ANNUAL
PERFORMANCE PLAN

2025 - 2026

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

2030 NDP

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Health
REPUBLIC OF SOUTH AFRICA

ANNUAL
PERFORMANCE PLAN
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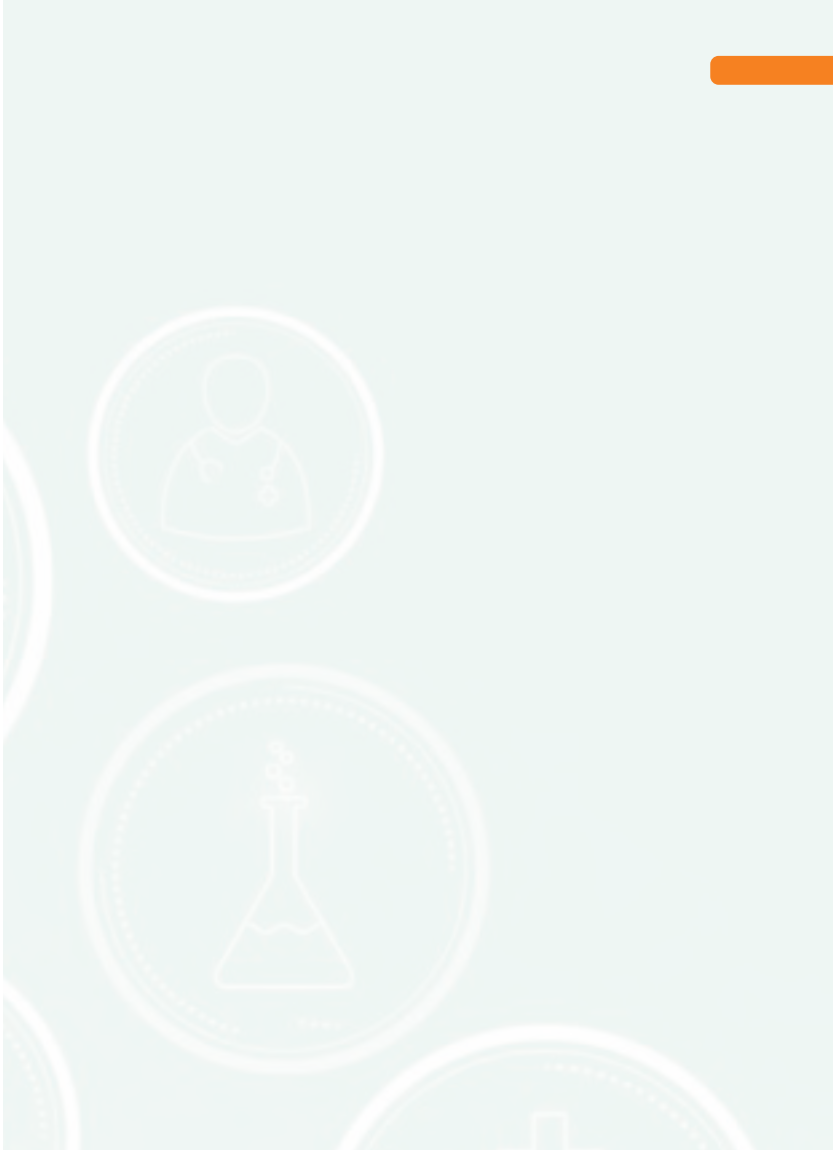


FOREWORD BY THE MINISTER OF HEALTH

Dr. P A Motsoaledi, MP
Minister of Health

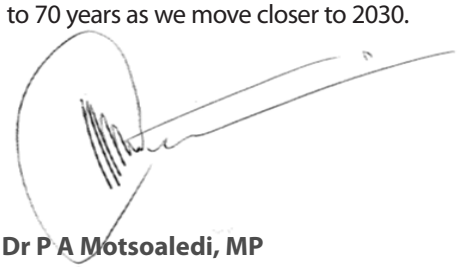
The year 2025/2026 marks the beginning of the implementation of the priorities for the 7th administration and for the health sector, great focus will be on health system strengthening reforms in line with the World Health Organisation (WHO) Six building blocks of the health system. In this Annual Performance Plan, the department commits to facilitating the preparatory work for the implementation of the National Health Insurance by establishing key frameworks that will pave the way for mechanisms of provision of care through the contracting units of Primary Health Care (CUPs). These mechanisms will further be supported by the development of information systems that will geared towards enhancing capability for the NHI Fund. The NHI will provide a service package that aligns with improving access and provision of key health programmes towards improvement of maternal and child health, reduction of deaths related to HIV, AIDS, TB and non-communicable Diseases (NCDs) targeted at key population/vulnerable groups.

The country as part of the United Nations signatory has committed to 95-95-95 targets for HIV and AIDS by ensuring that at least 95% of people with HIV know their status, and 95% of those who know their status are on Ante-Retroviral Treatment (ART) and 95% of those who are on ARTs are virally suppressed. Whilst the first 95% has been achieved, only 79% of people who know their HIV status are on ARTs. The sector has launched in February 2025, a campaign to close the gap through ensuring that 1.1 million people with HIV start and stay on HIV treatment by December 2025. This campaign is supported by various interventions which are targeted at finding men, youth and children who need to be initiated on HIV treatment.

Furthermore, retention in care is promoted by improving access to treatment through mechanisms of collecting medication closer to patient's homes.

The department remains committed responding to the demand of mental healthcare services in communities by ensuring that primary healthcare facilities are appropriately staffed with qualified health professionals that are able to diagnose and manage the range of mental health conditions/ills. Access to targeted health programmes such as School Health, Sexual and Reproductive Health and Adolescent Health will be improved through collaboration with key stakeholders to address barriers associated with seeking care. Our service delivery platform requires focused attention on improving the provision of care in line with community needs, which is enabled by a coordinated and functional community outreach service through Community Health Workers, supported by an equitable distribution of skilled health professionals and our efforts will be geared towards advancing these imperatives.

Health infrastructure maintenance and revitalisation are a key priority for the department for elevation of the service delivery platform at the level required for the provision of quality care. The department has committed to various infrastructure projects which will optimize the delivery of care. The above key interventions are critical in sustaining the gains in the improvement of life expectancy to 70 years as we move closer to 2030.



Dr P A Motsoaledi, MP
Minister of Health

STATEMENT BY THE DIRECTOR-GENERAL

Dr. SSS Buthelezi
Director General: Health

The financial year 2025/2026 marks 5 years before the end of the National Development Plan 2030 and the Sustainable Development Goals. The expected impact for the health sector is to improve the average life expectancy to 70 years by 2030, by ensuring that everyone has equal opportunity to access health services that are of good quality at the time of need irrespective of their social standing. In the medium term, the health sector is required to contribute towards empowering South Africans through improving access to equitable health services. The annual Performance Plan for 2025/2026 provides a focus that drives the improvement of quality of care through various interventions.

Preparatory work for the establishment of the NHI Fund began following the NHI Act being assented to law in May 2024. The Accreditation Framework for health care service providers is being developed to ensure that providers can deliver services of sufficient quality as well as to incentivize improvement of quality of care and outcomes. Furthermore, two NHI Ministerial Advisory Committees will be set up to establish mechanisms for determining the NHI health care benefits and ensuring that health interventions under the NHI are cost effective.

The health workforce remains a key component of the provision of health services and in this financial year, strategies are focused on ensuring that human resources are appropriately skilled to respond to the complex demand of care across all levels of the sector as well as to improve the skill mix of health professionals particularly in district hospitals where they are most needed. The workforce will further be supported by strengthening guidance on clinical governance which is aimed at addressing the current challenges in clinical care.

In addition to improving the quality of care, the sector has a responsibility to reduce the burden of disease and prevent premature mortality. The interventions geared towards this aspect are focused on health promotion and disease prevention through screening of common non-communicable diseases, health promotion awareness and messages communicated on various platforms to educate the public. Furthermore, access to care for patients on treatment will be promoted through systems that promote convenience to collection of medication, adherence clubs and tracing of patients in communities by community health workers.

The department will continue to strengthen and foster better coordination and collaboration with stakeholders in addressing social determinants of health and to leverage resources in order to maximize our impact.

Dr. SSS Buthelezi
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 PA. Motsoaledi
- Takes into account all 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 2025/26 - 2027/2028

Mr P. Mamogale
Acting Manager Programme 1: Administration — Signature:

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

Mr R. Morewane
Acting Manager Programme 3: Communicable and Non-Communicable Diseases — Signature:

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

Dr P. Mahlati
Manager Programme 5: Hospital Systems — Signature:

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

Mr P. Mamogale
Chief Financial Officer — **Signature:**

Approved by:

Dr S.S.S. Buthelezi
Director-General — **Signature:**

Dr P.A. Motsoaledi, MP
Minister of Health — **Signature:**

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.

Foodstufs, Cosmetics and Disinfectants Act, 1972 (Act No. 54 of 1972) - Provides for the regulation of foodstufs, 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 8(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.85 of 1993) - Provides for the requirements that employers must comply with in order to create a safe working environment for employees in the workplace.

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 morbidity. 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

In May 2024, the country made transition to the 7th Administration of government which led to the introduction of the Medium-Term Development Plan which sets priorities to be pursued by sector department.

The **Medium-Term Strategic Framework (MTSF)** is renamed to 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. The MTDP has a greater emphasis on development outcomes and are framed as an economic plan to address existing socio-economic challenges. The MTDP 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 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, preventive, curative, rehabilitative and pallative.

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 Organisation (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.[1] The implementation of the National Health Insurance (NHI) is the pathway that the Country has chosen to attain Universal Health Coverage[2]. 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;
- to provide Framework for the strategic purchasing of health care services by the Fund on behalf of users;
- to create mechanisms for the equitable, effective and efficient utilization of the resources of the Fund to meet the health needs of the population; and
- to preclude or limit undesirable, unethical and unlawful practices in relation to the Fund and its users[1]

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.

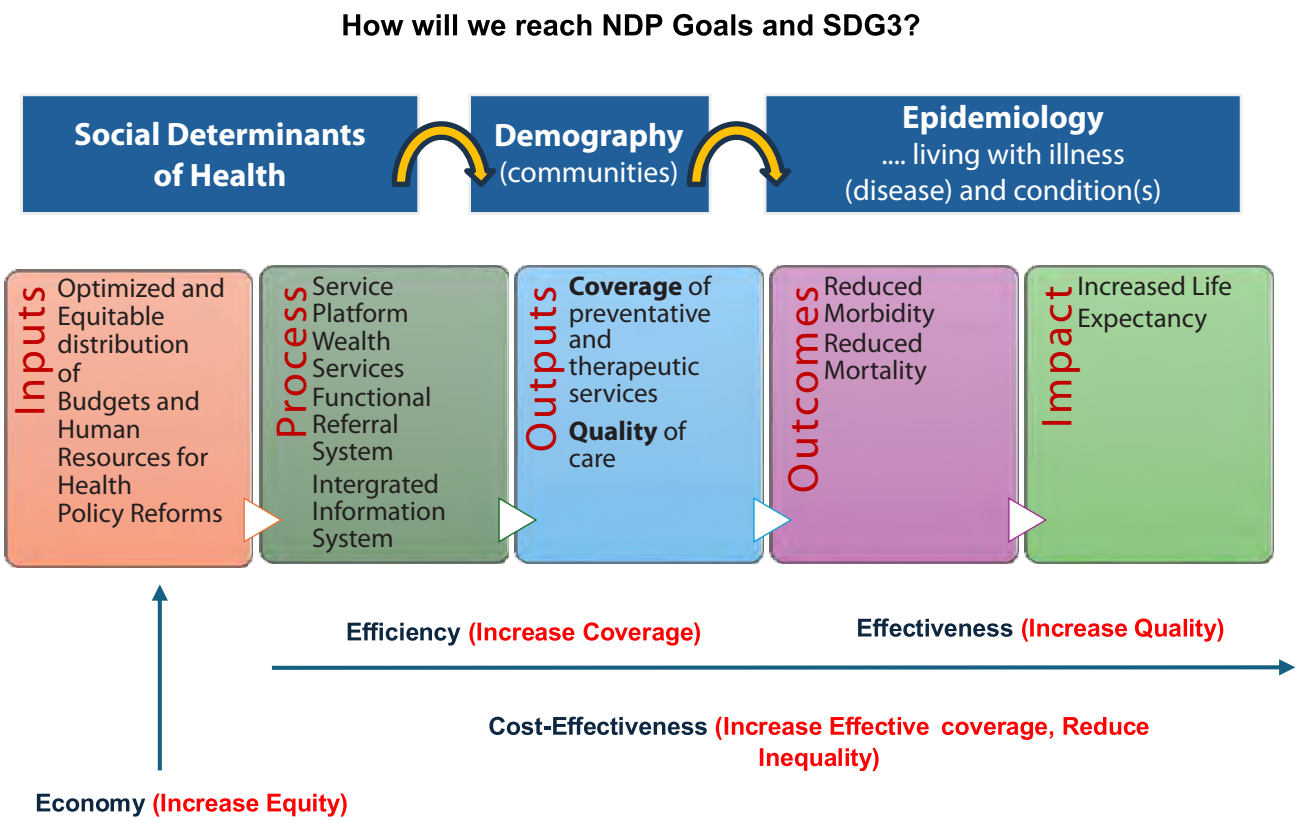
Pillar 8: Engage and empower the community to ensure adequate and appropriate community-based care.

Pillar 9: Develop an information system to guide the health system's policies, strategies and investments.

Pillar 10: Pandemic Preparedness and Response

[1] NHI Act 20, 2023

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



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. Interventions are based on priority areas to reduce inequality, through an integrated patient centered approach, supported by adequate inter-departmental and inter-sectoral collaborations.

Alignment of the NDP, MTDP and Presidential Health Compact

Table 1: Medium Term Priorities

NDP 2030	MTDP 2024-2029		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. ***StatsSA, Mid-Year Population Estimates, 2024, 30 July 2024***	**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	**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	**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.	**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	**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 performance at 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*

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 treated with courtesy and consideration;
- **Information:** Citizens should be given full, accurate information about the public services to which they are entitled;
- **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;"[3]

7. Situational Analysis

7.1 External Environmental Analysis

Burden of Disease

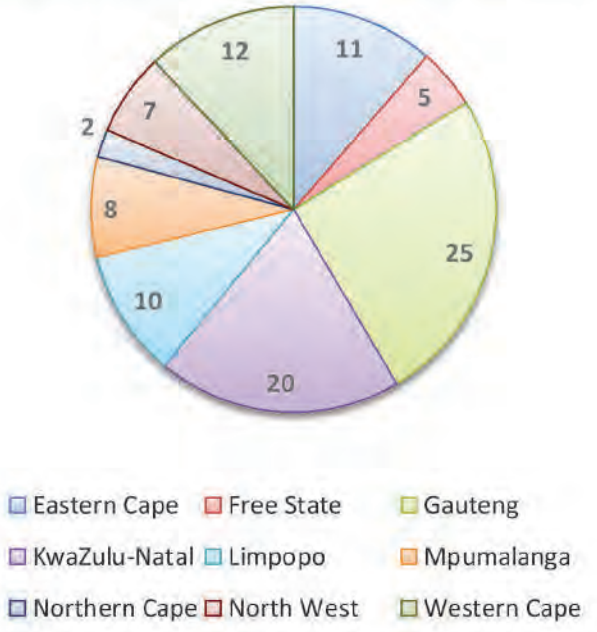
7.1.1 Demography

South African populations is estimated at 63,02 million with the female population accounting for 51% (approximately 32 million people) and the male population estimated at 31 million (49%).[1] Population estimates by provinces shows that Gauteng province has the largest share of the population at 25,3% (approximately 15,9 million people) followed by KwaZulu-Natal with 19,5% (approximately 12,3 million people). Northern Cape remains the province with the smallest share of the population with 1,37 million (2,2%) people.

The population distribution according to race:

Black Africans make the majority of the population estimated at 81,4% followed by Whites (7,3%), Indians (2,7%) and Coloureds at 8,2%. The figure below shows the breakdown of the population per province.

Figure 2. Proportion (%) of total population by Province

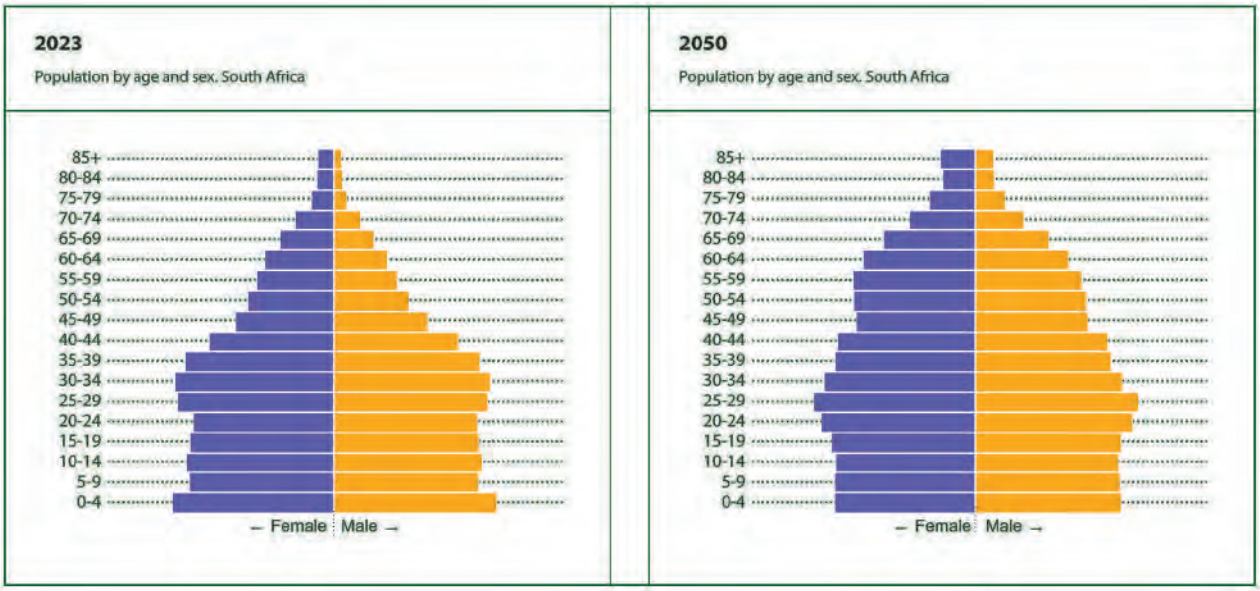


[2] StatsSA Mid-year population estimated, July 2024

[3] WHO, Social Determinants of health; Website: https://www.who.int/health-topics/social determinants-of-health#tab=tab_1 , accessed 28 Oct 2024.

Demographic change 2023 - 2050 (WHO, Population South Africa, 2023)

Figure 3. Demographic change of the population, 2023 - 2050



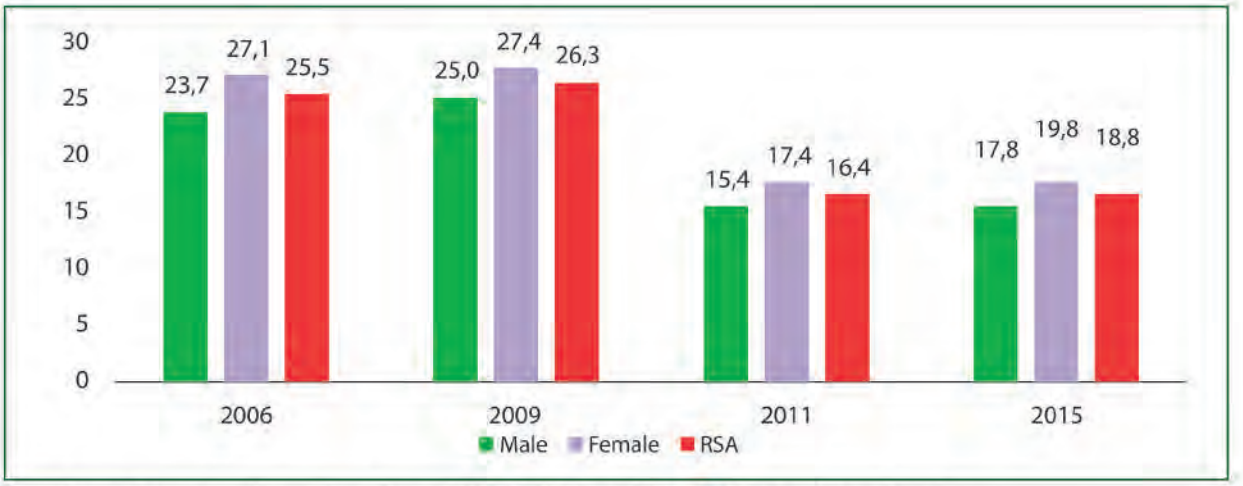
The figure depicts the change in population as presented by the pyramids, as predicted by WHO. It is noted that the 0-4 years population will reduce from 2.9 to 2.8 million; the population between 25-29 years will increase from 2.8 to 3.3 million, accounting for the children that will reach maturity at this age, and the 65+ will increase from 1.2 to 2.2 million. Of note, this group shows the greatest increase over this period, which supports the progressive planning necessary for providing increased geriatric services for our older population.

Social Determinants of Health for South Africa

"The social determinants of health (SDH) are the non-medical factors that influence health outcomes". [2] 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 a society.

SDG Goal: 1.1.1. Proportion of population below the international poverty line, by sex, age, employment status and geographical location (urban/rural)

Figure 4. Proportion of the population living below the international poverty line by sex



Source: Income and Expenditure Survey 2006 & 2011, Stats SA, and Living Conditions Survey 2009 & 2015, Stats SA

"The percentage of people in South Africa living below the international poverty line peaked at 26.3% in 2009 but dropped to 18.8% by 2015. This roughly translates to 10.6 million South Africans having less than R34 per day to survive in 2015 based on data from Stats SA (2006, 2009, 2011 & 2015)". Proportionately, more females are living below the poverty line at 19.8%, than men at 17.8%. The current international extreme poverty line is at US 2.15 (around R40 per person per day, as per May 2023 conversion rates, the World Bank, 2022), Stats SA, SDG country report, 2023.

SDG Goal: 1.4.1. Proportion of population living in households with access to basic services.

In South Africa, it is estimated that more than 50 million tons of general waste are generated every year, with only 1/3 being recycled, with the remainder ending up in landfill sites and dumpsites. Pollution from waste, are linked to diarrhea, respiratory illness and educational underachievement [4]

Table 2. Proportion of population living in households with access to basic services

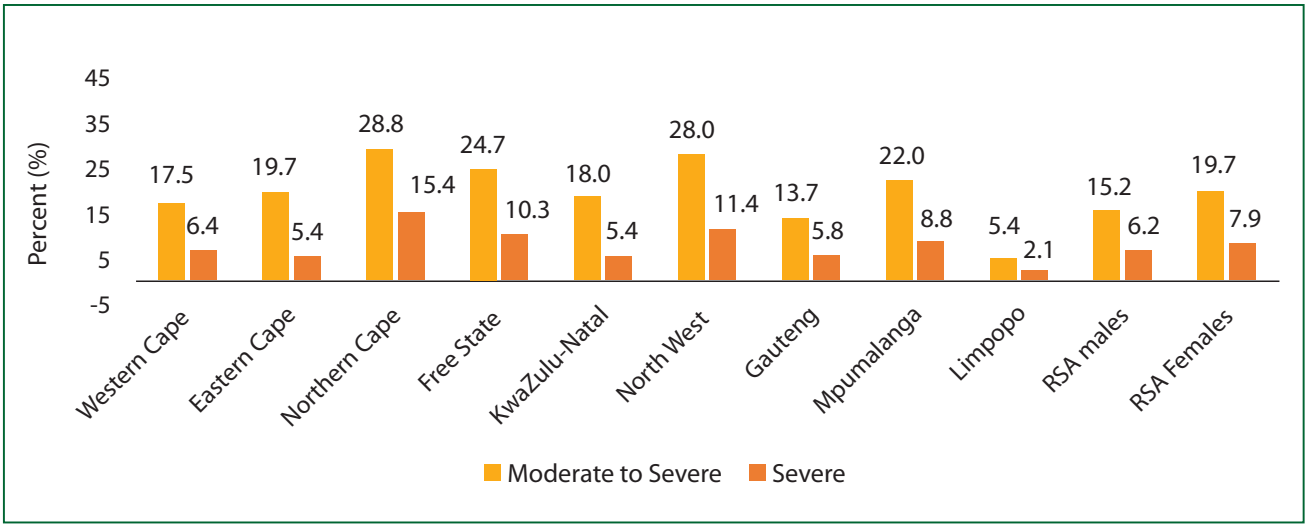
Basic sanitation services	*82.3 (2017)*	*82.6 (2019)*	*83.4 (2022)*
Basic drinking water services	*86.4 (2017)*	*86.2 (2019)*	*86.2 (2022)*
Access to electricity	*89.6 (2017)*	*90.7 (2019)*	*93.6 (2022)*
Access to waste removal	*62.4 (2017)*	*56.5 (2019)*	*57.3 (2022)*

The country report for South Africa, indicate that no significant progress was made in the access to waste removal services, from the baseline of 62,4% (2017) of the population living in households with access to waste removal services, with the current data, revealing 57,3% (2022) of households with access to waste removal services.

SDG 2.1.2 Prevalence of moderate or severe food insecurity in the population (based on the Community Childhood Hunger Identification Project (CCHIP) index)

Food Insecurity is primarily responsible for co-morbidities such as low birth weight and material malnutrition in women and children. SDG 2 seeks to eradicate hunger world wide by 2030. According to StatsSA country report, factors like load-shedding, inflation, unemployment and climate change are all contributing factors to food insecurity in South Africa.

Figure 5. Food inadequacy and hunger in South Africa, 2021[5]



As indicated, Northern Cape and North West are the provinces with the highest percentage of moderate to severe food insecurity in the populations. The Northern Cape is the province in the country with the highest percentage of severe food insecurity. South Africa has high stunting rates (22,8%)[6], a sign of chronic child malnutrition. Female headed households are also more likely to succumb to a lack of food and hunger[7]. The data from the SDG report also indicate that in South Africa, more women than men experience moderate and severe food insecurity, which have a ripple effect on the children of these households.

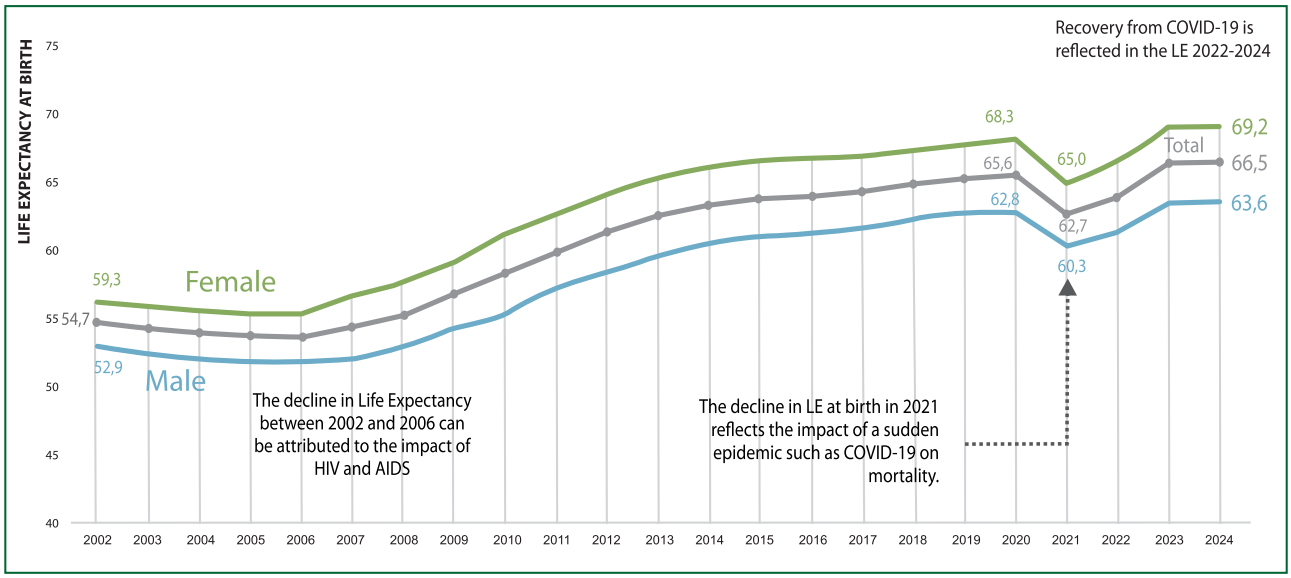
Life Expectancy and Healthy life expectancy

The definition of life expectancy according to WHO is "the average number of years that a newborn could expect to live". According to the latest StatsSA report[8], the current life expectancy is 63,6 years for males and 69,2 years for females with total life expectancy of 66,5 years.

Figure 6. Life Expectancy at birth from 2002 - 2024.

Total Life Expectancy (LE) at birth increased from 54,7 years in 2002 to 66,5 years in 2024

Total life expectancy at birth by sex over time, 2002 – 2024



The decline in life expectancy at birth in 2021 reflects the impact of COVID-19, however, the country is on a recovery trajectory.

The WHO Health data overview for the Republic South Africa[9] shows a healthy life expectancy at birth has improved by 4,28 years from 48,5 years in 2000 to 52,8 years in 2021. "Healthy life expectancy (HALE) at birth" is the average number of years that a person could expect to live in "full health" from birth. This measurement considers years lived in less than "full health" due to disease and/or injury.

Universal Health Index Score (UHC)

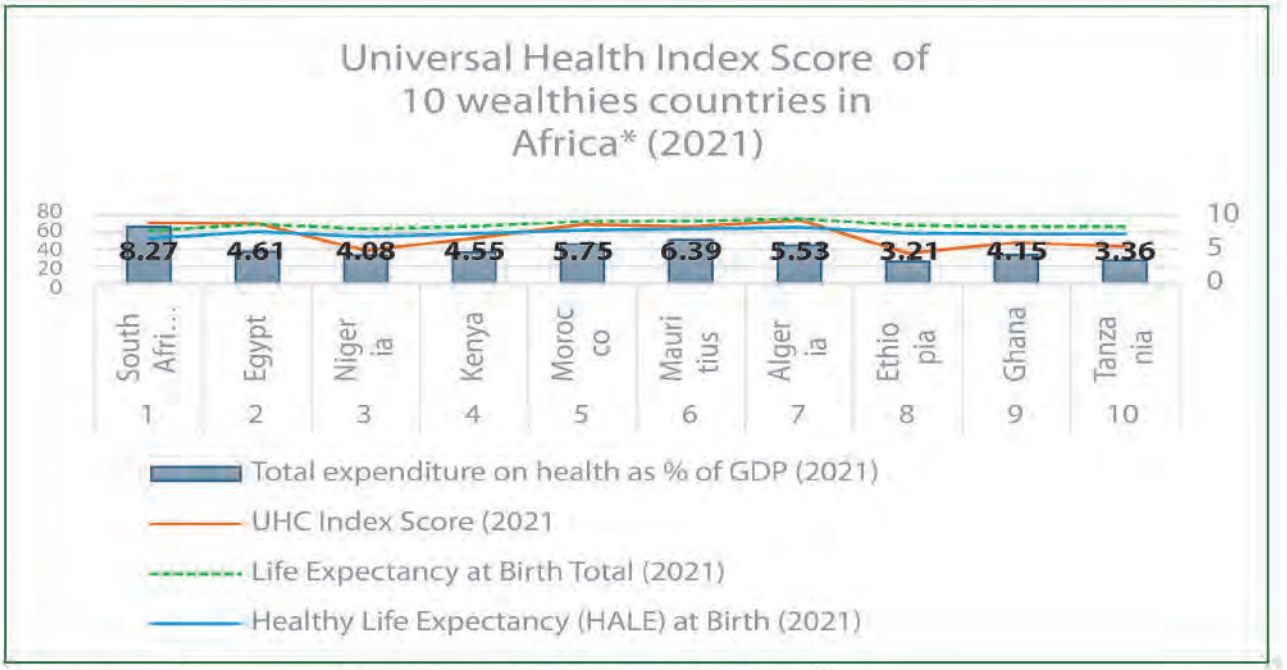
SDG Target 3,8 is defined as "Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all".

The WHO Universal Health Index Score is based on the coverage of essential health services as expressed as the average score of 14 tracer indicators of health service coverage. Figure 7, indicates the wealthiest countries, ranked from 1 to 10 for 2`21. Although South Africa has the highest UHC index score (71) in 2021, it is also spending the most on health as a percentage of GDP (8,27).

One variable that influences spending on health is related to the disease profile of the country, which is a factor in GDP spending of the country. Predominantly in South Africa, communicable diseases (TB and HIV) ranked amongst the ten leading causes of deaths, including non-communicable diseases like Diabetes and Hypertensive diseases. However, there is scope for improvement for efficiency spending. A recent systematic review recommends three main criteria for improving efficiency in health systems with clear links to expenditure and health service outcomes[10]. In order to improve health outcomes related to spending, the authors suggest that long-term financial sustainability requires ongoing focus and monitoring as opposed to responsive planning[11].

[4] Wasteaid, Website: https://wasteaid.org/programmes/current-programmes/south-africa/, accessed 28 Oct 2024.
[5] Data sourced from General Household Survey, StatsSA, 2021
[6] The State of Food Security and Nutrition in the World, WHO, 2023
[7] Prevention Stunting in South African Children Under 5: Evaluating the Combined Impacts of Maternal Characteristics and Low Socioeconomic Conditions, Wand, et. al., 2024
[8] 2024 Mid-year population estimates, StatsSA, 2024
[9] World Health Organization https://data.who.int/countries/710, accessed 16 Oct 2024
[10] Supporting efficiency improvements in public health systems: a rapid evidence synthesis, James et. Al, 2022, BMC Health Services Branch
[11] Data sourced from Mitropoulos P, Mitropoulos I, Kranikas H, Polyzos N. The impact of economic crisis on the Greek hospitals' productivity. Int J Health Plann Manage. 2018;33(1):171-84.

Figure 7. Universal Health Index Score compared to % of GDP expenditure and life expectancy measurements.

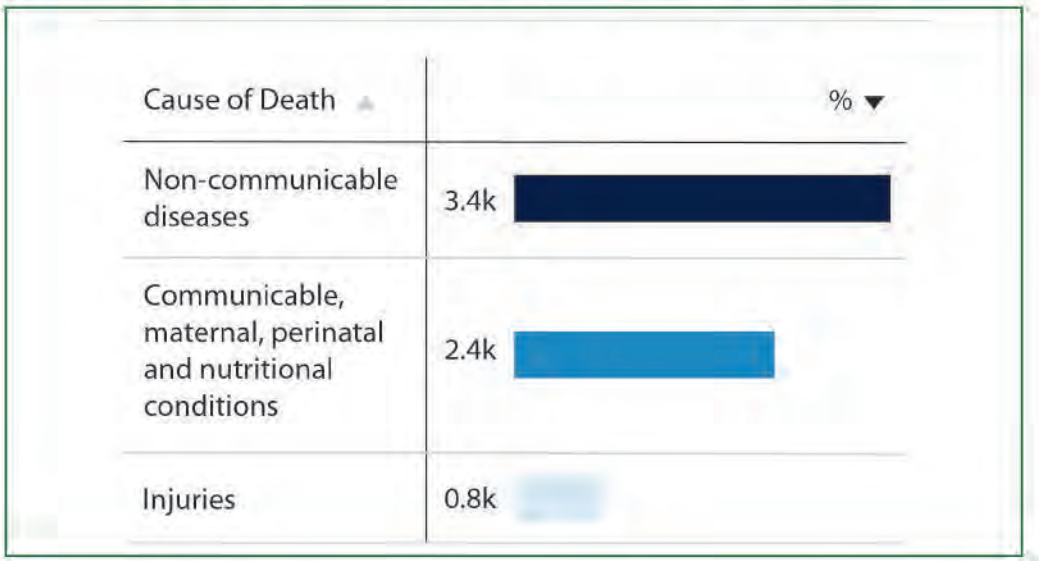


* *Based on the number of high-net-worth individuals (Dec 2023)*[12]

7.1.2. Epidemiology and Quadruple Burden of Disease

The WHO country report[13], using the latest data for 2019, indicate that non-communicable diseases accounted for most most deaths in the country, followed by communicable diseases.

Figure 8. South Africa: Share of deaths, grouped per broad cause of deaths, 2019.



[12] Heanley and Partners, https://www.henleyglobal.com/publications/africa-wealth-report-2024/africas-wealthiest-countries, accessed 16 Oct 2024

[13] WHO Global, Country report, 2019, website accessed 21 Oct 2024.

The latest StatsSA, mortality data reports that four of the ten leading natural causes of death were common for the four population groups (African, Coloured, Indian /Asian, Whites), namely, Diabetes mellitus, COVID-19, hypertensive disease and cerebrovascular diseases.

The disease profile amongst the population group in terms of ranking order differs also. For example, diabetes mellitus was the leading cause of death among black African population, accounting for 7.1% of all deaths in this group; and for the Coloured population, the leading cause of deaths was COVID-19 at 10.1% as well as for the Indian/Asians population at 14.5% of natural causes of deaths. The White population was dominated by non-communicable diseases, namely, ischemic heart diseases causing 11.2% of all natural deaths.

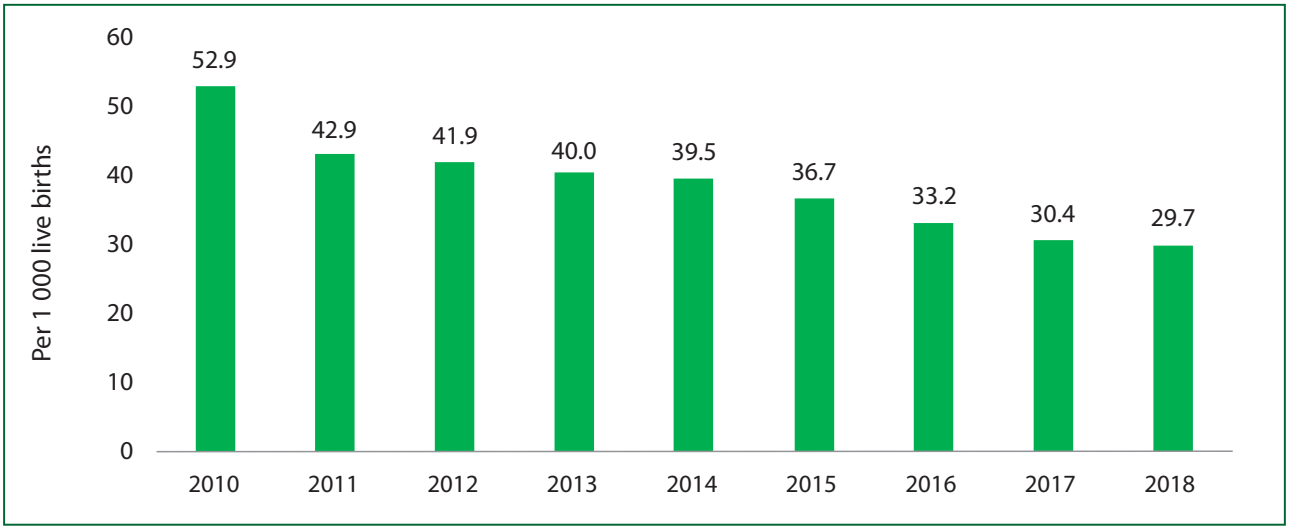
The percentage of deaths between both genders differs also. Between 2016 to 2018, males accounted for 52,8% of deaths and females for 47.2%. However, male deaths decreased to 51.1% in 2020, and female deaths increased to 48.9% for the same year. The highest number of deaths by age group in 2020 was in the aged group 65-69, accounting for 9.3% of all deaths.

Communicable Diseases

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 births by 2018.

Figure 9. Under-5 Mortality per 1, 000 live births



The infant and under-five mortality rates are proxy indicators for a country's health and development. Data on these age groups are typically recorded from vital registration systems. However, for many middle and lower-income countries, these data sources may be unreliable. An alternative approach to monitoring age-specific mortality nationally since 2009 is the rapid mortality surveillance system (RMS) based on the deaths recorded on the population register by the Department of Home Affairs[14].

In StasSA all-cause mortality report[15], it is noted that the three leading causes of death for children aged from 1-4 year were intestinal infectious diseases (7,6%), influenza and pneumonia (5,6%) and malnutrition (4,4%). Metabolic disorders (2,4%) was the fourth leading cause of death while tuberculosis (2,0%) was the fifth leading cause of death.

Deaths (Case Fatality Rate) due to Severe Acute Malnutrition (SAM); Pneumonia and Diarrhea are monitored in all health facilities as part of the child indicators. These indicators are an indication of sentinel conditions for the assessment of health services for children[16]. The overall rates for South Africa, case fatality rates for diarrhea 1,3%, (2023/24) shows improvement from 2,5%, (2020/21). Pneumonia case fatality rates are at 1,8%, improved from 2,1% in 2020/21. SAM is the only proxy indicator that remained constant at a case fatality rate of 7%. "Scaling up the implementation of management of severe acute malnutrition in healthcare facilities using the WHO guidelines can reduce case-fatalities related to this condition by 55%[17]". Breast feeding, complementary feeding and vitamin A supplementation are also known preventative interventions.

In 2020 The COVID-19 lockdown had positively influenced outcomes in the Under-5 and Infants mortality rates due to the restrictions on socializing and travel, protecting young children from infectious diseases that contribute to mortality as shown by the Rapid Mortality Surveillance Report 2019-2020[18].

Recent estimates from the Rapid Mortality Surveilance Report noted a rise in both groups mortality rates from 2020. These predictions will be confirmed by future publication of the causes of death data published by StatsSA[19].

Neonatal Mortality

Neonatal deaths are defined as infants that died within the first 28 days of life [neonats]. According to the World Health Organization[20], in 2020 the Sub-Saharan Africa (SSA) region recorded the highest neonatal mortality rates in the world, with 27 deaths oer 1000 live births. Despite reaching the SDG target of < 12 deaths per 1000 live births for neonatal deaths by 2030, South Africa has not managed to go beyond this number in the past 10 years.

Premature birth, birth complications (birth asphyxia/ trauma), neonatal infections and congenital anomalies remain the leading causes of neonatal deaths[21]. Birth asphyxia, defined as the failure to establish breathing at birth, accounts for an estimated 900,000 deaths each year globally, and is one of the primary causes of early neonatal mortality. (Reference: All-Cause Mortality, StatsSA, 2020)

The neonatal period is also the most vulnerable period due to the infant's underdeveloped immune system. Infections specific to the perinatal period (period from conception to 1 year after birth) is ranked fourth highest cause of death at 12.8% of deaths with respiratory and cardiovascular disorders in the perinatal period accounted for 26.7% of deaths[22].

Many of the deaths from infants up to under 5 years of age are preventable. Modifiable factors include: Better response in the community and clinics when danger signs are detected; e.g. Improving the referral to higher level of health care (e.g. from clinic to hospital); training caregivers to recognize the danger signs or severity of illness.

[14] All Cause Mortality, Appendix Q1; StatsSA, 2020
[15] Reference: Bradshaw D, Dorrington R, Nannan N, Laubscher R. Rapid Mortality Surveillance Report 2013. Cape Town: South African Medical Research Council, 2014.
[16] All Cause Mortality, StatsSA, 2020
[17] Child Health, Section A, DHB, HST, N McKerrow, 2016
[18] Integrated Management of Children with Acute Malnutrition in South Africa, 2015, NDoH
[19] Website: Child Mortality http://childrencount.uct.ac.za/indicator.php?domain=5&indicator=23,Statistic on children in South Africa, University of Cape Town, 2024
[20] Data compiled by Child Mortality, Authors; N Nannan (Burden of Disease research Unit, MRC) and Katharine Hall, Aug 2024, Website http://childrencount.uct.ac.za/indicator.php?domain=5&indicator=23; Accessed 15 Oct 2024
[21] WHO, Newborn mortality. Newsroom, 28 Jan 2022. https://www.who.int/news-room/fact-sheets/detail/levels-and-trends-in-child-mortality report -2021 (accessed 26 July 2022)
[22] WHO, https://www.who.int/news-room/fact-sheets/detail/newborn-mortality#:~:text=Premature%20birth%2C%20birth%20complications%20(birth,leading%20causes%20of%20neonatal%20deaths, accessed 23 Oct 2024.
[23] All Cause Mortality, StatsSA, 2020

The following recommendations are made by the National Committee for Confidential Enquiries into Maternal Deaths (NCCEMD) members[24]: The provision of a comprehensive package of preventive and promotive services to mother-infant pairs during the first 1000 days. Ensuring all Community Health Workers programmes have a clear focus on mothers and children; Attend to basic hospitals availability of highcare beds and daily ward rounds, triaging of patients and implementation of early warning signs. Furthermore performing clinical audits and monitoring of Quality Improvement Plan implementation and improve data on child deaths, especially community deaths and unnatural deaths.

Maternal Mortality

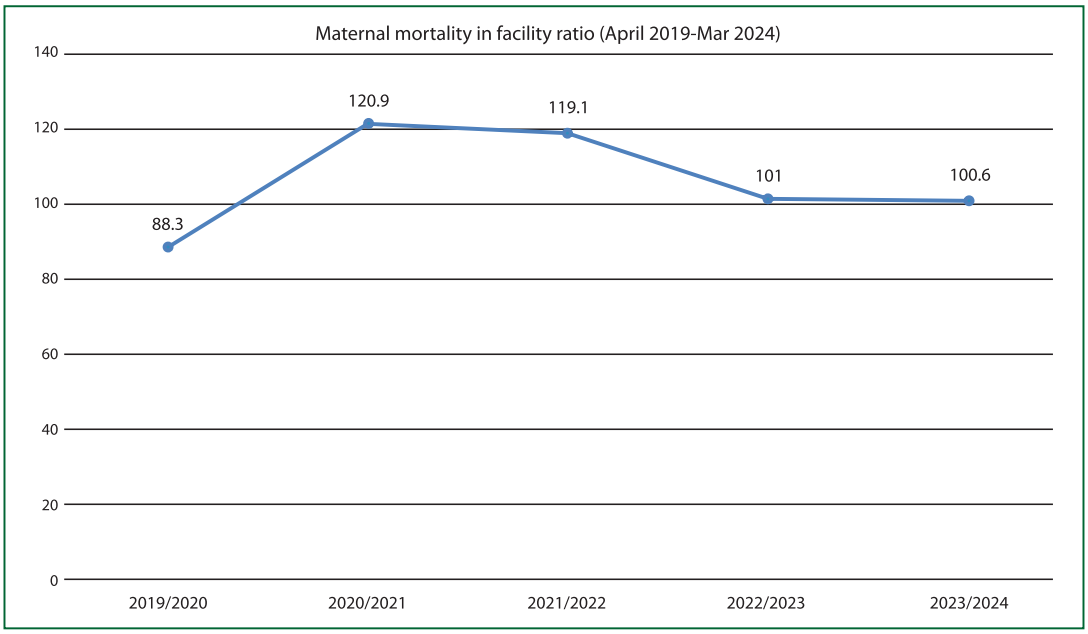
The SDG target for Maternal Mortality by 2030 is an incidence rate of less than 70 deaths per 100 000 live births. Maternal Mortality in facility ratio (iMMR) refers to a death occurring during pregnancy, childbirth and approximately 6 weeks after delivery or within 42 days of termination of pregnancy. The iMMR value serves as a proxy for the Maternal Mortality ratio of a country as per the SDG goals

Maternal Mortality in South Africa is improving since 2009, when the maternal mortality rate was recorded as 311 per 100 000 live births[25]. The reduction coincides with the increase in access to Antiretroviral therapy (ART)[26]. According to the Antenatal HIV Sentinel Survey, 2022 that monitors trends in HIV prevalence among 15-49 year pregnant women for those attending public antenatal care (ANC), the overall HIV prevalence at national level is 27.5%, a decline of 2.5% from 2019 estimate. The highest overall HIV prevalence is in KwaZulu-Natal 37.1%, followed by Eastern Cape (32.9%) and the lowest prevalence in Western Cape at 16.3%.

During 2020 to 2022 there were just over 3 million live births reported in the public facilities (DHIS)[27], which equates to 126 maternal deaths per 100 000 live births, compared to 113,8 in the previous triennium. There is an improvement in facility maternal mortality (iMMR) as seen in figure 10 below, from 120.9 deaths per 100 000 live births during COVID, to 100.6 (2023/2024).

There are notably considered variances in maternal deaths in provinces as average over this period, Free State resulted with the most deaths and Western Cape with the least deaths per 100 000 live births[28].

Figure 10. In-facility Mortality Rate (iMMR), April 2019 - Mar 2024[29]



[24] Dr S.N. Cebekhulu: Specialist ObGyn, Head of Clinical Unit DGMAH-SMHRU & NCCEMD Chairperson; Presentation, NDoH, 2023
[25] 30-Year Review Report, Health Sector, NDoH, 2023
[26] National Committee on the Confidential Enquiries into Maternal Deaths. Saving Mothers 2014-2016: Seventh triennial on confidential enquiries into maternal deaths in South Africa: Short report. Pretoria: NCCEMD, 2018
[27] District Health Information System, NDoH
[28] Saving Mothers Executive Summary, 2020-2022, NDoH
[29] Presentation, NDoH, 2024, Data sourced DHIS, NDoH

Non-pregnancy related infections (including COVID related death) are responsible for most of the deaths (29.1%). Obstetric hemorrhage (16.4%) and hypertensive disorders of pregnancy (14.7%) are the causes for most deaths during 2020-2022.

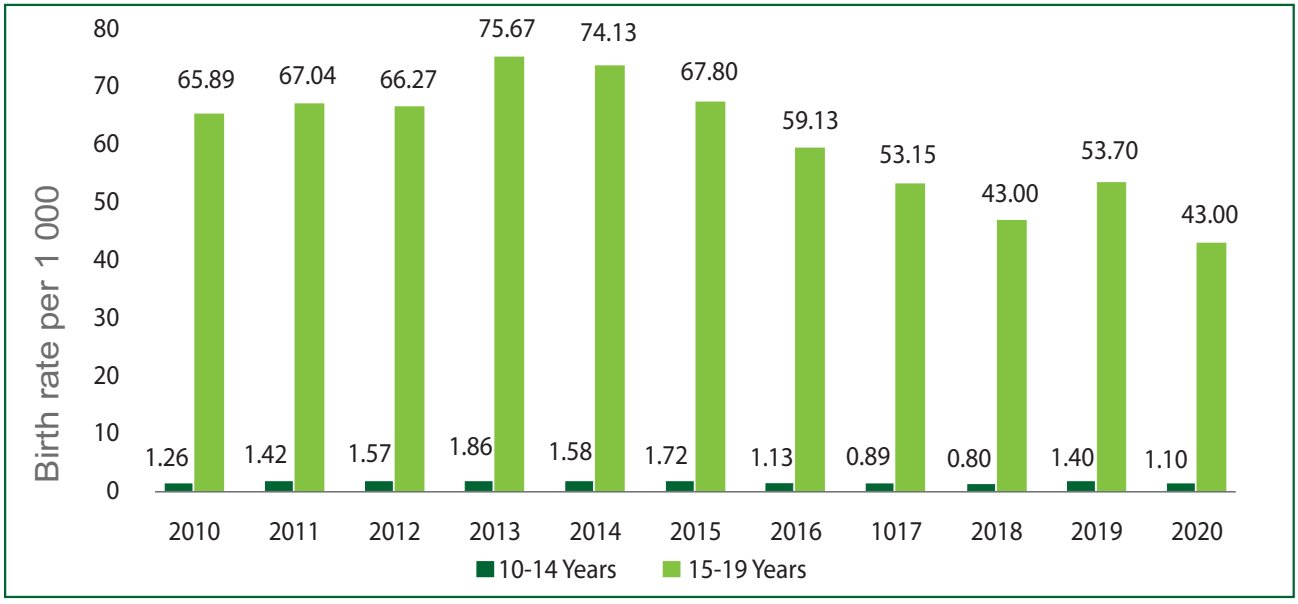
The latest report from the National Committee on the Confidential Enquiries into Maternal Deaths[30] recommends sustained political commitment amongst other interventions including strengthening clinical management and ongoing training. However, previous reports also highlighted the importance of these recommendations. "The inclusion of 'community issues' in the recommendations requires the health sector to look beyond health facilities and into ecosystem issues that affect maternal health and wellbeing"[31].

Adolescent Mothers

Adolescent Mothers are those females that fall pregnant between the ages of aged10-19 years. Globally, material conditions are among the top causes of disability-adjusted life years (DALY) and death among girls aged 15-19[32]. Based on 2019 data, 55% of unintended pregnancies among adolescent girls aged 15-19 years end in abortions. Despite the medical risks, the phenomenon of adolescent mothers has social and economic consequences as well.

Globally the adolescent birth rate for girls 10-14 years in 2023 was estimated at 1.5 per 1 000 women with higher rates in sub-Saharan Africa (4.4)[33]

Figure 11. Adolescent birth rate (births to women aged 10-14 years; aged 15-19 years) per 1 000 women in that age group[34]



The figure illustrates adolescent birth rate per 1 000 women in South Africa for 10-14 years old and 15-19 years old girls. Although the birth rate for both cohorts reduced in 2017, there were an increase in 2019 to 1.4 and 53.7 births per 1 000 women respectively.

Reasons for pregnancy in adolescent age group include amongst other, cases of statutory rape, or sexual relationships with elder men. The Criminal Law (Sexual Offences and Related Matters) Amendment Act (No 13 of 2012), protects children, where the minimum age to consent to sex is only once they turn 16 years of age.

The Department of Women, Youth and Persons with Disabilities has developed a Programme of Action (POA) aimed at tackling the issue of teenage pregnancy by implementing a Comprehensive National Gender-Based Violence Prevention Strategy (CNPS). Current intersectoral collaborations to mitigate teenage/adolescents' deliveries in facilities, are as follows:

- *The National Integrated School Health Programme (ISHP) Task Team, wherein DBE, DSD, DWYPD, UN agencies (WHO, UNICEF and UNFPA and now UNESCO, will be joining in 2025) as members.*

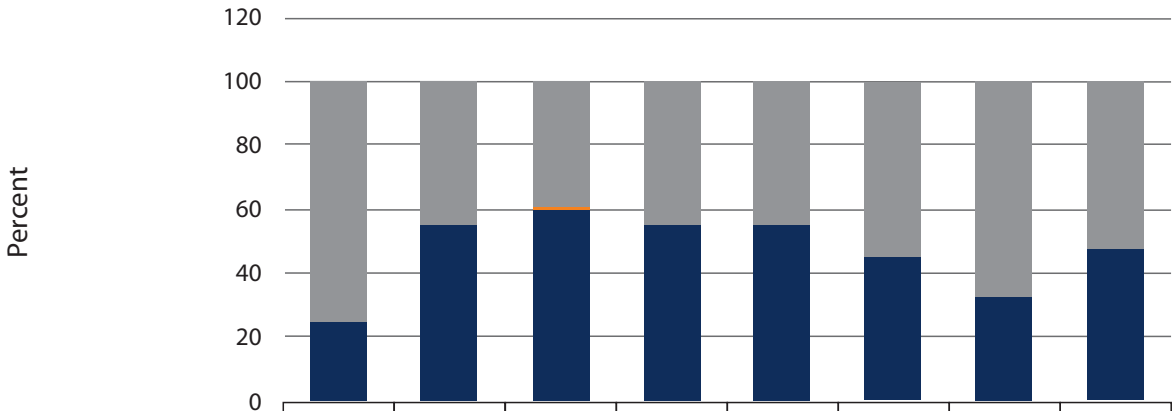
- *Quarterly Capacity building workshops that are conducted through the Departmental Knowledge Hub and session facilitated by DSD officials on mandatory reporting of child abuse and/or neglect to Department of Social Development Service Points.*
- *The provincial Adolescents and Youth Health programme managers embark on activation and Youth Zones in PHC facilities and have interventions geared on adolescents and youth with loveLife, Soul City and other implementing Partners.*
- *The South African Coalition on Menstrual Health and Hygiene Managemnt (SACMHM) Education Task Team and*
- *The Sanitary Dignity Programme led by DWYPD Forum*

Furthermore, intersectoral collaboration is needed to reduce the rates of unwanted pregnancies.

The proportion of pregnancy rate and terminations of pregnancy (abortions) are a concern to society.

The figure below indicates the distributions of all women by any contraceptive methods currently used by age groups 15-48 years, 2016[35]

Figure 12. Use of contraceptive method by women in different age groups (ages 15-49 years, 2016)



	15-19	20-24	25-29	30-34	35-39	40-44	45-49	SA
Not currently using	75,1	45,6	39,1	42,9	43,4	54	66,6	51,8
Any Traditional method	0	0,2	0,7	0,4	0,2	0,1	0,1	0,3
Any modern method	24,9	54,2	60,2	56,7	56,3	45,9	33,2	47,9

Source: SADHS, 2019

As noted, majority of sexually active women uses modern contraceptive methods such as injections in all the age groups and from 2018 to 2020 there has been changes in the type of contraceptives preferred. The injections are now preferred (47.9%) over Sub-dermal contraceptive implants (-28.9% change) from 2018.

[30] National Department of Health. Saving Mothers: Executive Summary 2020-2022: Includes data for COVID-19 pandemic. Pretoria: NDoH, 2023
[31] Will South Africa meet the Sustainable Development Goals target for maternal mortality by 2030? Y Pillay and J Moodely, S Afr Med J 2024
[32] Website, accessed 15 Oct 2024, https://data.unicef.org/topic/child-health/adolescent-health/
[33] WHO, Adolescent pregnancy, Website: https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy, accessed 15 Oct 2024
[34] Source: CRVS 2010-2020, StatsSA
[35] South African Demographic Health Survey, 2016 as published in The Status of Women's Health in South Africa: Evidence from selected indicators (2018)

HIV and AIDS

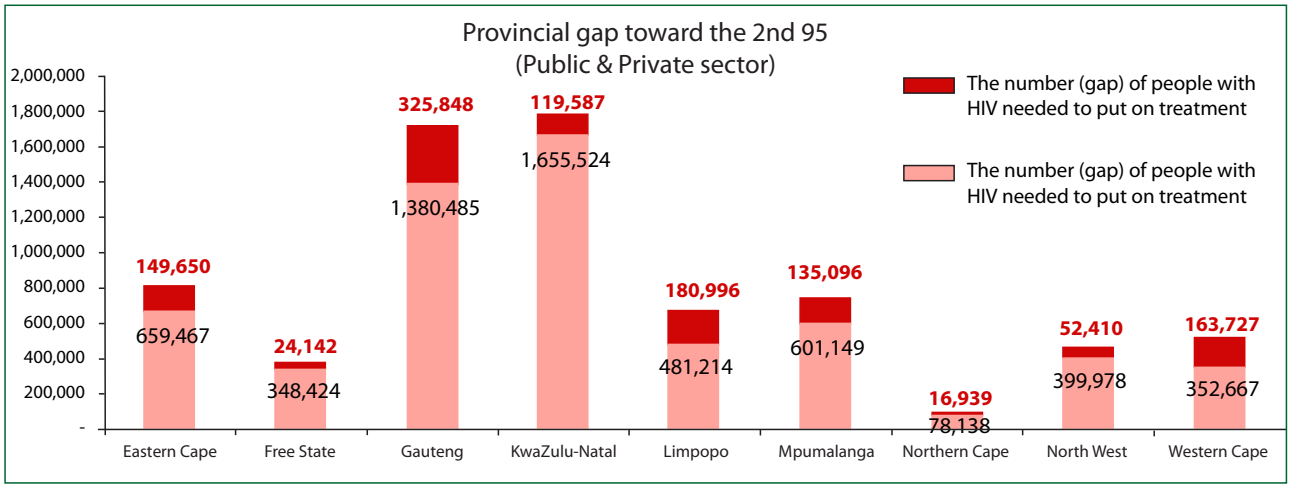
The country is dedicated to eradicating the AIDS epidemic by 2030, aligning with the Sustainable Development Goals (SDGs). To reach this objective, the joint United Nations Programme on HIV/AIDS (UNAIDS) has outlined the 95-95-95 targets. This means that 95% of those diagnosed with HIV should be receiving antiretroviral therapy (ART), and 95% of individuals on ART should achieve viral suppression (VLS). To meet these targets by March 2030, we need to enroll 7, 125,435 individuals in ART.

In South Africa, there are approximately 7,8 million people living with HIV. The latest progress data on the 95-95-95 National HIV treatment cascade indicates that as of July 2024, South Africa is currently achieving a status of 96-79-94 across the entire population served by both public and private sectors.

The statistics for specific sub-populations are as follows: Adult females at 96-81-94, adult males at 95-75-94, and children under 15 at 87-81-70. This shows that 76% of individuals with HIV who are aware of their status are receiving ART.

Among the provinces, Free State and KwaZulu-Natal are performing particularly well, both achieving 85% and above. To meet the 95-95-95 targets, South Africa must increase the number of individuals on ART by the following: Total clients on ART by 1,168,395; Adult females on ART by 630,788; Adult males on ART by 506,780; Children under 15 on ART by 30,827. Amongst the provinces, Free State and KwaZulu-Natal achieved 85% and above.

Figure 13. Provincial gap towards the 2nd 95 (Public and Private sector)



The biggest gap in terms of numbers on treatment is Gauteng and Limpopo province[36].

Amongst the challenges for the disease burden are: Low case finding (Mainly men and children under 15 years); poor linkage to care (Mostly men predominantly not willing to be linked to facilities); Gaps in treatment initiation and retention in care (1.1. Million Gap) with men and children bearing more proportion on treatment gap; High loss to follow-up and treatment interruptions at 6-12 months. Some of the interventions in promoting HIV testing services had been related to establishing "youth zones" for HIV self-screening services, (HIVSS) and index testing. This allows the youth to conduct the test themselves in safe spaces where the test can be provided by a counsellor. Through this initiative the youth is also linked to either prevention (condoms, PrEP, VMMC, abstinence) or treatment (ART and adherence counselling) services.

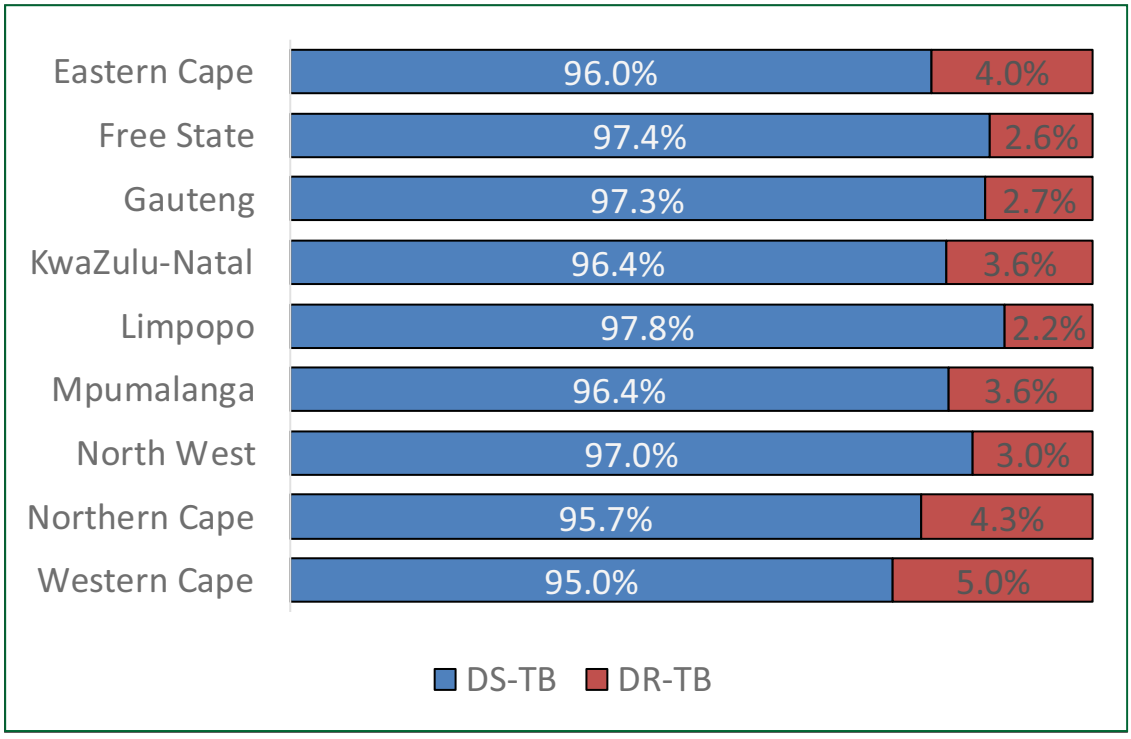
[36] HIV Activities, Progress, Challenges and Opportunities, NDoH Presentation, Sept 2024.

Apart from HIV testing and counselling, youth zones provide a preventative focus on health care, addressing issues related to NCDs, example, mental health care and obesity apart from addressing other social factors, e.g. relationship matters and preventative care. The Youth Zones are focusing on capacity building of youth through Partner intervention, focusing on youth to take an active leadership role

Tubercolosis

An estimated 222 042 TB cases were reported in South Africa in 2023[37]. The incidence of TB has reduced significantly, more than 41% from 2015, (from 454 000 to 270 000) in 2023, however, this remains very high at 427 people per 100 000 population incidence rate. There has been a marked reduction in the number of TB deaths at 43% from 2015 to 2022. However, the number of TB deaths remained high at 56 000 in 2022. The target is to attain a 90% reduction in the number of deaths by 2030 from the 2015 baseline. The treatment success rate in 2022 was 75% for drug-sensitive TB (DS-TB) and 62% for MDR-TB (Drug Resistant TB) in 2021. The HIV-TB co-infection rate is 53% with 90% of HIV positive TB patients on antiretroviral treatment.

Figure 14. DS and DR-TB Notifications by province, 2023 (TIER.Net and EDRWeb)



In 2022, the success rate for DS-TB varied in provinces between 61% in the Western Cape to 84% in Gauteng. None of of the provinces reached the 90% set target.

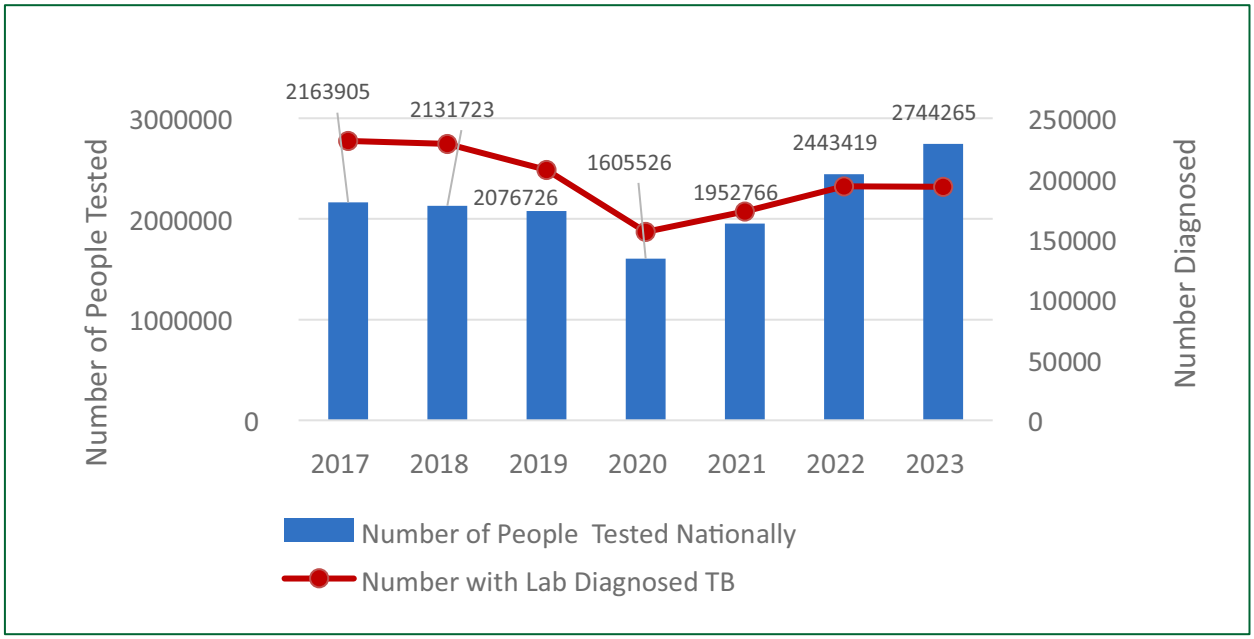
The fifth National Strategic Plan (NSP) for HIV, TB and STIs NSP 2023-2028 provides the strategic framework for a multi-sectoral approach. The NSP emphasizes the need to collaborate and maximize equitable access to HIV, TB and STI services.

TB testing increased following the introduction of the Policy on Targeted Universal TB Testing in 2022. This policy recommends testing people living with HIV (PHLHIV), household contacts and people previously treated for with TB[38] . This resulted in a 32% increase in TB testing from 2019, reversed the pre-pandemic declining trend. Approximately 4,6% of people tested in 2023, 6,8% tested positive for TB.

[37] WHO TB Global report, 2024

[38] Evaluating systematic targeted universal testing for tubercolosis in primary care clinics of South Africa: A cluster-randomized trial, Martinson, et al, 2022.

Figure 15. Number of people tested Nationally and those Diagnosed for TB, 2017-2023[39]



TB prevention, increasing ART coverage, strengthening community outreach services to reach all communities with TB services, tracing people lost to follow up, strengthening data use at all levels and addressing social determinants of health are key in the efforts to reduce the TB disease burden.

Malaria

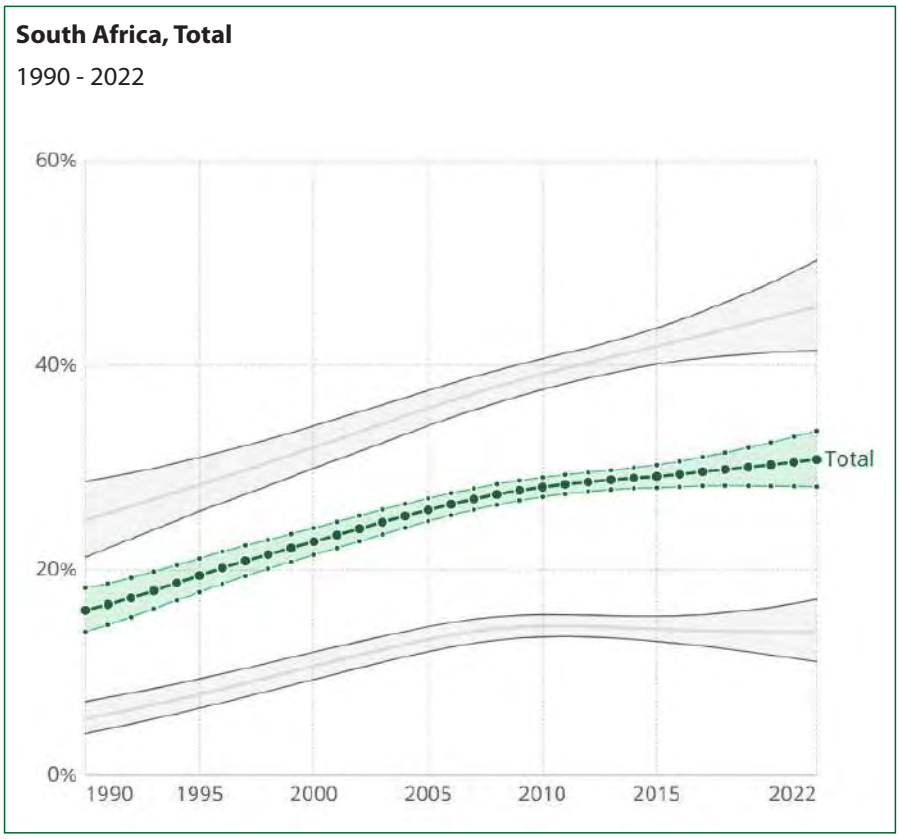
SDG goal 3.3.3. indicate that the epidemic of malaria incidence per 1000 population must be ended by 2030. The country report indicates progress from 0,98~1 (2015), an increase to 1,39 (2018) and the latest data shows a reduction to 0,6 (2021) malaria incidence per 1 000 population. The implementation of the foci clearing programmes plays a key role in the Malaria Elimination Strategic Plan (2019-2023)[40]. The foci programme is based on various steps namely, to investigate, trace and follow up on cases in order to treat, prevent and eliminate malaria.

[40] Source: Bill and Melinda Gates Foundation, 2014
[41] The Malaria Elimination Strategic Plan (2019-2023), NDoH

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[41].

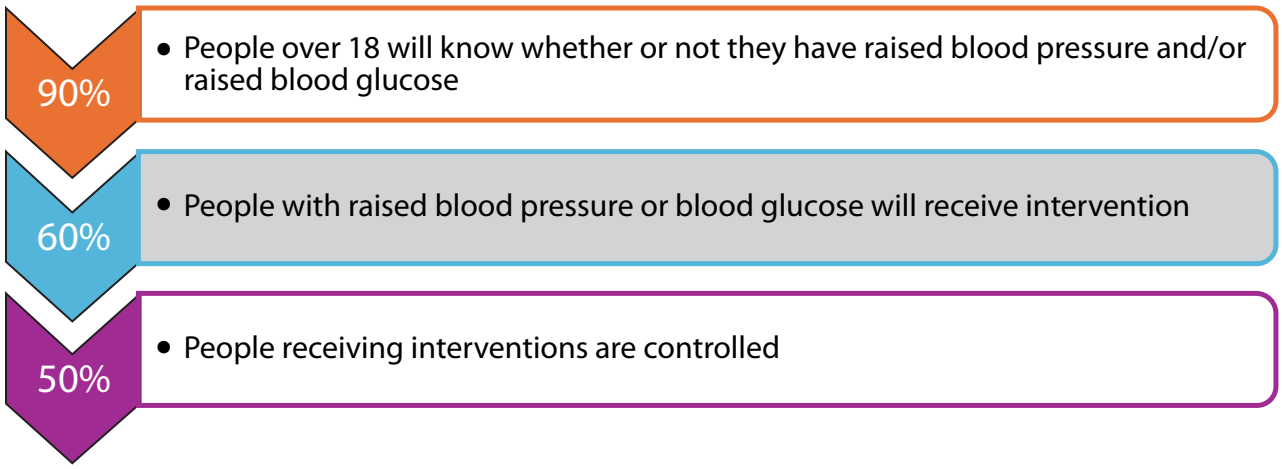
Figure 16. Age -standardized prevalence of obesity among adults (18+ years)



Data from the WHO data[42] country report on non-communicable diseases, indicates the percentage of adults in the country aged 18 and older with a body mass index of 30kg.m2 (BMI more or equal to 30), indicating obesity levels are rising. For the period from 1990-2022 according to WHO, the total percentage increase in obesity percentage was 16.1% in 1990 to 30.8% in 2022, with females at 45.8% at 2022 and males at 13.9%. Obesity is strongly linked to increased risk of developing type 2 diabetes.

The National Strategic Plan for Non-communicable diseases 2022-2027, adopted the same cascade approach as HIV and TB using the cascade as indicated below: The proposed 90-60-50 cascade for diabetes and hypertension is aimed at early detection and treatment of NCDs+ to improve the outcmes.

Figure 17. NCD+ cascade for hypertension and Diabetes[43]



[41] Sustainable Development Goals, 2030 Agenda, United Nations

[43] Data sourced from NCD NSP 2022-2027, NCD presentation, NDoh

Programmatic interventions amongst others:

- Continue strengthening screening services through campaigns.
- Ensuring that a (Chronic) medical electronic register is made available for proper data collection at all levels.
- Promote **multi-sectora**l coordinating mechanism between government departments, other sectors & civil society to address the challenges.
- Use platforms like **Operation Phuthuma** that will contribute to the improved health outcomes especially in NCDs.
- Expansion of the District Specialist teams to include the management of NCDs as a way of enhancing supervision and mentoring of colleagues.

Cancer

According to the Global Cancer Observatory, 2022[44] in South Africa, 120 266 total new cases of all cancer types in both genders were diagnosed, with 69 874 deaths. The top 3 leading cancers ranked by number of cases are in both sexes Breast, prostate and Cervix uteri (Cervical Cancer). The risk of dying from cancer before the age of 75 years (cumulative risk %) is higher for males at 13.2% than females at 10.4%.

Figure 18. Cancer Today, South Africa, 2022, Global Cancer Observatory

	Males	Females	Both sexes
Population	34 025 573	35 166 105	69 191 678
Incidence*			
Number of new cancer cases	55 929	64 297	120 226
Age-standardized incidence rate	224.1	186.2	197.4
Risk of developing cancer before the age of 75 years (cum. risk %)	22.4	18.3	19.9
Top 3 leading cancers (ranked by cases)**	Prostate Lung Colorectum	Breast Cervix uteri Colorectum	Breast Prostate Cervix uteri
Mortality*			
Number of cancer deaths	32 842	37 032	69 874
Age-standardized mortality rate	141.2	108.4	119.0
Risk of dying from cancer before the age of 75 years (cum. risk %)	13.2	10.4	11.6
Top 3 leading cancers (ranked by deaths)**	Prostate Lung Colorectum	Cervix uteri Breast Lung	Lung Cervix uteri Prostate
Prevalence*			
5-year prevalent cases	130 881	173 475	304 356

HPV vaccination is a screening program expected to result in a significant reducing in the number of new cervix cancer diagnoses, however, opinion leaders believes that there is a need for formal proactive screening programs for most common cancers, e.g. Breast and Prostate Cancer, to avoid poorer outcomes of cancers including increasing treatment of later stage presentation of cancers.

According to experts in the field, insufficient planning and funding for infrastructure maintenance, new equipment; slow HR processes of filling of crucial posts including training staff are some of the key needs to be addressed in order to improve the management of cancers.

[44] 2022 Global Cancer Observatory: Cancer Today, Lyon, France: International Agency for Research on Cancer. Available from: https://gco.iarc.who.int/today, accessed [14Oct2014]

Mental Health

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

Figure 19. Suicide mortality rate, 2011-2018, StatsSA, 2023

In South Africa, suicide mortality rate declined from a high 1.14 per 100 000 people to 0.58 in 2018. The burden associated with mental disorders in high locally and internationally. The Global Burden of Disease Study[45] found the 12-months prevalence *(the proportion of a population who have mental disorders at any point during a given period)* 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. WHO estimates indicates that suicide mortality rate per 100 000 population for both genders in South Africa is at 23.5, with females at 9.8 and males at 37.6.

The South African mental health legislation and policy propagates for integration of mental health into the general health services environment through strengthened mental health services delivery at community, primary health care and general hospitals to reduce the treatment gap, facilitate holistic care, reduce stigma and promote human rights. However, recent studies and reviews have found that there is continued overreliance on institutional care. Child and adolescent mental health services are lacking while an increasing number of people are accessing the mental health system through the criminal justice after they have relapsed and committed 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.

The National Mental Health Policy Framework and Strategic Plan 2023-2030 packages interventions that must be implemented to reduce the burden associated with mental health conditions, increase access to mental health services and also contributes to the SDG goal 3.4 referring to prevention, treatment and promotion of mental health and well-being.

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 Person with Disabilities (UNCRPD). The White Paper on the rights of Person with Disabilities was put into effect to improve the realization of the rights of persons with disabilities. Progress made with the improvement of the realization of the rights of persons with disabilities are provided to the Department of Women, Youth and Person 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 a bi-annual 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 realization of the rights of persons with disabilities.

[45] Global Burden of Disease Study 2017 (GBD 2017). Results [internet]
Institute for Health Metrics and Evaluation (IHME). http://ghdx.healthdata.org/gbd-results-tool,

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 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.

7.1.3 Service Delivery Platform

District health system

The District 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.

Hospital System

The ongoing hospital reforms are critical to address the lack of uniformity in planning, resource allocation and priority-setting in provinces which leads to under development of hospital services in some areas resulting in inefficient operational management and poor health outcome[46]. To address these challenges, various interventions are being implored to improve hospital management, governance and leadership, promote efficiencies in delivery of care and improve quality of care rendered.

Human Resources for Health

The health workforce remains the backbone of service delivery. Human Resources for Health (HRH) Strategy sets out the overall vision, goals and actions required to address persistent issues of inequity and inefficiencies in the health workforce. The goals of the strategy are as follows:

- Effective health workforce planning to ensure HRH aligned with current and future needs
- Institutionalize data-driven and research-informed health workforce policy, planning, management and investment
- Produce a competent and caring multi-disciplinary health workforce through an equity-oriented, socially accountable education and training system
- Ensure optimal governance, and build capable and accountable strategic leadership and management in the health system

There is notable improvement in the availability of Human Resources for Health, e.g. Medical doctors per 100 000 increased from 21.9 per 100 000 in 2000 to 32.6 per 100 000 in 2022. Pharmacists increased from 3.1 to 11.1 per 100 000 and professional nurses' categories also expanded.[47] The HRH interventions in the medium term will focus on promoting equity in distribution of 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

[46] The South African Health Reforms 2009-2014
[47] DPME. Synthesis Report on the implementation and impact of government programmes in South Africa

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-maitained health facilities. One of the interventions for the realization of this commitment is to explore innovative financing options for infrastructure development and maintenance. The health facility revitalization 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

In response to the demand of healthcare within the socio-economic challenges, the delivery of healthcare requires reforms to enable improving the quality of care through optimisation and digitilisation of health systems aimed at improving diagnostics and treatment, improved disease management and enhance patient's experience.

The Science, Technology and Innovation Decadal Plan, addresses the priority areas for health innovation, which include: Strong support for research, development of therapeutics, diagnostics and devices and digital health. The South African Medical Research Council, an entity of the department, is a key role player in the health innovation space through research projects informing improvements in diagnostics and treatment. Additionally the department has started a process of development of an electronic medical record which will introduce a single record for patient to enable improved access to patients records which is essential for continuity of care and reduce inefficiencies as a result of duplication of services rendered to patients.

The Health Patient Registration System (HPRS) is a software that enables registration of patients, by health facilities where patients can be traced by a unique identifier. In this financial year HPRS will be expanded to more facilities.

Nursing Services

The nursing programme develops, guides and monitors the implementation of a national policy framework for the development of required skills and capacity to deliver effective nursing services to healthcare users.

The focus is on ensuring consistent supply of nursing professionals with required skills mix to contribute to the goal of long and healthy life for all. Requisite clinical training platforms for all nurses following the new nursing curriculum were re-introduced in facilities accredited as public health facilities. Thus, promoting access to facility based clinical training opportunities for nursing students studying in public colleges and universities in the private sector. These Clinical Educational and Training Units (CETU) have been appropriately equipped as platforms for rolling out of Continuing Professional Development (CPD) programmes for nurses, midwives and nurse specialists. In addition, a framework to ensure ongoing competence for in-service nurse practitioners strengthening their capabilities in all areas of expertise including clinical care, leadership and management, ethics and professionalism was developed. Finally, the shortage of nurses was quantified, by category, and demographically. This exercise will inform forecasting, posting, retention and education and training strategies.

Access to medicine and other commodities

Access to medicine has 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 Assistants 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 of health facilities and improving quality of equipment.

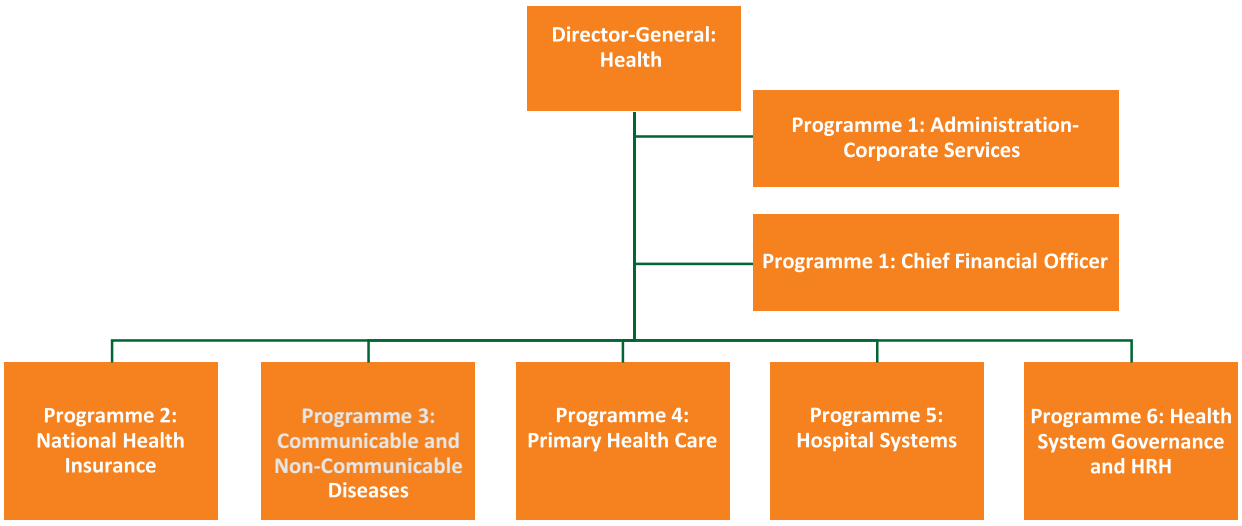
Quality of care and health system improvement

Delivering high-quality healthcare services is a critical aspect for the implementation of the National Health Insurance. Through the quality improvement initiative such as the ideal facility realisation programme, the department aims to ensure that all health facilities participate in a quality improvement programme which will facilitate compliance with the norms and standards regulations by the Office of Health Standards Compliance (OHSC). Additionally, an effective complaints management programme by health facilities enables the to address quality challenges to improve health outcomes. Patient experience of care surveys is another platform that is utilised by the sector to get feedback related to the quality of care from the client's perspective. 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 infrormation system, is essential in improving access to quality healthcare, the experience of care, the experience of care by clients and overall better health outcomes.

7.2. Internal Environmental

7.2.1 Organisational Structure

The budget programme structure shown below, depicts the organizational structure of the National Department of Health. The Department's organizational structure, which was endorsed by DPSA in 2012, is currently under review.



7.2.2 Personnel Information

Table 3. Personnel numbers and cost by salary level and programme

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

Programmes

1. Administration
2. National Health Insurance
3. Communicable and Non-communicable Diseases
4. Primary Health Care
5. Hospital Systems
6. Health System Governance and Human Resources

	Number of posts estimated for 31 March 2025		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 establish-ment	Actual			Revised estimate			Medium-term expenditure estimate							
			2023/24			2024/25			2025/26			2026/27			2027/28			2024/25 - 2027/28	
Health			Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost		
Salary level	**987**	**52**	**858**	**614.9**	**0.7**	**914**	**694.1**	**0.8**	**920**	**744.3**	**0.8**	**910**	**779.4**	**0.9**	**920**	**815.3**	**0.9**	**-0.6%**	**100.0%**
1 – 6	287	32	281	93.8	0.3	281	98.1	0.3	275	102.8	0.4	269	106.0	0.4	275	108.7	0.4	-2.5%	29.8%
7 – 10	371	5	334	222.9	0.7	345	240.5	0.7	351	260.5	0.7	348	273.7	0.8	351	287.6	0.4	0.2%	38.2%
11 – 12	197	7	141	152.2	1.1	176	190.8	1.1	183	207.3	1.1	184	220.2	1.2	183	231.6	1.3	1.4%	20.0%
13 – 16	130	8	100	140.8	1.4	100	159.2	1.4	109	167.8	1.5	106	173.3	1.6	109	180.9	1.7	-1.6%	11.8%
Other	2	--	2	5.3	2.7	2	5.6	2.8	2	5.9	3.0	2	6.2	3.1	2	6.6	3.3	0.0%	0.2%
Programme	**987**	**52**	**858**	**614.9**	**0.7**	**858**	**614.9**	**0.8**	**914**	**744.3**	**0.8**	**910**	**779.4**	**0.9**	**898**	**815.3**	**0.9**	**-0.6%**	**100.0%**
Programme 1	425	23	389	266.1	0.7	3362	255.8	0.7	354	267.5	0.7	350	279.8	0.8	344	292.5	0.8	-1.7%	38.7%
Programme 2	110	15	76	57.9	0.8	114	93.5	0.8	120	104.1	0.9	120	109.7	0.9	120	115.3	1.0	1.8%	13.0%
Programme 3	177	1	151	121.1	0.8	162	141.8	0.9	160	149.8	0.9	160	156.7	1.0	158	163.8	1.0	-0.8%	17.6%
Programme 4	74	13	63	43.2	0.7	88	62.0	0.7	92	68.4	0.7	90	71.6	0.8	88	74.8	0.8	0.1%	9.8%
Programme 5	33	–	29	25.1	0.9	33	30.0	0.9	34	32.3	0.9	34	33.7	1.0	33	35.3	1.1	-0.1%	3.7%
Programme 6	168	--	150	101.6	0.7	155	101.0	0.7	159	122.2	0.8	157	127.9	0.8	154	133.6	0.9	-0.3%	17.1%

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

2. Rand million.

7.2.3 Diagnosis - PESTEL

Political Factors	The medium-term planning environment happens at the time when the administration is constituted by var ious political parties in the form of the Government of National Unity. The National Health Insurance Act assented to in May 2024 paves the way for implementation of reforms towards universal health coverage to address the inequities to accessing healthcare in the country. Both the National Health Act and National Insurance Act are the two enabling legislatives for the sector and key regulations to give effect to the much needed reforms for the implementation of the NHI. The NHI enjoys political commitment from the Presidency and the Ministry.
Economic Factors	The sector is confronted with budget cuts which are further compounded by high medical inflation (medicines and equipment), due to foreign exchange, payment of medico-legal claims which negatively affects provision of essential services. The sector is currently explo-ring various mitigation strategies which include review of resource allocation (equitable share), improving revenue collection and streng-then financial reporting, monitoring and accountability.
Social Factors	Social determinants namely, low levels of income, access to housing, suboptimal food environment, high levels of alcohol and substance abuse, low levels of social cohesion, access to clean water and sanitation are contributory to premature mortality as they pre-dispose communities to ill health and negatively affect recovery from diseases. Patient Centered Care approach advocates for better through better coordination in communities and stakeholder engagements to encourage concerted efforts in addressing the social determinants as well as advocate for behavioral change for health, prevent diseases and delay progression if already diagnosed. Additionally, the high youth unemployment present an added risk to ill-health due to exposure to poverty, substance abuse and mental health conditions.
Technological Factors	Current challenges include inadequate ICT infrastructure across the sector. Advancement in technology requires departments to leverage ICT capabilities for improved operations. The sector utilize various digital platforms to improve access to services. The NDoH will embark on Enterprise Architecture development to ensure that the ICT infrastructure is Fit-for-purpose and align ICT strategy to business goals, integr-ation of systems, leverage on emerging technologies, as well as strengthening cyber security within the department.
Environmental Factors	District municipalities have the responsibility to ensure that environmental norms and standards are upheld. Recently communities have been faced with incidents of Food-borne illness, the sector in collaboration with stakeholders conducted investigation into the out-break of food related poisoning. Insufficient human resource capacity at municipalities to conduct inspections, were noted to be contributory to a high incidence of food-borne illness. To strengthen environmental safety in communities, the department will embark on improving the approach to the oversight assessments conducted for compliance with environmental health norms and standards. Emerging pathogens have emphasized more focus on Preparedness and Resilience for Emerging Threats, which has led to the launch of PRET by WHO for countries to strengthen their existing systems and capacities, avoid siloes and promote coherence and efficiency in time of pandemic.
Legal Factors	The management of Medico-legal claims in provinces requires drastic improvement in a holistic approach as the cost of medical litigati-on remain on the rise and affect the provision of essential services. Measures to strengthen the handling and management of Medico-Legal Claims include an establishment of an enabling legislation with the provision of future medical treatment, the implementation of the Case Management System and capacity building for provision to make use of the mediation process.

7.2.4 Employment Equity

The Department has made a progress towards in response to the employment equity targets for Women, Youth and People with Disabilities. Challenges 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. The department is responding to the evaluation of Gener Sensitive Policies.

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 including National Integrated Sexual and Reproductive Health and Rights Policy 2019 and National Adolescent and Youth Health Policy 2017.

The table below reflects current programmes led by the programs:

Program	Youth Development Area
Internship Programme	Youth are provided with experiential training in the workplace.
Skills Development	Interns are enrolled into a skills programme to ehance 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 Professional including Cuban Doctors recruitment
Employment Equity	Data on Youth Employment

7.3 Expenditure Overview

Over the medium term, the department will focus on strengthening primary health care, improving tertiary services and strengthening healthy systems. Work in these focus areas aims to ensure improvement in the public health sector in preparation for national health insurance. Given that health is a concurrent function, where most services are delivered at the provincial level, an estimated 89.8 percent (R181.4 billion) of the department's budget of R201.9 billion over the MTEF period comprises transfers to provincial departments of health through conditional grants. Total spending is projected to increase at an average annual rate of 4.1 percent, from R62.2 billion in 2024/25 to R70.2 billion in 2027/28.

Reprioritisations on the department's baseline, mainly from goods and services in the Administration programme, are affected to support emerging key policy areas. These include building capacity in the National Institute for Communicable Diseases to strengthen surveillance as part of overall pandemic preparedness efforts (R26 million over the MTEF period); improving the operations of the centralised chronic medicines dispensing and distribution programme by appointing staff previously funded by donors (R21 million over the MTEF period); supporting the establishment of the interim Traditional Health Practitioners Council towards it becoming self-financing (R21 million over the MTEF period); providing additional capacity to the Mines and Works Compensation Fund, recently deemed schedule 3A public entity in terms of the Public Finance Management Act (1999) (13.2 million over the MTEF period); and funding Mpox-related search to be commissioned by the South African Medical Research Council (R10 million in 2025/26).

To fund cost-of-living adjustments for personnel, additions of: R5.8 million in 2025/26, R6.9 million in 2026/27 and R7.9 million in 2027/28 are located to the department's compensation of employees budget; and R246.3 million in 2025/26, R264.3 million in 2026/27 and R276.7 million in 2027/28 are allocated to conditional grants to provinces. Further additional allocations are provisionally made to the provincial equitable share under National Treasury (and therefore not included in this chapter) to address shortfalls in compensation of employees and goods and services, as well as to assist in absorbing unemployed doctors who have completed their community service.

Strengthening primary health care

The district health programmes grant's allocation of R89 billion over the medium term (R78.3 billion for the comprehensive HIV and AIDS component and R10.7 billion for the district health services component) accounts for 44.1 percent of the department's projected spending over the period ahead. Although allocations to the grant's comprehensive HIV and AIDS component are set to increase at an average annual rate of only 3.3 percent, this is expected to be sufficient to cater for an increase in the number of clients on antiretroviral treatment from a targeted 5.7 million in 2024/25 to 6.5 million in 2027/28, an estimated 5.6 million clients were receiving antiretroviral treatment against an annual target of 5.7 million. To meet this target by the end of 2024/25, the department plans to enhance outreach efforts through community health workers and adopting innovative models of dispensing medicine.

Funding for outreach services is provided mainly through the grant's district health services component, in which expenditure is projected to increase at an average annual rate of 4.8 percent, from R3.2 billion in 2024/25 to R3.7 billion in 2027/28. This is expected to support the retention of an adequate number of community health workers, who play a critical role in linking patients to health care for communicable and non-communicable diseases. The district health component also funds human papillomvirus vaccinations and various interventions for malaria.

Allocations to the centralised chronic medication dispensing and distribution programme are set to increase by 4.8 percent per year, from R400.2 million in 2024/25 to R460.3 million in 2027/28, funded through the national health insurance indirect grant. It enhances access to chronic medications by allowing patients to collect their prescriptions from alternative pick-up points such as private pharmacies. At estimated 40 percent of the department's clients on antiretroviral treatment use this service.

Improving tertiary services

Tertiary services are highly specialised referrals available at central and tertiary hospitals. However, these are not evenly distributed across the country as only 35 hospitals, mainly in urban areas, offer them. As such, patients are frequently referred between provinces. This requires effective national coordination and financial support through the national tertiary services grant, which compensates provinces for delivering tertiary care to patients, including those from other provinces. The grant is allocated R50.2 billion over the MTEF period in the Hospital Systems programme, with expenditure set to increase at an average annual rate of 4.7 percent. To enhance equity and minimise the need for interprovincial referrals, part of the grant is designated for developing the capacity of tertiary services in provinces with insufficient resources by enabling them to buy equipment and recruit medical specialists.

Strengthening health systems

National health insurance will fundamentally affect the funding and organisation of health care in South Africa. Preparatory efforts for its rollout are primarily funded through the national health insurance indirect grant, which has an allocation of R8.5 billion over the medium term. The grant comprises health systems and health facility revitalisation components. The health systems component funds interventions such as developing patient information systems; addressing findings from the Office of Health Standards and Compliance in an effort to improve the quality of care in the public health sector; providing active support to facilities in the implementation of the ideal clinic initiative, including systems to track progress; enhancing the dispensing of medicines through the central chronic medication dispensing and distribution programme; and piloting contracting units for primary health care.

The health facility revitalisation component is allocated R6 billion over the medium term to fund strategic infrastructure projects. Of this allocation, an estimated R3 billion is sourced from the budget facility for infrastructure and earmarked for the construction of the Limpopo Academic Hospital and Siloam District Hospital. The allocation for the Siloam hospital will be used to construct a 224-bed hospital and facilities for allied health services such as audiology, physiotherapy and occupational therapy, and repurpose and refurbish parts of parts of the existing hospital, including the psychiatric ward and mortuary. A further R23 billion over the MTEF period is expected to be transferred to provinces through the direct health facility revitalisation grant. This will help accelerate maintenance, renovations, upgrades, additions and the constructions of infrastructure including the replacement and commissioning of health technology in existing facilities.

7.3.1 Expenditure trends and estimates

Table 4. Vote expenditure trends by programme and economic classification[1]

Vote expenditure trends by programme and economic classification[1]

Programmes

1. Administration
2. National Health Insurance
3. Communicable and Non-communicable Diseases
4. Primary Health Care
5. Hospital Systems
6. Health System Governance and Human Resources

Programme	Audited outcome			Adjusted appropriation	Average growth rate (%)	Average: Expen-diture/ Total (%)	Medium-term expenditure estimate			Average growth rate (%)	Average: Expen-diture/ Total (%)
R million	2021/22	2022/23	2023/24	2024/25	2021/22 - 2024/25		2025/26	2026/27	2027/28	2024/25 - 2027/28	
Programme 1	672.7	645.3	678.2	763.0	4.3%	1.1%	774.5	834.7	874.0	4.6%	1.2%
Programme 2	1 216.5	1 366.1	1 425.1	1 343.2	3.4%	2.2%	1 401.2	1 417.1	1 481.9	3.3%	2.1%
Programme 3	32 819.7	26 049.6	23 659.1	25 383.6	-8.2%	43.4%	25 600.7	26 784.0	27 991.4	3.3%	40.0%
Programme 4	3 056.2	5 149.2	2 989.8	3 318.4	2.8%	5.8%	3 494.2	3 655.8	3 821.2	4.8%	5.4%
Programme 5	21 011.8	22 198.4	22 130.8	23 906.7	4.4%	35.9%	25 771.2	26 122.1	27 531.9	4.8%	39.1%
Programme 6	6 360.5	7 487.4	7 429.1	7 510.5	5.7%	11.6%	7 765.3	8 113.9	8 482.8	4.1%	12.1%
Subtotal	**65 137.4**	**62 896.0**	**58 312.1**	**62 225.4**	**-1.5%**	**100%**	**64 807.2**	**66 927.7**	**70 183.1**	**4.1%**	**100%**
Total	**65 137.4**	**62 896.0**	**58 312.1**	**62 225.4**	**-1.5%**	**100%**	**64 807.2**	**66 927.7**	**70 183.1**	**4.1%**	**100%**
Change to 2024 Budget estimate[1]				–			1 110.9	530.2	579.0		
Economic classification											
Current payments	**9 976.9**	**3 601.6**	**2 204.9**	**2 366.9**	**-38.1%**	**7.3%**	**2 464.5**	**2 574.1**	**2 689.5**	**4.4%**	**3.8%**
Compensation of employees	884.2	761.0	614.9	694.1	-6.5%	1.2%	744.3	779.4	815.3	5.5%	1.1%
Goods and services[1]	9 128.6	2 840 6	1 590.0	1 672.8	-43.2%	6.1%	1 720.2	1 794.8	1 874.2	3.9%	2.7%
of which:					0.0%	0.0%				0.0%	0.0%
Consultants: Business and advisory services	335.6	294.4	153.6	206.0	-15.0%	0.4%	215.5	247.4	258.2	7.8%	0.4%
Contractors	404.0	530.9	452.0	608.2	14.6%	0.8%	619.7	614.0	641.7	1.8%	0.9%
Inventory: Medical supplies	38.3	33.9	34.0	72.1	23.5%	0.1%	69.6	78.3	78.4	2.9%	0.1%
Operating leases	160.5	102.9	111.8	129.9	-6.8%	0.2%	136.1	141.8	148.2	4.5%	0.2%
Travel and subsistence	49.4	103.8	100.0	124.0	35.9%	0.2%	132.8	141.1	147.7	6.0%	0.2%
Operating payments	189.7	104.0	161.9	99.6	-19.3%	0.2%	89.3	101.8	106.4	2.2%	0.2%
Transfers and subsidies[1]	**54 491.9**	**58 334.3**	**54 751.8**	**58 402.2**	**2.3%**	**90.9%**	**59 824.8**	**62 5667**	**62 5667**	**4.0%**	**93.3%**
Provinces and municipalities	52 462.2	56 251.5	52 743.4	56 357.9	2.4%	87.6%	57 696.1	60 351.0	63 375.7	4.0%	90.0%
Departmental agencies and accounts	1 842.1	1 889.1	1 806.6	1 794.4	-0.9%	2.9%	1 897.2	1 973.6	2 063.9	4.8%	2.9%
Foreign governments and international organisations	–	–	--	18.2	0.0%	0.0%	--	--	--	100%	0.0%
Non-profit institutions	181.4	189.0	196.3	222.2	7.0%	0.3%	231.4	242.1	253.0	4.4%	0.4%
Households	6.2	4.7	5.6	9.5	15.4%	0.0%	--	--	--	100%	0.0%
Payments for capital assets	**660.3**	**958.8**	**1 354.6**	**1 456.3**	**30.2%**	**1.8%**	**2 517.9**	**1 786.8**	**1 801.0**	**7.3%**	**2.9%**
Buildings and other fixed structures	591.3	930.3	1 259.8	1 333.4	31.1%	1.7%	2 355.6	1 623.4	1 630.2	6.9%	2.6%
Machinery and equipment	69.0	28.6	94.8	122.9	21.2%	0.1%	162.4	163.4	170.8	11.6%	0.2%
Payments for financial assets	**8.4**	**1.3**	**0.9**	**–**	**-100%**	**0.0%**	**–**	**–**	**–**	**0.0%**	**0.0%**
Total	**65 137.4**	**62 896.0**	**58 312.1**	**62 225.4**	**-1.5%**	**100.0%**	**64 807.2**	**66 927.7**	**70 183.1**	**4.1%**	**100.0%**

1. Tables with expenditure trends, annual budget, adjusted appropriation and audited outcome are available at www.treasury.gov.za and www.vulekamali.gov.za.

7.3.2 Transfers and subsidies expenditure trends and estimates

Table 5. Vote transfers and subsidies trends and estimates

Vote transfers and subsidies trends and estimates

R thousand	Audited outcome 2021/22	Audited outcome 2022/23	Audited outcome 2023/24	Adjusted appropriation 2024/25	Average growth rate (%) 2021/22 - 2024/25	Average: Expenditure/ Total (%) 2021/22 - 2024/25	Medium-term expenditure estimate 2025/26	Medium-term expenditure estimate 2026/27	Medium-term expenditure estimate 2027/28	Average growth rate (%) 2024/25 - 2027/28	Average: Expenditure/ Total (%) 2024/25 - 2027/28
Households											
Social benefits											
Current	6 181	4 527	5 247	--	-100%	--	--	--	--	--	--
Employee social benefits	6 181	4 527	5 247	--	-100%	--	--	--	--	--	--
Other transfers to households											
Current	--	149	345		--	--	--	--	--	-100%	--
Employee socila benefits	--	149	3	--	--	--	--	--	--	--	--
No-fault Compensation Scheme	--	--	342	9 500	--	--	--	--	--	-100%	--
Departmental agencies and accounts											
Departmental agencies (non-business entities											
Current	1 840 663	1 887 532	1 804 817	1 792 610	-0.9%	3.2%	1 895 341	1 971 620	2 061 804	4.8%	3.1%
Health and Welfare Sector Education and Training Authority	2 536	2 362	2 055	2 667	1.7%	--	2 786	2 914	3 046	4.5%	--
South African National AIDS Council	28 901	19 380	30 234	--	-100%	--	--	--	--	--	--
National Health Laboratory Services	643 547	772 521	706 425	598 842	-2.4%	1.2%	636 361	668 789	700 345	5.4%	1.1%
Office of Health Standards Compliance	157 997	157 509	161 546	181 599	4.8%	0.3%	191 749	200 076	209 079	4.8%	0.3%
South African Medical Research Council	855 214	779 523	760 147	833 489	-0.9%	1.4%	880 829	910725	979 148	5.5%	1.5%
Council for Medical Schemes	6 181	6 272	6 537	6 151	-0.2%	--	6 320	6 615	6 913	4.0%	--
South African Health Products Regulatory Authority	146 287	149 965	137 873	143 518	-0.6%	0.3%	149 301	156 242	163 273	4.4%	0.2%
South African Medical Research Council: Social Impact Bond	--	--	--	26 344	--	--	27 995	26 259	--	-100%	--
Social security funds											
Current	1 437	1 544	1 735	1 813	8.1%	--	1 894	1 981	2 070	4.5%	--
Mines and Works Compesation Fund	1 437	1 544	1 735	1 813	8.1%	--	1 894	1 981	2 070	4.5%	--
Foreign governments and international organisations											
Current	--	--	--	18 200	--	--	--	--	--	-100%	--
World Health Organisation	--	--	--	18 200	--	--	--	--	--	-100%	--
Provinces and municipalities											
Provincial revenue funds											
Current	46 027 032	49 471 990	46 063 505	41 199 537	2.2%	84.4%	50 450 442	52 773 258	55 160 207	3.9%	84.2%
National health insurance grant	268 677	693 747	694 675	455 956	19.3%	0.9%	466 680	475 960	497 493	2.9%	0.8%
HIV, TB, malaria and community outreach grant: Mental health services component	143 401	--	--	--	-100%	0.1%	--	--	--	--	--
HIV, TB, malaria and community outreach grant: Oncology services component	234 933	--	--	--	-100%	0.1%	--	--	--	--	--
HIV, TB, malaria and community outreach grant: HIV and AIDS component	22 563 773	–	–	–	-100%	10%	–	–	–	–	–
HIV, TB, malaria and community outreach grant: Tubercolosis component	506 117	--	--	--	-100%	0.2%	--	--	--	--	--
HIV, TB, malaria and community outreach grant: COVID-19 component	1 500 000	--	--	--	-100%	0.7%	--	--	--	--	--
District health programmes grant: Comprehensive HIV and AIDS component	--	24 134 521	22 934 604	24 724 358	--	31.8%	24 927 389	26 073 123	27 252 342	3.3%	41.8%

Vote transfers and subsidies trends and estimates

R thousand	Audited outcome 2021/22	Audited outcome 2022/23	Audited outcome 2023/24	Adjusted appropriation 2024/25	Average growth rate (%) 2021/22 - 2024/25	Average: Expen-diture/ Total (%) 2021/22 - 2024/25	Medium-term expenditure estimate 2025/26	Medium-term expenditure estimate 2026/27	Medium-term expenditure estimate 2027/28	Average growth rate (%) 2024/25 - 2027/28	Average: Expen-diture/ Total (%) 2024/25 - 2027/28
District health programmes grant: District health component	--	4 888 597	2 931 257	3 238 337	--	4.9%	3 411 515	3 569 381	3 730 846	4.8%	5.7%
HIV, TB malaria and community outreach grant: Human papillo-mavirus vaccine component	220 258	--	--	--	-100%	0.1%	--	--	--	--	--
HIV, TB malaria and community outreach grant: Malaria elimination component	104 181	--	--	--	-100%	--	--	--	--	--	--
HIV, TB malaria and community outreach grant: Community outreach services component	2 480 213	--	--	--	-100%	1.1%	--	--	--	--	--
National tertiary services grant	13 707 798	14 306 059	14 023 946	15 263 7848	3.6%	25.4%	24 927 389	26 073 123	27 252 342	3.3%	26.6%
Human resources and training grant	4 297 681	5 449 066	5 479 023	5 517 102	8.7%	9.2%	5 649 937	5 911 257	6 178 678	3.8%	9.4%
Capital	6 435 188	6 779 546	6 679 860	7 158 341	3.6%	12.0%	7 245 705	7 577 788	8 215 468	4.7%	12.3%
Health facility revitalisation grant	6 435 188	6 779 546	6 679 860	7 158 341	3.6%	12.0%	7 245 705	7 577 788	8 215 468	4.7%	12.3%
Non-profit institutions											
Current	181 401	189 000	196 286	222 174	7.0%	12.0%	231 385	242 069	253 011	4.4%	0.4%
Non-governmental organisation: LifeLine	28 030	28 875	28 986	27 288	-0.9%	0.1%	27 283	28 599	29 937	3.1%	--
Non-governmental organisation: loveLine	61 976	64 327	64 635	63 038	0.6%	0.1%	62 821	65 402	68 978	3.0%	0.1%
Non-governmental organisation: Soul City	24 331	25 065	25 262	24 291	-0.1%	--	24 361	25 535	26 735	3.2%	--
Non-governmental organisation: HIV and AIDS	63 989	67 529	67 788	64 832	0.4%	0.1%	62 281	65 402	68 586	1.9%	0.1%
South African Registry	447	460	461	482	2.5%	--	504	527	551	4.6%	--
South African Federation for Mental Health	473	488	490	512	2.7%	--	535	560	585	4.5%	--
South African National Council for the Blind	1 060	1 092	1 096	1 145	2.6%	--	1 196	1 251	1 308	4.5%	--
South African National AIDS Council	--	--	--	21 143	--	--	32 090	33 102	34 147	17.3%	--
National Council Against Smoking	1 095	1 164	1 169	1 221	3.7%	--	1 276	1 334	1 394	4.5%	--
Health Systems Research	--	--	6 500	18 222	--	--	19 038	19 895	20 790	4.5%	--
Total	**58 491 902**	**58 334 288**	**54 751 795**	**58 402 175**	**2.3%**	**100%**	**59 824 767**	**62 566 716**	**65 566 716**	**4.0%**	**100%**

1. Tables with expenditure trends, annual budget, adjusted appropriation and audited outcome are available at www.treasury.gov.za and www.vulekamali.gov.za.

PART C

MEASURING OUR *PERFORMANCE*

MEASURING OUR PERFORMANCE

Programme 1: Administration

Purpose:

To provide overall management of the Department and centralised support services. This programme consists of five sub-programmes: -

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

Financial Management ensure 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

Human Resources Management ensures that staff have the right skills and attitude, and equitably distributed.

Legal Resource Sub-programmeis responsible 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. This includes inter alia drafting, editing, and amending of legislation and regulations administered by the NDoH and contracts; provision of legal advice and management of litigation by and against the Department of Health.

Communications Sub-programme has two pillars, namely, Strategic Communication and Corporate Communication. Corporate Communication communicates and shares information on what is being done to manage the quadruple burden of diseases and internal communication within the NDoH. The purpose of strategic communication is to actively shape public opinion by influencing news media agenda and this pillar is led mainly by the Ministry of Health.

Programme 1: Outcomes, outputs, performance indicators and targets

Programme 1: Outcomes, outputs, performance indicators and targets														
	Outcome	Output	Output Indicator	Audited Performance			Estimated Performance	MTEF Targets						
								Annual Target 2025/26	Quarterly Targets				2026/2027	2027/2028
				2021/22	2022/23	2023/24	2024/25		Q1	Q2	Q3	Q4		
1.	Financial Management Strengthened in the health Sector	Audit outcome of National DoH	Audit outcome of National DoH	Unqualified audit opinion for 2020/21 FY received	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	Not Applicable	Not Applicable	Un-qualified Audit opinion for 2024/2025	Not Applicable	Un-qualified audit opinion	Unqualified audit opinion
2.	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	New Indicator	516 invoices out of 5144 (10%) were paid after 30 days of receiving from suppliers	0 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	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	100% invoices paid within 30 days of receiving valid invoices from suppliers	100% invoices paid within 30 days of receiving valid invoices from suppliers
3.	Reduced burden of disease	Health Promotion messages placed on integrated public communication platforms	Number of Health Promotion messages broadcasted on integrated platforms	443 health promotion messages broadcasted on integrated platforms	399 health promotion messages on NDOH social media placed	738 health promotion messages published on social media placed	200 health promotion messages on NDOH integrated platforms	800 health messages on NDOH integrated platforms	200	200	200	200	800 health messages on NDOH integrated platforms	800 health messages on NDOH integrated platforms
4.	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	New Indicator	46% of Women employed at SMS level in NDOH	45% 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	Not Applicable	Not Applicable	Not Applicable	50%	50% of Women employed at SMS level in NDOH	50% of Women employed at SMS level in NDOH
5.	Employment in line with equity targets	Employment of Youth in line with equity targets	Percentage of youth employed according to the equity targets	New Indicator	13% Youth appointed at NDOH according to the equity targets	5% Youth employed in NDOH	7.2% Youth employed in NDOH	10% of Youth employed in NDOH	Not Applicable	Not Applicable	Not Applicable	10%	15%	20%

	Programme 1: Outcomes, outputs, performance indicators and targets													
	Outcome	Output	Output Indicator	Audited Performance			Estimated Performance	MTEF Targets						
								Annual Target 2025/26	Quarterly Targets				2026/2027	2027/2028
				2021/22	2022/23	2023/24	2024/25		Q1	Q2	Q3	Q4		
6.	Employment in line with equity targets	Employment of People with disabilities according to the equity targets	Percentage of people with disabilities employed according to the equity targets	New Indicator	0.4% of People with disabilities appointed at NDOH accodingly 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	Not Applicable	Not Applicable	Not Applicable	2.5%	5% of People with disabilities employed in NDOH	7% of People with disabilities employed in NDOH
7.	Improved access to safe and quality healthcare	Policy Frame work for security and safety in health facilities	Policy Frame work for security and safety in health facilities developed	New Indicator	New Indicator	New Indicator	New Indicator	Draft Policy Framework for security and safety in health facilities finalised	Review of current NDOH Policy to inform inclusion of health facilities	Stakeholder consultation	Stakeholder consultation	Draft Policy Framework finalised	Policy Framework approved by National Health Council	Policy Framework implemented

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 for goods and services being rendered. There has been significant improvement in adherence to timeous payment of service providers and interventions will be sustained to ensure full compliance with this statutory requirement. The outlook on continued budget cuts requires mechanisms to leverage resources and improve efficiency, which will be explored with key stakeholders. The department will intensify public communication through various platforms for health promotion and awreness campaigns targeted at disease outbreaks to educate the public on safety measures. As part of redress, participation of vulnerable groups in key sectors of the society will be promoted by improving proportions of Women, Youth and People living with disabilities employed in the department.

Programme 1: Budget Allocations

Expenditure trends and estimates

Table 6. Administration expenditure trends and estimates by subprogramme and economic classification

Subprogramme	Audited outcome			Adjusted appropriation	Average growth rate (%)	Average: Expen-diture/ Total (%)	Medium-term expenditure estimate			Average growth rate (%)	Average: Expen-diture/ Total (%)
R million	2021/22	2022/23	2023/24	2024/25	2021/22 - 2024/25		2025/26	2026/27	2027/28	2024/25 - 2027/28	
Ministry	33.0	38.8	41.8	36.0	3.0%	5.4%	38.3	40.1	41.9	5.2%	4.8%
Management	7.2	6.2	14.8	11.4	16.8%	1.4%	12.0	12.5	13.1	4.7%	1.5%
Corporate Services	356.2	398.1	381.6	392.0	3.2%	55.4%	386.8	403.4	422.5	2.5%	49.4%
Property Management	172.9	114.2	141.7	170.4	-0.5%	21.7%	178.5	186.1	194.5	4.5%	22.5%
Financial Management	103.4	88.1	98.3	153.2	14.0%	16.1%	159.0	192.6	202.1	9.7%	21.8%
Total	**672.7**	**645.3**	**678.2**	**763.0**	**4.3%**	**100%**	**774.5**	**834.7**	**874.0**	**4.6%**	**100%**
Change to 2024 Budget estimate[1]							1 110.9	530.2	579.0		
Economic classification											
Current payments	**653.6**	**628.9**	**660.9**	**730.3**	**3.8%**	**7.3%**	**761.3**	**820.9**	**859.5**	**5.6%**	**97.7%**
Compensation of employees	246.2	235.2	266.1	255.8	1.3%	36.4%	267.5	279.8	292.5	4.6%	33.8%
Goods and services[1]	407.4	393.6	394.8	474.5	5.2%	60.5%	493.8	541.0	567.1	6.1%	64.0%
of which:											
Consultants: Business and advisory services	42.7	55.4	7.8	39.5	-2.6%	5.3%	44.5	71.0	74.4	23.5%	7.1%
Contractors	10.8	7.3	7.5	21.1	25.0%	1.7%	28.8	28.2	29.5	11.8%	3.3%
Operating leases	150.9	99.6	110.6	126.1	-5.8%	17.7%	132.2	137.8	144.0	4.5%	16.6%
Property payments	24.2	17.7	34.7	58.8	34.5%	4.9%	61.4	64.2	67.1	4.5%	7.7%
Travel and subsistence	27.8	58.1	34.2	44.9	17.4%	6.0%	50.9	55.8	58.6	9.3%	6.5%
Operating payments	26.8	2.3	30.1	36.5	10.8%	3.5%	23.4	32.9	34.3	-2.0%	3.9%
Transfers and subsidies[1]	**4.9**	**3.7**	**3.3**	**20.9**	**82.6%**	**1.2%**	**2.8**	**2.9**	**3.0**	**-47.3%**	**0.9%**
Departmental agencies and accounts	2.5	2.4	2.1	2.7	1.7%	0.3%	2.8	2.9	3.0	4.5%	0.4%
Foreign governments and international organisations	–	–	--	18.2	--	0.7%	--	--	--	-100.0%	0.6%
Households	2.3	1.3	1.3	--	-100.0%	0.2%	--	--	--	--	--
Payments for capital assets	**7.8**	**12.5**	**13.7**	**11.9**	**14.9%**	**1.7%**	**10.5**	**10.9**	**11.4**	**-1.3%**	**1.4%**
Machinery and equipment	7.8	12.5	13.7	11.9	14.9%	1.7%	10.5	10.9	11.4	-1.3%	1.4%
Payments for financial assets	**6.5**	**0.3**	**0.3**	**–**	**-100.0%**	**0.3%**	**–**	**–**	**–**	**–**	**–**
Total	**672.7**	**645.3**	**678.2**	**763.0**	**4.3%**	**100.0%**	**774.5**	**834.7**	**874.0**	**4.6%**	**100.0%**
Proportion of total programme expenditure to vote expenditure	**1.0%**	**1.0%**	**1.2%**	**1.2%**	**--**	**–**	**1.2%**	**1.2%**	**1.2%**	**--**	**–**
Details of transfers and subsidies											
Households Social benefits											
Current	2.3	1.3	1.3	--	-100.0%	0.2%	--	--	--	--	--
Employee social benefits	2.3	1.3	1.3	--	-100.0%	0.2%	--	--	--	--	--
Departmental agencies and accounts											
Departmental agencies (non-business entities											
Current	2.5	2.4	2.1	2.7	1.7%	0.3%	2.8	2.9	3.0	-4.5%	0.4%
Health and Welfare Sector Education and Training Authority	2.5	2.4	2.1	2.7	1.7%	0.3%	2.8	2.9	3.0	4.5%	0.4%
Foreign governments and international organisations											
Current	--	--	--	18.2	--	0.7%	--	--	--	-100%	0.6%
Employee social benefits	--	--	--	18.2	--	0.7%	--	--	--	-100%	0.6%

Programme 1: Personnel Information

Table 7. Administration personnel numbers and cost by salary level[1]

	Number of posts estimated for 31 March 2025		Number and cost[2] of personnel posts filled/planned for on funded established												Average growth rate (%)	Average: Salary level/ Total (%)
	Number of funded posts	Number of posts additional to the establish-ment	Actual			Revised estimate			Medium-term expenditure estimate							
			2023/24			2023/24			2023/24			2023/24			2023/24			2024/25 - 2027/28	
Administration			Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost		
Salary level	**425**	**23**	**389**	**266.1**	**0.7**	**362**	**255.8**	**0.7**	**354**	**267.5**	**0.8**	**350**	**279.8**	**0.8**	**344**	**292.5**	**0.8**	**-1.7%**	**100.0%**
1 - 6	170	20	165	54.7	0.3	155	54.5	0.4	150	56.9	0.4	146	58.3	0.4	142	60.4	0.4	-2.9%	42.0%
7 - 10	155	--	142	97.2	0.7	137	98.3	0.7	138	105.4	0.8	137	110.7	0.8	136	116.1	0.9	-0.2%	38.9%
11 - 12	54	--	43	50.9	1.2	38	47.8	1.3	35	47.0	1.3	36	50.3	1.4	36	53.1	1.5	-1.8%	10.3%
13 - 16	44	3	37	58.0	1.6	30	49.5	1.6	29	52.3	1.8	29	54.2	1.9	28	56.3	2.0	-1.9%	8.3%
Other	2	--	2	5.3	2.7	2	5.6	2.8	2	5.9	3.0	2	6.2	3.1	2	6.6	3.3	--	0.6%

1. Data has been provided by the department and may not necessarily reconcile with official government personnel data.
2. 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.

There are two budget sub-programmes:

- Health Financing and National Health Insurance
- Affordable Medicines

Sub-programmes

- *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.
- *Affordable Medicine* is responsible for developing systems to ensure the sustained availability of and equitable access to pharmaceutical commodities. This is achieved through the development of the governance frameworks to support: the selection and use of essential medicines, the development of standard treatment guidelines, the administration and management of pharmaceutical tenders, the development of provincial pharmaceutical budgets, the reformation of the medicine supply chain, and the licensing of people and premises that deliver pharmaceutical services.
- *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 subprogramme 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.

Programme 2: Outcomes, outputs, performance indicators and targets

Programme 2: Outcomes, outputs, performance indicators and targets														
	Outcome	Output	Output Indicator	Audited Performance			Estimated Performance	MTEF Targets						
								Annual Target 2025/26	Quarterly Targets				2026/2027	2027/2028
				2021/22	2022/23	2023/24	2024/25		Q1	Q2	Q3	Q4		
1.	Improved access to equitable healthcare services	Ministerial Advisory Committee (MAC) on Health Care Benefits	Ministerial Advisory Committee (MAC) on Health Care Benefits for NHI established	New Indicator	New Indicator	New Indicator	New Indicator	Terms of Reference for MAC finalised and approved for publication	Not Applicable	Not Applicable	Not Applicable	Terms of Reference for MAC finalised and approved for publication	Call for nomination for members to serve in the MAC	MAC on Health Care Benefit Established
2.	Improved access to equitable healthcare services	Ministerial Advisory Committee on Health Technology Assessment	Ministerial Advisory Committee (MAC) on Health Technology Assessment for NHI established	New Indicator	New Indicator	New Indicator	New Indicator	Terms of Reference for MAC developed	Not Applicable	Not Applicable	Not Applicable	Terms of Reference for MAC developed	Call for nomination for members to serve in the MAC	MAC on Health Technology Assessment Established
3.	Improved access to equitable healthcare services	NHI Accreditation framework for provider accreditation (PHC level)	Accreditation framework for PHC providers developed	New Indicator	New Indicator	New Indicator	Accreditation framework for health service providers submitted to NHC for approval	NHI Accreditation framework finalised	Not Applicable	Not Applicable	Not Applicable	NHI Accreditation framework finalised	Implementation of the Accreditation framework in the CUPS	Expanded Implementation of the Accreditation framework in the CUPS
4.	Improved access to equitable healthcare services	Essential Equipment List	Essential Equipment List for Primary Health Care developed	New Indicator	New Indicator	New Indicator	Draft Essential Equipment List for health care service package developed	Approved Essential Equipment List for Primary Health Care	Not Applicable	Not Applicable	Not Applicable	Approved Essential Equipment List for PHC	Draft Essential Equipment List for Hospitals	Approved Essential Equipment List for Hospitals

	Programme 2: Outcomes, outputs, performance indicators and targets												
	Outcome	Output	Output Indicator	Audited Performance			Estimated Performance	MTEF Targets					
								Annual Target 2025/26	Quarterly Targets				2026/2027	2027/2028
				2021/22	2022/23	2023/24	2024/25		Q1	Q2	Q3	Q4		
5.	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	3 300 000 active patients	3 500 000 million active patients	3 350 000	3 400 000	3 450 000	3 500 000	3 900 000 active patients	4 100 000 active patients (as per MTDP)
6.	Integrated electronic health record	Developme nt of an integrated Electronic Health Records	Phased developme nt of Electronic Medical Record - (EMR) for Primary Health Care Services	New Indicator	New Indicator	New Indicator	Development of Electronic Medical Records (EMR) - Minimum Viable Product (MVP)1 focusingon TB HIV	EMR - Minimum Viable Product 2 (PHC package) Developed	Not Applicable	Not Applicable	Not Applicable	EMR - MVP 2 Develop ed	Electronic Medical Record - Minimum Viable Product 3 (PHC Package) developed	Electronic Medical Record - Minimum Viable Product 1 (Hospital Package) developed

Explanation of planned performance over the medium-term period

The intervention in the programme are key in facilitating the implementation of the National Health Insurance through establishment of the Ministerial Advisory Committees which will set up key functions of the NHI entity, i.e., health care benefits and health technology assessments. These delivarables 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 at this level is imperative for those who render this services to ensure that the requirements are in place. The accreditation framework which is aimed at outlining the processes and requirements for service providers to participate in the NHI, will be finalized for piloting in the Contracting Units of the PHC (CUPs), to ensure its feasibilityprior to implementation. The phased development of electronic medical record will progress to the second phase PHC which will ensure the completion of the PHC package to be implemented in 2026/2027 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. Budget Allocations
Expenditure trends and estimates

Table 8. National Health Insurance expenditure trends and estimates by subprogramme and economic classification

Subprogramme	Audited outcome			Adjusted appropriation	Average growth rate (%)	Average: Expen-diture/ Total (%)	Medium-term expenditure estimate			Average growth rate (%)	Average: Expen-diture/ Total (%)
R million	2021/22	2022/23	2023/24	2024/25	2021/22 - 2024/25		2025/26	2026/27	2027/28	2024/25 - 2027/28	
Programme Management	4.6	10.2	8.2	9.3	26.1%	0.6%	9.7	10.1	10.6	4.3%	0.7%
Affordable Medicine	37.3	46.4	40.9	37.4	0.1%	3.0%	39.7	41.6	43.5	5.2%	2.9%
Health Financing and National Health Insurance	1 174.5	1 309.5	1 375.9	1 296.5	3.3%	96.4%	1 351.8	1 365.4	1 427.8	3.3%	96.4%
Total	**672.7**	**645.3**	**678.2**	**763.0**	**4.3%**	**100%**	**774.5**	**834.7**	**874.0**	**4.6%**	**100%**
Change to 2024 Budget estimate[1]							1 110.9	530.2	579.0		
Economic classification											
Current payments	**553.6**	**628.9**	**705.9**	**853.2**	**15.5%**	**52.0%**	**877.6**	**888.0**	**928.9**	**2.9%**	**62.9%**
Compensation of employees	42.7	48.1	57.9	93.5	29.9%	4.5%	104.1	109.7	115.3	7.2%	7.5%
Goods and services[1]	511.0	619.8	648.0	759.7	14.1%	47.4%	773.5	778.3	813.5	2.3%	55.4%
of which:											
Advertising	0.1	1.5	0.1	20.4	618.6%	0.4%	21.3	22.3	23.3	4.5%	1.5%
Minor assets	0.9	3.1	6.4	11.5	132.8%	0.4%	12.1	12.6	13.2	4.5%	0.9%
Consultants: Business and advisory services	4.4	2.8	0.5	86.4	170.4%	1.8%	92.0	97.9	102.3	5.8%	6.7%
Contractors	382.4	518.5	386.3	576.5	14.8%	34.8%	579.8	574.1	600.1	1.3%	41.3%
Agency and support/ outsourced services	--	--	--	31.9	--	0.6%	33.3	34.8	36.4	4.5%	2.4%
Travel and subsistence	0.3	5.4	9.6	15.9	269.7%	0.6%	17.1	17.9	18.7	5.6%	1.2%
Transfers and subsidies[1]	**647.3**	**693.9**	**694.9**	**456.0**	**82.6%**	**-11.0%**	**466.7**	**476.0**	**497.5**	**2.9%**	**33.6%**
Provinces and municipalities	647.0	693.7	694.7	456.0	1.7%	-11.0%	466.7	4760	497.5	2.9%	33.6%
Households	0.3	0.2	0.2	--	--	-100.0%	--	--	--	--	--
Payments for capital assets	**15.5**	**4.3**	**24.4**	**34.0**	**29.8%**	**1.5%**	**56.9**	**53.1**	**55.5**	**17.7%**	**3.5%**
Machinery and equipment	15.5	4.3	24.4	34.0	29.8%	1.5%	56.9	53.1	55.5	17.7%	3.5%
Payments for financial assets	**--**	**--**	**0.0**	**–**	**--**	**--**	**–**	**–**	**–**	**–**	**–**
Total	**1 216.5**	**1 366.1**	**1 425.1**	**1 343.2**	**3.4%**	**100.0%**	**1 401.2**	**1 417.1**	**1 481.9**	**3.3%**	**100.0%**
Proportion of total programme expenditure to vote expenditure	**1.9%**	**2.2%**	**2.4%**	**2.2%**	**--**	**–**	**2.2%**	**2.1%**	**2.1%**	**--**	**–**
Details of transfers and subsidies											
Households Social benefits											
Current	0.3	0.2	0.2	--	-100.0%	--	--	--	--	--	--
Employee social benefits	0.3	0.2	0.2	--	-100.0%	--	--	--	--	--	--
Provinces and municipalities											
Provincial revenue funds											
Current	6470	693.7	694.7	456.0	-11.0%	46.6%	466.7	476.0	497.5	2.9%	33.6%
National health insurance grant	268.7	693.7	694.7	456.0	19.3%	39.5%	466.7	476.0	497/5	2.9%	33.6%
HIV, TB, malaria and comm-unity outreach grant: Mental health services component	143.4	--	--	--	-100.0%	2.7%	--	--	--	4.5%	--%
HIV, TB, malaria and comm-unity outreach grant: Oncology services component	234.9	--	--	--	-100.0%	4.4%	--	--	--	4.5%	--%

Programme 2. Personnel Information

Table 9. National Health Insurance personnel numbers and cost by salary level[1]

	Number of posts estimated for 31 March 2025		Number and cost[2] of personnel posts filled/planned for on funded established													Average growth rate (%)	Average: Salary level/ Total (%)
	Number of funded posts	Number of posts additional to the establish-ment	Actual			Revised estimate			Medium-term expenditure estimate								
			2023/24			2024/25			2025/26			2026/27			2027/28			2024/25 - 2027/28	
National Health Insurance			Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost		
Salary level	**110**	**15**	**76**	**57.9**	**0.8**	**114**	**93.5**	**0.8**	**120**	**104.1**	**0.0**	**120**	**115.3**	**1.0**	**120**	**109.7**	**1.0**	**-1.8%**	**100.0%**
1 - 6	11	1	11	3.6	0.3	13	4.5	0.3	13	4.8	0.4	13	5.4	0.4	13	5.1	0.4	--	11.0%
7 - 10	31	5	27	13.9	0.5	31	16.4	0.5	34	19.5	0.6	35	22.6	0.6	34	20.8	0.6	4.1%	28.2%
11 - 12	49	4	28	27.0	1.0	53	49.8	0.9	55	54.5	1.9	55	60.3	1.1	55	57.1	1.1	1.2%	46.0%
13 - 16	19	5	10	13.3	1.3	17	22.7	1.3	18	25.3	1.4	17	27.1	1.6	18	26.7	1.6	0.6%	14.8%

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

Programme 3: Communicable and Non-communicable Diseases

Purpose:

To develop and support the implementation of national policies, guidelines, norms and standards, and the achievement of targets for the national response needed to decrease morbidity and mortality associated with communicable and non-communicable diseases. Develop strategies and implement programmes that reduce maternal and child mortality.

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 organisations, 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 subprogramme 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 subprogramme is also responsible for the coordination and management of the national response to the TB epidemic, and incorporates strategies needed to prevent, diagnose and treat both drug-sensitive TB and drug-resistant TB.

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 subprogramme 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 subprogramme 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 immunisation, and ensuring that health services are friendly to children and young people.

Communicable Diseases develops policies and supports provinces in ensuring the control of infectious diseases with the support of the National Institute for Communicable Diseases, a division of the National Health Laboratory Service. It improves surveillance for disease detection; strengthens preparedness and core response capacity for public health emergencies in line with international health regulations; and facilitates the implementation of

influenza prevention and control programmes, tropical disease prevention and control programmes, and malaria elimination. This subprogramme comprises 2 components – communicable disease control, and malaria and other vector-borne 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, as well as for older people; eye health; palliative care; mental health and substance abuse; and forensic mental health. The department implements a continuum of care from for these diseases, from primary prevention, early identification and screening through to treatment and control at all levels of care, including palliative.

Health Promotion and Nutrition formulates and monitors policies, guidelines, norms and standards for health promotion and nutrition. Focusing on South Africa's quadruple burden of disease (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 3: Outcomes, outputs, performance indicators and targets

Programme 3: Outcomes, outputs, performance indicators and targets														
	Outcome	Output	Output Indicator	Audited Performance			Estimated Performance	MTEF Targets						
								Annual Target 2025/26	Quarterly Targets				2026/2027	2027/2028
				2021/22	2022/23	2023/24	2024/25		Q1	Q2	Q3	Q4		
1.	HIV and AIDS related deaths reduced	Patients enrolled on Differentiated Model of Care (DMOC)	Number of HIV Patients enrolled on Differentiated Model of Care (DMOC)	New Indicator	New Indicator	New Indicator	3 300 000 HIV Stable Clients decanted to DMOC	3 200 000 HIV Stable Clients decanted to DMOC	2 900 000	2 950 000	3 100 000	3 200 000	3 500 000 HIV Stable Clents decanted to DMOC	4 000 000
2.	HIV and AIDS related deaths reduced	People Living with HIV on ART	Percentage of people Living with HIV on ART	New Indicator	New Indicator	New Indicator	79%	95%	82%	86%	90%	95%	95%	95%
3.	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	94%	95%	94%	94%	95%	95%	95%	95%
4.	Improved access to youth health programme	PHC facilities with youth zones	Number of PHC facilities with youth zones	1264 PHC facilities with youth zones	1845 PHC facilities with youth zones	2101 PHC facilities with youth zones	2200 PHC facilities with youth zones	2300 PHC facilities with youth zones	2225	2250	2275	2300	2400 PHC facilities with youth zones	2500 PHC facilities with youth zones
5.	TB Mortality reduced	Improved TB Treatment adherence	Drug-susceptible TB (DS-TB) Treatment Success rate	New Indicator	78%	72%	83%	79%	77.5%	78.0%	76.5%	79%	81%	83%
6.	TB Mortality reduced	Find and Treat people with TB disease	Number of people started on TB treatment	New Indicator	189 790	180 421	221 941	180 000	45 000	45 000	45 000	45 000	160 000	150 000
7.	Improved maternal and child health	Maternal mortality ratio reduced	Maternal Mortality in facility ratio (iMMR)	New Indicator	New Indicator	New Indicator	107.6 maternal deaths per 100,000 live births	< 100 maternal deaths per 100,000 live births	<105 maternal deaths per 100,000 live births	<105 maternal deaths per 100,000 live births	< 100 maternal deaths per 100,000 live births	< 100 maternal deaths per 100,000 live births	< 95 per 100,000 live births	< 90 per 100,000 live births

	Programme 3: Outcomes, outputs, performance indicators and targets													
	Outcome	Output	Output Indicator	Audited Performance			Estimated Performance	MTEF Targets						
								Annual Target 2025/26	Quarterly Targets				2026/2027	2027/2028
				2021/22	2022/23	2023/24	2024/25		Q1	Q2	Q3	Q4		
8.	Improved maternal and child health	Neonatal deaths reduced	Neonatal deaths in facility rate	New Indicator	New Indicator	New Indicator	12.9	12.7	12.9	12.8	12.7	12.7	12.5	12.3
9.	Improved maternal and child health	Improved surveillance for Vaccine-Preventable diseases (polio)	Non-polio Acute Flaccid Paralysis (NPAFP) detection rate in children < 15 years of age	New Indicator	New Indicator	8 Districts with a non-polio Acute Flaccid Paralysis (NPAFP) detection rate of more than 4 per 100 000 amongst children < 15 years of age	45 Districts with a non-polio Acute Flaccid Paralysis (NPAFP) detection rate of more than 4 per 100.000 amongst children < 15 years of age	Non-polio Acute Flaccid Pralysis (NPAFP) rate ≥ 2 (2 or more) per 100.000 children < 15 years of age	Not Applicable	Not Applicable	Not Applicable	Non-polio Acute Flaccid Paralysis (NPAFP) rate ≥ 2 per 100,000 children < 15 years of age	≥ 2.25 cases per 100,000 children under 15 years of age	≥ 2.25 cases per 100,000 children under 15 years of age
10.	Mortality due to Cervical Cancer Reduced	Districts performing HPV Screening for cervical cancer	Number of Districts performing HPV screeing for cervical cancer	New Indicator	New Indicator	0 Districts	18 Districts	40 Districts performing HPV screening for cervical cancer	23	28	34	40	52	Not Applicable
11.	Mortality due to Cervical Cancer Reduced	Primary prev-ention of HPV infection through vaccination	Number of girls aged 9-15 years vaccinated against HPV (1st dose)	New Indicator	New Indicator	New Indicator	405 299 (Baseline)	450 000	0	50 000	0	400 000	475 000	500 000
12.	Mortality due to Cervical Cancer Reduced	Early identification of women at risk of developing cancer of the cervix	Number of Cervical Cancer screening tests performed	New Indicator	New Indicator	New Indicator	808 429 (Baseline)	900 000	200 000	200 000	250 000	250 000	950 000	1 000 000

	Programme 3: Outcomes, outputs, performance indicators and targets													
	Outcome	Output	Output Indicator	Audited Performance			Estimated Performance	MTEF Targets						
								Annual Target 2025/26	Quarterly Targets				2026/2027	2027/2028
				2021/22	2022/23	2023/24	2024/25		Q1	Q2	Q3	Q4		
13.	Improved access to school health programme	Grade R learners screened	Number of Grade R learners screened	New Indicator	New Indicator	New Indicator	115 097 School Grade R learners screened	160 000 School Grade R learners screened	Not Applicable	Not Applicable	Not Applicable	160 000	170 000	180 000
14.	Malaria related deaths reduced	Malaria endemic sub-districts implementing the foci clearing programme	Number of sub-districts implementing the foci clearing programme	2 targeted sub-districts reporting zero local malaria cases	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	Not Applicable	Not Applicable	Not Applicable	14	18	22
15.	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	NSP for NCDs approved by NHC	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	16 709 215 screening conducted for elevated blood glucose	31 000 000 screenings conducted for elevated blood glucose	Not Applicable	Not Applicable	Not Applicable	31 000 000	33 000 000	35 000 000
16.	Reduced burden of disease	Screening for elevated blood pressure for prevention and early detection	Number of screening conducted to detect elevated blood pressure 18 years and older	NSP for NCDs approved by NHC	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	10 161 506 screening conducted for elevated blood pressure	32 000 000 screenings conducted for elevated blood pressure	Not Applicable	Not Applicable	Not Applicabe	32 000 000	34 000 000	36 000 000
17.	Mental health care integrated in Primary Health Care	Strengthening resourcing and functionality of Mental Health Review Boards	Roadmap on strengthening resourcing and functionality of Mental Health Review Boards developed	New Indicator	New Indicator	New Indicator	New Indicator	Roadmap on strengthening resourcing and functionality of Mental Health Review Borads developed	National Mental Health Care Review Boards Consultative Forum	Recommendations Report from the National Consultative Forum	Draft 1 of Roadmap developed	Final Draft Roadmap submitted for approval	Implementation of Roadmap in provinces	Monitoring implementation of Roadmap in provinces
18.	Mental health care integrated in Primary Health Care	Mental health care providers appointed in Primary Health Care increased	Percentage of Community Health Centers (CHCs) with at least one mental health care providers appointed	New Indicator	New Indicator	New Indicator	New Indicator	50% of CHCs with at least one mental health care providers appointed	45% of CHCs with at least one mental health care providers appointed	45% of CHCs with at least one mental health care providers appointed	50% of CHCs with at least one mental health care providers appointed	50% of CHCs with at least one mental health care providers appointed	60% of CHCs with at least one mental health care providers appointed	70% of CHCs with at least one mental health care providers appointed

Programme 3: Outcomes, outputs, performance indicators and targets														
	Outcome	Output	Output Indicator	Audited Performance			Estimated Performance	MTEF Targets						
								Annual Target 2025/26	Quarterly Targets				2026/2027	2027/2028
				2021/22	2022/23	2023/24	2024/25		Q1	Q2	Q3	Q4		
19.	Improved access to safe and quality Health Care	Hospitals meet the requirement of the food service policy	Number of hospitals assessed for compliance with the food service policy	100 hospitals obtain 75% and above on the food service policy assessment tool	Additional 84 hospitals including 2 Tertiary Hospitals obtain 75% and above on the food service policy assessment tool	297 hospitals (Addition al 96) obtain 75% and above on the food service policy assessmen t tool	351 hospitals (Additional 70) obtain 75% and above on the food service policy assessment tool	391 hospitals assessed for compliance with the food service policy	80	200	320	391	391 hospitals assessed for compliance with the food service policy	391 hospitals assessed for compliance with the food service policy

Explanation of planned performance over the medium-term period

The programme 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 endeavour to test more patients in order for those with TB to be initiated on treatment and minimize the risk of cross-infections in communities to significantly reduce new TB incidences. The sector will address the demand for mental health care services through improved integration in primary healthcare with the focus on appointing mental health care 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, diabetes and cervical cancer will be facilitated through continuous screening for patients which will be complemented by health promotions interventions for communities to be empowered to make better choices. 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). Non-polio Acute Flaccid Paralysis (NPAFP)detection ously. Furthermore, in collaboration with the Education sector, the department will increase the number of Grade R school learners who undergo health screening for early detection of hearing, visual, oral and other development challenges to facilitate appropriate care and referral where required.

Programme 3. Budget Allocations

Expenditure trends and estimates

Table 10. Communicable and Non-communicable Diseases expenditure trends and estimates by subprogramme and economic classification

Subprogramme	Audited outcome			Adjusted appropriation	Average growth rate (%)	Average: Expen-diture/ Total (%)	Medium-term expenditure estimate			Average growth rate (%)	Average: Expen-diture/ Total (%)
R million	2021/22	2022/23	2023/24	2024/25	2021/22 - 2024/25		2025/26	2026/27	2027/28	2024/25 - 2027/28	
Programme Management	2.9	1.4	3.1	8.2	41.2%	--	8.1	8.5	8.9	3.0%	--
HIV, AIDS and STIs	24 932.1	24 505.6	23 342.0	25 127.9	0.3%	90.7%	25 339.1	26 510.3	27 705.2	3.3%	99.0%
Tubercolosis Management	16.7	24.2	28.8	24.8	14.1%	0.1%	26.7	27.9	29.2	5.5%	0.1%
Women's Maternal and Reproductive Health	10.6	12.8	14.0	18.1	19.7%	0.1%	19.6	20.5	21.4	5.6%	0.1%
Child, Youth and School Health	22.6	21.9	24.9	27.4	6.7%	0.1%	29.0	30.4	31.8	5.0%	0.1%
Communicable Diseases	7 778.5	1 378.7	147.2	61.6	-80.1%	8.7%	54.6	57.1	59.7	-1.1%	0.2%
Non-communicable Diseases	28.7	57.0	68.0	83.0	42.4%	0.2%	89.5	93.7	97.9	5.7%	0.3%
Health Promotion and Nutrition	27.6	30.0	31.1	32.5	5.5%	0.1%	34.2	35.7	37.4	4.8%	0.1%
Total	**32 819.7**	**26 049.6**	**23 659.1**		**-8.2%**	**100%**	**25 600.7**	**26 784.0**	**27 991.4**	**3.3%**	**100.0%**
Change to 2024 Budget estimate[1]							75.6	87.6	87.8		
Economic classification											
Current payments	**8 036.6**	**1 704.0**	**500.0**	**444.0**	**-61.9%**	**9.9%**	**459.4**	**487.1**	**505.1**	**4.4%**	**1.8%**
Compensation of employees	127.4	120.5	3.1	8.2	3.6%	0.5%	149.8	156.7	163.8	4.9%	0.6%
Goods and services[1]	7 909.2	1 583.5	378.9	302.1	-66.3%	9.4%	309.6	330.4	341.3	4.2%	1.2%
of which:											
Consultants: Business and advisory services	58.2	62.8	35.9	37.4	-13.7%	0.2%	37.3	40.0	41.2	3.2%	0.1%
Agency and support/ outsourced services	0.1	5.2	11.3	17.8	421.9%	--	19.2	20.1	21.0	5.7%	0.1%
Inventory: Medical supplies	38.0	33.9	33.9	71.9	23.6%	0.2%	69.4	78.0	78.2	2.8%	0.3%
Inventory: Medicine	7 588.6	1 310.9	1.5	38.9	-82.8%	8.3%	41.2	43.0	45.0	5.0%	0.2%
Travel and subsistence	8.9	19.9	30.4	37.3	61.0%	0.1%	38.9	40.7	42.6	4.5%	0.2%
Operating payments	157.7	97.6	127.8	57.2			59.8	62.5	65.4		
Transfers and subsidies[1]	**24 781.3**	**24 343.9**	**23 156.0**	**24 937.8**	**0.2%**	**90.1%**	**25 139.7**	**26 295.3**	**27 484.6**	**3.3%**	**98.2%**
Provinces and municipalities	24 569.9	24 134.5	22 934.6	24 724.4	0.2%	89.3%	24 927.4	26 073.1	27 252.3	3.3%	97.4%
Departmental agencies and accounts	28.9	19.4	30.2	--	-100.0%	0.1%	--	--	--	--	--
Non-profit institutions	1 81.4	189.0	289.8	204.0	4.0%	0.7%	21.3	222.2	232.2	4.4%	0.8%
Households	1.1	1.0	1.4	9.5	106.5%	--	--	--	--	-100.0%	--
Payments for capital assets	**--**	**1.6**	**2.8**	**1.8**	**--**	**--**	**1.6**	**1.7**	**1.8**	**-1.1%**	**--**
Machinery and equipment	--	1.6	2.8	1.8	--	--	56.9	1.7	1.8	-1.1%	--
Payments for financial assets	**1.9**	**0.1**	**0.2**	**–**	**-100.0%**	**--**	**–**	**–**	**–**	**–**	**–**
Total	**32 819.7**	**26 049.6**	**23 659.1**	**25 383.6**	**-8.2%**	**100.0%**	**25 600.7**	**26 784.0**	**27 991.4**	**3.3%**	**100.0%**
Proportion of total programme expenditure to vote expenditure	**50.4%**	**41.4%**	**40.6%**	**40.8%**	**--**	**–**	**39.5%**	**40.0%**	**39.9%**	**--**	**–**
Details of transfers and subsidies											
Households Social benefits											
Current	1.1	0.9	1.1	--	-100.0%	--	--	--	--	--	--
Employee social benefits	1.1	0.9	1.1	--	-100.0%	--	--	--	--	--	--
Other transfers to households											
Current	--	0.1	0.3	9.5	--	--	--	--	--	-100.0%	--
Employee social benefits	--	0.1	0.3	--	--	--	--	--	--	--	--
No-fault Compenasation Scheme	--	--	0.3	9.5	--	--	--	--	--	-100.0%	--
Departmental agencies and accounts											
Departmental agencies (non-business entities)											
Current	28.9	19.4	30.2	--	-100.0%	0.1%	--	--	--	--	--
South African National AIDS Council	28.9	19.4	30.2	--	-100.0%	0.1%	--	--	--	--	--

Subprogramme	Audited outcome			Adjusted appropriation	Average growth rate (%)	Average: Expen-diture/ Total (%)	Medium-term expenditure estimate			Average growth rate (%)	Average: Expen-diture/ Total (%)
R million	2021/22	2022/23	2023/24	2024/25	2021/22 - 2024/25		2025/26	2026/27	2027/28	2024/25 - 2027/28	
Provinces and municipalities											
Provincial revenue funds											
Current	24 569.9	24 134.5	22 934.6	24 724.4	0.2%	89.3%%	24 927.4	26 073.1	27 252.3	3.3%	97.4%
HIV, TB, malaria and community outreach grant: HIV and AIDS component	22 563.8	--	--	--	-100.0%	20.9%%	--	--	--	--	--
HIV, TB, malaria and community outreach grant: Tubercolosis component	506.1	--	--	--	-100.0%	0.5%	--	--	--	--	--
HIV, TB, malaria and community outreach grant: COVID-19 component	1 500.0	--	--	--	-100.0%	1.4%	--	--	--	--	--
District health programmes grant: Comprehensive HIV and AIDS component	--	24 134.5	22 934.6	24 724.4	--	66.5%	24 927.4	26 073.1	27 252.3	3.3%	97.4%
Non-profit institutions											
Current	181.4	189.0	189.8	204.0	4.0%	0.7%	212.3	222.2	232.2	4.4%	0.8%
Non-governmental organisations: LifeLine	28.0	28.9	29.0	27.3	-0.9%	0.1%	27.3	28.6	29.9	3.1%	0.1%
Non-governmental organisations: loveLine	62.0	64.3	64.6	63.0	0.6%	0.2%	62.8	65.6	69.0	3.0%	0.2%
Non-governmental organisations: Soul City	24.3	25.1	25.2	24.3	-0.1%	0.1%	24.4	25.5	26.7	3.2%	0.1%
Non-governmental organisations: HIV and AIDS	64.0	67.5	67.8	64.8	0.4%	0.2%	62.3	65.4	68.6	1.9%	0.2%
South African Renal Registry	0.4	0.5	0.5	0.5	2.5%	--	0.5	0.5	0.6	4.6%	--
South African Federation for Mental Health	0.5	0.5	0.5	0.5	2.7%	--	0.5	0.6	0.6	4.5%	--
South African National Council for the Blind	1.1	1.1	1.1	1.1	2.6%	--	1.2	1.3	1.3	4.5%	--
South African National AIDS Council	--	--	--	21.1	--	--	32.1	33.1	34.1	17.3%	0.1%
National Council Against Smoking	1.1	1.2	1.2	1.2	3.7%	--	1.3	1.3	1.4	4.5%	--

Programme 3. Personnel Information

Table 11. Communicable and Non-communicable Diseases personnel numbers and cost by salary level[1]

	Number of posts estimated for 31 March 2025		Number and cost[2] of personnel posts filled/planned for on funded established												Average growth rate (%)	Average: Salary level/ Total (%)
	Number of funded posts	Number of posts additional to the establish-ment	Actual			Revised estimate			Medium-term expenditure estimate							
			2023/24			2024/25			2025/26			2026/27			2027/28			2024/25 - 2027/28	
Communicable and Non-communicable Diseases			Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost	Number	Cost	Unit cost		
Salary level	**177**	**1**	**151**	**121.1**	**0.8**	**162**	**141.8**	**0.9**	**160**	**149.8**	**0.9**	**160**	**149.8**	**1.0**	**158**	**163.8**	**1.0**	**-1.8%**	**100.0%**
1 - 6	22	1	22	7.9	0.4	22	8.4	0.4	21	8.5	0.4	21	9.0	0.4	21	9.4	0.4	-1.5%	13.3%
7 - 10	87	--	80	56.1	0.7	81	59.9	0.7	79	62.3	0.8	79	65.8	0.8	78	68.5	0.9	-1.1%	49.7%
11 - 12	45	--	34	38.5	1.1	39	46.5	1.2	41	51.3	1.3	41	56.5	1.3	42	58.9	1.4	2.9%	25.8%
13 - 16	23	--	15	18.6	1.2	20	27.0	1.3	19	27.6	1.5	19	25.4	1.6	16	26.9	1.6	-6.4%	11.2%

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

Programme 4: Primary Health Care

Develop and oversee implementation of legislation, policies, systems, and norms and standards for a uniform, well-functioning district health system, including for emergency, environmental and port health services

There are three budget sub-programmes:

- District Health Services
- Environmental and Port Health Services
- Emergency Medical Services and Trauma

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 subprogramme is responsible for managing the district health component of the district health programmes grant.

Environmental and Port Health Services coordinates the delivery of environmental health services, including the monitoring and delivery of municipal health services; and ensures compliance with international health regulations by coordinating port health services at all of South Africa's points of entry. This subprogramme provides oversight and support through policy development, support and implementation monitoring for district and metropolitan municipalities to deliver municipal health services.

Emergency Medical Services and Trauma is responsible for improving the governance, management and functioning of emergency medical services in South Africa by formulating policies, guidelines, norms and standards; strengthening the capacity and skills of emergency medical services personnel; identifying needs and service gaps; and providing oversight to emergency medical services in provinces.

Programme 4: Outcomes, outputs, performance indicators and targets

Programme 4: Outcomes, outputs, performance indicators and targets														
	Outcome	Output	Output Indicator	Audited Performance			Estimated Performance	MTEF Targets						
								Annual Target 2025/26	Quarterly Targets				2026/2027	2027/2028
				2021/22	2022/23	2023/24	2024/25		Q1	Q2	Q3	Q4		
1.	Improved access to safe and quality healthcare	PHC facilities that qualify as ideal clinics	Number of PHC facilities that qualify as ideal clinics	1928 PHC facilities qualify as ideal clinics	2046 PHC facilities qualify as ideal clinics	2706 PHC facilities qualify as ideal clinics	2700 PHC facilities qualify as ideal clinics	2600 PHC facilities that qualify as ideal clinic	Not Applicable	Not Applicable	Not Applicable	2600	2 900 PHC facilities that qualify as ideal clinic	3 000 PHC facilities that qualify as ideal clinic
2.	Improved responsive ness to Community needs	Community outreach services to households	Number of community outreach services to households' visits	New Indicator	New Indicator	19 549 643	14 000 000	15 000 000	Not Applicable	Not Applicable	Not Applicable	15 000 000	15 000 000	15 000 000
3.	Improved responsive ness to Community needs	Facilitate compliance of municipali ties to national environme ntal health norms and standards	Number of municipali ties assessed for compliance to National environme ntal health norms and standards	12 municipa lities (Districts and Metros) assessed for compliance to National environm ental health norms and standards	28 municipa lities (Districts and Metros) assessed for compliance to National environmen tal health norms and standards	26 municipa lities (Districts and Metros) assessed for compliance to National environmen tal health norms and standards	10 municipalities (Districts and Metros) assessed for compliance to National environmental health norms and standards	17 municipa lities (Districts and Metros) assessed for compliance to National environmental health norms and standards	2	5	5	5	17	17
4.	Improved responsi veness to Commun ity needs	National database of Emergency Medical Services resources	National database of Emergency Medical Services resources developed	New Indicator	New Indicator	New Indicatorl	New Indicator	National Database of Emergency Medical Services resources developed	Not Applicable	Not Applicable	Not Applicable	National Database of Emergency Medical Services resources developed	Pilot database on EMS Resources	National implementa tion of EMS Database

Explanation of planned performance over the medium-term period

Community based services will be carried out with an estimated 15 000 000 visits to households ensuring a coordinated and functional community outreach through Community Health Workers (CHWs). Environmental health service rendered through the municipalities will be monitored through structured assessments to facilitate compliance with environmental health 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 endemic sub-districts as it this has shown desired results in the reduction of malaria cases and deaths. Quality improvement will continuously be facilitate through the ideal clinic programme, to promote safety and provision of quality health care in all primary health care facilities. Additionally, the programme is key in preparing facilities to comply with the requirements of the Office of Health Standards Compliance for certification as part of NHI implementation.

Programme 4. Budget Allocations

Expenditure trends and estimates

Table 12. Primary Health Care expenditure trends and estimates by subprogramme and economic classification

Subprogramme	Audited outcome			Adjusted appropriation	Average growth rate (%)	Average: Expen-diture/ Total (%)	Medium-term expenditure estimate			Average growth rate (%)	Average: Expen-diture/ Total (%)
R million	2021/22	2022/23	2023/24	2024/25	2021/22 - 2024/25		2025/26	2026/27	2027/28	2024/25 - 2027/28	
Programme Management	4.0	4.5	3.9	6.8	19.4%	0.1%	7.1	7.5	7.8	4.5%	0.2%
District Health Services	2 819.1	4 906.4	2 947.6	3 258.3	4.9%	96.0%	3 430.7	3 589.5	3 752.0	4.8%	98.2%
Environmental and Port Health Services	226.4	229.3	17.0	44.1	-42.0%	3.6%	47.5	49.6	51.7	5.4%	1.4%
Emergency Medical Services and Trauma	6.7	9.1	11.3	9.1	10.7%	0.2%	8.9	9.3	9.7	2.0%	0.3%
Total	**3 056.2**	**5 149.2**	**2 989.8**	**3 318.4**	**2.8%**	**100.0%**	**3 494.2**	**3 655.8**	**3 821.2**	**4.8%**	**100.0%**
Change to 2024 Budget estimate[1]				--			28.1	30.0	31.4		
Economic classification											
Current payments	**250.2**	**258.6**	**55.9**	**79.1**	**-31.9%**	**4.4%**	**82.0**	**85.7**	**89.6**	**4.2%**	**2.4%**
Compensation of employees	223.3	228.0	43.2	62.0	-34.8%	3.8%	68.4	71.6	74.8	6.5%	1.9%
Goods and services[1]	27.0	30.5	12.7	17.1	-14.1%	0.6%	13.5	14.1	14.7	-4.8%	0.4%
of which:											
Catering: Departmental activities	0.0	0.1	0.1	0.5	200.2%	--	0.5	0.5	0.5	0.8%	--
Laboratory services	--	--	--	0.2	--	--	1.2	1.2	1.2	87.6%	--
Fleet services (including government motor transprot	19.4	17.4	1.8	6.5	-30.4%	0.3%	3.1	3.2	3.3	-20.8%	0.1%
Travel and subsistence	0.3	1.0	0.3	0.6	30.5%	--	0.7	0.7	0.7	4.6%	--
Travel and subsistence	3.8	7.2	7.5	5.9	16.1%	0.2%	5.1	5.4	5.7	-1.2%	0.2%
Venues and facilities	0.2	0.1	1.6	1.5	94.7%	--	1.5	1.6	1.7	4.5%	--
Transfers and subsidies[1]	**2 805.7**	**4 889.3**	**2 932.8**	**3 238.3**	**4.9%**	**95.5%**	**3 411.5**	**3 569.4**	**3 730.8**	**4.8%**	**97.6%**
Provinces and municipalities	2 804.7	4 888.6	2 931.3	3 238.3	4.9%	95.5%	3 411.5	3 569.4	3730.8	4.8%	97.6%
Households	1.1	0.7	1.5	--	-100.0%	--	--	--	--	--	--
Payments for capital assets	**0.2**	**1.2**	**1.1**	**1.0**	**63.9%**	**--**	**0.7**	**0.8**	**0.8**	**-7.6%**	**--**
Machinery and equipment	0.2	1.2	1.1	1.0	63.9%	--	0.7	0.8	0.8	-7.6%	--
Payments for financial assets	**--**	**0.1**	**1.1**	**–**	**--**	**--**	**–**	**–**	**–**	**–**	**–**
Total	**3 056.2**	**5 149.2**	**2 989.8**	**3 318.4**	**2.8%**	**100.0%**	**3 494.2**	**3 655.8**	**3 821.2**	**4.8%**	**100.0%**
Proportion of total programme expenditure to vote expenditure	**4.7%**	**8.2%**	**5.1%**	**5.3%**	**--**	**–**	**5.4%**	**5.5%**	**5.4%**	**--**	**–**
Details of transfers and subsidies											
Households Social benefits											
Current	1.1	0.7	1.5	--	-100.0%	--	--	--	--	--	--
Employee social benefits	1.1	0.7	1.5	--	-100.0%	--	--	--	--	--	--
Provinces and municipalities Provincial revenue funds											
Current	2 804.7	4 888.6	2 931.3	3 238.3	4.9%	95.5%	3 411.5	3 569.4	3 730.8	4.8%	97.6%
District health programme grant: District health component	--	4 888.6	2 931.3	3 238.3	--	76.2%	3 411.5	3 569.4	3 730.8	4.8%	97.6%
HIV, TB, malaria and community outreach grant: Human papillomavirus component	220.3	--	--	--	-100.0%	1.5%	--	--	--	--	--
HIV, TB, malaria and community outreach grant: Malaria elimination component	104.2	--	--	--	-100.0%	0.7%	--	--	--	--	--
HIV, TB, malaria and community outreach grant: Community outreach services component	2 480.2	--	--	--	-100.0%	17.1%	--	--	--	--	--

Programme 4. Personnel Information

Table 13. Communicable and Non-communicable Diseases personnel numbers and cost by salary level [1]

	Number of posts estimated for 31 March 2025		Number and cost[2] of personnel posts filled/planned for on funded established													Average growth rate (%)	Average: Salary level/ Total (%)
	Number of funded posts	Number of posts additional to the establish-ment	Actual			Revised estimate			Medium-term expenditure estimate								
			2023/24			2024/25			2025/26			2026/27			2027/28			2024/25 - 2027/28	
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	**74**	**13**	**63**	**43.2**	**0.7**	**88**	**62.0**	**0.7**	**92**	**68.4**	**0.7**	**90**	**71.6**	**0.8**	**88**	**74.8**	**0.8**	**0.1%**	**100.0%**
1 - 6	17	10	16	3.9	0.2	23	5.4	0.2	23	5.7	0.2	23	5.6	0.3	21	5.4	0.3	-3.0%	24.9%
7 - 10	29	--	24	15.5	0.6	32	21.5	0.7	34	24.4	0.7	33	25.5	0.8	33	26.6	0.8	0.5%	36.8%
11 - 12	19	3	15	13.8	0.9	22	20.6	0.9	24	23.7	1.0	24	24.8	1.0	24	26.2	1.1	2.9%	26.4%
13 - 16	9	--	8	10.0	1.3	11	14.5	1.3	10	14.6	1.4	11	15.7	1.5	11	26.6	1.6	-0.9%	12.0%

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

Programme 5: Hospital Systems

Programme Purpose

Develops national policy on hospital services and responsibilities by level of care; providing clear guidelines for referral and improved communication; developing specific and detailed hospital plans; and facilitating quality improvement plans for hospitals. The programme is further responsible for the management of the national tertiary services grant and ensures that planning, coordination, delivery and oversight of health infrastructure meets the health needs of the country.

There are two budget sub-programmes:

- Health Facilities Infrastructure Management
- Hospital Systems (Hospital Management; Tertiary Health Policy and Planning) Health Facilities Infrastructure Management

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 subprogramme 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.*

Programme 5: Outcomes, outputs, performance indicators and targets

Programme 5: Outcomes, outputs, performance indicators and targets														
	Outcome	Output	Output Indicator	Audited Performance			Estimated Performance	MTEF Targets						
								Annual Target 2025/26	Quarterly Targets				2026/2027	2027/2028
				2021/22	2022/23	2023/24	2024/25		Q1	Q2	Q3	Q4		
1.	Improved access to safe and quality healthcare	National clinical governance manual	National clinical governance manual developed	New Indicator	New Indicator	New Indicator	New Indicator	A national clinical governance manual developed	Not Applicable	Not Applicable	Not Applicable	A national clinical governance manual approved	Implementation of national clinical governance manual	Not Applicable
2.	Improved access to safe and quality healthcare	Patient Satisfaction	Patient Satisfaction Rate	New Indicator	New Indicator	New Indicator	New Indicator	90%	Not Applicable	Not Applicable	Not Applicable	90%	95%	95%
3.	Health infrastructure optimised for delivery of care	PHC facilities constructed or revitalised	Number of PHC facilities constructed or revitalised	52 PHC facilities constructed or revitalised	41 facilities constructed or revitalised (according to UAMPs assessed)	45 PHC facilities constructed or revitalised	42 facilities constructed or revitalised	58 facilities constructed or revitalised	Not Applicable	Not Applicable	Not Applicable	58	46	50
4.	Health infrastructure optimised for delivery of care	Public Hospitals constructed or revitalised	Number of Hospitals constructed or revitalised	21 Hospitals constructed or revitalised	25 Hospitals constructed or revitalised (according to IPMPs assessed)	30 Hospitals constructed or revitalised	50 Hospitals constructed or revitalised	50 Hospitals constructed or revitalised	Not Applicable	Not Applicable	Not Applicable	50	54	60
5.	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	121 public health facilities maintained, repaired and/or refurbished according to the Maintenance Plans assessed	157 public health facilities maintained, repaired and/or refurbished according to the Maintenance Plans assessed	299 public health facilities maintained, repaired and/or refurbished	400 public health facilities maintained, repaired and/or refurbished	400	Not Applicable	Not Applicable	Not Applicable	400	500	550

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 clinical governance manual to be developed aims at providing guidance on the implementation of strategies for improving clinical care in hospitals. Continuous maintenance, revitalization and repairs in facilities is key in ensuring that health faclities are fit-for-purpose and provide a conducive environment for the provision of care.

Programme 5. Budget Allocations

Expenditure trends and estimates

Table 14. 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	2021/22	2022/23	2023/24	2024/25	2021/22 - 2024/25		2025/26	2026/27	2027/28	2024/25 - 2027/28	
Programme Management	1.0	2.0	3.2	6.9	87.6%	--	7.1	7.4	7.7	4.1%	--
Health Facilities Infrastructure Management	7 295.6	7 882.6	8 096.0	8 625.8	5.7%	35.7%	9 757.6	9 359.5	10 011.2	5.1%	36.5%
Hospital Systems	13 715.2	14 313.9	14 031.6	15 274.1	3.7%	64.2%	16 006.5	16 755.1	17 512.9	4.7%	63.4%
Total	**21 011.8**	**22 198.4**	**22 130.8**	**23 906.8**	**4.4%**	**100.0%**	**25 771.2**	**26 122.1**	**27 531.9**	**4.8%**	**100.0%**
Change to 2024 Budget estimate[1]				--			937.0	343.7	383.7		
Economic classification											
Current payments	**232.2**	**174.9**	**116.5**	**84.5**	**-28.6%**	**0.7%%**	**90.1**	**88.5**	**92.5**	**3.1%**	**0.3%**
Compensation of employees	23.3	22.4	25.1	30.0	8.7%	0.1%	32.3	33.7	35.3	5.6%	0.1%
Goods and services[1]	208.9	152.4	91.4	54.6	-36.1%	0.6%	57.9	54.8	57.3	1.6%	0.2%
of which:											
Minor assets	--	--	1.1	4.6	--	--	4.8	5.0	5.2	4.5%	--
Consultants: Business and advisory services	206.2	149.6	86.4	16.7	-56.8%	--	14.2	9.8	10.3	-14.9%	--
Contractors	--	--	--	1.9	--	0.5%	1.9	2.0	2.1	4.5%	--
Fleet services (including government motor transprot	0.1	0.2	0.3	1.5	158.1%	--	1.6	1.7	1.8	4.5%	--
Consumable supplies	--	--	0.0	16.8	--	--	21.6	22.5	23.5	11.8%	0.1%
Travel and subsistence	1.7	2.1	2.9	10.9	86.3%	--	11.4	11.3	11.9	2.8%	--
Transfers and subsidies[1]	**20 143.2**	**21 085.9**	**20 704.0**	**22 422.1**	**3.6%**	**94.5%**	**23 240.6**	**24 321.3**	**25 716.3**	**4.7%**	**92.6%**
Provinces and municipalities	20 143.0	21 085.9	20 704.0	22 422.1	3.6%	94.5%	23 240.6	24 321.3	25 716.3	4.7%	92.6%
Households	0.2	0.3	0.2	--	-100.0%	--	--	--	--	--	--
Payments for capital assets	**636.4**	**937.6**	**1 310.4**	**1 400.0**	**30.1%**	**4.8%**	**2 440.5**	**1 712.2**	**1 723.0**	**7.2%**	**7.0%**
Building and other fixed structures	591.3	930.3	1 259.8	1 333.4	31.1%	4.6%	2 335.6	1 623.4	1 630.2	6.9%	6.7%
Machinery and equipment	45.1	7.4	50.6	66.7	13.9%	0.2%	84.9	88.8	92.8	11.7%	0.3%
Total	**21 011.8**	**22 198.4**	**22 130.8**	**23 906.7**	**4.4%**	**100.0%**	**25 771.2**	**26 122.1**	**27 531.9**	**4.8%**	**100.0%**
Proportion of total programme expenditure to vote expenditure	**32.3%**	**35.3%**	**38.0%**	**38.4%**	**--**	**–**	**39.8%**	**39.0%**	**39.2%**	**--**	**–**
Details of transfers and subsidies											
Households Social benefits											
Current	0.2	0.3	0.2	--	-100.0%	--	--	--	--	--	--
Employee social benefits	0.2	0.3	0.2	--	-100.0%	--	--	--	--	--	--
Provinces and municipalities											
Provincial revenue funds											
Current	13 707.8	14 306.1	14 023.9	15 263.8	3.6%	64.2%	15 994.9	16 743.5	17 500.8	4.7%	63.4%
National tertiary services grant	13 707.8	14 306.1	14 023.9	15 263.8	3.6%	64.2%	15 994.9	16 743.5	17 500.8	4.7%	63.4%
Capital	6 435.2	6 779.5	6 679.9	7 158.3	3.6%	30.3%	7 245.7	7 577.8	8 215.5	4.7%	29.2%
Health facility revitalisation grant	6 435.2	6 779.5	6 679.9	7 158.3	3.6%	30.3%	7 245.7	7 577.8	8 215.5	4.7%	29.2%

Programme 5. Personnel Information

Table 15. Hospital Systems personnel numbers and cost by salary level[1]

	Number of posts estimated for 31 March 2025		Number and cost[2] of personnel posts filled/planned for on funded established													Average growth rate (%)	Average: Salary level/ Total (%)
	Number of funded posts	Number of posts additional to the establish-ment	Actual			Revised estimate			Medium-term expenditure estimate								
			2023/24			2024/25			2025/26			2026/27			2027/28			2024/25 - 2027/28	
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**	--	**29**	**25.1**	**0.9**	**33**	**30.0**	**0.9**	**34**	**32.3**	**0.9**	**34**	**33.7**	**1.0**	**33**	**35.3**	**1.1**	**-0.1%**	**100.0%**
1 - 6	5	--	5	1.8	0.4	5	1.9	0.4	5	2.0	0.4	4	1.9	0.4	4	1.6	0.5	-10.5%	13.3%
7 - 10	9	--	9	5.4	0.6	10	6.2	0.6	10	6.6	0.7	10	7.0	0.7	10	7.3	0.7	--	29.8%
11 - 12	9	--	6	6.3	1.1	8	8.4	1.0	10	10.9	1.0	10	11.5	1.1	10	12.1	1.2	8.9%	29.3%
13 - 16	10	--	9	11.5	1.3	10	13.5	1.3	9	12.7	1.4	9	13.4	1.5	9	14.2	1.6	-3.5%	27.6%

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

Programme 6: Health System Governance and Human Resources

Programme 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.

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.

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.

Health Information, Monitoring and Evaluation develops and maintains an integrated national health information system, commissions and coordinates research, and monitors and evaluates departmental performance and strategic health programmes.

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

Food Control is responsible to develop legislation, policies and guidelines and administer the Foodstuffs component of the Foodstuffs, Cosmetics & Disinfectants Act, 1972 (Act 54 of 1972) (hereafter referred to as the "Foodstuffs Act"). The Foodstuffs Act is the principal Act governing food safety (chemical, microbiological, allergens and food hygeine) for the country. In terms of the Act, matters of non-communicable concern and of nutritional importance are also being addressed, e.g. sodium reduction, trans fat, labelling for consumer information, salt iodation, food fortification and foods for special medical purposes etc.

Compensation Commissioner in Mines and Works derives its mandate from the Occupational Diseases in Mines and Works Act, No. 78 of 1973 (ODMWA) and pays compensation to current and ex-workers in controlled mines and works who are certified to have compensable cardio-respiratory diseases.

Programme 6: Outcomes, outputs, performance indicators and targets

Programme 6: Outcomes, outputs, performance indicators and targets														
	Outcome	Output	Output Indicator	Audited Performance			Estimated Performance	MTEF Targets						
								Annual Target 2025/26	Quarterly Targets				2026/2027	2027/2028
				2021/22	2022/23	2023/24	2024/25		Q1	Q2	Q3	Q4		
1.	Governance of Public Entities strengthened	Board appointments for Public Entities and Statutory Councils	Number of Board appointments for Public Entities and Statutory Councils	New Indicator	New Indicator	Four (4) Board Council appointed recommen dations made prior to expiry of the team of office (SAPC, SANC, ITHPCSA and CMS)	SAPHRA, NHLS and SADTC Board appointed for the new term of office	3 Boards appointed (SAMRC, OHSC and HPCSA)	Not Applicable	Not Applicable	Not Applicable	3 Boards appointed (SAMRC, OHSC and HPCSA)	3 Boards appointed	1 Boards appointed
2.	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	New Indicator	4 Audit actio plans monitored	All audit action plans monitored	Not Applicable	Not Applicable	Not Applicable	All audit action plans monitored	All audit action plans monitored	All audit action plans monitored
3.	Equitable distribution of health professionals to health facilities	Provincial Nursing Leadership competency implement-ation plans	Number of provinces with Nursing Leadership competency framework implement-ation plans developed	New Indicator	New Indicator	New Indicator	New Indicator	Nine (9) Provincial Nursing Leadership competency framework implement-ation plans developed	Nursing Leadership Competency Framework developed	Three (3) provincial Nursing Leadership Competen-cy Framework implemen-tation plans developed	Six (6) provincial Nursing Leadership Competen-cy Framework implemen-tation plans developed	Nine (9) provincial Nursing Leadership Competen-cy Framework implemen-tation plans developed	Competency Framework for Nursing leadership implemented in 4 provinces	Competency Framework for Nursing leadership implemented in 5 provinces
4.	Equitable distribution of health profession-als to health facilities	Framework for distribution of Multi-disciplinary Teams for District Hospital	Draft Framework for distribution of Multi-disciplinary Teams for District Hospital developed	New Indicator	New Indicator	New Indicator	Assessment of the current distribution of multidisciplin-ary teams	Draft Framework for distribution of Multi-disciplinary Teams for District Hospital developed	Not Applicable	Not Applicable	Not Applicable	Draft Framework for distribution of Multi-disciplinary Teams for District Hospital developed	Framework approved by National Health Council	Framework implement-ation in District Hospitals

	Programme 6: Outcomes, outputs, performance indicators and targets													
	Outcome	Output	Output Indicator	Audited Performance			Estimated Performance	MTEF Targets						
								Annual Target 2025/26	Quarterly Targets				2026/2027	2027/2028
				2021/22	2022/23	2023/24	2024/25		Q1	Q2	Q3	Q4		
5.	Reduced burden of disease	Food labelling legislation revised	Food labelling regulations gazetted	New Indicator	New Indicator	Comments on draft food labelling Regulations were captured and analyzed	Draft set of final food regulations submitted for legal review	Revised Food labelling regulations gazetted	Not Applicable	Not Applicable	Not Applicable	Revised Food labelling regulations gazetted	Implement the final food labelling regulations	Not Applicable
6.	Early warning and integrated disease surveillance and response strengthened	Roll out of Event-based surveillance	Number of districts implement-ing EBS	New Indicator	New Indicator	New Indicator	3 Districts implementing EBS	6	3	4	5	6	12	18

Explanation of planned performance over the medium-term period

Health workforce is a critical resource for the sector and investment in this regard, will ensure 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 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 is in scarcity. In an effort to strengthen leadership and governance across the sector, the department will strengthen its oversight of public entities by ensuring continuity in governance through timeous appointments of board as well as monitoring audit action plans where there are material findings identified. Community safety 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. Budget Allocations

Expenditure trends and estimates

Table 16. Health Systems Governance and Human Resources expenditure trends and estimates by subprogramme and economic classifcation

Subprogramme	Audited outcome			Adjusted appropriation	Average growth rate (%)	Average: Expen-diture/ Total (%)	Medium-term expenditure estimate			Average growth rate (%)	Average: Expen-diture/ Total (%)
R million	2021/22	2022/23	2023/24	2024/25	2021/22 - 2024/25		2025/26	2026/27	2027/28	2024/25 - 2027/28	
Programme Management	5.4	4.3	5.0	8.5	16.1%	0.1%	8.8	9.2	9.7	4.5%	0.1%
Policy and Planning	5.8	11.2	5.5	7.4	8.7%	0.1%	7.8	8.1	8.5	4.8%	0.1%
Public Entities Man ement and Laboratories	1 982.3	1 937.0	1 848.7	1 876.6	-1.8%	26.6%	1 992.6	2 074.2	2 169.8	5.0%	25.5%
Nursing Services	8.5	19.0	10.2	10.3	6.4%	0.2%	10.8	11.3	11.8	4.7%	0.1%
Health Information, Monioring and Evaluation	37.8	47.8	58.5	69.9	22.7%	0.7%	73.5	76.9	80.4	4.8%	0.9%
Human Resources for Health	4 320.7	5 468.1	5 501.2	5 537.2	8.6%	72.4%	5 675.3	5 934.1	6 202.5	3.9%	73.2%
Total	**6 360.5**	**7 487.4**	**7 429.1**	**7 510.5**	**5.7%**	**100.0%**	**7 765.3**	**8 113.9**	**8 482.8**	**4.1%**	**100.0%**
Change to 2024 Budget estimate[1]				--			81.5	78.5	84.0		
Economic classification											
Current payments	**250.6**	**167.5**	**116.5**	**175.8**	**-11.1%**	**2.6%**	**194.1**	**204.0**	**214.0**	**6.8%**	**2.5%**
Compensation of employees	185.5	106.7	101.6	111.0	-15.7%	1.8%	122.2	127.9	133.6	6.4%	1.6%
Goods and services[1]	65.2	60.8	64.1	64.8	-0.2%	0.9%	71.9	76.1	80.3	7.4%	0.9%
of which:											
Audit costs: External	2.6	3.3	2.3	3.0	4.7%	–	3.1	3.2	3.4	4.5%	–
Consultants: Business and advisory services	24.0	23.7	23.1	25.8	2.4%	0.3%	27.2	28.6	29.9	5.0%	0.3%
Contractors	11.2	1.8	2.8	4.1	-28.4%	0.1%	4.2	4.5	4.7	4.2%	0.1%
Agency and support/ outsourced services	0.3	8.4	–	2.3	91.5%	–	6.4	7.5	8.6	56.1%	0.1%
Fleet services (including government motor transprot	1.7	1.7	3.1	3.5	26.7%	–	3.7	3.8	4.0	4.5%	–
Travel and subsistence	6.9	11.1	15.4	9.1	9.7%	0.1%	6.9	9.9	10.4	4.5%	0.1%
Transfers and subsidies	6 109.6	7 317.5	7 260.8	7 327.1	6.2%	97.3%	7 563.4	7 901.8	8 260.3	4.1%	97.4%
Provinces and municipalites	4 297.7	5 449.1	5 479.0	5 517.1	8.7%	72.1%	5 649.9	5 911.3	6 178.7	3.8%	73.0%
Departmental agencies and accounts	4 297.7	1 867.3	1 774.3	1 791.8	-0.3%	25.2%	1 894.4	1 970.7	2 060.8	4.8%	24.2%
Non-profit insstitutions	--	--	6.5	18.2	--	0.1%	19.0	19.9	20.8	4.5%	0.2%
Households	1.2	1.1	1.0	–	-100.0%	–	–	–	–	–	–
Payments for capital assets	0.3	1.7	2.3	7.5	191.3%	–	7.8	8.1	8.5	4.1%	0.1%
Buildings and other fixed structures	--	--	0.0	--	--	--	--	--	--	--	--
Machinery and equipment	0.3	1.7	2.2	7.5	191.3%	–	7.8	8.1	8.5	4.1%	0.1%
Payments for financial assets	--	0.8	0.3	--	--	--	--	--	--	--	--
Total	**6 360.5**	**7 429.1**	**7 429.1**	**7 529.1**	**5.7%**	**100.0%**	**7 765.3**	**8 113.9**	**8 482.8**	**4.1%**	**100.0%**
Proporton of total programme expenditure to vote expenditure	**9.8%**	**11.9%**	**12.7%**	**12.1%**	**--**	**–**	**12.0%**	**12.1%**	**12.1%**	**--**	**–**
Details of transfers and subsidies											
Households Social benefits											
Current	1.2	1.1	1.0	--	-100.0%	--	--	--	--	--	--
Employee social benefits	1.2	1.1	1.0	--	-100.0%	--	--	--	--	--	--
Departmental agencies and accounts											
Departmental agencies (non-business entities)											
Current	1 809.2	1 865.8	1 772.5	1 789.9	-0.4%	25.1%	1 892.6	1 968.7	2 058.8	4.8%	24.2%
Natonal Health Laboratory Service	643.5	772.5	706.4	598.8	-2.4%	9.5%	636.4	668.8	700.3	5.4%	8.2%
Office of Health Standards Compliance	158.0	157.5	161.5	181.6	4.8%	2.3%	191.7	200.1	209.1	4.8%	2.5%
South African Medical Research Council	855.2	779.5	760.1	833.5	-0.9%	11.2%	880.8	910.7	979.1	5.5%	11.3%
Council for Medical Scheme	6.2	6.3	6.5	6.2	-0.2%	0.1%	6.3	6.6	6.9	4.0%	0.1%
South African Health Products Regulatory Authority	146.3	150.0	137.9	143.5	-0.6%	2.0%	149.3	156.2	163.3	4.4%	1.9%
South African Medical Research Council: Social impact bond	–	–	–	263	–	0.1%	28.0	263	–	-100.0%	0.3%

Subprogramme	Audited outcome			Adjusted appropriation	Average growth rate (%)	Average: Expen-diture/ Total (%)	Medium-term expenditure estimate			Average growth rate (%)	Average: Expen-diture/ Total (%)
R million	2021/22	2022/23	2023/24	2024/25	2021/22 - 2024/25		2025/26	2026/27	2027/28	2024/25 - 2027/28	
Social security funds											
Current	1.4	1.5	1.7	1.8	8.1%	--	1.9	2.0	2.1	4.5%	–
Mines and Works Compensation Fund	1.4	1.5	1.7	1.8	-8.1%	--	1.9	2.0	2.1	4.5%	–
Provinces and municipalities											
Provincial revenue fund											
Current	4 297.7	5 449.1	5 479.0	5 517.1	8.7%	72.1%	5 649.9	5 911.3	6 178.7	3.8%	73.0%
Human resources and training grant	4 297.7	5 449.1	5 479.0	5 517.1	8.7%	72.1%	5 649.9	5 911.3	6 178.7	3.8%	73.0%
Non-profit insstitutions											
Current	4 297.7	5 449.1	5 479.0	5 517.1	8.7%	72.1%	5 649.9	5 911.3	6 178.7	3.8%	73.0%
Health Systems Research	4 297.7	5 449.1	5 479.0	5 517.1	8.7%	72.1%	5 649.9	5 911.3	6 178.7	3.8%	73.0%

Programme 6. Personnel Information

Table 17. Health Systems and Human Resources personnel numbers and cost by salary level[1]

	Number of posts estim ted for 31 March 2025		Number and cost[2] of personnel posts filled/planned for on funded established												Average growth rate (%)	Average: Salary level/ Total (%)
	Number of funded posts	Number of posts additional to the establish-ment	Actual			Revised estim te			Medium-term expenditure estim te							
			2023/24			2024/25			2025/26			2026/27			2027/28			2024/25 - 2027/28	
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**	**--**	**150**	**101.6**	**0.7**	**155**	**111.0**	**0.7**	**159**	**122.2**	**0.8**	**157**	**127.9**	**0.8**	**154**	**133.6**	**0.9**	**-0.3%**	**100.0%**
1 - 6	62	--	62	21.8	0.4	63	23.3	0.4	63	24.8	0.4	63	26.2	0.4	60	26.4	0.4	-1.7%	39.8%
7 - 10	60	--	52	34.8	0.7	54	38.1	0.7	56	42.3	0.8	55	44.0	0.8	55	46.4	0.8	0.4%	35.1%
11 - 12	21	--	15	15.8	1.1	16	17.6	1.1	17	19.8	1.2	16	19.9	1.2	16	21.0	1.3	--	10.4%
13 - 16	25	--	21	29.3	1.4	22	32.0	1.5	23	35.3	1.5	23	37.8	1.6	23	39.9	1.7	1.9%	14.7%

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

9. Key Risks

	Outcomes	Key Risks	Risk Mitigation
1.	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
2.	Improved access to equitable healthcare services	Delays in the implementation of the National Health Insurance	Facilitate and accelerate National Health Insurance by implementing provisions that are within the competency of the National Department of Health
3.	National Health Insurance awareness improved	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
4.	Governance of Public Entities strengthened	Delays in processes for finalization for appointment of boards for entities and council	Expedite administrative process to ensure that all boards are appointed prior to expiry of term of office
5.	Improved responsiveness to community needs	Reduced household services due to diminishing resources	Promote a coordinated and functional community outreach through CHWs
6.	Reduced burden of disease	Poor coordination/integration of community-based services	Continuous capacity building for Community Health Workers to identify patients requiring referrals to be linked to a care
7.	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
8.	TB Mortality reduced	Fewer patients tested for TB	Accelerate testing for vulnerable groups through targeted testing
9.	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
10.	Mortality due to Cervical Cancer reduced	Low uptake of HPV screening	Expand the HPV vaccination programme in order to vaccinate 90% of girls 9 - 15 years old
11.	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
12.	Improved access to School health programme	Inadequate resources to expand screening for Grade R learners	Strengthening stakeholders collaboration to leverage reaources for expansion of screening
13.	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
14.	Mental Health Care integrated in Primary Health Care	Slow progress in contracting mental health care providers at primary health care	Strategic purchasing of services from healthcare providers

	Outcomes	Key Risks	Risk Mitigation
15.	Early warning and integrated disease surveillance and response strengthened	Inadequate capacity at district to implement Event-Based Surveillance	Targeted capacity building by transferring resources where most required in line with implementations of EBS
16.	Improved access to safe 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
17.	Enabling legislation for effective service delivery	Delays in processes outside the control of the department	Expedite internal administrative process to facilitate the finalization of the amendment bills
18.	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 whre appropriate
19.	Equitable distribution of health professionals to health facilities	Poor implementation of Human Resources for Health policies	Strengthening accountability machanism to ensure that national policies to improve human resources for health are implemented by province
20.	Integrated electronic health record	Lack of financial resources required to accelerate the development of electronic health record	ICT infrastructure strategic purchasing
21.	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

10. Public Entities: Outputs and Indicators

Name of Public Entity	Mandate	Outcomes	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 interest of beneficiaries, controlling and coordinating the functioning of medical shemes, collecting and disseminating information about private health care, and advising the Minister of Health on any matter concerning medical schemes.	• Regulating entities in compliance with National Policy, the Medical Schemes Act and other legislation • Stakeholder engagement at local, regional and international level • Good governance and ethical leadership • To encourage risk pooling and innovation for the effective functioning of the private health care financing sector • Conducting policy-driven research, monitoring and evaluation of the medical schemes industry to facilitate decision-making and policy recommendations to the Health Ministry	R 230 819 719 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 tubercolosis treatment. The commissioner compensate the dependants of deceased workers and also administers pensions for qualifying ex-workers or their dependants.	• Ensure the effective and efficient management of the Compensation Commissioner for Occupational Diseases (CCOD)	R 402 343 000 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	• An efficient and effective Organisation • Modernised Laboratory Services • High-quality services • Performance Driven Organisation • Adequate and Suitably Qualified Workforce • Sustain a financially stable Organisation	R 13.9 Billion

Name of Public Entity	Mandate	Outcomes	Current Annual Budget (R thousand)
	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.		
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.	• Highly effective and financially sustainable OHSC • Increased communication initiatives in profiling OHSC programmes • Improved inspection coverage of Health Establishments • Improved quality of healthcare services and patient safety through the implementation of Ombuds recommendations • Improved access to health care services through registering and profiling of health facilities • Enhanced public trust in the safety and quality of healthcare services	R 181 599 000 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 of registration, licensing, manufacturing, importation, and all other aspects pertaining to active pharmaceutical ingredients, medicines, medical devices; and forconducting clinical trials in a manner compatible with the national medicines policy.	• Effective compliance, financial and performance management • Financial sustainability achieved • Responsive to stakeholders needs • A positive and enabling working culture created • Attract and retain talent • Digital transformation • Efficient and effective regulatory practices maintained	R 417 579 000 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)	• To ensure good governance, effective administration and compliance with government regulation • To promote the organisation's administrative efficiency to maximise the funds available for research, capacity development and innovation • To produce and promote scientific excellence and the reputation of South African health research • To provide leadership in the generation of new knowledge in health • To provide funding for the conduct of health research • To support the development of innovations and technologies aimed at improving health • To enhance the long-term sustainability of health research in South Africa by providing funding and supervision support for career development and/or institutional research capacity development • To facilitate the translation of health research	R 1.3 Billion

11. Infrastructure Projects

The prioritisation of healthcare infrastructure projects aligns with the National Health Insurance (NHI) Act, Presidential Health Compact, and National Development Plan (NDP) to address inequalities, expand specialist services, and improve healthcare accessibility. Several hospitals are being constructed, including Limpopo Central Hospital, Siloam District Hospital, Dihlabeng Regional Hospital, Bambisana District Hospital, and Zithulele District Hospital. Additionally, three existing central/academic hospitals, **including** Dr George Mukhari Academic Hospital (Gauteng), Nelson Mandela Academic Hospital (Eastern Cape), and Victoria Mxenge Hospital (KwaZulu-Natal) have been prioritised for replacement. The latter is under consideration for either revitalisation or the construction of a new academic hospital on land donated by the Nelson R. Mandela School of Medicine. Three new central hospitals are planned for North West, Mpumalanga, and Northern Cape to decentralise tertiary healthcare further.

The proposal also includes the construction of five new district hospitals; Soshanguve, Eldorado Park, Thabang (North of Soweto), Holomisa (Southwest of Soweto) and Diepsloot, to alleviate pressure on existing hospitals. Additionally, five new Community Health Centres (CHC); Senqu (Eastern Cape), Kraaifontein (Western Cape), KwaMakhutha (KwaZulu-Natal), Cato Manor (KwaZulu-Natal) and Matlakeng/Roleathunya (Free State); will be strengthen primary healthcare and reduce hospital congestion. The Health Portfolio Infrastructure System (HIPS) developed by the NDoH supports data-driven decision-making to prioritise maintenance and infrastructure needs. These projects align with the intention of the National Infrastructure Plan 2050 to ensure financial sustainability and long-term resilience in healthcare infrastructure, ultimately advancing universal health coverage and improvimg service delivery for all South Africans.

The prioritisation of these healthcare infrastructure projects, as presented in the State of the Nation Address (SONA), is guided by a comprehensive needs assessment and aligns with South Africa's National Health Insurance (NHI) Act, the Presidential Health Compact, and the National Development Plan (NDP). These projects are crucial for addressing long-standing healthcare inequalities, expanding access to specialist services, ensuring that underserved populations receive quality healthcare.

Healthcare Facilities Already Under Costruction

The following hospitals are already under construction, representing a significant step strengthening the public healthcare system and improving service delivery in their respective provinces:

- Limpopo Central Hospital (Limpopo)
- Siloam District Hospital (Limpopo)
- Dihlabeng Regional Hospital (Free State)
- Bambisana District Hospital (Eastern Cape)
- Zithulele District Hospital (Eastern Cape)
- Bophelong Psychiatric Hospital (North West)

Replacement of Three Existing Central/ Academic Hospitals

To modernise and expand access to highly specialised healthcare services, the following three existing Central/ Academic hospitals have prioritised for replacement:

1. Dr. George Mukhari Academic Hospital (DGMAH); Gauteng: A vital academic and referral hospital serving the northern Gauteng region and neighbouring provinces. The new facility will be modelled on the Limpopo Central Hospital prototype to enhance teaching, reasearch and patient care.
2. Nelson Mandela Academic Hospital (NMAH); Eastern Cape: As a tertiary referral hospital in Mthatha, NMAH is key in providing advanced healthcare to rural communities. The Dr. Pixley Ka Isaka Seme Memorial Hospital prototype will guide the redevelopment to improve service delivery and capacity.
3. Victoria Mxenge Hospital (formerly King Edward VII Hospital); KwaZulu-Natal: A critical teaching and referral hospital affiliated with the Nelson R. Mandela School of Medicine (UKZN). The KwaZulu-Natal department of Health has developed a Master Plan for its revitalisation. However, an alternative option is to construct a new academic hospital on land donated by the Nelson R. Mandela School of Medicine. Further clarity is revitalised or a new replacement hospital is constructed on the donated site.

Development of Three New Central Hospitals

To bridge regional gaps in tertiary and quarterly healthcare, three new central hospitals are proposed in the following provinces:

1. North West Province - The province lacks a central hospital, forcing patients to seek specialised care in Gauteng. A new central hospital will decentralise services and improve equitable access.
2. Mpumalanga Province - A central hospital is needed to complement the planned tertiary hospital in e-Malahleni (Witbank) and reduce relaince on Gauteng's healthcare system.
3. Northern Cape - The province's vast geographical spread makes access to high-level healthcare difficult. A new central hospital will bring much-needed specialist services closer to communities.

Development of Five New District Hospitals

The following five district hospitals have been prioritised based on population growth, healthcare demand and the need to alleviate pressure on existing tertiary facilities:

1. Soshanguve District Hospital (Gauteng) - Will serve as a relief hospital to Dr. George Mukhari Academic Hospital, which currently functions as a central and district hospital.
2. Eldorado Park District Hospital (Gauteng) - Needed to address healthcare service shortages in southern Johannesburg and reduce strain on Chris Hani Baragwanath amd Bheki Mlangeni hospitals.
3. Thabang District Hospital (North of Soweto, Gauteng)- Strategically located north of Soweto, this hospital will alleviate pressure on Bheki Mlangeni District Hospital and other district-level facilities in the surrounding area.
4. Holomisa District Hospital (Southwest of Soweto, Gauteng) - Positioned southwest of Soweto, this new facility will provide essential healthcare services to rapidly growing settlements and reduce congestion in the region's overburdened hospitals.
5. Diepsloot District Hospital (Gauteng) - Located in northern Johannesburg, Diepsloot District Hospital will relieve pressure on Helen Joseph Hospital, Rahima Moosa Mother and Child Hospital and Tembisa hospital, which currently serve the area's growing population.

Each district hospital will be based on the Elim District Hospital prototype, ensuring efficient layouts, streamlined workflows and sustainable operation models to enhance service delivery.

Development of Five New Community Health Centres (CHCs)

To strengthen primary healthcare services and reduce the burden on hospitals, the following five CHCs have been prioritised for development or revitalisation:

1. Senqu CHC (Eastern Cape) - Will provide expanded primary healthcare services in a rural district, improving accessibility.
2. Kraaifontein CHC (Western Cape) - A replacement facility for the Cipla Container Clinic, ensuring upgraded and expanded services.
3. KwaMakhutha CHC (KwaZulu-Natal) - Will strengthen the province's primary and maternal healthcare services.
4. Cato Manor CHC (KwaZulu-Natal) - A key facility for improving preventative healthcare and chronic disease management.
5. Matlakeng/Roleathunya CHC (Free State) - Addressing growing healthcare demands in the Free State province.

These CHCs will be modelled on the Balfour CHC prototype, ensuring standardised designs that improve efficiency, cost-effectiveness and sustainability.

Strategic Justification and National Impact

The selection of these projects is data-driven and informed by evidence-based planning through the Health Portfolio Infrastructure System (HIPS). The infrastructure investment will reduce healthcare disparties, improve regional access to specialised services, and promote operational efficiencies through standardised designs. 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.

With adequate funding, these projects will significantly enhance healthcare accessibility, support universal health coverage, and strengthen the resilience of the national healthcare system. Revising and expanding these Hospitals and CHCs will improve service delivery, reduce patient backlogs, and alleviate pressure on overburdened facilities, ensuring equitable and quality healthcare for all South Africans.

The Direct Health Facility Revitalisation Grant serves as the primary funding source for public health infrastructure, distributed to provincial health departments through the Health Facilities Infrastructure Management sub-programme. This sub-programme also administers the health facility

revitalisation component of the NHI indirect grant. Both funding streams are under strain due to long-term, large-scale construction projects requiring sustained financial support.

The projects listed below are funded through the health facility revitalisation component of the NHI indirect grant, managed and implemented by the National Department of Health. Notable among them is the planning and construction of the Limpopo Central Hospital in Polokwane, which is expected to reach practical compltion by the 2028/2029 finacial year. Additionally, projects like Siloam are pending the outcome of BFI fund applications for the 2025/2026 financial year. Once approved, specific budget allocations for these projects will be finalized.

Project Name	Project Details / Scope	Start Date	Esimated End Date	Total Project Cost (000's)	Expenditure to date (000's)
Bambisana Hospital Smart Revitalisation - PH 1	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: 29 October 2025 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: 24 November 2026	2015/04/14	2027/11/18	628,342	351,772
Bambisana Hospital Smart Revitalisation - PH 2	The construction will constitute of various activities: *(Details available on PMIS)* Bambisana Hospital Smart Revitalisation for the phase 2 works only.	2015/04/01	2027/11/30	300,000	6,749
Borwa PHC - Replacement	Borwa CHC - Replacement The Free State Department of Health has identified the replacement of Borwa CHC in Mantsopa Sub-District within Thabo Mofutsanyana District as a priority. It was therefore nominated to be constructed by the National Department of Health through their In Kind Grant Clinic Replacement Programme. The project will implemented the following: the Design & Construct methodology and consists of the following Main activities: *(Details available on PMIS)*	2013/04/02	2027/02/15	61,536	28,461
Christiana Hospital - Emergency Works	The work package is focused on addressing emergency and backlog building works required at Christiana Hospital. This project was affected by a fire.	2019/03/12	2025/10/31	144,228	96,848
Clocolan Clinic - Replacement	The scope of work for the project covers 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.	2015/01/16	2026/04/20	75,536	45,393
Comprehensive Maintenance - Tambo Memorial Hospital	Comprehensive maintenance and remedial works at Tambo Memorial Hospital: *(Details of scope on PMIS)*	2023/06/23	2029/03/30	620,000	21,921

Project Name	Project Details / Scope	Start Date	Esimated End Date	Total Project Cost (000's)	Expenditure to date (000's)
Comprehensive Maintenance _ WC	General Project Scope: Backlog maintenance, Refurbishment and Upgrades (Detail on the specific upgrades is in the Project Plan) Facilities included are Albertina Clinic; Riversdale Clinic; Riversdale Hospital; Blanco Clinic; Pacaltsdorp Clinic; Parkdene Clinic; Rosemoor Clinic; Dysselsdorp Clinic; Oudtshoorn Clinic and Oudtshoorn Hospital.	2016/07/26	2026/10/30	107,400	6,125
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.	2019/03/01	2026/02/28	167,930	52,890
Dihlabeng Hospital - PH 2	The smart revitalisation of the Dhlabeng Regional Hospital incorporates a myriad of interventions to ensure compliance with IUSS standards as adopted by the NDOH as well as local authoritylegislative compliance. The revitalisation 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 various activities *(see Project Plan on PMIS)*.	2016/10/26	2028/03/17	838,197	299,807
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 is currently consists of a total 123 buildings including hospital buildings, administration offices, heritage buildings and the residential houses. It it approximately 362 120 m2 in size. The hospital has 538 registered beds, howeve, only 330 beds were reported to be registered. The proposed Elim Hospital Replacement project will have 415 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 categoriesof staff as per the LDoH housing Policy that is being refined. This project has applied for BFI funding and is awaiting an outcome. The project can only proceed to construction once funding has been received.	2013/06/11	2030/05/23	2,750.000	128,932
Equipment Roll Out - National Department	Equipment as required for National Departmet of Health	2015/09/01	2027/03/31	246,180	280,343
Ethandakukhanya 24 hour CHC Replacement	Replacement of the existing Clinic with a New Community Health Centre	2019/09/18	2025/05/30	225,915	191,820
Harry Gwala Priority maintenance	Harry Gwala Priority Maintenance: *(Detailed scope on the PMIS)*	2023/10/26	2029/02/28	992,947	11,895

Project Name	Project Details / Scope	Start Date	Esimated End Date	Total Project Cost (000's)	Expenditure to date (000's)
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.	2017/05/01	2030/05/31	5,045.296	1,068.951
Msukaligwa 24 hour CHC Replacement	Replacement of the existing Clinic with a New Community Health Centre	2015/02/01	2025/07/11	191,798	100,435
NDOH Project Office - Admin Project	Resources have been appointed for National Department of Health to assist with management support.	2018/08/20	2029/11/31	380,000	179,651
OPEX PMO	Resources to be deployed to NDOH to assist with the OPEX project	2024/06/03	2029/01/31	64,783	--
Public Private Partnership (PPPs) 2023 onwards	Appointment of Professional Service Provider to Review Feasibility Study	2013/08/01	2035/03/31	--	--
Siloam Hospital - Phase 2 - New 224 Bed Hospital	Construction of New 224 Bed Hospital and Associated Services	2012/04/02	2026/12/15	1,612.962	929,001
Tshilidzini Hospital - Replacement	Through the Hospital Revitalisation Programme, the Department 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 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. The 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 project has applied for BFI funding and is awaiting an outcome. The project can only proceed to construction once funding has been received.	2015/07/01	2032/03/24	3,381.331	157,430
Zithulele Hospital Smart Revitalisation	Zithulele Hospital Smart 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 Section 1 - 4 (Details are available in the Project Plan)	2015/08/11	2028/05/15	1,067.651	427,919

PART D

TECHNICAL INDICATOR *DESCRIPTION LIST*

Programme 1: Administration

	Programme 1: Administration												
	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 outcome of National DoH	Audit opinion received for the period under review	Auditor General's Report confirming audit outcome for the period under review	Not Applicable	Not Applicable	Annual Report	Not Applicable	Not Applicable	Not Applicable	Non-cumulative	Annually	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-to-date)	Quarterly	All valid invoices paid within 30 days of receipt	Chief Financial Officer
3.	Number of Health promotion messages broadcasted on integrated platforms	Health messages on NDOH integrated public communication platforms are used to inform the community on health related issues.	Printouts/ screenshots/ links from the NDOH integrated platforms	Number of health promotion messages placed/ broadcasted on integrated platforms	No Denominator	Printouts/ screenshots/ links on NDOH integrated platforms	Accuracy of reporting	Not Applicable	All Districts	Cumulative (year-end)	Quarterly	800 health promotion messages on NDOH integrated platforms	Chief Director: Communication and Stakeholder Engagement
4.	Percentage of Women, employed at SMS level according to the equity targets	Appointment of women at SMS level 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	Non-cumulative	Annual	50% of Women employed at SMS level in NDOH	Chief Director: Health Sector Bargaining
5.	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	Non-cumulative	Annual	Higher percentage of Youth employed in NDOH	Chief Director: Health Sector Bargaining
6.	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	Disability	Not Applicable	Non-cumulative	Annual	Higher percentage of People with disabilities employed in NDOH	Chief Director: Health Sector Bargaining
7.	Policy Framework for security and safety in health facilities developed	Policy Framework to inform strategies and interventions to improve safety of users and staff in health facilities	Policy review recommendations, Attendance registers, recommendations/reports from stakeholder consultations, draft policy framework	Not Applicable	Not Applicable	Draft Policy Framework	Stakeholder corporation in providing inputs	Not Applicable	Not Applicable	Non-cumulative	Quarterly	Draft Policy Framework Finalised	Head of Corporate Services

Programme 2: National Health Insurance

	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 Transfor-mation (where applicable)	Calculation Type	Reporting Cycle	Desired perfor-mance	Indicator Respon-sibility
1.	Ministerial Advisory Committee (MAC) on Health Care Benefits for NHI established	The Ministerial Advisory Committee on Health Care Benefits for National Health Insurance - serves as a precursor to the Benefits Advisory Committee.	Terms of Reference for MAC	Not Applicable	Not Applicable	Terms of Reference for MAC	Not Applicable	Not Applicable	Not Applicable	Non-cumulative	Annual	Terms of Reference for MAC developed	Deputy Director General: National Health Insurance
2.	Ministerial Advisory Committee (MAC) on Health Technology Assessment for NHI established	The Ministerial Advisory Committee on Health Technology Assessment for National Health Insurance, established to advise the Minister on Health Technology Assessment to serve as a precursor to the Health Technology Assessment agency	Terms of Reference for MAC	Not Applicable	Not Applicable	Terms of Reference for MAC.	Not Applicable	Not Applicable	Not Applicable	Non-cumulative	Annual	Terms of Reference for MAC developed	Deputy Director General: National Health Insurance
3.	Accreditation framework for PHC providers developed	Accreditation framework is developed in consultation with various stakeholders and tabled at NHC for consideration.	Accreditation framework	Not Applicable	Not Applicable	Accreditation Framework	Not Applicable	Not Applicable	Not Applicable	Non-cumulative	Annual	Accreditation Framework finalised	Chief Director: User and Service Provider Manageme nt

	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**
4.	Essential Equipment List for Promary Care developed	The Essential Equipment List for medical devices, and health technologies that are considered as important for Primary Health Care	Approved list of essential equipment for PHC	Not Applicable	Not Applicable	PHC Essential Equipment List is available	Cooperation and participation from technical committee members, programmes and stakeholders	Not Applicable	Not Applicable	Non-cumulative	Annual	Approved Essential Equipment List for PHC	Chief Director: Sector-Wide procument
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	Chronic stable patients	Not Applicable	Cumulative (Year-to-date)	Quarterly	Higher number of active patients enrolled in the programme	Technical Specialist: NHI Service Provider
6.	Phased development of Electronic Medical Record - (EMR) for Primary Health Care Services	EMR is a digital version of paper records of a patient, delivered through an electronic platform	Documented evidence of EMR-MVP2	Not Applicable	Not Applicable	EMR-MVP2 solution on the production server	Not Applicable	Not Applicable	All Districts	Non-cumulative	Annual	EMR-MVP2 Developed	Chief Director: Health Systems-Digital Health

Programme 3: Communicable and non-communicable diseases

	Programme 3: Communicable and non-communicable diseases												
	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 HIV Patients enrolled on Differentiated Model of Care (DMOC)	Number of stable HIV clients who are virally suppressed are decanted to Differentiated Model of Care (DMoC) disaggregated into Facility Pick Up Point (FAC-P UP), Adherence Clubs (ACs), and External Pick Up Points (EX-PUP) (Definition for viral suppression is Viral Load ,50copies/ml). This enables improved linkage to care, adherence to treatment and retention in care.	DHIS	Number of HIV Patients enrolled on Differentiated Model of Care (DMOC)	No Denominator	DHIS Reports which indicate summary and provincial breakdown figures	Stable clients who are virally suppressed are decanted to DMOC.	HIV and AIDS patients	All Districts	Cumulative (Year-to-date)	Quarterly	A higher number of stable clients are decanted to DMOC	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	Number of HIV clients on ART	Total clients who tested positive	DHIS Reports which indicate summary and provincial breakdown figures	Accurate records provided by PHC Facilities	HIV and AIDS patients	All Districts	Cumulative (Year-end)	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	Number of clients who are virally suppressed	Total clients on ART	DHIS Reports which indicate summary and provincial breakdown figures	Accurate records provided by PHC Facilities	HIV and AIDS patients	All Districts	Cumulative (Year-end)	Quarterly	A higher number of clients that are virally suppressed	Chief Director: HIV and AIDS & STIs

	Programme 3: Communicable and non-communicable diseases												
	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 perfor-mance	Indicator Respon-sibility
4.	Number of PHC facilities with youth zones	Youth Zone is a dedicated space at a facility where young people's needs are addressed by staff trained to deal with the youth as required	Reports from PHC facilities confirming the activation of youth zones	Sum of PHC facilities with youth zones	No Denominator	Reports from PHC facilities confirming the activation of youth zones	The youth zones would remain active after the inspection and/ or support visit	Youth	All Districts	Cumulative (Year-to-date)	Quarterly	A higher number of youth zones available in the health facilities	Chief Director: HIV and AIDS & STIs
5.	Drug-susceptible TB (DS-TB) Treatment success rate	TB clients who started drug susceptible tubercolosis (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)	Facility TIER. Net reports	Not Applicable	TB Patients	All treating health facilities	Cumulative (Year-to-date)	Quarterly	Higher Success Rate	Chief Director: TB Control and Manageme-nt
6.	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	Facility level TIER.Net and EDR Web reports	None	TB Patients	All treating health facilities	Cumulative (Year-to-date)	Quarterly	Higher number of people started on TB treatment	Chief Director: TB Control and Manageme-nt

	Programme 3: Communicable and non-communicable diseases												
	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**
7.	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 deaths (obstretic and non-obstretic) 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	Minimal misalignment between data in DHIS and data collected through the National Confidential Enquiry into Maternal Deaths	Women	All Provinces	Non-cumulative	Quarterly	Lower maternal mortality in facility ratio	Chief Director: Maternal, Child and Women's Health
8.	Neonatal deaths in facility rate	Infants 0-28 days who died during their stay in the facility per 1 000 live births in facility	DHIS	Noenatal 0-28 days death in facility	Live birth in facility	DHIS Reports which indicate summary and provincial breakdown figures	Minimal misalignment between data in DHIS and data collected through the National Confidential Enquiry into Maternal Deaths	Infants	All Districts	Cumulative (Year-end)	Annual	Lower rates	Chief Director: Maternal, Child and Women's Health
9.	Non-polio Acute Flaccid Paralysis (NPAFP) detection rate in children < 15 years of age	Number of cases of Non-polio Acute Flaccid Paralysis per 100,000 children under 15 years of age	Reports from provinces and National Institute of Communicable Diseases (NICD)	Number of cases of Non-polio Acute Flaccid Paralysis in children under 15 years of age	Number of children under 15 years of age (calculated per 100 000)	Reports from provinces and NICD	None	Children	All Districts	Non-cumulative	Quarterly	Higher NPAFP detection rate indicating more sensitive surveillance	Chief Director: Child, Youth and School Health

	Programme 3: Communicable and non-communicable diseases												
	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
10.	Number of Districts performing HPV screening for cervical cancer	HPV screening included as the cervical cancer screening method in addition or substitute to cytology screening. The goal is to incrementally increase HPV screening in Districts to cover 40 Districts	NHLS report confirming requests for HPV screening	Number of Districts performing HPV screening for cervical cancer	No Denominator	Laboratory summary report, List of districts performing HPV screening for cervical cancer	NHLS has the capacity to perform HPV screening	Women	All provinces	Cumulative (Year-to-date)	Quarterly	Higher number of Districts performing HPV screening for cervical cancer	Chief Director: Maternal, Child and Women's Health
11.	Number of girls aged 9-15 years vaccinated against HPV (1st dose)	Number of girls aged 9-15 years vaccinated against HPV (1st dose)	HPV Registers	HPV(also known as Cevarix) 1st dose vaccination given to a girl 9 years and older	Not Applicable	HPV Registers	Campaign resources area available for vaccination	Girls	All provinces	Cumulative (Year-to-date)	Quarterly	Higher number of girls vaccinated	Chief Director: Maternal, Child and Women's Health
12.	Number of cervical cancer screening tests performed	Number of cervical cancer screening tests performed	DHIS	Cervical cancer screening in HIV positive women 20 years and older+ Cervical cancer screening in non HIV women 30-50 years	Not Applicable	DHIS	Not Applicable	Women	All provinces	Cumulative (Year-to-date)	Quarterly	Higher number of women screened for cervical precancer and cancer	Chief Director: Maternal, Child and Women's Health
13.	Number of Grade R learners screened	Grade R learners in the school screened by a nurse in line with the Integrated School Health Programme (ISHP) service package. 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	Funding is available to expand school health services	Children	All provinces	Cumulative (Year-end)	Annual	A higher number of Grade R learners are screened	Chief Director: Maternal, Child and Women's Health

	Programme 3: Communicable and non-communicable diseases												
	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
14.	Number of sub-districts implementing the foci clearing programme	Foci clearing programme is implemented in malaria-endemic sub-districts. There are 33 malaria-endemic sub-districts in the country, where the foci programme is implemented. This year the programme targets four additional endemic sub-districts.	MIS (Malaria Information Systems)- Web based DHIS2	Number of sub-districts implementing the foci clearing programme	Not Applicable	Provincial review reports	Provincial implementation of the foci clearing programme within targeted sub-districts will be in accordance with the NSP 2024-28	Endemic sub-districts	Endemic sub-districts	Cumulative (Year-end)	Annual	All endemic sub-districts implementing the foci clearing programmes	Chief Director: Communicable Diseases
15.	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 is dependent on the resources available	Adults	All Districts	Cumulative (Year-end)	Annual	A high number of screenings conducted	Chief Director: Non-Communicable Diseases
16.	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 for elevated blood pressure for early detection	DHIS	Number of screenings for hypertension	Not Applicable	DHIS Reports which indicate summary and provincial breakdown figures	Screening within Provinces is depecndent on the resources available	Adults	All Districts	Cumulative (Year-end)	Annual	A high number of screenings conducted	Chief Director: Non-Communicable Diseases
17.	Roadmap on strengthening resourcing and functionalty of Mental Health Review Boards developed	A roadmap guiding provinces to strengthen resourcing and functionality of Mental Health Care Review Boards	Records of consultative forum attendance, forum recommendations report. Draft 1 Roadmap and Final Draft of the Roadmap	Not Applicable	Not Applicable	Records of consultative forum attendance, forum recommendations report. Draft 1 Roadmap and Final Draft of the Roadmap	Stakeholders will be available to participate in the consultative forum, and required resources will be made available	Not Applicable	Not Applicable	Non-cumulative	Quarterly	Roadmap on strengthening resourcing and functionality of Mental Health Review Boards developed	Chief Director: Non-Communicable Diseases

	Programme 3: Communicable and non-communicable diseases												
	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**
18.	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-end)	Annual	Higher number of mental health care providers	Chief Director: Non-Communicable Diseases
19.	Number of hospitals assessed for compliance with the food service policy	Hospitals assessed for compliance with the food service management policy, per year.	Assessment reports for hospitals	Number of hospitals assessed for compliance with the food service policy	Not Applicable	Assessment tool used to measure compliance	Hospitals Implementing the food service policy	Not Applicable	All Districts	Cumulative (Year-to-date)	Quarterly	All public hospitals assessed for compliance	Chief Director: Non-Communicable Diseases

Programme 4: Primary Health Care

	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 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	Not Applicable	All Districts	Non-cumulative	Annual	Higher number of clinics obtained ideal clinic status	Chief Director: District Health Services
2.	Number of community outreach services to households' visits	Household visited by Community Health Workers (CHWs) first and follow up visits	DHIS	Number of households visited by CHWs	Not Applicable	DHIS Reports which indicate summary and provincial breakdown figures	Accurate records provided by PHC Facilities	Not Applicable	All Districts	Cumulative (Year-end)	Annual	Higher number of outreach services to households	Chief Director: District Health Services
3.	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 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: Environmental and Port Health services
4.	National database of Emergency Medical Services resources developed	The development of a standardized and comprehensive National Database of Provincial EMS resources (staffing, fleet, stations and emergency communication centers) for purpose of planning, monitoring and evaluation	A National database of EMS resources approved	Not Applicable	Not Applicable	A National database of EMS resources	Not Applicable	Not Applicable	All Districts	Non-cumulative	Annual	National database of EMS resources	Chief Director: Trauma, Violence, and EMS

Programme 5: Hospital Systems

	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 Transformation (where applicable)**	**Calculation Type**	**Reporting Cycle**	**Desired performance**	**Indicator Responsibility**
1.	National clinical governance manual developed	A national clinical governance manual to guide the improvement of clinical care governance in hospitals	Approved national clinical governance manual	Not Applicable	Not Applicable	Approved national clinical governance manual	NHCC members will be consulted for the finalisation of the national clinical governance manual; Finalisation subject to NHC Tech approval.	Not Applicable	All Provinces	Non-cumulative	Annual	A national clinical governance manual to guide the implementation of clinical governance in hospitals	Chief Director: Hospitals and Tertiary Health Services
2.	Patient Satisfaction Rate	Number of satisfied responses as a proportion of all responses from Patient Experience of Care survey questionnaires (Fixed PHC clinics/fixed CHCs/CDCs and public hospitals)	PEC module of the DHIS	Patient Experience of Care survey satisfied responses	Patient Experience of Care survey total responses	Patient Surveys	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Non-cumulative	Annual	Higher performance on patient satisfaction	Chief Director: Hospitals and Tertiary Health Services
3.	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	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	Not Applicable	All Districts	Cumulative (Year-end)	Annual	Higher number of PHC facilities constructed	Chief Director: Health Facilities & Infrastructure Management

	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 Transformation (where applicable)**	**Calculation Type**	**Reporting Cycle**	**Desired performance**	**Indicator Responsibility**
		(reached practical completion) of work aimed at improving the capacity and effectiveness of an asset above that of the initial design purpose of PHC facilities.											
4.	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 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	Cumulative (Year-end)	Annual	Higher number of Hospitals constructed or revitalised	Chief Director: Health Facilities & Infrastructure Management
5.	Number of Public Health facilities maintained, repaired or refurbished.	Optimizing infrastructure requirements in maintaining Health facilities efficiency, reliability, and safety in the delivery of the *Public Health Facilities include Clinics, Hospitals, Nursing Colleges ans 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 facilities maintained, repaired and/or refurbished, according to Maintenance Plans	Not Applicable	All Districts	Cumulative (Year-end)	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

	Programme 6: Hospital 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.	Number of Board appointments for Public Entities and Statutory Councils	Public Entities governance structures established for effective corporate governance of the institutions	Signed off submission and letters by the Minister	SAMRC: OHSC and HPCSA Boards appointed	Not Applicable	Signed off submission and letters of appointment by the Minister	Suitable nominations received for appointment	Not Applicable	Not Applicable	Non-cumulative	Annual	Boards appointed for the new term of office	Directorate: Public Entity Governance
2.	Audit action plans for Public Entities monitored	Review the annual report of public entities and develop an audit action plan for entities with mental findings to address the audit findings or root cause	(1) Approved Submission on the review of the annual report and action plan of public entities. (2) Entity's quarterly progress reports against audit action/ remedial plan	Number of annual reports received, and an audit action plan developed for each entity to address audit findings	Number of action audit plans monitored	Public Entities Annual reports	Annual Report audited	Not Applicable	Not Applicable	Non-cumulative	Annual	100% of annual reports received from public entities reviewed and action plan developed to address internal control deficiencies	Directorate: Public Entity Governance
3.	Number of provinces with Nursing Leadership competency framework implementation plans developed	Nursing leadership competency implementation palns based on the Nursing Leadership competency framework will be developed in all provinces	Provincial Nursing Leadership Competency Framework Implementation plans	Number of provinces with competency framework implementation plans developed	Not Applicable	Q1 Evidence: Validation workshop presentation; Attendance register for the validation workshop and Finalised Nursing Leadership Framework; Other Quarters: Provincial Nursing Leadership Competency Framework implementation plans	Resource are available to develop the plans	Not Applicable	All Provinces	Cumulative (Year-to-date)	Quarterly	All provinces to develop Nursing Leadership Competency Framework implementation plans	Chief Nursing Officer
4.	Draft Framework for distribution of Multidisciplinary teams for District hospitals developed	Framework for didtribution of Multidisciplinary teams to guide staffing norms for District hospitals	Draft Framework developed	Not Applicable	Not Applicable	Draft Framework developed	Stakeholders will cooperate for timeous finalisation	Not Applicable	All Provinces	Non-cumulative	Annual	First Draft Framework developed	Chief Director: Human Resources Health

	Programme 6: Hospital 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 Transfor-mation (where applicable)**	**Calculation Type**	**Reporting Cycle**	**Desired perfor-mance**	**Indicator Respon-sibility**
5.	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	Food labelling regulations gazetted	Directorate: Food Control
6.	Number of districts implementing EBS	District is 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 reports	Funding availability	Not Applicable	All Districts	Cumulative (Year-to-date)	Quarterly	Higher number of Districts	Chief Director: Health Information, Epidemiology, Research, Monitoring & Evaluation

ANNEXURE B

CONDITIONAL *GRANTS*

CONDITIONAL GRANTS

Direct Grants

Name of Grant	Purpose	Output Indicators	2025/26 Targets	2025/26 Annual Budget R'000
Statutory Human Resources & HP Training & Development	To appoint statutory positions in the health sector for systematic realisation 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 649 937
		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	R15 994 921
		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 Revitalisation Grant	To help accelerate construction, maintenance, upgrading and	Number of PHC facilities constructed or revitalised	40	R7 245 705

Name of Grant	Purpose	Output Indicators	2025/26 Targets	2025/26 Annual Budget R'000
	rehabilitation of new and existing infrastructure in health including, health technology, organisational 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 Hospitals constructed or revitalised	30	
		Number of Facilities maintained, repaired and/or refurbished	450	
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	R24 927 389
		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	

Name of Grant	Purpose	Output Indicators	2025/26 Targets	2025/26 Annual Budget R'000
		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	
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 school girls 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 roll out COVID-19 vaccine	Number of malaria-endemic municipalities with 95 per cent or more indoor residual spray (IRS) coverage	10	R3 411 515
		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 per cent of grade 5,6,7 school girls aged 9-14 years are vaccinated with a single dose of HPV vaccine, in **public and special schools.**	2 761 727	

Name of Grant	Purpose	Output Indicators	2025/26 Targets	2025/26 Annual Budget R'000
		90 percent of grade 5,6,7 schoolgirls aged 9-14 years are vaccinated with a single dose of HPV vaccine in **private and independent schools.**	154 984	
		90 percent 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	45 661	
		HIV defaulters traced	818 041	
		TB defaulters traced	99 672	
		Number of community health workers trained	22 895	
		Number of Community Outreach Services household visits	15 000 000	
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	
		Number of mental health care providers contracted	235	
		Number of users seen by contracted mental health care providers	205 000	R466 680

Indirect Grants

Name of Grant NATIONAL HEALTH INSURANCE INDIRECT GRANT	Purpose	Output Indicators	2025/26 Targets	2025/26 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	R2 485 381
		Number of Hospitals constructed or revitalised	1	
		Number of Facilities maintained, repaired and/or refurbished	0	
Health System 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 comorb dities non-comminicable diseases number of pickup points (state and non-state)	3.5 million	R797 173
		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	2025/26 Targets	2025/26 Annual Budget R'000
		Continue to socialise the use of the Interoperability Normative Standards Framework	Hosting of a projection with vendors developing patient information systems Purchasing of the required software to improve the operations of the Interoperability conformance testing laboratory	
		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 2 EMR focusing on Primary Health Care - Minimum Viable Product MVP2 available for roll-out and implementation	
		Number of primary health care 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	
		Intern Community Service Programme (ICSP) system maintained, and improvements effected	ICSP manages a total of 14 000 applicants per Annum divided as follows 9800 applicants to be allocated in October for the January appointments into funded posts that are 2500 medical interns and 7800 community service.	

Name of Grant NATIONAL HEALTH INSURANCE INDIRECT GRANT	Purpose	Output Indicators	2025/26 Targets	2025/26 Annual Budget R'000
			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 public health facilities in quality learning centres with self-assessments reports	100% public health facilities with self-assessment reports	

ANNEXURE C

STANDARDISED INDICATORS FOR *2025/26 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 amd 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

Annual Performance Plan of Provincial Departments of Health	
	Output Indicator Title
1.	Couple Year Protection Rate
2.	Number of Deliveries in 10-14 years in facility
3.	Antenatal 1st visit before 20 weeks rate
4.	Infant 1st PCR test positive at birth rate
5.	Immunisation under 1 year coverage
6.	MR 2nd dose 1 year coverage
7.	Child under 5 years diarrhoea case fatality rate
8.	Child under 5 years pneumonia case fatality rate
9.	Child under 5 years severe acute malnutrition case fatality rate
10.	Cervical Cancer Screening Coverage
11.	HIV positive 5-14 years (excl ANC) rate
12.	HIV positive 15-24 years (excl ANC) rate
13.	ART adult remain in care rate [12 months]
14.	ART child remain in care rate [12 months]
15.	ART adult viral loadsuppressed rate (below 50) [12 months]
16.	ART child viral loadsuppressed rate (below 50) [12 months]
17.	All DS-TB client Treatment Success Rate
18.	TB - Rifampicin resistant/Multidrug-Resistant Treatment Success Rate
19.	Malaria case fatality rate
20.	PHC Mental Disorders Treatment rate new
21.	Patient Experience of Care Survey rate
22.	Audit outcome for regulatory audit expressed by AGSA

Annexure D: District Development Model (DDM)

One of the key principles of the District Development Model One Plan is the incorporation of initiatives and interventions to deal with Gender Based Violence and Femicide as guided by the National Strategic Plan (NSP) on Gender Based Violence and Femicide (GBVF). The health sector has a critical role to play in providing support to victims of Gender Based Violence. These interventions include the designation of public health facilities to manage sexual offence cases and reporting on new cases of sexual assualt presenting at health facilities. The health facilities is usually the first point of contact for teenagers who are pregnant, and pregnancy in the age group of 10-14 year is particularly concerning. Interventions are geared to ensure that the health personnel are capacitated to manage and report cases appropriately in collaboration with all key stakeholders in other sectors.

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Dr. AB Xuma Building
1112 Voortrekker Road
Pretoria Townlands 351-JR
0001

National Department of Health
Private Bag X828
Pretoria
0001

Switchboard: +27 (0)12 395 8000

www.health.gov.za

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