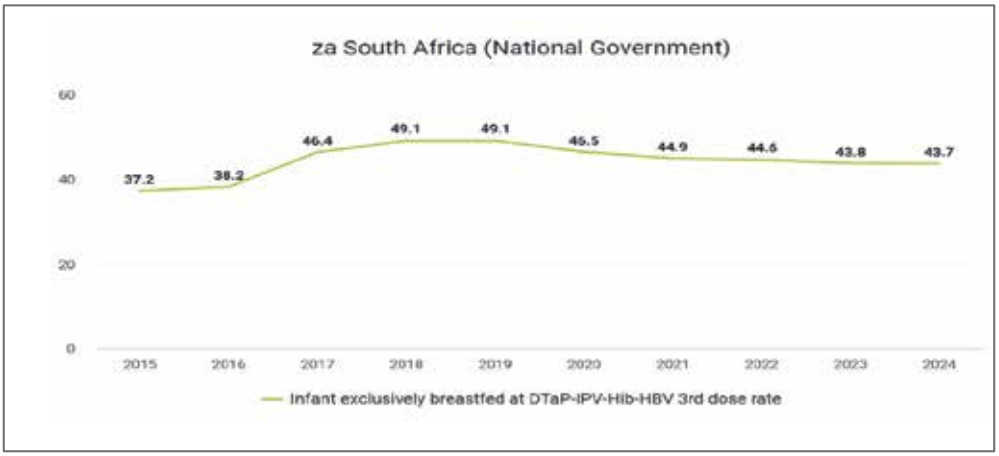
Multiple factors compound the current nutrition status in South Africa. Food and nutrition security remains a persistent challenge, with the COVID-19 pandemic reversing gains in some areas. Socio-economic factors, including high unemployment, unsustainable livelihoods, household food insecurity, and rising food and agricultural input costs, exacerbate malnutrition.

Figure 19: Trends in case fatality rate associated with Severe acute malnutrition (SAM) 2015-2024



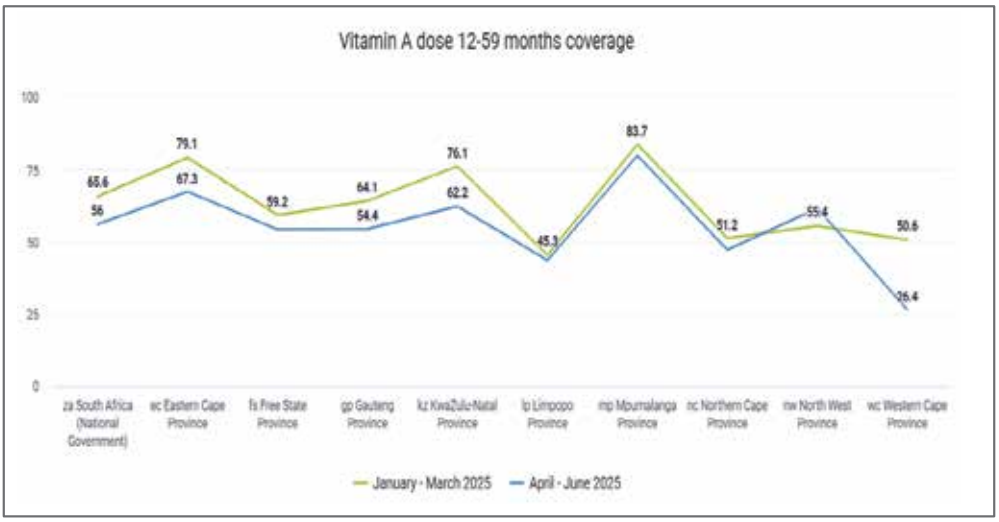
Infant and young child feeding practices remain suboptimal. Exclusive breastfeeding rates have declined from 32% in 2016 to 22% in 2024, with slow progress observed in exclusive breastfeeding at 14 weeks (hexavalent 3rd dose). Complementary feeding practices are often poor, characterized by low dietary diversity among children under five. Vitamin A supplementation coverage has also decreased due to temporary supply disruptions.

Figure 20: Trends in Exclusive breastfeeding at 14 weeks hexavalent 3rd dose (2015-2024)



Ensuring adequate maternal and child nutrition is critical for improving health outcomes, reducing morbidity and mortality, and supporting progress toward the Sustainable Development Goals (SDGs). Interventions must focus on strengthening maternal nutrition, improving infant and young child feeding practices, ensuring effective management of SAM, and addressing socio-economic and food security challenges.

Figure 21: Vitamin A supplementation coverage, quarter 4 (2024/25) versus quarter 1 (2025/26) Financial years



Relevant instruments and evidence based policies and evaluation, strategies and frameworks exists to guide priority actions required to strengthen maternal and infant and young child nutrition aligned to the national development plan vision 2030. Among these includes the sustainable development goals nutrition targets 2030 to reduce stunting by 50%, reducing or maintain overweight and obesity to below 3%, to reduce or maintain child wasting to below 3%, reduce low birth weights by 30%, improve exclusive breastfeeding to at least 70%.

Women's health

- **Contraception**

The most recent South Africa Demographic and Health Survey (2016) reported a contraceptive prevalence rate (CPR) of 55% of in-union women and 60% of sexually active women using a method of contraception. Couple year protection (rate CYPR) is routinely used as the indicator in the District Health Information System (DHIS) in South Africa, forming part of the National Department of Health's National Indicator Data Set2. South Africa has an overall national CYPR of 45.0% (2022/23)3. There was a 5.3% decrease in CYPR in 2022/23, compared to the previous year and over the past five years, CYPR has steadily decreased from 60.7% in 2018/19 to 45% in 2022/2023. Data between 2022 and 2023 shows a decrease in CYPR for condoms, NET-EN and the oral contraceptive pill, and an increase in intra-muscular DMPA and the sub-dermal implant. One in five women of reproductive age (15-49 years) are estimated to have an unmet need for contraception. Unmet need is higher for adolescent girls and young women: 31% among adolescent girls (15-19 years) and 28% among young women (20–24 years

National CYPR:

- Reached 55.4% in 2023/24, an increase of 10.4 percentage points from 2022/23.
- Positive trend, but still below the national target of 75% and below the 2016/17 historic peak of 69.9%.
- CYPR declined from 54.5% in 2019/20 to a low of 45% in 2022/23,reflecting reduced access to and uptake of contraceptive services, increasing the risk of unplanned pregnancies.

Provincial CYPR Performance:

- All provinces showed a steady increase from the previous year.
- Free State (FS) is the only province meeting the national target of 75% CYPR, achieving 87.5% (↑ 3.6 percentage points).
- Remaining provinces recorded CYPRs below 60%.
- Western Cape (WC) and Gauteng (GP) reported CYPRs below the national average of 55.4%.

Cervical Cancer

Cervical cancer remains the second most commonly diagnosed cancer among women in the country. For the 2025/26 financial year, the department has prioritised key interventions aligned with the WHO Cervical Cancer Elimination Strategy to reduce mortality from this preventable disease. The focus areas include expanding HPV screening services to more districts, increasing HPV vaccination coverage among girls aged 9–14 years, and scaling up the number of cervical cancer screening tests performed nationally.

In Quarter 1, a total of 187 367 cytology tests and 85 213 HPV tests were performed, bringing the national total to 272 580 tests (see Table 1). This exceeds the national target of 200 000 tests as outlined in the Annual Performance

Plan (APP). Cytology continues to make up the bulk of testing. This may be due to the NHLS's current limitation in distinguishing between primary cytology tests and reflex cytology tests, which could be inflating the cytology count.

Table 3: Cervical Cancer Screening Tests Performed in South Africa, April-June 2025

Province	Cytology Tests Conducted	HPV Tests Conducted	Total
Eastern Cape	11 236	16 628	27 864
Free State	11 940	1 937	13 877
Gauteng	41 761	12 162	53 923
KwaZulu-Natal	41 481	31 620	73 101
Limpopo	14 074	0	14 074
Mpumalanga	22 516	4 642	27 158
North West	13 236	16 241	29 477
Northern Cape	2 917	1 958	4 875
Western Cape	28 206	25	28 231
South Africa	**187 367**	**85 213**	**272 580**

In terms of district performance, all 52 districts are conducting cytology testing. Regarding HPV DNA testing, the target for Quarter 1 of 2025/26, as outlined in the APP, is 23 districts. At the sub-national level, 43 districts are implementing HPV DNA testing, surpassing the national target.

- **Choice on Termination of Pregnancy**

Maternal deaths from unsafe abortions have declined dramatically, but studies in 2024 reveal that unsafe abortions and related complications persist**.** As of 2024, less than 7% of public health facilities provide abortion services, making access difficult for many, especially those in rural areas. The majority of legal abortions are performed by a small number of providers in a limited number of facilities**.**

Integrated School Health Programme (ISHP)

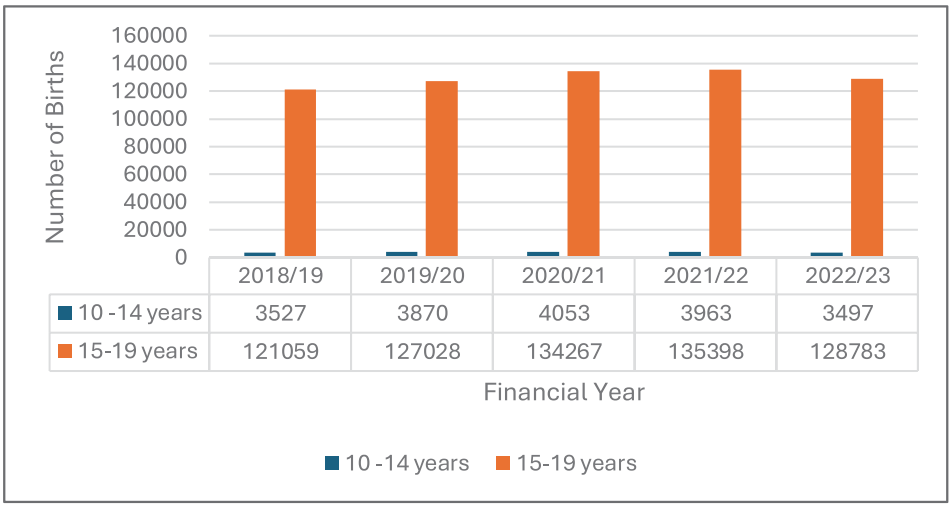
Sustainable development Goals which call for the reduction of maternal mortality to <70 per 100,000 live births and under-five mortality to reducing under 5 mortality to ≤25 deaths/1000 live births by 2030<30 per 1,000 live births. United Nation Convention on the Rights of the Child: provision of good quality health care, clean water, nutritious food, and a clean environment and education on health and well-being so that children can stay healthy**.** African Charter on the rights and well fare of the child: Every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health. (b) to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care.

Stepping up effective school health and nutrition: a partnership for healthy learners and brighter futures, UNESCO: United Nations Educational, Scientific and Cultural Organisation.World Health Organization, Maternal, newborn, child and adolescent health and ageing report,National Development Plan (NDP) 2030: Aims to reduce maternal mortality to <70 per 100,000 live births and under-five mortality to <30 per 1,000 live births. Medium-Term Development Plan (MTDP) 2024–2029: Focuses on universal health coverage, reducing preventable deaths, and improving service equity. National Health Insurance (NHI): Targets equitable access to quality healthcare, with phased implementation by 2026. National Health Act: Free health services for all (PHC) and free health (hospital) service for pregnant women and children under five years. Presidential Health Compact: Emphasizes multi-sectoral collaboration, infrastructure investment, and workforce development.

- **Adolescent pregnancy and childbearing**

Pregnancy and childbearing among adolescent girls are major obstacles to completion of their education, in addition to exposing them to health risks and stigma. The issue of adolescent pregnancy in South Africa has received a great deal of attention by the health, education and social development sectors, researchers and the media. Data from the DHIS on adolescent births in public health facilities suggest that concerns about teen pregnancy and early childbearing are warranted. The number of deliveries increased each year from 2018/19 to 2021/2022 and declined slightly in 2022/2023. The number of deliveries to adolescent girls 10-14 years, though much lower than those 15-19 years, is cause for concern as the age of sexual consent in South Africa is 16 years for girls and boys.

Figure 22: Number of deliveries by female adolescents in public health facilities by age group, South Africa: 2018/19 - 2022/23



Source: DHIS

Specific interventions to be implemented, to achieve to the SDGs and MTDP targets (Reduction of Maternal and Child Mortality)

- Prevent and Manage Childhood Infections**:** Strengthen early detection, treatment, vaccination, and hygiene programs to reduce deaths from pneumonia, diarrhoea, and other preventable infections.
- Address HIV and TB in Pregnancy**:** Integrate routine screening, treatment, and PMTCT services into maternal health care, supported by community engagement to ensure adherence and reduce vertical transmission, thereby reducing maternal and neonatal deaths.
- Improve Maternal and Child Nutrition: Provide targeted nutrition support, supplementation, and growth monitoring, alongside social support programs to address food insecurity and underlying determinants, improving maternal and child survival.
- Prevent and manage cervical cancer**:** Expand HPV vaccination, routine screening, and early treatment within primary and maternal health services to reduce maternal mortality.
- Reduce teen pregnancy: Promote adolescent reproductive health education, access to contraception, and youth-friendly health services to prevent early pregnancy and associated maternal and neonatal complications.
- Prevent neonatal mortality: Strengthen skilled birth attendance, essential newborn care, infection management, and referral systems to reduce deaths in the first 28 days of life.
- Strengthen disease surveillance**:** Implement robust maternal and child health surveillance systems to track infections, nutrition, immunization coverage, and emerging health threats, enabling timely interventions to reduce both maternal and child deaths.
- Strengthen health systems and community platforms: Enhance workforce capacity, supply chains, telemedicine, and community-based programs to ensure access, quality, and continuity of maternal and child health services.
- Promote intersectoral and data-driven collaboration: Coordinate health, education, social services, and WASH programs, supported by integrated data systems to target high-risk populations and optimize interventions, improving maternal and child outcomes.

HIV and AIDS

For decades, South Africa grappled with a devastating pandemic, experiencing a dramatic and terrifying acceleration of new HIV infections, which peaked around the critical inflection point of 1999–2000. Since that zenith, the nation has wrestled the epidemic into a state of sustained retreat, projecting a continued decline in incidence through 2025. This downturn, while a testament to national effort, is not uniform. The significant dip in HIV incidence observed from 2010 to 2024 varies dramatically in pace across different provinces, highlighting regional differences in resource allocation and local adherence.

More crucially, however, the burden of the epidemic remains profoundly skewed by gender. Despite the overall downward trend, **the HIV incidence rate consistently remains higher in females compared to males across all age groups.** This disparity is a flashing red light, pointing to socio-economic vulnerabilities, sexual violence, and persistent structural barriers that prevention campaigns alone cannot dismantle. The progress achieved is tangible, yet it remains incomplete so long as entire demographic groups shoulder disproportionate risk.

The deceleration of new infections, however varied and incomplete, is not accidental. It is the direct downstream effect of one of the world's most ambitious public health undertakings: the commitment to universal treatment access. This unwavering focus on controlling the virus within the population has allowed South Africa to translate treatment goals into actual, measurable epidemiological progress

Overall, South Africa has achieved significant milestones, reaching 96-78-94 in its "95-95-95" targets by July 2025. This means 96% of people living with HIV (PLHIV) are diagnosed, 78% of those diagnosed are on Antiretroviral Treatment (ART), and 94% of those on ART are virally suppressed.

However, a profound chasm remains approximately 1.1 million known HIV-positive individuals are not yet retained on life-saving treatment (the "second 95" gap). This critical shortfall is exacerbated by specific challenges. Subpopulation Disparities: Adult males (75% on treatment) and children under 15 (75% on treatment) lag significantly behind adult females (80%), highlighting urgent needs for targeted interventions.

Youth Vulnerability: High prevalence rates persist among Adolescent Girls and Young Women (AGYW), demanding intensified combination prevention and expanded Youth Zones.

STI Surge: An escalating rate of STIs necessitates improved syndromic management and commodity availability.

Operational Bottlenecks: While Differentiated Models of Care (DMOC) have improved efficiency, the slow uptake of 6-Month Multi-Month Dispensing (MMD) hinders retention and overburden facilities.

Funding Shifts: The transition from donor funding (PEPFAR, Global Fund) requires robust local absorption and integration of key population services into mainstream health.

Data Integrity: The absence of a unique patient identifier leads to repeat testing and difficulties tracing lost-to-follow-up patients, impacting data accuracy and continuity of care.

The Strategic Response: Pillars for 2026/2027

Driven by the National Strategic Plan 2023-2028 and aligned with the National Development Plan 2030, the 2026/2027 plan focuses on aggressive, targeted interventions:

- **Closing the Treatment Gap:**

Intensifying the "Close the Gap Campaign": A national drive to trace and initiate the 1.1 million missing PLHIV, leveraging community outreach and NGO collaboration.

Scaling DMOC and 6-MMD: Aggressive expansion of multi-month dispensing (up to 6 months) for stable patients to reduce facility visits and boost adherence.

Advanced HIV Disease (AHD) Management: Prioritising early screening and comprehensive management to reduce mortality.

- **Innovation and Prevention at Scale:**

The roll out of Lenacapavir, a game game-changing, twice-yearly injectable anti-HIV medication will begin in April 2026, offering new options for treatment and prevention, especially for those with adherence challenges. The roll out will begin in 23 high incidence districts across six provinces, targeting around 360 high performing public clinics within these areas for Phase 1 implementation. Preparatory work has begun in clinics at the selected sites for early integration of Lenacapavir delivery through the primary health care clinics extending to community-based sites linked to those clinics, which caters for all the at-risk population. Training healthcare providers will be undertaken so that nurses and counsellors are prepared to discuss this new option with clients, manage the administration of the injection, and handle any follow-up needs. Data systems will also be updated to incorporate Lenacapavir indicators into our national monitoring systems.

Combination Prevention: Doubling down on proven strategies like VMMC, PrEP expansion, and promoting female condom uptake.

U=U Messaging: Full implementation of the "Undetectable = Untransmittable" toolkit to combat stigma, encourage viral load testing, and improve adherence.

- **System Strengthening and Collaboration:**

Policy & Guideline Finalisation: Disseminating updated guidelines for ART and the HTS Policy.

Capacity Building: Equipping healthcare workers with enhanced skills in combination prevention and robust monitoring frameworks.

Digital Transformation: Collaborating with Digital Health to establish a unique patient identifier system and develop an “HIV Intelligence Centre” to improve data integrity and patient tracking.

Orchestrated Collaboration: Ensuring seamless coordination across internal programmes (TB, Mental Health) and external partners (NGOs, funders, civil society) to maximise resource utilisation and integrated service delivery, especially amidst donor transitions.

The 2026/2027 plan represents a crucial phase, demanding agility, innovation, and unwavering commitment. By strategically addressing the remaining treatment gaps, embracing new technologies, and fostering powerful partnerships, South Africa aims to accelerate its journey towards ending AIDS as a public health threat.

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Tuberculosis

In 2024, a total of 195,049 people (both drug susceptible TB [DS-TB] and drug-resistant TB [DR-TB]) were initiated on TB treatment in South Africa. Despite the implementation of numerous interventions, TB continues to be a major challenge plaguing health system in the country. The TB incidence remains high at an estimated 389 people per 100,000 population (249,000 estimated to get TB annually).

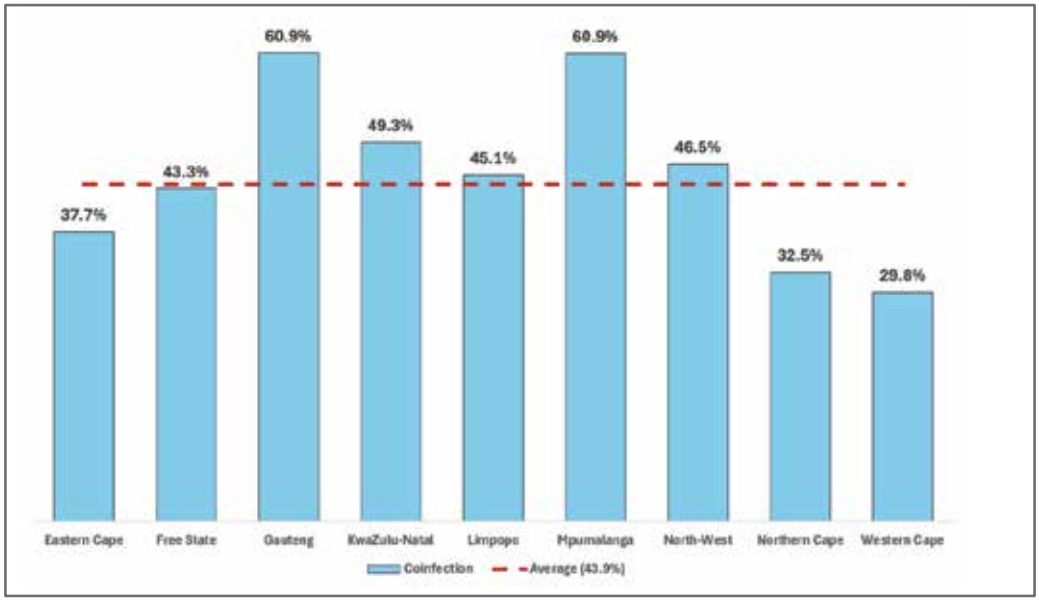
The TB incidence rate has reduced by approximately 60% between 2015 and 2024. This rate has surpassed the 2025 milestone of a 50% reduction. The intention is to further strengthen efforts to meet the 80% reduction by 2030 in line with the Sustainable Development Goals (SDG) target and 90% reduction by 2035 for the End TB Strategy target.

TB deaths has had 16% reduction between 2015 and 2023. Currently, an estimated 54,455 people succumbed to TB versus 56,000 in 2022. This reduction constituted less than 3% between 2022 and 2023. The National TB Control Programme (NTP) is highly unlikely to meet the SDG/End TB Strategy milestone of 75% reduction in the number of deaths by 2025, let alone the 90% and 95% milestones of 2030 and 2035, respectively.

Catastrophic costs for TB affected families still remain at 56% since no update surveys have been conducted since 2021. Further surveys are probably linked to evaluations that follow milestones, with the next likely to be expected 2026. Costs are inextricably linked to socio-economic factors like poverty, human settlement, inadequate social support and poor nutritional status. South Africa has a very high coefficient of inequality, with a GINI Index of 63 in terms of the 2014. The majority of TB patients are part of the low socio-economic group. This group is likely to contract and develop TB disease. Poor preventive measures and treatment outcomes are often associated with strenuous social and financial environment. A web of interacting factors impact on outcomes and require inclusion of a broader social cluster collaboration that includes Departments of Social Development; Human Settlement; Transport; Agriculture and Land Affairs; and so on.

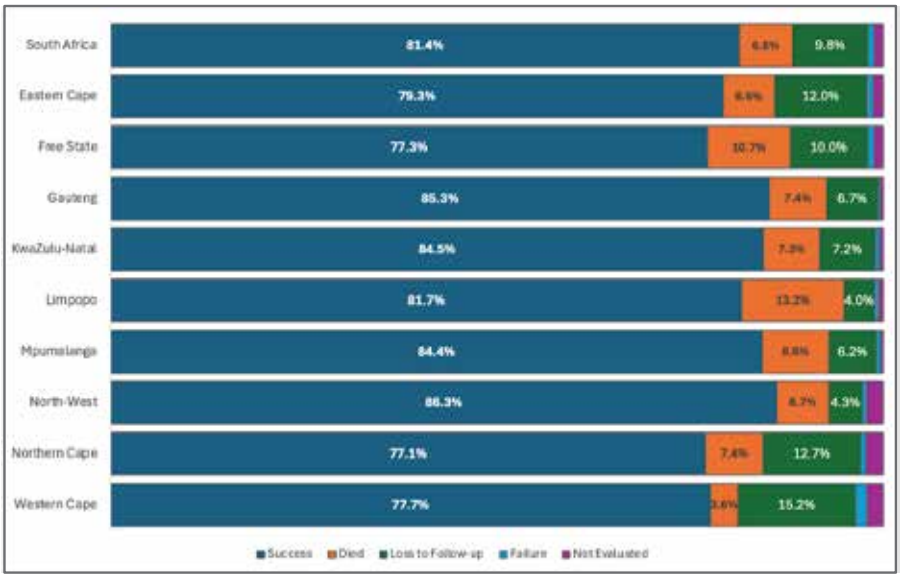
HIV co-infection is one of the major risk factors of TB. The country’s co-infection rate was reported at 54% in 2023. In 2024, a reduction of about 10% was realized. Two provinces recorded more than 60% co-infection rates while the Western Cape reported the lowest (29.8%). Data indicates major gains have been recorded with the largest Antiretroviral Therapy (ART) Programme internationally.

Figure 23: Percentage of TB/PLHIV per province with an average of 43.9%



The treatment success rate in 2023 was 81% for DS-TB and 63% for Multi-Drug Resistant TB (MDR-TB) in 2022. The national outlook of the favourable outcome (treatment success) indicated a slight positive shift of approximately 2% from 79%. Data quality, however, affects the true appreciation of achievement in terms of favourable outcomes.

Figure 24: Treatment outcome by province for the 2023 Cohort



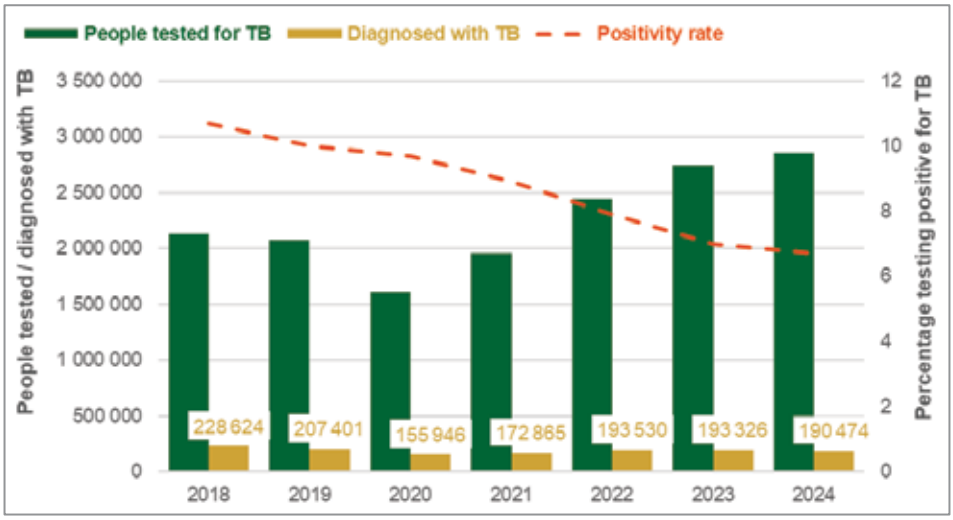
A review DR-TB patients on treatment between 2020 and 2024 showed that 69% of DR-TB patients were successfully treated against 59% for same period. There was also a significant difference in terms of death (16% in the group with low BMI and 12% in the group with normal BMI). Inadequate integration of TB, HIV and MCWH services is another challenge.

Strategic framework for TB Management

In 2022, the TB Recovery Plan was crafted as a target-driven, evidence-based plan aimed at finding people with undiagnosed TB, strengthening linkage of people diagnosed with TB to treatment, strengthening retention in TB care, and strengthening TB prevention. During year 3 of the TB Recovery Plan we noted an expansion of screening activities as well as the use of digital chest X-ray for TB screening. More than 3 million molecular TB tests were conducted during the year 2024. We have introduced more patient-friendly treatment regimens (4-month paediatric DS-TB and 6-month DR-TB regimen) in order to improve retention. It is noted that treatment success rate for MDR-TB increased from 62% to 75% after the introduction of the 6-month regimen. TB treatment loss to follow up has been reduced to 9%. There has been a scale up implementation of new TB preventive therapy including 3HP (3 months of weekly rifapentine and isoniazid oral treatment) to improve TB prevention and reduce transmission, especially among household contacts.

The launch of the END TB Campaign aiming at testing 5 million individuals during the year 2025 by the Deputy President came as an enhancement to the TB Recovery Plan. This campaign will help accelerate reduction of TB incidence and mortality.

Figure 25: Number of people tested and diagnosed with TB, 2018-2024



During the financial year 2026/2027, the 5th year of the implementation of the TB Recovery Plan and the 3rd year of the current HIV/TB National Strategic Plan will be an important year. A programme review should be conducted to establish the current status of HIV, TB, hepatitis, STIs and MCWH services in the country. Other key interventions will include the creation of demand for TB services through a robust social behavioural change communication, finding people with TB through enhanced TB screening, identification of hotspots, geo-mapping, improved contact tracing, molecular TB testing, linkage to TB care, retention to TB care through psychosocial support, integrated care and improved quality of TB care. We will also enhance TB in the mining sector and the use of TB data for decision making.

Communicable Disease Control

South Africa, as signatory to the International Health Regulations (2005) [IHR], has developed the National Action plan for Health Security (NAPHS) to mitigate the impact of public health emergencies in the country. The estimated cost of the implementation of the NAPHS for the first two years 9205 and 2026) is R914,427,349.00. Table 4 depicts the estimated cost of the Operational NAPHS. The coordination, monitoring and evaluation of the NAPHS implementation is one of the programme's priorities.

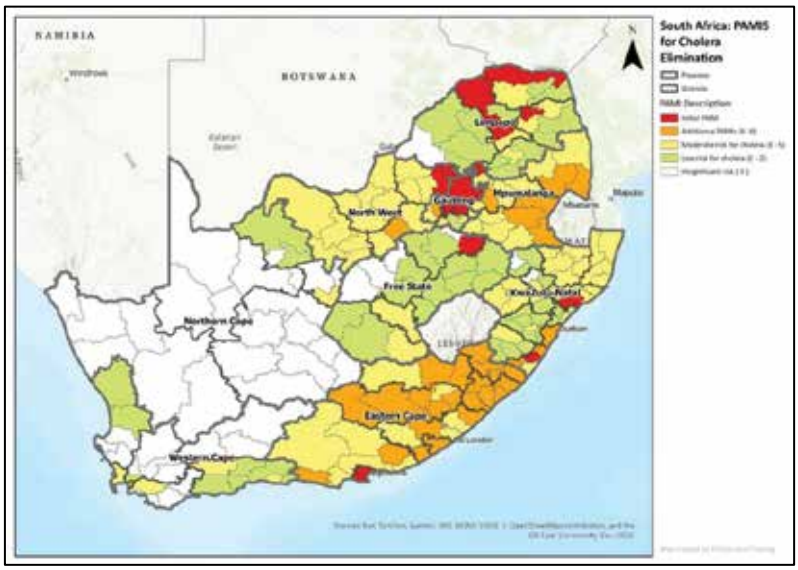
Table 4: South Africa Operational National Action Plan for Health Security (NAPHS) 2025-2026

Technical Area	2025	2026	TOTAL ZAR
P1. Legal instruments	1,592,385	2,674,185	4,266,570
P2. Financing	-	-	-
P3. IHR coordination, National IHR Focal Point functions and advocacy	13,886,482	17,356,882	31,243,364
P4. Antimicrobial resistance (AMR)	52,786,976	63,960,108	116,747,084
P5. Zoonotic diseases	3,441,691	6,383,131	9,824,822
P6. Food safety	12,414,080	12,411,840	24,825,920
P7. Biosafety and biosecurity	-	489,900	489,900
P8. Immunization	10,611,420	25,121,000	35,732,420
D1. National laboratory systems	71,817,400	130,375,400	202,192,800
D2. Surveillance	99,101,144	89,979,964	189,081,109
D3. Human resources	7,138,400	726,280	7,864,680
R1. Health emergency management	9,531,280	20,346,960	29,878,240
R2. Linking public health and security authorities	-	1,091,400	1,091,400
R3. Health services provision	3,262,200	3,262,200	6,524,400
R4. Infection prevention and control (IPC)	10,178,421	211,233,179	221,411,600
R5. Risk communication and community engagement (RCCE)	14,184,200	9,246,600	23,430,800
PoE: Points of entry and border health	616,520	3,215,720	3,832,240
CE. Chemical events	820,500	2,169,500	2,990,000
RE. Radiation emergencies	-	3,000,000	3,000,000
Other Technical/Focus Area	-	-	-
Total	311,383,099	603,044,249	914,427,349

The development and proposed implementation of the NAPHS was based on the recommendation that emanated from the Joint External Evaluation of the IHR implementation in South Africa. It took into consideration the 10th Pillar of the Presidential Health Compact - Pandemic Preparedness and Response, World Health Organization guidelines on Preparedness and Resilience for Emerging Threats (PRET) initiative, Global Task Force on Cholera Control (GTFCC), etc.

Cognizant of the global threat posed by cholera, the Global Task Force on Cholera Control (GTFCC), established by WHO in 1992, put forward a Global Roadmap to 2030 aiming to reduce cholera deaths by 90% and eliminate the disease in 20 countries by 2030. In the quest to strengthen the preparedness and response to Cholera outbreaks in the country, the programme embarked on the process to identify and strengthen Cholera Priority Areas for Multisectoral Interventions (PAMIs). The final map of the cholera risk in the country is depicted in Figure 26. The map will form the basis of the development of the National Cholera Plan in line with the Global Task Force on Cholera Control (GTFCC).

Figure 26: Cholera risk in South Africa



South Africa is endemic for Neglected Tropical Diseases (NTDs) that mainly affect poor and marginalized communities. Four NTDs that are endemic in South Africa, and which are of public health concerns are Soil-transmitted helminths (STHs) - Ascaris lumbricoides, Trichuris trichiura and hookworms (Necator americanus and Ancylostoma duodenale), schistosomiasis, Leprosy, and Rabies. These diseases cause chronic, disfiguring and disabling conditions and are among the leading perpetuators of the cycle of poverty, significantly diminishing economic productivity in affected adults and inhibiting intellectual and physical development of the next generation.

The National Department of Health in South Africa is committed to controlling NTDs in line with the requirements of both the Sustainable Development Goals (SDGs) and the **WHOs Ending the neglected to attain the Sustainable Development Goals – A road map for neglected tropical diseases 2021-2030.** The roadmap seeks to facilitate alignment among Member States and other stakeholders and to accelerate progress towards disease groups now prioritized by WHO and attaining the Sustainable Development Goals. The epidemiological trends of Schistosomiasis (bilharzia) in South Africa is depicted in Table 5 below.

Table 5: Epidemiological trends of Schistosomiasis (bilharzia) in South Africa: NMC report 2019 – 2024

	2019 (N = 14 761)	2020 (N = 11 203)	2021 (N = 7 680)	2022 (N = 13 943)	2023 (N = 11 581)	2024 (N = 12 080)	Overall
Age							
Median (IQR)	17 (14-22)	16 (13 -20)	14 (11 - 18)	14 (11-19)	14 (11-18)	14 (11-18)	15 (12 - 19)
Unknown	880	525	308	1 119	445	1 063	4 340
Sex							
Female	3 733 (25%)	2 707 (24%)	1 773 (23%)	3 464 (25%)	2 598 (22%)	3 180 (26%)	17 455 (24%)
Male	**11 028 (75%)**	**8 495 (76%)**	**5 907 (77%)**	**10 479 (75%)**	**8 981 (78%)**	**8 899 (74%)**	**53 789 (75%)**
Self-Defined	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (<0.1%)	0 (0%)	1 (<0.1%)
Unknown	0 (0%)	1 (<0.1%)	0 (0%)	0 (0%)	1 (<0.1%)	1 (<0.1%)	3 (<0.1%)
Province							
EC	**1 276 (8.6%)**	**932 (8.3%)**	**662 (8.6%)**	**971 (7.0%)**	**828 (7.1%)**	**567 (4.7%)**	**5 236 (7.3%)**
FS	13 (<0.1%)	3 (<0.1%)	6 (<0.1%)	9 (<0.1%)	10 (<0.1%)	6 (<0.1%)	47 (<0.1%)
GP	580 (3.9%)	448 (4.0%)	207 (2.7%)	364 (2.6%)	352 (3.0%)	397 (3.3%)	2 348 (3.3%)
KZN	**5 093 (35%)**	**3 783 (34%)**	**3 379 (44%)**	**6 673 (49%)**	**5 511 (48%)**	**3 415 (28%)**	**28 854 (31%)**
LP	**4 539 (31%)**	**3 470 (31%)**	**2 039 (27%)**	**3 319 (24%)**	**2 825 (24%)**	**5 951 (49%)**	**22 143 (31%)**
MP	**2 918 (20%)**	**2 340 (21%)**	**1 232 (16%)**	**2 176 (16%)**	**1 802 (16%)**	**1 493 (12%)**	**11 961 (17%)**
NC	4 (<0.1%)	1 (<0.1%)	1 (<0.1%)	6 (<0.1%)	4 (<0.1%)	8 (<0.1%)	24 (<0.1%)
NW	33 (0.2%)	26 (0.2%)	13 (0.2%)	25 (0.2%)	22 (0.2%)	41 (0.3%)	160 (0.2%)
WC	305 (2.1%)	200 (1.8%)	141 (1.8%)	200 (1.4%)	227 (2.0%)	202 (1.7%)	1 275 (1.8%)
Case definition							
Confirmed	**14 714 (99.7%)**	**11 153 (99.6%)**	**7 616 (99.2%)**	**13 881 (99.6%)**	**11 528 (99.5%)**	**12 009 (99.4%)**	**70 901 (99.5%)**
Suspected	47 (0.3%)	50 (0.4%)	64 (0.8%)	62 (0.4%)	53 (0.5%)	71 (0.6%)	347 (0.5%)
Vital Status							
Alive	550 (3.7%)	566 (5.1%)	412 (5.4%)	911 (6.5%)	1 358 (12%)	1 783 (15%)	5 580 (7.8%)
Deceased	**2 (<0.1%)**	**0 (0%)**	**1 (<0.1%)**	**4 (<0.1%)**	**5 (<0.1%)**	**6 (<0.1%)**	**18 (<0.1%)**
Unknown	14 209 (96%)	10 637 (95%)	7 267 (95%)	13 028 (93%)	10 218 (88%)	10 291 (85%)	65 650 (92%)

The department, in collaboration with the Department of Basic Education, has since 2016, used drugs donated by World Health Organization (WHO) to conduct large scale annual school-based preventive chemotherapy for soil-transmitted helminthes (STHs) only. The programme is planning to embark on rolling out the MDA in endemic districts of the country in collaboration with all relevant stakeholders.

The programme ii not exempted from human resources and budgetary constraints. The integration of the activities with other health programmes and partners will be catalytic in identifying cost effective approaches and platforms to deliver the services where necessary. The programme is enjoying technical and financial support from partners such as WHO, Africa CDC, Jhpeigo, Clinton Foundation, Leprosy Mission, academic and research institution as well as other government departments and agencies. The programme seeks to address three strategic objectives of the programme using the One Health Approach: namely

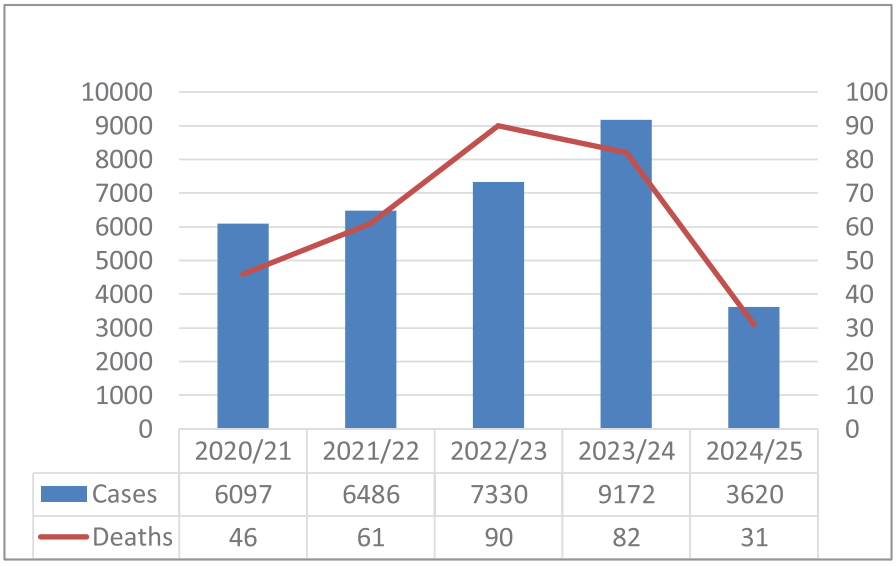
- Strengthening epidemic preparedness and response in line with the International Health Regulations (2005)
- Strengthening the prevention and control of Neglected Tropical Diseases; and
- Strengthening the prevention and control of Zoonotic Diseases.

Malaria

Malaria is an important indicator in the UN Sustainable Development 2030 Goals, where goal 3 particularly targets countries to end epidemics of malaria, among other diseases, where the key indicator is malaria cases per 1000 population at risk. Subsequently, the World Health Organization developed its Global Technical Strategy (GTS) 2016-2030. One of the key pillars of the GTS is to accelerate efforts towards elimination and the attainment of malaria-free status in 35 countries around the world.

South Africa's malaria elimination agenda is coordinated within the Malaria and Vector Borne Disease (MVBD) directorate. The Malaria Elimination Strategic plan 2025/26–2029/30 has been develop to guide implementation of interventions to reduce malaria incidence to zero. This strategic plan is closely aligned to national policy mandates, including the National Health Act, the National Development Plan, and the National Department of Health Strategic Plan 2020/21 and 2024/25 respectively.

Figure 27: Malaria cases and Deaths



	2020/21	2021/22	2022/23	2023/24	2024/25
Cases	6097	6486	7330	9172	3620
Deaths	46	61	90	82	31

Total malaria cases has significantly declined from 6097 to 3620; resulting in a **46%** decline between 2020/21 and 2024/25 financial years. Local cases for the same reporting period showed a greater decline from **2472** to **430**; **82%** decline; demonstrating significant progress towards malaria elimination in South Africa.

Malaria elimination in South Africa will be achieved through sustained efforts, continued vigilance, and strong collaboration with key stakeholders and neighbouring countries. The key strategies for elimination will be to strengthening of surveillance, health promotion, case management and vector control. The programme has adopted a systematic approach to malaria eliminating by targeting sub-district, with effective combination of established and novel tools to eliminate the foci of malaria transmission. A broad range of stakeholders and partners contribute to achieving malaria elimination planned outcomes this include, provincial malaria programme managers, World Health Organization, Southern Africa Development Community (SADC), United Nations, Developmental Partners (UNDP) RBM Partnership, Clinton Health Access Initiative, South African Medical Research Council, National Institute for Communicable Diseases and researchers within South Africa's universities.

Notably, resources are available for the acceleration of malaria elimination efforts through a conditional grant, targeting malaria endemic provinces (Limpopo, KwaZulu Natal and Mpumalanga). Additionally, there's funding available through a co-financing initiative targeting source reduction within Southern Mozambique' s high burden districts, this forms part of a global funding mechanisms to aid achievement of malaria elimination regionally.

Non-Communicable Diseases

SDG goal 3.4. stipulate that by 2030, premature mortality from non-communicable diseases should be reduced by prevention and treatment and the promotion of mental health and well-being. The National Strategic Plan for Non-communicable diseases 2022 – 2027 advocates for targeting the five major groups of NCDs (i.e. cardiovascular diseases, cancer, chronic respiratory diseases, diabetes and mental health, including neurological conditions) which have the highest morbidity and mortality rates of NCDs. It also aligns with the five shared behavioural risk factors (tobacco use, unhealthy diet, physical inactivity, harmful use of alcohol and air pollution).

The department is conducting screening for diseases which include hypertension and diabetes at facilities and all its events. There is also intensification of screening at the household and community level by training the community health

workers and traditional health care practitioners on hypertension, diabetes and cancer. These cadres are progressively provided with the tools of trade to enable them carryout this responsibility.

The strengthening of the use of Point of Care Test at healthcare facilities is contributing a great deal towards the prevention and control of non-communicable diseases by reducing tests result turnaround times in order to expedite rapid clinical decision-making. This has been achieved through the approval of contract: NDOH 35-2023/2024 for the Supply and Delivery of Point of Care Testing Devices, Software and Related Consumables to the Department of Health for Non-Communicable Diseases and Primary Health Care for a Three-Year Period.

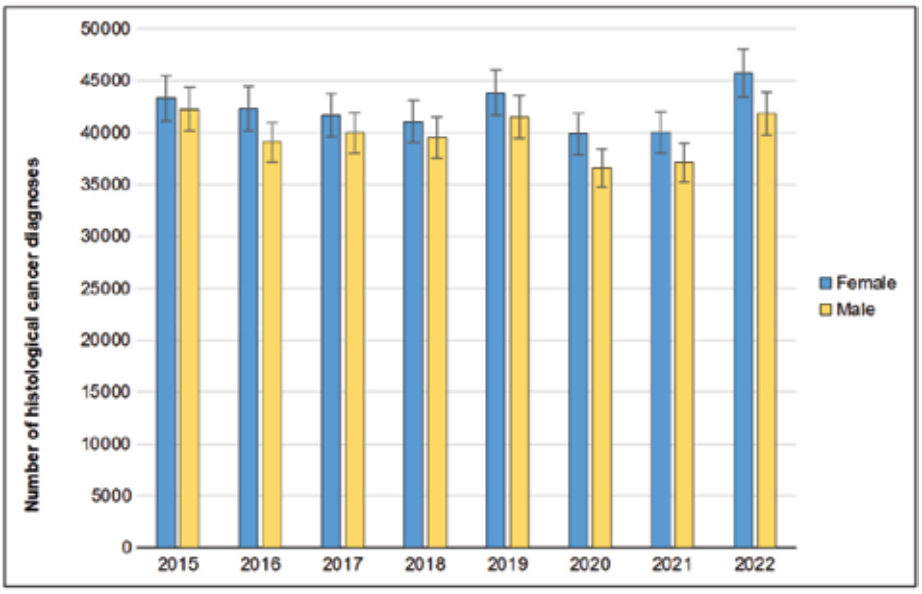
The directorate strengthens equitable access to comprehensive NCDs, Disability, geriatrics, cancer and palliative care services. The percentage of older persons in South Africa has increased to 9,7% in 2024 and it is expected that it will further increase to 10,2% by 2030 and to 15,4% by 2050. The United Nations announced the Decade of Healthy Ageing 2021–2030 in 2020 for countries to respond to the ageing population , focusing on the following areas - change how we think, feel and act towards age and ageing; ensure that communities foster the abilities of older persons; deliver person-centred integrated care and primary health services responsive to older persons; and to improve access to long-term care for older persons who need it. The National Department of Health is in the process of finalising a National Policy Framework and Strategy (NPFS) for Older Persons, based on the action areas of the Decade of Healthy Ageing 2021-2030 and to strengthen older persons' access to health care and improve the quality of care provided to them so that they can live a quality life.

Challenges that the directorate has experienced finalisation of the reviewal of expired strategic frameworks (Framework and Strategy on Disability and Rehabilitation 2015-2020, National policy framework and strategy on Palliative care- 2017-2022, National Cancer strategic Framework-2017-2022) Challenges that the directorate has are with regards to human resources, as there are posts that need to be created , e.g. ASDs for the different sub-directorates , this will enable high performance of the directorate and execution of all the strategic frameworks that sit in the directorate.

- ***Cancer***

Cancer is defined as a large group of diseases that can affect any part of the body, also known as neoplasms and malignancies (WHO). The incidences of cancer are rising globally. According to the Global Cancer Statistics 2020 (GLOBOCAN), in 2020 it was estimated that there were 19.3 million new cases and approximately 10 million cancer related deaths worldwide. In South Africa, cancers were found to be the fourth leading cause of death in 2028, with 9.7% of all mortality. The National Cancer Strategic Framework for South Africa 2017-2022 identified five priority cancers given the burden of disease, and these represents 40.6% of reported cancer diagnoses in 2019. Basal Cell Carcinoma of the skin cervical cancer and breast cancer were found to be the most common in in females whilst prostate cancer was the mostly frequently diagnosed cancer in males.

Figure 28: Number of diagnoses among males and females, 2015-2022



Source; South African Health Review, 2023. Health Systems Trust.

The figure shows a higher number of cancers reported in female than in males. Underreporting cancer cases remains a significant challenge in providing a comprehensive scope of the problem in order to put effective mechanisms in place. There is a critical need to enhanced data collection and reporting mechanisms for more precise identification of high-risk populations and regions, facilitating targeted public health interventions and tailored treatment strategies[3].

Access to oncology services is constantly being improved by acceleration of oncology infrastructure made possible by the national tertiary services grant and oncology grant. The grant contributes immensely towards the upgrading of medical equipment; the standard of care and quality of working life has been improved through the procurement of Clinical equipment. The procurement of all this clinical equipment goes a long way to ensuring compliance with the Health Technology life cycle. There is currently a drive to improve access to Oncology services through the development and improvement of these services. New Oncology projects are currently being developed at the following site in Eastern Cape Province (Nelson Mandela Academic Hospital), Gauteng Province (Chris Hani Baragwanath Hospital, Dr George Mukhari Hospital), KwaZulu Natal Province (Ngwelezane Hospital), Mpumalanga Province ()Rob Ferreira Hospital) and Northern Cape Province (Robert Mangaliso Sobukwe Hospital)

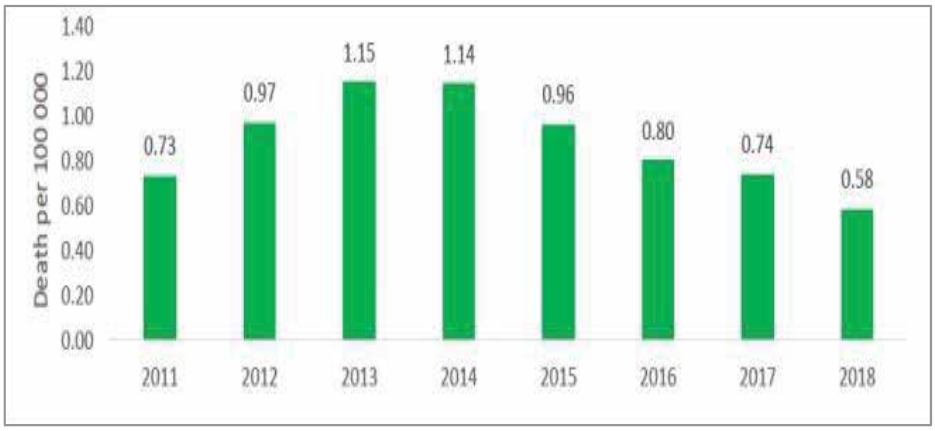
- ***Mental Health***

The SDG goal 3.4 refers to the prevention, treatment and promotion of mental health and well-being.

The Mental Health Care Act, 2002 (Act No 17 of 2002) as amended and the National Mental Health Policy Framework and Strategic Plan 2023-2030 provide a framework for delivery of mental health services in South Africa. The legislation and policy propagate for integration of mental health into the general health services environment at all levels of the health care system from community and primary health care upwards. Over and above the Mental Health Care Act, 2002 and National Mental Health Policy Framework and Strategic Plan 2023-2030 the subprogramme derive its additional mandate from the section 77, 78,79 of the Criminal Procedures Act, 1977 (Act No 51 of 1977 as amended in terms of forensic mental observations, Child Justice Act, 2008 (Act No 75 of 2008) mainly in terms of criminal capacity assessments of children between the ages of 12 and 14 years who come into contact with the law and the Prevention of and Treatment for Substance Abuse Act, 2008 (Act No 70 of 2008) in terms of prevention and treatment of substance use disorders.

The burden associated with mental disorders in high. The Global Burden of Disease study found the 12-months prevalence of (proportion of a population who have a mental disorder at any point during 12 months) in South Africa to be 15,9%. Depressive disorders, anxiety disorders and alcohol and other drug-use disorders are the most common mental disorders in South Africa. Emotional and behavioral disorders and post-traumatic stress disorders are also prevalent among adolescents. The SDG goal 3.4 refers to the prevention, treatment and promotion of mental health and wellbeing. Data from the 2023 Statistics South Africa Report on SDGs shows a reduction in suicide mortality rates from 1.15 per 100 000 population in 2013 to 0.58 per hundred thousand population in 2018.

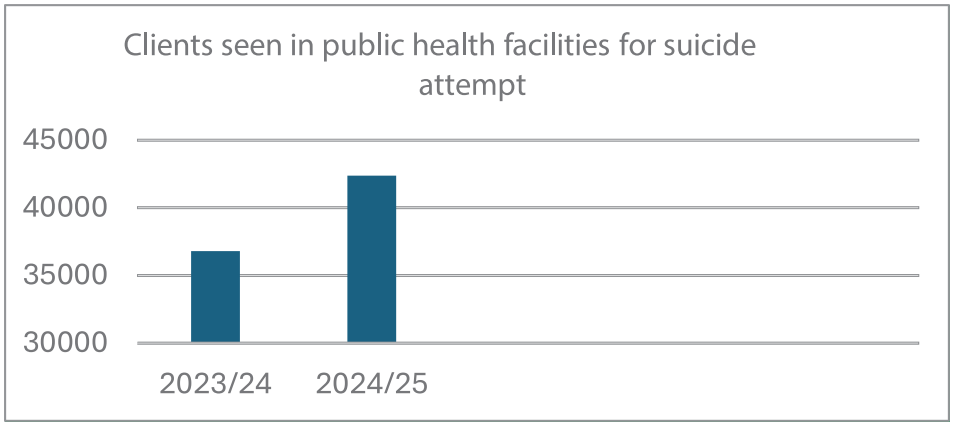
Figure 29: Suicide mortality rate, 2011 – 2018, StatsSA, 2023



The attempted suicide cases seen in public health facilities on the other hand increased on the District Health information System from 36 805 visits during the 2023/24 financial year to 42 385 during the 2024/25 financial year suggesting increasing levels of emotional distress. 30% of the clients seen for suicide attempts in public facilities were children below the age of 18yrs .

[3] Ndlovu, N., Gray,A., Blose, N. & Mokganya, M. (2003). South African Health Review

Figure 30: Number of Suicide attempts



Substance use disorders are also on the increase and remain one of the key drivers of psychiatric morbidity in the country. Data from the South African Medical Research Council's South African Community Epidemiology Network on Drug Use (SACENDU) project which collects data from the substance abuse treatment centers indicates that cannabis and methamphetamine have overtaken alcohol as a primary or secondary substance of abuse nationally and opioids have moved to the forth position.

An increasing number of people are accessing the mental health system through the criminal justice system either after they have relapsed and committed crimes or not identified until they commit crimes resulting in forensic mental enquiries and State patients' backlogs. There is also a high readmission rate which further add strain on the mental health services. Inadequate infrastructure, human resource gaps also continue to be a challenge despite the progress that is being made to address these.

A key strategic outcome of the department is for mental health care to be integrated within primary health care. The Department continue to make remarkable strides in the realisation of this key strategic outcome. Among others the strides include strengthening availability of mental health care professionals at primary health care level by contracting additional mental health professionals using the mental health conditional grant that was allocated, of psychotropic medication in the essential medicine lists for all the levels including primary health care, integration of mental health into the work of community health care workers that visit households, Mental health indicators are part of the national health information system use various platforms to educate the public on mental health issues.

Disability and Rehabilitation Services

The countries' disability and rehabilitation services are based on global frameworks and international instruments such as the UN Convention on the Rights of Persons with Disabilities (UNCRPD). The White Paper on the Rights of Persons with Disabilities was put into effect to improve the realisation of the rights of persons with disabilities. Progress made with the improvement of the realisation of the rights of persons with disabilities are provided to the Department of Women, Youth and Persons with Disabilities.

The National Disability Rights Machinery (NDRM) is a structure that emanated from the White Paper on the Rights of Persons with Disabilities. The NDRM has biannual meetings that provides a platform to track the implementation of the White Paper on the Rights of Persons with Disabilities and to discuss interventions to accelerate the implementation of the white paper. The National Department of Health is in the process of establishing an interim working group as a coordinating structure to fast track the progress made with improving the realisation of the rights of persons with disabilities.

The World Health Organisations' World Disability Report (2010) identified service delivery gaps which includes limited access to assistive technology and in they have placed emphasis on improving access to assistive technology in their action plan. The department was part of a task team that was set up by the Department of Basic Education to explore the status of the provisioning of assistive devices (wheelchairs; spectacles; hearing aids) to learners with disabilities. Most provinces indicated a backlog on the provisioning of assistive devices with the reasons being lack of funding for these services. While transversal contracts are in place for these critical devices to make the procurement process easier, the timeously renewal of these contracts were a challenge. Human Resources are also a major challenge with lack of specialised positions such as eye specialists and audiologists.

The following Strategic Frameworks that will improve access to rehabilitation services, need to be in place:

National Framework and Strategy for Disability and Rehabilitation services; Strategy on the Screening of Childhood Hearing; and a National Framework and Strategy for Eye Health Care.

Service Delivery Platform

- ***District health system***

The District Health System (DHS) is a central pillar of the health system where most contact with service users takes place. The DHS platform provides an interface for individuals, households as well as communities. As the country is well on its way to achieving Universal Health Coverage, community-based services are a critical enabler of this realization where access for all people who needed health services with no financial hardship is essential. Community-based services enable comprehensive response to community needs through Primary health care, community outreach programmes, school health and environmental health. The district health system will be capacitated in the planning aspect to strengthen alignment with National and Provincial plans for effective implementation of sector priorities.

While access to primary health care has improved nationally, gaps remain particularly in community outreach via Ward-Based Outreach Teams. Declining numbers of community health workers and team leaders, driven by financial constraints and safety concerns, hinder coverage. Fixed health facilities such as clinics and district hospitals face human resource shortages, leading to long waiting times and poor adherence to appointment systems. Infrastructure issues limited space, dilapidated buildings, and poor maintenance and lack of other resources contribute to clinic bypassing and overcrowding at higher-level hospitals.

Initiatives to improve access to community health worker services and Primary health care health establishment including district hospitals, include finalization of the Community health worker policy and framework and implementation of their transition into permanent post development and implementation of patient centered care, improved compassionate care, clinic bypass prevention framework and strategy, sharpening of clinical governance and skills and training in the referral policy

Governance structures (clinic committees and hospital boards) are inconsistently functional due to appointment delays. To address this oversight mechanisms and legislation in this regard will be reviewed.

Gaps in leadership, governance, monitoring, and supervision have led to poor facility management in some areas. The pilot implementation of capacity building in the improved performance management in primary health care is an opportunity that will be explored.

Sections 41 and 42 of the National Health Act (Act 61 of 2003) centralise the appointment of governance structures under the MEC, causing delays. Consultations on the development of Community Health Worker Policy Framework is concluded and will thereafter be finalized. This process will give way to the finalisation of the District Health Policy Framework and Strategy to enhance Universal Health Coverage through PHC. The Department collaborates with key stakeholders to address social determinants of health. These include Department of Social Development, Corporative Governance and Traditional Affairs, South African Social Security Agency, South African Police Services, Department of Basic Education, Department of Justice and Constitutional Affairs and Private Health Sector

In the medium terms the sectors will pursue permanent employment of community health workers to strengthen PHC access, implementation of the Integrated Patient Coordinated Care (IPCC) framework to improve service integration, development of provincial clinical governance frameworks and expansion of point-of-care testing and the introduction of a Clinic Bypass Prevention Framework and Strategy.

- ***Environmental and Port Health Services***

Environmental health is the foundation upon which public health, human well-being, and sustainable development are built, by ensuring clean air, safe water and food, safe management of chemicals and healthy homes and communities. Section 24 of the South African Constitution guarantees everyone “an environment that is not harmful to their health or well-being. The National Environmental Health Policy, 2013, the Hazardous Substances Act 15 of 1973, Foodstuffs, Cosmetics and Disinfectants Act 54 1972 and the National Norms and Standards for Environmental Health,2015 establish a framework within which Environmental Health Service’s priorities are aligned. Additionally, the International Health Regulations, 2005, which is a legally binding framework established by the World Health Organization (WHO), provides a primary purpose of preventing, protecting against, controlling, and providing a public health response to the international spread of disease.

Various challenges exist in the service delivery environment, which include limited financial and human resources reducing quality and efficiency of services. The rising demand of services due to urbanisation and climate change impacts have placed an additional burden on already constraint capacities. Challenges experienced in the service delivery environment will be addressed through strengthening oversight through monitoring and assessment of compliance to the norms and standards and establishing stronger collaboration in the 3 (three)

government spheres. Additionally, through strengthening monitoring of Points of Entry to ensure core capacities outlined in the amended IHR, 2005 are developed, strengthened and maintained.

Changes in national legislative frameworks, government priorities and policy direction may affect service delivery models. The successful implementation of the Annual Performance Plan may be adversely affected by political instability and budgetary limitations or restrictions.
Environmental health is fragmented between various government departments, such as the Department of Fisheries, Forestry and the Environment, Water and Sanitation, and Agriculture amongst others. Collaboration with these stakeholders is key to ensuring alignment of plans and sharing of data on environmental health risks, outbreaks, or service gaps, improving oversight and decision-making.

Climate change, although presenting various challenges to the health system, provides opportunities for strengthening environmental health programme through the raised political and donor attention. Climate adaptation emphasizes resilience at the community level, providing an opportunity to expand community engagement and monitoring to ensure safe water, sanitation, waste management, and vector control.
Climate change and pollution have a profound impact on the healthcare system. Rising global temperatures, extreme weather events, and poor air quality are contributing to an increase in respiratory illnesses, cardiovascular disease, heat-related conditions, and the spread of infectious diseases.

Health facilities themselves are also vulnerable i.e. health care services may be disrupted due to floods, storms, or heatwaves, straining emergency response capacity. Air Pollution is one of the leading environmental risk factors for premature death, driving higher healthcare costs and increasing the burden of chronic respiratory and other conditions. In response to these impacts, the process of finalizing a Climate Change and Health Adaptation Strategy for the health sector is underway, to ensure that healthcare systems and communities can adapt and built resilience to the impacts of climate change. The Strategy aims to promote green hospital initiatives, to improve on energy efficiency, reducing waste, and transitioning to renewable power. In addition, public health preparedness will be strengthened by integrating climate risk assessments into planning and emergency response. These reforms aim to reduce the healthcare sector's environmental footprint while ensuring it can adapt to the rising demands of a changing climate.

The 2022–2032 Science, Technology and Innovation (STI) Decadal Plan of South Africa outlines three primary Societal Grand Challenges (SGCs), Climate Change and Environmental Sustainability, Education, Skills, and the Future of Work and the Future of Society. These challenges are central to the Decadal Plan's mission to leverage STI for inclusive economic growth, social development, and environmental sustainability. The plan aims to enhance the National System of Innovation (NSI) by aligning it with national priorities and fostering a coordinated approach among government, academia, industry, and civil society. The development of the Climate Change and Health Adaptation Strategy aims to ensure that the health care sector adopt sound environmental management and sustainable practices in health care provision.

- ***Emergency Medical Services***

Emergency Medical Services (EMS) are a critical component of South Africa's health system, providing timely medical care during emergencies, interfacility transfers, and planned patient transport. EMS operates within a regulatory framework guided by the Constitution, the National Health Act (Act No. 61 of 2003), EMS Regulations (2017), and the Regulations Relating to Standards for EMS (2022). While the EMS Regulations set minimum requirements and accreditation processes, the Standards focus on maintaining and improving service quality. Together, these regulations aim to standardise EMS across provinces and ensure equitable access to care. The Department of Health is currently revising the EMS Regulations to enhance its implementation and to support interoperability between public and private EMS, in preparation for the implementation of the National Health Insurance (NHI).

South Africa's population is projected to exceed 62 million by 2028, with provinces such as Gauteng, KwaZulu-Natal, and the Western Cape seeing the highest EMS call volumes due to urbanisation and economic migration. Trauma from road accidents and violence, non-communicable diseases, and mental health emergencies further drive EMS demand.

In alignment with the National Department of Health's Strategic Plan, the National Committee on Emergency Medical Services (NCEMS) developed a medium-term EMS Strategic Plan. This plan is informed by the Medium-Term Development Plan (MTDP), the Presidential Health Compact, the National Development Plan 2030, and Annual Performance Plans. Its goal is to address challenges affecting EMS delivery to both communities and health facilities.

Key stakeholders include national and provincial health departments, the Health Professions Council of South Africa, academia, private EMS providers, NGOs, and community-based organisations. Current initiatives involve public-private partnerships for fleet management and communication centre upgrades, and academic partnerships to expand training. There is also a need to explore community-based models, particularly to improve rural access and response times.

Major challenges include inadequate funding, geographic inequity, poor transport infrastructure, staff shortages, limited ambulance availability, under-resourced facilities, and inefficient communication systems. These factors contribute to poor response times and limited access to aeromedical and patient transport services. The medium-term focus is on optimising fleet management, strengthening EMS training through public colleges, and aligning policies to enhance operations.

Emerging priorities include equipping EMS personnel with Occupational Health and Safety training and preparing for climate-related disasters such as floods and heatwaves.

- ***Hospital System***

Hospital performance in the country has been markedly variable. There are some examples of well-performing institutions that have motivated staff who render quality health services and manage to do this within their budget allocation. This is notwithstanding the demands on the facility. There is a culture of commitment and resilience in the public sector workforce which allows health workers to persevere despite challenging circumstances. However, there are many instances of hospitals that have failed to provide consistent quality care to patients, receive negative publicity from the poor quality of care, have unsustainable medico-legal expenditure, display poor leadership, governance, and responsiveness, have demotivated staff, and experience consistently qualified audit outcomes. The plan is to get approval of the Hospital Sector Strategy that addresses the above-mentioned hallenges in the hospitals.

Factors affecting services in the service delivery Classification of hospitals not aligned with service delivery reality whereby there is misalignment between hospital classification, service packages, staff establishment and budget allocation.Critical shortages of staff, that leads to poor clinical outcomes and poor staff attitudes.

Leadership instability at provincial and hospital levels – Most hospitals have vacancy rate at executive management. Variation in levels of support from provinces to hospitals - there are Provinces without someone appointed to lead or provide oversight to hospitals. Functional hospital boards which assist hospitals in community consultation. Functional governance structures. Oversight support from both National Department of Health and Provincial Department of Health.

Regional, Tertiary and District Hospitals are not adequately staffed to render their full-service packages as per their hospital designation categories. This results in a constant up referral of patients to the higher levels of care and ultimately creates bottlenecks at Tertiary institutions. The current infrastructure and staff establishment of the hospital hinders the expansion of tertiary/quaternary services.

- ***Human Resources for Health***

The health workforce also referred to as Human Resources for Health (HRH) is at the centre of any functional and resilient health system. Without health care workers, there can be no access to even basic health care services. The health workforce is an enabler of efficient and effective health care. Shortages of health care workers across the Provinces fueled by financial constraints persist, posing a threat to the attainment of the goals of improved population health, public health security, and economic growth.

Significant progress with implementation of a Human Resource Information System as envisaged in the 2030 HRH Strategy has been realized and is already providing insights on the number of health workers of different categories available to provide health promotion and disease prevention, as well as curative, therapeutic, rehabilitative and palliative services in the country. The Department has developed and implemented a Human Resources Information System (HRIS) that has significantly strengthened the Department's ability to manage, plan, and monitor its workforce. The HRIS has been expanded to integrate with payroll, finance, and other critical systems, enabling a seamless flow of data for strategic decision-making. Automated reporting tools and real-time dashboards have been introduced, reducing reliance on manual processes and improving the accuracy and timeliness of HR data. These improvements have not only enhanced efficiency in HR administration, but also provided a reliable evidence base for workforce planning, resource allocation, and compliance with national frameworks such as the DPSA guidelines and the HRH 2030 Strategy.

As guided by global goals and targets, including the Sustainable Development Goals which recommend an increase in health financing and in the recruitment, development, training and retention of the health workforce, especially in low- and middle-income countries. The United Nations High Level Commission on Health Employment and Economic Growth (HEEG) called for

investment in skills and the appropriate number of health workers recognizing the potential of HRH in contributing to overall economic growth by creating jobs, particularly for women and the youth. The 2030 Global HRH Strategy of the World Health Organization (WHO) further shaped and provided a foundation for the country's HRH Strategy.

Employment in the public service has been a challenge due to austerity and fiscal consolidation measures introduced by National Treasury. This has affected the public health sector's ability to employ health professionals post teir community service. The health workforce is at the heart of an efficient and well-functioning health system. There can be no delivery of health services without a skilled, enabled and supported health workforce. Hence the case for investing in the health workforce cannot be over-emphasized.

A Ministerial Advisory Committee has been established to review the challenges and potential reforms related to selected HRH retention policies namely Commuted Overtime; Community Service, Rural Allowance & Other Remunerated Work (formerly referred to as the Remunerated Work Outside the Public Service (RWOPS) policy).Funding has been secured from the Pandemic Fund to strengthen South Africa's human resources capacity to prevent, prepare for, and respond to future pandemics – in collaboration with the World Health Organisation (WHO), the Food and Agriculture Organisation (FAO), and the United Nations Children's Fund (UNICEF).

Over time, several concerns have been raised regarding the adequacy, relevance, and sustainability of the current Occupational Specific Dispensation (OSD) frameworks. A review of the OSDs has become necessary to establish the status of implementation, identify gaps, and recommend possible reforms that balance fiscal sustainability with the need to attract, motivate, and retain skilled health professionals.

- ***Health Infrastructure***

Appropriate health infrastructure is crucial to create an inducive environment for quality healthcare and workspace for workers. Despite the improvements made in infrastructure, maintenance repairs to health facilities remain a challenge in most provinces. Pillar 3 of the Presidential Health Compact commits towards execution of the infrastructure plan to ensure adequate, appropriately distributed and well-maintained health facilities. One of the interventions for the realisation of this commitment is to explore innovative financing options for infrastructure development and maintenance. The health facility revitalisation grant is the largest source of funds for public health infrastructure, which is aimed at accelerating construction, maintenance, upgrading and rehabilitation of new and existing infrastructure including technology. Monitoring and oversight activities are carried out to enhance capacity for delivery of infrastructure.

- ***Health Technology and Innovation***

The sector has committed to the development and implementation of a single electronic record in the 7th administration. This reform which is part of a broader strategy on digital health, will enable the users of health care to have one record managed though an electronic system which will be accessible to all health care providers that the patient will come in contact through the life course. An integrated electronic system that captures the individuals' medical records linked to which facilities and healthcare providers delivered which services associated with what diagnosis and treatment that feeds into a stock management system. The single patient record will promote continuity of care as patients get referred across different levels of care and will preserve the medical history as patients migrate within the country.

Digital health introduces a national transversal system for users, and providers which supports the portability of care and hence the most impactful opportunity. Digitalisation of data collection tools for community health workers is underway, aiming to enhance data quality and reporting.

Health Technology and Innovations projects :

- Provision of Leaner Management Information systems (LMIS) and Student Information Management Systems (SIMS) for all nursing colleges
- Wi-fi connection.
- Adequately equipped simulation laboratories for all colleges
- Updated Computer laboratory with sufficient stations for the number of students.
- Computer hardware for academic personnel.
- Teaching and learning equipment.

Technological innovations, such as mobile EMS applications, may empower communities to request help, track ambulances, and receive first aid guidance. Additionally, artificial intelligence and health technologies will be leveraged to improve EMS efficiency through predictive analytics, optimised dispatch, and enhanced clinical care.

In addition to the HRIS, the department has developed and is implementing an e-learning management system (LMS) – the Knowledge Hub system. The learning management system is a platform that provides access to curated professional development opportunities and resources, including online and blended-learning courses, webinar , self-study resources, policy documents, guidelines, and reference materials to healthcare professionals in support

of continuous professional development and skills and performance improvement.

- ***Nursing Services***

The nursing sub-programme develops, guides and monitors the implementation of a national policy framework for the development of required nursing skills and capacity to deliver effective nursing services to healthcare users.Nurses form the highest number of health care professionals. In that light achieving universal health coverage requires nurses who are fit for purpose, suitably qualified, and competent. The concomitant regulatory framework which includes standards, clinical governance and statutory support should therefore be aligned to enable and guide the safe practice of nurse practitioners.

The lack of mental health nurse training (undergraduate programme at NQF level 7) is a challenge since the introduction of the new nursing training programmes, aligned to the Higher Education Qualification Sub Framework (HEQSF). The shortage is causing misalignment with the Mental Health Act because of non-availability of suitably qualified nursing personnel to care for mental health care users.

There is a shortage of midwives currently which resulted firstly, from the existence of a large cohort of professional nurses from the legacy qualification under Regulation R683 who do not have Midwifery. Secondly, the training of General Nurses under Regulation 171 also are not midwifery qualified. Lastly, the time lag in the commencement of training of the Advanced Diploma in Midwifery under R1497.

There is also shortage of qualified Nurse/Midwife Specialists also known as the Post Graduate Diploma (PGDip) at NQF level 8. This might possibly be because of limited study leave opportunities. Delayed accreditation processes at Nursing Education Institution (NEI) level could also be contributory factors. For those NEIs that are accredited, the lack of suitably qualified nurse educators prevents the provision of PGDip.

The provincial Nursing Practice Directorates and Nursing Colleges play a pivotal role in the development of the NNLCF implementation plans. These stakeholders identify areas of development for each category of nurse in leadership positions according to the five dimensions(s) of the developed leadership frameworks. They play a leading role in the development of these plans, future implementation, and monitoring and evaluation thereof.

The Nursing Practice has limitations in leadership capabilities of nurses in leadership positions. A national nursing leadership competency framework has been developed to be used as an orientation and induction tool for newly appointed managers and a continuing professional development tool for those currently in leadership positions.The Nursing Education Directorate identified the need to establish the current categories of nurses and their training needs in relation to service delivery requirements. This resulted in the development of the National Differentiated Nursing Education and Training Plans which will be implemented in the medium-term period

In terms of the shortage of midwives and mental health care trained nurses, the cluster is collaborating with the SANC, Council of Higher Education (CHE) and nursing education institutions for the programme development of the undergraduate Mental Health Nursing at NQF level 7. Furthermore, the consideration of mass implementation of the undergraduate Midwifery programme, also at NQF level 7. These two interventions will enable an additional stream of articulation for nurses wanting to study towards the Post Graduate Diploma (PGDip) and qualify as nurse/midwife specialists.

There is an urgent need for the refurbishment, renovation and maintenance of nursing colleges and student accommodation. To this end the challenges will be referred to the Health Facility Infrastructure Revitalisation unit. Implementation of the National Nursing Leadership Competency Framework training for nurses in leadership positions. There is an opportunity from Health and Welfare Sector Education and Training Authority (HWSETA) to collaborate with the Forum of University Nursing Deans of South Africa (FUNDISA) for the provision of research capacity training for nurse educators.

- ***Access to medicine and other commodities***

Access to medicine has been improved through various strategies including the introduction of the Centralised Chronic Dispensing and Distribution Programmes (CCMDD), which enable collection of medicine parcels for stable chronic patients at a Pick-up Point of their choice thereby reducing congestion at health facilities. Additionally, the Differentiated Model of Care (DMOC) programme provides a similar platform where HIV clients are able to collect medicines at Facility Pick-Up-Points, Adherence clients and External Pick-Up points, which expand the medicine dispensing platform promoting adherence to treatment. With respect to medicine stock management, the implementation of a Stock Visibility System (SVS) which has been largely a success, has led to a reduction in stock-outs and reduced pressure at facilities. A key challenge during implementation largely relates to constraints around personnel capacity, where there has been a substantial lack of pharmacy assistances in facilities to drive SVS.

The sector will be implementing strategies to improve the availability of medical equipment which is affected by a myriad of challenges owing to the laborious process related to procurement. The interventions will be aimed at stabilising the supply of equipment to health facilities and improving quality of equipment.

- ***Quality of care and health system improvement***

Quality is a cross-cutting enabler for the provision of care, as well as the health sector investment in the improvement of health infrastructure, equipment, human resources and information system, is essential in improving access to quality healthcare, the experience of care, the experience of care by clients and overall better health outcomes.

Trend analyses based on Patients Experience of Care surveys and complaints reports.

Annually, the health department seeks feedback about the experienced quality of care from patients, focusing on six thematic areas of care, namely, patient access to healthcare services, availability and use of medications, cleanliness, patient physical safety when in our health establishments, values and attitudes of staff members towards patients, and patient waiting time for healthcare services. Although there is an improvement in the patient experience survey rate from 82.2% in 2024/25 to 94.8% in 2025/26 across the eight provinces, there is a general decline in the level of patient satisfaction across the five thematic areas of healthcare. The thematic area of availability and use of medications remains similar at 94.7% and 94.1% in 2023/24 and 2024/25, respectively. This demonstrated patient satisfaction with patient access to health services, i.e. 85.8% to 87.34% satisfaction in 2023/24 and 2024/25, respectively. However, general cleanliness of the health establishments and patient waiting time for services remains the highest determinants of patient dissatisfaction.

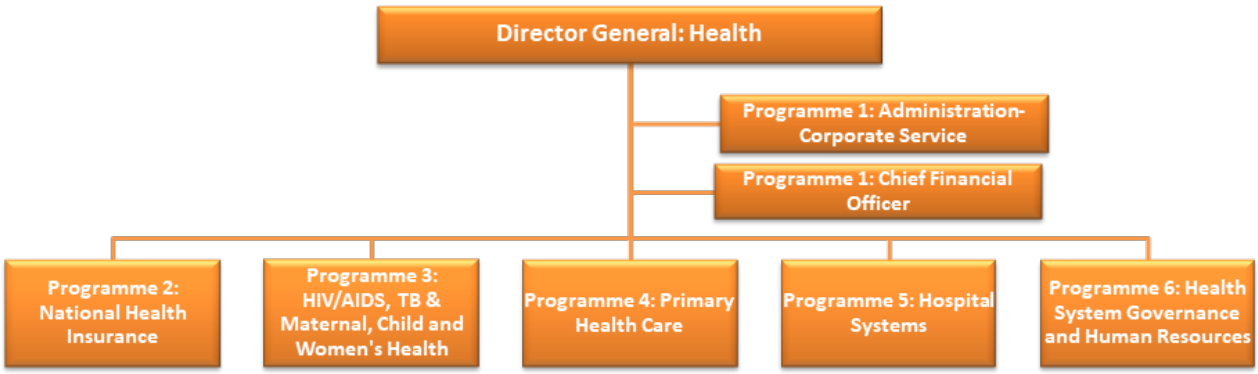
An effective complaints management programme by health facilities enables provinces to address quality challenges to improve health outcomes. In his State of the Nation Address 2025, the president of the country reiterated his intention to improve patient experience by putting more emphasis on reducing waiting times, ensuring cleanliness and improving staff attitudes in public health facilities[4]. To address these shortfall, the National Department of Health is continuing to sustain availability and use of medications through Stock Visibility System (SVS), management of patient waiting time for health care services including devolution of patients to satellite service points through CCMDD program, re-education of staff members about ethics and customer care and management of cleaning through infection prevention and control programs and improving building infrastructure through replacement of some health establishments and or construction of new health establishments.

The department will continue to implement the Ideal Health Facility Realisation and Maintenance Programme to enhance service quality. To date, 2,762 primary health care facilities have achieved ideal status. In 2024/25, six district hospitals joined the programme. Key barriers include infrastructure limitations, staffing shortages, non-compliance with Non-negotiable vital standards, and inadequate clinical governance prioritisation.

[4] **President Cyril Ramaphosa: State of the Nation Address.** State of the Nation Address by President Cyril Ramaphosa, Cape Town City Hall 06 Feb 2025

7.2 Internal environment analysis

7.2.1 Organisational Structure



- **Organisational capacity to deliver**

Delivering on the NHI Fund mandate requires the new entity to be established and given autonomy, and it must be sufficiently equipped and resourced, as well operate in a new institutional environment with a transformed culture. Limited capacity and resource constrain limit the ability to develop and implement or test proof of concepts for NHI Fund functions, as well as required continuous improvement and innovation. Delivering on the NHI Fund mandate requires the new entity to be established and given autonomy, and it must be sufficiently equipped and resourced, as well operate in a new institutional environment with a transformed culture.

- **Gender Responsive Procurement**

In line with Section 217 of the Constitution, the PFMA, and the Preferential Procurement Policy Framework Act (Act 5 of 2000, Regulations of 2022), the Department applies internal SCM policy which provides for preference points in procurement processes. For tenders, preference is allocated to five categories: Historically Disadvantaged Individuals (HDIs), women, persons with disabilities (PWDs), SMMEs, and South African-owned companies. For quotations, preference is allocated to three categories: HDIs, women, and PWDs.

Through this framework, the Department continues to prioritise inclusive procurement opportunities for PWD-owned enterprises. In 2024/25, procurement spend directed to disability-owned enterprises amounted to 0.24% of total tender spend and 1.34% of total quotation spend. While this reflects incremental progress, participation by PWD-owned enterprises remains well below target. This is largely due to systemic barriers, including supplier market readiness, limited representation on the National Treasury's Central Supplier Database (CSD), and the legislative requirement that suppliers register independently on the CSD before qualifying for participation.

As a result, the Department's ability to expand participation by PWD-owned suppliers is limited. However, SCM ensures that bid specifications and evaluation criteria remain accessible and inclusive, that PWDs are consistently included in preference point allocations, and that procurement spend directed to disability-owned enterprises is monitored and reported. Importantly, all reporting on procurement spend related to persons with disabilities is formally consolidated through the Annual Progress Report on inclusion and Mainstreaming of Persons with Disabilities in Programmes of National Departments and Offices of the Premier, as coordinated by the Department of Women, Youth and Persons with Disabilities (DWYPD) in terms of the Implementation Matrix of the White Paper on the Rights of Persons with Disabilities (WPRPD).

- **Challenges and Mitigation**

Despite deliberate inclusion of PWDs in preference point allocations, the Department continues to experience low participation by disability-owned enterprises remains due to limited registration of PWD-owned suppliers on the National Treasury Central Supplier Database (CSD) which is a prerequisite for participation; broader legislative constraints, as departments cannot compel or fast-track supplier registration; Structural barriers in the supplier base, including capacity and market readiness challenges. To mitigate these limitations, SCM ensures that Bid specifications and evaluation criteria are developed in a manner that supports accessibility and inclusivity, preference points for PWD-owned enterprises are consistently applied in both tenders and quotations, procurement outcomes are monitored and reported through the DWYPD's annual WPRPD reporting framework, ensuring visibility of progress at a national level.

- **Proportion of Procurement Spent on Women, Disability-Owned Enterprises and Other Preference Categories**

The Department's SCM Policy mandates the use of preference points to advance inclusive and transformative procurement. In 2024/25, procurement spend was distributed as follows; for Tender Spend, Persons with Disabilities (0.24%) Historically Disadvantaged Individuals (HDIs) (30.59%), Women (19.21%), SMMEs (8.36%) and South African-owned Companies (41.60%). In terms of Quotation Spend, Persons with Disabilities accounted for 1.34%, Historically Disadvantaged Individuals (HDIs) made up 63.20% and for Women the proportion was 35.46%.

- **Challenges and Mitigation**

For Women-Owned Enterprises, there is strong participation in quotations but limited in large tenders. The department will continue the use of preference points for both tenders and quotation. For Historically Disadvantaged Individuals (HDIs), there is high inclusion overall, but fewer HDI suppliers win high-value contracts. There is ongoing application of preference points and monitoring of spend patterns to widen access to larger bids. For Small, Medium and Micro Enterprises (SMMEs), compliance and capacity constraints hinder participation in complex tenders and there is a process to review specifications to avoid unnecessary restrictions, ensuring accessibility to smaller enterprises while maintaining compliance with legislative frameworks. There is high participation for South African-Owned Companies but risk of supplier concentration in certain supplier groups, which can reduce competition and increase reliance on a small pool of dominant or familiar suppliers. Therefore, the preference points maintained with monitoring to ensure competition and supplier diversity. The Department will continue to apply the approved preference point categories in line with internal SCM policy and report on progress annually, while ensuring compliance with applicable legislation and alignment with the DWYPD reporting framework under the WPRPD

7.2.2 Employment Equity

The Department has made progress towards in response to the employment equity targets for Women, Youth and People with Disabilities. Challenges amongst others are include financial constraints, delays in recruitment processes, unique challenges related to people with disabilities i.e., non-disclosure of disability on application forms and suitability of candidates. Interventions to address challenges**:**

NDoH Gender Sensitive Policies

The process of evaluating a policy for gender-responsiveness does not yield a "yes" or "no" response. In the revised draft gender policy, we introduced the following system for evaluating gender-responsiveness:

- **GEM-0**: No consideration for gender mainstreaming and women empowerment has been made, no gender analysis and no gender results can be measured
- **GEM-1**: Some planned policy focus/actions, but with limited or inconsistent contributions to gender equality and women empowerment
- **GEM-2**: Though not a principal objective, policy outputs make a significant contribution to gender equality and women empowerment.
- **GEM-3**: Gender equality and women empowerment are the principal objectives of the policy/output

Based on the above, the 2024 draft policy mentions a number of DoH policies that reflect gender-responsiveness. The text states as follows:

Since the democratic era, the health sector has undergone several reforms to establish a more equitable, accessible and affordable healthcare system, that can meet the health needs of all South African residents. The Department of Health has already adopted several policies, strategies and programs that include gender equality for health equity as a principle, strategic objective or outcome. Some of the policies include, for example -

- National Strategic Plan for HIV, TB and STIs 2023-2028
- National Mental Health Framework and Strategic Plan 2023-2030
- National Health Research Priorities for South Africa Revised 2021-2024
- National Digital Health Strategy for South Africa 2019 – 2024
- National Integrated Sexual and Reproductive Health and Rights Policy 2019
- National Adolescent and Youth Health Policy 2017

The table 6 below summarize, the policies find expression in the following programmes at the Department:

PROGRAM	YOUTH DEVELOPMENT AREA
Internship Programme	Youth are provided experiential training in the workplace.
Skills Development	Interns are enrolled into skills programme to enhance their skills in the workplace.
HIV and AIDS	HIV Youth Program
Child, Youth and School Health	Adolescent and Youth Health
Child, Youth and School Health	Integrated School Health
Human Resource Development	Young Professionals including Cuban Doctors recruitment
SETU	Internship
Employment Equity	Data on Youth Employment

7.2.3 Personnel Information

Personnel numbers and cost by salary level and programme[1]

Programmes

1. Administration
2. National Health Insurance
3. HIV/AIDS, Tuberculosis and Maternal, Child and Women's Health
4. Primary Health Care
5. Hospital Systems
6. Health System Governance and Human Resources

	Number of posts estimated for 31 March 2026		Number and cost[2] of personnel posts filled/planned for on funded establishment														Average growth rate (%)	Average: Salary level/ Total (%)
	Number of funded posts	Number of posts additional to the establishment	Actual			Revised estimate			Medium-term expenditure estimate									
			2024/25			2025/26			2026/27			2027/28			2028/29			2025/26 -2028/29	2026/27 -2028/29
Health			Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost		
Salary level	**982**	**36**	**841**	**639.3**	**0.8**	**894**	**719.3**	**0.8**	**950**	**779.4**	**0.8**	**947**	**815.3**	**0.9**	**933**	**840.6**	**0.9**	**1.5%**	**100.0%**
1 – 6	269	1	241	90.2	0.4	266	104.6	0.4	305	113.8	0.4	306	117.6	0.4	306	123.9	0.4	4.8%	32.4%
7 – 10	372	5	321	199.5	0.6	335	222.5	0.7	335	233.9	0.7	335	246.6	0.7	329	256.0	0.8	-0.6%	35.3%
11 – 12	188	3	145	171.7	1.2	170	209.1	1.2	181	233.7	1.3	177	242.0	1.4	174	250.2	1.4	0.6%	18.8%
13 – 16	128	4	109	167.0	1.5	108	173.3	1.6	115	188.1	1.6	115	198.9	1.7	110	200.2	1.8	0.7%	12.0%
Other	25	23	25	10.8	0.4	14	9.8	0.7	14	10.0	0.7	14	10.2	0.7	14	10.4	0.7	-0.0%	1.5%
Programme	**982**	**36**	**841**	**639.3**	**0.8**	**894**	**719.3**	**0.8**	**950**	**779.4**	**0.8**	**947**	**815.3**	**0.9**	**933**	**840.6**	**0.9**	**1.5%**	**100.0%**
Programme 1	417	15	360	282.7	0.8	361	293.6	0.8	370	319.9	0.9	366	338.0	0.9	361	348.0	1.0	-0.0%	38.8%
Programme 2	102	7	83	67.9	0.8	103	91.1	0.9	116	114.5	1.0	113	117.2	1.0	111	120.8	1.1	2.8%	12.0%
Programme 3	182	1	152	87.7	0.6	152	92.4	0.6	151	95.8	0.6	148	98.5	0.7	144	101.7	0.7	-1.7%	15.6%
Programme 4	80	13	68	84.8	1.2	82	107.9	1.3	77	102.5	1.3	85	108.8	1.3	84	112.8	1.3	0.9%	8.7%
Programme 5	33	–	31	37.1	1.2	31	39.2	1.3	69	45.0	0.6	69	46.8	0.7	69	48.2	0.7	30.6%	7.3%
Programme 6	168	–	147	79.0	0.5	165	95.1	0.6	167	101.7	0.6	166	106.0	0.6	164	109.2	0.7	-0.3%	17.5%

Data has been provided by the department and may not necessarily reconcile with official government personnel data.

1. Rand million.

Expenditure trends and estimates

Programme	Audited outcome			Adjusted appropriation	Average growth rate (%)	Average: Expenditure/ Total (%)	Medium-term expenditure estimate			Average growth rate (%)	Average: Expenditure/ Total (%)
R million	2022/23	2023/24	2024/25	2025/26	2022/23 - 2025/26		2026/27	2027/28	2028/29	2025/26 - 2028/29	2026/27 - 2028/29
Programme 1	693.1	736.7	702.7	840.2	6.6%	1.2%	828.4	879.2	903.7	2.5%	1.3%
Programme 2	1 366.1	1 425.1	1 168.7	1 433.3	1.6%	2.2%	1 434.3	1 467.9	1 515.0	1.9%	2.1%
Programme 3	24 583.9	23 412.8	25 249.7	26 019.3	1.9%	39.9%	26 470.3	27 578.5	28 474.1	3.1%	39.5%
Programme 4	6 605.8	3 224.8	3 440.1	3 672.0	-17.8%	6.8%	3 777.4	3 947.3	4 070.6	3.5%	5.7%
Programme 5	22 207.5	22 142.1	23 872.0	26 135.5	5.6%	37.9%	26 218.5	27 398.0	28 236.1	2.6%	39.2%
Programme 6	7 439.7	7 370.6	7 448.6	7 824.9	1.7%	12.1%	8 181.3	8 522.8	8 809.8	4.0%	12.2%
Subtotal	**62 896.0**	**58 312.1**	**61 881.8**	**65 925.1**	**1.6%**	**100.0%**	**66 910.2**	**69 793.8**	**72 009.3**	**3.0%**	**100.0%**
Total	**62 896.0**	**58 312.1**	**61 881.8**	**65 925.1**	**1.6%**	**100.0%**	**66 910.2**	**69 793.8**	**72 009.3**	**3.0%**	**100.0%**
Change to 2025 Budget estimate				–			(17.5)	(389.3)	(1 324.4)		
Economic classification											
Current payments	**3 601.6**	**2 204.9**	**2 054.0**	**2 543.1**	**-11.0%**	**4.2%**	**2 432.1**	**2 523.8**	**2 598.8**	**0.7%**	3.6%
Compensation of employees	761.0	614.9	639.3	744.3	-0.7%	1.1%	779.4	815.3	840.6	4.1%	1.2%
Goods and services[1]	2 840.6	1 590.0	1 414.8	1 798.8	-14.1%	3.1%	1 652.8	1 708.5	1 758.2	-0.8%	2.5%
of which:											
Consultants: Business and advisory services	*294.4*	*153.6*	*146.6*	*373.3*	*8.2%*	*0.4%*	*254.9*	*229.6*	*232.2*	*-14.6%*	*0.3%*
Contractors	*530.9*	*452.0*	*425.7*	*635.9*	*6.2%*	*0.8%*	*609.8*	*628.2*	*647.8*	*0.6%*	*0.9%*
Operating leases	*102.9*	*111.8*	*136.2*	*135.5*	*9.6%*	*0.2%*	*131.1*	*146.7*	*151.3*	*3.7%*	*0.2%*
Property payments	*18.3*	*35.8*	*17.7*	*63.1*	*51.1%*	*0.1%*	*65.6*	*68.2*	*70.4*	*3.7%*	*0.1%*
Travel and subsistence	*103.8*	*100.0*	*107.9*	*102.4*	*-0.4%*	*0.2%*	*110.7*	*117.8*	*123.4*	*6.4%*	*0.2%*
Operating payments	*104.0*	*161.9*	*115.4*	*85.8*	*-6.2%*	*0.2%*	*94.4*	*104.3*	*106.9*	*7.6%*	*0.1%*
Transfers and subsidies[1]	**58 334.3**	**54 751.8**	**58 390.3**	**60 890.3**	**1.4%**	**93.3%**	**62 702.7**	**65 483.8**	**67 568.9**	**3.5%**	**93.8%**
Provinces and municipalities	56 251.5	52 743.4	56 357.9	58 609.4	1.4%	89.9%	60 350.5	63 047.6	65 053.4	3.5%	90.3%
Departmental agencies and accounts	1 869.7	1 776.3	1 796.8	2 030.3	2.8%	3.0%	2 103.4	2 185.8	2 257.3	3.6%	3.1%
Foreign governments and international organisations	–	–	18.2	18.4	0.0%	0.0%	–	–	–	-100.0%	0.0%
Non-profit institutions	208.4	226.5	214.0	231.4	3.6%	0.4%	235.8	250.4	258.2	3.7%	0.4%
Households	4.7	5.6	3.4	0.8	-44.5%	0.0%	13.0	–	–	-100.0%	0.0%
Payments for capital assets	**958.8**	**1 354.6**	**1 400.6**	**2 491.7**	**37.5%**	**2.5%**	**1 775.4**	**1 786.2**	**1 841.6**	**-9.6%**	**2.6%**
Buildings and other fixed structures	930.3	1 259.8	1 357.0	2 323.2	35.7%	2.4%	1 615.0	1 613.6	1 663.7	-10.5%	2.3%
Machinery and equipment	28.6	94.8	43.5	168.5	80.6%	0.1%	160.3	172.6	177.9	1.8%	0.2%
Payments for financial assets	**1.3**	**0.9**	**36.9**	**–**	**-100.0%**	**0.0%**	**–**	**–**	**–**	**0.0%**	**0.0%**
Total	**62 896.0**	**58 312.1**	**61 881.8**	**65 925.1**	**1.6%**	**100.0%**	**66 910.2**	**69 793.8**	**72 009.3**	**3.0%**	**100.0%**

7.2.4 PESTEL ANALYSIS

Political factors	There are polarized views on health sector reform in the 7th Administration (Government of National Unity) which negatively affects the implementation the National Health Insurance. Centralisation of human resources and financial delegations at the Provincial level leads to delays in appointment, purchasing of essential equipment, drugs and consumables. Despite the financial injection for the sector to address priorities related to employment of doctors, community health workers, procurement of linen and beds as well as payment of accruals, the autonomy of provinces often creates misalignment between national priorities and financial spending.
Economic factors	Delivery of some services still relies heavily on donor partners for technical assistance and institutionalised functions (this is a massive risk). The PEPFAR withdrawal has led to reversal in some of the gains noted in key strategic progarmmes. The tendering process where there are no National or Provincial contracts for the sourcing of Medical Equipment results in accruals and underspending. Some National Tertiary Services Grant medical equipment is not available on the current contract, and the supply chain processes delaying the procurement. The lack of commitment towards NHI funding remain a key challenge.
Social factors	Socio-economic factors, including high unemployment, unsustainable livelihoods, household food insecurity, and rising food and agricultural input costs, exacerbate malnutrition. Food security challenges need to be addressed to improve infant and young child feeding practices, ensuring effective management of malnutrition. Socio-economic vulnerabilities, sexual violence, and persistent structural barriers contribute towards the disproportionate HIV incidence rates which are higher in females than males. The majority of TB patients are part of the low socio-economic group. This group is likely to contract and develop TB disease due to poor preventive measures and treatment outcomes that are often associated with strenuous social and financial environment.
Technological factors	Technological advances have drastically changed the face of health care. Artificial Intelligence presents both threats and opportunities to the health system and will require resources including financing and expertise to mitigate for the eminent risks and explore opportunities and as such the financial constraints are delaying the acceleration of technology in the sector.
Environmental factors	The rising demand of services due to urbanisation and climate change impacts have placed an additional burden on already constraint capacities. Climate change and pollution have a profound impact on the healthcare system. Rising global temperatures, extreme weather events, and poor air quality are contributing to an increase in respiratory illnesses, cardiovascular disease, heat-related conditions, and the spread of infectious diseases. Climate change, although presenting various challenges to the health system, provides opportunities for strengthening environmental health programme through the raised political and donor attention
Legal factors	There several active court cases against the NHI Act, three in the Constitutional court, all from private players with huge, vested interests. There is address the insufficient capacity to effectively regulate the private pharmaceutical sector and conduct necessary research, particularly due to a shortage of suitably skilled expertise.There is a need to address the regulatory gaps concerning pharmaceutical commodity donations within the private sector, particularly between private entities, where no clear authority is responsible for oversight.

PART C

MEASURING OUR PERFORMANCE

Programme 1: Administration

Purpose:

Provide strategic leadership, management and support services to the department, monitor health sector performance and strengthen surveillance and research systems.

Programme Management provide leadership to the programme for management and support to the department.

Corporate Services, comprise of legal services for the for the provision of effective and efficient legal support service in line with the Constitution of the Republic of South Africa and applicable legislation to enable the Department to perform and achieve on its mandate; Communications Sub-programme provides both strategic communication and corporate communication; Human Resources subprogramme responsible for recruitment, development and performance of staff; and Health Information, Epidemiology, Research, Monitoring & Evaluation sub-programme responsible for the national health information system, coordinating research and evaluating the departmental performance

Property Management ensures effective, transparent, and compliant financial management of property and immovable assets by enforcing adherence to all relevant legislative prescripts, maintaining sound financial controls, continuously reviewing policies and procedures for relevance and responsiveness to changing conditions, and supporting clean governance outcomes, including the achievement of an unqualified audit.

Financial Management ensures compliance with all relevant legislative prescript, review of policies and procedures to ensure relevance and responsiveness to changing circumstance and achievement of an unqualified audit.

Programme 1: Outcomes, outputs, performance indicators and targets

Outcome	Output	Output Indicator	Audited Performance			Estimated Performance	MTEF Targets						
			2022/23	2023/24	2024/25	2025/26	Annual Target 2026/27	Quarterly Targets				2027/2028	2028/2029
								Q1	Q2	Q3	Q4		
Financial Management strengthened in the health sector	Audit outcome of National DoH	Audit outcome of National DoH	Qualified audit opinion for 2021/22 FY received	Unqualified audit opinion for 2022/23 FY received	Unqualified audit opinion for 2023/24 FY received	Unqualified audit opinion for 2024/2025	Unqualified audit opinion for 2025/2026	Not Applicable	Not Applicable	Unqualified audit opinion for 2025/2026	Not Applicable	Unqualified audit opinion	Unqualified audit opinion
Financial Management strengthened in the health sector	Payment of Suppliers within 30 days from the date of receipt of invoices	Percentage of invoices paid within 30 days of receiving valid invoices from suppliers	New Indicator	516 invoices out of 5144 (10%) were paid after 30 days of receiving valid invoices from suppliers	7 invoices out of 2 571 (0,2%) paid after 30 days of receiving valid invoices from suppliers	100% invoices paid within 30 days of receiving valid invoices from suppliers	100% invoices paid within 30 days of receiving valid invoices from suppliers	100%	100%	100%	100% invoices paid within 30 days of receiving valid invoices from suppliers	100% invoices paid within 30 days of receiving valid invoices from suppliers	100% invoices paid within 30 days of receiving valid invoices from suppliers
Employment in line with equity targets	Employment of women in line with equity targets	Percentage of Women, employed at SMS level according to the equity targets	46 % of Women at SMS level, employed according to the equity targets	45% of Women employed at SMS level in NDoH	47.5% of women employed at SMS level in NDoH	50% of Women employed at SMS level in NDoH	50% of Women employed at SMS level in NDoH	50%	50%	50%	50% of Women employed at SMS level in NDoH	50% of Women employed at SMS level in NDoH	50% of Women employed at SMS level in NDoH
Employment in line with equity targets	Employment of Youth in line with equity targets	Percentage of youth employed according to the equity targets	13% Youth appointed at NDoH according to the equity targets	5% Youth employed in NDoH	6.8% of youth employed in NDoH	10% of Youth employed in NDoH	10 % of Youth employed in NDoH	10%	10%	10%	10% of Youth employed in NDoH	20% of Youth employed in NDoH	20% of Youth employed in NDoH
Employment in line with equity targets	Employment of People with disabilities in line with equity targets	Percentage of People with disabilities employed according to the equity targets	0.4% of People with disabilities appointed at NDoH accordingly to the equity targets	0.11% of People with disabilities appointed at NDoH accordingly to the equity targets	0.11% of People with disabilities employed in NDoH	2.5 % of People with disabilities employed in NDoH	2.5 % of People with disabilities employed in NDoH	2.5%	2.5 %	2.5%	2.5 % of People with disabilities employed in NDoH	4% of People with disabilities employed in NDoH	5% of People with disabilities employed in NDoH

Outcome	Output	Output Indicator	Audited Performance			Estimated Performance	MTEF Targets						
			2022/23	2023/24	2024/25	2025/26	Annual Target 2026/27	Quarterly Targets				2027/2028	2028/2029
								Q1	Q2	Q3	Q4		
Improved access to safe and quality healthcare	Minimum safety standards for public health facilities	Minimum safety standards for public health facilities finalised	New Indicator	New Indicator	New Indicator	Draft Policy Framework for security and safety in health facilities finalised	Minimum safety standards for public health facilities finalised	Terms of Reference for the Safety Structure/ Committee finalised	Draft Minimum Safety standards developed	Consultation with relevant stakeholders	Minimum Safety Standards for public health facilities finalised	Updated Policy Framework approved	Implemen-tation of the updated Framework for security and safety in public health facilities
Early warning and Response strengthened	Roll out of Event-based surveillance (EBS)	Number of districts implementing EBS	New Indicator	New Indicator	New Indicator	6	40	25	30	35	40	52	52

Explanation of planned performance over the medium-term period

The outputs for the administration programme are aligned to statutory requirements, firstly through strengthening financial management towards the achievement of unqualified audit opinion as well as to ensure that service providers are paid within 30 days of receipt of valid invoices from suppliers. The outlook on continued budget cuts does require mechanisms to leverage resources and improve efficiency, which will be explored with key stakeholders. In line with priorities of that seeks to redress by ensuring participation of vulnerable groups in key sectors of the society, the department will endeavor to improve proportions of Women, Youth ad People living with disabilities employed by implementing strategies which target employment for groups with low representation. The department will strengthen surveillance through the roll-out of event-based surveillance system for early warning response.

Programme 1 resource considerations

Expenditure trends and estimates

Administration expenditure trends and estimates by subprogramme and economic classification

Subprogramme	Audited outcome			Adjusted appropriation	Average growth rate (%)	Average: Expenditure/ Total (%)	Medium-term expenditure estimate			Average growth rate (%)	Average: Expenditure/ Total (%)
R million	2022/23	2023/24	2024/25	2025/26	2022/23 - 2025/26		2026/27	2027/28	2028/29	2025/26 -2028/29	2026/27 -2028/29
Ministry	38.8	41.8	43.2	38.3	-0.4%	5.5%	44.0	43.7	45.0	5.5%	5.1%
Management	6.2	14.8	9.5	12.0	24.7%	1.4%	12.5	13.1	13.5	3.9%	1.5%
Corporate Services	445.8	440.1	377.0	457.2	0.8%	57.9%	398.1	453.0	466.5	0.7%	50.5%
Property Management	114.2	141.7	146.7	178.5	16.0%	19.5%	175.1	192.5	198.5	3.6%	21.7%
Financial Management	88.1	98.3	126.3	154.3	20.5%	15.7%	198.7	177.0	180.2	5.3%	21.3%
Total	**693.1**	**736.7**	**702.7**	**840.2**	**6.6%**	**100.0%**	**828.4**	**879.2**	**903.7**	**2.5%**	**100.0%**
Change to 2025 Budget estimate				–			(83.2)	(75.2)	(93.6)		
Economic classification											
Current payments	**676.2**	**711.6**	**672.2**	**787.5**	**5.2%**	**95.8%**	**781.6**	**844.0**	**867.4**	**3.3%**	**95.5%**
Compensation of employees	260.6	290.5	282.7	294.6	4.2%	38.0%	319.9	338.0	348.0	5.7%	38.5%
Goods and services	415.7	421.1	389.5	492.9	5.8%	57.8%	461.7	506.1	519.4	1.8%	57.0%
of which:						–					–
Audit costs: External	*21.3*	*23.4*	*25.4*	*24.3*	*4.6%*	*3.2%*	*29.6*	*33.9*	*36.9*	*14.8%*	*3.8%*
Consultants: Business and advisory services	*73.9*	*23.8*	*29.6*	*60.7*	*-6.3%*	*6.3%*	*74.5*	*73.5*	*71.6*	*5.6%*	*8.4%*
Operating leases	*99.7*	*110.6*	*134.7*	*132.2*	*9.9%*	*16.1%*	*127.3*	*142.8*	*147.2*	*3.6%*	*16.0%*
Property payments	*17.7*	*34.7*	*16.7*	*61.4*	*51.4%*	*4.4%*	*63.9*	*66.4*	*68.5*	*3.7%*	*7.6%*
Travel and subsistence	*59.7*	*38.0*	*29.6*	*32.5*	*-18.4%*	*5.4%*	*32.3*	*38.8*	*40.7*	*7.8%*	*4.3%*
Operating payments	*2.3*	*30.1*	*25.3*	*23.4*	*116.5%*	*2.7%*	*27.7*	*34.0*	*35.1*	*14.5%*	*3.7%*
Transfers and subsidies	**3.8**	**10.2**	**21.9**	**40.2**	**120.4%**	**2.6%**	**35.6**	**23.6**	**24.3**	**-15.4%**	**3.2%**
Provinces and municipalities	–	–	0.0	–	–	0.0%	–	–	–	–	–
Departmental agencies and accounts	2.4	2.1	2.3	2.8	5.7%	0.3%	2.9	3.0	3.1	3.7%	0.3%
Foreign governments and international organisations	–	–	18.2	18.4	–	1.2%	–	–	–	-100.0%	–
Non-profit institutions	–	6.5	–	19.0	–	0.9%	19.8	20.6	21.2	3.7%	2.4%
Households	1.4	1.6	1.4	–	-100.0%	0.1%	13.0	–	–	–	0.5%
Payments for capital assets	**12.7**	**14.4**	**7.5**	**12.4**	**-0.9%**	**1.6%**	**11.2**	**11.6**	**12.0**	**-1.1%**	**1.3%**
Machinery and equipment	12.7	14.4	7.5	12.4	-0.9%	1.6%	11.2	11.6	12.0	-1.1%	1.3%
Payments for financial assets	**0.3**	**0.5**	**1.2**	**–**	**-100.0%**	**0.1%**	**–**	**–**	**–**	**–**	**–**
Total	**693.1**	**736.7**	**702.7**	**840.2**	**6.6%**	**100.0%**	**828.4**	**879.2**	**903.7**	**2.5%**	**100.0%**
Proportion of total programme expenditure to vote expenditure	**1.1%**	**1.3%**	**1.1%**	**1.3%**	**–**	**–**	**1.2%**	**1.3%**	**1.3%**	**–**	**–**
Details of transfers and subsidies											
Households											
Social benefits				–	-100.0%	0.1%				–	0.5%
Current	1.4	1.6	1.4				13.0	–	–		
Employee social benefits	1.4	1.6	1.4	–	-100.0%	0.1%	–	–	–	–	–
Early retirement and voluntary exit programmes	–	–	–	–	–	–	13.0	–	–	–	0.5%

Departmental agencies and accounts											
Departmental agencies (non-business entities)				2.8	5.7%	0.3%				3.7%	0.3%
Current	2.4	2.1	2.3				2.9	3.0	3.1		
Health and Welfare Sector Education and Training Authority	2.4	2.1	2.1	2.8	5.7%	0.3%	2.9	3.0	3.1	3.7%	0.3%
South African Broadcasting Corporation	–	–	0.1	–	–	–	–	–	–	–	–
Foreign governments and international organisations				18.4	–	1.2%				-100.0%	–
Current	–	–	18.2				–	–	–		
World Health Organisation	–	–	18.2	18.4	–	1.2%	–	–	–	-100.0%	–
Non-profit institutions				19.0	–	0.9%				3.7%	2.4%
Current	–	6.5	–				19.8	20.6	21.2		
Health Systems Trust	–	6.5	–	19.0	–	0.9%	19.8	20.6	21.2	3.7%	2.4%
Provinces and municipalities											
Provincial agencies and funds				–	–	–				–	–
Current	–	–	0.0				–	–	–		
Provincial agencies	–	–	0.0	–	–	–	–	–	–	–	–

Personnel information

Administration personnel numbers and cost by salary level[1]

	Number of posts estimated for 31 March 2026		Number and cost[2] of personnel posts filled/planned for on funded establishment														Average growth rate (%)	Average: Salary level/ Total (%)
	Number of funded posts	Number of posts additional to the establishment	Actual			Revised estimate			Medium-term expenditure estimate									
			2024/25			2025/26			2026/27			2027/28			2028/29			2025/26 -2028/29	2026/27 -2028/29
Administration			Number	Cost	Unit cost	Num-ber	Cost	Unit cost	Num-ber	Cost	Unit cost	Num-ber	Cost	Unit cost	Num-ber	Cost	Unit cost		
Salary level	**417**	**15**	**360**	**282.7**	**0.8**	**361**	**293.6**	**0.8**	**370**	**319.9**	**0.9**	**366**	**338.0**	**0.9**	**361**	**348.0**	**1.0**	**-0.0%**	**100.0%**
1 – 6	159	–	137	56.4	0.4	155	65.6	0.4	155	69.0	0.4	148	69.9	0.5	148	73.7	0.5	-1.4%	41.2%
7 – 10	152	–	132	93.9	0.7	132	100.0	0.8	132	105.1	0.8	132	110.8	0.8	130	115.0	0.9	-0.5%	35.9%
11 – 12	48	–	41	57.2	1.4	41	60.9	1.5	51	77.8	1.5	51	82.0	1.6	50	85.2	1.7	7.1%	13.9%
13 – 16	45	4	37	68.0	1.8	31	61.2	2.0	30	62.1	2.1	32	69.3	2.2	30	68.2	2.3	-1.1%	8.4%
Other	13	11	13	7.2	0.6	2	5.9	3.0	2	5.9	3.0	2	5.9	3.0	2	5.9	3.0	–	0.5%

Data has been provided by the department and may not necessarily reconcile with official government personnel data.

1. Rand million.

Programme 2: National Health Insurance

Purpose

Achieve universal health coverage by improving the quality and coverage of health services through the development and implementation of policies and health financing reforms.

Programme Management provides leadership to the programme to improve access to high-quality health care services by developing and implementing universal health coverage policies and health financing reform.

Health Products Procurement is responsible for developing systems to ensure the sustained availability of and equitable access to health products. This is achieved through the development of governance frameworks to support the selection and use of essential medicines and other essential health products, the development of standard treatment guidelines, the administration and management of pharmaceutical tenders, the development of provincial pharmaceutical budget forecasts and the reformation of the health products supply chain.

Health Financing and National Health Insurance designs and tests policies, legislation and frameworks to achieve universal health coverage and to inform proposals for national health insurance. It develops health financing reforms, including policies affecting the medical schemes environment; provides technical oversight of the Council for Medical Schemes; and manages the direct national health insurance grant and the national health insurance indirect grant. It also implements the single exit price regulations, including policy development and implementation initiatives in terms of dispensing and logistical fees. This sub-programme will increasingly focus on evolving health financing functions, such as user and provider management, health care benefits and provider payment, digital health information, and risk identification and fraud management.

Digital Health System Coordinates, develops and implements Digital Health Systems and Solutions for the digitisation of workflow process in preparation for National Health Insurance , that will enable improved patient care and service delivery and provide data for decision making and planning for the implementation of National Health Insurance.

Programme 2: Outcomes, outputs, performance indicators and targets

Outcome	Output	Output Indicator	Audited Performance			Estimated Performance		MTEF Targets					
			2022/23	2023/24	2024/25	2025/26	Annual Target 2026/27	Quarterly Targets				2027/2028	2028/2029
								Q1	Q2	Q3	Q4		
Improved access to equitable healthcare services	Framework on Health care benefits Prioritisation	Framework on Health care benefits Prioritisation finalised	New Indicator	New Indicator	New Indicator	Terms of Reference for Ministerial Advisory Committee (MAC) finalised and approved for publication	Framework on Health care benefits Prioritisation finalised by Ministerial Advisory Committee (MAC)	Not Applicable	Not Applicable	Not Applicable	Framework on Health care benefits Prioritisation finalised by MAC	Not Applicable	Not Applicable
Improved access to equitable healthcare services	Health Technology Assessment Strategic Plan	Health Technology Assessment Strategic Plan finalised	New Indicator	New Indicator	New Indicator	Terms of Reference for Ministerial Advisory Committee (MAC) developed	Health Technology Assessment Strategic Plan finalised by Ministerial Advisory Committee (MAC)	Not Applicable	Not Applicable	Not Applicable	Health Technology Assessment Strategic Plan finalised by MAC	Not Applicable	Not Applicable
Improved access to equitable healthcare services	NHI Accreditation framework for provider accreditation (PHC level)	Phase 2 of Health care service provider Accreditation Framework implementation research completed	New Indicator	New Indicator	Draft accreditation framework produced	Accreditation framework for health service providers finalized	Phase 2 of Health care service provider Accreditation Framework implementation research completed	Research protocol on the Implementation research finalised	Implementation plan of the Implementation research	Phase 1 of implementation research completed	Phase 2 of Health care service provider Accreditation Framework implementation research completed	Health care service provider Accreditation framework implementation research completed	Not Applicable
Improved access to equitable healthcare services	Essential Equipment List for Primary Health Care	Version 1 of PHC Essential Equipment List reviewed and published	New Indicator	New Indicator	Draft Essential Equipment List for health care service package developed	Approved Essential Equipment list for Primary Health Care	Version 1 of PHC Essential Equipment List reviewed and published	Not Applicable	Not Applicable	Not Applicable	Version 1 of PHC Essential Equipment List published	Not Applicable	Not Applicable

Outcome	Output	Output Indicator	Audited Performance			Estimated Performance	Annual Target 2026/27	MTEF Targets					
			2022/23	2023/24	2024/25	2025/26		Quarterly Targets				2027/2028	2028/2029
								Q1	Q2	Q3	Q4		
Improved access to equitable healthcare services	Active patients receive medicine through the CCMDD programme.	Number of active patients receiving medicine through the central chronic medication dispensing and distribution programme (CCMDD) programme.	New Indicator	New Indicator	New Indicator	3 500 000 active patients	3 900 000 active patients	3 750 000	3 800 000	3 850 000	3 900 000 active patients	4 100 000 active patients	4 300 000 active patients
Integrated electronic health record	Development of an integrated Electronic Health Record	Electronic Medical Record -Minimum Viable Product 3 (PHC Package) developed	New Indicator	New Indicator	Electronic Medical Record (EMR) - Minimum Viable Product (MVP)1 focusing on TB HIV developed	EMR-Minimum Viable Product 2 (PHC package) Developed	Electronic Medical Record-Minimum Viable Product 3 (PHC Package) developed	Not Applicable	Not Applicable	Not Applicable	Electronic Medical Record-Minimum Viable Product 3 (PHC Package) developed	Integrated electronic health record for PHC services	Not Applicable

Explanation of planned performance over the medium-term period

The interventions in the programme are key in facilitating the implementation of the National Health Insurance through preparatory activities which are key functions of the NHI entity, i.e., health care benefits and health technology assessments. These deliverables are geared towards ensuring that appropriate health care benefits are identified in line with the population needs as well as to ensure that the medical interventions under the NHI derive the greatest benefits for the population and are cost-effective. Additionally, the determination of an Essential Equipment List for primary health care as an entry point to the health system for patients is fundamental to ensure that resources are alignment with the needs of patients al this level of care. The accreditation framework which is aimed at outlining the processes and requirements for service providers to participate in the NHI, will be tested through implementation research for necessary modification prior to the roll-out. The phased development of electronic medical record will progress to the third phase PHC which will ensure the completion of the PHC package which will be followed by the integration of electronic records in 2027/2028 , to improve management of patient records, referrals and ensuring continuity of care as patients navigate through the health system during the course of life.

Programme 2 resource consideration

Expenditure trends and estimates

National Health Insurance expenditure trends and estimates by subprogramme and economic classification

Subprogramme	Audited outcome			Adjusted appropriation	Average growth rate (%)	Average: Expenditure/ Total (%)	Medium-term expenditure estimate			Average growth rate (%)	Average: Expenditure/ Total (%)
R million	2022/23	2023/24	2024/25	2025/26	2022/23 - 2025/26		2026/27	2027/28	2028/29	2025/26 -2028/29	2026/27 -2028/29
Programme Management	10.2	8.2	7.0	9.7	-1.6%	0.7%	9.1	9.5	9.9	0.7%	0.6%
Health Products Procurement	37.3	29.2	44.3	30.7	-6.3%	2.6%	35.5	35.7	36.8	6.2%	2.4%
Health Financing and National Health Insurance	1 309.5	1 375.9	1 111.9	1 383.9	1.9%	96.1%	1 380.2	1 413.0	1 458.4	1.8%	96.3%
Digital Health System	9.1	11.7	5.5	9.0	-0.1%	0.7%	9.5	9.6	9.9	3.1%	0.7%
Total	**1 366.1**	**1 425.1**	**1 168.7**	**1 433.3**	**1.6%**	**100.0%**	**1 434.3**	**1 467.9**	**1 515.0**	**1.9%**	**100.0%**
Change to 2025 Budget estimate				–			17.2	(14.0)	(33.4)		
Economic classification											
Current payments	**667.8**	**705.9**	**669.2**	**909.6**	**10.8%**	**54.7%**	**904.9**	**915.6**	**944.2**	**1.3%**	**62.6%**
Compensation of employees	48.1	57.9	67.9	104.1	29.4%	5.2%	114.5	117.2	120.8	5.1%	8.0%
Goods and services	619.8	648.0	601.3	805.5	9.1%	49.6%	790.4	798.4	823.4	0.7%	54.6%
of which:						–					–
Advertising	*1.5*	*0.1*	*34.1*	*21.3*	*141.0%*	*1.1%*	*22.2*	*23.1*	*23.8*	*3.7%*	*1.6%*
Minor assets	*3.1*	*6.4*	*2.9*	*12.1*	*56.6%*	*0.5%*	*12.5*	*13.0*	*13.4*	*3.7%*	*0.9%*
Consultants: Business and advisory services	*2.8*	*0.5*	*3.8*	*106.7*	*234.6%*	*2.1%*	*102.3*	*100.2*	*103.1*	*-1.1%*	*6.9%*
Contractors	*518.5*	*386.3*	*411.2*	*597.3*	*4.8%*	*35.5%*	*582.5*	*592.0*	*610.3*	*0.7%*	*40.4%*
Agency and support/outsourced services	–	–	–	*33.3*	–	*0.6%*	*34.7*	*36.0*	*37.2*	*3.7%*	*2.4%*
Travel and subsistence	*5.4*	*9.6*	*18.2*	*13.6*	*36.1%*	*0.9%*	*13.5*	*10.6*	*12.3*	*-3.4%*	*0.8%*
Transfers and subsidies	**693.9**	**694.9**	**456.1**	**466.7**	**-12.4%**	**42.9%**	**475.5**	**496.5**	**513.2**	**3.2%**	**33.6%**
Provinces and municipalities	693.7	694.7	456.0	466.7	-12.4%	42.9%	475.5	496.5	513.2	3.2%	33.6%
Households	0.2	0.2	0.1	–	-100.0%	0.0%	–	–	–	–	–
Payments for capital assets	**4.3**	**24.4**	**26.7**	**57.0**	**136.5%**	**2.1%**	**53.9**	**55.8**	**57.5**	**0.3%**	**3.8%**
Machinery and equipment	4.3	24.4	26.7	57.0	136.5%	2.1%	53.9	55.8	57.5	0.3%	3.8%
Payments for financial assets	**–**	**0.0**	**16.8**	**–**	**–**	**0.3%**	**–**	**–**	**–**	**–**	**–**
Total	**1 366.1**	**1 425.1**	**1 168.7**	**1 433.3**	**1.6%**	**100.0%**	**1 434.3**	**1 467.9**	**1 515.0**	**1.9%**	**100.0%**
Proportion of total programme expenditure to vote expenditure	**2.2%**	**2.4%**	**1.9%**	**2.2%**	**–**	**–**	**2.1%**	**2.1%**	**2.1%**	**–**	**–**
Details of transfers and subsidies											
Households											
Social benefits				–	-100.0%	–				–	–
Current	0.2	0.2	0.1				–	–	–		
Employee social benefits	0.2	0.2	0.1	–	-100.0%	–	–	–	–	–	–
Provinces and municipalities											
Provincial revenue funds				466.7	-12.4%	42.9%				3.2%	33.6%
Current	693.7	694.7	456.0				475.5	496.5	513.2		
National health insurance grant	693.7	694.7	456.0	466.7	-12.4%	42.9%	475.5	496.5	513.2	3.2%	33.6%

Personnel information

National Health Insurance personnel numbers and cost by salary level[1]

	Number of posts estimated for 31 March 2026		Number and cost[2] of personnel posts filled/planned for on funded establishment														Average growth rate (%)	Average: Salary level/ Total (%)
	Number of funded posts	Number of posts additional to the establishment	Actual			Revised estimate			Medium-term expenditure estimate									
			2024/25			2025/26			2026/27			2027/28			2028/29			2025/26 -2028/29	2026/27 -2028/29
National Health Insurance			Nuber	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost		
Salary level	**102**	**7**	**83**	**67.9**	**0.8**	**103**	**91.1**	**0.9**	**116**	**114.5**	**1.0**	**113**	**117.2**	**1.0**	**111**	**120.8**	**1.1**	**2.8%**	**100.0%**
1 – 6	11	1	11	3.7	0.3	11	4.0	0.4	11	4.2	0.4	11	4.4	0.4	11	4.7	0.4	–	9.7%
7 – 10	28	5	28	14.5	0.5	28	15.4	0.6	28	16.2	0.6	28	17.1	0.6	28	18.0	0.6	–	24.7%
11 – 12	44	–	29	30.7	1.1	45	46.4	1.0	45	48.8	1.1	43	49.6	1.2	42	51.7	1.2	-1.9%	38.1%
13 – 16	18	–	14	18.9	1.4	18	25.2	1.4	31	45.2	1.5	30	46.1	1.5	29	46.4	1.6	17.6%	26.7%
Other	1	1	1	0.1	0.1	1	0.1	0.1	1	0.1	0.1	1	0.1	0.1	1	0.1	0.1	–	0.9%

Data has been provided by the department and may not necessarily reconcile with official government personnel data.

1. Rand million.

Programme 3: HIV/AIDS, TB & MATERNAL, CHILD AND WOMEN'S HEALTH

Purpose

Develop national policies, guidelines, norms and standards, and targets to decrease the burden of disease related to the HIV and tuberculosis epidemics; support the implementation of these; and monitor and evaluate their impact. Develop strategies and implement programmes that minimise maternal and child mortality and morbidity, and optimise good health for children, adolescents and women.

Programme Management is responsible for ensuring that efforts by all stakeholders are harnessed to support the overall purpose of the programme. This includes ensuring that the efforts and resources of provincial departments of health, development partners, donors, academic and research organizations, and non- governmental and civil society organisations all contribute in a coherent and integrated way.

HIV, AIDS and STIs is responsible for policy formulation for HIV and sexually transmitted disease services, and monitoring and evaluation of these services. This entails ensuring the implementation of the health sector's national strategic plan on HIV, TB and STIs. This sub-programme also manages and oversees the comprehensive HIV and AIDS component of the district health programmes grant implemented by provinces, and the coordination and direction of donor funding for HIV and AIDS. This includes the United States President's Emergency Plan for AIDS Relief; the Global Fund to Fight AIDS, Tuberculosis and Malaria; and the United States Centres for Disease Control and Prevention.

Tuberculosis Management develops national policies and guidelines for TB services, sets norms and standards, and monitors their implementation in line with the vision of eliminating infections, mortality, stigma and discrimination. This sub-programme is also responsible for the coordination and management of the national response to the TB epidemic.

Women's Maternal and Reproductive Health develops and monitors policies and guidelines for maternal and women's health services, sets norms and standards, and monitors and evaluates the implementation of these services. This sub-programme supports the implementation of key initiatives as indicated in the maternal and child health strategic plan and the reports of the ministerial committees on maternal, perinatal and child mortality.

Child, Youth and School Health is responsible for policy formulation and coordination for, and the monitoring and evaluation of, child, youth and school health services. This sub-programme is also responsible for the management and oversight of the human papillomavirus vaccination programme, and coordinates stakeholders outside of the health sector to play key roles in promoting improved health and nutrition for children and young people.It supports provincial units responsible for the implementation of policies and guidelines and focuses on recommendations made by the ministerial committee on morbidity and mortality in children.These are aimed at reducing mortality in children younger than 5, increasing the number of HIV-positive children on treatment, strengthening the expanded programme on immunization, and ensuring that health services are friendly to children and young people.

Programme 3: Outcomes, outputs, performance indicators and targets

Outcome	Output	Output Indicator	Audited Performance			Estimated Performance		MTEF Targets					
			2022/23	2023/24	2024/25	2025/26	Annual Target 2026/27	Quarterly Targets				2027/2028	2028/2029
								Q1	Q2	Q3	Q4		
HIV and AIDS related deaths reduced	Assessment report on HIV, AIDS, and STIs response	Number of assessment reports on HIV and AIDS and STIs response.	New Indicator	New Indicator	New Indicator	New Indicator	4 Quarterly reports produced	1 Quarterly report produced	1 Quarterly report produced	1 Quarterly report produced	1 Quarterly report produced	04 Quarterly reports produced	04 Quarterly reports produced
HIV and AIDS related deaths reduced	Percentage of people Living with HIV on ART	Percentage of people Living with HIV on ART	New Indicator	New Indicator	New Indicator	95%	81%	80%	80%	81%	81%	84%	95%
HIV and AIDS related deaths reduced	Percentage of people on ART that are virally suppressed	Percentage of people on ART that are virally suppressed	New Indicator	New Indicator	New Indicator	95%	95%	94%	94%	95%	95%	95%	95%
TB Mortality reduced	Improved TB Treatment adherence	Drug-susceptible TB (DS-TB) Treatment success rate	78%	72%	83%	79%	81%	79%	80%	80.5%	81%	82%	83%
TB Mortality reduced	Find and Treat people with TB disease	Number of people started on TB treatment	189 790	180 421	180 566	180 000	204 705	50 000	52 353	52 352	50 000	196 517	188 656
Improved maternal and child health	Maternal mortality ratio reduced	Maternal Mortality in facility ratio (iMMR)	New Indicator	New Indicator	New Indicator	< 100 maternal deaths per 100,000 live births	< 95 per 100,000 live births	< 100 maternal deaths per 100,000 live births	< 98 maternal deaths per 100,000 live births	< 96 maternal deaths per 100,000 live births	< 95 maternal deaths per 100,000 live births	< 90 per 100,000 live births	< 85 per 100,000 live births
Improved maternal and child health	Neonatal deaths reduced	Neonatal deaths in facility rate	New Indicator	New Indicator	New Indicator	12,7 deaths per 1000 live births	≤ 12,5 deaths per 1000 live births	≤ 12,7 deaths per 1000 live births	≤ 12,6 deaths per 1000 live births	≤ 12,5 deaths per 1000 live births	≤ 12,5 deaths per 1000 live births	≤ 12,3 deaths per 1000 live births	≤ 12,2 deaths per 1000 live births
Improved access to school health programme	Grade R learners screened	Number of Grade R learners screened	New Indicator	New Indicator	New Indicator	160 000 School Grade R learners screened	442 500 School Grade R learners screened	110 625	110 625	132 750	88 500	635 000	745 000

Explanation of planned performance over the medium-term period:
The proramme will accelerate the achievement of Sustainable Development Goals and National Development Plans targets for 2030.Interventions for people living with HIV and AIDS are aimed at linking and retaining patients to care, targeting the Men, Youth and children to reduce HIV and AIDS related death. Similarly, the TB sub-programme will endeavor to test more patients for those with TB to be initiated on treatment and minimize the risk of cross-infections in communities to significantly reduce new TB incidences. Maternal and child health will be promoted through interventions that will address preventable causes of maternal mortalities based on recommendation from the National Committee for Confidential Enquiries into Maternal Deaths (NCCEMD). Furthermore, in collaboration with the Education sector Grade R school learners will undergo health screening for early detection of hearing, visual and developmental challenges to facilitate appropriate care and referral where required.

Programme 3 resource consideration

Expenditure trends and estimates

HIV/AIDS, Tuberculosis and Maternal, Child and Women's Health expenditure trends and estimates by subprogramme and economic classification

Subprogramme	Audited outcome			Adjusted appropriation	Average growth rate (%)	Average: Expenditure/ Total (%)	Medium-term expenditure estimate			Average growth rate (%)	Average: Expenditure/ Total (%)
R million	2022/23	2023/24	2024/25	2025/26	2022/23 - 2025/26		2026/27	2027/28	2028/29	2025/26 -2028/29	2026/27 -2028/29
Programme Management	19.4	3.1	4.0	8.1	-25.2%	0.0%	4.8	6.9	7.2	-4.1%	0.0%
HIV, AIDS and STIs	24 505.6	23 342.0	25 186.0	25 929.5	1.9%	99.7%	26 385.0	27 491.1	28 383.8	3.1%	99.7%
Tuberculosis Management	24.2	28.8	26.3	33.1	11.0%	0.1%	32.8	30.5	31.4	-1.7%	0.1%
Women's Maternal and Reproductive Health	12.8	14.0	10.0	19.6	15.0%	0.1%	17.4	18.3	19.0	-1.0%	0.1%
Child, Youth and School Health	21.9	24.9	23.5	29.0	9.8%	0.1%	30.3	31.7	32.7	4.0%	0.1%
Total	**24 583.9**	**23 412.8**	**25 249.7**	**26 019.3**	**1.9%**	**100.0%**	**26 470.3**	**27 578.5**	**28 474.1**	**3.1%**	**100.0%**
Change to 2025 Budget estimate				–			(127.3)	(218.0)	(570.2)		
Economic classification											
Current payments	**243.6**	**260.3**	**309.6**	**291.7**	**6.2%**	**1.1%**	**258.6**	**254.0**	**260.7**	**-3.7%**	**0.9%**
Compensation of employees	72.1	71.4	87.7	92.4	8.6%	0.3%	95.8	98.5	101.7	3.2%	0.4%
Goods and services	171.5	189.0	221.8	199.3	5.1%	0.8%	162.9	155.5	159.0	-7.2%	0.6%
of which:						–					–
Consultants: Business and advisory services	*33.5*	*24.1*	*22.5*	*30.7*	*-2.9%*	*0.1%*	*35.8*	*27.7*	*28.6*	*-2.3%*	*0.1%*
Contractors	*2.9*	*1.2*	–	*4.6*	*17.0%*	*0.0%*	*4.8*	*5.0*	*5.1*	*3.7%*	*0.0%*
Fleet services (including government motor transport)	*4.0*	*5.7*	*5.1*	*10.8*	*38.8%*	*0.0%*	*12.5*	*11.7*	*12.1*	*3.8%*	*0.0%*
Inventory: Medical supplies	*33.0*	*32.5*	*28.0*	*67.8*	*27.2%*	*0.2%*	*21.1*	*19.7*	*19.1*	*-34.5%*	*0.1%*
Travel and subsistence	*13.9*	*16.9*	*15.2*	*19.4*	*11.7%*	*0.1%*	*21.3*	*21.1*	*21.7*	*3.8%*	*0.1%*
Operating payments	*69.3*	*87.8*	*83.8*	*58.8*	*-5.4%*	*0.3%*	*60.1*	*62.5*	*64.4*	*3.1%*	*0.2%*
Transfers and subsidies	**24 340.2**	**23 151.9**	**24 935.1**	**25 726.6**	**1.9%**	**98.9%**	**26 210.6**	**27 323.5**	**28 212.2**	**3.1%**	**99.1%**
Provinces and municipalities	24 134.5	22 934.6	24 724.4	25 517.8	1.9%	98.0%	25 998.2	27 097.4	27 979.2	3.1%	98.2%
Departmental agencies and accounts	–	–	0.0	–	–	0.0%	–	–	–	–	–
Non-profit institutions	205.2	216.8	210.6	208.8	0.6%	0.8%	212.4	226.0	233.1	3.7%	0.8%
Households	0.5	0.5	0.1	–	-100.0%	0.0%	–	–	–	–	–
Payments for capital assets	**–**	**0.3**	**3.9**	**1.0**	**–**	**0.0%**	**1.0**	**1.1**	**1.1**	**3.7%**	**0.0%**
Machinery and equipment	–	0.3	3.9	1.0	–	0.0%	1.0	1.1	1.1	3.7%	0.0%
Payments for financial assets	**0.1**	**0.2**	**1.1**	**–**	**-100.0%**	**0.0%**	**–**	**–**	**–**	**–**	**–**
Total	**24 583.9**	**23 412.8**	**25 249.7**	**26 019.3**	**1.9%**	**100.0%**	**26 470.3**	**27 578.5**	**28 474.1**	**3.1%**	**100.0%**
Proportion of total programme expenditure to vote expenditure	**39.1%**	**40.2%**	**40.8%**	**39.5%**	**–**	**–**	**39.6%**	**39.5%**	**39.5%**	**–**	**–**
Details of transfers and subsidies											
Households											
Social benefits				–	-100.0%	–				–	–
Current	0.4	0.5	0.1				–	–	–		
Employee social benefits	0.4	0.5	0.1	–	-100.0%	–	–	–	–	–	–

Other transfers to households											
Current	0.1	0.0	–	–	-100.0%	–	–	–	–	–	–
Employee social benefits	0.1	0.0	–	–	-100.0%	–	–	–	–	–	–
Departmental agencies and accounts											
Departmental agencies (non-business entities)											
Current	–	–	0.0	–	–	–	–	–	–	–	–
South African Broadcasting Corporation	–	–	0.0	–	–	–	–	–	–	–	–
Non-profit institutions											
Current	205.2	216.8	210.6	208.8	0.6%	0.8%	212.4	226.0	233.1	3.7%	0.8%
Non-governmental organisations: LifeLine	28.9	29.0	27.3	27.3	-1.9%	0.1%	28.5	29.6	30.6	3.8%	0.1%
Non-governmental organisations: loveLife	64.3	64.6	63.0	62.8	-0.8%	0.3%	60.5	68.3	70.4	3.9%	0.2%
Non-governmental organisations: Soul City Institute	25.1	25.2	24.3	24.4	-0.9%	0.1%	25.4	26.5	27.3	3.8%	0.1%
Non-governmental organisations: HIV and AIDS	67.5	67.8	64.8	62.3	-2.7%	0.3%	65.1	67.9	70.0	4.0%	0.2%
South African National AIDS Council	19.4	30.2	31.1	32.1	18.3%	0.1%	32.9	33.8	34.8	2.8%	0.1%
Provinces and municipalities											
Provincial revenue funds	24 134.5	22 934.6	24 724.4	25 517.8	1.9%	98.0%	25 998.2	27 097.4	27 979.2	3.1%	98.2%
Current											
District health programmes grant: Comprehensive HIV and AIDS component	24 134.5	22 934.6	24 724.4	25 517.8	1.9%	98.0%	25 998.2	27 097.4	27 979.2	3.1%	98.2%

Personnel information

HIV/AIDS, Tuberculosis and Maternal, Child and Women's Health personnel numbers and cost by salary level[1]

	Number of posts estimated for 31 March 2026		Number and cost[2] of personnel posts filled/planned for on funded establishment														Average growth rate (%)	Average: Salary level/ Total (%)
	Number of funded posts	Number of posts additional to the establishment	Actual			Revised estimate			Medium-term expenditure estimate									
			2024/25			2025/26			2026/27			2027/28			2028/29			2025/26 -2028/29	2026/27 -2028/29
HIV/AIDS, Tuberculosis and Maternal, Child and Women's Health			Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost		
Salary level	**182**	**1**	**152**	**87.7**	**0.6**	**152**	**92.4**	**0.6**	**151**	**95.8**	**0.6**	**148**	**98.5**	**0.7**	**144**	**101.7**	**0.7**	**-1.7%**	**100.0%**
1 – 6	20	–	19	5.1	0.3	20	5.7	0.3	20	6.0	0.3	20	6.3	0.3	20	6.7	0.3	–	13.5%
7 – 10	92	–	77	33.5	0.4	77	35.7	0.5	77	37.5	0.5	77	39.6	0.5	73	39.5	0.5	-1.7%	51.3%
11 – 12	45	–	36	30.6	0.9	36	32.6	0.9	36	34.3	1.0	33	33.7	1.0	33	35.6	1.1	-2.5%	23.2%
13 – 16	24	–	19	18.3	1.0	18	18.3	1.0	17	17.8	1.1	17	18.8	1.1	17	19.8	1.2	-2.5%	11.3%
Other	1	1	1	0.1	0.1	1	0.1	0.1	1	0.1	0.1	1	0.1	0.1	1	0.1	0.1	–	0.7%

Data has been provided by the department and may not necessarily reconcile with official government personnel data.

1. Rand million.

Programme 4: Primary Health Care

Purpose

Develop and oversee the implementation of legislation, policies, systems, norms and standards for a uniform district health system, environmental and port health services, communicable and non-communicable disease control, health promotion and improved nutrition.

Programme Management supports and provides leadership for the development and implementation of legislation, policies, systems, norms and standards for a uniform district health system, and emergency, environmental and port health systems.

District Health Services promotes, coordinates, and institutionalises the district health system, integrates programme implementation using the primary health care approach by improving the quality of care, and coordinates the traditional medicine programme. This sub-programme is responsible for managing the district health component of the district health programmes grant.

Environmental Health and Communicable Diseases coordinates environmental and municipal health services, including port health, in line with international health regulations; supports provinces and municipalities in disease control, surveillance, and emergency preparedness; and implements targeted programmes for malaria, influenza, and other communicable diseases.

Non-communicable Diseases establishes policy, legislation and guidelines, and assists provinces in implementing and monitoring services for chronic non-communicable diseases. This includes disability and rehabilitation – including older people – eye health, palliative care, mental health and substance abuse, and forensic mental health.

Health promotion Nutrition and Oral Health formulates and monitors policies, guidelines, norms and standards for health promotion and nutrition. Focusing on TB, HIV and AIDS; maternal and child mortality; non-communicable, diseases; and violence, this subprogramme implements the health-promotion strategy of reducing risk factors for disease and promotes an integrated approach to working towards an optimal nutritional status for all South Africans.

Programme 4: Outcomes, outputs, performance indicators and targets

Outcome	Output	Output Indicator	Audited Performance			Estimated Performance		MTEF Targets					
			2022/23	2023/24	2024/25	2025/26	Annual Target 2026/27	Quarterly Targets				2027/2028	2028/2029
								Q1	Q2	Q3	Q4		
Malaria related deaths reduced	Malaria endemic sub-districts implementing the foci clearing programme	Number of sub-districts implementing the foci clearing programme	2 sub-districts implementing the foci clearing programme	2 sub-districts implementing the foci clearing programme	4 sub-districts implementing the foci clearing programme	14 sub-districts implementing the foci clearing programme	18 sub-districts implementing the foci clearing programme	Quarterly review of the implementation of the foci clearing programme was conducted.	Quarterly review of the implementation of the foci-clearing programme was conducted.	Quarterly review of the implementation of the foci-clearing programme was conducted.	18 sub-districts implementing the foci clearing programme	22 sub-districts implementing the foci clearing programme	26 sub-districts implementing the foci clearing programme
Reduced burden of disease	Screening for elevated blood glucose for prevention and early detection	Number of screenings conducted to detect elevated blood glucose 18 years and older	9 provinces progress reports on the implementation of provincial plans on the NSP for NCDS	9 provinces screen overall 79% of clients 18+ for diabetes	44 069 005 of clients 18+ screened for diabetes	31 000 000 screenings conducted for elevated blood glucose	33 000 000 screenings conducted for elevated blood glucose	8 250 000	16 500 000	24 750 000	33 000 000 screenings conducted for elevated blood glucose	35 000 000 screenings conducted for elevated blood glucose	37 000 000 screenings conducted for elevated blood glucose
Reduced burden of disease	Screening for elevated blood pressure for prevention and early detection	Number of screenings conducted to detect elevated blood pressure 18 years and older	9 provinces progress reports on the implementation of provincial plans on the NSP for NCDS	9 provinces screen overall 79% of clients 18+ for hypertension	44 602 922 of clients 18+ screened for hypertension	32 000 000 screenings conducted for elevated blood pressure	34 000 000 screenings conducted for elevated blood pressure	8 500 000	17 000 000	25 500 000	34 000 000 screenings conducted for elevated blood pressure	36 000 000 screenings conducted for elevated blood pressure	39 000 000 screenings conducted for elevated blood pressure
Mental Health Care integrated in Primary Health Care	Mental health care providers appointed in Primary Health Care	Percentage of Community Health Centers (CHCs) with at least one mental health care providers appointed	New Indicator	New Indicator	New Indicator	50% of CHCs with at least one mental health care providers appointed	65% of CHCs with at least one mental health care providers appointed	60%	60%	65%	65% of CHCs with at least one mental health care providers appointed	70% of CHCs with at least one mental health care providers appointed	75% of CHCs with at least one mental health care providers appointed

Outcome	Output	Output Indicator	Audited Performance			Estimated Performance		MTEF Targets					
			2022/23	2023/24	2024/25	2025/26	Annual Target 2026/27	Quarterly Targets				2027/2028	2028/2029
								Q1	Q2	Q3	Q4		
Improved Access to affordable and quality Health Care	Hospitals meet the requirement of the food service policy	Percentage of hospitals with food service units assessed for compliance with the food service policy	Additional 84 hospitals including 2 Tertiary Hospitals obtain 75% and above on the food service policy assessment	297 hospitals (Additional 97) obtain 75% and above on the food service policy assessment tool	77 hospitals	391 hospitals assessed for compliance with the food service policy	90% of hospitals with food service units assessed for compliance with the food service policy	Food Service Unit self-assessments conducted	30%	60%	90% of hospitals with food service units assessed for compliance with the food service policy	90% of hospitals with food service units assessed for compliance with the food service policy	90% of hospitals with food service units assessed for compliance with the food service policy
Improved access to affordable and quality healthcare	PHC facilities that qualify as Ideal clinics	Number of PHC facilities that qualify as Ideal clinics	2046 PHC facilities qualify as Ideal clinics	2706 PHC facilities qualify as Ideal clinics	2 762 PHC facilities that qualify as Ideal Clinics	2600 PHC facilities that qualify as Ideal clinic	2 700 PHC facilities that qualify as Ideal clinic	Progress report on PHC facilities that have conducted baseline status determination by Facility Operational Managers	Progress report of PHC facilities that have conducted baseline status determination by PPTICRMs	Progress report on implementation of QIP activities	2700 PHC facilities that qualify as Ideal clinic	2 750 PHC facilities that qualify as Ideal clinic	2 800 facilities that qualify as Ideal clinic
Improved responsiveness to Community needs	Facilitate compliance of municipalities to national environmental health norms and standards	Number of municipalities assessed for compliance to National environmental health norms and standards	28 municipalities (Districts and Metros) assessed for compliance to National Environmental Health Norms and Standards	26 municipalities (Districts and Metros) assessed for compliance to National Environmental Health Norms and Standards	10 municipalities (Districts and Metros) assessed for compliance to National Environmental Health Norms and Standards	17 municipalities (Districts and Metros) assessed for compliance to National environmental health norms and standards	35 municipalities (Districts and Metros) assessed for compliance to National environmental health norms and standards	8	8	10	9	20 municipalities (Districts and Metros) assessed for compliance to National environmental health norms and standards	32 municipalities (Districts and Metros) assessed for compliance to National environmental health norms and standards

Explanation of planned performance over the medium-term period

The sector will address the demand for mental health care services through improved integration in primary health care with the focus on appointing mental healthcare providers in community health centers to ensure that mental health conditions are appropriately treated. Early detection and prevention of non-communicable diseases (NCDs) with the focus on hypertension and diabetes will be facilitated through continuous screening. Environmental health service rendered through the municipalities will be monitored through structured assessment to facilitate compliance with environmental norms and standards, these efforts are aimed at ensuring a stronger approach in addressing health safety in communities. In pursuing the eradication of Malaria, the foci clearing programme will be expanded to additional four endemic sub-districts as it this has shown desired results in the reduction of malaria cases and deaths. Quality improvement in clinics will continuously be facilitated through the ideal clinic programme, to promote safety and provision of quality health care in all primary health care facilities.

Programme 4 resource consideration

Expenditure trends and estimates

Primary Health Care expenditure trends and estimates by subprogramme and economic classification

Subprogramme	Audited outcome			Adjusted appropriation	Average growth rate (%)	Average: Expenditure/ Total (%)	Medium-term expenditure estimate			Average growth rate (%)	Average: Expenditure/ Total (%)
R million	2022/23	2023/24	2024/25	2025/26	2022/23 - 2025/26		2026/27	2027/28	2028/29	2025/26 -2028/29	2026/27 -2028/29
Programme Management	4.5	3.9	2.8	7.1	16.4%	0.1%	5.3	5.6	5.8	-6.5%	0.1%
District Health Services	4 906.4	2 947.6	3 253.5	3 430.7	-11.2%	85.8%	3 571.1	3 713.8	3 829.2	3.7%	94.2%
Environmental Health and Communicable Diseases	1 607.9	174.1	80.4	103.6	-59.9%	11.6%	89.2	93.6	97.0	-2.2%	2.4%
Non-communicable Diseases	57.0	68.0	72.0	96.4	19.2%	1.7%	35.7	97.1	100.1	1.3%	2.0%
Health Promotion, Nutrition and Oral Health	30.0	31.1	31.4	34.2	4.4%	0.7%	76.3	37.3	38.4	4.0%	1.3%
Total	**6 605.8**	**3 224.8**	**3 440.1**	**3 672.0**	**-17.8%**	**100.0%**	**3 777.4**	**3 947.3**	**4 070.6**	**3.5%**	**100.0%**
Change to 2025 Budget estimate				–			(55.6)	(59.1)	(115.7)		
Economic classification											
Current payments	**1 710.3**	**284.4**	**178.8**	**251.5**	**-47.2%**	**14.3%**	**221.5**	**243.4**	**251.8**	**–**	**6.1%**
Compensation of employees	269.5	83.8	84.8	118.9	-23.9%	3.3%	102.5	108.8	112.8	-1.7%	2.7%
Goods and services	1 440.7	200.6	94.0	132.6	-54.8%	11.0%	119.0	134.6	139.0	1.6%	3.3%
of which:						–					–
Advertising	*0.5*	*3.0*	*11.1*	*8.0*	*153.4%*	*0.1%*	*12.9*	*11.2*	*11.5*	*13.1%*	*0.3%*
Consultants: Business and advisory services	*29.3*	*11.8*	*33.8*	*91.7*	*46.3%*	*1.0%*	*23.7*	*13.2*	*13.6*	*-47.0%*	*0.4%*
Agency and support/outsourced services	*5.2*	*11.3*	*–*	*0.7*	*-48.8%*	*0.1%*	*3.0*	*20.7*	*21.4*	*212.6%*	*0.4%*
Inventory: Medicine Travel and subsistence Venues and facilities	*1 310.4 12.3 2.4*	*1.5 19.8 14.0*	*– 16.0 12.3*	*5.5 16.8 1.5*	*-83.9% 11.0% -14.4%*	*7.8% 0.4% 0.2%*	*42.7 13.4 5.6*	*44.5 21.1 5.8*	*45.8 21.9 6.0*	*102.8% 9.3% 57.6%*	*1.1% 0.5% 0.1%*
Transfers and subsidies	**4 892.8**	**2 937.0**	**3 242.8**	**3 415.8**	**-11.3%**	**85.5%**	**3 554.6**	**3 696.5**	**3 811.4**	**3.7%**	**93.8%**
Provinces and municipalities	4 888.6	2 931.3	3 238.3	3 411.5	-11.3%	85.4%	3 551.0	3 692.7	3 807.5	3.7%	93.7%
Non-profit institutions	3.2	3.2	3.4	3.5	3.1%	0.1%	3.7	3.8	3.9	3.7%	0.1%
Households	1.0	2.5	1.1	0.8	-7.3%	0.0%	–	–	–	-100.0%	–
Payments for capital assets	**2.6**	**3.5**	**3.7**	**4.7**	**21.3%**	**0.1%**	**1.3**	**7.4**	**7.4**	**16.9%**	**0.1%**
Machinery and equipment	2.6	3.5	3.7	4.7	21.3%	0.1%	1.3	7.4	7.4	16.9%	0.1%
Payments for financial assets	**0.1**	**0.0**	**14.8**	**–**	**-100.0%**	**0.1%**	**–**	**–**	**–**	**–**	**–**
Total	**6 605.8**	**3 224.8**	**3 440.1**	**3 672.0**	**-17.8%**	**100.0%**	**3 777.4**	**3 947.3**	**4 070.6**	**3.5%**	**100.0%**
Proportion of total programme expenditure to vote expenditure	**10.5%**	**5.5%**	**5.6%**	**5.6%**	**–**	**–**	**5.6%**	**5.7%**	**5.7%**	**–**	**–**
Details of transfers and subsidies											
Households Social benefits Current	1.0	2.1	0.7	–	-100.0%	–	–	–	–	–	–
Employee social benefits	1.0	2.1	0.7	–	-100.0%	–	–	–	–	–	–
Other transfers to households Current	–	0.3	0.4	0.8	–	–	–	–	–	-100.0%	–
Other transfers to households	–	0.3	0.4	0.8	–	–	–	–	–	-100.0%	–
Non-profit institutions Current	3.2	3.2	3.4	3.5	3.1%	0.1%	3.7	3.8	3.9	3.7%	0.1%
South African Renal Registry	0.5	0.5	0.5	0.5	3.1%	–	0.5	0.5	0.6	3.7%	0.0%

National Council Against Smoking	1.2	1.2	1.2	1.3	3.1%	–	1.3	1.4	1.4	3.7%	0.0%
South African Federation for Mental Health	0.5	0.5	0.5	0.5	3.1%	–	0.6	0.6	0.6	3.7%	0.0%
South African National Council for the Blind	1.1	1.1	1.1	1.2	3.1%	–	1.2	1.3	1.3	3.7%	0.0%
Provinces and municipalities Provincial revenue funds Current	4 888.6	2 931.3	3 238.3	3 411.5	-11.3%	85.4%	3 551.0	3 692.7	3 807.5	3.7%	93.7%
District health programmes grant: District health component	4 888.6	2 931.3	3 238.3	3 411.5	-11.3%	85.4%	3 551.0	3 692.7	3 807.5	3.7%	93.7%

Personnel information

Primary Health Care personnel numbers and cost by salary level[1]

	Number of posts estimated for 31 March 2026		Number and cost[2] of personnel posts filled/planned for on funded establishment														Average growth rate (%)	Average: Salary level/ Total (%)
	Number of funded posts	Number of posts additional to the establishment	Actual			Revised estimate			Medium-term expenditure estimate									
			2024/25			2025/26			2026/27			2027/28			2028/29			2025/26 -2028/29	2026/27 -2028/29
Primary Health Care			Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost		
Salary level	**80**	**13**	**68**	**84.8**	**1.2**	**82**	**107.9**	**1.3**	**77**	**102.5**	**1.3**	**85**	**108.8**	**1.3**	**84**	**112.8**	**1.3**	**0.9%**	**100.0%**
1 – 6	10	–	8	5.0	0.6	11	7.2	0.7	11	7.5	0.7	19	8.7	0.5	19	9.2	0.5	19.8%	19.8%
7 – 10	31	–	26	27.7	1.1	31	34.7	1.1	31	36.5	1.2	31	38.5	1.2	31	40.6	1.3	–	37.8%
11 – 12	20	3	16	29.0	1.8	21	39.2	1.9	20	39.6	2.0	20	41.7	2.1	19	42.1	2.2	-3.0%	24.0%
13 – 16	9	–	8	19.6	2.5	9	23.0	2.6	5	14.9	2.9	5	15.7	3.1	5	16.6	3.2	-17.0%	6.3%
Other	10	10	10	3.5	0.3	10	3.7	0.4	10	3.9	0.4	10	4.1	0.4	10	4.3	0.4	–	12.2%

Data has been provided by the department and may not necessarily reconcile with official government personnel data.

1. Rand million.

Programme 5: Hospital Systems

Purpose

Develop national policies and plans for all levels of hospital services to strengthen the referral system and facilitate the improvement of hospitals and emergency medical services. Ensure that the planning, coordination, delivery and oversight of health infrastructure meet the country's health needs.

Programme Management supports and provides leadership for the development of national policy on hospital services, including the management of health facility infrastructure and hospital systems.

Health Facilities Infrastructure Management coordinates and funds health care infrastructure to enable provinces to plan, manage, modernise, rationalise and transform infrastructure, health technology and hospital management, and improve the quality of care. This sub-programme is also responsible for the direct health facility revitalisation grant and the health facility revitalisation component of the national health insurance indirect grant.

Hospital Systems focuses on the modernised and reconfigured provision of tertiary hospital services, identifies tertiary and regional hospitals to serve as centres of excellence for disseminating best practices for quality improvements and is responsible for the management of the national tertiary services grant.

Emergency Medical Services improves the governance, management and functioning of emergency medical services in South Africa by formulating policies, guidelines, norms and standards; strengthens the capacity and skills of emergency medical services personnel; identifies needs and service gaps; and provides oversight to emergency medical services in provinces

Programme 5: Outcomes, outputs, performance indicators and targets

Outcome	Output	Output Indicator	Audited Performance			Estimated Performance		MTEF Targets					
								Quarterly Targets				2027/2028	2028/2029
			2022/23	2023/24	2024/25	2025/26	Annual Target 2026/27	Q1	Q2	Q3	Q4		
Improved access to affordable and quality healthcare	Provinces trained on the implementation of the National Clinical Governance Manual	Number of provinces trained on the implementation of the National Clinical Governance Manual	New Indicator	New Indicator	New Indicator	A national clinical governance manual developed	9 Provinces trained on the implementation of the National Clinical Governance Manual	Not Applicable	Not Applicable	4 Provinces trained on the implementation of the National Clinical Governance Manual	5 Provinces trained on the implementation of the National Clinical Governance Manual	Monitoring the implementation of the National Clinical Governance Manual	Monitoring the implementation of the National Clinical Governance Manual
Improved access to affordable and quality healthcare	Amended regulations relating to categories of hospitals	Draft amended regulations relating to categories of hospitals developed	New Indicator	New Indicator	New Indicator	New indicator	Draft amended regulations relating to categories of hospitals developed	Concept document to guide the review of regulations relating to categories of hospitals	Provincial consultation on the review of regulations relating to categories of hospitals	Provincial consultation on the review of regulations relating to categories of hospitals	Draft amended regulations relating to categories of hospitals developed	Not Applicable	Not Applicable
Improved access to affordable and quality healthcare	Regional, Tertiary and Central hospitals attain ideal hospital status	Percentage of Regional, Tertiary and Central hospitals that attain ideal hospital status	New Indicator	New Indicator	New Indicator	New Indicator	70% of Regional, Tertiary and Central hospitals attain ideal hospital status	Not Applicable	Not Applicable	Not Applicable	70% of Regional, Tertiary and Central hospitals attain ideal hospital status	75% of Regional, Tertiary and Central hospitals attain ideal hospital status	80% of Regional, Tertiary and Central hospitals attain ideal hospital status
Health infrastructure optimised for delivery of care	PHC facilities constructed or revitalised	Number of PHC facilities constructed or revitalised	41 facilities constructed or revitalised (according to UAMPs assessed)	45 PHC facilities constructed or revitalised	47 PHC facilities constructed or revitalised	58 PHC facilities constructed or revitalised	46 PHC facilities constructed or revitalised	Not Applicable	Not Applicable	Not Applicable	46 PHC facilities constructed or revitalised	48 facilities constructed or revitalised	50 facilities constructed or revitalised
Health infrastructure optimised for delivery of care	Public Hospitals constructed or revitalised	Number of Hospitals constructed or revitalised	25 Hospitals constructed or revitalised (according to IPMPs assessed)	30 Hospitals constructed or revitalised	46 hospitals constructed or revitalised	50 Hospitals constructed or revitalised)	54 Hospitals constructed or revitalised)	Not Applicable	Not Applicable	Not Applicable	54 Hospitals constructed or revitalised)	58 Hospitals constructed or revitalised)	60 Hospitals constructed or revitalised)

Outcome	Output	Output Indicator	Audited Performance			Estimated Performance		MTEF Targets					
								Quarterly Targets				2027/2028	2028/2029
			2022/23	2023/24	2024/25	2025/26	Annual Target 2026/27	Q1	Q2	Q3	Q4		
Health infrastructure optimised for delivery of care	Public Health Facilities (Clinics, Hospitals, Nursing Colleges and EMS base stations) maintained, repaired or refurbished	Number of Public Health facilities maintained, repaired or refurbished	157 public health facilities maintained, repaired and/ or refurbished according to the Maintenance Plans assessed	299 public health facilities maintained, repaired and/or refurbished	403 public health facilities (clinics, hospitals, nursing colleges, EMS base stations) maintained, repaired and/or refurbished	400 public health facilities maintained, repaired and/or refurbished	500 public health facilities maintained, repaired and/ or refurbished	Not Applicable	Not Applicable	Not Applicable	500 public health facilities maintained, repaired and/ or refurbished	500 public health facilities maintained, repaired and/or refurbished	550 public health facilities maintained, repaired and/or refurbished

Explanation of planned performance over the medium-term period

To ensure provision of quality care in hospitals, improvement in clinical care is imperative to facilitate positive patient experience, through better patient management which results in reduction of adverse events. The programme is key in preparing facilities to comply with the requirement for the Office of Health Standards Compliance for certification as part of NHI implementation. The sector will pursue the amendment of regulations for the category of hospitals to align classification of hospitals with resources available for services. Continuous maintenance, revitalization and repairs in facilities is key in ensuring that health facilities are fit-for-purpose and provide a conducive environment for the provision of care. These various infrastructure projects signify the sector's commitment to the provision of quality care.

Programme 5 resource consideration

Expenditure trends and estimates

Hospital Systems expenditure trends and estimates by subprogramme and economic classification

Subprogramme	Audited outcome			Adjusted appropriation	Average growth rate (%)	Average: Expenditure/ Total (%)	Medium-term expenditure estimate			Average growth rate (%)	Average: Expenditure/ Total (%)
R million	2022/23	2023/24	2024/25	2025/26	2022/23 - 2025/26		2026/27	2027/28	2028/29	2025/26 -2028/29	2026/27 -2028/29
Programme Management	2.0	3.2	3.1	7.1	53.6%	0.0%	3.9	4.2	4.5	-14.3%	0.0%
Health Facilities Infrastructure Management	7 882.6	8 096.0	8 584.6	10 113.0	8.7%	36.7%	9 487.5	9 956.8	10 224.6	0.4%	36.2%
Hospital Systems	14 313.9	14 031.6	15 273.0	16 006.5	3.8%	63.2%	16 712.8	17 423.8	17 993.6	4.0%	63.7%
Emergency Medical Services	9.1	11.3	11.3	8.9	-0.8%	0.0%	14.3	13.2	13.5	15.0%	0.1%
Total	**22 207.5**	**22 142.1**	**23 872.0**	**26 135.5**	**5.6%**	**100.0%**	**26 218.5**	**27 398.0**	**28 236.1**	**2.6%**	**100.0%**
Change to 2025 Budget estimate				–			87.2	(143.5)	(541.8)		
Economic classification											
Current payments	**183.5**	**127.7**	**91.7**	**163.9**	**-3.7%**	**0.6%**	**98.2**	**105.5**	**108.7**	**-12.8%**	**0.4%**
Compensation of employees	29.3	34.3	37.1	39.2	10.2%	0.1%	45.0	46.8	48.2	7.1%	0.2%
Goods and services	154.3	93.4	54.6	124.7	-6.8%	0.5%	53.2	58.7	60.5	-21.4%	0.2%
of which:						–					–
Minor assets	*0.0*	*1.1*	*0.2*	*4.8*	*1237.1%*	*0.0%*	*5.0*	*5.2*	*5.3*	*3.7%*	*0.0%*
Consultants: Business and advisory services	*149.6*	*86.4*	*47.4*	*79.2*	*-19.1%*	*0.4%*	*9.8*	*10.2*	*10.5*	*-49.0%*	*0.0%*
Contractors	–	–	*0.1*	*1.9*	–	*0.0%*	*2.0*	*2.1*	*2.2*	*3.7%*	*0.0%*
Fleet services (including government motor transport)	*0.9*	*1.0*	*0.4*	*1.9*	*25.6%*	*0.0%*	*1.9*	*1.9*	*2.0*	*2.1%*	*0.0%*
Consumable supplies	–	*0.0*	*0.0*	*21.6*	–	*0.0%*	*17.5*	*23.2*	*24.0*	*3.5%*	*0.1%*
Travel and subsistence	*3.0*	*4.0*	*5.3*	*12.8*	*61.6%*	*0.0%*	*14.2*	*13.1*	*13.5*	*1.8%*	*0.0%*
Transfers and subsidies	**21 086.2**	**20 704.0**	**22 422.3**	**23 563.5**	**3.8%**	**93.0%**	**24 416.9**	**25 587.0**	**26 369.0**	**3.8%**	**93.3%**
Provinces and municipalities	21 085.6	20 703.8	22 422.1	23 563.5	3.8%	93.0%	24 416.9	25 587.0	26 369.0	3.8%	93.3%
Departmental agencies and accounts	–	–	0.0	–	–	0.0%	–	–	–	–	–
Households	0.6	0.2	0.1	–	-100.0%	0.0%	–	–	–	–	–
Payments for capital assets	**937.8**	**1 310.5**	**1 358.0**	**2 408.1**	**36.9%**	**6.4%**	**1 703.4**	**1 705.5**	**1 758.5**	**-9.9%**	**6.3%**
Buildings and other fixed structures	930.3	1 259.8	1 357.0	2 323.1	35.7%	6.2%	1 615.0	1 613.6	1 663.7	-10.5%	6.0%
Machinery and equipment	7.5	50.7	0.9	85.0	124.5%	0.2%	88.4	92.0	94.8	3.7%	0.3%
Total	**22 207.5**	**22 142.1**	**23 872.0**	**26 135.5**	**5.6%**	**100.0%**	**26 218.5**	**27 398.0**	**28 236.1**	**2.6%**	**100.0%**
Proportion of total programme expenditure to vote expenditure	**35.3%**	**38.0%**	**38.6%**	**39.6%**	**–**	**–**	**39.2%**	**39.3%**	**39.2%**	**–**	**–**
Details of transfers and subsidies											
Households Social benefits Current 0.6		0.2	0.1	–	-100.0%	–	–	–	–	–	–
Employee social benefits	0.6	0.2	0.1	–	-100.0%	–	–	–	–	–	–
Departmental agencies and accounts Departmental agencies (non-business entities) Current –		–	0.0	–	–	–	–	–	–	–	–
Com: Licences	–	–	0.0	–	–	–	–	–	–	–	–

Provinces and municipalities											
Provincial revenue funds											
Current	14 306.1	14 023.9	15 263.8	15 994.9	3.8%	63.2%	16 699.8	17 410.3	17 979.6	4.0%	63.6%
National tertiary services grant	14 306.1	14 023.9	15 263.8	15 994.9	3.8%	63.2%	16 699.8	17 410.3	17 979.6	4.0%	63.6%
Capital	6 779.5	6 679.9	7 158.3	7 568.5	3.7%	29.9%	7 717.1	8 176.7	8 389.3	3.5%	29.7%
Health facility revitalisation grant	6 779.5	6 679.9	7 158.3	7 568.5	3.7%	29.9%	7 717.1	8 176.7	8 389.3	3.5%	29.7%

Personnel information

Hospital Systems personnel numbers and cost by salary level[1]

	Number of posts estimated for 31 March 2026		Number and cost[2] of personnel posts filled/planned for on funded establishment													Average growth rate (%)	Average: Salary level/ Total (%)
	Number of funded posts	Number of posts additional to the establishment	Actual			Revised estimate			Medium-term expenditure estimate								
			2024/25			2025/26			2026/27			2027/28			2028/29			2025/26 -2028/29	2026/27 -2028/29
Hospital Systems			Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost		
Salary level	**33**	**–**	**31**	**37.1**	**1.2**	**31**	**39.2**	**1.3**	**69**	**45.0**	**0.6**	**69**	**46.8**	**0.7**	**69**	**48.2**	**0.7**	**30.6%**	**100.0%**
1 – 6	5	–	5	2.5	0.5	5	2.6	0.5	44	6.6	0.2	44	6.7	0.2	44	6.9	0.2	105.8%	63.0%
7 – 10	9	–	8	6.0	0.8	8	6.4	0.8	8	6.7	0.8	8	7.1	0.9	8	7.5	0.9	–	11.6%
11 – 12	9	–	8	10.9	1.4	8	11.4	1.5	8	12.0	1.5	8	12.7	1.6	8	13.4	1.7	–	11.4%
13 – 16	10	–	10	17.7	1.8	10	18.7	1.9	10	19.7	2.0	10	20.4	2.1	9	20.4	2.2	-2.4%	14.0%

Data has been provided by the department and may not necessarily reconcile with official government personnel data.

1. Rand million.

Programme 6: Health System Governance and Human Resources

Purpose

Develop policies and systems for the planning, managing and training of health sector human resources, and for planning, monitoring, evaluation and research in the sector. Provide oversight to all public entities in the sector and statutory health professional councils in South Africa and promote good corporate governance practices over health entities and statutory councils by ensuring compliance to applicable legislative prescripts.

Programme Management supports and provides leadership for health workforce programmes, key governance functions such as planning and monitoring, public entity oversight, and forensic chemistry laboratories.

Policy and Planning provides advisory and strategic technical assistance on policy and planning, coordinates the planning system of the health sector, and supports policy analysis and implementation.

Human Resources for Health is responsible for medium-term to long-term health workforce planning, development and management in the public health sector. This entails facilitating the implementation of the national human resources for health strategy, health workforce capacity development for sustainable service delivery, the coordination of transversal human resources management policies, and the provision of in-service training for health workers.

Nursing Services develops and monitors the implementation of a policy framework for the development of required nursing skills and capacity to deliver effective nursing services.

Public Entities Management and Laboratories supports the executive authority's oversight function and provides guidance to health entities and statutory councils that fall within the mandate of health legislation with regards to planning and budget procedures, performance and financial reporting, remuneration, governance and accountability.

Programme 6: Outcomes, outputs, performance indicators and targets

Outcome	Output	Output Indicator	Audited Performance			Estimated Performance		MTEF Targets					
			2022/23	2023/24	2024/25	2025/26	Annual Target 2026/27	Quarterly Targets				2027/2028	2028/2029
								Q1	Q2	Q3	Q4		
Governance of Public Entities strengthened	Public entities audit action plan (for public entities with material findings) monitored	Audit action plans for Public Entities monitored	New Indicator	New Indicator	4 audit action plans monitored	All audit action plans monitored	Public Entities Audit action plans monitored	Not Applicable	Not Applicable	Not Applicable	Public Entities Audit action plans monitored	Public Entities Audit action plans monitored	Public Entities Audit action plans monitored
Equitable distribution of health professionals to health facilities	Provincial Nursing Leadership competency framework implementation monitored	Number of provinces monitored for implementation of provincial nursing leadership competency framework.	New Indicator	New Indicator	New Indicator	9 Provincial Nursing Leadership competency framework implementation plans developed.	9 provinces monitored for implementation of provincial nursing leadership competency framework.	3 provinces monitored for implementation of provincial nursing leadership competency framework.	3 provinces monitored for implementation of provincial nursing leadership competency framework.	3 provinces monitored for implementation of provincial nursing leadership competency framework.	Not Applicable	Not Applicable	Not Applicable
Equitable distribution of health professionals to health facilities	Framework for distribution of Multidisciplinary Teams for District Hospital	Draft Framework for distribution of Multidisciplinary teams for District hospitals developed	New Indicator	New Indicator	New Indicator	Draft Framework for distribution of Multidisciplinary teams for District Hospitals developed	Draft Framework for distribution of Multidisciplinary teams for District Hospitals developed	Not Applicable	Not Applicable	Not Applicable	Draft Framework for distribution of Multidisciplinary teams for District Hospitals developed	Framework for distribution of Multidisciplinary teams for District Hospitals approved	Framework implementation in District Hospitals
Reduced burden of disease	Food labelling legislation revised	Revised Food labelling regulations gazetted	New Indicator	Comments on draft food labelling Regulations were captured and analysed	Draft set of final food regulations submitted for legal review	Revised Food labelling regulations gazetted	Revised Food labelling regulations gazetted	Not Applicable	Not Applicable	Not Applicable	Revised Food labelling regulations gazetted	Not Applicable	Not Applicable

Explanation of planned performance over the medium-term period

Health workforce is a critical resource for the sector and investment in this regard, will ensue that the training of Nursing professionals is responsive to the service delivery needs in each province. Furthermore, the distribution of health professionals is imperative to facilitate equitable access to health care. With the focus on district hospitals, the framework for distribution of health professionals is aimed at ensuring that the hospitals have the right mix of skills to respond to community needs, and ailments are treated at the appropriate level of care to reduce delays in care which results in complication of conditions later requiring expensive specialized care which s in scarcity. In an effort to strengthen leadership and governance across the sector, the department will strengthen its oversight of public entities by monitoring audit action plans where material findings related to audit outcomes are identified. Community empowerment will be promoted through finalization of the process to revise the food labelling regulations, which will ensure that nutritional information on food labels enables individuals to make informed decisions on what they consume.

Programme 6 resource consideration

Expenditure trends and estimates

Health System Governance and Human Resources expenditure trends and estimates by subprogramme and economic classification

Subprogramme	Audited outcome			Adjusted appropriation	Average growth rate (%)	Average: Expenditure/ Total (%)	Medium-term expenditure estimate			Average growth rate (%)	Average: Expenditure/ Total (%)
R million	2022/23	2023/24	2024/25	2025/26	2022/23 - 2025/26		2026/27	2027/28	2028/29	2025/26 -2028/29	2026/27 -2028/29
Programme Management	4.3	5.0	4.8	8.8	27.0%	0.1%	6.2	6.6	6.9	-7.7%	0.1%
Policy and Planning	11.2	5.5	8.4	7.8	-11.5%	0.1%	8.1	8.5	8.8	4.0%	0.1%
Public Entities Management	1 937.0	1 848.7	1 885.4	2 125.7	3.1%	25.9%	2 213.0	2 296.1	2 370.8	3.7%	27.0%
Nursing Services	19.0	10.2	9.7	10.8	-17.1%	0.2%	11.3	11.8	12.2	4.0%	0.1%
Human Resources for Health	5 468.1	5 501.2	5 540.2	5 671.8	1.2%	73.7%	5 942.6	6 199.8	6 411.1	4.2%	72.7%
Total	**7 439.7**	**7 370.6**	**7 448.6**	**7 824.9**	**1.7%**	**100.0%**	**8 181.3**	**8 522.8**	**8 809.8**	**4.0%**	**100.0%**
Change to 2025 Budget estimate				–			144.2	120.4	30.3		
Economic classification											
Current payments	**120.1**	**115.0**	**132.5**	**138.8**	**4.9%**	**1.7%**	**167.3**	**161.3**	**166.0**	**6.1%**	**1.9%**
Compensation of employees	81.4	77.2	79.0	95.1	5.3%	1.1%	101.7	106.0	109.2	4.7%	1.2%
Goods and services	38.7	37.8	53.5	43.8	4.1%	0.6%	65.5	55.3	56.8	9.1%	0.7%
of which:						–					–
Audit costs: External	*3.3*	*2.3*	*2.2*	*3.1*	*-2.3%*	*0.0%*	*3.2*	*3.3*	*3.4*	*3.7%*	*0.0%*
Consultants: Business and advisory services	*5.2*	*7.0*	*9.5*	*4.3*	*-6.2%*	*0.1%*	*8.8*	*4.7*	*4.9*	*4.1%*	*0.1%*
Contractors	*1.8*	*2.8*	*2.7*	*4.2*	*33.3%*	*0.0%*	*2.4*	*4.6*	*4.7*	*4.1%*	*0.0%*
Agency and support/outsourced services	*8.4*	*–*	*1.6*	*6.4*	*-9.0%*	*0.1%*	*14.8*	*8.5*	*8.7*	*11.2%*	*0.1%*
Fleet services (including government motor transport)	*1.3*	*2.0*	*2.1*	*3.0*	*31.4%*	*0.0%*	*3.2*	*3.3*	*3.4*	*4.0%*	*0.0%*
Travel and subsistence	*9.4*	*11.6*	*23.7*	*7.2*	*-8.3%*	*0.2%*	*16.0*	*13.0*	*13.3*	*22.4%*	*0.2%*
Transfers and subsidies	**7 317.4**	**7 254.0**	**7 312.2**	**7 677.5**	**1.6%**	**98.3%**	**8 009.5**	**8 356.7**	**8 638.7**	**4.0%**	**98.0%**
Provinces and municipalities	5 449.1	5 479.0	5 517.1	5 649.9	1.2%	73.4%	5 909.0	6 174.0	6 384.6	4.2%	72.4%
Departmental agencies and accounts	1 867.3	1 774.3	1 794.5	2 027.5	2.8%	24.8%	2 100.5	2 182.8	2 254.2	3.6%	25.6%
Households	1.0	0.7	0.6	–	-100.0%	0.0%	–	–	–	–	–
Payments for capital assets	**1.4**	**1.5**	**0.8**	**8.6**	**81.4%**	**0.0%**	**4.5**	**4.8**	**5.0**	**-16.2%**	**0.1%**
Buildings and other fixed structures	–	0.0	–	0.1	–	0.0%	–	–	–	-100.0%	–
Machinery and equipment	1.4	1.5	0.8	8.5	81.0%	0.0%	4.5	4.8	5.0	-16.0%	0.1%
Payments for financial assets	**0.7**	**0.1**	**3.0**	**–**	**-100.0%**	**0.0%**	**–**	**–**	**–**	**–**	**–**
Total	**7 439.7**	**7 370.6**	**7 448.6**	**7 824.9**	**1.7%**	**100.0%**	**8 181.3**	**8 522.8**	**8 809.8**	**4.0%**	**100.0%**
Proportion of total programme expenditure to vote expenditure	**11.8%**	**12.6%**	**12.0%**	**11.9%**	**–**	**–**	**12.2%**	**12.2%**	**12.2%**	**–**	**–**
Details of transfers and subsidies											
Households Social benefits Current	1.0	0.7	0.6	–	-100.0%	–	–	–	–	–	–
Employee social benefits	1.0	0.7	0.6	–	-100.0%	–	–	–	–	–	–

Departmental agencies and accounts										
Departmental agencies (non-business entities)		1 772.5	1 790.1	2 025.7	2.8%	24.8%	2 098.5	2 180.7	2 252.0	3.6%	25.6%
Current 1 865.8										
National Health Laboratory Service	772.5	706.4	598.8	636.4	-6.3%	9.0%	665.3	693.2	714.7	3.9%	8.1%
Office of Health Standards Compliance	157.5	161.5	181.6	191.7	6.8%	2.3%	206.0	214.9	222.4	5.1%	2.5%
South African Medical Research Council	779.5	760.1	833.5	1 013.9	9.2%	11.3%	1 039.0	1 104.1	1 141.3	4.0%	12.9%
Council for Medical Schemes	6.3	6.5	6.2	6.3	0.3%	0.1%	6.6	6.8	7.1	3.7%	0.1%
South African Health Products Regulatory Authority	150.0	137.9	143.5	149.3	-0.1%	1.9%	155.4	161.6	166.6	3.7%	1.9%
South African Medical Research Council: Social impact bond	–	–	26.3	28.0	–	0.2%	26.1 –		–	-100.0%	0.1%
South African Broadcasting Corporation	–	–	0.1	–	–	–	–	–	–	–	–
Social security funds										
Current	1.5	1.7	4.5	1.9	7.0%	–	2.0	2.0	2.1	3.7%	0.0%
Mines and Works Compensation Fund	1.5	1.7	4.5	1.9	7.0%	–	2.0	2.0	2.1	3.7%	0.0%
Provinces and municipalities										
Provincial revenue funds Current	5 449.1	5 479.0	5 517.1	5 649.9	1.2%	73.4%	5 909.0	6 174.0	6 384.6	4.2%	72.4%
Human resources and training grant	5 449.1	5 479.0	5 517.1	5 649.9	1.2%	73.4%	5 909.0	6 174.0	6 384.6	4.2%	72.4%

Personnel information

Health System Governance and Human Resources personnel numbers and cost by salary level[1]

	Number of posts estimated for 31 March 2026		Number and cost[2] of personnel posts filled/planned for on funded establishment													Average growth rate (%)	Average: Salary level/ Total (%)
	Number of funded posts	Number of posts additional to the establishment	Actual			Revised estimate			Medium-term expenditure estimate								
			2024/2			2025/2			2026/27			2027/28			2028/29			2025/26 -2028/29	2026/27 -2028/29
Health System Governance and Human Resources			**Number**	**Cost**	**Unit cost**	**Number**	**Cost**	**Unit cost**	**Number**	**Cost**	**Unit cost**	**Number**	**Cost**	**Unit cost**	**Number**	**Cost**	**Unit cost**		
Salary level	**168**	**–**	**147**	**79.0**	**0.5**	**165**	**95.1**	**0.6**	**167**	**101.7**	**0.6**	**166**	**106.0**	**0.6**	**164**	**109.2**	**0.7**	**-0.3%**	**100.0%**
1 – 6	64	–	61	17.5	0.3	64	19.4	0.3	64	20.4	0.3	64	21.5	0.3	64	22.7	0.4	–	38.7%
7 – 10	60	–	50	24.0	0.5	59	30.3	0.5	59	31.9	0.5	59	33.6	0.6	59	35.4	0.6	–	35.7%
11 – 12	22	–	15	13.1	0.9	20	18.4	0.9	22	21.1	1.0	22	22.3	1.0	21	22.3	1.1	1.0%	12.9%
13 – 16	22	–	21	24.4	1.2	22	26.9	1.2	22	28.3	1.3	21	28.6	1.4	20	28.7	1.4	-3.2%	12.7%

Data has been provided by the department and may not necessarily reconcile with official government personnel data.

1. Rand million.

Key Risks

Outcomes	Key Risks	Risk Mitigations
Financial Management strengthened in the health sector	Budget cuts which result in insufficient budget for essential services	Effective collaboration with National Treasury on Budget Review Sessions with Provincial Departments
Improved access to equitable healthcare services	Delays in commencement of Phase 1 and 2 of the implementation research due to the legal challenges	Additional sentence: Desktop planning and preparation for testing the draft accreditation framework is completed to permit for immediate implementation as soon as possible
National Health Insurance awareness improved/increased	Diminishing public trust due to information asymmetry on National Health Insurance purpose and benefits	Effectively implement the National Health Insurance communication plan in all sectors of society, with appropriate messaging tailored for targeted sectors
Improved responsiveness to community needs	Reduced household services due to diminishing resources	Promote a coordinated and functional community outreach through CHWs
Reduced burden of disease	Poor coordination/integration of community-based services	Strengthen community based mechanism to link patients to care
HIV and AIDS related deaths reduced	Poor linkage to care	Target specific (Men, Youth and Children), through community and formal structures to increase number of HIV clients on ARTs
TB Mortality reduced	Fewer patients tested for TB	Accelerate testing for vulnerable groups through targeted testing
Malaria related deaths reduced	Inadequate capacity in local areas to expand the foci malaria clearing programme	Continuous capacity building for effective implementation of foci clearing programme
Mortality due to NCDs reduced	Low uptake of HPV screening	Expand the HPV vaccination programme in order to vaccinate 90% of girls 9 – 15 years old
Improved maternal and child health	Slow progress in achieving the targets for reduced mortality	Promote ‘whole sector approach’ to tackling preventable causes of maternal and child health
Improved access to School health programme	Inadequate resources to expand screening for Grade R leaners	Strengthening stakeholder collaboration to leverage resources for expansion of screening
Improved access to Youth health programme	Primary Health Care of infrastructure not conducive to enable activation of Youth Zones	Collaborate with all relevant stakeholders to determine facilities that are ready to accommodate Youth Zones for expansion
Mental integrated in Primary Health Care	Slow progress in contracting mental health care providers at primary health care	Strategic purchasing of services from healthcare providers to support integration of mental health care ay primary health care level
Early warning and response strengthened	Inadequate capacity at district to implement Event-Based Surveillance	Targeted capacity building by transferring resources where most required in line with implementation of EBS
Improved access to affordable and quality healthcare	Health establishment not adequately prepared for certification by the Office of Health Standards Compliance	Establish monitoring mechanisms and partnerships with private sector for capacity building
Employment in line with equity targets	Targets for employment for targeted groups are not achieved due to inability to fill replacement posts as all vacancies must undergo a reprioritization process	Reprioritized posts to target Women, Youth and people living with disabilities where appropriate
Integrated electronic health record	Lack of financial resources required to accelerate the development of electronic health record	ICT infrastructure strategic purchasing
Equitable distribution of health professionals to health facilities	Poor implementation of Human Resources for Health policies	Strengthening accountability mechanism to ensure that national policies to improve human resources for health are implemented by province
Health infrastructure optimised for delivery of care	Lack of capacity at local level to keep up with the demand for maintenance of health facilities	Regular project monitoring and reporting to facilitate timeous delivery of projects deliverable

Public Entities: Outputs and Indicators

Name of Public Entity	Mandate	Key outputs	Current Annual Budget (R thousand)
Council for Medical Schemes	The Council for Medical Schemes was established in terms of the Medical Schemes Act (1998), as a regulatory authority responsible for overseeing the medical schemes industry in South Africa. Section 7 of the act sets out the functions of the council, which include protecting the interests of beneficiaries, controlling and coordinating the functioning of medical schemes, collecting and disseminating information about private health care, and advising the Minister of Health on any matter concerning medical schemes.	(a) Medical scheme rules comply with the MSA (b) Financial soundness of medical schemes (c) Complaints resolution (d) Enforcement action (e) Routine inspection reports	R250 757 million
Mines and Works Compensation Fund	The Compensation Commissioner for Occupational Diseases in Mines and Works was established in terms of the Occupational Diseases in Mines and Works Act (1973). The act gives the commissioner the mandate to: collect levies from controlled mines and works, to compensate workers and ex-workers in controlled mines and works for occupational diseases of the cardiorespiratory organs, and reimburse workers for loss of earnings incurred during tuberculosis treatment. The commissioner compensates the dependants of deceased workers and also administers pensions for qualifying ex-workers or their dependents.	(a) Certifications finalized on the Compensation Claims Management System (a) Claims finalised by the Fund (a) Benefit payments made by the Fund (a) Controlled mines and works inspected (a) Levies (funds) received from controlled mines and works liable for payment of levies	R 518 118 million
National Health Laboratory Service	The National Health Laboratory Service was established in 2001 in terms of the National Health Laboratory Service Act (2000). The entity is mandated to support the Department of Health by providing cost-effective diagnostic laboratory services to all state clinics and hospitals. It also provides health science training and education, and supports health research. The entity's specialised divisions include the National Institute for Communicable Diseases, the National Institute for Occupational Health, the National Cancer Registry and the Anti Venom Unit.	(a) Improved laboratory test turnaround times. (b) Improved equitable access to diagnostic services (c) Strengthened total quality management systems (d) Health research aligned to national priorities (e) Robust Surveillance and Outbreak Response Systems	R14 Billion

Name of Public Entity	Mandate	Key outputs	Current Annual Budget (R thousand)
Office of Health Standards Compliance	The Office of Health Standards Compliance was established in terms of the National Health Act (2003), as amended. The Office is mandated to: monitor and enforce the compliance of health establishments with the norms and standards prescribed by the Minister of Health in relation to the national health system; and ensure the consideration, investigation and disposal of complaints relating to non-compliance with prescribed norms and standards in a procedurally fair, economical and expeditious manner.	(a) Public Health establishments are inspected for compliance with the norms and standards (b) Private Health establishments are inspected for compliance with the norms and standards (c) Complaints resolved within 6 months through the issuance of the final investigation report (d) Recommendation report for improvement in the health sector completed and shared with relevant authorities, to ensure compliance with prescribed norms and standards (e) Health establishments registered and profiled	R206 043 000 Million
South African Health Products Regulatory Authority	The South African Health Products Regulatory Authority(SAHPRA) is established in terms of the Medicines and Related Substances Act, 1965 (Act No. 101 of 1965), as amended. SAHPRA is the regulatory authority responsible for the regulation and control of registration, licensing, manufacturing, importation, and all other aspects pertaining to active pharmaceutical ingredients, medicines, medical devices; and for conducting clinical trials in a manner compatible with the national medicines policy.	(a) New Chemical Entities (NCEs) applications finalised (human, and veterinary medicines) (b) Generic medicines applications finalised (human, veterinary medicines) (c) New GMP- and GWP-related licences finalized	R503 345 000 Million
South African Medical Research Council	The South African Medical Research Council (SAMRC) was established in terms of the South African Medical Research Council Act (1991). The SAMRC is mandated to promote the improvement of health and quality of life through research, development and technology transfers. Research and innovation are primarily conducted through funded research units located within the council (intramural units) and in higher education institutions (extramural units)	(a) Accepted and/or published conference proceedings, abstracts, journal articles, book chapters and books by SAMRC affiliated and funded authors (b) Accepted and/or published conference proceedings, abstracts, journal articles, book chapters and books by SAMRC grant-holders (c) Research grants awarded (d) Innovation and technology projects funded by the SAMRC (e) Full or partial awards (scholarships, fellowships and grants) funded by the SAMRC to female recipients for Masters', PhD, Postdoc, Early-Career and Mid-Career Scientists	R2.1 Billion

Infrastructure Projects

Project Name	Scope	Project Actual Start Date	Estimated Construction End Date	Project Estimated End Date	Sum of Total Project Cost	Expenditure To Date
Bambisana Hospital Smart Revitalisation - PH1	The Upgrading of the Bambisana District Hospital Contract [building and related works] will be constructed in three sections, due to fact that the existing hospital shall remain fully functional and operational during the construction. Section 1 - (Staff Accommodation P1-P3, Female General Ward & Infectious Disease Ward, helistop, road and parking areas). Original PC date: 13 October 2023. Revised PC date : 15 September 2024 Section 2 - (Gateway Clinic, Maternity, Theatres and CSSD , New accommodation and Renovations to existing accommodation, road and parking areas). Original PC date: 10 March 2025 Revised PC date: 22 January 2026 Section 3 - (OPD, Admissions and Pharmacy, Admin, New Gate House, Removal off site of existing prefabricated buildings). Original PC date: 12 May 2026 Revised PC date: 05 March 2027 The construction will constitute the following main activities: • Bulk Eskom Connection upgrade • Bulk Earthworks (cut/ fill and imported) to construct roads, parking areas and platforms. • Bulk Low Voltage (LV) reticulation network replacement / upgrades • Upgrade wastewater treatment works • Upgrade existing water treatment works • Upgrade sewer pump station • Staff accommodation (Permanent structures) • Hospital complex with access walkways • Installation of engineering services reticulations • Demolition of redundant existing buildings • The removal of existing prefabricated units off site • Helistop • Refurbishment of 5 existing buildings and 2 ancillary buildings • Installation concrete - and Terra-force retaining walls • Internal Fencing and Gates • Selected Subcontracts - Mechanical- and Electrical specialist installations • Procurement of Hospital Equipment, Furniture, Consumables, etc. – pre-and post-Practical completion per section • Implementation of SMME participation (30%) and Socio-Economic Deliverables	2/10/2015	5/3/2027	3/3/2028	R658,829,170.00	R453,682,340.00
Bambisana Hospital Smart Revitalisation - PH2	Bambisana Hospital Smart Revitalisation for the phase 2 works only.	1/4/2015	TBC	30/11/2029	R52,091,397.00	R6,749,395.00

Project Name	Scope	Project Actual Start Date	Estimated Construction End Date	Project Estimated End Date	Sum of Total Project Cost	Expenditure To Date
Christiana Hospital - Emergency Works	This work package is focused on addressing emergency and backlog building works required at Christiana Hospital.	12/3/2019	13/3/2026	31/5/2026	R189,676,505.00	R144,829,895.00
Clocolan Clinic - Replacement	As guided by the client's brief, the scope of work for the project covered the construction of: 1. A new clinic with six (6) consulting rooms, one (1) counselling room, and three (3) vitals rooms, and 2. Staff accommodation blocks with 6 beds.	7/4/2015	31/3/2026	30/11/2026	R76,647,737.00	R63,829,859.00

Project Name	Scope	Project Actual Start Date	Estimated Construction End Date	Project Estimated End Date	Sum of Total Project Cost	Expenditure To Date
Comprehensive Maintenance_Tambo Memorial Hospital	Comprehensive maintenance and remedial works at Tambo Memorial Hospital: PHASE 1 – REMEDIAL WORK X-RAY DEPARTMENT Floors There are no visible damages on the floors as a result of the explosion. The floor coverings show no signs of movement. Any visible damage is a result of general wear and tear. Walls The walls were not affected by the explosion but there are signs of water proofing defects that need to be attended to avoid further deterioration. Ceilings Parts of the suspended ceilings were moved out of position by the tremor from the explosion. It is therefore recommended that a thorough inspection of the grid is carried out to access its integrity. Roof Coverings and Trusses. The integrity of the roof coverings and trusses has not been compromised. Doors & Windows All external doors have been damaged including a majority of the glazing on the windows. The repair works have commenced under the supervision of the Gauteng Department of Infrastructure Development (GDID) Electrical Works All light fittings and plugs are fully operational and have not been affected by the incident. However, there are lights fittings that need to be put back into position as they may have moved off position due to the tremor. The bulk electrical supply to this section of the building has not been affected by the tremor or the explosion. Mechanical Works All heating, cooling and ventilation and air-condition (HVAC) equipment require major service or replacement as a result of the gas having affected the normal functioning of the equipment.	23/6/2023	6/7/2029	30/3/2029	R615,779,085.00	R23,720,808.00

Project Name	Scope	Project Actual Start Date	Estimated Construction End Date	Project Estimated End Date	Sum of Total Project Cost	Expenditure To Date
	AMBULANCE AND EMERGENCY DEPARTMENT (INCLUDING CASUALTY) Floors There are no visible damages on the floors as a result of the explosion. The floor coverings show no signs of movement. Any visible damage is a result of general wear and tear. Walls The walls in the porters' rooms and records/filing show structural damage as a result of the tremor caused by the explosion. The structural cracks must be attended to immediately as they pose a hazard for the hospital personnel in the area. The section of the building should not be in use until measures have been taken to repair the structural cracks. Ceilings The ceiling is completely damaged. Immediate replacement including a new grid is required prior to the building being put into use. The building has been fully decommissioned and must not be utilised until all related repair works are implemented. Roof Coverings and Trusses. From a visual inspection, there are no major noticeable damage to the roof however, a thorough structural inspection needs to be carried out to determine the stability of the trusses. Doors & Windows All external doors have been damaged including a majority of the glazing on the windows. The repair works have commenced under the supervision of the Gauteng Department of Infrastructure Development (GDID) Electrical Works A majority of the ceilings have been damaged including the light fittings. Major electrical works must be carried out. The A&E building has a lot of exposed power cables as a result of the light fitting having moved out of position resulting in them also being damaged. The bulk electrical supply to this section of the building affected by the tremor due to the explosion, we advised the electrical technician at the hospital to cut off power supply to the casualty section at the distribution board.					

Project Name	Scope	Project Actual Start Date	Estimated Construction End Date	Project Estimated End Date	Sum of Total Project Cost	Expenditure To Date
	The plugs are fully operational and have not been affected by the incident. However, with noted bulk power supply damages identified, a thorough inspection will be carried out upon the completion of the repair works related to the bulk power supply. The Information, Communications and Technology (ICT) infrastructure has been affected by the incident and will require detailed assessment to determine the full extent of the damage. Mechanical Works All heating, cooling and ventilation and air-condition (HVAC) equipment require major service or replacement as a result of the gas having affected the normal functioning of the equipment. The gas/oxygen reticulation system must be inspected and tested for leaks prior commissioning of the building. THEATRES Floors There are no visible damages on the floors as a result of the explosion. The floor coverings show no signs of movement. Any visible damage is a result of general wear and tear. Walls The walls were not affected by the explosion and are structurally sound. Ceilings Parts of the suspended ceilings were moved out of position by the tremor from the explosion. The ceiling panels have since been put back in place however we noted that the ceiling grid for the entire section of the hospital was moved out of position because of the tremor. Thus, a detailed assessment will need to be carried out to fully determine the full extent of the damage. Roof Coverings and Trusses. From a visual inspection, there are not major noticeable damage to the roof however a thorough structural inspection needs to be carried out to determine the stability of the roof coverings and trusses. Doors & Windows All external doors have been damaged including a majority of the glazing on the windows. The repair works have commenced under the supervision of the Gauteng Department of Infrastructure Development (GDID)					

Project Name	Scope	Project Actual Start Date	Estimated Construction End Date	Project Estimated End Date	Sum of Total Project Cost	Expenditure To Date
	Electrical Works All light fittings and plugs are fully operational and have not been affected by the incident. However, there are lights fittings that need to be put back into position as they may have moved off position by the tremor. The bulk electrical supply to this section of the building has not been affected by the tremor or the explosion. Mechanical Works All heating, cooling and ventilation and air-condition (HVAC) equipment require major service or replacement as a result of the gas having affected the normal functioning of the equipment. There is a noted gas leak in the theatre that requires immediate repairs. The theatre must immediately be decommissioned until the gas leak is fixed. MEDICAL EQUIPMENT AT TAMBO MEMORIAL HOSPITAL X-RAY DEPARTMENT CANON CT SCAN –repair the external monitor. ACCIDENT & EMERGENCY DEPARTMENT • Replace Five (5) Ceiling-Mount Examination lights for Resus. • Repair Two (2) damaged Ventilators. OPERATING THEATERS Repair medical gas. PHASE 2 – REMEDIAL WORK CIVIL WORKS Repair roads distresses (potholes and cracks Repair loose/replace missing paving blocks and realign uneven paving. Provide kerbing for the internal roads. Paint internal road markings Replace worn out road signage. Unblock storm water reticulation. Repair stormwater pipes, kerb inlets and grid inlets Provide apron slabs around the building to protect the foundation from rainwater. Replacing missing stormwater drainage infrastructure, grid covers Unblock and repair sewer reticulation system.					

Project Name	Scope	Project Actual Start Date	Estimated Construction End Date	Project Estimated End Date	Sum of Total Project Cost	Expenditure To Date
	ELECTRICAL WORKS Replace: - Small power plugs - Lighting - Distribution boards - Substations - Lighting protection - Generators - Medium voltage equipment HEATING VENTILATION & AIR CONDITIONING (HVAC) WORKS Hospital Block -Dispensary - Repair VRV c/w AHU - Install FA intake/ducting. Hospital Block - Physiotherapy - Install new Filter. - Repair fan - Install new air conditioning unit. Hospital Block – Public Toilets - Install new extract fan. Hospital Block – Medical Outpatient - Replace radiant heaters and fresh air fans. Hospital Block – Outpatients Department - Replace DX air conditioning units with new AHU Hospital Block – Casualty - Install new FA fan - Repair fan - Replace DX air conditioning units with new AHU Hospital Block – Xray - Repair VRV c/w AHU. - Install FA intake/ducting. Hospital Block – main Kitchen - Service extraction air kitchen canopy c/w FA system - Repair fan Hospital Block – Nursing Manager - Install new FA fan Hospital Block – Ward 3 - Relocate air-conditioning units - Replace DX split units with Chilled water systems. Hospital Block – Dietician - Install new FA fan - Install new DX air conditioning units Hospital Block – Speech - Install new FA fan Hospital Block – management Offices - Install new FA fan - Install new DX air conditioning units					

Project Name	Scope	Project Actual Start Date	Estimated Construction End Date	Project Estimated End Date	Sum of Total Project Cost	Expenditure To Date
	Hospital Block – ICU WARD - Relocate air-conditioning units. - Replace DX split units with Chilled water systems. Hospital Block – Theatres - Replace with Chilled water systems'/w AHU with 100% FA Hospital Block – National health Lab - Replace with Chilled water systems'/w AHU with FA intake Hospital Block – Laundry - Replace with Chilled water systems'/w AHU with FA intake. Hospital Block – Antenatal - Install FA System Hospital Block – Lab, Ward, ICU, Burns Unit, Surgical ward, Psychiatric Wards & Integrated Facility - Install FA System - Replace with Chilled water systems, c/w AHUs with FA intake Hospital Block – Clinic, Central stores and workshop, Occupational Therapy, Staff Clinic, Storerooms - Install AHU and FA Systems Hospital Block – Storerooms, Toilets, laundry - Install Ext systems. WET SERVICES - Repair leaks/replace with copper. - Replace Hot water calorifiers and Hot Water Pumps MEDICAL GAS - Repair leaks, supports. - Install new O2 ,Vacuum and LP Air |Plants and Reticulation . FIRE PROTECTION - Repair damaged pipes, supports. - Install sprinklers where required - Install fire detection - Install smoke management systems - Install signage - Install sprinkler tanks and pumps					

Project Name	Scope	Project Actual Start Date	Estimated Construction End Date	Project Estimated End Date	Sum of Total Project Cost	Expenditure To Date
Comprehensive Maintenance_WC	General Project Scope: Backlog maintenance, Refurbishment and Upgrades Albertinia Clinic • Backlog Maintenance • New Sputum Booth • Internal alterations • General repaint & repair • Electrical & mechanical Riversdale Clinic • Backlog Maintenance • Timber windows replacement • Burglar Proofing to windows • Pharmacy compliance • Physio gymnasium • New door between clinic wings & exit • General repaint & repair • Electrical & mechanical Riversdale Hospital • Backlog Maintenance • Upgrade public toilets • Emergency centre & ambulance drop off entrance • Female ward, Male ward & maternity ward • Outpatients • Staff restrooms / kiosk • X-rays, Main theatre • Partially open link • Burglar Proofing to windows • General repaint & repair • Electrical & mechanical Blanco Clinic • Backlog Maintenance • Municipal waste & medical waste areas • New store • New Sputum Booth • New extension dispensary, patient waiting area, ablutions, multi-disciplinary room & CCMDD • Consulting room 4 & 5	26/7/2016	29/5/2026	30/10/2026	R101,814,965.00	R6,584,231.00

Project Name	Scope	Project Actual Start Date	Estimated Construction End Date	Project Estimated End Date	Sum of Total Project Cost	Expenditure To Date
	Pacaltsdorp Clinic • Backlog Maintenance • New records, reception, multipurpose room, pharmacy sub-waiting area, managers office, male & female toilets • New consulting room 8 & 9 and counselling room 1 • New Sputum booth • Internal alterations & external work • Municipal waste & medical waste areas Parkdene Clinic • Backlog Maintenance • Existing entrance, new reception & new records room • New sputum booth • New Perspex roof to architect's specs • Existing covered waiting area • Change existing waiting to sub-waiting • CDU Rosemoor Clinic • Backlog Maintenance • Internal alterations • External work i.e., new ramp to existing park home -- This package has been put on hold due to the fire incident Dysselsdorp Clinic • Backlog Maintenance • Installation of elevated water tank Oudtshoorn Clinic • Backlog Maintenance • Disabled friendly toilet repairs & sputum booth • Replace broken plumbing duct covers • Repair pedestrian ramp • Municipal waste & medical waste areas • Rectify level changes at front of clinic building • Repair and service of mechanical ventilation & electrical installation • Repair all wall cracks and paint building Oudtshoorn Hospital • Backlog Maintenance • Delivery suite • Maternity Ward • Male Ward & Male 72-hour observation ward					

Project Name	Scope	Project Actual Start Date	Estimated Construction End Date	Project Estimated End Date	Sum of Total Project Cost	Expenditure To Date
	• Entrance, Kitchen & Bulk store • Theatre • Female ward • CSSD section • X-rays & Physio's • Storage, linen bank & staff restrooms • Social workers, counsellors & storage • Admissions, Emergency unit & records • Paediatric room & pharmacy • Outpatients & consulting • Tea room, passage, roofs & new kitchen yard roof • New covered theatre & CSSD link • HVAC installation • Fire Detection & Fire Protection & Signage					
Comprehensive Maintenance_Witbank Hospital (Heritage Building)	The scope of works to be undertaken for the project is based on the most economical methods to restore equipment and facilities to optimal functional and maintainable levels in compliance with statutory operating, energy efficiency and safety standards. Restoration, particularly of dysfunctional and/or obsolete building elements and equipment may automatically result in replacement and/or upgrading. Repairs and renovations to existing Heritage Building _Orthopedic Ward	18/11/2022	30/11/2026	12/3/2027	R167,930,241.00	R81,744,093.00

Project Name	Scope	Project Actual Start Date	Estimated Construction End Date	Project Estimated End Date	Sum of Total Project Cost	Expenditure To Date
Dihlabeng Hospital - (Ph2)	The smart revitalization of the Dihlabeng Regional Hospital incorporates a myriad of interventions to ensure compliance with IUSS standards as adopted by the NDOH as well as local authority legislative compliance. The revitalization of the Dihlabeng Regional Hospital Phase 2 will be constructed in multiple sections while the existing Hospital shall always remain functional. The Construction works will constitute the following main activities in sections as appropriate. •Bulk Earthworks (cut to fill and cut to spoil) to construct parking areas, platforms, and entrances. •Demolition of several single-story redundant buildings and structures including the existing Helipad, NHLS/SANBS building, Transport building, pedestrian link block C to D, concrete retaining walls, paving etc. •Installation of ring main water supply and fire supply lines. •Installation of new sewer drainage and diversions. •Installation of new storm water drainage and diversions. •Construction of new layer works and paving to falls and entrance upgrades creating vehicle and pedestrian access and parking for staff and visitors. •Upgrades to the N5 Entrance and Eeufees Street. •Construction of new Hospital buildings including multilevel concrete structure for blocks M&N. •Construction of new 2 story block O for the NHLS and SANBS services. •Extensions and refurbishment or alterations to some of the existing buildings including blocks A, B, C, D and H including extensions to blocks C and D. •Construction of retaining walls, Construction of new Helistop. •Removal of old and installation of new HVAC, electrical, Fire detection & protection, electronic services and Medical Gas supply into new build and refurbished areas. •Selected Sub-contracts for installations of: HVAC, electrical – bulk supply and reticulation, fire detection & protection, electronic services and Medical Gas supply into new build and refurbished areas. •Procurement of Health Technology including hospital equipment, furniture, consumables, etc. – prior to and post Practical Completion in sections.	1/1/2015	21/6/2028	9/2/2029	R1,056,766,918.00	R405,349,525.00
Dr Consulting Rooms - Hobhouse	Design and construction of a building, consisting of six consulting rooms and associated facilities, adjacent to the existing clinic building.	1/12/2014	31/3/2026	31/3/2026	R3,065,064.00	R2,749,089.00
Dr Consulting Rooms - Karatara	Design and construction of a building consisting of 6 Consulting Rooms and associated facilities adjacent to the existing clinic.	1/12/2014	14/10/2016	31/3/2026	R3,908,296.00	R2,463,200.00
Dr Consulting Rooms - Ladybrand Clinic	Design and construction of a building, consisting of six consulting rooms and associated facilities, adjacent to the existing clinic building.	30/9/2014	31/3/2026	31/3/2026	R3,047,814.00	R2,697,056.00

Project Name	Scope	Project Actual Start Date	Estimated Construction End Date	Project Estimated End Date	Sum of Total Project Cost	Expenditure To Date
Elim Hospital Replacement	The existing hospital is located in the Limpopo province and within the Vhembe District Municipality. The site is about 18km to the South East of Makhado and about 60km South West of Thohoyandou. The site currently consists a total 123 buildings including hospital buildings, administration offices, heritage buildings and the residential houses. It is approximately 362 120 m2 in size. The hospital has 538 registered beds, however, only 330 beds were reported to be utilised. The proposed Elim Hospital Replacement project will have 416 beds on a green field development (within the same site as the existing hospital) that will be independent from the existing hospital infrastructure, the replacement hospital will include accommodation for selected categories of staff as per the LDoH Housing Policy that is being refined.	1/7/2015	23/4/2029	23/5/2030	R3,013,242,222.00	R153,107,031.00
Ethandakukhanya 24 hour CHC replacement	The scope of work for the Ethandukukhanya Community Health Centre (CHC) involves the construction of a new 24-hour facility to replace the former clinic destroyed during community unrest in 2009. The new CHC will serve as a referral point for several primary healthcare clinics in the Mkhondo sub-district and will relieve patient load—particularly maternity cases—from Piet Retief Hospital. The facility will include 12 consulting rooms and offer comprehensive services such as a Maternity and Obstetric Unit (MOU), emergency care, dental and mental health services, rehabilitation, pharmacy, and eye care. Designed to meet Ideal Clinic standards, the CHC will accommodate a catchment population of approximately 25,843 and is expected to handle over 78,000 patient visits annually.	18/9/2019	9/10/2026	18/3/2027	R245,350,217.00	R198,791,850.00

Project Name	Scope	Project Actual Start Date	Estimated Construction End Date	Project Estimated End Date	Sum of Total Project Cost	Expenditure To Date
Harry Gwala Priority Maintenance	Harry Gwala Priority Maintenance: 1 Provision of decanting space: a.Boiler house - Conversion to Bulk Storage and removal of adjacent galvanized steel shed b.2x 36 bed wards (1x Medical & 1x Surgical) in multi- storey building. (Future imball Ward Relocation) c.Provision of Dental Department on Ground floor level of new multi- story Ward building. This requires relocation of Blood Bank, Stoma, and re-configuration of existing GOPD on ground floor level. Remove existing park home. d.Underground Services: Temporary Services, Relocation, re-alignment, etc. to accommodate new Multi-storey Building. 2 Maintenance work: • 100 No. Additional Parking Bays to be created. • Demarcating of additional Disabled parking bays at Residual buildings • New Façade to Main Building Front • Strengthening of columns and associated work in Main Building- This work can only commence once decanting space have been provided. • Reconstruction of non-compliant ramps, or new ramps, to adhere to building regulations. • Sewer & Storm Water Mainline Upgrade- as per findings of investigation in Contract 4 • Additional Paraplegic facilities, containing a toilet, basin and shower to be provided, where identified, to adhere to building regulations and NHI requirements. The focus is mainly on the Main Building, with critical areas only in identified residual buildings. • Additional disabled signage, to adhere to building regulations and NHI requirements. • Repair, service, upgrade ablution fittings, to DOH specifications. • Repair / replace / service doors and ironmongery in Main Building and selected critical residual buildings. • Provide ventilation and fenestration to identified rooms in Main Building. • Adequate directional signage to ensure compliance with NHI.	24/5/2024	31/3/2028	28/2/2029	R992,947,254.00	R15,044,282.00

Project Name	Scope	Project Actual Start Date	Estimated Construction End Date	Project Estimated End Date	Sum of Total Project Cost	Expenditure To Date
Limpopo Central Hospital	Limpopo Central Hospital is a new 488 bed tertiary hospital in Polokwane. All services associated with a tertiary hospital provided including academic training in support of medical school. All Infrastructure will be provided.	30/5/2023	8/6/2028	1/10/2029	R4,890,009,613.00	R1,691,286,953.00
Magwedzha Clinic Replacement	As guided by the client's brief, the scope of work for the project covered the construction of: 1. a new clinic with six (6) consulting rooms, three (3) counselling rooms, and three (3) vitals rooms, 2. a new maternity ward with two (2) pre-natal beds, a delivery room and two (2) ant-natal beds, and 3. a new staff accommodation block for 80% of the clinical nurse practitioners. The Implementation of the scope is being realised, excluding: The construction of the staff accommodation. The suspension of the staff accommodation was due to policy changes/ discussions within the LDoH, which seeks to amend the need for staff accommodation within the Limpopo Province.	2/12/2013	23/3/2027	9/12/2027	R78,251,809.00	R61,414,840.00
Makonde Clinic Replacement	As guided by the client's brief, the scope of work for the project covered the construction of: 1. a new clinic with six (6) consulting rooms, three (3) counselling rooms, and three (3) vitals rooms, and 3. a new staff accommodation block for 80% of the clinical nurse practitioners. The Implementation of the scope is being realised, excluding: 1. The construction of the staff accommodation. The suspension of the staff accommodation was due to policy changes/ discussions within the LDoH, which seeks to amend the need for staff accommodation within the Limpopo Province.	2/12/2013	31/12/2026	5/2/2027	R76,528,489.00	R58,630,010.00

Project Name	Scope	Project Actual Start Date	Estimated Construction End Date	Project Estimated End Date	Sum of Total Project Cost	Expenditure To Date
Msukaligwa 24 hour CHC replacement	The scope of work for the Ermelo Community Health Centre (CHC) in Msukaligwa Sub-District involves the operation and expansion of a 24-hour facility that serves as the main referral point for several primary healthcare clinics within the sub-district. These include Breyten, Davel, Emthonjeni, Kwachibikhu, Kwazanele, Lothair, MN Cindi, and the Ermelo Clinic itself. The Ermelo CHC plays a critical role in relieving patient load—particularly maternity, emergency, and chronic cases—from surrounding clinics that are often far from town and affected by poor road infrastructure. The facility currently includes 12 consulting rooms and offers comprehensive services such as a Maternity and Obstetric Unit (MOU), dental and mental health services, rehabilitation, pharmacy, and eye care. Designed to meet Ideal Clinic standards, the CHC accommodates a catchment population of approximately 18,922 and is expected to manage over 152,000 patient visits annually, including referrals from clinics as far as Lothair (52 km), Sheepmoor (45 km), and New Scotland (60 km). The facility plays a vital role in improving access to quality healthcare in a district where 80% of the population is uninsured and where rural conditions and unemployment remain key barriers to equitable health service delivery.	2/2/2015	26/11/2027	23/5/2028	R321,762,560.00	R108,520,312.00
Public Private Partnerships (PPP's) 2023 onwards	Appointment of Professional Service Provider to Review Feasability Study.	1/8/2013	31/3/2024	31/3/2035	R50,266,486.00	R2,217,194.00

Project Name	Scope	Project Actual Start Date	Estimated Construction End Date	Project Estimated End Date	Sum of Total Project Cost	Expenditure To Date
Siloam Hospital - New 224 Bed Hospital	PROJECT BACKGROUND Siloam Hospital, in the Vhembe district in Limpopo, was identified as a National Presidential Priority after a visit to the facility by President Zuma on 8 July 2011. The hospital has also been identified as a provincial priority for replacement of the hospital, the gateway clinic, the nurse's school and the upgrading of the hospital grounds and staff accommodation. The hospital was first opened in July 1940 and by 1961 had five wards including male, female and children's acute wards, maternity and TB. In 1970 four new wards were added as well as nurse's home by the 1980's, there were 300-400 beds. The condition of the hospital buildings have deteriorated substantially requiring the replacement of the infrastructure containing the hospital services . This has required the planning of a new, integrated facility, the development of which intends to respond to the department's mandate by providing an efficient, flexible, well-balanced and fully functional facility, which will contribute to the implementation of government's policy by: • Improved service delivery • Providing clinically safe facilities; • Increased financial efficiency; • Provide improved and safe working environment for hospital staff. A Business Case was developed by the Limpopo Department of Health based on a 350-bed hospital. The Business Case was approved by the National Department of Health in 2012 as a new hospital with new staff residences, a new nursing college and ancillary facilities. The current project is approved as a 224-bed hospital after a process involving the National Treasury to reduce the budget to a scope that was acceptable to the National Treasury. The process to get to this point at the current position where the Staff Accommodation has been completed; Phase 1 (enabling work) of the main hospital has been completed, Phase 2 (repurposing and refurbishment of the Mental Ward and Mortuary) was completed, handed back to the hospital and is operational, and Phase 3 (new 224 Bed District Hospital) is under construction, and work has commenced with Phase 4 (VO 1).	2/4/2012	17/9/2026	15/12/2026	R2,020,878,513.00	R1,584,949,972.00

Project Name	Scope	Project Actual Start Date	Estimated Construction End Date	Project Estimated End Date	Sum of Total Project Cost	Expenditure To Date
	The Siloam District Hospital project includes the building of a new 224 bed hospital, retaining part of the existing hospital infrastructure to be upgraded/repurposed and is to be phased as follows: 1) Phase 1 - Demolition of redundant structures and preparation of the site for the new building (enabled work completed); 2) Phase 2 – Repurposing and refurbishment of existing Mental Health Building and Mortuary (completed and operational); 3) Phase 3 – Building of a new 224 bed district hospital; and 4) Phase 4 – Variation Order 1 • Rehabilitation Centre • Bulk Store and Supply Chain Management • IT Services, Training and Clinical Engineering • Workshop, Hospital Transport and Estate Management • Transport Hub – Overnight Patient Waiting & Patient Transport Services: o 34-bed patient overnight transit unit (11 male & 23 female) with ablution facilities o Including 2 limited mobility rooms o Patient day waiting lodge with a large lounge, dining area, and kitchen o Baby change and washroom facilities o Drivers' office with 2-bed overnight accommodation o Groundskeeper accommodation (2 beds) o Service spaces, including the cleaner's store, IT room, sluice, and linen store • Lodger Mother Accommodation (16 bed) • Staff, Visitors and Patient Transport Parking • Demolishing of dilapidated buildings as indicated by the Department of Public Works SCOPE OF WORK The hospital statistics suggest that maternity and paediatrics are the largest component of the clinical demand, and that female ward space (surgical and medical clinical care) is in significantly greater demand than male ward space which is in keeping with the demographic profile. The hospital clinical inpatient organisation will therefore need to focus on provision for: • Maternal and child care(including neonatal care); • Female adult care (medical and surgical – including gynaecology and orthopaedics); • Male adult care (medical and surgical – including orthopaedics); • Emergencies (both medical and surgical);					

Project Name	Scope	Project Actual Start Date	Estimated Construc-tion End Date	Project Estimat-ed End Date	Sum of Total Project Cost	Expenditure To Date
	• Mental Health care; • Infectious diseases care, mainly TB; • Sub-acute care (transfers, sub-acute, awaiting discharge). Planning took into account the surrounding hospitals such as Elim - and Tshilidzini Hospitals, as well as Pietersburg Hospital (the referring tertiary hospital) as it is important that bed numbers (and distribution across clinical service needs) must be planned across the district and the province - failure to respond appropriately to a capacity deficiency in one hospital can impact adversely on other facilities and their services. The resulting recommendation was for the replacement hospital to consist of 230 beds, including 6 beds for lodgings for high-risk pregnant women who do not have ready access to hospital when labour arrives, and comprising the following components as outlined in the document: • Male Medical Ward • Female Medical Ward • Surgical Ward • High Care Unit • Maternity/Obstetric Wards • Paediatric Ward • Mental Health Short Stay Ward • Infectious Diseases Ward • Transit Ward • Day surgery /Observation Bed Unit • General Outpatient Department • Emergency Centre (24-hour trauma and medical emergency) • Rehabilitation inclusive of physiotherapy; occupational therapy; speech therapy & audiometry; social welfare and dietetics • Diagnostic and therapeutic support Departments (Radiology, Pharmacy, Laboratory, Theatres and CSSD)					

Project Name	Scope	Project Actual Start Date	Estimated Construction End Date	Project Estimated End Date	Sum of Total Project Cost	Expenditure To Date
Thengwe Clinic Replacement	As guided by the client's brief, the scope of work for the project covered the construction of: 1. a new clinic with six (6) consulting rooms, three (3) counselling rooms, and three (3) vitals rooms, 2. a new maternity ward with two (2) pre-natal beds, a delivery room and two (2) ant-natal beds, and 3. a new staff accommodation block for 80% of the clinical nurse practitioners. The Implementation of the scope is being realised, excluding: The construction of the staff accommodation. The suspension of the staff accommodation was due to policy changes/ discussions within the LDoH, which seeks to amend the need for staff accommodation within the Limpopo Province.	2/12/2013	31/8/2026	12/11/2026	R76,825,915.00	R67,305,910.00
Tshilidzini Hospital Replacement	Through the Hospital Revitalization Programme, the Departments of Health (DoH) prioritised the replacement/refurbishment of Tshilidzini Regional Hospital. The NDoH appointed the PSP being R&G Group and Lemeg Consortium on 17 September 2015. The said PSP is responsible for all technical advice and the implementation of the project. The LDoH's needs consisted of a Clinical Brief dated 20 November 2014 and a Technical Brief dated 23 June 2015. Both documents recommended a Regional Hospital facility but had different recommendations on bed numbers. As a point of departure, the stakeholders used the Clinical Brief as the initial basis, which suggested a 482-bed Regional Hospital, a gateway clinic, and staff housing. The said recommendation was also confirmed during the compilation of the Inception Report but was later increased to 513 beds during the compilation of the Master Planning process. This scope has, following the End-User's workshop increased the need to 533 beds, 144 staff housing units, with a gateway clinic remaining unchanged. It should be noted that there are 12 existing dilapidated buildings which are to be renovated. The site is in Makumbane Village in the Shayandima area in Thohoyandou, north of the R524 in the Limpopo Province. The local authority is Thulamela and it's within the Vhembe District Municipality. The site slopes towards the northeast and forms part of the Luvuvhu River Catchment area.	23/9/2015	29/5/2031	24/3/2032	R592,754,649.00	R200,582,601.00

Project Name	Scope	Project Actual Start Date	Estimated Construction End Date	Project Estimated End Date	Sum of Total Project Cost	Expenditure To Date
Zithulele Hospital Smart Revitalization	Zithulele Hospital Smart Revitalization Revitalization of existing district hospital service. Demolition of existing services, addition of new infrastructure and the renovation and refurbishment of existing hospital campus. The scope of work consists of Sections1 – 4 made up of the following; • Bulk Earthworks (cut and fill) to construct roads, parking areas and platforms. • Wastewater treatment works. • Water treatment works. • Sewer pump station. • Relocation of temporary structures for decanting purposes. • Staff accommodation (Permanent and temporary structures) • Hospital complex with access walkways • Installation of engineering services reticulations. • Demolition of redundant existing buildings. • The removal of existing prefabricated units off site. • Helistop. • Storm water attenuation ponds. • Refurbishment of 5 existing buildings. • Installation concrete and gabion retaining walls. • Internal Fencing and Gates • Selected Subcontracts – All Mechanical- and electrical specialist installations • Procurement of Hospital Equipment, Furniture, Consumables, etc. – pre- and post-Practical • completion per section • Implementation of SMME participation (30%) and further Socio-Economic deliverables to be achieved.	10/2/2015	4/7/2028	4/7/2029	R1,086,859,145.00	R591,601,479.00

PART D

TECHNICAL INDICATOR DESCRIPTION

Programme 1: Administration

	Output Indicator Title	Definition	Source of Data	Method of Calculation/ Assessment (Numerator)	Method of Calculation/ Assessment (Denominator)	Means of Verification	Assumptions	Disaggregationof Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
1.	Audit outcome of National DoH	Audit opinion received for the period under review	Annual Report	Not Applicable	Not Applicable	Auditor General's Report confirming audit outcome for the period under review	Not Applicable	Not Applicable	Not Applicable	Non- cumulative	Annual	Clean audit	Chief Financial Officer
2.	Percentage of invoices paid within 30 days of receiving valid invoices from suppliers	Number of valid invoices paid within 30 days as a proportion of all valid invoices received.	LOGIS Payment report which includes invoice received date and payment date	Number of valid invoices paid within 30 days in the period under review	Number of valid invoices received in the period under review	Date on which invoices are received verses the payment date.	All valid invoices received are dated or stamped on date of receipts	Not Applicable	Not Applicable	Cumulative (Year-end)	Quarterly	All valid invoices paid within 30 days of receipt	Chief Financial Officer
3.	Percentage of Women, employed at SMS level according to the equity targets	Appointment of women at SMS levels to ensure achievement of targets set for WYPD by NDoH	Staff Establishment report from persal	Number of Women employed at SMS level in NDoH	All SMS Employees in NDoH	Persal	All employees are recorded on Persal	Women	Not- Applicable	Cumulative (Year-end)	Quarterly	50% of Women employed at SMS level in NDoH	Chief Director: Health Sector Bargaining
4	Percentage of youth employed according to the equity targets	Appointment of Youth to ensure achievement of targets set for WYPD by NDoH	Staff Establishment report from persal	Number of Youth employed in NDoH	All NDoH Employees	Persal	All employees are recorded on Persal	Youth	Not- Applicable	Cumulative (Year-end)	Quarterly	Higher percentage of Youth employed in NDoH	Chief Director Health Sector Bargaining
5	Percentage of People with disabilities employed according to the equity targets	Appointment of People with disabilities to ensure achievement of targets set for WYPD by NDoH	Staff Establishment report from persal	Number of people with disabilities employed in NDoH	All NDoH Employees	Persal	All employees are recorded on Persal	People living with Disabilities	Not- Applicable	Cumulative (Year-end)	Quarterly	Higher percentage of People with disabilities employed in NDoH	Chief Director: Health Sector Bargaining
6.	Minimum safety standards for public health facilities finalised	Standards to guide safety measures to de undertaken in public health facilities are developed and finalised for approval of the NHC	Documented minimum safety standards for public health facilities as finalised	Not Applicable	Not Applicable	Documented evidence for TORs, consultation with stakeholders	Stakeholder corporation in finalising the minimum safety standards	Not Applicable	Not Applicable	Non-Cumulative	Quarterly	Minimum safety standards for public health facilities finalised	Head of Corporate Services
7	Number of districts implementing EBS	Districts implementing Event-based surveillance (EBS) when signals and events are reported on the Event Management System	Event Management System, Implementation reports	Number of districts implementing EBS	Not Applicable	EBS implementation progress report	Funding availability	Not Applicable	All Districts	Cumulative (Year-to-date)	Quarterly	Higher number of Districts implementing EBS	Chief Director: Health Information, Epidemiology, Research, Monitoring & Evaluation

Programme 2: National Health Insurance

	Output Indicator Title	Definition	Source of Data	Method of Calculation/ Assessment (Numerator)	Method of Calculation/ Assessment (Denominator)	Means of Verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
1.	Framework on health care benefits prioritisation finalised	The Ministerial Advisory Committee on Health Care Benefits will finalise the Framework which will guide prioritisation of health care benefits under the NHI for the Minister to consider	Framework on Prioritisation of health care benefits as finalised	Not Applicable	Not Applicable	Documented evidence of submission/ recommendations to the Minister for consideration Agenda for meetings; Attendance Registers; and Minutes of the MAC meetings	Not Applicable	Not Applicable	Not Applicable	Non- cumulative	Annual	Framework on health care benefits Prioritisation finalised.	Chief Director: Health Care Benefits and Provider Payment Design
2.	Health Technology Assessment Strategic Plan finalised	The Ministerial Advisory Committee on Health Technology Assessment will finalise the Strategic Plan for Health Technology Aasssesment (HTA) for the Minister to consider	Strategic Plan for Health Technology Assessment as finalised	Not Applicable	Not Applicable	Documented evidence of submission/recommendations to the Minister for consideration Agenda for meetings; Attendance Registers; and Minutes of the MAC meetings	Not Applicable	Not Applicable	Not Applicable	Non- cumulative	Annual	Strategic Plan for Health Technology Assessment finalised	Chief Director: Sector-Wide procurement
3.	Phase 2 of Health care service provider Accreditation Framework implementation research completed	Implementation research for the Accreditation Framework is conducted in phases. Phase 1 will focus on the implementation of the accreditation process. Phase 2 will include recommendations for adjustments of the accreditation framework.	Phase 1 progress report and Phase 2 progress report	Not Applicable	Not Applicable	Documented evidence of the research process (Protocol and implementation plan) and Research progress reports)	Not Applicable	Not Applicable	Not Applicable	Non- cumulative	Quarterly	Phase 2 of Health care service provider Accreditation Framework implementation research completed	Chief Director: User and Service Provider Management
4	Version 1 of PHC Essential Equipment List reviewed and published	Version 1 of the Essential Equipment List (EEL) for medical devices, medical equipment, and health technologies that are considered as important for Primary Health Care(PHC) is reviewed and published	Publication of Version 1 PHC EEL	Not Applicable	Not Applicable	Documented evidence for the process followed to review the EEL Version 1 and Proof of publication for the version	Cooperation and participation from technical committee members, programmes, and stakeholders	Not Applicable	Not Applicable	Non- cumulative	Annual	Version 1 of Primary Health Care Essential Equipment List is reviewed and published	Chief Director: Sector-Wide procurement
5.	Number of active patients receiving medicine through the central chronic medication dispensing and distribution programme (CCMDD) programme.	Active patients are patients registered on the CCMDD programme that have an active script.	Contracted Service Providers data base	Number of patients with active scripts	Not Applicable	Contracted Service Providers data base	Not Applicable	Not Applicable	Not Applicable	Cumulative (Year-to-date)	Quarterly	Higher number of active patients enrolled in the programme	Technical Specialist: NHI Service Provider
6.	Electronic Medical Record -Minimum Viable Product 3 (PHC Package) developed	EMR is a digital version of paper records of a patient, delivered through an electronic platform.	Documented evidence of EMR- MVP3	Not Applicable	Not Applicable	EMR-MVP3 solution on the production server	Not Applicable	Not Applicable	All Districts	Non- cumulative	Annual	EMR-MVP3 Developed	Chief Director: Health Systems - Digital Health

Programme 3: HIV/AIDS, TB & Maternal, Child and Women's Health

	Output Indicator Title	Definition	Source of Data	Method of Calculation/ Assessment (Numerator)	Method of Calculation/ Assessment (Denominator)	Means of Verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
1.	Number of assessment reports on HIV and AIDS and STIs response	Reports based on assessments carried out to monitor/ review the progress provinces have made in HIV and AIDS and STI response. Reports are of the preceding quarter	Provincial DORA Business Plan Reports	Number of reports produced	Not Applicable	Provincial reports DHIS TIER	Accurate reports provided by provinces	People Living with HIV	All provinces	Cumulative (Year-end)	Quarterly	4 Assessment Reports produced	Chief Director: HIV and AIDS & STIs
2.	Percentage of people Living with HIV on ART	Percentage of clients tested positive for HIV on ART	DHIS TIER	Number of HIV clients on ART	Total clients who tested positive	DHIS TIER	Accurate reports provided by provinces	People Living with HIV (by Gender and Age)	All provinces	Cumulative (Year-to-date)	Quarterly	A higher number of clients on ART	Chief Director: HIV and AIDS & STIs
3.	Percentage of people on ART that are virally suppressed	Percentage of clients on ART that are virally suppressed according to WHO guidelines	DHIS TIER	Number of clients who are virally suppressed	Total clients on ART	DHIS TIER	Accurate records provided by provinces	People Living with HIV (by Gender and Age)	All provinces	Cumulative (Year-to-date)	Quarterly	A higher number of clients that are virally suppressed	Chief Director: HIV and AIDS & STIs
4.	Drug- susceptible TB (DS-TB) Treatment success rate	TB clients who started drug susceptible tuberculosis (DS-TB) treatment and who successfully completed treatment as a proportion of all DS-TB clients who started treatment during the same reporting period (treatment cohort)	DHIS	Count of All DS-TB clients who successfully completed treatment	Count of All DS-TB clients who started treatment during the same reporting period (Treatment cohort)	Health Information Centre extracted data	Not Applicable	TB Patients	All health facilities	Cumulative (Year-to-date)	Quarterly	Higher TB Success Rate	Chief Director: TB Control and Management
5.	Number of people started on TB treatment	Count of all people who had a diagnosis of DS-TB and DR-TB who were started on treatment	DHIS	Number of people started on TB treatment	Not Applicable	Health Information Centre extracted data	Not Applicable	TB Patients	All health facilities	Cumulative (Year-end)	Quarterly	Higher number of people started on TB treatment	Chief Director: TB Control and Management
6.	Maternal Mortality in facility ratio (iMMR)	Maternal death is death occurring during pregnancy, childbirth and the puerperium of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy and irrespective of the cause of death (obstetric and non-obstetric) per 100,000 live births in facility	DHIS	Maternal death in facility	Live births known to the facility (Live birth in facility + Born alive before arrival at facility)	DHIS Reports which indicate summary and provincial breakdown figures	Accurate records provided by health facilities	Not Applicable	All health facilities	Cumulative (Year-to-date)	Quarterly	Lower maternal mortality in facility ratio	Chief Director: Maternal, Child and Women's Health
7.	Neonatal deaths in facility rate	Infants 0-28 days who died during their stay in the facility per 1000 live births in facility	DHIS	Neonatal 0-28 days death in facility	Live birth in facility	DHIS Reports which indicate summary and provincial breakdown figures	Accurate records provinces by health facilities	Not Applicable	All health facilities	Cumulative (Year-to-date)	Quarterly	Lower Neonatal deaths in facility rates	Chief Director: Maternal, Child and Women's Health
8.	Number of Grade R learners screened	Health screenings for Grade R learners by a nurse through the Integrated School Health Programme (ISHP) focus on early detection of barriers to learning. Screenings include vision, hearing, oral health, nutrition (weight/height), and general health checks.(This excludes follow-up visits and referrals, and each learner should be counted only once per school year)	DHIS	Number of Grade R learners screened	No denominator	DHIS Reports which indicate summary and provincial breakdown figures	Not Applicable	Not Applicable	All public schools	Cumulative (Year-end)	Quarterly	A higher number of Grade R learners are screened	Chief Director: Maternal, Child and Women's Health

Programme 4: Primary Health Care

	Output Indicator Title	Definition	Source of Data	Method of Calculation/ Assessment (Numerator)	Method of Calculation/ Assessment (Denominator)	Means of Verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
1.	Number of sub-districts implementing the foci clearing programme	Malaria foci clearing programme refers to clearing/ removing causative vectors in the areas where malaria transmission continues. The programme will be implemented progressively in the 33 sub-districts endemic.	MIS (Malaria Information System)- Web based DHIS2	Number of subdistricts implementing the foci clearing programme. These are all the sub-districts implementing Foci clearing programme from previous financial years to date .	Not Applicable	Provincial review reports	Provincial implementation of the foci clearing program within targeted sub-districts will be in accordance with the NSP 2024-28	Not Applicable	Endemic sub-districts	Cumulative	Quarterly	All endemic subdistricts implementing the foci clearing programme	Chief Director: Communicable Diseases
2.	Number of screenings conducted to detect elevated blood glucose 18 years and older	Number of screenings conducted per year for clients age 18 and older for elevated blood glucose for early detection.	DHIS	Number of screenings for elevated blood glucose levels	Not Applicable	DHIS Reports which indicate summary and provincial breakdown figures	Screening within Provinces are dependent on the resources available	Adults	All Districts	Cumulative (Year- to date)	Quarterly	A higher number of screenings conducted	Chief Director: Non-Com municable Diseases
3.	Number of screenings conducted to detect elevated blood pressure 18 years and older	Number of screenings conducted per year for clients age 18 and older to detect elevated blood pressure for early detection.	DHIS	Number of screenings for elevated blood pressure	Not Applicable	DHIS Reports which indicate summary and provincial breakdown figures	Screening within Provinces is dependent on the resources available	Adults	All Districts	Cumulative (Year-to date)	Quarterly	A higher number of screenings conducted	Chief Director: Non-Com municable Diseases
4.	Percentage of Community Health Centers (CHCs) with at least one mental health care providers appointed	Percentage of Community Health Centers (CHCs) with at least one mental health care provider (Psychiatrist, medical doctor with a post basic diploma in psychiatry, Psychologist, Social Worker, Occupational Therapist, Registered Counsellor and Psychiatric Nurse) appointed	Ideal Clinic Software	Number of CHC with at least one mental health care providers appointed	Number of fixed CHC	Ideal Clinic Software	Not Applicable	Mental health care users	Not Applicable	Cumulative (Year-to date)	Quarterly	Higher number of mental health care providers appointed	Chief Director: Non-Communicable Diseases
5.	Percentage of hospitals with food service unit assessed for compliance with the food service policy	Peer -review assessment carried out to determine compliance with food service policy in hospitals' food service units	Consolidated national food service unit assessment report	Number of hospitals assessed for compliance with the food service policy	Total number of hospitals with food service units	Assessment reports for hospitals assessed	Hospitals implementing the food service policy	Not Applicable	All Districts	Cumulative (Year-to date)	Quarterly	All public hospitals with food service units assessed for compliance	Chief Director: Health Promotion, Nutrition and Oral Health
6.	Number of PHC facilities that qualify as Ideal clinics	Fixed Primary Health Care facilities that obtained ideal clinic status per year.	Ideal clinic Monitoring System	Number of fixed PHC facilities that obtained an ideal clinic status	Not Applicable	Final Ideal facility status report available	Accurate records provided by PHC Facilities	Not Applicable	All Districts	Non- cumulative	Quarterly	Higher number of clinics obtained ideal clinic status	Chief Director: District Health Services
7.	Number of municipalities assessed for compliance to National environmental health norms and standards	Metropolitan and District Municipalities assessed environmental health norms and standards	Assessment reports of Metropolitan and District Municipalities	Number of metropolitan and district municipalities assessed	Not Applicable	Assessment tools and Reports	Resources are available to perform assessments	Not Applicable	All Districts	Cumulative (Year-end)	Quarterly	Higher number of Metropolitan and District Municipalities assessed for compliance with the national environmental health norms and standards	Chief Director: Environ- mental and Port Health Services

Programme 5: Hospital Systems

	Output Indicator Title	Definition	Source of Data	Method of Calculation/ Assessment (Numerator)	Method of Calculation/ Assessment (Denominator)	Means of Verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transfor- mation (where applicable)	Calculation Type	Reporting Cycle	Desired per- for- mance	Indicator Respon- sibility
1.	Number of provinces trained on the implementation of the National Clinical Governance Manual	Provinces are trained on the National Clinical Governance Manual for effective implementation	Training records for all provinces	Not Applicable	Not Applicable	Attendance Registers, training materials, training report	Not Applicable	Not Applicable	All Provinces	Cumulative (Year-end)	Quarterly	9 provinces trained on the implementation of the National Clinical Governance Manual	Chief Director: Hospitals and Tertiary Health Services
2.	Draft amended regulations relating to categories of hospitals developed	Regulations relating to categories of hospitals to guide access and delivery of health services are developed through amendment process for NHC to consider for approval	Amended regulations relating to categories of hospitals as finalised	Not Applicable	Not Applicable	Documented evidence for the amendment process followed as outlined in quarterly targets	Provinces will be consulted for the finalisation of the regulations relating to categories of hospital	Not Applicable	All Provinces	Non- cumulative	Quarterly	Draft amended regulations relating to categories of hospitals developed	Chief Director: Hospitals and Tertiary Health Services
3.	Percentage of Regional, Tertiary and Central hospitals that attain ideal hospital status	Proportion of Regional, Tertiary and Central hospitals that meet the requirements for ideal hospitals status based on self-assessment outcome)	Ideal Facility System	Number of Regional, Tertiary and Central hospitals that attain ideal hospital status	Total number of Regional, Tertiary and Central hospitals	Self - Assessment Reports	Not Applicable	Not Applicable	All Provinces	Non- cumulative	Annual	Higher number of Regional, Tertiary and Central hospitals attain ideal hospital status	Chief Director: Hospitals and Tertiary Health Services
4.	Number of PHC facilities constructed or revitalised	Constructed refers to concluding construction work (practical completion achieved) associated with new and replaced infrastructure for PHC facilities. Revitalised involves concluding of activities (reached practicalcompletion) of work aimed at improving the capacity and effectiveness of an asset above thatof the initial design purpose of PHC facilities.	Practical Project completion certificates	Total number of PHC facilities constructed or revitalised	Not Applicable	Practical Project completion certificates	Accurate record keeping for number of PHC facilities constructed or revitalised	Not Applicable	All Districts	Non- cumulative	Annual	Higher number of PHC facilities constructed or revitalised	Chief Director: Health Facilities & Infrastructure Management
5.	Number of Hospitals constructed or revitalised	Constructed refers to concluding of construction work (practical completion achieved) associated with new and replaced infrastructure for Hospitals. Revitalised involves concluding of activities (reached practical completion) of work aimed at completion) of work aimed at improving the capacity and effectiveness of an asset above that of the initial design purpose of hospitals.	Practical Project completion certificates	Total number of Hospitals constructed or revitalised	Not Applicable	Practical Project completion certificates	Accurate record keeping for number of Hospitals constructed or revitalised	Not Applicable	All Districts	Non- cumulative	Annual	Higher number of Hospitals constructed or revitalised	Chief Director: Health Facilities & Infrastructure Management

	Output Indicator Title	Definition	Source of Data	Method of Calculation/ Assessment (Numerator)	Method of Calculation/ Assessment (Denominator)	Means of Verification	Assumptions	Disaggre- gation of Beneficia- ries (where applicable)	Spatial Transfor- ma- tion (where applicable)	Calculation Type	Reporting Cycle	Desired per- for- mance	Indicator Re- spon- sibility
6.	Number of Public Health facilities maintained, repaired or refurbished	Optimizing infrastructure requirements in main- taining Health facilities efficiency, reliability, and safety in the delivery of the service. *Public Health Facilities include Clinics, Hospitals, Nursing Colleges and EMS base stations.	Practical Project completion certificates	Number of all public health facilities maintained, repaired and/or refurbished	Not Applicable	Practical Project completion certificates	Accurate record keeping for the number of facili- ties maintained, repaired and/ or refurbished, according to Maintenance Plans	Not Applicable	All Districts	Non- cumu- lative	Annual	Higher number of health facilities maintained, repaired and/or refurbished	Chief Director: Health Facilities & Infrastructure Management

Programme 6: Health System Governance and Human Resources

	Output Indicator Title	Definition	Source of Data	Method of Calculation/ Assessment (Numerator)	Method of Calculation/ Assessment (Denominator)	Means of Verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type	Reporting Cycle	Desired performance	Indicator Responsibility
1.	Audit action plans for Public Entities monitored	Review the annual reports of public entities to identify material audit findings and monitor the development and implementation of audit action plans by the entities to address the identified findings and the root causes	Entity's quarterly progress reports against audit action/ remedial plan	Not Applicable	Not Applicable	Public Entities Annual reports, Approved Submission on the review of the annual report and action plan of public entities, list of entities with material findings, audit action plans received	Annual Report audited	Not Applicable	Not Applicable	Non-Cumulative	Annual	All audit action plans for public entities with material findings monitores	Director: Public Entity Governance
2.	Number of provinces monitored for implementation of provincial nursing leadership competency framework	Nursing Leadership competency framework implementation in the provinces is monitored against the provincial plans	Consolidated report on monitoring of the implementation of nursing leadership framework in the 9 provinces	Number of provinces monitored on implementation of the provincial nursing leadership competency framework	Not Applicable	Attendance registers for provincial visits, Consolidated annual monitoring report on implementation of Provincial Nursing Leadership Competency Framework implementation plans	Provinces will have sufficient budget to implement the provincial nursing leadership competency framework	Not Applicable	All Provinces	Cumulative (Year- end)	Quarterly	9 provinces monitored on implementation of provincial nursing leadership competency framework	Chief Nursing Officer
3.	Draft Framework for distribution of Multidisciplinary Teams for District Hospital developed	Development of the Draft Framework for distribution of Multidisciplinary Team to be developed for further consultations	Draft Framework for distribution of Multidisciplinary Teams as finalised	Not Applicable	Not Applicable	Documented evidence for process followed to develop the draft framework	Stakeholders will cooperate for timeous finalisation	Not Applicable	All Provinces	Non-Cumulative	Annual	Draft Framework for distribution of Multidisciplinary teams for District hospitals developed	Chief Director: Human Resources for Health
4.	Revised Food labelling regulations gazetted	Regulations relating to the labelling of food to be gazetted prior to implementation	Gazette as published	Not Applicable	Not Applicable	Gazette as published	Not Applicable	Not Applicable	All Provinces	Non-Cumulative	Annual	Revised Food labelling regulations gazetted	Directorate: Food Control

ANNEXURE A
CONDITIONAL GRANTS

Direct Grants

Name of Grant	Purpose	Output Indicators	2026/2027 Targets	2026/2027 Annual Budget R'000
Statutory Human Resources & HP Training & Development	• To appoint statutory positions in the health sector for systematic realization of human resources for health strategy and phased-in of National Health Insurance • Support provinces to fund service costs associated with clinical training and supervision of health science trainees on the public service platform	Number of statutory posts funded from this grant (per category and discipline) and other funding sources.	3533	R5,908,985
		Number of registrars posts funded from this grant (per discipline) and other funding sources.	1336	
		Number of specialists posts funded from this grant (per discipline) and other funding sources	198	
National Tertiary Services Grant	• Ensure the provision of tertiary health services in South Africa • To compensate tertiary facilities for the additional costs associated with the provision of these services	Number of inpatient separations	721,489	R16,699,756
		Number of day patient separations	701,580	
		Number of outpatients first attendances	1,413,970	
		Number of outpatient follow-up attendances	3,480,138	
		Number of inpatient days	6,034,463	
		Average length of stay by facility	7 days	
		Bed utilization rate by facility	80%	
▪ Health Facility Revitalization Grant	• To help accelerate construction, maintenance, upgrading and rehabilitation of new and existing infrastructure in health including, health technology, organizational development systems and quality assurance. • To enhance capacity to deliver health infrastructure. • To accelerate the fulfilment of the requirements of occupational health and safety	Number of PHC facilities constructed or revitalized	46	R7,717,120
		Number of Hospitals constructed or revitalized	54	
		Number of Facilities maintained, repaired and/or refurbished	500	

Name of Grant	Purpose	Output Indicators	2026/2027 Targets	2026/2027 Annual Budget R'000
▪ District Health Programmes Grant (HIV/ AIDS/ TB Component)	▪ To enable the health sector to develop and implement an effective response to HIV and AIDS ▪ To enable the health sector to develop and implement an effective response to TB	Number of new patients started on ART	346 755	R25,998,245
		Total number of patients on ART remaining in care	6 138 487	
		Number of male condoms distributed	702 430 762	
		Number of female condoms distributed	20 824 538	
		Number of babies PCR tested at 10 weeks	180 304	
		Number of clients tested for HIV (including antenatal)	16 642 213	
		Number of medical male circumcisions performed	416 471	
		Number of HIV Positive clients initiated on Tuberculosis Preventative Therapy	341 100	
		Number of patients tested for TB using Xpert	2 968 787	
		Number of eligible HIV positive patients tested for TB using urine lipoarabinomannan assay	167 219	
		Drug Sensitive TB (DS TB) treatment start rate (under 5yrs and 5rys and older)	95%	
		Number of Rifampicin Resistant (RR)/ Multi Drug Resistant TB patients started on treatment.	84%	
		Number of TB contacts initiated on TB preventive treatment (Under 5yrs and 5yrs and older)	473 978	

Name of Grant	Purpose	Output Indicators	2026/2027 Targets	2026/2027 Annual Budget R'000
District Health Programmes Grant (District Health Component)	• To ensure provision of quality community outreach services through Ward Based Primary Health Care Outreach Teams • To improve efficiencies of the Ward Based Primary Health Care Outreach Teams programme by harmonising and standardising services and strengthening performance monitoring. • To enable the health sector to develop and implement an effective response to support the effective implementation of the National Strategic Plan on Malaria Elimination 2019 – 2023 • To enable the health sector to prevent cervical cancer by making available HPV vaccinations for all eligible grade seven schoolgirls aged 9-14 years with a single dose of HPV vaccine in all settings. • Progressive integration of Human Papillomavirus into the integrated school health programme • To enable the health sector to rollout COVID-19 vaccine	Number of malaria-endemic municipalities with 95 per cent or more indoor residual spray (IRS) coverage	10	R3,550,952
		Percentage of confirmed malaria cases notified within 24 hours of diagnosis in endemic areas	70%	
		Percentage of confirmed malaria cases investigated and classified within 72 hours in endemic areas	75%	
		Percentage of identified health facilities with recommended malaria treatment in stock	100%	
		Percentage of identified health workers trained on malaria elimination	90%	
		Percentage of population reached through malaria information education and communication (IEC) on malaria prevention and early health-seeking behavior interventions	90%	
		Percentage of vacant funded malaria positions filled as outlined in the business plan	90%	
		Number of malaria camps refurbished and/or constructed	7	
		90 percent of grade 5 girl learners are vaccinated with a single dose of HPV vaccine in public and special schools.	454 929	
		90 percent of grade 5 girl learners vaccinated with a single dose of HPV vaccine in private and independent schools.	27 577	
		90 per cent of **public and special schools** with eligible girls are reached with a single dose of HPV vaccine	14 894	
		90 percent of private and independent schools with eligible girls are reached with a single dose of HPV vaccine	1 969	
		Number of community health workers receiving a stipend	45 293	
		HIV defaulters traced	4 236 122	
		TB defaulters traced	43 969	
		Number of community health workers trained	19 950	
		Number of Community Outreach Services household visits	14 354 124	

Name of Grant	Purpose	Output Indicators	2026/2027 Targets	2026/2027 Annual Budget R'000
▪ National Health Insurance Grant	To expand the healthcare service benefits through the strategic purchasing of services from healthcare providers	Number of health care providers contracted	414	R475,483
		Number of mental health care providers contracted	235	
		Number of users seen by contracted mental health care providers	205 000	

Indirect Grants

Name of Grant NATIONAL HEALTH INSURANCE INDIRECT GRANT	Purpose	Output Indicators	2026/2027 Targets	2026/2027 Annual Budget R'000
Health Facility Revitalization Component	• To create an alternative track to improve spending, performance as well as monitoring and evaluation on infrastructure in preparation for National Health Insurance (NHI) • To enhance capacity and capability to deliver infrastructure for NHI • To accelerate the fulfilment of the requirements of occupational health and safety	Number of PHC facilities constructed or revitalised	3	R1,753,394
		Number of Hospitals constructed or revitalised	1	
		Number of Facilities maintained, repaired and/ or refurbished	0	
Health Systems Component: CCMDD, Ideal Clinic, Medicine Stock Surveillance System, Health Patient Registration System, Quality Improvement	• To expand the alternative models for the dispensing and distribution of chronic medication • To develop and roll out new health information systems in preparation for NHI, including human resource for health information systems • To enable the health sector to address the deficiencies in Primary Health Care (PHC) facilities systematically and to yield fast results through the implementation of the Ideal Clinic programme • To implement a quality improvement plan	• Number of active patients receiving medicine parcels through the CCMDD programme, broken down by the following: ▪ antiretroviral treatment ▪ antiretroviral with co-morbidities ▪ non-communicable diseases • number of pickup points (state and non-state)	3.5 million	R815,899
		▪ Number and percentage of PHC facilities peer reviewed against the Ideal Clinic standards	The number of facilities for peer reviews will be based on new facilities build and officially opened during 2025/2026 Financial Year 30 District Hospitals for peer reviews.	
		Number and percentage of PHC facilities achieving an ideal status	2800 (80%)	
		Number of public health facilities with the health patient registration system (HPRS) installed	3300 Public Health Facilities with the HPRS Installed	
		• National data centre hosting environment for NHI information systems established, managed and maintained	Maintenance and implementation of the National Data Centre for NHI information systems and 1st Phase development of the Secondary Site	

Name of Grant NATIONAL HEALTH INSURANCE INDIRECT GRANT	Purpose	Output Indicators	2026/2027 Targets	2026/2027 Annual Budget R'000
		▪ Development and Publication of the revised Normative Standards Framework for Digital Health Interoperability	The 2024 Normative Standards Framework for Digital Health Interoperability Developed and Published	
		▪ Development and implementation of the master Facility list policy	Publication of the Master Health Facility List and Standard Operation Procedures	
		▪ System development and implementation of the electronic medical record (EMR)	The Phase 1 EMR focusing of TB and HIV - Minimum Viable Product MVP1 available for roll-out and implementation.	
		▪ Number of primary healthcare facilities implementing an electronic stock monitoring system	2963	
		▪ Number of hospitals implementing an electronic stock management system	379	
		▪ Number of fixed health establishments reporting medicines availability to the national surveillance centre	3850	

Name of Grant NATIONAL HEALTH INSURANCE INDIRECT GRANT	Purpose	Output Indicators	2026/2027 Targets	2026/2027 Annual Budget R'000
		▪ Intern Community Service Programme (ICSP) system maintained and improvements effected	ICSP manages a total of 1 400 applicants per Annum divided as follows at least 9 800 applicants to be allocated in October for the January appointments into funded posts that are 2500 medical interns and 7800 community service. Allocation target is 90% of eligible South African Citizens and Permanent Residents allocated in funded approved posts. The mid-year cycle of around 2500 applicants at least 600 Medical interns and 1900 comm serve posts. Allocation target is 90% of South African Citizens and Permanent Residents allocated in funded approved posts	
		▪ Proportion of health facilities implementing the National Health Quality Improvement Programme	100% of public facilities implementing the National Health Quality Improvement Programme End March 2024	
		▪ Proportion of public health facilities in quality learning centres with self-assessments reports	100% public health facilities with self-assessments reports	

Annexure B: Standardised Indicators for 2026/27 FY for the Sector

As per the DPME framework for Strategic and Annual performance plans: Standardised indicators refer to a core set of indicators that have been developed and agreed to by all provincial institutions within a sector. The indicators are relevant to achieving sector-specific priorities and are approved by provincial Accounting Officers. They are incorporated into provincial institutions' APPs and form the basis of the quarterly and annual performance reporting process. The indicators listed below form part of the Results Based Framework to accomplish certain Outcomes and Impacts for the Health Sector.

Note: Performance of standardised indicators is dependent on Provincial operations and activities.

	HEALTH SECTOR INDICATORS 2026/27
Number	**Output Indicator**
1	Maternal mortality in facility ratio
2	Couple Year Protection Rate
3	Antenatal 1st visit before 20 weeks rate
4	Mother postnatal visit within 6 days rate
5	Neonatal death in facility rate
6	Infant PCR test around 6 months uptake rate
7	Immunisation under 1 year coverage
8	MR 2nd dose 1 year coverage
9	Child under 5 years severe acute malnutrition case fatality rate
10	Death under 5 years against live birth rate
11	Number of Grade R learners Screened
12	Cervical Cancer Screening Coverage
13	HIV positive 5-14 years (excl ANC) rate
14	HIV positive 15-24 years (excl ANC) rate
15	ART adult remain in care rate [12 months]
16	ART child remain in care rate [12 months]
17	ART adult viral load suppressed rate (below 50) [12 months]
18	ART child viral load suppressed rate (below 50) [12 months]
19	Number of people tested using TB-NAAT
20	TB - Rifampicin resistant/Multidrug-Resistant Treatment Success Rate * (* RR/MDR-TB outcome data is reported 12 months later)
21	Number of DS-TB treatment start 5 years and older
22	Number of DS-TB treatment start under 5 years
23	Number of TB Rifampicin resistant/Multidrug-Resistant confirmed client start on treatment
24	Malaria case fatality rate (Only standardised for endemic Provinces)
25	PHC Mental Health Conditions Treatment rate new
26	Patient Experience of Care survey rate

Annexure C: District Development Model

The planning framework in the sector involves a level of District Health Planning, which enables identification of challenges in the implementation environment that could potentially be used as an input for the District Development Model to accelerate service delivery. Additional at a programmatic level, data is utilized to identify districts that may need additional support for focused interventions to improve performance. These mechanisms can be used to streamline interventions at the district level which will require inter-sectoral collaboration at the level of the DDM.

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www.health.gov.za
RP: 43/2026
ISBN: 978-1-83491-676-7

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Department:
Health
REPUBLIC OF SOUTH AFRICA

2030 NDP