



Province of the
EASTERN CAPE
HEALTH

ANNUAL PERFORMANCE PLAN

2025/26

2027/28



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ABBREVIATIONS AND ACRONYMS

ACSM	Advocacy Communication and Social Mobilisation	CT	Cape Town
AIDC-EC	Automotive Industry Development Centre – Eastern Cape	CUP	Contracting Units for Primary Health Care
AIP	Audit Intervention Plan	CSSD	Central Sterile Supply Department
ALOS	Average Length of Stay	CSTL	Care and Support for Teaching and Learning
APP	Annual Performance Plan	CQI	Continuous Quality Improvement
APC	Adult Primary Care	DCSTs	District Clinical Specialist Team
ARP	Annual Recruitment Plan	DDG	Deputy Director-General
ART	Antiretroviral Therapy	DHA	Department of Home Affairs
BANC	Basic Ante-Natal Care	DHIS	District Health Information System
BoD	Burden of Disease	DHIMS	District Health Information Management System
BUR	Bed Utilisation Rate		
CCMDD	Central Chronic Medicine Dispensing and Distribution		
CCOD	Compensation / Commissioner for Occupational Disease		
CDC	Coega Development Corporation	DHP	District Health Plan
CFO	Chief Financial Officer	DHS	District Health Services
CIDB	Construction Industry Development Board	DM	District Municipality
CFR	Case Fatality Rate	DMT	District Management Team
CHCs	Community Health Centres	DoCS	Department of Correctional Services
CHE	Council for Higher Education	DoT	Department of Transport
CMH	Cecilia Makiwane Hospital	DSD	Department of Social Development
CHWs	Community Health Workers	DPWI	Department of Public Works Infrastructure
CETU	Clinical Education and Training Unit	DOA	Department of Agriculture
COGTA	Co-ordinate Governance and Traditional Affairs	DOE	Department of Education
COE	Compensation of Employees	DOH	Department of Health
COIDA	Compensation of Occupational Injuries and Diseases Act	DOJ	Department of Justice
COVID -19	Corona Virus 19	DME	Department of Monitoring & Evaluation
CP	Cerebral Palsy	DSD	Department of Social Development
CPD	Continuous Personal Development	DS -TB	Drugs Susceptible Tuberculosis
		DR - TB	Drug Resistant Tuberculosis

DSRAC	Department of Sports Recreation, Arts and Culture	HAIs	Hospital Acquired Infection
DWS	Department of Water and Sanitation	HAP	Health Action Plan
EAP	Employee Assistance Programme	HAST	HIV / AIDS, STI and TB Control
EC	Eastern Cape	HBB	Helping Babies Breathe
ECDoH	Eastern Cape Department of Health	HCSS	Health Care Support Services
ECAC	Eastern Cape AIDS Council	HDI	Human Development Index
ECCOEC	Eastern Cape College of Emergency Care	HFM	Health Facilities Management
ECDC	Eastern Cape Development Corporation	HIV/AIDS	Human Immuno - Deficiency Virus/Acquired Immune Deficiency Syndrome
ECPACC	Eastern Cape Provincial Art & Culture Council	HMS	Hospital Management System
ECLB	Eastern Cape Liquor Board	HMS2	Health Management System 2
ELIDZ	East London Industrial Development Zone	HPRS	Health Patient Registration System
ECGB	East London Gambling Board	HOD	Head of Department
ECSECC	Eastern Cape Socio-Economic Consultative Council	HP	Health Promotion
EDR-TB	Extreme Drug Resistance Tuberculosis	HPCSA	Health Professional Council of South Africa
EMS	Emergency Medical Services	HPRS	Health Patient Registration System
EPI	Expanded Programme on Immunisations	HST	Health Sciences and Training
EPWP	Expanded Public Works Programme	HPTD	Health Professions Training and Development (Grant)
EPRE	Estimate of the Provincial Revenue and Expenditure	HPV	Human Papilloma Virus
ESMOE	Essential Steps in the Management of Obstetric Emergencies	HRM	Human Resource Management
ETR	Electronic TB Register	HRD	Human Resource Development
EXCO	Executive Council	HRH	Human Resources for Health
GBV	Gender Based Violence.	HT	Health Technology
GPS	Global Positioning System	HVAC	Heating Ventilation and Conditioning
GIAMA	Government Immovable Asset Management Act	ICC	Institutional Consultative Committee
GP	General Practitioner	IHFRM	Ideal Health Facility Realisation and Maintenance
		ICSM	Integrated Clinical Services Management
		ICRM	Ideal Clinic Realisation and Maintenance

ICT	Information, Communications and Technology	MTCT	Mother-To-Child-Transmission
IDMS	Infrastructure Delivery Management System	MTDP	Medium Term Development Plan
IDIP	Infrastructure Delivery Improvement Programme	PMTDP	Provincial Medium Term Development Plan
IDPs	Integrated Development Plans	MTEF	Medium -Term Expenditure Framework
IGR	Inter Governmental Relations	N/A	Not Applicable
IHR	International Health Regulation	NCCEMD	National Committee on Confidential Enquiry on Maternal Deaths
IMAM	Integrated Management of Children with Acute Malnutrition	NCDs	Non-Communicable Diseases
IMCI	Integrated Management of Childhood Illnesses	NCS	National Core Standards
IMR	Infant Mortality Rate	NDHSC	National District Health Steering Committee
IPC	Infection Prevention and Control	NDoH	National Department of Health
ISHP	Integrated School Health Programme	NDP	National Development Plan
IT	Information Technology	NGO	Non-Governmental Organisation
LEDIS	Local Economic Development Implementation Strategy	NHA	National Health Act
MAC	Ministerial Advisory Committee	NHI	National Health Insurance
MBOD	Medical Bearuea for Occupational Diseases	NHLS	National Health Laboratory Services
MCWHN	Maternal Child Women's Health and Nutrition	NHP	National Health Plan
MDGs	Millennium Developmental Goals	NMAH	Nelson Mandela Academic Hospital
MDR-TB	Multi-Drug-Resistant TB	NMM	Nelson Mandela Metro
MEC	Member of the Executive Council	NMU	Nelson Mandela University
METROs	Medical Emergency Transport and Rescue Organizations	NPI	Non-Pharmaceutical Interventions
MLSIP	Medico-Legal Strategy Implementation Plan	PMDS	Performance Management Development System
MMR	Maternal Mortality Rate	PDE	Patient Day Equivalent
MOU	Maternal Obstetric Unit	NTSG	National Tertiary Services Grant
MOP	Medical Orthotic and Prosthetic	OD	Organisational Development
MPL	Member of Provincial Legislature	O&P	Orthotic and Prosthetic
MRC	Medical Research Council	OHH	Outreach Households
MRI	Magnetic Resonance Imaging	OHS	Occupational Health and Safety
MSSN	Management of Small and Sick Neonates	OPD	Outpatient Department
		OTP	Office of the Premier
		PAJA	Promotion of Administrative Justice Act

PAIA	Promotion of Access to Information Act	RPHC	Re-engineering the Primary Health Care System
PCR	Polymerase Chain Reactive	SADC	South African Development Community
PDE	Patient Day Equivalent		
PDMT	Provincial District Management Team	SDGs	Sustainable Development Goals
		SCM	Supply Chain Management
PDP	Provincial Development Plan	SITA	State Information Technology Agency
PEC	Patient Experience of Care		
PET	Positron Emission Tomography	SOP	Standard Operating Procedure
		SAHRC	South Africa Human Rights Council
PFMA	Public Finance Management Act	SAM	Severe Acute Malnutrition
PEPFAR	President's Emergency Plan for Aids Relief	SDM	Service Delivery Model
		SyNCH	Synchronised National Communication in Health
PERSAL	Personnel and Salaries System		
PGDP	Provincial Growth and Development Plan	SAHRC	South Africa Human Rights Council
PHC	Primary Health Care	SDC	South African Development Community
PMB	Prescribed Minimum Benefits		
PMTCT	Prevent Maternal to Child Transmission	Stats SA	Statistics South Africa
		SPCHD	Social Protection, Community and Human Development
POA	Programme of Action		
PrEP	Pre-exposure prophylaxis	TB	Tuberculosis
PT	Provincial Treasury	TROA	Total clients remaining On ART
PUP	Pick Up Points	TI	Sexual Transmitted Infection
PPTICRM	Perfect Permanent Team for Ideal Clinic Realization and Management	TPT	TB Preventative Therapy
		UNAIDS	United Nations Programme on HIV/AIDS
QIP	Quality Improvement Plan	WBPHCOT	Ward-Based Primary Health Care Outreach Teams
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EXECUTIVE AUTHORITY STATEMENT



As we embark on the seventh term of governance, the department is committed to realizing the vision of ensuring optimal health outcomes for the communities in the Eastern Cape, in alignment with the 2030 National Development Plan (NDP) and the 2024-2029 Medium Term Development Plan (MTDP). The realm of healthcare is undergoing rapid transformation through the implementation of the National Health Insurance scheme, aiming towards the achievement of Universal Health Coverage.

During the sixth term of governance, we faced an unprecedented global challenge with the outbreak of the Corona virus disease 19, which placed immense strain on the health systems. The challenges included the closure of international/national borders, disruptions in the supply chain, and socio-economic issues. The health system is still in the recovery phase, utilising the lessons learned. This, combined with global economic challenges had a detrimental impact on healthcare.

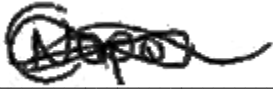
The insights gained from these global health crises have influenced our strategy, highlighting the necessity for Health Transformation, ensuring system resilience, enhancing accessibility, and promoting equity in health services. In the seventh term of governance, our focus remains on transforming health services through the implementation of the National Health Insurance, pooling resources to offer access to high-quality and affordable personal health services to all, regardless of their socio-economic status.

The Department of Health is involved in various initiatives aimed at optimising resource mobilization and ensuring prudence in the utilization of scarce resources, while embracing new technologies and methodologies that have the potential to revolutionize the care we provide. In this digital era, the provision of healthcare is intricately linked to enhancing technological infrastructure. The department is investing in digitalization aligned with the National Health Insurance and continues to introduce Health Management System² and electronic medical records. This system will ensure continuity of care for our clients. These innovative approaches will be instrumental in improving the availability of medication in healthcare facilities.

Over the next five years, we pledge to enhance service delivery through the repurposing and reclassification of facilities. This initiative aims to improve access, equity, and the quality of care for our clients. Hospital efficiencies and effectiveness will be bolstered through the hub and spoke model. The journey of repurposing and reclassification will involve meaningful consultations with stakeholders. We are committed to providing infrastructure that is fit for purpose to support the optimization of service delivery. Maintenance of existing infrastructure and assets (equipment) remains a priority in our plans. In this realm, we are dedicated to implementing our projects within the scope of the District Development Model, from planning to execution.

Human capital remains the most valuable asset, as it directly influences the quality of care. We continue to strive towards ensuring the safety of our staff and clients within our facilities. Recent incidents of violence against staff and clients in healthcare facilities remain a significant concern that needs to be eradicated through intersectoral collaboration with community leadership.

Finally, I express my wholehearted appreciation to the departmental management and staff for their determination and resilience in aiding the Department in fulfilling its constitutional mandate. We also acknowledge the support and contributions of the Department to all Social Partners for their exceptional contributions to healthcare delivery.



Hon. N. Capa, MPL

Member of the Executive Council

02 April 2025

STATEMENT BY THE HEAD AND ACCOUNTING OFFICER OF THE DEPARTMENT



This Annual Performance Plan serves as the introduction and foundation for the execution of the priorities set forth for the seventh term of government. The 2024 - 29 Medium Term Development Plan (MTDP) represents the final phase towards realizing the objectives outlined in the 2030 National Development Plan and the global 2030 Sustainable Development Goals. This marks a period of accelerated service delivery in alignment with our aspirations. As we contemplate the post-pandemic renewal phase following the unprecedented global event of the Covid-19 pandemic and its adverse impact on healthcare, the Department is actively engaged in mitigating these setbacks through its turnaround strategy.

Our new 2025/30 Strategic Plan is harmonized with the government's statement of intent for the seventh term, emphasizing investments in human capital through education, skills development, and accessible healthcare. Our strategies are in sync with the Medium Term Development Plan's three core priorities: Inclusive growth and job creation; Poverty alleviation and addressing the high cost of living; and fostering a competent, ethical, and progressive state.

The department's focus to interrupt the health-poverty cycle is underpinned by various strategies including the progressive realization of universal health coverage through the implementation of the National Health Insurance (NHI) to combat disparities and financial challenges in accessing quality healthcare. Moreover, the Department recognises that the province is undergoing a demographic and epidemiological transition, as our people live longer and experience a changing burden of diseases. Our efforts are therefore directed towards strengthening Primary Health Care systems by ensuring adequate resources and staffing for home-based, community, and clinic services; and for these to deliver comprehensive health and care that encompass health promotion, disease prevention, treatment, rehabilitation, and palliative care.

Enhancing healthcare quality across all levels of facilities, both public and private, optimizing human resources and healthcare infrastructure, and implementing a unified electronic health record system are pivotal in our resource management endeavours.

Improving healthcare accessibility is paramount in our agenda, leading us to reclassify and repurpose our facilities to cater to the evolving disease burden. This transformation is undertaken through inclusive consultations with internal and external stakeholders, placing significant emphasis on the needs of our service beneficiaries.

With a target of achieving a life expectancy of 70 years for both men and women by 2030, the province has made notable progress with the current life expectancy at birth standing at 63 years. The Department's commitment to fostering healthy communities and improving health outcomes is evident through its focus on managing non-communicable diseases and mental health, prioritizing preventive and early intervention measures through collaborative engagements with stakeholders across all levels of care.

To address the challenges posed by limited fiscal resources, natural disasters, and historic medico-legal liabilities, the department remains steadfast in fulfilling its constitutional mandate as enshrined in section 27 of the Constitution of the Republic of South Africa (Act 108, 1996). Alignment of the Department of Health's enterprise architecture with the National Department's eHealth strategy is underway, with a primary focus on developing and implementing universal Electronic Medical Records in public health facilities. Efforts are concentrated on bolstering ICT infrastructure within health facilities to ensure operational efficiency and drive innovative solutions within the eHealth domain.

The HMS2 electronic medical record system encompasses key features such as patient registration integrated with the National Health Patient Registration System (HPRS), billing, and revenue management. The ongoing project aims to connect several health facilities in the initial phase over the Medium-Term Expenditure Framework (MTEF). Collaboration with the State Information Technology Agency (SITA) is being strengthened to ensure timely implementation of the eHealth project for the ECDoH. Integration of HMS² with other essential healthcare technologies like telemedicine platforms and eHealth solutions is planned to enhance service delivery. Cybersecurity and data sovereignty remain paramount to safeguard patient information while adhering to regulatory standards. Health and business intelligence, building on the rich but disparate data from our legacy systems, will find increasing expression in the term ahead and will enhance resource planning, allocation & utilisation; support data-driven decision-making; measure operational performance and promote accountability.

In pursuit of ensuring habitable health facilities, a total of 42 capital infrastructure projects are planned for completion in the 2025/26 financial year. Scheduled preventive maintenance programs are being implemented to ensure optimal functioning of facilities, prevent breakdowns, asset failures, and mitigate high maintenance costs associated with deferred maintenance.

In conclusion, I call upon the stakeholders of the Department to continue to collaborate with us in the pursuit of universal health coverage and improved health outcomes for all. Together we can.



Dr R. Wagner

HOD for Health

02 April 2025

OFFICIAL SIGN-OFF OF THE ANNUAL PERFORMANCE PLAN 2025/26

It is hereby certified that this is the Annual Performance Plan:

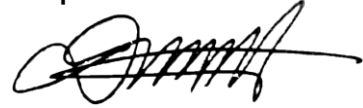
Was developed by the management of the Eastern Cape Department of Health under the guidance of MEC for Health, Hon. N. Capa, MPL, takes into account all the relevant policies, legislations, and other mandates for which the Eastern Cape Province is responsible. Accurately reflects the outcomes and outputs which the Eastern Cape Department of Health will endeavour to achieve over the period 2025/ 26 financial year.



Ms. N. Mavuso

Programme Manager: 1, 6, & 8

02 April 2025




Dr. M. Xamlashe

Programme Manager: 3, 4, 5 & 7

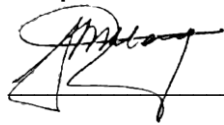
02 April 2025



Ms. N. Nokwe

Programme Manager 2

02 April 2025



Prof. S.T. Moko

Head Official Responsible for Planning

02 April 2025

Mr. G.G. Mhlanga

Acting Chief Financial Officer

02 April 2025



Dr. R Wagner

Accounting Officer

02 April 2025

Approved by:



Hon. N. Capa, MPL

Member of the Executive Council

02 April 2025



Province of the
EASTERN CAPE
HEALTH

ANNUAL PERFORMANCE PLAN 2025/26-2027/28

PART A

OUR MANDATE

PART A - OUR MANDATE

I. CONSTITUTIONAL MANDATE

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

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

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

Section 9 of the Constitution states that everyone has the right to equality, including access to health care services. This means that individuals should not be unfairly excluded in the provision of health care. People also have the right to access information if it is required for the exercise or protection of a right.

This may arise in relation to accessing one's own medical records from a health facility to lodge a complaint or for giving consent for medical treatment.

This right also enables people to exercise their autonomy in decisions related to their own health, an important part of the right to human dignity and bodily integrity in terms of sections 9 and 12 of the Constitutions respectively.

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

- (1) Everyone has the right to have access to:
 - (a) Health care services, including reproductive health care.
 - (b) Sufficient food and water; and
 - (c) Social security, including, if they are unable to support themselves and their dependents, appropriate social assistance.
- (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights; and
- (3) No one may be refused emergency medical treatment.

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

2. LEGISLATIVE AND POLICY MANDATES

National Health Act, 2003 (Act No. 61 of 2003)

Provides a framework for a structured health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial, and local governments with regard to health services.

The objectives of the National Health Act (NHA) are to:

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

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

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

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

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

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

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

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

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

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

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

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

Sexual Offences Act 2007 – Ensures that children of certain ages are not held criminally liable for engaging in consensual acts with each other. Also to give presiding officers a discretion in order to decide in individual cases.

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

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

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

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

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

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

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

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

Other legislation applicable to the Department:

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

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

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

Compensation for Occupational Injuries and Diseases Act, 1993 (Act No. 130 of 1993) -

Provides for compensation for disablement caused by occupational injuries or diseases sustained or contracted by employees in the course of their employment, and for death resulting from such injuries or disease.

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

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

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

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

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

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

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

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

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

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

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

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

Disaster Management Act 2002 (No. 57 of 2002) – establish a framework to prevent and reduce the risk of disasters, mitigating the severity of disaster, emergency preparedness, rapid and effective response to disasters and post-disaster recovery through the establishment of national, provincial and municipal disaster management centre.

3. INSTITUTIONAL POLICIES AND STRATEGIES OVER THE FIVE-YEAR

National Health Insurance (NHI) Act

The National Health Insurance bill was passed by both houses of parliament (National Assembly and National Council of Provinces) in 2023. The phased implementation of National Health Insurance (NHI) is intended to ensure integrated health financing mechanisms that draw on the capacity of the public and private sectors to the benefit of all South Africans. The policy objective of NHI is to ensure that everyone has access to appropriate, efficient, affordable, and quality health services.

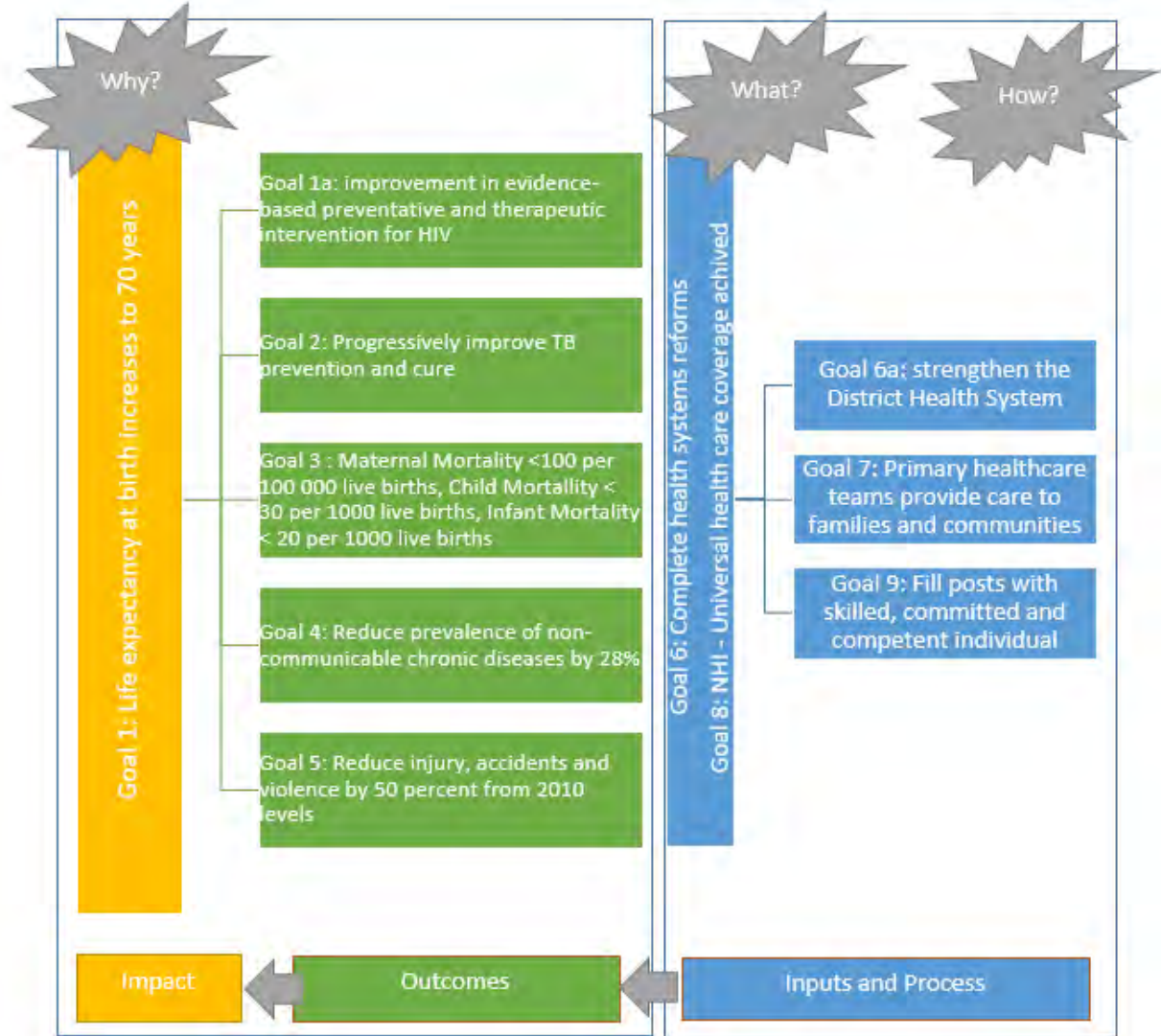
The act will improve the operations of the department through Ideal Clinic Realisation and Maintenance (ICRM) model which will improve our infrastructure and quality improvement of services and the enrolment of Contracting Units of Primary Health Care (CUP) which is at the initiation stage of the Re-engineering of Primary Health Care to improve health outcomes through Integrated School Health Programme (ISHP), Ward-Based PHC Outreach Teams, District Clinical Specialist Teams (DCSTs) and General Practitioners (GP) contracting services.

The NHI bill was assented into in May 2024.

National Development Plan (NDP): Vision 2030

The South African Government is entering its last 5 year cycle towards the 2030 vision. The overarching goal that measures impact is “Average male and female life expectancy at birth increased to at least 70 years”. The NDP goals measure health outcomes, requiring the health system to reduce premature mortality and morbidity. Also tracking the health system that essentially measure inputs and processes to derive outcomes.

Figure 1: National Development Plan



Sustainable Development Goals

The Department is committed in implementing Goal 3 of the Sustainable Development Goals (2030) - to ensure healthy lives and promote well-being for all at all ages, particularly focussing on the following:

- Reduction of the maternal mortality ratio to less than 70 per 100,000 live births.
- End preventable deaths of new-borns and children under 5 years of age, aiming to reduce neonatal mortality and under-5 mortality.
- Reduce the impact of the epidemics of HIV/AIDS, Tuberculosis, Malaria and neglected tropical diseases and combat hepatitis, water-borne diseases, and other communicable diseases like COVID-19.
- Reduce premature mortality from non-communicable diseases through prevention and treatment and promotion of mental health and well-being, deaths and injuries from road traffic accidents.

- Achieve Universal Health Coverage (UHC), including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

2024-2029 Medium-Term Development Plan (MDTP)

The plan comprehensively responds to the priorities identified by the cabinet of the 7th administration of democratic South Africa, which are embodied in the Medium-Term Development Plan for the period 2024- 2029.

Strategic Priority 2: Reduce poverty and tackle the high cost of living. The following outcomes and sub-outcomes guide the 2025/26 – 2029/30 planning cycle.

Outcome: Improved access to affordable and quality healthcare

Sub outcomes:

- i Pursue the achievement of universal health coverage, in which everyone in South Africa has equal access to equitable, accessible, quality health services.
- ii Implement the National Health Insurance through, among other things, finalising the implementation of the National Quality Improvement Plan to ensure public and private facilities pass inspection and are accredited to provide health care under the NHI Fund.
- iii Fast-track the strengthening of healthcare infrastructure, employ more personnel and finalise the creation of a single electronic health record.
- iv Strengthen the delivery of Primary Health Care (PHC) and ensure that clinics are well-resourced and appropriately staffed.
- v Strengthen the implementation of the National Drug Master Plan to ensure a South Africa free of substance abuse.

Provincial Medium-Term Development Plan and Mandate Paper

The Eastern Cape Provincial Administration is strengthening and consolidating planning and promotes government departments to operate in an integrated manner. There are nine Integration Areas (IAs) the province has identified. The Department of Health must develop plans for Integration Area eight (8) – Non-Communicable Diseases, Mental Health and Social Determinants of Health.

Table 1: Provincial Integrated Programmes led by Social Protection, Community and Human Development (SPCHD) Cluster

FINAL NINE INTEGRATION PROGRAMMES	LEADER	SUPPORTING INSTITUTIONS
1. Inclusive Early Childhood Development and Learner Attainment	DOE	DSD, DOH, DSRAC, DOCS, DRDAR, DHS, DHA, ECLB
2. Transformation, Governance & Municipal Support	COGTA	OTP, PT, MISA, ECSECC, DWS, StatsSA, DHS, Amatola Water, Municipalities
3. Social cohesion, moral regeneration, community safety & GBVF	DOCS	DSRAC, DOE, DSD, DOH, OTP, COGTA, ECBGB, ECLB, ECPACC
4. Anti-Poverty & Sustainable Livelihoods	DSD	DRDAR, DEDEAT, PT, DHS, DOH, DSRAC, ECRDA, ECDC, DOE, DHA, ECPTA, ELIDZ
5. Infrastructure, human settlements & broadband	DPWI	OTP, PT, DoT, DHS, DSRAC, ELIDZ, CDC, DOE, DOH , DRDAR, DSD, DoEL, DWS, ECSECC, ECPTA, Municipalities
6. Food Security, Land reform & agriculture commercialisation	DRDAR	DSD, DEDEAT, DoT, DOE, ECRDA, DALRRD, COGTA, Amatola Water, CDC, DOH, DHS, ELIDZ, AIDC
7. Inclusive Economic Growth	DEDEAT	DPWI, DRDAR, DoT, DOH , OTP, DSRAC, DOE, ECRDA, ECSECC, ECPAC, DME, COEGA SEZ, ELIDZ, AIDC-EC, ECDC, StatsSA, DoEL, ESKOM, Transnet, ECGB, ECLB; Local Government; Municipal Agencies
8. Non-Communicable Diseases, mental health & social determinants of health	DOH	DOE, DSRAC, DSD, OTP, COGTA, DHS, DPWI, DOCS, DWS, DRDAR, Municipalities, Development & Social Partners
9. Youth development, skills development & training for the Economy	OTP	ALL INSTITUTIONS, DoT, DOE, DOH, DSRAC, DSD, OTP, COGTA, PT, DOCS, DRDAR, SETA, Municipalities, CDC, ELIDZ, ECDC, ECPACC, DoEL, HRD Council

Table 2: Integration Priorities with Health interventions and Health support

MTDP/ P-MTDP STRATEGIC PRIORITY	PRIORITY FOCUS	INTEGRATION PROGRAMMES	INTERVENTIONS	2025/26 TARGETS	MTEF BUDGET
2. REDUCE POVERTY AND TACKLE THE HIGH COST OF LIVING	Social Security	4. Anti-Poverty & Sustainable Livelihoods	i. Ensure regular access to adequate and nutritious food to mitigate against Child Poverty & Malnutrition. ii. Develop sustainable Integrated Community Development interventions and increase economic opportunities towards self-reliant communities.	9 % of children under 5 years severe acute malnutrition case fatality to be reduced 77% children 12-59months on vitamin A supplementation to reduce micro nutrient malnutrition	R39 000 000
	Education & Health	I. Inclusive Early Childhood Development and Learner Attainment	i. Universal availability of comprehensive age-, and stage-appropriate quality Early Childhood Development services. ii. Increase Social Support to education for improved learner attainment.	13 000 Grade I Learners to be screened 10 000 Grade 8 Learners to be screened	R43 823 000
		Non-Communicable Diseases, mental health & social determinants of health	i. Strengthen the implementation of Prevention and Control of Non-Communicable Diseases. ii. Strengthen the implementation of Integrated Mental	2% Hypertension positivity rate >_45 years 2% Diabetes positivity rate >_45 years	R873 307

MTDP/ P-MTDP STRATEGIC PRIORITY	PRIORITY FOCUS	INTEGRATION PROGRAMMES	INTERVENTIONS	2025/26 TARGETS	MTEF BUDGET
			Health Services.	Enrol 490 050 active patients on Central Chronic Medicines Dispensing and Distribution (CMDD)	
				94 % of Grade 5,6 and 7 girl Learners in public and special schools vaccinated with the single dose HPV	R43 823 000
				0.2% of headcount - New clients Primary Health Care mental health condition treated	R951 900 000
3. BUILD A CAPABLE, ETHICAL AND DEVELOPMENTAL STATE	DOCS	3. Social cohesion, moral regeneration, community safety & GBVF	I. Community conversations through Local leaders and heroes having conversations with communities and youth. II. Improve GBVF provincial response by upscaling early Interventions and Prevention Measures.	Reduction of child and teenage pregnancy to < 330 births	

MTDP/ P-MTDP STRATEGIC PRIORITY	PRIORITY FOCUS	INTEGRATION PROGRAMMES	INTERVENTIONS	2025/26 TARGETS	MTEF BUDGET
I. INCLUSIVE GROWTH AND JOB CREATION	DPWI	5. Infrastructure, human settlements & broadband	i. Respond to ageing infrastructure in order to meet universal access to basic services and support economic growth	70% % awards of Infrastructure capital expenditure items (monetary value)	R7.5bn
			ii. Improve access to social amenities	Procured from local Suppliers / Manufacturers	
			iii. Increase access to water, sanitation and electricity for health facilities and schools		
I. INCLUSIVE GROWTH AND JOB CREATION	DEDEAT	6. Inclusive Economic Growth	iv. Integrated urban space and public transport programme	6 Solar panels in health facilities installed	R60mil
			v. Rollout of broadband connectivity to various government facilities across the province	Connect 67 hospitals and 349 Primary Health care facilities to internet	
			vi. Support the development of the electricity transmission grid in the province.		
I. INCLUSIVE GROWTH AND JOB CREATION	DEDEAT	6. Inclusive Economic Growth	vii. Enable pipeline of utility scale energy projects		
I. INCLUSIVE GROWTH AND JOB CREATION	DEDEAT	6. Inclusive Economic Growth	i. Revenue generation ii. Creation of public employment opportunities iii. Skills development for the economy	Rand value of revenue generated	339.7mil
3. BUILD A CAPABLE, ETHICAL AND DEVELOPMEN	OTP	I. Youth development, skills development	I. Job Creation II. Inclusive Economy III. Development)	205 nursing students complete	

MTDP/ P-MTDP STRATEGIC PRIORITY	PRIORITY FOCUS	INTEGRATION PROGRAMMES	INTERVENTIONS	2025/26 TARGETS	MTEF BUDGET
TAL STATE		& training for the Economy	IV. Food Security	training Six (6) Emergency care Practitioners complete the qualification 889 youth placed on youth training programs 64 bursary students complete their training 25 registrars complete their specialist training	
Cross Cutting Priorities			i. Addressing Social Determinants of Health & Education & Social Development. ii. Strengthen Provincial Coordination and implementation of Provincial Integrated Anti-Poverty Strategy (PIAPS).	1 500 000 households reached through Community based Outreach Services	R212 602 000
Department-specific (but critical) priorities			i. National Health Insurance - Accelerate implementation National Health	65% Ideal PHC facilities status obtained	150 000 000 (excluding infrastructure budget)

MTDP/ P-MTDP STRATEGIC PRIORITY	PRIORITY FOCUS	INTEGRATION PROGRAMMES	INTERVENTIONS	2025/26 TARGETS	MTEF BUDGET
			ii. Insurance. Medico-legal - Strengthen the implementation of Integrated Medico-Legal Strategy to mitigate and manage medico- legal risks.	Reduce Contingent liability of medico – legal cases – rand value to R21,471bn Strengthen implementati on of administrative interventions with a specific focus on patient records and medico-legal claims through digitalisation of records management e.g. ePAIA, HMS2	R186 000 000

Theory of change – Health Care Delivery

Problem Statement

The Province is undergoing a demographic and epidemiological transition, experiencing an increasing burden of disease and mortality associated with inadequate access, structural inequality, system inefficiencies and high cost of delivering health services, within a constrained fiscal environment.

Impact

The department of health impact is “Long, healthy and quality life for the people of the Eastern Cape”. To achieve the above-mentioned impact, the department will strive to implement these outcomes. Only high-level outputs that were included in the table below.

Table 3: Theory of change for Health Care Delivery

Theory of change	
Inputs : Resources and Investments	- Human Resources: Trained healthcare workers, community health workers, Developmental partners' workers - Financial Resources: Equitable share, conditional grants, other funding sources - Infrastructure: Hospitals, clinics, telemedicine platforms, mobile clinics, WBPHCOT, pharmaceutical depots, EMS, forensic pathology; Colleges of Nursing and EMS; plant, machinery and equipment - Technology: Electronic Medical Records (EMRs), diagnostics equipment, mobile apps, health information systems and infrastructure - Policy & Governance: Health regulations, universal healthcare policies - Community Engagement: Awareness programs, patient education initiatives, ICROP
Activities: Key interventions	- Implement National Health Insurance Prevention and promotion of healthy living e.g. immunisations, healthy eating etc. - Implement re-engineering of Primary Health Care through implementation of Ward Based Primary Health Care outreach teams (WBPHCOT), - Implementation of school health services - Increase access to mental health services in Primary health care - Early detection and management of Non-communicable diseases - Implement the 95-95-95 UNAIDS strategy for management of HIV/AIDS and TB. - Prevent childhood illnesses and death - Promote contraception to prevent unwanted pregnancies and reduce maternal deaths - Strengthening health workforce through training and capacity building for healthcare workers - Implement digital health solutions for data-driven decision-making - Improve patient experience of care and curb medico legal litigations
Outputs: High level outputs	- Unwanted and teenage pregnancies prevented - Early and good quality antenatal care services rendered - Hypertension and diabetes screening and treatment. - Mental health care services integrated in Primary Health Care 95% of people know their HIV/TB status, 95% are on treatment and 95 % are viral suppressed and cured for TB. The above outputs are possible if the health system is strengthened through management of resource like human, material (medication, laboratory, health technology, equipment, digital, information management)
Outcomes: To achieve the Impact	- Reduce maternal, neonatal and child mortality - Reduced mortality due to Communicable and Non-Communicable Diseases - Mental health care integrated into Primary Health Care - Quality of health services improved, including improved patient experience of care - Financial management strengthened in the health sector

4. UPDATES TO RELEVANT COURT RULINGS

The department has been affected negatively by the Ikamva matter, which was a ruling against the ECDOH and DPWI. IKAMVA matter is a service-related matter. The default judgement was issued against the Department and the Department of Public Works on 01 December 2015, in the amount of

R41 031 279,48. Interest accrued from 18 August 2008 to 31 July 2024 was at R114 540 608,65. The payment above amounts were to be shared equally between the two Departments.

The Nalithemba matter deals with the PPP arrangement involving Port Alfred and Settlers hospitals where the department has also been negatively impacted by the court order and is still battling another claim against Nalithemba Pty Ltd.

The department has been waiting, since 2024 September the court outcomes on the TN obo BN matter. This matter was taken on appeal by the plaintiffs challenging the February 2023 ruling on the provision of health care services in lieu of lumpsum payments.

ANNUAL PERFORMANCE PLAN 2025/26-2027/28

**PART
B**

STRATEGIC FOCUS



PART B: STRATEGIC FOCUS

5. VISION

Optimal health outcomes for the people of the Eastern Cape Province.

6. MISSION

To attain Universal Health Coverage (UHC) for the people of the Eastern Cape Province, through Primary Health Care (PHC) approach utilising resources efficiently, to enable present and future generations to achieve optimal health outcomes and quality.

7. VALUES

The department's activities will be anchored on the following values in the next five years and beyond:

- Professionalism
- Fairness
- Accountability
- Commitment
- Team work
- Compassionate
- Responsive

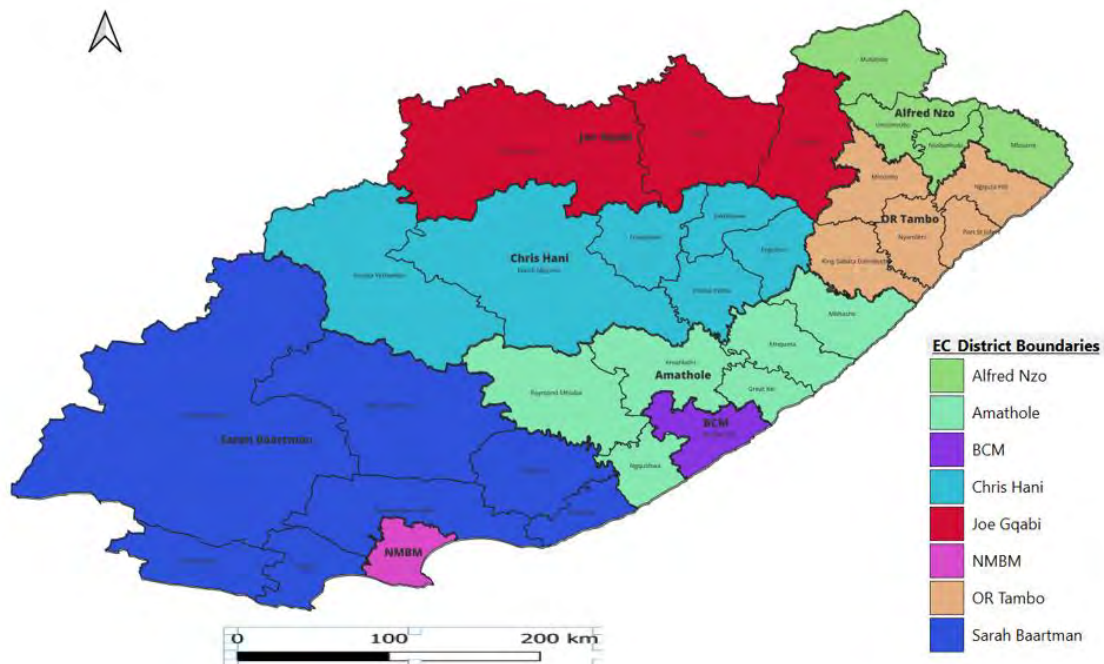
8. SITUATION ANALYSIS

8.1 External environmental analysis

8.1.1 Overview of the Province

The Eastern Cape is located on the east coast of South Africa between the Western Cape and KwaZulu-Natal provinces. Inland, it borders the Northern Cape and Free State provinces, as well as Lesotho. The region boasts remarkable natural diversity, ranging from the semi-arid Great Karoo to the forests of the Wild Coast and the Keiskamma Valley, the fertile Langkloof, and the mountainous southern Drakensberg region.

Figure 2: Map of the Eastern Cape



Source: EC DoH

8.1.2 Demographic Profile of the Eastern Cape Province

According to Statistics South Africa 2024 mid-year population estimates, the Eastern Cape Province is home to 7,176,232 people, comprising 46.7% males and 53.3% females. The youth (15-34 yrs) constitute about 31.5% of the provincial population and about 10.9% of the general population are children under 5 years of age. The Census is, however, showing a declining youth cohort (15-34) years. This decline may have a substantial impact on the Province, leading to the skills drainage.

At birth, both males and females have almost the same numbers until becoming young adults. With males having a slight edge over their female counterparts up to age 35 years. More women live beyond the age of 35 years when compared to men. As a result, the capacity of the EC province is usually overstretched due to the high demand for basic services like education, health care services, social services, employment opportunities and housing.

The Province is divided into two metropolitan municipalities (Buffalo City and Nelson Mandela Metropolitan) and six district municipalities (Alfred Nzo, Amathole, Chris Hani, Joe Gqabi, OR Tambo and Sarah Baartman), which are further divided into 31 local municipalities.

Population Pyramid

Figure 3: Eastern Cape Population by age and sex (Stats SA mid-year population estimates, 2024)

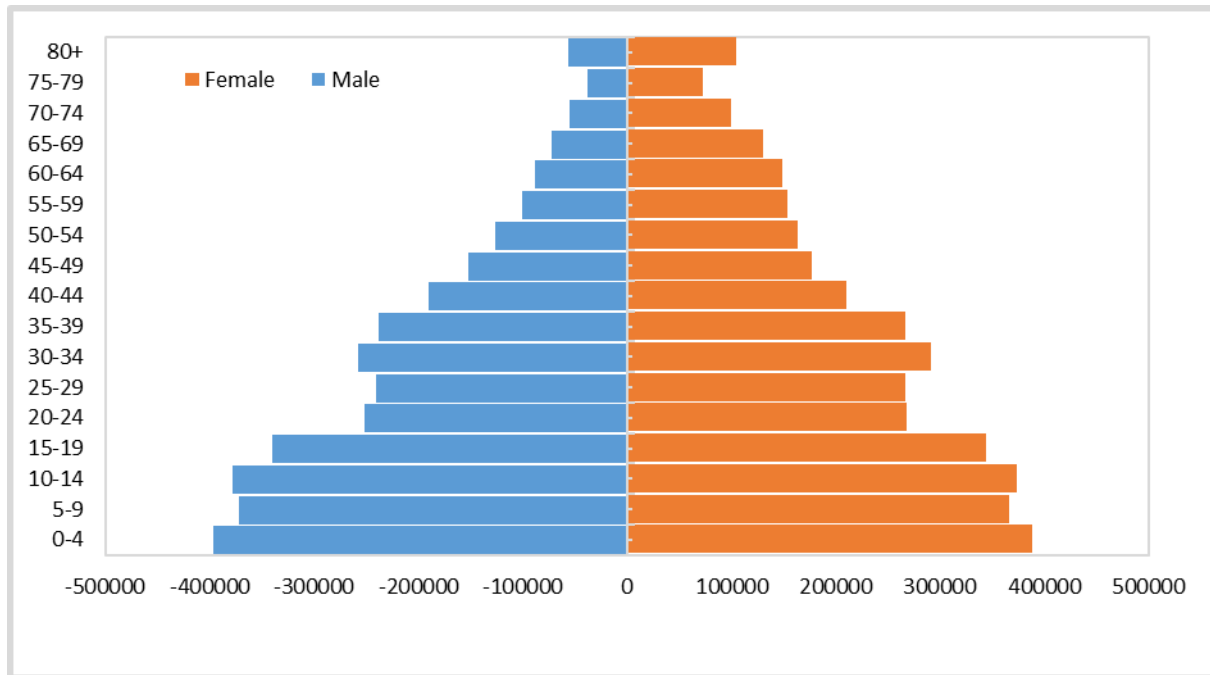


Table 4: Population Distribution by Health District Municipality (DM), 2022 estimates

District	% of total population ¹	Total population ¹	Males ¹	Females ¹	Size of area (km ²) ²
Alfred Nzo	12,5	899 932	383 096	516 836	10 731.2
Amathole	11,8	844 253	399 609	444 644	21 594.9
Buffalo City Metro	12,3	880 910	419 706	461 204	2 535.9
Chris Hani	10,5	752 480	348 123	404 357	36 143.5
Joe Gqabi	5,1	368 767	172 959	195 808	25 662.7
N Mandela Metro	17,6	1 262 388	600 737	661 651	1 958.9
OR Tambo	23,0	1 647 014	774 893	872 121	12 095.5
Sarah Baartman	7,3	520 485	249 478	271 007	58 243.3
Eastern Cape	100.0	7 176 229	3 348 601	3 827 628	168,966.0

Data Sources: ¹Stats SA mid-year population estimates 2024; ²Population Census, 2022

8.1.3 Social Determinants of Health: EC Province

Poverty, unemployment, low literacy rates, poor housing, access to piped water and sanitation are the social determinants of health that characterize the Eastern Cape Province. The Census 2022 revealed an overall improvement in basic services to households, including access to clean water, sanitation, energy, refuse removal, and shelter. Eastern Cape has the lowest proportion of households residing in formal dwellings (83.5%) Access to proper housing is a fundamental human need that promotes physical and mental well-being.

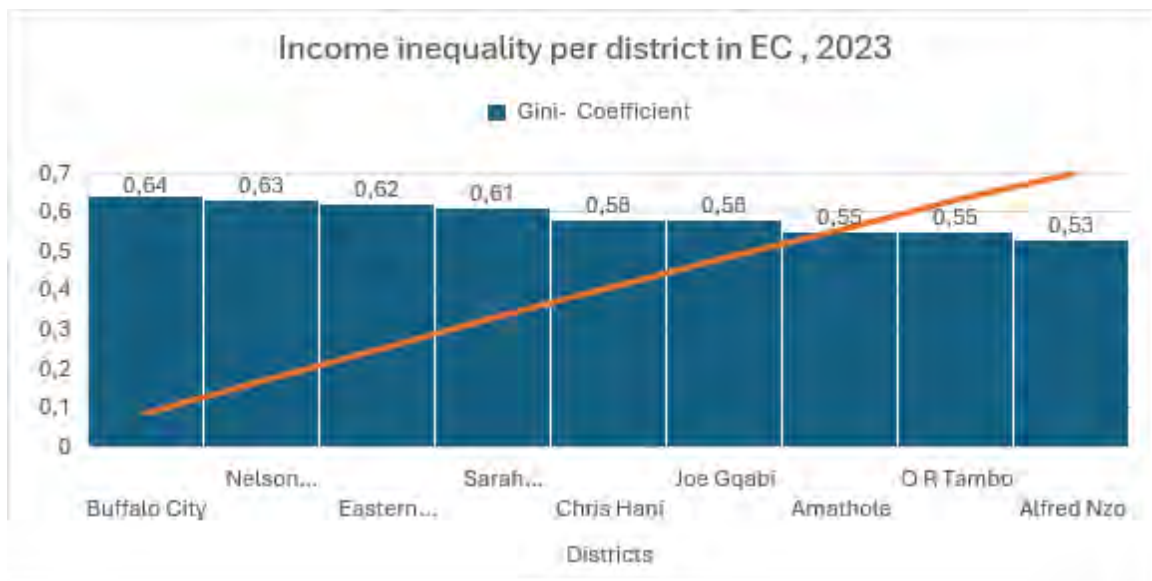
Working-Age Population: The working-age population (15-64 years) increased by 2.3 percentage points in 2022. A larger working-age population can contribute to increased economic productivity and growth

potential. Given high levels of unemployment in the Eastern Cape, the Province should focus on creating job opportunities to absorb the increasing number of working-age individuals entering the labor market, supporting entrepreneurship, and providing access to skill development programs to harness this potential.

Dependency Ratio: The dependency ratio has decreased by 6 index points. A declining dependency ratio presents both challenges and opportunities for societies. In the Eastern Cape, this ratio is influenced by a declining population of children. Effective policies addressing the social and economic implications can help navigate these changes and promote the well-being of individuals across different age groups.

Income Inequality in the Eastern Cape: Figure 4 below illustrates the Gini coefficient, which quantifies the degree of economic inequality within a society, ranging from 0 (perfect equality, where everyone has the same income or wealth) to 1 (perfect inequality, where one person has all the income or wealth). Both metros, Buffalo City (0.64) and NMB (0.63). Higher levels of inequality can hinder overall development outcomes in the Province, exacerbating poverty and limiting access to services.

Figure 4: Income Inequality per district in EC, 2023



Source: ECSSECC report, 2024

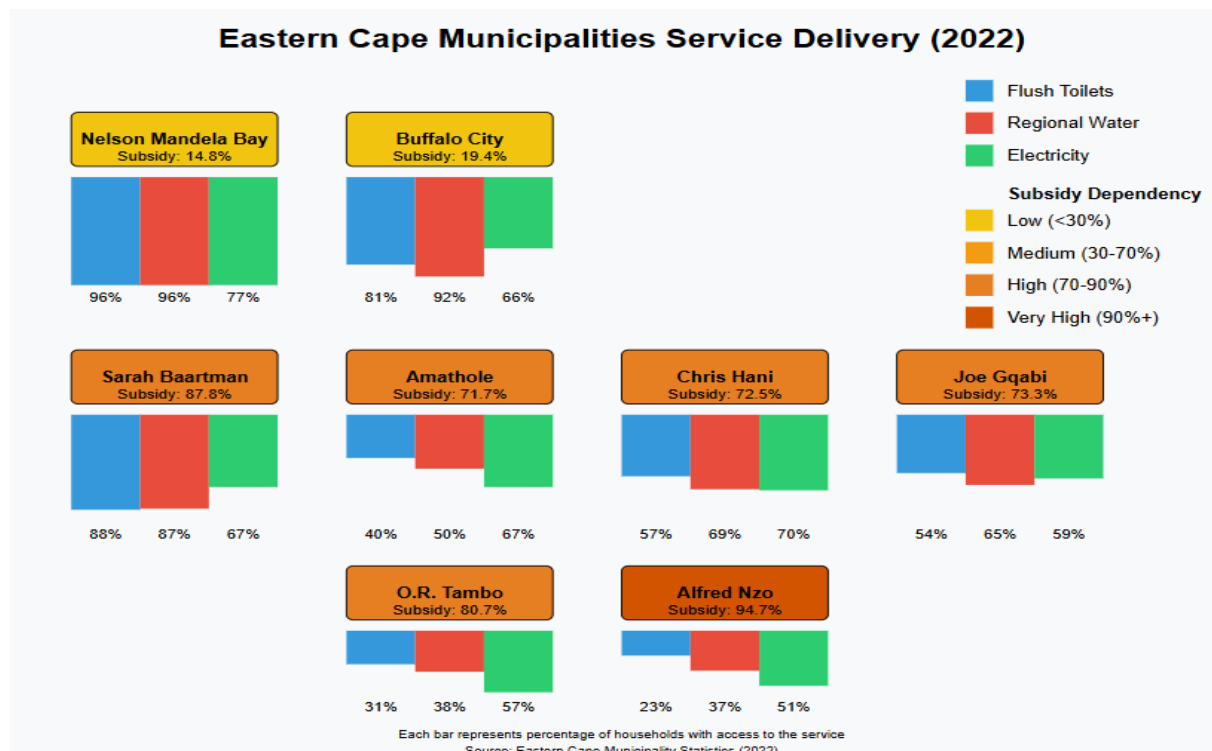
Educational Attainment: The percentage of individuals aged 20 and older with no education has decreased by 3.3 percentage points, while those with a high level of education increased by 1.5 percentage points. The socio-economic implications of an increased number of highly educated individuals are generally positive, as they can drive economic growth, innovation, and improved living standards.

The figure 5 below reveals significant inequities in basic services throughout the districts of Eastern Cape. Although the Nelson Mandela Bay Metro, Buffalo City Metro and Sarah Baartman have achieved almost complete coverage of piped water, sewage, and electricity, areas such as Alfred Nzo and Joe Gqabi still face challenges, with just 50% having access to piped water and 56% having access to electricity. The uneven

distribution of resources emphasizes a need for prioritized efforts to address these disparities and ensure that all individuals have fair and equal access to essential services for their health and well-being.

The Eastern Cape Municipality Service Delivery 2022 visualization demonstrates the district inequalities in basic service delivery, with the correlation between subsidy dependency and the service delivery outcomes. Metropolitan areas with low dependency show higher service levels in water, sanitation, and electricity, while rural district areas struggle with access to basic services. This draws attention to the systemic problems in rural districts and advocates for focused infrastructure investment.

Figure 5: Eastern Cape Municipalities Service Delivery (2022)



8.1.4 Epidemiology and Burden of Disease

Generally, the disease burden is high, and the service platform is overburdened due to social determinants of health that the Department alone has no control over. The intervention that the Department had put in place is Inter-Governmental Relations (IGR) collaboration and integrated planning across sectors. According to Stats SA 2022, the causes of mortality as per the mortality report; were COVID-19, Diabetes, Hypertension and Tuberculosis were among the top causes of mortality in the Eastern Cape Province in 2020. Other external causes of accidental injury, assault and transport accidents were among the top unnatural causes of death.

Most common underlying causes of natural and un-natural deaths in EC

Figure 6: Natural causes

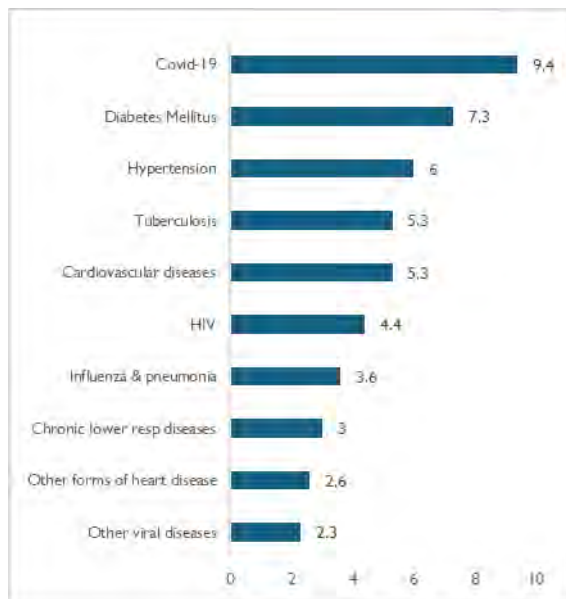
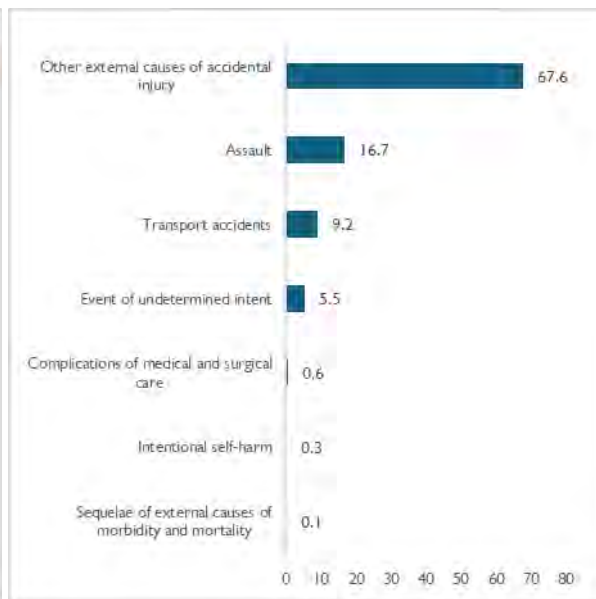


Figure 7: Un-natural causes



Source: Stats SA Mortality and causes of death report 2024

Disability

Figure 8: Disabled prevalence by Province

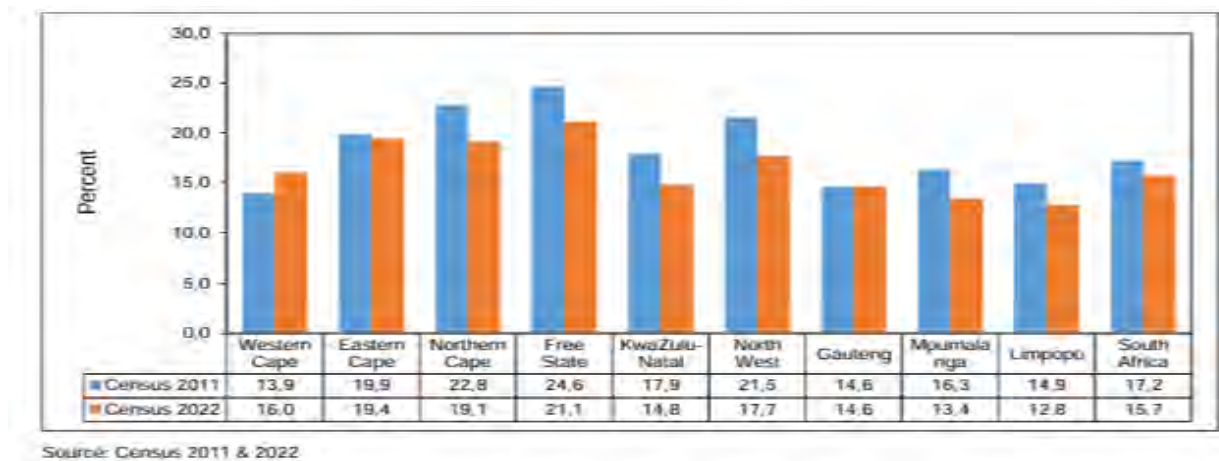


Figure 8 above depicts provincial variations in disability prevalence for 2011 and 2022. The results show that Free State had the highest disability prevalence rates for both years. For the reference period, all the provinces recorded a decrease in proportion of persons with disabilities except the Western Cape, while Gauteng remained the same. In 2022, Limpopo and Mpumalanga recorded the lowest prevalence of persons with disabilities (12.8% and 13.4% respectively).

HIV/AIDS & STI

The country has subscribed to the global vision of achieving an HIV-free generation by implementing strategies that are guided by the World Health Organization (WHO), among those strategies is the mandate to reach 95-95-95 by year 2028. 95% of people living with HIV (PLHIV) should be aware of their status, 95% of PLHIV should be on antiretroviral treatment (ART) and 95% of PLHIV on ART should be viral logically suppressed.

As of Feb 2025, Eastern Cape is at 93-81-93 for the total population serviced through the Public & Private sector. Results for each of the sub-populations vary, with Adult Females at 94-84-93; Adult Males at 92-74-93 and Children (<15) at 83-67-73.

Figure 9: 95-95-95 Cascade in Public & Private sector (EC, Feb 2025)

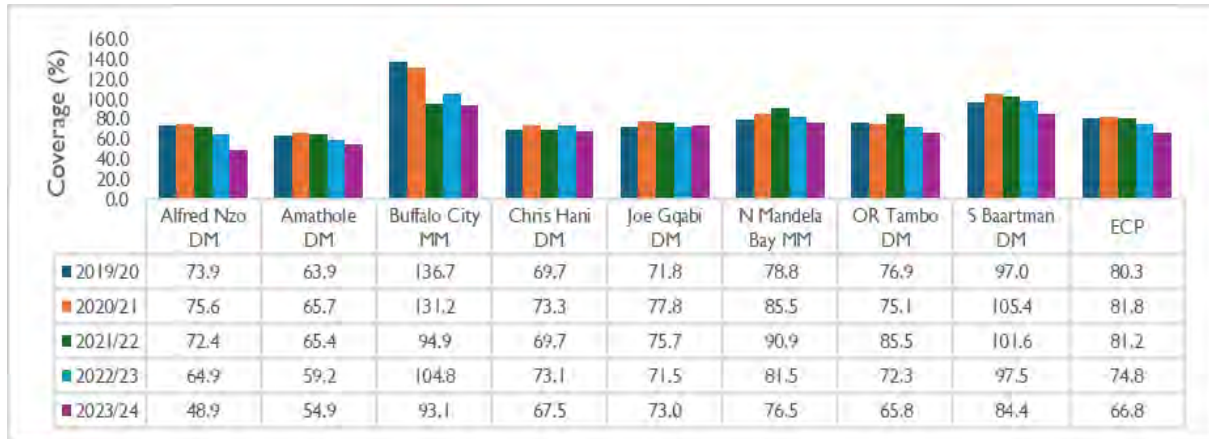


Source: NDoH 2024

To achieve 95-95-95 targets, Eastern Cape must increase the number of Total Clients on ART by 134,662; Adult Females on ART by 66,767; Adult Males on ART by 59,440 and Children (<15) on ART by 8,455.

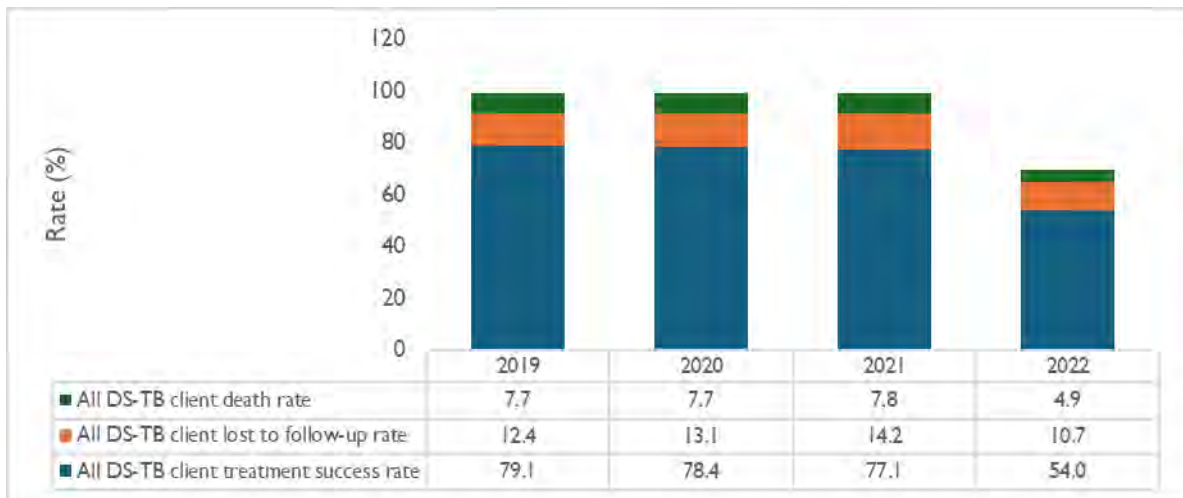
The HIV pandemic remains among the leading causes of morbidity and mortality in the province. Some HIV-positive clients continue to be picked when attending antenatal care. The DS-TB HIV-positive clients on ART remains above 90% in the last five financial years.

Figure 10: Antenatal client HIV 1st test positive rate, 2018/19-2023/24



Source: DHIS 2024

Figure 11: TB outcomes



Source: DHIS 2024

Maternal & Child Health

Consistent increases on maternal mortality rate were observed in Nelson Mandela Metro and OR Tambo districts in the past three years. Maternal mortality increased from 108,2 per 100 000 in 2019/20 to 136.2 per 100 000 in 2023/24 with the highest increase (146.2 per 100 000) noted in 2020/21 during the COVID-19 pandemic.

Figure 12: Maternal Mortality (per 100,000) per District in the EC, 2019/20 - 2023/24



Source: DHIS 2024

The province has reported an increase in early neonatal deaths in the past financial year from 10.3% in 2022/23 to 11.8% in 2023/24. OR Tambo district remained the most affected when compared with the other districts. There is a concern with the Amathole, Chris Hani and Nelson Mandela Metro where there were constant increases over the past 5 financial years.

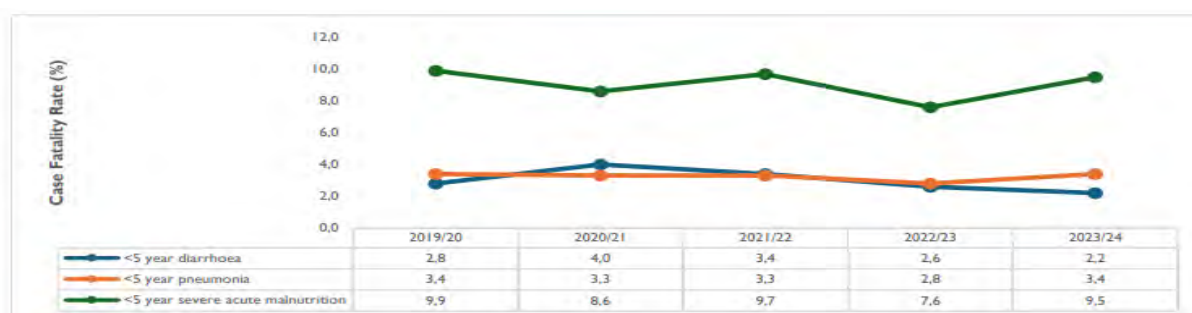
Figure 13: Neonatal Mortality per District in the EC, 2019/20- 2023/24



Source: DHIS 2024

There was a steady decline in the diarrheal case fatality rate among children under 5 years of age in the past four financial years. The case fatality rate for severe acute malnutrition has been fluctuating over the years.

Figure 14: Early neonatal death in facility rate by district in the EC, 2019/20 - 2023/24



Source: DHIS 2024

Non Communicable Disease (NCDs)

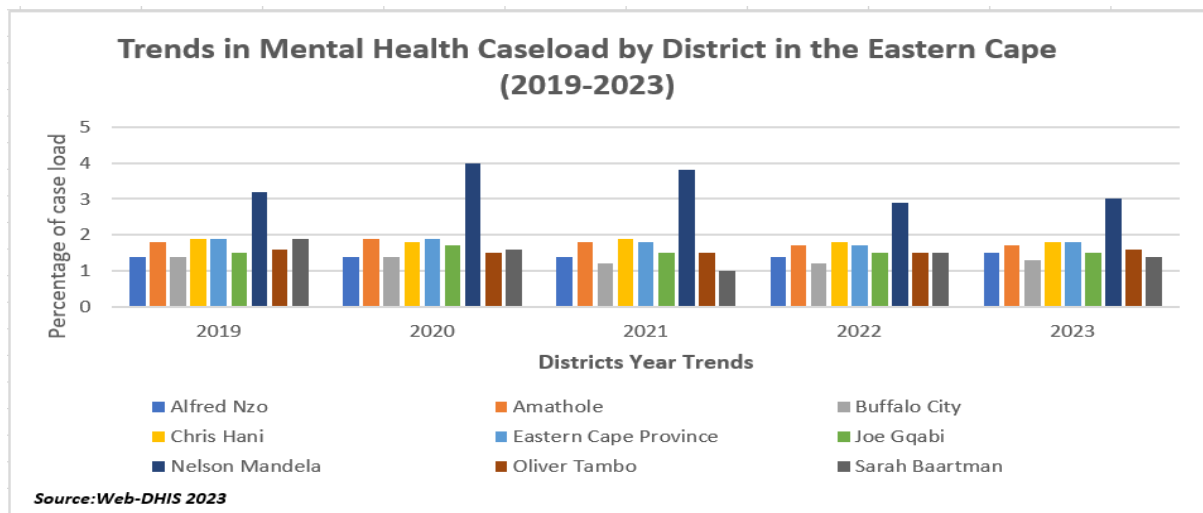
The global trend of escalating Non-Communicable Diseases is evident in South Africa and the Province. Diseases of lifestyle such as obesity, hypertension, and diabetes result, inevitably, in costly hospital admissions for complications such as stroke, renal failure, heart disease and blindness. The COVID-19 pandemic has escalated the importance of dealing with Non-Communicable Diseases and co-morbidities.

According to the Stats SA NCD report of 2023, deaths due to major non-communicable diseases, cardiovascular, cancer, diabetes and chronic lower respiratory diseases increased by 13,1% between 2008 and 2018. The biggest increase was for diabetes-related deaths, which increased by 36,5%, and cancer-related deaths increased by 29,3%. The province plans to establish a surveillance system for Non-Communicable Diseases. Strengthen the digitalisation of information management in NCDs management e.g. Vula app; SYNCH etc. The Department in partnership with the Department of Sport Recreation Arts and Culture have started a partnership in implementing a “Move for Health” project.

Mental Health

Overall, the mental health caseload appears to be relatively stable across all districts over the years. Nelson Mandela Bay Health Metro consistently has the highest caseload, while Sarah Baartman district has the lowest caseload. There was a slight increase in caseload for Alfred Nzo and Joe Gqabi districts in 2023.

Figure 15: Mental Health caseload by District in the EC.



The province appointed a child and adolescent psychiatrist thus paving the way to open the mental health unit with 14 beds capacity in Fort England hospital to manage acute and subacute mentally challenged children in the province. Mental illness associated with substance abuse is a public health concern and partnerships will be explored to render the relevant services to prevent and treat substance abuse effectively.

The burden of disease has shown a radical increase in substance abuse in the province and the country, thus increasing the need for social service and rehabilitation services. There is a critical need for facilities offering

rehabilitation services to augment the 91 beds available from the public and private sectors.

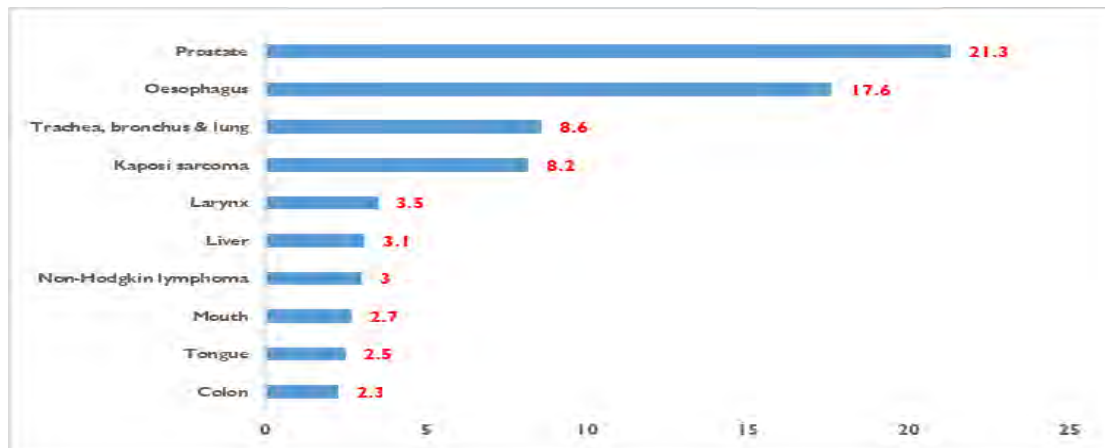
Cancer

Prostate cancer is the most leading amongst males with 21.3 % and cervix uteri is the most leading amongst females with 35% of population in Eastern Cape Province.

This data presents a clear and striking image, however, knowledge serves as the first weapon in this battle. Early identification, preventive measures such as social and behaviour change interventions and immunizations, improved access to health care, and allocation of resources towards research are essential measures for overcoming cancer in Eastern Cape Province.

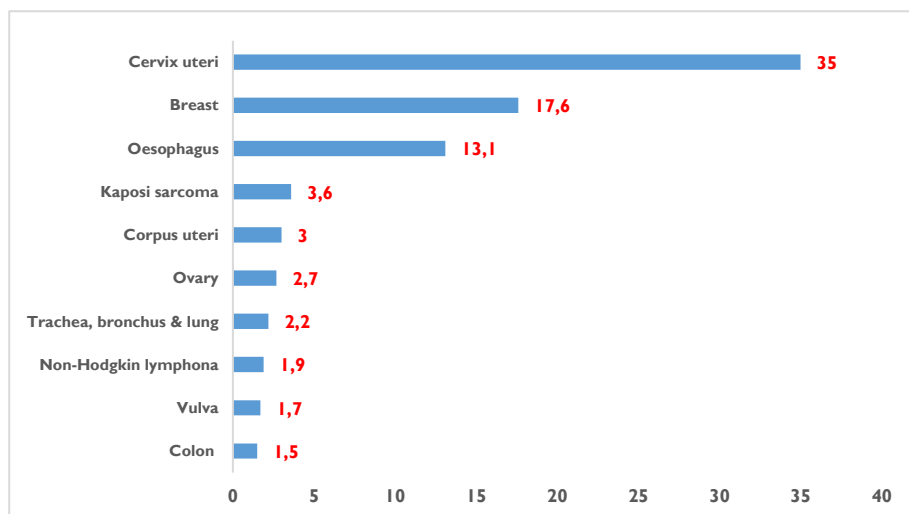
Figures 16 & 17 below are showing the 10 most common cancers by sex in the Eastern Cape Province. Prostate cancer is leading among the males and cervix among the female population.

Figure 16: Male common cancers in EC



Source: SAMRC 2020

Figure 17: Female common cancers in EC



Source: SAMRC 2020

8.2 Internal Environment Analysis

8.2.1 Service Delivery Platform / Public Health Services

The EC service delivery platform has 1 091 facilities as listed below in Table 5

Table 5: Delivery platform per facility type

Org Unit Type	Alfred Nzo DM	Amathole DM	Buffalo City MM	Chris Hani DM	Joe Gqabi DM	N Mandela Bay MM	O Tambo DM	S Baartman DM	Grand Total
Clinic	72	143	74	152	52	39	142	60	734
Community Health Centre	3	5	5	7	-	9	11	3	43
District Hospital	6	12	2	14	11	1	9	10	65
EMS Station	7	11	3	18	10	4	9	23	85
Mobile Service	9	23	11	28	13	7	12	26	129
National Central Hospital	-	-	-	-	-	-	1	-	1
Provincial and Tertiary Hospital	-	-	1	-	-	1	-	1	3
Regional Hospital	-	-	1	1	-	1	2	-	5
Satellite Clinic	-	-	2	-	2	3	-	2	9
Specialised Clinic	-	-	-	-	-	1	-	-	1
Specialised Hospital	1	2	2	1	-	4	1	5	16
Grand Total	98	196	101	221	88	70	187	130	1091

Seven hundred and seventy-seven (777) fixed PHC facilities exist across the province, which are made up of 734 Clinics and 43 Community Health Centres (CHCs). PHC facilities are the entry points to the health system and provide PHC package relevant for each level; and are referral points for the community-based services. The EC has 90 hospitals, the highest number in the country, despite being the fourth-largest province by population and second-largest by land mass. The province is implementing service delivery optimisation to improve efficiencies in the service delivery platform to address the 19 hospitals, which have less than 50 beds and do not fit the formal definition of a district hospital in terms of “Policy on Management of Public Hospitals (2012).

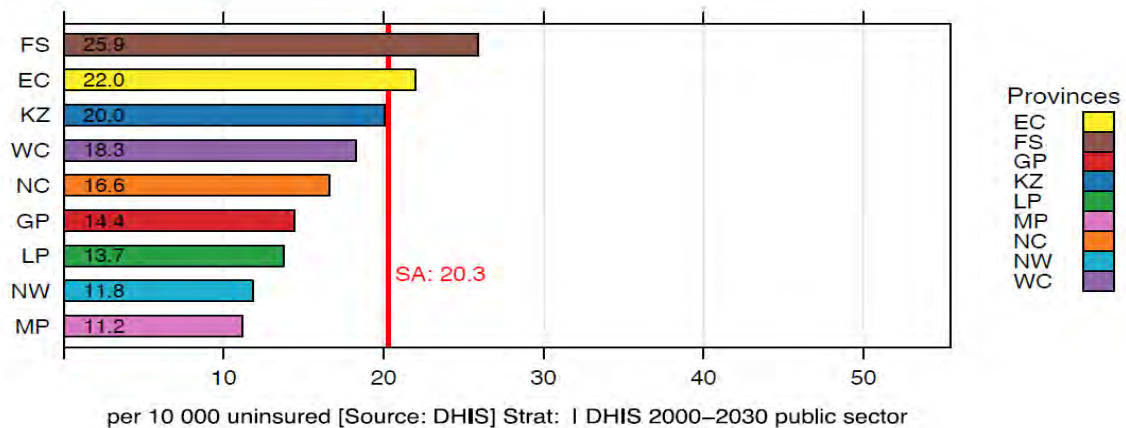
According to the district Health Barometer 2022, the district hospital PDE declined by 21% from 2021/22 to 2022/23 and this contributed to the increase in expenditure per PDE where the province moved from being the lowest-spending province to fifth place in spending. This may partly explain the increase in PHC headcount which also resulted in a decline in PHC expenditure per headcount from R655 in 2021/22 to R600 in 2022/23. The province relies more on the PHC service platform with its utilisation rate per uninsured person at 2.3

visits, which is above the national average of 2.0 visits. However, a concern is that the PHC expenditure per capita and per headcount remains below the national average. This may signal possible underfunding which may result in compromised quality care.

The decline in PHC expenditure per capita and DHS expenditure per capita from 2021/22 to 2022/23 varies across districts, which suggests that some districts may have been slightly protected over others during budget reductions. However, the order of expenditure in the districts did not change significantly from the previous year, as the rate at which districts spend did not shift so much from previous years. For instance, Alfred Nzo remained the lowest-spending district under PHC expenditure per capita in 2021/22 and 2022/23, with a decline of 1.8% in the same period, while Buffalo City was the highest-spending district under PHC expenditure per capita, with a decline of 12.8% in the same period.

Hospital services according to the 2022/23 District Health Barometer, hospital bed ratios differ markedly across provinces, the figure below outlines those variations. There are significant variances between the provinces, with the Free State (FS) recording the highest number of beds per 10,000 population at 25.9 and Mpumalanga (MP) the lowest at 11.2 beds

Figure 18: Hospital bed ratios per 10,000 population per Province as of March 2023.



In hospital services, bell weather surgical and orthopaedic capabilities must be developed at selected district hospitals, forming a hub to treat communities closer to where they live and work. In addition, specialist outreach services to these facilities are essential to take services closer to communities. Ten district hospitals were identified to receive basic specialist services in the province. For phase one, Dr Malizo Mpehle, Madzikane kaZulu, All Saints, St Barnabas, Taylor Bequest (Matatiele), Aliwal North, Butterworth, Uitenhage, Settlers and Victoria hospitals are prioritised.

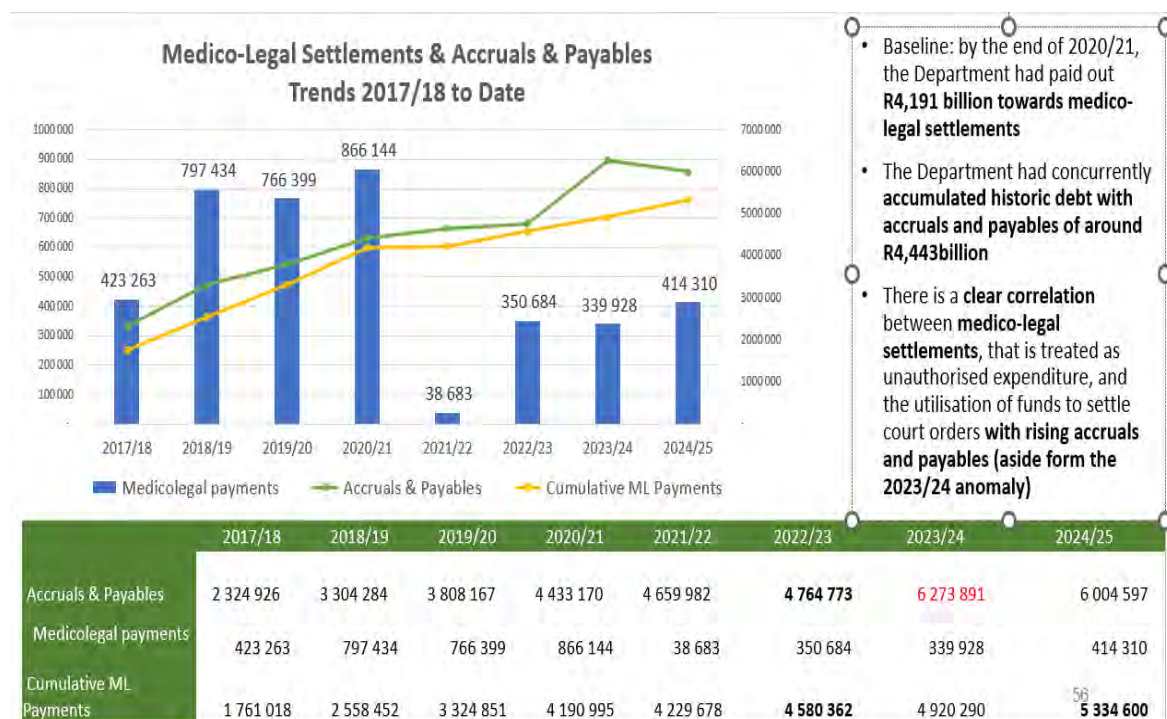
8.3 Organisational Environment

Towards Sustainable Financing for Health and Care

The department continues to operate within a fragile financial space and experiences intractable service pressures daily. This is in the face of increased demand for care as we recover from COVID19 and undergo the epidemiological and demographic transition. According to StatsSA 2022 census, 64% of our people are under the age of 35 years – this typically equates to a high demand for basic services, women's reproductive health, and child and adolescent services; but, at the same time, around 11% of our people are over the age of 60 years. The latter requires us to provide for diseases typically seen in the elderly such as diabetes, hypertension, strokes, cardiovascular diseases, cancers and so on.

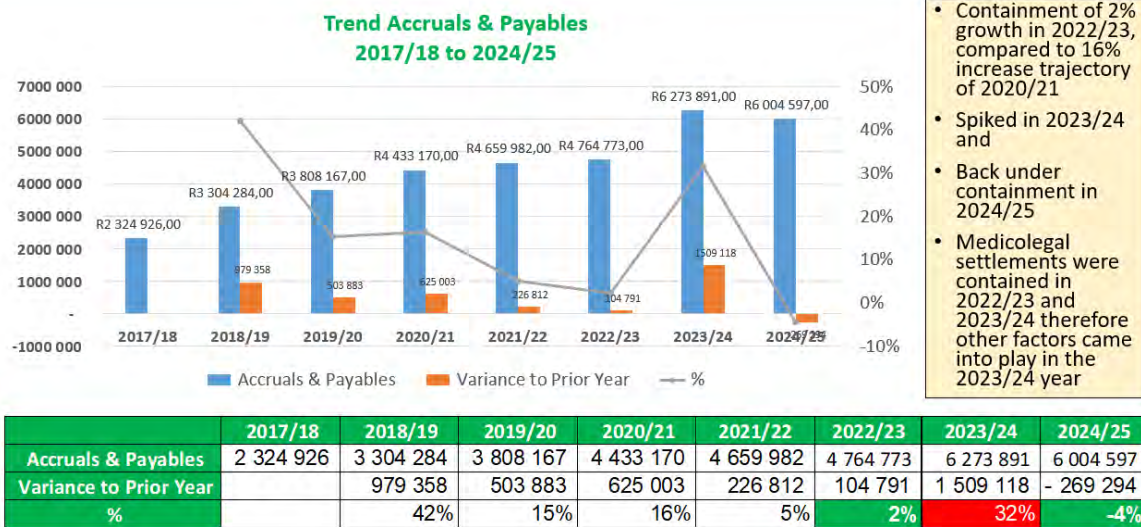
The greatest challenge we face is the accruals and payables that arise out of the historic medico-legal settlements in prior years (see correlation between accruals and payables and medico-legal settlements in Figure 20 below).

Figure 19: Medico Legal settlements, accruals and payables trends (2017/18 – 2024/25)



The Department has made some headway in 2024/25 with containing accruals and payables (preliminary figures) once more, despite the significant budget cuts and the allocations not keeping pace with medical inflation (see Figure 20 below).

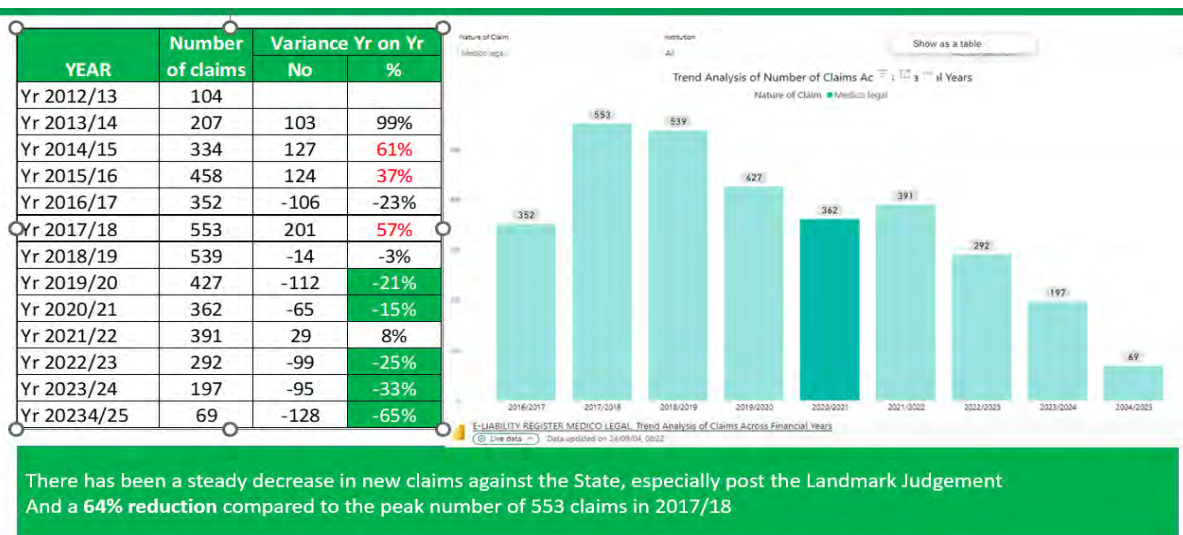
Figure 20: Trend accruals and payables (2017/18 – 2024/25)



The integrated medico-legal strategy is yielding some benefits in that the number of new claims continues to decrease; and the lump sum settlements have decreased significantly since the inception of the strategy. However, the ultimate solution is the establishment of a Compensatory Fund for medico-legal claims and requires the Law reform processes to be concluded.

The Department is working with the National Department of Health and the Department of Justice in pursuit of this remedy.

Figure 21: Trend analysis of number of claims accumulated in years



The accruals and payables are an albatross on the neck of the department, making it extremely difficult to manage the day-to-day operations with service providers threatening to withdraw their services for delayed payments. The debt restructuring proposal will find expression in the year ahead, as we work technically with

the Treasuries and the World Bank, setup negotiations with the top creditors and take the unauthorised expenditure and Finance Bill through the condonement processes of SCOPA.

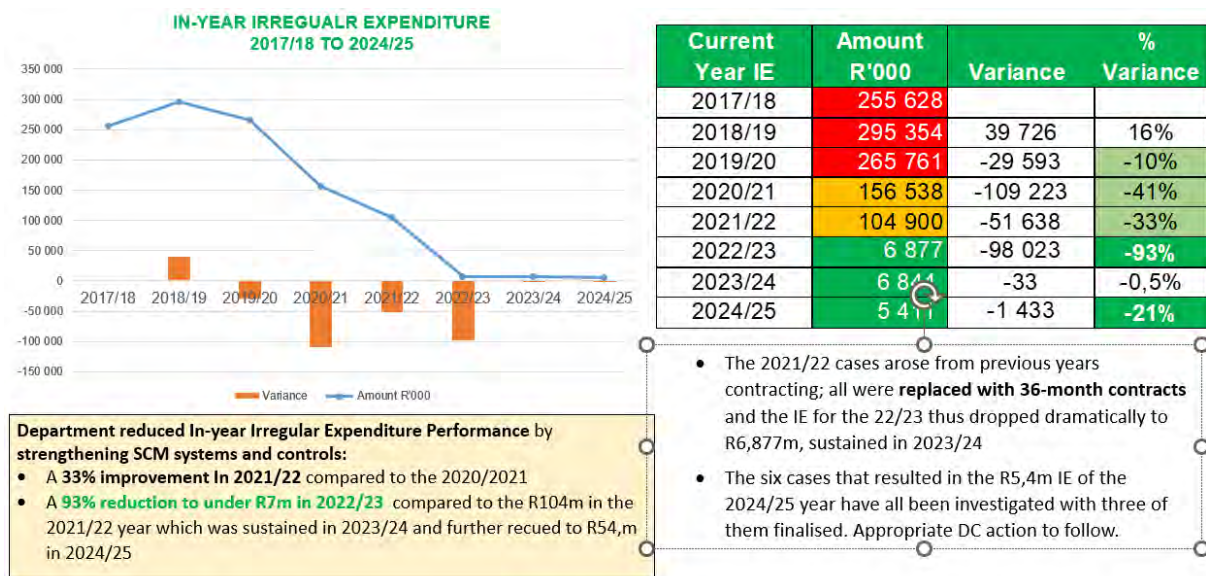
By the same token, the Department is committed to the implementation of the cost-savings and efficiency projects like the service delivery model and optimisation with an appropriate organogramme; containing and minimising leakages in the cost-drivers like NHLS, security, medicines and commuted overtime, to name a few of the critical interventions.

Financial stability with respect to the debt and COE pressures required hard decisions in the 2024/25 financial year – we managed to flatten the debt curve and significantly reduce the projected COE over-expenditure from over R900m projection to around R450m by year end. However, this came with a heavy price because we had a net loss of staff.

This will become better in the year and MTEF ahead as we adjust our Annual Recruitment Plan 2025/26 to accommodate the additional budget for employing critical staff recently announced by the Honourable MEC for Treasury in the Budget speech.

The department has also strengthened controls with a steady decrease in In-year irregular expenditure, year-on-year, since 2021/22, and decreased further in 2024/25 (see Figure 22 below)

Figure 22: In – year irregular expenditure (2017/18 – 2024/25)



The department has also implemented drastic austerity measures to contain spiralling expenditure and mitigate against over expenditure of the departmental budget vote.

Notwithstanding the dire financial picture above, the department continues to put measures into place to address the bottlenecks that have resulted in the tight financial position which threatens the delivery of quality

health care. The measurable improvements shared above, encourages us to accelerate our interventions with the right technical support in the MTEF ahead.

The Department is implementing the turnaround plan supported by the National Department of Health, Office of the Premier and Provincial Treasury. Five working streams that focus on the following areas were established during the 2024/25 year: a) Human Resources, Leadership and Change Management b) Financial Sustainability c) Clinical Services Management d) Infrastructure and e) Digitisation and Medico-Legal.

There are good strides in some of the streams, notwithstanding slower progress in others. The primary objective is to materially and progressively reduce the department's gross debt over a three-to-seven-year period identified for development and implementation during the 7th administration.

The Department's Financial Management Strategy has a programme of action and projects to achieve five strategic objectives in our bid to obtain financial liquidity.

Digital Journey: Path to Evidence-Based Organisational Performance & Accountability

The department has made significant progress in the rollout of the Health Management System 2 (HMS2), with phase one rolled out to 40 facilities and phase 2 rolled out to the regional, tertiary and central hospitals. The CSIR is assessing the scalability of the system as a potential national solution for NHI, following the successful implementation of our HMS2 in 14 facilities in the Free State. Other provinces have already demonstrated an interest in the system, coming to our province to benchmark our innovation.

Through the HMS2 Patient billing and electronic database interchange, the direct billing of insured patients for National Health Laboratory Services and South African National Blood Services are on schedule - the interoperability capabilities of the system allow us to do this. The patient billing module has been rolled out to thirty-nine (39) health facilities that have been identified as revenue generating facilities.

Our digital transformation journey in the MTEF includes following:

- 1) The accelerated development and roll out of HMS² to identified facilities
- 2) The scanning of hard copy patient folders and saving them electronically at digitisation hubs and
- 3) The enhancement of HMS² and other software applications with AI-driven systems & analytics
- 4) The rollout of the Call and Dispatching EMS system
- 5) Electronic SCM systems - as part of our digital transformation journey, the department has embarked on various interventions in the past year to automate the systems for quotations and records management – we stand ready to launch these systems with effect from the 1st April 2025:
 - a) CSD e-Quotation system that involves the distribution of requests for quotations and the submission of quotations by potential bidders. The solution was developed by National Treasury and adopted by the Eastern Cape Province
 - b) A tender management tool that involves tracking our procurement plan and managing the records for quotation and bid processes valued at R30 000 and above

- c) e-Tender Portal for the advertisement of bids, recording received bids and awards for transparency to the market.
- 6) HR electronic systems- consolidating the eRecruitment system and the internally developed NMIR (National Minimum Information Requirements) reporting and eLeave which is in the pipeline through OTP

The Department is intentional in bringing AI capabilities into these projects because AI can:

- Enable data-driven resource allocation in our constrained environment
- Automate routine tasks to relieve our overburdened healthcare workers
- Transform our ability to predict and prevent health system challenges before they affect patient care
- Improve our ability to monitor and respond to public health trends across our diverse province
- Promote accountability and transparency with routine performance reporting

The Eastern Cape Department of Health's decade-long investment in HMS2 has established more than just a digital healthcare infrastructure; it has laid the groundwork for a transformative healthcare revolution that we believe, humbly, that South Africa urgently needs. Our Digital Transformation programme is an investment in the people of the Eastern Cape Province, and a commitment to ensuring that every citizen has the right to access quality healthcare, regardless of their location.

Human Resources Management

The department has 45 779 approved posts of which 40 307 were filled and 5 472 vacant. The vacancy rate is at 11.96% and it is quite high when compared to the national norm of 5%. The Department spent almost 70% of its budget on the Cost of Employees (COE), spending R19,952 151 billion against a final adjusted appropriation of R19,983 901 billion for the financial year ending 31 March 2024.

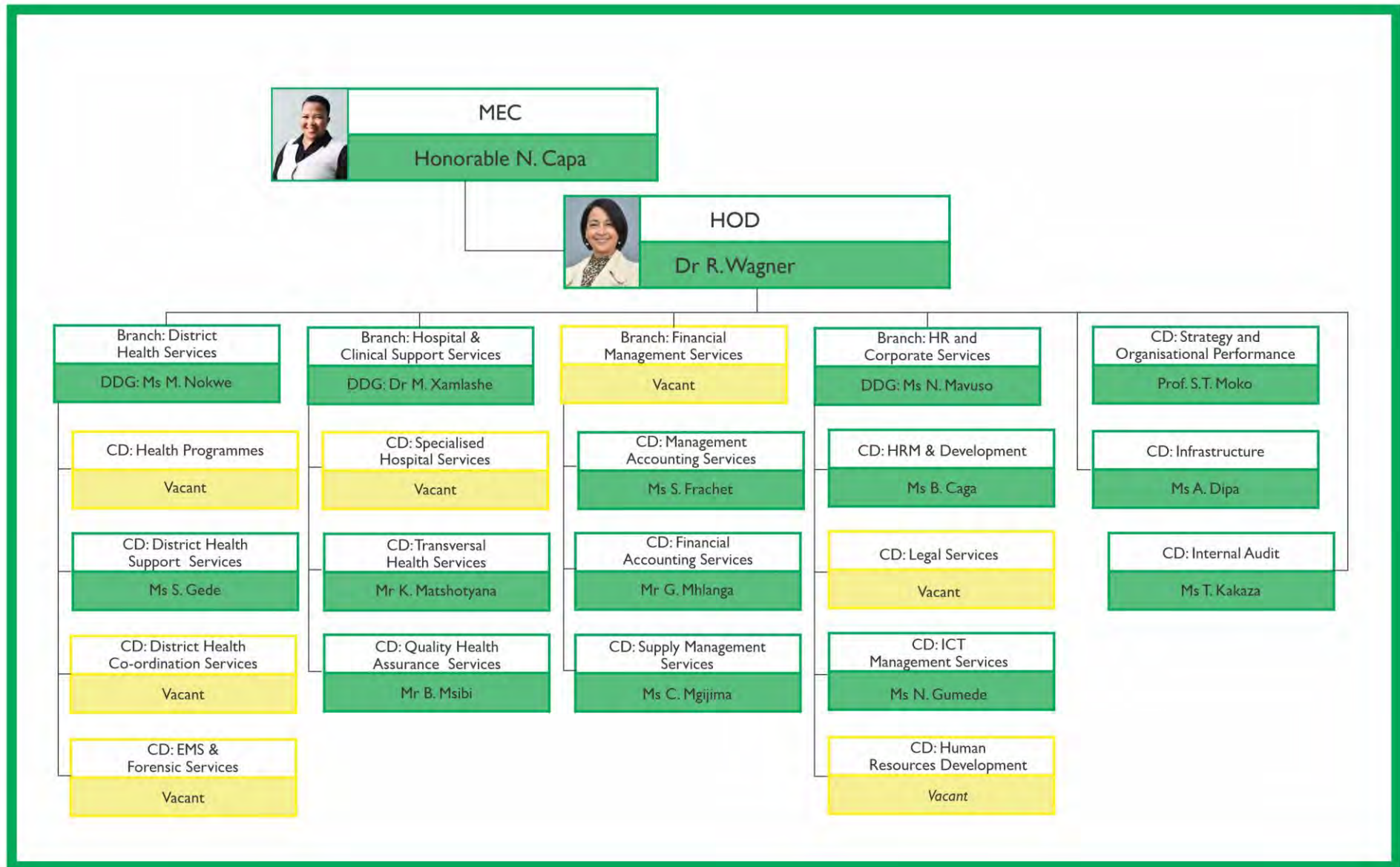
Employment and Vacancies

Table 6: Employment and vacancies by programme as of 31 March 2024

Programme	Number of Posts on Approved Establish-ment	Number of Posts Filled	Vacancy Rate (Includes Frozen Posts)	Number of Employees Additional to the Establish-ment
PRG2: District Health Services, Permanent	12,00	6,00	50,00	0,00
PRG1: Administration, Permanent	738,00	645,00	12,60	18,00
PRG2: District Health Services, Permanent	26 677,00	23 983,00	10,10	1 050,00
PRG2: District Health Services, Temporary	53,00	53,00	0,00	0,00
PRG3: Emergency Medical Services, Permanent	2 795,00	2 487,00	11,00	0,00
PRG4: Provincial Hospital Service, Permanent	8 019,00	7 470,00	6,80	206,00
PRG4: Provincial Hospital Service, Temporary	16,00	16,00	0,00	0,00
PRG5: Central Hospital Services, Permanent	6 753,00	6 144,00	9,00	533,00
PRG5: Central Hospital Services, Temporary	17,00	17,00	0,00	0,00

Programme	Number of Posts on Approved Establish-ment	Number of Posts Filled	Vacancy Rate (Includes Frozen Posts)	Number of Employees Additional to the Establish-ment
PRG6: Health Sciences & Training, Permanent	679,00	525,00	22,70	20,00
PRG7: Health Care Support Services, Permanent	193,00	169,00	12,40	2,00
PRG8: Health Facilities Management, Permanent	44,00	41,00	6,80	0,00
TOTAL	45 996,00	41 556,00	9,70	1 829,00

Figure 23: Organisational Structure



9 PROGRAMME RESOURCE CONSIDERATION

Table 7: Summary of payment estimates by programme: Health

R thousand	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2024/25
	2021/22	2022/23	2023/24		2024/25		2025/26	2026/27	2027/28	
1. Administration	716 793	773 703	758 667	988 331	968 331	862 946	888 753	912 159	944 412	3,0
2. District Health Services	15 094 877	15 077 221	15 618 193	15 568 004	15 660 045	15 739 260	15 773 326	16 666 348	17 350 499	0,2
3. Emergency Medical Services	1 353 522	1 452 877	1 360 385	1 562 632	1 564 583	1 496 420	1 638 706	1 650 100	1 749 214	9,5
4. Provincial Hospital Services	3 686 353	3 926 710	4 253 340	4 231 168	4 350 027	4 647 012	4 701 833	4 702 086	4 957 257	1,2
5. Central Hospital Services	4 751 526	4 713 574	4 928 873	5 036 282	5 085 431	4 979 798	5 760 414	5 291 362	5 502 618	15,7
6. Health Sciences and Training	774 759	985 706	1 076 571	1 165 111	1 123 111	1 015 205	1 186 843	1 128 613	1 180 850	16,9
7. Health Care Support Services	112 986	115 053	112 696	248 787	248 787	194 175	248 101	250 631	263 799	27,8
8. Health Facilities Management	1 087 913	1 071 575	1 018 088	1 306 528	1 306 528	1 372 027	1 454 706	1 425 666	1 450 518	6,0
Total payments and estimates	27 578 729	28 116 419	29 126 813	30 106 843	30 306 843	30 306 843	31 652 682	32 026 965	33 399 167	4,4

Table 7 above shows the summary of payments and estimates by programme. The total payments increased from R27.578 billion in 2021/22 to a revised estimate of R30.306 billion in 2024/25. In 2025/26, the budget increases by 4.4 per cent from R30.306 billion in 2024/25 to R31.652 billion due to additional allocation to strengthen medical records for the reduction of medico legal contingencies, COE adjustments for wage agreement and funding for payables and accruals of non-negotiable items, as well as additional funding on conditional grants. The department reprioritised funds from other programmes to fund Programmes 5, 6 and 7 as evident by growth which more than 10 per cent.

Table 8: Summary of provincial payments and estimates by economic classification

R thousand	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2024/25
	2021/22	2022/23	2023/24		2024/25		2025/26	2026/27	2027/28	
Current payments	26 074 390	26 295 225	27 499 448	28 168 389	28 367 353	28 256 403	29 727 939	30 138 008	31 466 127	5,2
Compensation of employees	18 479 937	18 712 799	19 952 151	20 011 717	20 010 479	20 010 479	21 196 760	21 439 161	22 095 691	5,9
Goods and services	7 589 769	7 543 539	7 528 082	8 156 672	8 356 874	8 245 924	8 531 178	8 698 847	9 370 436	3,5
Interest and rent on land	4 684	38 887	19 215	–	–	–	–	–	–	–
Transfers and subsidies to:	332 597	519 529	520 844	352 565	456 230	567 180	311 256	416 825	435 582	(45,1)
Provinces and municipalities	–	–	–	–	–	–	–	–	–	–
Departmental agencies and accounts	13 075	16 866	14 721	14 401	14 401	14 401	14 886	21 867	22 851	3,4
Higher education institutions	–	–	–	–	–	–	–	–	–	–
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–	–
Public corporations and private enterprises	–	–	–	–	–	–	–	–	–	–
Non-profit institutions	–	26 528	35 450	35 942	35 942	35 942	17 892	29 874	31 218	(50,2)
Households	319 522	476 135	470 673	302 222	405 887	516 837	278 478	365 084	381 513	(46,1)
Payments for capital assets	1 171 742	1 301 665	1 106 521	1 585 889	1 483 260	1 483 260	1 613 488	1 472 132	1 497 458	8,8
Buildings and other fixed structures	575 252	461 114	352 588	602 057	683 004	683 004	795 925	742 725	715 119	16,5
Machinery and equipment	596 490	840 551	753 933	983 832	800 256	800 256	817 562	729 407	782 339	2,2
Heritage Assets	–	–	–	–	–	–	–	–	–	–
Specialised military assets	–	–	–	–	–	–	–	–	–	–
Biological assets	–	–	–	–	–	–	–	–	–	–
Land and sub-soil assets	–	–	–	–	–	–	–	–	–	–
Software and other intangible assets	–	–	–	–	–	–	–	–	–	–
Payments for financial assets	–	–	–	–	–	–	–	–	–	–
Total economic classification	27 578 729	28 116 419	29 126 813	30 106 843	30 306 843	30 306 843	31 652 682	32 026 965	33 399 167	4,4

Table 8 above shows the summary of payments and estimates by economic classification. Compensation of Employees shows an increase of 5.9 per cent from R20.010 billion in 2024/25 to R21.196 billion in 2025/26 when compared to revised estimate due to additional funding for wage agreement.

Good and Services show a growth of 3.5 per cent from R8.245 billion in 2024/25 to R8.531 billion in 2025/26 when compared to the revised estimate due to additional allocation for strengthen medical records for the reduction of medico legal contingencies and funding for payables and accruals of non-negotiable items.

Transfers and subsidies show a negative growth of 45.1 per cent from R567.180 million in 2024/25 to R311.256 million in 2025/26 due to high revised estimate emanating from the payment of medico legal claims in 2024/25.

Payments for capital assets show a growth of 8.8 per cent from R1.483 billion to R1.613 billion when compared to the 2024/25 revised estimate due to additional allocation on Health Facilities Revitalisation Grant for the benefit of Buildings and other fixed structures projects particularly the upgrades and additions of the Oncology Building at Nelson Mandela Academic Hospital.



Province of the
EASTERN CAPE
HEALTH

ANNUAL PERFORMANCE PLAN 2025/26-2027/28

PART C

MEASURING OUR PERFORMANCE



ANNUAL PERFORMANCE PLAN 2025/26-2027/28

PROGRAMME

01

HEALTH ADMINISTRATION AND MANAGEMENT



PART C – MEASURING OUR PERFORMANCE

PROGRAMME I: HEALTH ADMINISTRATION AND MANAGEMENT

The Health Administration and Management programme comprises of two main components: The Administration component, which refers to the Executive Authority and lies with the Office of the Member of Executive Council (MEC); and the second component, which is the Management of the organisation and is primarily the function of the Office of the Head of Department.

1.1 Sub-Programme: Health Administration - Office of the MEC

Sub - programme purpose

To provide political and strategic direction to the Department by focusing on transformation and change management.

IMPACT STATEMENTS

Impact	Long, healthy and quality life for the people of the Eastern Cape
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The standardised indicators are marked as per colour in the legend where's Provincial Indictors are not marked

Legend	Standardised indicators colour
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Table 9: Outcomes, Outputs and Output indicators and targets for the next MTEF for the Office of the MEC

Outcome (as per SP 2025/26- 2029/30)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2021/22	2022/23	2023/24	2024/25	2025/26	2025/26 Quarterly Targets				2026/27	2027/28
								Q1	Q2	Q3	Q4		
12. Quality of health services improved	Statutory document submitted	12.16.1 Number of statutory documents tabled at Legislature	8 statutory documents	7 statutory documents	8 statutory documents	1 statutory documents	8 statutory documents	1	2	1	4	8 statutory documents	8 statutory documents

I.2 Sub-Programme: Health Management

Sub-Programme Purpose

To manage human, financial, information and infrastructure resources. This is where all the policy, strategic planning and development, coordination, monitoring and evaluation, including regulatory functions of head office, are located.

The management component under the Head of Departments' supervision is comprised of four branches with their sub-components (clusters) as listed below:

Finance Branch

- Financial Management Services
- Integrated Budget Planning and Expenditure Review
- Supply Chain Management (SCM)

Human Resource & Corporate Services Branch

- Information, Communication and Technology (ICT)
- Integrated Human Resource Management (IHRM)
- Human Resource Development (HRD)
- Corporate Services
- Infrastructure
- Internal Audit
- Strategy & Organisational Performance

Hospital and Clinical Support Management Branch

- Hospital Services
- Clinical Support Services
- Emergency Medical Services
- Quality Care Assurance Services

District Health Services Management Branch

- District Health Support
- District Management Coordination
- Communicable Diseases
- Health Programmes
- Forensic Services

Table 10: Output indicators and targets for the next MTEF for Health Management

Outcome (as per SP 2025/26- 2029/30)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performan ce	MTEF Targets							
			2021/22	2022/23	2023/24		2024/25	2025/26	2025/26 Quarterly Targets				2026/27	2027/28
									Q1	Q2	Q3	Q4		
10. Financial Managemen t strengthene d in the health sector	Audit opinion of provincial DOH achieved	10.1.1 Audit outcome for regulatory audit expressed by AGSA	Unqualified	Qualified	Qualified	Qualified	Unqualified	-	Unqualified	-	-	Unqualifi ed	Unqualified	
		10.1.2 % of valid invoices paid within 30 days	New indicator	New indicator	New indicator	New indicator	100%	100%	100%	100%	100%	100%	100%	
	Approved procuremen t plan in place	10.1.3 Approved Annual Procurement Plan	Signed Final 2022/23 Procure- ment Plan submitted to Provincial Treasury	Signed Final 2023/24 Procure- ment Plan submitte d to Provincial Treasury before 31 March 2023	2024/25 Approve d Annual Procure- ment Plan submitte d to Treasury by 29 February 2024	2025/26 2 nd Draft Annual Procurement Plan submitted to Provincial Treasury	2026/27 Approved Annual Procure- ment Plan	-	1 st draft Annual Procureme nt Plan	2 nd Draft Annual Procure- ment Plan	2026/27 Approved Annual Procure- ment Plan	2027/28 Approve d Annual Procure- ment Plan	2028/29 Approved Annual Procure- ment Plan	
	Increased revenue collection	10.1.4 Amount Revenue generated (R)	74 mil	186,7mil	227,6mil	38.0 mil	339.7 mil	41,8mil	67,6mil	95,8mil	134,5mil	355,0mil	370,9mil	

Outcome (as per SP 2025/26- 2029/30)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performan ce	MTEF Targets							
			2021/22	2022/23	2023/24		2024/25	2025/26	2025/26 Quarterly Targets				2026/27	2027/28
									Q1	Q2	Q3	Q4		
12. Quality of health services improved	Approved costed Human Resource Plan (HRP) to create share vision to realise NHI	12.1.1 Human Resource Plan approved	New Indicator	New Indicator	New Indicator	New Indicator	Approved Human Resource Plan	-	-	-	Approved Human Resource Plan	-	-	
	Medico legal claims reduced	12.2.1 Contingent liability of medico – legal cases – rand value	New Indicator	R26,345,655bn	R26,442,526bn	R23,857bn	R21,471bn	-	-	-	R21,471bn	R19,324bn	R17,391bn	
	Improved connectivity in health facilities	12.3.1 Percentage of Hospitals with connectivity	New Indicator	New Indicator	50.6%	41.5%	64%	-	-	-	64%	75%	76%	
		Numerator			45 (23 new)	47 (10 new)	57 (10 new)				57 (10 new)	67 (10 new)	68 (11 new)	
		Denominator			89	89	89				89	89	89	
		12.3.2 Percentage of fixed PHC facilities with connectivity	New Indicator	13.4%	29.7%	32%	38.5%	-	-	-	38.5%	38.5%	38.5%	
		Numerator		104	230 (126 new)	249 (50 new)	299 (50 new)				299 (50 new)	299 (50 new)	299 (50 new)	
		Denominator		776	775	777	777				777	777	777	

Explanation of planned performance over the medium-term period

Audit improvement: The Department received qualified opinion in the past three years, and will continue to implement an audit improvement plan (AIP) which outlines the strategies to be undertaken in order to achieve the desired audit outcome of unqualified audit opinion. The qualifications emanate mainly from the unauthorised expenditure due to the challenges of medico legal contingency liability.

Medico legal

The integrated medico-legal strategy is yielding some benefits in that the number of new claims continues to decrease; and the lump sum settlements have decreased significantly since the inception of the strategy. This strategy is driven by the Department of Health (DOH), Office of the Premier (OTP), and Provincial Treasury (PT), working on a joint medico legal strategy that outlines the responsibilities of the 3 parties in the fight against medico legal claims. The Department has invested much effort into ensuring that the accounting policy on how to deal with medico-legal claims, aligning court processes with accounting frameworks; and on developing a reliable and accurate eLiability register.

Through the hub approach, our clinical teams led by our specialists are playing a very critical role in formulating the department's defence. The department is working tirelessly to ensure that all CP units and Centres of Excellence in Dora Nginza, Cecilia Makiwane and Frere Hospitals are ready to serve and have all the necessary capabilities. The project has been rolled out to 11 facilities.

Digitisation: The Department of Health is in the process of aligning its enterprise architecture to the National Department eHealth strategy. This will set in motion the development and implementation of various eHealth initiatives across all levels of care that will seamlessly interface with the National Department of Health eHealth systems and strategy to enable systems interoperability.

The HMS² system will undergo continuous expansion to all hospitals within the province, ensuring that every facility benefits from its advanced healthcare management capabilities. The rollout will prioritise high-traffic hospitals first, highly litigated facilities, followed by district and rural facilities, ensuring equitable access to streamlined patient management, digital records, and improved operational efficiency. Additionally, ongoing user training and system enhancements will be key focus areas, ensuring that healthcare professionals can maximise the benefits of the system while adapting to evolving healthcare needs. Continuous refinement of reporting and analytics features will further support data-driven decision-making at both hospital and provincial levels. A key priority will also be the strengthening of the Eastern Cape Department of Health's (ECDoH) internal capacity to become self-sustainable in system implementation, as well as in the effective use of business intelligence and artificial intelligence for enhanced decision-making and operational efficiencies.

A critical component of HMS²'s five-year plan will be its close collaboration and integration within the National Health Insurance (NHI) ecosystem. This includes aligning with NHI's digital health strategy to enable seamless data exchange, improving patient referral management, and ensuring interoperability with national health

databases. Efforts will also be made to integrate HMS² with other critical healthcare technologies, such as telemedicine platforms and eHealth solutions, to enhance service delivery. Cybersecurity and data protection will remain top priorities, ensuring that patient information remains secure while complying with regulatory standards. By fostering strong partnerships with stakeholders, including hospital administrators, policymakers, and technology providers, HMS² will continue to evolve into a robust, future-ready healthcare management solution.

HMS² electronic medical record system key features included patient registration that is integrated to the National Health Patient Registration System (HPRS), billing, and revenue management. A total of 1089 health facilities will be connected over the Medium-Term Expenditure Framework (MTEF). The department has strengthened the strategic alliance with State Information Technology Agency (SITA) in leveraging the on-site prioritisation and timing together with SITA.

Human Resource Management:

The Department is committed to the implementation of the cost-savings and efficiency projects like the service delivery model and optimisation with an appropriate organogram. Annually, the department develops the Annual Recruitment Plan (ARP) based on the prioritised critical, new and replacement posts during the financial year. The vacancy rate reduced from 11.96% in 2022/23 to 9.7% in 2023/24 and it is still quite high when compared to the national norm of 5%. The Department is reviewing the implementation of Committed Overtime policy in pursuit of realising savings to fill vacancies and replacement positions. Also the Department is committed to filling of management and leadership positions at health facilities and head office to strengthen governance and accountability.

The department is further striving to address employment equity underrepresentation, youth employment and to achieve the 50/50 % target for Women and Men at SMS level. The department is striving to maintain 50/50 % target for Women and Men at SMS level. Currently, the Department has a total of 91 SMS members with 46 being female officials (50.5%) and 45 being male officials (49.5%). Employment Equity is also one the key priorities for the department. However, the department is below the target of 2% by 0.24%. The number of People with Disability is 98. Youth employment is achieved through employment from the developmental program categories such as community service health professionals.

The Department prioritises mentoring and coaching of staff as a valuable tool in supporting professional development, improving performance, and fostering a culture of learning and collaboration. Mentoring involves a more experienced practitioners guiding a less experienced colleague, while coaching focuses on unlocking potential and achieving goals through questioning and inquiry.

Revenue generation

The Department collects most of its revenue from patient fees for health care services rendered to the public. The fees are minimal for indigent patients and full tariffs are charged to funded patients including inter alia Road Accident Fund (RAF), Medical Aid Schemes, Correctional Services, SAPS, Department of Justice (DOJ) and Compensation of Occupational Injuries and Diseases Act (COIDA). Of the above, most fees are collected from the RAF and DOJ.

Revenue generation // Cost Recovery takes place at the public health institutions where services are rendered. Public health revenue generation is a value chain that involves multi-stakeholders, namely patient administration (patient registration, patient records, ward clerks), clinical (consultation with patients and diagnosis thereof, recording of healthcare services rendered, pharmaceuticals) and finance (billing, and coding of services rendered, claims submission, debt management, cash management).

Revenue management at hospital level is a back end function, mainly dependent on inputs and activities from patient administration and clinical departments. The need to harmonise the stakeholders in this value chain is noteworthy.

There is a need to strengthen collections from the RAF, Medical Aid Schemes and other streams which are often missed due to incorrect classification of patients, prescription due to late billing, insufficient information to conclude claims and in some instances revenue due is not collected because of the inability to identify billable services.

Enhanced Revenue Collection

A number of events have converged to focus attention on government own revenue and, in particular, on the Eastern Cape Department of Health which is one of the departments that are showing the greatest potential to maximise provincial own revenue through inter alia: -

Revenue Source	Reference to Revenue Study
Patient fees: Enhanced billing - identification of patients for means test.	Efficiencies in collection of current revenue sources.
Healthcare establishment licensing applications	Registration (once off), licence renewal (annually) and annual inspection fees charged to all private hospitals / EMS in a province.
Enhanced amenities	Enhanced Amenities / Enhanced billing by ECDoH as designated service provider (DSP) – to Government Employees Medical Scheme (GEMS).
Rehabilitation Centres	The treatment of Road Accident Fund (RAF) patients in the public vs private health sector.
Enhanced Billing at Emergency Medical Services - road and air ambulance	Enhanced collections pre hospitalization / admittance from transporting of patients – targeted RAF patients.
Designated Service Providers	A Designated Service Provider (DSP) is a healthcare provider (doctor, pharmacist, hospital, etc.) that is a medical scheme's first choice when

Revenue Source	Reference to Revenue Study
	its members need diagnosis, treatment or care for a Prescribed Minimum Benefits (PMB) conditions. Enhanced billing is needed as there is demand from the medical aid schemes.
Psychiatric services	Increase the number of available Psycho-Legal evaluation beds in the province There is primarily only one hospital that conducts the majority of psycho-legal evaluations in the province.
High value equipment	Obtain revenue streams by renting out / leasing High Value Medical Equipment in non-peak hours. High Value equipment with maintenance contracts including Cardiology, Oncology, Haematology. CT Scanners, MRIs etc. could be rented in non-peak times to generate revenue.

I.3 PROGRAMME RESOURCE CONSIDERATION

Table 11: Summary of payments and estimates by sub-programme: Programme 1: Administration

Outcome				Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2024/25
R thousand	2021/22	2022/23	2023/24	2024/25			2025/26	2026/27	2027/28	
1. Office of the MEC	7 576	8 252	12 267	8 965	13 054	16 392	19 143	14 379	15 132	16,8
2. Management	709 217	765 451	746 400	979 366	955 277	846 554	869 610	897 780	929 280	2,7
Total payments and estimates	716 793	773 703	758 667	988 331	968 331	862 946	888 753	912 159	944 412	3,0

Table 11 above shows the summary of payments and estimates for Administration from 2021/22 to 2024/25 and over the 2025 MTEF period per sub-programme. The programme's total expenditure increased from R716.793 million in 2021/22 to a revised estimate of R862.946 million in 2024/25. In 2025/26, the budget increases by 3 per cent from R862.946 million to R888.753 million when compared to the 2024/25 revised estimate due to reprioritisation to fund the Digitalisation of E-Health and additional funding for strengthening of medical records for the reduction of medico legal claims,

Table 12: Summary of payments and estimates by economic classification: Programme 1: Administration

Outcome				Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2024/25
R thousand	2021/22	2022/23	2023/24	2024/25			2025/26	2026/27	2027/28	
Current payments	657 247	658 648	721 165	915 089	893 522	786 024	804 533	832 433	861 098	2,4
Compensation of Employees	397 632	396 013	411 475	507 133	507 133	419 426	465 219	505 022	475 446	10,9
Goods and services	257 042	259 724	305 606	407 956	386 389	366 598	339 314	327 411	385 652	(7,4)
Interest and rent on land	2 573	2 911	4 084	—	—	—	—	—	—	—
Transfers and subsidies to:	10 257	4 200	3 303	2 107	2 107	4 220	2 201	2 302	2 406	(47,8)
Provinces and municipalities	—	—	—	—	—	—	—	—	—	—

	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2024/25
Households	10 257	4 200	3 303	2 107	2 107	4 220	2 201	2 302	2 406	(47,8)
Payments for capital assets	49 289	110 855	34 199	71 135	72 702	72 702	82 019	77 424	80 908	12,8
Buildings and other fixed structures	–	–	–	–	–	–	–	–	–	
Machinery and equipment	49 289	110 855	34 199	71 135	72 702	72 702	82 019	77 424	80 908	12,8
Heritage Assets	–	–	–	–	–	–	–	–	–	
Specialised military assets	–	–	–	–	–	–	–	–	–	
Software and other intangible assets	–	–	–	–	–	–	–	–	–	
Payments for financial assets	–	–	–	–	–	–	–	–	–	
Total economic classification	716 793	773 703	758 667	988 331	968 331	862 946	888 753	912 159	944 412	3,0

Table 12 above shows the summary of payments and estimates for Administration from 2021/22 to 2024/25 and over the 2025 MTEF period per economic classification.

Compensation of Employees shows a growth of 10.9 per cent from R419.426 million to R465.219 million when compared to the 2024/25 revised estimate due to additional funding for wage agreement.

Goods and services shows a negative growth 7.4 per cent from R366.598 million to R339.314 million when compared to the 2024/25 revised estimate due to budget cut for the Broadband.

Transfers and subsidies show a negative growth of 47.8 per cent from R4.220 million in 2024/25 to R2.201 million in 2025/26 due to high revised estimate attributable to the payment of leave gratuities for officials who have left the public service in 2024/25.

Payments for capital assets show a growth of 12.8 per cent from R72.702 million to R82.019 million when compared to the 2024/25 revised estimate due to an additional allocation for strengthening of medical records for the reduction of medico legal claims.

I.4 Key Risks

The table below outlines the key risks.

Table 13: Key Risks and mitigating factors

Outcome	Risk	Mitigating factors
Financial strengthened in the Management health sector	Non-payment of creditors within 30 days	Monitor and strengthen implementation of Supplier Payment Plan. Strengthen support visits and training.
	Budget cuts due to shrinking economy and increase in exchange rate for medicines and medico legal claims (not able to budget for)	Allocation of resources as far as the budget allows, strengthen fees collection value chain, training and monitoring. Maintain approval threshold. Monitoring compliance with the policies, procedures and SOPs.
	Inadequate management of revenue Perpetration of fraudulent and corrupt activities	Provincial and District Cost Containment Committee structures implementation of the resolutions of the Cost Containment meetings. Continued Improvement of consequence management. Effective implementation and regular reporting on the audit improvement strategy. Enforce compliance with the policies, procedures and SOPs.
Quality of Health Service Improved	Inadequate provision of ICT (Information communication technology) services to support service delivery	Influence the prioritisation of the connectivity of health institutions with OTP. Software to validate patient income levels.
	Delays in recruitment and inadequate retention of staff	Filling of vacant funded posts. Monitoring compliance with the policies, procedures and SOPs. Enforce compliance with the policies, procedures and SOPs. Implementation of the resolutions of the meetings. Conduct continuous staff training. HR delegations register monitored monthly. Recruitment time reduced to 3 months. HR Management Information System (HR MIS) in place. Annual intake plan fully functional and updated annually. Implementation of interventions to address staff attitude. Maintain lower vacancy rate. Strengthening deadline compliance for all reports and plans. Staff are replaced within three months. Registrar program remains operational. The Special Employee Relations Training Unit is fully functional. PILIR management outsourced to Metropolitan and SOMA. Alignment of PERSAL to the organogram.
	Employees whose benefits are not paid within 3 months.	Fast track payment of employee benefits Ensure continuous trainings on capped leave are conducted at all districts. Ensure timeous implementation of the statistical results detailed on the reports.

Outcome	Risk	Mitigating factors
		Implementation of meetings action list.
	Transition from the old to the new organogram.	Conduct consultations with the relevant stakeholders. Full implementation of migration plan and its terms of reference - ensure correct implementation of the organogram. Approval of micro organogram.
	Lack of 100% Occupational Health and Safety compliance with statutory structures (H&S Reps and H&S Committees).	Appointment of statutory structures (16.2 appointments, safety reps, fire). Ensure compliance with employee wellness framework and reporting tool. Programme marketing. Ensure training and capacitation. Ensure compliance with OHS policies and SOP's. Develop OHS correction plan.
	Increased litigation	Appointment of paralegal secretaries for deployment at districts and the targeted highly litigated facilities. Contracting of medico legal expert firm to defend the cases in court. Contracting of the Special Investigation Unit (SIU) to investigate elements of fraud and corruption relating to theft of files. Strengthen the quality of reports (adverse events reports). Implementation of meetings action list.
	Inadequate contract management leading to medico legal claims	Filling of vacant funded posts. Communicating renewal of expiring contracts. Implementation of meetings action lists Enforce compliance with the Policies, Procedures and SOPs All contracts must have SLAs. Continuous monitoring and reporting on the existing contracts Ensure proper management of contractual disputes. Continuous monitoring and reporting on the existing Contracts and Dispute Registers. Maintain updated contracts and dispute registers.
	Inadequate reporting of Contingent Liability	Recruitment of staff. Enforcement of the Service Level Agreement (SLA) between OTP and ECDOH, as well as State Attorney and Service Provider. Develop an Accounting Policy Framework regarding the measurement and recognition of the Contingent Liability. Implementation of meetings action list.

ANNUAL PERFORMANCE PLAN 2025/26-2027/28

PROGRAMME

02

**DISTRICT HEALTH
SERVICES (DHS)**



PROGRAMME 2: DISTRICT HEALTH SERVICES (DHS)

Programme purpose

To ensure the delivery of primary health care services through the implementation of the District Health System.

Programme description

The District Health Services (DHS) programme is responsible for the management of health services in the six (6) districts and two (2) metropolitans of the Province. The services offered are mainly preventive and minor curative, maternal, child and women's health and nutrition, HIV and AIDS, STI and TB (HAST), prevention and control of chronic diseases, public health / other community-based services such as waste management and coroner services. These are offered through the following service delivery platforms: Community Health Clinics, Community Health Centres (CHCs) and District Hospitals.

Based on the current structure, the DHS programme is composed of nine sub-programmes, namely:

- 2.1 District Management
- 2.2 Community Health Clinics
- 2.3 Community Health Centres (CHCs)
- 2.4 Community-Based Services
- 2.5 Other Community Based Services - Public Health
- 2.6 HIV & AIDS - STI and TB (HAST) Control
- 2.7 Maternal, Child and Women's Health & Nutrition
- 2.8 Coroner Services
- 2.9 District Hospitals

2.1 Sub – Programme: District Management

Sub-Programme purpose

The sub-programme manages the effectiveness, functionality and the coordination of health services, referrals, supervision, planning, monitoring & evaluation and reporting as per provincial and national policies and requirements.

Table 14: Outcomes, Outputs and Output indicators and targets for the next MTEF for District Management

Outcome (as per SP 2025/26- 2029/30)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2021/22	2022/23	2023/24	2024/25	2025/26	2025/26 Quarterly Targets				2026/27	2027/28
								Q1	Q2	Q3	Q4		
12. Quality of health services improved	District performance reviews conducted quarterly	12.17.1 Number of districts conducted quarterly performance reviews	New Indicator	New Indicator	6	8	8	8	8	8	8	8	8

2.2 Sub-Programme: Community Health Clinics

Sub- Programme purpose

The sub-programme manages the implementation of the comprehensive Primary Health Care Service Package which is the provision of preventive, promotive, curative and rehabilitative care, in the 6 districts and 2 metros.

Table 15: Outcomes, Outputs and Output indicators and targets for the next MTEF for Community Health Clinics

Outcome (as per SP 2025/26- 2029/30)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets							
			2021/22	2022/23	2023/24		2024/25	2025/26	2025/26 Quarterly Targets				2026/27	2027/28
									Q1	Q2	Q3	Q4		
12. Quality of health services improved	PHC facilities that qualify as Ideal increased	12.4.1 Ideal PHC facilities status obtained rate	5.2%	24.7%	63%	38%	65%	-	-	-	65%	70%	75%	
		Numerator	40	192	491(125 new)	292 (100 new)	505 (45 new)				505 (45 new)	543 (38 new)	582 (39 new)	
		Denominator	775	775	777	777	777				777	777	777	
11. Improved Patient Experience of Care	Patient experience of care in fixed public health facilities improved	11.1.1 Patient Experience of Care survey rate	New Indicator	New Indicator	New Indicator	New Indicator	60%	-	60%	-	-	70%	80%	
		Numerator					440		440			512	587	
		Denominator					734		734			734	734	
12. Quality of health services improved	Patient safety improved	12.6.1 Severity Assessment Code (SAC) I incident reported within 24 hours rate	New Indicator	New Indicator	71%	100%	86%	86%	86%	86%	86%	88%	88%	
		Numerator			5	1	6	6	6	6	6	7	7	
		Denominator			7	1	7	7	7	7	7	8	8	
		12.6.2 Patient Safety Incident (PSI) case closure rate	New Indicator	New Indicator	95%	91%	95%	95%	95%	95%	95%	96%	97%	
		Numerator			74	10	74	18	18	19	19	75	76	
		Denominator			78	11	78	19	19	20	20	78	78	

2.3 Sub – Programme: Community Health Centers (CHCs)

Sub – Programme purpose

The sub-programme renders 24-hour health services, maternal health at midwifery units, provision of trauma services and the integration of community-based mental health services within the down referral system.

Table 16: Outcomes, Outputs and Output indicators and targets for the next MTEF for Community Health Centers (CHCs)

Outcome (as per SP 2025/26- 2029/30)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2021/22	2022/23	2023/24	2024/25	2025/26	2024/25 Quarterly Targets				2026/27	2027/28
								Q1	Q2	Q3	Q4		
11. Improved Patient Experience of Care	Patient experience of care in public health facilities improved	11.1.2 Patient Experience of Care survey rate	New Indicator	New Indicator	New Indicator	New Indicator	60%	-	60%	-	-	70%	79%
		Numerator				26		26			30	34	
		Denominator				43		43			43	43	
12. Quality of health services improved	Patient safety improved	12.6.3 Severity Assessment Code (SAC) I incident reported within 24 hours rate	New Indicator	New Indicator	62%	33%	63%	63%	63%	63%	63%	64%	65%
		Numerator			13	2	12	12	12	12	12	10	11
		Denominator			21	6	19	19	19	19	19	18	18
		12.6.4 Patient Safety Incident (PSI) case closure rate	New Indicator	New Indicator	93%	88%	90%	90%	90%	90%	90%	95%	98%
		Numerator			37	7	36	9	9	9	9	38	39
		Denominator			40	8	40	10	10	10	10	40	40

Explanation of Planned Performance over the Medium-Term Period:

Sub programs	Planned Performance over the Medium-Term Period:
Strengthen District Health Governance leadership and management	Implementation of the district health system strategy and policy framework.
	Facilitate community participation and involvement in health planning and provision through functional health governance structures (Provincial Health Council, District Health Council, Hospital boards and Primary Health Care Committees) to ensure also transparency and accountability.
	Development of an integrated District Health Plan aligned with the department Annual Performance Plan and the Integrated Development Plan for each district.
	Consistent District Quarterly Performance Reviews conducted by each district management team to reinforce integrated coordination of health services, integrated improvement plans that are patient and population health centred.
	Supportive supervision of Primary Health care facilities through district and sub district teams to reinforce efficient use of resources, quality health care and continuity of care.
Improve Quality of Health Services in PHC facilities	Health System Strengthening program will continue through the implementation of an ideal Clinic Status determinations on quarterly basis to enhance quality improvement plans (QIPs) towards provision of a comprehensive PHC service package in six districts and two Metros. Patient experience of care surveys will be conducted in 80% of the facilities with focus on the six priority areas, (waiting times, cleanliness, infection control, safety and security, availability of medicine, staff attitudes) and development of QIPs to improve the Patient Safety Incident rates.
Access to Primary Health Care Service package	Provision of mobile health clinic services in areas of poor access to fixed facilities. Improve access to medical doctor services at PHC facilities through the NHI health practitioner grant. Improve service package of CHCs by resourcing the clinical support services (rehabilitation services) in identified CHCs with spaces for outreach.

2.4 Sub-Programme: Community Based Services – Disease Prevention and Control (Non-Communicable Diseases)**Sub – Programme purpose**

The Community-based Services Sub-programme manages the implementation of the Community-Based Health Services. This includes:

- Implementation of disease-prevention strategies at a community level.
- Providing chronic and geriatric services including rehabilitation as a supportive service.
- Providing oral health services at a community level (including schools and old age homes).
- Strengthening the prevention of mental disorders, substance, drug, and alcohol abuse to reduce unnatural deaths.

Table 17: Outcomes, Outputs and Output indicators and targets for the next MTEF for Community Based services – Disease Prevention and control Non communicable diseases

Outcome (as per SP 2025/26- 2029/30)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2021/22	2022/23	2023/24	2024/25	2025/26	2025/26 Quarterly Targets				2026/27	2027/28
								Q1	Q2	Q3	Q4		
7. Mortality due to NCDs reduced	Clients early detection of illness and prevention.	7.1.1 Positivity rate for hypertension 18 - 44 years	New Indicator	New Indicator	0.5%	<2%	<2%	<2%	<2%	<2%	<2%	<2.5%	<3%
		Numerator			15 513	13 554	67 363	16 840	16 841	16 841	16 841	84 204	101 045
		Denominator			3 368 187	677 724	3 368 187	842 046	842 047	842 047	842 047	3 368 187	3 368 187
		7.1.2 Positivity rate for hypertension ≥ 45 years	New Indicator	New Indicator	1.4%	2.4%	2%	2%	2%	2%	2%	2.5%	3%
		Numerator			24 993	7 838	34 488	8 622	8 622	8 622	8 622	43 110	51 731
		Denominator			1 724 382	330 657	1 724 382	431 095	431 095	431 096	431 096	1 724 382	1 724 382
		7.2.1 Positivity rate for diabetes 18 - 44 years	New Indicator	New Indicator	0.4%	<2%	<2%	<2%	<2%	<2%	<2%	<2.5%	<3%
		Numerator			13 488	22 698	64 640	16 160	16 160	16 160	16 160	80 801	96 961
		Denominator			3 232 040	1 134 880	3 232 040	808 010	808 010	808 010	808 010	3 232 040	3 232 040
		7.2.2 Positivity rate for diabetes ≥ 45 years	New Indicator	New Indicator	0.8%	1.1%	2%	2%	2%	2%	2%	2.5%	3%
		Numerator			17 936	5 399	47 001	11 751	11 750	11 750	11 750	58 751	70 509
		Denominator			2 350 033	471 854	2 350 033	587 509	587 508	587 508	587 508	2 350 033	2 350 033

Outcome (as per SP 2025/26- 2029/30)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets							
			2021/22	2022/23	2023/24		2024/25	2025/26	2025/26 Quarterly Targets				2026/27	2027/28
									Q1	Q2	Q3	Q4		
8. Mental Health Care Integrated into Primary health care	Prevention and early detection of mental illness	8.1.1 PHC mental health condition treatment rate new	0.07%	0.1%	0.03%	0.04%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	
		Numerator	9 562	12 663	4 440	1 372	27 886	6 971	6 971	6 972	6 972	27 886	27 886	
		Denominator	13 692 661	14 117 664	13 943 191	3 129 300	13 943 191	3 485 797	3 485 798	3 485 798	3 485 798	13 943 191	13 943 191	
7. Mortality due to NCDs reduced	Reduction of blindness	7.4.1 Cataract surgery rate	231.1/1 000 000	181.8/1 000 000	513.4/1 000 000	752/1 000 000	380/1 000 000	380/1 000 000	380/1 000 000	380/1 000 000	380/1 000 000	400/1 000 000	441/1 000 000	
		Numerator	1 552	1 092	3 083	4 516	2 283	2 283	2 283	2 283	2 283	2 403	2648	
		Denominator	6 714 789	6 006 715	6 004 621	6 003 438	6 006 715	6 006 715	6 006 715	6 006 715	6 006 715	6 006 715	6 006 715	

Explanation of planned performance over the medium-term period

The National Strategy on Prevention and Control of Non-Communicable Diseases (NCDs) 2022-2027 has introduced the NCD Cascade of 90-60-50 for hypertension and diabetes:

- 90% of individuals aged 18 and above will be aware of their elevated blood pressure and/or blood glucose levels.
- 60% of those with high blood pressure or blood glucose levels will receive necessary interventions.
- 50% of individuals receiving interventions will achieve control over their condition.

The prevalence of NCDs in the country is on the rise due to shifting lifestyles characterized by decreased physical activity and increased consumption of alcohol, high-salt, and high-sugar foods. Diabetes and hypertension directly contribute to the onset of cardiovascular and cerebrovascular diseases, which are becoming leading causes of mortality in the region. Eye health issues, stemming from an aging population and NCD-related complications, are increasingly affecting younger individuals. Cataracts and refractive errors contribute to poverty and hinder economic development. The set cataract targets will be met through collaborations with Non-Governmental Organizations (NGOs) to facilitate cataract tours scheduled for the 2025-2030 period. Youth, women, and individuals with disabilities are encompassed in the 18-44 and 45 years and older age groups for NCD interventions.

Cataract surgeries are performed in established eye health facilities such as Frontier, PE Provincial, CMH, NMA hospitals, and selected district hospitals through cataract surgery outreach programs. Partnerships with organizations like the South African National Council for the Blind (SANCB) and Grace Vision provide resources (equipment, surgical supplies, and medications) to enhance the cataract surgery rate over a 3-year time-frame. The cataract surgery rate goal remains modest and easily attainable with the support of SANCB.

Planned strategies to address eye health challenges involve allocating sufficient funds for cataract supplies, procured centrally and distributed to eye units and certain district hospitals offering outreach services. Schoolchildren and adults will receive prescribed spectacles and reading glasses through the approved provincial tender for a 3-year period in areas where optometrists are stationed, with the assistance of the Ke Ready organization contracted with the Department of Health for six districts.

Interventions planned to tackle these issues encompass integrated management of NCDs (utilizing Community Health Workers, Health Promotion initiatives, Nutrition programs, Training, etc.) to encourage positive health-related behaviors, promote screening and early detection, as well as ensure individuals diagnosed with NCDs receive proper treatment and continuous care. Universal Health Coverage will be greatly facilitated by promoting health and illness prevention, raising awareness about NCDs, reducing the need for medical interventions, and delivering high-quality, patient-centered care within a well-integrated, efficient healthcare system.

2.5 Sub-Programme: Other Community Based Services - Public Health

Sub- Programme purpose

The Other Community Services sub-programme manages, monitor and evaluate environmental health services in the Province (including health care waste management in public health facilities and hazardous substances control).

Table 18: Outcomes, Outputs and Output indicators and targets for the next MTEF for Other Community Base Services – Public Health

Outcome (as per SP 2025/26- 2029/30)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2021/22	2022/23	2023/24	2024/25	2025/26	2025/26 Quarterly Targets				2026/27	2027/28
								Q1	Q2	Q3	Q4		
12. Quality of health services improved	Hospitals comply with health care risk waste norms and standards	12.8.1 Percentage of hospitals complying with health care risk waste norms and standards	65%	69.6%	74.1%	79%	85%	85%	85%	85%	85%	88%	94%
		Numerator	58	62	66	70	72	72	72	72	72	75	80
		Denominator	89	89	89	89	85	85	85	85	85	85	85
	Households advocate for accessibility to health services increased	12.9.1 Number of CHWs on Stipend	New Indicator	New Indicator	New Indicator	4004	4049(45 new)	-	4049(45 new)	-	-	4329 (200 new)	4529(200 new)
		12.9.2 Grade R Learners screened	New Indicator	New Indicator	New Indicator	New Indicator	10 000	2 000	4 000	2 000	2 000	10 500	11 025

Explanation of Planned Performance over the Medium-Term Period

Environmental health services are performed at provincial and municipal levels although the provincial department of health has a responsibility to plan, coordinate, monitor and evaluate the environmental health services rendered by municipalities. The control of hazardous substances according to the Hazardous Substances act 15 of 1973 is to control the selling of these substances that may cause injury or ill-health to or death of human beings. The provincial Department of Health has public health facilities that generate health care waste including medical waste and as such is a major generator as stipulated by the National Environmental Management Waste Act 59 of 2008 (NEMWA). This type of waste should be properly managed according to the NEMWA which also requires the department to have integrated waste management plans. The department has a responsibility to manage the waste generated by public health facilities as such the department has a tender that assist in managing health risk waste. As the management of the waste is highly legislated the department saw it fit to have a service provider to assist in this regard.

The National Environmental Health Norms and Standards for premises and acceptable monitoring standards for environmental health practitioners talks to the health facility standards which include management of health care waste. It is in the interest of the department to achieve the planned performance to:

- Strengthen of Infection Prevention and Control (IPC) in health facilities.
- Manage and reduce the budget utilised in the collection, transportation, treatment and disposal of health care risk/medical waste.
- Prevent litigations of the department by green scorpions, municipalities and communities due to improper management of health care risk waste.

The planned interventions to manage health care waste are:

- Procurement of central storage areas for health facilities to store health care risk waste while waiting for collection.
- Monitoring the tender on health care risk waste in the department.
- Routine assessments of health facilities to ensure compliance with relevant standards and prescripts.
- Appointment or designation of Health Care Waste officer in health facilities.
- Ensure availability of waste committees or any committees which includes health care waste management in terms of reference.

South Africa made its intentions clear to have a health system that provides universal access to healthcare. This system is based on the approach of keeping people healthy and caring for themselves when they are in poor health condition.

The government committed to strengthening the effectiveness of the health system highlighting the need to overhaul the health services delivery platform from one that is based on curative, high-cost care model, to one that promotes cost-effective PHC services that are delivered as close to communities and households as possible, and is centred around health promotion, prevention and community involvement. During the MTEF, the sub programme through its Ward-Based Primary Health Care Outreach Teams (WBPHCOTs) will perform the following duties which are aligned to the voted budget: in addition to the voted budget allocated for this sub programme, there will be assistance from the developmental partners for the following activities:

- Mobilising communities for screening (contact tracing).
- Visit households and advocate for accessibility to health services.
- Identify households with children, pregnant women, chronic and refer them to health facilities.
- Identify individuals who default treatment and refer to clinics in a welcome back campaign.
- Providing adherence support.
- Screening and testing for Non - Communicable Diseases (NCD) like hypertension and diabetes.
- Conduct testing in communities to identify pregnancy and refer them.
- Strengthen referral pathways to relevant services.

2.6 Sub-Programme: HIV & AIDS, STI & TB (HAST) Control

Sub – Programme purpose

To control the spread of HIV infection, reduce and manage the impact of the disease to those infected and affected in line with Provincial Development Plan (PDP) goals, and to control the spread of TB, manage individuals infected with the disease and reduce the impact of the disease in the communities.

Table 19: Outcomes, Outputs and Output indicators and targets for the next MTEF for HAST

Outcome (as per SP 2025/26- 2029/30)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2021/22	2022/23	2023/24	2024/25	2025/26	2025/26 Quarterly Targets				2026/27	2027/28
								Q1	Q2	Q3	Q4		
4. HIV/ AIDS related deaths reduced	HIV new cases identified and initiated on ART	4.1.1 HIV test done – sum	1 701 524	1 896 429	2 061 702	1 625 060	2 102 936	525 734	525 734	525 734	525 734	2 144 995	2 187 895
		4.1.2 HIV positive 5-14 years (excl ANC) rate	New Indicator	New Indicator	New Indicator	New Indicator	<1%	<1%	<1%	<1%	<1%	<1%	<1%
		Numerator					1 293	323	323	323	324	1 293	1 293
		Denominator					143 691	35 922	35 923	35 923	35 923	143 691	143 691
		4.1.3 HIV positive 15-24 years (excl. ANC) rate	2.2%	2%	1.7%	1.2%	<1.5%	<1.5%	<1.5%	<1.5%	<1.5%	<1.5%	<1.5%
		Numerator	12 355	12 245	11 655	2 382	9 545	2 387	2 386	2 386	2 386	9 545	9 545
		Denominator	553 802	616 736	681 771	194 738	681 771	170 442	170 443	170 443	170 443	681 771	681 771
		4.1.4 ART client naïve start ART during month – sum	50 541	48 808	47 221	29 333	58 672	14 668	14 668	14 668	14 668	59 303	59 934
	People living with HIV retained on care	4.1.5 ART adult remain in care rate [12 months]	62.3%	63%	63.3%	67%	70%	70%	70%	70%	70%	73%	75%
		Numerator	30 103	27 972	28 207	6 931	35 383	9 755	8 562	8 798	8 268	36 899	37 910

Outcome (as per SP 2025/26- 2029/30)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2021/22	2022/23	2023/24	2024/25	2025/26	2025/26 Quarterly Targets				2026/27	2027/28
								Q1	Q2	Q3	Q4		
		Denominator	48 302	44 391	44 590	10 352	50 547	13 935	12 231	12 568	11 813	50 547	50 547
		4.1.6 ART child remain in care rate [12 months]	73.4%	73.8%	74.8%	76.9%	77%	77%	77%	77%	77%	80%	85%
		Numerator	838	745	776	214	844	256	206	219	163	877	932
		Denominator	1 142	1 009	1 038	277	1 096	333	267	284	212	1 096	1 096
	People viral load undetected	4.1.7 ART Adult viral load suppressed rate (below 50) [12 months]	88.5%	89%	82.8%	85.5%	85%	85%	85%	85%	85%	88%	90%
		Numerator	19 632	18 142	16 924	3 503	42 965	11 845	10 396	10 683	10 041	44 481	45 492
		Denominator	22 186	20 385	20 444	4 096	50 547	13 935	12 231	12 568	11 813	50 547	50 547
		4.1.8 ART Child viral load suppressed rate (below 50) [12 months]	64%	62%	50.2%	54.2%	60%	60%	60%	60%	60%	65%	70%
		Numerator	376	310	271	64	657	200	160	170	127	712	767
		Denominator	588	500	540	118	1 096	333	267	284	212	1 096	1 096
5. TB incidence reduced by 10%	TB/HIV co-infected clients identified and initiated	5.1.1 TB/ HIV co-infected client on ART rate	92.6%	93.3%	94.3%	95%	95%	95%	95%	95%	95%	95%	95%
		Numerator	13 724	14 051	17 426	14 310	17 187	4 296	4 297	4 297	4 297	17 187	17 187
		Denominator	14 816	15 063	18 476	15 063	18 092	4 523	4 523	4 523	4 523	18 092	18 092
	TB Positive clients initiated and cured	5.1.2 TB test 5 years and older using TB Nucleic Acid Amplification Test (NAAT)	New indicator	New indicator	New indicator	93 980	421 728	105 432	105 432	105 432	105 432	502 074	607 289

Outcome (as per SP 2025/26- 2029/30)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2021/22	2022/23	2023/24	2024/25	2025/26	2025/26 Quarterly Targets				2026/27	2027/28
								Q1	Q2	Q3	Q4		
		5.1.3 DS – TB treatment start 5 years and older	32 658	36 741	38 235	8 898	39 733	9 933	9 933	9 933	9 934	39 733	39 733
		5.1.4 DS-TB treatment start under 5 years	New indicator	New indicator	New indicator	New indicator	1 198	299	300	299	300	1 225	1 253
		5.2.1 TB Rifampicin resistant /MDR confirmed client start on treatment	New Indicator	New Indicator	New Indicator	New Indicator	504	126	126	126	126	536	544
6. TB Mortality reduced by 10%	TB Positive clients initiated and cured	6.1.1 All DS -TB client treatment success rate (* All DS-TB outcome data is reported 12 months later)	77.5%	76.7%	72%	74.7%	76%	76%	76%	76%	76%	77%	80%
		Numerator	25 482	27 189	32 591	9 856	34 407	8 602	8 602	8 602	8 601	34 859	36 218
		Denominator	32 881	35 436	45 098	12 527	45 272	11 318	11 318	11 318	11 318	45 272	45 272
		6.1.2 TB Rifampicin resistant/Multidrug - Resistant treatment success rate (* RR/MDR-TB outcome data is reported 12 months later)	New Indicator	New Indicator	70%	68%	70%	70%	70%	70%	70%	73%	75%
		Numerator			754	181	1 028	257	257	257	257	1 072	1 101
		Denominator			1 082	267	1 468	367	367	367	367	1 468	1 468

Outcome (as per SP 2025/26- 2029/30)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2021/22	2022/23	2023/24	2024/25	2025/26	2025/26 Quarterly Targets				2026/27	2027/28
								Q1	Q2	Q3	Q4		
		6.1.3 TB Pre-XDR treatment success rate	New Indicator	New Indicator	65%	51%	60%	60%	60%	60%	60%	65%	68%
		Numerator			76	20	92	23	23	23	23	100	105
		Denominator			117	39	154	39	39	38	38	154	154
	Lost clients tracked and re-initiated	6.1.4 All DS – TB client lost to follow – up rate	14.1%	14.7%	14%	13.8%	<12%	<12%	<12%	<12%	<12%	<10%	<10%
		Numerator	4 622	5 194	6 181	1 732	5 432	1 358	1 358	1 358	1 358	4 482	4 482
		Denominator	32 881	35 436	45 098	12 527	45 272	11 318	11 318	11 318	11 318	45 272	45 272
9. Malaria related deaths reduced	Prevention and early detection of malaria cases managed	9.1.1 Malaria deaths reported	New Indicator	1	1	0	0	0	0	0	0	0	0

Explanation of planned performance over the medium-term period

The programme has transitioned to 95-95-95 from April 2023 as per UNAIDS goals, however these targets were missed by a significant margin due to various reasons of which the main was shortage of programme management staff at provincial and district levels.

The provincial HAST programme has intensified support to districts in the implementation of Operation Phuthuma (nerve centres), this approach facilitates data-driven and focused quality improvement, and scale up implementation of the case finding & retention strategies for TB, HIV and STIs.

TB Recovery Plan to address the discrepancies that happened during Covid-19 era is being implemented across the province. The plan focuses on upscaling 5 pillars: Communicate and Advocate; Find and Link; Treat and Retain; Prevent and Prepare; Monitor and Assess.

The programme plans to implement updated guidelines for both HIV and TB to improve clinical management of patients and programme performance to reach the 95-95-95 targets.

- 1st 95: Scaling up implementation of the case finding strategies for TB, HIV and STIs in order to close the minor gap by implementing Operation Phuthuma and TB Recovery Plan, the programme will ensure that demand creation takes place through communication and advocacy; intensify finding the missing TB and HIV cases through screening in health facilities and communities (TB health-check, HIV self-screening, and digital chest x-ray) and link them to care. Continue to improve diagnostic yield by implementing the use of GeneXpert Ultra and of Lipoarabinomannan Assay (LAM) policies for TB as well as Index Testing and HIVSS for HIV to improve the expected positivity rate. In the TB sub-programme, key populations who are regarded as high risk are tested despite TB screening results comprise of all household TB contacts including adolescents and adults, ex-TB patients, HIV positive, pregnant women, ex-miners and uncontrolled diabetics. For HIV positive people where TB is excluded, the implementation of TB Preventative Therapy (TPT) will be intensified and has been extended to 14 weeks HIV positive clients, which is an addition to adults and adolescents to prevent the progression of latent TB to active TB. TB-HIV integration program ensures that all TB diagnosed patients know their HIV status, the HIV positive diagnosed are started on ARV treatment for comprehensive care. The HIV diagnosed clients are screened for TB and tested using GeneXpert test irrespective of TB symptoms, TB positive diagnosed clients are started on TB treatment.
- 2nd 95: The focus is to get back to care the patients that are missing their appointments. The province will be implementing the 1.1 Million ART Gap campaign as announced by the President in the 2025 SONA and subsequently launched by the Minister of Health in Gauteng in February 2025. Implementing this will assist the province in getting back the 148 000 patients estimated as a target towards the national 1.1 Million.
- The province through the Provincial Nerve Center has set up Technical Working Groups to support districts and drive performance improvement using the Operation Phuthuma approach and a Catch-Up Plan has been developed and shared with districts, this focused strategy will assist in factoring the desired outputs.
- The focus is to have 95% of people with confirmed HIV or drug susceptible TB (DS-TB) initiated on treatment, whether confirmed clinically or bacteriologically. For multidrug resistant TB (MDR), Bedaquiline, Pretonamide, Lenozinade and Levofloxacin (BPAL-L) have been introduced as the shortened 6 months regimen following the successful study conducted in Nelson Mandela Metro and Buffalo City Metro. BPAL-L roll-out to other districts is planned for 2025/26 financial year, the regimen is hoped to increase retention on treatment due to less pill burden and reduced treatment course.
- The World Health Organization (WHO) proposed that the BPAL-L be implemented worldwide as the recommended regimen and was first launched and implemented on the 1st of September 2023 in Nelson

Mandela Metro. Adherence counselling at each encounter and patient education through media engagements are offered.

- Tracking and tracing the lost to follow up clients through the community-based intervention teams, monitoring of indicator performance in partnership with various stakeholders.
- 3rd 95: The province will strengthen intervention to ensure good treatment outcome for both TB and HIV that will achieve 95% treatment successes. Treatment success will be monitored by strengthening management of viral load and sputum tests on scheduled intervals in line with the guidelines.
- Patients on ART that are treated successfully, with suppressed viral load will be enrolled into Differentiated Models of Care (DMC), to collect their medication either in Facility Pick-up Points, Community Pick-up Points or Adherence Clubs. This intends to reduce the facility congestion where stable patients can access their medication outside the facilities.

2.7 Sub – Programme: Maternal, Child and Women’s Health and Nutrition (MCWH&N)

Sub – Programme purpose

To reduce mother, new born and child mortality through strengthened maternal and child as well as nutrition health services across the Eastern Cape Province.

Table 20: Outcomes, Outputs and Output indicators and targets for the next MTEF for MCWH&N

Outcome (as per SP 2025/26- 2029/30)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2021/22	2022/23	2023/24	2024/25	2025/26	2025/26 Quarterly Targets				2026/27	2027/28
								Q1	Q2	Q3	Q4		
I. Maternal Mortality Ratio reduced	Family planning improved	I.1.1 Couple Year Protection Rate	41.5%	49%	58.4%	New indicator	50%	50%	50%	50%	50%	55%	60%
		Numerator	810 499	794 005	949 178		810 892	202 723	202 723	202 723	202 723	891 981	973 070
		Denominator	1 952 5 56	1 620 419	1 621 783		1 621 783	405 445	405 446	405 446	405 446	1 621 783	1 621 783
	Increased ANC visits before 20 weeks	I.1.2 Antenatal 1 st visit before 20 weeks rate	63%	63.5%	62.8%	65.7%	65%	65%	65%	65%	65%	66%	67%
		Numerator	76 980	71 748	63 640	13 695	65 880	16 470	16 470	16 470	16 470	66 894	67 907
		Denominator	122 229	112 913	101 354	20 831	101 354	25 338	25 338	25 339	25 339	101 354	101 354
	Increased uptake of ART by antenatal client	I.1.3 Antenatal client start on ART rate	90.4%	89.8%	99.4%	96.2%	98%	98%	98%	98%	98%	99%	99.5%
		Numerator	7 827	6 269	5 076	920	5 003	1 251	1 251	1 251	1 250	5 054	5 079
		Denominator	8 662	6 981	5 105	956	5 105	1 277	1 276	1 276	1 276	5 105	5 105

Outcome (as per SP 2025/26- 2029/30)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets							
			2021/22	2022/23	2023/24		2024/25	2025/26	2025/26 Quarterly Targets				2026/27	2027/28
									Q1	Q2	Q3	Q4		
	Increase access to family planning by teenagers	I.1.4 Delivery 10 - 14 years In facility	New Indicator	New Indicator	New Indicator	74	<330	75	75	75	75	<320	<300	
		I.1.5 Delivery 15-19 years in facility	New Indicator	New Indicator	New Indicator	New Indicator	<15000	<3750	<3750	<3750	<3750	<14500	<14000	
	Low birth weight reduced	I.1.6 Low birth weight rate	14.3%	14.9%	16.5%	16.8%	<13%	<13%	<13%	<13%	<13%	<12%	<12%	
		Numerator	15 839	14 783	14 687	3 193	11 498	2 874	2 874	2 875	2 875	10 607	10 607	
		Denominator	110 833	99 503	89 137	18 964	89 137	22 284	22 284	22 284	22 285	89 137	89 137	
	Postnatal care coverage increased	I.1.7 Mother postnatal visit within 6 days rate	78.6%	80.7%	82.8%	82.2%	83%	83%	83%	83%	83%	84%	85%	
		Numerator	85 685	80 488	74 389	15 684	74 601	18 650	18 650	18 650	18 651	75 500	76 399	
		Denominator	108 975	99 915	89 881	19 086	89 881	22 470	22 470	22 471	22 470	89 881	89 881	
	Maternal mortality reduced	I.1.8 Maternal Mortality in facility ratio (per 100 000 live births)	114.6/100 000	124.5/100 000	136.2/100 000	152.2/100 000	<120.6/100 000	<120.6/100 000	<120.6/100 000	<120.6/100 000	<120.6/100 000	<120/100 000	<120/100 000	
		Numerator	136	133	131	34	116	29	29	29	29	115	115	
		Denominator	118 711	107 025	96 157	22 339	96 156	24 039	24 039	24 039	24 039	96 156	96 156	

Outcome (as per SP 2025/26- 2029/30)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2021/22	2022/23	2023/24		2024/25	2025/26	2025/26 Quarterly Targets				2026/27
		Q1				Q2			Q3	Q4			
1.Neonatal deaths (0- 28 days) in facility rate reduced	Mother-to- child transmissio n eliminated	2.1.1 Infant 1 st PCR test positive at birth rate	New Indicator	New Indicator	New indicator	New indicator	1%	1%	1%	1%	1%	0,5%	0,4%
		Numerator					102	25	25	26	26	51	41
		Denominator					10 152	2 538	2 538	2 538	2 538	10 152	10 152
	Child mortality reduced	2.1.2 Neonatal death in facility	13.2/10 00	13.8/100 0	15.1/100 0	15.8/1000	12/1000	12/1000	12/1000	12/1000	12/1000	11/1000	11/1000
		Numerator	1 464	1 374	1 350	300	1 070	267	267	268	268	981	981
		Denominator	110 833	99 503	89137	18 964	89 137	22 285	22 284	22 284	22 284	89137	89137
3. Under 5 mortality rate reduced	Child fully immunised	3.1.1 Immunisation under 1 year coverage	88.7%	82.1%	78.6%	67.2%	85%	85%	85%	85%	85%	87%	89%
		Numerator	116 122	108 031	103 687	22 356	111 867	27 966	27 967	27 967	27 967	114 501	117 134
		Denominator	130 901	131 213	131 611	132 313	131 611	32 903	32 903	32 903	32 904	131 611	131 611
		3.1.2 MR 2 nd dose 1 year coverage	83.3%	81.6%	79.2%	65.5%	85%	85%	85%	85%	85%	87%	89%
		Numerator	111 128	106 690	103 524	21 484	110 781	27 696	27 697	27 697	27 697	113 788	115 995
		Denominator	133 378	130 526	130 331	130 202	130 331	32 582	32 582	32 583	32 583	130 331	130 331
	Micro and macro nutrient	3.1.3 Vitamin A dose 12-59 months coverage	63.7%	75.1%	76.1%	69.9%	77%	77%	77%	77%	77%	78%	79%

Outcome (as per SP 2025/26- 2029/30)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets							
			2021/22	2022/23	2023/24		2024/25	2025/26	2025/26 Quarterly Targets				2026/27	2027/28
									Q1	Q2	Q3	Q4		
	malnutrition reduced	Numerator	706 625	809 978	810 011	184 568	817 555	817 555	817 555	817 555	817 555	828 173	838 790	
		Denominator	1 109 626	1 082 218	1 061 760	1 084 016	1 061 760	1 061 760	1 061 760	1 061 760	1 061 760	1 061 760	1 061 760	
		3.1.4 Child under 5 years diarrhoea case fatality rate	3.4%	2.6%	2.2%	1.7%	2%	2%	2%	2%	2%	2.1%	2%	
		Numerator	152	119	110	18	100	25	25	25	25	103	98	
		Denominator	4 489	4 539	4 908	1 056	4 908	1 227	1 227	1 227	1 227	4 908	4 908	
		3.1.5 Child under 5 years pneumonia case fatality rate	3.3%	2.8%	3.4%	2.2%	2.7%	2.7%	2.7%	2.7%	2.7%	2.6%	2.5%	
		Numerator	117	139	127	21	101	25	25	25	26	97	93	
		Denominator	3 592	5 049	3 736	939	3 736	934	934	934	934	3 736	3 736	
		3.1.6 Child under 5 years severe acute malnutrition case fatality rate	9.7%	7.6%	9.5%	6.5%	9%	9%	9%	9%	9%	9.1%	9%	
		Numerator	127	98	109	13	106	26	26	27	27	105	104	
		Denominator	1 314	1 287	1 151	201	1 151	287	288	288	288	1 151	1 151	
			Child mortality reduced	3.1.7 Death under 5 years against live birth in rate	2%	2.1%	2.3%	2.4%	<2%	<2%	<2%	<2%	<2%	<2%
Numerator	2 181			2 095	2 079	487	1 783	445	446	446	446	1 783	1 783	
Denominator	110 833			99 503	89 137	20 185	89 137	22 285	22 284	22 284	22 284	89 137	89 137	

Outcome (as per SP 2025/26- 2029/30)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets							
			2021/22	2022/23	2023/24		2024/25	2025/26	2025/26 Quarterly Targets				2026/27	2027/28
									Q1	Q2	Q3	Q4		
7. Mortality due to NCDs reduced	Clients early detection of illness and prevention.	7.3.1 Cervical cancer screening coverage	New Indicator	New Indicator	New Indicator	46.1%	45%	45%	45%	45%	45%	46%	47%	
		Numerator				23 507	365 350	91 337	91 337	91 338	91 338	373 468	381 587	
		Denominator				202 972	811 888	202 972	202 972	202 972	202 972	811 888	811 888	

Explanation of planned performance over the medium-term period

The sub-programme is determined to ensure that the outcomes on Maternal, Child, Women's health and nutrition related outcomes are improved whilst ensuring that quality of life is not compromised. The sub-programme has identified the following performance challenges in the previous financial year: Maternal Mortality, Neonatal and under five child mortality rates. The following were identified as contributory factors: Increased teenage pregnancy, low immunization rate and severe acute malnutrition. Maternal HIV and TB contributed significantly to maternal mortality rate. Whilst the sub-programme had these performance challenges, improvement was noticed on diarrhoea and pneumonia death rates.

The Department will link interventions to strengthen clinical accountability and governance through the District Clinical Specialist Teams. Primary Health Care and Community-Based Services (CBS) are intended to impact directly on the demand side of patient care. This will be achieved through health education programmes aimed at women, mothers and children to improve health care seeking behaviour.

There is an increased effort to screen all women of reproductive age at community and facility levels. This will improve early booking of pregnant women before 20 weeks to reduce maternal mortality rate. Early booking will assist in early identification of pregnant and HIV/ TB infected women to minimise pregnancy-associated complications, congenital birth defects, and reduce Vertical Transmission of HIV and promotion of early access to termination of pregnancy services. The Department is also continuing to improve strategies aimed at reducing Maternal Deaths which include training on Essential Steps in Managing Obstetric Emergencies (ESMOE) and Basic Antenatal Care (BANC).

The Province has clustered all district hospitals to conduct Facility Assessment Supporting Tool (FAST) to improve maternal and neonatal outcomes. Furthermore, the following interventions are planned for the next five years; Improving and maintaining effective clinical skills levels through structured skills training, mentoring, proper placement of competent clinical staff and minimise rotation of skilled personnel.

In an effort to reduce teenage pregnancy, family planning is key in curbing the challenge including risks. This will be achieved through collaborating with tertiary institutions to improve access to sexual reproductive health services by students on campus. A signed Memorandum of Understanding (MOU) is in place between Department of Health and Institutions Higher Learning.

The Province is establishing youth zones in health facilities to improve the appeal of Sexual Reproductive Health services to the youth. The department is currently working with United Nations Population Fund Agency (UNFPA) and Beyond Zero (NGO) to improve Sexual Reproductive Health services through behavioural interventions in and out of school.

To improve immunisation coverage, Expanded Programme on Immunisation (EPI) catch-up drives are conducted. The Province continues with supporting the districts that are underperforming including hard to

reach areas, and monitor effective analysis and verification of data. Cold Chain Management continues to be improved by ensuring proper storage of available vaccines through procurement of specialised vaccination refrigerators and continuous temperature monitoring devices. Integration of EPI and HIV is implemented in the facilities to improve management of children on antiretroviral.

The department is continuously training clinicians on Integrated Management of Childhood Illnesses (IMCI) and Integrated Management of Children with Acute Malnutrition (IMAM) to reduce child mortality rate. To address social determinants of health associated with malnutrition and diarrhoea, inter-sectoral collaboration will be strengthened with sector departments and Developmental Partners. This is done through Integrated Community Registration and outreach programme (ICROP), Provincial Integrated Anti-Poverty Programme (PIAPS) and non-governmental organisations.

There are also health education activities including Side by Side campaign covering important elements (growth monitoring, nutrition, love and care, protection from diseases) to improve child health outcomes. In the Eastern Cape, teenage pregnancy and HIV infection contribute to low rate of exclusive breastfeeding that are consistently below 50% which is a target set by World Health Organisation. The Mother Baby Friendly Initiative (MBFI) programme will be strengthened to improve breastfeeding rates in an effort to reduce child malnutrition.

The department of Health signed a memorandum of understanding with the Institutions of Higher Learning in the province that are led by Higher Health. The objective is to increase access to the sexual reproductive health services as it was noticed that the target group is on campus during the day and by the time they come to facilities its already closing time. Furthermore, it is to capacitate campus nurses and their health promotion on contraceptives especially emergency contraceptives. Campuses are attached to the nearest health facilities close by for the commodities.

Bumbingomso extended a hand for Buffalo City branch John Knox in Mdantsane to conduct a weekly clinic. The campuses are working together with the districts on their “First things first” campaign that target first years every year where we market the SRH services. TVET colleges are also under Higher Health and already had the dispensing machines for Sanitary Pads, condoms and lubricants and the department is planning to apply to Pharmacy Council for additions of emergency contraceptives and pregnancy test strips. Bumbingomso is working in Buffalo City and Amathole West on their Ikhwelolethu Programme focusing at 10-14 years strengthening the behavioral modification

2.8 Sub-Programme: Coroner Services

Sub-Programme Purpose

- To strengthen the capacity and functionality of forensic pathology institutions within the province and facilitate access to forensic pathology services at all material times.
- The Coroner Services sub-programme renders forensic pathology services in order to establish the circumstances and causes surrounding unnatural deaths.

Table 21: Outcomes, Outputs and Output indicators and targets for the next MTEF for Coroner Services

Outcome (as per SP 2025/26- 2029/30)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2021/22	2022/23	2023/24	2024/25	2025/26	2025/26 Quarterly Targets				2026/27	2027/28
								Q1	Q2	Q3	Q4		
12. Quality of health services improved	All post mortem cases finalised	12.10.1 Percentage of post – mortem performed within 72 hours	97.7%	95%	95.5%	91.5%	96%	96%	96%	96%	96%	97%	98%
		Numerator	2 905	10 354	9 824	2 795	9 891	2 472	2 473	2 473	2 473	9 994	10 097
		Denominator	2 972	10 897	10 303	3 055	10 303	2 575	2 576	2 576	2 576	10 303	10 303

Explanation of Planned Performance over the Medium-Term Period

Coroner Services will improve capacity of the staff through recruitment of forensic pathologists and training of medical officers and forensic pathology officers. Expansion of Forensic Pathology service sites across the province (new dissecting facility at Ngcobo, opening of holding facilities at Dutywa, Port Alfred, Thafalofefe and Molteno) with procurement of disaster truck per region, additional body collecting vehicles and installation of Lodox Machines.

Infrastructure improvements include redesigning and reconstruction of frontline offices at all dissecting facilities, construction of visitor's holding/waiting rooms and counselling facilities and installation of technological and innovative features to control body movement and prevent body loss. The forensic Pathology suites need to increase security and install maximum-security features. Forensic officers deal with major trauma and provision of trauma debriefing services and counsel is a priority. Improve cooperation and coordination of un-identified and unclaimed bodies through stakeholder's management and facilitate paupers' burial processes

2.9 Sub Programme: District Hospitals

Sub-Programme Purpose

To provide comprehensive and quality district hospital services to the people of the Eastern Cape Province through implementation of the District Hospital Package.

Table 22: Outcomes, Outputs and Output indicators and targets for the next MTEF for District Hospitals

Outcome (as per SP 2025/26- 2029/30)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets							
			2021/22	2022/23	2023/24		2024/25	2025/26	2025/26 Quarterly Targets				2026/27	2027/28
									Q1	Q2	Q3	Q4		
	District hospitals attained Ideal hospital status	12.4.1.2 Ideal hospital status rate	New Indicator	New Indicator	New Indicator	New Indicator	5%	-	-	-	5%	5%	5%	
		Numerator					3				3	3	3	
		Denominator					65				65	65	65	
11. Improved Patient Experience of Care	Patient satisfaction surveys conducted	11.1.3 Patient Experience of Care survey rate	New Indicator	New Indicator	New Indicator	New Indicator	98.4%		98.4%			98.4%	98.4%	
		Numerator					64		64			64	64	
		Denominator					65		65			65	65	
12. Quality of health services improved	Patient Safety Improved	12.6.5 Severity Assessment Code (SAC) I incident reported within 24 hours rate	55%	74.4%	74%	94.8%	76%	76%	76%	76%	76%	77%	78%	
		Numerator	205	346	444	92	459	114	115	115	115	468	471	
		Denominator	371	465	604	97	604	151	151	151	151	604	604	

Outcome (as per SP 2025/26- 2029/30)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets							
			2021/22	2022/23	2023/24	2024/25	2025/26	2025/26 Quarterly Targets				2026/27	2027/28	
								Q1	Q2	Q3	Q4			
		12.6.6 Patient Safety Incident (PSI) case closure rate	New Indicator	91.5%	95%	94.9%	96%	96%	96%	96%	96%	97%	98%	
		Numerator		1 114	1 107	223	1 122	280	281	281	280	1 134	1 146	
		Denominator		1 217	1 170	235	1 169	293	292	292	292	1 169	1 169	
	Hospital efficiencies improved	12.10.1 Average Length of Stay	4.5 days	4.7 days	4.9 days	4.7 days	4.5 days	4.5 days	4.5 days	4.5 days	4.5 days	4.5 days	4.5 days	4.5 days
		Numerator	1 012 207		1 089 938	265 310.5	999 027	249 756	249 757	249 757	249 757	999 027	999 027	
		Denominator	2 215 975		222 006	56 327	222 006	55 501	55 502	55 502	55 502	222 006	222 006	
		12.10.2 Inpatient (usable) bed utilisation rates	New Indicator	46.2%	48.8%	47.5%	48%	48%	48%	48%	48%	48%	48%	
		Numerator		1 032 948	1 089 938	265 310.5	1 071 991	267 997	267 998	267 998	267 998	1 071 991	1 071 991	
		Denominator		2 236 965	2 233 315	558 329	2 233 315	558 328	558 329	558 329	558 329	2 233 315	2 233 315	
		12.10.3 Expenditure per PDE	R3,288.8	R3,826.4	R4 079.2	R3,760.2	R4 079.2	R4 079.2	R4 079.2	R4 079.2	R4 090	R4 080	R4 090	
		Numerator	R5 184 555 657		R6 433 531 794.2	1 489 172 054.9	6 433 284 288	1 608 321 147	1 608 321 147	1 608 321 147	1 608 321 147	6 434 861 760	6 450 633 480	
		Denominator	1 576 417		1 577 172	396 031	1 577 172	394 293	394 293	394 293	394 293	1 577 172	1 577 172	

Explanation of planned performance over the medium-term period

The bed utilisation rate is affected by the decline in number of admissions at hospitals and decent them to be managed Primary Health Care (PHC) facilities at community level. However, patients are not keen to go to smaller hospitals or PHC where there are no specialists' medical interventions. Currently the province has a high number of district hospitals with poor efficiencies and thinly spread resources with direct referral into the expensive higher-level facilities.

To increase maternity waiting beds for high-risk patients so that they are closely observed until delivery. Improvement will be sought through finalisation of the optimisation process.

Patient Experience of Care survey is a critical initiative to source feedback from the service users to establish the level of satisfaction. There has been non-compliance with regards to six ministerial priority areas especially Infection Prevention & Control. The department is concentrating on improving laundry services, availability of hand wash facilities, procurement of linen patient clothing and hand wash facilities is part of the endeavours to improve patient satisfaction.

Handwash drives is one of the strategies to ensure that health personnel are aware of the impact of proper handwashing to prevent health acquired infections that can result in medico legal lawsuits

Patient Safety Incidents reporting has improved significantly through strengthening of Clinical Governance, inculcating the culture of timeous reporting and management of Patient Safety Incidents when they arise. Continuous trainings will be conducted, and overseeing that clinical audits are conducted to prevent occurrence and recurrence of patient safety incidents.

To fully utilise the Ideal Hospital Realisation tool as an important vehicle for the hospitals to assess performance periodically, identify gaps and develop turnaround strategies for poor/non-performance.

To improve maternal and child health through constant vigilance by conducting clinical audits as part of prevention strategy to curb the mortality rate and reduce Patient Safety Incidents.

Increasing the number of maternal waiting beds for high-risk pregnant women will be key for close observation and management before delivery.

Enhancing growth monitoring through clinical governance structures within the facility by prioritising essential equipment. Forging relations with PHC facilities in the catchment population for community engagement and education regarding malnutrition and childhood illnesses.

2.10 Programme Resource Consideration

Table 23: Summary of payments and estimates by sub-programme: Programme 2: District Health Services

R thousand	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2024/25
	2021/22	2022/23	2023/24	2024/25			2025/26	2026/27	2027/28	
1. District Management	1 107 030	1 084 075	1 035 993	1 080 408	1 074 930	1 030 453	1 086 510	1 150 410	1 179 821	5,4
2. Community Health Clinics	3 196 102	2 942 147	3 284 094	2 903 549	2 781 239	3 182 723	3 000 844	3 297 201	3 327 978	(5,7)
3. Community Health Centres	1 417 103	1 409 766	1 541 482	1 533 299	1 531 947	1 534 925	1 579 790	1 633 211	1 698 596	2,9
4. Community Based Services	585 025	819 164	789 961	864 597	864 597	804 852	867 187	915 379	956 574	7,7
5. Other Community Services	77 412	208 015	54 756	75 956	75 956	67 843	87 972	81 420	85 005	29,7
6. Hiv/Aids	2 851 055	2 795 830	2 696 995	2 833 287	2 833 681	2 833 679	2 853 800	3 137 853	3 279 727	0,7
7. Nutrition	30 100	31 097	30 355	38 720	38 720	24 827	38 714	40 510	42 316	55,9
8. Coroner Services	137 156	132 897	142 661	116 596	121 256	127 958	126 307	131 215	137 111	(1,3)
9. District Hospitals	5 693 894	5 654 230	6 041 896	6 121 592	6 337 719	6 132 000	6 132 202	6 279 149	6 643 371	0,0
Total payments and estimates	15 094 877	15 077 221	15 618 193	15 568 004	15 660 045	15 739 260	15 773 326	16 666 348	17 350 499	0,2

Table 23 above shows the summary of payments and estimates for District Health Services from 2021/22 to 2024/25 per sub-programme and economic classification. The programme's total expenditure increased from R15.094 billion in 2021/22 to a revised estimate of R15.739 billion in 2024/25. In 2025/26, the budget shows minimal increase of 0.2 per cent from R15.739 billion to R15.773 billion when compared to the 2024/25 revised estimate due to additional funding for wage agreement and funding for the medicines, medical supplies, medical gas, surgical implants, property payments, food for patients and medical and chemical waste. In 2025/26 and 2027/28, the programme allocation amounts to R16.666 billion and R17.350 billion respectively.

Table 24: Summary of payments and estimates by economic classification: P2- District Health Services

R thousand	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2024/25
	2021/22	2022/23	2023/24				2025/26	2026/27	2027/28	
Current payments	14 810 440	14 663 863	15 202 615	15 232 678	15 272 766	15 333 669	15 474 498	16 380 701	17 052 000	0,9
Compensation of employees	10 117 843	10 137 436	10 770 463	10 824 105	10 816 710	10 796 259	11 134 063	11 512 202	11 774 738	3,1
Goods and services	4 691 268	4 504 824	4 424 004	4 408 573	4 456 056	4 537 410	4 340 435	4 868 499	5 277 262	(4,3)
Interest and rent on land	1 329	21 603	8 148	–	–	–	–	–	–	–
Transfers and subsidies to:	113 039	296 649	278 389	149 993	206 028	224 340	131 354	151 920	158 756	(41,4)
Provinces and municipalities	–	–	–	–	–	–	–	–	–	–
Departmental agencies and accounts	–	–	–	–	–	–	–	–	–	–
Higher education institutions	–	–	–	–	–	–	–	–	–	–
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–	–
Public corporations and private enterprises	–	–	–	–	–	–	–	–	–	–
Non-profit institutions	–	26 528	35 450	35 942	35 942	35 942	17 892	29 874	31 218	(50,2)
Households	113 039	270 121	242 939	114 051	170 086	188 398	113 462	122 046	127 538	(39,8)
Payments for capital assets	171 398	116 709	137 189	185 333	181 251	181 251	167 474	133 727	139 743	(7,6)
Buildings and other fixed structures	–	–	2 257	–	–	–	–	–	–	–
Machinery and equipment	171 398	116 709	134 932	185 333	181 251	181 251	167 474	133 727	139 743	(7,6)
Heritage Assets	–	–	–	–	–	–	–	–	–	–
Specialised military assets	–	–	–	–	–	–	–	–	–	–
Biological assets	–	–	–	–	–	–	–	–	–	–
Land and sub-soil assets	–	–	–	–	–	–	–	–	–	–
Software and other intangible assets	–	–	–	–	–	–	–	–	–	–
Payments for financial assets	–	–	–	–	–	–	–	–	–	–
Total economic classification	15 094 877	15 077 221	15 618 193	15 568 004	15 660 045	15 739 260	15 773 326	16 666 348	17 350 499	0,2

Table 24 above shows the summary of payments and estimates for District Health Services from 2021/22 to 2024/25 and over the 2025 MTEF per economic classification.

Compensation of Employees and Goods and services, which make up current payments, are the major cost drivers of the programme. Compensation of Employees shows growth of 3.1 per cent from R10.796 billion to R11.134 billion when compared to the 2024/25 revised estimate due to additional allocation for wage agreement.

Goods and services show a negative growth of 4.3 per cent from R4.537 billion to R4.340 billion when compared to the 2024/25 revised estimate due to high revised estimate resulting from over expenditure emanating from the payment of accruals and payables.

Transfers and subsidies show a negative growth of 41.4 per cent from R224.340 million to R131.354 million when compared to the 2024/25 revised estimate due to high revised estimates resulting from the payment of medico legal claims.

Payments for capital assets show a negative growth of 7.6 per cent from R181.251 million to R167.474 million when compared to the 2024/25 due to budget cuts for the Broadband.

2.11 Key Risks

The table below outlines the key risks.

Table 25: Key Risks and mitigating factors

Outcome	Risk	Mitigating factors
- HIV/ AIDS related deaths reduced - TB incidence reduced by 10% - TB Mortality reduced by 10% - Malaria related deaths reduced	- Lack of leadership in coordination of Primary Health Care Services at sub district level - Non adherence to National Guidelines and Policies on management of TB, HIV & AIDS and STI patients resulting to inadequate management of client with HIV, TB & STI	- Filing of funded strategic posts In the ARP. - Strengthened Infection Prevention and Control strategies. - Conduct monitoring support visits to districts and facilities quarterly. - Twelve decentralised sites to be converted to fully fledged MDR sites with the necessary resources. - Conduct HAST awareness campaign roadshows in all districts/metros. - Conduct a comprehensive training of HAST Programmes for the Outreach Teams. - Enforce compliance with policies, procedures and SOPs. - Continuous monitoring and analysis of patient data reports.
- Maternal Mortality in Facility Ratio reduced - Neonatal deaths (0-28 days) in facility rate reduced	High Maternal and Perinatal Mortality Rate	- Implementation of the quarterly community mobilisation and education in each district. - Revive & strengthen District Hospital Neonatal units (increase resources and training). - Establishment of rehabilitation units for children with Cerebral Palsy in priority hospitals. - Implementation of prioritised posts in Annual Recruitment Plan. - Conduct monitoring support visits and continuously monitoring the trends from the analysis reports. - Implementation of meetings action list
Death under 5 years against live birth rate reduced	High Child Mortality Rate	- Continuous training and capacitation of staff personnel on Child Health Policy Guidelines. - Monitoring the implementation of immunisation catch-up campaigns. - Conduct monitoring support visits to priority Institutions. - Ensure monitoring and implementation of the Annual Recruitment Plan. - Implementation of meetings actions list.
- Mortality due to NCDs reduced - Mental Health Care Integrated into Primary health care	Challenges with prevention, early detection and management of Non-Communicable and Chronic Diseases.	- Continuous training and capacitation of staff on management of chronic diseases. - Implementation of meetings actions list.

ANNUAL PERFORMANCE PLAN 2025/26-2027/28

PROGRAMME

03

EMERGENCY MEDICAL SERVICES (EMS)



PROGRAMME 3: EMERGENCY MEDICAL SERVICES (EMS)

Programme Purpose

To render quality and efficient prehospital emergency services, inter-hospital transfers and planned patient transport services. Based on the current structure, Emergency Medical Services has two sub-programs.

Sub-Programme 3.1: Emergency Transport: The sub-program is solely for emergency incidents (prehospital care and inter-hospital transfer) and has components that underpin its functionality:

- Communication Services: Call taking and dispatching of emergency calls.
- Road ambulances and Aeromedical Services: modes of patient transport to definitive care.
- Specialised Services: Medical Rescue and Disaster Management.
- Inter facility transfers of patients between health facilities

Sub-Programme 3.2: Planned Patient Transport: The sub-program deals with non-emergency transport of booked outpatients to referral centre and patients referred to step-down facilities.

- This includes all ECDOH outpatient referral pathways: inter-district, intra-district and inter-provincial referrals.
- Pre booking is essential to map out drop off and pick up points for outpatients.

3.1 Sub-Programme: Emergency Transport

Sub-Programme Priorities

- Increase number of licensed ambulances and bases in accordance with EMS regulations (Ideal EMS status).
- Rollout of computer aided dispatch system and monitoring of call escalation rate.
- Maintain functional multi- sectoral committee for disaster management.
- Ensure optimal utilisation of air ambulance services

3.2 Sub-Programme: Planned Patient Transport

Sub-Programme Priorities

- Deployment or appointment of dedicated planned patient transport staff.
- Implementation of optimal fleet management system

Table 26: Outcomes, Outputs and Output indicators and targets for the next MTEF for Emergency Medical Services (EMS)

Outcome (as per SP 2025/26- 2029/30)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2021/22	2022/23	2023/24	2024/25	2025/26	2025/26 Quarterly Targets				2026/27	2027/28
								Q1	Q2	Q3	Q4		
12. Quality of health services improved	EMS response time adhered to	12.11.1 EMS PI urban response under 30 minutes rate	48.2%	55.2%	68.8%	67.2%	60%	60%	60%	60%	60%	65%	65%
		Numerator	26 228	23 555	25 095	6 771	21 875	5 468	5 469	5 469	5 469	23 698	23 698
		Denominator	54 436	42 647	36 459	10 082	36 459	9 114	9 115	9 115	9 115	36 459	36 459
		12.11.2 EMS PI rural response under 60 minutes rate	65.8%	64.4%	62.2%	61.3%	65%	65%	65%	65%	65%	66%	67%
		Numerator	72 893	54 875	52 502	12 525	54 848	13 712	13 712	13 712	13 712	55 692	56 536
		Denominator	110 831	85 144	84 382	20 424	84 382	21 095	21 095	21 096	21 096	84 382	84 382
	Functional PTVs available	12.11.3 Number of Patients transported on the PTV services	40 688	192 616	245 397	88 725	190 000	47 500	47 500	47 500	47 500	185 000	180 000

Explanation of planned performance over the medium-term period

The program has devised a strategy to enhance the performance in the response rate for priority one calls, inter-facility transfers, and planned patient transport services. These three elements of the program rely on a functional communication system, availability of adequately skilled staff in the category of emergency care officers, and appropriate equipment for managing patients, as well as the availability of suitably configured vehicles for emergency medical care.

The decentralisation of ambulance resources closer to communities is also set for expansion in the medium term. This approach is guided by the national norm of one ambulance per population of 10,000. The program has initiated the use of global positioning system (GPS) to coordinate and review the current locations of EMS bases across the province. This analysis aims to connect the EMS bases with the community and the referral health facility. The subsequent phase will then assess the rational positioning of bases to ensure proximity to the communities and referral health facilities. In addition to the population, the program is factoring in the geographical size of the area as this also affects the response time. Once this strategy's implementation is finalized, the response time will be reduced as ambulances, when dispatched, will originate from the local base closer to communities.

A second method of decentralisation involves assigning dedicated ambulances at priority hospitals for inter-facility transfers. The program has initiated the placement of ambulances at high-volume hospitals to handle referrals (both upward and downward) and discharges. Inter-facility transfers constitute the majority of cases managed by EMS, often exceeding 30% per quarter. These cases mainly involve patients being referred to the next level of care and discharges from higher levels of care to district hospitals. An increase in inter-facility transfer cases leads to delays in responding to pre-hospital emergencies from the community. The program has introduced a method to assign ambulances at selected hospitals exclusively for inter-facility transfer cases. Already, an ambulance is stationed at Nelson Mandela Academic Hospital for referrals between NMAH, Mthatha Regional, and Bedford Orthopaedic hospitals. A similar service is provided at health centers in Gqeberha to transport critical patients from the health center to either Livingstone Tertiary or Dorah Nginza Regional hospitals.

Over the medium term, the program will expand the service to other hospitals in the list of 28 priority hospitals, commencing in the 2025/26 financial year with Butterworth, Bhisho, Grey, and Tafalofefe hospitals. Enhancing response times for priority I calls in both rural districts and urban metropolitan municipalities directly contributes to the provincial objective of enhancing the quality of healthcare for all Eastern Cape residents. Priority I calls mainly encompass maternal and neonatal care, cardiac-related incidents, and trauma incidents. The capability to respond to these incidents by qualified emergency care practitioners, with appropriate equipment, will ensure that the healthcare quality provided to the community and residents of the Eastern Cape is of the highest caliber. Since the majority of priority I cases necessitate advanced emergency care skills, the department will invest in increasing the number of paramedics with specialized skills to manage

emergencies. The deployment of these paramedics will prioritize rural districts such as Alfred Nzo, Joe Gqabi, Amathole, OR Tambo, and Sarah Baartman.

Other resources allocated to enhance response times to priority 1 calls include the air ambulance (helicopter ambulance and fixed-wing aircraft). The helicopter will operate from Nelson Mandela Metro, Buffalo City Metro, and OR Tambo district. These locations will serve as primary points, while the service will be accessible to the entire province, western districts, central/northern districts, and eastern districts respectively. The service will be dispatched to highly critical emergencies, especially in hard-to-reach parts of the province where road transfer would be time-consuming, potentially compromising care outcomes. Additionally, the program will utilize a fixed-wing air ambulance service on an ad hoc basis to transfer patients to specialist hospitals in the Western Cape and Kwa-Zulu Natal provinces.

The program is planning to refine the coordination and planning of the planned patient transport services, which transport stable patients for reviews and assessments to regional, tertiary, and specialized hospitals. There is a necessity to transition the booking system and route planning to an electronic format, making it visible to all clinical users. The Planned Patient Transport (PPT) service remains a crucial component in facilitating patient access to services.

The completion of the rollout of the electronic call-taking and dispatch solution is slated for this financial year. The program has invested in computer equipment and infrastructure, as well as customized the solution for electronic call-taking and dispatch over the past year. Additional call takers have been recruited and trained on call taking and dispatch at the EMS College in Gqeberha. Network connectivity challenges, both local and wide area network, have been addressed at the designated locations for the rollout. Interoperability with other applications such as the vehicle tracker has been finalized. The remaining project period will be dedicated to implementing the solution and addressing potential maintenance needs. Call takers and dispatchers at the EMS communication centers will continue to receive training on the solution and be supported to deliver efficient customer care and allocate EMS resources effectively to the community.

Frequent telephone network outages due to power interruptions and cable theft often impede community access to the EMS communication centers. The program will establish a system to divert calls during network disruptions to the department's shared contact centers and explore utilizing the SA Police Services lines and disaster management call centers in respective districts. This is to ensure minimal inconvenience to the community when ambulance services are needed. Long-term solutions to the power outages and cable theft issues will be explored comprehensively as part of government interventions.

The program is also making significant efforts to ensure compliance with the Emergency Medical Services regulations (Health Act 61 of 2003 as amended). Over the medium term, the department will allocate resources to renovate the EMS stations to provide appropriate wash bays and comply with occupational health and safety standards. The enhancement of staff from the basic life support category to higher levels will be supported by the human resource development program.

The successful attainment of the targets in program 3 also necessitated collaboration with stakeholders such as local community leaders and the police to safeguard staff responding to emergencies.

The program has observed a rise in ambulance calls, placing strain on the limited available resources. The department will launch an initiative to educate communities on the utilization of ambulance services and the types of cases and incidents warranting ambulance assistance. This initiative aims to reduce the number of non-emergency cases referred to ambulance services.

The program is planning to refine the coordination and planning of the planned patient transport services, which transport stable patients for reviews and assessments to tertiary and specialized care. The transition of the booking system and route planning to electronic format, making it visible to all clinical users, is imperative. The PPT service remains a vital component in facilitating patient access to services. The program will collaborate with programs 4 and 5 to expand the outreach services bringing specialist care to patients in their local communities. The Chronic Medicines Dispensing and Distribution (CCMDD) initiative will make medications more accessible to patients without requiring them to travel long distances for prescription refills. The successful achievement of the targets in programme 3 also required cooperation with such stakeholders as local community leader and the police to protect the staff when responding to emergencies.

3.2 PROGRAMME RESOURCE CONSIDERATION

Table 27: Summary of payments and estimates by sub-programme: Programme 3: Emergency Medical Services

R thousand	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2024/25
	2021/22	2022/23	2023/24	2024/25			2025/26	2026/27	2027/28	
1. Emergency Transport	1 089 966	1 209 639	1 069 678	1 289 079	1 291 030	1 203 015	1 350 299	1 348 232	1 432 896	12,2
2. Planned Patient Transport	263 556	243 238	290 707	273 553	273 553	293 405	288 407	301 868	316 318	(1,7)
Total payments and estimates	1 353 522	1 452 877	1 360 385	1 562 632	1 564 583	1 496 420	1 638 706	1 650 100	1 749 214	9,5

Table 27 above show the summary of payments and estimates for Emergency Medical Services from 2021/22 to 2024/25 and over the 2025 MTEF per sub-programme. The programme's total expenditure increased from R1.353 billion in 2021/22 to a revised estimate of R1.496 billion in 2024/25. In 2025/26, the budget increased by 9.5 per cent from R1.496 billion to R1.638 billion when compared to the 2024/25 revised estimate due to additional funding for the wage agreement.

Table 28: Summary of payments and estimates by sub-programme: Programme 3: Emergency Medical Services

R thousand	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2024/25
	2021/22	2022/23	2023/24	2024/25			2025/26	2026/27	2027/28	
Current payments	1 210 602	1 264 249	1 217 706	1 436 326	1 438 277	1 370 052	1 506 741	1 512 064	1 604 966	10,0
Compensation of employees	998 795	1 022 603	1 049 361	1 163 141	1 163 141	1 068 411	1 200 076	1 151 493	1 227 943	12,3
Goods and services	211 807	241 646	168 345	273 185	275 136	301 641	306 665	360 571	377 023	1,7
Interest and rent on land	–	–	–	–	–	–	–	–	–	
Transfers and subsidies to:	3 971	3 028	2 846	4 216	4 216	4 278	4 405	4 608	4 815	3,0
Provinces and municipalities	–	–	–	–	–	–	–	–	–	
Departmental agencies and accounts	–	–	–	–	–	–	–	–	–	
Higher education institutions	–	–	–	–	–	–	–	–	–	
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–	
Public corporations and private enterprises	–	–	–	–	–	–	–	–	–	
Non-profit institutions	–	–	–	–	–	–	–	–	–	
Households	3 971	3 028	2 846	4 216	4 216	4 278	4 405	4 608	4 815	3,0
Payments for capital assets	138 949	185 600	139 833	122 090	122 090	122 090	127 560	133 428	139 433	4,5
Buildings and other fixed structures	–	–	–	–	–	–	–	–	–	
Machinery and equipment	138 949	185 600	139 833	122 090	122 090	122 090	127 560	133 428	139 433	4,5
Heritage Assets	–	–	–	–	–	–	–	–	–	
Specialised military assets	–	–	–	–	–	–	–	–	–	
Biological assets	–	–	–	–	–	–	–	–	–	
Land and sub-soil assets	–	–	–	–	–	–	–	–	–	
Software and other intangible assets	–	–	–	–	–	–	–	–	–	
Payments for financial assets	–	–	–	–	–	–	–	–	–	
Total economic classification	1 353 522	1 452 877	1 360 385	1 562 632	1 564 583	1 496 420	1 638 706	1 650 100	1 749 214	9,5

Table 28 above shows the summary of payments and estimates for Emergency Medical Services from 2021/22 to 2024/25 and over the 2025 MTEF period per economic classification.

Compensation of Employees shows a growth of 12.3 per cent from R1.068 billion to R1.200 billion in 2025/26 when compared to the 2024/25 revised estimate due additional funding for wage agreement.

Goods and services show a growth 1.7 per cent from R301.641 million to R306.665 million when compared to the 2024/25 revised estimate due to additional funding for the payment of accruals and payables for the non-negotiable items.

Transfers and subsidies show a growth of 3 per cent from R4.278 million to R4.405 million when compared to the 2024/25 revised estimate due to provision for payment of leave gratuities.

Payments for capital assets show a growth of 4.5 per cent from R122.090 million to R127.560 million when compared to the 2024/25 revised estimate due to high 2025/26 indicative budget attributed to previous reprioritisation implemented to fund fleet management shortfall.

3.3 Key Risks

The table below outlines the key risks.

Table 29: Key Risks and mitigating factors

Outcome	Risk	Mitigating factors
Quality of health services improved.	Inadequate EMS Services	- Filling of funded strategic posts. - Introduction and training of personnel. - Ensure the implementation of the electronic call taking dispatch system. - Increase the number of functional vehicles suitable for the rural terrain. - Integrated quarterly management and human capital (supervision, labour relations, development). - Establish a formal memorandum of understanding between DOH/EMS and provincial SAPS and Transport. - Introduction and training of personnel.

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PROGRAMME

04

**PROVINCIAL HOSPITAL SERVICES
(REGIONAL AND SPECIALISED)**



PROGRAMME 4: PROVINCIAL HOSPITAL SERVICES (REGIONAL AND SPECIALISED)

Programme Purpose

To provide cost-effective, good quality secondary hospital services and specialised services, which include psychiatry and TB hospital services.

Sub-Programme 4.1 - General (Regional) Hospitals

General (Regional) Hospital Services: Rendering of hospital services at general specialist level and providing a platform for research and the training of health workers:

- Cecilia Makiwane
- Frontier
- St Elizabeth
- Dora Nginza
- Mthatha

Sub-Programme 4.2 - Tuberculosis (TB) Hospitals

TB hospital Services: To convert current tuberculosis hospitals into strategically placed centres of excellence in which a small percentage of patients may undergo hospitalization under conditions that allow for isolation during the intensive phase of treatment, as well as the application of the standard multi-drug resistant (MDR) protocols:

- Jose Pearson
- Nkqubela
- Majorie Parish
- PZ Meyer
- Majorie Parks
- Winter Berg
- Khotsong

Sub-Programme 4.3 - Psychiatric / Mental Hospitals

Psychiatric Mental Hospital Services: Rendering a specialist psychiatric hospital service for people with mental illness and intellectual disability and providing a platform for training of health workers and research:

- Elizabeth Donkin Psychiatric hospital
- Komani Psychiatric hospital
- Tower Psychiatric hospital – provide long-term.
- Cecilia Makiwane hospital acute psychiatric Unit
- Holy Cross hospital acute psychiatric Unit
- Mthatha Regional hospital acute psychiatric Unit
- Dora Nginza hospital: 72-hour observation Unit

4.1 Sub-Programme: - General (Regional) Hospitals

Table 30: Outcomes, Outputs and Output indicators and targets for the next MTEF for Regional Hospitals

Outcome (as per SP 2025/26- 2029/30)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets							
			2021/22	2022/23	2023/24		2024/25	2025/26	2025/26 Quarterly Targets				2026/27	2027/28
									Q1	Q2	Q3	Q4		
11. Improved Patient Experience of Care	Patient satisfaction surveys conducted	11.1.4 Patient Experience of Care survey rate	New Indicator	New Indicator	New Indicator	New Indicator	100%		100%			100%	100%	
		Numerator				5		5			5	5		
		Denominator				5		5			5	5		
12. Quality of health services improved	Patient Safety Improved	12.6.7 Severity Assessment Code (SAC)I incident reported within 24 hours rate	75%	90%	93%	90%	93%	93%	93%	93%	93%	94%	95%	
		Numerator	394	624	438	73	439	109	110	110	110	444	448	
		Denominator	449	696	472	81	472	118	118	118	118	472	472	
		12.6.8 Patient Safety Incident (PSI) case closure rate	New Indicator	93.4%	97%	90%	96%	96%	96%	96%	96%	97%	98%	
		Numerator			661	113	652	163	163	163	163	658	665	
		Denominator			679	125	679	169	170	170	170	679	679	
	Efficiency indicators improved	12.10.4 Average length of stay	5.8 days	6.2 days	6.4 days	5.3 days	5.7 days	5.7days	5.7 days	5.7 days	5.7 days	5.7 days	5.7 days	
		Numerator	518 553		543 278	133 005	488 070	122 017	122 018	122 018	122 017	488 070	488 070	
		Denominator	88 740		84 259	20 984	84 259	21 064	21 065	21 065	21 065	84 259	84 259	

Outcome (as per SP 2025/26- 2029/30)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets							
			2021/22	2022/23	2023/24		2024/25	2025/26	2025/26 Quarterly Targets				2026/27	2027/28
									Q1	Q2	Q3	Q4		
		12.10.5 Inpatient (usable) bed utilisation rates	New Indicator	68.4%	72.6%	71.2%	72%	72%	72%	72%	72%	73%	74%	
		Numerator		527 157.5	543 278.5	133 005	538 602	134 650	134 650	134 651	134 651	546 082	553 563	
		Denominator		770 934.1	748 058	186 718	748 058	187 014	187 014	187 015	187 015	748 058	748 058	
		12.10.6 Expenditure per PDE	R3,921	R3,984	R4 276.2	R4,171	R4,548	R4,548	R4,548	R4,548	R4,548	R4,558	R4,568	
		Numerator	R2 726 081 943	2 878 883	3 264 138 883,3	776 727 603.2	3 471 773 936	867 943 484	867 943 484	867 943 484	867 943 484	3 479 253 582	3 486 886 872	
		Denominator	695 292	722 684	763 329	186 203	763 329	190 832	190 832	190 832	190 833	763 329	763 329	

4.2 Sub – Programme: Tuberculosis (TB) Hospitals

Table 31: Outcomes, Outputs and Output indicators and targets for the next MTEF for Tuberculosis (TB) Hospitals

Outcome (as per SP 2025/26- 2029/30)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets							
			2021/22	2022/23	2023/24		2024/25	2025/26	2025/26 Quarterly Targets				2026/27	2027/28
									Q1	Q2	Q3	Q4		
11. Improved Patient Experience of Care	Patient satisfaction surveys conducted	11.1.5 Patient Experience of Care survey rate	New Indicator	New Indicator	New Indicator	New Indicator	100%		100%			100%	100%	
		Numerator					7		7			7	7	
		Denominator					7		7			7	7	

Outcome (as per SP 2025/26- 2029/30)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2021/22	2022/23	2023/24	2024/25	2025/26	2025/26 Quarterly Targets				2026/27	2027/28
								Q1	Q2	Q3	Q4		
12. Quality of health services improved	Patient Safety Improved	12.6.9 Severity Assessment Code (SAC)I incident reported within 24 hours rate	50%	75%	86%	100%	90%	90%	90%	90%	90%	90%	90%
		Numerator	1	6	6	1	9	9	9	9	9	9	9
		Denominator	2	8	7	1	10	10	10	10	10	10	10
		12.6.10 Patient Safety Incident (PSI) case closure rate	New Indicator	98%	100%	92.8%	91%	91%	91%	91%	91%	91%	91%
		Numerator			77	13	80	20	20	20	20	80	80
		Denominator			77	14	88	22	22	22	22	88	88
	Hospital efficiencies improved	12.10.7 Average length of stay	41 days	42.4 days	37.1 days	36.4 days	40 days	40 days	40 days	40 days	40 days	40 days	40 days
		Numerator	113 797	26.9% 129 296	129 344.5	28 571	139 320	34 830	34 830	34 830	34 830	139 320	139 320
		Denominator	2 776	3 049	3 483	785	3 483	871	871	871	870	3 483	3 483
		12.10.8 Inpatient (usable) bed utilisation rates	New Indicator	26.9%	31%	27.1%	30%	30%	30%	30%	30%	30%	30%
		Numerator		129 296	129 344.5	28 571	125 172	31 293	31 293	31 293	31 293	125 172	125 172
		Denominator		481 487.8	417 240.7	105 496.6	417 240	104 310	104 310	104 310	104 310	417 240	417 240
		12.10.9 Expenditure per PDE	R3 887.5	R3 286.2	R3 461.4	R3,695	R3,800	R3,800	R3,800	R3,800	R3,800	R3,810	R3,820
		Numerator	R458 255 800.5		459 603 682.8	108 103 206.1	504 560 200	126 140 050	126 140 050	126 140 050	126 140 050	505 887 990	507 215 780
		Denominator	117 880		132 779	29 253	132 779	33 195	33 195	33 195	33 194	132 779	132 779

4.3 Sub – Programme: Psychiatric / Mental Hospitals

Sub- Programme Priorities

- Development of District Mental Health Specialist Teams.
- Creating Mental Health Units in districts, regional and tertiary hospitals.
- Screening of Mental Health patients at PHC and district levels.
- Re capacitation of the clinical health professionals on mental health programmes.

Table 32: Outcomes, Outputs and Output indicators and targets for the next MTEF for Psychiatric / Mental Hospitals

Outcome (as per SP 2025/26- 2029/30)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performa nce	MTEF Targets						
			2021/22	2022/23	2023/24		2024/25	2025/26	2025/26 Quarterly Targets				2026/27
		Q1				Q2			Q3	Q4			
11. Improved Patient Experience of Care	Patient satisfaction surveys conducted	11.1.6. Patient Experience of Care survey rate	New Indicator	New Indicator	New Indicator	New Indicator	100%	-	100%	-	-	100%	100%
		Numerator					3		3			3	3
		Denominator					3		3			3	3
12. Quality of health services improved	Patient Safety Improved	12.6.11 Severity Assessment Code (SAC) I incident reported within 24 hours rate	80%	93.3%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Numerator	4	28	34	5	31	7	8	8	8	31	31
		Denominator	5	30	34	5	31	7	8	8	8	31	31
		12.6.12 Patient Safety Incident (PSI) case closure rate	New Indicator	98.5%	96%	100%	97%	97%	97%	97%	97%	99%	100%
		Numerator			343	67	262	65	65	65	65	265	268
		Denominator			356	67	268	67	67	67	67	268	268

Explanation of planned performance over the medium-term period

The department is currently finalizing the selection process for vacant and crucial leadership positions in four regional hospitals. The role of Chief Executive Officer (CEO) at Frontier Regional Hospital, recently vacated, will be filled to enhance governance and leadership. Additionally, the enhancement of clinical management will be pursued through the recruitment of specialized professionals at Cecilia Makiwane, Frontier, and Dora Nginza hospitals. Clinical leadership will focus on direct clinical care and improved outcomes, particularly through an outreach program aimed at reducing surgical backlogs. Moreover, the establishment of regional clinical governance committees and subcommittees targeting various clinical domains within healthcare facilities will enhance clinical governance.

The department is placing a priority on implementing regional clinical services at Oliver and Adelaide Tambo District Hospital in two distinct phases. The initial phase will concentrate on Obstetrics and Gynecology, General Surgery, Family Medicine, Orthopedics, Pediatrics, and Anesthesiology. The subsequent phase, expected to be completed within three years, will introduce Internal Medicine, Ophthalmology, and Dermatology. By establishing specialized regional services at OARTH, the necessity for referrals to Nelson Mandela Academic Hospital will be minimized, thereby bringing essential medical services closer to local communities. Additional strategic measures include reallocating funds from Program 2 to Program 4, implementing a more sophisticated organizational structure, and restructuring reporting protocols from the District office to the Chief Directorate of Hospital Services within the Regional Hospitals sub-program.

4.4 PROGRAMME RESOURCE CONSIDERATION

Table 33: Summary of payments of estimates: Programme 4 – Provincial Hospital Services

Outcome				Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2024/25
R thousand	2021/22	2022/23	2023/24	2024/25			2025/26	2026/27	2027/28	
1. General (Regional) Hospitals	2 748 880	2 909 523	3 181 458	3 063 292	3 155 779	3 448 154	3 446 233	3 459 611	3 672 879	(0,1)
2. TB Hospitals	382 771	387 954	411 707	473 078	462 398	465 489	488 181	513 594	530 447	4,9
3. Psychiatric Mental Hospitals	554 702	629 233	660 175	694 798	731 850	733 369	767 419	728 881	753 931	4,6
Total payments and estimates	3 686 353	3 926 710	4 253 340	4 231 168	4 350 027	4 647 012	4 701 833	4 702 086	4 957 257	1,2

Table 33 above shows the summary of payments and estimates for Provincial Hospital Services from 2021/22 to 2024/25 and over the 2025 MTEF period per sub-programme. The programme's total expenditure increased from R3.686 billion in 2021/22 to a revised estimate of R4.647 billion in 2024/25. In 2025/26, the budget shows a minimal increase to 1.2 per cent from R4.647 billion to R4.701 billion when compared to the 2024/25 revised estimate due to additional funding for the wage agreement and funding for the medicines, medical supplies, medical gas, surgical implants, property payments, food for patients and medical and chemical waste.

Table 34: Summary of payments and estimates by economic classification: P4 – Provincial Hospitals

R thousand	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2024/25
	2021/22	2022/23	2023/24	2024/25			2025/26	2026/27	2027/28	
Current payments	3 646 550	3 797 684	4 103 701	4 100 126	4 186 167	4 468 175	4 635 634	4 633 308	4 885 384	3,7
Compensation of employees	2 979 731	3 056 817	3 323 115	3 085 561	3 133 718	3 465 235	3 510 692	3 584 587	3 813 462	1,3
Goods and services	666 224	728 650	777 252	1 014 565	1 052 449	1 002 940	1 124 942	1 048 721	1 071 922	12,2
Interest and rent on land	595	12 217	3 334	–	–	–	–	–	–	
Transfers and subsidies to:	25 773	120 207	140 192	60 991	93 033	108 010	53 063	55 037	57 514	(50,9)
Provinces and municipalities	–	–	–	–	–	–	–	–	–	
Departmental agencies and accounts	–	–	–	–	–	–	–	–	–	
Higher education institutions	–	–	–	–	–	–	–	–	–	
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–	
Public corporations and private enterprises	–	–	–	–	–	–	–	–	–	
Non-profit institutions	–	–	–	–	–	–	–	–	–	
Households	25 773	120 207	140 192	60 991	93 033	108 010	53 063	55 037	57 514	(50,9)
Payments for capital assets	14 030	8 819	9 447	70 051	70 827	70 827	13 136	13 741	14 359	(81,5)
Buildings and other fixed structures	–	–	–	–	–	–	–	–	–	
Machinery and equipment	14 030	8 819	9 447	70 051	70 827	70 827	13 136	13 741	14 359	(81,5)
Heritage Assets	–	–	–	–	–	–	–	–	–	
Specialised military assets	–	–	–	–	–	–	–	–	–	
Biological assets	–	–	–	–	–	–	–	–	–	
Land and sub-soil assets	–	–	–	–	–	–	–	–	–	
Software and other intangible assets	–	–	–	–	–	–	–	–	–	
Payments for financial assets	–	–	–	–	–	–	–	–	–	
Total economic classification	3 686 353	3 926 710	4 253 340	4 231 168	4 350 027	4 647 012	4 701 833	4 702 086	4 957 257	1,2

Table 34 above shows the summary of payments and estimates for Provincial Hospital Services per economic classification.

Compensation of Employees shows a growth of 1.3 per cent from R3.465 billion to R3.510 billion in 2025/26 when compared to the 2024/25 revised estimate due to additional funding for the wage agreement.

Goods and services show a growth of 12.2 per cent from R1.002 billion to R1.124 billion in 2025/26 when compared to the 2024/25 revised estimate due to additional funding for the medicines, medical supplies, medical gas, surgical implants, property payments, food for patients and medical and chemical waste.

Transfers and subsidies show a negative growth of 50.9 per cent from R108.010 million to R53.063 million in 2025/26 when compared to the 2024/25 revised estimate due to a high revised estimate attributable to the payment of Medico Legal Claims.

Payments for capital assets show a negative growth of 81.5 per cent from R70.827 million to R13.136 million in 2025/26 when compared to the 2024/25 revised estimate, due to high revised estimate in 2024/25 emanating from reprioritisation during 2024 MTEF for purchase of medical equipment and assistive devices in General Hospitals.

4.5 Key Risks

The table below outlines the key risks.

Table 35: Key Risks and mitigating factors

Outcome	Risk	Mitigating factors
- Improved Patient Experience of Care - Quality of health services improved.	Non-adherence to policies and guidelines on referrals and services between Primary, Secondary and Tertiary Services.	- Implementation of the referral policy / protocol. - Strengthen the clinical services platform. - Functional Hospital Boards - Ensure timeous filling of critical and replacement posts. - Enforcement of policies and SOPs. - Implementation of the meeting resolutions. - Strengthen the quality of reports. - Procurement of appropriate healthcare technology as per APP.

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PROGRAMME

05

CENTRAL & TERTIARY HOSPITAL SERVICES



PROGRAMME 5: CENTRAL & TERTIARY HOSPITAL SERVICES

5.1 Sub-programme: Central Hospital Services

Central Hospital: Nelson Mandela Academic Hospital

Sub-Programme Purpose

To strengthen and continuously develop the modern tertiary services platform to adequate levels to be responsive to the demands of the specialist service needs of the community of the Eastern Cape Province. There are two Tertiary hospitals (Frere and Livingstone hospitals) and one Central hospital (Nelson Mandela Academic) in the Eastern Cape Province:

Table 36: Outcomes, Outputs and Output indicators and targets for the next MTEF for Central Hospital Services

Outcome (as per SP 2025/26- 2029/30)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets							
			2021/22	2022/23	2023/24		2024/25	2025/26	2025/26 Quarterly Targets				2026/27	2027/28
									Q1	Q2	Q3	Q4		
11. Improved Patient Experience of Care	Patient satisfaction surveys conducted	11.1.7 Patient Experience of Care survey rate	New Indicator	New Indicator	New Indicator	New Indicator	100%		100%			100%	100%	
		Numerator												
		Denominator												
12. Quality of health services improved	Patient Safety improved	12.6.13 Severity Assessment Code (SAC) I incident reported within 24 hours rate	63%	85%	92%	100%	91%	91%	91%	91%	91%	91%	92%	
		Numerator	135	205	196	4	192	48	48	48	48	193	195	
		Denominator	215	241	213	4	212	53	53	53	53	212	212	
		12.6.14 Patient Safety Incident (PSI) case closure rate	New Indicator	99%	99%	100%	100%	100%	100%	100%	100%	100%	100%	

Outcome (as per SP 2025/26- 2029/30)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets							
			2021/22	2022/23	2023/24		2024/25	2025/26	2025/26 Quarterly Targets				2026/27	2027/28
									Q1	Q2	Q3	Q4		
		Numerator			211	6	180	45	45	45	45	160	140	
		Denominator			213	6	180	45	45	45	45	160	140	
	Hospital efficiencies improved	12.10.10 Average length of stay	8.3 days	8.4 days	8.8 days	8.5days	8days	8days	8days	8days	8days	8days	8days	8days
		Numerator	220 348		208 283	49 209.5	189 240	47 310	47 310	47 310	47 310	189 240	189 240	
		Denominator	26 605		23 655	5 806	23 655	5 913	5 914	5 914	5 914	23 655	23 655	
		12.10.11 Inpatient (usable) bed utilisation rates	New Indicator	73.4%	75.3%	71.8%	80%	80%	80%	80%	80%	81%	82%	
		Numerator		203 213	208 283	49 209	221 360	55 340	55 340	55 340	55 340	224 127	226 894	
		Denominator		276 700	276 700	68 536.2	276 700	69 175	69 175	69 175	69 175	276 700	276 700	
		12.10.12 Expenditure per PDE	R4 831	R5,436	R6.683.9	R7,223	R6,800	R6,800	R6,800	R6,800	R6,800	R6,810	R6,820	
		Numerator	R1 425 746 512	R1 502 623 451	R1 909 806 838	R483 682 285	R1 942 970 800	R485 742 700	R485 742 700	R485 742 700	R485 742 700	R1 945 828 110	R1 948 68 5 420	
		Denominator	295 148	276 405	285 731	66 964	285 731	71 432	71 433	71 433	71 433	285 731	285 731	

5.2 Sub-Programmes: Provincial Tertiary Hospital Services

- Livingstone hospital
- Frere hospital

Sub-Programme Purpose

To strengthen and continuously develop the modern tertiary services platform to adequate levels in order to be responsive to the demands of the specialist service needs of the community of the Eastern Cape Province. There are two tertiary hospitals in the Eastern Cape Province:

Table 37: Outcomes, Outputs and Output indicators and targets for the next MTEF for Provincial Tertiary Hospital Services

Outcome (as per SP 2025/26- 2029/30)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets							
			2021/22	2022/23	2023/24		2024/25	2025/26	2025/26 Quarterly Targets				2026/27	2027/28
									Q1	Q2	Q3	Q4		
11. Improved Patient Experience of Care	Patient satisfaction surveys conducted	11.1.8 Patient Experience of Care survey rate	New Indicator	New Indicator	New Indicator	New Indicator	100%	-	100%	-	-	100%	100%	
		Numerator					2		2			2	2	
		Denominator					2		2			2	2	
12. Quality of health services improved	Patient safety improved	12.6.15 Severity Assessment Code (SAC) I incident reported within 24 hours	72%	88%	68%	96%	90%	90%	90%	90%	90%	91%	92%	
		Numerator	34	130	141	49	188	47	47	47	47	189	191	
		Denominator	47	148	208	51	208	52	52	52	52	208	208	
		12.6.16 Patient Safety Incident (PSI) case closure rate	New Indicator	93%	98%	99%	99%	99%	99%	99%	99%	100%	100%	
		Numerator			556	164	562	140	140	141	141	568	568	

Outcome (as per SP 2025/26- 2029/30)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets							
			2021/22	2022/23	2023/24		2024/25	2025/26	2025/26 Quarterly Targets				2026/27	2027/28
									Q1	Q2	Q3	Q4		
		Denominator			568	165	568	142	142	142	142	568	568	
	Hospital efficiencies improved	12.10.13 Average length of stay	5.6 days	6.8 days	6.8 days	7 days	6 days	6 days	6 days	6 days	6 days	6 days	6 days	
		Numerator	430 324		476 682.5	114 971	422 460	105 615	105 615	105 615	105 615	422 460	422 460	
		Denominator	76 783		70 410	16 479	70 410	17 602	17 602	17 603	17 603	70 410	70 410	
		12.10.14 Inpatient (usable) bed utilisation rates	New Indicator	68.8%	74.5%	71.9%	77%	77%	77%	77%	77%	78%	79%	
		Numerator		447 638	476 686.5	114 971	492 454	123 113	123 113	123 114	123 114	498 849	505 244	
		Denominator		650 501.3	639 550.1	159 887.5	639 550	159 887	159 887	159 888	159 888	639 550	639 550	
		12.10.15 Expenditure per PDE	R3 522	R4,021	R4 433.9	R5,178	R5,006	R5,006	R5,006	R5,006	R5,006	R5,010	R5,020	
		Numerator	R 671 922 270	R2 607 184 998	R3 070 107 079	R855 926 347	R3 466 254 520	R866 56 3 630	R866 56 3 630	R866 56 3 630	R866 563 630	R3 469 02 4 200	R3 475 9 48 400	
		Denominator	758 675	648 449	692 420	165 293	692 420	173 105	173 105	173 105	173 105	692 420	692 420	

Explanation of planned performance over the medium-term period

The department has been acquiring cutting-edge health technology equipment to enhance the quality of life in the Eastern Cape Province. Substantial advancements have been made in the development of oncology and radiotherapy services at the Nelson Mandela Academic Hospital in Mthatha. Furthermore, the department is set to introduce a highly specialised in vitro fertilisation service for the first time in the province at Nelson Mandela Academic Hospital, along with the procurement of equipment worth 10 million and the recruitment of clinical personnel.

To improve tertiary service provision, the department is focusing on the modernisation of tertiary services. This initiative includes upgrading existing services with state-of-the-art healthcare technology to offer highly specialised interventions and improve the quality and efficiency of service delivery. The enhancements will encompass COE, Goods and Services, Capital Equipment, and Computerized Health Systems. Additionally, these improvements will be extended to identified outreach facilities/interventions to expand tertiary services at St. Elizabeth, Madzikane Ka Zulu, and Butterworth.

The department's primary objective is to prioritize the establishment of an Oncology center at Nelson Mandela Academic Hospital, where such a service was previously unavailable. The allocation for the Oncology grant is currently project-based, with the province planning to utilize it for infrastructure development. Construction on-site is expected to commence in May 2025. In the meantime, chemotherapy services are operational at the NMAH Centre of Excellence, while patients requiring radiation treatment are referred to the Frere oncology unit. Nelson Mandela Academic Hospital remains dedicated to evolving into a comprehensive central hospital by continuously developing sub-specialties.

5.3 Sub-Programmes 5.3: Specialised Tertiary Hospital

- Fort England (Specialised Psychiatric Hospital)

Sub-Programme Purpose

To strengthen and continuously develop the modern tertiary services platform to adequate levels in order to be responsive to the demands of the specialist service needs of the community of the Eastern Cape Province. There is one specialised tertiary hospital in the Eastern Cape Province:

Table 38: Outcomes, Outputs and Output indicators and targets for the next MTEF for Specialised Tertiary Hospital

Outcome (as per SP 2025/26- 2029/30)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2021/22	2022/23	2023/24	2024/25	2025/26	2025/26 Quarterly Targets				2026/27	2027/28
								Q1	Q2	Q3	Q4		
11 Improved Patient Experience of Care	Patient satisfaction surveys conducted	11.1.9 Patient Experience of Care survey rate	New Indicator	New Indicator	New Indicator	New Indicator	100%	-	100%	-	-	100%	100%
		Numerator					1		1			1	1
		Denominator					1		1			1	1
12. Quality of health services improved	Patient safety improved	12.6.17 Severity Assessment Code (SAC)I incident reported within 24 hours rate	100%	93.3%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Numerator	3	28	3	2	12	3	3	3	3	13	13
		Denominator	3	30	3	2	12	3	3	2	3	13	13
		12.6.18 Patient Safety Incident (PSI) case closure rate	New Indicator	98.4%	99%	100%	100%	100%	100%	100%	100%	100%	100%
		Numerator			84	13	80	20	20	20	20	80	80
		Denominator			85	13	80	20	20	20	20	80	80

Explanation of planned performance over the medium-term period

The Department will continue strengthening the clinical governance platform and fill critical vacant positions within the fiscal consolidation measures to enhance financial prudence. Community participation will be strengthened through hospital board effectiveness.

5.4 PROGRAMME RESOURCE CONSIDERATION

Table 39: Summary of payments and estimates by sub-programme: Programme 5: Central Hospital Services

R thousand	Outcome			Main appropriation	Adjusted appropriation 2024/25	Revised estimate	Medium-term estimates			% change from 2024/25
	2021/22	2022/23	2023/24				2025/26	2026/27	2027/28	
1. Central Hospital Services	1 521 690	1 702 835	1 751 326	1 685 599	1 741 206	1 717 041	1 829 053	1 644 205	1 718 065	6.5
2. Provincial Tertiary Services	3 229 836	3 010 739	3 177 547	3 350 683	3 344 225	3 262 757	3 931 361	3 647 157	3 784 553	20.5
Total payments and estimates	4 751 526	4 713 574	4 928 873	5 036 282	5 085 431	4 979 798	5 760 414	5 291 362	5 502 618	15.7

Table 39 above shows the summary of payments and estimates for Central Hospital Services from 2021/22 to 2024/25 and over the 2025 MTEF per sub-programme. The programme's total expenditure increased from R4.751 billion in 2021/22 to a revised estimate of R4.979 billion in 2024/25. In 2025/26, the budget increases by 15.7 per cent from R4.979 billion to R5.760 billion when compared to the 2024/25 revised estimate due to additional funding for the wage agreement and funding for the medicines, medical supplies, medical gas, surgical implants, property payments, food for patients and medical and chemical waste.

Table 40: Summary of payments and estimates by economic classification: Programme 5: Central Hospital Service

R thousand	Outcome			Main appropriation	Adjusted appropriation 2024/25	Revised estimate	Medium-term estimates			% change from 2024/25
	2021/22	2022/23	2023/24				2025/26	2026/27	2027/28	
Current payments	4 657 936	4 512 638	4 718 032	4 752 835	4 822 445	4 722 436	5 489 126	5 041 719	5 241 741	16.2
Compensation of employees	3 409 840	3 196 308	3 465 164	3 374 193	3 374 193	3 374 184	3 874 082	3 657 176	3 725 054	14.8
Goods and services	1 247 909	1 314 174	1 249 219	1 378 642	1 448 252	1 348 252	1 615 044	1 384 543	1 516 687	19.8
Interest and rent on land	187	2 156	3 649	–	–	–	–	–	–	–
Transfers and subsidies to:	23 202	37 772	53 869	68 418	87 736	82 112	49 424	63 263	66 110	(39.8)
Provinces and municipalities	–	–	–	–	–	–	–	–	–	–
Departmental agencies and account	–	–	–	–	–	–	–	–	–	–
Higher education institutions	–	–	–	–	–	–	–	–	–	–
Foreign governments and internatio	–	–	–	–	–	–	–	–	–	–
Public corporations and private ente	–	–	–	–	–	–	–	–	–	–
Non-profit institutions	–	–	–	–	–	–	–	–	–	–
Households	23 202	37 772	53 869	68 418	87 736	82 112	49 424	63 263	66 110	(39.8)
Payments for capital assets	70 388	163 164	156 972	215 029	175 250	175 250	221 864	186 380	194 767	26.6
Buildings and other fixed structures	–	17 509	14 449	48 171	41 587	41 587	–	–	–	(100.0)
Machinery and equipment	70 388	145 655	142 523	166 858	133 663	133 663	221 864	186 380	194 767	66.0
Heritage Assets	–	–	–	–	–	–	–	–	–	–
Specialised military assets	–	–	–	–	–	–	–	–	–	–
Biological assets	–	–	–	–	–	–	–	–	–	–
Land and sub-soil assets	–	–	–	–	–	–	–	–	–	–
Software and other intangible assets	–	–	–	–	–	–	–	–	–	–
Payments for financial assets	–	–	–	–	–	–	–	–	–	–
Total economic classification	4 751 526	4 713 574	4 928 873	5 036 282	5 085 431	4 979 798	5 760 414	5 291 362	5 502 618	15.7

Table 40 above shows the summary of payments and estimates for Central Hospital Services from 2021/22 to 2024/25 and over the 2025 MTEF per economic classification.

Compensation of Employees shows a growth of 14.8 per cent from R3.374 billion to R3.874 billion in 2025/26 when compared to the 2024/25 revised estimate due to additional funding for the wage agreement.

Goods and services show a growth 19.8 per cent from R1.348 billion to R1.615 billion in 2025/26 when compared to the 2024/25 revised estimate due to additional funding medicines, medical supplies, medical gas, surgical implants, property payments, food for patients and medical and chemical waste.

Transfers and subsidies show a negative growth of 39.8 per cent from R82.112 million to R49.424 million in 2025/26 when compared to the 2024/25 revised estimate due to a high revised estimate emanating from the payment of Medico Legal Claims.

Payments for capital assets show a growth of 26.6 per cent from R175.250 million to R221.864 million in 2025/26 when compared to the 2024/25 revised estimate due to additional funding for National Tertiary Services Grant to fund the procurement of medical equipment.

5.5 Key Risks

The table below outlines the key risks.

Table 41: Key Risks and mitigating factors

Outcome	Risk	Mitigating factors
Quality of health services improved.	Non -adherence to policies and guidelines on referrals and services between Primary, Secondary and Tertiary Services.	- Implementation of the referral policy / protocol. - Strengthen the clinical services platform. - Functional Hospital Boards. - Ensure timeous filling of critical and replacement posts. - Enforcement of Policies and SOPs. - Implementation of the meeting resolutions. - Strengthen the quality of reports. - Procurement of appropriate healthcare technology as per APP.

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PROGRAMME

06

**HEALTH SCIENCES AND
TRAINING (HST)**



PROGRAMME 6: HEALTH SCIENCES AND TRAINING (HST)

Programme Purpose

To develop a capable health workforce for the Eastern Cape provincial health system as part of a quality people value stream.

HRD Chief Directorate is comprised of the following services

- 6.1 Lilitha Training Colleges
- 6.2 Eastern Cape College of Emergency Care (ECCOEC)
- 6.3 Bursaries
- 6.4 Other Training : comprised of:-
 - a. Health Professionals Training & Specialist Development Grant
 - b. Skills Development Levy Fund (HR Utilisation and Capacitation Services)

Strategies to reach the targets over the three-year period

- Research the current priority competencies that are available within the Department.
- Identify the competencies per selected occupational categories that are critical for effective service delivery at primary, secondary and tertiary levels of care.
- Profile the current competencies within the department against the required competencies identified and to identify critical education, training and development strategies.
- Education, training and development needs of health and support professionals in the Department are indicated through the continued engagement with all the appropriate Higher Education Institutions (HEIs) in South Africa.

Table 42: Outcomes, Outputs and Output indicators and targets for the next MTEF for Health Science and Training (HST)

Outcome (as per SP 2025/26- 2029/30)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets						
			2021/22	2022/23	2023/24	2024/25	2025/26	2025/26 Quarterly Targets				2026/27	2027/28
								Q1	Q2	Q3	Q4		
12. Quality of health services improved	Completed training and qualification obtained	12.12.1 Number of students completed the 4 - year Nursing comprehensive course	New Indicator	386	446	96	22	-	-	-	22	-	-
		12.12.2 Number of Students completed the 3 – year Diploma	New Indicator	New Indicator	New Indicator	New Indicator	183	-	-	-	183	-	-
		12.12.3 Number of EMS Practitioners completed Emergency Care Qualification	New Indicator	17	6	9	6	-	-	-	6	-	-
		12.12.4 Number of registrars qualified as specialist	24	13	23	20	25	-	-	-	25	25	25
		12.12.5 Number of bursary students completed training	New Indicator	New Indicator	57	74	64	-	-	-	64	31	12
	Youth programme conducted	12.12.6 Number of youth placed on youth programs	1548	1028	1367	1350	889	-	-	-	889	850	800

Explanation of planned performance over the medium-term period

The Skills Development Programme is planning to implement a range of capacity development programmes for existing workforce such as NQF aligned/and or Continuous Professional Development (CPD) points aligned skills development programmes, and bursaries for existing workforce in order to obtain qualifications and specialist clinical skills, and also youth development programmes to create a pool of qualified individuals from which the department can recruit by implementing learnerships, internships, traineeships' programmes and bursaries for unemployed youth.

The department has partnered with Health and Welfare Sector Education Training Authority (HWSETA) to implement Learnerships, specifically the Basic and Post Basic Pharmacy Assistance, but the intake for 2025/26, 2026/27 and 2027/28 there will be no intake due to the changes in the education landscape and the cost of training which has been exacerbated by the fact that there is only one Lab in the country which has been accredited for practical training of the Learners which is in Gauteng Province, and they can only accommodate a limited number (100 x Basic and 200 x Post Basic Pharmacy Assistants)

The Performance Management Development System (PMDS) programme is intended to have all officials and employees of the department contracted by the 31st May each year, to be able to and attain 100% compliance. Those who have qualified for a Performance Incentive are employees on levels 1- 12 and SMS Members who have gone through the PMDS moderation and have been found to have performed within required standards and therefore awarded performance incentives as a token of appreciation for their contribution to improved service delivery and organisational performance.

The Eastern Cape College of Emergency Care (ECCOEC) is planning for an intake in collaboration with Nelson Mandela University for the Higher Certificate in Emergency Medical Care (HCert:EMC) during the 2025 academic year. Due to the shortage of qualified emergency care providers within the ECDOH and limited intake is expected. The college plan implemented in 2024 will be continued in 2025/2026 financial year which is to allow staff to study on full time bursaries at accredited institutions towards the Bachelors Degree in Emergency Medical Care, Diploma in Emergency Care as well as the Higher Certificate in Emergency Medical Care with the aim to address the skill shortage.

The Department of Higher Education and Training has introduced changes or transformation processes on education and training by all colleges including Nursing Education Institutions (NEI) within the country. Lilitha College of Nursing is amongst these NEIs, this includes development of new programmes bended at higher education level and accreditation process of the new programs viz: - 3-year Diploma in Nursing, 1- Year Higher Certificate in Nursing, and a number of Post Graduate Diplomas in nursing (NQF 8). Presently the 3-Year Diploma received full accreditation from all accreditation bodies and commenced in March 2023.

The Higher certificate has received provisional accreditation from SANC and is with CHE for accreditation and submission to SAQA for final registration. Advanced Diploma in Midwifery (NQF 7) and Postgraduate Diploma Mental Health (NQF 8) have been submitted to SANC and received conditional accreditation for two years. The College is in the process of submitting documents to the Council for Higher Education. The Post Graduate Diplomas of different speciality areas (which are still to be developed) will also be provided once the course regulatory process has been completed successfully.

The Bursary Programme is monitoring students on the database, the projections indicated on the table are for students who will be completing their final year of study during the next financial year and for the two outer years within the MTEF. The student bursars who are enrolled for Medical and Pharmacy Bachelor's programmes will, after completing university study years, be appointed by the department as interns, where in medical students will be appointed for a period of two years, whilst pharmacy students will only be appointed for one year. All other students in the Allied Health and Nursing Professions will be appointed in a community

service programme for one year, straight after passing their final year, whilst the medical and pharmacy bursary students will be appointed into Community Services after they have completed their Internship programme.

The Registrar Programme is conducted in 3 Tertiary Institutions (Frere, Nelson Mandela Academic, Livingstone) 3 Regional Institutions (Dora Nginza, Cecilia Makiwane, Mthatha Regional) and 2 Psychiatric facilities (Fort England, and Elizabeth Donkin hospitals) through the Eastern Cape Department of Health. The programme is being funded under the Statutory Human Resource and Development Grant, Equitable Share and National Tertiary Services Grant in the various facilities.

Lilitha College of Nursing in the next five-year Strategic Period years to Develop speciality nurses (Post Graduate level) as aligned with NQF to be responsive to priority service delivery needs. Establish a digitized education and training platform by acquisition of the Learner Management System(LMS). Enhance an academic training platform through infrastructure and teaching and learning technology improvements. Develop capacity of academic and key support staff in alignment with the transitional fundamentals of Higher Education bend.

Strengthen partnerships with key stakeholders in Higher Education Institutions, Clinical Practice Institutions and Social Partners. Align College governance structures with Higher Education legislation.

6.1 PROGRAMME RESOURCE CONSIDERATION

Table 43: Summary of payments and estimates by sub-programme: Programme 6: Health Sciences and Training

R thousand	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2024/25
	2021/22	2022/23	2023/24				2025/26	2026/27	2027/28	
1. Nursing Training Colleges	259 301	237 777	235 211	336 558	302 070	231 371	239 882	235 220	228 385	3,7
2. EMS Training College	11 960	10 522	13 248	33 717	33 717	32 606	27 250	15 987	16 658	(16,4)
3. Bursaries	179 132	49 152	38 549	69 054	61 542	61 542	80 855	121 516	127 022	31,4
4. Other Training	324 366	688 255	789 563	725 782	725 782	689 686	838 856	755 890	808 785	21,6
Total payments and estimates	774 759	985 706	1 076 571	1 165 111	1 123 111	1 015 205	1 186 843	1 128 613	1 180 850	16,9

Table 43 above shows the summary of payments and estimates for Health Sciences and Training from 2021/22 to 2024/25 and over the 2025 MTEF per sub-programme. The programme's total expenditure increased from R774.759 million in 2021/22 to a revised estimate of R1.015 billion in 2024/25. In 2025/26, the budget increases by 16.9 per cent from R1.015 billion to R1.186 billion when compared to the 2024/25 revised estimate due to additional funding additional funding for the wage agreement and funding for medicines, medical supplies, medical gas, surgical implants, property payments, food for patients, medical and chemical waste.

Table 44: Summary of payments and estimates by economic classification: Programme 6: Health Sciences and Training

R thousand	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2024/25
	2021/22	2022/23	2023/24	2024/25			2025/26	2026/27	2027/28	
Current payments	606 611	917 579	1 022 218	1 080 025	1 044 537	936 597	1 097 197	972 376	1 017 584	17,1
Compensation of employees	483 560	809 225	829 418	930 502	888 502	780 562	881 942	894 694	936 374	13,0
Goods and services	123 051	108 354	192 800	149 523	156 035	156 035	215 255	77 682	81 210	38,0
Interest and rent on land	–	–	–	–	–	–	–	–	–	
Transfers and subsidies to:	156 311	57 589	41 812	66 840	60 328	60 362	67 886	139 695	145 981	12,5
Provinces and municipalities	–	–	–	–	–	–	–	–	–	
Departmental agencies and accounts	13 075	16 866	14 721	14 401	14 401	14 401	14 886	21 867	22 851	3,4
Higher education institutions	–	–	–	–	–	–	–	–	–	
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–	
Public corporations and private entities	–	–	–	–	–	–	–	–	–	
Non-profit institutions	–	–	–	–	–	–	–	–	–	
Households	143 236	40 723	27 091	52 439	45 927	45 961	53 000	117 828	123 130	15,3
Payments for capital assets	11 837	10 538	12 541	18 246	18 246	18 246	21 760	16 542	17 285	19,3
Buildings and other fixed structures	–	–	–	–	–	–	–	–	–	
Machinery and equipment	11 837	10 538	12 541	18 246	18 246	18 246	21 760	16 542	17 285	19,3
Heritage Assets	–	–	–	–	–	–	–	–	–	
Specialised military assets	–	–	–	–	–	–	–	–	–	
Biological assets	–	–	–	–	–	–	–	–	–	
Land and sub-soil assets	–	–	–	–	–	–	–	–	–	
Software and other intangible assets	–	–	–	–	–	–	–	–	–	
Payments for financial assets	–	–	–	–	–	–	–	–	–	
Total economic classification	774 759	985 706	1 076 571	1 165 111	1 123 111	1 015 205	1 186 843	1 128 613	1 180 850	16,9

Table 44 above shows the summary of payments and estimates for Health Sciences and Training from 2021/22 to 2024/25 and over the 2025 MTEF per economic classification.

Compensation of Employees shows a growth of 13 per cent from R780.562 million to R881.942 million in 2025/26 when compared to the 2024/25 revised estimate due to additional funding for the wage agreement.

Goods and services show a growth of 38 per cent from R156.035 million to R215.255 million in 2025/26 when compared to the 2024/25 revised estimate due to additional funding for medicines, medical supplies, medical gas, surgical implants, property payments, food for patients, medical and chemical waste.

Transfers and subsidies show a growth of 12.5 per cent from R60.362 million to R67.886 million in 2025/26 when compared to the 2024/25 revised estimate due to low revised estimate emanating from reprioritisation of funds from external bursaries during the 2024 MTEF.

Payments for capital assets show a growth of 19.3 per cent from R18.246 million to R21.760 million in 2025/26 when compared to the 2024/25 revised estimate due to reprioritisation to reduce cost pressure for the purchase of medical equipment.

6.2 Key Risks

The table below outlines the key risks.

Table 45: Key Risks and mitigating factors

Outcome	Risk	Mitigating factors
Quality of health services improved	- Inadequate number of registrars trained. - Inadequate number of nurses trained on Post Basic Courses. - Delayed accreditation of new programmes	- Ensure timeous filling of critical and replacement posts. - Enforcement of policies and SOPs. - Implementation of the meeting resolutions. - Intercession by the Executive Management of the department of delayed accreditation process. - Strengthen the quality of reports. - Create, implement and maintain a clear training plan for registrars and nurses. - Have an SLA and good working relationship with institutions of higher learning.

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PROGRAMME

07

**HEALTH CARE SUPPORT
SERVICES (HCSS)**



PROGRAMME 7: HEALTH CARE SUPPORT SERVICES (HCSS)

Programme Purpose

To render quality, effective and efficient transversal health (orthotic & prosthetic, rehabilitation, laboratory, social work services and radiological services) and pharmaceutical services to the communities of the Eastern Cape. Health Care Support Services consist of two sub-programmes: Transversal Health Services and Pharmaceutical Services.

Transversal Health Services consists of:

- The orthotic & prosthetic (O&P) services sub-programme, which has three existing O&P centres. The centres are based within the three hospitals namely in Gqeberha at PE Provincial hospital, in East London at Frere hospital, and in Mthatha at Bedford Orthopaedic hospital. The prescriptions received from medical professionals and the referrals especially from the outreach programme determine the need for the service.
- Rehabilitation, laboratory, social work services rendered at all hospitals and/or community health centres. Radiological services are rendered in all hospitals and most Community Health Centres.
- Rehabilitation services is provided in 61 hospitals and 13 Primary Health Care services throughout the province. The services have been rolled out to three PHC facilities (Flagstaff CHC, Lisikisiki village clinic and Baziya clinic) in OR Tambo to support NHI project with Flagstaff CHC having full complement of rehabilitation services.

Pharmaceutical Services is responsible for

- Coordination of the full spectrum of the Pharmaceutical Management Framework including medicine selection, supply, distribution, and utilization.
- Pharmaceutical standards development and monitoring for health facilities and the two medical depots are coordinated under this programme.
- Promote rational use of essential medicines and medical products.

Medico-legal compensatory services

The new sub-programme is focusing on the departmental medico-legal strategy of public health care defense. Under this sub-programme, the department will:

- Coordinate the implementation of the court orders awarded under the public health defense remedy
- Procure goods and services as prescribed in the public healthcare defense court orders

Strategies to reach the targets over the three-year period

- Resource mobilization to strengthen the management of children with Cerebral Palsy (CP) as part of the medico legal mitigation strategy.
- Fully establish centres of excellence for the management of Cerebral Palsy.

- Develop the capacity of the rehabilitation health professionals on such skills as wheelchair seating, Cerebral Palsy management, early childhood screening to establish normal or abnormal child development.
- Strengthen rehabilitation services at district hospitals, Primary Health Care facilities and at community level.
- Strengthen partnerships with private, not-for-profit organizations and promote interdepartmental collaboration to support the achievement of rehabilitation programme outcomes.
- Establishment of wheelchair repair centres to improve cost effectiveness and efficiency in the provision of wheelchairs.
- Outreach services for the Medical Orthotist and Prosthetics (MOP) to improve access to prostheses and orthoses for people with disabilities to maintain their dignity.
- Introduce efficiencies in blood and blood products, and laboratory service utilization.
- Strengthen the functioning of the provincial pharmaceutical and therapeutics committee to promote rational use of medicine and pharmaceutical products.
- Expand the Central Chronic Medication, Dispensing and Distribution (CCMDD) programme to reach more clients in more wards around the province.
- Promoting compliance to relevant legislation e.g. South African Pharmacy Council, Office of Health Standards Compliance, and South African Health Products Regulatory Authority.
- Strengthen and promote efficiency in the medicines supply chain management.
- Establish of contracts for goods and services required in the implementation of public healthcare defence court orders.

Table 46: Outcomes, Outputs and Output indicators and targets for the next MTEF for Health Care Support Services (HCSS)

Outcome (as per SP 2025/26- 2029/30)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performan ce	MTEF Targets							
			2021/22	2022/23	2023/24		2024/25	2025/26	2025/26 Quarterly Targets				2026/2 7	2027/28
									Q1	Q2	Q3	Q4		
12. Quality of health services improved	Availability of assistive devices in primary health care	12.13.1 Wheelchair issued adult 19 years and older rate	59,3%	34.2%	24.3%	69.1%	60%	10%	20%	40%	60%	60%	60%	
		Numerator	1 483	1 483	2 240	1 801	1800	300	600	1 200	1 800	1 740	1 680	
		Denominator	2 500	4 340	9 389	2 661	3000	3000	3000	3000	3000	2 900	2 800	
		12.13.2 Wheelchair issued child 0-18 years rate	165,6%	41.6%	27.5%	69.4%	60%	10%	20%	40%	60%	60%	60%	
		Numerator	497	373	594	363	816	136	272	544	816	780	720	
		Denominator	300	897	2 158	523	1 360	1 360	1 360	1 360	1 360	1 300	1 200	
		12.13.3 Hearing aid issued adult 19 years and older rate	85,3%	67.6%	50.7%	36.1%	70%	10%	30%	50%	70%	70%	70%	
		Numerator	1 030	1 362	1 456	599	1050	150	450	750	1050	1050	1050	
		Denominator	1 200	2 016	2 872	1 657	1 500	1 500	1 500	1 500	1 500	1 500	1 500	
		12.13.4 Hearing aid issued child 0-18 years rate	68,4%	54.6%	58.9%	68.7%	70%	10%	30%	50%	70%	70%	70%	
		Numerator	342	459	441	363	210	30	90	150	210	210	210	
		Denominator	500	840	749	523	300	300	300	300	300	300	300	

Outcome (as per SP 2025/26- 2029/30)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performan ce	MTEF Targets						
			2021/22	2022/23	2023/24		2024/25	2025/26	2025/26 Quarterly Targets				2026/2 7
						Q1			Q2	Q3	Q4		
	Availability of medicine in depos and facilities	12.14.1 Percentage Order fulfilment for essential drugs at depot	76.15%	70%	62.8%	70%	80%	80%	80%	80%	80%	82%	82%
		Numerator	438 502	367 893	379 893	104 285	483 757	120 940	120 939	120 939	120 939	495 851	495 851
		Denominator	575 736	522 210	604 696	148 227	604 696	151 174	151 174	151 174	151 174	604 696	604 696
		12.14.2 Percentage availability of essential medicine at facilities.	86.1%	82.9%	80%	82%	80%	80%	80%	80%	80%	85%	85%
		Numerator	68.9	63.3	64	66	64	64	64	64	64	68	68
		Denominator	80	80	80	80	80	80	80	80	80	80	80
		12.14.3 Number of active patients on CCMDD	283 525	304 424	383 761	474 890	490 050	456 500	467 500	478 500	490 050	539 055	5880 055
	Management of child disabilities	12.15.1 Number of Cerebral Palsy cases managed	New Indicator	New Indicator	New Indicator	New Indicator	10	3	5	7	10	12	15

Explanation of planned performance over the medium-term period

The health care support programme is critical in the delivery and provision of quality health services in the province. The sub-programme orthotic and prosthetic services also focus on programme focuses on ensuring access to laboratory and blood services, in addition to the rehabilitation services activities. The second sub-programme (Medicine Trading Account) is responsible for the medicines and pharmaceutical supply management systems. Lastly the third sub-programme is a new subprogramme which deals with the public health defence, a part of the departmental medico legal strategy.

The key outputs of this programme include improved availability of assistive devices in primary healthcare, and availability of medicines. The department has developed strategies to achieve these key outputs.

Availability of assistive devices in primary health care

The availability of assistive devices, adequately skilled personnel and access to rehabilitation services are essential inputs to the quality of care provided to persons with disabilities. The Eastern Cape province has seen an increase in demand for assistive devices due to high cases of trauma and injury, and the prevalence of chronic diseases such as diabetes. The programme provides/issues assistive devices, to people who have been clinically assessed by qualified rehabilitation professionals, orthotic and prosthetic and orthopaedic and ear, nose, throat (ENT) specialists in the hospitals. Physiotherapy, Occupational therapy, Speech therapy, audiology services and orthotic and prosthetic services are provided to eligible clients by the multi-disciplinary team of registered professionals at various levels of care.

The provision of comprehensive care for children with Cerebral Palsy (CP) remains a priority intervention of the department as part of the medico-legal mitigation strategy. The programme continues to build capacity at various institutions to provide care and treatment to children with Cerebral Palsy. The province is currently providing cerebral palsy management services at 43 health facilities. There are 11 health facilities that have been identified as centres of excellence for the provision of cerebral palsy management.

	NAME OF HOSPITAL	DISTRICT	LEVEL OF CARE
1	Madzikane kaZulu Memorial Hospital	Alfred Nzo	District Hospital
2	Butterworth Hospital	Amathole	District Hospital
3	Cecelia Makiwane Hospital	Buffalo City Metro	Regional Hospital
4	Frere Hospital	Buffalo City Metro	Tertiary Hospital
5	Frontier Hospital	Chris Hani	Regional Hospital
6	Aliwal North Hospital	Joe Gqabi	District Hospital
7	Uitenhage Provincial Hospital	Nelson Mandela Metro	District Hospital
8	Dora Nginza Hospital	Nelson Mandela Metro	Regional Hospital
9	Nelson Mandela Academic Hospital	OR Tambo	Tertiary Hospital
10	St Elizabeth Hospital	OR Tambo	Regional Hospital
11	Andries Vosloo Hospital	Sarah Baartman	District Hospital

These facilities are at different stages of development in terms of infrastructure and human resources. Significant progress is being made to address the infrastructure challenges in Nelson Mandela Academic

Hospital, Dora Nginza Hospital, and Cecelia Makiwane Hospital. Twenty-three (23) physiotherapists, twenty (20) Occupational therapists, six (6) audiologists and 12 speech therapists were allocated at these hospitals in the 2025 community services placement. In this financial year, the department will assign officers to serve as case managers in these institutions. These officers have a responsibility to manage and coordinate the care for all children with cerebral palsy that are managed in their institutions.

Laboratory services and blood products are amongst the major cost drivers in the department. The programme will work with clinicians, and the blood and laboratory service providers (National Health Laboratory Services (NHLS) and South African National Blood Services (SANBS)) to introduce efficiencies which include the improved implementation of the electronic gate keeping (e-Gatekeeping) system, enforcement of the essential laboratory list, and establishment of the Blood and Laboratory Users committees at all regional and tertiary hospitals. The programme implement plans to reduce the laboratory and blood services expenditure as part of the provincial cost containment measures. Wastage of blood supply and laboratory services will be reduced significantly through interventions which include capacity building of clinicians and other measures which will be developed by each institutional clinical governance forum. Inventory management of laboratory commodities will also be prioritized as the wastage and misuse of laboratory commodities has been identified as an area of financial inefficiency. The programme will also work with the HMS2 developers to design a module for laboratory order entry which will track all laboratory requests generated from the department and reconcile these with the invoices from NHLS.

Availability of medicine in depots and facilities

The uninterrupted availability and rational use of medicines remains a key input of the programme towards achieving quality health care targets in programmes 2, 4 and 5. The achievement of health outcomes rests on the department's ability to efficiently procure, warehouse, distribute and dispense quality assured medicines for the management of common health conditions. The current fiscal space forces the department to consider various efficiency measures in the procurement and supply chain management of essential medicines to the clinics and hospitals around the province. The programme will work to realign the medicines procurement and ensure there is value for money and compliance with public procurement regulations in the medicines procurement and distribution. Stock management at health facilities, especially in clinics will be strengthened.

Availability of skilled pharmacy personnel remains an important input in our efforts to achieve the goal of uninterrupted availability of essential medicines. Human resources such as the community service pharmacists placed at district hospitals and increased number of pharmacist assistants for clinics are the main personnel related interventions over the medium term. The programme will work with programme 6 to develop the skills of all pharmacy personnel in stock management and promoting rational use of medicines. In the medium term, the department will ensure that community service pharmacists are assigned the responsibility to supervisor and support medicines availability systems in the clinics within the catchment area of their hospital (community service pharmacists are placed community health centres or hospitals).

The rollout of RxSolution application for inventory management will be fast tracked at hospitals, linking it to the digitalization project of the department. RxSolution is installed in 78 Hospitals and all 78 using RxSolution – Inventory Management module. There is a focus to have all these facilities dispensing using this application. 100% regional, tertiary and central hospitals are actively using RxSolution

The stock visibility system (SVS) will be used to track stock levels at clinics and make decision on resupply and redistribution. The availability of the appropriate number of personnel at the depot is important to ensure that orders are processed and released to facilities to prevent stock outs. The department has received support through the Health and welfare SETA in the form of 20 pharmacists experiential learners to support the deport system. In addition, the DG Murray Trust has also placed about 50 candidates working 18 hours a week (through the Presidential Youth Employment Scheme). These resources assist the department to close the staffing gaps in the inventory management and general warehouse activities at the two depots.

The pharmaceutical depots have not yet achieved the accreditation with the SA Health Products Regulatory Authority. This is a gap that the department has been working to address over the past 3 years, mainly focusing on infrastructure challenges at these facilities. The Mthatha pharmaceutical depot is currently undergoing refurbishments which seek to address the gaps identified in the previous inspection by the SAHPRA inspectorate. This refurbishment work is expected to be completed in the first half of the financial year. The Gqeberha (Port Elizabeth) pharmaceutical depot is still on the pipeline to address temperature mapping and other minor alterations to their facility. The department is committed to prioritize the compliance requirements in the next financial year.

Compensatory services

The department has allocated a budget for compensatory services and undertaking to pay, which are the key interventions in the provincial medico legal strategy. This budget is allocated to support the implementation of the public health defence court orders. Currently there are 3 children benefiting from this budget, this number is projected to increase over the next year.

7.2 PROGRAMME RESOURCE CONSIDERATION

Table 47: Summary of payments and estimates by sub-programme: Programme 7: Health Care Support Services

R thousand	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2024/25
	2021/22	2022/23	2023/24	2024/25			2025/26	2026/27	2027/28	
1. Orthotic & Prosthetic Services	50 920	53 386	49 762	68 872	68 872	63 358	61 537	64 975	69 772	(2,9)
2. Medicine Trading Account	62 066	61 667	62 934	74 915	74 915	75 326	78 586	81 899	85 601	4,3
3. Medico-Legal Compensatory Ser	–	–	–	105 000	105 000	55 491	107 978	103 757	108 426	94,6
Total payments and estimates	112 986	115 053	112 696	248 787	248 787	194 175	248 101	250 631	263 799	27,8

Table 47 above shows a summary of payments and estimates for Health Care Support Services from 2021/22 to 2024/25 and over the 2025 MTEF period per sub-programme. The programme's total expenditure increased from R112.986 million in 2021/22 to a revised estimate of R194.175 million in 2024/25. In 2025/26, the budget increased by 27.8 per cent from R194.175 million to R248.101 million when compared to the 2024/25 revised estimate due to reprioritisation to cater for the new Sub-programme 7.3: Medico-Legal Compensatory Services during 2024 MTEF.

Table 48: Summary of payment and estimates by economic classification: Programme 7: Health Care Support Services

R thousand	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2024/25
	2021/22	2022/23	2023/24	2024/25			2025/26	2026/27	2027/28	
Current payments	110 469	109 355	110 619	224 938	214 124	159 512	217 802	230 271	242 522	36,5
Compensation of employees	69 782	70 240	71 912	79 845	79 845	74 742	84 074	86 529	92 275	12,5
Goods and services	40 687	39 115	38 707	145 093	134 279	84 770	133 728	143 742	150 247	57,8
Interest and rent on land	–	–	–	–	–	–	–	–	–	
Transfers and subsidies to:	39	31	431	–	2 782	2 782	2 923	–	–	5,1
Provinces and municipalities	–	–	–	–	–	–	–	–	–	
Departmental agencies and accounts	–	–	–	–	–	–	–	–	–	
Higher education institutions	–	–	–	–	–	–	–	–	–	
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–	
Public corporations and private entities	–	–	–	–	–	–	–	–	–	
Non-profit institutions	–	–	–	–	–	–	–	–	–	
Households	39	31	431	–	2 782	2 782	2 923	–	–	5,1
Payments for capital assets	2 478	5 667	1 646	23 849	31 881	31 881	27 376	20 360	21 277	(14,1)
Buildings and other fixed structures	–	–	–	–	–	–	–	–	–	
Machinery and equipment	2 478	5 667	1 646	23 849	31 881	31 881	27 376	20 360	21 277	(14,1)
Heritage Assets	–	–	–	–	–	–	–	–	–	
Specialised military assets	–	–	–	–	–	–	–	–	–	
Biological assets	–	–	–	–	–	–	–	–	–	
Land and sub-soil assets	–	–	–	–	–	–	–	–	–	
Software and other intangible assets	–	–	–	–	–	–	–	–	–	
Payments for financial assets	–	–	–	–	–	–	–	–	–	
Total economic classification	112 986	115 053	112 696	248 787	248 787	194 175	248 101	250 631	263 799	27,8

Table 48 above shows a summary of payments and estimates for Health Care Support Services from 2021/22 to 2024/25 and over the 2025 MTEF period per economic classification.

Compensation of Employees shows a growth of 12.5 per cent from R74.742 million to R84.074 million in 2025/26 when compared to the 2024/25 revised estimate due to reprioritisation to fund shortfall on COE and additional funding for the wage agreement.

Goods and services show a growth of 57.8 per cent from R84.770 million to R133.728 million in 2025/26 when compared to the 2024/25 revised estimate due to reprioritisation to cater for the new Sub-programme 7.3: Medico-Legal Compensatory Services during 2024 MTEF.

Transfers and subsidies show a growth of 5.1 per cent from R2.782 million to R2.923 million when compared to the 2024/25 revised estimate due to reprioritisation for the payment of Medico legal claims- and leave gratuities.

Payments for capital assets show a negative growth of 14.1 per cent from R31.881 million to R27.376 million when compared to the 2024/25 revised estimate due to reprioritisation for the purchase of medical equipment.

7.3 Key Risks

The table below outlines the key risks.

Table 49: Key Risks and mitigating factors

Outcome	Risk	Mitigating factors
Quality of health services improved.	Interrupted inventory supply and availability (medicine and medical supplies)	- Capacity building and staff development. - Recruitment of pharmaceutical posts at depots and institutions. - Roll out Remote Demander Module for electronic medicines and consumables ordering. - Continual Medicine Supply Chain training. - Monitor Contract Management of Medicine suppliers. - Establish a provincial contract for certain essential medicines and supplies that are not on national contract. - Expansion of Direct Delivery to hospitals. - Continue employment of pharmacy assistants. - Implementation of the meeting resolutions. - Strengthen the quality of reports.

ANNUAL PERFORMANCE PLAN 2025/26-2027/28

PROGRAMME

08

HEALTH FACILITIES MANAGEMENT (HFM)



PROGRAMME 8: HEALTH FACILITIES MANAGEMENT (HFM)

Programme Purpose

To improve access to health care services through provision of new health facilities, upgrading and revitalisation, maintenance of existing facilities, including the provision of appropriate health care technology equipment.

The programme comprises of four (4) directorates to ensure that it delivers to its mandate effectively and efficiently. These directorates are:

- Infrastructure Planning
- Infrastructure Programme Delivery
- Health Technology
- Engineering & Technical Support Services

The programme has 5 sub-programmes, which it supports namely:

- Community Health Facilities
- Emergency Medical Services
- District Hospital Services
- Provincial Hospital services
- Other facilities

Priorities

- Provide building infrastructure support to health care services through constructing new and upgrading existing health facilities.
- Facilitate major and minor building maintenance for health facilities (buildings and health equipment).
- Provide essential health equipment to health facilities.

Table 50: Outcomes, Outputs and Output indicators and targets for the next MTEF for Health Facilities Management (HFM)

Outcome (as per SP 2025/26- 2029/30)	Outputs	Output Indicator	Audited/Actual performance			Estimated Performance	MTEF Targets							
			2021/22	2022/23	2023/24		2024/25	2025/26	2025/26 Quarterly Targets				2026/27	2027/28
									Q1	Q2	Q3	Q4		
12. Quality of health services improved	Planning and provision of Health facilities	12.5.1 Number of health facilities upgraded	New Indicator	New Indicator	New Indicator	New Indicator	6	0	1	2	3	8	10	
	Health care facilities maintained	12.5.2 Number of health facilities with major maintenance completed	New Indicator	New Indicator	New Indicator	New Indicator	10	2	2	0	6	12	14	
		12.5.3 Number of health facilities with minor maintenance completed	New Indicator	New Indicator	New Indicator	New Indicator	48	0	0	7	41	43	45	

Explanation of planned performance over the medium-term period

Health Facilities Management (Programme 8) has the responsibility of improving access to health care services through the provision of new health care facilities, upgrading and revitalisation and maintenance of existing facilities. In the Programme's effort to deliver on these expectations, the programme has planned to complete 64 projects in 2025/26 financial year. The projects constitute of six (6) facilities were upgrades and additions will be completed.

The following projects will be implemented and monitored during the financial year: Amongst these projects there will be

- Construction of Balfour Clinic in Amathole,
- Construction of Haytor Clinic and Frontier Hospital staff accommodation in Chris Hani,
- Upgrades & additions to Bhongweni Clinic Phase I and Dora Nginza hospital Phase I in Sarah Baartman and Nelson Mandela Bay respectively.
- Provision of new prefabricated structures for clinical use in Ugie Clinic Joe Gqabi.

To accelerate maintenance in health facilities, Health Facilities Management has established an Infrastructure Improvement Programme which is aimed at implementing both major and minor maintenance through rehabilitating, renovating and refurbishing existing facilities to ensure that they are in a habitable state. In this pool of projects, major maintenance will be implemented to ten (10) projects. These will include but are not limited to repairs and renovation to Nelson Mandela Academic Hospital and water and sanitation upgrades at Sir Henry Elliot in OR Tambo, completion of Nokatshile Clinic and repairs to Mathubeni clinic in Alfred Nzo. Furthermore, minor maintenance will be implemented in 48 facilities in all the districts.

8.1 PROGRAMME RESOURCE CONSIDERATION

Table 51: Summary of payments and estimates by sub-programme: Programme 8: Health Facilities Management

R thousand	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2024/25
	2021/22	2022/23	2023/24	2024/25			2025/26	2026/27	2027/28	
1. Community Health Facilities	186 906	215 004	207 593	375 013	441 294	439 827	449 953	590 423	531 745	2,3
2. Emergency Medical Rescue Servi	–	–	–	4 000	–	–	10 000	19 000	8 360	
3. District Hospital Services	595 470	567 534	621 985	586 763	528 323	526 404	622 904	563 658	665 197	18,3
4. Provincial Hospital Services	275 833	287 279	173 426	298 429	316 063	383 095	360 849	229 585	236 856	(5,8)
5. Other Facilities	29 704	1 758	15 084	42 323	20 848	22 701	11 000	23 000	8 360	(51,5)
Total payments and estimates	1 087 913	1 071 575	1 018 088	1 306 528	1 306 528	1 372 027	1 454 706	1 425 666	1 450 518	6,0

Tables 51 above shows the summary of payments and estimates for Health Facilities Management from 2021/22 to 2024/25 and over the 2025 MTEF period per sub-programme. The programme's total expenditure increased from R1.087 billion in 2021/22 to a revised estimate of R1.372 billion in 2024/25. In 2025/26, the budget increases by 6 per cent from R1.372 billion to R1.454 billion when compared to the 2024/25 revised estimate due to additional funding for wage the agreement and additional funding for the Health Facilities Revitalisation Grant.

Table 52: Summary of payments and estimates by economic classification: P8 – Health Facilities Management

R thousand	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2024/25
	2021/22	2022/23	2023/24	2024/25			2025/26	2026/27	2027/28	
Current payments	374 535	371 209	403 392	426 372	495 515	479 938	502 408	535 136	560 832	4,7
Compensation of employees	22 754	24 157	31 243	47 237	47 237	31 660	46 612	47 458	50 399	47,2
Goods and services	351 781	347 052	372 149	379 135	448 278	448 278	455 795	487 678	510 433	1,7
Interest and rent on land	–	–	–	–	–	–	–	–	–	
Transfers and subsidies to:	5	53	2	–	–	81 076	–	–	–	(100,0)
Provinces and municipalities	–	–	–	–	–	–	–	–	–	
Departmental agencies and accounts	–	–	–	–	–	–	–	–	–	
Higher education institutions	–	–	–	–	–	–	–	–	–	
Foreign governments and international organisations	–	–	–	–	–	–	–	–	–	
Public corporations and private enterprises	–	–	–	–	–	–	–	–	–	
Non-profit institutions	–	–	–	–	–	–	–	–	–	
Households	5	53	2	–	–	81 076	–	–	–	(100,0)
Payments for capital assets	713 373	700 313	614 694	880 156	811 013	811 013	952 299	890 530	889 686	17,4
Buildings and other fixed structures	575 252	443 605	335 882	553 886	641 417	641 417	795 925	742 725	715 119	24,1
Machinery and equipment	138 121	256 708	278 812	326 270	169 596	169 596	156 373	147 805	174 567	(7,8)
Heritage Assets	–	–	–	–	–	–	–	–	–	
Specialised military assets	–	–	–	–	–	–	–	–	–	
Biological assets	–	–	–	–	–	–	–	–	–	
Land and sub-soil assets	–	–	–	–	–	–	–	–	–	
Software and other intangible assets	–	–	–	–	–	–	–	–	–	
Payments for financial assets	–	–	–	–	–	–	–	–	–	
Total economic classification	1 087 913	1 071 575	1 018 088	1 306 528	1 306 528	1 372 027	1 454 706	1 425 666	1 450 518	6,0

Table 52 above shows the summary of payments and estimates for Health Facilities Management from 2021/22 to 2024/25 and over the 2025 MTEF period per economic classification.

Compensation of Employees shows a growth of 47.2 per cent from R31.660 million to R46.612 million in 2025/26 when compared to the 2024/25 revised estimate due to additional funding for wage agreement.

Goods and services show a growth 1.7 per cent from R448.278 million to R455.795 million in 2025/26 when compared to the 2024/25 revised estimate due to high revised estimate.

Payments for capital assets show a growth of 17.4 per cent from R811.013 million to R952.299 million in 2025/26 when compared to the 2024/25 revised estimate due to additional funding on Health Facilities Revitalisation Grant.

8.2 Key Risks

The table below outlines the key risks.

Table 53: Key Risks and mitigating factors

Outcome	Risk	Mitigating factors
Quality of health services improved.	• Unsuitable infrastructure.	• Strengthen and monitor compliance to the terms of the existing Contracts and SLAs. • Upgrade and additions of selected facilities in the Province. • Conduct condition assessments on health facilities. • Implementation of repairs, renovations and rehabilitation to dignify facilities in the province. • Planned maintenance to respond to larger infrastructure requirements. • Implement day- to- day maintenance.
	• Inadequate Management of Infrastructure Projects and Maintenance	• Implement the programme's management framework ○ Improve human resource capacitation within the unit in the build environment profession. ○ Strengthen and monitor compliance to the terms of the SLA. • Monitoring of the Implementing Agents through monthly monitoring meetings
	• Power Outages	• Monitor the implementation of the terms of the Maintenance Agreement.

9. PUBLIC ENTITIES

Not applicable

10. INFRASTRUCTURE PROJECTS

Table 54: B5 Infrastructure projects

No	Project Name	Project Details / Scope	Budget Programme Name	Start Date	End Date	Budget 2025/2026	Budget 2026/2027	Budget 2027/2028
I.	Upgrading of Security in Livingstone Hospital	Phase 1: Livingstone PEPH Hospital Complex involves replacing the existing fencing with Clearview or Beta Fence at the old EMS Site and a section of Livingstone Hospital's fence. Phase 2: At the same complex, the project includes the removal and replacement of existing fencing at PE Provincial Hospital and 44 Park Drive Flats with Clearview or Beta Fence. This phase also encompasses the construction of two guard houses at PE Provincial Hospital and security OHS enhancements for Protea Flats. Security upgrades at Livingstone Hospital are to include biometric systems, enhanced street lighting, entrance metal detectors, security cameras, panic button stations, and a centralized security control and response center for Nelson Mandela Bay. The project reached the tender evaluation milestone; however, the bid was cancelled due to the Health Department's budgetary constraints. Consequently, implementation is postponed until 2026. The cancellation of this bid means a longer turnaround time for the Department to respond to the Health and Safety risks, which the Livingstone PEPH Hospital Complex staff	Programme 8	2023/04/04	2026/10/02	R500 000,00	R40 000 000,00	R0,00

No	Project Name	Project Details / Scope	Budget Programme Name	Start Date	End Date	Budget 2025/2026	Budget 2026/2027	Budget 2027/2028
		and patients are exposed to, and they'll remain vulnerable to health & safety risks related to the poor dilapidated safety & security infrastructure. These planned interventions will now require a different implementation approach. Some minor interventions can be undertaken during the 2025/2026 as an amount of R3 million was allocated in the 3-year IPMP.						
2.	Alfred Nzo District - Maintenance and repairs	Maintenance and repairs for various works at 6 facilities in Alfred Nzo District Greenville Hospital St Patrick Hospital Sipetu Hospital Madzikane KaZulu Memorial Hospital Khotsong Hospital Taylor Bequest Hospital - Mt Fletcher	Programme 2	2018/01/15	2025/03/29	R8 200 000,00	R9 200 000,00	R0,00
3.	All Saints Hospital Kitchen and Laundry Refurbishments	Construction of Kitchen and Laundry services at All Saints including replacement of machinery and equipment. The mortuary was condemned and the scope has been included. The storeroom was also included.	Programme 8	2024/11/11	2027/09/22	R5 000 000,00	R2 000 000,00	R2 079 996,00
4.	All Saints Hospital Phase 1 & 2- Health Professional & student accommodation upgrade, improvements	All Saints Hospital Phase 1 & 2- Health Professional & student accommodation upgrade, improvements to existing buildings for use a Gateway Clinic and staff accommodation houses.	Programme 8	2023/08/04	2025/08/13	R500 000,00	R15 000 000,00	R0,00
6.	All Saints Hospital: Water Treatment and Sanitation Plant Upgrade	Sewage Inlet works, Maturation Ponds refurbishment, pipe reticulation and Raw water pump station supply lines and security structuring	Programme 8	2022/02/08	2025/09/01	8200000	2000000	2079996

No	Project Name	Project Details / Scope	Budget Programme Name	Start Date	End Date	Budget 2025/2026	Budget 2026/2027	Budget 2027/2028
7.	Amathole - Maintenance and repairs	Maintenance and repairs for various works at 12 facilities in Amathole DM: Victoria Hospital Tafalofefe Hospital Stutterheim Hospital SS Gida Hospital Nompomelelo Hospital Madawaleni Hospital Komga Hospital Fort Beaufort Hospital Cathcart Hospital Butterworth Hospital Bedford Orthopaedic Hospital Adelaide Hospital	Programme 2	2018/01/15	2025/03/31	R3 000 000,00	R9 660 000,00	R10 143 000,00
8.	Andries Vosloo Hospital, Sundays Valley, Midlands Hospital	Andries Vosloo Hospital, Sundays Valley, Midlands Hospital	Programme 8	2022/11/05	2025/12/01	R500 000,00	R0,00	R0,00
10.	Bedford Orthopaedics Hospital - Minor Renovations and Renovation Works	Minor Renovations and Refurbishment Works (Maintenance)	Programme 8	2022/11/15	2025/10/15	R1 500 000,00	R500 000,00	R0,00
11.	Bhisho Hospital: Urgent repairs and maintenance	Urgent repairs and maintenance	Programme 8	2021/12/03	2029/04/30	R4 096 809,00	R0,00	R0,00
12.	Bhongweni Clinic Phase I - Renovations & Extensions	- Renovation and Refurbishment of existing clinic - Extensions include construction of new pharmacy; new sputum booth; under-cover waiting area with ablution facilities - Renovations and repairs includes replacement of all existing screeds and floor coverings with new screeds and vinyl sheeting; installation of new locksets; replacement of existing doors;	Programme 8	2018/04/02	2025/06/30	R8 200 000,00	R2 000 000,00	R3 380 226,00

No	Project Name	Project Details / Scope	Budget Programme Name	Start Date	End Date	Budget 2025/2026	Budget 2026/2027	Budget 2027/2028
		replacement of parts of existing ceilings and cornices with new plasterboard ceilings and cornices; replacement of all existing sanitary fittings with new fittings and replace damaged pipework where necessary; installation of new cupboards, worktops and counters; installation of new internal signage; installation of new steel shelving; replacement of internal plaster where required; painting all internal walls, door frames, existing windows, doors and skirtings; electrical installation; HVAC installation						
13.	Butterworth Hospital - Repairs and Renovations Ph2	Maternity Phase 2, repairing of the steel bridge linking	Programme 8	2021/01/26	2026/10/30	R13 000 000,00	R9 000 000,00	R1 000 000,00
14.	Canzibe Hospital Upgrade Phase I - Urgent Maintenance and Repairs Works	Phase I - Urgent Maintenance and Repair Work	Programme 8	2015/02/23	2025/11/30	R8 200 000,00	R0,00	R0,00
15.	Cecelia Makiwane Hospital - Refurbishments Cerebral Palsy, Family Med, Mental Health & Nurse TU	Cecelia Makiwane Hospital - Infrastructure Improvements, alterations and additions to accommodate the Cerebral Palsy, Family medicine, Mental Health & Nurse training Units	Programme 8	2022/10/11	2025/10/13	R17 000 000,00	R900 000,00	R0,00
16.	Chris Hani District Hospitals: Lift Replacement 2018/2019	This is a day to day maintenance, servicing and repairs of lifts in the facilities done in compliance with the Lift, Escalator and Passenger Conveyor Regulations. 2009 Regulation.	Programme 8	2022/11/23	2025/03/28	21000000	1500000	3000000
17.	Cofimvaba Hospital Infrastructure Improvements - Phase I	Renovations and refurbishments of existing staff accommodation houses located across the road to the hospital, new parking area, and access roads, roof repairs & temporary MDR TB clinic	Programme 8	2024/04/01	2026/04/01	R2 300 000,00	R3 000 000,00	R0,00

No	Project Name	Project Details / Scope	Budget Programme Name	Start Date	End Date	Budget 2025/2026	Budget 2026/2027	Budget 2027/2028
18.	Completion of Nokhatsile Clinic_	Completion of Nokhatsile Clinic_ Completion of municipality donated clinic SCOPE: Completion of the Clinic Provisions: 1. Staff accommodation 2. Water reticulation 3. Provision of electrical supply. Facility Coordinates: -30.707656, 29.654142	Programme 8	2024/09/27	2025/03/28	R3 180 000,00	R7 500 000,00	R4 900 000,00
19.	Conditional Assessments to all Health Facilities - Alfred Nzo	Conditional Assessments to all Health Facilities - Alfred Nzo	Programme 8	2021/07/21	2025/12/03	500000	R0	R0
20.	Conditional Assessments to all Health Facilities - Amathole	Conditional Assessments to all Health Facilities - Amathole	Programme 8	2021/07/21	2027/09/15	1000000	3618000	2842720
	Conditional Assessments to all Health Facilities - Buffalo City	Conditional Assessments to all Health Facilities - Buffalo City	Programme 8	2021/07/21	2027/06/09	R3 800 000,00	R2 300 000,00	R2 842 720,00
21.	Conditional Assessments to all Health Facilities - Chris Hani	Conditional Assessments to all Health Facilities - Chris Hani	Programme 8	2021/07/21	2027/06/09	10000000	2370800	2000000
22.	Conditional Assessments to all Health Facilities - Joe Gqabi	Conditional Assessments to all Health Facilities - Joe Gqabi	Programme 8	2021/07/21	2027/09/21	R14 000 000,00	R1 370 800,00	R505 632,00
23.	Conditional Assessments to all Health Facilities - OR Tambo	Conditional Assessments to all Health Facilities - OR Tambo	Programme 8	2021/07/21	2027/04/12	1800000	2618000	2000000
24.	Conditional Assessments to all Health Facilities Sarah Baartman	Conditional Assessments	Programme 8	2021/07/21	2027/06/09	R29 836 982,00	R1 370 800,00	R2 000 000,00
25.	Conditional Assessments to all Ideal Clinics - Amathole	Conditional Assessments to all Ideal Clinics - Amathole	Programme 8	2021/07/20	2027/11/17	33800000	3618000	2842720
26.	Conditional Assessments to all Ideal Clinics - Buffalo City	Conditional Assessments to all Ideal Clinics - Buffalo City	Programme 8	2020/11/09	2027/09/09	7000000	5000000	2842720
27.	Conditional Assessments to all	Conditional Assessments to all Ideal Clinics -	Programme 8	2020/11/09	2027/07/22	1000000	3618000	2000000

No	Project Name	Project Details / Scope	Budget Programme Name	Start Date	End Date	Budget 2025/2026	Budget 2026/2027	Budget 2027/2028
	Ideal Clinics - Chris Hani	Chris Hani						
28.	Conditional Assessments to all Ideal Clinics - Joe Gqabi	Conditional Assessments to all Ideal Clinics - Joe Gqabi	Programme 8	2020/11/09	2027/10/25	500000	2618000	2842720
29.	Conditional Assessments to all Ideal Clinics - OR Tambo	Conditional Assessments to all Ideal Clinics - OR Tambo	Programme 8	2021/07/21	2027/08/27	2000000	2618000	2000000
30.	Conditional Assessments to all ideal clinics Sarah Baartman	Conditional Assessments	Programme 8	2020/11/09	2027/10/23	3904573	2494400	2000000
31.	Construction of a New Clinic at Xhora Mouth	New Building including site works and bulk services	Programme 8	2020/03/25	2028/12/29	R1 500 000,00	R23 000 000,00	R8 000 000,00
32.	Construction of a New Clinic in Mpozolo	Construction of a New Clinic in Mpozolo	Programme 8	2024/04/01	2026/10/01	R5 000 000,00	R12 000 000,00	R15 000 000,00
33.	Construction of a new CHC in NUI4	Construction of a new CHC in NUI4	Programme 8	2024/07/09	2025/09/09	R16 000 000,00	R543 000,00	R0
34.	Construction of a new Clinic in Cebe Village	New Building including site works and bulk services	Programme 8	2021/04/06	2026/05/15	R8 000 000,00	R3 000 000,00	R2 000 000,00
35.	Construction of Balfour Clinic	New Building including accommodation, site works and bulk services to replace an already existing condemned facility.	Programme 8	2023/03/27	2025/03/27	R30 000 000,00	R9 000 000,00	R1 000 000,00
36.	Cwele Clinic - New Replacement Clinic and Staff Accommodation	Replacement of Clinic building, 2 nos of new staff accommodation units and other associated works and services.	Programme 8	2012/07/02	2026/02/26	R5 000 000,00	R16 000 000,00	R20 000 000,00
37.	Disaster Projects in Alfred Nzo Region	Disaster Projects in Alfred Nzo Region	Programme 8	2022/05/03	2028/03/31	R4 911 000,00	R31 446 631,00	R32 738 487,00
38.	Dora Nginza Hospital – Improvements to existing buildings	The Scope involves the improvements to Security Infrastructure, including the construction of a new perimeter concrete wall, roof repairs and addressing back-log maintenance. It has an 11-month contract period, and the value is R32 million. I. During the period under review the JBCC Contract was signed, SMME's procured, and	Programme 8	2023/04/01	2025/12/19	R4 500 000,00	R40 560 888,00	R4 000 000,00

No	Project Name	Project Details / Scope	Budget Programme Name	Start Date	End Date	Budget 2025/2026	Budget 2026/2027	Budget 2027/2028
		the Site Handover possession certificate issued on the 5th of July 2024. The 1st Progress meeting took place on the 23rd of July 2024, and no project challenges were reported. Project is currently not experiencing any challenges and progress is consistent with the planned milestones. The Contract value is R32 million. 2. The Phase 2 Upgrade Bid Evaluation report was approved by BAC on 15 July 2024, and SCM Contracts Management is in the process of issuing the LOA. 3. The Phase 3 Upgrade Bid Evaluation report is ready for presentation to BAC IN August 2024. The scope involves the upgrade of 2 vacant buildings, for accommodating a cerebral palsy treatment center of excellence. The estimate is R59,1m. 3. Dora Nginza Hospital - The Department has also completed improvements to an existing space in Casualty Department for use as a Cerebral Palsy OPD Centre at existing Casualty, estimated value R at a value of 950k. 4. The Phase 4 Upgrade Bid involves the repairs to all the roofs at Dora Nginza Hospital, and the planning and procurement is scheduled for the 2nd & 3rd Qtr. of the 2025/2026 FY.						
39.	Electrification and water connections - Alfred Nzo	Refurbishment of Solar Installations, New Grid Connections/Conversions, Water Storage, Water Borne Sewage System and	Programme 8	2018/10/01	2026/12/31	1000000	662500	689000

No	Project Name	Project Details / Scope	Budget Programme Name	Start Date	End Date	Budget 2025/2026	Budget 2026/2027	Budget 2027/2028
		Associated Plumbing						
40.	Electrification and water connections - Amathole	Refurbishment of Solar Installations, New Grid Connections/Conversions, Water Storage, Water Borne Sewage System and Associated Plumbing	Programme 8	2018/10/01	2026/12/31	2217203	5000000	0
42.	Electrification and water connections - Chris Hani	Refurbishment of Solar Installations, New Grid Connections/Conversions, Water Storage, Water Borne Sewage System and Associated Plumbing	Programme 8	2018/04/16	2026/12/31	1000000	5000000	5200000
	Electrification and water connections - OR Tambo	Refurbishment of Solar Installations, New Grid Connections/Conversions, Water Storage, Water Borne Sewage System and Associated Plumbing	Programme 8	2018/10/01	2028/03/31	2500000	5000000	5200000
43.	Empilisweni Hospital Phase I - Temporary Staff Accommodation	INITIAL SCOPE OF WORK 1. Temporary staff accommodation for doctors and health professionals. (Provision of Park Homes) 2. Provision of electrical and civil works bulk services. 3. Demolition of condemned buildings. COMPLETION OF SCOPE OF WORK 1. Refurbishment of the old Nurses Home into Staff Accommodation for doctors and health professionals 2. Refurbishment of the remaining park home to a short stay-over facility for patients. 3. Refurbishment and upgrades of two (2) doctor houses in the town of Sterkspruit. 4. Upgrades and reconfiguration of the COVID-19 ward to an isolation facility. 5. Upgrades and additions to the mortuary building.	Programme 8	2018/06/05	2026/12/05	R2 394 245,00	R6 360 000,00	R9 118 044,00

No	Project Name	Project Details / Scope	Budget Programme Name	Start Date	End Date	Budget 2025/2026	Budget 2026/2027	Budget 2027/2028
44.	Fort Beaufort Hospital- Upgrading of the Hospital	Planning for the construction of an OPD, Casualty and general maintenance of buildings at Fort Beaufort Hospital. Upgrading of water reticulation system and plumbing works and repairs and renovations to Staff Accommodation.	Programme 8	2021/08/31	2025/12/12	R1 000 000,00	R1 000 000,00	R15 000 000,00
45.	Frere Hospital Extension of the Orthopaedic theatre	Frere Hospital Extension of the Orthopaedic theatres and construction of a new Orthopaedic ward.	Programme 8	2017/10/06	2027/06/30	R5 000 000,00	R500 000,00	R0,00
47.	Frontier Hospital Upgrade of Health Professional Accommodation	Health Professional Accommodation Repairs, renovations & reconfiguration of existing Health Professional Accommodation, at Frontier Hospital: Section 1: (18 months) 1.1 Frontier hospital: Double Storey Administration building, Single storey Hall and storage area, Double Storey Hostel Building - 12 beds 1.2 Komani Hospital: Double Storey student Accommodation Building (The Palms) - 40 beds 1.3 Kingsway Double storey Flats - 7 beds 1.4 House – 18 Buxton Street - 5 beds All associated external works and Electrical works Section 2: (12 months) 2.1 Frontier hospital: Single storey Hostel Building, Single Storey Doctor's accommodation Flat 1, 2 & 3, Single Storey Accommodation Flat 4 & 5 - 33 beds 2.2 House - 61 Wodehouse Street - 5 beds 2.3 House – 24 Winterberg Road - beds	Programme 8	2023/02/02	2025/08/02	R500 000,00	R3 000 000,00	R0,00

No	Project Name	Project Details / Scope	Budget Programme Name	Start Date	End Date	Budget 2025/2026	Budget 2026/2027	Budget 2027/2028
		All associated external works and Electrical works						
48.	Goodhope Clinic Phase 2	The project scope includes the following elopements the specific requirements of which is further detailed in the schedule of accommodation provided in this document. i. This new Ideal Clinic has an estimated size of 814m², including circulation and excluding staff accommodation, on a Brownfield site identified by the community and the Traditional Leadership of Makhwaleni Village. ii. This clinic will be composed of a. Guard house at an estimated floor area of 18 m² b. Clinical building of 6 x Consulting rooms, 2 x Counselling rooms & the respective clinical support spaces, at an estimated total floor area of 679m² c. Housing component of 3 x 2bedroom units at an estimated total floor area 410 m². iii. Appropriate External Works, including fencing, paved access road, parking, pedestrian walkways, ramps, civil works, storm water control and landscaping. iv. Appropriate bulk services improvements such as: electrical (including appropriate backup for medicine store, emergency lighting and data capture office), ICT, water (including backup bulk tank and stand), sewer & storm water. v. Air-conditioning split units to the medicine store and consulting rooms.	Programme 8	2024/03/25	2026/07/25	R4 000 000,00	R11 000 000,00	R10 000 000,00
49.	Greenville Hospital- Upgrading of the existing 100 Bedded District	Upgrading of the existing 100 Bedded District Hospital including but not limited to bulk	Programme 8	2022/09/06	2028/03/31	R660 022,00	R75 000 000,00	R49 000 000,00

No	Project Name	Project Details / Scope	Budget Programme Name	Start Date	End Date	Budget 2025/2026	Budget 2026/2027	Budget 2027/2028
	Hospital and support services	earthworks, electrical works, civil works, staff accommodation, construction of the Gateway Clinic, Completion of the Guardhouse, procurement and commissioning of medical equipment, upgrading of water treatment works at Greenville Hospital in Winnie Mandela Municipality.						
50.	Haytor Clinic - Infrastructure Improvements	Haytor Clinic - Maintenance & improvements	Programme 8	2018/02/05	2025/12/01	R5 000 000,00	R1 000 000,00	R0,00
51.	Infrastructure Improvement projects, including ABT at Health Facilities, in Alfred Nzo District ES	Minor repairs to building items, internal & external painting	Programme 8	2023/03/01	2026/12/01	R6 000 000,00	R15 300 000,00	R22 000 000,00
52.	Infrastructure Improvement projects, including ABT at Health Facilities, in Amathole District	Infrastructure Improvement projects, including ABT at Health Facilities, in Amathole District	Programme 8	2023/02/02	2026/12/31	R2 700 000,00	R15 000 000,00	R26 000 000,00
53.	Infrastructure Improvement projects, including ABT at Health Facilities, in BCM Health District	Infrastructure Improvement projects, including ABT at Health Facilities, in BCM Health District	Programme 8	2023/02/07	2025/12/31	R8 200 000,00	R17 359 580,00	R30 000 000,00
54.	Infrastructure Improvement projects, including ABT at Health Facilities, in Chris Hani District	Infrastructure Improvement projects, including ABT at Health Facilities, in Chris Hani District	Programme 8	2023/12/01	2026/12/01	R8 000 000,00	R16 360 000,00	R17 000 000,00
55.	Infrastructure Improvement projects, including ABT at Health Facilities, in Joe Gqabi District	Infrastructure Improvement projects, including ABT at Health Facilities, in Joe Gqabi District PACKAGED PROJECTS (IMPLEMENTED BY ECDOH UTILISING PMUI) Package 1: Aliwal Poly Clinic - RRR Package 2: Ncemu Clinic - RRR Package 3: Sonwabile Clinic - RRR Package 4: Macacuma Clinic - RRR Package 5: Masibulele Clinic - RRR	Programme 8	2024/05/13	2025/01/17	R10 000 000,00	R15 000 000,00	R25 969 725,00

No	Project Name	Project Details / Scope	Budget Programme Name	Start Date	End Date	Budget 2025/2026	Budget 2026/2027	Budget 2027/2028
		Package 6: Robert Mjobo Clinic - RRR Package 7: Sonwabo Zandile (Barkley East) Clinic - RRR Package 8: Sterkspruit Town Clinic - RRR Package 9: Jamestown Clinic - RRR Package 10: Venterstad Clinic - RRR PACKAGED PROJECTS (IMPLEMENTED BY ECDOH UTILISING PSP'S WALTER SISULU DISTRICT) Package 11: Aliwal North hospital - Nurses home - RRR Package 12: Oviston Satellite Clinic - RRR Package 13: Eureka clinic Package 14: Khayamnandi clinic Package 15: Maletswai clinic						
56.	Infrastructure Improvement projects, including ABT at Health Facilities, in NMB District	The Project consist of several packages. The assessments of 28 facilities have been concluded and the Design Documentation and Bid Specification documents are at an advanced stage of finalisation. SCMU3-P23/24-0872-NMM: SIBONESENI CONSTRUCTION (3 months) REMOVING AND CARTING AWAY EXISTING VIBRACRETE FENCE AND INSTALLING NEW 2,1M HIGH VIBRACRETE WALL AT WALMER CLINIC AND NEW STORMWATER PIPE AND HEADWALL AT GQEBERHA CHC This Project reached Practical Completion Stage. Progress is consistent with the planned milestones, and Practical Completion was	Programme 8	2023/04/03	2026/10/24	R15 913 459,00	R15 000 000,00	R22 000 000,00

No	Project Name	Project Details / Scope	Budget Programme Name	Start Date	End Date	Budget 2025/2026	Budget 2026/2027	Budget 2027/2028
		achieved on 13 August 2024.						
57.	Infrastructure Improvement projects, including ABT at Health Facilities, in OR Tambo District	Infrastructure Improvement projects, including ABT at Health Facilities, in OR Tambo District	Programme 8	2023/12/01	2026/12/01	R6 414 775,00	R15 180 000,00	R20 000 000,00
58.	Infrastructure Improvement projects, including ABT at Health Facilities, in Sarah Baartman District	Infrastructure Improvement projects, including ABT at Health Facilities, in Sarah Baartman District	Programme 8	2024/05/13	2026/12/01	R12 000 000,00	R15 000 000,00	R20 839 930,00
59.	Infrastructure Improvements to Health Facilities: NMBM - Sub District A: NU 11 Clinic; Upgrade & Add	The Project consist of several packages. The assessments of 28 facilities have been concluded and the Design Documentation and Bid Specification documents are at an advanced stage of finalisation. Refurbishment and rehabilitation including the provision of ABT structures, adhoc and planned buildings maintenance to provide health services	Programme 8	2023/04/03	2026/12/01	R500 000,00	R15 000 000,00	R7 815 376,00
60.	Isilimela Hospital Upgrade Phase I - Refurbishment of Existing Staff Accommodation	Refurbishment of existing staff accommodation units, provision of temporary prefabricated accommodation units, including 2nos of two bedroomed units, 1 no. of three bedroomed unit, 1nos unit of six bedrooms including associated works and services.	Programme 8	2015/03/02	2026/05/29	R4 000 000,00	R0,00	R0,00
61.	Isilimela Hospital Upgrade Phase 02	Isilimela Hospital - Minor repairs to building items, internal & external painting	Programme 8	2017/07/03	2026/09/30	R8 200 000,00	R0,00	R0,00
62.	Joe Gqabi - Maintenance and repairs	Maintenance and repairs for various works at Joe Gqabi	Programme 2	2018/01/15	2024/03/29	R2 815 000,00	R8 400 000,00	R8 820 000,00
63.	Jose Pearson TB Hospital - Improvements to existing buildings to accommodate the	Jose Pearson TB Hospital - Improvements to existing buildings to accommodate the Clinical Services in terms of the revised	Programme 8	2022/06/09	2026/03/31	R2 385 999,00	R1 000 000,00	R12 000 000,00

No	Project Name	Project Details / Scope	Budget Programme Name	Start Date	End Date	Budget 2025/2026	Budget 2026/2027	Budget 2027/2028
	Clinical Services i	Service Delivery Model of the NMB District Improvements to existing Pediatric ward, Admissions Areas, provision of piped oxygen, diesel storage capacity and electrical installations. Project achieved Practical completion on two packages						
64.	Lady Grey Hospital Phase 2 - Medium Term Intervention	1. DEMOLITION OF CONDEMNED UNSAFE/ INAPPROPRIATE EASTERN WING STRUCTURE 2. RECONFIGURATION AND UPGRADE OF THE EXISTING HOSPITAL BUILDING ADDITIONS - New Guardhouse and fencing - New Out Patients Department - New Accidents and Emergencies - New Pharmacy	Programme 8	2023/04/03	2026/04/03	R2 385 999,00	R2 000 000,00	R5 000 000,00
65.	Livingstone Hospital - Renovations To Cathlab and CSSD HFRG	The scope of works involves the completion of the outstanding remaining works, which includes the ICU & CSSD as part of the Cathlab project at Livingstone PEPH Hospital Complex. The Bid to procure a replacement Contractor closed on 01 December 2023. The Bids received are currently being evaluated and tender award is expected in February 2024.	Programme 8	2017/09/01	2026/03/05	R500 000,00	R2 000 000,00	R0,00
66.	Madwaleni Hospital: Upgrade & Renovations	Upgrading of main hospital campus with the phase I works. Inclusive of new maternity wards, theatre & CSSD complex, perimeter fence, guardhouse, mortuary, upgrade pharmacy and associated site works. Includes professional staff accommodation.	Programme 8	2023/05/15	2028/05/01	R500 000,00	R99 430 000,00	2023/05/15

No	Project Name	Project Details / Scope	Budget Programme Name	Start Date	End Date	Budget 2025/2026	Budget 2026/2027	Budget 2027/2028
67.	Madwaleni Hospital: Upgrade & Renovations	Upgrading of main hospital campus with the phase I works. Inclusive of new maternity wards, theatre & CSSD complex, perimeter fence, guardhouse, mortuary, upgrade pharmacy and associated site works. Includes professional staff accommodation.	Programme 8	2023/05/15	2028/05/01	R500 000,00	R99 430 000,00	R178 426 360,00
68.	Maintenance and repairs - Provincial /Tertiary Hospitals (ELIZABETH DONKIN HOSPITAL)	Maintenance and repairs - Provincial /Tertiary Hospitals (ELIZABETH DONKIN HOSPITAL)	Programme 5	2023/04/01	2025/12/01	R2 500 000,00	R2 100 000,00	R2 205 000,00
69.	Maintenance and repairs - Provincial /Tertiary Hospitals (FORT ENGLAND HOSPITAL)	Maintenance and repairs - Provincial /Tertiary Hospitals (FORT ENGLAND HOSPITAL)	Programme 5	2023/04/01	2025/12/01	R2 000 000,00	R2 100 000,00	R2 205 000,00
70.	Maintenance and repairs - Provincial /Tertiary Hospitals (KOMANI HOSPITAL)	Maintenance and repairs - Provincial /Tertiary Hospitals (KOMANI HOSPITAL)	Programme 5	2024/01/08	2026/12/01	R2 000 000,00	R2 000 000,00	R2 000 000,00
71.	Maintenance and repairs - Provincial /Tertiary Hospitals (LIVINGSTONE/PE PROVINCIAL)	Maintenance and repairs - Provincial /Tertiary Hospitals (LIVINGSTONE/PE PROVINCIAL)	Programme 5	2023/04/01	2026/12/01	R6 050 000,00	R18 050 000,00	R19 152 500,00
72.	Maintenance and repairs - Provincial /Tertiary Hospitals (Ngqubela TB Hospital)	Maintenance and repairs - Provincial /Tertiary Hospitals (Ngqubela TB Hospital)	Programme 5	2023/04/01	2026/12/01	R3 872 000,00	R2 100 000,00	R2 205 000,00
73.	Maintenance and repairs - Regional Hospitals (Frontier Hospital)	Decentralized maintenance budget.	Programme 4	2018/04/02	2026/09/01	R3 735 000,00	R68 426 000,00	R81 243 250,00
74.	Matubeni Clinic Renovation and Refurbishment to entire clinic	Matubeni Clinic Renovation and Refurbishment to entire clinic	Programme 8	2021/04/01	2025/06/30	R3 856 000,00	R510 000,00	R0
75.	Molteno Town Clinic Maintenance & improvements	Molteno Town Clinic Maintenance & improvements	Programme 8	2018/02/05	2025/12/10	R3 630 000,00	R5 000 000,00	R0
76.	Mthatha General Hospital - Rehabilitation of Mthatha Nursing	Renovations, reconfiguration and refurbishment of existing multi-storey building	Programme 8	2017/09/06	2025/02/28	R2 000 000,00	R0	R0

No	Project Name	Project Details / Scope	Budget Programme Name	Start Date	End Date	Budget 2025/2026	Budget 2026/2027	Budget 2027/2028
	Accommodation and Medical Depot	for Mthatha Nursing Students' Accommodation and Medical Depot.						
77.	Ndofela Clinic Phase 2 - Upgrade and Additions to the Clinic	1. Alterations to the Existing Clinic Building: 67sqm 2. Additions to the Existing Clinic: 67sqm 847sqm 3. Alterations to the Nurses Home building: 21sqm 4. Additions to the Nurses Home building: 174sqm 5. Alterations to the Guard House Home building: 16sqm 6. Additions to the Guard House Home building: 9sqm Total Anticipated Floor Area: 1133sqm	Programme 8	2017/07/04	2026/06/28	R2 000 000,00	R5 000 000,00	R3 000 000,00
78.	Nelson Mandela Academic Hospital - Urgent Repairs and Maintenance Works	Various repairs and maintenance of floors, roofs, bumper rails, and windows.	Programme 8	2021/10/08	2025/11/29	R2 000 000,00	R3 000 000,00	R0
79.	Nelson Mandela Academic Hospital - Maintenance and Repairs (Maintenance of Central Hospitals - OR T)	Maintenance and repairs for Mthatha Hospital Complex (Mthatha Hospital, Nelson Mandela Academic Hosp - Central Hospital Services) titled Nelson Mandela Academic Hospital - Maintenance and Repairs	Programme 5	2018/01/15	2026/09/30	R2 025 000,00	R31 501 000,00	R34 470 250,00
80.	Nelson Mandela Academic Hospital - New Oncology Building	New Oncology building including associated external works and services.	Programme 8	2017/10/20	2025/02/15	R2 000 000,00	R7 200 000,00	R0
81	Nelson Mandela Academic Hospital - New Oncology Building ES	New Oncology building including associated external works and services.	Programme 8	2017/10/20	2026/12/01	R783 000,00	R0	R0
82	Nelson Mandela Academic Hospital- Construction of a Dental Laboratory	Nelson Mandela Academic Hospital- Construction of a Dental Laboratory	Programme 8	2023/12/04	2025/12/01	R2 000 000,00	R0	R0
83.	Nelson Mandela Bay -	Maintenance and repairs of Various works at	Programme 8	2018/01/15	2026/12/31	R1 000	R9 660	R10 143

No	Project Name	Project Details / Scope	Budget Programme Name	Start Date	End Date	Budget 2025/2026	Budget 2026/2027	Budget 2027/2028
	Maintenance and Repairs	NMB				000,00	000,00	000,00
84.	Nelson Mandela District Hospitals: Lift Replacement for 2018/2019	Day to day maintenance and repairs of lifts in all facilities in the ECDoH's District, Regional, Central, Provincial and Tertiary Hospitals as per the Occupational Health and Safety Act of 1993.	Programme 8	2022/11/23	2026/03/31	1000000	5000000	8400000
85.	Nessie Knight Hospital Phase 7 - Refurbishment of Existing Wards, Support buildings and Lilitha Coll	Nessie Knight Hospital Phase 7 - Refurbishment of Existing Wards, Support buildings and Lilitha College, including external works	Programme 8	2023/06/09	2026/09/30	R3 630 000,00	R11 483 200,00	R0
86.	Ntshele Clinic - Modification, Extension and Additions	Ntshele Clinic - Modification, Extension and Additions to comply with Ideal Clinic Requirements	Programme 8	2024/08/05	2026/05/27	R3 025 000,00	R5 000 000,00	R0
88.	Ntsimbini Clinic - Construction of a new clinic	Ntsimbini Clinic - Construction of a new clinic	Programme 8	2022/11/19	2026/12/01	R3 025 000,00	R500 000,00	R0
90.	PE Central Clinic - Minor repairs to building items, internal & external painting	PE Central Clinic - Upgrading & Additions	Programme 8	2022/10/03	2026/12/11	R3 672 344,00	R0	R0
91.	Preventative Maintenance in Cecilia Makiwane Regional Hospital	Decentralized maintenance budget.	Programme 4	2019/05/06	2026/11/22	R2 172 344,00	R8 400 000,00	R8 820 000,00
92.	Project Management Services HFRG	Main Maintenance & Professional Services PSP / Project Management Services	Programme 8	2018/10/01	2025/03/31	R3 036 786,00	R5 000 000,00	R5 000 000,00
93.	Provision of Alternative Renewable Energy Supplies at Health Care Facilities in the Eastern Cape	Provision of Alternative Renewable Energy Supplies at Health Care Facilities in the Eastern Cape	Programme 8	2024/11/06	2025/12/01	2172344	R0	R0
94.	Refurbishment of all Clinics in Joe Gqabi	CLEAN UP PROGRAMME I. LSA District Offices: Infrastructure refurbishment to accommodate patients and	Programme 8	2020/11/17	2026/03/28	R2 172 344,00	R1 499 662,00	R31 000 000,00

No	Project Name	Project Details / Scope	Budget Programme Name	Start Date	End Date	Budget 2025/2026	Budget 2026/2027	Budget 2027/2028
		staff. 2. Maclear Hospital: Mortuary & Kitchen refurbishment and alterations to accommodate patients and staff. 3. Cloete Joubert Hospital: Refurbishment and maintenance to accommodate patients and staff. (Mortuary and kitchen) 4. Empilisweni Hospital: Refurbishment and alterations to accommodate patients and staff. 5. Umlamli Hospital: Maintenance eradication 6. St Michaels Clinic: Infrastructure refurbishment and alterations to accommodate patients and staff. 7. Aliwal North Hospital: Refurbishment and alterations to accommodate patients and staff. 8. Burgersdorp Hospital: Mortuary & Kitchen refurbishment and alterations to accommodate patients and staff. 9. Jamestown Hospital: Refurbishment and alterations to accommodate patients and staff						
95.	Repairs and Renovations to Forensic Pathology Facilities, Lilitha Colleges in NMB and SBD Districts	Repairs and Renovations to Forensic Pathology Facilities, Lilitha Colleges in 8 Districts Facilities earmarked in Nelson Mandela Bay Health District: 1. New Brighton FPL 2. Gelvandale FPL 3. Mount Road FPL 4. Uitenhage FPL Facilities earmarked in Sarah Baartman Health District: 1. Makhanda FPL - Estimate: R49mil 2. Port Alfred FPL - Estimate: R43mil	Programme 8	2021/08/31	2025/12/31	R2 172 344,00	R0	R0

No	Project Name	Project Details / Scope	Budget Programme Name	Start Date	End Date	Budget 2025/2026	Budget 2026/2027	Budget 2027/2028
		3. Graaff Reinet FPL - Estimate: R29mil 4. Joubertina CHC FPL - Estimate: R6mil						
96.	Repairs and Renovations to Forensic Pathology Facilities, Lilitha Colleges in BCM, Ama and ORT	Repairs and Renovations to Forensic Pathology Facilities, Lilitha Colleges in 8 Districts Facilities earmarked in Buffalo City Metro: 1. Mdantsane FPL 2. Woodbrook FPL 3. Bhisho FPL Facilities earmarked in Amathole District: 1. Butterworth FPL 2. Adelaide FPL 3. Idutywa FPL 4. Tafalofefe FPL	Programme 8	2021/08/31	2027/12/31	R500 000,00	R0	R0
97.	Sir Henry Elliot Water and Sanitation Upgrade	Sir Henry Elliot Water and Sanitation Upgrade	Programme 8	2022/11/16	2025/12/01	R6 000 000	R1 000 000	R0
98.	SS Gida Hospital - Renovations & refurbishments	SS Gida Hospital - Renovations & refurbishments	Programme 8	2021/11/16	2025/05/01	R8 000 000	R9 000 000	R1 000 000

II . PUBLIC-PRIVATE PARTNERSHIPS (PPPs)

The current PPP for Humansdorp contract is still in the process of being handed over and will end on the 30th September 2025.

ANNUAL PERFORMANCE PLAN 2025/26-2027/28

**PART
D**

**APP TIDS FOR
PROVINCIAL DOH**

PART D: APP TIDS FOR PROVINCIAL DOH**N:B Population based indicators are not divided by 4 when it comes to quarterly targets**

Table 55: Technical Indicator Data Set

Provincial APP 2025/26 (Standardi zed Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end); cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme	
				Numerator	Denominator										
Output Indicators															
PROGRAMME I: HEALTH ADMINISTRATION															
		12.16.1 Number of statutory documents tabled at Legislature	Statutory documents submitted and tabled at the Provincial Legislature	Departm ental website Head Office	Statutory documents submitted	Not applicable	Head Office - Copies of the documents Submission letters	Accuracy dependent of submission of valid informatio n	Not applicab le	Not applicab le	Cumulative year - end	Quarte rly	Higher	Office of the MEC	1
x		10.1.1 Audit outcome for regulatory audit expressed by AGSA	Audit opinion for Provincial Department of Health for financial performance	Annual report	Audit outcome for regulatory audit expressed by AGSA for the previous financial year	Not applicable	Auditor General report	Accuracy dependent of submission of valid documents	Not applicab le	All District s	Not applicable	Annual	Unquali fied Audit Opinio n	Chief Financi al Officer	1
		10.1.2 % of valid invoices paid within 30	Payment of suppliers using verified invoices	BAS	Valid invoices paid within 30 days	Total number of invoices received	Financial management system	Accuracy dependent of submission	Not applica ble	Not applica ble	Non-cumulative	Quarter ly	Higher	Manag er: Supply Chain	1

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
	days	within 30 days					of valid documents						Management	
	10.1.3 Approved Annual Procurement Plan	List of projects according to capital budget	SCM	Procurement plan submitted	Not applicable	SCM office: Final approved procurement plan	Accuracy dependent of submission of valid documents	Not applicable	Not applicable	Cumulative year end	Quarterly	Annual procurement plan approved	Manager: Supply Chain Management	I
	10.1.4 Amount Revenue generated (R)	Amount of revenue to be collected by districts	Financial management system	Amount of revenue collected	Not applicable	Financial management system	Client affordability	Not applicable	All districts	Cumulative year end	Quarterly	Higher	Manager: Financial Management	I
	12.1.1 Human Resource Plan approved	Approved Human Resource Plan for Health	Human Resource Plan	Human Resource Plan approved	Not applicable	HR Pan	Plan developed and approved	Not applicable	Not applicable	Non-cumulative	Annual	Higher	HR manager	I
	12.2.1 Contingent liability of medico – legal cases – rand value	Total rand value of the medico legal claims for all backlog cases that were on the case register as at	Medico-legal case management system	Total rand value of the medico legal claims for all backlog cases that were on the case register as at	Not Applicable	Medico-legal case management system	Accuracy dependent of reporting of data into the system	Not Applicable	All Districts	Non-cumulative	Annual	Lower	Legal Services	I

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
		31 March 2024		31 March 2024										
	12.3.1 Percentage of Hospitals with connectivity	Provision of Hospitals with alternative connectivity or broad band	Rollout report (spreadsheets) for sites that are live or with alternative connectivity	Total Number of hospitals with minimum 2 Mbps connectivity	Total Number of Hospitals	Reports (spreadsheets) for sites that are live or with alternative connectivity of data connectivity in hospitals	Depending on Provincial broadband Provision of departmental alternative connectivity	Not applicable	All districts	Non-cumulative	Annual	Higher	ICT Directorate / Chief Directorate	I
	12.3.2 Percentage of fixed PHC facilities with connectivity	Provide all fixed PHC facilities with alternative connectivity or broad band	Rollout report (spreadsheets) for sites that are live or with alternative connectivity	Total Number of fixed PHC facilities with minimum 1Mbps connectivity	Total Number of fixed PHC Facilities	Reports (spreadsheets) for sites that are live or with alternative connectivity of data in fixed PHC facilities	Depending on Provincial broadband Provision of departmental alternative connectivity	Not applicable	All districts	Non-cumulative	Annual	Higher	ICT Directorate / Chief Directorate	I
PROGRAMME 2: DISTRICT HEALTH SERVICES														
SUB PROGRAMME 2.1: DISTRICT MANAGEMENT														
	12.17.1	Districts	District	Number of	Not applicable	Reports	Accuracy	Not	All	Non-	Quarter	Higher	DHS	2

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
	Number of districts conducted quarterly performance reviews	conducting performance reviews per quarter	reports	Districts conducted quarterly performance reviews		Attendance register	dependent of submission of valid data for the performance reviews	applicable	Districts	cumulative	Quarterly		Manager	
SUB PROGRAMME 2.2: COMMUNITY HEALTH CLINICS														
	12.4.1 Ideal PHC facilities status obtained rate	Fixed PHC health facilities that obtained Ideal Clinic status (silver, gold, platinum) as a proportion of fixed PHC clinics and CHCs and or CDCs	Ideal health facility monitoring software	Fixed PHC health facility obtained Ideal status	Fixed PHC clinics or fixed CHCs and or CDCs Formula: Total number of clinics + Total number of CHCs and or CDCs	Ideal Health Facility monitoring software	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	Non-cumulative	Annual	Higher	Quality Assurance Manager	2
x	11.1.1 Patient Experience of Care survey rate	Fixed health facilities that have conducted Patient Experience of	National PEC Surveys Module	Facility PEC Survey done	Fixed PHC Clinics + fixed CHCs + fixed CDCs + public hospitals Formula:	Patient Surveys	Accuracy dependent on quality of data submitted by health	Not Applicable	All Districts	Non-cumulative	Annual	Higher	Quality Assurance Manager	2

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
		Care Surveys as a proportion of fixed health facilities			Total number of Clinics + total number of CHCs + total number CDCs + total number of public hospitals		facilities							
	12.6.1 Severity Assessment Code (SAC) I incident reported within 24 hours rate	Severity assessment code I incidents reported within 24 hours as a proportion of Severity assessment code I incident reported	Patient Safety Incident register	Severity assessment code I incidents reported within 24 hours	Severity assessment code I incident reported	Patient Safety Incident report	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Non - cumulative	Quarterly	Higher	Quality Assurance	2
	12.6.2 Patient Safety Incident (PSI) case closure rate	Patient Safety Incident (PSI) case closed in the reporting month as a proportion of Patient Safety	Patient safety incident register	Patient Safety Incident (PSI) case closed	Patient Safety Incident (PSI) case reported	Patient Safety Incident report	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	Non - cumulative	Quarterly	Higher	Quality Assurance	2

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
		Incident (PSI) cases reported in the reporting month												
SUB PROGRAMME 2.3: COMMUNITY HEALTH CENTERS														
x	11.1.2 Patient Experience of Care survey rate	Fixed health facilities that have conducted Patient Experience of Care Surveys as a proportion of fixed health facilities	National PEC Surveys Module	Facility PEC Survey done	Fixed PHC Clinics + fixed CHCs + fixed CDCs + public hospitals Formula: Total number of Clinics + total number of CHCs + total number CDCs + total number of public hospitals	Patient Surveys	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Non-cumulative	Annual	Higher	Quality Assurance Manager	2
	12.6.3 Severity Assessment Code (SAC) I incident reported within 24	Severity assessment code I incidents reported within 24 hours as a proportion of	Patient Safety Incident register	Severity assessment code I incidents reported within 24 hours	Severity assessment code I incident reported	Patient Safety Incident report	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Non - cumulative	Quarterly	Higher	Quality Assurance	2

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
	hours rate	Severity assessment code I incident reported												
	12.6.4 Patient Safety Incident (PSI) case closure rate	Patient Safety Incident (PSI) case closed in the reporting month as a proportion of Patient Safety Incident (PSI) cases reported in the reporting month	Patient safety incident register	Patient Safety Incident (PSI) case closed	Patient Safety Incident (PSI) case reported	Patient Safety Incident report	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	Non - cumulative	Quarterly	Higher	Quality Assurance	2
SUB PROGRAMME 2.4: COMMUNITY BASED SERVICES: DISEASE PREVENTION AND CONTROL (DPC)														
	7.1.1 Positivity rate for hypertension 18 - 44 years	Number of clients 18 - 44 years screened for hypertension and who will require being put on treatment for	PHC Comprehensive Tick Register; OPD Tick Register	Client 18 - 44 years screened for hypertension and requiring/referred for treatment for hypertension	Total number of clients 18 - 44 years screened for hypertension	DHIS report PHC Comprehensive Tick Register; OPD Tick Register and Accident and Emergency	Accuracy dependent of submission of valid documents	Not Applicable	All Districts	Non - cumulative	Quarterly	Higher	Health programmes	2

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
		hypertension				(Casualty) and Trauma unit Register								
	7.1.2 Positivity rate for hypertension 45 years and older	Number of clients ≥ 45 years screened for hypertension and who will require being put on treatment for hypertension	PHC Comprehensive Tick Register; OPD Tick Register	Client 45 years and older screened for hypertension and requiring/referred for treatment for hypertension	Total number of clients ≥ 45 years screened for hypertension	PHC Comprehensive Tick Register; OPD Tick Register and Accident and Emergency (Casualty) and Trauma unit Register	Accuracy dependent of submission of valid documents	Not Applicable	All Districts	Non - cumulative	Quarterly	Higher	Health programmes	2
	7.2.1 Positivity rate for diabetes 18 - 44 years	Number of clients 18 - 44 years screened for diabetes and who will require being put on treatment for diabetes	PHC Comprehensive Tick Register; OPD Tick Register	Client 18 - 44 years screened for diabetes and requiring/referred for treatment for diabetes.	Total number of clients 18 - 44 years screened for diabetes.	PHC Comprehensive Tick Register; OPD Tick Register and Accident and Emergency (Casualty) and Trauma unit Register	Accuracy dependent of submission of valid documents	Not Applicable	All Districts	Non - cumulative	Quarterly	Higher	Health programmes	2
	7.2.2 Positivity	Number of clients ≥ 45	PHC Comprehensive	Client 45 years and	Total number of clients ≥ 45	PHC Comprehensive	Accuracy dependent	Not Applicable	All District	Non - cumulative	Quarterly	Higher	Health progra	2

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
	rate for diabetes 45 years and older	years screened for diabetes and who will require being put on treatment for diabetes	ensive Tick Register; OPD Tick Register	older screened for diabetes and requiring/referred for treatment for diabetes	years screened for diabetes	ive Tick Register; OPD Tick Register and Accident and Emergency (Casualty) and Trauma unit Register	of submission of valid documents	ble	s				mme	
x	8.1.1 PHC mental health condition treatment rate new	Clients treated for the first time for mental conditions (depression, anxiety, dementia, psychosis, mania, suicide attempt, developmental disorders, behavioural disorders and substance abuse/addiction disorders) as a	PHC Comprehensive tick register	PHC client treated for mental health conditions - new	PHC headcount – total Formula: PHC headcount under 5 years + PHC headcount 5-9 years] + PHC headcount 10-14 years] + PHC headcount 15-19 years + PHC headcount 20 years and older]	PHC Comprehensive Tick Register	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Non-cumulative	Quarterly	Higher	Health programmes	2

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
		proportion of total PHC headcount												
	7.4.1 Cataract surgery rate	Clients who had cataract surgery per 1 million uninsured populations.	Theatre Register	Cataract surgery -total	Total uninsured population (80% of total population) Formula: Total population minus 20% of total population (MedicAid)	Theatre Register	Accuracy dependent on quality of data from health facilities	Not applicable	Districts	Non - Cumulative	Quarterly	Higher	Hospital Services Manager	2
SUB PROGRAMME 2.5: OTHER COMMUNITY SERVICE - PUBLIC HEALTH														
	12.8.1 Percentage of hospitals complying with health care risk waste norms and standards	This measure hospitals that dispose waste in line with SANS 10248 regulation as a proportion of the total health facilities	Waste disposal management system	Number of Hospitals that dispose waste in line with SANS 10248 regulation at a given reporting period	Total number of Hospitals.	Waste Disposal Certificate	Accuracy dependent of policy compliance	Not applicable	All Districts	Non - Cumulative	Quarterly	Higher	Manager health programmes	2
	12.9.1 Number of CHWs on	Number of Community Healthcare	Persal	Number of CHWs contracted by	Not applicable	Persal report	Accuracy dependent on quality	Not applicable	All districts	Non-cumulative	Quarterly	Higher	Programmes Manager	2

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
	Stipend	Workers on stipend to visit households and advocate for accessibility to health services.		the department			of data from health facilities						r for reengineering of Primary health	
	12.9.2 School grade R Learners screened	Grade R learners in the school screened by a nurse in line with the ISHP service package. This excludes follow-up visits and referrals, and each learner should be counted only once per school year	Tick register school health	Grade R Learners screened	Not applicable	ISHP register	Accuracy dependent on quality of data from health facilities	Children under or equal to 6 years	All districts	Non – Cumulative	Quarterly	Higher	Programmes Manager for reengineering of Primary health	2
SUB PROGRAMME 2.6: HIV & AIDS, STI & TB (HAST) CONTROL														
	4.1.1 HIV	Total number	HTS	HIV test done	Not applicable	HTS register	Dependent	Not	District	Non -	Quarterly	Higher	HIV/AI	2

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
	test done – sum	of HIV Tests done in all age groups	Register	total Formula: Antenatal HIV 1st test+Antenatal client HIV re-test+HIV test 18 -59 months+HIV test 5-14 years (excl ANC)+ HIV test 15 years and older (excl ANC) + HIV test 15-24 years female (excl ANC)+ HIV test 15-24 years male + HIV test 25-49 years (excl ANC) + HIV test 50 years and older			on the accuracy of facility register	applicab s		Cumulative	rly		DS Programme Manager	
x	4.1.2 HIV positive 5-14 years (excl	Children 5 to 14 years who tested HIV	PHC comprehensive	HIV positive 5-14 years (excl ANC)	HIV test 5-14 years (excl ANC)	HTS register	Dependent on the accuracy of	Children 5-14 years	All Districts	Non-cumulative	Quarterly	Lower	HIV/AIDS Programme	2

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
	ANC) rate	positive as a proportion of children who were tested for HIV in this age group	tick register HTS register				facility register						mme Manager	
x	4.1.3 HIV positive 15-24 years (excl. ANC) rate	Adolescents and youth 15 to 24 years who tested HIV positive as a proportion of children who were tested for HIV in this age group.	HIV Testing Services (HTS) register or HTS module in TIER.Net	HIV positive 15-24 years (excl ANC) Formula: HIV positive test 15-24 years female (excl ANC) + HIV positive test 15-24 years male	HIV test 15-24 years (excl ANC) Formula: HIV test 15-24 years female (excl ANC) + HIV test 15-24 years male	HTS register	Dependent on the accuracy of facility register	Youth 15-24 years	All Districts	Non-cumulative	Quarterly	Lower	HIV/AIDS Programme Manager	2
	4.1.4 ART client naïve start ART during month – sum	Total naïve clients who started life-long ART Include the following: - Clients who have never been exposed to ART for more than 30	ART clinical records captured in TIER.Net, SMARTER	ART adult and child under 15 years naïve start ART during month Formula: ART adult naïve start ART in month + ART child	None	ART clinical records captured in TIER.Net report, SMARTER	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	Non - Cumulative	Quarterly	Higher	HIV/AIDS Programme Manager	2

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
		days in total - Pregnant women enrolled onto life-long ART (Option B+) This also includes clients initiated on life-long triple therapy from the: - PEP programme - dual PMTCT programme		under 15 years naïve start ART in month										
x	4.1.5 ART adult remain in care rate [12 months]	ART adults remain in care - total as a proportion of ART adult start minus cumulative transfer out	ART clinical records captured in TIER.Net; SMARTER	ART adult remain in care (RIC) Formula: ART adult on first -line regimen + ART adult on second-line regimen + ART adult on	ART adult start minus cumulative transfer out Formula: ART adult naïve start (TOT) - ART adult cumulative transfer out	ART clinical records captured in TIER.Net; SMARTER	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	Non-cumulative	Quarterly	Higher	HIV/AIDS Programme Manager	2

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
				third-line regimen + ART adult stop treatment										
x	4.1.6 ART child remain in care rate [12 months]	ART child remain in care - total as a proportion of ART child start minus cumulative transfer out	ART clinical records captured in TIER.Net; SMARTER	ART child remain in care – total Formula: ART child on first-line regimen + ART child on second-line regimen + ART child on third-line regimen + ART child stop treatment	ART child start minus cumulative transfer out Formula: ART child under 15 years naive start - ART child cumulative transfer out	ART clinical records captured in TIER.Net report SMARTER	Accuracy dependent on quality of data submitted by health facilities	Children and adolescents	All Districts	Non-cumulative	Quarterly	Higher	HIV/AIDS Programme Manager	2
x	4.1.7 ART Adult viral load suppressed rate (below 50) [12 months]	ART adult viral load under 50 as a proportion of ART adult viral load done	ART clinical records captured in TIER.Net; SMARTER	ART adult viral load under 50	ART adult viral load done	ART clinical records captured in TIER.Net report; SMARTER	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	Non-cumulative	Quarterly	Higher	HIV/AIDS Programme Manager	2

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
			R											
x	4.1.8 ART Child viral load suppressed rate (below 50) [12 months]	ART child viral load under 50 as a proportion of ART child viral load done	ART clinical records captured in TIER.Net ; SMARTER	ART child viral load under 50	ART child viral load done	ART clinical records captured in TIER.Net report; SMARTER	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	Non-cumulative	Quarterly	Higher	HIV/AIDS Programme Manager	2
	5.1.1 TB/HIV co-infected client on ART rate	TB/HIV co-infected client on ART as a proportion of all HIV positive TB clients.	Clinical stationery	TB/HIV co-infected client on ART Formula: Count of all TB/HIV co-infected client on ART	ALL DS-TB client known HIV positive Formula: Count of ALL DS-TB client known HIV positive	Clinical stationery	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	Non - Cumulative	Quarterly	Higher	HIV/AIDS Programme Manager	2
	5.1.2 TB test 5 years and older using TB Nucleic Acid Amplification Test (NAAT)	TB symptomatic and asymptomatic client 5 years and older who was tested using TB Nucleic Acid	TB identification register	TB test 5 years and older using TB Nucleic Acid Amplification Test (NAAT)	Not Applicable	TB identification register	Accuracy dependent on quality of data submitted by health facilities	Clients 5 years and older	All Districts	Non - Cumulative	Quarterly	Higher	TB Programme Manager	2

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
		Amplification Test (NAAT)												
x	5.1.3 DS – TB treatment start 5 years and older	Clients 5 years and older who were started on DS-TB Treatment	TB identification register	DS – TB treatment start 5 years and older	Not Applicable	Clinical stationery	Accuracy dependent on quality of data submitted by health facilities	Clients 5 years and older	All Districts	Non-cumulative	Quarterly	Higher	TB Programme Manager	2
x	5.1.4 DS-TB treatment start under 5 years	Child under 5 years who were started on DS-TB Treatment	TB identification register	DS-TB treatment start under 5 years	Not Applicable	Clinical stationery	Accuracy dependent on quality of data submitted by health facilities	Clients under 5 years	All Districts	Non-cumulative	Quarterly	Higher	TB Programme Manager	2
x	5.2.1 TB Rifampicin resistant (RR) and or Multidrug-Resistant (MDR) TB client start on treatment	TB Rifampicin resistant (RR) and or Multidrug-Resistant (MDR) TB client start on treatment	Patient Folder EDRWEB	TB Rifampicin resistant /MDR confirmed client start on treatment	Not applicable	EDRWEB report	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	Non - Cumulative	Quarterly	Higher	TB Programme Manager	2
x	6.1.1 All DS - TB client treatment	All TB clients who started drug	Clinical stationery	All DS -TB successfully completed	All DS TB Treatment Start Formula:	TIER .Net report	Accuracy dependent on quality	Not applicable	All Districts	Non-cumulative	Quarterly	Higher	TB Programme	2

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
	success rate (* All DS-TB outcome data is reported 12 months later)	susceptible tuberculosis (DS TB) treatment and subsequently successfully completed treatment as a proportion of all those who started DS-TB treatment	TIER .Net	treatment Formula: All DS -TB client successfully completed treatment	Count all DS TB treatment start		of data submitted by health facilities						Manager	
x	6.1.2 TB Rifampicin resistant/Multidrug - Resistant treatment success rate	TB Rifampicin Resistant/Multidrug Resistant clients successfully completed treatment as a proportion of TB Rifampicin Resistant/Multidrug Resistant clients started on treatment	Patient folder EDRWeb	TB Rifampicin resistant/Multidrug Resistant successfully completed treatment Formula: TB RR /Multidrug Resistant MDR successfully completed treatment	TB Rifampicin Resistant/Multidrug Resistant client started on treatment Formula: Count of TB Rifampicin resistant/Multidrug Resistant client started on treatment	EDRWeb report	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Non - Cumulative	Quarterly	Higher	TB Programme Manager	2
	6.1.3 TB Pre-	TB Pre-XDR	Patient	TB Pre-XDR	TB Pre-XDR	EDRWeb	Accuracy	Not	All	Non -	Quarterly	Higher	TB	2

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
	XDR treatment success rate	clients successfully completed treatment as a proportion of TB Pre-XDR clients started on treatment	folder EDRWeb	client who successfully completed treatment Formula: TB Pre-XDR TB successfully completed treatment	client started on treatment Formula: Count of TB Pre-XDR client started on treatment	report	dependent on quality of data submitted by health facilities	Applicable	Districts	Cumulative	Quarterly	success rate	Programme Manager	
	6.1.4 All DS – TB client lost to follow – up rate	ALL TB clients who started drug-susceptible tuberculosis (DS-TB) treatment and who were subsequently lost to follow-up as a proportion of all those who started DS TB treatment	Clinical Stationery	All DS-TB lost to follow-up Formula: All DS-TB client lost to follow-up	All DS TB Treatment Start Formula: Count of all DS TB Treatment Start	TIER.Net report	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Non - Cumulative	Quarterly	Lower lost to follow up rate	TB Programme Manager	2
x	9.1.1 Malaria deaths reported	Malaria deaths reported in South Africa. The death	Malaria Information System	Malaria deaths reported	Not applicable	Malaria Information System	Accuracy dependent on quality of data	Not Applicable	All Districts	Non - Cumulative	Quarterly	Lower	Communicable Disease	2

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
		resulting from primary malaria diagnosis at the time of death	Midnight census				submitted by health facilities						s	
SUB – PROGRAMME 2.7: MCWH&N														
x	I.I.I Couple Year Protection Rate	Women protected against pregnancy by using modern contraceptive methods, including sterilisations, as proportion of female population 15-49 year. Couple year protection are the total of (Oral pill cycles / 15) + (Medroxyprogesterone injection / 4)	PHC Comprehensive Tick Register, Birth Register, Labour, Combined and Postnatal ward Health Facility Register, Theatre register, Tick register OPD, Delivery	Couple year protection Formula: Oral pill cycle + Medroxyprogesterone injection + Norethisterone enanthate injection + IUCD inserted + Male condoms distributed + Sterilisation - male + Sterilisation - female + Female condoms	Population 15-49 years females: Formula: (Female 15-44 years + Female 45-49 years)	PHC Comprehensive Tick Register, Birth Register, Labour, Combined and Postnatal ward Health Facility Register, Theatre register, Tick register OPD, Delivery register	Accuracy dependent on quality of data submitted by health facilities	Females 15-49 years	All Districts	Non - Cumulative	Quarterly	Higher rates	MCYW H&N Programme	2

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
		+ (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).	register	distributed + Sub-dermal implant inserted										
x	1.1.2 Antenatal 1 st visit before 20 weeks rate	Women who have a first visit before they are 20 weeks into their pregnancy as proportion of	PHC Comprehensive Tick Register Tick register OPD	Antenatal 1 st visit before 20 weeks	Antenatal 1 st visit- total Formula: Antenatal 1 st visit 20 weeks or later + Antenatal 1 st visit before 20	PHC Comprehensive Tick Register Tick register OPD	Accuracy dependent on quality of data submitted by health facilities	Females	All Districts	Non - Cumulative	Quarterly	Higher	MCW&H Programme Manager	2

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
		all antenatal 1st visits			weeks									
	1.1.3 Antenatal client start on ART rate	Antenatal clients who started on ART as a proportion of the total number of antenatal clients who are HIV positive and not previously on ART	PHC Comprehensive Tick Register Tick register OPD	Antenatal start on ART	Antenatal known HIV positive but NOT on ART at 1st visit Formula: Antenatal known HIV positive but NOT on ART at 1st visit + Antenatal HIV 1st test positive + Antenatal HIV re-test positive	ART clinical record captured in Tier.net	Accuracy dependent on quality of data submitted by health facilities	Females	All Districts	Non - cumulative	Quarterly	Higher	MCW&H Programme Manager	2
x	1.1.4 Delivery in 10 – 14 years In facility	Delivery where the mother is 10-14 years old. These deliveries are done in facilities under the supervision of trained	Midnight Census, Inpatient sick neonatal admission register (ISNAR), Birth Register, Paeds	Delivery 10-14 years in facility	Not applicable	Midnight Census, Inpatient sick neonatal admission register (ISNAR), Birth Register, Paeds Register	Accuracy dependent on quality of data submitted by health facilities	Females 10- 14 years	All Districts	Non - Cumulative	Quarterly	Lower	MCW&H Programme Manager	2

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
		medical / nursing staff.	Register											
	1.1.5 Delivery 15-19 years in facility	Delivery where the mother is 15-19 years old. These deliveries are done in facilities under the supervision of trained medical / nursing staff.	Midnight Census, Inpatient sick neonatal admission register (ISNAR), Birth Register, Paeds Register	Delivery 15-19 years in facility	Not applicable	Midnight Census, Inpatient sick neonatal admission register (ISNAR), Birth Register, Paeds Register	Accuracy dependent on quality of data submitted by health facilities	Females 15- 19 years	All Districts	Non - Cumulative	Quarterly	Lower	MCW&H Programme Manager	2
	1.1.6 Low birth weight rate	Infants of born alive weighing less than 2500g regardless the gestational age as proportion of total Infants born alive in health facilities (Low birth weight)	Delivery register	Live birth under 2500g in facility	Live birth in facility	Delivery register	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Non-cumulative	Quarterly	Lower rates	MCW H&N Programme	2

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
x	I.1.7 Mother postnatal visit within 6 days rate	Mothers who received postnatal care within 6 days after delivery as proportion of deliveries in health facilities	PHC Comprehensive Tick Register, Post-natal register, Maternity Register, OPD register	Mother postnatal visit within 6 days after delivery	Delivery in facility – total Formula: Delivery 10-14 years in facility + delivery 15-19 years in facility + delivery 20 years and older in facility	Midnight Census, Inpatient sick neonatal admission register (ISNAR), Birth Register, Paeds Register,	Accuracy dependent on quality of data submitted by health facilities	Females	All Districts	Non - Cumulative	Quarterly	Higher rates	MCW H&N Programme	2
	I.1.8 Maternal Mortality in facility ratio (per 100 000 live births)	Maternal death is death occurring during pregnancy, childbirth and the puerperium of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of	PHC Comprehensive Tick Register Ward; Tick register OPD delivery and ICU Register, Midnight census	Maternal death in facility	Live births known to facility Formula: Live births in facility + Born alive before arrival in facility	PHC Comprehensive Tick Register Ward; Tick register OPD delivery and ICU Register, Midnight census	Accuracy dependent on quality of data submitted by health facilities	Females	All Districts	Non - Cumulative	Quarterly	Lower ratios	MCW&H Programme Manager	2

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
		the duration and site of pregnancy and irrespective of the cause of death (obstetric and non-obstetric) per 100,000 live births in facility												
x	2.1.1 Infant 1 st PCR test positive at birth rate	Infants tested PCR positive for the first time at birth as proportion of infants PCR tested at birth	PHC registers, paediatric registers, TIER.Net Delivery register Tick register casualty	Infant 1st PCR test positive at birth	Infant 1st PCR test at birth	PHC registers, paediatric registers, Tier.net	Accuracy dependent on quality of data submitted by health facilities	Children	All Districts	Non - Cumulative	Quarterly	Lower rates	MCW H&N Programme	2
	2.1.2 Neonatal death in facility rate	Infants 0-28 days who died during their stay in the facility per 1000 live	Midnight Census, Inpatient sick neonatal admission	Neonatal deaths (under 28 days) in facility Formula:	Live birth in facility	Midnight Census, Inpatient sick neonatal admission register	Accuracy dependent on quality of data submitted by health	Not applicable	All Districts	Non - Cumulative	Quarterly	Lower rate	MCW & H Programme Manager	2

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
		births in facility.	n register (ISNAR), Birth Register, Paeds Register	Death in facility 0-6 days + Death in facility 7-28 days		(ISNAR), Birth Register, Paeds Register	facilities						er	
x	3.1.1 Immunisation under 1 year coverage	Children under 1 year who completed their primary course of immunisation as a proportion of population under 1 year	PHC Comprehensive Tick Register	Immunised fully under 1 year new	Population under 1 year Formula Female under 1 year + Male under 1 year	PHC Comprehensive Tick Register	Accuracy dependent on quality of data submitted by health facilities	Children under 1 year	All Districts	Non - Cumulative	Quarterly	Higher coverage	EPI Programme manager	2
x	3.1.2 MR 2 nd dose 1 year coverage	Children 12 months old who received MR 2 nd dose, as a proportion of the 1-year population. Both measles	PHC Comprehensive Tick Register Hospital Paediatric tick register	MR 2 nd dose	Target population 1 year Formula Male 1 year + Female 1 year	PHC Comprehensive Tick Register	Accuracy dependent on quality of data submitted by health facilities	Children under 1 year	All Districts	Non - Cumulative	Quarterly	Higher coverage	EPI Programme manager	2

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
		and MR doses will form part of the numerator to ensure accurate coverage of historical data												
	3.1.3 Vitamin A dose 12-59 months coverage	Children 12-59 months who received Vitamin A 200,000 units, every six months as a proportion of population 12-59 months.	PHC Comprehensive Tick Register OPD Tick register,	Vitamin A dose 12-59 months Formula Vitamin A dose 12-59 months + COS Vitamin A dose 12-59 months	Target population 12-59 months * 2 Formula (Female 1 year + Female 02-04 years + Male 1 year + Male 02-04 years) * 2	PHC Comprehensive Tick Register OPD Tick register, CHW Daily Activity Tracker	PHC register is not designed to collect longitudinal record of patients. The assumption is that the calculation proportion of children would have received two doses based on this	Children 12-59 months	All Districts	Non - Cumulative	Quarterly	Higher coverage	MCW H&N Programme	2

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
							calculation							
x	3.1.4 Child under 5 years diarrhoea case fatality rate	Diarrhoea deaths in children under 5 years as a proportion of diarrhoea separations under 5 years in health facilities	Paediatric Ward register	Diarrhoea death under 5 years	Diarrhoea separation under 5 years	Paediatric Ward register	Accuracy dependent on quality of data submitted by health facilities	Children under 5 years	All Districts	Non - Cumulative	Quarterly	Lower rate	MCW H&N Programme	2
x	3.1.5 Child under 5 years pneumonia case fatality rate	Pneumonia deaths in children under 5 years as a proportion of pneumonia separations under 5 years in health facilities	Paediatric Ward register	Pneumonia death under 5 years	Pneumonia separation under 5 years	Paediatric Ward register	Accuracy dependent on quality of data submitted by health facilities	Children under 5 years	All Districts	Non - Cumulative	Quarterly	Lower rate	MCW H&N Programme	2
x	3.1.6 Child under 5 years severe acute malnutrition	Severe acute malnutrition deaths in children under 5 years	Paediatric Ward register	Severe acute malnutrition death under 5 years	Severe acute malnutrition inpatient separation under 5 years	Paediatric Ward register	Accuracy dependent on quality of data submitted	Children under 5 years	All Districts	Non - Cumulative	Quarterly	Lower rate	MCW H&N Programme	2

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
	case fatality rate	as a proportion of severe acute malnutrition (SAM) under 5 years in health facilities					by health facilities							
	3.1.7 Death under 5 years against live birth in rate	Children under 5 years who died during their stay in the facility as a proportion of all live births	Midnight Census, Inpatient sick neonatal admission register (ISNAR), Birth Register, Paeds Register	Death in facility under 5 years total Formula: Death in facility 0-6 days + Death in facility 7-28 days + Death in facility 29 days - 11 months + Death in facility 12-59 months	Live birth in facility	Midnight Census, Inpatient sick neonatal admission register (ISNAR), Birth Register, Paeds Register	Accuracy dependent on quality of data submitted by health facilities	Children under 5 years	All Districts	Non - Cumulative	Quarterly	Lower rate	MCW H&N Programme	2
x	7.3.1 Cervical cancer screening coverage	Cervical smears in women 30 years and older as a	PHC Comprehensive Tick Register;	Cervical cancer screening done Formula:	[(80% women aged 30-50yrs/10)+(20% women aged 20 years and above	PHC Comprehensive Tick Register ;OPD tick	Accuracy dependent on quality of data submitted	Women	All Districts	Non - Cumulative	Quarterly	Higher Rate of Cervical Cancer	MCW H&N Programme	2

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
		proportion of the female population 30-50 years (80% of these women should be screened for cervical cancer every 10 years and 20% must be screened every 3 years) which should be included in the denominator because it is estimated that 20% of women 20 years and older are HIV positive	OPD tick register, Inpatient register	Cervical cancer screening in non HIV woman 30-50 years + Cervical cancer screening in HIV positive woman 20 years and older + cervical cancer screening 30 years and older + cervical cancer screening HIV positive woman 30 years and older	/3)	register, Inpatient register	by health facilities					Screening		
SUB-PROGRAMME 2.8: CORONER SERVICES														
x	12.9.1 Percentage	Measures number of	Post - mortem	Number of cold bodies	Total number of cold bodies	Post-mortem form	Accuracy dependent	Not applicab	All District	Non - Cumulative	Quarterly	Higher rate	Hospital	2

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				Numerator	Denominator									
	of post – mortem performed within 72 hours	post-mortems performed by Forensic Pathologists within a period of 3 days of receiving the body from the SAPS as a percentage of the total number of bodies received	management system	with post-mortem performed within 72 hrs. of receipt of body	received from SAPS	Register	of turnaround time for post mortem performed	le	s				services Programme Manager	
SUB – PROGRAMME 2.9: DISTRICT HOSPITALS														
	12.4.2 Ideal Hospitals status obtained rate	Health facilities that obtained Ideal status (silver, gold, platinum) as a proportion of fixed Hospitals	ICS	Health facilities obtained Ideal status	Number of hospitals	Ideal Health Monitoring Software	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	Non-cumulative	Annual	Higher	Quality Assurance Manager	2
x	11.1.3 Patient Experience	Fixed health facilities that have	National PEC Surveys	Facility PEC Survey done	Fixed PHC Clinics + fixed CHCs + fixed	Patient Surveys	Accuracy dependent on quality	Not Applicable	All Districts	Non-cumulative	Annual	Higher	Quality Assurance	2

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
	of Care survey rate	conducted Patient Experience of Care Surveys as a proportion of fixed health facilities	Module		CDCs + public hospitals Formula: Total number of Clinics + total number of CHCs + total number CDCs + total number of public hospitals		of data submitted by health facilities						Manager	
	12.6.5 Severity assessment code (SAC) 1 incident reported within 24 hours rate	Severity assessment code 1 incidents reported within 24 hours as a proportion of Severity assessment code 1 incident reported	Patient Safety Incident register	Severity assessment code 1 incidents reported within 24 hours	Severity assessment code 1 incident reported	Patient Safety Incident report	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Non - cumulative	Quarterly	Higher	Quality Assurance	2
	12.6.6 Patient Safety	Patient Safety Incident (PSI) case closed in	Patient safety incident	Patient Safety Incident (PSI) case closed	Patient Safety Incident (PSI) case reported	Patient Safety Incident	Accuracy dependent on quality	Not applicable	All Districts	Non - cumulative	Quarterly	Higher	Quality Assurance	2

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
	Incident (PSI) case closure rate	the reporting month as a proportion of Patient Safety Incident (PSI) cases reported in the reporting month	register			report	of data submitted by health facilities							
	12.10.1 Average Length of Stay	The average number of client days an admitted client spends in hospital before separation. Inpatient separation is the total of Inpatient discharges, Inpatient deaths and Inpatient transfers out. Include all specialities	Midnight Census	Inpatient days + 1/2 Day clients Formula: Inpatient days total + Day patient total	Inpatient separations Formula: Inpatient deaths - total + inpatient discharges - total + inpatient transfers out - total	Midnight Census	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	Non - cumulative	Quarterly	Higher	Hospital manager	2

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
	12.10.2 Inpatient (usable) bed utilisation rates	Inpatient bed days used as proportion of inpatient beds usable- total days (inpatient beds x days in period) available. Include all specialities	Midnight Census, Bed approval letter	Inpatient days + 1/2 Day patients Formula: Inpatient days total + Day patient total	Inpatient beds usable - total bed days available Formula: Inpatient beds usable - total * 30.42	Midnight Census, Bed approval letter	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	Non - cumulative	Quarterly	Higher	Hospital manager	2
	12.10.3 Expenditure per PDE	Average cost per patient day equivalent (PDE). PDE is the Inpatient days total + Day Patients * 0.5 + (Emergency headcount + OPD headcount total) * 0.3333333	Accident and Emergency unit (Casualty) and Trauma unit register, Midnight Census, Management – BAS report, Ambulatory	Expenditure - total	Patient Day Equivalent – Total Formula: Sum ([Inpatient days total x 1]) + ([Day patient total x 0.5]) + ([OPD headcount not referred new x 0.3333333]) + SUM([OPD headcount referred new x 0.3333333]) + ([OPD headcount	Accident and Emergency unit (Casualty) and Trauma unit register, Midnight Census, Management – BAS report, Ambulatory register	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	Non-Cumulative	Quarterly	Lower	Hospital manager	2

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
			register		follow-up x 0.3333333)+([Casualty headcount - Emergency x 0.3333333)+([Casualty headcount - non-emergency x 0.3333333])									
PROGRAMME 3: EMERGENCY MEDICAL SERVICES														
	12.11.1 EMS PI urban response under 30 minutes rate	EMS PI calls in urban locations with response times under 30 minutes as a proportion of EMS PI urban responses	EMS Province specific data collection tools	EMS PI urban response under 30 minutes	EMS PI urban response	EMS Province specific data collections tools	Accuracy dependent on quality of data from reporting EMS station	Not Applicable	All Districts	Non-Cumulative	Quarterly	Higher response rate under 30 min	Emergency Medical Services Manager	3
	12.11.2 EMS PI rural response under 60 minutes rate	EMS PI calls in rural locations with response times under 60 minutes as a proportion	EMS Province specific data collection tools	EMS PI rural response under 60 minutes	EMS PI rural response	EMS Province specific data collections tools	Accuracy dependent on quality of data from reporting EMS	Not Applicable	All Districts	Non-Cumulative	Quarterly	Higher response rate under 60 min	Emergency Medical Services Manager	3

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
		of EMS PI rural responses					station							
	12.11.3 Number of Patients transported on the PTV services	Patients transported on the PTV referred to the next level of care	EMS province specific data collection tool.	Number of Patients transported on the PTV services	Not applicable	Logbook	Accuracy dependent of valid on the road PTVs and patients to be transported	Not applicable	All districts	Non - cumulative	Quarterly	Lower	Emergency Medical Services Manager	3
PROGRAMME 4														
SUB-PROGRAMME 4.1: GENERAL (REGIONAL) HOSPITALS														
x	11.1.4 Patient Experience of Care survey rate	Fixed health facilities that have conducted Patient Experience of Care Surveys as a proportion of fixed health facilities	National PEC Surveys Module	Facility PEC Survey done	Fixed PHC Clinics + fixed CHCs + fixed CDCs + public hospitals Formula: Total number of Clinics + total number of CHCs + total number CDCs + total number of public	Patient Surveys	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Non-cumulative	Annual	Higher	Quality Assurance Manager	2

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
					hospitals									
	12.6.7 Severity Assessment Code (SAC) I incident reported within 24 hours rate	Severity assessment code I incidents reported within 24 hours as a proportion of Severity assessment code I incident reported	Patient Safety Incident register	Severity assessment code I incidents reported within 24 hours	Severity assessment code I incident reported	Patient Safety Incident report	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Non - cumulative	Quarterly	Higher	Quality Assurance	4
	12.6.8 Patient Safety Incident (PSI) case closure rate	Patient Safety Incident (PSI) case closed in the reporting month as a proportion of Patient Safety Incident (PSI) cases reported in the reporting month	Patient safety incident register	Patient Safety Incident (PSI) case closed	Patient Safety Incident (PSI) case reported	Patient Safety Incident report	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	Non - cumulative	Quarterly	Higher	Quality Assurance	4
	12.10.4 Average	The average number of	Midnight Census	Inpatient days + 1/2 Day	Inpatient separations	Midnight Census	Accuracy dependent	Not applicab	All District	Non - cumulative	Quarterly	Higher	Hospital	4

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
	length of stay-total	client days an admitted client spends in hospital before separation. Inpatient separation is the total of Inpatient discharges, Inpatient deaths and Inpatient transfers out. Include all specialities		clients Formula: Inpatient days total + Day patient total	Formula: Inpatient deaths - total + inpatient discharges - total + inpatient transfers out - total		on quality of data submitted by health facilities	le	s				manage r	
	12.10.5 Inpatient (usable) bed utilisation rates	Inpatient bed days used as proportion of inpatient beds usable- total days (inpatient beds x days in period) available. Include all specialities	Midnight Census, Bed approval letter	Inpatient days + 1/2 Day patients Formula: Inpatient days total + Day patient total	Inpatient beds usable - total bed days available Formula: Inpatient beds usable - total * 30.42	Midnight Census, Bed approval letter	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	Non - cumulative	Quarterly	Higher	Hospital manager	4

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
	12.10.6 Expenditure per PDE	Average cost per patient day equivalent (PDE). PDE is the Inpatient days total + Day Patients * 0.5 + (Emergency headcount + OPD headcount total) * 0.33333333	Accident and Emergency unit (Casualty) and Trauma unit register, Midnight Census, Management – BAS report, Ambulatory register	Expenditure - total	Patient Day Equivalent – Total Formula: Sum ([Inpatient days total x 1]) + ([Day patient total x 0.5]) + ([OPD headcount not referred new x 0.33333333]) + SUM([OPD headcount referred new x 0.33333333]) + ([OPD headcount follow-up x 0.33333333]) + ([Casualty headcount - Emergency x 0.33333333]) + ([Casualty headcount - non-emergency x 0.33333333])	Accident and Emergency unit (Casualty) and Trauma unit register, Midnight Census, Management – BAS report, Ambulatory register	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	Non-Cumulative	Quarterly	Lower	Hospital manager	4
SUB-PROGRAMME 4.2: TUBERCULOSIS (TB) HOSPITALS														

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
	11.1.5 Patient Experience of Care survey rate	Fixed health facilities that have conducted Patient Experience of Care Surveys as a proportion of fixed health facilities	National PEC Surveys Module	Facility PEC Survey done	Fixed PHC Clinics + fixed CHCs + fixed CDCs + public hospitals Formula: Total number of Clinics + total number of CHCs + total number CDCs + total number of public hospitals	Patient Surveys	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Non-cumulative	Annual	Higher	Quality Assurance Manager	2
	12.6.9 Severity Assessment Code (SAC) I incident reported within 24 hours rate	Severity assessment code I incidents reported within 24 hours as a proportion of Severity assessment code I incident reported	Patient Safety Incident register	Severity assessment code I incidents reported within 24 hours	Severity assessment code I incident reported	Patient Safety Incident report	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Non - cumulative	Quarterly	Higher	Quality Assurance	4
	12.6.10	Patient Safety	Patient	Patient Safety	Patient Safety	Patient	Accuracy	Not	All	Non -	Quarter	Higher	Quality	4

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
	Patient Safety Incident (PSI) case closure rate	Incident (PSI) case closed in the reporting month as a proportion of Patient Safety Incident (PSI) cases reported in the reporting month	safety incident register	Incident (PSI) case closed	Incident (PSI) case reported	Safety Incident report	dependent on quality of data submitted by health facilities	applicable	Districts	cumulative	Quarterly		Assurance	
	12.10.7 Average length of stay	The average number of client days an admitted client spends in hospital before separation. Inpatient separation is the total of Inpatient discharges, Inpatient deaths and Inpatient transfers out.	Midnight Census	Inpatient days + 1/2 Day clients Formula: Inpatient days total + Day patient total	Inpatient separations Formula: Inpatient deaths - total + inpatient discharges - total + inpatient transfers out - total	Midnight Census	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	Non - cumulative	Quarterly	Higher	Hospital manager	4

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
		Include all specialities												
	12.10.8 Inpatient (usable) bed utilisation rates	Inpatient bed days used as proportion of inpatient beds usable- total days (inpatient beds x days in period) available. Include all specialities	Midnight Census, Bed approval letter	Inpatient days + 1/2 Day patients Formula: Inpatient days total + Day patient total	Inpatient beds usable - total bed days available Formula: Inpatient beds usable - total * 30.42	Midnight Census, Bed approval letter	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	Non - cumulative	Quarterly	Higher	Hospital manager	4
	12.10.9 Expenditure per PDE	Average cost per patient day equivalent (PDE). PDE is the Inpatient days total + Day Patients * 0.5 + (Emergency headcount + OPD headcount total) * 0.33333333	Accident and Emergency unit (Casualty) and Trauma unit register, Midnight Census, Management – BAS report,	Expenditure - total	Patient Day Equivalent – Total Formula: Sum ([Inpatient days total x 1]) + ([Day patient total x 0.5]) + ([OPD headcount not referred new x 0.33333333]) + SUM([OPD headcount referred new x	Accident and Emergency unit (Casualty) and Trauma unit register, Midnight Census, Management – BAS report, Ambulatory register	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	Non-Cumulative	Quarterly	Lower	Hospital manager	4

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
			Ambulatory register		0.3333333))+([OPD headcount follow-up x 0.3333333))+([Casualty headcount - Emergency x 0.3333333))+([Casualty headcount - non-emergency x 0.3333333]))									
SUB-PROGRAMME 4.3: PSYCHIATRIC / MENTAL HOSPITALS														
x	11.1.6. Patient Experience of Care survey rate	Fixed health facilities that have conducted Patient Experience of Care Surveys as a proportion of fixed health facilities	National PEC Surveys Module	Facility PEC Survey done	Fixed PHC Clinics + fixed CHCs + fixed CDCs + public hospitals Formula: Total number of Clinics + total number of CHCs + total number CDCs + total number of public hospitals	Patient Surveys	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Non-cumulative	Annual	Higher	Quality Assurance Manager	2
	12.6.11	Severity	Patient	Severity	Severity	Patient	Accuracy	Not	All	Non -	Quarte	Higher	Quality	5

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
	Severity Assessment Code (SAC) I incident reported within 24 hours rate	assessment code I incidents reported within 24 hours as a proportion of Severity assessment code I incident reported	Safety Incident register	assessment code I incidents reported within 24 hours	assessment code I incident reported	Safety Incident report	dependent on quality of data submitted by health facilities	Applicable	Districts	cumulative	Quarterly		Assurance	
	12.6.12 Patient Safety Incident (PSI) case closure rate	Patient Safety Incident (PSI) case closed in the reporting month as a proportion of Patient Safety Incident (PSI) cases reported in the reporting month	Patient safety incident register	Patient Safety Incident (PSI) case closed	Patient Safety Incident (PSI) case reported	Patient Safety Incident report	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	Non - cumulative	Quarterly	Higher	Quality Assurance	5
PROGRAMME 5: CENTRAL & TERTIARY HOSPITAL SERVICES														
SUB PROGRAMME 5.1- CENTRAL														
x	11.1.7	Fixed health	National	Facility PEC	Fixed PHC	Patient	Accuracy	Not	All	Non-	Annual	Higher	Quality	2

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
	Patient Experience of Care survey rate	facilities that have conducted Patient Experience of Care Surveys as a proportion of fixed health facilities	PEC Surveys Module	Survey done	Clinics + fixed CHCs + fixed CDCs + public hospitals Formula: Total number of Clinics + total number of CHCs + total number CDCs + total number of public hospitals	Surveys	dependent on quality of data submitted by health facilities	Applicable	Districts	cumulative			Assurance Manager	
	12.6.13 Severity Assessment Code (SAC) I incident reported within 24 hours rate	Severity assessment code I incidents reported within 24 hours as a proportion of Severity assessment code I incident reported	Patient Safety Incident register	Severity assessment code I incidents reported within 24 hours	Severity assessment code I incident reported	Patient Safety Incident report	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Non - cumulative	Quarterly	Higher	Quality Assurance	5
	12.6.14 Patient	Patient Safety Incident (PSI)	Patient safety	Patient Safety Incident (PSI)	Patient Safety Incident (PSI)	Patient Safety	Accuracy dependent	Not applicable	All District	Non - cumulative	Quarterly	Higher	Quality Assurance	5

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
	Safety Incident (PSI) case closure rate	case closed in the reporting month as a proportion of Patient Safety Incident (PSI) cases reported in the reporting month	incident register	case closed	case reported	Incident report	on quality of data submitted by health facilities	le	s				nce	
	12.10.10 Average length of stay	The average number of client days an admitted client spends in hospital before separation. Inpatient separation is the total of Inpatient discharges, Inpatient deaths and Inpatient transfers out. Include all	Midnight Census	Inpatient days + 1/2 Day clients Formula: Inpatient days total + Day patient total	Inpatient separations Formula: Inpatient deaths - total + inpatient discharges - total + inpatient transfers out - total	Midnight Census	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	Non - cumulative	Quarterly	Higher	Hospital manager	5

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
		specialities												
	12.11.11 Inpatient (usable) bed utilisation rates	Inpatient bed days used as proportion of inpatient beds usable- total days (inpatient beds x days in period) available. Include all specialities	Midnight Census, Bed approval letter	Inpatient days + 1/2 Day patients Formula: Inpatient days total + Day patient total	Inpatient beds usable - total bed days available Formula: Inpatient beds usable - total * 30.42	Midnight Census, Bed approval letter	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	Non - cumulative	Quarterly	Higher	Hospital manager	5
	12.12.12 Expenditure per PDE	Average cost per patient day equivalent (PDE). PDE is the Inpatient days total + Day Patients * 0.5 + (Emergency headcount + OPD headcount total) * 0.33333333	Accident and Emergency unit (Casualty) and Trauma unit register, Midnight Census, Management – BAS report, Ambulat	Expenditure - total	Patient Day Equivalent – Total Formula: Sum ([Inpatient days total x 1])+([Day patient total x 0.5])+([OPD headcount not referred new x 0.33333333])+SUM([OPD headcount referred new x 0.33333333])+([	Accident and Emergency unit (Casualty) and Trauma unit register, Midnight Census, Management – BAS report, Ambulatory register	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	Non-Cumulative	Quarterly	Lower	Hospital manager	5

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
			ory register		OPD headcount follow-up x 0.33333333)+([Casualty headcount - Emergency x 0.33333333)+([Casualty headcount - non-emergency x 0.33333333])									
SUB-PROGRAMME 5.2: PROVINCIAL TERTIARY HOSPITAL SERVICES														
x	11.1.8 Patient Experience of Care survey rate	Fixed health facilities that have conducted Patient Experience of Care Surveys as a proportion of fixed health facilities	National PEC Surveys Module	Facility PEC Survey done	Fixed PHC Clinics + fixed CHCs + fixed CDCs + public hospitals Formula: Total number of Clinics + total number of CHCs + total number CDCs + total number of public hospitals	Patient Surveys	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Non-cumulative	Annual	Higher	Quality Assurance Manager	2
	12.6.15 Severity	Severity assessment	Patient Safety	Severity assessment	Severity assessment code	Patient Safety	Accuracy dependent	Not Applicable	All District	Non - cumulative	Quarterly	Higher	Quality Assurance	5

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
	Assessment Code (SAC) I incident reported within 24 hours	code I incidents reported within 24 hours as a proportion of Severity assessment code I incident reported	Incident register	code I incidents reported within 24 hours	I incident reported	Incident report	on quality of data submitted by health facilities	ble	s				nce	
	12.6.16 Patient Safety Incident (PSI) case closure rate	Patient Safety Incident (PSI) case closed in the reporting month as a proportion of Patient Safety Incident (PSI) cases reported in the reporting month	Patient safety incident register	Patient Safety Incident (PSI) case closed	Patient Safety Incident (PSI) case reported	Patient Safety Incident report	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	Non - cumulative	Quarterly	Higher	Quality Assurance	5
	12.10.13 Average length of stay	The average number of client days an admitted client spends	Midnight Census	Inpatient days + 1/2 Day clients Formula: Inpatient days	Inpatient separations Formula: Inpatient deaths - total +	Midnight Census	Accuracy dependent on quality of data submitted	Not applicable	All Districts	Non - cumulative	Quarterly	Higher	Hospital manager	5

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
		in hospital before separation. Inpatient separation is the total of Inpatient discharges, Inpatient deaths and Inpatient transfers out. Include all specialities		total + Day patient total	inpatient discharges - total + inpatient transfers out - total		by health facilities							
	12.10.14 Inpatient (usable) bed utilisation rates	Inpatient bed days used as proportion of inpatient beds usable- total days (inpatient beds x days in period) available. Include all specialities	Midnight Census, Bed approval letter	Inpatient days + 1/2 Day patients Formula: Inpatient days total + Day patient total	Inpatient beds usable - total bed days available Formula: Inpatient beds usable - total * 30.42	Midnight Census, Bed approval letter	Accuracy dependent on quality of data submitted by health facilities	Not applicable	All Districts	Non - cumulative	Quarterly	Higher	Hospital manager	5
	12.10.15 Expenditure per PDE	Average cost per patient day equivalent	Accident and Emergen	Expenditure - total	Patient Day Equivalent – Total	Accident and Emergency unit	Accuracy dependent on quality	Not applicable	All Districts	Non-Cumulative	Quarterly	Lower	Hospital manager	5

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
		(PDE). PDE is the Inpatient days total + Day Patients * 0.5 + (Emergency headcount + OPD headcount total) * 0.33333333	cy unit (Casualty) and Trauma unit register, Midnight Census, Management – BAS report, Ambulatory register		Formula: Sum ([Inpatient days total x 1])+([Day patient total x 0.5])+([OPD headcount not referred new x 0.33333333])+SUM([OPD headcount referred new x 0.33333333])+([OPD headcount follow-up x 0.33333333])+([Casualty headcount - Emergency x 0.33333333])+([Casualty headcount - non-emergency x 0.33333333])	(Casualty) and Trauma unit register, Midnight Census, Management – BAS report, Ambulatory register	of data submitted by health facilities						r	
SUB-PROGRAMME 5.3: SPECIALISED TERTIARY HOSPITAL														
x	11.1.9 Patient Experience	Fixed health facilities that have	National PEC Surveys	Facility PEC Survey done	Fixed PHC Clinics + fixed CHCs + fixed	Patient Surveys	Accuracy dependent on quality	Not Applicable	All Districts	Non-cumulative	Annual	Higher	Quality Assurance	2

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
	of Care survey rate	conducted Patient Experience of Care Surveys as a proportion of fixed health facilities	Module		CDCs + public hospitals Formula: Total number of Clinics + total number of CHCs + total number CDCs + total number of public hospitals		of data submitted by health facilities						Manager	
	12.6.17 Severity Assessment Code (SAC) I incident reported within 24 hours rate	Severity assessment code I incidents reported within 24 hours as a proportion of Severity assessment code I incident reported	Patient Safety Incident register	Severity assessment code I incidents reported within 24 hours	Severity assessment code I incident reported	Patient Safety Incident report	Accuracy dependent on quality of data submitted by health facilities	Not Applicable	All Districts	Non - cumulative	Quarterly	Higher	Quality Assurance	5
	12.6.18 Patient Safety Incident (PSI)	Patient Safety Incident (PSI) case closed in the reporting	Patient safety incident register	Patient Safety Incident (PSI) case closed	Patient Safety Incident (PSI) case reported	Patient Safety Incident report	Accuracy dependent on quality of data	Not applicable	All Districts	Non - cumulative	Quarterly	Higher	Quality Assurance	5

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
	case closure rate	month as a proportion of Patient Safety Incident (PSI) cases reported in the reporting month					submitted by health facilities							
PROGRAMME 6: HEALTH SCIENCES AND TRAINING														
	12.12.1 Number of students completed the 4 - year Nursing comprehensive course	Nurses trained on four year diploma to improve service delivery	Training database	Number of students trained	Not applicable	Attendance Registers and Completion register	Dependant on practitioners not dropping out the study course	Not Applicable	All Districts	Non - Cumulative	Annual	Higher	Human Resources Development Programme Manager	6
	12.12.2 Number of students completed the 3 year Nursing diploma	Nurses trained on three year diploma to improve service delivery	Training database	Number of students trained	Not applicable	Attendance Registers and Completion register	Dependant on practitioners not dropping out the study course	Not Applicable	All Districts	Non - Cumulative	Annual	Higher	Human Resources Development Programme Manager	

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
	12.12.3 Number of EMS Practitioners completed Emergency Care Qualification	EMS practitioners trained on emergency care qualification	Training database	Number of EMS practitioners trained	Not applicable	Attendance Registers and Completion register	Dependant on practitioners not dropping out the study course	Not applicable	All district	Non - Cumulative	Annually	Higher	Programme Manager – Health Science and training	6
	12.12.4 Number of registrars qualified as specialist	Specialist doctors trained to improve clinical care	Training database	Number of registrars trained	Not applicable	Attendance Registers and Completion register	Dependant on practitioners not dropping out the study course	Not applicable	All district	Non - Cumulative	Annually	Higher	Programme Manager – Health Science and training	6
	12.12.5 Number of bursary students completed training	Bursary awarded to qualified applicants for training purposes	Training database	Number of students awarded bursaries	Not applicable	Attendance Registers and Completion register	Dependant on practitioners not dropping out the study course	Not applicable	All district	Non - Cumulative	Annually	Higher	Programme Manager – Health Science and training	6
	12.12.6 Number of youth placed on youth	Youth placed in different your programmes	Training database	Number of youth placed in youth programmes	Not applicable	Attendance Registers and Completion	Dependant on practitioners not	Not applicable	All district	Non - Cumulative	Annually	Higher	Programme Manager –	6

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
	programs					register	dropping out the study course						Health Science and training	
PROGRAMME 7: HEALTH CARE AND SUPPORT														
	12.13.1 Wheelchair issued adult 19 years and older rate	Wheelchairs issued as a proportion of the applications for wheelchairs received for adults 19 years and older	PHC comprehensive tick register, Tick register OPD	Wheelchair issued 19 years and older Formular: Wheelchair issued adults 19 years and older + wheelchair issued adult within the reporting month	Wheelchair required 19 years and older Formular: Wheelchair required 19 years and older	Health Care and Support Database	Depending on assessment and specialised need	Adults 19 years and older	All districts	Cumulative year end	Quarterly	Higher	Clinical support manager	7
	12.13.2 Wheelchair issued child 0-18 years rate	Wheelchairs issued as a proportion of the applications for wheelchairs received for children 0-18	PHC comprehensive tick register, Tick register OPD	Wheelchair issued to children 0 - 18 years Formular: Wheelchair issued to child 0 - 18 years within the	Wheelchairs required by children 0 - 18 years Formular: Wheelchair required 0-18 years and older	Health Care and Support Database	Depending on assessment and specialised need	Children 0-18 years	All districts	Cumulative year end	Quarterly	Higher	Clinical support manager	7

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
		years		reporting month										
	12.13.3 Hearing aid issued adult 19 years and older rate	Hearing aids issued as a proportion of the applications for hearing aids received for adult 19 years and older	PHC comprehensive tick register, Tick register OPD	Hearing aid issued to adults 19 years and older	Hearing aid required by adults 19 years and older	Health Care and Support Database	Depending on assessment and specialised need	900 of 19 years and older for both females and males	All districts	Cumulative year end	Quarterly	Higher	Clinical support manager	7
	12.13.4 Hearing aid issued child 0-18 years rate	Hearing aids issued as a proportion of the applications for hearing aids received for children 0-18 years	PHC comprehensive tick register, Tick register OPD Health Care and Support Database	Hearing aid issued to children 0 - 18 years within reporting month	Hearing aid required by children 0 - 18 years	Health Care and Support Database	Depending on assessment and specialised need	300 of 0-18 years and older for both females and males	All districts	Cumulative year end	Quarterly	Higher	Clinical support manager	7
	12.14.1 Percentage Order fulfilment for	Drug orders fulfilled completely	MEDSAS	Number of order fulfilled completely	Number of orders received x 100	MEDSAS report	Poor maintenance of stock levels by	Not applicable	All districts	Cumulative year end	Quarterly	Higher	Clinical support manager	7

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
	essential drugs at depot						the depot							
	12.14.2 Percentage of availability of essential medicine at facilities.	Manage number of essential medicines on stock	MEDSAS	Number of essential medicines available on stock	Total number of essential medicines	MEDSAS report	Poor maintenance of essential medicines stock levels at the depot	Not applicable	All districts	Cumulative year end	Quarterly	Higher	Clinical support manager	7
	12.14.3 Number of active patients on CCMDD	CCMDD clients who opted to collect their patient medicine parcels from CCMDD contracted external pick up points	CCMDD database	CCMDD Client collecting medicine parcel from contracted external pick up points (PUP)	Not applicable	CCMDD register	Poor maintenance of essential medicines stock levels at the depot	Not applicable	All districts	Non - Cumulative	Annual	Higher	Clinical support manager	7
	12.15.1 Number of Cerebral Palsy cases managed	Clinical management of Cerebral Palsy cases managed	Patient files Awarded court orders with a	Number of Cerebral Palsy cases managed	Not Applicable	Patient files Awarded court orders with a public healthcare remedy	Depending on assessment and specialised need	Not applicable	All Districts	Non - Cumulative	Quarterly	Higher	Clinical support manager	7

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
			public healthcare remedy											
PROGRAMME 8: HEALTH FACILITIES MANAGEMENT														
	12.5.1 Number of health facilities upgraded	Number of existing health facilities upgraded	Capital infrastructure project list, Schedule d Maintenance project list, and Contract projects).	Number of health facilities upgraded	Not applicable	Practical Completion Certificate	Accuracy dependent on reliability of information captured on project lists.	Not applicable	All districts	Non - Cumulative	Quarterly	Higher	Manager Health facilities	8
	12.5.2 Number of health facilities with major maintenance completed	Number of existing health facilities where major capital scheduled maintenance have been completed.	Capital infrastructure project list, Schedule d Maintenance project	Number of health facilities with major maintenance completed	Not applicable	Practical Completion Certificate	Accuracy dependent on reliability of information captured on project lists.	Not applicable	All districts	Non - Cumulative	Quarterly	Higher	Manager Health facilities	8

Provincial APP 2025/26 (Standardized Indicators)	Indicator or Title	Definition	Source of Data	Method of Calculation/Assessment		Means of verification	Assumptions	Disaggregation of Beneficiaries (where applicable)	Spatial Transformation (where applicable)	Calculation Type (Cumulative year-end; cumulative (year-to-date) or	Reporting Cycle	Desired performance	Indicator Responsibility	Budget programme
				Numerator	Denominator									
			list, and Management Contract projects).											
	12.5.3 Number of health facilities with minor maintenance completed	Number of existing health facilities where minor capital scheduled maintenance have been completed.	Capital infrastructure project list, Scheduled Maintenance project list, and Management Contract projects).	Number of health facilities with minor maintenance completed	Not applicable	Practical Completion Certificate	Accuracy dependent on reliability of information captured on project lists.	Not applicable	All districts	Non - Cumulative	Quarterly	Higher	Manger Health facilities	8

ANNEXURES TO THE ANNUAL PERFORMANCE PLAN

ANNEXURE B: CONDITIONAL GRANTS

Table 56: Conditional Grants

Name conditional grant	Purpose of the grant	Outputs	Current Annual Budget (R thousand)	Period of Grant
Human Resource and Training	- To appoint statutory positions in the health sector for systematic realisation of the human resources for health strategy and phased in of National Health Insurance; - Support provinces to fund service cost associated with clinical training and supervision of health science trainee on the public service platform	- Number and percentage of statutory posts funded from this grant (per category and discipline) and other funding sources - Number and percentage of registrar's posts funded from this grant (per discipline) and other funding sources - Number and percentage of specialist's posts funded from this grant (per discipline) and other funding sources - Number and percentage of other health professionals (clinical and allied) appointed (total by district, category and discipline)	596,426	MTEF
District Health Programme Grant	To enable the health sector to develop and implement an effective response to HIV/AIDS	HIV positive new clients identified and initiated; People living with HIV retained on care;	3,110,225	MTEF
	Prevention and protection of health workers from exposure to workplace	HIV new cases identified and tested (adults and children)		
	To enable the health sector to develop and implement an effective response to a TB	TB co-infected positive clients initiated and cured;		
National Tertiary services	Ensure the provision of tertiary health services in South Africa To compensate tertiary facilities for the additional costs associated with the provision of these services	•Number of inpatient separations •Number of day patient separations •Number of outpatient first attendances •Number of outpatient follow-up attendances •Number of inpatient days •Average length of stay by facility (tertiary) •Bed utilisation rate by facility (all levels of care)	1,351,007	MTEF
Health Facility Revitalization Grant	To help accelerate construction, maintenance, upgrading and rehabilitation of new and existing infrastructure in health including health technology (HT).	Health care facilities upgraded, rehabilitated, maintained to provide better access to clients. Quality of care at health care facilities improved	755,953	MTEF

Name conditional grant	Purpose of the grant	Outputs	Current Annual Budget (R thousand)	Period of Grant
	Organisational design (OD) systems and quality assurance (QA) To enhance capacity to deliver health infrastructure	Appointment of staff with requisite skills and qualifications to ensure that health infrastructure is delivered properly in line with norms and standards		
National Health Insurance Grant	To achieve Universal Health Access through the phased implementation of National Health Insurance (NHI) and to improve access to quality health care services.	- No. of District Health Professionals Appointed - No. Mobile healthcare Units Procured - No. of CHC Rehabilitative Sites Commissioned - No. of Dental Service Sites Commissioned - No. of Professional Service Groups Contracted - Commissioning of an Oncology Radiotherapy Bunker - No. of Decentralised Chemotherapy Sites Commissioned - No. of Mental Health Service Professionals Appointed	64,899	MTEF
Expanded Public Works Programme - Integrated	To create work opportunities related to Infrastructure Development	- Number of people employed and receiving income through the EPWP - Increased average duration of the work opportunities created	12,111	2025/26

ANNEXURE C: CONSOLIDATED INDICATORS*Table 57: Consolidated Outputs Indicators for Quality Assurance, Child Health and Womans health in facility in Primary Health Care and Hospitals*

Institution	Output Indicator (As per approved Standardised Indicators)	Annual Target 2025/26	Q1 target	Q2 target	Q3 target	Q4 target	Data Source
District Health Management (Clinics, CHCS & District Hospitals)	Patient Experience of Care survey rate	63%	-	63%	-	-	Patient Surveys
	Numerator	530		530			
	Denominator	842		842			
	Severity Assessment Code (SAC) I incident reported within 24 hours rate (Prog 4 Combined)	75%	75%	75%	75%	75%	Patient safety incident register
	Numerator	478	119	119	120	120	
	Denominator	632	158	158	158	158	
	Patient safety Incident (PSI) case closure rate	95%	95%	95%	95%	95%	Patient safety incident register
	Numerator	1 210	302	302	303	303	
	Denominator	1 268	317	317	317	317	
Provincial Hospital Services (Regional, TB & Psychiatric Hospitals)	Patient Experience of Care survey rate	100%	-	100%	-	-	Patient Surveys
	Numerator	15		15			
	Denominator	15		15			
	Severity Assessment Code (SAC) I incident reported within 24 hours rate (Prog 4 Combined)	93%	93%	93%	93%	93%	Patient safety incident register
	Numerator	478	119	119	120	120	
	Denominator	513	128	128	128	129	
	Patient safety Incident (PSI) case closure rate	96%	96%	96%	96%	96%	Patient safety incident register
	Numerator	994	153	154	154	153	
	Denominator	1 038	248	248	249	249	
Central, Tertiary & Specialised Tertiary Hospitals	Patient Experience of Care survey rate	100%	-	100%	-	-	Patient Surveys
	Numerator	4		4			
	Denominator	4		4			
	Severity Assessment Code (SAC) I incident reported within 24 hours rate (Prog 4 Combined)	90%	90%	90%	90%	90%	Patient safety incident register

Institution	Output Indicator (As per approved Standardised Indicators)	Annual Target 2025/26	Q1 target	Q2 target	Q3 target	Q4 target	Data Source
	Numerator	390	97	97	98	98	
	Denominator	433	108	108	108	109	
	Patient safety Incident (PSI) case closure rate	99%	99%	99%	99%	99%	Patient safety incident register
	Numerator	822	205	205	206	206	
	Denominator	828	207	207	207	207	

ANNEXURE D: DISTRICT DEVELOPMENT MODEL

Table 58: DDM Projects

#	Work Streams	Project Name	Scope of Work	Budget Programme Name	District	Latitude	Longitude	Budget 2025/26	Budget 2026/27	Budget 2027/28	Project Leader	Social Partner
I.	Capital Infrastructure	Upgrading of Zithulele District Hospital - Construction of the Main Hospital Complex and Staff Accommodation	Replacement of existing hospital to a Level I District Hospital – Services to include: • 157 Bed Inpatient Facilities • General Male & Female Wards • Obstetric & Basic Gynaecology Inpatient Care • Paediatric Care • Infectious diseases Unit • General Outpatient Services • 24hr Emergency Unit • Clinical Support Services • Rehabilitation and sub-acute services • Gateway Clinic • Staff Accommodation	District Hospital	OR Tambo	32.04918228000	29.06018109000	R108 750 000,00	R23 359 246,63	-	Manager Infrastructure	NDOH, ECDOH & COGTA

#	Work Streams	Project Name	Scope of Work	Budget Programme Name	District	Latitude	Longitude	Budget 2025/26	Budget 2026/27	Budget 2027/28	Project Leader	Social Partner
2.	Capital Infrastructure	Upgrading of Bambisana District Hospital - Construction of the Main Hospital Complex and Staff Accommodation	Phase 1 -Clinical Services, Infectious Diseases and General Ward, Theatre, Maternity and Clinical Support • Staff Accommodation Phase 2 – Paediatric Ward and Male General Ward Rehabilitation Unit Services Buildings(Laundry, Kitchen, Mortuary, Stores, Workshop and Waste Management	District Hospital	OR Tambo	31,45045408000	29.45394919000	R 206 250 000,00	R40 901 644,93	-	Manager Infrastructure	NDOH,ECDOH & COGTA

ANNEXURE E: PROCESS FOR DEVELOPING THE 2025/26 ANNUAL PERFORMANCE PLAN (APP)

In preparing for the development of the 2025/26-2029/30 Strategic Plan and 2025/26 Annual Performance Plan, the Department conducted an internal and external environment scanning to inform the situation analysis. These sessions included the following: - consultation session for pre planning session were held with Programme and Sub-Programme managers with their teams in August as follows:

- Sub programme 2 - District Management, Clinics and Community Health Centres
- Sub programme 2 - HAST
- Programme 6 – Human Resource Development
- Sub programme 2 - MCWH & N
- Sub programme 2 - NCD
- Programme 8 - Health Facilities
- Programme 3 – Emergency Medical Services
- Programme 7 – Health Care Support Services

A strategic planning session was hosted with internal and external stakeholders to ensure that the department addresses appropriate strategic issues of the Department. The departmental strategic planning session was held at Regent Hotel physically and Virtually from 03-04 October 2024. The objectives of the session were:

- To engage the internal and external stakeholders towards the development of core emerging priorities
- Engage on the MTDP outcomes to inform the development of the new five-year 2025/26 – 2029/30 Strategic Plan and the 2025/26 Annual Performance Plan.
- To consider the best strategic options and define core interventions towards improving health outcomes and increasing life expectancy.
- To clearly define stakeholder roles, and support needed (including resources) and foster integration within identified planning programs.
- To consider the mandate paper and the budget prioritization framework priorities
- The Strategic Planning unit further organized a planners' forum for the Districts from the 06-07 November 2024 to consult and communicate priorities for planning for the next five years and also to communicate the new list of proposed standardized indicators, District health planning framework for the 7th administration including Medium Term Development Framework priorities for the next five years. Provincial programme managers and District Managers, District Information Managers, District Planners and Hospital planners were invited to the session.
- The department hosted a vetting session to allow executive and top management an opportunity to confirm alignment with outcomes of the strategic planning session and final budget allocation including outstanding information in order to finalise the development of 2025/26-2029/30 Strategic Plan and 2025/26 APP.
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ANNEXURE F: PROGRAMME OUTPUTS RELATING TO WOMAN, YOUTH AND PEOPLE WITH DISABILITIES

Table 59: Woman, Youth and people with disabilities

Output Indicator	Programme / Sub Programme	Annual Target 2025/26
Output for Elderly and Children		
Cataract surgery rate	Sub program 2.4	380/1 000 000
Output for women		
Couple year protection rate	Sub program 2.7	50%
Antenatal 1 st visit before 20 weeks rate	Sub program 2.7	65%
Antenatal client start on ART rate	Sub program 2.7	98%
Delivery in 10 – 14 years in facility	Sub program 2.7	<330
Live birth under 2500g in facility rate	Sub program 2.7	<13%
Mother postnatal visit within 6 days rate	Sub program 2.7	83%
Cervical cancer screening coverage	Sub program 2.7	45%
Output for Children		
Infant PCR test positive at birth rate	Subprogram 2.7	1%
Immunisation under 1year coverage	Subprogram 2.7	85%
Measles 2nd dose 1year coverage	Subprogram 2.7	85%
Vitamin A dose 12-59-months coverage	Subprogram 2.7	77%
Child under 5 years diarrhoea case fatality rate	Subprogram 2.7	2.1%
Child under 5 years pneumonia case fatality rate	Subprogram 2.7	2.7%
Child under 5 years severe acute malnutrition case fatality rate	Subprogram 2.7	9.2%
Outputs for youth		
Number of students completed the 4 - year comprehensive course	Programme 6	22
Number of EMS Practitioners completed Emergency Care Qualification	Programme 6	6
Number of registrars qualified as specialist	Programme 6	25
Number of bursary students completed training	Programme 6	49
Number of youth placed on youth programs	Programme 6	889
Outputs for disability		
Wheelchair issued adult 19 years and older rate	Programme 7	60%
Wheelchair issued child 0-18 years rate	Programme 7	60%
Hearing aid issued adult 19 years and older rate	Programme 7	70%
Hearing aid issued child 0-18 years rate	Programme 7	70%

CONCLUSION

This is the Final 2025/26 Annual Performance Plan of the Department, which stands as a proposal to accelerate service delivery towards the achievement of its vision and mission as set out in the 2025/26 – 2029/30 Strategic Plan of the Department. The department is committed to its mantra of “ready; able and capable “- the year of decisive action to advance the people’s health interests.
