health
MPUMALANGA PROVINCE
REPUBLIC OF SOUTH AFRICA

Mpumalanga Department of Health

Annual Performance Plan

2026/2027

March 2026

MPUMALANGA
THE PLACE OF THE RISING SUN

"A Long and Healthy Life For All South Africans..."

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Executive Authority Statement

The Mpumalanga Department of Health remains committed to advancing the health and well-being of the people of Mpumalanga through the provision of equitable, accessible, and quality health services. This Annual Performance Plan (APP) for the 2026/2027 financial year outlines the Department's strategic priorities, performance indicators, and targets that will guide the implementation of programmes aimed at strengthening the provincial health system and improving health outcomes across all districts. The APP is aligned with the priorities of the Government of South Africa and the vision articulated in the National Development Plan 2030, which seeks to ensure a long and healthy life for all South Africans. It further supports the implementation of the Medium-Term Development Plan (MTDP) 2024–2029, which sets out government's development priorities over the medium term. Through this plan, the Department contributes to MTDP priorities that seek to improve the quality of basic services, strengthen human capabilities, reduce poverty and inequality, and build a capable, ethical and developmental state.

In alignment with the MTDP, the Department's programmes and performance indicators contribute directly to key national outcomes related to improving life expectancy, reducing maternal and child mortality, strengthening the response to HIV and TB, and improving the quality of healthcare services. The APP therefore sets measurable targets that focus on improving primary health care performance, expanding access to quality hospital services, strengthening emergency medical services, and enhancing disease prevention and health promotion interventions. The Department also aligns its priorities with the developmental agenda of the Mpumalanga Provincial Government, which emphasizes improving service delivery, strengthening social development, building resilient communities, and ensuring that public institutions function effectively and accountably. Through targeted interventions in health infrastructure development, human resources for health, digital health systems, and community-based health services, the Department aims to contribute meaningfully to improving the overall quality of life of the people of Mpumalanga.

The Department remains committed to advancing the implementation of the National Health Insurance as a transformative reform aimed at achieving Universal Health Coverage. In preparation for the progressive implementation of National Health Insurance, the Department will prioritise strengthening facility readiness through the Ideal Clinic Realisation and Maintenance programme, improving quality of care, and ensuring compliance with standards set by the Office of Health Standards Compliance. These initiatives are critical to ensuring that health facilities are capable of delivering safe, high-quality and patient-centred services. The Department recognises that the achievement of improved health outcomes requires strong governance, accountability, and sound financial management. In this regard, the Department will continue to strengthen internal control systems, performance management, monitoring and evaluation, and risk management processes in line with the requirements of the Public Finance Management Act and other applicable regulatory frameworks. Particular emphasis will be placed on improving data integrity, strengthening performance reporting, and addressing audit findings in order to enhance accountability and transparency in the use of public resources.

As part of the Department's commitment to good governance, deliberate efforts will be undertaken to strengthen audit readiness processes, improve compliance with financial and performance management prescripts, and progressively improve audit outcomes. These efforts reflect the Department's determination to move towards clean administration and clean audit outcomes, while ensuring that governance systems support efficient service delivery and public confidence in the health system.

Despite fiscal constraints and the increasing demand for public health services, the Department remains committed to ensuring that available resources are utilised efficiently and strategically to maximize impact. Collaboration with municipalities, other government departments, development partners, academic institutions, and communities will continue to be strengthened in order to address the social determinants of health and promote a whole-of-government and whole-of-society approach to health.

As Executive Authority, I remain confident that through the dedication of our healthcare workers, the leadership of our management teams, and the support of our stakeholders and communities, the Department will successfully implement the priorities outlined in this APP. Together, we will continue working towards building a resilient, responsive, and people-centred health system that improves the quality of life of all people in Mpumalanga.

I therefore present the Annual Performance Plan of the Mpumalanga Department of Health for the 2026/2027 financial year, reaffirming our unwavering commitment to improving health outcomes, strengthening governance, and ensuring that every resident of Mpumalanga has access to quality healthcare services.

Signature: 

Date: 31 | 03 | 2026.

Honorable SJ Manzini

Executive Authority: Department Health

Accounting Officer Statement

The Mpumalanga Department of Health has developed this Annual Performance Plan (APP) for the 2026/2027 financial year to translate the Department's strategic priorities into measurable programmes, indicators, and targets that will guide implementation and service delivery across the province. This APP is aligned with the Department's Strategic Plan, the priorities of the Government of South Africa, and the Medium-Term Development Plan (MTDP) 2024–2029. It outlines the Department's planned outputs across all programmes and provides clear performance indicators and targets that will enable the Department to track progress in improving health outcomes and strengthening the provincial health system.

The APP reflects the Department's commitment to improving service delivery through strengthened primary health care services, improved hospital care, enhanced emergency medical services, and strengthened public health programmes aimed at addressing both communicable and non-communicable diseases. Particular attention is given to improving maternal, neonatal, child and women's health outcomes, accelerating the response to HIV and TB, and strengthening disease surveillance and prevention interventions.

The Department will continue to strengthen its readiness for the implementation of the National Health Insurance through targeted interventions aimed at improving quality of care and facility performance. In this regard, the Department will continue to implement the Ideal Clinic Realisation and Maintenance programme and ensure compliance with the standards of the Office of Health Standards Compliance to improve the quality and safety of healthcare services provided in public health facilities.

To support effective implementation of this APP, the Department will continue strengthening monitoring and evaluation systems, data management processes, and performance reporting mechanisms. These systems will ensure that performance information is reliable, credible, and aligned with the District Health Information System (DHIS) and other national health information platforms used to monitor health indicators.

The Department also recognises the importance of sound financial management and strong governance in achieving its delivery objectives. In line with the requirements of the Public Finance Management Act and other applicable regulatory frameworks, the Department will continue to strengthen internal controls, risk management processes, and compliance with financial and performance management prescripts. Particular focus will be placed on improving data integrity, addressing audit findings, and strengthening oversight mechanisms to support improved audit outcomes.

The successful implementation of this plan will require coordinated efforts across provincial programmes, districts, and health facilities. Programme managers, district management teams, and facility managers will be responsible for ensuring that planned targets are implemented effectively and that progress is monitored regularly through established performance management and reporting systems The Department remains committed to improving efficiency in the utilisation of available resources, strengthening accountability, and ensuring that public funds are used responsibly to maximize health service delivery impact.

As Accounting Officer, I confirm that the Annual Performance Plan for the 2026/2027 financial year was developed in accordance with the applicable legislative and policy frameworks governing planning, performance management, and reporting in the public service. The performance indicators and targets

contained in this APP are considered realistic, achievable, and aligned with the Department's available resources and capacity.

I therefore submit this Annual Performance Plan for the Mpumalanga Department of Health for the 2026/2027 financial year as the basis for monitoring and reporting on the Department's performance in the year ahead.

Signature: _____

Date: 31/3/2026

Dr LK Ndhlovu

Executive Authority: Department Health

Official Sign Off:

It is hereby certified that this Annual Performance Plan submitted **on 13 March 2026,**

- Was developed by the management of the Mpumalanga Department of Health under the guidance of Mpumalanga Provincial Government
- Takes into account all the relevant policies, legislation and other mandates for which the Mpumalanga Province is responsible
- Accurately reflects the Outcomes and Outputs which the Mpumalanga Department of Health will achieve over the period 2026-2027 FY

[Ms JR Nkosi] Signature:

Manager Programme 1: Administration

[Dr C Nelson] Signature:

Manager Programme 2: District Health Services

[Mr NW Sithole] Signature:

Manager Programme 3: Emergency Medical Services

[Ms M Mohale] Signature:

Manager Programme 4: General (Regional) Hospitals, Programme 5: Tertiary and Central Hospitals, Programme 7: Health Care Support Services

[Mr B Magagula] Signature:

Manager Programme 6: Health Sciences and Training

[Mr EL Mokwane] Signature:

Manager Programme 8: Infrastructure

[Ms CA Nkuna] Signature:

Deputy Director General: Finance

[Mr PB Mdlovu] Signature:

[Head Official responsible for Planning]

[Dr LK Ndhlovu] Signature:

Accounting Officer

Approved by:

[Hon. SJ Manzini] Signature:

Executive Authority

Acknowledgements

The development of the annual performance plan has benefited from the unwavering commitment and contributions of several stakeholders from the Districts, Provincial Department of Health including departments, and organisations supporting the department. Appreciation goes to the following stakeholders for their contributions and dedication to the finalization of the annual performance plan for the year 2026-2027 under the leadership of the Department of Health.

1. All participants in the consultations
2. The Department of Health provincial management and programme management teams
3. The Department of Health district management and programme management teams
4. The National Department of Health

Acronyms

AIDS	Acquired Immuno deficiency syndrome
ANC	Antenatal Care Services
ART	Antiretroviral Therapy Treatment
BUR	Bed Utilization Rate
CCMDD	Central Chronic Medicine Dispensing and Distribution
CEOs	Chief Executive Office
CHW	Community Health Worker
COS	Community Outreach Services
CV19	Covid 19
DHB	District Health Barometer
DHIS	District Health Information System
DMoC	Differentiated Models of Care
DOH	Department of Health
DS-TB	Drug Sensitive Tuberculosis
EA	Enterprise Architecture
EML	Essential Medicine List
EMS	Emergency Medical Services
EPWP	Sector Expanded Public Works Programme
FPS	Forensic Pathology Services
GPS	Global Positioning System
HAST	HIV/AIDS, STI's and Tuberculosis
HbA1C	Haemoglobin A1C
HIV	Human Immunodeficiency Virus
HPRS	Health Patient Registration System
ICT	Information and Communication Technology
ICU	Intensive Care Unit
IMMR	In facility maternal mortality ratio
ISHP	Integrated School health Program
LTFU	Loss to Follow Up
MCWH&N	Mother to Child Woman's' Health and Nutrition
MEC	Member of the Executive Council
MMR	Maternal Mortality Ratio
MP	Mpumalanga
NCDs	Non-Communicable Diseases
NDOH	National Department of Health
NDP	National Development Plan
NHA	National Health Act
NHI	National Health Insurance
NMIR	National Minimum Information Requirements
PCR	Polymerase Chain Reaction
PHC	Primary Health Care
PLHIV	People Living with Human Immunodeficiency Virus
PrEP	Pre-Exposure Prophylaxis
PSI	Patient Safety Incidents
SAC	Severity Assessment Code
SAM	Severe Acute Malnutrition
SCM	Supply Chain Management
SDG	Sustainable Development Goals
SRH	Sexual and Reproductive Health
STATSA	Statistics South Africa
TB	Tuberculosis
TRIPS	Trade-Related Aspects of Intellectual Property Rights
UHC	Universal Health Coverage

PART A: OUR MANDATE

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

1.1. Legislation 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, considering the obligations imposed by the Constitution and other laws on the national, provincial, and local governments regarding 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 decentralized 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.

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 provides for transparency in the pricing of medicines.

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

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.

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.

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.

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.

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.

Academic Health Centres Act, (Act No. 86 of 1993): - Provides for the establishment, management, and operation of academic health centres.

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.

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

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.

Council for Medical Schemes Levy Act, 2000 (Act No. 58 of 2000): - Provides a legal framework for the Council to charge medical schemes certain fees.

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.

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.

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.

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

National Health Insurance Act, 2023 (Act No. 20 of 2023): - Provides for the establishment and maintenance of a National Health Insurance Fund that will serve as the single purchaser and single payer of health care services

1.2. Other legislation applicable to the Department

Criminal Procedure Act, 1977 (Act No.51 of 1977), Sections 212 4(a) and 212 8(a): - Provides for establishing the cause of non-natural deaths.

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

Occupational Health and Safety Act, 1993 (Act No.85 of 1993): - Provides for the requirements that employers must comply with to create a safe working environment for employees in the workplace.

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.

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

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

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.

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.

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

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.

Division of Revenue Act, (Act No 7 of 2003): - Provides a way revenue generated may be disbursed.

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.

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.

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.

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

2.1. National Health Insurance Act

South Africa is in the midst of effecting significant and much needed changes to its health system financing mechanisms. The changes are based on the principles of ensuring the right to health for all, entrenching equity, social solidarity, and efficiency and effectiveness in the health system to realise Universal Health Coverage. To achieve Universal Health Coverage, institutional and organisational reforms are required to address structural inefficiencies; ensure accountability for the quality of the health services rendered and ultimately to improve health outcomes particularly focusing on the poor, vulnerable and disadvantaged groups.

In many countries, effective Universal Health Coverage has been shown to contribute to improvements in key indicators such as life expectancy through reductions in morbidity, premature mortality (especially maternal and child mortality) and disability. An increasing life expectancy is both an indicator and a proxy outcome of any country's progress towards Universal Health Coverage.

The phased implementation of NHI is intended to ensure integrated health financing mechanisms that draw on the capacity of the public and private sectors to the benefit of all South Africans. The policy objective of NHI is to ensure that everyone has access to appropriate, efficient, affordable, and quality health services.

Phase 1 (2024-2026): Focuses on establishing foundational institutions and legal frameworks, setting up the NHI Fund, developing policies, strengthening healthcare delivery systems, and accrediting healthcare providers.

Phase 2 (2026-2028): Involves scaling up to full NHI operations, with the NHI Fund actively purchasing services and enrolling providers.

The potential impact of the NHI Bill is significant, aiming to achieve universal health coverage by establishing a single public purchaser of healthcare services. The NHI Fund will pool public revenue through mandatory prepayment, ensuring equitable, efficient, and affordable healthcare for all South Africans.

To support strengthening of the health system and improving quality of care, several healthcare facilities will be constructed across the country, including district, regional and central hospitals. Existing facilities will undergo modernisation, improvement and maintenance.

2.2. National Development Plan: Vision 2030

The National Development Plan (Chapter 10) has outlined 9 goals for the health system that it must reach by 2030. The NDP goals are best described using conventional public health logic framework.

Goal 1: - Average male and female life expectancy at birth increases to 70 years

Goal 2: - Progressively improve TB prevention and cure

Goal 3: - Reduce maternal, infant and child mortality

Goal 4: - Significantly reduce prevalence of non-communicable chronic diseases

Goal 5: - Reduce injury, accidents and violence by 50 percent from 2010 levels

Goal 6: - Complete health systems reforms

Goal 7: - Primary healthcare teams provide care to families and communities

Goal 8 - Universal health care coverage

Goal 9: - Fill posts with skilled, committed and competent individuals

2.3. Sustainable Development Goals

South Africa is one of the 193 signatories to United Nations and adopted new agenda for 2030 Sustainable Development, entitled to transform the world. These Global Goals include ending extreme poverty, giving people better healthcare, and achieving equality for women. Goal number 3: Good Health and Well-Being is directly linked to health sector and they are as follows:

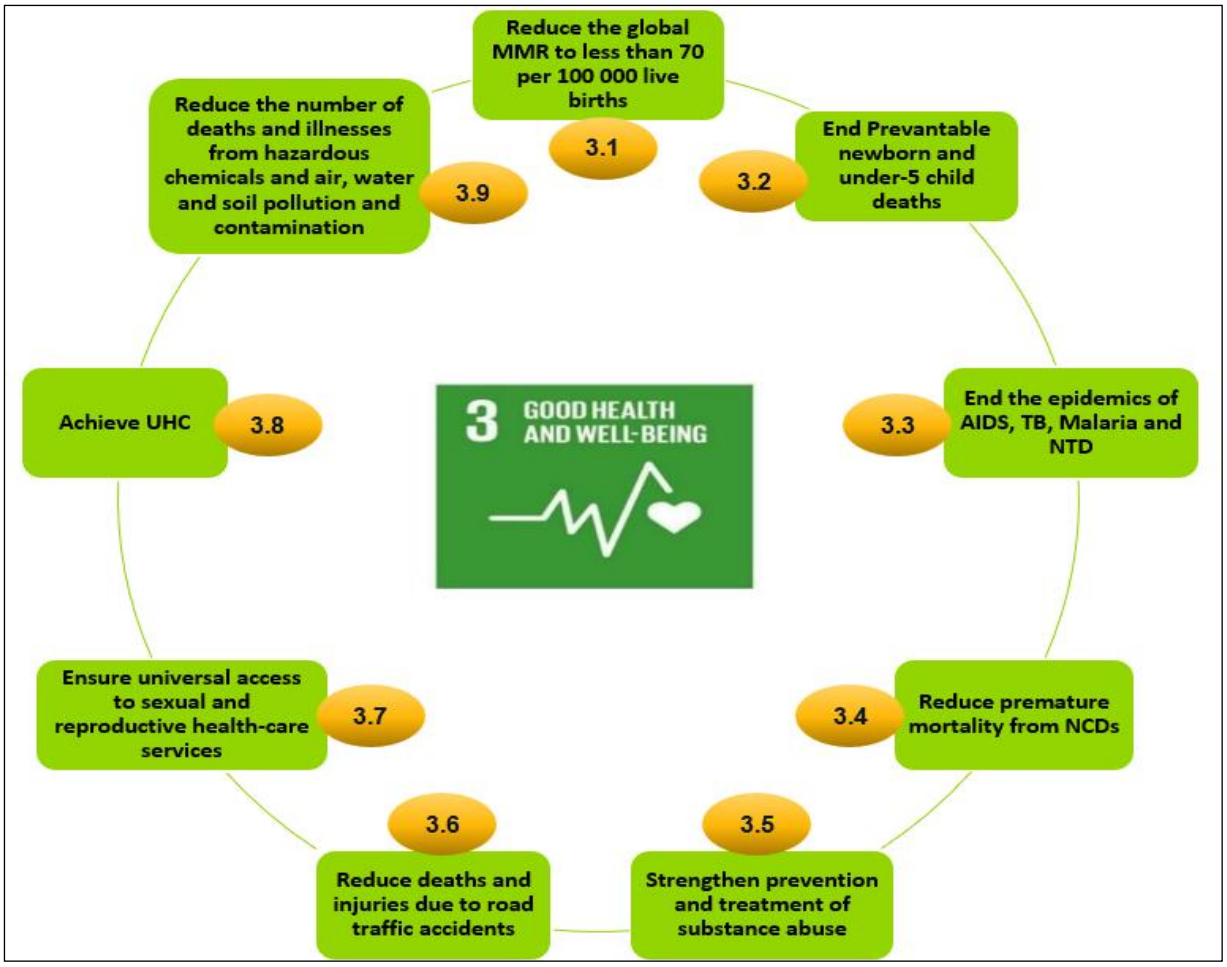


Figure 1: Sustainable Development Goals

The table below outlines each goal contributing towards Sustainable Development Goal 3.

Table 1: SDG Goals

Goal 3: Ensure Healthy lives and promote well-being for all at all ages	
3.1	By 2030, reduce the global maternal **mortality ratio to less than 70 per 100,000 live births**
3.2	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.
3.3	By 2030, **end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases** and combat hepatitis, water-borne diseases, and other communicable diseases
3.4	By 2030, **reduce by one third premature mortality from non-communicable diseases** through prevention and treatment and promote mental health and well-being
3.5	Strengthen the **prevention and treatment of substance abuse,** including narcotic drug abuse and harmful use of alcohol
3.6	By 2020, **halve the number of global deaths and injuries from road traffic accidents**
3.7	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
3.8	Achieve **universal health coverage, including financial risk protection**, access to quality essential health-care services and access to safe, effective, quality, and affordable essential medicines and vaccines for all
3.9	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.**

2.4. Medium Term Development Plan

The Seventh Administration's strategic priorities, announced by President Ramaphosa on July 18, 2024, focus on:

- Drive inclusive growth and job creation
- Reduce poverty and tackle the high cost of living
- Build a capable, ethical and developmental state.

Further to this, the Government of National Unity has outlined the 4 health sector priorities to be implemented in this current term:

Strategic Priority 2: Maintain and optimise the social wage – *investing in people through education, skills development and affordable quality health care.*

1. Pursue achievement of *universal health coverage* through the implementation of the National Health Insurance to address inequity and financial hardship in accessing quality healthcare,
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*,
3. Improve the *quality of healthcare* at all levels of the health establishments, inclusive of public and private facilities,
4. Improve resource management by optimising *human resources* and healthcare *infrastructure* and implementing a single *electronic health record*.

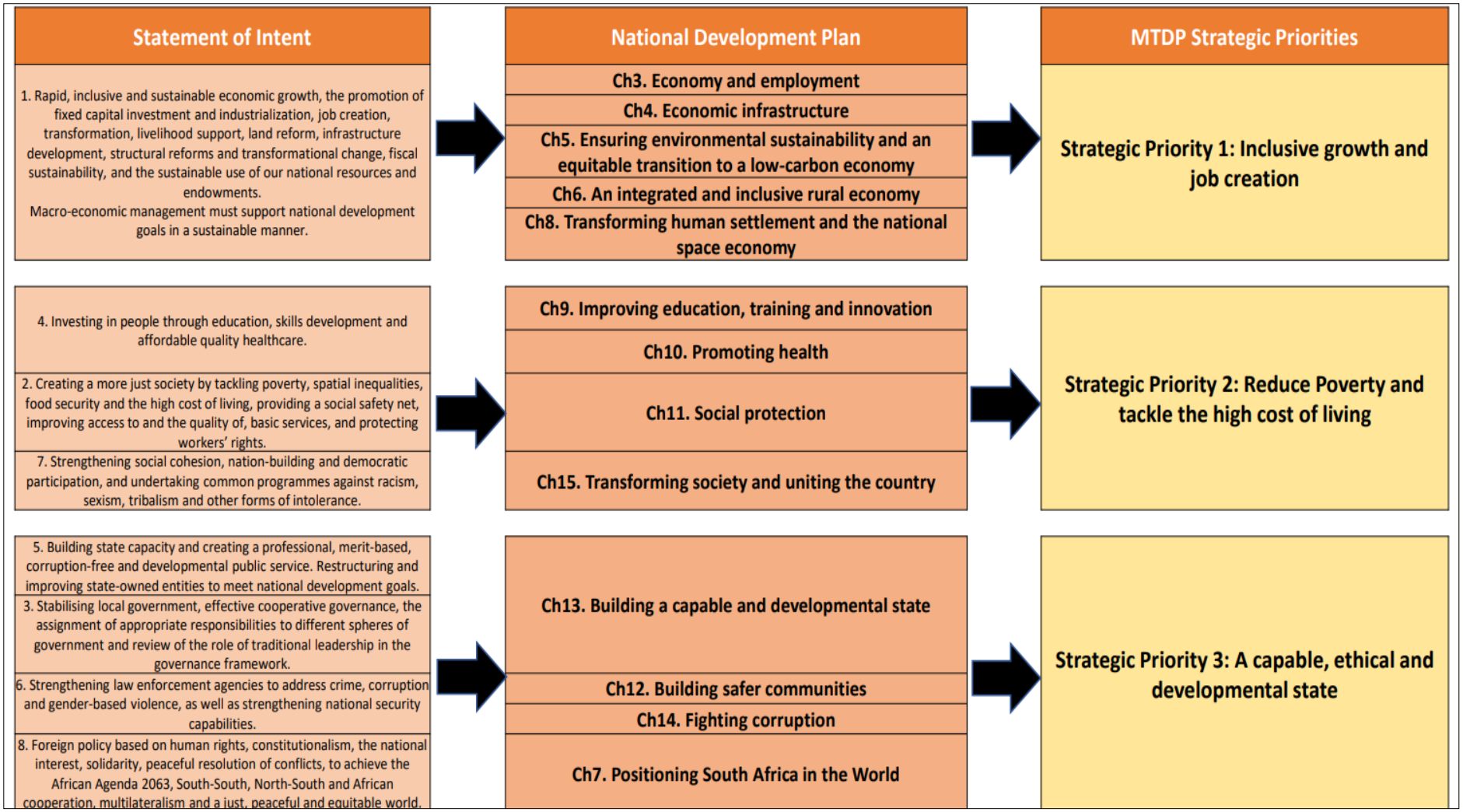


Figure 2: Alignment of GNU Statement of Intent, NDP and MTDP Priorities

2.5. Sector MTDP 2025 – 2030: Alignment of Key Strategies

Table 2: Alignment of Key Strategies: NDP 2030, MTDP 2024-2029, and Presidential Health Compact 2024-2029

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 is 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 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.

2.6. Updates to relevant court rulings

Recent court decisions about medical-negligence claims have important consequences for the Mpumalanga Department of Health. This case dealt with how government should compensate people, often children who suffer cerebral palsy during birth because of negligence in public facilities.

The first judgment, from the Supreme Court of Appeal (SCA) on 11 February 2026, overturned an earlier decision of the Eastern Cape High Court. The High Court had tried a new approach: instead of ordering the government to pay a lump-sum for a child's lifelong medical needs, it ordered the province to provide all treatment and equipment through the public health system, and to pay or reimburse costs when certain services had to be obtained privately. However, the SCA ruled that courts cannot make such a major change to the law on their own. It held that long-standing legal rules, where damages must be paid once, upfront, in money, can only be changed by Parliament, not judges. As a result, the SCA restored the traditional system of lump-sum payouts in medical-negligence cases.

The earlier High Court judgment (7 February 2023) had gone into detailed planning for the child's treatment, including therapy treatments, equipment, caregivers, and even systems for case management. It required the province to ensure these services were available in public hospitals or pay for them privately. It also tried to create a legal framework that would apply to future cases. This entire approach has now been set aside by the SCA.

For the Mpumalanga Department of Health, these developments have several practical implications.

First, large lump-sum payments remain the national standard. Until Parliament passes new legislation, provinces must continue paying full damages upfront when they lose medical-negligence cases. This means Mpumalanga must plan for the financial risk of sudden, high-value claims. These payouts can run into tens of millions of rands per case and can reduce funds available for other health services.

Second, the judgments highlight the need for strengthening the quality of care. The High Court record showed how negligence cases can arise from systemic issues such as shortages, limited therapy capacity, and financial pressures. These insights should encourage Mpumalanga to invest in better clinical governance, patient-safety systems, and early-warning mechanisms to prevent avoidable harm. Reducing negligence is the most effective way to lower medico-legal exposure.

In short, these judgments confirm that, for now, Mpumalanga must continue budgeting for lump-sum medical-negligence claims, while improving service delivery and engaging in national reform efforts to secure a more sustainable future system.

The best estimate value across the medical categories reflects the varying financial risks associated with different forms of medical negligence. Cerebral Palsy cases account for the greatest fiscal exposure, with a best estimate closing balance of approximately R4.55 billion, reflecting both the high cost and frequency of severe birth-related injuries. Obstetrics and Gynecology follow as another major contributor, with a best estimate of roughly R1.53 billion, driven by birth injuries, caesarean-related negligence, and maternal or neonatal harm. Medical cases, including misdiagnosis and delayed treatment, contribute an estimated R677 million, showing the broad financial impact of general negligence beyond surgical or obstetric categories. Orthopedic claims primarily involve fracture mismanagement and amputations total about R480 million, while Surgical cases contribute close to R362 million, reflecting injury severity but lower frequency than obstetric claims. Smaller categories include Mental Health (R6.73 million), MVA-related medical claims (R0.5 million), Other cases (R0.53 million), and Security and Safety

(R42.3 million). Overall, the department faces an estimated financial exposure of R7.91 billion from 1,214 cases, with obstetric-related categories representing the predominant share.

PART B: MEASURING OUR PERFORMANCE

3. Vision

A healthy long living Society.

4. Mission

To provide sustainable health services that are people-centric and aims at ensuring healthier, longer, and better lives focusing on access, equity, efficiency, and quality for the inhabitants of Mpumalanga.

5. Values

The department is committed to enhance quality and accessibility by improving efficiency and accountability. The following Batho Pele principles are adopted by the department as values to apply when rendering service to south African community.

- **Consultation:** Citizens should be consulted about their needs
- **Standards:** All citizens should know what service to expect
- **Redress:** All citizens should be offered an apology and solution when standards are not met
- **Accessible:** All citizens should have equal access to services
- **Courtesy:** All citizens should be treated courteously
- **Informative:** All citizens are entitled to full, accurate information
- **Openness and transparency:** All citizens should know how decisions are made and how departments are run.
- **Value for money:** All services provided should offer value for money.

6. Situational analysis

6.1. External environment analysis

6.1.1. Demographic profile

Mpumalanga province, affectionately known as the place of the rising sun, owing to the translation of the word Mpumalanga and the fact that it lies in the most eastern part of the country. The province is the second-smallest province in South Africa after Gauteng, is in the north-eastern part of the country, bordering Swaziland and Mozambique to the east. It also shares borders with the Provinces of Limpopo, Gauteng, Free State, and KwaZulu-Natal. Mbombela (previously Nelspruit) is the capital of the province and the administrative and business centre of the Lowveld region. The province is also popularly known for its coal mining operations, with over 80% of South Africa's coal mined in the province. The province contributed about 8% towards the country's gross domestic product (GDP) in 2022 (Stats SA, 2023). In addition, tourism and agro-processing are also high-value sectors.

Agriculture in Mpumalanga is characterised by a combination of commercialized farming, subsistence and livestock farming, and emerging crop farming. Crops such as subtropical fruits, nuts, citrus, cotton, tobacco, wheat, vegetables, potatoes, sunflowers, and maize are produced in the region. Mpumalanga is rich in coal reserves and home to South Africa's major coal-fired power stations. eMalahleni is the biggest coal producer in Africa and is also the site of the country's second-largest oil-from-coal plant after Sasolburg. Most of the manufacturing production in Mpumalanga occurs in the southern Highveld region. In the Lowveld sub-region, industries are concentrated around the manufacturing of products from agricultural and raw forestry material.

Mpumalanga Province has the fourth smallest population of all the provinces, with a population size of 5 335 784[1]. Population size is affected by multiple factors, including life expectancy, fertility rate, and migration patterns. Life expectancy has increased over the last 2.5 decades[1]. For males, life expectancy in the province has increased from 50.7 (2001-2006) to 62.8 years (2021-2026). For women, this increase has been from 55.1 (2001-2006) to 67.7 years (2021-2026). Over the same period, the fertility rate has been decreasing, from 2.8 (2001-2006) to 2.25 (2021-2016). MP has seen a slightly increased share of the total population from 7,8% to 8,3% between 2002 and 2025.

Province	2025 Mid-Year Estimated Population	
	n	*% of total*
Eastern Cape	7 360 759	11.5
Free State	3 007 133	4.7
Gauteng	15 676 119	24.5
KwaZulu-Natal	12 761 819	20.0
Limpopo	6 870 452	10.7
Mpumalanga	5 335 784	8.3
North West	3 917 542	6.1
Northern Cape	1 379 432	2.2
Western Cape	7 609 795	11.9
Total	**63 918 837**	**100.0**

Figure 3: Mid-year population estimates for South Africa by province,2025

Figure 3. On the left, the provinces with an increasing share are Gauteng (GP), which rises from 24.0 % in 2002 to 25.5 % in 2025, and the Western Cape (WC), which grows from 10.6 % to 11.9 %. In the middle, the provinces with a stable share are the Northern Cape (NC), moving slightly from 2.3 % to 2.2 %, and the Northwest (NW), changing from 6.4 % to 6.1 %. On the right, the provinces with a declining share are KwaZulu-Natal (KZN), dropping from 21.2 % to 20.0 %, Eastern Cape (EC) falling from 14.7 % to 11.5 %, Limpopo (LP) decreasing from 11.2 % to 10.7 %, and Free State (FS) shrinking from 5.9 % to 4.7 %. The data source is Stats SA's Mid-Year Population estimates 2025.

[1] Statistics South Africa Mid-Year Population Estimates, July 2025

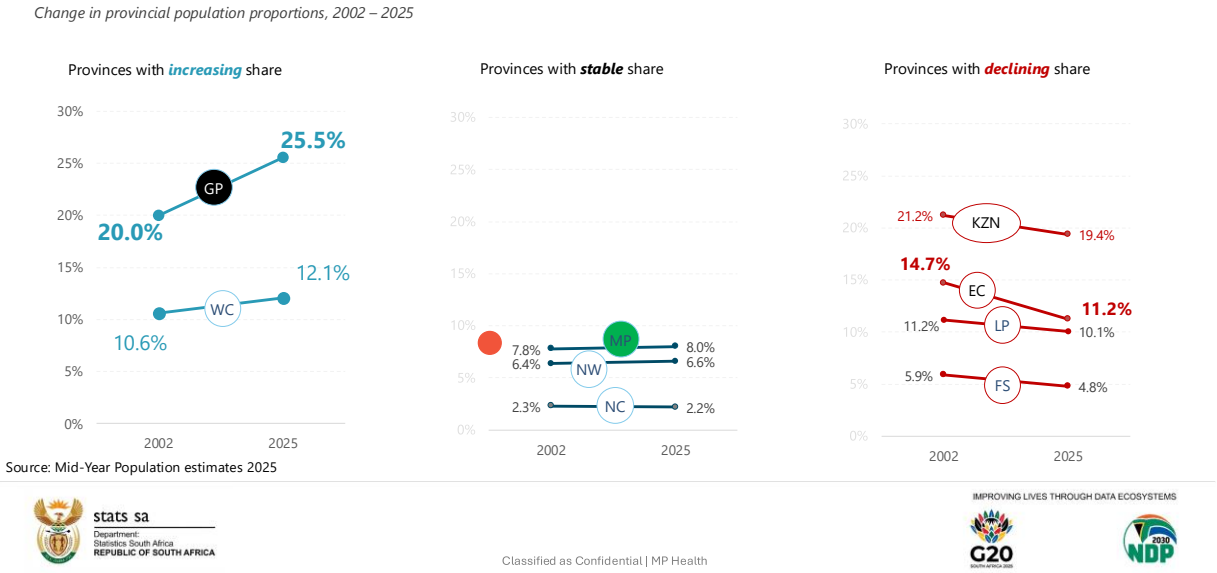


Figure 4: change in provincial population proportions, 2002-2025

Figure 4, The graph titled Change in provincial population proportions, 2002 – 2025 shows how South Africa's nine provinces have shifted in their share of the national population over the period. On the left, the provinces with an increasing share are Gauteng (GP), which rises from 20.0 % in 2002 to 25.5 % in 2025, and the Western Cape (WC), which grows from 10.6 % to 12.1 %. In the middle, the provinces with a stable share are the Northern Cape (NC), moving slightly from 2.3 % to 2.2 %, and the Northwest (NW), changing from 6.4 % to 6.0 %. On the right, the provinces with a declining share are KwaZulu-Natal (KZN), dropping from 21.2 % to 19.4 %, Eastern Cape (EC) falling from 14.7 % to 11.2 %, Limpopo (LP) decreasing from 11.2 % to 10.1 %, and Free State (FS) shrinking from 5.9 % to 4.8 %. The data source is Stats SA's Mid-Year Population estimates 2025.

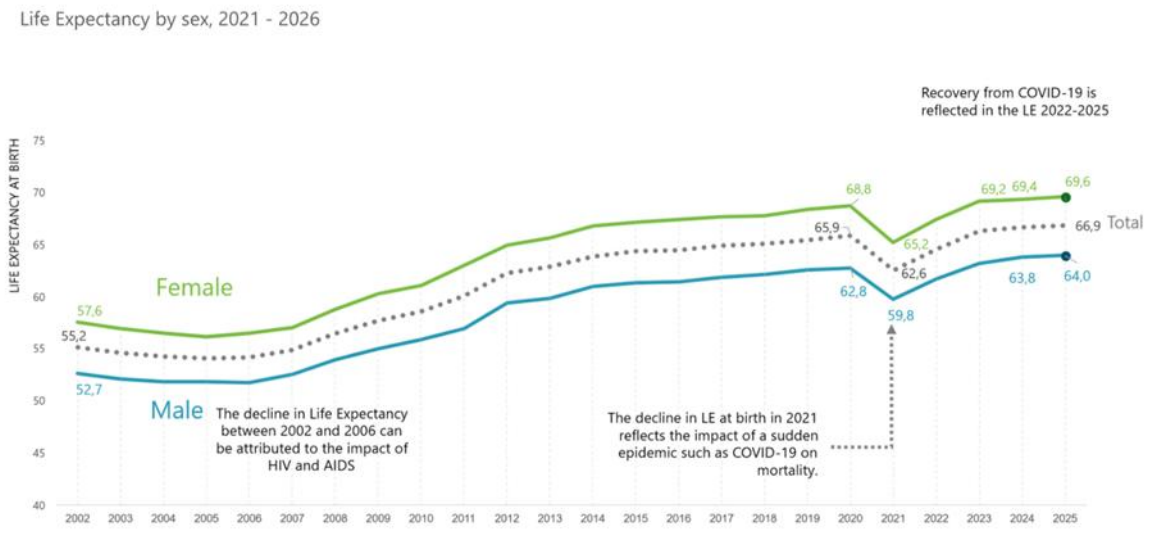


Figure 5: Life expectancy by sex, 2021-2026

Life Expectancy by sex, 2021 – 2026 shows three curves tracking life expectancy at birth from 2002 to 2025: a green line for females, a blue line for males, and a dotted black line for the total population. (Figure 5) from 2002 to 2006, the male line dropped from about 57.6 to 52.7 years, explained by the impact of HIV and AIDS, while the female line stayed relatively stable around 55.2 years. After 2006, both sexes experienced a steady rise, with females consistently outliving males. A sharp dip appears in 2021 for all groups, attributed to the COVID-19 epidemic's effect on mortality, followed by a recovery phase from 2022 to 2025, where life expectancy climbs again. By 2025, the figures reach roughly 69.6 years for females, 64.0 years for males, and 66.9 years for the total population, indicating a post-COVID rebound in longevity.

The gender difference in life expectancy in South Africa highlights critical disparities in health risks and access that guide targeted intervention planning. Males consistently experience lower life expectancy than females, largely due to higher mortality from HIV/AIDS, tuberculosis, injuries, and non-communicable diseases. These patterns underscore the need for male-focused interventions, particularly for young men aged 15–34, who face disproportionate mortality from infectious diseases and external causes. Strengthening HIV and TB testing, improving treatment uptake, and expanding violence- and injury-prevention programmes can significantly reduce excess male mortality[2].

At the same time, South Africa must intensify chronic disease prevention and management, as disparities in circulatory and respiratory disease mortality drive gaps in older age. Integrated screening and long-term care models that account for sex-specific risk patterns are therefore essential[1].

Given the role of structural inequality, an intersectional approach is required. Women live longer but spend more years with multimorbidity, reflecting socioeconomic and caregiving burdens. Addressing social determinants is central to reducing inequities[3].

[2] Multimorbid Life Expectancy Across Race, Socioeconomic Status, and Gender in South Africa, Lam et al, 2022, MPIDR Working Paper

[3] From sex differences to sex inequalities in life expectancy: A cross-country observational benchmarking analysis, Chan et al, 2025, PLOS Medicine

Improving gender-responsive access to health services is equally important. Men's under-utilisation of health services calls for targeted service-delivery models, adapted clinic hours, and male-centred outreach, while sustaining programmes that support women's health, including maternal and reproductive services.

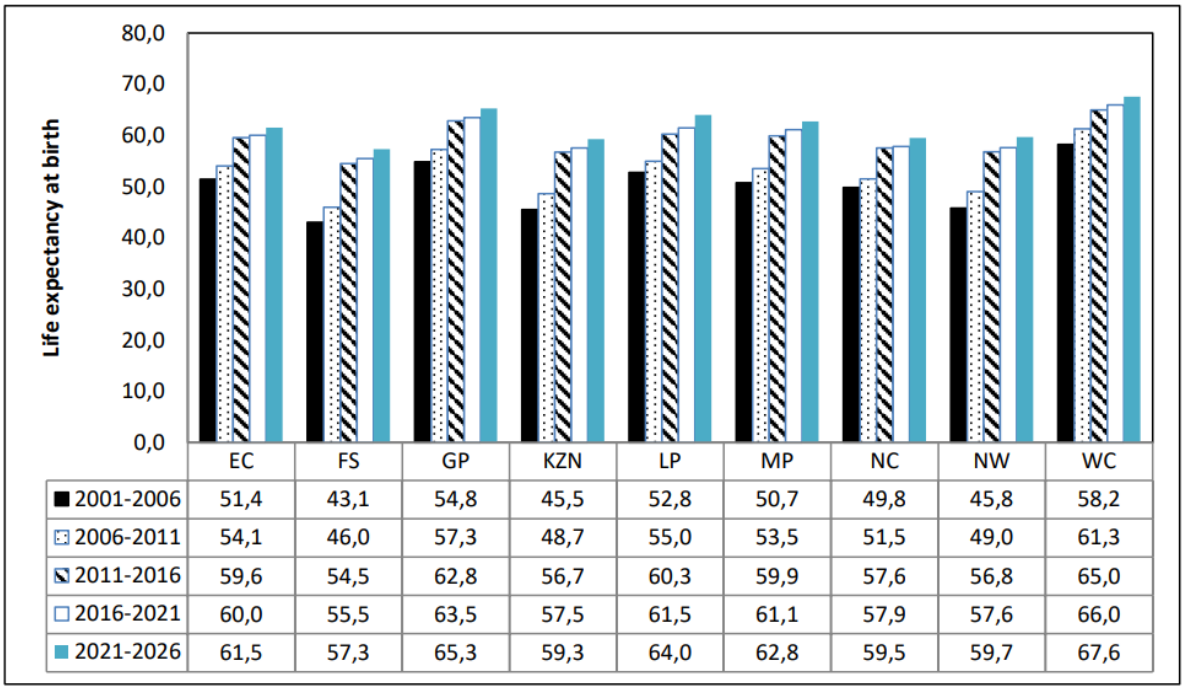
Overall, these patterns reveal the need for comprehensive, gender-sensitive strategies that reduce excess male mortality, support women's long-term health, and close persistent gaps in life expectancy across the population[4].

The table below shows a number of studies that were done in Mpumalanga Province, looking at prevalent factors which affect life expectancy:

Factor	Effect on Life Expectancy	Source (from PPT)
Maternal mortality	Reduces female life expectancy	Bathusi Patricia Motlhasi-Ndlovu (2024)
Neonatal deaths	Lowers under-5 survival	Bathusi Patricia Motlhasi-Ndlovu (2024)
High HIV prevalence	Increases mortality from AIDS	TB HIV Care – Thabile Mthethwa (2024); Phindile Doreen Lukhele (2023)
Poor ART adherence	Leads to viral rebound & death	Masechaba Phooko (2024); Mathepe Thosago (2023)
Violence among PWID	Raises injury & mortality risk	TB HIV Care – Thabile Mthethwa (2024)
TB prevalence	Major cause of death	TB HIV Care – Thabile Mthethwa (2024)
Bypassing PHC facilities	Delays treatment of chronic disease	HST – Thobelani Majola (2024)
Poor quality of care	Increases preventable mortality	CK Mavimbela (2024/2025); Busisiwe Goodness Nkosi (2028)
Patient safety incidents	Increase maternal/infant deaths	CK Mavimbela (2025)
Staff shortages	Reduces access to care	Busisiwe Goodness Nkosi (2028)
Litigation links to CP cases	Reflect system failures linked to mortality	CK Mavimbela (2025)
Migrant treatment interruptions	Interrupt treatment & increase deaths	Matolengwe (2024); IOM – Tronny Mawadzwa (2025)
Mental health barriers	Raises suicide & chronic disease risk	Rethabile Mokwena (2024); Yang et al. (2023)
Healthcare worker burnout	Increases errors & mortality	Yang et al. (2023)
Inappropriate prescribing	Affects safety & outcomes	MT Silinda (2023)

Table 3: Number of studies that were done in Mpumalanga Province

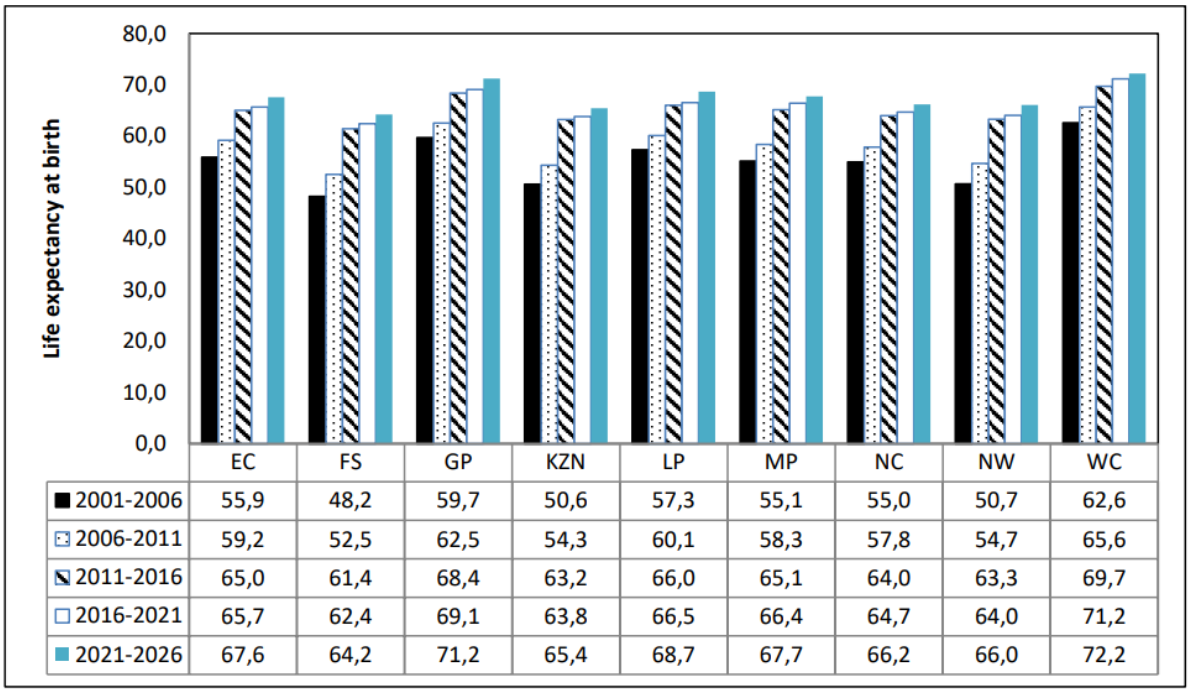
[4] An analysis of gender-based reversal in life expectancy in southern Africa, Jusrut and Kalipeni, 2010, GeoJournal



	EC	FS	GP	KZN	LP	MP	NC	NW	WC
2001-2006	51,4	43,1	54,8	45,5	52,8	50,7	49,8	45,8	58,2
2006-2011	54,1	46,0	57,3	48,7	55,0	53,5	51,5	49,0	61,3
2011-2016	59,6	54,5	62,8	56,7	60,3	59,9	57,6	56,8	65,0
2016-2021	60,0	55,5	63,5	57,5	61,5	61,1	57,9	57,6	66,0
2021-2026	61,5	57,3	65,3	59,3	64,0	62,8	59,5	59,7	67,6

Figure 6: Life expectancy at birth for males, per province

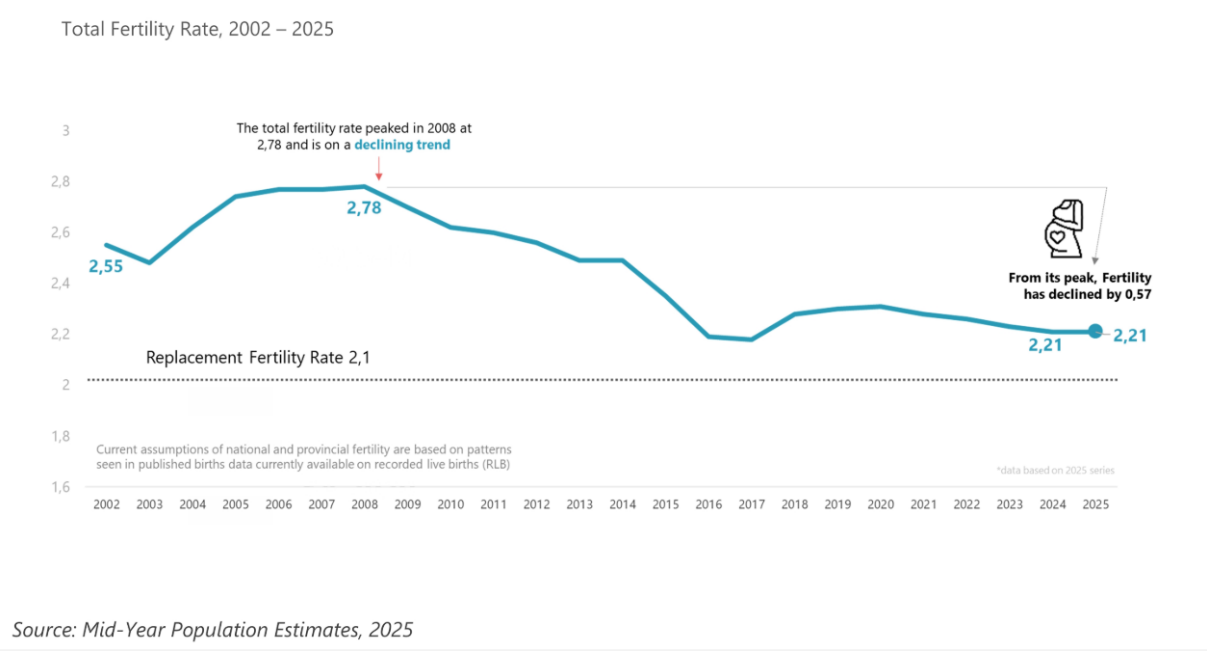
Figure 6 tracks male life expectancy at birth across South Africa's nine provinces over five time slices from 2001 to 2026. It shows a steady rise in life expectancy for every province, with the Western Cape leading the pack in 2021-2026 at 72.2 years, while Gauteng experiences the biggest jump, climbing from 59.7 years in 2001-2006 to 71.2 years in 2021-2026. The data also highlights provincial disparities, with KZN and EC generally lagging the higher-income provinces like GP and WC. A note on the figure mentions that the recovery from COVID-19 is reflected in the life-expectancy figures for 2022-2025, implying the latest period captures post-pandemic improvements in male lifespan.



	EC	FS	GP	KZN	LP	MP	NC	NW	WC
2001-2006	55,9	48,2	59,7	50,6	57,3	55,1	55,0	50,7	62,6
2006-2011	59,2	52,5	62,5	54,3	60,1	58,3	57,8	54,7	65,6
2011-2016	65,0	61,4	68,4	63,2	66,0	65,1	64,0	63,3	69,7
2016-2021	65,7	62,4	69,1	63,8	66,5	66,4	64,7	64,0	71,2
2021-2026	67,6	64,2	71,2	65,4	68,7	67,7	66,2	66,0	72,2

Figure 7: Life expectancy at birth for females, per province

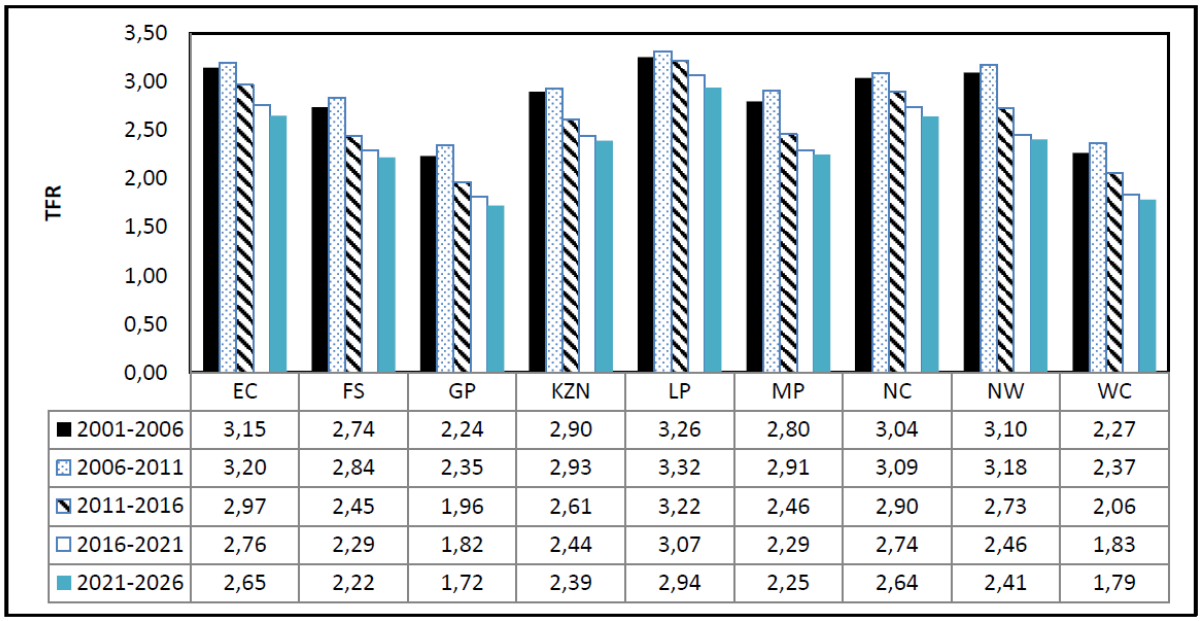
Figure 7 shows life expectancy at birth for females across the nine South African provinces over five time periods from 2001-2006 and then projected to 2021-2026. In each province, the blue bar represents the earliest period and the black bar the latest, with striped bars indicating the intermediate years. The data reveal a general upward trend in female life expectancy over time in all provinces. Western Cape (WC) consistently has the highest life expectancy, rising from 62.6 to a projected 72.2 years, while Free State (FS) shows the lowest values, increasing from 48.2 to a forecast of 64.2 years. The biggest gains appear in provinces like GP and WC, indicating improved health conditions or interventions in those regions



Source: Mid-Year Population Estimates, 2025

Figure 8: Total fertility rate, South Africa (2002-2025)

The total fertility rate for 2002-2025 replacement fertility rate of 2.1. This rate indicates the average number of children per woman needed for a population to remain stable without migration (Figure 8). Mpumalanga's total fertility rate (TFR) in 2025. Is 2.25, which is slightly above the replacement fertility rate of 2.1, and the graph (Figure 9) presents a clustered bar chart of the average total fertility rate (TFR) for South Africa's nine provinces across five time periods from 2001-2006 to 2021-2026. Each province is shown with five differently shaded bars that reveal a general decline in TFR over time. For example, GP's fertility drops from 2.24 to 1.72, and WC's falls from 2.27 to 1.79, indicating movement toward sub-replacement levels. Provinces like LP maintain relatively high rates near 3.0, while EC, NC, and NW start with higher fertility than FS, MP, and the low-fertility provinces GP and WC, whose bars show the steepest decreases



	EC	FS	GP	KZN	LP	MP	NC	NW	WC
2001-2006	3,15	2,74	2,24	2,90	3,26	2,80	3,04	3,10	2,27
2006-2011	3,20	2,84	2,35	2,93	3,32	2,91	3,09	3,18	2,37
2011-2016	2,97	2,45	1,96	2,61	3,22	2,46	2,90	2,73	2,06
2016-2021	2,76	2,29	1,82	2,44	3,07	2,29	2,74	2,46	1,83
2021-2026	2,65	2,22	1,72	2,39	2,94	2,25	2,64	2,41	1,79

Figure 9: Average fertility rates, per province

South Africa's fertility rate has steadily declined due to a combination of economic, social, and health-related factors. Rising childcare costs make larger families less affordable, with annual expenses reaching nearly R100,000 per child, prompting many households to opt for fewer children. Improved access to contraception and maternal healthcare has also empowered women to plan pregnancies more effectively, reducing unintended births and contributing to lower fertility overall[5].

Social shifts play an equally significant role. Young adults increasingly delay marriage and parenthood to pursue education and career goals, a trend strongly tied to declining fertility rates. Women's growing workforce participation further influences decisions to postpone or limit childbearing. Urbanisation deepens this shift: provinces like Gauteng and the Western Cape exhibit lower fertility rates due to lifestyle changes, improved contraceptive access, and reduced marriage rates, while rural provinces such as Limpopo and the Eastern Cape maintain comparatively higher fertility levels[6].

Demographic research also highlights that education, wealth, and younger age at first pregnancy significantly shape fertility patterns. Higher education and household wealth tend to reduce childbearing, while race, household size, and contraceptive use remain strong predictors of fertility behaviour. Collectively, these factors illustrate how South Africa's fertility decline reflects broader socioeconomic transformation[7].

Ehlanzeni district has the highest population size, followed by Nkangala District, and then Gert Sibande with the smallest population. Figures 8 and 9 show the population density in each district and subdistrict. City of Mbombela, Bushbuckridge, Govan Mbeki, Mkhondo, Emalahleni and Thembisile Hani sub districts with the highest subdistrict populations.

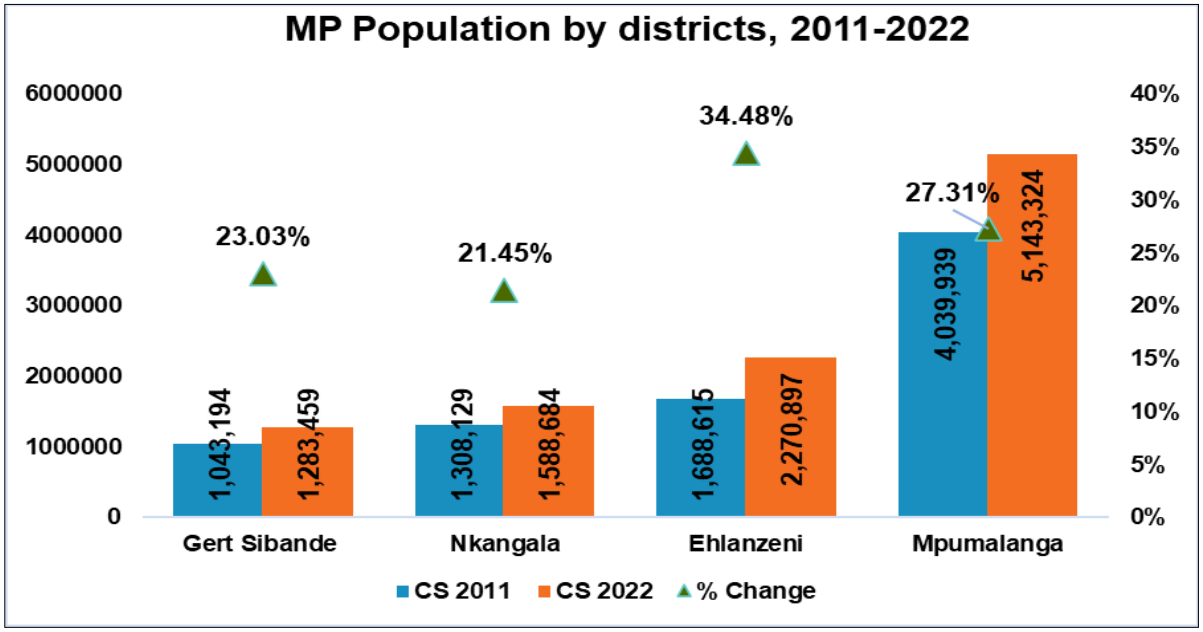


Figure 10: Population per district

[5] South Africa's low birth rate: Causes and impacts, Z Sekothe, 2025, https://www.laladyhouse.co.za/south-africas-low-birth-rate-causes-and-impacts/

[6] WHY South Africa is having LESS babies in 2025, R. Leathern, 2025, https://www.thesouthafrican.com/lifestyle/why-south-africa-is-having-less-babies-in-2025/

[7] Patterns of fertility in contemporary South Africa: Prevalence and associated factors, Biney et al, 2021, Cogent Social Sciences

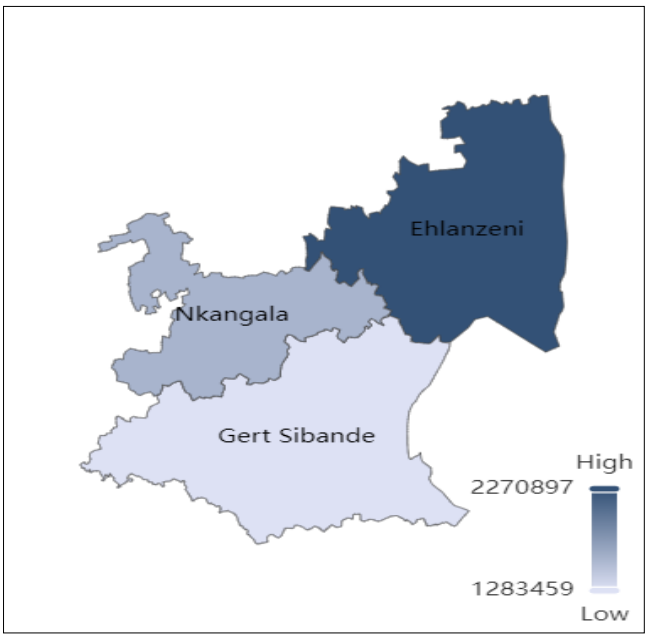


Figure 11:Population density per district

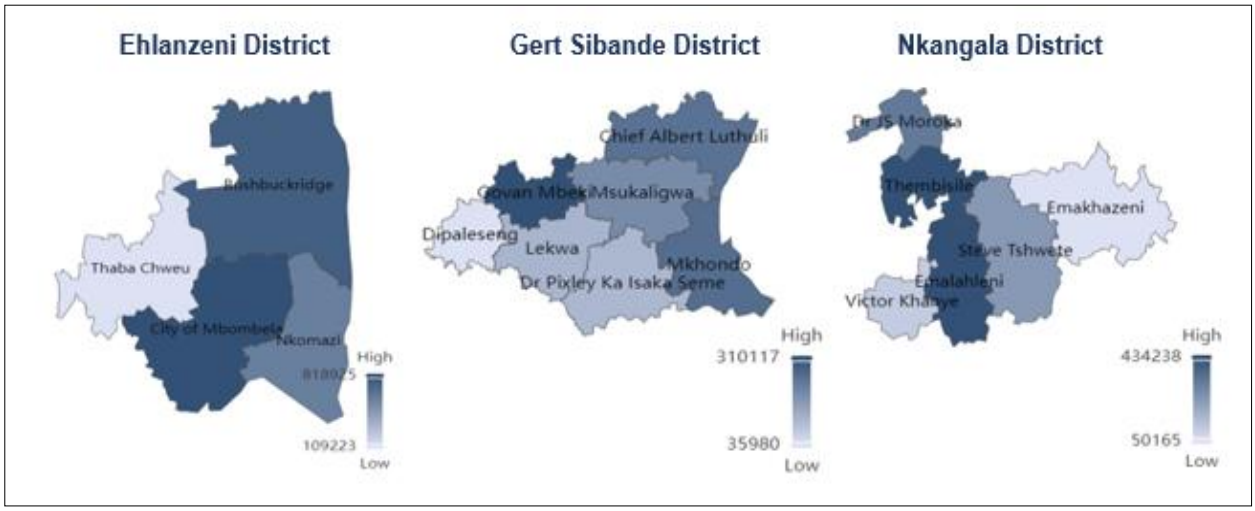


Figure 12: Sub-district population density

Furthermore, Ehlanzeni District is the most populous, while Gert Sibande is the least. Gert Sibande also has the biggest area, which means that the population density is lower. This can lead to challenges in service delivery and traveling distance to facilities.

As is the case for many other countries, South Africa serves as a destination for migration. Migration has an impact on migrant communities and host communities[8]. This includes an impact on health services, particularly if migrants

[8] https://www.acsrm-au.org/work/migration-and-health/

form part of vulnerable or marginalised communities in the country of origin. The health services must absorb the additional load in the current climate of shrinking fiscal space.

The province was one of 6 provinces receiving a positive net migration over the period of 2021 to 2026, as illustrated in Figure 13 below. Mpumalanga ranks fourth in comparison to other provinces, with a net migration inflow estimated at 82492 between 2021 and 2026.

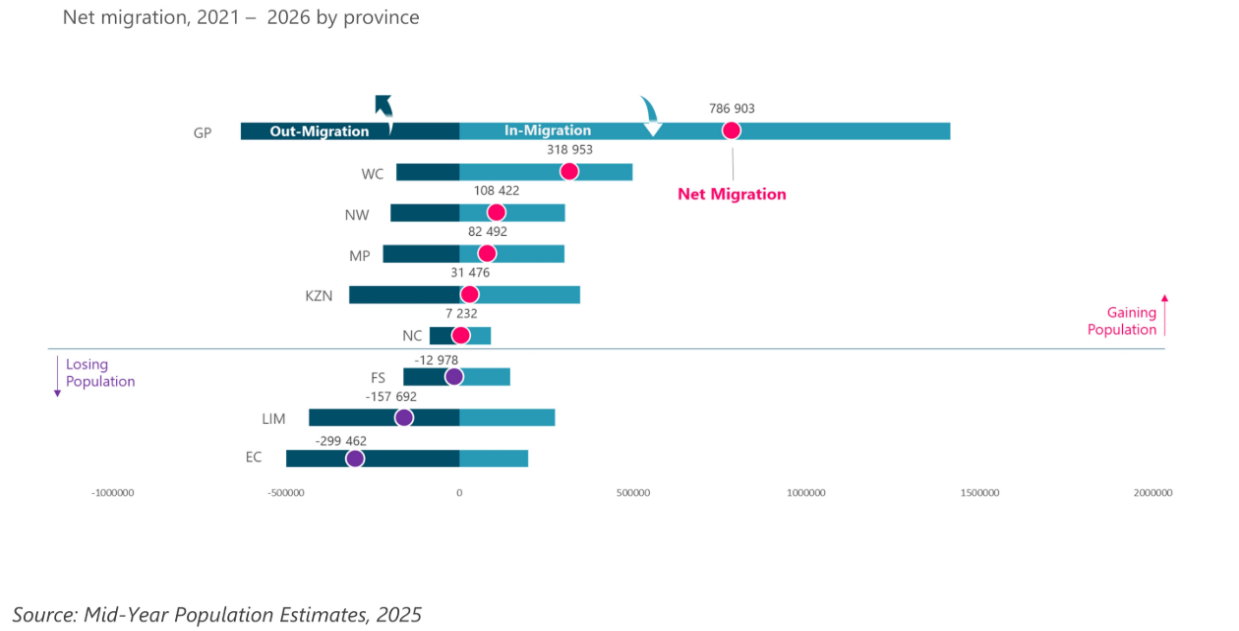


Figure 13: In-and out-migration per province

6.1.2. Social Determinants of Health

In 2025, from the mid-year population estimates, Mpumalanga province is home to approximately 1.542 million households, each with its own unique story. About a quarter of these households are solo acts. A third are small families or roommates with 2-3 people, while another quarter have 4-5 members under one roof. Interestingly, 15% of households are big, lively gatherings with 6 or more people. Notably, nearly half (46.7%) of these households are led by women, a testament to the strength and resilience of Mpumalanga's female residents, outpacing the national average of 42.4%.

Many children in the province (86.5%) have both parents still alive. For the remainder, 9.3, 2.5, and 1.7 per cent are paternal, maternal and double orphans, respectively. Half (53.3 per cent) of all children live with only their mother, while a quarter (24.8 per cent) live with both parents. Of children aged 0-4 years, 32.3 per cent are in some form of education (creche, Edu-care centre, or nursery school). Of children aged 5 years and older, 64.6 per cent attended no-fee schooling. The percentage of learners attending public schools benefitting from the school nutrition programme increased from 69.5 per cent in 2009 to 88.4 per cent in 2024.

Further to this, the following key parameters have been found[9]:

- 86% of learners in the province benefit from a School Nutrition Programme.

[9] Geneal Household Survey 2024, Statistics South Africa

- 10.4% of the population in the province belongs to a medical aid scheme.
- 4.8% of those 5 years and older are living with a disability.
- 59.1% of households are receiving a social grant, while 46.9% of individuals receive a social grant.
- MP has the 3rd highest number (46,7%) of all households headed by females.
- 42,9% of Households headed by Women in MP do not have an employed household member within the household.
- MP has the largest proportion (53,3%) of children living with their mother alone.
- In 2024, 73,1% of household members first consulted personnel at a Public Clinic or hospital, while 25,3% turned to the private sector.
- MP had an official unemployment rate sitting at 34,0%.
- 90.1% of the population live in formal dwellings.
- 86.6% of households have access to piped water in dwellings, off-site or on-site, with 8.5% not collecting water, 73.5% spending less than 30 minutes, 17.6% spending 31-90 minutes, and 0,4% spending more than 90 minutes collecting water.
- 66.9% of households reported interruptions to the water supply for at least 2 days over the preceding year.
- 89.7% of households are connected to the mains electricity supply, up from 81.1% in 2002, with 92.3% using a prepaid meter.
- 43.8% of households receive refuse removal services once a week or less often, 5.1% use a communal refuse dump, and 48.4% use their own refuse dump.
- 95.1% of the population have only a cellular telephone, and 2.5% have a cellular telephone and a landline.
- 78.5% have access to internet services, with 76.9% of the population using their mobile phones for this.
- 43.6% of the population used public transport in the preceding week (31.6% using taxi services and 12% using the bus).
- 58.9% of households received income from a salary, and 59.5% receive income from a grant. Furthermore, 49.3% of households have a salary as the main source of income.
- 70% of households have adequate access to food.
- 33.1% of households are involved in agricultural activity, which contributes towards food security. 80.2% of these households use agriculture as an additional source of food.

These data point to a few things in Mpumalanga Province. Firstly, great strides have been made in increasing access to basic services in the province over the last 20 years. These include access to electricity, water, and sanitation services. Secondly, many people in the province are the recipients of governmental interventions, which contribute to the basic human needs that need to be met to support the life course of an individual. These include access to a school nutrition programme and access to social grant services. These programmes are vital to things such as educational outcomes, ability to find employment, and ability to contribute to society economically. Finally, although many gains have been made, there is still a way to go to ensure all people in the province experience food security and income security.

Global growth is projected at 3.3 percent for 2026 and 3.2 percent for 2027. However, this is still below the historical average of 3.7 percent (2000-2019). Global inflation is expected to fall, but US inflation will return to target more gradually. Key downside risks are reevaluation of technology expectations and escalation of geopolitical tensions.

The South African economy is expected to perform below the global average, with real GDP growth predicted to be 1.4 and 1.5 per cent in 2026 and 2027, respectively. The official unemployment rate in South Africa at the end of quarter 4 of 2025 was 31.4 per cent, while that in the Mpumalanga was 32.3 per cent. Furthermore, Mpumalanga

recorded a decrease in the official unemployment rate, down by 1.7 percentage points from year-on-year. Furthermore, 34 per cent of those aged 15-24 years are currently not in employment, education or training.

The World Economic Forum Global Risks Report 2025 indicates that the five biggest risks posed to South Africa are: unemployment or lack of economic opportunity; insufficient public services and social protections (including education, infrastructure and pensions); crime and illicit economic activity; disruptions to critical infrastructure; and economic downturn (e.g. economic downturn and stagnation.

All of these risks pose threats to the public health system as the demand on it increases. This could be due to loss of access to private health care as people can no longer afford it due to increasing cost of living coupled with stagnating wages, or loss of income. In addition, water supply issues could increase risk of communicable disease outbreaks, which further increase demand for healthcare services.

The current socio-economic conditions not only exacerbate the existing burden of disease, but they can also have knock-on effects in other sectors. A 2018 study by De Wet and Frade (2018)[10] found that both communicable and non-communicable conditions amongst adolescents were associated with grade repetition. This can have an impact on multiple things, including learner dropout rate, strain on the education system as learners remain in the system for longer, and a slower rate of people entering higher education or the workforce. This in turn, could influence the economic outcomes of the country.

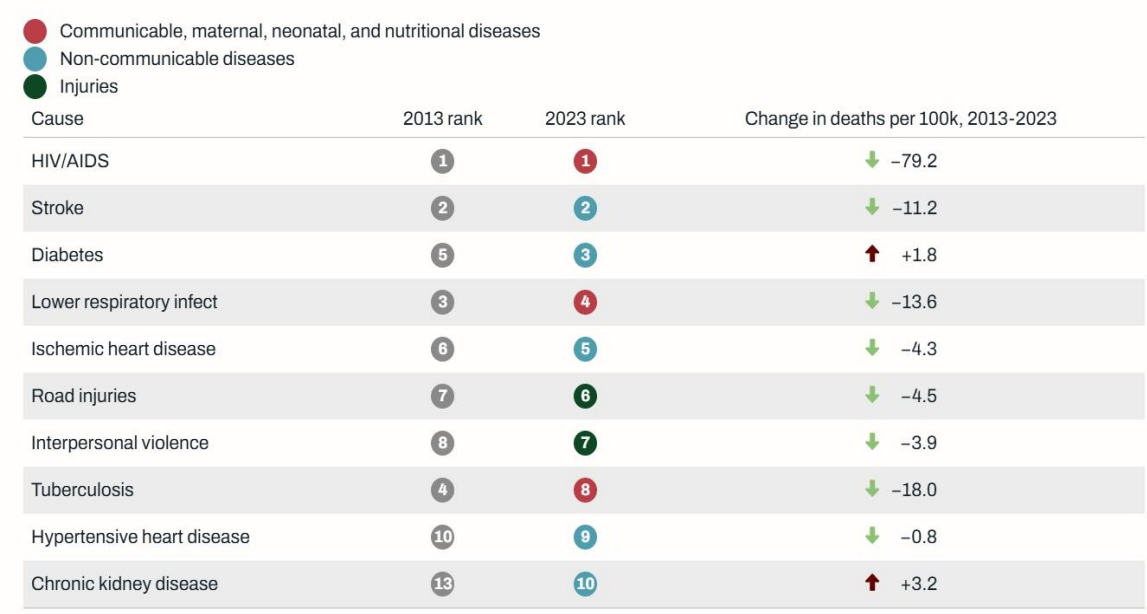
6.1.3. Epidemiology and the quadruple burden of disease

South Africa is unique in terms of its disease burden in that it is the only country in the world to experience a quadruple burden of disease. The four arms of this are:

- Maternal, newborn, and child health.
- HIV/AIDS and tuberculosis.
- Non-communicable diseases.
- Violence and injury.

In South Africa, the top 10 causes of death in 2023 were led by HIV/AIDS and remained the top cause, but saw the biggest drop, 79.2 deaths per 100 000. Stroke kept the 2nd rank with an 11.2 reduction, while diabetes moved from 5th to 3rd, and deaths rose by 1.8 per 100 000. Lower respiratory infections fell from 3rd to 4th with a 13.6 decrease, and tuberculosis slipped from 4th to 8th, dropping 18.0 deaths per 100k. Non-communicable diseases like ischemic heart disease and hypertensive heart disease shifted ranks with modest declines, whereas chronic kidney disease rose from 13th to 10th, increasing deaths by 3.2 per 100 000. Injuries (road and interpersonal violence) also declined slightly. Overall, communicable disease mortality fell sharply, while some non-communicable diseases showed rising trends. The causes are grouped into communicable, maternal, neonatal, and nutritional diseases (HIV/AIDS, lower respiratory infections, tuberculosis, diarrheal diseases), non-communicable diseases (diabetes, stroke, ischemic heart disease, hypertensive heart disease, chronic kidney disease), and injuries (road injuries). This shifting of ranks is a testament to the changing dynamics of the quadruple burden of disease and that the health sector should be paying attention to each of these health conditions to reduce premature mortality and improve quality of life.

[10] De Wet and Frade. Disease prevalence and grade repetition among adolescents in South Africa: Is there any relationship? South African Journal of Child Health, DOI:10.7196/SAJCH.2018.v12i2.1504



Communicable, maternal, neonatal, and nutritional diseases
Non-communicable diseases
Injuries

Cause	2013 rank	2023 rank	Change in deaths per 100k, 2013-2023
HIV/AIDS	1	1	↓ −79.2
Stroke	2	2	↓ −11.2
Diabetes	5	3	↑ +1.8
Lower respiratory infect	3	4	↓ −13.6
Ischemic heart disease	6	5	↓ −4.3
Road injuries	7	6	↓ −4.5
Interpersonal violence	8	7	↓ −3.9
Tuberculosis	4	8	↓ −18.0
Hypertensive heart disease	10	9	↓ −0.8
Chronic kidney disease	13	10	↑ +3.2

Figure 14: Top 10 causes of death in South Africa https://www.healthdata.org/research-analysis/health-by-location/profiles/south-africa

Figure 14. The top causes of death are ranked as follows: HIV/AIDS is the leading cause (rank 1), followed by stroke (rank 2). Diabetes is the third major cause (rank 3), followed by lower respiratory infections (rank 4), and ischemic heart disease (rank 5). Road injuries are ranked 6, interpersonal violence 7, tuberculosis 8, hypertension disease 9, and chronic kidney disease 10.

Communicable, maternal, neonatal, and nutritional diseases
Non-communicable diseases
Injuries

Cause	2013 rank	2023 rank	Change in deaths per 100k, 2013-2023
HIV/AIDS	1	1	↓ −71.9
Lower respiratory infect	2	2	↓ −18.1
Diabetes	6	3	↑ +2.2
Stroke	3	4	↓ −21.2
Road injuries	5	5	↓ −15.4
Tuberculosis	4	6	↓ −21.9
Ischemic heart disease	8	7	↓ −6.5
Diarrheal diseases	7	8	↓ −14.5
Hypertensive heart disease	9	9	↓ −5.7
Chronic kidney disease	12	10	↓ −0.4

Figure 15: Top ten causes of death in Mpumalanga Province https://www.healthdata.org/research-analysis/health-by-location/profiles/south-africa-mpumalanga

Figure 15 The leading causes of death in Mpumalanga Province look like those seen in the country, with the inclusion of diarrhoeal diseases and neonatal disorders. The top causes of death are ranked as follows: HIV/AIDS

is the leading cause (rank 1), followed by lower respiratory infections (rank 2). Diabetes is the third major cause (rank 3), followed by stroke (rank 4), and road injuries (rank 5). Tuberculosis ranked 6, ischemic heart disease 7, diarrheal diseases 8, hypertensive heart disease 9, and chronic kidney disease10.

Metabolic risks
Environmental/occupational risks
Behavioral risks

Risk	2013 rank	2023 rank	Change in DALYs per 100k, 2013-2023
Unsafe sex	1	1	↓ −3,095.7
Malnutrition	2	2	↓ −1,990.4
High body-mass index	5	3	↑ +46.6
High fasting plasma glucose	7	4	↑ +167.5
WaSH	3	5	↓ −1,225.0
Tobacco	8	6	↓ −302.0
Sexual violence against children and bullying	9	7	↓ −228.4
High blood pressure	6	8	↓ −517.7
Dietary risks	10	9	↓ −114.2
Air pollution	4	10	↓ −760.9

Figure 16: Top ten risk factors in Mpumalanga Province (https://www.healthdata.org/research-analysis/health-by-location/profiles/south-africa-mpumalanga)

Figure 15 shows the top 10 risk factors that contribute to the most disability and death. Half of these are behavioural factors (tobacco use, dietary habits, malnutrition, and unsafe sex). A further 3 of these are arguably linked to behavioural factors (high blood pressure, high fasting plasma glucose, and high body-mass index). This underscores the importance of prevention of disease, health promotion, and healthier lifestyles.

Maternal, Newborn, and Child Mortality

- **Child Immunization**

The childhood immunization coverage in Mpumalanga shows a concerning decline from 2021 to 2026. In the 2021/22 financial year, the province achieved impressive rates: 97.8% for measles 1st dose under 1 year, 97.4% for measles 2nd dose, and 97.3% for fully immunised under 1 year. However, subsequent years saw sharp drops. By 2022/23, measles 1st dose fell to 85.0%, while the 2nd dose rose slightly to 90.4%, with full immunization at 89.1%. In 2023/24, the 1st dose slipped further to 81.5%, and the 2nd dose coverage declined sharply to 68.3%, with full immunization at 88.2% experiencing a decline in 2024/25, the 1st dose at 69.5%, and the 2nd dose declining to 82.1% and fully immunised at 79.5%. by 2025/26 for measles 1st dose under 1 year at 52.9%, for measles 2nd dose at 62.7%, and 61.8% for fully immunised under 1 year.

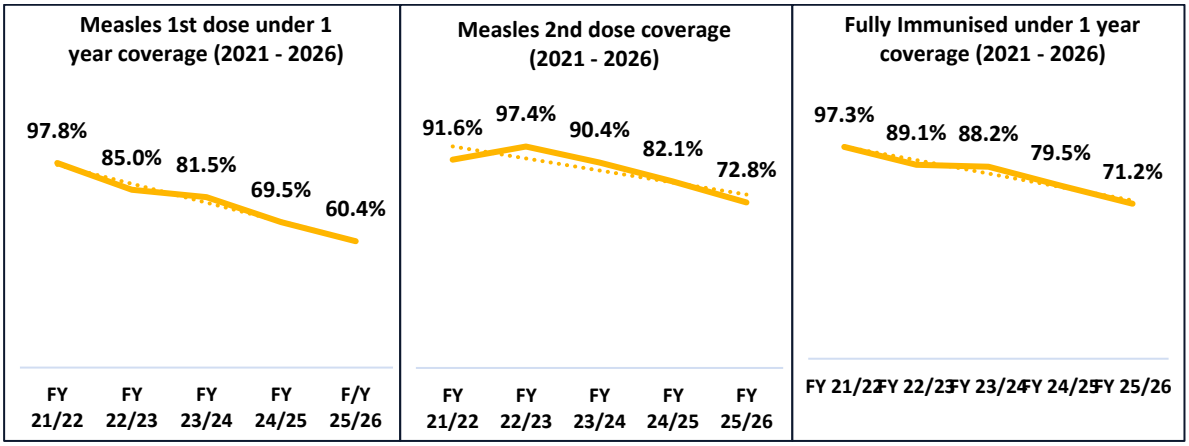


Figure 17: Childhood immunisation coverage

- **Antenatal and Post Natal Health**

Antenatal 1st visit before 20 weeks coverage has remained consistent above 70% since 2021/22 to 2026 (Figure 19). A drop in the rate of first visits before 20 weeks was observed from 2022/23 to 2023/24, likely due to lockdown associated restriction-of movement during the COVID-19 pandemic. This was followed by an overall improvement to 77.8% coverage in 2024/25 and slightly increased to 78.5% in 2025/26.

Mother postnatal visit within 6 days rate has increased steadily, from 74.2 percent in 2021/22 to 76.2 percent in 2022/23 (Figure 19). A constant improvement shows that the primary health care and outreach platform is working well and is on track for further improvements in the coming years with 88.1% in 2025/26).

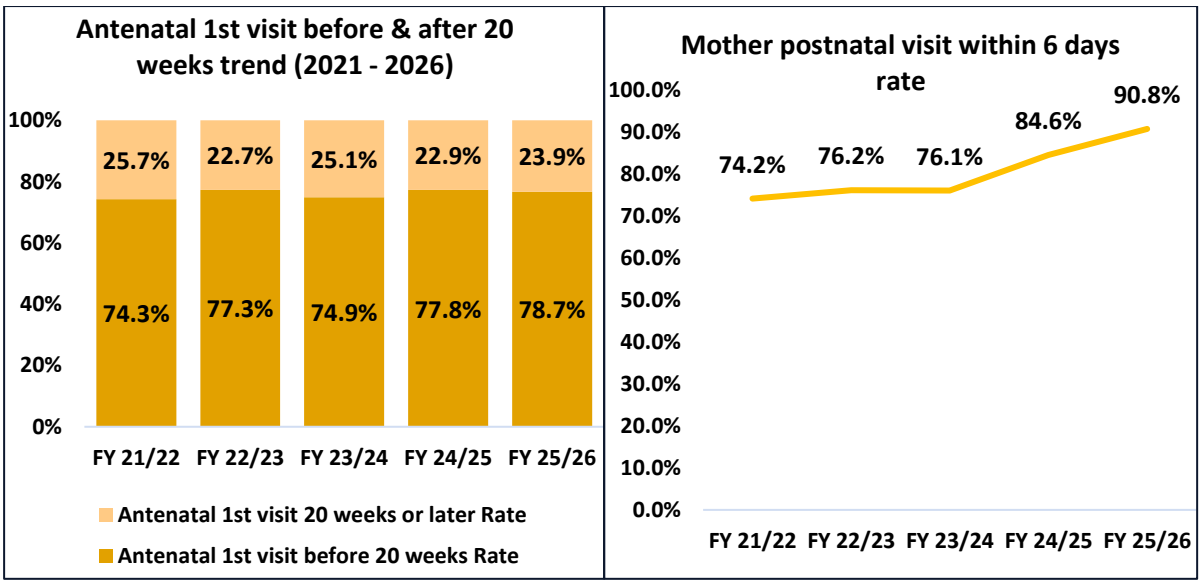


Figure 18: Antenatal first visit before 20 weeks and Mother postnatal visit within 6 days rate

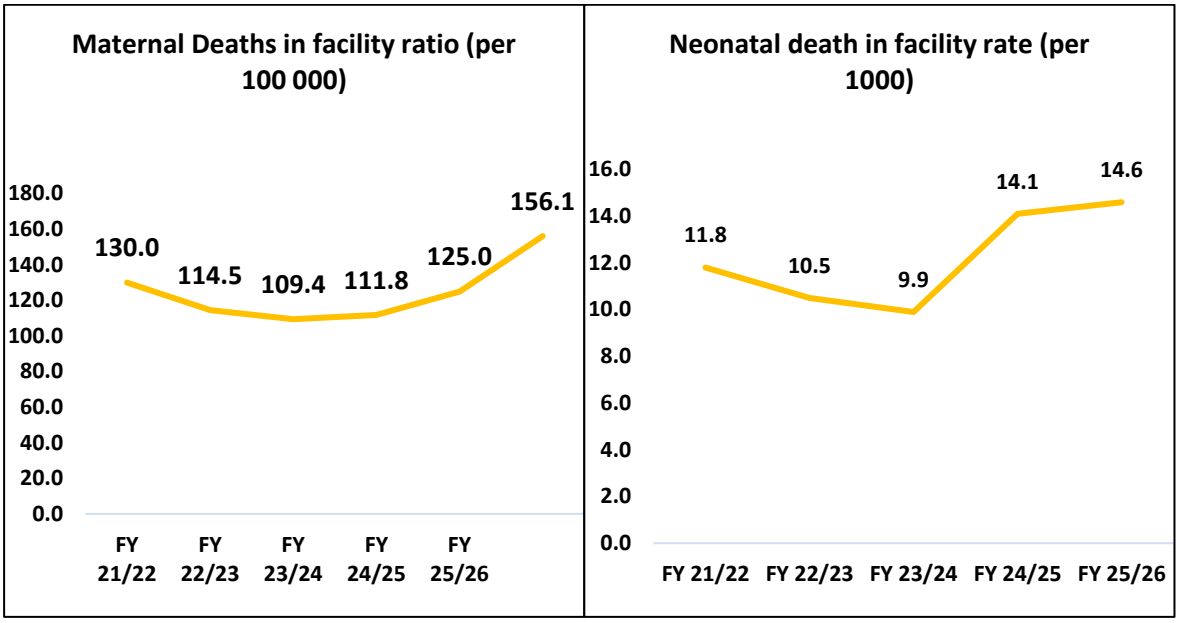


Figure 19: In facility Maternal Mortality Rate and Neonatal Death Rate

In-facility maternal death ratio (per 100 000), which starts at 130.0 in 2021/22, drops to 114.5 in 2022/23, drastically decreases to 109.4 in 2023/24, and then climbs back to 111.8 in 2024/2025 and 125.0 in 2025/26, indicating some fluctuations. Neonatal death in-facility rate (per 1000), beginning at 11.8 in 2021/22, decreasing to 10.5 in 2022/23, and then sharply dropping to 9.9 in 2023/24, reflecting a steady decrease to 14.1 in 2024/25 and a decrease to 12.9 in 2025/26.

- **Reproductive Health**

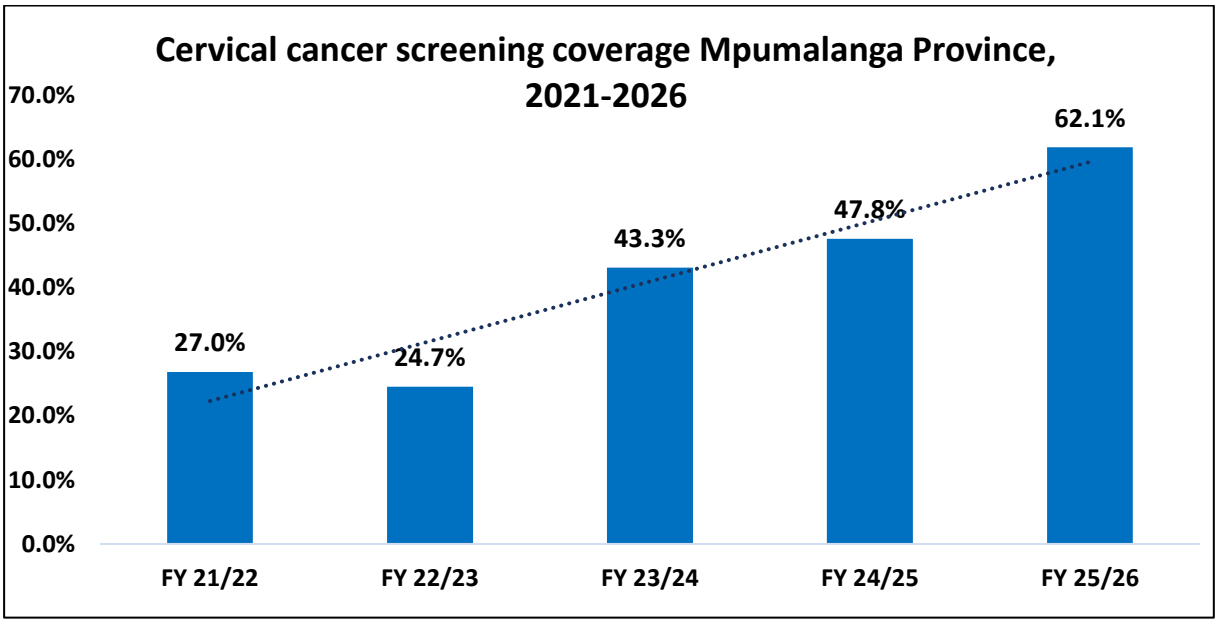


Figure 20: Cervical cancer screening coverage

Cervical cancer screening coverage in 2021/22 the screening rate was 27.0%, dropping slightly to 24.7% in 202223, which represents a sharp decline. The coverage then jumps to 43.3% in 2023/24, indicating a strong increase. It eases back to 47.8% in 2024/25 and sharp increase seating at 51.1% in 2025/26.

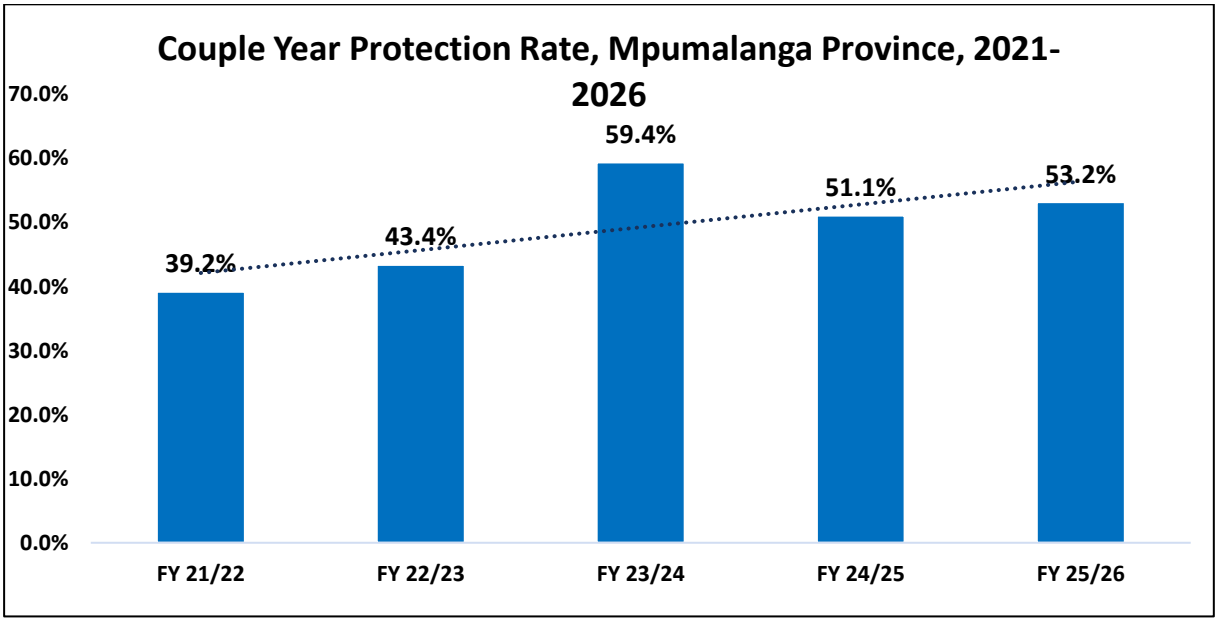


Figure 21: Couple year protection rate

Cervical screening is of importance as it allows for the timely identification of women in need of colposcopy services to prevent the development of cervical cancer. In addition, timely screening and intervention, where necessary, is

less costly than the treatment required for cervical cancer. This cost can be described as financial, as women who are ill are unable to or have limited ability to participate in economic activities, in addition to cervical cancer treatment being more expensive for the Department to treat than prevention. There is also a cost to society as women may be lost to their families, including their children.

- **Under 5 Years Child Mortality**

Management and treatment of childhood illnesses have been prioritised in the province, as ending preventable deaths of children under 5 is one of the Sustainable Development Goals. In 2021/22, there was an increase in the case fatality rates of diarrhoea, pneumonia, and severe acute malnutrition in children under 5 (figure 24), with the case fatality rate due to pneumonia more than doubling. Between 2021/22 and 2022/23, under 5 case fatality rates decreased, with the death rate due to severe acute malnutrition more than halving.

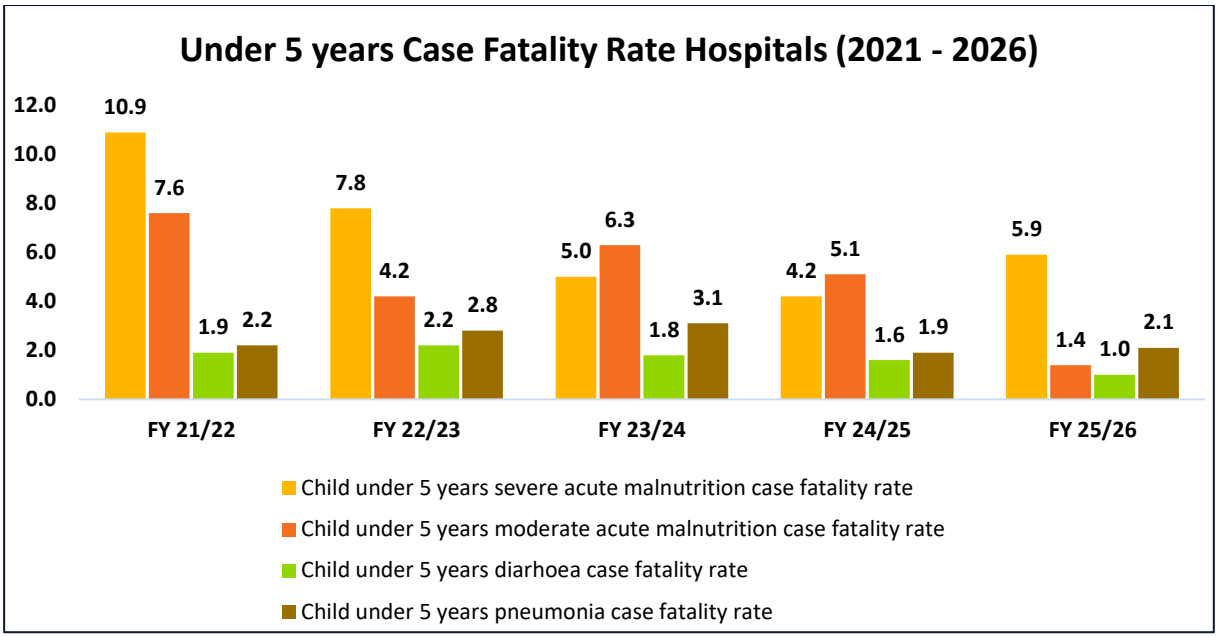


Figure 22: Severe acute malnutrition, moderately acute malnutrition, pneumonia, and diarrhoea under 5 case fatality rates

Figure 22 shows the SAM death trends across the 3 hospital platforms. Over time, since 2021/22, SAM death rates have been decreasing at all hospital levels. This could be due to improved case management as the death rates decreased roughly in district, regional, and tertiary hospitals, respectively.

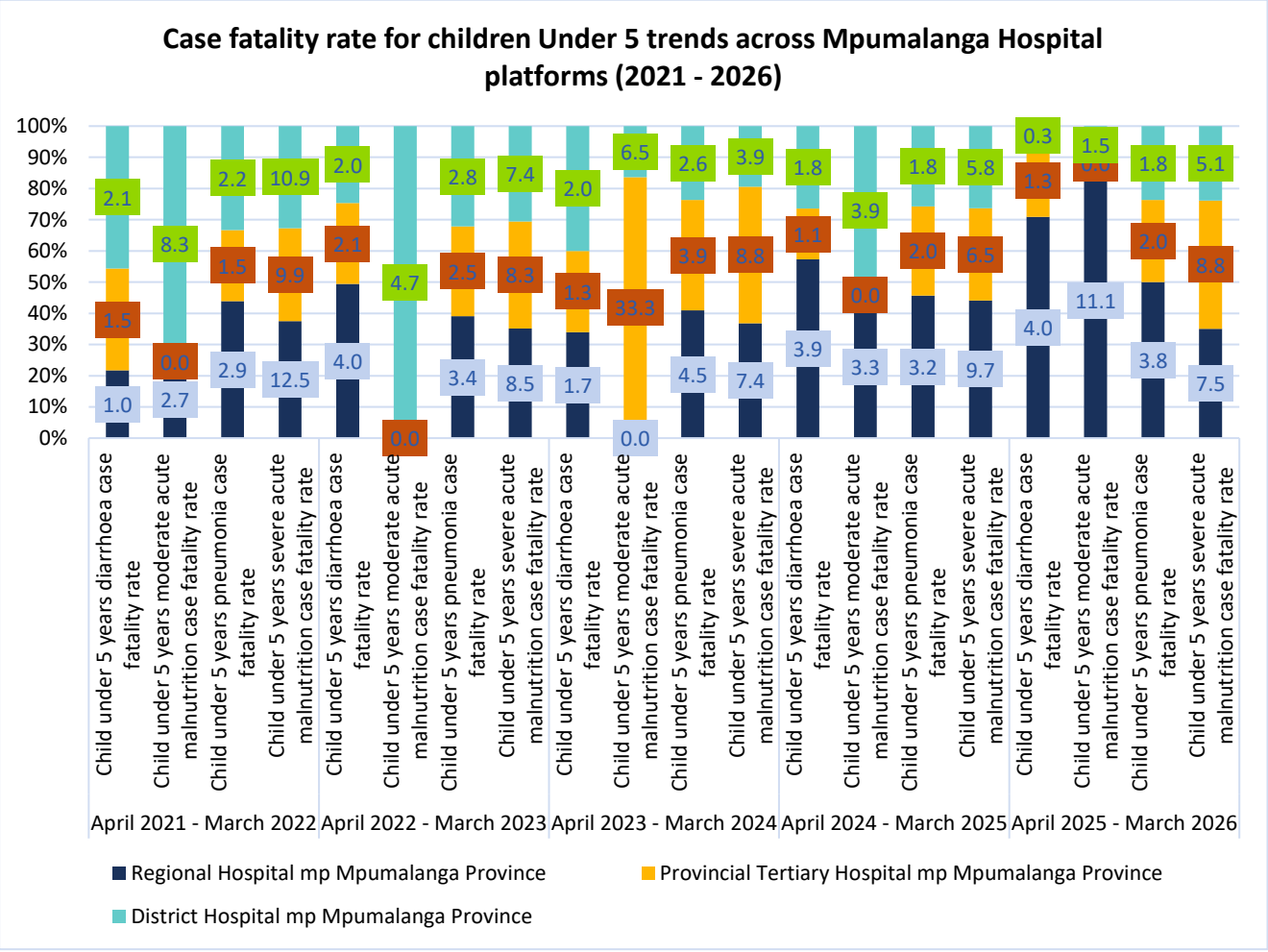


Figure 23: Case Fatality Rate for children under 5 with diarrhoea, pneumonia, moderate acute malnutrition *and severe acute malnutrition (DHIS) and trends of SAM CFU death trends across the 3 hospital platforms*

Case fatality rate for children under 5 across Mpumalanga hospital platforms from 2021 to 2026. In District Hospitals, the fatality rate started at 45 per 1,000 cases in FY 21/22, dropped to 34 in FY 22/23, then fell further to 15 in FY 23/24, 12 in FY 24/25, and 12 in FY 25/26. Regional Hospitals began with a rate of 8 in FY 21/22, rose to 10 in FY 22/23, then declined to 5 in FY 23/24, 3 in FY 24/25, and 3 in FY 25/26. Provincial Tertiary Hospitals had a rate of 7 in FY 21/22, increased to 10 in FY 22/23, stayed at 7 in FY 23/24, and dropped sharply to 1 in FY 25/26. Overall, all three hospital types show a downward trend in under-5 case fatality rates over the five-year period, with the steepest reduction seen in District Hospitals.

HIV/AIDS and Tuberculosis

- HIV/AIDS

The Sixth South African HIV Prevalence, Incidence, and Behaviour Survey (SABSMM) was conducted in 2022, and the results were released in 2024. The results showed that in 2022, Mpumalanga Province had the highest HIV prevalence of all provinces (17.4%). This means that 890 000 people in the province are living with HIV.

Among youth aged 15-24 years, the prevalence was 7.8%, with males in this age group having a 1.5 times higher prevalence than females in the same age category. Among adults aged 25-49 years was 26.4%, with females

having an HIV prevalence 1.6 times higher than that for males. Furthermore, HIV prevalence was higher in rural formal or farm areas (21.1%) and rural informal areas (18.4%) compared to urban areas (15.5%).

HIV prevalence peaked in the 45–49-year age group (40.8%), compared to a peak among 35–39-year-olds (39.0%) in 2017. This could suggest a possibility of continued new infections or People Living with HIV (PLHIV) living longer due to the scale up of ART. However, among younger age groups, there is a downward shift in the epidemic curve.

Antiretroviral treatment (ART) coverage increased to 81.8% in 2022 – an increase from 65.4% in 2017. In total, 630 000 people living with HIV are receiving ART. Among those aged 15-24 years, ART coverage was 56.4%, while in those aged 25-29 years, ART coverage was 83.9%. ART coverage was similar in urban areas (79.8%) and rural informal areas (79.7%).

In terms of progress towards the 95-95-95 targets among those aged 15 and older, the status of the province is currently at 87.3-94.5-94.0. This means that 87.3% of those living with HIV aged 15 years and older know their HIV status, 94.5% of those who know their status are on ARTs, and 94% of those receiving ART are virally suppressed. Adolescents and youth (15-24 years) were significantly behind for the first and second target (70.6 and 79.7%, respectively) compared to those aged 25-49 years (87.8 and 95.6%, respectively).

In testament to the success of the ARV programme in the Province, Mpumalanga has the second highest viral load suppression rate in the country among people living with HIV, at 96%. This is an increase from 60% in 2017. Viral load suppression was 72.8 and 83% among 15–24-year-olds and 25–49-year-olds living with HIV, respectively.

Notable is the fact that, adolescents and youth account disproportionately for treatment gaps. This age group accounts for only 9.4% of people living with HIV, but only 16.9% know their HIV status. Similarly, those residing in urban areas account for the majority of people living with HIV in the Province and they account for the majority of the treatment gaps.

In February 2025, the Close the Gap campaign was launched by the South African Government. The goal of the campaign was to identify and support 1.1 million people living with HIV who are not on antiretroviral treatment by December 2025.

The campaign in Mpumalanga aims to:

- Increase HIV and TB testing, targeting mainly those who have never tested for HIV.
- Initiate those who tested positive for HIV and never started ART.
- Bring back and re-initiate ART for those who stopped treatment.
- Improve retention in care.

In total, 134 243 people living with HIV in our province need to be engaged, re-engaged, and retained in care.

Targeted populations are men, children 0-14 years, youth 14-24 years, and key populations such as sex workers and drug users.

Campaign pillars are:

- Stakeholder and Social Mobilization.

- Service Delivery and Quality Improvement.
- Communication.
- Resource mobilization.
- Monitoring and Evaluation.

A sum of 72,124 has been returned to care, meaning that the 134,243 gaps have been closed by at least 54%. The province's 95-95-95 status is currently 96-87-96. The campaign has been extended to December 2026.

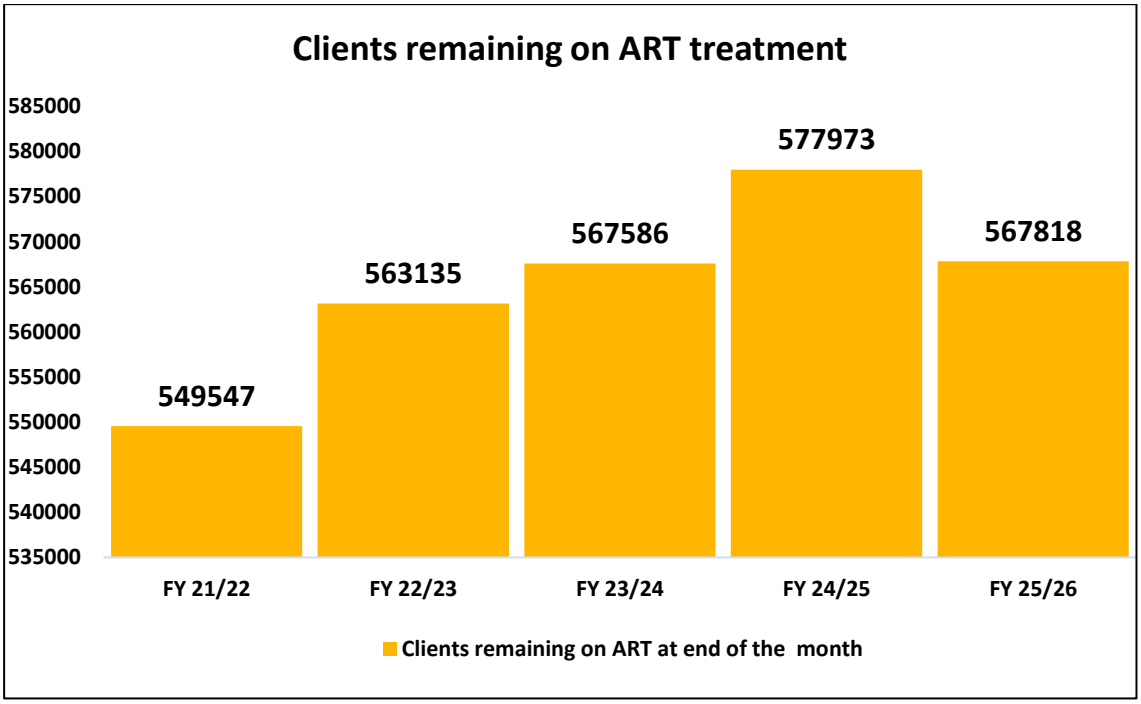


Figure 24: ART clients remaining in care at the end of the month

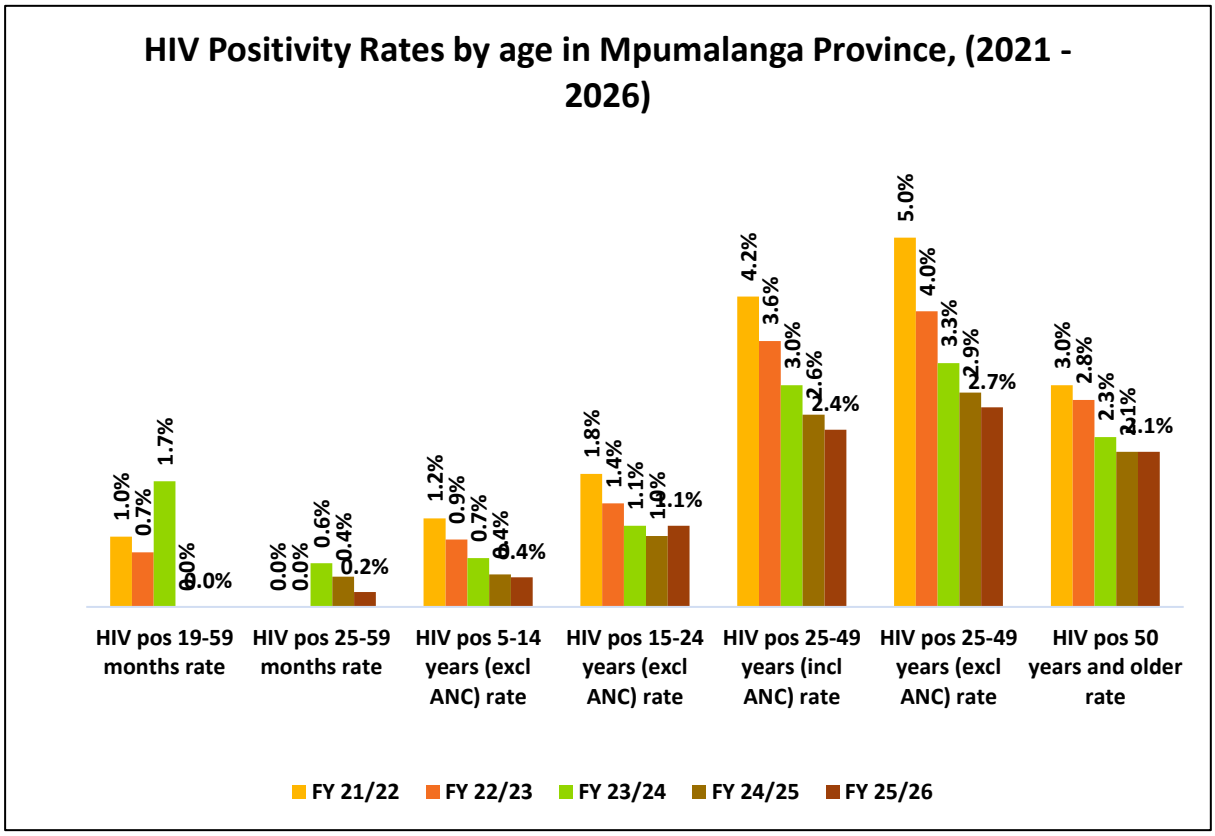


Figure 25: Provincial HIV Positivity Rates by Age

The graph shows HIV positivity rates by age group in Mpumalanga Province from FY 2021/22 to FY 2025/26. It compares six age categories amongst 19–59 months, 25–59 months, 5–14 years (excluding ANC), 15–24 years (excluding ANC), 25–49 years (including ANC), 25–49 years (excluding ANC), and 50 years and older. Over the years, the rates generally increased over with age, with the highest positivity in the 25–49 years (excluding ANC) group, peaking at 5.0% in FY 2025/26. The 50+ age group also shows high rates, while the youngest groups (19–59 months and 5–14 years) have the lowest rates, mostly below 1.2%. it shows a trend of rising HIV positivity in older age groups compared to younger ones.

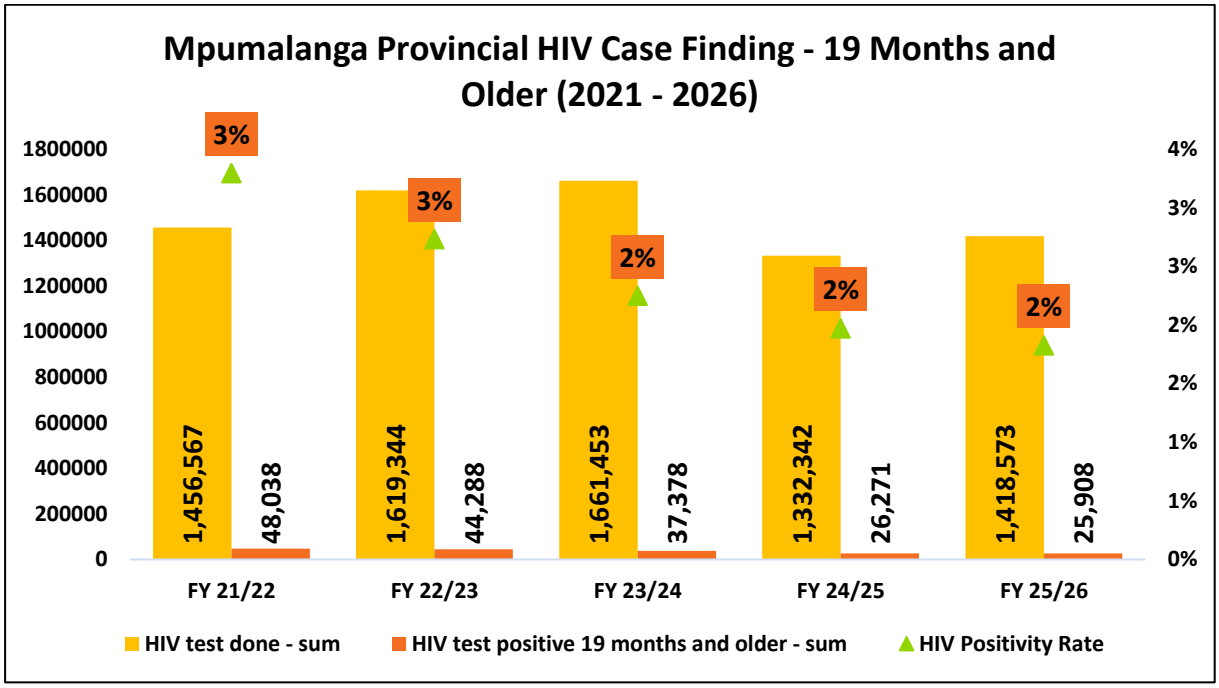


Figure 26: Provincial HIV Case finding Trends

Figure 26 shows the TB screening rates for children under 5 years of age at 100.4%, which is above the national average of 94.5%. Whilst the TB screening rate for clients 5 years and older is 96.2%, which is below the national average of 97.6%.

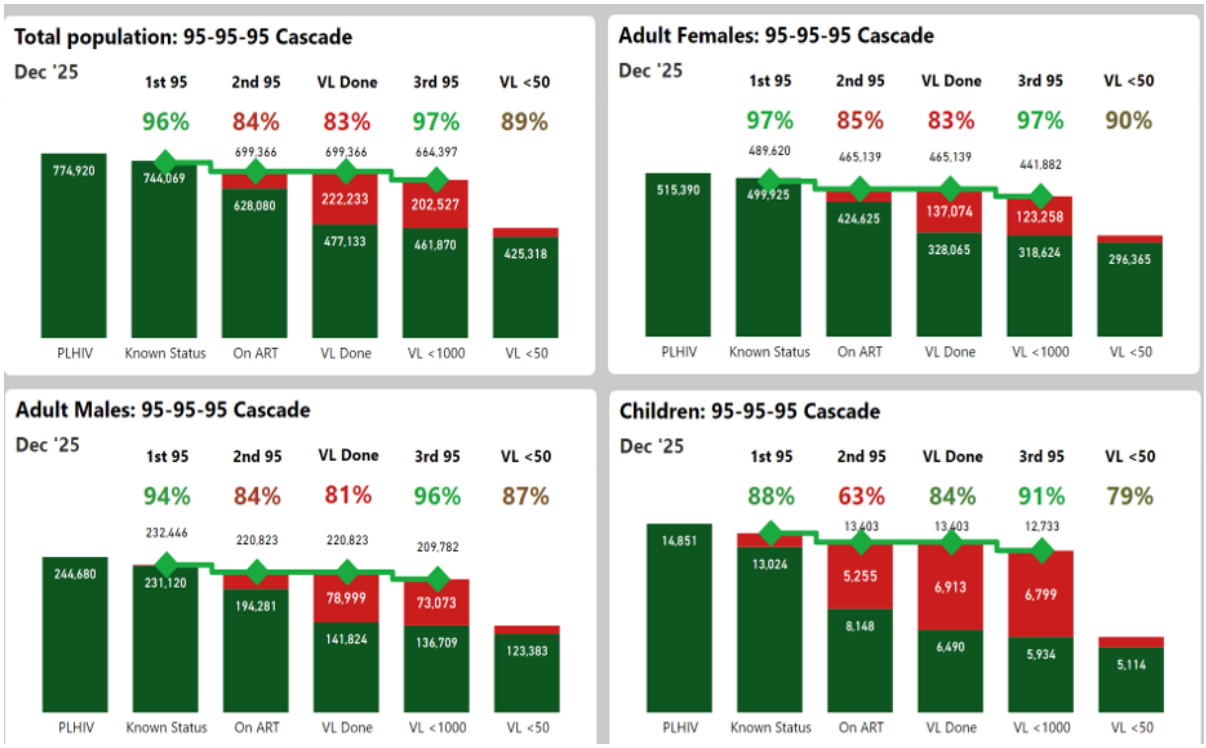


Figure 27: Provincial 95-95-95 Performance - December 2025

Test positivity rate has been declining since 2020/21. Over the same period, the total number of HIV tests conducted have also been decreasing (Figure 28). This decrease in test positivity, therefore, needs to be interpreted with caution, as the testing levels may not be high enough to find all people living with HIV. For the province to reach the 95-95-95 targets, testing will be increased to meet the first 95 target (95 per cent of all people living with HIV know their status). This is crucial as the second and third 95 targets (95 per cent of all HIV positive people are on antiretroviral treatment, and 95 per cent of all people on antiretroviral treatment are virally suppressed, respectively. Strategies to address the HIV epidemic and challenges in Mpumalanga Province include:

- Long-term planning to care for individuals in an aging HIV epidemic.
- Heighten focus on campaigns and other strategies to promote uptake and sustained use of ART, especially among young people, and adult men.
- Assess and address district-level gaps to improve access to HIV prevention, care, and treatment services.
- Enhance prevention efforts that target groups disproportionately affected by the drivers of HIV infection, such as women and young people.
- Integrate HIV, TB services with other health, child and men's health interventions.
- Enhance accurate public awareness and targeted demand for effective HIV prevention measures, including HIV testing and counselling, condom use, and PrEP.

- Tuberculosis.

Mpumalanga province is committed to ending the TB epidemic by adopting the Global end TB strategy in 2014 targeting to reduce the number of deaths caused by TB by 75 percent by 2025, and 90% by 2030. Furthermore, in 2015, South Africa adopted the SDGs.

The national TB prevalence survey report estimated the prevalence of all TB in 2018 to be 737 per 100 000, which translates to an incidence of 390 000. The TB notification in 2018 were 235 652, which translates to 154 348 people who have TB disease in the communities were not diagnosed and started on treatment. The report further suggests that the population groups who are missed are youth in the age group 15-24 years and the elderly 65 and above years, with the prevalence being higher in the male population than females (NDOH 2020).

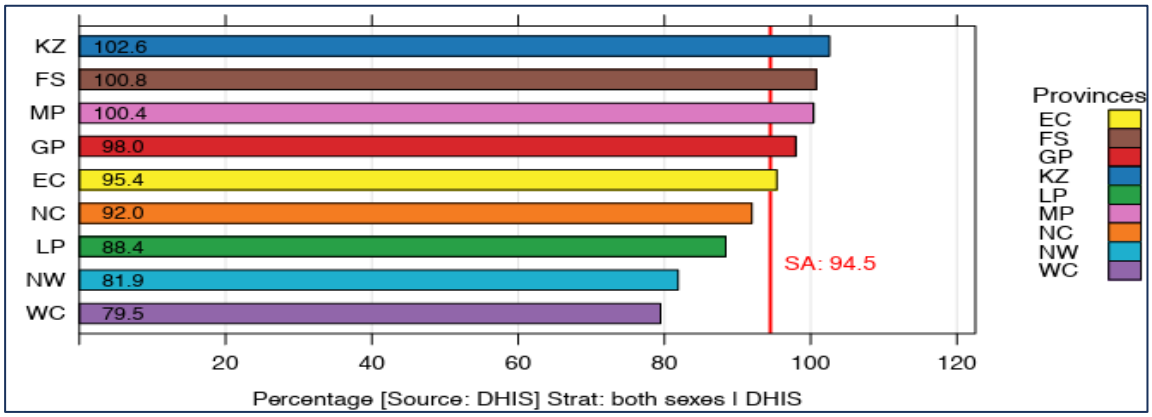


Figure 28: TB Symptom child under 5 years screened in facility rate by province 2022/23 (DHB 2023)

Treatment initiation rates for DS-TB-positive clients has been steadily declining since 2019/20 (Figure 28). In 2023/24, the treatment initiation rate for clients 5 years and older was 90.9%. The rate for children under 5 years was lower at 83.8%. Although these rates are relatively high, strategies to prevent declining treatment initiation rates should be employed.

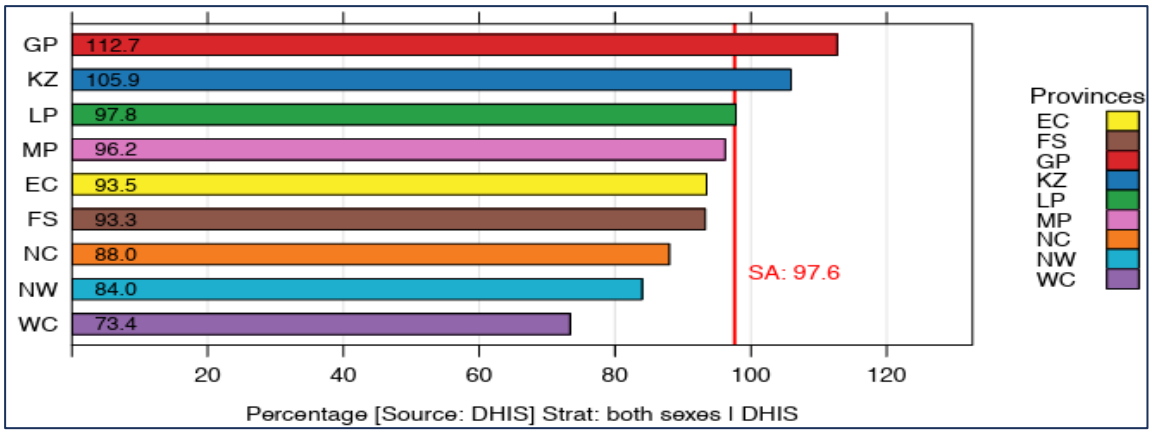


Figure 29: TB Symptom 5 years and older screened in facility rate by province 2022/23 (DHB 2023)

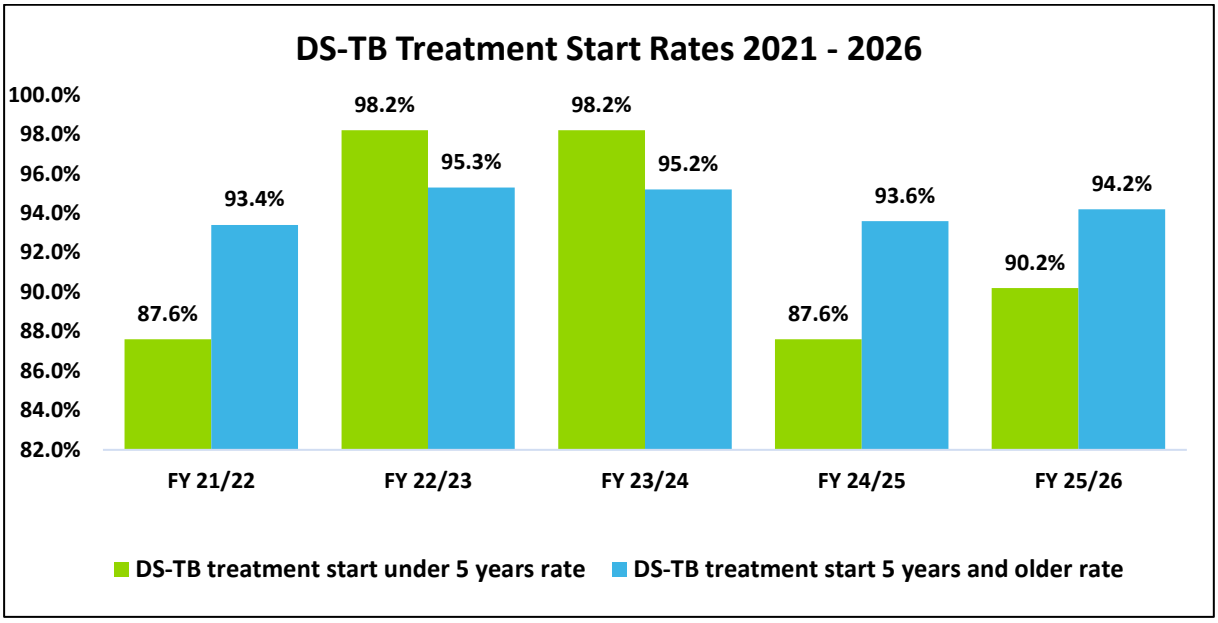


Figure 30: DS TB treatment start rates (DHIS)

Mpumalanga province DS-TB treatment success rate of 75.2%, however, is still below the National Strategic Plan (NSP) target of 90%. Strategies to mitigate program shortfalls need to be put in place in line with the TB recovery plan. The DS-TB treatment success rate among provinces ranged from 68.9% in LP to 84.2% in NW. Only NW reached the target of 80%. Two provinces, Eastern Cape (EC) and Gauteng (GP), reported declines in the DS-TB treatment success rate between 2021 and 2022. TB DS treatment success rate by province,

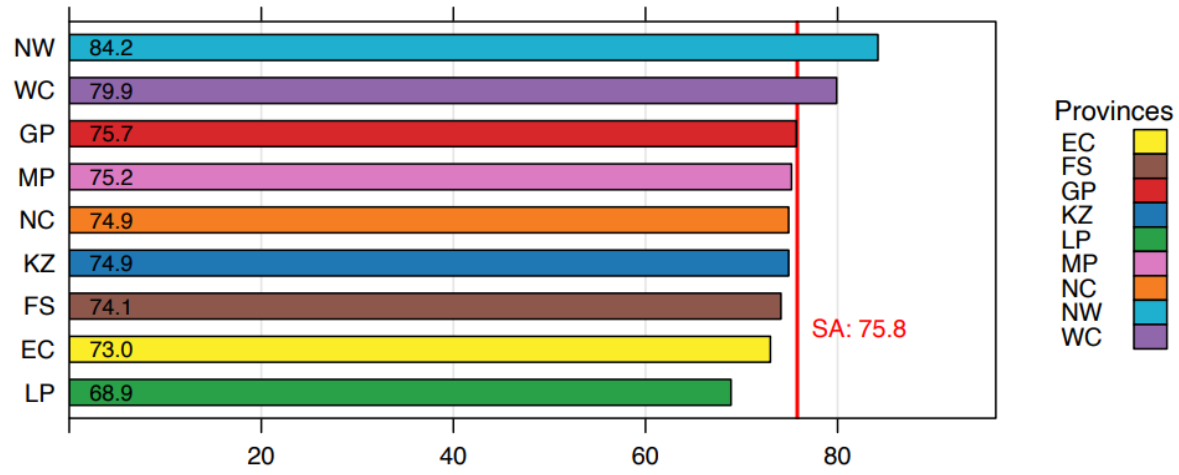


Figure 31: DS-TB treatment success rates by province 2021 (DHB 2023)

Non-Communicable Diseases

Non-communicable diseases (NCD) include those diseases that are not infectious and are often referred to as diseases of lifestyle. Risk factors for these diseases of lifestyle include a sedentary lifestyle, smoking, excess alcohol consumption, obesity, and over-eating, particularly of non-nutritious and fast food.

Addressing the burden of NCDs involves two major approaches. The first is to minimise the risk of citizens acquiring these chronic diseases. This approach requires a multi-sectoral approach and should involve long-term strategies that can be implemented upstream of the health system. An example of this is the sugar tax on sugar-sweetened beverages, which has been shown to decrease self-reported consumption of sugar-sweetened beverages[11].

The second approach to addressing NCDs is to identify those who have these conditions through screening and then ensuring those who require treatment are linked to care. Once clients are linked to care, their conditions need to be controlled through treatment.

In South Africa, there is a scarcity of data on the prevalence of Diabetes Mellitus, although the burden of glucose intolerance is estimated to be high[12]. A cross-sectional study[13] conducted in Mkhondo municipality in Gert Sibande District found that among the study participants prevalence of glycaemic control[14] (HbA1C > 7%) was 77.71%, while prevalence of very poor glycaemic control (HbA1C > 9%) was 50.6%. The study authors recommended that strategies to address glycaemic control should target dietary practices and dyslipidaemia. However, it is noted that the study design was cross-sectional and therefore considered glycaemic control in study participants at one point in time. Longitudinal studies are needed to monitor glycaemic control over time, which will also give a better understanding of which strategies are needed, and which are working.

Citizens of Mpumalanga Province were found to have a high risk for hypertension[15]. This is not surprising, as South Africa has a significant burden of disease due to hypertension. Risk factors for hypertension include age, alcohol consumption, smoking, being overweight, having high blood sugar levels, high blood cholesterol, angina, and stroke. Therefore, strategies to address hypertension should address these lifestyle and key health metric factors.

The mental health burden is also high in Mpumalanga, with the prevalence of depression and anxiety found to be 25.1% 14.6%, respectively[16]. In addition to increasing the demand on the healthcare system, poor mental health has an adverse effect on society as people are unable to reach their full human potential, contribute to society, and thrive.

12 Prevalence of Type 2 Diabetes in South Africa: A Systematic Review and Meta-Analysis, Pheiffer et al, Int. J. Environ. Res. Public Health 2021, 18, 5868. https://doi.org/10.3390/ ijerph18115868

13 Factors associated with glycemic control among South African adult residents of Mkhondo municipality living with diabetes mellitus, Masilela et al, Medicine, 2020

14 Glycaemic control is the optimal serum glucose concentration in diabetic patients.

15 Mapping the Burden of Hypertension in South Africa: A Comparative Analysis of the National 2012 SANHANES and the 2016 Demographic and Health Survey, Kandala et al, Int J Environ Res Public Health, 2021

16 The prevalence of probable depression and probable anxiety, and associations with adverse childhood experiences and socio-demographics: A national survey in South Africa, Craig et al, *Front Public Health*, 2022.

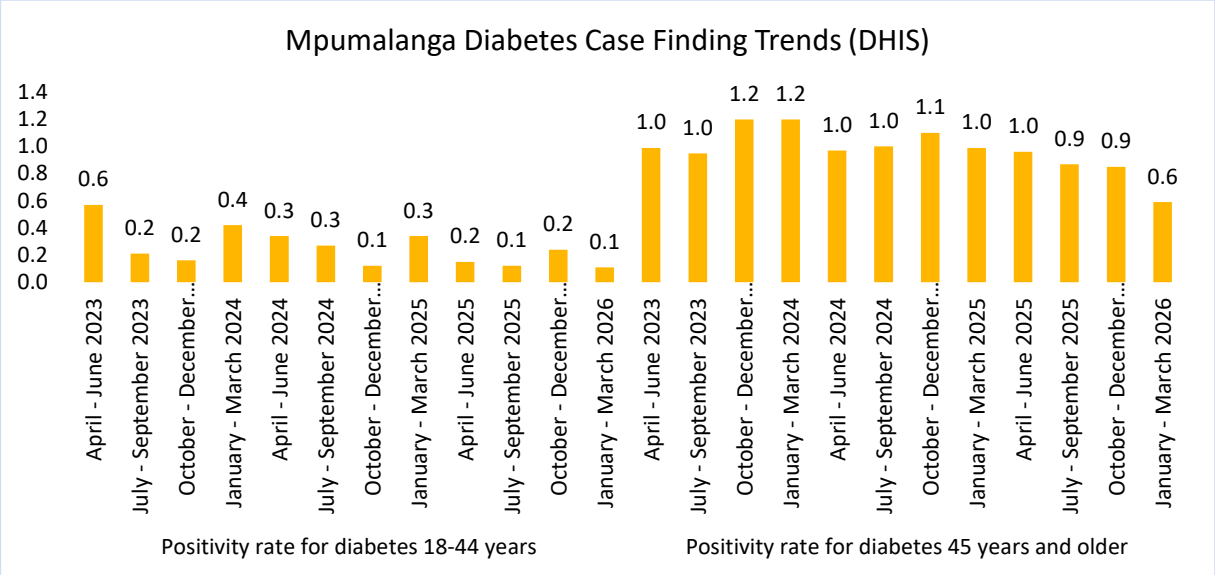


Figure 32: Mpumalanga Diabetes Case Finding Trends (DHIS)

Figure 32 shows the diabetes test positivity rate for those aged 18-44 years and those aged 45 years and older, from April 2023 to December 2025. The graph shows us that while the burden of diabetes is higher in those aged 45 years and older, it is still a condition that needs to be addressed in the younger age category. Therefore, screening, testing, and linkage to care should not be neglected in the younger age category. In addition, differentiated models of care and strategies should be employed to retain both older and younger people in care.

For hypertension, there is a similar pattern seen among the two age categories (Figure 33).

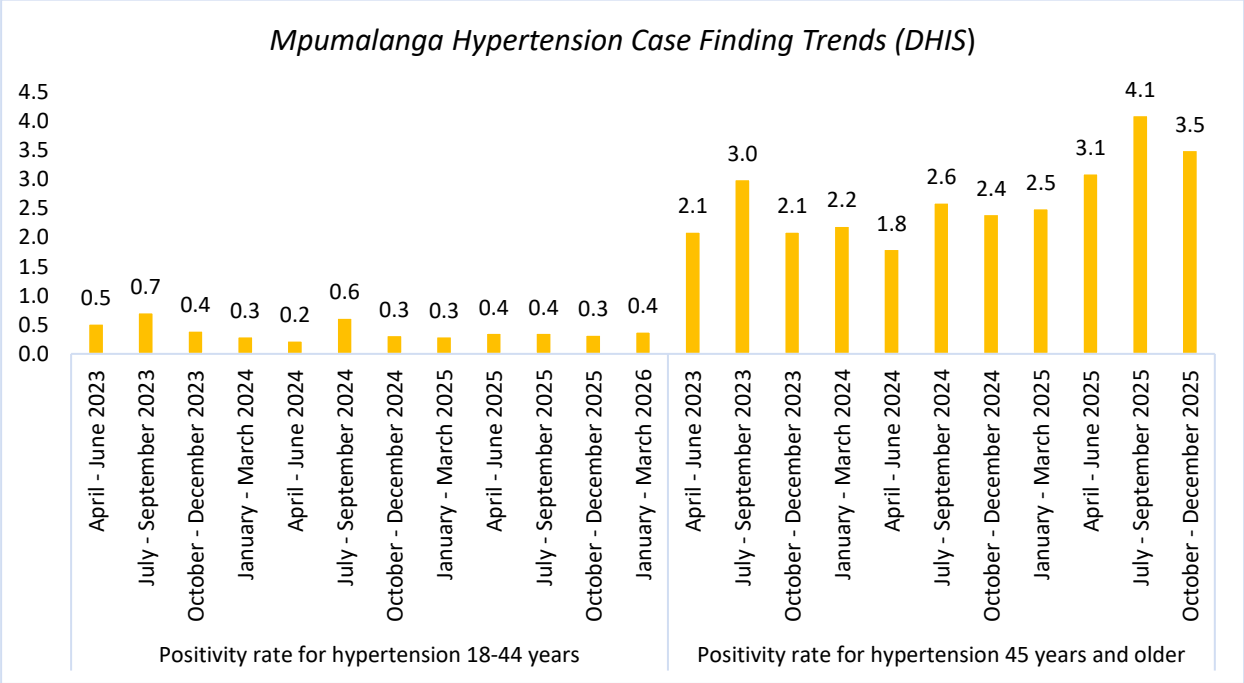


Figure 33: Mpumalanga Hypertension Case Finding Trends (DHIS)

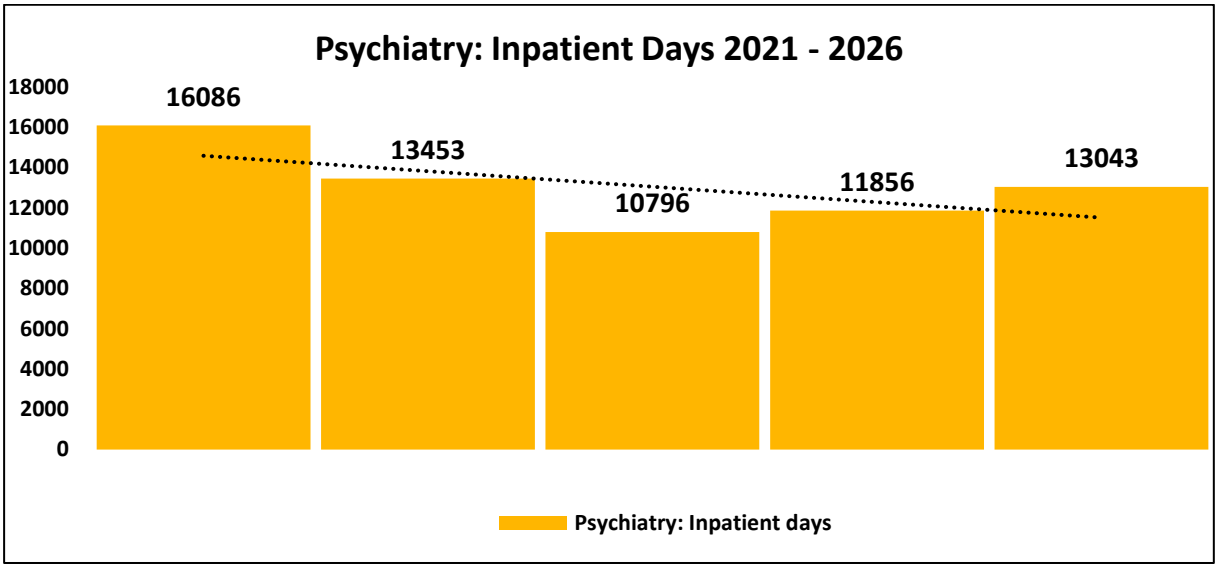


Figure 34: Provincial Mental Health Inpatient Days trends

Figure 34 shows the number of inpatient days from 2021/22 to 2025/26. Since 2021/26, there has been a downward trend in inpatient days, possibly indicating barriers to services during the lockdown period. However, this trend continues in 2022/23 and 2023/24, when lockdown measures and de-escalation of services were reversed. This could be attributed to the competition for beds between different conditions, given that we have a quadruple burden of disease. To increase the number of dedicated mental health beds, an additional mental ward is being constructed with a capacity of 60 beds at Kwa Mhlanga Hospital.

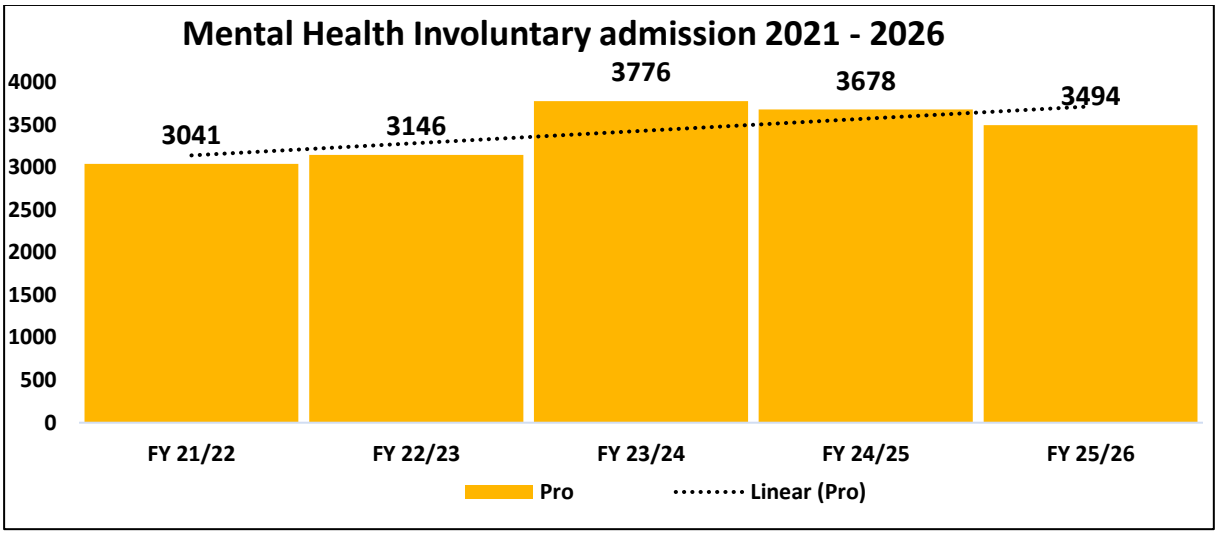


Figure 35: Provincial Mental Health Involuntary Admission Trends

The number of mental health involuntary admissions has been fluctuating since 2021/22, as shown in Figure 35 above. This underscores the burden of mental health conditions in our province. This has been addressed by mental health care services expanding using the NHI Conditional Grant, through the appointment of a clinical psychologist, 4 social workers, 19 registered workers, and 1 occupational health worker.

Violence and Injury

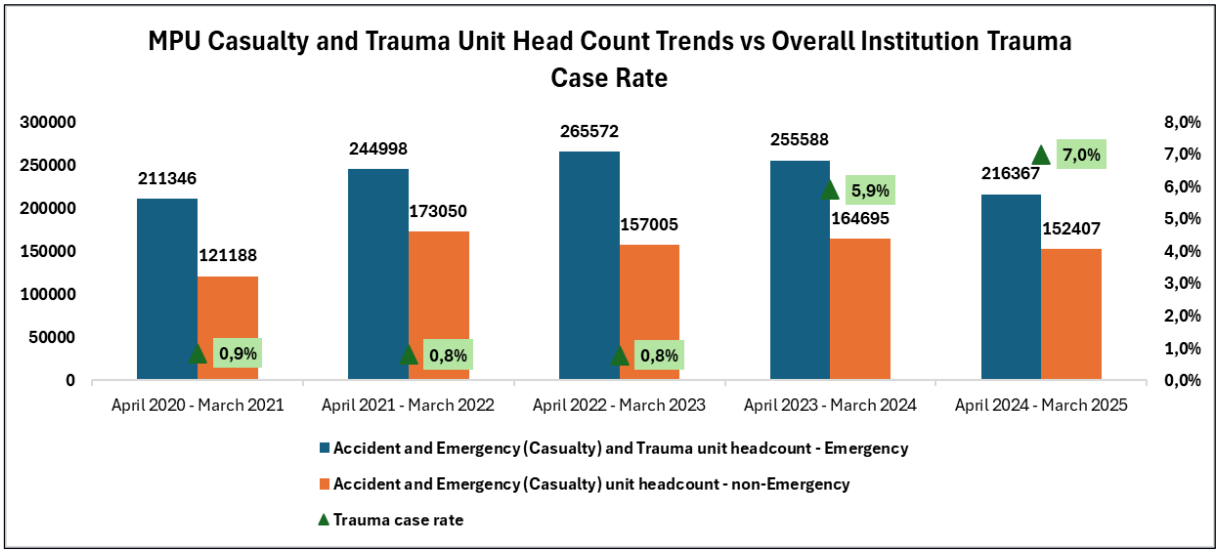


Figure 36: Mpumalanga casualty and trauma head count and overall trauma case rate trends

Figure 36 shows the Casualty and Trauma unit headcount from April 2020 to March 2025. Emergency cases have increased from 2020 to 2023 and then decreased again to 2025. Non-emergency cases have shown the same general pattern. Of note is the trauma case rate, which remained under 1% from April 2020 to March 2025, but increased to 5.9% and 7%, respectively, in the following 2 years.

6.2. Internal environment analysis

6.2.1. Service Delivery Platform

There are 457 health service delivery establishments and points in the province, of which 186 serve the Ehlanzeni District population, 128 serving the Gert Sibande District population, and 143 serving the Nkangala District population. Fixed facilities comprise of 2 Tertiary, 3 Regional, 23 District, 1 TB Specialized Hospitals, 60 Community Health Centres, and 292 Primary Health Care Centres. Table 8 provides a break-down of the facility types, inclusive of mobiles and satellite clinics, where Figure 38 shows the population distribution, local municipality boundaries, and facility locations per district.

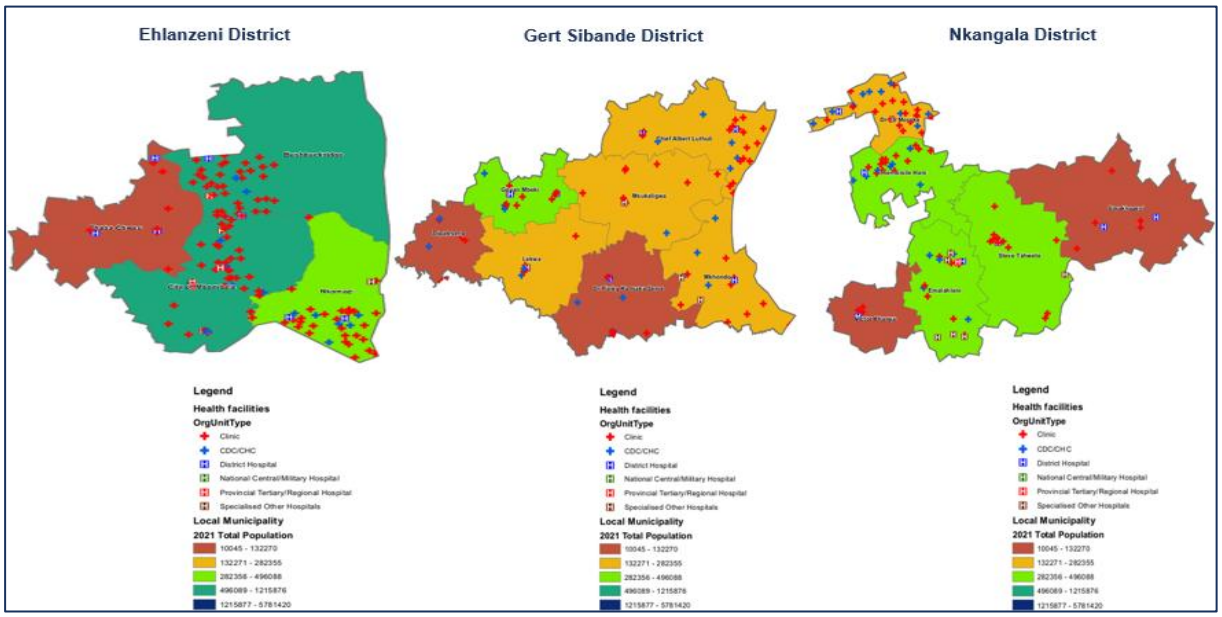


Figure 37: Population distribution, Local municipality boundaries and health facility locations (DHB 2022/23)

Facility Type	Ehlanzeni District	Gert Sibande District	Nkangala District	Total
Tertiary Hospitals	1	0	1	**2**
Regional Hospitals	2	1	0	**3**
District Hospitals	8	8	7	**23**
Specialized TB Hospitals	1	0	0	**1**
24-hour facilities (CHC)	15	20	24	**59**
8 -hour facilities (Clinic)	107	53	71	**231**
Mobile Services	32	23	21	**76**
Satellite Clinics	4	0	0	**4**
Total number of facilities	**170**	**105**	**124**	**399**

Table 4: Mpumalanga Health Facilities Distribution

Demand on the PHC healthcare platforms.

Figure 38 shows PHC headcount and Community-Based Outreach Services headcount from 2021 to 2025. Since April 2021, there has been a slight increase in headcount. The community outreach programme forms a significant portion of the primary headcount, underscoring the Department's commitment to taking services to the people. This is particularly important for clients who live in areas where the infrastructure makes it harder for them to reach our facilities. Community outreach services also ensure that clients are screened and appropriately referred to facilities, thereby avoiding unnecessary trips and the burden on clinics.

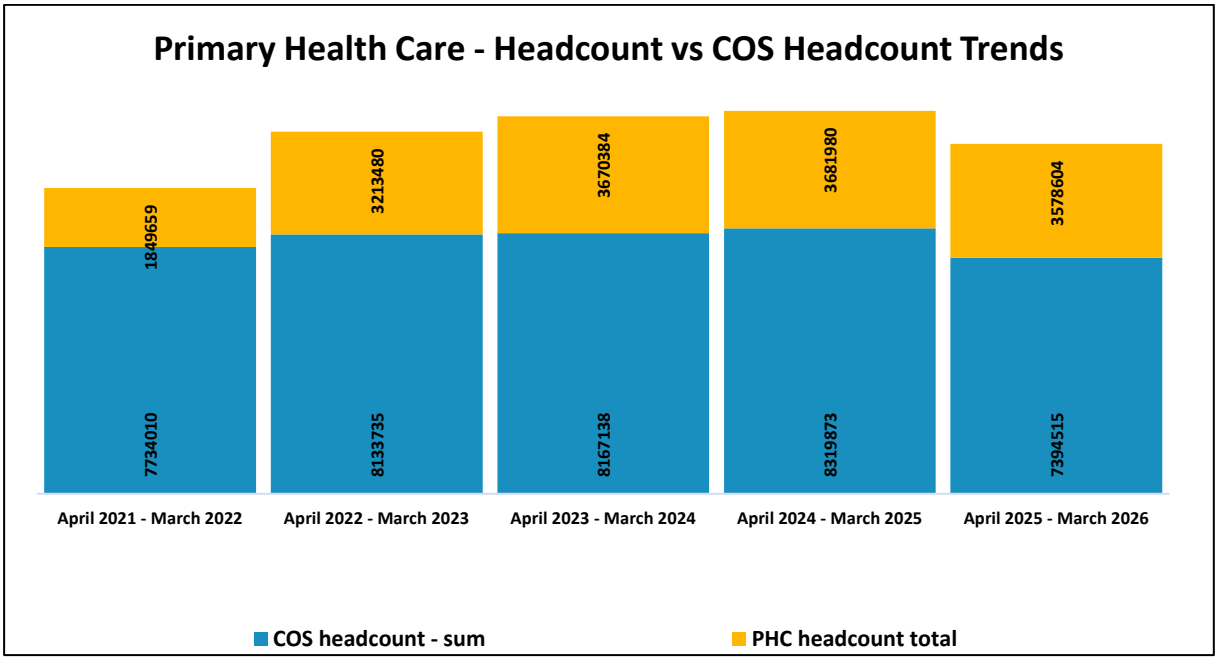


Figure 38: Provincial PHC Headcounts vs COS Headcount trends 2025 (DHIS)

As the Department pivots to NHI and full implementation of UHC, there is a need to strengthen the primary healthcare platform through a more robust home and community-based care system. This also ties in with the priority of strengthening Health Promotion. There are currently 5 396 community health workers (CHW) providing various health services at the household level, but challenges include high staff turnover and inadequate coverage.

These CHWs support the early detection of chronic diseases through screening and improving chronic care services through tracing of defaulters. The Department will prioritise the replacement of the community health workers who exit the system and the procurement of more devices needed by CHWs to screen the community.

Demand on the hospital healthcare platforms.

The average length of stay has increased overall for both district and regional hospitals from 2021/22 to 2023/24 (Figure 39). This could be because people only seek care when their conditions are more advanced and require care at a higher level. The average length of stay at Tertiary hospitals increased between 2019/20 and 2021/22 and remained the same in 2022/23. This was followed by two consecutive years of decreases. From 2022/23 onward, the average length of stay in district and regional hospitals increased, while at the same time decreasing in tertiary hospitals. It is unclear if there is a link between these concomitant changes. Strategies to decrease the average length of stay should address:

- Client education so that they seek health care services earlier when their conditions are less advanced. This will also result in the cost of treatment for clients, as healthcare costs increase with the level of care.
- Optimising the referral system between different levels of care to ensure patients are being treated at the correct level and by the correct type of medical professional.
- Effective discharge planning to identify post-hospital treatment needs early in treatment.
- Implementing evidence-based clinical pathways to guide treatment and expedite patient progress.

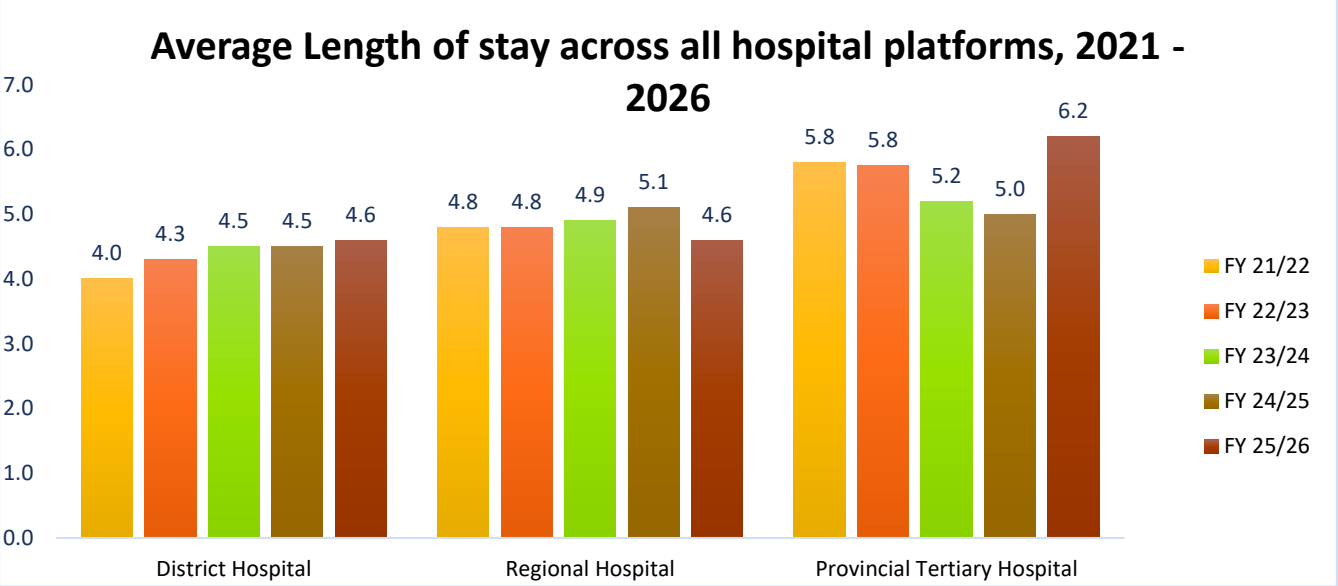


Figure 39: Average Length of stay across hospital platforms trends (DHIS)

Emergency Medical Services

Emergency Medical Services (EMS) contribute to coordinating health services across the care continuum and reorienting the health system towards primary health care. Emergency medical services (EMS) are an essential component of the chain of care, which also enhances primary health care and preventative services.

The EMS current fleet status is reflected as follows:

Emergency Medical Services operates with 171 ambulances, 10 intensive care units, 3 mental health units,1 helicopter, 3 primary response vehicles, 70 patient transporters, 55 logistics and management vehicles. To improve emergency services, the province has procured 15 additional ambulances to the current fleet.

The 785 operational personnel located across the 38 EMS Stations and 3 Emergency Communication Centres enable the operation of 63 ambulances for emergency response, interfacility transfers, planned patient transport, and events.

Staffing shortages, an inadequate fleet, and a lack of technology tools to accurately track response times are some of the EMS's challenges. While the department is creating a technology-based platform to increase the efficacy and efficiency of emergency response, EMS has started using a paper-based dispatch system. This will enhance overall program efficiency and provide accurate reporting on response times and performance metrics.

The establishment of the College of Emergency Care at the old Middelburg Hospital is in progress. The objective of the project is to train and qualify personnel for emergency medical care services to address the critical shortage of skilled personnel into the tertiary EMS qualifications. The Emergency Medical Services personnel will be supported in attaining these industry qualifications to sustain the organization.

6.2.2. People Management

- **Organisational Design**

The Department has an approved organizational structure, which is being reviewed for the purposes of alignment with the priorities of the 7th Administration and for the purposes of the implementation of the Sub District Model and processes towards the implementation of the National Health Insurance.

The Department has a total number of 24 086 permanent funded posts, of which 21 076 are filled, and 3 010 are in the process of being filled. The department vacancy rate presently stands at 12,4%.

- **Efficiency Projects**

During the reporting period, the Department conducted the following projects to optimise human resources for health:

- Overtime reforms with a view of utilising the budget for the employment of additional staff.
- Compliance with National Minimum Information Requirements (NMIR).
- Implementation of shift work for the purposes of improving service delivery and staff utilisation.
- Digitisation of human resource practices systems.
- Career Incidents and Other Challenges.
- Alignment of the HR processes to the Human Resource for Health strategy.

The Department embarked on the efficiency project informed by the monthly monitoring of health care programme spending trends, which is conducted by the Health Economics Unit, which outlines the Bed Utilization Rate (BUR), overtime spending, and staff workload. Based on the process of Health Economics and the information on the District Health Information system (DHIS), a needs-based assessment was commissioned with the aim to improve efficiency through rationalization of staff from the institutions as listed below.

- **Employee Health and Wellness**

The Employee Health and Wellness programme has designed a set of activities and programmes to encourage and help employees maintain physical, emotional, and mental health.

The unit is responsible for the following:

- Coordinating and monitoring SHERQ programmes.
- Provision of psychotherapy for all employees, especially to employees at high risk, such as EMS, Forensic Services, and Health professionals.
- Integration with Occupational Health on programmes such as disease management.
- Advocates for issues of gender-based since they impact the mental health of employees.
- Established a wellness Wednesday which encourages employees to participate in sporting activities and indigenous games, however, ensuring continuity of services.
- Continuously support the wellness indaba.

- Occupational Health and Safety.

The staff satisfaction survey is a direct feedback tool that allows employees to share their opinions and experiences. The surveys are conducted annually to improve staff morale. The survey is conducted by the department to develop intervention strategies that will improve staff satisfaction, and the results will be used to improve staff welfare and wellness.

The objective of the staff satisfaction survey is:

- To determine employees perceived well-being and wellness.
- To determine employees perceived safety and security.
- To determine employees' knowledge and understanding of departmental policies and procedures. including Batho Pele principles in the workplace.

The Department is in the process of conducting the staff satisfaction survey for the 2025/2026 financial year.

- **Filling of Posts**

The Department has successfully managed to fill 12 critical posts, including both Key Strategic Senior Management and Clinical Posts, as follows**:**

Table 5: Key Strategic Senior Management and clinical posts filled.

POST NAME	STATION
Director: Community Health Based Services	Provincial Office
Director: Corporate Services	Ehlanzeni District Office
Director: TB Control Programme	Provincial Office
Director: Human Resource Practices & Administration	Provincial Office
Director: Hospital Services	Nkangala District Office
Director: Infrastructure Programme Delivery	Provincial Office
Chief Director: Ehlanzeni District Health	Ehlanzeni District Office
Director: Primary Health Care	Ehlanzeni District Office
Director: Primary Health Care	Nkangala District Office
Director: Corporate Services	Gert Sibande District Office
Director: Supply Chain Management	Provincial Office
Chief Executive Officer: Ermelo Hospital	Gert Sibande District Office

Training and Development Programmes

A total of 4 487 health workers has been trained on various critical clinical skills as prioritised during the strategic planning session. The Department has put focus on developing management and leadership skills to support a solid succession plan that will ensure business continuity. This includes putting ten (10) young managers on the

Albertina Sisulu Executive Leadership Programme, as well as training 75 junior managers on two-week short courses offered by the University of Pretoria as well as 50 on a Health Leadership programme offered by the University of the Witwatersrand.

In addition, a total of ten (10) students have been awarded bursaries to study medicine in Cuba. The Department continues to implement the Compulsory Induction programme mandated by the DPSA, and to date, more than 600 have been trained since the financial year started.

Gender, youth, and disability mainstreaming

The concept of gender-, youth- and disability-responsive mainstreaming exists to drive an approach to policymaking which considers the concerns and needs of these specific groups. Mainstreaming refers to integrating an equality perspective into policies, programmes, and projects, at every level. These groups have different needs and circumstances to their counterparts and unequal access to power, resources, and the justice system, including human rights institutions. Circumstances also differ according to country, region, age, and other factors such as personal situation. The department will use mainstreaming to consider these differences when designing, implementing, and evaluating policies, programmes, and projects, so that everyone in the province benefits from the Department's services equally and equitably. In addition, everyone should have access to employment opportunities within the Department regardless of their status.

6.2.3. Information and Communication Technology

The ICT Strategic Plan is the key component that will enable the Department to deliver its services. The ICT/IT unit/Directorate cannot implement its objectives in isolation of the business needs/requirements, hence the approach of the Enterprise Architecture (EA) project. The purpose of the ICT Strategic Plan is to provide the Department with a measurable and actionable five-year (2025/6 – 2029/30) roadmap. The ICT Strategic Plan is a key business document that provides business insight and aligns the ICT/IT unit/Directorate with the strategic objectives.

The ICT Strategic Plan was conducted through the Enterprise Architecture (EA) projects' information gathering sessions with the management of business units in the Department, which resulted in valuable information gathered during these sessions. The information sessions focused on the different units' functions and services, which must be enabled by the ICT/IT capabilities of its resources. The business units highlighted their challenges and strengths in terms of support from the ICT/IT unit/Directorate. Gaps have been identified and will be addressed through a number of opportunities and solutions/initiatives spread over a five-year period.

Process Inefficiencies Affecting ICT Service Delivery

The Department's ICT environment still relies heavily on manual, non-digitised processes, which reduces efficiency and delays service delivery. Key gaps include:

- ICT project management processes are not consistently enforced.
- Data governance is absent—no data framework, strategy, or structures exist.
- Health facilities procure ICT systems directly from vendors, bypassing ICT governance structures.
- Systems are not centralised nor integrated, resulting in duplicated data and re-capturing.
- Poorly defined processes and a lack of control mechanisms increase fraud risk APP Implication.

Introduce standardised ICT business processes, enforce ICT project governance, and implement data governance frameworks to strengthen service delivery and risk management.

Technology Limitations Constraining Performance

The Department faces multiple technology-related constraints:

- Insufficient network bandwidth across health sites, limiting system performance.
- Ageing ICT infrastructure requiring upgrade and refresh.
- Need to develop and implement a digital strategy to support modernisation APP Implication:

Prioritise network optimisation, infrastructure upgrades, and full rollout of departmental digital strategy initiatives.

External Dependencies Impacting ICT Performance

The Department depends on:

- National Department of Health for directives and core health information systems.
- External health management systems for integration and information sharing.

APP Implication:

Strengthen collaboration mechanisms and alignment with national systems to ensure continuity and interoperability.

Key Operational Risks from the External Environment

The situational analysis highlights:

- Security challenges in health facilities.
- Dependencies on national health care management systems.

APP Implication:

Implement facility-level ICT security measures and ensure contingency planning for system dependencies.

Digitalisation Priorities Identified by the Department

To modernise health service delivery, the Department has prioritised:

- Digitisation of medical equipment in facilities.
- Digitisation of inactive patient records in regional and tertiary hospitals.
- Rollout of the enrolment system to district hospitals.
- Investment in AI and robotic systems to address workforce shortages.
- Expansion of social media platforms for communication and engagement APP Implication:

Align annual targets to digital transformation milestones records digitisation, system rollouts, AI readiness assessment, and digital communication initiatives.

Integrated APP Ready Strategic Outcomes:

Improved ICT Governance and Process Efficiency

- Establish and institutionalise ICT project management processes.
- Implement comprehensive data governance frameworks and structures.
- Centralise and integrate ICT systems to eliminate duplication.

Strengthened ICT Infrastructure Capabilities

- Upgrade network bandwidth and optimise connectivity at all sites.
- Modernise and refresh departmental ICT infrastructure.
- Implement the departmental digital strategy.

Modernised Digital Health Service Delivery

- Digitise priority medical and administrative processes.
- Expand enrolment systems across all district hospitals.
- Conduct feasibility and readiness studies on AI and robotics.

- Improve digital communication channels.

Enhanced Collaboration and Interoperability

- Strengthen alignment with the National Department of Health systems and directives.
- Enable seamless integration with national health information platforms.

Reduced Risk and Improved Security

- Strengthen ICT controls to mitigate fraud risks.
- Improve digital and physical security in health facilities.

6.2.4. Infrastructure Developments

Infrastructure has been identified as a critical enabler for the Mpumalanga Province in ensuring the Department delivers on its mandate to provide access to quality health services. Mpumalanga Province is implementing five important infrastructure projects:

- Mapulaneng Hospital currently under construction,
- Kwa Mhlanga Maternity Ward currently under construction,
- Mpumalanga Psychiatric Hospital currently under planning,
- Linah Malatjie Tertiary Hospital currently under planning, and
- Rob Ferreira Hospital Oncology (Radiotherapy) under planning

These projects are expected to not only benefit the health system but also provide economic spin-offs for the surrounding communities as part of the Department's contribution to jobs and economy.

Other infrastructure priorities include PHC facilities, Acute Psychiatric Units, extensions and upgrades to various hospitals and infrastructure maintenance. Reducing the health infrastructure carbon footprint also remains high on the agenda. Some of the projects include:

- Troya clinic under construction
- MN Cindi clinic under construction
- Dumphries clinic under construction
- Siyabuswa CHC under construction
- Langkloof clinic under construction
- Alexander clinic under construction
- Lebohang clinic under construction
- Lefiswane clinic under construction
- Barberton Clinic under construction
- Vezubuhle clinic under construction
- Kinros clinic under construction

South Africa's National Infrastructure Plan 2050 of February 2022 highlights five cross-cutting sections focused on its regional agenda for infrastructure, namely finance, strengthening institutions for delivery, rebuilding the civil

construction and supplier sector, and the approach to monitoring and reporting on progress. Three of these, impact the Provincial Infrastructure Development and Technical Services and are listed below with the current response to each:

- Strengthening institutions for delivery: Mpumalanga Department of Health has an official functional structure in place for its Chief Directorate: Infrastructure Development and Technical Services. This unit is capacitated with appropriately qualified, skilled, and experienced staff. In addition, the Department's current implementer, DPWRT, has an official functional structure.
- Financing infrastructure and maintenance: Although the infrastructure budget allocation has constantly been reducing in recent years, allocations provided are used by the Department to finance its capital infrastructure and maintenance requirement as best possible.
- Monitoring and reporting: the infrastructure unit reports at various levels with respect to performance of projects as well as financial and non-financial performance. These range from internal in-house meetings and reports, to inter-departmental, provincial as well as national. Improving performance, mitigating the risk of under expenditure, etc. are also discussed and solutions proposed for implementation.

6.2.5. Ideal Clinic and Ideal Hospital

Overall, in the 2025/26 financial year, 286 (98.6%) primary health care facilities attained Ideal Clinic Status. Of these, the majority achieved Platinum Status (70.4%), followed by Gold Status (23.7%) and Silver Status (3.4%). Only one facility did not achieve Ideal Clinic Status following the peer review assessment conducted in the third quarter of 2025/26. Three facilities were not assessed due to contextual infrastructural challenges: Troya Clinic and Lefiswane Clinic are currently under construction, and Delmas Clinic is temporarily closed. Regarding hospitals, only one out of the 23 district hospitals achieved Ideal Hospital Status.

The common factors that resulted in non-compliance across the system are:

- Unavailability of emergency trolley equipment.
- Inconsistent supply of emergency trolley medical class II stock from the depot.
- Inconsistent supply of emergency trolley medication from the depot.
- Unavailability of oxygen (piped / mobile cylinders).
- Unavailability of suction units (piped / mobile units).
- Poor back-up generator checks.
- Unavailability of infrastructure and equipment maintenance plans and implementation thereof.

To address these, the Department will develop a quality improvement plan, the implementation of which will have an impact on patient safety, patient outcomes, and staff satisfaction. Unavailability of emergency trolley equipment in addition, all pharmaceutical stock (not only emergency trolley stock) is to be considered as high priority and must always be available at facilities. Unavailability of medicine and surgical sundries in general has a negative impact on the management of patients and demoralizes staff at the ground level. Unavailability of NNV pharmaceutical stock is a high risk on management of patients in an emergency, indirectly contributing to preventable deaths and high litigation cases.

6.2.6. Litigations

The increase in medical litigation claims has both direct and indirect implications on financial sustainability of health care services in the public sector. This challenge takes away financial resources of the department, where resources meant for service delivery are directed to payment of litigation and legal fees. The key priority is to mitigate the rising medicolegal claims by addressing contributing factors and improving patient safety to ensure that these cases are prevented in the future and that those who are non-compliant with prescripts are held accountable. Further enhance medical record management, implement clinical governance, and litigation management strategies.

Strategies to strengthen the Department against litigation:

- Implementation of existing legislation and instruments.
- Implementation of existing report findings and plans.
- Full implementation of the Medico-Legal Strategy.
- Establishment of a structure to deal with and advise on Medico-Legal claims.
- Full implementation of the Clinical Governance Strategy.
- Implementation of Patient Safety Days in all health care establishments.
- Oversight role by Provincial Clinical and Infrastructure Teams.
- Development of common law principles.
- Conducting marathon clinical interventions.
- Implementation of consequence management.
- Revive the global commitment and develop South African Guidelines for Patient Safety.
- Management and Digitization of medical records.
- Attracting specialized skills within the province.
- Collaborate with Law Enforcement Agencies to minimize the risk of fraudulent claims.
- Develop paperless Health records-electronic patient file system (EMR).
- Review the curriculum offered by the Mpumalanga College of Nursing and launch a new curriculum to cater to risks associated with litigation e.g., midwifery.

6.2.7. Progress Against the 5-year Strategic Planning Targets

OUTCOME: **IMPROVEMENT OF ACCESS TO AFFORDABLE AND QUALITY HEALTHCARE**			
Outcome Indicator	Baseline	5-year target	Progress to date
Life expectancy	65 F, 63 M	70 F, 70 M	67.7 F, 62.8 M
Maternal mortality rate	114.5/100 000 live births	70/100 000 live births	123.5/100 000 live births
Inpatient neonatal dearth rate per 1000 births	10.5/1000 live births	<9/1000 live births	13.6/1000 live births
HIV status awareness	95%	95%	96%
HIV treatment rate	84%	95%	84%
HIV viral suppression rate	93%	95%	97%
Percentage of clinics obtaining ideal clinic status rating	63%	100%	98.3%
Percentage of hospital obtaining ideal hospital status rating	0%	100%	4.3%
Percentage of facilities accredited to provide healthcare under the NHI fund	0%	100%	93.8%
Number of health professionals (doctors)	34	50	65
Number of health professionals (nurses)	70	350	258
Number of hospitals providing full tertiary health care services through infrastructure development	0	2	0

OUTCOME: **IMPROVEMENT OF ACCESS TO AFFORDABLE AND QUALITY HEALTHCARE**			
Hospital providing mental health services through infrastructure development established	0	1	0
Number of healthcare personnel employed	13 456	19 456	13 613
Percentage of facilities implementing Health Patient Registration System (HPRS)	91%	100%	97.9%
Immunization coverage <1 year	89.1%	95%	76.1%
Measles second dose coverage	97%	98%	74%
TB Drug susceptible client treatment success rate	56.3%	95%	78%

OUTCOME: **PROMOTE THE RIGHTS OF WOMEN, YOUTH, CHILDREN, MILITARY VETERANS AND PERSONS WITH DISABILITY**			
Outcome Indicator	Baseline	5-year target	Progress to date
Percentage of women employed in senior management positions	47%	50%	54%
Percentage of persons with disabilities appointed across all levels	1%	3%	0.51%
Percentage of youths appointed	21%	30%	20%

6.2.8. The Planning Process

The Department convened its Annual Strategic Planning session as part of the annual performance planning cycle to reflect on organisational performance, identify key challenges, and determine priorities that will guide service delivery and resource allocation over the medium term. The session was structured around a standardised priority setting tool, which was provided to all participating groups to ensure a consistent, evidence-based approach to planning.

At the outset, participants were briefed on the purpose of the session and the methodology to be followed. Each group was to use the information contained in the template as a point of departure and to systematically discuss areas around the Medium-Term Development Plan (MTDP) priorities, sector priorities, programmes, performance indicators, targets, performance achievements, deviations, challenges, and proposed interventions.

Groups began by reaffirming the Department's Vision and Mission to ensure shared understanding and alignment with the broader mandate of providing sustainable, people-centred health services that promote access, equity, efficiency and quality. Particular emphasis was placed on MTDP Priority 2, which focuses on reducing poverty and addressing the high cost of living, as well as on sector priorities related to universal health coverage, strengthening primary health care, improving quality of care, and optimising resource management.

Using the tool, each group analysed existing performance indicators. This analysis enabled groups to identify areas of underperformance, emerging risks, and systemic constraints impacting the achievement of departmental objectives.

Once performance gaps and deviations from targets were identified, groups documented the key challenges contributing to these outcomes. The structured nature of the template ensured that discussions moved beyond problem identification to a focused consideration of solutions.

Based on the challenges recorded, each group formulated targeted interventions and activities aimed at addressing root causes and improving future performance. These proposed interventions were then distilled into clear priorities to support achievement of departmental outcomes. The prioritisation process took into account strategic impact, feasibility, alignment with policy priorities, and the potential to improve service delivery and organisational performance.

The completed templates were used as a basis for plenary discussions, during which groups presented their findings and proposed priorities. This enabled consolidation of inputs and promoted a shared understanding of the Department's performance challenges and strategic focus areas.

6.2.9. Linking Planning to Budgeting

The Department has allocated MTEF budget in line with the MTDP priorities, which include the following:

Reduction in the Number of Preventable Maternal and Neonatal Deaths in Health Facilities

To advance its commitment to reducing preventable maternal and neonatal deaths, the Department of Health will prioritise a comprehensive strengthening of clinical quality and workforce capacity across district hospitals and Community Health Centres (CHCs). A province-wide skills audit and clinical quality assessment will be conducted to identify gaps in midwifery, obstetric emergency management, neonatal resuscitation, and adherence to maternity care protocols.

A structured 5-day integrated maternal and neonatal health training programme will be implemented in every sub-district, targeting midwives, advanced midwives, medical officers, and professional nurses, ensuring consistent and standardised clinical competence.

In partnership with universities, the Department will capacitate at least 30 clinicians through advanced obstetric and maternal health programmes. To relieve district hospitals of unnecessary pressure and bring safe delivery services closer to communities, the Department will strengthen low-risk delivery services at three pilot CHCs: Siphosensimbi, Embalenhle, and Nelspruit.

Reduction in the Number of Neonatal Deaths

Improving neonatal survival rates will be supported through strategic investment in essential clinical infrastructure and specialised human resources. The Department will procure critical medical equipment required to establish High Care Areas in 2 hospitals, enabling improved monitoring and management of high-risk newborns.

To reinforce specialist capacity, the Department will proceed with the appointment of four medical specialists dedicated to neonatal and maternal care. Furthermore, the procurement of 15 bakkies for DCST doctors will ensure consistent physical presence in facilities, enabling frequent clinical mentorship, onsite case reviews, and rapid response to emerging challenges in neonatal care.

All People Living with HIV Know Their Status

To increase HIV status awareness, the Department will implement community-centred and high-impact HIV testing strategies. This includes the establishment of three men's clinics across the districts—safe, male-friendly sites designed to increase testing uptake among men.

The Department will further implement the three-test HIV testing strategy, distribute HIV self-screening kits through partner organisations, and promote a combination prevention approach that includes PrEP, condoms, Lenacapavir, and medical circumcision.

95% of PLHIV Are on ARVs

To improve treatment initiation and retention, the Department will scale up the Universal Test and Treat approach, ensuring immediate initiation on ART for all who test positive. Implementation of the 3- and 6-month multi-month dispensing policy will be expanded to improve continuity of care and reduce facility congestion.

The Department will also continue rolling out the Close the Gap Campaign, which aims to identify patients not yet in care, bring them back into the treatment cascade, and improve long-term treatment adherence.

95% of PLHIV on ARVs Are Virally Suppressed

Achieving viral suppression will be driven by strengthened psychosocial support and clinical follow-up. The Department will implement Advanced Adherence Counselling without interruptions, ensuring patients struggling with treatment adherence receive targeted support.

In addition, facilities will continue applying the Results-for-Action policy, using real-time viral load data to trigger immediate follow-up and intervention for patients with elevated viral loads.

Increased Number of Facilities Achieving and Maintaining Ideal Clinic Status

To maintain momentum in improving primary healthcare quality, the Department will invest in the procurement of medical equipment and key material resources required for sustained Ideal Clinic Status across all PHC facilities.

These upgrades will ensure that infrastructure, equipment, and essential supplies remain at the required standards to deliver high-quality care.

Increased Number of Facilities Achieving and Maintaining Ideal Hospital Status

To support district hospitals in reaching and maintaining Ideal Hospital standards, the Department will procure the necessary medical equipment and maintenance resources. This strategic investment will enable hospitals to meet quality standards relating to infrastructure, safety, efficiency, and patient-centred care.

Increased Access to PHC Services Through Mobile Clinic Services

To expand PHC access in underserved and remote communities, the Department will procure and convert nine mobile clinics, distributed as follows: four for Ehlanzeni, three for Gert Sibande, and two for Nkangala. These mobile units will allow broader coverage, increase service availability, and reduce barriers to essential healthcare services.

Improved Performance on HIV, TB, MCWYH, NCDs and Ideal Clinic Subcomponent 53 through Community Health Worker Strengthening

The Department will enhance community-level health outcomes by strengthening the capacity of Community Health Workers (CHWs). A total of 3,000 CHWs will be trained on Foundation Phase competencies and health promotion practices.

To modernise data collection, 1,500 tablets will be contracted to digitize household screening data. Additionally, uniforms will be provided for 1,120 CHWs to address current shortages and support a professional community health workforce.

Reduction of Vaccine-Preventable Diseases

The Department will strengthen immunisation services by procuring nine mobile health service units, enhancing outreach capacity. Additionally, 50 vaccine fridges and related consumables will be purchased to maintain cold chain integrity, and growth-monitoring equipment and consumables will be procured to support comprehensive child health services.

Expansion of Specialised Tertiary Services

To widen access to specialised medical care, the Department will train 20 medical officers in partnership with academic institutions. This expanded registrar training programme will improve the province's capacity to deliver advanced and specialised healthcare services.

New PHC Facilities Operationalised

To improve PHC access, the Department will operationalise several new clinics by providing essential equipment and furniture. Facilities include Ethandukukhanya, Barberton, Lefisoane, Kinross, Lebohang, Dumphries, Alexandra, Langkloof, Vezokuhle, and Troya. These facilities will expand the geographic availability of primary healthcare services and strengthen community-level access.

New Hospital Facility Operationalised

To improve access to high-quality specialised services, the Department will operationalise King Nyabela Hospital, ensuring the delivery of necessary equipment and furniture to support full clinical functionality.

Strengthened Community Mental Health Services

To expand mental health access, the Department will establish and operationalise community mental health programmes. The mental health workforce will be strengthened through the appointment of 20 registered counsellors. To support diagnostic and therapeutic services, 23 assessment tools will also be procured

6.3. MTEF Priorities

National Statement of Intent: Investing in people through education, skills development, and affordable healthcare
***MTDP Strategic Priority 2*:** Reduce poverty and tackle the high cost of living
Outcome: Develop and empower South Africans
Sector Outcome: Improved access to affordable and quality healthcare

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

    - Ideal Clinic Status Realisation
      The Department will conduct ideal clinic assessments, undertake clinical audits, and implement Quality Improvement Plans (QIPs), guidelines, and policies to ensure all PHC facilities meet Ideal Clinic standards.

    - Ideal health facility realisation and maintenance (Ideal Hospital)
      To achieve Ideal Hospital status, the Department will ensure a reliable supply chain for non-negotiable items (NNVs) and medical equipment, enabling consistent service delivery.

    - Improved access to equitable healthcare services
      The Department will procure all required linen and patient clothing to strengthen facility operations and ensure patient dignity across districts.

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.

    - Decrease Neonatal Mortality
      In an effort to reduce neonatal mortality, neonates will be relocated from the Paediatric Ward to the Postnatal Ward at Standerton Hospital to improve the quality and suitability of neonatal care.

    - Improved access to integrated school health services
      The Department will appoint 25 school health nurses to strengthen comprehensive learner screening services for Grade R and Grade 8 learners across all districts.

    - Reduction in health care risk waste costs
      Two Assistant Directors will be appointed within Environmental Health Services to monitor and improve the performance of healthcare risk waste service providers.

    - Increased access to PHC services through mobile clinic services
      To expand PHC access in underserved and remote communities, the department will procure and convert nine mobile clinics

    - Strengthened Community Mental Health Services

The mental health workforce will be strengthened through the appointment of 20 registered counsellors. To support diagnostic and therapeutic services, 23 assessment tools will also be procured.

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

   - Improve maternal and child health and reduce NCD-related mortality
     To operationalise new critical care beds at Mapulaneng Hospital, a full complement of specialised staff, including professional nurses, enrolled nurses, and nursing assistants, will be appointed.

   - Entrench ethical behaviour in the Department
     To strengthen ethical behaviour, the Department will procure National School of Government induction manuals to support compulsory induction for 80 employees.

   - Improvement of nursing specialist skills
     The Department will identify specialist clinical training courses and facilitate the attendance of 30 nurses in areas such as advanced midwifery, theatre care, orthopaedics, and paediatrics.

   - Training of EMS healthcare workers
     Advanced emergency care capacity will be enhanced through the identification and appointment of training providers, securing training venues, and procuring accommodation for EMS staff undergoing ACLS/ATLS training.

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

   - Improve representation of persons with disabilities (PWDs)
     To advance inclusivity within the Department, 102 persons with disabilities will be appointed across all operational levels, ensuring improved representation and alignment with transformation priorities.

   - Revenue collection improved
     The Department will enhance workforce capacity and improve administrative efficiency through the appointment of graduates into entry-level posts across all districts.

   - Improved planning and policy processes
     To strengthen strategic planning and policy coordination, two Assistant Director posts within the Strategic Planning Unit will be filled, supporting improved alignment between planning, budgeting, and reporting

   - Improve medicine availability by addressing infrastructure requirements
     A canopy will be installed at the main entrance of the Nkangala pharmaceutical depot to improve logistical management during loading and offloading.

   - Financial management strengthened in the health sector
     A Supply Chain Management procurement system which integrates audit and risk modules will be procured.

- Increased access to PHC services
  Three new clinics will be constructed: Molapomogale clinic, Nhlazatshe 3 clinic, and Madyembi clinic.

PART C: MEASURING OUR PERFORMANCE

7. MEASURING OUR PERFORMANCE

7.1. Programme 1: Administration

Programme Purpose 1.

To conduct the strategic management and overall administration of the Department of Health.

Sub-Programme 1.1: MECs Office

Rendering of advisory, secretarial and office support services.

This sub programme renders a: secretarial support, administrative, public relations/communication; and parliamentary support.

Sub-Programme 1.2: Management

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

Programme 1: Administration

Outputs, Outcomes, Performance Indicators and Targets

Outcome	Outputs	Output Indicator	Audited Performance			Estimated Performance	MTEF Targets		
			2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29
Financial management strengthened in the health sector	Implement controls and mitigate risks	Audit opinion of Provincial DoH	Unqualified	Unqualified	Unqualified	Unqualified	Unqualified	Unqualified	Unqualified
Employment in line with equity targets	Achieve gender equity targets	Percentage of women appointed in Senior Management positions	44%	40%	48.2%	51.6%	50%	50%	50%
		Numerator	-	-	-	33	32	32	32
		Denominator	-	-	-	64	64	64	64
Employment in line with equity targets	Improve representation of persons with disability	Percentage of persons with disabilities appointed across all levels	0.54%	0.53%	0.93%	0.6%	0.8%	1%	1.5%
		Numerator	-	-	-	146	198	223	365
		Denominator	-	-	-	23 918	24 337	24 362	24 362
Employment in line with equity targets	Reduce youth unemployment	Percentage of youth appointed	37.06%	38.84%	34.3%	20.8%	23%	26%	28%
		Numerator	-	-	-	4 976	5 598	6 334	6 821
		Denominator	-	-	-	23 918	24 337	24 362	24 362

Table 6: Programme 1 Administration - Outputs, Outcomes, Performance Indicators and Targets

Programme 1: Administration

Output Indicators – Annual and Quarterly Targets

Output Indicators	Annual Targets	Q1	Q2	Q3	Q4
Audit opinion of Provincial DoH	Unqualified	-	-	-	Unqualified
Percentage of women appointed in Senior Management positions	50%	50%	51%	50%	50%
Numerator	32	31	32	32	32
Denominator	64	62	63	64	64
Percentage of persons with disabilities appointed across all levels	0.8%	0.6%	0.6%	0.8%	0.8%
Numerator	198	146	146	198	198
Denominator	24 337	23 918	23 918	24 337	24 337
Percentage of youth appointed	23%	20%	20%	22%	23%
Numerator	5 598	4 784	4 940	5 340	5 598
Denominator	24 337	23 918	23 918	24 337	24 337

Table 7: Programme 1 – Outputs indicator Annual and Quarterly Targets

Explanation of planned performance over the medium-term period

The planned performance over time reflects a consistent effort to strengthen governance, equity, and workforce transformation within the health sector. Audit outcomes show strong stability, with Provincial Departments of Health maintaining unqualified audit opinions across all years, indicating sustained compliance and effective control measures. Gender equity targets display a gradual improvement, with women in senior management projected to increase from 48.2% in 2024/25 to a stable 50% in the Medium-Term Expenditure Framework (MTEF) period, supporting broader sector priorities of workforce diversity and gender representation.

Similarly, representation of persons with disabilities is planned to rise significantly from 0.93% in 2024/25 to 2% by 2028/29 aligning with commitments to inclusive employment practices and equity targets highlighted in the departmental strategic priorities. Youth employment shows a downward adjustment from previously higher levels, stabilizing from 20% in 2025/26 to 28% by 2028/29, reflecting a more realistic, targeted approach to addressing youth unemployment within public health staffing.

Overall, the performance trajectory demonstrates progressive improvement in equity, accountability, and institutional capacity, aligning closely with the broader healthcare strengthening pillars outlined in the provincial strategic plans.

Programme resource considerations

R thousand	Outcome 2022/23	2023/24	2024/25	Main appropriation	Adjusted appropriation 2025/26	Revised estimate	Medium-term estimates 2026/27	2027/28	2028/29
1. Office of the MEC	15,810	13,638	18,574	16,135	16,135	16,135	16,646	17,235	17,769
2. Management	317,068	325,079	365,611	404,956	437,643	437,643	419,682	433,195	446,727
Total payments and estimates: Programme 1	**332,878**	**338,717**	**384,185**	**421,091**	**453,778**	**453,778**	**436,328**	**450,430**	**464,496**

Payments and estimates by economic classification.

R thousand	Outcome 2022/23	2023/24	2024/25	Main appropriation	Adjusted appropriation 2025/26	Revised estimate	Medium-term estimates 2026/27	2027/28	2028/29
Current payments	**325,800**	**335,345**	**374,496**	**415,557**	**447,859**	**446,881**	**434,873**	**448,929**	**462,947**
Compensation of employees	159,546	169,126	178,234	206,474	206,474	205,496	230,758	240,997	248,701
Goods and services	166,254	166,138	196,261	209,083	241,385	241,339	204,115	207,932	214,246
Interest and rent on land	–	81	1	–	–	46	–	–	–
Transfers and subsidies	**7,058**	**1,565**	**2,992**	**1,262**	**1,262**	**2,240**	**1,320**	**1,379**	**1,422**
Provinces and municipalities	1,091	1,135	1,207	1,262	1,262	914	1,320	1,379	1,422
Departmental agencies and accounts	–	–	–	–	–	–	–	–	–
Higher education institutions	–	–	–	–	–	–	–	–	–
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–
Public corporations and private enterprises	–	–	–	–	–	–	–	–	–
Non-profit institutions	–	–	–	–	–	–	–	–	–
Households	5,967	430	1,785	–	–	1,326	–	–	–
Payments for capital assets	**20**	**1,807**	**6,697**	**4,272**	**4,657**	**4,657**	**135**	**122**	**127**
Buildings and other fixed structures	–	–	–	–	–	–	–	–	–
Machinery and equipment	20	1,807	6,697	4,272	4,657	4,657	135	122	127
Heritage assets	–	–	–	–	–	–	–	–	–
Specialised military assets	–	–	–	–	–	–	–	–	–
Biological assets	–	–	–	–	–	–	–	–	–
Land and sub-soil assets	–	–	–	–	–	–	–	–	–
Software and other intangible assets	–	–	–	–	–	–	–	–	–
Payments for financial assets	–	–	–	–	–	–	–	–	–
Total economic classification: Programme 1	**332,878**	**338,717**	**384,185**	**421,091**	**453,778**	**453,778**	**436,328**	**450,430**	**464,496**

Transfers and subsidies

R thousand	Outcome 2022/23	2023/24	2024/25	Main appropriation	Adjusted appropriation 2025/26	Revised estimate	Medium-term estimates 2026/27	2027/28	2028/29
Current payments	**325,800**	**335,345**	**374,496**	**415,557**	**447,859**	**446,881**	**434,873**	**448,929**	**462,947**
Compensation of employees	159,546	169,126	178,234	206,474	206,474	205,496	230,758	240,997	248,701
Salaries and wages	136,502	145,463	152,887	178,966	178,966	177,988	199,895	208,766	215,437
Social contributions	23,044	23,663	25,347	27,508	27,508	27,508	30,863	32,231	33,264
Goods and services	166,254	166,138	196,261	209,083	241,385	241,339	204,115	207,932	214,246
Administrative fees	599	502	1,045	1,512	1,428	1,429	1,582	1,653	1,704
Advertising	1,331	2,966	3,480	3,447	1,447	1,447	3,379	3,308	3,411
Minor assets	–	–	181	–	–	–	–	–	–
Audit costs: External	26,011	23,491	26,126	25,241	25,241	25,241	25,241	25,241	26,023
Catering: Departmental activities	537	581	1,573	605	1,193	1,193	605	605	623
Communication (G&S)	7,090	10,787	6,447	6,776	8,322	10,001	7,088	7,407	7,637
Computer services	40,843	35,733	32,698	53,893	82,413	58,429	49,172	51,450	52,940
Consultants: Business and advisory services	4,386	2,706	9,366	11,923	12,157	12,157	12,103	12,291	12,672
Legal services (G&S)	55,810	50,415	66,273	61,115	61,109	66,320	61,115	61,115	63,010
Contractors	–	443	2,054	1,777	1,777	13,916	1,859	1,943	2,003
Agency and support/outsourced services	592	662	322	658	500	661	688	719	741
Fleet services (incl. government motor transport)	(2,556)	3,041	7,530	5,352	5,352	10,098	5,598	5,850	6,031
Inventory: Food and food supplies	73	–	–	95	134	135	99	103	106
Consumable supplies	570	596	1,278	2,844	2,674	2,674	1,131	1,157	1,166
Consumables: Stationery, printing and office supplies	1,203	1,458	1,916	1,051	1,087	1,087	1,051	1,051	1,084
Operating leases	2,341	2,711	2,039	2,098	2,098	2,098	2,195	2,294	2,365
Rental and hiring	190	253	3,250	439	439	439	439	439	453
Property payments	8,252	7,056	4,781	10,948	7,409	7,409	11,440	11,955	12,326
Transport provided: Departmental activity	–	–	14	–	–	–	–	–	–
Travel and subsistence	18,680	21,851	23,367	18,852	24,177	24,177	18,852	18,852	19,437
Training and development	24	16	–	–	110	110	–	–	–
Operating payments	132	403	126	161	252	252	168	175	180
Venues and facilities	146	467	2,395	296	2,066	2,066	310	324	334
Interest and rent on land	–	81	1	–	–	46	–	–	–
Interest (Incl. interest on unitary payments (PPP))	–	81	1	–	–	46	–	–	–
Transfers and subsidies	**7,058**	**1,565**	**2,992**	**1,262**	**1,262**	**2,240**	**1,320**	**1,379**	**1,422**
Provinces and municipalities	1,091	1,135	1,207	1,262	1,262	914	1,320	1,379	1,422
Provinces	1,091	1,135	1,207	1,262	1,262	914	1,320	1,379	1,422
Provincial agencies and funds	1,091	1,135	1,207	1,262	1,262	914	1,320	1,379	1,422
Households	5,967	430	1,785	–	–	1,326	–	–	–
Social benefits	1,937	430	1,785	–	–	188	–	–	–
Other transfers to households	4,030	–	–	–	–	1,138	–	–	–
Payments for capital assets	**20**	**1,807**	**6,697**	**4,272**	**4,657**	**4,657**	**135**	**122**	**127**
Machinery and equipment	20	1,807	6,697	4,272	4,657	4,657	135	122	127
Transport equipment	–	786	–	–	–	800	–	–	–
Other machinery and equipment	20	1,021	6,697	4,272	4,657	3,857	135	122	127
Payments for financial assets	–	–	–	–	–	–	–	–	–
Total economic classification: Programme 1	**332,878**	**338,717**	**384,185**	**421,091**	**453,778**	**453,778**	**436,328**	**450,430**	**464,496**

7.2. Programme 2: District Health Services

Purpose:

To render comprehensive Primary Health Care Services to the community using District Health System as a model.

Sub-programme 2.1. District Management

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

Sub-programme 2.2. Community health clinics

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

Sub-programme 2.3. Community health centres

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

Sub-programme 2.4. Community based services

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

Sub-programme 2.5. Other community services

Rendering environmental, port health and part-time district surgeon services, etc.

Sub-programme 2.6. HIV/Aids

Rendering a primary health care service in respect of HIV/Aids campaigns and Special Projects.

Sub-programme 2.7. Nutrition

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

Sub-programme 2.8. Coroner services

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

Sub-programme 2.9 District hospitals

Rendering of hospital service at district level.

Programme 2: District Health Services

Outputs, Outcomes, Performance Indicators and Targets

Outcome	Outputs	Output Indicator	Audited Performance			Estimated Performance	MTEF Targets		
			2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29
Improved access to safe and quality healthcare	Patient experience of care improved	Patient Experience of Care Survey Rate (PHC)	Not Required to Report	Not Required to Report	Not Required to Report	99.3%	100%	100%	100%
		Numerator	-	-	-	287	289	289	293
		Denominator	-	-	-	289	289	289	293
		Patient Experience of Care Survey Rate (District Hospitals)	Not Required to Report	Not Required to Report	Not Required to Report	100%	100%	100%	100%
		Numerator	-	-	-	23	23	23	23
		Denominator	-	-	-	23	23	23	23

Table 8: Programme 2 – District Health Services Outputs, Outcomes, Performance Indicators and Targets

Programme 2: District Health Services

Output Indicators – Annual and Quarterly Targets

Output Indicators	Annual Targets	Q1	Q2	Q3	Q4
Patient Experience of Care Survey Rate (PHC)	100%	-	100%	-	-
Numerator	289	-	289	-	-
Denominator	289	-	289	-	-
Patient Experience of Care Survey Rate (District Hospitals)	100%	-	100%	-	-
Numerator	23	-	23	-	-
Denominator	23	-	23	-	-

Explanation of planned performance over the medium-term period

The performance presented shows strong alignment with the MDTP priority of improving access to affordable and quality healthcare. The Patient Experience of Care Survey Rate directly supports the MDTP objective of improving service quality and ensuring that healthcare users receive dignified, reliable, and patient-centered care. These results reinforce the MDTP's emphasis on facility compliance, improved patient satisfaction, and strengthened quality assurance systems as essential components of a responsive health system.

The growth in positive patient experience further contributes to the MDTP's broader goals of increasing community trust, improving health-seeking behavior, and supporting the shift toward strengthened primary healthcare. By targeting near-universal satisfaction rates, facilities demonstrate readiness to meet MDTP ambitions related to ideal clinic status, improved service standards, and expanded NHI implementation. These outcomes reflect meaningful progress in enhancing user experience, a critical enabler for improving coverage of priority health services such as immunization, maternal health, HIV care, and chronic disease management outlined within the MDTP.

Overall, the planned performance contributes significantly to the MDTP's five-year vision of a high-quality, patient-centred provincial health system.

Programme 2: District Health Services (TB)

Outputs, Outcomes, Performance Indicators and Targets

Outcome	Outputs	Output Indicator	Audited Performance			Estimated Performance	MTEF Targets		
			2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29
TB Mortality reduced	Eligible people started on TB treatment	Number of DS-TB treatment start under 5 years	359	297	298	300	350	350	350
		Numerator	-	-	-	300	350	350	350
		Number of DS-TB treatment start 5 years and older	8 816	9 331	9 226	9 200	9500	9500	9 500
		Numerator	-	-	-	9 200	9500	9500	9 500
		Number of TB Rifampicin resistant/Multidrug-Resistant confirmed client start on treatment	361	401	310	300	300	300	300
		Numerator	-	-	-	300	300	300	300
	Improve TB treatment success	TB - Rifampicin resistant/Multidrug-Resistant Treatment Success Rate	74.7%	73.3%	76.6%	65.6%	73%	75%	76%
		Numerator	-	-	-	181	202	207	210
		Denominator	-	-	-	276	276	276	276
		All DS-TB Client Treatment Success Rate	74.5%	75%	77%	78%	80%	82%	85%
		Numerator	-	-	-	8620	8800	9050	9400
		Denominator	-	-	-	11051	11000	11000	11000
	Reduce loss to follow-up cases	All DS-TB client lost to follow-up rate	5.8%	6.1%	5.7%	5.9%	<6%	5.5%	<5%
		Numerator	-	-	-	652	605	605	440
		Denominator	-	-	-	11051	11000	11000	11000
		Rifampicin resistant/Multidrug Resistant lost to follow-up rate	7.9%	8.8%	10.9%	<10%	<10%	<10%	<10%

Outcome	Outputs	Output Indicator	Audited Performance			Estimated Performance	MTEF Targets		
			2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29
		Numerator	-	-	-	26	24	26	26
		Denominator	-	-	-	276	276	276	276
	People with TB identified	Number of people tested using TB-NAAT	New indicator	New indicator	New indicator	390 329	389 317	389 307	389 307
		Numerator	-	-	-	390 329	389 317	389 307	389 307

Table 9:District Health Services Outputs, Outcomes, Performance Indicators and Targets TB)

Programme 2: District Health Services (TB)

Output Indicators – Annual and Quarterly Targets

Output Indicators	Annual Targets	Q1	Q2	Q3	Q4
Number of DS-TB treatment start under 5 years	350	87	174	262	350
Numerator	350	87	174	262	350
Number of DS-TB treatment start 5 years and older	9500	2375	4 750	7 125	9 500
Numerator	9500	2375	4 750	7 125	9 500
Number of TB Rifampicin resistant/Multidrug-Resistant confirmed client start on treatment	300	85	160	230	300
Numerator	300	85	160	230	300
TB - Rifampicin resistant/Multidrug-Resistant Treatment Success Rate	73%	73%	73%	73%	73%
Numerator	202	51	102	152	202
Denominator	276	69	138	207	276
All DS-TB Client Treatment Success Rate	80%	80%	80%	80%	80%
Numerator	8800	2200	4400	6600	8800
Denominator	11000	2750	5500	8250	11000
All DS-TB clients lost to follow-up rate	<6%	<6%	<6%	<6%	<6%
Numerator	605	151	302	453	605
Denominator	11000	2750	5500	8250	1100
Rifampicin resistant/Multidrug Resistant lost to follow-up rate	<10%	<10%	<10%	<10%	<10%
Numerator	24	6	12	18	24
Denominator	276	69	138	207	276
Number of people tested using TB-NAAT	389 317	97329	194658	291 987	389317
Numerator	389 317	97329	194658	291 987	389317

Table 10: Programme 2 District Health Services – Output Indicators – Annual and Quarterly Targets (TB)

Explanation of planned performance over the medium-term period

The performance presented demonstrates substantial progress toward the MDTP's strategic priority of improving access to affordable and quality healthcare. The steady increase in treatment initiation for both drug-susceptible TB in children under five and individuals over five supports the MDTP's focus on strengthening responses to communicable diseases and ensuring early detection and treatment. This aligns with the priority programmes aimed at reducing disease burden and improving life expectancy.

Improved TB treatment success directly advances MDTP goals of enhancing service quality and ensuring better patient outcomes. These trends reflect strengthened adherence support, better clinical management, and more reliable access to treatment, key interventions highlighted in the MDTP's approach to reducing preventable deaths and improving care continuity.

Furthermore, the reduction of loss-to-follow-up rates supports the MDTP emphasis on retention in care across all major health programmes, ensuring patients remain linked to services throughout treatment. Combined with the introduction of NAAT testing, these achievements build a stronger primary healthcare platform capable of delivering on the MDTP's long-term vision for a resilient, patient-centered health system.

Programme 2: District Health Services (HAS)

Output Indicators – Annual and Quarterly Targets

Outcome	Outputs	Output Indicator	Audited Performance			Estimated Performance	MTEF Targets		
			2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29
Improved Maternal and child health	Mother-to-child transmission eliminated	Infant PCR test around 6 months uptake rate	Not required to report on	Not required to report on	Not required to report on	36%	40%	44%	50%
		Numerator	-	-	-	1 135	1 389	1 590	1 971
		Denominator	-	-	-	3 152	3 472	3 613	3 942
HIV and AIDS related deaths reduced	Children tested for HIV	HIV positive 5-14 years (excl ANC) rate	New indicator	New indicator	0,43	1%	1%	1%	1%
		Numerator	-	-	-	333	338	343	358
		Denominator	-	-	-	33 362	33 831	34 329	35 758
	Adolescent and Youth tested for HIV	HIV positive 15-24 years (excl ANC) rate	1.4%	1.1%	0,98	1%	1%	1%	1%
		Numerator	-	-	-	2 734	2 812	2 913	2 071
		Denominator	-	-	-	273 432	281 274	291 324	207 111
	Adult living with HIV remain in care	ART adult remain in care rate [12 months)	71.9%	71.7%	72%	76.3%	80%	85%	90%
		Numerator	-	-	-	16 195	13 859	13 287	13 433
		Denominator	-	-	-	21 226	17 324	15 632	14 926
	Children living with HIV remain in care	ART child remain in care rate [12 months]	76,7%	78.2%	78%	70.9%	75%	80%	90%
		Numerator	-	-	-	357	248	239	274
		Denominator	-	-	-	504	331	299	289
	Viral load suppressed to 95% of clients on ART	ART Adult viral load suppressed rate (below 50) [12 months]	69.4%	74.2%	92%	79.0%	85%	90%	95%

Outcome	Outputs	Output Indicator	Audited Performance			Estimated Performance	MTEF Targets		
			2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29
		Numerator	-	-	-	10 262	15 635	14 108	13 471
		Denominator	-	-	-	12 980	16 458	14 850	14 180
		ART child viral load suppressed rate (below 50) [12 months]	33.8%	39.5	66%	51.6%	60%	65%	70%
		Numerator	-	-	-	176	188	185	193
		Denominator	-	-	-	341	314	284	275

Figure: Programme 2 District Health Services – Output Indicators – Annual and Quarterly Targets (HAS)

Programme 2: District Health Services (HAS)

Output Indicators – Annual and Quarterly Targets

Output Indicators	Annual Targets	Q1	Q2	Q3	Q4
Infant PCR test around 6 months uptake rate	40%	40%	40%	40%	40%
Numerator	1 389	347	694	1041	1389
Denominator	3 472	868	1736	2604	3472
HIV positive 5-14 years (excl ANC) rate	1%	1%	1%	1%	1%
Numerator	338	84	168	253	338
Denominator	33 831	8 458	16915	25373	33831
HIV positive 15-24 years (excl ANC) rate	1%	1%	1%	1%	1%
Numerator	2 812	703	1406	2109	2812
Denominator	281 274	70 318	140636	210955	281274
ART adult remain in care rate [12 months]	80%	80%	80%	80%	80%
Numerator	13 859	3 465	6929	10394	13859
Denominator	17 324	4 331	8662	12993	17324
ART child remain in care rate [12 months]	75%	75%	75%	75%	75%
Numerator	248	62	124	186	248
Denominator	331	83	166	249	331
ART Adult viral load suppressed rate (below 50) [12 months]	85%	85%	85%	85%	85%
Numerator	13989	3 497	6994	10491	13989
Denominator	16 458	4 114	8228	12343	16458
ART child viral load suppressed rate (below 50) [12 months]	60%	60%	60%	60%	60%
Numerator	188	47	94	141	188
Denominator	314	78	156	235	314

Figure: Programme 2 District Health Services – Output Indicators – Annual and Quarterly Targets (HAS)

Explanation of planned performance over the medium-term period

The performance reflected demonstrates significant contributions to MDTP's priority of improving access to affordable and quality healthcare. The gradual increase in infant PCR testing uptake strengthens the MDTP's focus on reducing mother-to-child transmission and improving early HIV detection. These efforts support priority interventions aimed at increasing life expectancy and addressing communicable diseases.

Furthermore, improved retention in care among adults receiving ART aligns directly with the MDTP emphasis on strengthening linkage, adherence, and continuity of care. This is reinforced by gains in viral load suppression for adults, showing progress toward the MDTP's goal of meeting the 95-95-95 targets through enhanced treatment outcomes and service quality.

The planned performance also highlights incremental improvements in HIV positivity rates among adolescents and young adults, reflecting preventive efforts consistent with MDTP strategies to mobilize communities and promote early health-seeking behaviors. Overall, the performance targets illustrate meaningful work towards system-wide progress toward MDTP's five-year priorities of reducing HIV-related mortality, improving care outcomes, and ensuring equitable access to essential services

Programme 2: District Health Services (MCWH&N)

Outputs, Outcomes, Performance Indicators and Targets

Outcome	Outputs	Output Indicator	Audited Performance			Estimated Performance	MTEF Targets		
			2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29
Improved maternal and child health	Reduction in Maternal Mortality	Maternal Mortality in facility Ratio	114/100000 live births	109.5/100000 live births	111.8/100000 live births	124.64/100000 live births	120/100000 live births	110/100000 live births	100/100000 live births
		Numerator	-	-	-	78	86	80	74
		Denominator	-	-	-	62 582	71 500	73 250	74 500
Improved maternal and child health	Neonatal death in facility reduced	Neonatal death in facility rate	18.06 /1000 live births	13.5/1000 live births	14.1/1000 live births	13/1000 live births	12.5 /1000 live births	12/1000 live births	12/1000 live births
		Numerator	-	-	-	769	861	821	800
		Denominator	-	-	-	60 505	68 835	68 085	67 635
	Under 5 mortality reduced	Death under 5 years against live birth rate	5.3%	5.1%	1.9/1000 live birth	1.8/1000 live birth	1.7/1000 live birth	1.6/1000 live birth	1.5/1000 live birth
		Numerator	-	-	-	1 089	1 170	11 089	1 015
		Denominator	-	-	-	60 505	68 835	68 085	67 635
		Child under 5 years severe acute malnutrition case fatality rate	5.0%	5.0%	6.4%	8%	7.5%	7%	6.5%
		Numerator	-	-	-	31	30	27	24
		Denominator	-	-	-	382	395	391	373
	Reduction in Maternal Mortality	Couple Year Protection Rate	48.3%	59.4%	Not required to report in the APP	60.8%	61%	62%	63%
		Numerator	-	-	-	75 307	99 363	82 392	58 521
		Denominator	-	-	-	123 890	16 2890	132 890	92 890

Outcome	Outputs	Output Indicator	Audited Performance			Estimated Performance	MTEF Targets		
			2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29
Improve maternal and child health	Reduction in Maternal Mortality	Antenatal 1st visit before 20 weeks rate	77%	74.9%	77.8%	78%	78%	79%	80%
		Numerator	-	-	-	66 376	68 771	71 045	73 383
		Denominator	-	-	-	85 097	88 168	89 931	91 729
	Reduction in Maternal Mortality	Mother postnatal visit within 6 days rate	76.20%	76.1%	84.6%	84%	86%	87%	88%
		Numerator	-	-	-	71 287	88 006	88 375	88 299
		Denominator	-	-	-	85 256	102 368	101 528	100 694
	Grade R learners screened	Number of Grade R learners screened	New indicator	New indicator	New indicator	20 000	31 770	41 770	51 770
		Numerator	-	-	-	20 000	31 770	41 770	51 770
	children fully immunised	Immunisation under 1-year coverage	89.1%	88.2%	85.3%	79%	87%	89%	90%
		Numerator	-	-	-	77 998	85 890	88 265	89 186
		Denominator	-	-	-	99 109	98 666	98 666	98 665
		MR 2nd dose 1 year coverage	97.5%	90.5%	86%	74.4%	87%	88%	89%
		Numerator	-	-	-	73 737	85 839	86 828	87 812
		Denominator	-	-	-	99 109	98 666	98 666	98 665
Mortality due to Cervical	Early identification	Cervical cancer	New Indicator	New indicator	50.2%	44.65%	43.56%	43.73%	44.23%

Outcome	Outputs	Output Indicator	Audited Performance			Estimated Performance	MTEF Targets		
			2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29
Cancer Reduced	of women at risk of developing cancer of the cervix	screening coverage							
		Numerator	-	-	-	73 703	76 034	77 939	80 295
		Denominator	-	-	-	165 056	174 567	178 236	181 520

Table 11: Programme 2 District Health Services – Outputs, Outcomes, Performance Indicators and Targets (MCWH&N)

Programme 2: District Health Services (MCWH&N)

Output Indicators – Annual and Quarterly Targets

Output Indicators	Annual Targets	Q1	Q2	Q3	Q4
Maternal Mortality in facility Ratio	120/100000 live birth	128.7/100000 live birth	120.3/100000 live birth	117.5/100000 live birth	120/100000 live birth
Numerator	86	23	43	63	86
Denominator	71 500	17 875	35 750	53 625	71 500
Neonatal death in facility rate	12.5/1000 live birth	12.5/1000 live birth	12.5/1000 live birth	12.5/1000 live birth	12,5/1000 live birth
Numerator	861	215	430	645	861
Denominator	68 835	17 209	34 417	51 625	68 834
Death under 5 years against live birth rate	1.7%	1.7%	1.7%	1.7%	1.7%
Numerator	1170	292	585	878	1170
Denominator	68 835	17 209	34 417	51 262	66 835
Child under 5 years severe acute malnutrition case fatality rate	7.5%	7.14%	7.10%	7.43%	7.5%
Numerator	30	7	14	22	30
Denominator	395	98	197	296	395
Couple Year Protection Rate	61%	61%	61%	61%	61%
Numerator	99 363	24 840	24 841	24 841	24 841
Denominator	162 890	40 722	40 722	40 723	40 723
Antenatal 1st visits before 20 weeks rate	78%	78%	78%	78%	78%
Numerator	68 771	17 192	34 385	51 578	68 771
Denominator	88 168	22 042	44 048	66 126	88 168
Mother postnatal visit within 6 days rate	86%	86%	86%	86%	86%
Numerator	88 006	22 001	44 002	66 004	88 006
Denominator	102 368	25 592	51 184	76 776	102 363
Number of Grade R learners screened	31 770	7 942	7 943	7 943	7 942
Numerator	31 770	7 942	7 943	7 943	7 942
Immunization under 1-year coverage	87%	87%	87%	87%	87%
Numerator	85 890	21 472	21 472	21 473	21 473
Denominator	98 666	24 666	24 666	24 667	24 667
MR 2nd dose 1-year coverage	87%	87%	87%	87%	87%

Output Indicators	Annual Targets	Q1	Q2	Q3	Q4
Numerator	85 839	21 459	21 460	21 460	21 460
Denominator	98 666	24 666	24 666	24 667	24 667
Cervical cancer screening coverage	43.56%	43.56%	43.56%	43.56%	43.56%
Numerator	76 034	19 008	19 008	19 009	19 009
Denominator	174 567	43 641	43 642	43 642	43 642

Table 12: Programme 2 District Health Services – Output Indicators – Annual and Quarterly Targets (MCWH&N)

Explanation of planned performance over the medium-term period

The targets here directly contribute to strengthening and operationalizing the priorities outlined in the MTDP and province's healthcare goals. The MTDP emphasizes improving access to affordable and quality healthcare, with specific focus on reducing maternal and neonatal mortality, increasing immunization coverage, and enhancing antenatal and postnatal care services.

The sub-programme contributes to these priorities by targeting multi-year progress towards the desired outcomes. This includes lowering maternal mortality ratios, supporting the MTDP's aim to lower maternal deaths through strengthened antenatal care and earlier ANC bookings. Similarly, neonatal mortality trends and improved postnatal visit rates align with efforts to reduce neonatal deaths and enhance early child health.

In addition, immunization coverage, measles prevention, and cervical cancer screening form part of the performance markers for the sub-programme, reinforcing the MTDP's initiatives to reduce the disease burden through expansion of preventative services. The sub-programme thus presents a cohesive framework linking strategic priorities with measurable health system performance.

Programme 2: District Health Services (Disease Prevention and Control)

Outputs, Outcomes, Performance Indicators and Targets

Outcome	Outputs	Output Indicator	Audited Performance			Estimated Performance	MTEF Targets		
			2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29
Malaria related deaths reduced	Prevention, early detection of malaria cases	Malaria case fatality rate	0.5%	0.77%	0.28%	<0,5%	<0,5%	<0,5%	<0,5%
		Numerator	-	-	-	2	1	1	1
		Denominator	-	-	-	1 000	910	900	800
Mental healthcare integrated in primary health care	Prevention and early detection of mental health conditions	PHC Mental Health Conditions Treatment rate new	New Indicator	New Indicator	0%	0.03%	0.04%	0.05%	0.05%
		Numerator	-	-	-	1 718	3 212	4 015	4 015
		Denominator	-	-	-	5 727 463	8 029 064	8 029 064	8 029 064

Table 13:Programme 2 District Health Services – Outputs, Outcomes, Performance Indicators and Targets (Disease Prevention and Control)

Programme 2: District Health Services (Disease Prevention and Control)

Output Indicators – Annual and Quarterly Targets

Output Indicators	Annual Targets	Q1	Q2	Q3	Q4
Malaria case fatality rate	<0,5%	-	-	-	<0,5%
Numerator	1	-	-	-	1
Denominator	910	-	-	-	910
PHC Mental Health Conditions Treatment rate new	0.04%	0.04%	0.04%	0.04%	0.04%
Numerator	3 212	803	1 606	2 409	3 212
Denominator	8 029 064	2 007 266	4 014 532	6 021 798	8 029 064

Table 14: Programme 2 District Health Services – Output Indicators – Annual and Quarterly Targets (Disease Prevention and Control)

Explanation of planned performance over the medium-term period

The performance highlighted demonstrates meaningful progress toward the strategic priorities outlined in the MDTP. The continued reduction of the malaria case fatality rate directly supports the MDTP priority of improving access to affordable and quality healthcare by strengthening communicable disease control and reducing preventable mortality. This aligns with interventions focused on community-level prevention, early diagnosis, and improved treatment pathways identified in the MDTP.

Similarly, the integration of mental healthcare into primary health services advances the MDTP objective of expanding primary healthcare capacity and ensuring more equitable access to essential services. As mental health conditions increasingly burden communities, PHC-level mental health treatments reflect strengthened service readiness and supports MDTP goals related to service expansion, quality improvement, and better patient outcomes.

Overall, the performance trends demonstrate a strategic shift toward a more resilient, prevention-oriented, community-centred health system that is well aligned with the province's medium-term transformation agenda.

Programme resource considerations.

R thousand	Outcome 2022/23	2023/24	2024/25	Main appropriation	Adjusted appropriation 2025/26	Revised estimate	Medium-term estimates 2026/27	2027/28	2028/29
1. District Management	837,813	647,449	616,959	632,036	627,604	628,117	647,991	676,027	696,856
2. Community Health Clinics	1,776,742	1,929,222	2,070,419	2,066,053	2,127,197	2,127,234	2,183,714	2,280,498	2,350,889
3. Community Health Centres	1,122,804	1,198,724	1,350,819	1,478,521	1,519,813	1,519,866	1,599,687	1,670,637	1,723,305
4. Community-based Services	16,933	20,085	20,077	10,044	149,331	201,218	17,472	10,918	11,256
5. Other Community Services	–	–	–	–	–	–	–	–	–
6. HIV/Aids	2,663,824	2,602,722	2,573,952	2,618,843	2,737,062	2,620,178	3,029,309	3,156,649	3,258,615
7. Nutrition	9,226	9,334	3,557	9,313	9,313	9,313	9,733	9,823	10,127
8. Coroner Services	–	–	–	–	–	–	–	–	–
9. District Hospitals	4,069,644	4,264,709	4,807,947	4,964,449	5,062,507	5,109,578	5,295,236	5,529,879	5,713,398
Total payments and estimates: Programme 2	**10,496,986**	**10,672,245**	**11,443,730**	**11,779,259**	**12,232,827**	**12,215,504**	**12,783,142**	**13,334,431**	**13,764,446**

Payments and estimates by economic classification.

R thousand	Outcome 2022/23	2023/24	2024/25	Main appropriation	Adjusted appropriation 2025/26	Revised estimate	Medium-term estimates 2026/27	2027/28	2028/29
Current payments	**10,215,749**	**10,456,210**	**11,244,685**	**11,666,978**	**12,016,340**	**12,000,106**	**12,400,102**	**12,940,284**	**13,354,176**
Compensation of employees	6,778,048	7,200,202	7,580,975	8,202,091	8,443,898	8,427,664	9,045,369	9,448,790	9,759,602
Goods and services	3,437,666	3,255,922	3,663,607	3,464,887	3,572,442	3,572,370	3,354,733	3,491,494	3,594,574
Interest and rent on land	35	86	103	–	–	72	–	–	–
Transfers and subsidies	**141,701**	**102,467**	**82,822**	**53,510**	**157,555**	**156,466**	**296,910**	**306,161**	**319,175**
Provinces and municipalities	–	–	–	–	–	–	–	–	–
Departmental agencies and accounts	149	48	148	159	159	82	80	84	86
Higher education institutions	–	–	–	–	–	–	–	–	–
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–
Public corporations and private enterprises	–	–	–	–	–	59	–	–	–
Non-profit institutions	2,580	5,238	9,403	19,344	123,389	71,338	263,390	272,630	284,612
Households	138,972	97,181	73,271	34,007	34,007	84,987	33,440	33,447	34,477
Payments for capital assets	**139,161**	**113,568**	**116,223**	**58,771**	**58,932**	**58,932**	**86,130**	**87,986**	**91,095**
Buildings and other fixed structures	–	–	–	–	–	–	1,800	1,865	1,949
Machinery and equipment	139,161	113,568	116,223	58,771	58,932	58,932	84,330	86,121	89,146
Heritage assets	–	–	–	–	–	–	–	–	–
Specialised military assets	–	–	–	–	–	–	–	–	–
Biological assets	–	–	–	–	–	–	–	–	–
Land and sub-soil assets	–	–	–	–	–	–	–	–	–
Software and other intangible assets	–	–	–	–	–	–	–	–	–
Payments for financial assets	375	–	–	–	–	–	–	–	–
Total economic classification: Programme 2	**10,496,986**	**10,672,245**	**11,443,730**	**11,779,259**	**12,232,827**	**12,215,504**	**12,783,142**	**13,334,431**	**13,764,446**

Transfers and subsidies

R thousand	Outcome 2022/23	2023/24	2024/25	Main appropriation	Adjusted appropriation 2025/26	Revised estimate	Medium-term estimates 2026/27	2027/28	2028/29
Current payments	**10,215,749**	**10,456,210**	**11,244,685**	**11,666,978**	**12,016,340**	**12,000,106**	**12,400,102**	**12,940,284**	**13,354,176**
Compensation of employees	6,778,048	7,200,202	7,580,975	8,202,091	8,443,898	8,427,664	9,045,369	9,448,790	9,759,602
Salaries and wages	5,910,280	6,233,068	6,529,374	7,016,871	7,239,654	7,214,520	7,666,255	8,002,886	8,263,825
Social contributions	867,768	967,134	1,051,601	1,185,220	1,204,244	1,213,144	1,379,114	1,445,904	1,495,777
Goods and services	3,437,666	3,255,922	3,663,607	3,464,887	3,572,442	3,572,370	3,354,733	3,491,494	3,594,574
Administrative fees	178,603	174,072	186,179	215,100	218,812	218,808	190,730	199,622	205,314
Advertising	35,393	20,780	13,471	3,167	10,267	10,267	3,313	3,462	3,569
Minor assets	3,093	1,512	4,012	6,306	5,683	5,641	6,171	6,223	6,428
Catering: Departmental activities	5,521	6,565	5,923	3,590	8,601	8,547	3,724	3,861	3,981
Communication (G&S)	28,822	32,768	33,854	30,566	34,350	32,567	32,523	33,981	35,043
Computer services	22,446	7,113	68,266	31,565	33,698	31,757	33,017	34,502	35,572
Consultants: Business and advisory services	7	5	–	–	–	–	–	–	–
Laboratory services	654,027	625,760	700,159	660,105	660,116	660,115	636,936	660,170	678,762
Legal services (G&S)	–	–	6,706	–	–	8,523	–	–	–
Contractors	266,563	161,932	193,075	103,207	177,141	181,283	105,952	110,738	114,142
Agency and support/outsourced services	29,497	33,865	57,798	38,285	38,295	37,591	40,046	41,849	43,302
Fleet services (incl. government motor transport)	78,487	61,895	63,295	57,487	57,487	52,033	60,141	62,847	64,795
Inventory: Food and food supplies	56,565	52,521	56,131	51,908	51,965	51,964	54,302	56,398	58,146
Inventory: Medical supplies	283,249	317,177	390,964	385,090	367,462	367,461	408,946	427,295	440,627
Inventory: Medicine	1,226,154	1,354,765	1,328,448	1,535,028	1,311,969	1,311,833	1,339,082	1,393,300	1,432,510
Consumable supplies	191,944	102,866	172,006	80,401	218,945	216,806	143,181	149,163	154,630
Consumables: Stationery, printing and office supplies	123,591	73,388	98,506	31,631	72,337	72,563	32,063	32,505	33,512
Operating leases	10,213	9,141	12,753	14,645	16,197	16,217	15,976	16,689	17,205
Rental and hiring	315	702	761	1,054	1,447	1,406	1,102	1,152	1,188
Property payments	146,331	150,131	189,311	184,191	196,371	196,371	184,588	192,997	198,659
Transport provided: Departmental activity	334	294	241	400	390	390	418	437	451
Travel and subsistence	83,017	60,179	71,077	29,382	75,689	75,078	61,082	63,564	65,975
Training and development	1,301	1,707	927	–	1,822	1,699	742	–	–
Operating payments	4,312	605	876	667	652	705	698	729	753
Venues and facilities	7,881	6,179	8,868	1,112	12,746	12,745	–	10	10
Interest and rent on land	35	86	103	–	–	72	–	–	–
Interest (Incl. interest on unitary payments (PPP))	35	86	103	–	–	72	–	–	–
Transfers and subsidies	**141,701**	**102,467**	**82,822**	**53,510**	**157,555**	**156,466**	**296,910**	**306,161**	**319,175**
Departmental agencies and accounts	149	48	148	159	159	82	80	84	86
Departmental agencies (non-business entities)	149	48	148	159	159	82	80	84	86
Public corporations and private enterprises	–	–	–	–	–	59	–	–	–
Public corporations	–	–	–	–	–	59	–	–	–
Subsidies on products and production (pc)	–	–	–	–	–	59	–	–	–
Non-profit institutions	2,580	5,238	9,403	19,344	123,389	71,338	263,390	272,630	284,612
Households	138,972	97,181	73,271	34,007	34,007	84,987	33,440	33,447	34,477
Social benefits	32,114	36,339	25,729	14,713	14,713	22,208	14,168	14,175	14,608
Other transfers to households	106,858	60,842	47,542	19,294	19,294	62,779	19,272	19,272	19,869
Payments for capital assets	**139,161**	**113,568**	**116,223**	**58,771**	**58,932**	**58,932**	**86,130**	**87,986**	**91,095**
Buildings and other fixed structures	–	–	–	–	–	–	1,800	1,865	1,949
Buildings	–	–	–	–	–	–	1,800	1,865	1,949
Machinery and equipment	139,161	113,568	116,223	58,771	58,932	58,932	84,330	86,121	89,146
Transport equipment	43,505	78,422	11,586	14,445	5,874	6,962	42,833	34,151	35,466
Other machinery and equipment	95,656	35,146	104,637	44,326	53,058	51,970	41,497	51,970	53,680
Payments for financial assets	375	–	–	–	–	–	–	–	–
Total economic classification: Programme 2	**10,496,986**	**10,672,245**	**11,443,730**	**11,779,259**	**12,232,827**	**12,215,504**	**12,783,142**	**13,334,431**	**13,764,446**

7.3. Programme 3: Emergency Medical Services

Purpose:

The rendering of pre-hospital Emergency Medical Services including Inter-hospital Transfers and Planned Patient Transport.

Sub-programme 3.1. Emergency Transport

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

Sub-programme 3.2. Planned Patient Transport

Rendering Planned Patient Transport including Local Outpatient Transport (within the boundaries of a given town or local area) and Inter-City/Town Outpatient Transport (Into referral centers).

Programme 3: Emergency Medical Services

Outputs, Outcomes, Performance Indicators and Targets

Outcome	Outputs	Output Indicator	Audited Performance			Estimated Performance	MTEF Targets		
			2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29
Improved responsiveness to community needs	EMS P1 Urban response time improved	EMS P1 urban response under 30 minutes	65%	65%	65%	28%	45%	55%	65%
		Numerator	-	-	-	16	100	122	143
		Denominator	-	-	-	58	220	220	220
Improved responsiveness to community needs	EMS P1 rural response time improved	EMS P1 rural response under 60 minutes	69%	69%	65%	88%	69%	69%	69%
		Numerator	-	-	-	344	258	258	258
		Denominator	-	-	-	390	374	374	374

Table 15: Emergency Medical Services – Outputs, Outcomes, Performance Indicators and Targets

Programme 3: Emergency Medical Services

Output Indicators – Annual and Quarterly Targets

Output Indicators	Annual Targets	Q1	Q2	Q3	Q4
EMS P1 urban response under 30 minutes	45%	45%	45%	45%	45%
Numerator	100	25	25	25	25
Denominator	220	55	55	55	55
EMS P1 rural response under 60 minutes	69%	70%	68%	68%	70%
Numerator	258	65	64	64	65
Denominator	374	93	94	94	93

Table 16: Programme3: Emergency Medical Services – Output Indicators – Annual and Quarterly Targets

Explanation of planned performance over the medium-term period

The planned performance trends reflect a clear alignment with the broader health system objectives outlined in the departmental priorities. The progressive improvement in EMS P1 urban and rural response times directly supports the overarching goal of improving access to affordable and quality healthcare, particularly by strengthening emergency and primary care responsiveness. As shown, urban response times are planned to rise from 28% in 2025/26 to 65% by 2028/29, while rural response performance stabilizes at 69%, demonstrating a focused effort to enhance timely emergency care for all communities.

These improvements contribute to strengthening service delivery platforms, including better linkages to care, improved clinic and hospital performance, and expanded infrastructure such as new clinics and tertiary services. Similarly, the introduction and planned stabilization of interfacility transfer indicators with targets kept below 12% for general transfers and 17% for obstetric transfers illustrate efforts to streamline patient movement across facilities and reduce delays in accessing higher levels of care.

Collectively, the performance trajectory demonstrates a coherent strategy to enhance responsiveness, efficiency, and equity in health service delivery, fully supporting the health system strengthening priorities.

Programme Resource Considerations

R thousand	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
	2022/23	2023/24	2024/25		2025/26		2026/27	2027/28	2028/29
1. Emergency transport	426,066	461,494	523,577	558,509	557,944	557,944	571,193	596,895	614,527
2. Planned Patient Transport	13,293	12,450	25,170	17,798	17,798	17,798	18,617	19,455	20,058
Total payments and estimates: Programme 3	**439,359**	**473,944**	**548,747**	**576,307**	**575,742**	**575,742**	**589,810**	**616,350**	**634,585**

Payments and estimates by economic classification.

R thousand	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
	2022/23	2023/24	2024/25		2025/26		2026/27	2027/28	2028/29
Current payments	**437,688**	**456,211**	**502,174**	**549,599**	**549,599**	**549,599**	**562,433**	**587,854**	**605,206**
Compensation of employees	331,485	352,569	382,458	409,565	409,565	409,565	415,960	434,790	447,387
Goods and services	106,203	103,642	119,716	140,034	140,034	140,014	146,473	153,064	157,819
Interest and rent on land	–	–	–	–	–	20	–	–	–
Transfers and subsidies	**1,243**	**1,651**	**1,903**	**1,677**	**1,677**	**1,677**	**1,671**	**1,671**	**1,723**
Provinces and municipalities	660	1,064	1,029	1,208	1,208	931	1,203	1,203	1,240
Departmental agencies and accounts	–	–	–	–	–	–	–	–	–
Higher education institutions	–	–	–	–	–	–	–	–	–
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–
Public corporations and private enterprises	–	–	–	–	–	–	–	–	–
Non-profit institutions	–	–	–	–	–	–	–	–	–
Households	583	587	874	469	469	746	468	468	483
Payments for capital assets	**428**	**16,082**	**44,670**	**25,031**	**24,466**	**24,466**	**25,706**	**26,825**	**27,656**
Buildings and other fixed structures	–	–	–	–	–	–	–	–	–
Machinery and equipment	428	16,082	44,670	25,031	24,466	24,466	25,706	26,825	27,656
Heritage assets	–	–	–	–	–	–	–	–	–
Specialised military assets	–	–	–	–	–	–	–	–	–
Biological assets	–	–	–	–	–	–	–	–	–
Land and sub-soil assets	–	–	–	–	–	–	–	–	–
Software and other intangible assets	–	–	–	–	–	–	–	–	–
Payments for financial assets	–	–	–	–	–	–	–	–	–
Total economic classification: Programme 3	**439,359**	**473,944**	**548,747**	**576,307**	**575,742**	**575,742**	**589,810**	**616,350**	**634,585**

Transfers and subsidies

R thousand	Outcome 2022/23	Outcome 2023/24	Outcome 2024/25	Main appropriation 2025/26	Adjusted appropriation 2025/26	Revised estimate 2025/26	Medium-term estimates 2026/27	Medium-term estimates 2027/28	Medium-term estimates 2028/29
Current payments	**437,688**	**456,211**	**502,174**	**549,599**	**549,599**	**549,599**	**562,433**	**587,854**	**605,206**
Compensation of employees	331,485	352,569	382,458	409,565	409,565	409,565	415,960	434,790	447,387
Salaries and wages	274,353	290,694	315,224	338,020	338,020	338,020	344,050	359,622	369,925
Social contributions	57,132	61,875	67,234	71,545	71,545	71,545	71,910	75,168	77,462
Goods and services	106,203	103,642	119,716	140,034	140,034	140,014	146,473	153,064	157,819
Administrative fees	3	6	15	29	29	29	30	31	32
Minor assets	219	74	–	–	–	–	–	–	–
Catering: Departmental activities	–	–	–	–	35	35	–	–	–
Communication (G&S)	1,882	2,154	2,287	1,931	1,931	1,931	2,017	2,108	2,173
Computer services	–	–	256	20,901	8,274	8,274	21,862	22,846	23,554
Contractors	18,082	16,996	20,979	19,956	19,956	19,394	20,873	21,812	22,488
Fleet services (incl. government motor transport)	78,181	80,517	89,811	84,659	84,659	84,659	88,554	92,539	95,408
Inventory: Medical supplies	2,729	754	1,043	5,522	5,522	5,522	5,776	6,036	6,223
Consumable supplies	2,427	407	2,000	1,942	10,558	11,072	2,031	2,122	2,188
Consumables: Stationery, printing and office supplies	530	903	1,053	667	4,678	4,678	698	729	752
Operating leases	1,481	965	1,147	3,520	2,900	2,900	3,683	3,849	3,978
Property payments	371	345	360	446	446	446	467	488	503
Travel and subsistence	298	521	765	461	1,046	1,074	482	504	520
Interest and rent on land	–	–	–	–	–	20	–	–	–
Interest (Incl. interest on unitary payments (PPP))	–	–	–	–	–	20	–	–	–
Transfers and subsidies	**1,243**	**1,651**	**1,903**	**1,677**	**1,677**	**1,677**	**1,671**	**1,671**	**1,723**
Provinces and municipalities	660	1,064	1,029	1,208	1,208	931	1,203	1,203	1,240
Provinces	660	1,064	1,029	1,208	1,208	931	1,203	1,203	1,240
Provincial agencies and funds	660	1,064	1,029	1,208	1,208	931	1,203	1,203	1,240
Households	583	587	874	469	469	746	468	468	483
Social benefits	583	500	874	469	469	746	468	468	483
Other transfers to households	–	87	–	–	–	–	–	–	–
Payments for capital assets	**428**	**16,082**	**44,670**	**25,031**	**24,466**	**24,466**	**25,706**	**26,825**	**27,656**
Machinery and equipment	428	16,082	44,670	25,031	24,466	24,466	25,706	26,825	27,656
Transport equipment	–	16,082	44,670	23,827	24,381	23,789	24,502	25,621	26,415
Other machinery and equipment	428	–	–	1,204	85	677	1,204	1,204	1,241
Payments for financial assets	–	–	–	–	–	–	–	–	–
Total economic classification: Programme 3	**439,359**	**473,944**	**548,747**	**576,307**	**575,742**	**575,742**	**589,810**	**616,350**	**634,585**

7.4. Programme 4: Provincial Hospital Services

Purpose

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

Sub-programme 4.1. General (Regional) Hospitals

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

Sub-programme 4.2. Tuberculosis Hospitals

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

Sub-programme 4.3. Psychiatric/Mental Hospitals

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

Sub-programme 4.4. Sub-acute, Step down and Chronic Medical Hospitals

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

Sub-programme 4.4. Dental training hospitals

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

Programme 4: Regional Hospital Services

Outputs, Outcomes, Performance Indicators and Targets

Outcome	Outputs	Output Indicator	Audited Performance			Estimated Performance	MTEF Targets		
			2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29
Improve maternal and child health	Reduce maternal deaths in facility	Number of Maternal deaths in facility	New Indicator	33	28	14	20	18	16
		Numerator	-	-	-	14	20	18	16
Mortality due to NCDs reduced	Reduce all death under 5 years in facility	Number of Death in facility under 5 years	New Indicator	288	302	250	240	230	220
		Numerator	-	-	-	250	240	230	220
Improved access to safe and quality healthcare	Patient experience of care improved	Patient Experience of Care survey rate (Regional Hospitals)	New Indicator	New Indicator	New Indicator	100%	100%	100%	100%
		Numerator	-	-	-	3	3	3	3
		Denominator	-	-	-	3	3	3	3
		Severity assessment code (SAC) 1 incident reported within 24 hours rate	New Indicator	80%	100%	100%	100%	100%	100%
		Numerator	-	-	-	59	59	59	59
		Denominator	-	-	-	59	59	59	59
		Patient Safety Incident (PSI) case closure rate	New Indicator	93%	95%	98%	99%	100%	100%
		Numerator	-	-	-	140	141	142	142
		Denominator	-	-	-	142	142	142	142

Table 17: Programme 4: Regional Hospital Services – Outputs, Outcomes, Performance Indicators and Targets

Programme 4: Regional Hospital Service

Output Indicators – Annual and Quarterly Targets

Output Indicators	Annual Targets	Q1	Q2	Q3	Q4
Number of Maternal deaths in facility	20	5	10	15	20
Numerator	20	5	10	15	20
Number of Death in facility under 5 years	240	60	60	60	60
Numerator	240	60	60	60	60
Patient Experience of Care survey rate (Regional Hospitals)	100%	-	100%	-	-
Numerator	3	-	3	-	-
Denominator	3	-	3	-	-
Severity assessment code (SAC) 1 incident reported within 24 hours rate	100%	100%	100%	100%	100%
Numerator	59	14	29	44	59
Denominator	59	14	29	44	59
Patient Safety Incident (PSI) case closure rate	99%	97%	100%	100%	100%
Numerator	141	35	36	35	35
Denominator	142	36	36	35	35

Table 18: Programme 4: Regional Hospital Services Output Indicators – Annual and Quarterly Targets

Programme 4: Specialised Hospital Services

Outputs, Outcomes, Performance Indicators and Targets

Outcome	Outputs	Output Indicator	Audited Performance			Estimated Performance	MTEF Targets		
			2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29
Improved access to safe and quality healthcare.	Patient experience of care improved	Patient Experience of Care Survey Rate (Specialized Hospitals)	New Indicator	New Indicator	New Indicator	100%	100%	100%	100%
		Numerator	-	-	-	1	1	1	1
		Denominator	-	-	-	1	1	1	1

Table 19: Programme 4: Specialised Hospital Services – Outputs, Outcomes, Performance Indicators and Targets

Programme 4: Specialised Hospital Services

Output Indicators – Annual and Quarterly Targets

Output Indicators	Annual Targets	Q1	Q2	Q3	Q4
Patient Experience of Care survey rate (Specialised Hospitals)	100%	-	100%	-	-
Numerator	1	-	1	-	-
Denominator	1	-	1	-	-

Table 20: Programme 4: Specialised Hospital Services – Output Indicators – Annual and Quarterly Targets

Explanation of planned performance over the medium-term period

The planned performance outlined in the table reflects a clear, structured effort to advance the health system priorities set out in the MDTP. The steady reduction in maternal deaths from 33 in 2023/24 to a projected 16 by 2028/29 directly supports the objective of reducing maternal mortality through strengthened antenatal care, early ANC booking, and improved postnatal follow-up. Similarly, the declining trend in under-5 deaths in facilities, projected to decrease from 302 in 2023/24 to 220 by 2028/29, aligns with the department's focus on expanding neonatal services, improving critical care capacity, and strengthening immunization and early childhood interventions.

Improvements in patient experience of care, targeted at a consistent 100% implementation rate, reinforce the broader aim of enhancing quality and accessibility of healthcare services. This is further supported by the rising performance in severity assessment reporting (SAC 1) and the sustained patient safety incident closure rate, both of which advance the strategic objective of improving clinical governance and facility accountability.

Overall, the planned performance trajectory demonstrates a strong alignment with MDTP priorities, showing deliberate, phased improvements that strengthen maternal health, child survival, and the overall quality of care across the province.

Programme resource considerations.

R thousand	Outcome 2022/23	2023/24	2024/25	Main appropriation	Adjusted appropriation 2025/26	Revised estimate	Medium-term estimates 2026/27	2027/28	2028/29
1. General (Regional) Hospitals	1,495,795	1,523,195	1,672,876	1,807,345	1,875,268	1,875,211	1,958,987	2,040,485	2,104,906
2. Tuberculosis Hospitals	136,414	127,295	129,387	136,511	139,734	139,791	142,047	148,402	153,002
3. Psychiatric/ Mental Hospitals	47,449	59,662	58,950	56,386	56,386	56,386	58,980	61,634	63,545
4. Sub-acute, Step down and Chronic Medical Hospitals	–	–	–	–	–	–	–	–	–
5. Dental Training Hospitals	–	–	–	–	–	–	–	–	–
6. Other Specialised Hospitals	–	–	–	–	–	–	–	–	–
Total payments and estimates: Programme 4	**1,679,658**	**1,710,152**	**1,861,213**	**2,000,242**	**2,071,388**	**2,071,388**	**2,160,014**	**2,250,521**	**2,321,453**

Payments and estimates by economic classification.

R thousand	Outcome 2022/23	2023/24	2024/25	Main appropriation	Adjusted appropriation 2025/26	Revised estimate	Medium-term estimates 2026/27	2027/28	2028/29
Current payments	**1,633,144**	**1,678,439**	**1,840,444**	**1,969,719**	**2,037,646**	**2,037,646**	**2,124,248**	**2,214,577**	**2,284,318**
Compensation of employees	1,234,639	1,316,032	1,419,895	1,555,398	1,563,143	1,563,143	1,652,452	1,726,308	1,780,321
Goods and services	398,499	362,400	420,538	414,321	474,503	474,503	471,796	488,269	503,997
Interest and rent on land	6	7	11	–	–	–	–	–	–
Transfers and subsidies	**44,494**	**27,977**	**15,756**	**28,697**	**28,697**	**28,697**	**28,554**	**28,554**	**29,438**
Provinces and municipalities	–	–	–	–	–	–	–	–	–
Departmental agencies and accounts	29	30	95	51	51	–	51	51	52
Higher education institutions	–	–	–	–	–	–	–	–	–
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–
Public corporations and private enterprises	–	1	–	–	–	22	–	–	–
Non-profit institutions	–	–	–	–	–	–	–	–	–
Households	44,465	27,946	15,661	28,646	28,646	28,675	28,503	28,503	29,386
Payments for capital assets	**1,561**	**3,736**	**5,013**	**1,826**	**5,045**	**5,045**	**7,212**	**7,390**	**7,697**
Buildings and other fixed structures	–	–	–	–	–	–	–	–	–
Machinery and equipment	1,561	3,736	5,013	1,826	5,045	5,045	7,212	7,390	7,697
Heritage assets	–	–	–	–	–	–	–	–	–
Specialised military assets	–	–	–	–	–	–	–	–	–
Biological assets	–	–	–	–	–	–	–	–	–
Land and sub-soil assets	–	–	–	–	–	–	–	–	–
Software and other intangible assets	–	–	–	–	–	–	–	–	–
Payments for financial assets	459	–	–	–	–	–	–	–	–
Total economic classification: Programme 4	**1,679,658**	**1,710,152**	**1,861,213**	**2,000,242**	**2,071,388**	**2,071,388**	**2,160,014**	**2,250,521**	**2,321,453**

Transfers and subsidies.

R thousand	Outcome 2022/23	2023/24	2024/25	Main appropriation	Adjusted appropriation 2025/26	Revised estimate	Medium-term estimates 2026/27	2027/28	2028/29
Current payments	**1,633,144**	**1,678,439**	**1,840,444**	**1,969,719**	**2,037,646**	**2,037,646**	**2,124,248**	**2,214,577**	**2,284,318**
Compensation of employees	1,234,639	1,316,032	1,419,895	1,555,398	1,563,143	1,563,143	1,652,452	1,726,308	1,780,321
Salaries and wages	1,081,279	1,148,370	1,237,397	1,360,398	1,224,749	1,224,749	1,442,260	1,506,745	1,553,844
Social contributions	153,360	167,662	182,498	195,000	338,394	338,394	210,192	219,563	226,477
Goods and services	398,499	362,400	420,538	414,321	474,503	474,503	471,796	488,269	503,997
Administrative fees	8,785	11,384	14,377	10,423	10,403	10,620	10,903	11,394	11,747
Minor assets	54	189	453	1,543	1,933	1,933	1,543	1,543	1,607
Catering: Departmental activities	53	59	78	94	102	102	94	94	97
Communication (G&S)	4,174	4,176	4,390	4,284	4,271	4,267	4,480	4,681	4,827
Computer services	5,824	–	–	–	–	–	–	–	–
Laboratory services	23,834	22,677	33,577	36,856	58,821	58,822	80,285	82,396	85,540
Contractors	136,892	73,224	58,954	114,879	93,955	90,746	117,020	119,200	122,896
Agency and support/outsourced services	11,450	9,479	6,737	13,858	13,403	13,946	14,495	15,148	15,678
Fleet services (incl. government motor transport)	7,048	5,989	4,063	5,800	5,836	6,663	6,067	6,340	6,537
Inventory: Food and food supplies	17,259	18,746	21,223	21,464	21,169	21,169	22,453	23,463	24,190
Inventory: Medical supplies	90,895	97,523	135,796	96,622	117,375	117,376	101,067	105,615	108,889
Inventory: Medicine	43,563	61,709	74,092	47,205	82,205	82,205	49,373	51,595	53,195
Consumable supplies	9,097	10,781	16,660	9,202	11,529	13,154	9,625	10,058	10,354
Consumables: Stationery, printing and office supplies	1,923	1,699	3,685	2,159	2,833	2,833	2,159	2,159	2,226
Operating leases	1,111	846	1,108	1,413	1,413	1,413	1,478	1,544	1,591
Property payments	33,622	41,045	42,290	45,879	45,945	45,945	47,992	50,152	51,646
Transport provided: Departmental activity	105	111	106	216	271	271	226	236	244
Travel and subsistence	2,330	2,720	2,581	2,159	2,749	2,748	2,258	2,360	2,433
Operating payments	185	43	368	265	290	290	278	291	300
Venues and facilities	295	–	–	–	–	–	–	–	–
Interest and rent on land	6	7	11	–	–	–	–	–	–
Interest (Incl. interest on unitary payments (PPP))	6	7	11	–	–	–	–	–	–
Transfers and subsidies	**44,494**	**27,977**	**15,756**	**28,697**	**28,697**	**28,697**	**28,554**	**28,554**	**29,438**
Departmental agencies and accounts	29	30	95	51	51	–	51	51	52
Departmental agencies (non-business entities)	29	30	95	51	51	–	51	51	52
Public corporations and private enterprises	–	1	–	–	–	22	–	–	–
Public corporations	–	1	–	–	–	22	–	–	–
Subsidies on products and production (pc)	–	1	–	–	–	22	–	–	–
Households	44,465	27,946	15,661	28,646	28,646	28,675	28,503	28,503	29,386
Social benefits	6,645	7,133	6,678	3,699	3,699	3,728	3,684	3,684	3,798
Other transfers to households	37,820	20,813	8,983	24,947	24,947	24,947	24,819	24,819	25,588
Payments for capital assets	**1,561**	**3,736**	**5,013**	**1,826**	**5,045**	**5,045**	**7,212**	**7,390**	**7,697**
Machinery and equipment	1,561	3,736	5,013	1,826	5,045	5,045	7,212	7,390	7,697
Other machinery and equipment	1,561	3,736	5,013	1,826	5,045	5,045	7,212	7,390	7,697
Payments for financial assets	459	–	–	–	–	–	–	–	–
Total economic classification: Programme 4	**1,679,658**	**1,710,152**	**1,861,213**	**2,000,242**	**2,071,388**	**2,071,388**	**2,160,014**	**2,250,521**	**2,321,453**

7.5. Programme 5: Central Hospital Services

Purpose:

To provide tertiary health services and create a platform for the training of health workers.

Sub-programme 5.1. Central Hospital Services

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

Sub-programme 5.2. Provincial Tertiary Hospital Services

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

Programme 5: Central Hospital Services

Outputs, Outcomes, Performance Indicators and Targets

Outcome	Outputs	Output Indicator	Audited Performance			Estimated Performance	MTEF Targets		
			2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29
Improve maternal and child health	Reduce maternal deaths in facility	Number of Maternal deaths in facility	New Indicator	17	20	22	26	24	22
		Numerator	-	-	-	22	26	24	22
Mortality due to NCDs reduced	Reduce all death under 5 years in facility	Number of Death in facility under 5 years	New Indicator	373	315	250	250	240	230
		Numerator	-	-	-	250	250	240	230
Improved access to safe and quality healthcare	Patient experience of care improved	Patient Experience of Care survey rate (Tertiary Hospitals)	New Indicator	New Indicator	New Indicator	100%	100%	100%	100%
		Numerator	-	-	-	2	2	2	2
		Denominator	-	-	-	2	2	2	2
	Patient experience of care improved	Severity assessment code (SAC) 1 incident reported within 24 hours rate	New Indicator	97%	98%	100%	100%	100%	100%
		Numerator	-	-	-	36	9	9	9
		Denominator	-	-	-	36	9	9	9
		Patient Safety Incident (PSI) case closure rate	New Indicator	98%	92%	92%	92%	92%	92%
		Numerator	-	-	-	113	115	117	118
		Denominator	-	-	-	124	124	124	124

Table 21: Programme 5: Central Hospital Services – Outputs, Outcomes, Performance Indicators and Targets

Programme 5: Central Hospital Services

Output Indicators – Annual and Quarterly Targets

Output Indicators	Annual Targets	Q1	Q2	Q3	Q4
Number of Maternal deaths in facility	26	6	7	7	6
Numerator	26	6	7	7	6
Number of Death in facility under 5 years rate	250	62	63	63	62
Numerator	250	62	63	63	62
Patient Experience of Care survey rate (Tertiary Hospitals)	100%	-	100%	-	-
Numerator	2	2	2	2	2
Denominator	2	2	2	2	2
Severity assessment code (SAC) 1 incident reported within 24 hours rate	100%	100%	100%	100%	100%
Numerator	36	9	18	27	36
Denominator	36	9	18	27	36
Patient Safety Incident (PSI) case closure rate	93%	94%	94%	94%	90%
Numerator	115	29	29	29	28
Denominator	124	31	31	31	31

Table 22: Programme 5: Central Hospital Services – Output Indicators – Annual and Quarterly Targets

Explanation of planned performance over the medium-term period

The planned performance overtime in the table demonstrates clear alignment with the health system priorities. The gradual reduction in maternal deaths, projected to decline from 22 in 2025/26 to 22 by 2028/29 after a temporary rise, directly supports the objective of reducing maternal mortality through strengthened antenatal care, improved early booking, and enhanced clinical quality of care. Similarly, reductions in under-5 deaths, decreasing from 373 in 2023/24 to 230 by 2028/29, reinforce efforts to scale up child health interventions, including expanded neonatal capacity, improved immunization coverage, and strengthened primary healthcare services.

The consistent 100% targets for patient experience of care surveys and the upward stabilization of SAC 1 incident reporting within 24 hours illustrate a commitment to patient-centered care and robust clinical governance, echoing priorities on quality improvement, facility compliance, and strengthened accountability systems. The sustained 95% patient safety incident closure rate further supports objectives to improve patient safety culture and operational efficiency.

Overall, these performance trends indicate deliberate progress toward improving maternal and child outcomes, enhancing service quality, and strengthening community responsiveness key pillars of the MDTP strategic framework.

Programme resource considerations.

R thousand	Outcome 2022/23	2023/24	2024/25	Main appropriation	Adjusted appropriation 2025/26	Revised estimate	Medium-term estimates 2026/27	2027/28	2028/29
1. Central Hospital Services	–	–	–	–	–	–	–	–	–
2. Provincial Tertiary Hospital Services	1,727,170	1,841,571	2,084,537	2,204,272	2,262,618	2,262,618	2,406,457	2,501,525	2,583,771
Total payments and estimates: Programme 5	**1,727,170**	**1,841,571**	**2,084,537**	**2,204,272**	**2,262,618**	**2,262,618**	**2,406,457**	**2,501,525**	**2,583,771**

Payments and estimates by economic classification

R thousand	Outcome 2022/23	2023/24	2024/25	Main appropriation	Adjusted appropriation 2025/26	Revised estimate	Medium-term estimates 2026/27	2027/28	2028/29
Current payments	**1,691,371**	**1,796,517**	**1,994,770**	**2,112,142**	**2,175,747**	**2,175,747**	**2,299,306**	**2,398,591**	**2,473,729**
Compensation of employees	1,061,505	1,186,804	1,292,980	1,435,100	1,440,400	1,440,400	1,550,106	1,618,921	1,669,285
Goods and services	629,866	609,713	701,662	677,042	735,347	735,296	749,200	779,670	804,444
Interest and rent on land	–	–	128	–	–	51	–	–	–
Transfers and subsidies	**16,992**	**3,875**	**21,505**	**3,588**	**3,820**	**3,820**	**3,589**	**3,590**	**3,701**
Provinces and municipalities	–	–	–	–	–	–	–	–	–
Departmental agencies and accounts	12	32	–	27	27	27	28	29	30
Higher education institutions	–	–	–	–	–	–	–	–	–
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–
Public corporations and private enterprises	–	–	–	–	–	–	–	–	–
Non-profit institutions	–	–	–	–	–	–	–	–	–
Households	16,980	3,843	21,505	3,561	3,793	3,793	3,561	3,561	3,671
Payments for capital assets	**18,807**	**41,179**	**68,262**	**88,542**	**83,051**	**83,051**	**103,562**	**99,344**	**106,341**
Buildings and other fixed structures	–	–	–	20,000	41,278	41,278	29,412	21,841	22,518
Machinery and equipment	18,807	41,179	68,262	68,542	41,773	41,773	74,150	77,503	83,823
Heritage assets	–	–	–	–	–	–	–	–	–
Specialised military assets	–	–	–	–	–	–	–	–	–
Biological assets	–	–	–	–	–	–	–	–	–
Land and sub-soil assets	–	–	–	–	–	–	–	–	–
Software and other intangible assets	–	–	–	–	–	–	–	–	–
Payments for financial assets	–	–	–	–	–	–	–	–	–
Total economic classification: Programme 5	**1,727,170**	**1,841,571**	**2,084,537**	**2,204,272**	**2,262,618**	**2,262,618**	**2,406,457**	**2,501,525**	**2,583,771**

Transfers and subsidies

R thousand	Outcome 2022/23	2023/24	2024/25	Main appropriation	Adjusted appropriation 2025/26	Revised estimate	Medium-term estimates 2026/27	2027/28	2028/29
Current payments	**1,691,371**	**1,796,517**	**1,994,770**	**2,112,142**	**2,175,747**	**2,175,747**	**2,299,306**	**2,398,591**	**2,473,729**
Compensation of employees	1,061,505	1,186,804	1,292,980	1,435,100	1,440,400	1,440,400	1,550,106	1,618,921	1,669,285
Salaries and wages	929,878	1,036,711	1,127,575	1,255,081	1,261,137	1,261,137	1,361,166	1,421,714	1,465,921
Social contributions	131,627	150,093	165,405	180,019	179,263	179,263	188,940	197,207	203,364
Goods and services	629,866	609,713	701,662	677,042	735,347	735,296	749,200	779,670	804,444
Administrative fees	7,425	13,018	17,998	17,602	17,606	17,484	18,412	19,241	19,837
Minor assets	408	232	720	1,397	1,076	1,076	1,461	1,527	1,593
Catering: Departmental activities	10	22	30	–	10	10	–	–	–
Communication (G&S)	2,394	3,252	3,299	3,235	3,235	3,235	3,384	3,536	3,646
Computer services	247,817	174,046	114,542	108,392	108,392	134,317	113,269	118,366	122,030
Laboratory services	27,928	27,432	41,968	51,976	52,205	52,200	66,055	67,887	70,147
Legal services (G&S)	–	–	–	–	–	4,672	–	–	–
Contractors	64,841	81,011	88,104	65,985	77,061	46,687	67,385	70,417	72,600
Agency and support/outsourced services	13,623	10,050	10,533	20,907	20,907	20,907	21,890	22,875	23,709
Fleet services (incl. government motor transport)	1,939	1,513	1,176	2,383	2,383	2,383	2,493	2,605	2,686
Inventory: Food and food supplies	14,679	18,556	25,323	25,851	25,851	25,851	27,035	28,252	29,128
Inventory: Medical supplies	130,591	140,735	210,658	188,837	206,212	206,212	196,126	204,952	211,306
Inventory: Medicine	57,222	69,454	103,191	114,054	129,128	129,128	151,893	156,758	162,067
Consumable supplies	6,739	9,914	10,762	8,122	8,067	8,067	8,495	8,877	9,132
Consumables: Stationery, printing and office supplies	1,443	2,820	1,916	2,943	2,743	2,743	2,943	2,941	3,032
Operating leases	1,195	856	1,174	1,267	1,267	1,267	1,325	1,385	1,428
Property payments	51,014	56,049	69,519	63,611	78,654	78,391	66,532	69,526	71,556
Transport provided: Departmental activity	81	94	37	40	40	40	42	44	45
Travel and subsistence	507	585	632	380	450	566	397	415	434
Training and development	–	–	28	–	–	–	–	–	–
Operating payments	10	74	52	60	60	60	63	66	68
Interest and rent on land	–	–	128	–	–	51	–	–	–
Interest (Incl. interest on unitary payments (PPP))	–	–	128	–	–	51	–	–	–
Transfers and subsidies	**16,992**	**3,875**	**21,505**	**3,588**	**3,820**	**3,820**	**3,589**	**3,590**	**3,701**
Departmental agencies and accounts	12	32	–	27	27	27	28	29	30
Departmental agencies (non-business entities)	12	32	–	27	27	27	28	29	30
Households	16,980	3,843	21,505	3,561	3,793	3,793	3,561	3,561	3,671
Social benefits	2,125	2,755	4,025	2,227	2,459	2,983	2,227	2,227	2,296
Other transfers to households	14,855	1,088	17,480	1,334	1,334	810	1,334	1,334	1,375
Payments for capital assets	**18,807**	**41,179**	**68,262**	**88,542**	**83,051**	**83,051**	**103,562**	**99,344**	**106,341**
Buildings and other fixed structures	–	–	–	20,000	41,278	41,278	29,412	21,841	22,518
Buildings	–	–	–	20,000	41,278	41,278	29,412	21,841	22,518
Machinery and equipment	18,807	41,179	68,262	68,542	41,773	41,773	74,150	77,503	83,823
Transport equipment	359	–	–	–	–	–	–	–	–
Other machinery and equipment	18,448	41,179	68,262	68,542	41,773	41,773	74,150	77,503	83,823
Payments for financial assets	–	–	–	–	–	–	–	–	–
Total economic classification: Programme 5	**1,727,170**	**1,841,571**	**2,084,537**	**2,204,272**	**2,262,618**	**2,262,618**	**2,406,457**	**2,501,525**	**2,583,771**

7.6. Programme 6: Health Science and Training

Purpose:

Rendering of training and development opportunities for actual and potential employees of the Department of Health.

Sub-programme 6.1. Nurse Training College

Training of nurses at undergraduate and post-basic level. Target group includes actual and potential employees.

Sub-programme 6.2. Emergency Medical Services (EMS) Training College

Training of rescue and ambulance personnel. Target group includes actual and potential employees.

Subprogramme 6.3. Bursaries

Provision of bursaries for health science training programmes at undergraduate and postgraduate levels. Target group includes actual and potential employees.

Sub-programme 6.4. Primary Healthcare (PHC) Training

Provision of PHC related training for personnel, provided by the regions.

Sub-programme 6.5. Training (other)

Provision of skills development interventions for all occupational categories in the Department. Target group includes actual and potential employees.

Programme 6: Health Science and Training

Outputs, Outcomes, Performance Indicators and Targets

Outcome	Outputs	Output Indicator	Audited Performance			Estimated Performance	MTEF Targets		
			2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29
Equitable distribution of Health professionals to Health facilities	Increase capacity in Health facilities	Number of Healthcare workers who received training on priority critical clinical skills	5 732	6 004	5 538	3 000	4 000	4 000	4 000
		Number of first year nursing students who received bursaries	70	70	70	70	70	70	70
		Number of frontline workers who received training on customer care	273	712	612	200	300	250	300
		Number of managers who received training on Leadership & Management skills	Not required to report	Not required to report	282	75	75	75	75
		Number of employees who underwent the Compulsory Induction Programme	New Indicator	New Indicator	New Indicator	New Indicator	250	300	300
		Number of clinicians who received training on capturing Clinical Documentation	New Indicator	New Indicator	New Indicator	75	75	75	75

Table 23: Programme 6: Health Science and Training – Outputs, Outcomes, Performance Indicators and Targets

Programme 6: Health Science and Training

Output Indicators – Annual and Quarterly Targets

Output Indicators	Annual Targets	Q1	Q2	Q3	Q4
Number of Healthcare workers who received training on priority critical clinical skills	4 000	500	2 000	1 000	500
Number of first year nursing students who received bursaries	70	0	0	0	70
Number of frontline workers who received training on customer care	300	50	150	70	30
Number of employees who received training on Leadership & Management skills	75	0	25	50	0
Number of employees who underwent the Compulsory Induction Programme	250	50	100	50	50
Number of clinicians who received training on capturing clinical documentation	75	0	25	50	0

Table 24: Programme 6: Health Science and Training – Output Indicators – Annual and Quarterly Targets

Explanation of planned performance over the medium-term period

The planned performance over time reflects a strong alignment with the Department's strategic objective of improving access to affordable and quality healthcare by strengthening the health workforce. The consistent allocation of bursaries for first-year nursing students, maintained at 70 annually, directly supports scaling the availability of trained health professionals to meet rising service demands. Similarly, the continued training of healthcare workers in critical clinical skills, stabilizing at 4 000 per year from 2025/26 onwards, reinforces focus on enhancing clinical competency and improving quality of care across all service platforms.

The introduction of indicators such as the Compulsory Induction Programme and Clinical Documentation training demonstrates a shift toward strengthening organizational culture and ensuring consistent standards of care, supporting the goals of improving facility compliance and strengthening governance systems. Additionally, the ongoing training of frontline workers and managers contributes to better patient experience and more efficient service delivery, which aligns with the priority to enhance patient-centered care and operational efficiency.

Overall, the performance trajectory highlights a deliberate, sustained effort to build a competent, well-distributed health workforce critical to achieving the long-term objectives of the Department.

Programme Resource considerations

R thousand	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
	2022/23	2023/24	2024/25		2025/26		2026/27	2027/28	2028/29
1. Nurse Training Colleges	143,655	144,534	143,615	172,668	155,711	155,711	180,015	188,045	193,873
2. EMS Training Colleges	2,850	1,157	3,261	1,331	1,331	2,644	1,385	1,447	1,492
3. Bursaries	28,724	8,049	14,051	26,469	19,669	19,669	26,713	26,472	27,294
4. Primary Health Care Training	3,553	3,147	3,216	4,103	4,103	4,103	4,271	4,463	4,601
5. Training Other	340,422	358,388	355,765	382,669	382,535	381,222	405,131	416,374	429,376
Total payments and estimates: Programme 6	**519,204**	**515,275**	**519,908**	**587,240**	**563,349**	**563,349**	**617,515**	**636,801**	**656,636**

Payments and estimates by economic classification

R thousand	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates		
	2022/23	2023/24	2024/25		2025/26		2026/27	2027/28	2028/29
Current payments	**459,093**	**478,254**	**475,091**	**533,041**	**515,813**	**515,813**	**563,215**	**583,399**	**601,578**
Compensation of employees	379,361	389,065	389,686	423,480	423,742	423,742	442,000	456,810	470,967
Goods and services	79,732	89,189	85,405	109,561	92,071	92,071	121,215	126,589	130,611
Interest and rent on land	–	–	–	–	–	–	–	–	–
Transfers and subsidies	**56,901**	**34,916**	**42,762**	**51,024**	**45,519**	**45,519**	**50,980**	**49,933**	**51,481**
Provinces and municipalities	–	–	–	–	–	–	–	–	–
Departmental agencies and accounts	29,526	29,145	30,484	29,985	29,985	29,885	29,963	29,439	30,352
Higher education institutions	–	–	–	–	–	–	–	–	–
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–
Public corporations and private enterprises	–	–	–	–	–	–	–	–	–
Non-profit institutions	–	–	–	–	–	–	–	–	–
Households	27,375	5,771	12,278	21,039	15,534	15,634	21,017	20,494	21,129
Payments for capital assets	**3,210**	**2,105**	**2,055**	**3,175**	**2,017**	**2,017**	**3,320**	**3,469**	**3,577**
Buildings and other fixed structures	–	–	–	–	–	–	–	–	–
Machinery and equipment	3,210	2,105	2,055	3,175	2,017	2,017	3,320	3,469	3,577
Heritage assets	–	–	–	–	–	–	–	–	–
Specialised military assets	–	–	–	–	–	–	–	–	–
Biological assets	–	–	–	–	–	–	–	–	–
Land and sub-soil assets	–	–	–	–	–	–	–	–	–
Software and other intangible assets	–	–	–	–	–	–	–	–	–
Payments for financial assets	–	–	–	–	–	–	–	–	–
Total economic classification: Programme 6	**519,204**	**515,275**	**519,908**	**587,240**	**563,349**	**563,349**	**617,515**	**636,801**	**656,636**

Transfers and subsidies

R thousand	Outcome 2022/23	2023/24	2024/25	Main appropriation	Adjusted appropriation 2025/26	Revised estimate	Medium-term estimates 2026/27	2027/28	2028/29
Current payments	**459,093**	**478,254**	**475,091**	**533,041**	**515,813**	**515,813**	**563,215**	**583,399**	**601,578**
Compensation of employees	379,361	389,065	389,686	423,480	423,742	423,742	442,000	456,810	470,967
Salaries and wages	359,335	367,584	367,082	388,518	395,263	395,263	404,724	419,507	432,509
Social contributions	20,026	21,481	22,604	34,962	28,479	28,479	37,276	37,303	38,458
Goods and services	79,732	89,189	85,405	109,561	92,071	92,071	121,215	126,589	130,611
Administrative fees	2,759	3,064	2,635	3,987	3,540	3,440	4,169	4,356	4,492
Advertising	6	–	–	6	–	–	6	6	6
Minor assets	117	995	47	510	–	–	532	556	573
Bursaries: Employees	515	–	–	–	–	100	–	–	–
Catering: Departmental activities	2,144	2,819	2,416	1,325	4,911	4,966	1,325	1,325	1,366
Communication (G&S)	254	300	398	621	1,104	1,052	650	680	701
Computer services	–	–	502	19,053	9,000	9,000	19,915	20,811	21,456
Consultants: Business and advisory services	4	–	–	70	70	70	73	76	78
Contractors	–	–	85	–	–	–	–	–	–
Agency and support/outsourced services	4,587	4,047	5,080	4,500	4,500	4,500	4,700	4,976	5,129
Fleet services (incl. government motor transport)	2,015	1,536	1,066	2,070	2,070	2,070	2,165	2,262	2,332
Inventory: Food and food supplies	9,035	7,891	12,732	10,522	10,522	10,522	11,006	11,501	11,858
Inventory: Medical supplies	–	287	–	34	34	34	36	38	39
Consumable supplies	2,055	2,216	2,395	2,563	3,495	3,495	4,380	4,554	4,719
Consumables: Stationery, printing and office supplies	6,812	1,564	3,317	2,506	2,866	2,866	2,621	2,738	2,822
Operating leases	139	112	426	227	227	227	237	248	256
Rental and hiring	39	226	2	4	–	–	4	4	4
Property payments	716	–	1,776	690	4,905	4,905	722	754	777
Travel and subsistence	40,605	54,728	43,902	51,786	34,401	34,372	54,168	56,606	58,363
Training and development	6,096	7,008	6,052	7,605	7,227	7,350	12,955	13,478	13,969
Operating payments	255	1,134	1,455	613	1,992	1,895	642	670	691
Venues and facilities	1,579	1,262	1,119	869	1,207	1,207	909	950	980
Interest and rent on land	–	–	–	–	–	–	–	–	–
Transfers and subsidies	**56,901**	**34,916**	**42,762**	**51,024**	**45,519**	**45,519**	**50,980**	**49,933**	**51,481**
Departmental agencies and accounts	29,526	29,145	30,484	29,985	29,985	29,885	29,963	29,439	30,352
Departmental agencies (non-business entities)	29,526	29,145	30,484	29,985	29,985	29,885	29,963	29,439	30,352
Households	27,375	5,771	12,278	21,039	15,534	15,634	21,017	20,494	21,129
Social benefits	594	845	2,775	559	1,054	1,154	559	559	576
Other transfers to households	26,781	4,926	9,503	20,480	14,480	14,480	20,458	19,935	20,553
Payments for capital assets	**3,210**	**2,105**	**2,055**	**3,175**	**2,017**	**2,017**	**3,320**	**3,469**	**3,577**
Machinery and equipment	3,210	2,105	2,055	3,175	2,017	2,017	3,320	3,469	3,577
Transport equipment	3,077	–	–	–	–	–	–	–	–
Other machinery and equipment	133	2,105	2,055	3,175	2,017	2,017	3,320	3,469	3,577
Payments for financial assets	–	–	–	–	–	–	–	–	–
Total economic classification: Programme 6	**519,204**	**515,275**	**519,908**	**587,240**	**563,349**	**563,349**	**617,515**	**636,801**	**656,636**

7.7. Programme 7: Health Care Support Services

Purpose

Sub- programme 7.1: Laundry services

Rendering a laundry service to hospitals, care and rehabilitation centers and certain local authorities.

Sub-programme 7.2. Engineering Service

Rendering a maintenance service to equipment and engineering installations, and minor maintenance to buildings.

Sub-programme 7.3. Forensic Services

Rendering specialized forensic and medico-legal services in order to establish the circumstances and causes surrounding unnatural death.

Sub-programme 7.4. Orthotic and Prosthetic Services

Rendering specialized orthotic and prosthetic services.

Sub-programme 7.5. Medicine Training Account

Managing the supply of pharmaceuticals and medical sundries to hospitals, Community Health Centres and local authorities

Programme 7: Health Care Support Services

Outputs, Outcomes, Performance Indicators and Targets

Outcome	Outputs	Output Indicator	Audited Performance			Estimated Performance	MTEF Targets		
			2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29
Improved access to affordable and quality healthcare	Maintain EML stock	Percentage Availability of Essential Medicine List (EML) at the Depot	80%	80.3%	75%	90%	90%	90%	90%
		Numerator	-	-	-	230	207	207	207
		Denominator	-	-	-	287	229	229	229
Improved access to equitable healthcare services	Increase number of orthotic and prosthetic devices issued	Number of Orthotic and Prosthetic devices issued	5 710	6 059	Not reported in the APP	4829	5000	5200	5400
		Numerator	-	-	-	4829	5000	5200	5400

Table 25: Programme 7: Health Care Support Services – Outputs, Outcomes, Performance Indicators and Targets

Programme 7: Health Care Support Services

Output Indicators – Annual and Quarterly Targets

Output Indicators	Annual Targets	Q1	Q2	Q3	Q4
Percentage Availability of Essential Medicine List (EML) at the Depot	90%	90%	90%	90%	90%
Numerator	207	207	207	207	207
Denominator	229	229	229	229	229
Number of Orthotic and Prosthetic devices issued	5 000	1 000	1 500	1 500	1 000

Table 26: Programme 7: Health Care Support Services – Output Indicators – Annual and Quarterly Targets

Explanation of planned performance over the medium-term period

The performance outlined directly advances the healthcare priorities captured in the MDTP. The consistent availability of Essential Medicines at the depot — maintaining levels above 75% and targeting 90% supports the priority of improving access to affordable and quality healthcare. Reliable medicine supply strengthens treatment continuity for HIV, TB, maternal health, and chronic diseases, all of which are highlighted as priority intervention areas in the MDTP.

Similarly, the steady increase in orthotic and prosthetic devices issued aligns with the priority of expanding equitable access to healthcare services. By improving mobility and rehabilitation outcomes, the programme contributes to broader goals such as reducing the burden of disease, enhancing patients' quality of life, and supporting inclusive access for people with disabilities. These outputs complement MDTP interventions aimed at strengthening primary healthcare, improving service delivery capacity, and ensuring that vulnerable groups receive appropriate care.

Overall, the performance results demonstrate tangible progress toward the province's mid-term and five-year targets by enhancing service capacity, improving patient access, and supporting the systemic reforms outlined in the MDTP priorities.

Programme Resource considerations.

R thousand	Outcome 2022/23	2023/24	2024/25	Main appropriation	Adjusted appropriation 2025/26	Revised estimate	Medium-term estimates 2026/27	2027/28	2028/29
1. Laundries	44,923	41,781	64,140	41,227	105,707	105,628	62,784	65,369	67,686
2. Engineering	38,182	80,360	88,781	103,969	104,599	104,717	82,919	106,938	102,721
3. Forensic Services	107,726	123,381	110,795	124,300	141,330	141,107	136,473	142,506	139,389
4. Orthotic and Prosthetic Services	7,989	9,073	8,988	9,198	9,198	10,110	9,527	9,873	10,179
5. Medicine Trading Account	83,143	106,078	126,840	128,334	128,334	127,606	134,121	140,154	144,498
Total payments and estimates: Programme 7	**281,963**	**360,673**	**399,544**	**407,028**	**489,168**	**489,168**	**425,824**	**464,840**	**464,473**

Payments and estimates by economic classification.

R thousand	Outcome 2022/23	2023/24	2024/25	Main appropriation	Adjusted appropriation 2025/26	Revised estimate	Medium-term estimates 2026/27	2027/28	2028/29
Current payments	**254,630**	**279,934**	**330,951**	**315,857**	**411,831**	**411,757**	**359,321**	**375,111**	**376,498**
Compensation of employees	141,357	139,902	147,391	160,385	170,275	170,201	176,716	184,549	179,738
Goods and services	113,273	140,032	183,560	155,472	241,556	241,556	182,605	190,562	196,760
Interest and rent on land	–	–	–	–	–	–	–	–	–
Transfers and subsidies	**117**	**396**	**774**	**136**	**136**	**210**	**136**	**136**	**140**
Provinces and municipalities	–	–	–	–	–	–	–	–	–
Departmental agencies and accounts	–	–	–	–	–	–	–	–	–
Higher education institutions	–	–	–	–	–	–	–	–	–
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–
Public corporations and private enterprises	–	–	–	–	–	–	–	–	–
Non-profit institutions	–	–	–	–	–	–	–	–	–
Households	117	396	774	136	136	210	136	136	140
Payments for capital assets	**27,216**	**80,343**	**67,819**	**91,035**	**77,201**	**77,201**	**66,367**	**89,593**	**87,835**
Buildings and other fixed structures	–	–	–	–	–	–	–	–	–
Machinery and equipment	27,216	80,343	67,819	91,035	77,201	77,201	66,367	89,593	87,835
Heritage assets	–	–	–	–	–	–	–	–	–
Specialised military assets	–	–	–	–	–	–	–	–	–
Biological assets	–	–	–	–	–	–	–	–	–
Land and sub-soil assets	–	–	–	–	–	–	–	–	–
Software and other intangible assets	–	–	–	–	–	–	–	–	–
Payments for financial assets	–	–	–	–	–	–	–	–	–
Total economic classification: Programme 7	**281,963**	**360,673**	**399,544**	**407,028**	**489,168**	**489,168**	**425,824**	**464,840**	**464,473**

Transfer and subsidies

R thousand	Outcome 2022/23	2023/24	2024/25	Main appropriation	Adjusted appropriation 2025/26	Revised estimate	Medium-term estimates 2026/27	2027/28	2028/29
Current payments	**254,630**	**279,934**	**330,951**	**315,857**	**411,831**	**411,757**	**359,321**	**375,111**	**376,498**
Compensation of employees	141,357	139,902	147,391	160,385	170,275	170,201	176,716	184,549	179,738
Salaries and wages	123,284	120,653	126,695	137,394	145,306	145,232	150,820	157,512	154,014
Social contributions	18,073	19,249	20,696	22,991	24,969	24,969	25,896	27,037	25,724
Goods and services	113,273	140,032	183,560	155,472	241,556	241,556	182,605	190,562	196,760
Administrative fees	96	18,771	104	7,662	8,006	8,017	8,014	8,374	8,633
Minor assets	42	99	3,050	–	–	–	–	–	–
Catering: Departmental activities	–	30	7	38	103	102	38	38	39
Communication (G&S)	1,282	1,474	1,664	1,467	1,485	1,601	1,534	1,602	1,652
Contractors	4,421	769	4,137	3,839	14,354	14,424	4,016	4,197	4,327
Agency and support/outsourced services	805	2,182	1,333	1,747	897	897	1,827	1,909	1,968
Fleet services (incl. government motor transport)	8,037	7,460	5,583	8,824	8,824	8,619	9,230	9,645	9,944
Inventory: Medical supplies	13,020	25,829	52,366	28,740	29,676	29,676	30,062	31,415	32,389
Inventory: Medicine	54,984	50,968	63,290	75,046	75,046	75,046	78,498	82,030	84,573
Consumable supplies	20,622	23,084	42,229	18,182	87,399	87,399	39,018	40,534	42,081
Consumables: Stationery, printing and office supplies	521	276	182	368	303	77	368	368	380
Operating leases	3,392	3,111	3,166	3,876	3,833	3,813	4,054	4,236	4,367
Property payments	1,780	2,065	1,991	1,240	4,206	4,469	1,297	1,355	1,397
Transport provided: Departmental activity	231	150	2	317	–	–	332	347	358
Travel and subsistence	3,779	3,764	4,094	4,114	6,637	6,628	4,304	4,498	4,638
Operating payments	12	–	362	12	12	12	13	14	14
Venues and facilities	249	–	–	–	775	776	–	–	–
Interest and rent on land	–	–	–	–	–	–	–	–	–
Transfers and subsidies	**117**	**396**	**774**	**136**	**136**	**210**	**136**	**136**	**140**
Households	117	396	774	136	136	210	136	136	140
Social benefits	117	396	774	136	136	210	136	136	140
Payments for capital assets	**27,216**	**80,343**	**67,819**	**91,035**	**77,201**	**77,201**	**66,367**	**89,593**	**87,835**
Machinery and equipment	27,216	80,343	67,819	91,035	77,201	77,201	66,367	89,593	87,835
Transport equipment	–	15,679	–	4,000	4,033	3,849	4,180	4,368	4,503
Other machinery and equipment	27,216	64,664	67,819	87,035	73,168	73,352	62,187	85,225	83,332
Payments for financial assets	–	–	–	–	–	–	–	–	–
Total economic classification: Programme 7	**281,963**	**360,673**	**399,544**	**407,028**	**489,168**	**489,168**	**425,824**	**464,840**	**464,473**

7.8. Programme 8: Health Facilities Management

Purpose

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

Sub-programme 8.1. Community Health Facilities

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

Sub-programme 8.2. Emergency Medical Rescue Services

Construction of new and refurbishment, upgrading and maintenance of existing EMS facilities.

Sub-programe 8.3. District Health Services

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

Sub-programme 8.4. Provincial Hospital Services

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

Sub-programme 8.5. Central Hospital Services

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

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Programme 8: Health Facilities Management

Outputs, Outcomes, Performance Indicators and Targets

Outcome	Outputs	Output Indicator	Audited Performance			Estimated Performance	MTEF Targets		
			2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29
Improved access to quality healthcare services through adequate and functional health infrastructure	Upgrades and additions projects	Number of Infrastructure Upgrades and additions projects completed	4	4	2	2	3	1	2
	New and replacement Infrastructure projects	Number of new and replacement infrastructure projects completed	3	5	4	1	7	5	1
		New and replacement projects under planning	Not required to report	Not required to report	Not required to report	2	7	2	0
		Number of new and replacement infrastructure projects under construction	Not required to report	Not required to report	Not required to report	7	10	1	1
	Improve access to Health care through maintenance of Medical (Lifesaving)equipment	Number of facilities with life-saving equipment serviced	Not required to report	Not required to report	Not required to report	325	325	325	325
	Refurbishment/rehabilitations/repairs (Capital Maintenance)	Number of Primary Health Care facilities under refurbishment/rehabilitations/repairs (Capital Maintenance)	Not required to report	Not required to report	Not required to report	21	6	4	6
	Refurbishment/rehabilitations/repairs (Capital Maintenance)	Number of Hospitals under refurbishment/rehabilitations/repairs (Capital Maintenance)	Not required to report	Not required to report	Not required to report	4	3	3	3

Table 27: Programme 8: Health Facilities Management – Outputs, Outcomes, Performance Indicators and Targets

Programme 8: Health Facilities Management

Output Indicators – Annual and Quarterly Targets

Output Indicators	Annual Targets	Q1	Q2	Q3	Q4
Number of Infrastructure Upgrades and additions projects completed	3	0	0	1	2
Number of new and replacement infrastructure projects completed	7	0	0	3	4
New and replacement projects under planning	7	0	3	4	0
Number of new and replacement infrastructure projects under construction	10	0	5	2	3
Number of facilities with life-saving equipment serviced	325	75	100	100	50
Number of Primary Health Care facilities under refurbishment/rehabilitation/repairs (Capital Maintenance)	6	2	1	1	2
Number of Hospitals under refurbishment/rehabilitations/repairs (Capital Maintenance)	3	0	1	1	1

Table 28: Programme 8: Health Facilities Management – Output Indicators – Annual and Quarterly Targets

Explanation of planned performance over the medium-term period

The performance outlined demonstrates clear progress toward the healthcare priorities presented in the MDTP. The completion of infrastructure upgrades and new replacement projects directly supports the overarching priority of improving access to affordable, quality healthcare services. By delivering upgrade projects and advancing new and replacement facilities, the department strengthens the service platform needed to achieve improved clinical outcomes, such as reduced maternal and neonatal mortality, increased ideal clinic and hospital status attainment, and expanded NHI readiness.

Furthermore, the servicing of life-saving medical equipment across facilities ensures that essential clinical services remain functional and safe, reinforcing MDTP priorities related to strengthening antenatal care, expanding tertiary services, and improving management of communicable and non-communicable diseases. The refurbishment and rehabilitation of both clinics and hospitals also enhance reliability and quality of care, enabling improved patient flow, better infection control, and increased capacity for priority programmes such as immunization, TB treatment success, and HIV retention in care.

Overall, the infrastructure and maintenance performance provides the physical and operational foundation required to deliver the MDTP's targeted improvements in health access, quality, and outcomes.

Programme Resource considerations.

R thousand	Outcome 2022/23	Outcome 2023/24	Outcome 2024/25	Main appropriation 2025/26	Adjusted appropriation 2025/26	Revised estimate 2025/26	Medium-term estimates 2026/27	Medium-term estimates 2027/28	Medium-term estimates 2028/29
1. Community Health Facilities	1,069,518	1,284,253	1,254,199	1,301,414	1,312,994	1,309,786	1,269,368	1,323,215	1,364,235
2. Emergency Medical Rescue Services	–	–	–	–	–	–	–	–	–
3. District Hospital Services	–	–	–	–	–	–	–	–	–
4. Provincial Hospital Services	462,160	470,089	454,218	474,122	474,122	494,653	504,907	430,805	454,407
5. Central Hospital Services	–	–	–	–	–	–	–	–	–
6. Other Facilities	–	–	–	–	–	–	–	–	–
Total payments and estimates: Programme 8	**1,531,678**	**1,754,342**	**1,708,417**	**1,775,536**	**1,787,116**	**1,804,439**	**1,774,275**	**1,754,020**	**1,818,642**

Payments and estimates by economic classification.

R thousand	Outcome 2022/23	Outcome 2023/24	Outcome 2024/25	Main appropriation 2025/26	Adjusted appropriation 2025/26	Revised estimate 2025/26	Medium-term estimates 2026/27	Medium-term estimates 2027/28	Medium-term estimates 2028/29
Current payments	**555,654**	**518,761**	**561,105**	**445,975**	**518,066**	**535,352**	**570,043**	**627,898**	**703,222**
Compensation of employees	36,211	39,693	54,165	74,196	53,313	70,599	92,397	78,792	81,971
Goods and services	519,443	479,068	491,878	371,779	464,753	464,753	477,646	549,106	621,251
Interest and rent on land	–	–	15,062	–	–	–	–	–	–
Transfers and subsidies	**140**	**613**	**97**	**–**	**91**	**128**	**–**	**–**	**–**
Provinces and municipalities	–	–	–	–	–	–	–	–	–
Departmental agencies and accounts	–	–	–	–	–	–	–	–	–
Higher education institutions	–	–	–	–	–	–	–	–	–
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–
Public corporations and private enterprises	–	–	–	–	–	–	–	–	–
Non-profit institutions	–	–	–	–	–	–	–	–	–
Households	140	613	97	–	91	128	–	–	–
Payments for capital assets	**975,884**	**1,234,968**	**1,147,215**	**1,329,561**	**1,268,959**	**1,268,959**	**1,204,232**	**1,126,122**	**1,115,420**
Buildings and other fixed structures	949,877	1,194,013	1,122,163	1,329,561	1,202,357	1,202,357	1,089,192	1,093,582	1,078,435
Machinery and equipment	26,007	40,955	25,052	–	66,602	66,602	115,040	32,540	36,985
Heritage assets	–	–	–	–	–	–	–	–	–
Specialised military assets	–	–	–	–	–	–	–	–	–
Biological assets	–	–	–	–	–	–	–	–	–
Land and sub-soil assets	–	–	–	–	–	–	–	–	–
Software and other intangible assets	–	–	–	–	–	–	–	–	–
Payments for financial assets	–	–	–	–	–	–	–	–	–
Total economic classification: Programme 8	**1,531,678**	**1,754,342**	**1,708,417**	**1,775,536**	**1,787,116**	**1,804,439**	**1,774,275**	**1,754,020**	**1,818,642**

Transfers and subsidies

R thousand	Outcome 2022/23	2023/24	2024/25	Main appropriation	Adjusted appropriation 2025/26	Revised estimate	Medium-term estimates 2026/27	2027/28	2028/29
Current payments	**555,654**	**518,761**	**561,105**	**445,975**	**518,066**	**535,352**	**570,043**	**627,898**	**703,222**
Compensation of employees	36,211	39,693	54,165	74,196	53,313	70,599	92,397	78,792	81,971
Salaries and wages	32,125	34,751	47,798	55,549	36,805	62,991	67,918	55,668	57,931
Social contributions	4,086	4,942	6,367	18,647	16,508	7,608	24,479	23,124	24,040
Goods and services	519,443	479,068	491,878	371,779	464,753	464,753	477,646	549,106	621,251
Administrative fees	78	60	98	219	169	166	229	239	246
Minor assets	1,014	164	366	–	1,939	1,981	10,000	–	–
Catering: Departmental activities	51	29	62	60	60	60	60	60	62
Communication (G&S)	420	520	473	490	490	534	512	535	556
Laboratory services	–	28	–	–	–	5	–	–	–
Contractors	23,638	25,323	39,472	23,752	36,425	35,524	21,000	13,585	14,000
Agency and support/outsourced services	–	6,297	19,753	–	–	–	–	–	–
Fleet services (incl. government motor transport)	–	–	1	–	–	86	–	–	–
Inventory: Medical supplies	892	3,619	1,624	–	–	–	–	–	–
Inventory: Medicine	–	–	–	–	–	136	–	–	–
Consumable supplies	168,748	143,642	166,862	144,886	134,804	134,804	200,119	204,941	206,416
Consumables: Stationery, printing and office supplies	425	–	29	–	150	150	–	–	–
Operating leases	16,868	17,932	18,359	19,998	26,998	26,998	23,228	25,551	28,106
Rental and hiring	–	–	277	–	–	41	–	–	–
Property payments	302,712	277,277	238,465	176,840	257,890	257,890	212,766	299,045	366,516
Travel and subsistence	4,537	4,106	5,783	4,400	4,977	5,483	4,627	4,835	5,020
Training and development	18	28	205	1,134	551	551	5,105	315	329
Operating payments	–	43	49	–	–	44	–	–	–
Venues and facilities	42	–	–	–	300	300	–	–	–
Interest and rent on land	–	–	15,062	–	–	–	–	–	–
Interest (Incl. interest on unitary payments (PPP))	–	–	15,062	–	–	–	–	–	–
Transfers and subsidies	**140**	**613**	**97**	**–**	**91**	**128**	**–**	**–**	**–**
Households	140	613	97	–	91	128	–	–	–
Social benefits	140	613	97	–	91	128	–	–	–
Payments for capital assets	**975,884**	**1,234,968**	**1,147,215**	**1,329,561**	**1,268,959**	**1,268,959**	**1,204,232**	**1,126,122**	**1,115,420**
Buildings and other fixed structures	949,877	1,194,013	1,122,163	1,329,561	1,202,357	1,202,357	1,089,192	1,093,582	1,078,435
Buildings	949,877	1,194,013	1,122,163	1,329,561	1,202,357	1,202,357	1,089,192	1,093,582	1,078,435
Machinery and equipment	26,007	40,955	25,052	–	66,602	66,602	115,040	32,540	36,985
Transport equipment	6,712	58	–	–	–	–	8,100	8,100	8,100
Other machinery and equipment	19,295	40,897	25,052	–	66,602	66,602	106,940	24,440	28,885
Payments for financial assets	–	–	–	–	–	–	–	–	–
Total economic classification: Programme 8	**1,531,678**	**1,754,342**	**1,708,417**	**1,775,536**	**1,787,116**	**1,804,439**	**1,774,275**	**1,754,020**	**1,818,642**

Updated key risks and mitigations from the Strategic Plan

Table 29: Updated Key Risks and Mitigations from the Strategic Plans

Outcomes	Risk Description	Contributory factors	Risk Mitigation Measures
Financial Management strengthened in the health sector	Inadequate financial management	1. Inadequate human resource capacity. 2. Inadequate training 3. Inadequate financial systems	1. Filing of vacant funded posts. 2. Develop and implement financial management training plan. 3. Integrate PEIS with speed point.
Improved access to equitable healthcare services National Health Insurance awareness improved Improved access to affordable and quality healthcare	Poor quality of healthcare services	1. Shortage of skilled personnel 2. Shortage of medical equipment 3. Inadequate and dilapidated infrastructure 4. Incomplete package of healthcare services at all levels	1. Filling of funded vacant posts 2. Procurement of medical equipment as per the approved plan 3. Implementation of infrastructure plan 4. Develop and implement a plan to enhance expanded healthcare services at all levels
Improved responsiveness to community needs	Lack of community involvement and participation	1. Non-functional of governance structures 2. Poor implementation of communication strategy 3. Inadequate health promotion activities	1. Develop and implement training plan 2. Review and implement the communication strategy 3. Develop and implement health promotion plan
Reduced burden of disease	Inadequate health promotion	1. Shortage of staff 2. Insufficient coverage of ward-based outreach teams	1. Filling of funded vacant posts 2. Expand coverage of ward-based outreach teams
HIV and AIDS related deaths reduced TB Mortality reduced	Increased new infections of HIV and TB	1. Inadequate awareness 2. High rates of loss to follow up among patients receiving HIV & AIDS and TB treatment	1. Utilise CHWs for follow up of patients receiving HIV and TB treatment 2. 90% of stable patients to be on CCMDD
Improved maternal and child health	Maternal and child morbidity and mortality	1.Late booking for antenatal care. 2. High teenage pregnancy. 3. Shortage of specialised skills on Obstetrics & Gynaecology, Paediatrics, Family Medicine, Advanced midwifery and newborn care. 4. Limited resources e.g. (Medical equipment, neonatal ICU) 5. Inadequate mentoring and coaching of healthcare professionals 6. Inadequate clinical skills and experience. 7. Inadequate uptake of Sexual and Reproductive Health services	1.1. Conduct community awareness campaigns during open days 1.2. Monitor the implementation of routine pregnancy testing. 2.1. Activation of AYFS (Adolescent and Youth Friendly Services) in facilities 2.2. Conduct community awareness campaigns during open days 3.1. Appointment of identified DCST (District Clinical Specialist Team). 3.2. Training of advanced midwives at identified CHC's (Community Health Centres). 4.Submit Identified resources for procurement (e.g. medical equipment, neonatal ICU) 5.1. Create a database of healthcare professional

			mentors 5.2. Identify newly appointed healthcare professionals for coaching and mentoring 6.Training of newly qualified and inadequately skilled clinicians. 7.1. Training of healthcare workers on Sexual and Reproductive Health services 7.2 Conduct onsite mentoring and coaching for at least six facilities providing SRHR services. 7.3. Expand second trimester Choice on Termination of Pregnancy (CTOP), one facility per district 7.4. Conduct value clarification training for Health facility managers in all facilities.
Improved access to School health programme	Shortage of school health teams	1. Inadequate budget	1. Prioritise funding for appointment of school health teams
Improved access to Youth health programme	Inadequate access to healthcare services	1. Shortage of space	1. Implementation of the maintenance plan
Malaria related deaths reduced	Inadequate management of malaria cases	1. Late Presentation at Healthcare facilities 2. Poor case management 3. Cross border movement due to porous borders	1. Conduct awareness campaigns 2. Capacity building of healthcare professionals 3. Revive the cross-border MOUs
Mortality due to NCDs reduced Mental health care integrated in Primary Health Care	Poor management of Mental Health Care Users in primary health care.	1. Inadequate multi-disciplinary team (MDT) 2. Inadequate skilled personnel (forensic and child Psychiatrists, Clinical Psychologists, Advanced Psychiatric nurses, Occupational Therapists and Social Workers) 3. Lack of community based mental health facilities 4. Lack of District Specialist Mental Health Teams 5.Lack of Specialised Mental Health Hospitals. 6. Inadequate training in mental health care Act. 7. Inability to appoint the Director for mental health as per the National mental health policy framework and strategic plan - 2023-2030 as well as the deputy manager for unit	1. Appointment of dedicated multi-disciplinary team (MDT) in all designated hospitals 2. Participation in clinical brief planning and monitoring of progress on infrastructure construction of mental health facilities 3. Conduct awareness campaign programmes, radio slots, health education and provide detox services. 4. Construction of 3 inpatients units in the 3 identified hospitals (Mapulaneng, KwaMhlanga, and Mpumalanga specialised psychiatrist hospitals). 5. Appointment of District specialist mental health teams 6.Establish a functional mental health inspection team
Health infrastructure optimised for delivery of care	Inadequate and dilapidated infrastructure	1. Inadequate roll out of the costed plans 2. Aging infrastructure 3. Non-compliance with applicable legislation	1. Reviewing and implement infrastructure assets management plan 2. Monitor and implement the assets management plan
Management of patient safety incidents improved	Poor quality of healthcare services	1. Inadequate skilled personnel 2. Inadequate supervision of personnel 3. Inadequate implementation of clinical guidelines and protocols	1&4 Develop and implement training plan 2. Implement consequence management 3. Conduct clinical audits and implement QIPs

		4. Inadequate implementation of complaints and PSI incidents guidelines	
Early warning and response strengthened	Inappropriate management and control of outbreaks	1. Inadequate of functional of outbreak response team 2. Poor coordination 3. Inadequate skills	1. Establish and appoint of functional of outbreak response team 2. Establish public health emergency operation centre 3. Capacity building of health professionals
Employment in line with equity targets	Inability to appoint targeted groups	1. Inadequate awareness on gender and transformation policies 2. Inadequate of clear equity plan targets 3. Inadequate implementation of Gender Equality and Job Access Strategic Frameworks 4.Non-functional employment equity forum/committees	1. Prioritise awareness workshops on gender and transformation policies 2. Review and implement the equity plan 3. Establishment of Gender management systems forums (Women, Men and Disability) 4. Establish and Revive employment equity fora/committees

Public Entities

Not applicable

Key Infrastructure Projects

Table 30: Key Infrastructure Projects

No	Project name	Programme	Description	Output	Start date Contractual	Completion date Contractual	Total estimated project cost	Expenditure To date 2025/26	Current year Budget 2026/27
UPGRADING AND ADDITIONS									
1	Siyabuswa CHC – Upgrades and additions to the existing facility	8	Upgrades and additions to the existing facility	Upgraded maternity ward	19/09/2025	20/09/2027	R 77,451,440	0	R41,000,000
2	KwaMhlanga Hospital – Construction of the new Martenity Ward	8	Construction of the new Martenity Ward	Upgraded maternity ward	06/02/2024	22/01/2027	R 445,379,525	R 90,687,482	R 65,899,000
3	Matikwane Hospital: Renovations of interior of Maternity Ward (Phase 1B)	8	Renovations of interior of Maternity Ward (Phase 1B)	Upgraded maternity ward	07/10/2025	31/10/2026	R 10,000,000	R 4,609,309	R 10,000,000
4	Matikwane Hospital: Renovations of interior of Paediatric Ward (Phase 1C) – Maternity wards	8	Renovations of interior of Paediatric Ward (Phase 1C) – Maternity wards	Upgraded Paediatric ward	07/10/2025	31/03/2026	R 7,600,000	R 4,313,921	R 7,600,000
NEW AND REPLACEMENT									

No	Project name	Programme	Description	Output	Start date Contractual	Completion date Contractual	Total estimated project cost	Expenditure To date 2025/26	Current year Budget 2026/27
HOSPITAL PROGRAMME									
1	Linah Malatjie Tertiary Hospital	8	Planning, design and construction of the proposed New Linah Malatjie Tertiary Hospital	A Tertiary Hospital	TBC	TBC	TBC	R 6,557,742	R 136,632,000
2	Mpumalanga Psychiatric Hospital	8	Planning, design and construction of the proposed Mpumalanga Psychiatric Hospital	A Psychiatric Hospital	TBC	TBC	TBC	R2,225,687	R 50,836,000
PRIMARY HEALTH CARE (PHC) FACILITIES									
1	Langkloof clinic – Construction of a new clinic	8	Construction of a new clinic	A Clinic	09/09/2025	26/06/2026	R19,321,950	R2,439,997	R 15,000,000
2	Alexander clinic – Construction of a new clinic	8	Construction of a new clinic	A Clinic	29/08/2025	29/07/2026	R21,354,287	0	R 12,000,000

No	Project name	Programme	Description	Output	Start date Contractual	Completion date Contractual	Total estimated project cost	Expenditure To date 2025/26	Current year Budget 2026/27
3	Lebohang clinic – Construction of a new clinic	8	Construction of a new clinic	A Clinic	29/08/2025	29/06/2026	R19,557,302	R 1,060,722	R 15,000,000
4	Lefiswane clinic – Construction of a new clinic	8	Construction of a new clinic	A Clinic	29/08/2025	29/06/2026	R19,083,280	R 339,479	R 15,000,000
5	Barberton clinic – Construction of a new clinic	8	Construction of a new clinic	A Clinic	17/09/2025	17/06/2026	R17,670,752	R2,874,808.72	R 15,000,000
6	Vezubuhle clinic – Construction of a new clinic	8	Construction of a new clinic	A Clinic	10/09/2025	25/06/2026	R17,193,202	0	R 15,000,000
7	Kinross clinic – Construction of a new clinic	8	Construction of a new clinic	A Clinic	22/09/2025	22/06/2026	R17,111,711	0	R 15,000,000
8	MN Cindi Clinic - Construction of new clinic	8	Construction of a new clinic	A Clinic	16/10/2024	30/06/2026	R 46,625,120	R8,676,983	R 28,000,000
	Dumphries Clinic – Construction of a new clinic	8	Construction of a new clinic	A Clinic	16/10/2024	30/06/2026	R 35,843,678	R 30,295,239	R 5,000,000

Public-Private Partnerships (PPPs)

- DONATIONS

Construction of Reitkuil clinic in Steve Tshwete municipality in partnership with Tshikululu Trust.

PART D: TECHNICAL INDICATOR DESCRIPTION (TIDS) FOR ANNUAL PERFORMANCE PLAN

Programme 1: Administration Technical Indicator Descriptions for Annual Performance Plan

Table 31: Programme 1: Administration Technical Indicator Descriptions for Annual Performance Plan

INDICATOR TITLE	Audit opinion of Provincial DoH
Definition	Audit opinion for Provincial Departments of Health for financial performance
Source of data	Auditor General Report Management report
Method of calculation / assessed	Audit outcome for regulatory audit expressed by AGSA for 2025/26 financial year
Means of verification	N/A
Assumptions	N/A
Disaggregation of beneficiaries	N/A
Spatial transformation	All Districts
Calculation type	Annual
Reporting Cycle	Annual
Desired Performance	Unqualified audit opinion
Indicator responsibility	Chief Financial Officer
Notes	The audit opinion expressed for a particular financial year refers to the audit outcome for the previous financial year.

INDICATOR TITLE	Percentage of women appointed in Senior Management positions
Definition	Number of women that are employed within the Department in Senior Management positions.
Source of data	PERSAL System
Method of calculation / assessed	Number of women appointed in senior management positions/ total number of employed persons in senior management
Means of verification	PERSAL System
Assumptions	Women apply for advertised vacancies

INDICATOR TITLE	Percentage of women appointed in Senior Management positions
Disaggregation of beneficiaries	Women
Spatial transformation	N/A
Calculation type	Cumulative year-to-date
Reporting Cycle	Quarterly
Desired Performance	Higher
Indicator responsibility	Human Resources
Notes	N/A

INDICATOR TITLE	Percentage of persons with disabilities appointed across all levels
Definition	Number of persons with disability appointed in the Department
Source of data	PERSAL System
Method of calculation / assessed	Number of persons with disability appointed in the Department / total number employed
Means of verification	PERSAL System
Assumptions	Persons with disabilities apply for advertised vacancies
Disaggregation of beneficiaries	N/A
Spatial transformation	N/A
Calculation type	Cumulative year-to-date
Reporting Cycle	Quarterly
Desired Performance	Higher
Indicator responsibility	Human Resources
Notes	

INDICATOR TITLE	Percentage of youth appointed
Definition	Number of youths aged less than 35 employed in the Public Sector
Source of data	PERSAL System
Method of calculation / assessed	Number of youth appointed in the Department/ total number employed
Means of verification	PERSAL System
Assumptions	N/A
Disaggregation of beneficiaries	N/A
Spatial transformation	N/A
Calculation type	Cumulative year-to-date
Reporting Cycle	Quarterly
Desired Performance	Higher
Indicator responsibility	Human Resources
Notes	

Table 34: Programme 1: Administration Technical Indicator Descriptions for Annual Performance Plan

Programme 2: District Health Services Primary Health Care Technical Indicator Descriptions for Annual Performance Plan

Table 32: Programme 2: District Health Services Primary Health Care Technical Indicator Descriptions for Annual Performance Plan

INDICATOR TITLE	Patient Experience of Care Survey Rate (PHC)
Definition	Fixed health facilities that have conducted Patient Experience of Care Surveys as a proportion of fixed primary health care and community health facilities.
Source of data	DHIS/Patient Surveys
Method of calculation / assessed	Facility Patient Experience of Care survey done/(Fixed PHC clinics +Fixed CHCs)
Means of verification	Patient Surveys
Assumptions	Accuracy dependent on quality of data submitted by health facilities
Disaggregation of beneficiaries	Not Applicable
Spatial transformation	All Districts
Calculation type	Cumulative (year-to-date)
Reporting Cycle	Annual
Desired Performance	Higher satisfaction survey rate
Indicator responsibility	Quality Assurance
Notes	

INDICATOR TITLE	Patient Experience of Care Survey Rate (District Hospitals)
Definition	Fixed health facilities that have conducted Patient Experience of Care Surveys as a proportion of District Hospitals
Source of data	Patient Surveys
Method of calculation / assessed	Facility PEC Survey done/Fixed district hospitals
Means of verification	Patient Surveys
Assumptions	Accuracy dependent on quality of data submitted by health facilities
Disaggregation of beneficiaries	Not Applicable
Spatial transformation	All Districts
Calculation type	Cumulative (year-to-date)
Reporting Cycle	Annual
Desired Performance	Higher satisfaction survey rate
Indicator responsibility	Quality Assurance
Notes	

Programme 2: District Health Services HAST Technical Indicator Descriptions for Annual Performance Plan

Table 33: Programme 2: District Health Services HAST Technical Indicator Descriptions for Annual Performance Plan

INDICATOR TITLE	Number of DS-TB treatment start under 5 years
Definition	Child under 5 years who were started on DS-TB treatment.
Source of data	DHIS/TB Identification register
Method of calculation / assessed	DS-TB treatment start under 5 years of age
Means of verification	DHIS
Assumptions	Accuracy dependent on quality of data submitted by health facilities
Disaggregation of beneficiaries	Not Applicable
Spatial transformation	All Districts
Calculation type	Cumulative (year-to-date)
Reporting Cycle	Quarterly
Desired Performance	Higher
Indicator responsibility	TB Programme Manager
Notes	

INDICATOR TITLE	Number of DS-TB treatment start 5 years and older
Definition	Clients 5 years and older who were started on DS-TB treatment
Source of data	DHIS/TB Identification register
Method of calculation / assessed	DS-TB treatment start 5 years and older
Means of verification	DHIS
Assumptions	Accuracy dependent on quality of data submitted by health facilities

INDICATOR TITLE	Number of DS-TB treatment start 5 years and older
Disaggregation of beneficiaries	Not Applicable
Spatial transformation	All Districts
Calculation type	Cumulative (year-to-date)
Reporting Cycle	Quarterly
Desired Performance	Higher numbers
Indicator responsibility	TB Programme Manager
Notes	

INDICATOR TITLE	Number of TB Rifampicin resistant/Multidrug-Resistant confirmed client start on treatment
Definition	TB Rifampicin resistant (RR) and or Multidrug - Resistant (MDR) TB clients started on treatment
Source of data	EDRWeb
Method of calculation / assessed	TB Rifampicin Resistant/Multidrug Resistant confirmed start on treatment
Means of verification	EDRWeb
Assumptions	Accuracy dependent on quality of data submitted by health facilities
Disaggregation of beneficiaries	Accuracy dependent on quality of data submitted by health facilities
Spatial transformation	All Districts
Calculation type	Cumulative (year-to-date)
Reporting Cycle	Quarterly
Desired Performance	Quarterly
Indicator responsibility	TB Programme Manager
Notes	

INDICATOR TITLE	TB Rifampicin resistant/Multidrug – Resistant treatment success rate
Definition	TB Rifampicin Resistant-Multidrug Resistant clients successfully completed treatment as a proportion of TB Rifampicin Resistant/Multidrug Resistant clients started on treatment.
Source of data	EDRWeb
Method of calculation / assessed	(TB Rifampicin Resistant + Multidrug Resistant successfully completed treatment)/ TB Rifampicin Resistant-Multidrug Resistant client started on treatment
Means of verification	EDRWeb
Assumptions	Accuracy dependent on quality of data submitted by health facilities
Disaggregation of beneficiaries	Not Applicable
Spatial transformation	All District
Calculation type	Cumulative (year-to-date)
Reporting Cycle	Quarterly
Desired Performance	Higher success rate
Indicator responsibility	TB Programme Manager
Notes	

INDICATOR TITLE	All DS-TB Client Treatment Success Rate
Definition	ALL TB clients who started drug-susceptible tuberculosis (DS-TB) treatment and subsequently successfully completed treatment as a proportion of ALL those who started DS-TB treatment
Source of data	DHIS
Method of calculation / assessed	All DS-TB client successfully completed treatment/ All DS-TB treatment start
Means of verification	DHIS
Assumptions	Accuracy dependent on quality of data submitted by health facilities

INDICATOR TITLE	All DS-TB Client Treatment Success Rate
Disaggregation of beneficiaries	Not Applicable
Spatial transformation	All Districts
Calculation type	Cumulative (year-to-date)
Reporting Cycle	Quarterly
Desired Performance	Higher success rate
Indicator responsibility	TB Programme Manager
Notes	

INDICATOR TITLE	All DS-TB client lost to follow up rate
Definition	ALL TB clients who started drug-susceptible tuberculosis (DS-TB) treatment and who were subsequently lost to follow-up as a proportion of all those who started DS-TB treatment
Source of data	DHIS
Method of calculation / assessed	All DS-TB client loss to follow-up / All DS TB treatment start
Means of verification	DHIS
Assumptions	Accuracy dependent on quality of data submitted by health facilities
Disaggregation of beneficiaries	Not Applicable
Spatial transformation	All Districts
Calculation type	Cumulative (year-to-date)
Reporting Cycle	Quarterly
Desired Performance	Lower lost to follow up rate
Indicator responsibility	TB Programme Manager
Notes	

INDICATOR TITLE	TB Rifampicin resistant/Multidrug Resistant lost to follow-up rate
Definition	TB Rifampicin Resistant/Multidrug Resistant client's loss to follow-up as a proportion of TB Rifampicin Resistant/Multidrug Resistant clients started on treatment
Source of data	EDRWeb
Method of calculation / assessed	TB Rifampicin Resistant/Multidrug Resistant client's loss to follow-up/ TB Rifampicin Resistant/Multidrug Resistant client started on treatment
Means of verification	EDRWeb
Assumptions	Accuracy dependent on quality of data submitted by health facilities
Disaggregation of beneficiaries	Not Applicable
Spatial transformation	All Districts
Calculation type	Cumulative (year-to-date)
Reporting Cycle	Quarterly
Desired Performance	Lower lost to follow up rate
Indicator responsibility	TB Programme Manager
Notes	

INDICATOR TITLE	Number of clients tested using TB NAAT
Definition	TB symptomatic and asymptomatic clients who was tested using TB Nucleic Acid Amplification Test (NAAT)
Source of data	DHIS
Method of calculation / assessed	TB test under 5 years using TB Nucleic Acid Amplification Test (NAAT) + TB test 5 years and older using TB Nucleic Acid Amplification Test (NAAT)
Means of verification	TB identification register
Assumptions	Accuracy dependent on quality of data submitted by health facilities.

INDICATOR TITLE	Number of clients tested using TB NAAT
Disaggregation of beneficiaries	N/A
Spatial transformation	All District
Calculation type	Cumulative (year-to-date)
Reporting Cycle	Quarterly
Desired Performance	Higher number of people tested
Indicator responsibility	TB Programme manager
Notes	

INDICATOR TITLE	Infant PCR test around 6 months uptake rate
Definition	PCR Test done around 6 months as a proportion of live births to HIV positive mothers
Source of data	DHIS
Method of calculation / assessed	Infant PCR test around 6 months / Live births to HIV positive mothers (live births to HIV positive mothers subtract/minus (PCR test positive at birth+ PCR test positive around 10 weeks))
Means of verification	PHC Comprehensive Tick Register, Paediatric Register, Tier.Net
Assumptions	Accuracy dependent on quality of data submitted by health facilities
Disaggregation of beneficiaries	Children
Spatial transformation	All Districts
Calculation type	Cumulative (year-to-date)
Reporting Cycle	Quarterly
Desired Performance	Higher Uptake
Indicator responsibility	PMTCT Programme
Notes	

INDICATOR TITLE	HIV positive 5-14 years (excl ANC) rate
Definition	Children 5 to 14 years who tested HIV positive as a proportion of children who were tested for HIV in this age group
Source of data	PHC Comprehensive Tick Register
Method of calculation / assessed	HIV positive 5-14 years (excl ANC)/ HIV test 5-14 years (excl ANC)
Means of verification	PHC Comprehensive Tick Register
Assumptions	Accuracy dependent on quality of data submitted by health facilities
Disaggregation of beneficiaries	Children
Spatial transformation	All Districts
Calculation type	Cumulative (year-to-date)
Reporting Cycle	Quarterly
Desired Performance	Lower rate
Indicator responsibility	PMTCT Programme
Notes	

INDICATOR TITLE	HIV positive 15-24 years (excl ANC) rate
Definition	Adolescents and youth 15 to 24 years who tested HIV positive as a proportion of those who were tested for HIV in this age group
Source of data	HTS Register (HIV Testing Services) or HTS module in TIER.Net,
Method of calculation / assessed	HIV positive 15-24 years (excl ANC)/ HIV test 15-24 years (excl ANC
Means of verification	HTS Register (HIV Testing Services) or HTS module in TIER.Net,
Assumptions	Accuracy dependent on quality of data submitted by health facilities

INDICATOR TITLE	HIV positive 15-24 years (excl ANC) rate
Disaggregation of beneficiaries	Youth
Spatial transformation	All Districts
Calculation type	Cumulative (year-to-date)
Reporting Cycle	Quarterly
Desired Performance	Lower rate
Indicator responsibility	HIV/ AIDS Programme manager
Notes	

INDICATOR TITLE	ART adult remain in care rate (12 months)
Definition	ART adult remain in care - total as a proportion of ART adult start minus cumulative transfer out
Source of data	DHIS
Method of calculation / assessed	ART adult remain in care – total/ ART adult start minus cumulative transfer out
Means of verification	DHIS, TIER.Net
Assumptions	Accuracy dependent on quality of data submitted by health facilities
Disaggregation of beneficiaries	Not Applicable
Spatial transformation	All Districts
Calculation type	Cumulative (year-to-date)
Reporting Cycle	Quarterly
Desired Performance	Higher rates
Indicator responsibility	HIV/ AIDS Programme manager
Notes	

INDICATOR TITLE	ART child remain in care rate [12 months]
Definition	ART child remain in care - total as a proportion of ART child start minus cumulative transfer out
Source of data	DHIS
Method of calculation / assessed	ART child remain in care – total/ ART child start minus cumulative transfer out
Means of verification	DHIS; TIER.Net;
Assumptions	Accuracy dependent on quality of data submitted by health facilities
Disaggregation of beneficiaries	Children and adolescent
Spatial transformation	All Districts
Calculation type	Cumulative (year-to-date)
Reporting Cycle	Quarterly
Desired Performance	Higher rates
Indicator responsibility	HIV/ AIDS Programme manage
Notes	

INDICATOR TITLE	ART Adult viral load suppressed rate (below 50) [12 months]
Definition	ART adult viral load under 50 as a proportion of ART adult viral load done at 12 months
Source of data	DHIS
Method of calculation / assessed	ART adult viral load under 50 (at 12 months)/ ART child viral load done (at 12 months)
Means of verification	DHIS; TIER.Net;
Assumptions	Accuracy dependent on quality of data submitted by health facilities
Disaggregation of beneficiaries	Not Applicable

INDICATOR TITLE	ART Adult viral load suppressed rate (below 50) [12 months]
Spatial transformation	All District
Calculation type	Cumulative (year-to-date)
Reporting Cycle	Quarterly
Desired Performance	Higher suppressed rate
Indicator responsibility	HIV/ AIDS Programme manager
Notes	

INDICATOR TITLE	ART child viral load suppressed rate (below 50) [12 months]
Definition	ART child viral load under 50 as a proportion of ART child viral load done at 12 months
Source of data	DHIS
Method of calculation / assessed	ART child viral load under 50 (at 12 months)/ ART child viral load done (at 12 months)
Means of verification	DHIS; TIER.Net
Assumptions	Accuracy dependent on quality of data submitted by health facilities
Disaggregation of beneficiaries	Children and adolescent
Spatial transformation	All District
Calculation type	Cumulative (year-to-date)
Reporting Cycle	Quarterly
Desired Performance	Higher suppressed rate
Indicator responsibility	HIV/ AIDS Programme manager
Notes	

Programme 2: District Health Services MWCHN Technical Indicator Descriptions for Annual Performance Plan

Table 34: Programme 2: District Health Services MWCHN Technical Indicator Descriptions for Annual Performance Plan

INDICATOR TITLE	Maternal Mortality in facility Ratio
Definition	Maternal death is death occurring during pregnancy, childbirth and the puerperium of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy and irrespective of the cause of death (obstetric and non-obstetric) per 100,000 live births in facility
Source of data	DHIS
Method of calculation / assessed	Maternal death in facility / Live births known to facility [Live birth in facility + Born alive before arrival at facility] per 100 000
Means of verification	Maternal death register (Maternal Morbidity and Mortality Audit System), Birth Register, Labour, Combined and Postnatal ward Health Facility Register, DHIS
Assumptions	Accuracy dependent on quality of data submitted by health facilities
Disaggregation of beneficiaries	Females
Spatial transformation	All Districts
Calculation type	Cumulative (year-to-date)
Reporting Cycle	Quarterly
Desired Performance	Lower rates
Indicator responsibility	MCWH&N Programme
Notes	

INDICATOR TITLE	Neonatal (<28 days) death in facility rate
Definition	Infants 0-28 days who died during their stay in the facility per 1000 live births in facility
Source of data	DHIS
Method of calculation / assessed	Neonatal deaths (under 28 days) in facility/ Live birth in facility
Means of verification	Birth Register, Labour, Combined and Postnatal ward Health Facility Register

INDICATOR TITLE	Neonatal (<28 days) death in facility rate
Assumptions	Accuracy dependent on quality of data submitted by health facilities
Disaggregation of beneficiaries	Children
Spatial transformation	All Districts
Calculation type	Cumulative (year-to-date)
Reporting Cycle	Quarterly
Desired Performance	Lower rates
Indicator responsibility	MCWH&N Programme
Notes	

INDICATOR TITLE	Death under 5 years against live birth rate
Definition	Children under 5 years who died during their stay in the facility as a proportion of all live births
Source of data	DHIS
Method of calculation / assessed	Death in facility under 5 years total [in DHS and Referral Hospitals]/ Live birth in facility [in DHS and Referral Hospitals]
Means of verification	Birth Register, Labour, Combined and Postnatal ward Health Facility Register
Assumptions	Accuracy dependent on quality of data submitted by health facilities
Disaggregation of beneficiaries	Children
Spatial transformation	All District
Calculation type	Cumulative (year to date)
Reporting Cycle	Quarterly
Desired Performance	Lower rate
Indicator responsibility	MCWH&N Programme

INDICATOR TITLE	Death under 5 years against live birth rate
Notes	

INDICATOR TITLE	Number of Grade R learners screened
Definition	Grade R learners in the school screened by a nurse in line with the Integrated School Health Programme service package. This excludes follow up visits and referrals, and each learner should be counted only once per school year
Source of data	DHIS
Method of calculation / assessed	Number of Grade R learners screened/ No Denominator
Means of verification	School Health Tick Register
Assumptions	Accuracy dependent on quality of data submitted
Disaggregation of beneficiaries	Children
Spatial transformation	All Districts
Calculation type	Cumulative (Year-end)
Reporting Cycle	Quarterly
Desired Performance	A higher number of Grade R learners screened
Indicator responsibility	MCHW&N Programme
Notes	

INDICATOR TITLE	Couple Year Protection Rate
Definition	Women protected against pregnancy by using modern contraceptive methods, including sterilisations, as proportion of female population 15-49 years.
Source of data	DHIS
Method of calculation / assessed	Couple Year Protection/ Population 15-49 years females

INDICATOR TITLE	Couple Year Protection Rate
Means of verification	PHC Comprehensive Tick Register Health Facility Registers, DHIS, Condom Warehouse Register
Assumptions	Accuracy dependent on quality of data submitted by health facilities
Disaggregation of beneficiaries	Females
Spatial transformation	All districts
Calculation type	Cumulative (year-to-end)
Reporting Cycle	Quarterly
Desired Performance	Higher rates
Indicator responsibility	MCYWH&N Programme
Notes	

INDICATOR TITLE	Antenatal 1st visit before 20 weeks rate
Definition	Women who have a first booking visit before they are 20 weeks into their pregnancy as proportion of all antenatal 1st visits
Source of data	DHIS
Method of calculation / assessed	Antenatal 1st visit before 20 weeks/ Antenatal 1st visit - total
Means of verification	PHC/CHC Comprehensive Tick Register
Assumptions	Accuracy dependent on quality of data submitted by health facilities
Disaggregation of beneficiaries	Females
Spatial transformation	All Districts
Calculation type	Cumulative (year to date)
Reporting Cycle	Quarterly

INDICATOR TITLE	Antenatal 1st visit before 20 weeks rate
Desired Performance	Higher rates
Indicator responsibility	MCWH&N Programme
Notes	

INDICATOR TITLE	Mother postnatal visit within 6 days rate
Definition	Mothers who received postnatal care within 6 days after delivery as proportion of deliveries in health facilities
Source of data	DHIS
Method of calculation / assessed	Mother postnatal visit within 6 days after delivery/ Delivery in facility total
Means of verification	PHC/CHC Comprehensive Tick Register; Health Facility Register,
Assumptions	Accuracy dependent on quality of data submitted by health facilities
Disaggregation of beneficiaries	Females
Spatial transformation	All Districts
Calculation type	Cumulative (year-to-date)
Reporting Cycle	Quarterly
Desired Performance	Higher rates
Indicator responsibility	MCWH&N Programme
Notes	

INDICATOR TITLE	Immunisation under 1-year coverage
Definition	Children under 1 year who completed their primary course of immunization as a proportion of population under 1 year
Source of data	DHIS

INDICATOR TITLE	Immunisation under 1-year coverage
Method of calculation / assessed	Immunized fully under 1 year new/ Population under 1 year
Means of verification	PHC Comprehensive Tick Register Stats SA
Assumptions	Accuracy dependent on quality of data submitted by health facilities
Disaggregation of beneficiaries	Children
Spatial transformation	All District
Calculation type	Cumulative (year-to-date)
Reporting Cycle	Quarterly
Desired Performance	Higher coverage
Indicator responsibility	EPI Programme manager
Notes	

INDICATOR TITLE	MR 2nd dose 1 year coverage
Definition	Children 12 months old who received MR 2nd dose, as a proportion of the 1-year population.
Source of data	DHIS
Method of calculation / assessed	MR 2nd dose / Target population 1 year (female 1 year+ male 1 year)
Means of verification	PHC Comprehensive Tick Register, Hospital Paediatric Register
Assumptions	Accuracy dependent on quality of data submitted by health facilities
Disaggregation of beneficiaries	Children
Spatial transformation	All District
Calculation type	Cumulative (year-to-end)

INDICATOR TITLE	MR 2nd dose 1 year coverage
Reporting Cycle	Quarterly
Desired Performance	Higher
Indicator responsibility	EPI Programme manager
Notes	

INDICATOR TITLE	Child under 5 years severe acute malnutrition case fatality rate
Definition	Severe acute malnutrition deaths in children under 5 years as a proportion of severe acute malnutrition (SAM) under 5 years in health facilities
Source of data	DHIS
Method of calculation / assessed	Severe acute malnutrition (SAM) death under 5 years/ Severe acute malnutrition inpatient separation under 5 years
Means of verification	DHIS
Assumptions	Accuracy dependent on quality of data submitted by health facilities
Disaggregation of beneficiaries	Children
Spatial transformation	All Districts
Calculation type	Cumulative (year-to-date)
Reporting Cycle	Quarterly
Desired Performance	Lower rates
Indicator responsibility	MCWH&N Programme
Notes	

INDICATOR TITLE	Cervical cancer screening coverage
Definition	Cervical smears in women 30 years and older as a proportion of the female population 30-50 years (80% of these women should be screened for cervical cancer every 10 years and 20% must be screened every 3 years) which should be included in the denominator because it is estimated that 20% of women 20 years and older

INDICATOR TITLE	Cervical cancer screening coverage
	The proportion of women screened for cervical cancer annually based on the target population and the recommended frequency of screening. The annual target includes 80% of women aged 30 - 50 years representing women who are not living with HIV (divided by 10 as these women should be screened every 10 years) added to 20% of women 20 years and older representing women who are living with HIV (divided by 3 as these women should be screened every 3 years)
Source of data	DHIS
Method of calculation / assessed	Cervical cancer screening done (Cervical cancer screening in non-HIV woman 30-50 years + Cervical cancer screening in HIV positive women 20 years and older)/ (Female 30-34 years + SUM[Female 35-39 years] + SUM[Female 40-44 years + SUM[Female 45-49] *0.8)/10) + (Female 20-24 years + Female 25-29 years + Female 30-34 years + Female 35-39 years + Female 40-44 years + Female 45-49 years) * 0.2) / 3).
Means of verification	PHC Comprehensive Tick Register; OPD
Assumptions	Accuracy dependent on quality of data submitted by health facilities
Disaggregation of beneficiaries	Not Applicable
Spatial transformation	All District
Calculation type	Cumulative (year - to-end)
Reporting Cycle	Quarterly
Desired Performance	Higher Rate of Cervical Cancer Screening coverage
Indicator responsibility	MCWH&N Programme
Notes	

Programme 2: District Health Services DPC Technical Indicator Descriptions for Annual Performance Plan

Table 35: Programme 2: District Health Services DPC Technical Indicator Descriptions for Annual Performance Plan

INDICATOR TITLE	Malaria case fatality rate
Definition	Malaria deaths reported in South Africa as a proportion of malaria cases reported. The death resulting from primary malaria diagnosis at the time of death
Source of data	Malaria Information System
Method of calculation / assessed	Malaria death reported/ Malaria new case reported.
Means of verification	Malaria Information System
Assumptions	Accuracy dependent on quality of data submitted by health facilities
Disaggregation of beneficiaries	Not applicable
Spatial transformation	All Districts
Calculation type	Non-cumulative
Reporting Cycle	Annual
Desired Performance	Lower
Indicator responsibility	CDC
Notes	

INDICATOR TITLE	PHC Mental Health Conditions Treatment rate new
Definition	Clients treated for the first time for mental health conditions (depression, anxiety, dementia, psychosis, mania, suicide attempt, developmental disorders, behavioural disorders and substance abuse/addiction disorders) as a proportion of total PHC headcount.
Source of data	DHIS
Method of calculation / assessed	PHC client treated for mental health conditions- new/ PHC headcount - Total (PHC headcount under 5 years + PHC headcount 5-9 years] + PHC headcount 10-14 years] + PHC headcount 15-19 years + PHC headcount 20 years and older])

INDICATOR TITLE	PHC Mental Health Conditions Treatment rate new
Means of verification	DHIS, PHC Comprehensive Tick Register, Facility Health Registers
Assumptions	Accuracy dependent on quality of data submitted by health facilities
Disaggregation of beneficiaries	Not Applicable
Spatial transformation	All District
Calculation type	Cumulative (year - to-date)
Reporting Cycle	Quarterly
Desired Performance	Higher
Indicator responsibility	CDC
Notes	

Table 35: Programme 2: District Health Services Primary Health Care Technical Indicator Descriptions for Annual Performance Plan

Programme 3: Emergency Medical Services Technical Indicator Descriptions for Annual Performance Plan

Table 36: Programme 3: Emergency Medical Services Technical Indicator Descriptions for Annual Performance Plan

INDICATOR TITLE	EMS P1 urban response under 30 minutes
Definition	Emergency P1 calls in urban locations with response times under 30 minutes where response times equals from the time that the call is received to the time of the first dispatched medical resource arrives on scene. P1 (Priority 1) calls refer to calls where the clients have life-threatening injuries or illnesses and urgently need to go to a medical facility.
Source of data	DHIS
Method of calculation / assessed	EMS P1 urban response under 30 minutes / EMS P1 urban dispatched
Means of verification	Log sheet/ Call Register
Assumptions	EMS Logging system that is functioning
Disaggregation of beneficiaries	N/A
Spatial transformation	All Districts
Calculation type	Cumulative Year End
Reporting Cycle	Quarterly
Desired Performance	Higher
Indicator responsibility	Emergency Medical Services Programme Manager
Notes	Exclude Interfacility Transfers

INDICATOR TITLE	EMS P1 rural response under 60 minutes
Definition	Emergency P1 calls in rural locations with response times under 60 minutes where response times equals from the time that the call is received to the time of the first dispatched medical resource arrives on scene. P1 (Priority 1) calls refer to calls where the clients have life-threatening injuries or illnesses and urgently need to go to a medical facility.
Source of data	DHIS

INDICATOR TITLE	EMS P1 rural response under 60 minutes
Method of calculation / assessed	EMS P1 rural response under 60 minutes/ EMS P1 rural dispatched
Means of verification	Log sheet/ Call Register
Assumptions	EMS call logging functional
Disaggregation of beneficiaries	N/A
Spatial transformation	All Districts
Calculation type	Cumulative Year End
Reporting Cycle	Quarterly
Desired Performance	Higher
Indicator responsibility	Emergency Medical Services Programme Manager
Notes	Excluding interfacility transfers

Table 39: Programme 3: Emergency Medical Services Technical Indicator Descriptions for Annual Performance Plan

Programme 4 & 5 Regional, Specialized and Tertiary Hospital Services Technical Indicator Descriptions for Annual Performance Plan

Table 37: Programme 4 & 5 Regional, Specialized and Tertiary Hospital Services Technical Indicator Descriptions for Annual Performance Plan

INDICATOR TITLE	**Number of Maternal death in facility.**
Definition	Maternal death is death occurring during pregnancy, childbirth and the puerperium of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy and irrespective of the cause of death (obstetric and non-obstetric) per 100,000 live births in facility
Source of data	DHIS
Method of calculation / assessed	Number of Maternal deaths in facility (Regional Hospitals)
Means of verification	Maternal death register, Delivery register
Assumptions	Accuracy dependent on quality of data submitted by health facilities
Disaggregation of beneficiaries	Females
Spatial transformation	All Districts
Calculation type	Cumulative (year-to-date)
Reporting Cycle	Annual
Desired Performance	Lower numbers
Indicator responsibility	MCWH&N Programme
Notes	

INDICATOR TITLE	**Number of Death in facility under 5 years**
Definition	Children under 5 years who died during their stay in the facility as a proportion of all live births.
Source of data	DHIS
Method of calculation / assessed	Death in facility 0-6 days + Death in facility 7-28 days + Death in facility 29 days - 11 months + Death in facility 12-59 months

INDICATOR TITLE	Number of Death in facility under 5 years
Means of verification	Neonatal Admission Register, Birth Register, Paeds Register
Assumptions	Accuracy dependent on quality of data submitted by health facilities
Disaggregation of beneficiaries	Children
Spatial transformation	All Districts
Calculation type	Cumulative (year-end)
Reporting Cycle	Quarterly
Desired Performance	Lower rate
Indicator responsibility	MCWH&N Programme
Notes	

INDICATOR TITLE	Severity assessment code (SAC) 1 incident reported within 24 hours rate
Definition	Severity assessment code 1 incidents reported within 24 hours as a proportion of Severity assessment code 1 incident reported
Source of data	DHIS
Method of calculation / assessed	Severity assessment code 1 incidents reported within 24 hours / Severity assessment code 1 incident reported
Means of verification	Patient Safety Incident Software
Assumptions	Accuracy dependent on quality of data submitted by health facilities
Disaggregation of beneficiaries	Not Applicable
Spatial transformation	All Districts
Calculation type	Cumulative (year-to-date)
Reporting Cycle	Quarterly
Desired Performance	Higher SAC 1 incidents reported within 24 hours
Indicator responsibility	Quality Assurance
Notes	

INDICATOR TITLE	Patient Safety Incident (PSI) case closure rate
Definition	Patient Safety Incident (PSI) case closed in the reporting month as a proportion of Patient Safety Incident (PSI) cases reported in the reporting month
Source of data	DHIS
Method of calculation / assessed	Patient safety Incident (PSI) case closed/ Patient Safety Incident (PSI) case reported
Means of verification	Patient Safety Incident Software
Assumptions	Accuracy dependent on quality of data submitted by primary health care facilities
Disaggregation of beneficiaries	Not Applicable
Spatial transformation	All Districts
Calculation type	Cumulative (year-to-year)
Reporting Cycle	Quarterly
Desired Performance	Higher numbers of facilities with clinic committees
Indicator responsibility	Monitoring and Evaluation
Notes	

INDICATOR TITLE	Patient experience of care survey rate (Regional Hospital)
Definition	Fixed health facilities that have conducted Patient Experience of Care Surveys as a proportion of fixed health facilities (Regional Hospital)
Source of data	DHIS
Method of calculation / assessed	Facility Patient Experience of Care survey done in regional hospitals/ fixed health facilities (Regional Hospital)
Means of verification	Patient Surveys, PEC survey module of the DHIS
Assumptions	Accuracy is dependent on the quality of date that is captured in the PEC survey module of the DHIS
Disaggregation of beneficiaries	Not Applicable
Spatial transformation	All Districts
Calculation type	Non-Cumulative
Reporting Cycle	Annual
Desired Performance	Higher survey rate
Indicator responsibility	Quality Assurance and Improvement

INDICATOR TITLE	Patient experience of care survey rate (Regional Hospital)
Notes	

INDICATOR TITLE	Patient Experience of Care survey rate (Specialised Hospitals)
Definition	Total number of Satisfied responses as a proportion of all responses from Patient Experience of Care survey questionnaires (in Specialised Hospitals)
Source of data	DHIS
Method of calculation / assessed	Patient Experience of Care survey satisfied responses/ Patient Experience of Care survey total responses
Means of verification	Patient Surveys, PEC survey module of the DHIS
Assumptions	Accuracy dependent on quality of data submitted by health facilities
Disaggregation of beneficiaries	Not Applicable
Spatial transformation	All Districts
Calculation type	Cumulative (year-to-date)
Reporting Cycle	Annual
Desired Performance	Higher satisfaction survey rate
Indicator responsibility	Quality assurance
Notes	

Programme 6: Health Science and Training Technical Indicator Descriptions for Annual Performance Plan

Table 38: Programme 6: Health Science and Training Technical Indicator Descriptions for Annual Performance Plan

INDICATOR TITLE	Number of Healthcare workers who received training on priority critical clinical skills
Definition	Number of healthcare professional who have undergone training on critical clinical skills that support programme performance as detailed in the Workplace skills Plan
Source of data	Training data base
Method of calculation / assessed	Number of healthcare workers trained on critical clinical skills
Means of verification	Attendance register
Assumptions	Available budget for training
Disaggregation of beneficiaries	Not Applicable
Spatial transformation	All districts
Calculation type	Cumulative year end
Reporting Cycle	Quarterly
Desired Performance	Higher
Indicator responsibility	Human Resource Development Programme manager
Notes	

INDICATOR TITLE	Number of first year nursing students who received bursaries
Definition	Number of first year students enrolled in nursing college and offered bursaries by the Provincial Department of Health
Source of data	Bursary database
Method of calculation / assessed	Number of bursaries awarded to first year nursing students
Means of verification	Bursary contracts
Assumptions	Bursary requirements are met by applicants
Disaggregation of beneficiaries	Not Applicable

INDICATOR TITLE	Number of first year nursing students who received bursaries
Spatial transformation	All districts
Calculation type	Non-Cumulative
Reporting Cycle	Annual
Desired Performance	Higher
Indicator responsibility	Human Resource Development Programme manager
Notes	

INDICATOR TITLE	Number of frontline workers who received training on customer care
Definition	Number of frontline healthcare workers that have undergone training on customer care
Source of data	Training data base
Method of calculation / assessed	Number of frontline healthcare workers trained on customer care
Means of verification	Attendance register
Assumptions	Availability of employees to attend training
Disaggregation of beneficiaries	Not Applicable
Spatial transformation	All districts
Calculation type	Cumulative year end
Reporting Cycle	Quarterly
Desired Performance	Higher
Indicator responsibility	Human Resource Development Programme manager
Notes	

INDICATOR TITLE	Number of managers who received training on Leadership & Management skills
Definition	Managers that have undergone training on leadership and management skills.
Source of data	Training data base.
Method of calculation / assessed	Number of employees trained on leadership and management development
Means of verification	Attendance register
Assumptions	Managers are available for training
Disaggregation of beneficiaries	Not Applicable
Spatial transformation	All districts
Calculation type	Cumulative year end
Reporting Cycle	Quarterly
Desired Performance	Higher
Indicator responsibility	Human Resource Development Programme manager
Notes	

INDICATOR TITLE	Number of Clinicians who received training on capturing clinical documentation
Definition	Clinicians that have undergone training on medical records
Source of data	Attendance register
Method of calculation / assessed	Number of clinicians trained on capturing clinical records
Means of verification	Attendance register
Assumptions	Clinicians are available for training
Disaggregation of beneficiaries	Not Applicable
Spatial transformation	All districts
Calculation type	Cumulative year end
Reporting Cycle	Quarterly

INDICATOR TITLE	Number of Clinicians who received training on capturing clinical documentation
Desired Performance	Higher
Indicator responsibility	Human Resource Development Programme manager
Notes	

INDICATOR TITLE	Number of employees who received training on the Compulsory Induction Programme
Definition	Number of employees who have undergone training on the Compulsory Induction Programme
Source of data	Training data base
Method of calculation / assessed	Number of employees trained on Compulsory Induction
Means of verification	Attendance register
Assumptions	Availability of employees to attend training
Disaggregation of beneficiaries	Not Applicable
Spatial transformation	All districts
Calculation type	Cumulative year end
Reporting Cycle	Quarterly
Desired Performance	Higher
Indicator responsibility	Human Resource Development Programme manager
Notes	

Table 41: Programme 6: Health Science and Training Technical Indicator Descriptions for Annual Performance Plan

Programme 7: Healthcare Support Services Technical Indicator Descriptions for Annual Performance Plan

Table 39: Programme 7: Healthcare Support Services Technical Indicator Descriptions for Annual Performance Plan

INDICATOR TITLE	Percentage Availability of Essential Medicine List (EML) at the Depot
Definition	Percentage of the available items on the Essential Medicine List at depot for supply to the facilities
Source of data	PDS system
Method of calculation / assessed	Number of available essential medicine on stock/ total number of medicine prescribed as essential as per EML
Means of verification	Issue Report
Assumptions	Availability of medicine in markets
Disaggregation of beneficiaries	Not applicable
Spatial transformation	All facilities
Calculation type	None- cumulative
Reporting Cycle	Quarterly
Desired Performance	Higher
Indicator responsibility	Pharmaceutical Manager
Notes	

INDICATOR TITLE	Number of Orthotic and Prosthetic devices issued
Definition	Count of Medical orthotic and prosthetic devices given to people with disabilities
Source of data	Orthotic and Prosthetic Register
Method of calculation / assessed	Number of Orthotic and Prosthetic devices issued
Means of verification	Patient files
Assumptions	Patient who the service will be available

INDICATOR TITLE	Number of Orthotic and Prosthetic devices issued
Disaggregation of beneficiaries	People living with disability
Spatial transformation	Rob Ferreira, Mapulaneng and Ermelo hospitals centres
Calculation type	Cumulative year end
Reporting Cycle	Quarterly
Desired Performance	Higher
Indicator responsibility	Pharmaceutical Manager
Notes	

Table 42: Programme 7: Healthcare Support Services Technical Indicator Descriptions for Annual Performance Plan

Programme 8: Health Facility Management Technical Indicator Descriptions for Annual Performance Plan

Table 40: Programme 8: Health Facility Management Technical Indicator Descriptions for Annual Performance Plan

INDICATOR TITLE	**Number of Infrastructure Upgrades and additions projects completed**
Definition	Number of infrastructure upgrades and additions projects within existing health facilities that have achieved Practical Completion during the financial year under review. Upgrades and additions refer to capital infrastructure works that expand, improve or modernise existing facilities.
Source of data	PMIS
Method of calculation / assessed	Number of infrastructure upgrades and additions projects that achieved Practical completion within the reporting period.
Means of verification	Signed Practical Completion Certificate
Assumptions	• Budget availability • Contract awards made on time by Implementing Agent • Implementing agents, PSP's and contractors performance • Statutory approvals and inspection obtained timeously • Timeous provisions of bulk services and utility connections by Eskom and Municipality • No major site disruptions due to community unrest or force majeure events • Timely submission and processing of invoices to support project continuity • Effective intergovernmental coordination
Disaggregation of beneficiaries	No disaggregation
Spatial transformation	Identified municipalities
Calculation type	Cumulative year-end
Reporting Cycle	Quarterly
Desired Performance	Higher
Indicator responsibility	Health Infrastructure
Notes	Only capital infrastructure projects classified as Upgrades and additions within the existing health facilities that have achieved practical completion under the financial year will be counted.

INDICATOR TITLE	**Number of New and replacement infrastructure projects completed**
Definition	Number of new and replacement health infrastructure projects that have achieved practical completion during the financial year under review. New and replaced projects refer to capital infrastructure projects involving the construction of new facilities or complete replacement of existing facilities that are no longer fit for purpose
Source of data	PMIS
Method of calculation / assessed	Number of infrastructure upgrades and addition projects that achieved Practical completion within the reporting period.
Means of verification	Signed Practical Completion Certificate
Assumptions	• Budget availability • Contract awards made on time by Implementing Agent • Implementing agents, PSP's and contractors' performance • Statutory approvals and inspection obtained timeously • Timeous provisions of bulk services and utility connections by Eskom and Municipality • No major site disruptions due to community unrest or force majeure events • Timely submission and processing of invoices to support project continuity • Effective intergovernmental coordination
Disaggregation of beneficiaries	No disaggregation
Spatial transformation	Identified Municipalities
Calculation type	Cumulative year-end
Reporting Cycle	Quarterly
Desired Performance	Higher
Indicator responsibility	Health Infrastructure
Notes	Only capital infrastructure projects classified as New and replacement within the existing health facilities that have achieved practical completion under the financial year will be counted.

INDICATOR TITLE	**Number of new and replacement infrastructure projects under construction**
Definition	Number of new and replaced health infrastructure projects that are under construction during the financial year under review. New and replaced infrastructure projects refer to capital infrastructure projects involving the construction of new facilities or complete replacement of existing facilities that are no longer fit for purpose
Source of data	PMIS/ Monthly Progress reports
Method of calculation / assessed	Number of new and replaced infrastructure projects under construction within the reporting period
Means of verification	Monthly Progress report
Assumptions	• Budget availability • Contract awards made on time by Implementing Agent • Implementing agents, PSP's and contractors performance • Statutory approvals and inspection obtained timeously • Timeous provisions of bulk services and utility connections by Eskom and Municipality • No major site disruptions due to community unrest or force majeure events • Timely submission and processing of invoices to support project continuity • Effective intergovernmental coordination
Disaggregation of beneficiaries	No disaggregation
Spatial transformation	Identified municipalities
Calculation type	Cumulative year end
Reporting Cycle	Quarterly
Desired Performance	Higher
Indicator responsibility	Health Infrastructure
Notes	Only capital infrastructure projects classified as New and replaced within the existing health facilities that are under construction in the financial year will be counted.

INDICATOR TITLE	**Number of new and replacement projects under planning**
Definition	Number of projects under planning during the relevant financial year. These include all projects at various stages of the planning lifecycle.
Source of data	Infrastructure report
Method of calculation / assessed	Number of projects under planning
Means of verification	Progress report
Assumptions	• Availability of funds • Land availability and finalisation of relevant Municipal requirements • Appointment and performance of PSPs • Performance of DPWRT
Disaggregation of beneficiaries	N/A
Spatial transformation	All Municipalities
Calculation type	Cumulative year end
Reporting Cycle	Quarterly
Desired Performance	Higher
Indicator responsibility	Infrastructure
Notes	4 projects under planning are, Linah Malatjie Tertiary Hospital, Mpumalanga Psychiatric Hospital, Rob Ferreira Hospital Oncology & Molapo Clinic

INDICATOR TITLE	**Number of facilities with life-saving equipment serviced**
Definition	The total number of health facilities where identified critical and life-saving equipment has been serviced within the reporting period in accordance with approved maintenance schedules and statutory compliance requirements. Life-saving equipment includes but is not limited to: Boilers, Theatre Air Conditioners, Autoclaves, Laundry Machines, Medical Gas Points and Gas Banks, Medical Vacuum Systems, Medical Compressors, Split Air Conditioners (Pharmacy and Bulk Storerooms in Clinics), equipment in Maternity, Waiting Areas, Casualty, Paediatrics, Hospital Pharmacy, UPS Systems, Boreholes, Steam Systems

INDICATOR TITLE	**Number of facilities with life-saving equipment serviced**
	(including steam leaks), Transformers, Lifts, Mortuary Cold Rooms, Kitchen Equipment, Forensic Mortuary equipment, and Standby Generators.
Source of data	• Maintenance schedules • Job cards and service reports • Contractor service reports • Asset management system records • Facility maintenance registers • Compliance certificates (where applicable)
Method of calculation / assessed	Total number of facilities where servicing of identified life-saving equipment was completed and recorded.
Means of verification	• Signed service reports • Completed job cards • Maintenance compliance certificates • Asset management system printouts • Payment certificates linked to verified service completion • Photographic evidence (where applicable) • Facility manager confirmation
Assumptions	• Adequate budget is available for planned maintenance. • Service providers are appointed and contracted on time. • Facilities provide access to equipment for servicing.
Disaggregation of beneficiaries	▪ By facility type (Clinic, Community Health Centre, District Hospital, Regional Hospital, Tertiary Hospital, Forensic Mortuary) ▪ By district / region ▪ By equipment category ▪ By priority service area (Maternity, Casualty, Paediatrics, Pharmacy, etc.)
Spatial transformation	Prioritisation of historically under-resourced, rural, and underserved districts to ensure equitable access to functional life-saving equipment across all geographic areas.
Calculation type	Cumulative Year-End

INDICATOR TITLE	**Number of facilities with life-saving equipment serviced**
Reporting Cycle	Quarterly reporting with annual consolidation.
Desired Performance	100% of identified facilities with life-saving equipment serviced in accordance with the approved maintenance plan within the financial year.
Indicator responsibility	• Chief Directorate: Infrastructure / Technical Services • Directorate: Maintenance and Engineering Services • Project Managers • Facility Managers (verification level)
Notes	• Only planned and completed services within the reporting period will be counted. • Breakdown maintenance may be reported separately unless included in the approved maintenance plan. • Servicing must comply with relevant statutory regulations (e.g., Occupational Health and Safety requirements). • Each facility is counted once per reporting cycle regardless of the number of equipment items serviced.

INDICATOR TITLE	**Number of primary health care (PHC) facilities under refurbishment/ rehabilitation/ repairs (Capital maintenance)**
Definition	The total number of Primary Health Care (PHC) facilities undergoing refurbishment, rehabilitation, or capital repairs during the reporting period as part of the approved Capital Maintenance Programme. This includes planned capital maintenance interventions aimed at restoring, improving, or extending the useful life of infrastructure components, systems, and building elements to ensure compliance with health, safety, and service delivery standards. Capital Maintenance excludes routine or day-to-day maintenance activities.
Source of data	• Approved Infrastructure Programme Management Plan (IPMP) • Infrastructure Project Implementation Plan (IPIP)

INDICATOR TITLE	**Number of primary health care (PHC) facilities under refurbishment/ rehabilitation/ repairs (Capital maintenance)**
	• Project registers • Infrastructure Reporting Model (IRM) reports • Works orders and contractor reports • Infrastructure Delivery Management System (IDMS) documentation • Financial expenditure reports
Method of calculation / assessed	Total number of PHC facilities where capital maintenance projects have commenced (site handover completed) during the reporting period.
Means of verification	• Signed site handover certificates • Appointment letters of contractors • Approved project scope documents • Project progress reports • Practical completion certificates (where applicable) • Photographic evidence • Payment certificates • Infrastructure Reporting Model submissions
Assumptions	• Capital budget allocation is approved and available. • Supply chain processes are completed within planned timelines. • No community disruptions, contractor insolvency, or force majeure events. • Professional teams are appointed where required. • Facilities remain operational or partially operational during implementation (where applicable)
Disaggregation of beneficiaries	• By district / region • By rural vs urban classification • By facility size (small clinic, CHC, gateway clinic) • By project type (refurbishment, rehabilitation, major repairs)
Spatial transformation	Priority allocation of capital maintenance projects to rural, underserved, and historically disadvantaged communities to promote equitable access to safe and compliant PHC infrastructure.
Calculation type	Cumulative year-end

INDICATOR TITLE	**Number of primary health care (PHC) facilities under refurbishment/ rehabilitation/ repairs (Capital maintenance)**
Reporting Cycle	Quarterly
Desired Performance	100% of planned PHC facilities identified in the Annual Performance Plan (APP) placed under refurbishment / rehabilitation / capital repairs within the financial year.
Indicator responsibility	• Chief Directorate: Infrastructure Planning and Delivery • Directorate: Infrastructure Projects / Capital Maintenance • Project Managers • Programme / Project Manager

Notes	• Only projects funded under Capital Maintenance budget classification are included.
	• Routine maintenance projects are excluded.
	• Emergency repairs may be reported separately unless formally approved under Capital Maintenance.
	• A facility will not be counted unless physical works have commenced.
	• A facility is counted once per project cycle, regardless of the number of work packages within that facility.
	• Projects must have:
	  ○ Approved scope
	  ○ Allocated budget
	  ○ Official site handover or construction commencement certificate

Table 43: Programme 8: Health Facility Management Technical Indicator Descriptions for Annual Performance Plan

ANNEXURES

Annexure A: Amendments to the Strategic Plan

There have been no amendments to the Strategic Plan

Annexure B: Conditional grants

1. Health Facility Revitalisation Grant

Name of grant	**HEALTH FACILITY REVITALISATION GRANT**
Purpose	• **To help accelerate construction, maintenance, upgrading and 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 & safety**
Current annual budget (R thousands)	**504 907 000**
Period of grant	• **Annual**

Performance Indicators	
Submission of the U-AMP for relevant financial year by Provincial Departments to National Treasury and NDOH by 29 June annually Submission of the IPMP for relevant financial year by Provincial Departments to National Treasury and NDOH by 31 August annually Submission of the Final AIP with the MTEF allocations for relevant financial year by Provincial Departments to National Treasury and NDOH by 4 March annually	**Meeting performance requirements**

Table 41: Health Facility Revitalisation Grant Details

2. Statutory Human Resources and Training Grant

Name of grant	**Statutory Human resources and Training Grant**	
Purpose	To appoint statutory positions in the health sector for systematic realisation of the human resources for health strategy and the phase-in of National Health Insurance; support provinces to fund service costs associated with clinical training	
Current annual budget (R thousands)	**R299,521,000**	
Period of grant	**2026/2027**	
	Performance Indicators	**Target**
	Number of medical specialists funded	53
	Number of medical registrars in training in different fields of speciality	13
	Number of clinical supervisors funded to train student nurses and pharmacy interns (Nurse preceptors and pharmacy tutors)	12
	Number of Medical Interns funded	166

Table 42: Statutory Human resources and Training Grant Details

3. National Tertiary Services Grant

Name of grant	**National Tertiary Services Grant**
Purpose	• Ensure the provision of tertiary health services in South Africa • To compensate tertiary facilities for the additional costs associated with the provision of tertiary services
Current annual budget (R thousands)	**R266,661,000**
Period of grant	**2026/27**

Performance Indicators	**Target**
No. of Medical Specialists funded	49
No of Medical Officers funded	9
No. of specialised nurses funded	63
No. of Allied Health professionals funded	26
No. of grant management posts funded	0
Number of inpatient separations	40,106
Number of day patient separations	19,958
Number of outpatient first attendances	22,872
Number of outpatient follow-up attendances	69,531
Number of inpatient days	100,351
Average length of stay by facility (tertiary)	5 days
Bed utilization rate by facility (tertiary)	75%
No. and type of services established	1 x Nephrology unit (Satellite at Ermelo Hospital)
No. and type of services enhanced / upgraded	1 x Catheterization Laboratory
No of Radiotherapy patients referred	10
No of Chemotherapy patients serviced	517

Table 43: National Tertiary Services Grant Details

4. District Health Programmes Grant

Name of Grant:	**District Health Programmes Grant**
Purpose of the Grant:	To enable the health sector to develop and implement an effective response to HIV/AIDS & TB, Prevention and protection of health workers from exposure to hazards in the workplace. To enable the health sector to prevent cervical cancer by making available HPV vaccinations to eligible girls in-and-out of schools. To enable the health sector to develop and implement an effective response to support the implementation of the National Strategic Plan on Malaria Elimination 2025/26 -2029/30. To ensure provision of quality community outreach services through WBPHCOTs by ensuring Community Health Workers (CHWs) receive remuneration, tools of trade and training in line with scope of work
Current annual budget (R thousands)	**R 2 723 670 000**
Period of grant	**2026/27**

Performance Indicators	**Target**
No of Male condoms distributed	56 857 818
No of Female condoms distributed	1 975 884
No of active Lay counsellors on stipend	520
No of HIV test done-Sum	1 438 672
No of health facilities offering MMC	78
No of MMC performed	100 056
No of HTA intervention sites	100
No of Peer educators receiving stipends	0.00
Individuals who received an HIV service /referral at High Transmission Area sites (HTS, ART, PreP, TB, STIS, Psych)	25 381
Male Urethritis Syndrome treated - new episode	72 929
No of Clients started on Pre-Exposure Prophylaxis	48 895
New sexual assault case HIV negative issued with Post Exposure Prophylaxis	1 900
Antenatal start on ART	2 800

Name of Grant:	District Health Programmes Grant
Infant PCR test around 10 weeks	12 300
ART Client naïve start ART during month- Sum	24 874
ART Client remain on ART end of month- Sum	653 734
Total HIV patients enrolled in repeat prescription collection strategies (RPCs)or Differentiated Models of Care of Care	252 862
HIV positive clients screened for TB	24 874
HIV positive clients on ART initiated on Tuberculosis Preventative Therapy	22 387
Doctors trained on HIV/AIDS, TB, STIs and other chronic diseases	360
Nurses trained on HIV/AIDS, TB, STIs and other chronic diseases	10 250
Non-professional trained on HIV/AIDS, TB, STIs and other chronic diseases	3 640
Number of TB contacts initiated on TB preventive treatment (Under 5yrs and 5yrs and older combined)	6 000
Number of patients tested for TB using TB Nucleic Acid Amplification Test (TB-NAAT)	389 317
Number of eligible HIV positive patients tested for TB using urine lateral flow lipoarabinomannan (LF-LAM) assay	12 671
Drug susceptible TB treatment start rate (under 5yrs, 5yrs and older combined)	95%
Rifampicin resistant/ multi drug resistant TB confirmed treatment start rate	80%

Table 44: Comprehensive HIV & AIDS, TB and COS grant: HIV & AIDS component Details

NHI Grant

Name of grant	**NHI Grant**
Purpose	**National Health Insurance Grant**
Current annual budget (R thousands)	**HP Contracting R20 760 000** **Mental Health Contracting R15 194 000** **Total R35 954 000**
Period of grant	**2026/27**

Performance Indicators	**Target**
Number of health care providers contracted (HPC) – Medical Officer	44
Number of health care providers contracted (HPC) - Optometrists	8
Number of health care providers contracted (HPC) – Dental assistants	5
Number of sessions covered by contracted health care providers (HPC) – Medical Officer	20 880
Number of sessions covered by contracted health care providers (HPC) - Optometrists	3 840
Number of sessions covered by contracted health care providers (HPC) – Dental assistants	2 400
Number of mental health care providers contracted – Psychiatrist	0
Number of mental health care providers contracted - Psychologist	1
Number of mental health care providers contracted – Registered councillor	15
Number of mental health care providers contracted – Occupational therapist	1
Number of mental health care providers contracted – Social worker	5
Number of mental health care providers contracted – Medical officer	0
Number of users seen by the contracted mental health care providers - Psychiatrist	0
Number of users seen by the contracted mental health care providers - Psychologist	1 200
Number of users seen by the contracted mental health care providers – Registered councillor	24 000
Number of users seen by the contracted mental health care providers – Occupation therapist	600
Number of users seen by the contracted mental health care providers – Social worker	3 200

Number of users seen by the contracted mental health care providers – Medical officer	29 000

Table 45: NHI Grant

Name of grant	**EPWP Integrated Grant**	
Purpose	**To incentivise Provincial Departments to expand their job creation efforts ib both Infrastructure and Social Sectors. The aim is to strengthen and broaden social and infrastructure services programmes with high employment potential.**	
Current annual budget (R thousands)	**R10 148 000.00**	
Period of grant	**2026/27**	
	Performance Indicators	**Target**
	Cleaning of Health Facilities	182 EPWP participants recruited

Annexure C: Consolidated Indicators

Not applicable

Annexure D: District Development Model

District Development Model

Area of intervention	2026/27-2027/28					
	Project description	Budget allocation	District Municipality	Location	Project leader	GPS Coordinates
Infrastructure	MN Cindi Clinic: Upgrade of the clinic	R 5,000,000.00	Gert Sibande	Ermelo	Chief Director: Infrastructure	26.492909728767778, 29.96838888129621
	Dumphries Clinic: Construction of New Clinic	R 28,000,000.00	Ehlanzeni	Bushbuckridge	Chief Director: Infrastructure	Not available
	Mpumalanga New Psychiatric Hospital: Construction of New Hospital (former Impungwe Hospital)	R 57,836,000.00	Ehlanzeni	Witbank	Chief Director: Infrastructure	25.982720164606505, 29.277227856906908
	Mapulaneng Hospital: Construction of building works (Phase 3A)	R 280,213,000.00	Ehlanzeni	Bushbuckridge	Chief Director: Infrastructure	24.843357158803443, 31.055614644231266
	Linah Malatji Tertiary Hospital: Construction of New Hospital	R 136,632,000.00	Nkalanga	Witbank	Chief Director: Infrastructure	Not available
	Siyabuswa CHC: Upgrade to the facility	R 41,000,000.00	Nkangala	Siyabuswa	Chief Director: Infrastructure	25.117569006134918, 29.061461765887024
	KwaMhlanga Hospital Maternity Ward	R 65,899,000.00	Nkangala	KwaMhlanga	Chief Director: Infrastructure	25.418180642931333, 28.703550908229786
	Matikwane Hospital- Phase 1B	R 10,000,000.00	Ehlanzeni	Mkhuhlu	Chief Director: Infrastructure	24.985770782613546, 31.236000298783235
	Matikwane Hospital- Phase 1C	R 7,000,000.00	Ehlanzeni	Mkhuhlu	Chief Director: Infrastructure	24.985770782613546, 31.236000298783235
	Matikwane Hospital- Phase 2A	R 20,000,000.00	Ehlanzeni	Mkhuhlu	Chief Director: Infrastructure	24.985770782613546, 31.236000298783235

Area of intervention	2026/27-2027/28					
	Project description	Budget allocation	District Municipality	Location	Project leader	GPS Coordinates
	Barberton Town Clinic - Construction of a new clinic	R 15,000,000.00	Ehlanzeni	Barberton	Chief Director: Infrastructure	25.776202243390824, 31.043903732750127
	Langkloof Clinic - Construction of a new clinic	R 15,000,000.00	Nkangala	Thembisile Hani	Chief Director: Infrastructure	Not available
	Alexandria Clinic- Construction of a new clinic	R 12,000,000.00	Ehlanzeni	Bushbuckridge	Chief Director: Infrastructure	Not available
	Lefisoane Clinic - Construction of a new clinic	R 15,000,000.00	Nkangala	Dr JS Moroka	Chief Director: Infrastructure	24.961525071260784, 28.85049130820823
	Lebogang Clinic - Construction of a new clinic	R 15,000,000.00	Gert Sibande	Govern Mbeki	Chief Director: Infrastructure	26.374278036946095, 28.92163587533171
	Kinross Town Clinic - Construction of a new clinic	R 15,000,000.00	Gert Sibande	Kinross	Chief Director: Infrastructure	Not available
	Nhlazatshe 3 Clinic – Planning design & construction of new clinic	R 27,500,000.00	Gert Sibande	Nhlazatshe	Chief Director: Infrastructure	Not available
	Madyebeni Clinic – Planning design & construction of new clinic	R 25,000,000.00	Ehlanzeni	Bushbuckridge	Chief Director: Infrastructure	Not available
	Molapomolage Clinic – Planning design & construction of new clinic	R 25,000,000.00	Nkangala	Molapomolage	Chief Director: Infrastructure	Not available

Table 46: District Development Model