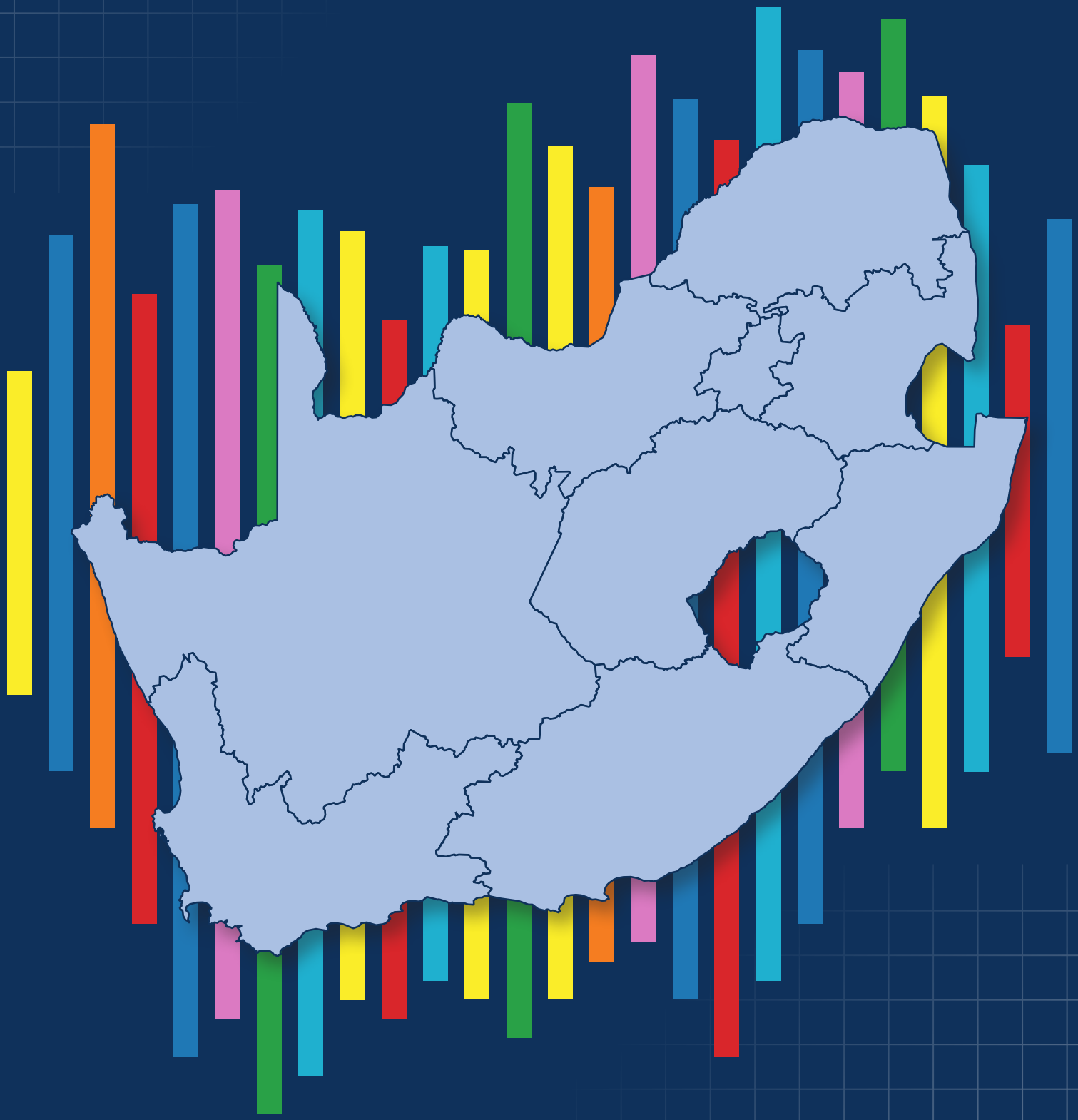
HEALTH SYSTEMS TRUST

DISTRICT HEALTH BAROMETER

2023/24



DISTRICT HEALTH BAROMETER 2023/24

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LIST OF ABBREVIATIONS

AGYW	adolescent girls and young women
ALOS	average length of stay
ANC	antenatal care
AR6	Assessment Synthesis Report 6
ARV	antiretrovirals
ASIR	age standardised incidence rate
BAS	Basic Accounting Database
BPaL-L	Bedaquiline, Pretomanid, Linezolid, Levofloxacin regimen
BUR	bed utilisation rate
CCMDD	central chronic medicines dispensing and distribution
CFR	case fatality rate
CMS	Council for Medical Schemes
CoMMiC	Committee on Morbidity and Mortality in Children under 5 Years
COPD	chronic obstructive pulmonary disease
CPAP	continuous positive airway pressure
CPR	contraceptive prevalence rate
CYPR	couple year protection rate
DCST	district clinical specialist team
DFFE	Department of Forestry, Fisheries and the Environment
DFID	Department of International Development (UK)
DHB	District Health Barometer
DHIS	District Health Information System
DHS	district health services
DMPA	depot medroxyprogesterone acetate
DS-TB	drug-susceptible tuberculosis
DTaP	diphtheria, tetanus, and pertussis
EBF	exclusive breastfeeding
EC	Eastern Cape
EPI	Expanded Programme on Immunisation
EML	Essential Medicines List
EN	enrolled nurse
ENA	enrolled nursing assistant
ESMOE	essential steps in the management of obstetric emergencies
ETAT	emergency triage assessment and treatment
FP	family planning
FS	Free State
GAPPD	Global Action Plan for the Prevention and Control of Pneumonia and Diarrhoea
GIZ	German Agency for International Cooperation
GHG	greenhouse gas
GNP	Global Nutrition Programme
GNT	Global Nutrition Target

GP	Gauteng
HBV	hepatitis B virus
HHWS	heat-health warning systems
Hib	haemophilus influenzae type B
HIV	human immunodeficiency virus
HIV/AIDS	human immunodeficiency virus/acquired immunodeficiency syndrome
HOD	head of department
HPV	human papilloma virus
HReH	human resource for eye health
HRH	human resources for health
ICRM	Ideal Clinic Realisation And Maintenance Programme
IGME	Inter-Agency Group for Child Mortality Estimation
IIPCC	Intergovernmental Panel on Climate Change
IMCI	integrated management of childhood illness
iMMR	in-facility maternal mortality ratio
IPC	Integrated Food Security Phase Classification
IPV	inactivated polio vaccine
IUCD	intra-uterine contraceptive device
IYCF	infant and young child feeding
KZ	KwaZulu-Natal
LARC	long-acting reversible contraceptive
LBC	liquid-based cytology
LG	local government
LMICs	low- and middle-income countries
LM/SDs	local municipalities/sub-districts
LP	Limpopo
MAM	moderate acute malnutrition
MAMMAS	maternal mortality and morbidity audit system
MDR-TB	multidrug-resistant tuberculosis
MMR	maternal mortality ratio
MP	Mpumalanga
MTCT	mother-to-child transmission
MUAC	mid-upper arm circumference
NAAT	nucleic acid amplification test
NC	Northen Cape
NCCEMD	National Committee on Confidential Enquiries into Maternal Deaths
NCCHSC	National Climate Change and Health Steering Committee
NCCRP	National Climate Change Response Policy
NCDs	non-communicable diseases
NDoH	National Department of Health
NEI	nursing education institution
NET-EN	norethisterone enanthate (Nur-Isterate)
NHI	National Health Insurance
NIDS	National Indicator Data Set
NSP	National Strategic Plan for HIV, TB and sexually transmitted diseases

NW	North West
OOP	out-of-pocket
OPD	outpatient department
OSD	occupation specific dispensation
OT	occupational therapist
PDE	patient day equivalent
PDoH	provincial department of health
PHC	primary healthcare
PLHIV	people living with HIV
pre-XDR-TB	pre-extensively drug-resistant tuberculosis
PrEP	pre-exposure prophylaxis
PT	physiotherapist
RWOPS	remunerated work outside the public service
SA	South Africa
SADHS	South Africa Demographic Health Survey
SAMRC	South African Medical Research Council
SDG	Sustainable Development Goal
SRH	sexual and reproductive health
SSA	sub-Saharan Africa
SAM	severe acute malnutrition
ST	speech therapist
Stats SA	Statistics South Africa
STGs	standard treatment guidelines
TB	tuberculosis
TPT	tuberculosis prophylactic therapy
TUTT	targeted universal testing for TB
UHC	universal health coverage
UNICEF	United Nation Children's Fund
V&A	vulnerability and adaptation
WBPHOT	ward-based PHC outreach team
WC	Western Cape
WHO	World Health Organization
WHZ	weight-for-height z-scores
WLHIV	women living with HIV
WUENIC	WHO/UNICEF estimates of national immunization coverage
XDR-TB	extensively drug-resistant tuberculosis
ZA	South Africa

FOREWORD

We are pleased to present the 17th edition of the *District Health Barometer (DHB)* – a vital statistical and analytical resource that provides an overall view of district health performance on key health systems indicators in South Africa.

This edition of the DHB provides information across a wide range of district health services, covers over 30 indicators and continues to provide policy-makers, health workers, planners, researchers, academics and stakeholders a unique overview of the performance of public health services in South Africa. By providing a detailed analysis of health indicators, trends, and challenges at the district level, the DHB equips district managers and other stakeholders with the data necessary to identify priorities, plan and implement targeted interventions, and monitor progress. This edition was also supplemented with the publication of the District Health Profiles, which provides more in-depth information at local-municipality/subdistrict level where available.

This edition not only tracks key health system indicators but also expands its scope, reflecting the evolving landscape of healthcare challenges and opportunities. Notably, it includes a chapter on the health impacts of climate change in South Africa, highlighting the challenges the health sector faces and advocates for the health system to make the necessary preparations to address these impacts and emphasises the need for indicators to measure and mitigate adverse effects.

We have also improved the functionality of our online dashboard introduced in 2024 which offers dynamic, user-friendly access to subdistrict-level data. These enhancements mark a shift toward more responsive and accessible health intelligence, empowering decision-makers to drive evidence-based improvements in service delivery.

This edition would not have been possible without the dedication and expertise of the HST team, along with the many contributors and collaborators who have worked tirelessly to develop this invaluable resource. Their commitment ensures that the DHB remains a vital tool for strengthening the health system through data-driven insights.

We hope the DHB continues to support evidence-informed decision-making, driving meaningful improvements in district health services and contributing to a healthier future for all South Africans. As always, we welcome feedback on its relevance and impact, as well as suggestions for enhancing future editions.

Dr Themba L. Moeti
Chief Executive Officer | Health Systems Trust

INTRODUCTION AND OVERVIEW

Background

The 2023/24 *District Health Barometer (DHB)* provides an overview of the delivery of selected healthcare services in the public health sector across the provinces, districts and local municipalities/sub-districts of South Africa. Data are drawn from the web-based District Health Information System (WebDHIS), Statistics South Africa (Stats SA) surveys, the National Treasury Basic Accounting System (BAS) and the Personnel Administration System (PERSAL). The publication seeks to highlight inequities in health outcomes and health-resource allocation and delivery, and to track the efficiency of health processes across all provinces and districts.

The DHB publication is available at http://www.hst.org.za. and the interactive online dashboard is accessible from http://www.dhb.hst.org.za

Methodology and data sources

Indicators used in the 2023/24 DHB

The indicators[1] in this DHB focus mainly on South Africa's progress towards achievement of the Sustainable Development Goals (SDGs) and universal health coverage (UHC).. The indicators in this publication are categorised according to the UHC index[2] (reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases, service capacity and access); where applicable, the indicator names are also replicated from the National Indicator Data Set. Indicators based on health facility data were updated from webDHIS for the financial years ending March, up to 2023/24, and downloaded in July 2024.

Population data

Indicators requiring population denominators (human resources for health and financial indicators) were assigned mid-year population estimates for the relevant year, as available at the time of calculation. The district population estimates (five-year age groups), developed by Stats SA for 2000 – 2030, are used. Population-denominated indicators from WebDHIS used the time series loaded in that system at the time of extraction.

Uninsured population estimates

The uninsured population time series was based on district-level modelled estimates of medical scheme coverage developed by Daniel Shapiro of Insight Actuaries and Consultants, together with the population time series estimates. Overall, medical scheme coverage has remained remarkably static at around 16% ± 1%. Therefore, for the purpose of this analysis, it was considered adequate to apply a single-year estimate of medical scheme coverage to the whole population time series, since the variation in coverage between districts is more relevant than are changes in coverage over time.

1 A table with definitions, references and terms for each indicator used in this report is available in Appendix 1.
2 Hogan DR, Stevens GA, Hosseinpoor AR, Boerma T. Monitoring universal health coverage within the Sustainable Development Goals: development and baseline data for an index of essential health services. The Lancet Global Health. 2018;6(2):e152-e68.

The number of covered and uncovered lives were estimated using Insight's small area model. The model uses different sets of survey data to estimate the population and the number of medical scheme beneficiaries for small areas contained in the South African Census. The small area estimates are then aggregated to municipalities according to the current municipal demarcations. Small areas population was estimated by rescaling Census 2011 person data to the total population by local municipalities as per the 2016 Community Survey, and the total population by metros as per the 2018 General Household Survey.

The number of medical scheme beneficiaries was estimated using a predictive model. Household information from the 2018 General Household Survey was used to model the number of medical scheme beneficiaries in a household, based on predictors also available in Census data. Separate models were built for the probability of a household having coverage and for the number of individuals covered, given that a household has coverage. The predictors included gender of the household head, age of the household head, province, metro, income category and number of household members. The models were then applied to Census data to predict the number of medical scheme members in households for each small area. Household information was taken from Descriptive Community Profile data of the Census and scaled using the 2016 Community Survey and 2018 General Household Survey total populations. The predicted number of medical scheme beneficiaries was scaled to the number of medical scheme beneficiaries by metro from the 2018 General Household Survey and to the number of medical scheme beneficiaries by province in the Council for Medical Schemes Annual Report.

District health expenditure indicators

Provincial health expenditure up to 2023/24 was extracted from the National Treasury BAS. Expenditure allocated to specific health facilities (under the 'Responsibility level' hierarchy) was coded to the latest DHIS facility information. All other expenditure that could not be clearly allocated to a specific district (such as, for example, provincial-level expenditure) was allocated to each district in proportion to the population share of the areas involved.

Provincial expenditure was coded according to the programmes and sub-programmes published by the National Treasury. Expenditure from sub-programmes 2.2–2.7 (community health clinics, community health centres, community-based services, other community services, and HIV and nutrition) constitutes the non-hospital Primary Health Care (PHC) expenditure under District Health Services. Total District Health Services expenditure includes all sub-programmes under Programme 2: District Health Services, except sub-programme 2.8 (Coroner services).

Additional data sources used include:

- Data on local government expenditure on PHC from the National Treasury. Net expenditure was used, i.e. expenditure less revenue (which includes transfers from provinces to local government).
- Factors for inflation adjustments based on the Consumer Price Index (CPI) (Stats SA) were used to convert expenditure for all years to real 2023/24 prices. This means that increases in expenditure over time reflect greater availability of resources rather than merely increases to cover the increasing cost of health care due to inflation.
- Uninsured population estimates, derived from modelled estimates of medical scheme coverage and the DHIS population time series.

Per capita expenditure indicators use public sector expenditure divided by the uninsured population. However, the General Household Survey[3] and other sources indicate that the uninsured population makes significant use of private sector services, and the insured population also makes some use of public sector services. As such, it is acknowledged that there is a wide range of uncertainty surrounding the true size of the population that is dependent on public sector services, which affects the accuracy of the per capita expenditure indicators.

3 Statistics South Africa. General Household Survey. Pretoria: Stats SA; 2015.

Indicator maps and ranking

Thematic mapping was conducted using R[4], employing various spatial data manipulation and visualisation packages.

The spatial dataset was prepared by importing a shapefile containing local municipal boundaries using the *sf* package, which allowed for the representation of districts and provinces within South Africa.[5,6] Indicator data was sourced from a Microsoft Excel file and processed using *dplyr*, where district identifiers were standardised to match those in the shapefile. A left join was performed to merge the indicator dataset with the spatial boundaries, ensuring that each district's geographic representation was linked to its respective indicator values.

Thematic maps were generated using a continuous colour scale from the *viridis* package, with the scale_fill_viridis_c function applied for its perceptually uniform gradient, which is colourblind-friendly and well-suited for continuous data visualisation.[7] The plasma colour scheme was used, assigning lighter, yellowish shades to high values and darker, purplish shades to low values to enhance interpretability. Districts without available data were outlined in red to highlight gaps, while those with data were outlined in grey. Provincial borders were delineated by aggregating district geometries and displaying them with black outlines for clear regional distinction (Figure 1).

For labelling, the *shadowtext* package was employed to improve text readability, with district names displayed in black text on a white halo for areas with data, while districts without data were labelled in red to further emphasize missing information.[8]

The final maps were exported in A4 landscape format using the ggsave function from *ggplot2*, ensuring high-resolution output suitable for reports and presentations.[9,10]

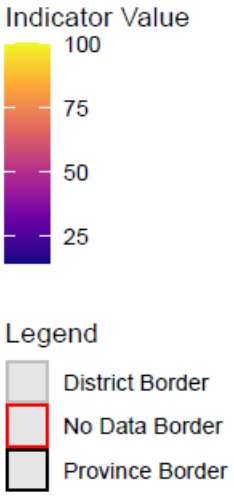

Figure 1 Indicator colour scheme and legend

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Averages

All averages (provincial and national) are weighted averages, based on the total numerator and denominator for all the sub-areas included, and are, therefore, not averages of the district indicator values. These averages may appear 'skewed' for any indicator in any province where there are districts of very different sizes or workloads, and where a bigger district has a very different value from the other smaller districts in a province.

Data display

Financial year and calendar year

Indicators from the DHIS and the BAS financial system cover the 12 months from April to March, which is the financial year of the NDoH. Indicators for financial years are annotated as 2023/24 or FY 2024. The TB data cover a calendar year. Data from the Stats SA surveys correspond with the period of the survey. Human resource data are cross-sectional (for a specific month in a year). In the Excel file produced with the DHB, the single year indicated for summary purposes is the one including the majority of the data.

Indicator ranking – is first always best?

The districts are ranked from 1 to 52 (for the various indicators in the league table graphs where number 1 represents the best performance and number 52 the worst performance). However, with some indicators such as the expenditure indicators, an indicator in the number 1 position does not mean best performance; 'best' is usually in the middle range close to the South African average. For these indicators, order from top to bottom should therefore not necessarily be considered as best to worst. Individual indicators are therefore ranked as either ascending (low values are best, for example maternal mortality ratios) or descending (high values are best, for example immunisation coverage).

In the DHB data file, the indicator ranks for all districts are coloured from green to red. It must be noted that this is merely a crude indication of performance and is based on the position of a district relative to the other 51 districts and not based on a target or fixed standard. Therefore, it is possible that an indicator may improve in a district, but it could drop in rank (i.e. move from green towards red) if other districts have improved to a greater extent.

Trends

Annual indicator trends (district and provincial) are included in some chapters in Section A: Indicator Comparisons per programme (Figure 2). Indicator comparisons by district help the reader to explore how an indicator varies over a number of years across districts and provinces. As the scale of the y-axis is the same for all the graphs, one can notice differences easily. Annual trends also reveal variation and change within the districts in a particular province over time.

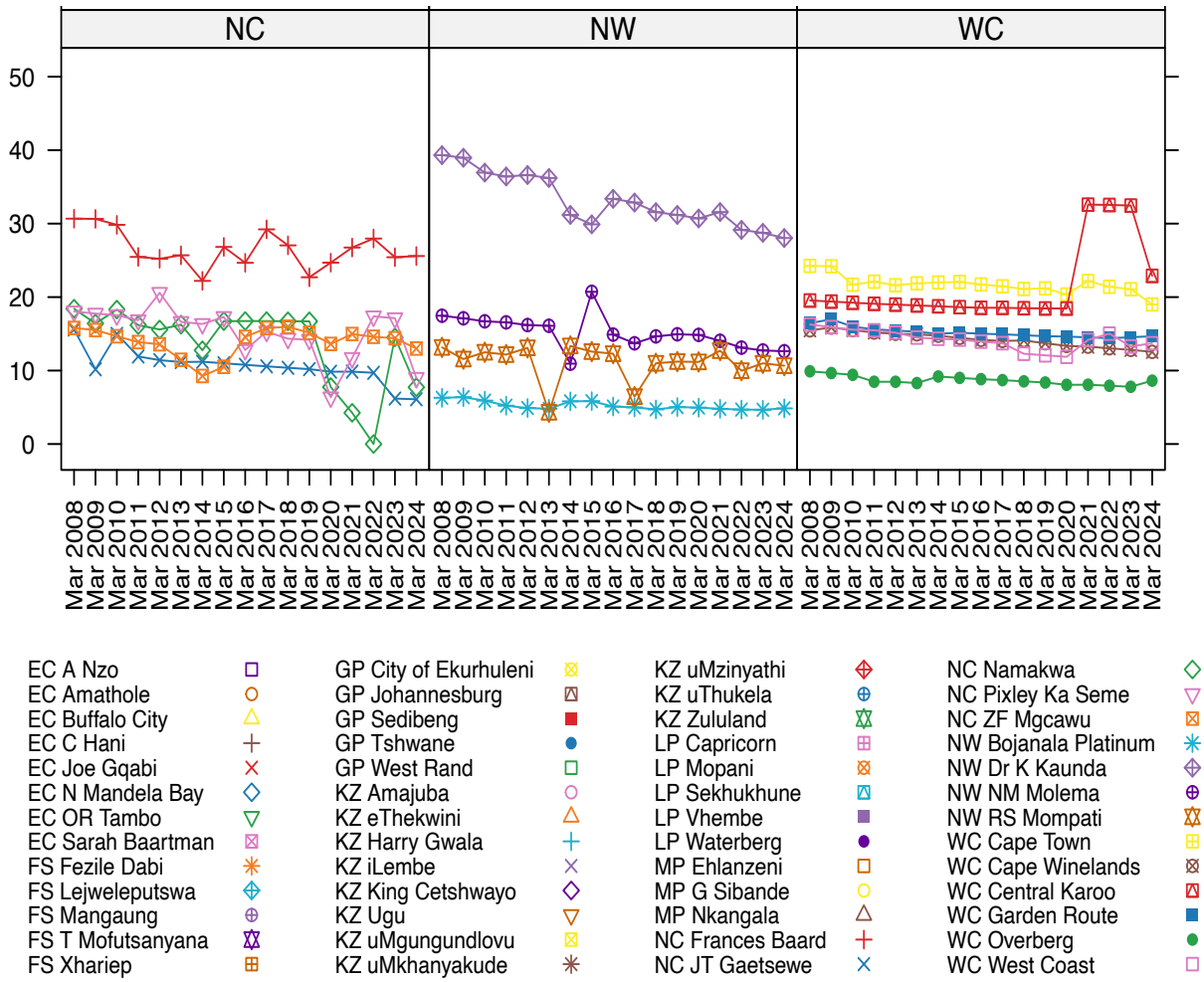


Figure 2 Example of annual indicator trends over a number of years across districts and provinces

In section B of the report, composite graphs show annual trends for all districts for the majority of indicators included in Section A: Indicator Comparisons per programme of the DHB as well as additional indicators. The district indicator value is shown together with the relevant provincial averages and ZA national averages (Figure 3).

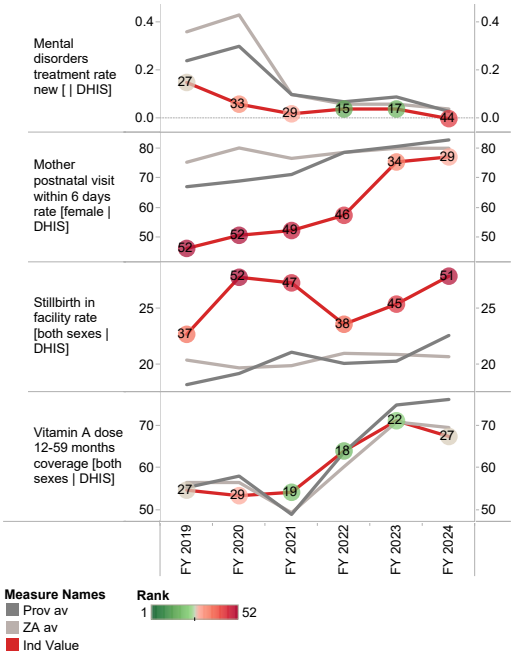


Figure 3 Example of annual indicator trends for districts

01 Reproductive, maternal, newborn and child health

1.1 Maternal and neonatal

Maria Jose, Hassan Mahomed

Key findings

- Multiple barriers to accessing antenatal care remain, comprising direct and indirect costs associated with accessing antenatal care.
- There has been a 7.0 percentage point decline in antenatal 1st visit coverage which continues a downward trend in antenatal care attendance noted since 2021/22. It may in part be due to budget constraints in more recent years that may have negatively impacted on the accessibility of services.
- Amongst women who received antenatal care, 69.6% accessed this care within the first 20 weeks of gestation.
- There is a 21.4 percentage point variation in the antenatal 1st visit coverage between provinces, which ranges from 64.7% in KwaZulu-Natal (KZ) to 86.1% in Northern Cape (NC).
- There is a difference of 45.9 percentage points between the districts with the highest and lowest coverage levels with a 1.9-fold variation.
- There is a general trend towards declining antenatal 1st visit coverage, with 50 out of 52 districts recording a decline in coverage over the past year.

Introduction

The World Health Organization highlights the role of antenatal care in supporting healthy pregnancy and infant outcomes through maternal and foetal assessments, nutrition advice, screening and management of symptoms of pregnancy and medical co-morbidities as well as counselling and support for delivery.[1] Antenatal care also contributes to achieving the United Nations' Sustainable Development Goals, by increasing uptake of institutional delivery and reducing complications during delivery and the postnatal period, resulting in improved maternal and neonatal mortality rates.[1]

The definition of antenatal 1st visit coverage used in this analysis is *the proportion of potential antenatal clients coming for at least one (booked) antenatal visit.* The numerator is antenatal 1st visits, the denominator is calculated *based on the projected Census estimate of number of children under one year*,[2] factorised by 1.15 – the extra 0.15 (15%) is a rough estimate to cater for late miscarriages (~10 to 26 w), stillbirths (after 26 weeks' gestation), and infant mortality. Pregnant women are regarded as potential antenatal clients from around 10 weeks' gestation, i.e., spontaneous abortions before that as well as termination of pregnancy cases are excluded.

National overview

At a national level, the antenatal 1st visit coverage was 69.4% in 2023/24 (Table 1). This represents a 7.0 percentage point decrease from the previous year's coverage of 76.4%, and continues a downward trend in antenatal attendance since 2020/2. The figure also constitutes the lowest documented coverage in the past five years. The antenatal 1st visit before 20 weeks of gestation rate for 2023/24 was 69.9% which is comparable to pre-COVID-19 levels last seen in 2019/20 and has remained steady over the last five years.

1 World Health Organization. Recommendations on antenatal care for positive pregnancy experience. Luxembourg: WHO; 2016.
2 National Department of Health. National Indicator Data Set: 2023. Pretoria: NDoH; 2023.

Table 1 National trend in antenatal 1st visit coverage and antenatal 1st visit before 20 weeks rate, 2019/20 – 2023/24 (%)

NATIONAL INDICATOR	2019/20	2020/21	2021/22	2022/23	2023/24
Antenatal 1st visit before 20 weeks rate	69.7	67.9	68.9	70.1	69.9
Antenatal 1st visit coverage	83.1	83.9	81.5	76.4	69.4

Source: DHIS

In 2023/24, 906 788 women booked for antenatal care compared to 998 043 in 2022/23. Of the women who booked for antenatal care in 2023/24, 634 246 (69.9%) booked within the first 20 weeks of gestation, which is comparable with the 699 885 (70.1%) who booked for antenatal care within 20 weeks in 2022/23.

Provincial overview

Figure 1 shows the provincial antenatal 1st visit coverage with an interprovincial variation of 21.4 percentage points, ranging from a low of 64.7% coverage in KZ to a high of 86.1% in the NC. This difference is slightly narrower than the 21.6 percentage point difference seen in 2022/23 between the same two provinces. Five provinces achieved a coverage level greater than the national average of 69.4%, while four were below the provincial average, namely, Free State (FS), Eastern Cape (EC), North West (NW), and KZ.

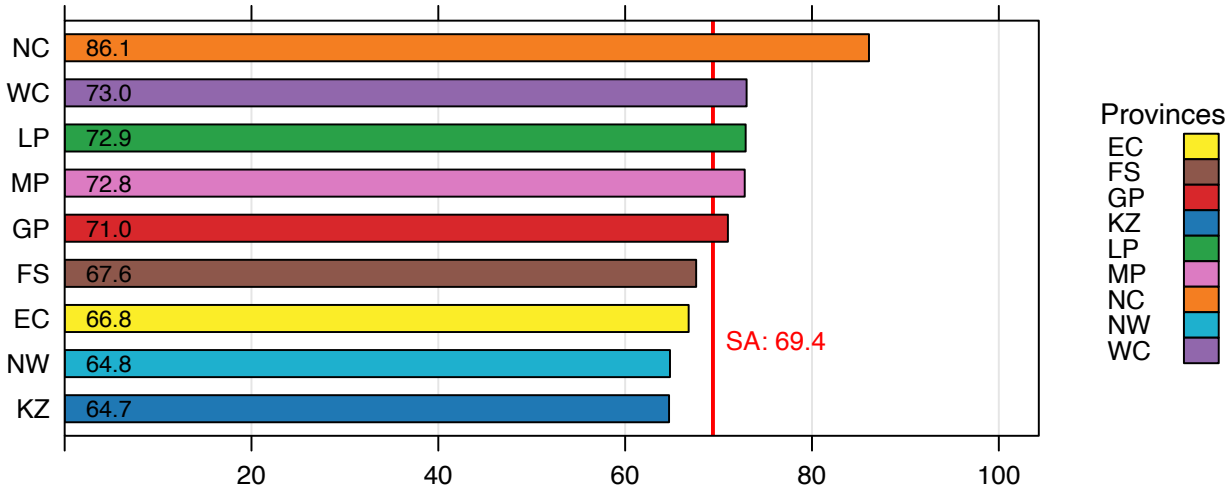


Figure 1 Antenatal 1st visit coverage by province, 2023/2024

Source: DHIS

Table 2 documents the annual trend in the antenatal 1st visit coverage per province and notes the continued decline in coverage affecting all provinces since 2021/22. The greatest decline was noted in Limpopo (LP) with 15.1 percentage points compared with NC which reported the smallest decline of 2.5 percentage points.

Table 2 Annual trend in antenatal 1st visit coverage by province, 2019/20 – 2023/24 (%)

PROVINCE	2019/20	2020/21	2021/22	2022/23	2023/24	PERCENTAGE POINT DIFFERENCE BETWEEN 2021/22 AND 2023/24
Eastern Cape	68.7	68.2	81.2	74.8	66.8	-14.4
Free State	79.3	78.5	78.9	75.4	67.6	-11.3
Gauteng	90.2	88.3	82.5	76.1	71.0	-11.5
KwaZulu-Natal	75.0	76.3	77.3	75.1	64.7	-12.6
Limpopo	90.7	93.9	88.0	80.1	72.9	-15.1
Mpumalanga	92.7	107.4	87.6	78.1	72.8	-14.8
North West	105.6	109.9	88.6	91.2	86.1	-2.5
Northern Cape	77.7	76.4	72.1	69.6	64.8	-7.3
Western Cape	91.1	86.7	82.6	78.6	73.0	-9.6

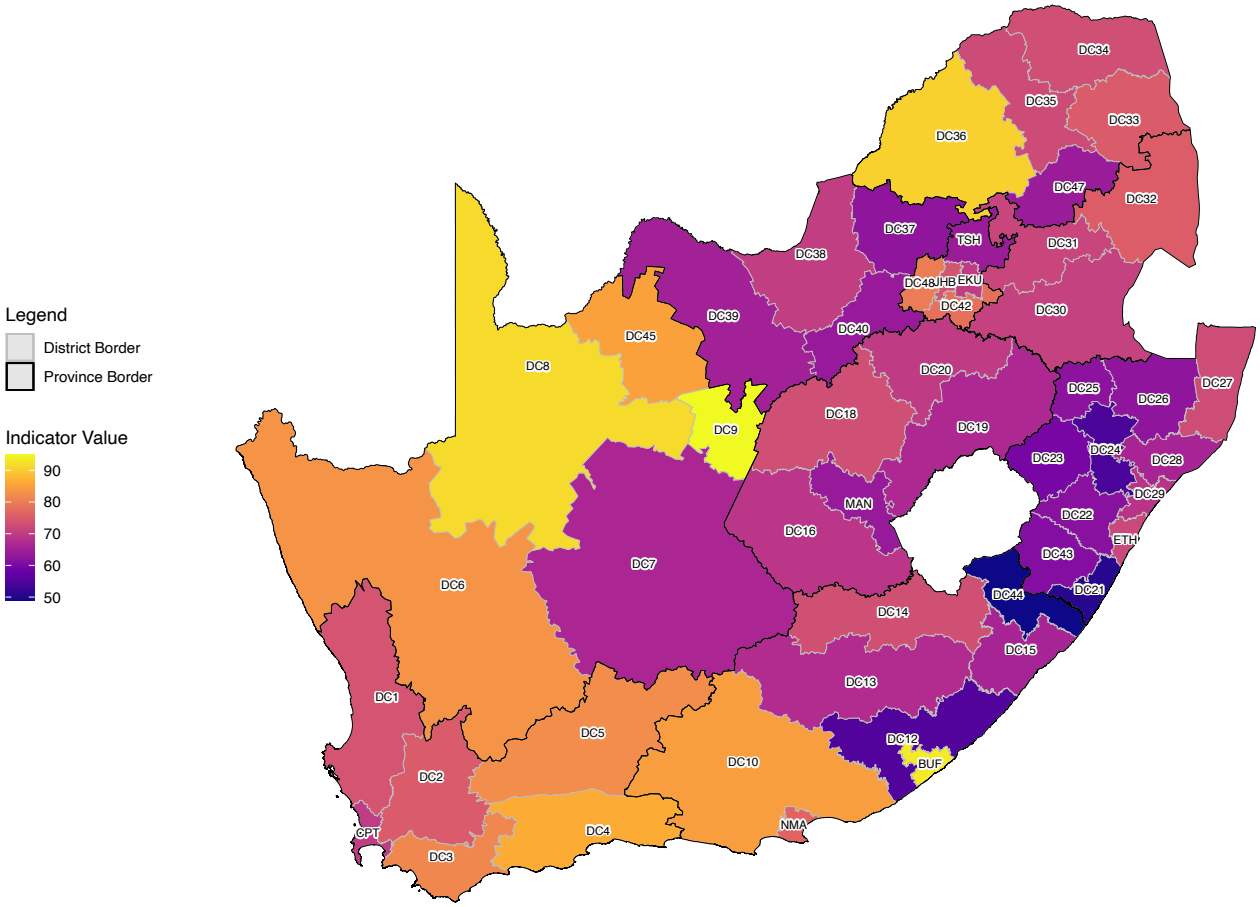
Source: DHIS

District overview

The antenatal 1st visit coverage across the 52 districts in the country is reflected in Map 1 and Figure 2 which show a gap of 45.9 percentage points and a 1.9-fold variation between the districts with the highest and lowest coverage levels.

Based on the district ranking illustrated in Figure 2, the 10 districts with the highest coverage included four from NC, three in the Western Cape (WC), two in EC, and one in LP. KwaZulu-Natal had seven districts among the 10 with the lowest coverage levels while EC had two districts and NW had one district in the lowest performing 10 districts.

Coverage ranged from 48.9% in Alfred Nzo (EC) to 94.8% in Frances Baard (NC). Thirty districts (57.7%) achieved an antenatal 1st visit coverage level above the national average of 69.4%. Western Cape and Mpumalanga (MP) achieved a coverage level above the national average in all their districts.



MAP 1 Antenatal 1st visit coverage by district, 2023/24

Source: DHIS

An analysis of annual trends in antenatal care (ANC) 1st visit coverage is shown in Figure 3. Between 2022/23 and 2023/24, the antenatal 1st visit coverage improved in just two districts. The greatest improvement occurred in Namakwa (NC) with a 9.0 percentage points increase from 74.0% to 83.0% followed by Joe Gqabi (EC) with an increase of 1.5 percentage points from 71.5% to 73.0% (Table 3). There was a reduction in coverage over the past year in the remaining 50 districts with the greatest decline in Harry Gwala (KZ) where the coverage level fell by 20.8 percentage points from 81.7%to 60.9%.

While 40 districts (76.9%) showed consecutive declines in antenatal 1st visit coverage over the past two years, only Namakwa (NC) had consecutive increases in coverage during the past two years. Eleven districts (21.2%) experienced a decline in antenatal 1st visit coverage over the past year of greater than 10 percentage points. An above average antenatal 1st visit coverage was reported by 30 districts (57.6%). All districts in MP and WC reported antenatal 1st visit coverage above the average.

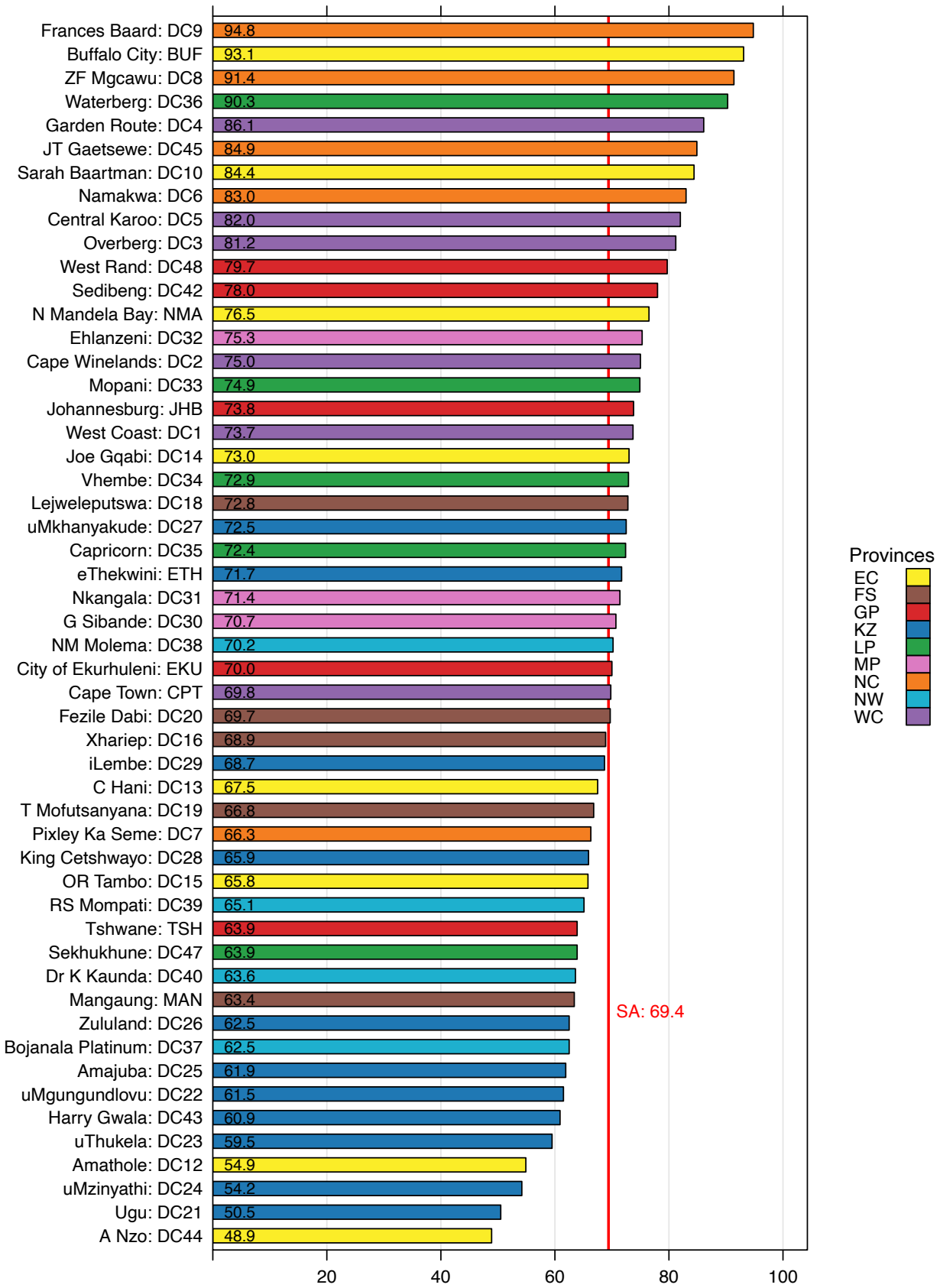


Figure 2 Antenatal 1st visit coverage by district, 2023/2024

Source: DHIS

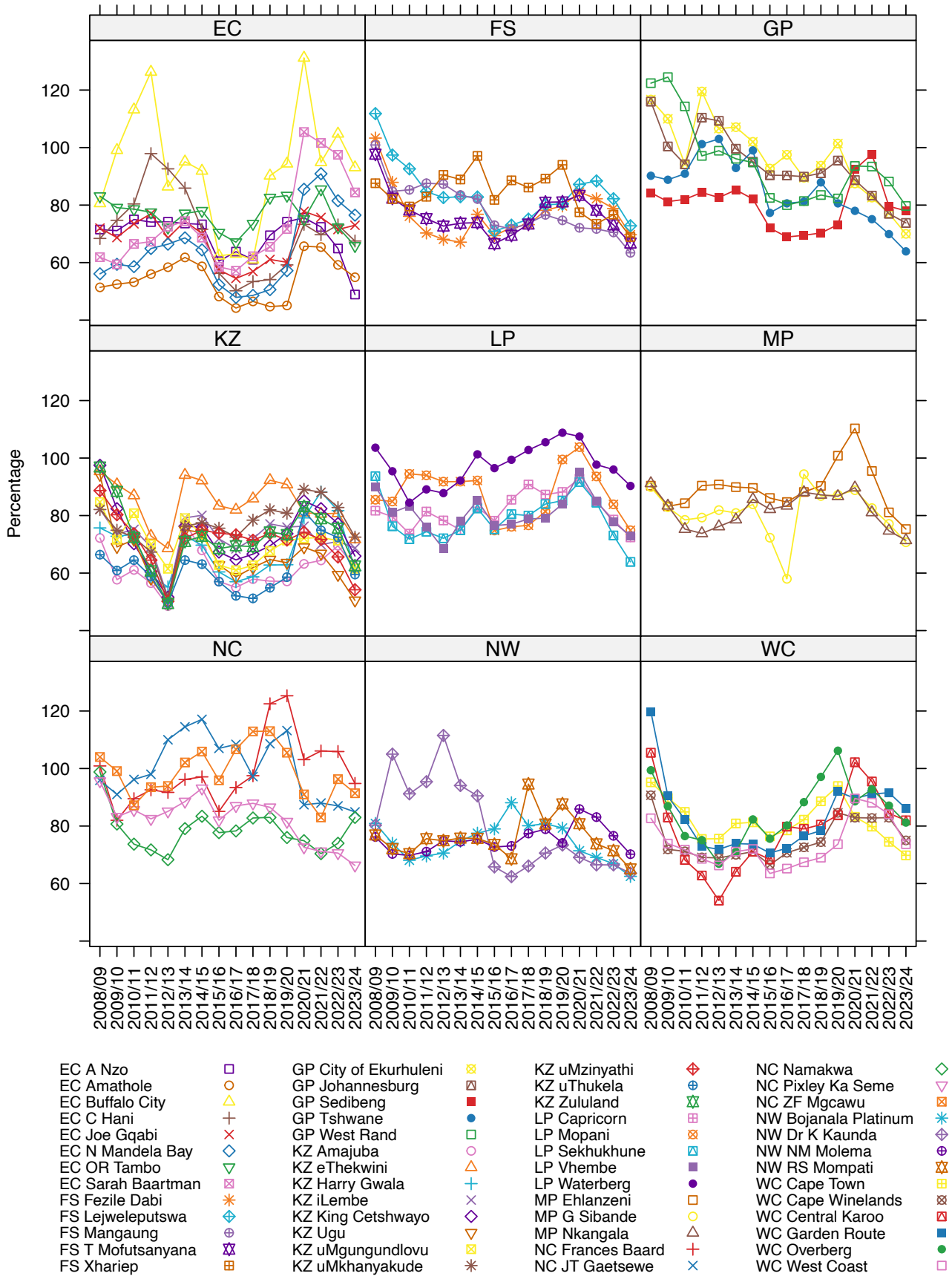


Figure 3 Annual trends: antenatal 1st visit coverage by province and district 2008/09 – 2023/24

Source: DHIS

Table 3 Annual trends in antenatal 1st visit coverage by district, 2019/20 – 2023/24 (%)

PROVINCE	DISTRICT	2019/20	2020/21	2021/22	2022/23	2023/24	Percentage point difference between 2022/23 and 2023/24
Eastern Cape	Alfred Nzo	74.2	75.6	72.4	64.9	48.9	-16
	Amathole	45.1	65.7	65.4	59.2	54.9	-4.3
	Buffalo City	94.4	131.2	94.9	104.8	93.1	-11.7
	Chris Hani	59.2	73.3	69.7	73.1	67.5	-5.6
	Joe Gqabi	60.1	77.8	75.7	71.5	73	1.5
	Nelson Mandela Bay	57.2	85.5	90.9	81.5	76.5	-5
	OR Tambo	83.3	75.1	85.5	72.3	65.8	-6.5
	Sarah Baartman	71.7	105.4	101.6	97.5	84.4	-13.1
Free State	Fezile Dabi	79.7	84.5	82.2	78.8	69.7	-9.1
	Lejweleputswa	80.4	87.2	88.4	82.2	72.8	-9.4
	Mangaung	74.7	72.1	71.7	70.5	63.4	-7.1
	Thabo Mofutsanyana	81.1	83.4	78.2	73.1	66.8	-6.3
	Xhariep	94	77.5	73.5	76.7	68.9	-7.8
Gauteng	Ekurhuleni	101.4	87.5	82.6	77.1	70	-7.1
	Johannesburg	95.5	88.7	83.3	77	73.8	-3.2
	Sedibeng	73.2	92.4	97.7	79.6	78	-1.6
	Tshwane	80.6	78	75.1	69.9	63.9	-6
	West Rand	82.3	93.6	93.4	88.2	79.7	-8.5
KwaZulu-Natal	Amajuba	57.1	63.2	64.4	69.5	61.9	-7.6
	eThekwini	90.8	81	80.6	80.8	71.7	-9.1
	Harry Gwala	62.9	79.2	88.2	81.7	60.9	-20.8
	iLembe	76	76.3	69.9	71	68.7	-2.3
	King Cetshwayo	73.7	85.1	82.4	77.2	65.9	-11.3
	Ugu	63.6	69	66.8	59.4	50.5	-8.9
	uMgungundlovu	71.3	72.1	72.4	71.3	61.5	-9.8
	uMkhanyakude	80.8	89.1	88.1	82.8	72.5	-10.3
	uMzinyathi	71.5	74.2	71.7	65.6	54.2	-11.4
	uThukela	58.6	81.5	74.9	72.4	59.5	-12.9
	Zululand	73.4	83.1	78.9	75.6	62.5	-13.1
Limpopo	Capricorn	88.2	92.9	84.7	78.6	72.4	-6.2
	Mopani	99.5	103.8	93.6	83.9	74.9	-9
	Sekhukhune	85.2	91.7	84.5	73.1	63.9	-9.2
	Vhembe	84	95	85.1	77.8	72.9	-4.9
	Waterberg	108.8	107.5	97.7	96	90.3	-5.7
Mpumalanga	Ehlanzeni	100.8	110.3	95.5	81.1	75.3	-5.8
	Gert Sibande	87.2	88.8	82.6	77.1	70.7	-6.4
	Nkangala	86.7	89.7	81.1	74.7	71.4	-3.3
Northern Cape	Frances Baard	125.3	103.1	106.1	105.9	94.8	-11.1
	JT Gaetsewe	113.2	87.4	88	87	84.9	-2.1
	Namakwa	76	74.9	70.4	74	83	9
	Pixley Ka Seme	81.5	72.6	71.2	70.6	66.3	-4.3
	ZF Mgcawu	105.5	91	83	96.3	91.4	-4.9
North West	Bojanala Platinum	79.3	71.4	69.1	66.9	62.5	-4.4
	Dr K Kaunda	73.4	69.1	66.5	66.5	63.6	-2.9
	NM Molema	74.1	85.9	83.1	76.6	70.2	-6.4
	RS Mompati	87.7	80.8	73.8	71.4	65.1	-6.3

Western Cape	Cape Town	93.9	83.2	79.8	74.5	69.8	-4.7
	Cape Winelands	84.6	82.9	82.8	82.9	75	-7.9
	Central Karoo	83.8	102.2	95.5	84.4	82	-2.4
	Garden Route	92	89.6	91.1	91.6	86.1	-5.5
	Overberg	106.2	88.6	92.8	87.1	81.2	-5.9
	West Coast	73.7	89.6	88.1	84.1	73.7	-10.4

Source: DHIS

Live birth rates

An analysis of live birth rates per district,[3] demonstrates that while numbers of live births increased annually in 88% of districts between 2019 and 2020 there has been a trend of declining live birth rates year-on-year across most districts with only one district reporting increased number of live births in 2023/24 compared to 2022/23. The overall downward trend in birth rates is confirmed by decreasing Home Affairs birth registration rates[4] The projected Census estimate of number of children under one year used in the DHIS is in line with this trend and shows a decline in the under-one population from 1 139 380 in 2021/22 to 1 135 771 in 2022/23 to 1 132 896 in 2023/24.

While reduced access during the COVID-19 years may have been significant, this cannot explain the more recent declines. These factors require further investigation. Globally, declining live birth rates have been noted in high-income countries, with speculation that economic instability motivates women to postpone or forego pregnancy.[5] Indeed, according to Statistics South Africa (Stats SA) birth data referenced above, the average age of pregnancy in South Africa is increasing. There is currently no empirically substantiated reason to believe that a lower demand amongst pregnant women for antenatal care is responsible for the observed decline.

Alternatively, budget constraints in more recent years may have negatively impacted on the accessibility of services. Multiple barriers to accessing antenatal care remain, such as the direct and indirect costs associated with accessing antenatal care, which should motivate for policies that improve access to quality antenatal health care for all.[6]

Conclusion

There is a clear decreasing national antenatal 1st visit coverage trend in recent years while the proportion of pregnant women accessing antenatal care before 20 weeks gestation has remained fairly constant over the last five years. There is a need to investigate whether other remediable factors such as decreasing access due to the worsening economic climate is responsible for the observed trends. It is recognised that early booking is desirable for improved outcomes and further advocacy is needed to encourage early booking for pregnant women.

Recommendations

- Investigate reasons for dropping antenatal coverage rates nationally through research or expanded analyses.
- In an increasingly budget constrained environment, ensure that maternal care services are protected with sufficient skilled staff.
- Expand access to antenatal care and early booking through advocacy, patient education and outreach with appropriate specialist support.

3 Web-based District Health Information System. National Department of Health.
4 Statistics South Africa. Recorded Live Births, 2023. Pretoria: Stats SA; 2024.
5 Bujard M, Andersson G. Fertility declines near the end of the COVID-19 pandemic: evidence of the 2022 birth declines in Germany and Sweden. Eur J Popul. 2024;40(1):4. doi: 10.1007/s10680-023-09689-w
6 Ataguba JE, Nwosu CO, Obse AG. Is socioeconomic inequality in antenatal care coverage widening or reducing between- and within-socioeconomic groups? A case of 19 countries in sub-Saharan Africa. SSM Popul Health. 2023;23(101402) 2352-8273. https://doi.org/10.1016/j.ssmph.2023.101402

Maternal mortality in facility ratio

Lawrence Chauke

Key findings

- The national in-facility maternal mortality ratio (iMMR) declined from 101.0 in 2022/23 to 100.6 per 100 000 live births in 2023/24. This raises concerns regarding South Africa's capacity to achieve the 2030 Sustainable Development Goal (SDG) 3.1, which aims to reduce maternal mortality to less than 70 per 100 000 live births by 2030.
- There is wide variation in the iMMR across provinces, reflecting disparities in access to quality healthcare services.
- The iMMR declined in five provinces – Western Cape (WC), Gauteng (GP), Mpumalanga (MP), Limpopo (LP) and Northwest (NW) – in 2023/24 compared to eight in 2022/23; however, only Western Cape (iMMR of 48.3 per 100 000 live births) met the SDG target 3.1.
- The gap between the worst – Eastern Cape (EC) and best, WC province – increased from 2.0 to 2.8-fold in 2022/23 and 2023/24, respectively.
- Frances Baard in the Northern Cape (NC) was the worst performing district and had the highest increase in the iMMR between 2022/23 and 2023/24 (207.0 per 100 000 live births in 2023/2024 and 105.9 in 2022/2023).
- Three districts – Namakwa (NC), Central Karoo and West Coast (both WC) – reported zero iMMR in 2023/24 compared to four – Overberg (WC), Namakwa (NC), Xhariep (Free State (FS)), and Joe Gqabi (EC) in 2022/23.
- Only 17 districts out of the 52 districts achieved the SDG 3.1 of reducing maternal deaths to less than 70 per 100 000 live births.

Introduction

The South African National Department of Health's Indicator Data Set (NIDS) utilises the iMMR, defined as the number of women who die in health facilities during pregnancy, childbirth, and the puerperium, or within 42 days of the termination of pregnancy, irrespective of the duration, site, and cause of death, per 100 000 live births.[1] It is a critical indicator of the overall health of a society, reflecting the effectiveness of healthcare systems in delivering timely and quality care for pregnant women. The iMMR provides valuable insights into the quality and safety of care delivered in healthcare facilities (antenatal, intrapartum and postpartum care) and eliminates external factors that could influence maternal mortality outside the healthcare environment, such as access to care, transportation, and socioeconomic conditions. This creates opportunities for assessing and tracking health system performance, benchmarking against other healthcare facilities, identifying areas for improvement, and guiding policy directions and resource allocation.

In South Africa, the maternal mortality ratio can be calculated from three sources: the District Health Information System (DHIS), the Maternal Mortality and Morbidity Audit System (MAMMAS) database managed by the National Committee on Confidential Enquiries into Maternal Deaths (NCCEMD), and the South Africa Demographic and Health Survey (SADHS). The DHIS records maternal deaths from public healthcare facilities only, while the MAMMAS collects information on maternal deaths occurring in private, public, and outside of healthcare institutions.

Maternal mortality is a critical indicator of the SDGs, specifically within the context of Goal 3.1, which aims to reduce the global incidence of maternal deaths to fewer than 70 maternal deaths per 100 000 live births by 2030.[2] In addition to this global commitment, the South African National Department of Health (NDoH) has set a target to reduce maternal mortality to fewer than 100 maternal deaths per 100 000 live births by the 2024/25 financial year.[3]

1 National Department of Health. National Indicator Data Set 2023. Pretoria: NDoH, 2023.
2 United Nations. Sustainable Development Goals 2023: Special Report – towards a rescue for the planet. New York: UN; 2023. https://unstats.un.org/sdgs/report/2023/
3 World Health Organization. Trends in maternal mortality 2000 to 2020: Estimates by WHO, UNICEF, UNFPA, World Bank Group & UNDESA/Population Division. Geneva: World Health Organization; 2023. https://iris.who.int/bitstream/handle/10665/366225/9789240068759-eng.pdf?sequence=1

Global statistics

According to the World Health Organization (WHO), an estimated 287 000 women -equivalent to 800 women per day or one woman every two minutes – died from preventable pregnancy-related complications in 2020.[3,4] This corresponds to a global maternal mortality ratio (MMR) of 223 maternal deaths per 100 000 live births. A total of 272 650 (95%) of these deaths, occurred in low- and middle-income countries (LMICs), with sub-Saharan Africa (SSA) contributing a total of 202 000 (74%) of the total deaths from LMICs. The most common contributing factors to the high maternal mortality rates in LMICs include social determinants of health, harmful gender practices, health system failures, humanitarian crises, and, more recently, climate change.[6] The leading causes of maternal mortality worldwide include obstetric haemorrhage, complications related to hypertension during pregnancy, infections, complications arising from unsafe abortion, and complications during labour and delivery of which evidence-based and low-cost solutions are available.[5,6] The global maternal mortality rate declined by 3% annually from 2000 to 2015; however, this rate of decline has slowed to 0.5% between 2016 and 2022.[5] To achieve the 2030 SDGs, an annual reduction of 11.4% in the maternal mortality rate is required. Consequently, it is highly unlikely that the global target will be met by 2030.[5,6]

National overview

Maternal healthcare is a priority area for both the national and provincial departments of health. This focus has led to investments in service packages that span the continuum of care, from primary healthcare to tertiary services. These investments include family planning services, community education, a nationwide rollout of antiretroviral treatments (ARVs), and the training of healthcare workers in essential steps in the management of obstetric emergencies (ESMOE), among others. Consequently, there has been a gradual decline in the national iMMR between 2013 and 2019 (Figure 1). However, the iMMR began to rise in 2020/21, a trend that persisted into 2021/22, followed by a subsequent decline in 2022/23. This represents a five-year annual decline rate of 1.2%, which, if sustained, would achieve the national target of reducing maternal mortality to less than 100 per 100 000 live births by the end of 2024/25. However, this would not be sufficient to achieve a reduction of the national iMMR to less than 70 per 100 000 live births within the remaining six years before 2030. The observed increase in the national iMMR during 2020 and 2021 was attributed to both the direct and indirect impacts of the Coronavirus disease (COVID-19) pandemic on the health system.[6] Unfortunately, the decline now appears to be stagnating, further heightening concerns regarding the country's capacity to meet the 2030 SDG 3.1 without additional interventions.

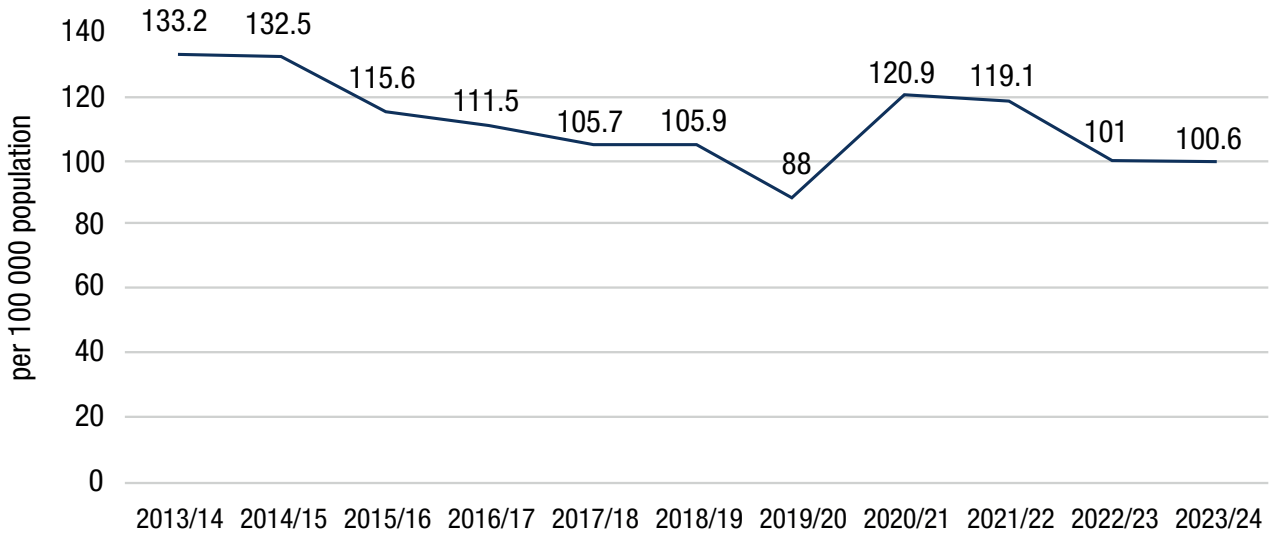


Figure 1 Trend in national maternal mortality in facility ratio, 2013/14 – 2023/2024

Source: DHIS

4 World Health Organization. Maternal mortality. https://www.who.int/news-room/fact-sheets/detail/maternal-mortality
5 Bill and Melinda Gates Foundation. Goalkeepers 2023 report: Imagine a world where innovations could save the lives of 2 million more mothers and babies. Bill and Melinda Gates Foundation; 2023. https://www.gatesfoundation.org/goalkeepers/downloads/2023-report/2023-goalkeepers-report_en.pdf
6 National Department of Health. Saving Mothers. Executive summary 2020-20224: Includes data for COVID-19 pandemic. Pretoria: NCCEMD.

Provincial overview

Table 1 and Figure 2 present a summary of the provincial iMMR for 2023/24, alongside a five-year trend in the provincial iMMR. In 2023/24, five provinces (WC, GP, MP, LP and NW) reported a decline in the iMMR compared to the figures from 2022/23. Only two provinces (WC and KwaZulu-Natal (KZ)) had iMMRs below the national average of 100.6 per 100 000 live births, with the WC meeting the SDG 3.1 at 48.3 per 100 000 live births. Eastern Cape had the highest iMMR (136.2 per 100 000 live births) in 2023/24 and NC had the highest increase in the iMMR between 2022/23 and 2023/24 (from 80.0 to 115.8 per 100 000 live births). The gap between the worst (EC) and best (WC) performing province increased from 2.0 to 2.8-fold between 2022/23 and 2023/24. The significant variation in iMMR between provinces highlights the inequity in access to quality healthcare and is consequently a matter of concern.

Table 1 Annual trend in maternal mortality in facility ratio by province, 2018/19 – 2023/24

PROVINCE	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Eastern Cape	106.1	108.2	146.2	114.6	124.3	136.2
Free State	168.3	116.2	178.8	156.5	95.1	104.8
Gauteng	122.8	102.9	118.7	129.3	118.5	107.3
KwaZulu-Natal	88.4	76.9	123.9	100.6	78.5	89.2
Limpopo	111.6	97.8	120.1	134.6	109	104.7
Mpumalanga	92.4	67.1	108.3	130.0	114.5	109.4
Northern Cape	71.3	109.9	80.6	157.5	80.0	115.8
North West	137.4	88.0	124.6	129.9	118.0	110.2
Western Cape	66.8	43.6	83.9	75.1	62.0	48.3

Source: DHIS

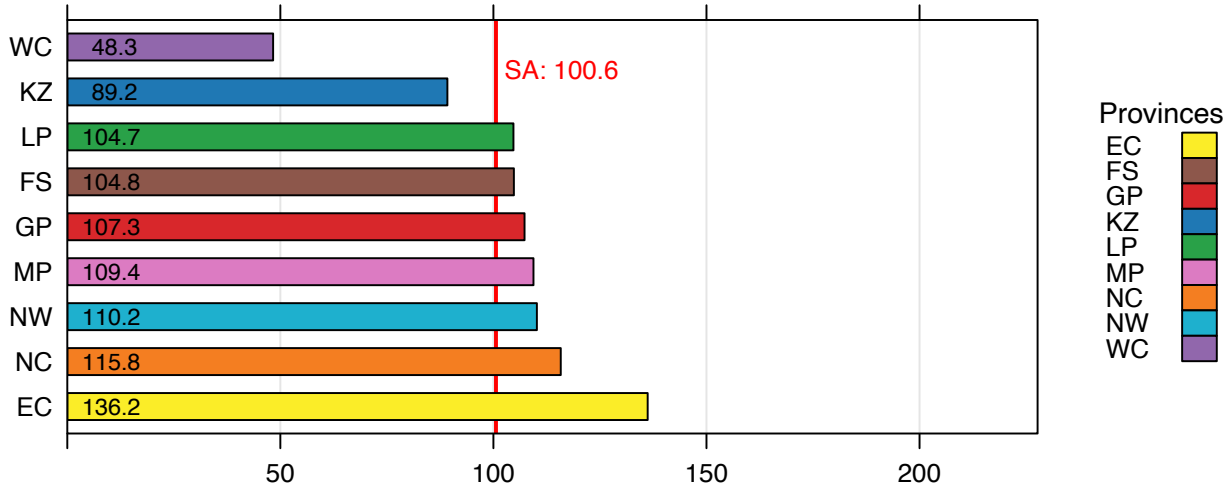


Figure 2 Maternal mortality in facility ratio by province, 2023/24

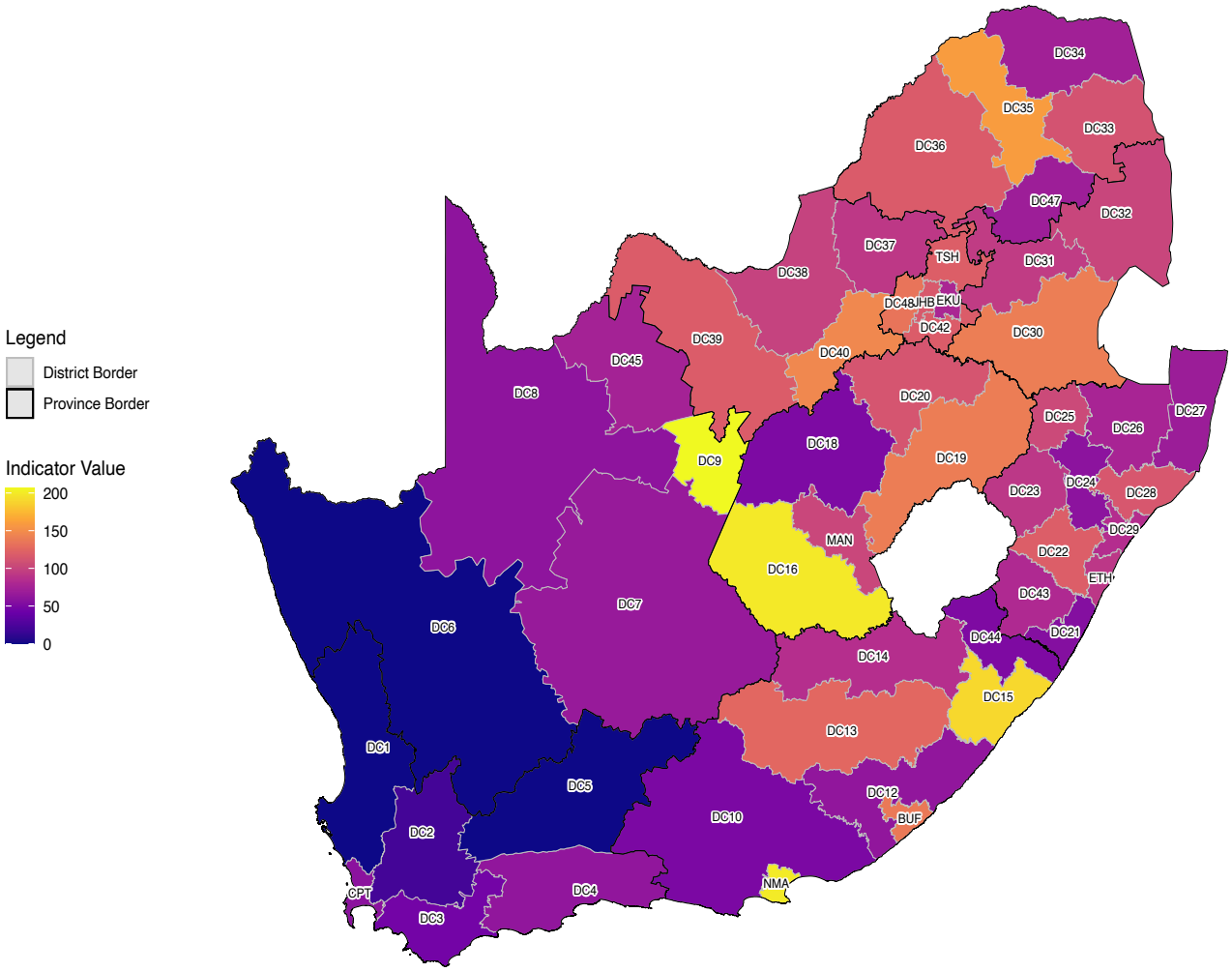
Source: DHIS

District overview

The iMMR across the 52 districts of South Africa are illustrated in Map 1, Figures 3 and 4, and Table 2. In 2023/24, three districts – Namakwa (NC), Central Karoo (NC), and West Coast (WC) – reported zero maternal deaths, in contrast to four districts – Waterberg (LP), Namakwa (NC), Xhariep (FS), and Joe Gqabi (EC) – that recorded zero maternal deaths in 2022/23. Notably, only Namakwa has achieved zero maternal deaths for two consecutive years. The highest iMMR (207 per 100 000 live births) was reported in Frances Baard (NC). The iMMR in this district almost doubled between 2022/23 (105.0 per 100 000 live births) and 2023/24.

The maternal deaths in Frances Baard (NC) in this period increased from 10 to 19 (Table 2). Ekurhuleni (GP) had a decrease of 37 maternal deaths in the same period, from 84 maternal deaths to 47. Twenty-five (48.1%) districts had an increase in the number of maternal deaths. Thirty (57.7%) districts achieved an iMMR below the national average of 100.6, and 17 (32.6%) achieved SDG 3.1 by reducing maternal mortality ratio to less than 70 per 100 000 live births in 2023/2024.

Of the 17 districts that achieved an iMMR of less than 70 per 100 000 live births, six were from WC (35.3%), two from EC (17.6%), three from KZ (17.6%), four from NC (17.6%), and one each from LP (5.9%) and FS (5.9%). Only WC managed to achieve an iMMR below the national average across all its districts. The interprovincial and intra-provincial differences (variations within districts in the same province) in the iMMR further highlight the disparities in access to quality healthcare across and within provincial boundaries.



MAP 1 Maternal mortality in facility ratio by district, 2023/24

Source: DHIS

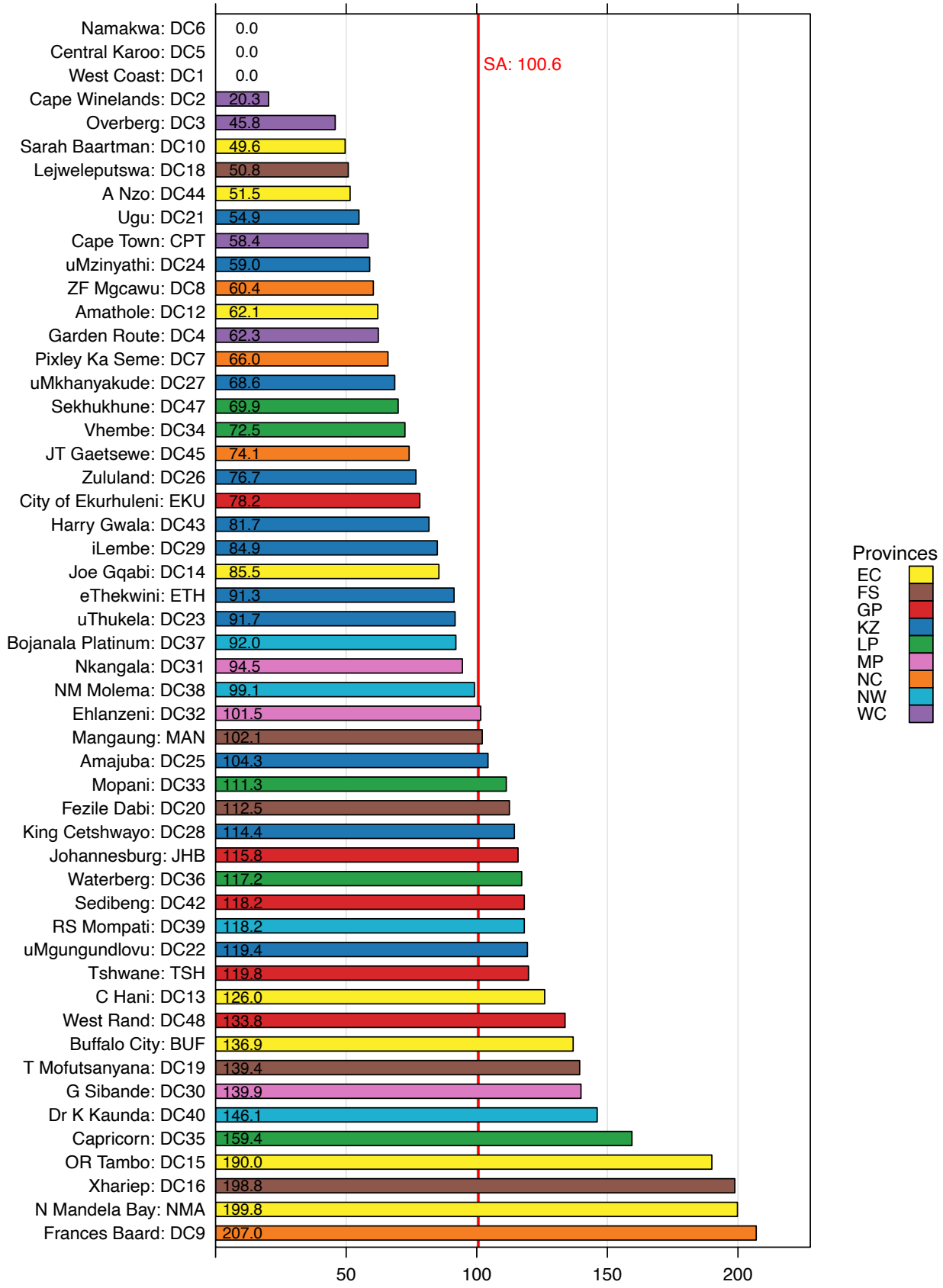


Figure 3 Maternal mortality in facility ratio by district, 2023/24

Source: DHIS

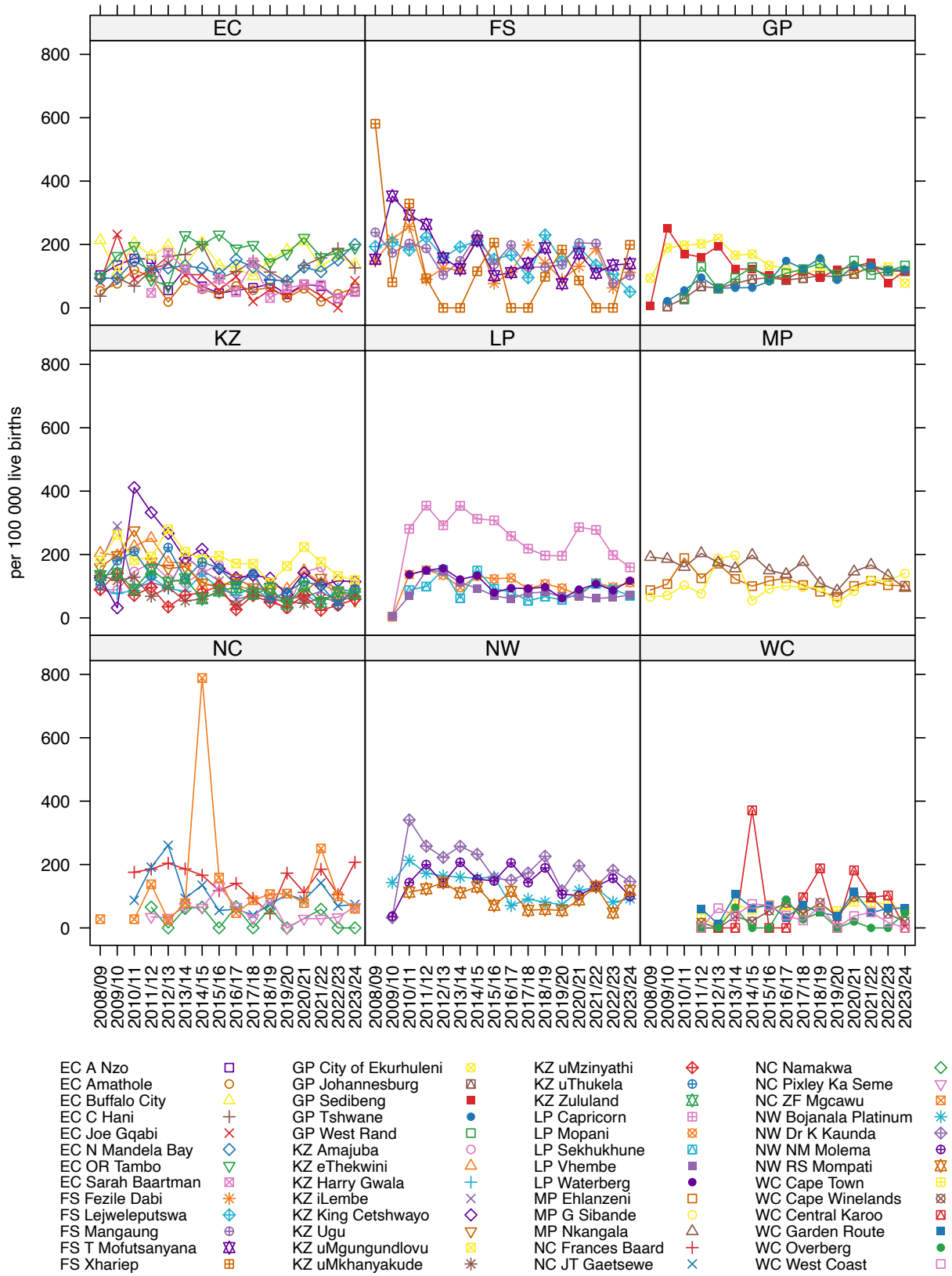


Figure 4 Annual trend: maternal mortality in facility ratio by province and district 2008/09 – 2023/24

Source: DHIS

Table 2 Maternal deaths by district, 2022/23 – 2023/24

PROVINCE	DISTRICT	2022/23 (No.)	2023/24 (No.)
Eastern Cape	Alfred Nzo	4	6
	Amathole	4	5
	Buffalo City	23	18
	Chris Hani	21	13
	Joe Gqabi	0	4
	Nelson Mandela Bay	28	35
	OR Tambo	51	47
	Sarah Baartman	2	3
Free State	Fezile Dabi	5	8
	Lejweleputswa	12	5
	Mangaung	13	15
	Thabo Mofutsanyana	18	17
	Xhariep	0	2
Gauteng	Ekurhuleni	84	47
	Johannesburg	88	83
	Sedibeng	11	15
	Tshwane	63	58
	West Rand	19	20
KwaZulu-Natal	Amajuba	4	10
	eThekwini	57	58
	Harry Gwala	8	6
	iLembe	6	9
	King Cetshwayo	26	22
	Ugu	13	7
	uMgungundlovu	27	22
	uMkhanyakude	9	10
	uMzinyathi	5	6
	uThukela	6	11
	Zululand	15	12
Limpopo	Capricorn	55	41
	Mopani	26	27
	Sekhukhune	24	17
	Vhembe	19	20
	Waterberg	13	16
Mpumalanga	Ehlanzeni	43	37
	Gert Sibande	25	27
	Nkangala	29	19
Northern Cape	Frances Baard	10	19
	JT Gaetsewe	4	4
	Namakwa	0	0
	Pixley Ka Seme	1	2
	ZF Mgcawu	5	3

North West	Bojanala Platinum	18	19
	Dr K Kaunda	26	19
	NM Molema	26	15
	RS Mompati	5	11
Western Cape	Cape Town	45	34
	Cape Winelands	7	3
	Central Karoo	1	0
	Garden Route	6	6
	Overberg	0	2
	West Coast	1	0

Source: DHIS

Recommendations

- The NDoH and provincial departments of health should ring-fence dedicated budgets for maternal and neonatal services to address health system challenges and support South Africa's commitment to prioritising maternal healthcare.
- The NDoH and provincial departments of health, as well as districts, should ensure access to contraceptive services by using strategies such as provision of contraceptives services after hours and on weekends, including using drug dispensers.
- Improve access to antenatal care by extending telemedicine services and providing antenatal care services on weekends.
- Overcrowding in healthcare facilities should be addressed to reduce hospital diverts which are causing harm to patients.
- Strengthen the district health system to provide quality maternal and neonatal services through injection of resources and supportive leadership.
- Revitalise and strengthen district clinical specialist teams (DCSTs) across all districts and provinces to enhance their capacity to support maternal and neonatal services.
- The NCCEMD should include socio-demographic factors and other socio-determinants of maternal deaths in its analysis and reporting of maternal mortality to guide interventions at national and provincial levels.
- The 'Saving Mothers' report should have a dedicated chapter on maternal deaths amongst migrant women to map the extent of the problem and to assist in targeted interventions.
- Facilities and districts should conduct regular morbidity and mortality audits and utilise the information to develop quality improvement plans.
- All healthcare practitioners working in maternity units should receive ongoing training in ESMOE and respectful maternity care.
- All healthcare facilities performing deliveries should conduct regular obstetric emergency drills.
- The NDoH should establish and operationalise national staffing norms, as well as minimum infrastructure and equipment standards for maternity and neonatal units.
- Safe Caesarean standards should be implemented in all facilities performing Caesarean sections.
- Positions should be created within the public healthcare sector for Clinical Associates to address the human resource and skills shortages in maternity and neonatal services, particularly in remote areas.
- Ongoing investment and interventions should be directed at accelerating reduction in the top five causes of maternal deaths (HIV, haemorrhage, hypertension, medical and surgical complications, and early pregnancy losses – complications of unsafe abortion and ectopic pregnancy).
- Technology should be leveraged to improve access to maternity health services (e.g., 'MomConnect', 'Vula' app, telemedicine, electronic case records, decision support software, etc.). Emergency transport challenges in all provinces should be addressed.
- Encourage healthcare facilities, districts, and provinces to share best practices to accelerate reduction in maternal deaths within and across the provinces.
- Healthcare workers, faith-based organisations, civil society, and women's support groups should work together and with government to end preventable maternal deaths.
- Society should hold the government accountable for all preventable maternal deaths occurring within healthcare facilities.

Neonatal death in facility rate

Ute Feucht

Key findings

- The national neonatal death in facility rate has shown a concerning trend over the past nine years. After an initial drop from 13.3 per 1 000 live births in 2015/16, to below the Sustainable Development Goal (SDG) target of ≤12 per 1 000 (namely 11.9 per 1 000 in 2019/20), the trend reversed upwards during the COVID-19 pandemic.
- Only one province reached the SDG target, namely Western Cape (WC).
- The unfavourable trend in the indicator has not yet abated, even after the COVID-19 pandemic has subsided, with the most recent rate of 13.4 per 1 000 live births being the highest over the nine-year period since 2015/16. The total number of recorded neonatal deaths in 2023/24 was 11 547.
- Overall, South Africa has had a 12.6% increase in the neonatal death in facility rate from its lowest point in 2019/20.
- Interprovincial variation in the indicator is high, with a more than 2-fold difference between the provinces. The highest rate is in Free State (FS) at 18.7 per 1 000 live births whereas the lowest rate is the in WC at 8.3 per 1 000 live births.
- Three provinces, Mpumalanga (MP), Gauteng (GP) and FS, had higher neonatal mortality rates in 2023/24 compared to nine years ago (2015/16).
- The overall recorded yearly number of live births in the country has dropped by more than 145 000 in the past five years, with a pronounced drop in the past two years. The reduction has been recorded in all provinces except the Northern Cape (NC). The percentage of low birth weight babies (<2500g) has concomitantly increased to 14.1%.

Introduction

The neonatal death in facility rate is an indication of the quality of and access to antenatal, intrapartum, and postnatal care provided to mother-newborn pairs. This current analysis utilises the District Health Information System (DHIS) as the data source, which primarily reports on neonatal deaths occurring within health facilities in the South African public health system. Deaths that occurred at home are therefore not included. The indicator definition is as such: Infants aged 0–28 days who died during their stay in the health facility per 1 000 live births in facility (numerator: neonatal deaths (under 28 days) in facility; denominator: live births in facility). Related indicators include early (0–6 days) and late (day 7–28 days) neonatal death in facility rates.

The United Nations Inter-Agency Group for Child Mortality Estimation (UN IGME) report of 2023 provides insights into global child mortality trends.[1] Of note, is that the annual number of global under-five deaths in 2022 fell to 4.9 (4.6–5.4) million deaths, showing a 51% decline since the year 2000. The neonatal period remains a significant contributor to the under-five mortality rate, accounting for 2.3 million of the deaths. While the child mortality numbers are declining, averages mask persistent inequities, with an 80x mortality risk difference between the countries with the highest and lowest under-five mortality rate.

The neonatal mortality rate is included in the global goals encompassed in the SDGs, namely under goal 3.2, with a target of ≤12 per 1 000 live births by the year 2030.[2] According to the South African Medium-Term Development Plan (2024–2029), the mid-term target for the neonatal in facility mortality rate has been set at ≤12 per 1 000 live births, with the end-term target for 2029 set at ≤10 per 1 000 live births, making it a key indicator for the country to achieve.

1 United Nations Inter-Agency Group for Child Mortality Estimation (UN IGME). Levels and trends in child mortality, Report 2023. UNICEF; 2024. URL: https://data.unicef.org/resources/levels-and-trends-in-child-mortality-2024/
2 United Nations Development Programme. Sustainable Development Goals. UNDP; 2024. URL: https://southafrica.un.org/en/sdgs/3

The causes of neonatal deaths are well known. The multi-country CHAMPS study published data of neonatal deaths that occurred between December 2016 and December 2021.[3] Data collection included a clinical record review and family interviews using standardised verbal autopsy, as well as investigation of post-mortem specimens collected through minimally invasive tissue sampling within 24–72 hours of death. The main causes of neonatal deaths identified in South Africa included prematurity/low birth weight (55.9%), complications of intrapartum events (15.6%), infections (13.8%), and congenital abnormalities (11.2%).

National overview

The national neonatal death in facility rate was recorded as 13.4 per 1 000 live births over the 12-month period of the financial year 2023/24 (Figure 1). This is above the SDG target, and an increase from the 12.7 per 1 000 in 2022/23. The overall pattern is unsatisfactory when evaluated over the past nine years. In 2015/16, the neonatal death rate was 13.3/1 000, followed by years of steady decline (12.4 per 1 000 live births in 2016/17; 12.3 in 2017/18; 12.1in 2018/19, reaching the nadir of 11.9 per 1 000 in 2019/20). This decline likely indicated improvements in neonatal care within the healthcare setting at that time.

Unfortunately, there was a subsequent reversal of this improving trend (12.6 per 1 000 live births in 2020/21; 13.1 per 1 000 in 2021/22) within the context of the COVID-19 pandemic, with negative effects from quality of care and hospital capacities. This trend has not reversed yet, with the rate of 13.4 per 1 000 live births in 2023/24 being the highest recorded in this dataset (n=11 547), indicating continued challenges in neonatal care and/or other health-related issues even after the COVID-19 pandemic. Challenges likely include suboptimal healthcare infrastructure, resource and staff allocation, training, mentoring and clinical governance, as well as challenging socio-economic conditions for the population in South Africa.

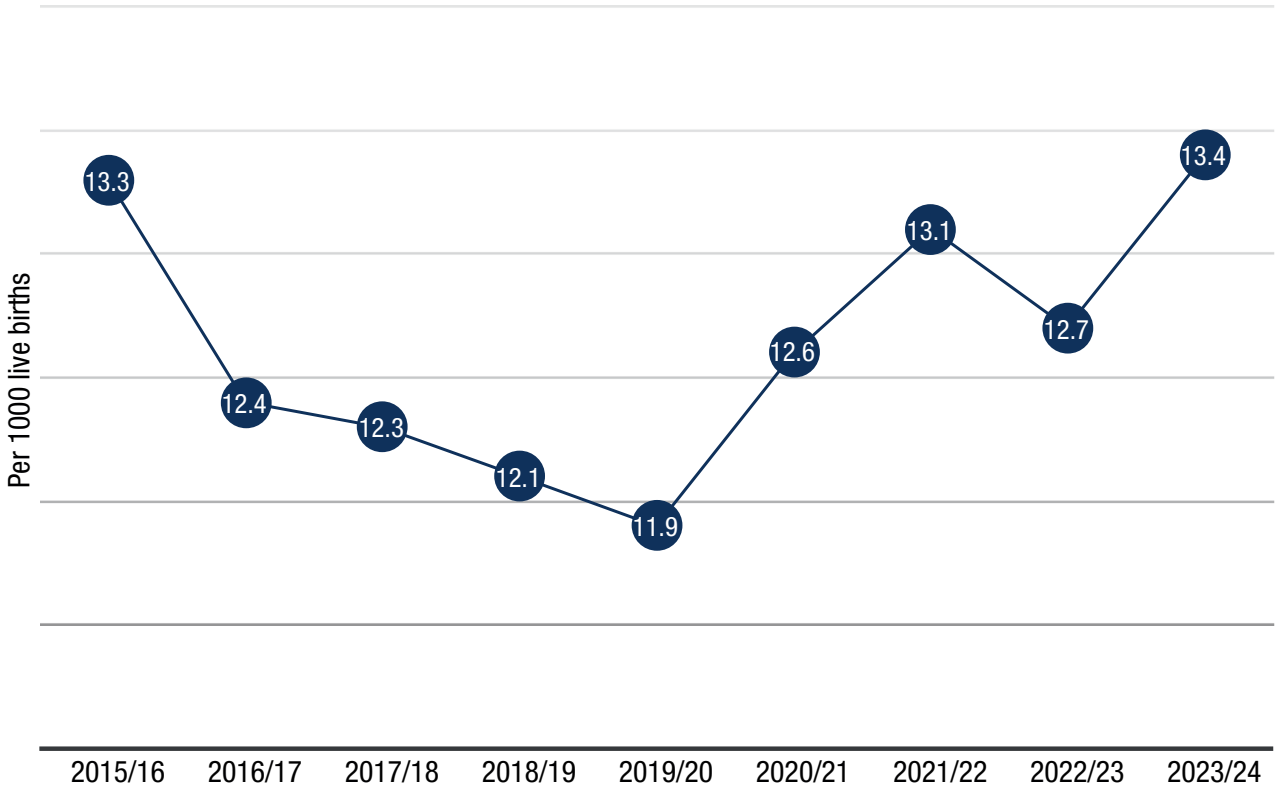


Figure 1 National neonatal death in facility rate, 2015/16 – 2023/24

Source: DHIS

3 Mahtab S, Madhi SA, Baillie VL, Els T, Thwala BN, et al. (2023) Causes of death identified in neonates enrolled through Child Health and Mortality Prevention Surveillance (CHAMPS), December 2016 – December 2021. PLOS Global Public Health 3(3): e0001612. https://doi.org/10.1371/journal.pgph.0001612

Concordantly, the early neonatal death in facility rate had not improved, but has moved sideways in recent years (between 10.7 per 1 000 live births and 9.6 per 1 000, ending on 10.2 per 1 000 in 2023/24), showing no improvement (Table 1). The same sideways pattern is also noted in the related stillbirth in facility rate (fluctuating between 21.3/1 000 and 19.7 per 1 000 total births, with data concerns in terms of undercounting during 2020/21 linked to the COVID-19 pandemic, and ending on 20.7 per 1 000 in 2023/24). Of note, is that the stillbirth in facility rate has in essence been double the early neonatal death rate during the entire period.

Table 1 National neonatal, early neonatal, and stillbirth in facility rates, 2015/16–2023/24 (%)

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Neonatal mortality in facility rate (per 1 000 live births)	13.3	12.4	12.3	12.1	11.9	12.6	13.1	12.7	13.4
Early neonatal mortality in facility rate (per 1 000 live births)	10.7	9.9	10.2	9.8	9.6	9.7	10.0	9.6	10.1
Stillbirth in facility rate (per 1 000 total births)	21.3	20.2	21.1	20.4	19.7	19.9	21.0	20.9	20.7

Source: DHIS

Provincial overview

The interprovincial variation in the neonatal death in facility rate is shown in Figure 2, with a more than a two-fold difference between WC (with the lowest rate of 8.3 per 1 000 live births) and FS (with the highest recorded rate of 18.7 per 1 000). Only three provinces achieved a neonatal death in facility rate below the national average of 13.4 per 1 000 live births, namely WC (8.3 per 1 000), KwaZulu-Natal (KZ) (13.0 per 1 000) and NC (13.3 per 1 000), while MP equalled the national average of 13.4 per 1 000. Only WC was below the SDG target of ≤12 deaths per 1 000 live births and also superseded the end-term target of the South African Medium Term Development Plan (2024–2029) of ≤10 per 1 000 live births.

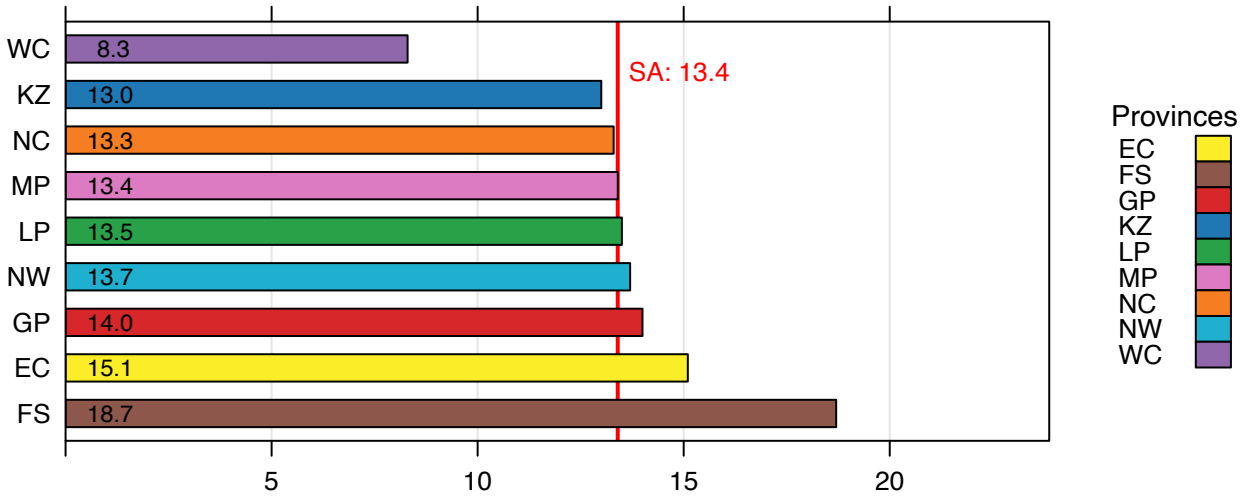


Figure 2 Neonatal death in facility rate by province, 2023/24

Source: DHIS

The provincial trends in the neonatal death in facility rate over the past nine years are shown in Table 2. Three provinces (MP, GP and FS) had higher neonatal mortality rates in 2023/24 compared to the baseline in 2015/16. Four provinces had their lowest points in 2019/20, aligned to the overall country's nadir (KZ, MP, GP, and Eastern Cape (EC)), with earlier nadirs in Limpopo (LP) (in 2016/17) and NC, North West (NW), and FS (in 2017/18). Only WC had a later nadir, namely 7.7 per live births 1 000 in 2021/22.

Table 2 Neonatal death in facility rate by province, 2015/16–2023/24 (%)

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
South Africa	13.3	12.4	12.3	12.1	11.9	12.6	13.1	12.7	13.4
Eastern Cape	21.6	18.6	19.6	18.2	19.2	21.1	20.1	20.3	22.6
Free State	27.2	26.9	26.2	26.7	23.8	27.1	26.3	25.7	25.1
Gauteng	19.5	19.0	19.3	19.0	18.8	19.7	19.2	20.3	18.7
KwaZulu-Natal	23.7	21.2	23.3	22.0	21.2	23.6	22.8	23.1	23.0
Limpopo	20.6	19.6	21.4	20.3	19.5	20.5	19.0	18.6	19.0
Mpumalanga	21.8	20.9	21.4	20.2	18.8	3.0	20.8	21.3	19.7
Northern Cape	22.6	22.4	21.6	24.6	24.0	22.6	33.6	21.7	23.1
North West	22.7	23.6	22.1	21.9	21.7	23.4	22.4	21.1	20.8
Western Cape	17.5	17.3	18.7	18.5	16.5	18.3	18.1	17.8	18.7

Source: DHIS

Overall, South Africa had a 12.6% increase in the neonatal death in facility rate from the lowest point in 2019/20.

Importantly, the neonatal death in facility rate needs to be interpreted in light of the recorded denominator data, namely the live birth in facility. Overall, South Africa recorded a large drop in live births of more than 145 000 per year between 2019/20 and 2023/24, most pronounced in the past two years, with reductions in live births noted in all provinces except for NC (Table 3). And although this has coincided with a drop in the absolute numbers of live births under 2 500g, the percentage of low-birth-weight babies born during this period has increased from 12.9% to 14.1%.

Table 3 Number of live births in facility and live births under 2500g by province, 2019/20–2023/24

		2019/20	2020/21	2021/22	2022/23	2023/24	Change 2019/20 – 2023/24
Live birth in facility	South Africa	1 007 551	1 037 528	1 014 556	947 395	861 717	-145 834
	Western Cape	103 728	104 315	99 630	92 956	89 466	-14 262
	KwaZulu-Natal	218 420	214 887	217 443	212 530	184 881	-33 539
	Northern Cape	21 521	22 403	22 322	22 487	21 793	272
	Mpumalanga	83 835	96 346	91 061	79 570	71 140	-12 695
	Limpopo	132 743	140 384	133 099	120 626	110 790	-21 953
	North West	60 854	62 196	61 017	59 304	54 068	-6 786
	Gauteng	230 417	238 749	229 179	214 128	199 342	-31 075
	Eastern Cape	107 079	109 775	110 833	99 503	89 137	-17 942
	Free State	48 954	48 473	49 972	46 291	41 100	-7 854
Live birth under 2 500g	South Africa	130 226	130 445	133 807	129 040	121 664	-8 563
	Western Cape	14 390	14 213	14 299	13 541	13 351	-1 039
	KwaZulu-Natal	25 458	25 306	26 636	26 964	24 533	-925
	Northern Cape	4 072	3 738	4 074	4 303	3 856	-216
	Mpumalanga	9 734	11 025	10 966	9 913	9 427	-307
	Limpopo	14 082	15 009	14 083	14 010	12 915	-1 168
	North West	8 276	8 300	8 511	8 278	7 593	-684
	Gauteng	32 122	30 975	32 030	30 340	28 977	-3 144
	Eastern Cape	15 138	14 894	15 826	14 776	14 701	-437
	Free State	6 954	6 986	7 382	6 915	6 311	-643

Source: DHIS

District overview

The neonatal death in facility rates across the 52 districts in the country are shown in Figure 3, displaying the gap between the lowest rate of 3.8 deaths per 1 000 live births (deaths: n=3, live births: n=780, the lowest absolute number of live births for any district) in Xhariep, to a high of 21.7 deaths per 1 000 live births (deaths: n=194, live births: n=8 933) in Lejweleputswa (both districts in FS). Twenty-nine districts had a neonatal death in facility rate below the national average of 13.4 per 1 000, one district, Johannesburg (GP), equalled the national average, while 22 districts were above the average. The SDG target of ≤12 per 1 000 was met by only 21 of the 52 districts (40%).

In terms of the ten best performing districts, four were from WC, two from EC, and one each from FS, NC, KZ and LP. Conversely, in terms of the ten worst performing districts with regard to the neonatal death in facility rate, three were from FS and EC each, while MP, NW, KZ and LP each contributed one district. Map 1 visually depicts the ten worst performing districts: Lejweleputswa (FS), Fezile Dabi (FS), Capricorn (LP), Mangaung (FS), OR Tambo (EC), uMgungundlovu (KZ), Ngaka Modiri Molema (NW), Gert Sibande (LP), Nelson Mandela Bay (EC), and Buffalo City (EC).

In WC, all districts except for the Central Karoo, had a neonatal death in facility rate well below the national average, while in the Free State, the opposite was true, apart from Xhariep, all four other districts had rates above the national average. The trends over a nine-year period in terms of the neonatal death in facility rate are shown in Figure 4, indicating marked variations across all provinces over time.

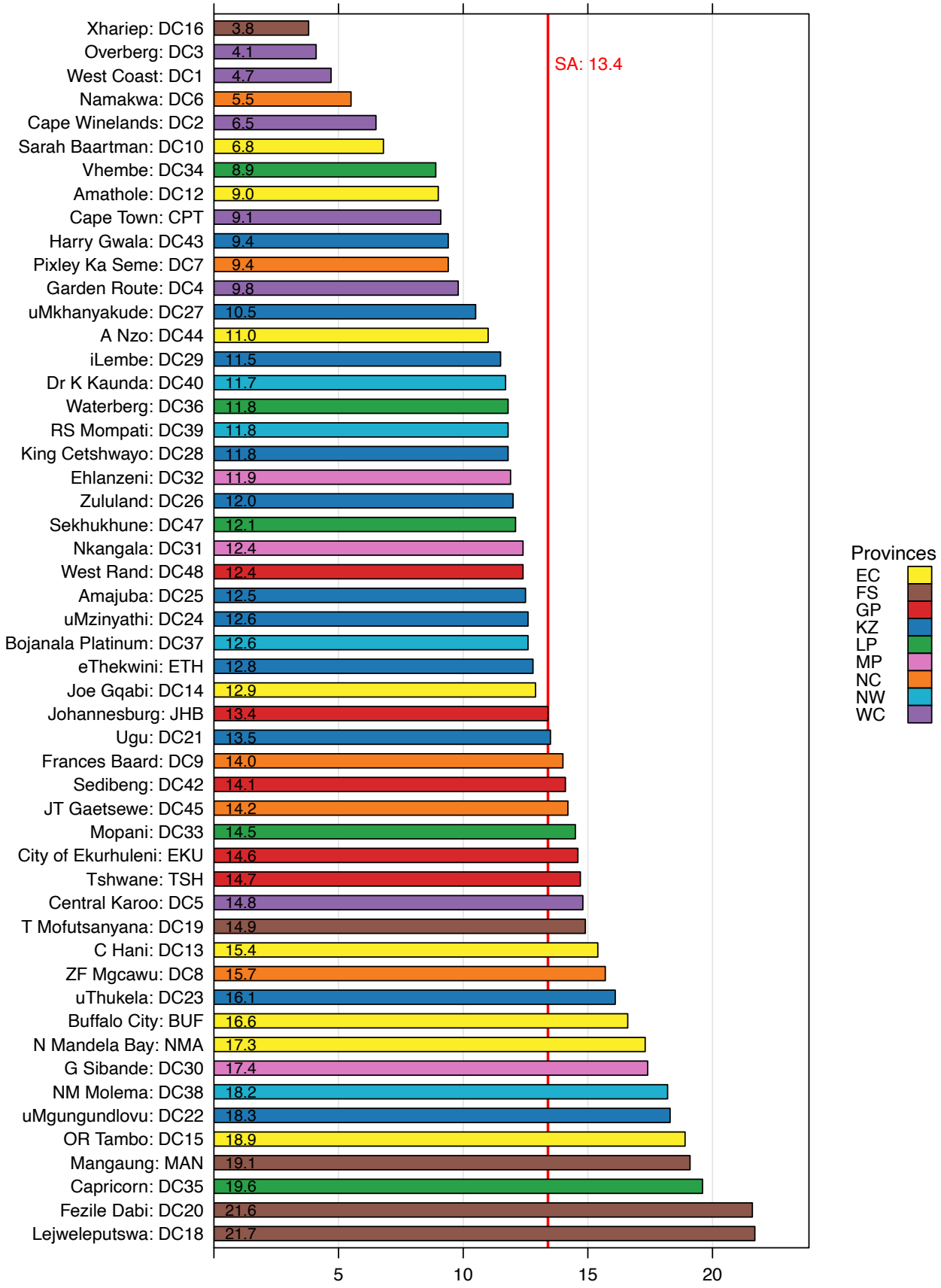
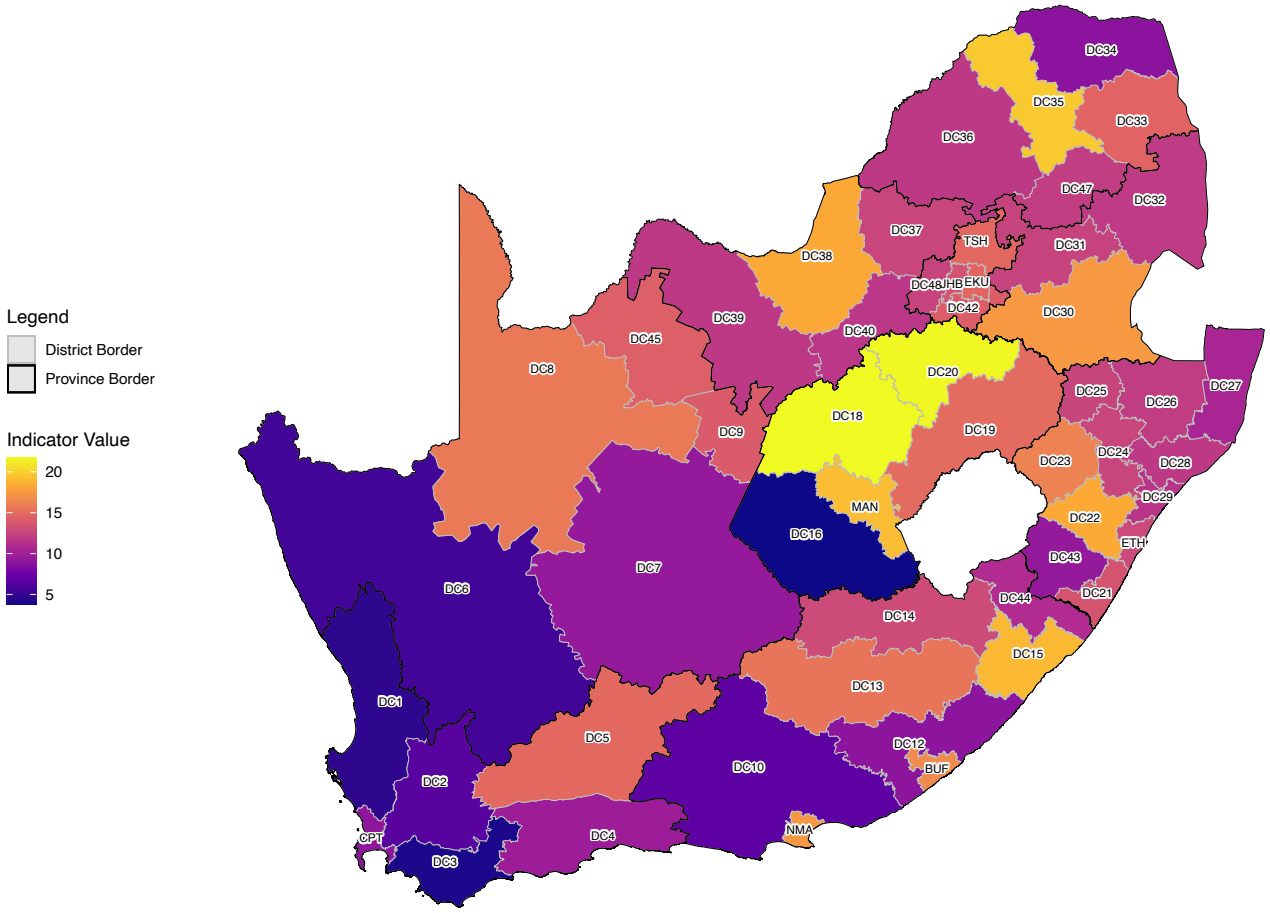


Figure 3 Neonatal death in facility rate by district, 2023/24

Source: DHIS



MAP 1 Neonatal death in facility rate by district, 2023/24

Source: DHIS

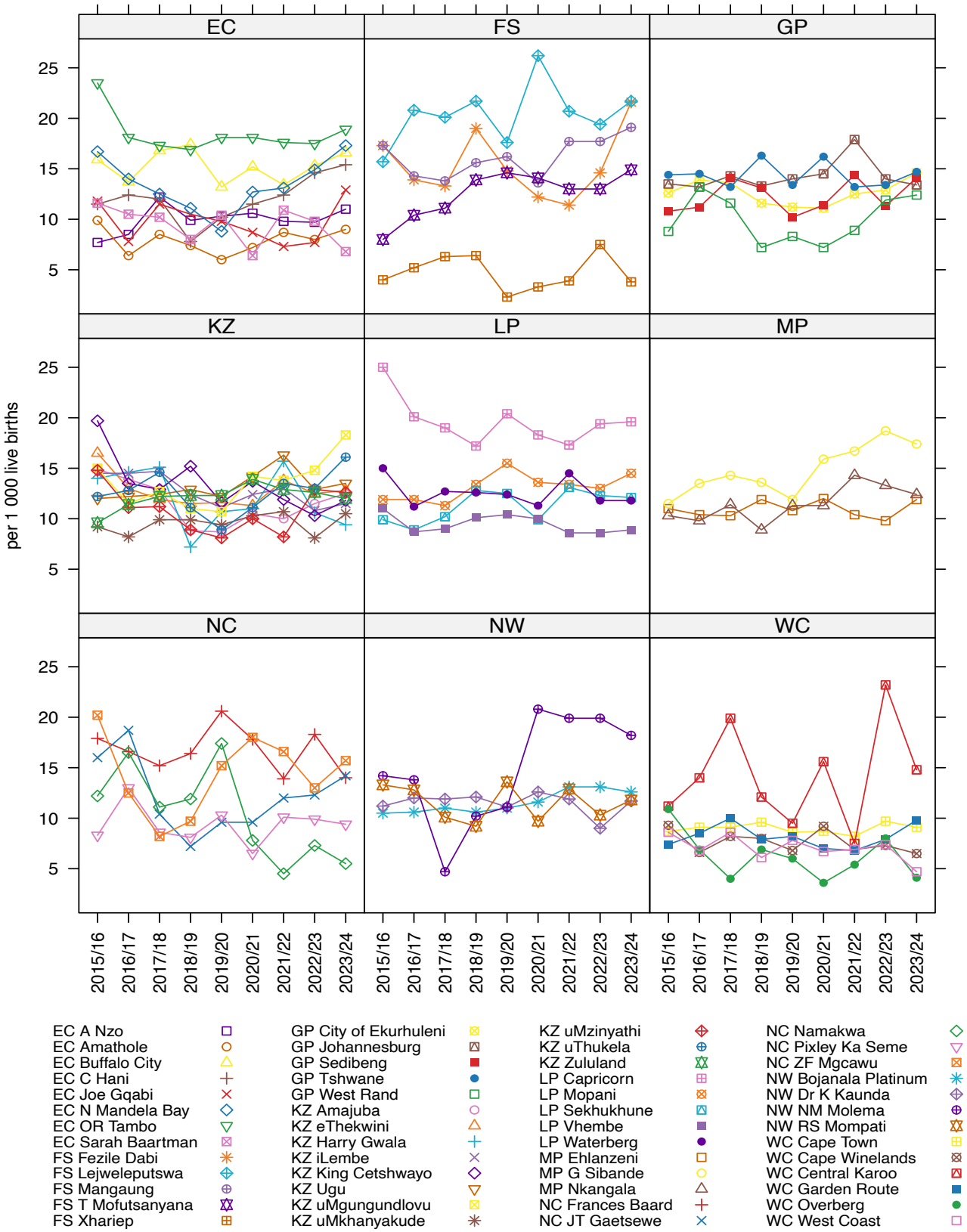


Figure 4 Annual trends: neonatal death in facility rate by district, 2015/16-2023/24

Source: DHIS

Recommendations

South Africa was able to reduce the neonatal death in facility rate between 2015/16 and 2019/20 by improving access to well-described interventions, including a focus on earlier pregnancy first visits, an increase of antenatal care visits to eight visits, administration of antenatal steroids during premature labour, improved neonatal resuscitation, broader availability to continuous positive airway pressure for neonates with respiratory distress, standardisation and training of the management of sick and small newborns at district level, Kangaroo Mother Care, and systematic mortality review auditing for neonatal deaths. These gains were, however, reversed during the COVID-19 pandemic, and concerningly, this deterioration has not yet been undone, even after the end of the pandemic. This negative trend has occurred despite an almost 15% drop in recorded live births in the past two years.

Improvement in the neonatal death in facility rate will require the following:

- Strong advocacy regarding the concerning reversal of the trend in the indicator during the COVID-19 pandemic, without subsequent improvements.
- Political will to prioritise the burden of neonatal deaths as a national priority.
- Coordination and resourcing of country-level strategic actions for ending preventable newborn mortality.
- Implementation of systems to hold managers at each health care level accountable for the outcomes in their neonatal services.
- Addressing administrator and staff-related factors contributing to neonatal deaths, including shortage of health workers, overcrowding in neonatal units and staff training/mentoring.
- Effective oversight, clinical governance, and support for neonatal services at all levels, including provincial, district, facility and community levels.
- Enhanced implementation of existing evidence-based interventions, with sharing of best practices between provinces and districts.
- A culture of innovations and evidence creation to ensure better outcomes in terms of neonatal morbidity and mortality.

Delivery in 10–19 years in facility rate

Livhuwani Mashamba, Naomi Massyn

Key findings

- The national delivery in 10–19 years in facility rate was 14.1% in 2023/24, marginally higher than the 13.9% in 2022/23. However, the number of deliveries in the age group 10–19 years decreased from 132 280 to 122 302 between 2022/23 and 2023/24.
- The proportion of deliveries 10–14 years in facility of the deliveries 10–19 years decreased annually from 2.9% in 2020/21 to 2.2% in 2023/24.
- There was a 1.8-fold variation between Gauteng (GP), with the lowest delivery in 10–19 years in facility rate of 9.9%, and the Eastern Cape (EC), with the highest rate of 18.0%. KwaZulu-Natal (KZ) had the highest number of deliveries in the age category 10–19 years at 31 088 and Northern Cape (NC) the lowest number at 3 608.
- Western Cape (WC) had the highest percentage of deliveries for 10–14 years of the deliveries 10–19 years at 2.9%, followed by Mpumalanga (MP) at 2.5%. However, the provinces with the highest number of deliveries in the 10–14 years age group were KZ (610 deliveries) and GP (430 deliveries).
- The delivery in 10–19 years in facility rate was the lowest in Johannesburg (GP) (8.8%) and highest in Alfred Nzo (EC) 24.9%), a 2.8-fold difference.
- Six of the top 10 districts with the lowest rates were metropolitan districts. The districts with the highest rates were in the deep rural districts.

Introduction

Regardless of the well documented fatal implications of teenage and adolescent pregnancy and childbearing, high teenage prevalence rates continue to be recorded in many poor regions. The global burden for maternal morbidity of 15% is attributed to health risks during pregnancy and childbirth among teenagers and adolescent girls.[1] For teenage and adolescent girls, the majority of these pregnancies are unintended and unplanned, consequently resulting in unsafe abortions with a high risk of mortality.[2] Common implications for teenage and adolescent pregnancies and childbearing are preterm and premature rupture of membranes as they have immature uterine and cervical blood circulation and are more susceptible to underdiagnosed and diagnosed infections.[3] Infants of teenage and adolescent mothers are characterised by low birth-weight, increased chance of still-birth, and unnecessary high neonatal deaths.[2] South Africa is among the countries in sub-Saharan Africa with persisting high deliveries amongst 10–19 years in facility rates.

Sustainable Development Goal (SDG) 3.7 demands universal healthcare access, including sexual reproductive healthcare services, by 2030.[4] Given only five years remain to 2030, the uncontrolled rise in teenage and adolescent pregnancy prevalence rates prompts concern. However, it also presents opportunities towards improving access to appropriate sexual and reproductive health services through better implementation of adolescent and youth friendly health services at all health facilities and strengthening multi-sectoral stakeholder collaboration to combat teenage and adolescent pregnancy prevalence rates in South Africa.

The delivery in 10–19 years in facility rate measures the deliveries to women under the age of 20 years as a proportion of total deliveries in the public health facility presented as a percentage.[5] The numerator is the number of deliveries to women aged 10–19 years in the facility, while the denominator is the total number of deliveries in the facility. For the numerator, two data elements are included as the deliveries for teenagers, namely delivery 10–14 years and 15–19 years in the facility. The indicator is a proxy for the adolescent birth rate. The adolescent birth rate measures the annual number of live births to adolescent girls per 1 000 adolescent girls and is used as one of the indicators for measuring performance progress towards achievement of the globally set SDG 3.7.2 – to ensure universal access to sexual and reproductive health care services by 2030.

1 Todhunter L, Hogan-Roy M, Pressman EK, eds. Complications of pregnancy in adolescents. Seminars in Reproductive Medicine. New York: Thieme Medical Publishers; 2021.
2 Maheshwari MV, Khalid N, Patel P. D., Alghareeb R, Hussain A. Maternal and neonatal outcomes of adolescent pregnancy: a narrative review. Cureus. 2022;14(6):e2592. https://doi.org/10.7759/cureus.25921
3 Lee MC, Suhng LA, Lu TH, Chou MC. Association of parental characteristics with adverse outcomes of adolescent pregnancy. Fam Pract. 1998;15(4):336–42.
4 United Nations, Department of Economic and Social Affairs. Global indicator framework for the Sustainable Development Goals and targets of the 2030 Agenda for Sustainable Development. UN DESA; 2023. URL: https://unstats.un.org/sdgs/indicators/Global%20Indicator%20Framework%20after%202023%20refinement_Eng.pdf
5 National Department of Health. National Indicator Data Set 2023. Pretoria: NDoH; 2023.

National overview

Figure 1 shows a slight increase of 0.2 percentage points for the delivery in 10–19 years in facility rate from 13.9% in 2022/23 to 14.1% in 2023/24. Since 2021/22, an upward/increasing trend for the rate has been observed.

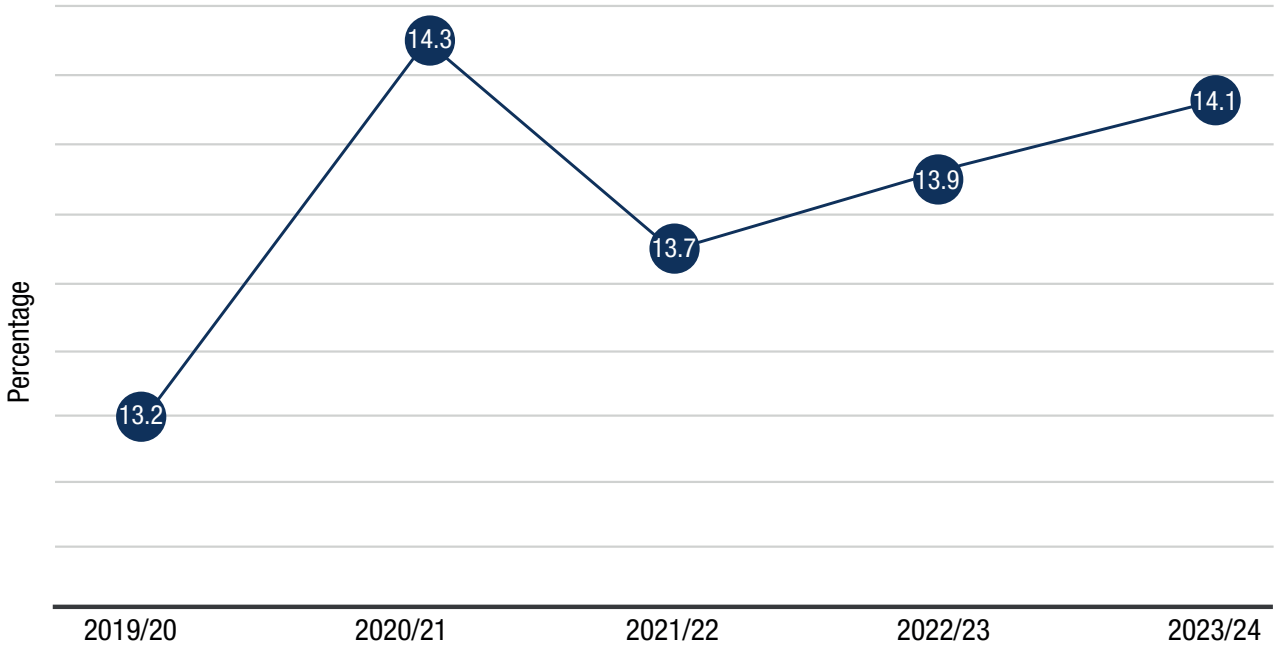


Figure 1 National delivery in 10–19 years in facility rate, 2019/20 – 2023/24

Source: DHIS

Table 1 presents the annual trend for the number of deliveries in facility for both teenage groups: 10–14 and 15–19 years. The number of deliveries in the age group 10–19 years in facility was the highest during the Coronavirus disease (COVID-19) pandemic in 2021/22 with 139 361 deliveries. The number of deliveries then dropped by 5.4% to 132 280 in 2022/23 and by 7.5% to 122 302 in 2023/24. The highest decline was the number of deliveries in the age group 10–14 years, which dropped by 13.3% between 2021/22 and 2022/23 (3 963 to 3 497) and by 22.3% (3 497 to 2 716) in 2023/24. The deliveries for the 10–14-year-olds as a proportion of the deliveries in age group 10–19 years decreased annually and was 2.2% in 2023/24, 2.6% in 2022/23, 2.8% in 2021/22 and 2.9% in 2020/21.

Table 1 Number of deliveries in facility by age group, 2019/20 – 2023/24

	2019/20	2020/21	2021/22	2022/23	2023/24
Delivery 10–14 years in facility (number)	3 870	4 053	3 963	3 497	2 716
Delivery 15–19 years in facility (number)	127 028	134 267	135 398	128 783	119 586
Delivery 10–19 years in facility (number)	130 898	138 320	139 361	132 280	122 302
Proportion delivery 10–14 years in facility of delivery 10–19 years in facility (%)	3.0	2.9	2.8	2.6	2.2

Source: DHIS

Provincial overview

Figure 2 shows a 1.8-fold variation between GP with the lowest delivery in 10–19 years in facility rate of 9.9% and EC with the highest rate of 18.0%. The rate in five provinces was higher than the national rate of 14.1%: Limpopo (LP), KZ, MP, NC and EC.

The delivery in 10–19 years in facility rate declined in only two provinces between 2022/23 and 2023/24 (Table 2). Although the rate increased in the other seven provinces, the increases were less than one percentage point in all provinces. Limpopo had the highest increase in the rate at 0.8 percentage points.

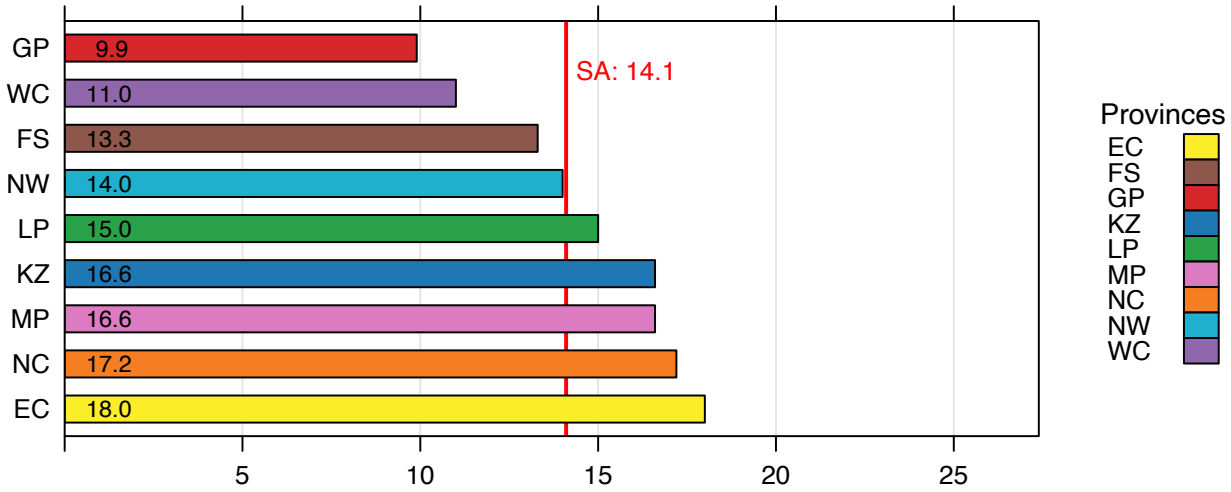


Figure 2 Delivery in 10–19 years in facility rate by province, 2023/24

Source: DHIS

According to the World Health Organization, interventions for preventing pregnancy in 10–14-year-olds are not the same as those for 15–19-year-olds. Monitoring the deliveries for these two age groups individually is important to inform age-focused interventions.

Table 2 shows the number of deliveries for the teenage age categories: 10–14 years, 15–19 years, and total deliveries among 10–19-year-olds. In 2023/24, KZ had the highest number of deliveries in the age category 10–19 years at 31 088, while NC had the lowest number at 3 608. Western Cape had the highest per cent deliveries for 10–14 years of the deliveries 10–19 years at 2.9%, followed by MP at 2.5%. However, the provinces with the highest number of deliveries in the 10–14 years age group were KZ (610 deliveries) and GP (430 deliveries).

Table 2 Deliveries by age group, 2023/24

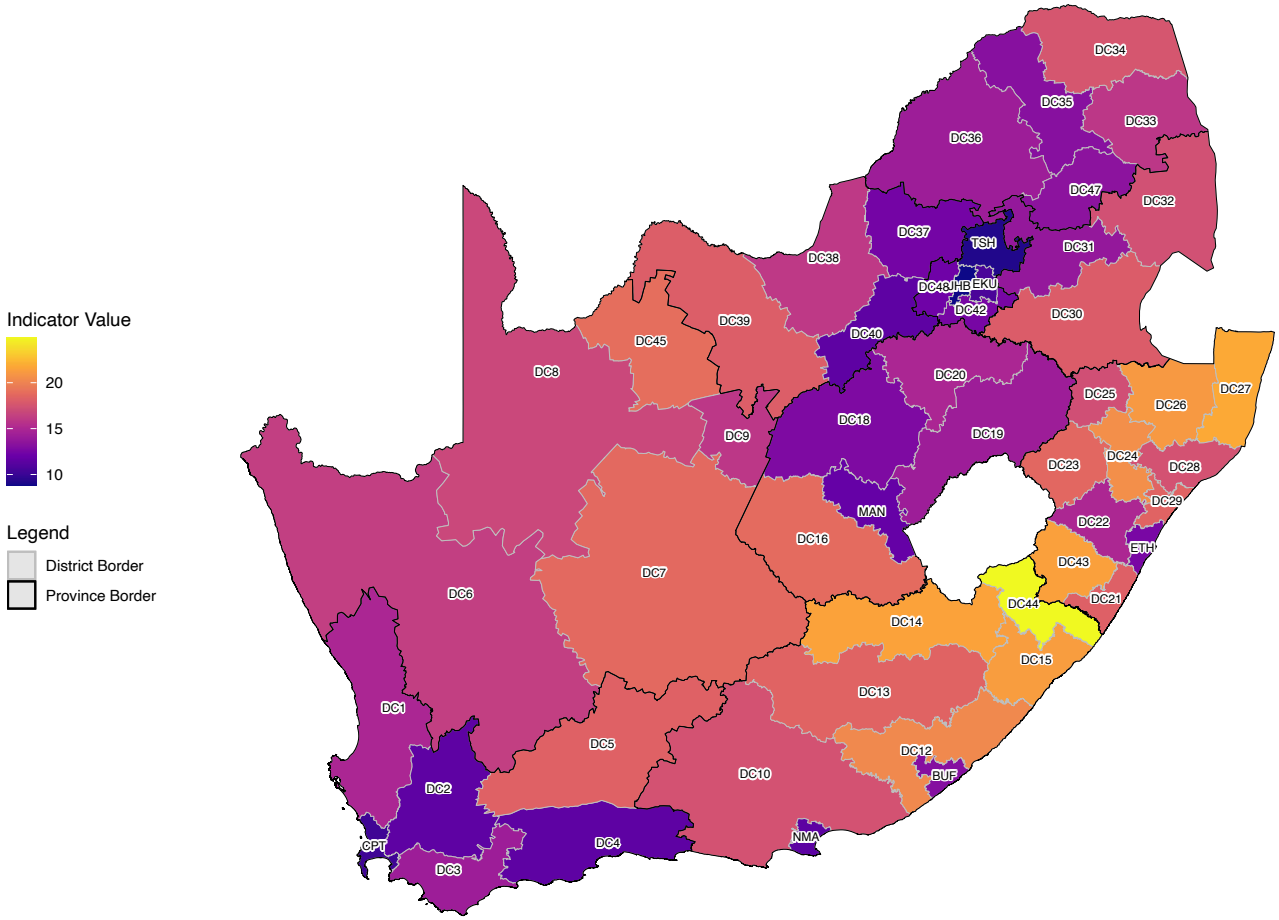
Province	Total deliveries (Number)	10–14 years			15–19 years			10–19 years	
		Deliveries 10–14 years (Number)	% of deliveries 10–19 years	% of total deliveries	Deliveries 15–19 years (Number)	% of deliveries 15–19 years	% of total deliveries	Deliveries 10–19 years (Number)	% of total deliveries
Eastern Cape	89 881	395	2.4	0.4	15 827	97.6	17.6	16 222	18.0
Free State	41 392	106	1.9	0.3	5 395	98.1	13.0	5 501	13.3
Gauteng	200 367	430	2.2	0.2	19 406	97.8	9.7	19 836	9.9
KwaZulu-Natal	186 725	610	2.0	0.3	30 478	98.0	16.3	31 088	16.6
Limpopo	111 151	375	2.3	0.3	16 262	97.7	14.6	16 637	15.0
Mpumalanga	71 388	293	2.5	0.4	11 534	97.5	16.2	11 827	16.6
Northern Cape	21 027	70	1.9	0.3	3 538	98.1	16.8	3 608	17.2
North West	54 739	151	2.0	0.3	7 525	98.0	13.7	7 676	14.0
Western Cape	89 912	286	2.9	0.3	9 621	97.1	10.7	9 907	11.0
South Africa	866 582	2 716	2.2	0.3	119 586	97.8	13.8	122 302	14.1

Source: DHIS

District overview

The delivery in 10–19 years in facility rate across the 52 districts in the country is reflected in Map 1 and Figure 3 with the lowest rates of 8.8% in Johannesburg (GP) and the highest rate of 24.9% in Alfred Nzo (EC), representing a 2.8-fold difference. More than half of the districts, 34 (65.4%) had a delivery in 10–19 years in facility rate higher than the national rate of 14.1% including all six districts from EC and 10 of the 11 districts in KZ. Six of the top 10 districts with the lowest rates were metropolitan districts: Johannesburg (GP) (8.8%), Tshwane (GP) (9.2%), Cape Town (WC) (10.2%), Ekurhuleni (GP) (10.6%), Nelson Mandela Bay (EC) (11.4%), and Mangaung (FS) (11.8%). The districts with the highest rates were in the deep rural regions.

The delivery in 10–19 years in facility rate decreased by more than one percentage point in five districts between 2020/21 and 2023/24, with the highest percentage point drops in JT Gaetsewe (9.3) and Pixley Ka Seme (4.0) (both NC). The rate increased in 36 districts over the same period (Figure 4). The districts with the highest increase of 2.8 percentage points were Sarah Baartman (EC), Ekurhuleni (GP), and Amathole (EC).



MAP 1 Delivery in 10–19 years in facility rate by district, 2023/24

Source: DHIS

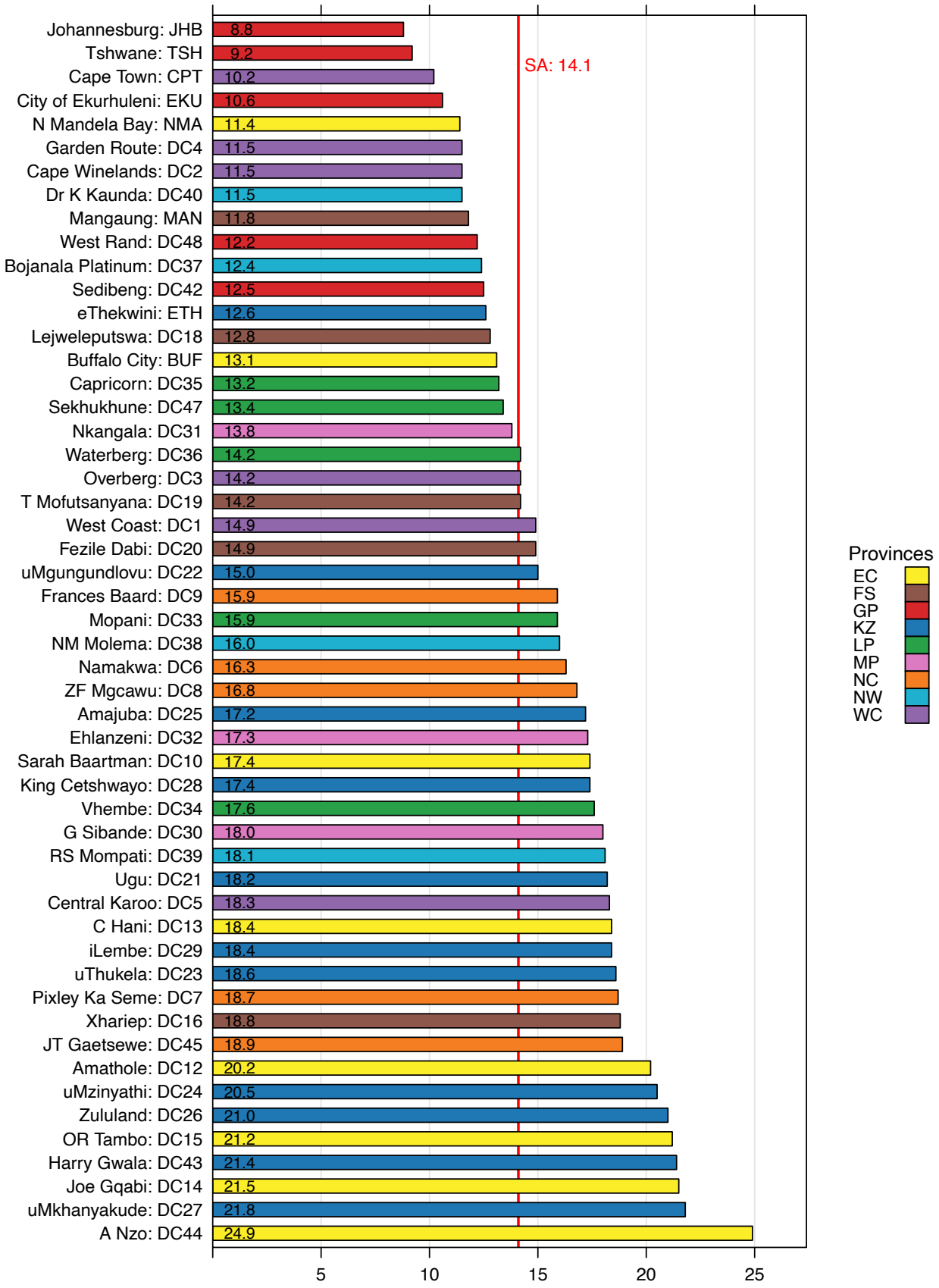


Figure 3 Delivery in 10–19 years in facility rate by district, 2023/24

Source: DHIS

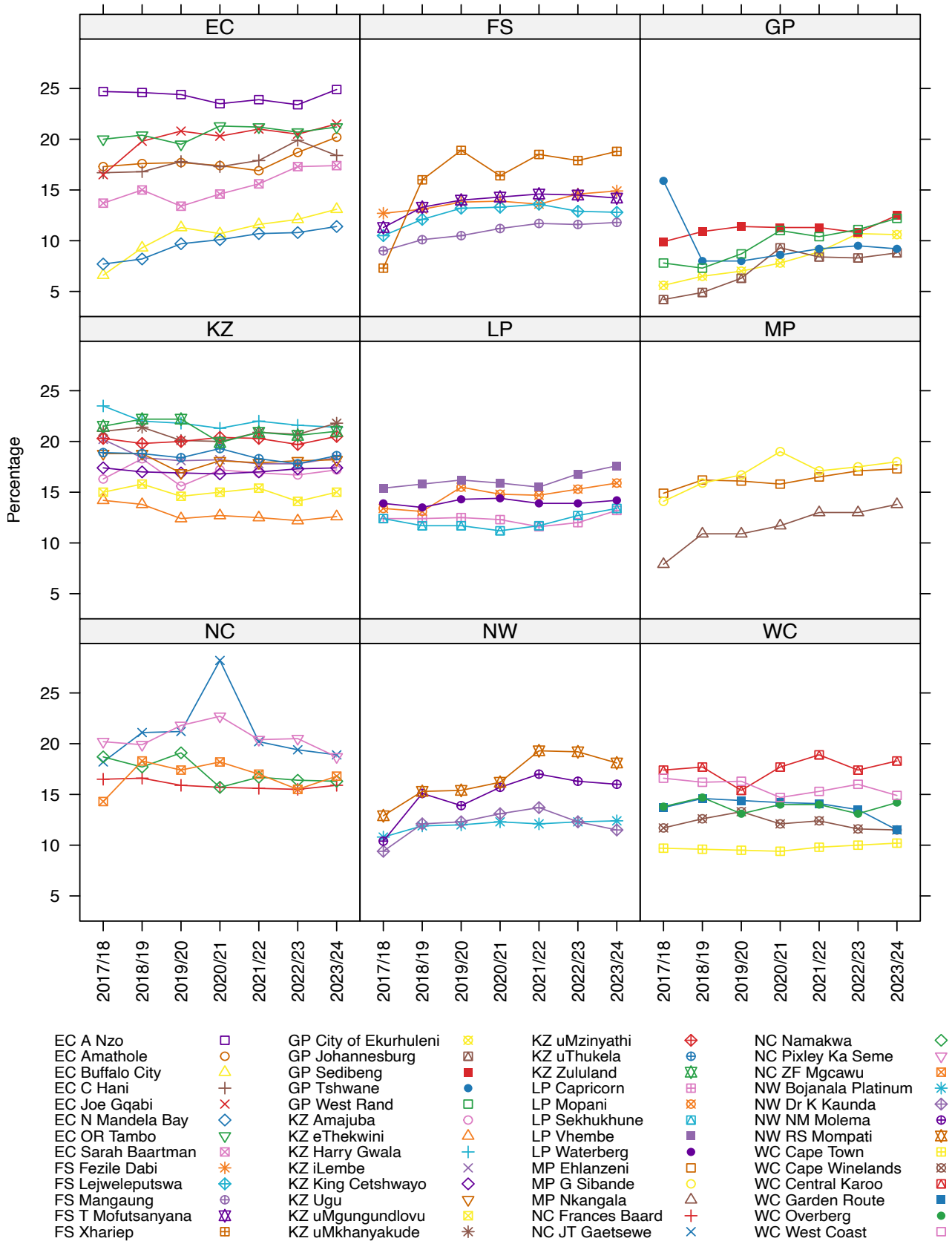


Figure 4 Annual trends: delivery in 10-19 years in facility rate by district, 2017/18–2023/24

Source: DHIS

Recommendations

Ongoing improvement in the delivery in 10–19 years in facility rate requires:

- A mult-sectoral approach for targeted interventions to address the high teenage and adolescent pregnancy rates, involving:
  - Government sectors: Department of Education, Department of Social Development, and Department of Health.
  - Other stakeholders: Civil society, traditional leaders, religious institutions, and community-based organisations.
- Political will to mitigate social determinants leading to teenage pregnancy and improve the socio-economic environment of children and adolescents in the country.
- Relevant messaging material demonstrating the effects of teenage pregnancy.
- Education on teenage pregnancy for both boys and girls at different levels of education to empower young boys and girls with necessary skills for their reproductive health.
- Integrate age-appropriate sexual and reproductive health services at different levels within the health facilities and schools.
- Robust monitoring and evaluation of sexual reproductive healthcare at facility and school level for continuous improvement.

1.2 Child health and nutrition

Pneumonia case fatality under five years rate

Jenny Nash, Lizelle Keet

Key findings

- The pneumonia case fatality rate (CFR) for children under five years decreased from 2.5% in 2020/21 to 1.5% in 2022/23. In 2023/24 the rate of 1.8% was slightly higher than the rate for the previous two years.
- Only three provinces recorded a CFR under the national average of 1.8% in 2023/24 - Western Cape (WC) (0.3%), North West (NW) (1.1%) and Gauteng (GP) (1.7%).
- The highest pneumonia CFRs were reported by the Free State (FS) (4.4%), Eastern Cape (EC) (3.4%), Mpumalanga (MP) (3.1%), and the Northern Cape (NC) (3.1%).
- The five best performing districts were from WC, namely: Garden Route, West Coast, Cape Winelands, City of Cape Town and Overberg.
- The five worst performing districts were Frances Baard (NC) at 10.5%, Fezile Dabi (FS) at 8.8%, OR Tambo (EC) at 7.4%, John Taolo Gaetsewe (NC) at 6.1%, and Thabo Mofutsanyana (FS) at 5.4%.
- Two districts reported no deaths of children under five years due to pneumonia in 2023/24, namely, Pixley ka Seme (NC) and Xhariep (FS).
- The five districts with the highest number of pneumonia deaths in 2023/24 were eThekwini (KwaZulu-Natal (KZ)) (71), OR Tambo (EC) (62), City of Johannesburg (GP) (49), Ehlanzeni (MP) (46), and Fezile Dabi (FS) (45).

Introduction

Globally, pneumonia is a leading cause of infectious mortality in children under five years. The World Health Organization (WHO) estimates that 14% of deaths in children under five years is due to pneumonia.[1] The latest WHO report indicates that in 2019, approximately 740 180 children globally died of pneumonia, with over 50% of these deaths reported in sub-Saharan Africa.

The Global Action Plan for the Prevention and Control of Pneumonia and Diarrhoea (GAPPD) aims to assist countries to reduce deaths from pneumonia and diarrhoea. The goals are to reduce mortality from pneumonia in children under five to less than 3 per 1 000 live births, and to reduce the incidence of severe pneumonia by 75% by 2025, compared to levels in 2010.[1]

The pneumonia case fatality under five years rate is defined as the number of pneumonia deaths in children under five years as a proportion of children under five years who are admitted as inpatients with pneumonia (measured as pneumonia separations) in public health facilities.

In South Africa, pneumonia and influenza contribute to 8% of the deaths among children below five years, making them the second-leading underlying cause of mortality among this age group.[2] Risk factors for pneumonia include low vaccination status against Streptococcus pneumonia and Haemophilus influenza. Exclusive breastfeeding is protective against developing pneumonia, so children who are not breastfed are at higher risk. Other risk factors are malnutrition, exposure to indoor air pollution and smoke, and living in crowded accommodation. The risk of hospitalisation with lower respiratory tract infections is also higher in immune-compromised HIV-infected children than in HIV-uninfected children.

1 Qazi S, Aboubaker S, MacLean R, et al. Ending preventable child deaths from pneumonia and diarrhoea by 2025. Development of the integrated Global Action Plan for the Prevention and Control of Pneumonia and Diarrhoea. Arch Dis Child. 2015;100(sup 1):S23-S8.
2 Ndlovu N, Padarath A, editors. District Health Barometer 2022/2023. Durban: Health Systems Trust; 2024.

National overview

The national pneumonia case fatality rate in 2023/24 increased to 1.8% compared to 1.5% in 2022/23 (Figure 1). In 2020/21, the pneumonia case fatality rate was 2.5%, which coincided with the COVID-19 pandemic which might have played a contributing role as health services were disrupted.

It has been noted that often children with asthma, bronchiolitis, and croup are not included as pneumonia separation. It is important to recognise that the pneumonia under five case fatality rate is influenced by other factors such as vaccination status, exclusive breastfeeding, HIV positivity, and viral load suppression rate in HIV positive children. In 2019/20 the immunisation under one year rate was 83.5% but dropped to 79.5% in 2020/21 (Figure 2). However, in 2023/24 the rate was in line with the 2019/20 rate at 83.3%. The exclusive breastfeeding at DTaP-IPV-Hib-HBV 3rd dose rate was 48.8% in 2019/20 and decreased in subsequent years to only 43.3% in 2023/24. Unfortunately, the child with viral load suppressed rate in 2023/24 was only 60.1%, having decreased from 63.9% in 2020/21.

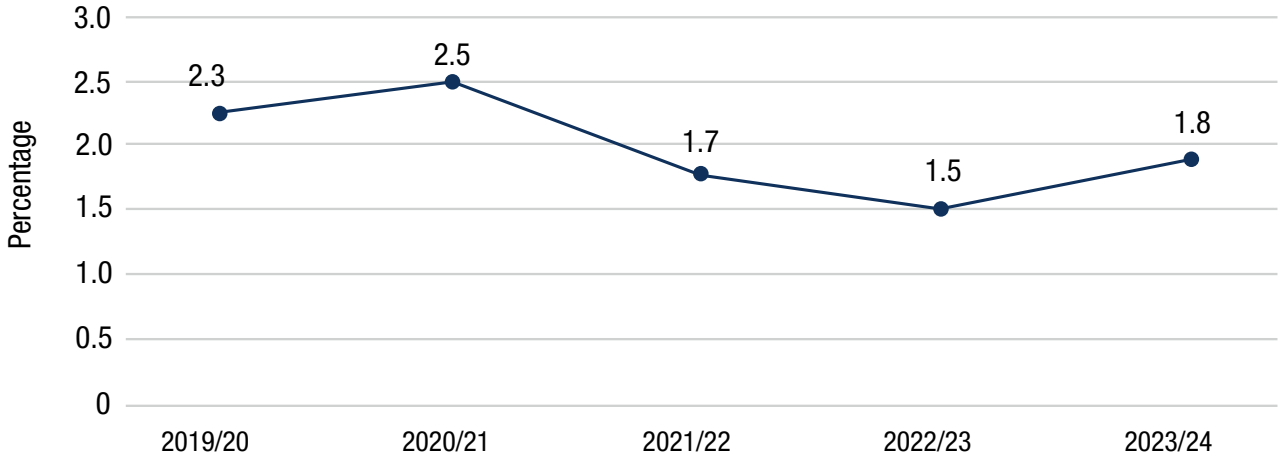


Figure 1 National trend in pneumonia case fatality rate, 2019/20 – 2023/24

Source: DHIS

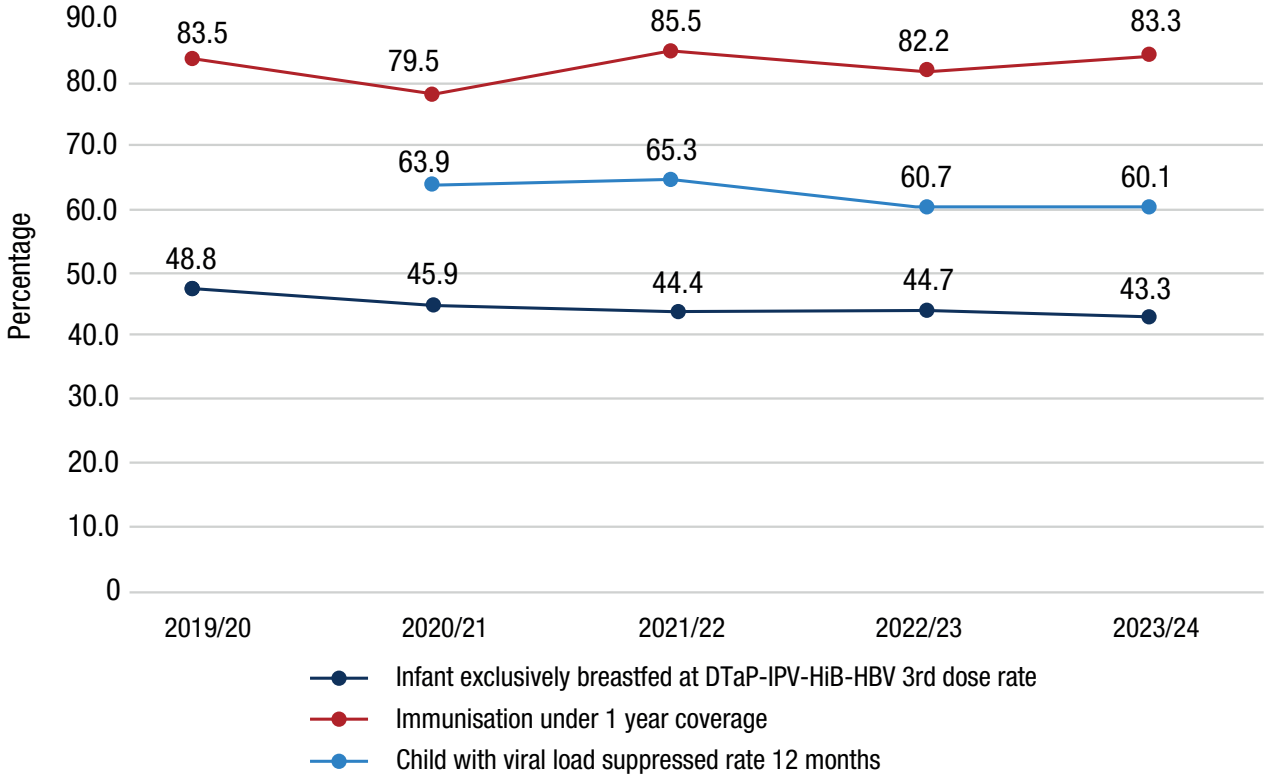


Figure 2 National trend in infant exclusive breastfed at DTaP-IPV-Hib-HBV 3rd dose rate, immunisation under 1 year coverage and child with viral suppressed rate a 12 month, 2019/20 – 2023/24

Source: DHIS

Provincial overview

Figure 3 shows the pneumonia case fatality under five years rate by province. The Western Cape recorded a pneumonia case fatality rate of 0.3% followed by NW with 1.1% and GP at 1.7%, while the rest of the provinces reported a case facility rate above the national rate of 1.8%. Seven provinces had an increase in the rate between 2022/23 and 2023/34 with the highest increase in FS (2.7 percentage points) (Table 1).

Table 2 shows the number of deaths under five years due to pneumonia. Free State had the highest increase in the number of deaths under five years due to pneumonia between 2022/23 and 2023/34 – the deaths increased from 26 in 2022/23 to 98. Limpopo reported 56 deaths less in 2023/24 compared to the number of deaths in 2022/23 which was 161 deaths. A reason for the high number of pneumonia deaths might be the incorrect interpretation of the definition of a death due to pneumonia in the National Indicator Data Set (NIDS) of the National Department of Health. The pneumonia case fatality rate denominator causes confusion for health care workers on the ground. It has been noted that often children with asthma, bronchiolitis and croup are not included as pneumonia separation (see NIDS definition). This results in inconsistencies in the data and might explain the wide variations within provinces and year to year comparisons. The definition in NIDS for pneumonia separation needs to be simplified to ensure improved data quality.

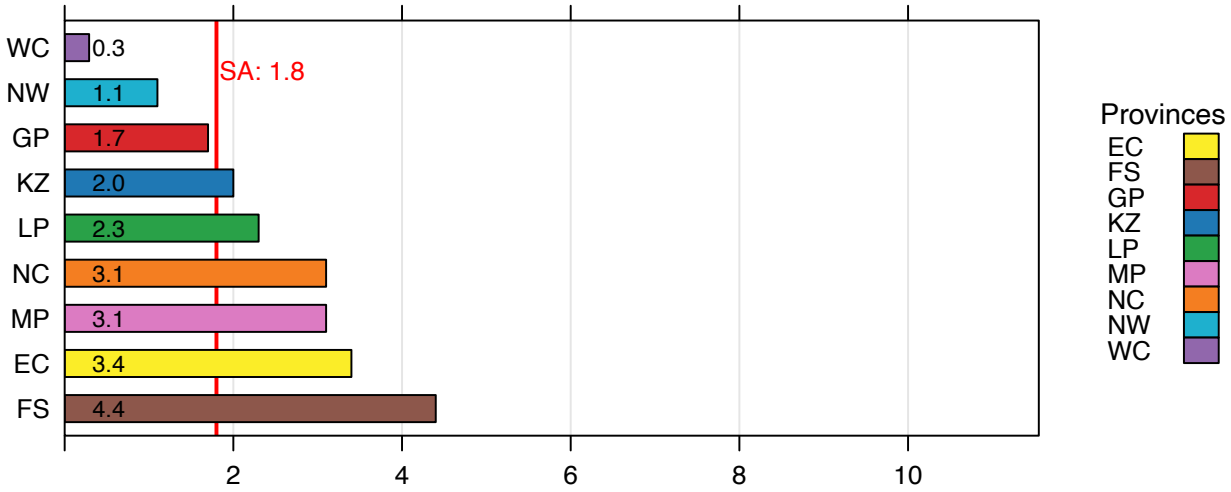


Figure 3 Pneumonia case fatality under 5 years rate by province, 2023/24

Source: DHIS

Table 1 Pneumonia case fatality rate by province, 2019/20 – 2023/24 (%)

PROVINCE	2019/20	2020/21	2021/22	2022/23	2023/24	Percentage point difference between 2022/23 and 2023/24
Eastern Cape	3.4	3.6	3.3	2.8	3.4	0.6
Free State	2.2	3.1	3.2	1.7	4.4	2.7
Gauteng	2.6	3.2	1.5	1.5	1.7	0.2
KwaZulu-Natal	2.1	2.3	2.2	1.9	2.0	0.1
Limpopo	3.7	4.2	2.3	2.6	2.3	-0.3
Mpumalanga	2.3	5.3	2.2	2.8	3.1	0.3
Northern Cape	1.9	2.1	3.0	2.4	3.1	0.7
North West	1.6	3.2	2.3	1.4	1.1	-0.3
Western Cape	0.3	0.2	0.2	0.2	0.3	0.1

Source: DHIS

Table 2 Deaths under 5 years due to pneumonia by province, 2022/23 – 2023/24

PROVINCE	2022/23	2023/24	Number of deaths difference between 2022/23 and 2023/24
Eastern Cape	139	127	-12.0
Free State	46	98	52.0
Gauteng	168	145	-23.0
KwaZulu-Natal	220	222	2.0
Limpopo	161	105	-56.0
Mpumalanga	99	91	-8.0
Northern Cape	26	23	-3.0
North West	40	25	-15.0
Western Cape	40	34	-6.0
South Africa	939	870	-69.0

Source: DHIS

District overview

Figure 4 and Map 1 show the pneumonia case fatality under five years rate by district. There were 23 districts that had a pneumonia case fatality rate less than the national average of 1.8%. The five best performing districts were districts from WC, namely Garden Route, West Coast, Cape Winelands, City of Cape Town, and Overberg. The five worst performing districts were Frances Baard (NC) at 10.5%; Fezile Dabi (FS) at 8.8%; OR Tambo (EC) at 7.4%, John Taolo Gaetsewe (NC) at 6.1%, and Thabo Mofutsanyana (FS) at 5.4%.

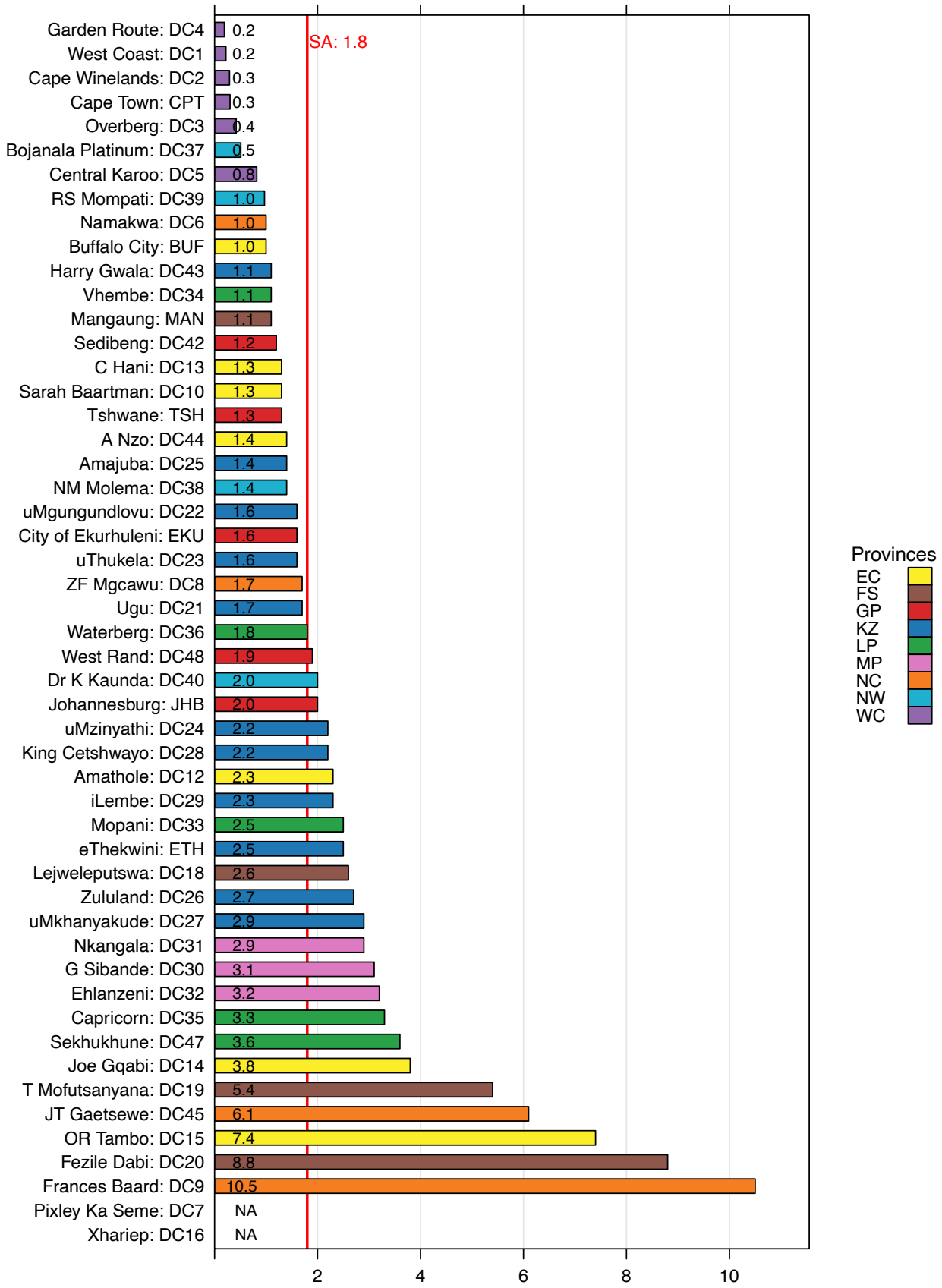
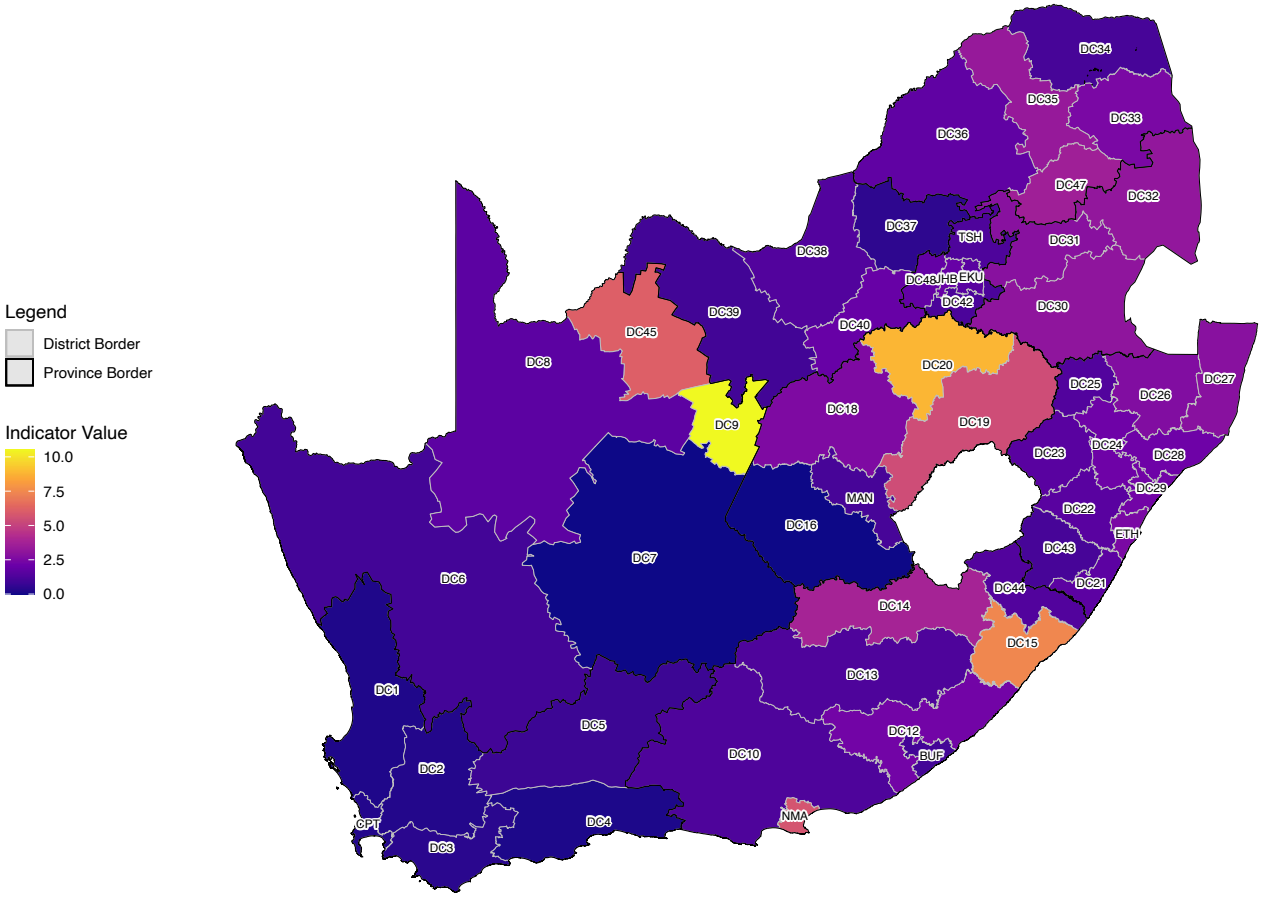


Figure 4 Pneumonia case fatality under 5 years rate by district 2023/24

Source: DHIS

Two districts reported no deaths under five years due to pneumonia in 2023/24, namely, Pixley ka Seme (NC) and Xhariep (FS). In 2022/23, both these districts performed better than the national average of 1.5% (Xhariep 0.6% and Pixley ka Seme 1%).[2] The five districts with the highest number of pneumonia deaths in 2023/24 were eThekwini (KZ) (71), OR Tambo (EC) (62), City of Johannesburg (GP) (49), Ehlanzeni (MP) (46), and Fezile Dabi (FS) (45) (Table 3 and Figure 5). Fezile Dabi had 31 more peumonia deaths in 2023/24 than in 2022/23, Thabo Mofutsanyana (FS) had 19 more and City of Johannesburg (GP) had 15 more death over the same period. Seven districts had more that 10 pneumonia deaths less in 2023/24 compared to the pneumonia deaths in 2022/23, namely, Tshwane (GP) (-31), Capricorn (LP) (-18), Waterberg (LP) (-17), Vhembe (LP) (-16), Ehlanzeni (MP) (-14), Chris Hani (EC) (-13), and Mopani (LP) (-11).



MAP 1 Pneumonia case fatality under 5 years rate by district 2023/24

Source: DHIS

Table 3 Deaths under 5 years due to pneumonia by district, 2022/23 – 2023/24

PROVINCE	DISTRICT	2022/23	2023/24	Number of deaths difference between 2022/23 and 2023/24
Eastern Cape	Alfred Nzo	8	6	-2
	Amathole	3	8	5
	Buffalo City	12	7	-5
	Chris Hani	20	7	-13
	Joe Gqabi	3	7	4
	Nelson Mandela Bay	19	27	8
	OR Tambo	65	62	-3
	Sarah Baartman	9	3	-6

Free State	Fezile Dabi	14	45	31
	Lejweleputswa	8	14	6
	Mangaung	8	5	-3
	Thabo Mofutsanyana	15	34	19
	Xhariep	1	0	-1
Gauteng	Ekurhuleni	47	38	-9
	Johannesburg	34	49	15
	Sedibeng	10	7	-3
	Tshwane	61	30	-31
	West Rand	16	21	5
KwaZulu-Natal	Amajuba	9	5	-4
	eThekwini	79	71	-8
	Harry Gwala	13	9	-4
	iLembe	13	16	3
	King Cetshwayo	21	26	5
	Ugu	26	25	-1
	uMgungundlovu	17	21	4
	uMkhanyakude	11	17	6
	uMzinyathi	7	10	3
	uThukela	16	11	-5
	Zululand	8	11	3
Limpopo	Capricorn	43	25	-18
	Mopani	36	25	-11
	Sekhukhune	22	28	6
	Vhembe	29	13	-16
	Waterberg	31	14	-17
Mpumalanga	Ehlanzeni	60	46	-14
	Gert Sibande	21	22	1
	Nkangala	18	23	5
Northern Cape	Frances Baard	8	8	0
	JT Gaetsewe	9	10	1
	Namakwa	1	1	0
	Pixley Ka Seme	2	0	-2
	ZF Mgcawu	6	4	-2
North West	Bojanala Platinum	6	4	-2
	Dr K Kaunda	11	8	-3
	NM Molema	10	9	-1
	RS Mompati	13	4	-9
Western Cape	Cape Town	20	19	-1
	Cape Winelands	5	5	0
	Central Karoo	2	2	0
	Garden Route	9	3	-6
	Overberg	1	3	2
	West Coast	3	2	-1

Source: DHIS

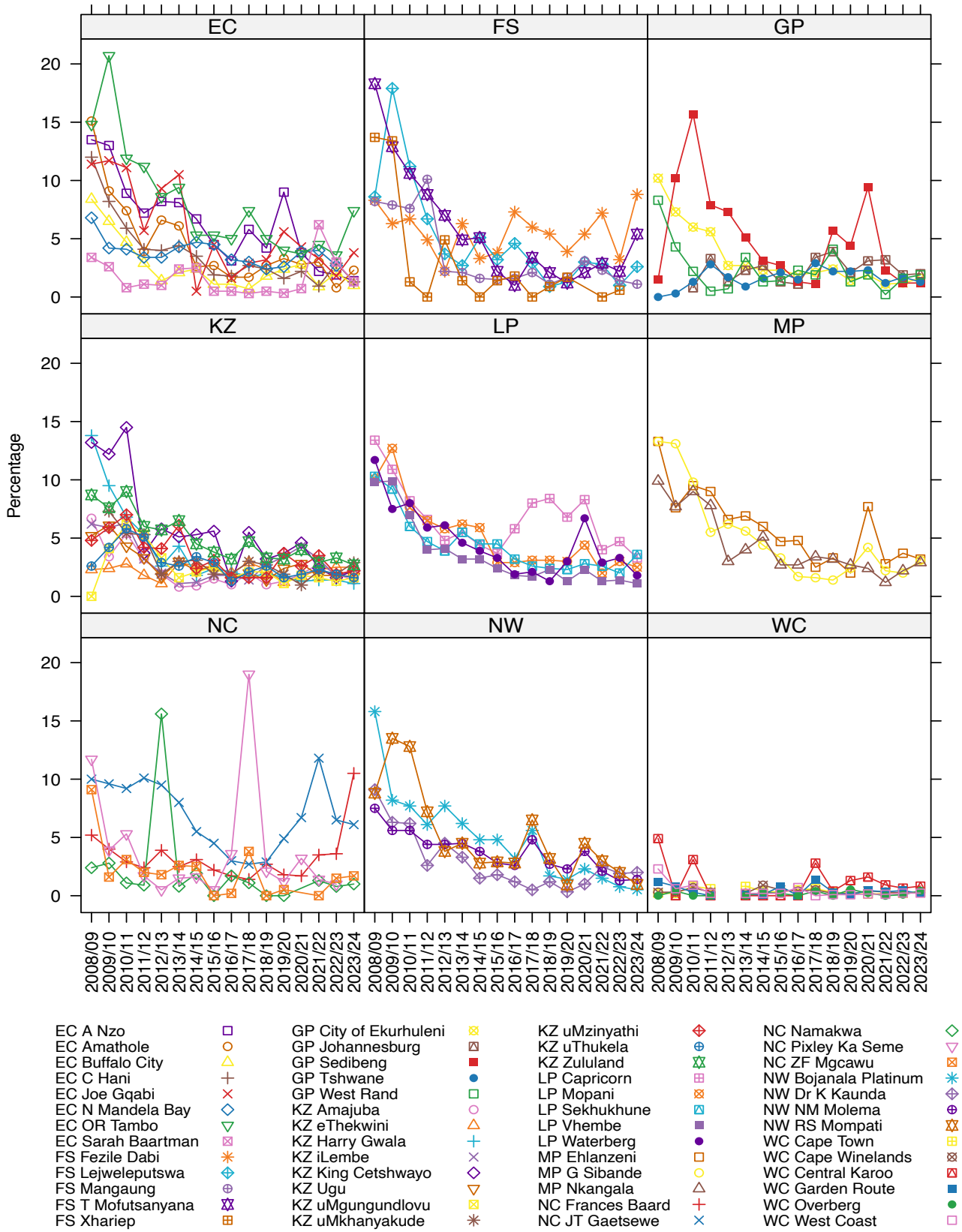


Figure 5 Annual trends: Pneumonia case fatality under 5 years rate by district, 2008/09 – 2023/24

Source: DHIS

Recommendations

- Clarify the NIDS definition of pneumonia deaths and ensure that all clinicians are trained on the definition. This will improve the quality of the data being submitted.
- Quantify the percentage of low birth weight babies who die from pneumonia in the first six months of life.
- Ensure maternal pertussis vaccination during pregnancy.
- Tuberculosis prophylactic therapy (TPT) implementation guidelines need to be urgently reviewed and standardised to ensure that pregnant women with advanced HIV disease are able to access TPT. This will also reduce the risk of neonatal tuberculosis.
- The updated paediatric tuberculosis guidelines have been released by the NDoH but are still in the early stages of implementation at the provincial level. It is important that the same tuberculosis diagnostics are available in all National Health Laboratory Service laboratories in all provinces. For example, stool NAAT (nucleic acid amplification test) is a new diagnostic modality and would potentially improve the diagnosis of tuberculosis in children. Many of these children are being admitted to hospitals with signs and symptoms suggestive of pneumonia and health care workers are struggling to diagnose tuberculosis.
- Improve the management of respiratory tract infections at the primary health care level. The Ideal Clinic Realisation and Maintenance programme recommends three streams of care in primary health care clinics. There is sometimes confusion amongst health workers working in primary health care clinics which stream the child with acute illness belongs to: either in the acute stream, or in the Maternal and Child stream. This often leads to children with acute illness being incorrectly triaged and managed by less experienced professional nurses who often do not follow the Integrated Management of Childhood Illness (IMCI) guidelines. This results in children being incorrectly managed, delayed diagnoses, and complicated admissions.
- The use of the IMCI guidelines is not uniform across the provinces. All professional nurses working at primary health care facilities need to register with the Knowledge Hub online platform and complete the IMCI course. This is a cost-effective way of ensuring knowledge dissemination and improved diagnosis and care of children at primary health care level.
- Make use of the Knowledge Hub for other courses such as ETAT (Emergency Triage Assessment and Treatment) for children. Due to austerity measures, it is increasingly difficult to run face-to-face training for health care workers. On-line training can assist with increasing access to training for health care workers working in district hospitals and primary health care facilities, especially those in remote areas.
- Improve the management of children admitted to district hospitals with pneumonia. The Committee on Morbidity and Mortality in Children under five years (CoMMiC) has recommended that children admitted to district hospitals should be reviewed on a daily basis in the ward or high-care ward. Non-rebreather oxygen masks should be available and high flow oxygen available at priority district hospitals. Consumables for high-flow/continuous positive airway pressure (CPAP) machines are costly and should be ordered centrally to ensure availability. The Essential Medicines List (EML) and paediatric standard treatment guidelines (STGs) should be followed to ensure updated protocols are followed and rational antibiotic prescribing is practiced. This includes the availability of medicines at district hospitals, such as azithromycin, for example, for treating atypical pneumonia.

Infant exclusively breastfed at DTaP–IPV–Hib–HBV 3rd dose rate

Perpetua Modjadji

Key findings

- The national infant exclusively breastfed at DTaP–IPV–Hib–HBV 3rd dose rate was 43.3% in 2023/24.
- The rate increased exponentially from 7% in 1998 to 48.8% in 2019/20 and then decreased to 43.3% in 2023/24.
- The highest infant exclusively breastfed at DTaP–IPV–Hib–HBV 3rd dose rate was observed in KwaZulu-Natal (KZ) (55.6%) and the lowest in Limpopo (LP) (32.1%) with an inter-provincial variation of 23.5 percentage points.
- None of the districts in KZ and Northern Cape (NC) had rates below the national rate (43.3%).
- The lowest infant exclusively breastfed at DTaP–IPV–Hib–HBV 3rd dose rate was observed in Joe Gqabi (16.8%) in Eastern Cape (EC) and the highest rate of 72.6% in uMzinyathi (KZ), representing a 4.3-fold variation.
- Overall, 22 districts had infant exclusively breastfed at DTaP–IPV–Hib–HBV 3rd dose rates below the national rate while 30 districts reported higher rates.
- Between 2022/23 and 2023/24, infant exclusively breastfed at DTaP–IPV–Hib–HBV 3rd dose rates increased in 20 districts and decreased in 30 districts.
- All districts in Mpumalanga (MP) showed declining EBF rates, considerably, for example in Nkangala (-12.8 percentage points). Other considerable declines were observed in Sekhukhune (LP) (-12.3 percentage points), Sarah Baartman (EC) (-12.2 percentage points), Sedibeng (Gauteng (GP)) (-8.0 percentage points), and Joe Gqabi (EC) (7.4 percentage points).
- Garden Route (Western Cape (WC)) had the highest increase in the same period of 8.7 percentage points, followed by Central Karoo (WC) (8.3 percentage points), Tshwane (GP) (5.8 percentage points), Mangaung (Free State (FS)) (5.7 percentage points,) and Xhariep (FS) (5.1 percentage points).

Introduction

Exclusive breastfeeding (EBF) occurs when an infant is solely fed breast milk in the first six months of life, excluding oral rehydrating solutions, syrups/drops consisting of vitamins and/or mineral supplements, or medicines.[1] Emphasis is given to initiation of breastfeeding within the first hour after birth, followed by EBF for the first six months of life and then continuation of breastfeeding, supplemented with adequate complementary foods, for two years or beyond.[1,2] Benefits of EBF include reduced incidences of pneumonia, diarrhoea, and mortality rates in infants.[3]

Globally, 48% of infants under six months are exclusively breastfed, approaching a targeted 50% by 2025 in line with the World Health Organization (WHO) expectations.[4] Only one third of African countries were estimated to be on track between 2000 and 2017 to meeting WHO's Global Nutrition Target (GNT) by 2025, indicating that the majority of African nations are not aligned to achieve nutrition targets.[5] Of late, the Global Breastfeeding Collective of WHO and UNICEF (United Nation Children's Fund) has been targeting 70% EBF by 2030.[6]

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2 United Nations Children's Fund. Breastfeeding: A mother's gift, for every child. UNICEF; 2018.
3 Akachi Y, Steenland M, Fink G. Associations between key intervention coverage and child mortality: An analysis of 241 sub-national regions of sub-Saharan Africa. Int J Epidemiol. 2018;47:740-751. doi:10.1093/ije/dyx262
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6 UNICEF, WHO. Global breastfeeding scorecard 2023 rates: Rates of breastfeeding increases around the world through improved protection and support. New York, Geneva: UNICEF, WHO; 2023. https://wwwuniceforg/media/150586/file/Global%20breastfeeding%20scorecard%202023pdf

The South African National Department of Health (NDoH) has prioritised infant and young child feeding (IYCF) for the past two decades,[7,8] and it remains one of the major public health concerns.[9–11] The country recorded improved EBF rates from 7% (1998), 8% (2003) and 11% (2011) to 32% (2016),[12–14] although it is lagging behind the global target of reaching 50% by 2025.[5,12] Despite concerted efforts, policy reform, and evidence-based knowledge on the benefits of EBF,[10,11] this lag has been attributed to only partial translation of policy into practice. Low rates of EBF are also attributed to a high prevalence of HIV (30.8%) in mothers attending antenatal care (ANC).[10,11] Currently, all mothers regardless of their HIV status are encouraged to exclusively breastfeed and continue breastfeeding until the infant is one year old in South Africa.[12,13] This is enabled by a large coverage of anti-retroviral therapy (ART) to prevent mother-to-child-transmission (MTCT).[17,18]

National overview

Figure 1 show the rate of infants exclusively breastfed at DTaP–IPV–Hib–HBV 3rd dose over the years. The rate increased exponentially from 7% in 1998 to 32% in 2016.[12-14] The national infant exclusively breastfed at DTaP–IPV–Hib–HBV 3rd dose rate was 48.8% in 2019/20 but dropped to 43.3% in 2023/24.

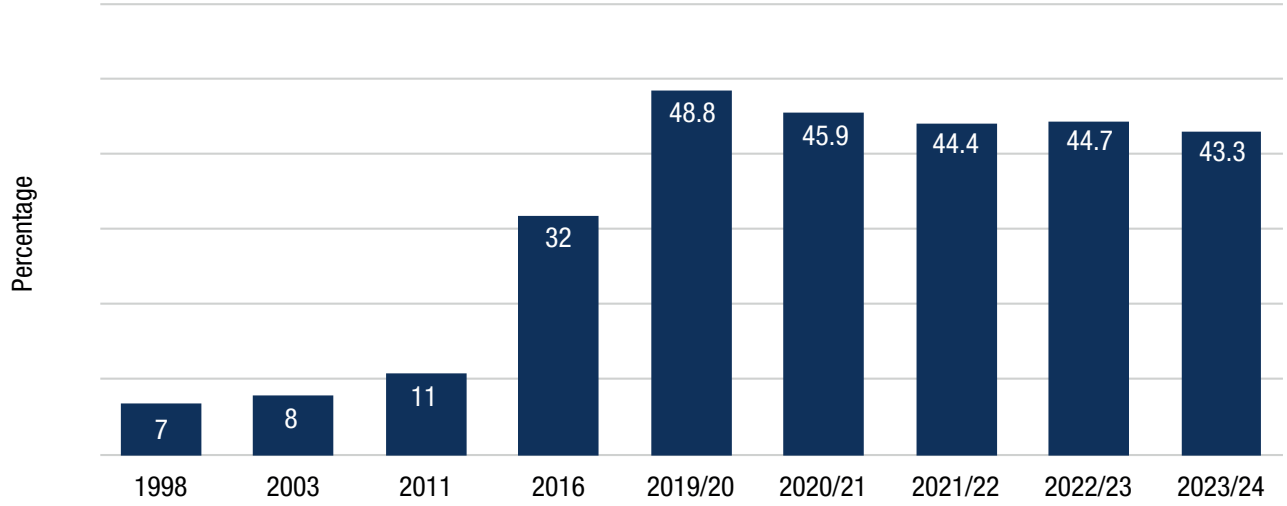

Figure 1 **National exclusive breastfeeding and infant exclusively breastfed at DTaP–IPV–Hib–HBV 3rd dose rates, 1998 – 2023**

Sources: DHIS, Niewoudt et al. (2019), SADHS 1998, SAHDS 2003[12-14]

Provincial overview

Figure 2 shows the rates of infant EBF at DTaP–IPV–Hib–HBV 3rd dose in 2023/24. An inter-provincial variation of 23.5 percentage points, ranging from low rates of 32.1% in LP to 55.6% in KZ was observed. In addition to KZ, FS (44.1%), GP (47.3%), ~~and NC (50.9%) reported infant EBF at DTaP–IPV–Hib–HBV 3rd dose rates higher than the national average. Rates in LP (32.1%)~~

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13 National Department of Health, Medical Research Council. Demographic and Health Surveys MII: South Africa Demographic and Health Survey, 1998 Report. Macro & Rockville: NDoH & MRC;1998.
14 National Department of Health. South Africa Demographic & Health Survey 2003. Pretoria: NDoH; 2007.
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16 Department of Health. The Tshwane declaration of support for breastfeeding in South Africa. S Afr J Clin Nutr. 2011;24:214.
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18 National Department of Health. Infant and young child feeding policy. Pretoria: NDoH; 2013.

together with North West (NW) (32.7%), MP (34.1%), and EC (39.6%) were below the national rate of 43.3%.

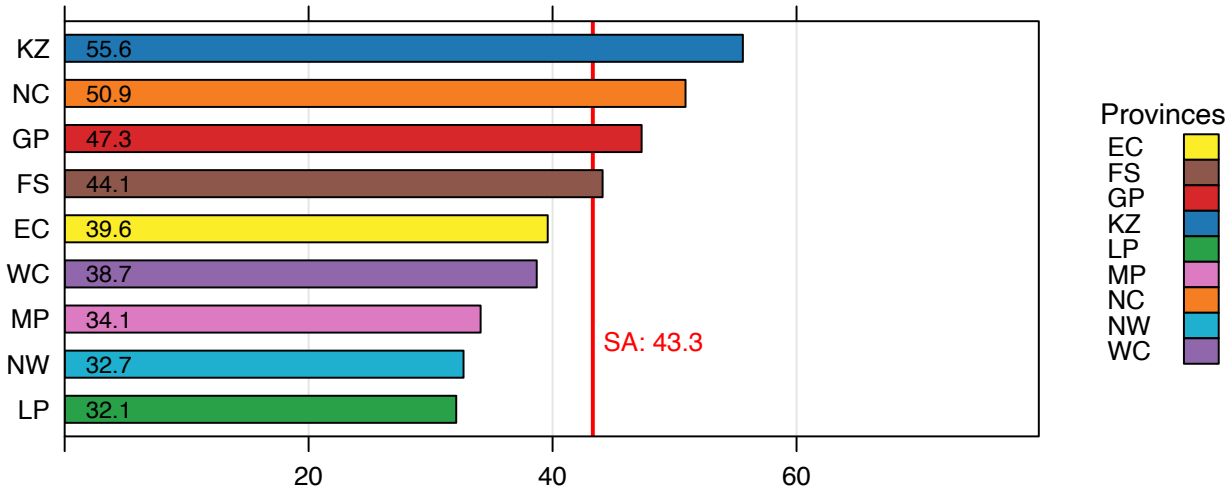


Figure 2 Infant exclusively breastfed at DTaP–IPV–Hib–HBV 3rd dose rate by province, 2023/24

Source: DHIS

District overview

The infant EBF at DTaP–IPV–Hib–HBV 3rd dose rates across the 52 districts in the country are reflected in Figure 3 and Map 1. These show a 4.3-fold variation between the lowest rate of 16.8% in Joe Gqabi (EC) and the highest rate of 72.6% in uMzinyathi (KZ). Overall, 22 districts had rates below the national average (43.3%) and 30 districts reported higher rates. None of the districts in KZ and NC had rates below 43.3%, while one district each in GP (Ekurhuleni) and FS (Lejweleputswa), and all the districts in LP were below the national average.

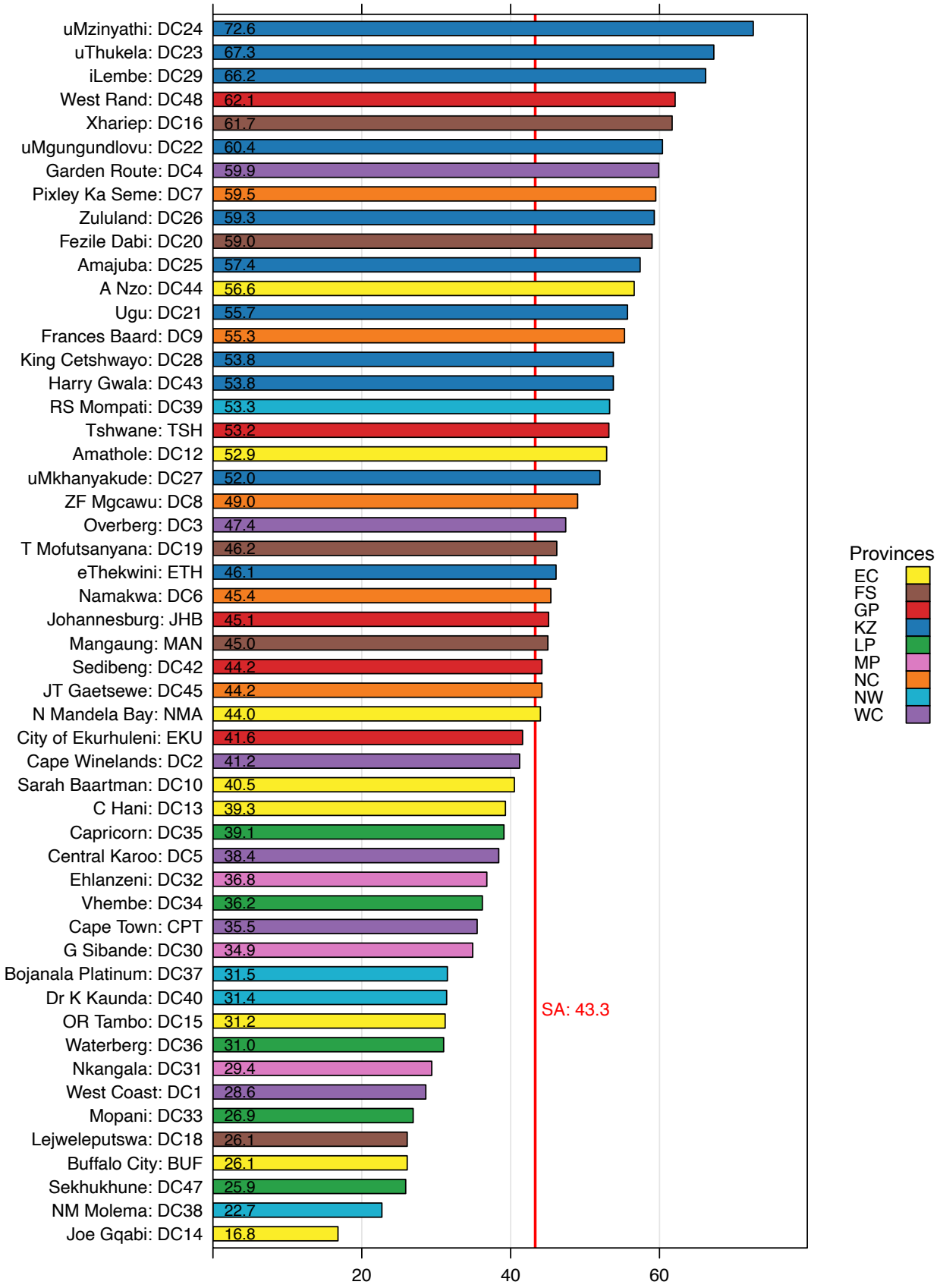
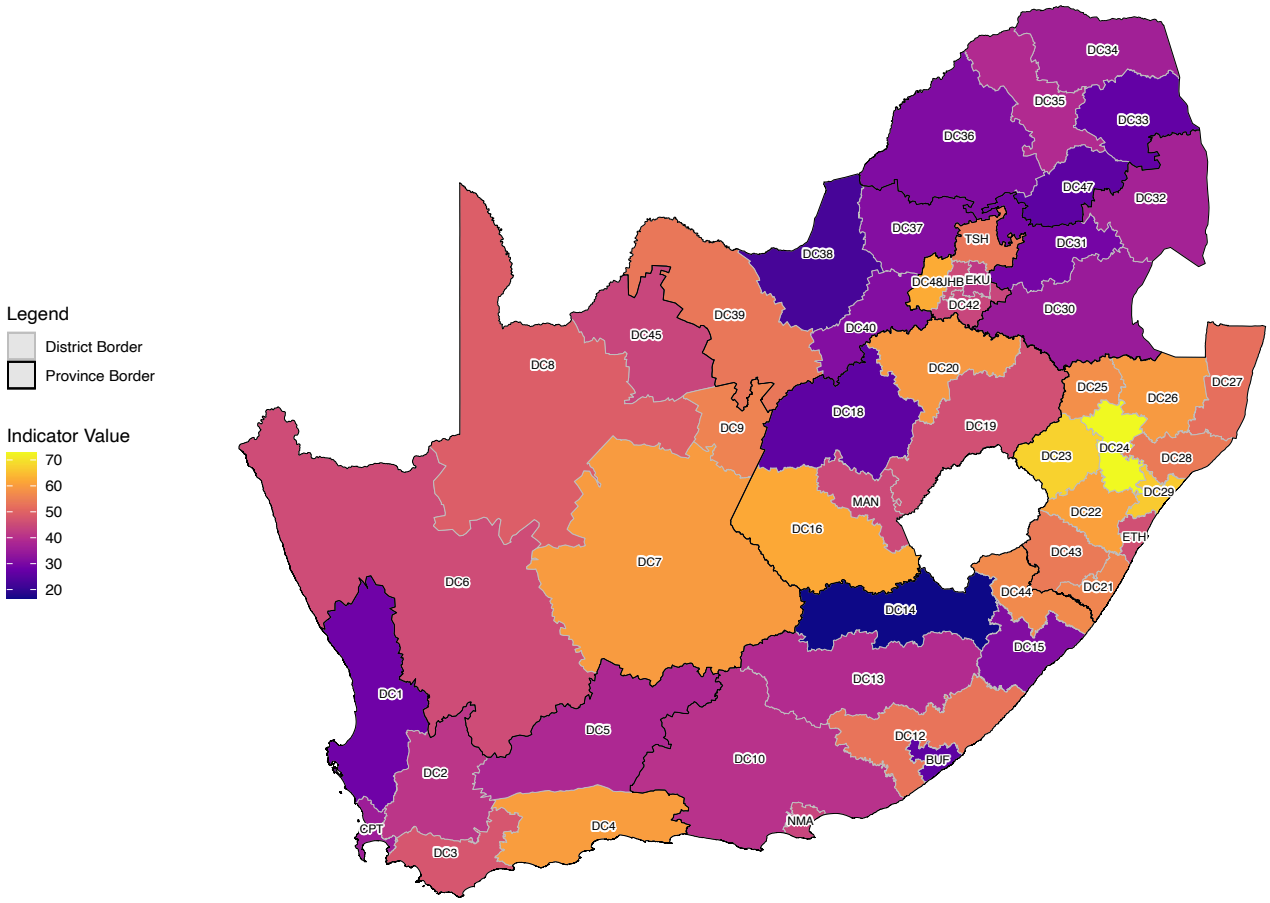


Figure 3 Infant exclusively breastfed at DTaP–IPV–Hib–HBV 3rd dose rate by district, 2023/20242023/24

Source: DHIS



MAP 1 Infant exclusively breastfed at DTaP–IPV–Hib–HBV 3rd dose rate by district, 2023/24

Source: DHIS

The annual trends in infant EBF at DTaP–IPV–Hib–HBV 3rd dose rate for all districts are presented in Table 2 and Figure 4. These show marked variations of rates between and within the nine provinces and 52 districts from one year to the next over a period of nine years (2015/16 to 2023/24). The rates increased in 22 districts, and decreased in 30 districts. Only one district in NC (Pixley Ka Seme) showed an increase in the rate. No district in MP managed to increase or sustain rates between 2022/23 and 2023/24. All MP districts showed declining rates, considerably in Nkangala (-12.8 percentage points). Other considerable declines were observed in Sekhukhune (LP) (-12.3 percentage points), Sarah Baartman (EC) (-12.2 percentage points), Sedibeng (GP) (-8.0 percentage points) and Joe Gqabi (EC) (7.4 percentage points). Garden Route (WC) had the highest increase in the same period of 8.7 percentage points, followed by Central Karoo (WC) (8.3 percentage points), Tshwane (GP) (5.8 percentage points), Mangaung (FS) (5.7 percentage points), and Xhariep (FS) (5.1 percentage points).

Table 2 Infant exclusively breastfed at DTaP–IPV–Hib–HBV 3rd dose rate by district, 2019/20 – 2023/24 (%)

PROVINCE	DISTRICT	2019/20	2020/21	2021/22	2022/23	2023/24	Percentage point difference between 2022/23 and 2023/24
Eastern Cape	Alfred Nzo	59.0	57.9	55.7	60.1	56.6	-3.5
	Amathole	51.3	41.9	48.4	50.1	52.9	2.8
	Buffalo City	33.3	31.2	24.6	25.3	26.1	0.8
	Chris Hani	46.0	50.7	45.2	39.1	39.3	0.2
	Joe Gqabi	41.1	34.0	28.8	24.2	16.8	-7.4
	Nelson Mandela Bay	50.8	47.6	49.3	44.4	44.0	-0.4
	OR Tambo	45.6	41.4	39.2	35.6	31.2	-4.4
	Sarah Baartman	56.6	52.2	47.8	52.7	40.5	-12.2

Free State	Fezile Dabi	60.9	55.8	62.1	65.1	59.0	-6.1
	Lejweleputswa	48.2	41.0	27.7	26.7	26.1	-0.6
	Mangaung	52.8	44.6	44.9	39.3	45.0	5.7
	Thabo Mofutsanyana	53.5	45.7	43.9	43.0	46.2	3.2
	Xhariep	59.2	55.8	53.7	56.6	61.7	5.1
Gauteng	Ekurhuleni	51.8	49.3	47.0	44.5	41.6	-2.9
	Johannesburg	41.2	42.1	44.1	47.9	45.1	-2.8
	Sedibeng	43.2	39.4	48.6	52.2	44.2	-8.0
	Tshwane	42.8	45.6	46.9	47.4	53.2	5.8
	West Rand	58.6	51.0	56.8	60.3	62.1	1.8
KwaZulu-Natal	Amajuba	60.2	61.0	59.4	58.8	57.4	-1.4
	eThekwini	50.6	51.9	49.4	46.3	46.1	-0.2
	Harry Gwala	61.5	64.1	64.6	59.6	53.8	-5.8
	iLembe	60.0	60.2	64.3	62.0	66.2	4.2
	King Cetshwayo	55.4	53.7	52.6	50.3	53.8	3.5
	Ugu	52.0	53.0	51.6	51.7	55.7	4.0
	uMgungundlovu	52.8	53.9	55.1	57.9	60.4	2.5
	uMkhanyakude	59.9	54.9	54.6	52.6	52.0	-0.6
	uMzinyathi	75.3	77.9	75.4	74.6	72.6	-2.0
	uThukela	71.5	71.7	68.7	70.4	67.3	-3.1
	Zululand	48.7	46.7	53.6	55.2	59.3	4.1
Limpopo	Capricorn	48.3	48.3	40.1	40.7	39.1	-1.6
	Mopani	31.9	28.9	24.9	27.1	26.9	-0.2
	Sekhukhune	37.7	37.3	34.4	38.2	25.9	-12.3
	Vhembe	38.9	36.1	32.3	35.4	36.2	0.8
	Waterberg	48.7	41.8	32.2	30.7	31.0	0.3
Mpumalanga	Ehlanzeni	51.1	39.8	36.2	39.4	36.8	-2.6
	Gert Sibande	51.4	44.6	40.5	37.9	34.9	-3.0
	Nkangala	53.7	47.4	42.3	42.2	29.4	-12.8
Northern Cape	Frances Baard	59.2	56.1	53.5	59.9	55.3	-4.6
	JT Gaetsewe	42.7	43.9	36.4	45.1	44.2	-0.9
	Namakwa	53.1	51.9	58.4	52.3	45.4	-6.9
	Pixley Ka Seme	63.3	56.1	51.7	55.8	59.5	3.7
	ZF Mgcawu	64.4	56.6	50.5	53.8	49.0	-4.8
North West	Bojanala Platinum	57.3	45.6	36.8	34.4	31.5	-2.9
	Dr K Kaunda	62.0	42.5	31.7	30.9	31.4	0.5
	NM Molema	59.9	37	24.5	24.8	22.7	-2.1
	RS Mompati	62.6	38.9	39	48.4	53.3	4.9
Western Cape	Cape Town	39.3	35.7	39.9	38	35.5	-2.5
	Cape Winelands	34.5	36.5	37.9	37.7	41.2	3.5
	Central Karoo	52.9	47.3	38.9	30.1	38.4	8.3
	Garden Route	49.6	49.9	49.3	51.2	59.9	8.7
	Overberg	47.4	51.9	52.2	46.5	47.4	0.9
	West Coast	32.8	29.8	28.9	30.6	28.6	-2.0

Source: DHIS

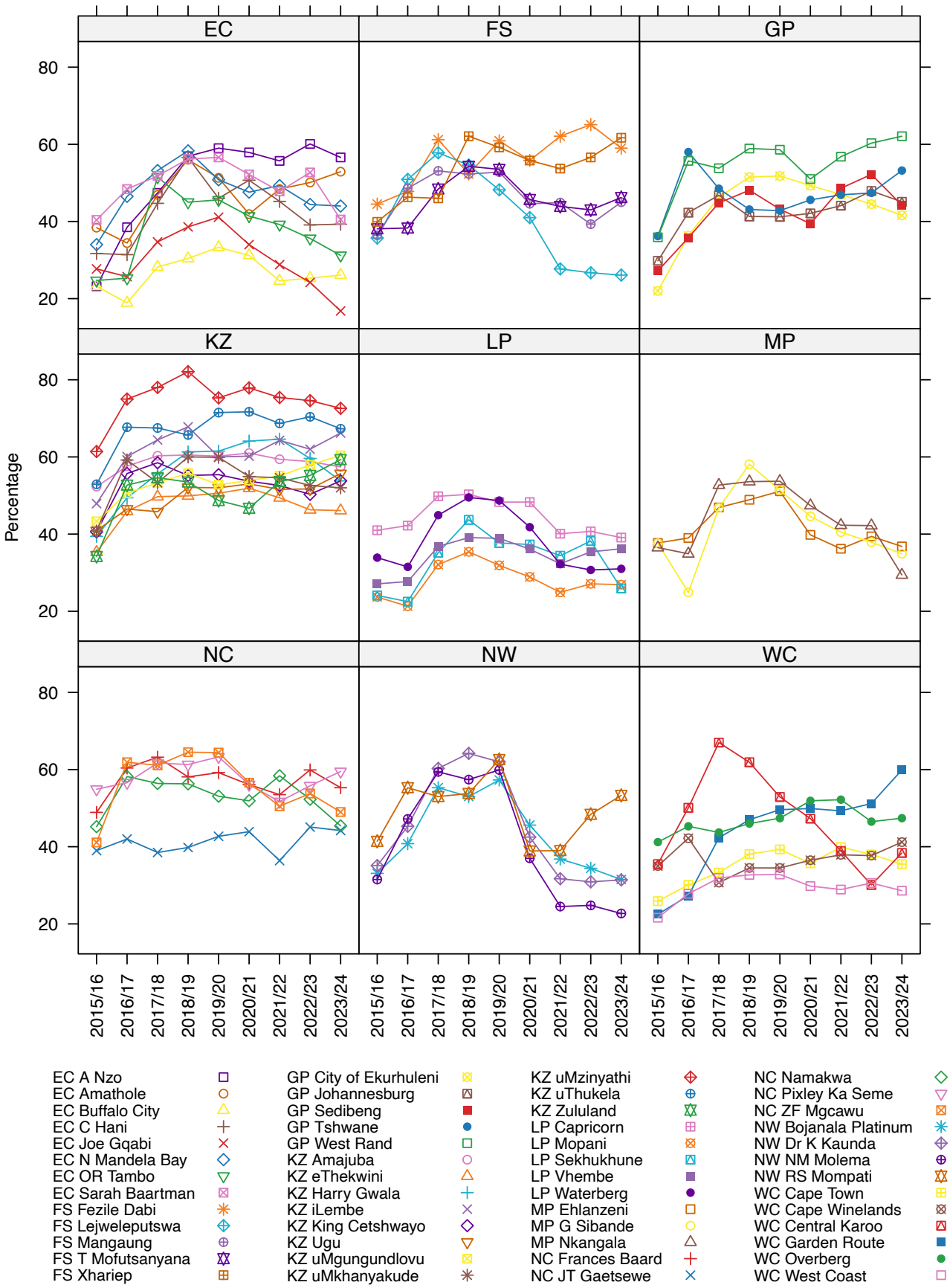


Figure 4 Annual trends: infant exclusively breastfed at DTaP–IPV–Hib–HBV 3rd dose rate by district, 2015/16 – 2023/24

Source: DHIS

Recommendations

Interventions for improving EBF rates among infants in South Africa, to achieve the WHO/UNICEF targets of 50% to 70% in the first six months of life by 2025 should consider:

- Improving IYCF, particularly increasing and sustaining EBF rates until six months of age and promote continued breastfeeding until two years, while enhancing complementary feeding practices and nutritional support.

The above recommendation should be coupled with:

- Continuous education to mothers on the benefits of EBF.
- Collaborative efforts to translate nutrition-related knowledge into appropriate feeding practices among mothers.

Additionally,

- The cultural diversity of South Africa calls for strategies and intervention programmes that consider socio-cultural beliefs and the context of each province and within the districts to improve EBF rates.
- Owing to current trends, special attention should be given to Limpopo, Mpumalanga, North West, Western Cape and Eastern Cape, while the EBF rates in Gauteng, Free State, KwaZulu-Natal, and Northern Cape should be sustained.

Child under 5 years severe acute malnutrition case fatality rate

Perpetua Modjadji

Key findings

- Severe acute malnutrition (SAM) case fatality rate (CFR) has declined from 7.7% to 7% in the past five years.
- The highest SAM CFR was observed in LP (12.9%) and the lowest in NW (2.1%).
- EC (9.5%) and FS (9.3%) also had higher SAM CFR than the national average.
- The highest SAM CFR (17.4%) was observed in Amathole district (EC), followed by Sekhukhune (16%), Mopani (15.2%), and Vhembe (15%) in LP, and Lejweleputswa (14.8%) in FS.
- Between 2022/23 and 2023/24, SAM CFR decreased in 29 districts.
- Eighteen districts had an increase in the SAM CFR that varies between 13.1 and 0.2 percentage points. The highest increases were in Mopani (LP), Amathole (EC), Sekhukhune (LP), Alfred Nzo (EC) and Sedibeng (Gauteng (GP).

Introduction

Low-and middle-income countries (LMICs) are still plagued with acute malnutrition in children aged under five exposed to short duration nutritional deficits due to poor social, economic, and environmental factors.[1,2,3] Acute malnutrition manifests as either moderate (MAM) or severe (SAM) based on anthropometric and biochemical measurements, in addition to clinical assessment.[4] Specifically, SAM in the under-fives is characterised by weight-for-height z-scores (WHZ) below -3 standard deviations of the median World Health Organization (WHO) growth standards, or mid-upper arm circumference (MUAC) below 115 mm, or the presence of nutritional oedema.[5] Approximately 58 million children under five years of age are affected by acute malnutrition in LMICs, of whom 65% are from Asia and 28% from Africa.[6] By 2025, over half of LMICs will still have acute malnutrition estimates above WHO's Global Nutrition Target of less than 5%.6 Of great concern, is the high SAM case fatality rate (i.e., proportion of deaths to cases identified) among hospitalised children aged under-five, which is used as an indicator to monitor treatment outcomes.[3,7] Children with SAM die predominantly from acute gastroenteritis (i.e., diarrhoeal disease) and pneumonia due to extensive dysfunctions of digestive and immune systems.[8,9] To date, SAM case fatality rates (SAM CFR) are estimated between 50% and 60% in the under-fives residing in poor resource settings in LMICs, raising concerns for the implementation of the WHO guidelines.[10] According to WHO, SAM CFR can be reduced to less than 10% in hospitalised children provided guidelines are adhered to properly on stabilisation, rehabilitation, discharge and follow-up.[5]

1 Dipasquale V, Cucinotta U, Romano C. Acute malnutrition in children: pathophysiology, clinical effects and treatment. Nutrients. 2020;12. DOI: 10.3390/nu12082413
2 IPC Global Support Unit. Integrated Food Security Phase Classification. Concepts, tools, and procedures to be used to classify areas based on acute malnutrition. IPC Nutrition Working Group and Technical Normative Development. 2016.
3 Collins S. Treating severe acute malnutrition seriously. Arch Dis Child. 2007;92:453-461. DOI: 10.1136/adc.2006.098327
4 Abate HK, Kidane SZ, Feyessa YM, et al. Mortality in children with severe acute malnutrition. Clin Nutr ESPEN. 2019;33:98-104. DOI: https://doi.org/10.1016/j.clnesp.2019.07.001
5 World health Organization. Updates on the management of severe acute malnutrition in infants and children. Geneva: WHO; 2013.
6 Kinyoki DK, Ross JM, Lazzar-Atwood A, et al. Mapping local patterns of childhood overweight and wasting in low- and middle-income countries between 2000 and 2017. Nat Med. 2020;26:750-759. DOI: 10.1038/s41591-020-0807-6
7 Mantha S. Ratio, rate, or risk? Lancet Infect Dis. 2021;21:165-166. DOI: 10.1016/S1473-3099(20)30439-4
8 Thaxton GE, Melby PC, Manary MJ, et al. New insights into the pathogenesis and treatment of malnutrition. Gastroenterol Clin. 2018;47:813-827.
9 National Department of Health. 3rd triennial report of the committee on morbidity and mortality in children under five years: 2015-2017. Pretoria: Committee on Morbidity and Mortality in Children Under 5 Years; 2017.
10 Trehan I, Goday, PS. Malnutrition in children in resource-limited settings: Clinical assessment. In: UpToDate, Post TW (Ed), UpToDate, Waltham, MA. [Accessed September 25, 2024]. Available from:https://wwwuptodatecom/contents/malnutrition-in-children-in-resource-limited-settings-clinical-assessment

South Africa has adapted and implemented the WHO guidelines in the local context to improve mortality outcomes in children with SAM.[11] From 2011 to 2017, the country recorded a decline in SAM CFR from 13.1% to 8% in children aged under five.[12] This suggests improved inpatient SAM management which is encouraging, however, much effort is still required to end preventable deaths of newborns and children under five if sustainable development (SDG) goal 3.2 is to be achieved by 2030.[13] Poor treatment outcomes among the under-fives are still attracting attention in some parts of South Africa, especially in health facilities located in rural settings which experience constraints.[14]

National overview

Figure 1 shows SAM CFR for children under five from 2019/20 – 2023/24. The national SAM CFR for 2023/2024 was 7%. In the past five years, SAM CFR has fluctuated but declined overall from 7.7% (2019/20) to 7.0% (2023/24).

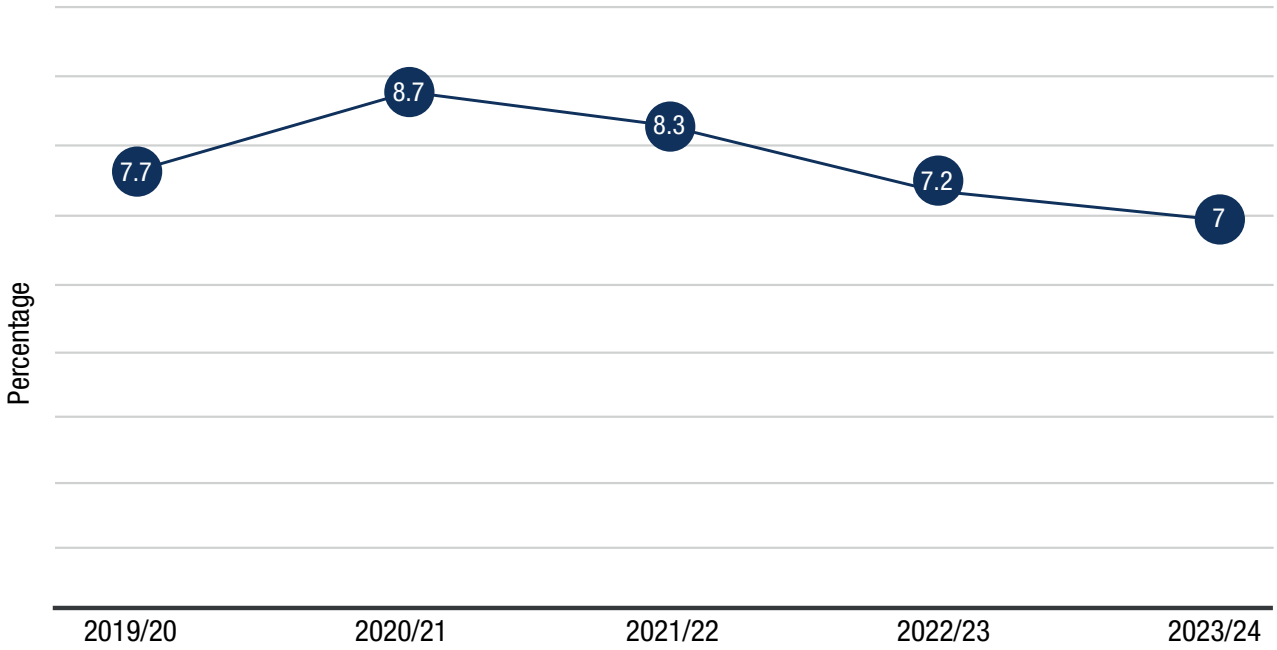


Figure 1 SAM CFR for children under five years, 2019/20 – 2023/24

Source: DHIS

Provincial overview

Figure 2 shows SAM CFR for under-fives by province, 2023/24. An inter-provincial variation of 10.8 percentage points ranging from low rates of 2.1% in both North West (NW) and Western Cape, to 12.9% in Limpopo (LP) was observed. In addition to LP, Eastern Cape (EC) (9.5%) and Free State (FS) (9.3%) reported SAM CFRs higher than the national average (7.0%).

11 National Department of Health. Integrated management of children with acute malnutrition in South Africa: Operational guidelines. Pretoria: NDoH; 2015.
12 Bamford L, Barron P, Kauchali S, et al. Inpatient case fatality rates improvements in children under 5: Diarrhoeal disease, pneumonia and severe acute malnutrition. S Afr Med J. 2018;108:S33-S37.
13 Statistics South Africa. Sustainable Development Goals: Country Report 2023. Pretoria: Stats SA; 2023
14 Muzigaba M, Van Wyk B, Puoane T. Management of severe acute malnutrition in children under 5 years through the lens of health care workers in two rural South African hospitals. Af J Prim Health Care Fam Med. 2018;10:e1-e8. DOI: 10.4102/phcfm.v10i1.1547

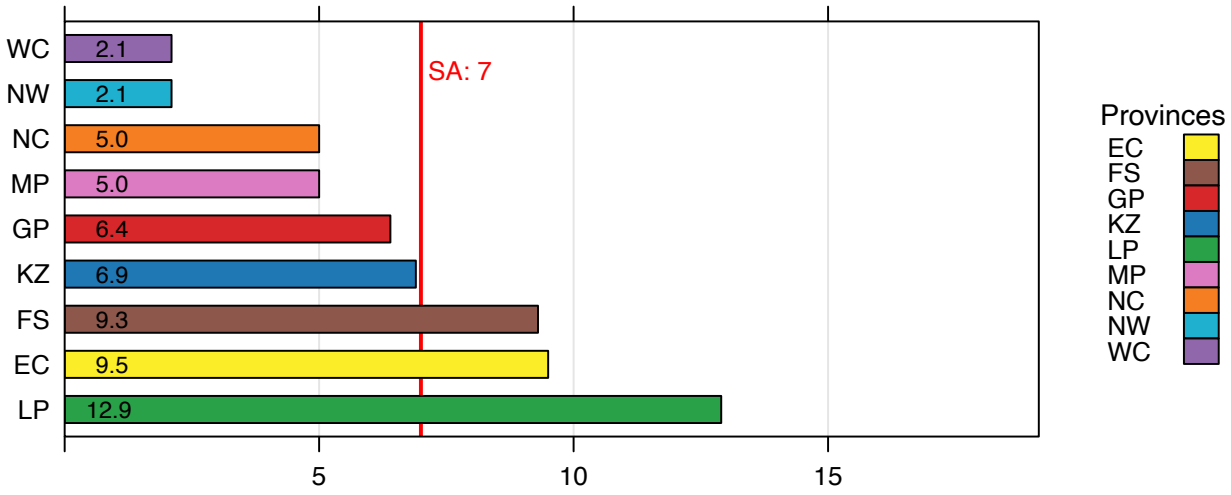


Figure 2 Severe acute malnutrition case fatality under five years rate by province, 2023/24

Source: DHIS

District overview

Figure 3 and Map 1 show SAM CFR for under-five years rates by district in 2023/24. There are 52 districts in South Africa, and the highest SAM CFR (17.4%) was recorded in Amathole (EC). Two districts in WC (West Coast and Central Karoo), and one district in NW (Ngaka Modiri Molema) reported a zero SAM CFR, while RS Mompati (NW) reported 1.1%. In addition to these three districts, 23 districts reported SAM CFRs higher than the national average (7.0%).

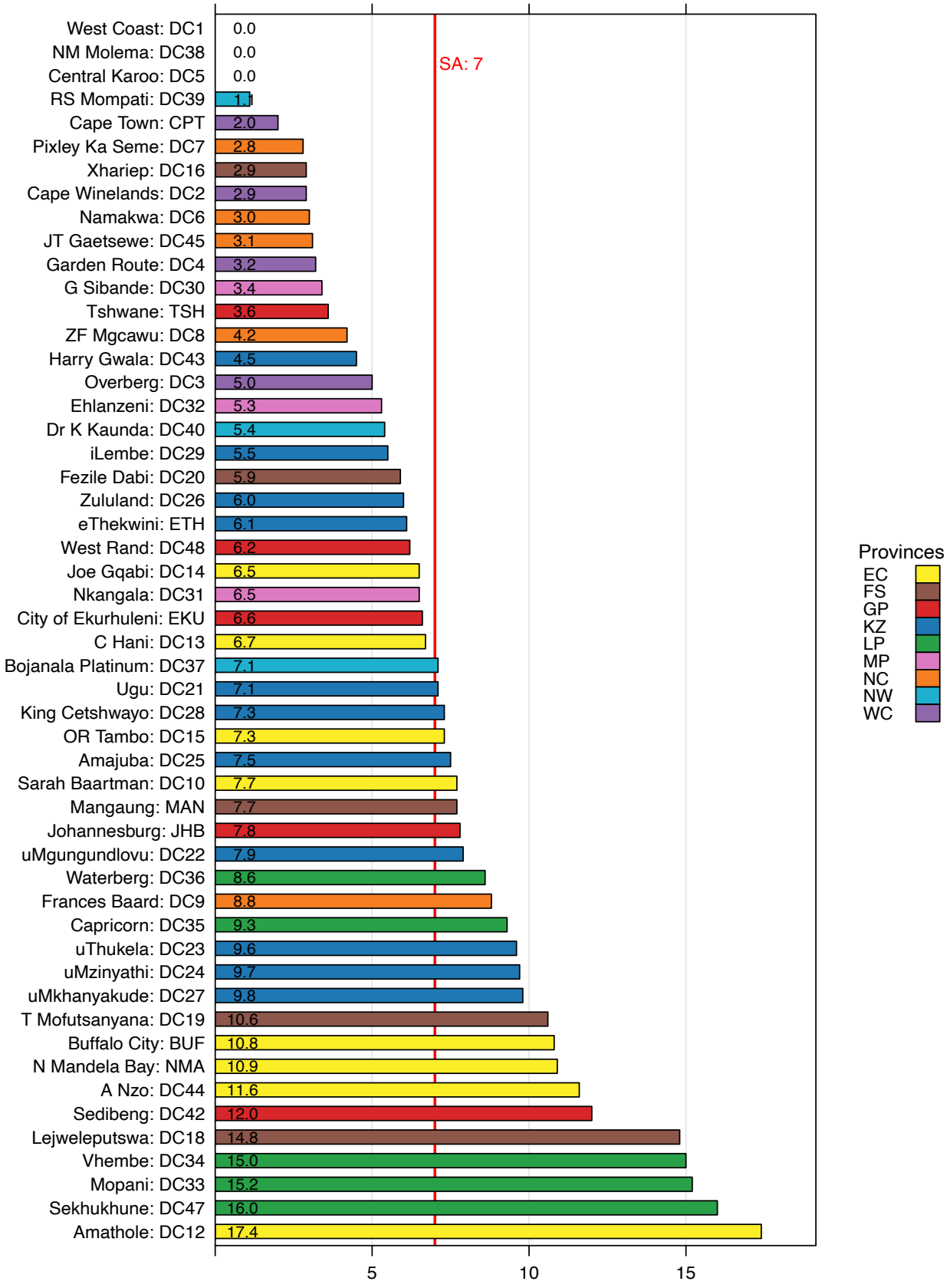
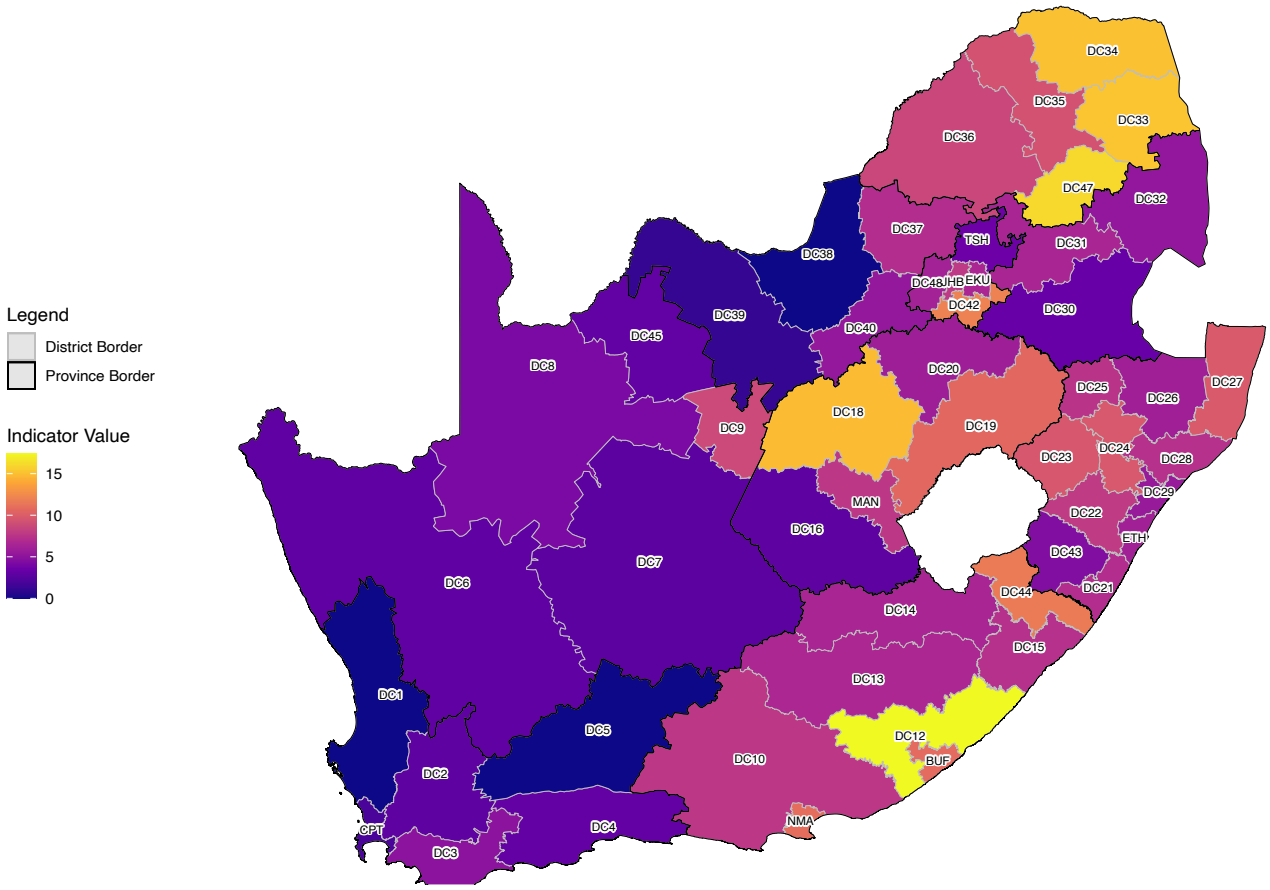


Figure 3 Severe acute malnutrition case fatality under five years rate by district, 2023/24

Source: DHIS



MAP 1 Severe acute malnutrition case fatality under five years rate by district, 2023/24

Source: DHIS

Figure 4 shows the annual trends of SAM CFR by district between 2009/10 and 2023/24, with annual marked variation between districts across all provinces. In the past two years, SAM CFR decreased in 29 districts; of these, eight were in KwaZulu-Natal; five in Eastern Cape; four in Northern Cape; two each in Free State, Gauteng, Limpopo, and North West; and one in Western Cape. Mpumalanga was the only province with decreased SAM CFR in all the three districts. Eighteen districts had an increase in the SAM CFR that varies between 13.1 and 0.2 percentage points. The highest increases were in Mopani (LP), Amathole (EC), Sekhukhune (LP), Alfred Nzo (EC) and Sedibeng (GP).

Table 1 Severe acute malnutrition case fatality under five years rate by district, 2019/20 – 2023/24 (%)

PROVINCE	DISTRICT	2019/20	2020/21	2021/22	2022/23	2023/24	Percentage point difference between 2022/23 and 2023/24
Eastern Cape	Alfred Nzo	8.6	7.7	11.5	4	11.6	7.6
	Amathole	12.2	14.1	19	7	17.4	10.4
	Buffalo City	22.9	16.7	25.6	14.3	10.8	-3.5
	Chris Hani	12.7	10.8	4.9	7.7	6.7	-1.0
	Joe Gqabi	4.9	13.1	7.4	7.6	6.5	-1.1
	Nelson Mandela Bay	8.2	4.7	8.3	11.8	10.9	-0.9
	OR Tambo	9.2	7.3	10.3	8.3	7.3	-1.0
	Sarah Baartman	8	7.5	9	3	7.7	4.7

Free State	Fezile Dabi	5.4	5	3.6	9.4	5.9	-3.5
	Lejweleputswa	9.9	4.3	13.2	11.2	14.8	3.6
	Mangaung	5.8	1.5	4.3	7.5	7.7	0.2
	Thabo Mofutsanyana	7.7	7.5	13	11.5	10.6	-0.9
	Xhariep	1.2		0	2.9	2.9	0
Gauteng	Ekurhuleni	11	8.4	6.7	6.6	6.6	0
	Johannesburg	4.4	7.6	12.4	6.8	7.8	1.0
	Sedibeng	9.3	5.4	10.7	5.5	12	6.5
	Tshwane	5.7	8.8	6.8	6.5	3.6	-2.9
	West Rand	0.96	2.4	5.5	6.3	6.2	-0.1
KwaZulu-Natal	Amajuba	5.7	4.7	12	6.7	7.5	0.8
	eThekwini	5.9	11.5	10.2	8.3	6.1	-2.2
	Harry Gwala	7.7	11.2	9.7	1.7	4.5	2.8
	iLembe	7.2	12.2	6.5	8.8	5.5	-3.3
	King Cetshwayo	8	11.3	12.6	12	7.3	-4.7
	Ugu	4.8	10.3	11.9	11	7.1	-3.9
	uMgungundlovu	3.6	5.0	11.1	5.8	7.9	2.1
	uMkhanyakude	6.6	5.7	5.7	10.3	9.8	-0.5
	uMzinyathi	10.7	14.9	10.9	14.5	9.7	-4.8
	uThukela	11.7	8.6	9.7	13.9	9.6	-4.3
	Zululand	18.3	12.7	15.1	10.6	6.0	-4.6
Limpopo	Capricorn	21.6	13.8	8.5	13.8	9.3	-4.5
	Mopani	3.2	2.5	1.5	2.1	15.2	13.1
	Sekhukhune	8.2	14.3	7.3	7.4	16.0	8.6
	Vhembe	6.9	16.4	12.2	13.7	15.0	1.3
	Waterberg	8.1	10.6	12.5	8.7	8.6	-0.1
Mpumalanga	Ehlanzeni	7.1	19.7	10.3	6.5	5.3	-1.2
	Gert Sibande	8.1	8.3	10.1	7.0	3.4	-3.6
	Nkangala	17.6	20.3	13.6	12.1	6.5	-5.6
Northern Cape	Frances Baard	4.8	3.3	9.4	14.6	8.8	-5.8
	JT Gaetsewe	10.3	22	13.3	8.3	3.1	-5.2
	Namakwa	3.7	6.3	0	0	3.0	3.0
	Pixley Ka Seme	3.2	3.9	2.0	7.0	2.8	-4.2
	ZF Mgcawu	0.64		1.4	5.4	4.2	-1.2
North West	Bojanala Platinum	16	8.5	9.4	5.5	7.1	1.6
	Dr K Kaunda	8.6	4.4	10.2	4.2	5.4	1.2
	NM Molema	10	2.6	0.3	0.86	0	-0.86
	RS Mompati	13.3	8.3	9	5.8	1.1	-4.7
Western Cape	Cape Town	0.4	0.6	0.7	2.0	2.0	0
	Cape Winelands	3.8	4.7	6.0	5.0	2.9	-2.1
	Central Karoo	7.1		3.4	0	0	0
	Garden Route	0	2.4	1.3	0	3.2	3.2
	Overberg	0	7.1	3.8	4.5	5	0.5
	West Coast	0	3.3	0	0	0	0

Source: DHIS

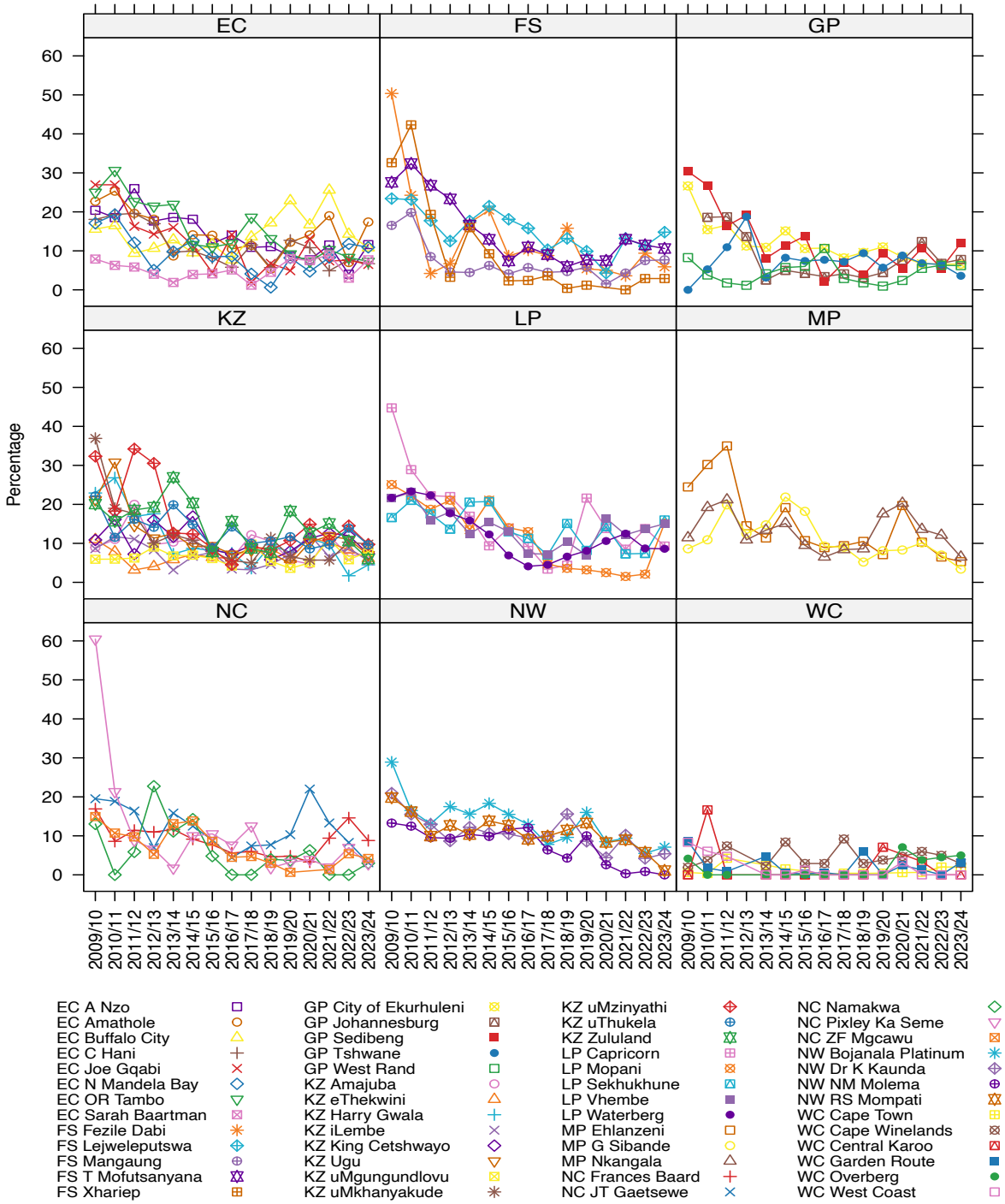


Figure 4 Annual trends: Severe acute malnutrition case fatality under five years rate by district, 2009/10 – 2023/24

Source: DHIS

Recommendations

To end preventable deaths of newborns and children age under five and thus achieve SDG 3.2, will entail:

- Intensifying child growth monitoring for early detection of faltering growth.
- Preventing SAM through addressing underlying causes associated with poverty and food insecurity.
- Strengthening community-based approaches for timely detection of SAM and providing alternative treatment in the absence of medical complications.
- Addressing constrictions affecting the successful implementation of SAM management guidelines in health facilities.
- Enforcing multisectoral collaboration and commitment towards intervention coherence.

1.3 Immunisation

Nishi Prabdial-Sing, Kerrigan McCarthy, Natalie Mayet

Key findings

- In 2023/24, the national immunisation under 1 year coverage and measles 2nd dose coverage were 83.3% and 84.9%, respectively, both below the 95% target required for the successful elimination of childhood diseases.
- Between 2018/19 and 2023/24, the average immunisation under 1 year coverage per province ranged from 69.4% in Limpopo (LP) to 93.3% in Mpumalanga (MP), the measles 2nd coverage average per province were slightly higher ranging from 73.0% in North West (NW) to 90.6% in Mpumalanga. In the same period, none of the nine provinces attained the 95% target for immunisation under 1 year coverage and measles 2nd dose coverage rates.
- KwaZulu-Natal (KZ) was the only province to achieve almost 95% for immunisation under 1 year coverage in 2023/24 at 94.5% and reached the target of 95% for measles 2nd dose coverage at 95.6%.
- In 2023/34, eight of the 52 districts had an immunisation under 1 year coverage of more than 95%, of which seven of the eight were in KZ and one in Gauteng (GP). Sekhukhune (LP) and Pixley Ka Seme (Northern Cape (NC)) had the lowest immunisation under 1 year coverage at 62.9% and 65.4% respectively.
- Eight districts also achieved 95% measles 2nd dose coverages in 2023/24, of which seven were in KZ and one in GP. The districts with the lowest measles 2nd coverage were Thabo Mofutsanyana in Free State (FS) and Pixley Ka Seme (NC), with 67.7% and 67.0%, respectively.

Introduction

One of the major successes in history remains immunisation, which reduces childhood deaths by 4 million each year and is estimated to prevent 50 million deaths between 2021 and 2030.[1] Measles vaccination has prevented disease and death more than 12-fold in the 21st century compared with the previous century. This year marks the global 50th anniversary of the expanded programme on immunisation (EPI), which has contributed to saving 154 million lives, 94 million of which have been children protected by the measles vaccine.[2] Initially, the EPI targeted seven childhood diseases: smallpox, tuberculosis (TB), diphtheria, tetanus, pertussis, measles and polio. Today, there are more than 20 vaccines which prevent life-threatening diseases mostly in infants, children and adolescents.[3]

Globally, immunisation has accounted for a 40% decline in infant mortality, with a remarkable decline of 52% in Africa.[2] The global vaccine coverage rate increased from less than 5% five decades ago, to 86% in 2019. The current, 2023, estimation is 84% as immunisation programmes recover from the COVID-19 pandemic.[4] In Africa, measles-containing vaccine 1st dose coverage decreased from 70% in 2017 to 68% in 2021, with a concomitant increase in measles incidence from 69 per 1 million population to 82 per 1 million population in the same period.[5] South Africa, like many other African countries, will need to recover from the impact that the COVID-19 pandemic had on surveillance and immunisation uptake, for all vaccine preventable diseases.

Of the pathogens targeted in the EPI, poliovirus is earmarked for eradication (zero cases worldwide) and measles, rubella, neonatal tetanus and hepatitis B for elimination at regional level by 2030.[6] Measles elimination indicates the absence of endemic measles virus transmission in a geographical region for more than 12 months, together with high quality surveillance that meets target indicators. Measles virus is highly transmissible with a reproduction number of around 12, meaning that one person can spread

1 U.S. Centers for Disease Control and Prevention. Global Immunization: Fast facts on global immunization. Atlanta: CDC; 2024
2 Shattock A, Johnson HC, Sim SY, et al. Contribution of vaccination to improved survival and health: modelling 50 years of the Expanded Programme on Immunization. Lancet. 2024; 403:2307-16.
3 World Health Organization. Vaccines and immunization. Geneva, WHO; 2024. URL: https://www.who.int/health-topics/vaccines-and-immunization#tab=tab_1.
4 WHO, UNICEF. South Africa: WHO and UNICEF estimates of national immunization coverage: 2023 revision. Geneva, New York: 2024
5 Masresha BG, Hatcher C, Lebo E, et al. Progress towards measles elimination-African Region, 2017-2021. MMWR. 2023; 72(36):985-991.
6 World Health Organization. Immunization Agenda 2030.Geneva: WHO; 2024. URL: https://www.who.int/teams/immunization-vaccines-and-biologicals/strategies/ia2030

the virus to 12 susceptible others. For elimination of measles, the reproductive number is required to be less than one.[7] This may not be attainable for many large parts of Africa and other regions, as accessibility to vaccines, displacements of people, and pockets of under-immunised and un-immunised individuals and communities may drive ongoing transmission. However, what may be more achievable will be increasing measles 1st and 2nd dose coverage to more than 95%.

There are varied sources of immunisation coverage data for countries, including data from administration dosage, national/ geographic surveys, and extrapolations from sentinel cohorts. Although administrative data or surveys can be biased and inaccurate, these can provide estimates of national coverage. World Health Organization (WHO)/ United Nations Children's Fund (UNICEF) Estimates of National Immunization Coverage (WUENIC) accounts for coverage of measles-containing vaccine 1st dose as the percentage of surviving infants who received the first dose of measles at 12 months or later based on a country's disease epidemiology. The measles-containing vaccine 2nd dose (MCV2) is reflected as the percentage of children who receive MCV2 according to the nationally recommended schedule.[8] It is noteworthy to reflect that the 2017–2023 immunisation coverage data for South Africa, using official/administration data, aligned with WUENIC data, as compared to earlier data from 2000–2016.[9]

This section covers two indicators, namely the immunisation under 1 year coverage and measles 2nd dose coverage The data source is the District Health Information System (DHIS).

Immunisation under 1 year coverage measures the number of children under 1 year who have completed their primary course of immunisation as a proportion of the population under 1 year. The indicator is expressed as a percentage with the numerator being the total number of children younger than 12 months who have received BCG; OPV 0, OPV 1; DTaP-IPVHib-HBV 1, 2 and 3; PCV 1, 2 and 3; RV 1 and 2; and measles 1 vaccines, and the denominator being the target population of children under 1 year old. The child is counted as fully immunised once they have received the PCV 3rd dose administered at nine months of age, and there is documented proof of all the required vaccines having been administered in the Road-to-Health booklet.

The measles 2nd dose coverage measures protection of children against measles. This indicator measures the proportion of children aged 1 year who received measles 2nd dose as a proportion of the 1 year population. This parameter monitors protection of children against measles and as the first measles dose is only around 85% effective, the second dose is important as a booster.

National overview

The immunisation under 1 year coverage for South Africa over a six year period ranged from 81.9% in 2018/19 to 83.3% in 2023/24 (Figure 1). The measles 2nd dose coverage in the same time period ranged from 76.5% to 84.9% (Figure 2). Nationally, the lowest immunisation under 1 year coverage, as well as measles 2nd dose coverage, were seen in 2020/21, being 79.5% and 76.4%, respectively, owing to the restrictions implemented during the COVID-19 pandemic.

7 Hayman DTS. Measles vaccination in an increasingly immunized and developed world. Hum Vaccin Immunother. 2019; 15(1):28-33.
8 World Health Organization. Measles immunization coverage. Geneva: WHO; 2024. URL: https://immunizationdata.who.int/global/wiise-detail-page/measles-vaccination-overage?CODE=ZAF&ANTIGEN=MCV1&YEAR
9 World Health Organization. Global Health Observatory: Indicators index. Geneva: WHO; 2024. URL: https://www.who.int/data/gho/data/indicators/indicators-index

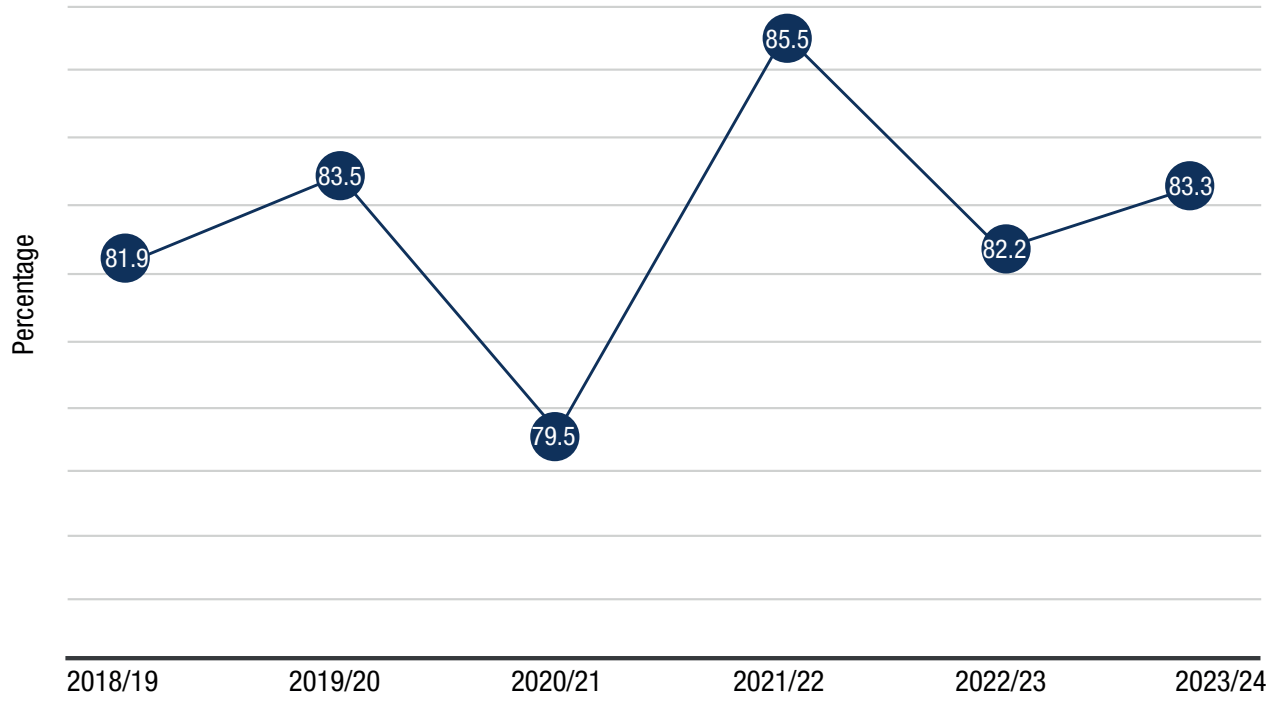


Figure 1 National immunisation under 1 year coverage, 2018/19–2023/24

Source: DHIS

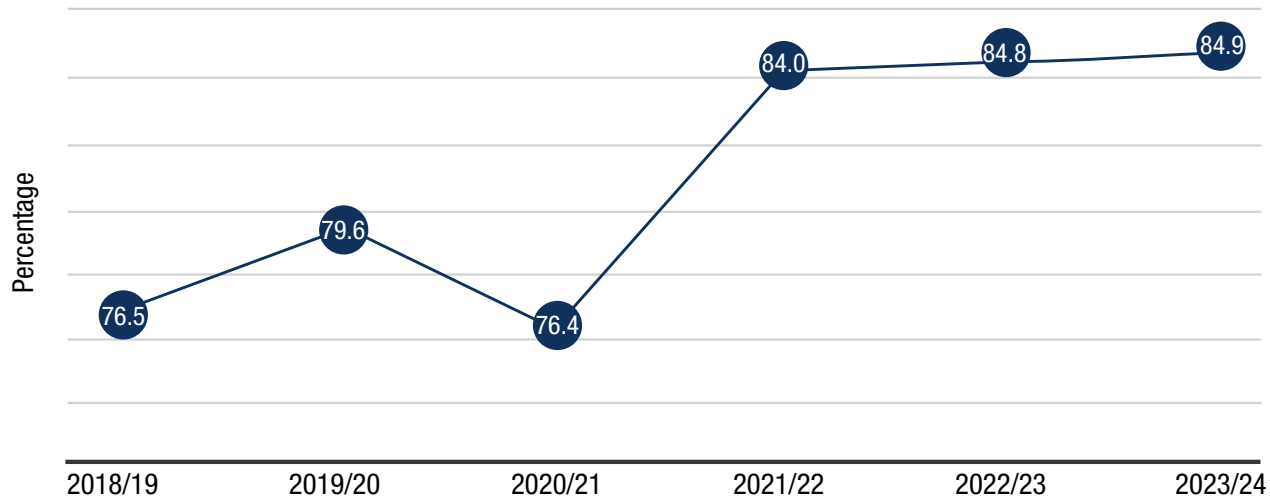


Figure 2 National measles 2nd dose coverage, 2018/19–2023/24

Source: DHIS

Provincial overview

On averages calculated for the period 2018/19 to 2023/24, none of the nine provinces reached the 95% vaccine coverage targets for either immunisation under 1 year coverage or measles 2nd coverage. The average immunisation under 1 year coverage per province ranged from 69.4% in LP to 93.3% in MP (Table 1). The measles 2nd coverage averages per province were slightly higher ranging from 73.0% in NW to 90.6% in MP (Table 2). Mpumalanga showed overall the highest percentages for both immunisation under 1 year coverage and measles 2nd coverage, followed by KZ and GP. In 2023/24, KZ almost reached the 95% target for immunisation under 1 year coverage at 94.5% (Figure 3) and met the 95% target for measles 2nd coverage at 95.6% (Figure 4).

Table 1 Immunisation under 1 year coverage by province, 2018/19–2023/24 (%)

PROVINCE	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	Mean
Eastern Cape	71.9	76.0	69.5	88.7	82.3	78.6	77.8
Free State	74.8	77.4	75.9	83.6	79.7	76.2	77.9
Gauteng	84.4	86.9	85.0	88	83.2	83.6	85.2
KwaZulu-Natal	90.8	91.4	86.4	94.8	92.2	94.5	91.7
Limpopo	71.0	73.6	60.6	69.2	67.5	74.3	69.4
Mpumalanga	96.8	96.6	91.5	97.3	89.1	88.2	93.3
Northern Cape	87.5	89.0	79.9	72.8	75.9	77.1	80.4
North West	68.4	63.0	71.2	62.8	74.1	81.2	70.1
Western Cape	82.7	84.9	85.0	83.2	75.7	74.8	81.1

Source: DHIS

Table 2 Measles 2nd dose coverage by province, 2018/19–2023/24 (%)

PROVINCE	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	Mean
Eastern Cape	65.1	73.7	66.7	83.3	81.7	79.2	75.0
Free State	72.1	73.3	73.3	77.5	80.0	73.9	75.0
Gauteng	78.9	79.8	77.8	83.2	83.9	81.0	80.8
KwaZulu-Natal	77.9	82.6	80.6	91.3	89.5	95.6	86.3
Limpopo	80.5	79.0	76.3	83.2	86.6	84.1	81.6
Mpumalanga	85.9	93.9	84.2	91.6	97.4	90.4	90.6
Northern Cape	86.3	89.8	83.5	72.2	73.6	77.7	80.5
North West	69.0	66.9	65.0	71.5	76.4	89.3	73.0
Western Cape	77.6	80.0	80.6	79.2	77.7	75.6	78.5

Source: DHIS

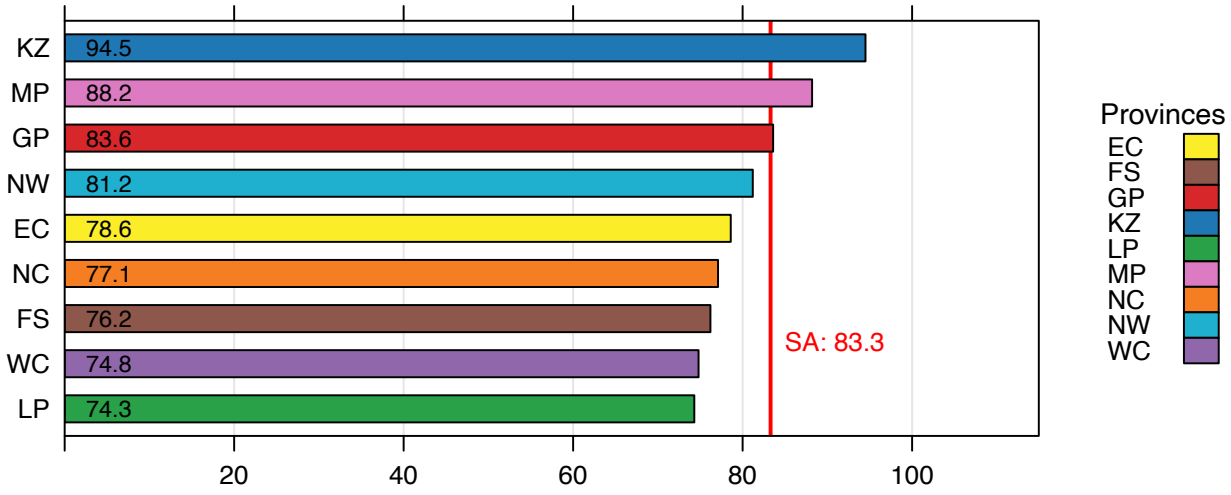


Figure 3 Immunisation under 1 year coverage by province, 2023/24

Source: DHIS

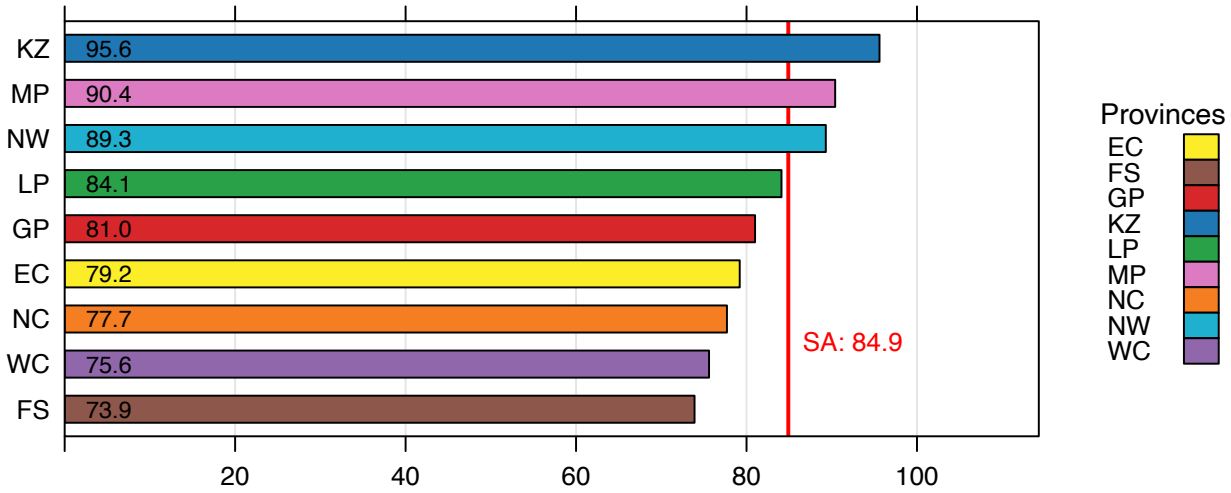


Figure 4 Measles 2nd dose coverage by province, 2023/24

Source: DHIS

District overview

In 2023/24, eight of the 52 districts had an immunisation under 1 year coverage of more than 95%, of which seven of the eight were in KZ and one in GP (Figure 5 and Map 1).

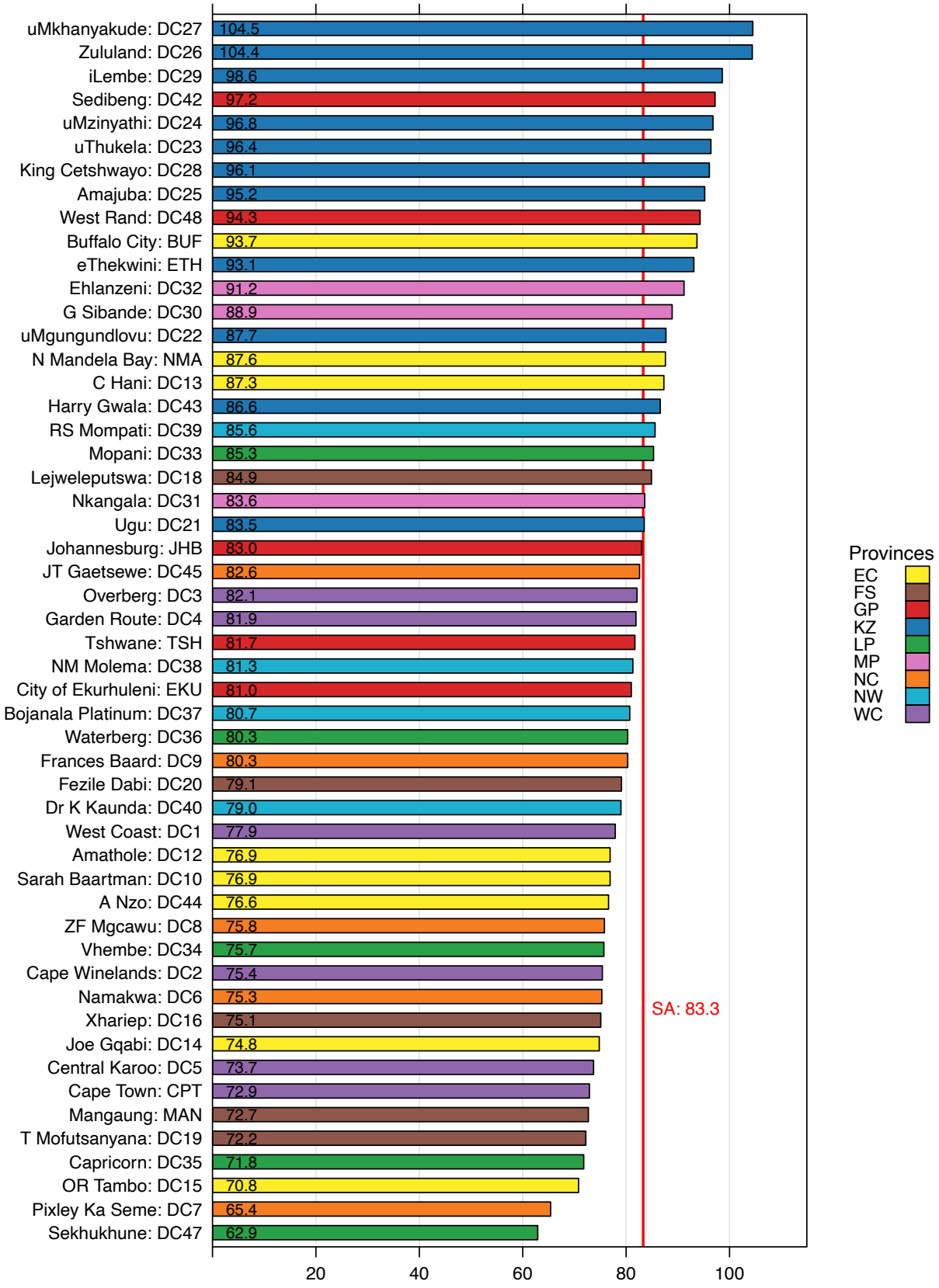


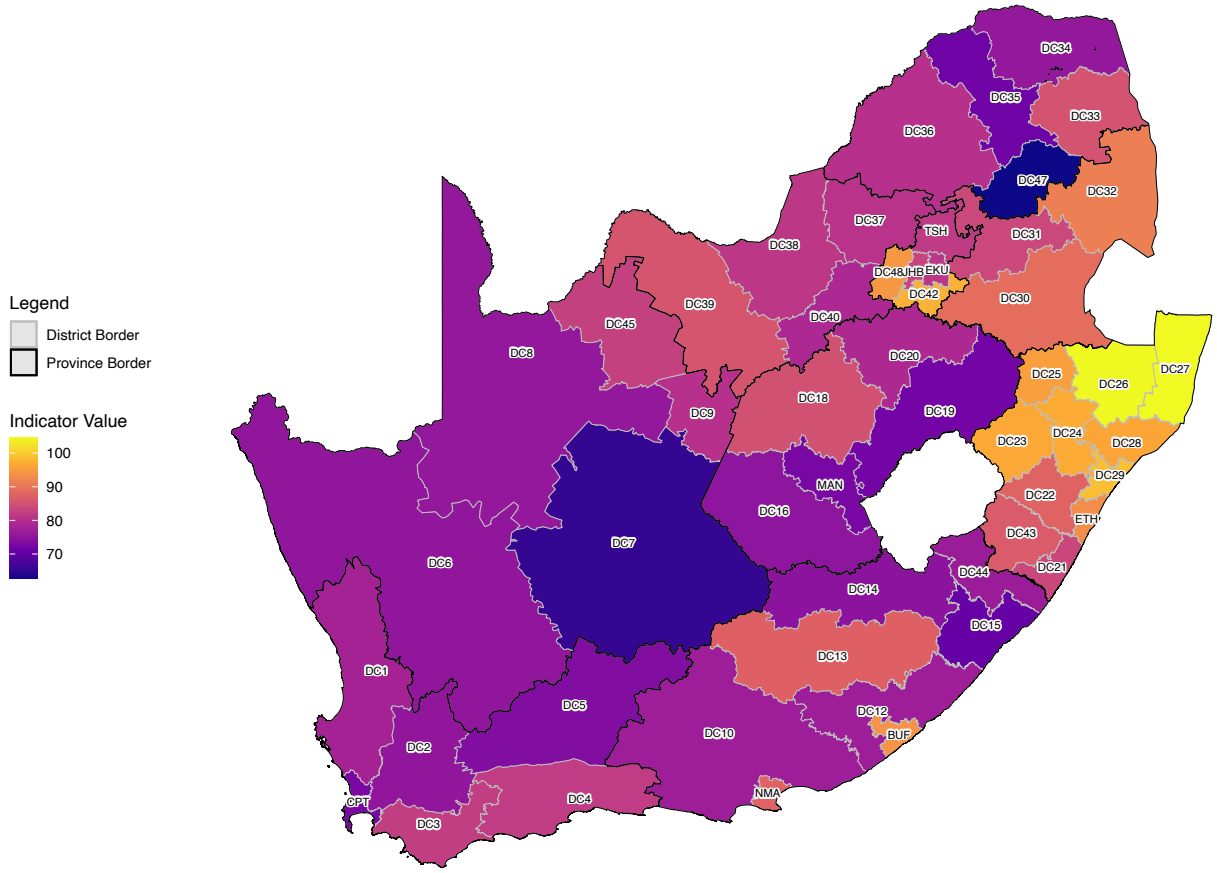
Figure 5 Immunisation under 1 year coverage by district, 2023/24

Source: DHIS

Sekhukhune (LP) and Pixley Ka Seme (NC) had the lowest immunisation under 1 year coverage at 62.9% and 65.4%, respectively. Retrospectively, these two districts showed a high number of measles cases[10] and rubella cases,[11] in 2020/21.

Eight districts also achieved 95% measles 2nd dose coverage in 2023/24, of which seven were in KZ and one in GP (Figure 6 and Map 2). The districts with the lowest measles 2nd coverage were Thabo Mofutsanyana (FS) and Pixley Ka Seme (NC), with 67.7% and 67.0%, respectively

Tshwane (GP) was the first district to experience a number of measles cases in early 2022.[12] Eastern Cape (EC) did not experience the measles outbreak between 2022 and 2024 and KZ was among the last provinces to detect positive cases during that outbreak.[11]



MAP 1 **Immunisation coverage under 1 year by district, 2023/24**

Source: DHIS

10 National Institute for Communicable Diseases: NICD Communique Bulletin. Measles in Limpopo, June 2023. 22(6):4. Johannesburg: NICD; 2023.
11 National Institute for Communicable Diseases: NICD Communique Bulletin. Measles and Rubella surveillance, November 2023. 22(11):5. Johannesburg: NICD; 2023.
12 National Institute for Communicable Diseases: NICD Communique Bulletin. Measles Outbreak in Tshwane District, Gauteng province, July 2022 update. 21(7):1. Johannesburg: NICD; 2022.

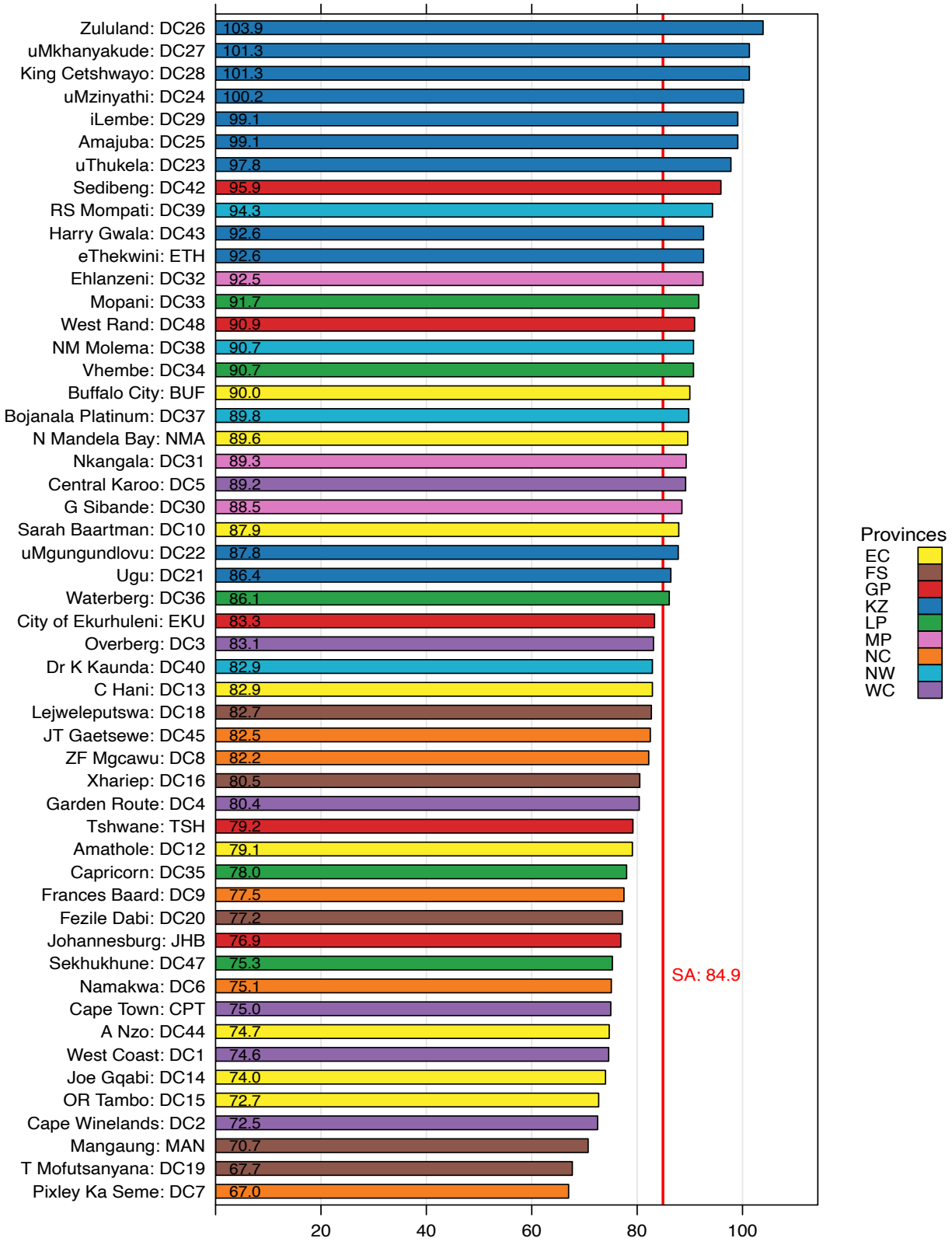
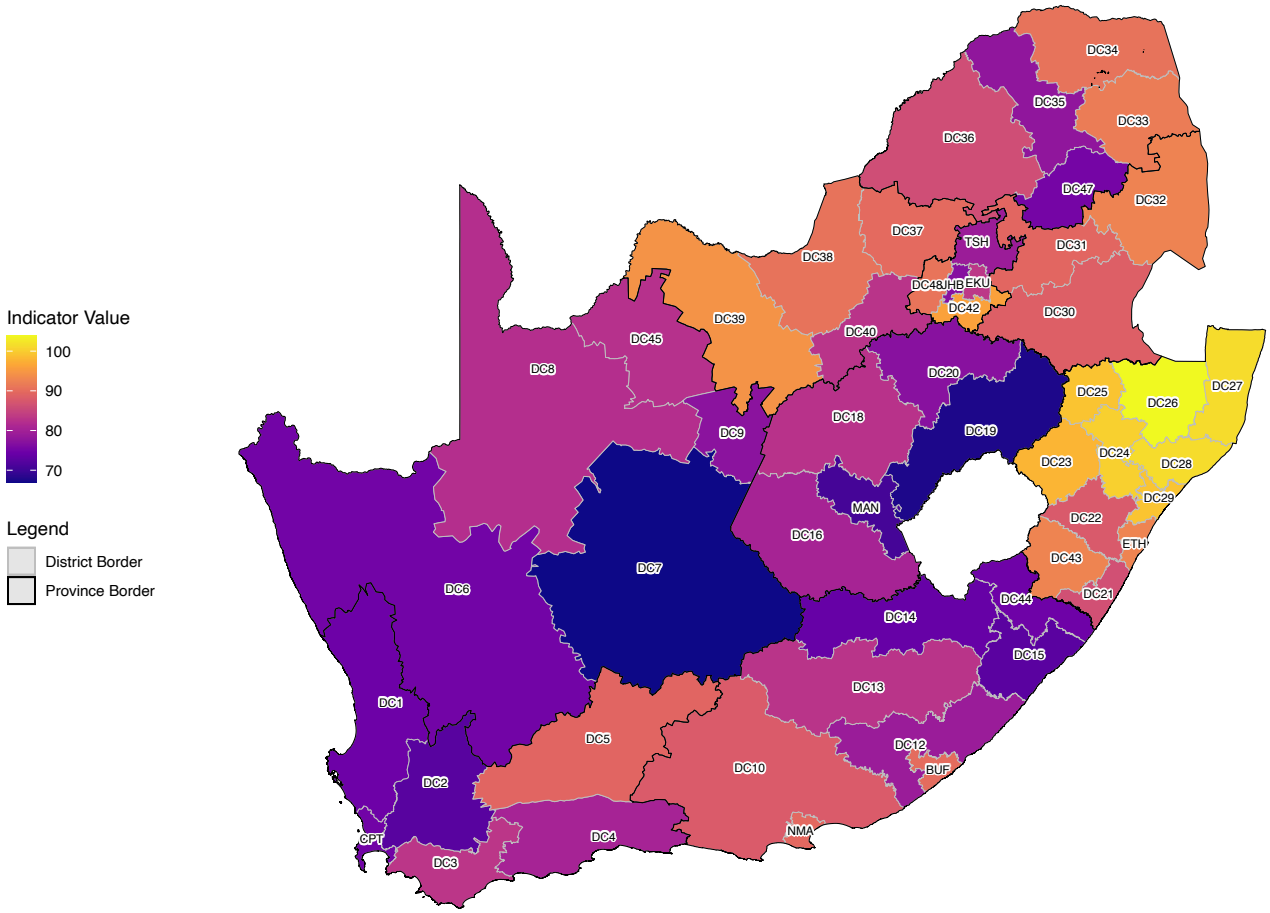


Figure 6 Immunisation under 1 year coverage by district, 2023/24

Source: DHIS



MAP 2 **Measles 2nd dose coverage by district, 2023/24**

Source: DHIS

The immunisation under 1 year coverage annual trends show year-on-year fluctuations in most districts since 2008/09 (Figure 7).

The annual trends for measles 2nd dose coverage amongst KZ districts showed a steady increase in coverage over the period 2017/18 to 2023/24 (Figure 8). Other districts showed annual fluctuating measles 2nd dose coverage.

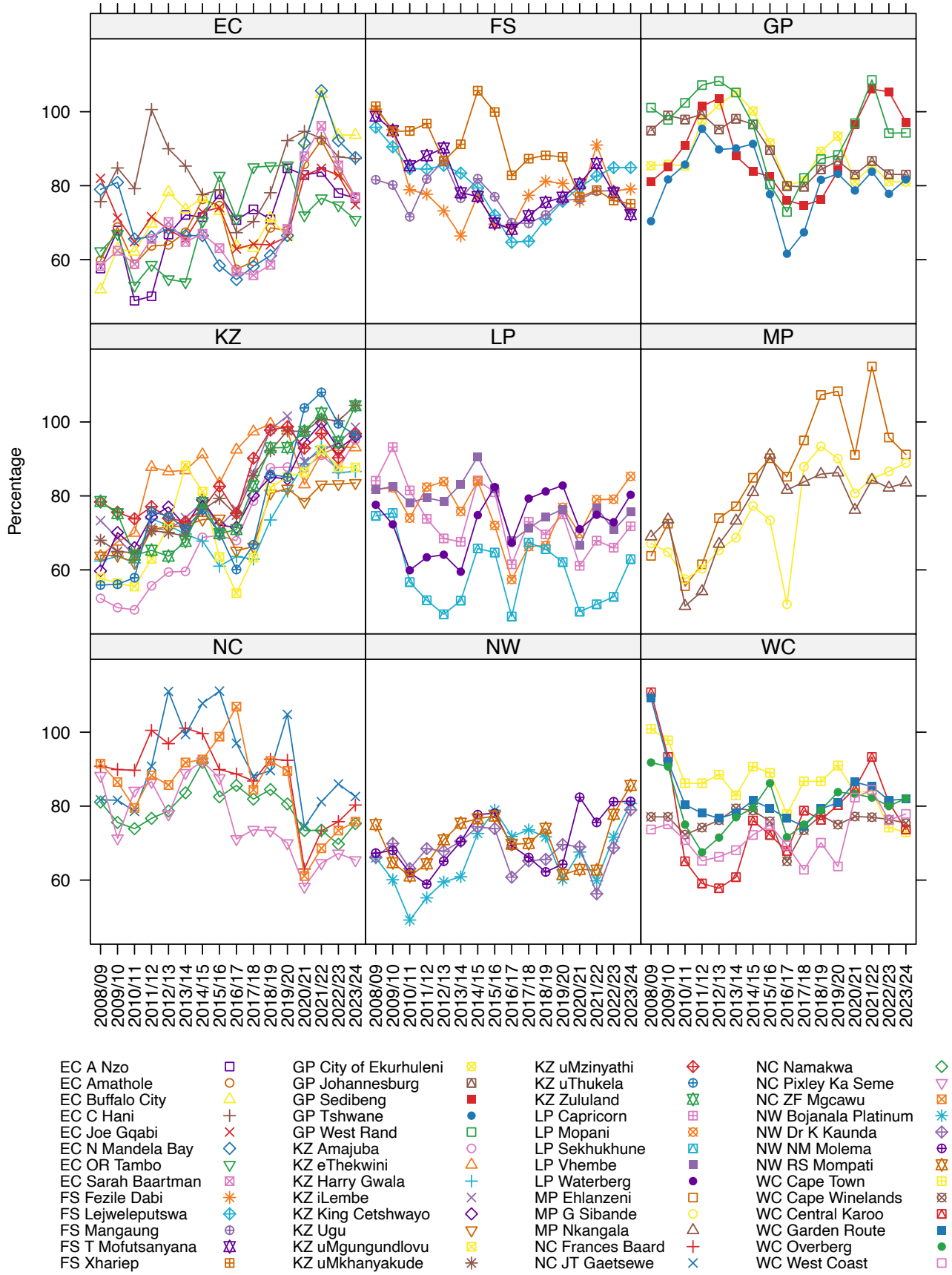


Figure 7 Annual trends: immunisation under 1 year coverage by district, 2008/09–2023/24

Source: DHIS

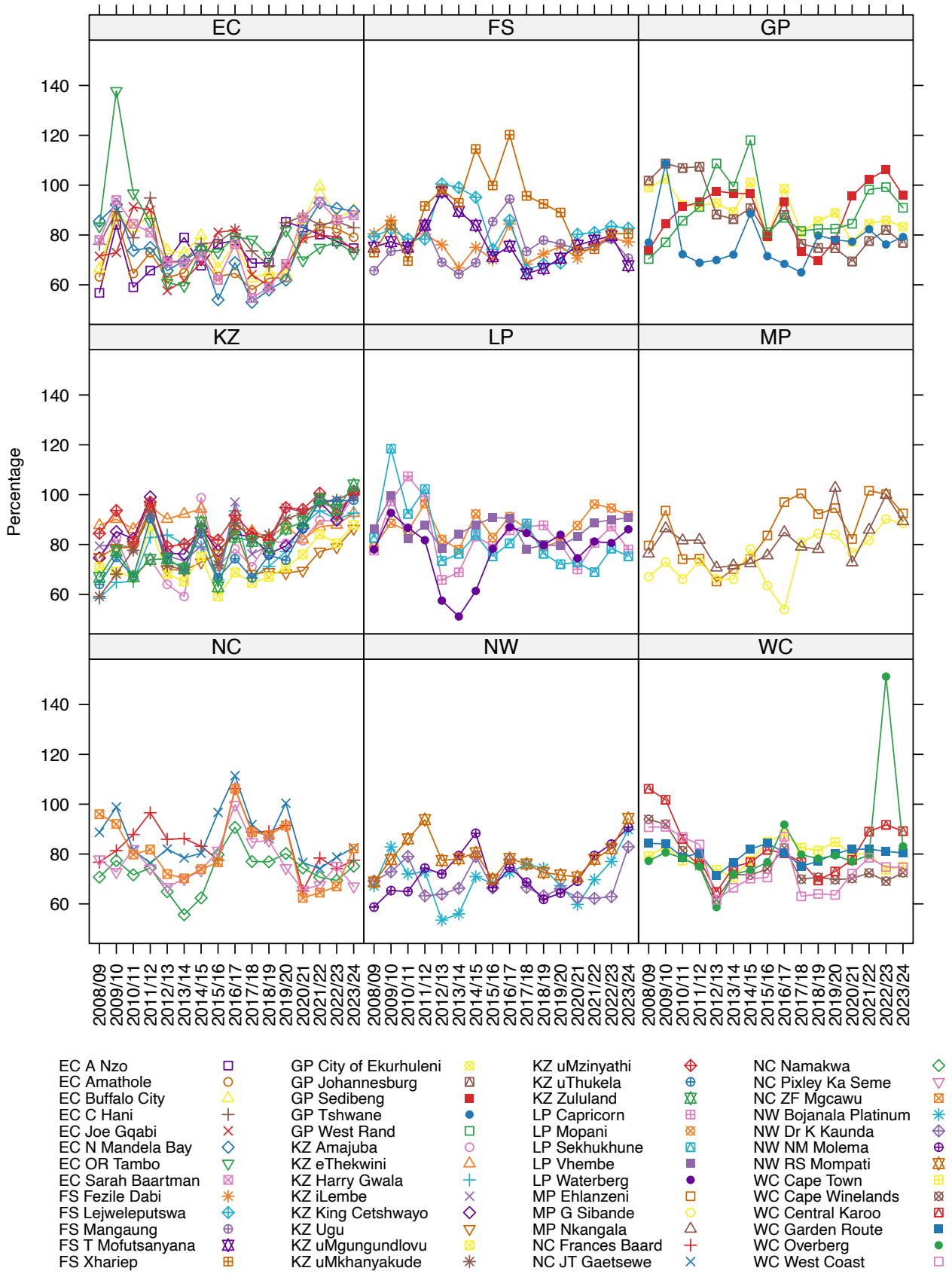


Figure 8 Annual trends: measles 2nd dose coverage by district, 2008/09–2023/24

Source: DHIS

Recommendations

- Collection and validation of the immunisation data is required and systems using registries should be implemented for robust data.
- All birth notifications at Home Affairs should be shared at the time of the birth with health facilities to enable tracking of immunisation data per birth cohort.
- Estimates of 'Zero dose' children who may not have had their first dose of DTP (DTaP in the hexavalent vaccine) may add some value in future reports.
- Continue surveillance and monitoring of movements of peoples into South Africa to assess risk of transmission.
- Surveillance and collation of immunisation data for the newly introduced measles and rubella vaccine will be paramount to assess implementation and coverage.
- There is need for effective communication on vaccine uptake and acceptance and to develop this on social media platforms to remind mothers and caregivers to fully vaccinate their children.
- All child admissions at PHC facilities or hospitals should have vaccination history recorded.
- Reintroduce vaccine card submission as a requirement for school entrance.
- Increase clinical awareness among all sectors of care in the country.
- Maintain effective vaccine supply chains so as not to have stock-outs that turn mothers and caregivers away from facilities.

1.4 Couple year protection rate

Kim Jonas

Key findings

- The national couple year protection rate (CYPR) fluctuated annually over the past five years and increased from 45.0% in 2022/23 to 55.4% in 2023/24. Despite the increase, the 2023/24 CYPR falls short by 19.6% of the expected national target of 75%. The overall contraceptive years equivalent for 2023/24 increased by 35.3% compared to 2022/23.
- The number of condoms distributed nationally has increased overall, with female condom distribution increasing by 35.3% in 2023/24, while male condom distribution substantially increased by 49.1% from the previous year (2022/23).
- All provinces had a steady increase in the CYPR from the previous year, with Free State (FS) province remaining the only province that currently meets the 75% CYPR target at 87.5%, a 3.6% increase from the previous year. Free State is also the only province where all five districts had a CYPR above 80%.
- Two provinces (Western Cape (WC) and Gauteng (GP)) had CYPRs below the national average (55.4%).
- Overall, the majority of districts observed an increase in their CYPR in 2023/24. Nine districts (distributed across provinces) made substantial increases of between 20 and 30 percentage points, with the highest percentage point increase seen in the Northern Cape (NC) at 34.3% in 2023/24.
- Forty-two local municipalities/sub-districts (LM/SDs) reported a CYPR of less than 30% in 2023/24.
- Four of the 10 lowest-performing LM/SDs are located in Mpumalanga (MP) – Govan Mbeki, Thembisile Hani, Steve Tshwete, and Dipaleseng.

Introduction

This section reports on the indicators related to contraception. Couple year protection rate (CYPR) and contraceptive prevalence rate (CPR) are the two main indicators used in South Africa to measure progress towards availability and utilisation of contraceptives over a 12-month period.[1] CPR is described as the percentage of in-union or sexually active women or all women aged 15–49 years who are currently using a modern method of contraception.[2] The numerator is the number of women of reproductive age (15–49 years) currently using a modern contraceptive, while the denominator is the total number of all women of reproductive age in-union or sexually active who should be accessing and using a modern contraceptive. CYPR is defined as the estimated protection provided by family planning (FP) methods during a one-year period, based on the volume of all contraceptives dispensed to clients during that period.[3]

The CYPR remains a vital metric in family planning and reproductive health, measuring the number of years of contraceptive protection provided to couples through the distribution of contraceptives. However, it has the potential to overestimate the proportion of couples protected because it does not differentiate between the use of a single contraceptive method and a combination of two methods, for example, using both a condom and contraceptive pill; nor does it account for whether the contraceptive method is actually used.[2] It is a proxy indicator for CPR and has been the indicator routinely used in the District Health Information System (DHIS) in South Africa and forms part of the National Department of Health's (NDoH) 2023 National Indicator Data Set (NIDS).[4]

1 United Nations Department of Economic and Social Affairs, Population Division. Family Planning and the 2030 Agenda for Sustainable Development: Data Booklet. (ST/ESA/ SER.A/429);2019.
2 United Nations Population Fund. UNFPA Strategy for Family Planning, 2022 – 2030. New York. UNFPA; 2022.
3 National Department of Health, Statistics South Africa, South African Medical Research Council, ICF. South Africa Demographic and Health Survey 2016. Pretoria: NDoH, Stats SA, SAMRC, and ICF; 2019.
4 National Department of Health. National Indicator Data Set: 2023. Pretoria: NDoH; 2023.

National overview

South Africa had an overall national CYPR of 55.4% in 2023/24, an increase of 10.4 percentage points from 2022/23 (Figure 1). The rate fluctuated over the past five years, with the overall national CYPR being 54.5% in 2019/20, deceasing to 49.8% in 2020/21, then increasing to 50.3% in 2021/22, and again decreasing by 5.1 percentage points to 45.0% in 2022/23, then increasing in 2023/24 to 55.4%. The current increase is positive; however, it is still far from the annual target of 75% for the year and far from the 2016/17 level which was the highest national average ever reached at 69.9%. Thus, the 2023/24 CYPR falls short by 19.6% of the expected target but is similar to the one reported by the Demographic and Health Survey (DHS) of 2016 at 55.0% among women in-union and 60.0% among sexually active women.[3] Thus, not much progress has been made towards improving contraception availability and utilisation in the country.

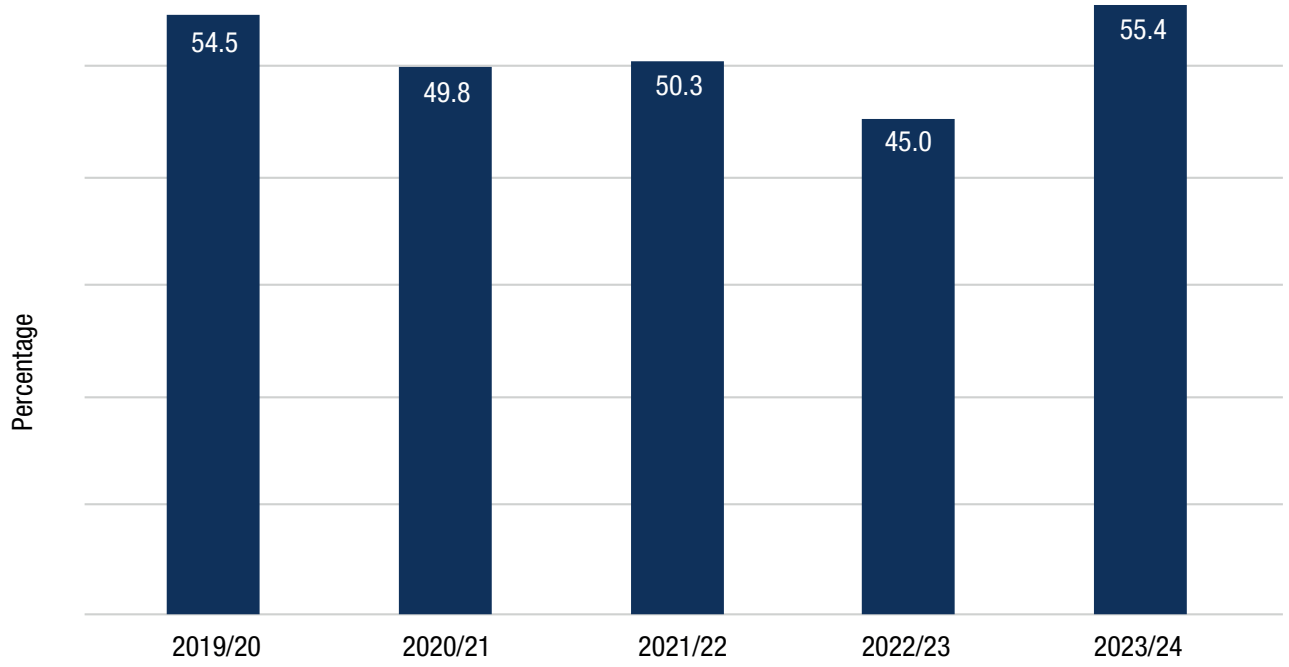


Figure 1 National couple year protection rate, 2019/20 – 2023/24

Source: DHIS

Table 1 shows the number of contraceptive years equivalent and contraceptive data elements for the last three financial years, namely: 2021/22, 2022/23 and 2023/24. The overall contraceptive years equivalent for 2023/24 increased by 25.2% compared to 2022/23.

The number of female condoms distributed increased by 35.3% between 2022/23 and 2023/24 (Table 1). Encouragingly, male condom distribution substantially increased by 49.1% from the previous year. The increased distribution of both male and female condoms is positive, given the dual protection provided by these barrier methods.

In terms of the two long-acting reversible contraceptives (LARCs) which are highly effective with high continuation rates, the number of intra-uterine contraceptive devices (IUCDs) continued to increase by 10.9 % and the sub-dermal implant increased by 12.2% in 2023/24 compared to the previous year. Of the two injectable methods, provision of depot medroxyprogesterone acetate (known as Depo or DMPA) increased by 5.3%, while provision of Nur-Isterate (NET-EN) – the two-monthly injection – decreased by 6.5% in 2023/24 compared to 2022/23. The uptake of NET-EN has consistently declined over the last two years, from 3 911 874 in 2021/22 to 3 067 619 in 2023/24. The decline in uptake of NET-EN can be attributed to the stock-outs which remain a big challenge in the country, particularly for NET-EN.[5,6]

5 Stop Stockouts Project. Stop Stock Outs 4th National Survey Report (2017): The Fragile System. Johannesburg: Stop Stockouts Project; 2017. URL: https://section27.org.za/downloads/Stop%20Stockouts%20V4.pdf

6 Rucell, J. Contraceptive Supply Chain: Stockouts and their causes. April 2022 – June 2023. Johannesburg: Stop Stockouts Project; 2023. URL: https://www.tac.org.za/wp-content/uploads/2024/08/Stop-Stockouts-Final-2024-comp.pdf

The oral contraceptive pill gained a little ground from the previous year and increased by 2.3%. Sterilisation, both female and male, has always played a small part in contraceptive choice among South African men and women, and both these methods experienced a reduction in uptake from the previous year. Female sterilisations decreased by 1.5% in 2023/24, and male sterilisation uptake reduced from 1 216 in the previous year to 1 048 in this year (-13.8%).

Table 1 Total contraceptive years equivalent and contraception data elements, 2021/22–2023/24

	2021/22 (number)	Contraceptives years* equivalent	2022/23 (number)	Contraceptives years* equivalent	2023/24 (number)	Contraceptives years* equivalent	% Change (2022/23-2023/24)
Contraceptive years* equivalent	6 513 038	8 213 497	6 288 406	7 461 028	7 509 331	9 339 106	25.2
Female condoms distributed	17 487 705	145 731	15 512 957	129 275	20 981 405	174 845	35.3
Male condoms distributed	545 372 354	4 544 770	402 808 623	3 356 739	600 716 263	5 005 969	49.1
Depot medroxyprogesterone acetate injection	4 400 217	1 100 054	5 602 230	1 400 558	5 897 365	1 474 341	5.3
Norethisterone enanthate injection	3 911 874	651 979	3 279 852	546 642	3 067 619	511 270	-6.5
Oral pill cycle	3 802 555	253 504	3 330 238	222 016	3 406 204	227 080	2.3
Female sterilisation	50 748	507 480	53 849	538 490	53 045	530 450	-1.5
Male sterilisation	1 002	10 020	1 216	12 160	1 048	10 480	-13.8
IUCD	52 358	235 611	53 999	242 996	59 898	269 541	10.9
Sub-dermal contraceptive implant	305 739	764 348	404 861	1 012 152	454 052	1 135 130	12.2

*Calculated based on all methods distributed and a conversion factor which annualises their contraceptive protection.

Source: DHIS

Provincial overview

Figure 2 shows the CYPR per province for 2023/24. All provinces had a steady increase from the previous year. However, FS province remains the only province that currently meets the 75% CYPR target at 87.5%, with a 3.6% increase from the previous year. Three other provinces – North West (NW), KwaZulu-Natal (KZ), and Limpopo (LP) – had a CYPR above 60% (64.7%, 64.0%, and 60.3%, respectively). All other provinces had CYPRs below 60%, while two provinces (WC and GP) had CYPRs below the national average (55.4%).

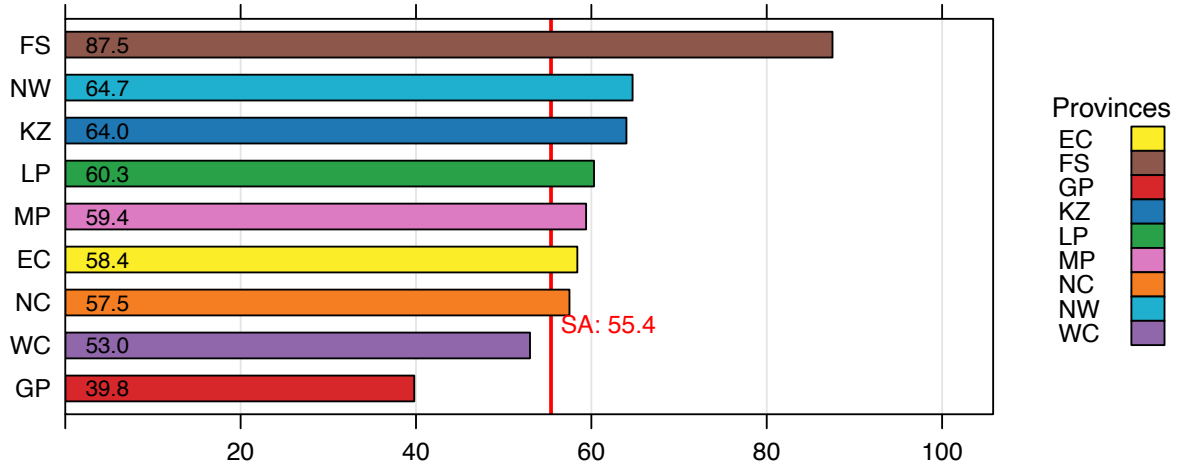


Figure 2 Couple year protection rate by province, 2023/24

Source: DHIS

Table 2 compares the CYPR among provinces between 2021/22 and 2023/24. All provinces showed an increase from the previous year, with NC reflecting the highest increase (19.2 percentage points) followed by EC (17.0 percentage points), NW (16.4 percentage points), and MP (16.0 percentage points).

Table 2 Couple year protection rate by province, 2021/22 – 2023/24 (%)

Province	2021/22	2022/23	2023/24	Percentage point difference between 2022/23 and 2023/24
Eastern Cape	49.0	41.4	58.4	17.0
Free State	84.7	83.9	87.5	3.6
Gauteng	37.8	28.6	39.8	11.2
KwaZulu-Natal	60.3	58.4	64.0	5.6
Limpopo	51.9	46.5	60.3	13.8
Mpumalanga	39.2	43.4	59.4	16.0
Northern Cape	46.8	38.3	57.5	19.2
North West	52.3	48.3	64.7	16.4
Western Cape	56.9	50.2	53.0	2.8
South Africa	50.3	45.0	55.4	10.4

Source: DHIS

Table 3 shows the number of contraceptive methods issued by province, comparing 2021/22 through to 2023/24.

Table 3 Number of contraceptive methods issued by province, 2021/22 – 2023/24

Province	Year	IUCD inserted	DMPA injection	NET-EN injection	Oral pill cycle	Sterilisation – female	Sterilisation – male	Subdermal implant inserted	Female condoms distributed	Male condoms distributed
Eastern Cape	2021/22	4 623	650 700	548 770	254 978	5 396	3	19 406	2 089 400	45 839 588
	2022/23	5 742	729 352	468 311	246 085	5 403	4	37 046	1 279 500	25 490 700
	2023/24	5 884	734 757	422 676	243 587	5 024	22	55 265	1 115 600	54 528 760
Free State	2021/22	1 146	338 412	139 392	131 361	3 738	63	9 407	1 421 800	55 352 800
	2022/23	1 197	350 660	122 794	126 536	3 877	46	14 960	2 182 220	52 469 700
	2023/24	1 966	345 114	110 938	125 407	4 087	49	20 462	1 111 040	55 754 600
Gauteng	2021/22	5 930	755 067	711 707	1 298 893	9 206	1	53 874	5 228 585	129 075 303
	2022/23	8 421	1 001 632	718 019	1 055 912	10 294	2	69 155	4 497 159	69 220 678
	2023/24	10 462	1 063 608	708 374	1 063 903	11 118	0	85 351	8 813 833	126 622 060
KwaZulu-Natal	2021/22	29 180	670 486	843 718	666 454	13 426	619	131 919	3 813 200	106 967 000
	2022/23	26 571	1 203 512	391 873	517 324	14 001	672	159 184	3 047 100	89 664 600
	2023/24	29 464	1 319 137	348 478	562 048	13 339	511	156 978	4 410 300	109 730 000
Limpopo	2021/22	3574	525 804	614 399	645 564	5 098	1	7 782	738 500	52 862 900
	2022/23	2 205	625 257	602 014	553 500	5 355	0	15 793	1 071 100	38 910 442
	2023/24	1 715	636 440	577 000	512 651	5 395	1	15 822	1 813 600	65 719 420
Mpumalanga	2021/22	1 388	153 291	484 008	212 508	3 415	4	18 557	1 997 762	31 364 066
	2022/23	1 390	342 651	367 895	181 637	3 677	7	19 669	1 367 918	35 627 000
	2023/24	1 340	424 705	344 916	220 423	3 263	4	18 707	1 214 936	60 522 573
Northern Cape	2021/22	136	121 287	62 352	49 161	1 362	2	6 444	113 700	9 518 000
	2022/23	306	144 620	47 703	48 574	1 448	0	8 398	101 513	5 194 000
	2023/24	364	142 198	47 538	46 819	1 468	10	9 005	185 168	12 985 880
North West	2021/22	1 438	326 680	238 599	145 933	2 712	0	10 575	931 858	42 361 097
	2022/23	3 116	322 176	275 366	202 064	3 160	0	28 635	708 047	30 810 803
	2023/24	3 818	376 082	215 926	228 573	3 037	6	40 960	1 218 328	48 649 570
Western Cape	2021/22	4 943	858 490	268 929	397 703	6 395	309	47 775	1 152 900	72 031 600
	2022/23	5 051	882 370	285 877	398 606	6 634	485	52 021	1 258 400	55 420 700
	2023/24	4 885	855 324	291 773	402 793	6 314	445	51 502	1 098 600	66 203 400

Source: DHIS

Provincial Trends in Contraceptive Uptake and Distribution (2021/22 – 2023/24)

- **Intrauterine contraceptive device:** Most provinces showed an increase in IUCD insertions, except for three provinces (WP, MP and LP). KwaZulu-Natal showed a decrease in 2022/23 at 26 571 which then improved in 2023/24 to 29 464 and the province continues to lead as the province with the largest number of IUCDs inserted for both years and also the largest increase in insertions in 2023/24 (29 464). This was followed by GP at 10 462 and the EC at 5 884.
- **Depot medroxyprogesterone acetate (DMPA) injection:** DMPA uptake increased in most provinces in the same period, except for FS, NC, and WC. The NW province had a slight decline between 2021/22 and 2022/23 (from 326 680 to 322 176) but increased substantially in the current year (376 082). The largest decrease was seen in the WC which fell by 27 046 injections, below the levels seen in 2021/22. Mpumalanga had the biggest uptake with an increase of 82 054 injections.
- **Norethisterone enanthate injection (NET-EN):** Consistent with the previous years' trends, almost all provinces showed a decrease in the number of NET-EN issued, with the exception of WC which had an increase in uptake from 285 877 in the previous year to 291 773 in the current year.
- **Oral pill cycle:** Five provinces saw an increase in oral pill cycle numbers, with the largest increase in KZ (44 724 more oral pill cycles issued), followed by MP (38 786 more). The least increases were seen in WC (just over 4 000 more cycles issued) and GP (just under 8 000 more) compared to the previous year. Uptake in the other four provinces decreased slightly, with the largest decrease seen in LP falling short with 40 849 less cycles issued from the previous year.
- **Female sterilisation:** In 2023/24, most provinces showed an overall decrease in female sterilisations with the largest decrease seen in KZ (662 fewer sterilisation uptake) compared to the previous year. Despite the largest decrease seen in KZ, the province continues to lead the uptake of sterilisation nationally, with 13 339 sterilisations, more than three times as many as found in most other provinces. Encouragingly, four other provinces saw an increase in sterilisation overall, with GP recording the largest increase of 824 more sterilisations in 2023/24.
- **Male sterilisation:** Male sterilisation remains low across provinces in 2023/24. Only four provinces – EC, FS, NC and NW – showed an increase in male sterilisation, with the largest increase seen in EC (18 more sterilisation). Although NW saw an increase, it is among the four provinces which recorded single digit increases, with less than 10 male sterilisations in 2023/24. Only two provinces reported more than 400 male sterilisations: KZ (which leads at 511; however, the number decreased from 672 in 2022/23), and WC (with 445 male sterilisations, 40 fewer than in 2022/23).
- **Sub-dermal implants inserted:** In 2023/24, most provinces showed an increase in implant insertions, except for three provinces–KZ, MP and WC. The largest increases were seen in EC with 18 219 more insertions (from 37 046 in 2022/23 to 55 265 in 2023/24), followed by GP with 16 196 more insertions, and NW with 12 325 more insertions than in 2022/23. KwaZulu-Natal continues to lead in implant insertions with 156 978, although the province experienced a decrease in 2023/24 insertions–2 206 fewer insertions than 2022/23. It is worth noting that NC is the only province with fewer than 10 000 insertions in 2023/24.
- **Condom distribution:** Five provinces had a substantial increase in female condom distribution. The remaining four provinces – EC, FS, MP and WC – recorded decreases in female condom distribution. Gauteng and KZ continue to lead the distribution of female condoms with over eight million distributed in GP in 2023/24, which is almost double the 2022/23 distributions of 4 497 159. Notably, NC is the only province with under a million distributions of female condoms at 185 165 in 2023/24. Male condom distribution increased nationally in 2023/24 by 49.1% from the previous year. All provinces showed a substantial increase with NC having the largest increase of more than double the 2022/23 distributions at 12 985 880 (a 150.0% increase from 2022/23). Encouragingly, GP saw an increase in condom distribution with 126 662 060 distributions recorded in 2023/24, a significant 83% increase from 2022/23, and continues to lead the distributions.

District overview

Figure 3 and Map 1 show the CYPR by district. Xhariep (FS) had the highest rate at 96.2% and Johannesburg (GP) had the lowest rate at 32.7%. Although Xhariep (FS) had the highest rate, this is a decrease from the 2022/23 rate of 103.5%. The decrease could be due to improvements in data quality and accuracy as it is suspected that the proportion of the female population aged 15–49 years could have been underestimated which resulted in a rate above 100%, or poor data quality resulted in inflated rates being reported. Free State is the only province with all five districts having a CYPR above 80%. Some provinces showed wide differences

in their district CYPRs; for instance, GP had an overall CYPR of 39.8% yet one of its districts, West Rand, performed well with a CYPR of 87.4% (amongst the top five-performing districts in the country). Unfortunately, three of the five GP districts and one of the eight EC districts had CYPRs less than 50% in 2023/24. Several other provinces showed similar patterns with some districts performing well above the national average but with one or two districts having a CYPR below the national average, bringing down the overall provincial rate. Three of the eight districts in EC, three of the five in GP, and three of the 11 districts in KZ had CYPRs below the national rate of 55.4%. However, one of the districts in KZ (Zululand) had the second highest CYPR nationally at 94.4%, representing a 11.6% increase from 2022/23.

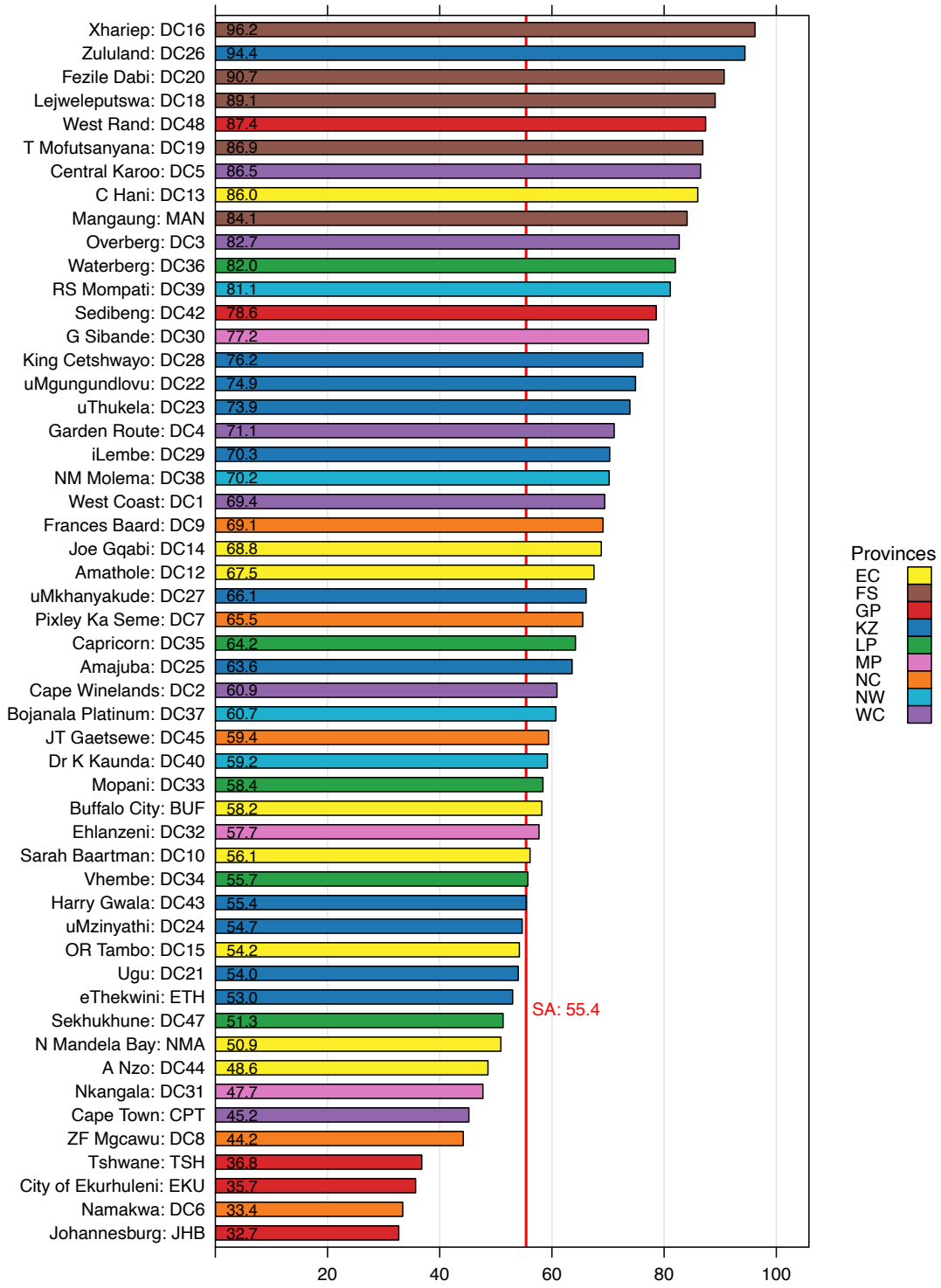
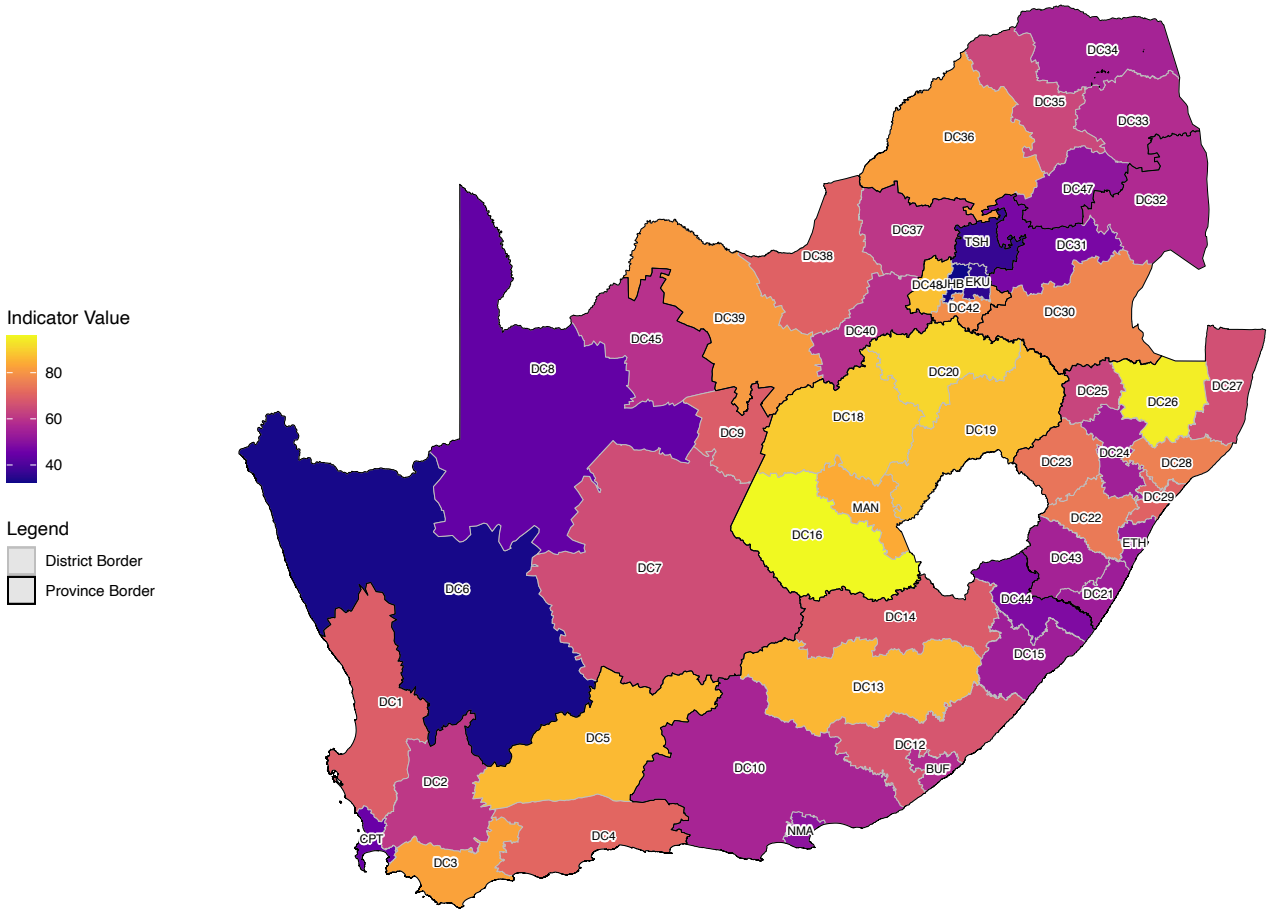


Figure 3 Couple year protection rate by district 2023/24

Source: DHIS



MAP 1 Couple year protection rate by district, 2023/24

Source: DHIS

Table 4 shows the CYPR by district between 2021/22 and 2023/24. Overall, 47 of the 52 national districts observed an increase in their CYPR in 2023/24. The five districts with a decrease in their CYPRs comprise one in FS (Xhariep) (-7.3 percentage points) and four in KZ (Harry Gwala, iLembe, uMkhanyakude, and uMzinyathi) with uMzinyathi district having the biggest drop (8.5%) in 2023/24.

Encouragingly, nine districts (distributed across provinces) made substantial increases in the rate of between 20 and 30 percentage points between 2022/23 and 2023/24 with the highest percentage point increase seen in JT Gaetsewe (NC) at 34.3 percentage points.

Table 4 Couple year protection rate by district 2020/21 – 2023/24 (%)

Province	District	2021/22	2022/23	2023/24	Percentage point difference between 2022/23 and 2023/24
Eastern Cape	Alfred Nzo	36.9	32.8	48.6	15.8
	Amathole	59.3	51.2	67.5	16.3
	Buffalo City	50.7	40.9	58.2	17.3
	Chris Hani	85.4	62.8	86.0	23.2
	Joe Gqabi	47.6	49.5	68.8	19.3
	Nelson Mandela Bay	52.9	49.0	50.9	1.9
	OR Tambo	33.4	28.7	54.2	25.5
	Sarah Baartman	48.6	34.4	56.1	21.7

Free State	Fezile Dabi	89.0	82.2	90.7	8.5
	Lejweleputswa	78.2	81.0	89.1	8.1
	Mangaung	78.7	80.6	84.1	3.5
	T Mofutshanyana	90.1	88.0	86.9	1.1
	Xhariep	109.5	103.5	96.2	-7.3
Gauteng	Ekurhuleni	36.3	25.6	35.7	10.1
	Johannesburg	27.6	22.5	32.7	10.2
	Sedibeng	84.8	65.3	78.6	13.3
	Tshwane	37.0	27.6	36.8	9.2
	West Rand	76.9	56.9	87.4	30.5
KwaZulu-Natal	Amajuba	53.7	51.8	63.6	11.8
	eThekwini	51.4	48.5	53.0	4.5
	Harry Gwala	65.4	61.0	55.4	-5.6
	iLembe	80.9	71.7	70.3	-1.4
	King Cetshwayo	59.2	60.1	76.2	16.1
	Ugu	55.6	53.9	54.0	0.1
	uMgungundlovu	63.5	53.6	74.9	21.3
	uMkhanyakude	73.7	70.6	66.1	-4.5
	uMzinyathi	60.6	63.2	54.7	-8.5
	uThukela	66.1	73.3	73.9	0.6
	Zululand	73.2	82.8	94.4	11.6
Limpopo	Capricorn	56.2	46.9	64.2	17.3
	Mopani	50.9	50.4	58.4	8.0
	Sekhukhune	41.9	37.6	51.3	13.7
	Vhembe	46.1	43.5	55.7	12.2
	Waterberg	75.2	60.7	82.0	21.3
Mpumalanga	Ehlanzeni	44.5	42.5	57.7	15.2
	Gert Sibande	41.9	52.8	77.2	24.4
	Nkangala	31.2	37.2	47.7	10.5
Northern Cape	Frances Baard	49.2	43.7	69.1	25.4
	JT Gaetsewe	40.2	25.1	59.4	34.3
	Namakwa	39.8	33.3	33.4	0.1
	Pixley Ka Seme	50.7	46.6	65.5	18.9
	ZF Mgcawu	49.9	40.5	44.2	3.7
North West	Bojanala Platinum	44.5	42.2	60.7	18.5
	Dr K Kaunda	47.4	46.0	59.2	13.2
	Dr RS Mompati	48.6	63.5	81.1	17.6
	NM Molema	74.7	55.7	70.2	14.5
Western Cape	Cape Town	49.8	43.1	45.2	2.1
	Cape Winelands	59.9	56.5	60.9	4.4
	Central Karoo	66.6	81.5	86.5	5.0
	Garden Route	82.3	69.3	71.1	1.8
	Overberg	94.8	83.2	82.7	0.5
	West Coast	65.8	59.0	69.4	10.4

Source: DHIS

Figure 4 shows the annual trends in CYPR from 2008/09 to 2023/24 between districts across all provinces. Most districts within the provinces showed consistent patterns across the years with the exception of a few districts in EC, FS, GP, KZ, and WC. Sedibeng (GP) had a sharp increase in 2016/17 which was followed by a corresponding sharp decline in the following year (2017/18). Similarly, uMgungundlovu (KZ) had a sharp increase in 2014/15 followed by a decline in the following year (2015/16); while uMzinyathi (KZ) had a sharp increase in 2016/17 following by decline in 2017/18.

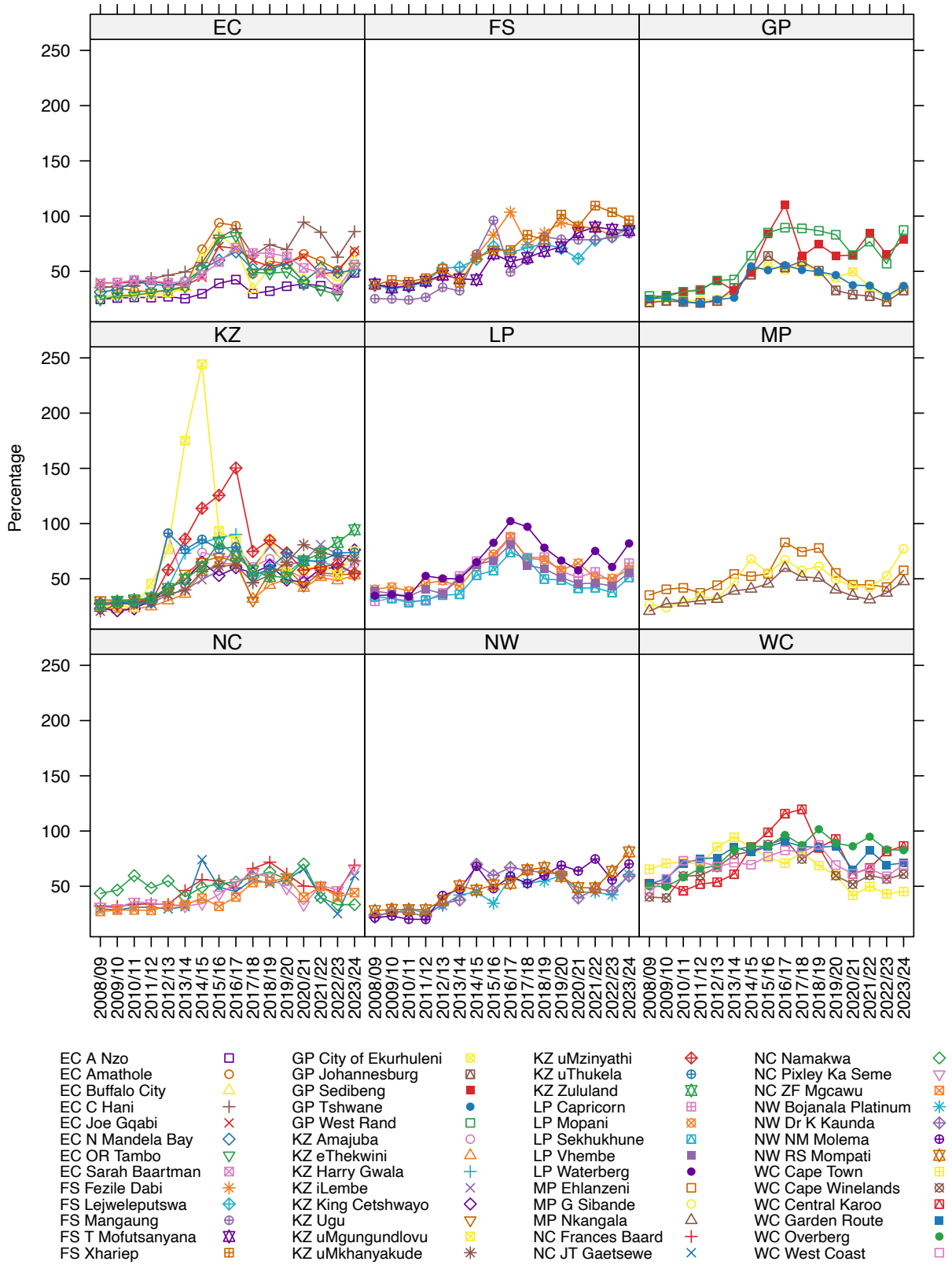


Figure 4 Annual trends: couple year protection rate, 2008/2009 – 2023/24

Source: DHIS

Local municipality/sub-district overview

Forty-two local municipalities/sub-districts (LM/SDs) reported a CYPR of less than 30% in 2023/24. This is an improvement from 2022/23 when 62 LM/SDs reported a CYPR below 30%. Of the 42 LM/SDs with a CYPR below 30%, 12 were located in MP, nine in KZ, and eight in NC. Two provinces (FS and LP) had no LM/SDs with a rate below 30%. Two LMs (one each in MP and NC) had a CYPR below 15%. Thirty-one LM/SDs had a CYPR above 100% with the highest rates found in Msukaligwa in Gert Sibande (MP), Naledi in Mangaung (FS), and Ulundi in Zululand (KZ). These figures are almost double the previous year's (2022/23) which reported 18 LM/SDs with figures over 100%. These rates above 100% require further investigation to ensure accuracy and quality of reported data.

Table 5 shows the 10 LM/SDs with the lowest CYPR (below 20%) in 2023/24, with a range between 12.5% and 18.1%. Three districts from NC (Zwelentlanga Fatman Mgcawu, Namakwa, and Pixley Ka Seme) and two districts each from MP (Gert Sibande and Nkangala) and GP (Ekurhuleni and Tshwane) have LM/SDs ranked among the 10 lowest-performing LM/SDs. Four of the 10 lowest-performing LM/SDs are in MP (Govan Mbeki, Thembisile Hani, Steve Tshwete and Dipaleseng).

Table 5 Ten local municipalities with the lowest couple year protection rate, 2023/24

Province	District	Local municipality/sub-district	Couple year protection rate
Mpumalanga	Gert Sibande	Govan Mbeki	12.5
Northern Cape	Zwelentlanga Fatman Mgcawu	Kgatelopele	12.8
Mpumalanga	Nkangala	Thembisile Hani	15.7
Northern Cape	Namakwa	Richtersveld	15.7
KwaZulu-Natal	uMgungundlovu	uMngeni	15.8
Gauteng	Ekurhuleni	Ekurhuleni South 2	16.8
Gauteng	Tshwane	Tshwane 4	17.3
Mpumalanga	Nkangala	Steve Tshwete	17.6
Northern Cape	Pixley Ka Seme	Siyancuma	18.0
Mpumalanga	Gert Sibande	Dipaleseng	18.1

Source: DHIS

Recommendations

- The positive increase in CYPR in 2023/24 is very encouraging. However, the fact that it is almost 20% lower than the national target is a cause for concern. Accelerated efforts towards demand-creation strategies are needed to ensure awareness of contraceptive options and to promote the uptake of LARCs and other under-utilised methods, like the female condom, which is an important barrier method that provides dual protection.
- There is a need to review provinces and districts that reported large drops in the CYPR in 2023/24 in LM/SDs to identify facilities that are experiencing low levels of CYPR, to investigate the possible causes thereof, and to initiate quality improvement processes to address challenges and gaps.
- Data age groups need to be disaggregated to draw special attention to adolescent girls and young women (AGYW) who often experience significant barriers to access and use of contraceptives. Addressing AGYW's barriers to contraception access and promoting awareness and demand-creation for contraceptive use among AGYW are urgently needed.
- There is a need to leverage digital health technologies as they have a potential to transform contraception service delivery enhancing access and convenience. Mobile health (mHealth) interventions such as SMS reminders and mobile apps improve contraceptive adherence and continuation rates and are needed to improve CYPR in the country.

- Health systems need to be strengthened to ensure access to quality contraceptive services and to achieve high CYPR. A well-functioning health system, characterised by adequate funding, trained personnel and available infrastructure and resources enables effective contraceptive service delivery. A health system with strong supply chains and logistics can maintain consistent contraceptive stock levels reducing stock-outs and increasing CYPR.
- Stronger health information systems are also needed as a number of districts and LM/SDs recorded CYPRs above 100%. These will facilitate better quality data management for monitoring and evaluation of contraceptive programmes and will support evidence-based decision-making processes for contraception programming and scale-up.
- A focus on reducing barriers to both the supply and demand side of service delivery is needed. Supply-side factors such as stock-outs and counselling to demystify and counteract myths and misinformation need to be addressed urgently.
- CYPR remains a critical indicator of family planning programme effectiveness. Family planning programmes should prioritise method mix diversity and encourage user-compliance.
- Policymakers should address socioeconomic determinants of contraceptive use. Education is a crucial determinant with higher levels of education associated with increased contraceptive prevalence and CYPR. Research has also shown that women's empowerment measured by decision-making autonomy and economic independence positively correlates with contraceptive use.[10] Further, societal norms and cultural beliefs shape contraceptive attitudes and behaviours highlighting the need for context-specific interventions to address the gaps in contraceptive uptake.
- Additionally, there is a need to integrate contraceptive services along with HIV prevention service delivery such as pre-exposure prophylaxis (PrEP) to improve uptake of contraception and HIV prevention services.
- User compliance plays a critical role in determining the effectiveness of contraceptive methods and CYPR. Adherence to contraceptive regimens significantly impacts CYPR with inconsistent use leading to reduced effectiveness and thus decreased CYPR.[9] Interventions targeting user compliance, such as counselling and reminders, can increase contraceptive adherence and continuation and improve CYPR.
- Researchers should continue exploring innovative strategies to improve CYPR. By addressing these factors and implications, family planning programmes can optimise CYPR, improve reproductive health outcomes and achieve Sustainable Development Goals (SDGs) particularly SDG goal 3.7 which calls on countries to ensure universal access to sexual and reproductive health services.
- Additionally, the inclusion of emergency contraception in the list of measured contraceptive methods used for CYPR will also enhance method mix diversity and improve CYPR.[8] Therefore, family planning programmes should prioritise expanding the method mix to cater for diverse user needs.

02 Infectious disease control

2.1 Tuberculosis

Waasila Jassat, Hlengani T. Mathema, Sicelo Dlamini, Sajid Sheriff, Norbert Ndjeka

Key findings

- The national TB child under 5 years start on treatment rate in 2023/24 was 73.8%, ranging from 61.4% in Northern Cape (NC) to 98.2% in Mpumalanga (MP).
- The national TB client 5 years and older start on treatment rate in 2023/24 was 90.3%, ranging from 77.2% in NC to 95.2% in MP.
- The national DS-TB treatment success rate in 2022 was 75.8%, ranging from 68.9% in Limpopo (LP) to 84.2% in North West (NW). Only NW reached the target of 80%. Eleven districts achieved the target of 80%.
- The national MDR-TB treatment success rate was 62.4% in 2022, ranging from 52.5% in Western Cape (WC) to 68.5% in KwaZulu-Natal (KZ).
- No province reached the target of 73%. Seven districts reached the target of 73%.
- The national pre-XDR and XDR-TB treatment success rate was 51.0% in 2022, ranging from 42.8% in WC to 65.0% in NW.

Introduction

Despite tuberculosis (TB) being a preventable and typically curable infectious disease, it remains a leading cause of death worldwide from a single infectious agent. South Africa is one of thirty high TB burden countries which accounted for 87% of the world's TB cases in 2023. The incidence was estimated at 270 000 (427 per 100 000 population) in 2023, with more than half of those cases occurring in HIV-infected people (145 000 cases).[1] The TB mortality rate among HIV-negative individuals was 39 per 100 000, and 49 per 100 000 among people living with HIV (PLHIV). National TB Programme efforts over the past decade have resulted in important gains in TB control. Between 2015 and 2023, overall incidence reduced by 57% and overall mortality by 16%. TB remains one of the leading causes of death in South Africa.[2]

The fifth South African National Strategic Plan (NSP) outlines the country's response plan and targets for HIV, TB, and sexually transmitted infections for 2023 – 2028.[3] The TB NSP sets out key activities to move toward a vision for 2028 that sees TB as a priority across all sectors.[4] The TB Recovery Plan 2024/2025 provides an opportunity to accelerate TB control efforts to help reach global commitments to end TB in South Africa.[5] Targeted universal testing for TB (TUTT) is the spearhead of the National TB Recovery Plan – to test all those considered at high-risk of contracting TB, regardless of symptomatology.

Political commitment to tackle TB has intensified, marked by the first UN high-level meeting on TB in 2018 and a second in 2023, which reinforced previous commitments and established new targets for 2023 – 2027.[6] South Africa remains committed to the Global TB targets contained in the World Health Organization (WHO) End TB Strategy,[7] which aims for an end to the TB epidemic by 2030, specifically:

- To achieve an 80% reduction in the TB incidence rate (new and relapse cases per 100 000 population per year) by 2030, compared with the 2015 – 2020 milestone;
- A 90% reduction in the annual number of TB deaths by 2030, compared with the 2015 – 2020 milestone, and
- To have no households affected by TB facing catastrophic costs by 2030.

1 World Health Organization. Global TB Report 2024. Geneva: WHO; 2024.
2 Statistics South Africa. Mortality and causes of death in South Africa, 2020: Findings from death notification. Pretoria: Stats SA; 2024.
3 National Department of Health. National Strategic Plan for HIV, TB, STIs, 2023 – 2028. Pretoria: NDoH; 2023.
4 National Department of Health. Vision 2028. TB Strategic Plan 2023 – 2028. Pretoria: NDoH; 2024.
5 National Department of Health. National TB Recovery Plan 3.0. April 2024 – March 2025. Pretoria: NDoH; 2024.
6 United Nations. Political declaration of the high-level meeting of the General Assembly on the fight against tuberculosis. New York: UN; 2023.
7 World Health Organization. The End TB Strategy. Geneva: WHO; 2015.

This chapter reports on the following TB indicators:

Linkage to care

- TB child under 5 years start on treatment rate
- TB client 5 years and older start on treatment rate

Treatment outcomes

- Drug-susceptible (DS-TB) treatment success rate
- Multidrug-resistant (MDR-TB) treatment success rate
- Pre-extensively-drug resistant TB (pre-XDR-TB) and extensively-drug resistant TB (XDR-TB) treatment success rate

Methodological note

The data source for DS-TB start on treatment rate is DHIS, and treatment success rate is the TIER.Net system and indicators as reported on DHIS. The data source for MDR-TB and pre-XDR-TB/XDR-TB is the EDRWeb system. There are no National TB Programme targets for start on treatment rate. The target for DS-TB treatment success rate for the 2022 cohort (80%) is contained in the TB Recovery Plan 2023/24. The target for MDR-TB treatment success rate for the 2022 cohort (73%) is contained in the TB Recovery Plan 2024/25.

There are several limitations in the TB data related to the data sources and data completeness and quality. The WC Department of Health does not use the national reporting systems and therefore the data reported may have some gaps relating to data merging processes. Issues with data cleaning and delayed reporting may affect outcomes reported. Persistent data quality challenges (use of old clinical stationery, data capturing gaps) may also affect the reliability of the TB data reported in this chapter.

TB child under 5 years start on treatment rate

Key findings

- The national TB child under 5 years start on treatment rate in 2023/24 was 73.8%, a 24.5% decline from 97.8% in 2022/23.
- Provincial performance ranged from 61.4% in NC to 98.2% in MP. Seven provinces reported a reduction in the rate between 2022 and 2023.
- District performance ranged from 30.0% in iLembe (KZ) to 131.4% in Gert Sibande (MP). Forty-four districts reported a reduction in the rate between 2022 and 2023.

Introduction

The TB child under 5 years start on treatment rate measures TB clients under 5 years started on treatment as a proportion of all symptomatic children under 5 years.

National and provincial overview

The national TB child under 5 years start on treatment rate was 73.8% in 2023/24, a 24.5% decline from 97.8% in 2022/23 (Figure 1 and Table 1). The rate among provinces ranged from 61.4% in NC to 98.2% in MP. All but one province, Free State (FS), reported declines in the treatment start rate between 2022 and 2023, with the largest decline reported by KZ (36.7%).

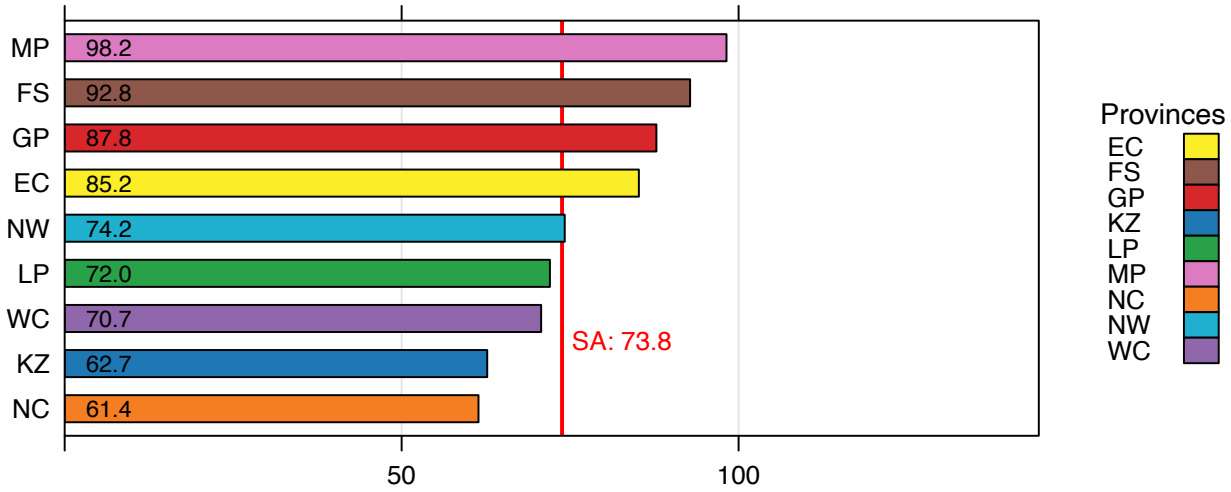


Figure 1 TB child under 5 years start on treatment rate by province, 2023/24

Source: DHIS

Table 1 TB child under 5 years start on treatment rate by province, 2021–2023 (%)

PROVINCE	2021/22	2022/23	2023/24	PERCENTAGE POINT DIFFERENCE BETWEEN 2022/23 AND 2023/24
Eastern Cape	79.6	98.1	85.2	-13.1
Free State	65.5	87.8	92.8	+5.7
Gauteng	98.7	97.8	87.8	-10.2
KwaZulu-Natal	101.8	99.0	62.7	-36.7
Limpopo	105.7	105.3	72.0	-31.6
Mpumalanga	87.6	98.2	98.2	0
Northern Cape	114.4	91.6	61.4	-33.0
North West	108.9	105.0	74.2	-29.3
Western Cape	96.5	96.8	70.7	-27.0
South Africa	94.8	97.8	73.8	-24.5

Source: DHIS

District overview

At a district level, the TB child under 5 years start on treatment rate varied from 30.0% in iLembe (KZ) to 131.4% in Gert Sibande (MP) (Figure 2 and Table 2). The rate increased in only six districts between 2022 and 2023. Mangaung (FS) had the highest increase in this period at 20.0%. The highest declines were in iLembe (KZ) at 69.0% and RS Mompati (NW) at 68.6% in the same period.

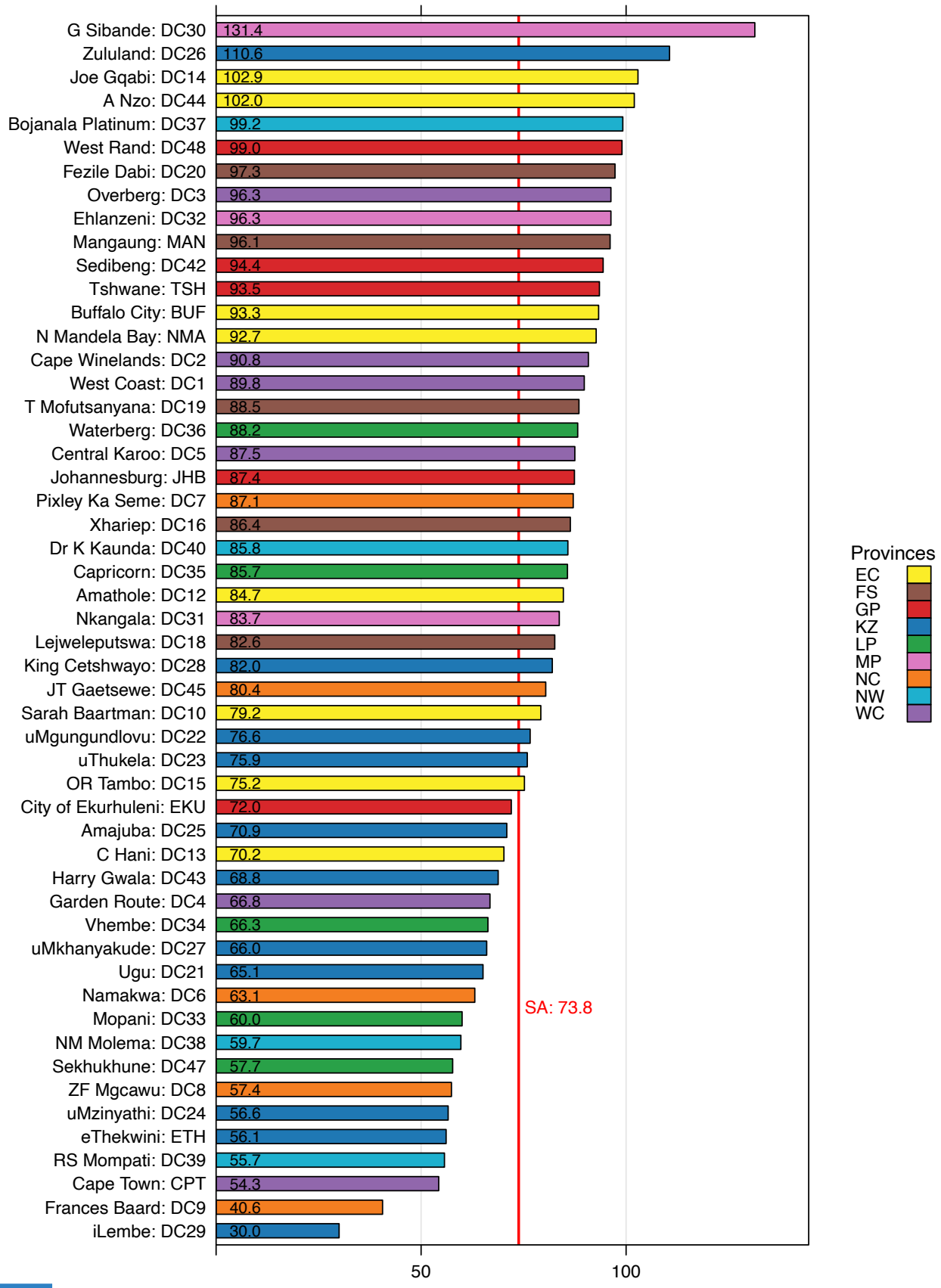
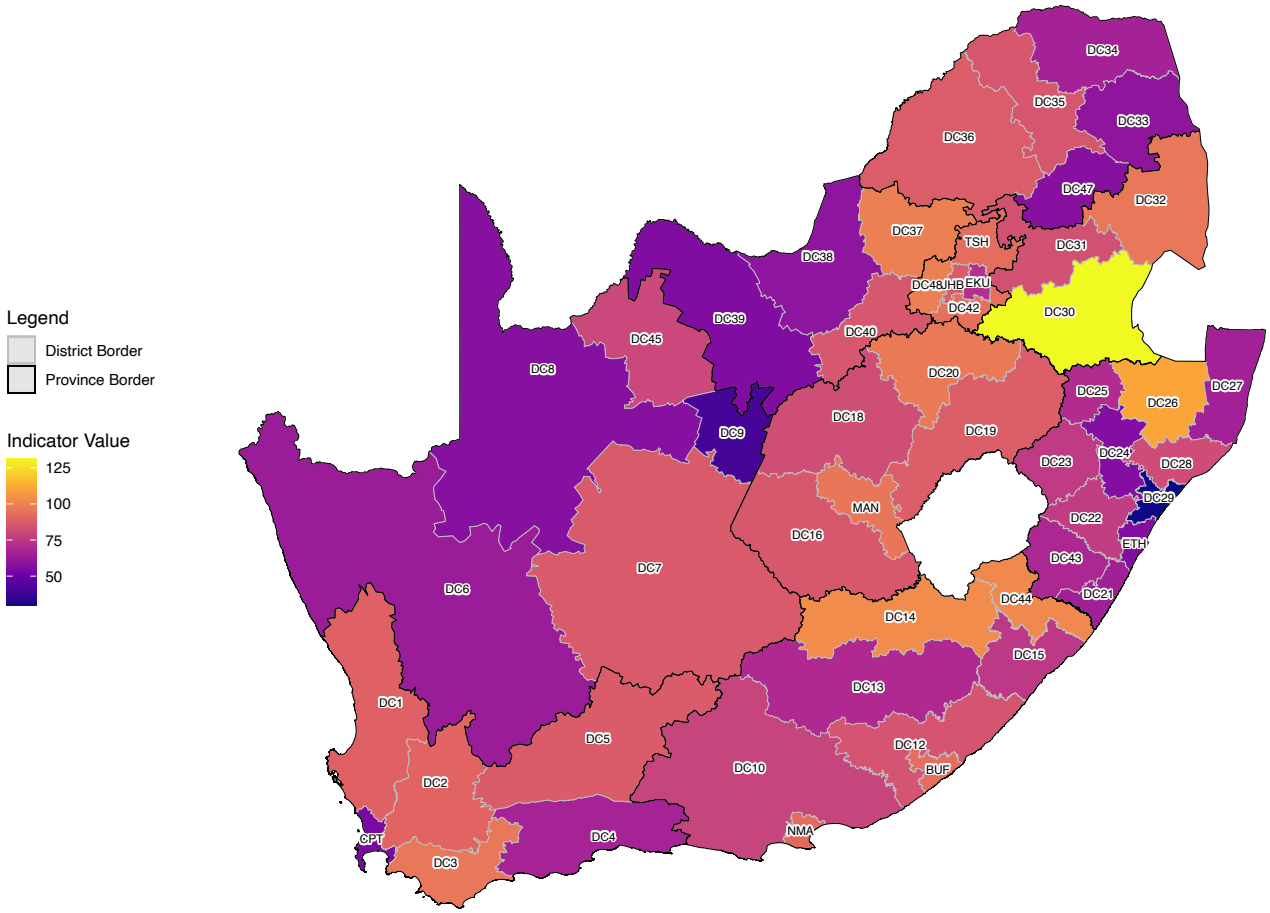


Figure 2 TB child under 5 years start on treatment rate by district, 2023/24

Source: DHIS



MAP 1 TB child under 5 years start on treatment rate by district, 2023/24

Source: DHIS

Table 2 TB child under 5 years start on treatment rate by district, 2021 – 2023 (%)

PROVINCE	DISTRICT	2021/22	2022/23	2023/24	PERCENTAGE POINT DIFFERENCE BETWEEN 2022/23 AND 2023/24
Eastern Cape	A Nzo	85.0	108.3	102.0	-5.8
	Amathole	103.3	102.4	84.7	-17.3
	Buffalo City	94.8	95.4	93.3	-2.2
	C Hani	119.7	77.2	70.2	-9.1
	Joe Gqabi	106.4	90.2	102.9	+14.1
	N Mandela Bay	101.2	105.2	92.7	-11.9
	OR Tambo	57.8	98.9	75.2	-24.0
	Sarah Baartman	81.1	98.7	79.2	-19.8
Free State	Fezile Dabi	96.3	94.2	97.3	+3.3
	Lejweleputswa	97.7	88.1	82.6	-6.2
	Mangaung	49.8	80.1	96.1	+20.0
	T Mofutsanyana	94.1	116.0	88.5	-23.7
	Xhariep	93.8	97.0	86.4	-10.9
Gauteng	City of Ekurhuleni	99.7	94.6	72.0	-23.9
	Johannesburg	101.3	99.8	87.4	-12.4
	Sedibeng	97.5	99.2	94.4	-4.8
	Tshwane	94.5	96.7	93.5	-3.3
	West Rand	91.2	99.1	99.0	-0.1

PROVINCE	DISTRICT	2021/22	2022/23	2023/24	PERCENTAGE POINT DIFFERENCE BETWEEN 2022/23 AND 2023/24
KwaZulu-Natal	Amajuba	97.6	94.5	70.9	-25.0
	eThekwini	110.1	100.0	56.1	-43.9
	Harry Gwala	101.9	98.8	68.8	-30.4
	iLembe	104.4	96.8	30.0	-69.0
	King Cetshwayo	96.0	97.1	82.0	-15.6
	Ugu	94.7	106.0	65.1	-38.6
	uMgungundlovu	100.9	106.1	76.6	-27.8
	uMkhanyakude	89.1	100.0	66.0	-34.0
	uMzinyathi	100.0	97.7	56.6	-42.1
	uThukela	79.5	83.7	75.9	-9.3
	Zululand	96.6	100.0	110.6	+10.6
Limpopo	Capricorn	99.0	103.2	85.7	-17.0
	Mopani	126.9	102.1	60.0	-41.2
	Sekhukhune	102.6	100.0	57.7	-42.3
	Vhembe	123.5	133.3	66.3	-50.3
	Waterberg	98.0	102.6	88.2	-14.0
Mpumalanga	Ehlanzeni	82.4	96.5	96.3	-0.2
	G Sibande	136.7	122.2	131.4	+7.5
	Nkangala	93.9	100.0	83.7	-16.3
Northern Cape	Frances Baard	161.5	93.3	40.6	-56.5
	JT Gaetsewe	172.2	93.9	80.4	-14.4
	Namakwa	60.0	86.2	63.1	-26.8
	Pixley Ka Seme	97.1	98.2	87.1	-11.3
	ZF Mgcawu	87.2	85.7	57.4	-33.0
North West	Bojanala Platinum	127.8	100.6	99.2	-1.4
	Dr K Kaunda	100.8	103.1	85.8	-16.8
	NM Molema	116.0	97.7	59.7	-38.9
	RS Mompati	84.2	177.3	55.7	-68.6
Western Cape	Cape Town	98.9	96.4	54.3	-43.7
	Cape Winelands	97.2	98.3	90.8	-7.6
	Central Karoo	103.7	82.1	87.5	+6.6
	Garden Route	97.2	96.1	66.8	-30.5
	Overberg	81.8	104.4	96.3	-7.8
	West Coast	95.3	92.6	89.8	-3.0

Source: DHIS

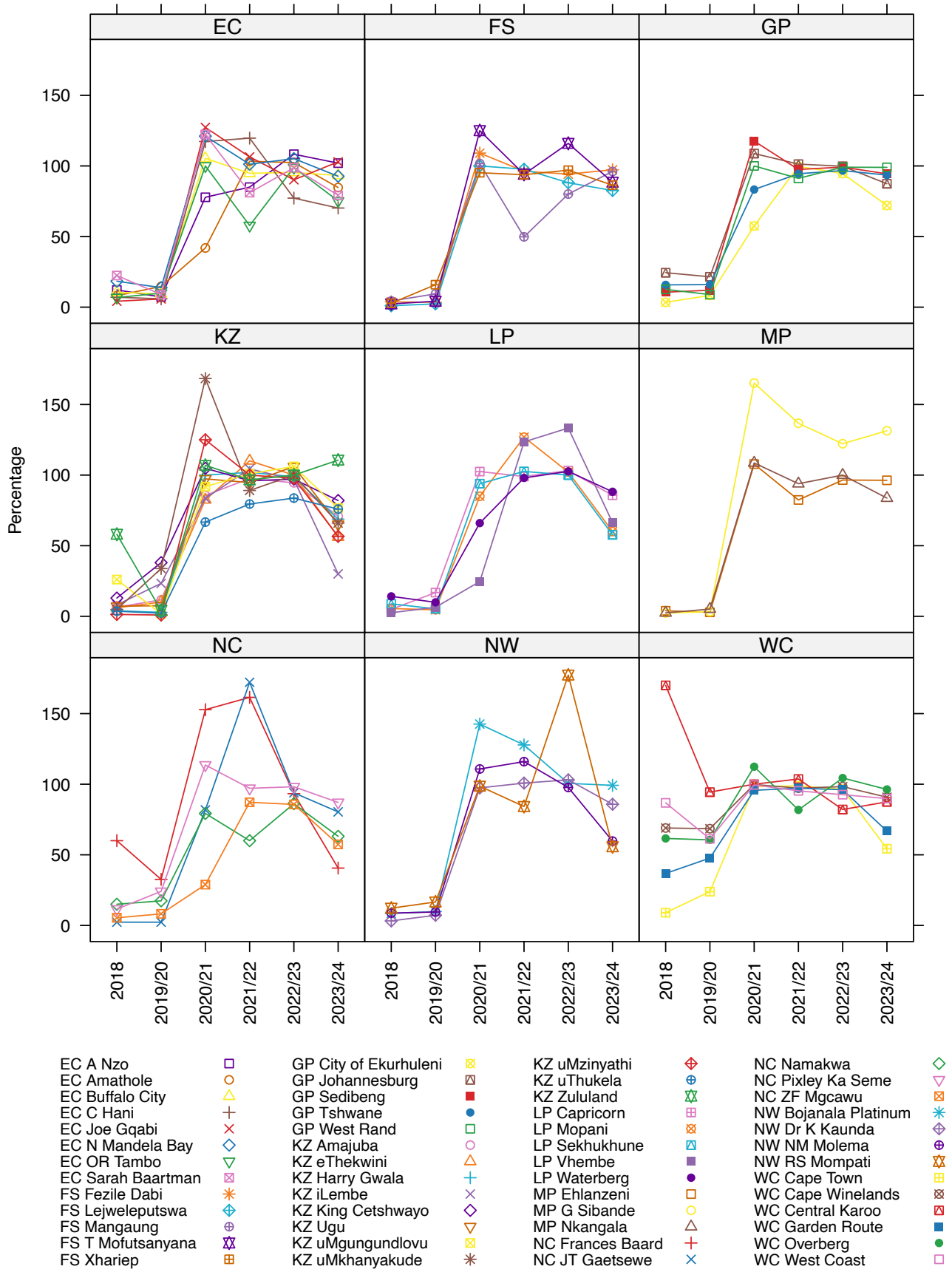


Figure 3 Annual trend: TB child under 5 years start on treatment rate, 2018 – 2023/24

Source: DHIS

TB client 5 years and older start on treatment rate

Key findings

- The TB client 5 years and older start on treatment rate in 2023/24 was 90.3%, a 4.5% decline from 94.6% in 2022/23.
- Provincial performance ranged from 77.2% in NC to 95.2% in MP. All provinces reported a reduction in the rate between 2022 and 2023.
- District performance ranged from 50.9% in Garden Route (WC) to 100.6% in Cape Town (WC). Forty districts reported a reduction in the rate between 2022 and 2023.

Introduction

The TB client 5 years and older start on treatment rate measures the TB client 5 years and older started on treatment as a proportion of all TB symptomatic clients 5 years and older testing positive.

National and provincial overview

The national TB client 5 years and older start on treatment rate was 90.3% in 2023/24, a 4.5% decline from 94.6% in 2022/23 (Figure 4 and Table 3). The rate among provinces ranged from 77.2% in NC to 95.2% in MP. All provinces reported declines in the treatment start rate between 2022 and 2023, with the largest decline reported by NC (20.7%).

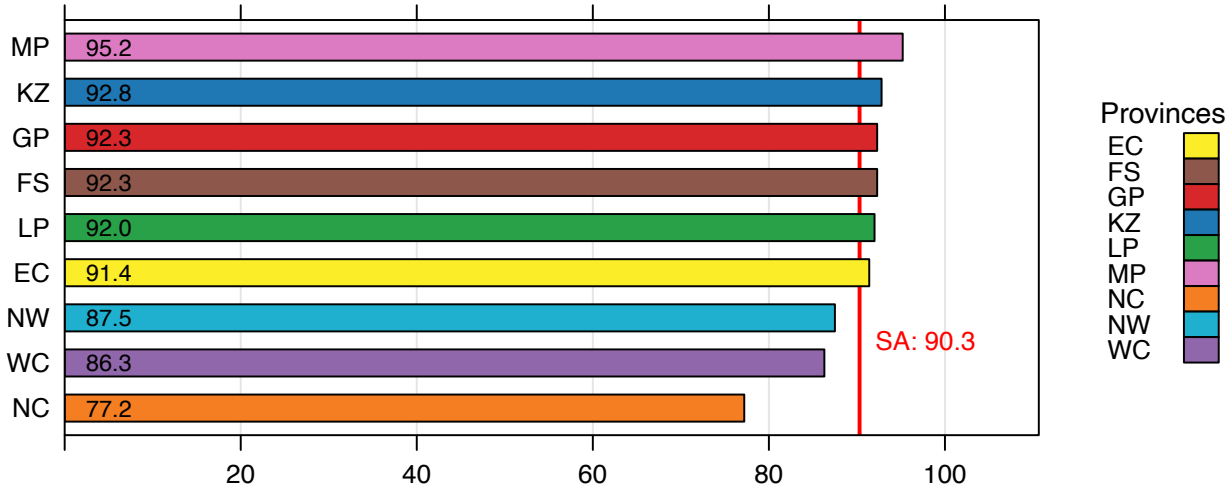


Figure 4 TB client 5 years and older start on treatment rate by province, 2023/24

Source: DHIS

Table 3 TB client 5 years and older start on treatment rate by province, 2021 – 2023 (%)

PROVINCE	2021/22	2022/23	2023/24	PERCENTAGE POINT DIFFERENCE BETWEEN 2022/23 AND 2023/24
Eastern Cape	92.7	93.1	91.4	-1.8
Free State	90.6	92.6	92.3	-0.3
Gauteng	94.8	95.1	92.3	-2.9
KwaZulu-Natal	94.8	96.4	92.8	-3.7
Limpopo	97.2	97.3	92.0	-5.4
Mpumalanga	93.4	95.3	95.2	-0.1
Northern Cape	87.9	97.3	77.2	-20.7
North West	95.3	95.4	87.5	-8.3
Western Cape	91.4	92.2	86.3	-6.4
South Africa	93.4	94.6	90.3	-4.5

Source: DHIS

District overview

At a district level, the TB client 5 years and older start on treatment rate varied from 50.9% in Garden Route (WC) to 100.6% in Cape Town (WC) (Figure 5 and Table 4). Forty districts recorded declines in the treatment start rate between 2022 and 2023. The largest decrease was recorded in Garden Route (WC) at 23.9% and the largest increase was recorded in Cape Town (WC) at 11.0%.

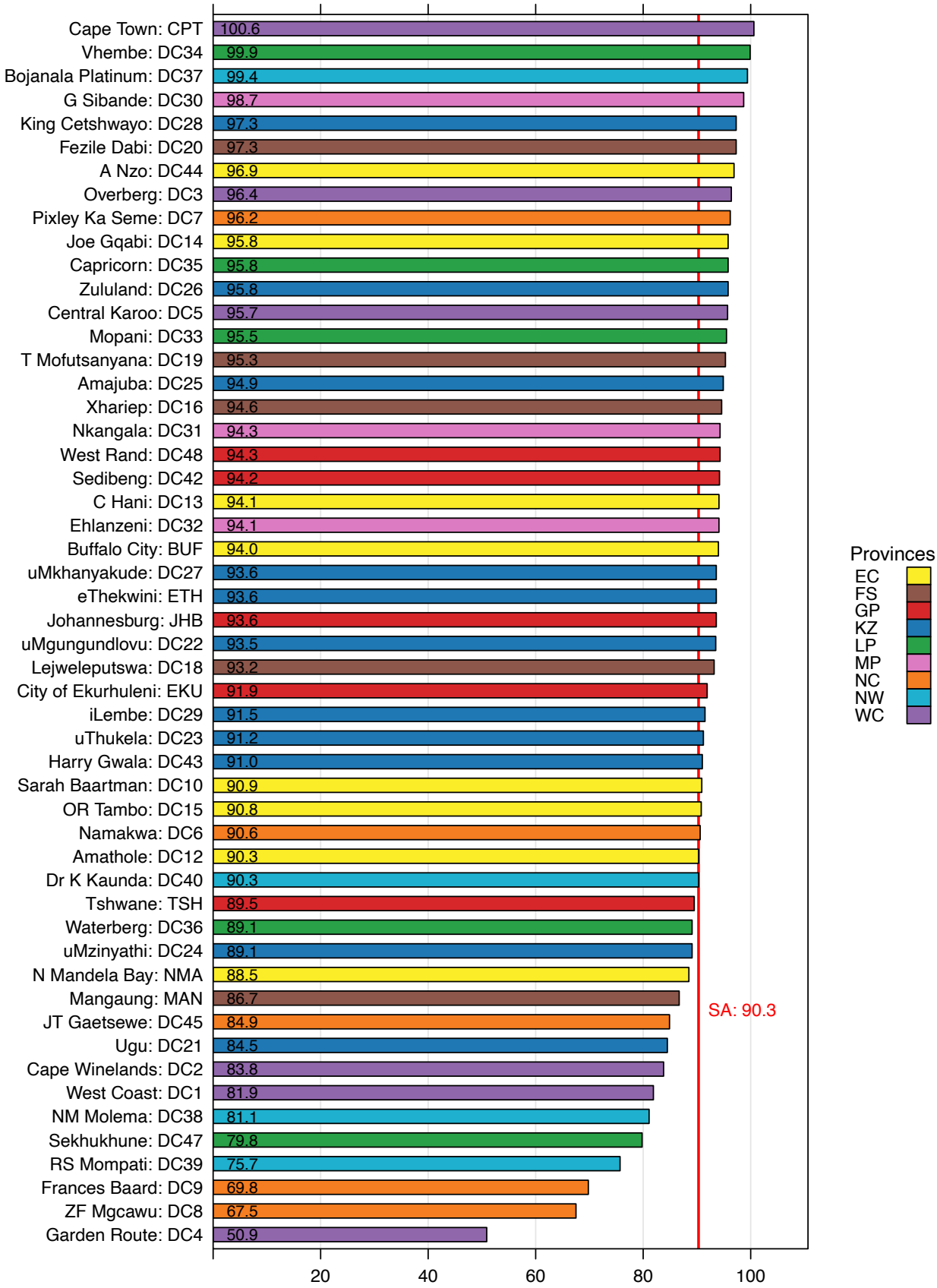
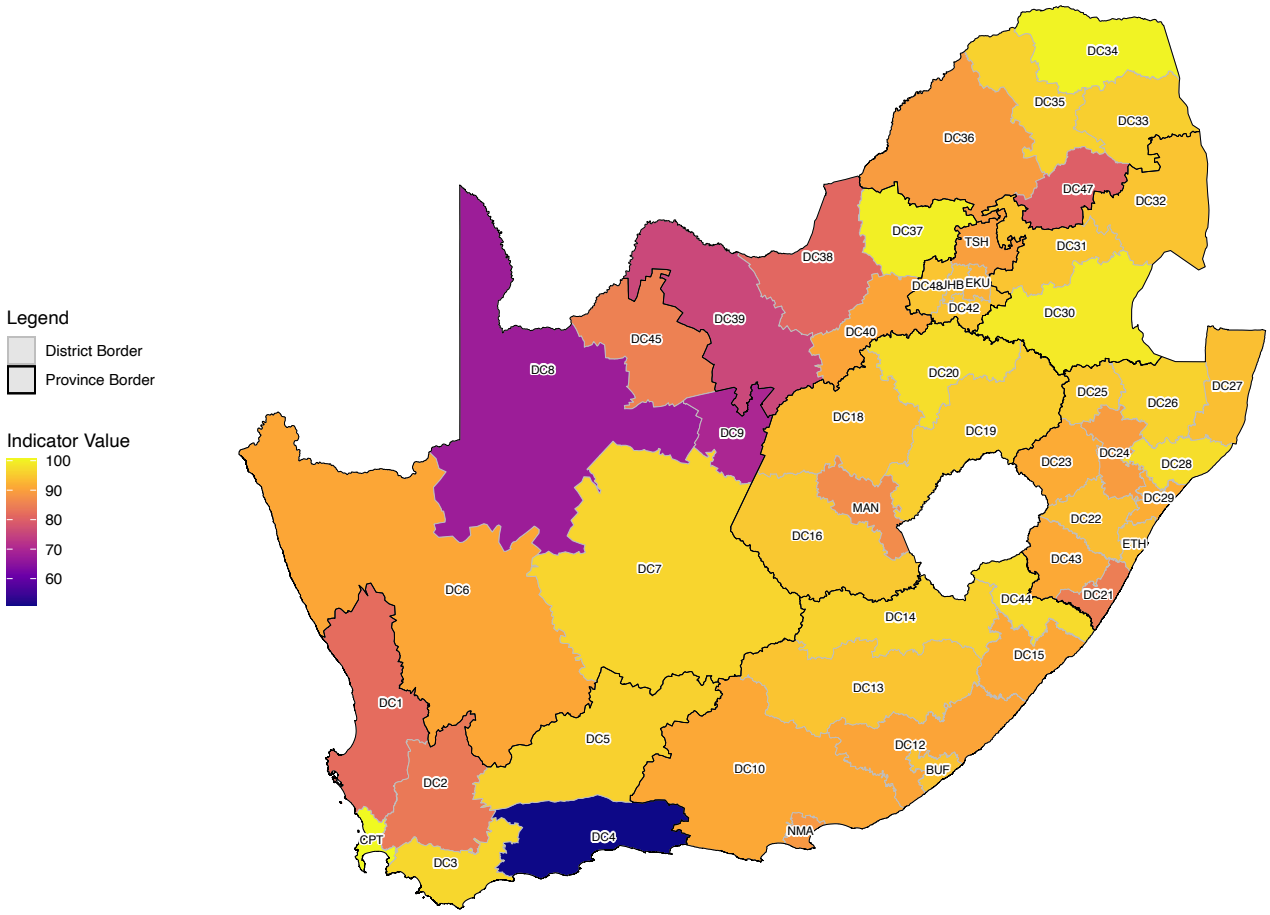


Figure 5 TB client 5 years and older start on treatment rate by district, 2023/24

Source: DHIS



MAP 2 TB client 5 years and older start on treatment rate by district, 2023/24

Source: DHIS

Table 4 TB client 5 years and older start on treatment rate by district, 2021 – 2023 (%)

PROVINCE	DISTRICT	2021/22	2022/23	2023/24	PERCENTAGE POINTS DIFFERENCE BETWEEN 2022/23 AND 2023/24
Eastern Cape	A Nzo	99.6	95.3	96.9	+1.7
	Amathole	89.7	92.8	90.3	-2.7
	Buffalo City	91.2	92.8	94.0	+1.3
	C Hani	92.7	90.2	94.1	+4.3
	Joe Gqabi	86.3	93.5	95.8	+2.5
	N Mandela Bay	91.3	91.8	88.5	-3.6
	OR Tambo	96.1	94.8	90.8	-4.2
	Sarah Baartman	91.9	94.6	90.9	-3.9
Free State	Fezile Dabi	94.7	95.1	97.3	+2.3
	Lejweleputswa	93.6	92.6	93.2	+0.6
	Mangaung	84.6	89.3	86.7	-2.9
	T Mofutsanyana	94.2	95.8	95.3	-0.5
	Xhariep	93.4	94.8	94.6	-0.2
Gauteng	City of Ekurhuleni	91.5	92.7	91.9	-0.9
	Johannesburg	97.0	96.3	93.6	-2.8
	Sedibeng	90.7	91.9	94.2	+2.5
	Tshwane	96.6	97.0	89.5	-7.7
	West Rand	94.4	95.0	94.3	-0.7

KwaZulu-Natal	Amajuba	99.5	99.9	94.9	-5.0
	eThekwini	93.6	96.8	93.6	-3.3
	Harry Gwala	95.8	98.8	91.0	-7.9
	iLembe	96.6	97.4	91.5	-6.1
	King Cetshwayo	94.6	94.9	97.3	+2.5
	Ugu	96.8	96.2	84.5	-12.2
	uMgungundlovu	93.7	94.8	93.5	-1.4
	uMkhanyakude	95.8	96.8	93.6	-3.3
	uMzinyathi	98.7	96.1	89.1	-7.3
	uThukela	89.4	93.0	91.2	-1.9
	Zululand	95.3	96.3	95.8	-0.5
Limpopo	Capricorn	96.8	97.6	95.8	-1.8
	Mopani	99.4	100.6	95.5	-5.1
	Sekhukhune	97.5	94.7	79.8	-15.7
	Vhembe	97.0	96.7	99.9	+3.3
	Waterberg	95.8	97.0	89.1	-8.1
Mpumalanga	Ehlanzeni	92.4	95.2	94.1	-1.2
	G Sibande	94.0	96.8	98.7	+2.0
	Nkangala	95.8	94.4	94.3	-0.1
Northern Cape	Frances Baard	94.2	100.9	69.8	-30.8
	JT Gaetsewe	71.8	108.0	84.9	-21.4
	Namakwa	91.4	95.2	90.6	-4.8
	Pixley Ka Seme	92.5	96.8	96.2	-0.6
	ZF Mgcawu	89.9	90.3	67.5	-25.2
North West	Bojanala Platinum	96.1	97.1	99.4	+2.4
	Dr K Kaunda	95.0	95.8	90.3	-5.7
	NM Molema	97.1	94.2	81.1	-13.9
	RS Mompati	92.1	93.4	75.7	-19.0
Western Cape	Cape Town	89.1	90.6	100.6	+11.0
	Cape Winelands	93.9	94.8	83.8	-11.6
	Central Karoo	98.5	97.7	95.7	-2.0
	Garden Route	94.2	90.7	50.9	-43.9
	Overberg	103.0	98.3	96.4	-1.9
	West Coast	90.0	93.6	81.9	-12.5

Source: DHIS

Recommendations

- The National Department of Health (NDoH) should prioritise provinces with the lowest treatment start rates.
- Provinces should facilitate sharing of good practices between districts to diffuse learning and enable improvement of poorly-performing districts to ensure an increase in the TB start on treatment rates.
- Strategies to improve the TB treatment start rate include delivery of TB results to people with TB and better linkage between hospitals and PHC facilities. This will also require efforts to improve advocacy, communication, and social mobilisation to provide health education to patients, communities, and healthcare workers, reduce stigma, and address issues related to financial and social protection.

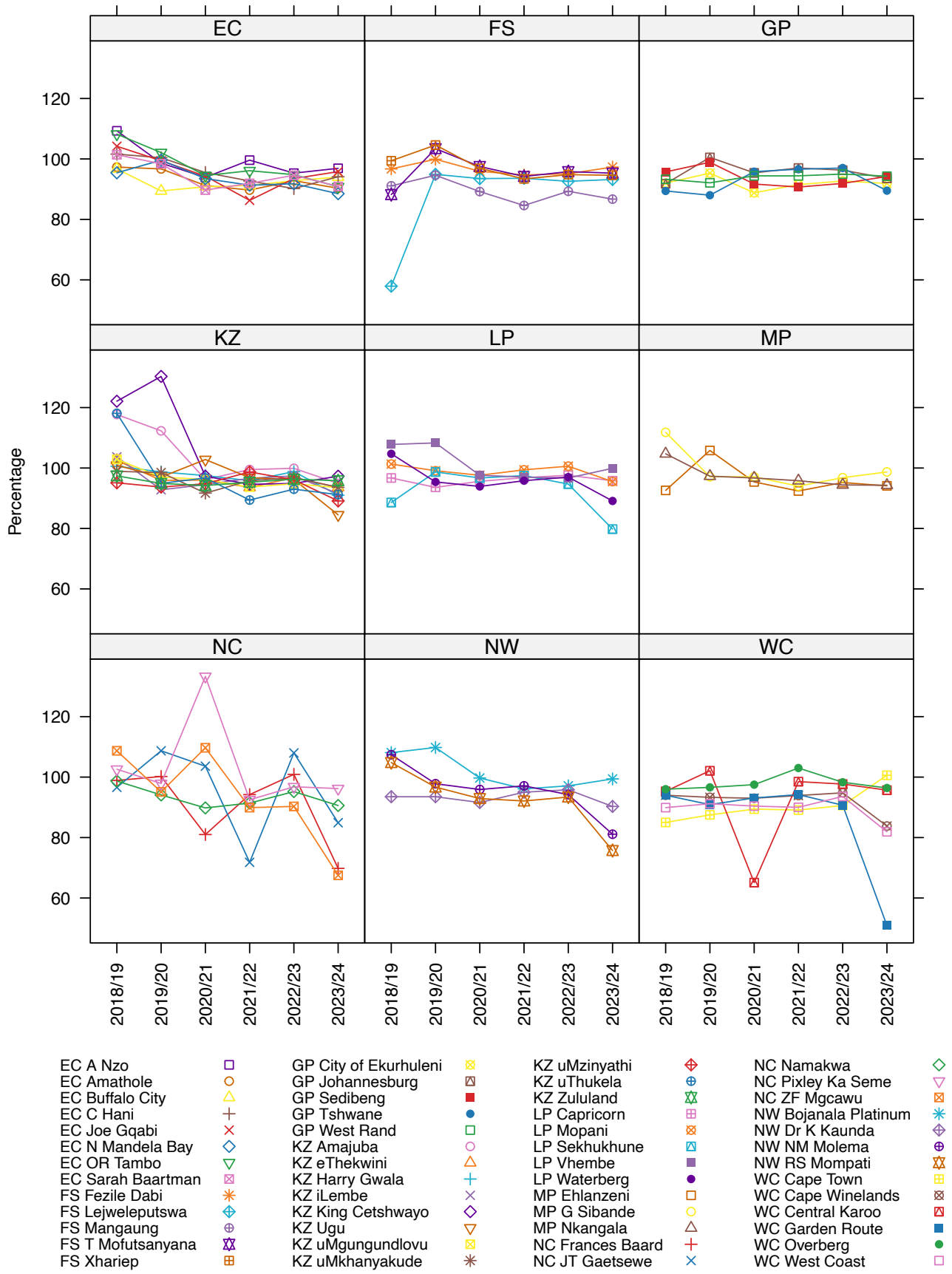


Figure 6 Annual trend: TB client 5 years and older start on treatment rate, 2018/19 – 2023/24

Source: DHIS

Drug-susceptible TB client treatment success rate

Key findings

- The national DS-TB treatment success rate in 2022 was 75.8%, a 0.5% improvement from 75.4% in 2021.
- Provincial performance ranged from 68.9% in LP to 84.2% in NW. Only NW reached the target of 80%. Two provinces reported declines in the DS-TB treatment success rate.
- District performance ranged from 63.1% in Vhembe (LP) to 87.7% in uMkhanyakude (KZ). Eleven districts reached the target of 80%. Twenty-five districts reported declines in the DS-TB treatment success rate.

Introduction

The DS-TB client treatment success rate measures DS-TB clients who have successfully completed treatment (both cured and treatment completed) as a proportion of all DS-TB clients started on treatment. This applies to all DS-TB clients (new, retreatment, other, pulmonary, and extrapulmonary). The national target for this indicator, according to the TB Recovery Plan 2023/24, is 80%.

National and provincial overview

The national DS-TB treatment success rate was 75.8% in 2022, a 0.5% improvement from 75.4% in 2021 (Figure 7 and Table 5). The DS-TB lost to follow-up (LTFU) rate was 12.3% and the death rate 7.3% in 2022. 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.

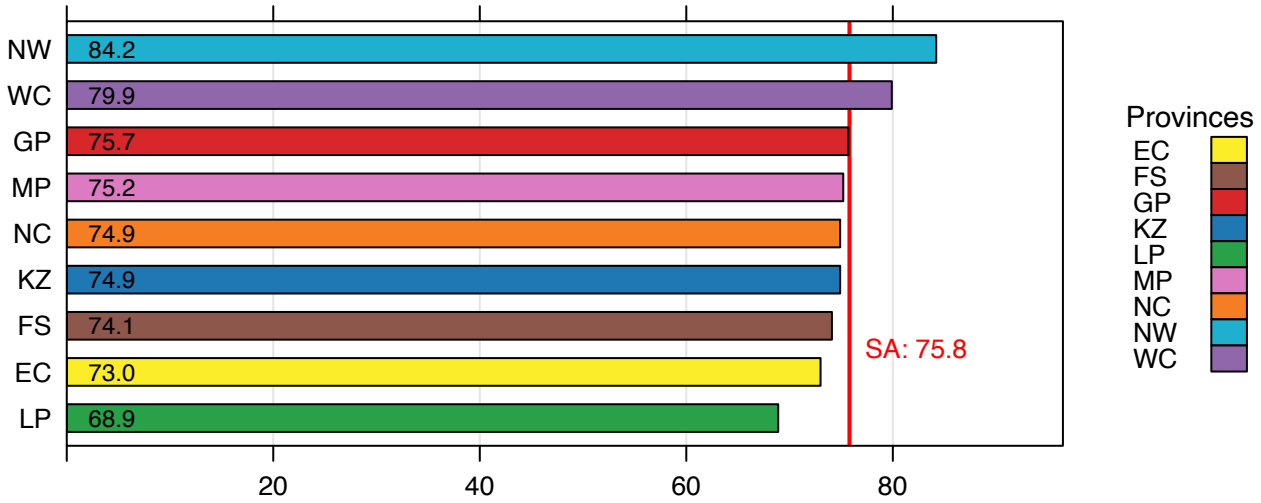


Figure 7 Drug-susceptible TB treatment success rate by province, 2022

Source: DHIS

Table 5 Drug-susceptible TB treatment success rate by province, 2020 – 2022 (%)

PROVINCE	2020	2021	2022	PERCENTAGE POINT DIFFERENCE BETWEEN 2021 AND 2022
Eastern Cape	78.2	74.9	73.0	-2.5
Free State	75.6	73.7	74.1	+0.5
Gauteng	75.0	76.4	75.7	-0.9
KwaZulu-Natal	75.6	74.5	74.9	+0.5
Limpopo	66.4	68.6	68.9	+0.4
Mpumalanga	75.2	74.4	75.2	+1.1
Northern Cape	75.8	74.9	74.9	0
North West	76.3	78.4	84.2	+7.4
Western Cape	79.1	78.1	79.9	+2.3
South Africa	76.1	75.4	75.8	+0.5

Source: DHIS

District overview

At a district level, the DS-TB treatment success rate varied from 63.1% in Vhembe (LP) to 87.7% in uMkhanyakude (KZ) (Figure 8 and Table 6). Eleven districts reached the target of 80%, three each in WC and KZ, and four in NW. Twenty-five districts recorded declines in the DS-TB treatment success rate between 2021 and 2022. The largest declines were recorded in Joe Gqabi (EC) at 15.2% and JT Gaetsewe (NC) at 11.9%. The largest increases were recorded in Capricorn (LP) at 14.1% and Dr K Kaunda (NW) at 14.5%.

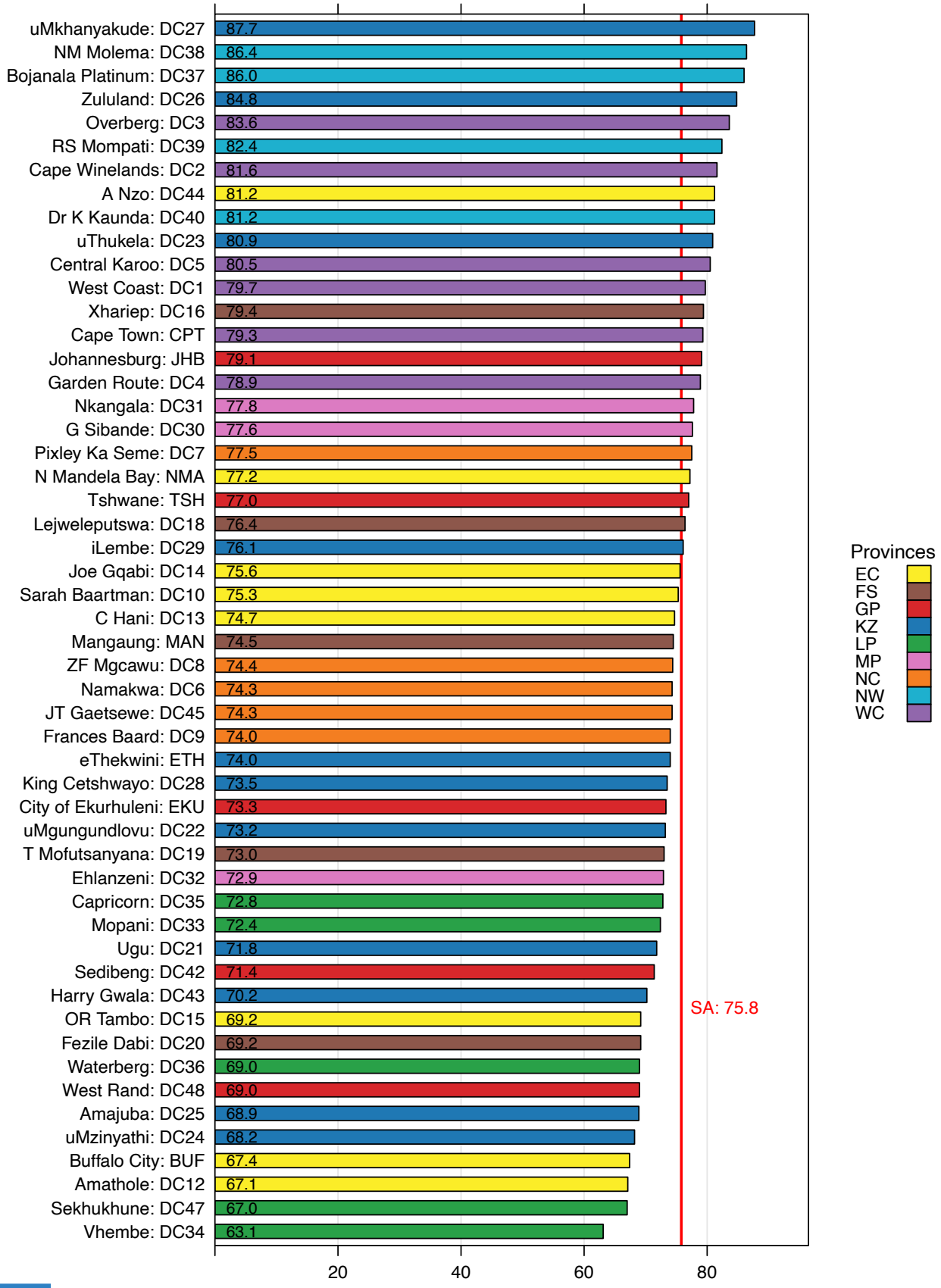
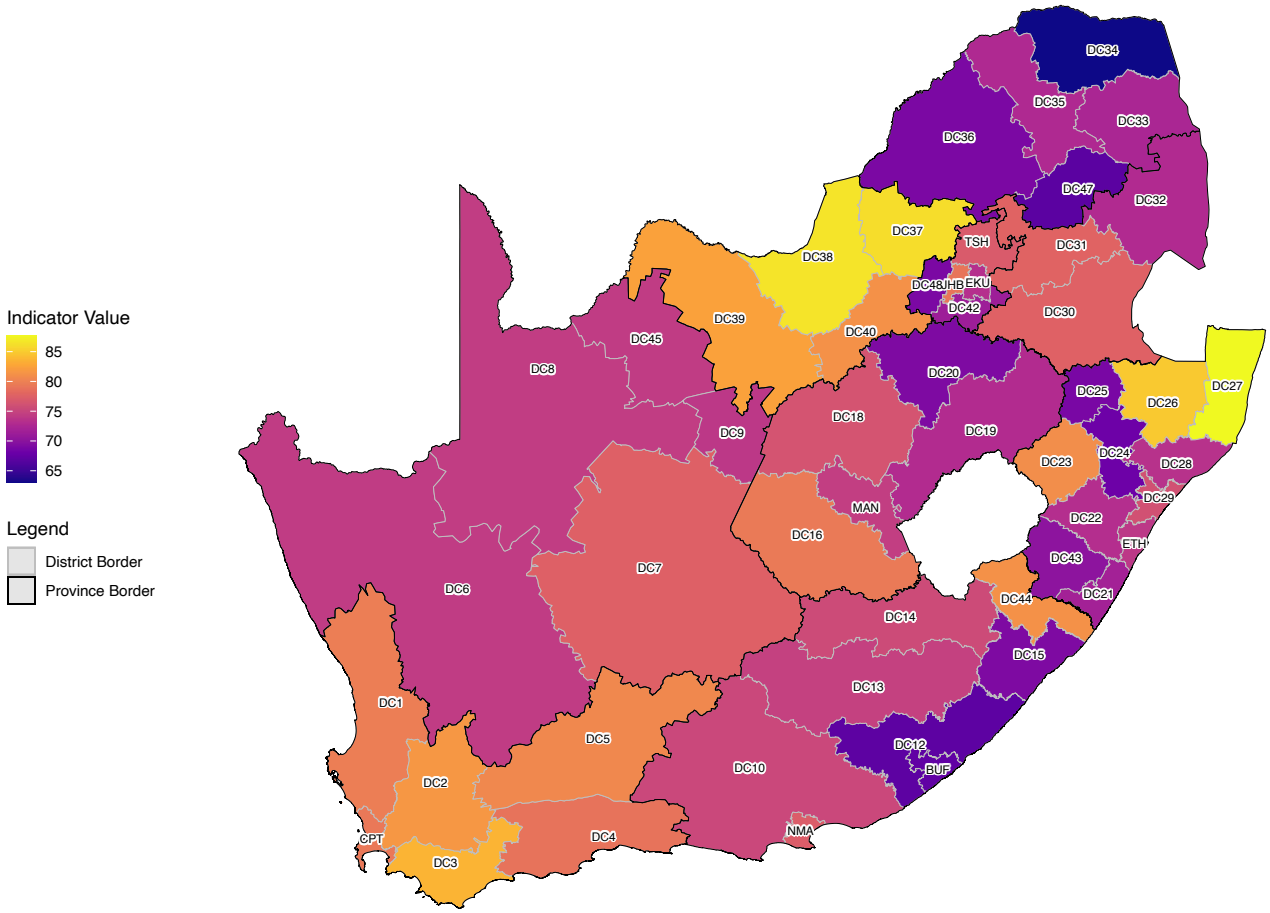


Figure 8 Drug-susceptible TB treatment success rate by district, 2022

Source: DHIS



MAP 3 Drug-susceptible TB treatment success rate by district, 2022

Source: DHIS

Table 6 Drug-susceptible TB treatment success rate by district, 2020 – 2022 (%)

PROVINCE	DISTRICT	2020	2021	2022	PERCENTAGE POINT DIFFERENCE BETWEEN 2021 AND 2022
Eastern Cape	A Nzo	78.9	76.7	81.2	+5.9
	Amathole	73.5	69.8	67.1	-3.9
	Buffalo City	74.2	69.3	67.4	-2.7
	C Hani	86.1	82.1	74.7	-9.0
	Joe Gqabi	87.6	89.1	75.6	-15.2
	N Mandela Bay	82.5	78.8	77.2	-2.0
	OR Tambo	74.2	72.7	69.2	-4.8
	Sarah Baartman	76.4	72.2	75.3	+4.3
Free State	Fezile Dabi	66.6	70.5	69.2	-1.8
	Lejweleputswa	80.5	79.2	76.4	-3.5
	Mangaung	76.1	69.1	74.5	+7.8
	T Mofutsanyana	79.8	79.4	73.0	-8.1
	Xhariep	68.6	71.6	79.4	+10.9
Gauteng	City of Ekurhuleni	65.8	70.7	73.3	+3.7
	Johannesburg	87.7	83.2	79.1	-4.9
	Sedibeng	71.6	67.0	71.4	+6.6
	Tshwane	72.9	77.4	77.0	-0.5
	West Rand	65.1	71.3	69.0	-3.2

KwaZulu-Natal	Amajuba	67.5	63.0	68.9	+9.4
	eThekwini	76.8	75.1	74.0	-1.5
	Harry Gwala	70.2	65.9	70.2	+6.5
	iLembe	70.6	72.3	76.1	+5.3
	King Cetshwayo	73.5	72.2	73.5	+1.8
	Ugu	66.8	73.0	71.8	-1.6
	uMgungundlovu	70.4	72.0	73.2	+1.7
	uMkhanyakude	98.0	91.0	87.7	-3.6
	uMzinyathi	63.7	69.6	68.2	-2.0
	uThukela	93.4	83.9	80.9	-3.6
	Zululand	85.5	80.2	84.8	+5.7
Limpopo	Capricorn	62.8	63.8	72.8	+14.1
	Mopani	71.1	78.6	72.4	-7.9
	Sekhukhune	69.6	69.7	67.0	-3.9
	Vhembe	60.9	62.4	63.1	+1.1
	Waterberg	69.1	71.4	69.0	-3.4
Mpumalanga	Ehlanzeni	73.2	71.5	72.9	+2.0
	G Sibande	76.6	76.1	77.6	+2.0
	Nkangala	78.2	80.2	77.8	-3.0
Northern Cape	Frances Baard	74.0	71.8	74.0	+3.1
	JT Gaetsewe	82.2	84.3	74.3	-11.9
	Namakwa	82.5	81.1	74.3	-8.4
	Pixley Ka Seme	72.2	74.5	77.5	+4.0
	ZF Mgcawu	74.8	72.4	74.4	+2.8
North West	Bojanala Platinum	80.9	82.9	86.0	+3.7
	Dr K Kaunda	65.6	70.9	81.2	+14.5
	NM Molema	83.2	76.4	86.4	+13.1
	RS Mompati	76.4	84.8	82.4	-2.8
Western Cape	Cape Town	80.1	78.8	79.3	+0.6
	Cape Winelands	78.1	75.9	81.6	+7.5
	Central Karoo	80.9	75.3	80.5	+6.9
	Garden Route	73.4	75.3	78.9	+4.8
	Overberg	84.5	83.6	83.6	0
	West Coast	80.2	80.1	79.7	-0.5

Source: DHIS

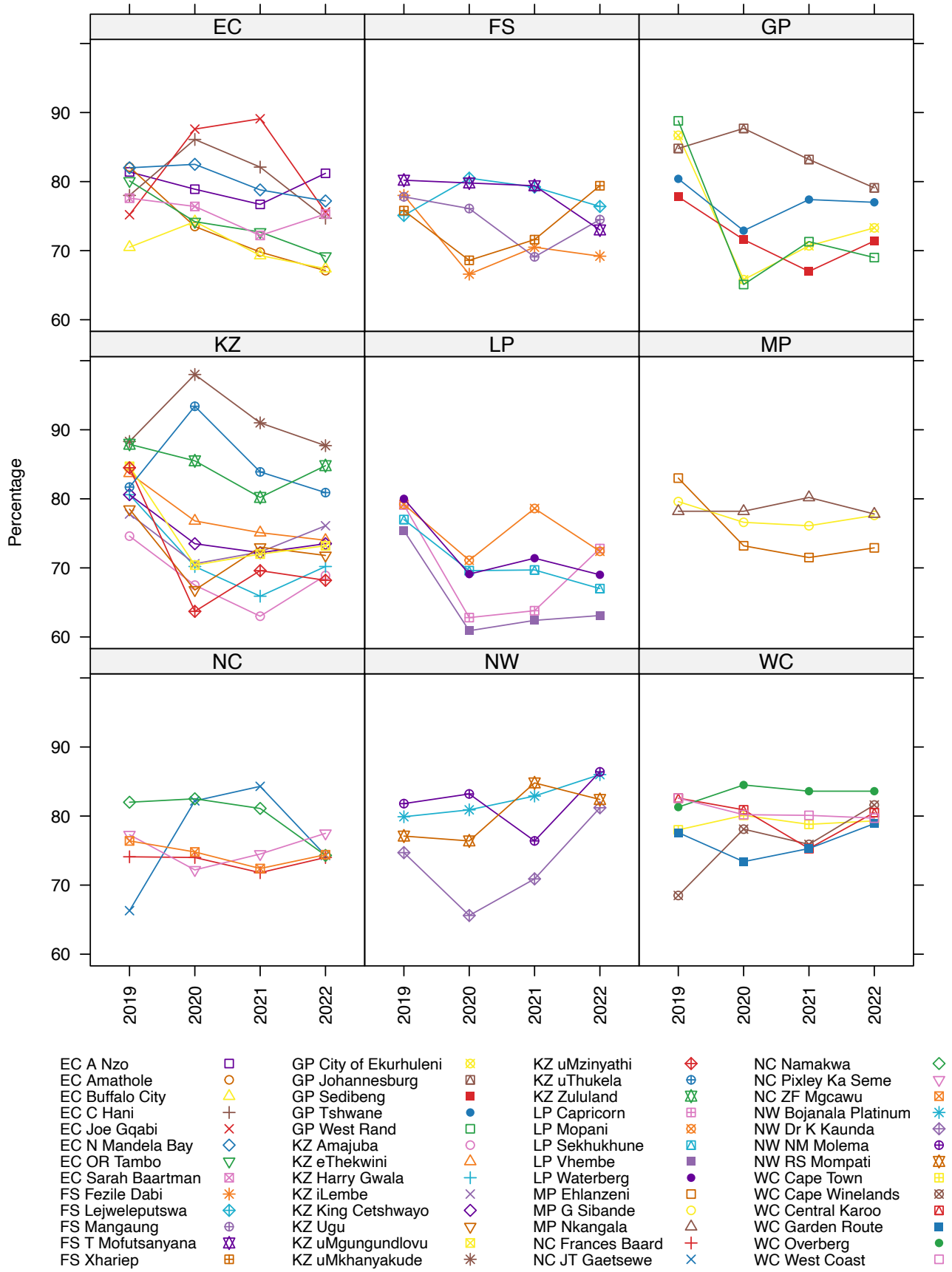


Figure 9 Annual trends: DS-TB success rate

Source: DHIS

TB multidrug-resistant treatment success rate

Key findings

- The national MDR-TB treatment success rate was 62.4% in 2022, a 0.3% decline from 62.2% in 2021.
- Provincial performance ranged from 52.5% in WC to 68.5% in KZ.
- No province reached the target of 73%.
- Four provinces reported declines in the rate between 2021 and 2022.
- District performance ranged from 42.1% in Central Karoo (WC) to 87.0% in uMkhanyakude (KZ).
- Seven districts reached the target of 73%. Twenty districts reported declines in the rate between 2021 and 2022.

Introduction

The MDR-TB treatment success rate measures the MDR-TB clients cured and completing treatment as a proportion of MDR-TB-confirmed clients started on treatment. The national target for this indicator, according to the TB Recovery Plan 2024/25, is 73%.

National and provincial overview

The national MDR-TB treatment success rate was 62.4% in 2022, a 0.3% improvement from 62.2% in 2021 (Figure 10 and Table 7). The MDR-TB LTFU rate was 17.5% and the death rate 15.6% in 2022. The MDR-TB treatment success rate among provinces ranged from 52.5% in WC to 68.5% in KZ. No province reached the target of 73%. Four provinces reported declines in the MDR-TB treatment success rate between 2021 and 2022, with the largest decline reported by MP (6.3%).

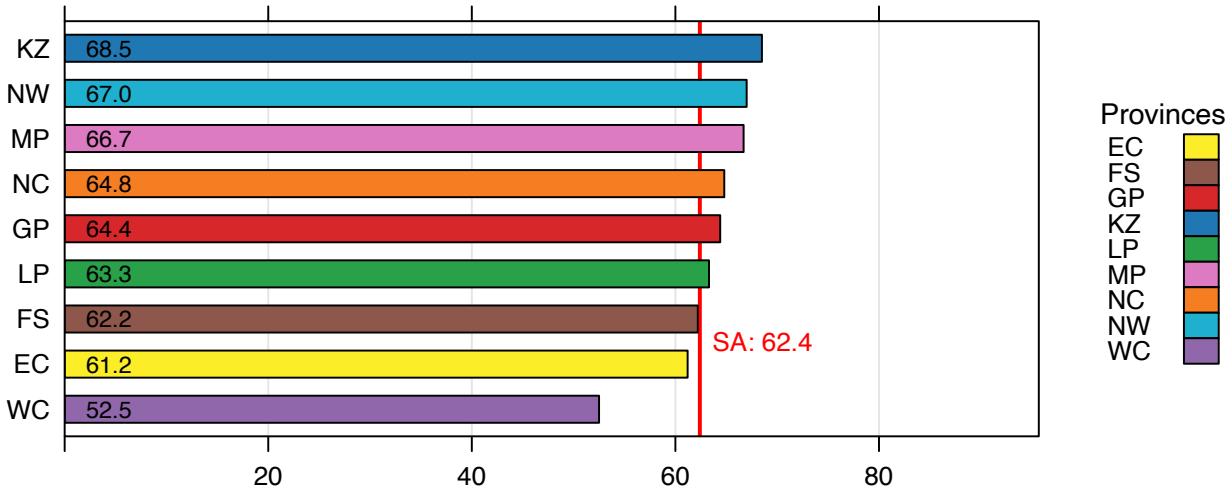


Figure 10 MDR-TB treatment success rate by province, 2022

Source: EDRWeb

Table 7 MDR-TB treatment success rate by province, 2020 – 2022 (%)

PROVINCE	2020	2021	2022	PERCENTAGE POINT DIFFERENCE BETWEEN 2021 AND 2022
Eastern Cape	60.8	60.4	61.2	+1.3
Free State	59.4	61.2	62.2	+1.7
Gauteng	61.2	64.7	64.4	-0.3
KwaZulu-Natal	67.0	67.4	68.5	+1.7
Limpopo	64.5	65.2	63.3	-2.9
Mpumalanga	68.3	71.2	66.7	-6.3
Northern Cape	62.4	57.4	64.8	+12.8
North West	68.2	65.3	67.0	+2.6
Western Cape	53.1	53.7	52.5	-2.1
South Africa	62.0	62.2	62.4	+0.3

Source: EDRWeb

District overview

At a district level, the MDR-TB treatment success rate in 2022 varied from 42.1% in Central Karoo (WC) to 87.0% in uMkhanyakude (KZ) (Figure 11 and Table 8). Seven districts reached the target of 73%, five in KZ and two in FS. The worst performing 12 districts included five from WC and four from EC. Three districts in the NC (JT Gaetsewe, Namakwa and Pixley Ka Seme) still refer MDR-TB clients to neighbouring districts and, as such, do not report any MDR-TB treatment data.

Twenty-eight districts reported an improvement in the MDR-TB treatment success rate between 2021 and 2022, with Xhariep (FS) showing the greatest improvement of 28.6%. The largest decline in MDR-TB treatment success rate was in Harry Gwala (KZ) at 39.0%.

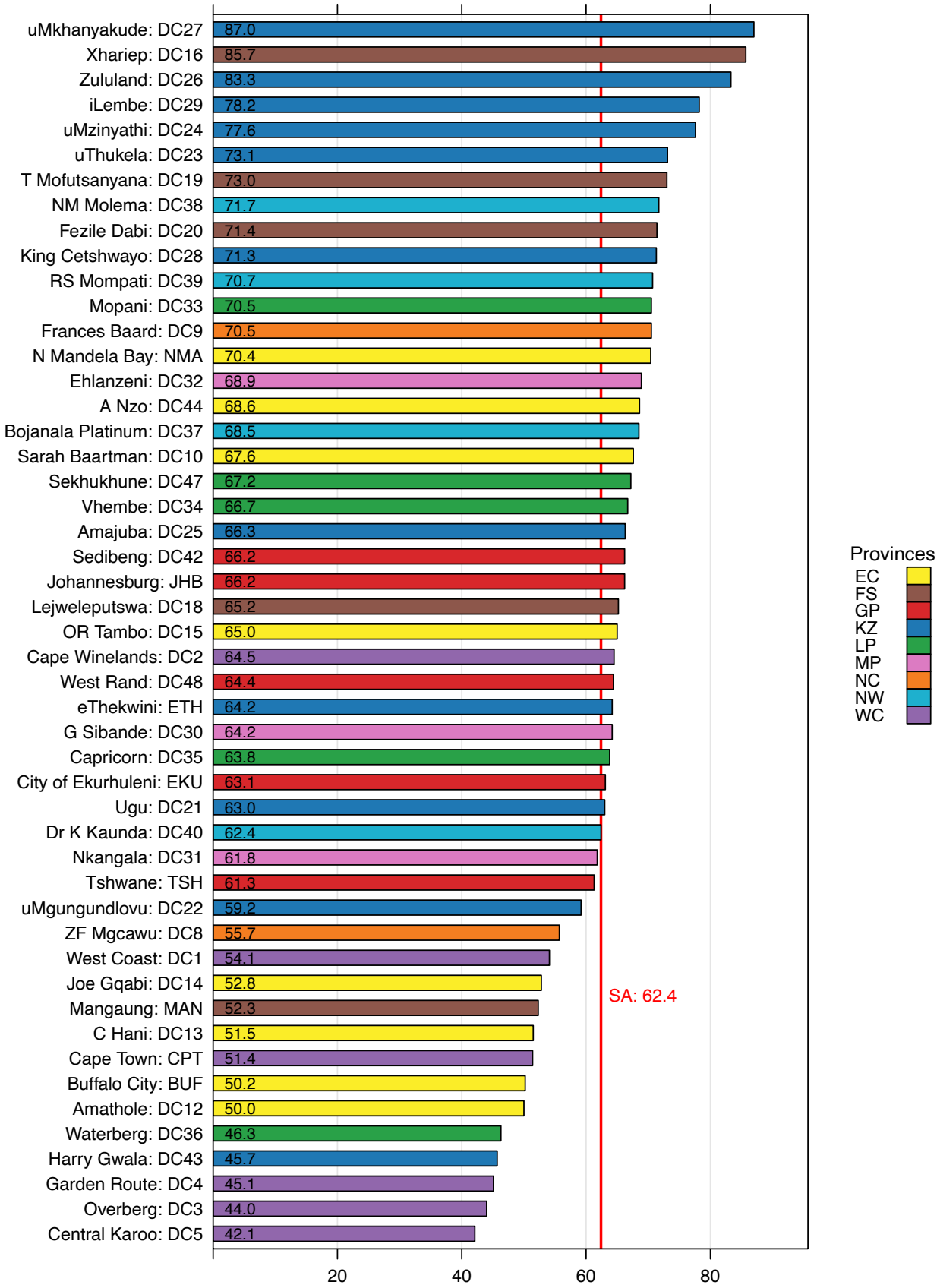
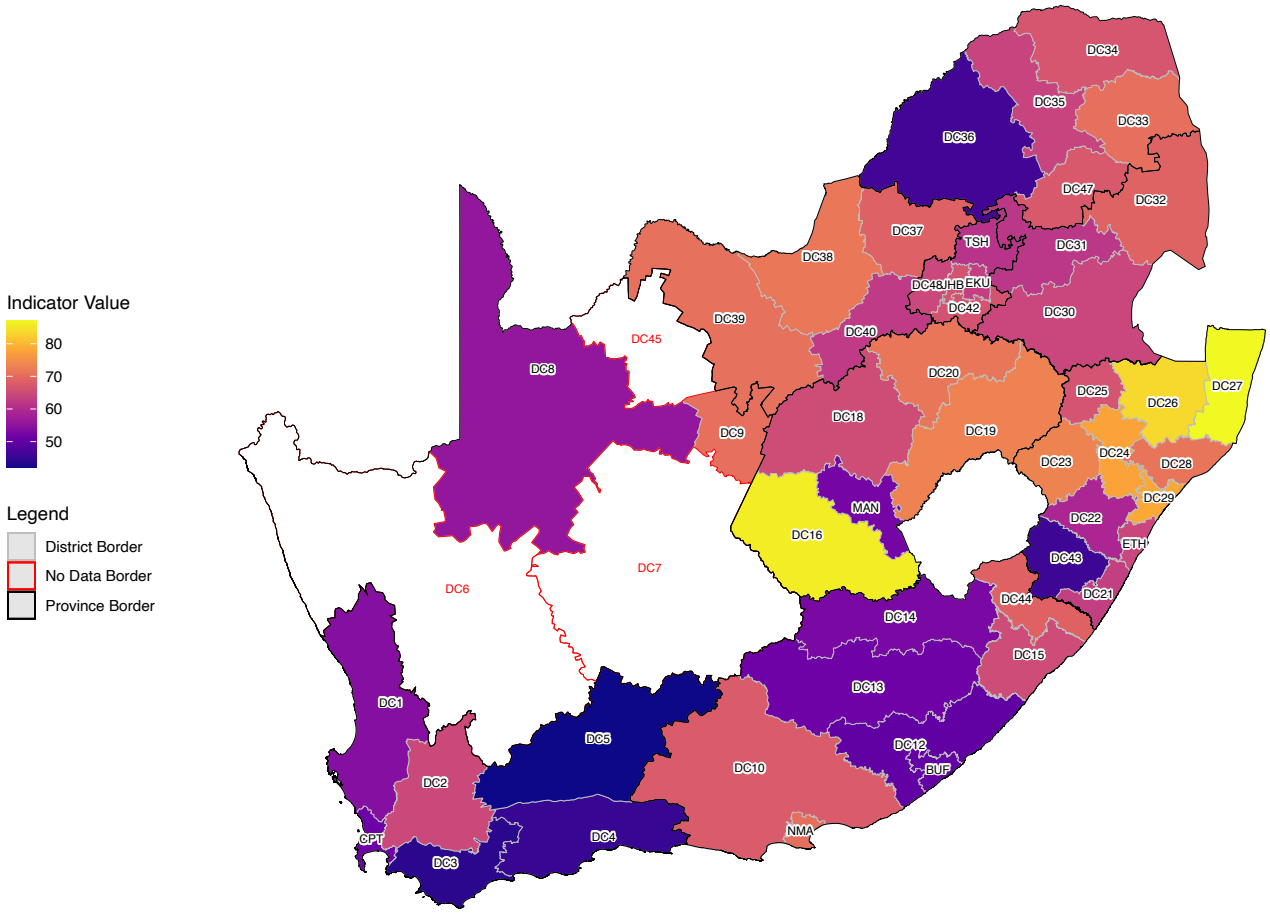


Figure 11 MDR-TB treatment success rate by district, 2022

Source: EDRWeb



MAP 4 MDR-TB treatment success rate by district, 2022

Source: EDRWeb

Table 8 MDR-TB treatment success rate by district, 2020 – 2022 (%)

PROVINCE	DISTRICT	2020	2021	2022	PERCENTAGE POINT DIFFERENCE BETWEEN 2021 AND 2022
Eastern Cape	A Nzo	65.5	66.7	68.6	+2.9
	Amathole	43.9	52.2	50.0	-4.2
	Buffalo City	52.8	49.3	50.2	+2.0
	C Hani	58.3	56.9	51.5	-9.5
	Joe Gqabi	48.7	50.0	52.8	+5.7
	N Mandela Bay	66.8	64.9	70.4	+8.5
	OR Tambo	66.5	70.5	65.0	-7.7
	Sarah Baartman	68.8	64.4	67.6	+4.9
Free State	Fezile Dabi	78.0	61.4	71.4	+16.4
	Lejweleputswa	77.1	60.5	65.2	+7.8
	Mangaung	51.5	54.6	52.3	-4.2
	T Mofutsanyana	52.6	76.9	73.0	-5.1
	Xhariep	40.0	66.7	85.7	+28.6

Gauteng	City of Ekurhuleni	49.5	60.3	63.1	+4.5
	Johannesburg	67.6	64.2	66.2	+3.1
	Sedibeng	62.9	67.2	66.2	-1.6
	Tshwane	59.6	72.1	61.3	-15.1
	West Rand	62.7	63.6	64.4	+1.2
KwaZulu- Natal	Amajuba	60.6	60.6	66.3	+9.4
	eThekwini	65.4	65.4	64.2	-1.8
	Harry Gwala	62.8	75.0	45.7	-39.0
	iLembe	65.7	68.8	78.2	+13.6
	King Cetshwayo	71.2	66.9	71.3	+6.6
	Ugu	66.2	68.6	63.0	-8.2
	uMgungundlovu	63.3	57.3	59.2	+3.3
	uMkhanyakude	78.6	89.0	87.0	-2.3
	uMzinyathi	59.3	73.9	77.6	+4.9
	uThukela	58.0	66.7	73.1	+9.7
	Zululand	78.0	73.5	83.3	+13.3
Limpopo	Capricorn	55.3	55.1	63.8	+15.8
	Mopani	66.0	58.1	70.5	+21.3
	Sekhukhune	66.7	71.9	67.2	-6.4
	Vhembe	68.3	71.7	66.7	-7.0
	Waterberg	65.3	69.7	46.3	-33.5
Mpumalanga	Ehlanzeni	72.8	74.2	68.9	-7.3
	G Sibande	60.0	53.7	64.2	+19.6
	Nkangala	64.8	71.1	61.8	-13.2
Northern Cape	Frances Baard	66.7	61.7	70.5	+14.2
	JT Gaetsewe				
	Namakwa				
	Pixley Ka Seme				
	ZF Mgcawu	56.1	51.0	55.7	+9.3
North West	Bojanala Platinum	77.5	65.0	68.5	+5.4
	Dr K Kaunda	59.5	66.1	62.4	-5.6
	NM Molema	73.4	61.2	71.7	+17.1
	RS Mompati	67.8	67.3	70.7	+5.1
Western Cape	Cape Town	53.9	52.0	51.4	-1.2
	Cape Winelands	57.0	60.2	64.5	+7.1
	Central Karoo	38.9	42.1	42.1	0
	Garden Route	45.6	52.3	45.1	-13.7
	Overberg	51.1	39.0	44.0	+12.8
	West Coast	55.7	63.2	54.1	-14.3

Source: EDRWeb

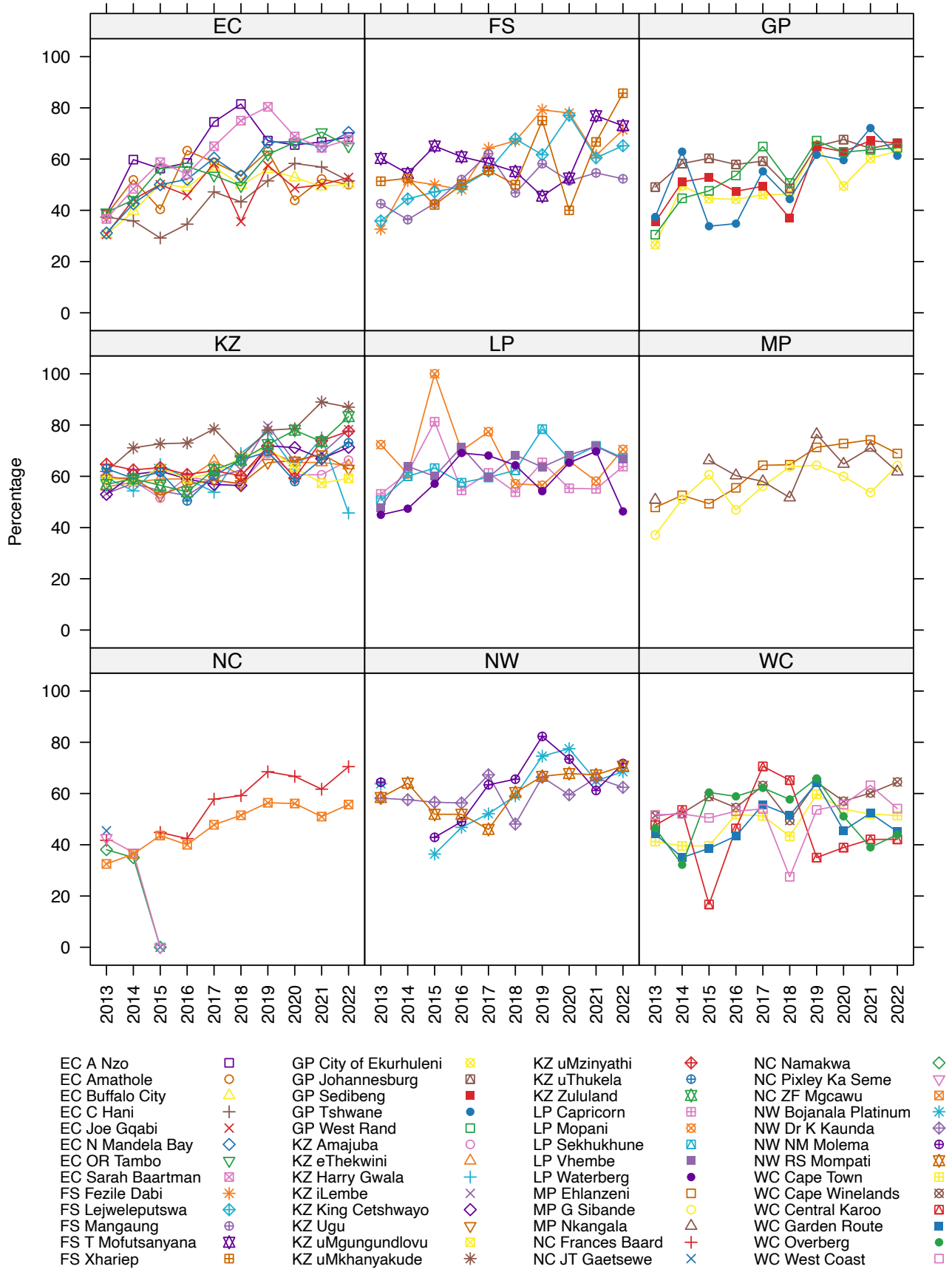


Figure 12 Annual trends: MDR-TB success rate, 2013 – 2022

Source: EDRWeb

Pre-extensively drug-resistant and extensively drug-resistant TB treatment success rate

Key findings

- The national pre-XDR and XDR-TB treatment success rate was 51.0% in 2022, a 5.5% decline from 53.9% in 2021.
- Provincial performance ranged from 42.8% in WC to 65.0% in NW.
- Six provinces reported declines in the pre-XDR and XDR-TB treatment success rate between 2021 and 2022.
- Twenty-two districts reported declines between 2021 and 2022.

Introduction

The pre-XDR-TB and XDR-TB treatment success rate measures the number of pre-XDR and XDR-TB clients successfully completing treatment as a proportion of pre-XDR and XDR-TB-confirmed clients started on treatment. There is no national target for this indicator.

National and provincial overview

The national pre-XDR and XDR-TB treatment success rate was 51.0% in 2022, a 5.5% decline from 53.9% in 2021 (Figure 13 and Table 9). The pre-XDR and XDR-TB LTFU rate was 16.2% and the death rate 20.1% in 2022. The pre-XDR and XDR-TB treatment success rate among provinces ranged from 42.8% in WC to 65.0% in NW. Six provinces reported declines in the rate between 2021 and 2022, with the largest declines reported by GP (26.2%).

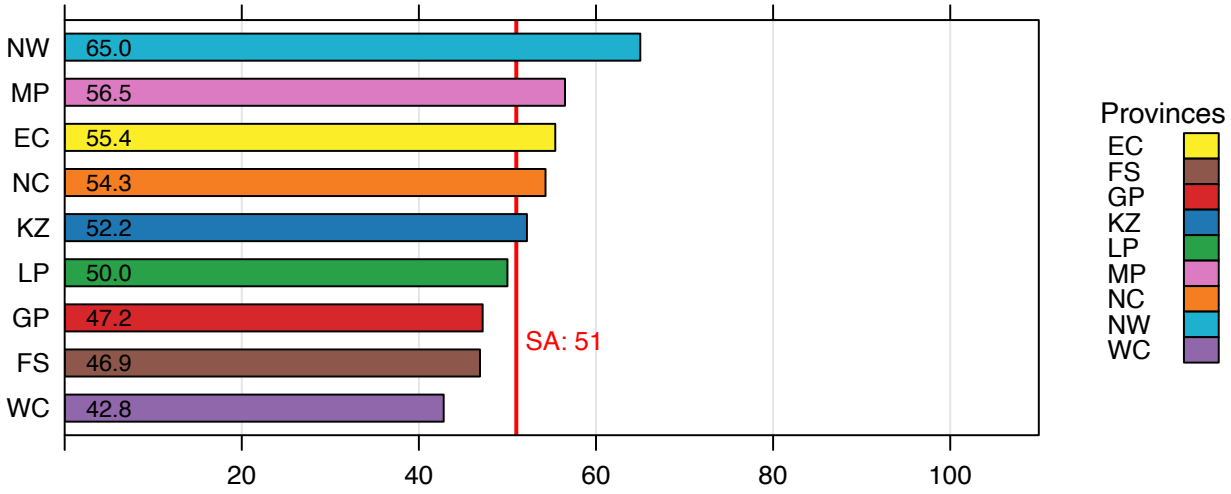


Figure 13 Pre-XDR TB and XDR-TB treatment success rate by province, 2022

Source: EDRWeb

Table 9 Pre-XDR TB and XDR-TB treatment success rate by province, 2020 – 2022 (%)

PROVINCE	2020	2021	2022	PERCENTAGE POINT DIFFERENCE BETWEEN 2021 AND 2022
Eastern Cape	51.7	55.2	55.4	+0.3
Free State	50.0	56.3	46.9	-16.7
Gauteng	61.8	64.0	47.2	-26.2
KwaZulu-Natal	57.0	53.8	52.2	-3.0
Limpopo	61.5	40.0	50.0	+25.0
Mpumalanga	63.2	63.6	56.5	-11.2
Northern Cape	50.0	51.3	54.3	+5.9
North West	47.1	71.4	65.0	-9.0
Western Cape	55.2	47.0	42.8	-8.9
South Africa	54.4	53.9	51.0	-5.5

Source: EDRWeb

District overview

At a district level, the pre-XDR and XDR-TB treatment success rates in 2022 varied from 0% in iLembe, Sekhukhune, Central Karoo, Bojanala, Joe Gqabi, Harry Gwala and T Mofutsanyana, to 100.0% in NM Molema, Lejweleputswa, Vhembe, West Rand and Mopani (Figure 10 and Table 10). Twenty-two districts reported declines between 2021 and 2022. However, due to the small numbers of cases diagnosed with pre-XDR and XDR-TB, the information should be interpreted with caution.

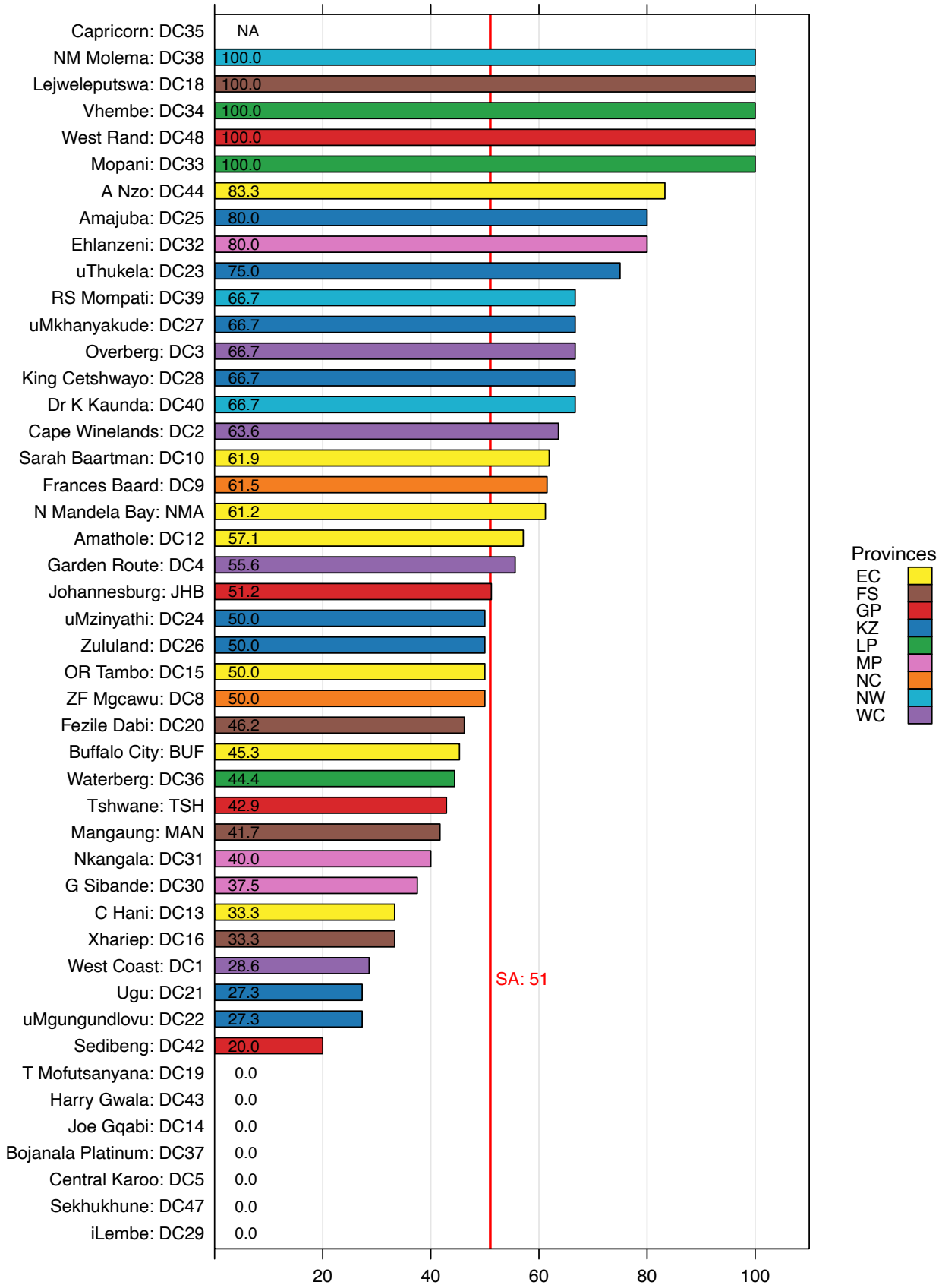
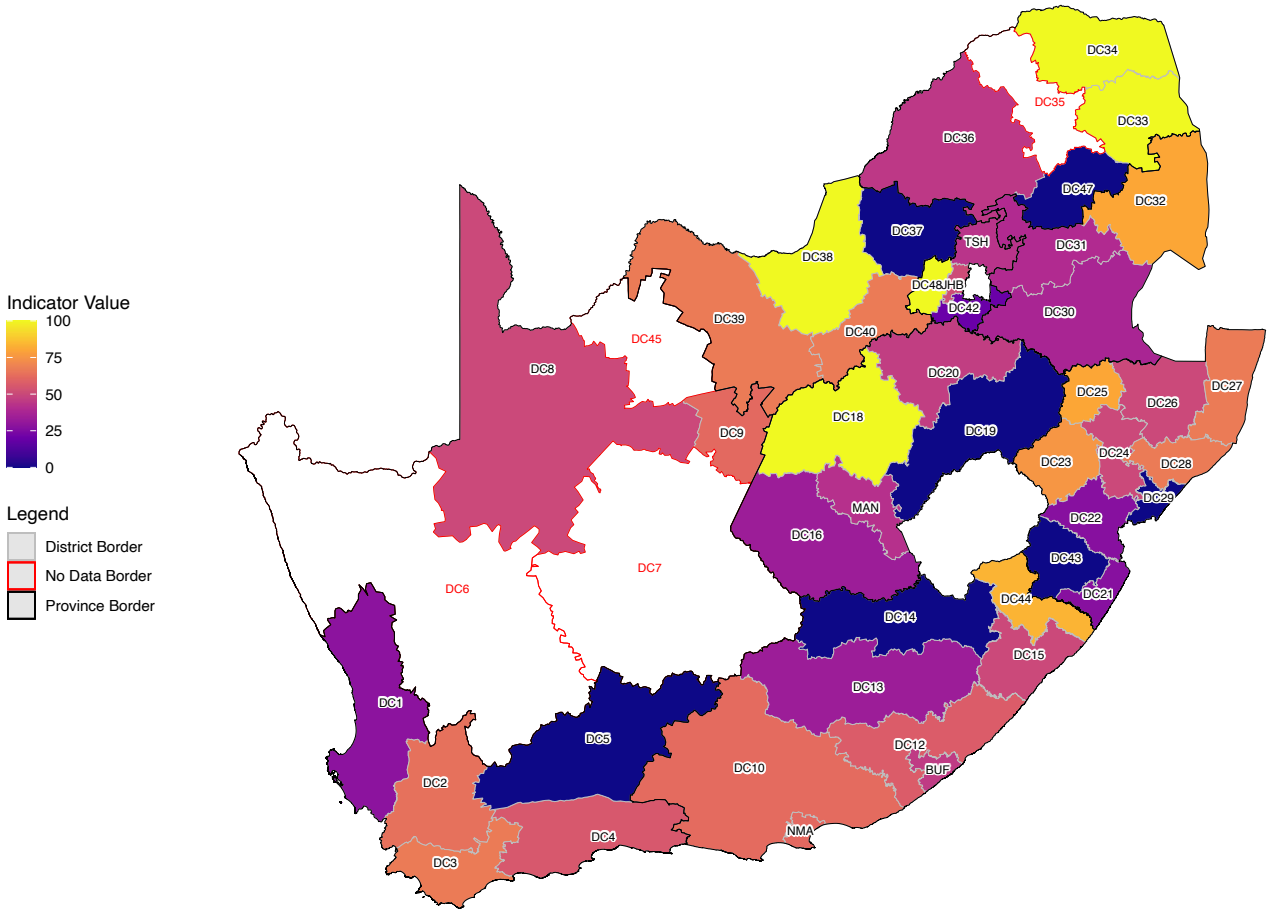


Figure 14 Annual trend: Pre-XDR TB and XDR-TB treatment success rate by district, 2022

Source: EDRWeb



MAP 5 Pre-XDR TB and XDR-TB treatment success rate by district, 2022

Source: EDRWeb

Table 10 Pre-XDR TB and XDR-TB treatment success rate by district, 2020 – 2022 (%)

PROVINCE	DISTRICT	2020	2021	2022	PERCENTAGE POINTS DIFFERENCE BETWEEN 2021 AND 2022
Eastern Cape	A Nzo	66.7	50.0	83.3	+66.7
	Amathole	50.0	50.0	57.1	+14.3
	Buffalo City	49.5	40.8	45.3	+11.1
	C Hani	33.3	42.9	33.3	-22.2
	Joe Gqabi	0	100.0	0	-100.0
	N Mandela Bay	52.6	63.6	61.2	-3.9
	OR Tambo	64.7	80.0	50.0	-37.5
	Sarah Baartman	50.0	50.0	61.9	+23.8
Free State	Fezile Dabi	66.7	66.7	46.2	-30.8
	Lejweleputswa	14.3	75.0	100.0	+33.3
	Mangaung	53.3	37.5	41.7	+11.1
	T Mofutsanyana	100.0	80.0	0	-100.0
	Xhariep	0	100.0	33.3	-66.7
Gauteng	City of Ekurhuleni	50.0	68.4	43.8	-36.1
	Johannesburg	75.0	59.3	51.2	-13.7
	Sedibeng	-	-	20.0	
	Tshwane	33.3	100.0	42.9	-57.1
	West Rand	33.3	0	100.0	

KwaZulu- Natal	Amajuba	54.5	50.0	80.0	+60.0
	eThekwini	58.9	63.5	57.4	-9.7
	Harry Gwala	33.3	-	0	
	iLembe	50.0	25.0	0	-100.0
	King Cetshwayo	28.6	35.7	66.7	+86.7
	Ugu	46.2	0	27.3	
	uMgungundlovu	72.7	57.1	27.3	-52.3
	uMkhanyakude	71.4	100.0	66.7	-33.3
	uMzinyathi	80.0	50.0	50.0	0
	uThukela	50.0	-	75.0	
	Zululand	55.6	66.7	50.0	-25.0
Limpopo	Capricorn	50.0	-	-	
	Mopani	-	100.0	100.0	0
	Sekhukhune	-	0	0	
	Vhembe	75.0	33.3	100.0	+200.0
	Waterberg	57.1	40.0	44.4	+11.1
Mpumalanga	Ehlanzeni	42.9	72.7	80.0	+10.0
	G Sibande	-	0	37.5	
	Nkangala	75.0	75.0	40.0	-46.7
Northern Cape	Frances Baard	57.9	66.7	61.5	-7.7
	JT Gaetsewe	-	-	-	
	Namakwa	-	-	-	
	Pixley Ka Seme	-	-	-	
	ZF Mgcawu	42.9	41.7	50.0	+20.0
North West	Bojanala Platinum	0	25.0	0	-100.0
	Dr K Kaunda	66.7	85.7	66.7	-22.2
	NM Molema	0	-	100.0	
	RS Mompati	0	100.0	66.7	-33.3
Western Cape	Cape Town	49.5	48.7	40.6	-16.6
	Cape Winelands	69.2	59.1	63.6	+7.7
	Central Karoo	-	0	0	
	Garden Route	92.3	15.4	55.6	+261.1
	Overberg	100.0	-	66.7	
	West Coast	46.7	46.7	28.6	-38.8

Source: EDRWeb

Recommendations

- The NDoH should prioritise provinces with the worst TB treatment success rates. Provinces should focus on root cause analyses and improvements on the lowest-performing districts in the country.
- Strategies to ensure an increase in TB treatment success rates include intensive tracking and follow-up of people on TB treatment, improved documentation of patient information, and better data management. Efforts are also required to improve messaging to patients and communities, implement adherence support, and address financial and social protection.
- For MDR-TB, provinces should prioritise implementation of the 6-month shortened treatment regimen, BPaL-L (Bedaquiline, Pretomanid, Linezolid, Levofloxacin).

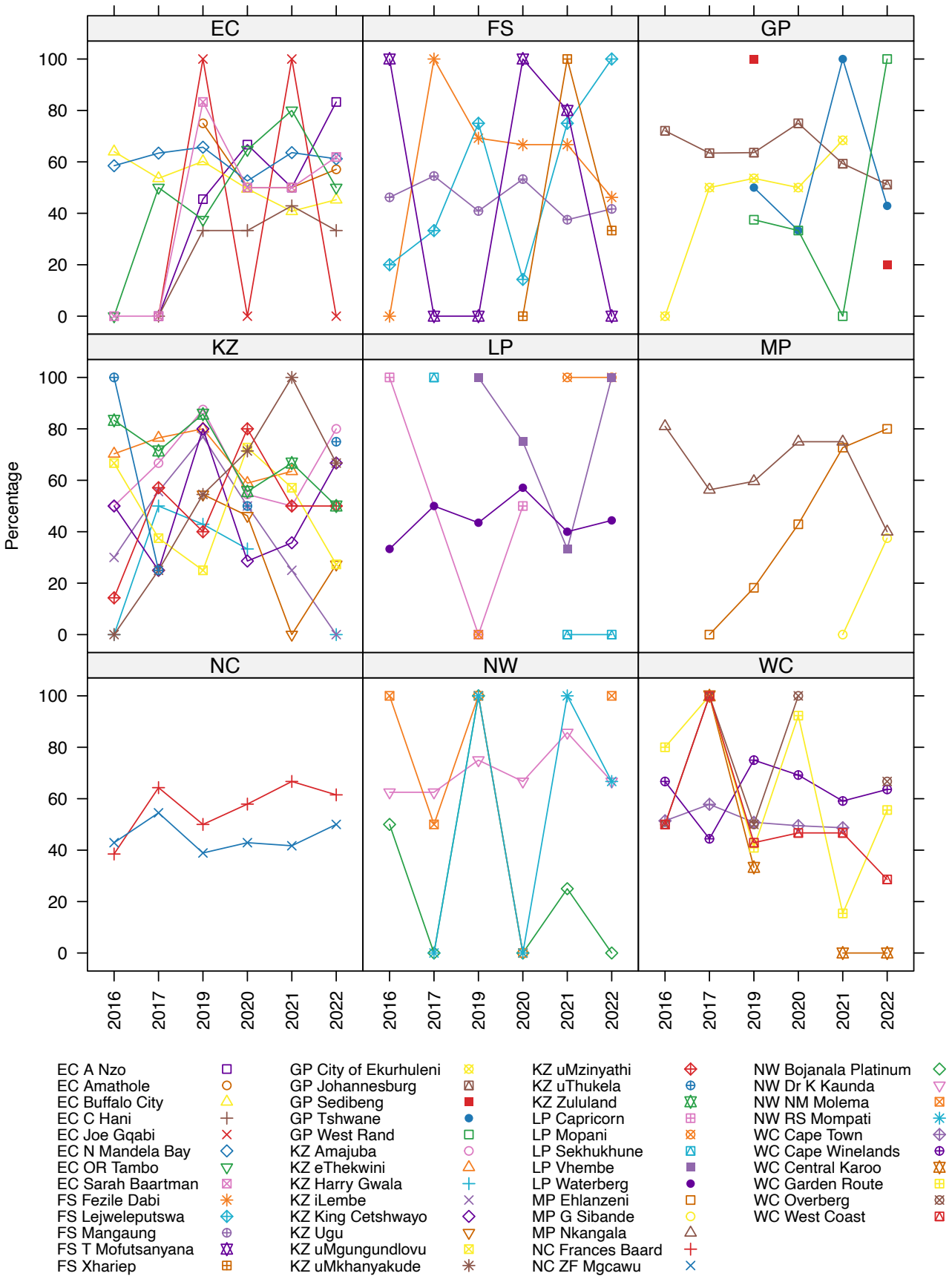


Figure 15 Annual trend: XDR-TB Treament success rate, 2016 - 2022

Source: EDRWeb

2.2 HIV and AIDS

Mhairi Maskew, Gesine Meyer-Rath

Introduction

The end of the first quarter of 2024 marked a significant milestone in the South African HIV/AIDS epidemic – 20 years since the official rollout of South Africa's National antiretroviral therapy (ART) programme. During the past two decades, consistent updates and revisions of the national ART guidelines for adults and children have had important impacts on the national programme's treatment goals including:

- progressive expansion of access to ART by reducing and then removing eligibility criteria for ART initiation to the current era of universal access to same-day ART initiation;
- improving standard ART regimens from multiple tablets with frequent side effects taken several times a day to a once-daily dolutegravir-based combination tablet with better tolerability and a robust genetic barrier against the development of HIV drug resistance;
- early access to life-long triple therapy ART for pregnant and breast-feeding women with resultant dramatic decreases in rates of mother-to-child transmission of HIV nationally, and
- implementing and refining the early infant diagnosis strategy to identify vertical transmissions and link infants to HIV care as soon as possible after birth.

As a result, South Africa's national ART programme is one of the largest globally. In 2023, UNAIDS estimated that 7.7 million [uncertainty interval 7.0–8.3 million] South Africans were living with HIV and 5.9 million of those were currently accessing ART.[1] Since 2010, the rate of new (incident) HIV infections has decreased by 58% and AIDS-related mortality has declined by 66%. Most recently, even HIV prevalence has started declining.[2] Despite these substantial achievements, South Africa has not yet succeeded in its efforts to meet the second and third of the UNAIDS 95–95–95 targets[3] for 2025 aimed at ending HIV as a public health threat by 2030. Specifically, the targets require that 95% of all People Living with HIV (PLHIV) should know their HIV status, 95% of those who know their HIV status should be on treatment, and 95% of those on treatment should achieve viral suppression by 2025. These targets build on the earlier UNAIDS 90–90–90 targets set for 2020, which were not fully achieved. The UNAIDS 95–95–95 targets can also be estimated among all PLHIV, not just those aware of their HIV status or currently receiving treatment. When expressed in this way, the cascade offers a population-level understanding of treatment coverage and viral suppression, and the figures required to achieve the UNAIDS 95–95–95 targets translate to 95–90–86.

One of the key challenges to achieving these goals is successfully retaining clients on ART through to sustained viral suppression. In efforts to address this challenge, the 2023 South African ART Clinical Guidelines[4] has made important strides towards improving efficiency and client-centred practice through integration of HIV care with other health services as well as expansion of differentiated service delivery models to the early treatment period. This approach adopts community- and people-centred strategies and aims to tailor HIV service delivery to meet the specific needs and preferences of PLWHIV while also decongesting high volume ART facilities.

1 Joint United Nations Programme on HIV/AIDS. UNAIDS DATA 2024. Geneva: UNAIDS; 2024. URL: https://www.unaids.org/en/regionscountries/countries/southafrica
2 Johnson LF, et al. The effect of HIV programs in South Africa on national HIV incidence trends, 2000-2019. J Acquir Immune Defici Syndr. 2022;90:115-123.
3 Joint United Nations Programme on HIV/AIDS. Understanding measures of progress towards the 95–95–95 HIV testing, treatment and viral suppression targets. Geneva: UNAIDS; 2023. URL: https://www.unaids.org/sites/default/files/media_asset/progress-towards-95-95-95_en.pdf
4 South African National Department of Health. ART Clinical Guidelines for the Management of HIV in Adults, Pregnancy and Breastfeeding, Adolescents, Children, Infants and Neonates. Pretoria: NDoH; 2023. URL: https://knowledgehub.health.gov.za/elibrary/2023-art-clinical-guidelines-management-hiv-adults-pregnancy-and-breastfeeding-adolescents

Within this context, this section covers three key HIV programmatic indicators for the South African National ART programme in the 2023/24 reporting period, i.e., the time period 1 April 2023 to 31 March 2024:

1. Clients remaining on ART rate;
2. ART client viral load suppressed rate among children and adults, and
3. Antiretroviral effective coverage.

Clients remaining on antiretroviral therapy rate

Key findings

- In March 2024, the total number of clients on antiretroviral therapy (ART) in South Africa, according to DHIS, was 5 549 084 compared to the 5 437 913 in March 2023. Though not yet achieving the Joint United Nations Programme on HIV/AIDS (UNAIDS) target for the second 95 of the 95–95–95 targets, steady progress towards this has been made over the past five years with clients remaining on ART rate. The national ART rate increased by 5.6 percentage points from 65.1% in March 2019 to 70.7% in March 2024.
- The province with the highest clients remaining on ART rate was KwaZulu-Natal (KZ) with a rate of 78.8%, while the Free State (FS) and Mpumalanga (MP) achieved rates of 75.6% and 75.2% respectively. The provinces with the lowest rates were Limpopo (LP) (62.7%) and Western Cape (WC) (61.1%).
- Although no district achieved the second UNAIDS 95 target for clients remaining on ART in March 2024, Johannesburg (Gauteng (GP)) achieved the highest rate of all districts at 93.0%, while Tshwane (GP) recorded the lowest rate at 35.7%.

This section details the rate of clients remaining on ART from a national, provincial, and district perspective. This indicator measures the percentage of estimated people living with HIV who are currently receiving ART among the total estimated population living with HIV. The indicator includes both adults and children. The numerator is the total number of clients remaining on ART at the end of the month and the denominator is the estimated number of PLHIV.

National overview

In March 2024, the total number of clients on ART according to the DHIS was 5 549 084 compared to the 5 437 913 in March 2023. Figure 1 shows the national clients remaining on ART rate from March 2019 to March 2024. Though not yet achieving the target for the second 95, steady progress towards this has been made over the past five years, the rate increased by 5.6 percentage points from 65.1% in March 2019 to 70.7% in March 2024.

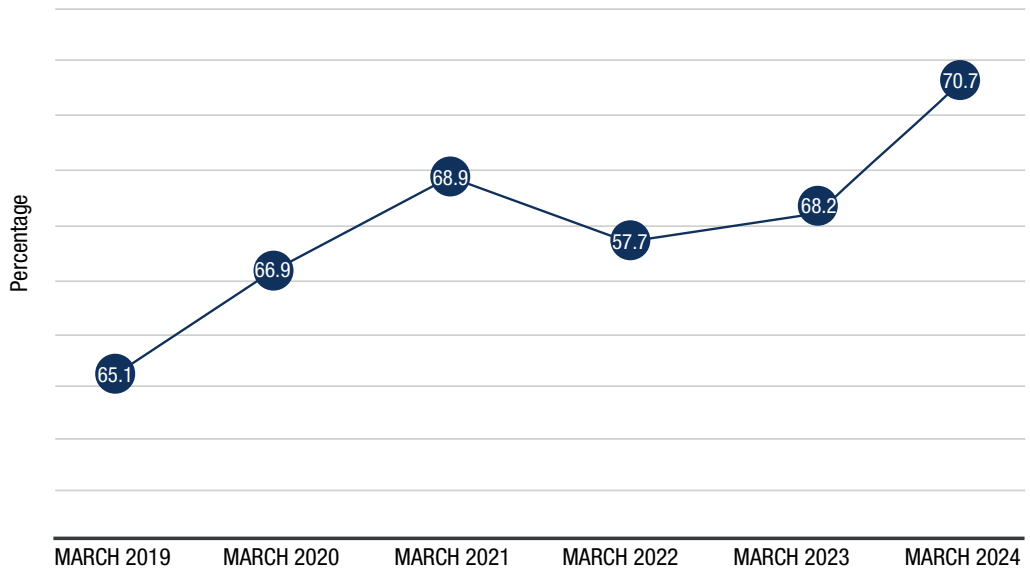


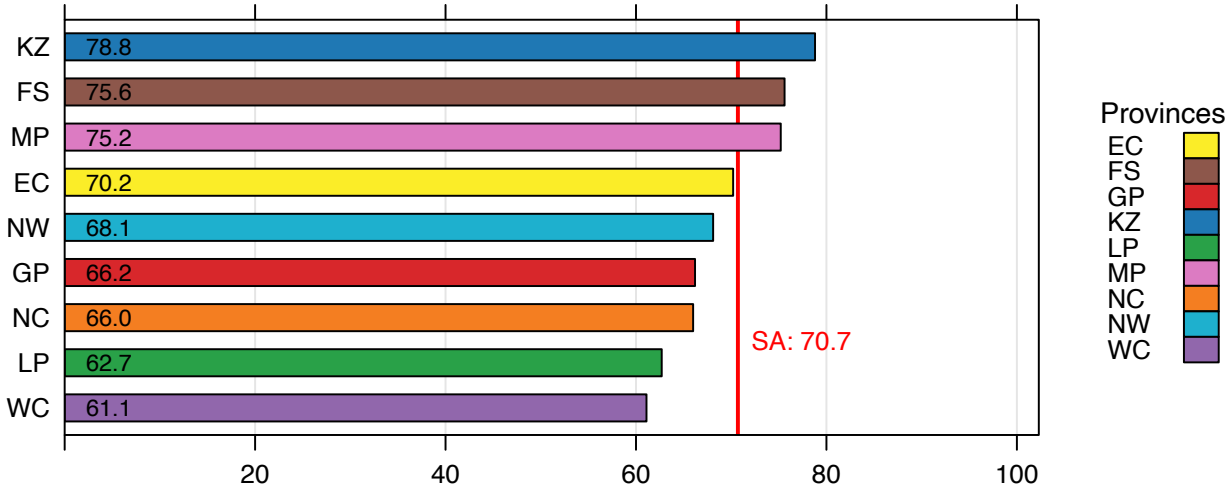
Figure 1 National clients remaining on ART rate, March 2019 – March 2023/24

Source: DHIS

Provincial overview

By the end of March 2024, none of South Africa's nine provinces had achieved the second 95 target (Figure 2). The province with the highest percentage of clients remaining on ART was KZ with a rate of 78.8%, while FS and MP achieved rates of 75.6% and 75.2%, respectively. Overall, the provinces with the lowest rates of clients remaining on ART were LP (62.7%) and WC (61.1%).

Figure 2 Clients remaining on ART rate by province, March 2024



Source: DHIS

Table 1 reports the provincial clients remaining on ART rate annually for the period March 2019–March 2024. During this period, only NC, LP and WC did not report an absolute increase in the client remaining on ART rate. North West recorded the largest absolute increase (10.3 percentage points) from March 2019 to March 2024, while GP had the largest relative increase with an 18.2% increase in clients remaining on ART rate by March 2024. Limpopo recorded the largest decline in clients remaining on ART, with an absolute decrease of 16 percentage points by March 2024 and a relative decrease of 20.3% from March 2019 to March 2024.

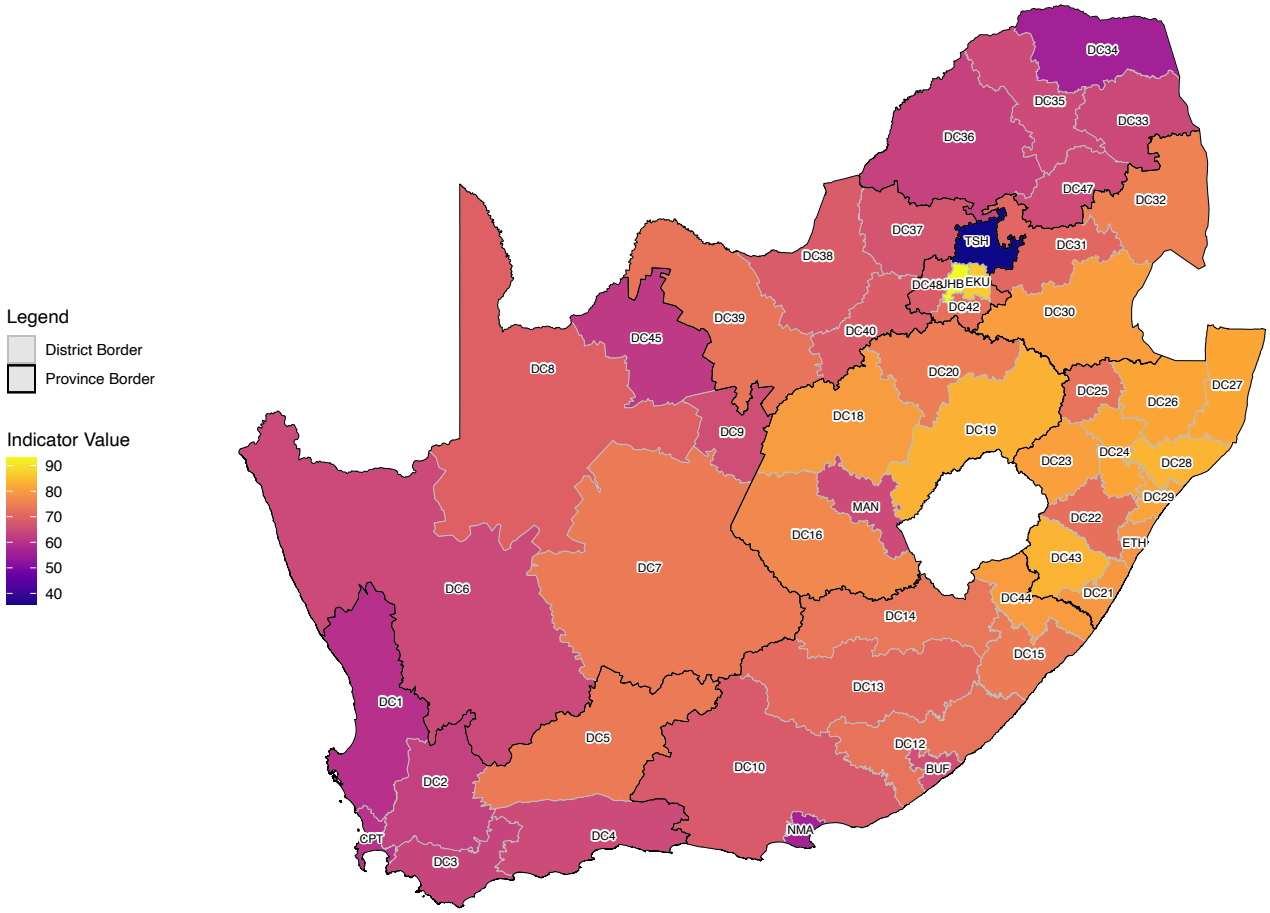
Table 1 Client remaining on ART rate by province, March 2019–March 2024 (%)

PROVINCE	March 2019	March 2020	March 2021	March 2022	March 2023	March 2024	Percentage point difference between 2019 – 2024 (absolute)	Percentage increase between 2019 -2024 (relative)
Eastern Cape	62.9	62.4	63.4	65.6	65.4	70.2	7.3	11.6
Free State	74.1	69.4	71.9	75.7	74.8	75.6	1.5	2.0
Gauteng	56.0	58.9	63.1	62.6	65.7	66.2	10.2	18.2
KwaZulu-Natal	70.5	72.2	78.2	77.6	76.0	78.8	8.3	11.7
Limpopo	78.7	77.8	66.3	59.1	60.4	62.7	-16.0	-20.3
Mpumalanga	68.0	73.1	75.6	73.4	74.1	75.2	7.2	10.5
Northern Cape	73.5	77.5	58.4	56.7	60.6	66.0	-7.5	-10.2
North West	57.8	59.9	65.7	64.8	65.3	68.1	10.3	17.7
Western Cape	63.7	67.1	60.1	54.9	54.4	61.1	-2.6	-4.0

Source: DHIS

District overview

Although no district achieved the second 95 target for clients remaining on ART rate in March 2024, Johannesburg (GP) achieved the highest rate of all districts at 93.0%, while Ekurhuleni (GP) achieved 86.6% (Map 1 and Figure 3). Seven of the top 10 performing districts in March 2024 were in KZ. Tshwane (GP) recorded the lowest rate of clients remaining on ART at 35.7%.



MAP 1 Clients remaining on ART rate by district, 2023/24

Source: DHIS

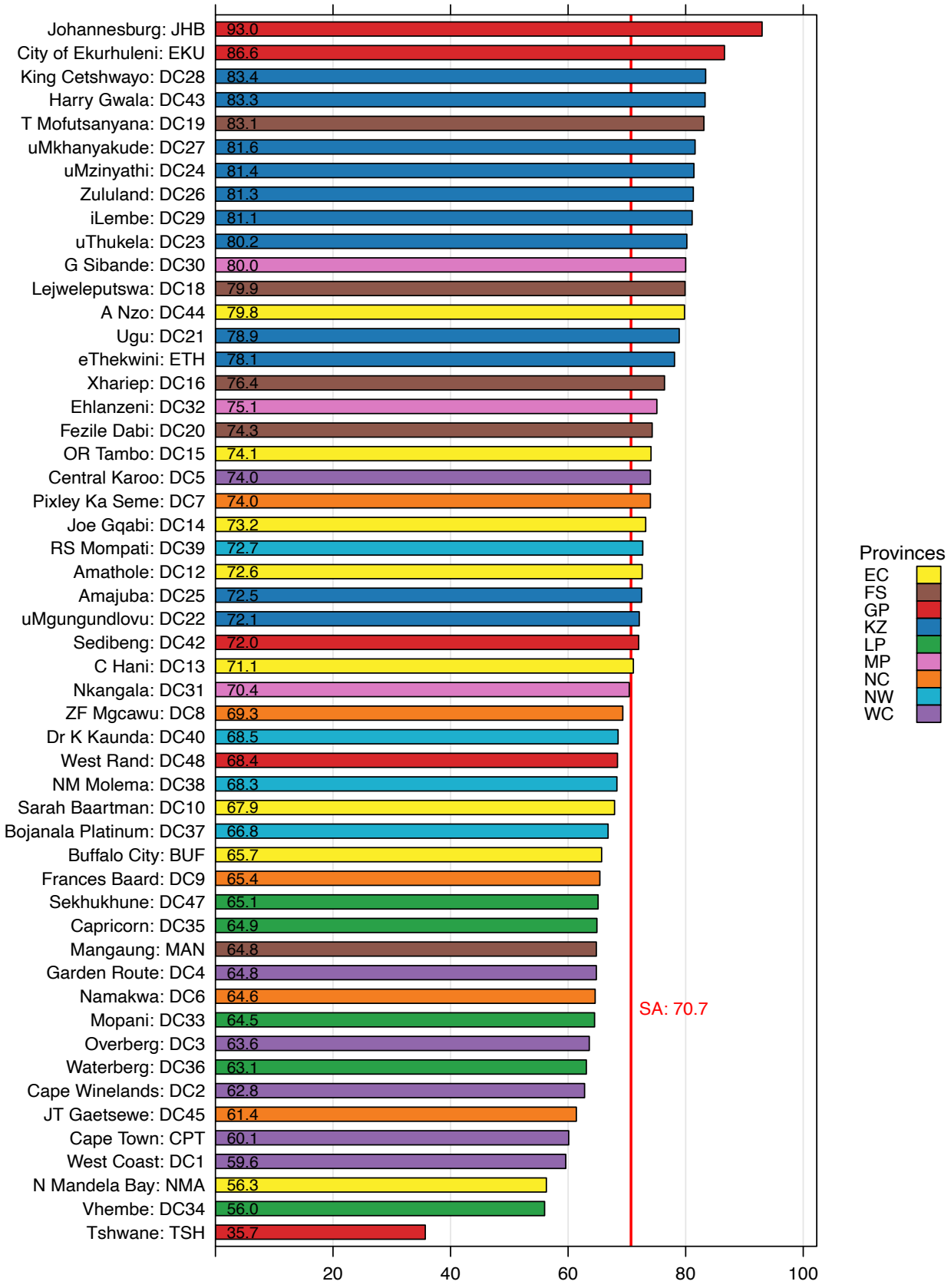


Figure 3 Clients remaining on ART rate by district, 2023/24

Source: DHIS

Comparing March 2023 with March 2024 (Figure 4), WC was the only province where all reporting districts showed an increase in the clients remaining on ART rate. Among the Western Cape districts, the top performing district was the Central Karoo (74.0%). The districts with the largest increases in the rate between March 2023 and March 2024 were Johannesburg (GP) with a 30.3 percentage point increase, Ekurhuleni (GP) with a 25.5 percentage point increase, ZF Mgcawu (NC) with a 22.7 percentage point increase, and West Coast (WC) with a 21.5 percentage point increase. The district with the most marked decline in the clients remaining on ART rate was Tshwane (GP) with a 34.7 percentage point drop between March 2023 and March 2024.

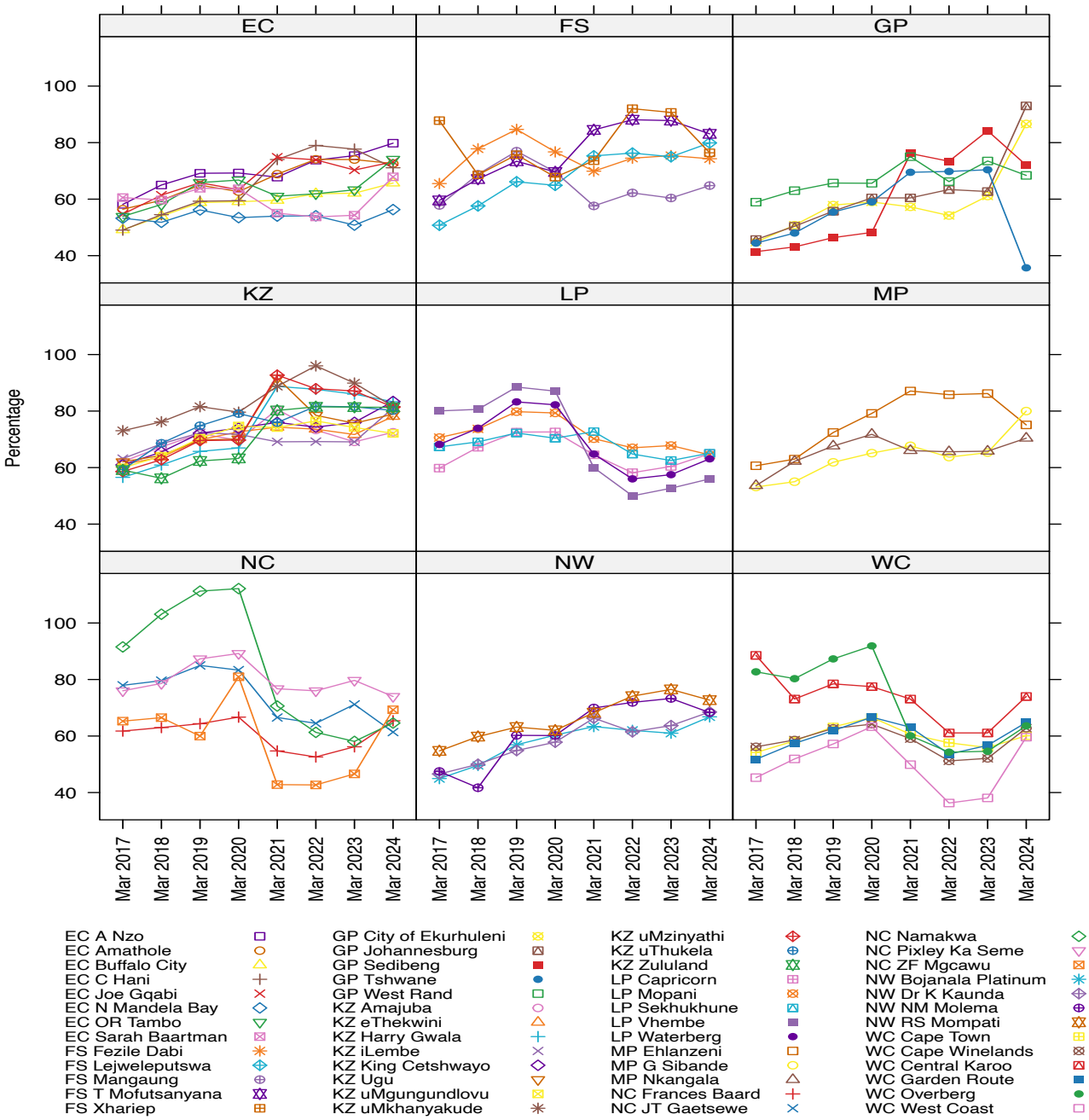


Figure 4 Annual trends in clients remaining on ART rate by province and district, March 2017 - March 2024

Source: DHIS

Recommendations

- Estimates in clients remaining on ART should be monitored closely for accuracy, particularly where estimates differ sharply from annual trends, and should be interpreted in light of changes in data collection or reporting procedures.
- Indicators from districts with high client mobility (such as high-density urban locations) may be more sensitive to the effect of silent transfers, and data from these districts may thus under-estimate numbers of clients remaining on ART.

- Additionally, in districts with highly mobile populations, rates can be artificially high if residents from neighbouring districts prefer accessing treatment in that district, or artificially low if many of the district's residents access care elsewhere.
- Scaled implementation of a national unique client identifier would allow for more accurate reporting of clients remaining on ART robust to client mobility and transfers.
- Continued strengthening of the implementation of the 2023 National Adherence Guidelines is recommended across all provinces, but particularly in districts with large gaps still to cover in order to meet the second 95 target by next year.
- Shifting eligibility for differentiated service delivery options to the fourth month after ART initiation or earlier may assist clients struggling with adherence to HIV care in the early treatment period, thus improving rates of clients remaining on ART at 12 months post initiation. Additionally, strategies to address challenges in continuity of care immediately after ART initiation are still needed.

ART client viral load suppressed rate

- Though not yet achieving the target for the UNAIDS third 95, the national viral load suppressed rate among adults aged 15-years and older increased consistently from 88.1% in Quarter 1 2020 to 92.4% in Quarter 1 2024, only 2.6 percentage points away from achieving the third 95 target.
- KwaZulu-Natal, WC and MP were within two percentage points of achieving the third 95 target, at least for people on ART for 12 months. The Northern Cape (NC) recorded the lowest rate of adult viral suppression at 84.4%.
- In Quarter 1 2024, seven districts achieved the third 95 target for adult viral load suppressed rate at 12 months. The district with the highest rate was Amajuba (KZ) at 97.4% and the district with the lowest was Namakwa (NC) with 72.2% adults virally suppressed at 12 months on ART.
- The national ART client viral load suppressed rate among children aged 0–14 years has remained well below the UNAIDS third 95 target. However, the rate increased by 6.6 percentage points from 60.1% in Quarter 1 2023 to 66.7% in Quarter 1 2024.
- The province with the highest rates of paediatric viral suppression in Quarter 1 2024 was FS with a rate of 81.2% and the province with the lowest was NC (20.0%).
- Two districts, Joe Gqabi (Eastern Cape (EC)) (n=197) and Xhariep (FS) (n=286) recorded 100% viral suppression among children 0–14 years in Quarter 1 2024. The districts with the lowest recorded rates of children with viral load suppressed at 12 months on ART were Amathole (EC) at 36.8%, RS Mompati (NW) at 36.4%, and ZF Mgcawu (NC) at 14.3%.

Suppression of HIV viral load to undetectable limits remains the overarching goal of ART. Monitoring of HIV viral load suppressed rates serves several important purposes: 1) monitoring individual health and treatment outcomes; 2) tracking progress towards national targets and ART programme goals and understanding population viremia levels; 3) assisting in encouraging clients to improve adherence, and 4) identifying potential for development of drug resistance.

ART client HIV viral load suppressed rate is estimated as the proportion of HIV-positive people on ART with viral load suppressed at different time intervals. This indicates the population level immunological impact of clients on ART. For this report, the time point reported is at 12 months on ART as reported in the DHIS. Suppression rates are reported separately for adults (aged 15-years and older) and children (0–14 years). The numerator is the total number of clients on ART with viral load suppressed at 12 months and the denominator is the total number living with HIV.

National overview

Figure 5 shows the national ART client viral load suppressed rate at 12 months, over the period Quarter 1 2020 to Quarter 1 2024, by age group. Though not yet achieving the target for the third 95, the viral load suppressed rate among adults aged 15-years and older increased consistently from 88.1% in Quarter 1 2020 to 92.4% in Quarter 1 2024; only 2.6 percentage points away from achieving the UNAIDS third 95 target and consistently above the cascade target of 86%. While the national ART client viral load suppressed rate among children aged 0–14 years at 12 months has remained well below the 95 target, a 6.6 percentage point increase from 60.1% to 66.7% was recorded between Quarter 1 2023 and Quarter 1 2024, according to DHIS estimates.

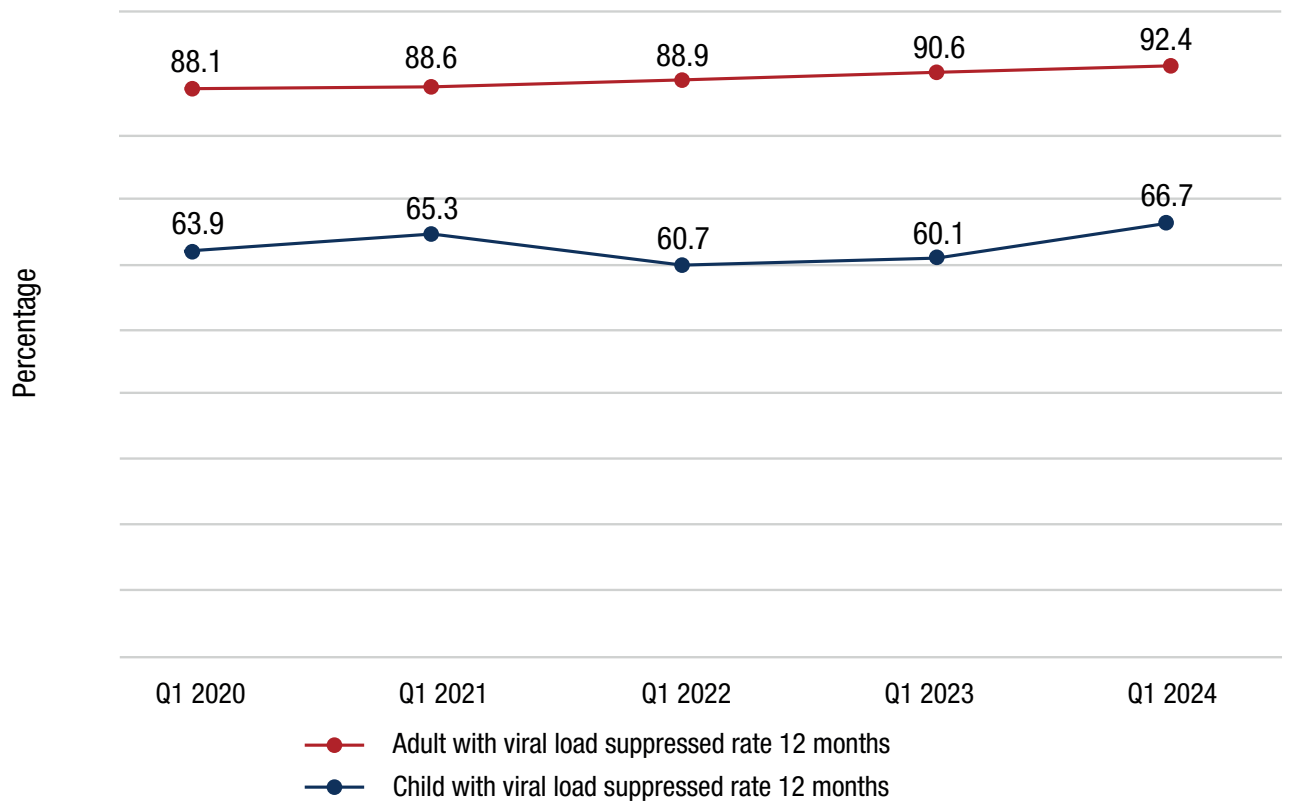


Figure 5 National ART client viral load suppressed rate at 12 months by age group, Quarter 1 2020 – Quarter 1 2024

Source: DHIS

Provincial overview

Although no province achieved the third 95 target for adults by the end of the first quarter of 2024, all nine provinces, with the exception of NC, had achieved viral load suppression rates of more than 90% (Figure 6) within 12 months on ART. KwaZulu-Natal, WC and MP were within two percentage points of achieving the third 95 target, at least for people on ART for 12 months. Northern Cape recorded the lowest rate of adult viral suppression at 84.4%.

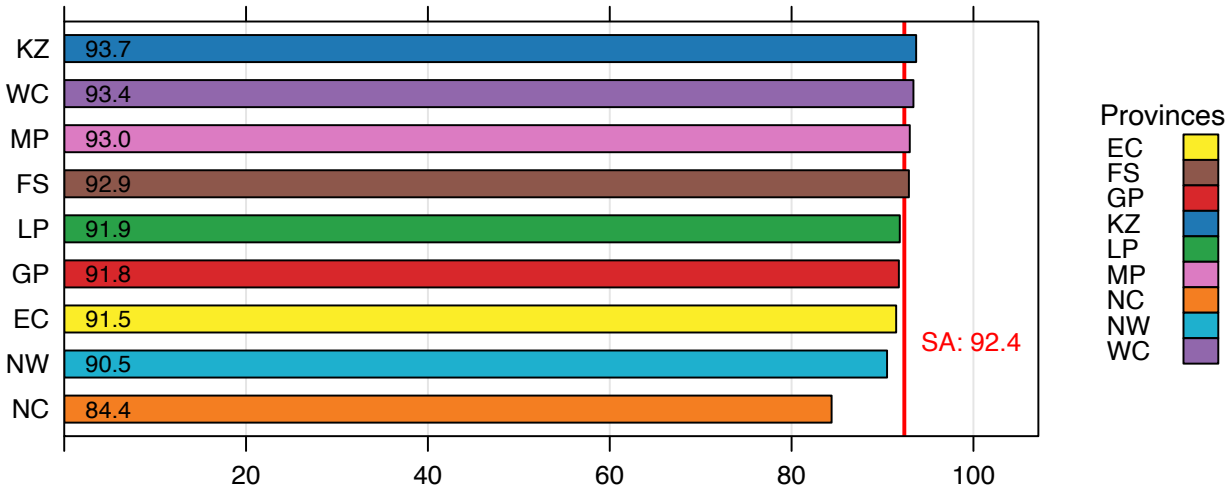


Figure 6 Adult with viral load suppressed rate 12 months by province, Quarter 1 2024

Source: DHIS

The child 0 to 14 years with viral load suppressed rates at 12 months were lower than adult rates across all provinces (Figure 7). The province with the highest rate in Quarter 1 2024 was FS with a rate of 81.2%, while KZ and MP provinces achieved rates of 73.8% and 66.5%, respectively. Overall, the province with the lowest rate of viral load suppression among children 0 to 14 years was NC (20.0%).

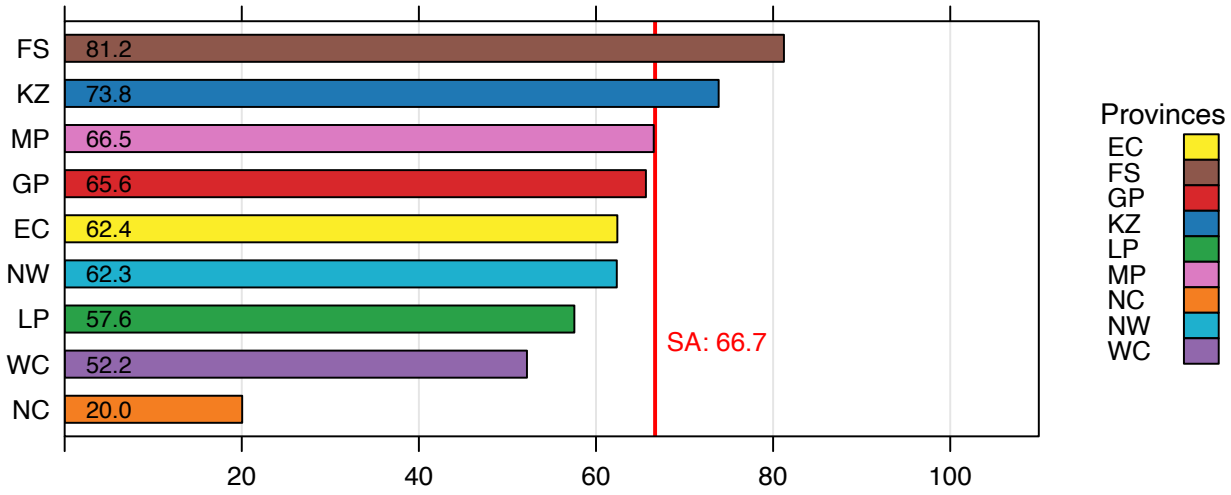
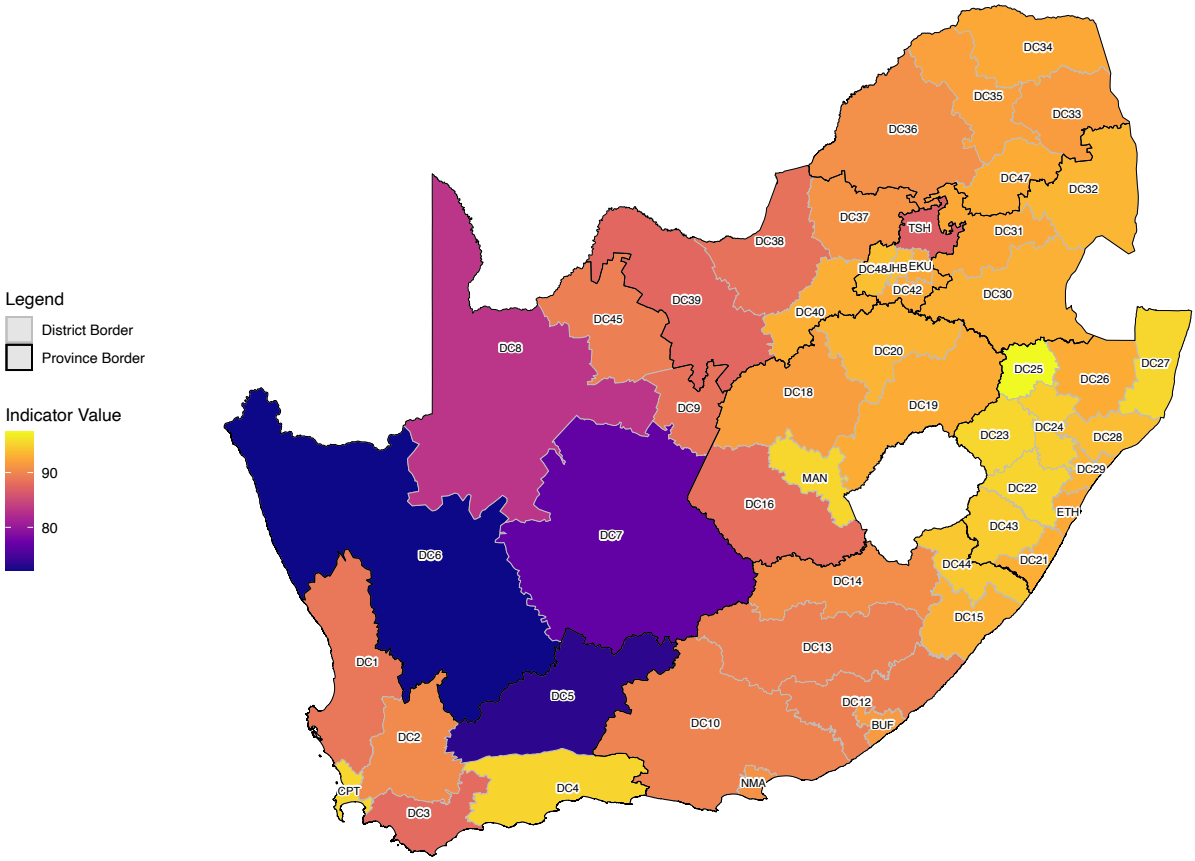


Figure 7 Child with viral load suppressed rate 12 months by province, Quarter 1 2024

Source: DHIS

District overview

In the first quarter of 2024, seven districts achieved the third 95 target for adult viral load suppressed rate at 12 months (Map 2, Figure 8). The district recording the highest rate of adult viral load suppression was Amajuba (KZ) at 97.4%. Six of the top 10 performing districts were from KZ, and four of these had achieved the third 95 target among adults in Quarter 1 2024. The district with the lowest recorded rate of adult viral suppression was Namakwa (NC) with 72.2% adults virally suppressed at 12 months on ART.



MAP 2 Adult with viral load suppressed rate at 12 months by district, Quarter 1 March 2024

Source: DHIS

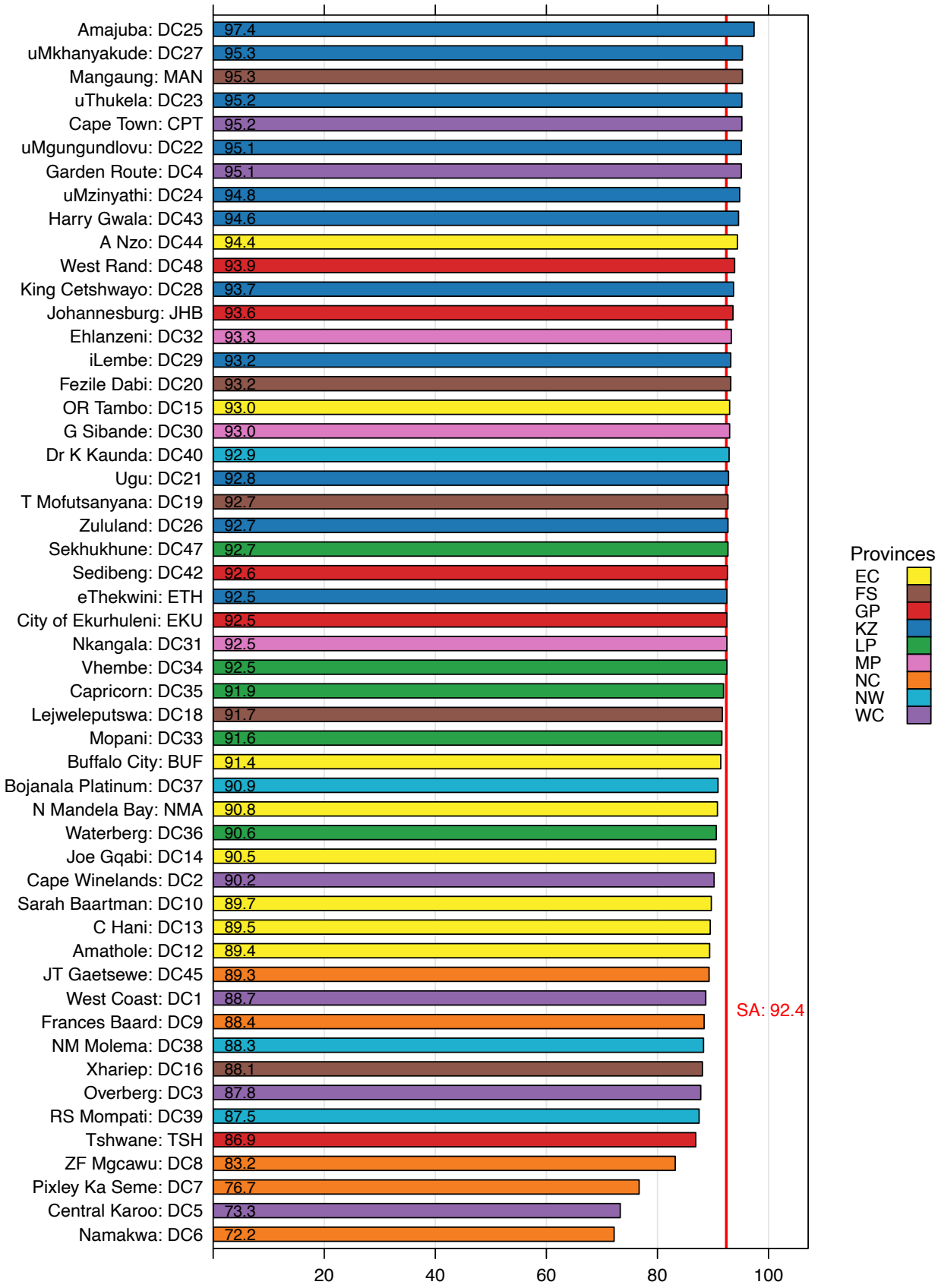
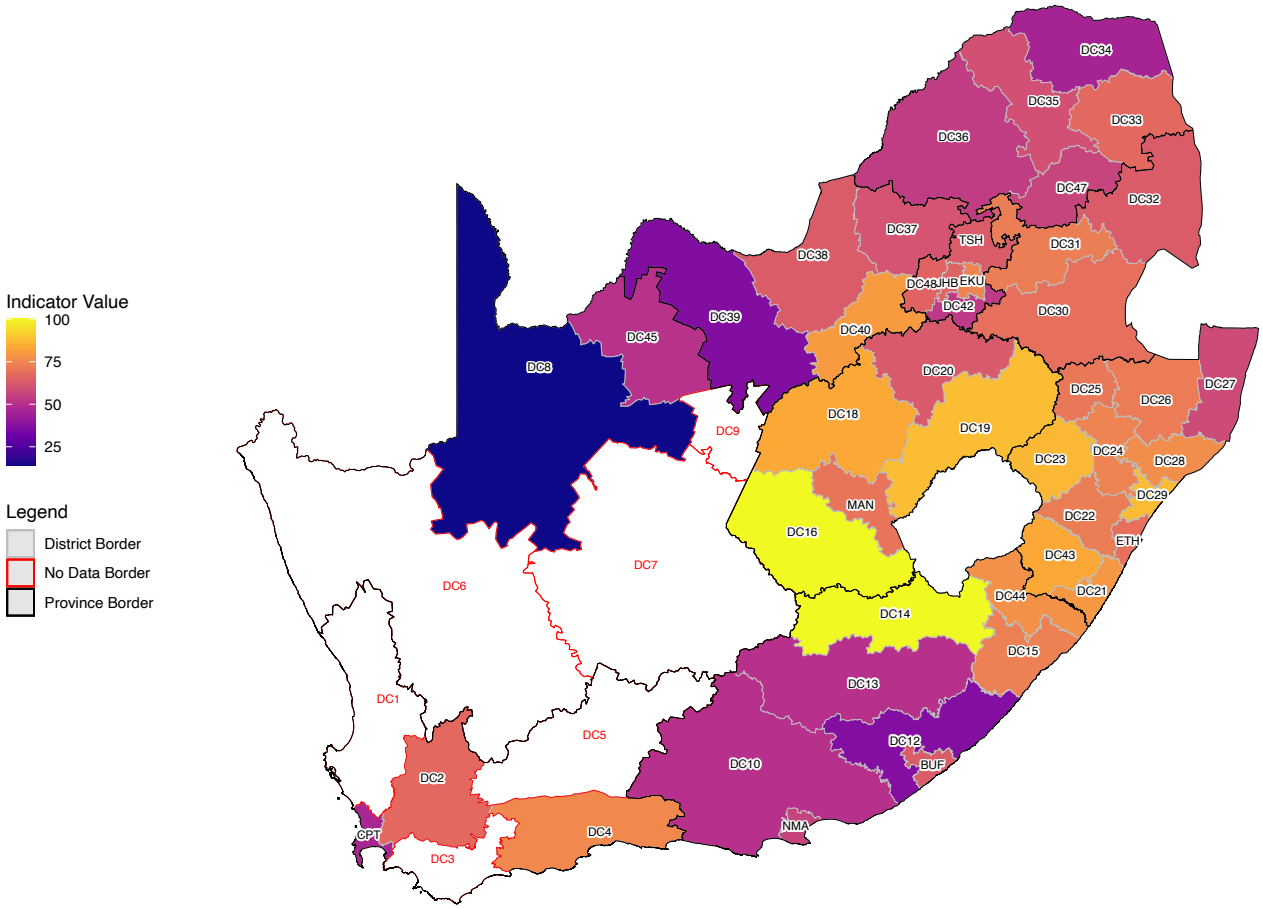


Figure 8 Adult with viral load suppressed rate at 12 months by district, Quarter 1 2024

Source: DHIS

Two districts, Joe Gqabi (EC) (n=197) and Xhariep (FS) (n=286), recorded 100% viral suppression among children 0–14 years in Quarter 1 2024 (Map 3, Figure 9). A review of the accuracy of these estimates should be considered before conclusions are drawn from these data. No other district achieved the third 95 target for viral load suppression among children in this reporting period. Four of the top 10 performing districts were in KZ. The districts with the lowest recorded rates of children with viral load suppressed at 12 months on ART were Amathole (EC) at 36.8%, RS Mompati (NW) at 36.4%, and ZF Mgcawu (NC) at 14.3%. Six districts did not report estimates for viral suppression rates among children in March 2024; three of these were districts in NC and three were in WC.



MAP 3 Child with viral load suppressed rate at 12 months by district, Quarter 1 2024

Source: DHIS

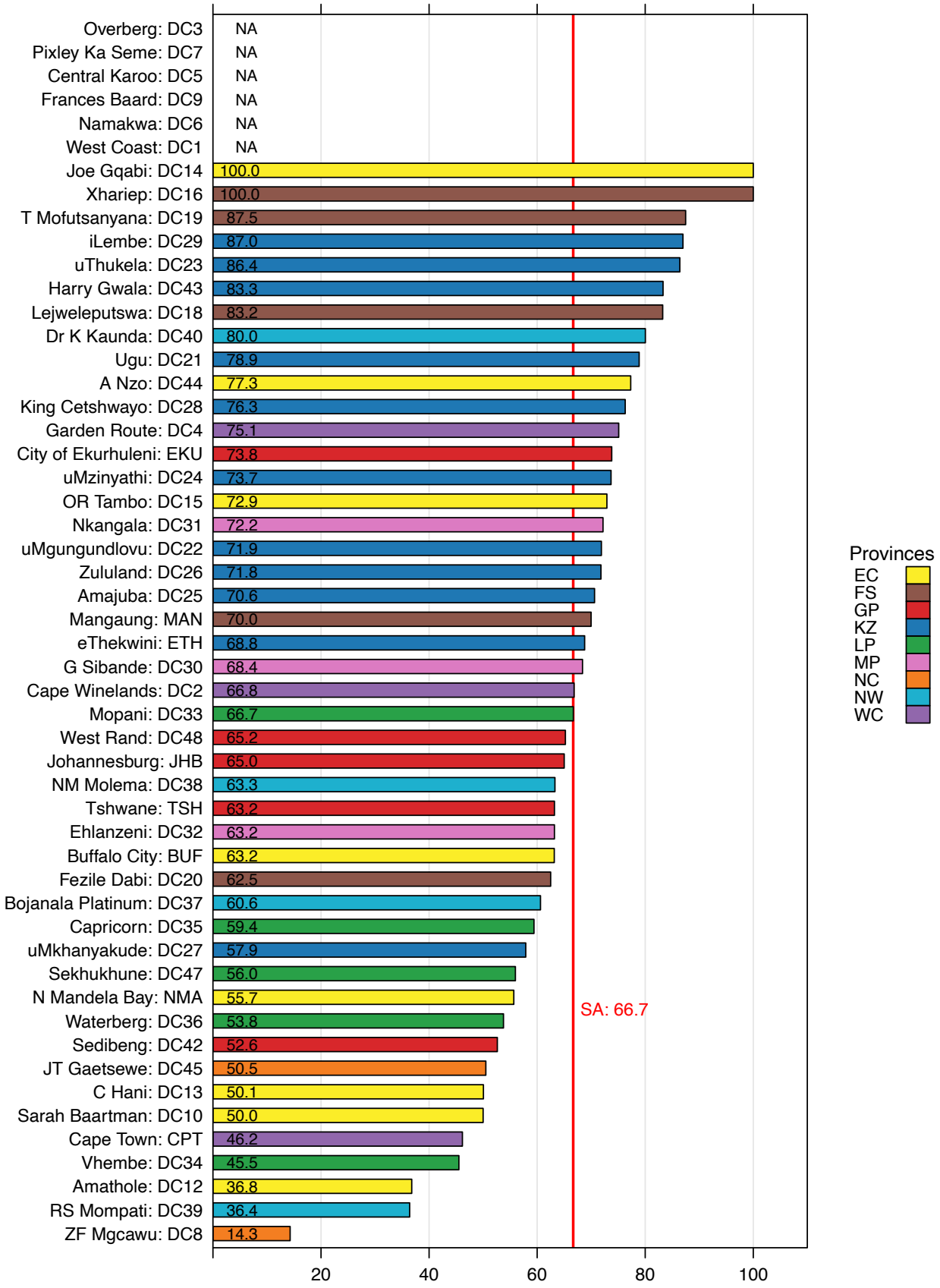


Figure 9 Child with viral load suppressed rate at 12 months by district, March 2024

Source: DHIS

The adult viral load suppressed rate at 12 months decreased in 12 districts between Quarter 1 2023 and Quarter 1 2024, and the child viral load suppressed rate at 12 months decreased in 19 districts in the same period (Table 2). For adult with viral load suppressed rate at 12 months, the biggest decrease was in Namakwa (NC) with 27.8 percentage points, and for the child viral load suppressed rate at 12 months it was in Fezile Dabi (FS) with 37.5 percentage points. No data were reported for Quarter 1 2024 in West Coast, Overberg, Central Karoo (all WC) and Pixey Ka Seme (NC).

Table 2 Adult with viral load suppressed rate at 12 months and child with viral load suppressed rate at 12 months by district, Quarter 1 2023 – Quarter 1 2024 (%)

Province	District	Adult with viral load suppressed rate at 12 months			Child with viral load suppressed rate at 12 months		
		Q1 2023	Q1 2024	Percentage point difference between Q1 2023 and Q1 2024	Q1 2023	Q1 2024	Percentage point difference between Q1 2023 and Q1 2024
Eastern Cape	Alfred Nzo	93.9	94.4	0.5	84.6	77.3	-7.3
	Amathole	90.0	89.4	-0.6	50.0	36.8	-13.2
	Buffalo City	90.7	91.4	0.7	80.0	63.2	-16.8
	Chris Hani	89.5	89.5	0.0	66.7	50.1	-16.6
	Joe Gqabi	92.9	90.5	-2.4	60.0	100.0	40.0
	Nelson Mandela Bay	86.7	90.8	4.1	54.5	55.7	1.2
	OR Tambo	91.1	93.0	1.9	62.5	72.9	10.4
	Sarah Baartman	87.6	89.7	2.1	40.0	50.0	10.0
Free State	Fezile Dabi	90.9	93.2	2.3	100.0	62.5	-37.5
	Lejweleputswa	87.3	91.7	4.4	28.6	83.2	54.6
	Mangaung	92.9	95.3	2.4	57.1	70.0	12.9
	T Mofutsanyana	91.7	92.7	1.0	65.4	87.5	22.1
	Xhariep	94.5	88.1	-6.4		100.0	100.0
Gauteng	Ekurhuleni	89.0	92.5	3.5	65.2	73.8	8.6
	Johannesburg	92.4	93.6	1.2	52.3	65.0	12.7
	Sedibeng	90.1	92.6	2.5	39.1	52.6	13.5
	Tshwane	83.3	86.9	3.6	43.8	63.2	19.4
	West Rand	93.2	93.9	0.7	58.8	65.2	6.4
KwaZulu-Natal	Amajuba	95.9	97.4	1.5	61.5	70.6	9.1
	eThekwini	91.1	92.5	1.4	67.4	68.8	1.4
	Harry Gwala	91.9	94.6	2.7	64.3	83.3	19.0
	iLembe	90.8	93.2	2.4	61.9	87.0	25.1
	King Cetshwayo	92.1	93.7	1.6	80.0	76.3	-3.7
	Ugu	91.0	92.8	1.8	100.0	78.9	-21.1
	uMgungundlovu	92.3	95.1	2.8	68.8	71.9	3.1
	uMkhanyakude	92.4	95.3	2.9	40.9	57.9	17.0
	uMzinyathi	91.4	94.8	3.4	58.3	73.7	15.4
	uThukela	91.1	95.2	4.1	64.3	86.4	22.1
	Zululand	89.9	92.7	2.8	68.3	71.8	3.5
Limpopo	Capricorn	89.7	91.9	2.2	66.7	59.4	-7.3
	Mopani	91.3	91.6	0.3	50.0	66.7	16.7
	Sekhukhune	88.3	92.7	4.4	70.6	56.0	-14.6
	Vhembe	91.5	92.5	1.0	39.1	45.5	6.4
	Waterberg	87.9	90.6	2.7	46.7	53.8	7.1
Mpumalanga	Ehlanzeni	91.7	93.3	1.6	56.8	63.2	6.4
	Gert Sibande	92.8	93.0	0.2	75.9	68.4	-7.5
	Nkangala	90.7	92.5	1.8	50.0	72.2	22.2

Northern Cape	Frances Baard	92.3	88.4	-3.9			0.0
	JT Gaetsewe	82.2	89.3	7.1	66.7	50.5	-16.2
	Namakwa	100.0	72.2	-27.8			0.0
	Pixley Ka Seme	88.5	76.7	-11.8	100.0		-100.0
	ZF Mgcawu	81.8	83.2	1.4	40.0	14.3	-25.7
North West	Bojanala Platinum	90.0	90.9	0.9	63.3	60.6	-2.7
	Dr K Kaunda	89.3	92.9	3.6	58.3	80.0	21.7
	NM Molema	89.6	88.3	-1.3	65.0	63.3	-1.7
	RS Mompati	88.5	87.5	-1.0	50.0	36.4	-13.6
Western Cape	Cape Town	94.6	95.2	0.6	70.8	46.2	-24.6
	Cape Winelands	90.6	90.2	-0.4		66.8	66.8
	Central Karoo	78.9	73.3	-5.6			0.0
	Garden Route	93.9	95.1	1.2	75.0	75.1	0.1
	Overberg	93.2	87.8	-5.4	50.0		-50.0
	West Coast	89.6	88.7	-0.9	100.0		-100.0

Source: DHIS

Recommendations

- Rates of viral load suppression reported by these indicators should be interpreted in conjunction with estimates of viral load test completion rates among adults and children. Estimates of viral load test completion rate at 12 months on ART was 71.1% in Quarter 1 2019. High rates of viral suppression in a small subset of the population will not be sufficient to achieve overall programmatic goals despite reaching reported indicator targets.
- The adult with viral load suppressed rate at 12 months is close to achieving the third 95 target in several provinces. Provinces and districts recording limited progress or declines in viral suppression rates should be prioritised for support to achieve these goals. Strengthening the implementation of the 2023 National ART adherence guidelines may improve continuity of HIV care through successful viral suppression.
- Children remain a priority group for strengthening viral load monitoring and suppression targets across all provinces. Optimisation of early infant diagnosis and linkage to care strategies will support progress towards reducing the gap between viral suppression rates among adults and children.
- Combined assessments of the data of maternal-infant pairs may identify programmatic differences between adult and paediatric HIV care service delivery that are driving lower viral suppression rates among children. Opportunities to align and integrate adult HIV service delivery with infant/ paediatric care should be pursued.

Antiretroviral effective coverage

- In Quarter 1 2024, national antiretroviral effective coverage was estimated at 50.9% among adults 15-years and older, a 7.4 percentage point increase from 43.5% in Quarter 1 2019. The antiretroviral effective coverage among children 0 to 14 years was lower than adult rates across all time points observed, and the Quarter 1 2024 rate of 24.8% represents a 4.2 percentage point increase since Quarter 1 2019 (20.6%).
- Mpumalanga (MP) recorded the highest rate of antiretroviral coverage among adults at 62.4% followed by KZ at 61.4%. Western Cape (WC) recorded the lowest antiretroviral effective coverage rate in Quarter 1 2024 at 13.1%.
- The provincial antiretroviral effective coverage rates among children 0-14 years were lower than adult rates across all provinces. KwaZulu-Natal recorded the highest coverage rate for children (31.3%), followed by NW (27.4%). Northern Cape (NC) recorded the lowest coverage at 2.7%.
- Among clients 15-years and older, coverages ranged from 68.1% in uMzinyathi (KZ) and Zululand (KZ), to 11.0% in Cape Town (WC) in Quarter 1 2024. Six of the top 10 performing districts in Quarter 1 2024 were from KZ, while half of the 10 districts with lowest recorded antiretroviral effective coverage rates for Quarter 1 2024 were in WC.

- Antiretroviral effective coverage rates among children 0–14 years also varied by district, though all rates were consistently below estimates recorded among clients 15-years and older. Xhariep (FS) recorded the highest coverage rate of 55.4% in Quarter 1 2024, while the lowest recorded estimate for children 0–14 years was 5.4% in JT Gaetsewe and 6.8% in ZF Mgcawu (both NC).

The antiretroviral effective coverage indicator estimates the proportion of PLHIV who are on ART and virally suppressed at 12 months after initiation out of all PLHIV. Data for this indicator is sourced from DHIS. The indicator numerator is the total number of clients on ART with HIV viral load suppressed at 12 months and the denominator is the total estimated number of PLHIV.

National Overview

Figure 10 summarises the national antiretroviral effective coverage rate by age group from Quarter 1 2019 to Quarter 1 2024. In Quarter 1 2024, national coverage was estimated at 50.9% among adults 15 years and older, a 7.4 percentage point increase from 43.5% in Quarter 1 2019. Estimates of antiretroviral effective coverage among children 0 to 14 years were lower than adult rates across all time points observed, and the Quarter 1 2024 rate of 24.8% recorded a 4.2 percentage point increase since Quarter 1 2019 (20.6%).

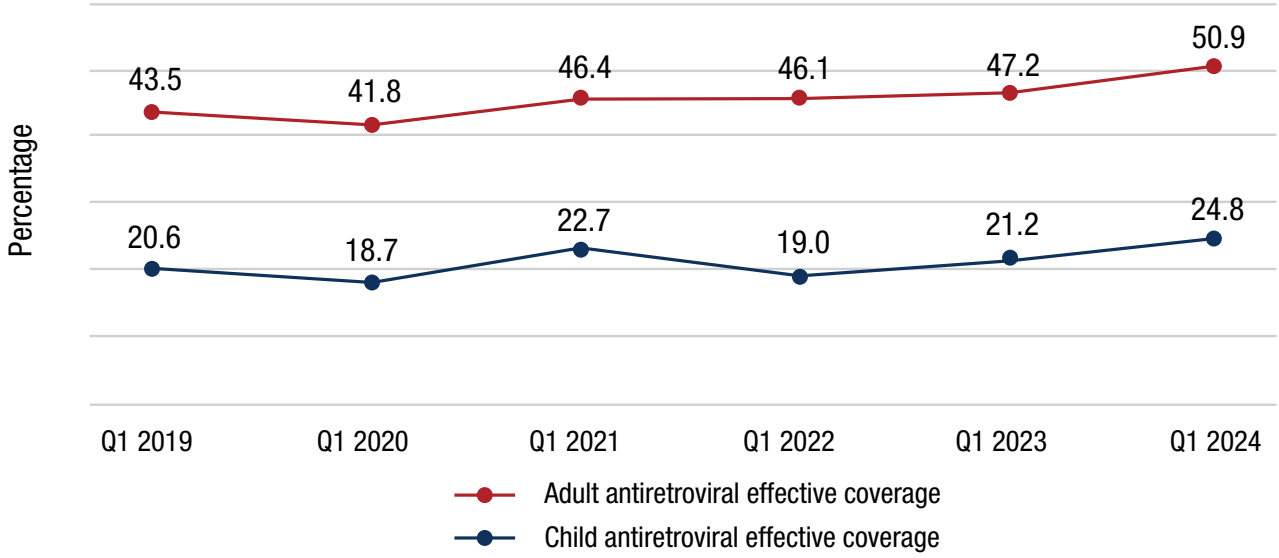


Figure 10 National antiretroviral effective coverage by age group, Q1 2019 – Q1 2024
Source: DHIS

Provincial overview

In Quarter 1 2024, MP recorded the highest rate of antiretroviral coverage among adults at 62.4% followed by KZ at 61.4% (Figure 11). The Western Cape recorded the lowest antiretroviral effective coverage rate in Quarter 1 2024 at 13.1%, though this data point should be reviewed for accuracy based on other indicators. North West recorded the largest increase in coverage with a 21.5 percentage point increase in Quarter 1 2024 compared to Quarter 1 2019 (Table 3). All provinces except NC and WC recorded increases in antiretroviral coverage rate among adults.

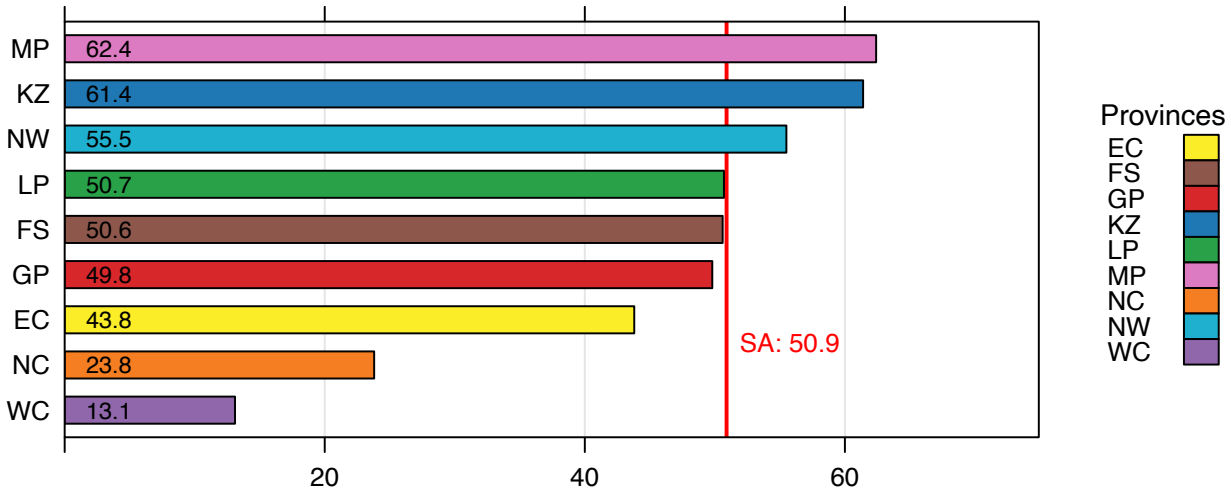


Figure 11 Provincial antiretroviral effective coverage among clients 15+ years, 2024

Source: DHIS

Table 3 Antiretroviral effective coverage 15 years and older by province, Quarter 1 2018–Quarter 1 2024 (%)

PROVINCE	Quarter 1 2018	Quarter 1 2019	Quarter 1 2020	Quarter 1 2021	Quarter 1 2022	Quarter 1 2023	Quarter 1 2024	Percentage point difference Q1 2018-Q1 2024 (Absolute)	Percentage difference Q1 2018-Q1 2024 (Relative)
Eastern Cape	36.8	38.2	37.8	40.7	40.7	40.8	43.8	7.0	19.1
Free State	44.1	46.6	39.9	44.9	51.1	49.2	50.6	6.5	14.8
Gauteng	37.4	41.1	41.6	45.6	46.0	46.4	49.8	12.4	33.2
KwaZulu-Natal	46.5	49.0	49.0	53.5	57.3	58.2	61.4	14.9	32.0
Limpopo	49.7	53.7	53.6	45.6	37.5	45.2	50.7	1.0	2.0
Mpumalanga	45.9	50.9	52.5	51.3	52.0	57.5	62.4	16.5	35.9
Northern Cape	30.2	26.4	17.8	23.0	22.5	18.5	23.8	-6.4	-21.1
North West	34.0	38.2	37.7	44.3	44.8	50.5	55.5	21.5	63.4
Western Cape	37.0	24.1		33.0	20.1	11.5	13.1	-23.9	-64.6

Source: DHIS

In Quarter 1 2024, the provincial antiretroviral effective coverage rates among children 0–14 years were lower than adult rates across all provinces (Figure 12). KwaZulu-Natal recorded the highest coverage rate for children 0–14 years (31.3%) followed by NW. The NC recorded the lowest estimates at 2.7%.

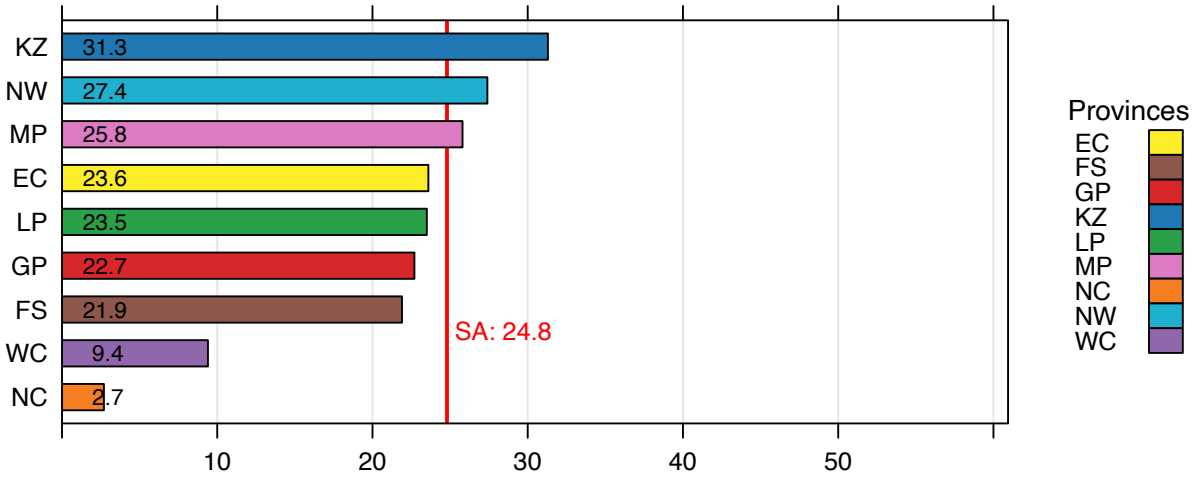
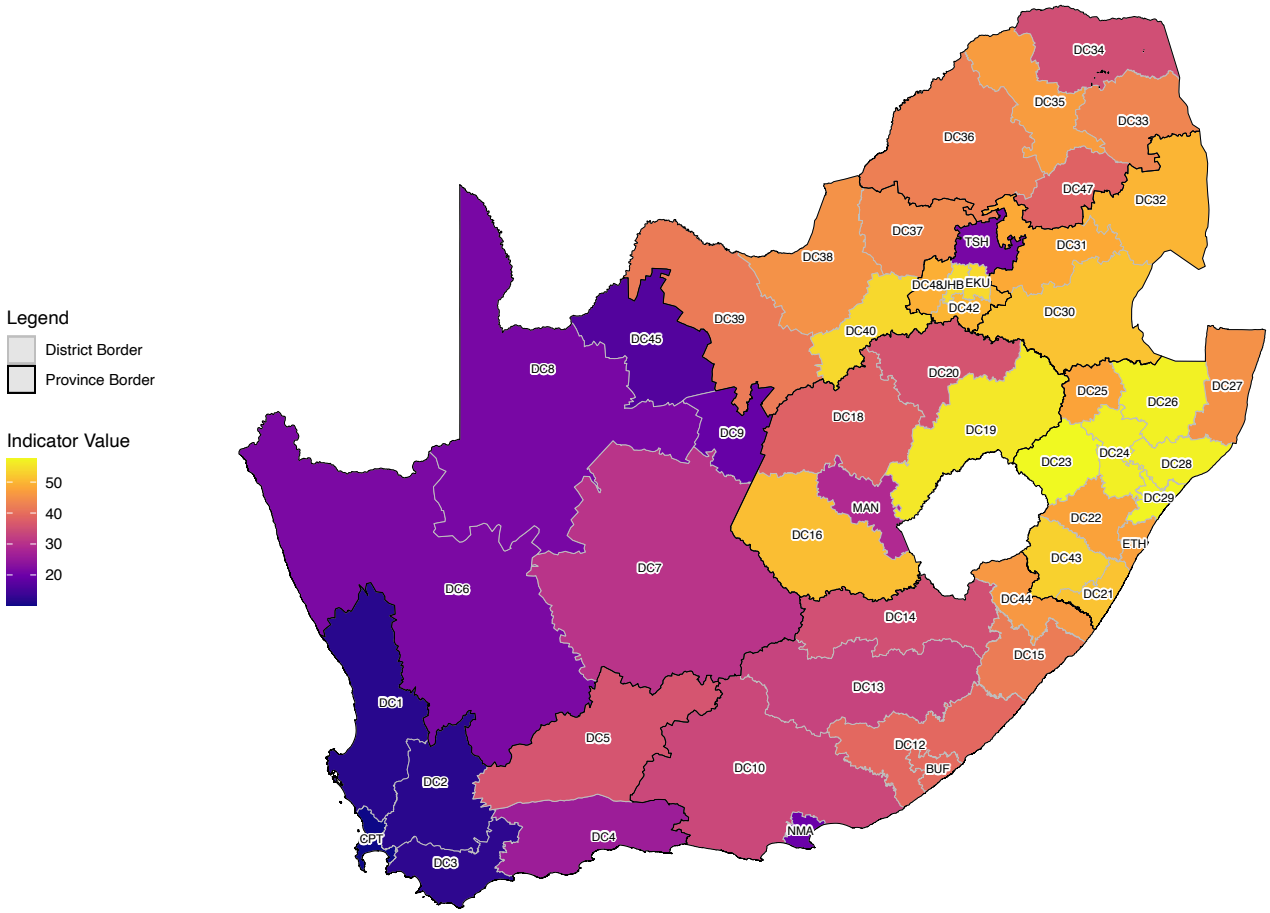


Figure 12 Antiretroviral effective coverage among children 0–14 years by province, 2024

Source: DHIS

District overview

District estimates of antiretroviral effective coverage among clients 15 years and older varied widely by district (Map 4 and Figure 13). Coverages ranged from 68.1% in uMzinyathi (KZ) and Zululand (KZ) to 11.0% in Cape Town (WC) in Quarter 1 2024. Six of the top 10 performing districts in Quarter 1 2024 were from KZ, while half of the 10 districts with lowest recorded antiretroviral effective coverage rates for Quarter 1 2024 were in WC. Several provinces have made steady increases in antiretroviral effective coverage over recent years (Figure 14) while Johannesburg and Ekurhuleni (both GP) recorded the largest improvements in adult antiretroviral effective coverage between Quarter 1 2023 and Quarter 1 2024.



MAP 4 Antiretroviral effective coverage among clients 15 years and older by district, Quarter 1 2024

Source: DHIS

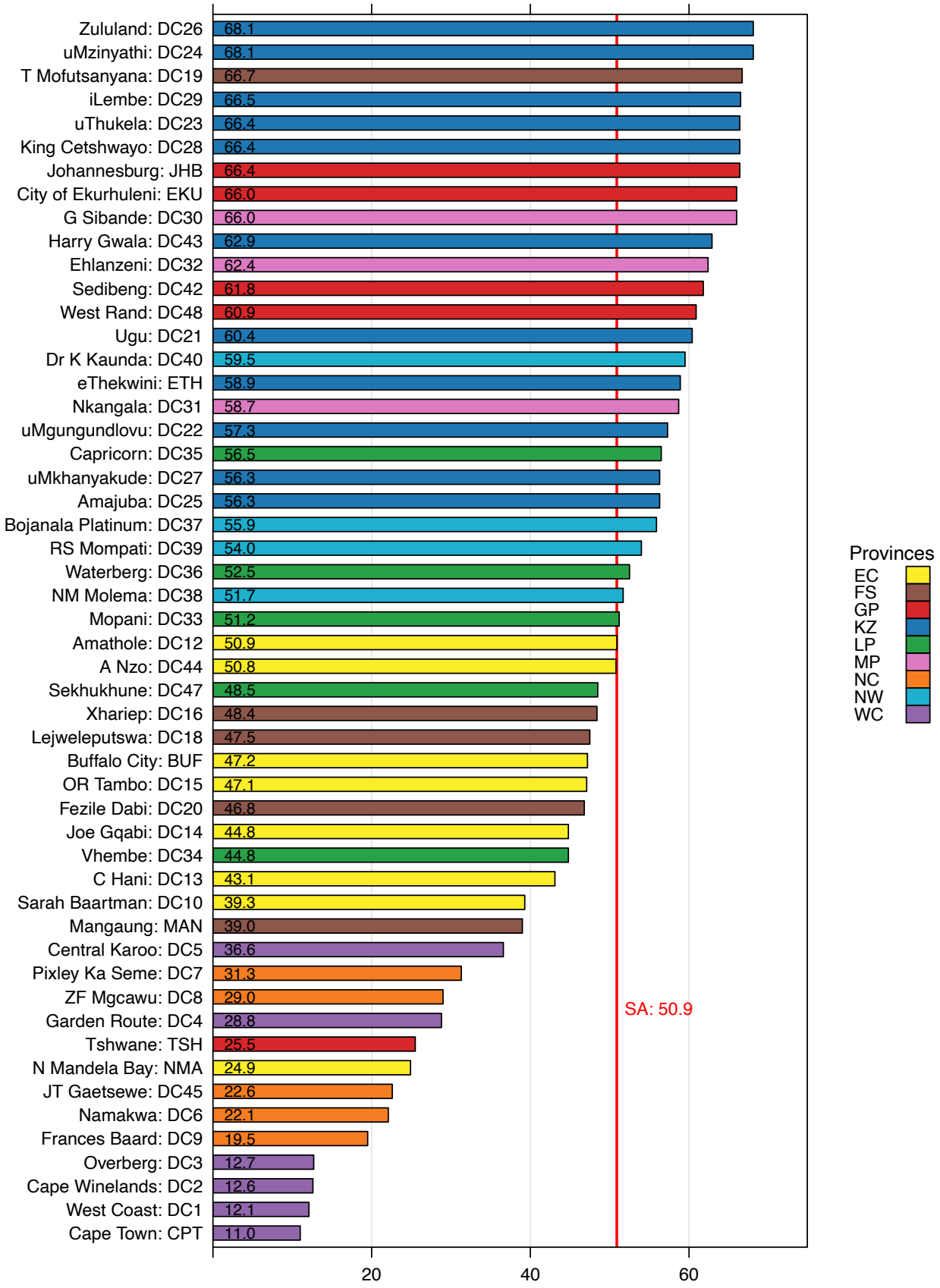


Figure 13 Antiretroviral effective coverage among clients 15 years and older by district, Quarter 1 2024

Source: DHIS

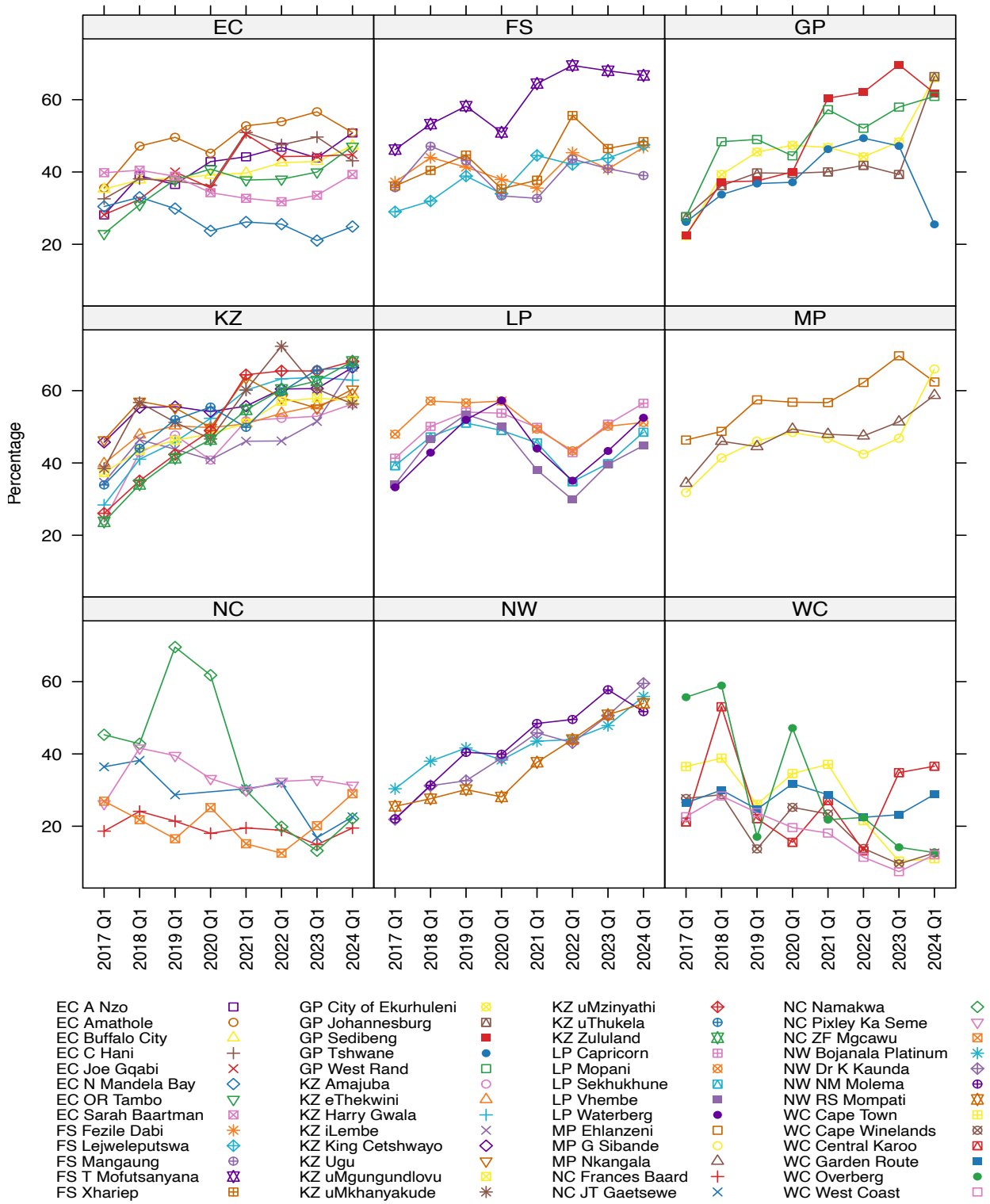


Figure 14 Annual trends: antiretroviral effective coverage among clients 15 years and older by district, Quarter 1 2017 – Quarter 1 2024

Source: DHIS

Antiretroviral effective coverage rates among children 0–14 years also varied by district (Figure 15) though all rates were consistently below estimates recorded among clients 15 years and older. Six districts did not report on antiretroviral effective coverage for children 0–14 years. The districts not reporting were the same six districts that did not report estimates for viral suppression among children 0–14 years, and thus antiretroviral effective coverage calculations could not be done for districts missing viral suppression data. Xhariep (FS) recorded the highest coverage of 55.4% in the Quarter 1 2024 while the lowest recorded estimate for children 0–14 years was 5.4% in JT Gaetsewe and 6.8% in ZF Mgcawu (both NC). Six of the top 10 performing districts were in KZ.

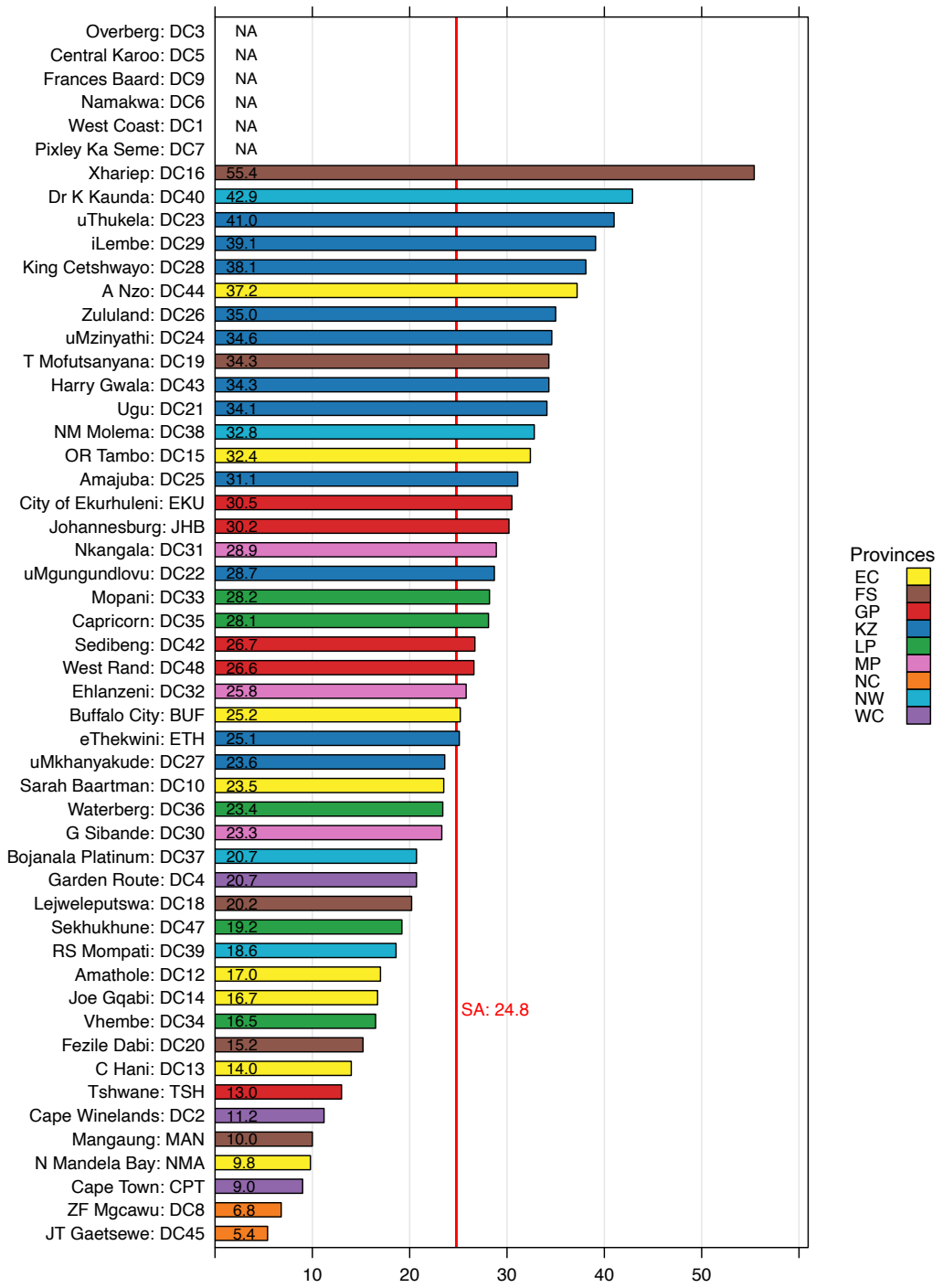


Figure 15 Antiretroviral effective coverage among children 0–14 years by district, Quarter 1 2024

Source: DHIS

Recommendations

- Strengthening of national data systems and creation of opportunities to harmonise and link datasets could enable more precise estimates of ART effective coverage at the national and provincial level.
- Improvements in antiretroviral effective coverage rates are needed across all sectors, particularly among children 0–14 years.
- Universal access to ART has improved rates of initiation on ART but sustaining continuity of care through viral suppression remains challenging.
- Effective implementation of the 2023 South African ART guidelines which expands access to differentiated service delivery models in the first six months on ART may improve coverage rates and advance South Africa's effort to achieve epidemic control.

03 Non-communicable diseases

Non-communicable diseases (NCDs) are a leading cause of illness and death worldwide, accounting for approximately 74% of global deaths annually.[1] NCDs include a large number of conditions which are non-infectious, progress slowly and require long-term or lifelong treatment and care. The burden of NCDs is highest in low- and middle-income countries, and includes conditions such as cardiovascular diseases, hypertension, chronic respiratory diseases, diabetes, cancers, and mental illness.

This chapter covers one indicator, namely cervical cancer screening coverage, which is used as a proxy measure for cancer detection and treatment.

Cervical cancer screening coverage

Rakshika Bhana

Key findings

- All provinces and districts had an increase in the cervical screening coverage in 2023/24. The national coverage was 40.5% reflecting a 19.1 percentage point increase compared to 2022/23.
- KwaZulu-Natal (KZ) province performed the best with a coverage of 72.3% and was the only province to reach the World Health Organization (WHO) cervical cancer screening coverage target of 70%.
- North West (NW) had the lowest coverage at 24.7% with one of its three districts obtaining a coverage above the national average.
- Thirty districts performed above the national average of 40.5%.
- Eight districts reached and exceeded the WHO coverage target of 70%; one from the Eastern Cape (EC) and seven from KwaZulu-Natal.
- The 2023/24 national coverage places the country closer to the pre-COVID-19 national cervical screening coverage reported in 2019/20 of 46.8%.
- The improvement in cervical cancer screening coverage nationally highlights opportunities for inter-provincial and district sharing of best practices to inform focused evidence-based interventions towards attainment of the WHO elimination targets for cervical cancer by 2030.

Introduction

Cervical cancer is a preventable form of cancer and can be treated or cured when detected in early stages, yet remains one of the leading causes of female mortality worldwide. Globally, cervical cancer accounts for 6.8% of all cancers reported in women and is ranked as the fourth most common cause of death in women, with an estimated 661 021 new cases and 348 189 deaths in 2022.[2] The highest burden of these cases (90%) occurred in low- and middle-income countries where limited access to human papilloma virus (HPV) vaccination and high quality screening and treatment options for women prevail.[2] Cervical cancer is caused by persistence of an infection from the HPV with the highest risk HPV genotypes, 16 and 18, accounting for approximately 70% of global cervical cancer cases.[3]

1 World Health Organization. Non Communicable Diseases. Key Facts. WHO; 2023. URL: https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases
2 Bray F, Laversanne M, Sung H, et al. Global cancer statistics 2022: GLOBCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. CA Cancer J Clin. 2024;74(3):229263. URL: https://doi.org/10.3322/caac.21834
3 UNITAID. Screening and treatment of precancerous lesions for secondary prevention of cervical cancer. Technology landscape report. 2024.URL: https://unitaid.org/ assets/Screening-and-treatment-of-precancerous-lesions-for-secondary-prevention-of-cervical-cancer-technology-landscape-report.pdf

In South Africa, cervical cancer is ranked as the second most commonly diagnosed cancer and the leading cause of cancer deaths in women.[4] In 2022, 7 499 new cases of cervical cancer were reported, accounting for 16.4% of female cancer cases.[4] The age standardised incidence rate (ASIR) for cervical cancer was 23 per 100 000 women in 2022 compared to 19.63 per 100 000 women in 2021.[4] Cervical cancer remains the most common cancer diagnosed in black women with an ASIR of 26 per 100 000 women, contributing to 6 174 cases of all cervical cancer cases nationally.[4]

The WHO launched the Global Strategy to Accelerate Elimination of Cervical Cancer by 2030 in their response to address cervical cancer as a public health problem.[5] This comprehensive population-based strategy aims to put countries on a path to elimination to achieve the ambitious goal of an incidence rate of less than 4 per 100 000 women per year. This strategy emphasises the need for improved surveillance and monitoring of cervical cancer, with focused action across the continuum of care for impact. The WHO 90–70–90 targets for the three pillars of vaccination, screening, and treatment, to be attained by 2030 include:

- **Vaccination:** 90% of girls fully vaccinated with the HPV vaccine by age 15;
- **Screening:** 70% of women screened with a high-performance test at 35 years and again at 45 years;
- **Treatment:** 90% of women identified with cervical cancer disease to receive treatment, specifically:
  - 90% of women with pre-cancer symptoms are treated, and
  - 90% of women with invasive cancer are managed.

South Africa reported a persistently high ASIR for cervical cancer in 2022 (23 per 100 000 women), which was notably driven by the interplay between human immunodeficiency virus (HIV) and HPV infections.[6] Women living with HIV (WLHIV) face a six-fold higher relative risk of cervical cancer as compared to HIV negative women.[7] The 2017 National Department of Health Cervical Cancer Prevention and Control Policy advises that WLHIV are to be screened more often starting from diagnosis and then at three-year intervals. In October 2023, the National Department of Health released a mandate to transition to HPV Deoxyribonucleic acid (DNA) testing as the primary method for cervical screening at the primary health care level. This mandate changes the routine age for screening for WLHIV to start from 25 years if they have not been screened before. This method of screening, aligned to the 2017 policy, enables more accurate detection of high-risk HPV strains and early identification of women at risk of developing cervical cancer.

The data source for the cervical cancer coverage indicator is the District Health Information System (DHIS). The National Indicator Data Set (NIDS) defines cervical screening coverage as cervical smears in women 30 years and older as a proportion of the female population between 30–50 years. Eighty percent (80%) of these women should be screened for cervical cancer every 10 years and 20% must be screened every 3 years. This should be included in the denominator because it is estimated that 20% of women 20 years and older are HIV positive. The numerator is: [(Cervical cancer screening in non-HIV woman 30–50 years) + (Cervical cancer screening in HIV positive women 20 years and older) + (Cervical cancer screening 30 years and older) + (Cervical cancer screening in non-HIV woman 30 years and older)]. The denominator is: [(80% of women aged 30–59yrs/10) + (20% of women aged 20–59yrs/3) + (Cervical cancer screening of women 30 years and older)].[8]

4 National Cancer Registry. Cancer in South Africa. 2022 Full Report. National Institute of Communicable Diseases; 2022. URL: https://www.nicd.ac.za/centres/national-cancer-registry/

5 World Health Organization. Global strategy to accelerate the elimination of cervical cancer as a public health problem. World Health Organization; 2020. URL: https://www.who.int/publications/i/item/9789240014107

6 Kawonga M. Leveraging implementation science for secondary prevention of cervical cancer in South Africa. S Afr Health Rev. 2024;26. URL: https://doi.org/10.61473/001c.120636

7 Sorbye SW, Falang BM, Botha MH, et al. Enhancing cervical cancer prevention in South African women: Primary HPV mRNA screening in different genotype combinations. Cancers. 2023;15:5453. URL: https://www.mdpi.com/2072-6694/15/22/5453

8 National Department of Health. National Indicator Data Set. 2023.

National overview

The national average for cervical cancer screening coverage in 2023/24 was 40.5%, which was a 19.1 percentage point increase compared to the 2022/23 coverage. This is still lower than the WHO target of 70% and places the country closer but still below the pre-COVID-19 national coverage reported in 2019/20 of 46.8%. The increase in 2023/24 is indicative of improvements made to recover from the negative impact of the COVID-19 pandemic on routine primary health care services in South Africa.[9]

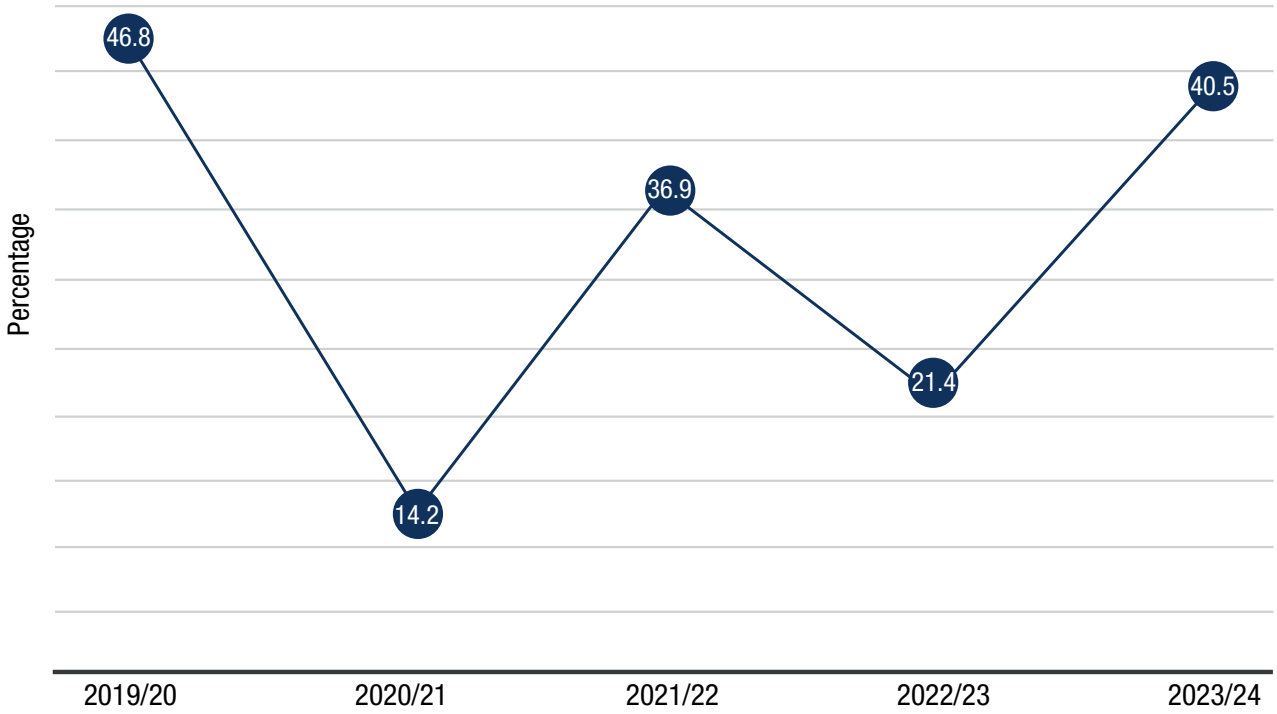


Figure 1 National Cervical cancer screening coverage, 2019/20 – 2023/24

Source: DHIS

Provincial overview

The cervical cancer screening coverage in five provinces exceeded the national average of 40.5% and four provinces fell significantly below the average (Figure 2).

KwaZulu-Natal (KZ) was the best performing province with a coverage of 72.3%, and the only province to reach the WHO target of 70% in 2023/24; a milestone achievement for the country. Eastern Cape (EC) was the second best performing province at 52.6% followed by the Free State (FS) at 45.3%. The cervical screening coverage in the North West (NW) was lowest at 24.7% followed by Limpopo (LP) at 27.0%.

All provinces had an increase in the cervical screening coverage compared to 2022/23; the highest increase was in KZ with 33.4 percentage points followed by the Northern Cape (NC) with 31.3 percentage points. Northern Cape, the lowest ranking province over the four-year period since 2020/21 had a marked improvement in the cervical screening coverage from 5.1% to 40.9% in 2023/24 (Table 1).

9 Pillay Y, Pienaar S, Barron P, et al. Impact of COVID-19 on routine primary health care services in South Africa. S Afr Med J. 2021; 111(8):714-719. URL: https://doi.org/10.7196/SAMJ.2021.v111i8.15786

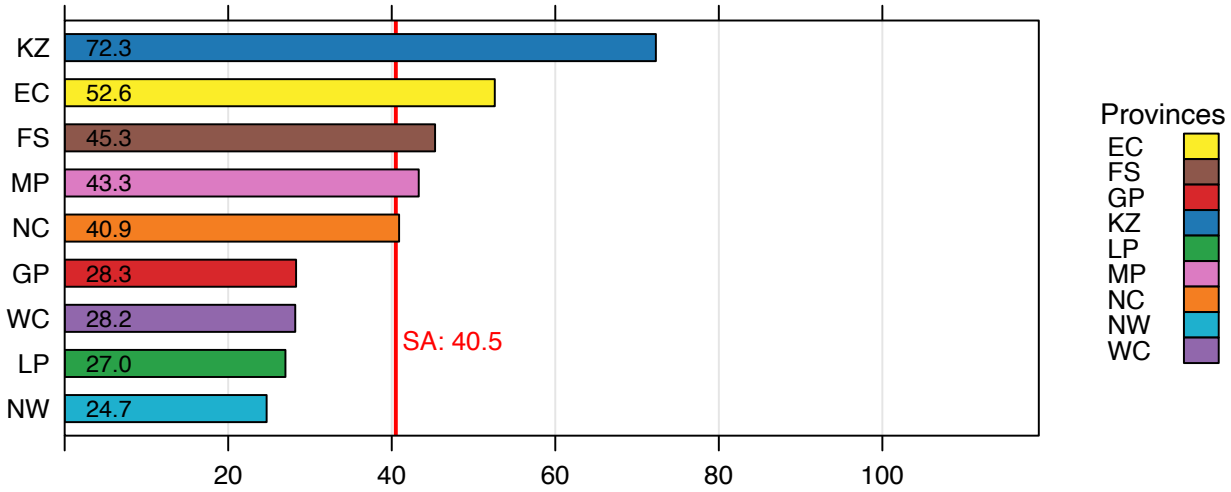


Figure 2 Cervical screening coverage by province, 2023/24

Source: DHIS

Table 1 Cervical cancer screening coverage by province, 2019/20 – 2023/24 (%)

PROVINCE	2019/20	2020/21	2021/22	2022/23	2023/24	PERCENTAGE POINT DIFFERENCE BETWEEN 2022/23 AND 2023/24
Eastern Cape	50.0	16.5	32.9	22.7	52.6	29.9
Free State	46.0	16.0	35.2	24.0	45.3	21.3
Gauteng	42.2	7.3	31.4	16.9	28.3	11.4
KwaZulu-Natal	55.9	22.9	56.8	38.9	72.3	33.4
Limpopo	33.3	9.7	25.1	12.0	27.0	15.0
Mpumalanga	57.9	24.2	42.7	24.7	43.3	18.6
Northern Cape	32.0	5.1	15.3	9.6	40.9	31.3
North West	55.9	12.2	22.8	9.7	24.7	15.0
Western Cape	41.8	14.2	40.0	17.4	28.2	10.8

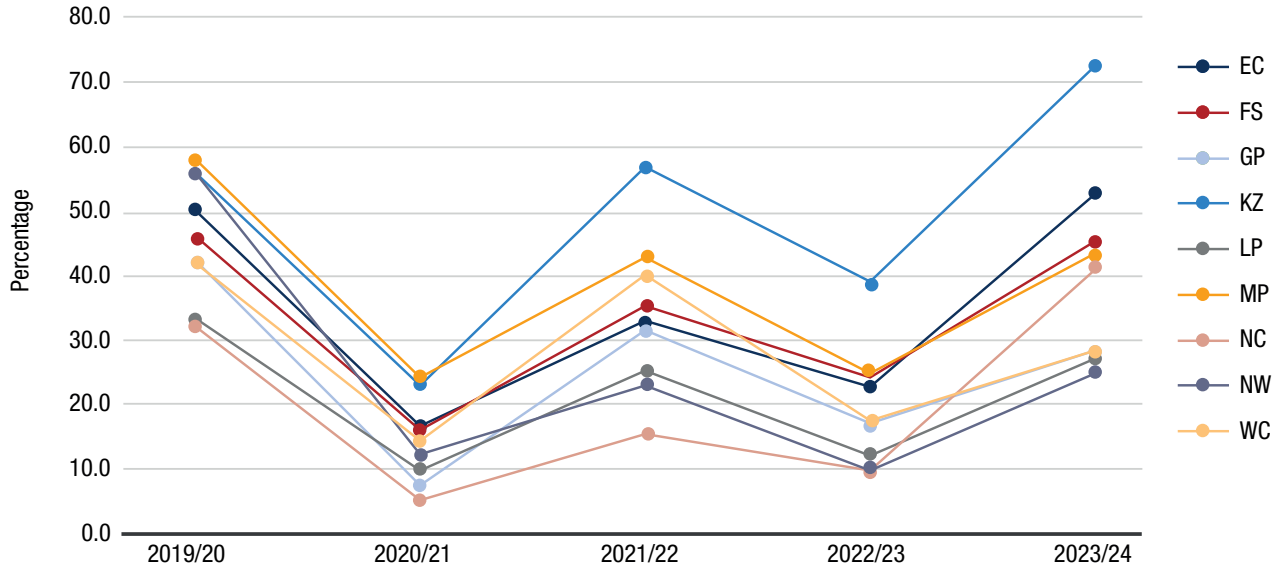


Figure 3 Cervical cancer screening coverage by province, 2019/20 – 2023/24

Source: DHIS

The cervical cancer screening coverage improved significantly in 2023/24 compared to 2022/23. Leading provinces were consulted to share insights into priority activities and interventions undertaken to strengthen their programmes. Feedback from the provinces highlights the following:

- Raising awareness about early cervical cancer screening at both facility and community levels results in a greater number of women being empowered and taking proactive measures in seeking screening services.
- Integrating cervical screening services into existing sexual and reproductive health and antenatal care services ensures all eligible women are screened at entry points at primary care level.
- Regular and proactive screening of WLHIV as part of their comprehensive and holistic treatment plan improves coverage.
- Using liquid-based cytology (LBC) for Papanicolaou (Pap) smears as the primary screening method improves the adequacy rate of Pap smears.
- Setting daily targets for clinicians performing Pap smears and regular monitoring of targets to prioritise cervical cancer screening at facility level.
- Capacity strengthening of health care cadres across priority health programmes on cervical cancer screening.

District overview

The cervical cancer screening coverage among districts shows a 6.6-fold variation between Vhembe in Limpopo with the lowest coverage at 16.3% and Zululand in KZ with the highest coverage of 108.3% (Figure 4 and Map 1). A coverage above 100% in Zululand may be indicative of data challenges including an underestimation in the denominator. Thirty districts (57.7%) performed above the national average of 40.5%. In KZ, nine of the 11 districts were ranked among the top ten performing districts with seven districts reaching and exceeding the WHO target of 70%. In EC five of the eight districts performed above the national average with Amathole exceeding the WHO target at 88.5%, placing the province second best in provincial performance. This is a milestone achievement for KZ and Eastern Cape provinces and highlights the need for benchmarking across districts to inform evidence-based interventions for scaling-up cervical cancer screening and treatment. All five districts in the FS province performed above the national average.

Among the ten lowest ranking districts were three districts in the WC (West Coast, 20.4%), (Central Karoo, 24.9%) and (Cape Town, 26.1%), two in LP (Vhembe, 16.3%) and (Mopani, 22.4%), two in GP (City of Ekurhuleni, 21.2%) and (City of Johannesburg, 22.4%), two in the NW (Bojanala Platinum, 18.9%) and (Dr Kenneth Kaunda, 22.5%) and one in EC (Joe Gqabi, 27.2%).

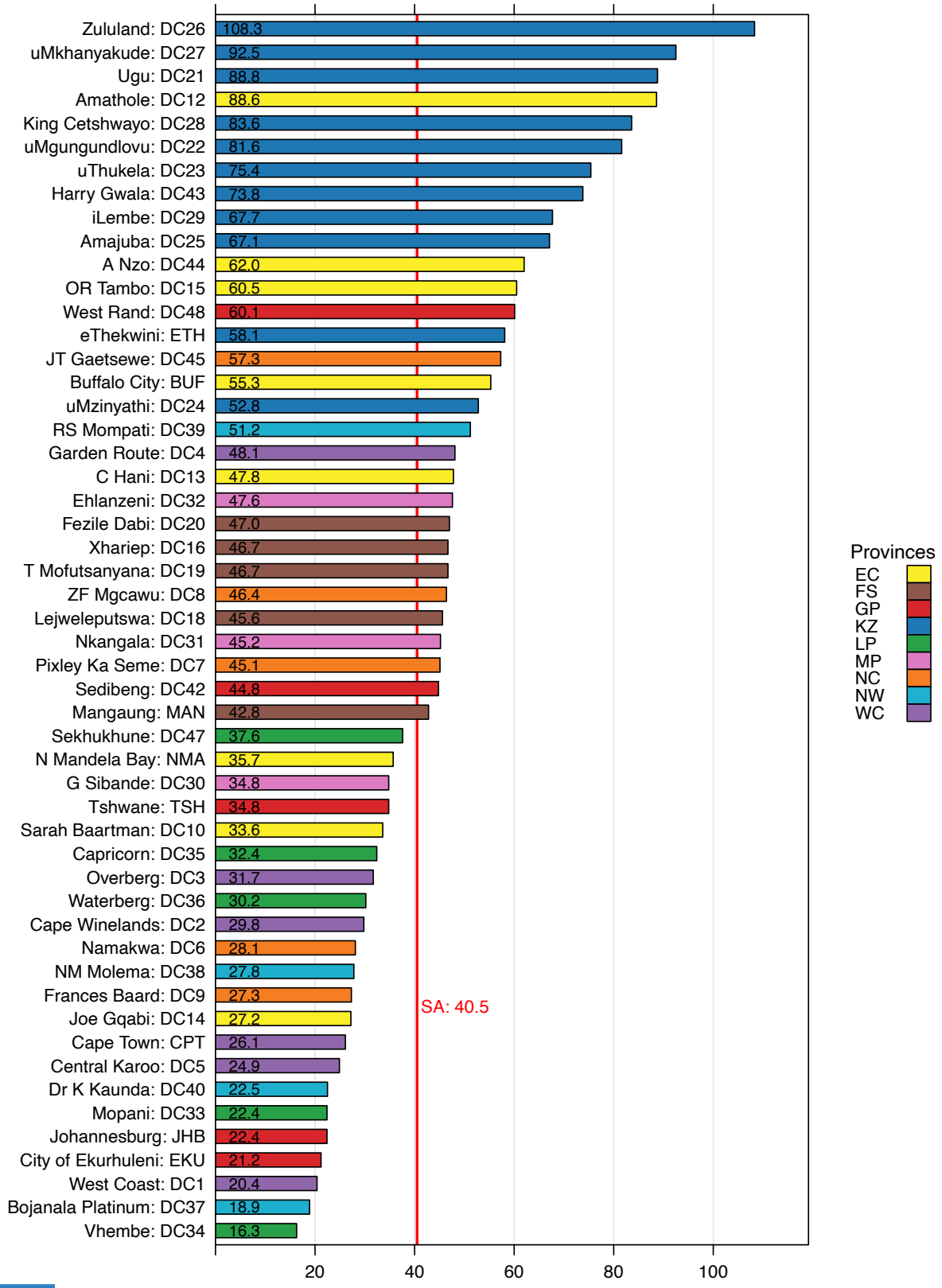
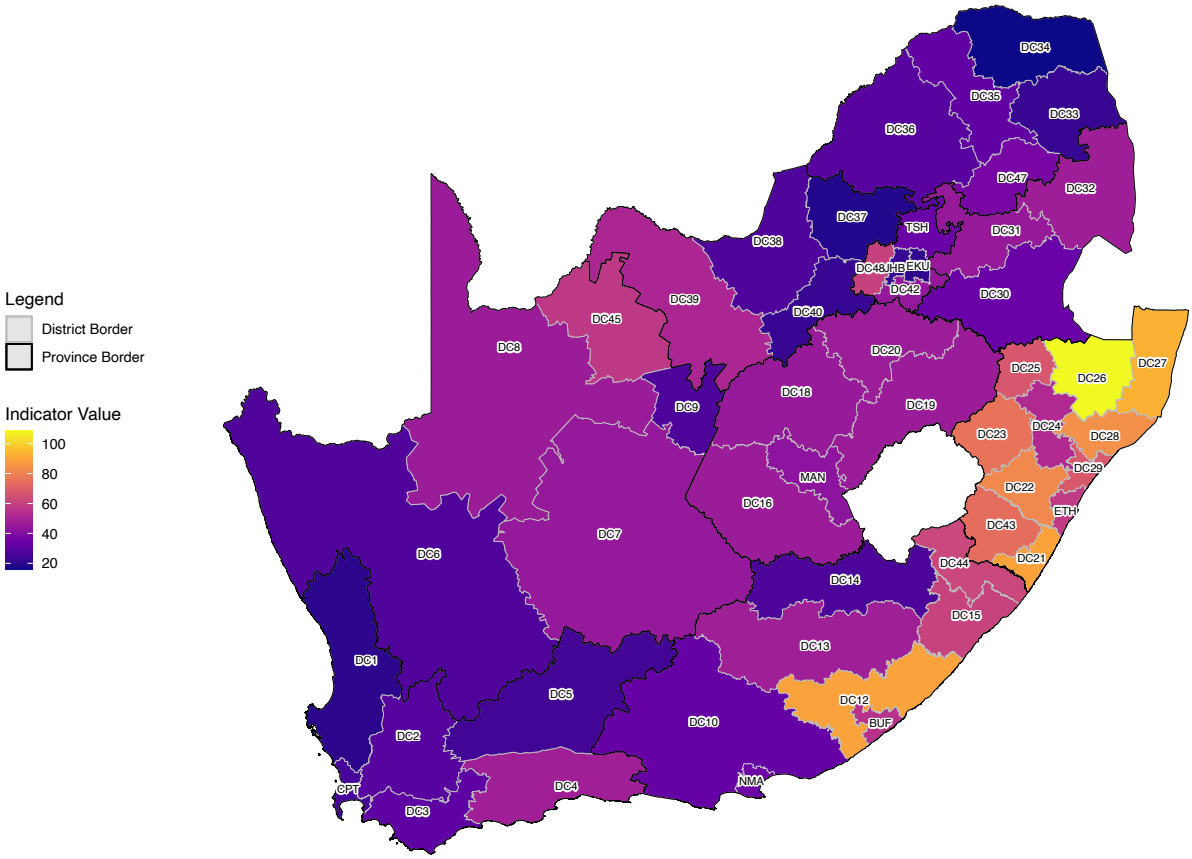


Figure 4 Cervical cancer screening coverage by district, 2023/24

Source: DHIS



MAP 1 Cervical cancer screening coverage by district, 2023/24

Source: DHIS

Table 2 shows the cervical cancer screening coverage by district between 2019/20 and 2023/24. All districts (n=52) had an increase in the cervical cancer screening coverage in 2023/24 compared to the coverage in 11 districts in 2022/23. The average percentage point increase for districts was 24.1 with the highest increase in Amatole (EC) with 53.8 percentage points, followed by King Cetshwayo and Zululand (both in KZ) with 51.3 and 50.4 percentage points respectively. Among districts with the lowest increase in the cervical cancer screening coverage were City of Ekurhuleni (GP), Vhembe (LP), Cape Town (WC) and Bojanala Platinum (NW) with increases of 6.4, 7.5, 9.3 and 9.6 percentage points respectively.

Table 2 Cervical cancer screening coverage by district, 2019/10 – 2023/24 (%)

PROVINCE	DISTRICT	2019/20	2020/21	2021/22	2022/23	2023/24	PERCENTAGE POINT DIFFERENCE BETWEEN 2022/23 AND 2023/24
Eastern Cape	A Nzo	45.7	24.3	16.7	24.6	62.0	37.4
	Amathole	56.4	28.6	31.0	34.8	88.6	53.8
	Buffalo City	59.8	16.9	18.3	25.0	55.3	30.3
	C Hani	52.0	24.2	22.3	27.9	47.8	19.9
	Joe Gqabi	57.5	19.1	13.7	15.7	27.2	11.5
	N Mandela Bay	38.0	5.4	6.3	8.6	35.7	27.1
	OR Tambo	53.5	15.7	22.0	29.8	60.5	30.7
	Sarah Baartman	43.5	11.2	11.0	17.5	33.6	16.1
Free State	Fezile Dabi	50.5	16.9	17.6	21.0	47.0	26.0
	Lejweleputswa	46.4	9.2	16.7	19.9	45.6	25.7
	Mangaung	39.2	15.1	22.5	21.5	42.8	21.3
	T Mofutsanyana	48.8	20.2	25.5	32.8	46.7	13.9
	Xhariep	55.1	29.1	22.9	20.5	46.7	26.2

Gauteng	City of Ekurhuleni	45.0	6.7	12.9	14.8	21.2	6.4
	Johannesburg	35.9	5.0	11.3	11.1	22.4	11.3
	Sedibeng	45.3	9.5	20.6	26.6	44.8	18.2
	Tshwane	44.3	8.5	16.0	21.4	34.8	13.4
	West Rand	55.3	18.1	29.1	40.3	60.1	19.8
KwaZulu-Natal	Amajuba	50.8	18.3	25.2	29.9	67.1	37.2
	eThekwini	47.2	18.1	29.1	34.3	58.1	23.8
	Harry Gwala	80.9	27.1	38.2	37.9	73.8	35.9
	iLembe	61.7	22.2	34.9	35.4	67.7	32.3
	King Cetshwayo	61.3	17.5	27.1	32.3	83.6	51.3
	Ugu	49.6	25.8	33.0	40.9	88.8	47.9
	uMgungundlovu	61.0	30.3	35.9	45.5	81.6	36.1
	uMkhanyakude	66.9	28.0	41.0	48.3	92.5	44.2
	uMzinyathi	63.3	18.6	20.2	22.3	52.8	30.5
	uThukela	50.5	36.4	61.4	59.4	75.4	16.0
	Zululand	61.9	30.6	46.4	57.9	108.3	50.4
Limpopo	Capricorn	28.1	8.6	7.3	11.4	32.4	21.0
	Mopani	38.3	12.8	7.8	12.3	22.4	10.1
	Sekhukhune	30.7	10.5	8.8	12.5	37.6	25.1
	Vhembe	31.6	5.9	5.0	8.8	16.3	7.5
	Waterberg	43.7	12.5	13.8	18.2	30.2	12.0
Mpumalanga	Ehlanzeni	58.7	24.6	28.1	29.0	47.6	18.6
	G Sibande	63.8	30.8	29.1	21.3	34.8	13.5
	Nkangala	52.0	18.8	24.4	22.6	45.2	22.6
Northern Cape	Frances Baard	30.3	4.5	4.3	8.1	27.3	19.2
	JT Gaetsewe	35.5	5.7	5.4	12.9	57.3	44.4
	Namakwa	35.1	5.6	4.9	5.3	28.1	22.8
	Pixley Ka Seme	32.8	5.4	6.7	14.0	45.1	31.1
	ZF Mgcawu	30.3	5.0	4.6	7.4	46.4	39.0
North West	Bojanala Platinum	54.1	9.3	10.1	9.3	18.9	9.6
	Dr K Kaunda	62.4	15.8	12.5	9.0	22.5	13.5
	NM Molema	57.7	15.0	10.5	8.3	27.8	19.5
	Dr RS Mompati	49.1	12.5	12.1	15.6	51.2	35.6
Western Cape	Cape Town	39.1	13.9	20.7	16.8	26.1	9.3
	Cape Winelands	40.8	12.4	18.8	16.0	29.8	13.8
	Central Karoo	68.8	10.6	13.0	13.7	24.9	11.2
	Garden Route	59.2	24.3	26.1	29.1	48.1	19.0
	Overberg	52.1	11.5	18.8	20.9	31.7	10.8
	West Coast	33.2	9.6	11.5	10.0	20.4	10.4

Source: DHIS

Recommendations

- Use existing platforms and develop networks for sharing lessons and good practices within and across districts and provinces for scaling-up focused interventions towards meeting the 2030 WHO elimination targets.
- Apply capacity building models for undertaking implementation science research to inform evidence-based cervical cancer services nationally.
- Increase and sustain efforts to raise awareness of cervical cancer screening among under-screened populations through the use of culturally relevant communication approaches.
- Leverage HPV vaccination campaigns as an opportunity to educate young women about comprehensive cervical cancer prevention, including the need for regular screening.
- Transition fully to HPV DNA testing for cervical cancer screening to enable more accurate detection of high-risk HPV strains.
- Review the NIDS for inclusion of additional data elements for monitoring the entire treatment cascade for cervical cancer.
- Implement quality improvement processes at various levels, i.e., facility, district, and sub-district/local municipalities to address barriers in the cervical cancer prevention and treatment programmes.

Acknowledgements

Dr Nompumelelo Ntshangase-Mpanza is thanked for her technical review of the chapter.

04 Service capacity and access

4.1 Hospital beds per 10 000 target population

Krishna Vallabhjee, Noluthando Ndlovu, Lesley Shand, Edwina Mabuela

Key findings

- In March 2024, hospital bed density for all types of hospitals was 16.0 per 10 000 population. This is a decrease of 0.3 compared to 2023 and 1.2 compared to 2019.
- In absolute terms, hospital beds for all types have largely remained stable.
- In absolute terms, district hospital beds have fluctuated year-on-year with an increase of 85 beds from March 2023 to March 2024. The biggest increases were in two metropolitan districts, with an increase of 76 beds in Mangaung in Free State (FS), and 84 beds in Cape Town in Western Cape (WC).
- Extreme ranges in district hospital beds continue at the district level, with 0.6 beds per 10 000 uninsured population in Ekurhuleni (Gauteng (GP)) and 22.9 beds in Central Karoo (WC), representing a 38-fold variation. The largest intra-provincial ranges are in WC, KwaZulu-Natal (KZ), and Eastern Cape (EC).
- In general, district hospitals showed low bed utilisation rates (BUR). Only Cape Town Metro and Cape Winelands (both WC) had bed occupancies greater than 80%.
- The low occupancy of district hospitals has been a concern over many years. While performance of these hospitals needs to be investigated to improve efficiencies, in deep rural areas, the trade-off for equitable access must be borne in mind.
- Some of the fluctuations in bed numbers year-on-year is due to data quality errors. Using the data that is collected is an important part of the cycle to improve data quality, in addition to employing other data verification and data quality measures.
- In March 2024, the hospital beds for all types of hospitals in the public sector ratio was 16.0 per 10 000 uninsured population, which is a relatively substantial decrease from 17.5 in March 2018 and 17.1 in March 2020, pre-COVID-19.
- The total number of beds in all hospitals decreased slightly from 85 890 in March 2019 to 85 119 in March 2024 (0.9 %).

Introduction

The indicator 'hospital beds per 10 000 target population' measures the number of inpatient beds per 10 000 target population. For public sector beds, the uninsured population is used as the target.

The 2023 National Indicator Data Set (NIDS)[1] of the National Department of Health (NDoH), defines a 'bed' as a unit of accommodation for admitted patients, that is, for patients who undergo the formal admission process as either an inpatient or a day patient because they require care that cannot be administered on an outpatient basis.

The NIDS identifies two types of hospital beds: 'approved beds' and 'usable beds'. The number of approved beds is a semi-permanent data element. Any increase or decrease must be motivated and can only be done through the office of the Head of Department (HOD) and the NDoH should be informed when such changes occur. Inpatient usable beds are beds actually available for use within the facility (regardless of whether they are occupied by a patient or lodger) and are dependent on available resources. In some provinces, these are referred to as 'operational beds'. For the purposes of this chapter, the data that is reflected indicates usable beds.

Depending on the level of care and the services provided, hospitals may have different categories of beds such as: medicine, surgery, gynaecology, orthopaedics, paediatrics, maternity, psychiatry, intensive care unit (ICU), neonatal ICU, and high care. There are also different types of hospitals such as acute hospitals from district, regional, tertiary and central hospitals, as well

1 National Department of Health. National Indicator Data Set 2023. Pretoria: NDoH; March 2023.

as specialised hospitals such as maternity, rehabilitation, children, tuberculosis (TB), and psychiatric, as well as intermediate or transitional care facility beds. In this chapter, the total hospital beds per geographic population crudely includes usable beds across all types of hospitals, unless specified for district hospitals only. In some cases, such as in the WC, there are maternity beds in Midwife Obstetric Units (approximately 177). While these may not be counted as hospital beds, they do impact on the utilisation and throughput of beds within hospitals.

The number of inpatient beds per 10 000 uninsured population[2] can change over time due to various factors, including changes in healthcare infrastructure, population growth, and shifts in healthcare delivery models. These changes are apparent in this chapter, and are indicative of substantial stresses on the health infrastructure since the 2022/23 DHB last reviewed these data.[3]

Hospital bed density is associated with equitable access and is linked to health outcomes.[4] It is important to note that while hospital bed density is a valuable indicator, it should be considered alongside other indicators to provide a comprehensive assessment of healthcare service access and coverage. While it is evident that extremely low levels of hospital bed density suggest poor access to essential health services, there is no global norm for the density of hospital beds in relation to total population. There is no global target for the number of beds per country because the choice of the optimal hospital bed density for a population is highly contextual and dependent on factors such as demographics and burden of disease. Caution must be exercised in interpreting these numbers across countries to ensure definitions are consistent and apples are compared with apples.

Distribution of hospital services remains a conundrum, even in high-income societies. Where the population is dispersed and distances are great, access to hospital and emergency services becomes more problematic. There are currently approximately 44 hospitals with less than 50 beds in South Africa, the majority of which are in EC (22) and WC (10). The financial sustainability of small hospitals in rural and remote areas has become a major concern in terms of both capital expenditure and running costs. Attracting highly skilled staff to rural and remote locations remains a further challenge.[5] These issues factor into the trade-off between equitable access versus efficiency that has been documented globally.[6]

South Africa has adopted universal health coverage (UHC) as part of its commitment to the Sustainable Developmental Goals (SDGs), and has passed the National Health Insurance (NHI) Act 2023 to ensure that needed health services of adequate quality are accessible to everyone, regardless of their status and place of living.[7]

Hospital beds per 10 000 target population (all hospital types)

The total number of hospital beds includes inpatient beds usable in all categories of hospitals in the public sector, namely: district, regional, provincial tertiary, national central, specialised TB, specialised psychiatric, specialised orthopaedic, and specialised chronic hospitals, and rehabilitation centres. This excludes intermediary care and step-down/step-up beds.

2 Shapiro D. Modelled estimates of the uninsured population from Census, Community Survey, General Household Survey and Council for Medical Schemes. Insight Actuaries.
3 Ndlovu N, Padarath A, eds. District Health Barometer 2022/23. Durban: Health Systems Trust; 2024.
4 Tian F, Pam J. Hospital bed supply and inequality as determinants of maternal mortality in China between 2004 and 2016. Int J Equity Health. 2021;20(51). doi: https://doi.org/10.1186/s12939-021-01391-9
5 Massyn N, Barron P, Day C, Ndlovu N, Padarath A. eds. District Health Barometer 2018/19. Durban: Health Systems Trust; 2020.
6 Culyer AJ. Efficiency, equity and equality in health and health care. Technical Report. York: University of York; January 2015.
7 Republic of South Africa. Government Gazette No. 4826 16 May 2024 Act No. 20 of 2023: National Health Insurance Act 2023.

National overview

In March 2024, the hospital beds for all types of health facilities in the public sector per 10 000 uninsured population was 16.0 (Figure 1). The beds decreased by 1.84% when compared to the March 2023 value of 16.3 per 10 000 uninsured population. This was due to the real decrease in the number of usable beds, from 85 542 in March 2023, to 85 119 in March 2024 (0.5% decrease) (Table 1).

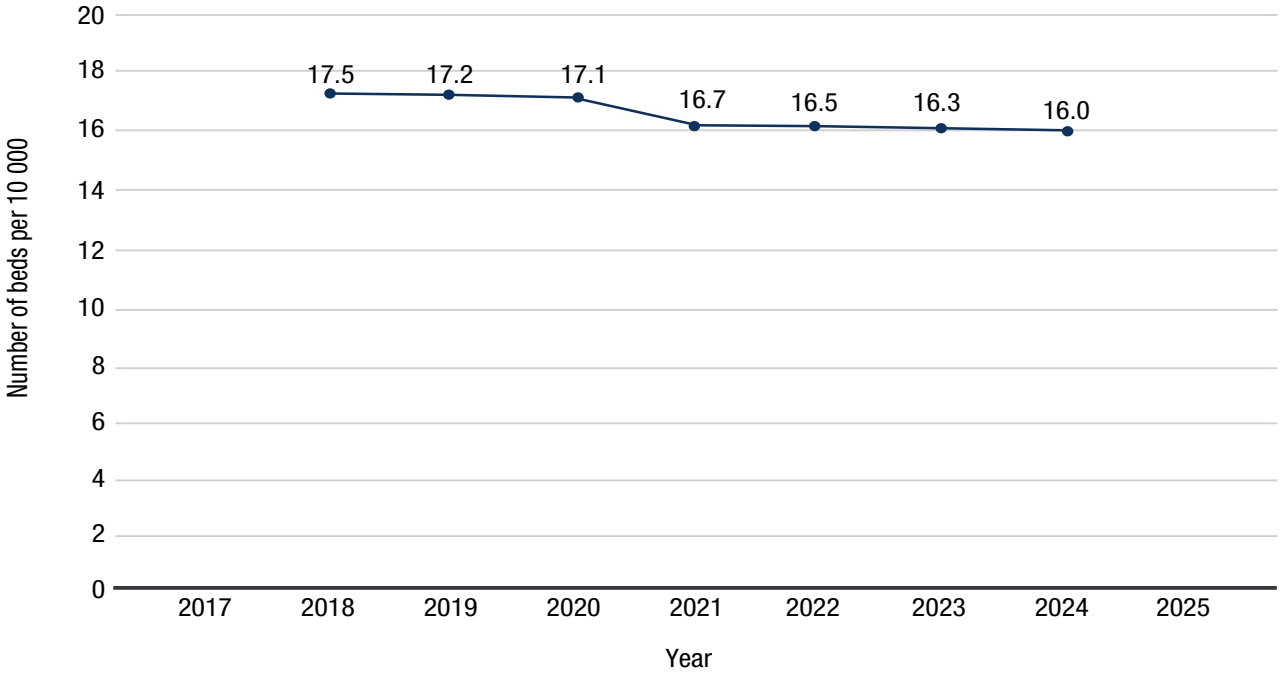


Figure 1 National hospital beds per 10 000 uninsured population (all types of hospitals), March 2018 – March 2024

Source: DHIS

The 2022/23 edition of the DHB showed a significant increase in the number of hospital beds at 20.3 per 10 000 in March 2023 from 17.0 in the previous year. The number of beds in the Northern Cape (NC) had been incorrectly captured in one facility as 18 000 instead of only 18, which increased the overall number of beds in the country in 2023. This has been corrected in Figure 1 above to 16.3 in March 2023.

Table 1 Total hospital beds by district, 2019 – 2024 (all types)

Province	District	March 2019 Inpatienrt beds usable - total	March 2020 Inpatient beds usable - total	March 2021 Inpatient beds usable - total	March 2022 Inpatient beds usable - total	March 2023 Inpatient beds usable - total	March 2024 Inpatient beds usable - total	Total Pop (2024)	Beds per 10 000 uninsured population - all hospitals (March 2024)
EC	A Nzo	994	1 019	1 037	1 040	1 039	1 039	802 520	12.9
	Amathole	1 766	1 766	1 671	1 641	1 671	1 701	729 269	23.3
	Buffalo City	2 026	2 041	2 041	2 041	2 041	2 039	612 053	33.3
	C Hani	1 902	1 902	1 899	1 883	1 904	1 837	658 136	27.9
	Joe Gqabi	568	521	551	552	552	552	317 310	17.4
	N Mandela Bay	2 561	2 561	2 453	2 325	2 336	2 306	971 018	23.7
	OR Tambo	2 449	2 437	2 390	2 445	2 445	2 404	1 521 530	15.8
FS	S Baartman	1 211	1 211	1 180	1 199	1 236	1 233	445 586	27.7
	Fezile Dabi	582	619	619	618	511	556	441 311	12.6
	Lejweleputswa	754	735	735	719	730	732	568 286	12.9
	Mangaung	2 467	2 469	2 384	2 346	2 366	2 460	720 491	34.1
	T Mofutsanyana	904	937	938	941	932	928	689 353	13.5
	Xhariep	155	148	151	157	150	146	114 351	12.8

GP	Ekurhuleni	3 394	3 499	3 240	3 354	3 561	3 509	3 305 283	10.6
	Johannesburg	5 788	5 934	5 880	5 728	6 148	5 918	5 162 083	11.5
	Tshwane	5 531	5 517	5 395	5 681	5 488	5 506	2 862 989	19.2
	Sedibeng	1 115	1 068	1 085	1 130	1 148	1 123	772 845	14.5
	West Rand	1 948	1 902	1 943	1 943	1 869	1 817	767 541	23.7
KZ	Amajuba	1 124	1 124	1 005	1 003	1 010	1 010	545 173	18.5
	eThekwini	7 410	7 256	7 161	6 962	7 081	6 677	3 387 761	19.7
	Harry Gwala	1 080	1 080	1 080	1 080	1 026	1 026	492 436	20.8
	iLembe	879	882	882	919	927	919	648 391	14.2
	King Cetshwayo	2 013	1 972	1 972	1 972	2 052	2 052	899 584	22.8
	Ugu	906	1 116	1 205	1 205	1 159	1 165	801 177	14.5
	uMgungundlovu	3 260	3 095	3 097	3 116	3 102	3 255	1 060 527	30.7
	uMkhanyakude	1 109	1 099	1 040	1 042	1 037	1 007	659 762	15.3
	uMzinyathi	1 171	1 171	1 171	1 171	1 171	1 171	557 621	21.0
	uThukela	913	950	900	900	903	903	670 765	13.5
	Zululand	1 302	1 321	1 321	1 316	1 321	1 321	836 522	15.8
LP	Capricorn	2 186	2 192	2 134	2 174	2 180	2 192	1 252 504	17.5
	Mopani	1 547	1 544	1 548	1 548	1 548	1 548	1 164 386	13.3
	Sekhukhune	1 260	1 271	1 271	1 271	1 271	1 271	1 202 505	10.6
	Vhembe	1 799	1 799	1 806	1 823	1 773	1 763	1 427 882	12.3
	Waterberg	1 051	1 051	1 084	1 084	1 084	1 079	719 154	15.0
MP	Ehlanzeni	2 373	2 373	2 557	2 582	2 384	2 387	1 687 796	14.1
	G Sibande	1 333	1 333	1 344	1 339	1 270	1 254	1 150 988	10.9
	Nkangala	1 039	1 242	1 178	1 178	1 113	1 080	1 482 610	7.3
NC	Frances Baard	767	862	925	976	893	923	360 717	25.6
	JT Gaetsewe	233	229	233	233	151	151	247 841	6.1
	Namakwa	73	73	40	0	73	73	94 455	7.7
	Pixley ka Seme	114	114	104	167	167	167	185 366	9.0
	ZF Mgcawu	319	319	326	322	322	322	247 668	13.0
NW	Bojanala	815	822	813	813	825	878	1 806 554	4.9
	Dr K Kaunda	2 141	2 141	2 235	2 093	2 093	2 069	737 914	28.0
	RS Mompati	489	489	558	440	486	473	443 649	10.7
	NM Molema	1 216	1 216	1 156	1 086	1 061	1 060	839 140	12.6
WC	Cape Winelands	1 052	1 052	1 052	1 052	1 052	1 057	842 381	12.5
	Central Karoo	212	212	212	212	212	150	65 511	22.9
	Cape Town	7 271	7 283	7 389	7 247	7 255	7 334	3 858 850	19.0
	Garden Route	753	756	756	756	768	782	532 683	14.7
	Overberg	202	202	202	202	202	232	268 992	8.6
	West Coast	455	455	552	595	535	562	409 810	13.7
South Africa		85 982	86 382	85 901	85 622	85 634	85 119	53 051 029	16.0

Source: DHIS

Provincial overview

Review of Table 1 in conjunction with Figure 2 indicate that there are significant variances between the provinces, with EC recording the highest number of beds per 10 000 population at 21.7 and Mpumalanga (MP) the lowest at 10.9 beds. In four provinces (EC, KZ, WC and FS), the number of hospital beds per 10 000 was higher than the national average of 16.0 beds per 10 000 population.

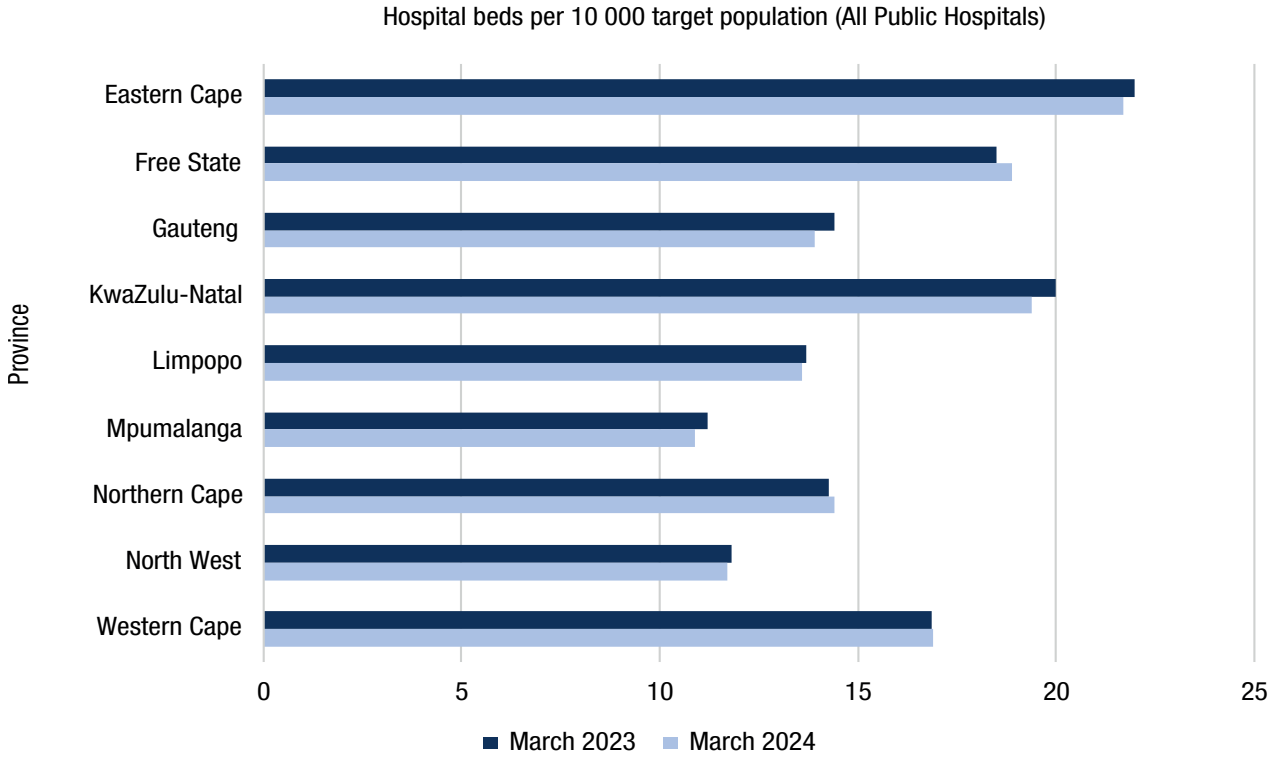


Figure 2 Comparison of hospital beds per 10 000 uninsured population by province, March 2023 and 2024 (all types of hospitals)
Source: DHIS

District overview

The number of hospital beds per 10 000 uninsured population varied largely across districts, from a minimum of 4.9 beds per 10 000 uninsured population in Bojanala Platinum (North West (NW)), to approximately a 7-fold bed density increase of 34.1 per 10 000 in Mangaung (FS) (Figure 3).

This large variability must be interpreted cautiously because this analysis includes hospital beds at all levels of care, especially beds in provincial tertiary, national central, and specialised hospitals which are counted in each district where they are located but serve populations well beyond the boundaries of the district and, often, the province. This fact helps to explain why most metropolitan districts (where provincial tertiary and national central hospitals are located) have more hospital beds than the national average of 16.0 per 10 000 uninsured population. Johannesburg and Ekurhuleni (both Gauteng (GP)) are outliers with 11.5 and 10.6 respectively.

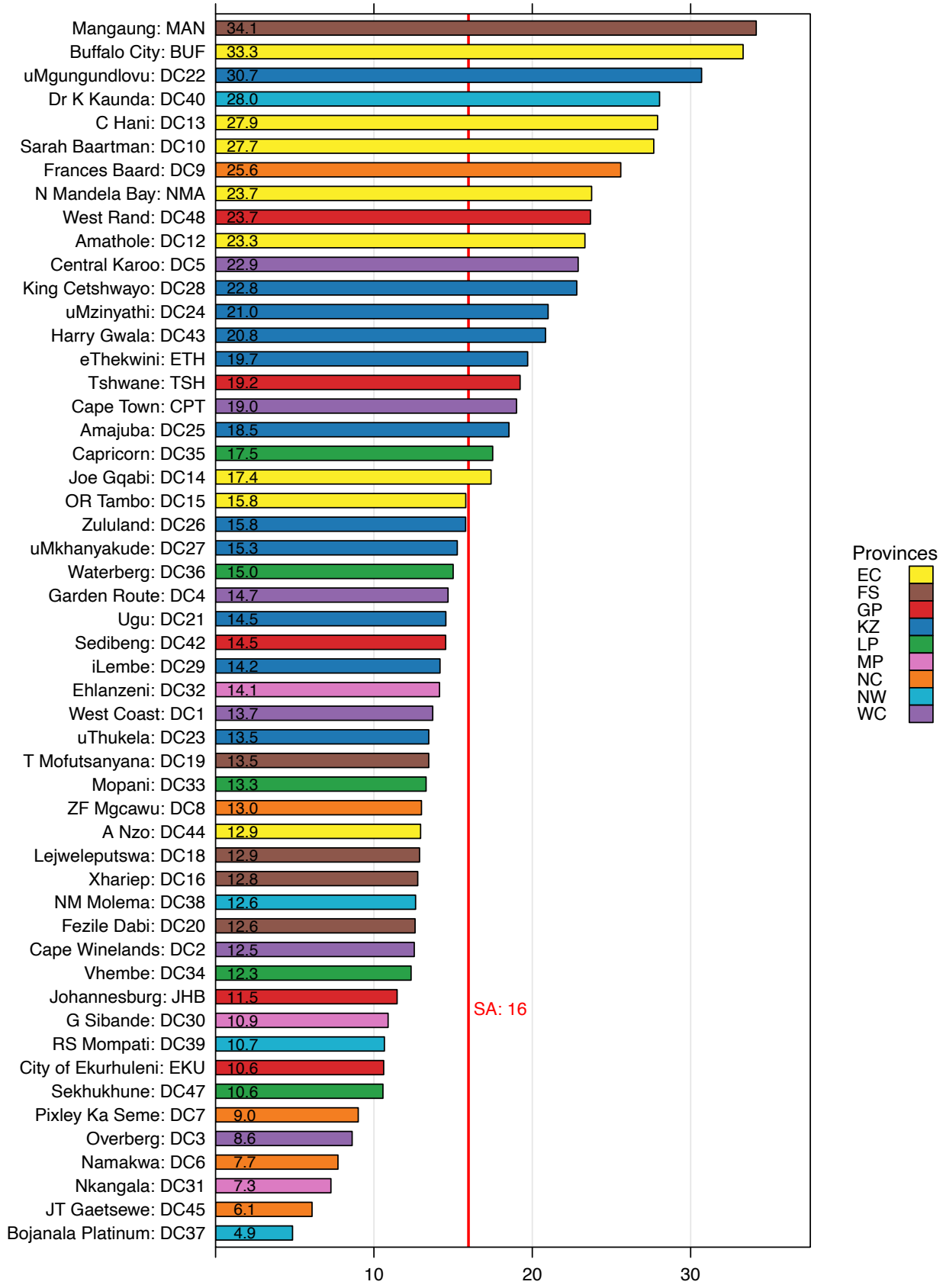
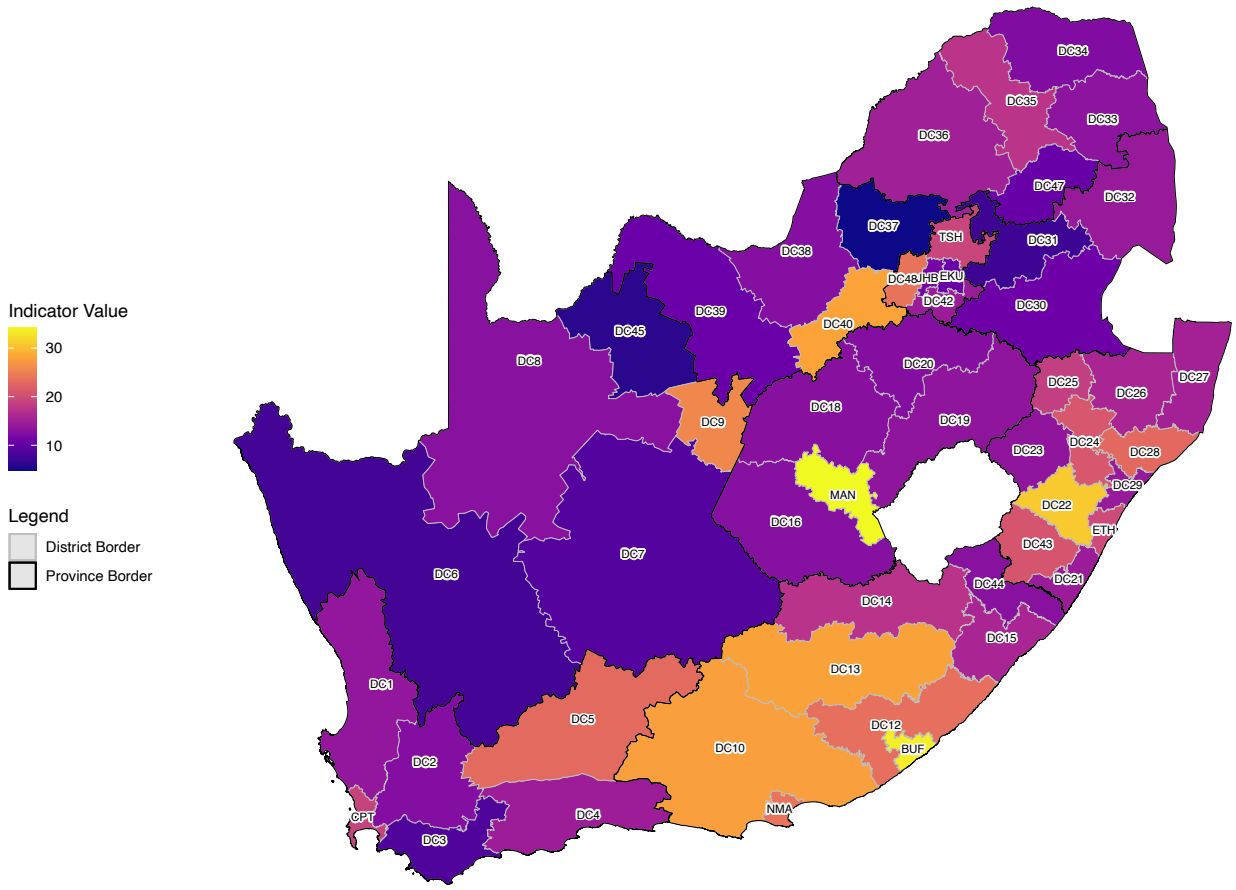


Figure 3 Hospital beds per 10 000 uninsured population by district, March 2024 (all types of hospitals)

Source: DHIS



MAP 1 Hospital beds per 10 000 uninsured population by district, March 2024 (all types of hospitals)
Source: DHIS

The range of values depicted in Figure 3 and geographic spread shown in Map 1 point clearly to a high level of inequality in the distribution of hospital beds across the country. This is exemplified within several provinces, but must be interpreted with caution given that all hospital beds are counted in this instance.

Notwithstanding the above-mentioned caution, the most equal distribution of beds between districts in a province is in MP and Limpopo (LP), where the range is only 6.9 beds per 10 000 (Table 2).

Table 2 Variance of beds per 10 000 uninsured population by province, March 2024 (all public hospitals)

Province	Lowest number of beds per 10 000	Highest number of beds per 10 000	Variance
Eastern Cape	12.9	33.3	20.4
Free State	12.6	34.1	21.5
Gauteng	10.6	23.7	13.1
KwaZulu-Natal	13.5	30.7	17.2
Limpopo	10.6	17.5	6.9
Mpumalanga	7.3	14.1	6.8
Northern Cape	6.1	25.6	19.5
North West	4.9	28.0	23.1
Western Cape	3.2	22.9	19.7

Source: DHIS

Long-term trends in the number of hospital beds per 10 000 uninsured population per province are shown in Figure 4. Taking into account data quality problems as likely explanations for the implausibly rapid oscillations evident in some graphs, the data suggest, for most districts, an overall slight downward trend in the number of hospital beds per 10 000 population.

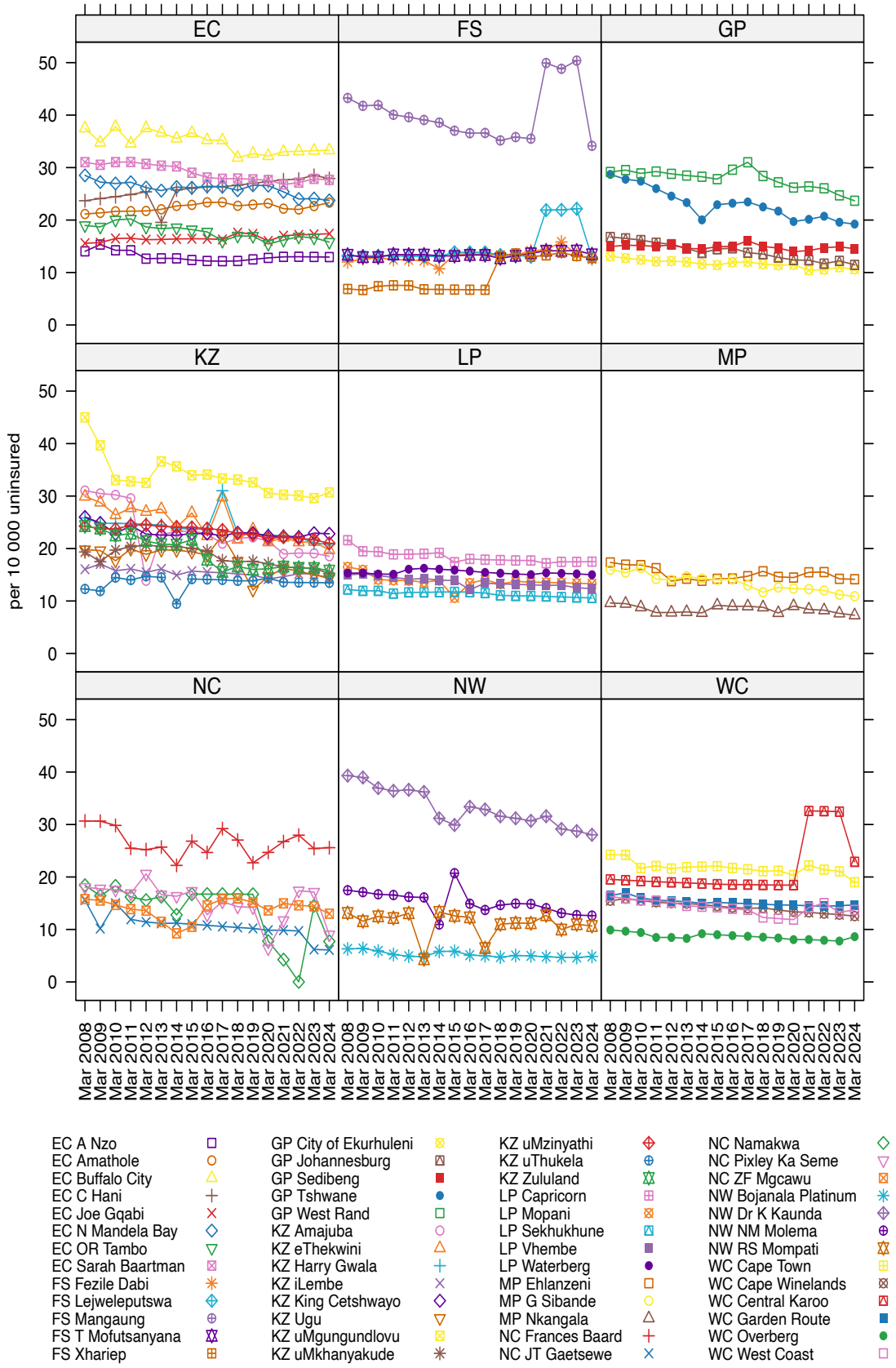


Figure 4 Annual trend: hospital beds per 10 000 target population by district, March 2008-March 2024 (all types of hospitals)

Source: DHIS

Hospital beds per 10 000 target population (district hospitals)

The total number of hospital beds considered in this section includes only usable hospital beds in public sector district hospitals, thus excluding those in hospitals at higher levels (regional, provincial, national, and specialised) and those in rehabilitation centres and other specialised hospitals.

National overview

In March 2024, there were 5.9 hospital beds per 10 000 uninsured population in district hospitals in the public sector (Figure 5). The beds per 10 000 uninsured population show a decrease between March 2018 (6.2 beds per 10 000 uninsured population) and March 2024 (5.9 beds per 10 000 uninsured population). In terms of absolute numbers, the total number of district hospital beds in March 2024 was 31 360 compared to 31 275 in 2023 and 30 909 in 2019 (Table 3).

Table 3 Number of inpatient beds by district hospitals, March 2019–March 2024

Province	District	Total beds - district hospital (March 2019)	Total beds - district hospital (March 2020)	Total beds - district hospital (March 2021)	Total beds - district hospital (March 2022)	Total beds - district hospital (March 2023)	Total beds - district hospital (March 2024)	Total Pop (2024)	Beds per 10 000 uninsured population - district hospitals (March 2024)
EC	A Nzo	866	899	917	920	919	919	802 520	11.5
	Amathole	1 266	1 266	1 266	1 236	1 266	1 266	729 269	17.4
	Buffalo City	272	272	272	272	272	272	612 053	4.4
	C Hani	1 165	1 165	1 162	1 146	1 167	1 160	658 136	17.6
	Joe Gqabi	568	521	551	552	552	552	317 310	17.4
	N Mandela Bay	238	238	238	237	238	238	971 018	2.5
	OR Tambo	1 104	1 084	1 059	1 084	1 084	1 084	1 521 530	7.1
FS	S Baartman	601	601	574	593	630	627	445 586	14.1
	Fezile Dabi	270	279	279	278	279	276	441 311	6.3
	Lejweleputswa	285	285	285	269	280	282	568 286	5.0
	Mangaung	483	485	400	395	400	476	720 491	6.6
	T Mofutsanyana	501	497	501	501	501	494	689 353	7.2
	Xhariep	155	148	151	157	150	146	114 351	12.8
GP	Ekurhuleni	305	297	247	257	245	199	3 305 283	0.6
	Johannesburg	518	522	566	574	559	555	5 162 083	1.1
	Tshwane	1 021	999	1 043	1 111	1 035	1 042	2 862 989	3.6
	Sedibeng	340	340	350	361	366	369	772 845	4.8
	West Rand	468	468	503	503	483	431	767 541	5.6
KZ	Amajuba	56	56	33	54	50	50	545 173	0.9
	eThekwini	1 016	961	947	1 240	1 120	1 120	3 387 761	3.3
	Harry Gwala	706	706	706	706	706	706	492 436	14.3
	iLembe	379	382	382	382	382	382	648 391	5.9
	King Cetshwayo	1 208	1 167	1 167	1 167	1 167	1 167	899 584	13.0
	Ugu	597	807	870	870	823	829	801 177	10.3
	uMgungundlovu	739	571	571	571	614	630	1 060 527	5.9
	uMkhanyakude	1 109	1 099	1 040	1 042	1 037	1 007	659 762	15.3
	uMzinyathi	1 134	1 134	1 134	1 134	1 134	1 134	557 621	20.3
	uThukela	455	464	442	442	445	445	670 765	6.6
	Zululand	1 242	1 261	1 261	1 256	1 261	1 261	836 522	15.1

LP	Capricorn	773	773	753	793	773	773	1 252 504	6.2
	Mopani	877	874	878	878	878	878	1 164 386	7.5
	Sekhukhune	679	679	679	679	679	679	1 202 505	5.6
	Vhembe	1 186	1 186	1 186	1 186	1 174	1 186	1 427 882	8.3
	Waterberg	723	723	729	729	729	724	719 154	10.1
MP	Ehlanzeni	1 253	1 253	1 362	1 373	1 264	1 264	1 687 796	7.5
	G Sibande	949	949	982	977	1 044	994	1 150 988	8.6
	Nkangala	431	634	656	656	665	642	1 482 610	4.3
NC	Frances Baard	93	93	100	93	83	91	360 717	2.5
	JT Gaetsewe	233	229	233	233	151	151	247 841	6.1
	Namakwa	73	73	40		73	73	94 455	7.7
	Pixley ka Seme	114	114	104	167	167	167	185 366	9.0
	ZF Mgcawu	92	92	99	95	95	95	247 668	3.8
NW	Bojanala	445	445	436	436	448	448	1 806 554	2.5
	Dr K Kaunda	88	88	88	102	102	88	737 914	1.2
	RS Mompati	356	356	438	320	366	353	443 649	8.0
	NM Molema	507	507	447	377	352	351	839 140	4.2
WC	Cape Winelands	247	247	247	247	247	268	842 381	3.2
	Central Karoo	120	120	120	120	120	150	65 511	22.9
	Cape Town	1 683	1 687	1 717	1 706	1 706	1 790	3 858 850	4.6
	Garden Route	396	396	396	396	396	421	532 683	7.9
	Overberg	202	202	202	202	202	232	268 992	8.6
	West Coast	322	322	353	396	396	423	409 810	10.3
South Africa		30 909	31 016	31 162	31 471	31 275	31 360	53 051 029	5.9

Source: DHIS

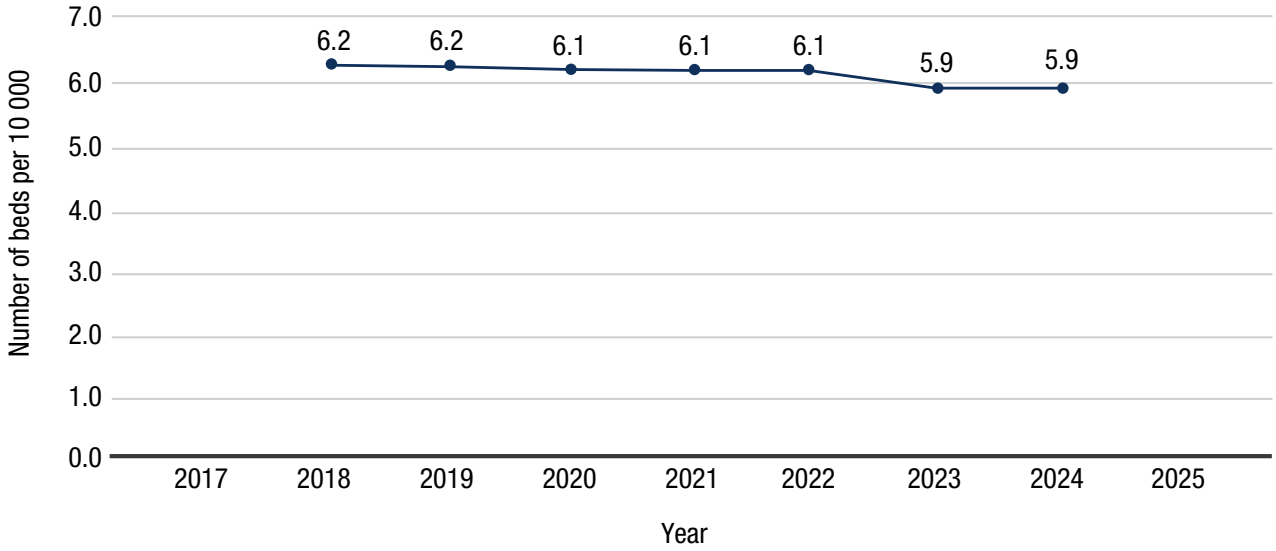


Figure 5 National hospital beds per 10 000 uninsured population (district hospitals), March 2018–March 2024

Source: DHIS

Provincial overview

The provincial hospital beds per 10 000 uninsured population for district hospitals is shown in Figure 6. Values range from the minimum observed in GP (at 2.0 per 10 000 uninsured population) to the maximum of 10.1 per 10 000 uninsured population in EC, a 5-fold variation. The bed trends between 2023 and 2024 are largely stable with slight increases observed in FS and WC.

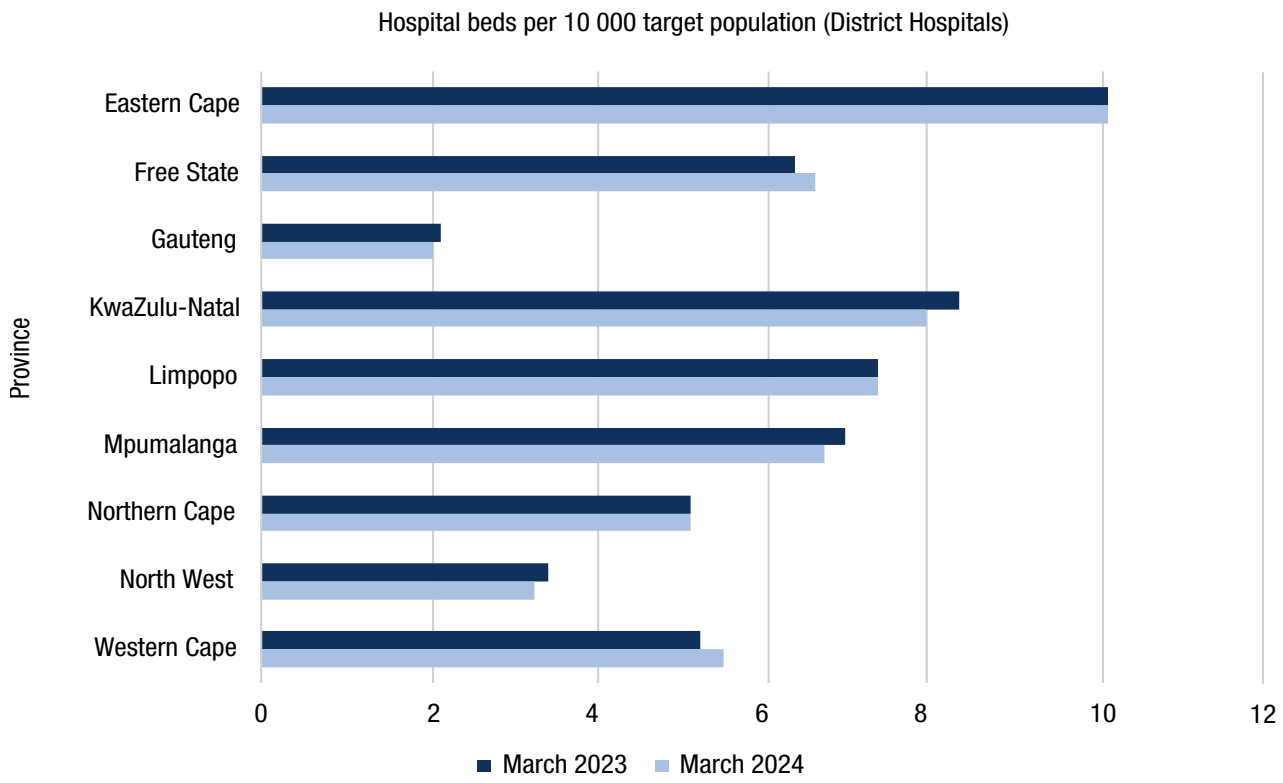
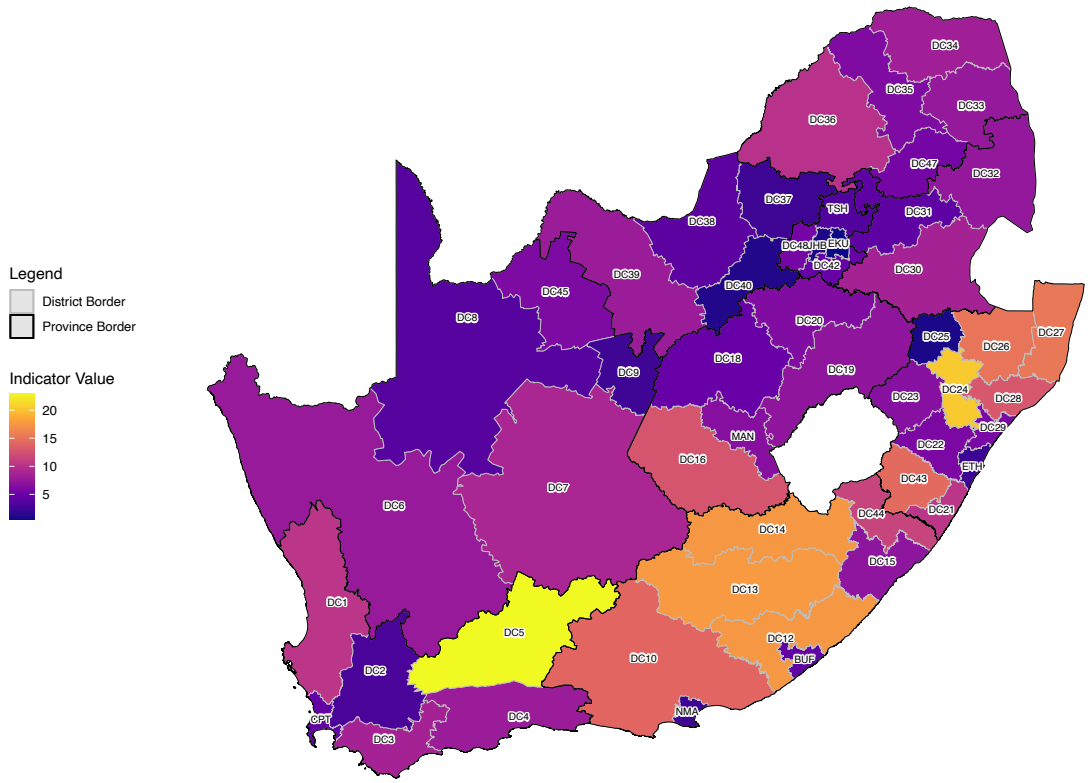


Figure 6 Hospital beds per 10 000 uninsured population by province, March 2023 and March 2024 (district hospitals)

Source: DHIS

District overview

The number of district hospital beds per 10 000 uninsured population observed in March 2024 varies widely across districts (Map 2). There is a higher concentration of district hospital beds across EC and KZ.



MAP 2 Hospital beds per 10 000 uninsured population by district, March 2024

Source: DHIS

The extreme variations in district hospital beds continue at a district level, with a minimum of 0.6 beds per 10 000 uninsured population in Ekurhuleni (GP) to a maximum of 22.9 beds in Central Karoo (WC), representing a 38-fold variation (Figure 7). The national average of district hospital beds per 10 000 population is 5.9. The range of district hospital beds within provinces is shown in Table 4. The largest ranges are in WC, KZ and EC. These differences are a robust indicator of inequity between districts as they comprise only one variable–district hospital beds. However, this should be interpreted with caution given that other contributing factors have not been taken into consideration. Further analysis is required. For example, Central Karoo (WC) has a low BUR which indicates that the useable beds are not fully utilised; however, it is a sparsely populated area with a large geographical footprint. It is also on a transport route (N1) notorious for accidents and therefore services not only the district's population, but traffic passing through and thus needs to have the capacity to deal with those emergencies too. This could partly explain the high ratio and low BUR. The ALOS seems normal. The usable beds–150–are quite a bit higher than the approved beds (120) which is probably in response to the ad hoc requirement to cater for emergencies - most of these beds are at Beaufort West Hospital. There are also no private hospitals in the area.

Table 4 Range of district hospital beds across provinces, March 2024

Province	Lowest number of beds per 10 000	Highest number of beds per 10 000	Variance
Eastern Cape	2.5	17.6	15.1
Free State	5	12.8	7.8
Gauteng	0.6	5.6	5.0
KwaZulu-Natal	0.9	20.3	19.4
Limpopo	5.6	10.1	4.4
Mpumalanga	4.3	8.6	4.3
Northern Cape	2.5	9.0	6.5
North West	1.2	8.0	6.8
Western Cape	8.6	22.9	14.3

Source: DHIS

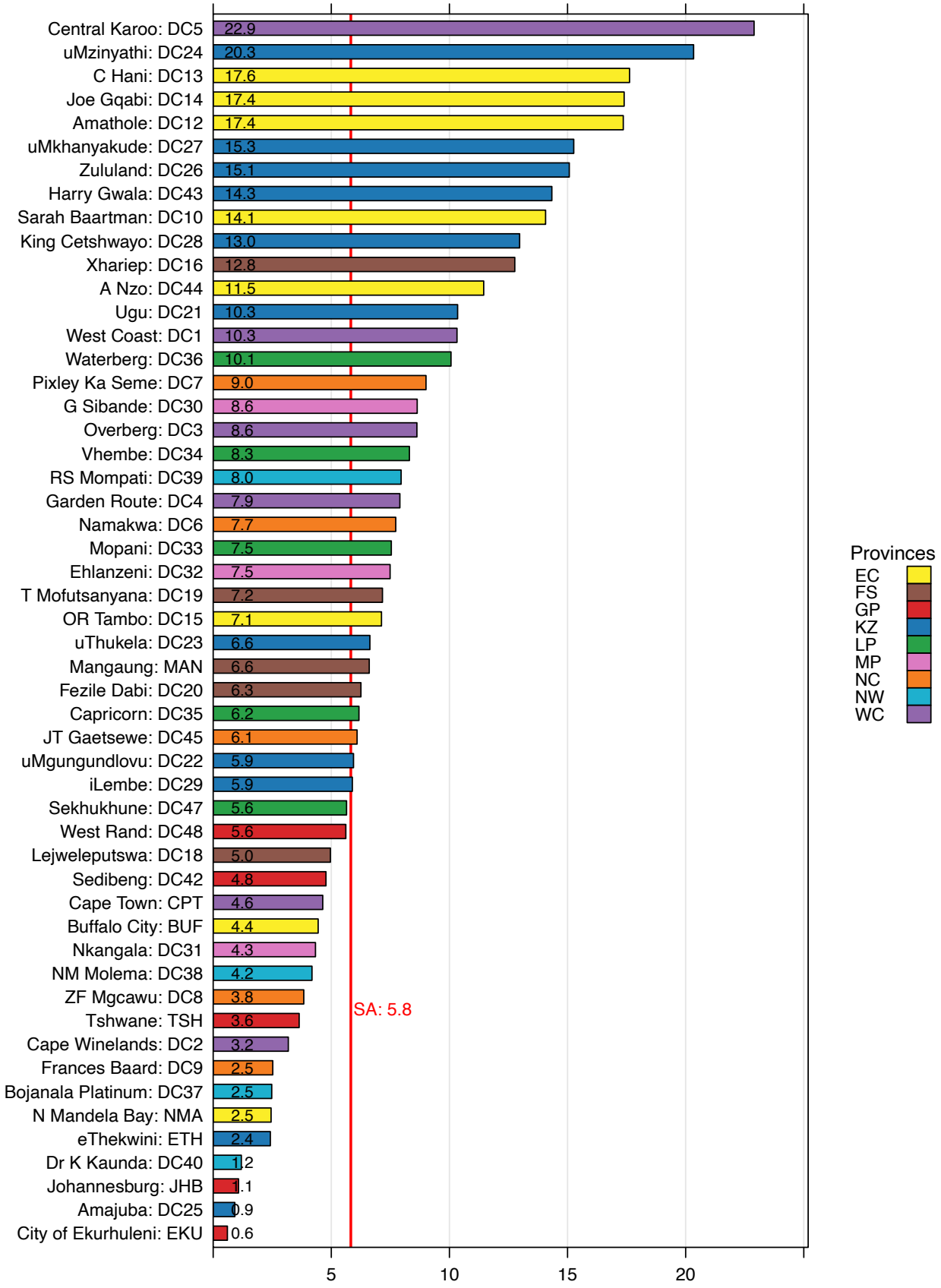


Figure 7 Hospital beds per 10 000 uninsured population by district, March 2024 (district hospitals)

Source: DHIS

An analysis of the number of district hospital beds in March each year for the past four years (March 2021–March 2024) indicates that the global number of district beds for the country fluctuated year-on-year. There was an increase in absolute numbers of beds of 309 from 2021 to 2022, followed by a decrease of 196 beds in 2023, and then an increase of 85 beds in 2024.

The bed utilisation rate measures occupancy of hospitals and is one of the indicators used to measure if hospital capacity is used efficiently. It is calculated as follows: number of inpatient days added to half the number of day patients, and divided by usable bed days.

Average length of stay refers to the average number of days that patients spend in hospital. It is calculated as follows: total number of inpatient days during a year plus half the number of day patients, divided by the number of separations (deaths, discharges, and transfers out). If the ALOS is persistently long, it suggests that patients spend too much time in hospital either because they are not discharged, appropriately treated, or transferred timeously, or the acuity of patients is severe and therefore requires longer periods to be treated. If the ALOS is persistently short, it could mean that patients are being discharged prematurely owing to service pressures.

Table 5 shows the hospital beds per 10 000 uninsured population, BUR and ALOS for district hospitals. The national average BUR for district hospitals in 2023/24 was 62.9%. Evidence suggests that a BUR greater than 85% will likely result in bed shortages and increases in adverse health outcomes such as increased hospital acquired infections.[8] A BUR rate of 80–85% ensures efficient hospital operations while maintaining flexibility to accommodate sudden surges in demand or emergencies.

Forty-four district hospitals have less than 50 beds. District hospitals range in size from small, medium to large and the packages of care delivered also vary. Thus, the functioning of district hospitals must be looked at within its broader context and in conjunction with other indicators and parameters. This also makes the case for rationalisation and redesign of hospital services to improve efficiencies as well as to better align with evolving needs while ensuring equitable access to quality care. Poor performance at district hospital level results in increased inappropriate referrals to higher levels of care.

Table 5 Hospital beds per 10 000 uninsured population, bed utilisation rate and average lengths of stay for district hospitals by district, March 2024

Province	District	Beds per 10 000 uninsured population	Inpatient bed utilisation rate	Average length of stay
Eastern Cape	Alfred Nzo	11.5	64.5	5.2
	Amathole	17.4	41.5	4.9
	Buffalo City	4.4	46.0	5.9
	Chris Hani	17.6	41.0	4.8
	Joe Gqabi	17.4	46.1	4.7
	Nelson Mandela Bay	2.5	72.6	4.8
	OR Tambo	7.1	46.4	5.4
	Sarah Baartman	14.1	53.8	4.1
Free State	Fezile Dabi	6.3	58.5	3.8
	Lejweleputswa	5.0	44.7	2.7
	Mangaung	6.6	52.3	3.9
	T Mofutsanyana	7.2	52.0	2.9
	Xhariep	12.8	45.9	4.2

8 National Institute for Health and Care Excellence. Guideline 94: Ch 39 - Bed Occupancy. NICE; National Guideline Centre, hosted by the Royal College of Physicians: March 2018.

Gauteng	Ekurhuleni	0.6	78.3	6.3
	Johannesburg	1.1	72.8	5.2
	Sedibeng	4.8	73.4	5.1
	Tshwane	3.6	73.2	5.0
	West Rand	5.6	68.2	4.8
KwaZulu-Natal	Amajuba	0.9	57.8	4.6
	eThekwini	2.4	65.0	5.0
	Harry Gwala	14.3	58.9	5.6
	iLembe	5.9	47.0	5.4
	King Cetshwayo	13.0	39.0	5.5
	Ugu	10.3	62.8	5.1
	uMgungundlovu	5.9	69.6	5.5
	uMkhanyakude	15.3	62.2	5.6
	uMzinyathi	20.3	46.5	5.7
	uThukela	6.6	65.3	6.3
	Zululand	15.1	50.9	4.6
Limpopo	Capricorn	6.2	75.2	4.4
	Mopani	7.5	73.8	4.6
	Sekhukhune	5.6	65.6	3.9
	Vhembe	8.3	66.6	4.6
	Waterberg	10.1	61.9	4.5
Mpumalanga	Ehlanzeni	7.5	61.8	4.4
	Gert Sibande	8.6	57.2	4.5
	Nkangala	4.3	68.2	4.8
Northern Cape	Frances Baard	2.5	30.6	2.8
	JT Gaetsewe	6.1	65.8	3.9
	Namakwa	7.7	64.7	2.4
	Pixley Ka Seme	9.0	49.5	4.2
	ZF Mgcawu	3.8	49.7	3.2
North West	Bojanala Platinum	2.5	72.2	4.6
	Dr K Kaunda	1.2	65.1	4.0
	NM Molema	4.2	58.2	4.2
	RS Mompati	8.0	66.8	4.7
Western Cape	Cape Town	4.6	98.3	4.2
	Cape Winelands	3.2	84.3	3.2
	Central Karoo	22.9	52.2	3.2
	Garden Route	7.9	74.1	2.9
	Overberg	8.6	67.3	3.0
	West Coast	10.3	76.3	3.0

Source: DHIS

The presence of some outliers (such as the extremely low number of district hospital beds compared to the uninsured population in Johannesburg and Ekurhuleni (both GP), is partly explained by the fact that provincial regional, tertiary, and national central hospitals also admit patients who should be treated at a lower level of care. Also, hospitals generally have a mixed patient profile across levels of care. Some are inappropriately admitted at the wrong level of care while other patients may be deemed

level 2 or 3 on admission but then improve and become level 1 patients for their remaining stay in hospital.[9] This leads to inefficiency and increases in costs for the health system. While it may not be appropriate or desirable to move patients when their acuity improves unless they have to remain for step-down care for much longer periods, admitting patients at the right level of care with good discharge planning will improve efficiencies. This is also impacted by, amongst others, the availability of intermediate care beds, patient transport, and the home environment of the patient.

The package of care rendered in district hospitals and the effectiveness of the primary health care (PHC) system in acting as a filter in reducing the number of inappropriate or avoidable hospital admissions, also are far from uniform across different geographical areas. Each province has adapted the national referral policy and applies different criteria for referral for admission. These differences imply that the 'ideal' value of bed density is not the same across districts and provinces. Drawing conclusions regarding equity of access to health system resources requires deeper analysis, well beyond the scope of this chapter.

The discrepancies and variations seen in the hospital bed trends is complex and cannot be interpreted and understood in isolation from the range of other related indicators, the varying contextual realities across districts and provinces, the broader health service platform, and the health system as a whole. While this is beyond the scope of this chapter, the challenges in inequity and inefficiency in hospitals that have been identified must be systematically analysed and addressed both at a national level as well as within provinces.

Recommendations

- The performance of hospitals, including their low utilisation levels, needs to be systematically addressed within provinces. This needs to happen within the context of the broader health ecosystem as well as within the specific local conditions. The trade-off between equitable access and efficiency must be carefully considered especially in deep rural areas. Provinces should be charged with the responsibility to explicitly include steps to improve equity in hospital services in their planning process.
- The huge variance in district hospitals at the district level is a more robust indicator of inequity between districts given that they only comprise one variable - district hospital beds. District hospitals provide first-line acute hospital services to communities and addressing equity should be an important priority.
- The decrease in hospital beds to below pre-COVID-19 levels requires more granular analysis at facility level to better understand the reasons.
- Data collection procedures at facility and district level, and a mechanism of verification at provincial and national levels, should be implemented to ensure the correctness of the data elements used for the calculation of hospital bed indicators. There needs to be clarity and consistency in the data collected and analysed especially in regard to approved beds versus usable beds. The use of data will in itself surface outliers and errors and serve to improve the quality of data. The large hospital infrastructure in the country, much of which is poorly utilised, makes the case for a review and re-configuration of hospital services that are more efficient, responsive to emerging population needs, equitably accessible, and offer optimal quality. This can only happen within a broader health system planning process.
- Given the strategic intent towards pooling of resources within the NHI, mapping both public and private hospitals per district and province in a future edition of the DHB will be useful.
- While the focus of the DHB is on districts and district hospitals, understanding the trends in data of all type hospitals will be enhanced by the provision of disaggregated data for regional, tertiary, central, and specialised hospitals across provinces. Analysing these hospitals only at district level will have limited value as they serve wider geographical areas; a provincial level analysis may be more appropriate.
- A more in-depth analysis should be conducted to explore additional variables that influence the bed-to-population ratio, BUR, and ALOS. These variables include geographical distance between districts, transport routes, patterns of population migration, demographic characteristics, and the availability of private hospitals and other public healthcare facilities in the area. Understanding these factors will provide a more comprehensive assessment of hospital bed capacity and utilisation.

9 Vallabhjee KN, Jinabhai CC, Gouws E, Bradshaw D, Naidoo K. Levels of health care at academic and regional hospitals in KwaZulu-Natal. SAMJ. 1997;87(10): 1355-1359.

4.2 FINANCE

Noxolo Madela, Mark Blecher, Aisha Khoele

Key findings

- In 2023/24, all provinces saw a decline in district health services (DHS) spending per capita compared to 2022/23. The spending per capita for the uninsured population ranged from R1 834 in Gauteng to R2 788 in Limpopo, with Limpopo remaining the highest spending province in DHS, given its district hospitals.
- DHS spending saw a nominal increase of 2.2% in 2023/24, increasing by R2.7 billion compared to the previous year. The total expenditure for 2023/24 was R124.2 billion, an average annual growth of 4.7% from R103.5 billion spent in 2019/20 (pre-COVID-19).
- Expenditure per headcount, expressed in 2023/24 real prices, spiked significantly from R657 in 2019/20 to R886 in 2020/21 due to decreased utilisation during the COVID-19 pandemic. However, post-COVID-19, primary health care (PHC) expenditure per headcount has gradually decreased from R886 in 2020/21 to R724 in 2023/24, owing to a partial rebound in utilisation in recent years. Additionally, headcount numbers, which were at a high of 119.8 million in 2019/20, dropped to 95.3 million in 2020/21 and have started picking up again, reaching 104.8 million in 2023/24.
- High reliance on district hospitals and bypassing of PHC facilities remains a concern in Gauteng (GP). Sedibeng (GP) may be facing somewhat of a high workload in district hospitals, with an average length of stay (ALOS) of 5.1 days and a high outpatient department (OPD) new client not referred rate (80.8%), suggesting over-reliance on hospital care due to limited PHC facility utilisation.
- Disparities in spending across and within provinces highlight the need for a thorough review of the healthcare service delivery models at both PHC and district hospitals levels. With the National Health Insurance (NHI) plan to overhaul the PHC system, several critical issues can potentially be addressed, including, equitable distribution of resources, improved efficient use of resources, enhanced utilisation of PHC facilities, and reduced reliance on costly hospital services.

Introduction

Primary Health Care is designed to be the first point of contact for individuals within the public healthcare system, emphasising preventive care, health promotion, and the management of chronic diseases. This approach is crucial for addressing the health needs of the population comprehensively and equitably. By reinforcing PHC, South Africa is making significant strides towards Universal Health Coverage (UHC) and the successful implementation of the NHI, ensuring that all citizens have access to quality health care services.

Financing of PHC in South Africa remains crucial, with allocative and technical efficiencies being fundamental to a functional PHC platform and the overall health system. Effective financing ensures that resources are distributed equitably and used optimally to improve population health outcomes. This includes allocative efficiencies, which entail directing resources to areas where they are most needed and includes funding for infrastructure, workforce development, and essential medical supplies, ensuring that essential health services are accessible to all, especially underserved communities.[1] Technical efficiencies involve maximising the output from available resources. Improvements in quality of care are required through better management practices, adopting cost-effective technologies, and reducing wastage.[2] Together, these efficiencies support a robust PHC system that can deliver comprehensive, high-quality care, ultimately contributing to better health outcomes and the success of initiatives like UHC and the anticipated NHI scheme.

The NHI Act 20 of 2023 was signed into law in May 2024. Although it has not yet been promulgated and the regulations for its

1 Fraser-Hurt N, Hou X, Wilkinson T, et al. Using allocative efficiency analysis to inform health benefits package design for progressing towards Universal Health Coverage: Proof-of-concept studies in countries seeking decision support. PLoS One. 2021;16(11): e0260247.
2 Rosko MD. Measuring technical efficiency in health care organizations. J Med Syst. 1990;14: 307–322.

implementation have not been gazetted, significant reforms are anticipated. Reforms through the NHI aim to overhaul South Africa's current PHC system, with a major focus on achieving UHC.[3]

Tracking longitudinal trends and the spatial distribution of health expenditure is essential for assessing health system performance, prioritisation, efficiency, and equity. In this chapter, the focus is on four key health financing indicators that measure the equity and efficiency of PHC and district hospital spending across South Africa, namely:

- Provincial and local government (LG) DHS expenditure per capita (uninsured population)
- Provincial and LG PHC expenditure per capita (uninsured population)
- Provincial and LG PHC expenditure per PHC headcount
- Expenditure per patient day equivalent (PDE) (district hospitals).

Health financing context

South Africa's fiscal position was severely affected by the COVID-19 pandemic which had a combined effect of slowing the national economy and reducing revenue (R113.3 billion national revenue shortfall was projected for 2024/25 and 2025/26). Concurrently, debt interest payments have risen by about R32.5 billion per annum on average, absorbing a larger share of the budget than health, education and social protection. Job losses were so severe during the pandemic that income protection measures (i.e. the COVID Social Relief of Distress grant) had to be introduced and have been extended for several years (at a cost of around R33.6 billion per annum) further weakening the fiscal position. This situation has resulted in substantial reductions in government budgets with reductions of around R27 billion per annum in government non-interest expenditure as announced in budget 2024/25. In the 2024/25 Budget, the national health budget was reduced by R1.3 billion in 2024/25, R3 billion in 2025/26 and R3.3 billion in 2026/27. Despite adding R7.1 billion to provincial health budgets for 2024/25, the 2024/25 Budget is projected to be R8.3 billion less than the pre-COVID-19 periods in 2019/20. As a share of total government spending, health's spending represents 14.1% of non-interest expenditure in 2023/24 and 13.7% in 2026/27. There has been a small increase in the share of income protection going to the social development sector following COVID-19.

Over the past two decades, South Africa experienced a significant increase in health spending, with government health expenditure per capita more than doubling from 2000/01 to 2020/21. This surge peaked in 2020/21 due to substantial additional funding to combat the COVID-19 pandemic. However, the economic impact of the pandemic, including decreased tax revenue and rising national debt, has resulted in declining health budgets from 2021/22 onwards. According to the 2023 Budget forecast, real health spending per capita is projected to revert to approximately 2010/11 levels by 2025/26, with minimal budget growth expected in the coming years. The analysis presented in this chapter provides a perspective on health spending, particularly as it concerns district health services including PHC, a backbone of healthcare and provides a basis for studies which might interrogate the possible impact of the declining health budgets in the post-COVID-19 era.

Given that this publication focuses on past expenditure, rather than budgets going forward, the results presented below do not yet show the full potential impact of the increasingly constrained budget environment, but the decline is starting to be seen in 2023/24.

The introduction and overview section of this publication provides a detailed explanation of the methodology used to calculate the indicators. In brief, up to 2023/24, provincial health expenditure was sourced from the Basic Accounting System (BAS) database,[4] while local government health expenditure was obtained from the Local Government Database and Reporting System.

3 Republic of South Africa. Government Gazette No. 4826 16 May 2024 Act No. 20 of 2023: National Health Insurance Act 2023.
4 The figures presented in this chapter may differ from those published in the provinces' annual statements. This is because numbers in the BAS system can be adjusted even after the auditing process is completed, and the figures used here are drawn some time after the audit is finalised.

Since municipal health services receive partial funding through transfers from provincial health departments, these transfers are included in provincial spending. Consequently, LG health expenditure only accounts for spending from its own revenue to prevent double-counting. Expenditure assigned to specific health facilities under the 'Responsibility' segment of BAS was matched to the latest District Health Information System (DHIS) facility data to determine the district where the expenditure occurred. Unless otherwise noted, all expenditure changes are presented in real 2023/24 prices, adjusted using Statistics South Africa's (Stats SA) Consumer Price Index. This approach ensures that changes over time reflect actual resource use rather than inflationary cost changes.

Overview of DHS expenditure

District Health expenditure is allocated through a dedicated programme within the budget structure of provincial health departments. This programme comprises nine core subprogrammes, detailed in Box 1, which are primarily categorised by the level of care or type of services they fund. Additionally, this chapter includes LG health expenditure from LG's own revenue to ensure comprehensive reporting of total government PHC spending.

District management: Planning and administration of services; managing personnel and financial administration; co-ordination and management of the day hospital organisation and community health services rendered by local authorities and non-governmental organisations within the metro; determining work methods and procedures; and exercising district control.

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

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

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

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

HIV and AIDS: Rendering a PHC service in respect of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) campaigns and special projects.

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

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

District hospitals: Rendering of a hospital service at district level.

Box 1 District Health Services subprogramme objectives

Provincial budget structures have eight programmes and, as shown in Figure 1, DHS is by far the largest programme. It accounted for almost half of total health expenditure in 2022/23, increasing from below 40% in 2004/05. This is to a large extent driven by increases in the HIV/AIDS programme (see Figure 1) as a result of the rollout and expansion of antiretroviral therapy (ART), which now covers more than 5 million people.

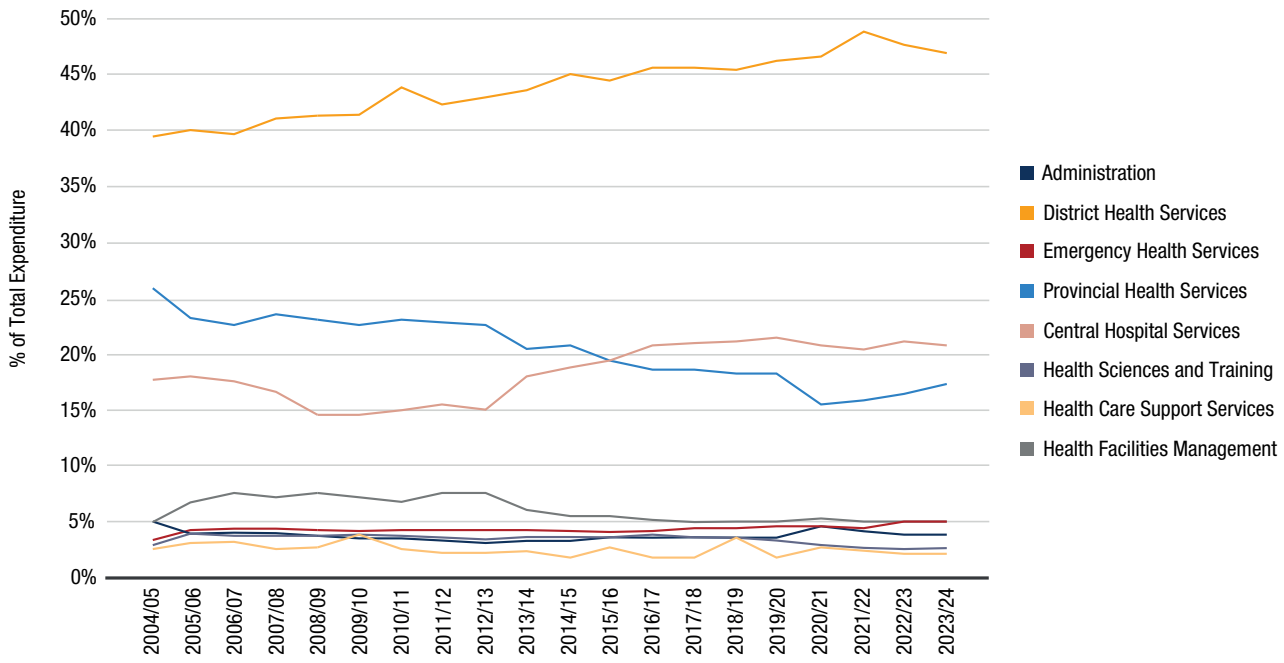


Figure 1 Percentage of provincial health expenditure by programme, 2004/05 – 2023/24

Source: BAS

Figure 2 shows each subprogramme and LG expenditure as a percentage of total district health services expenditure from 2004/05 to 2023/24.

The HIV/AIDS subprogramme has grown considerably as a result of the increased coverage of ART. The peak in 2021/22 is also partly due to once-off COVID-19 allocations.

Although some subprogrammes, notably district hospitals, make up a declining share of total DHS expenditure it should be noted that all subprogrammes saw a real increase in total spending over the period as shown in Figure 2.

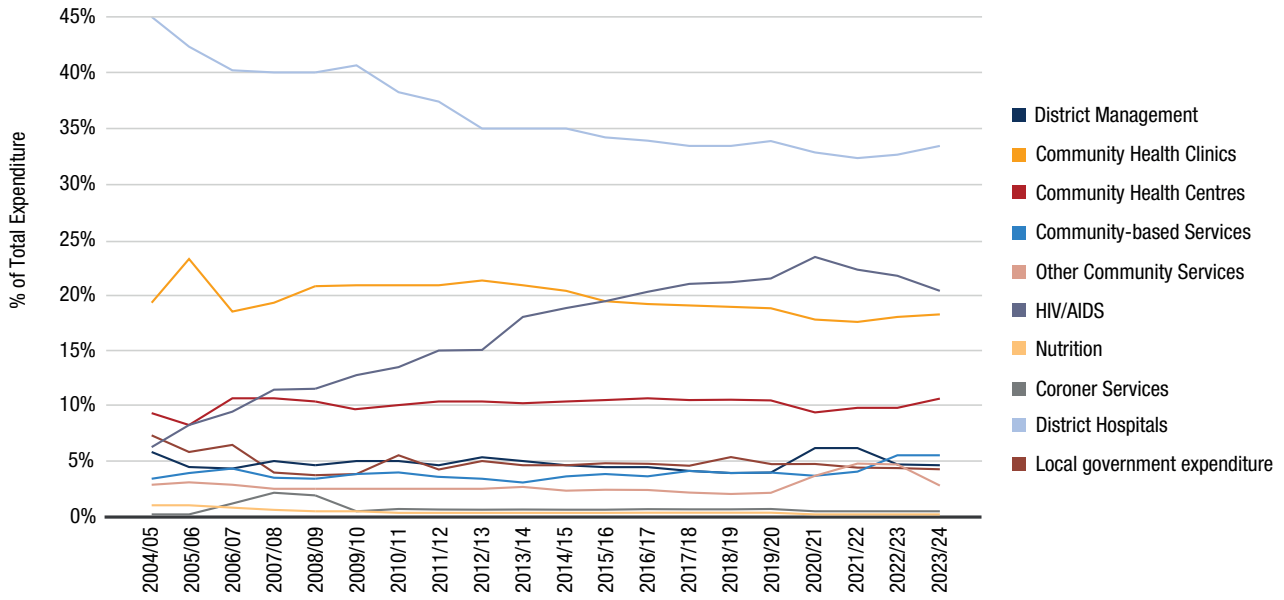


Figure 2 Percentage of provincial DHS expenditure by subprogramme, 2004/05 – 2023/24

Source: BAS

Table 1 Trends in district health services programme expenditure (R'000 nominal)

	2019/20	2020/21	2021/22	2022/23	2023/24
District Health Services	**98 648 778**	**107 781 314**	**115 083 767**	**116 406 468**	**118 956 876**
District Management	4 395 698	5 431 375	6 915 933	5 713 222	5 873 081
Community Health Clinics	18 969 616	19 383 560	19 927 108	20 452 396	22 138 549
Community Health Centres	10 915 658	10 854 747	11 828 834	11 837 770	13 121 673
Community-based Services	4 130 488	4 165 423	4 629 537	6 590 606	6 791 596
Other Community Services	2 044 107	3 902 429	5 551 792	5 570 354	3 069 357
HIV/AIDS	22 293 318	27 090 484	27 773 437	26 713 560	25 256 671
Nutrition	198 239	201 798	220 821	244 351	232 438
Coroner Services	701 071	749 803	774 162	816 315	845 994
District Hospitals	35 000 583	36 001 695	37 462 142	38 467 893	41 627 516
Local government expenditure	**4 828 131**	**5 392 247**	**5 157 842**	**5 140 494**	**5 285 262**
Grand Total	**103 476 908**	**113 173 561**	**120 241 609**	**121 546 962**	**124 242 138**

Source: BAS

Table 1 shows trends in DHS expenditure by budget subprogramme. If converted into 2023/24 real prices this reflects significant reductions (1.1% decline, from R128.5 billion in 2019/20 to R124.4 billion in 2023/24), particularly in the HIV/AIDS and other community services subprogrammes. Part of this reflects the removal of some COVID-19 expenditure and part reflects reductions given the economic and fiscal situation post-COVID-19 and part is due to cheaper processes for ARVs.

Provincial & LG DHS expenditure per capita (uninsured population)

Provincial and LG DHS expenditure per capita for the uninsured represents the total DHS expenditure allocated per person not covered by a private medical scheme. In South Africa, about 16% of the population are members or beneficiaries of private medical schemes and are thus excluded from the population denominators used in this chapter's indicators, as they typically do not rely on the public healthcare system for their health needs. Significant variations in this expenditure across provinces and/or districts may indicate potential inequities in resource allocation and highlight areas where spending may need to be adjusted to improve healthcare access and quality of care for the population in need.

National overview

In real 2023/24 prices, DHS spending saw a significant decline in 2023/24, dropping by R3.6 billion compared to the previous year. The total expenditure for 2023/24 was R124.2 billion, considerably lower than the R128.5 billion spent in 2019/20 (pre-COVID-19)–expressed in real 2023/24 prices. This regression underlines the growing challenges in maintaining adequate health budgets over time.

Several factors contributed to the decline in 2023/24 spending, including the phasing out of COVID-19-related allocations and the implementation of fiscal consolidation measures. These measures often involve cuts to non-essential services and a freeze on filling vacant positions, further straining healthcare delivery systems. The return to spending levels below those seen six years ago raises concerns about the long-term sustainability of district health services. This is particularly troubling given the increasing demand for healthcare services driven by population growth, a rising disease burden, and socio-economic inequalities. The reduced budget allocation not only has potential to impact service delivery negatively but also risks undermining key programmes, including those focused on HIV/AIDS, maternal and child health, and chronic disease management. However, at the same time it is worth noting that the number of PHC visits has declined raising questions about whether additional workload measures should be considered such as central chronic medicines dispensing and distribution (CCMDD), ward based PHC outreach teams (WBPHOTs), integrated school health programmes, etc. The Provincial and LG DHS expenditure per capita for the uninsured in 2023/24 was R2 355 compared to R2 454 in 2022/23 (Figure 3).

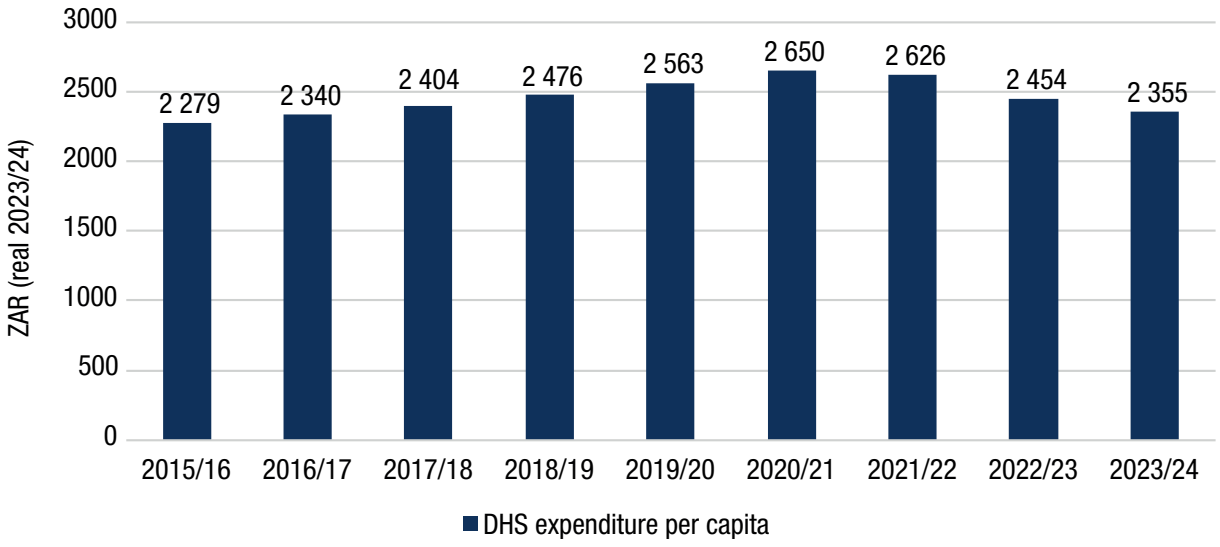


Figure 3 Provincial and LG DHS expenditure per capita (uninsured) real 2023/24 prices, 2015/16 – 2023/24

Source: BAS

Provincial overview

All provinces experienced a decline in DHS spending per capita from 2022/23 to 2023/24. In 2023/24, DHS spending per capita (uninsured) ranges from R1 834 in Gauteng to R2 788 in Limpopo (Figure 4). Limpopo (LP) remains the highest spending province in DHS, primarily due to its heavy reliance on district hospitals, as noted in previous editions of the District Health Barometer (DHB). Although Northern Cape's (NC) spending (R2 641) is close to that of LP's, there are significant disparities within the province.

Overall, there have been few changes in spending outcomes across provinces compared to previous years. However, notable shifts occurred in KwaZulu-Natal (KZ), where spending declined by 5.6% from R2 801 in 2022/23 to R2 644 in 2023/24, moving the province from the second highest to the third-highest spender. While all provinces saw a reduction in spending, NC experienced the smallest decline of just 0.6% (from R2 667 in 2022/23 to R2 647 in 2023/24), whereas Free State (FS) faced the largest decline of 8.2% (from R2 511 in 2022/23 to R2 305 in 2023/24).

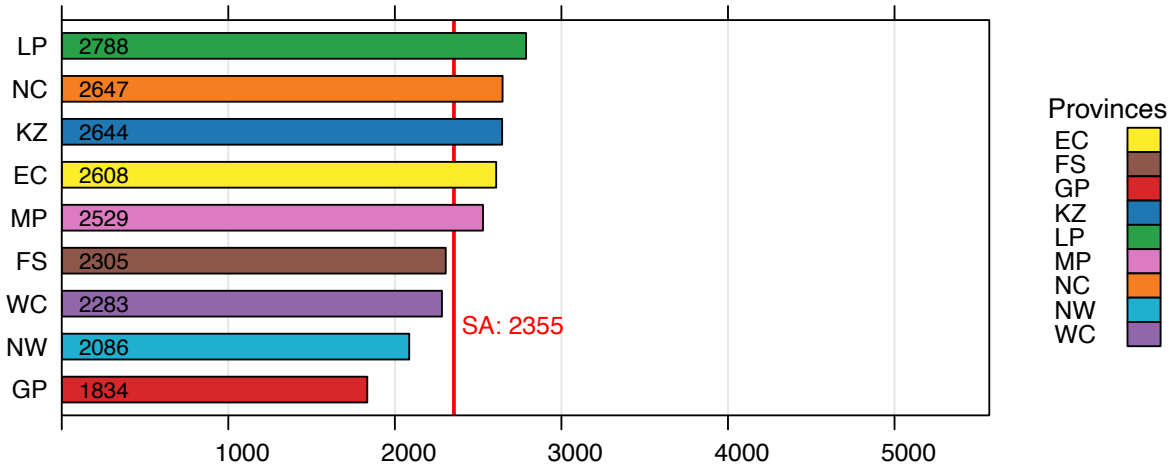


Figure 4 Provincial and LG DHS expenditure per capita (uninsured) by province, 2023/24

Source: BAS

District overview

The disparities in spending across districts have not only persisted but have also widened significantly over time, with a notable increase in the standard deviation from R654 in the 2015/16 financial year to R740 in 2023/24. This indicates growing inequality in resource allocation between districts. Among the provinces, the disparities are most pronounced in the Western Cape (WC) and NC, while they are relatively less significant in Mpumalanga (MP) and LP. The Central Karoo district (WC) continues to be the highest-spending district in the country, followed closely by the Namakwa district (NC) (Figure 5 and Map 1). Both districts have consistently maintained these positions over an extended period.

It is worth noting that Central Karoo and Namakwa districts are large, sparsely populated areas with unique challenges, such as higher costs for transportation, infrastructure development, and service delivery. This necessitates higher per capita spending compared to more densely populated districts. The lesser spending disparities in MP and LP could result from a more equitable resource distribution strategy, possibly influenced by their relatively homogenous socio-economic conditions and higher population densities, which enable more cost-effective service delivery.

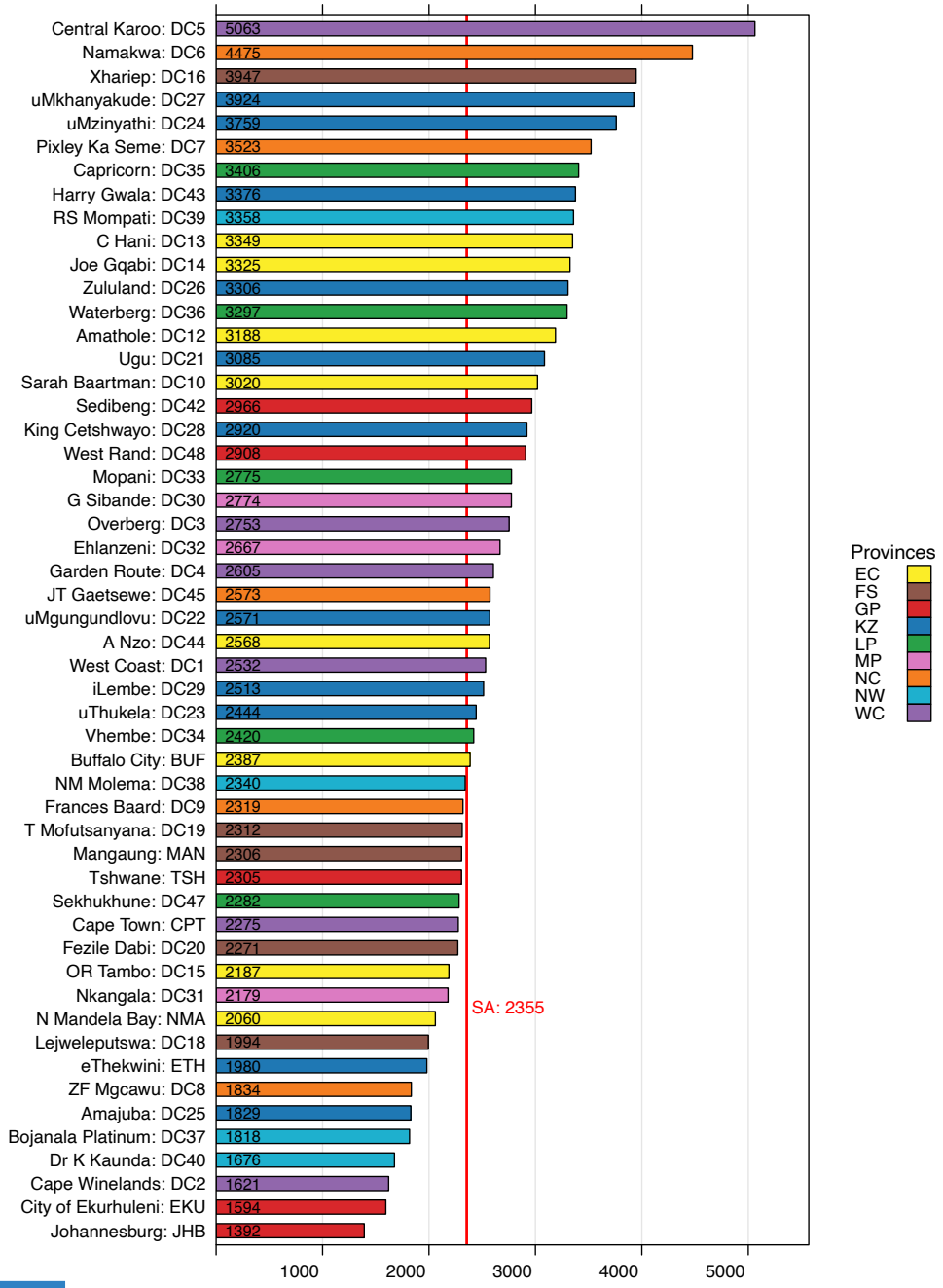
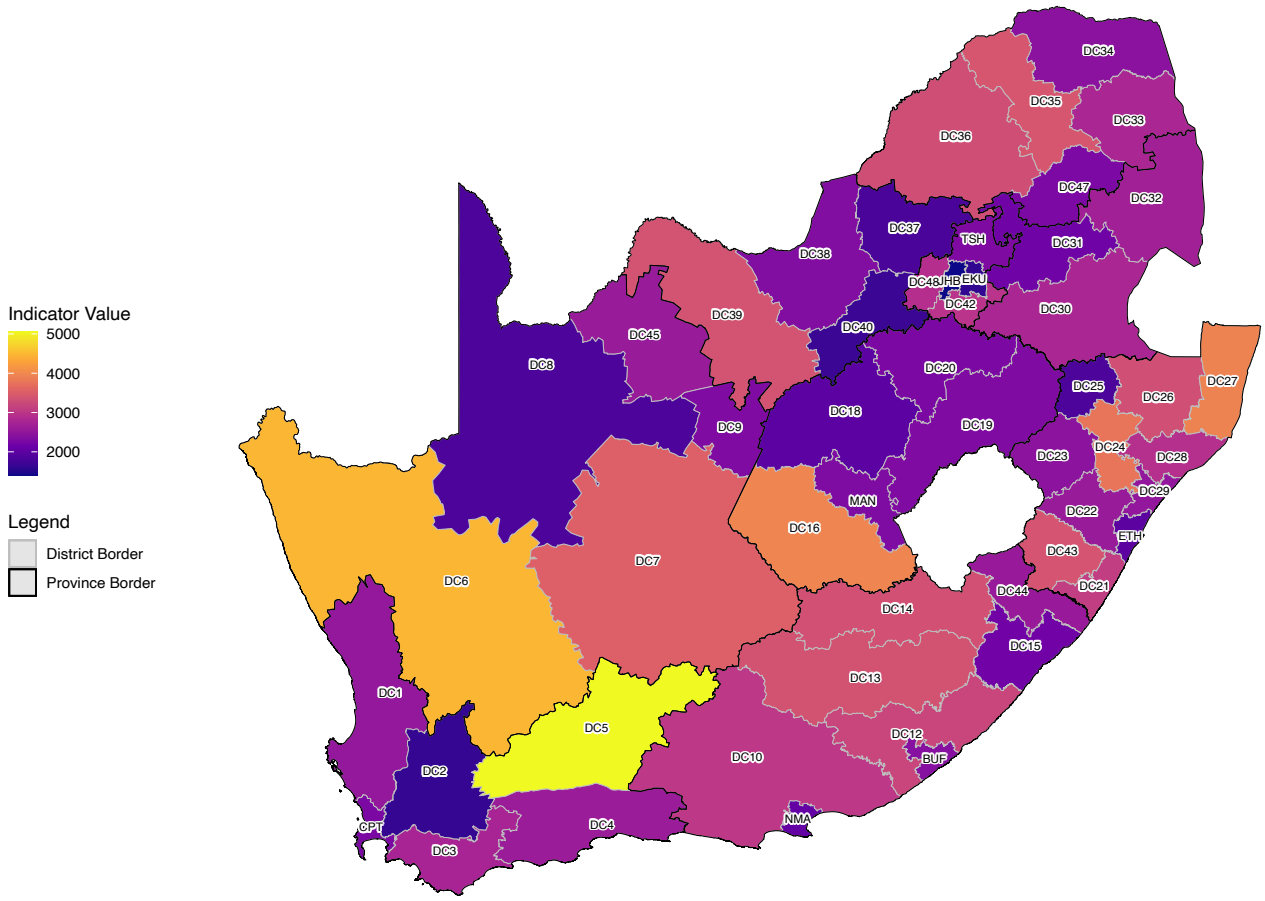


Figure 5 Provincial and LG DHS expenditure per capita (uninsured) by district, 2023/24

Source: BAS



MAP 1 Provincial and LG DHS expenditure per capita (uninsured) by district, 2023/24

Source: BAS

Provincial & LG PHC expenditure per capita (uninsured population)

Provincial and LG PHC expenditure per capita for the uninsured population is calculated similarly to DHS expenditure per capita, but it excludes costs related to district hospitals and district management. Since district hospitals, which are often unevenly distributed due to various logistical and historical reasons, are excluded from this measure, PHC expenditure per capita is expected to show a more balanced distribution across regions.

However, expenditure differences can still be influenced by factors such as demographic characteristics (age and sex), disease burden, socio-economic conditions, and population density. Significant variations in per capita spending may indicate inequities in resource distribution. Extremely high per capita expenditures could suggest inefficiencies, while very low spending levels may indicate under-resourcing, potentially affecting the accessibility and quality of primary healthcare services.

National overview

Between 2015/16 and 2019/20, PHC per capita spending increased steadily in real terms, rising from R1 380 to R1 581, with an average annual growth rate of 3.4% (Figure 6). However, this trend reversed over the next three years, with spending dropping to R1 556 in 2022/23 and further to R1 448 in 2023/24. This decline is due to the phasing out of COVID-19 allocations and broader budget cuts driven by austerity measures, including a freeze on filling vacant positions.

A significant driver of PHC expenditure growth in earlier years was spending on HIV/AIDS programmes, which accounted for 37% of PHC spending in 2021/22. This proportion has decreased compared to previous years, in 2022/23 it was 34.9% and 33.3% in 2023/24, likely due to budget reductions from fiscal consolidation efforts as well as cheaper prices for ARVs.

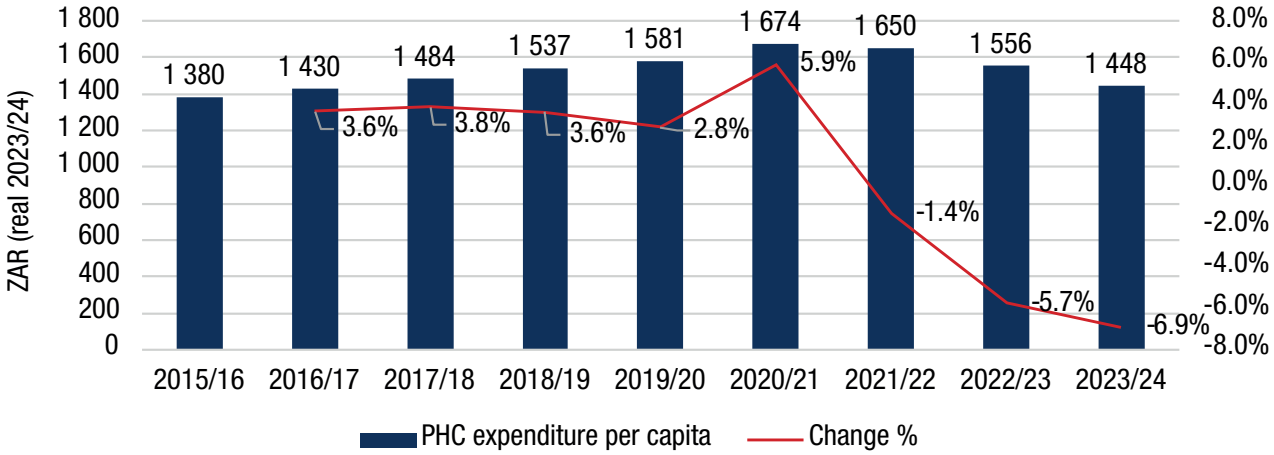


Figure 6 Provincial and LG PHC expenditure (real 2023/24 prices) per capita (uninsured population), 2015/16 – 2023/24

Source: BAS

Provincial overview

The variation and changes in PHC spending per capita across different provinces over the years reflect general shifts in the health budget and the prioritisation of PHC in these regions. In the past three years (2021/22, 2022/23, and 2023/24), the top three provinces for PHC spending per capita have been KZ, NC and FS.

KwaZulu-Natal continues to lead in spending followed by NC. All provinces experienced changes in spending, with an average reduction of 6.9% from 2022/23 to 2023/24. The Eastern Cape (EC) had the smallest decline at just 2.0%.

This overall reduction in spending has also decreased the variation in spending across provinces, with the standard deviation dropping from R175 in 2022/23 to R132 in 2023/24. This may suggest a more equitable distribution of resources. However, the impact on service delivery in provinces with significant spending cuts needs further investigation to assess impact on service delivery and health outcomes, as reduced spending does not always equate to improved efficiency and vice versa. It is crucial to understand whether these budget adjustments are leading to improved health services or if they are compromising the quality of care provided to the population.

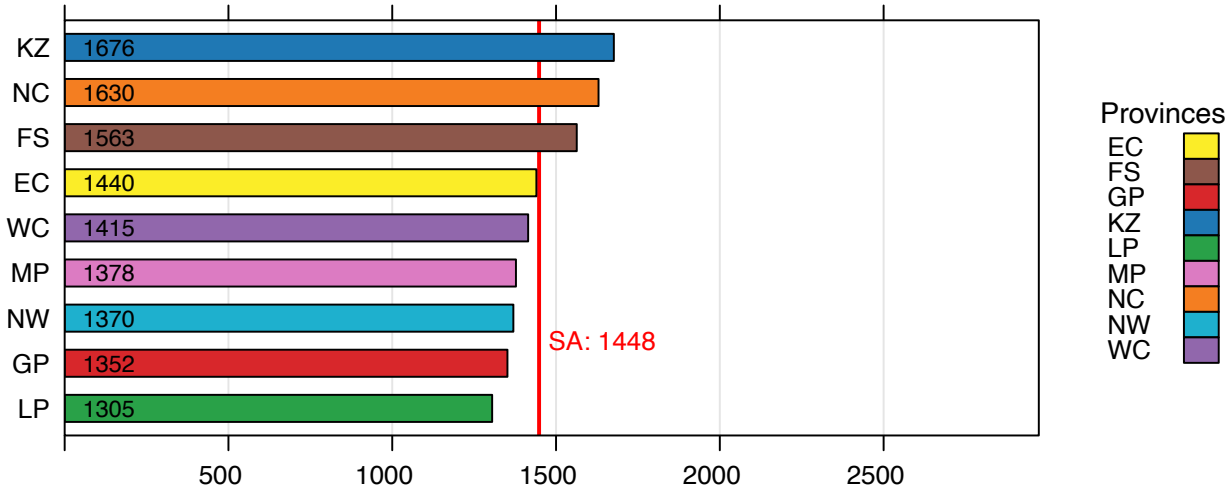


Figure 7 Provincial and LG PHC expenditure per capita (uninsured) by province, 2023/24

Source: BAS

District overview

As can be seen in Figure 8 and Map 2, the variation in district-level spending closely mirrors trends observed at the provincial level. In 2023/24, Namakwa (NC) became the highest-spending district with R2 703 per capita, an increase from its second-place position of R2 385 in 2022/23. Xhariep (FS) dropped to third place in 2023/24 with R2 361, after leading in 2022/23 with R2 499. Sekhukhune (LP) saw a significant decline, falling from R1 304 in 2022/23 to R1 072 in 2023/24, making it the lowest-spending district. This replaced Alfred Nzo (EC), which rose from R1 070 in 2022/23 to R1 161 in 2023/24, moving up to the fifth-lowest spending district nationally.

These shifts align with broader provincial trends. The EC, which had the smallest overall decline in provincial spending, allocated 8% more to Alfred Nzo district, while all other districts in the province experienced budget cuts. This suggests a deliberate effort to address inequities. However, there were significant disparities within the province. Joe Gqabi (EC) had the largest spending decrease at 12%, compared to Buffalo City's (EC) smaller reduction of 5%. Despite this, Buffalo City remains the highest-spending district in the province.

Overall, nationally, district-level spending variation has slightly decreased, with the standard deviation dropping from R345 in 2022/23 to R343 in 2023/24, this is still above levels last seen in 2019/20 (R332). It is not immediately clear whether this variation could be taken as a proxy for inequitable distribution of resources, challenges in returning to pre-COVID-19 service delivery arrangement and distribution of resources or a fair response to differing socio-economic factors etc. Nevertheless, provincial disparities persist. Mpumalanga has the smallest variation across districts, with a difference of just R113 from the mean, while the NC continues to show the highest variation, with a standard deviation of R631.

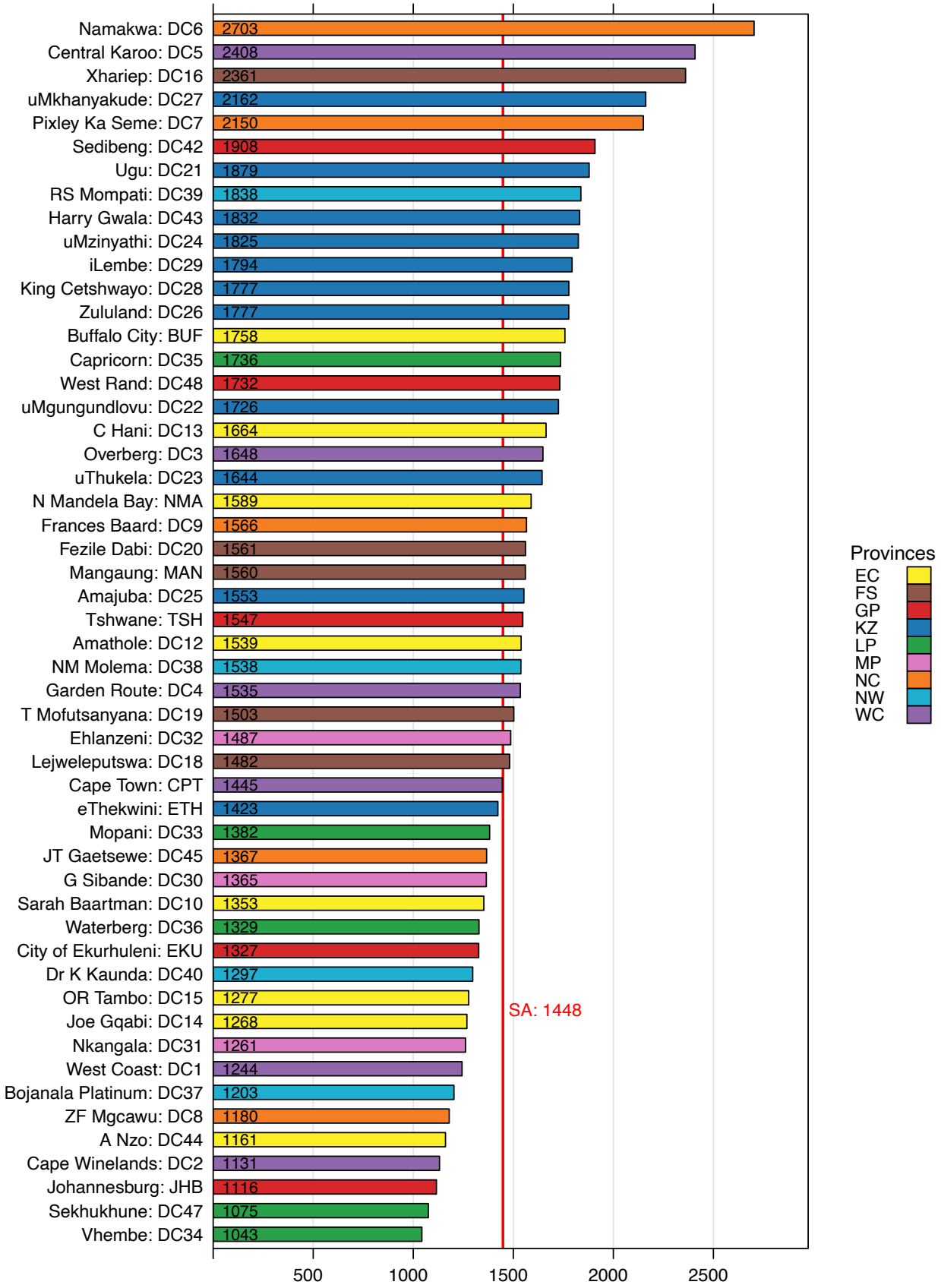
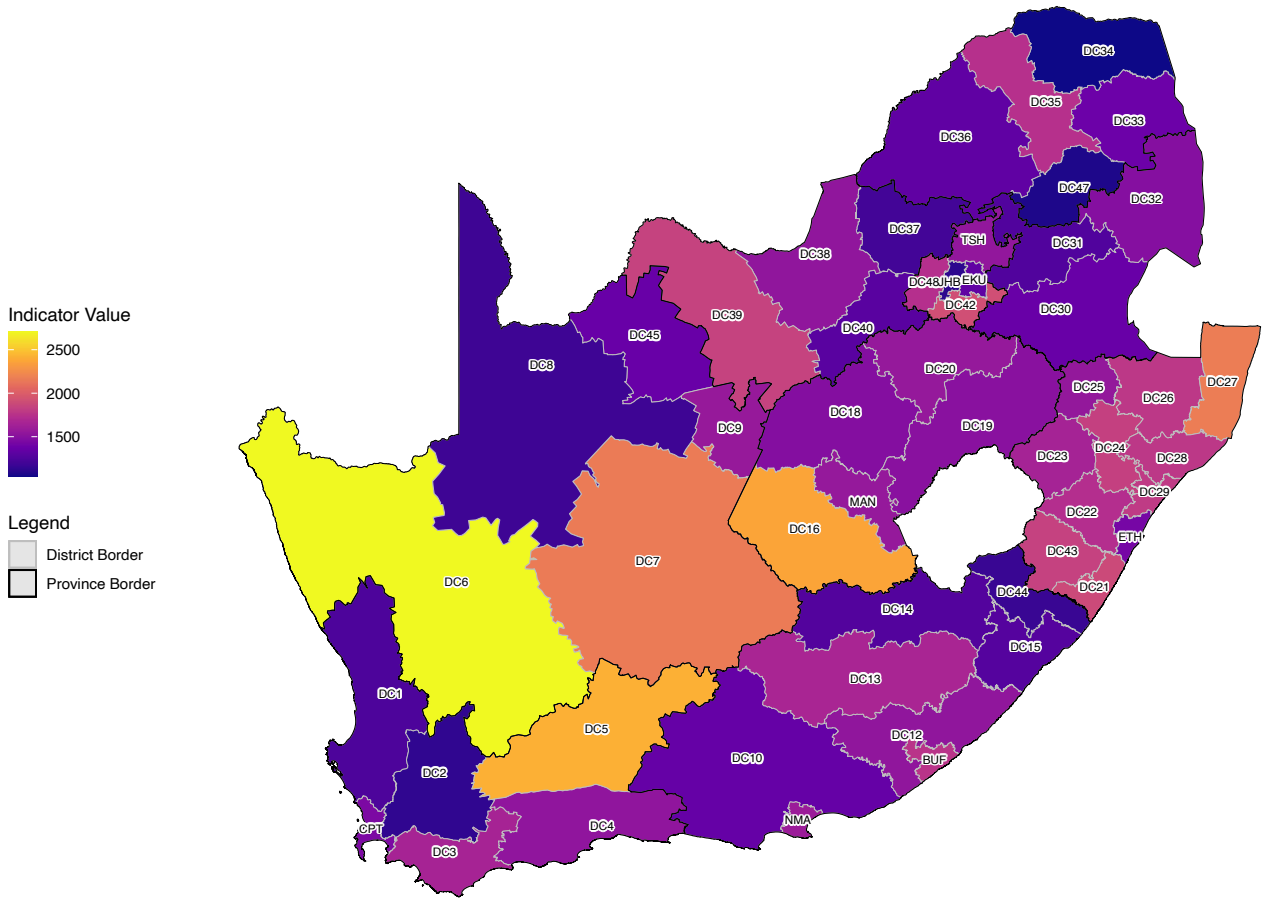


Figure 8 Provincial and LG PHC expenditure per capita (uninsured) by district, 2023/24

Source: BAS



MAP 2 Provincial and LG PHC expenditure per capita (uninsured) by district, 2023/24
Source: BAS

Provincial & LG PHC expenditure per PHC headcount

Expenditure per PHC headcount focuses on efficiency and productivity by linking financial investment to actual healthcare utilisation. This indicator indicates how much is spent relative to the number of patient visits provided at the PHC facility level, thereby reflecting the cost-efficiency of healthcare delivery in each area.

Districts with high expenditure per PHC headcount may require closer examination to determine if their resources exceed patient demand, potentially indicating inefficiencies or resource wastage. Conversely, areas with lower expenditure per headcount might seem highly efficient, but this could also suggest underfunding that may compromise care quality, as limited resources could lead to constrained service provision.

Since this analysis offers only a high-level overview, more detailed studies are necessary to understand the specific factors driving these expenditure patterns and their implications. A deeper investigation could clarify whether high spending is due to inefficiencies or necessary investments to enhance service quality, while low spending could indicate efficiency or, alternatively, risks to patient care quality due to under-resourcing.

National overview

Over the years, real Provincial and LG expenditure per PHC headcount has shown a significant increase, a trend observed in previous editions of the DHB. In 2020/21, expenditure per PHC headcount spiked significantly due to decreased utilisation during the COVID-19 pandemic. Since then, it has gradually increased owing to a partial rebound in PHC utilisation in recent years post-COVID-19. Figure 9 reflects this upward trajectory starting from 2015/16. This is coupled with a decline in PHC headcount

from 119 853 421 in 2019/20 to 104 773 184 in 2023/24 (note: PHC headcount is also picking up gradually, from 95 346 987 in 2020/21 to 104 773 184 in 2023/24).

While outreach services provided by community health workers, the integrated school health programme, and the CCMDD programme may somewhat mitigate the decline in PHC headcount, it is important to note that these programmes are not new. They have been in place for a considerable time and were already effective before the COVID-19 pandemic.

Therefore, the decline in utilisation of PHC facilities cannot be fully attributed to these programmes. This becomes even more interesting when considering various literature on the impact of CHWs in promoting health-seeking behaviour and encouraging populations to seek medical help following CHW consultations.[5] However, it is important to note that CHWs and other PHC linked outreach programmes are designed to reduce the burden on facilities, which can lead to fewer visits to PHC facilities.[6] Notably, CHWs headcount has doubled, increasing from 22.5 million in 2019/20 to 46.5 million in 2023/24. On the other hand, PHC headcount which seemed to increase in 2022/23 from 2021/22 has now declined in 2023/24 by 1.6 million from 2022/23. Therefore, it is likely necessary to examine the real causes and contributing factors driving the decline in facility utilisation.

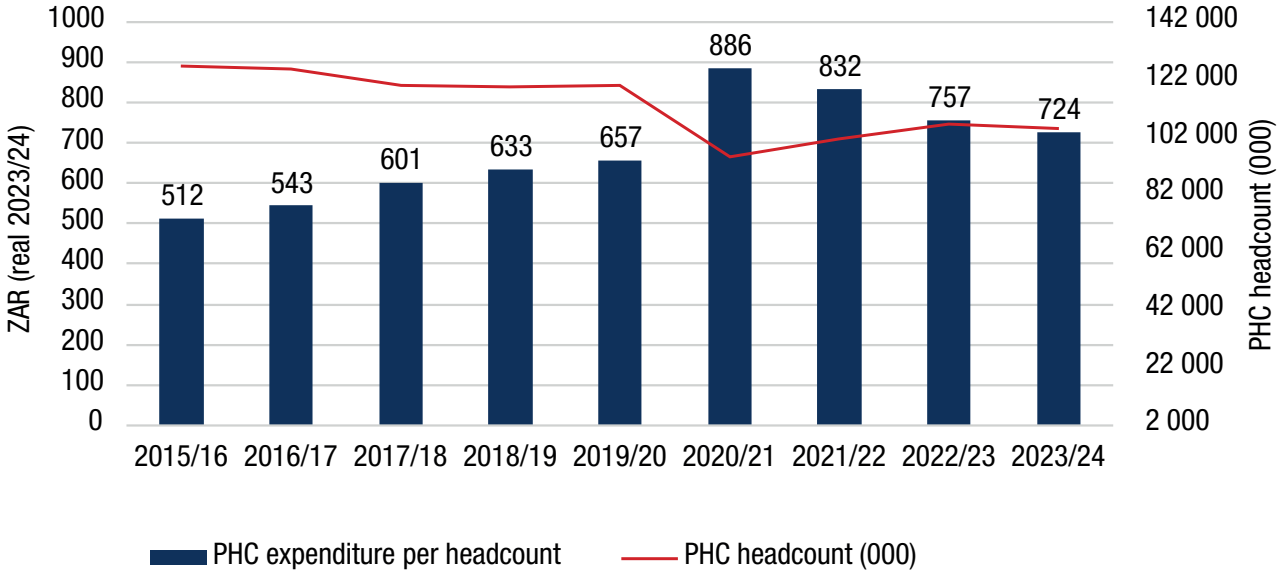


Figure 9 Provincial and LG PHC expenditure per PHC headcount, (real 2023/24 prices) 2015/16 – 2023/24
Source: BAS

Provincial overview

Provincial and LG expenditure per headcount in 2023/24 ranged from R883 in GP and R600 in LP with a national average of R724 as seen in Figure 10. Provinces which are below the national average may be due to efficient resource management, providing necessary services at a lower cost. Another possibility is of underfunding, with provinces receiving less funding compared to others having less resources available for health care services, hence the differences. Gauteng is the highest spending province (R883) in this indicator, and this has been the case for a long time. Some of the reasons raised for this is that there is poor utilisation of PHC facilities in GP compared to other provinces. For instance, in the past four years, the provincial utilisation rate has been an average of 1.5 days per annum per uninsured person. This is the lowest across the country and below the national average (i.e., 2.0 days). The highest utilisation rate was 2.4 visits per annum per uninsured person in NC, followed by EC and KZ with 2.3 visits.

5 Johnson LJ, Schopp LH, Waggie F, Frantz JM. Challenges experienced by community health workers and their motivation to attend a self-management programme. Afr J Prim Health Care Fam Med. 2022;14(1):e1–e9.URL: https://pmc.ncbi.nlm.nih.gov/articles/PMC8831930/
6 Saah FI, Amu H, Seidu A-A, Bain LE. Health knowledge and care seeking behaviour in resource-limited settings amidst the COVID-19 pandemic: A qualitative study in Ghana. PLoS One. 2021;6(5): e0250940.

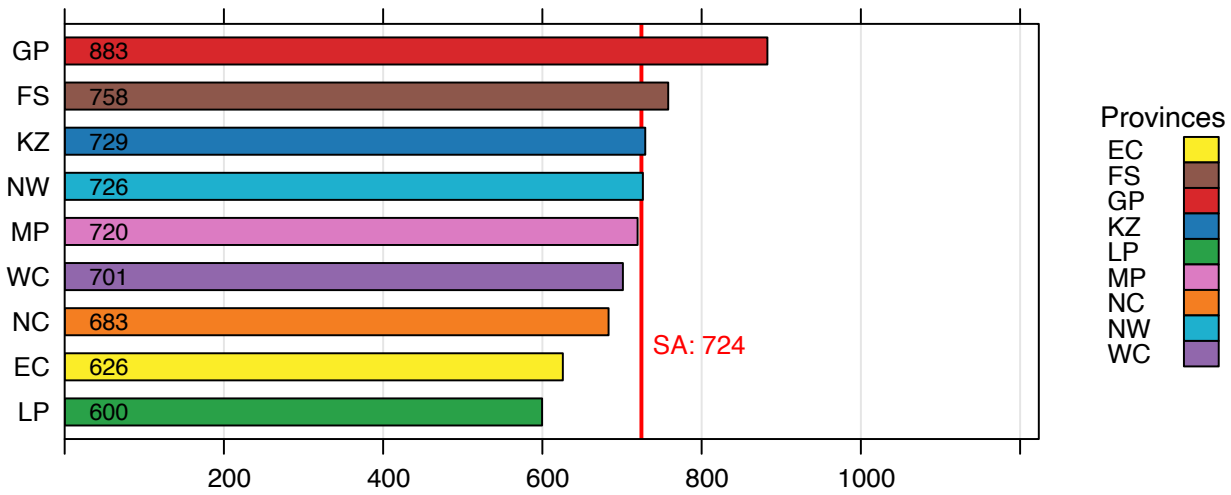


Figure 10 Provincial and LG PHC expenditure per PHC headcount by province, 2023/24

Source: BAS

District overview

The PHC expenditure per headcount in districts showed a decrease from 2022/23 levels. In GP, all districts were above the national average of R724, with Tshwane leading the country at R1 112 per headcount, followed by Sedibeng at R991. Vhembe (LP) spent the least at R501 (Figure 11 and Map 3).

All EC districts fell below the national average, however, their spending per headcount increased by 4.3% from 2022/23 to 2023/24. In the NC, there were significant differences among districts: Frances Baard (765), Namakwa (R763) and Pixley Ka Seme (R746) were all above the national average, but both JT Gaetsewe and ZF Mgcawu fell below average. This highlights concerns about the possible equitable and efficient distribution of resources in NC.

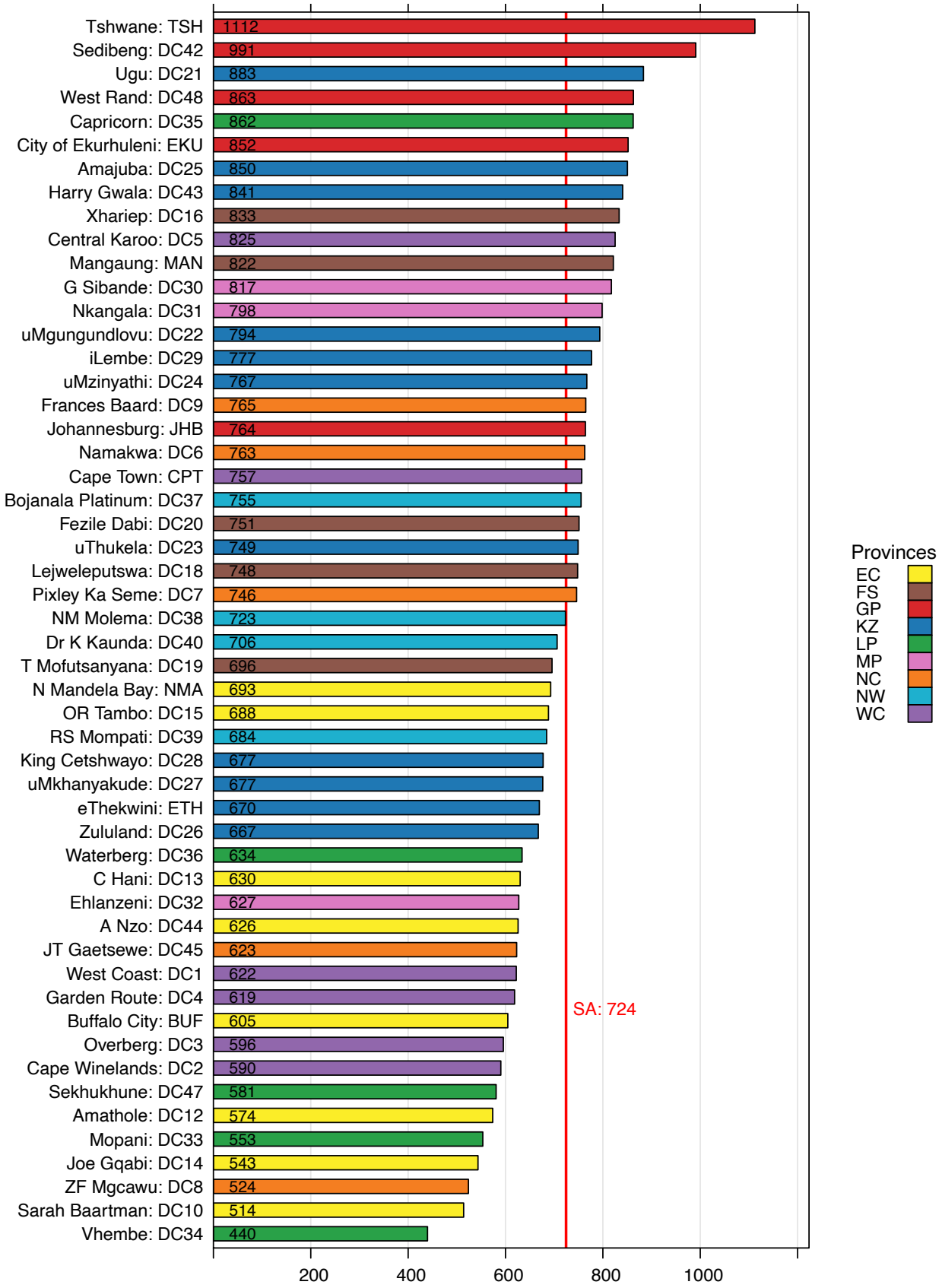
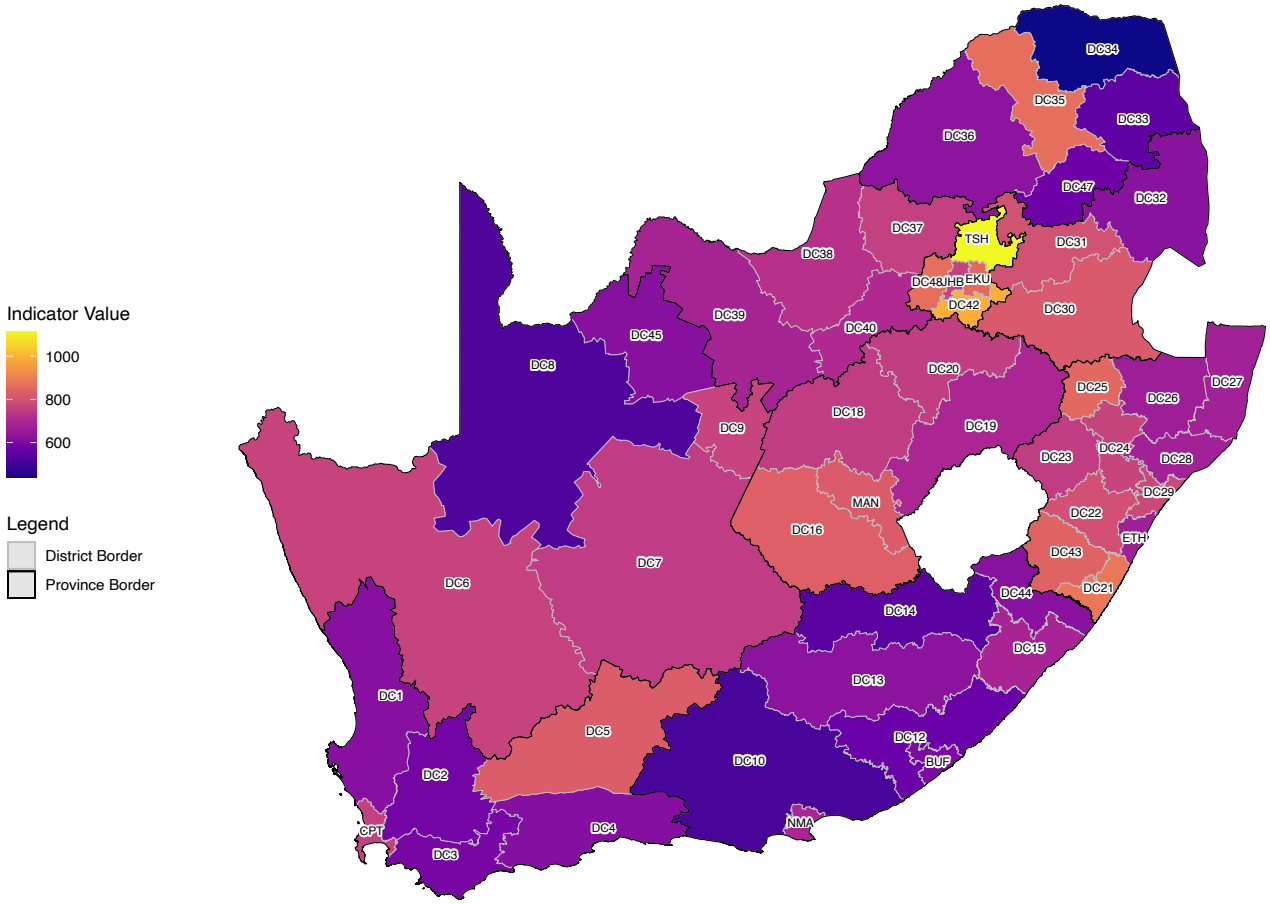


Figure 11 Provincial and LG PHC expenditure per PHC headcount by district, 2023/24

Source: BAS



MAP 3 PHC expenditure per headcount by district, real 2023/24 prices

Source: BAS

Expenditure per patient day equivalent (district hospitals)

A patient day equivalent (PDE) is a measure used to assess hospital utilisation across various patient categories, such as inpatient stays, day patients, OPD visits, and emergency visits. Because each patient type requires different levels of resources, the PDE standardises these into a single metric equivalent to the resources needed for one inpatient day. For example, a day patient is considered as half an inpatient day, whereas OPD and emergency visits each count as one-third of an inpatient day.

District hospital expenditure per PDE is determined by dividing the expenditure of the district hospital subprogramme within provincial health departments by the number of district hospital PDEs. A high expenditure per PDE might indicate inefficiency, while a low expenditure per PDE could suggest either efficient service delivery or underfunding, which could impact the quality of care. Although South Africa lacks specific benchmarks for expenditure per PDE, considering the varying socioeconomic factors and disease burdens across districts, it is still crucial to compare provinces and districts to evaluate operational efficiencies in hospitals.

National overview

The national district hospital expenditure per PDE in real prices decreased from R3 964 in 2019/20 to R3 751 in 2023/24 (Figure 12). The number of PDE's increased slightly from 10 044 621 in 2022/23 to 10 734 341 in 2023/24.

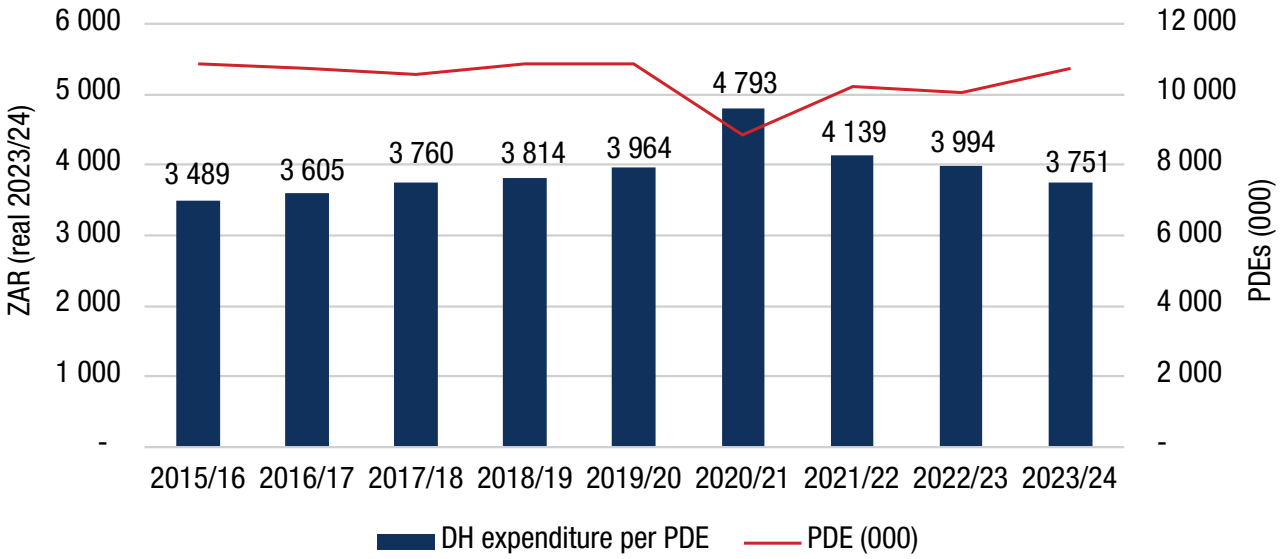


Figure 12 District hospital expenditure per PDE and number of PDEs, 2015/16 - 2023/24

Source: BAS

Provincial overview

As shown in Figure 13, expenditure per PDE in district hospitals in 2023/24 ranged from R4 683 in NW and R3 409 in FS with a national average of R3 754. The difference in expenditure per PDE across the provinces is mainly due to differences in resource allocations, where some provinces receive more funding than others based on various factors like patient load, health needs, and socioeconomic conditions. In 2023/24, GP had the highest PHC OPD headcount (5.3 million) followed by KZ (4.6 million).

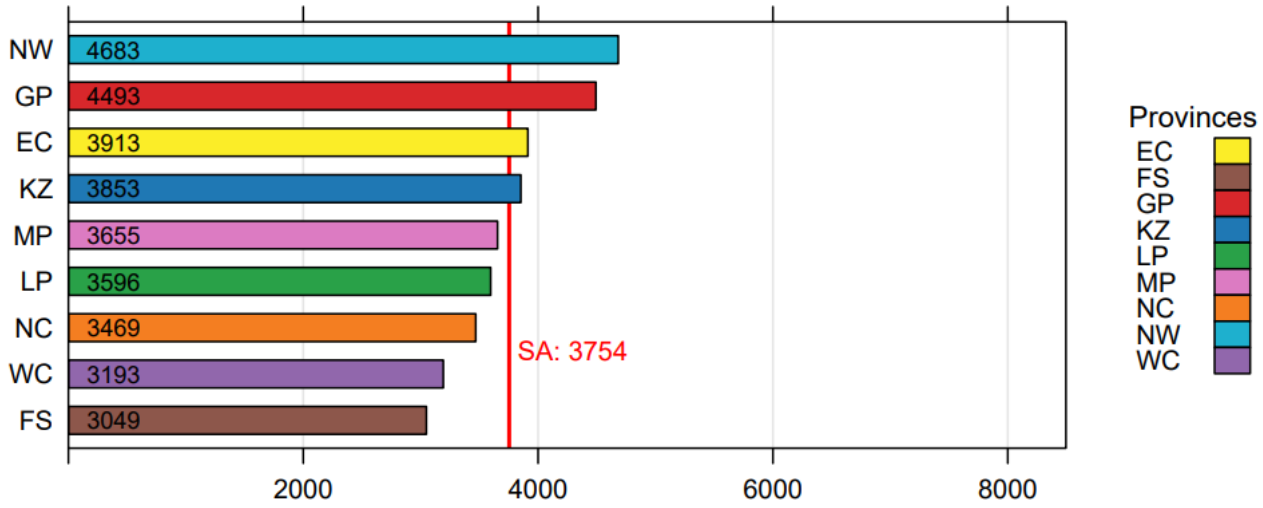


Figure 13 Expenditure per PDE (district hospitals) by province, 2023/24

Source: BAS

District overview

At the district level, there was a significant variation in expenditure per PDE. Amajuba (KZ) stands out with the highest expenditure per PDE at R7 723 although this is a significant decrease from 2022 where expenditure per PDE was R9 991 (Figure 14 and Map 4). This is because Niemeyer Hospital, the only hospital in the district, was repurposed in 2020 solely for COVID-19 isolation and admission of positive cases. During this period, other services such as paediatric, maternal, and general services were halted and resumed only in June 2022. However, for a long time Amajuba has been substantially over the national average. It is encouraging to see that spending might be moving towards pre-COVID-19 levels.

Even when excluding Amajuba as an outlier, there is a notable discrepancy between the lowest spending district, ZF Mgcawu (NC) at R1 879, and the second highest, Frances Baard (NC) at R6 137 — making Frances Baard expenditure 3.3 times higher than ZF Mgcawu district.

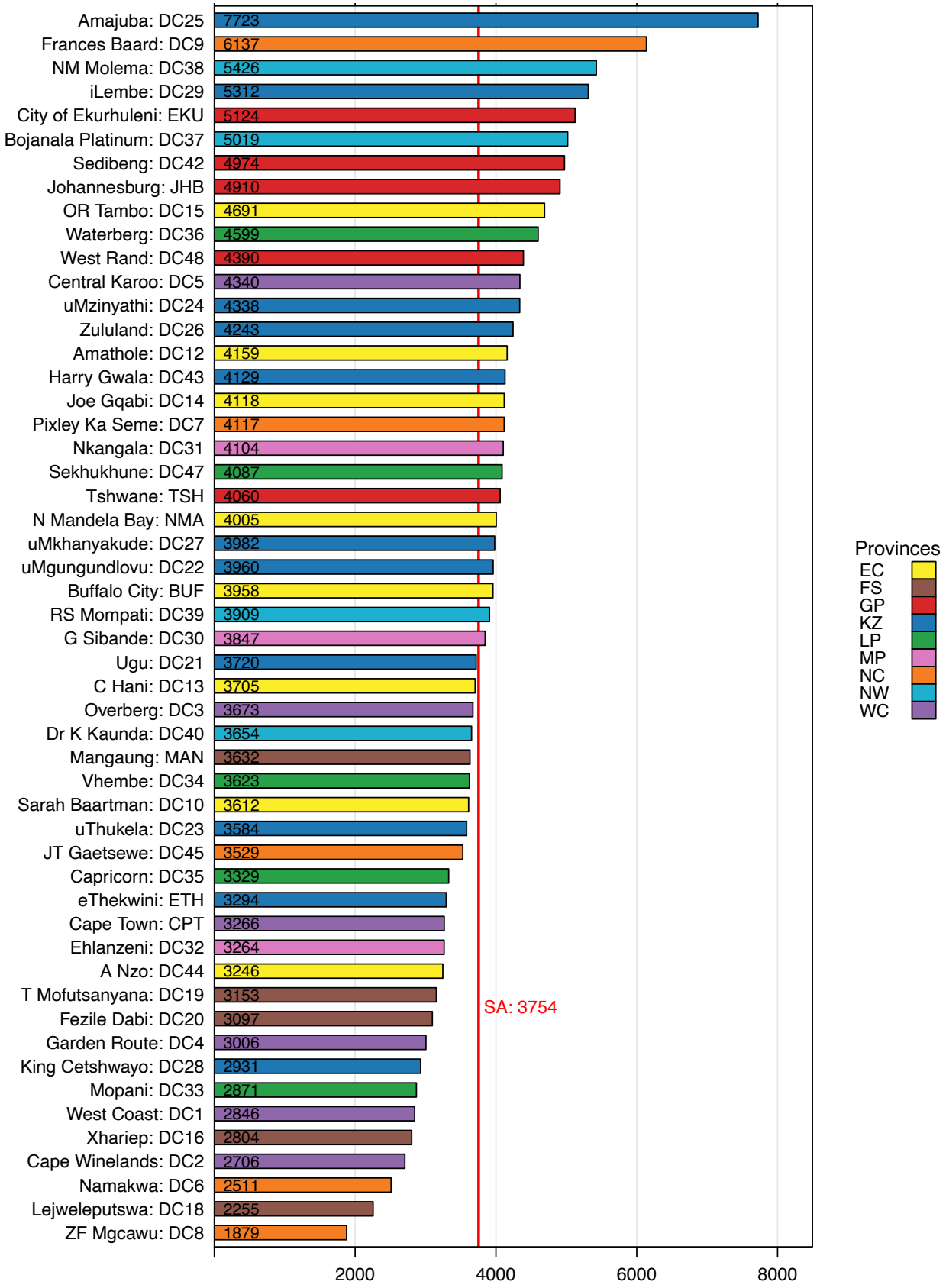
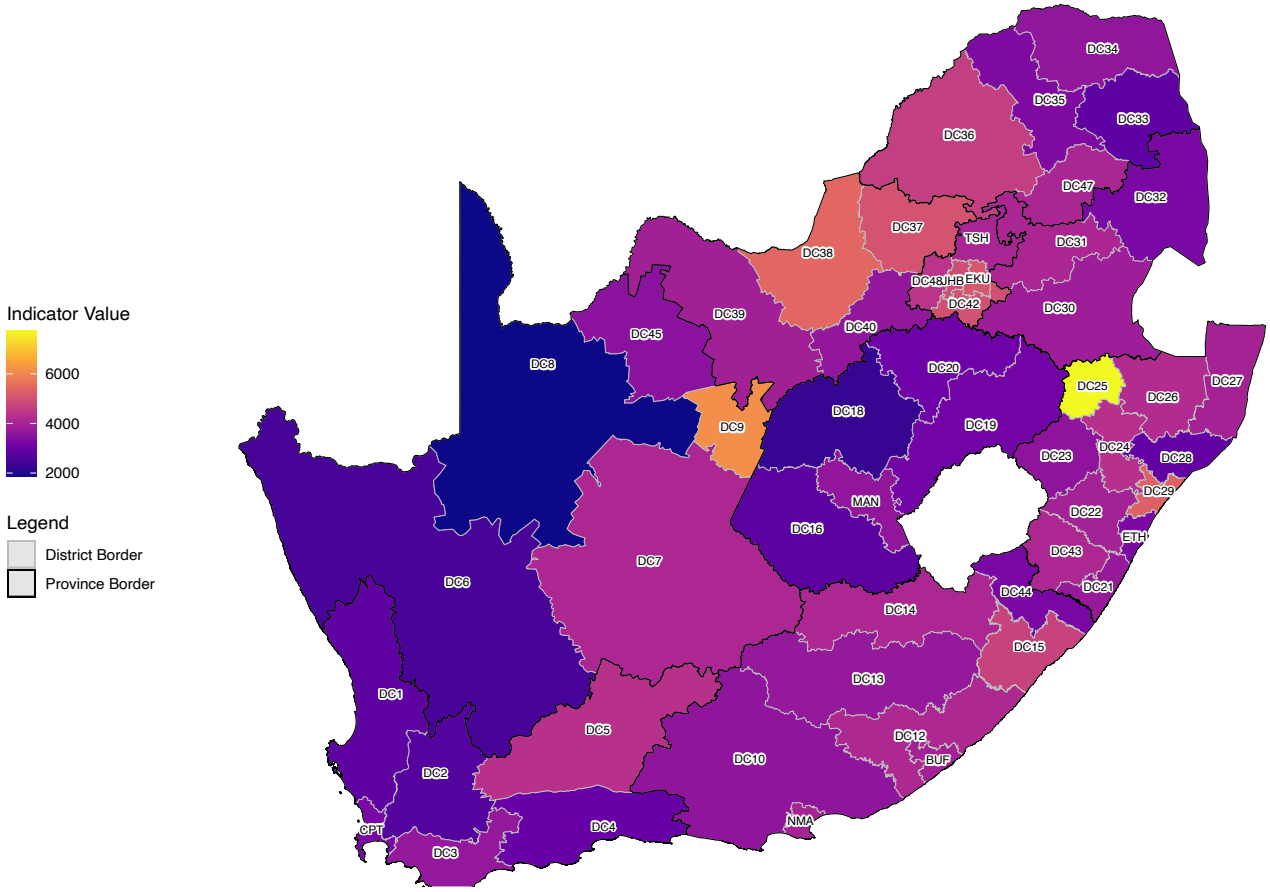


Figure 14 Expenditure per PDE (district hospitals) by province, 2023/24

Source: BAS



MAP 4 Expenditure per PDE by district and province, real 2023/24 prices

Source: BAS

Table 2 Comparison between expenditure per PDE, OPD new client not referred rate and average length of stay (district hospitals)

	Province	District	Expenditure per PDE (Rand)	OPD	Average length of stay (days)
Top 10 spending districts	KZ	Amajuba	7 723	46.5	4.6
	NC	Frances Baard	6 137	93.4	2.8
	NW	Dr RS Mompati	5 426	51.3	4.7
	EC	NM Molema	5 426	51.3	4.2
	GP	Ekurhuleni	5 124	63.6	6.3
	NW	Bojanala Platinum	5 019	30.9	4.6
	GP	Sedibeng	4 974	80.8	5.1
	GP	Johannesburg	4 910	56.8	5.2
	EC	OR Tambo	4 691	61.9	5.4
	LP	Waterberg	4 449	82.6	4.5
	GP	West Rand	4 390	57.1	3
	WC	Central Karoo	4 340	1.1	3.2
	KZ	uMzinyathi	4 338	74.1	5.7
	KZ	Zululand	4 243	53.7	4.6
	EC	Amathole	4 159	49.4	4.9
	KZ	Harry Gwala	4 129	20.5	5.6
	EC	Joe Gqabi	4 122	78.7	4.7
	NC	Pixley Ka Seme	4 117	66.8	4.2

	MP	Nkangala	4 104	51.9	4.8
	LP	Sekhukhune	4 087	81	3.9
	GP	Tshwane	4 060	62.7	5
	EC	Nelson Mandela Bay	4 005	21.7	4.8
	KZ	uMkhanyakude	3 982	45.7	5.6
	KZ	uMgungundlovu	3 960	45.6	5.5
	EC	Buffalo City	3 958	35.4	5.9
	NW	RS Mompati	3 909	44.1	4.2
	MP	Gert Sibane	3 847	54.2	4.5
	KZ	Ugu	3 720	45.9	5.1
	EC	C Hani	3 705	63.7	4.8
	WC	Overberg	3 673	3.7	3
	NW	Dr K Kaunda	3 654	24.3	4
	FS	Mangaung	3 632	54.9	3.9
	EC	Sarah Baartman	3 612	62.2	4.1
	KZ	uThukela	3 584	45.3	6.3
	LP	Vhembe	3 565	63.2	4.6
	NC	JT Gaetsewe	3 529	57.4	3.9
	KZ	iLembe	3 473	66.9	5.4
	LP	Capricon	3 395	70.5	4.4
	WC	Cape Town	3 272	19.6	4.2
	MP	Ehlanzeni	3 264	70.8	4.4
	EC	A Nzo	3 246	70.9	5.2
	FS	T Mofutunyana	3 153	53.4	2.9
	FS	Fezile Dabi	3 097	55.1	3.8
Bottom 10 spending districts	WC	Garden Route	3 006	15.1	2.9
	KZ	King Cetshwayo	2 931	76.1	5.5
	LP	Mopani	2 860	60.2	4.6
	WC	West Coast	2 846	10.7	3
	FS	Xhariep	2 804	48.6	4.2
	WC	Cape Winelands	2 706	10.1	3.2
	NC	Namakwa	2 511	47.2	2.4
	FS	Lejweleputswa	2 255	59.4	2.7
	NC	ZF Mgcawu	1 879	79.2	3.2
	KZ	eThekwini	1 790	36	5

Source: DHIS, BAS

OPD new client not referred rate (district hospitals)

The OPD new client not referred rate measures the percentage of clients who enter the hospital without a referral, essentially bypassing PHC facilities. This can be due to factors such as a poor referral system and limited access to PHC facilities. Frances Baard (NC) has the highest rate of new OPD clients not referred at 93.4% (Table 2). Interestingly, the PHC headcount in this district has slightly surpassed pre-COVID-19 levels, with 345 826 in 2019/20 and 357 887 in 2023/24. Additionally, PHC expenditure per headcount in Frances Baard is above the national average, which may indicate inefficiencies in utilisation of PHC facilities. High new client OPD visits and increasing PHC headcount may indicate accessibility of PHC facility or preferred hospital services being preferred which may be due to various perceptions by patients of service quality and reliability. The average length of stay is low at 2.8 days, raising concerns about whether clients have adequate access to and receive proper treatment at these facilities. Other districts with high rates of new OPD clients not referred include Waterberg (LP) at 82.6%, Sekhukhune (LP) at 81.0%, and Sedibeng (GP) at 80.8%. These reflect possible systemic issues such as poor referral systems and limited access to PHC services.

Western Cape is the only province with a relatively low OPD new client not referred rate, which entails better use of PHC service platforms and may also indicate accessibility of PHC services including a functional referral system. On average, the province spends R3 193 per PDE compared to the national average of R3 754.

Average length of stay

Shorter ALOS with low expenditure per PDE may be seen as an indication of efficient use of resources, better bed turnover and efficient allocation of resources. Districts exemplary of this include Lejweleputswa (FS) and to a lesser extent Garden Route (WC). Whereas a high expenditure per PDE with high ALOS may indicate complex cases of illnesses or poor patient flow management, and inefficient use of resources. An example of the latter is Amajuba (KZ), which has the highest expenditure per PDE while also ALOS is 4.6 days (this is slightly higher than the national average of 4.4 days). While Amajuba (KZ) has a long history of very high expenditure per PDE even pre-COVID-19 (in 2019/20 the district was the highest spending district in the country), this has not changed, in fact the rate of spending has increased even more in 2023/24. An ALOS of 5.1 days and the high OPD new client not referred rate in Sedibeng (GP) may be an indication of the district being overburdened with patients, noting also an expenditure per PDE (R4 974) which is higher than the national average of R3 754. The higher ALOS and expenditure per PDE may be indicative of inefficiencies within the system that require attention to improve patient flow and care quality.

Provincial summary

Eastern Cape

District Health Service and LG expenditure declined in 2023/24 real prices by R761.5 million from 2022/23 to 2023/24. Much of this decline emanates from the HIV/AIDS subprogramme (R430.6 million), other community services (R372.9 million), district hospitals (R131.6 million) and community-based services (R96.1 million). Despite this decrease in district hospitals spending, the province is the highest spending province (R 3 909) in expenditure per PDE in district hospitals.

It is interesting to note that from 2022/23 to 2023/24, Joe Gqabi district had the largest decrease (12%) in PHC and LG expenditure per capita compared to Buffalo City which had a decrease of 5% although it is still the highest spending district in the province. Additionally, Joe Gqabi may appear as either under resourced or operating efficiently compared to Buffalo City when considering the PHC and LG expenditure per headcount. A further analysis to draw a conclusion on this (by reviewing service quality, patient satisfaction and health outcomes) will need to be commissioned.

Free State

The province has the lowest expenditure per PDE at R1 946, compared to the national average of R2 883. However, it spends R758 per headcount in PHC, which is significantly above the national average.

Interestingly, FS is one of the three provinces that saw an increase in PHC utilisation from 2022/23 to 2023/24, with a rise of 2.6%. Despite this, PHC expenditure per capita has been on a downward trend since 2020/21. In 2023/24, it decreased by 9.6%, from R1 730 in 2022/23 to R1 563 in 2023/24. Although this figure is slightly above the national average, the decrease is concerning as it may impact service delivery.

District Health Services spending per capita also fell by 8.2%, from R2 511 in 2022/23 to R2 305 in 2023/24. Lejweleputswa (10.7%) and Thabo Mofutsanyana (8.1%) districts experienced the highest decreases. Meanwhile, Xhariep remains the highest spending district in terms of DHS spending per capita, PHC expenditure per capita, PHC expenditure per headcount and the lowest spending in expenditure per PDE district hospitals. PHC utilisation is the highest in Xhariep (2.8 visits per person uninsured per annum). Mangaung spends R822 in PHC expenditure per headcount, but utilisation is the lowest in the province, suggesting there may be some inefficiency in operations or limited accessibility to services, which are worth further investigation.

Gauteng

Overall, the DHS and LG expenditure increased by 0.5% from 2022/23-2023/24 (in real 2023/24 prices). However, it is noted that R518.5 million was shifted away from HIV/AIDS subprogramme, representing a decline of 8.1%. Of this amount, R343.6 million was reallocated to the district management subprogramme, R133 million to district hospitals, and close to R100 million to community-based services. It will be interesting to see the impact of these reallocations on service outcomes. The province spends R4 493 which is higher than the national average per PDE in district hospitals (R3 754), Tshwane is the lowest spending district but still above the national average.

The province spends above the national average in PHC and LG expenditure per headcount due to generally lower use of PHC services compared to district hospitals. PHC utilisation in GP remains the lowest in the country at 1.5 visits per person per year, with a 4.3% drop from 2022/23 to 2023/24. This spending pattern suggests that the province is not prioritising PHC, as PHC and LG expenditure per capita is R1 350, which is the second lowest in the country. This trend is similar to LP, which also relies heavily on district hospitals and is the lowest spending province in PHC expenditure per capita.

KwaZulu-Natal

District Health Services total expenditure decreased remarkably in 2023/24 real prices, from R29 billion 2022/23 to R27.6 billion in 2023/24. It would be interesting to understand the impact of these budget reductions on service delivery and health outcomes. However, a 10.4% increase is noted under district hospitals, where expenditure increased from R8.8 billion in 2022/23 to R9.7 billion in 2023/24.

KwaZulu-Natal holds the highest record of ALOS in the country. 5.4 days compared to the national average of 4.4 days. It is also worth noting that KZ is also positioned second for utilisation of PHC facilities (2.3 visits per person per annum). Expenditure per PDE (R3 853) exceeds the national average of R3 754. The high PHC utilisation rate is a positive sign, indicating that PHC services are generally accessible to the population, while the lower expenditure per headcount may be an indication of an under resourced PHC platform, a threat to quality of health care services, patient satisfaction, and good health outcomes.

Limpopo

Limpopo continues to have the highest OPD new clients not referred rate (69.4%). As noted in previous DHB publications, this remains a concern because it means that LP delivers PHC services at the most expensive rate. This contradicts the core principle of the PHC platform, which aims to provide accessible, cost-effective care at the community level before patients require higher-level, more expensive hospital services.

This inefficiency is evident in LP spending patterns across the indicators. The province has the highest DHS expenditure per capita at R2 788 and lowest spending in PHC expenditure per capita at R1 305. This imbalance suggests that more patients are bypassing PHC facilities due to various reasons and going directly to hospitals, resulting in higher costs for services that could have been provided more affordably at the PHC level.

While LP's expenditure per PDE in district hospitals is slightly below the national average, Sekhukhune within the province spends almost double the national average at R4 087. Sekhukhune also has a very high rate of new OPD visits not referred (81.0%), alongside a moderate ALOS of 3.9 days.

Addressing these issues will require a twofold approach: improving access to and efficiency of PHC services while strengthening referral pathways to ensure appropriate use of hospital facilities. This will not only enhance service delivery but also help reduce overall healthcare costs in the province.

Mpumalanga

District Health Services and LG expenditure declined by 3.4%, from R11.2 billion in 2022/23 to R10.8 billion in 2023/24. Much of this reduction was reflected in the district management programme (R234 million). Only R79 million of this amount was reallocated within the programme, leading to increases in community-based services (12.7%), community health clinics (3.2%), and community health centres (1.5%). This may present a strategic shift towards strengthening community based care. The decline in PHC expenditure per capita (3.4%) is consistent with this. PHC expenditure per headcount declined by 2.5% from R738 in 2022/23 to R720 in 2023/24. This is not much of a concern because it is still above the national average of R703, largely driven by high spending in Gert Sibande and Nkangala districts. Additionally, PHC utilisation dropped slightly by 0.9% from the previous year, which may necessitate the need for closer monitoring of access.

In Ehlanzeni, PHC expenditure per headcount was considerably lower than the national average, at R627. This may be because the district has the highest PHC utilisation rate in the province, with 2.4 visits per person per year. Ehlanzeni also has the highest rate of new OPD clients not referred (70.8%) and a moderate ALOS of 4.4 days. These factors suggest a heavy reliance on district hospitals and a poor referral system. However, the high utilisation of PHC facilities indicates a strong demand for healthcare services, likely necessitating more investment in the PHC platform. It is encouraging to note that more funds are being directed towards community-based services, with these funds coming from administrative savings rather than cuts to direct services.

Northern Cape

Northern Cape is one of the provinces with very glaring disparities across districts. For instance, expenditure per PDE in district hospitals varies widely across districts, with a standard deviation of R1 711. In 2023/24, Frances Baard district spent R6 137 (second highest in the country) while ZF Mgcawu spent R1 879 which is way below the national average. Frances Baard also has the highest rate of new OPD clients not referred (93.4%) alongside a low ALOS of 2.8 days. This suggests that, similar to Limpopo, PHC services are largely accessed at district hospital level by the population which has significant implications financially. Conversely, despite having the lowest expenditure per PDE in district hospitals, ZF Mgcawu also has a high rate of new OPD clients not referred (79.2%) and an ALOS of 3.2 days.

These disparities warrant further investigation to understand the underlying causes. It could indicate that ZF Mgcawu is more efficient while Frances Baard is less efficient, or that ZF Mgcawu is under-resourced. Regardless of the cause, these issues have implications for service quality. Therefore, the province should invest time and resources to identify and address the real problems accordingly.

North West

North West province had the second-lowest spending per capita on DHS at R2 086 and the third-lowest expenditure per capita on PHC at R1 370. However, its expenditure per PDE is the highest at R4 683 among the provinces. Additionally, the spending per PHC headcount is among the highest at R726, compared to the national average of R724.

These levels of spending suggests that district hospitals and PHC facilities might be underutilised, possibly due to low health-seeking behaviour or poor accessibility of healthcare services for the population. Further analysis is needed to identify the root causes and explore strategies to reduce costs while improving efficiency. Additionally, the OPD new client not referred rate averages 33.1%, while the ALOS is 4.4 days. The low utilisation of PHC facilities and district hospitals, particularly in the Bojanala, may be due to its proximity to Waterberg (LP), Tshwane, and West Rand (GP). This could indicate that Bojanala is sharing its burden of care with these neighbouring districts. However, an assessment would be necessary to confirm this.

Western Cape

Overall, the DHS and LG expenditure decreased by 4.1% or R571 million from R14 billion in 2022/23 to R13.4 billion in 2023/24. Much of this reduction stems from a decline of 4.6% (R225.2 million) in 2023/24 year on year in district hospitals, zero spending under other community services (R208.8 million) and a decline of 9.1% (R186.3 million) under the HIV/AIDS subprogramme. PHC expenditure per capita in a few rands (R1 415) above the national average. The province has a PHC utilisation rate of 2 visits per person per annum, but there was a slight decline of 3.4% from the previous year.

Disparities across districts are notable, with Central Karoo being the second highest (R2 408) spending district in the country and Cape Winelands the third lowest spending (R1 131) district in the country. Central Karoo also spends the highest (R825) in the province on PHC per headcount and Cape Winelands spends the lowest (R590). The relationship between expenditure per headcount and PHC utilisation rate is inverse in this case, as Cape Winelands has a lower PHC utilisation rate (1.9 visits per person per annum) compared to Central Karoo (2.9 visits per person per annum). The problem has been identified to be sparsity of the population in Central Karoo leading to increased costs of inputs for service delivery.

Western Cape has the third lowest ALOS (3.6 days) in the country and lowest OPD new client not referred rate (15.1%). However, it is noted that expenditure per PDE (R3 193) is below the national average of R3 754. While this may indicate operational efficiency in managing resources and patient care, it also points to an opportunity for the province to increase its expenditure on health services to bring the cost per PDE closer to the national average. This could help enhance the quality and comprehensiveness of care, particularly in areas that might still require additional resources

Recommendations

- A further analysis on the expenditure outcomes of the PHC linked programmes (i.e., CCMDD and CHW programme) along with their effectiveness, will help determine their role in improving operational efficiencies within the health sector and accessibility to healthcare services.
- It is not entirely clear to what extent declines in PHC utilisation reflect these alternate care options as opposed to decreasing access.
- A further analysis that breaks down PDE expenditure by spending components, e.g. staff, medicines and equipment and relates those to ALOS would help identify areas of inefficiencies and where cost reductions could be implemented without affecting quality of services.
- It is quite evident that provinces are battling with budget reduction and it becoming difficult to prioritise effectively. It is important to investigate the impact of austerity measures on healthcare service delivery and performance outcomes. Simply looking at expenditure outcomes makes it difficult to determine how efficiently facilities are operating.
- Given the high-level nature of the analysis in this chapter, some of the conclusions and recommendations should be considered tentative. They are subject to more comprehensive research using data beyond routine health service information. In many instances, these findings should be tested at the local level, considering context-specific factors.

4.3 Human resources for health

Suhavna Khalawan, Jodi Wishnia

Key findings

- The National Health Insurance (NHI) Act, signed in May 2024, aims to provide Universal Health Coverage (UHC) in South Africa. However, as it stands, the Act faces critical implementation challenges, notably the shortage of human resources for health (HRH), which hampers progress toward the goal of UHC. There is a significant gap between current HRH supply and the 2030 HRH strategy equity-based targets. Furthermore, those targets were not developed based on need and therefore are likely to fall short of accurately addressing population healthcare needs.
- South Africa's HRH policy goals also lack a corresponding forecasted health budget, which will undoubtedly create a gap between policy/plans and implementation.
- Additionally, each HRH cadre has unique supply issues requiring tailored solutions to fill the shortage. A systematic, sector-wide approach to HRH planning is essential to achieve effective HRH ratios and skills mix to enhance healthcare delivery, which will improve operational efficiency and support better health outcomes. In terms of supply, medical practitioners and pharmacists in the public sector showed positive growth in numbers between March 2009 and March 2023, with pharmacists experiencing the highest growth rate at 186% between March 2009 and March 2016. However, since March 2023, there has been a decline in medical practitioners and pharmacists, resulting in a current ratio of medical practitioners of 35.6 per 100 000 uninsured population and pharmacists of 12.1 per 100 000 against the HRH 2030 targets of 37.88 and 15.13 per 100 000, respectively, by 2025.
- The trend in supply among professional nurses in South Africa has been marked by stagnation and decline. As of March 2024, there were 141.3 professional nurses per 100 000 uninsured population, a 4% decrease from 2023 and below the March 2016 target ratio of 143.1, highlighting a concerning lack of real growth in the nursing workforce.
- The decline in supply of professional nurses is driven by an ageing workforce, with 38% of all nurses nearing retirement in the next 15 years, along with other factors like emigration, career changes, and a diminished capacity in the nursing training education system. Recent changes to the nursing qualifications framework have raised entry requirements and limited training opportunities, while disinvestment in lower-cadre nurse training in the private sector has further decreased output.
- In terms of need, South Africa remains far from its stated HRH targets and policy goals, with some health cadres more affected than others. Most goals set for 2025 have not been met yet, making the 2030 strategy unlikely to be achieved without significant interventions.
- There is no standardisation in the mix of clinical staff required across districts (for example, professional nurse to assistant nurse ratios). This demonstrates the lack of national workforce planning guidance on the optimal mix and ratio of staff to one another and to the population.
- There is huge inequity between districts within provinces for medical practitioners, pharmacists, professional nurses, nursing assistants, dental practitioners, optometrists, and allied health professionals per 100 000 uninsured population.
- The Sustainable Development Goals (SDGs) for 2030, to which South Africa is a signatory, have a target ratio of 830 nurses per 100 000 population, which would require more than doubling our current nursing workforce.
- While South Africa possibly has an adequate number of optometrists overall, the public sector is critically underserved, housing only 249 optometrists (6.7% of the total). This results in a ratio of just 0.5 optometrists per 100 000 uninsured people in the public sector, far below the HRH 2030 target of 5 per 100 000 uninsured population. Urgent interventions are necessary to redistribute these resources, as no district meets the target, with rural and underserved populations being particularly affected with limited access to eye care services.
- The need for allied health professionals is large, and one in three people with a disease or injury would benefit from rehabilitative care from an allied health professional. Allied health professionals should be seen as a critical part of the clinical team, particularly within primary health care settings.
- The National Department of Health's (NDoH) commitment to establishing needs-based targets is a positive step, but achieving this requires enhanced data for accurate forecasting. Strengthening public-private partnerships is crucial to leverage resources and expertise for training and service delivery. Furthermore, significant investment in health education, supported by scholarships and grants, is vital for closing HRH gaps and aligning with national health goals.

Introduction

More than 80%[1] of the South African population relies on the public health sector for essential healthcare services. It is therefore crucial that this sector delivers high-quality care to safeguard the health and well-being of the population. Health professionals are the backbone of the public healthcare system. The largest portion of public health spending is dedicated to these HRH, reflecting their importance in the healthcare system.[2]

This chapter focuses on medical practitioners, nurses and pharmacists who are the frontline HRH and form the foundation of primary healthcare (PHC) within the public health system. As the first point of contact for individuals entering the system, PHC is essential for delivering accessible, community-based healthcare services. The combined efforts of these HRH ensure that the healthcare system remains efficient, sustainable and capable of addressing the diverse health challenges of the population.

Given the context of the impending National Health Insurance (NHI),[3] the analysis of these HRH cadres extends to the full health system and not just the PHC requirements of this chapter. Doctors, nurses and pharmacists comprise the majority of HRH in the public health system (Figure 1). The relative availability of these cadres is indicative of the overall performance of the health system.

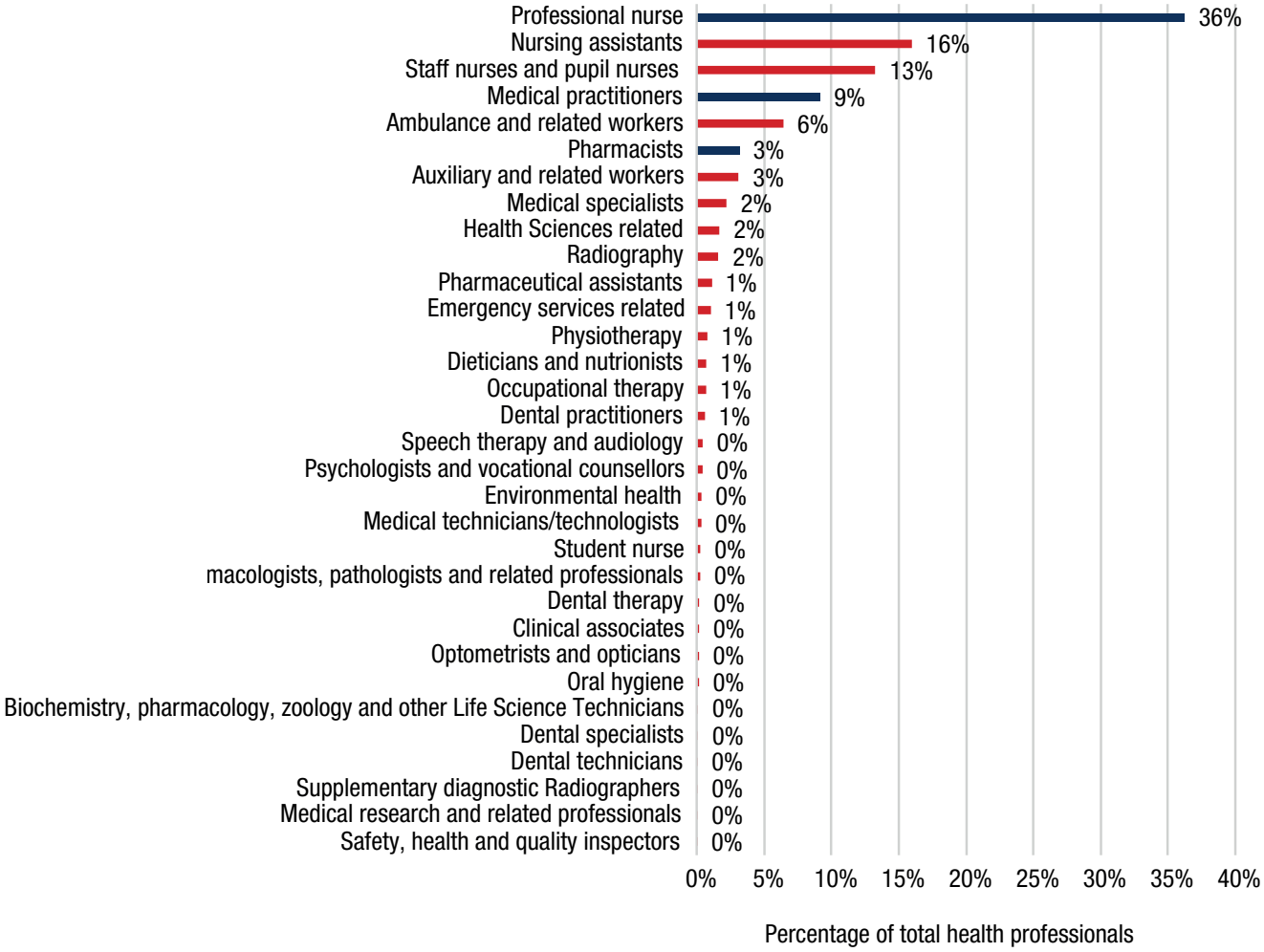


Figure 1 **Health professionals as a percentage of total in South Africa's public health sector, per cadre: March 2024**

Source: PERSAL

The NHI Act is highly relevant to the discussion of HRH, especially as one of its more controversial clauses proposes the closure

1 The Presidency Republic of South Africa. One step closer to affordable quality health care for all. Pretoria; 2024. URL: https://www.thepresidency.gov.za/node/8149
2 National Department of Health: South Africa. 2030 Human Resources for Health Strategy: Investing in the Health Workforce for Universal Health Coverage. Pretoria: NDoH; 2020.
3 van Weel C, Kidd MR. Why strengthening primary health care is essential to achieving universal health coverage. CMAJ. 2018;190(15):E463-E466. doi: 10.1503/cmaj.170784. PMID: 29661815; PMCID: PMC5903888

of medical schemes,[4] effectively removing a large contributor to the funding of private healthcare in South Africa. The size and service offerings of the private healthcare sector under the NHI remains uncertain, but according to the Act, they will be limited to only those services not offered by the NHI (referred to as supplementary services or supplementary cover).

However, if private healthcare prices remain at current levels and medical schemes are eliminated or only able to offer supplementary services, private healthcare will become unaffordable for a substantial portion of the population that currently relies on it. One of the risks of closing down medical aids, is that some South Africans choose to pay out-of-pocket (OOP)[4] expenses to still access private health sector services and providers. The percentage of OOP payments for healthcare services is one of the indicators used to assess progress towards UHC.[5] Therefore, there is a risk that in enacting the NHI, South Africa's OOP expenditure may increase, making it a worse performer in terms of achieving UHC.

Simultaneously, as the risk pool in medical schemes declines (to only those who choose to have cover for supplementary services), the cost of cover will increase, creating an even more unaffordable private healthcare system. As people divest from the private sector, the public health sector will need to expand access to absorb the additional lives into its service offerings. The Council for Medical Schemes (CMS), which regulates the medical scheme industry, stated in its 2023/2024 annual report that there are 9 million people covered by medical schemes in South Africa.[6] This means that the public health service will need to accommodate an additional 9 million lives for the services the NHI will provide. Given the current economic, HRH, and funding constraints in the public sector, this will be challenging.

The shortage of HRH relative to the country's stated targets is highlighted in the HRH 2030 strategy,[7] which defines targets for the ratio of different health cadres to the population. These targets are 'equity based' targets, the calculation of which is based on bringing all provinces to a more equitable share of the current number of HRH, rather than a determination of a target based on each province's unique demographic and epidemiological needs. The targets are therefore not sufficiently detailed nor developed to give a true picture of the needs for specific HRH. They do, however, give a view of what would be required for all provinces to get to an equitable share of the total specified HRH, which is an important first step towards target setting.

Nevertheless, even if all HRH from both sectors in South Africa were combined, there would still be a shortage of HRH to serve the country's population against the 'equity based' targets in the HRH 2030 strategic policy. These shortages are seen more acutely in peri-urban and rural regions, although many urban areas also show evidence of a shortage due to high population density.[8]

The identified HRH shortage, against the goal of increasing workforce levels to enhance access to healthcare under the NHI, highlights a significant disconnect between policy ambitions, the supply pipeline, and the allocated health budget.

The small annual increase in the health budget, 3.5% from 2023/24 to 2024/25,[9] is one of the major stumbling blocks for

4 Republic of South Africa. Government Gazette No. 4826 16 May 2024 Act No. 20 of 2023: National Health Insurance Act 2023.
5 Arhin K, Oteng-Abayie EF, Novignon J. Assessing the efficiency of health systems in achieving the universal health coverage goal: evidence from Sub-Saharan Africa. Health Econ Rev. 2023;13:25.
6 Council for Medical Schemes. Annual Report 2023/24. Johannesburg: Council for Medical Schemes; 2024.
7 National Department of Health: South Africa. 2030 Human Resources for Health Strategy: Investing in the Health Workforce for Universal Health Coverage. Pretoria: NDoH; 2020.
8 Van Ryneveld M, Schneider H, Lehmann U. Looking back to look forward: a review of human resources for health governance in South Africa from 1994 to 2018. Hum Resour Health. 2020;18(1):92.

implementation. Price inflation, set at 4.5% for 2025,[10] is itself higher than the health budget increase, and medical inflation tends to be 2–3% higher than price inflation.

When also considering the annual population growth of ~1%,[11,12] the health budget increase on a per capita basis is minimal. This modest increase limits the number of HRH that provincial departments of health (PDoH) can hire, especially because hiring HRH is more than a one-year commitment.

A persistent shortage in HRH poses a threat to the sustainability of South Africa's healthcare system, leaving it ill-equipped to meet the growing needs of an ageing and complex population. With the restricted health budget, the gap between supply and need will continue to widen, leading to reduced access to care, longer waiting times, and a decline in the quality of healthcare services. This shortage also places an immense burden on the existing HRH, increasing workloads and resulting in long work hours that often lead to physical and mental exhaustion. Over time, this can drive healthcare workers to leave the profession, shift to the private sector, emigrate, or face health challenges of their own, further depleting the already strained HRH pool and deepening the supply-need gap, resulting in a vicious cycle.

A shortage in HRH has serious implications for population health and the overall quality of healthcare. It could lead to a sicker, less employable workforce in a country where unemployment is already among the highest in the world,[13] having a knock-on financial impact for the country. Additionally, the strain on healthcare services increases the likelihood of medical negligence due to overstretched and overworked HRH. Medicolegal claims are financially crippling for PDoHs.

Understanding the current and future HRH needs in South Africa is critical for effective workforce planning and cost estimation, particularly in the context of NHI. Comprehensive workforce planning must include all healthcare and allied healthcare professionals, with regular and detailed target-setting to ensure the right levels and skills mix are in place. Workforce planning needs to be regularly updated to keep pace with technological advancements and changing healthcare needs, ensuring the system remains responsive and uses all opportunities available to lighten the load in a constrained environment.

The NDoH's commitment to developing needs-based targets is a step in the right direction, but it requires improved data for accurate forecasting. Additionally, deeper public-private partnerships are necessary to leverage resources and expertise for training and service delivery. A strong investment in health education, supported by scholarships and grants for promising learners, is essential to close HRH gaps and align with national health goals.

National overview

9 National Department of Health. Minister Aaron Motsoaledi: Health Department Budget Vote 2024/25 Speech. Cape Town: South African Government;11 July 2024.
10 South African Reserve Bank. Statement of the Monetary Policy Committee September 2024. Pretoria: SARB; 2024. URL: https://www.resbank.co.za/en/home/publications/publication-detail-pages/statements/monetary-policy-statements/2024/Statement-of-the-Monetary-Policy-Committee-September-2024
11 Statistics South Africa. Mid-year population estimates 2024. Pretoria:Stats SA; 2024.
12 Global Burden of Disease Collaborative Network. Global Burden of Disease Study 2021 (GBD 2021). Seattle, United States: Institute for Health Metrics and Evaluation (IHME), 2024.
13 Statistica. The 20 countries with the highest unemployment rate in 2023. Germany: Statistica, 2024. URL: https://www.statista.com/statistics/264656/countries-with-the-highest-unemployment-rate/

Figure 2 below shows the trends in numbers of professional nurses, medical practitioners and pharmacists (including those completing their mandatory community service year) between March 2009 and March 2024. The total number of each cadre was converted into a ratio of HRH per 100 000 uninsured population, which allows for standardised comparisons and helps assess workforce levels relative to population size and growth.

The increase of HRH per 100 000 population from March 2009 to March 2016 was due to output from training institutions entering the workforce as well as the introduction of the occupation-specific dispensation (OSD) which was a financial incentive introduced to retain and attract health professionals in and to the public sector.[14] OSD had the dual effect of increasing the number of HRH in the system, as well as dramatically increasing the wage bill.[15]

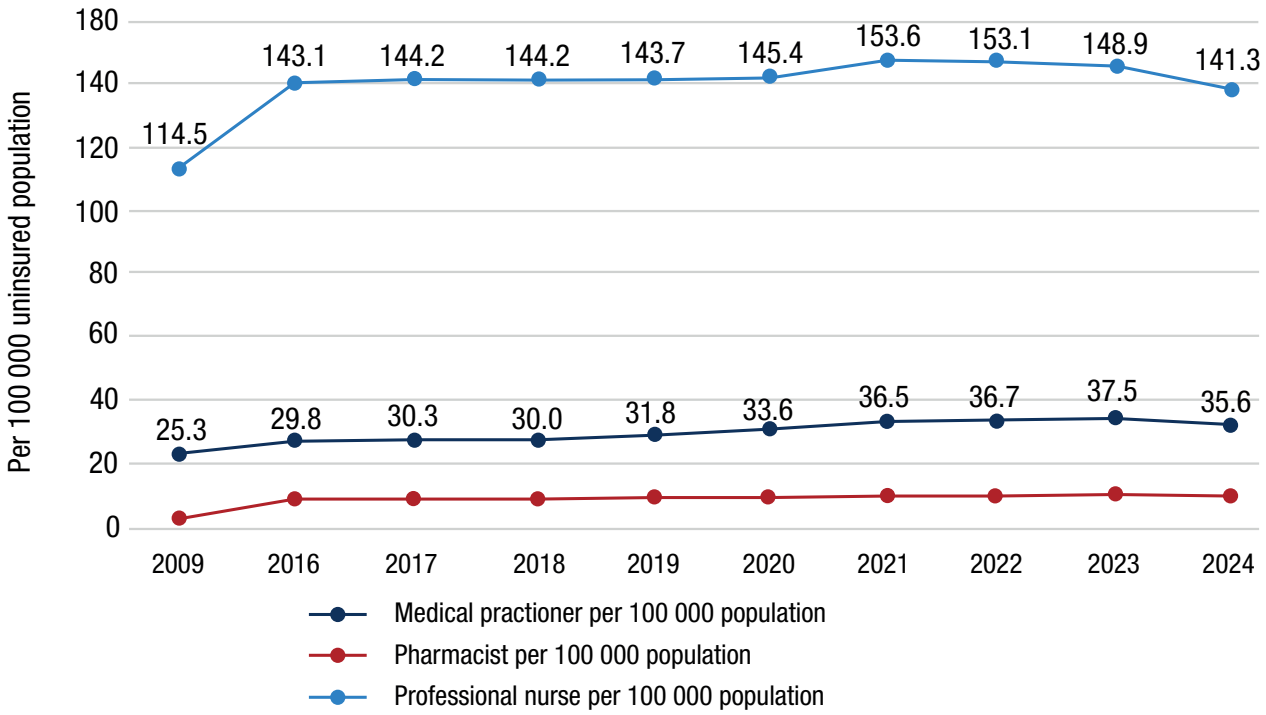


Figure 2 Ratio of professional nurses, pharmacists and medical practitioners per 100 000 uninsured population, March 2009 – March 2024

Source: PERSAL

Medical practitioners

The number of medical practitioners and pharmacists in the public sector has seen growth in both absolute numbers and ratios per 100 000 uninsured population since 2016. As of March 2024, there were 35.6 medical practitioners per 100 000 population in the public sector, an 18% increase from 30.0 per 100 000 in March 2018 (pre-COVID-19). In terms of absolute numbers, medical practitioners in the public sector grew by 28%, from 14 764 in March 2018 to 18 950 in March 2024. The most significant growth occurred during the COVID-19 period (2019–2021), after which the growth rate slowed, and subsequently reduced between March 2023 and March 2024. The HRH 2030 strategy set a target of 37.9 medical practitioners per 100 000 population by 2025. While the ratio was close to this target in 2023 (37.5 per 100 000), it has since fallen short of this target in 2024 due to a 4% and 5% decline in the total number and ratio of medical practitioners, respectively. The country requires 1 239 (or 2.3 per 100 000 population) more medical practitioners to achieve this target.

14 Ditlopo P, Blaauw D, Rispel Laetitia C, Thomas S, Bidwell P. Policy implementation and financial incentives for nurses in South Africa: a case study on the occupation-specific dispensation. Glob Health Action. 2013; 6(1):19289.

15 Blecher M, Kollipara A, Maharaj Y, Mansvelder A, Davén J, Gaarekwe O. Health spending at a time of low economic growth and fiscal constraint. In: Padarath A, Barron P, editors. South African Health Review 2017. URL: http://www.hst.org.za/publications/south-african-health-review-2017

Pharmacists

Between March 2009 and March 2016, pharmacists experienced the highest growth among the three focal health cadres, driven by the introduction of the OSD. The number of pharmacists in the public sector increased by 186%, from 1 855 in 2009 to 6 557 in 2016 (reflecting a 151% growth in the availability of pharmacists during this period). Since then, the annual growth rate of pharmacists has varied between 1% and 3%, with the largest increase (3%) occurring during the COVID-19 period. As of March 2023, there were 6 448 pharmacists in the public sector, equating to a ratio of 12.1 per 100 000 uninsured population. Despite the growth, this still falls short of the HRH 2030 strategy target of 15.13 pharmacists per 100 000 uninsured population.

Additionally, both the absolute number of pharmacists and the ratio declined between March 2023 and March 2024 by 2% and 3%, respectively. This trend was observed amongst many HRH, which is concerning.

Professional nurses

The trend among professional nurses has been characterised by stagnation and decline rather than sustained growth. Any gains in one period have often been offset by losses in the next, as shown in Figure 3 below. After the first increase in 2016, nurse levels remained relatively stable between March 2017 and March 2020. The year 2021 showed a larger increase in nurses due to COVID-19 but this was not sustained. Therefore, the nursing sector shows an overall pattern of small fluctuations without real growth.

There are 75 294 professional nurses as of March 2024, a decrease of 4% from March 2023 (78 340). This represents a ratio of 141.3 per 100 000 uninsured population in 2024. This level is below the March 2016 ratio of 143.1 per 100 000 uninsured population, and well below the HRH 2030 strategy target of 176.51 professional nurses per 100 000 uninsured population by 2025.

If all nurse cadres (excluding specialist nurses, for which there is no reliable data) are considered, the country has 256 nurses per 100 000 uninsured population as of March 2024. However, the 2030 SDGs aim for 830 nurses per 100 000 population.[16] Even when including specialist nurses, who naturally make up the smallest numbers of nurses, South Africa still falls significantly short of the SDG 2030 goal.

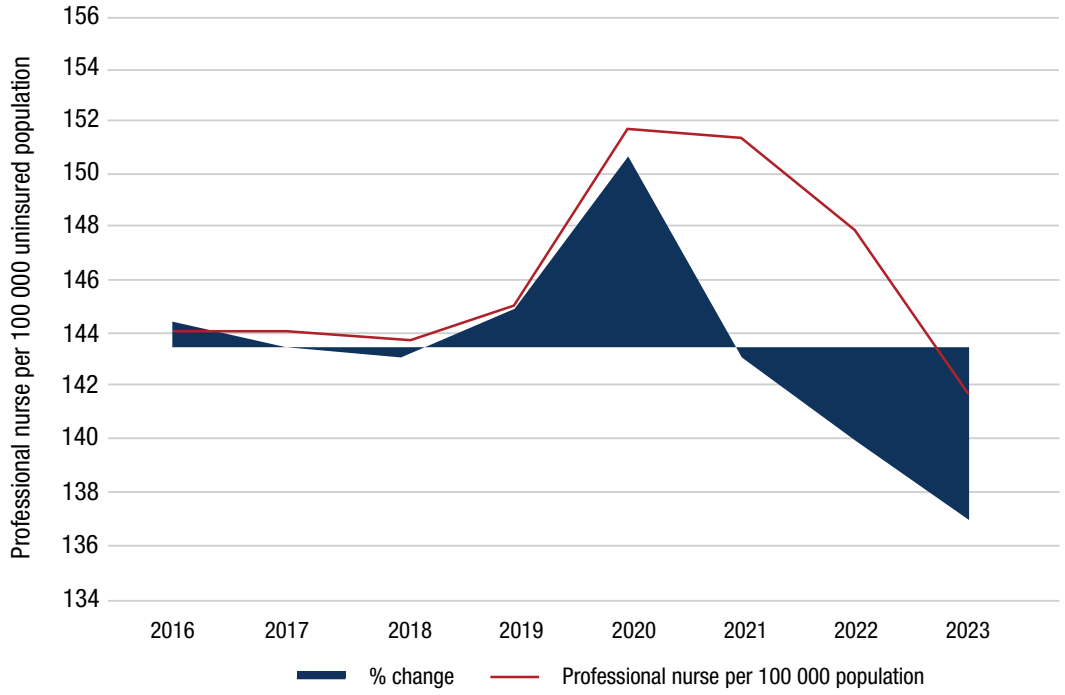


Figure 3 Ratio of professional nurses per 100 000 uninsured population and percentage change per year, March 2009 – March 2024

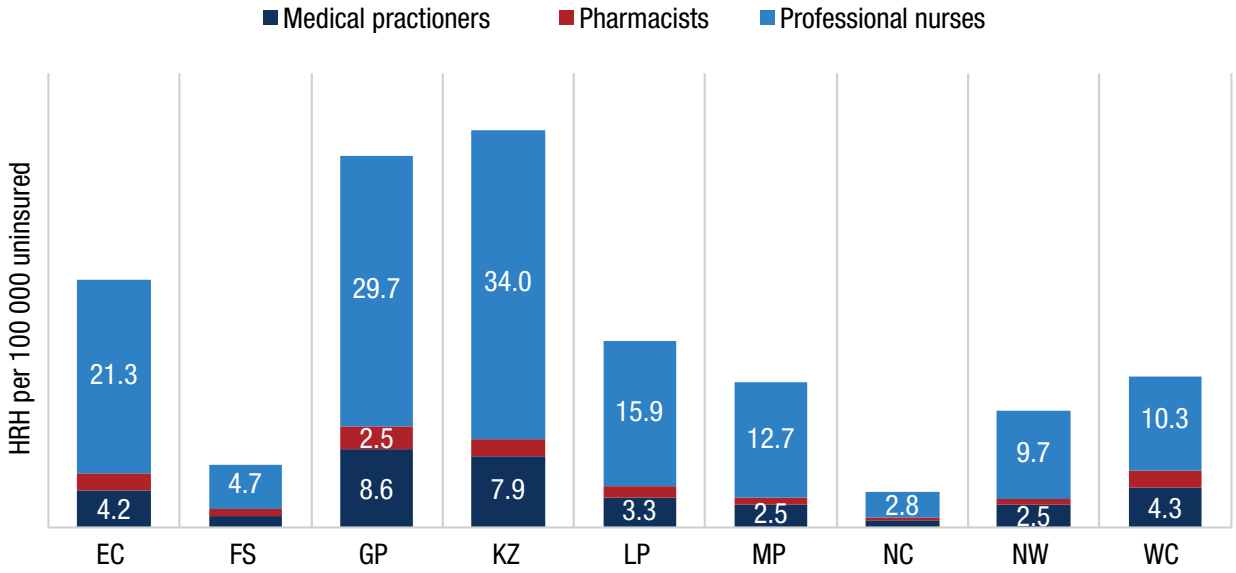
Source: PERSAL

16 Bakibinga P. Africa can and must do more to support nurses and midwives. The Conversation; 2020. URL: http://theconversation.com/africa-can-and-must-do-more-to-support-nurses-and-midwives-135722

The supply of professional nurses in South Africa, like other nursing cadres, has been declining. The workforce is ageing, with data from March 2023 showing that 38% of professional nurses are over 50 and nearing retirement (age 65), when they will exit the workforce.[17] Beyond retirements, the workforce also faces exits due to emigration, death, and career changes. South Africa's nursing education system once produced more nurses, but its capacity has diminished for various reasons, some of which are discussed below, making it difficult for nursing education institutions (NEIs) to replace the large portion of nurses set to exit. Recent changes to the nursing qualifications framework, including raising the entry requirements for studying, has reduced the pool of eligible candidates.[18] This was done in attempt to increase the quality of nurses in the South African health system. Additionally, the transition from legacy qualifications to new ones has limited training opportunities, as fewer institutions are accredited for the new qualifications.[19] In the private sector, disinvestment in training lower-cadre nurses, due to the removal of bridging programmes for enrolled nurses (ENs) and enrolled nursing assistants (ENAs) to eventually qualify as higher category nurses, such as professional nurses, has further decreased training output. Literature shows that in 2017, the bridging course produced the largest number of professional nurses, more than universities and public colleges put together.[20]

Provincial overview

According to Statistics South Africa's (Stats SA) mid-year population estimate for 2024, more than half of the country's population (56.8%) live in three of South Africa's nine provinces. Of this 56.8%, 25.3% live in Gauteng (GP), 19.5% live in KwaZulu-Natal (KZ), and 12% live in the Western Cape (WC). However, Figure 4 shows that the combined total of the three HRH cadres under review is the highest in KZ (23% of total HRH, or 43.8 per 100 000), GP has 22% of total HRH or 40.9 per 100 000, and the Eastern Cape (EC) has 14% or 27.3 per 100 000. The WC, despite being the third most populated province, has only the fifth highest ratio of the three HRH cadres combined with 9% or 16.7 per 100 000 uninsured population.



	EC	FS	GP	KZ	LP	MP	NC	NW	WC
Total HRH	27.3	6.9	40.9	43.8	20.6	16.0	4.0	12.9	16.7
% of total	14%	4%	22%	23%	11%	8%	2%	7%	9%

Figure 4 Ratio of medical practitioners, pharmacists and professional nurses combined per 100 000 uninsured population per province: March 2024

Source: PERSAL

17 Ndlovu N, Padarath A, editors. District Health Barometer 2022/23. Durban: Health Systems Trust; 2024.
18 South African Nursing Council. Circular 7/2016. Pretoria: SANC; December 2016. URL: https://www.sanc.co.za/2016/12/20/circular-7-2016/
19 Crowley T, Daniels F. Nursing education reform in South Africa: Implications for postgraduate nursing programmes. URL: https://www.sciencedirect.com/science/article/pii/S2214139123000033
20 Armstrong SJ, Geyer N, Bell CA. Capacity of South African nursing education institutions to meet healthcare demands: A looming disaster? Int J Afr Nurs Sci. 2019;10:92 -101. URL: www.sciencedirect.com/science/article/pii/S2214139118300660

These inter-provincial disparities in access to HRH are important, but there are no specific targets for each province's unique burden of disease and demographic breakdown. It is possible that the WC's lower ratio is suitable for a predominantly urban province, or that the EC's workforce of medical practitioners, professional nurses, and pharmacists is larger than necessary. While health outcomes are the gold standard on which to judge health system effectiveness, the availability of HRH is also an indicator when analysing why some provinces perform well and others do not.[21]

The trend in combined HRH per 100 000 uninsured population is shown in Figure 5. The proportional growth of combined HRH across provinces has remained consistent over time, with no significant shifts between provinces. What stands out, however, is that the combined HRH per 100 000 uninsured population in 2024 has decreased and now closely mirrors 2018 and 2019 levels, being only 2% and 1% higher, respectively. This trend can be attributed to the large proportion of professional nurses in the overall HRH mix, therefore reflecting the same pattern seen in professional nurses (one of a substantial number of expected exits due to the ageing nursing workforce).

Although the combined HRH ratio increased by 2% from March 2018 to March 2024, there are notable interprovincial differences in growth rates, as shown in Figure 6. Three provinces experienced a decline in HRH per 100 000 uninsured population (Limpopo (LP), Northern Cape (NC), and EC), while two provinces saw substantial growth (Mpumalanga (MP) and North West (NW). The larger fluctuations in provinces like NC, NW and MP are partly due to them starting from a smaller base.

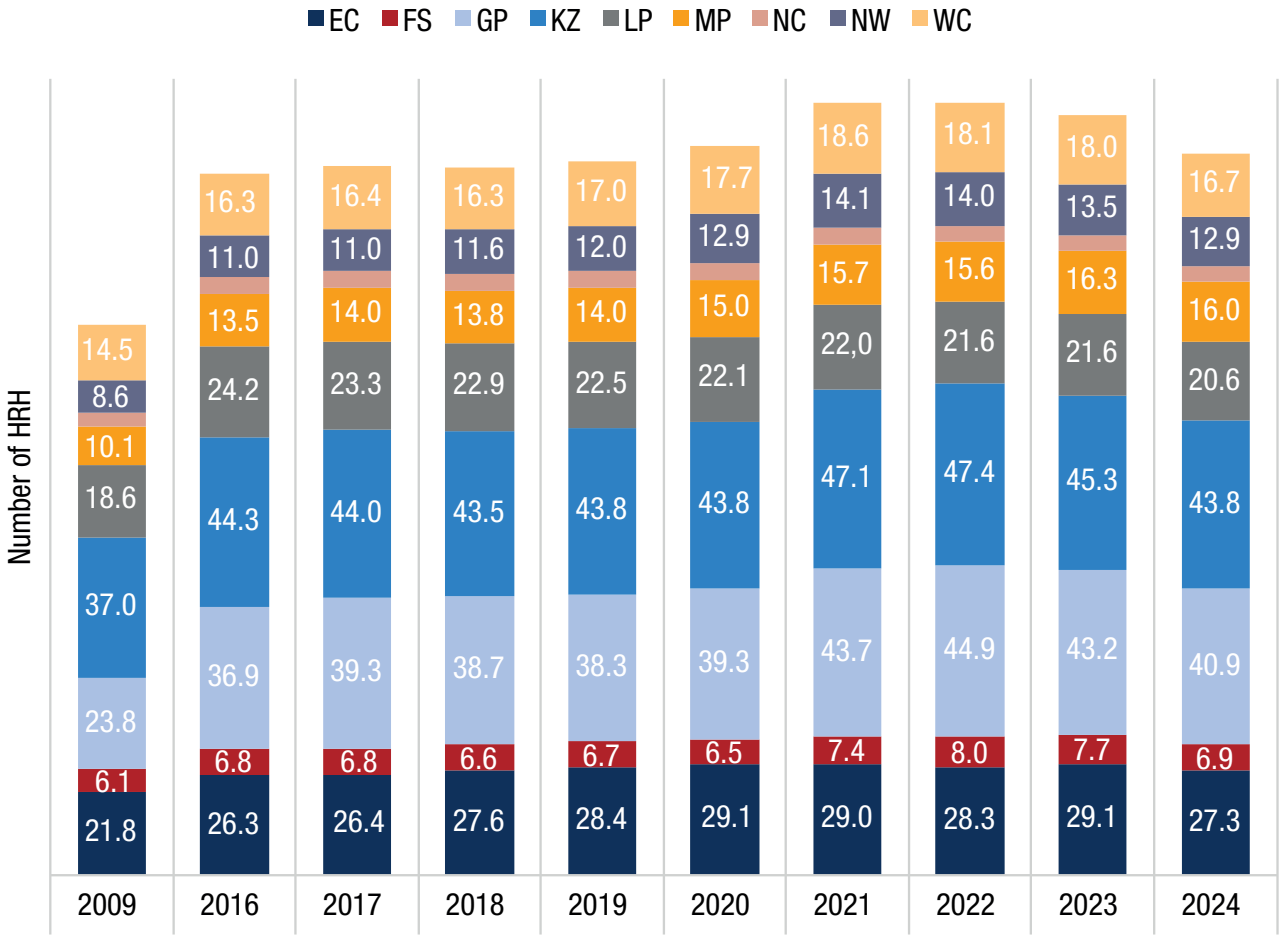


Figure 5 Trend in combined HRH per 100 000 uninsured, per province: March 2009 – March 2024
Source: PERSAL

21 Ndlovu N, Padarath A, editors. District Health Barometer 2022/23. Durban: Health Systems Trust; 2024.

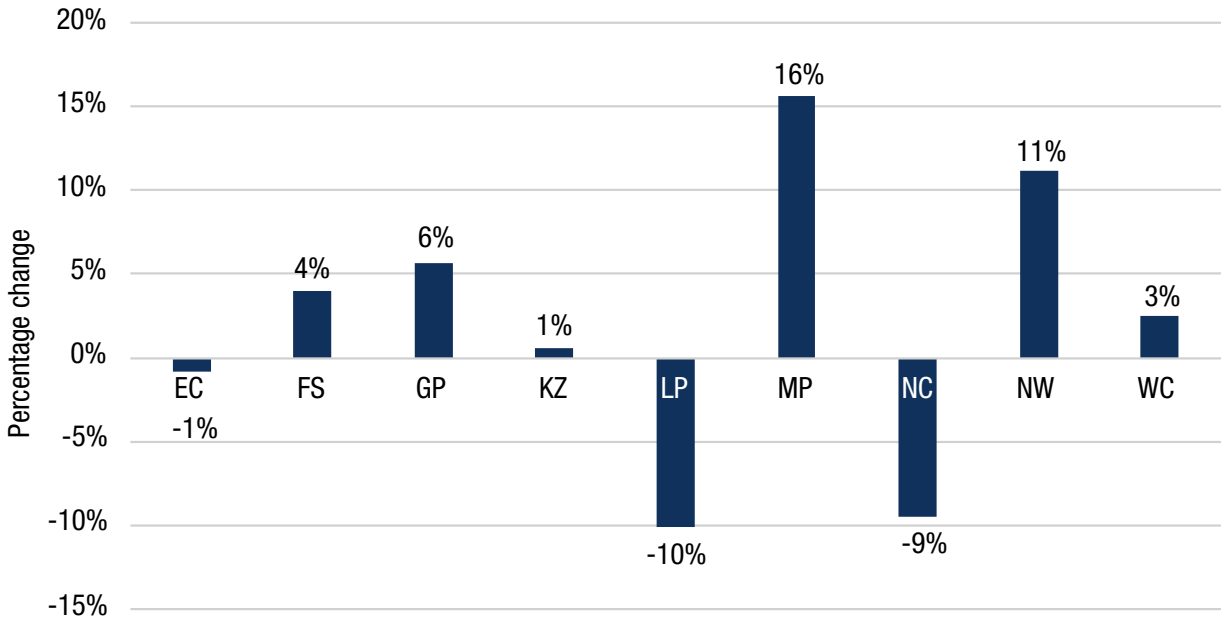


Figure 6 Six-year percentage change in combined HRH per 100 000 population from March 2018 (pre-COVID-19) to March 2026

Source: PERSAL

The figures below (Figure 7, Figure 8 and Figure 9) analyse each HRH cadre by province as of March 2024. The WC ranks among the top three provinces for medical practitioners and pharmacists but has the lowest number of professional nurses per 100 000 uninsured population. KwaZulu-Natal, which is among the top three provinces for medical practitioners and nurses, has one of the lowest pharmacist levels. The EC is consistently in the upper half across all three HRH cadres, while GP ranks in the middle to lower tier for each.

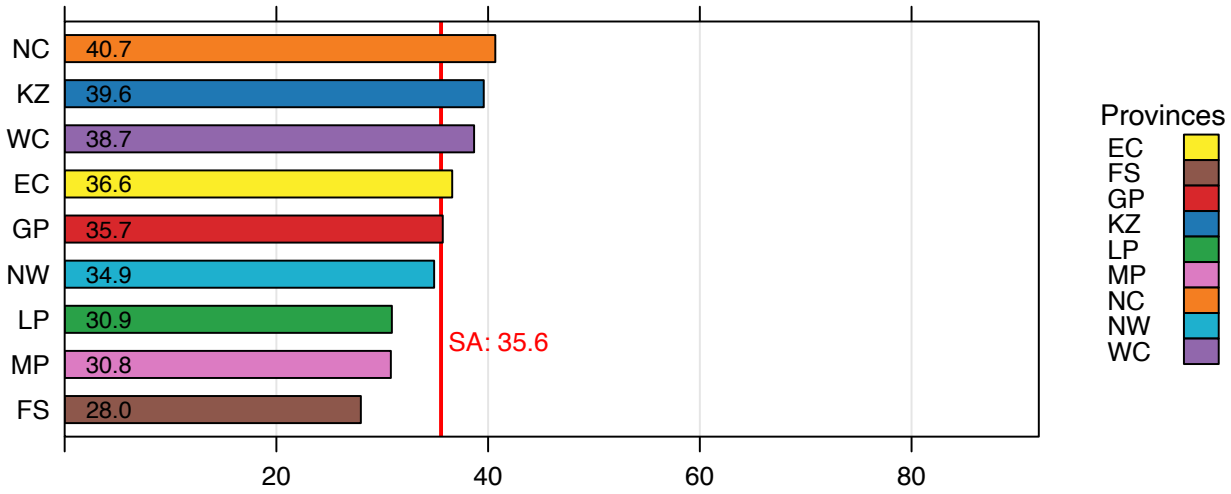


Figure 7 Medical practitioners per 100 000 population by province, March 2024

Source: PERSAL

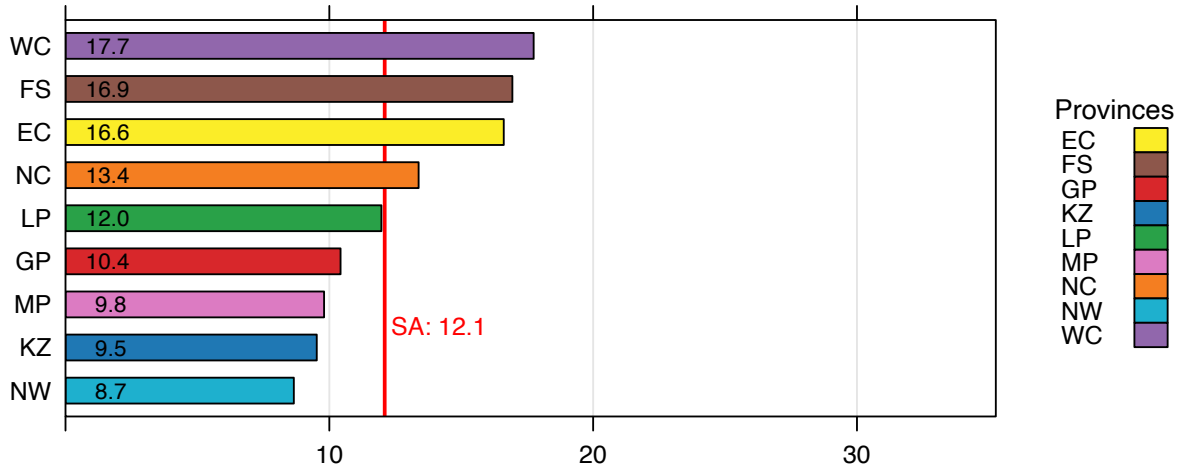


Figure 8 Pharmacists per 100 000 population by province, March 2024

Source: PERSAL

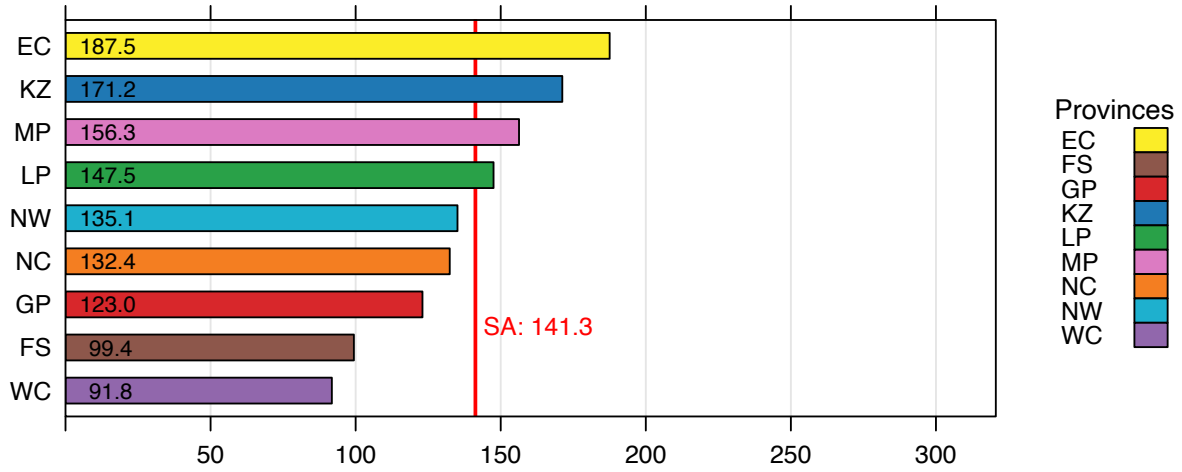


Figure 9 Professional nurses per 100 000 population by province, March 2024

Source: PERSAL

District overview

Medical practitioners

Figure 10 illustrates the ratio of medical practitioners per 100 000 uninsured population across districts as of March 2024. Similar to 2023, Buffalo City (EC) has the highest medical practitioner ratio at 83.7 (slightly down from 84.7 in 2023), while ZF Mgcawu (NC) has the lowest at 6.9 per 100 000 (down from 7.4 in 2023).

Map 1 highlights that intra-provincial inequities are more pronounced than the inequity between provinces. For example, in NW, Dr Kenneth Kaunda and Ngaka Modiri Molema districts have 67.5 and 33.0 medical practitioners per 100 000 uninsured population, respectively, as of March 2024. These neighbouring districts have similar populations, Dr Kenneth Kaunda had approximately 809 000 people in 2019[22] while Ngaka Modiri Molema had around 937 723[23] about 19% more. Despite their proximity, Dr Kenneth Kaunda is more densely populated due to its smaller geographic size.[24] Dr Kenneth Kaunda district benefits from the Klerksdorp/Tshepong Hospital Complex which attracts more medical practitioners, and has the highest medical scheme coverage in the province. This creates opportunities for doctors to work in private sector while also working in the public sector, referred to as remunerated work outside the public service (RWOPS). RWOPS is legal but permission must be granted by facility management.

22 Corporate Governance and Traditional Affairs. Profile and Analysis District development model: Dr Kenneth Kaunda District NW. Pretoria; 2020.
23 Corporate Governance and Traditional Affairs. Profile and Analysis District development model: Ngaka Modiri Molema District NW. Pretoria; 2020.
24 Massyn N, Day C, Ndlovu N, Padayachee T. Editors. District Health Barometer 2019/20. Durban: Health Systems Trust; December 2020.

Map 1 also reveals a similar trend between urban and rural districts, likely for similar reasons.

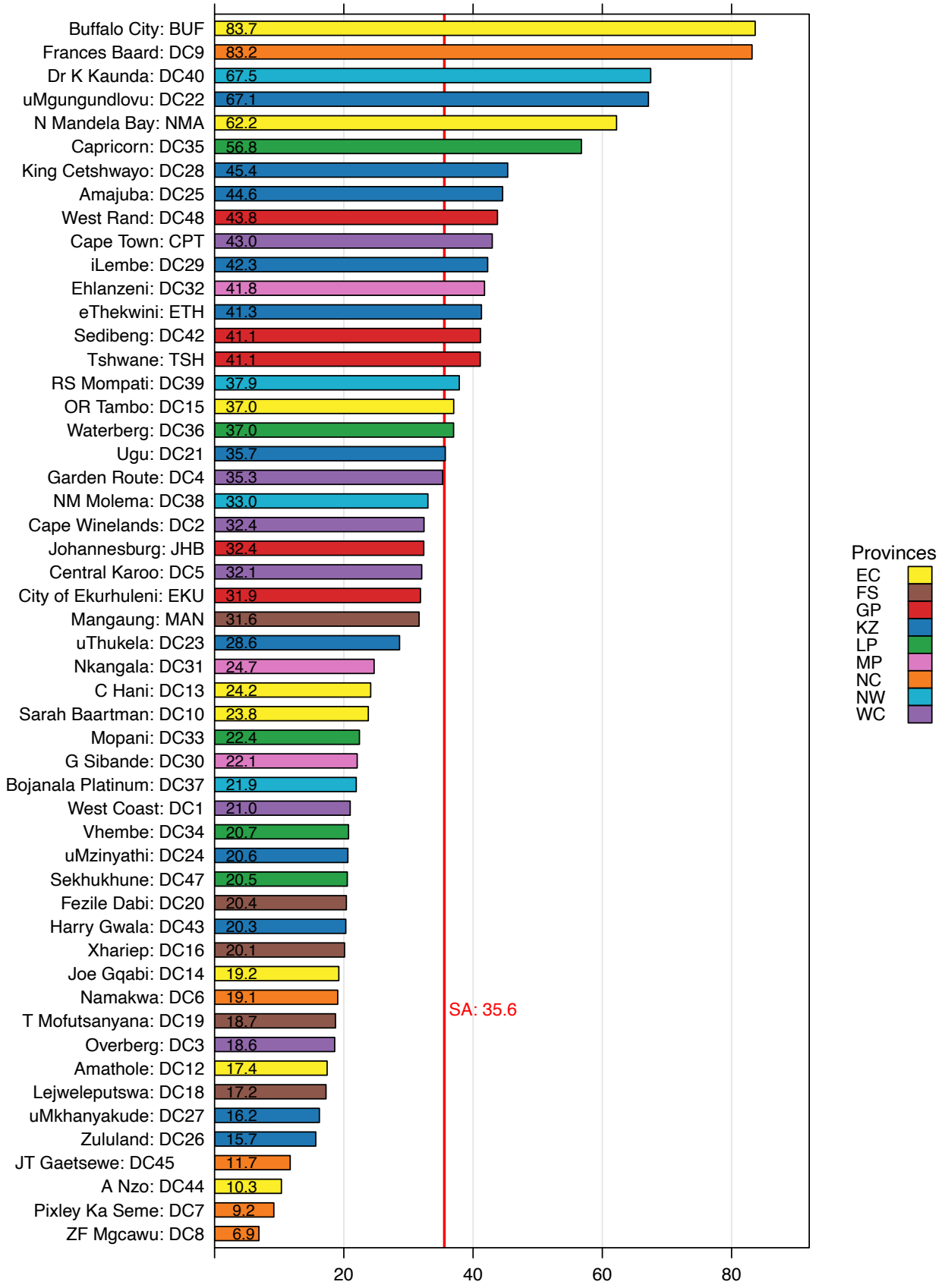
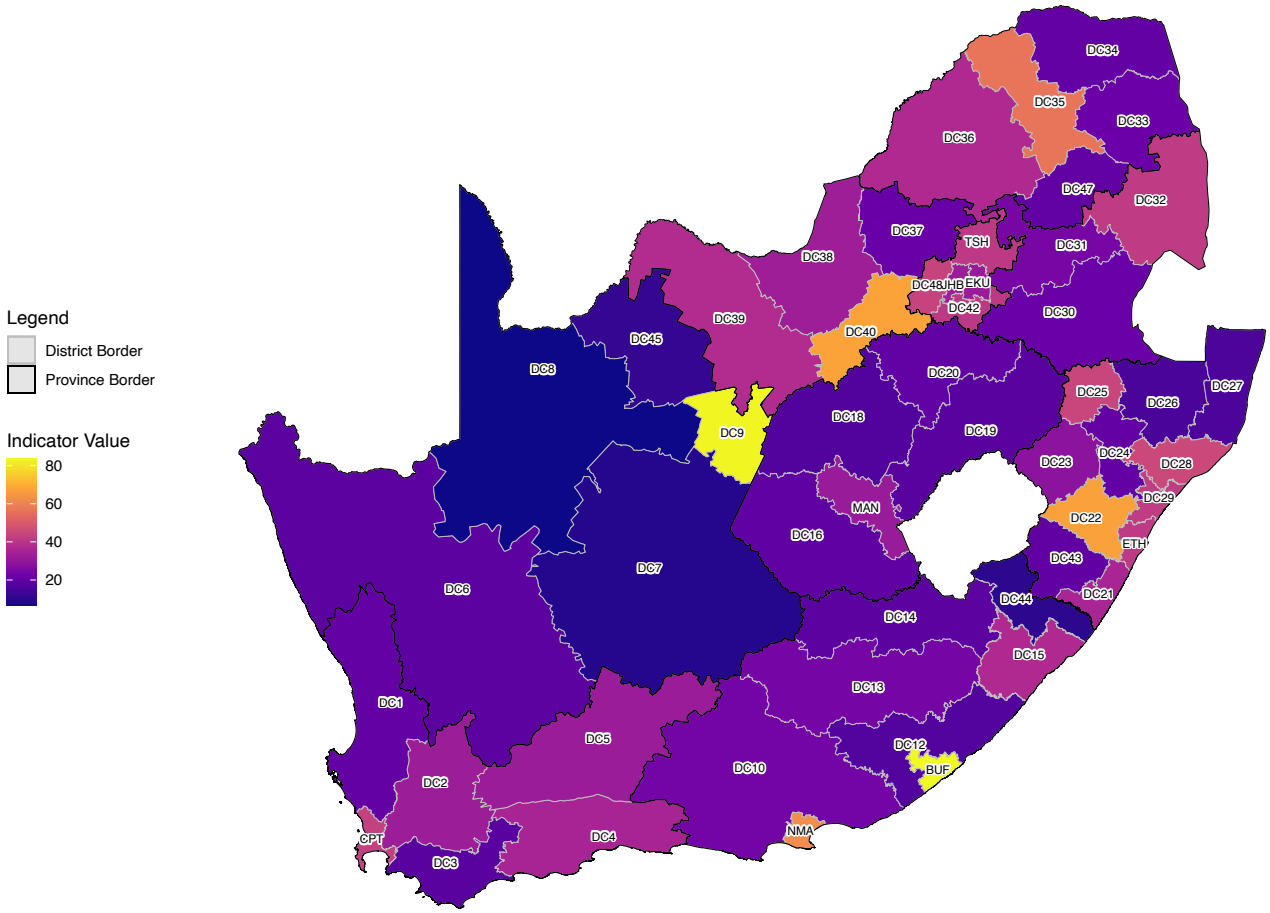


Figure 10 Medical practitioners per 100 000 population by district, March 2024

Source: PERSAL



MAP 1 Medical practitioners per 100 000 uninsured population by district, March 2024

Source: PERSAL

Pharmacists

District-level disparities in pharmacist ratios are striking, as shown in Figure 11. The district with the highest ratio, Central Karoo (WC), has 32.1 pharmacists per 100 000 uninsured population in March 2024, a figure 27% higher than the second-ranked district, Buffalo City (EC), which has 25.3 per 100 000 uninsured population. Central Karoo's ratio also shows a 13.4-fold difference compared to the district with the lowest number of pharmacists, ZF Mgcawu (NC), which has only 2.4 pharmacists per 100 000 uninsured population. Notably, all six districts in WC and six of the eight in EC exceed the national average of 12.1 pharmacists per 100 000 uninsured population. In contrast, all districts in KZ and MP fall below the national average.

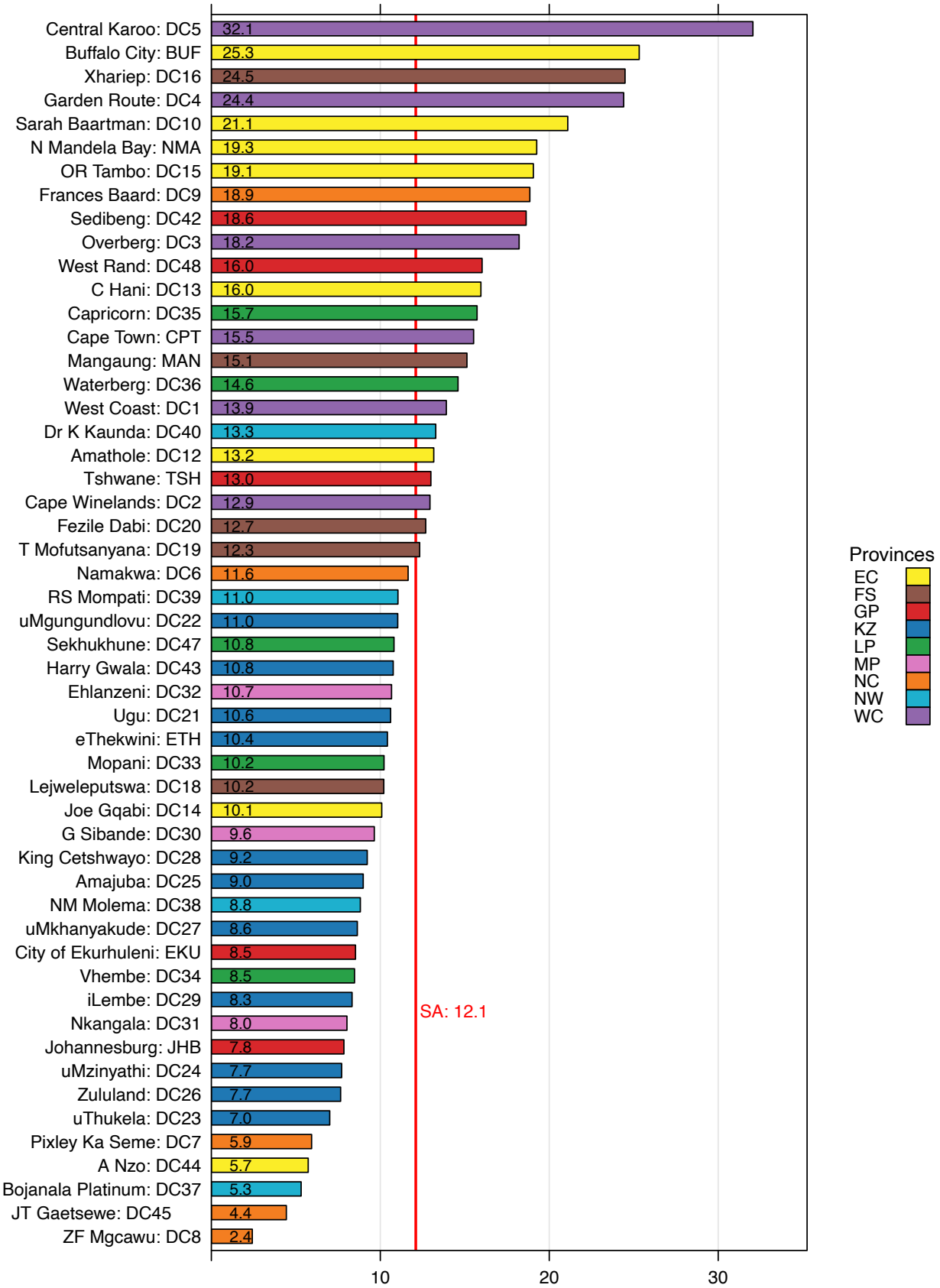
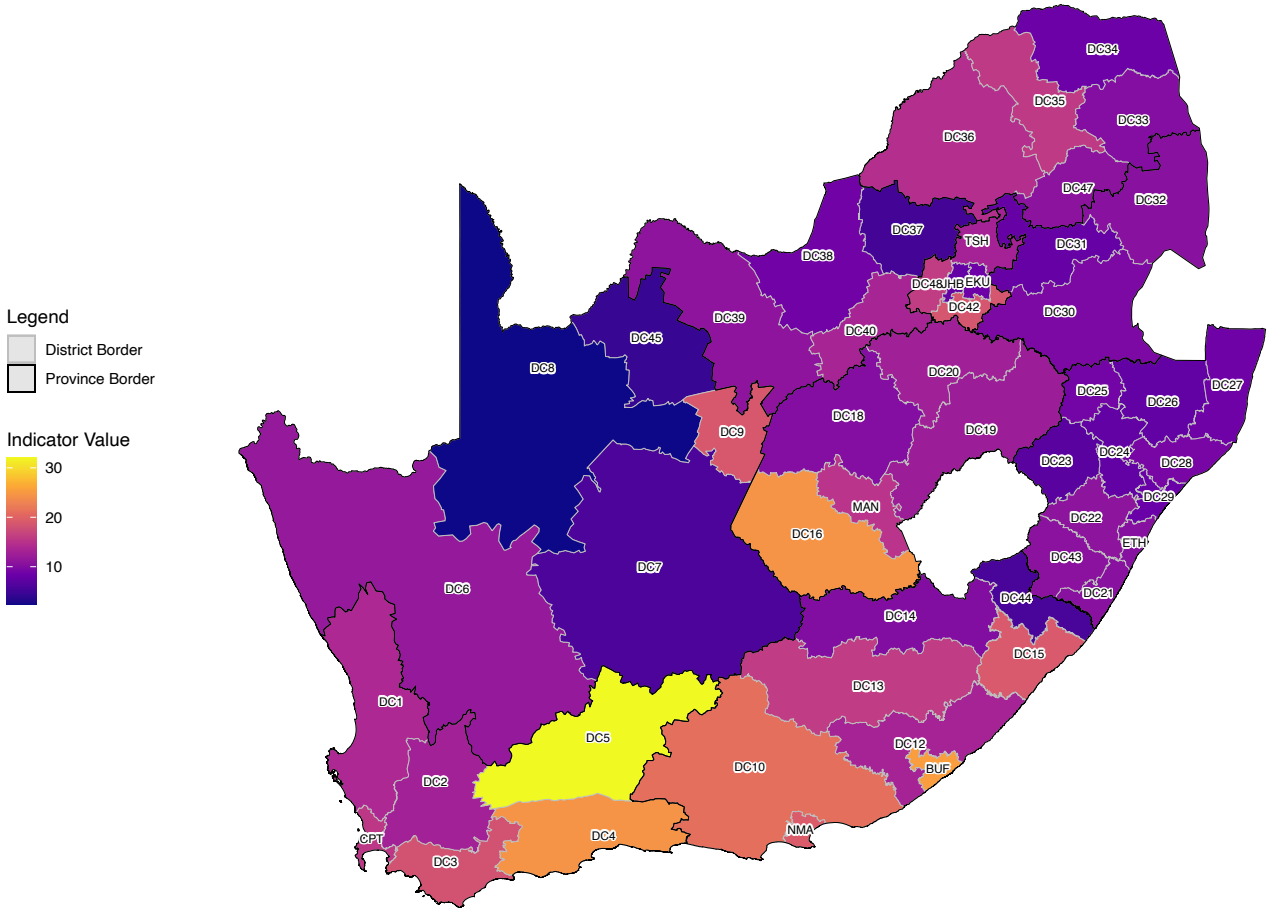


Figure 11 Pharmacists per 100 000 population by district, March 2024

Source: PERSAL

The district disparities highlighted above are evident in Map 2. In NC, Frances Baard and Namakwa have pharmacist ratios of 18.9 and 11.6 per 100 000 uninsured population, while JT Gaetsewe and ZF Mgcawu have notably lower ratios of 4.4 and 2.4, respectively. Pixley Ka Seme (NC) saw a significant drop from a ratio of 13.1 in March 2023 to 5.9 in March 2024, whereas Namakwa increased from 7.4 in 2023 to 11.6 over the same period. Frances Baard, a more urbanised area with the economic and administrative hub of Kimberley, likely attracts pharmacists more readily. In contrast, Namakwa, JT Gaetsewe and ZF Mgcawu districts are more rural districts, but Namakwa has a much higher ratio. This is probably due to the higher population numbers in JT Gaetsewe and ZF Mgcawu districts. Namakwa has a smaller, more dispersed population, meaning that there are fewer people to care for.[25]



MAP 2 Pharmacists per 100 000 uninsured population by district, March 2024

Source: PERSAL

Professional nurses

Figure 12 illustrates the district disparities in the ratio of professional nurses per 100 000 uninsured population in March 2024, revealing a 5.5-fold variation between the highest and lowest performing districts: Buffalo City (EC) at 291.5 and Lejweleputswa (Free State (FS)) at 53.0. Notably, five of the eight districts in EC rank among the top ten for the highest professional nurse ratios, whereas four out of five districts in FS fall among the ten lowest. In fact, all districts in WC, FS and NC report ratios below the national average of 141.3. Map 3 further highlights this within-province discrepancy. For instance, in KZ, the more urban uMgungundlovu district, which contains Pietermaritzburg (the second largest city in the province), has a significantly higher ratio (251.4) of professional nurses than the more rural uThukela district (138.2). As a larger city, Pietermaritzburg likely attracts nurses more readily than the smaller, more rural areas in uThukela.

25 Department of Corporate Governance and Traditional Affairs. Profile and Analysis District Development Model: Namakwa district: Northern Cape. Pretoria; 2020.

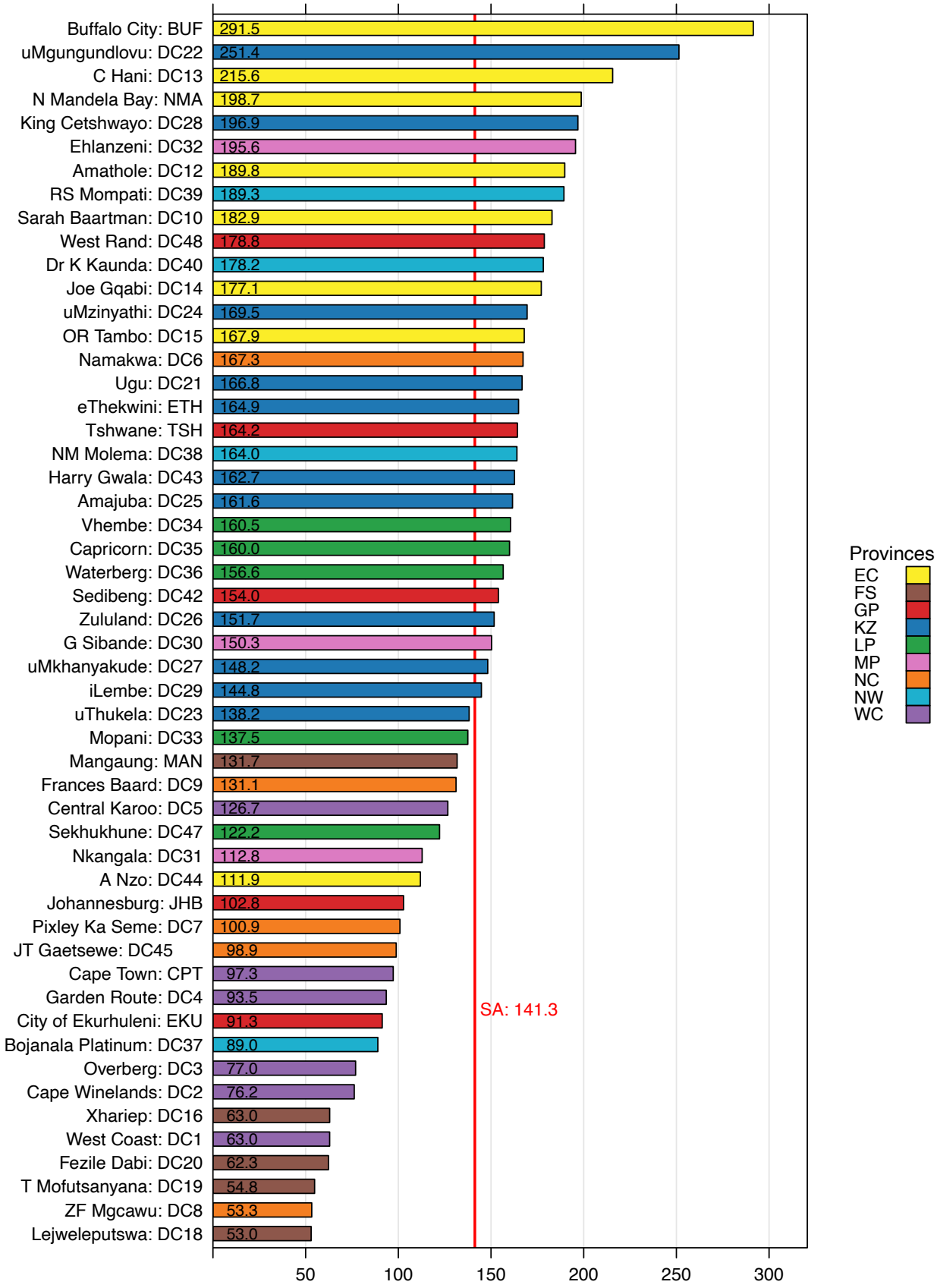
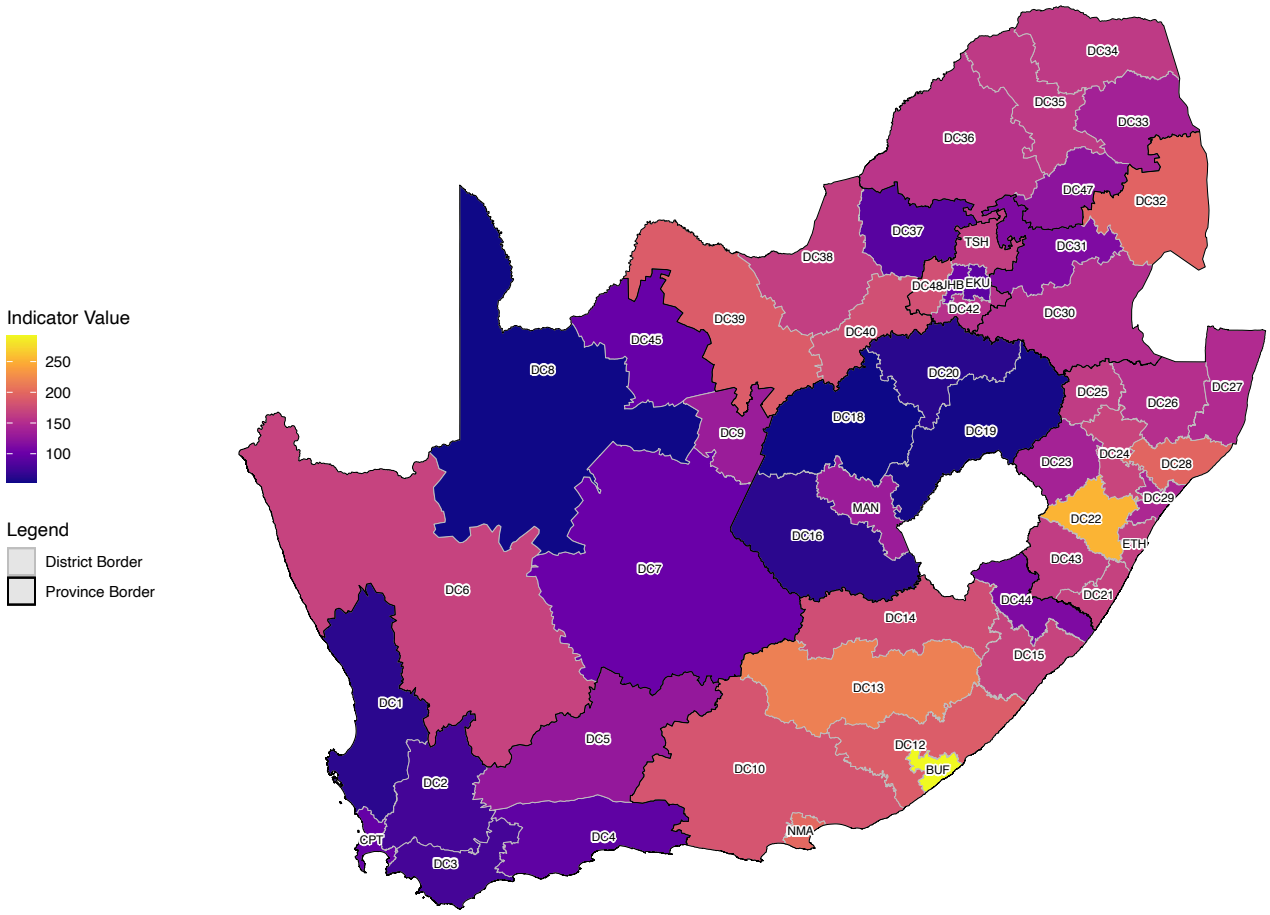


Figure 12 Professional nurses per 100 000 population per district, March 2024

Source: PERSAL



MAP 3 Professional nurses per 100 000 population per district, March 2024

Source: PERSAL

Nursing assistants

Nursing assistants (auxiliary nurses) perform the essential daily caregiving tasks. They are critical to ensuring that professional nurses can concentrate on more complex cases and are an integral part of nursing teams.

Nursing assistant ratios show less intra-provincial discrepancy, but the inter-provincial inequity is stark, except for FS. In March 2024, the intra-provincial discrepancy in FS is high, Mangaung has the highest ratio of nursing assistants (129.8), whereas Lejweleputswa has the lowest (28.9).

The South African average for nursing assistants is 62.3 per 100 000 uninsured population in March 2024 (Figure 13). However, the maximum ratio in Mangaung (FS) is double that of the average, while the smallest ratio in Overberg (WC) is less than half (24.9). In these same two districts, the professional nurse ratios were 131.7 in Mangaung (below the professional nurse country average of 141.3) and 77.0 per 100 000 in Overberg (also below the national average). Notably, Mangaung has an almost one-to-one ratio of professional nurses to nursing assistants, whereas Overberg has nearly three professional nurses for each nursing assistant. This broad range highlights a lack of strategic planning around the ideal mix and ratio of staff to population needs.

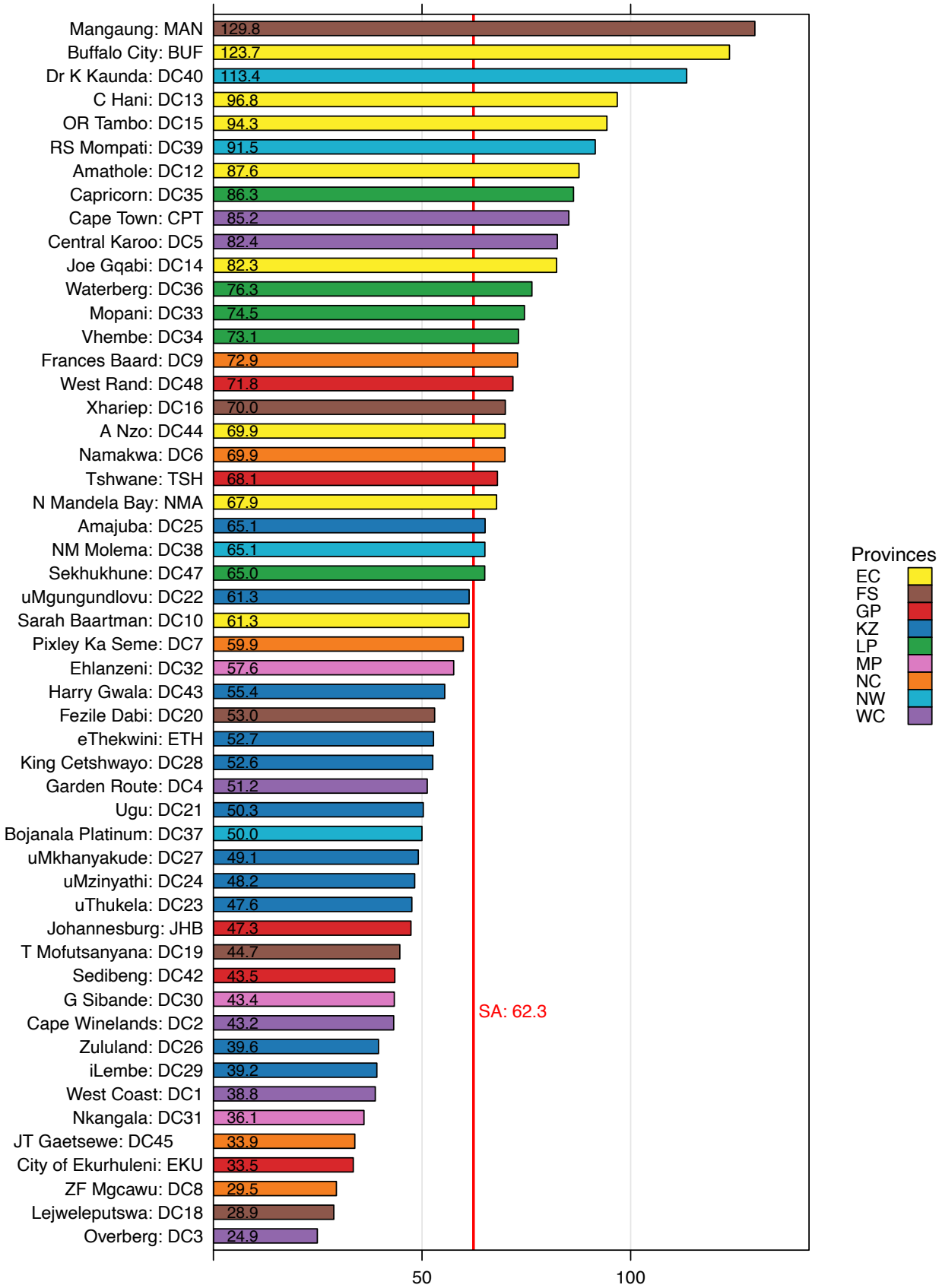


Figure 13 Nursing assistants per 100 000 uninsured population per district, March 2024

Source: PERSAL

Dental practitioners

Figure 14 illustrates the disparities in the number of dental practitioners per 100 000 uninsured population across various districts in South Africa in March 2024. Although the differences appear significant, the actual numbers remain low, with an average of only 2.2 dental practitioners per 100 000 uninsured population. This figure is 1.6 times lower than the HRH 2030 target of 3.49, which aims to achieve the national average needed for equitable provincial distribution. Notably, only the first seven districts exceed this target.

Four districts in EC rank among the top ten districts with the most dental practitioners, while FS, GP, KZ and MP lack representation in the top ten. Additionally, the figure highlights intra-provincial disparities. These disparities are visible in NC, where Frances Baard has the highest ratio of dental practitioners at 5.3 per 100 000 uninsured population and ZF Mgcawu has the lowest ratio at just 0.4 per 100 000 uninsured population. This statistic again emphasises that urban areas are generally more attractive to health professionals compared to their rural counterparts.

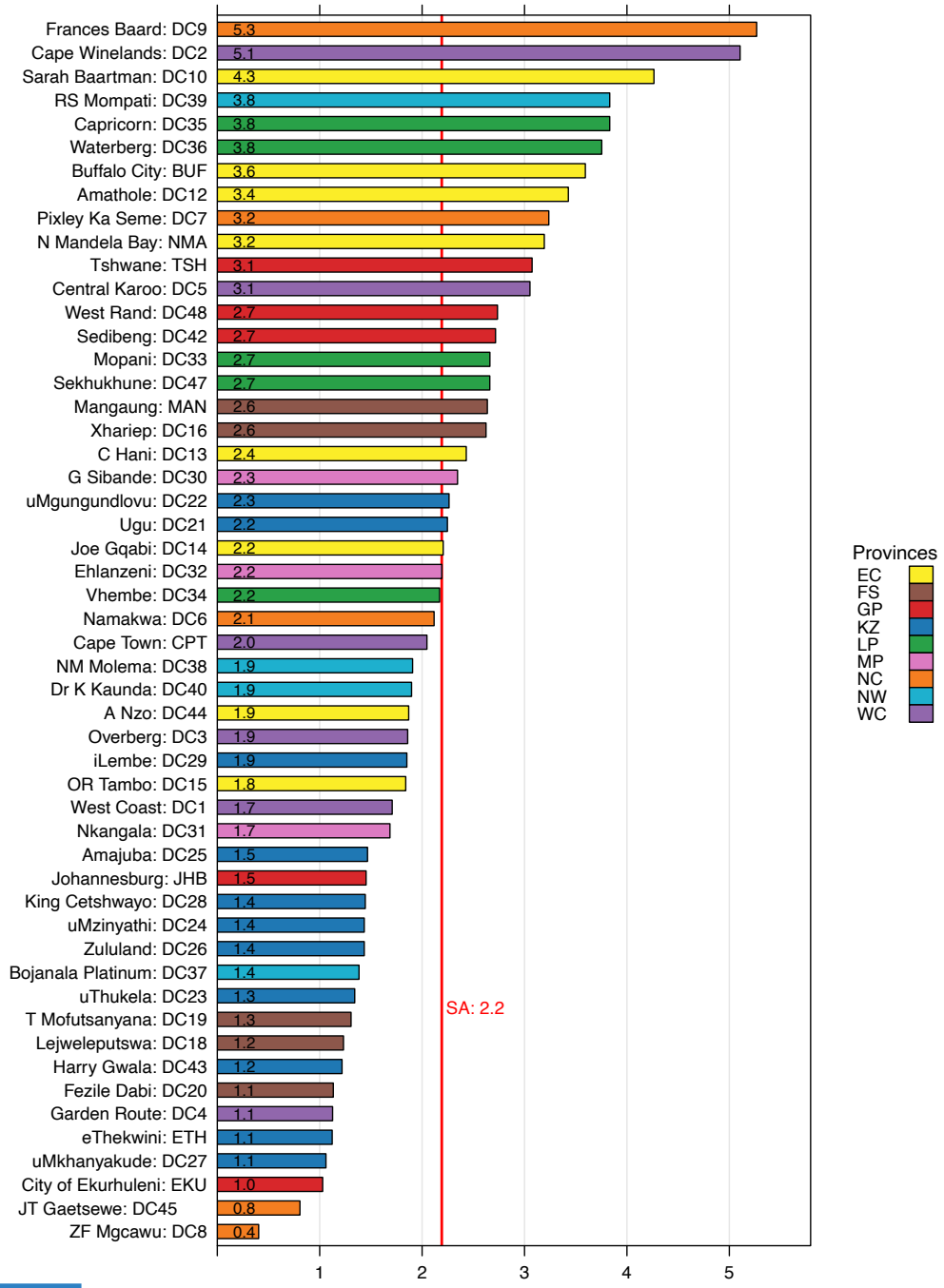


Figure 14 Dental practitioners per 100 000 uninsured population per district, March 2024

Source: PERSAL

Optometrists

Human resources for eye health (HReH) in the public sector is severely lacking,[26] making eye care largely inaccessible for the uninsured population, who are then left to either pay out of pocket or live with easily correctable conditions. As of March 2024, data from the PERSAL system show that there are only 249 optometrists and opticians, including those in community service, who work in the public sector. This accounts for approximately 6.7% of all optometrists in the country, with a staggering 93.3% working in the private sector.[26] The HRH 2030 strategy emphasises a target of 2 656 optometrists or 5.0 per 100 000 uninsured population by 2025, but with only 10% of this target currently achieved in 2024, it is clear that the HRH 2030 target will not be met.

A 2023 study suggested that there were 4 204 registered optometrists in the country across both public and private sectors.[27] This would give South Africa a ratio of 7.9 optometrists per 100 000 population which is more than the HRH 2030 target, and would be particularly useful if these HRH could be distributed equitably between sectors. However, due to the current landscape and split between sectors, the public sector has a ratio of only 0.5 optometrists per 100 000 people (Figure 15), representing a tenth of the HRH target. All districts in the country fall short of the target, and one district in WC has no optometrists at all. Even the districts with higher ratios of optometrists (many of those in LP) still fall far short. The district-level disparities in optometry coverage illustrate the systemic issues at play:

- While overall optometrist coverages exceed targets, this is inequitably distributed across sectors.
- Within the public sector, rural and underserved areas are disproportionately impacted by a lack of eye care.

26 Zulu NL, Van Staden D. Experiences and perceptions of South African optometry students toward public eye care services. Afr Vision Eye Health. 2023;82(1), a726. https://doi.org/10.4102/aveh.v82i1.726

27 Hansraj R, Dlamini N, Khan S, Mtolo PC, Ntuli NG, Prithipal C, Salajee H, Xulu-Kasaba ZNQ. Ocular therapeutics and the profession of optometry in South Africa. Afr J Prim Health Care Fam Med. 2024 Jan 16;16(1):e1-e10. doi: 10.4102/phcfm.v16i1.4140. PMID: 38299541; PMCID: PMC10839208

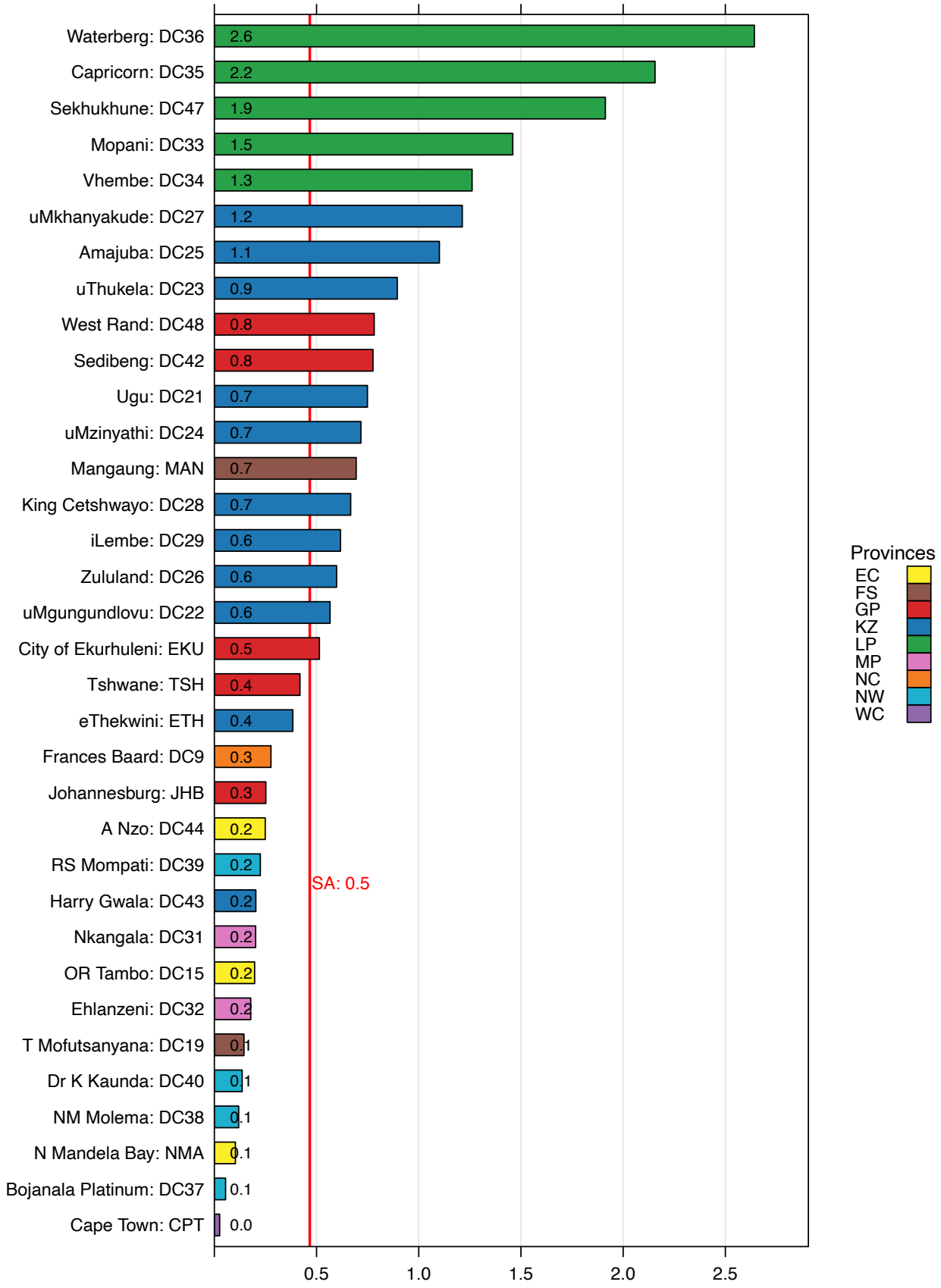


Figure 15 Optometrists per 100 000 uninsured population per district, March 2024

Source: PERSAL

Allied health professionals

Allied health professionals, made up predominantly of occupational therapists (OTs), physiotherapists (PTs) and speech therapists (STs) work with patients to support them in living as full and independent a life as possible. They often work in teams, given the nature of the rehabilitation process. This section discusses the first two cadres of allied health professionals.

Occupational therapists and PTs and particularly the rehabilitation team, are widely known to be integral to patients' quality of life. These professionals are also a cost-saving measure for health systems as they can help to prevent costly hospitalisation due to complications resulting from untreated disabilities (whether permanent or temporary disabilities).[28] A 2020 study found that one in three people with a disease or injury would benefit from rehabilitative care from an allied health professional.[29]

Figure 16 and Figure 17 show the distribution of OTs and PTs by district. In stark contrast to the combined average for medical practitioners, professional nurses and pharmacists, which exceeds 100 per 100 000 in March 2024, the ratios for allied health professionals are much lower, with only 2.6 OTs and 2.9 PTs per 100 000 uninsured population. The Framework and Strategy for Disability and Rehabilitation: 2015–2030, released in 2015, emphasises the country's intentions of broadening access to allied health multidisciplinary teams.[26]

A positive policy change between the previous HRH strategy 2011/12–2016/17 and the current HRH 2030 strategy is the inclusion of allied health professionals in workforce planning. The older strategy made no room for allied health professionals within the PHC environment and de-prioritised them against other clinical cadres (doctors and nurses mostly).[26]

The World Federation of Occupational Therapists recommends a ratio of 75 per 100 000 population for OTs. South Africa is performing well below this recommendation at 2.7 per 100 000 uninsured population. The recommended target for PTs is unavailable, but one can assume that it would be similar to the OT ratio given the similarity in the patient profile with which these two professions work. Even with such a low target, the country is still sitting at less than half that ratio in the public health sector.

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28 Cieza A, Causey K, Kamenov K, Hanson SW, Chatterji S, Vos T. Global estimates of the need for rehabilitation based on the Global Burden of Disease Study 2019: a systematic analysis for the Global Burden of Disease Study 2019. Lancet. 2020;396(10267):2006-17.

29 Ned L, Tiwari R, Buchanan H, Van Niekerk L, Sherry K, Chikte U. Changing demographic trends among South African occupational therapists: 2002 to 2018. Hum Resour Health. 2020; 18:22.

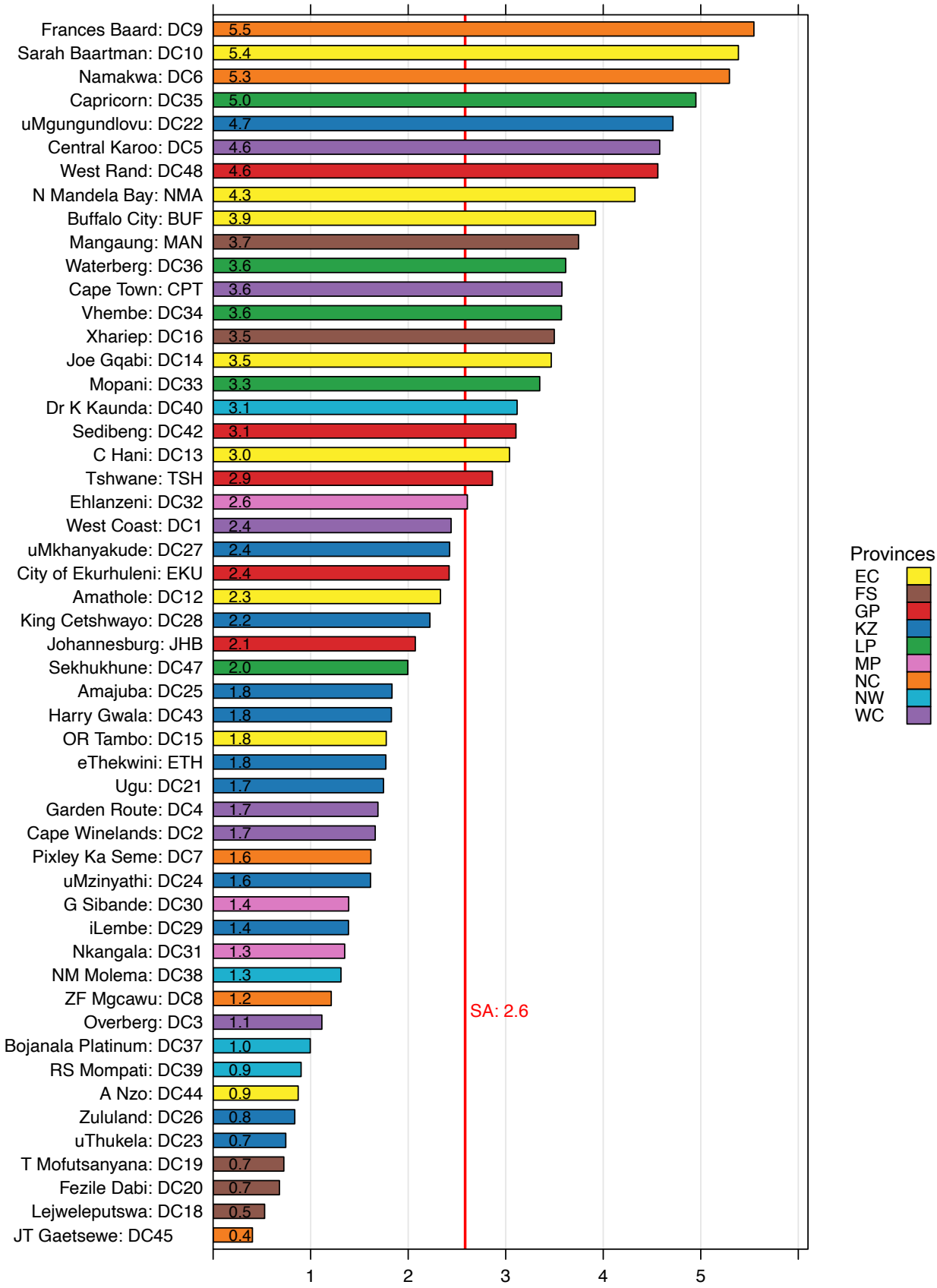

Figure 16 Occupational therapists per 100 000 uninsured population per district, March 2024

Source: PERSAL

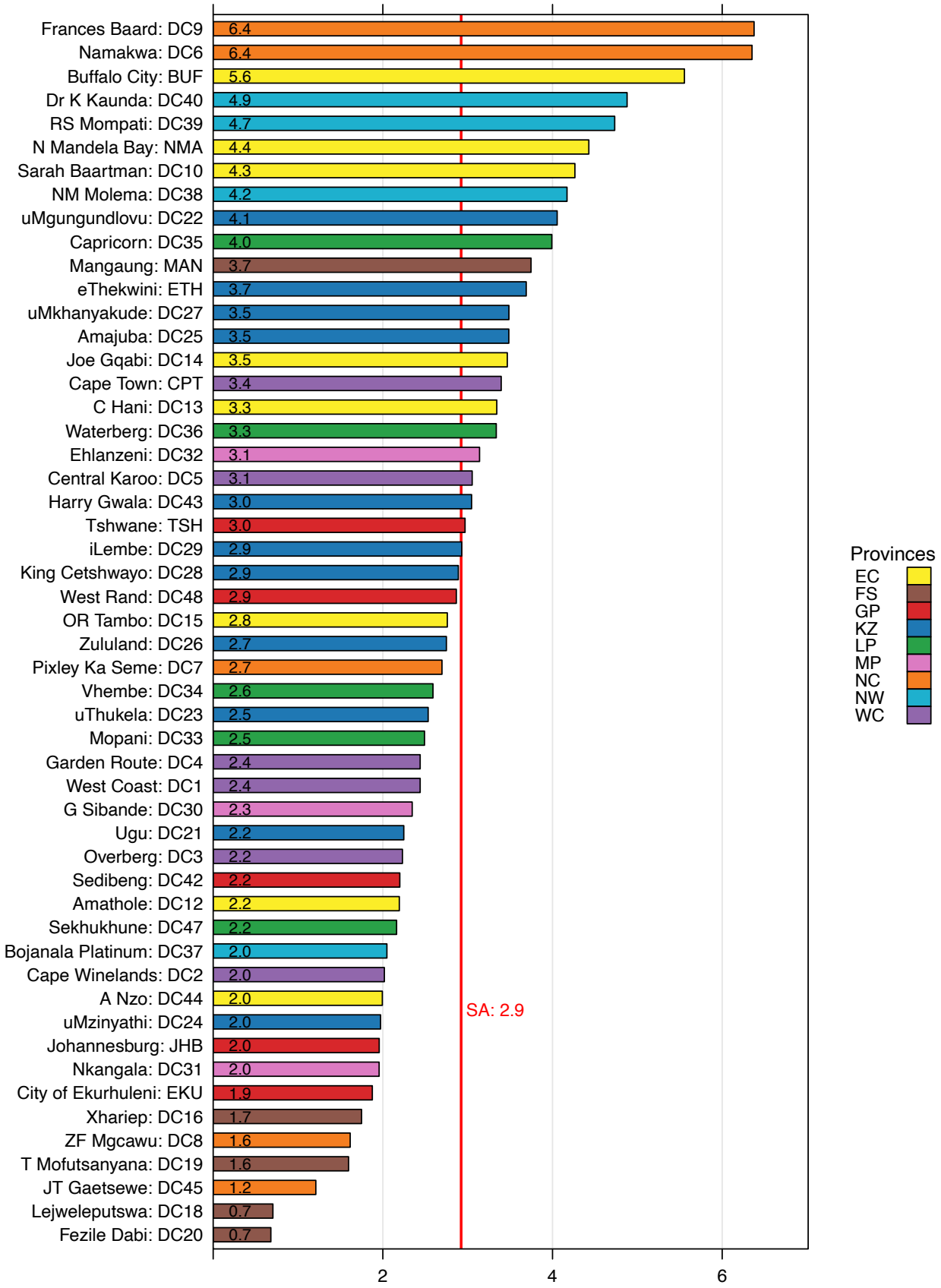

Figure 17 Physiotherapists per 100 000 uninsured population per district, March 2024

Source: PERSAL

Recommendations

- Given the current fiscal climate and uncertainties surrounding the incoming NHI, it is challenging to recommend immediate increases in staff for the PDoHs. Every additional Rand spent must be carefully considered against multiple priorities. However, effective planning is essential now to lay the groundwork for a future that aligns with UHC and promotes equitable access and quality for all.
- Foundational policy work should focus on establishing evidence-based targets to support more effective workforce planning in South Africa.
- The NDoH should prioritise the development of needs-based target ratios for all health professions, informed by demographic and epidemiological needs, and consider geographic disparities for improved accuracy. This task is complex due to data limitations and requires collaboration across the public and private sectors, taking into account factors like skills mix, evolving qualification pathways, technological advancements, and changing health risks, including those driven by external factors such as climate change. Once this information is available, the NDoH can guide training institutions in increasing supply to meet future demands.
- The NDoH's commitment to developing needs-based targets is a positive step but requires enhanced data for accurate forecasting. Additionally, deeper public-private partnerships are essential to leverage resources and expertise for training and service delivery. Strong investments in health education, supported by scholarships and grants, are critical to addressing HRH gaps and aligning with national health goals.
- Another key recommendation, aligned with current NHI policy intentions, is to improve working conditions in the public sector. This remains a priority for South Africa, as there is a direct relationship between working conditions and emigration or migration of health professionals to the private sector. Previous policies, such as the OSD and rural allowances, have shown that financial incentives alone are insufficient to retain the health workforce in the public sector; adequate support and resources are essential to prevent out-migration.

05 Climate change and health

5.1 Climate change-related health impacts in South Africa: preparing the health sector and calling for indicators to measure and prevent adverse effects

Caradee Y Wright, Thandi Kapwata, Natasha Naidoo, Candice Webster, Rajen N Naidoo, Muthise Bulani, Ngwako Kwatala, Gloria Maimela, Celeste Madondo, Tebogo Maomela, Lesibana Malinga, Sifiso Ngubeni, Bono Nemukula

Introduction

Climate change is considered one of the greatest threats to human health and well-being globally[1] and in South Africa, where growing evidence suggests that these threats most affect vulnerable and lower-income populations.[2] As greenhouse gas (GHG) emissions continue to drive rising global surface temperatures and erratic weather patterns, low- and middle-income countries (LMICs) remain disproportionately affected by climate change, while having the least adaptive capacity to prevent adverse impacts.[3]

Extreme weather events, such as frequent and intense heat waves, lead to heat-related illnesses and deaths, injuries, and displacement, among others.[4] Prolonged droughts deplete water supplies, leading to dehydration, food insecurity, and malnutrition, particularly in already vulnerable populations.[5] Floods and storms contribute to the spread of communicable diseases and create long-term mental health challenges for affected communities. Increased flooding combined with warmer temperatures expand the habitats of mosquitoes and ticks, leading to a heightened prevalence of vector-borne diseases such as malaria, dengue fever, and Lyme disease.[6] The combination of these direct and indirect health impacts underscores the complex relationship between climate change and public health.

In general, LMICs contribute the least to global GHG emissions, so mitigating GHG emissions and transitioning to renewable energy requires a global effort to be effective. Adaptation to climate change impacts is more pertinent to LMICs where evidence-based early warning systems and public health interventions to build community resilience are urgently needed. South Africa needs to focus on a multi-sectoral approach in order to improve human health in the midst of an escalating climate crisis. This chapter aims to present an update on the available evidence, together with the gaps, and the potential for a practical evidence base of climate change-related impacts on human health and well-being in South Africa to inform decision- and policy-making in the health sector.

The chapter provides insights to strengthen and guide climate and health policy and action toward climate-resilient health systems. While the chapter is relevant to a wide audience, it is particularly useful to health policymakers and managers who need support to better understand the impact of climate change on health in South Africa. Health service delivery and health-related infrastructure within the health system that will benefit from resilience-building and adaptive capacity practices are identified. Finally, the chapter calls for the development and implementation of climate change-related health indicators for South Africa to ensure that the health of the country's population is monitored and the risks that climate change poses are understood.

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3 Chancel L, Bothe P, Voituriez T. Climate Inequality Report 2023. World Inequality Lab Study 2023/1. Creative Commons Licence CC BY 4.0; 2023.
4 Miller KA, Mcunu N, Anhäuser A, Farrow A, Santillo D, Johnston P. Weathering the storm. Extreme weather events and climate change in Africa. Greenpeace Research Laboratories Technical Report; 2020.
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6 Caminade C, McIntyre KM, Jones AE. Impact of recent and future climate change on vector-borne diseases. Ann NY Acad Sci. 2019;1436(1):157–173. URL: https://doi.org/10.1111/nyas.13950

Overview of climate change and health impacts in South Africa

The Intergovernmental Panel on Climate Change (IPCC 2021) Assessment Synthesis Report 6 (AR6) highlights significant direct health impacts due to climate change, primarily driven by chronic exposure to abnormal weather elements, for example, heat, air pollution, etc., and by extreme weather events including heat waves, floods, and droughts. The increasing frequency, intensity, and duration of heatwaves result in heat-related illnesses and deaths. Floods and storms lead to injuries, drowning, displacement, the spread of communicable diseases, and subsequent mental health issues. Thus, extreme weather events not only cause immediate harm and disrupt livelihoods, but also have long-term health implications in affected populations.

Indirect health impacts are also a major concern. Climate change affects food security and nutrition by disrupting crop yields and reducing the quantity and nutritional quality of food.[7] This leads to food shortages and increased malnutrition, particularly in vulnerable regions. Water scarcity, driven by altered precipitation patterns and increased evaporation, exacerbates health issues by limiting access to clean and safe water.[8] Furthermore, warmer temperatures and increased flooding enhance the spread of infectious diseases. These indirect impacts highlight the intricate link between climate change and various aspects of public health.

Vulnerable populations are disproportionately affected by climate change. Due to geographic and socioeconomic factors, certain regions such as low-lying coastal areas and small island developing states, as well as informal urban settlements that are densely populated and have poor vegetation cover (urban heat islands), are at greater risk for extreme heat exposure. Moreover, children, the elderly, pregnant women, and individuals with pre-existing health conditions are at increased risk due to their physiological and social vulnerabilities.[9] Addressing these challenges requires improving awareness, strengthening community and health systems, developing early warning systems for natural disasters and extreme weather events, and implementing public health interventions to promote resilience. Mitigation efforts, such as reducing GHG emissions and transitioning to renewable energy sources, are crucial in addressing the root cause of climate change to limit future health impacts. The IPCC AR6 underscores the urgency of comprehensive multi-sectoral actions to protect global health in the face of climate change.

Given the immense burden that climate change and extreme weather events are placing on South Africa's health system, the overall scope and calibre of climate resilience research on health and within the health sector seems insufficient.[10] In addition, it is difficult to gauge the effectiveness of adaptation measures in the population, and ongoing efforts are required to ensure that adaptation strategies are effective.[11] Research on extreme weather events, which include extreme heat, wildfires, storms, droughts, and flooding, is a priority to inform strategies for disaster management and early warning systems.[12] Studies focusing on the effects of climatic conditions on the rising prevalence of infectious diseases in South Africa must be prioritised.[13] The challenge of air pollution and how it interacts with climate change impacts, especially in light of its link with detrimental health outcomes and the impacts of poor air quality in low-income communities, must remain a key area of research.[14,15] Figure 1 illustrates the climate change-related factors influencing health and health outcomes in South Africa. In recent years, the health impacts associated with climate change and extreme weather events have been experienced across South Africa. Figure 2 shows some of these specific impacts and events in different regions of the country. Urbanisation in South Africa is growing, and the urban heat island effect must be avoided, as such, city planners should prioritise cooling strategies, urban green strategies, and green building designs. Moreover, low-income communities are less likely to find practical strategies to adapt to extreme heat. For example, the building design and materials used for low-cost housing and schools located in low-income or rural areas are presently inadequate for protecting citizens from extreme heat.

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15 Roomaney RA, Cairncross E, Tesfaye M, et al. Estimating the burden of disease attributable to ambient air pollution (ambient PM2.5 and ambient ozone) in South Africa for 2000, 2006 and 2012. S Afr Med J. 2022;112(8B):705–717. URL: https://doi.org/10.7196/SAMJ.2022.v112i8b.16483

Figure 1 Climate change-related drivers and associated health impacts in South Africa

Source: South African Medical Research Council

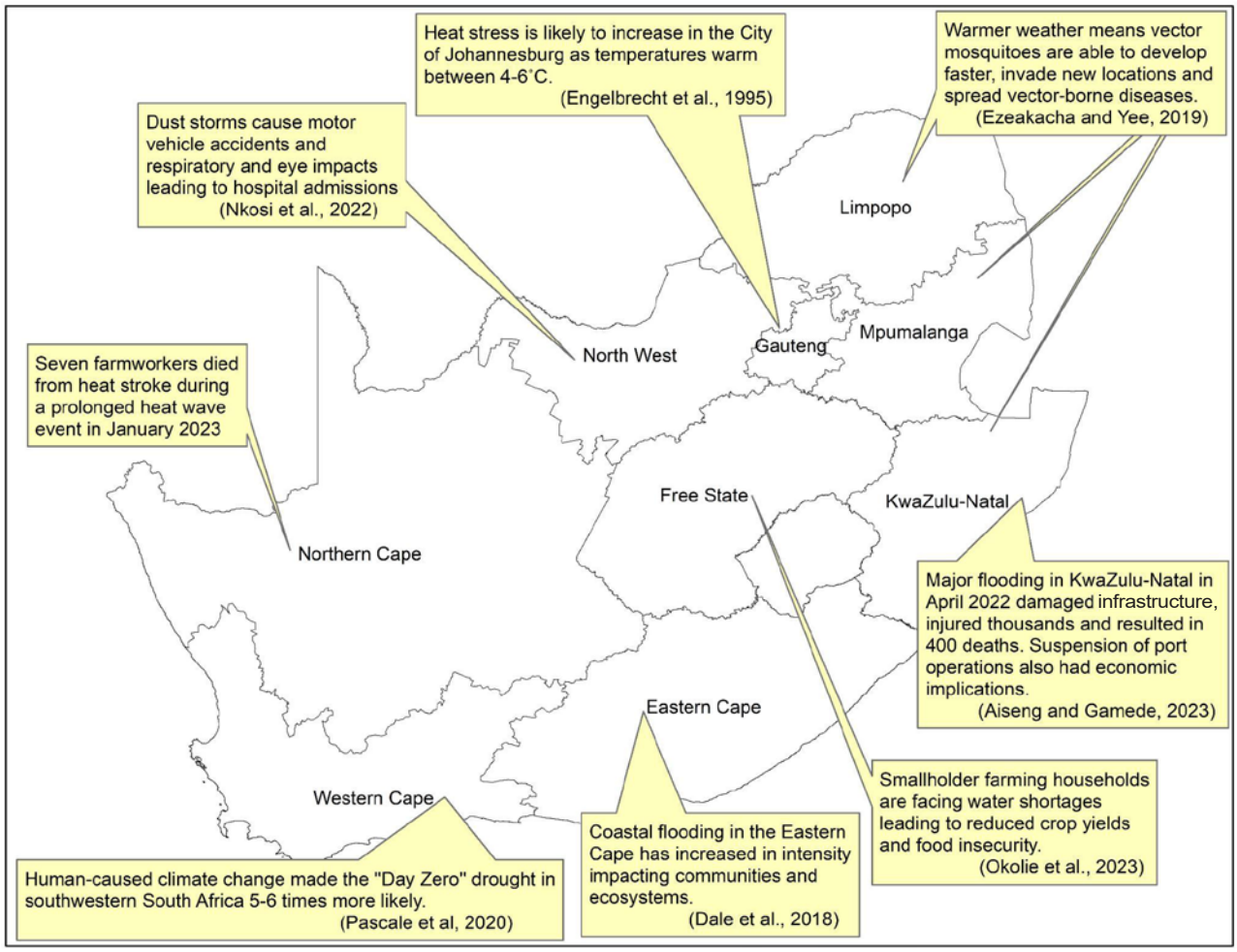

Figure 2 Illustrative examples of climate change and extreme weather events and their health impacts around South Africa

A study in South African district municipalities showed that high temperatures (>32ºC) are statistically significant predictors of all-cause mortality.[16] In addition, there is a strong association between heat-related deaths and regional climate patterns, with threshold variations across the country's climate zones. The hot, arid provinces of the Northern Cape and North West have some of the highest heat thresholds, compared to districts in the temperate interior (mountains) or coastal regions. As population exposure to heat rises, evidence-based heat-health warning systems (HHWS) are essential to reduce heat-related mortality and morbidity. The implementation of heat alerts as part of comprehensive heat-health action plans is critical for public safety. Even with the characterisation of thermal comfort thresholds, working with stakeholders proved to be crucial to developing a HHWS in Rustenburg.[17] In that study, thermal comfort indicators were categorised into colour codes with three being characterised as critical risk (red), twenty-eight as medium-high risk (yellow), and six as low risk (green) in the Rustenburg municipality. Using that categorisation, researchers were able to advise communities on short-term actions, and partnerships between local government and communities were forged to build heat-health resilience. The heatwave incident in late January 2023 left five farm workers dead from heatstroke in the Northern Cape Province.[18] This incident indicates the importance of research and surveillance of heatwaves in all provinces of South Africa.

16 Kapwata T, Abdelatif N, Scovronick N, Gebreslasie MT, Acquaotta F, Wright CY. Identifying heat thresholds for South Africa towards the development of a heat-health warning system. Int J Biometeorol. 2024;68(2):381–392. URL: https://doi.org/10.1007/s00484-023-02596-z

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Despite the rising heat due to climate change, floods are more common than drought in the Southern African Development Community region.[12] In April 2022, flooding caused significant loss of life and extensive damage to roads and infrastructure. The frequency of flooding events in eThekwini district rose from an average of ~1.1 occurrences per year between 1850 and 1899 to ~1.7 occurrences per year between 1900 and 2022.[19] The severe storms and floods in eThekwini have left many residents homeless, placing immense pressure on disaster management efforts.[25] The response and recovery efforts face significant challenges, including a shortage of personnel, insufficient funding, and a lack of capacity to implement critical initiatives. While non-profit organisations have become increasingly involved in relief efforts, the private sector's participation remains limited. Additionally, poor collaboration among internal departments within the interdepartmental committee has further hampered the effectiveness of disaster response and recovery strategies.[22] Strengthening interdepartmental coordination and fostering greater public-private partnerships are essential for improving disaster management in the region. Floods are also reported to affect tourism sites, such as national parks in South Africa, with >15 flooding hotspots in Kruger National Park and >9 hotspots in Mapungubwe National Park.[20] Although South Africa has a legal framework for disaster management, it is uncertain to what extent the government and municipalities are required by law to prevent damage caused by ever-increasing natural disasters, particularly when flooding occurs.[21]

Dust storms have been linked to poor health outcomes, including skin and eye irritation, reduced lung function, cardiovascular issues, increased hospital visits, and greater use of emergency services.[22] South Africa occasionally experiences major dust storms, particularly in the Free State and North West provinces, where their frequency increased between 2006 and 2016. Notable storms occurred in October 2014 and January 2016, with one in October 2014 originating in the Northern Cape and moving across Gauteng and North West province. In September 2019, satellite images showed that dust storms turned the skies red in Alexander Bay. While the South African Medical Research Council (SAMRC) conducted a pilot study on the health effects of these events, more research is needed to understand the full health impacts of dust storms in South Africa.

Climate change has a significant impact on maternal, foetal, and child health in South Africa.[23] Evidence of climate change-related impacts on pregnant women and children in South Africa comes from studies on hypertension during pregnancy resulting from extreme heat, malnutrition due to food insecurity, waterborne diseases, vector-borne diseases, and mental health effects.[26] The maternal medical services profiles in the Northern Cape and KwaZulu-Natal reveal a fragile health system with little resilience to climate shocks.[24] A South African follow-up case study on a representative sample of expectant mothers showed 17.9 infants per 1 000 births died within the first week of life, with the highest rates seen in North West province.[29] In North West and Northern Cape provinces, infant deaths were predicted to be more likely to occur during El Niño conditions, whereas in provinces like KwaZulu-Natal, this connection was weaker.[29] In rural Kwazulu-Natal, a significant association between miscarriages and excessive heat was seen in 3% (105/3477) of expectant mothers, with a 26% increase in the risk of miscarriage with each additional hot day.[25] As climate change progresses, the challenges associated with the reproductive health of women in hotter parts of South Africa are set to increase. However, presently there remains a paucity of studies analysing the climate change-related risks to pregnant women and children.

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24 Benschop ND, Chironda-Chikanya G, Naidoo S, Jafta N, Ramsay LF, Naidoo RN. El Niño, rainfall and temperature patterns influence perinatal mortality in South Africa: Health services preparedness and resilience in a changing climate. In: Akhtar R. (ed). Climate change and human health scenarios. Global perspectives on health geography. Cham: Springer; 2023. URL: https://doi.org/10.1007/978-3-031-38878-1_21

25 Moodley Y, Asare K, Tanser F, Tomita A. Maternal exposure to heat and its association with miscarriage in rural KwaZulu-Natal, South Africa: A population-based cohort study. Womens Health. 2024;20. URL: https://doi.org/10.1177/17455057241259171

Currently, there is little evidence regarding the associations between high temperatures and the risk of preterm birth, low birth weight, and stillbirths. In addition, there is insufficient epidemiological evidence of climate change-related factors that are linked to a significant rise in morbidity and mortality in pregnant women in the South African population that could be useful for informing policy – this research gap needs to be addressed. Practical adaptation plans and policies need to be revisited to meet the needs of maternal and child health in response to the impacts of climate change.[29] With the growing concerns of rising temperatures and poor air quality exacerbating challenges to foetal development, foetal and infant weight gain, maternal discomfort, and other detrimental maternal and child health outcomes, increased surveillance studies are required to characterise causative putative environmental factors.

Climate change directly affects the locations and spread of infectious diseases. South Africa is one of the leading global nations in the field of infectious disease research.[26] With one of the highest incidences of tuberculosis and HIV in the world,[27] South Africa has a large population that is vulnerable to the effects of climate change.[28] People living with HIV and AIDS are particularly vulnerable, as rising temperatures, water scarcity, air pollution, and potential water- and vector-borne disease outbreaks all have a negative impact on their already diminished immune systems.[28] Rainfall, temperature, and air quality have been linked to increased caseloads of pneumonia, asthma, malaria, and diarrhoea.[29] Similarly, a correlation between climatic variables and disease cases has been observed in hospitals in Limpopo, where the incidence of pneumonia increased after a period of lower average daily temperature and lower relative humidity.[30] These associations pose situations of concern that require careful monitoring.

The regional incidence of malaria in different parts of the world has changed over time, with climate change rendering some areas unsuitable for the life cycle of the mosquito vectors and other areas becoming more suitable for vector life cycles.[31] The incidence rate of malaria in South Africa increased to 3.95 per 1 000 population in 2017 and was linked to a lagged effect of a rise in temperatures between 2011 and 2016.[32] Historically, South Africa has experienced malaria cases in the low-lying areas of KwaZulu-Natal, Mpumalanga, and Limpopo.[33] However, with changes in meteorological conditions and the suitability of different areas for vector life cycles, monitoring and reporting of vector-borne disease cases is advised to inform changes in vector-control interventions.

Non-communicable diseases (NCDs) have not been researched as extensively as infectious diseases. Recent epidemiological evidence shows a significantly higher mortality rate due to NCDs in South Africa than previous years.[34] Several prevalent NCDs are sensitive to changes in climate. These include respiratory conditions, allergies, bronchitis, chronic obstructive pulmonary disease (COPD), type 2 diabetes, obesity, cancer of the skin and lungs, cerebrovascular disease, and cardiovascular disease.[35–36] The significant association between temperature and hospital admissions of cardiovascular disease cases in Limpopo gives some evidence that NCDs are related to climate variables.[37] Skin cancer is likely to increase with a warming climate, as incidence may be dependent on airborne pollutants, solar UVR, ambient temperature, and rainfall, among other factors related to behaviour.[38] More attention needs to be placed on epidemiological research, linking NCDs to climatic variables in South Africa.

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South Africa's response to climate change

Legislative and policy mandates

South Africa has several legislative and policy mandates and guidelines that support its response to climate change. These include the following:

1. The Constitution of the Republic of South Africa

Section 24 stipulates that:

Everyone has the right:

a. to an environment that is not harmful to their health or well-being; and

b. to have the environment protected, for the benefit of present and future generations, through reasonable legislative and other measures that:

i. prevent pollution and ecological degradation

ii. promote conservation; and

iii. secure ecologically sustainable development and use of natural resources while promoting justifiable economic and social development.

2. National Building Regulations and Building Standards Act 103 of 1977
3. National Health Act 61 of 2003
4. National Environment: Air Quality Act 39 of 2004
5. National Climate Change and Health Adaptation plan 2014/2019
6. National Climate Change Response Policy (NCCRP) 2011
7. National Environmental Health Policy 2013
8. National Environmental Health Norms and Standards for Premises and Acceptable Monitoring Standards for Environmental Health 2015
9. National Heat Health Action Guidelines: Guide to extreme heat planning in South Africa for the human health sector, October 2022
10. National Climate Change Act 22 of July 2024

South Africa's climate priorities span climate adaptation and mitigation. The South African Cabinet has approved key climate actions, including creating a Presidential Climate Commission, South Africa's Low Emissions Development Strategy, a National Climate Change Adaptation Strategy, a carbon tax, and a Just Transition Framework. Presently, South Africa is focusing efforts to fund climate change-related resilience strategies and disaster management programmes.[39] Thus, the government has worked with the private sector to establish a Climate Change Response Fund. The fund aims to build resilience by focusing on climate-proofing existing infrastructure across all types of facilities, including food systems and healthcare.

Governance and steering committees within the policy framework

The Department of Health established the National Climate Change and Health Steering Committee (NCCHSC) in 2022, which is a technical body responsible for oversight of the implementation of the National Climate Change and Health Adaptation Plan, National Heat Health Action Guidelines and other climate change activities within the Department of Health. The steering committee is comprised of stakeholders from research, academic institutions, civil society groups, national and provincial departments, municipalities, United Nations organisations, and organs of state etc. The NCCHSC recognises the need for evidence-based adaptation strategies that are cost-effective and efficient. In addition, the committee will develop nodes of expertise in health impact assessments and epidemiological studies that are urgently needed to provide much needed data that will assist in the development of adaptation strategies. In this regard, the need for more research-based evidence is highly apparent.

39 Government of the Republic of South Africa. South Africa strengthens its response to climate change. Government Communications. 2024. URL: https://www.gov.za/blog/south-africa-strengthens-its-response-climate-change

Role of the health sector

Health systems preparedness for climate resilience

Climate change-related health risks are expected to increase the burden on South Africa's already fragile health system. The most significant increases will be caused by health emergencies, increased occurrence of food and water scarcity, and vector-borne diseases, as well as the health repercussions of air pollution and poor nutrition. Moreover, health infrastructure has not been built to withstand extreme weather. Between 2001 and 2021, 56% of public health events in Africa were linked to climate change with access to service delivery and care being severely affected.[40] Among the important considerations is the selection of the location of new clinics and district hospitals by policymakers and health leaders.

Health system preparedness aims to build resilience to the impact of climate change on health and enhance the health system's ability to cope, respond, reorganise, and maintain essential functions.[41] To be resilient, health systems need to reduce their vulnerability to the impact of climate change by limiting exposure, reducing sensitivity and enhancing systems' adaptive capacity.[19] Health systems also need to increase capacity to respond to new climate change-related threats.[42] This will determine whether or not health systems recover from climate change-related impacts. The UK's Department for International Development conceptual framework for resilience adapted by the World Health Organization for health systems (Figure 3A)[43] highlights how vulnerability influences the ability of health systems to deal with disturbances like shocks and stresses from climate change. The outcomes of this resilience building range from recovery to collapse depending on health systems' ability to reduce vulnerability and improve choices and opportunities to deal with climate change-related stressors. There are many sectors involved in the operational framework (Figure 3B).

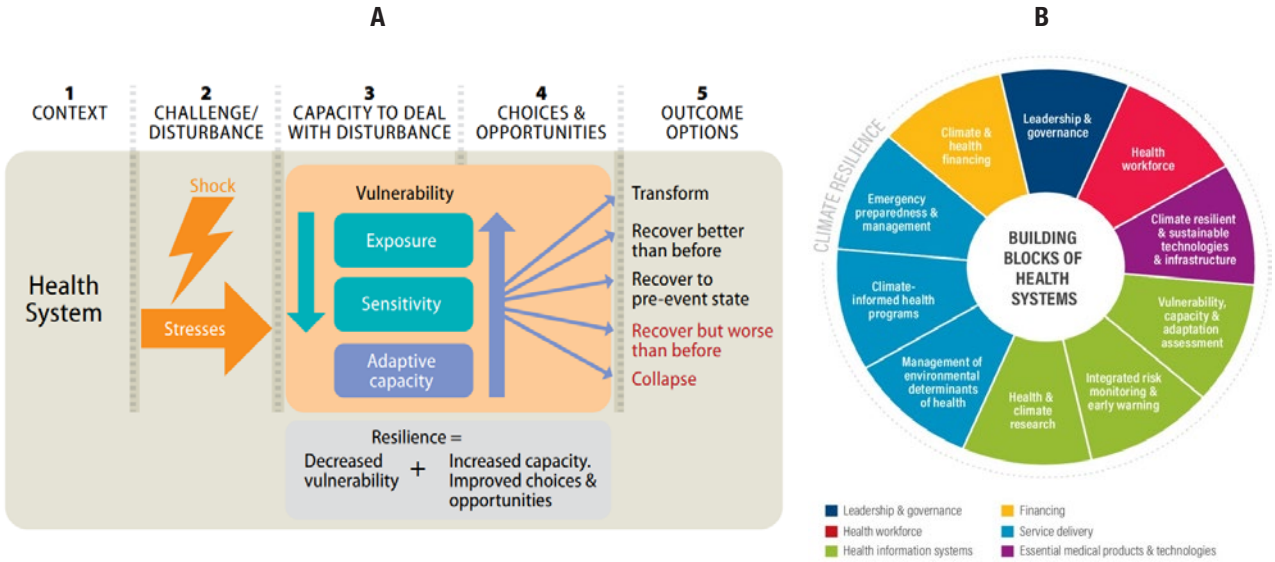


Figure 3 Operational framework for health system resilience

Source: World Health Organization, 2015.[44]

40 World Health Organization Regional Office for Africa. Africa faces rising climate-linked health emergencies. WHO. 2024. URL: https://www.afro.who.int/news/africa-faces-rising-climate-linked-health-emergencies

42 World Health Organization . Health systems resilience toolkit: A WHO global public health good to support building and strengthening of sustainable health systems resilience in countries with various contexts. Geneva: World Health Organization; 2022. Licence: CC BY-NC-SA 3.0 IGO

43 Ansah EW, Amoadu M, Obeng P, et al. Health systems response to climate change adaptation: A scoping review of global evidence. BMC Public Health. 2024;24:2015. URL: https://doi.org/10.1186/s12889-024-19459-w

44 World Health Organization. Operational framework for building climate resilient health systems. WHO. 2015. URL: https://staging.afro.who.int/sites/default/files/2017-06/9789241565073_eng.pdf

45 World Health Organization. Operational framework for building climate resilient health systems. WHO; 2015.URL: https://staging.afro.who.int/sites/default/files/2017-06/9789241565073_eng.pdf

Specifically, there are 10 components that holistically provide an integrative approach to climate resilience and allow for vertical programmes that can strengthen health systems, no matter where in the world they are based.

In summary, health systems must anticipate, respond to, cope with, and recover from climatic shocks while continuing to provide necessary services.[51] This strategy of preparedness must be integrated into all health systems and extended to non-health systems that can be determinants of illness. For a complete approach to health system readiness, the following must be examined and addressed: vulnerability and adaptation (V&A) assessments, surveillance and early warning systems, emergency preparedness and response, workforce training, public health education, policy integration and governance, climate resilient supply chains, and research and innovation.

Components of health system resilience

Vulnerability and adaptation assessments

V&A assessments aim to:

- Identify people who are most at risk to climate-related impacts, e.g., children, the elderly, pregnant women, people with pre-existing conditions, and outdoor workers.
- Evaluate health infrastructure vulnerability to identify weaknesses in the systems and analyse the ability of infrastructure to withstand extreme weather events.
- Conduct geospatial analysis to map climate risks and anticipate future health threats.
- The Department of Health, with support from the Department of Forestry, Fisheries and the Environment (DFFE) together with the German Agency for International Cooperation (GIZ), has conducted a Risk and Vulnerability Assessment in all 52 health districts.
- V&A assessments need to be conducted across all health systems, with the scope extending to sectors and communities outside of health that shape determinants of ill health. V&As should be iterative in nature and specify interventions that need to be taken in a changing climate/environment.

Health surveillance and early warning systems

There is a need for integrated risk monitoring through health surveillance and the development of early warning systems. Climate health surveillance includes monitoring for climate-sensitive infectious diseases (dengue fever, malaria, etc.) and other climate induced health risks (heat stress, respiratory and mental health disorders).

Machine learning can be used to merge health and environmental data to generate early warning systems for heat, floods, and other extreme events to support decision making and inform targeted interventions. Early warning systems should incorporate messages aimed at vulnerable populations, advising them of the necessary steps to take to protect themselves.

Emergency preparedness and response

This should entail the following:

- Disaster response planning with facilities developing plans to respond to health emergencies as a result of extreme weather events.
- Emergency stockpiling of medicines, vaccines, medical equipment, etc.
- Deployment of mobile and telehealth services to maintain essential services.

Workforce training

Some obstacles to a successful adaptation response include uncertain climate and health policy directives; a lack of understanding at the patient and community level; a lack of transdisciplinary, multi-stakeholder healthcare professional training, and an underutilised network of climate activism and justice.[45] There is a need to develop a climate and health competent workforce that has the technical and professional expertise to respond to climate impacts on health. This can be achieved through the following:

- Capacity building on the impacts of climate on health through formal and informal training.
- Preparedness and response training so that the workforce is equipped to manage climate-related health disasters.
- Identification and training of new cadres, for example, climate champions and climate health clinical specialists, to increase the health system's workforce capacity to respond.

The Department of Health has conducted training of healthcare workers in all nine provinces on the Heat Health Action Guidelines and Risk and Vulnerability Assessments. The trainings were conducted from 2022 to 2024 and over 1 000 health care workers participated.

Public health education

There is an ever-increasing need to engage communities on climate-related health risks to enable prevention and preparedness. These include:

- Education and awareness for behavioural change, for example, being well hydrated during heatwaves, minimising exposure to extreme weather elements, etc.
- Identification of adaptation and mitigation interventions at local level, for example, community shading spots, tree planting, etc.

Policy integration and governance

This can be achieved through the following:

- The development of Health National Adaptation Plans that are cascaded down to provincial and district levels.
- Multisectoral collaborations with partnerships between health, environmental, agricultural, and infrastructural sectors including Department of Social Development, etc. to adequately respond to the complexities of climate change.
- Climate health financing to fund health adaptation and mitigation interventions at scale.

Climate resilient supply chains

Supply chains need to be strengthened to ensure that:

- Essential medicines and medical equipment are available during times of climate-related disasters.
- Climate sensitive medical products, such as temperature sensitive medicines and vaccines are transported and stored in a manner that they remain efficacious.

Research and innovation

There needs to be investment in the following:

- Climate and health research funding to generate local knowledge on the effect of climate change on communicable and non-communicable diseases, maternal and child health, nutrition, mental health, etc.
- Technologies, for example, digital health technologies that can be deployed during climate disasters.
- Innovations to develop climate-sensitive medical products.

45 Maimela, G. Strengthening health systems for mitigating climate change: responding to climate change as public health professionals. Wits J Clin Med. 2022;4(3):181. URL: https://doi.org/10.18772/26180197.2022.v4n3a9

Health surveillance

Health surveillance for well-established (or reasonably well-established) health outcomes associated with heat exposure needs to be developed. The effects of extreme weather are easily recognised, but the gradual increase in temperature across the country contributes to hidden epidemics that need attribution and detection studies.[46] Data need to be available to monitor various health outcomes in the context of climate change. For instance, among the numerous conditions that are directly associated with heat, it may not be immediately apparent that chronic kidney disease is attributed to chronic heat exposure. More complex conditions (for example, reproductive outcomes) may not be easily associated with heat exposure. However, these outcomes need to be continuously monitored to consider future impacts from a changing climate to ensure prevention of adverse health effects.

Environmental surveillance

The IPCC Sixth Assessment Report indicates evidence of rising heat extremes and an increase in the frequency and intensity of heavy precipitation events, that are currently significant climate change-related risks across Africa and are set to persist during the 21st century.[47] Therefore, monitoring environmental variables associated with these climate change drivers is critical to inform intervention and mitigation policies aimed at reducing the impacts of climate change on health. Previous studies have summarised key environmental indicators proposed by several stakeholders for surveillance of climate change-related public health outcomes.[48] Table 1 presents the variables that are useful to monitor temperature and precipitation in South Africa. It is important to note that there is a lack of research on cold extremes, not only in South Africa but also in Africa. However, research has shown that low temperatures have more significant adverse impacts on health outcomes compared to high temperatures.[49] This indicates the importance of metrics to monitor cold extremes that should be included as environmental indicators in the Global South.

Table 1 Environmental indicators of climate change with South African studies that have used these indicators

Variable	Metric	Studies from South Africa
Temperature	Maximum, minimum, mean and diurnal temperature	Scovronick N, Sera F, Acquaotta F, et al. **The association between ambient temperature and mortality in South Africa: A time-series analysis.** Environ Res. 2018;161:229-235. URL: https://doi.org/https://doi.org/10.1016/j.envres.2017.11.001 Kapwata T, Abdelatif N, Scovronick N, Gebreslasie MT, Acquaotta F, Wright, CY. **Identifying heat thresholds for South Africa towards the development of a heat-health warning system.** Int J Biometeorol. 2024;68(2):381-392.
	Future projections of extreme heat	Mbokodo I, Bopape M-J, Chikoore H, Engelbrecht F, Nethengwe N. **Heatwaves in the future warmer climate of South Africa.** Atmosphere. 2020;11(7):712. Engelbrecht F, Adegoke J, Bopape M-J, et al. **Projections of rapidly rising surface temperatures over Africa under low mitigation.** Environ Res Lett. 2015;10(8):085004.
	Extreme heat days and heat events	Meque A, Pinto I, Maúre G, Beleza A. **Understanding the variability of heatwave characteristics in southern Africa.** Weather Clim Extrem. 2022;38:100498. URL: https://doi.org/https://doi.org/10.1016/j.wace.2022.100498 Kapwata T, Gebreslasie MT, Wright CY. **An analysis of past and future heatwaves based on a heat-associated mortality threshold: Towards a heat health warning system.** Environ Health. 2022;21(1):112. URL: https://doi.org/10.1186/s12940-022-00921-4
	Aridity (drought/dryness)	Benschop ND, Chironda-Chikanya G, Naidoo S, Jafta N, Ramsay LF, Naidoo RN. **El Niño, rainfall and temperature patterns influence perinatal mortality in South Africa: Health services preparedness and resilience in a changing climate.** In: Akhtar R. (ed) Climate change and human health scenarios. Global perspectives on health geography. Cham: Springer; 2023. URL: https://doi.org/10.1007/978-3-031-38878-1_21

46 Ebi KL, Åström C, Boyer CJ, et al. Using detection and attribution to quantify how climate change is affecting health. Health Aff. 2020;39(12):2168-2174. URL: https://doi.org/10.1377/hlthaff.2020.01004

48 Intergovernmental Panel on Climate Change. Africa. In: Pörtner DC, Roberts M, Tignor ES, et al. (eds). Climate change 2022: Impacts, adaptation and vulnerability. Cambridge: Cambridge University Press, 2023; p.1285-45. URL: https://doi.org/10.1017/9781009325844.011

49 Moulton AD, Schramm PJ. Climate change and public health surveillance: Toward a comprehensive strategy. J Public Health Manag Pract. 2017;23(6):618-26. URL: https://doi.org/10.1097/PHH.0000000000000550

50 Seltenrich N. Between extremes: Health effects of heat and cold. Environ Health Perspect. 2015;123(11). URL: https://doi.org/10.1289/ehp.123-A275

Rainfall	Heavy precipitation days, heavy precipitation events, total rainfall from heavy precipitation events	Manhique A, Reason C, Silinto B, et al. **Extreme rainfall and floods in southern Africa in January 2013 and associated circulation patterns.** Nat Hazards. 2015;77:679-691. Sen Roy S, Rouault M. **Spatial patterns of seasonal scale trends in extreme hourly precipitation in South Africa.** Appl Geog. 2013;39:151-157. URL: https://doi.org/https://doi.org/10.1016/j.apgeog.2012.11.022

The need for climate change and health indicators

Climate change-related health indicators are crucial for a country as they enable policymakers to monitor the direct and indirect health impacts of climate change on its population. As global temperatures rise, countries face increased risks of heatwaves, natural disasters, and the spread of vector-borne diseases like malaria and dengue. Health indicators allow governments to track how these factors are affecting public health, providing the data needed to allocate resources, design public health interventions, and create policies that protect vulnerable populations. Without such indicators, it becomes difficult to measure the effectiveness of mitigation and adaptation strategies, leaving the population more vulnerable to climate-related health crises.

Additionally, climate change-related health indicators help raise public awareness and foster international cooperation on climate issues. By gathering comprehensive data on health impacts, countries can contribute to global efforts to combat climate change, share best practices, and learn from the experiences of others. These indicators also provide a framework for holding governments accountable, ensuring they prioritise public health in their climate policies. In doing so, countries can better protect their citizens' health while contributing to the global fight against climate change.

South Africa is in the process of developing climate change-related health indicators, building on existing datasets but also calling for new surveillance systems to ensure that all climate change-related health outcomes are carefully monitored.

Drawing on the international literature, below is a comprehensive list of potential climate change and health indicators, which could be considered for implementation in South Africa.

Table 2 Climate change related indicators and associated impacts on health

Indicator	Health impact/s	Health outcomes
Extreme heat events	Heat related illness/ mortality	Incidence of heat stroke, heat exhaustion and other heat-related health conditions Increased rates of hypertension, heart attack episodes and strokes (myocardial infarction) Hydration-related disorders Occupational heat stress: incidence of heat-related illnesses and injuries among outdoor and manual labour workers due to rising temperatures (e.g., chronic kidney disease)
	Food-borne illnesses	Increased rates of illnesses from bacteria like Salmonella or *E. coli* that thrive in warmer temperatures
Air pollution (includes emissions and wildfires)	Respiratory diseases	Increased rates of asthma, acute presentation of wheeze episodes particularly among children, chronic obstructive pulmonary disease, and other respiratory conditions linked to poor air quality More emergency room visits for asthma–correlation with higher levels of air pollutants and allergens during climate events
	Cardiovascular diseases	Increased rates of heart attacks and strokes
	Skin cancers	Linked to increased exposure to UV radiation due to ozone layer depletion–influence of emissions
Extreme weather events	Mental health impacts	Increased incidence of stress, anxiety, and depression related to climate disasters, displacement, or environmental changes
	Displacement-related health impacts	Health conditions linked to migration and displacement caused by climate-related disasters
	Mortality	Deaths and injuries from floods, hurricanes, droughts, wildfires, and other natural disasters
	Health system	Disruptions in medical services and destruction of key infrastructure - such as electricity and water provision Increased hospital admissions Detrimental impact on the capacity and resilience of healthcare infrastructure
	Food security	Increased rates of malnutrition or undernutrition linked to disruptions in food supply
Floods and droughts	Waterborne diseases	Incidence of cholera, diarrhoea, and other illnesses from contaminated water, often worsened by floods or drought
	Water access and/or quality	Reduction in availability of safe drinking water in areas affected by drought or contamination from climate events

Climate change (combination of change in temperature, rainfall)	Disease patterns, prevalence, and transmission rates	Prevalence of diseases like malaria, dengue, Zika virus, and Lyme disease are influenced by changing temperature and precipitation patterns Changes in incidence of infectious diseases due to shifting ecosystems and increased human-wildlife interaction Changes in the geographical range of disease vectors, such as mosquitoes and ticks
	Infant and child health outcomes	Increased incidence of vitamin and mineral deficiencies resulting from decreased food diversity and quality Impact on children's health, such as birth weight or developmental delays linked to maternal nutrition during extreme weather events
	Nutrition	
	Allergies	Rates of pollen-related allergic reactions increase with longer pollen seasons due to warming temperatures

Conclusion

Preparedness in the health sector is essential to mitigate the growing threats posed by climate change. Rising temperatures, extreme weather events, and shifts in disease patterns are already straining healthcare systems worldwide, making it critical for nations, including South Africa, to strengthen their public health infrastructure. By integrating climate change into health preparedness plans, countries can better anticipate and respond to the wide range of health challenges exacerbated by a changing climate, such as heat-related illnesses, food and water security issues, and emerging infectious diseases. A proactive approach, with an emphasis on prevention and resilience, is key to protecting the well-being of communities in the face of an increasingly unstable environment.

A crucial part of this preparedness involves embedding climate change-related health indicators into routine health surveillance. These indicators will provide the necessary data to track health trends associated with climate change, enabling timely interventions and informed policymaking. Without this integration, South Africa risks being unprepared for future health crises linked to climate change. Now is the time for decisive action, government, health organisations, and communities must collaborate to incorporate these indicators into the national health system, to ensure that the country's health sector is equipped to face the challenges of a warming planet.

SECTION B
District Health Profiles

06 South Africa

In 2023, South Africa had an estimated population of just over 62.1 million. The provincial population estimates are listed in Table 1.

Table 1 Provincial population estimates, 2023

Eastern Cape	6 709 060
Free State	2 930 982
Gauteng	16 723 636
KwaZulu-Natal	11 801 471
Limpopo	6 165 877
Mpumalanga	4 880 047
Northern Cape	1 324 275
North West	4 293 016
Western Cape	7 369 569
South Africa	62 197 933

Source: DHIS

The national and provincial indicator averages included in the *District Health Barometer* for the period 2019 – 2023[1] are listed in Tables 2 and 3.

Table 2 SA averages, 2019 – 2023 (abbreviations given in footnote)[2]

	INDICATOR	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Maternal and Neonatal	Antenatal 1st visit before 20 weeks rate	69.7	67.9	68.9	70.1	69.9
	Antenatal 1st visit coverage	83.1	83.9	81.5	76.4	69.4
	Delivery by Caesarean section rate (District Hospital)	24.7	25.5	25.9	27.0	28.1
	Delivery by Caesarean section rate	29.0	29.1	29.6	31.3	32.4
	Delivery in 10 to 19 years in facility rate	13.2	14.3	13.7	13.9	14.1
	Maternal mortality in facility ratio	88.0	120.9	119.1	101.0	100.6
	Neonatal death in facility rate	11.9	12.6	13.1	12.7	13.4
Immunisation	Immunisation under 1 year coverage	83.5	79.5	85.5	82.2	83.3
	Measles 2nd dose coverage	79.6	76.4	84.0	84.8	84.9
Child health and nutrition	Diarrhoea case fatality under 5 years rate	1.8	2.6	1.8	1.7	1.3
	Death under 5 years against live birth rate	1.7	1.6	1.8	1.8	1.9
	Early neonatal death in facility rate	9.6	9.7	10.0	9.6	10.1
	Pneumonia case fatality under 5 years rate	1.6	2.1	1.7	1.5	1.8
	Severe acute malnutrition case fatality under 5 years rate	7.8	7.3	7.9	7.2	7.0
Women's health	Couple year protection rate	54.5	49.8	50.3	45.0	55.4
Tuberculosis	TB child under 5 years start on treatment rate	11.3	93.2	94.8	97.8	73.8
	TB client 5 years and older start on treatment rate	97.0	94.8	93.4	94.6	90.3
	TB DS death rate	8.3	7.7	7.3	–	–
	TB DS treatment success rate	78.9	77.9	80.2	–	–
	TB MDR client death rate	17.6	16.7	15.6	–	–
	TB MDR treatment success rate	62.0	62.2	62.4	–	–
	TB symptom child under 5 years screened in facility rate	87.6	88.9	92.6	94.5	97.7

Tuberculosis	TB symptom 5 years and older screened in facility rate	88.6	87.6	95.8	97.6	98.6
	TB XDR client death rate	18.5	17.5	20.1	–	–
	TB XDR treatment success rate	54.4	53.9	51.0	–	–
HIV/AIDS	Adult with viral load suppressed rate 12 months	88.1	88.6	88.9	90.6	92.4
	ART client viral load suppressed rate (VLS)	87.5	88.0	88.0	90.0	92.0
	Child with viral load suppressed rate 12 months	63.9	65.3	60.7	60.1	66.7
	Clients remaining on ART rate	66.9	68.9	67.7	68.2	70.7
	Antiretroviral effective coverage (0-14 years)	18.7	22.7	19.0	21.2	24.8
	Antiretroviral effective coverage (15+ years)	41.8	46.4	46.1	47.2	50.9
	Antiretroviral effective coverage	40.8	45.5	45.1	46.4	50.2
Non-communicable diseases	Cervical cancer screening coverage	46.8	14.2	36.9	21.4	40.5
Inpatient Management	Hospital beds per 10 000 target population (District Hospitals)	6.1	6.1	6.1	5.9	5.9
	Hospital beds per 10 000 target population (All hospitals)	17.1	16.7	16.5	16.3	16.0
Human Resources	Medical practitioners per 100 000 population	33.6	36.5	36.7	37.5	35.6
	Pharmacists per 100 000 population	11.8	12.1	12.3	12.5	12.1
	Professional nurses per 100 000 population	145.4	153.6	153.1	148.9	141.3
Finance	Provincial & LG District Health Services expenditure per capita (uninsured) (Rand)	2563	2650	2626	2454	2355
	Expenditure per patient day equivalent (district hospitals) (Rand)	3949	4793	4139	3994	3754
	Provincial & LG PHC expenditure per capita (uninsured) (Rand)	1581	1674	1650	1556	1448
	Provincial & LG PHC expenditure per PHC headcount (Rand)	657	886	832	757	724
Extra	Antenatal client initiated on ART rate	96.2	94.9	95.0	94.1	95.4
	Infant exclusively breastfed at DTaP-IPV-Hib-HBV 3rd dose rate	48.8	45.9	44.4	44.7	43.3
	Live birth under 2500g in facility rate	12.9	13.2	13.2	13.6	14.1
	Male condom distribution coverage	32.1	26.5	26.1	18.9	27.6
	Medical male circumcision 15 years and older rate	46.4	59.1	55.8	50.6	54.1
	Mental disorder treatment rate	0.4	0.1	0.1	0.1	0.0
	Infant PCR test positive around 10 weeks rate	0.7	0.6	0.6	0.4	0.4
	Mother postnatal visit within 6 days rate	80.1	76.6	78.6	80.0	80.0
	School Grade 1 screening coverage	34.2	4.0	14.3	21.2	23.2
	School Grade 8 screening coverage	26.4	1.7	7.9	14.5	16.6
	Stillbirth rate	19.7	19.9	21.0	20.9	20.7
	Vitamin A dose 12-59 months coverage	56.6	49.5	60.3	70.8	69.5
	Average length of stay - total (District Hospitals)	4.2	4.1	4.2	4.3	4.5
	Average length of stay - total	6.1	5.9	6.1	6.2	6.4
	Inpatient crude death rate	4.6	5.7	5.3	4.6	4.7
	Inpatient bed utilisation rate - total (District Hospitals)	64.8	53.6	57.3	60.0	61.4
	Inpatient bed utilisation rate - total	72.4	60.7	65.9	66.9	69.4
	OPD new client not referred rate (District Hospitals)	60.0	57.5	47.0	58.3	57.4
	OPD new client not referred rate	46.5	47.0	39.5	42.6	41.8
	PHC utilisation rate	2.0	1.6	1.7	1.7	1.7

1 Indicators from webDHIS and the BAS financial system cover the 12 months from April to March, which is the financial year of the NDoH. Indicators for financial years are annotated as 2023/24 or FY 2024. Other sources, such as the TB data from EDRWeb cover a calendar year.

2 Ave = Average; ART = Antiretroviral treatment; CDC = Community Day Center; CHC = Community Health Center; DS = Drug-susceptible; HIV = Human immunodeficiency virus; LG = Local Government; MDR = Multi-drug-resistant; OPD=Outpatient department; PHC = Primary Health Care; TB = Tuberculosis; XDR = Extremely drug resistant.

Table 3 Provincial averages, 2019 – 2023 (abbreviations given in footnote)[3]

Eastern Cape

	INDICATOR	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Maternal and Neonatal	Antenatal 1st visit before 20 weeks rate	62.5	62.5	63.0	63.5	62.8
	Antenatal 1st visit coverage	68.7	68.2	81.2	74.8	66.8
	Delivery by Caesarean section rate (District Hospital)	25.4	25.5	25.9	26.8	27.2
	Delivery by Caesarean section rate	30.9	31.7	32.3	33.2	33.9
	Delivery in 10 to 19 years in facility rate	16.7	17.1	17.4	17.6	18.0
	Maternal mortality in facility ratio	108.2	146.2	114.6	124.3	136.2
	Neonatal death in facility rate	12.3	13.1	13.2	13.8	15.1
Immunisation	Immunisation under 1 year coverage	76.0	69.5	88.7	82.3	78.6
	Measles 2nd dose coverage	73.7	66.7	83.3	81.7	79.2
Child health and nutrition	Diarrhoea case fatality under 5 years rate	2.8	4.0	3.4	2.6	2.2
	Death under 5 years against live birth rate	2.0	1.8	2.0	2.1	2.3
	Early neonatal death in facility rate	10.0	10.4	10.3	10.3	11.8
	Pneumonia case fatality under 5 years rate	3.4	3.3	3.3	2.8	3.4
	Severe acute malnutrition case fatality under 5 years rate	9.9	8.6	9.7	7.6	9.5
Women's health	Couple year protection rate	55.2	41.0	49.0	41.4	58.4
Tuberculosis	TB child under 5 years start on treatment rate	9.6	99.5	79.6	98.1	85.2
	TB client 5 years and older start on treatment rate	98.3	93.0	92.7	93.1	91.4
	TB DS death rate	7.7	7.8	6.7	–	–
	TB DS treatment success rate	78.2	76.6	72.7	–	–
	TB MDR client death rate	19.6	18.0	17.4	–	–
	TB MDR treatment success rate	60.8	60.4	61.2	–	–
	TB symptom child under 5 years screened in facility rate	85.4	91.8	95.5	95.4	103.6
	TB symptom 5 years and older screened in facility rate	85.7	85.7	90.6	93.5	93.4
	TB XDR client death rate	19.7	20.9	21.2	–	–
	TB XDR treatment success rate	51.7	55.2	55.4	–	–
HIV/AIDS	Adult with viral load suppressed rate 12 months	86.8	88.6	86.7	90.6	91.5
	ART client viral load suppressed rate (VLS)	85.9	87.8	86.0	90.0	91.0
	Child with viral load suppressed rate 12 months	62.9	62.3	63.2	64.9	62.4
	Clients remaining on ART rate	62.4	63.4	65.6	65.4	70.2
	Antiretroviral effective coverage (0-14 years)	19.1	20.0	21.2	20.2	23.6
	Antiretroviral effective coverage (15+ years)	37.8	40.7	40.7	40.8	43.8
	Antiretroviral effective coverage	36.8	39.9	40.0	40.2	43.3
Non-communicable diseases	Cervical cancer screening coverage	50.0	16.5	32.9	22.7	52.6
Inpatient Management	Hospital beds per 10 000 target population (District Hospitals)	10.0	10.0	10.0	10.1	10.1
	Hospital beds per 10 000 target population (All hospitals)	22.2	21.8	21.7	21.9	21.7
Human Resources	Medical practitioners per 100 000 population	34.1	35.7	36.1	39.9	36.6
	Pharmacists per 100 000 population	15.4	16.2	15.8	16.4	16.6
	Professional nurses per 100 000 population	193.8	194.0	190.6	197.1	187.5

Finance	Provincial & LG District Health Services expenditure per capita (uninsured) (Rand)	2774.0	3010.0	2819.0	2639.0	2608.0
	Expenditure per patient day equivalent (district hospitals) (Rand)	3955.0	5220.0	3263.0	4029.0	3913.0
	Provincial & LG PHC expenditure per capita (uninsured) (Rand)	1477.0	1619.0	1557.0	1470.0	1440.0
	Provincial & LG PHC expenditure per PHC headcount (Rand)	545.0	758.0	689.0	631.0	626.0
Extra	Antenatal client initiated on ART rate	95.3	91.8	90.4	89.8	99.4
	Infant exclusively breastfed at DTaP-IPV-Hib-HBV 3rd dose rate	48.2	45.2	43.2	42.1	39.6
	Live birth under 2500g in facility rate	14.1	13.6	14.3	14.9	16.5
	Male condom distribution coverage	34.7	22.3	22.4	12.4	26.2
	Medical male circumcision 15 years and older rate	59.5	88.6	79.3	76.4	93.2
	Mental disorder treatment rate	0.3	0.1	0.1	0.1	0.0
	Infant PCR test positive around 10 weeks rate	0.9	0.7	0.8	0.6	0.5
	Mother postnatal visit within 6 days rate	69.0	71.2	78.6	80.6	82.8
	School Grade 1 screening coverage	19.0	3.3	3.5	4.9	9.1
	School Grade 8 screening coverage	15.7	2.7	2.3	1.5	7.5
	Stillbirth rate	19.2	21.1	20.1	20.3	22.6
	Vitamin A dose 12-59 months coverage	58.1	49.1	63.7	74.8	76.1
	Average length of stay - total (District Hospitals)	4.6	4.4	4.5	4.7	4.9
	Average length of stay - total	6.8	6.3	6.4	6.9	7.0
	Inpatient crude death rate	5.8	7.7	6.4	6.2	6.3
	Inpatient bed utilisation rate - total (District Hospitals)	54.5	42.2	46.0	46.2	48.8
	Inpatient bed utilisation rate - total	64.0	50.8	55.4	56.5	59.1
	OPD new client not referred rate (District Hospitals)	63.7	62.2	24.5	60.2	62.6
	OPD new client not referred rate	50.0	49.0	26.0	44.8	48.0
	PHC utilisation rate	2.2	1.7	2.0	2.1	2.1

3 Ave = Average; ART = Antiretroviral treatment; DS = Drug-susceptible; HIV = Human immunodeficiency virus; LG = Local Government; MDR = Mullti-drug-resistant; OPD=Outpatient department; PHC = Primary Health Care; TB = Tuberculosis; XDR = Extremely drug resistant.

Free State

	INDICATOR	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Maternal and Neonatal	Antenatal 1st visit before 20 weeks rate	66.6	61.3	60.5	62.1	62.8
	Antenatal 1st visit coverage	79.3	78.5	78.9	75.4	67.6
	Delivery by Caesarean section rate (District Hospital)	14.9	13.9	14.0	14.9	17.7
	Delivery by Caesarean section rate	31.8	30.4	32.3	34.3	34.1
	Delivery in 10 to 19 years in facility rate	12.7	13.1	13.3	13.3	13.3
	Maternal mortality in facility ratio	116.2	178.8	156.5	95.1	104.8
	Neonatal death in facility rate	15.6	16.0	15.9	16.2	18.7
Immunisation	Immunisation under 1 year coverage	77.4	75.9	83.6	79.7	76.2
	Measles 2nd dose coverage	73.3	73.3	77.5	80.0	73.9
Child health and nutrition	Diarrhoea case fatality under 5 years rate	0.9	2.7	2.3	1.8	1.3
	Death under 5 years against live birth rate	2.1	2.0	2.2	2.4	2.8
	Early neonatal death in facility rate	11.9	11.9	12.6	11.6	14.4
	Pneumonia case fatality under 5 years rate	1.8	3.1	3.2	1.7	4.4
	Severe acute malnutrition case fatality under 5 years rate	6.0	3.2	8.6	9.7	9.3
Women's health	Couple year protection rate	78.9	74.9	84.7	83.9	87.5
Tuberculosis	TB child under 5 years start on treatment rate	4.5	103.7	65.6	87.8	92.8
	TB client 5 years and older start on treatment rate	97.6	93.2	90.6	92.6	92.3
	TB DS death rate	12.6	12.9	12.3	–	–
	TB DS treatment success rate	74.6	71.3	71.9	–	–
	TB MDR client death rate	26.7	23.2	21.3	–	–
	TB MDR treatment success rate	59.4	61.2	62.2	–	–
	TB symptom child under 5 years screened in facility rate	109.5	95.8	97.7	100.8	100.5
	TB symptom 5 years and older screened in facility rate	110.1	85.9	89.3	93.3	94.9
	TB XDR client death rate	23.5	21.9	28.1	–	–
	TB XDR treatment success rate	50.0	56.3	46.9	–	–
HIV/AIDS	Adult with viral load suppressed rate 12 months	89.7	89.3	92.8	91.2	92.9
	ART client viral load suppressed rate (VLS)	89.0	89.1	92.0	90.0	93.0
	Child with viral load suppressed rate 12 months	64.3	72.5	61.4	58.5	81.2
	Clients remaining on ART rate	69.4	71.9	75.7	74.8	75.6
	Antiretroviral effective coverage (0-14 years)	17.4	20.6	17.8	19.2	21.9
	Antiretroviral effective coverage (15+ years)	39.9	44.9	51.1	49.2	50.6
	Antiretroviral effective coverage	38.8	43.9	49.9	48.2	49.8
Non-communicable diseases	Cervical cancer screening coverage	46.0	16.0	35.2	24.0	45.3
Inpatient Management	Hospital beds per 10 000 target population (District Hospitals)	6.8	6.4	6.3	6.4	6.6
	Hospital beds per 10 000 target population (All hospitals)	19.6	19.2	18.9	18.5	18.9
Human Resources	Medical practitioners per 100 000 population	27.9	33.3	32.9	35.3	28.0
	Pharmacists per 100 000 population	14.4	15.1	18.9	17.4	16.9
	Professional nurses per 100 000 population	88.7	102.3	112.7	108.0	99.4

Finance	Provincial & LG District Health Services expenditure per capita (uninsured) (Rand)	2357.0	2711.0	2616.0	2511.0	2305.0
	Expenditure per patient day equivalent (district hospitals) (Rand)	3777.0	4155.0	3817.0	3456.0	3049.0
	Provincial & LG PHC expenditure per capita (uninsured) (Rand)	1481.0	1886.0	1807.0	1730.0	1563.0
	Provincial & LG PHC expenditure per PHC headcount (Rand)	685.0	980.0	950.0	860.0	758.0
Extra	Antenatal client initiated on ART rate	98.4	98.1	97.7	95.1	100.7
	Infant exclusively breastfed at DTaP-IPV-Hib-HBV 3rd dose rate	53.6	46.4	43.8	42.5	44.1
	Live birth under 2500g in facility rate	14.2	14.4	14.8	15.0	15.4
	Male condom distribution coverage	52.3	50.9	56.1	52.7	55.3
	Medical male circumcision 15 years and older rate	32.2	73.5	50.3	51.5	48.5
	Mental disorder treatment rate	1.1	0.2	0.0	0.0	0.0
	Infant PCR test positive around 10 weeks rate	0.5	0.5	0.6	0.4	0.3
	Mother postnatal visit within 6 days rate	80.5	79.9	76.6	78.2	84.2
	School Grade 1 screening coverage	37.8	6.4	17.0	23.4	19.1
	School Grade 8 screening coverage	33.6	0.0	2.7	19.9	13.0
	Stillbirth rate	23.8	27.1	26.3	25.7	25.1
	Vitamin A dose 12-59 months coverage	52.1	48.1	55.7	61.3	58.9
	Average length of stay - total (District Hospitals)	3.3	3.0	3.2	3.0	3.4
	Average length of stay - total	5.6	5.7	5.9	5.7	5.8
	Inpatient crude death rate	4.1	5.4	5.2	4.2	4.2
	Inpatient bed utilisation rate - total (District Hospitals)	57.7	47.0	51.5	52.1	51.4
	Inpatient bed utilisation rate - total	72.4	57.1	66.6	67.7	62.4
	OPD new client not referred rate (District Hospitals)	66.1	59.2	53.0	56.0	54.5
	OPD new client not referred rate	57.4	50.9	44.4	45.5	45.0
	PHC utilisation rate	1.8	1.6	1.6	1.7	1.8

Gauteng

	INDICATOR	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Maternal and Neonatal	Antenatal 1st visit before 20 weeks rate	66.5	63.3	66.8	69.3	69.9
	Antenatal 1st visit coverage	90.2	88.3	82.5	76.1	71.0
	Delivery by Caesarean section rate (District Hospital)	27.5	30.7	33.2	33.1	34.1
	Delivery by Caesarean section rate	31.2	30.3	30.6	32.5	33.2
	Delivery in 10 to 19 years in facility rate	7.5	8.9	9.1	9.6	9.9
	Maternal mortality in facility ratio	102.9	118.7	129.3	118.5	107.3
	Neonatal death in facility rate	12.4	13.2	14.3	13.2	14.0
Immunisation	Immunisation under 1 year coverage	86.9	85.0	88.0	83.2	83.6
	Measles 2nd dose coverage	79.8	77.8	83.2	83.9	81.0
Child health and nutrition	Diarrhoea case fatality under 5 years rate	1.7	2.7	1.8	1.9	1.4
	Death under 5 years against live birth rate	1.6	1.7	1.9	1.9	1.9
	Early neonatal death in facility rate	9.3	9.6	10.5	9.3	9.8
	Pneumonia case fatality under 5 years rate	1.8	2.3	1.5	1.5	1.7
	Severe acute malnutrition case fatality under 5 years rate	6.4	7.7	7.7	6.5	6.4
Women's health	Couple year protection rate	43.7	44.9	37.8	28.6	39.8
Tuberculosis	TB child under 5 years start on treatment rate	15.0	80.0	98.7	97.8	87.8
	TB client 5 years and older start on treatment rate	95.5	93.4	94.8	95.1	92.3
	TB DS death rate	9.2	9.0	7.2	–	–
	TB DS treatment success rate	82.4	82.5	75.7	–	–
	TB MDR client death rate	18.5	14.7	12.8	–	–
	TB MDR treatment success rate	61.2	64.7	64.4	–	–
	TB symptom child under 5 years screened in facility rate	87.3	90.7	95.8	98.0	97.1
	TB symptom 5 years and older screened in facility rate	98.1	98.9	111.4	112.7	111.1
	TB XDR client death rate	23.5	10.0	22.2		
	TB XDR treatment success rate	61.8	64.0	47.2		
HIV/AIDS	Adult with viral load suppressed rate 12 months	87.6	88.7	91.3	89.4	91.8
	ART client viral load suppressed rate (VLS)	87.1	88.3	91.0	89.0	91.0
	Child with viral load suppressed rate 12 months	64.3	65.2	63.2	52.9	65.6
	Clients remaining on ART rate	58.9	63.1	62.6	65.7	66.2
	Antiretroviral effective coverage (0-14 years)	18.8	22.4	18.7	17.4	22.7
	Antiretroviral effective coverage (15+ years)	41.6	45.6	46.0	46.4	49.8
	Antiretroviral effective coverage	40.9	45.0	45.3	45.8	49.2
Non-communicable diseases	Cervical cancer screening coverage	42.2	7.3	31.4	16.9	28.3
Inpatient Management	Hospital beds per 10 000 target population (District Hospitals)	2.2	2.2	2.3	2.1	2.0
	Hospital beds per 10 000 target population (All hospitals)	15.2	14.5	14.5	14.4	13.9
Human Resources	Medical practitioners per 100 000 population	33.9	38.3	39.7	38.5	35.7
	Pharmacists per 100 000 population	10.7	11.1	11.0	10.5	10.4
	Professional nurses per 100 000 population	124.1	136.4	138.4	131.1	123.0

Finance	Provincial & LG District Health Services expenditure per capita (uninsured) (Rand)	2014.0	2109.0	2030.0	1863.0	1834.0
	Expenditure per patient day equivalent (district hospitals) (Rand)	4529.0	5683.0	5079.0	4450.0	4493.0
	Provincial & LG PHC expenditure per capita (uninsured) (Rand)	1560.0	1633.0	1510.0	1408.0	1352.0
	Provincial & LG PHC expenditure per PHC headcount (Rand)	842.0	1134.0	976.0	880.0	883.0
Extra	Antenatal client initiated on ART rate	97.2	98.6	99.3	99.8	99.7
	Infant exclusively breastfed at DTaP-IPV-Hib-HBV 3rd dose rate	45.7	45.2	46.7	48.1	47.3
	Live birth under 2500g in facility rate	13.9	13.0	14.0	14.2	14.6
	Male condom distribution coverage	25.1	26.3	21.1	11.1	19.7
	Medical male circumcision 15 years and older rate	38.3	38.9	38.5	43.6	50.4
	Mental disorder treatment rate	0.3	0.2	0.1	0.1	0.1
	Infant PCR test positive around 10 weeks rate	0.7	0.7	0.7	0.5	0.3
	Mother postnatal visit within 6 days rate	85.5	75.0	74.7	78.3	79.8
	School Grade 1 screening coverage	30.9	7.5	22.8	30.2	31.8
	School Grade 8 screening coverage	30.7	2.8	20.0	28.8	32.8
	Stillbirth rate	18.8	19.7	19.2	20.3	18.7
	Vitamin A dose 12-59 months coverage	52.7	47.4	57.1	64.8	64.9
	Average length of stay - total (District Hospitals)	4.2	4.3	4.4	4.7	5.1
	Average length of stay - total	6.7	6.9	7.0	7.2	7.5
	Inpatient crude death rate	5.0	6.3	6.1	5.3	5.4
	Inpatient bed utilisation rate - total (District Hospitals)	70.2	59.9	63.7	67.7	72.8
	Inpatient bed utilisation rate - total	82.0	70.7	75.0	77.2	78.7
	OPD new client not referred rate (District Hospitals)	66.8	66.4	64.6	64.9	62.0
	OPD new client not referred rate	30.6	24.9	30.0	27.6	23.0
	PHC utilisation rate	1.5	1.2	1.2	1.2	1.2

KwaZulu-Natal

	INDICATOR	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Maternal and Neonatal	Antenatal 1st visit before 20 weeks rate	74.5	74.6	74.2	73.8	76.3
	Antenatal 1st visit coverage	75.0	76.3	77.3	75.1	64.7
	Delivery by Caesarean section rate (District Hospital)	28.2	29.1	29.3	30.2	31.6
	Delivery by Caesarean section rate	33.7	35.3	36.4	36.8	38.9
	Delivery in 10 to 19 years in facility rate	16.3	16.5	16.6	16.2	16.6
	Maternal mortality in facility ratio	76.9	123.9	100.6	78.5	89.2
	Neonatal death in facility rate	10.9	12.1	13.0	12.0	13.0
Immunisation	Immunisation under 1 year coverage	91.4	86.4	94.8	92.2	94.5
	Measles 2nd dose coverage	82.6	80.6	91.3	89.5	95.6
Child health and nutrition	Diarrhoea case fatality under 5 years rate	1.7	2.6	1.8	1.8	1.2
	Death under 5 years against live birth rate	1.6	1.6	1.8	1.8	1.9
	Early neonatal death in facility rate	8.7	9.4	9.8	9.1	9.8
	Pneumonia case fatality under 5 years rate	2.0	2.3	2.2	1.9	2.0
	Severe acute malnutrition case fatality under 5 years rate	7.6	10.5	10.4	9.2	6.9
Women's health	Couple year protection rate	56.5	51.5	60.3	58.4	64.0
Tuberculosis	TB child under 5 years start on treatment rate	11.1	92.4	101.8	99.0	62.7
	TB client 5 years and older start on treatment rate	99.0	96.4	94.8	96.4	92.8
	TB DS death rate	8.0	7.6	6.5	–	–
	TB DS treatment success rate	83.0	82.1	74.9	–	–
	TB MDR client death rate	16.7	15.6	13.8	–	–
	TB MDR treatment success rate	67.0	67.4	68.5	–	–
	TB symptom child under 5 years screened in facility rate	98.2	101.4	100.9	102.6	103.6
	TB symptom 5 years and older screened in facility rate	99.7	98.3	104.9	105.9	107.4
	TB XDR client death rate	12.8	17.9	14.2		
	TB XDR treatment success rate	57.0	53.8	52.2		
HIV/AIDS	Adult with viral load suppressed rate 12 months	90.6	89.1	90.5	91.4	93.7
	ART client viral load suppressed rate (VLS)	89.9	88.5	90.0	91.0	93.0
	Child with viral load suppressed rate 12 months	68.8	53.1	55.8	66.3	73.8
	Clients remaining on ART rate	72.2	78.2	77.6	76.0	78.8
	Antiretroviral effective coverage (0-14 years)	21.2	29.1	22.7	26.8	31.3
	Antiretroviral effective coverage (15+ years)	49.0	53.5	57.3	58.2	61.4
	Antiretroviral effective coverage	47.6	52.6	56.0	57.2	60.5
Non-communicable diseases	Cervical cancer screening coverage	55.9	22.9	56.8	38.9	72.3
Inpatient Management	Hospital beds per 10 000 target population (District Hospitals)	8.5	8.3	8.5	8.3	8.2
	Hospital beds per 10 000 target population (All hospitals)	20.7	20.3	19.9	19.8	19.4
Human Resources	Medical practitioners per 100 000 population	39.1	41.7	41.7	40.0	39.6
	Pharmacists per 100 000 population	9.3	9.4	9.6	9.6	9.5
	Professional nurses per 100 000 population	169.8	184.1	186.2	178.1	171.2

Finance	Provincial & LG District Health Services expenditure per capita (uninsured) (Rand)	2847.0	2930.0	3030.0	2801.0	2644.0
	Expenditure per patient day equivalent (district hospitals) (Rand)	4081.0	4992.0	4743.0	4201.0	3853.0
	Provincial & LG PHC expenditure per capita (uninsured) (Rand)	1825.0	1984.0	2100.0	1912.0	1676.0
	Provincial & LG PHC expenditure per PHC headcount (Rand)	646.0	882.0	900.0	801.0	729.0
Extra	Antenatal client initiated on ART rate	98.4	98.9	98.9	96.6	97.8
	Infant exclusively breastfed at DTaP-IPV-Hib-HBV 3rd dose rate	56.5	56.7	56.3	54.9	55.6
	Live birth under 2500g in facility rate	11.7	11.8	12.3	12.7	13.3
	Male condom distribution coverage	30.1	26.6	29.0	24.0	28.9
	Medical male circumcision 15 years and older rate	47.6	79.2	60.1	40.1	39.7
	Mental disorder treatment rate	0.0	0.0	0.1	0.1	0.0
	Infant PCR test positive around 10 weeks rate	0.5	0.4	0.4	0.3	0.3
	Mother postnatal visit within 6 days rate	76.1	76.2	79.3	78.6	77.4
	School Grade 1 screening coverage	28.8	4.3	12.4	21.8	32.4
	School Grade 8 screening coverage	24.3	2.3	4.3	13.2	19.6
	Stillbirth rate	21.2	23.6	22.8	23.1	23.0
	Vitamin A dose 12-59 months coverage	68.2	60.6	78.2	91.3	85.7
	Average length of stay - total (District Hospitals)	5.2	4.9	5.0	5.0	5.3
	Average length of stay - total	6.6	6.3	6.4	6.4	6.9
	Inpatient crude death rate	4.6	5.8	5.0	4.5	4.7
	Inpatient bed utilisation rate - total (District Hospitals)	59.2	47.6	50.2	53.7	55.2
	Inpatient bed utilisation rate - total	65.0	51.9	56.5	59.3	62.2
	OPD new client not referred rate (District Hospitals)	52.1	55.0	57.1	54.7	53.5
	OPD new client not referred rate	48.2	48.5	48.6	46.8	46.0
	PHC utilisation rate	2.4	1.9	2.1	2.1	2.0

Limpopo

	INDICATOR	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Maternal and Neonatal	Antenatal 1st visit before 20 weeks rate	69.0	66.8	66.7	67.5	61.7
	Antenatal 1st visit coverage	90.7	93.9	88.0	80.1	72.9
	Delivery by Caesarean section rate (District Hospital)	22.5	24.8	24.4	25.6	26.7
	Delivery by Caesarean section rate	21.4	23.1	23.2	25.5	26.7
	Delivery in 10 to 19 years in facility rate	14.1	13.8	13.5	14.2	15.0
	Maternal mortality in facility ratio	97.8	120.1	134.6	109.0	104.7
	Neonatal death in facility rate	14.3	12.7	13.2	13.1	13.5
Immunisation	Immunisation under 1 year coverage	73.6	60.6	69.2	67.5	74.3
	Measles 2nd dose coverage	79.0	76.3	83.2	86.6	84.1
Child health and nutrition	Diarrhoea case fatality under 5 years rate	2.8	3.8	2.4	2.0	1.7
	Death under 5 years against live birth rate	1.9	1.7	1.8	1.9	1.9
	Early neonatal death in facility rate	12.5	10.6	10.7	10.6	10.7
	Pneumonia case fatality under 5 years rate	2.7	4.2	2.3	2.6	2.3
	Severe acute malnutrition case fatality under 5 years rate	7.9	8.0	6.2	7.4	12.9
Women's health	Couple year protection rate	55.3	46.9	51.9	46.5	60.3
Tuberculosis	TB child under 5 years start on treatment rate	7.6	62.9	105.7	105.3	72.0
	TB client 5 years and older start on treatment rate	98.8	96.2	97.2	97.3	92.0
	TB DS death rate	13.8	13.3	12.4	–	–
	TB DS treatment success rate	77.7	78.9	68.8	–	–
	TB MDR client death rate	17.5	17.2	19.0	–	–
	TB MDR treatment success rate	64.5	65.2	63.3	–	–
	TB symptom child under 5 years screened in facility rate	88.0	83.9	88.2	88.4	96.2
	TB symptom 5 years and older screened in facility rate	95.3	88.9	95.2	97.8	101.4
	TB XDR client death rate	15.4	40.0	21.4	–	–
	TB XDR treatment success rate	61.5	40.0	50.0	–	–
HIV/AIDS	Adult with viral load suppressed rate 12 months	86.5	88.3	79.9	89.8	91.9
	ART client viral load suppressed rate (VLS)	85.3	87.3	79.0	89.0	91.0
	Child with viral load suppressed rate 12 months	51.5	68.4	62.3	54.8	57.6
	Clients remaining on ART rate	77.8	66.3	59.1	60.4	62.7
	Antiretroviral effective coverage (0-14 years)	19.1	15.7	14.6	19.1	23.5
	Antiretroviral effective coverage (15+ years)	53.6	45.6	37.5	45.2	50.7
	Antiretroviral effective coverage	51.6	44.2	36.5	44.3	49.8
Non-communicable diseases	Cervical cancer screening coverage	33.3	9.7	25.1	12.0	27.0
Inpatient Management	Hospital beds per 10 000 target population (District Hospitals)	7.6	7.5	7.5	7.4	7.4
	Hospital beds per 10 000 target population (All hospitals)	14.0	13.9	13.9	13.7	13.6
Human Resources	Medical practitioners per 100 000 population	24.8	26.0	27.4	31.2	30.9
	Pharmacists per 100 000 population	10.5	10.4	11.5	13.7	12.0
	Professional nurses per 100 000 population	164.5	163.4	159.0	153.9	147.5

Finance	Provincial & LG District Health Services expenditure per capita (uninsured) (Rand)	3096.0	3024.0	2899.0	2868.0	2788.0
	Expenditure per patient day equivalent (district hospitals) (Rand)	4153.0	4740.0	4452.0	4239.0	3596.0
	Provincial & LG PHC expenditure per capita (uninsured) (Rand)	1394.0	1419.0	1397.0	1438.0	1305.0
	Provincial & LG PHC expenditure per PHC headcount (Rand)	541.0	642.0	619.0	627.0	600.0
Extra	Antenatal client initiated on ART rate	95.2	96.8	98.0	97.3	94.8
	Infant exclusively breastfed at DTaP-IPV-Hib-HBV 3rd dose rate	40.3	38.1	32.7	34.8	32.1
	Live birth under 2500g in facility rate	10.6	10.7	10.6	11.6	11.7
	Male condom distribution coverage	35.5	27.5	28.3	20.6	34.2
	Medical male circumcision 15 years and older rate	24.4	85.9	78.7	48.1	43.3
	Mental disorder treatment rate	1.3	0.5	0.2	0.2	0.1
	Infant PCR test positive around 10 weeks rate	0.7	0.7	0.8	0.5	0.4
	Mother postnatal visit within 6 days rate	104.2	94.7	95.2	97.6	93.6
	School Grade 1 screening coverage	48.3	–	6.6	11.3	3.3
	School Grade 8 screening coverage	28.3	–	6.3	10.1	0.6
	Stillbirth rate	19.5	20.5	19.0	18.6	19.0
	Vitamin A dose 12-59 months coverage	46.5	43.6	49.5	57.2	55.4
	Average length of stay - total (District Hospitals)	4.2	4.0	4.0	4.2	4.4
	Average length of stay - total	5.3	5.1	5.3	5.4	5.7
	Inpatient crude death rate	4.8	5.2	5.2	4.6	4.6
	Inpatient bed utilisation rate - total (District Hospitals)	72.9	60.9	62.6	66.6	68.7
	Inpatient bed utilisation rate - total	74.2	63.1	66.2	68.5	69.8
	OPD new client not referred rate (District Hospitals)	71.8	69.3	69.8	71.7	69.4
	OPD new client not referred rate	65.4	61.1	59.5	62.8	62.0
	PHC utilisation rate	2.4	2.0	2.1	2.1	2.0

Mpumalanga

	INDICATOR	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Maternal and Neonatal	Antenatal 1st visit before 20 weeks rate	77.4	74.9	74.3	77.3	74.9
	Antenatal 1st visit coverage	92.7	107.4	87.6	78.1	72.8
	Delivery by Caesarean section rate (District Hospital)	21.2	20.2	20.4	22.3	23.1
	Delivery by Caesarean section rate	22.4	21.0	20.3	23.4	24.3
	Delivery in 10 to 19 years in facility rate	14.9	15.5	15.8	16.2	16.6
	Maternal mortality in facility ratio	67.1	108.3	130.0	114.5	109.4
	Neonatal death in facility rate	11.2	12.7	12.9	12.9	13.4
Immunisation	Immunisation under 1 year coverage	96.6	91.5	97.3	89.1	88.2
	Measles 2nd dose coverage	93.9	84.2	91.6	97.4	90.4
Child health and nutrition	Diarrhoea case fatality under 5 years rate	2.1	2.5	1.9	2.2	1.8
	Death under 5 years against live birth rate	1.5	1.7	1.7	1.8	1.9
	Early neonatal death in facility rate	9.6	10.3	10.5	10.5	10.7
	Pneumonia case fatality under 5 years rate	2.3	5.3	2.2	2.8	3.1
	Severe acute malnutrition case fatality under 5 years rate	10.6	16.0	10.9	7.8	5.0
Women's health	Couple year protection rate	48.2	39.8	39.2	43.4	59.4
Tuberculosis	TB child under 5 years start on treatment rate	3.5	122.3	87.6	98.2	98.2
	TB client 5 years and older start on treatment rate	101.1	96.0	93.4	95.3	95.2
	TB DS death rate	10.5	9.2	8.1	–	–
	TB DS treatment success rate	80.6	82.8	75.2	–	–
	TB MDR client death rate	19.6	16.2	16.8	–	–
	TB MDR treatment success rate	68.3	71.2	66.7	–	–
	TB symptom child under 5 years screened in facility rate	90.5	94.7	96.1	100.4	101.6
	TB symptom 5 years and older screened in facility rate	87.1	86.1	95.7	96.2	98.4
	TB XDR client death rate	21.1	9.1	34.8		
	TB XDR treatment success rate	63.2	63.6	56.5		
HIV/AIDS	Adult with viral load suppressed rate 12 months	86.2	88.3	87.7	91.7	93.0
	ART client viral load suppressed rate (VLS)	85.5	87.7	87.0	91.0	92.0
	Child with viral load suppressed rate 12 months	60.9	64.0	53.1	58.7	66.5
	Clients remaining on ART rate	73.1	75.6	73.4	74.1	75.2
	Antiretroviral effective coverage (0-14 years)	20.2	24.2	18.1	22.3	25.8
	Antiretroviral effective coverage (15+ years)	52.5	51.3	52.0	57.5	62.4
	Antiretroviral effective coverage	50.8	50.3	50.6	56.3	61.3
Non-communicable diseases	Cervical cancer screening coverage	57.9	24.2	42.7	24.7	43.3
Inpatient Management	Hospital beds per 10 000 target population (District Hospitals)	6.9	7.2	7.1	7.0	6.7
	Hospital beds per 10 000 target population (All hospitals)	12.1	12.2	12.1	11.2	10.9
Human Resources	Medical practitioners per 100 000 population	27.0	28.9	28.0	31.3	30.8
	Pharmacists per 100 000 population	8.6	9.2	9.6	10.0	9.8
	Professional nurses per 100 000 population	149.9	155.6	154.6	160.1	156.3

Finance	Provincial & LG District Health Services expenditure per capita (uninsured) (Rand)	2770.0	2680.0	2828.0	2652.0	2529.0
	Expenditure per patient day equivalent (district hospitals) (Rand)	3616.0	4273.0	3974.0	3774.0	3655.0
	Provincial & LG PHC expenditure per capita (uninsured) (Rand)	1518.0	1489.0	1521.0	1426.0	1378.0
	Provincial & LG PHC expenditure per PHC headcount (Rand)	664.0	833.0	816.0	738.0	720.0
Extra	Antenatal client initiated on ART rate	98.8	96.6	97.6	99.1	99.2
	Infant exclusively breastfed at DTaP-IPV-Hib-HBV 3rd dose rate	51.9	43.0	38.8	39.9	34.1
	Live birth under 2500g in facility rate	11.6	11.5	12.0	12.5	13.2
	Male condom distribution coverage	32.8	23.9	19.1	21.3	35.4
	Medical male circumcision 15 years and older rate	52.5	67.4	68.6	64.5	71.6
	Mental disorder treatment rate	1.2	0.1	0.0	0.0	0.0
	Infant PCR test positive around 10 weeks rate	0.9	0.6	0.6	0.5	0.3
	Mother postnatal visit within 6 days rate	70.9	73.9	74.2	76.2	76.1
	School Grade 1 screening coverage	34.5	1.3	10.5	22.1	23.0
	School Grade 8 screening coverage	26.9	0.7	3.5	11.0	13.1
	Stillbirth rate	18.8	3.0	20.8	21.3	19.7
	Vitamin A dose 12-59 months coverage	65.6	51.1	57.9	77.1	81.2
	Average length of stay - total (District Hospitals)	4.1	3.9	4.0	4.3	4.5
	Average length of stay - total	4.5	4.2	4.5	4.7	4.8
	Inpatient crude death rate	4.6	4.7	4.9	4.4	4.4
	Inpatient bed utilisation rate - total (District Hospitals)	67.0	57.0	58.7	61.7	61.5
	Inpatient bed utilisation rate - total	63.6	57.4	59.8	64.4	64.2
	OPD new client not referred rate (District Hospitals)	64.3	63.0	63.4	63.5	64.0
	OPD new client not referred rate	56.5	58.1	54.8	52.6	54.0
	PHC utilisation rate	2.0	1.6	1.6	1.7	1.7

Northern Cape

	INDICATOR	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Maternal and Neonatal	Antenatal 1st visit before 20 weeks rate	65.0	58.6	56.3	58.5	57.2
	Antenatal 1st visit coverage	105.6	109.9	88.6	91.2	86.1
	Delivery by Caesarean section rate (District Hospital)	15.5	19.9	15.7	16.9	18.2
	Delivery by Caesarean section rate	21.5	23.9	22.2	26.9	26.6
	Delivery in 10 to 19 years in facility rate	18.4	19.3	17.6	17.0	17.2
	Maternal mortality in facility ratio	109.9	80.6	157.5	80.0	115.8
	Neonatal death in facility rate	15.5	13.8	12.9	14.2	13.3
Immunisation	Immunisation under 1 year coverage	89.0	79.9	72.8	75.9	77.1
	Measles 2nd dose coverage	89.8	83.5	72.2	73.6	77.7
Child health and nutrition	Diarrhoea case fatality under 5 years rate	1.5	2.3	2.1	1.5	1.8
	Death under 5 years against live birth rate	2.2	1.9	1.8	2.2	1.8
	Early neonatal death in facility rate	13.1	11.5	10.3	11.3	10.9
	Pneumonia case fatality under 5 years rate	1.7	2.1	3.0	2.4	3.1
	Severe acute malnutrition case fatality under 5 years rate	4.7	5.0	5.9	8.5	5.0
Women's health	Couple year protection rate	56.6	50.9	46.8	38.3	57.5
Tuberculosis	TB child under 5 years start on treatment rate	11.6	70.1	114.4	91.6	61.4
	TB client 5 years and older start on treatment rate	99.5	99.8	87.9	97.3	77.2
	TB DS death rate	8.4	8.3	7.7	–	–
	TB DS treatment success rate	68.4	64.9	74.4	–	–
	TB MDR client death rate	19.4	21.5	15.6	–	–
	TB MDR treatment success rate	62.4	57.4	64.8	–	–
	TB symptom child under 5 years screened in facility rate	64.8	69.1	83.3	92.0	91.2
	TB symptom 5 years and older screened in facility rate	68.9	65.2	80.1	88.0	87.5
	TB XDR client death rate	25.0	20.5	34.3	–	–
	TB XDR treatment success rate	50.0	51.3	54.3	–	–
HIV/AIDS	Adult with viral load suppressed rate 12 months	83.6	83.3	85.0	86.4	84.4
	ART client viral load suppressed rate (VLS)	83.2	81.5	84.0	85.0	85.0
	Child with viral load suppressed rate 12 months	75.2	69.8		50.0	20.0
	Clients remaining on ART rate	77.5	58.4	56.7	60.6	66.0
	Antiretroviral effective coverage (0-14 years)	13.9	14.1		17.6	2.7
	Antiretroviral effective coverage (15+ years)	17.8	23.0	22.5	18.5	23.8
	Antiretroviral effective coverage	17.6	22.5	21.5	18.4	23.1
Non-communicable diseases	Cervical cancer screening coverage	32.0	5.1	15.3	9.6	40.9
Inpatient Management	Hospital beds per 10 000 target population (District Hospitals)	5.5	5.2	5.3	5.1	5.1
	Hospital beds per 10 000 target population (All hospitals)	14.7	14.8	15.3	14.3	14.4
Human Resources	Medical practitioners per 100 000 population	37.9	40.9	41.2	40.0	40.7
	Pharmacists per 100 000 population	13.1	14.5	12.6	13.2	13.4
	Professional nurses per 100 000 population	146.1	152.1	140.9	135.6	132.4

Finance	Provincial & LG District Health Services expenditure per capita (uninsured) (Rand)	2859.0	2815.0	2920.0	2663.0	2647.0
	Expenditure per patient day equivalent (district hospitals) (Rand)	3989.0	4961.0	4490.0	3808.0	3469.0
	Provincial & LG PHC expenditure per capita (uninsured) (Rand)	1756.0	1744.0	1805.0	1673.0	1630.0
	Provincial & LG PHC expenditure per PHC headcount (Rand)	692.0	858.0	852.0	734.0	683.0
Extra	Antenatal client initiated on ART rate	93.4	88.6	90.4	90.0	88.1
	Infant exclusively breastfed at DTaP-IPV-Hib-HBV 3rd dose rate	55.9	52.7	49.0	53.6	50.9
	Live birth under 2500g in facility rate	18.9	16.7	18.2	19.1	17.7
	Male condom distribution coverage	28.9	23.8	20.9	11.2	27.5
	Medical male circumcision 15 years and older rate	51.6	59.8	40.5	41.0	38.8
	Mental disorder treatment rate	0.3	0.1	0.1	0.1	0.0
	Infant PCR test positive around 10 weeks rate	1.3	1.0	1.1	0.8	1.2
	Mother postnatal visit within 6 days rate	68.6	66.8	61.1	64.4	65.2
	School Grade 1 screening coverage	16.4	–	14.0	14.3	16.6
	School Grade 8 screening coverage	19.6	–	7.5	3.6	9.5
	Stillbirth rate	24.0	22.6	33.6	21.7	23.1
	Vitamin A dose 12-59 months coverage	48.4	47.6	42.5	54.0	47.9
	Average length of stay - total (District Hospitals)	3.5	3.0	3.1	3.1	3.4
	Average length of stay - total	5.1	5.2	5.4	5.3	5.7
	Inpatient crude death rate	5.2	5.8	6.6	4.8	5.2
	Inpatient bed utilisation rate - total (District Hospitals)	53.6	48.8	43.4	47.4	52.8
	Inpatient bed utilisation rate - total	61.7	62.0	59.4	31.1	61.5
	OPD new client not referred rate (District Hospitals)	70.8	65.4	64.2	69.6	68.7
	OPD new client not referred rate	64.9	63.7	64.1	66.5	65.0
	PHC utilisation rate	2.2	1.8	1.8	1.9	2.0

North West

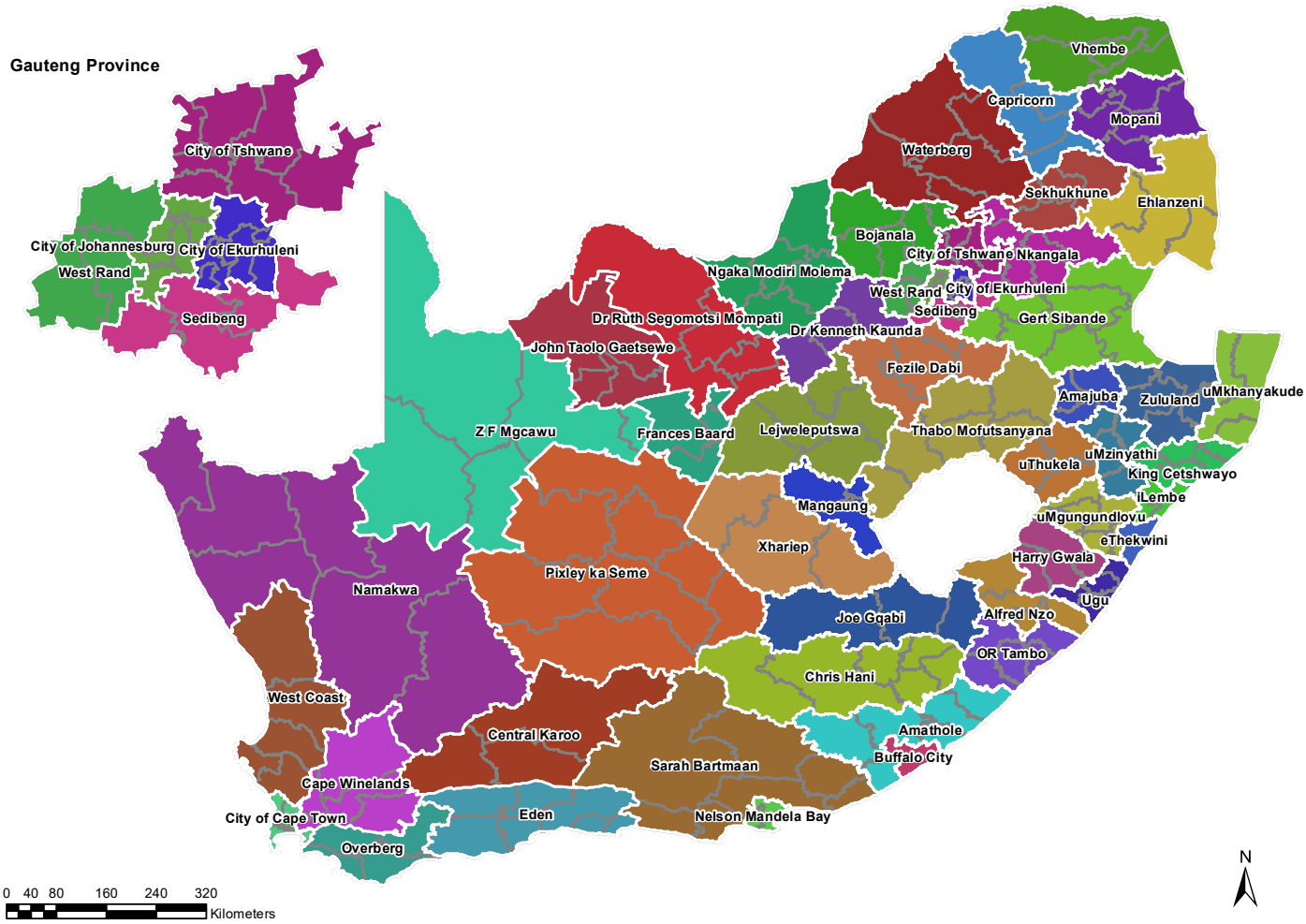
	INDICATORS	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Maternal and Neonatal	Antenatal 1st visit before 20 weeks rate	70.9	68.0	70.1	71.2	73.9
	Antenatal 1st visit coverage	77.7	76.4	72.1	69.6	64.8
	Delivery by Caesarean section rate (District Hospital)	29.8	28.9	28.6	33.0	33.5
	Delivery by Caesarean section rate	25.0	24.1	23.4	25.7	26.7
	Delivery in 10 to 19 years in facility rate	13.1	14.0	15.0	14.5	14.0
	Maternal mortality in facility ratio	88.0	124.6	129.9	118.0	110.2
	Neonatal death in facility rate	11.5	13.9	14.6	13.4	13.7
Immunisation	Immunisation under 1 year coverage	63.0	71.2	62.8	74.1	81.2
	Measles 2nd dose coverage	66.9	65.0	71.5	76.4	89.3
Child health and nutrition	Diarrhoea case fatality under 5 years rate	2.8	2.7	2.3	1.3	1.0
	Death under 5 years against live birth rate	1.9	1.7	2.1	1.9	2.0
	Early neonatal death in facility rate	9.5	10.8	11.1	10.4	9.5
	Pneumonia case fatality under 5 years rate	1.2	3.2	2.3	1.4	1.1
	Severe acute malnutrition case fatality under 5 years rate	11.8	4.9	6.6	3.9	2.1
Women's health	Couple year protection rate	62.4	48.0	52.3	48.3	64.7
Tuberculosis	TB child under 5 years start on treatment rate	10.1	108.7	108.9	105.0	74.2
	TB client 5 years and older start on treatment rate	99.9	95.3	95.3	95.4	87.5
	TB DS death rate	10.3	8.8	7.4	–	–
	TB DS treatment success rate	79.1	82.1	84.0	–	–
	TB MDR client death rate	15.4	22.1	18.4	–	–
	TB MDR treatment success rate	68.2	65.3	67.0	–	–
	TB symptom child under 5 years screened in facility rate	70.3	65.4	74.3	81.9	91.3
	TB symptom 5 years and older screened in facility rate	76.6	70.9	80.0	84.0	88.4
	TB XDR client death rate	41.2	7.1	15.0	–	–
	TB XDR treatment success rate	47.1	71.4	65.0	–	–
HIV/AIDS	Adult with viral load suppressed rate 12 months	85.5	86.5	84.3	89.6	90.5
	ART client viral load suppressed rate (VLS)	84.9	86.1	84.0	89.0	90.0
	Child with viral load suppressed rate 12 months	65.3	68.0	59.4	61.4	62.3
	Clients remaining on ART rate	59.9	65.7	64.8	65.3	68.1
	Antiretroviral effective coverage (0-14 years)	17.5	20.0	17.4	23.9	27.4
	Antiretroviral effective coverage (15+ years)	37.7	44.3	44.8	50.5	55.5
	Antiretroviral effective coverage	36.8	43.5	43.8	49.7	54.8
Non-communicable diseases	Cervical cancer screening coverage	55.9	12.2	22.8	9.7	24.7
Inpatient Management	Hospital beds per 10 000 target population (District Hospitals)	3.9	3.8	3.3	3.4	3.2
	Hospital beds per 10 000 target population (All hospitals)	12.9	13.0	11.9	11.8	11.7
Human Resources	Medical practitioners per 100 000 population	28.3	32.9	33.3	35.1	34.9
	Pharmacists per 100 000 population	9.5	9.8	9.4	8.9	8.7
	Professional nurses per 100 000 population	142.9	153.8	152.8	144.2	135.1

Finance	Provincial & LG District Health Services expenditure per capita (uninsured) (Rand)	2 245	2 363	2 520	2 234	2 086
	Expenditure per patient day equivalent (district hospitals) (Rand)	4 560	5 144	4 590	4 655	4 683
	Provincial & LG PHC expenditure per capita (uninsured) (Rand)	1 535	1 455	1 486	1 450	1 370
	Provincial & LG PHC expenditure per PHC headcount (Rand)	708	835	825	770	726
Extra	Antenatal client initiated on ART rate	98.1	93.2	90.3	94.6	95.7
	Infant exclusively breastfed at DTaP-IPV-Hib-HBV 3rd dose rate	59.7	41.6	33.2	34.0	32.7
	Live birth under 2500g in facility rate	13.6	13.3	14.0	14.0	14.1
	Male condom distribution coverage	38.7	27.4	28.1	20.1	30.9
	Medical male circumcision 15 years and older rate	61.1	94.5	84.3	83.5	70.0
	Mental disorder treatment rate	0.2	0.0	0.0	0.0	0.0
	Infant PCR test positive around 10 weeks rate	0.9	0.7	0.6	0.3	0.5
	Mother postnatal visit within 6 days rate	93.2	94.9	102.6	98.2	100.7
	School Grade 1 screening coverage	60.2	8.1	33.2	27.4	34.4
	School Grade 8 screening coverage	49.5	3.4	17.6	21.7	28.9
	Stillbirth rate	21.7	23.4	22.4	21.1	20.8
	Vitamin A dose 12-59 months coverage	41.6	37.9	50.9	63.2	72.3
	Average length of stay - total (District Hospitals)	4.3	4.0	4.3	4.3	4.5
	Average length of stay - total	6.8	6.0	6.3	6.1	6.2
	Inpatient crude death rate	5.5	5.8	5.8	4.8	4.7
	Inpatient bed utilisation rate - total (District Hospitals)	62.8	52.7	59.3	62.7	66.2
	Inpatient bed utilisation rate - total	73.8	63.6	72.2	73.2	73.7
	OPD new client not referred rate (District Hospitals)	57.8	53.6	58.6	52.2	42.5
	OPD new client not referred rate	38.2	49.6	56.6	46.6	32.7
	PHC utilisation rate	1.9	1.6	1.6	1.7	1.7

Western Cape

	INDICATOR	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Maternal and Neonatal	Antenatal 1st visit before 20 weeks rate	71.9	70.6	72.6	74.3	73.9
	Antenatal 1st visit coverage	91.1	86.7	82.6	78.6	73.0
	Delivery by Caesarean section rate (District Hospital)	27.2	27.0	28.5	28.3	30.0
	Delivery by Caesarean section rate	29.9	30.0	30.9	32.0	33.0
	Delivery in 10 to 19 years in facility rate	11.1	10.8	11.2	11.2	11.0
	Maternal mortality in facility ratio	43.6	83.9	75.1	62.0	48.3
	Neonatal death in facility rate	8.2	8.3	7.7	9.0	8.3
Immunisation	Immunisation under 1 year coverage	84.9	85.0	83.2	75.7	74.8
	Measles 2nd dose coverage	80.0	80.6	79.2	77.7	75.6
Child health and nutrition	Diarrhoea case fatality under 5 years rate	0.2	0.2	0.3	0.3	0.3
	Death under 5 years against live birth rate	1.1	1.1	1.1	1.3	1.2
	Early neonatal death in facility rate	6.5	6.5	6.1	7.1	6.4
	Pneumonia case fatality under 5 years rate	0.2	0.2	0.2	0.2	0.3
	Severe acute malnutrition case fatality under 5 years rate	1.5	2.2	2.4	2.4	2.1
Women's health	Couple year protection rate	64.5	50.5	56.9	50.2	53.0
Tuberculosis	TB child under 5 years start on treatment rate	40.7	99.2	96.5	96.8	70.7
	TB client 5 years and older start on treatment rate	90.0	90.3	91.4	92.2	86.3
	TB DS death rate	4.0	3.9	5.4	–	–
	TB DS treatment success rate	74.9	73.0	115.5	–	–
	TB MDR client death rate	13.7	14.6	14.6	–	–
	TB MDR treatment success rate	53.1	53.7	52.5	–	–
	TB symptom child under 5 years screened in facility rate	71.5	73.9	80.6	79.5	82.0
	TB symptom 5 years and older screened in facility rate	53.4	61.9	72.5	73.4	74.1
	TB XDR client death rate	13.6	12.8	15.6	–	–
	TB XDR treatment success rate	55.2	47.0	42.8	–	–
HIV/AIDS	Adult with viral load suppressed rate 12 months	92.4	90.3	91.6	93.4	93.4
	ART client viral load suppressed rate (VLS)	92.0	88.6	91.0	93.0	92.0
	Child with viral load suppressed rate 12 months		64.5	69.3	71.0	52.2
	Clients remaining on ART rate	67.1	60.1	54.9	54.4	61.1
	Antiretroviral effective coverage (0-14 years)		18.0	17.2	11.6	9.4
	Antiretroviral effective coverage (15+ years)		33.0	20.1	11.5	13.1
	Antiretroviral effective coverage	32.6	32.6	20.0	11.5	13.0
Non-communicable diseases	Cervical cancer screening coverage	41.8	14.2	40.0	17.4	28.2
Inpatient Management	Hospital beds per 10 000 target population (District Hospitals)	5.3	5.3	5.3	5.2	5.5
	Hospital beds per 10 000 target population (All hospitals)	17.6	17.7	17.2	16.9	16.9
Human Resources	Medical practitioners per 100 000 population	41.6	43.7	41.7	42.4	38.7
	Pharmacists per 100 000 population	18.4	18.2	18.5	18.6	17.7
	Professional nurses per 100 000 population	100.0	106.0	102.7	99.5	91.8
Finance	Provincial & LG District Health Services expenditure per capita (uninsured) (Rand)	2513	2625	2550	2421	2283
	Expenditure per patient day equivalent (district hospitals) (Rand)	3337	3982	3447	3237	3193
	Provincial & LG PHC expenditure per capita (uninsured) (Rand)	1566	1678	1590	1502	1415
	Provincial & LG PHC expenditure per PHC headcount (Rand)	598	976	824	719	701

Extra	Antenatal client initiated on ART rate	80.2	67.9	68.5	63.3	62.7
	Infant exclusively breastfed at DTaP-IPV-Hib-HBV 3rd dose rate	39.7	37.6	40.3	39.0	38.7
	Live birth under 2500g in facility rate	13.9	13.6	14.4	14.6	14.9
	Male condom distribution coverage	33.2	21.4	27.3	20.5	23.9
	Medical male circumcision 15 years and older rate	71.2	91.2	92.5	92.6	89.9
	Mental disorder treatment rate	0.0	–	–	–	0.0
	Infant PCR test positive around 10 weeks rate	0.3	0.3	0.6	0.2	0.3
	Mother postnatal visit within 6 days rate	60.1	53.7	57.1	60.2	58.8
	School Grade 1 screening coverage	44.2	0.2	16.1	35.0	30.2
	School Grade 8 screening coverage	15.4	0.1	1.2	9.6	7.4
	Stillbirth rate	16.5	18.3	18.1	17.8	18.7
	Vitamin A dose 12-59 months coverage	53.9	44.0	51.4	58.3	50.4
	Average length of stay - total (District Hospitals)	3.4	3.5	3.6	3.6	3.6
	Average length of stay - total	5.3	5.6	5.6	5.6	5.7
	Inpatient crude death rate	2.9	4.2	4.1	3.2	3.4
	Inpatient bed utilisation rate - total (District Hospitals)	90.4	78.5	90.0	92.8	86.9
	Inpatient bed utilisation rate - total	86.9	73.7	82.2	84.9	86.7
	OPD new client not referred rate (District Hospitals)	9.6	15.5	20.3	14.8	15.1
	OPD new client not referred rate	11.3	17.4	16.1	11.3	11.2
	PHC utilisation rate	2.2	1.4	1.5	1.7	1.6



07 Eastern Cape Province

Buffalo City Metropolitan Municipality (BUF)

Overview of the district

The Buffalo City Metropolitan Municipality[1] is a Category A municipality situated on the east coast of the Eastern Cape Province. The boundaries of the newly established municipality now make up a large area characterised by very different features. Two former municipalities, Transitional Local Councils – that of East London and King William's Town – have merged into one. Other areas that were previously not included in either of them is now part of Buffalo City.

Area: 2 753km²

Population (2023)[2] : 788 728

Householdsa: 253 477

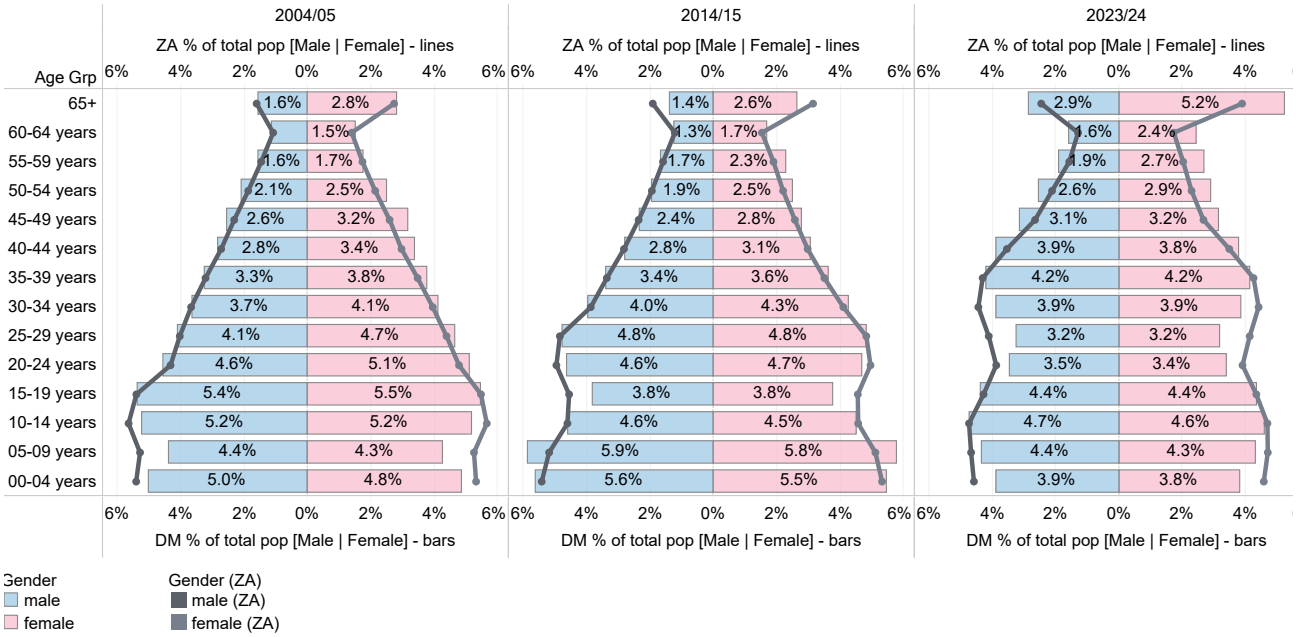
Formal dwellings[1]: 70.2%

Cities/Towns: Beacon Bay, Berlin, Bisho, Breidbach, Dimbaza, East London, Kidd's Beach, King William's Town, Mdantsane, Phakamisa, Potsdam, Zwelitsha.

Main Economic Sectors: Community services (25%), finance (24%), manufacturing (24%), trade (12%), transport (12%).

District percentage population by age-gender group compared to South Africa

Buffalo City MM (BUF)

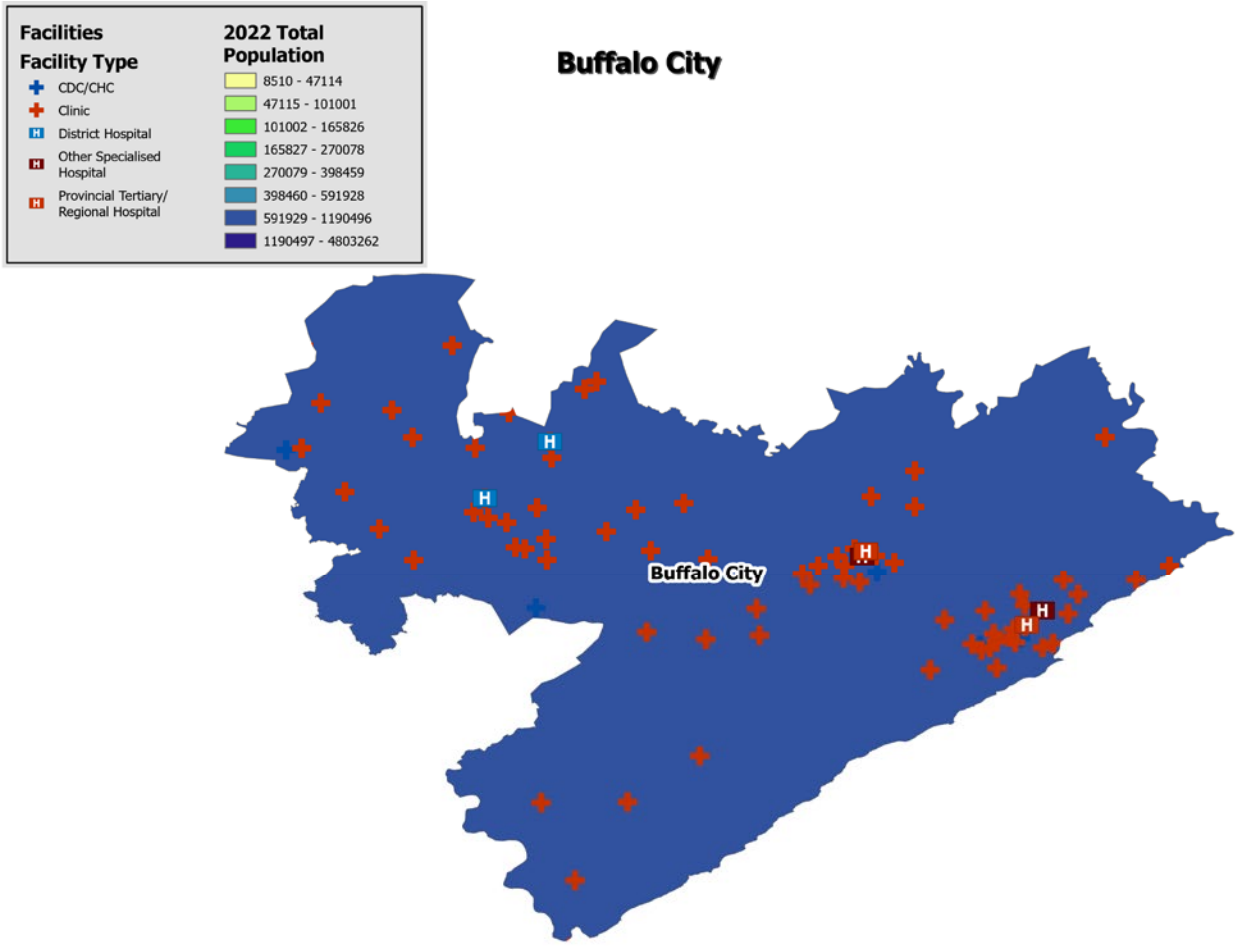


Source: DHIS

1 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

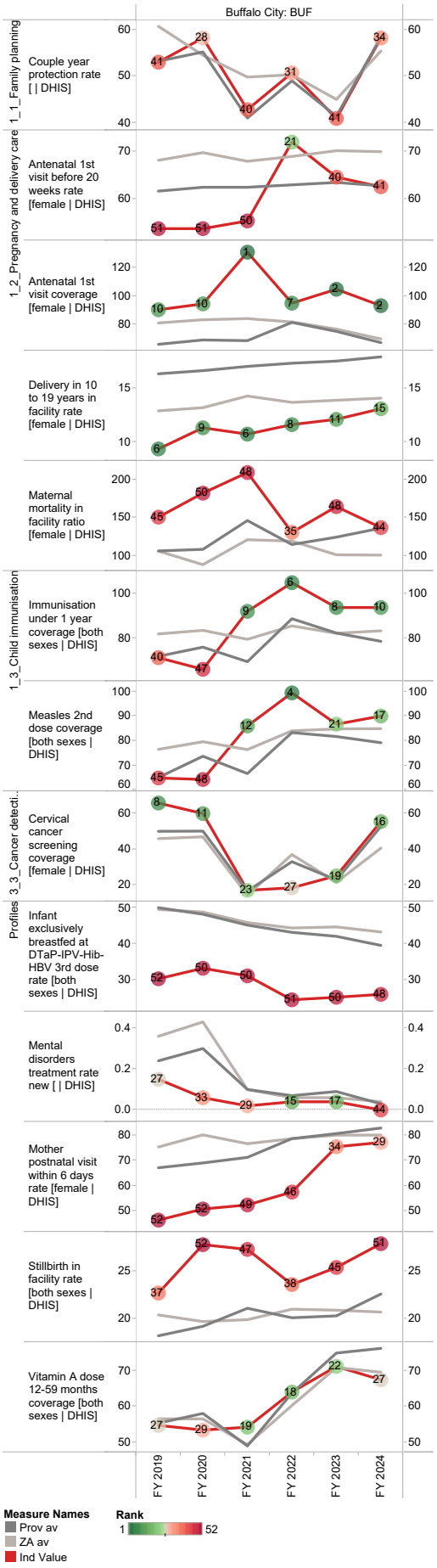
2 Mid-year Population Estimates 2023, DHIS.

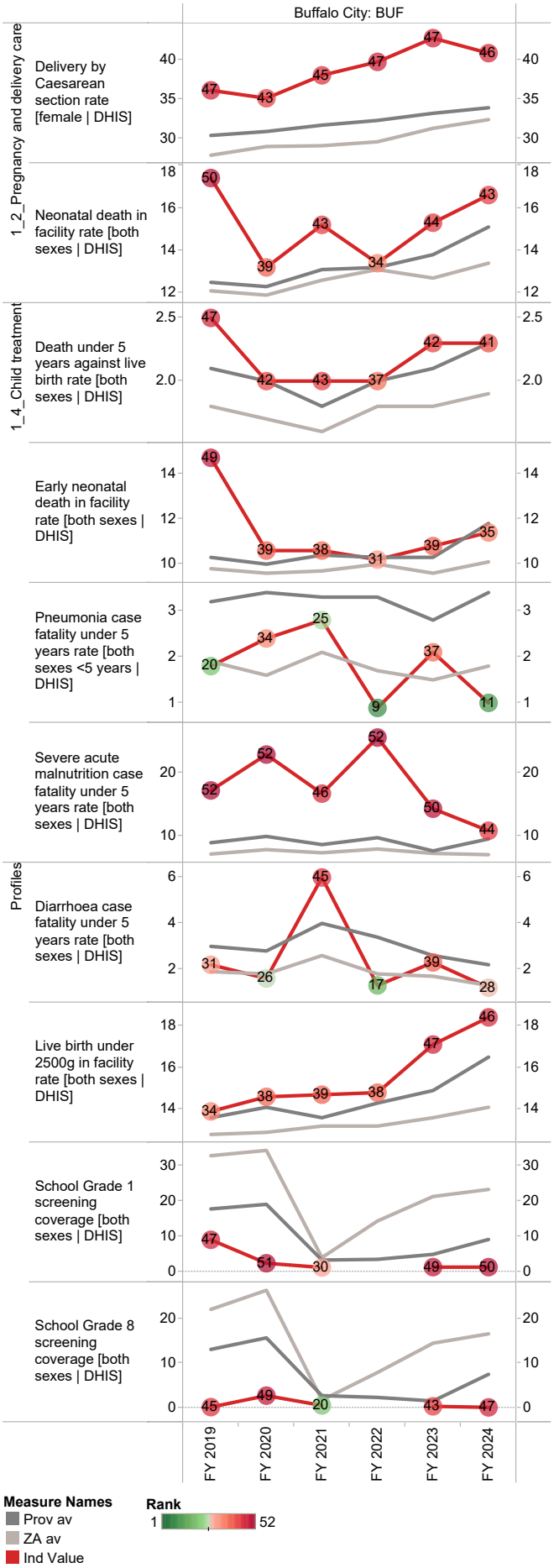
Population distribution, sub-district boundaries and health facility locations

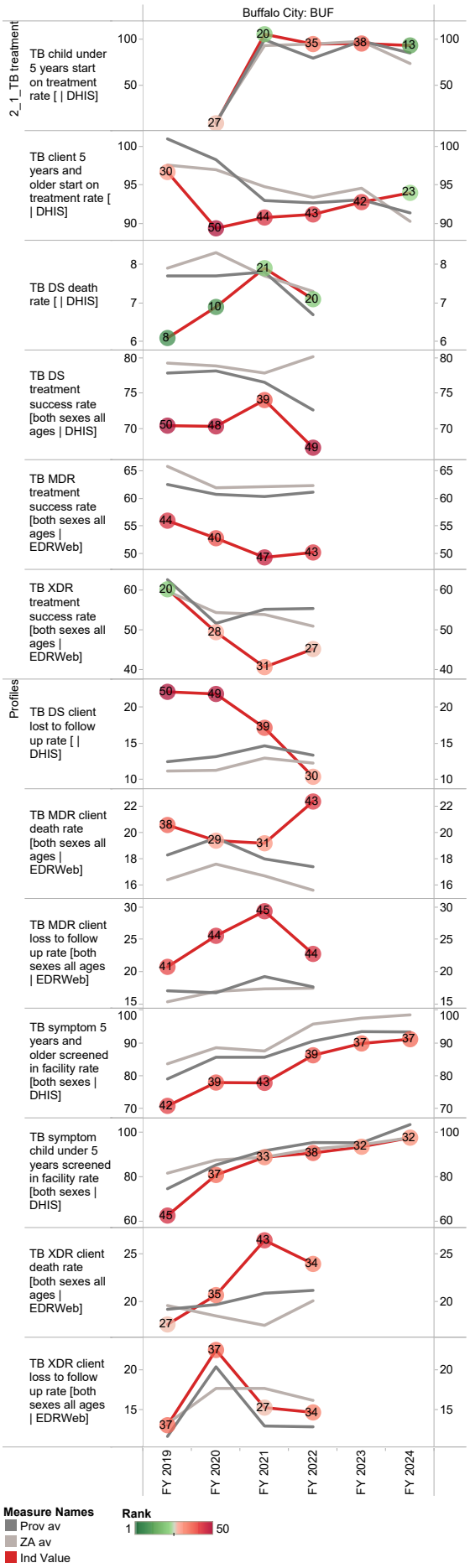


Source: DHIS

Annual trends, 2018/19–2023/24






Buffalo City: BUF
2_1_TB treatment
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
TB DS death rate [| DHIS]
TB DS treatment success rate [both sexes all ages | DHIS]
TB MDR treatment success rate [both sexes all ages | EDRWeb]
TB XDR treatment success rate [both sexes all ages | EDRWeb]
Profiles
TB DS client lost to follow up rate [| DHIS]
TB MDR client death rate [both sexes all ages | EDRWeb]
TB MDR client loss to follow up rate [both sexes all ages | EDRWeb]
TB symptom 5 years and older screened in facility rate [both sexes | DHIS]
TB symptom child under 5 years screened in facility rate [both sexes | DHIS]
TB XDR client death rate [both sexes all ages | EDRWeb]
TB XDR client loss to follow up rate [both sexes all ages | EDRWeb]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
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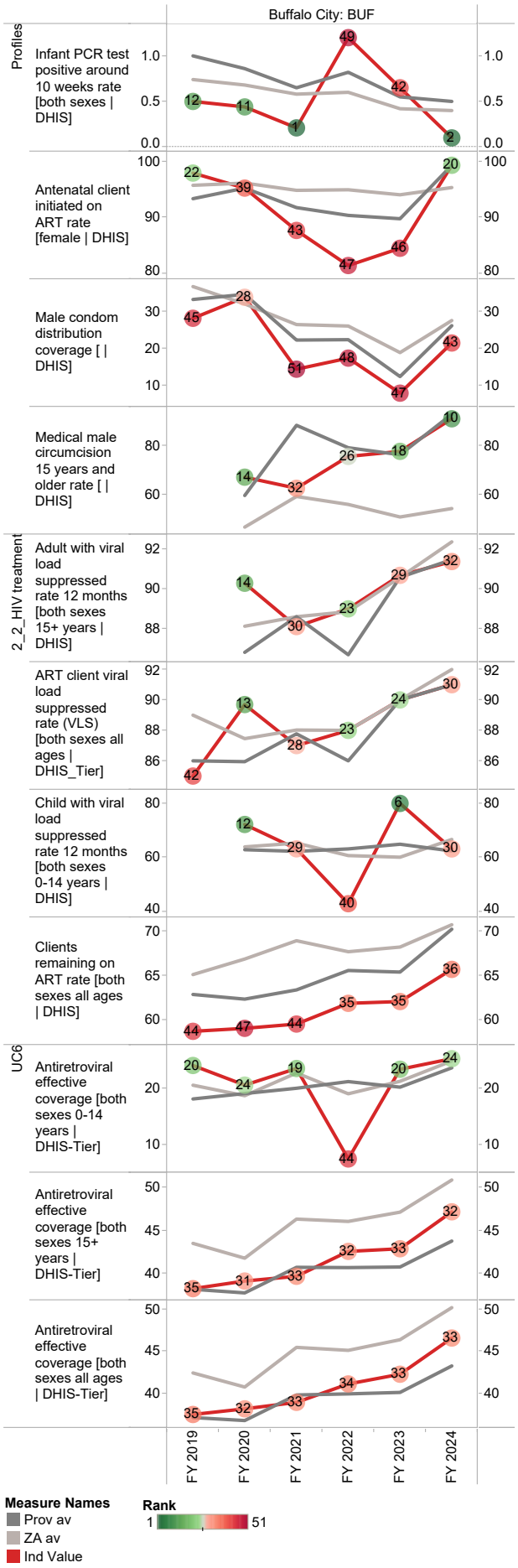
50


Buffalo City: BUF
Profiles
Infant PCR test positive around 10 weeks rate [both sexes | DHIS]
Antenatal client initiated on ART rate [female | DHIS]
Male condom distribution coverage [| DHIS]
Medical male circumcision 15 years and older rate [| DHIS]
2_2_HIV treatment
Adult with viral load suppressed rate 12 months [both sexes 15+ years | DHIS]
ART client viral load suppressed rate (VLS) [both sexes all ages | DHIS_Tier]
Child with viral load suppressed rate 12 months [both sexes 0-14 years | DHIS]
Clients remaining on ART rate [both sexes all ages | DHIS]
UC6
Antiretroviral effective coverage [both sexes 0-14 years | DHIS-Tier]
Antiretroviral effective coverage [both sexes 15+ years | DHIS-Tier]
Antiretroviral effective coverage [both sexes all ages | DHIS-Tier]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
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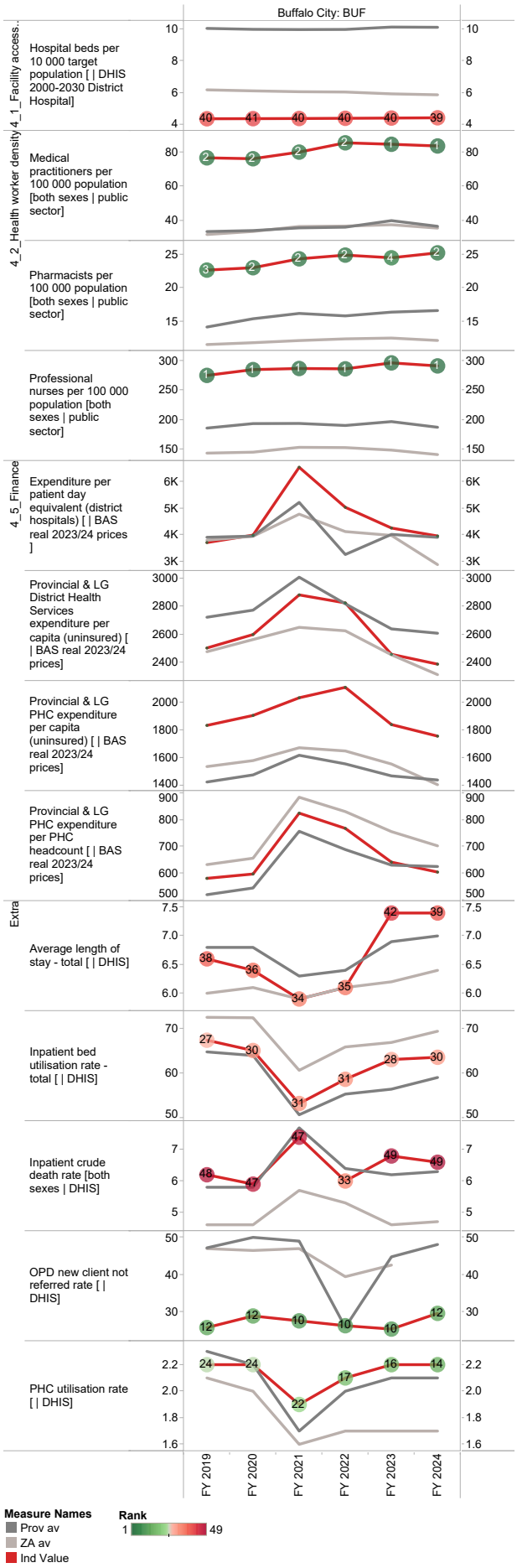
51


Buffalo City: BUF
4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
4_2_Health worker density
Medical practitioners per 100 000 population [both sexes | public sector]
Pharmacists per 100 000 population [both sexes | public sector]
Professional nurses per 100 000 population [both sexes | public sector]
4_5_Finance
Expenditure per patient day equivalent (district hospitals) [| BAS real 2023/24 prices]
Provincial & LG District Health Services expenditure per capita (uninsured) [| BAS real 2023/24 prices]
Provincial & LG PHC expenditure per capita (uninsured) [| BAS real 2023/24 prices]
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Extra
Average length of stay - total [| DHIS]
Inpatient bed utilisation rate - total [| DHIS]
Inpatient crude death rate [both sexes | DHIS]
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PHC utilisation rate [| DHIS]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
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49

Sarah Baartman District Municipality (DC10)

The Sarah Baartman District Municipality[3] is a Category C municipality situated in the Eastern Cape Province. Sarah Baartman is the largest district in the province, making up approximately a third of its geographical area. It comprises seven local municipalities: Dr Beyers Naudé, Blue Crane Route, Makana, Ndlambe, Sundays River Valley, Kouga and Koukamma.

Area: 58 244km²

Population (2023)[4]: 488 581

HouseholdsC: 138 182

Formal dwellings[3]: 87.1%

Cities/Towns:

Dr Beyers Naudé: Aberdeen, Adendorp, Graaff-Reinet, Jansenville, Kendrew, Klipplaat, Nieu-Bethesda, Rietbron, Steytlerville, Waterford, Willowmore

Blue Crane Route: Cookhouse, Pearston, Petersburg, Somerset East

Makana: Alicedale, Makhanda (Grahamstown), Riebeek East, Sidbury,

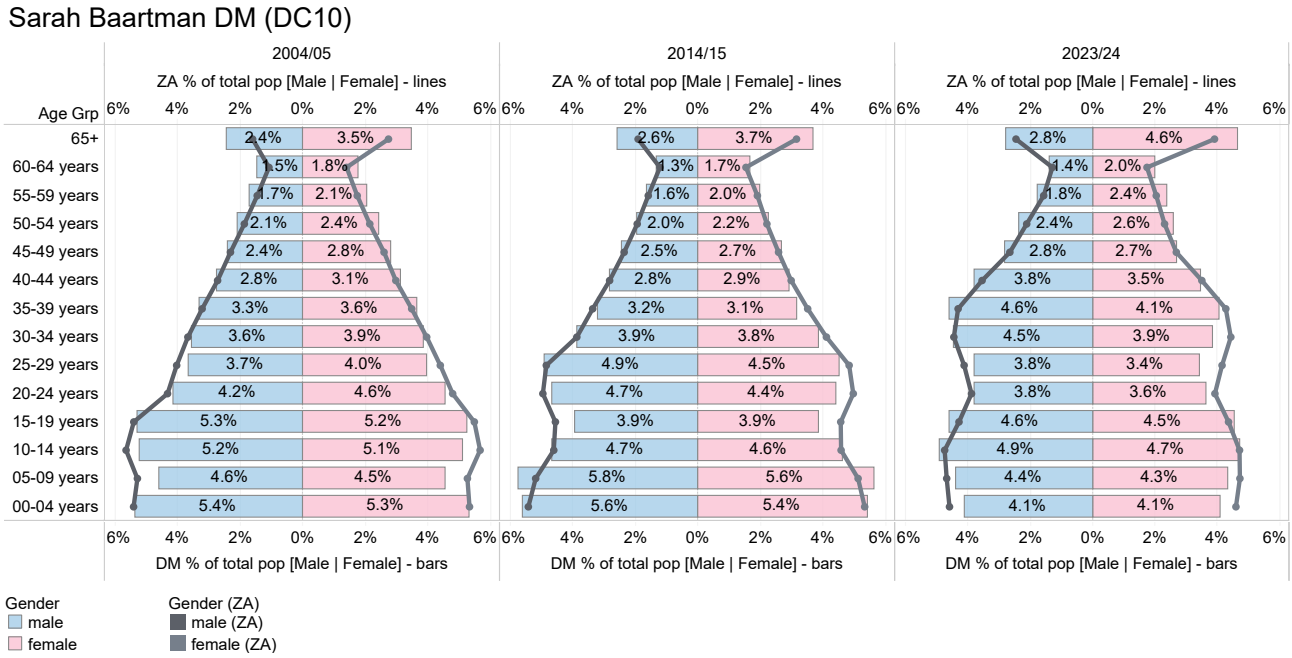
Ndlambe: Alexandria, Bathurst, Boknes/Cannon Rocks, Bushmans River, Kenton-on-Sea, Port Alfred, Seafield

Sundays River Valley: Addo, Kirkwood, Paterson

Kouga: Cape St Francis, Hankey, Humansdorp, Jeffreys Bay, Loerie, Oyster Bay, Patensie, St Francis Bay, Thornhill

Koukamma: Clarkson, Joubertina, Kareedouw, Krakeel River, Louterwater, Misgund, Nompumelelo, Sanddrif, Storms River, Woodlands

District percentage population by age-gender group compared to South Africa

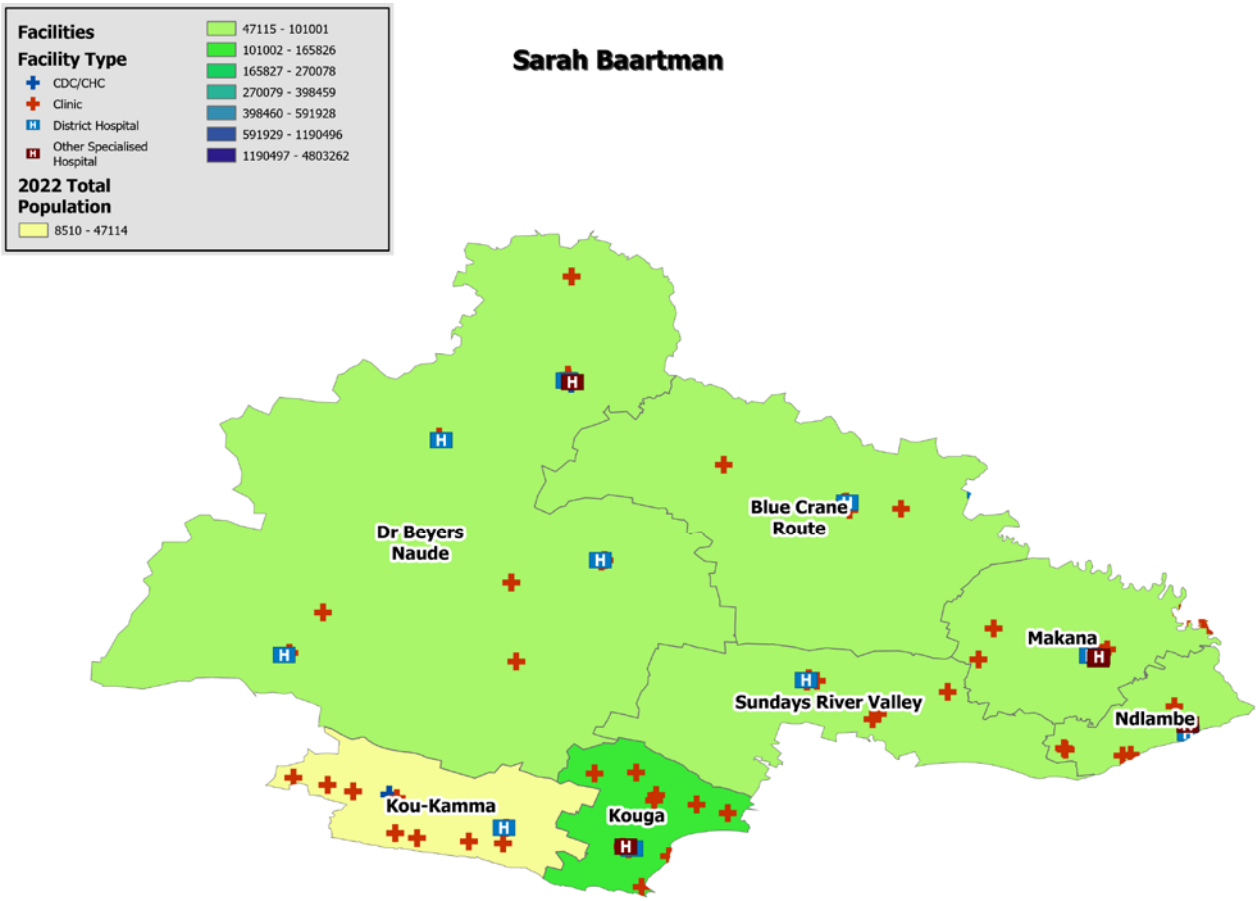


Source: DHIS

3 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

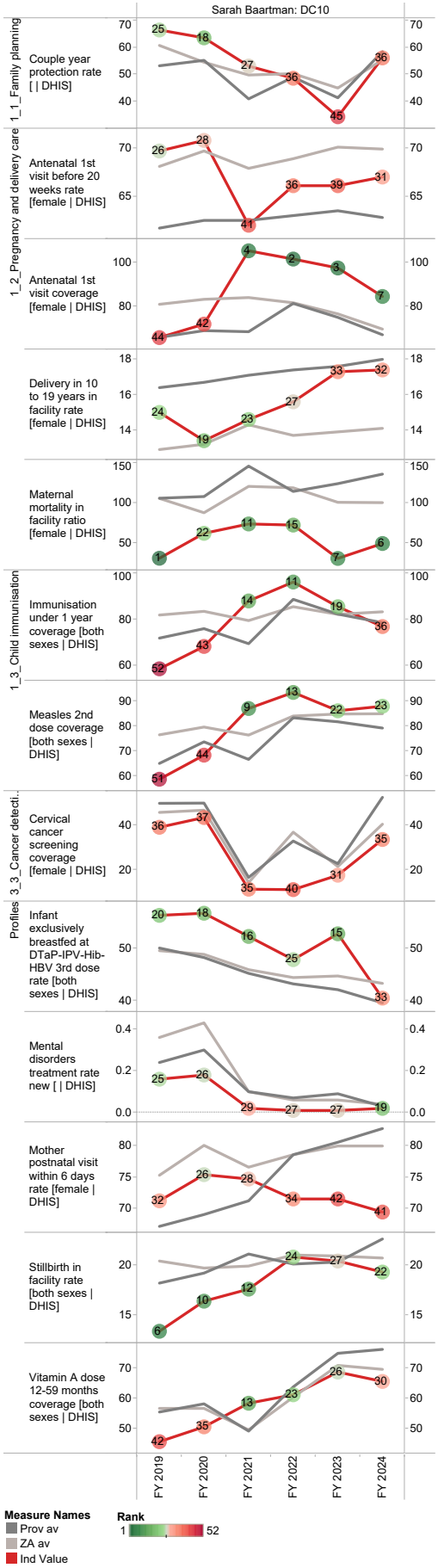
4 Mid-year Population Estimates 2023, DHIS.

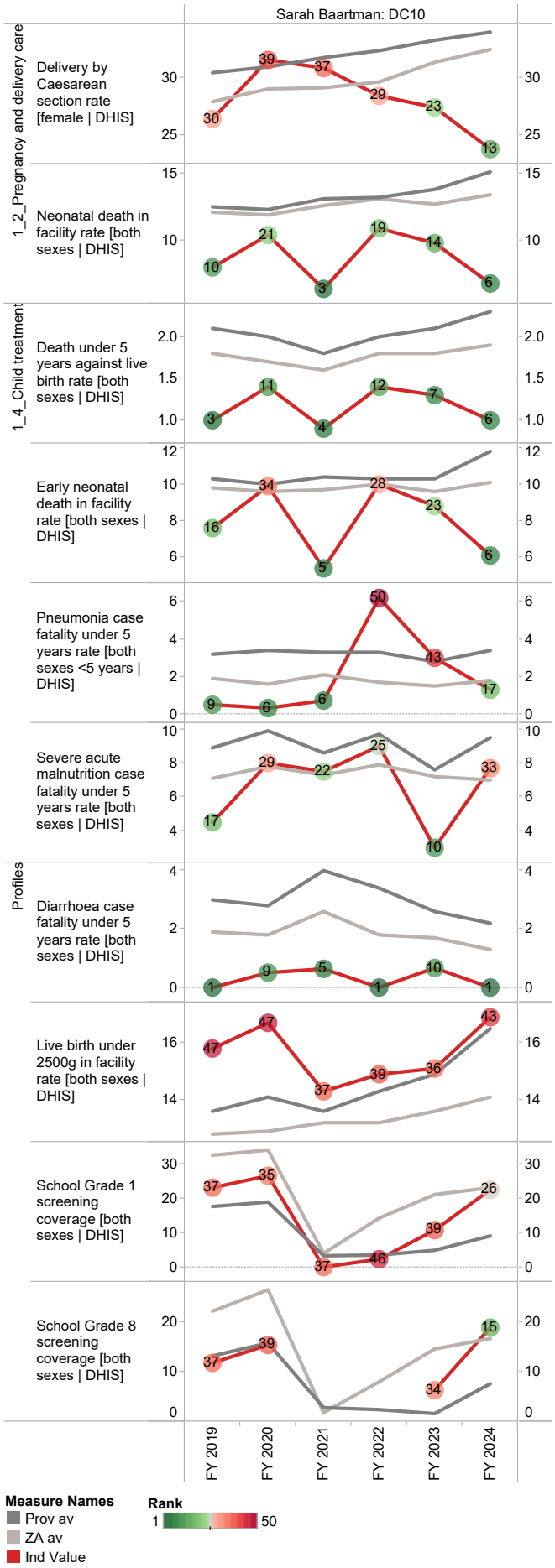
Population distribution, sub-district boundaries and health facility locations

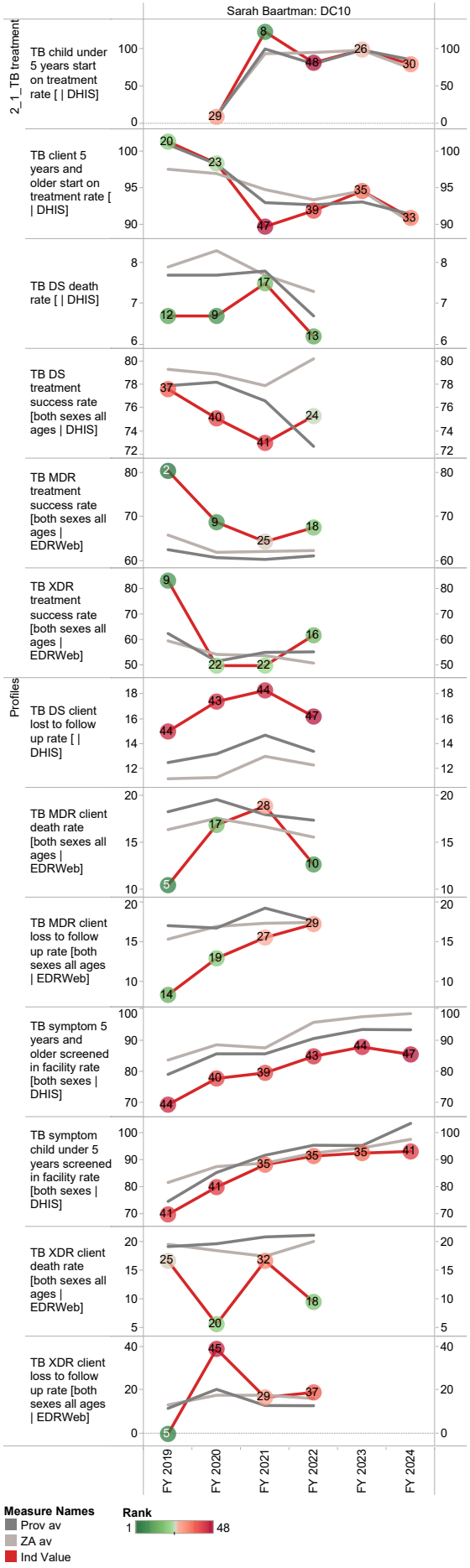


Source: DHIS

Annual trends, 2018/19–2023/24






Sarah Baartman: DC10
2_1_TB treatment
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
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TB DS treatment success rate [both sexes all ages | DHIS]
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FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
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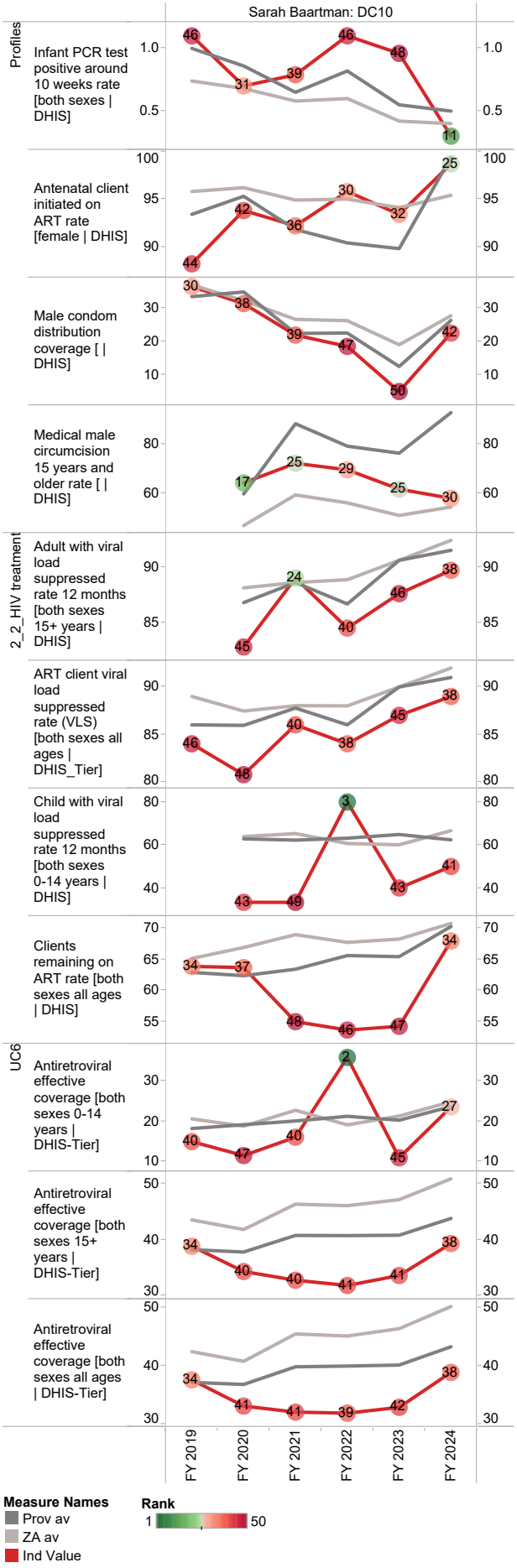
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Infant PCR test positive around 10 weeks rate [both sexes | DHIS]
Antenatal client initiated on ART rate [female | DHIS]
Male condom distribution coverage [| DHIS]
Medical male circumcision 15 years and older rate [| DHIS]
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FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
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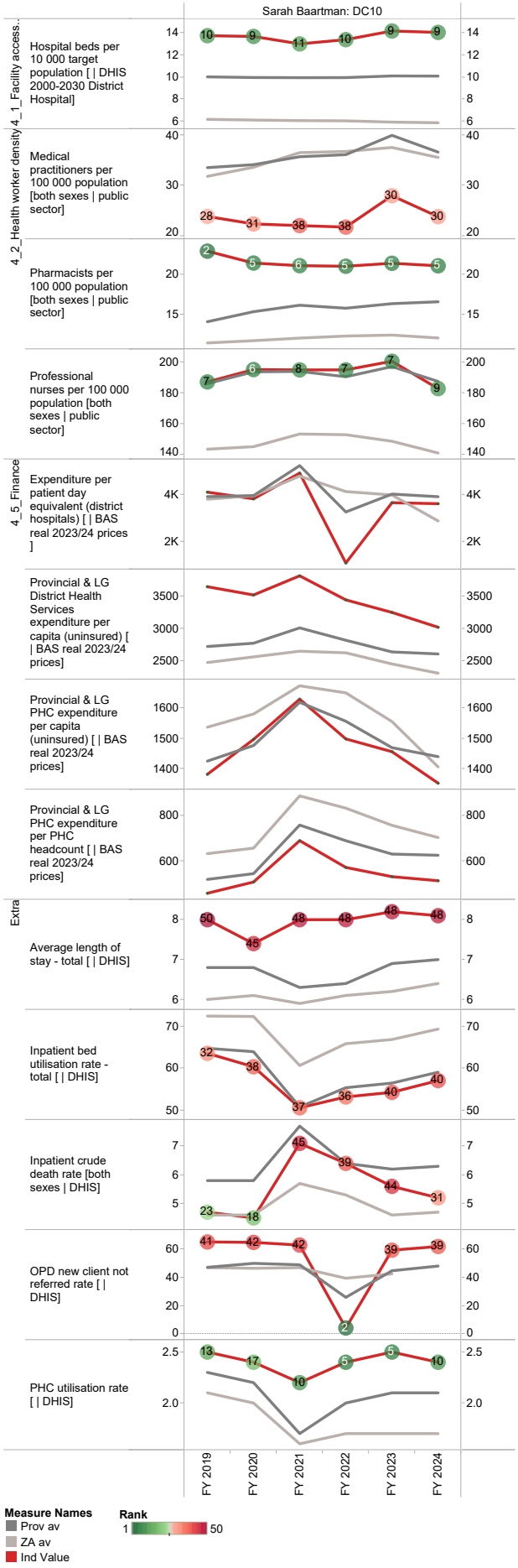
50


Sarah Baartman: DC10
4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
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FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
1
50

Amathole District Municipality (DC12)

The Amathole District Municipality[5] is a Category C municipality situated in the central part of the Eastern Cape. The district comprises six local municipalities: Mbhashe, Mnquma, Great Kei, Amahlathi, Ngqushwa and Raymond Mhlaba.

Area: 21 114km²

Population (2023)[6]: 762 037

Householdse: 213 763

Formal dwellings[5]: 55.9%

Cities/Towns:

Amahlathi: Cathcart, Kei Road, Keiskammahoek, Stutterheim

Great Kei: Komga, Morgan Bay, Kei Mouth, Amatola Coastal

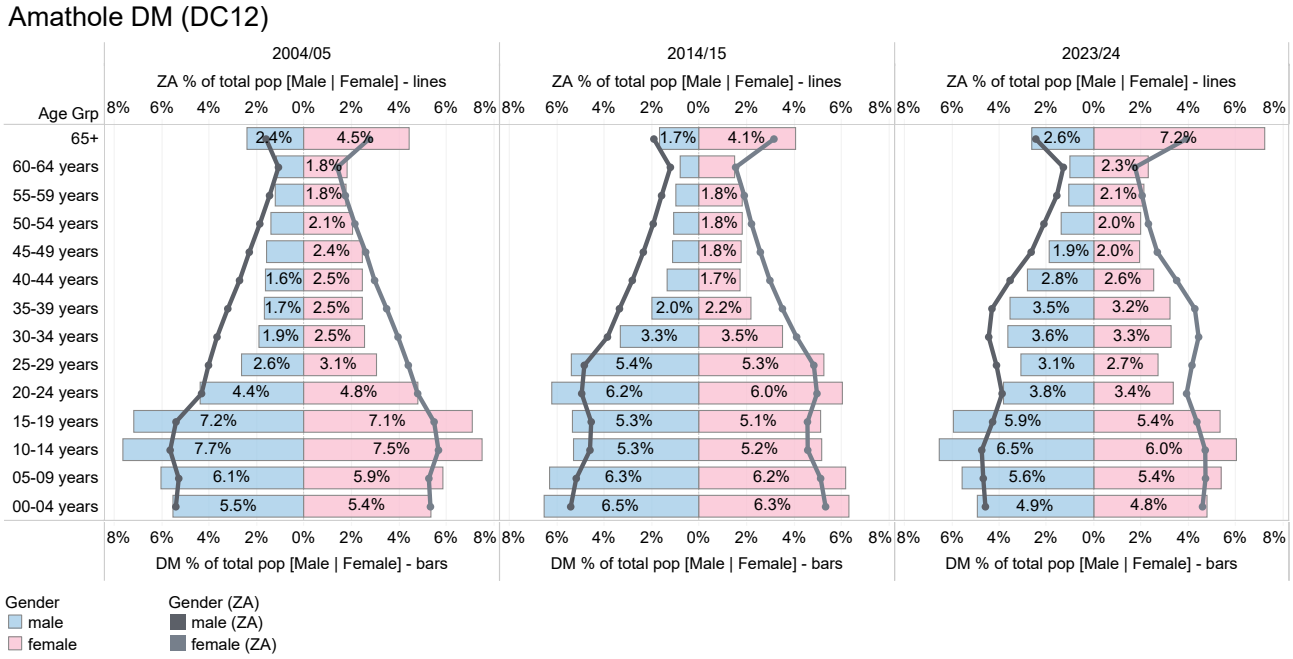
Mbhashe: Dutywa, Elliotdale, Fort Beaufort, Willowvale

Mnquma: Butterworth, Kentani, Ngqamakhwe

Ngqushwa: Hamburg, Peddie

Raymond Mhlaba: Adelaide, Alice, Bedford, Hogsback, Middeldrift, Seymore

District percentage population by age-gender group compared to South Africa

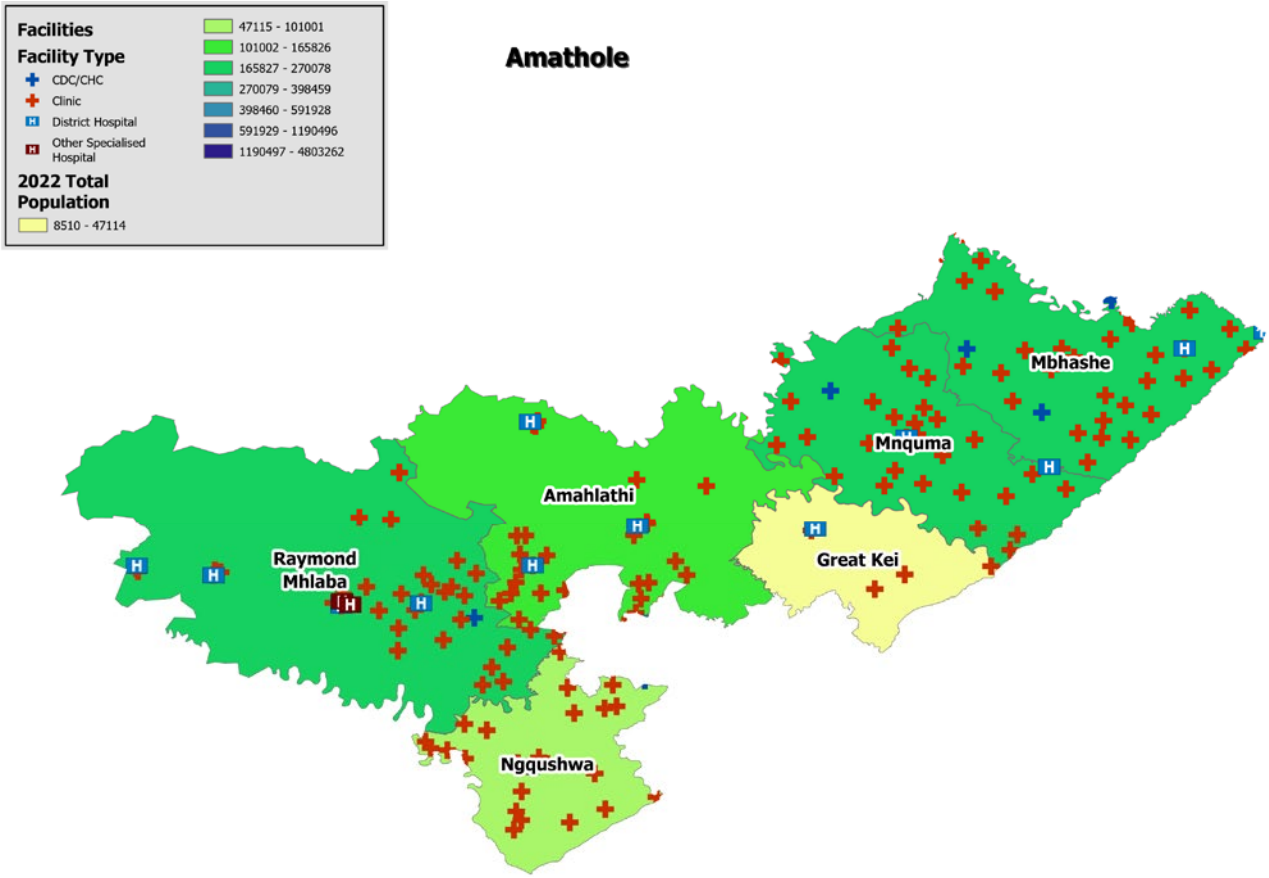


Source: DHIS

5 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

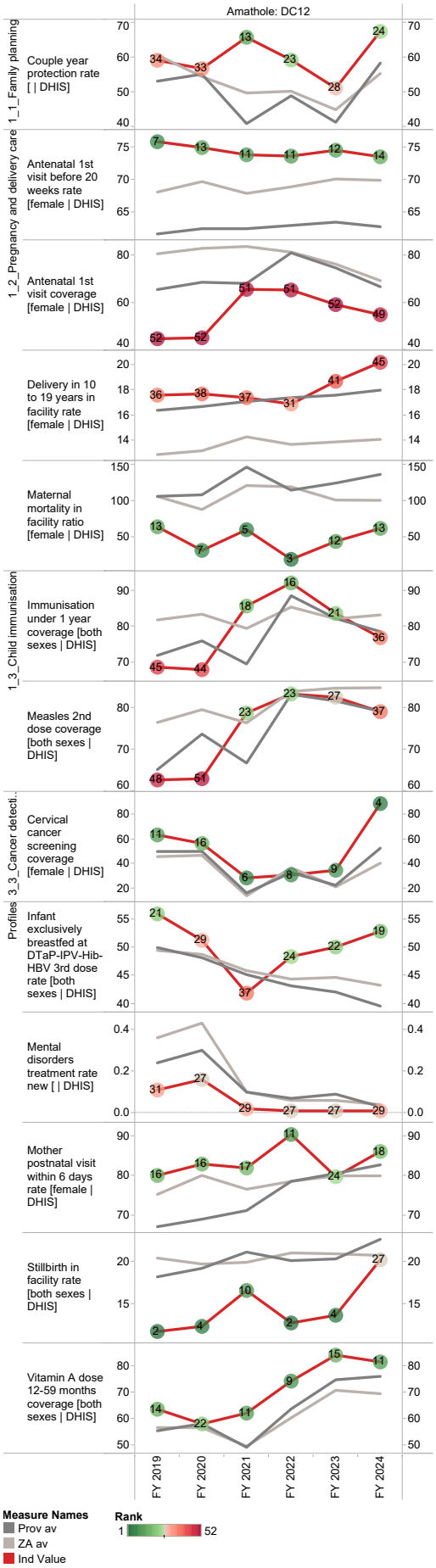
6 Mid-year Population Estimates 2023, DHIS.

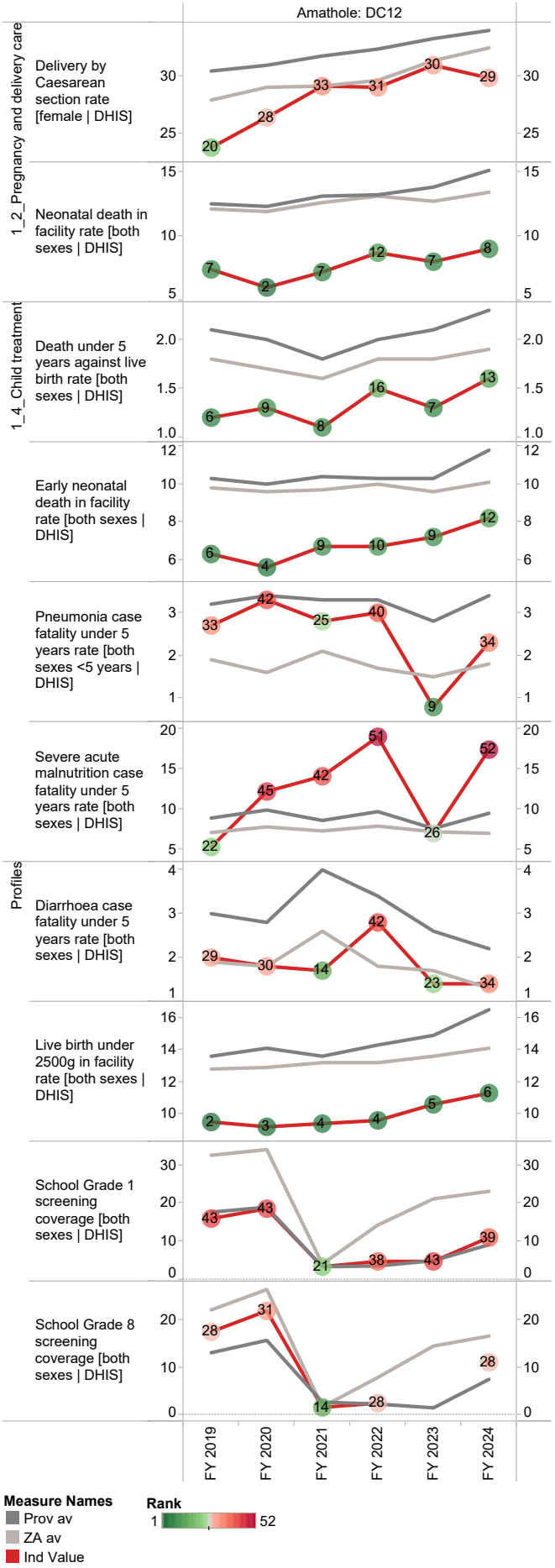
Population distribution, sub-district boundaries and health facility locations

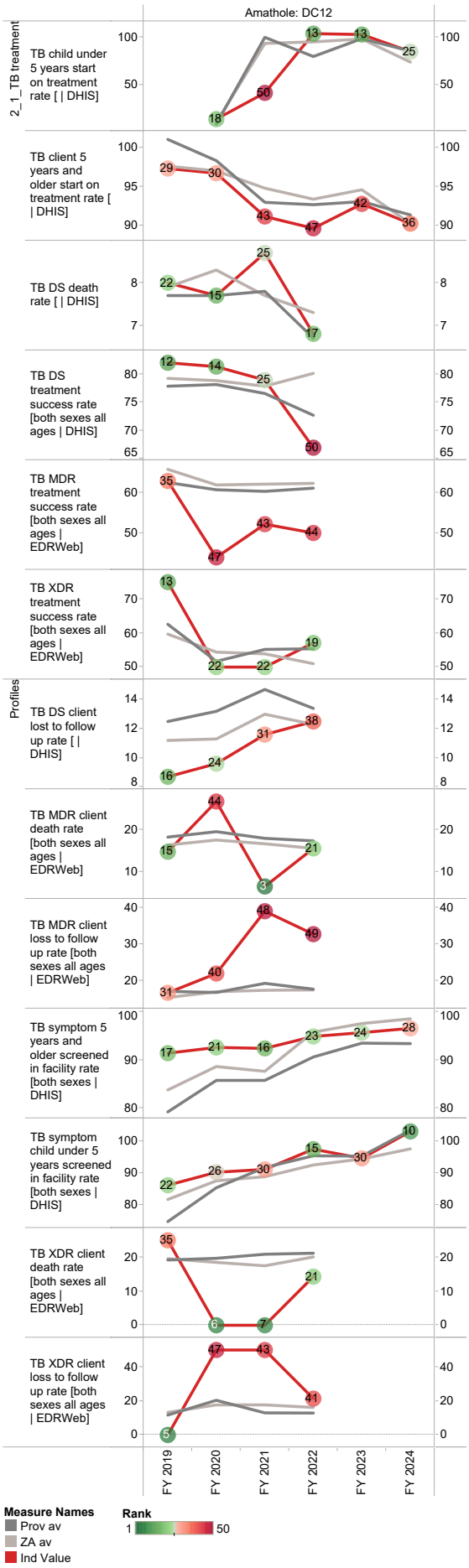


Source: DHIS

Annual trends, 2018/19–2023/24






Amathole: DC12
2_1_TB treatment
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
TB DS death rate [| DHIS]
TB DS treatment success rate [both sexes all ages | DHIS]
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TB symptom child under 5 years screened in facility rate [both sexes | DHIS]
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FY 2019
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Measure Names
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Ind Value
Rank
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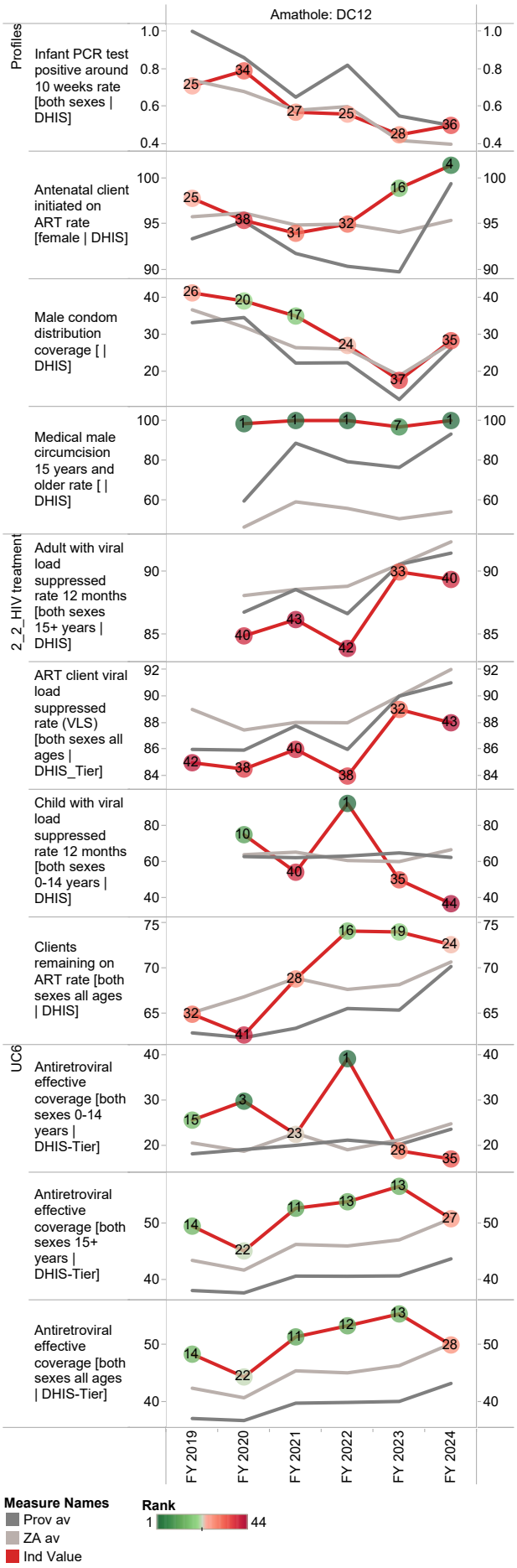
50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Infant PCR test positive around 10 weeks rate [both sexes | DHIS]
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FY 2019
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Ind Value
Rank
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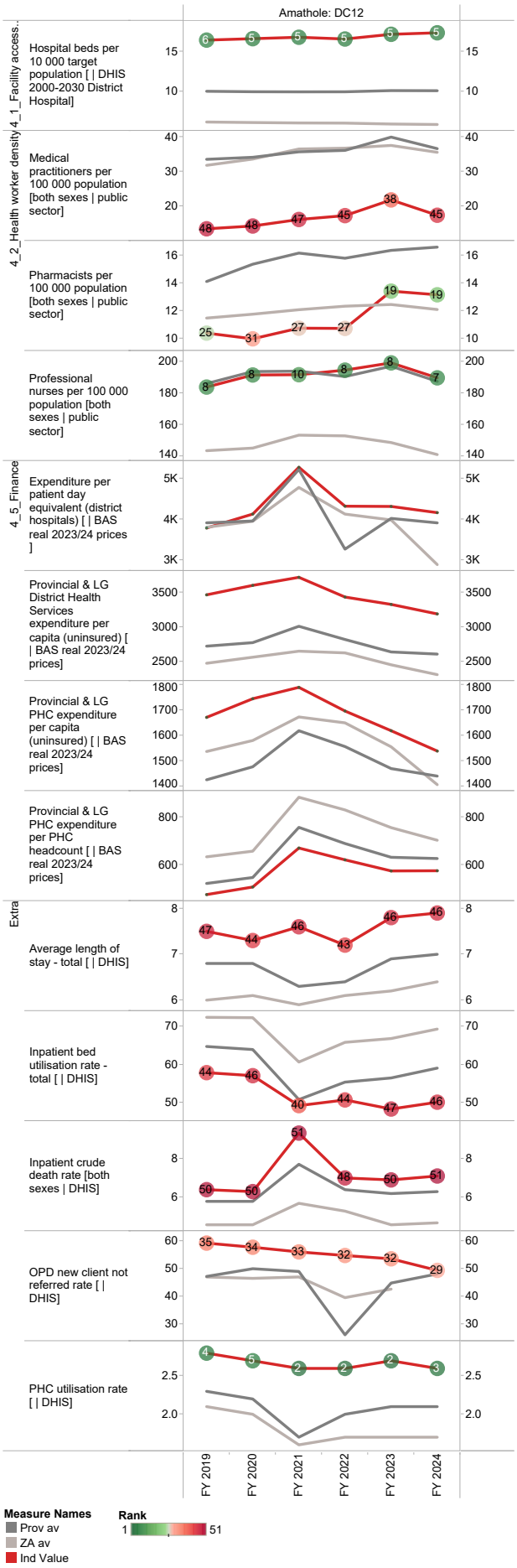
44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PHC utilisation rate [| DHIS]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
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Prov av
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51

Chris Hani District Municipality (DC13)

The Chris Hani District Municipality[7] is a Category C municipality situated in the north-eastern part of the Eastern Cape, and is a linking node to all regions in the province. Chris Hani is the second-largest district in the province, making up almost a third of its geographical area. The district comprises six local municipalities: Inxuba Yethemba, Enoch Mgijima, Intsika Yethu, Engcobo, Sakhisizwe and Emalahleni.

Area: 36 406km²

Population (2023)[8]: 692 046

Householdsg: 194 291

Formal dwellings[7]: 56.3%

Cities/Towns:

Inxuba Yethemba: Cradock, Middelburg, Mount Zebra National Park

Enoch Mgijima: Hofmeyr, Komani (Queenstown), Molteno, Sada, Sterkstroom, Tarkastad, Whittlesea

Intsika Yethu: Cofimvaba, Tsomo

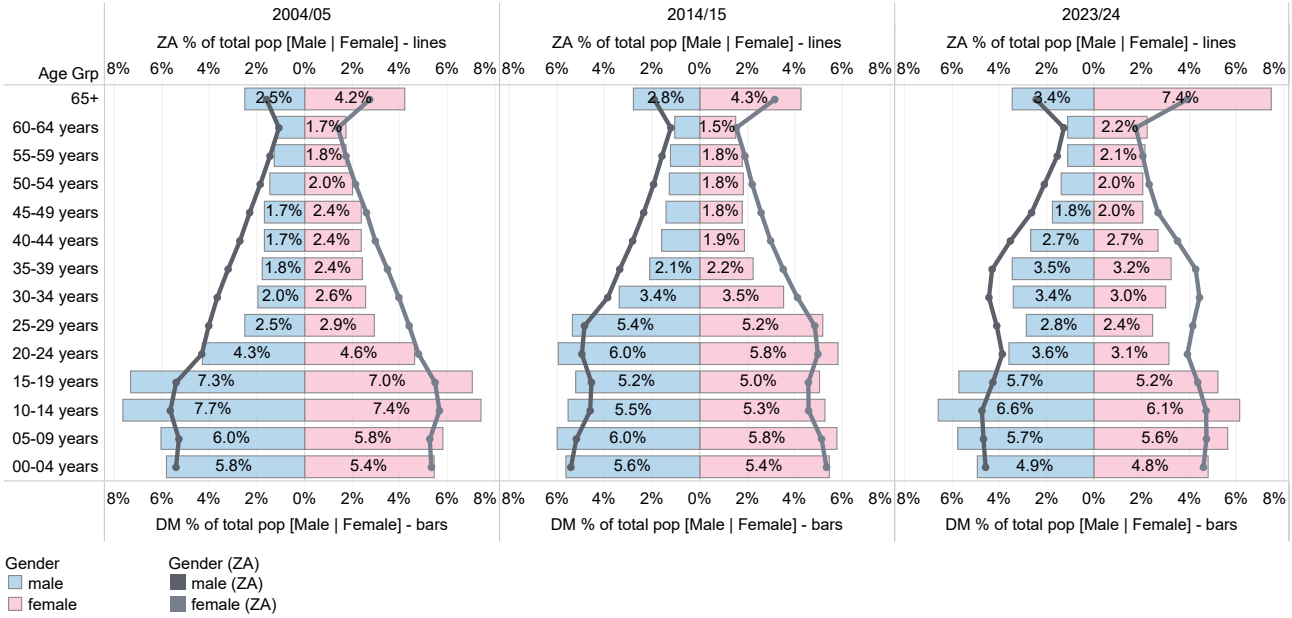
Engcobo: Engcobo

Sakhisizwe: Cala, Khowa (Elliot)

Emalahleni: Cacadu (Lady Frere), Dordrecht, Indwe

District percentage population by age-gender group compared to South Africa

C Hani DM (DC13)



Source: DHIS

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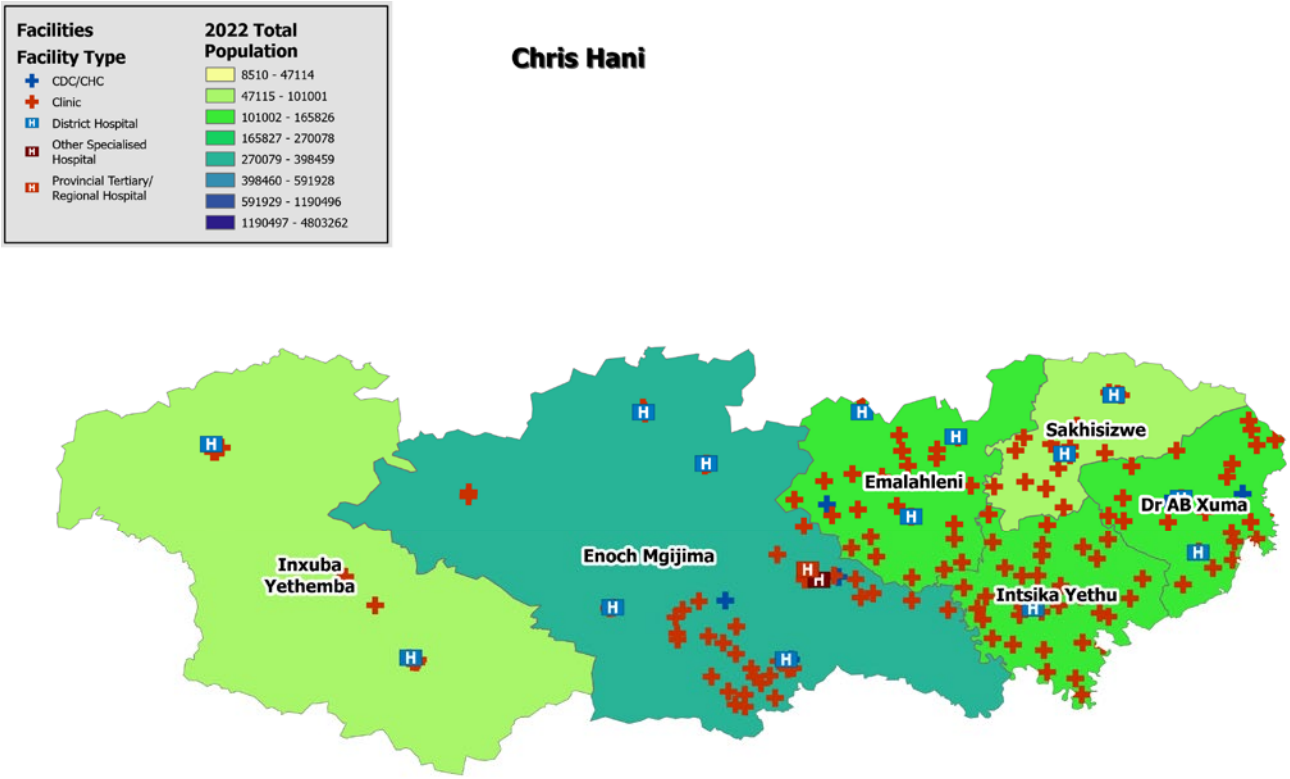
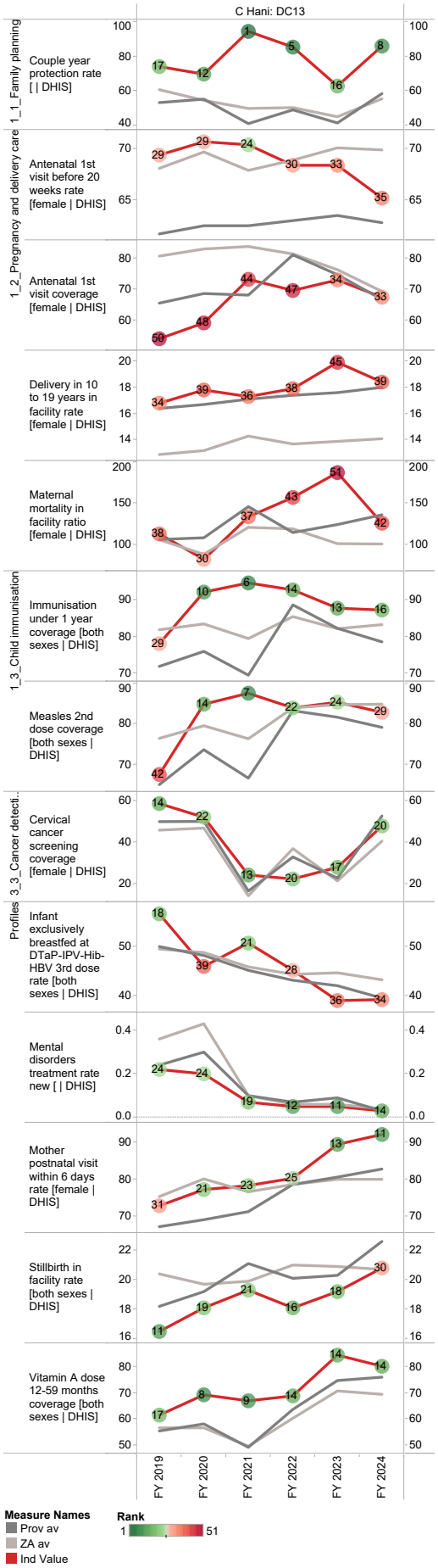
8 Mid-year Population Estimates 2023, DHIS.

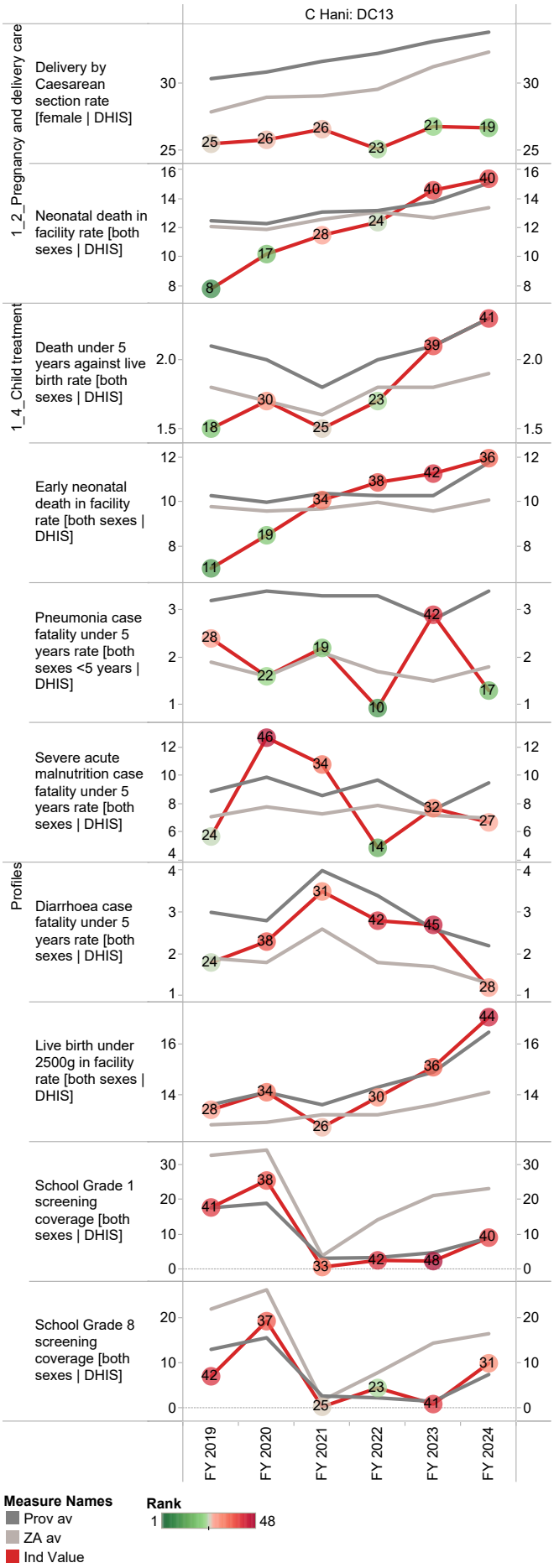
Population distribution, sub-district boundaries and health facility locations

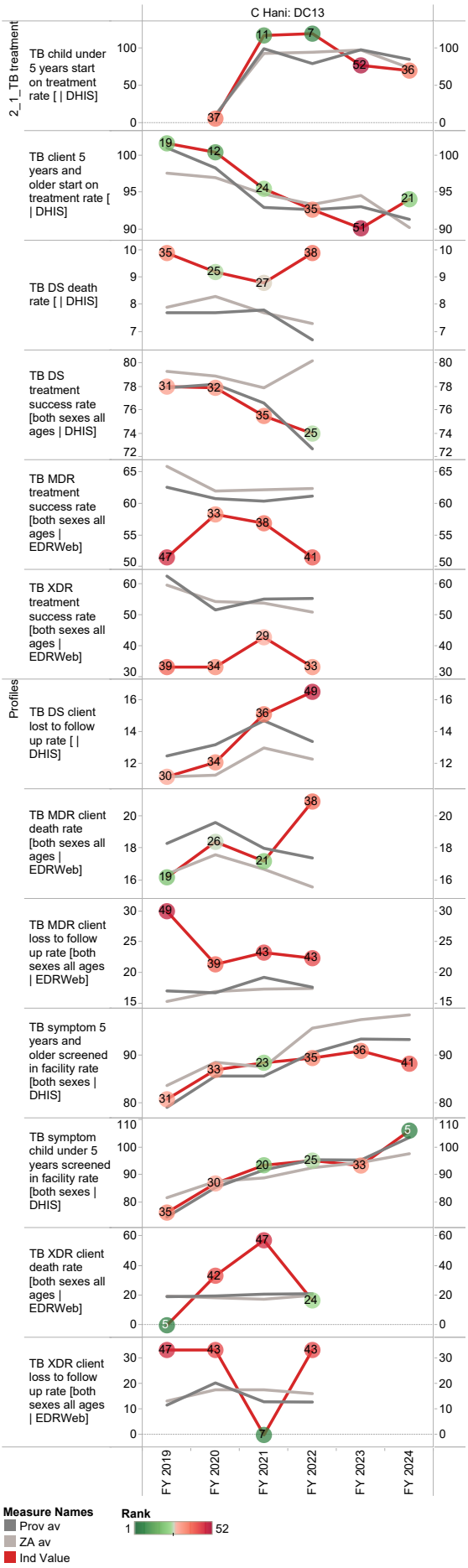


Source: DHIS

Annual trends, 2018/19–2023/24






C Hani: DC13
2_1_TB treatment
Profiles
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FY 2019
FY 2020
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FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
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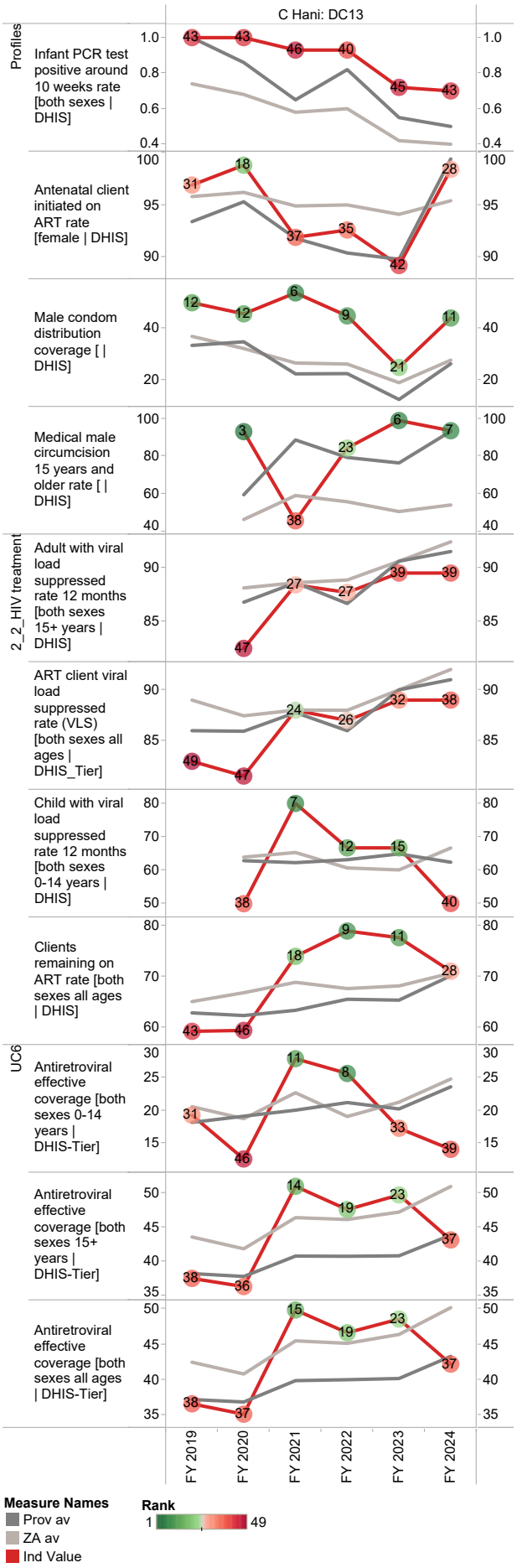
52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FY 2019
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FY 2022
FY 2023
FY 2024
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Prov av
ZA av
Ind Value
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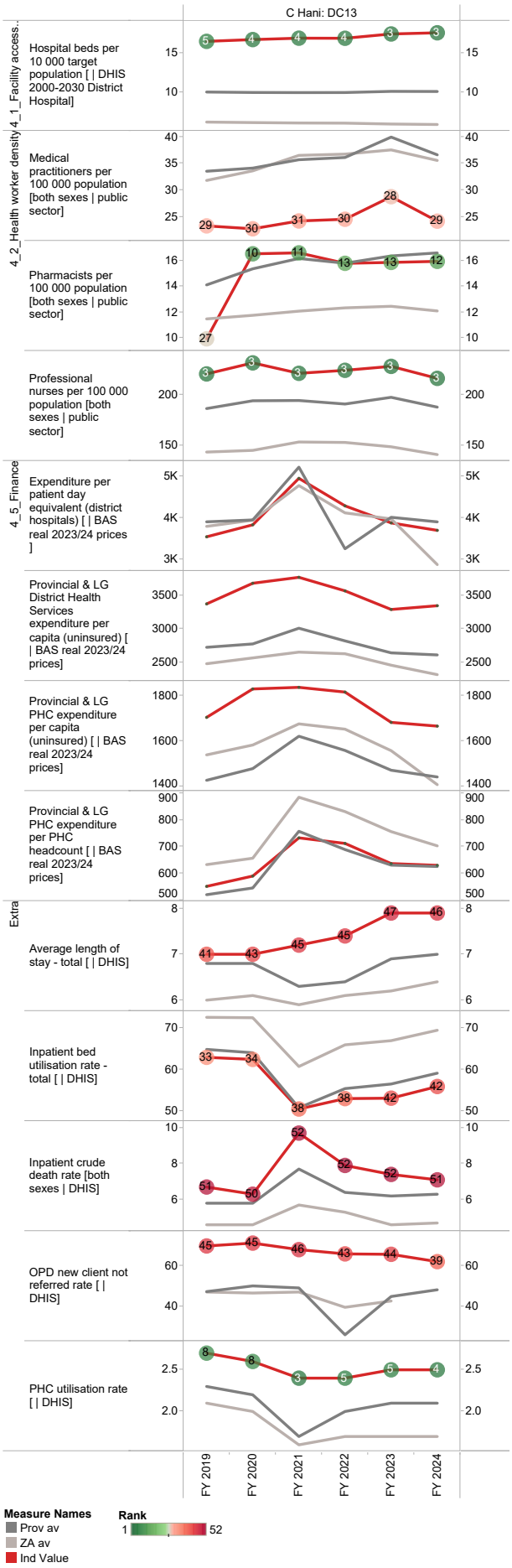
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4_1_Facility access...
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FY 2019
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FY 2023
FY 2024
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1
52

Joe Gqabi District Municipality (DC14)

The Joe Gqabi District Municipality[9] is a Category C municipality located within the Eastern Cape. It consists of three local municipalities: Elundini, Walter Sisulu and Senqu.

Area: 25 617km²

Population (2023)[10]: 334 011

Householdsi: 95 107

Formal dwellings[9]: 69.6%

Cities/Towns:

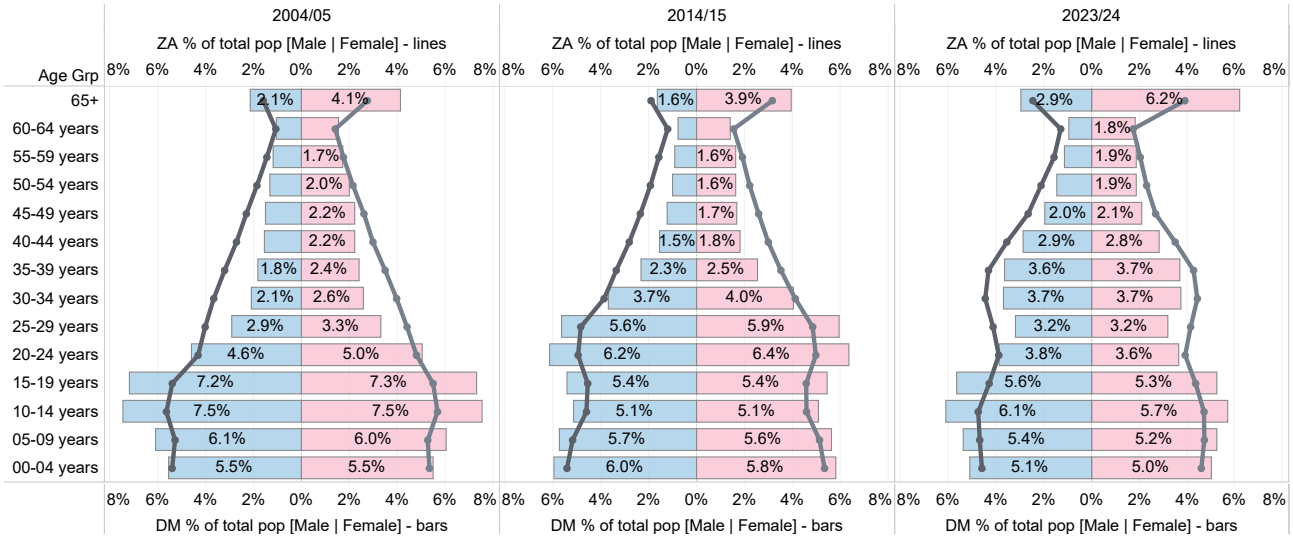
Elundini: Maclear, Mount Fletcher, Ugie

Walter Sisulu: Aliwal North, Burgersdorp, Jamestown, Oviston, Steynsburg, Venterstad

Senqu: Barkly East, Lady Grey, Rhodes, Rossouw, Sterkspruit

District percentage population by age-gender group compared to South Africa

Joe Gqabi DM (DC14)

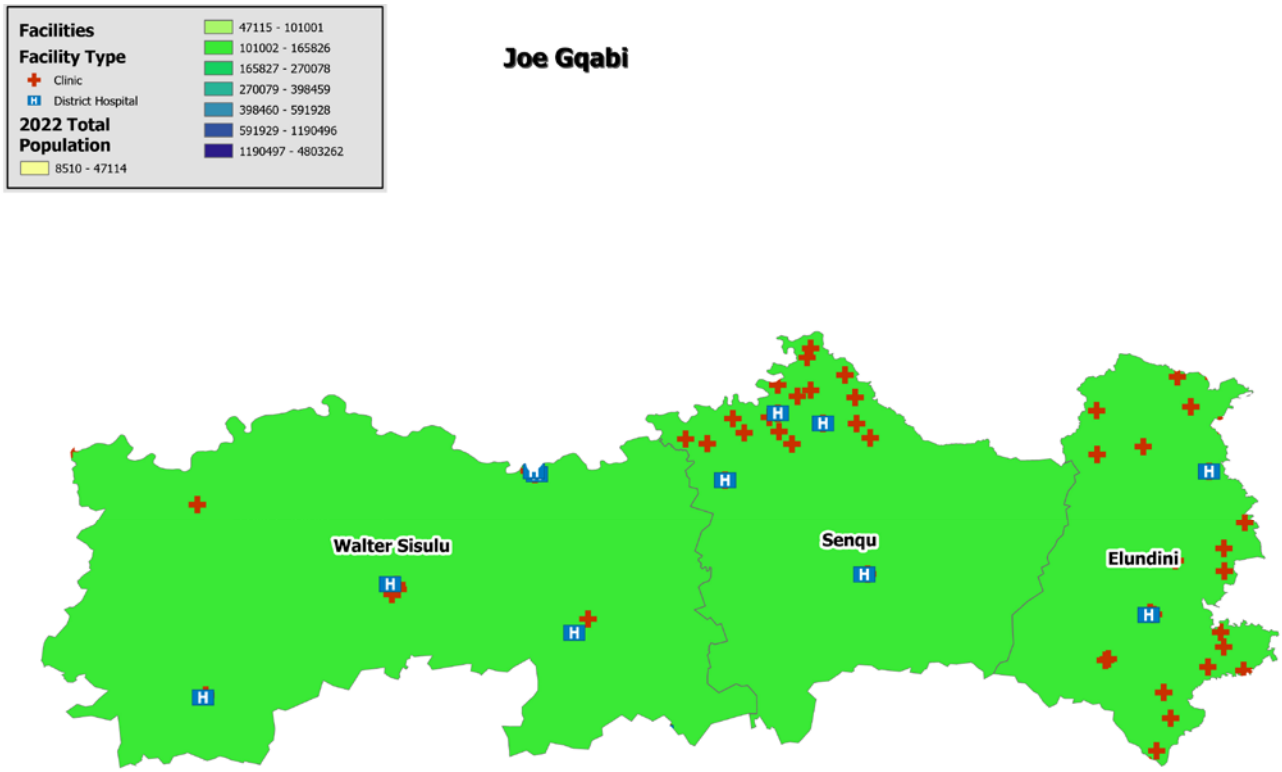


Source: DHIS

9 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

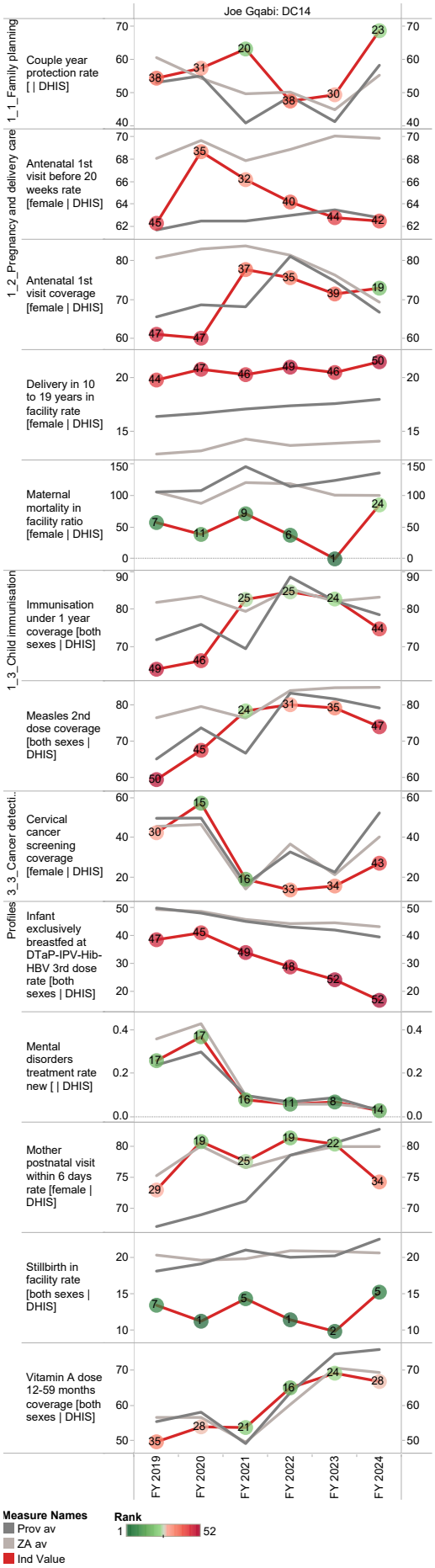
10 Mid-year Population Estimates 2023, DHIS.

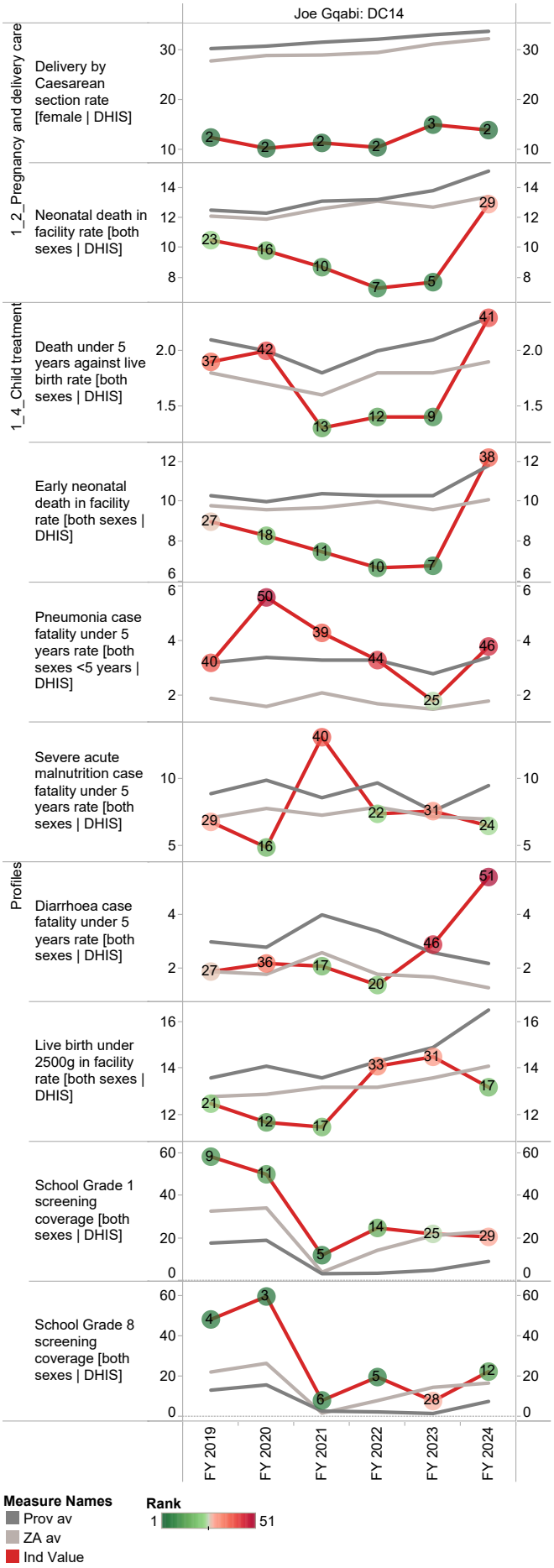
Population distribution, sub-district boundaries and health facility locations

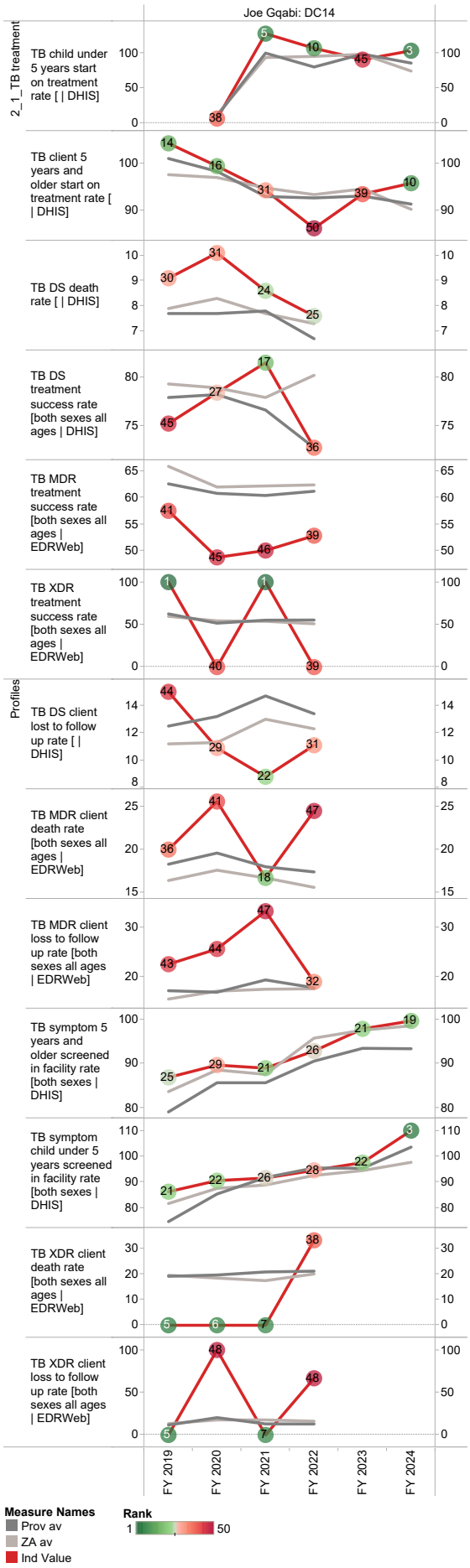


Source: DHIS

Annual trends, 2018/19–2023/24






Joe Gqabi: DC14
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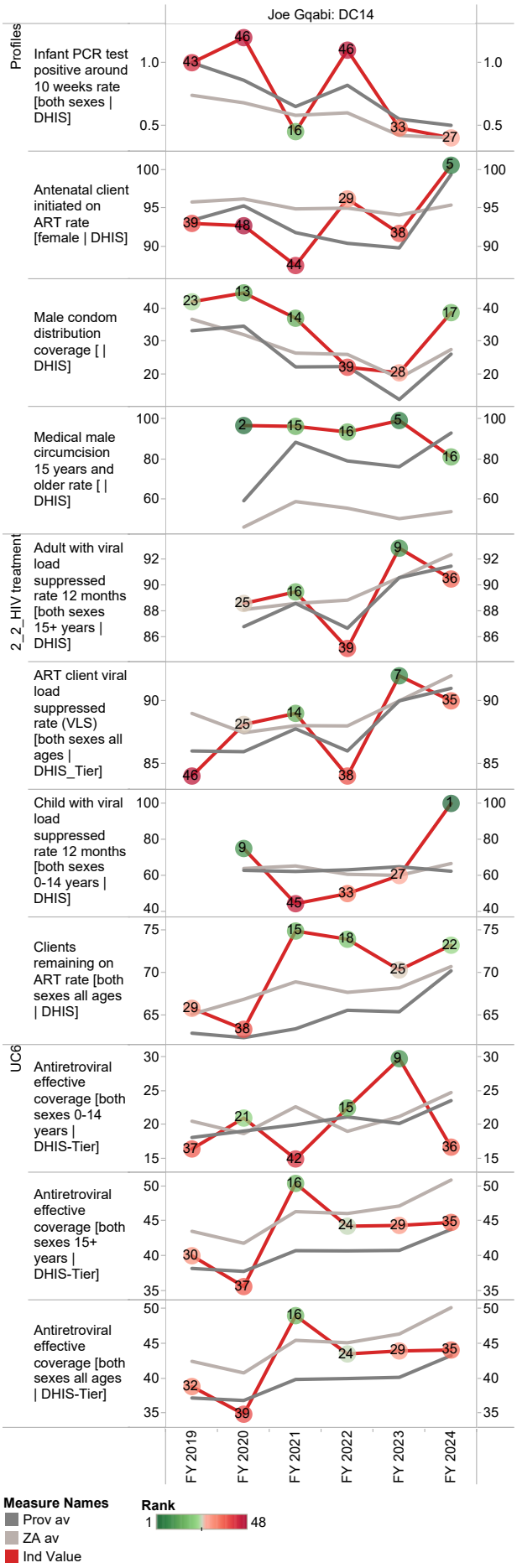
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FY 2019
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FY 2024
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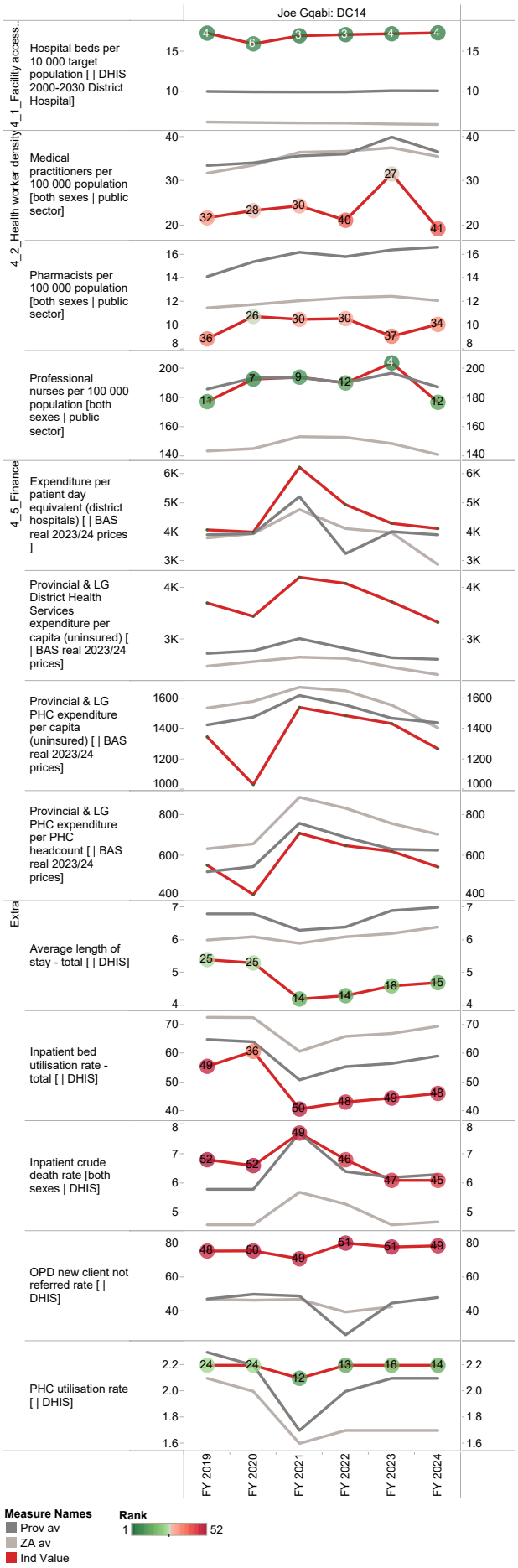
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FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
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Ind Value
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52

OR Tambo District Municipality (DC15)

The OR Tambo District Municipality[11] is a Category C municipality located to the east of the Eastern Cape Province. It covers about 80% of what used to be marginalised homeland in the Transkei. The district is formed by five local municipalities: King Sabata Dalindyebo, Nyandeni, Mhlontlo, Port St Johns and Ingquza Hill.

Area: 12 141km²

Population (2023)[12]: 1 588 236

Householdsk: 314 080

Formal dwellings[11]: 43.6%

Cities/Towns:

King Sabata Dalindyebo: Mqanduli, Mthatha (previously Umtata)

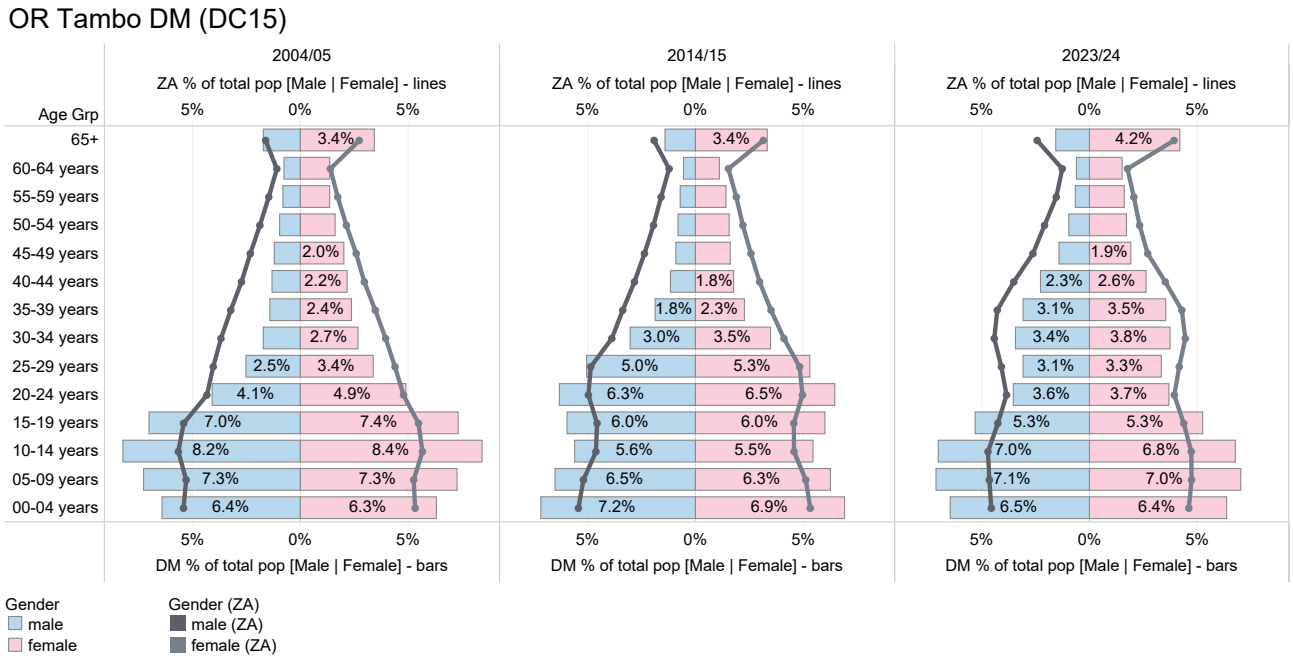
Nyandeni: Libode, Ngqeleni

Mhlontlo: Qumbu, Tsolo

Port St Johns: Port St Johns

Ingquza Hill: Flagstaff, Lusikisiki

District percentage population by age-gender group compared to South Africa



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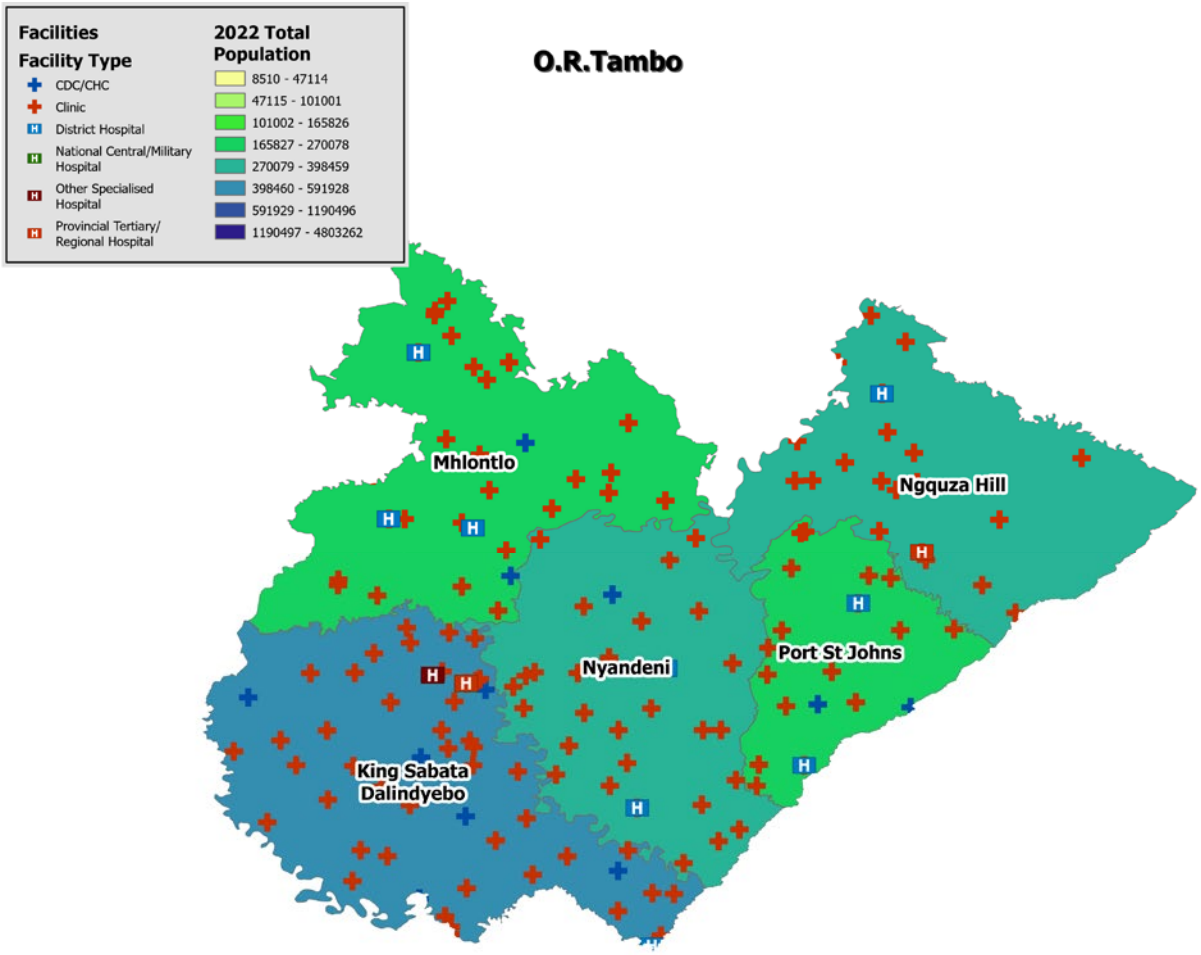

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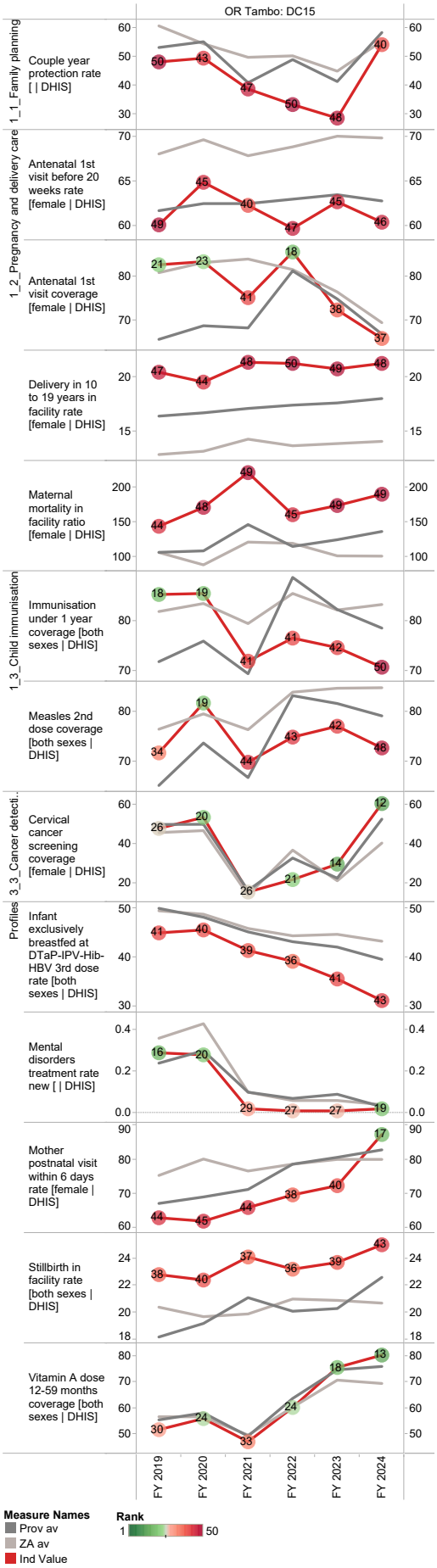

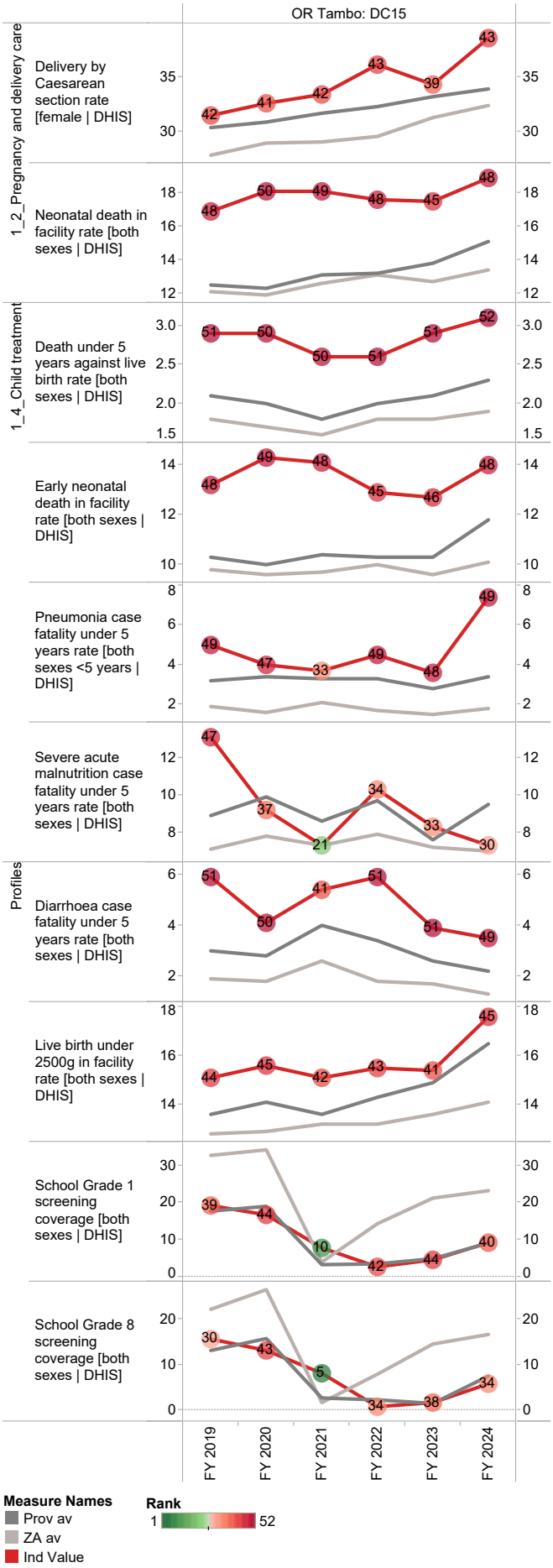

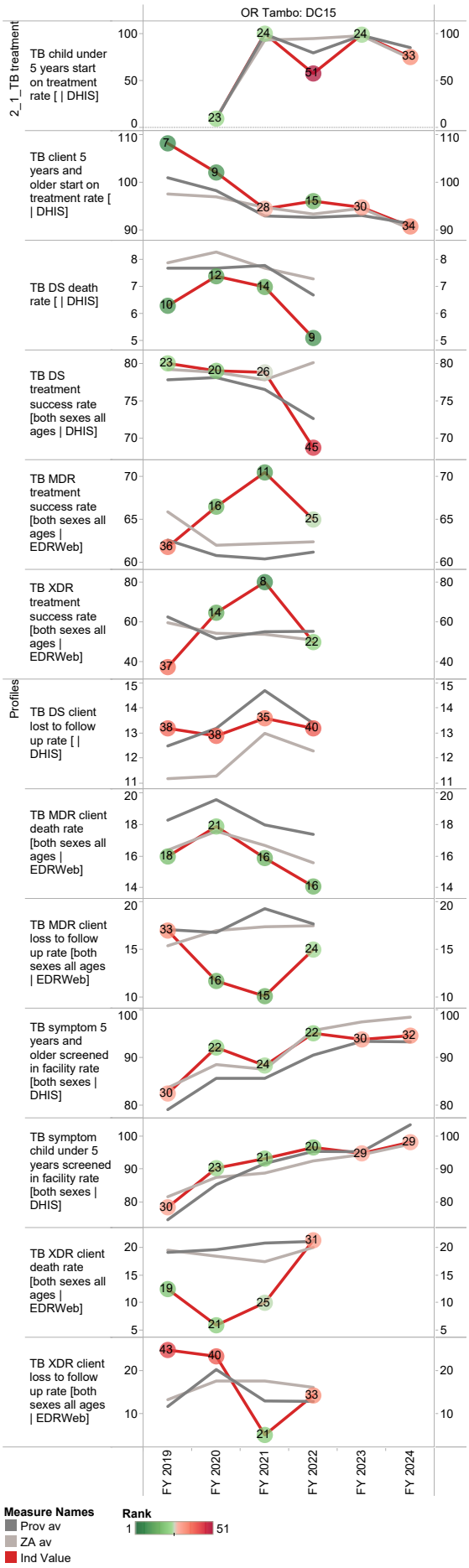
OR Tambo: DC15
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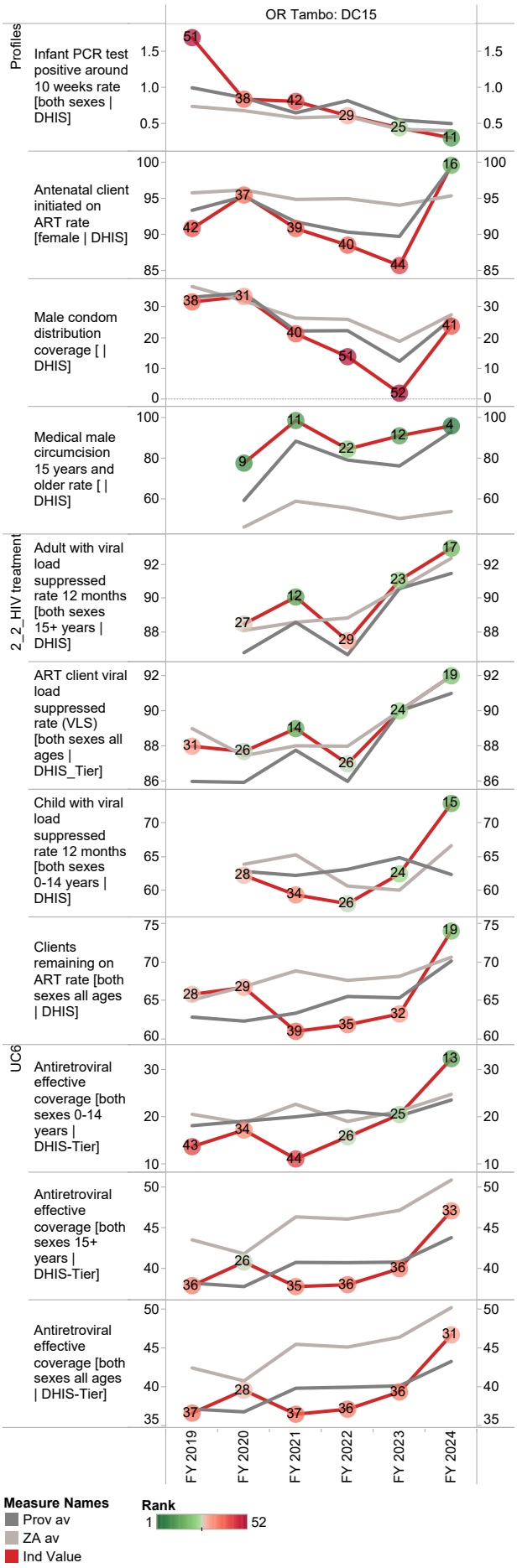
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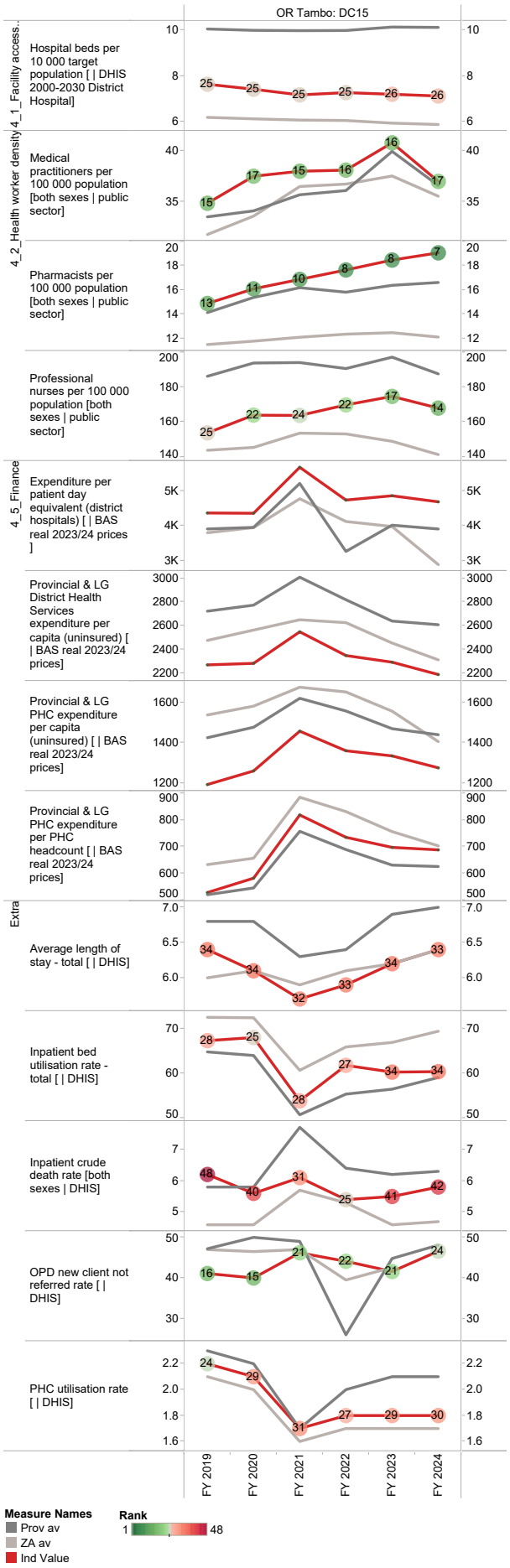
1
52


OR Tambo: DC15
4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
4_2_Health worker density
Medical practitioners per 100 000 population [both sexes | public sector]
Pharmacists per 100 000 population [both sexes | public sector]
Professional nurses per 100 000 population [both sexes | public sector]
4_5_Finance
Expenditure per patient day equivalent (district hospitals) [| BAS real 2023/24 prices]
Provincial & LG District Health Services expenditure per capita (uninsured) [| BAS real 2023/24 prices]
Provincial & LG PHC expenditure per capita (uninsured) [| BAS real 2023/24 prices]
Provincial & LG PHC expenditure per PHC headcount [| BAS real 2023/24 prices]
Extra
Average length of stay - total [| DHIS]
Inpatient bed utilisation rate - total [| DHIS]
Inpatient crude death rate [both sexes | DHIS]
OPD new client not referred rate [| DHIS]
PHC utilisation rate [| DHIS]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
1
48

Alfred Nzo District Municipality (DC44)

The Alfred Nzo District Municipality[13] is a Category C municipality located in the north-eastern corner of the Eastern Cape Province. Alfred Nzo is the smallest district in the province, covering only 6% of the geographical area. The district comprises the Matatiele, Ntabankulu, Winnie Madikizela-Mandela (previously Mbizana) and Umzimvubu Local Municipalities.

Area: 10 731km²

Population (2023)[14]: 834 220

Householdsm: 195 975

Formal dwellings[13]: 42.6%

Cities/Towns:

Matatiele: Cedarville, Matatiele

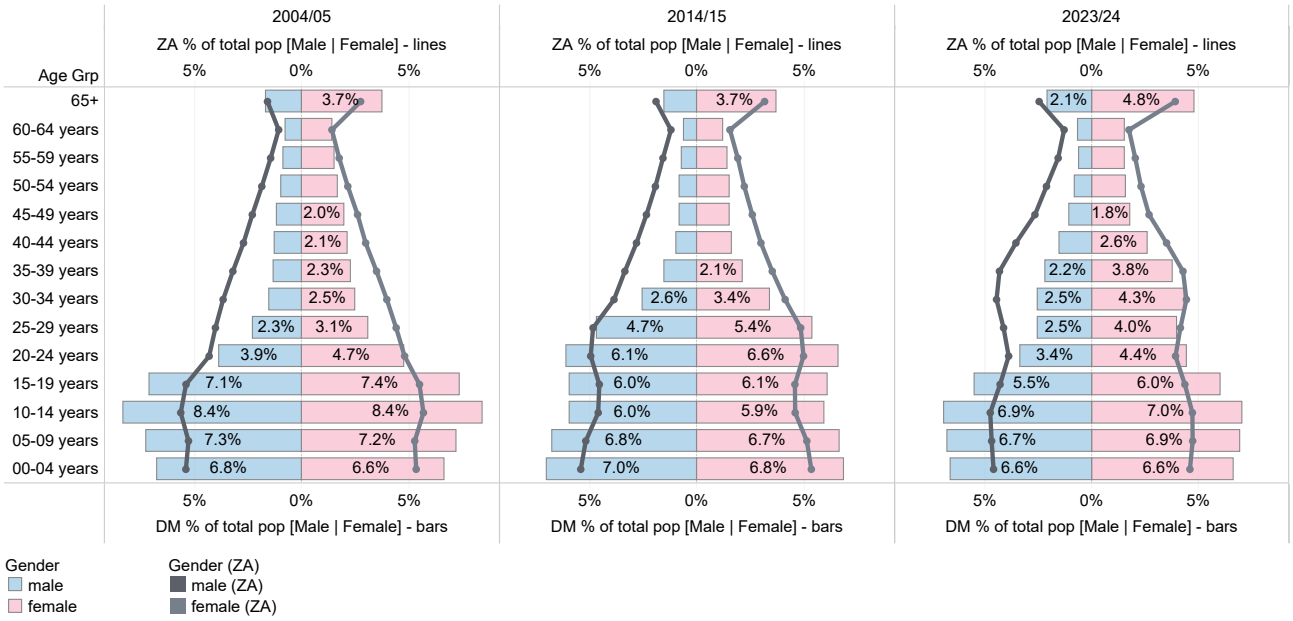
Ntabankulu: Tabankulu

Winnie Madikizela-Mandela (Mbizana): Bizana

Umzimvubu: eMaxesibeni (Mount Ayliff), KwaBhaca (Mount Frere)

District percentage population by age-gender group compared to South Africa

A Nzo DM (DC44)

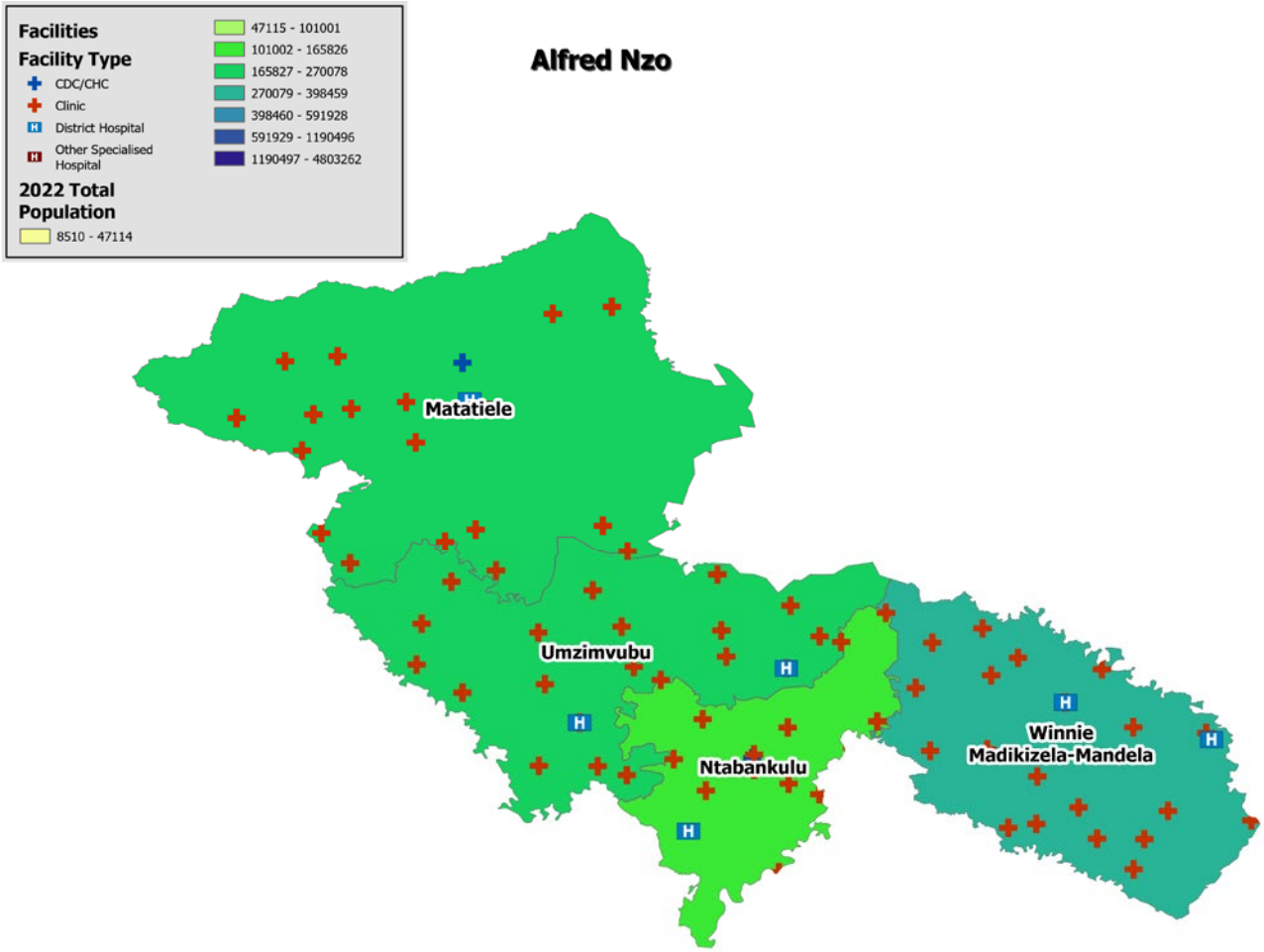


Source: DHIS

13 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

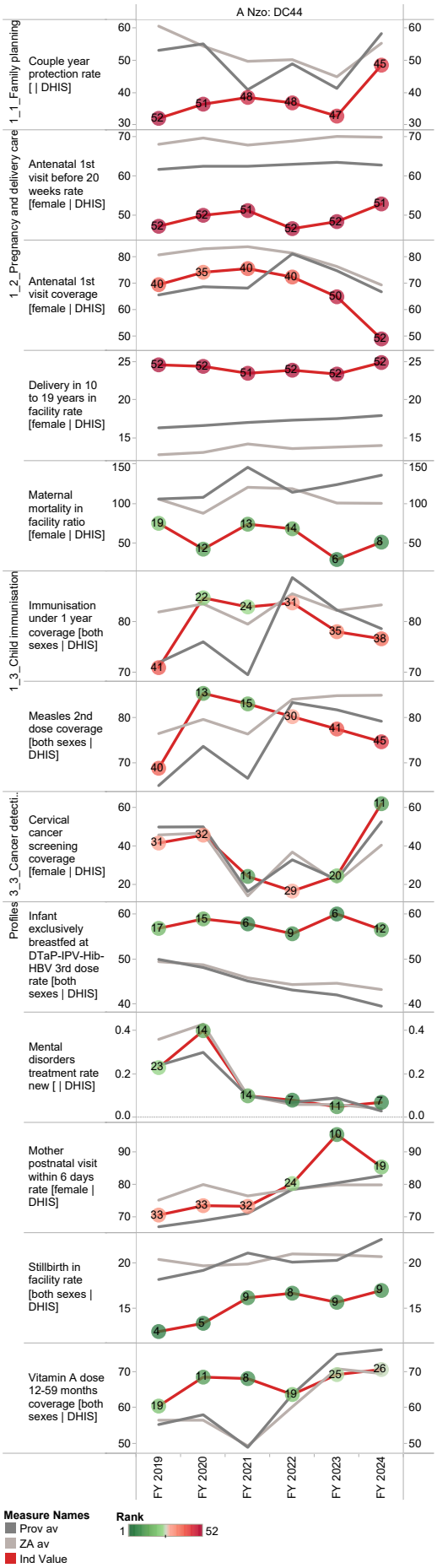
14 Mid-year Population Estimates 2023, DHIS.

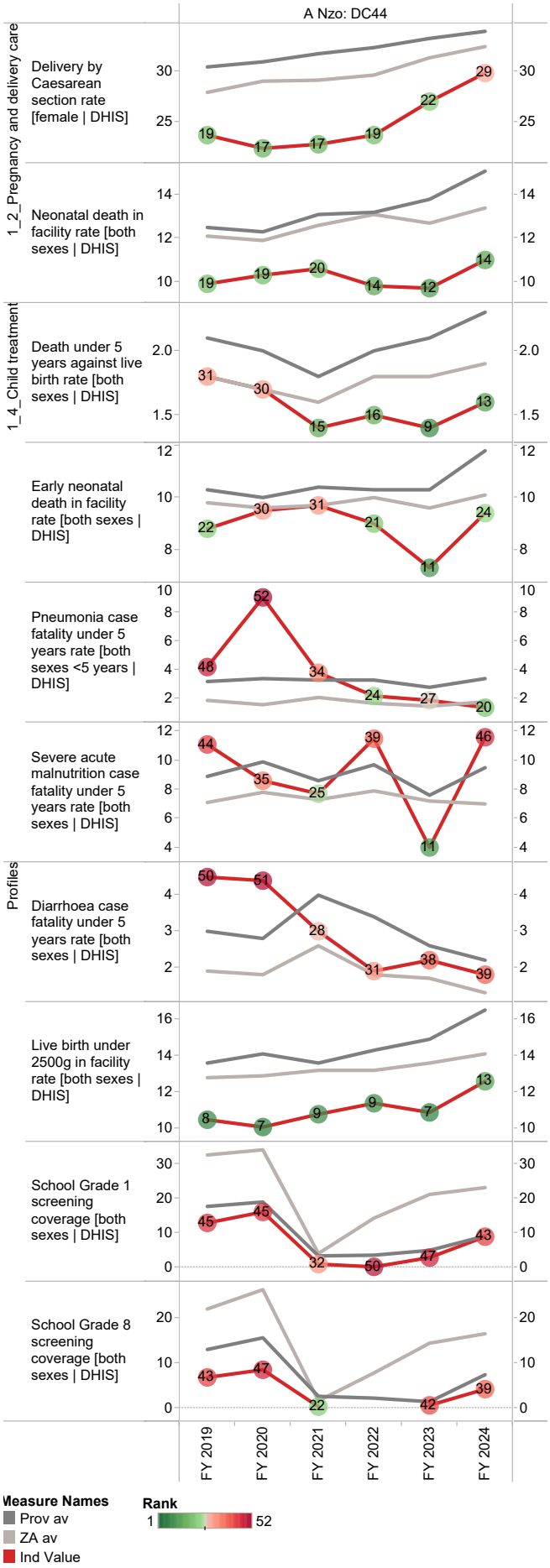
Population distribution, sub-district boundaries and health facility locations

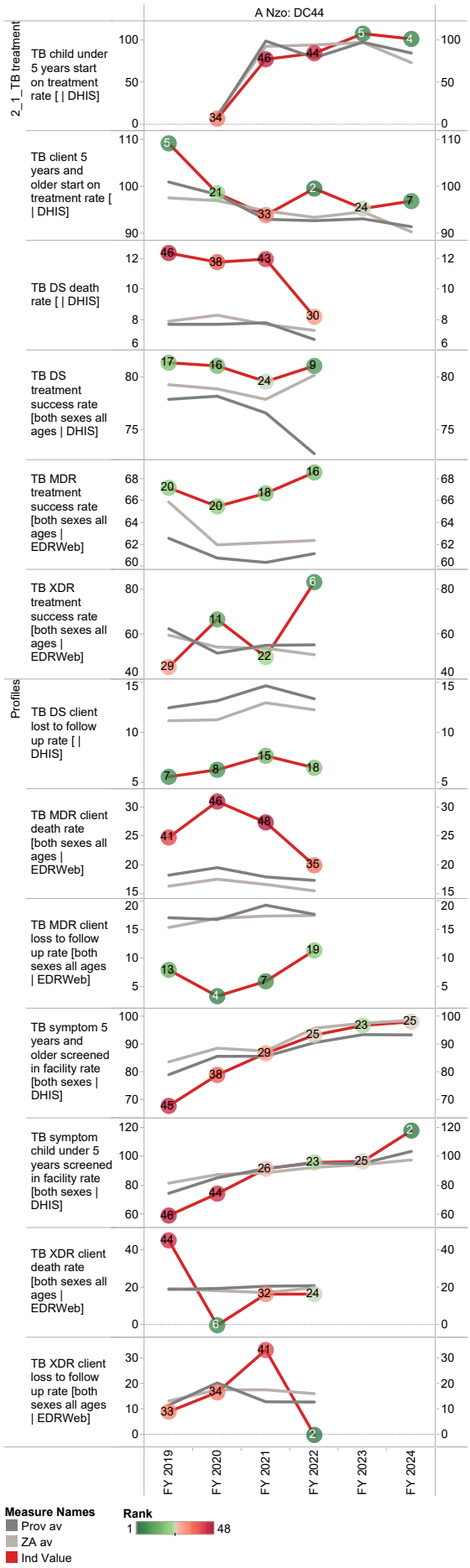


Source: DHIS

Annual trends, 2018/19–2023/24






A Nzo: DC44
2_1_TB treatment
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
TB DS death rate [| DHIS]
TB DS treatment success rate [both sexes all ages | DHIS]
TB MDR treatment success rate [both sexes all ages | EDRWeb]
TB XDR treatment success rate [both sexes all ages | EDRWeb]
Profiles
TB DS client lost to follow up rate [| DHIS]
TB MDR client death rate [both sexes all ages | EDRWeb]
TB MDR client loss to follow up rate [both sexes all ages | EDRWeb]
TB symptom 5 years and older screened in facility rate [both sexes | DHIS]
TB symptom child under 5 years screened in facility rate [both sexes | DHIS]
TB XDR client death rate [both sexes all ages | EDRWeb]
TB XDR client loss to follow up rate [both sexes all ages | EDRWeb]
FY 2019
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FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
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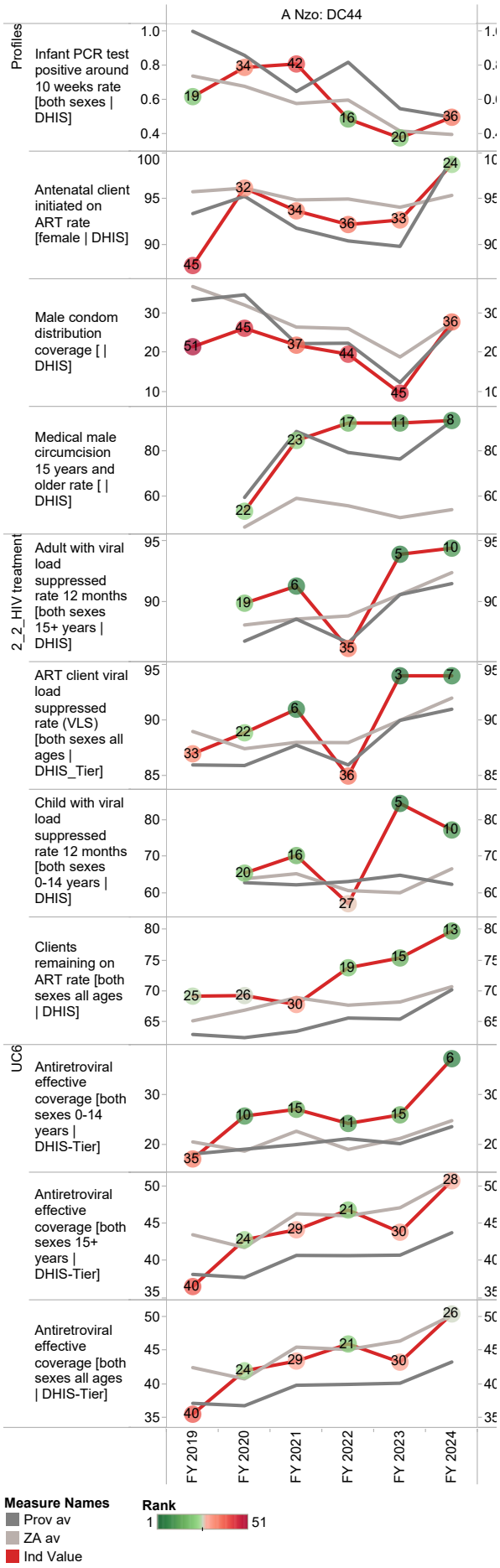
48


A Nzo: DC44
Profiles
Infant PCR test positive around 10 weeks rate [both sexes | DHIS]
Antenatal client initiated on ART rate [female | DHIS]
Male condom distribution coverage [| DHIS]
Medical male circumcision 15 years and older rate [| DHIS]
2_2_HIV treatment
Adult with viral load suppressed rate 12 months [both sexes 15+ years | DHIS]
ART client viral load suppressed rate (VLS) [both sexes all ages | DHIS_Tier]
Child with viral load suppressed rate 12 months [both sexes 0-14 years | DHIS]
Clients remaining on ART rate [both sexes all ages | DHIS]
UC6
Antiretroviral effective coverage [both sexes 0-14 years | DHIS-Tier]
Antiretroviral effective coverage [both sexes 15+ years | DHIS-Tier]
Antiretroviral effective coverage [both sexes all ages | DHIS-Tier]
FY 2019
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FY 2022
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FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
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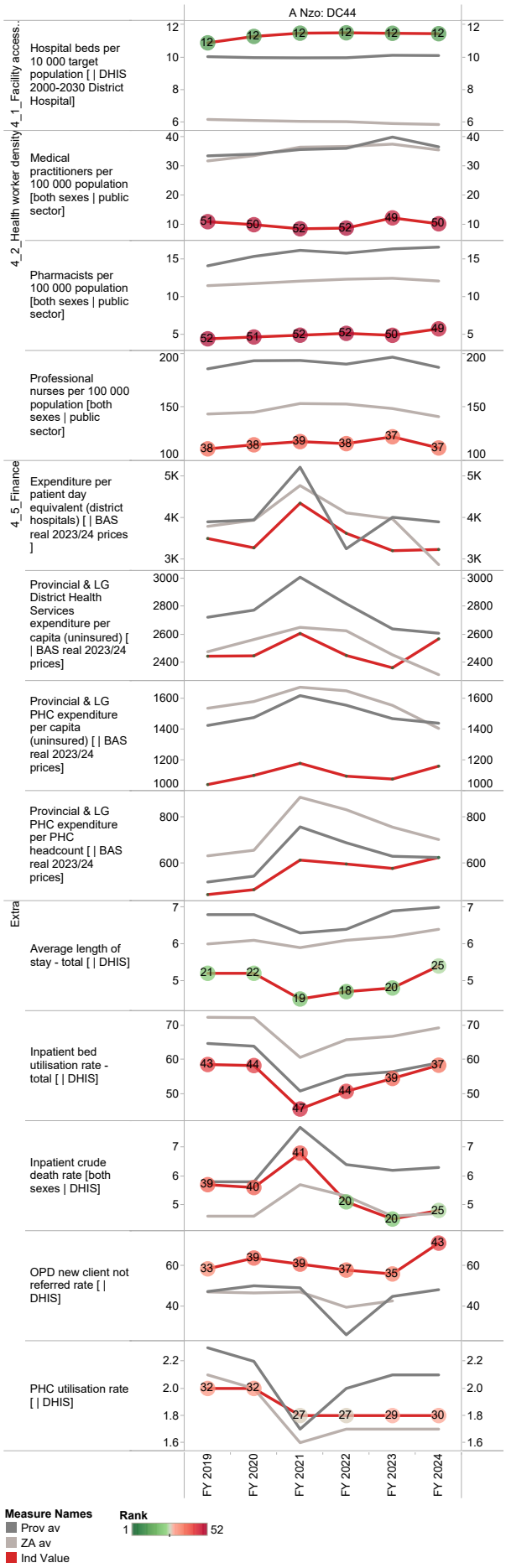
51


A Nzo: DC44
4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
4_2_Health worker density
Medical practitioners per 100 000 population [both sexes | public sector]
Pharmacists per 100 000 population [both sexes | public sector]
Professional nurses per 100 000 population [both sexes | public sector]
4_5_Finance
Expenditure per patient day equivalent (district hospitals) [| BAS real 2023/24 prices]
Provincial & LG District Health Services expenditure per capita (uninsured) [| BAS real 2023/24 prices]
Provincial & LG PHC expenditure per capita (uninsured) [| BAS real 2023/24 prices]
Provincial & LG PHC expenditure per PHC headcount [| BAS real 2023/24 prices]
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Average length of stay - total [| DHIS]
Inpatient bed utilisation rate - total [| DHIS]
Inpatient crude death rate [both sexes | DHIS]
OPD new client not referred rate [| DHIS]
PHC utilisation rate [| DHIS]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
1
52

Nelson Mandela Bay Metropolitan (NMA)

The Nelson Mandela Bay Metropolitan Municipality[15] is a Category A municipality. As a major seaport and automotive manufacturing centre located on the south-eastern coast of Africa, it is the economic powerhouse of the Eastern Cape. The Metropolitan Municipality comprises three health sub-districts, namely: Nelson Mandela A, Nelson Mandela B and Nelson Mandela C.

Area[15]: 1 957km²

Population (2023)[16]: 1 219 872

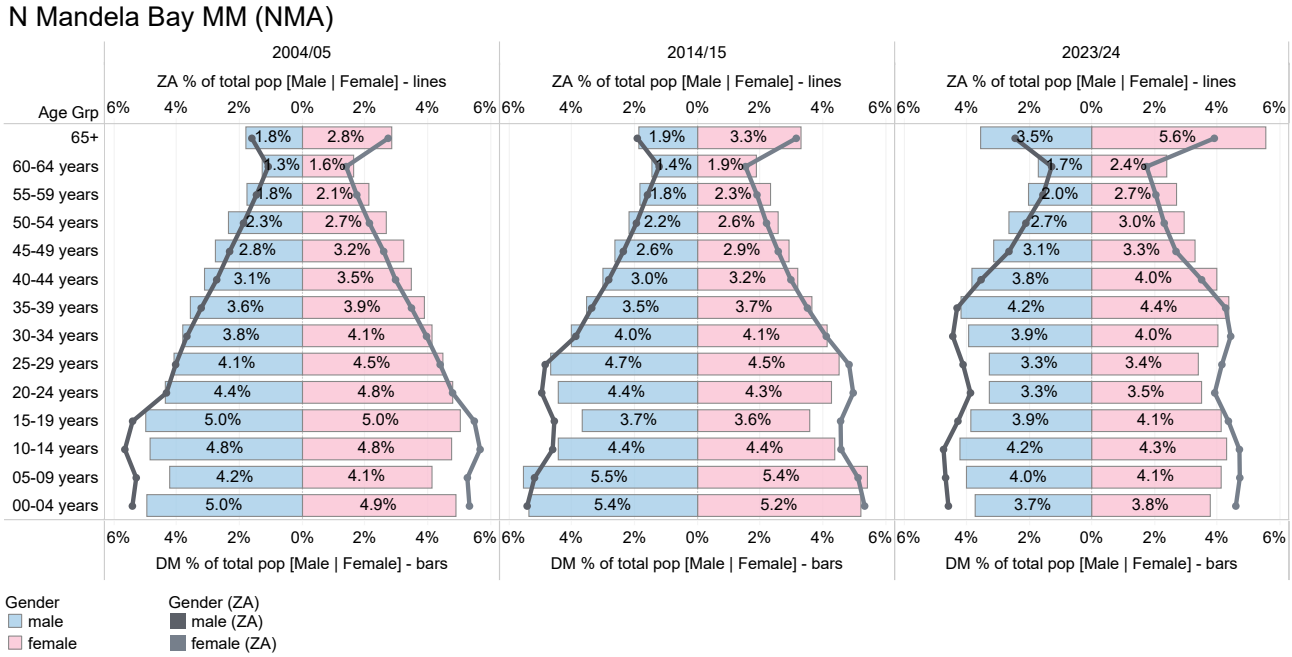
Households[15]: 368 520

Formal dwellings[15]: 92.5%

Cities/Towns:

Bethelsdorp, Bloemendal, Blue Horizon Bay, Clarendon Marine, Despatch, KwaNobuhle, Motherwell, Gqeberha (Port Elizabeth), Summerstrand, Swartkops, Uitenhage

District percentage population by age-gender group compared to South Africa

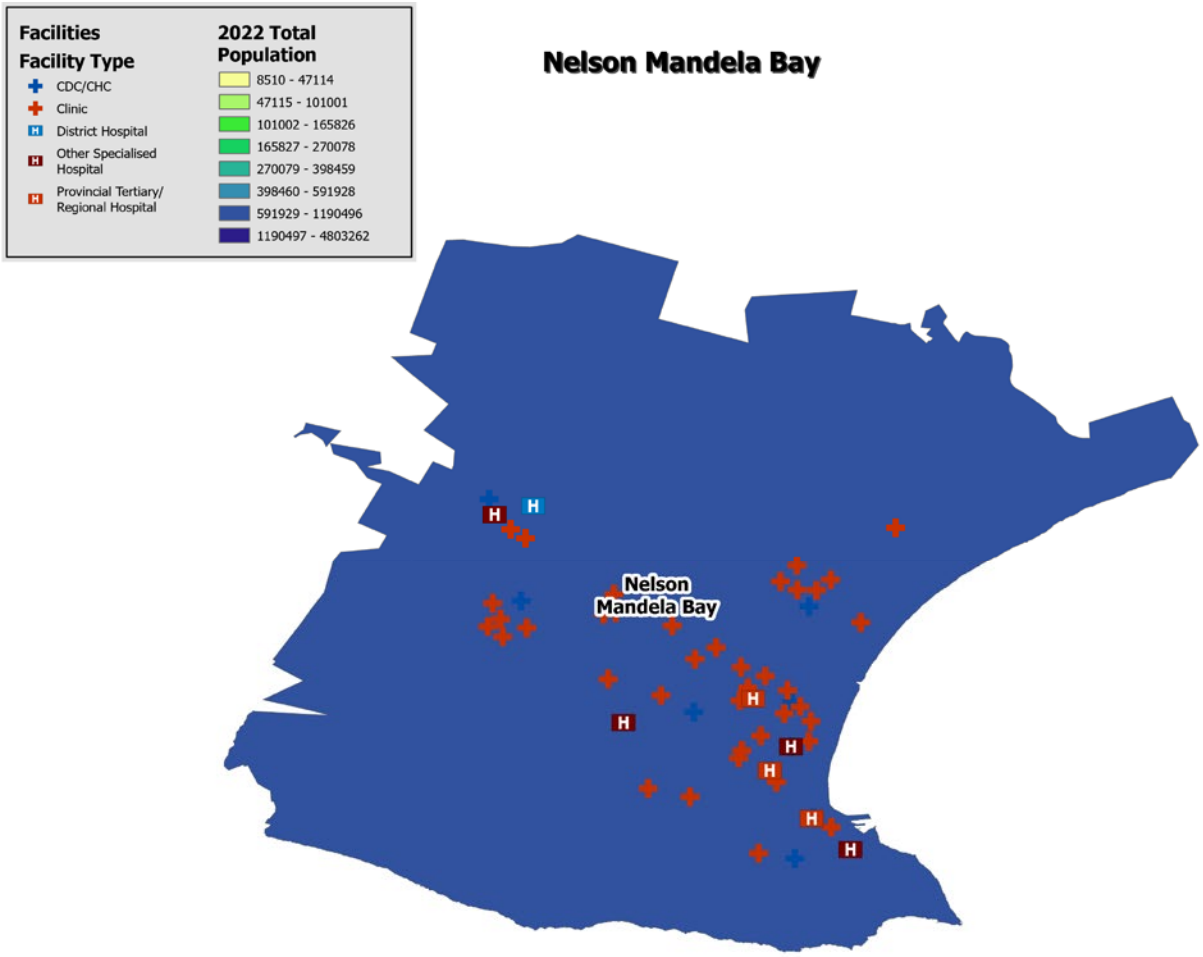


Source: DHIS

15 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

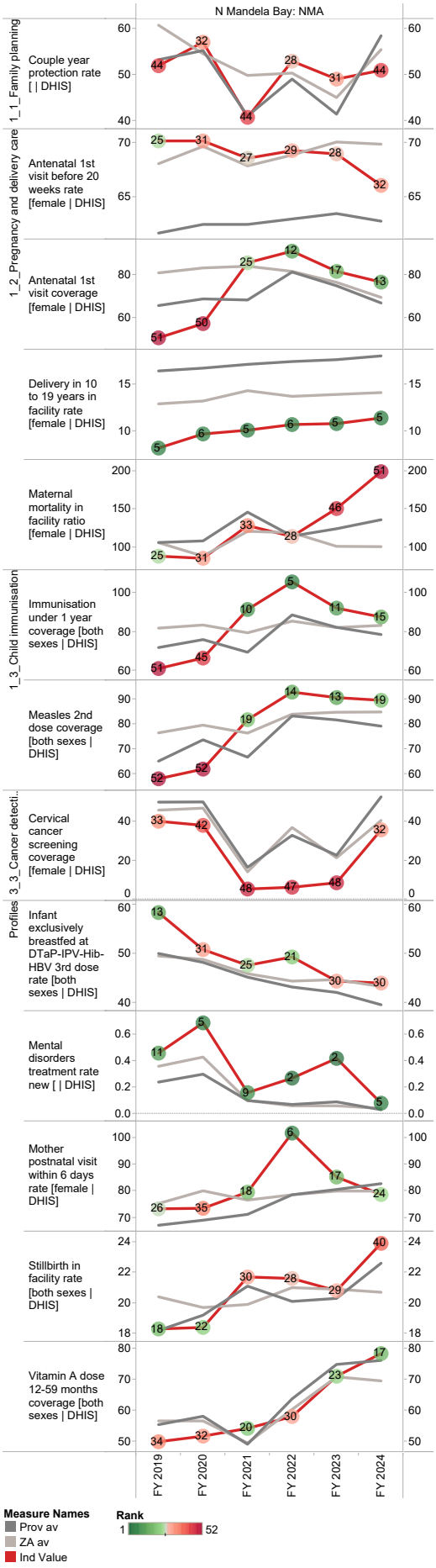
16 Mid-year Population Estimates 2023, DHIS.

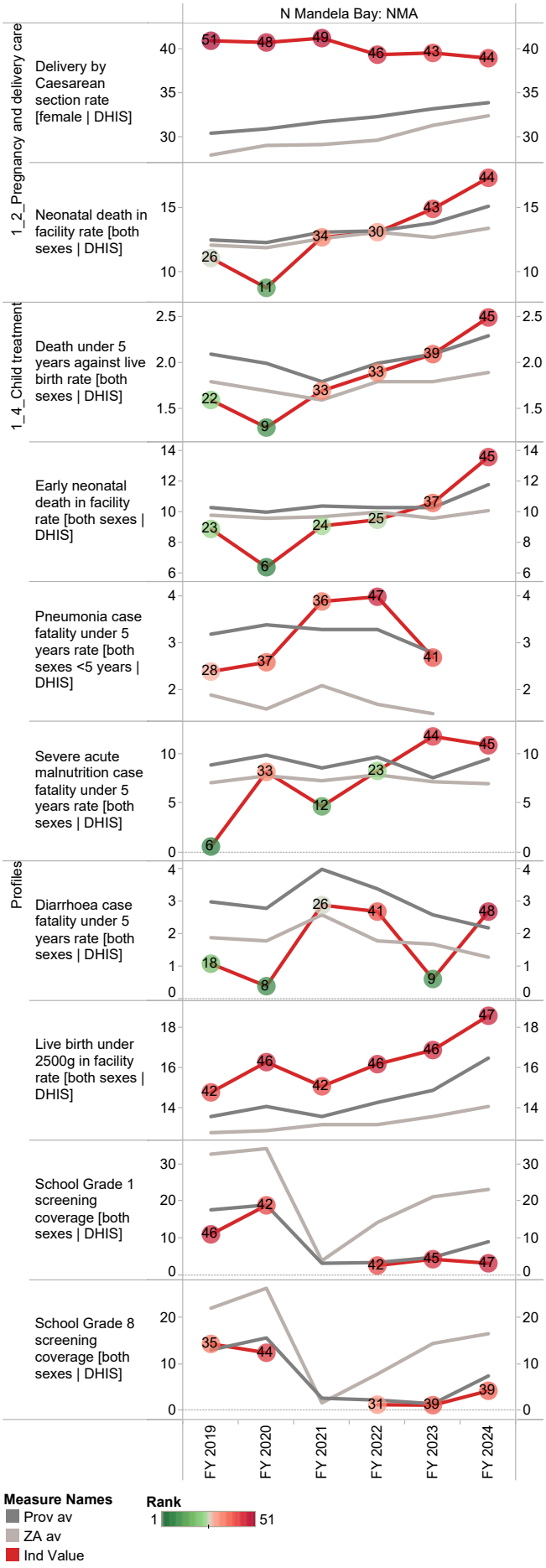
Population distribution, sub-district boundaries and health facility locations

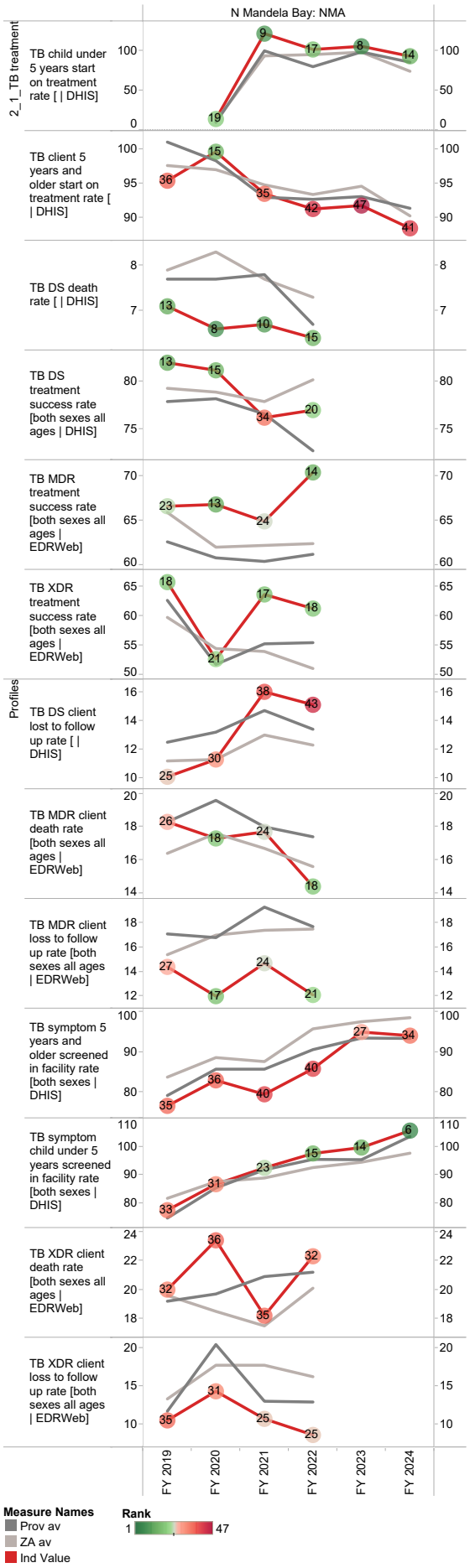


Source: DHIS

Annual trends, 2018/19–2023/24






N Mandela Bay: NMA
2_1_TB treatment
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
TB DS death rate [| DHIS]
TB DS treatment success rate [both sexes all ages | DHIS]
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TB symptom child under 5 years screened in facility rate [both sexes | DHIS]
TB XDR client death rate [both sexes all ages | EDRWeb]
TB XDR client loss to follow up rate [both sexes all ages | EDRWeb]
FY 2019
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FY 2022
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FY 2024
Measure Names
Prov av
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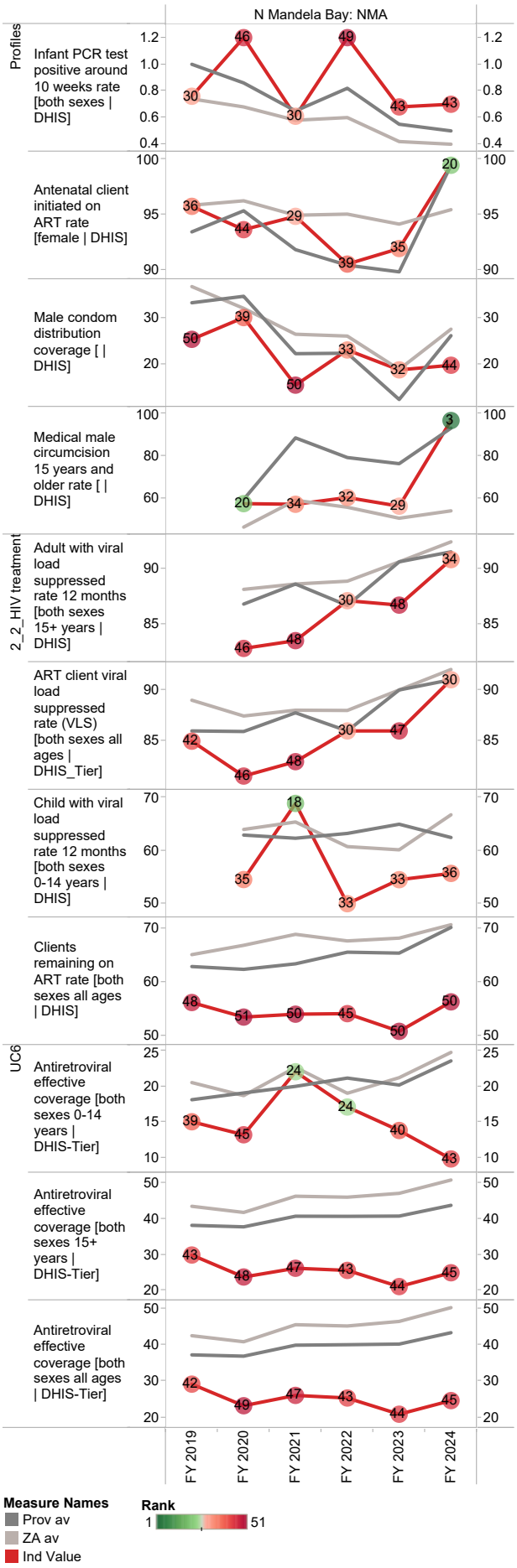
47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UC6
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Antiretroviral effective coverage [both sexes all ages | DHIS-Tier]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
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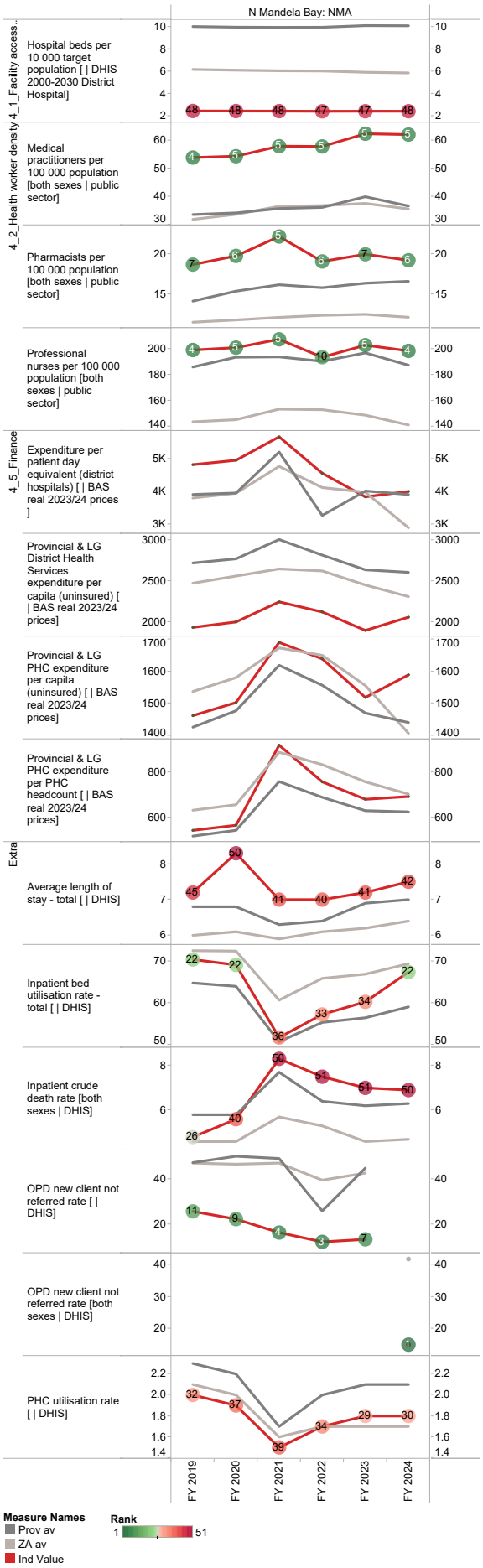
N Mandela Bay: NMA
4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
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Medical practitioners per 100 000 population [both sexes | public sector]
Pharmacists per 100 000 population [both sexes | public sector]
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OPD new client not referred rate [| DHIS]
OPD new client not referred rate [both sexes | DHIS]
PHC utilisation rate [| DHIS]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
1
51

08 Free State Province

Xhariep District Municipality (DC16)

The Xhariep District Municipality[1] is a Category C municipality situated in the southern part of the Free State. It is the largest district in the province, making up just more than a third of its geographical area. It comprises three local municipalities: Letsemeng, Kopanong and Mohokare.

Area: 34 250km²

Population (2023)[2]: 127 766

Households[1]: 44 767

Formal dwellings[1]: 89.1%

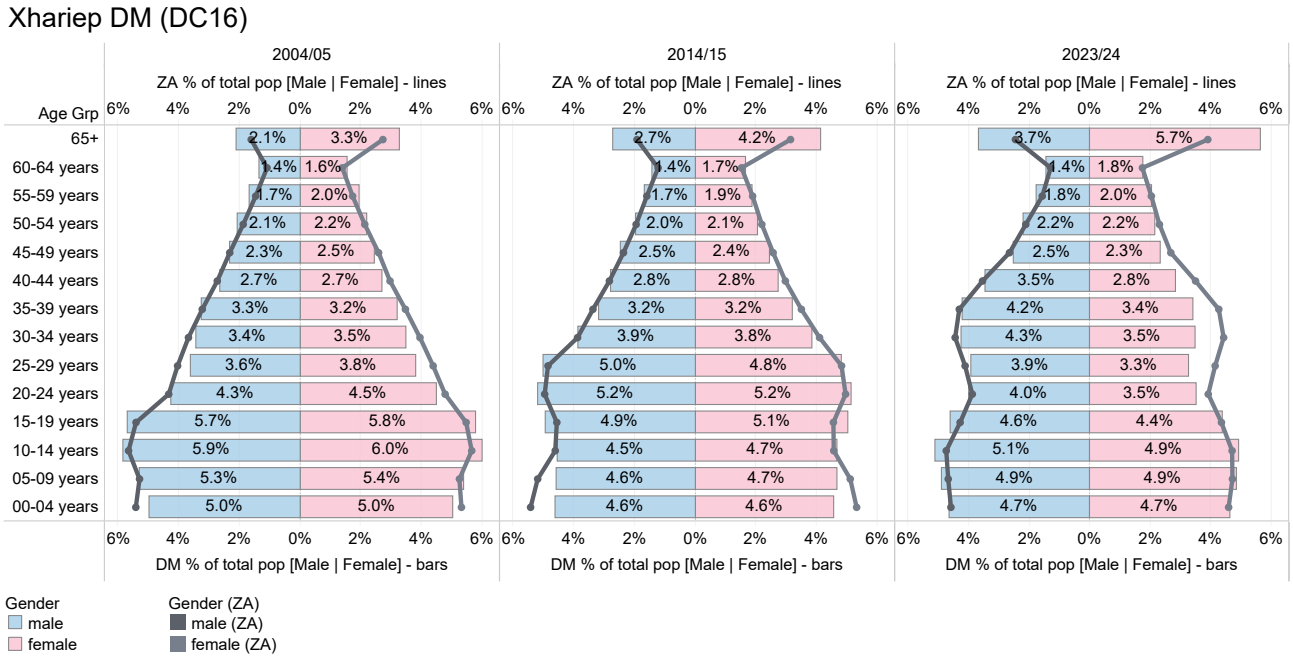
Cities/Towns:

Letsemeng: Jacobsdal, Koffiefontein, Luckhoff, Oppermansgronde, Petrusburg

Kopanong: Bethulie, Edenburg, Fauresmith, Gariep Dam, Jagersfontein, Philippolis, Reddersburg, Springfontein, Trompsburg, Waterkloof

Mohokare: Rouxville, Smithfield, Zastron

District percentage population by age-gender group compared to South Africa

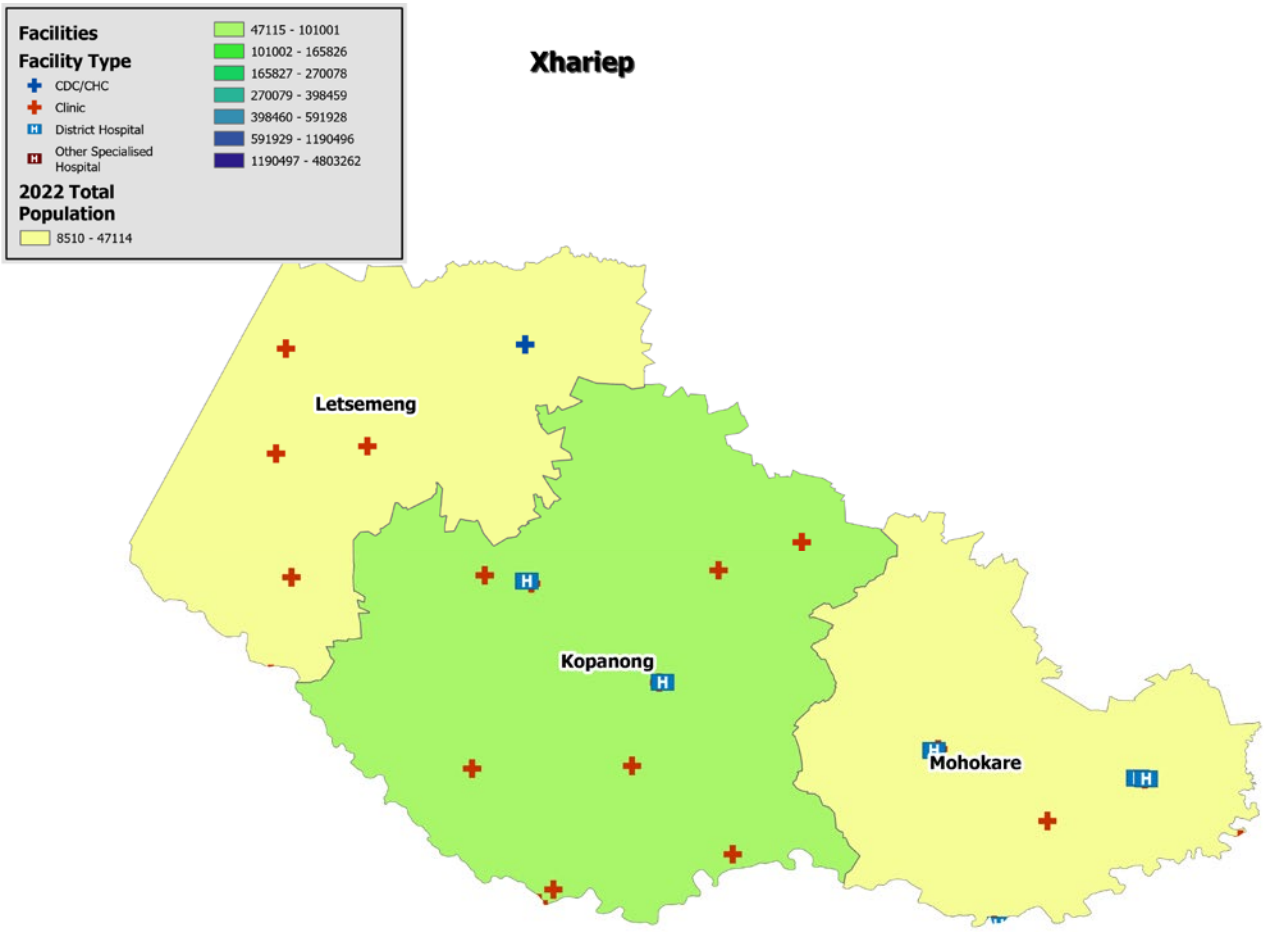


Source: DHIS

1 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

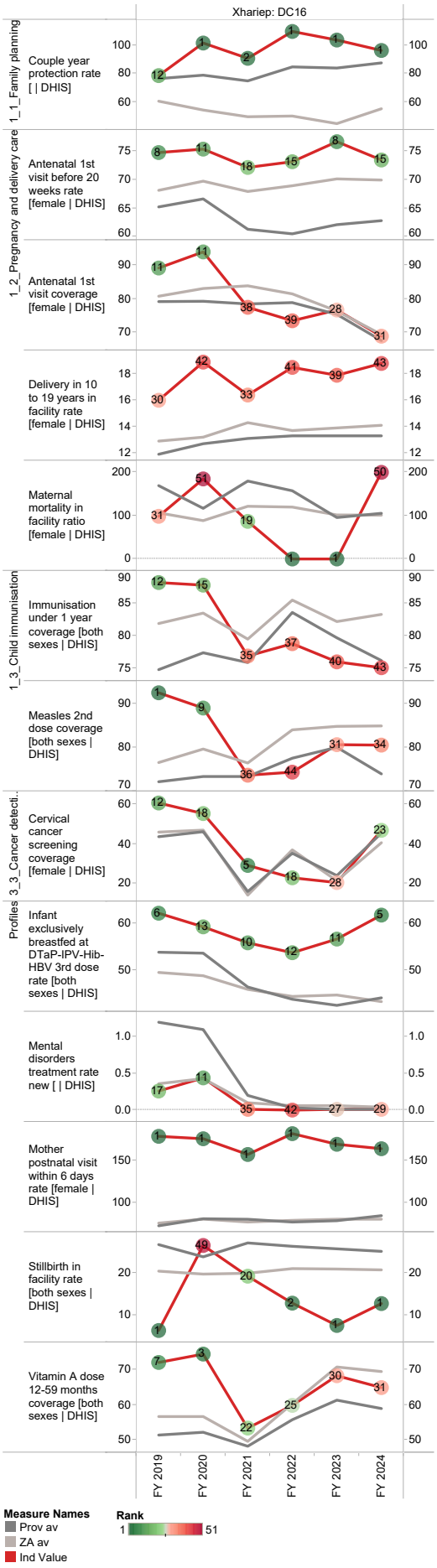
2 Mid-year Population Estimates 2023, DHIS.

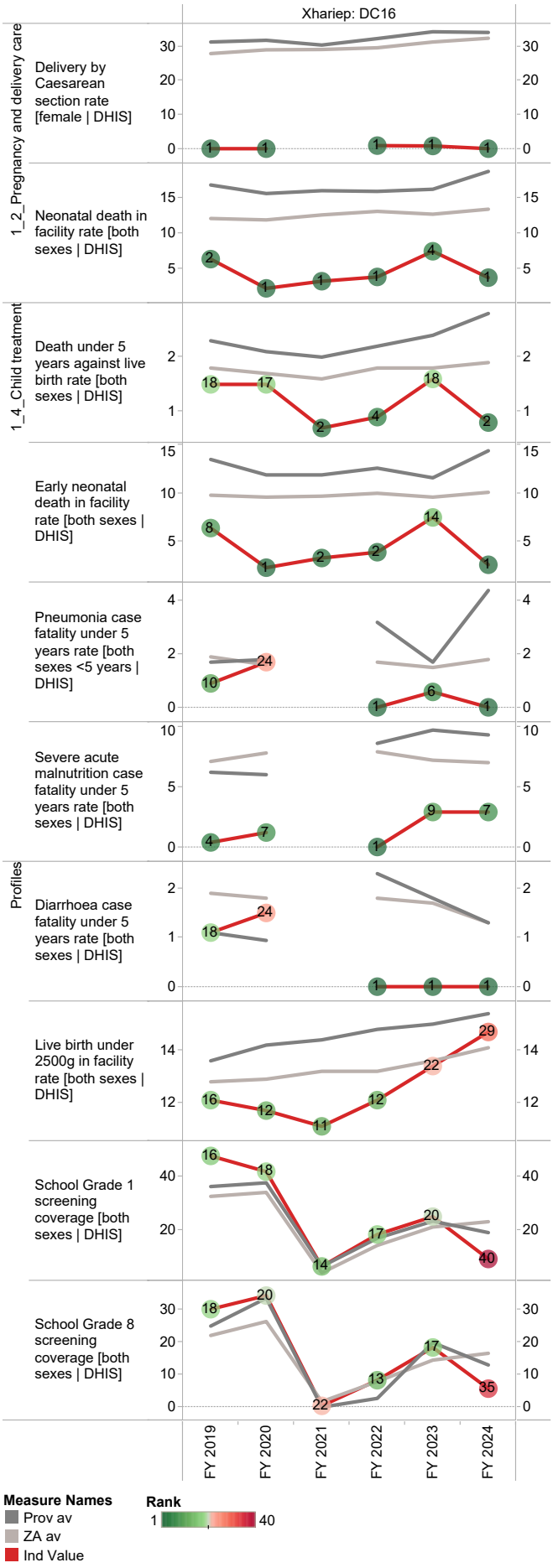
Population distribution, sub-district boundaries and health facility locations

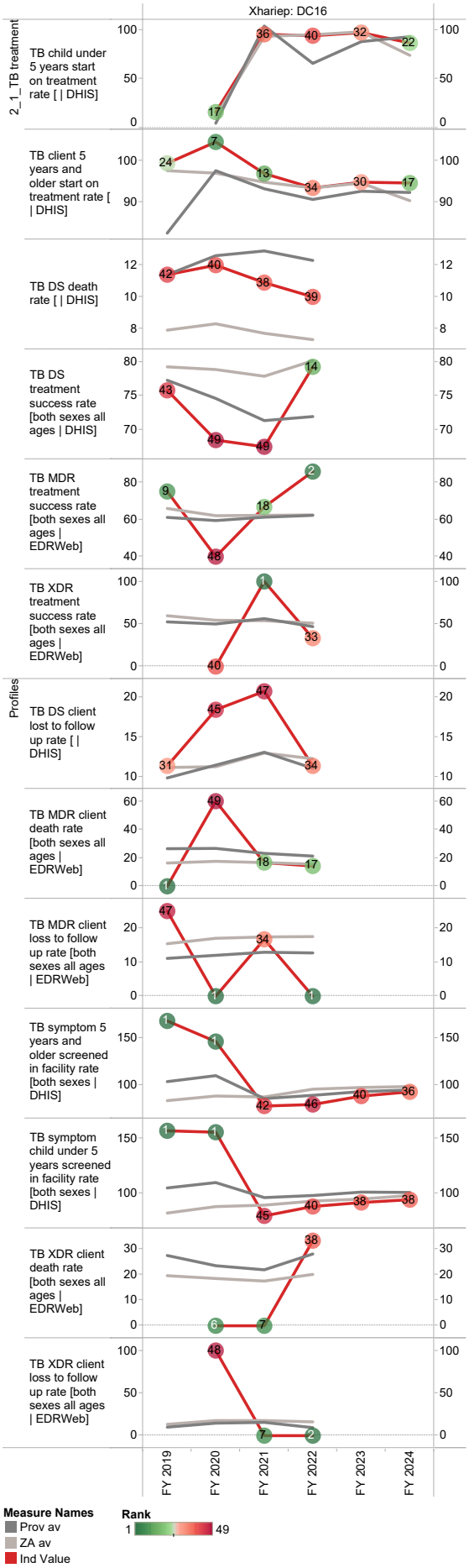


Source: DHIS

Annual trends, 2018/19–2023/24






Xhariep: DC16
2_1_TB treatment
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
TB DS death rate [| DHIS]
TB DS treatment success rate [both sexes all ages | DHIS]
TB MDR treatment success rate [both sexes all ages | EDRWeb]
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FY 2019
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FY 2021
FY 2022
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FY 2024
Measure Names
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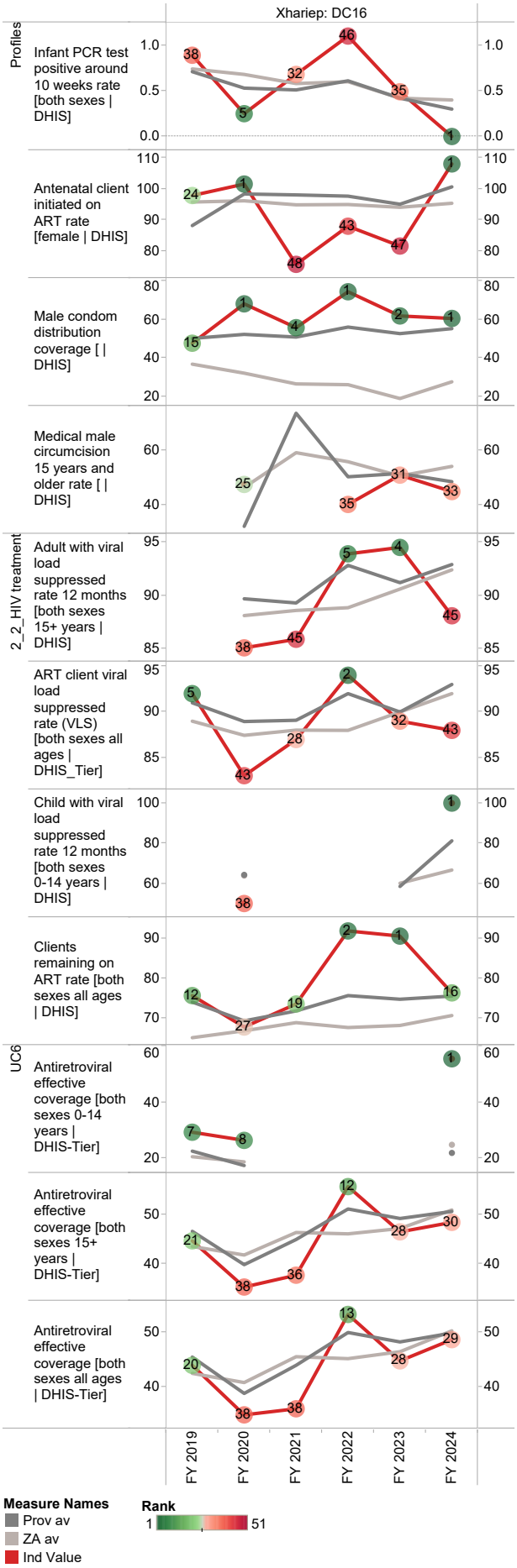
Xhariep: DC16
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Infant PCR test positive around 10 weeks rate [both sexes | DHIS]
Antenatal client initiated on ART rate [female | DHIS]
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FY 2019
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FY 2022
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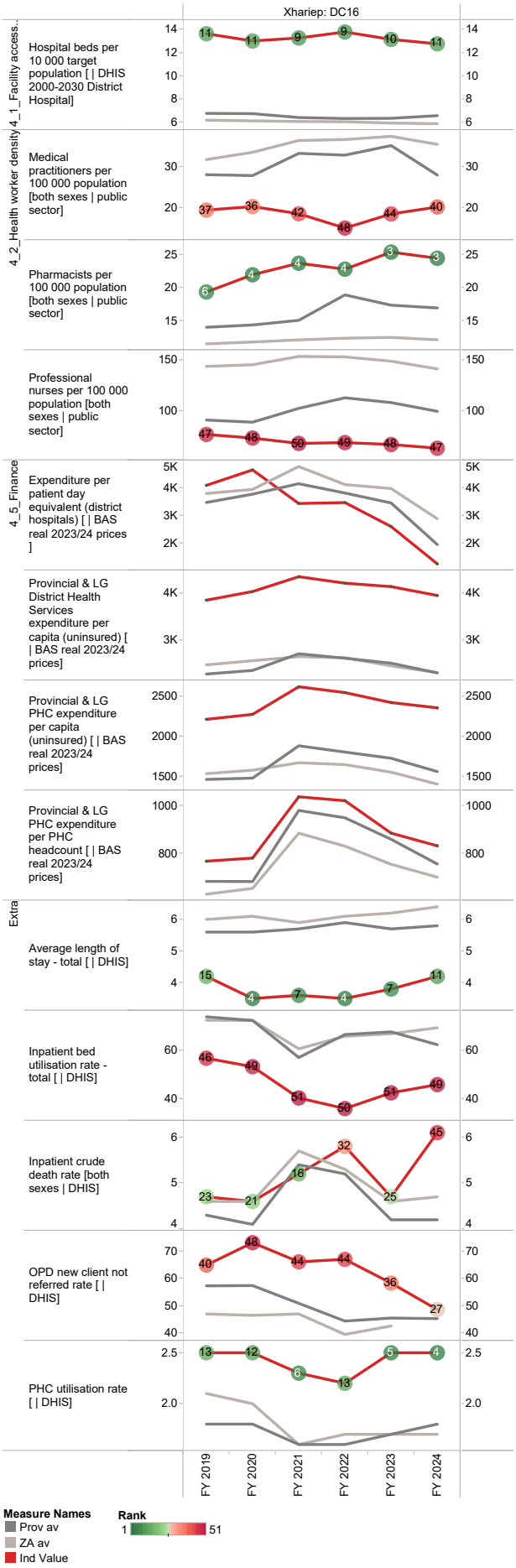
Xhariep: DC16
4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
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PHC utilisation rate [| DHIS]
FY 2019
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FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
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Ind Value
Rank
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51

Lejweleputswa District Municipality (DC18)

The Lejweleputswa District Municipality[3] is a Category C municipality situated in the north-western part of the Free State. The district makes up almost a third of the province, and consists of the following five local municipalities: Masilonyana, Tokologo, Tswelopele, Matjhabeng and Nala.

Area: 32 287km²

Population (2023)[4]: 645 780

Households[3]: 217 911

Formal dwellings[3]: 82.2%

Cities/Towns:

Masilonyana: Brandfort, Soutpan, Theunissen, Verkeerdevlei, Winburg

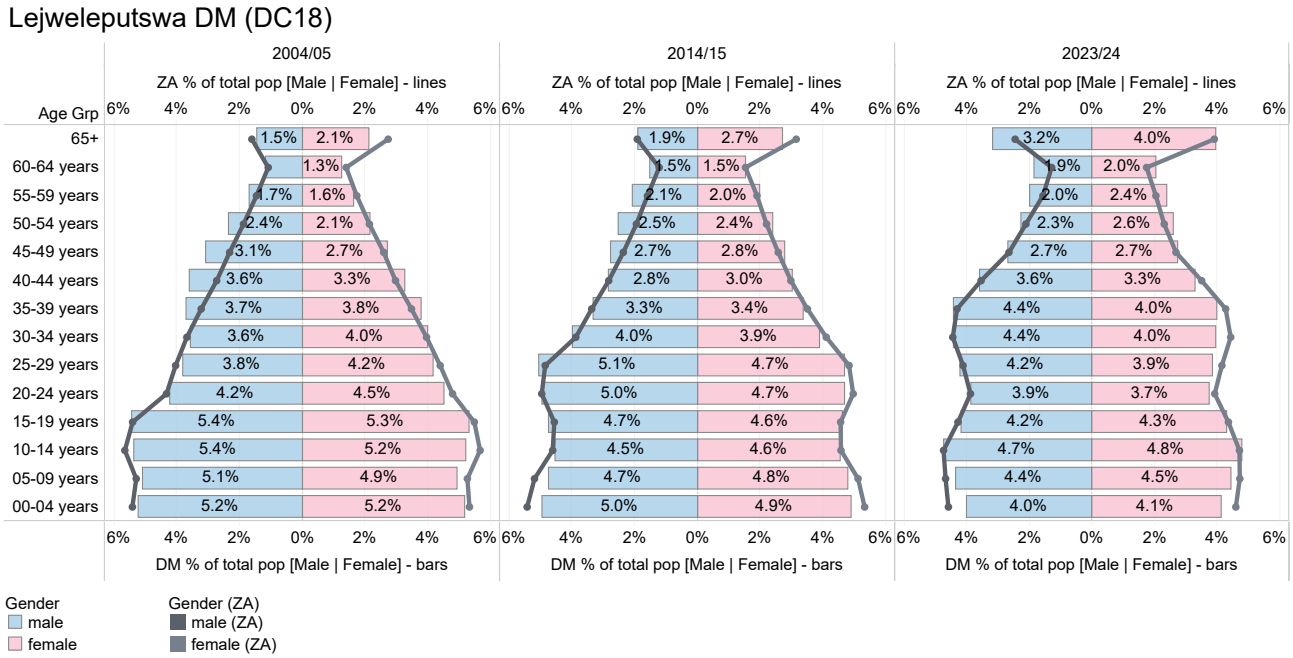
Tokologo: Boshof, Dealesville, Hertzogville

Tswelopele: Bultfontein, Hoopstad,

Matjhabeng: Allanridge, Hennenman, Odendaalsrus, Ventersburg, Virginia, Welkom

Nala: Bothaville, Wesselsbron

District percentage population by age-gender group compared to South Africa

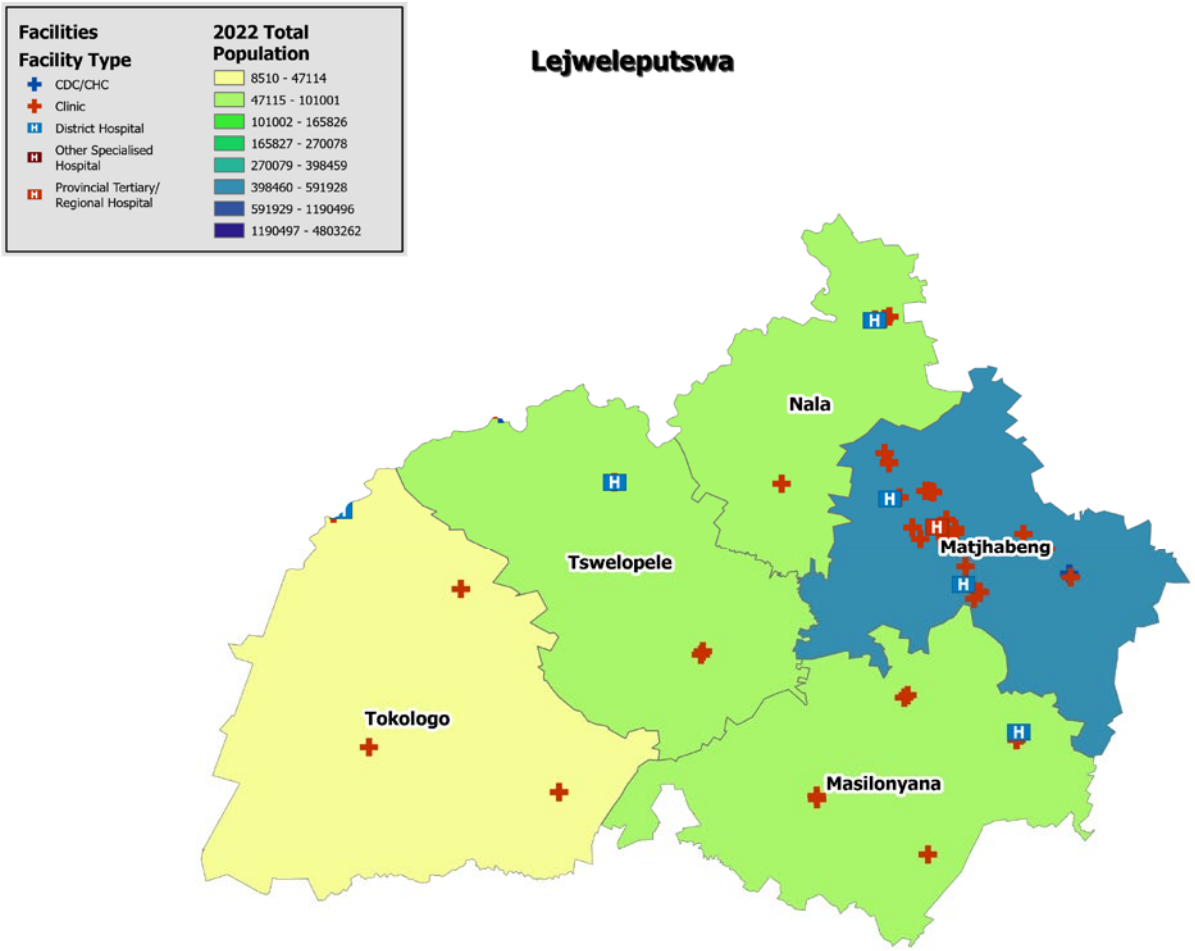


Source: DHIS

3 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

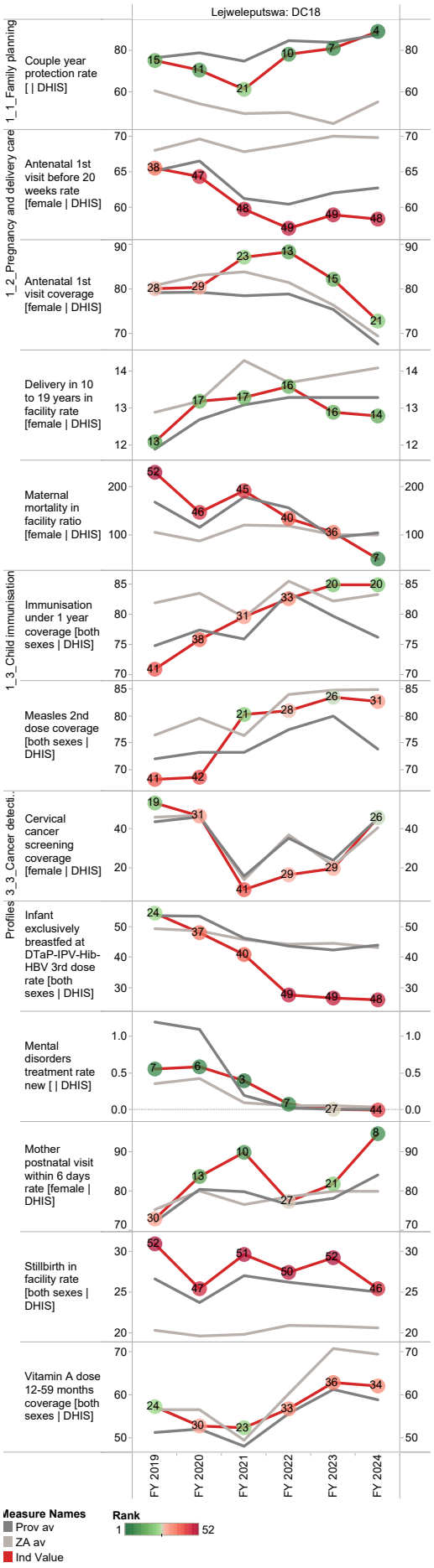
4 Mid-year Population Estimates 2023, DHIS.

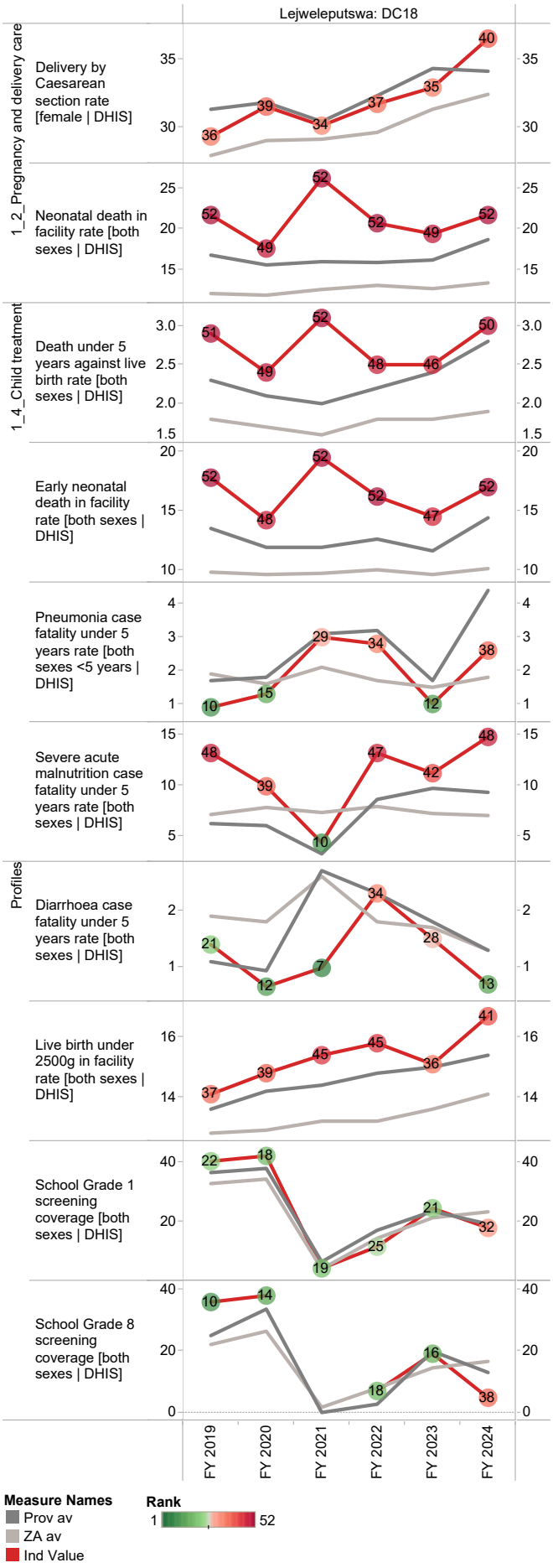
Population distribution, sub-district boundaries and health facility locations

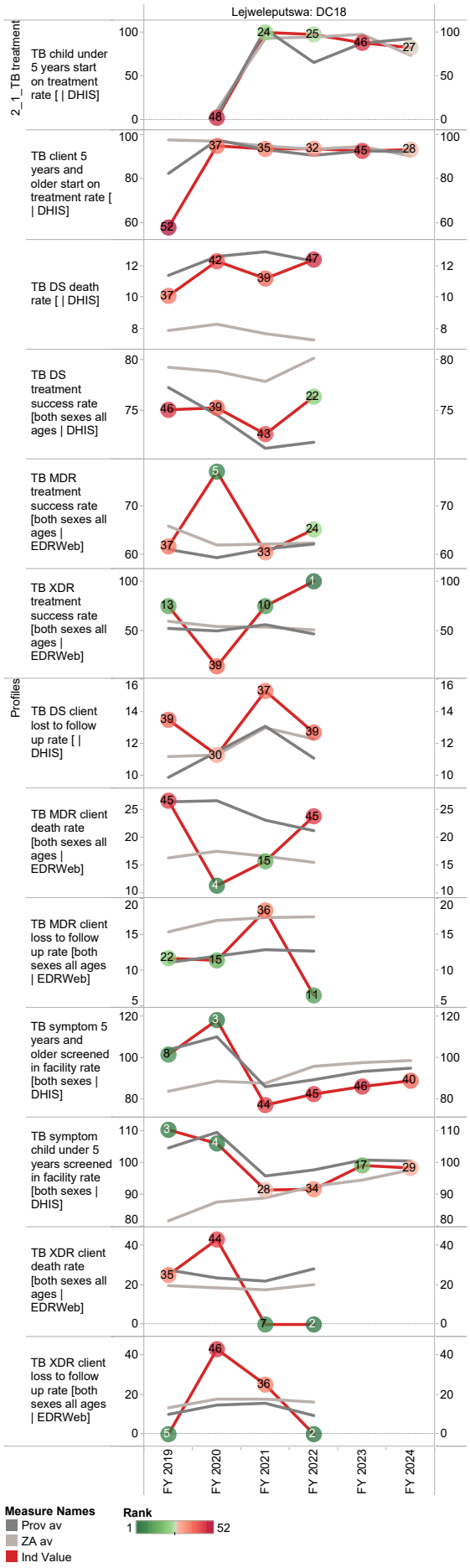


Source: DHIS

Annual trends, 2018/19–2023/24






Lejweleputswa: DC18
2_1_TB treatment
Profiles
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
TB DS death rate [| DHIS]
TB DS treatment success rate [both sexes all ages | DHIS]
TB MDR treatment success rate [both sexes all ages | EDRWeb]
TB XDR treatment success rate [both sexes all ages | EDRWeb]
TB DS client lost to follow up rate [| DHIS]
TB MDR client death rate [both sexes all ages | EDRWeb]
TB MDR client loss to follow up rate [both sexes all ages | EDRWeb]
TB symptom 5 years and older screened in facility rate [both sexes | DHIS]
TB symptom child under 5 years screened in facility rate [both sexes | DHIS]
TB XDR client death rate [both sexes all ages | EDRWeb]
TB XDR client loss to follow up rate [both sexes all ages | EDRWeb]
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Measure Names
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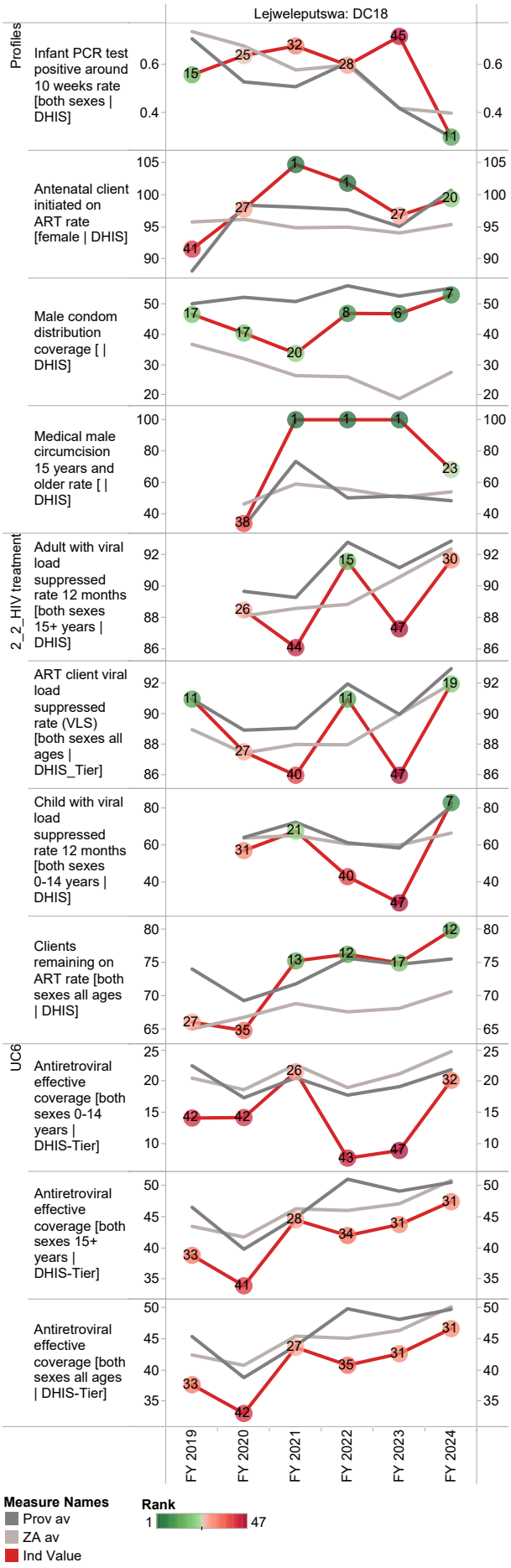
52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Profiles
Infant PCR test positive around 10 weeks rate [both sexes | DHIS]
Antenatal client initiated on ART rate [female | DHIS]
Male condom distribution coverage [| DHIS]
Medical male circumcision 15 years and older rate [| DHIS]
2_2_HIV treatment
Adult with viral load suppressed rate 12 months [both sexes 15+ years | DHIS]
ART client viral load suppressed rate (VLS) [both sexes all ages | DHIS_Tier]
Child with viral load suppressed rate 12 months [both sexes 0-14 years | DHIS]
Clients remaining on ART rate [both sexes all ages | DHIS]
UC6
Antiretroviral effective coverage [both sexes 0-14 years | DHIS-Tier]
Antiretroviral effective coverage [both sexes 15+ years | DHIS-Tier]
Antiretroviral effective coverage [both sexes all ages | DHIS-Tier]
FY 2019
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Measure Names
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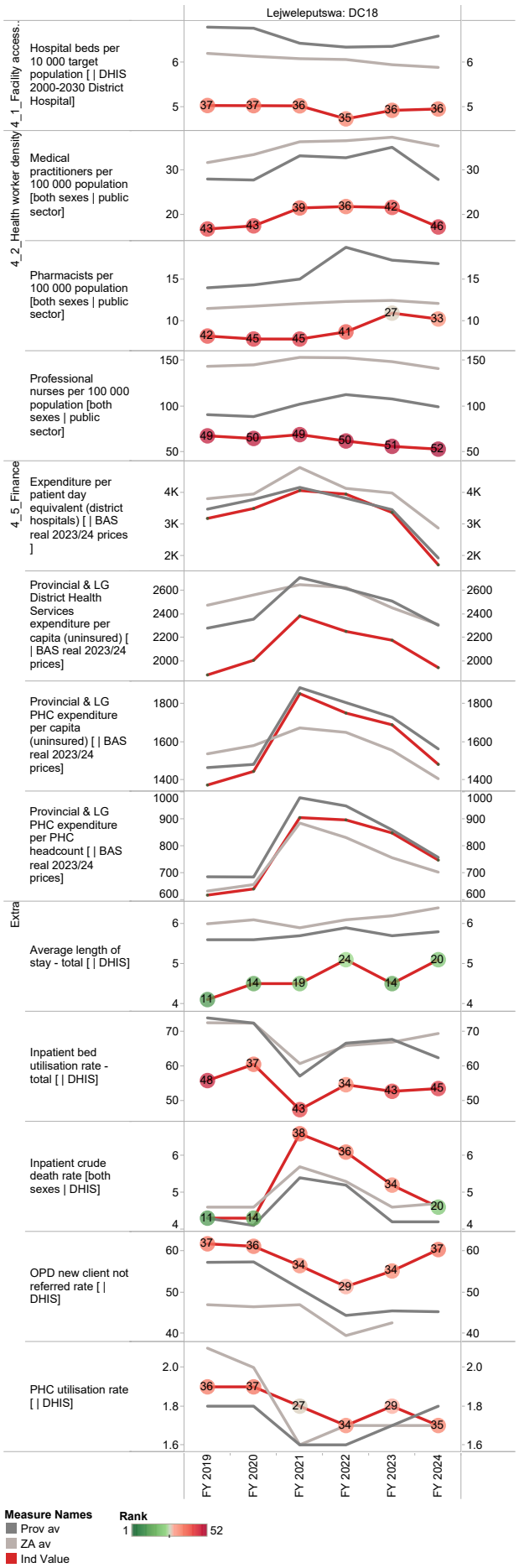
47


Lejweleputswa: DC18
4_1_Facility access..
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
4_2_Health worker density
Medical practitioners per 100 000 population [both sexes | public sector]
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Professional nurses per 100 000 population [both sexes | public sector]
4_5_Finance
Expenditure per patient day equivalent (district hospitals) [| BAS real 2023/24 prices]
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Inpatient bed utilisation rate - total [| DHIS]
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OPD new client not referred rate [| DHIS]
PHC utilisation rate [| DHIS]
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Measure Names
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52

Thabo Mofutsanyana District Municipality (DC19)

The Thabo Mofutsanyana District Municipality[5] is Category C municipality located in the eastern Free State Province, and borders on Lesotho. It comprises six local municipalities: Setsoto, Dihlabeng, Nketoana, Maluti-A-Phofung, Phumelela and Mantsopa.

Area: 32 730km²

Population (2023)[6]: 759 199

Households[5]: 246 029

Formal dwellings[5]: 77.7%

Cities/Towns:

Setsoto: Clocolan, Ficksburg, Marquard, Senekal

Dihlabeng: Bethlehem, Clarens, Fouriesburg, Golden Gate Highlands National Park, Paul Roux, Rosendal

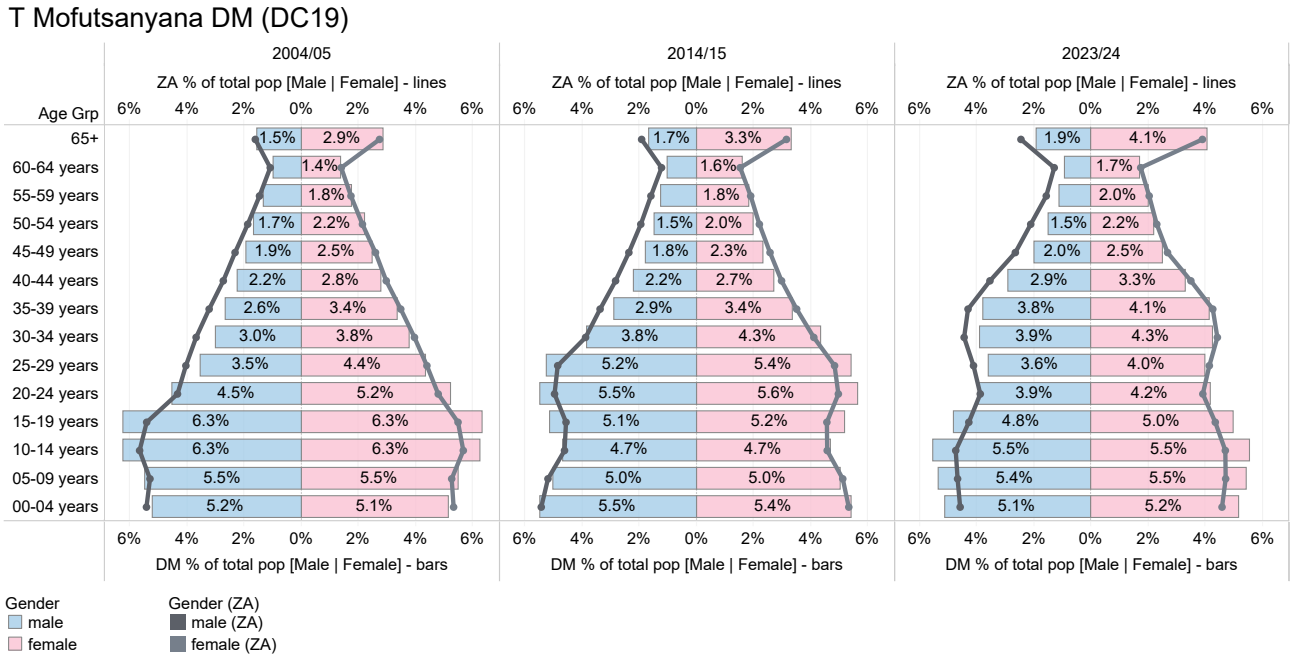
Nketoana: Arlington, Lindley, Petrus Steyn, Reitz

Maluti-A-Phofung: Harrismith, Kestell, Phuthaditjhaba

Phumelela: Memel, Vrede, Warden

Mantsopa: Excelsior, Hobhouse, Ladybrand, Thaba Patchoa, Tweespruit,

District percentage population by age-gender group compared to South Africa

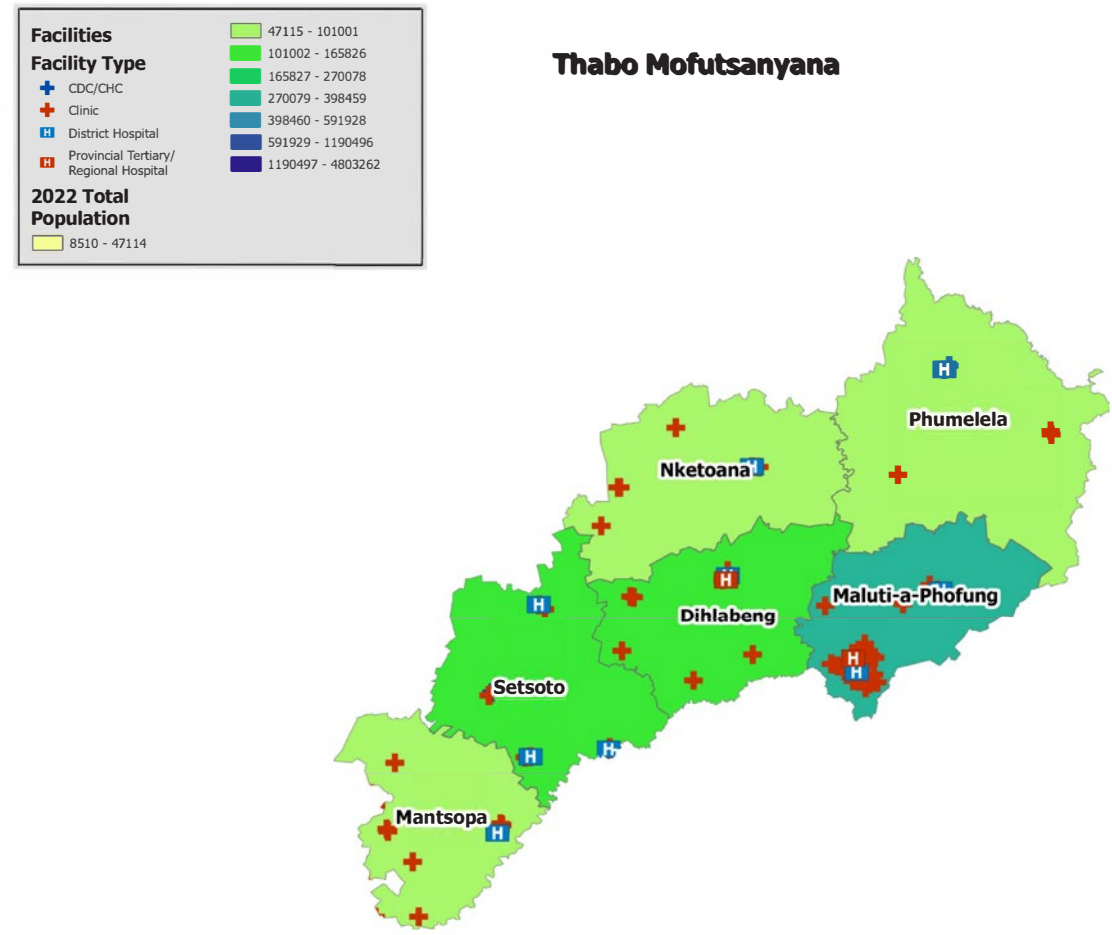


Source: DHIS

5 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

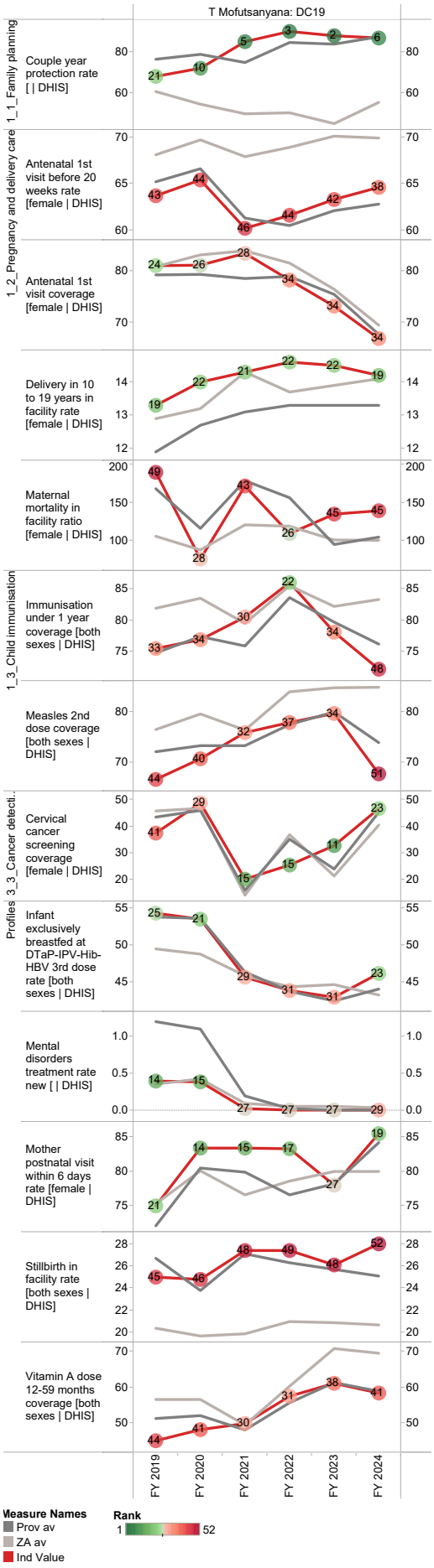
6 Mid-year Population Estimates 2023, DHIS.

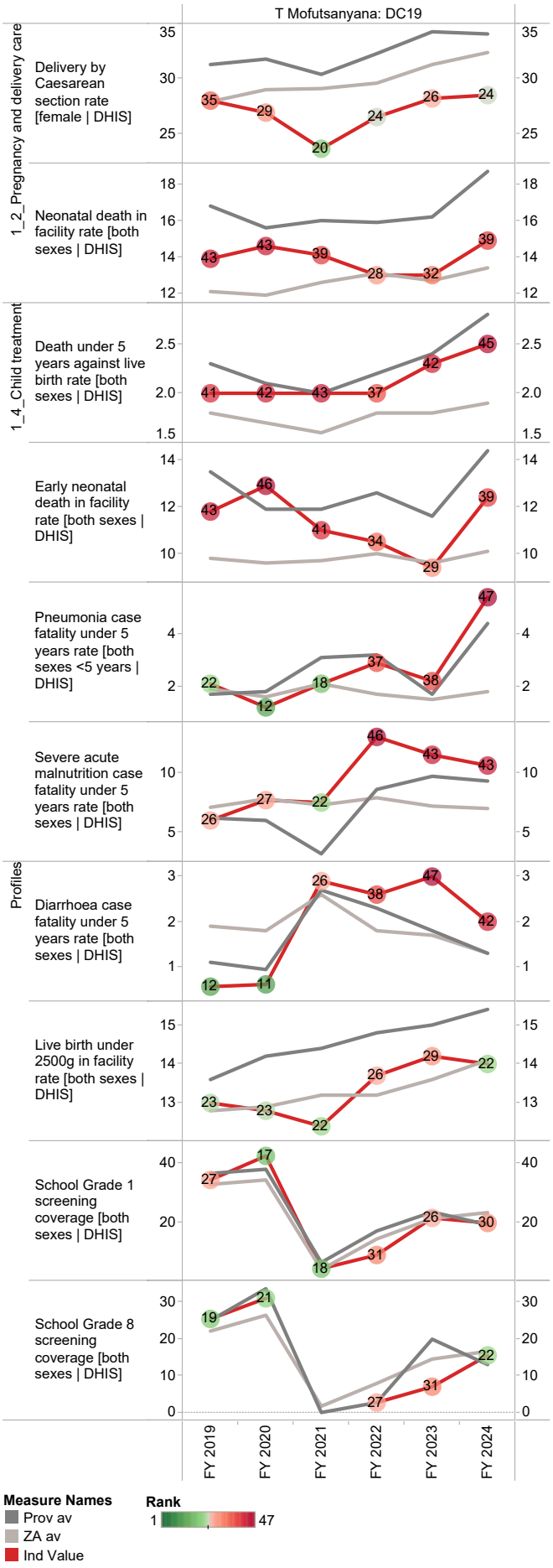
Population distribution, sub-district boundaries and health facility locations

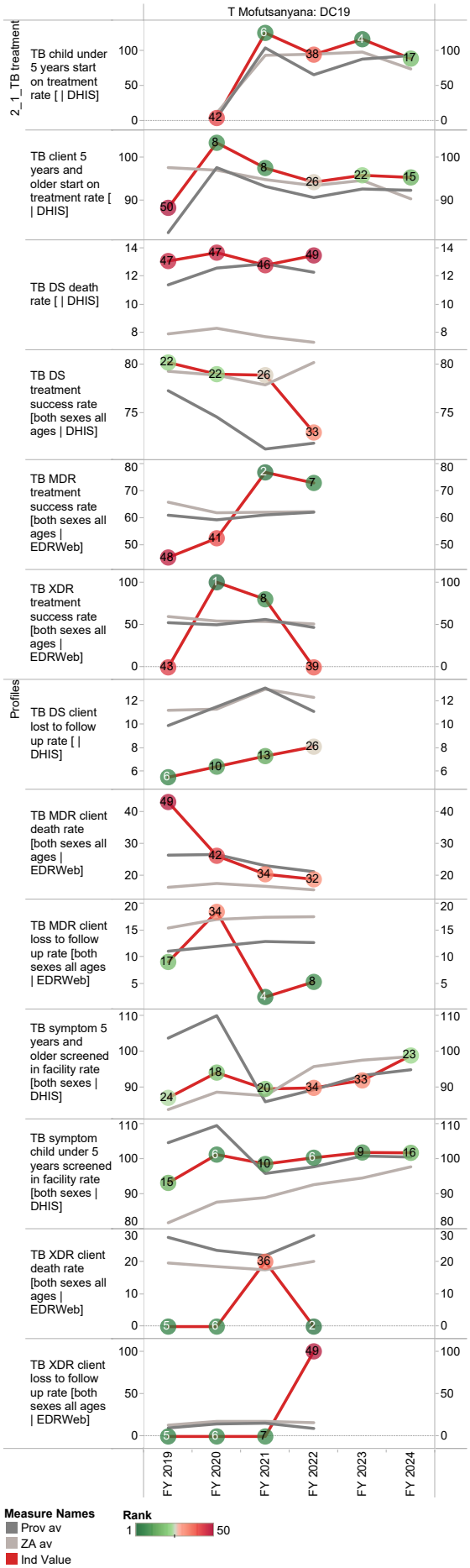


Source: DHIS

Annual trends, 2018/19–2023/24






T Mofutsanyana: DC19
2_1_TB treatment
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
TB DS death rate [| DHIS]
TB DS treatment success rate [both sexes all ages | DHIS]
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TB symptom 5 years and older screened in facility rate [both sexes | DHIS]
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TB XDR client death rate [both sexes all ages | EDRWeb]
TB XDR client loss to follow up rate [both sexes all ages | EDRWeb]
FY 2019
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FY 2021
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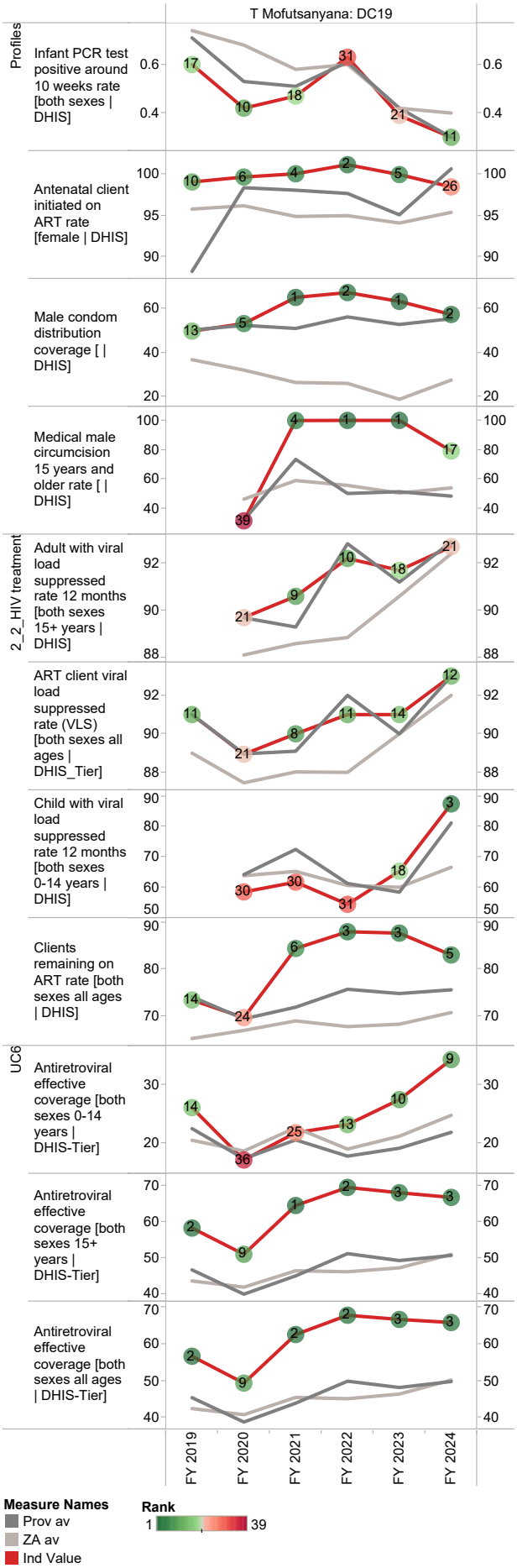
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
1
50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Infant PCR test positive around 10 weeks rate [both sexes | DHIS]
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Child with viral load suppressed rate 12 months [both sexes 0-14 years | DHIS]
Clients remaining on ART rate [both sexes all ages | DHIS]
UC6
Antiretroviral effective coverage [both sexes 0-14 years | DHIS-Tier]
Antiretroviral effective coverage [both sexes 15+ years | DHIS-Tier]
Antiretroviral effective coverage [both sexes all ages | DHIS-Tier]
FY 2019
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FY 2021
FY 2022
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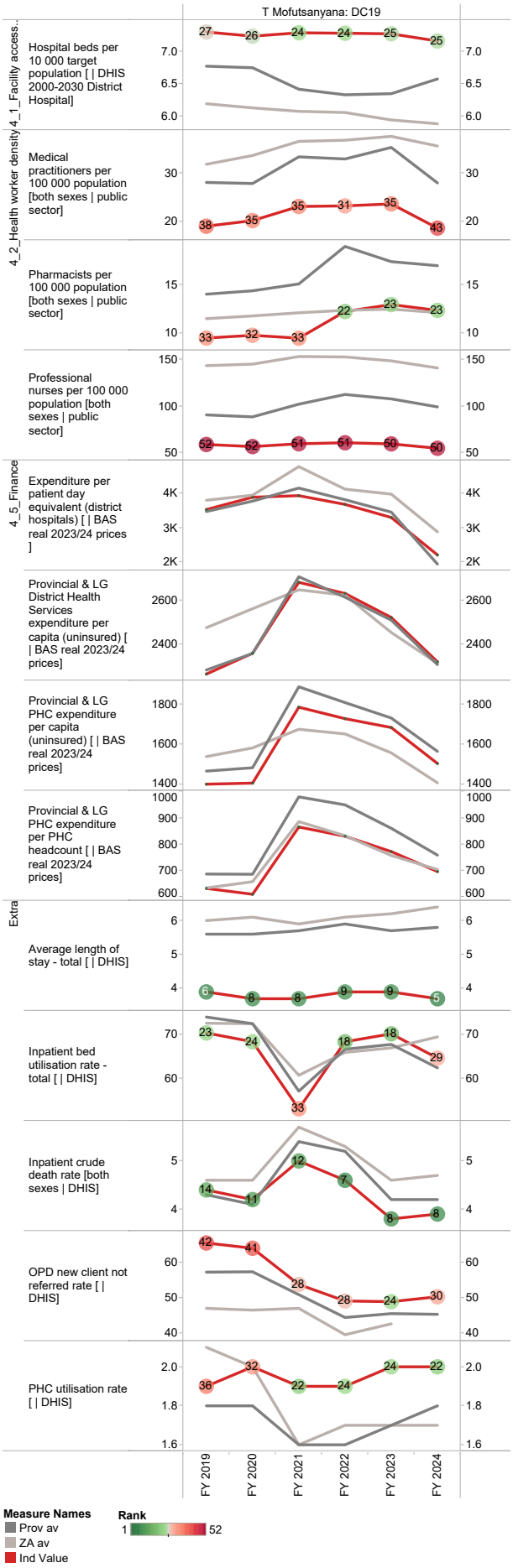
ZA av
Ind Value
Rank
1
39


T Mofutsanyana: DC19
4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
4_2_Health worker density
Medical practitioners per 100 000 population [both sexes | public sector]
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Expenditure per patient day equivalent (district hospitals) [| BAS real 2023/24 prices]
Provincial & LG District Health Services expenditure per capita (uninsured) [| BAS real 2023/24 prices]
Provincial & LG PHC expenditure per capita (uninsured) [| BAS real 2023/24 prices]
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Average length of stay - total [| DHIS]
Inpatient bed utilisation rate - total [| DHIS]
Inpatient crude death rate [both sexes | DHIS]
OPD new client not referred rate [| DHIS]
PHC utilisation rate [| DHIS]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
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Measure Names
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52

Fezile Dabi District Municipality (DC20)

The Fezile Dabi District Municipality[7] is Category C municipality. The municipality is the smallest district in the province, making up 16% of its geographical area. It consists of four local municipalities: Moqhaka, Metsimaholo, Ngwathe and Mafube.

Area: 20 668km²

Population (2023)[8]: 508 423

Households[7]: 172 370

Formal dwellings[7]: 85.6%

Cities/Towns:

Moqhaka: Kroonstad, Renovaal, Steynsrus, Vierfontein, Viljoenskroon

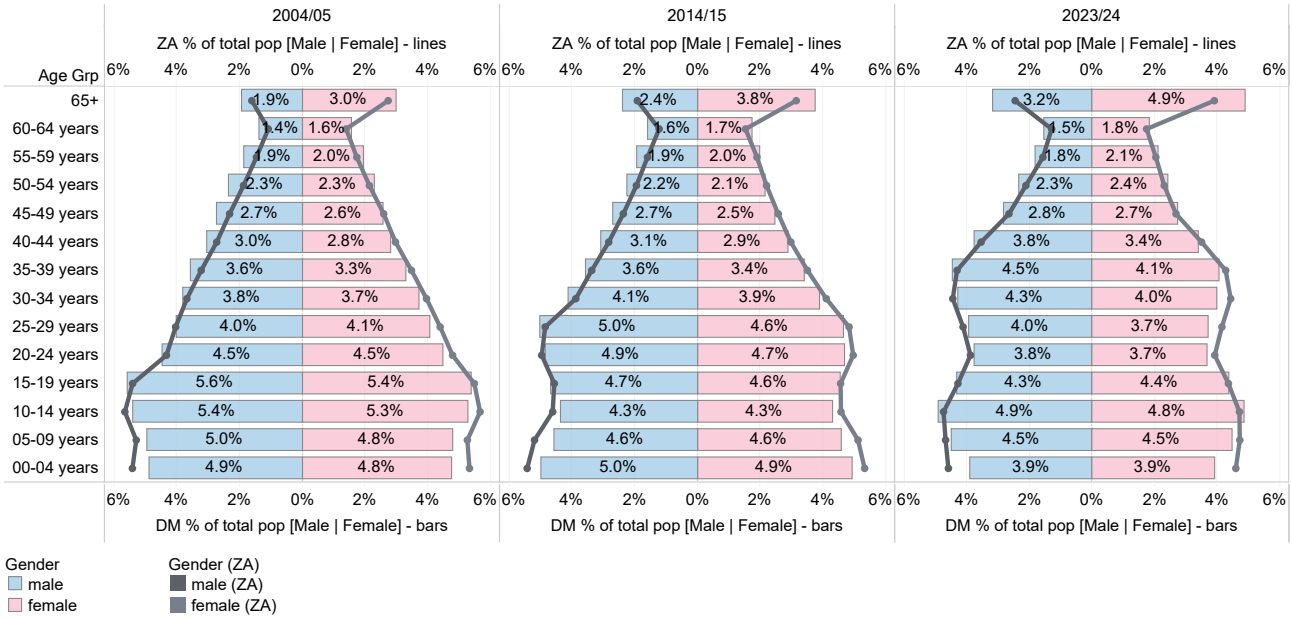
Metsimaholo: Deneysville, Kragbron, Oranjeville, Sasolburg

Ngwathe: Edenville, Heilbron, Koppies, Parys, Vredefort

Mafube: Cornelia, Frankfort, Tweeling, Villiers

District percentage population by age-gender group compared to South Africa

Fezile Dabi DM (DC20)

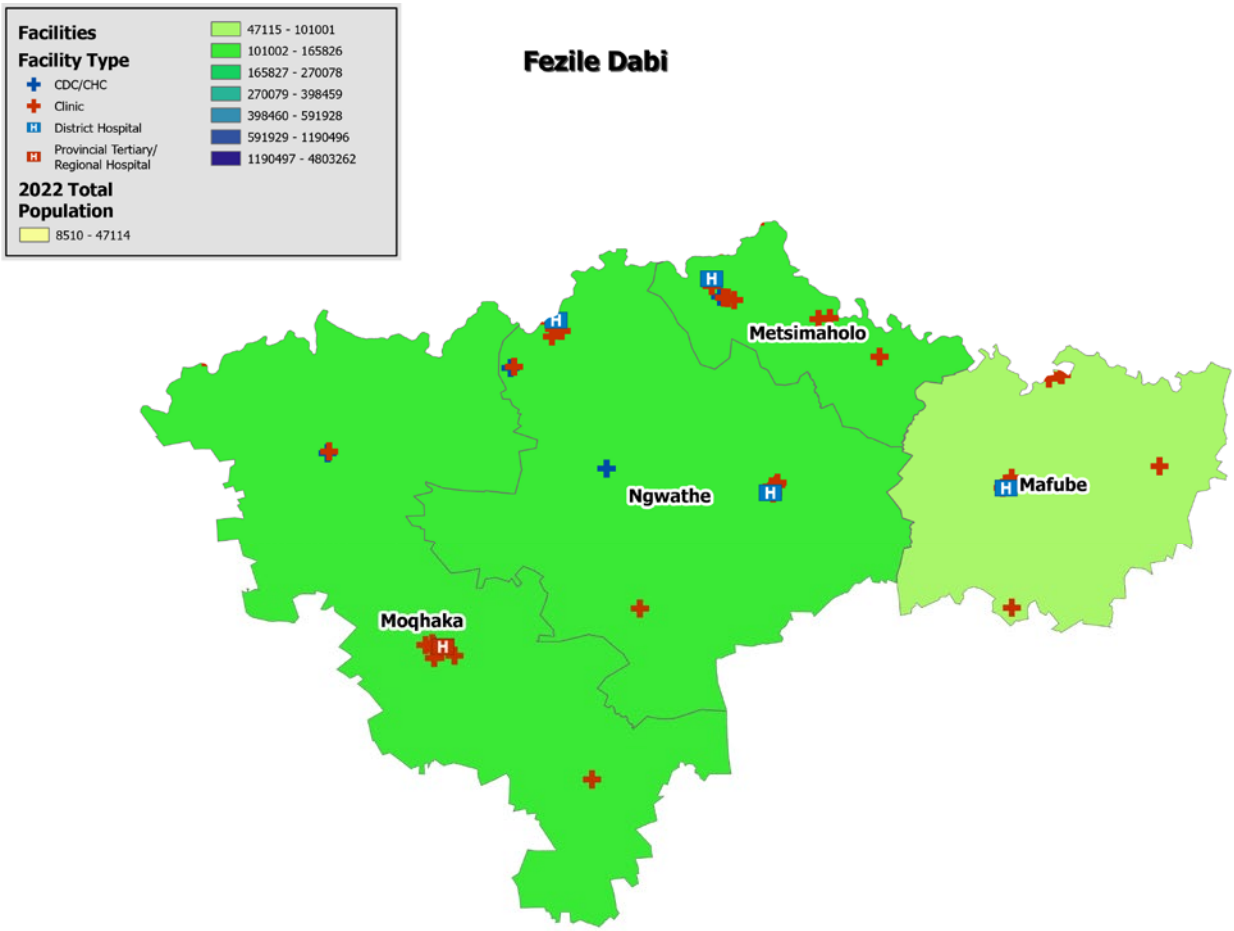


Source: DHIS

7 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

8 Mid-year Population Estimates 2023, DHIS.

Population distribution, sub-district boundaries and health facility locations



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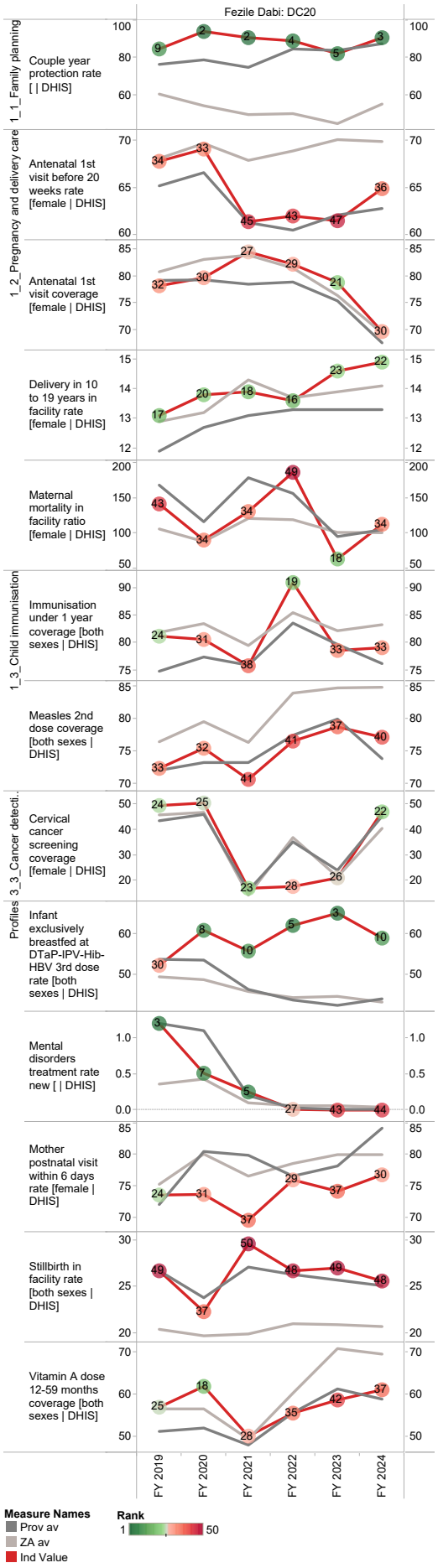
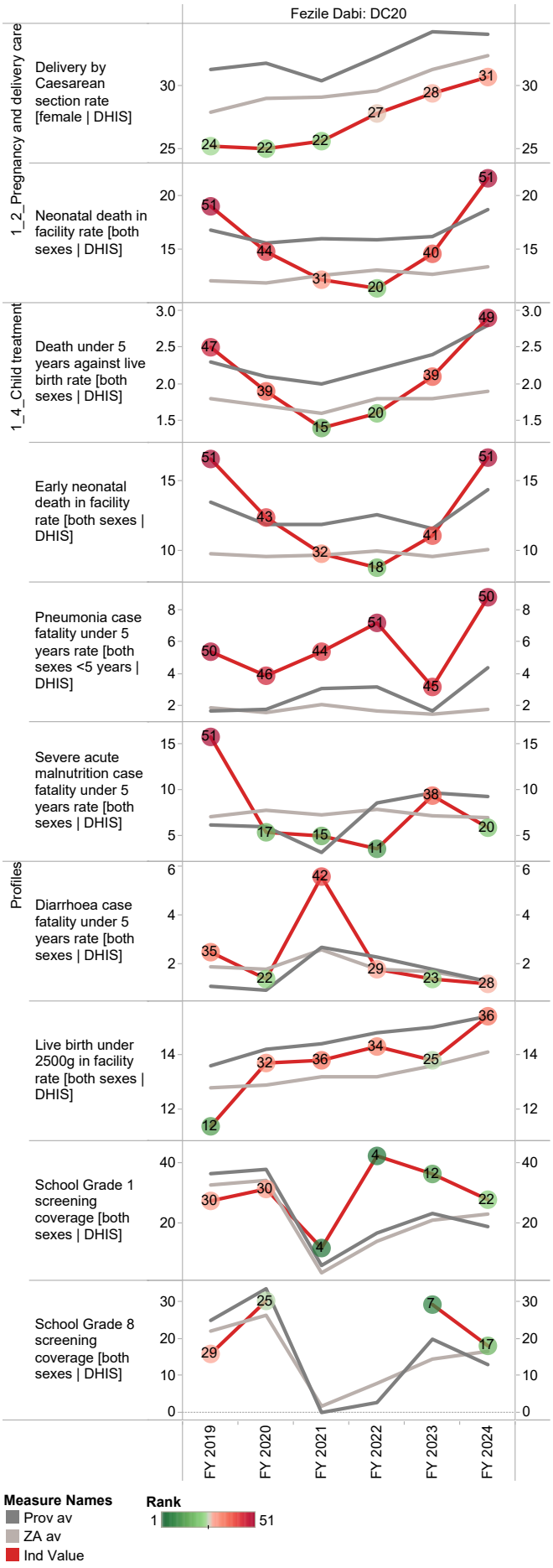
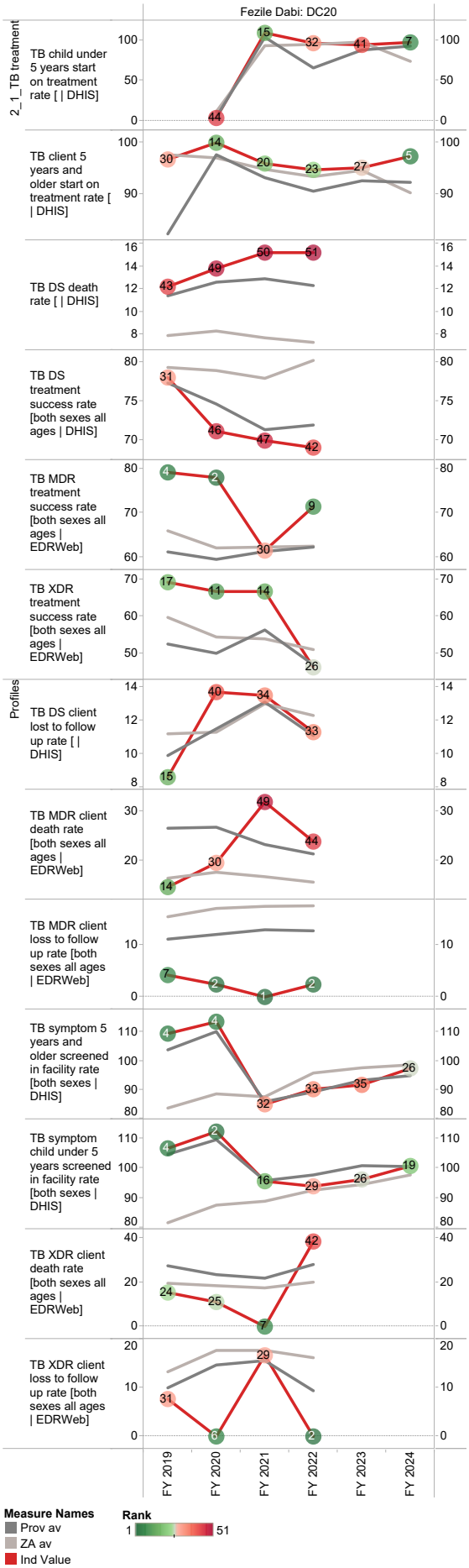
Annual trends, 2018/19–2023/24






Fezile Dabi: DC20
2_1_TB treatment
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
TB DS death rate [| DHIS]
TB DS treatment success rate [both sexes all ages | DHIS]
TB MDR treatment success rate [both sexes all ages | EDRWeb]
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Profiles
TB DS client lost to follow up rate [| DHIS]
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TB symptom 5 years and older screened in facility rate [both sexes | DHIS]
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TB XDR client death rate [both sexes all ages | EDRWeb]
TB XDR client loss to follow up rate [both sexes all ages | EDRWeb]
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Measure Names
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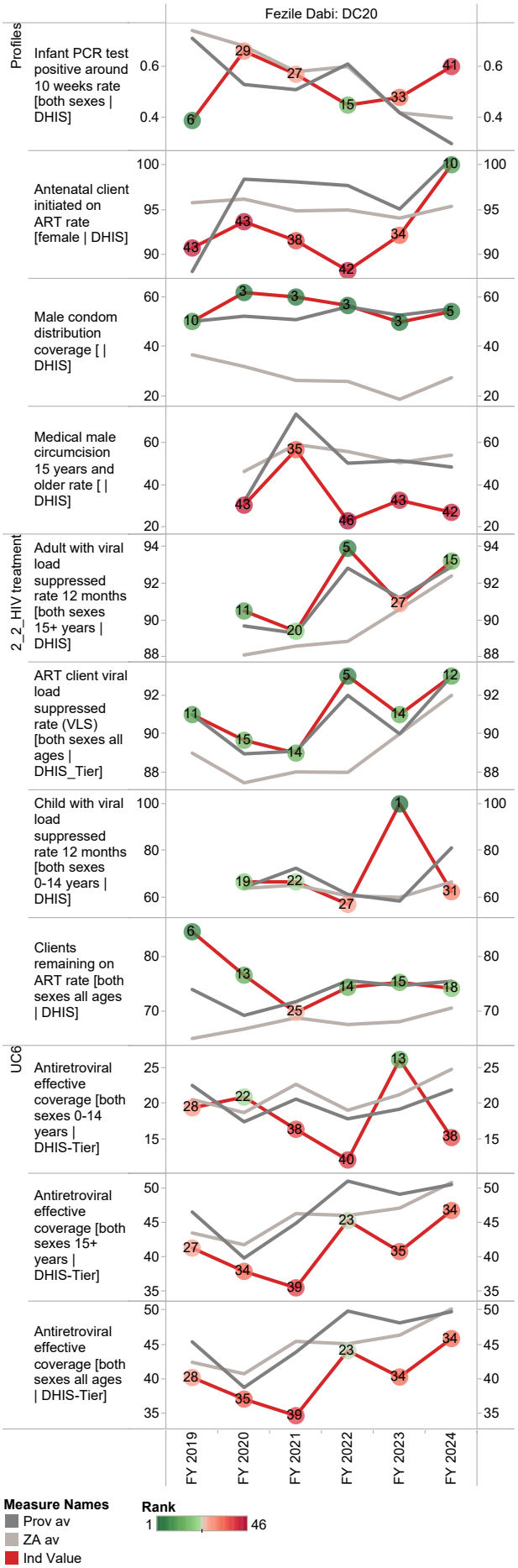
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Profiles
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Antenatal client initiated on ART rate [female | DHIS]
Male condom distribution coverage [| DHIS]
Medical male circumcision 15 years and older rate [| DHIS]
2_2_HIV treatment
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ART client viral load suppressed rate (VLS) [both sexes all ages | DHIS_Tier]
Child with viral load suppressed rate 12 months [both sexes 0-14 years | DHIS]
Clients remaining on ART rate [both sexes all ages | DHIS]
UC6
Antiretroviral effective coverage [both sexes 0-14 years | DHIS-Tier]
Antiretroviral effective coverage [both sexes 15+ years | DHIS-Tier]
Antiretroviral effective coverage [both sexes all ages | DHIS-Tier]
FY 2019
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FY 2024
Measure Names
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ZA av
Ind Value
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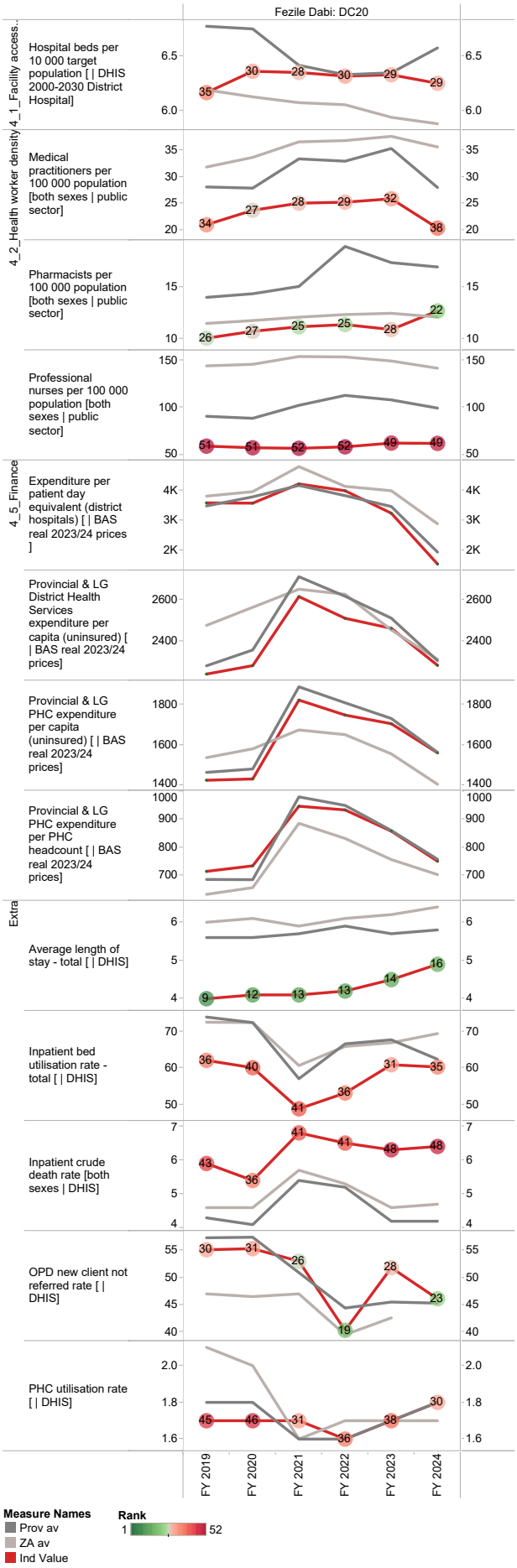
Fezile Dabi: DC20
4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
4_2_Health worker density
Medical practitioners per 100 000 population [both sexes | public sector]
Pharmacists per 100 000 population [both sexes | public sector]
Professional nurses per 100 000 population [both sexes | public sector]
4_5_Finance
Expenditure per patient day equivalent (district hospitals) [| BAS real 2023/24 prices]
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Inpatient crude death rate [both sexes | DHIS]
OPD new client not referred rate [| DHIS]
PHC utilisation rate [| DHIS]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
1
52

Mangaung Metropolitan Municipality (MAN)

The Mangaung Metropolitan Municipality[9] is a Category A municipality, and comprises four health sub-districts, namely: Bloemfontein, Botshabelo, Naledi and Thaba N'chu.

Area: 9 886km²

Population (2023)[10]: 900 614

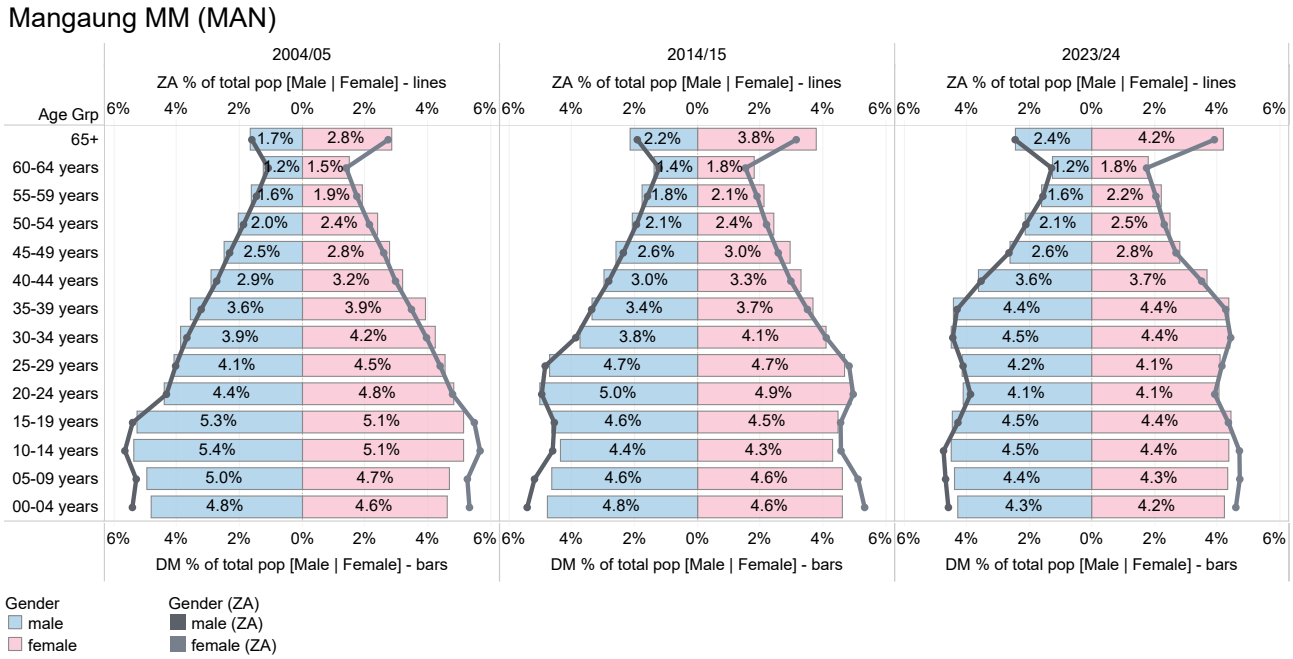
Households[9]: 265 561

Formal dwellings[9]: 87.1%

Cities/Towns:

Bloemfontein, Botshabelo, Dewetsdorp, Mangaung, Soutpan, Thaba Nchu, Van Stadensrus, Wepener

District percentage population by age-gender group compared to South Africa

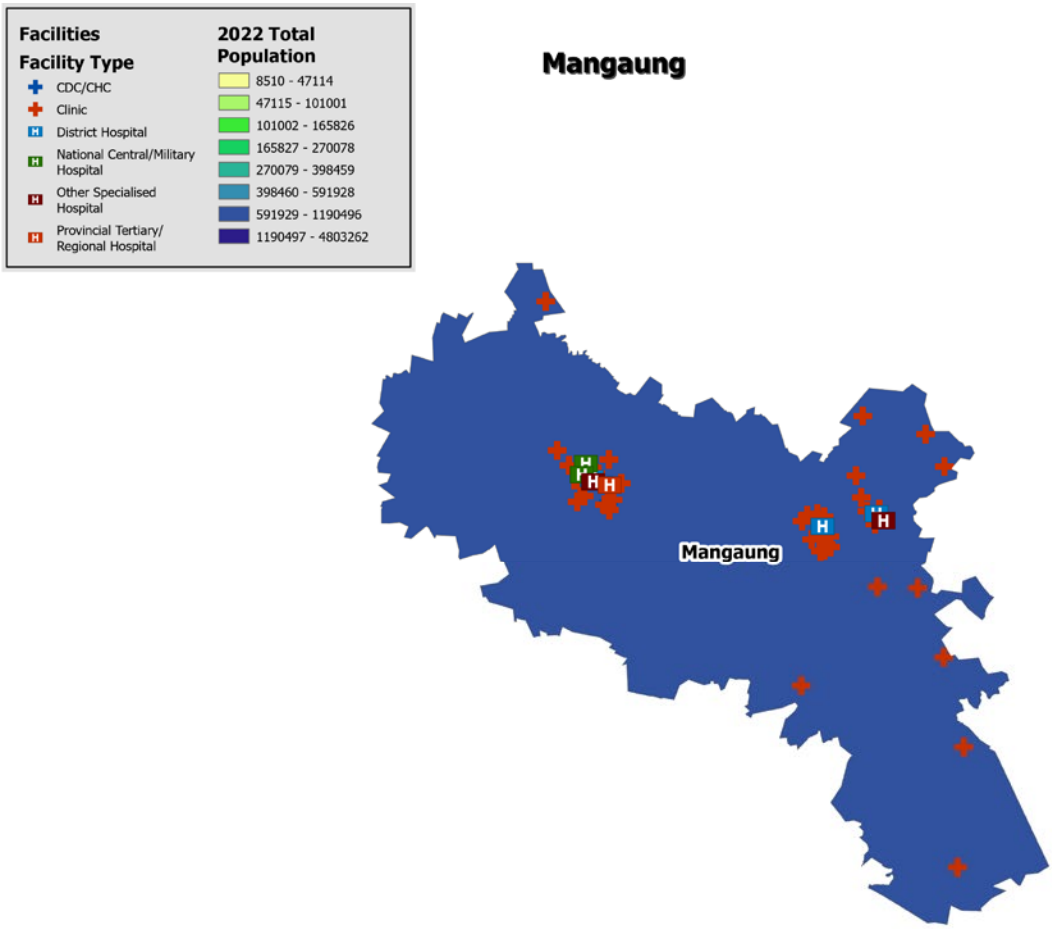


Source: DHIS

9 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

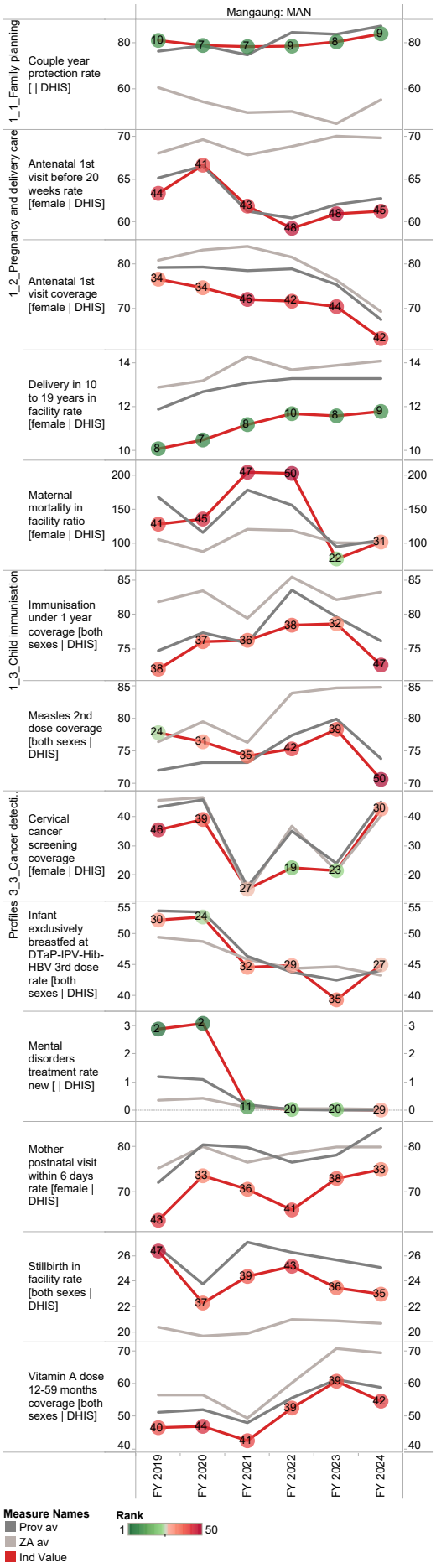
10 Mid-year Population Estimates 2023, DHIS.

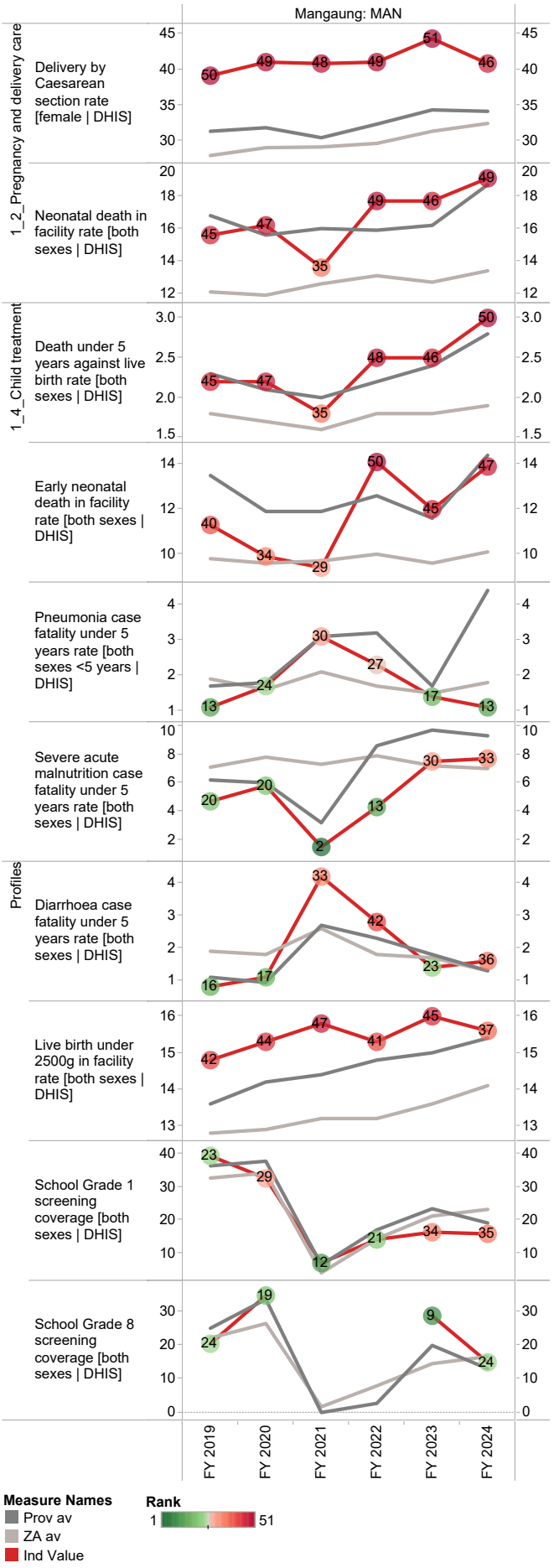
Population distribution, sub-district boundaries and health facility locations

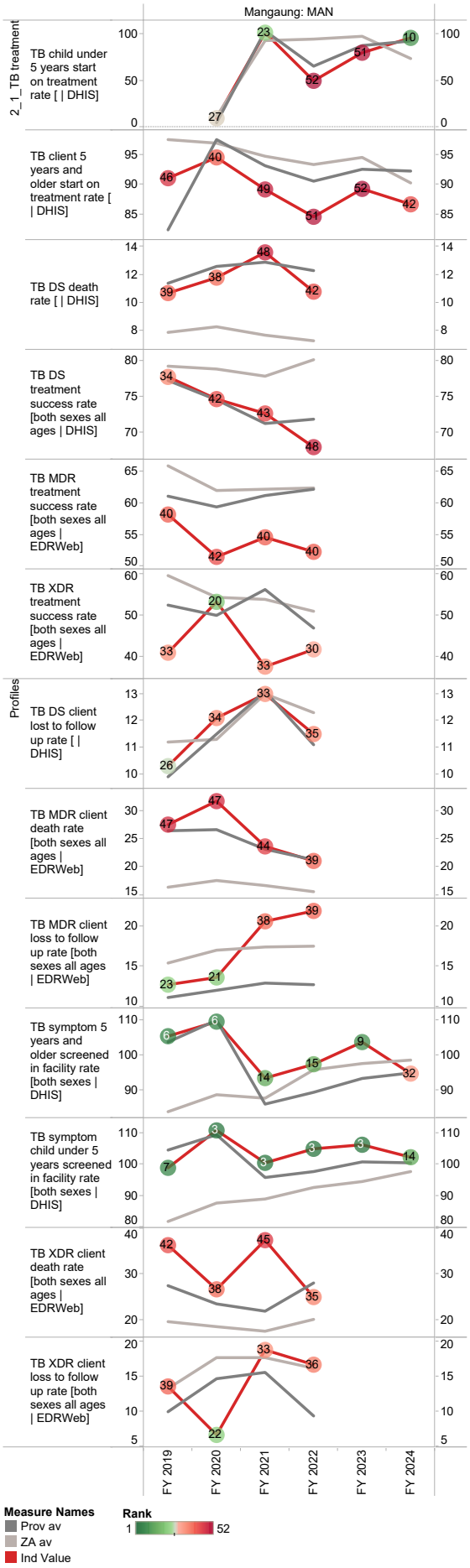


Source: DHIS

Annual trends, 2018/19–2023/24






Mangaung: MAN
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Profiles
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FY 2019
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FY 2024
Measure Names
Prov av
ZA av
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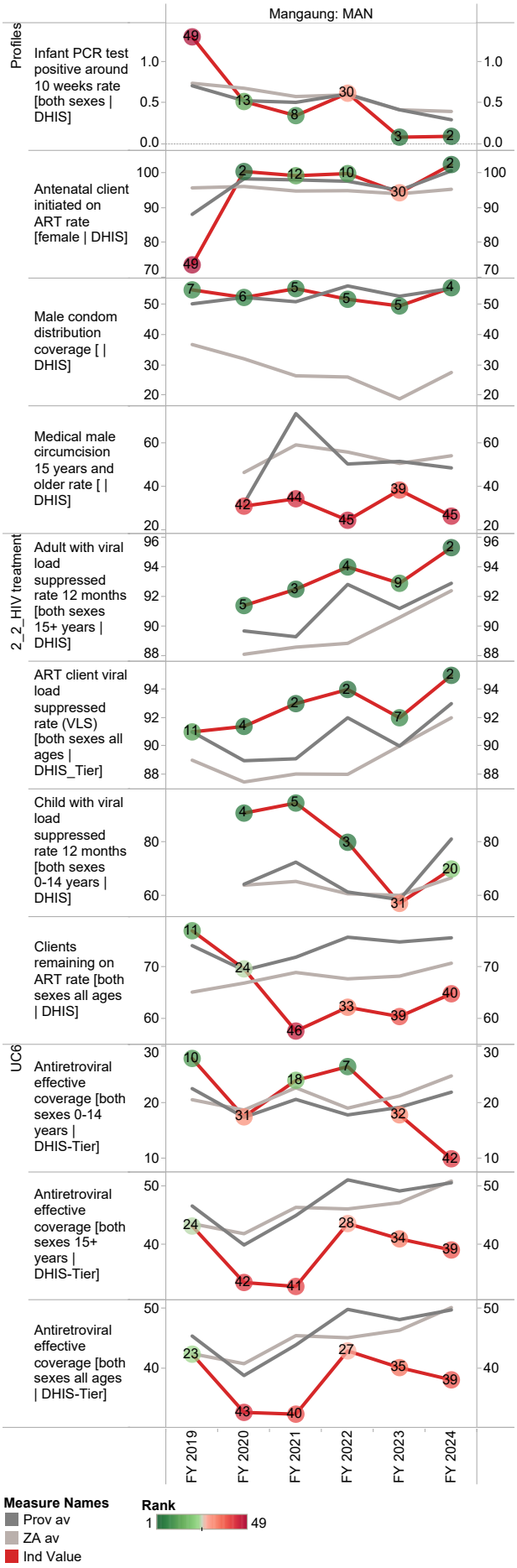
Mangaung: MAN
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Infant PCR test positive around 10 weeks rate [both sexes | DHIS]
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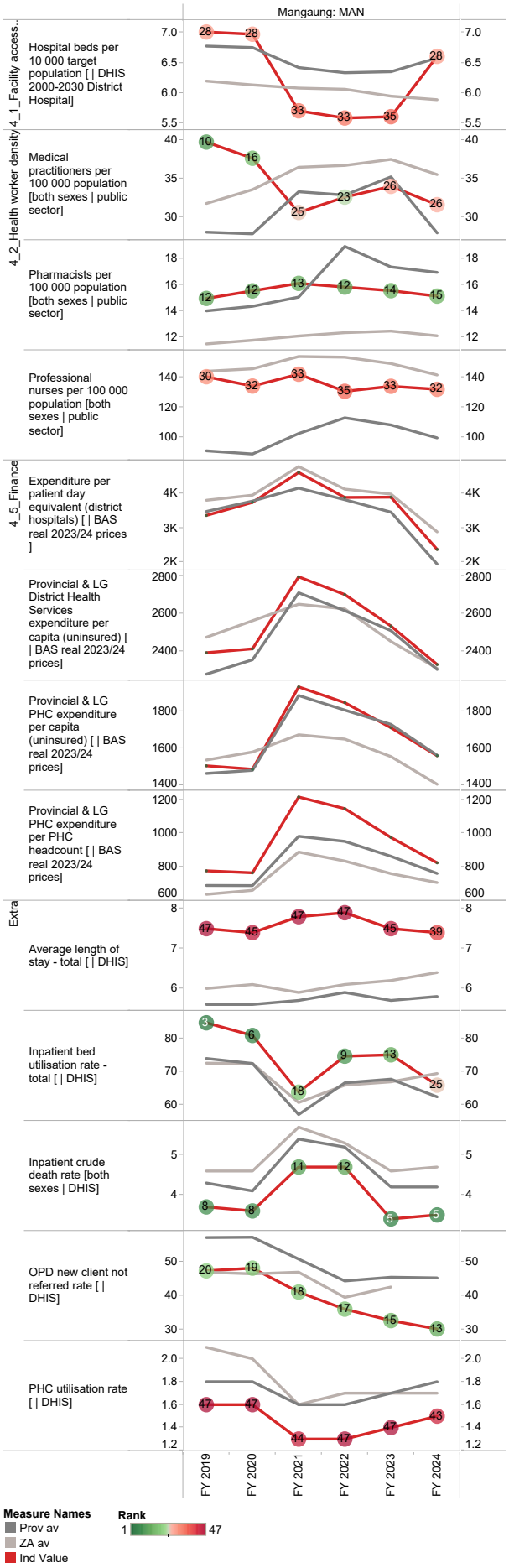
Mangaung: MAN
4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
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FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
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47

09 Gauteng Province

Sedibeng District Municipality (DC42)

The Sedibeng District Municipality[1] is a Category C municipality situated on the southern tip of the Gauteng Province and it comprises the Emfuleni, Lesedi and Midvaal Local Municipalities.

Area: 4 173km²

Population (2023)[2]: 975 815

Households[1]: 330 828

Formal dwellings[1]: 86.7%

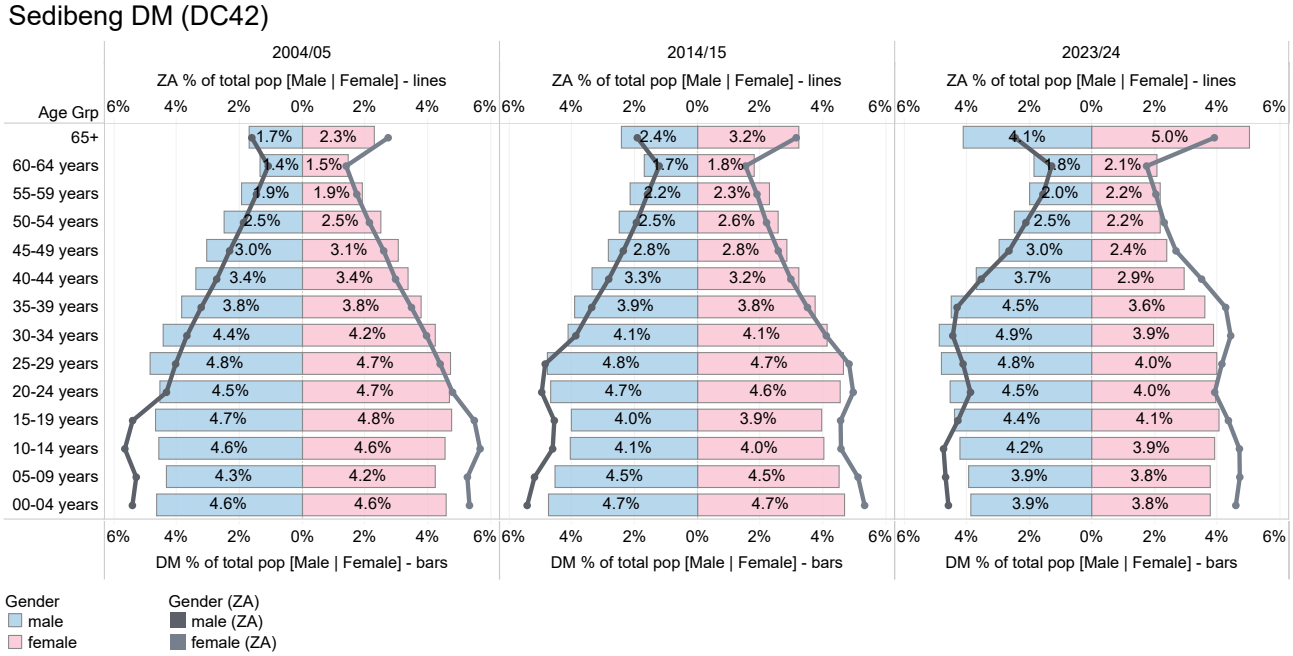
Cities/Towns:

Emfuleni: Evaton, Sebokeng, Vaal Oewer, Vanderbijlpark, Vereeniging

Lesedi: Devon, Heidelberg, Nigel, Vischkuil

Midvaal: De Deur/Walkerville, Eikenhof, Meyerton, Vaal Marina

District percentage population by age-gender group compared to South Africa

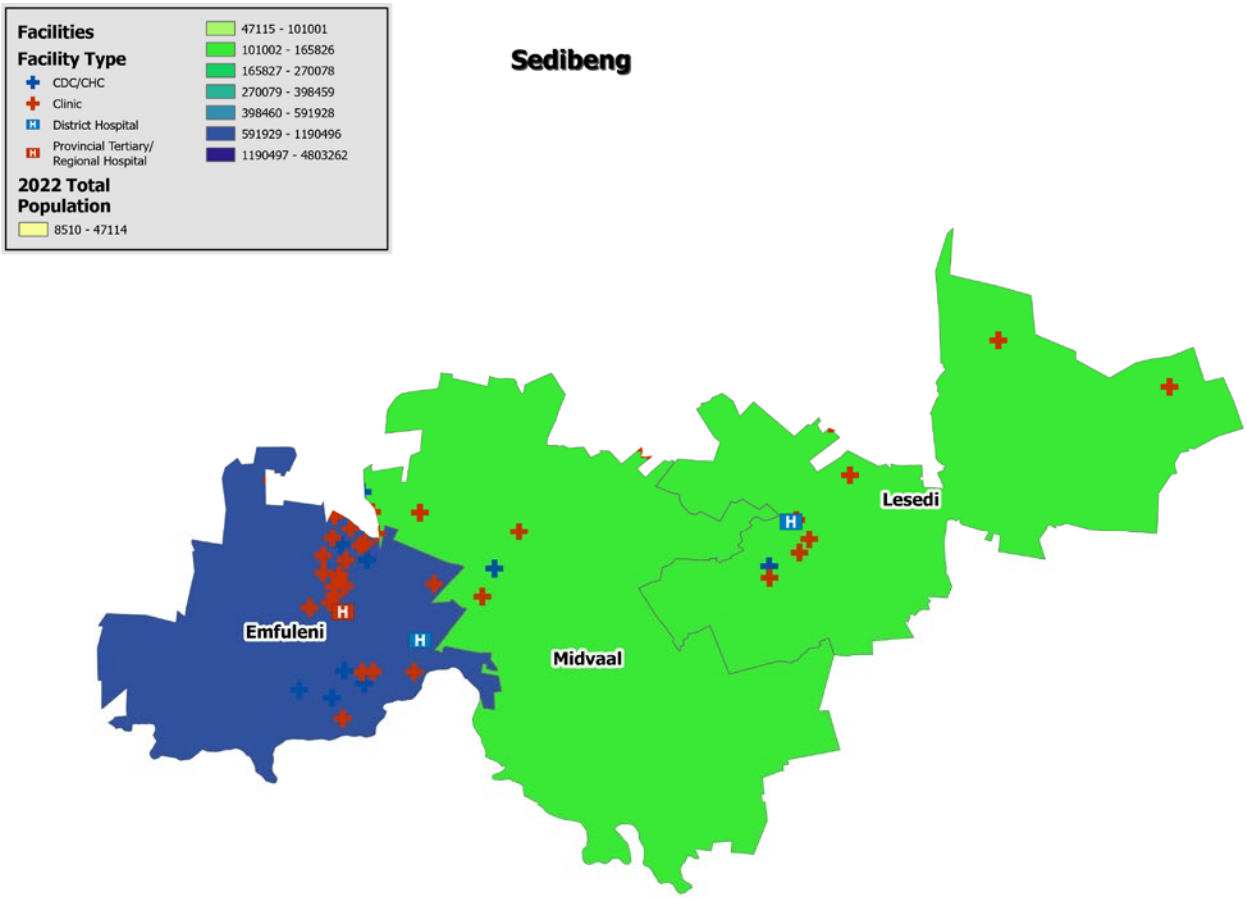


Source: DHIS

1 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

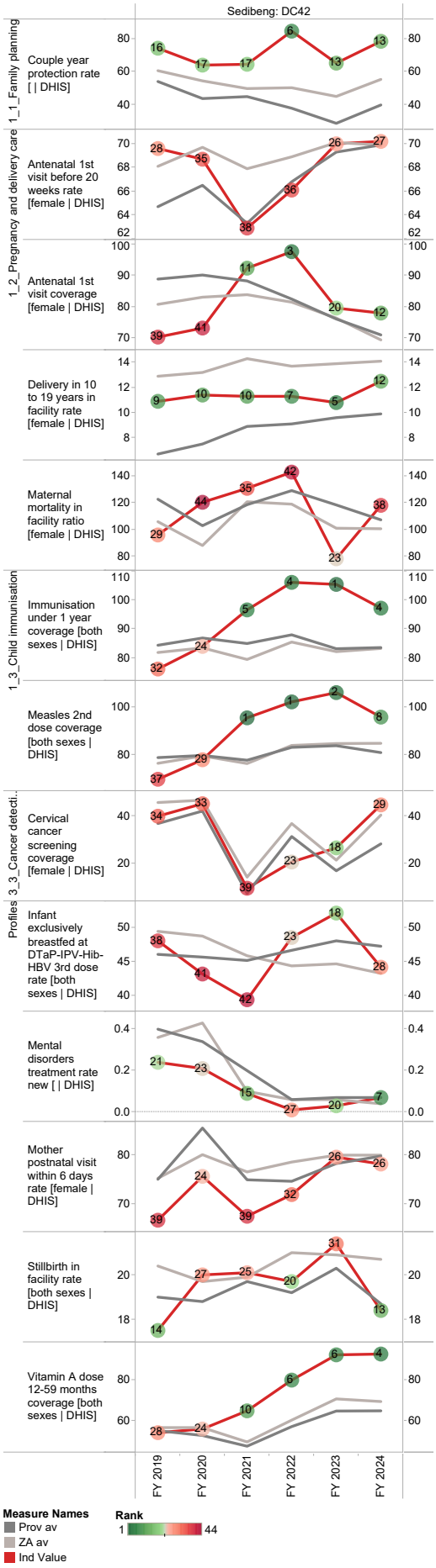
2 Mid-year Population Estimates 2023, DHIS.

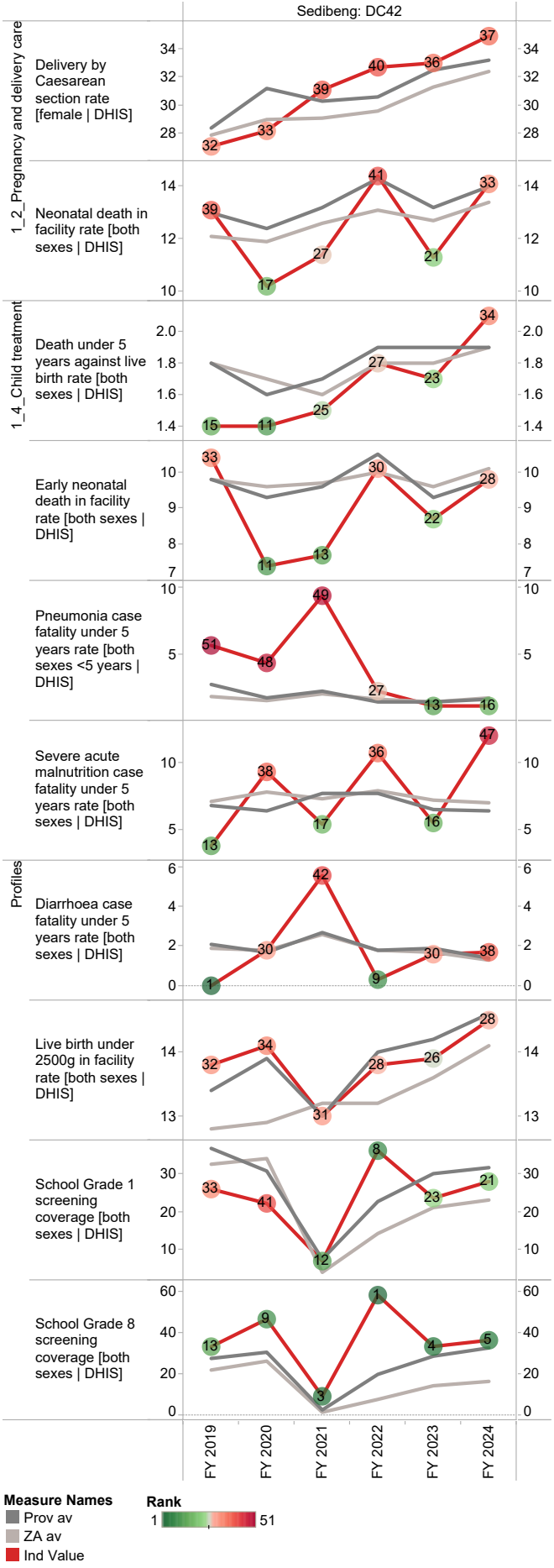
Population distribution, sub-district boundaries and health facility locations

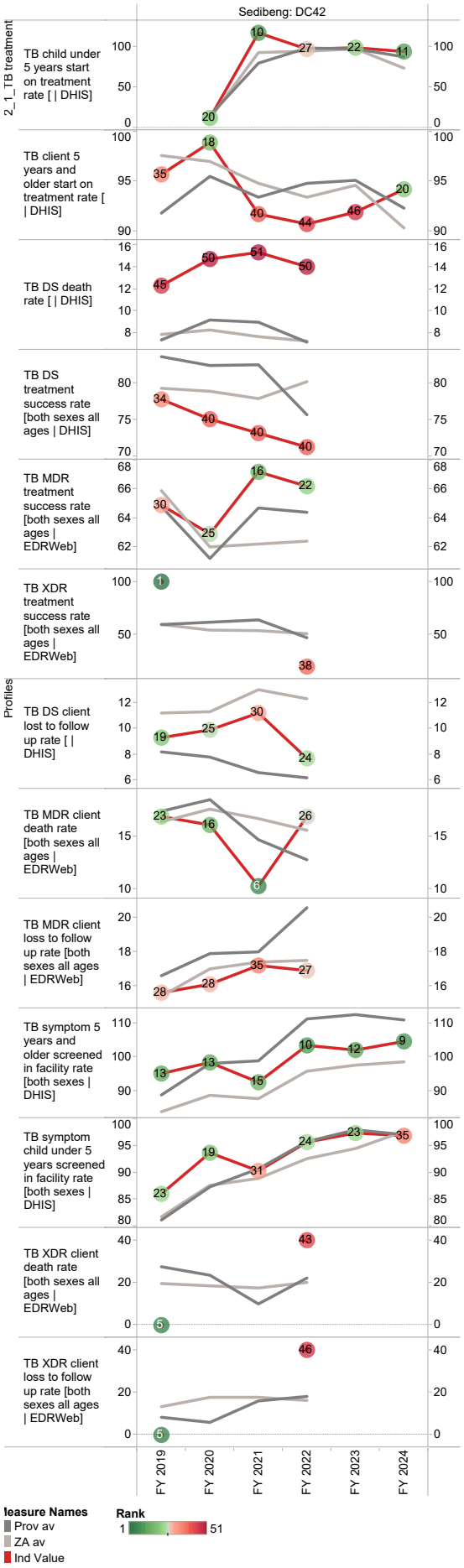


Source: DHIS

Annual trends, 2018/19–2023/24






Sedibeng: DC42
2_1_TB treatment
Profiles
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
TB DS death rate [| DHIS]
TB DS treatment success rate [both sexes all ages | DHIS]
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TB XDR treatment success rate [both sexes all ages | EDRWeb]
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FY 2019
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FY 2022
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Measure Names
Prov av
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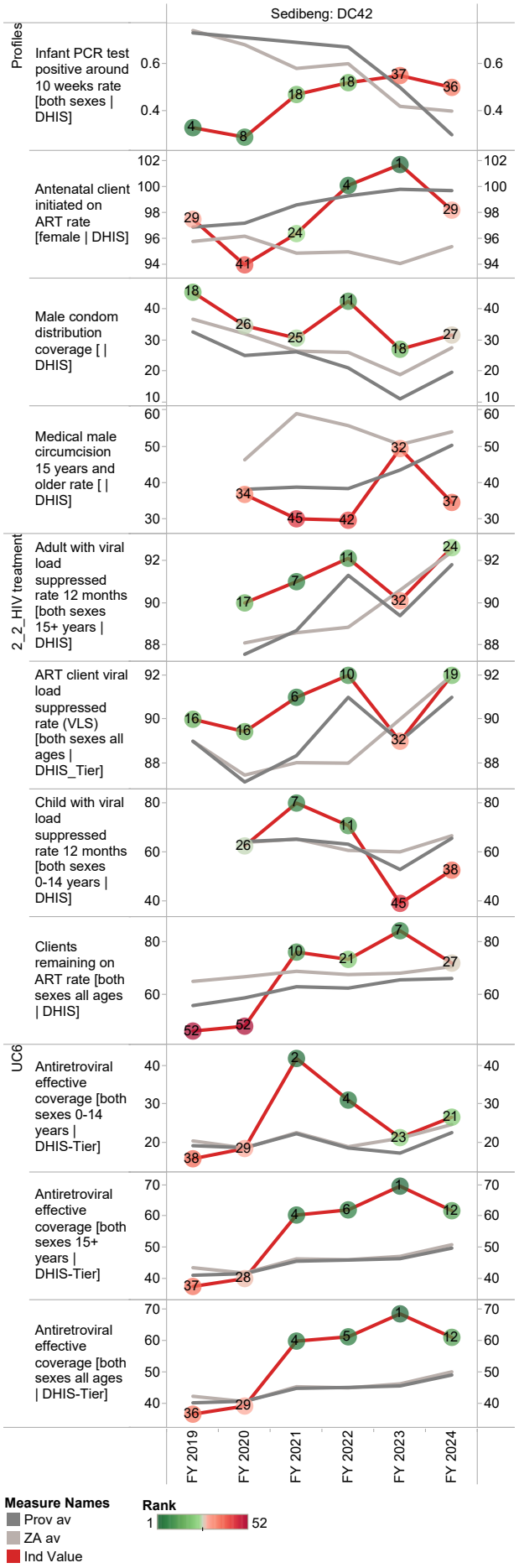
Ind Value
Rank
1
51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Antenatal client initiated on ART rate [female | DHIS]
Male condom distribution coverage [| DHIS]
Medical male circumcision 15 years and older rate [| DHIS]
2_2_HIV treatment
Adult with viral load suppressed rate 12 months [both sexes 15+ years | DHIS]
ART client viral load suppressed rate (VLS) [both sexes all ages | DHIS_Tier]
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UC6
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FY 2019
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FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
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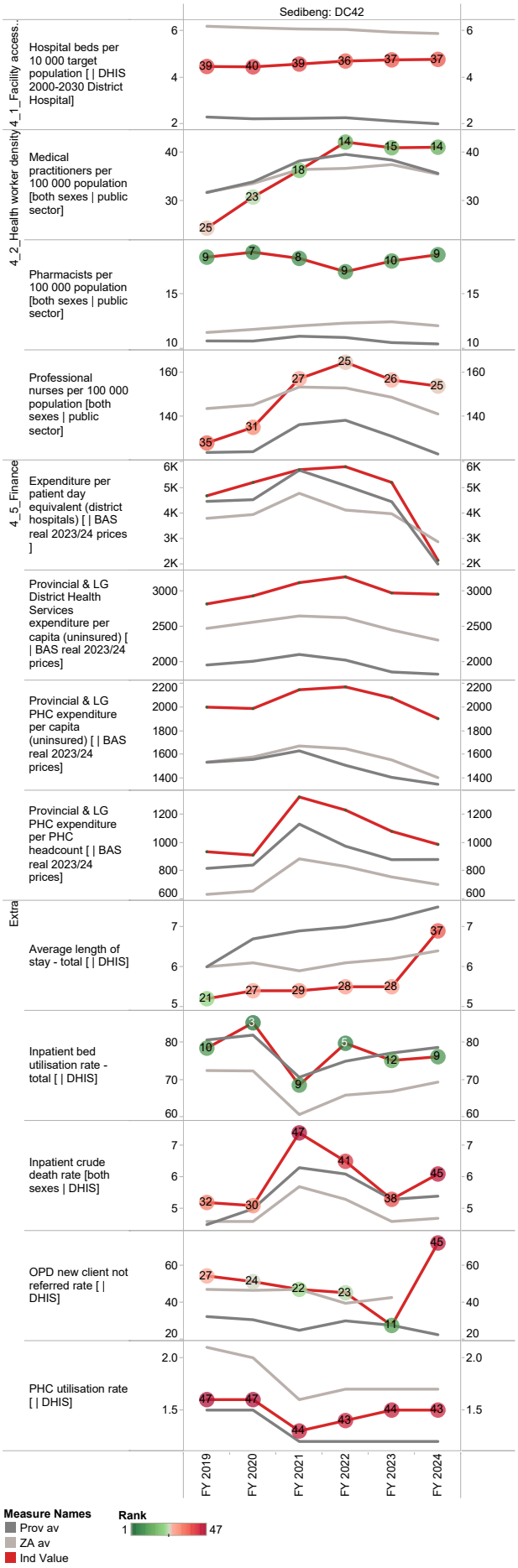
52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4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
4_2_Health worker density
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Professional nurses per 100 000 population [both sexes | public sector]
4_5_Finance
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Provincial & LG PHC expenditure per PHC headcount [| BAS real 2023/24 prices]
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Average length of stay - total [| DHIS]
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PHC utilisation rate [| DHIS]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
1
47

West Rand District Municipality (DC48)

The West Rand District Municipality[3] is a Category C municipality located in the west of the Gauteng Province. It comprises three local municipalities: Merafong, Mogale and Rand West Cities.

Area: 4 090km²

Population (2023)[4]: 1 011 253

Households[3]: 330 572

Formal dwellings[3]: 76.3%

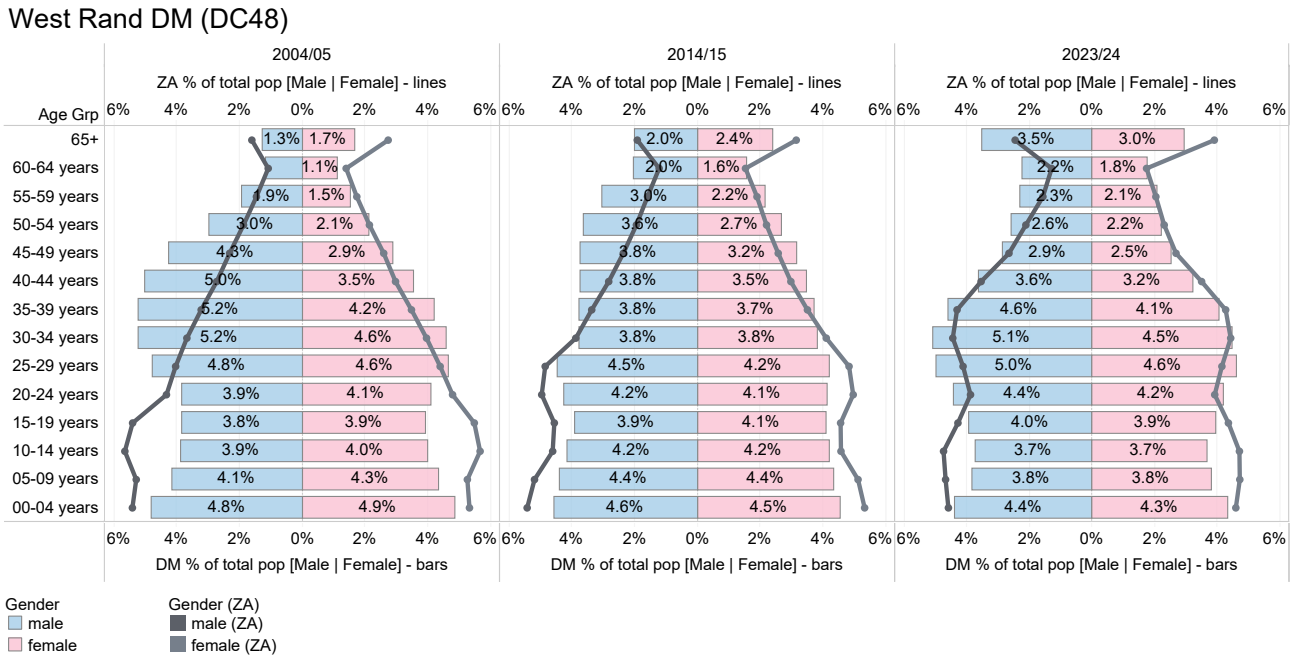
Cities/Towns:

Merafong: Carletonville, Fochville, Wedela

Mogale: Krugersdorp, Magaliesburg, Muldersdrift

Rand West: Randfontein, Westonaria

District percentage population by age-gender group compared to South Africa

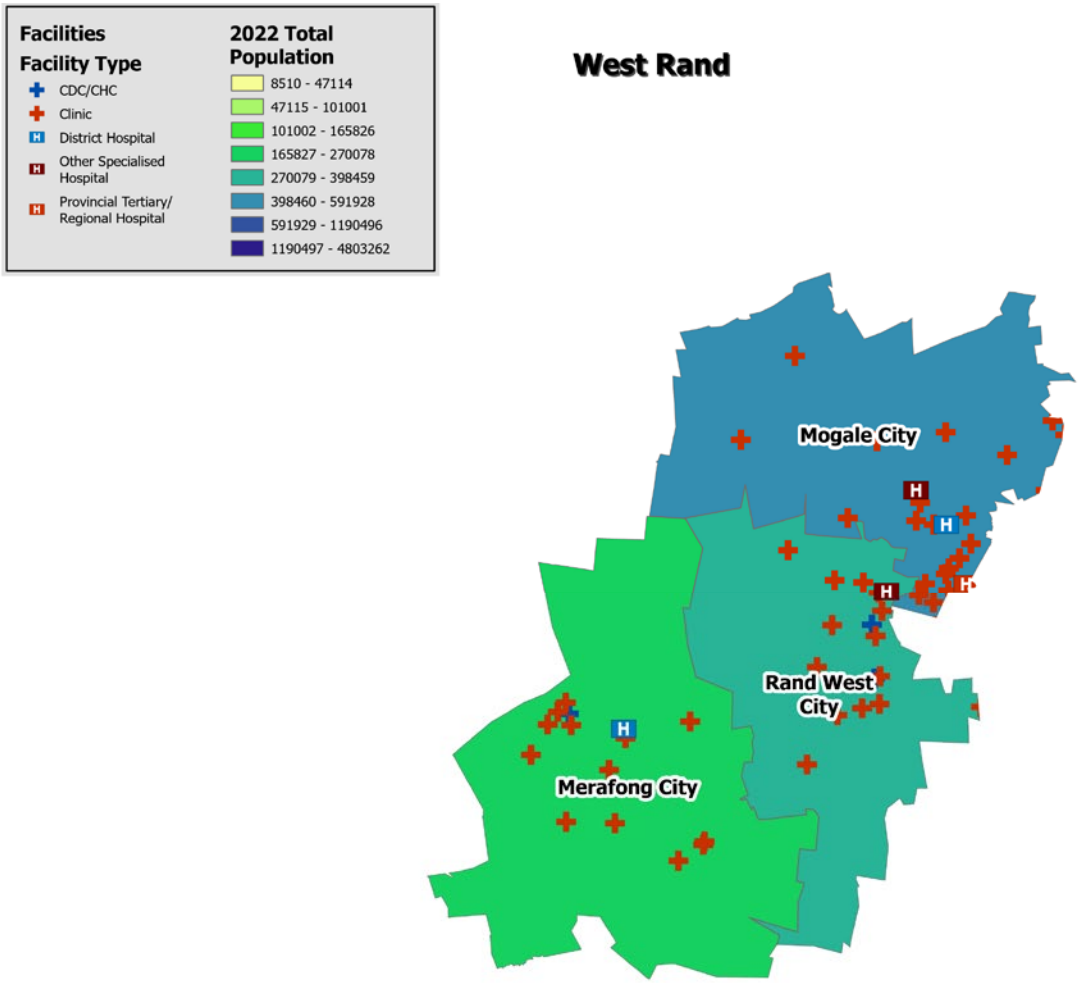


Source: DHIS

3 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

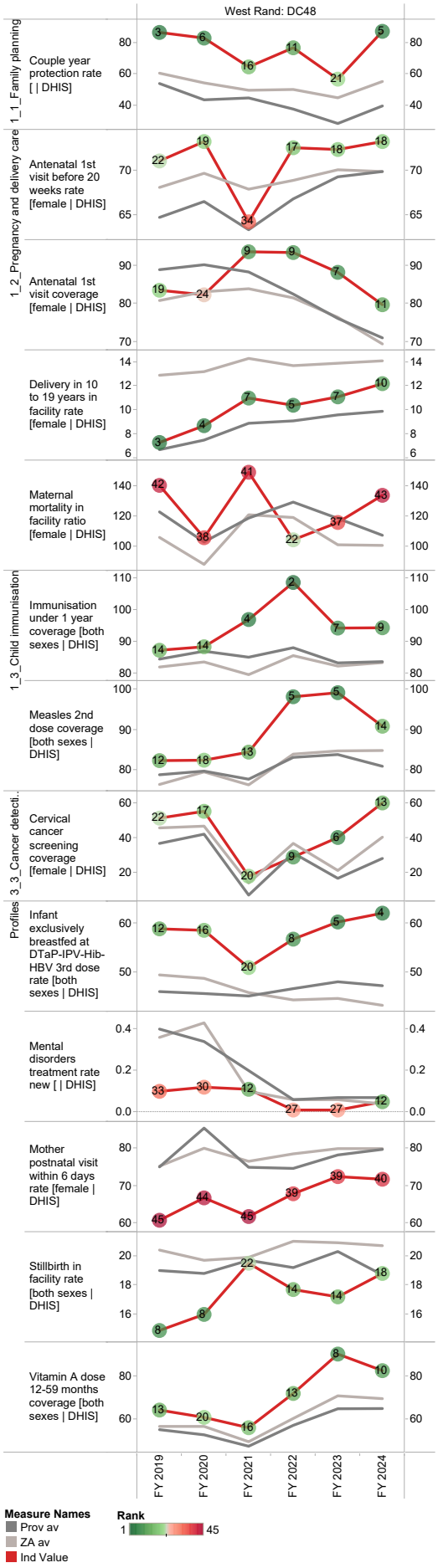
4 Mid-year Population Estimates 2023, DHIS.

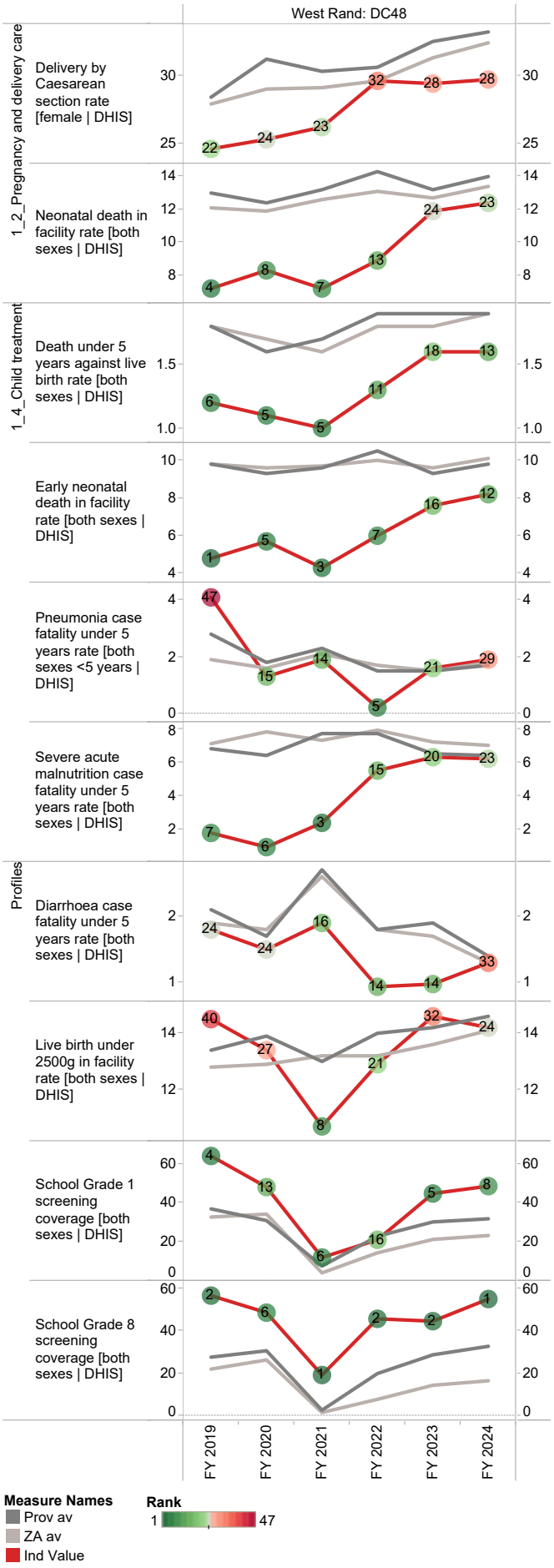
Population distribution, sub-district boundaries and health facility locations

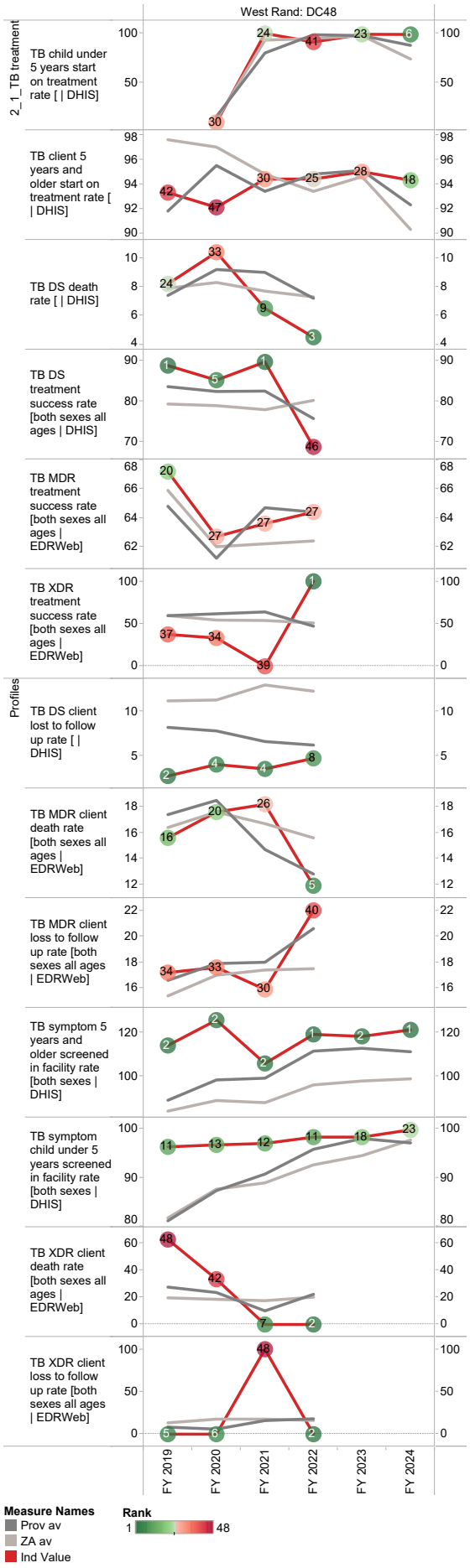


Source: DHIS

Annual trends, 2018/19–2023/24






West Rand: DC48
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FY 2019
FY 2020
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FY 2022
FY 2023
FY 2024
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Prov av
ZA av
Ind Value
Rank
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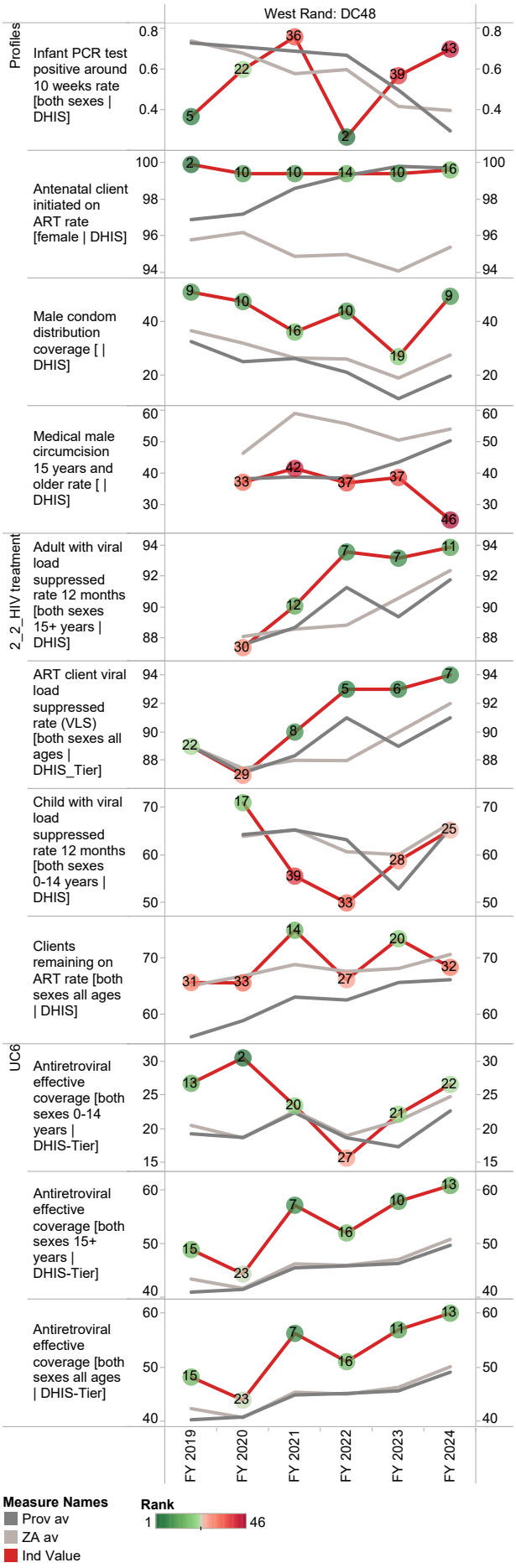
48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FY 2019
FY 2020
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FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
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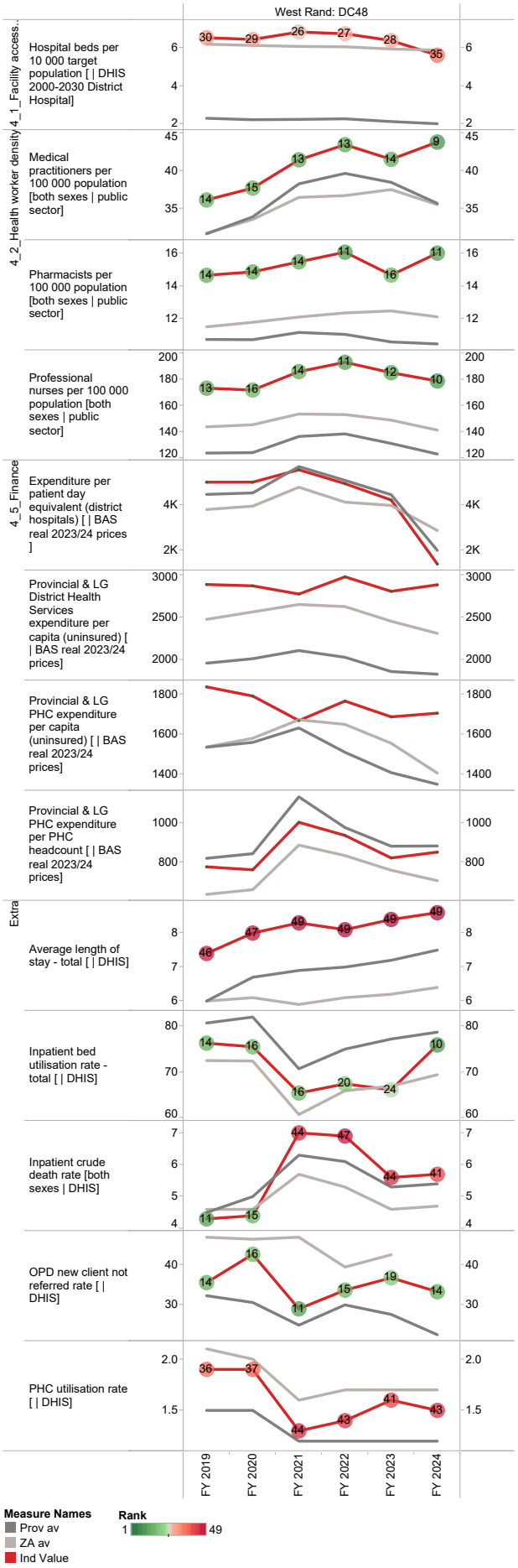
46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FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
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49

Ekurhuleni Metropolitan Municipality (EKU)

The City of Ekurhuleni Metropolitan Municipality[5] Category A municipality in Gauteng Province. The former administrations of the nine towns in the former East Rand were amalgamated into the metropolitan municipality, along with the Khayalami Metropolitan Council and the Eastern Gauteng Services Council. It is one of the most densely populated areas in the province, and in the country. It comprises six health sub-districts, namely: Ekurhuleni East 1 and East 2, Ekurhuleni North 1 and North 2, and Ekurhuleni South 1 and South 2.

Area: 1 975km²

Population (2023)[6]: 4 337 642

Households[5]: 1 299 490

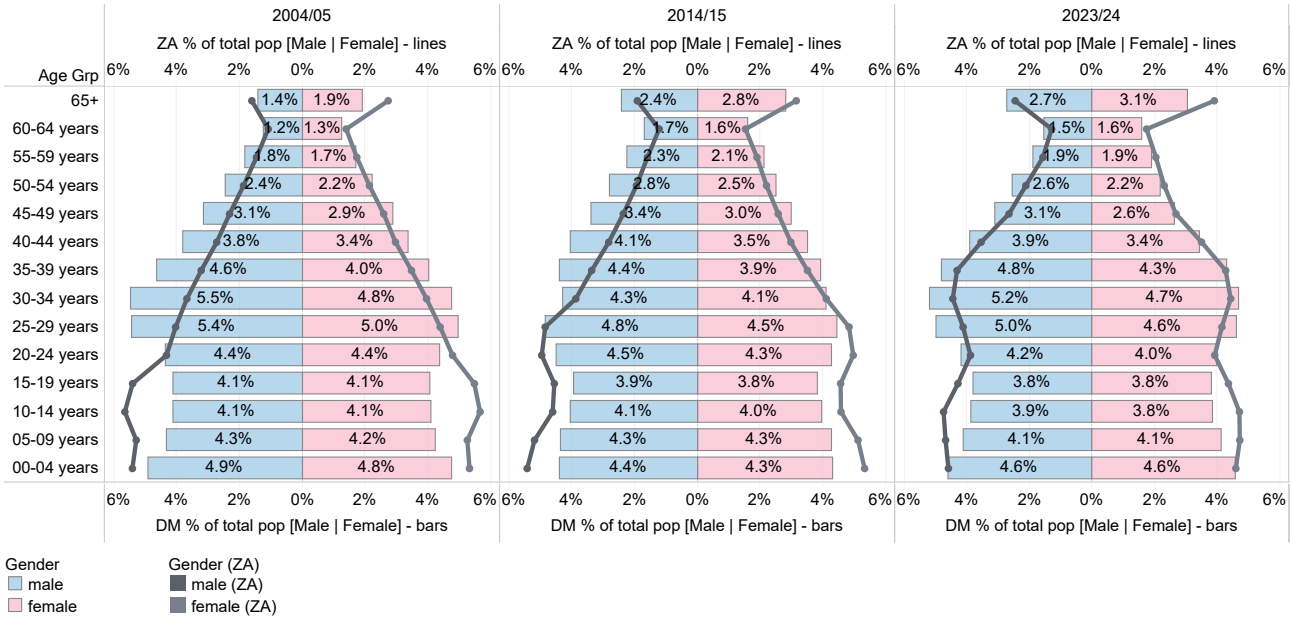
Formal dwellings[5]: 80.4%

Cities/Towns:

Alberton, Bedfordview, Benoni, Birchleigh, Boksburg, Brakpan, Clayville, Daveyton, Dunnottar, Edenvale, Geduld, Germiston, Katlehong, Kempton Park, Kwa-Thema, Machenzieville, Nigel, Olifantsfontein, Springs, Tembisa, Tokoza, Vosloorus, Vorsterkroon

District percentage population by age-gender group compared to South Africa

City of Ekurhuleni MM (EKU)

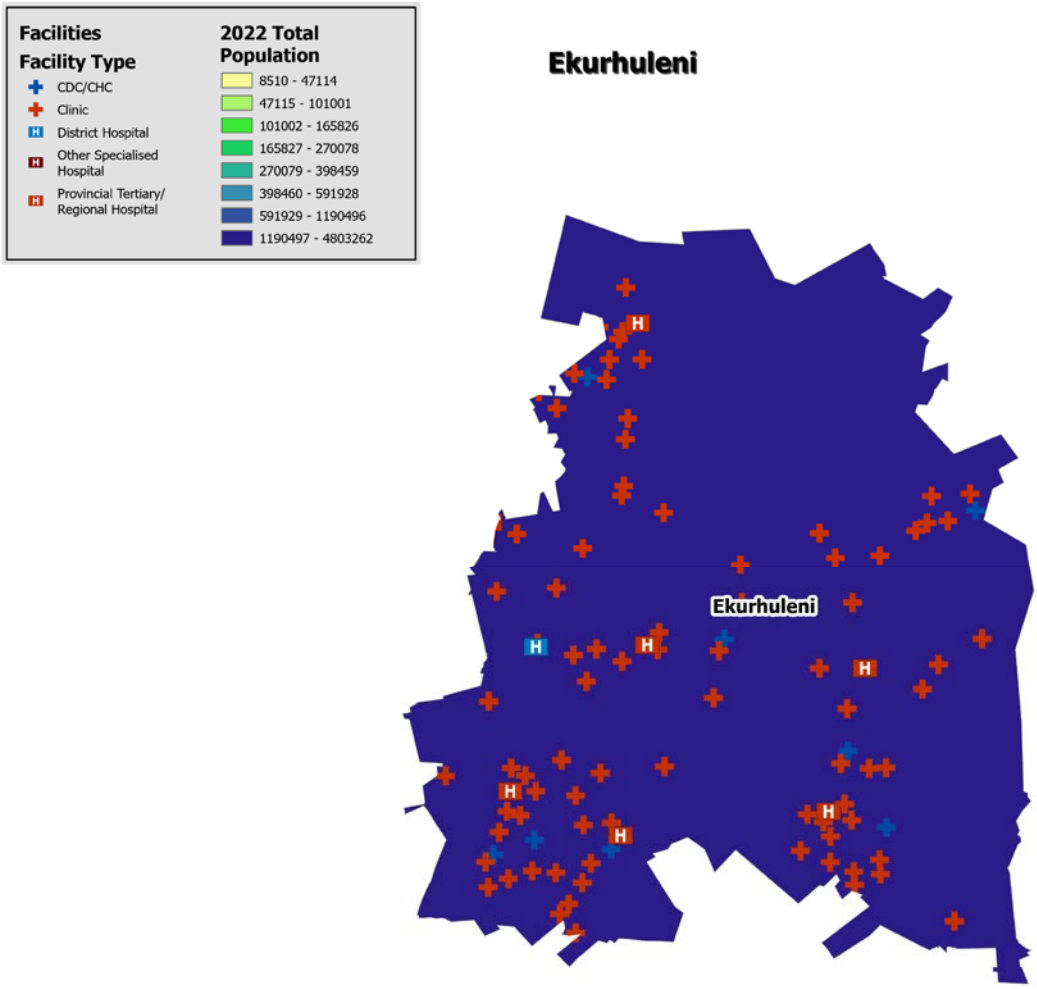


Source: DHIS

5 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

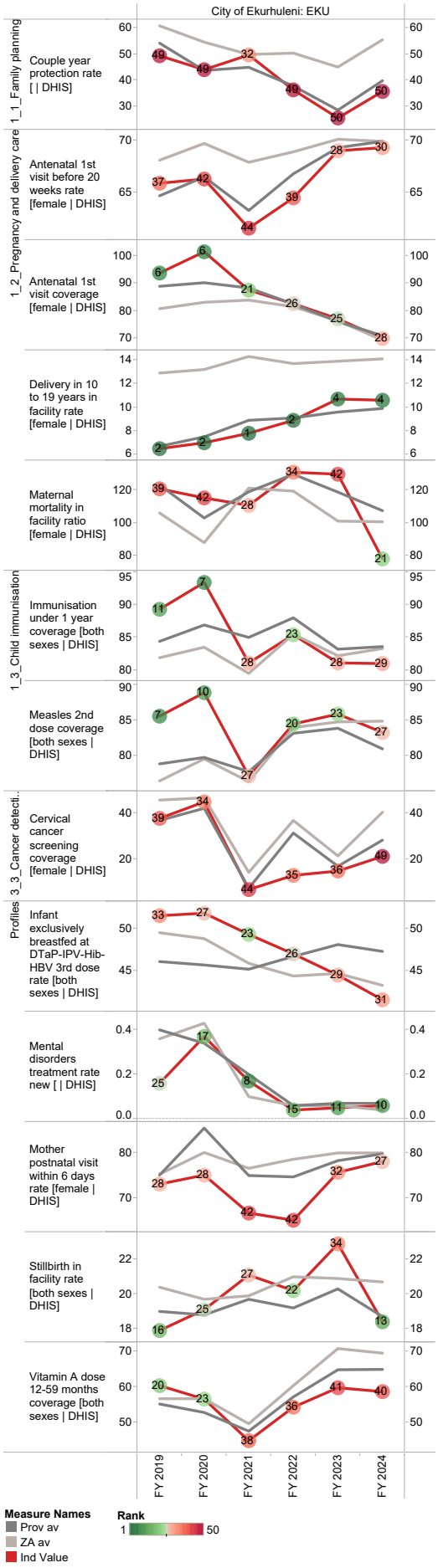
6 Mid-year Population Estimates 2023, DHIS.

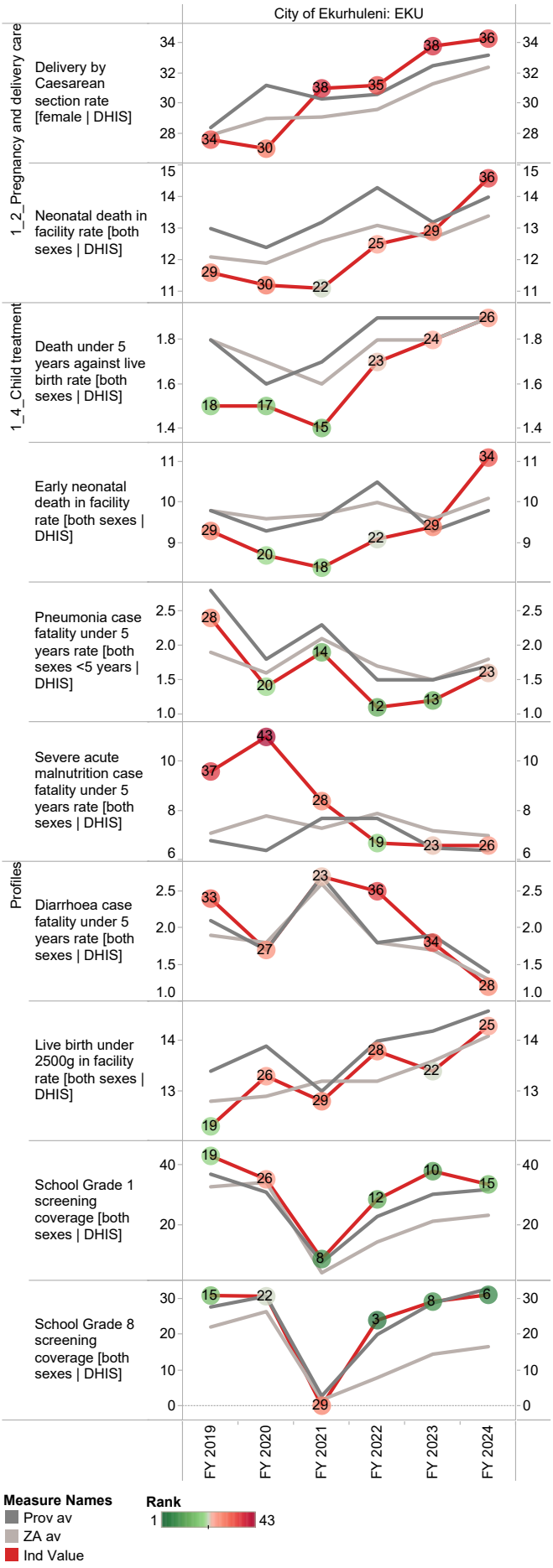
Population distribution, sub-district boundaries and health facility locations

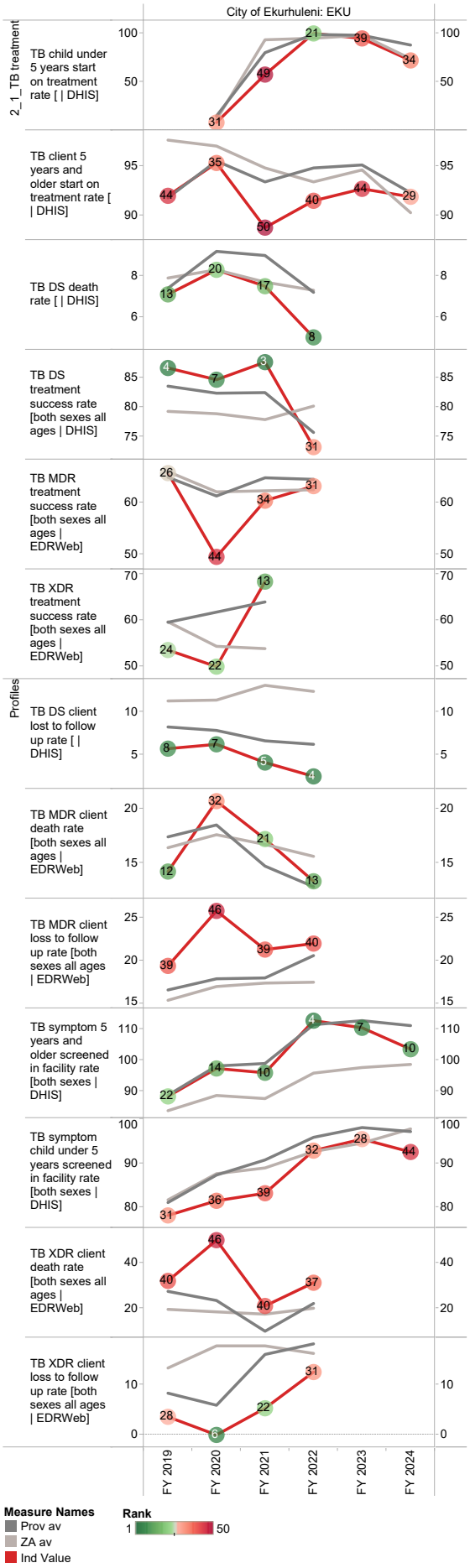


Source: DHIS

Annual trends, 2018/19–2022/23






City of Ekurhuleni: EKU
2_1_TB treatment
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
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FY 2019
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FY 2024
Measure Names
Prov av
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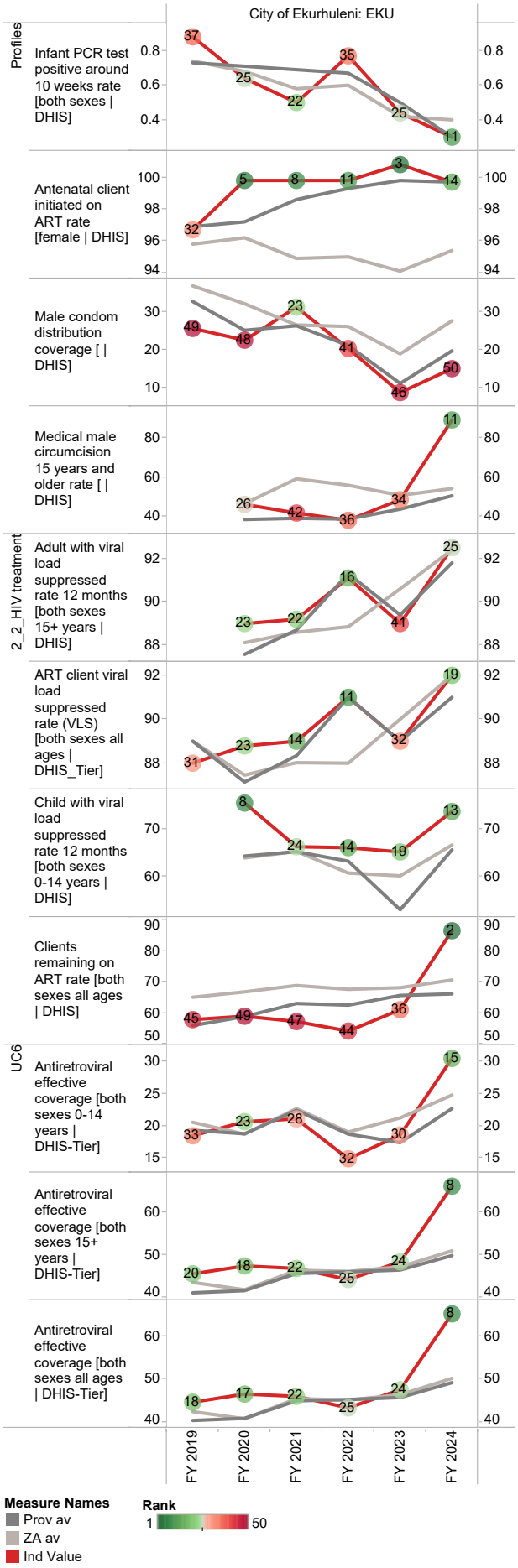
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FY 2024
Measure Names
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Rank
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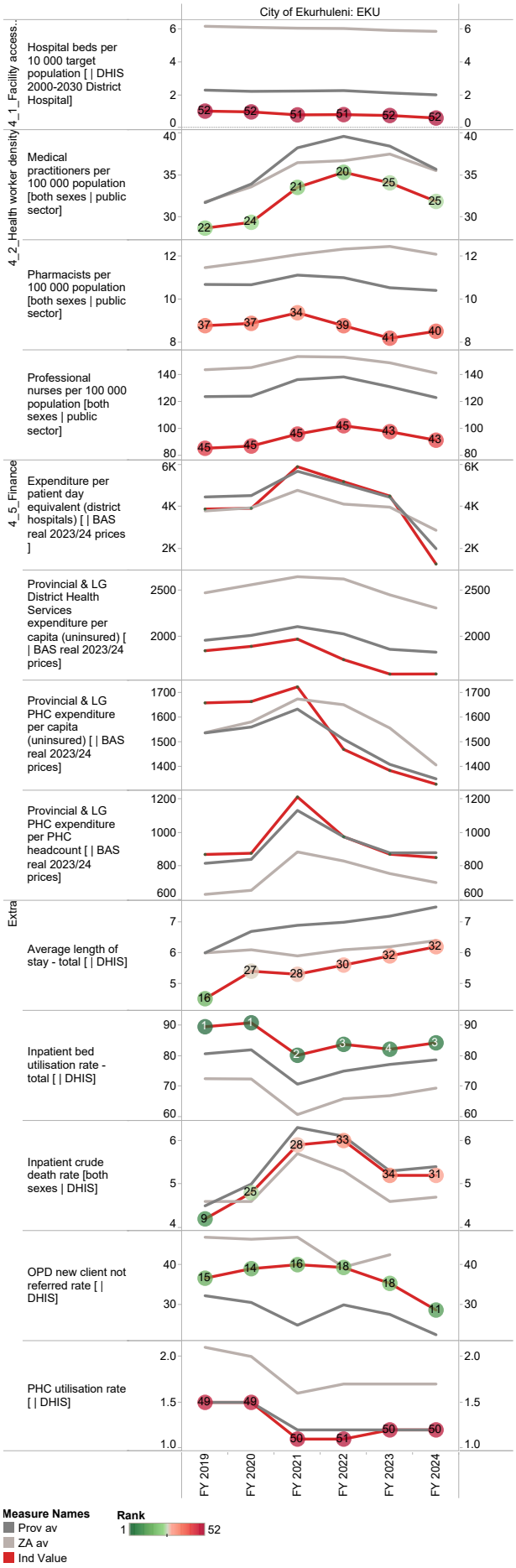
City of Ekurhuleni: EKU
4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
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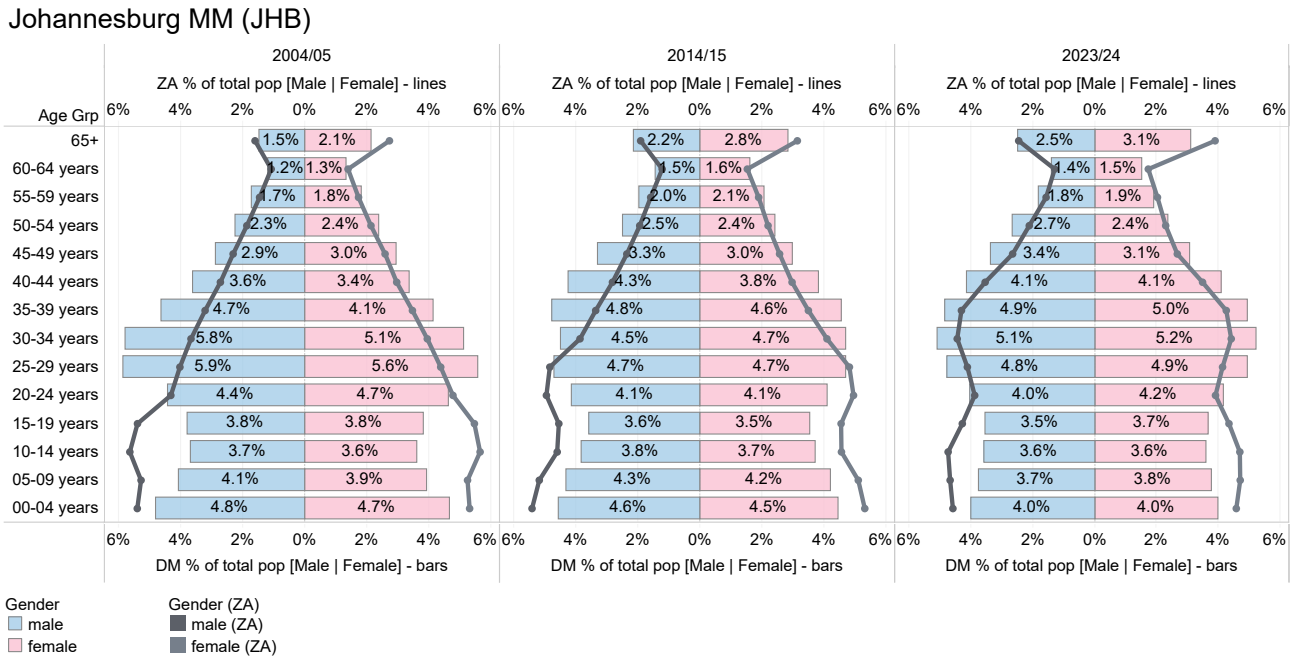
PHC utilisation rate [| DHIS]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
1
52

Johannesburg Metropolitan Municipality (JHB)

The City of Johannesburg Metropolitan Municipality[7] is Category A municipality in Gauteng Province. Johannesburg is the most advanced commercial city in Africa and the engine-room of the South African and regional economy. It is divided into seven health sub-districts, named Johannesburg Sub-district A to Johannesburg Sub-district G.

Cities/Towns:
Alexandra, Diepkloof, Diepsloot, Ennerdale, Johannesburg, Johannesburg South, Lawley, Lenasia, Lenasia South, Meadowlands East, Meadowlands West, Midrand, Orange Farm, Pimville, Randburg, Roodepoort, Sandton, Soweto
Area: 1 643km²
Population (2023)[8]: 6 635 086
Households[7]: 1 853 371
Formal dwellings[7]: 81.3%

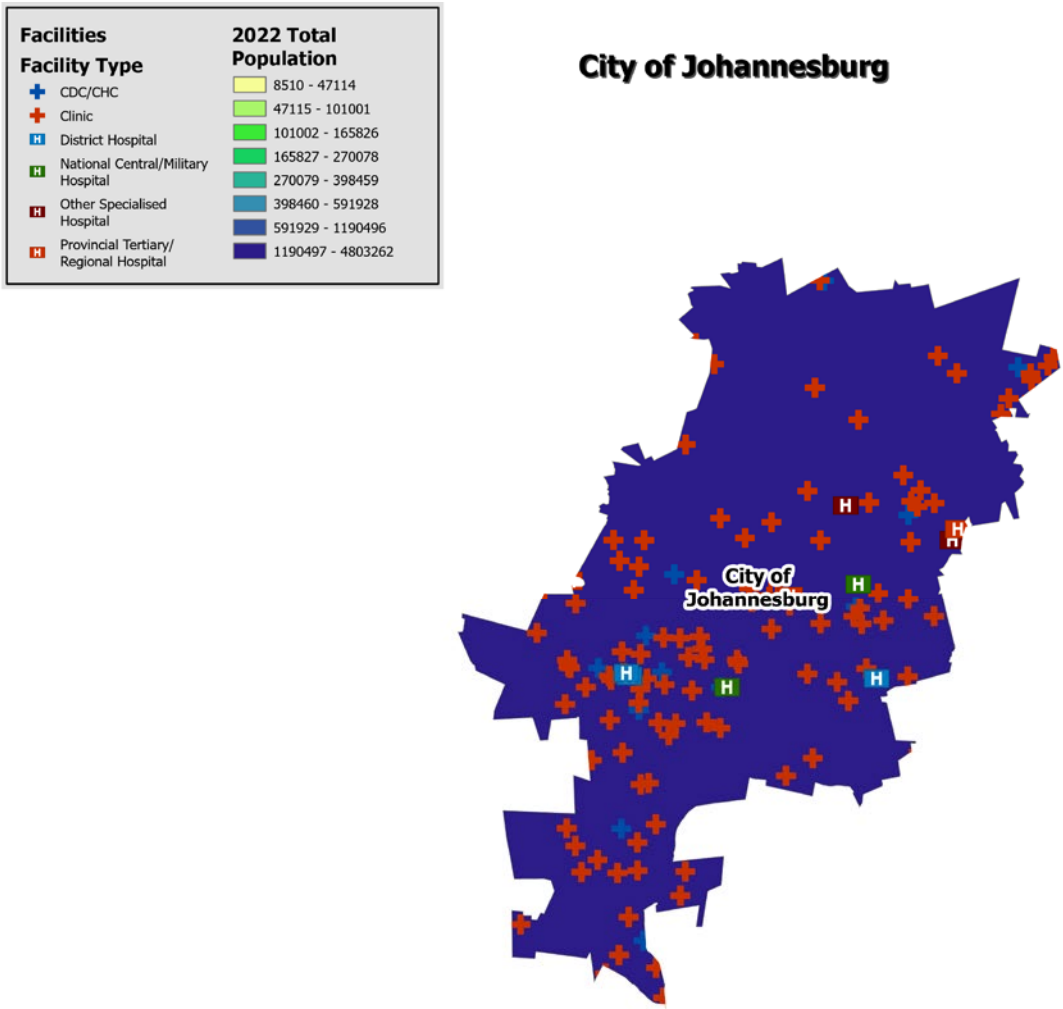
District percentage population by age-gender group compared to South Africa



Source: DHIS

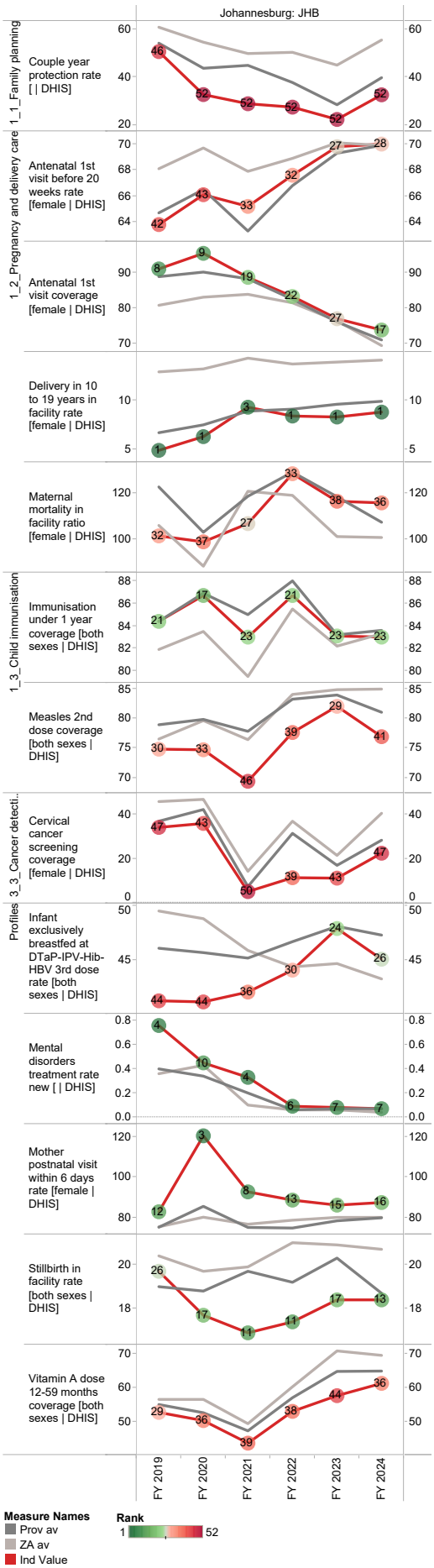
7 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023
8 Mid-year Population Estimates 2023, DHIS.

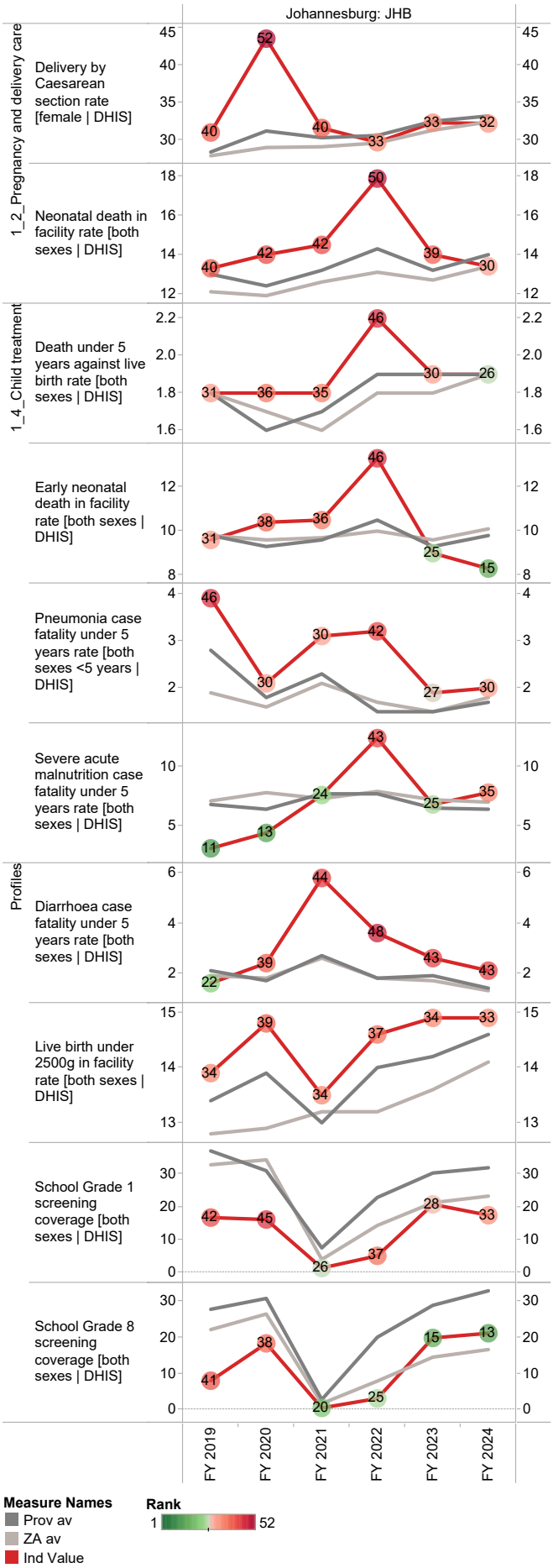
Population distribution, sub-district boundaries and health facility locations

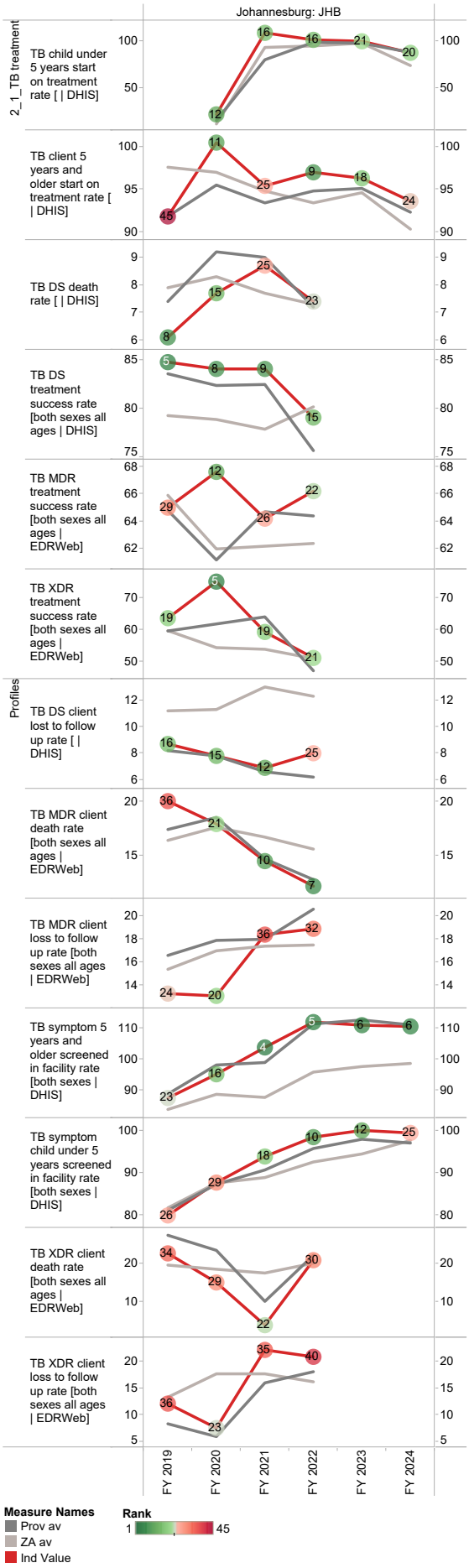


Source: DHIS

Annual trends, 2018/19–2023/24






Johannesburg: JHB
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FY 2019
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Measure Names
Prov av
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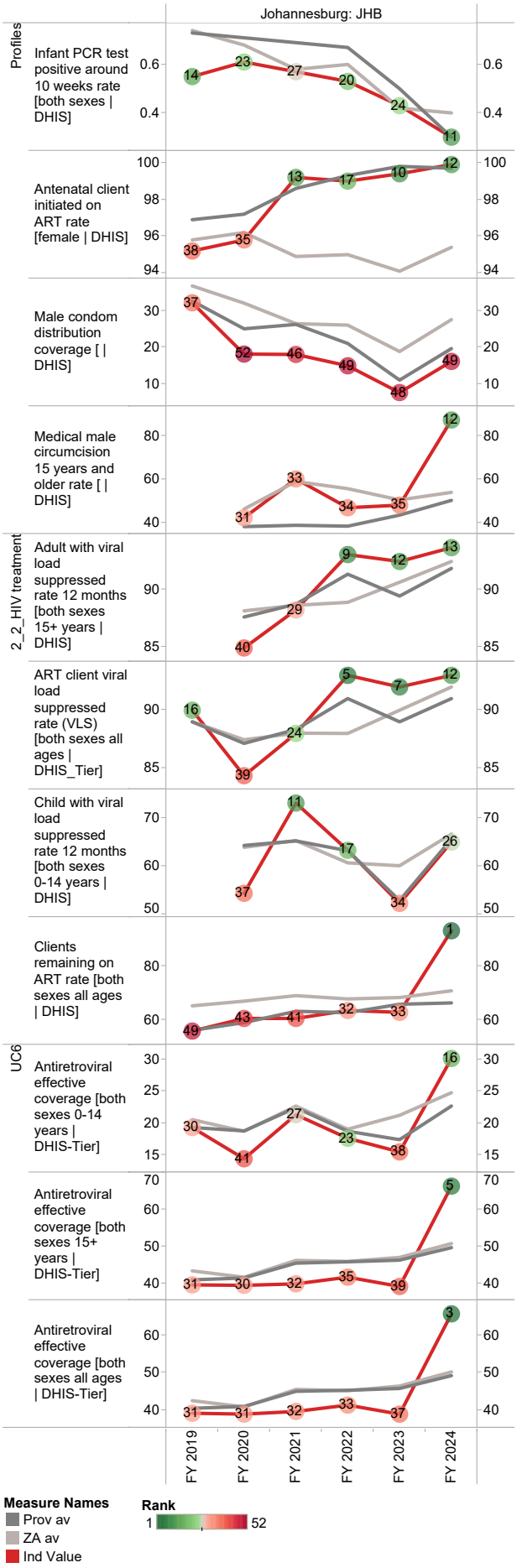
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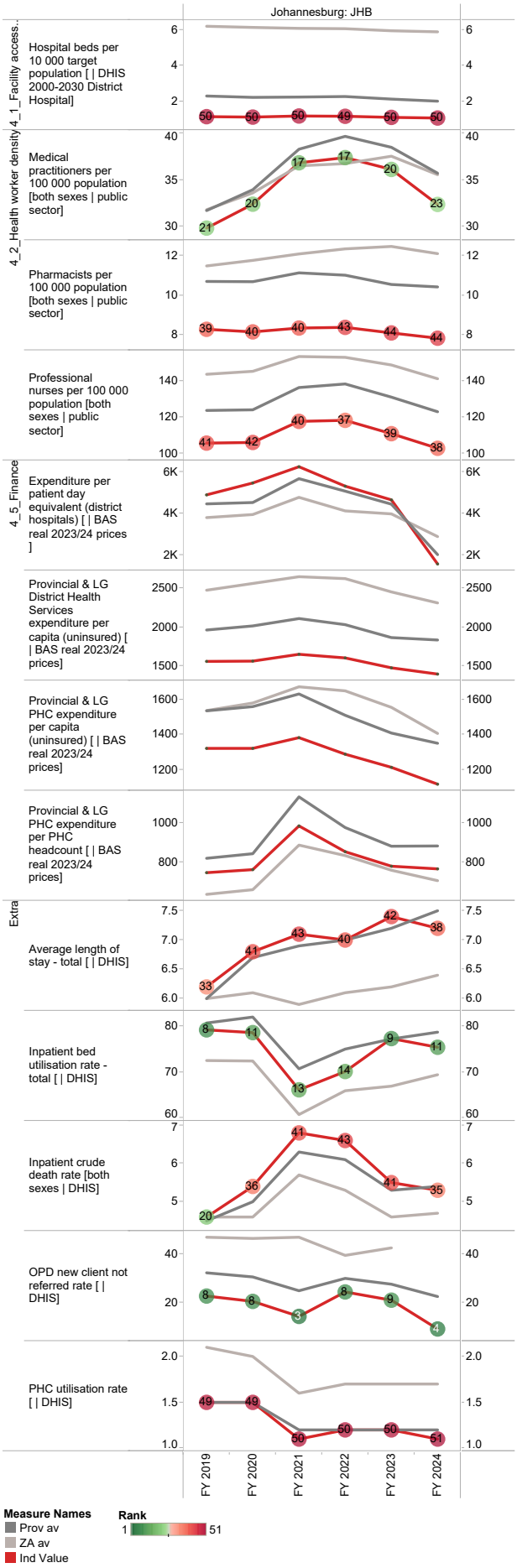
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Provincial & LG PHC expenditure per PHC headcount [| BAS real 2023/24 prices]
Extra
Average length of stay - total [| DHIS]
Inpatient bed utilisation rate - total [| DHIS]
Inpatient crude death rate [both sexes | DHIS]
OPD new client not referred rate [| DHIS]
PHC utilisation rate [| DHIS]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
1
51

Tshwane Metropolitan Municipality (TSH)

The City of Tshwane Metropolitan Municipality[9] is a Category A municipality situated in the Gauteng Province. Tshwane is the single-largest metropolitan municipality in the country. It comprises seven health sub-districts, named Tshwane HealthSub-district 1 to Tshwane Health Sub-district 7.

Area: 6 298km²

Population (2023)[10]: 4 125 344

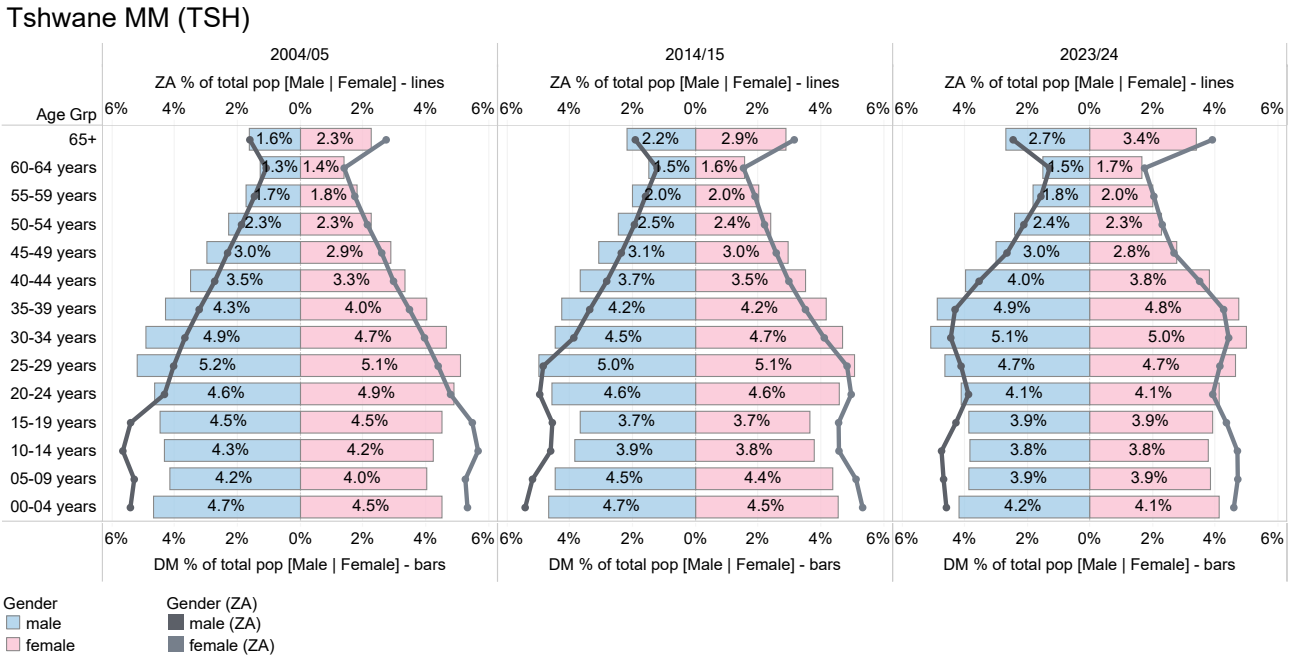
Households[9]: 1 136 877

Formal dwellings[9]: 82.6%

Cities/Towns:

Akasia, Atteridgeville, Bronkhorstspruit, Centurion, Cullinan, Ekangala, Ga-Rankuwa, Garsfontein, Hammanskraal, Irene, Kudube, Mabopane, Mamelodi, Pretoria, Pretoria North, Rayton, Refilwe, Roodeplaat, Soshanguve, Temba, Winterveldt

District percentage population by age-gender group compared to South Africa

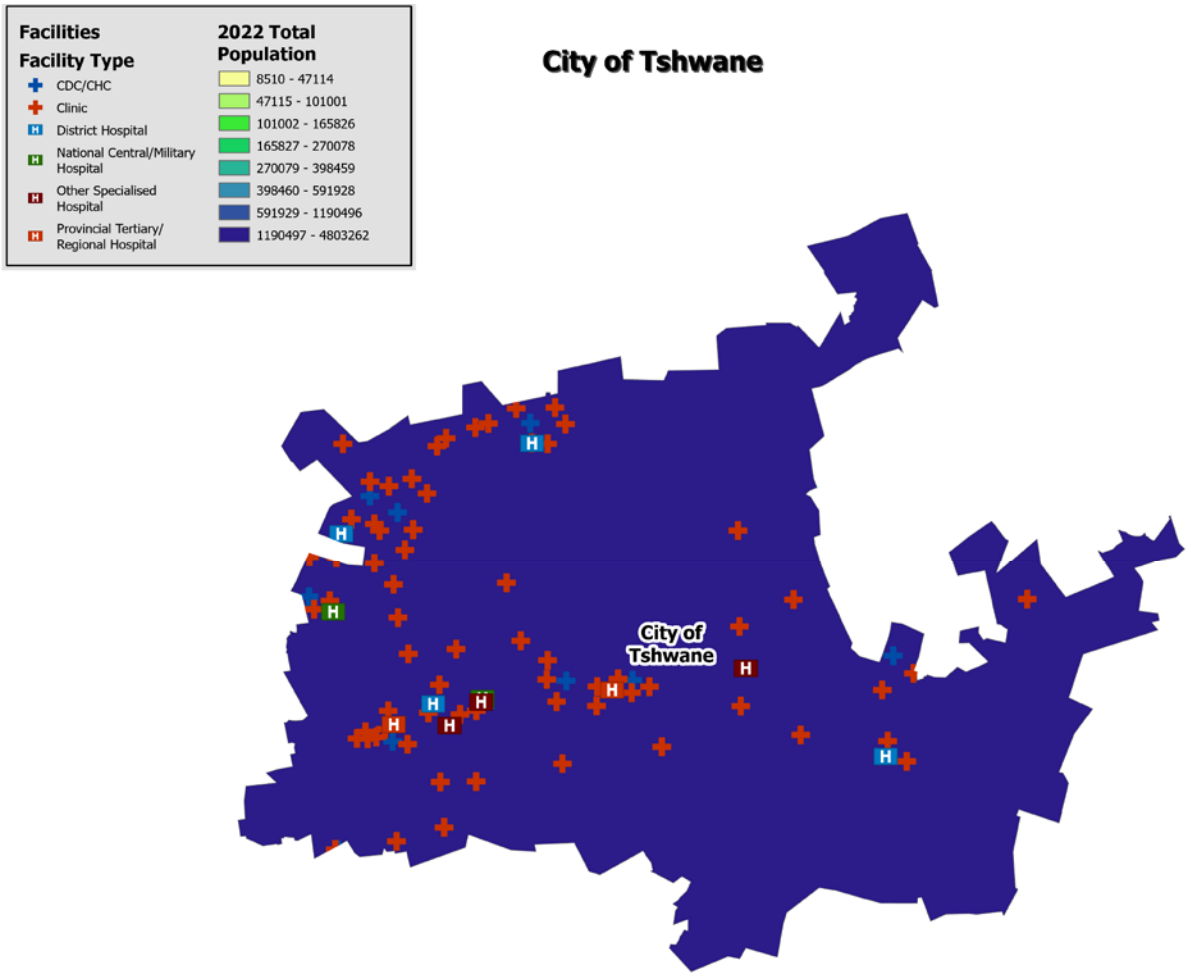


Source: DHIS

9 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

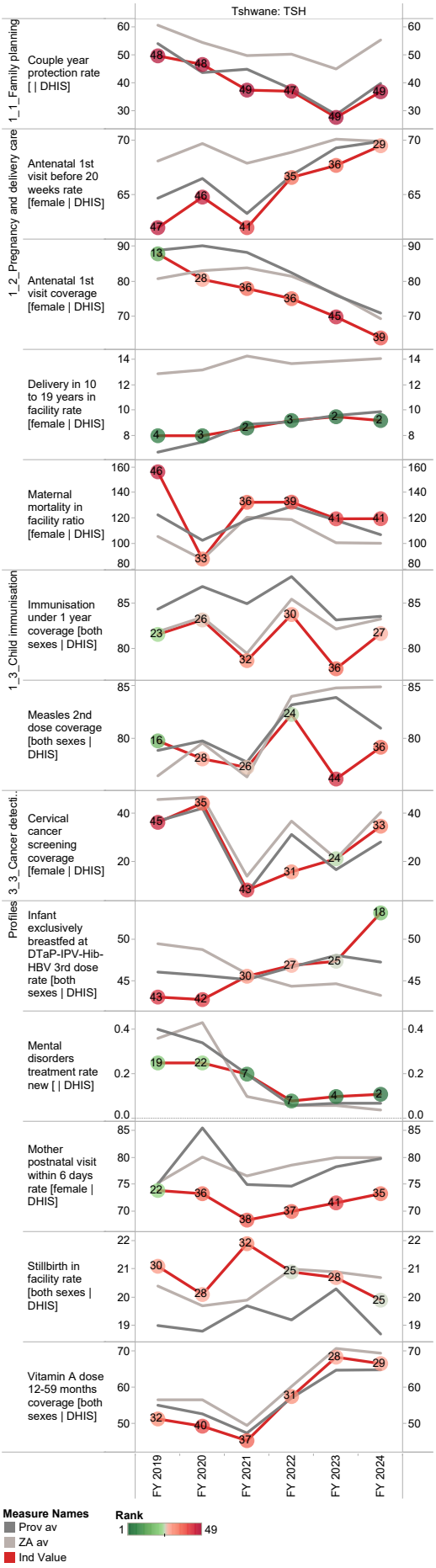
10 Mid-year Population Estimates 2023, DHIS.

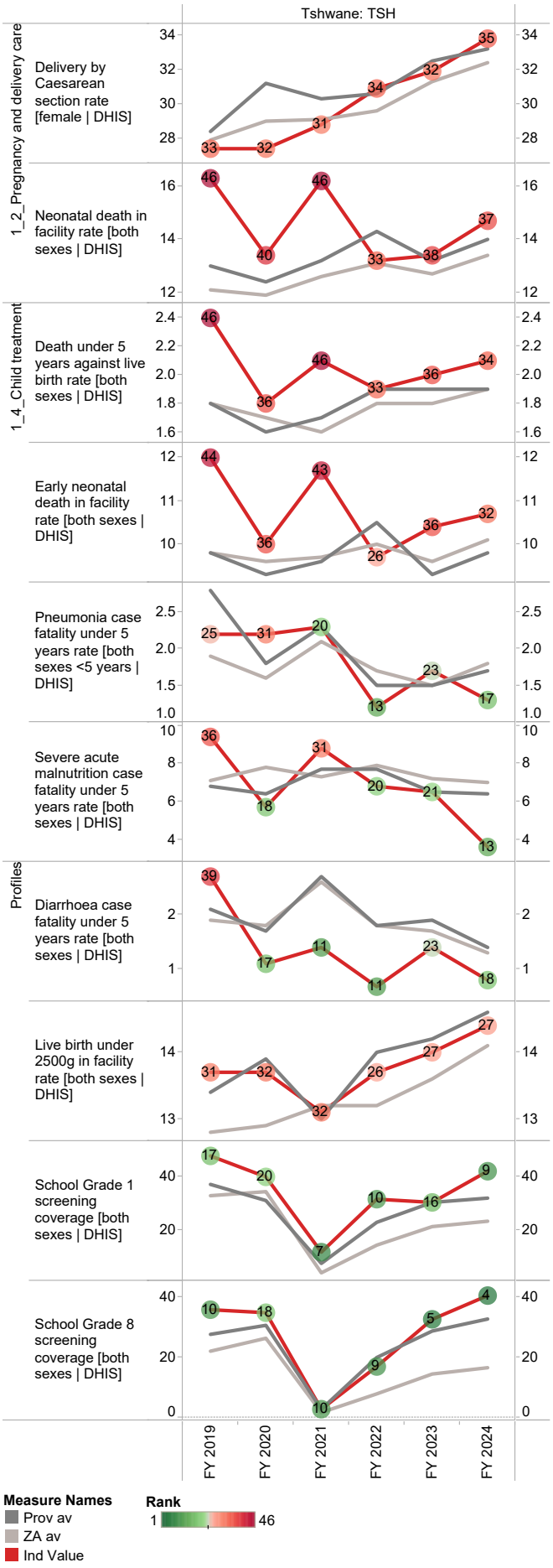
Population distribution, sub-district boundaries and health facility locations

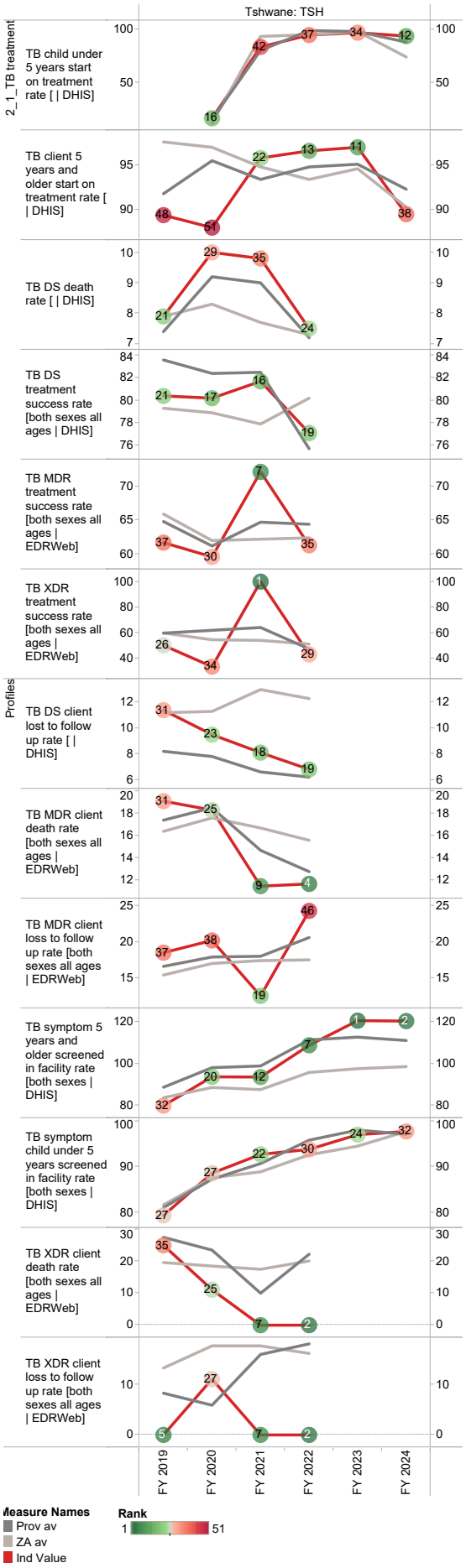


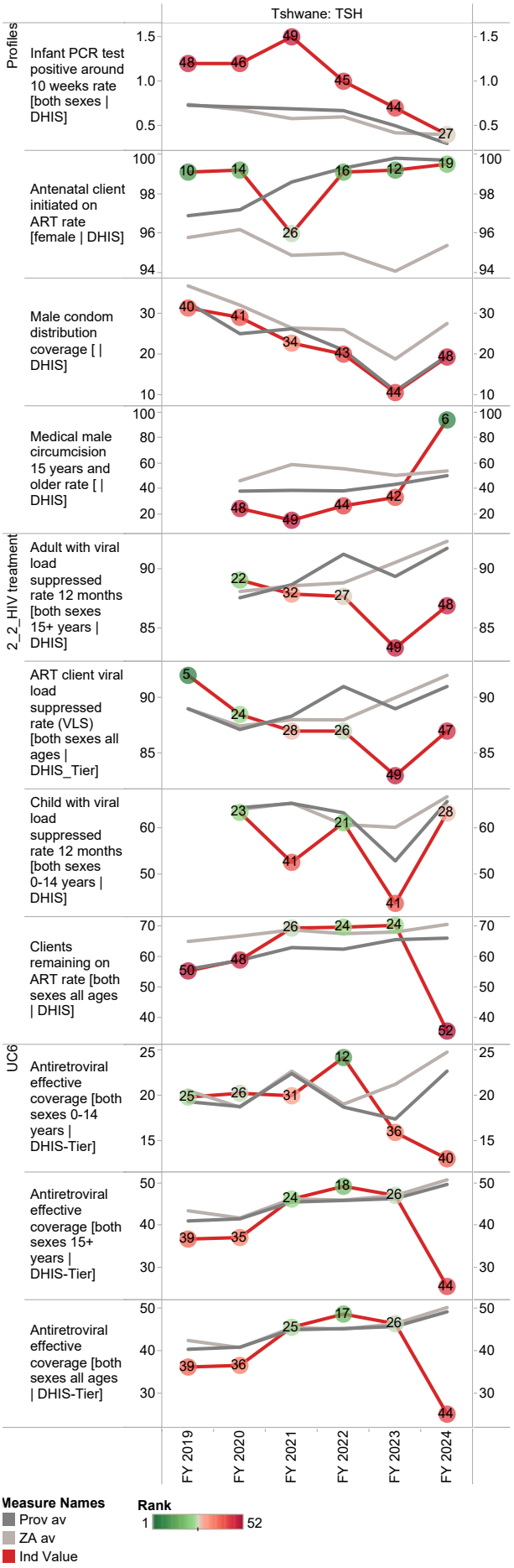
Source: DHIS

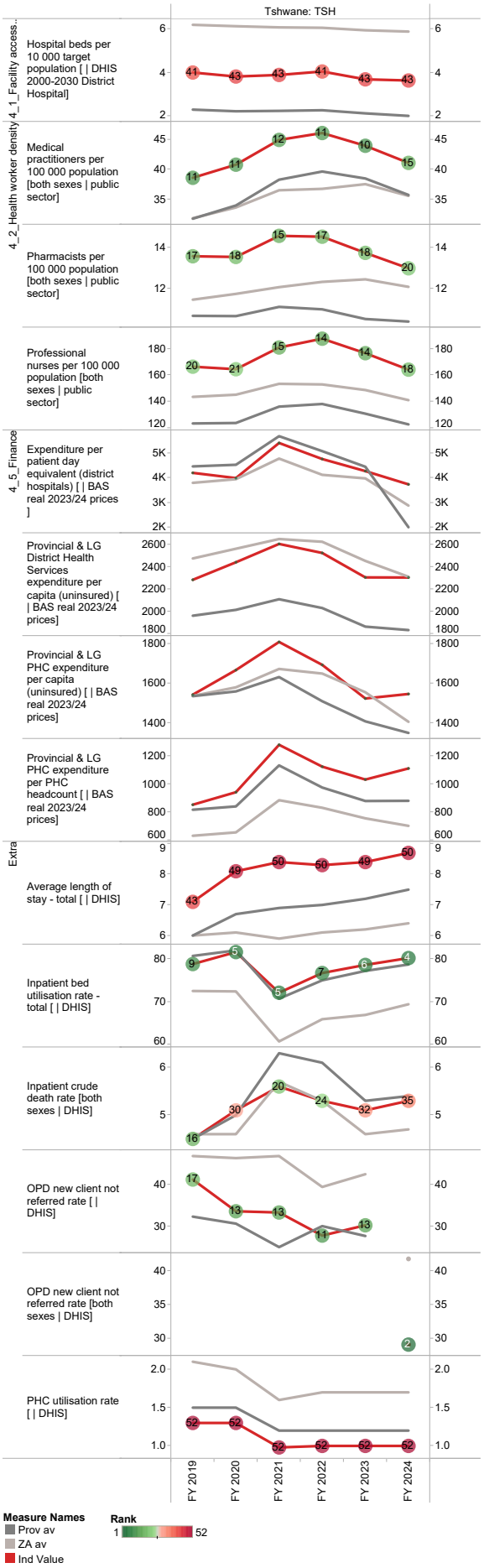
Annual trends, 2018/19–2023/24






Tshwane: TSH
2_1_TB treatment
Profiles
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
TB DS death rate [| DHIS]
TB DS treatment success rate [both sexes all ages | DHIS]
TB MDR treatment success rate [both sexes all ages | EDRWeb]
TB XDR treatment success rate [both sexes all ages | EDRWeb]
TB DS client lost to follow up rate [| DHIS]
TB MDR client death rate [both sexes all ages | EDRWeb]
TB MDR client loss to follow up rate [both sexes all ages | EDRWeb]
TB symptom 5 years and older screened in facility rate [both sexes | DHIS]
TB symptom child under 5 years screened in facility rate [both sexes | DHIS]
TB XDR client death rate [both sexes all ages | EDRWeb]
TB XDR client loss to follow up rate [both sexes all ages | EDRWeb]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
1
51


Tshwane: TSH
Profiles
2_2_HIV treatment
UC6
Infant PCR test positive around 10 weeks rate [both sexes | DHIS]
Antenatal client initiated on ART rate [female | DHIS]
Male condom distribution coverage [| DHIS]
Medical male circumcision 15 years and older rate [| DHIS]
Adult with viral load suppressed rate 12 months [both sexes 15+ years | DHIS]
ART client viral load suppressed rate (VLS) [both sexes all ages | DHIS_Tier]
Child with viral load suppressed rate 12 months [both sexes 0-14 years | DHIS]
Clients remaining on ART rate [both sexes all ages | DHIS]
Antiretroviral effective coverage [both sexes 0-14 years | DHIS-Tier]
Antiretroviral effective coverage [both sexes 15+ years | DHIS-Tier]
Antiretroviral effective coverage [both sexes all ages | DHIS-Tier]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
1
52


Tshwane: TSH
4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
4_2_Health worker density
Medical practitioners per 100 000 population [both sexes | public sector]
Pharmacists per 100 000 population [both sexes | public sector]
Professional nurses per 100 000 population [both sexes | public sector]
4_5_Finance
Expenditure per patient day equivalent (district hospitals) [| BAS real 2023/24 prices]
Provincial & LG District Health Services expenditure per capita (uninsured) [| BAS real 2023/24 prices]
Provincial & LG PHC expenditure per capita (uninsured) [| BAS real 2023/24 prices]
Provincial & LG PHC expenditure per PHC headcount [| BAS real 2023/24 prices]
Extra
Average length of stay - total [| DHIS]
Inpatient bed utilisation rate - total [| DHIS]
Inpatient crude death rate [both sexes | DHIS]
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OPD new client not referred rate [both sexes | DHIS]
PHC utilisation rate [| DHIS]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
1
52

10 KwaZulu-Natal Province

Ugu District Municipality (DC21)

The Ugu District Municipality[1] is a Category C municipality situated in the far south of KwaZulu-Natal. The district is made up of four local municipalities: uMdoni, uMzumbe, Ray Nkonyeni and uMuziwabantu.

Area: 4 790km²

Population (2023)[2]: 850 331

Households[1]: 175 146

Formal dwellings[1]: 58.6%

Cities/Towns:

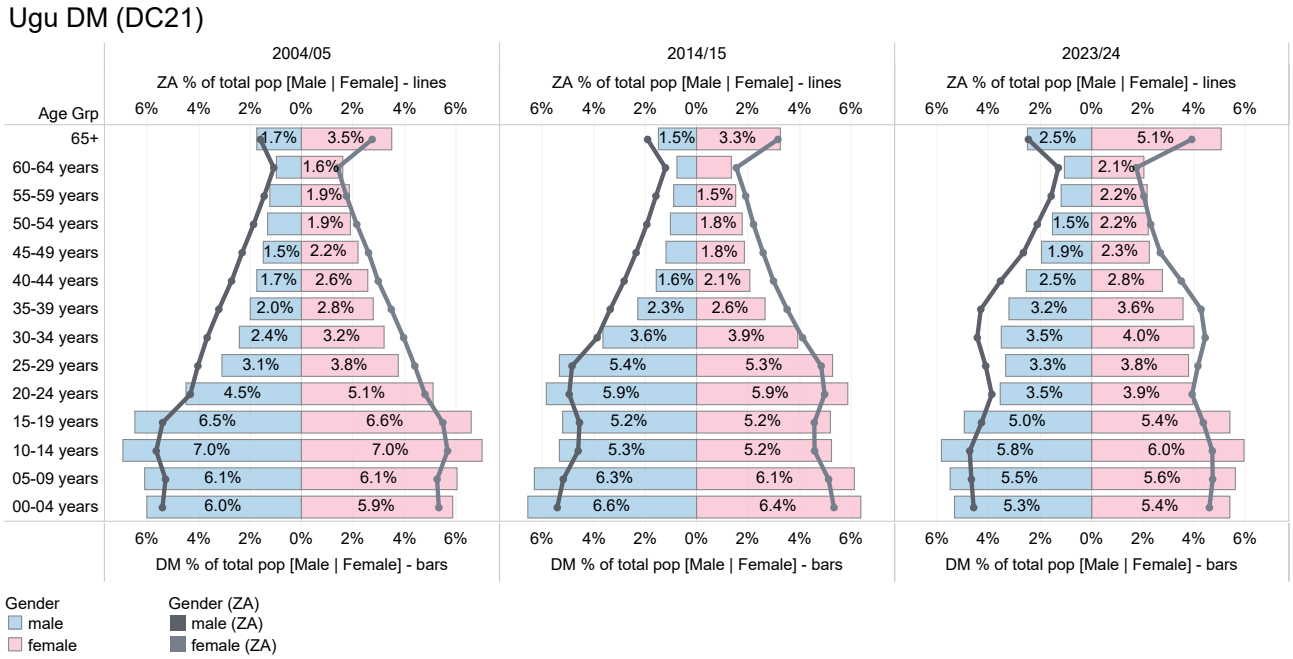
uMdoni: Pennington, Scottburgh/Umzinto North

uMzumbe: Southbroom

Ray Nkonyeni: Hibberdene, Margate, Port Edward, Port Shepstone

uMuziwabantu: Harding

District percentage population by age-gender group compared to South Africa

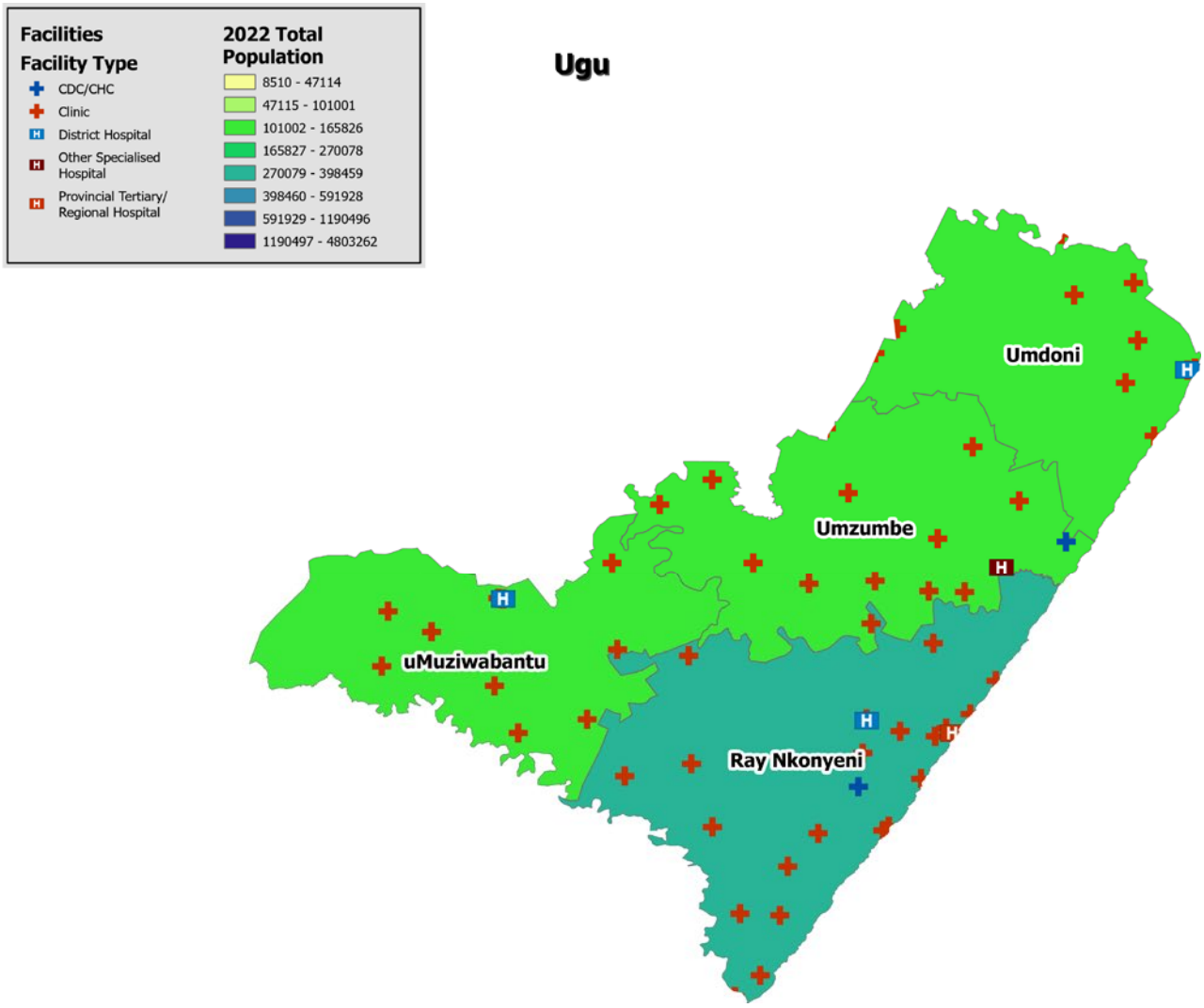


Source: DHIS

1 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

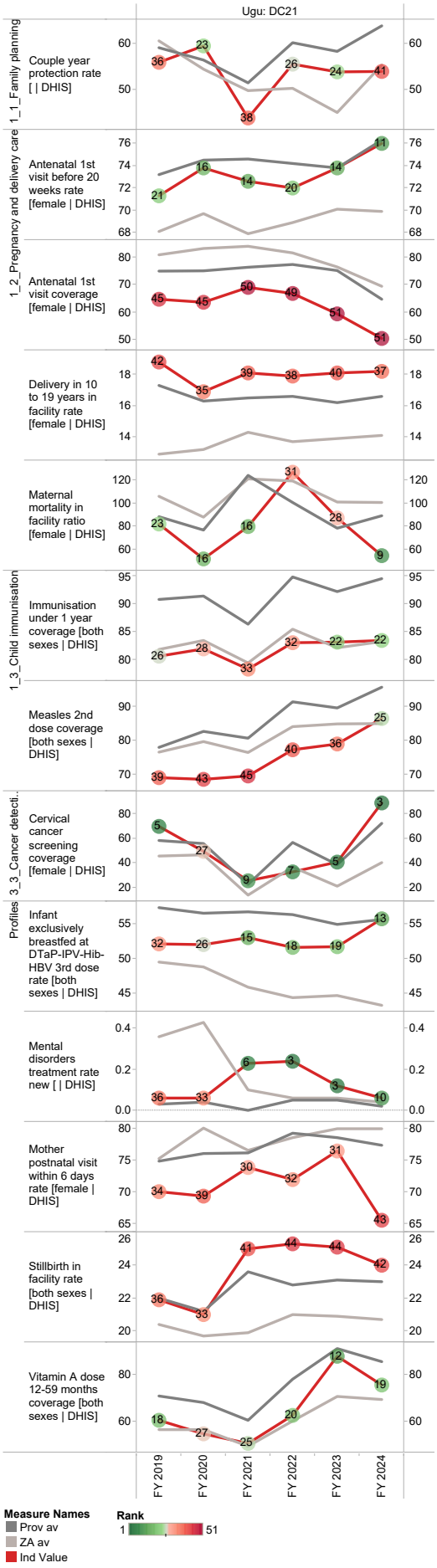
2 Mid-year Population Estimates 2023, DHIS.

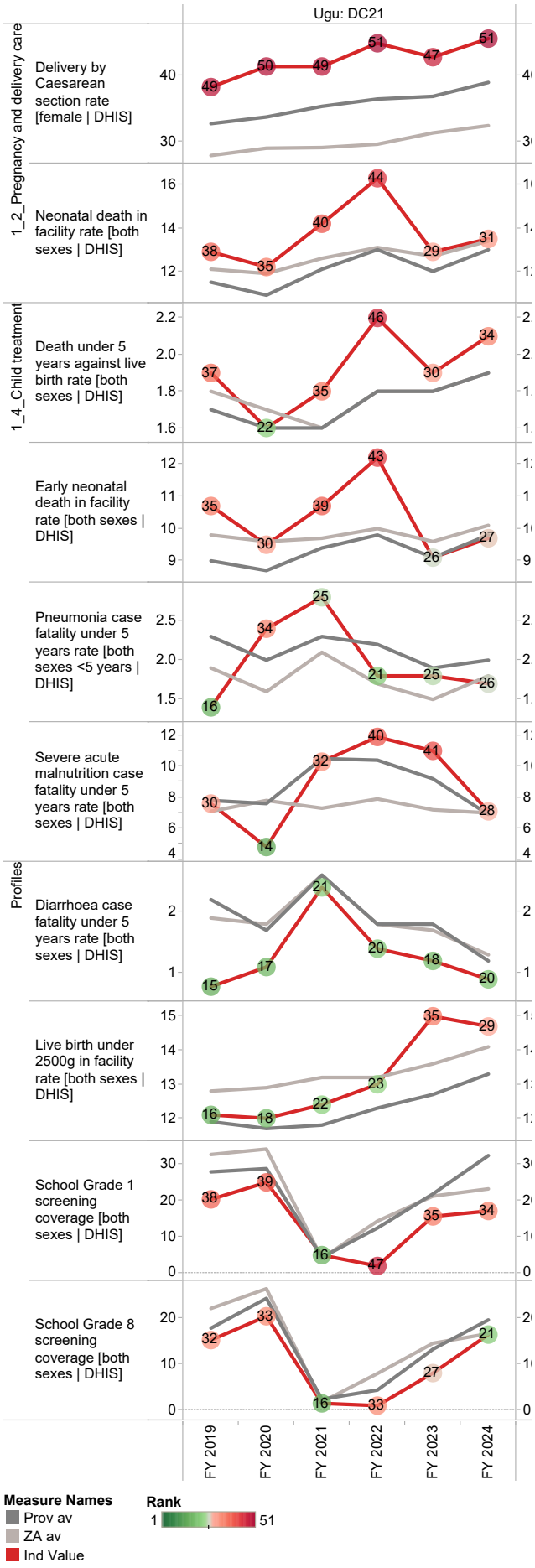
Population distribution, sub-district boundaries and health facility locations

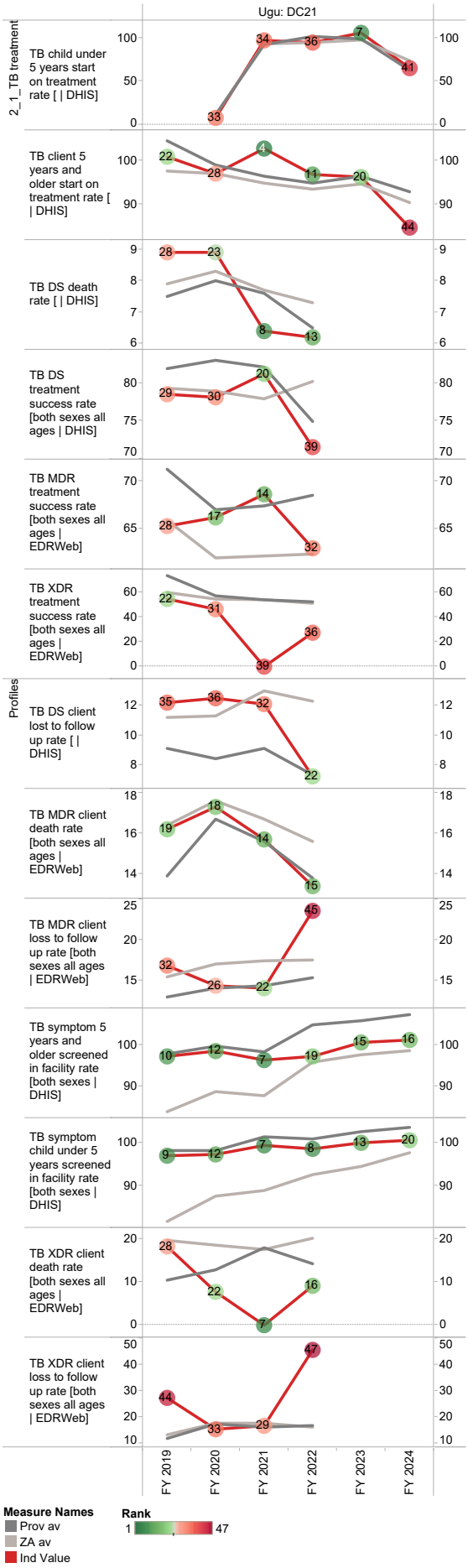


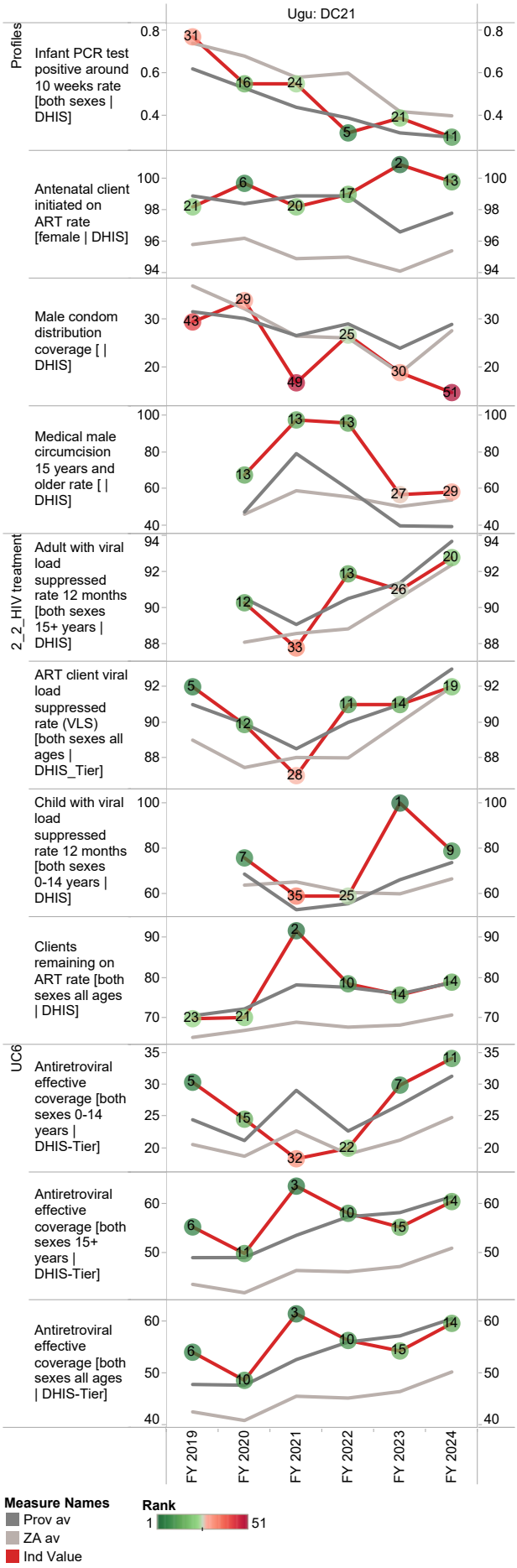
Source: DHIS

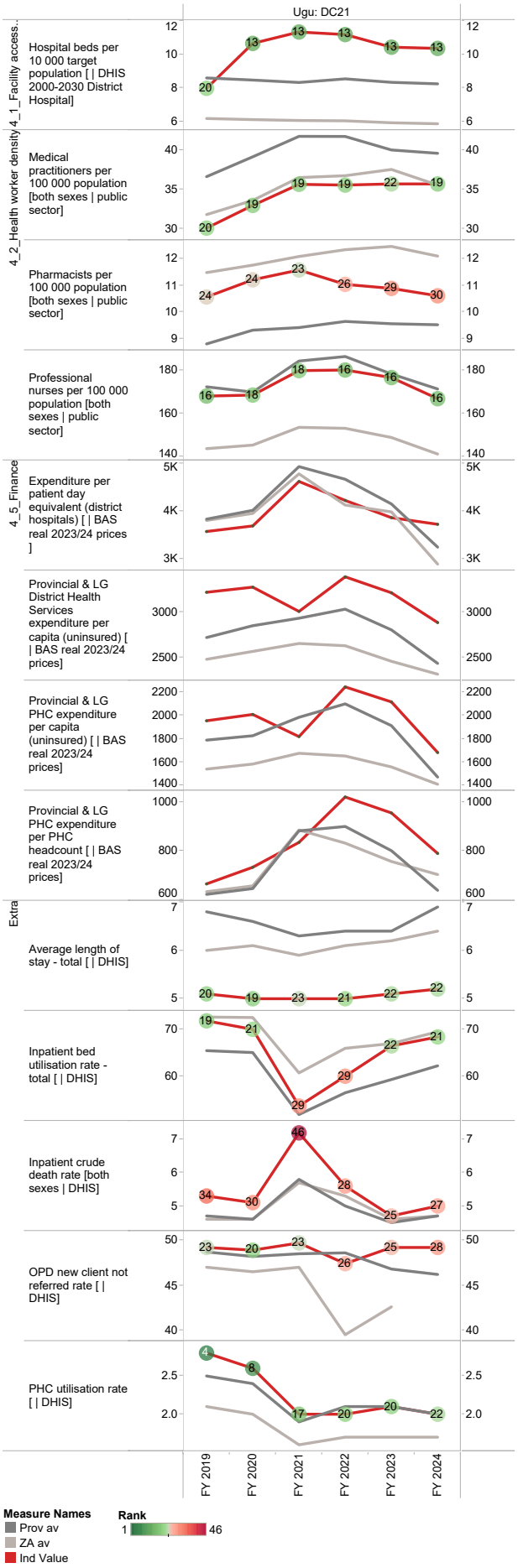
Annual trends, 2018/19–2023/24






Ugu: DC21
2_1_TB treatment
Profiles
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
TB DS death rate [| DHIS]
TB DS treatment success rate [both sexes all ages | DHIS]
TB MDR treatment success rate [both sexes all ages | EDRWeb]
TB XDR treatment success rate [both sexes all ages | EDRWeb]
TB DS client lost to follow up rate [| DHIS]
TB MDR client death rate [both sexes all ages | EDRWeb]
TB MDR client loss to follow up rate [both sexes all ages | EDRWeb]
TB symptom 5 years and older screened in facility rate [both sexes | DHIS]
TB symptom child under 5 years screened in facility rate [both sexes | DHIS]
TB XDR client death rate [both sexes all ages | EDRWeb]
TB XDR client loss to follow up rate [both sexes all ages | EDRWeb]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
1
47


Ugu: DC21
Profiles
Infant PCR test positive around 10 weeks rate [both sexes | DHIS]
Antenatal client initiated on ART rate [female | DHIS]
Male condom distribution coverage [| DHIS]
Medical male circumcision 15 years and older rate [| DHIS]
2_2_HIV treatment
Adult with viral load suppressed rate 12 months [both sexes 15+ years | DHIS]
ART client viral load suppressed rate (VLS) [both sexes all ages | DHIS_Tier]
Child with viral load suppressed rate 12 months [both sexes 0-14 years | DHIS]
Clients remaining on ART rate [both sexes all ages | DHIS]
UC6
Antiretroviral effective coverage [both sexes 0-14 years | DHIS-Tier]
Antiretroviral effective coverage [both sexes 15+ years | DHIS-Tier]
Antiretroviral effective coverage [both sexes all ages | DHIS-Tier]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
1
51


Ugu: DC21
4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
4_2_Health worker density
Medical practitioners per 100 000 population [both sexes | public sector]
Pharmacists per 100 000 population [both sexes | public sector]
Professional nurses per 100 000 population [both sexes | public sector]
4_5_Finance
Expenditure per patient day equivalent (district hospitals) [| BAS real 2023/24 prices]
Provincial & LG District Health Services expenditure per capita (uninsured) [| BAS real 2023/24 prices]
Provincial & LG PHC expenditure per capita (uninsured) [| BAS real 2023/24 prices]
Provincial & LG PHC expenditure per PHC headcount [| BAS real 2023/24 prices]
Extra
Average length of stay - total [| DHIS]
Inpatient bed utilisation rate - total [| DHIS]
Inpatient crude death rate [both sexes | DHIS]
OPD new client not referred rate [| DHIS]
PHC utilisation rate [| DHIS]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
1
46

uMgungundlovu District Municipality (DC22)

The uMgungundlovu District Municipality[3] is a Category C municipality located in the KwaZulu-Natal Midlands. The district comprises the following seven local municipalities: Impendle, Mkhambathini, Mpofana, Msunduzi, Richmond, uMngeni, and uMshwathi.

Area: 9 602km²

Population (2023)[4]: 1 177 092

Households3: 296 463

Formal dwellings[c]: 76.6%

Cities/Towns

Impendle: Impendle

Mkhambathini: Camperdown

Mpofana: Mooi River

Msunduzi: Ashburton, Pietermaritzburg

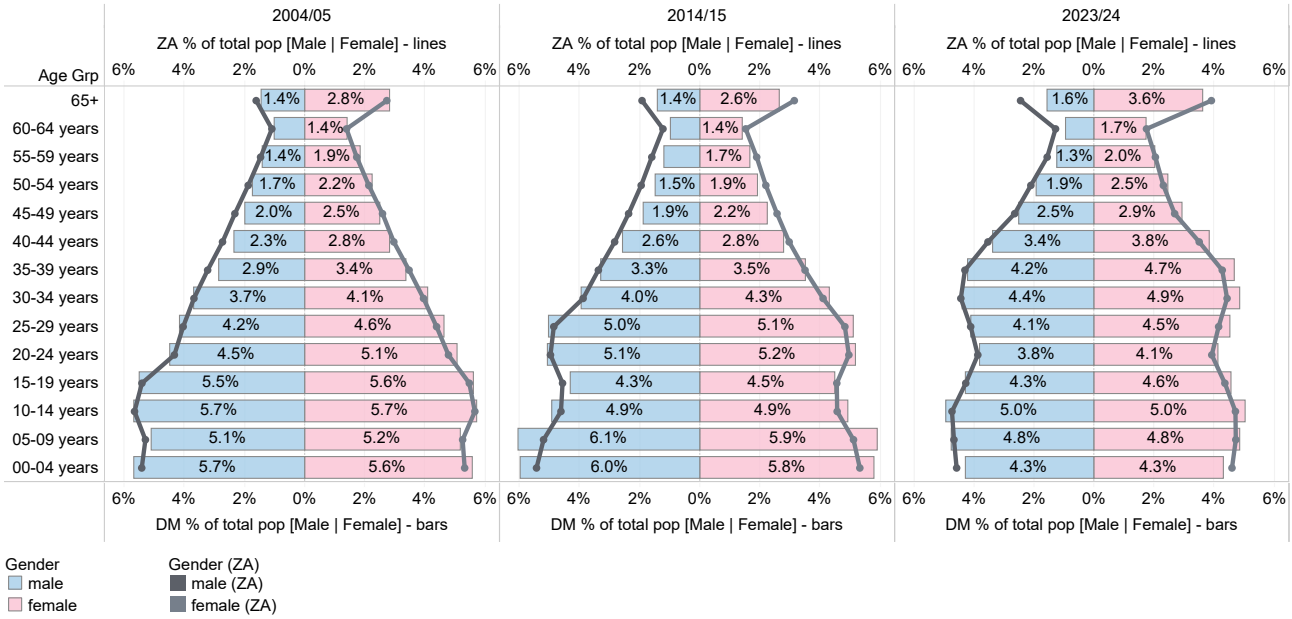
Richmond: Richmond

uMngeni: Hilton, Howick

uMshwathi: Cool Air, Dalton, New Hanover, Wartburg

District percentage population by age-gender group compared to South Africa

uMgungundlovu DM (DC22)

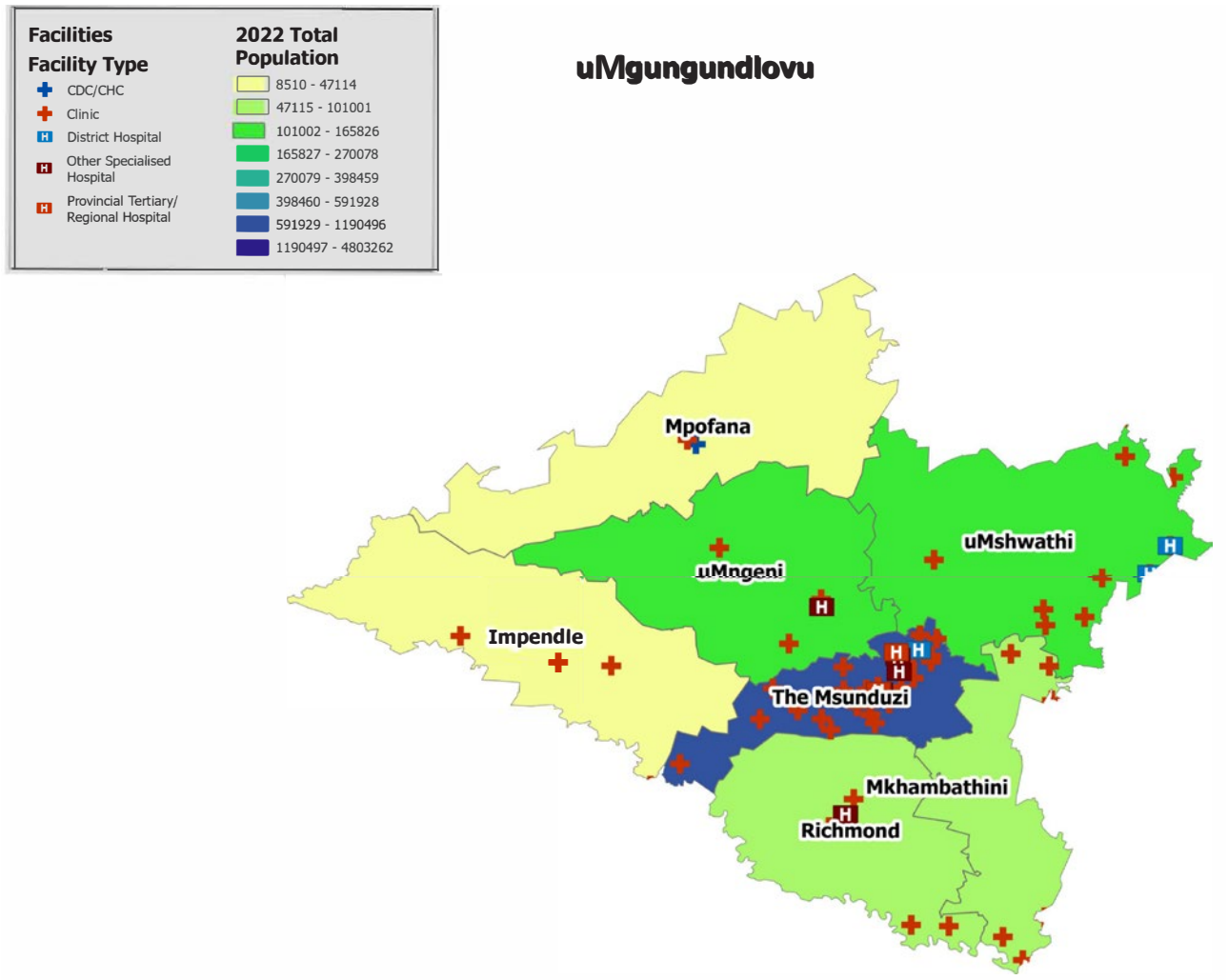


Source: DHIS

3 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

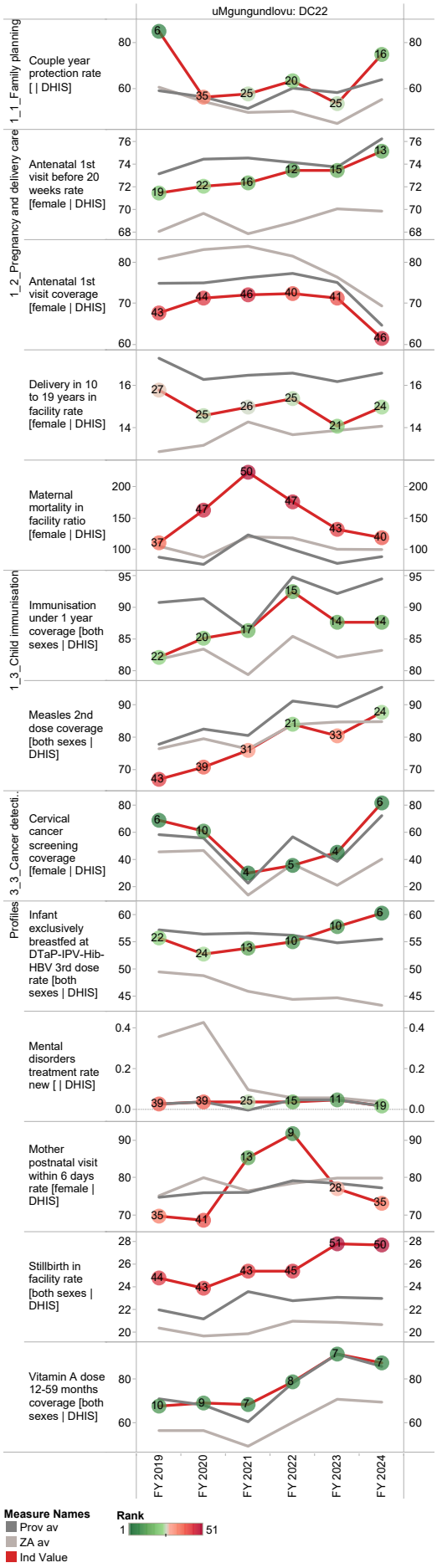
4 Mid-year Population Estimates 2023, DHIS.

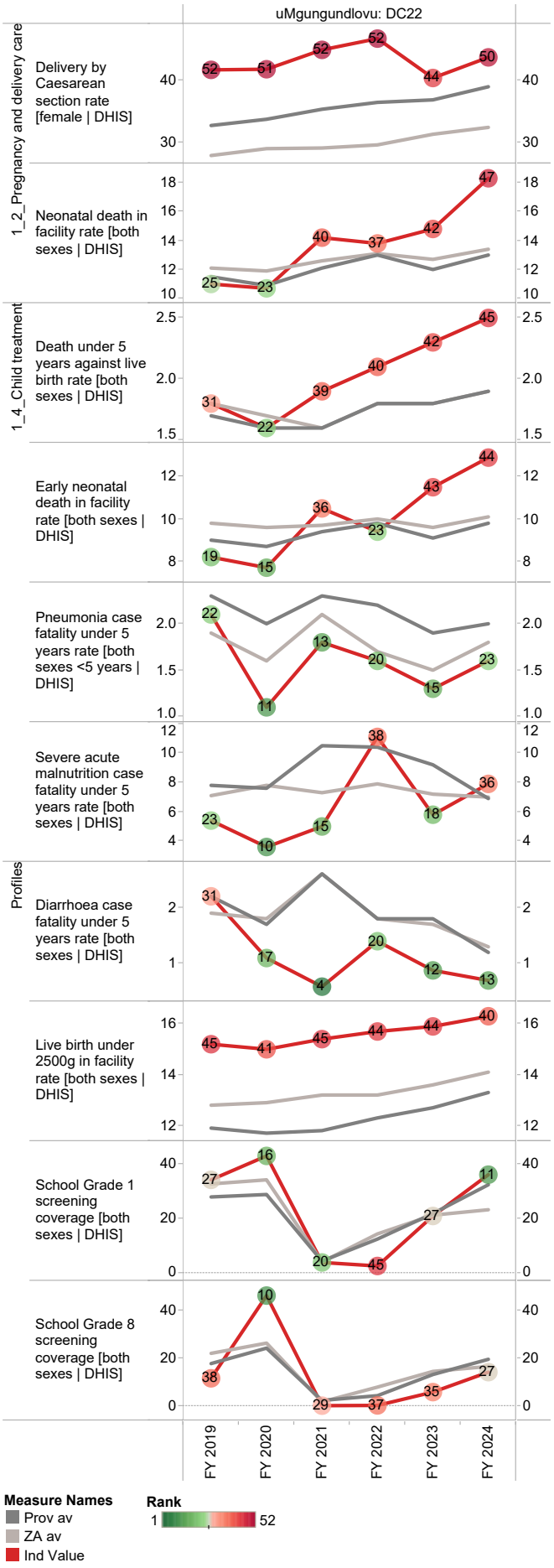
Population distribution, sub-district boundaries and health facility locations

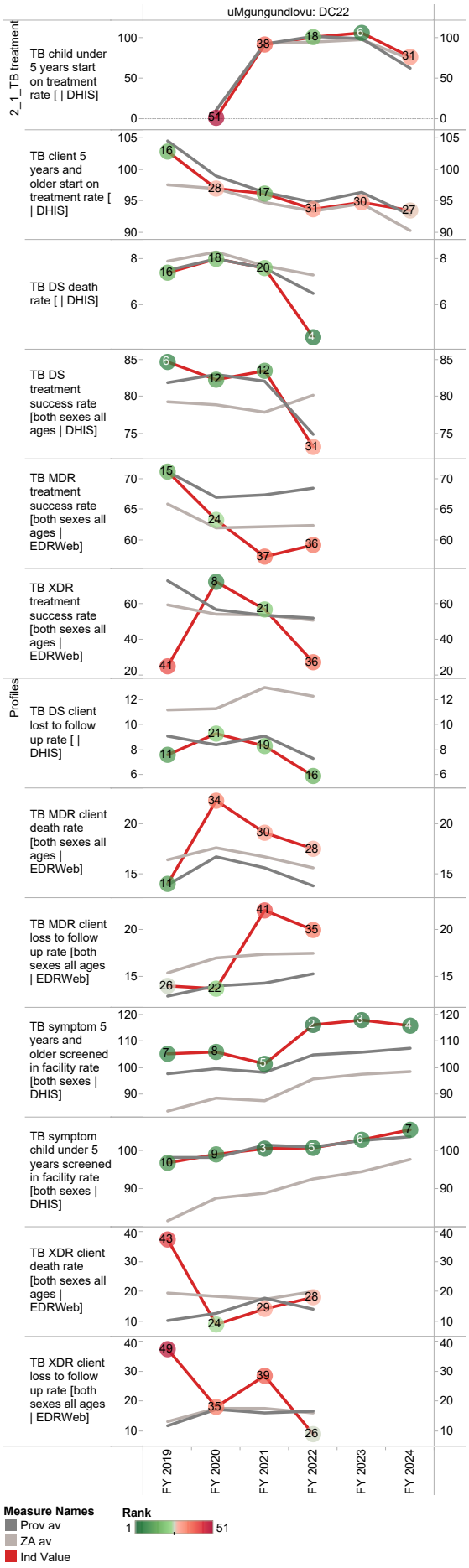


Source: DHIS

Annual trends, 2018/19–2023/24






uMgungundlovu: DC22
2_1_TB treatment
Profiles
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
TB DS death rate [| DHIS]
TB DS treatment success rate [both sexes all ages | DHIS]
TB MDR treatment success rate [both sexes all ages | EDRWeb]
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TB symptom 5 years and older screened in facility rate [both sexes | DHIS]
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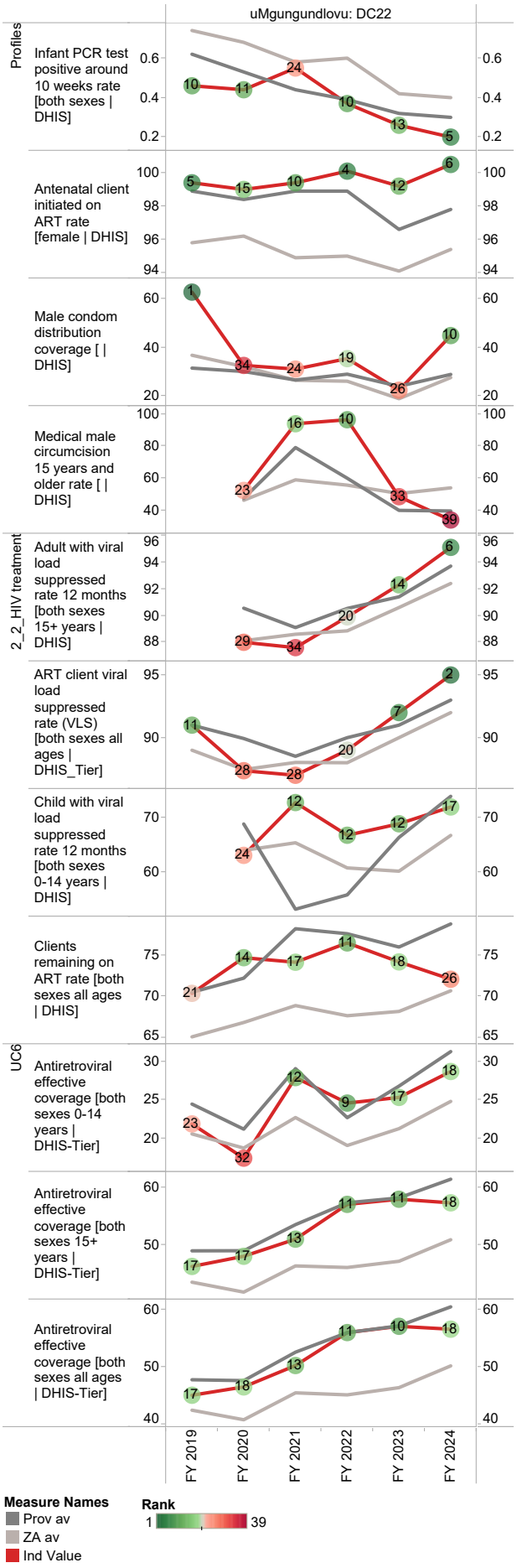
TB XDR client death rate [both sexes all ages | EDRWeb]
TB XDR client loss to follow up rate [both sexes all ages | EDRWeb]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
1
51


uMgungundlovu: DC22
Profiles
Infant PCR test positive around 10 weeks rate [both sexes | DHIS]
Antenatal client initiated on ART rate [female | DHIS]
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Medical male circumcision 15 years and older rate [| DHIS]
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Clients remaining on ART rate [both sexes all ages | DHIS]
UC6
Antiretroviral effective coverage [both sexes 0-14 years | DHIS-Tier]
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Antiretroviral effective coverage [both sexes all ages | DHIS-Tier]
FY 2019
FY 2020
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FY 2022
FY 2023
FY 2024
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ZA av
Ind Value
Rank
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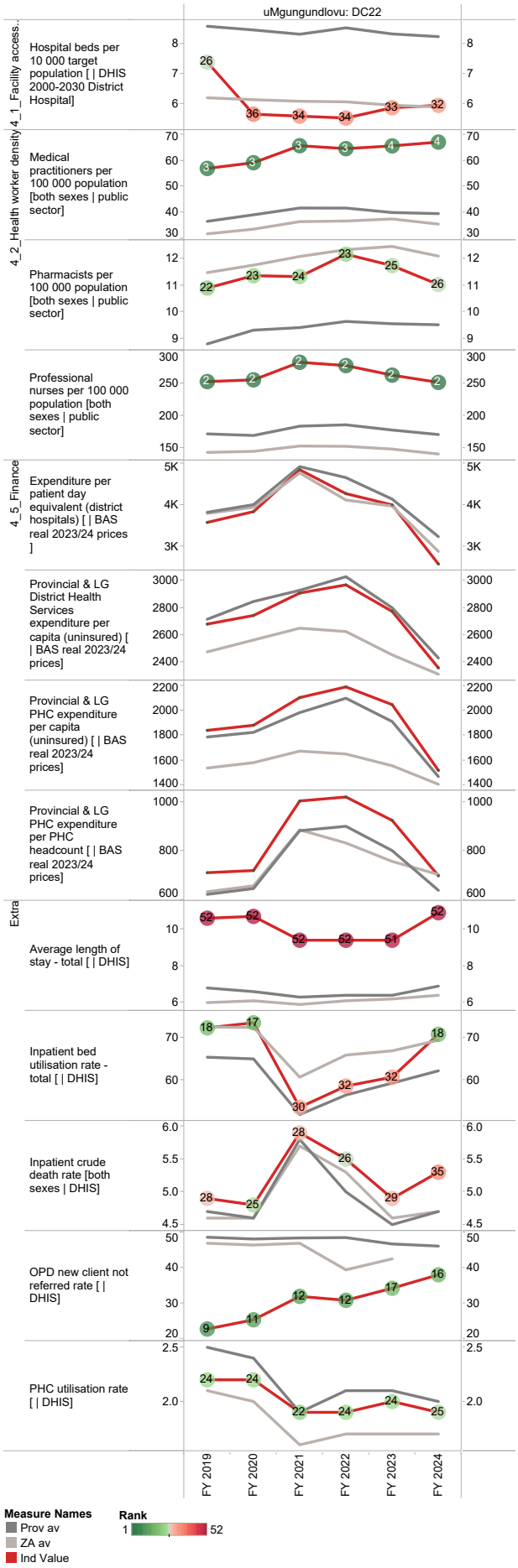
39


uMgungundlovu: DC22
4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
4_2_Health worker density
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PHC utilisation rate [| DHIS]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
1
52

uThukela District Municipality (DC23)

The uThukela District Municipality[5] is a Category C municipality and is located on the western boundary of the KwaZulu-Natal Province. It consists of three local municipalities: Okhahlamba, Alfred Duma and Inkosi Langalibalele.

Area: 11 134km²

Population (2023)[6]: 714 070

Households[5]: 161 788

Formal dwellings[5]: 69.8%

Cities/Towns:

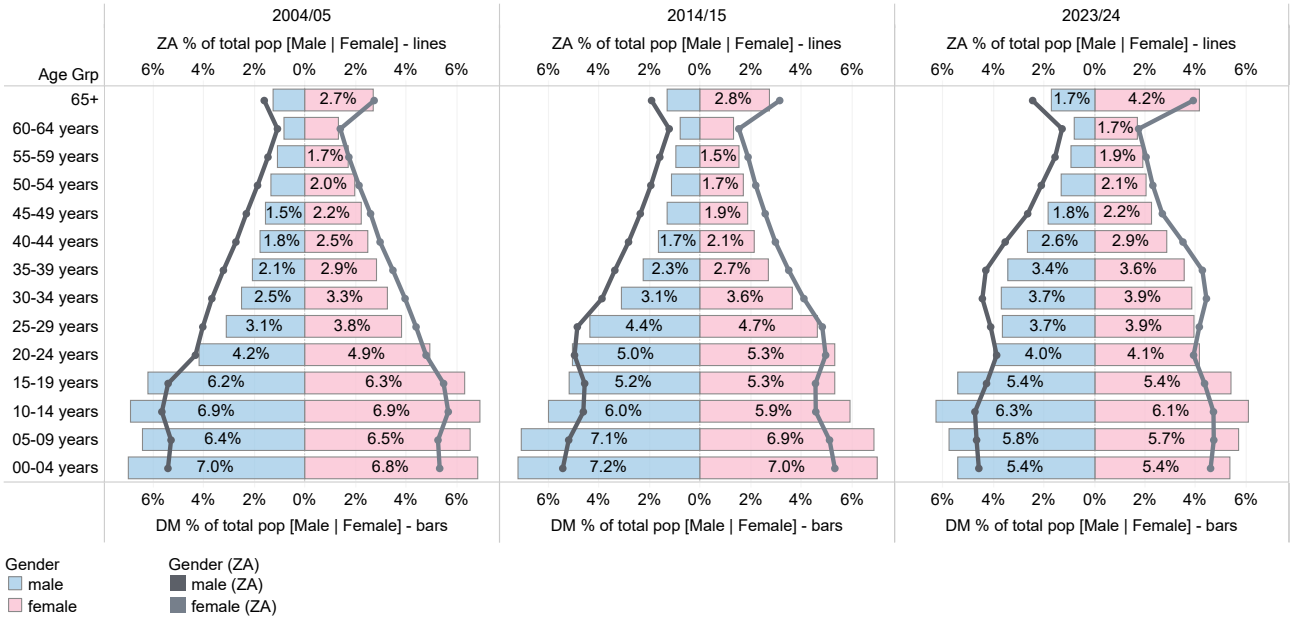
Okhahlamba: Bergville, Cathkin Park, Winterton

Alfred Duma: Colenso, Ladysmith, Van Reenen

Inkosi Langalibalele: Estcourt, Weenen,

District percentage population by age-gender group compared to South Africa

uThukela DM (DC23)

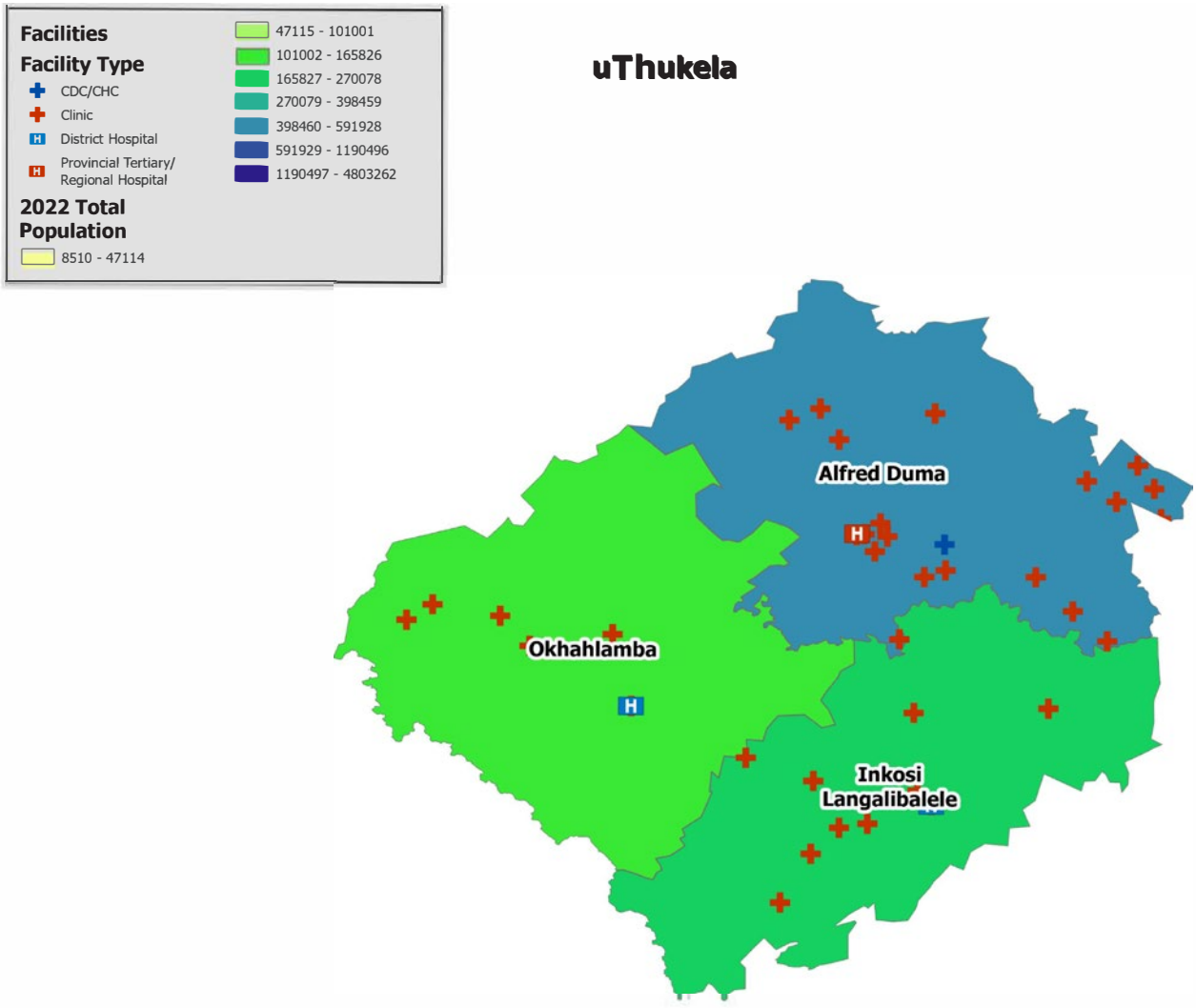


Source: DHIS

5 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

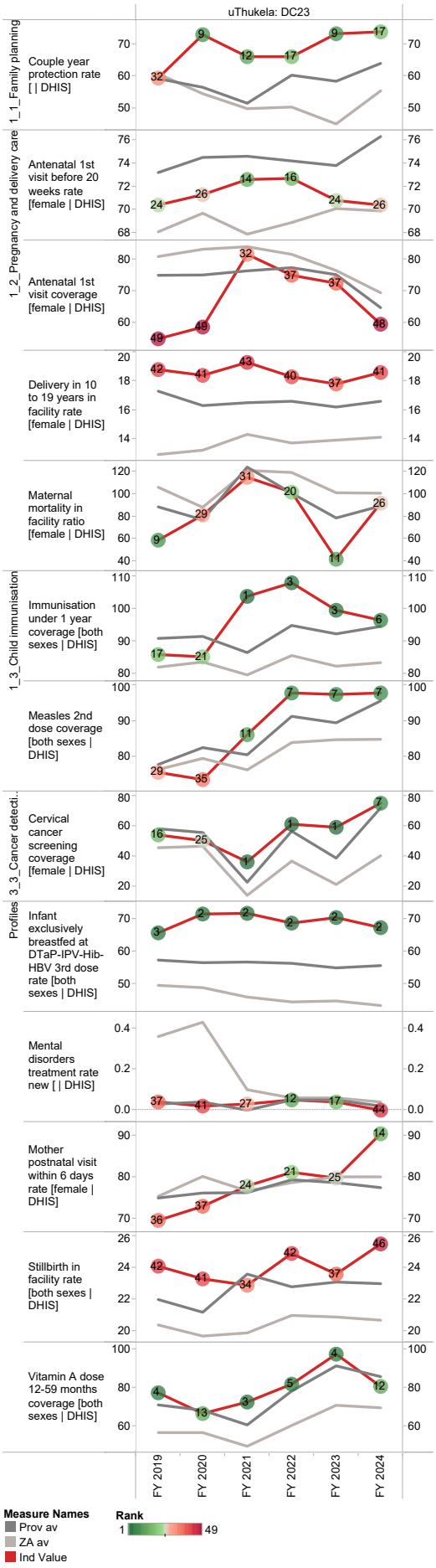
6 Mid-year Population Estimates 2023, DHIS.

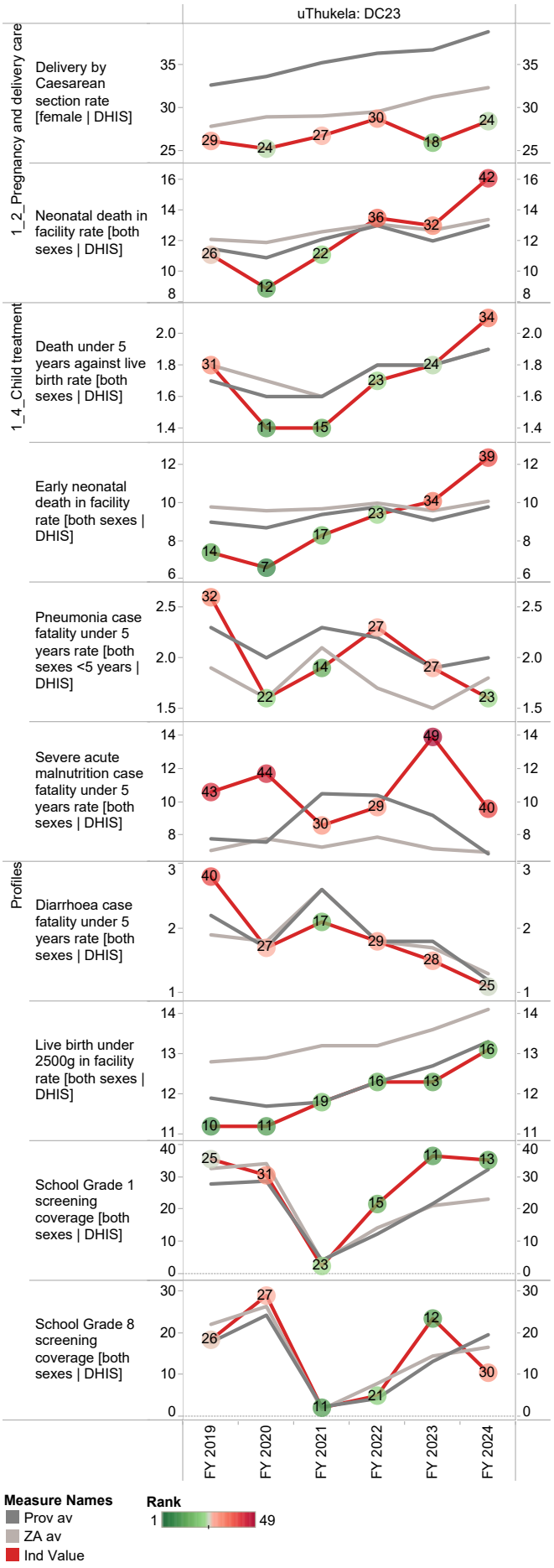
Population distribution, sub-district boundaries and health facility locations

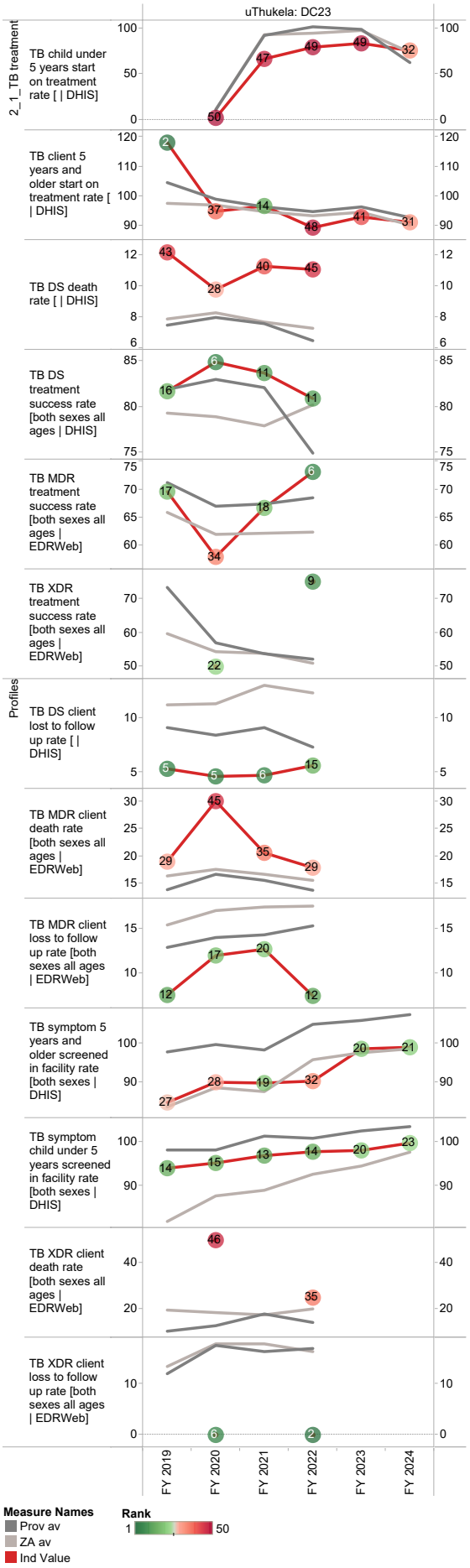


Source: DHIS

Annual trends, 2018/19–2023/24






uThukela: DC23
2_1_TB treatment
Profiles
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
TB DS death rate [| DHIS]
TB DS treatment success rate [both sexes all ages | DHIS]
TB MDR treatment success rate [both sexes all ages | EDRWeb]
TB XDR treatment success rate [both sexes all ages | EDRWeb]
TB DS client lost to follow up rate [| DHIS]
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TB symptom 5 years and older screened in facility rate [both sexes | DHIS]
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TB XDR client death rate [both sexes all ages | EDRWeb]
TB XDR client loss to follow up rate [both sexes all ages | EDRWeb]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
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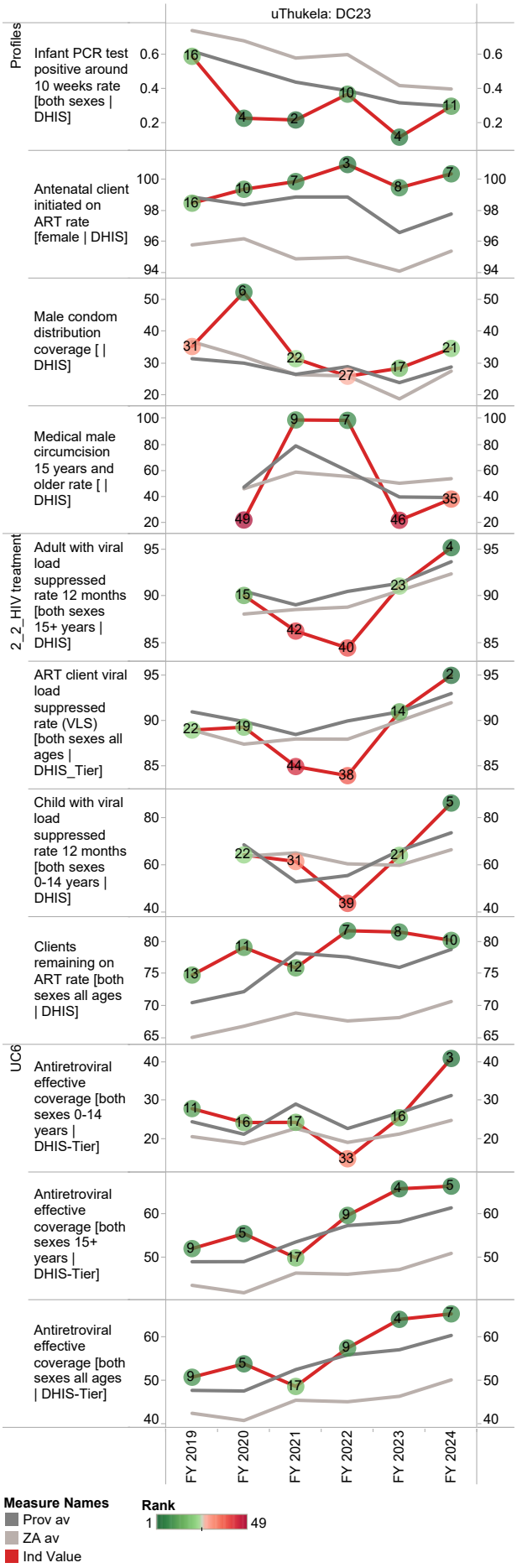
50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Profiles
Infant PCR test positive around 10 weeks rate [both sexes | DHIS]
Antenatal client initiated on ART rate [female | DHIS]
Male condom distribution coverage [| DHIS]
Medical male circumcision 15 years and older rate [| DHIS]
2_2_HIV treatment
Adult with viral load suppressed rate 12 months [both sexes 15+ years | DHIS]
ART client viral load suppressed rate (VLS) [both sexes all ages | DHIS_Tier]
Child with viral load suppressed rate 12 months [both sexes 0-14 years | DHIS]
Clients remaining on ART rate [both sexes all ages | DHIS]
UC6
Antiretroviral effective coverage [both sexes 0-14 years | DHIS-Tier]
Antiretroviral effective coverage [both sexes 15+ years | DHIS-Tier]
Antiretroviral effective coverage [both sexes all ages | DHIS-Tier]
FY 2019
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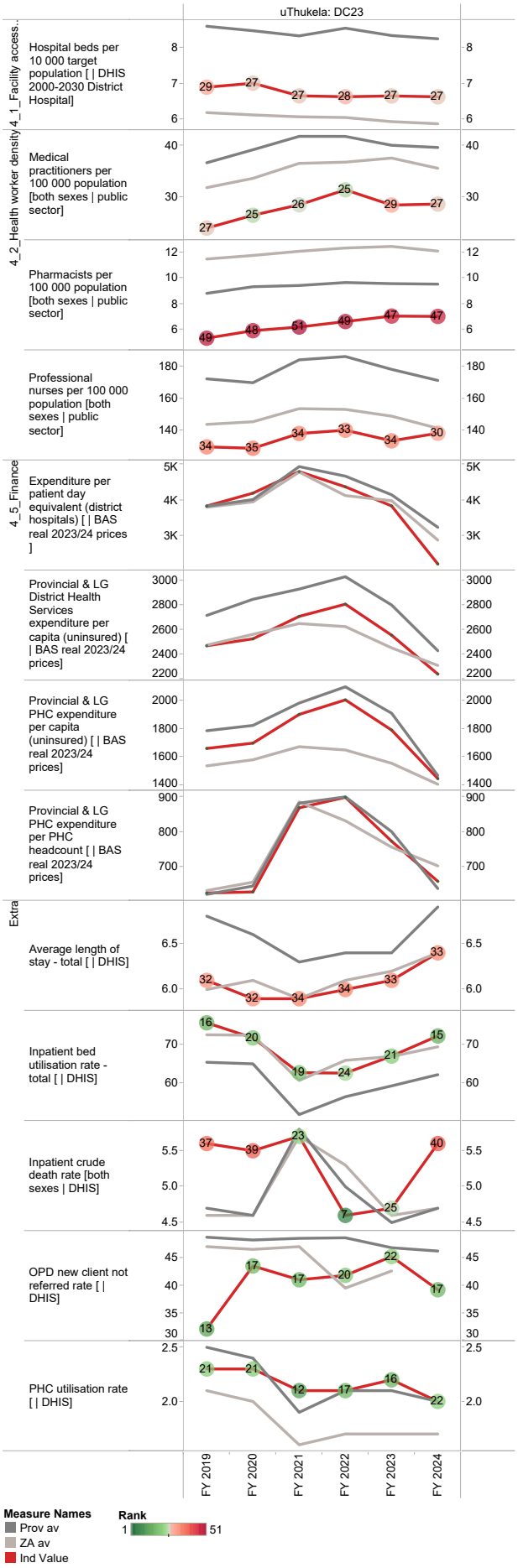
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
1
49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4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
4_2_Health worker density
Medical practitioners per 100 000 population [both sexes | public sector]
Pharmacists per 100 000 population [both sexes | public sector]
Professional nurses per 100 000 population [both sexes | public sector]
4_5_Finance
Expenditure per patient day equivalent (district hospitals) [| BAS real 2023/24 prices]
Provincial & LG District Health Services expenditure per capita (uninsured) [| BAS real 2023/24 prices]
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Extra
Average length of stay - total [| DHIS]
Inpatient bed utilisation rate - total [| DHIS]
Inpatient crude death rate [both sexes | DHIS]
OPD new client not referred rate [| DHIS]
PHC utilisation rate [| DHIS]
FY 2019
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FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
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Ind Value
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51

uMzinyathi District Municipality (DC24)

The uMzinyathi District Municipality[7] is a Category C municipality located in the north and central areas of the KwaZulu-Natal Province. The district consists of four local municipalities: Endumeni, Nquthu, Msinga and Umvoti.

Area: 8 652km²

Population (2023)[8]: 582 409

Households[7]: 126 791

Formal dwellings[7]: 47.0%

Cities/Towns:

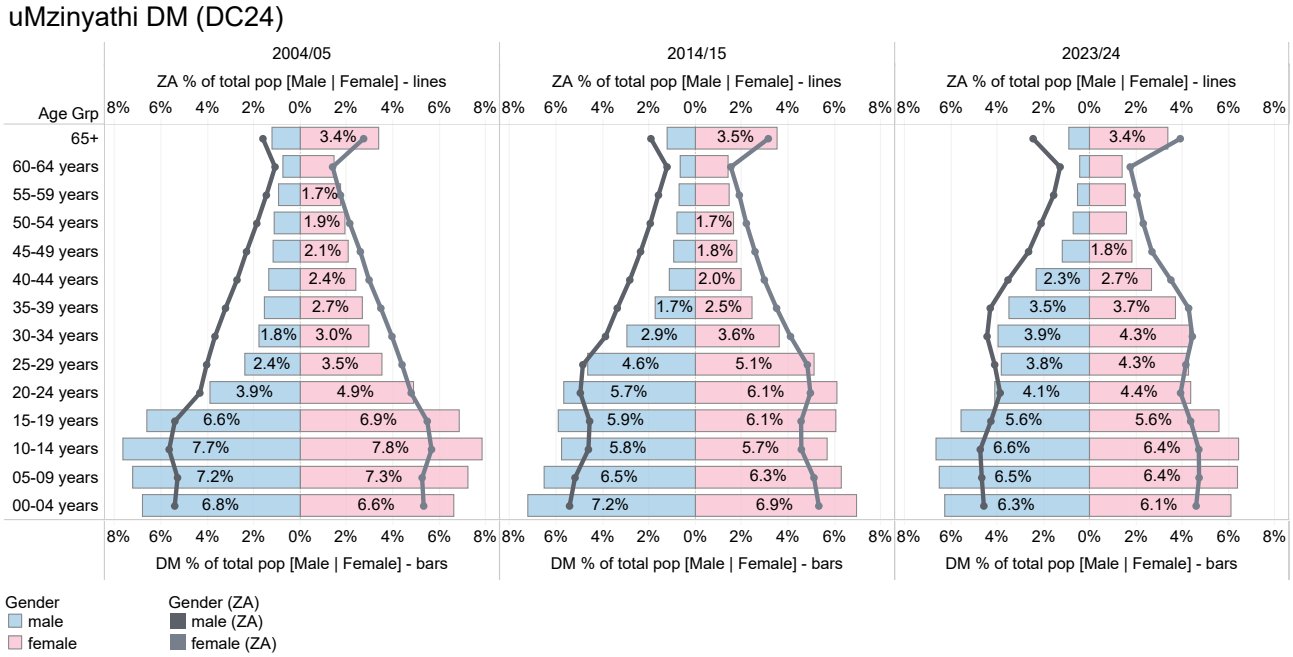
Endumeni: Dundee, Glencoe

Nquthu: Nquthu

Msinga: Pomeroy

Umvoti: Greytown, Kranskop,

District percentage population by age-gender group compared to South Africa

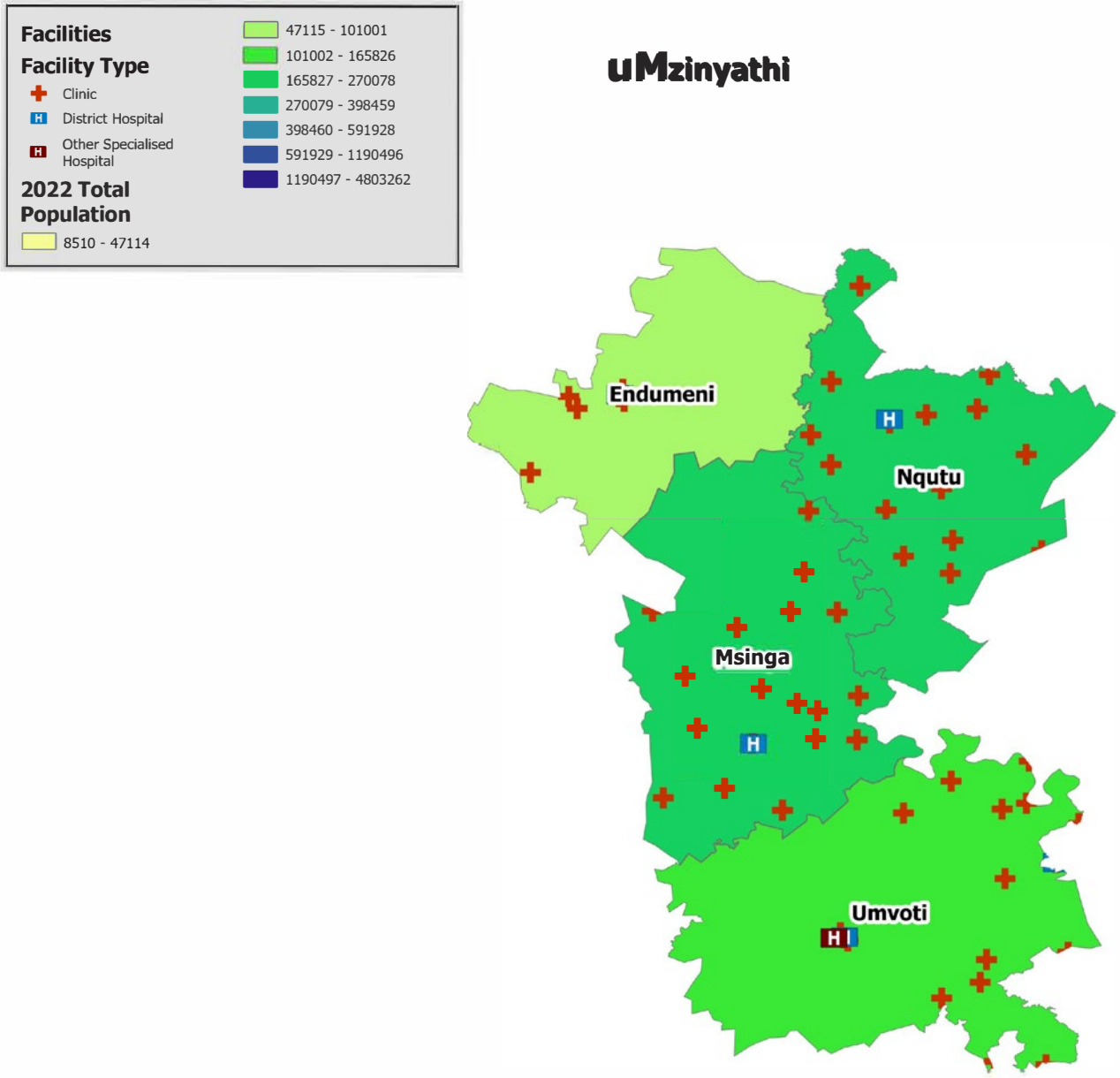


Source: DHIS

7 The Local Government Handbook South Africa 2022. A complete guide to municipalities in South Africa. Twelfth Edition. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

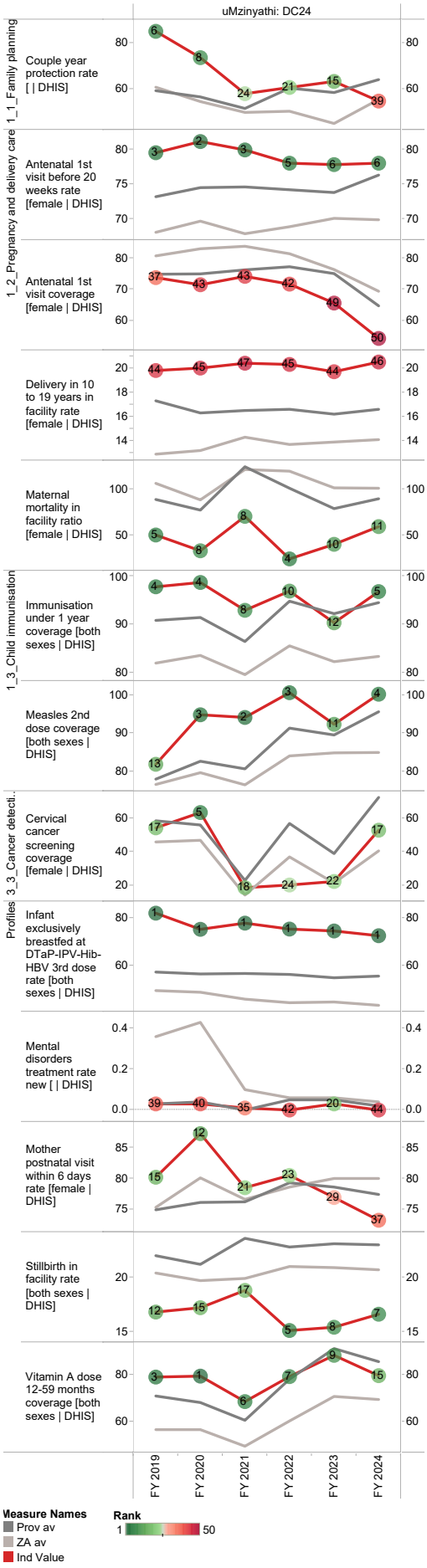
8 Mid-year Population Estimates 2022, Stats SA.

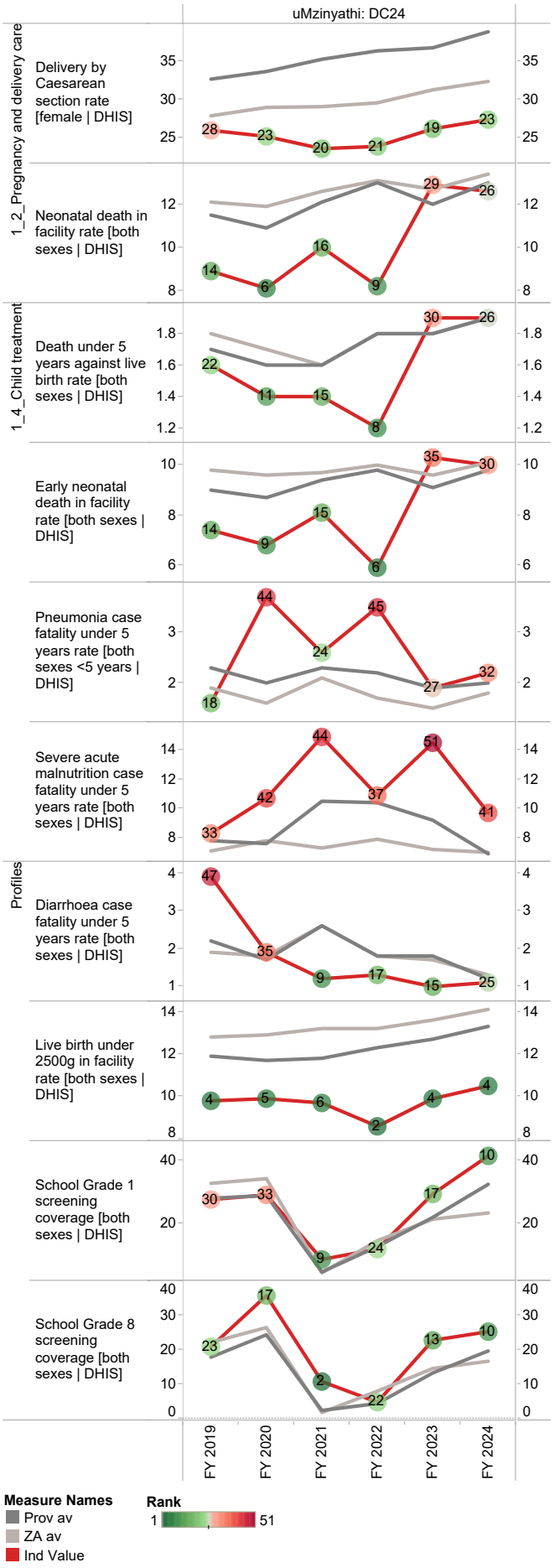
Population distribution, sub-district boundaries and health facility locations

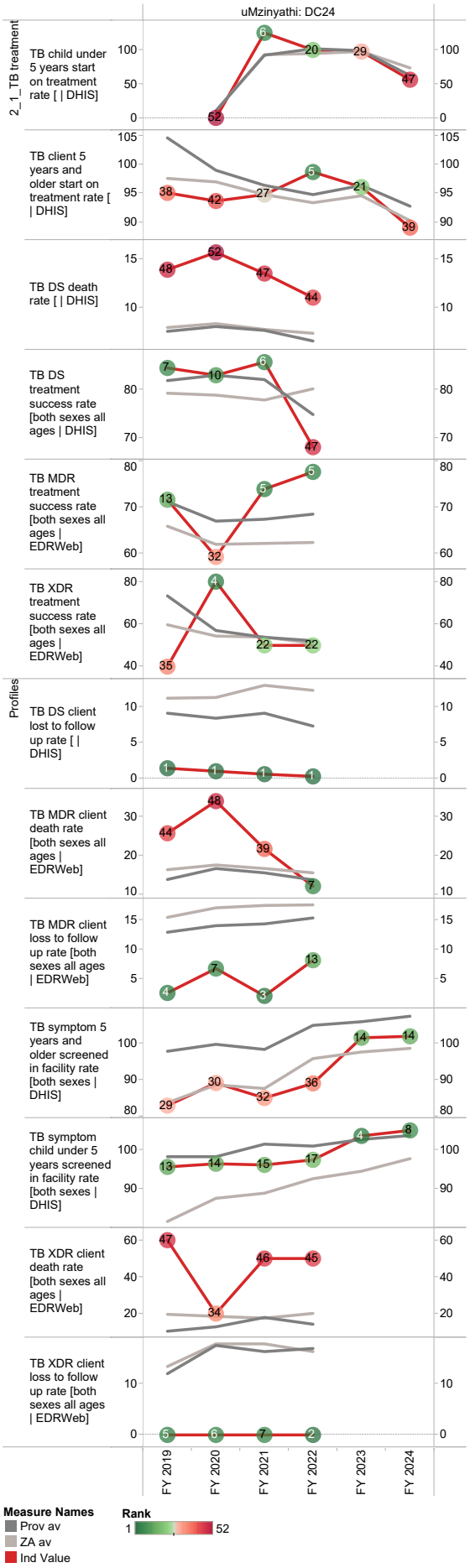


Source: DHIS

Annual trends, 2018/19–2023/24



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2_1_TB treatment
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
TB DS death rate [| DHIS]
TB DS treatment success rate [both sexes all ages | DHIS]
TB MDR treatment success rate [both sexes all ages | EDRWeb]
TB XDR treatment success rate [both sexes all ages | EDRWeb]
Profiles
TB DS client lost to follow up rate [| DHIS]
TB MDR client death rate [both sexes all ages | EDRWeb]
TB MDR client loss to follow up rate [both sexes all ages | EDRWeb]
TB symptom 5 years and older screened in facility rate [both sexes | DHIS]
TB symptom child under 5 years screened in facility rate [both sexes | DHIS]
TB XDR client death rate [both sexes all ages | EDRWeb]
TB XDR client loss to follow up rate [both sexes all ages | EDRWeb]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
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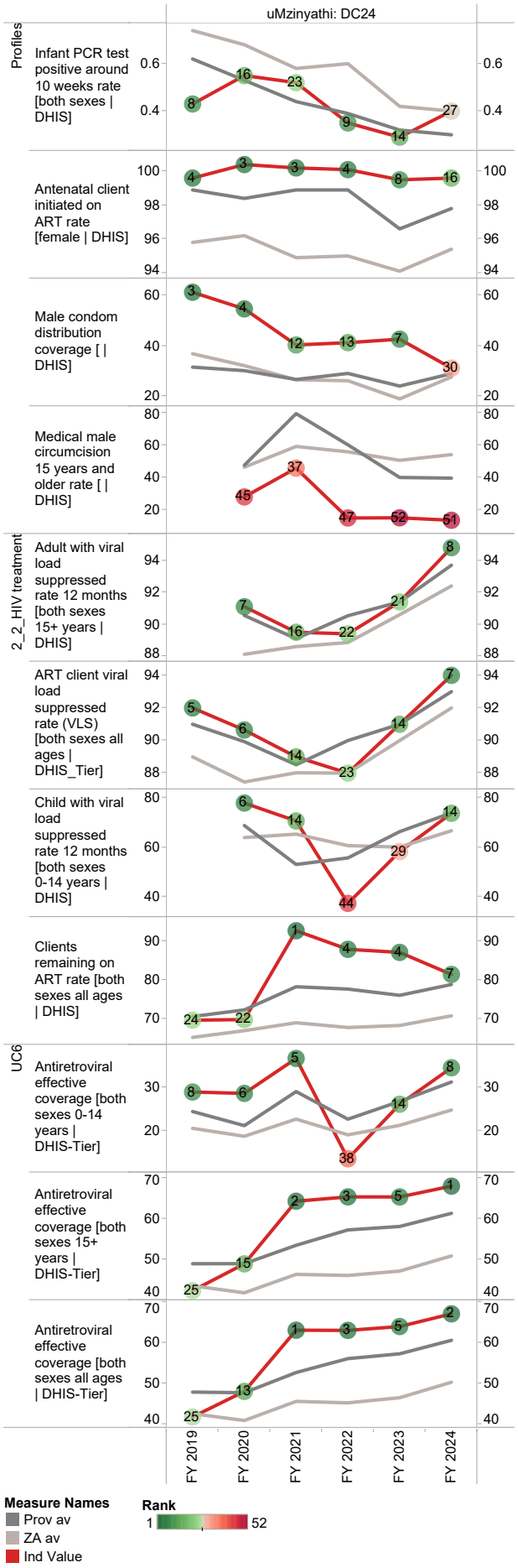
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Profiles
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Male condom distribution coverage [| DHIS]
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UC6
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FY 2019
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FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
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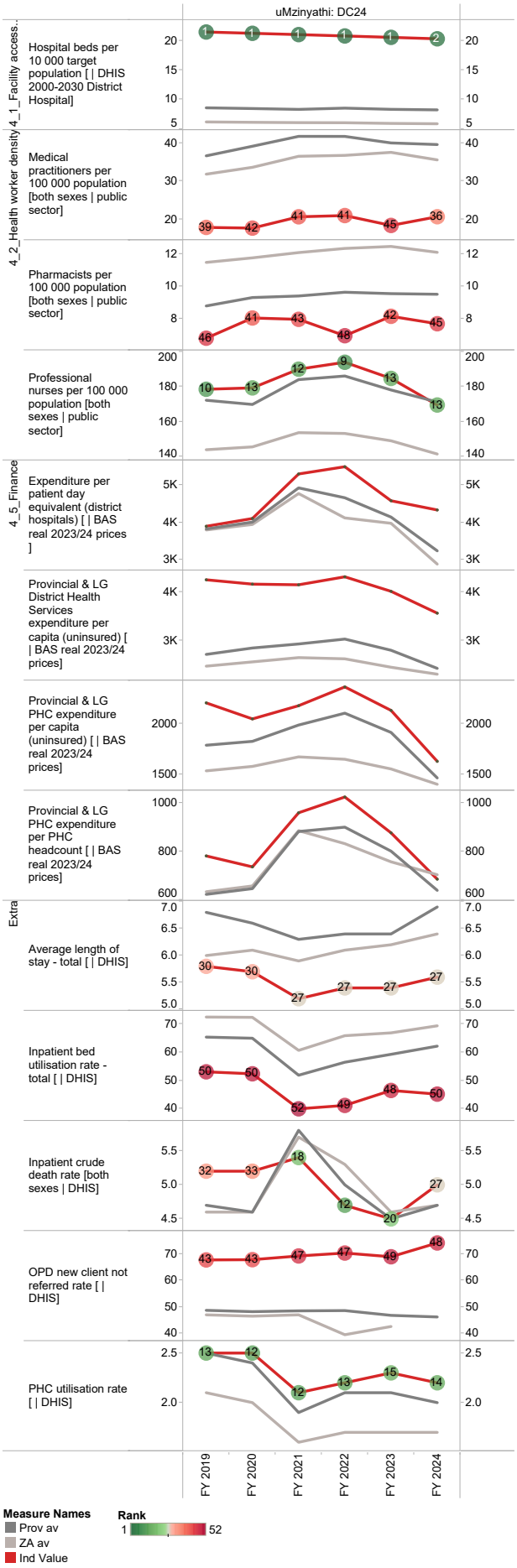
52


uMzinyathi: DC24
4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
4_2_Health worker density
Medical practitioners per 100 000 population [both sexes | public sector]
Pharmacists per 100 000 population [both sexes | public sector]
Professional nurses per 100 000 population [both sexes | public sector]
4_5_Finance
Expenditure per patient day equivalent (district hospitals) [| BAS real 2023/24 prices]
Provincial & LG District Health Services expenditure per capita (uninsured) [| BAS real 2023/24 prices]
Provincial & LG PHC expenditure per capita (uninsured) [| BAS real 2023/24 prices]
Provincial & LG PHC expenditure per PHC headcount [| BAS real 2023/24 prices]
Extra
Average length of stay - total [| DHIS]
Inpatient bed utilisation rate - total [| DHIS]
Inpatient crude death rate [both sexes | DHIS]
OPD new client not referred rate [| DHIS]
PHC utilisation rate [| DHIS]
FY 2019
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FY 2021
FY 2022
FY 2023
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Measure Names
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52

Amajuba District Municipality (DC25)

The Amajuba District Municipality[9] is a Category C municipality located in the north-western corner of KwaZulu-Natal. It is one of the smallest districts in the province, making up only 8% of its geographical area. The district comprises three local municipalities: Newcastle, eMadlangeni and Dannhauser.

Area: 7 102km²

Population (2023)[10]: 577 873

Households[9]: 117 256

Formal dwellings[9]: 84.4%

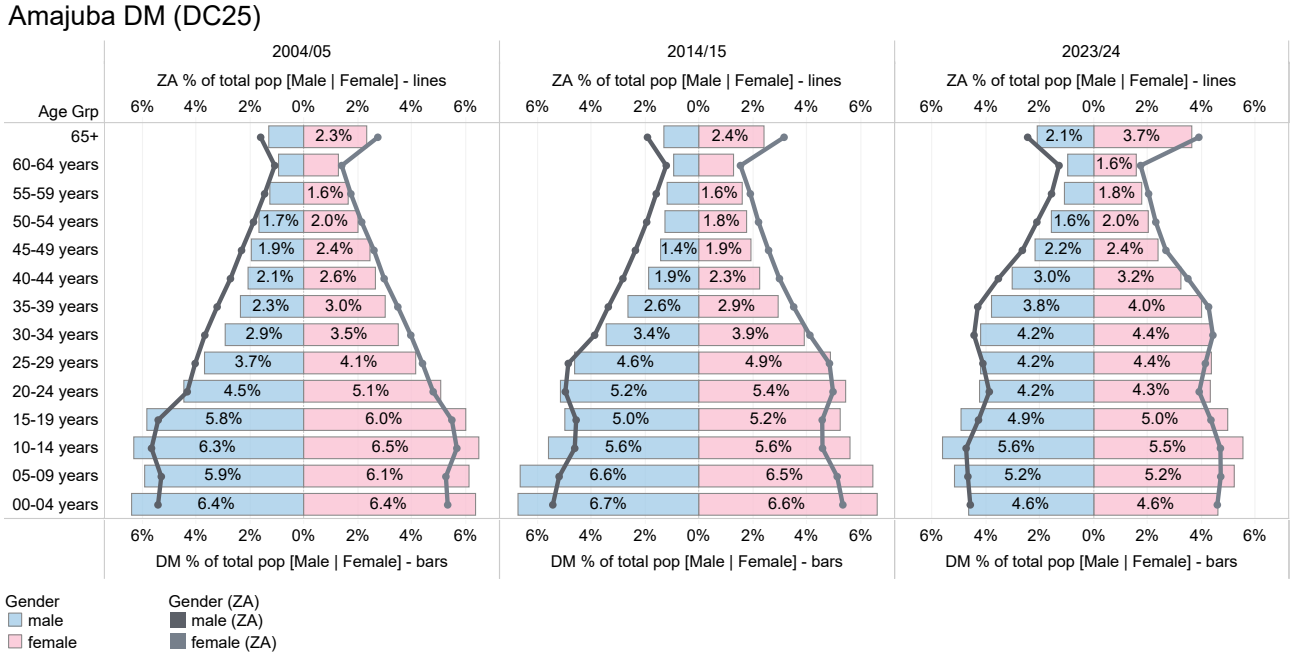
Cities/Towns:

Newcastle: Charlestown, Newcastle

eMadlangeni: Utrecht

Dannhauser: Dannhauser, Hattingspruit

District percentage population by age-gender group compared to South Africa

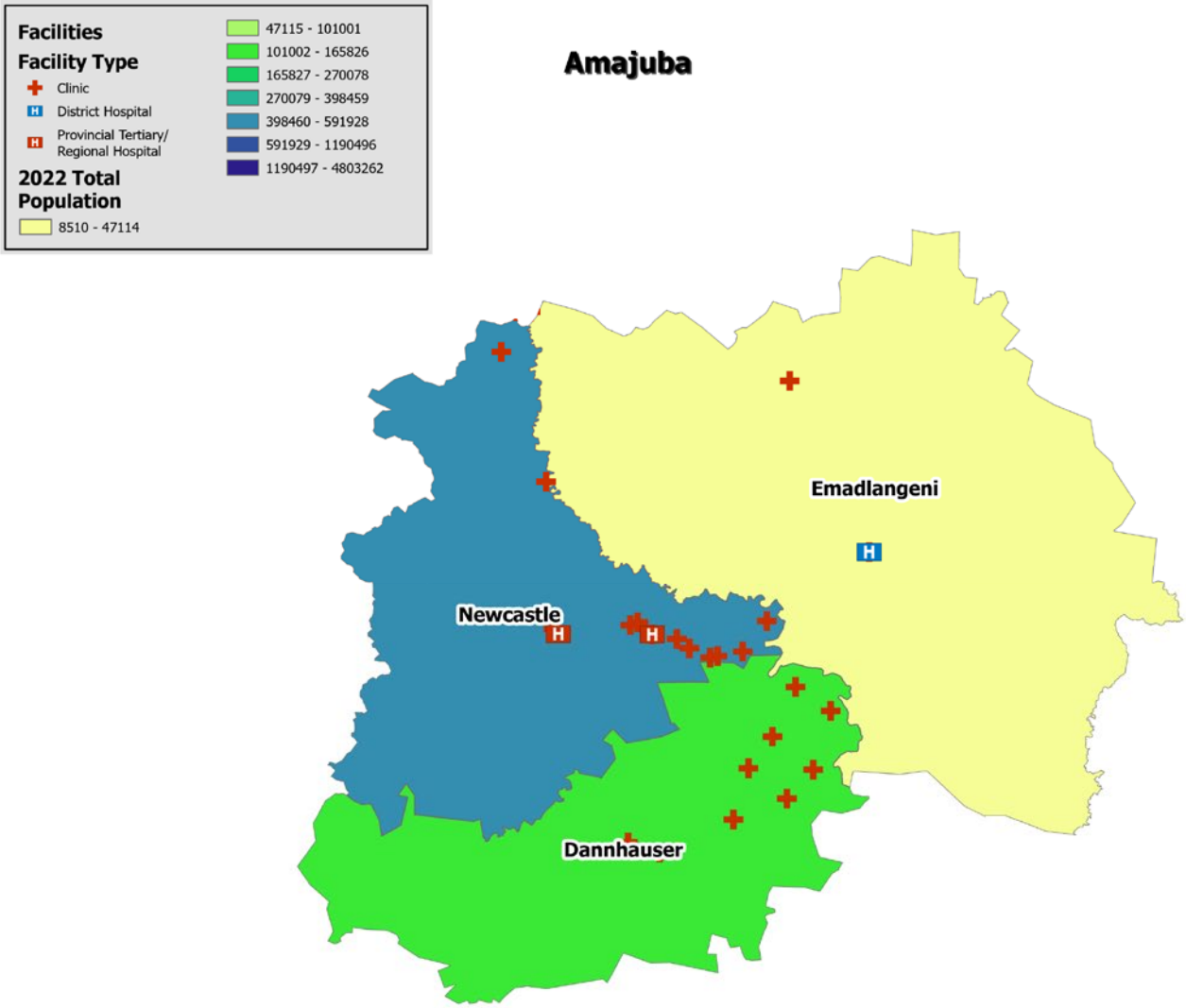


Source: DHIS

9 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

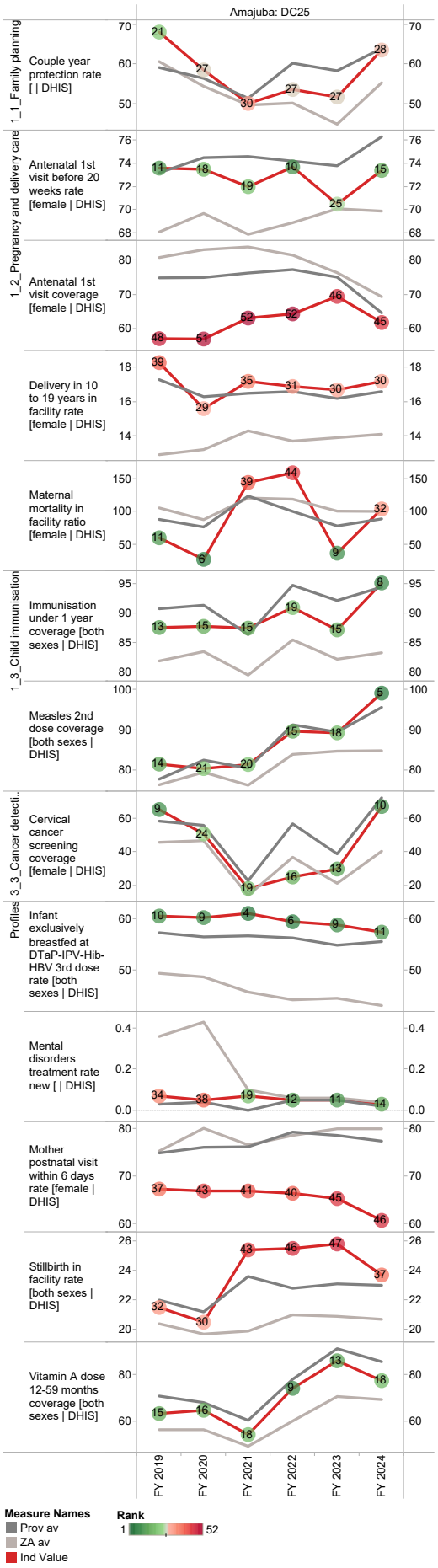
10 Mid-year Population Estimates 2023, DHIS.

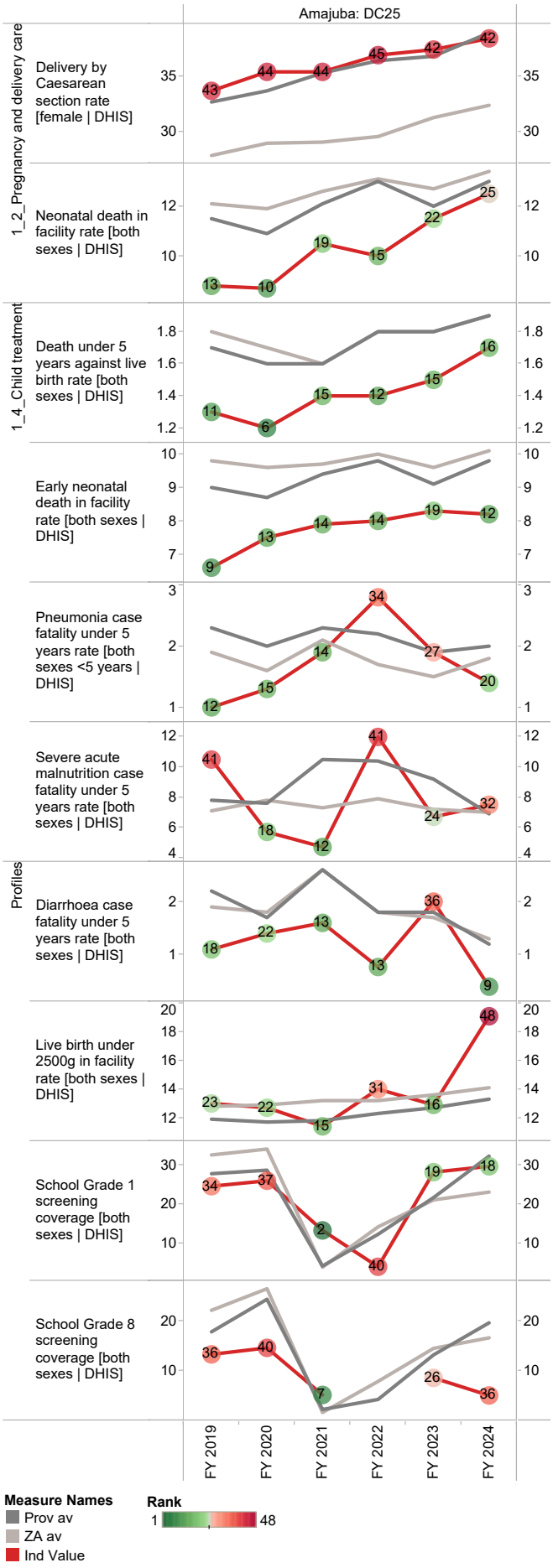
Population distribution, sub-district boundaries and health facility locations

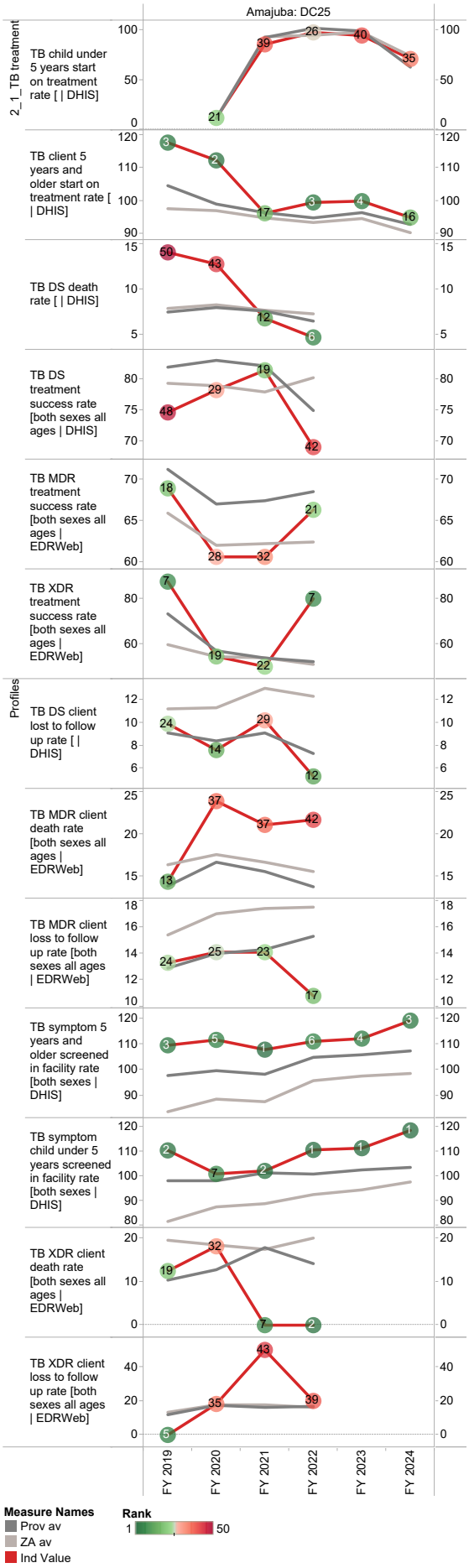


Source: DHIS

Annual trends, 2018/19–2023/24






Amajuba: DC25
2_1_TB treatment
Profiles
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
TB DS death rate [| DHIS]
TB DS treatment success rate [both sexes all ages | DHIS]
TB MDR treatment success rate [both sexes all ages | EDRWeb]
TB XDR treatment success rate [both sexes all ages | EDRWeb]
TB DS client lost to follow up rate [| DHIS]
TB MDR client death rate [both sexes all ages | EDRWeb]
TB MDR client loss to follow up rate [both sexes all ages | EDRWeb]
TB symptom 5 years and older screened in facility rate [both sexes | DHIS]
TB symptom child under 5 years screened in facility rate [both sexes | DHIS]
TB XDR client death rate [both sexes all ages | EDRWeb]
TB XDR client loss to follow up rate [both sexes all ages | EDRWeb]
FY 2019
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FY 2022
FY 2023
FY 2024
Measure Names
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ZA av
Ind Value
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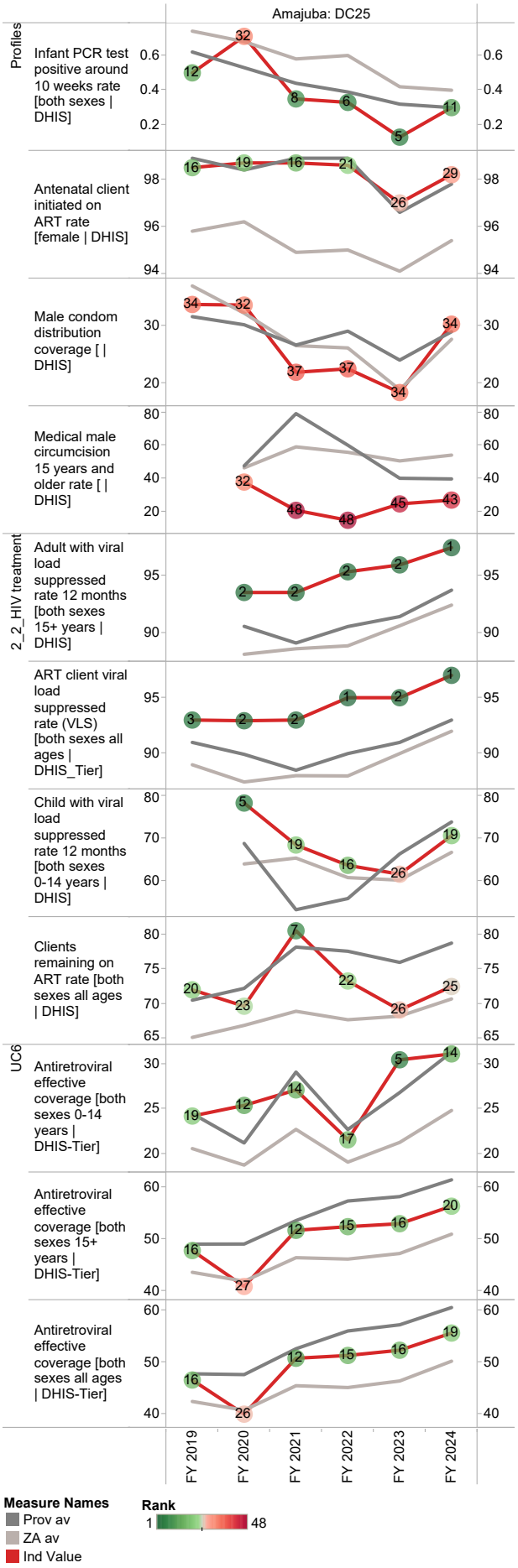
Amajuba: DC25
Profiles
Infant PCR test positive around 10 weeks rate [both sexes | DHIS]
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ART client viral load suppressed rate (VLS) [both sexes all ages | DHIS_Tier]
Child with viral load suppressed rate 12 months [both sexes 0-14 years | DHIS]
Clients remaining on ART rate [both sexes all ages | DHIS]
UC6
Antiretroviral effective coverage [both sexes 0-14 years | DHIS-Tier]
Antiretroviral effective coverage [both sexes 15+ years | DHIS-Tier]
Antiretroviral effective coverage [both sexes all ages | DHIS-Tier]
FY 2019
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FY 2021
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FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
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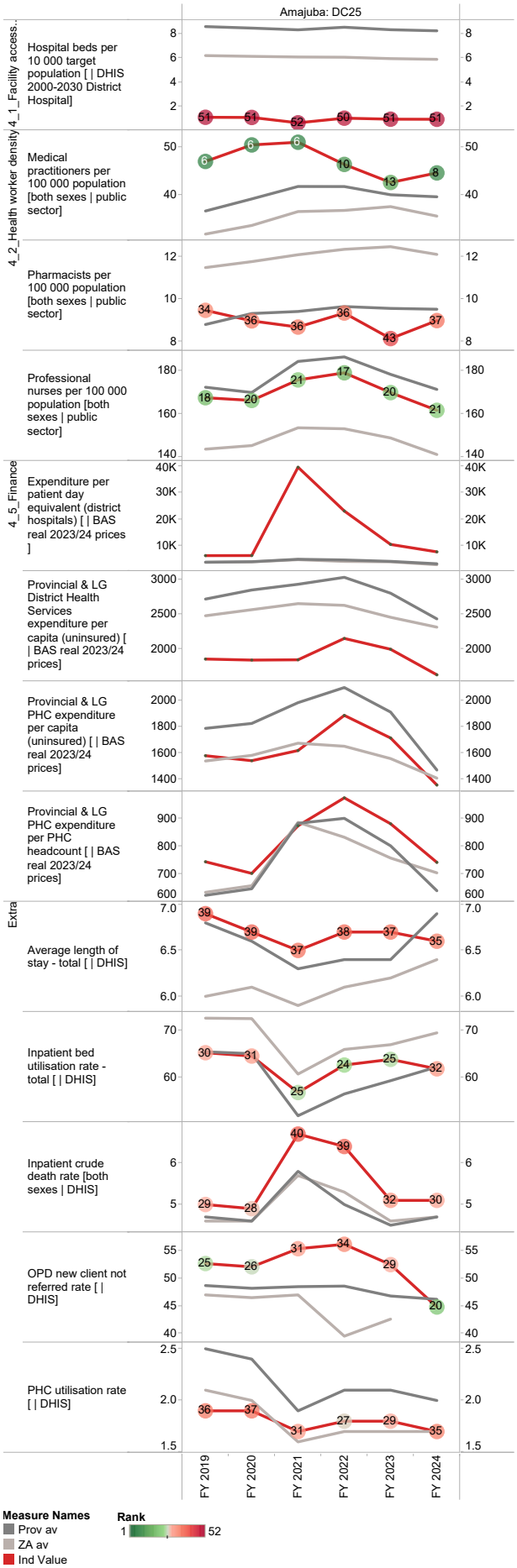
48


Amajuba: DC25
4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
4_2_Health worker density
Medical practitioners per 100 000 population [both sexes | public sector]
Pharmacists per 100 000 population [both sexes | public sector]
Professional nurses per 100 000 population [both sexes | public sector]
4_5_Finance
Expenditure per patient day equivalent (district hospitals) [| BAS real 2023/24 prices]
Provincial & LG District Health Services expenditure per capita (uninsured) [| BAS real 2023/24 prices]
Provincial & LG PHC expenditure per capita (uninsured) [| BAS real 2023/24 prices]
Provincial & LG PHC expenditure per PHC headcount [| BAS real 2023/24 prices]
Extra
Average length of stay - total [| DHIS]
Inpatient bed utilisation rate - total [| DHIS]
Inpatient crude death rate [both sexes | DHIS]
OPD new client not referred rate [| DHIS]
PHC utilisation rate [| DHIS]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
1
52

Zululand District Municipality (DC26)

The Zululand District Municipality[11] is a Category C municipality situated in the north-eastern part of KwaZulu-Natal. It is the largest district in the province, making up 16% of its geographical area. It comprises five local municipalities: Ulundi, Nongoma, uPhongolo, eDumbe and AbaQulusi.

Area: 14 800km²

Population (2023)[12]: 877 196

Households[11]: 178 516

Formal dwellings[11]: 62.1%

Cities/Towns:

Ulundi: Ulundi,

Nongoma: Nongoma

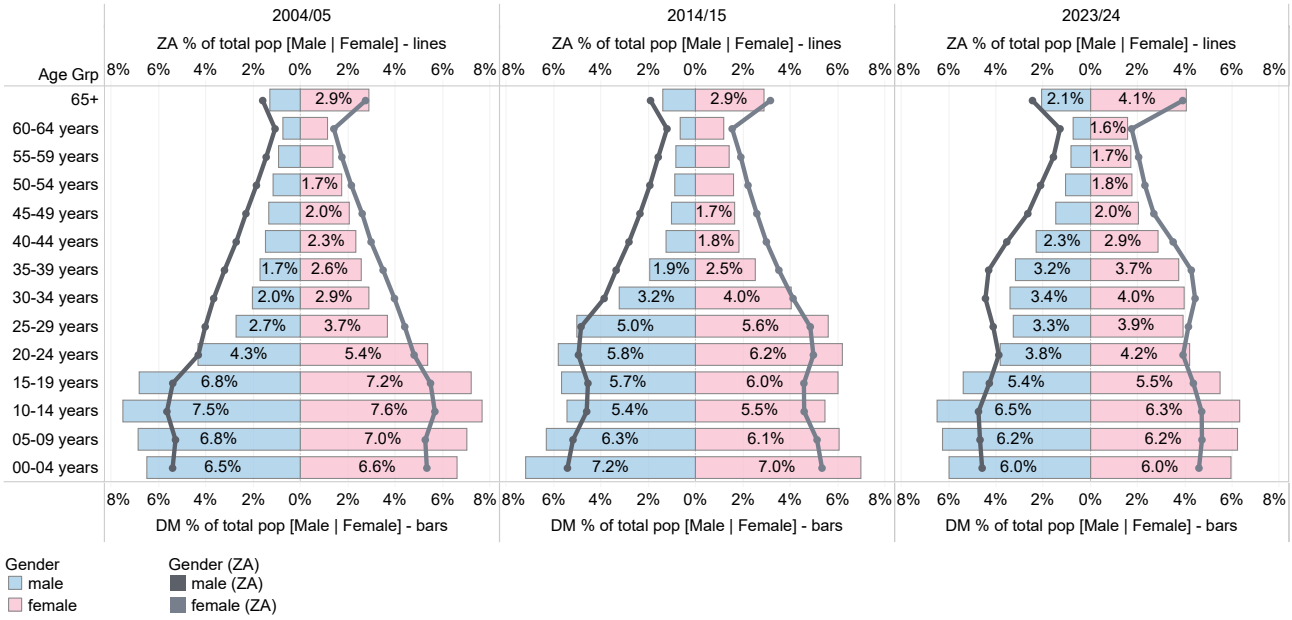
uPhongolo: Pongola

eDumbe: Paulpietersburg

AbaQulusi: Louwsburg, Vryheid

District percentage population by age-gender group compared to South Africa

Zululand DM (DC26)

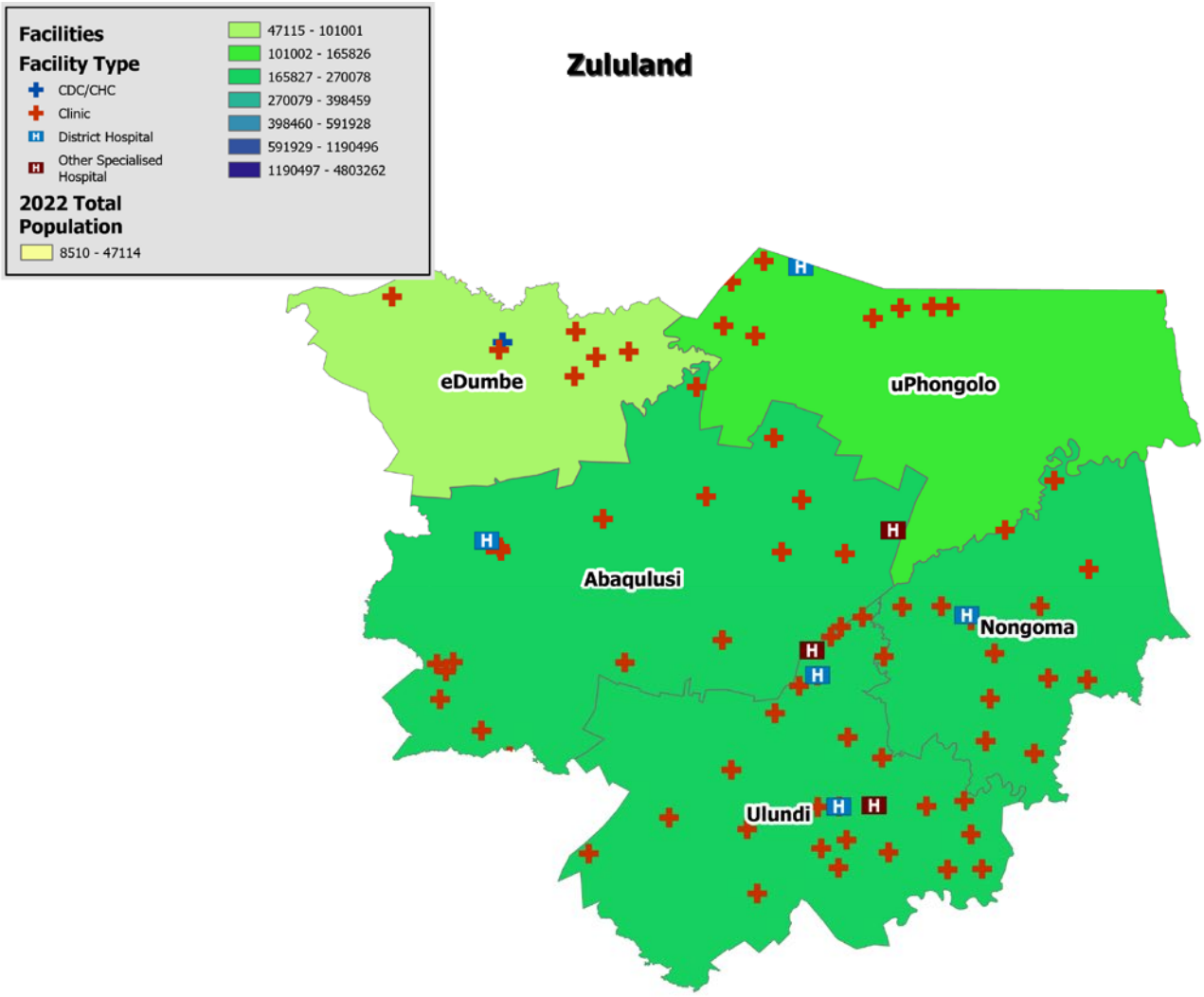


Source: DHIS

11 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

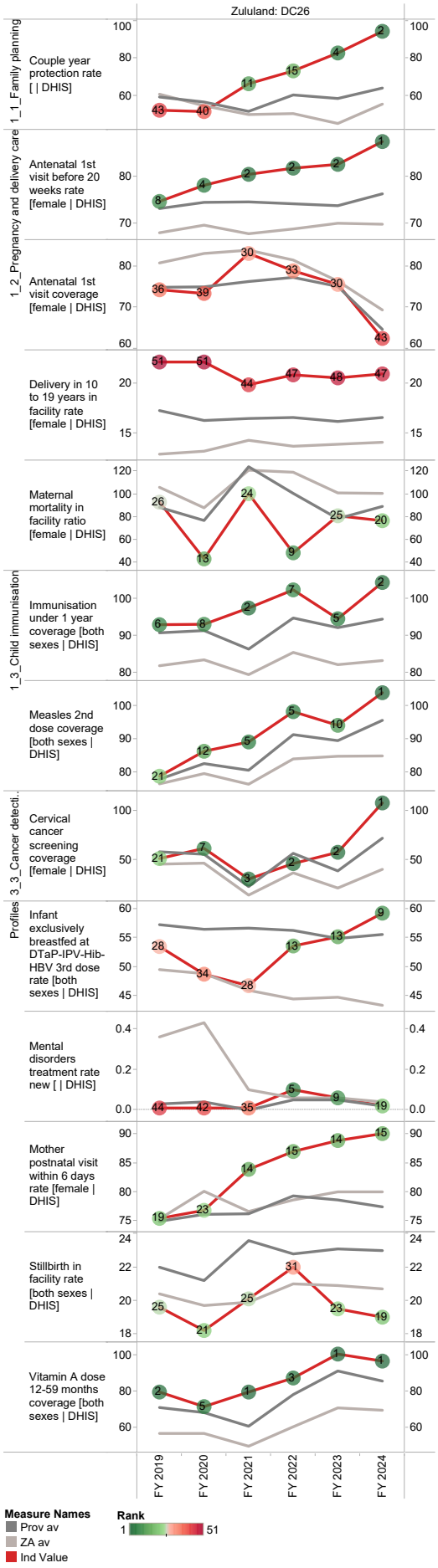
12 Mid-year Population Estimates 2023, DHIS.

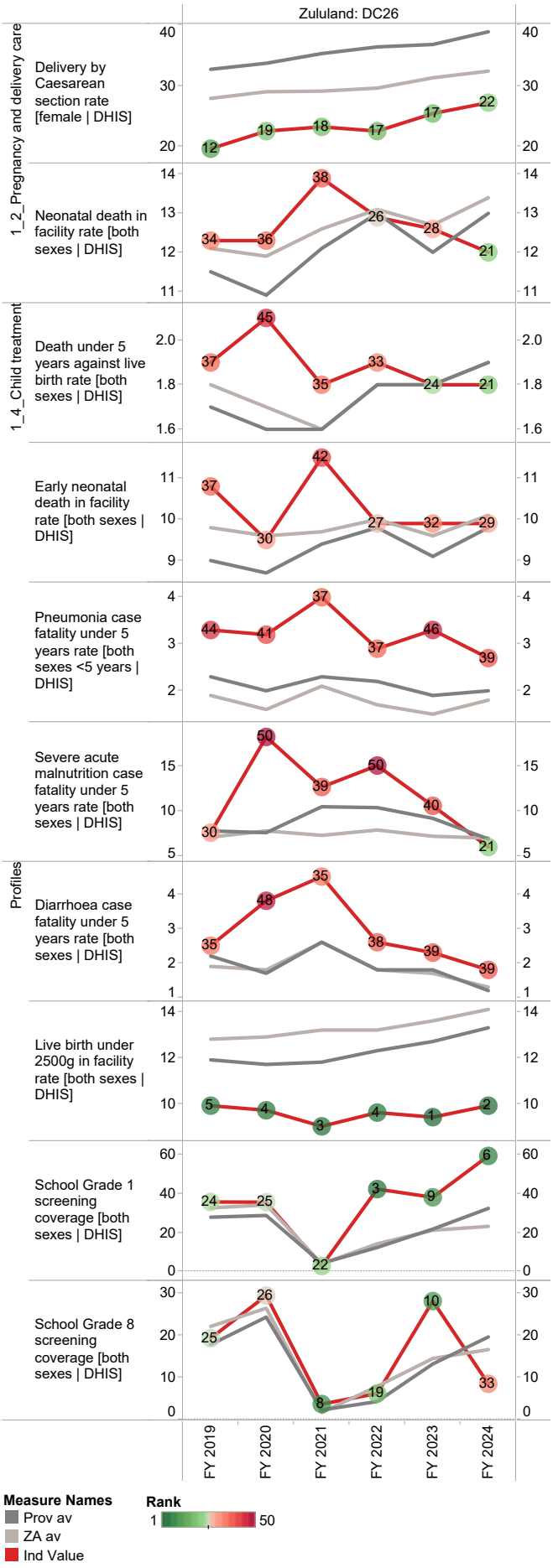
Population distribution, sub-district boundaries and health facility locations

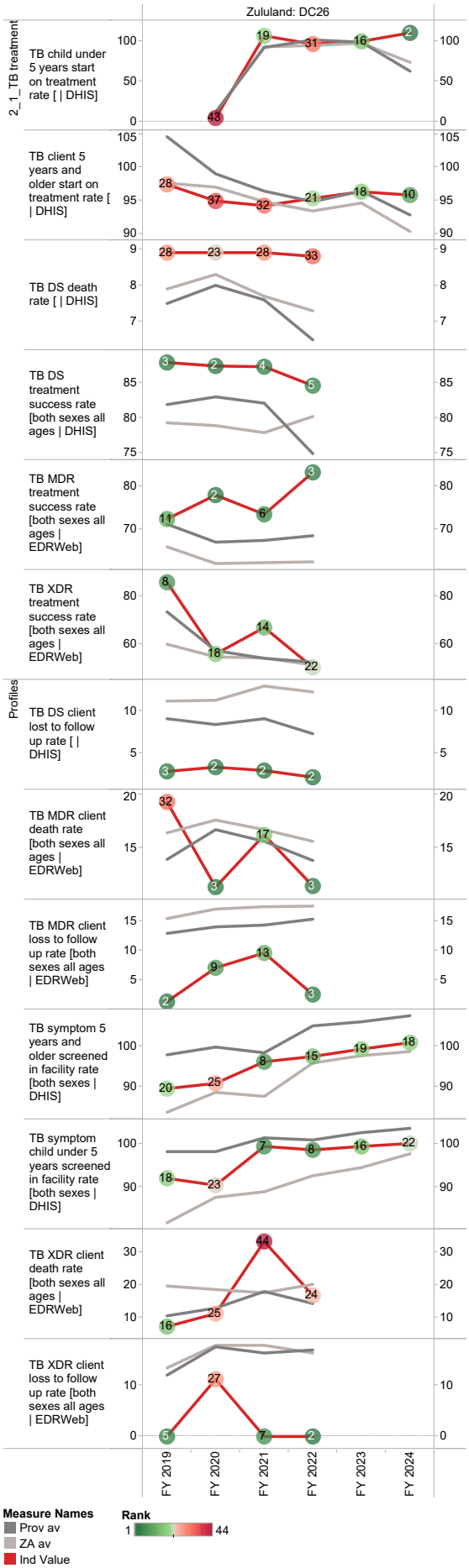


Source: DHIS

Annual trends, 2018/19–2023/24






Zululand: DC26
2_1_TB treatment
Profiles
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
TB DS death rate [| DHIS]
TB DS treatment success rate [both sexes all ages | DHIS]
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TB symptom 5 years and older screened in facility rate [both sexes | DHIS]
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TB XDR client death rate [both sexes all ages | EDRWeb]
TB XDR client loss to follow up rate [both sexes all ages | EDRWeb]
FY 2019
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Measure Names
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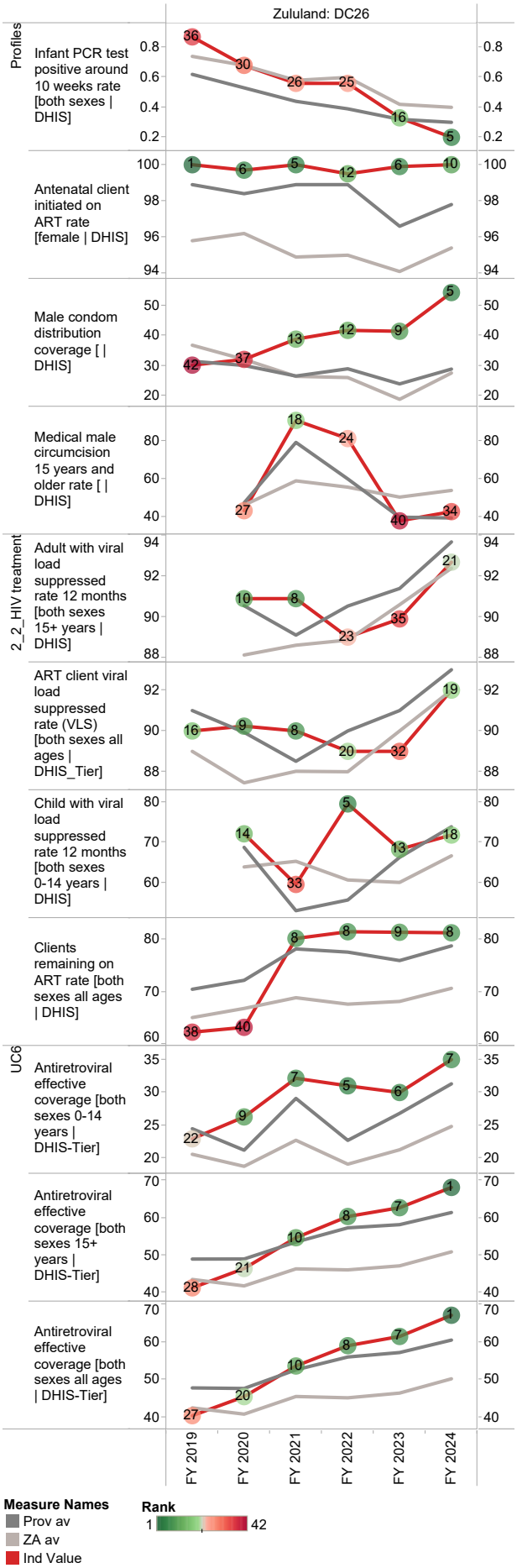
Zululand: DC26
Profiles
Infant PCR test positive around 10 weeks rate [both sexes | DHIS]
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Measure Names
Prov av
ZA av
Ind Value
Rank
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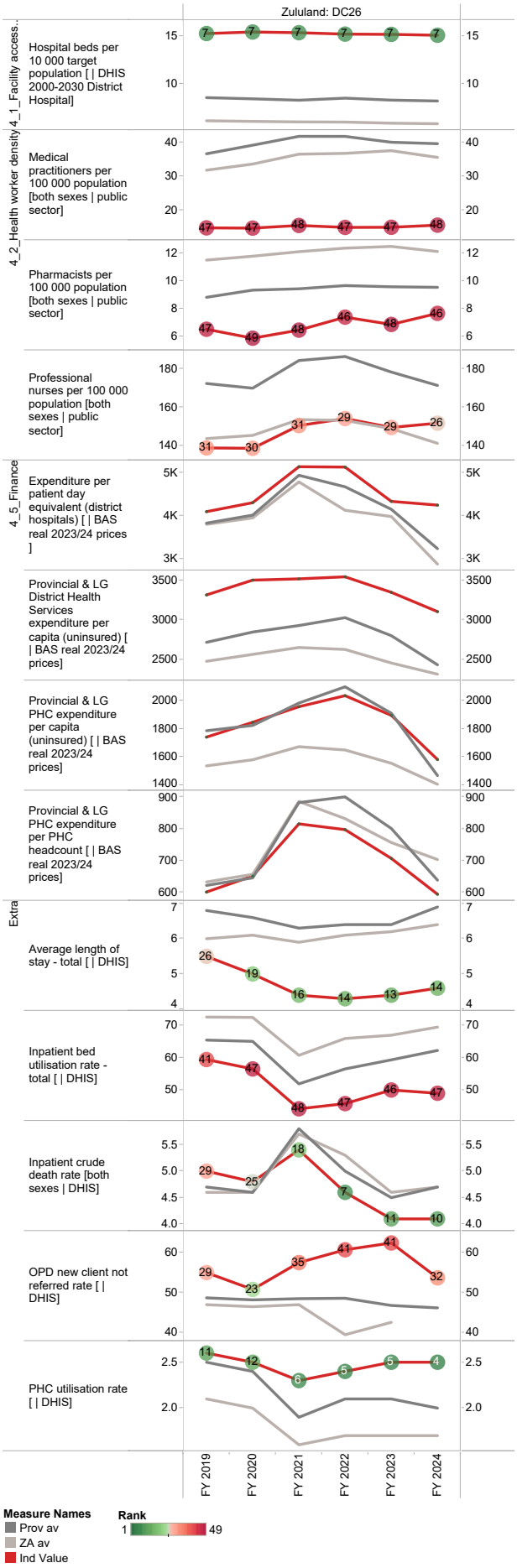
42


Zululand: DC26
4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
4_2_Health worker density
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FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
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ZA av
Ind Value
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49

uMkhanyakude District Municipality (DC27)

The uMkhanyakude District Municipality[13] is a Category C municipality located along the coast in the far north of the KwaZulu-Natal Province. It shares its borders with Swaziland and Mozambique, and consists of the following four local municipalities: uMhlabuyalingana, Jozini, Big 5 Hlabisa and Mtubatuba.

Area: 13 855km²

Population (2023)[14]: 690 188

Households[13]: 151 245

Formal dwellings[13]: 70.1%

Cities/Towns:

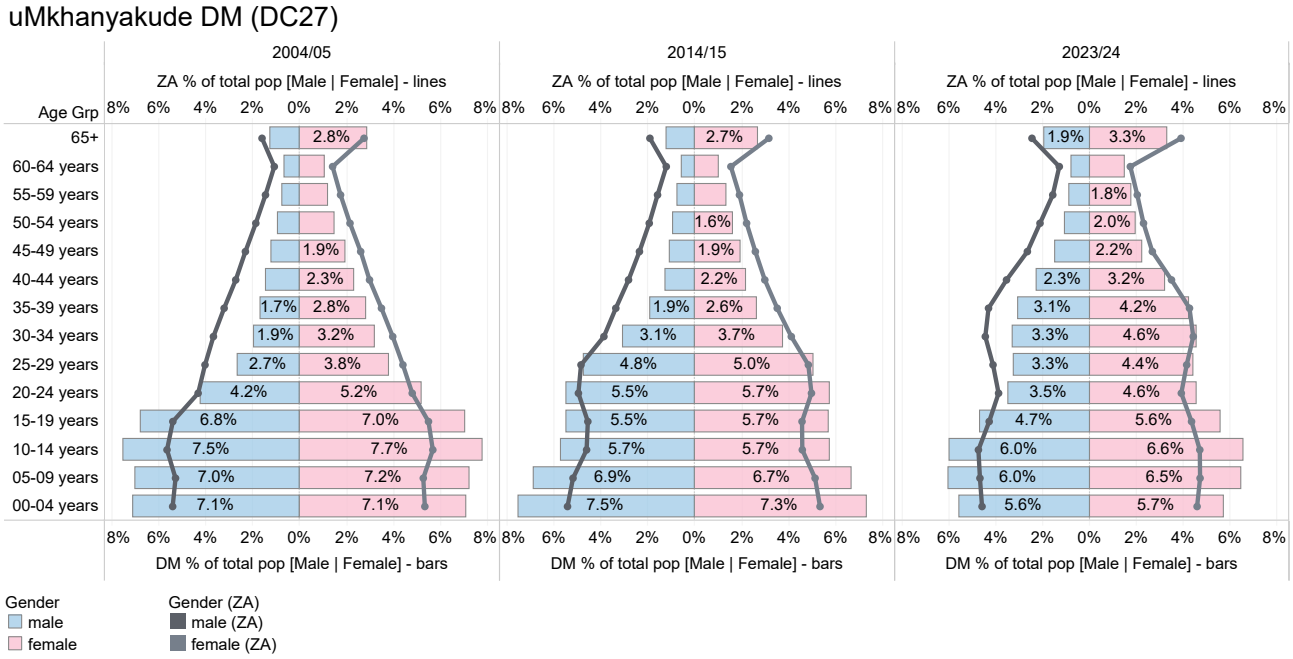
uMhlabuyalingana: Mbazwana

Jozini: Ingwavuma, Jozini, Mkuze

Big 5 Hlabisa: Hlabisa, Hluhluwe

Mtubatuba: Mtubatuba, St Lucia

District percentage population by age-gender group compared to South Africa

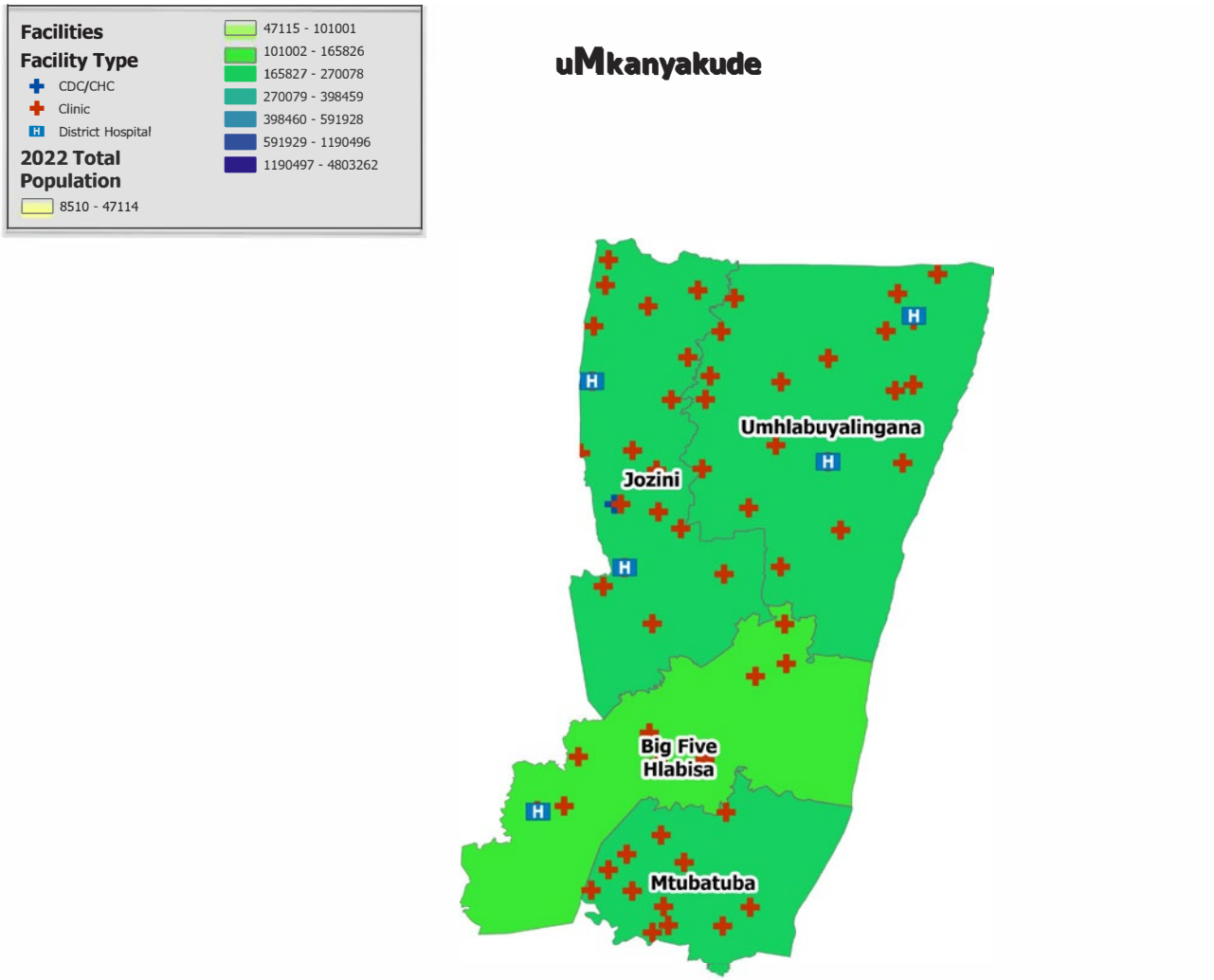


Source: DHIS

13 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

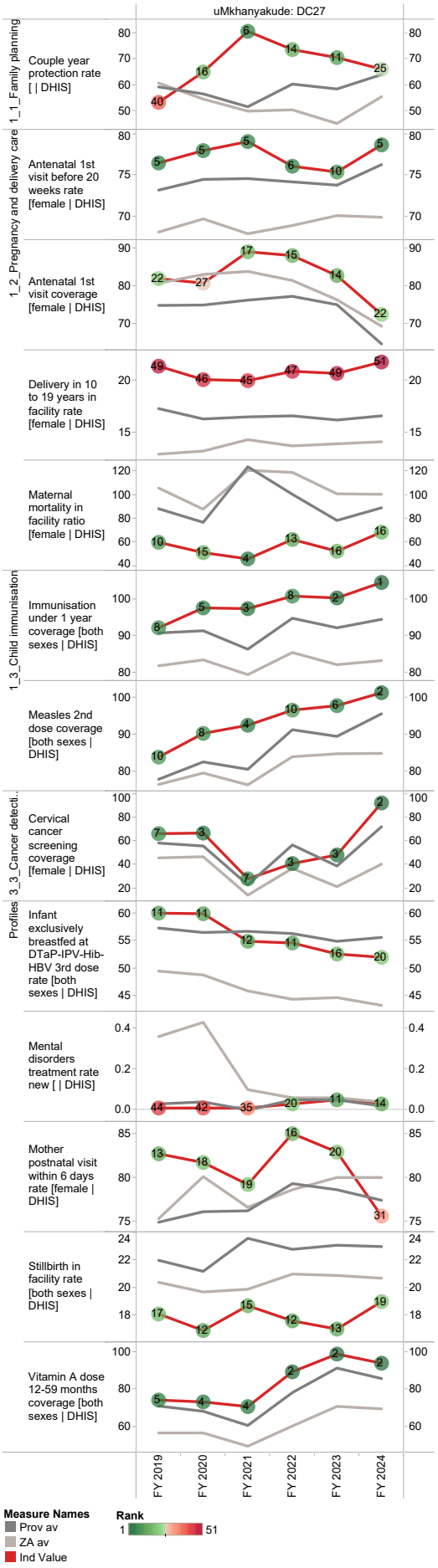
14 Mid-year Population Estimates 2023, DHIS.

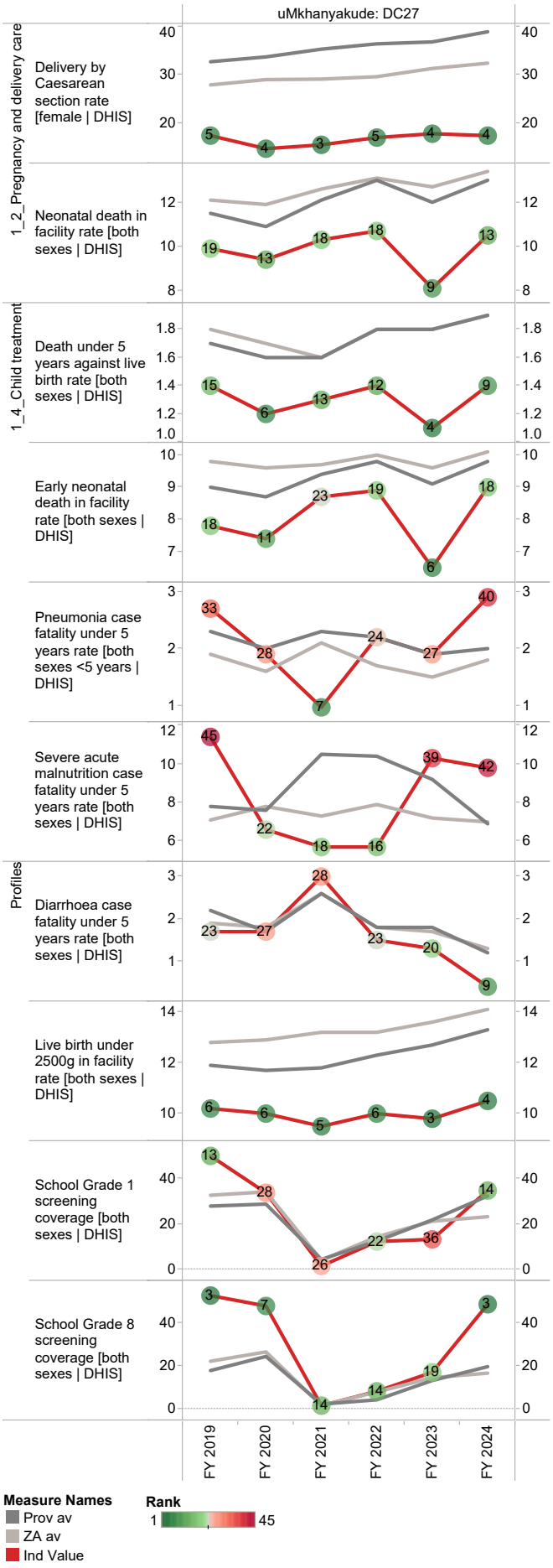
Population distribution, sub-district boundaries and health facility locations

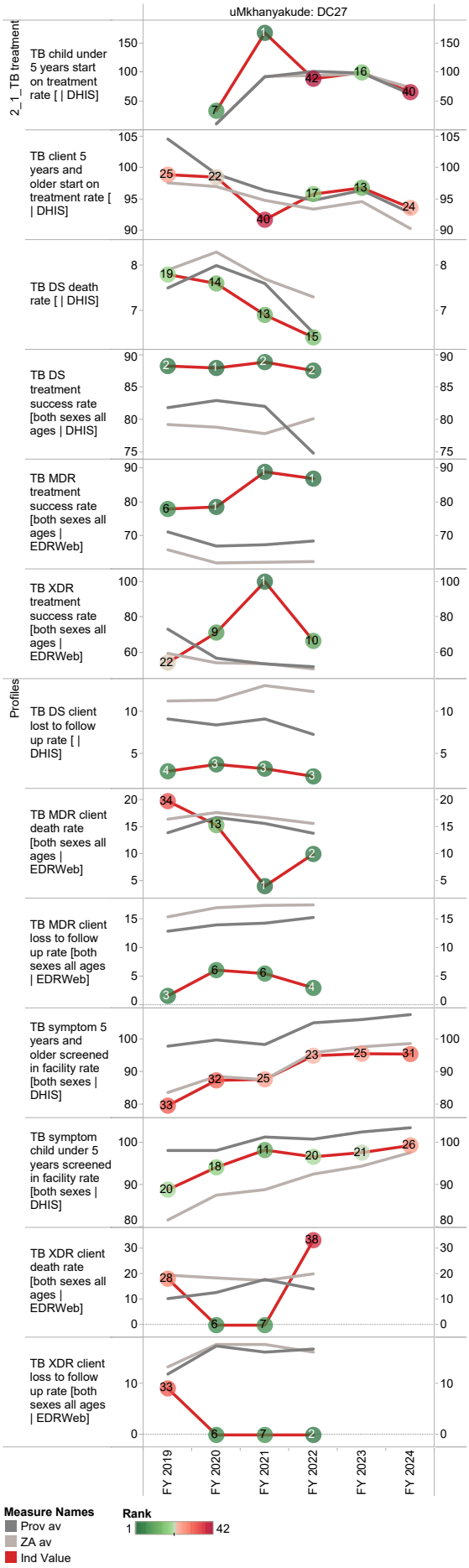


Source: DHIS

Annual trends, 2018/19–2023/24



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2_1_TB treatment
Profiles
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
TB DS death rate [| DHIS]
TB DS treatment success rate [both sexes all ages | DHIS]
TB MDR treatment success rate [both sexes all ages | EDRWeb]
TB XDR treatment success rate [both sexes all ages | EDRWeb]
TB DS client lost to follow up rate [| DHIS]
TB MDR client death rate [both sexes all ages | EDRWeb]
TB MDR client loss to follow up rate [both sexes all ages | EDRWeb]
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TB XDR client death rate [both sexes all ages | EDRWeb]
TB XDR client loss to follow up rate [both sexes all ages | EDRWeb]
FY 2019
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Measure Names
Prov av
ZA av
Ind Value
Rank
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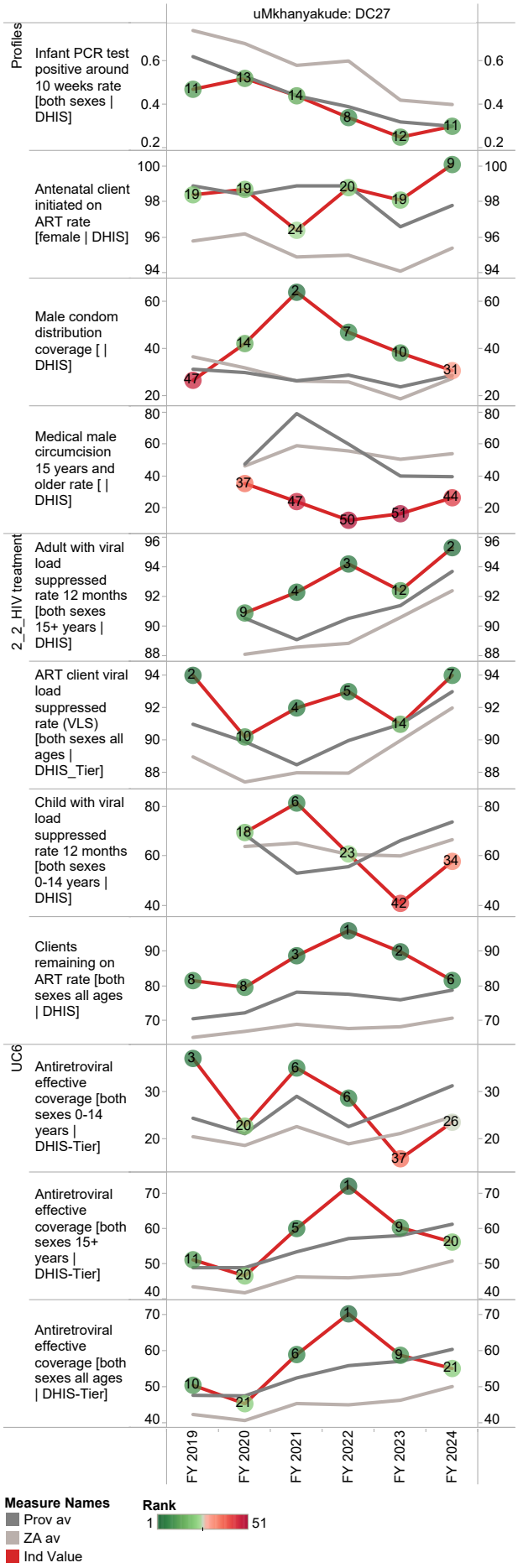
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Profiles
Infant PCR test positive around 10 weeks rate [both sexes | DHIS]
Antenatal client initiated on ART rate [female | DHIS]
Male condom distribution coverage [| DHIS]
Medical male circumcision 15 years and older rate [| DHIS]
2_2_HIV treatment
Adult with viral load suppressed rate 12 months [both sexes 15+ years | DHIS]
ART client viral load suppressed rate (VLS) [both sexes all ages | DHIS_Tier]
Child with viral load suppressed rate 12 months [both sexes 0-14 years | DHIS]
Clients remaining on ART rate [both sexes all ages | DHIS]
UC6
Antiretroviral effective coverage [both sexes 0-14 years | DHIS-Tier]
Antiretroviral effective coverage [both sexes 15+ years | DHIS-Tier]
Antiretroviral effective coverage [both sexes all ages | DHIS-Tier]
FY 2019
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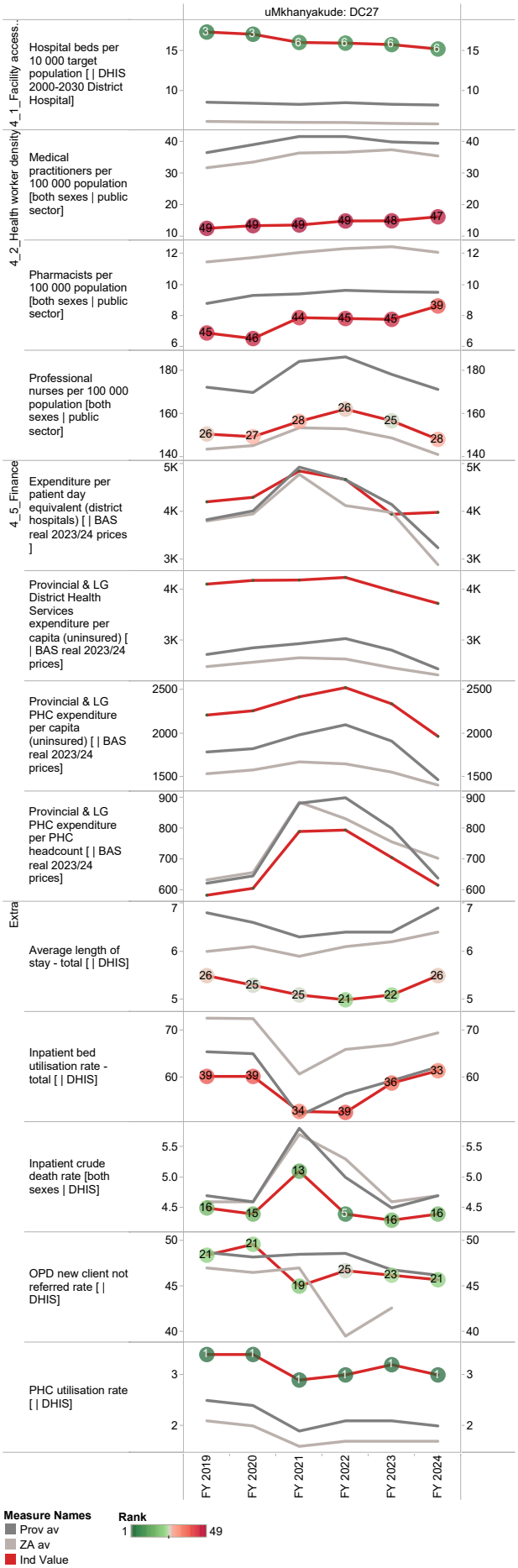
Measure Names
Prov av
ZA av
Ind Value
Rank
1
51


uMkhanyakude: DC27
4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
4_2_Health worker density
Medical practitioners per 100 000 population [both sexes | public sector]
Pharmacists per 100 000 population [both sexes | public sector]
Professional nurses per 100 000 population [both sexes | public sector]
4_5_Finance
Expenditure per patient day equivalent (district hospitals) [| BAS real 2023/24 prices]
Provincial & LG District Health Services expenditure per capita (uninsured) [| BAS real 2023/24 prices]
Provincial & LG PHC expenditure per capita (uninsured) [| BAS real 2023/24 prices]
Provincial & LG PHC expenditure per PHC headcount [| BAS real 2023/24 prices]
Extra
Average length of stay - total [| DHIS]
Inpatient bed utilisation rate - total [| DHIS]
Inpatient crude death rate [both sexes | DHIS]
OPD new client not referred rate [| DHIS]
PHC utilisation rate [| DHIS]
FY 2019
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FY 2021
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FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
1
49

King Cetshwayo District Municipality (DC28)

The King Cetshwayo District Municipality[15] is a Category C municipality and is located in the north-eastern region of the KwaZulu-Natal Province. The district is home to five local municipalities: City of uMhlathuze, uMlalazi, Mthonjaneni, Nkandla and uMfolozi.

Area: 8 214km²

Population (2023)[16]: 980 188

Households[15]: 225 797

Formal dwellings[15]: 70.6%

Cities/Towns:

City of uMhlathuze: Empangeni, Richards Bay

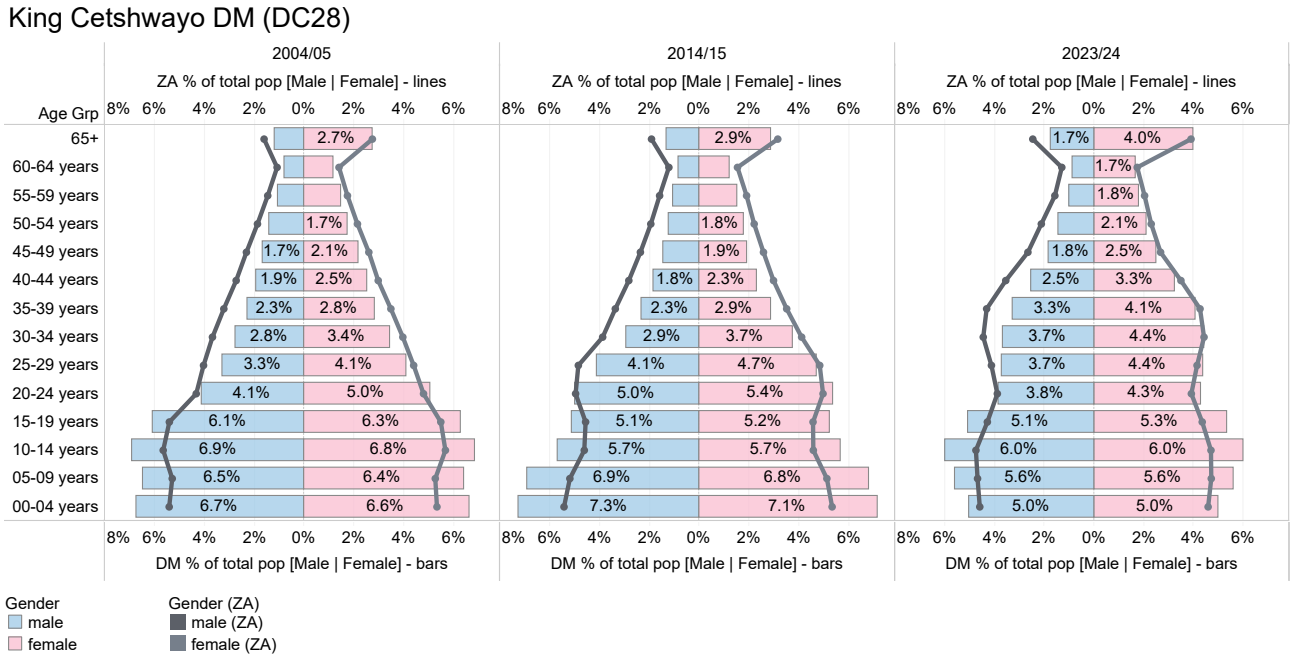
uMlalazi: Eshowe, KwaGingindlovu, Mtunzini

Mthonjaneni: Melmoth, Ntambanana

Nkandla: Nkandla

uMfolozi: KwaMbonambi

District percentage population by age-gender group compared to South Africa

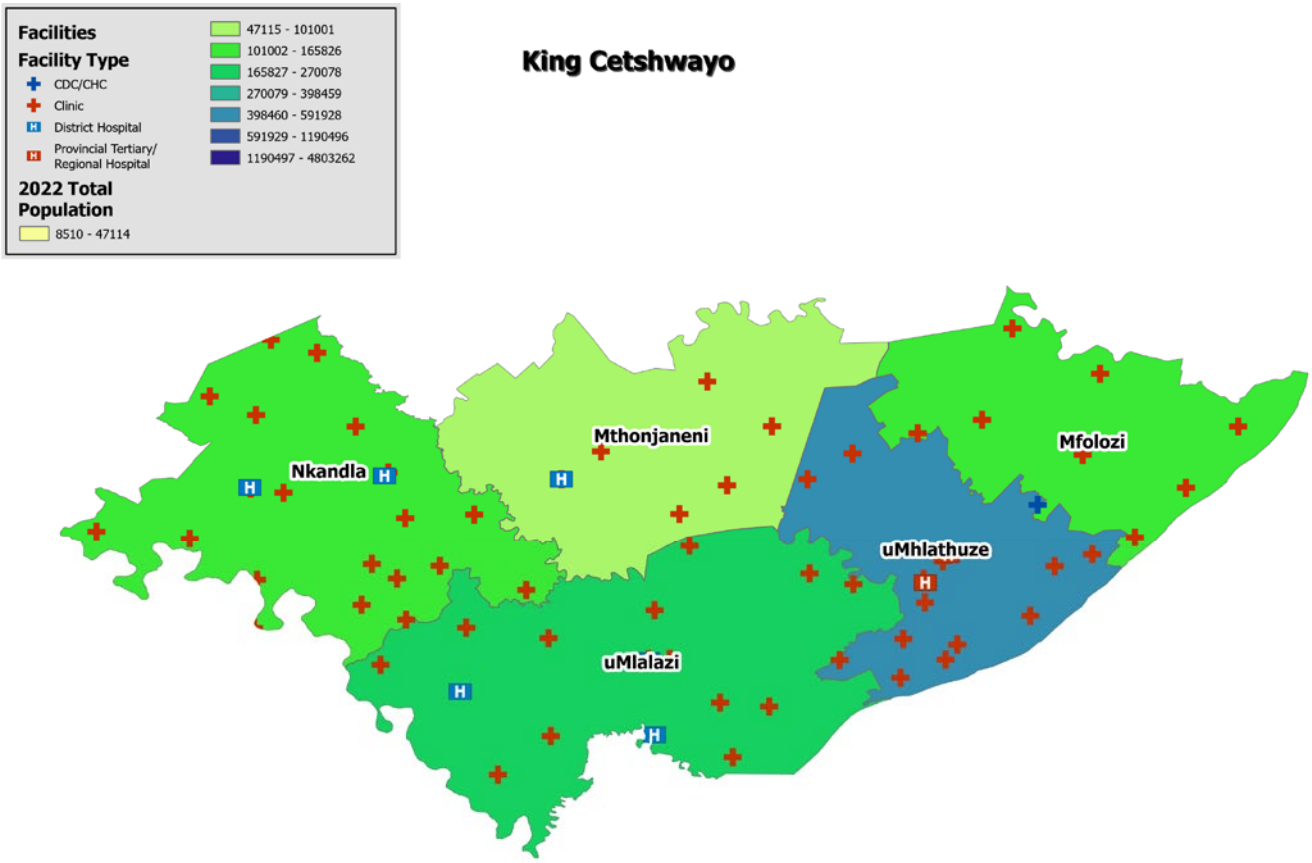


Source: DHIS

15 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

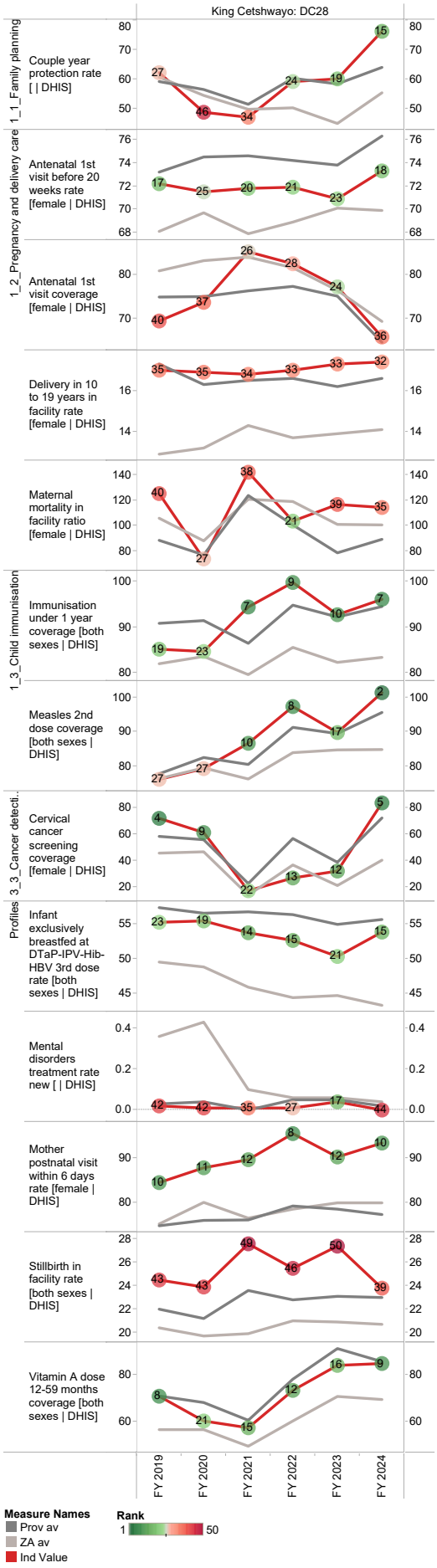
16 Mid-year Population Estimates 2023, DHIS.

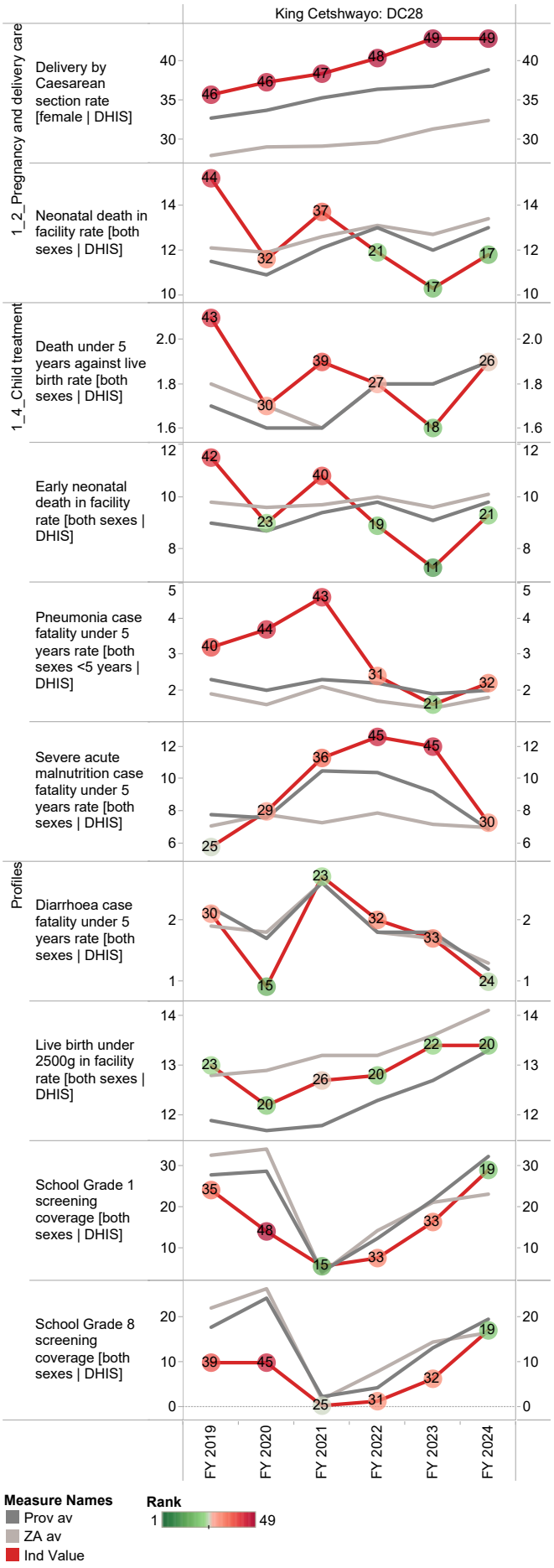
Population distribution, sub-district boundaries and health facility locations

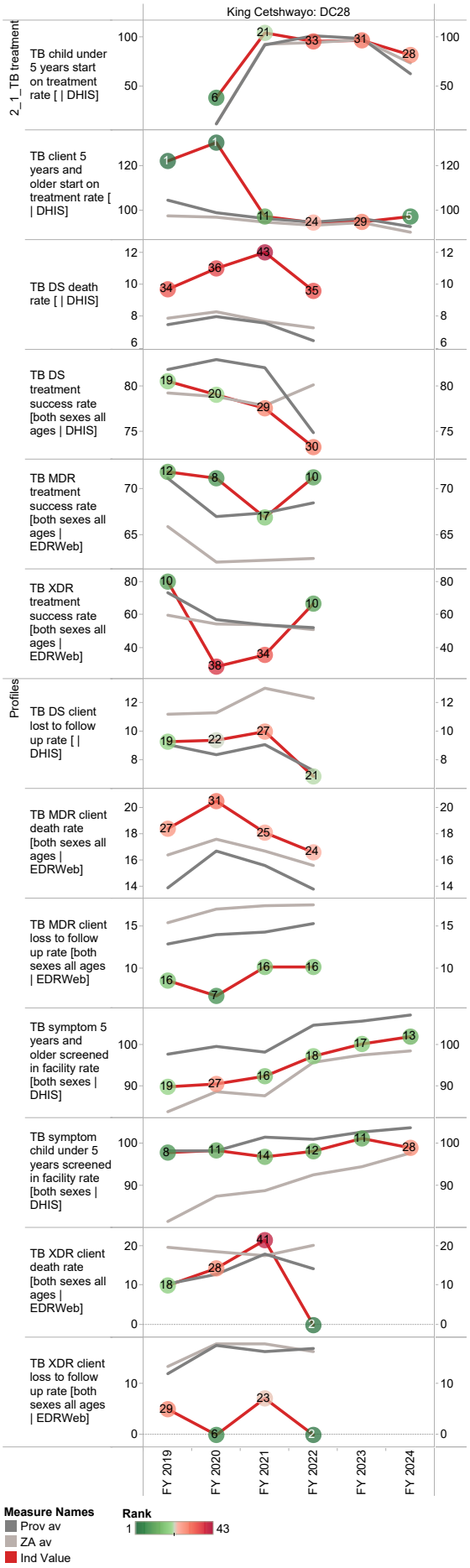


Source: DHIS

Annual trends, 2018/19–2023/24






King Cetshwayo: DC28
2_1_TB treatment
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
TB DS death rate [| DHIS]
TB DS treatment success rate [both sexes all ages | DHIS]
TB MDR treatment success rate [both sexes all ages | EDRWeb]
TB XDR treatment success rate [both sexes all ages | EDRWeb]
Profiles
TB DS client lost to follow up rate [| DHIS]
TB MDR client death rate [both sexes all ages | EDRWeb]
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TB symptom 5 years and older screened in facility rate [both sexes | DHIS]
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TB XDR client death rate [both sexes all ages | EDRWeb]
TB XDR client loss to follow up rate [both sexes all ages | EDRWeb]
FY 2019
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FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
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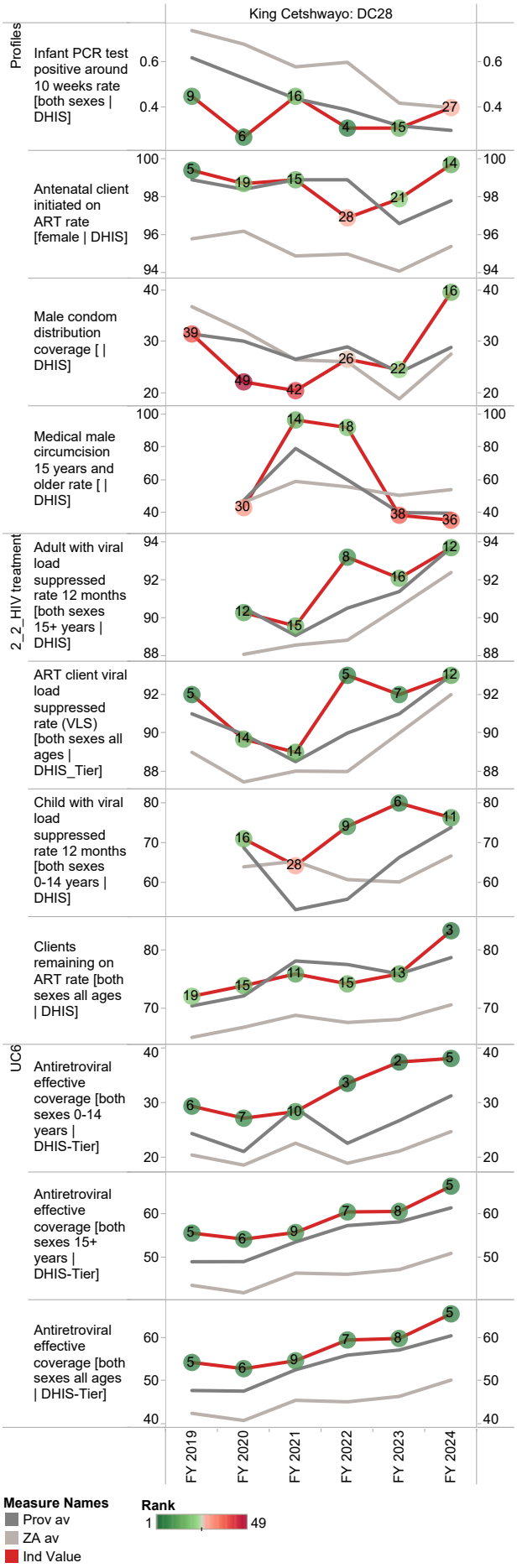
43


King Cetshwayo: DC28
Profiles
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Male condom distribution coverage [| DHIS]
Medical male circumcision 15 years and older rate [| DHIS]
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ART client viral load suppressed rate (VLS) [both sexes all ages | DHIS_Tier]
Child with viral load suppressed rate 12 months [both sexes 0-14 years | DHIS]
Clients remaining on ART rate [both sexes all ages | DHIS]
UC6
Antiretroviral effective coverage [both sexes 0-14 years | DHIS-Tier]
Antiretroviral effective coverage [both sexes 15+ years | DHIS-Tier]
Antiretroviral effective coverage [both sexes all ages | DHIS-Tier]
FY 2019
FY 2020
FY 2021
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FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
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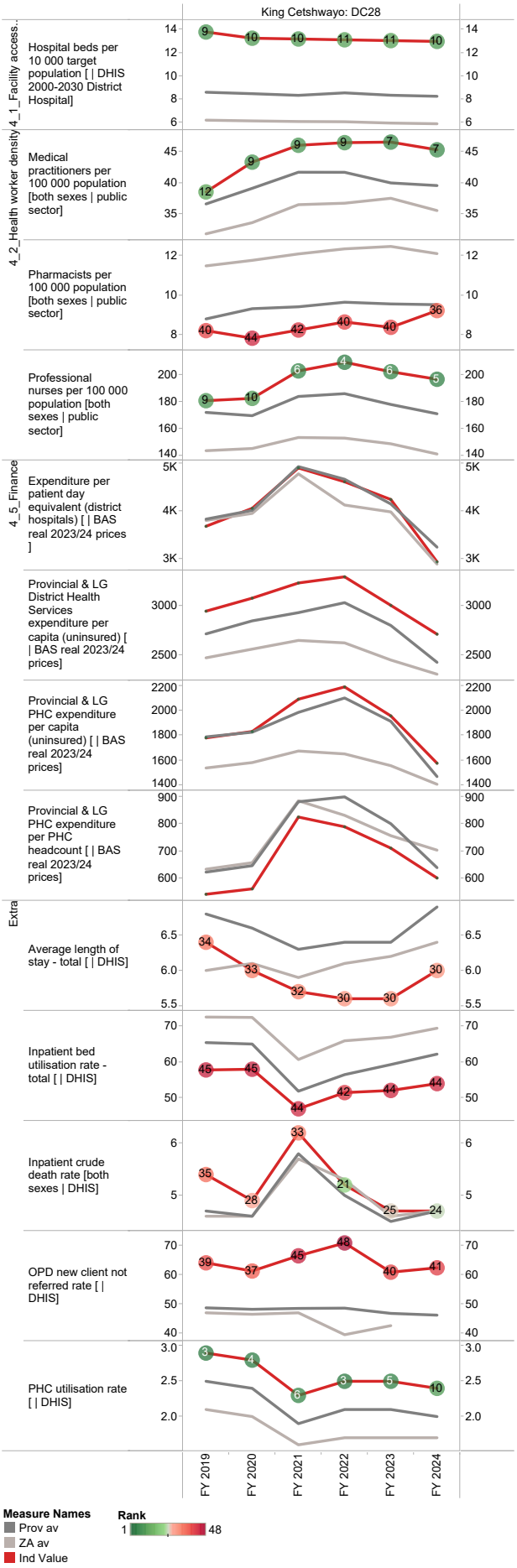
King Cetshwayo: DC28
4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
4_2_Health worker density
Medical practitioners per 100 000 population [both sexes | public sector]
Pharmacists per 100 000 population [both sexes | public sector]
Professional nurses per 100 000 population [both sexes | public sector]
4_5_Finance
Expenditure per patient day equivalent (district hospitals) [| BAS real 2023/24 prices]
Provincial & LG District Health Services expenditure per capita (uninsured) [| BAS real 2023/24 prices]
Provincial & LG PHC expenditure per capita (uninsured) [| BAS real 2023/24 prices]
Provincial & LG PHC expenditure per PHC headcount [| BAS real 2023/24 prices]
Extra
Average length of stay - total [| DHIS]
Inpatient bed utilisation rate - total [| DHIS]
Inpatient crude death rate [both sexes | DHIS]
OPD new client not referred rate [| DHIS]
PHC utilisation rate [| DHIS]
FY 2019
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FY 2021
FY 2022
FY 2023
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Measure Names
Prov av
ZA av
Ind Value
Rank
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48

iLembe District Municipality (DC29)

The iLembe District Municipality[17] is a Category C municipality situated on the east coast of KwaZulu-Natal. It is the smallest of the province's district municipalities, making up a mere 3% of its geographical area. iLembe consists of four local municipalities located between Durban and Richards Bay: Mandeni, KwaDukuza, Maphumulo and Ndwedwe.

Area: 3 270km²

Population (2023)[18]: 703 372

Households[17]: 191 369

Formal dwellings[17]: 73.9%

Cities/Towns:

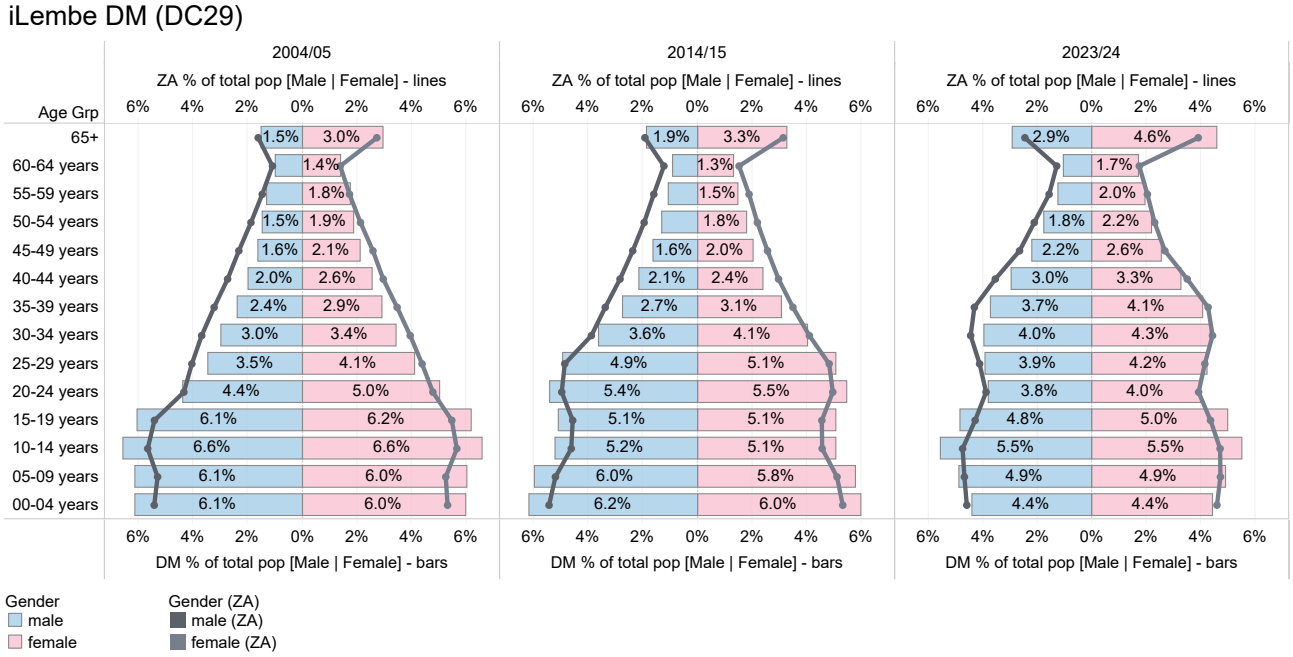
Mandeni: Isithebe, Mandeni

KwaDukuza: Dolphin Coast/Ballito, KwaDukuza, Nkwazi/Zinkwazi Beach

Maphumulo: Maphumulo

Ndwedwe: Ndwedwe

District percentage population by age-gender group compared to South Africa

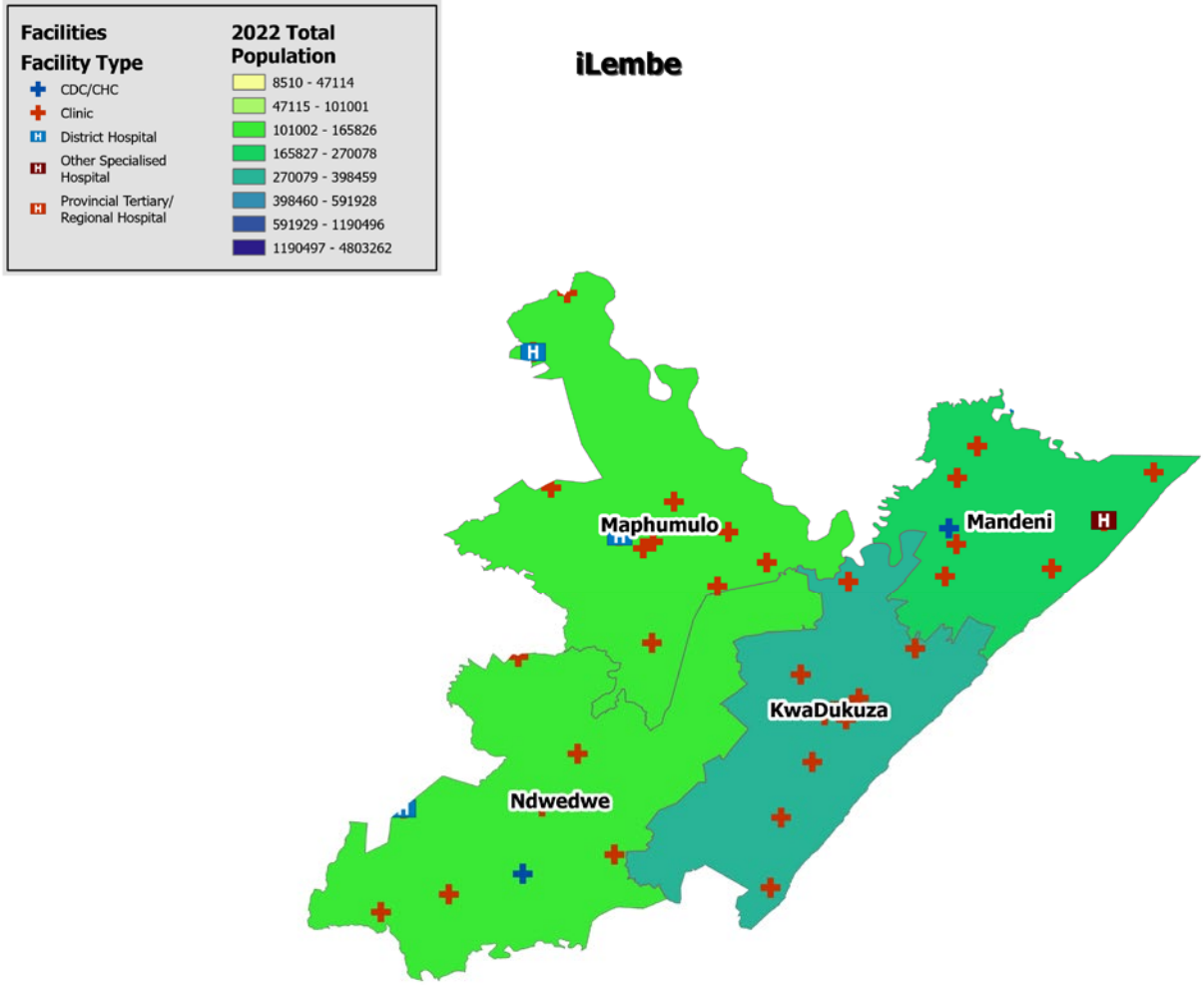


Source: DHIS

17 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

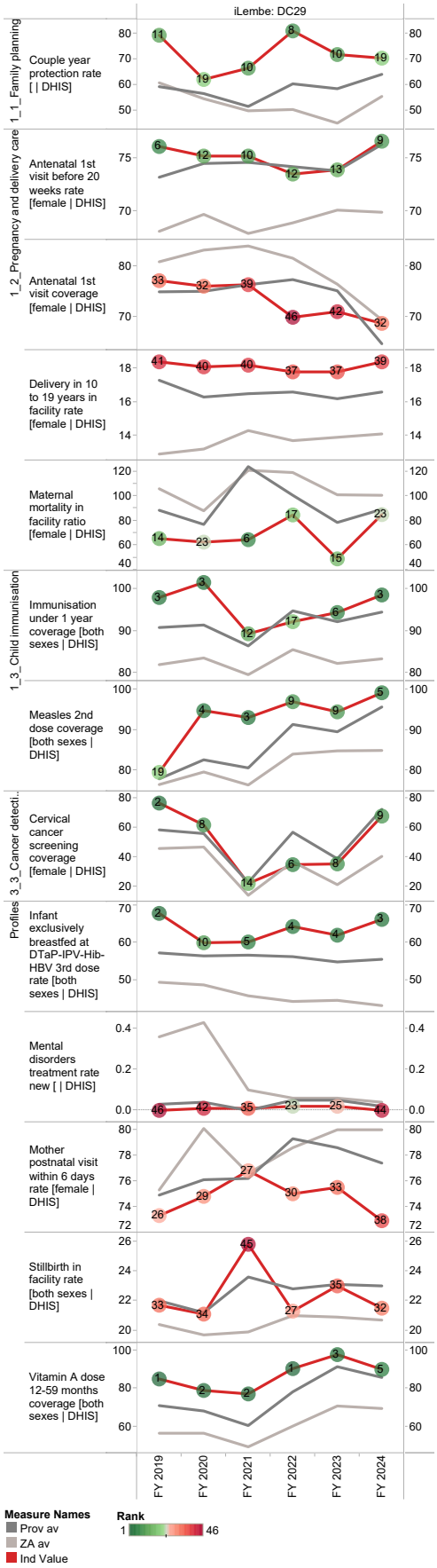
18 Mid-year Population Estimates 2023, DHIS.

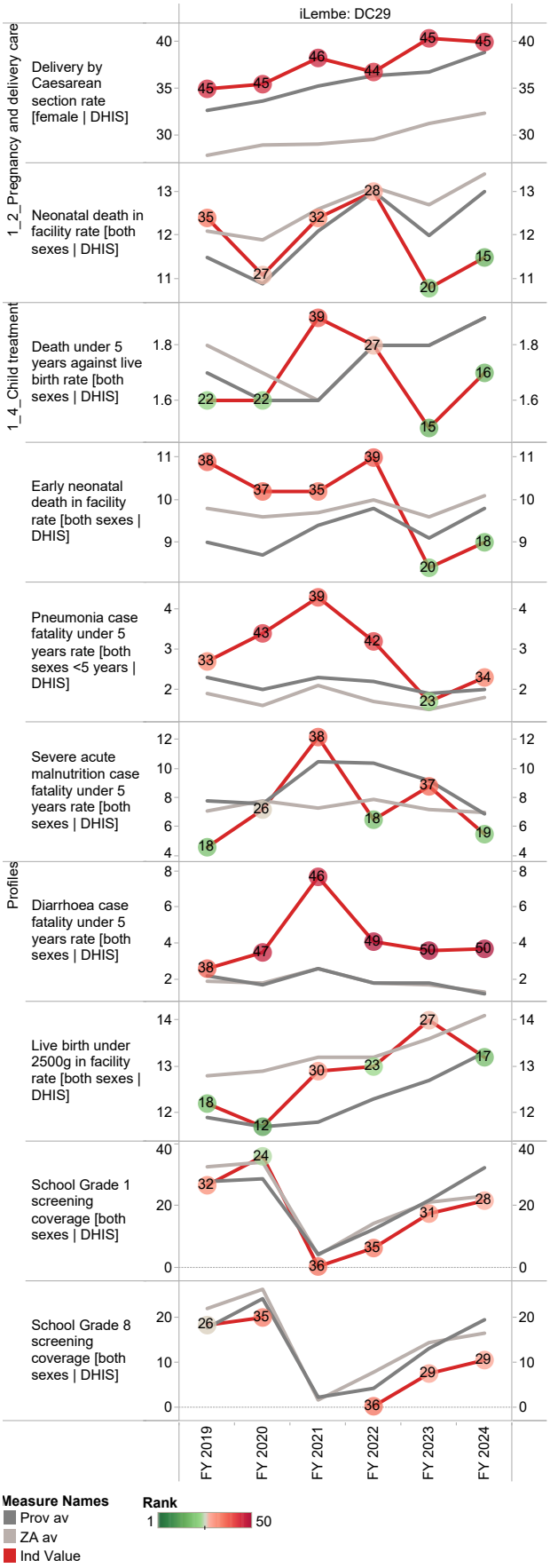
Population distribution, sub-district boundaries and health facility locations

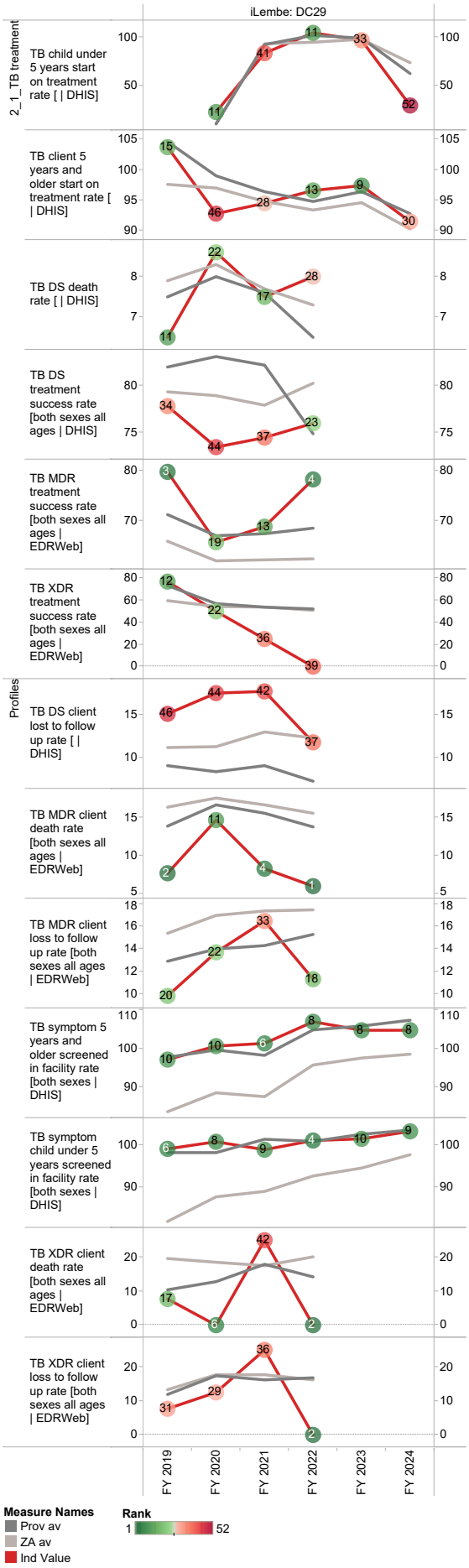


Source: DHIS

Annual trends, 2018/19–2023/24






iLembe: DC29
2_1_TB treatment
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
TB DS death rate [| DHIS]
TB DS treatment success rate [both sexes all ages | DHIS]
TB MDR treatment success rate [both sexes all ages | EDRWeb]
TB XDR treatment success rate [both sexes all ages | EDRWeb]
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TB DS client lost to follow up rate [| DHIS]
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TB symptom 5 years and older screened in facility rate [both sexes | DHIS]
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TB XDR client death rate [both sexes all ages | EDRWeb]
TB XDR client loss to follow up rate [both sexes all ages | EDRWeb]
FY 2019
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Measure Names
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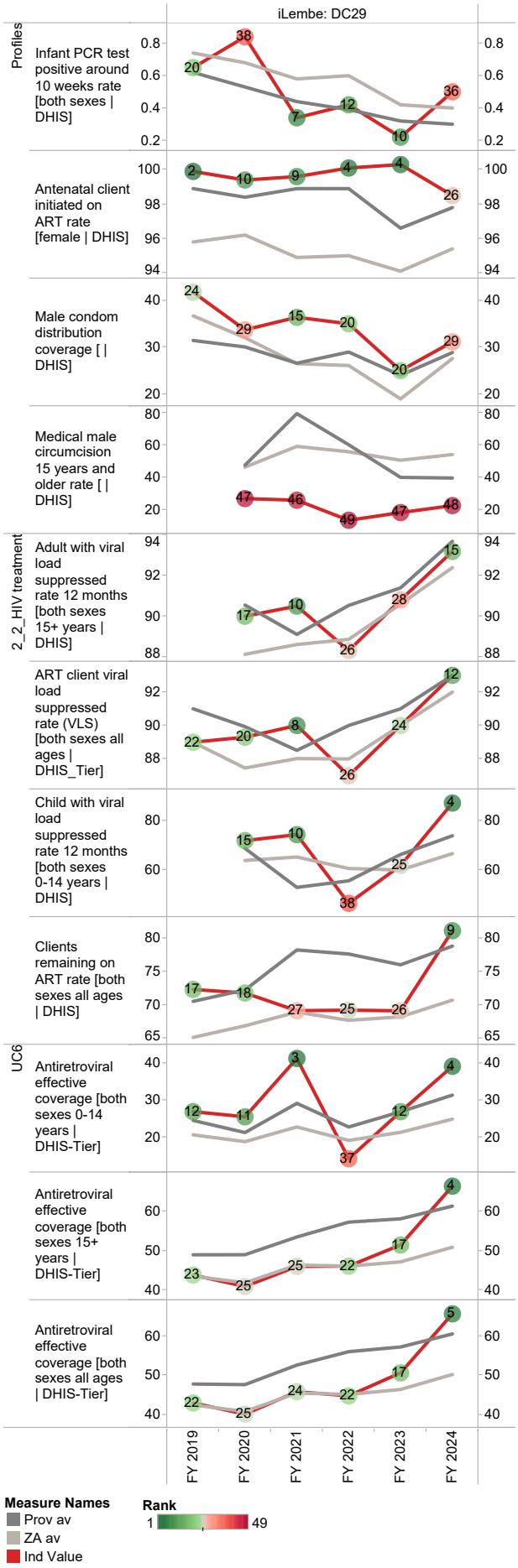
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Infant PCR test positive around 10 weeks rate [both sexes | DHIS]
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ART client viral load suppressed rate (VLS) [both sexes all ages | DHIS_Tier]
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Antiretroviral effective coverage [both sexes all ages | DHIS-Tier]
FY 2019
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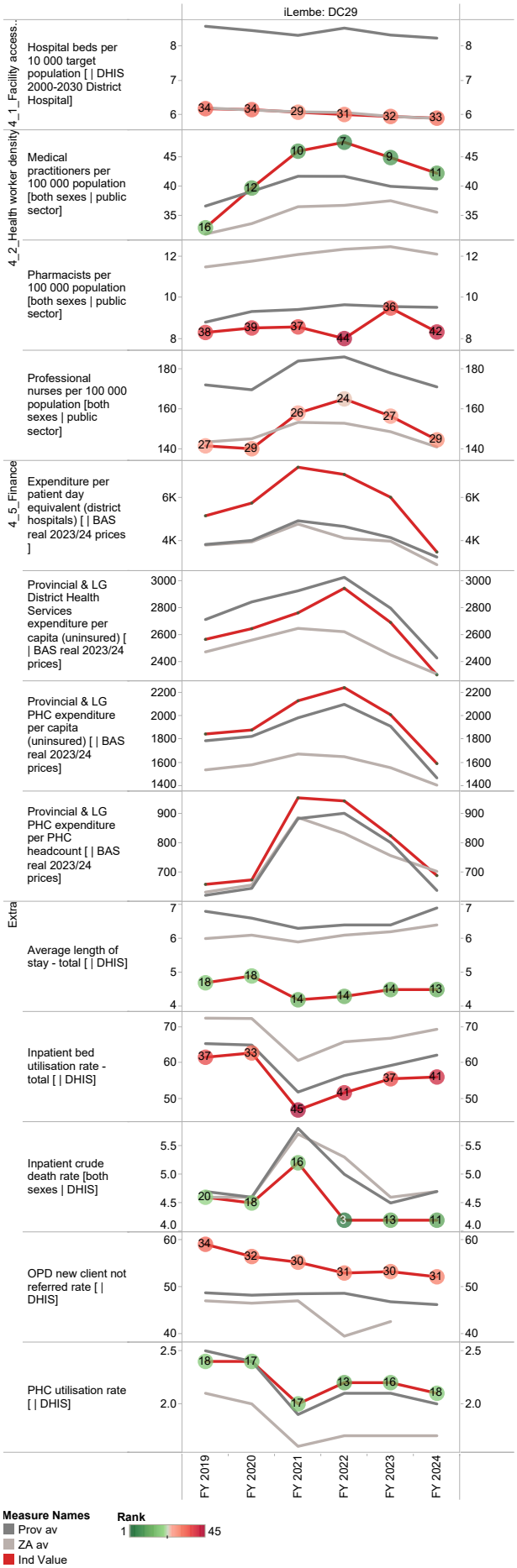
iLembe: DC29
4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
4_2_Health worker density
Medical practitioners per 100 000 population [both sexes | public sector]
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Provincial & LG PHC expenditure per capita (uninsured) [| BAS real 2023/24 prices]
Provincial & LG PHC expenditure per PHC headcount [| BAS real 2023/24 prices]
Extra
Average length of stay - total [| DHIS]
Inpatient bed utilisation rate - total [| DHIS]
Inpatient crude death rate [both sexes | DHIS]
OPD new client not referred rate [| DHIS]
PHC utilisation rate [| DHIS]
FY 2019
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FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
1
45

Harry Gwala District Municipality (DC43)

The Harry Gwala District Municipality[19] is a Category C municipality situated south of KwaZulu-Natal, bordering Lesotho. The district comprises four local municipalities: Dr Nkosazana Dlamini Zuma, uMzimkhulu, Greater Kokstad and Ubuhlebezwe.

Area: 10 388m²

Population (2023)[20]: 517 618

Households[19]: 123 705

Formal dwellings[19]: 41.7%

Cities/Towns:

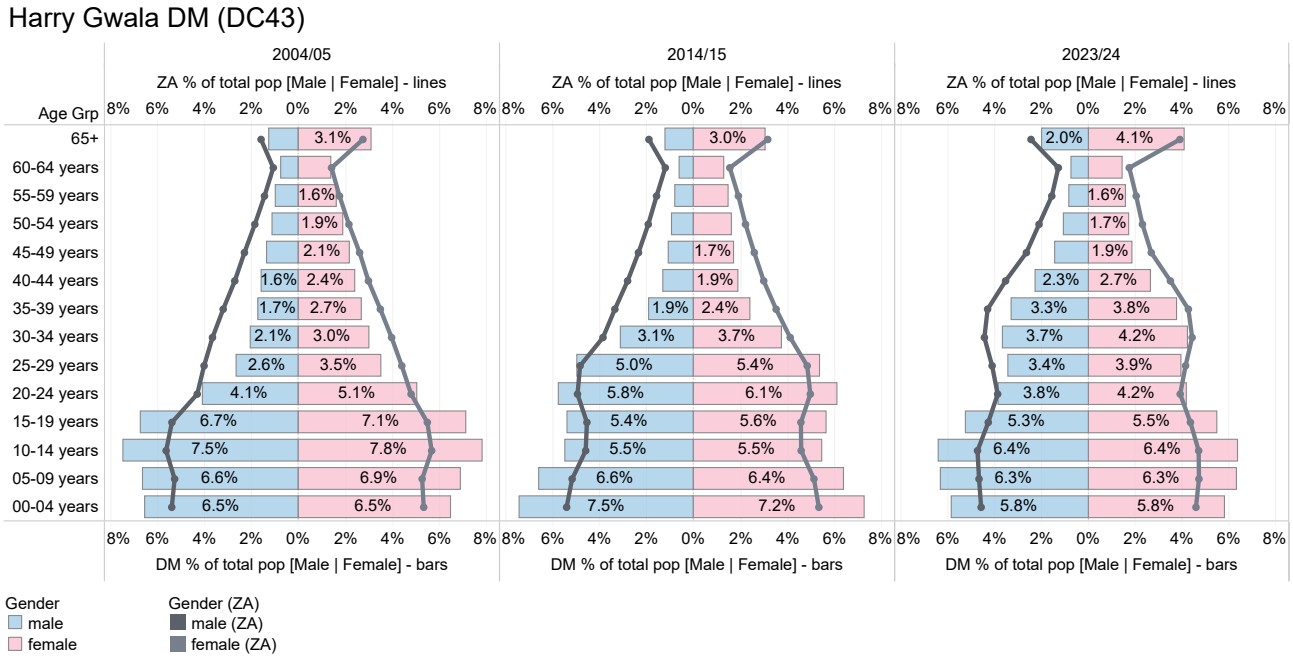
Dr Nkosazana Dlamini Zuma: Creighton, Himeville, Underberg

uMzimkhulu: uMzimkhulu

Greater Kokstad: Kokstad

Ubuhlebezwe: Ixopo

District percentage population by age-gender group compared to South Africa

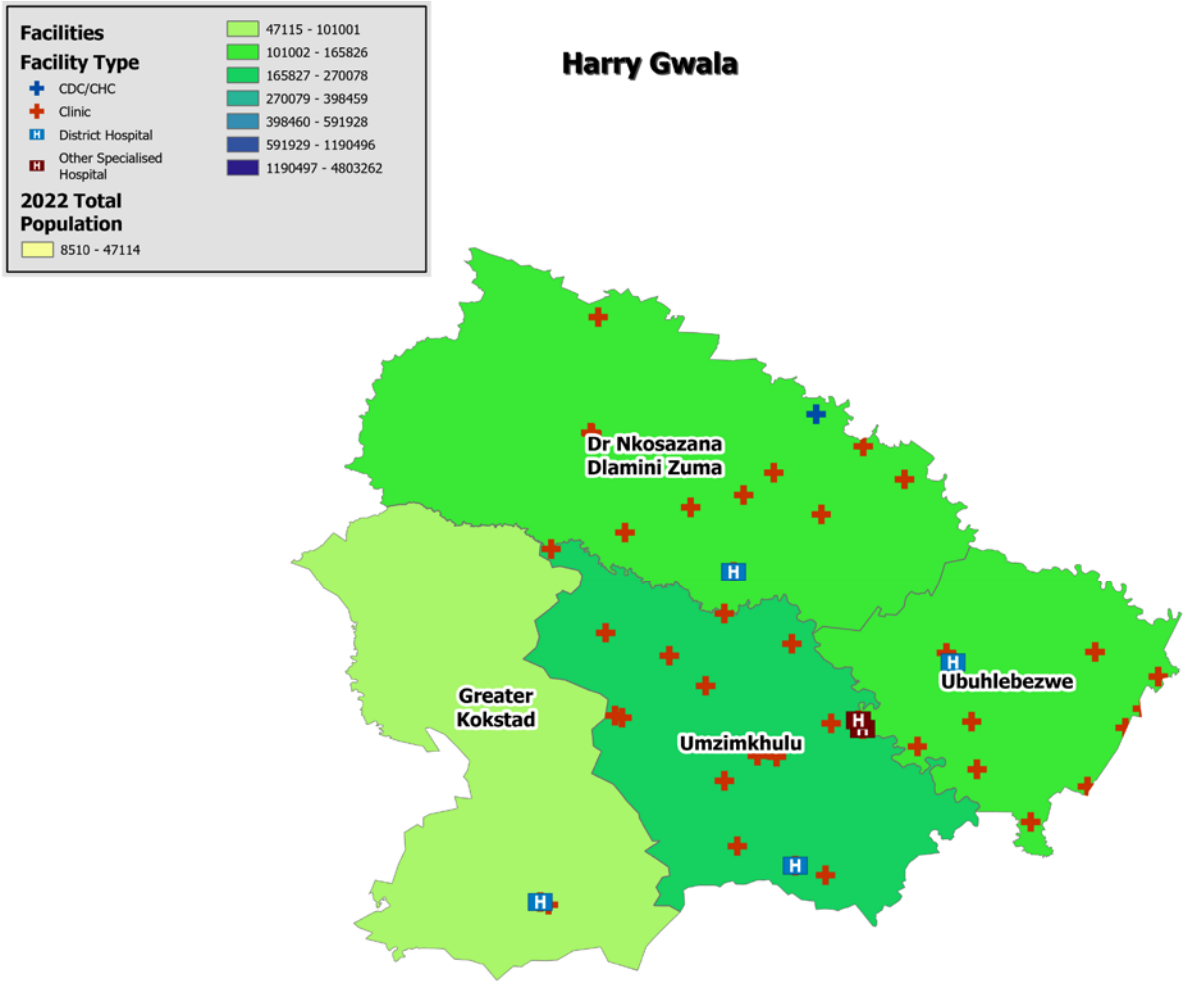


Source: DHIS

19 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

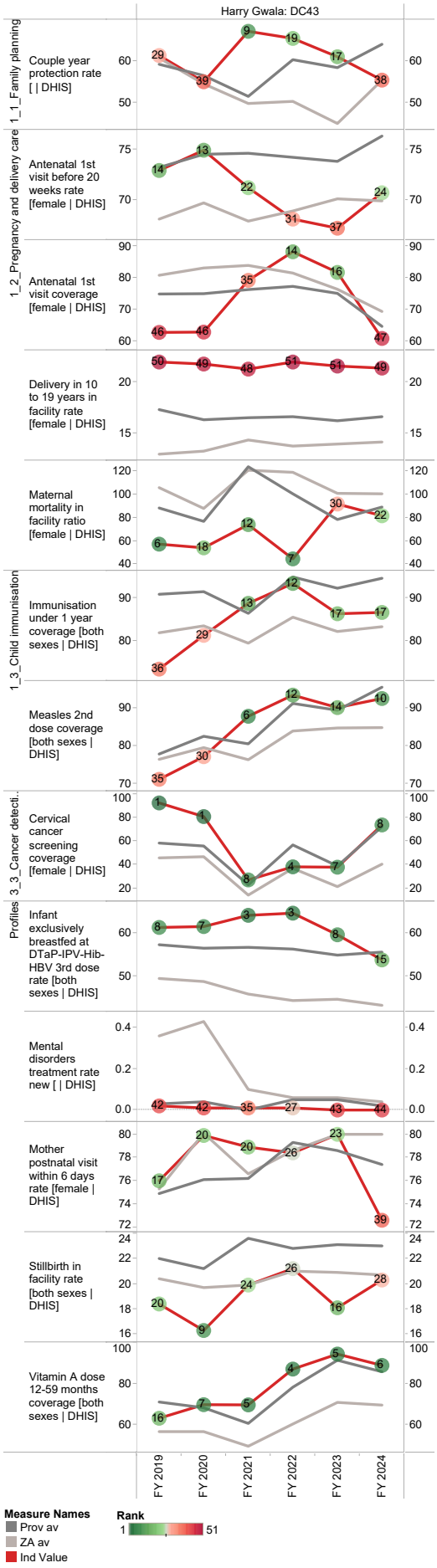
20 Mid-year Population Estimates 2023, DHIS.

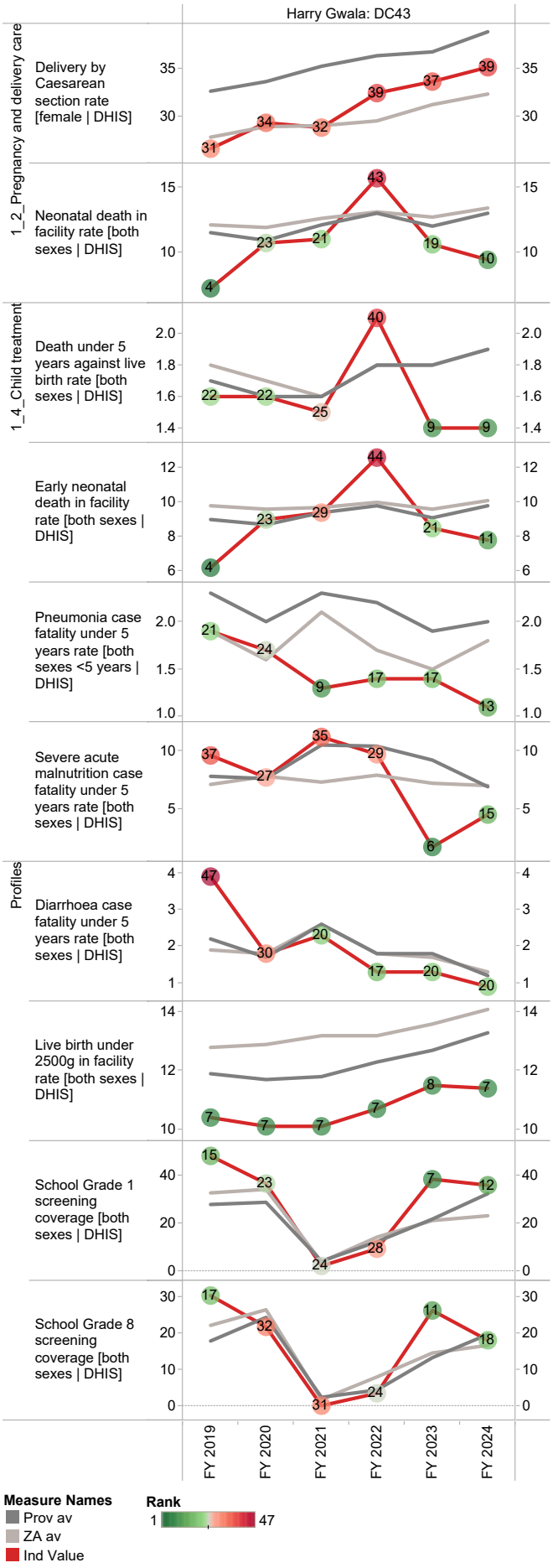
Population distribution, sub-district boundaries and health facility locations

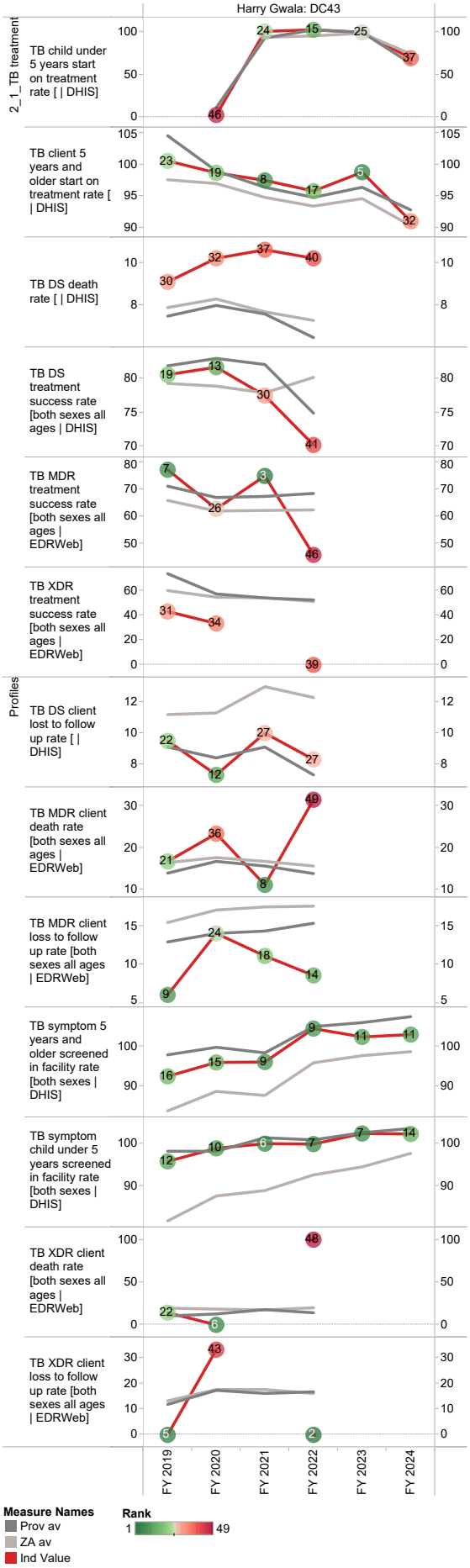


Source: DHIS

Annual trends, 2018/19–2023/24






Harry Gwala: DC43
2_1_TB treatment
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
TB DS death rate [| DHIS]
TB DS treatment success rate [both sexes all ages | DHIS]
TB MDR treatment success rate [both sexes all ages | EDRWeb]
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TB DS client lost to follow up rate [| DHIS]
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TB symptom child under 5 years screened in facility rate [both sexes | DHIS]
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TB XDR client loss to follow up rate [both sexes all ages | EDRWeb]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
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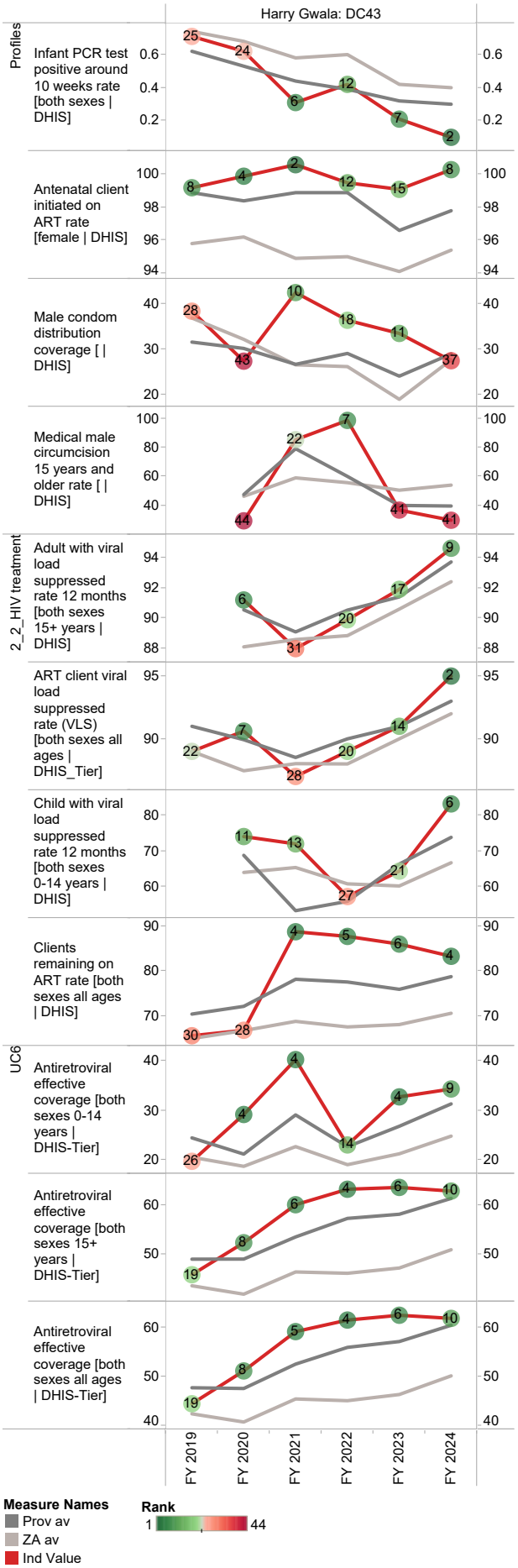
Harry Gwala: DC43
Profiles
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FY 2024
Measure Names
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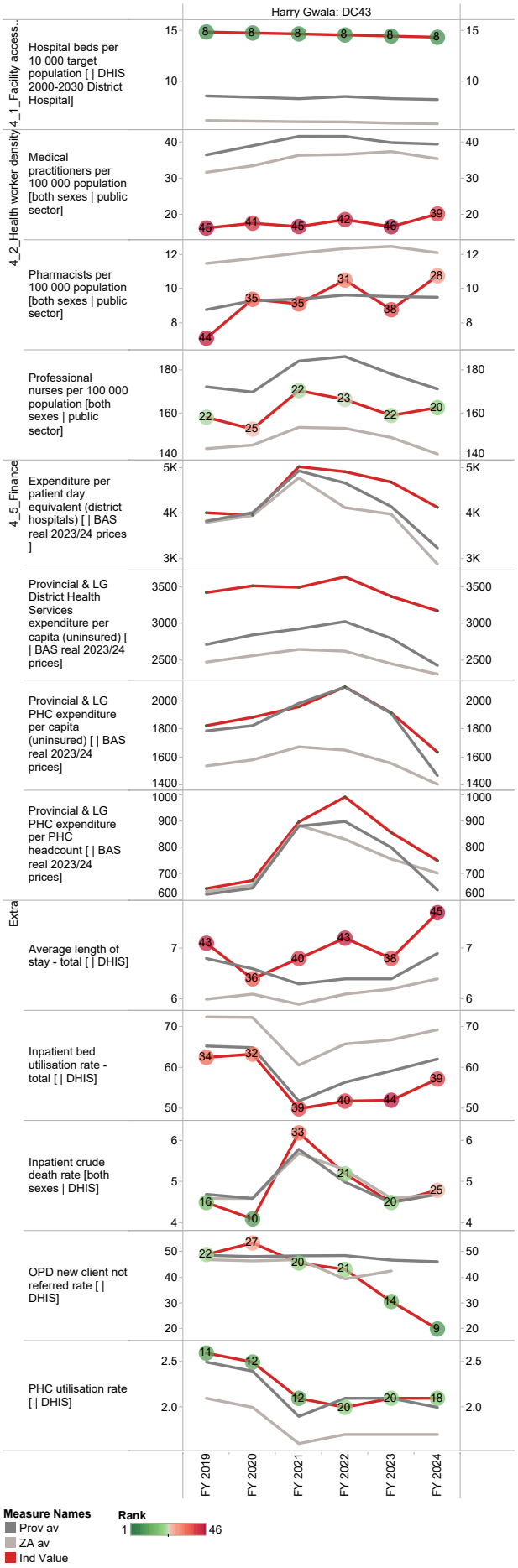
44


Harry Gwala: DC43
4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
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FY 2021
FY 2022
FY 2023
FY 2024
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Prov av
ZA av
Ind Value
Rank
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46

eThekwini Metropolitan Municipality (ETH)

The eThekwini Metropolitan Municipality[21] is a Category A municipality located in KwaZulu-Natal. eThekwini is the third largest city in the country and its land area is comparatively larger than that of other South African cities.

Cities/Towns: Amalanga, Amanzimtoti, Amaotana, Berea, Blackburn, Bluff, Cato Ridge, Cele/Vumengazi, Chatsworth, Cibane, Clermont, Clifton Canyon, Craigieburn, Dassenhoek, Desainager, Durban, Durban International Airport, Durban North, Durban South, Emalangeni, Embo/Nksa Isimahla, Emona, Ethekwini, Everton, Ezembeni, Folweni, Gcumisa, Genazzano, Gillitts, Glenashley, Golokodo-Ensimbini, Hambanathi, Hammarsdale, Hillcrest, Ilanga, Ilfracombe, Illovo North, Illovo South, Inanda, Inchanga, Iqadi, Isipingo, Isipingo Beach, Kingsburgh, Klaarwater, Kloof, KwaDabeka, KwaMashu, KwaNdengezi, La Mercy, Lotus Park, Luganda, Luthuli/Umnini Trust, Magabeni, Malagazi, Mangangeni/Vumazonke, Maphephetha, Mariannhill, Mawotana, Mawothi, Molweni, Mount Edgecombe, Mount Moreland, Mpolo, Mpumalanga, New Germany, Newlands East, Newlands West, Ngcolosi, Ngqungqulu, Ntuzuma, Oceans, Outer West Durban, Phoenix, Pinetown, Prospecton, Qadi, Qiniselani Manyuswa, Queensburgh, Redcliffe, Roseneath, Sapref, Shallcross, Sobonakhona, Thoyana, Tongaat, Tongaat Beach, Tshelimnyama, Umgogintwini, Umbumbulu, Umdloti, Umgababa, Umhlanga, Umkomaas, Umlazi, Verulam, Waterfall, Westbrook, Westville, Ximba

Area: 2 556km²

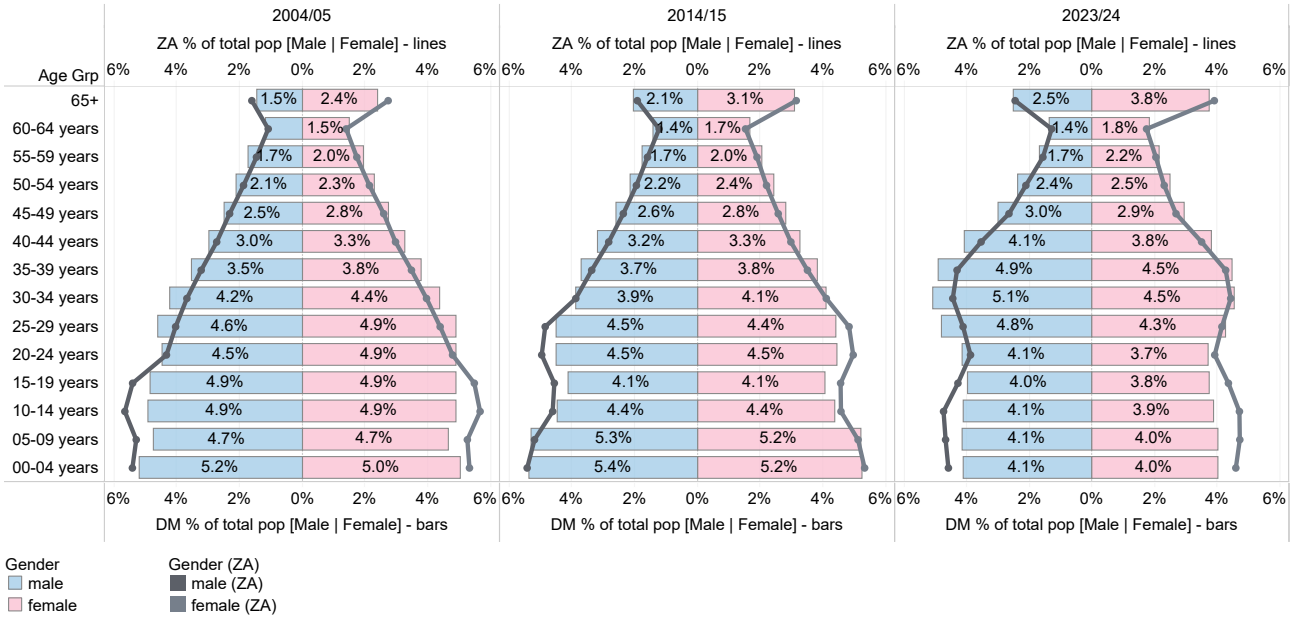
Population (2023)[22]: 4 125 608

Households[21]: 1 125 767

Formal dwellings[21]: 81.5%

District percentage population by age-gender group compared to South Africa

eThekwini MM (ETH)

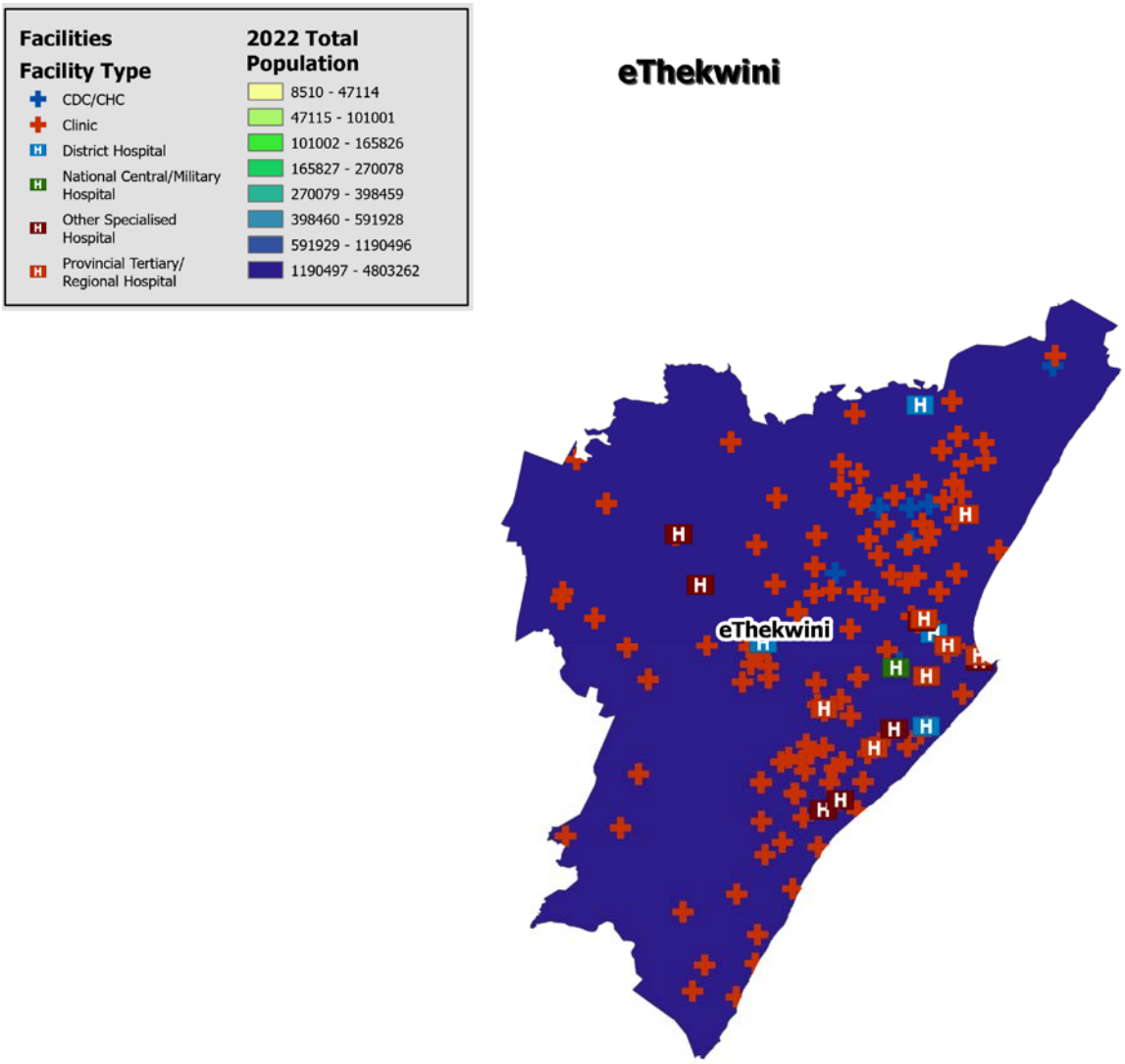


Source: DHIS

21 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

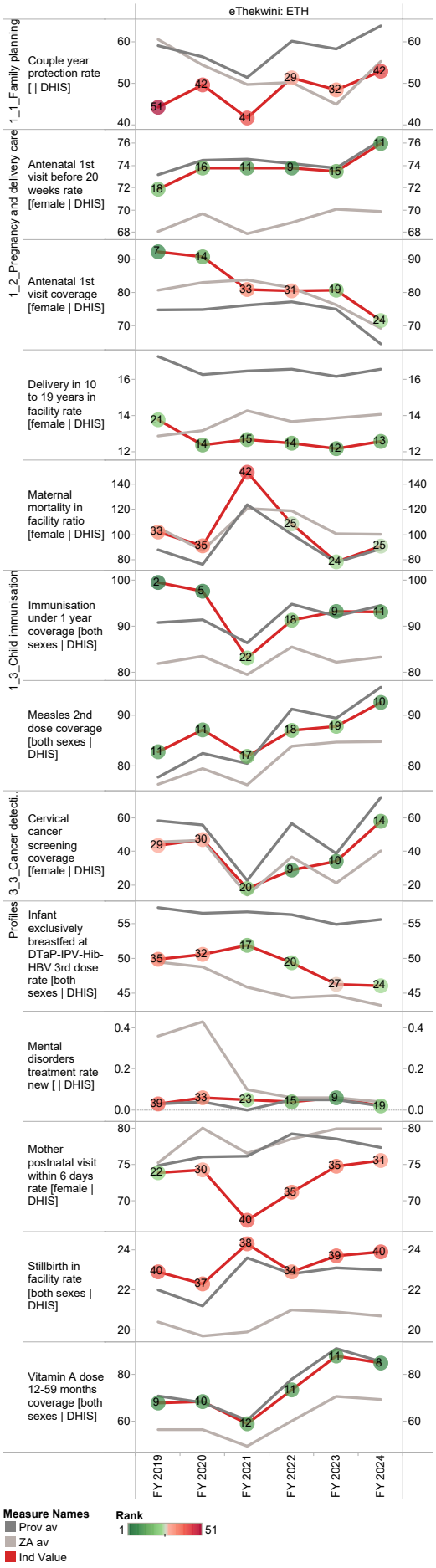
22 Mid-year Population Estimates 2023, DHIS.

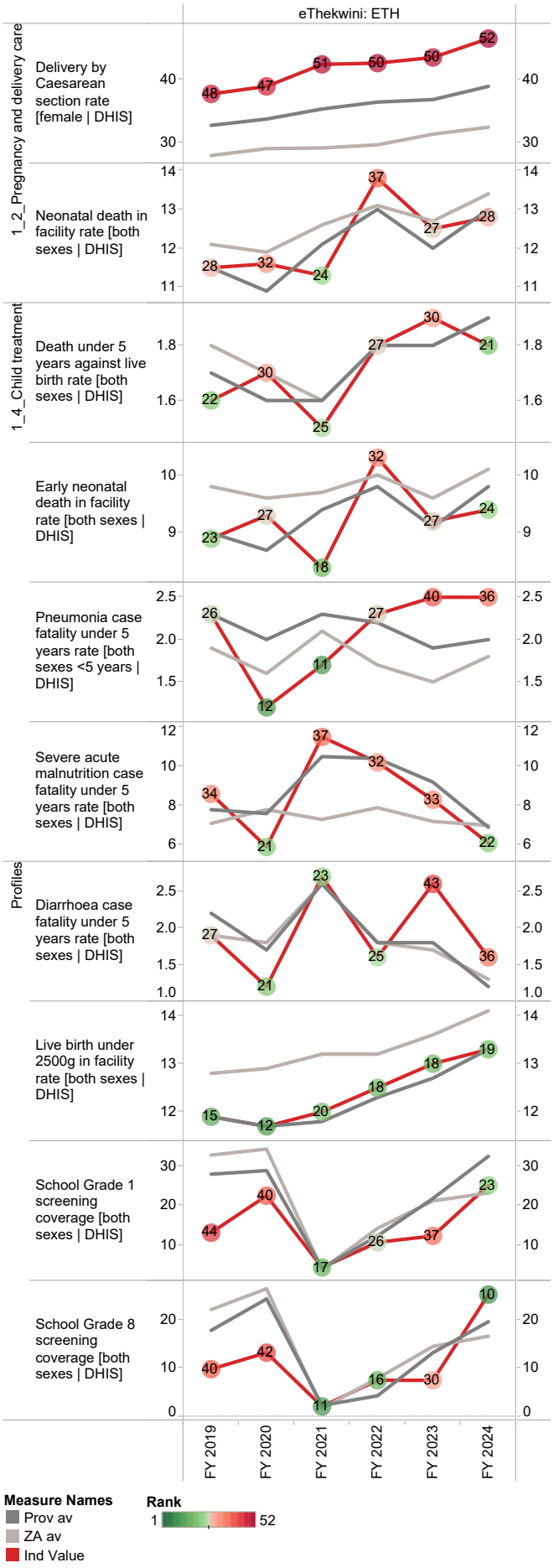
Population distribution, sub-district boundaries and health facility locations

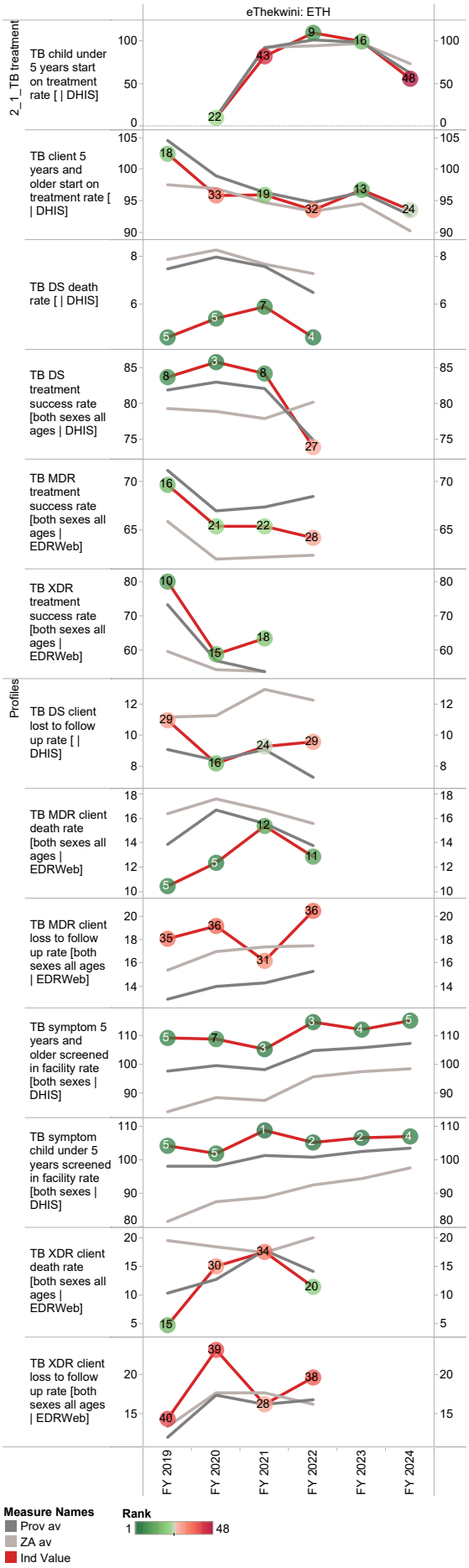


Source: DHIS

Annual trends, 2018/19–2023/24






eThekwini: ETH
2_1_TB treatment
Profiles
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
TB DS death rate [| DHIS]
TB DS treatment success rate [both sexes all ages | DHIS]
TB MDR treatment success rate [both sexes all ages | EDRWeb]
TB XDR treatment success rate [both sexes all ages | EDRWeb]
TB DS client lost to follow up rate [| DHIS]
TB MDR client death rate [both sexes all ages | EDRWeb]
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TB symptom 5 years and older screened in facility rate [both sexes | DHIS]
TB symptom child under 5 years screened in facility rate [both sexes | DHIS]
TB XDR client death rate [both sexes all ages | EDRWeb]
TB XDR client loss to follow up rate [both sexes all ages | EDRWeb]
FY 2019
FY 2020
FY 2021
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FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
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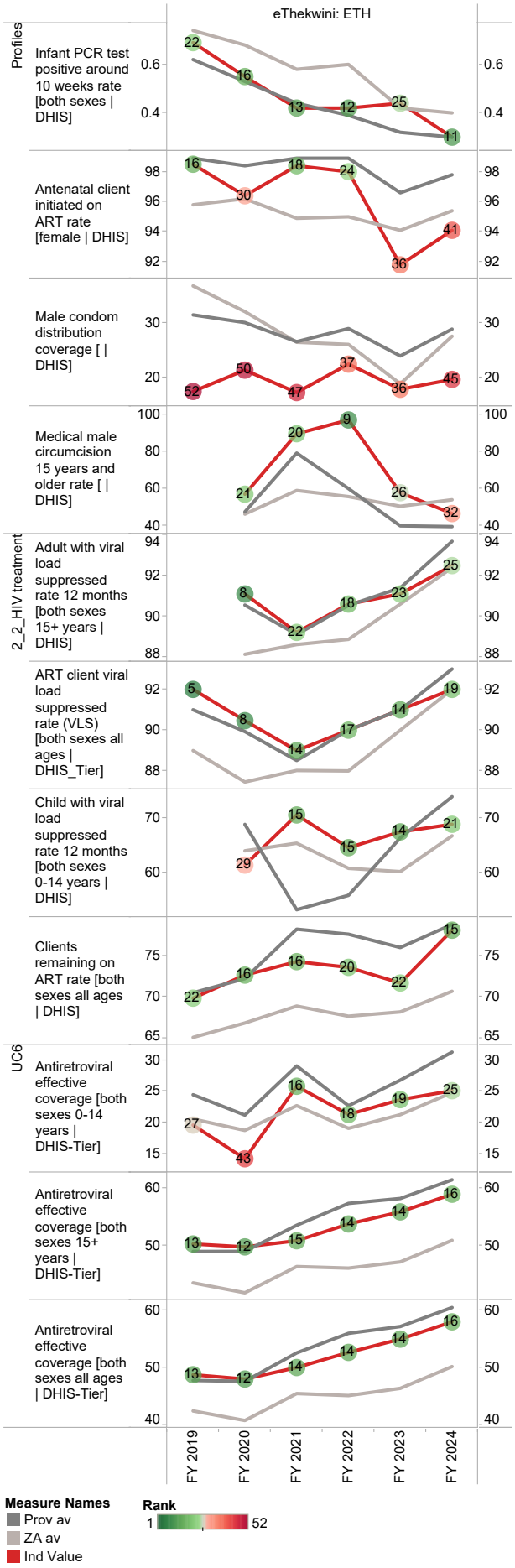
48


eThekwini: ETH
Profiles
Infant PCR test positive around 10 weeks rate [both sexes | DHIS]
Antenatal client initiated on ART rate [female | DHIS]
Male condom distribution coverage [| DHIS]
Medical male circumcision 15 years and older rate [| DHIS]
2_2_HIV treatment
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ART client viral load suppressed rate (VLS) [both sexes all ages | DHIS_Tier]
Child with viral load suppressed rate 12 months [both sexes 0-14 years | DHIS]
Clients remaining on ART rate [both sexes all ages | DHIS]
UC6
Antiretroviral effective coverage [both sexes 0-14 years | DHIS-Tier]
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FY 2019
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FY 2024
Measure Names
Prov av
ZA av
Ind Value
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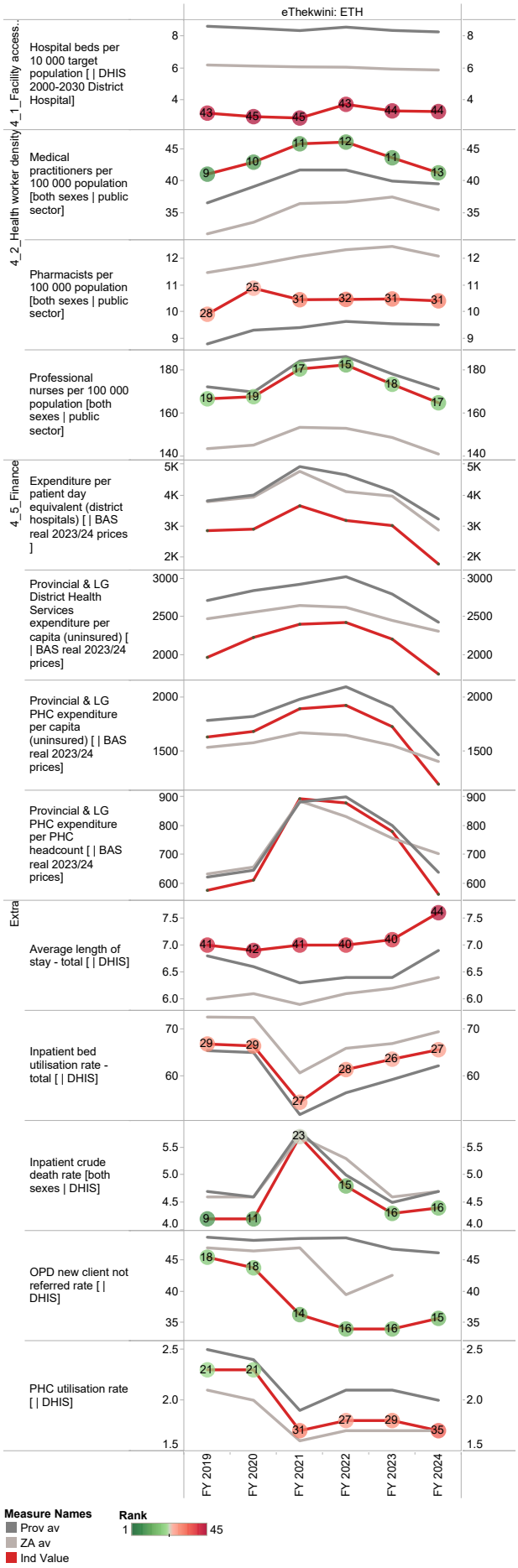
52


eThekwini: ETH
4_1_Facility access..
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
4_2_Health worker density
Medical practitioners per 100 000 population [both sexes | public sector]
Pharmacists per 100 000 population [both sexes | public sector]
Professional nurses per 100 000 population [both sexes | public sector]
4_5_Finance
Expenditure per patient day equivalent (district hospitals) [| BAS real 2023/24 prices]
Provincial & LG District Health Services expenditure per capita (uninsured) [| BAS real 2023/24 prices]
Provincial & LG PHC expenditure per capita (uninsured) [| BAS real 2023/24 prices]
Provincial & LG PHC expenditure per PHC headcount [| BAS real 2023/24 prices]
Extra
Average length of stay - total [| DHIS]
Inpatient bed utilisation rate - total [| DHIS]
Inpatient crude death rate [both sexes | DHIS]
OPD new client not referred rate [| DHIS]
PHC utilisation rate [| DHIS]
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FY 2020
FY 2021
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FY 2024
Measure Names
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ZA av
Ind Value
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45

11 Limpopo Province

Mopani District Municipality (DC33)

The Mopani District Municipality[1] is a Category C municipality located within the north-eastern quadrant of the Limpopo Province. It is bordered in the north by Zimbabwe and in the east by Mozambique. The district consists of five local municipalities: Ba-Phalaborwa, Greater Giyani, Greater Letaba, Greater Tzaneen and Maruleng.

Area: 20 012km²

Population (2023)[2]: 1 241 931

Households[1]: 338 427

Formal dwellings[1]: 90.7%

Cities/Towns:

Ba-Phalaborwa: Gravelotte, Leydsdorp

Greater Giyani: Giyani

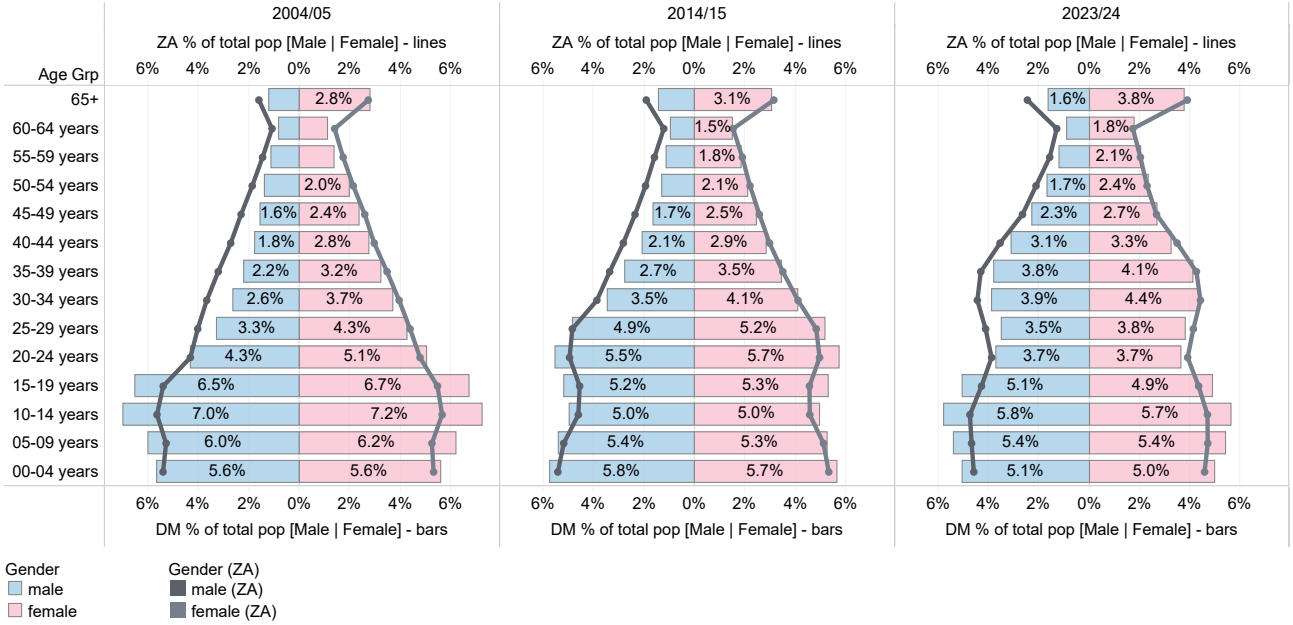
Greater Letaba: Modjadjiskloof

Greater Tzaneen: Haenertsburg, Tzaneen

Maruleng: Hoedspruit

District percentage population by age-gender group compared to South Africa

Mopani DM (DC33)

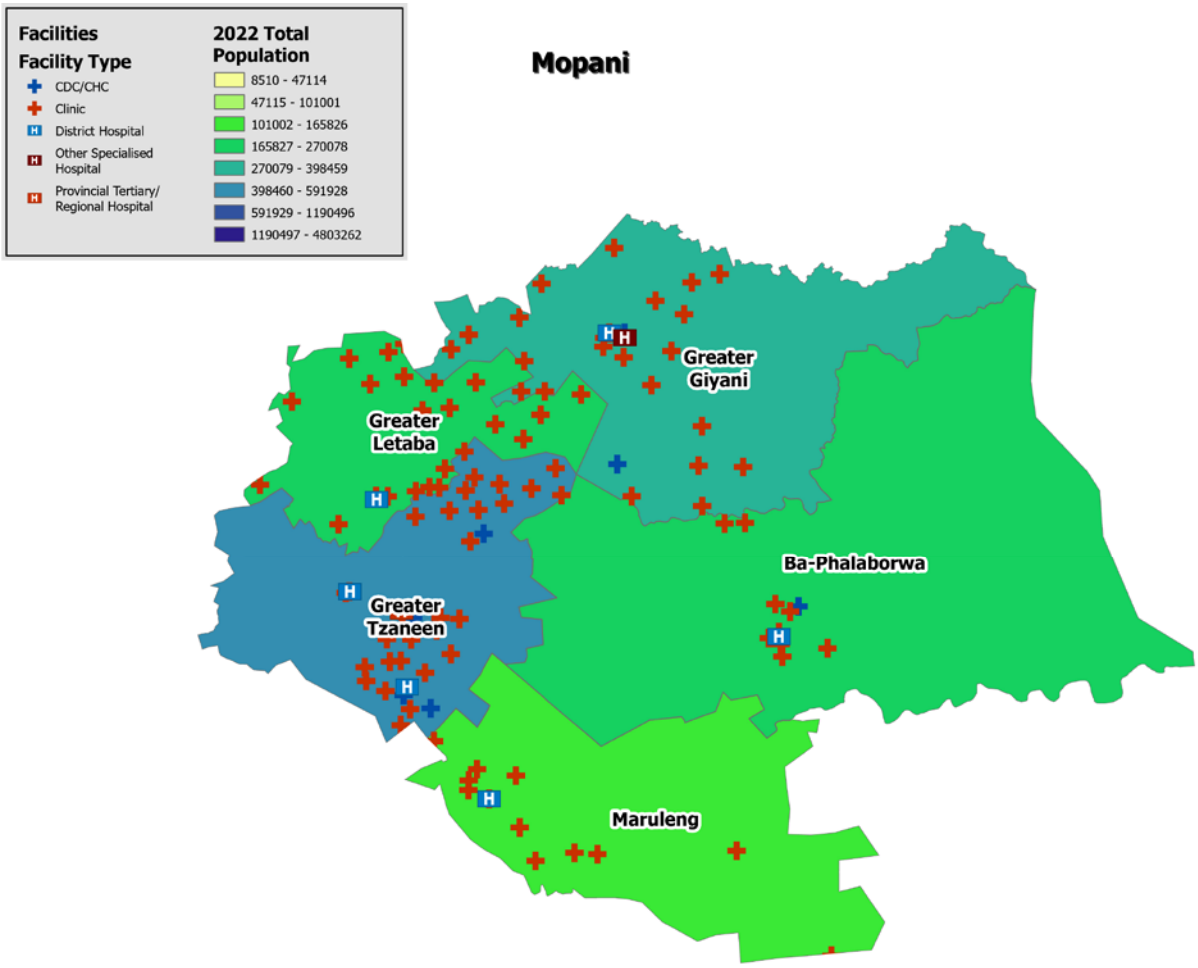


Source: DHIS

1 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

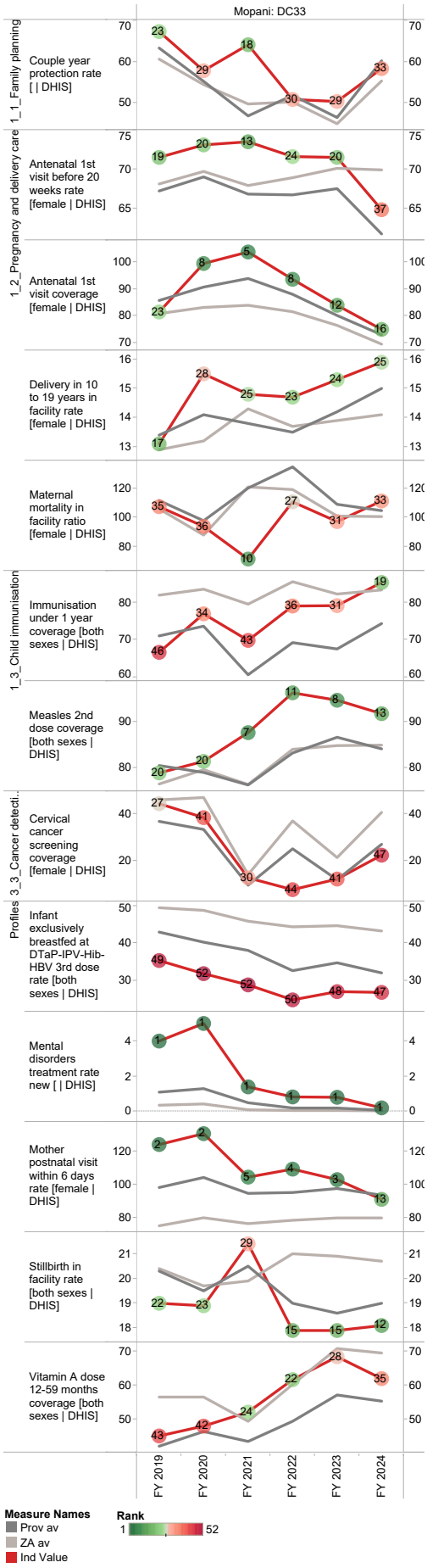
2 Mid-year Population Estimates 2023, DHIS.

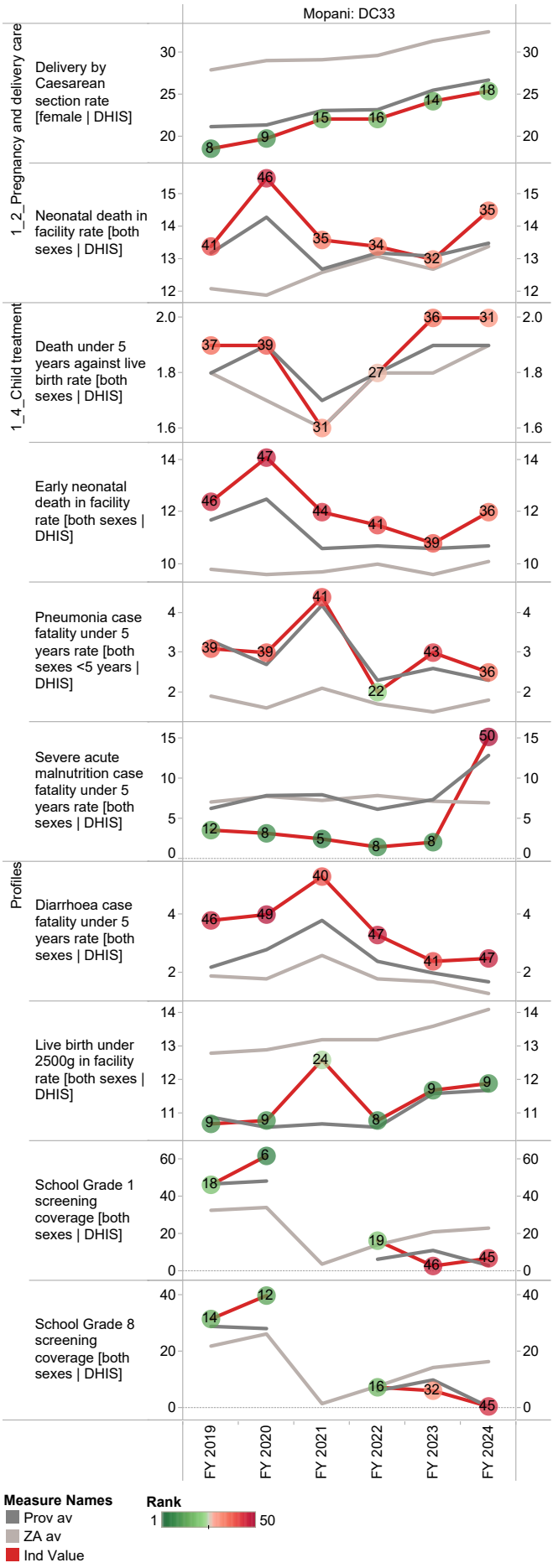
Population distribution, sub-district boundaries and health facility locations

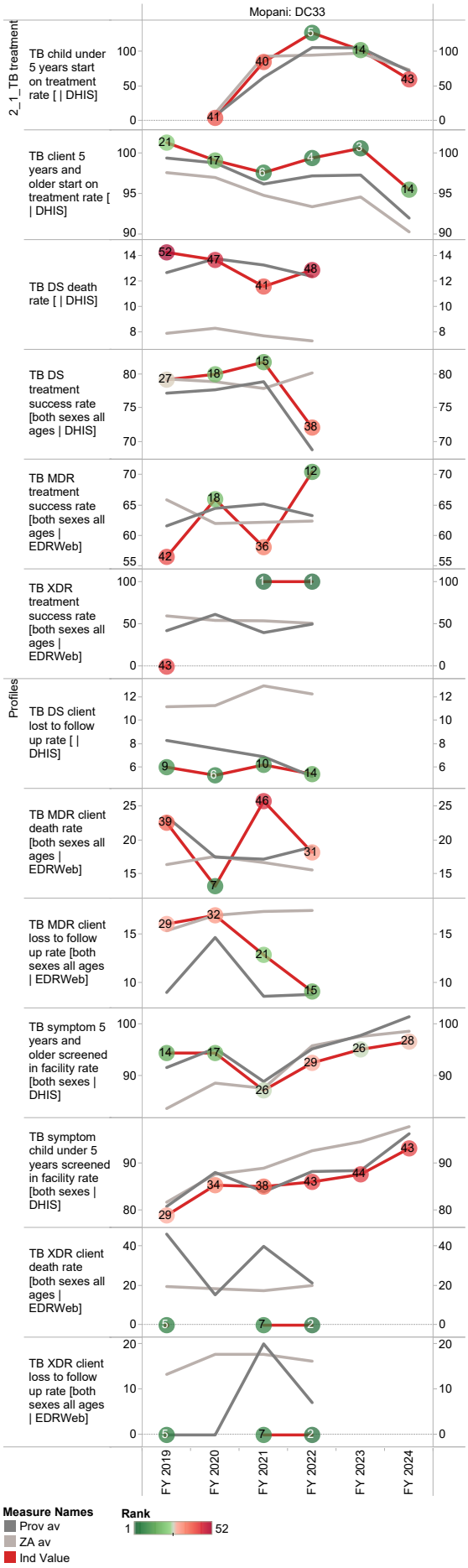


Source: DHIS

Annual trends, 2018/19–2023/24






Mopani: DC33
2_1_TB treatment
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Measure Names
Prov av
ZA av
Ind Value
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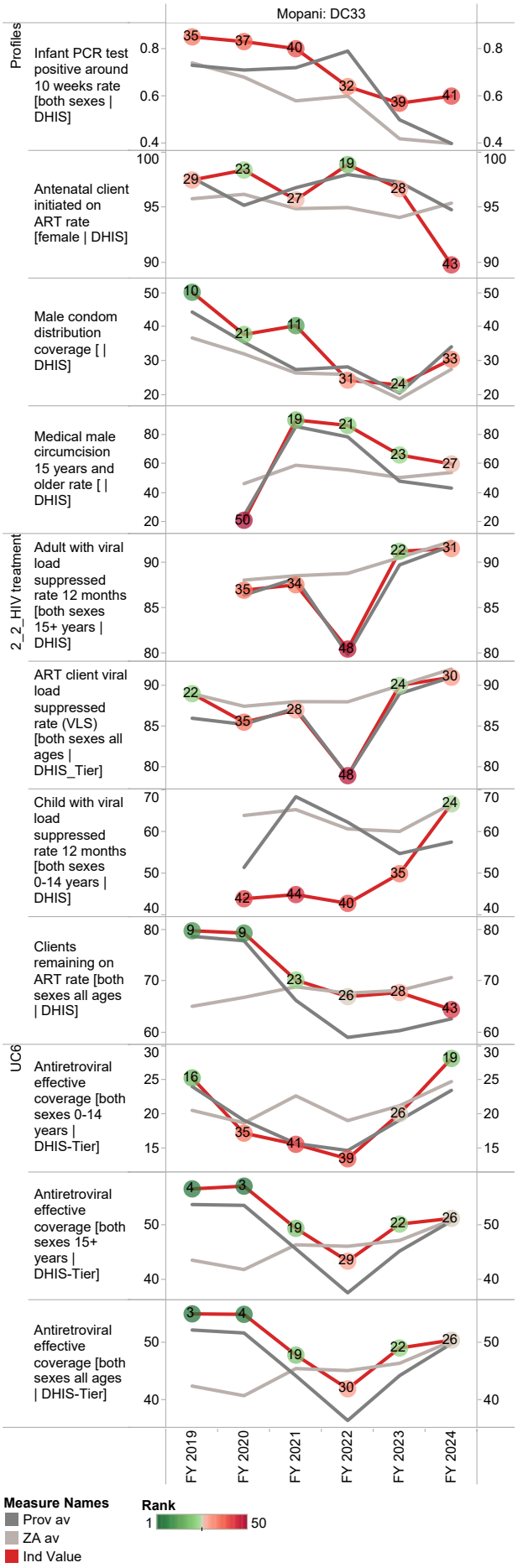
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FY 2024
Measure Names
Prov av
ZA av
Ind Value
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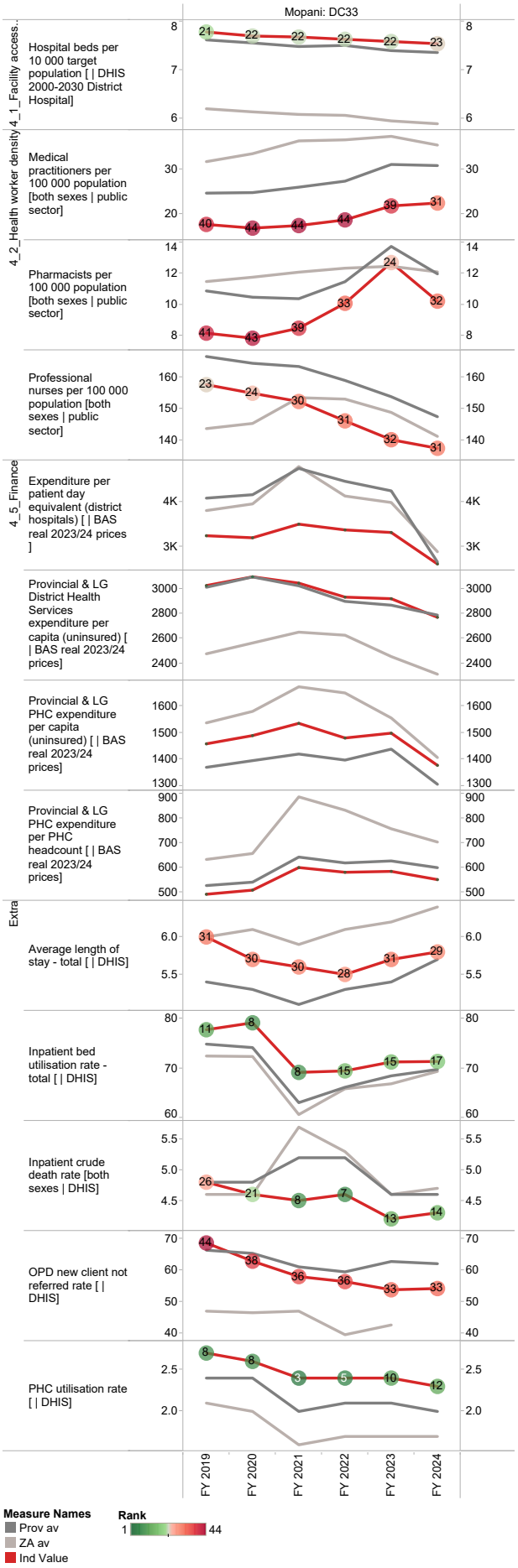
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PHC utilisation rate [| DHIS]
FY 2019
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FY 2021
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FY 2023
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Measure Names
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44

Vhembe District Municipality (DC34)

The Vhembe District Municipality[3] is a Category C municipality located in the northern part of the Limpopo Province. It shares borders with Zimbabwe and Botswana in the north-west and Mozambique in the south-east through the Kruger National Park. It comprises four local municipalities: Musina, Thulamela, Makhado and Collins Chabane.

Area: 25 597km²

Population (2023)[4]: 1 514 770

Households[3]: 382 357

Formal dwellings[3]: 86.3%

Cities/Towns:

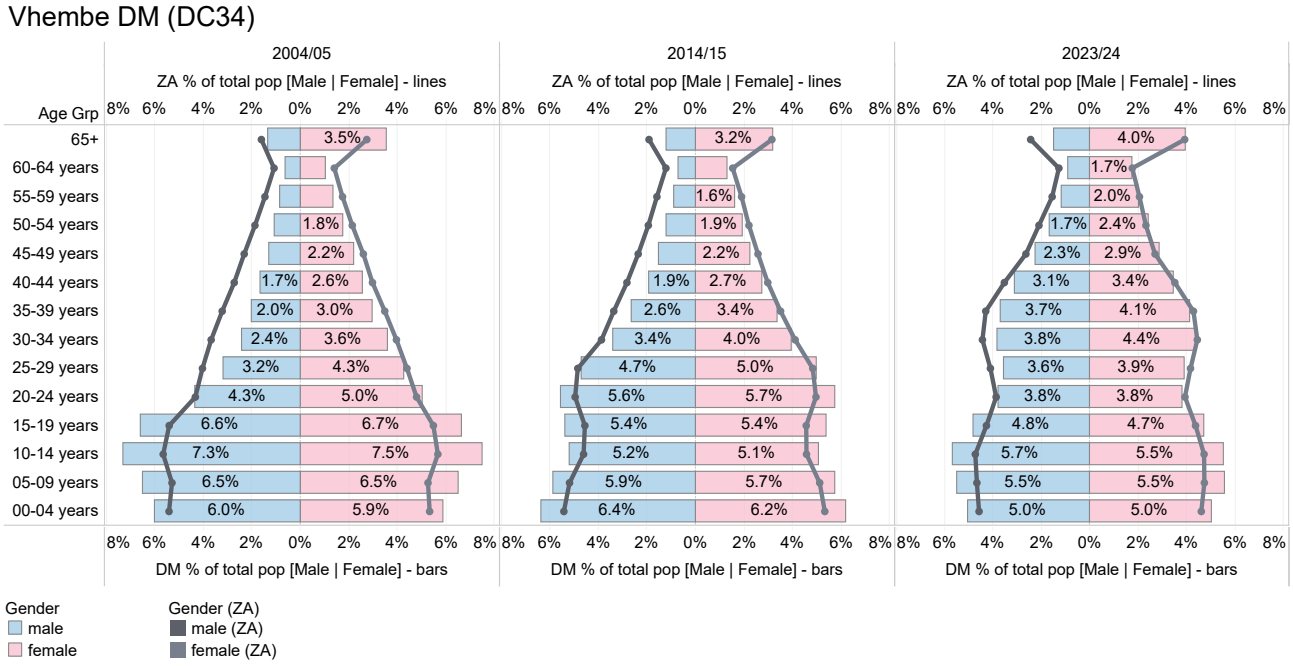
Musina: Musina

Thulamela: Thohoyandou

Makhado: Makhado

Collins Chabane: Malamulele,

District percentage population by age-gender group compared to South Africa

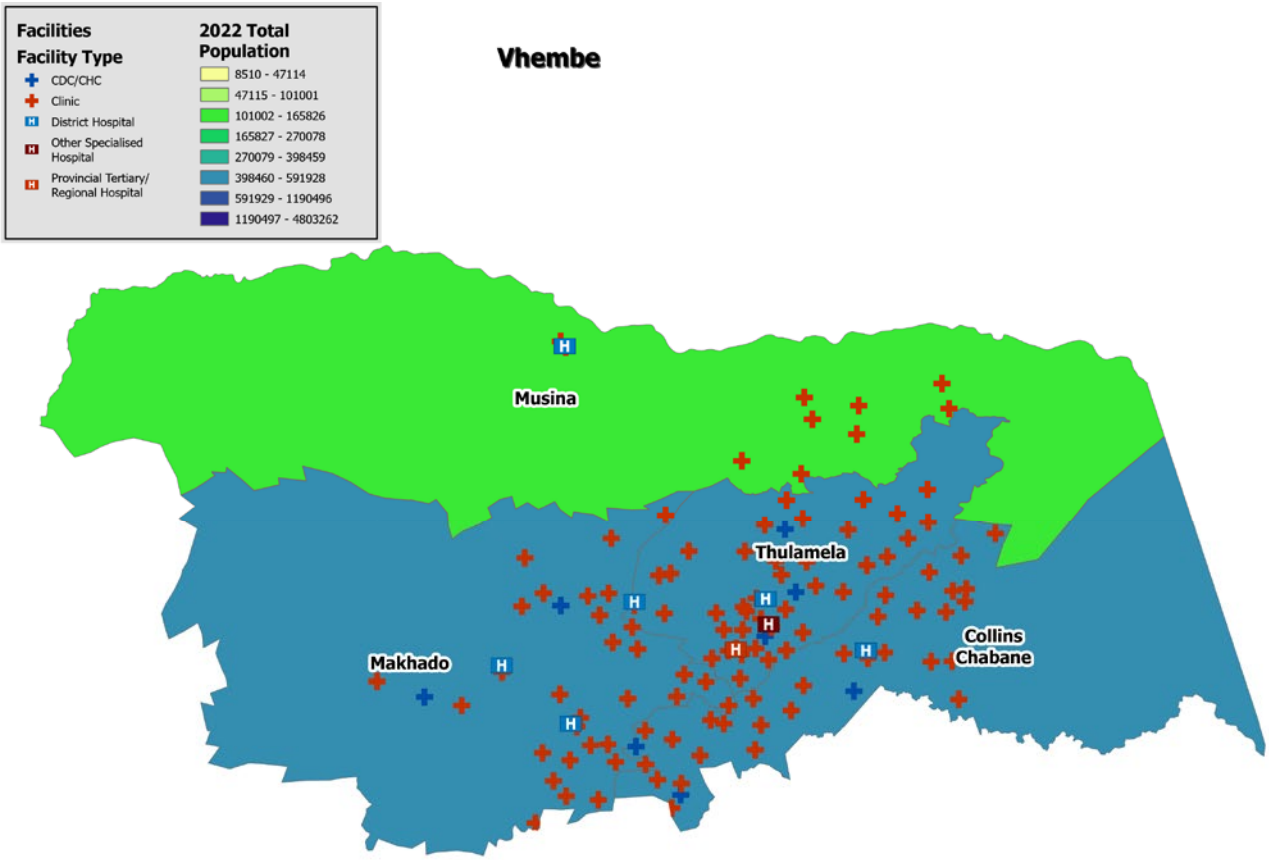


Source: DHIS

3 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

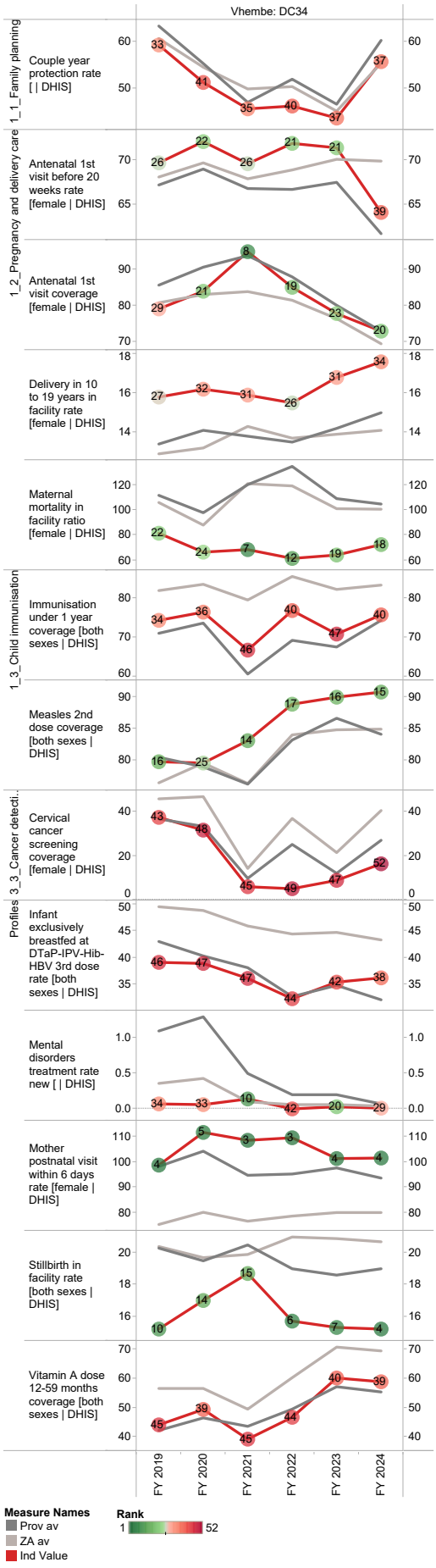
4 Mid-year Population Estimates 2023, DHIS.

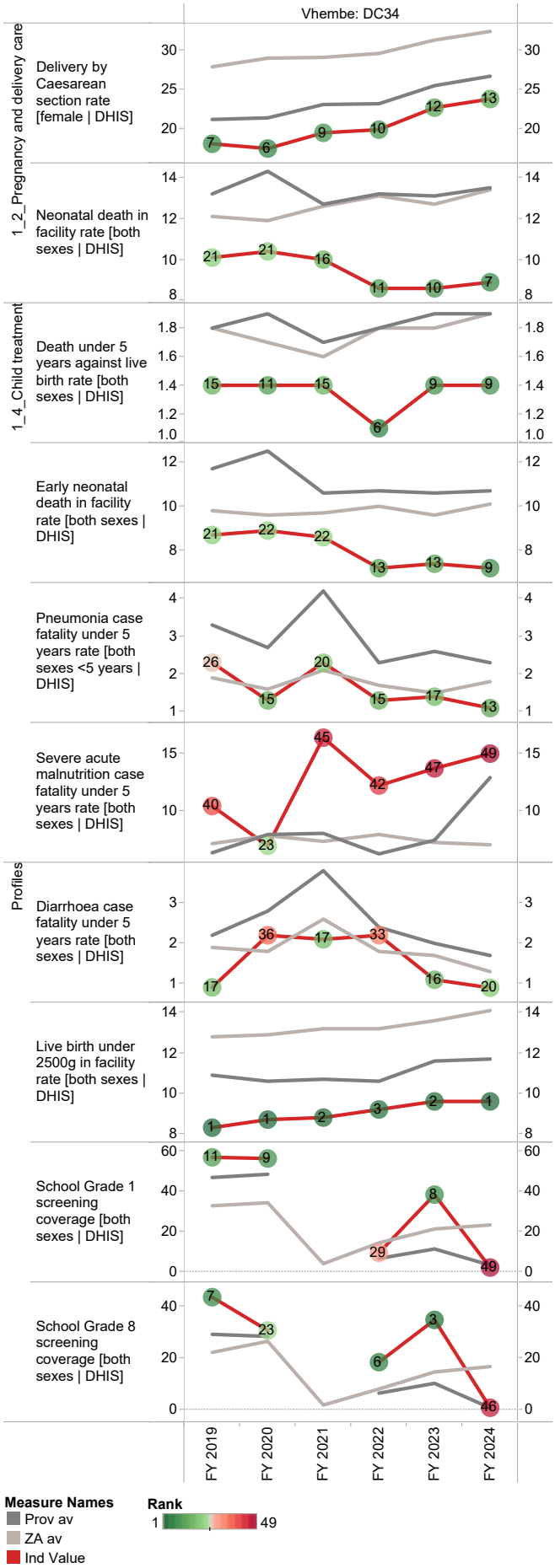
Population distribution, sub-district boundaries and health facility locations

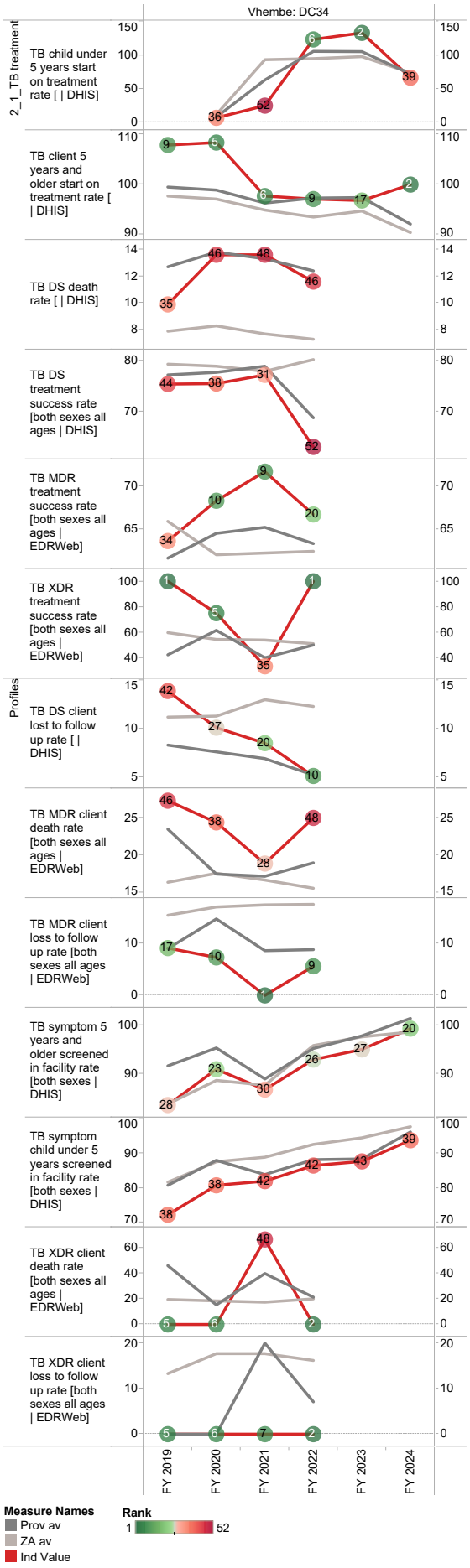


Source: DHIS

Annual trends, 2018/19–2023/24






Vhembe: DC34
2_1_TB treatment
Profiles
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FY 2024
Measure Names
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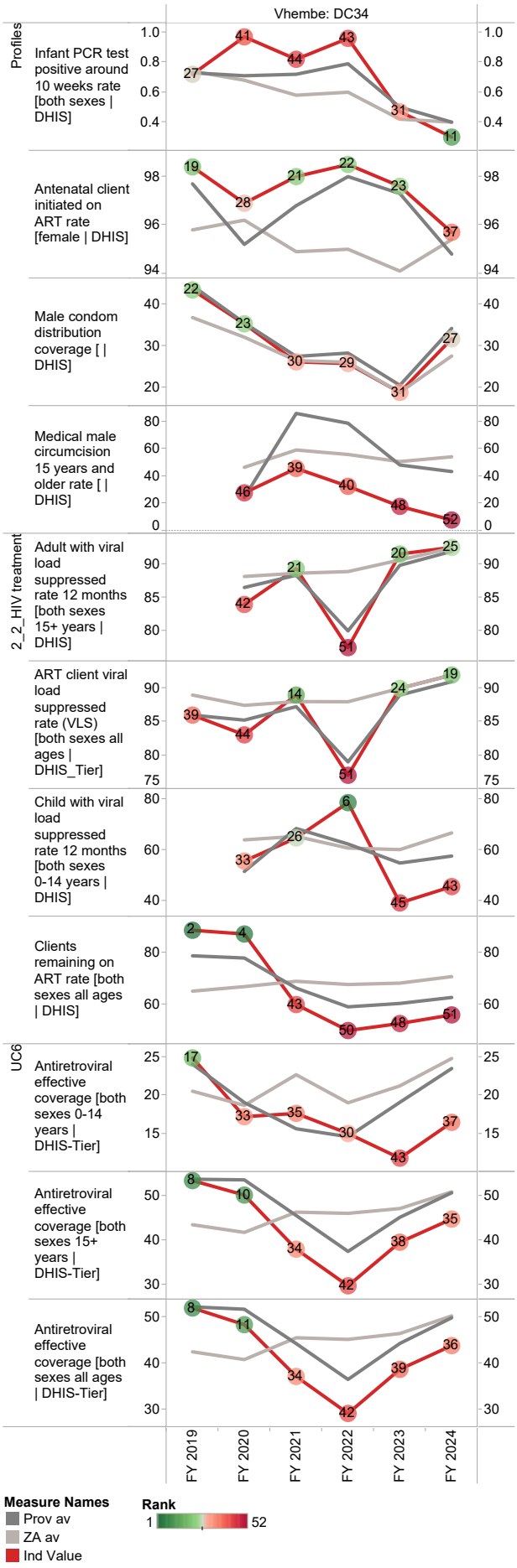
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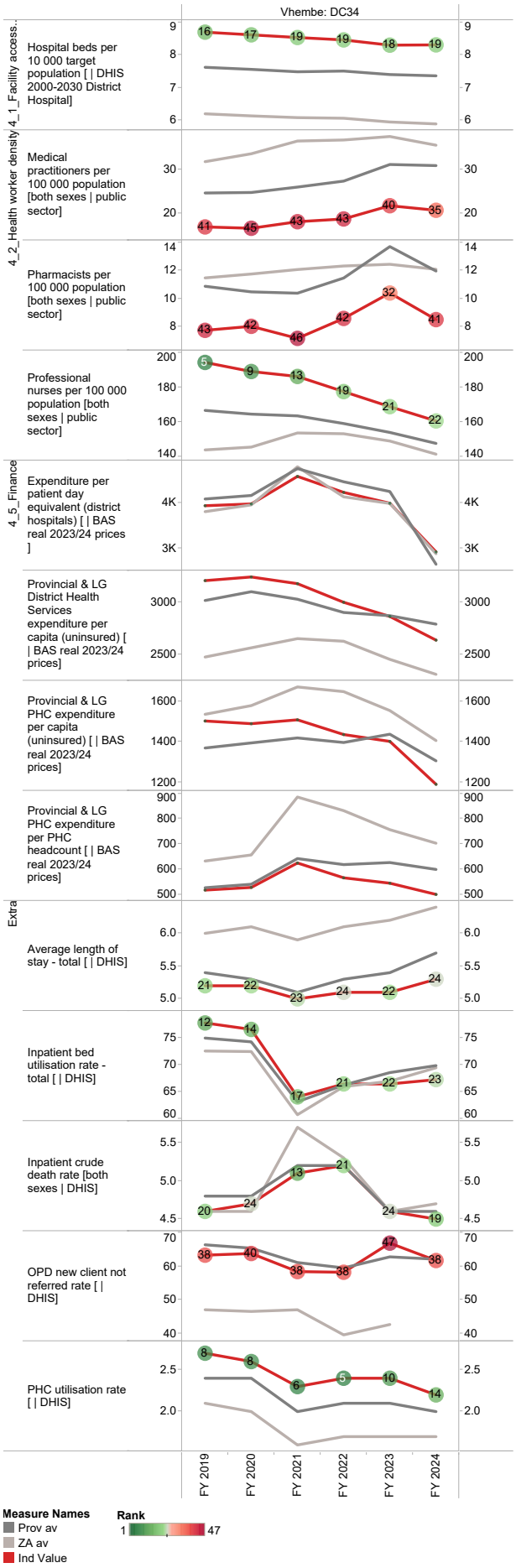
Vhembe: DC34
4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
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FY 2023
FY 2024
Measure Names
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Ind Value
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47

Capricorn District Municipality (DC35)

The Capricorn District Municipality[5] is a Category C municipality situated in the Limpopo Province. It forms a gateway to Botswana, Zimbabwe and Mozambique, and consists of the following four local municipalities: Blouberg, Lepelle-Nkumpi, Molemole and Polokwane.

Area: 21 706km²

Population (2023)[6]: 1 361 654

Households[5]: 378 301

Formal dwellings[5]: 93.2%

Cities/Towns:

Blouberg: Alldays, Senwabarwana (Bochum)

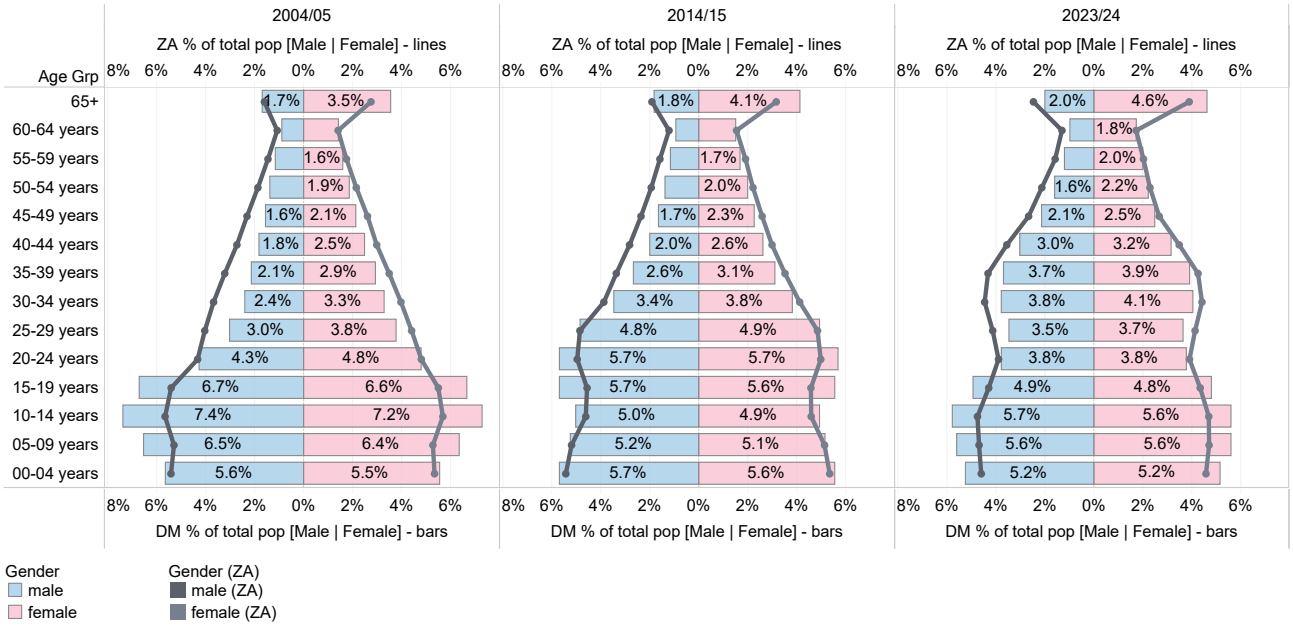
Lepelle-Nkumpi: Zebediela

Molemole: Dendron, Morebeng (Soekmekaar)

Polokwane: Polokwane

District percentage population by age-gender group compared to South Africa

Capricorn DM (DC35)

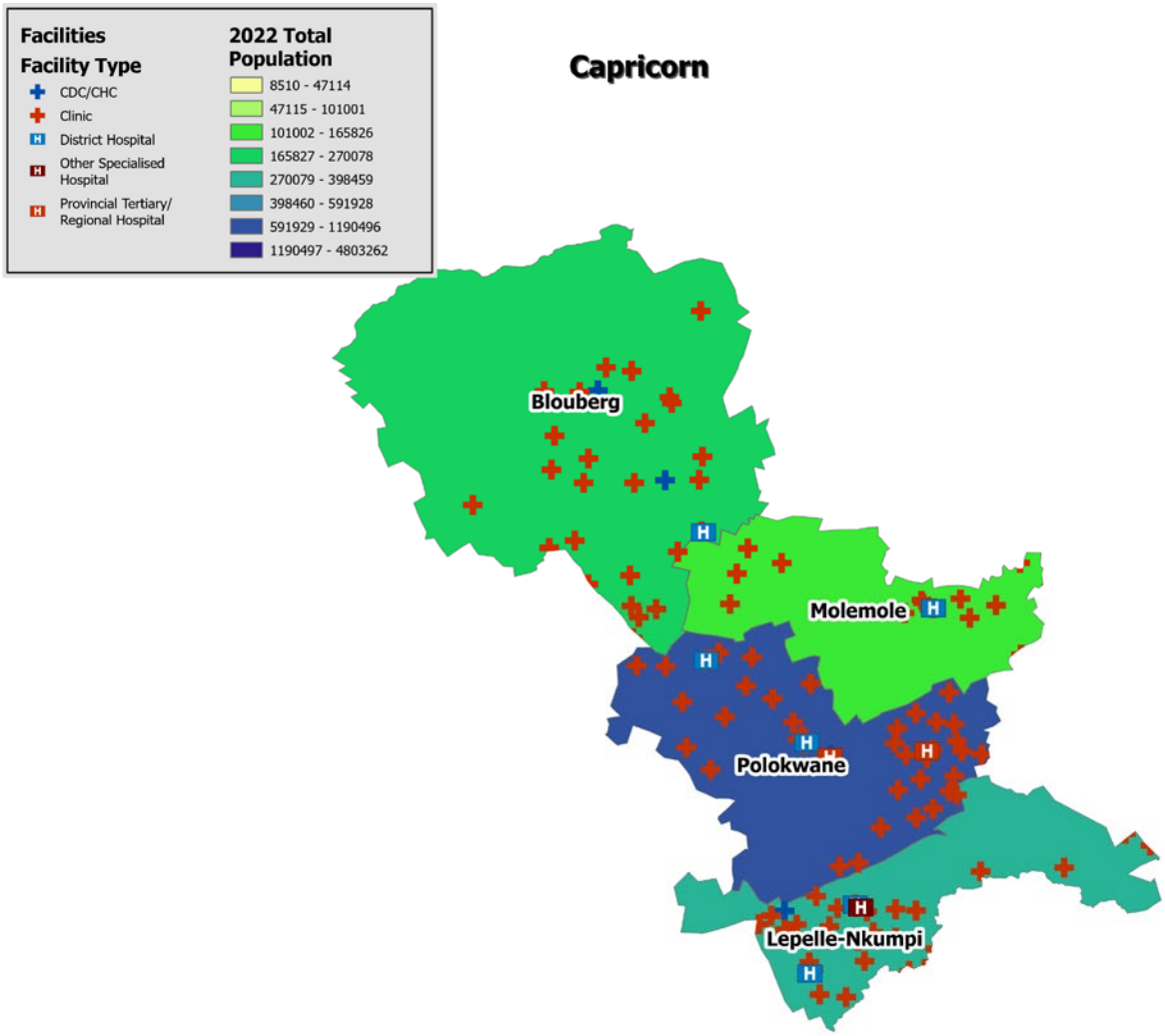


Source: DHIS

5 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

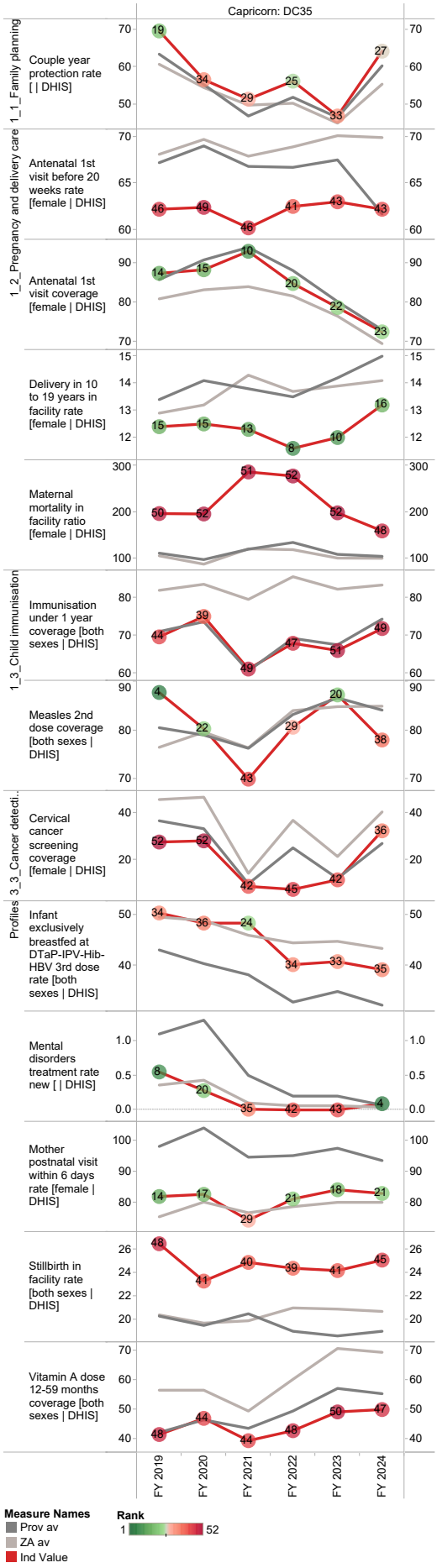
6 Mid-year Population Estimates 2023, DHIS.

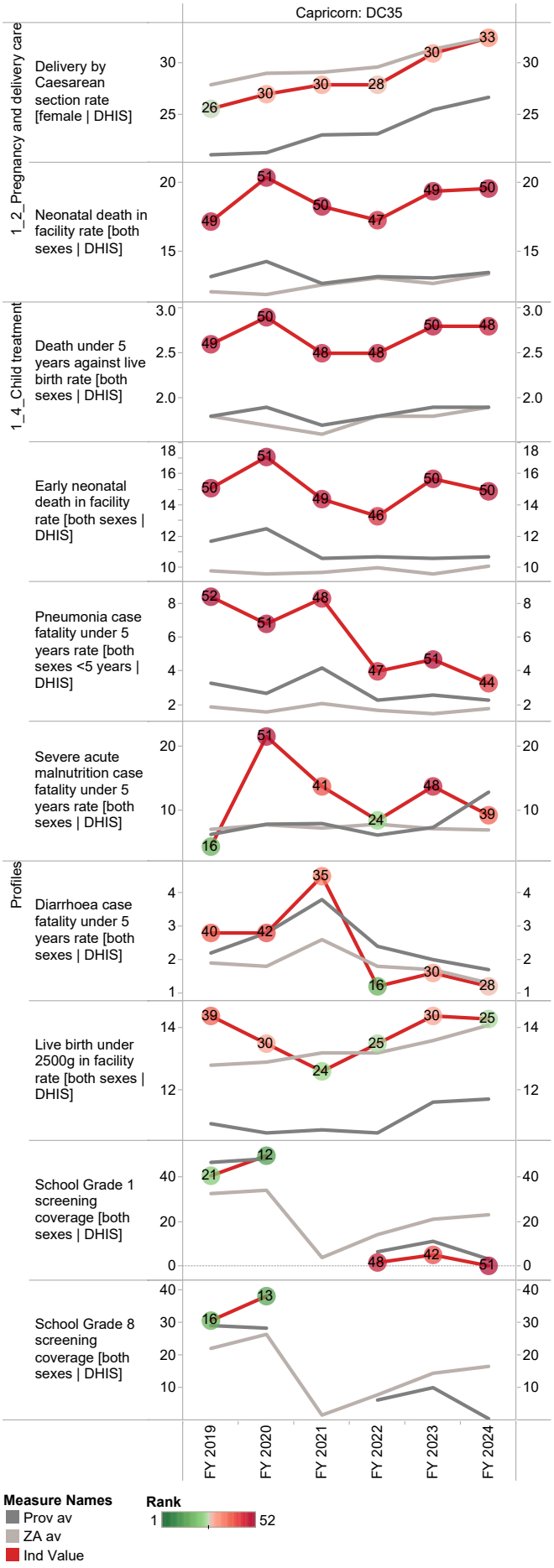
Population distribution, sub-district boundaries and health facility locations

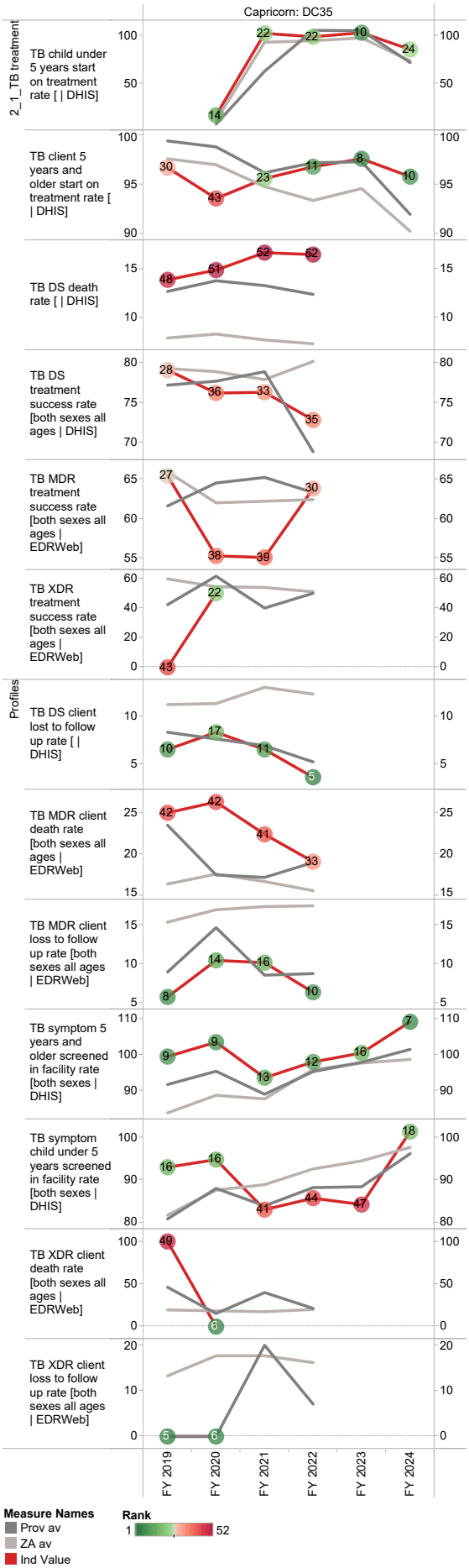


Source: DHIS

Annual trends, 2018/19–2023/24






Capricorn: DC35
2_1_TB treatment
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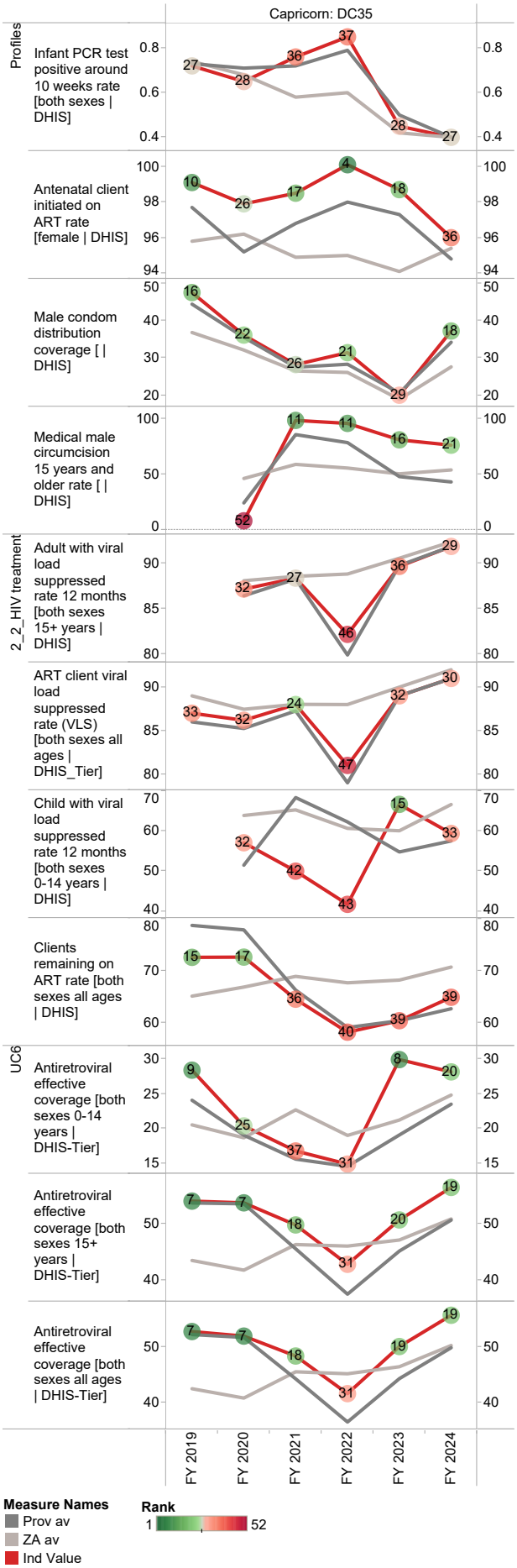
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
1
52


Capricorn: DC35
Profiles
Infant PCR test positive around 10 weeks rate [both sexes | DHIS]
Antenatal client initiated on ART rate [female | DHIS]
Male condom distribution coverage [| DHIS]
Medical male circumcision 15 years and older rate [| DHIS]
2_2_HIV treatment
Adult with viral load suppressed rate 12 months [both sexes 15+ years | DHIS]
ART client viral load suppressed rate (VLS) [both sexes all ages | DHIS_Tier]
Child with viral load suppressed rate 12 months [both sexes 0-14 years | DHIS]
Clients remaining on ART rate [both sexes all ages | DHIS]
UC6
Antiretroviral effective coverage [both sexes 0-14 years | DHIS-Tier]
Antiretroviral effective coverage [both sexes 15+ years | DHIS-Tier]
Antiretroviral effective coverage [both sexes all ages | DHIS-Tier]
FY 2019
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FY 2021
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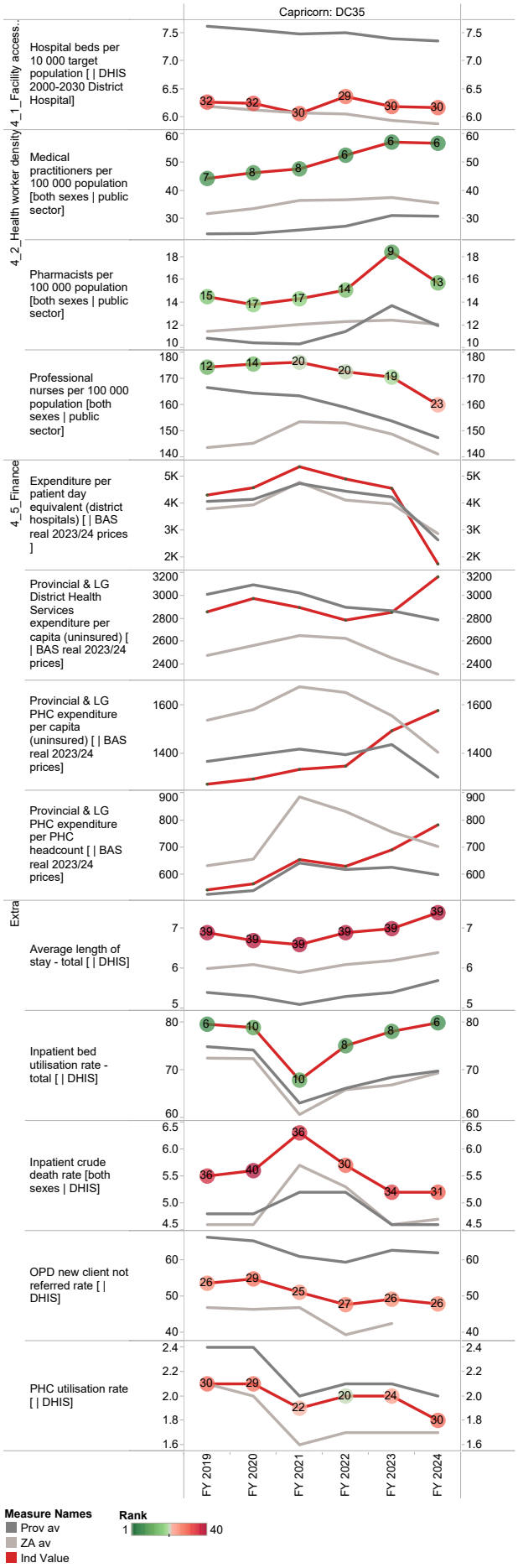
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
1
52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4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
4_2_Health worker density
Medical practitioners per 100 000 population [both sexes | public sector]
Pharmacists per 100 000 population [both sexes | public sector]
Professional nurses per 100 000 population [both sexes | public sector]
4_5_Finance
Expenditure per patient day equivalent (district hospitals) [| BAS real 2023/24 prices]
Provincial & LG District Health Services expenditure per capita (uninsured) [| BAS real 2023/24 prices]
Provincial & LG PHC expenditure per capita (uninsured) [| BAS real 2023/24 prices]
Provincial & LG PHC expenditure per PHC headcount [| BAS real 2023/24 prices]
Extra
Average length of stay - total [| DHIS]
Inpatient bed utilisation rate - total [| DHIS]
Inpatient crude death rate [both sexes | DHIS]
OPD new client not referred rate [| DHIS]
PHC utilisation rate [| DHIS]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
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1
40

Waterberg District Municipality (DC36)

The Waterberg District Municipality[7] is a Category C municipality located in the western part of the Limpopo Province. It shares its five border-control points with Botswana, and comprises five local municipalities: Bela-Bela, Lephalale, Modimolle-Mookgophong, Mogalakwena and Thabazimbi.

Area: 44 914km²

Population (2023)[8]: 786 231

Households[7]: 211 471

Formal dwellings[7]: 85.0%

Cities/Towns:

Bela-Bela: Bela-Bela, Pienaarsrivier

Lephalale: Lephalale

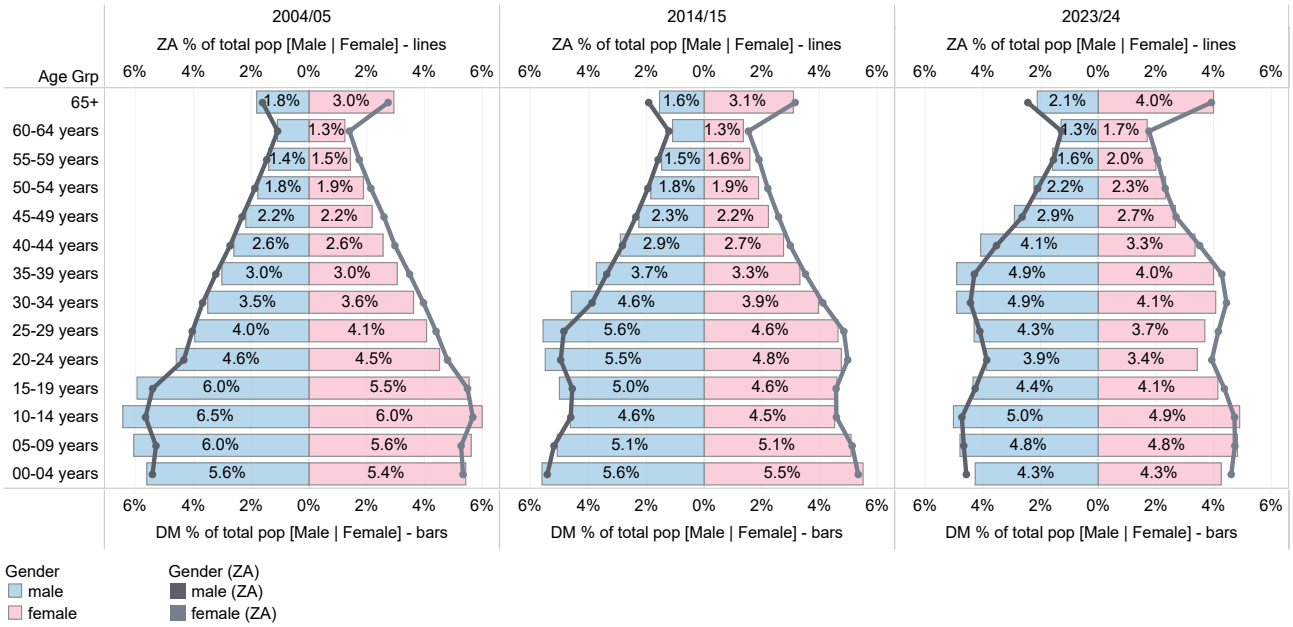
Modimolle-Mookgophong: Modimolle, Mookgophong (Naboomspruit), Vaalwater

Mogalakwena: Mokopane (Potgietersrus)

Thabazimbi: Amandelbult Mine Town, Thabazimbi

District percentage population by age-gender group compared to South Africa

Waterberg DM (DC36)

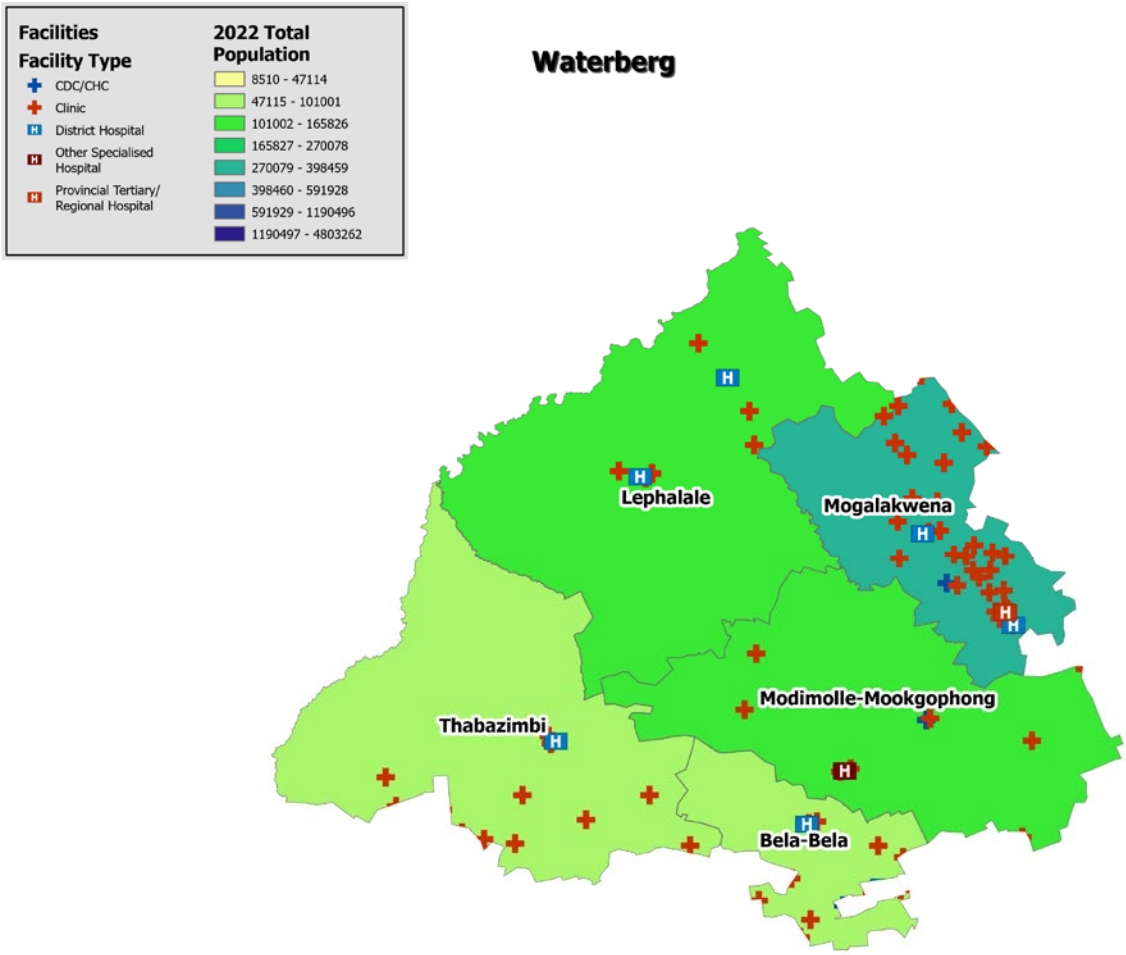


Source: DHIS

7 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

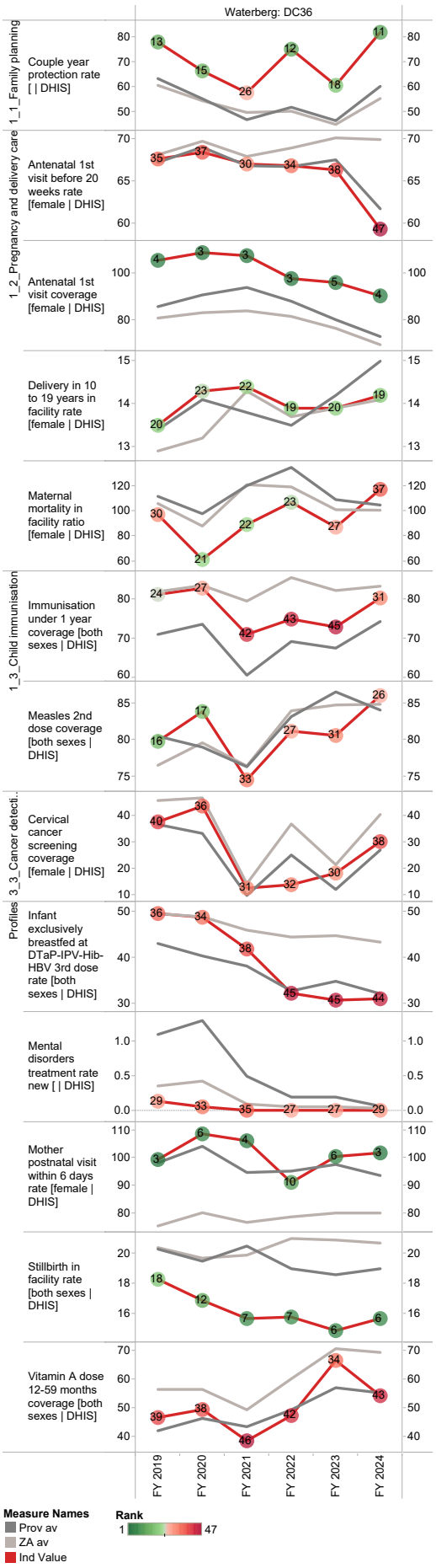
8 Mid-year Population Estimates 2023, DHIS.

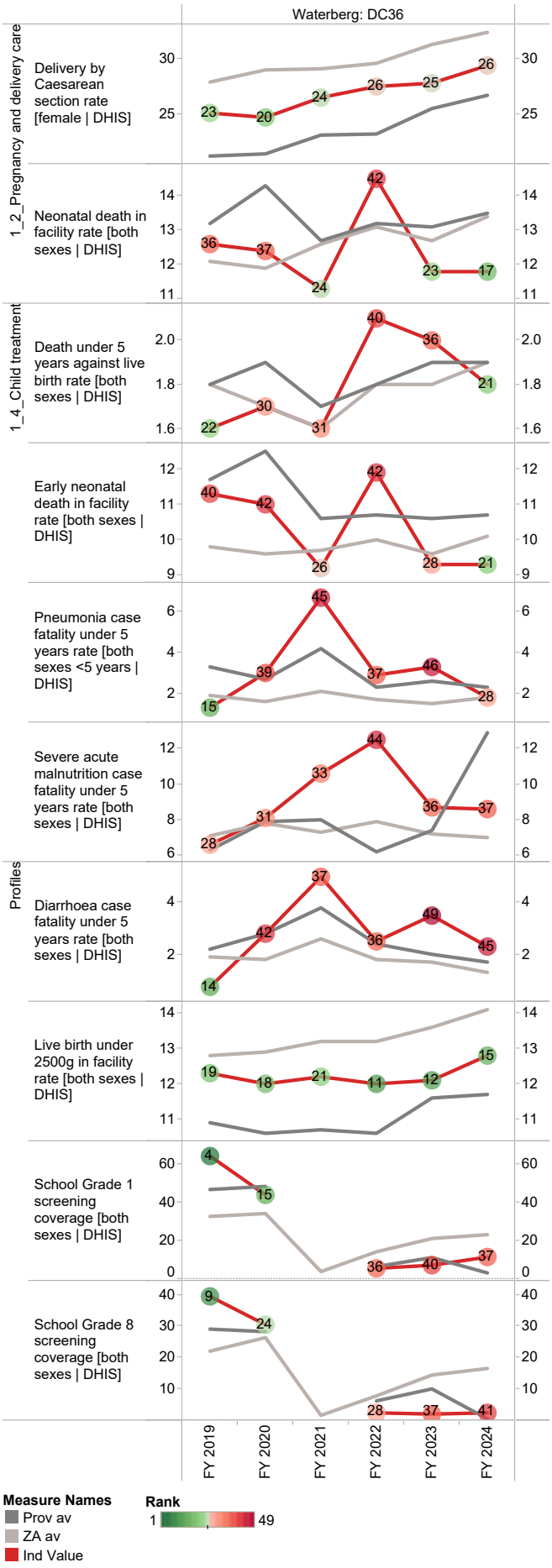
Population distribution, sub-district boundaries and health facility locations

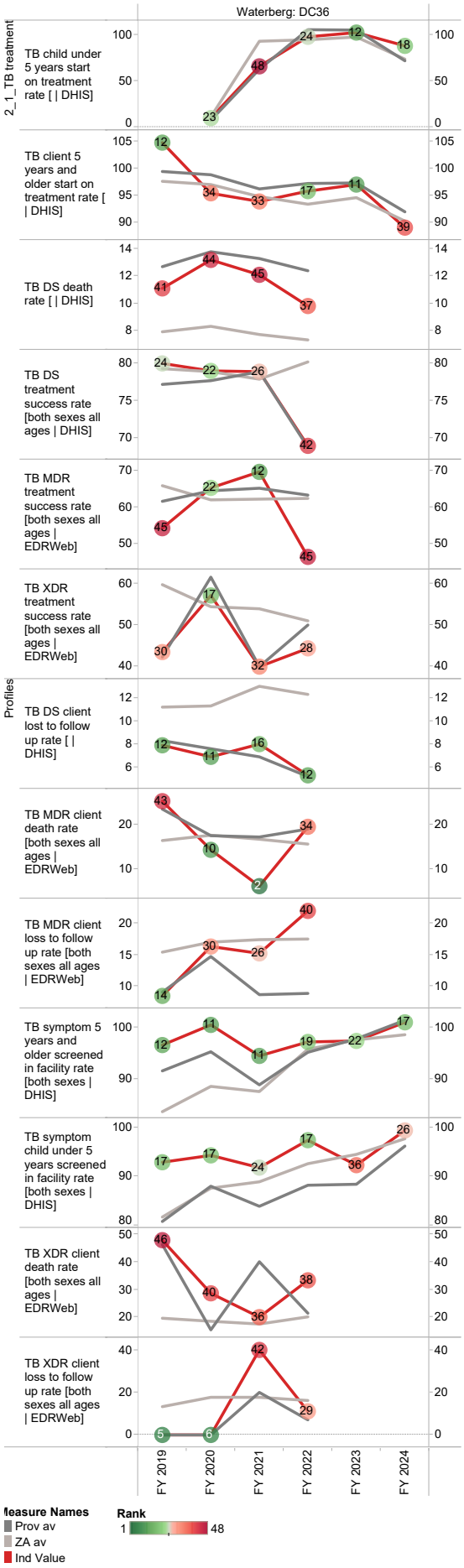


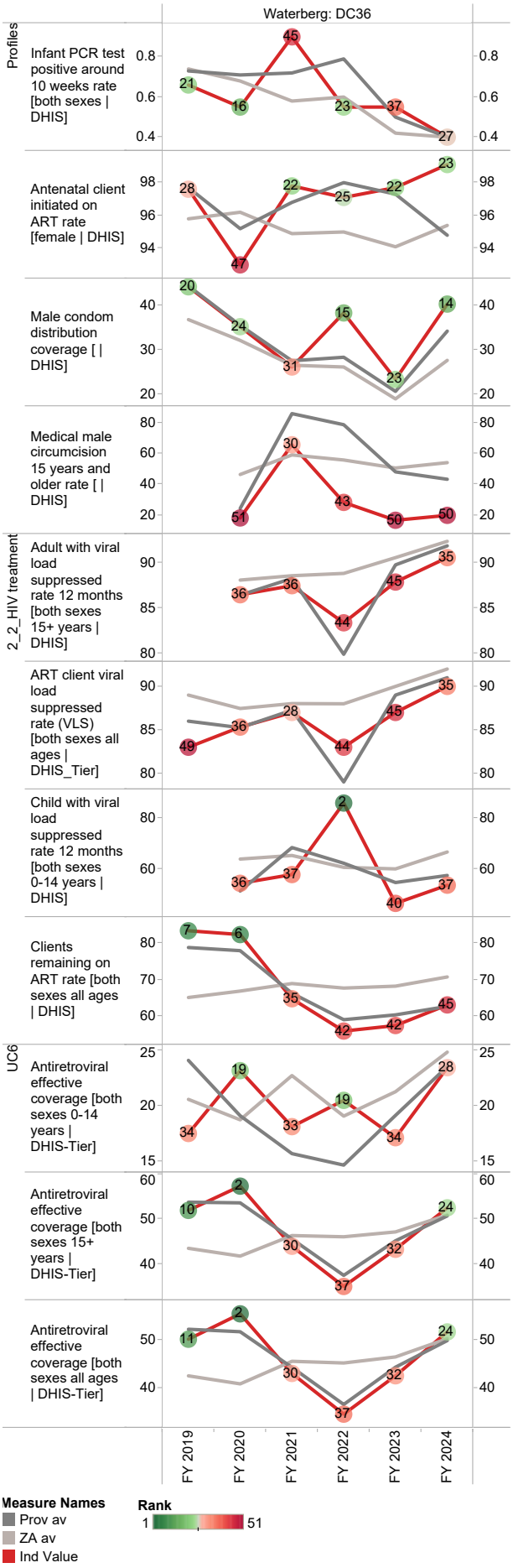
Source: DHIS

Annual trends, 2018/19–2023/24






Waterberg: DC36
2_1_TB treatment
Profiles
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
TB DS death rate [| DHIS]
TB DS treatment success rate [both sexes all ages | DHIS]
TB MDR treatment success rate [both sexes all ages | EDRWeb]
TB XDR treatment success rate [both sexes all ages | EDRWeb]
TB DS client lost to follow up rate [| DHIS]
TB MDR client death rate [both sexes all ages | EDRWeb]
TB MDR client loss to follow up rate [both sexes all ages | EDRWeb]
TB symptom 5 years and older screened in facility rate [both sexes | DHIS]
TB symptom child under 5 years screened in facility rate [both sexes | DHIS]
TB XDR client death rate [both sexes all ages | EDRWeb]
TB XDR client loss to follow up rate [both sexes all ages | EDRWeb]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
1
48


Waterberg: DC36
Profiles
Infant PCR test positive around 10 weeks rate [both sexes | DHIS]
Antenatal client initiated on ART rate [female | DHIS]
Male condom distribution coverage [| DHIS]
Medical male circumcision 15 years and older rate [| DHIS]
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ART client viral load suppressed rate (VLS) [both sexes all ages | DHIS_Tier]
Child with viral load suppressed rate 12 months [both sexes 0-14 years | DHIS]
Clients remaining on ART rate [both sexes all ages | DHIS]
UC6
Antiretroviral effective coverage [both sexes 0-14 years | DHIS-Tier]
Antiretroviral effective coverage [both sexes 15+ years | DHIS-Tier]
Antiretroviral effective coverage [both sexes all ages | DHIS-Tier]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
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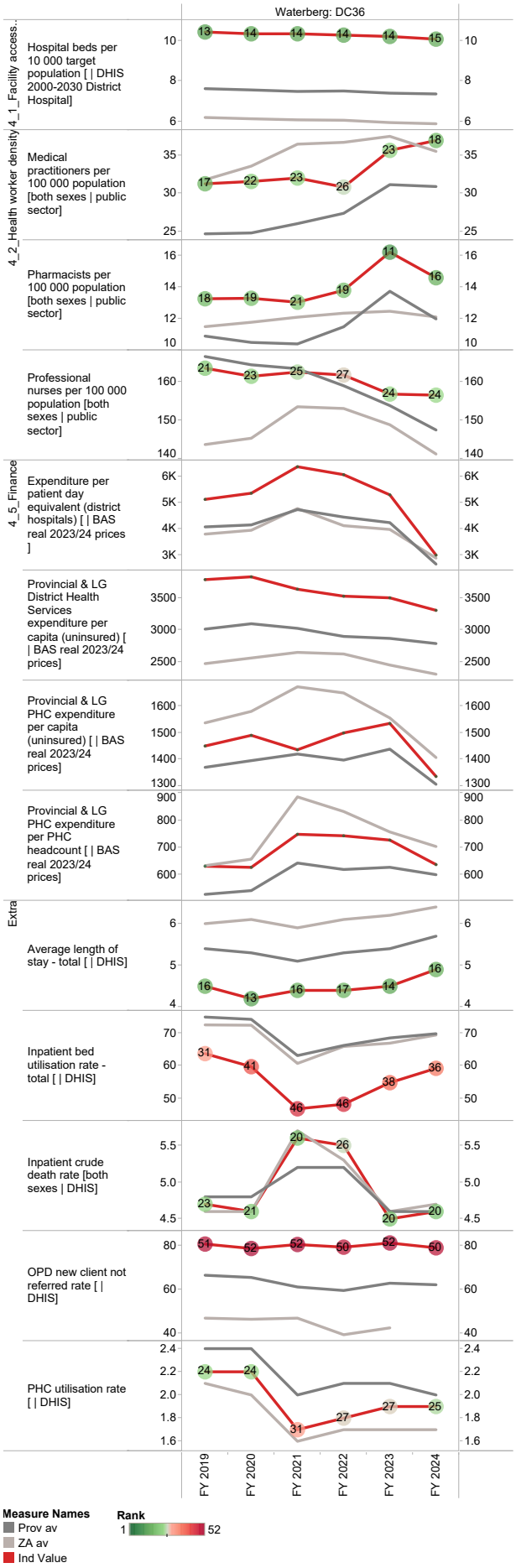
Waterberg: DC36
4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
4_2_Health worker density
Medical practitioners per 100 000 population [both sexes | public sector]
Pharmacists per 100 000 population [both sexes | public sector]
Professional nurses per 100 000 population [both sexes | public sector]
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Expenditure per patient day equivalent (district hospitals) [| BAS real 2023/24 prices]
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Provincial & LG PHC expenditure per capita (uninsured) [| BAS real 2023/24 prices]
Provincial & LG PHC expenditure per PHC headcount [| BAS real 2023/24 prices]
Extra
Average length of stay - total [| DHIS]
Inpatient bed utilisation rate - total [| DHIS]
Inpatient crude death rate [both sexes | DHIS]
OPD new client not referred rate [| DHIS]
PHC utilisation rate [| DHIS]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
1
52

Sekhukhune District Municipality (DC47)

The Sekhukhune District Municipality[9] is a Category C municipality located in the Limpopo Province, the northernmost part of South Africa. The district is the smallest in the province, making up 11% of its geographical area. It comprises four local municipalities: Elias Motsoaledi, Ephraim Mogale, Makhuduthamaga and Fetakgomo Tubatse.

Area: 13 527km²

Population (2023)[10]: 1 261 291

Households[9]: 290 527

Formal dwellings[9]: 87.6%

Cities/Towns:

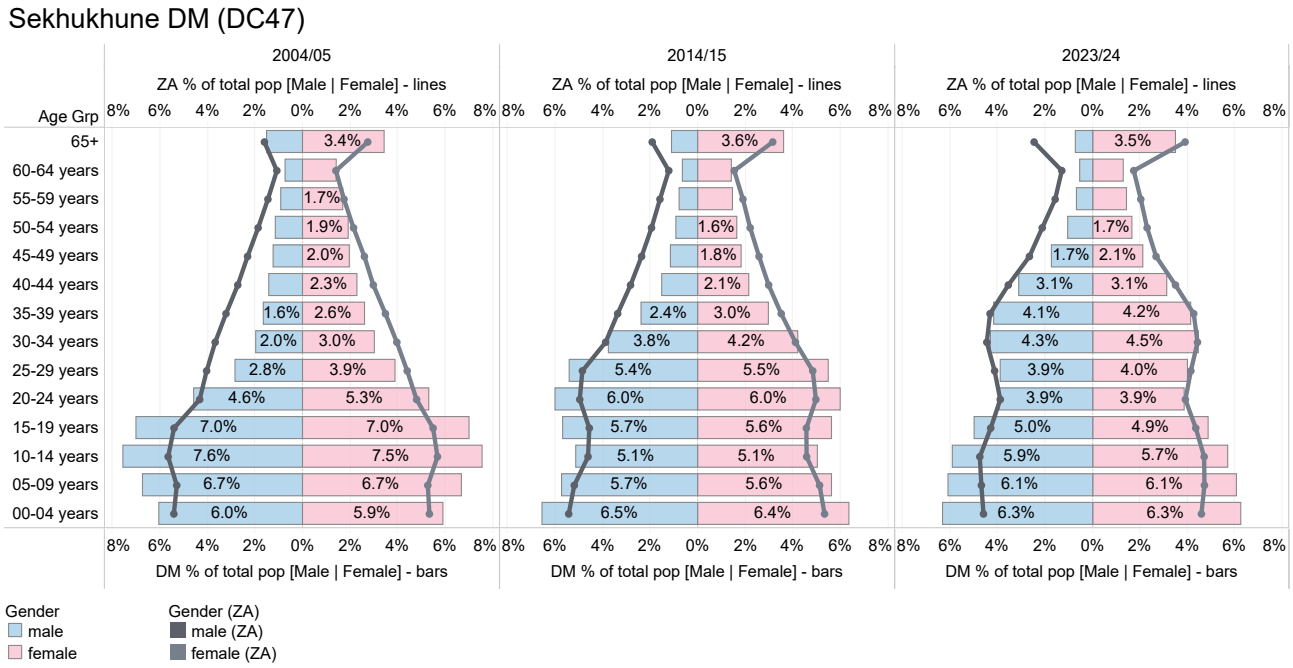
Elias Motsoaledi: Groblersdal, Roossenekal

Ephraim Mogale: Marble Hall, Schuinsdraai Nature Reserve

Makhuduthamaga: Makhuduthamaga

Fetakgomo Tubatse: Burgersfort, Ohrigstad, Steelpoort

District percentage population by age-gender group compared to South Africa

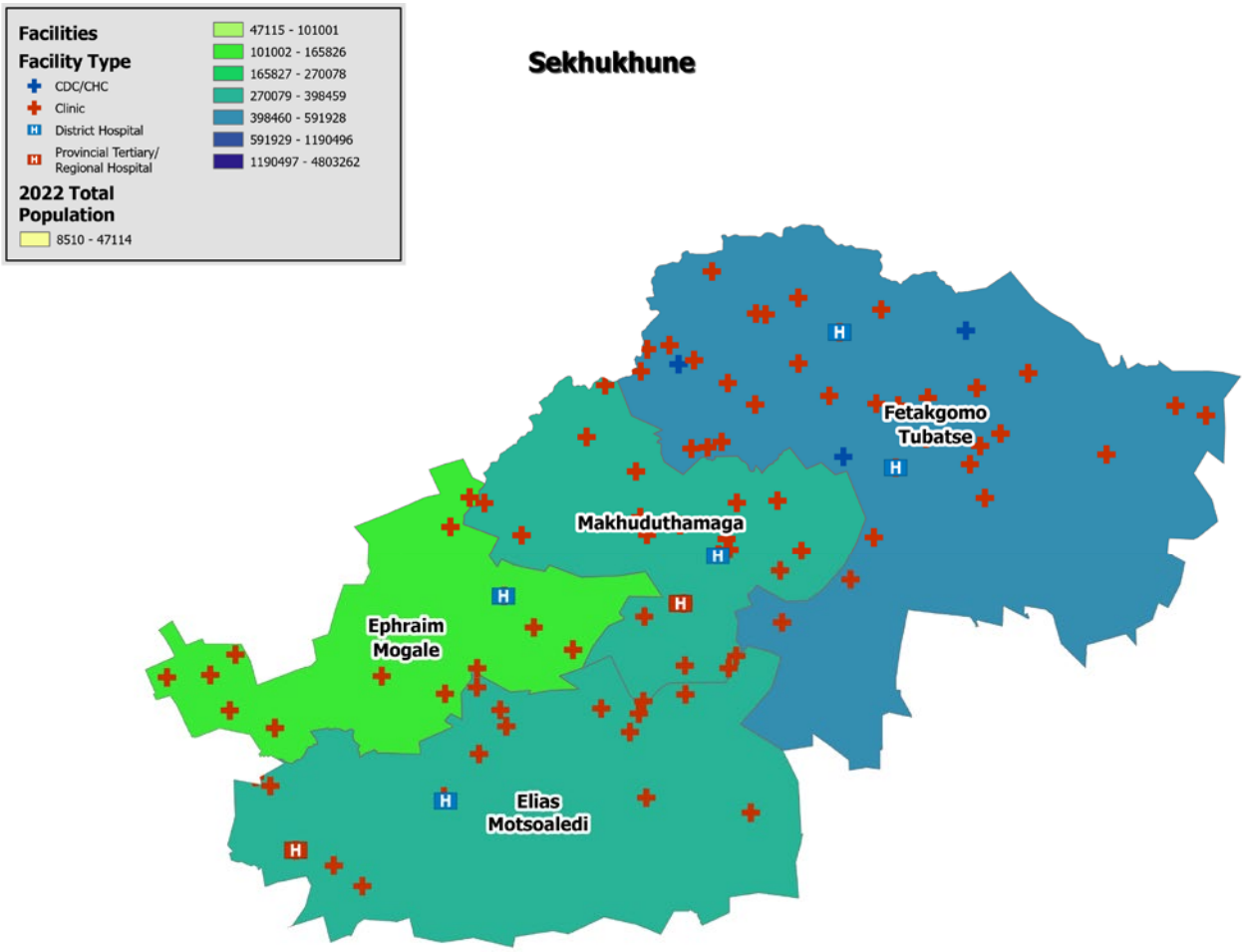


Source: DHIS

9 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

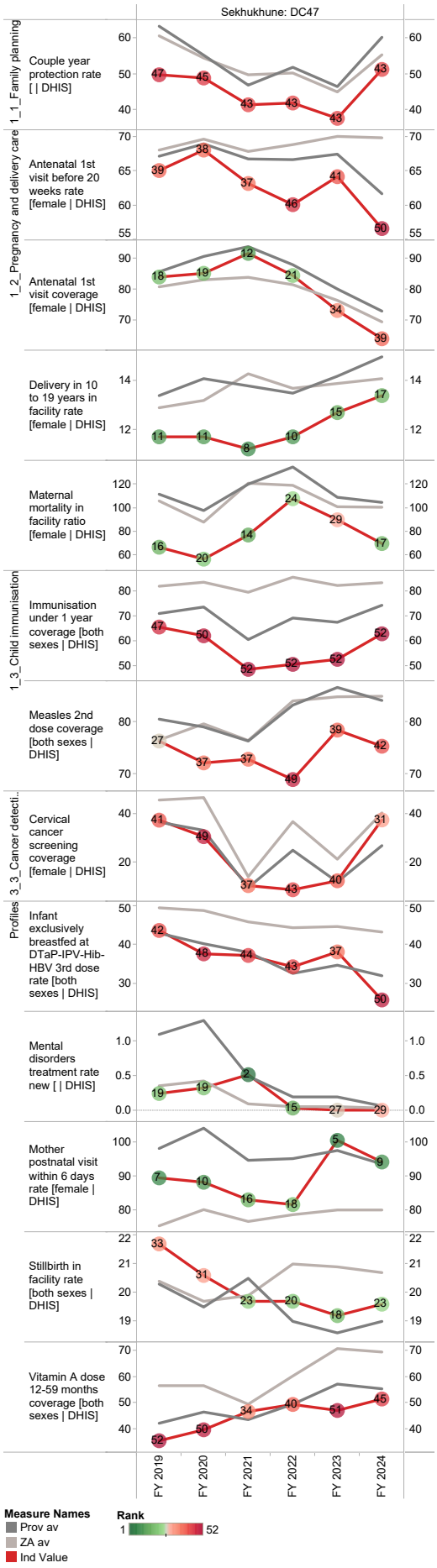
10 Mid-year Population Estimates 2023, DHIS.

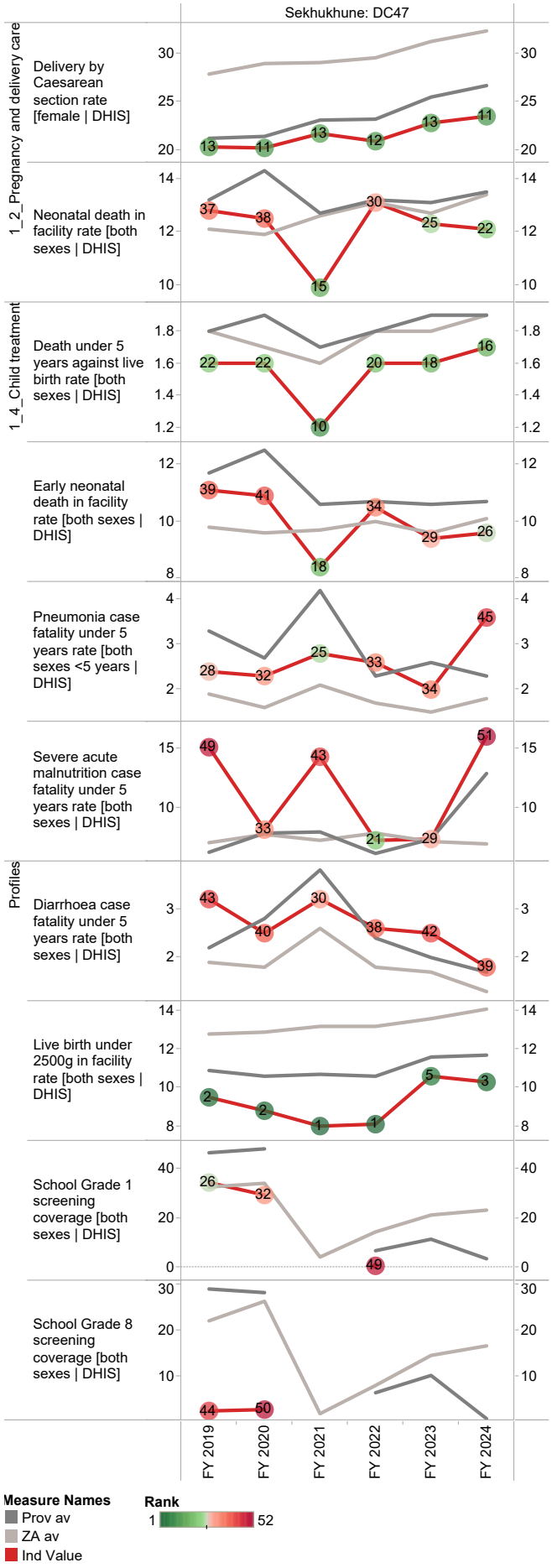
Population distribution, sub-district boundaries and health facility locations

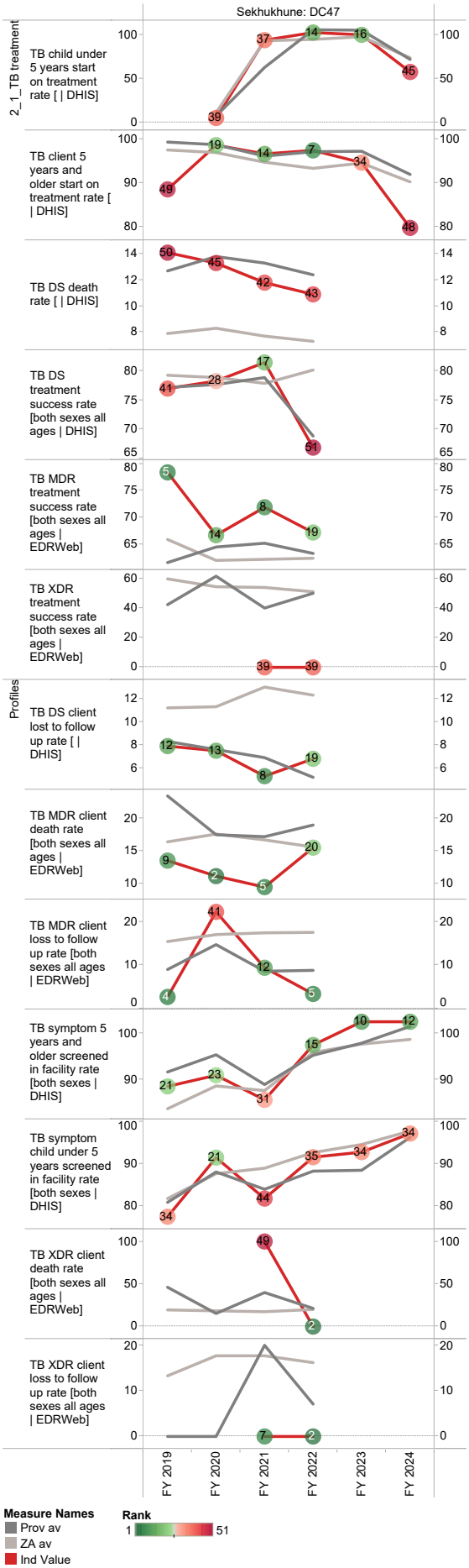


Source: DHIS

Annual trends, 2018/19–2023/24






Sekhukhune: DC47
2_1_TB treatment
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
TB DS death rate [| DHIS]
TB DS treatment success rate [both sexes all ages | DHIS]
TB MDR treatment success rate [both sexes all ages | EDRWeb]
TB XDR treatment success rate [both sexes all ages | EDRWeb]
Profiles
TB DS client lost to follow up rate [| DHIS]
TB MDR client death rate [both sexes all ages | EDRWeb]
TB MDR client loss to follow up rate [both sexes all ages | EDRWeb]
TB symptom 5 years and older screened in facility rate [both sexes | DHIS]
TB symptom child under 5 years screened in facility rate [both sexes | DHIS]
TB XDR client death rate [both sexes all ages | EDRWeb]
TB XDR client loss to follow up rate [both sexes all ages | EDRWeb]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
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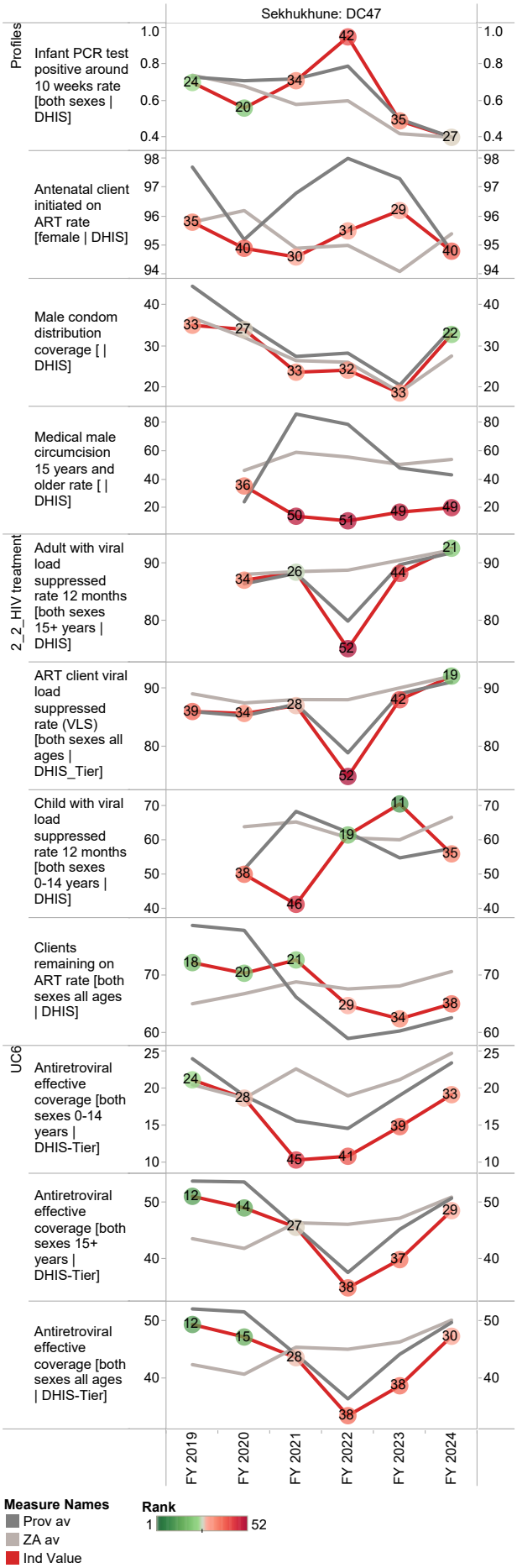
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Profiles
Infant PCR test positive around 10 weeks rate [both sexes | DHIS]
Antenatal client initiated on ART rate [female | DHIS]
Male condom distribution coverage [| DHIS]
Medical male circumcision 15 years and older rate [| DHIS]
2_2_HIV treatment
Adult with viral load suppressed rate 12 months [both sexes 15+ years | DHIS]
ART client viral load suppressed rate (VLS) [both sexes all ages | DHIS_Tier]
Child with viral load suppressed rate 12 months [both sexes 0-14 years | DHIS]
Clients remaining on ART rate [both sexes all ages | DHIS]
UC6
Antiretroviral effective coverage [both sexes 0-14 years | DHIS-Tier]
Antiretroviral effective coverage [both sexes 15+ years | DHIS-Tier]
Antiretroviral effective coverage [both sexes all ages | DHIS-Tier]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
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ZA av
Ind Value
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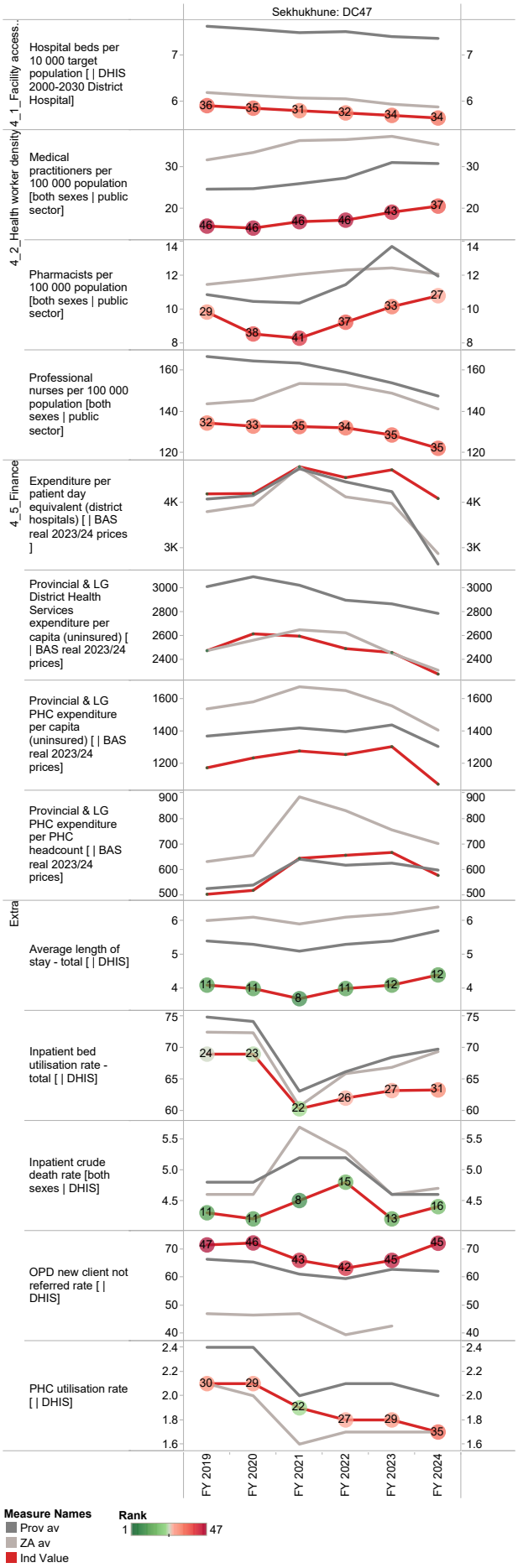

Sekhukhune: DC47
4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
4_2_Health worker density
Medical practitioners per 100 000 population [both sexes | public sector]
Pharmacists per 100 000 population [both sexes | public sector]
Professional nurses per 100 000 population [both sexes | public sector]
4_5_Finance
Expenditure per patient day equivalent (district hospitals) [| BAS real 2023/24 prices]
Provincial & LG District Health Services expenditure per capita (uninsured) [| BAS real 2023/24 prices]
Provincial & LG PHC expenditure per capita (uninsured) [| BAS real 2023/24 prices]
Provincial & LG PHC expenditure per PHC headcount [| BAS real 2023/24 prices]
Extra
Average length of stay - total [| DHIS]
Inpatient bed utilisation rate - total [| DHIS]
Inpatient crude death rate [both sexes | DHIS]
OPD new client not referred rate [| DHIS]
PHC utilisation rate [| DHIS]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
1
47

12 Mpumalanga Province

Gert Sibande District Municipality (DC30)

The Gert Sibande District Municipality[1] is Category C municipality located in the Mpumalanga Province and borders eSwatini. It comprises seven local municipalities: Govan Mbeki, Chief Albert Luthuli, Msukaligwa, Dipaleseng, Mkhondo, Lekwa and Dr Pixley Ka Seme.

Area: 31 840km²

Population (2023)[2]: 1 304 284

Households[1]: 333 815

Formal dwellings[1]: 78.0%

Cities/Towns:

Govan Mbeki: Bethal, Charl Cilliers, Embalenhle, Evander, Kinross, Leandra, Secunda, Trichardt

Chief Albert Luthuli: Carolina, Ekulindeni, Empuluzi, eManzana,

Msukaligwa: Breyten, Chrissiesmeer, Davel, Ermelo, Lothair

Dipaleseng: Balfour, Greylingstad, Grootvlei

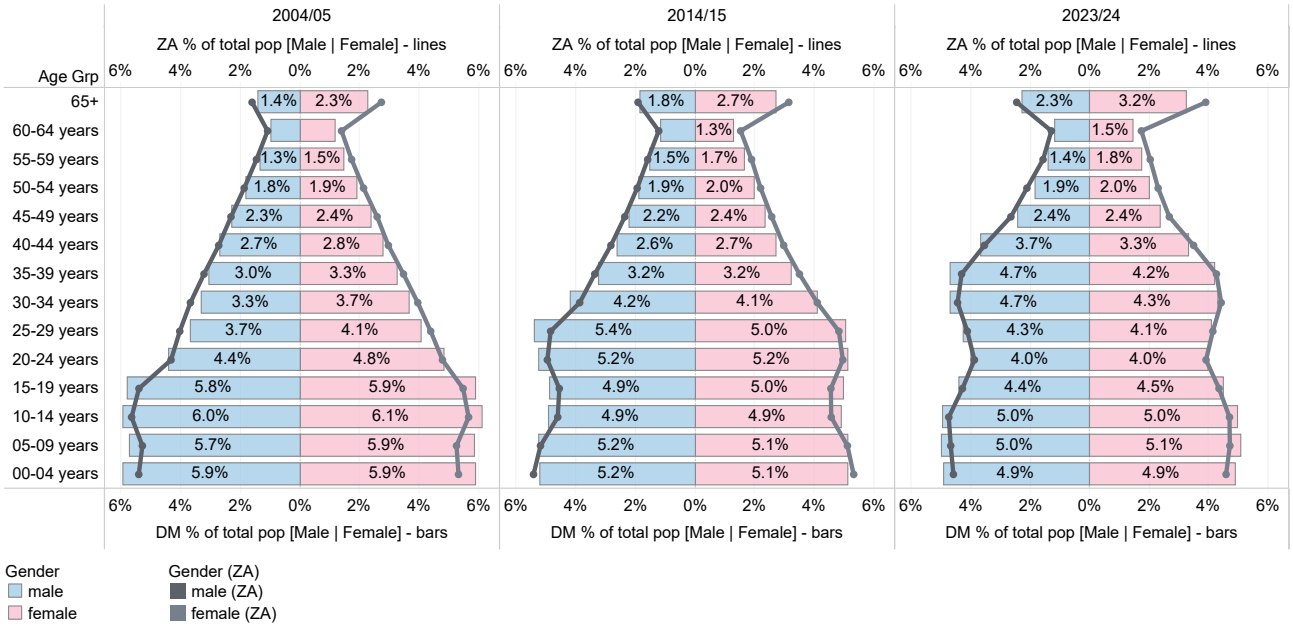
Mkhondo: Amsterdam, eMkhondo (Piet Retief)

Lekwa: Morgenzon, Standerton

Dr Pixley Ka Seme: Amersfoort, Perdekop, Volksrust, Wakkerstroom

District percentage population by age-gender group compared to South Africa

G Sibande DM (DC30)

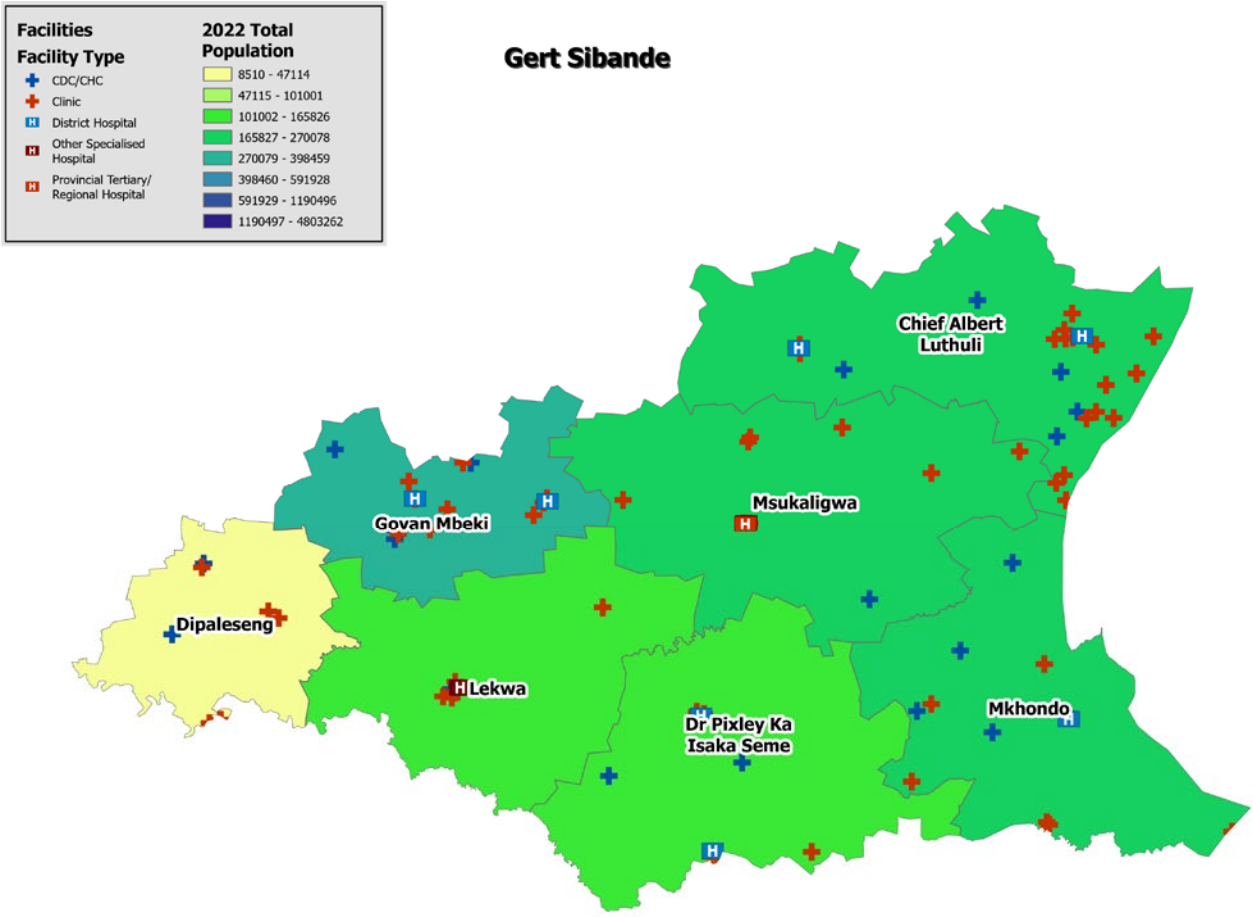


Source: DHIS

1 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

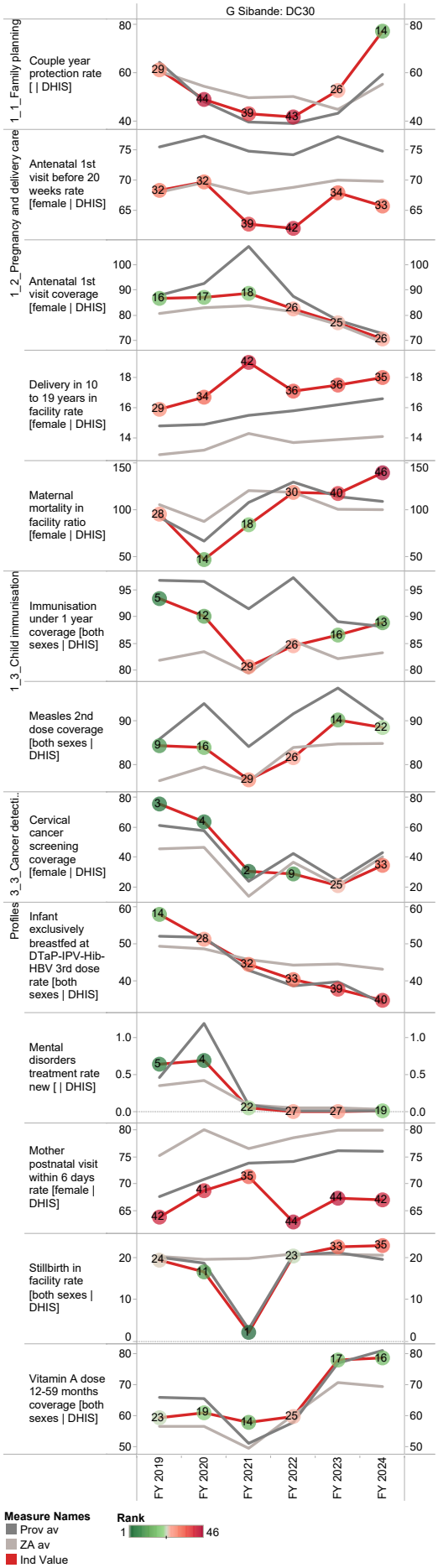
2 Mid-year Population Estimates 2023, DHIS.

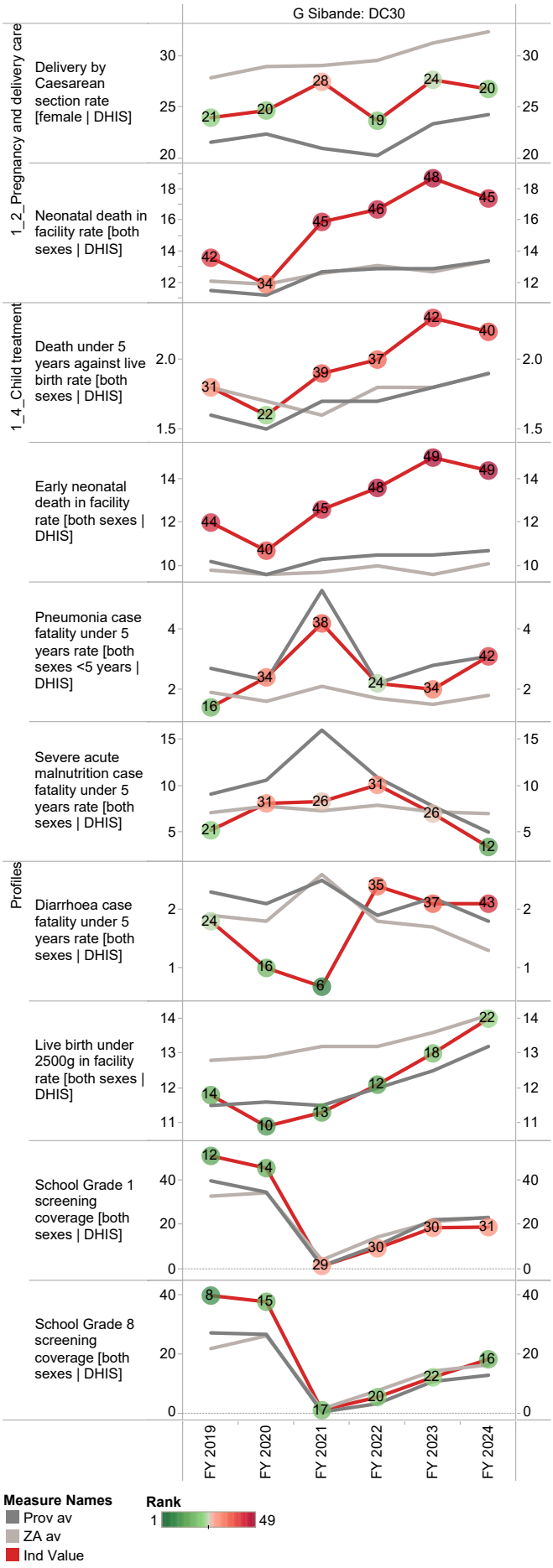
Population distribution, sub-district boundaries and health facility locations

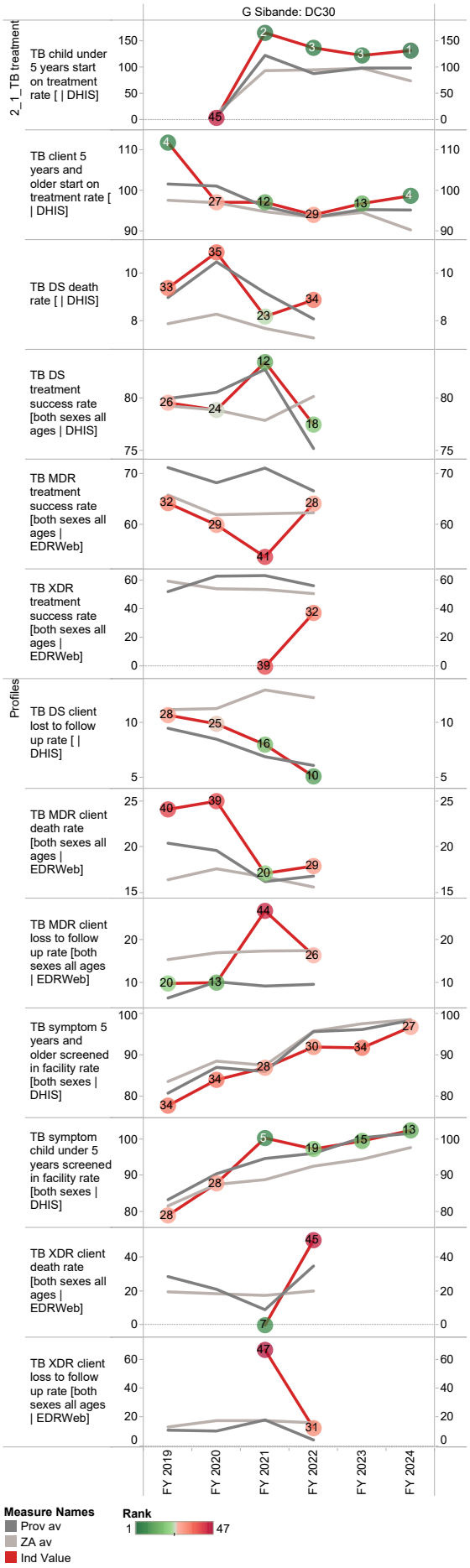


Source: DHIS

Annual trends, 2018/19–2023/24






G Sibande: DC30
2_1_TB treatment
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
TB DS death rate [| DHIS]
TB DS treatment success rate [both sexes all ages | DHIS]
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TB DS client lost to follow up rate [| DHIS]
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TB symptom 5 years and older screened in facility rate [both sexes | DHIS]
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FY 2019
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Measure Names
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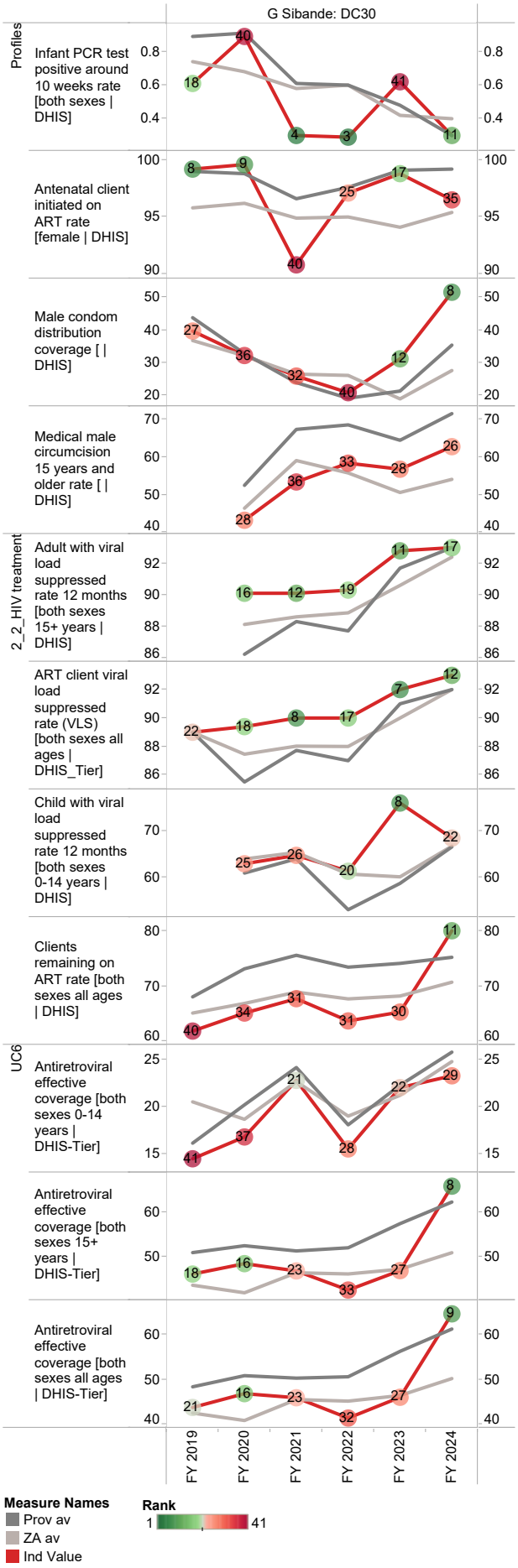
G Sibande: DC30
Profiles
Infant PCR test positive around 10 weeks rate [both sexes | DHIS]
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UC6
Antiretroviral effective coverage [both sexes 0-14 years | DHIS-Tier]
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Antiretroviral effective coverage [both sexes all ages | DHIS-Tier]
FY 2019
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FY 2024
Measure Names
Prov av
ZA av
Ind Value
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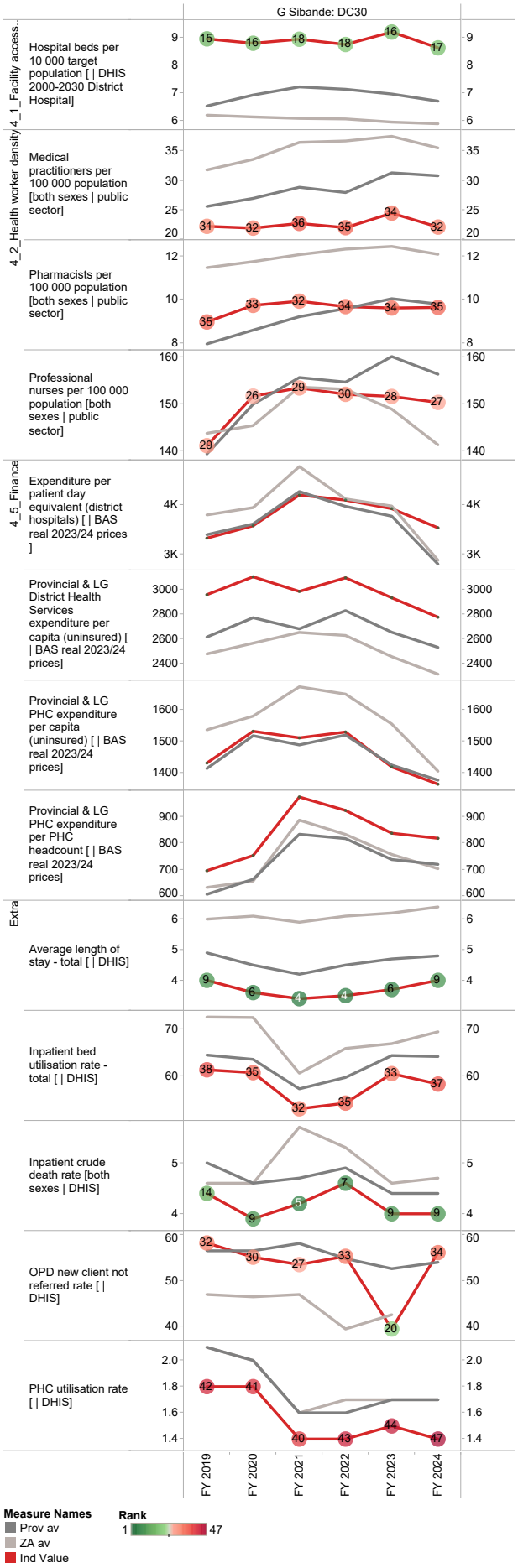
G Sibande: DC30
4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
4_2_Health worker density
Medical practitioners per 100 000 population [both sexes | public sector]
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PHC utilisation rate [| DHIS]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
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Ind Value
Rank
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47

Nkangala District Municipality (DC31)

The Nkangala District Municipality[3] is a Category C municipality in the Mpumalanga Province. It is the smallest district of the three in the province, and consists of six local municipalities: Victor Khanye, Emalahleni, Steve Tshwete, Emakhazeni, Thembisile Hani, and Dr JS Moroka.

Area: 16 758km²

Population (2023)[4]: 1 708 843

Households[3]: 421 144

Formal dwellings[3]: 81.6%

Cities/Towns:

Victor Khanye: Delmas

Emalahleni: Kriel, Ogies, eMalahleni

Steve Tshwete: Hendrina, Middelburg, Pullens Hope, Rietkuil

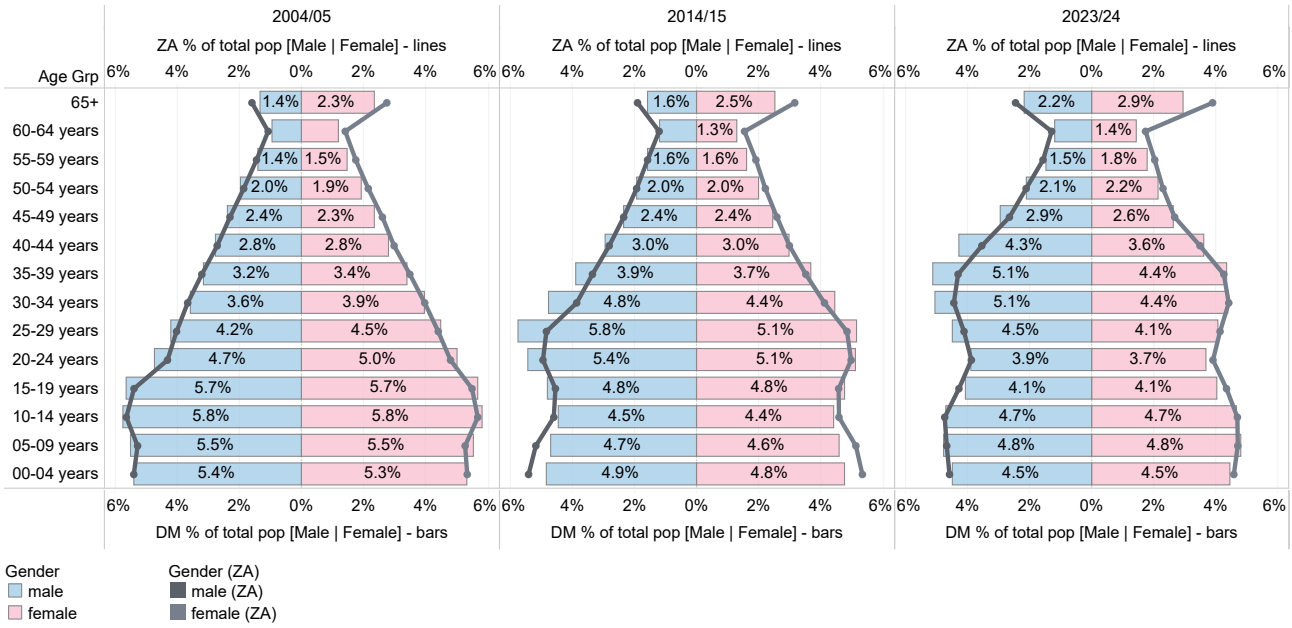
Emakhazeni: Dullstroom, Emgwenya (Waterval Boven), eMakhazeni, eNtokozweni (Machadodorp)

Thembisile Hani: KwaMhlanga

Dr JS Moroka: Mdala Nature Reserve

District percentage population by age-gender group compared to South Africa

Nkangala DM (DC31)

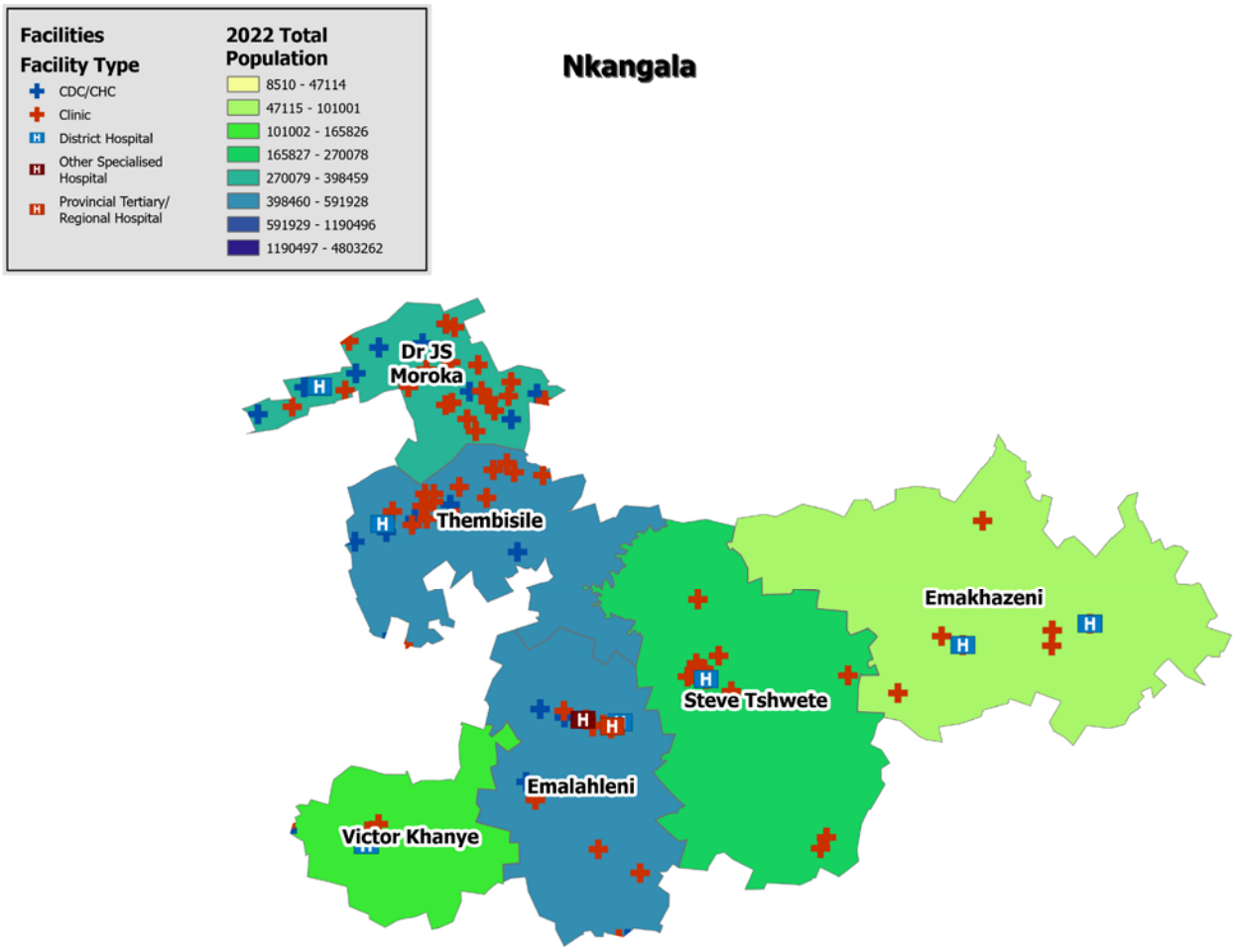


Source: DHIS

3 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

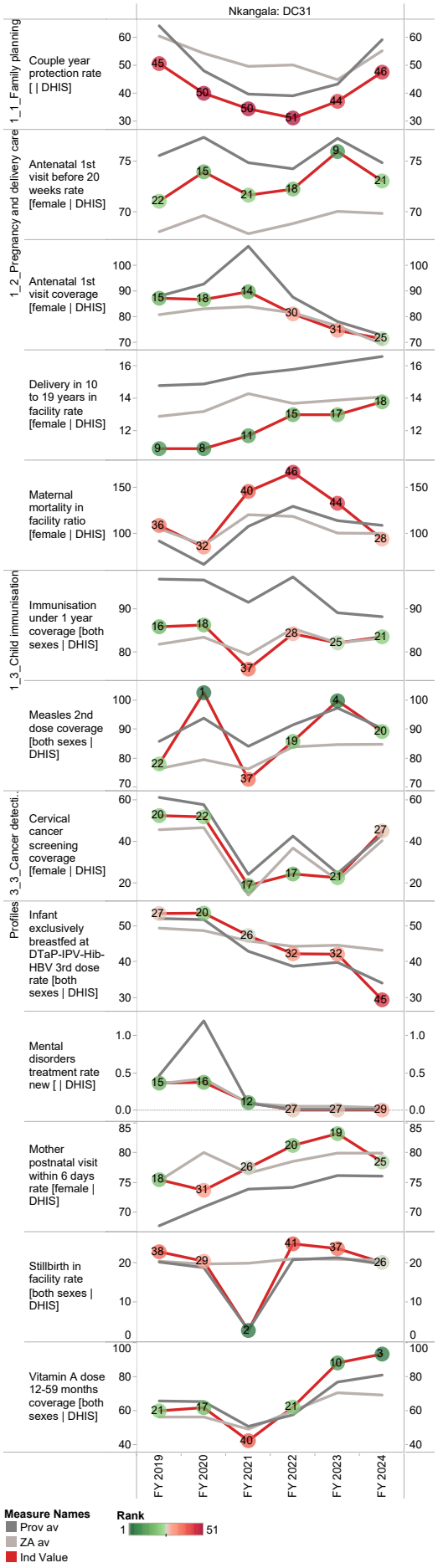
4 Mid-year Population Estimates 2023, DHIS.

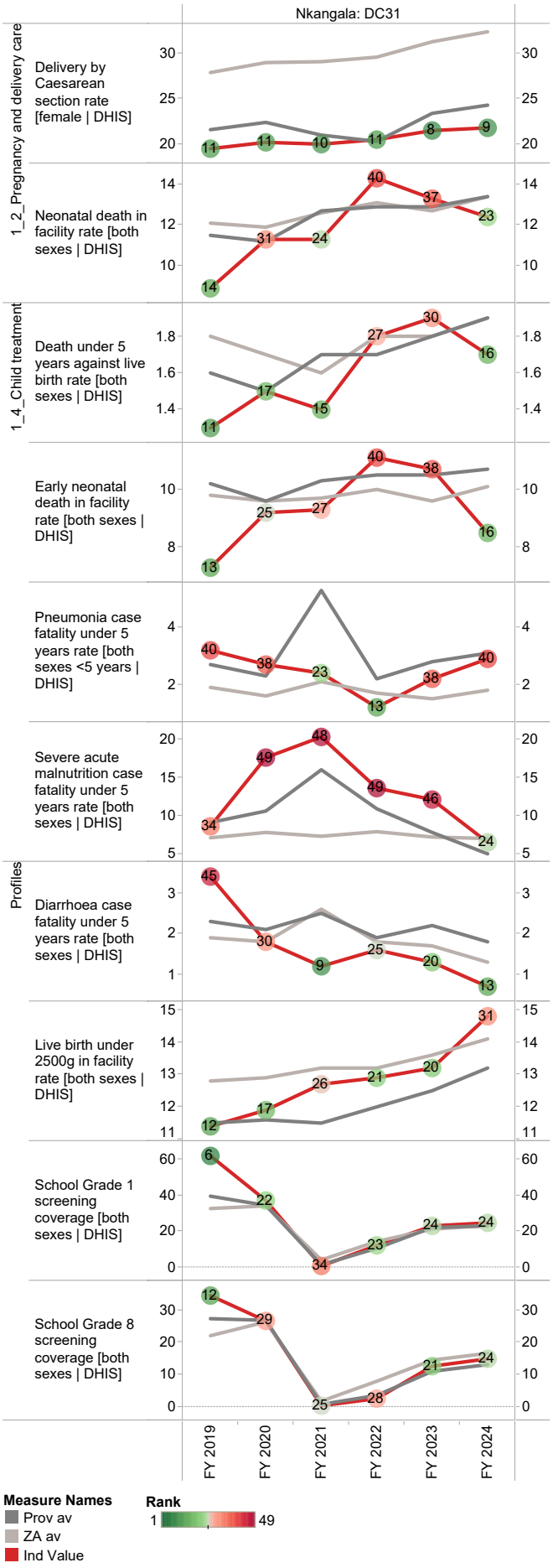
Population distribution, sub-district boundaries and health facility locations

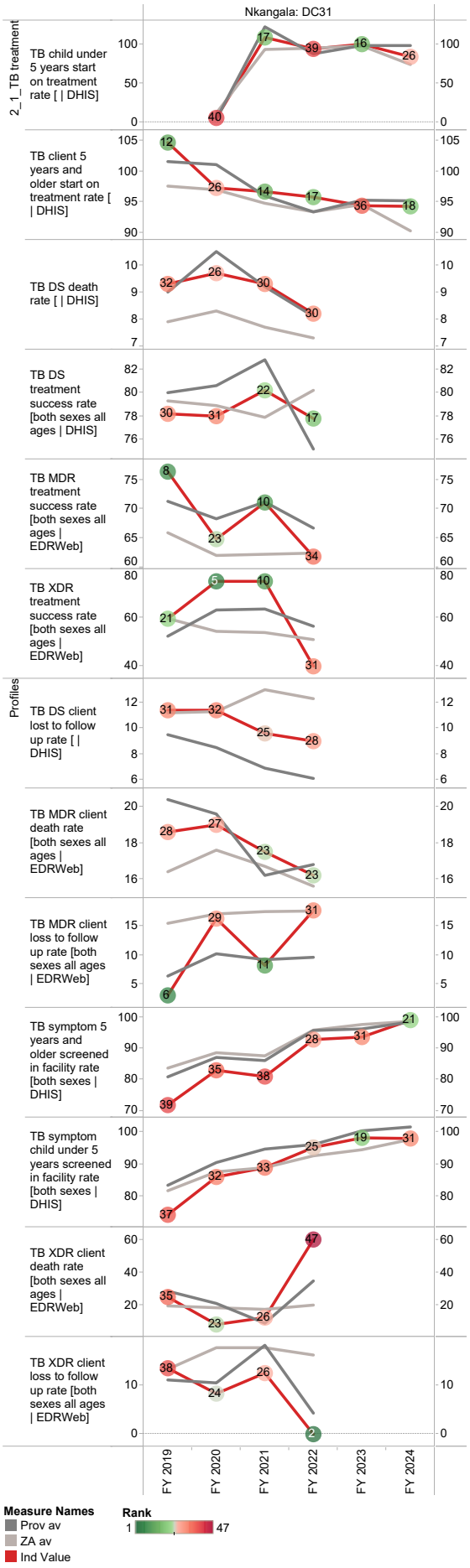


Source: DHIS

Annual trends, 2018/19–2023/24



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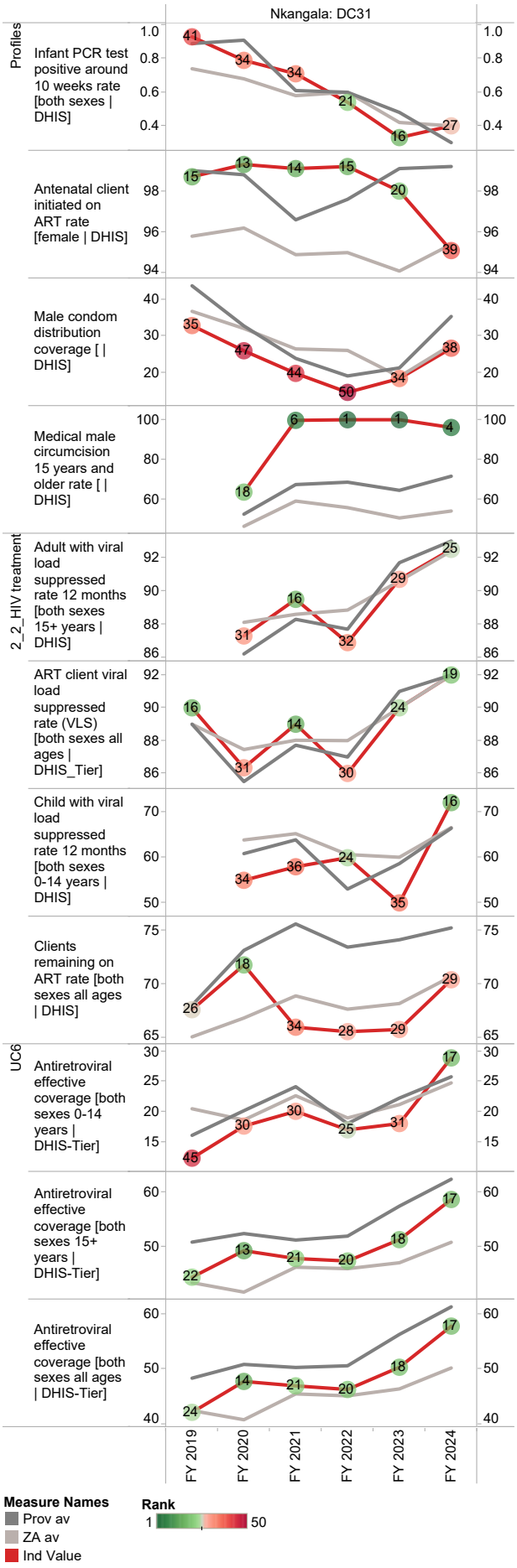
2_1_TB treatment
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
TB DS death rate [| DHIS]
TB DS treatment success rate [both sexes all ages | DHIS]
TB MDR treatment success rate [both sexes all ages | EDRWeb]
TB XDR treatment success rate [both sexes all ages | EDRWeb]
Profiles
TB DS client lost to follow up rate [| DHIS]
TB MDR client death rate [both sexes all ages | EDRWeb]
TB MDR client loss to follow up rate [both sexes all ages | EDRWeb]
TB symptom 5 years and older screened in facility rate [both sexes | DHIS]
TB symptom child under 5 years screened in facility rate [both sexes | DHIS]
TB XDR client death rate [both sexes all ages | EDRWeb]
TB XDR client loss to follow up rate [both sexes all ages | EDRWeb]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
1
47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Profiles
Infant PCR test positive around 10 weeks rate [both sexes | DHIS]
Antenatal client initiated on ART rate [female | DHIS]
Male condom distribution coverage [| DHIS]
Medical male circumcision 15 years and older rate [| DHIS]
2_2_HIV treatment
Adult with viral load suppressed rate 12 months [both sexes 15+ years | DHIS]
ART client viral load suppressed rate (VLS) [both sexes all ages | DHIS_Tier]
Child with viral load suppressed rate 12 months [both sexes 0-14 years | DHIS]
Clients remaining on ART rate [both sexes all ages | DHIS]
UC6
Antiretroviral effective coverage [both sexes 0-14 years | DHIS-Tier]
Antiretroviral effective coverage [both sexes 15+ years | DHIS-Tier]
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FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
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ZA av
Ind Value
Rank
1
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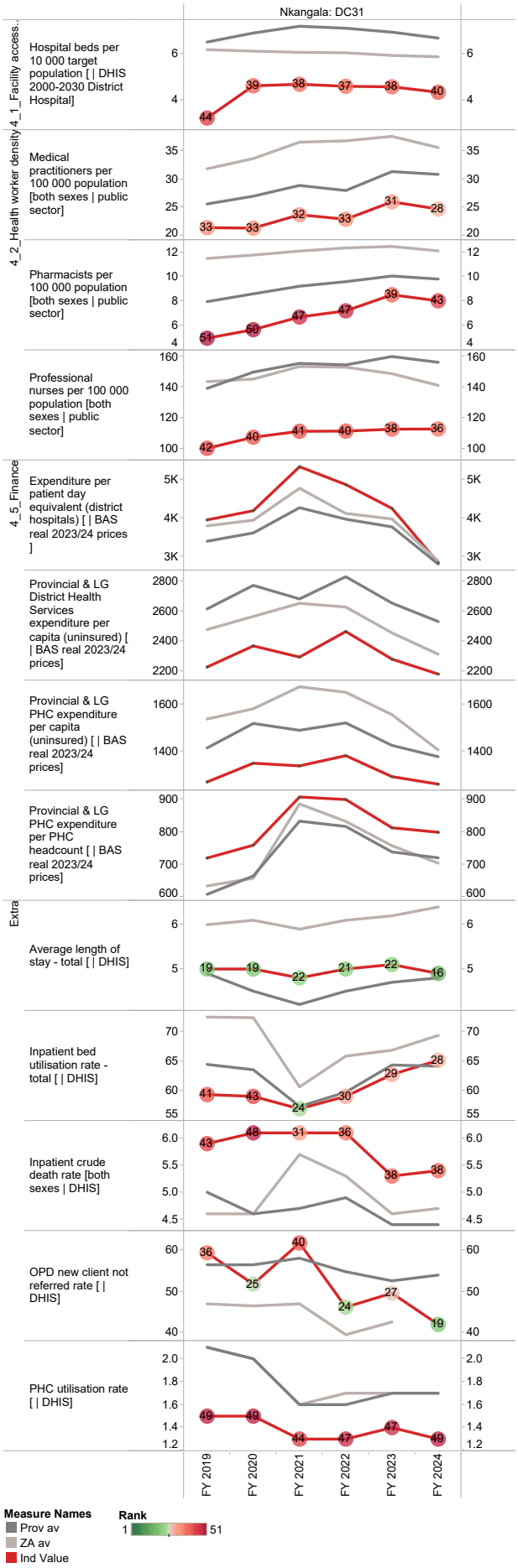
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4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
4_2_Health worker density
Medical practitioners per 100 000 population [both sexes | public sector]
Pharmacists per 100 000 population [both sexes | public sector]
Professional nurses per 100 000 population [both sexes | public sector]
4_5_Finance
Expenditure per patient day equivalent (district hospitals) [| BAS real 2023/24 prices]
Provincial & LG District Health Services expenditure per capita (uninsured) [| BAS real 2023/24 prices]
Provincial & LG PHC expenditure per capita (uninsured) [| BAS real 2023/24 prices]
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Extra
Average length of stay - total [| DHIS]
Inpatient bed utilisation rate - total [| DHIS]
Inpatient crude death rate [both sexes | DHIS]
OPD new client not referred rate [| DHIS]
PHC utilisation rate [| DHIS]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
1
51

Ehlanzeni District Municipality (DC32)

The Ehlanzeni District Municipality[5] is a Category C municipality situated in the north-east of the Mpumalanga Province. The district comprises four local municipalities: Bushbuckridge, City of Mbombela, Nkomazi and Thaba Chweu.

Area: 27 895km²

Population (2023)[6]: 1 866 920

Households[5]: 483 903

Formal dwellings[5]: 91.9%

Cities/Towns:

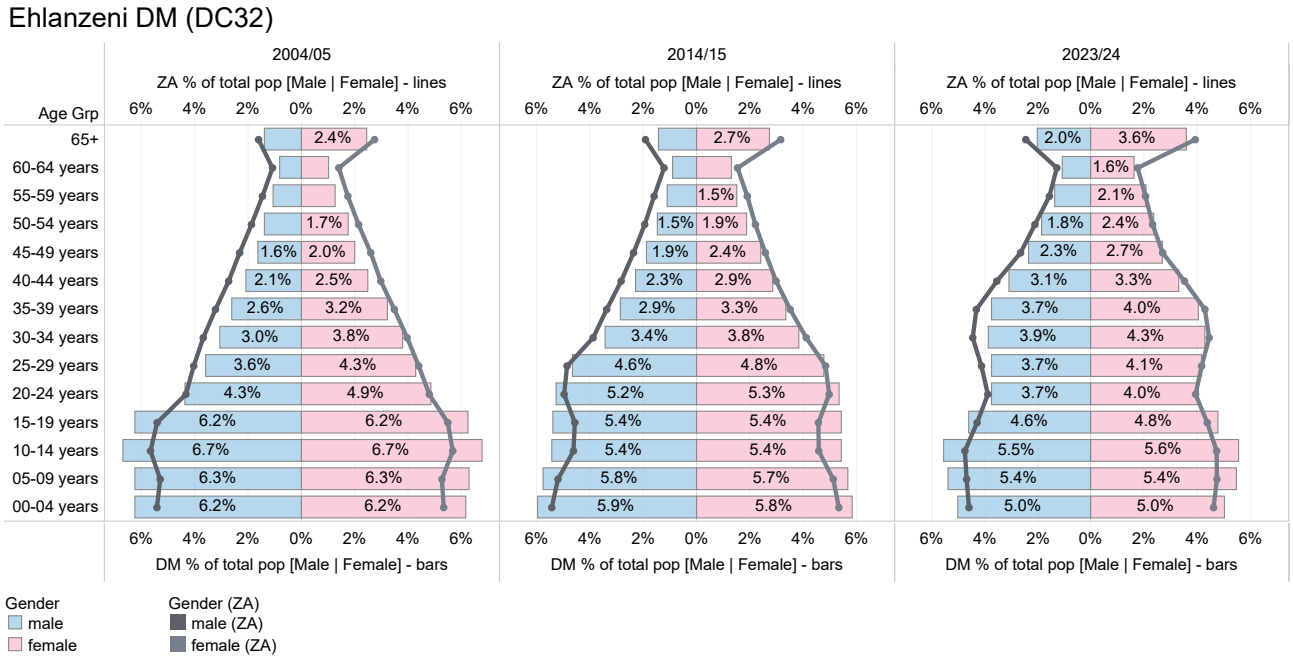
Bushbuckridge: Sabie Park

City of Mbombela: Barberton, Emoyeni, Entokozweni, Hazyview, Kaapschehoop, Kabokweni, Kanyamazane, Luphisi, Matsulu, Mbombela, Mpakeni, Msogwaba, Ngodwana, Skukuza, Tekwane, White River

Nkomazi: Komatipoort, Malalane, Marloth Park

Thaba Chweu: Graskop, Lydenburg, Mashishing, Pilgrim's Rest, Sabie

District percentage population by age-gender group compared to South Africa

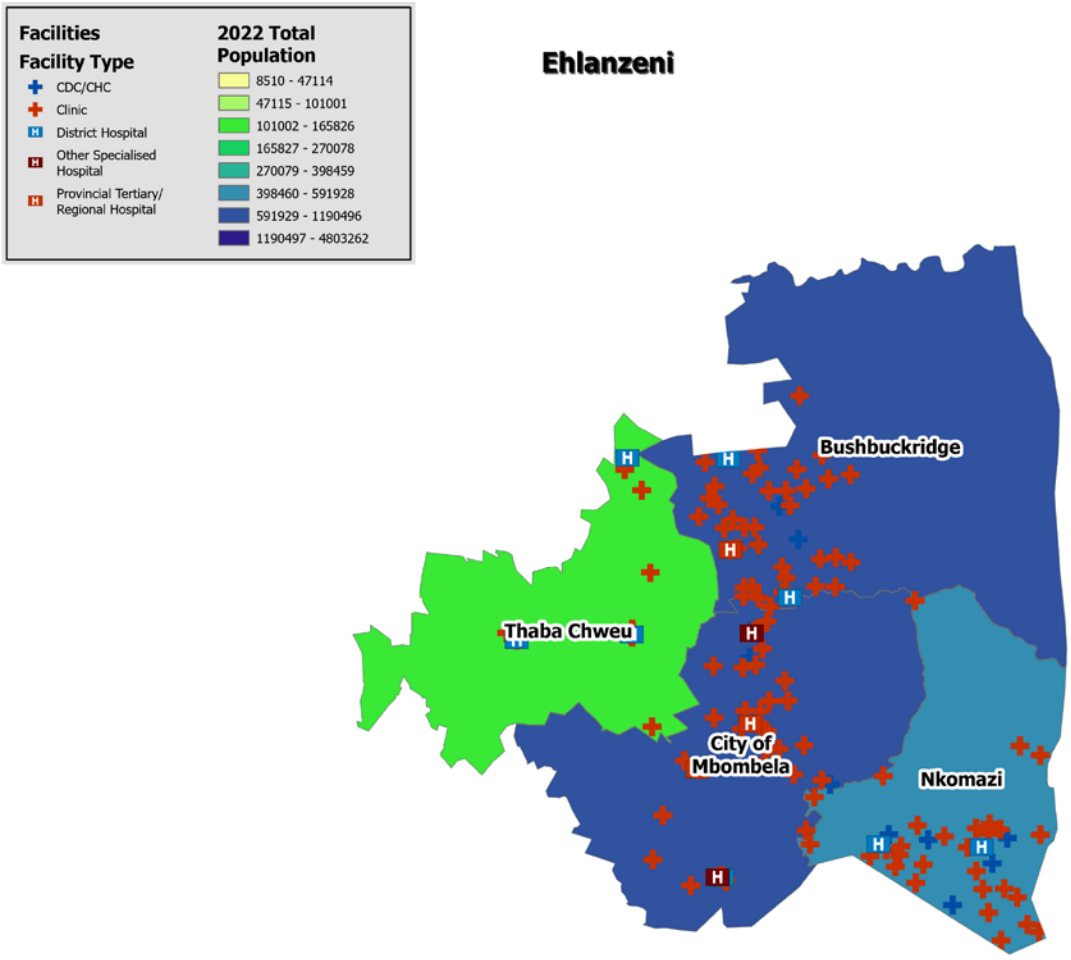


Source: DHIS

5 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

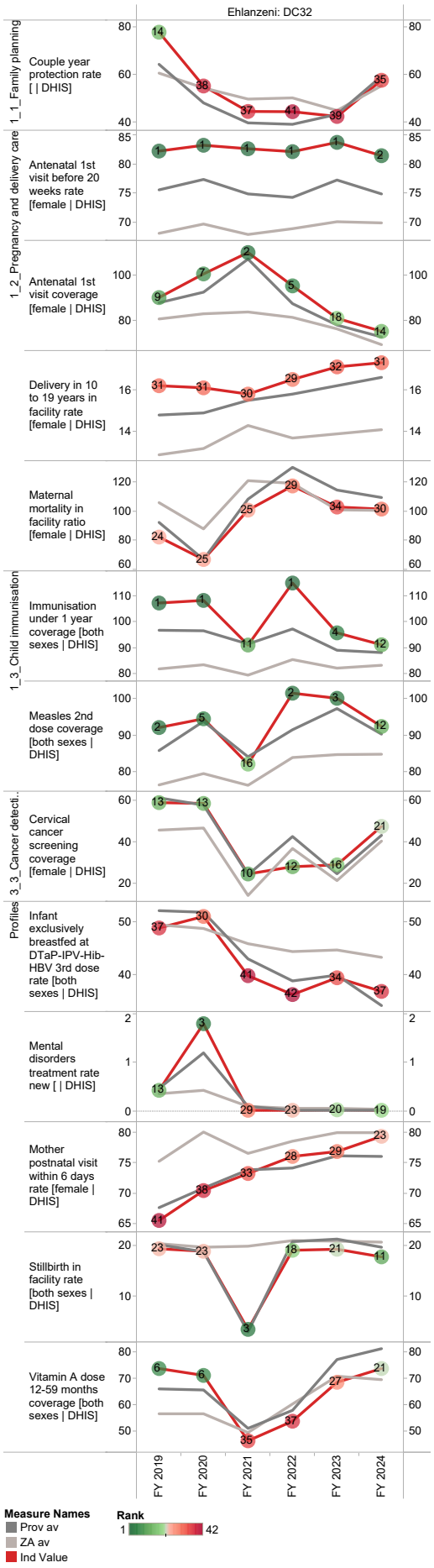
6 Mid-year Population Estimates 2023, DHIS.

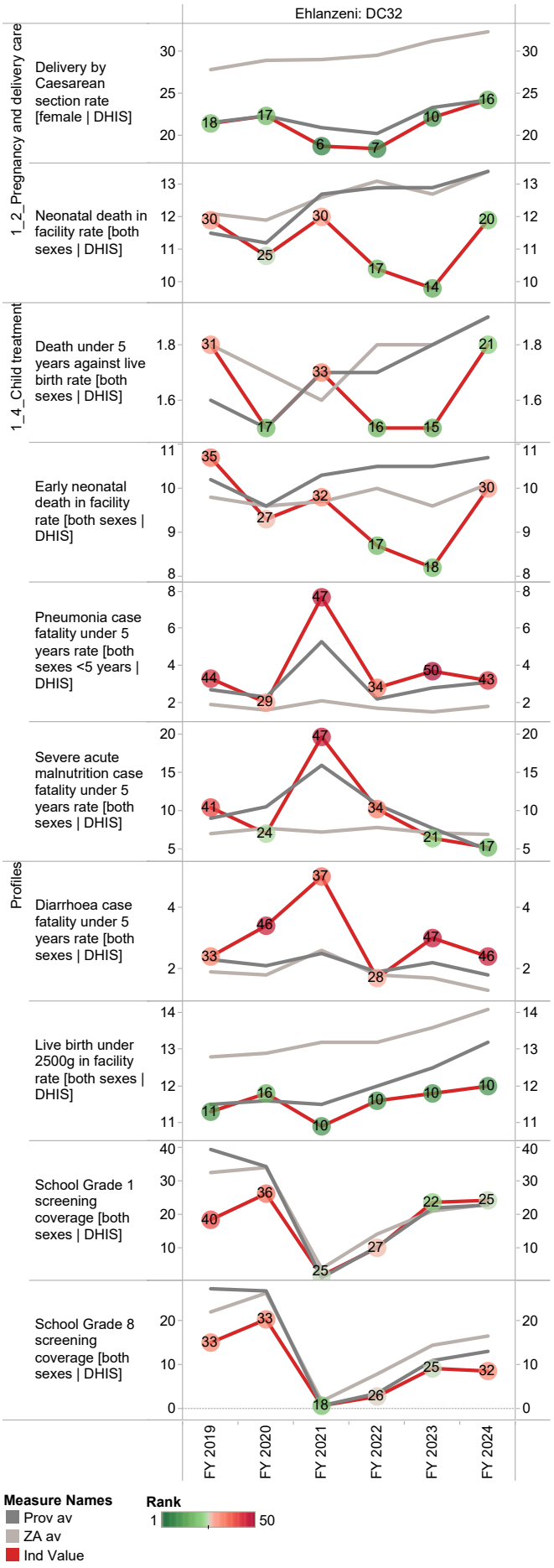
Population distribution, sub-district boundaries and health facility locations

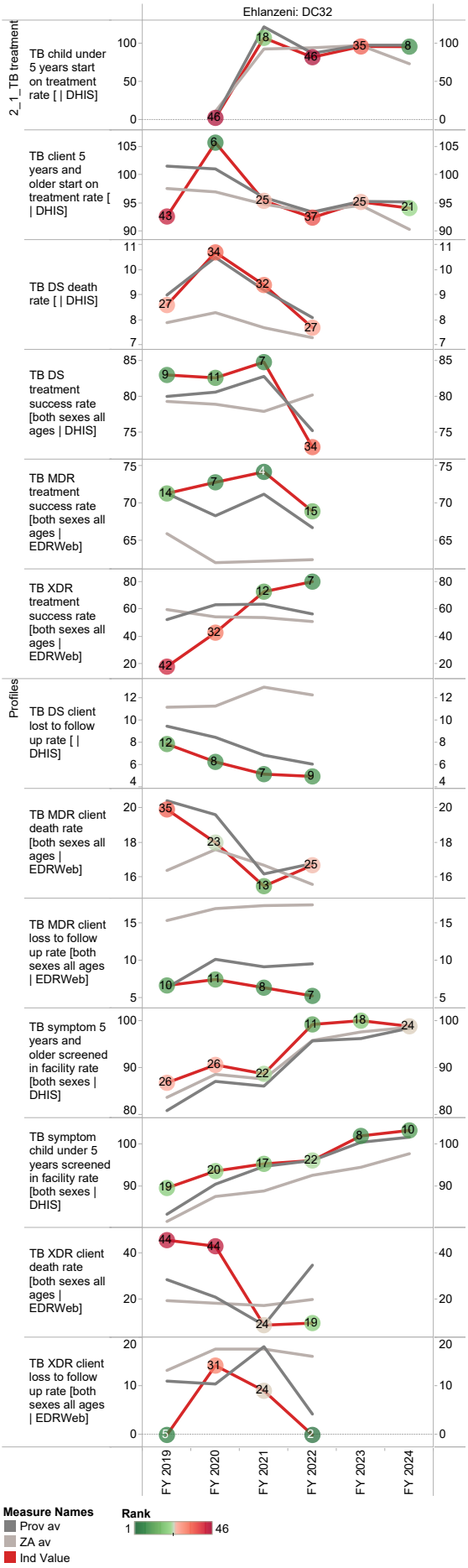


Source: DHIS

Annual trends, 2018/19–2023/24






Ehlanzeni: DC32
2_1_TB treatment
Profiles
TB child under 5 years start on treatment rate [| DHIS]
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TB DS death rate [| DHIS]
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FY 2019
FY 2020
FY 2021
FY 2022
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FY 2024
Measure Names
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ZA av
Ind Value
Rank
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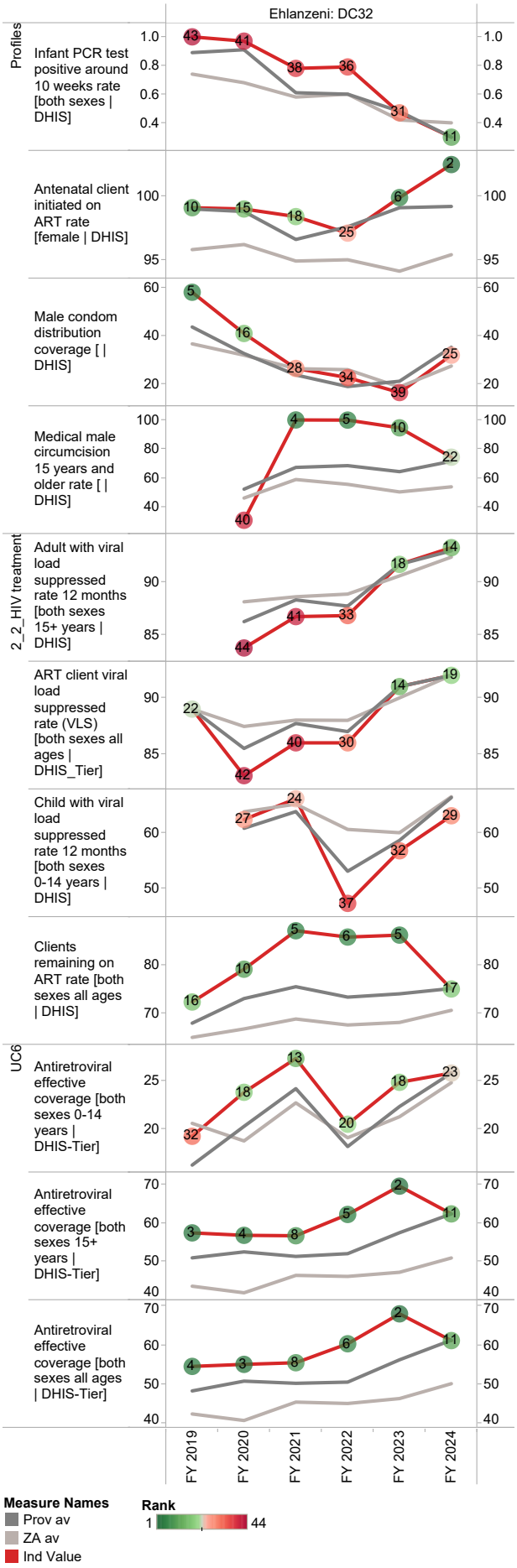
46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Antiretroviral effective coverage [both sexes all ages | DHIS-Tier]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
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ZA av
Ind Value
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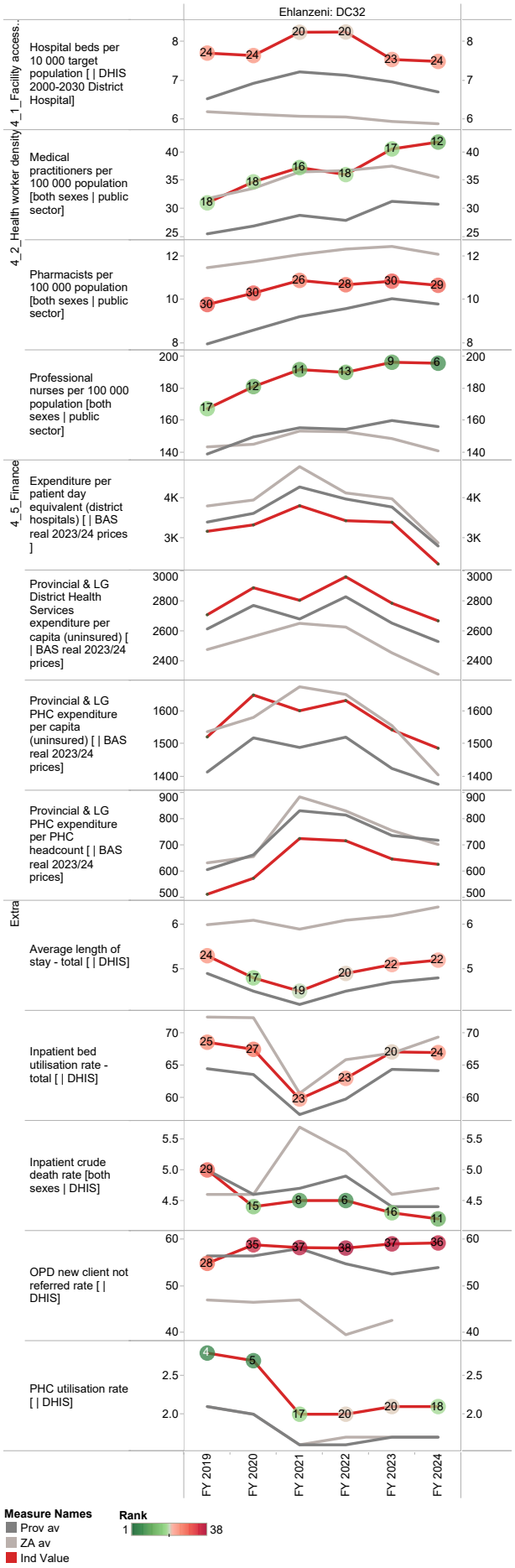
Ehlanzeni: DC32
4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
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PHC utilisation rate [| DHIS]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
1
38

13 Northern Cape Province

John Taolo Gaetsewe District Municipality (DC45)

The John Taolo Gaetsewe District Municipality[1] is a Category C municipality located in the north of the Northern Cape Province, bordering Botswana in the west. It comprises the three local municipalities of Gamagara, Ga-Segonyana and Joe Morolong.

Area: 27 323km²

Population (2023)[2]: 283 463

Households[1]: 73 310

Formal dwellings[1]: 80.6%

Cities/Towns:

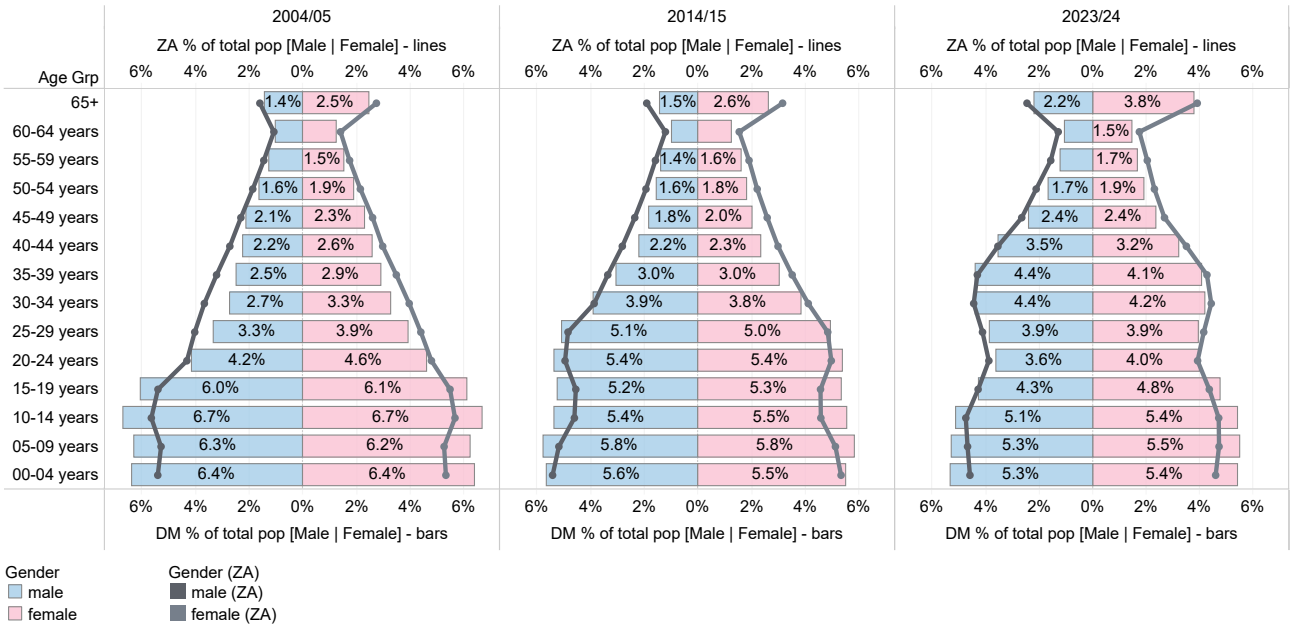
Gamagara: Deben, Kathu, Olifantshoek

Ga-Segonyana: Bankhara-Bodulong, Kuruman, Mothibistad

Joe Morolong: Hotazel, Santoy, Van Zylsrus

District percentage population by age-gender group compared to South Africa

JT Gaetsewe DM (DC45)

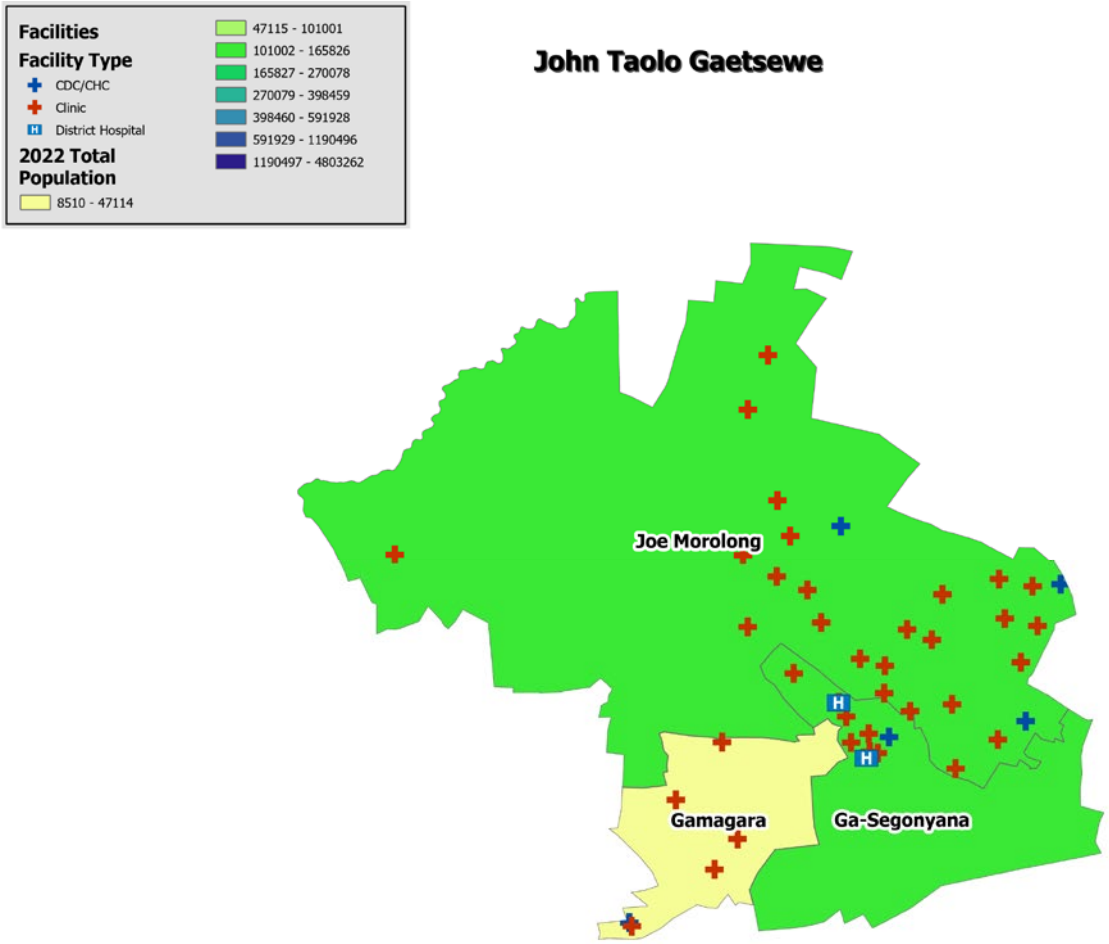


Source: DHIS

1 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

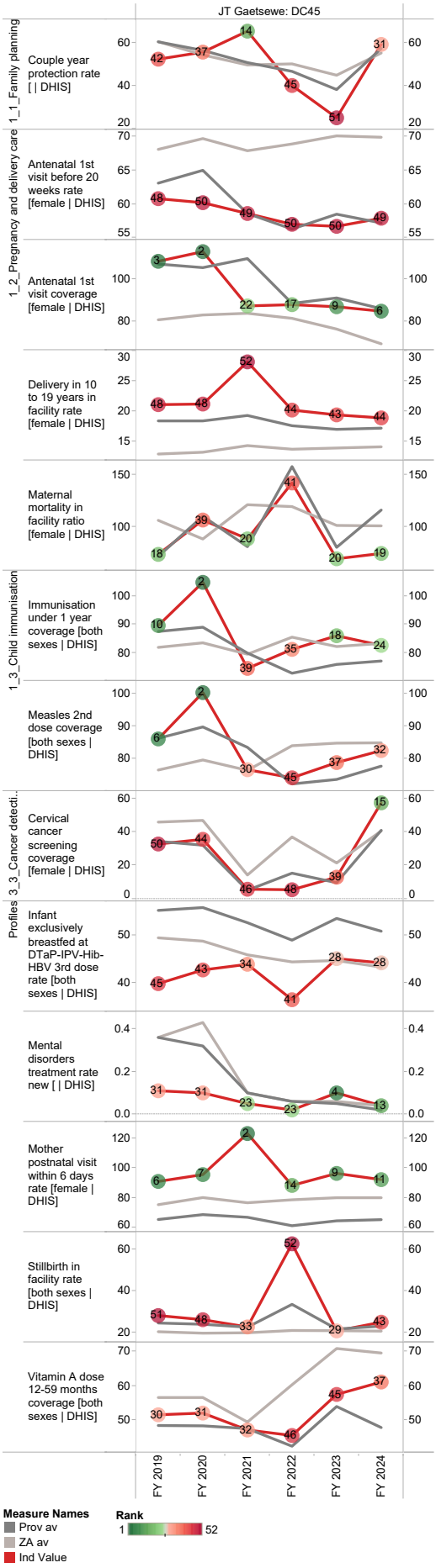
2 Mid-year Population Estimates 2023, DHIS.

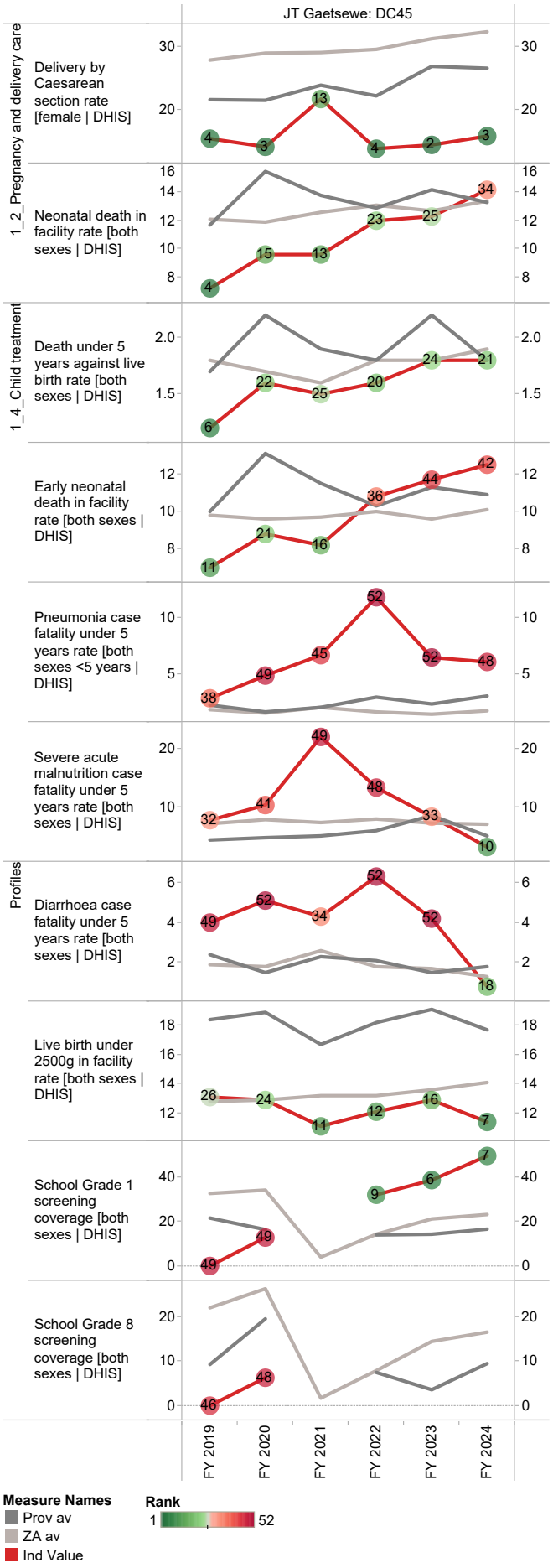
Population distribution, sub-district boundaries and health facility locations

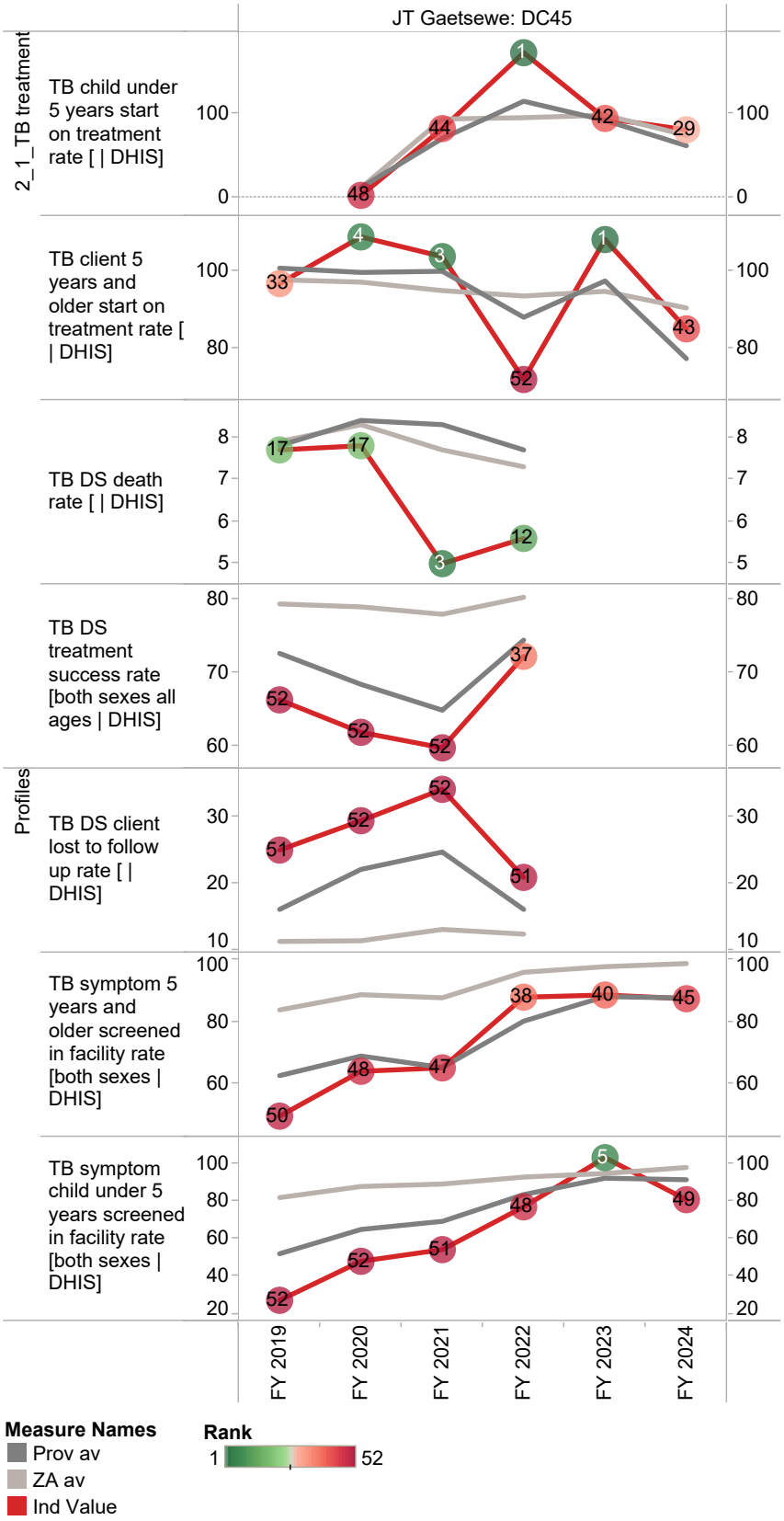


Source: DHIS

Annual trends, 2014/19–2023/24






JT Gaetsewe: DC45
2_1_TB treatment
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
TB DS death rate [| DHIS]
TB DS treatment success rate [both sexes all ages | DHIS]
Profiles
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TB symptom 5 years and older screened in facility rate [both sexes | DHIS]
TB symptom child under 5 years screened in facility rate [both sexes | DHIS]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
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Ind Value
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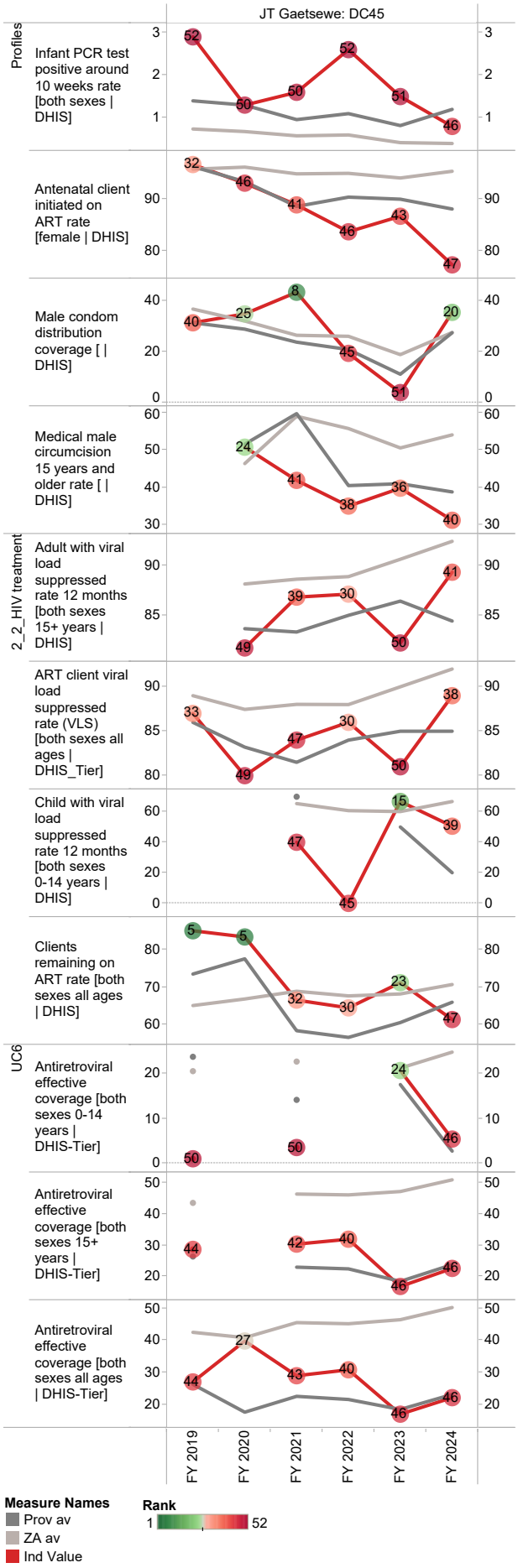
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FY 2019
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FY 2022
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FY 2024
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Ind Value
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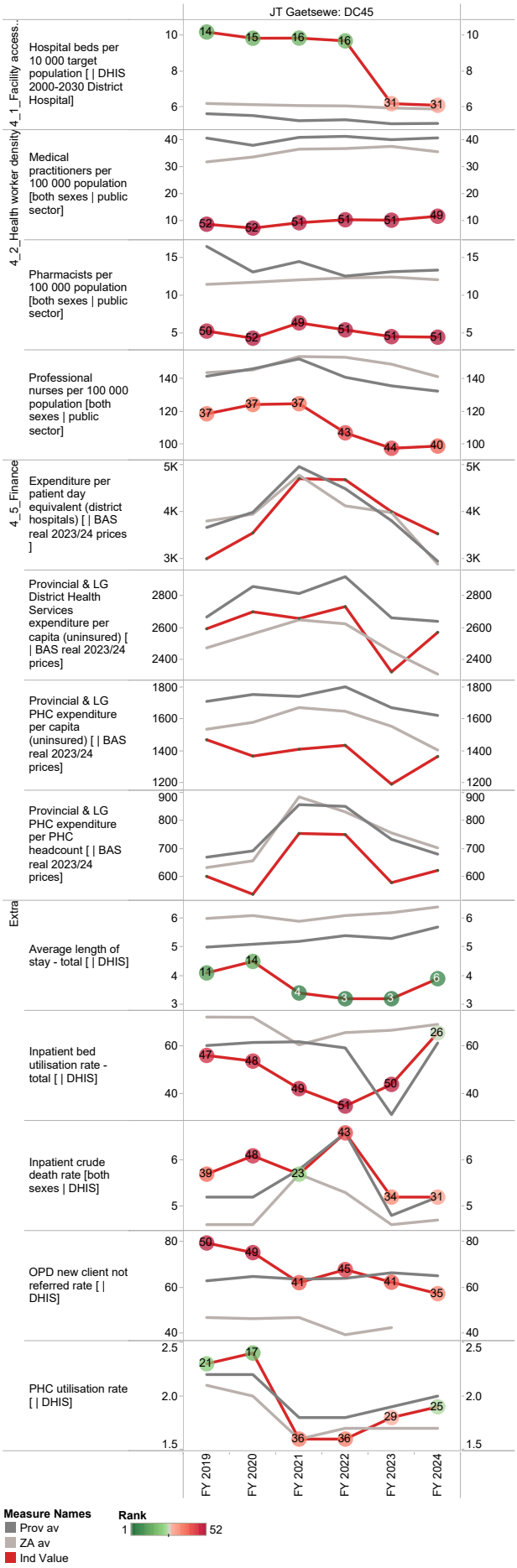
JT Gaetsewe: DC45
4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
4_2_Health worker density
Medical practitioners per 100 000 population [both sexes | public sector]
Pharmacists per 100 000 population [both sexes | public sector]
Professional nurses per 100 000 population [both sexes | public sector]
4_5_Finance
Expenditure per patient day equivalent (district hospitals) [| BAS real 2023/24 prices]
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PHC utilisation rate [| DHIS]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
1
52

Namakwa District Municipality (DC6)

The Namakwa District Municipality[3] is a Category C municipality located in the Northern Cape Province. It is bordered by the Republic of Namibia in the north and is the largest district in the province, making up over a third of its geographical area. It comprises six local municipalities: Nama Khoi, Hantam, Khai-Ma, Kamiesberg, Karoo Hoogland and Richtersveld.

Area: 126 836km²

Population (2023)[4]: 114 367

Households[3]: 37 669

Formal dwellings[3]: 95.2%

Cities/Towns:

Nama Khoi: Bulletrap, Carolusberg, Concordia, Kleinzee, Komaggas, Nababeep, O'Kiep, Springbok, Steinkopf

Hantam: Brandvlei, Calvinia, Loeriesfontein, Middelpos, Nieuwoudtville, Onderste Doorns

Khai-Ma: Aggeneys, Pella, Pofadder

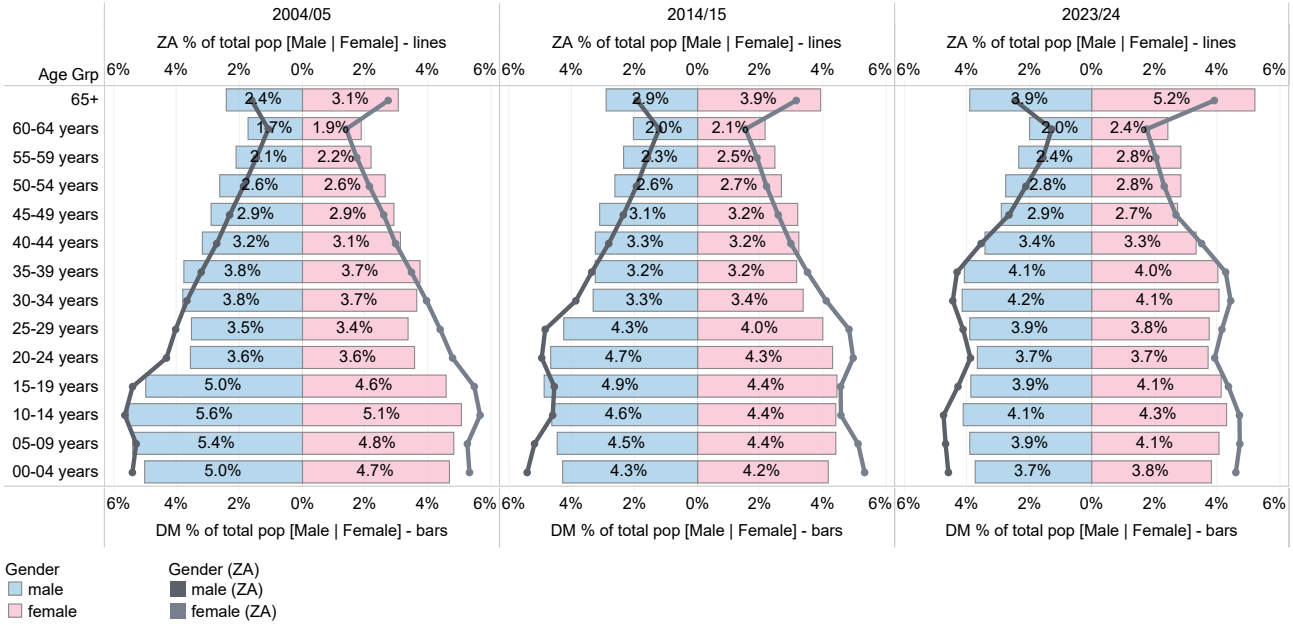
Kamiesberg: Garies, Hondeklip Bay, Kamieskroon, Koingnaas, Leliefontein/Kamiesberg

Karoo Hoogland: Frasersburg, Sutherland, Williston

Richtersveld: Alexander Bay, Eksteensfontein, Kuboes, Port Nolloth, Richtersveld, Sanddrift

District percentage population by age-gender group compared to South Africa

Namakwa DM (DC6)



Source: DHIS

3 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

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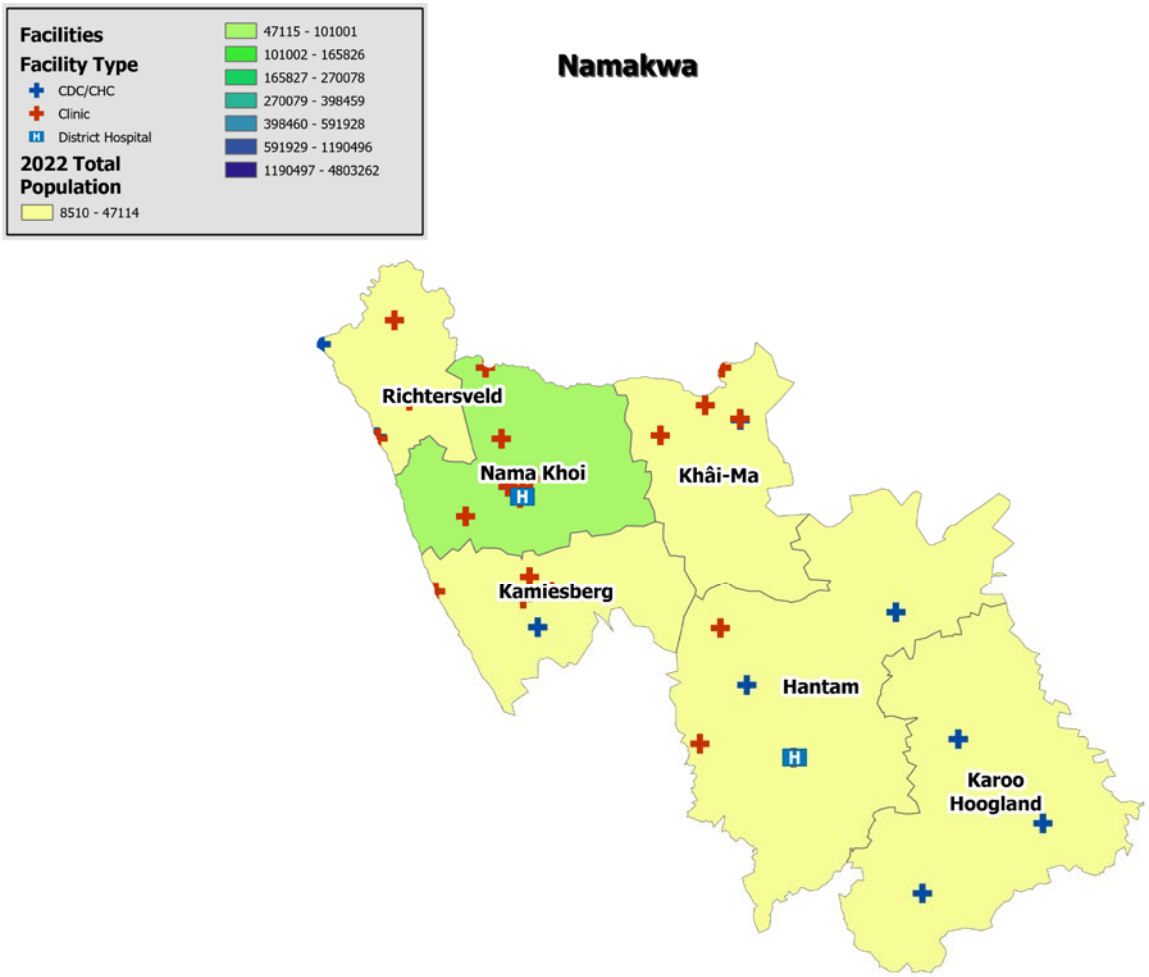

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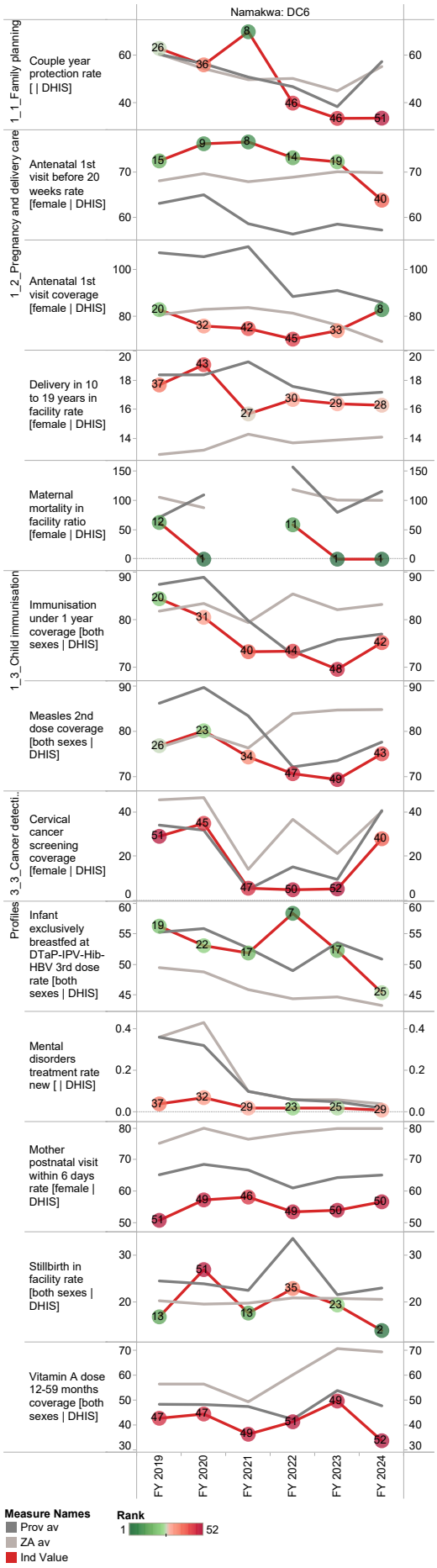
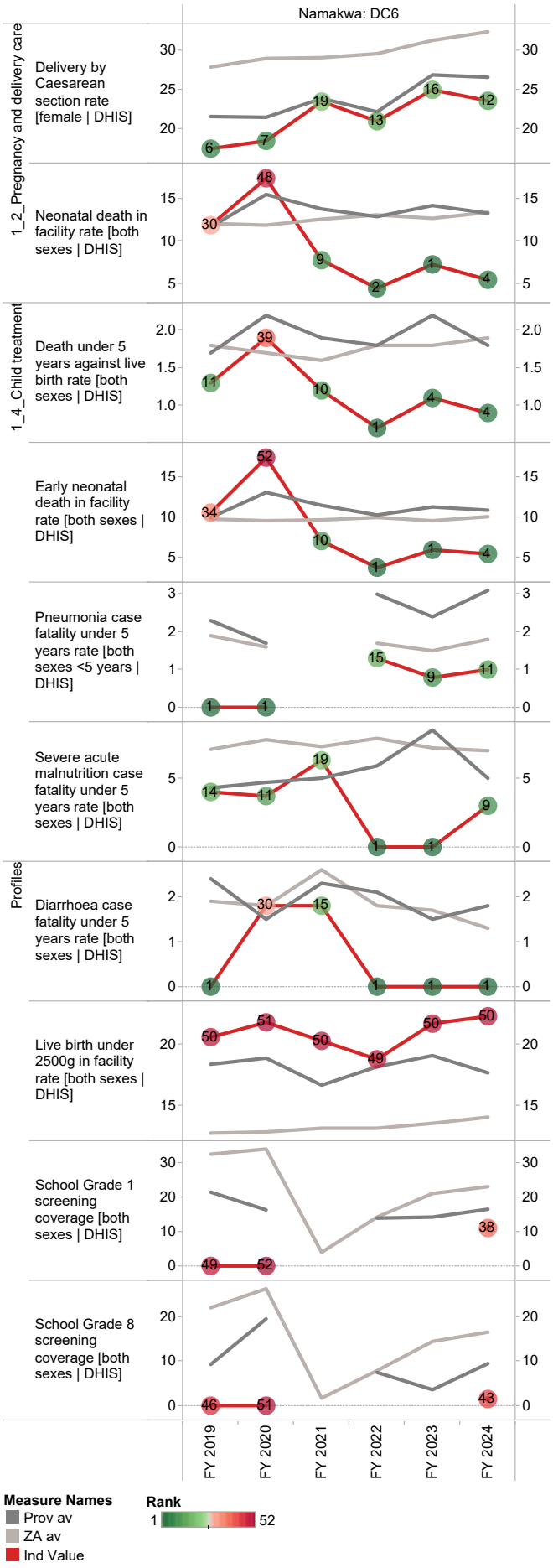
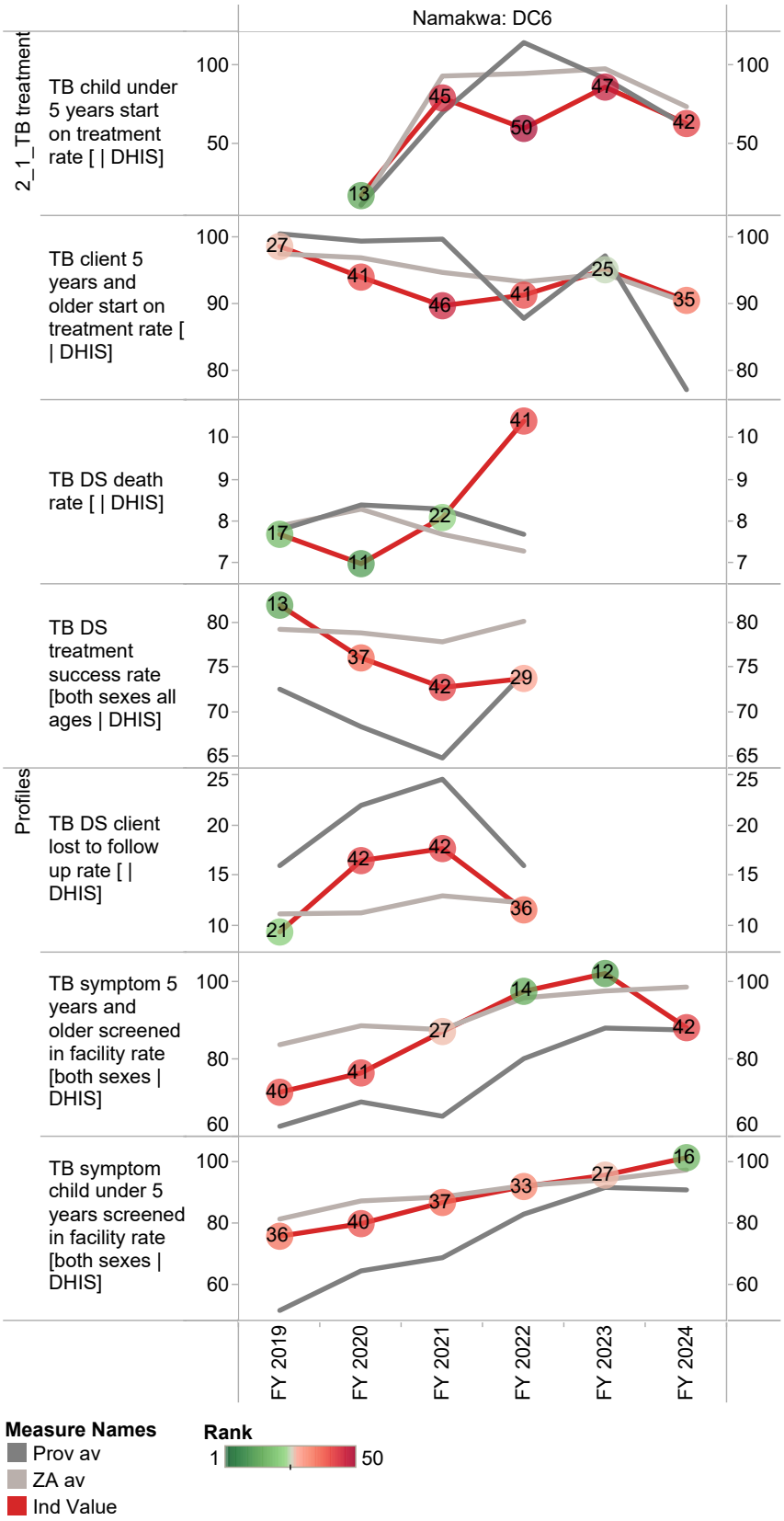
Annual trends, 2014/19–2023/24






Namakwa: DC6
2_1_TB treatment
Profiles
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TB client 5 years and older start on treatment rate [| DHIS]
TB DS death rate [| DHIS]
TB DS treatment success rate [both sexes all ages | DHIS]
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TB symptom 5 years and older screened in facility rate [both sexes | DHIS]
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FY 2019
FY 2020
FY 2021
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FY 2023
FY 2024
Measure Names
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Rank
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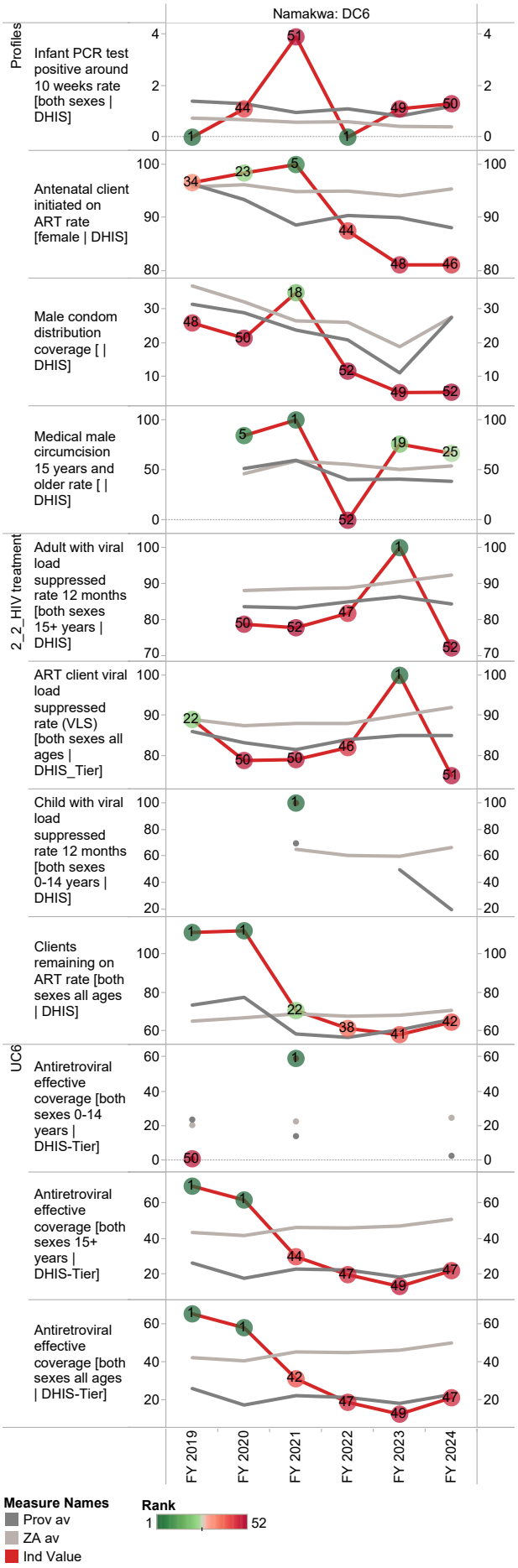
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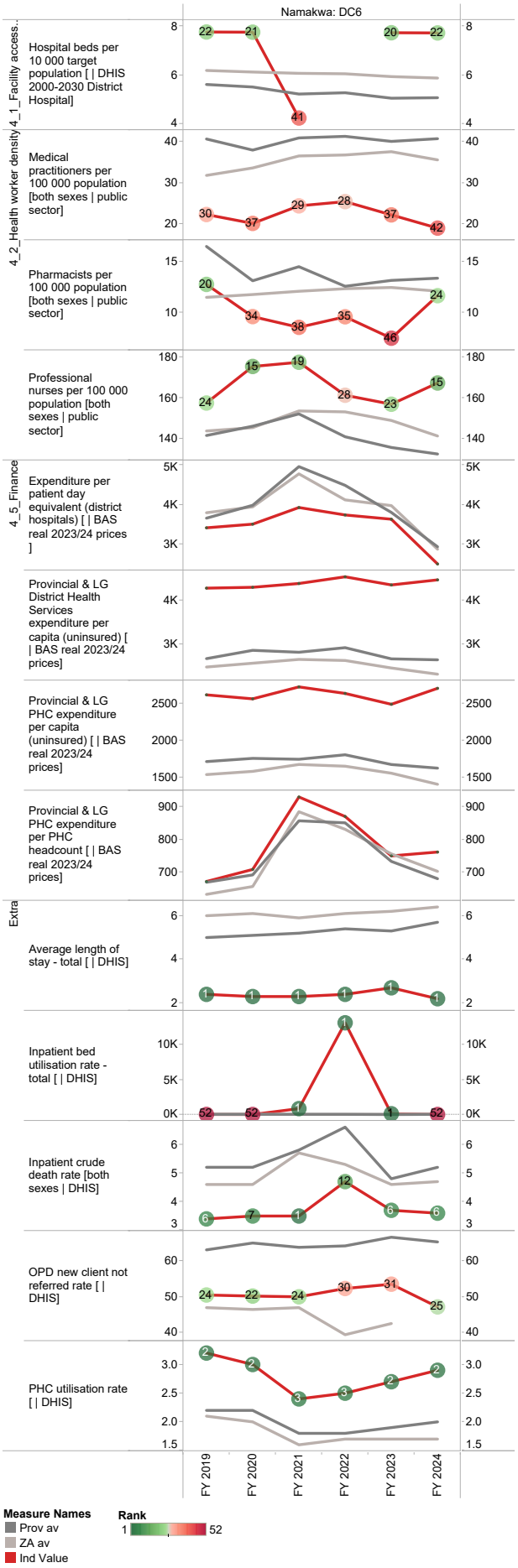
Namakwa: DC6
4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
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Inpatient bed utilisation rate - total [| DHIS]
Inpatient crude death rate [both sexes | DHIS]
OPD new client not referred rate [| DHIS]
PHC utilisation rate [| DHIS]
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Pixley Ka Seme District Municipality (DC7)

The Pixley Ka Seme District Municipality[5] is a Category C municipality situated in the south-east of the Northern Cape Province. The district consists of eight local municipalities: Ubuntu, Umsobomvu, Emthanjeni, Kareeberg, Renosterberg, Thembelihle, Siyathemba and Siyancuma.

Area: 103 222km²

Population (2023)[6]: 211 609

Households[5]: 56 309

Formal dwellings[5]: 89.0%

Cities/Towns:

Ubuntu: Hutchinson, Loxton, Richmond, Victoria West

Umsobomvu: Colesberg, Norvalspont, Noupoort

Emthanjeni: Britstown, De Aar, Hanover

Kareeberg: Carnarvon, Vanwyksvlei, Vosburg

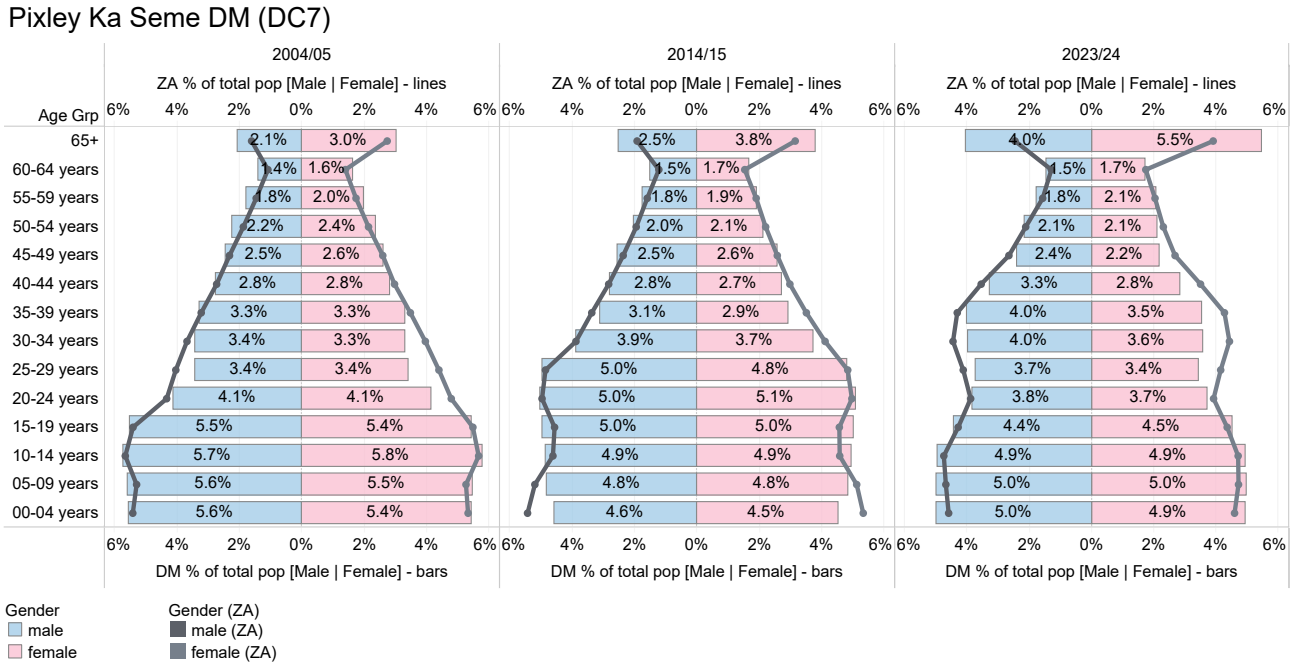
Renosterberg: Petrusville, Philipstown, Van der Kloof

Thembelihle: Hopetown, Strydenburg

Siyathemba: Copperton, Marydale, Niekerkshoop, Prieska

Siyancuma: Campbell, Douglas, Griekwastad, Schmidtsdrif

District percentage population by age-gender group compared to South Africa

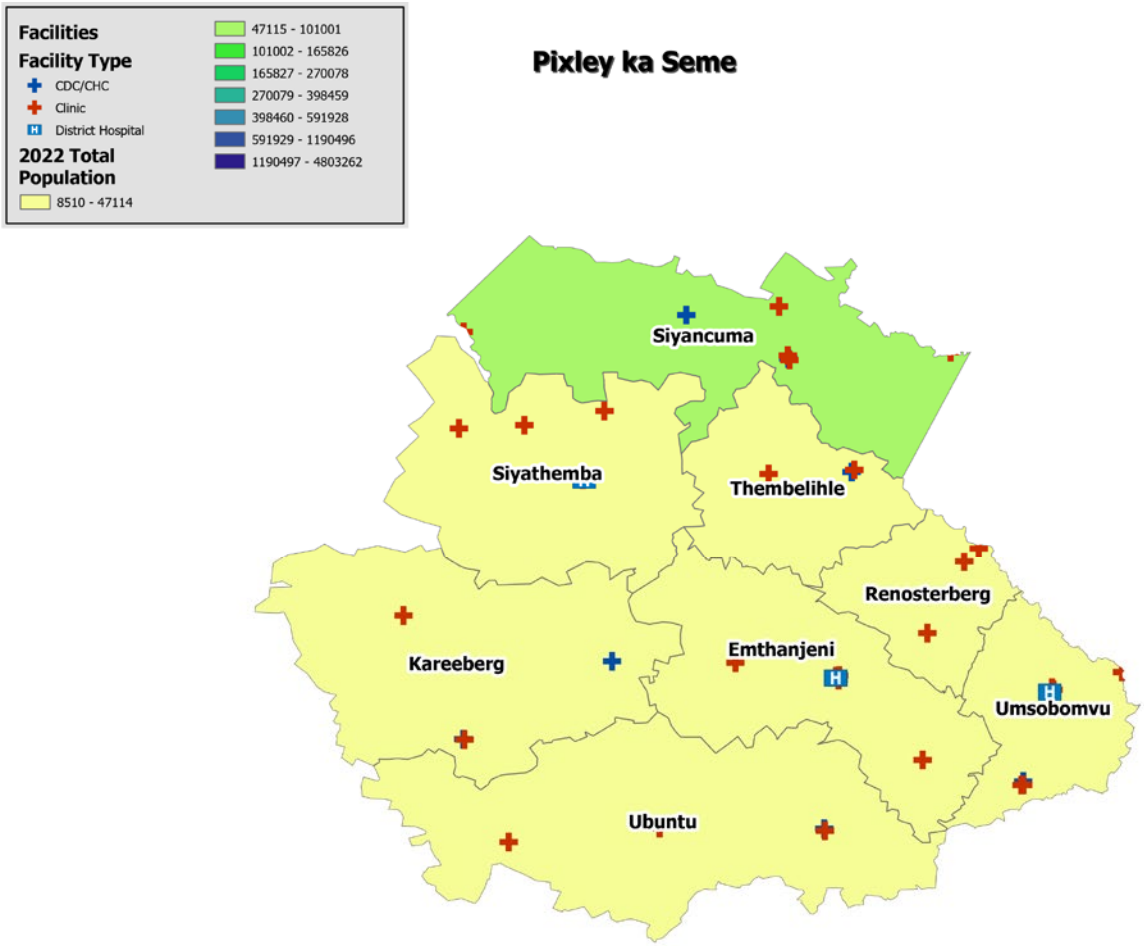


Source: DHIS

5 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

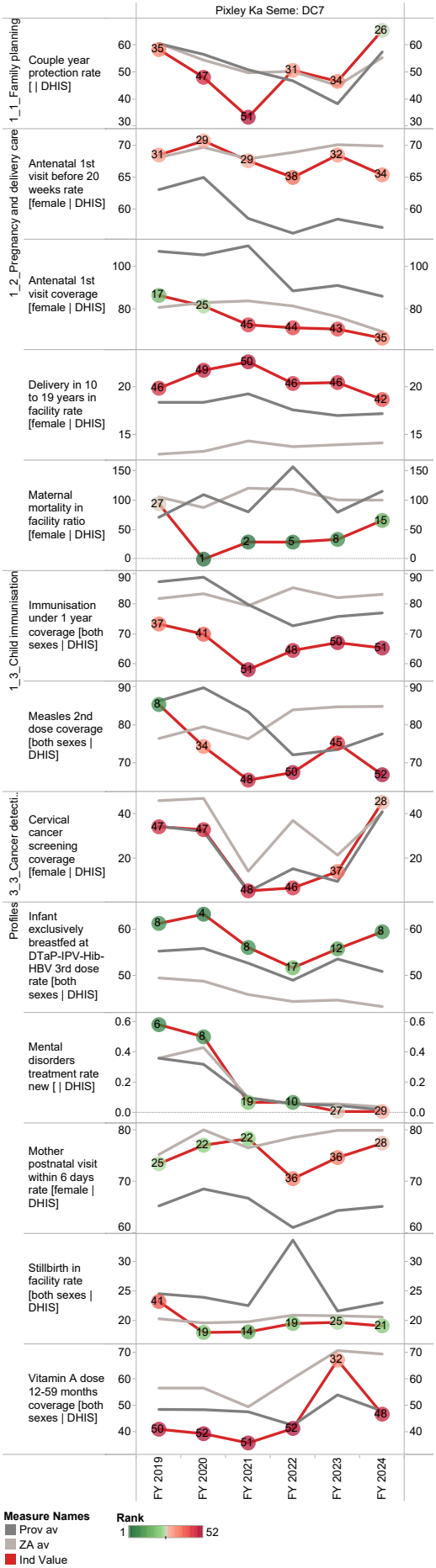
6 Mid-year Population Estimates 2023, DHIS.

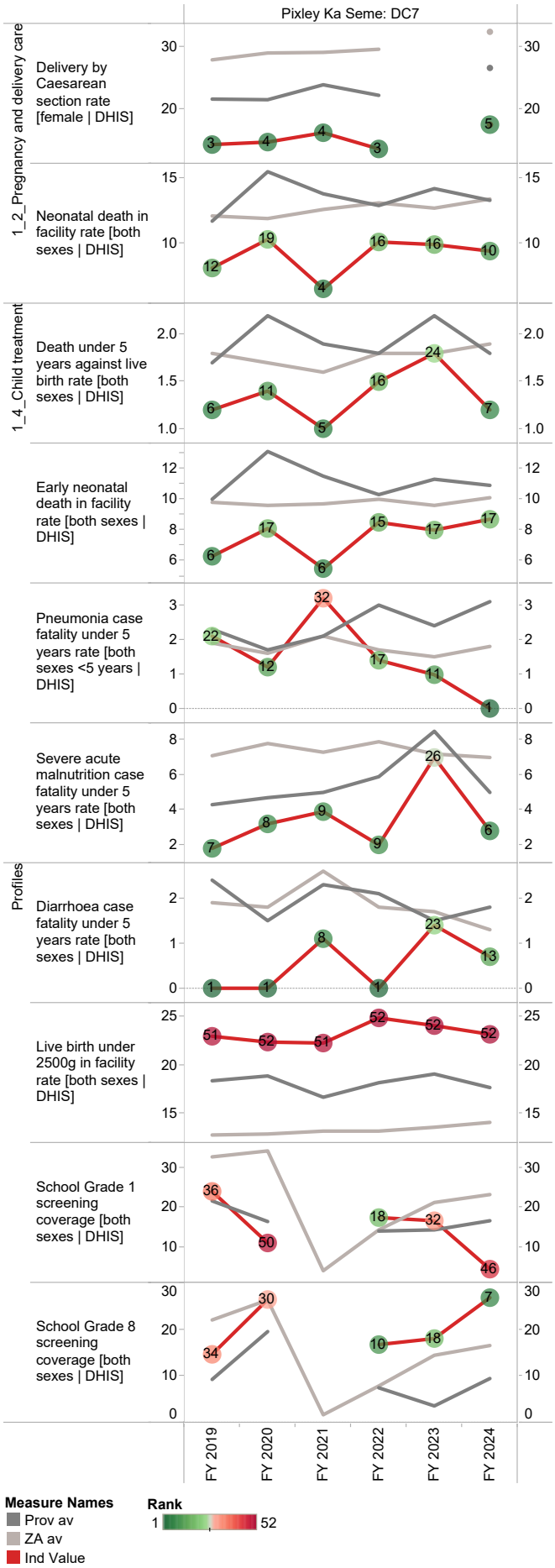
Population distribution, sub-district boundaries and health facility locations

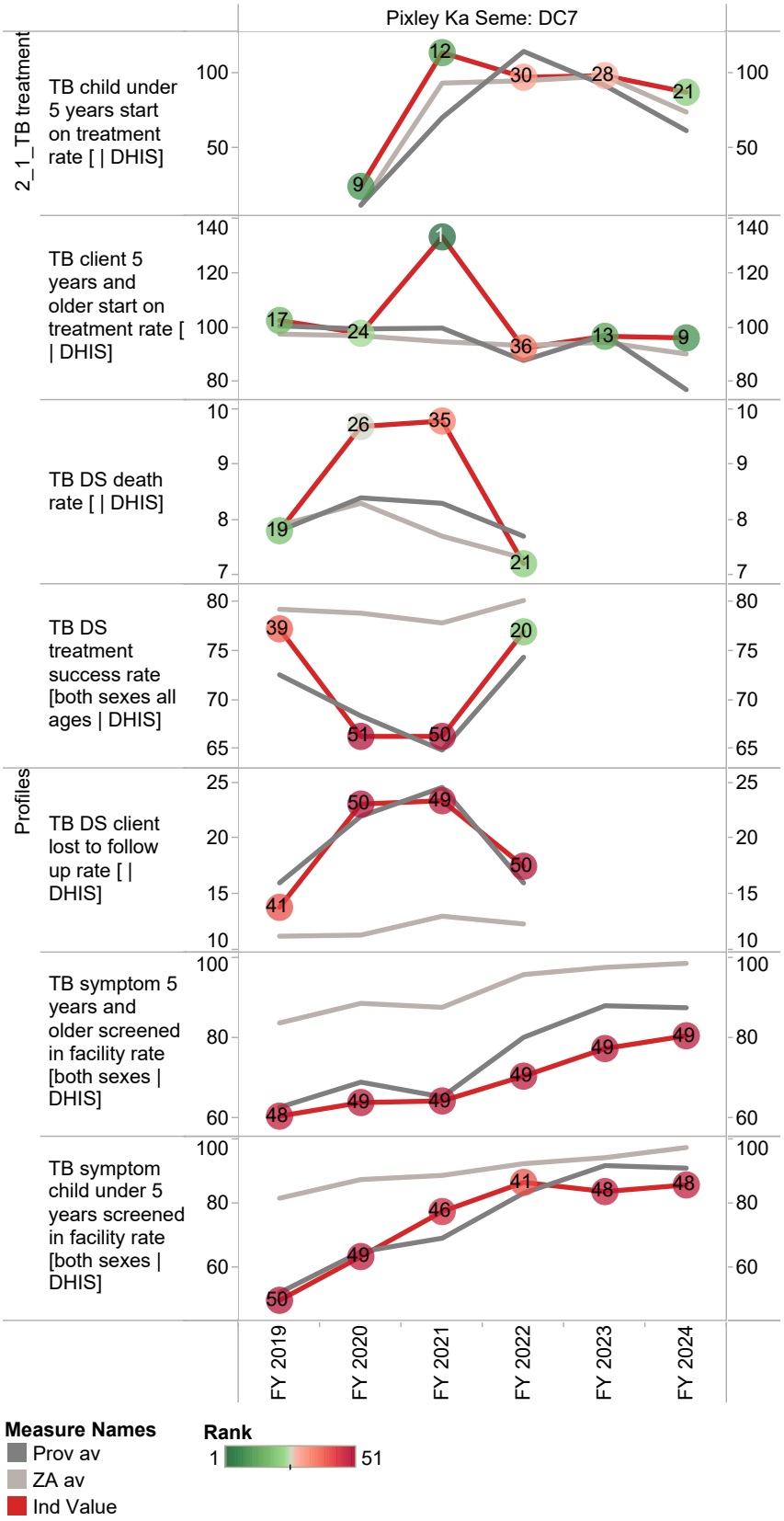


Source: DHIS

Annual trends, 2014/19–2023/24






Pixley Ka Seme: DC7
2_1_TB treatment
Profiles
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
TB DS death rate [| DHIS]
TB DS treatment success rate [both sexes all ages | DHIS]
TB DS client lost to follow up rate [| DHIS]
TB symptom 5 years and older screened in facility rate [both sexes | DHIS]
TB symptom child under 5 years screened in facility rate [both sexes | DHIS]
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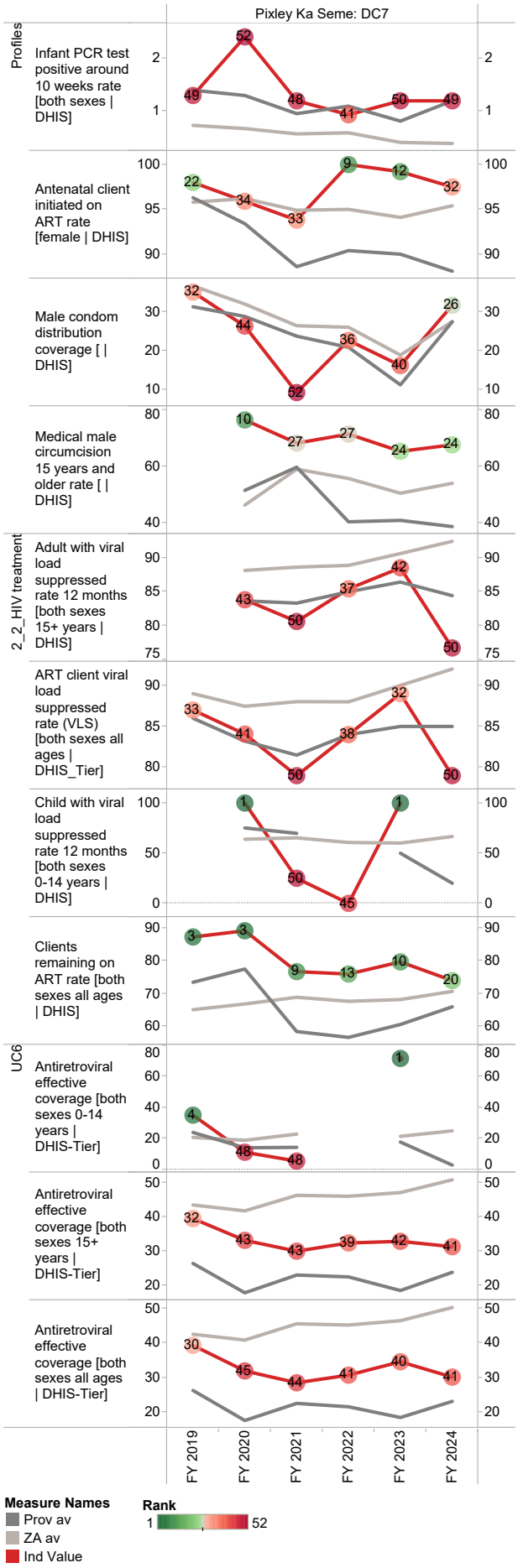
Pixley Ka Seme: DC7
Profiles
Infant PCR test positive around 10 weeks rate [both sexes | DHIS]
Antenatal client initiated on ART rate [female | DHIS]
Male condom distribution coverage [| DHIS]
Medical male circumcision 15 years and older rate [| DHIS]
2_2_HIV treatment
Adult with viral load suppressed rate 12 months [both sexes 15+ years | DHIS]
ART client viral load suppressed rate (VLS) [both sexes all ages | DHIS_Tier]
Child with viral load suppressed rate 12 months [both sexes 0-14 years | DHIS]
Clients remaining on ART rate [both sexes all ages | DHIS]
UC6
Antiretroviral effective coverage [both sexes 0-14 years | DHIS-Tier]
Antiretroviral effective coverage [both sexes 15+ years | DHIS-Tier]
Antiretroviral effective coverage [both sexes all ages | DHIS-Tier]
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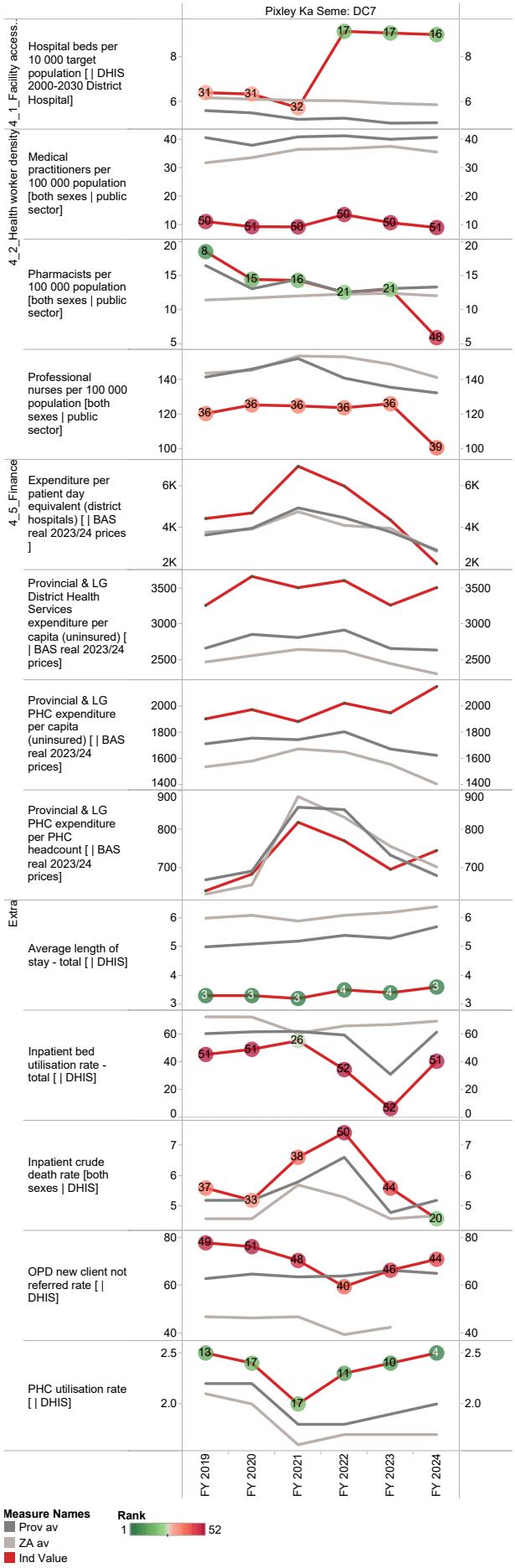
Pixley Ka Seme: DC7
4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
4_2_Health worker density
Medical practitioners per 100 000 population [both sexes | public sector]
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Professional nurses per 100 000 population [both sexes | public sector]
4_5_Finance
Expenditure per patient day equivalent (district hospitals) [| BAS real 2023/24 prices]
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Inpatient crude death rate [both sexes | DHIS]
OPD new client not referred rate [| DHIS]
PHC utilisation rate [| DHIS]
FY 2019
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FY 2021
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FY 2024
Measure Names
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Zwelentlanga Fatman Mgcawu District Municipality (DC8)

The Zwelentlanga Fatman Mgcawu District Municipality[7] is a Category C municipality forming the mid-northern section of the Northern Cape Province, bordering Botswana in the north and Namibia in the west. This district comprises five local municipalities: Dawid Kruiper, Kai!Garib, Tsantsabane, !Kheis and Kgatelopele. Upington is the district municipal capital, where the municipal government is located.

Area: 102 504km²

Population (2023)[8]: 290 296

Households[7]: 74 091

Formal dwellings[7]: 75.9%

Cities/Towns:

Dawid Kruiper: Mier, Rietfontein, Upington

Kai!Garib: Eksteenskuil, Kakamas, Keimoes, Kenhardt

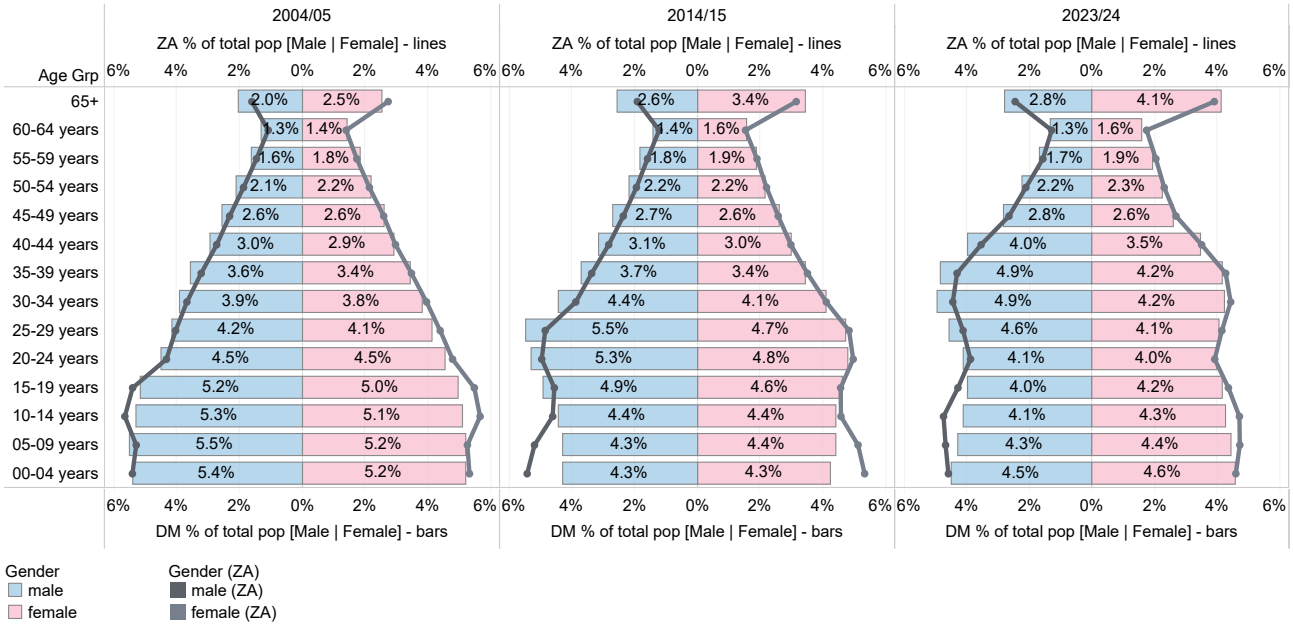
Tsantsabane: Beeshoek, Postmasburg

!Kheis: Brandboom, Groblershoop

Kgatelopele: Danielskuil, Lime Acres

District percentage population by age-gender group compared to South Africa

ZF Mgcawu DM (DC8)

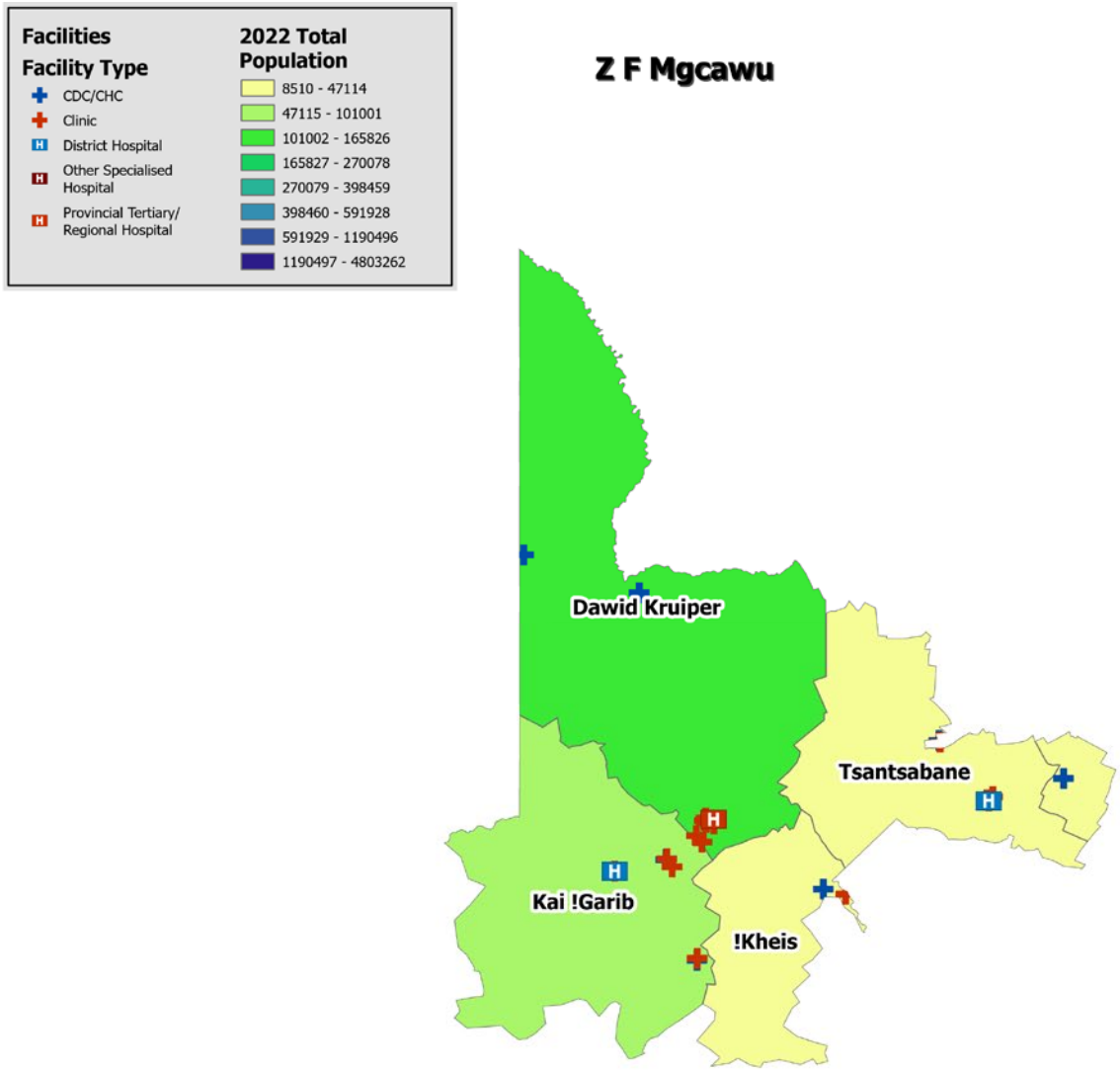


Source: DHIS

7 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

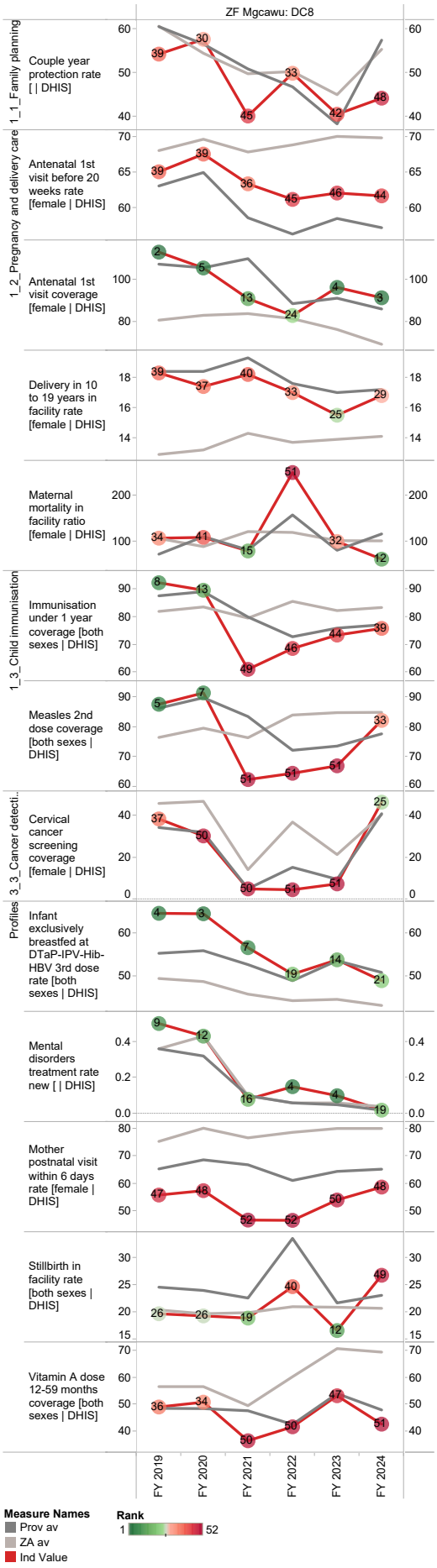
8 Mid-year Population Estimates 2023, DHIS.

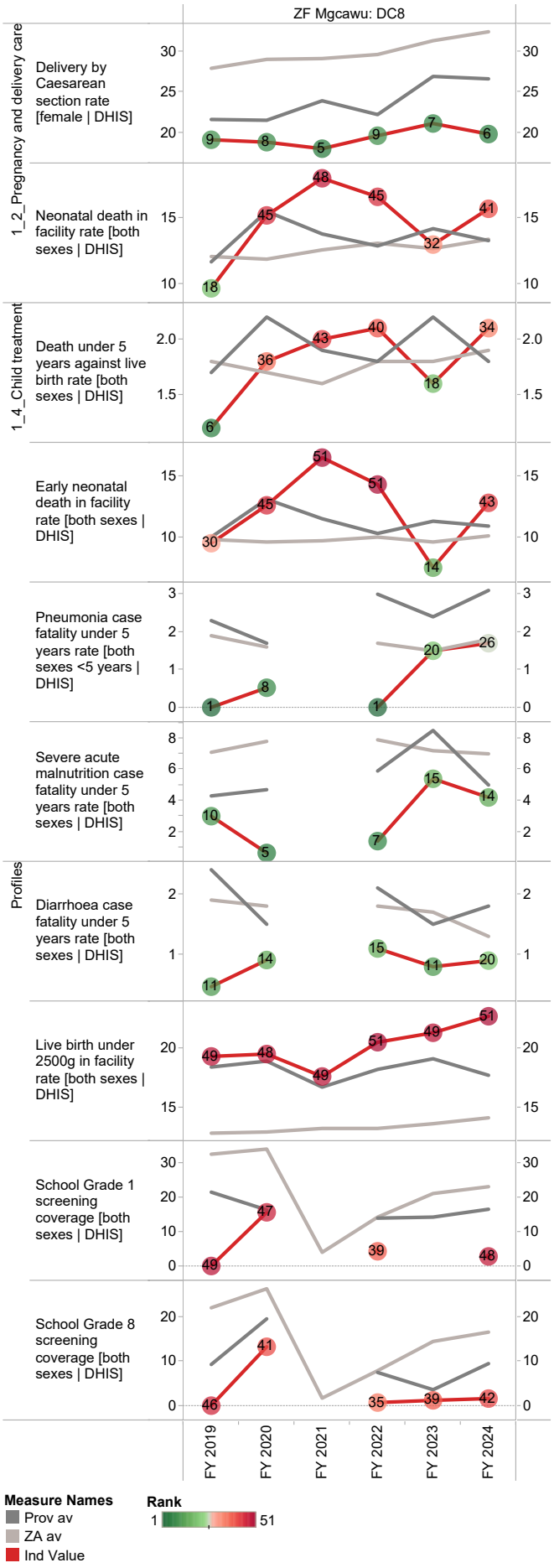
Population distribution, sub-district boundaries and health facility locations

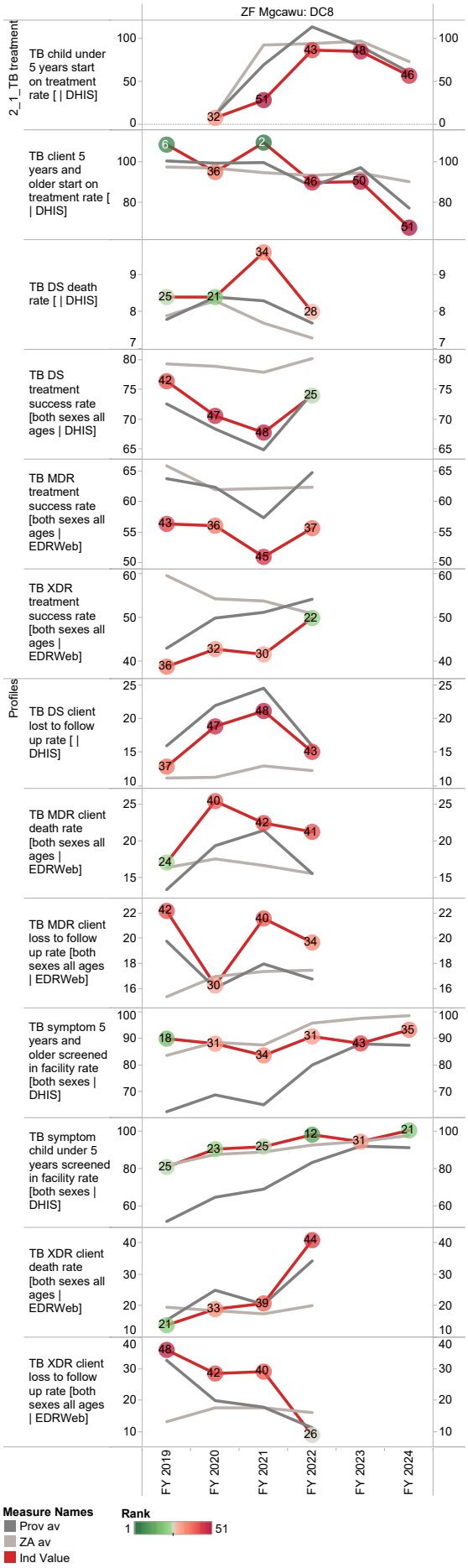


Source: DHIS

Annual trends, 2014/19–2023/24






ZF Mgcawu: DC8
2_1_TB treatment
Profiles
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
TB DS death rate [| DHIS]
TB DS treatment success rate [both sexes all ages | DHIS]
TB MDR treatment success rate [both sexes all ages | EDRWeb]
TB XDR treatment success rate [both sexes all ages | EDRWeb]
TB DS client lost to follow up rate [| DHIS]
TB MDR client death rate [both sexes all ages | EDRWeb]
TB MDR client loss to follow up rate [both sexes all ages | EDRWeb]
TB symptom 5 years and older screened in facility rate [both sexes | DHIS]
TB symptom child under 5 years screened in facility rate [both sexes | DHIS]
TB XDR client death rate [both sexes all ages | EDRWeb]
TB XDR client loss to follow up rate [both sexes all ages | EDRWeb]
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Measure Names
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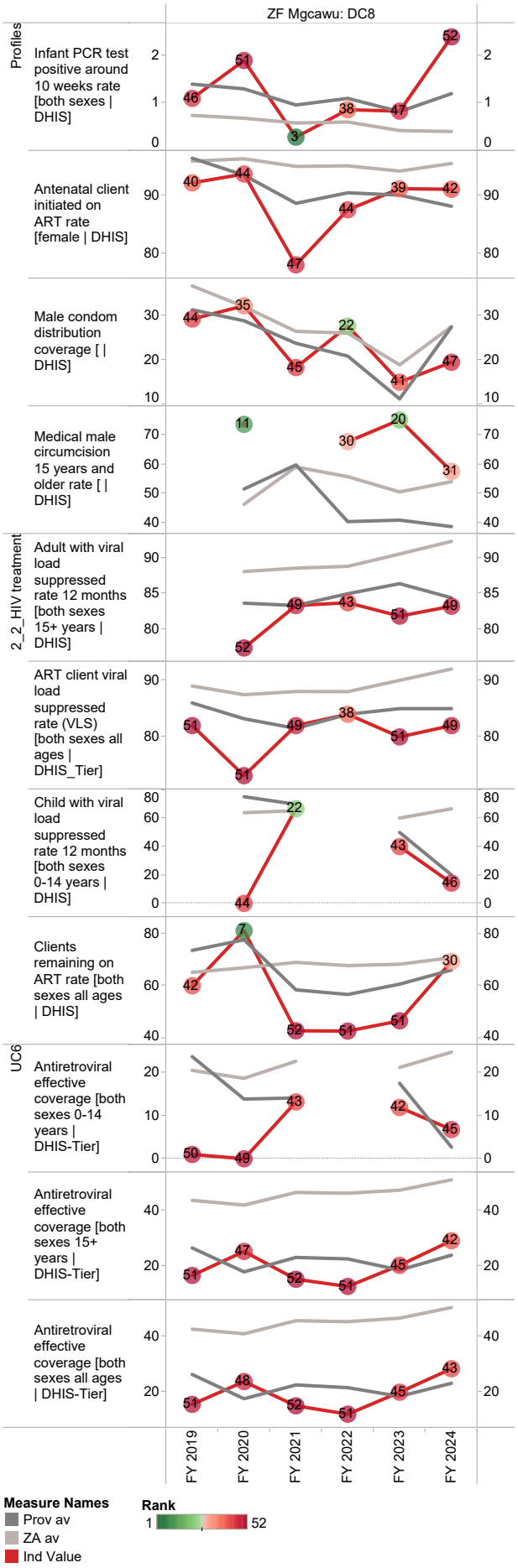
ZF Mgcawu: DC8
Profiles
2_2_HIV treatment
UC6
Infant PCR test positive around 10 weeks rate [both sexes | DHIS]
Antenatal client initiated on ART rate [female | DHIS]
Male condom distribution coverage [| DHIS]
Medical male circumcision 15 years and older rate [| DHIS]
Adult with viral load suppressed rate 12 months [both sexes 15+ years | DHIS]
ART client viral load suppressed rate (VLS) [both sexes all ages | DHIS_Tier]
Child with viral load suppressed rate 12 months [both sexes 0-14 years | DHIS]
Clients remaining on ART rate [both sexes all ages | DHIS]
Antiretroviral effective coverage [both sexes 0-14 years | DHIS-Tier]
Antiretroviral effective coverage [both sexes 15+ years | DHIS-Tier]
Antiretroviral effective coverage [both sexes all ages | DHIS-Tier]
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Measure Names
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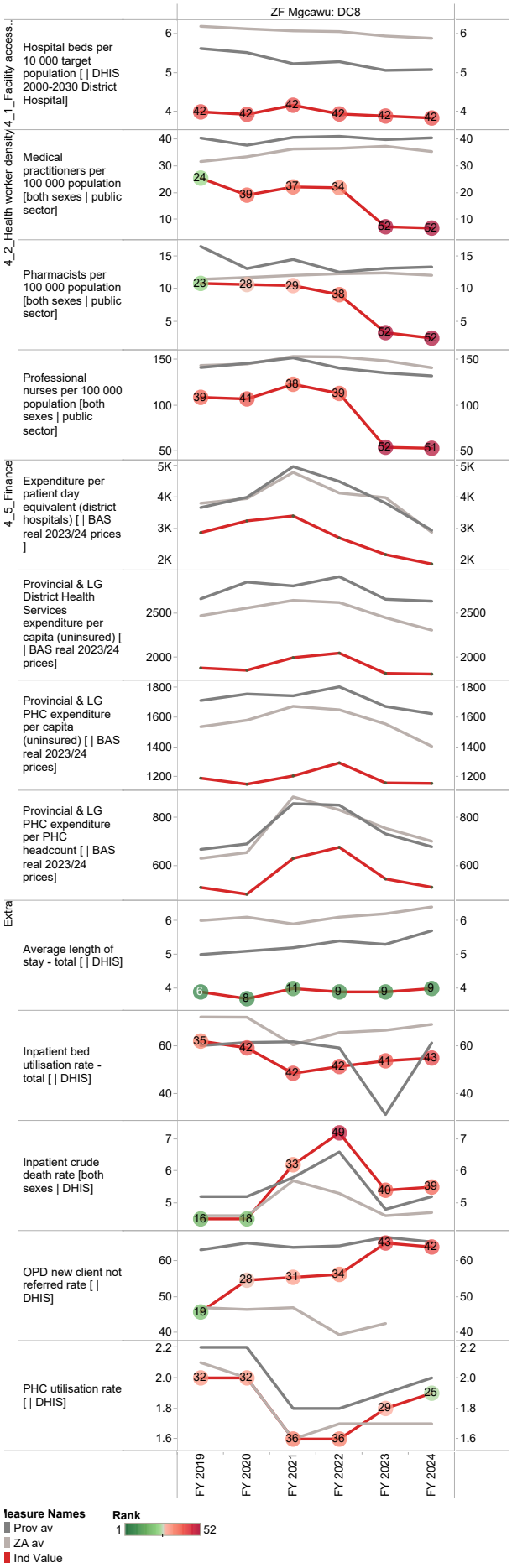
ZF Mgcawu: DC8
4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
4_2_Health worker density
Medical practitioners per 100 000 population [both sexes | public sector]
Pharmacists per 100 000 population [both sexes | public sector]
Professional nurses per 100 000 population [both sexes | public sector]
4_5_Finance
Expenditure per patient day equivalent (district hospitals) [| BAS real 2023/24 prices]
Provincial & LG District Health Services expenditure per capita (uninsured) [| BAS real 2023/24 prices]
Provincial & LG PHC expenditure per capita (uninsured) [| BAS real 2023/24 prices]
Provincial & LG PHC expenditure per PHC headcount [| BAS real 2023/24 prices]
Extra
Average length of stay - total [| DHIS]
Inpatient bed utilisation rate - total [| DHIS]
Inpatient crude death rate [both sexes | DHIS]
OPD new client not referred rate [| DHIS]
PHC utilisation rate [| DHIS]
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Frances Baard District Municipality (DC 9)

The Frances Baard District Municipality[9] is a Category C municipality located in the far eastern portion of the Northern Cape Province. The municipality is the smallest district in the Northern Cape, making up only 3% of its geographical area. It comprises the four local municipalities of Dikgatlong, Magareng, Phokwane and Sol Plaatje.

Area: 13 002km²

Population (2023)[10]: 424 540

Households[9]: 113 330

Formal dwellings[9]: 83.7%

Cities/Towns:

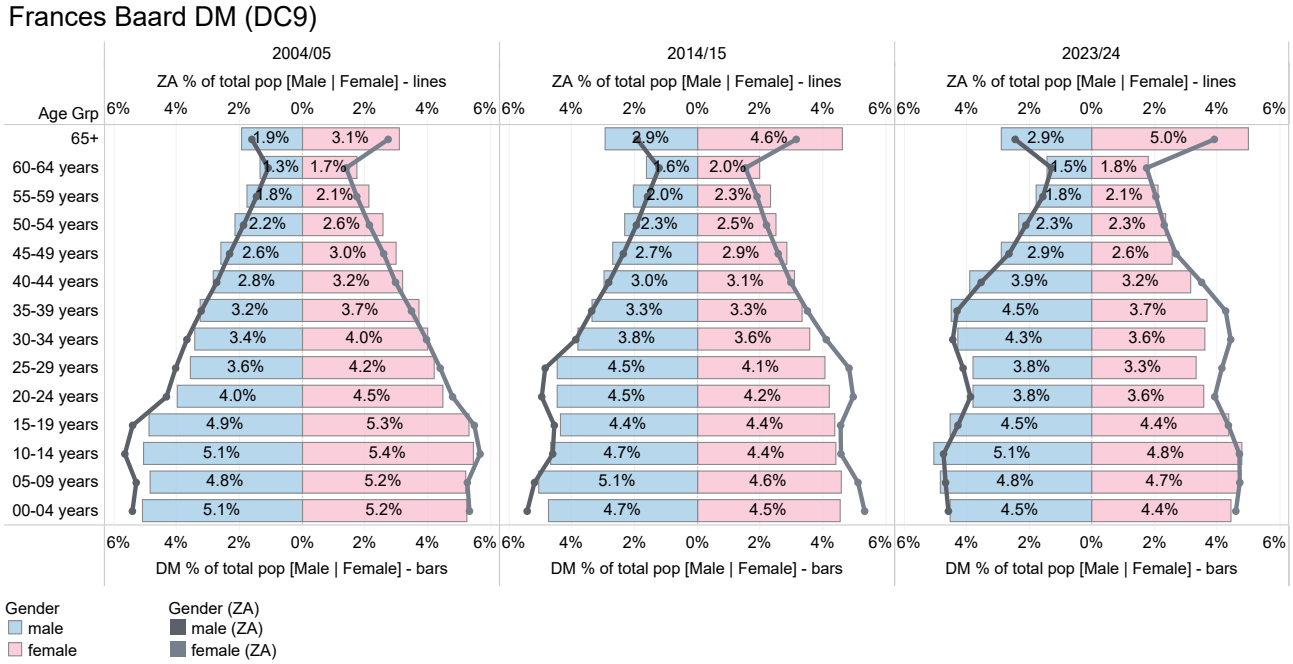
Dikgatlong: Barkly West, Delportshoop, Windsorton

Magareng: Warrenton

Phokwane: Hartswater, Jan Kempdorp, Pampierstat

Sol Plaatje: Kimberley, Ritchie

District percentage population by age-gender group compared to South Africa

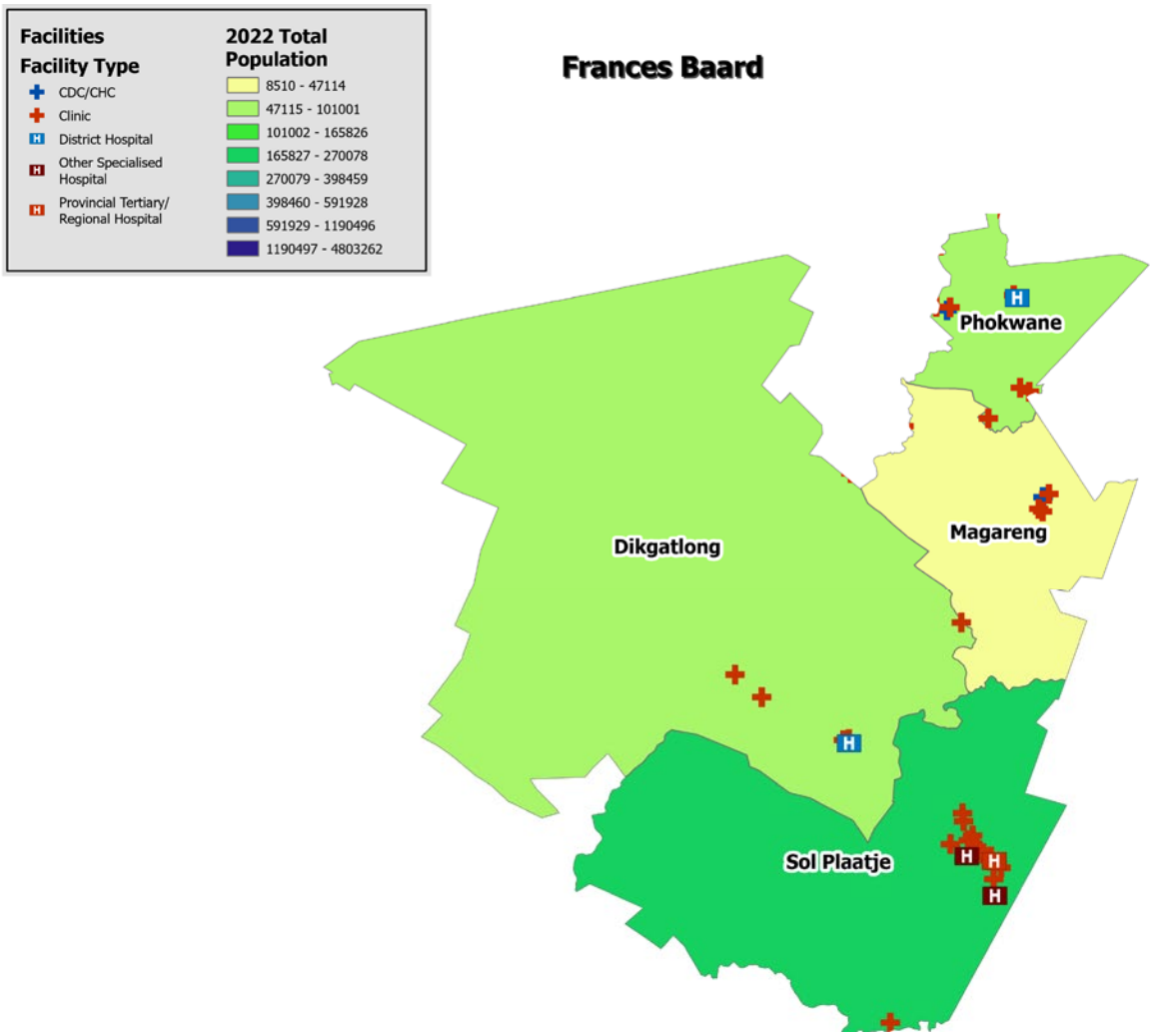


Source: DHIS

9 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

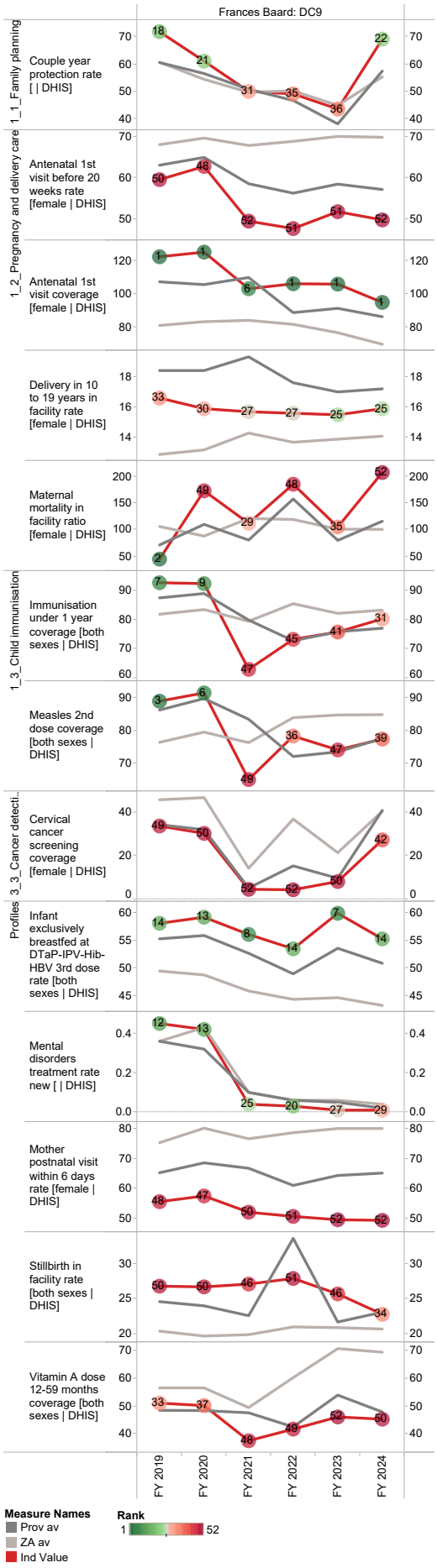
10 Mid-year Population Estimates 2023, DHIS.

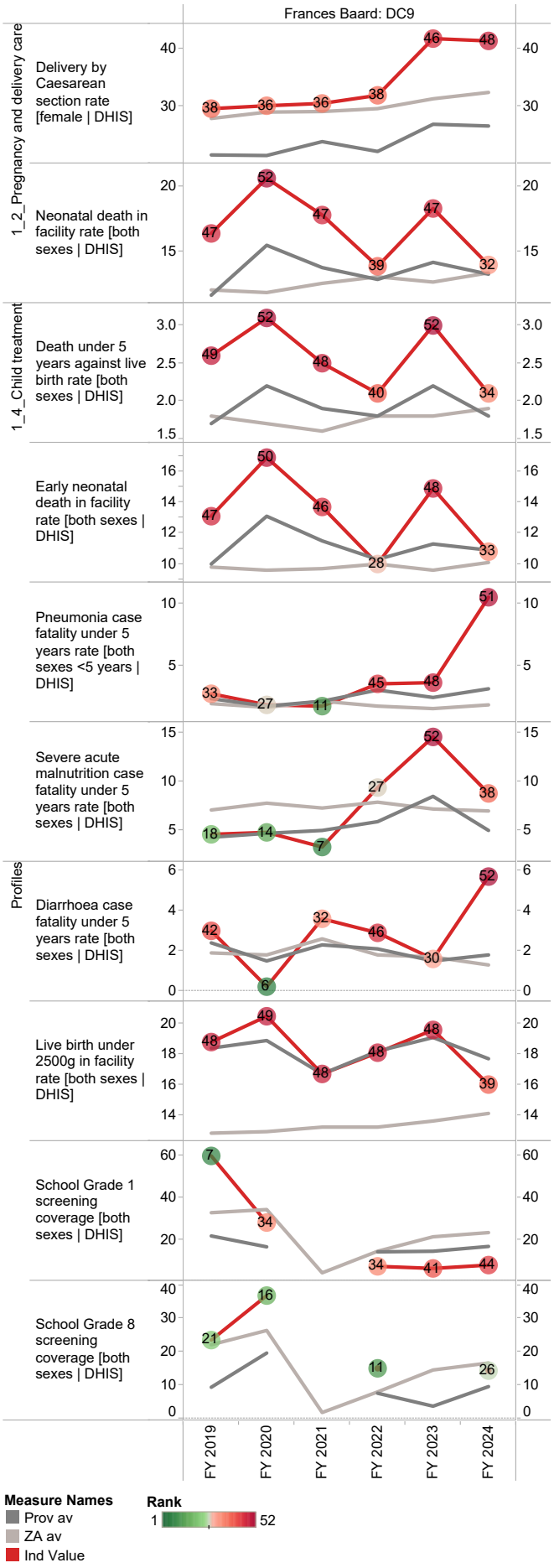
Population distribution, sub-district boundaries and health facility locations

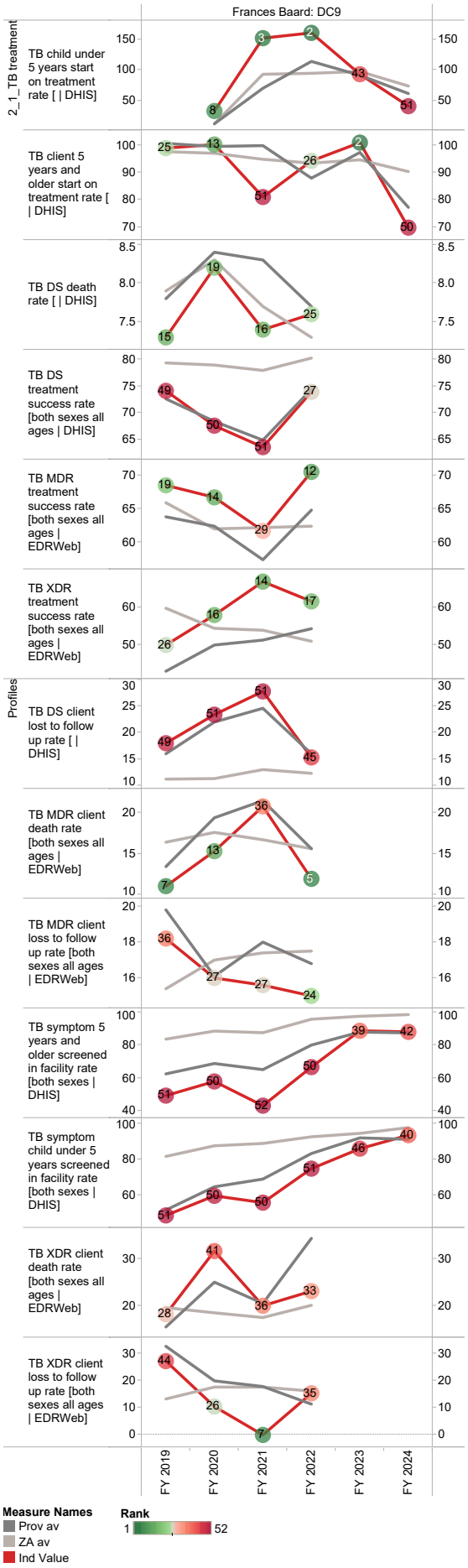


Source: DHIS

Annual trends, 2014/19–2023/24






Frances Baard: DC9
2_1_TB treatment
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
TB DS death rate [| DHIS]
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Profiles
TB DS client lost to follow up rate [| DHIS]
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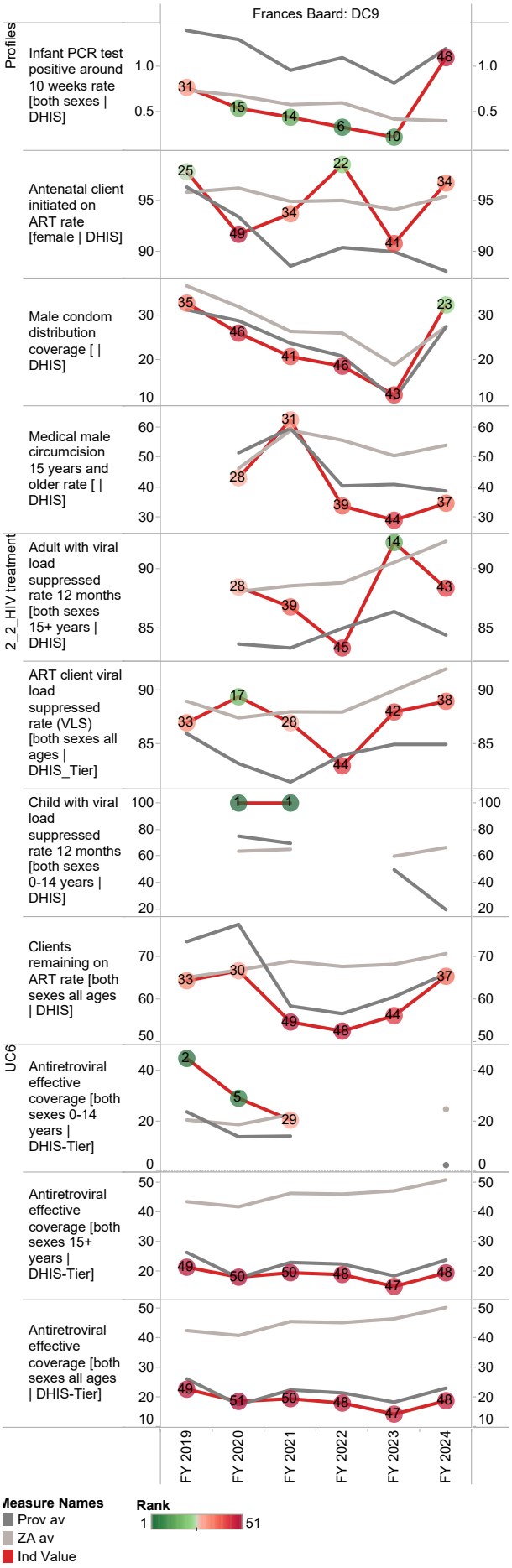
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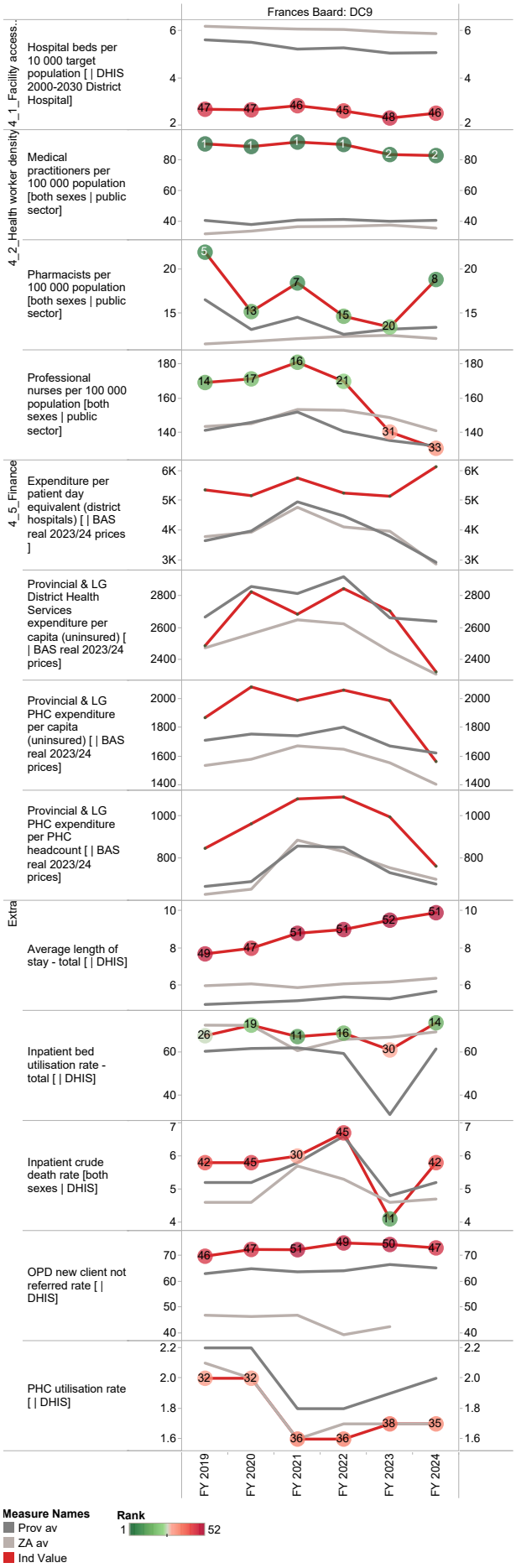
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4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
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FY 2019
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FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
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Rank
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14 North West Province

Bojanala Platinum District Municipality (DC37)

The Bojanala Platinum District Municipality[1] is Category C municipality situated in the North West Province. It comprises five local municipalities: Kgetlengrivier, Madibeng, Moses Kotane, Moretele and Rustenburg.

Area: 18 333km²

Population (2023)[2]: 2 058 230

Households[1]: 611 144

Formal dwellings[1]: 70.6%

Cities/Towns:

Kgetlengrivier: Derby, Koster, Swartruggens

Madibeng: Brits, Hartbeespoort, Mooinooi

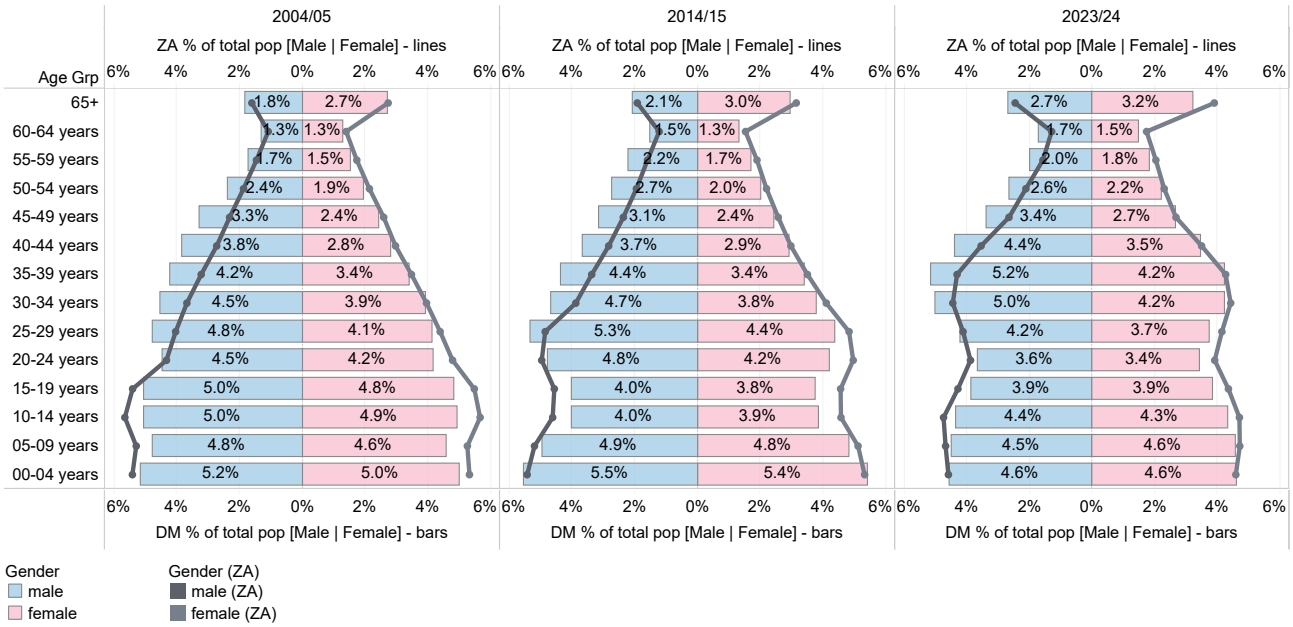
Moses Kotane: Madikwe

Moretele: Moretele

Rustenburg: Hartbeesfontein-A, Marikana, Phatsima, Rustenburg, Tlhabane

District percentage population by age-gender group compared to South Africa

Bojanala Platinum DM (DC37)

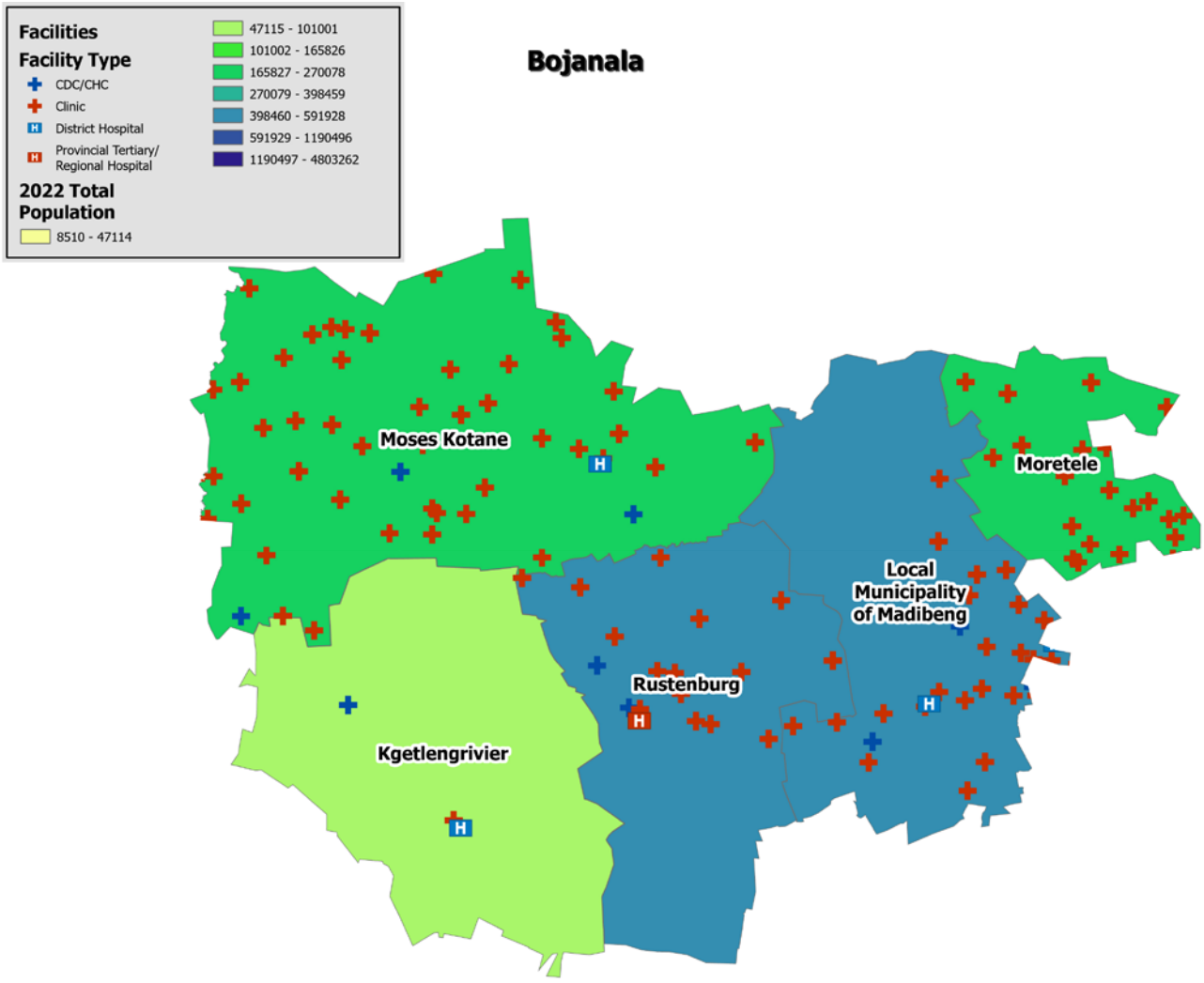


Source: DHIS

1 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

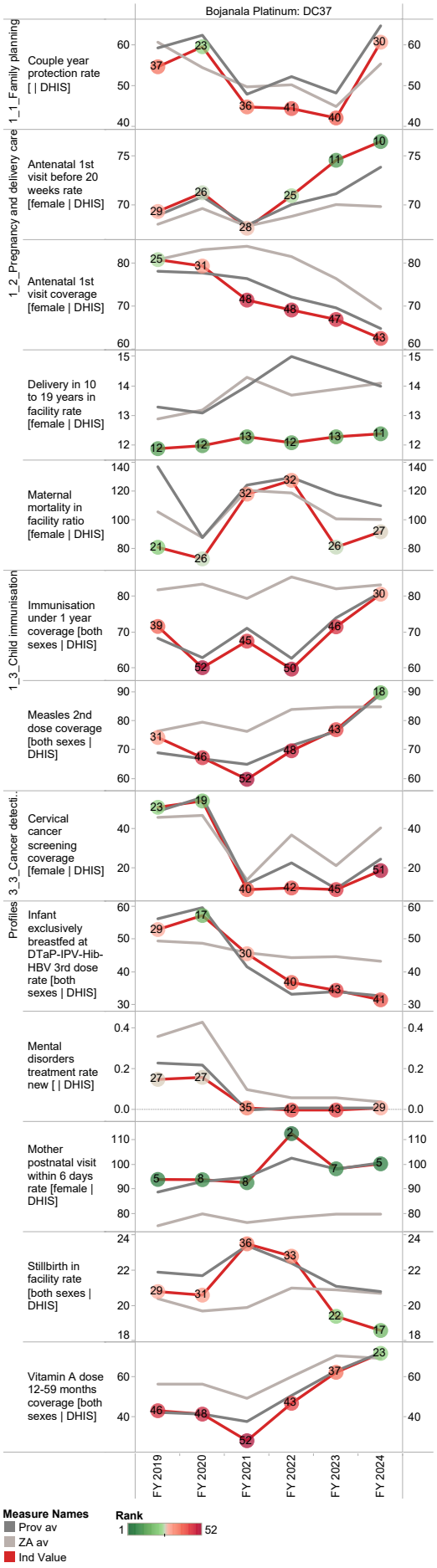
2 Mid-year Population Estimates 2023, DHIS.

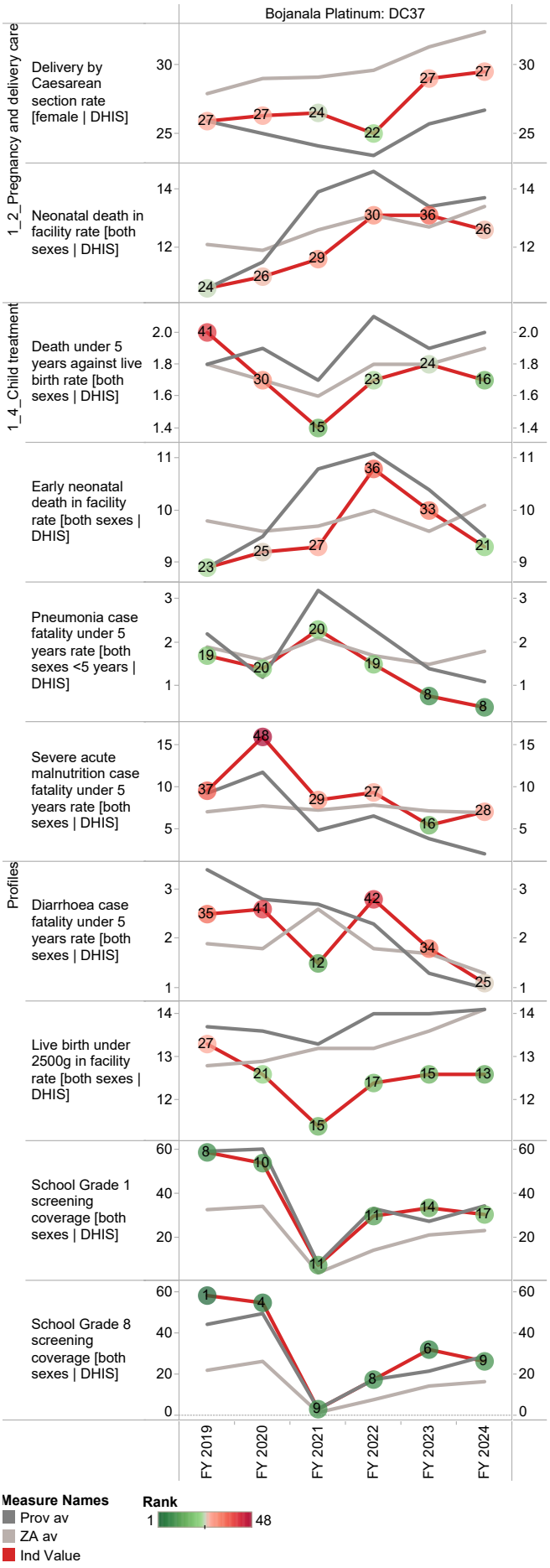
Population distribution, sub-district boundaries and health facility locations

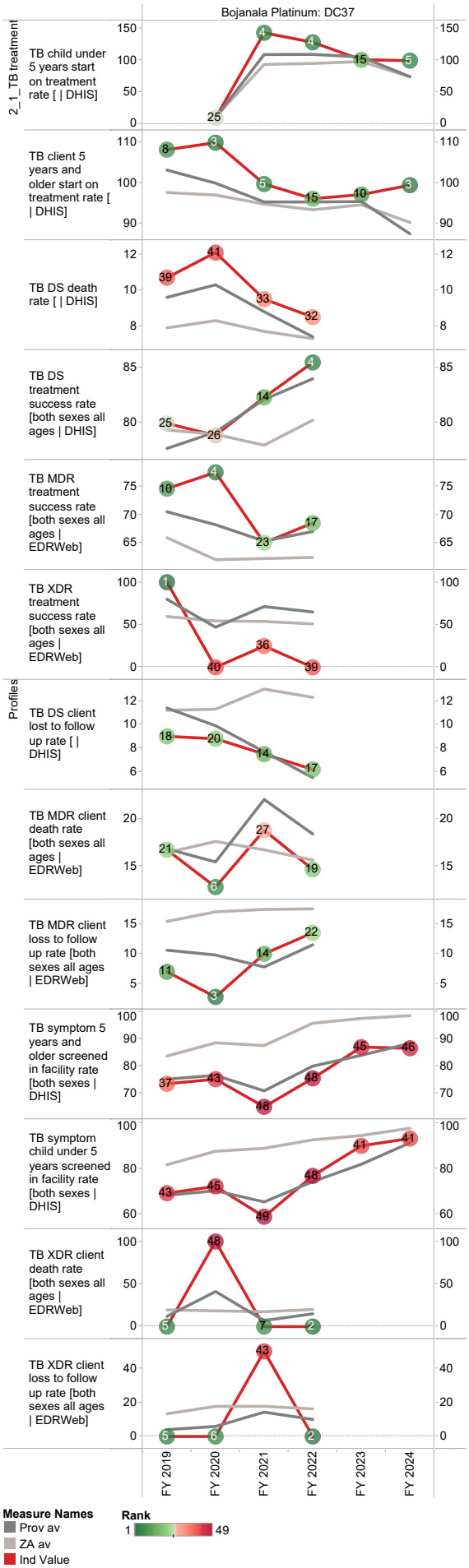


Source: DHIS

Annual trends, 2018/19–2023/24






Bojanala Platinum: DC37
2_1_TB treatment
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
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TB DS treatment success rate [both sexes all ages | DHIS]
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TB XDR client loss to follow up rate [both sexes all ages | EDRWeb]
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Measure Names
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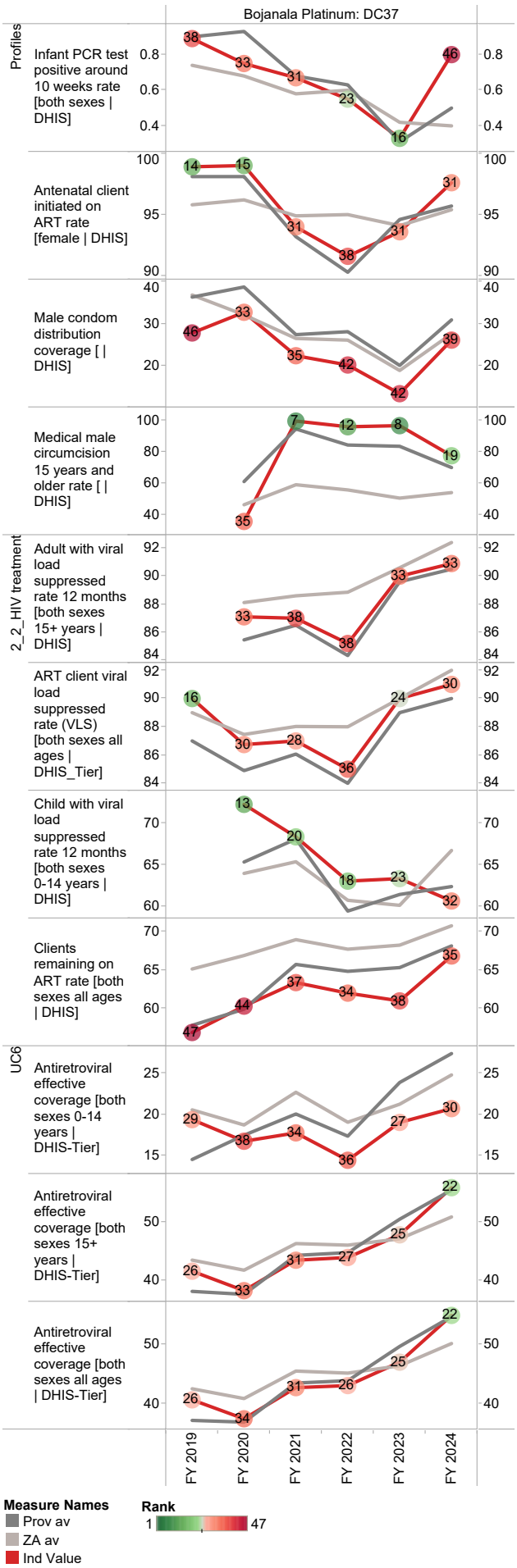
Bojanala Platinum: DC37
Profiles
Infant PCR test positive around 10 weeks rate [both sexes | DHIS]
Antenatal client initiated on ART rate [female | DHIS]
Male condom distribution coverage [| DHIS]
Medical male circumcision 15 years and older rate [| DHIS]
2_2_HIV treatment
Adult with viral load suppressed rate 12 months [both sexes 15+ years | DHIS]
ART client viral load suppressed rate (VLS) [both sexes all ages | DHIS_Tier]
Child with viral load suppressed rate 12 months [both sexes 0-14 years | DHIS]
Clients remaining on ART rate [both sexes all ages | DHIS]
UC6
Antiretroviral effective coverage [both sexes 0-14 years | DHIS-Tier]
Antiretroviral effective coverage [both sexes 15+ years | DHIS-Tier]
Antiretroviral effective coverage [both sexes all ages | DHIS-Tier]
FY 2019
FY 2020
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Measure Names
Prov av
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Rank
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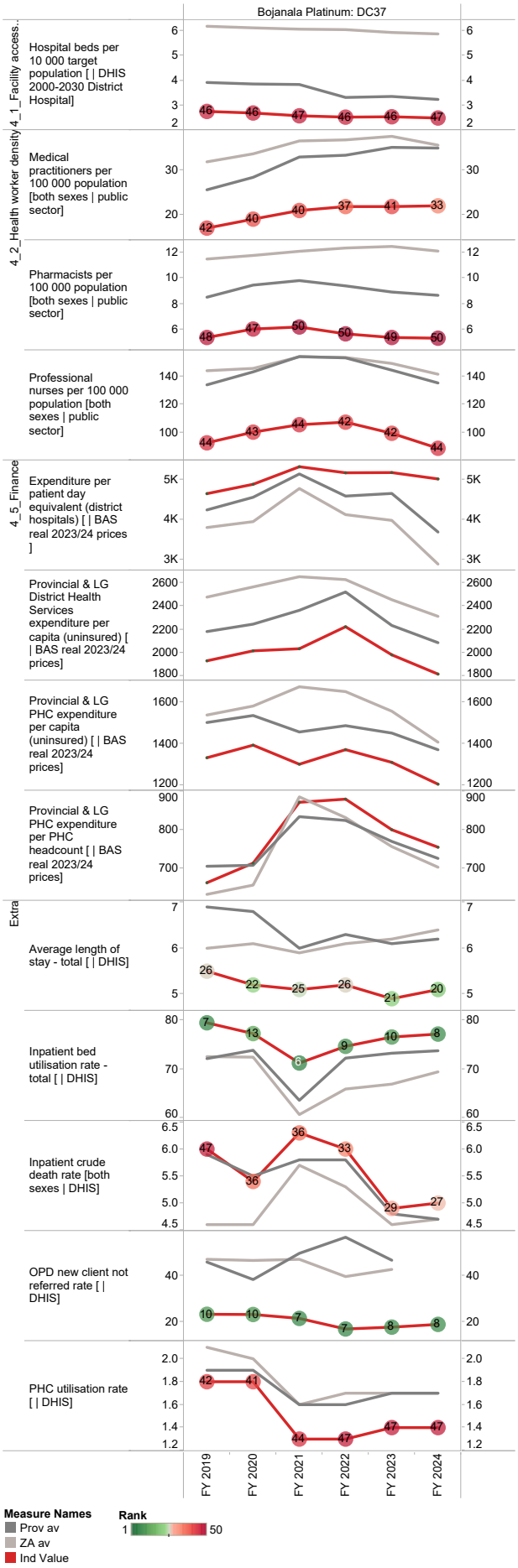
47


Bojanala Platinum: DC37
4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
4_2_Health worker density
Medical practitioners per 100 000 population [both sexes | public sector]
Pharmacists per 100 000 population [both sexes | public sector]
Professional nurses per 100 000 population [both sexes | public sector]
4_5_Finance
Expenditure per patient day equivalent (district hospitals) [| BAS real 2023/24 prices]
Provincial & LG District Health Services expenditure per capita (uninsured) [| BAS real 2023/24 prices]
Provincial & LG PHC expenditure per capita (uninsured) [| BAS real 2023/24 prices]
Provincial & LG PHC expenditure per PHC headcount [| BAS real 2023/24 prices]
Extra
Average length of stay - total [| DHIS]
Inpatient bed utilisation rate - total [| DHIS]
Inpatient crude death rate [both sexes | DHIS]
OPD new client not referred rate [| DHIS]
PHC utilisation rate [| DHIS]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
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Ind Value
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1
50

Ngaka Modiri Molema District Municipality (DC38)

The Ngaka Modiri Molema District Municipality[3] is a Category C municipality in the North West Province and borders Botswana. It consists of five local municipalities: Mahikeng, Ratlou, Ramotshere Moiloa, Ditsobotla and Tswaing.

Area: 28 125km²

Population (2023)[4]: 922 575

Households[3]: 269 977

Formal dwellings[3]: 82.7%

Cities/Towns:

Mahikeng: Mahikeng, Mmabatho, Ottoshoop

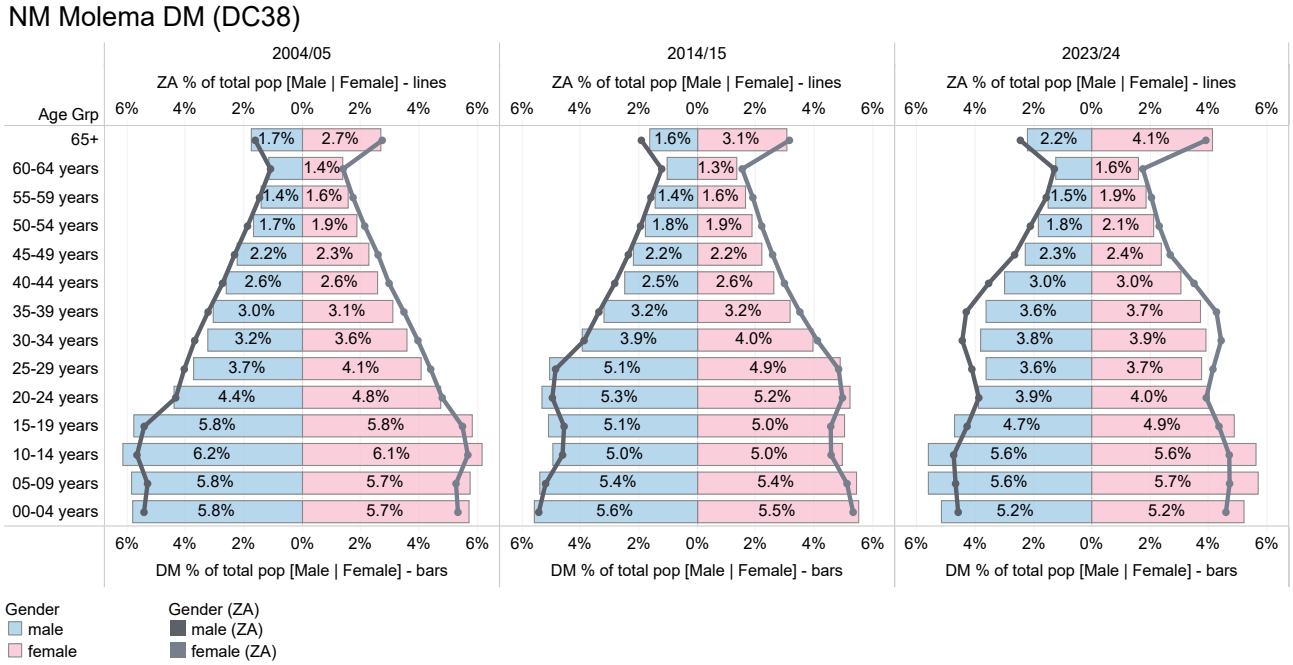
Ratlou: Disaneng, Kraaipan, Madibogo, Setlagole

Ramotshere Moiloa: Groot Marico, Zeerust

Ditsobotla: Biesiesvlei, Coligny, Lichtenburg

Tswaing: Delareyville, Ottosdal, Sannieshof

District percentage population by age-gender group compared to South Africa

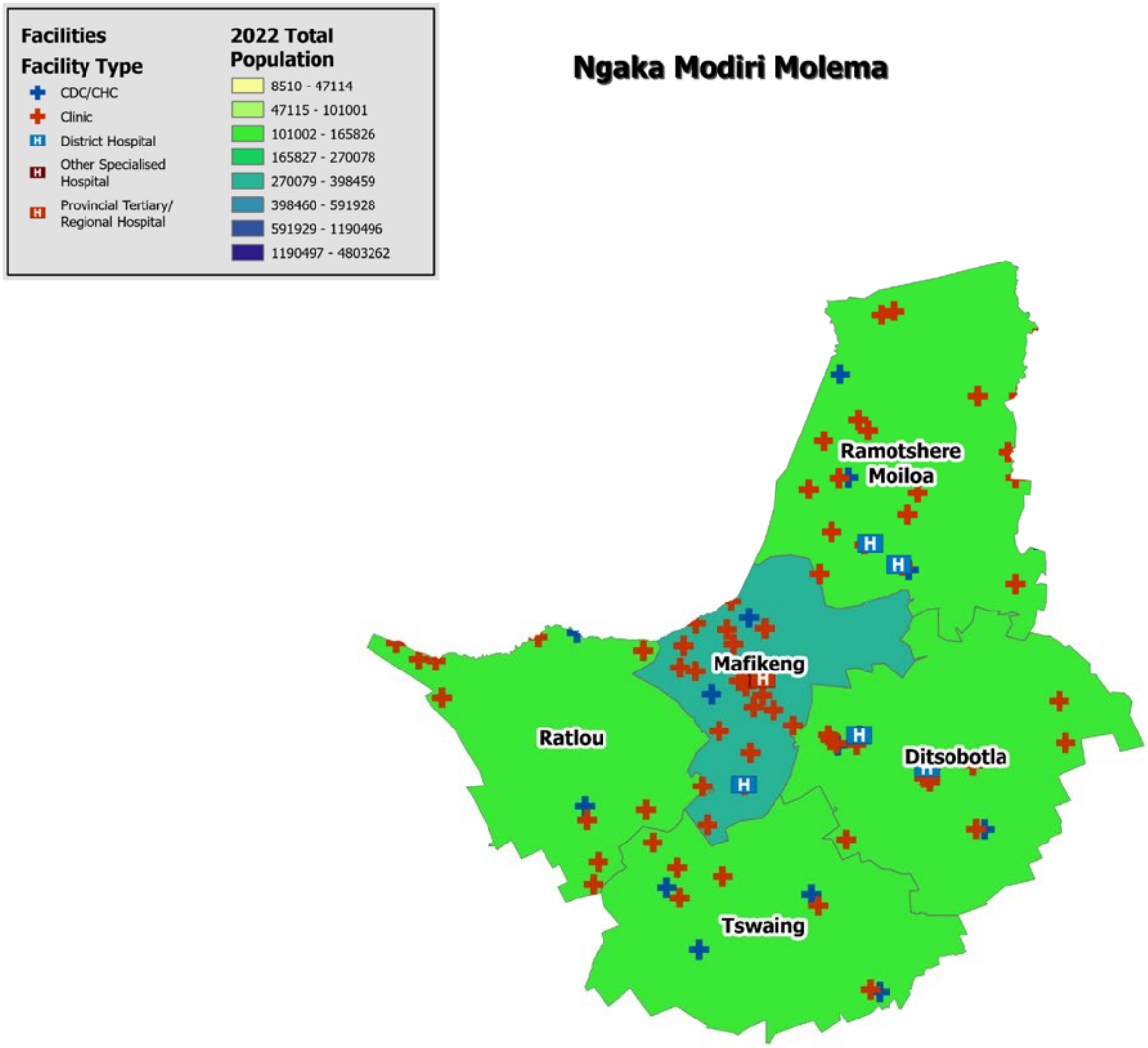


Source: DHIS

3 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

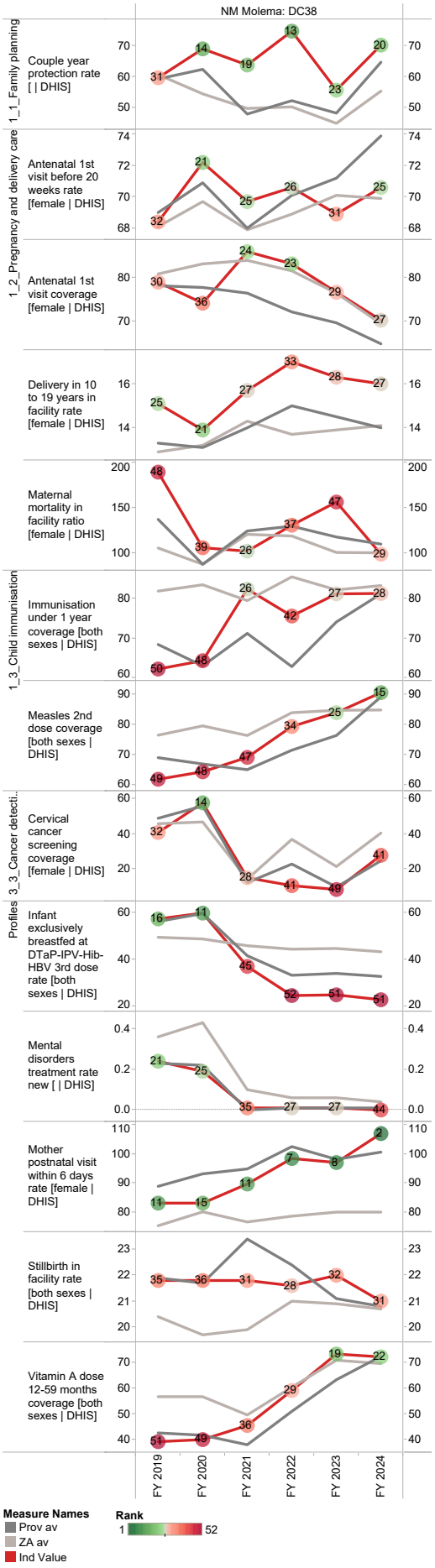
4 Mid-year Population Estimates 2023, DHIS.

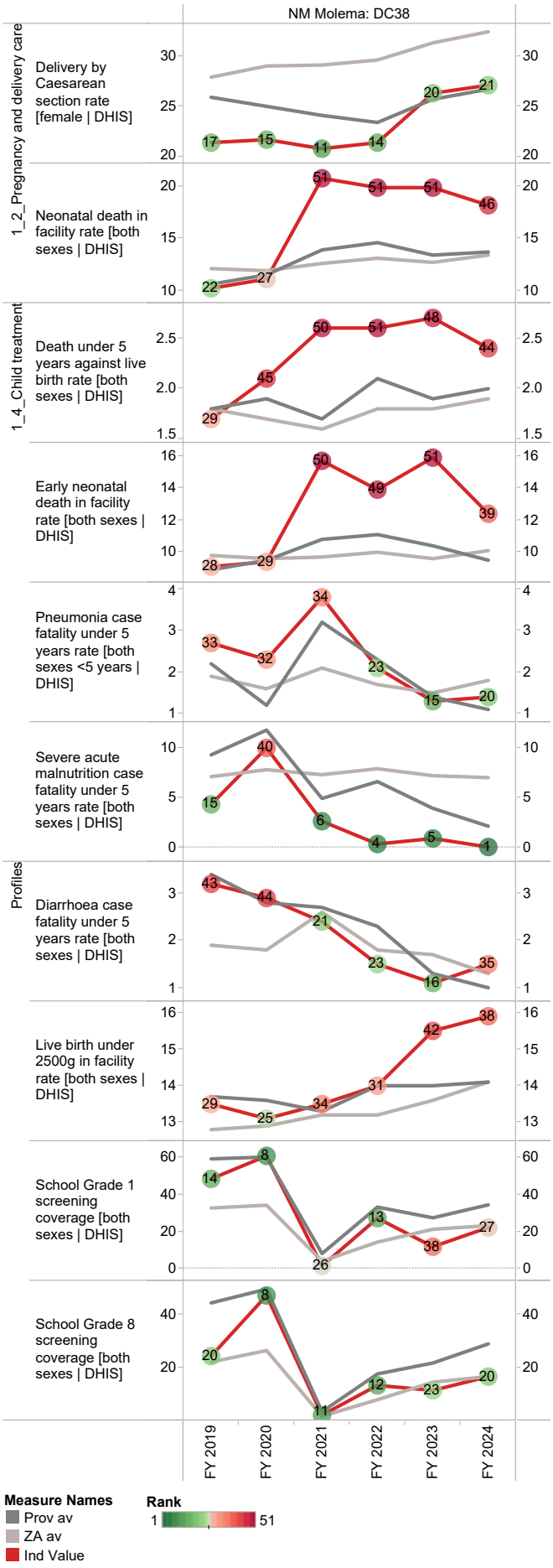
Population distribution, sub-district boundaries and health facility locations

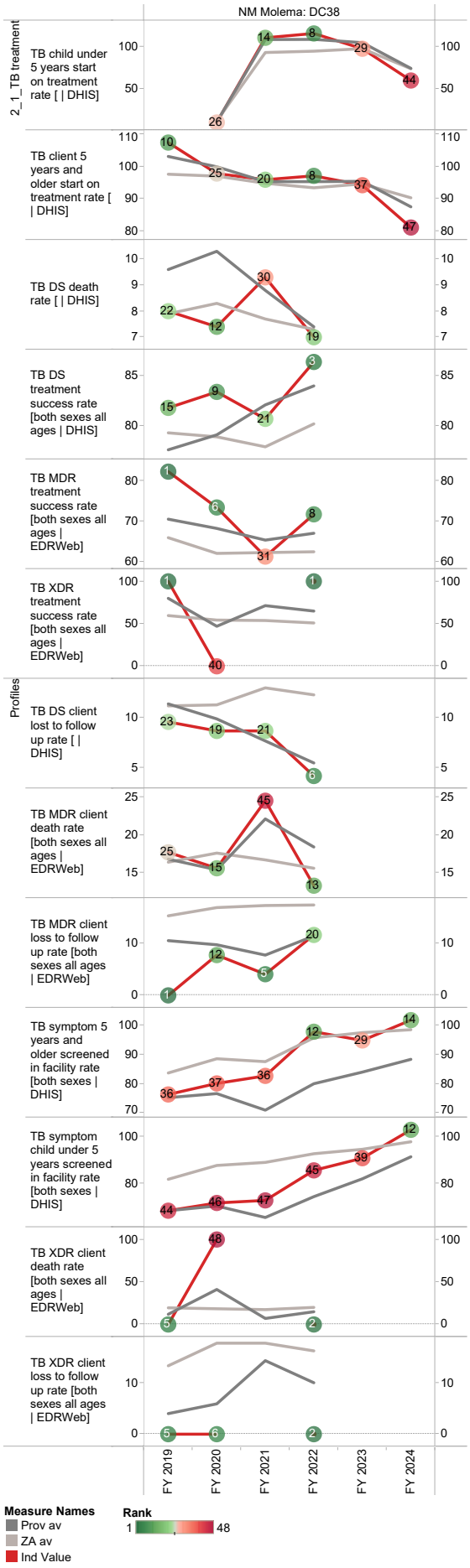


Source: DHIS

Annual trends, 2018/19–2023/24






NM Molema: DC38
2_1_TB treatment
Profiles
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
TB DS death rate [| DHIS]
TB DS treatment success rate [both sexes all ages | DHIS]
TB MDR treatment success rate [both sexes all ages | EDRWeb]
TB XDR treatment success rate [both sexes all ages | EDRWeb]
TB DS client lost to follow up rate [| DHIS]
TB MDR client death rate [both sexes all ages | EDRWeb]
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TB symptom 5 years and older screened in facility rate [both sexes | DHIS]
TB symptom child under 5 years screened in facility rate [both sexes | DHIS]
TB XDR client death rate [both sexes all ages | EDRWeb]
TB XDR client loss to follow up rate [both sexes all ages | EDRWeb]
FY 2019
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Measure Names
Prov av
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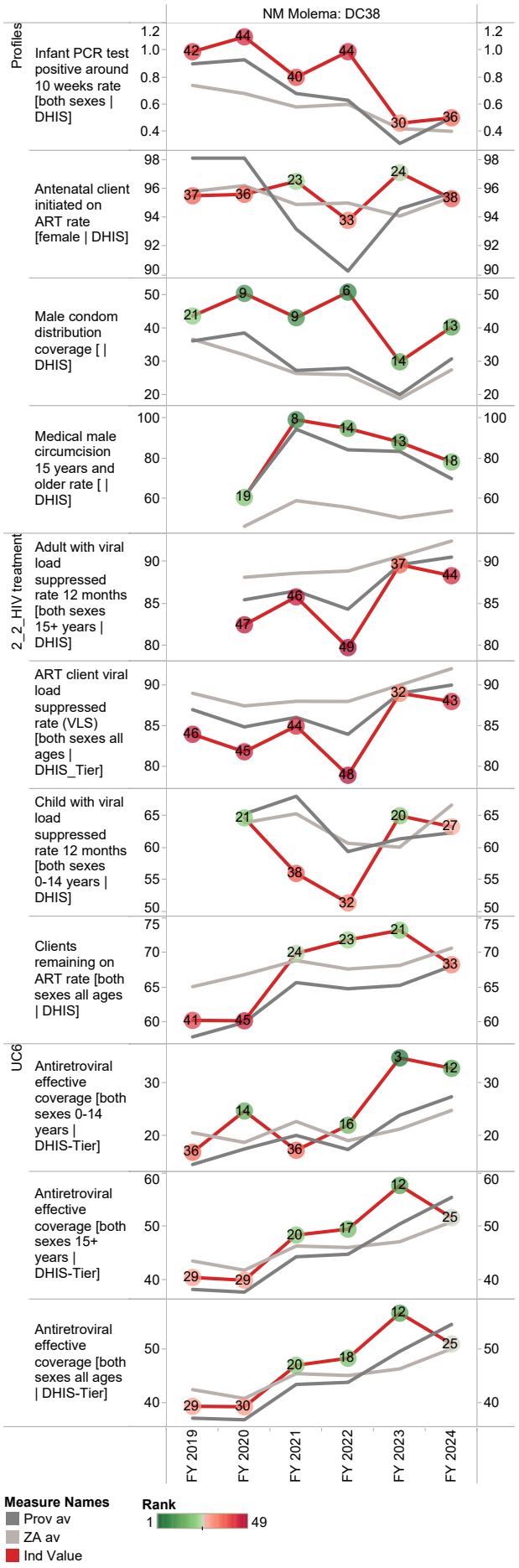
48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Profiles
2_2_HIV treatment
UC6
Infant PCR test positive around 10 weeks rate [both sexes | DHIS]
Antenatal client initiated on ART rate [female | DHIS]
Male condom distribution coverage [| DHIS]
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Antiretroviral effective coverage [both sexes all ages | DHIS-Tier]
FY 2019
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Measure Names
Prov av
ZA av
Ind Value
Rank
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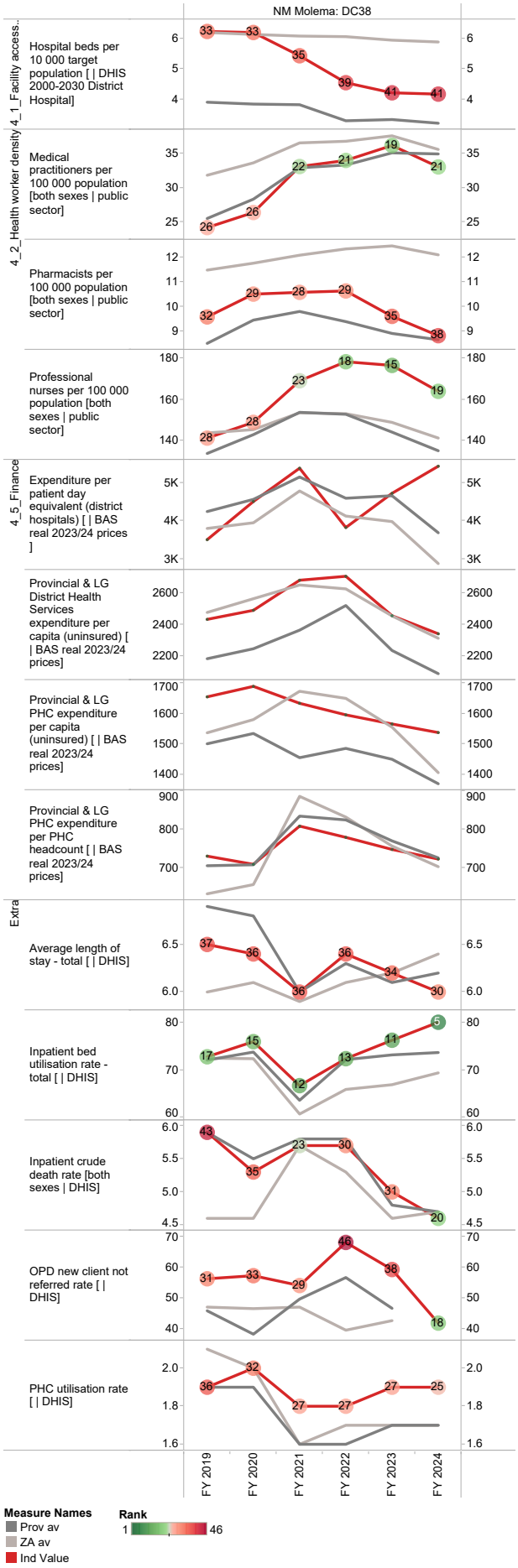
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4_1_Facility access..
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
4_2_Health worker density
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PHC utilisation rate [| DHIS]
FY 2019
FY 2020
FY 2021
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FY 2023
FY 2024
Measure Names
Prov av
ZA av
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Dr Ruth Segomotsi Mompati District Municipality (DC39)

The Dr Ruth Segomotsi Mompati District Municipality[5] is a Category C municipality located in the North West Province. It is the largest district in the province, making up almost half of its geographical area. The district comprises five local municipalities: Naledi, Greater Taung, Kagisano-Molopo, Mamusa and Lekwa-Teemane.

Area: 43 753km²

Population (2023)[6]: 477 280

Households[5]: 127 103

Formal dwellings[5]: 89.9%

Cities/Towns:

Naledi: Stella, Vryburg

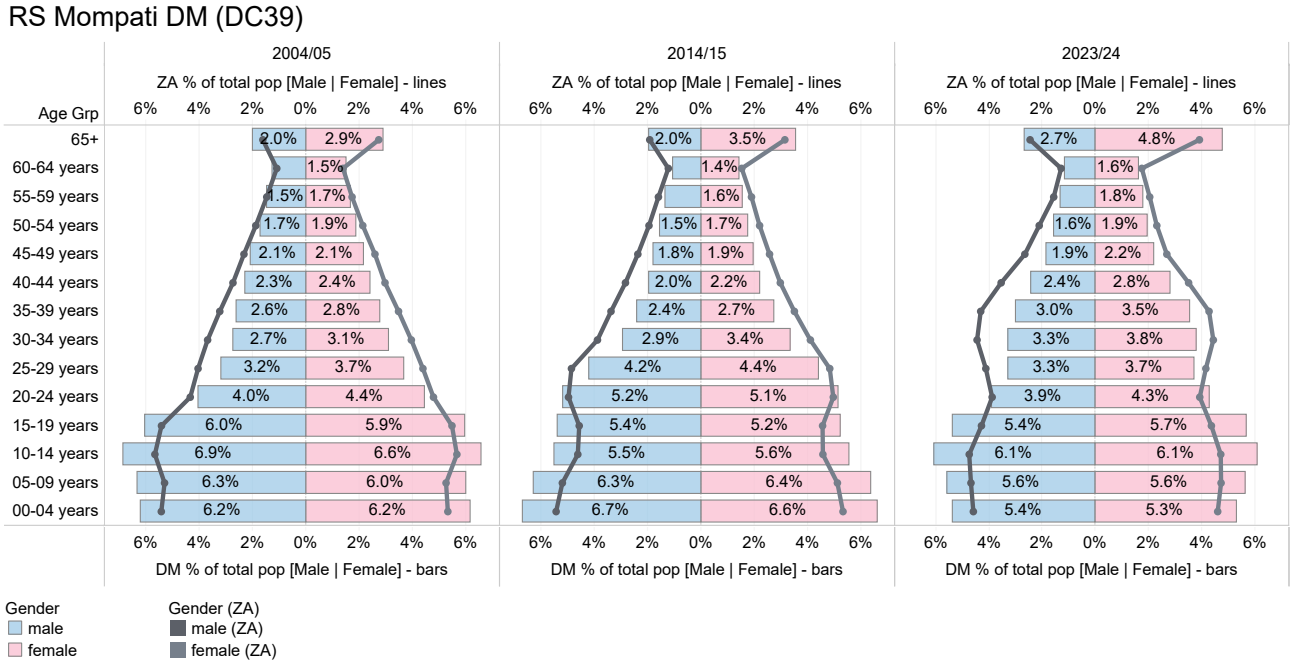
Greater Taung: Pudimoe, Reivilo, Taung

Kagisano-Molopo: Piet Plessis, Pomfret

Mamusa: Amalia, Schweizer-Reneke

Lekwa-Teemane: Bloemhof, Christiana

District percentage population by age-gender group compared to South Africa

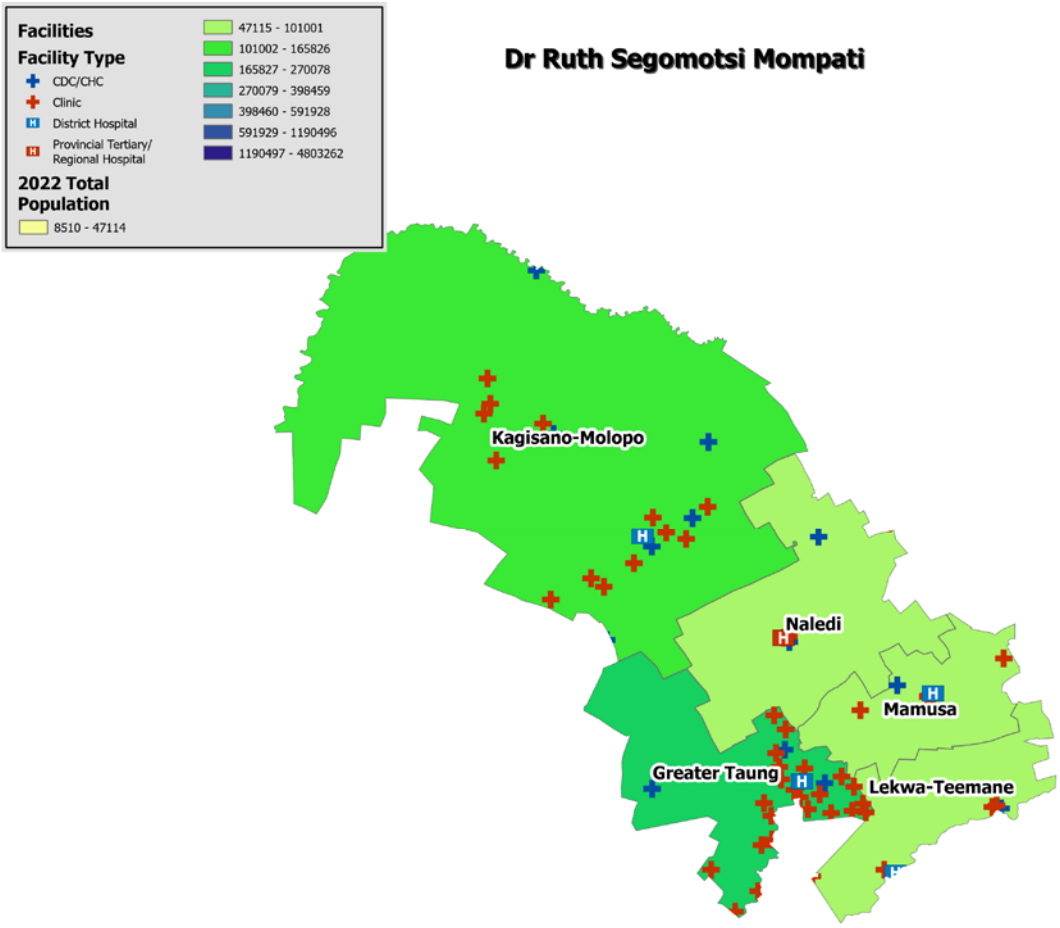


Source: DHIS

5 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

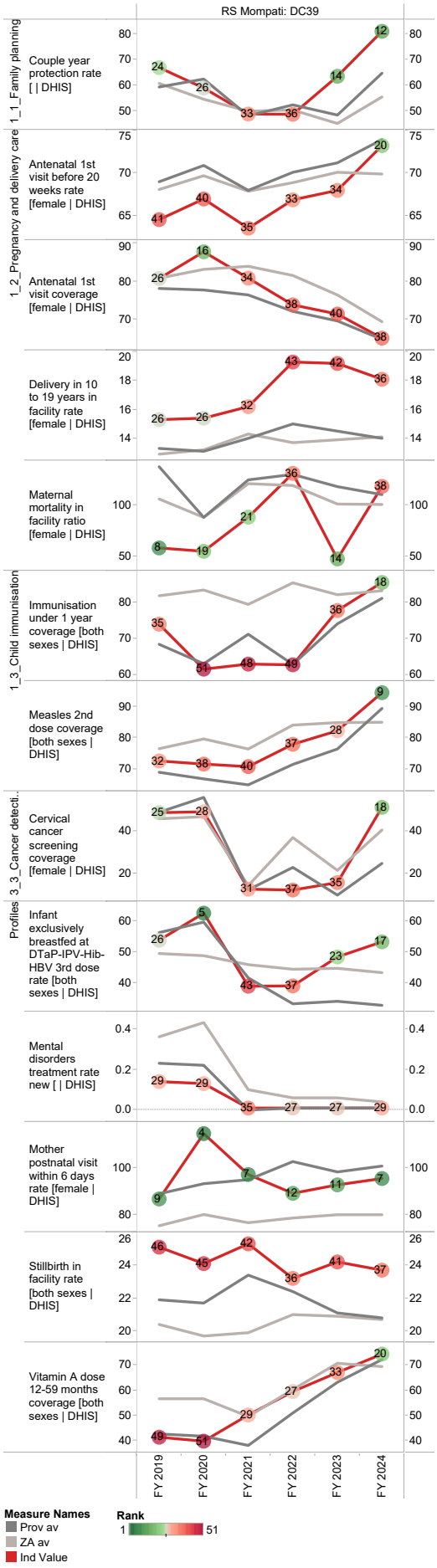
6 Mid-year Population Estimates 2023, DHIS.

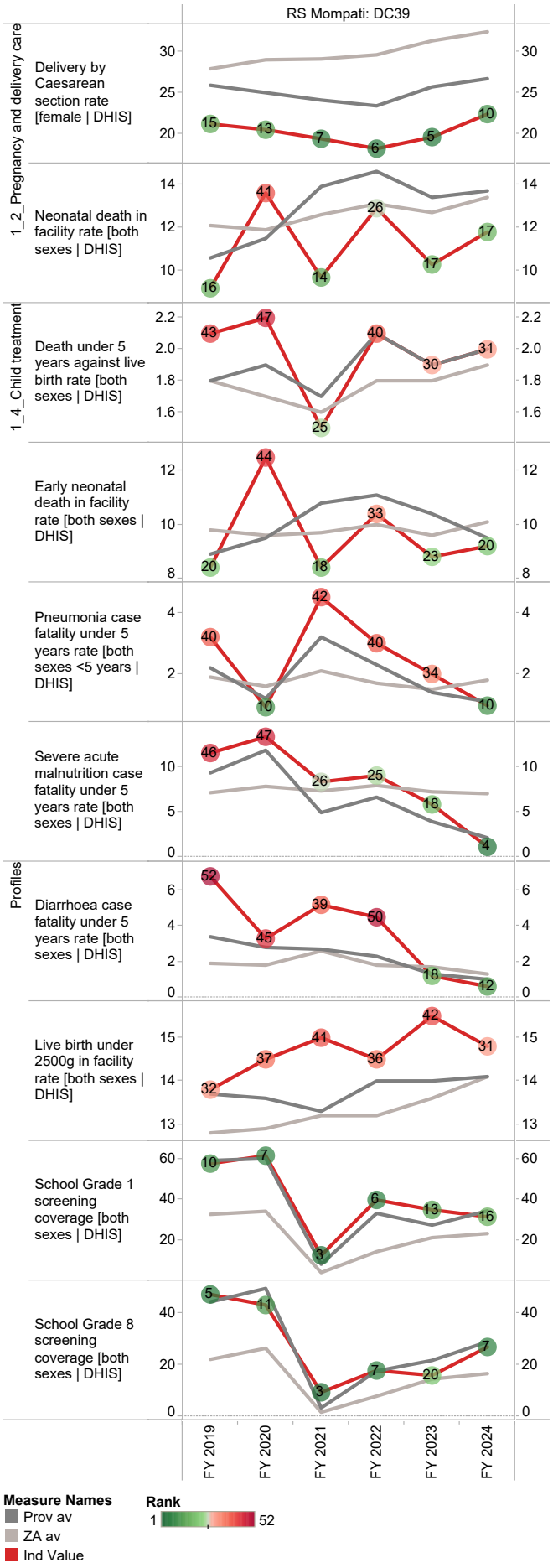
Population distribution, sub-district boundaries and health facility locations

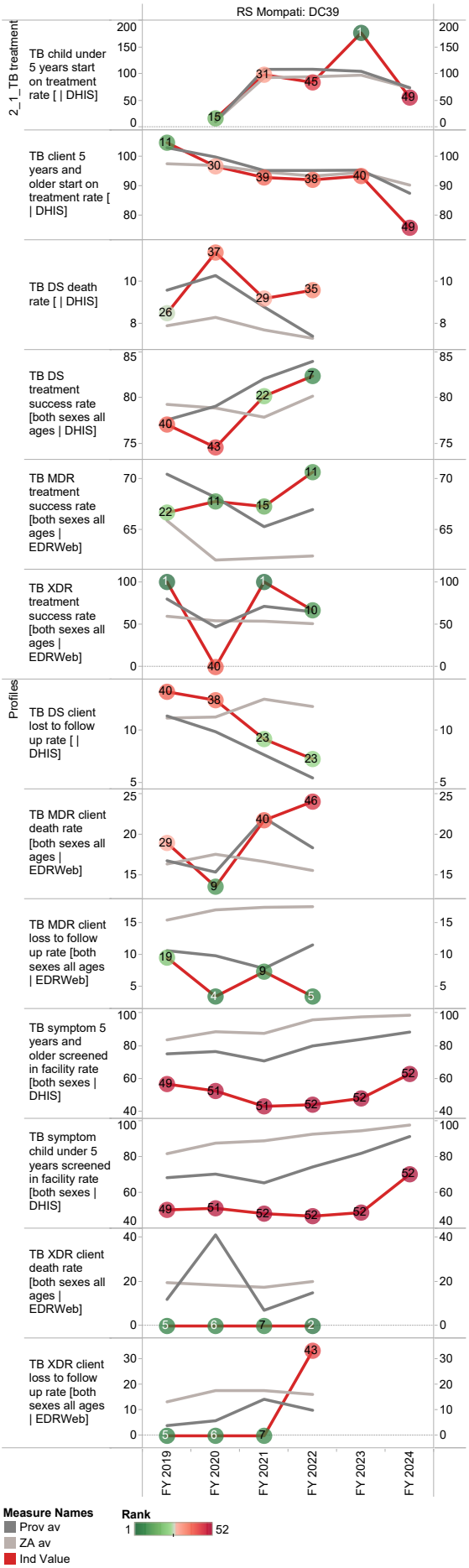


Source: DHIS

Annual trends 2018/19–2023/24






RS Mompati: DC39
2_1_TB treatment
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
TB DS death rate [| DHIS]
TB DS treatment success rate [both sexes all ages | DHIS]
TB MDR treatment success rate [both sexes all ages | EDRWeb]
TB XDR treatment success rate [both sexes all ages | EDRWeb]
Profiles
TB DS client lost to follow up rate [| DHIS]
TB MDR client death rate [both sexes all ages | EDRWeb]
TB MDR client loss to follow up rate [both sexes all ages | EDRWeb]
TB symptom 5 years and older screened in facility rate [both sexes | DHIS]
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FY 2019
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FY 2022
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FY 2024
Measure Names
Prov av
ZA av
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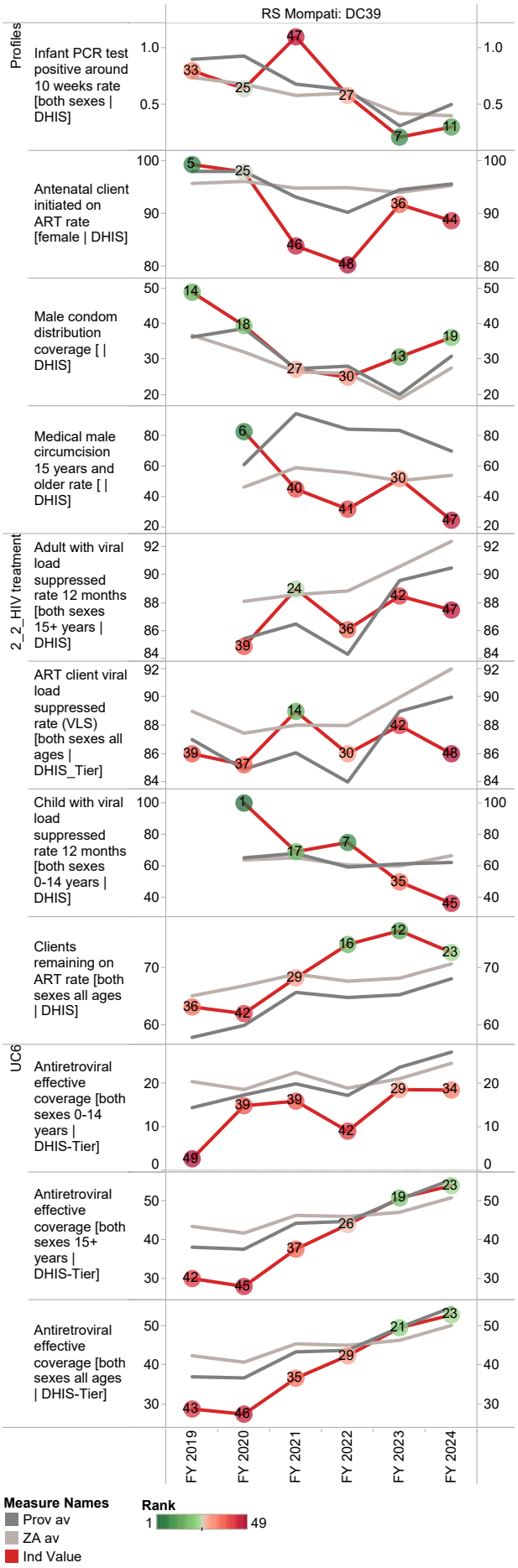
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FY 2019
FY 2020
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FY 2022
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FY 2024
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ZA av
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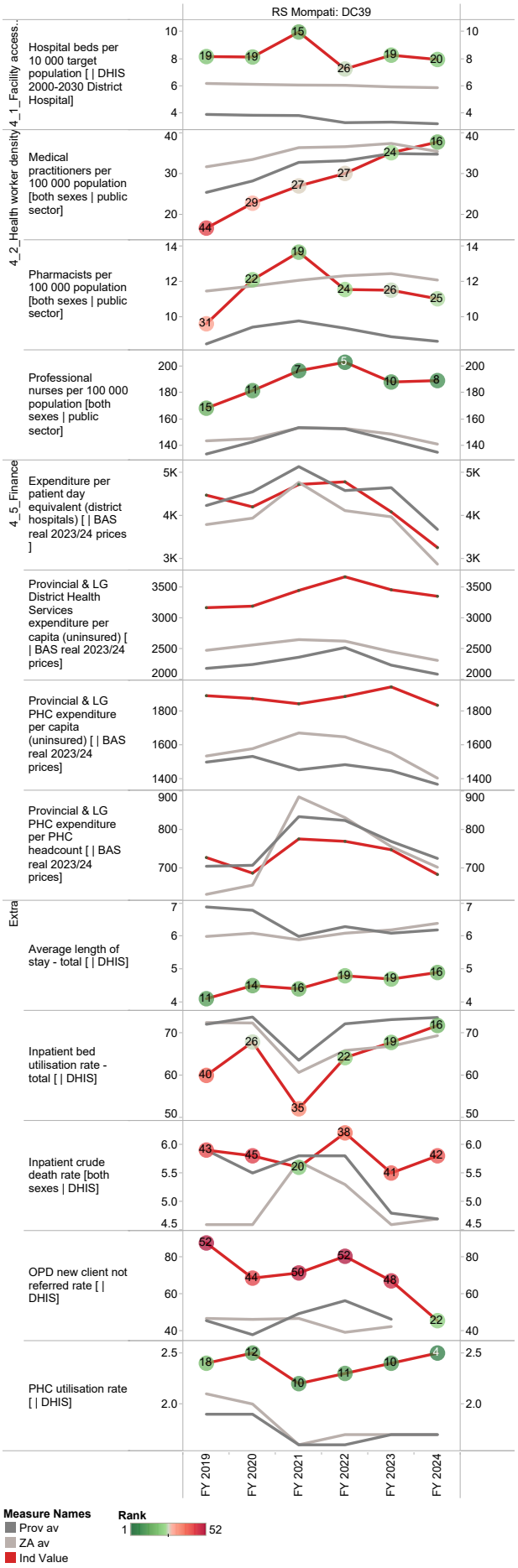
RS Mompati: DC39
4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
4_2_Health worker density
Medical practitioners per 100 000 population [both sexes | public sector]
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4_5_Finance
Expenditure per patient day equivalent (district hospitals) [| BAS real 2023/24 prices]
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PHC utilisation rate [| DHIS]
FY 2019
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FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
1
52

Dr Kenneth Kaunda District Municipality (DC40)

The Dr Kenneth Kaunda District Municipality[7] is a Category C municipality in the North West Province. It is the smallest district in the province, making up 14% of its geographical area. The district consists of three local municipalities: JB Marks, City of Matlosana and Maquassi Hills.

Area: 14 671km²

Population (2023)[8]: 834 931

Households[7]: 240 534

Formal dwellings[7]: 86.4%

Cities/Towns:

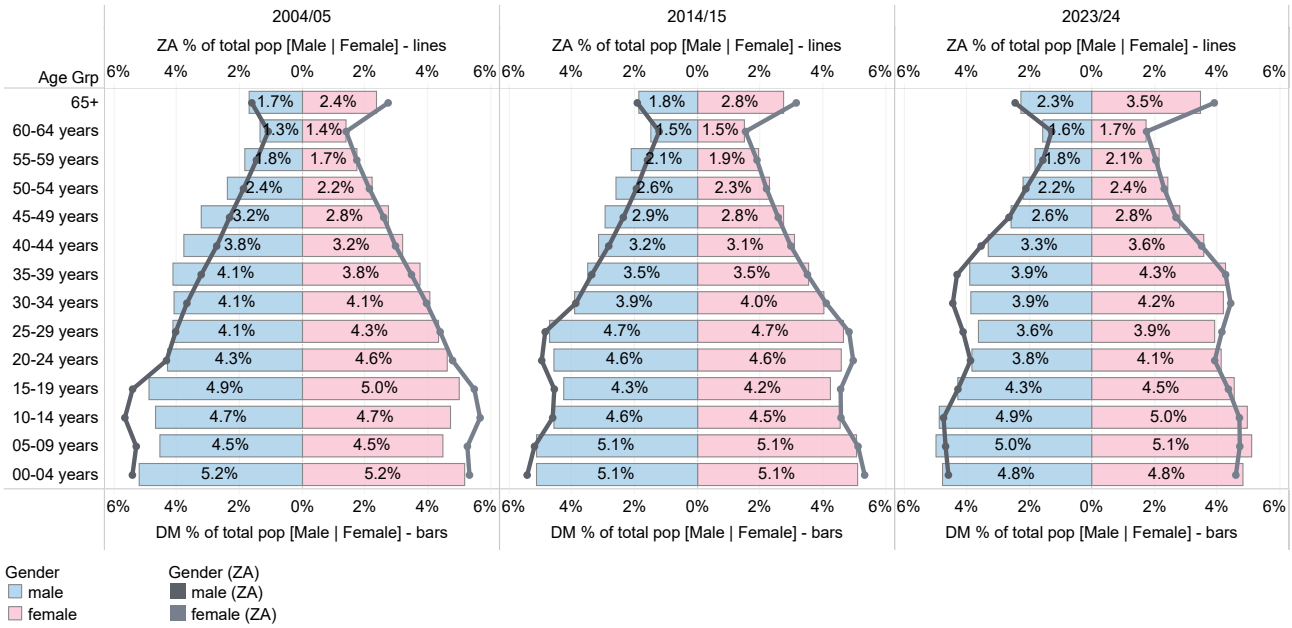
JB Marks: Potchefstroom, Ventersdorp

City of Matlosana: Hartbeesfontein, Klerksdorp, Orkney, Stilfontein

Maquassi Hills: Leeudoringstad, Makwassie, Witpoort, Wolmaransstad

District percentage population by age-gender group compared to South Africa

Dr K Kaunda DM (DC40)

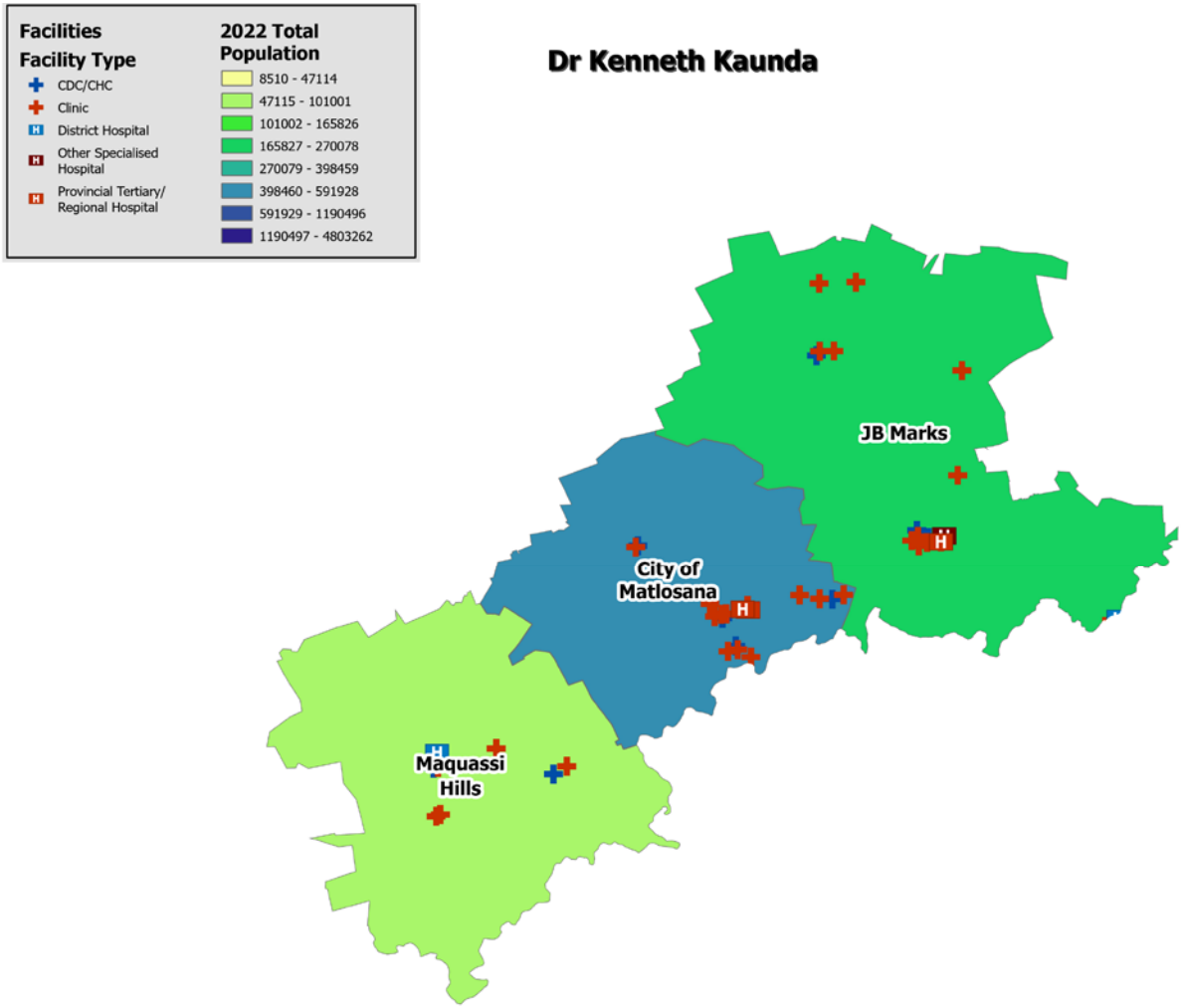


Source: DHIS

7 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

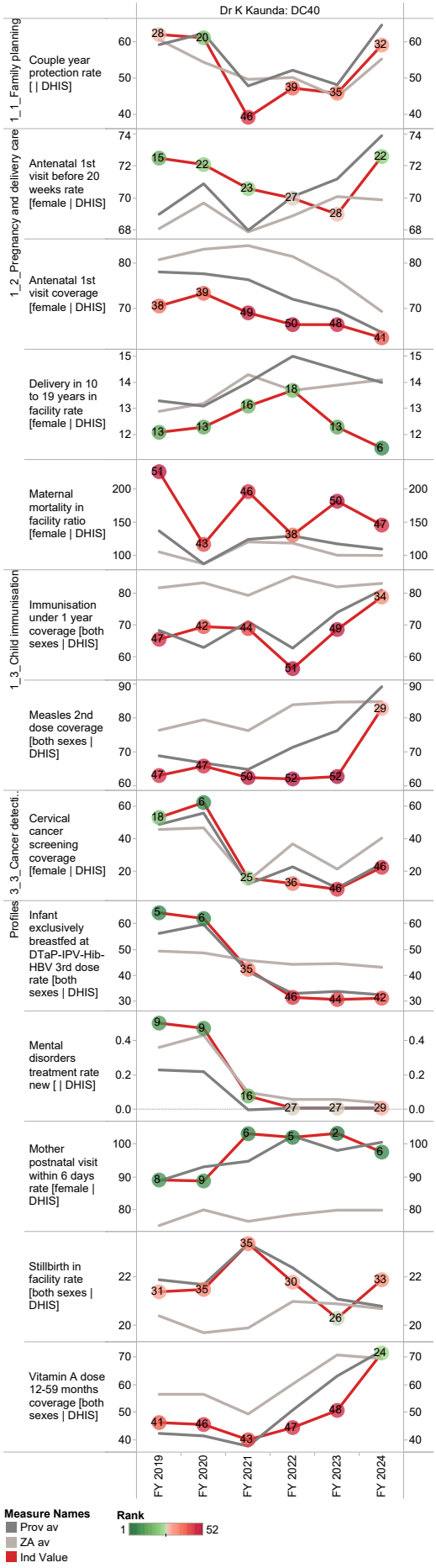
8 Mid-year Population Estimates 2023, DHIS.

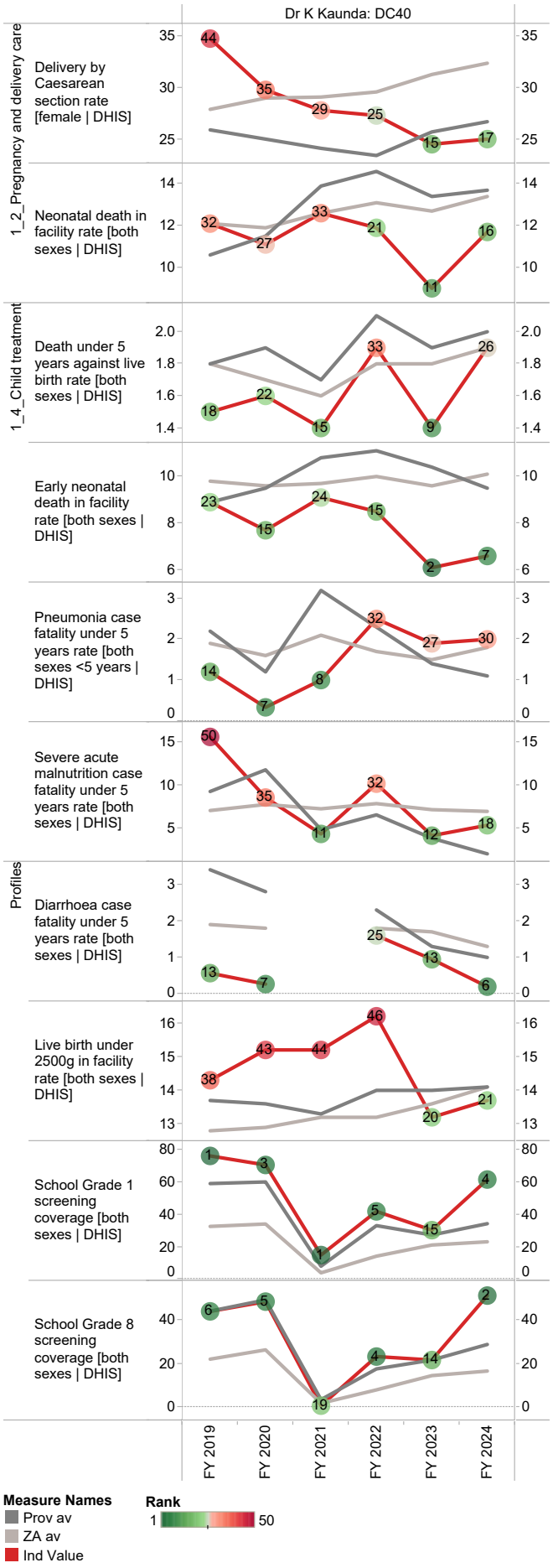
Population distribution, sub-district boundaries and health facility locations

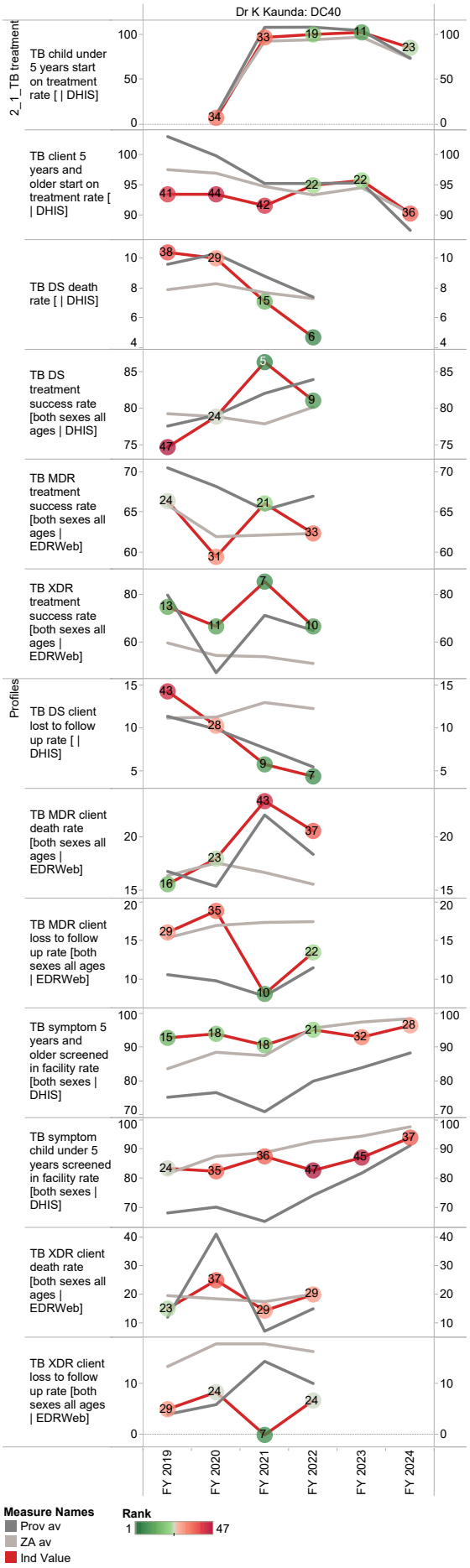


Source: DHIS

Annual trends, 2018/19–2023/24






Dr K Kaunda: DC40
2_1_TB treatment
Profiles
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
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FY 2024
Measure Names
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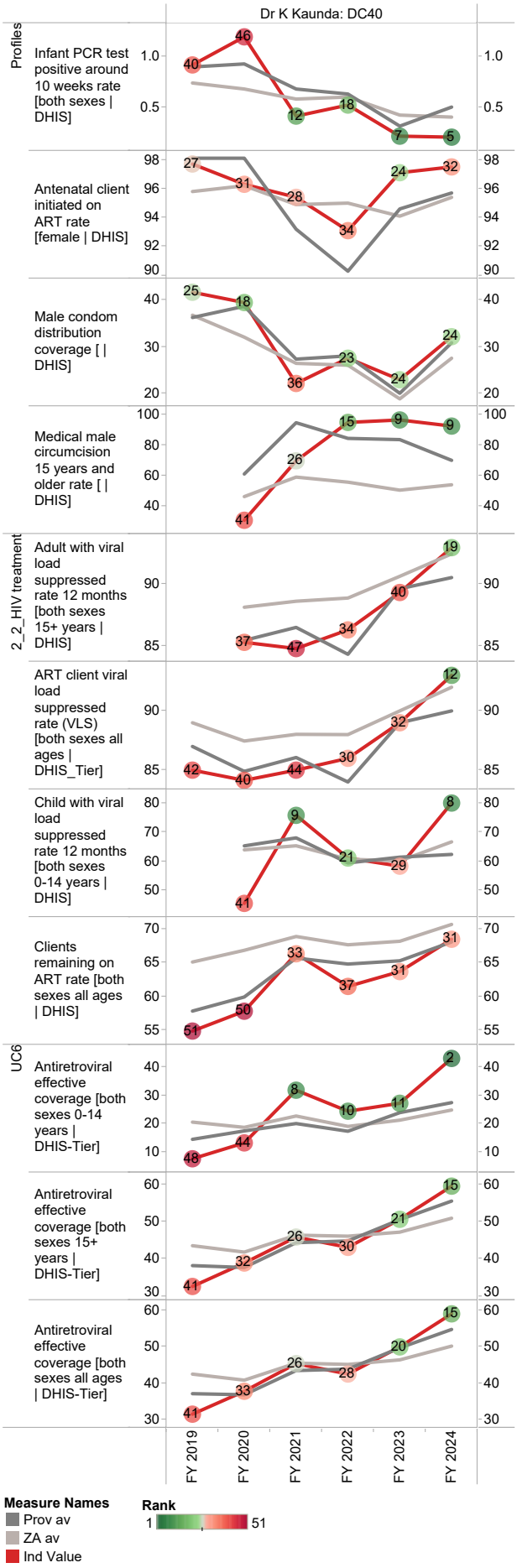
Dr K Kaunda: DC40
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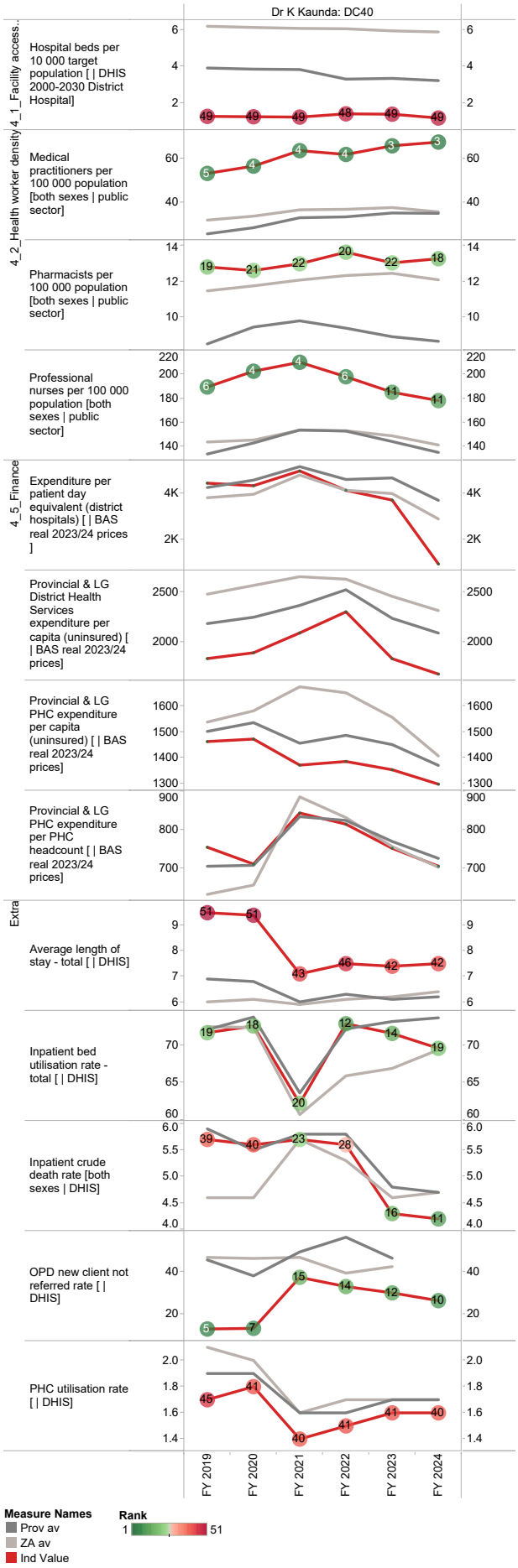
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FY 2021
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FY 2023
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Measure Names
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Rank
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15 Western Cape Province

Cape Town Metropolitan Municipality (CPT)

The City of Cape Town Metropolitan municipality is situated on the southern peninsula of the Western Cape Province.[1] The City of Cape Town Metropolitan Municipality incorporates eight health sub-districts, namely: Cape Town Eastern, Cape Town Northern, Cape Town Southern, Cape Town Western, Khayelitsha, Klipfontein, Mitchell's Plain and Tygerberg.

Cities/Towns: Athlone, Atlantis, Belhar, Bellville, Blackheath, Blouberg, Blue Downs, Brackenfell, Cape Point, Cape Town, Delft, Durbanville, Elsies Rivier, Fish Hoek, Goodwood, Gordon's Bay, Grassy Park, Guguletu, Hout Bay, Khayelitsha, Kommetjie, Kraaifontein, Kuils River, Langa, Macassar, Matroosfontein, Melkbosstrand, Milnerton, Mitchells Plain, Muizenberg, Noordhoek, Nyanga, Parow, Philadelphia, Philippi, Robben Island, Scarborough, Simon's Town, Sir Lowry's Pass, Somerset West, Southern Suburbs, Strand, Table View

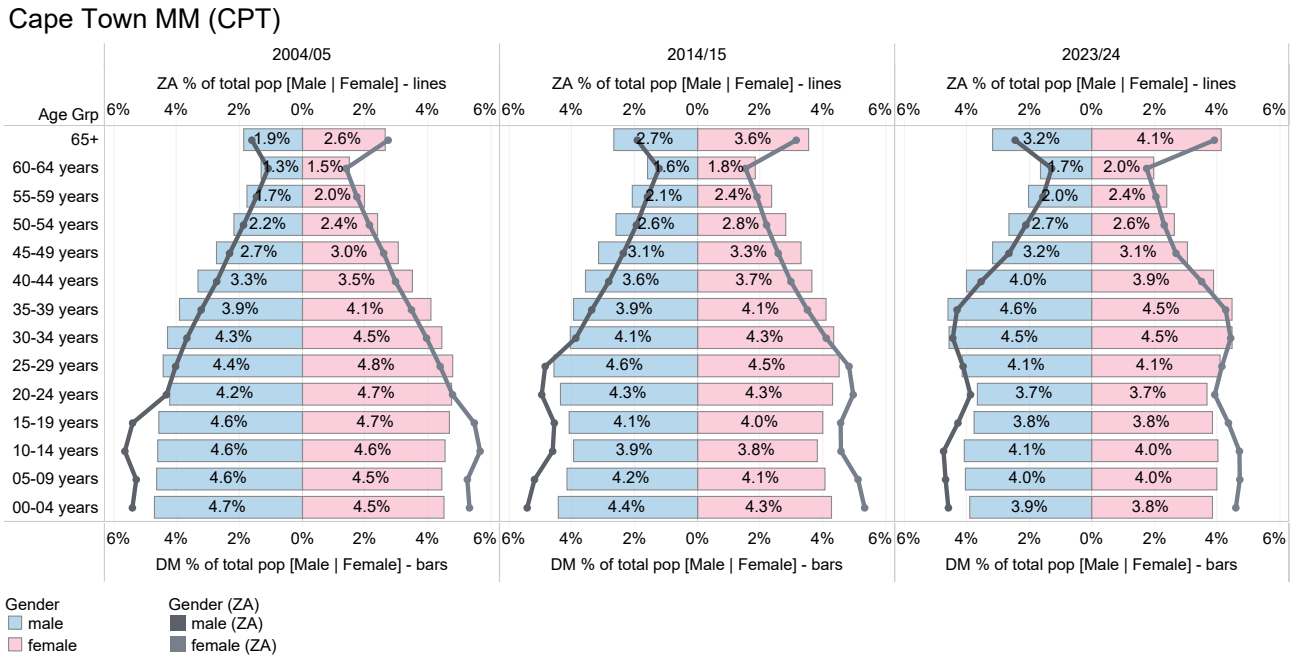
Area: 2 441km²

Population (2023)[2]: 4 867 548

Households[1]: 1 264 949

Formal dwellings[1]: 81.6%

District percentage population by age-gender group compared to South Africa



Source: DHIS

1 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

2 Mid-year Population Estimates 2023, DHIS.

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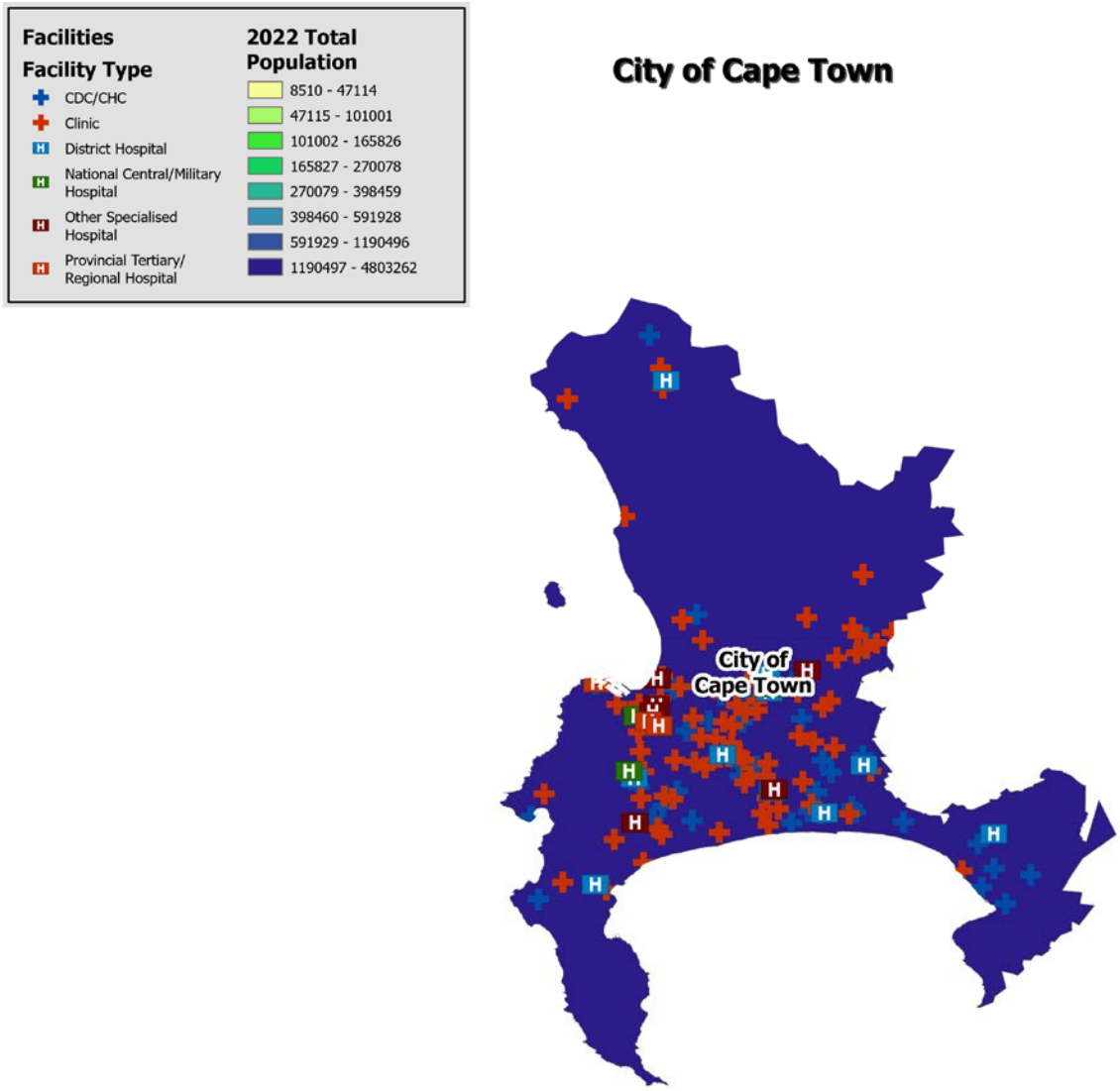
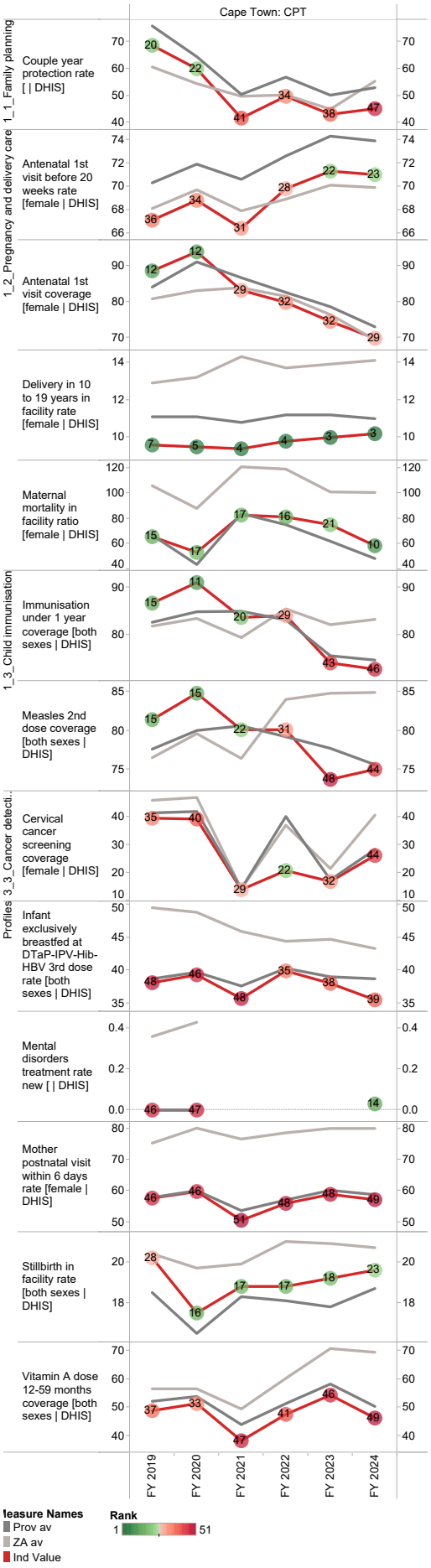
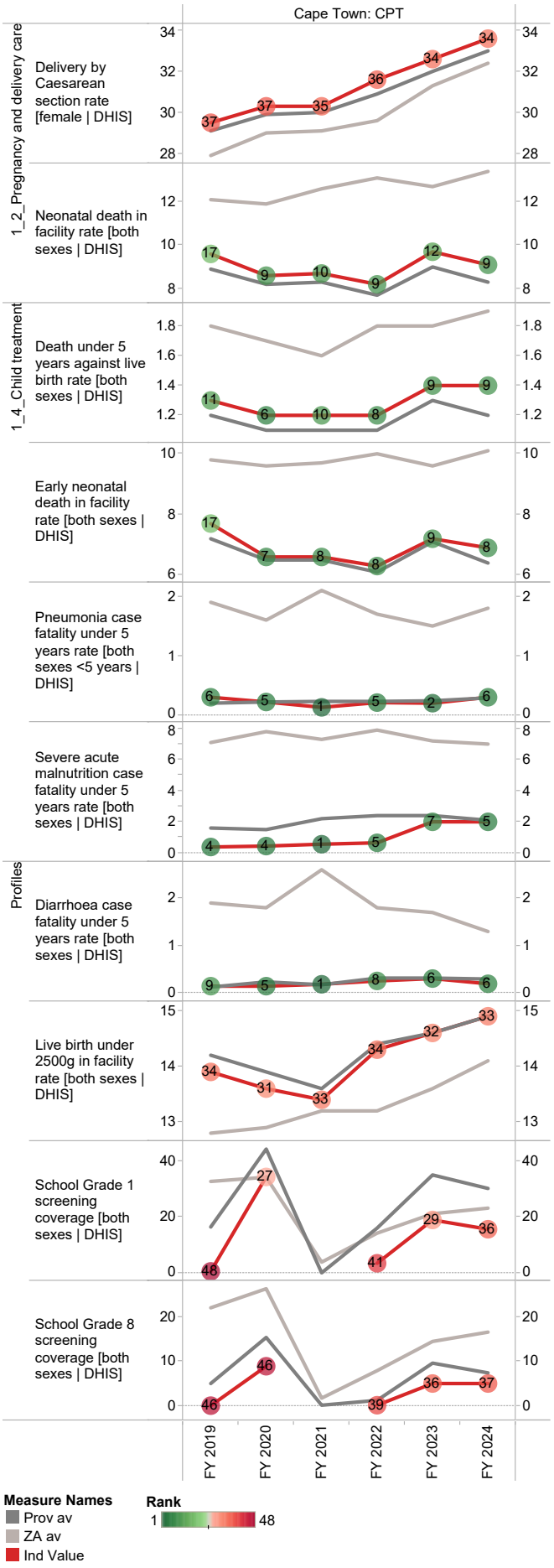
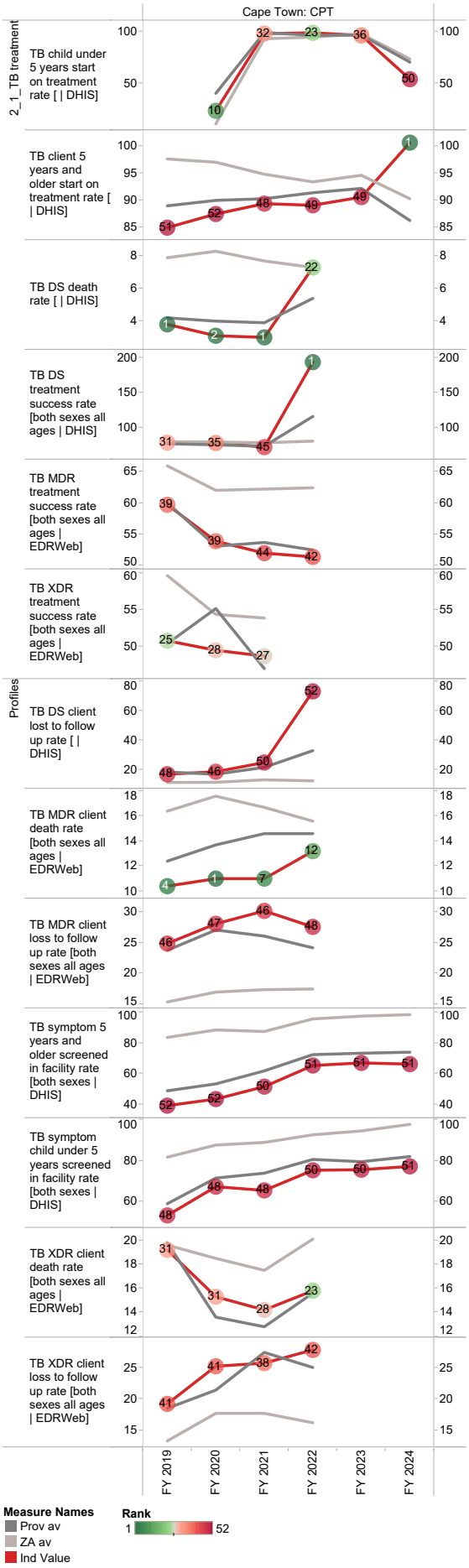


Source: DHIS

Annual trends, 2014/19–2023/24






Cape Town: CPT
2_1_TB treatment
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
TB DS death rate [| DHIS]
TB DS treatment success rate [both sexes all ages | DHIS]
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TB XDR client death rate [both sexes all ages | EDRWeb]
TB XDR client loss to follow up rate [both sexes all ages | EDRWeb]
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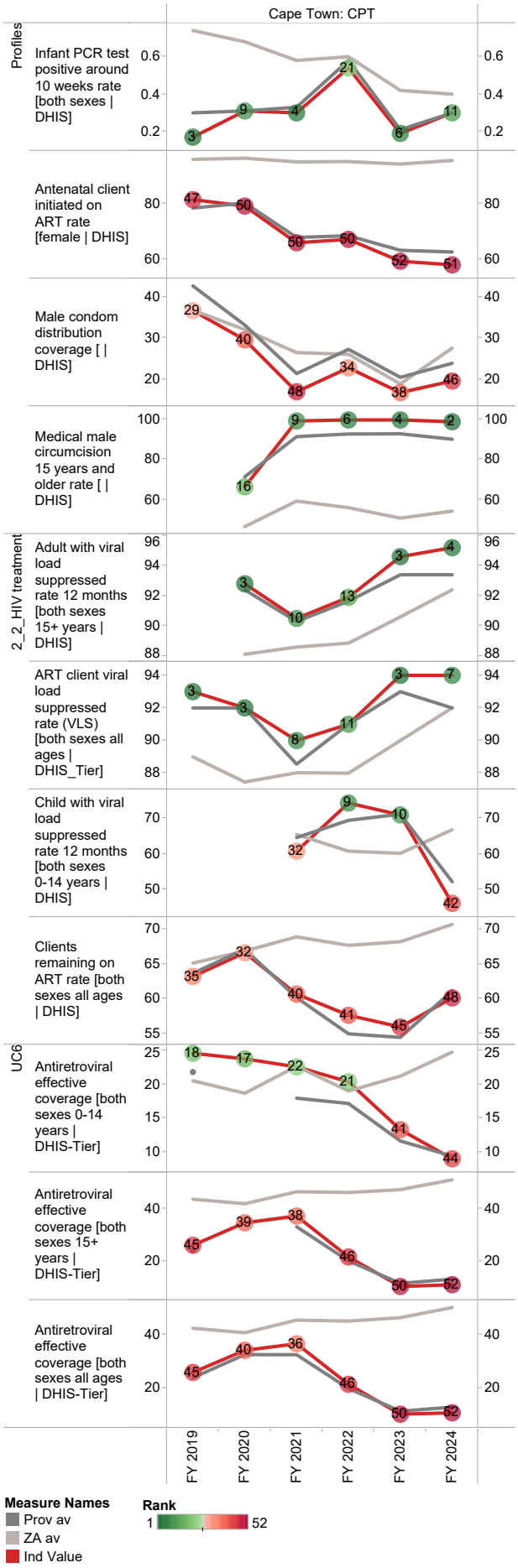
Cape Town: CPT
Profiles
Infant PCR test positive around 10 weeks rate [both sexes | DHIS]
Antenatal client initiated on ART rate [female | DHIS]
Male condom distribution coverage [| DHIS]
Medical male circumcision 15 years and older rate [| DHIS]
2_2_HIV treatment
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ART client viral load suppressed rate (VLS) [both sexes all ages | DHIS_Tier]
Child with viral load suppressed rate 12 months [both sexes 0-14 years | DHIS]
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Antiretroviral effective coverage [both sexes 0-14 years | DHIS-Tier]
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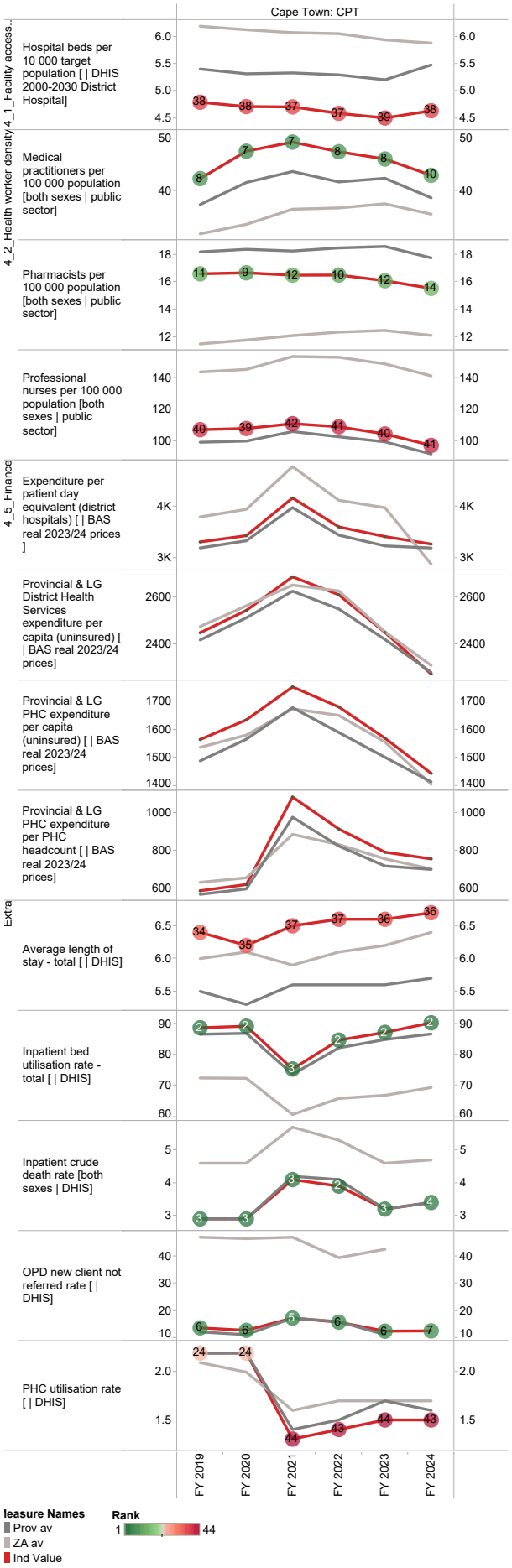
Cape Town: CPT
4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
4_2_Health worker density
Medical practitioners per 100 000 population [both sexes | public sector]
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Professional nurses per 100 000 population [both sexes | public sector]
4_5_Finance
Expenditure per patient day equivalent (district hospitals) [| BAS real 2023/24 prices]
Provincial & LG District Health Services expenditure per capita (uninsured) [| BAS real 2023/24 prices]
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Provincial & LG PHC expenditure per PHC headcount [| BAS real 2023/24 prices]
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Average length of stay - total [| DHIS]
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OPD new client not referred rate [| DHIS]
PHC utilisation rate [| DHIS]
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West Coast District Municipality (DC1)

The West Coast District Municipality[3] is a Category C municipality located in the Western Cape Province. It comprises five local municipalities: Swartland, Bergrivier, Matzikama, Cederberg, and Saldanha Bay.

Area: 31 118km²

Population (2023)[4]: 487 115

Households[3]: 129 862

Formal dwellings[3]: 85.8%

Cities/Towns:

Swartland: Abbotsdale, Chatsworth, Darling, Grotto Bay, Kalbaskraal, Koringberg, Malmesbury, Moorreesburg, Riebeeck Kasteel, Riebeeck West, Riverlands, Yzerfontein

Bergrivier: Aurora, Eendekuil, Piketberg, Porterville, Redelinghuys, Velddrif,

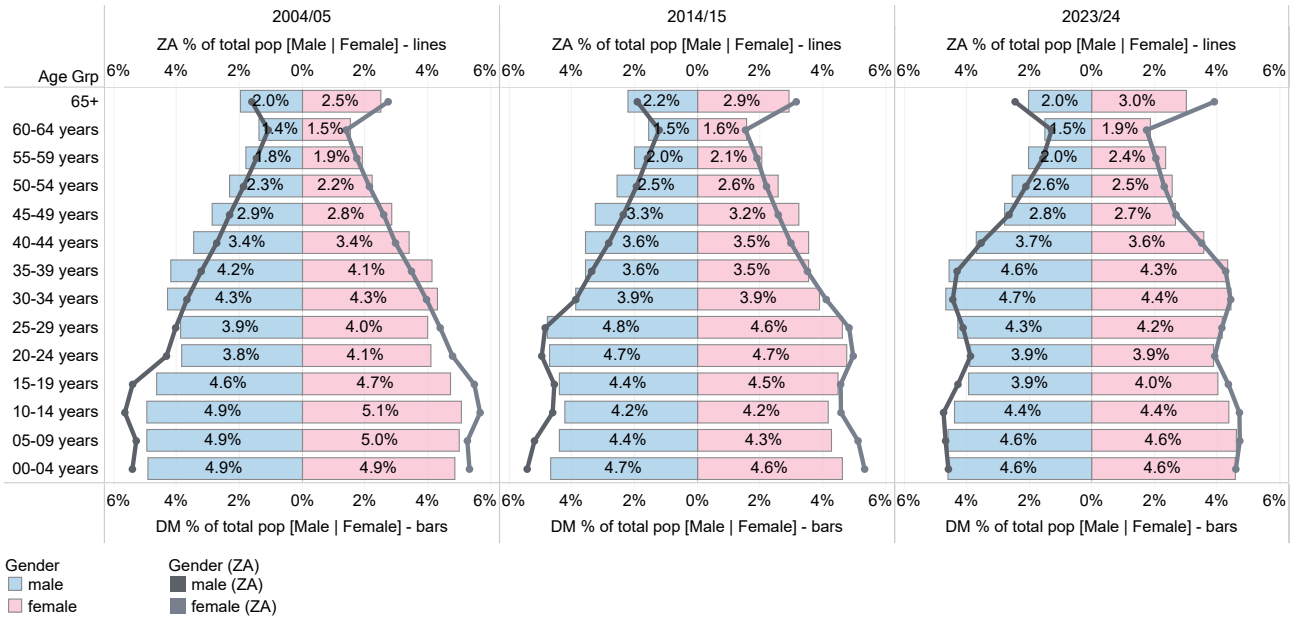
Matzikama: Bitterfontein, Doring Bay, Ebenhaezer, Klawer, Kliprand, Koekenaa, Lutzville, Molsvlei, Nuwerus, Putsekloof, Rietpoort, Stofkraal, Strandfontein, Vanrhynsdorp, Vredendal

Cederberg: Citrusdal, Clanwilliam, Elands Bay, Graafwater, Lamberts Bay, Leipoldtville, Wupperthal

Saldanha Bay: Hopefield, Jacobs Bay, Langebaan, Paternoster, Saldanha, St Helena Bay, Vredenburg

District percentage population by age-gender group compared to South Africa

West Coast DM (DC1)

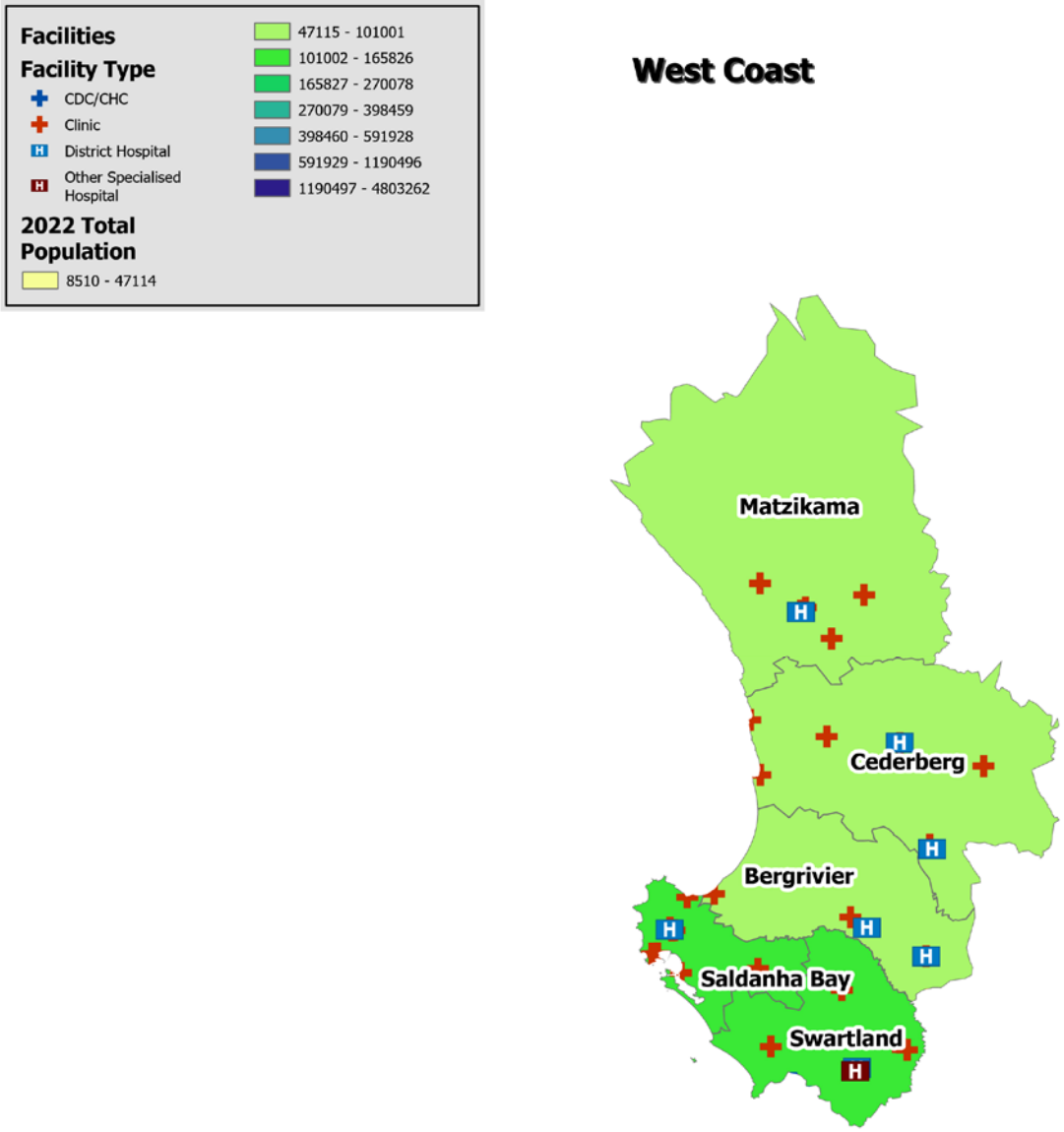


Source: DHIS

3 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

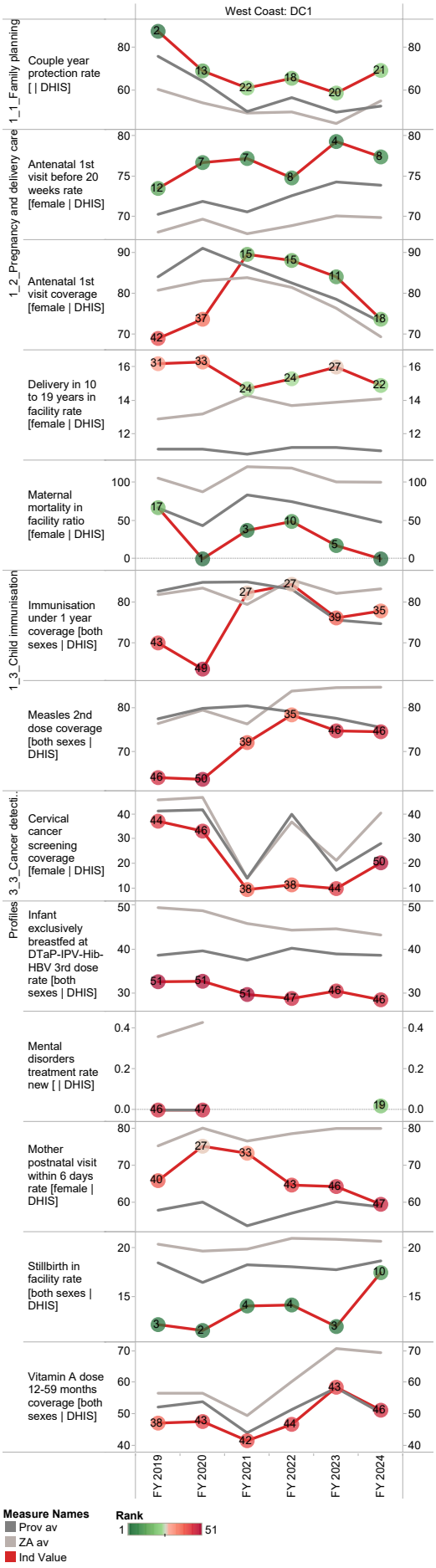
4 Mid-year Population Estimates 2023, DHIS.

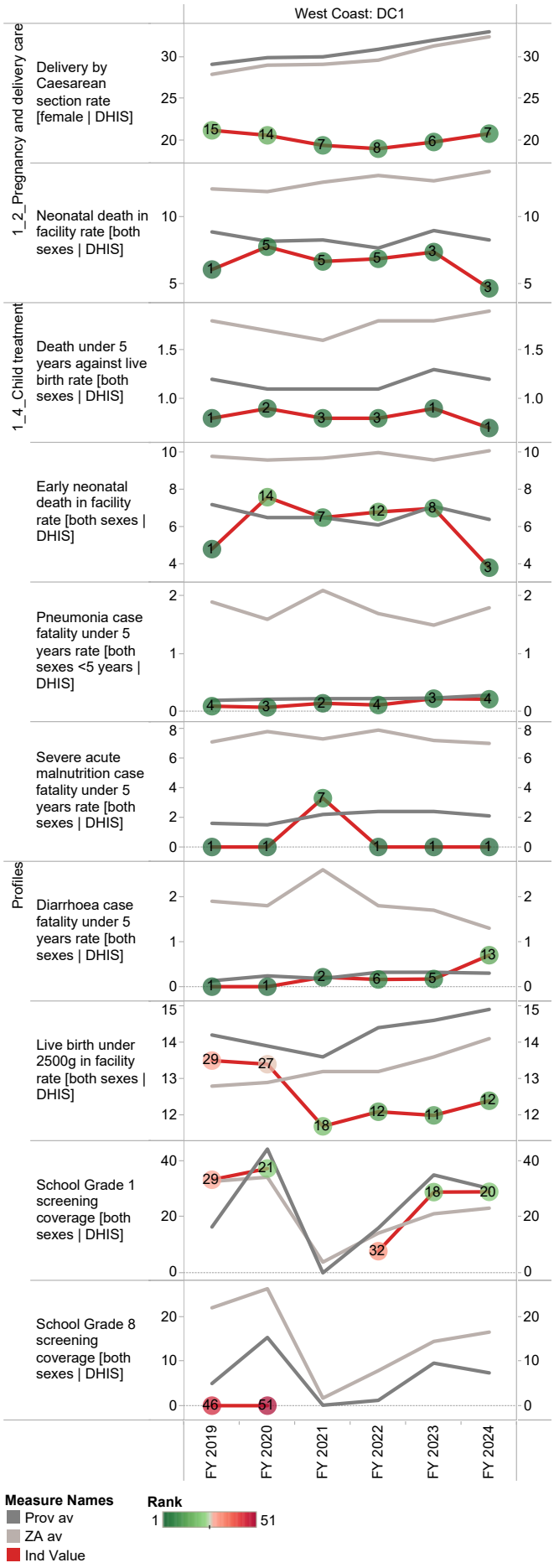
Population distribution, sub-district boundaries and health facility locations

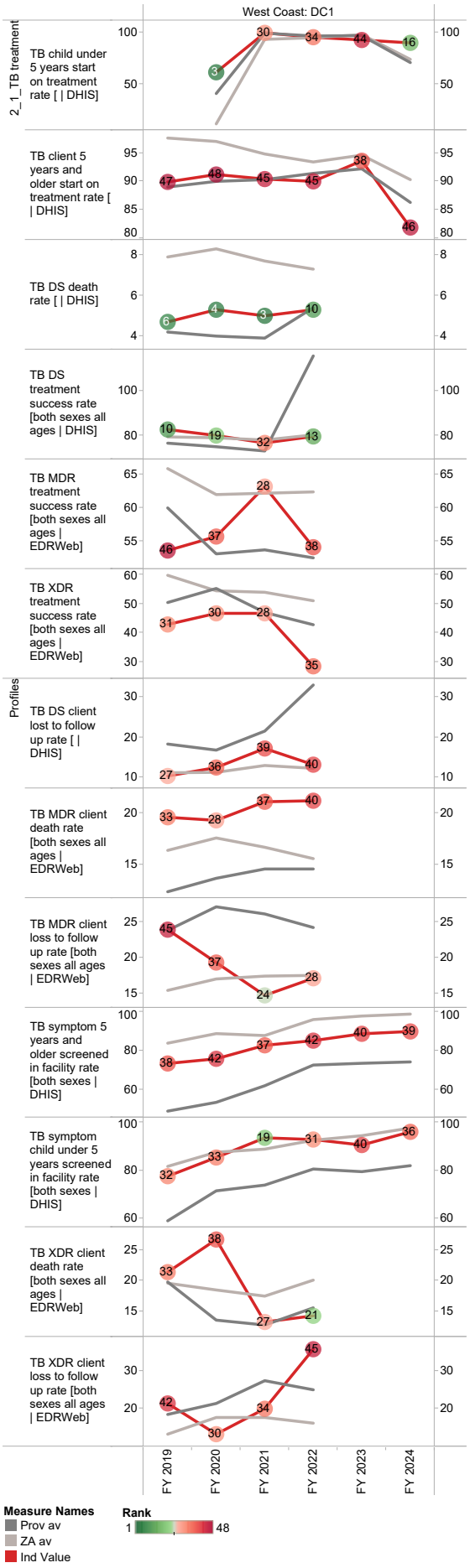


Source: DHIS

Annual trends, 2014/19–2023/24






West Coast: DC1
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TB child under 5 years start on treatment rate [| DHIS]
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FY 2019
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Measure Names
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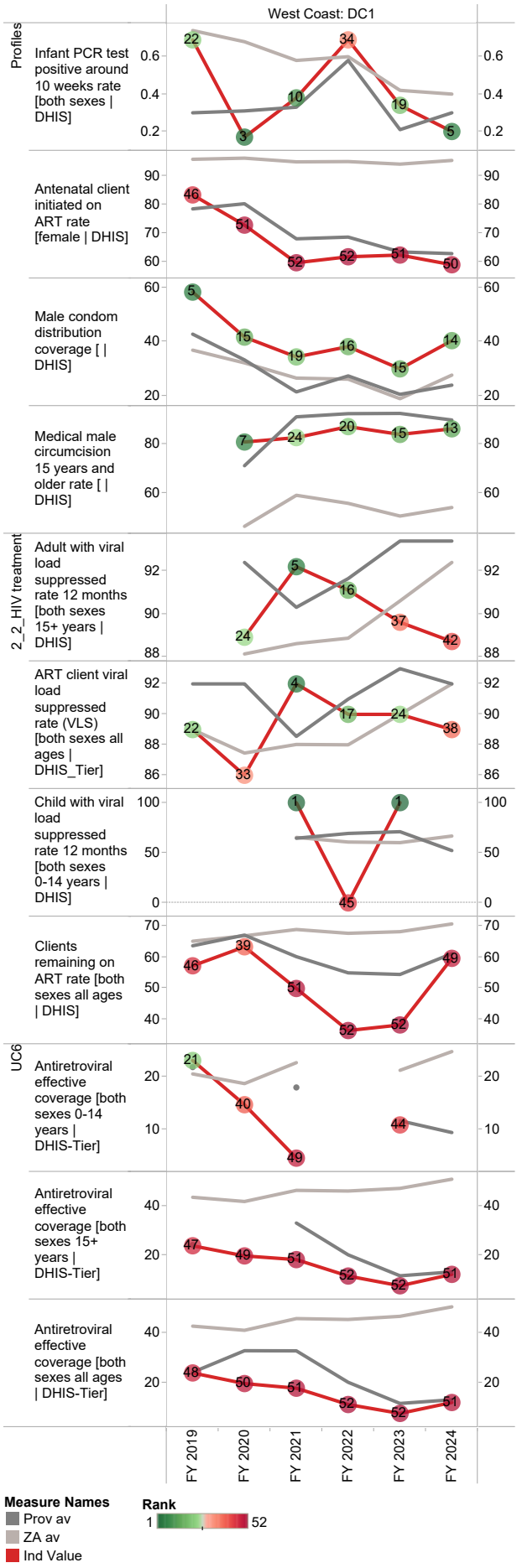
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Medical male circumcision 15 years and older rate [| DHIS]
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Antiretroviral effective coverage [both sexes all ages | DHIS-Tier]
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FY 2024
Measure Names
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Ind Value
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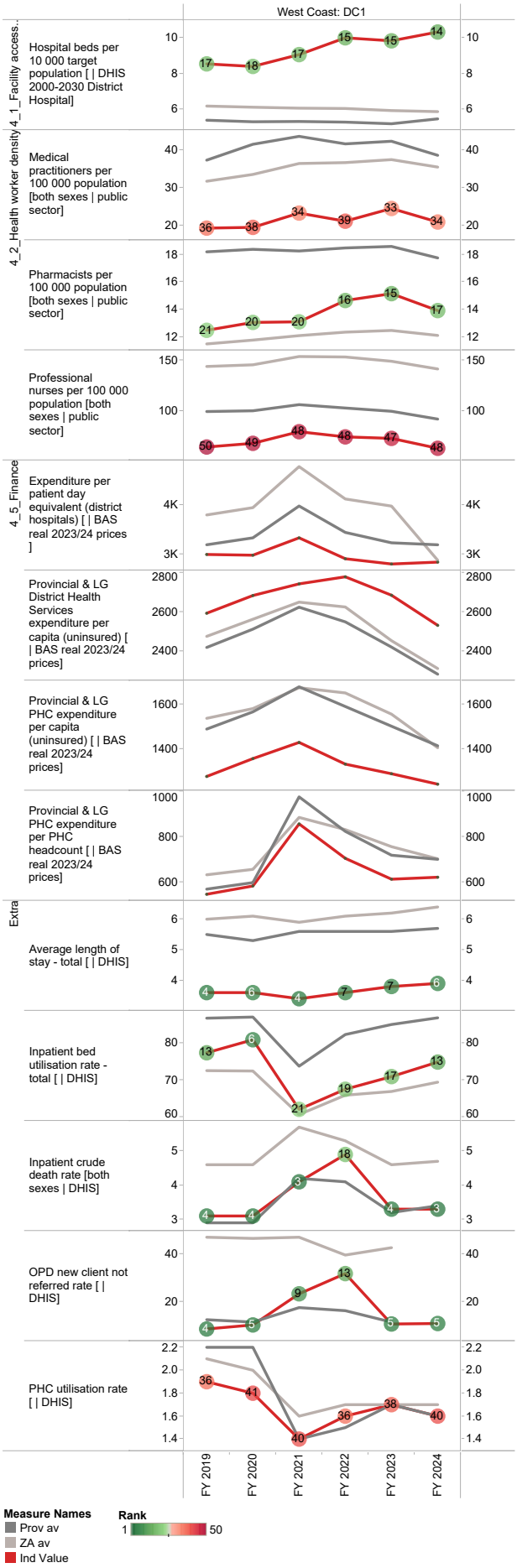
West Coast: DC1
4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
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Professional nurses per 100 000 population [both sexes | public sector]
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Inpatient crude death rate [both sexes | DHIS]
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PHC utilisation rate [| DHIS]
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50

Cape Winelands District Municipality (DC2)

The Cape Winelands District Municipality[5] is a Category C municipality situated in the Western Cape Province. The district consists of five local municipalities, namely: Drakenstein, Stellenbosch, Witzenberg, Breede Valley and Langeberg.

Area: 21 478km²

Population (2023)[6]: 991 117

Households[5]: 235 906

Formal dwellings[5]: 81.0%

Cities/Towns:

Drakenstein: Gouda, Paarl, Saron, Wellington

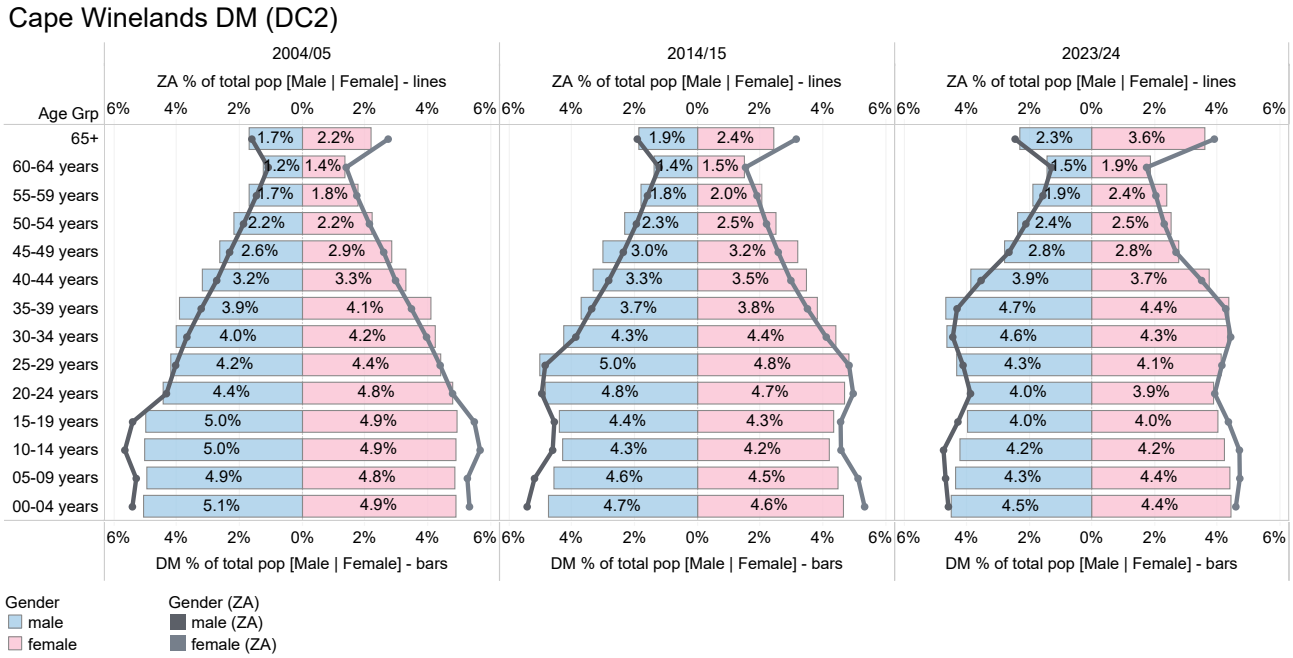
Stellenbosch: Franschhoek, Klapmuts, Pniel, Stellenbosch, Stellenbosch Farms

Witzenberg: Ceres, Op-Die-Berg, Prince Alfred Hamlet, Tulbagh, Wolseley

Breede Valley: De Doorns, Rawsonville, Touws River, Worcester

Langeberg: Ashton, Bonnievale, McGregor, Montagu, Robertson

District percentage population by age-gender group compared to South Africa

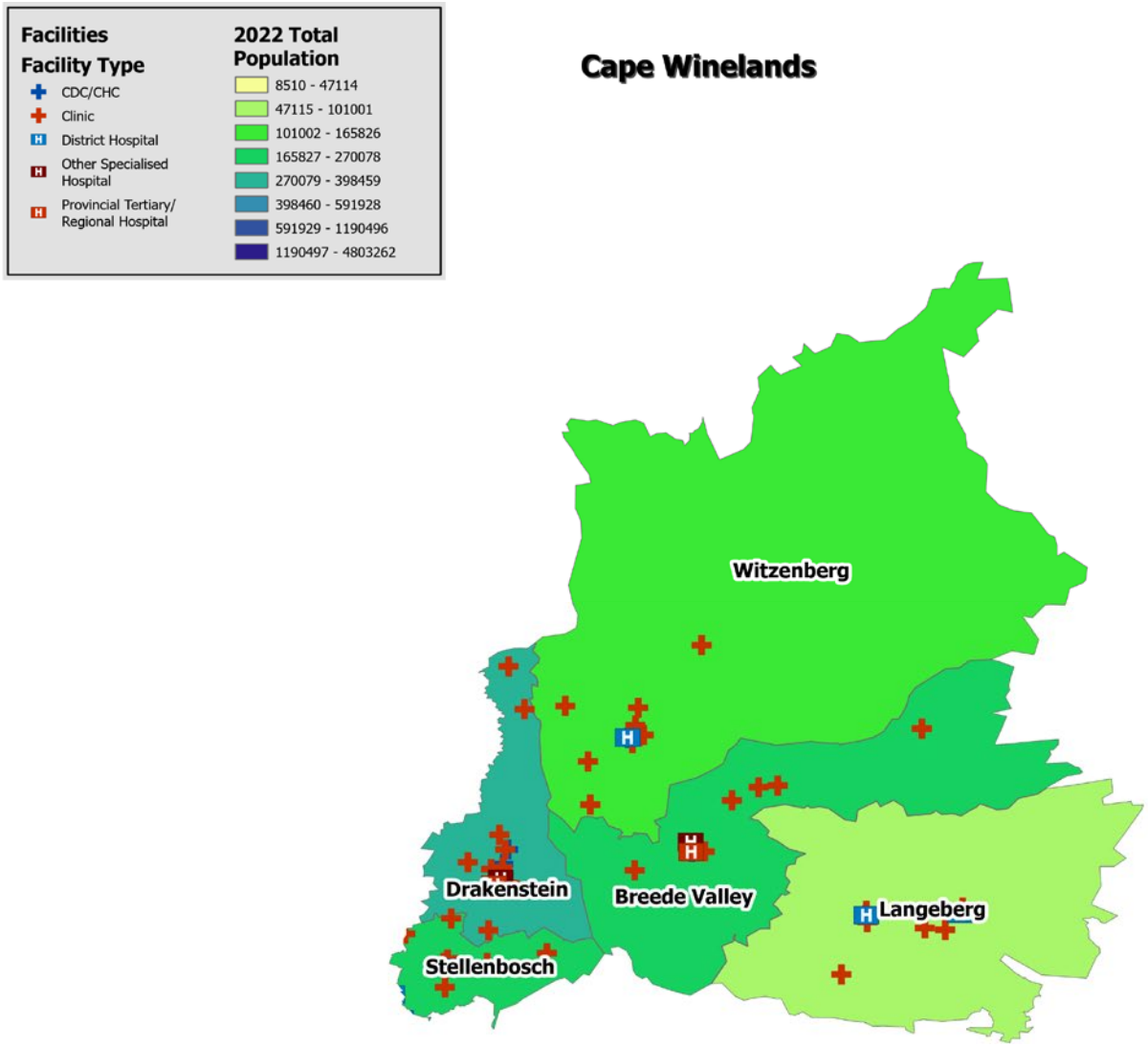


Source: DHIS

5 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

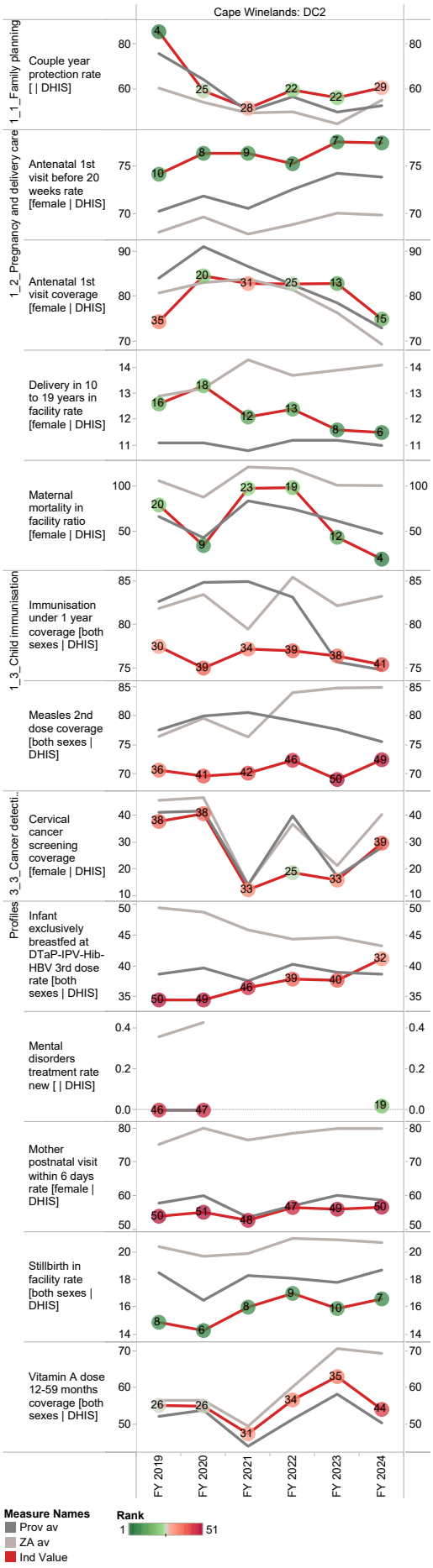
6 Mid-year Population Estimates 2023, DHIS.

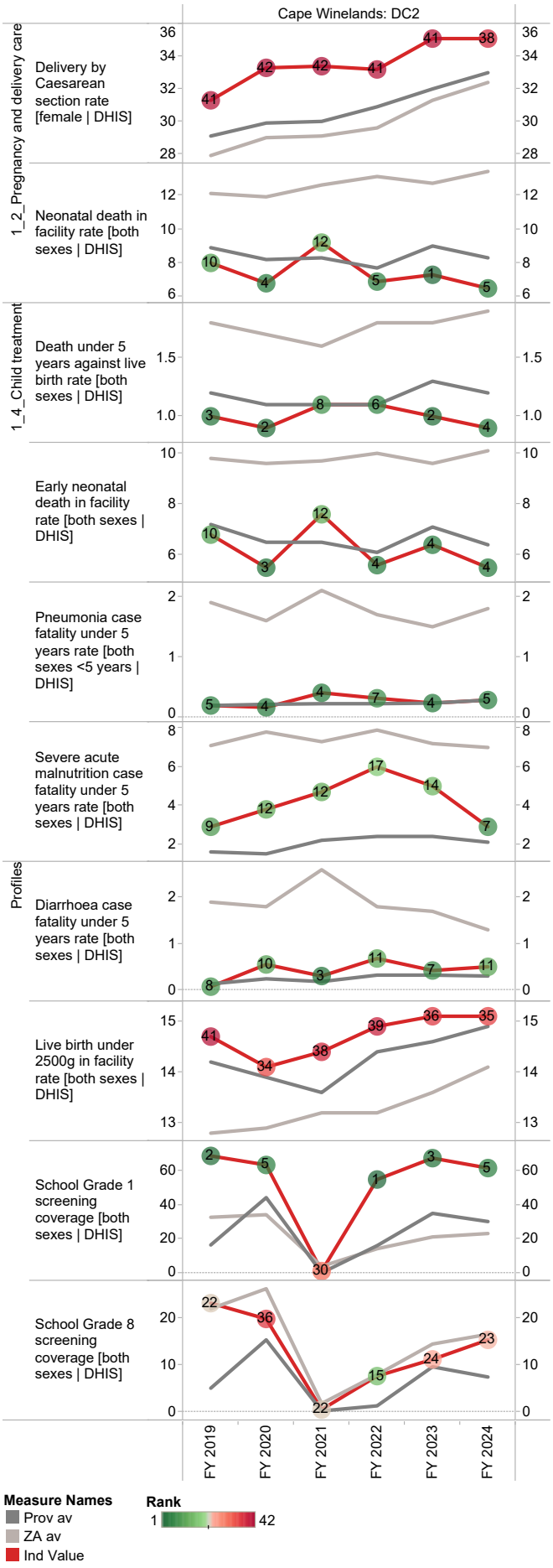
Population distribution, sub-district boundaries and health facility locations

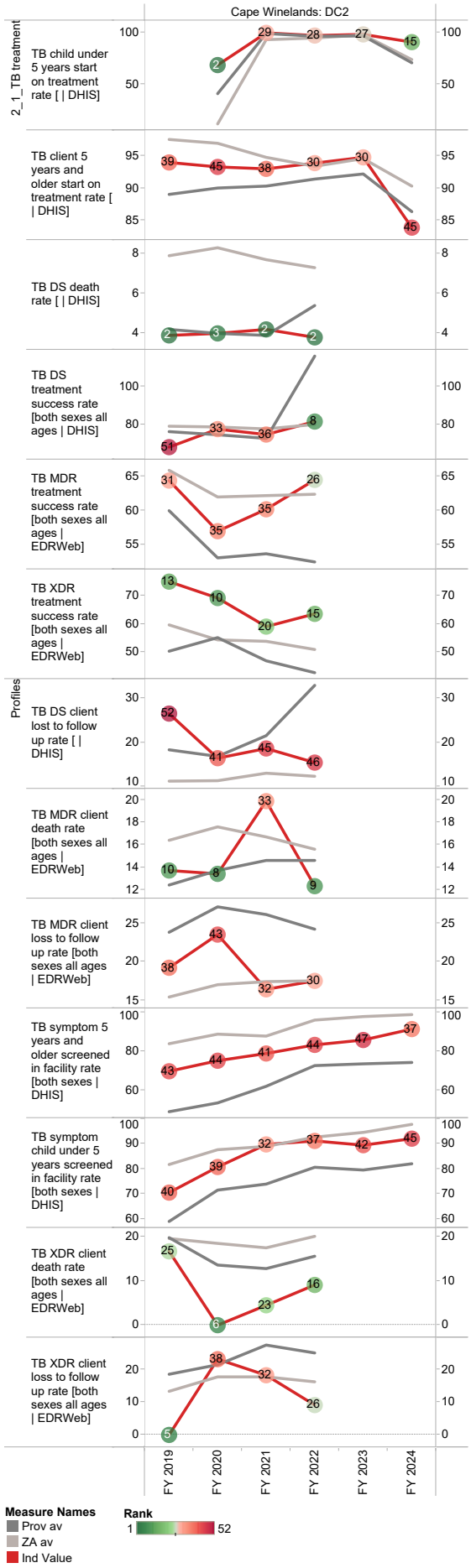


Source: DHIS

Annual trends, 2014/19–2023/24






Cape Winelands: DC2
2_1_TB treatment
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
TB DS death rate [| DHIS]
TB DS treatment success rate [both sexes all ages | DHIS]
TB MDR treatment success rate [both sexes all ages | EDRWeb]
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Profiles
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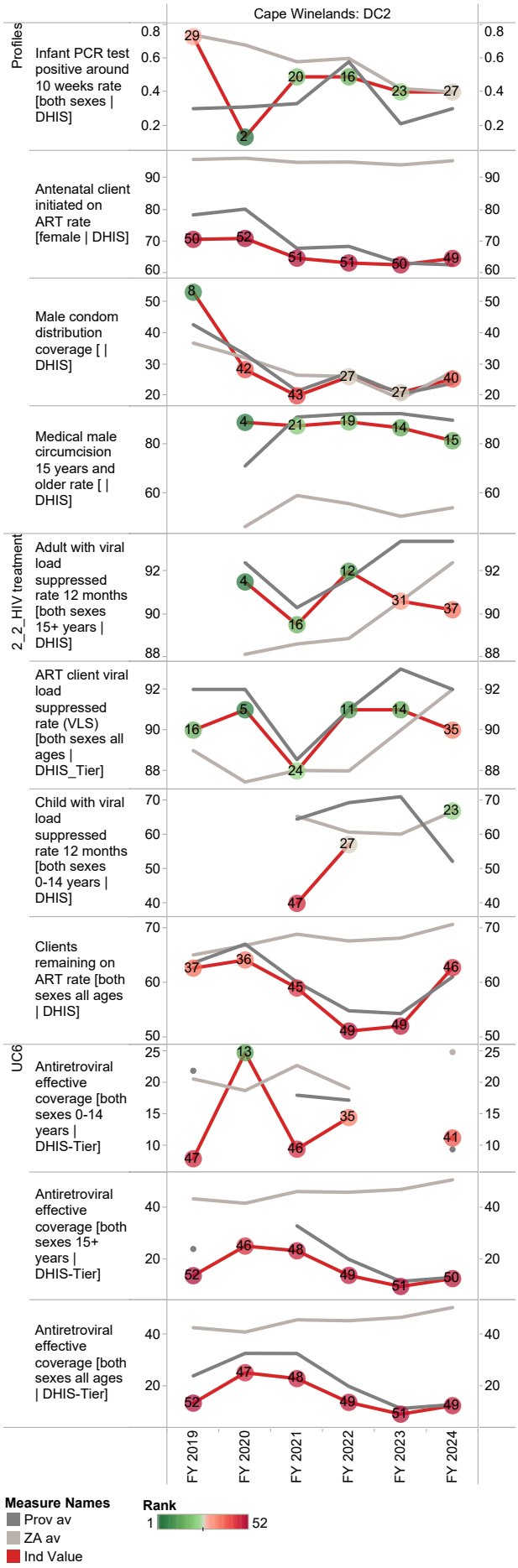
Cape Winelands: DC2
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Measure Names
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Ind Value
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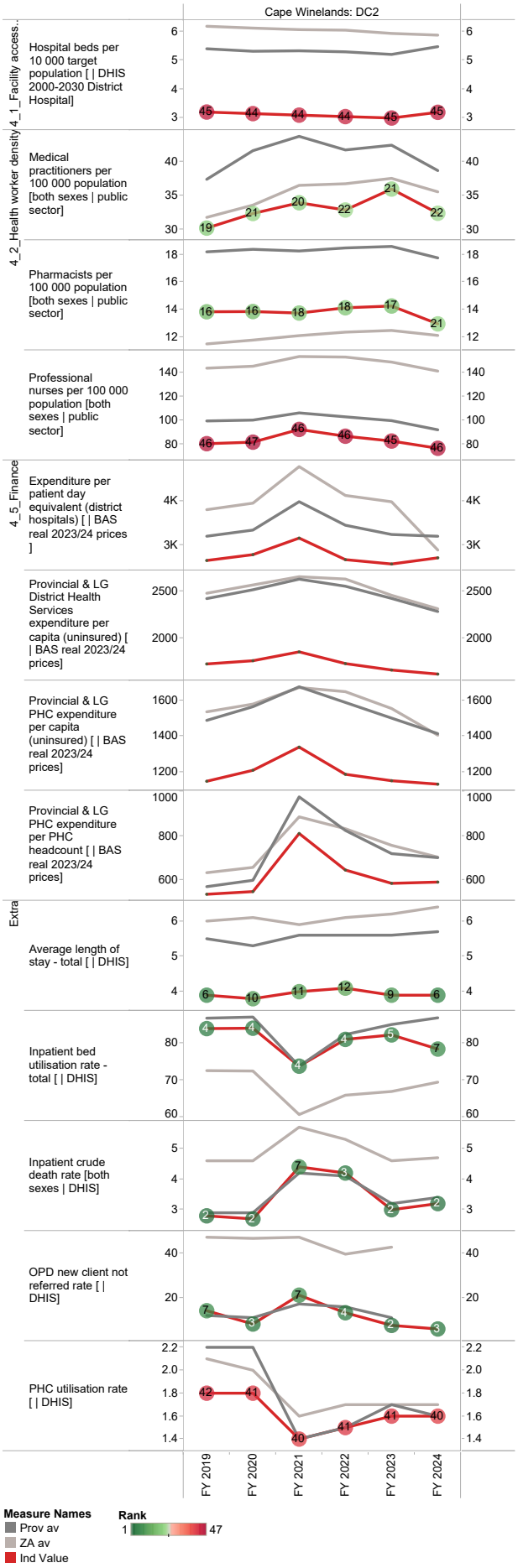
Cape Winelands: DC2
4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
4_2_Health worker density
Medical practitioners per 100 000 population [both sexes | public sector]
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PHC utilisation rate [| DHIS]
FY 2019
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FY 2022
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Measure Names
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Overberg District Municipality (DC3)

The Overberg District Municipality[7] is a Category C municipality situated in the Western Cape Province. The municipality is the smallest district in the province, making up only 9% of its geographical area. The following local municipalities form the Overberg District: Theewaterskloof, Swellendam, Overstrand and Cape Agulhas.

Area: 12 241km²

Population (2023)[8]: 316 173

Households[7]: 91 835

Formal dwellings[7]: 81.8%

Cities/Towns:

Theewaterskloof: Bot River, Caledon/Myddleton, Genadendal, Grabouw, Greyton, Riviersonderend, Theewaterskloof, Villiersdorp

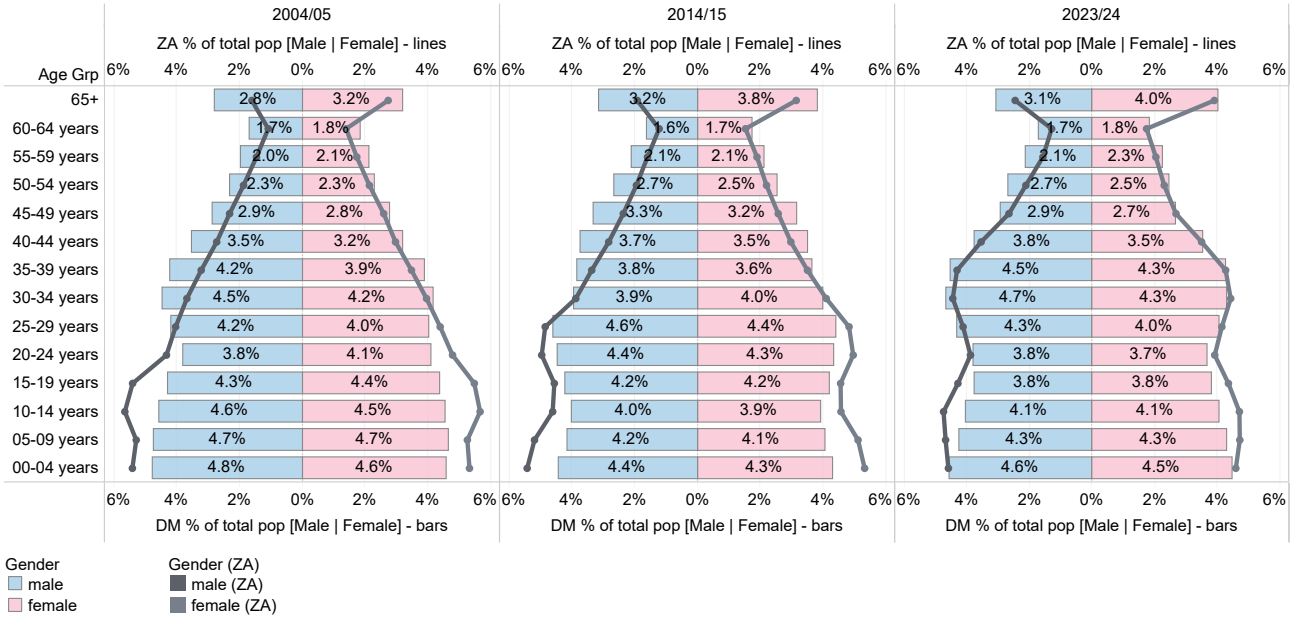
Swellendam: Barrydale, Buffeljagsrivier, Infanta, Malagas, Suurbraak, Swellendam

Overstrand: Betty's Bay, Birkenhead, De Kelders, Fishershaven, Franskraal, Gans Bay, Hawston, Hermanus, Kleinmond, Onrus, Pearly Beach, Pringle Bay, Rooi-Els, Sand Bay, Stanford, Van Dyks Bay, Vermont

Cape Agulhas: Agulhas, Arniston, Bredasdorp, Elim, Klipdale, Napier, Protem, Struis Bay, Suiderstrand

District percentage population by age-gender group compared to South Africa

Overberg DM (DC3)

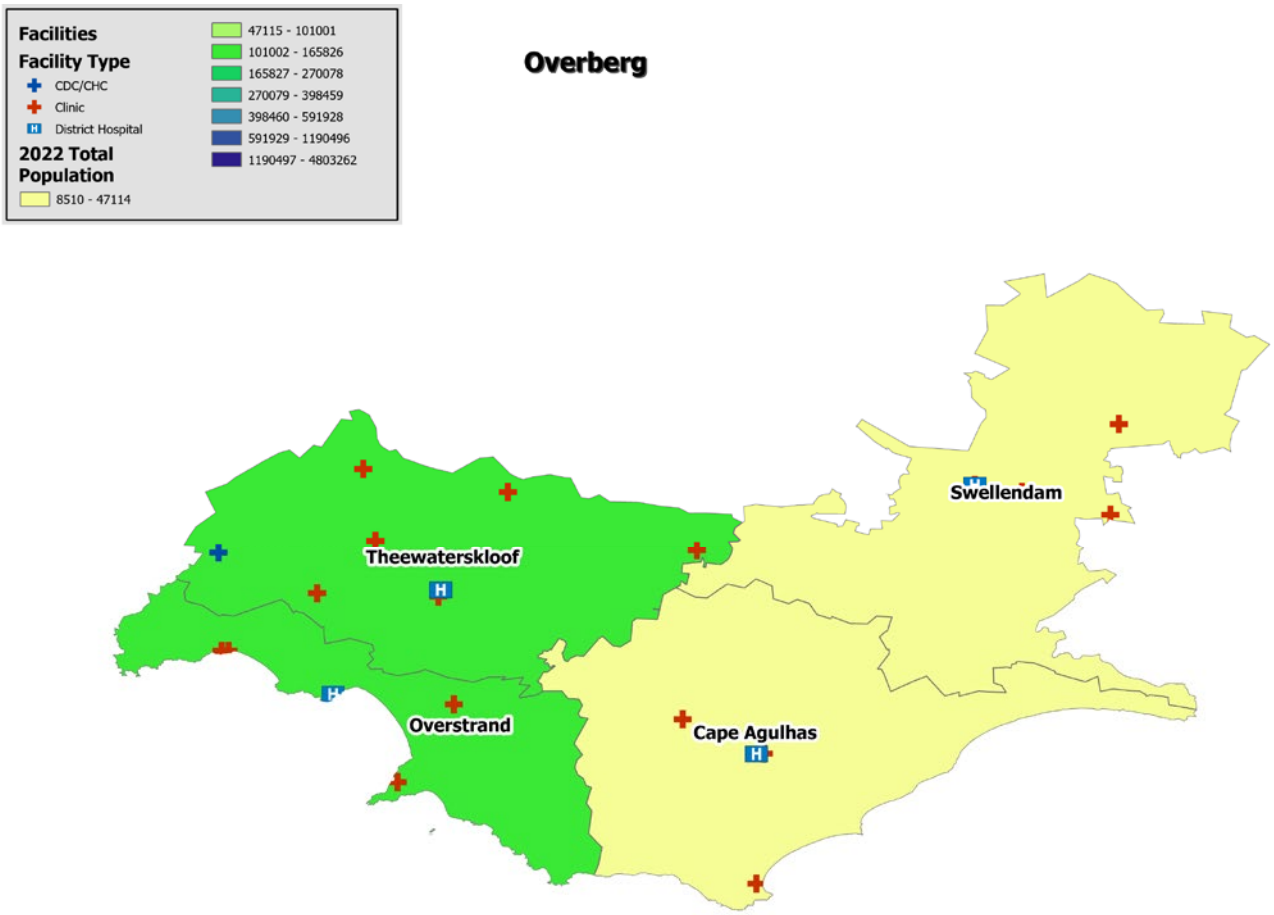


Source: DHIS

7 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

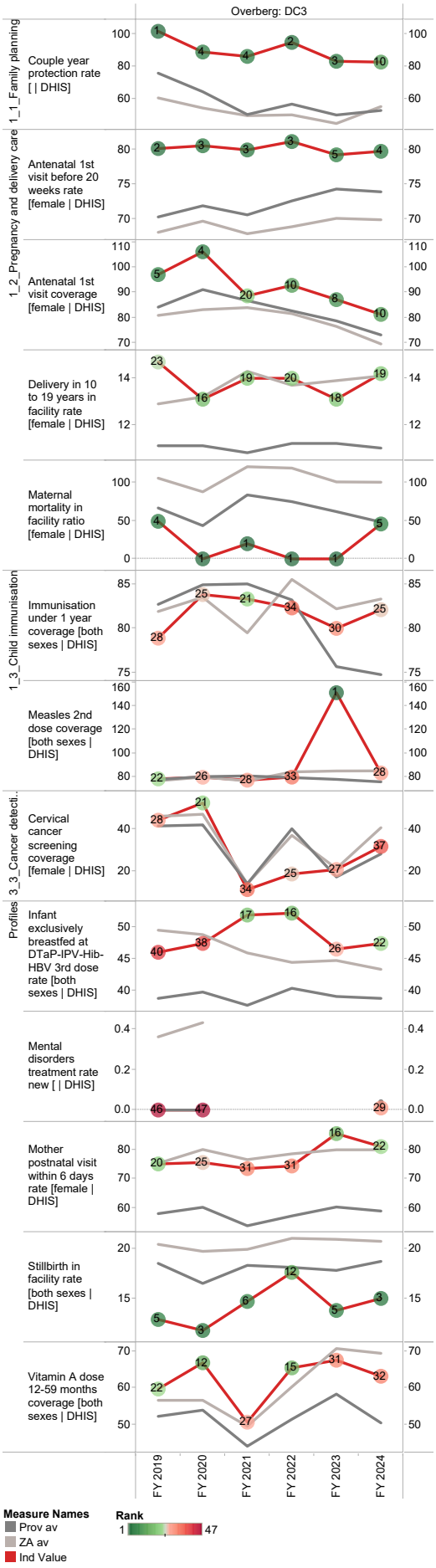
8 Mid-year Population Estimates 2023, DHIS.

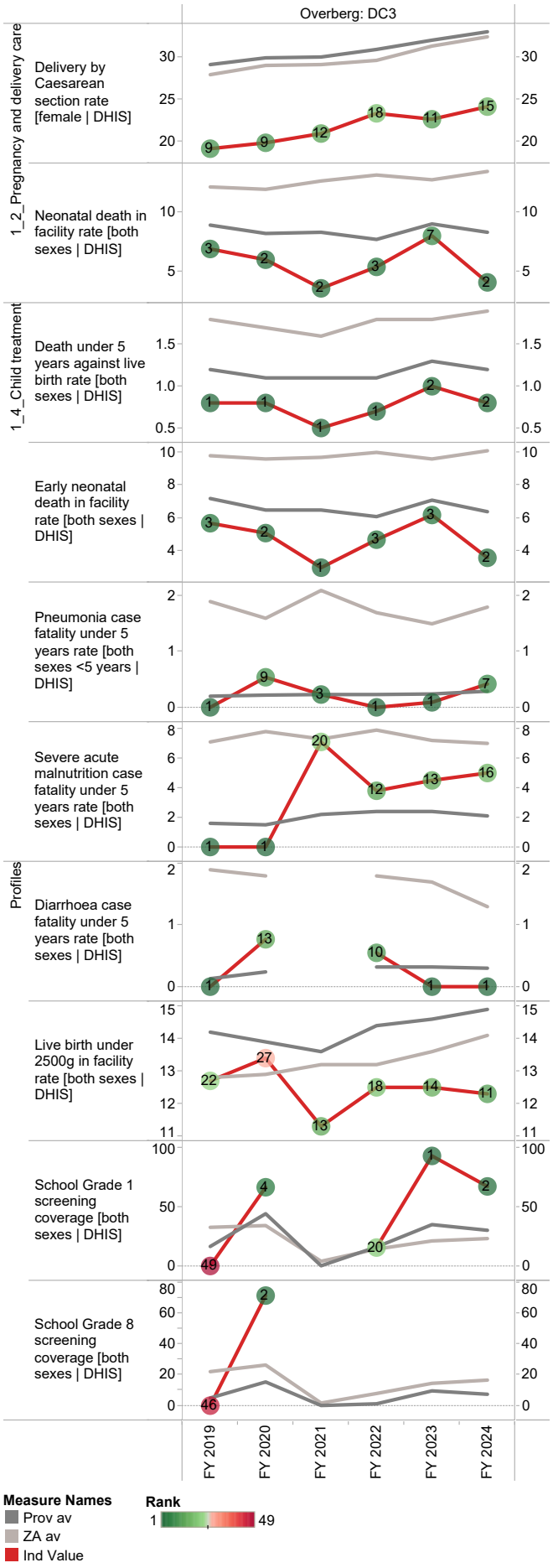
Population distribution, sub-district boundaries and health facility locations

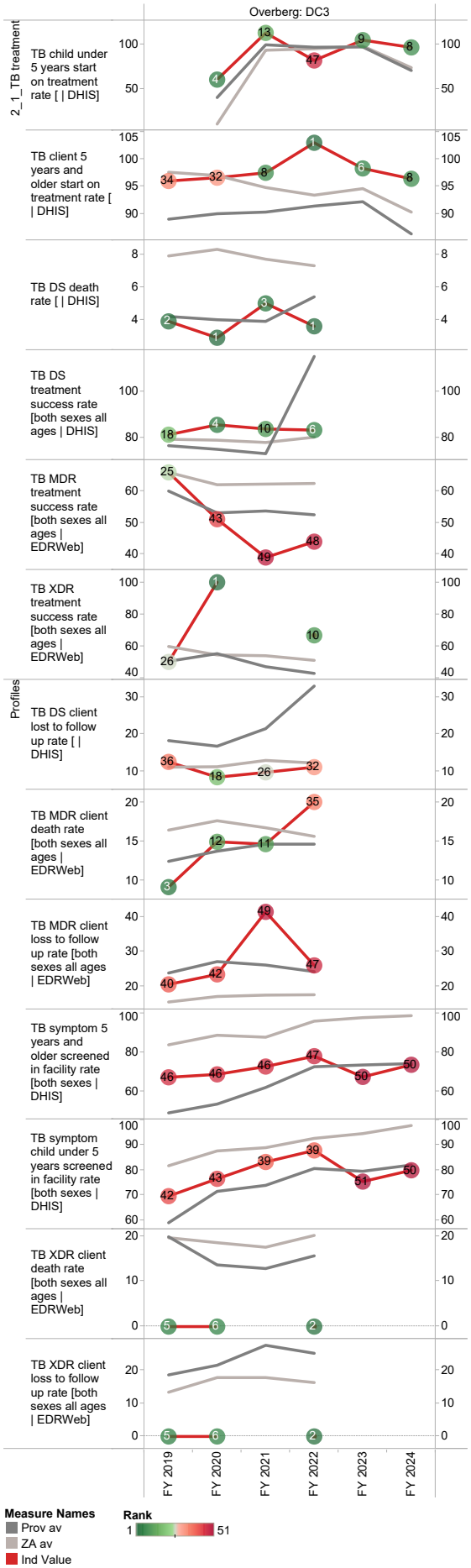


Source: DHIS

Annual trends, 2014/19–2023/24






Overberg: DC3
2_1_TB treatment
Profiles
TB child under 5 years start on treatment rate [| DHIS]
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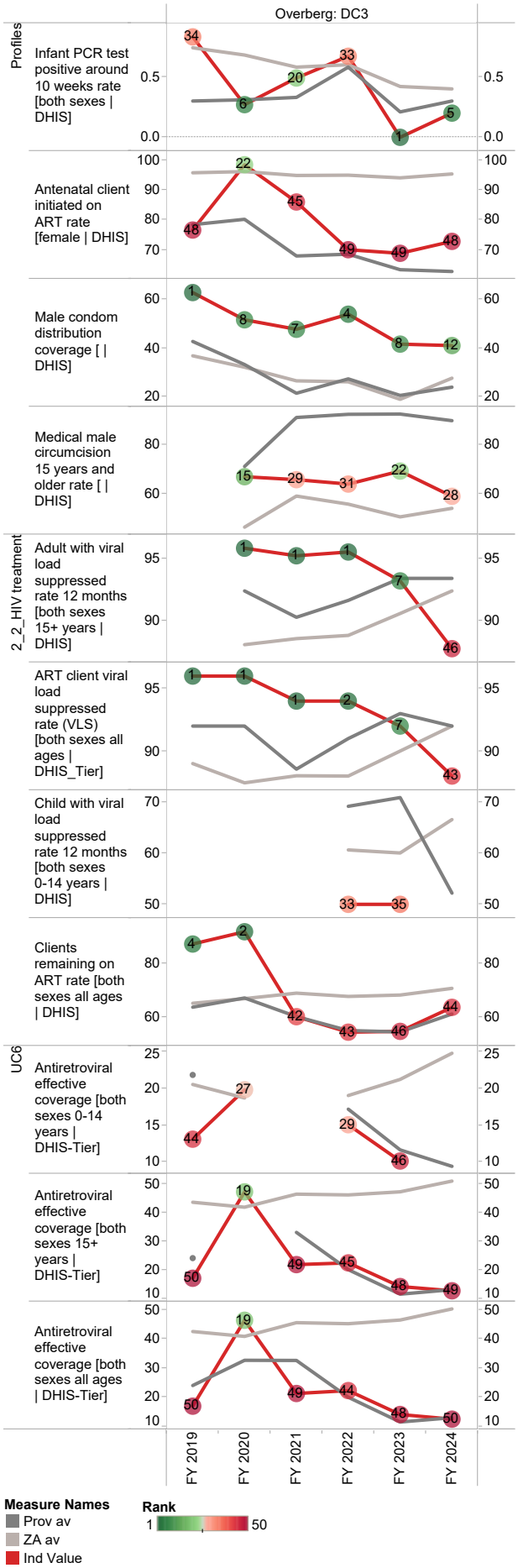
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FY 2019
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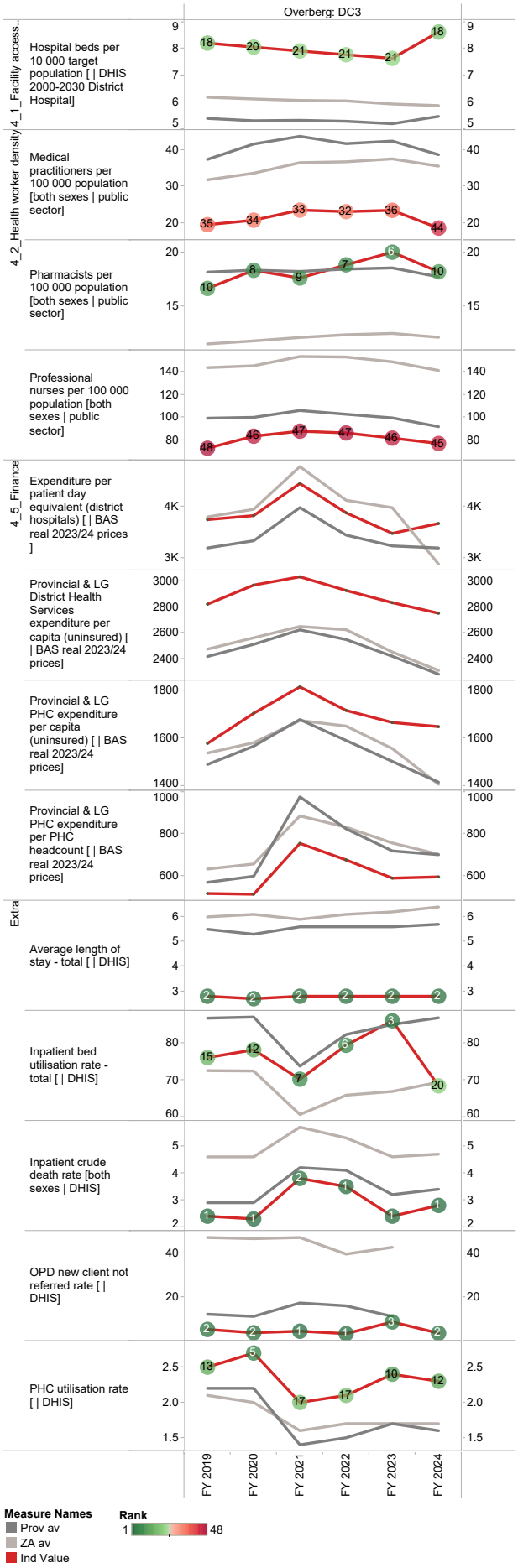
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Pharmacists per 100 000 population [both sexes | public sector]
Professional nurses per 100 000 population [both sexes | public sector]
4_5_Finance
Expenditure per patient day equivalent (district hospitals) [| BAS real 2023/24 prices]
Provincial & LG District Health Services expenditure per capita (uninsured) [| BAS real 2023/24 prices]
Provincial & LG PHC expenditure per capita (uninsured) [| BAS real 2023/24 prices]
Provincial & LG PHC expenditure per PHC headcount [| BAS real 2023/24 prices]
Extra
Average length of stay - total [| DHIS]
Inpatient bed utilisation rate - total [| DHIS]
Inpatient crude death rate [both sexes | DHIS]
OPD new client not referred rate [| DHIS]
PHC utilisation rate [| DHIS]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
1
48

Garden Route District Municipality (DC4)

The Garden Route District Municipality[9] (previously known as Eden District Municipality) is a Category C municipality situated in the Western Cape Province. The district comprises seven local municipalities: George, Mossel Bay, Knysna, Bitou, Oudtshoorn, Hessequa and Kannaland.

Area: 23 331km²

Population (2023)[10]: 633 013

Households[9]: 189 345

Formal dwellings[9]: 85.7%

Cities/Towns:

George: George, Haarlem, Herolds Bay, Uniondale, Victoria Bay, Wilderness,

Mossel Bay: Boggoms Bay, Brandwag, Friemersheim, Great Brak River, Herbertsdale, Mossel Bay, Vleesbaai

Knysna: Brenton, Brenton-on-Sea, Buffels Bay, Knoetzie, Knysna, Rheenendal, Sedgefield

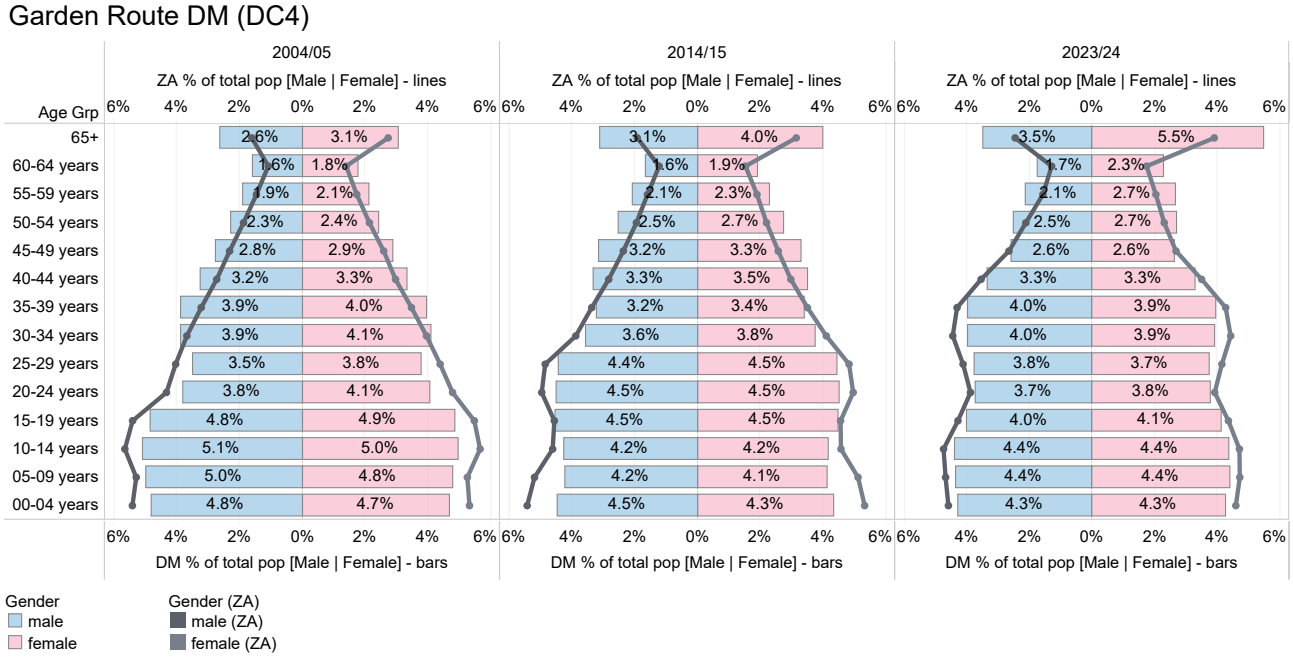
Bitou: Keurboomstrand, Krantshoek, Kurland, Kwanokuthula, Nature's Valley, Plettenberg Bay, Wittedrift,

Oudtshoorn: De Rust, Dysselsdorp, Oudtshoorn

Hessequa: Albertinia, Gouritsmond, Heidelberg, Jongensfontein, Riversdale, Slangrivier, Still Bay, Witsand

Kannaland: Calitzdorp, Ladismith, Vanwyksdorp, Zoar

District percentage population by age-gender group compared to South Africa

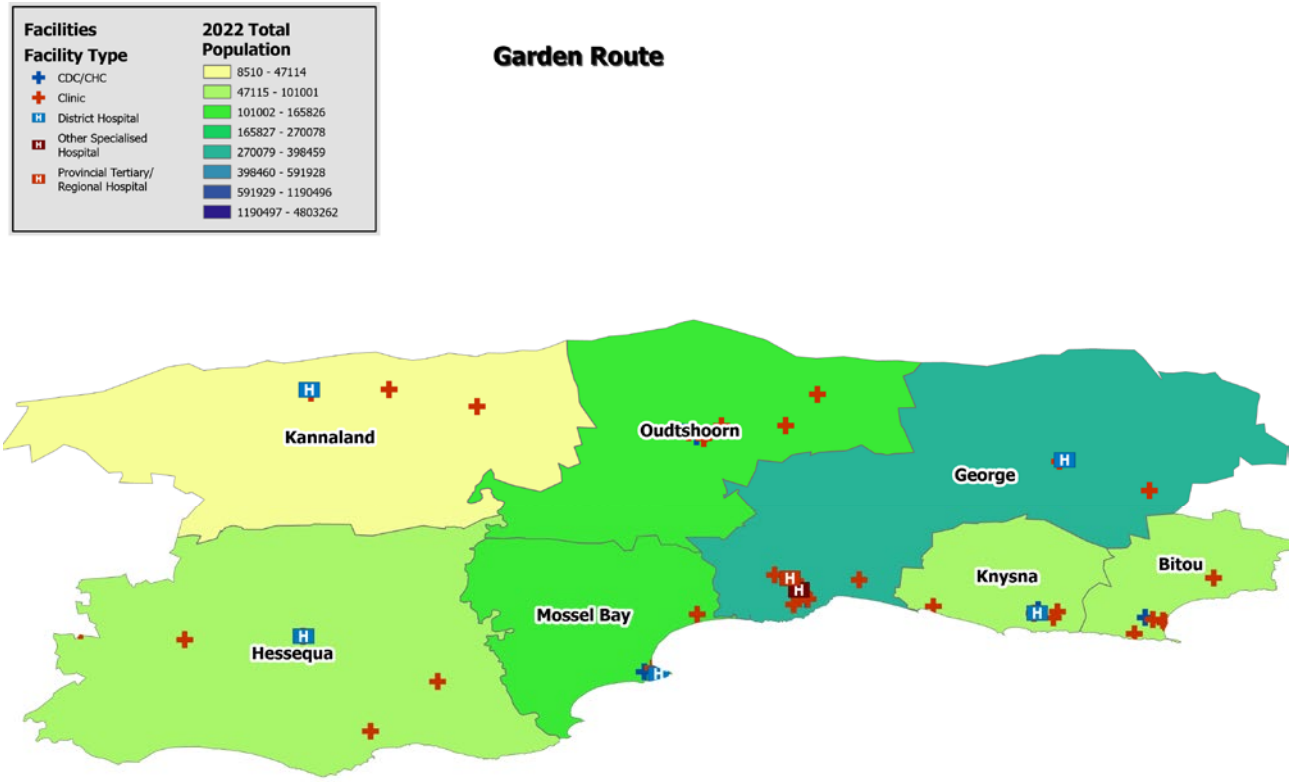


Source: DHIS

9 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

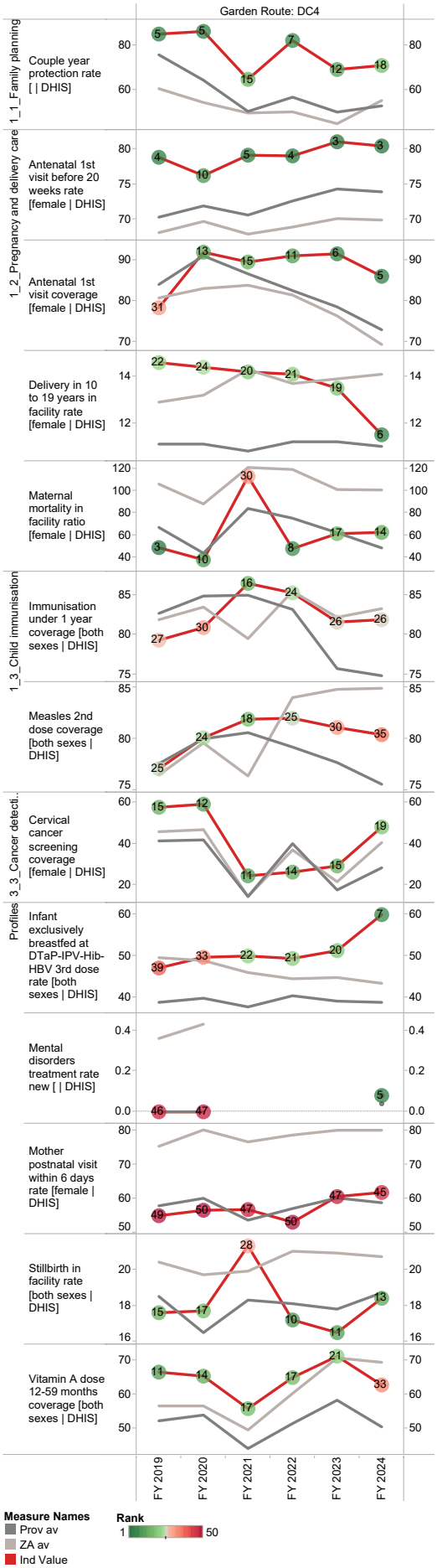
10 Mid-year Population Estimates 2023, DHIS.

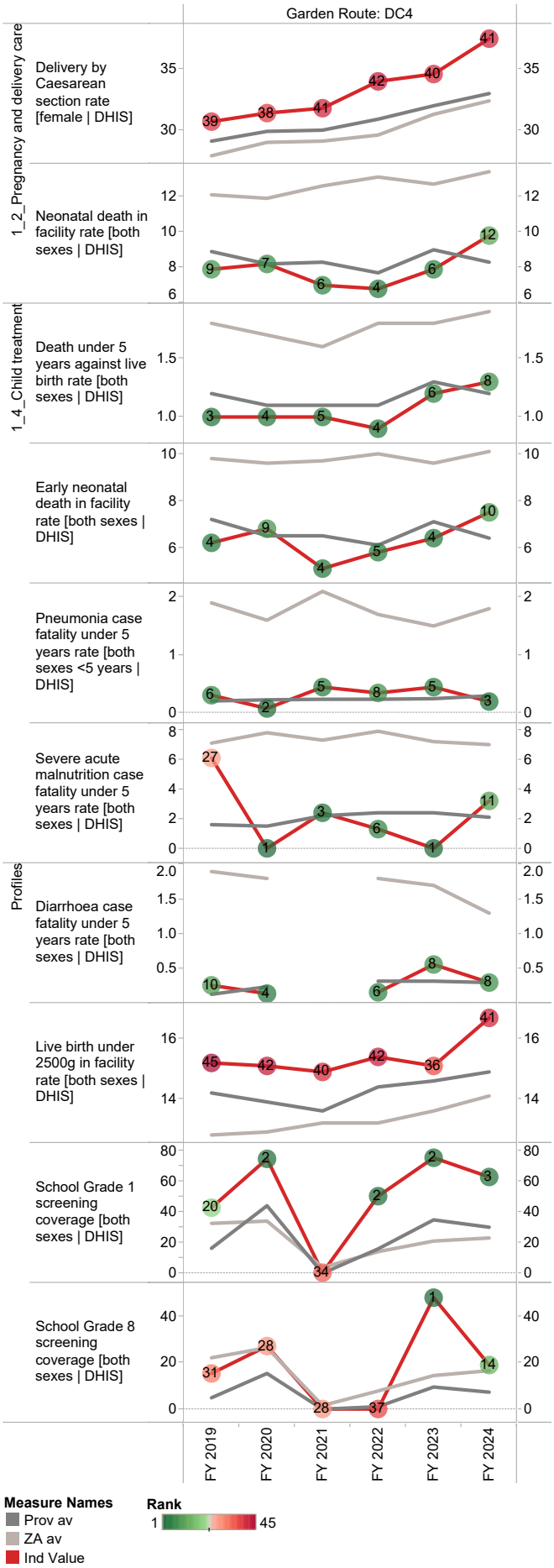
Population distribution, sub-district boundaries and health facility locations

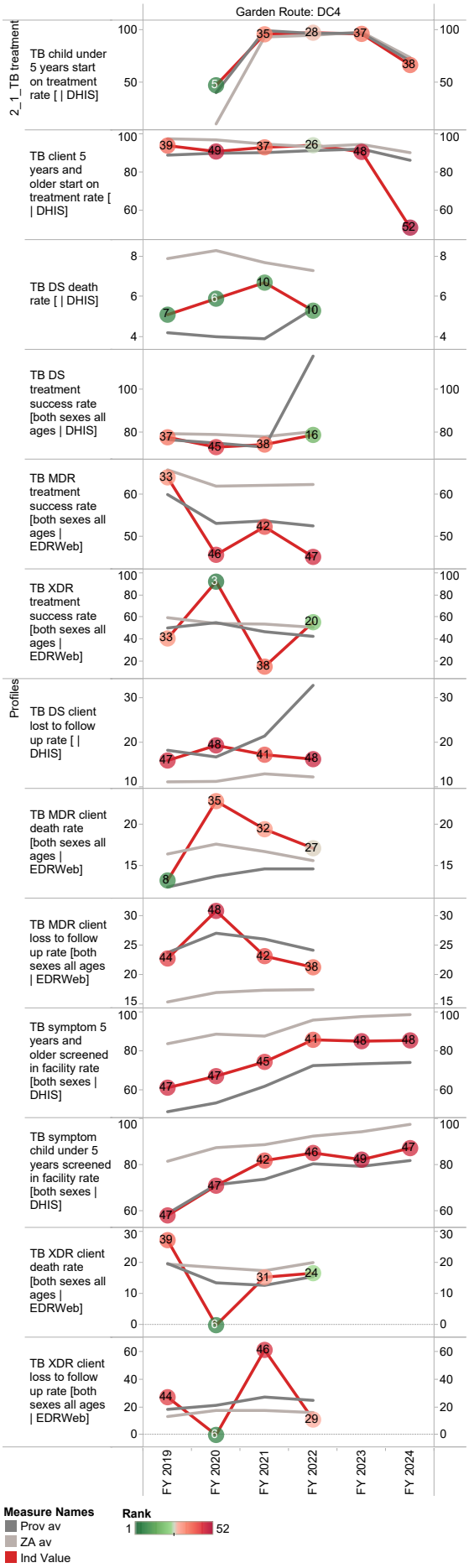


Source: DHIS

Annual trends, 2014/19–2023/24






Garden Route: DC4
2_1_TB treatment
Profiles
TB child under 5 years start on treatment rate [| DHIS]
TB client 5 years and older start on treatment rate [| DHIS]
TB DS death rate [| DHIS]
TB DS treatment success rate [both sexes all ages | DHIS]
TB MDR treatment success rate [both sexes all ages | EDRWeb]
TB XDR treatment success rate [both sexes all ages | EDRWeb]
TB DS client lost to follow up rate [| DHIS]
TB MDR client death rate [both sexes all ages | EDRWeb]
TB MDR client loss to follow up rate [both sexes all ages | EDRWeb]
TB symptom 5 years and older screened in facility rate [both sexes | DHIS]
TB symptom child under 5 years screened in facility rate [both sexes | DHIS]
TB XDR client death rate [both sexes all ages | EDRWeb]
TB XDR client loss to follow up rate [both sexes all ages | EDRWeb]
FY 2019
FY 2020
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FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
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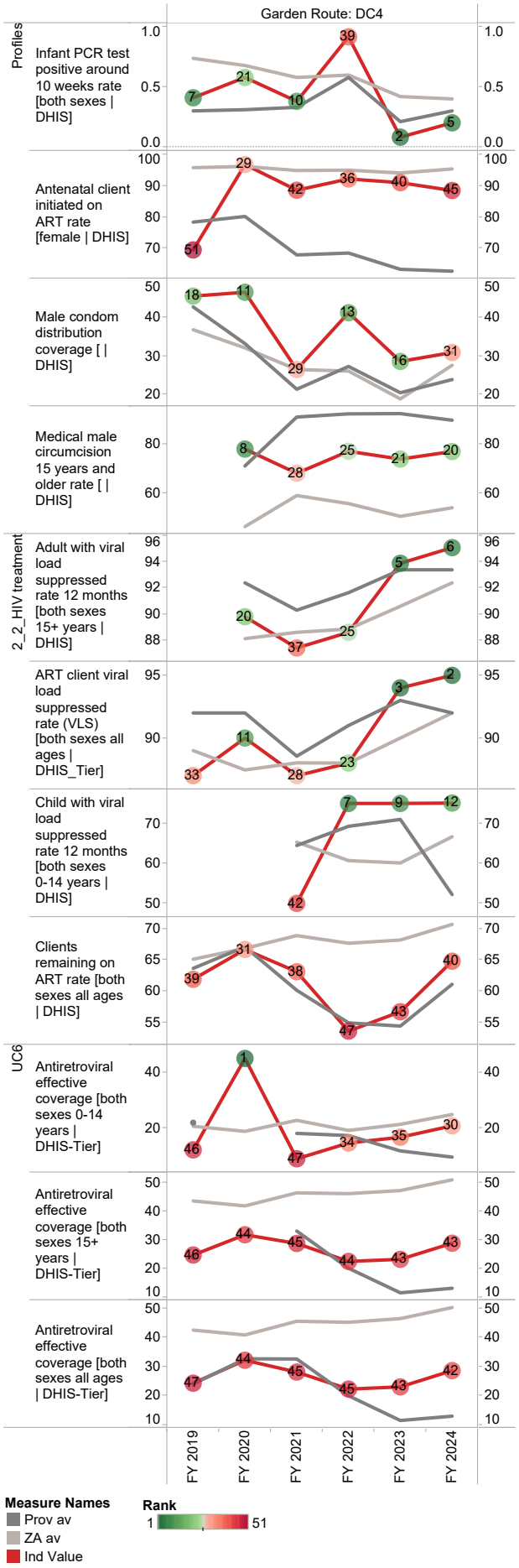
Garden Route: DC4
Profiles
Infant PCR test positive around 10 weeks rate [both sexes | DHIS]
Antenatal client initiated on ART rate [female | DHIS]
Male condom distribution coverage [| DHIS]
Medical male circumcision 15 years and older rate [| DHIS]
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ART client viral load suppressed rate (VLS) [both sexes all ages | DHIS_Tier]
Child with viral load suppressed rate 12 months [both sexes 0-14 years | DHIS]
Clients remaining on ART rate [both sexes all ages | DHIS]
UC6
Antiretroviral effective coverage [both sexes 0-14 years | DHIS-Tier]
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Measure Names
Prov av
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Ind Value
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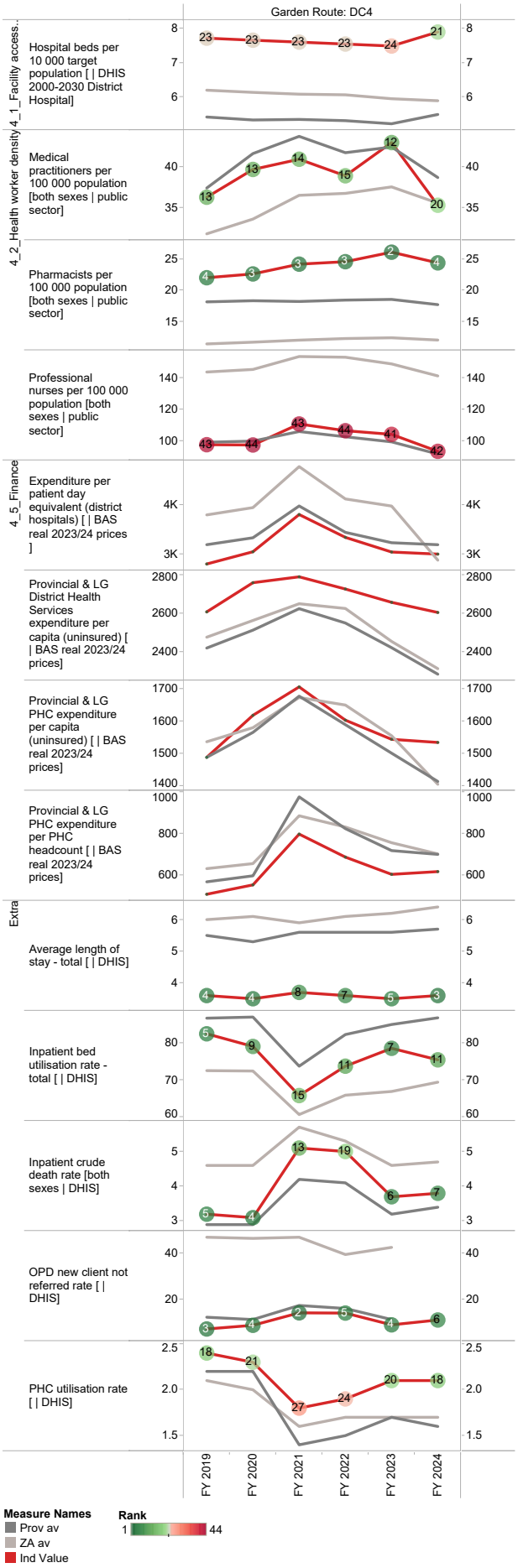
Garden Route: DC4
4_1_Facility access...
Hospital beds per 10 000 target population [| DHIS 2000-2030 District Hospital]
4_2_Health worker density
Medical practitioners per 100 000 population [both sexes | public sector]
Pharmacists per 100 000 population [both sexes | public sector]
Professional nurses per 100 000 population [both sexes | public sector]
4_5_Finance
Expenditure per patient day equivalent (district hospitals) [| BAS real 2023/24 prices]
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PHC utilisation rate [| DHIS]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
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Measure Names
Prov av
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44

Central Karoo District Municipality (DC5)

The Central Karoo District Municipality[11] is a Category C municipality located in the Western Cape Province. Central Karoo is the largest district in the province, making up a third of its geographical area, and comprises three local municipalities: Laingsburg, Prince Albert and Beaufort West.

Area: 38 854km²

Population (2023)[12]: 74 630

Households[11]: 21 980

Formal dwellings[11]: 97.8%

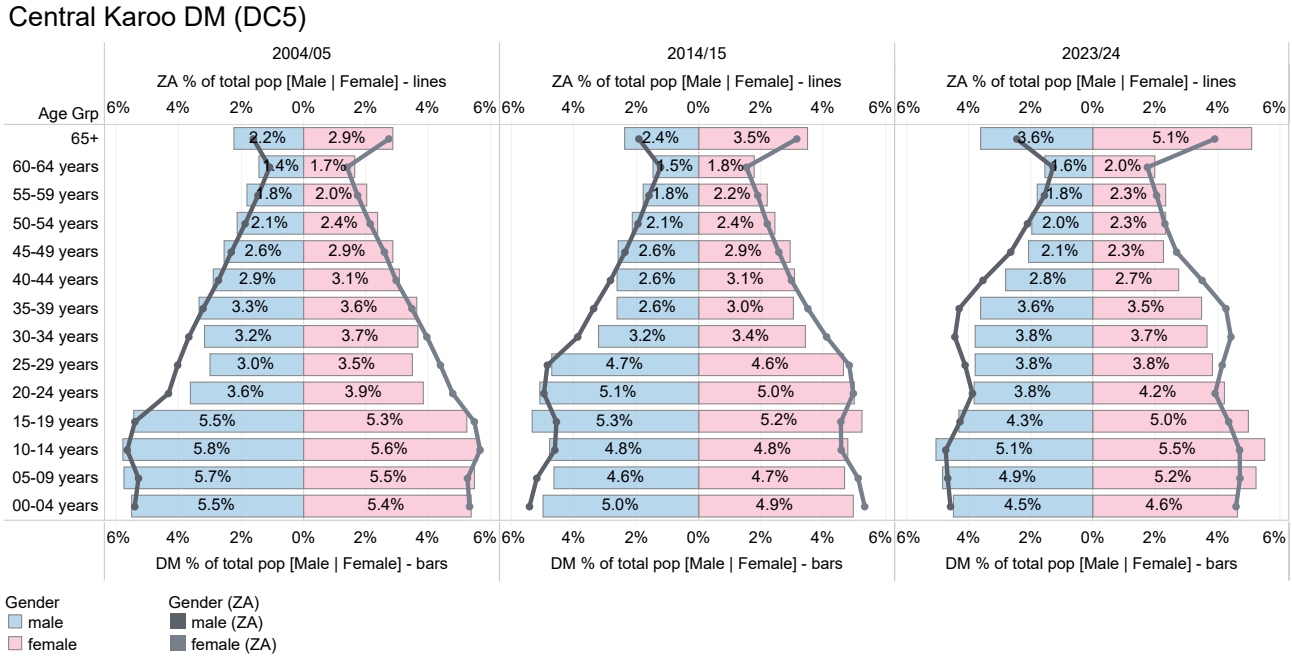
Cities/Towns:

Laingsburg: Laingsburg, Matjiesfontein

Prince Albert: Klaarstroom, Leeu Gamka, Prince Albert, Welgemoed

Beaufort West: Beaufort West, Merweville, Murraysburg, Nelspoort

District percentage population by age-gender group compared to South Africa

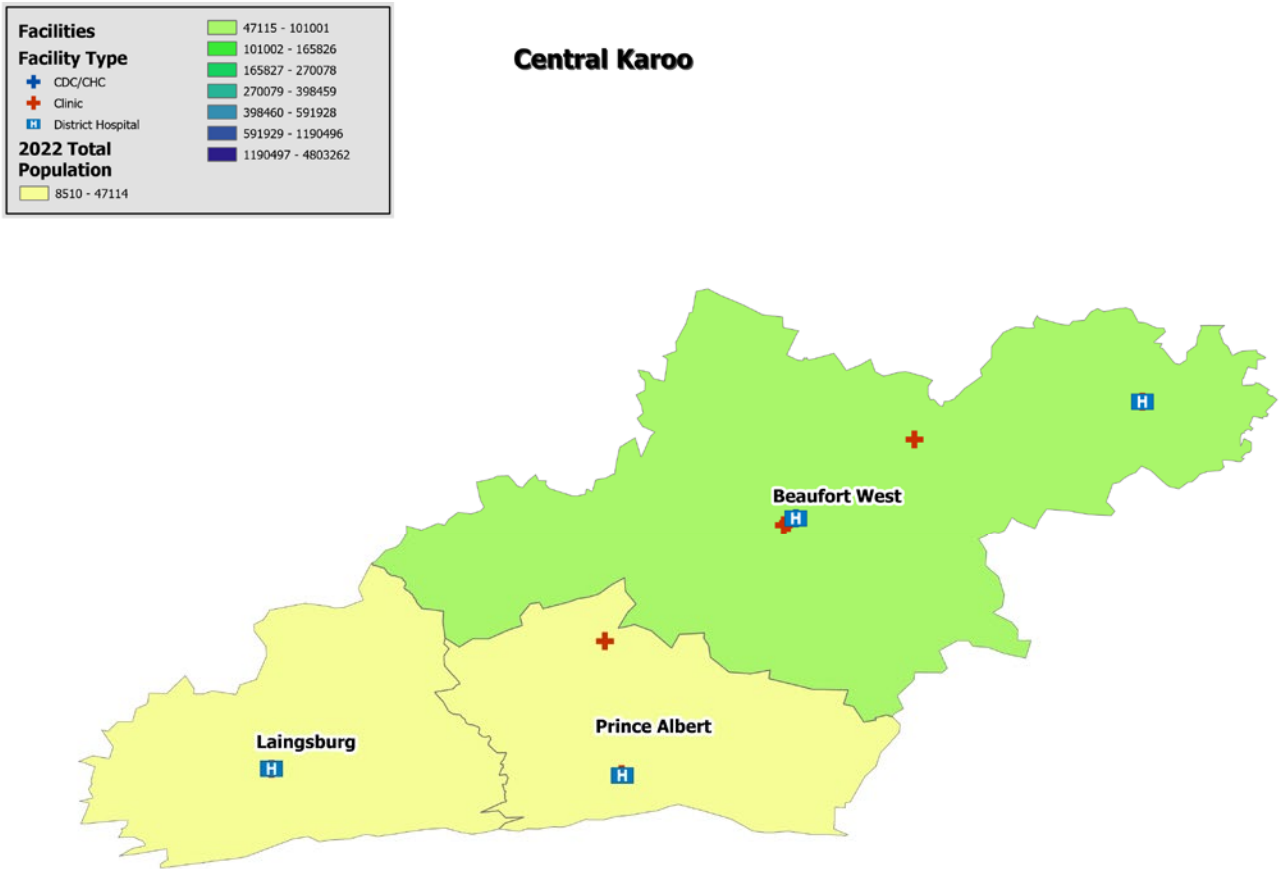


Source: DHIS

11 Local Government Handbook: South Africa 2023. The complete guide to local government in South Africa. Cape Town: Yes Media. 2023. Accessible at: https://issuu.com/yesmedia/docs/localgovernmenthandbook_southafrica2023

12 Mid-year Population Estimates 2023, DHIS.

Population distribution, sub-district boundaries and health facility locations



Source: DHIS

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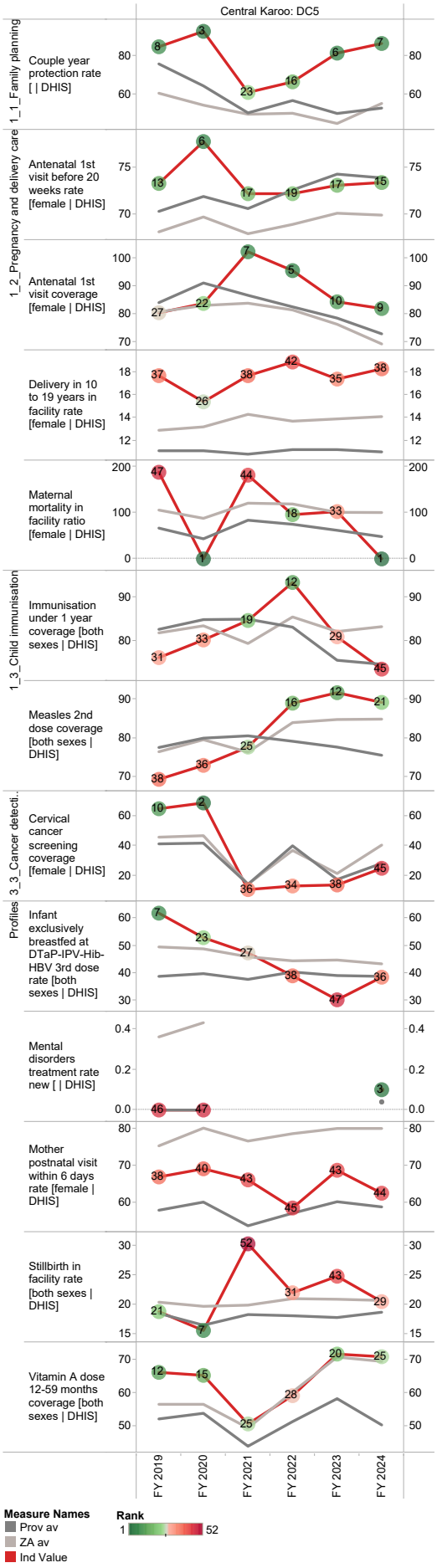

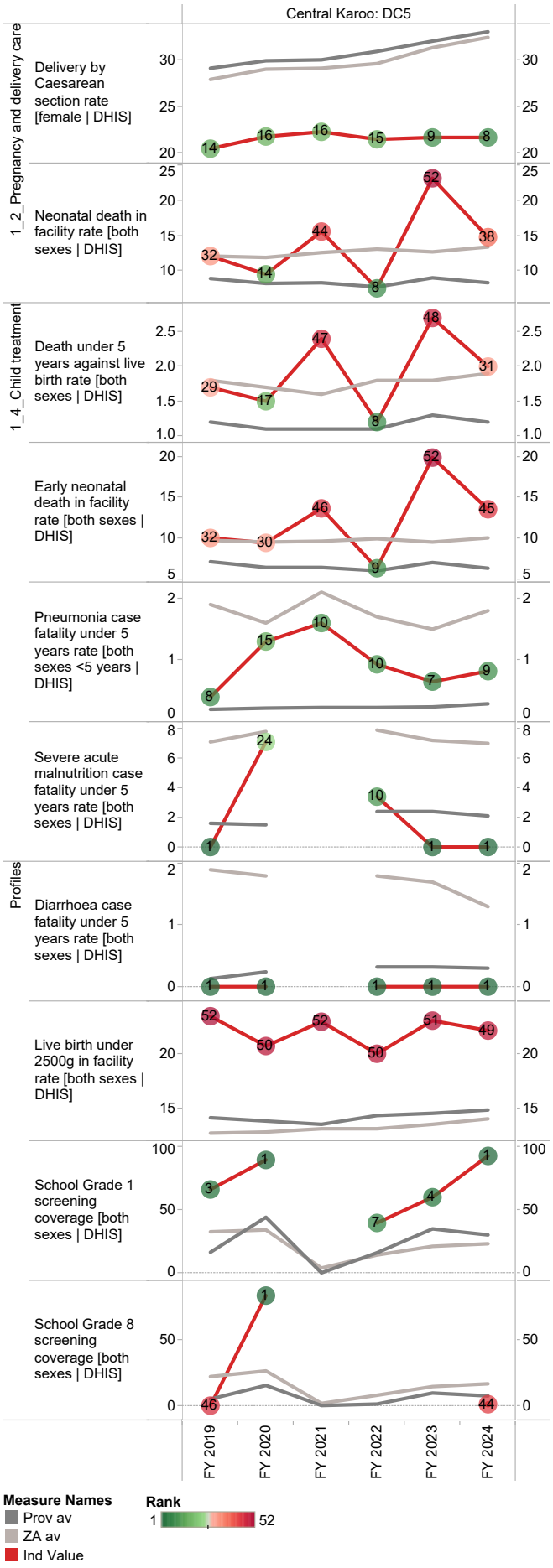

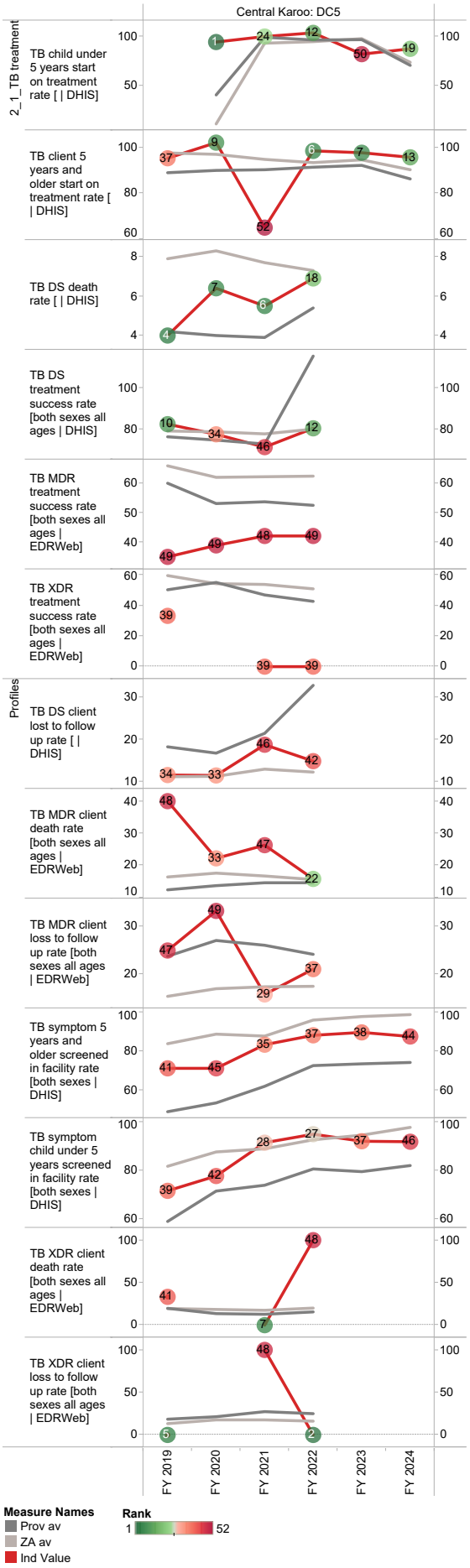
Central Karoo: DC5
2_1_TB treatment
TB child under 5 years start on treatment rate [| DHIS]
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FY 2022
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FY 2024
Measure Names
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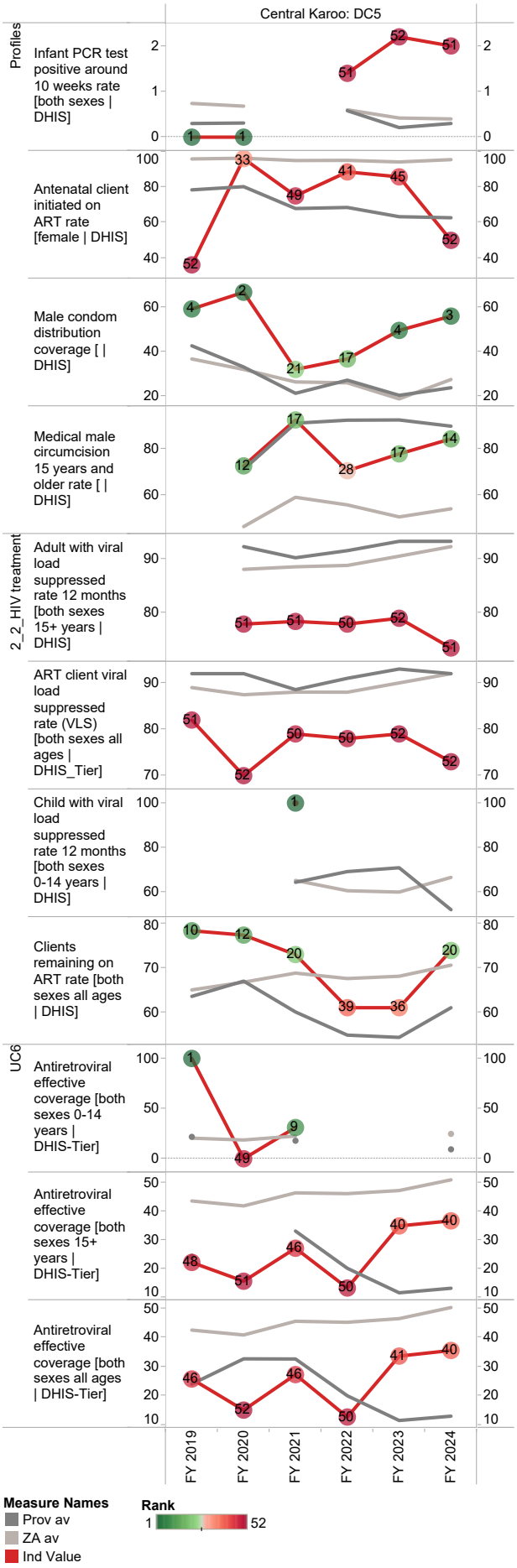
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FY 2024
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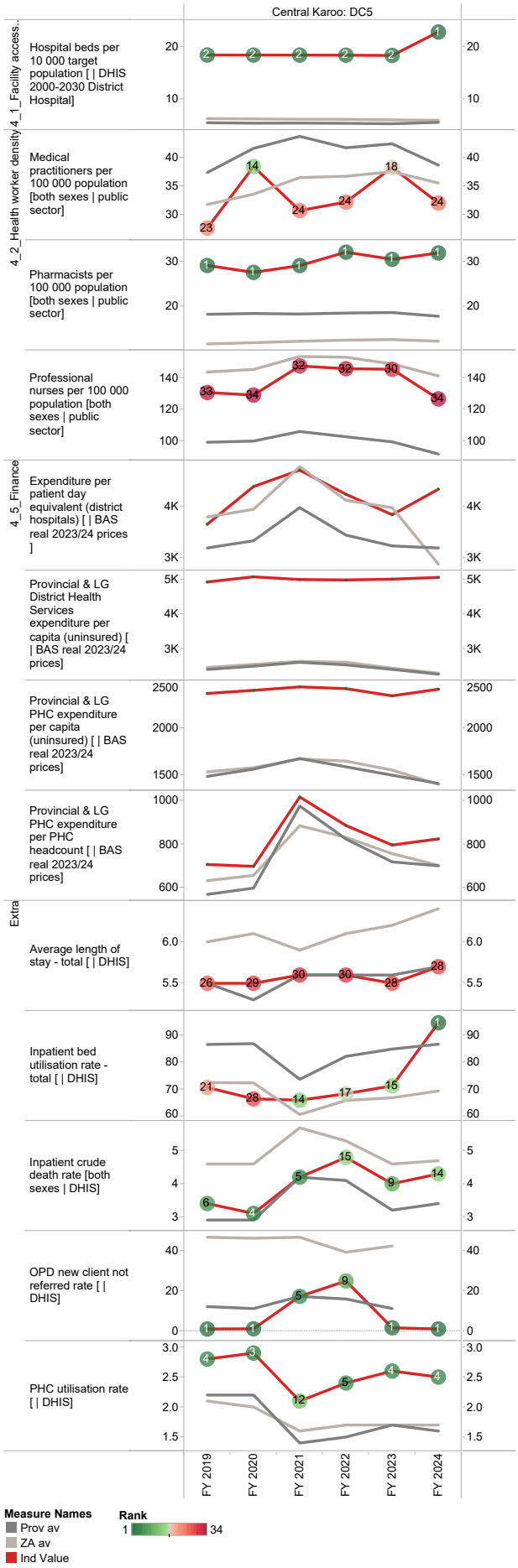
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PHC utilisation rate [| DHIS]
FY 2019
FY 2020
FY 2021
FY 2022
FY 2023
FY 2024
Measure Names
Prov av
ZA av
Ind Value
Rank
1
34

Definitions and sources (abbreviations given in footnote)

Group	Indicator	Description	Numerator	Denominator	Source
Deprivation	South African Index of Multiple Deprivation Rank (1= most deprived)	Ranking for composite index of deprivation. Indicators cover the following domains: income and material deprivation, employment deprivation, education deprivation, and living environment deprivation			Southern African Social Policy Research Institute (SASPRI), based on data from Stats SA Census 2011
Maternal, neonatal and child health	Antenatal 1st visit coverage	The proportion of potential antenatal clients coming for at least one (booking) antenatal visit. The census number of children under one year factorised by 1.15 is used as a proxy denominator – the extra 0.15 (15%) is a rough estimate to cater for late miscarriages (~10 to 26 w), stillbirths (after 26 weeks' gestation) and infant mortality. Pregnant women are regarded as potential antenatal clients from around 10 weeks' gestation, i.e. spontaneous abortions before that as well as ToP cases are excluded	Antenatal 1st visit – total	Estimated pregnant women ~10 weeks' gestation	webDHIS
	Delivery in 10–19 years in facility rate	Deliveries where the mother is 10–19 years old and such delivery is conducted by a trained healthcare worker in a health facility	Deliveries among women aged 10–19 years	Number of deliveries – total	webDHIS
	Maternal mortality in facility ratio	Women who died in hospital as a result of childbearing, during pregnancy or within 42 days of delivery or termination of pregnancy, per 100 000 live births in facility	Maternal deaths in facility	Live births in facility	webDHIS
	Early neonatal death in facility rate	Early neonatal deaths per 1000 infants who were born alive in health facilities.	Death in facility 0-6 days	Live birth in facility	webDHIS
	Neonatal death in facility rate	Infants 0–28 days who died during their stay in the facility as a proportion of live births in facility	Neonatal 0–28 days death in facility	Live birth in facility	webDHIS
	Child under 5 years pneumonia case fatality rate	Proportion of children under 5 years admitted with pneumonia who died	Child under 5 years pneumonia death	Child under 5 years pneumonia admitted	webDHIS
	Death under 5 years against live birth rate	Children under 5 years who died during their stay in the facility as a proportion of all live births	Death in facility under 5 years total	Live birth in facility	webDHIS
	Immunisation coverage under 1 year	Percentage of all children in the target area under 1 year who complete their primary course of immunisation. A primary course comprises BCG, OPV 1, DTaP-IVP-Hib-HBV 1, 2 and 3, PCV 1,2 and 3, RV 1 and 2 and measles 1	Children fully immunised under 1 year	Target population under 1 year	webDHIS
	Measles 2nd dose coverage	Children 1 year (12 months) who received measles 2nd dose, as a proportion of the 1 year population.	Measles 2nd dose	Target population 1 year	webDHIS

Group	Indicator	Description	Numerator	Denominator	Source
Women's health	Couple year protection rate	Women protected against pregnancy by using modern contraceptive methods, including sterilisations, as proportion of female population 15–49 year. Contraceptive years are the total of (Oral pill cycles / 15) + (Medroxyprogesterone injection / 4) + (Norethisterone enanthate injection / 6) + (IUCD x 4.5) + (Sub-dermal implant x 2.5) + Male condoms distributed / 120) + (Female condoms distributed / 120) + (Male sterilisation x 10) + (Female sterilisation x 10)	Contraceptive years dispensed (including sterilisations)	Female target population 15–44 years	webDHIS
Tuberculosis	TB symptom child under 5 years screened in facility rate	Children under 5 years screened for TB symptoms as a proportion of PHC headcount under 5 years	Child under 5 years screened for TB symptoms	PHC headcount under 5 years	webDHIS
	TB symptom 5 years and older screened in facility rate	Clients 5 years and older screened for TB symptoms as a proportion of PHC headcount 5 years and older	Client 5 years and older screened for TB symptoms	PHC headcount 5 years and older	webDHIS
	TB drug-susceptible successful treatment rate	Proportion TB clients (ALL types of TB) cured plus those who completed treatment	TB client cured OR completed treatment	TB client initiated on treatment	webDHIS
	TB drug-susceptible client loss to follow-up rate	TB clients who started drug-susceptible tuberculosis treatment and who subsequently became loss to follow-up as a proportion of all those in the treatment outcome cohort	All drug-susceptible TB loss to follow-up	All drug-susceptible TB patients in treatment outcome cohort	webDHIS
	TB drug-susceptible death rate	TB clients who started drug-susceptible tuberculosis treatment and who subsequently died as a proportion of all those in the treatment outcome cohort	All drug-susceptible TB client died	All drug-susceptible TB patients in treatment outcome cohort	webDHIS
	TB multidrug-resistant treatment success rate	TB-MDR client successfully completing treatment as a proportion of TB- MDR confirmed clients started on treatment	TB-MDR client successfully complete treatment	TB-MDR confirmed client start on treatment	webDHIS
	TB-XDR treatment success rate	TB-XDR clients successfully completing treatment as a proportion of TB-XDR confirmed clients started on treatment	TB-XDR client successfully complete treatment	TB-XDR confirmed client start on treatment	webDHIS
HIV	Clients remaining on ART rate	Percentage of estimated people living with HIV who remain on ART	Total clients remaining on ART at end of the month	Estimated number of people living with HIV	webDHIS
	Adult with viral load suppressed rate 12 months	Proportion of adult ART clients with viral load suppressed at 12 months	ART client viral load under 400 cps/mL at 12 months	ART viral load done	webDHIS
	Child with viral load suppressed rate 12 months	Proportion of ART clients with viral load suppressed at different time intervals. This indicates the population level immunological impact of clients on ART.	ART Child Viral Load Suppressed (VLS)	ART Child client viral load done (VLD)	webDHIS
	ART client viral load suppressed rate (VLS)	ART viral load suppressed - total as a proportion of ART viral load done - total	ART viral load suppressed - total	ART viral load done - total	webDHIS

Group	Indicator	Description	Numerator	Denominator	Source
Non-communicable diseases	Cervical cancer screening coverage	Cervical smears in women 30 years and older as a proportion of the female population 30 years and older. 80% of these women should be screened for cervical cancer every 10 years and 20% must be screened every 3 years	Cervical cancer screening in non- HIV woman 30 years and older + cervical cancer screening in women 20 years and older	80% women aged 30-59yrs / 10 + 20% women aged 20-59yrs / 3	webDHIS
PHC management PHC management	PHC utilisation rate	The rate at which PHC services are utilised by clients of all ages in the catchment population, represented as the average number of PHC visits per client per year in the target population. The denominator is usually Census-derived population	Total PHC headcount	Total population	webDHIS
Inpatient management	Average length of stay	Average number of patient days that an admitted patient spends in hospital before separation	Inpatient days + 1/2 day patients	Separations = Discharges (including day patients) + Deaths + Transfers out	webDHIS
	Inpatient bed utilisation rate	Inpatient bed days used as proportion of maximum Inpatient bed days (inpatient beds x days in period) available	Total patient days = (Inpatient days + 1/2 day patients) x 100	Total usable bed days = (Inpatient beds – total) x 30.42	webDHIS
	Patient day equivalent	Weighted data element as proxy for estimating resources for all types of patients in terms of inpatient days	The sum of inpatient days total x 1, day patient total x 0.5, and OPD/emergency total headcount x 0.3333333	-	webDHIS
	Inpatient crude death rate	Proportion of admitted patients/separations who died during hospital stay	Inpatient deaths – total	Separations = Discharges (including day patients) + Deaths + Transfers out	webDHIS
	Hospital beds per 10 000 target population	Number of inpatient beds per 10 000 target population. For public sector beds, the uninsured population is used as the target	Inpatient beds	Uninsured population (total population less medical scheme coverage x population)	webDHIS

Group	Indicator	Description	Numerator	Denominator	Source
Finance	Provincial and Local Government expenditure on District Health Services per capita (uninsured)	Total amount spent on DHS per person without medical scheme coverage	Provincial expenditure on DHS (excluding 2.8 Coroner) plus net LG expenditure on PHC	Uninsured population (total population less medical scheme coverage x population)	Calculated from BAS, Treasury data on LG expenditure, webDHIS population and GHS modelled for medical scheme coverage
	Provincial PHC expenditure per capita (uninsured)	Total amount spent on non-hospital PHC health services per person without medical scheme coverage	Provincial expenditure on PR2.2-2.7 of DHS + net LG expenditure	Uninsured population (total population less medical scheme coverage x population)	Calculated from BAS, Treasury data on LG expenditure, webDHIS population and GHS modelled for medical scheme coverage
	Provincial expenditure per PHC headcount	Total amount spent on non-hospital PHC health services per headcount	Provincial expenditure on PR2.2-2.7 of DHS + net LG expenditure	Total PHC headcount	BAS, webDHIS
	Expenditure per Patient Day Equivalent	Average cost per patient per day seen in a hospital (expressed as Rand per PDE)	Total expenditure on health per hospital	PDE total	BAS, webDHIS
Human resources	Medical practitioners per 100 000 uninsured population	Ratio of the number of medical practitioners (Doctors) to the population (per 100 000). Note that the measure of the number of personnel may differ for the public and private sectors, and that the population may be adjusted to be the population assumed to be dependent on that sector	Medical practitioners registered to practice, total number	Uninsured population (total population less medical scheme coverage x population)	Calculated from PERSAL, webDHIS population and GHS modelled estimates of medical scheme coverage
	Professional nurses per 100 000 uninsured population	Ratio of the number of Professional Nurses to the population (per 100 000). Note that the measure of the number of personnel may differ for the public and private sectors, and that the population may be adjusted to be the population assumed to be dependent on that sector	Professional Nurses registered to practice, total number	Uninsured population (total population less medical scheme coverage x population)	Calculated from PERSAL, webDHIS population and GHS modelled estimates of medical scheme coverage
	Pharmacists per 100 000 uninsured population	Ratio of the number of Pharmacists to the population (per 100 000). Note that the measure of the number of personnel may differ for the public and private sectors, and that the population may be adjusted to be the population assumed to be dependent on that sector	Pharmacists registered to practice, total number	Uninsured population (total population less medical scheme coverage x population)	Calculated from PERSAL, webDHIS population and GHS modelled estimates of medical scheme coverage
Extra	Medical aid coverage	Percentage of population who have medical scheme insurance	Number of medical scheme beneficiaries	Total population	GHS modelled estimates of medical scheme coverage

ART = antiretroviral treatment; BAS = National Treasury Basic Accounting System; BCG = bacille Calmette-Guerin; BP = blood pressure; CDC = Community Day Centre; CHC = Community Health Centre; DHIS = District Health Information System; DHS = District Health Services; DTaP-IVP-Hib-HBV = Diphtheria, Tetanus, Inactivated Polio Vaccine, Haemophilus Influenza B, Hepatitis Vaccine; GHS = General Household Survey; HIV = Human Immunodeficiency Virus; LG = Local Government; MDR = multidrug-resistant; NCDs = non-communicable diseases; NDoH = National Department of Health; OPD = outpatient department; OPV = oral polio vaccine; PCR = polymerase chain reaction; PCV = pneumococcal conjugate vaccine; PDE = patient day equivalent; PHC = Primary Health Care; PR = programme; RV = Rotavirus vaccine;; Stats SA = Statistics South Africa; TB = tuberculosis; ToP = termination of pregnancy; XDR = extremely drug-resistant;

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