

• KEY INSIGHTS FROM THE

District Health Barometer

2024/25

Noluthando Ndlovu

Programme Manager: Research and Implementation Science · Health Systems Trust

LAUNCH

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DISTRICT HEALTH BAROMETER 2024/25



REPORT COVER

What we will cover this morning

1

The publication at a glance

What the 2024/25 edition covers, what's new, and how to read it

2

RMNCH: women, babies, children

Maternal mortality, neonatal care, child nutrition, immunisation, reproductive health

3

Infectious diseases: TB and HIV

Case finding, treatment success, viral suppression, ART coverage

4

Non-communicable diseases

Cervical cancer screening and mental health services at PHC

5

Service capacity, finance, workforce

Ideal Clinics, inpatient management, PHC expenditure, nursing and medical HRH, surgical care

6

The equity story and what it asks of us

District-level variation, cross-cutting insights, call to action

7

Live demo: the DHB interactive dashboard

dhb.hst.org.za → how to navigate, filter, and compare your district

The 2024/25 edition at a glance

~20 years



Tracking district performance

HST's flagship since 2005

52 districts



Every district, every indicator

League tables, maps, and trend lines

40+ authors



A collective achievement

NDoH, provinces, universities, MRC, UNICEF, WHO, HST

4 sources



WebDHIS · BAS · PERSAL · Stats SA

Service delivery, expenditure, workforce, demographics

What's inside the 2024/25 edition

Section A

District ranking by indicator: 5 programme areas, ~30 indicators, every district ranked 1–52 with narrative interpretation by subject experts.

Section B

National, provincial and district profiles: trend graphs and composite views, plus indicators aligned to the District Health Plan template.

Interactive dashboard

dhb.hst.org.za: every indicator explorable by district, province, and year, with downloadable data.

A word on denominators: read before comparing editions



What changed

Population estimates have been refreshed in DHIS for the full period **2000/01 – 2028/29**, incorporating the latest Stats SA mid-year estimates.

This matters because **every coverage indicator** e.g. immunisation, antenatal booking, PHC utilisation per capita, uses population as its denominator.

Some indicator values in this edition may therefore differ from earlier DHBs **even where service volumes have not changed.**

What this means for you

- 1 Compare within this edition**
Historical trends in this DHB have been recomputed on the new denominator.
- 2 Don't cross-compare editions**
A value here and a value in the 2023/24 DHB are not on the same baseline.
- 3 Service delivery ≠ coverage**
An apparent coverage shift may reflect a denominator change, not a programme change.
- 4 See Box 1 in the Introduction**
Full technical note on the update, scope, and interpretation caveats.

01

SECTION 1

Reproductive, maternal, newborn and child health

Where the health system meets women, mothers, babies and children



Progress on early booking yet mortality moving the wrong way

72.8%



ANC 1st visit before 20 weeks

↑ 3.0 pp since 2019/20 · Zululand 89.3% best · Alfred Nzo 54.9% worst

105.4



In-facility maternal mortality (per 100 000 live births)

Up from 100.6 in 2023/24 · SDG target <70 · only 14/52 districts achieve it

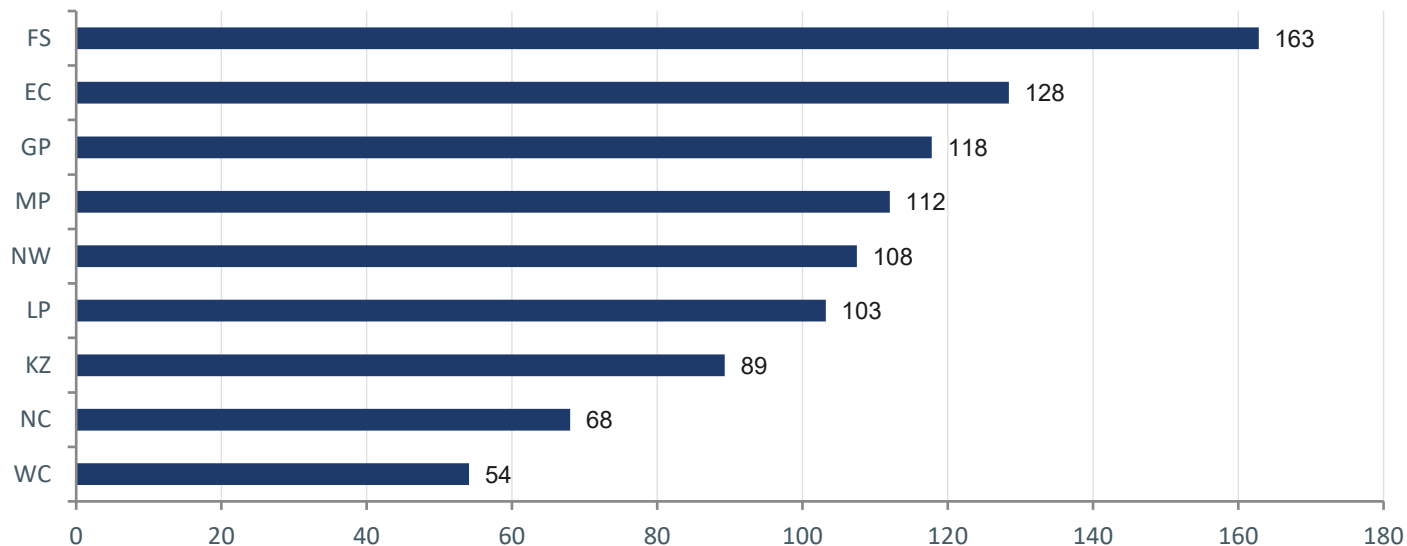
13.0



Neonatal death in facility (per 1 000 live births)

Above the SDG target of ≤12 · 15-fold district variation

In-facility maternal mortality ratio by province, 2024/25



The signal we cannot miss

Lejweleputswa (FS) has become the worst-performing district, with iMMR rising from 50.8 to 216.5 per 100 000 which is more than four-fold in a single year.

Zululand (KZ) stands at 28.1 per 100 000: a seven-fold gap within the same country.

No districts reported zero maternal deaths in 2024/25.

Cracks in our most basic childhood protections

75.1 %



Immunisation under 1 year coverage

↓ from 78.7% · ~298,727 children un-/under-immunised

76.2 %



Measles MCV2 at 1 year

Herd immunity threshold: ≥95% · linked to 2022–2024 outbreak

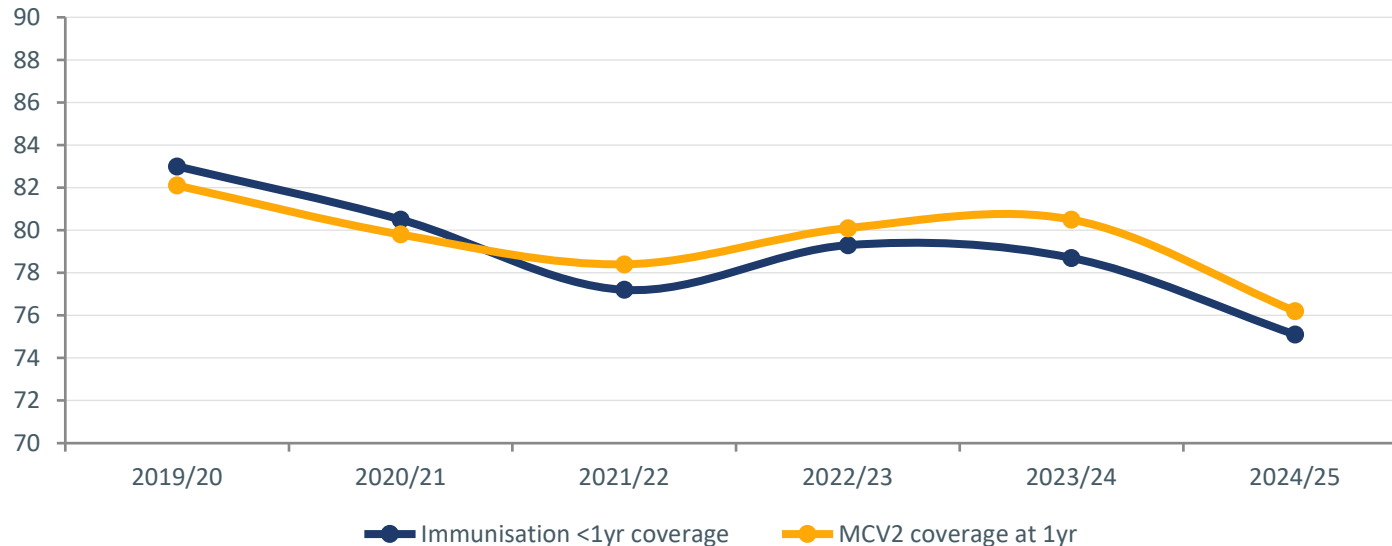
6.9 %



Child under-5 SAM case fatality

Target <5% · only NW (1.7%) and WC (2.2%) meet it

Childhood immunisation coverage is sliding backwards



Why this matters

The 2022–2024 measles outbreak was concentrated in districts with poor MCV2 coverage → a foreseeable cost of coverage decline.

30 of 52 districts are below the national average & the gap is geographic, not random.

SAM case fatality 'hotspots' persist year after year → EC 11.0%, LP 10.7%, FS 8.3%.

Contraceptive protection improving but target still out of reach

60.6 %



Couple year protection rate (CYPR)

↑ from 54.9% in 2023/24 · Target 75% not met

14.4 %



Deliveries to 10–19 year olds

Johannesburg 8.8% lowest · Alfred Nzo 25.1% highest

2 of 9



Provinces exceeding CYPR target

Only Mpumalanga (82.5%) and Free State (77.1%)

Three stories from the reproductive health data

The overall trend is positive

National CYPR rose 5.7 percentage points year-on-year. Male condom distribution is up. The building blocks are strengthening.

Teen deliveries falling in absolute terms

Deliveries in 10–14 year olds fell from 4 053 (2020/21) to 2 387 (2024/25). Rural-metro gap persists but narrowing.

Data-quality flags need action

Districts reporting CYPR > 100% (Sedibeng, Zululand, Nkangala) warrant verification. Female condom distribution remains low.

02




SECTION 2

Infectious disease control

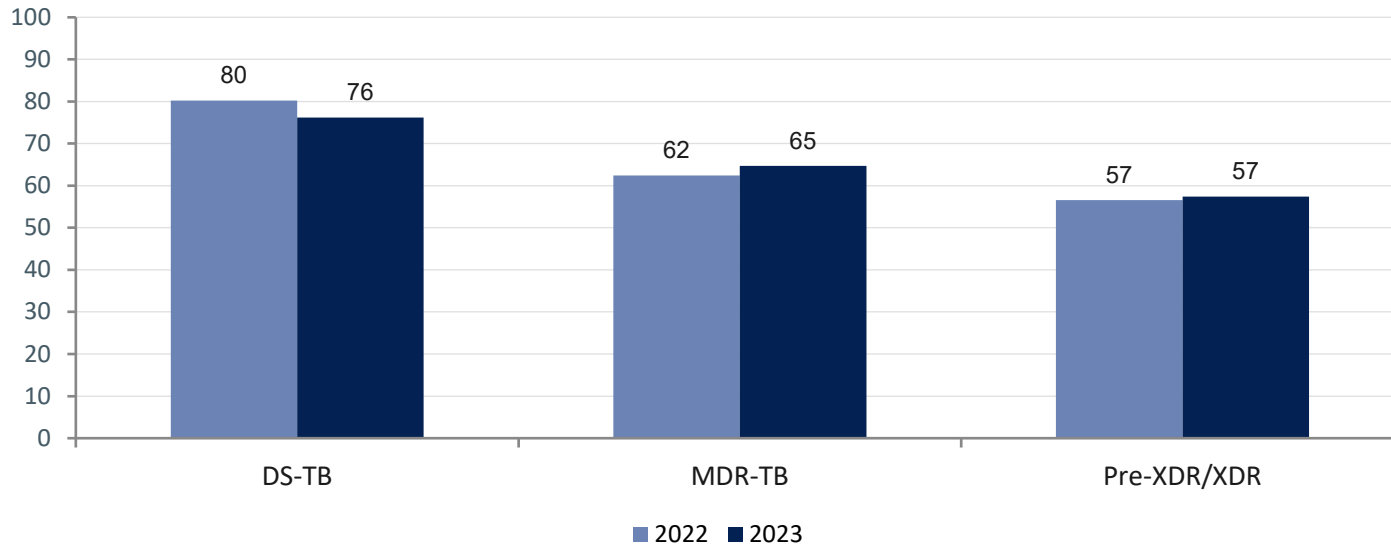
Tuberculosis and HIV: the backbone of South Africa's clinical programmes



Case finding strengthening but treatment success under pressure

| | | |
|---|---|--|
| <h2 style="color: green;">98.2 %</h2>  <p>Target tested for TB (2024) ↑ 6.5 pp from 92.2% in 2023 · 7 provinces improved</p> | <h2 style="color: red;">76.2 %</h2>  <p>DS-TB treatment success (2023) ↓ from 80.2% · Only NW meets 83% target</p> | <h2 style="color: orange;">64.7 %</h2>  <p>MDR-TB treatment success Only NW meets 73% target · 11 districts meet it</p> |
|---|---|--|

TB treatment success rate by category (%)



The TB story in one line

We are finding more TB but converting that to treatment success is getting harder.

TB child under-5 start-on-treatment: 90.8%, up 23 percentage points

The challenge now is retention, regimen adherence, and drug-resistant disease.

Strong viral suppression – harder story on effective coverage

8M+



People living with HIV in SA

25% in KZ · 7.6M know status · 5.6M on ART

92.4 %



Adult viral load suppression

Within reach of UNAIDS 95% target

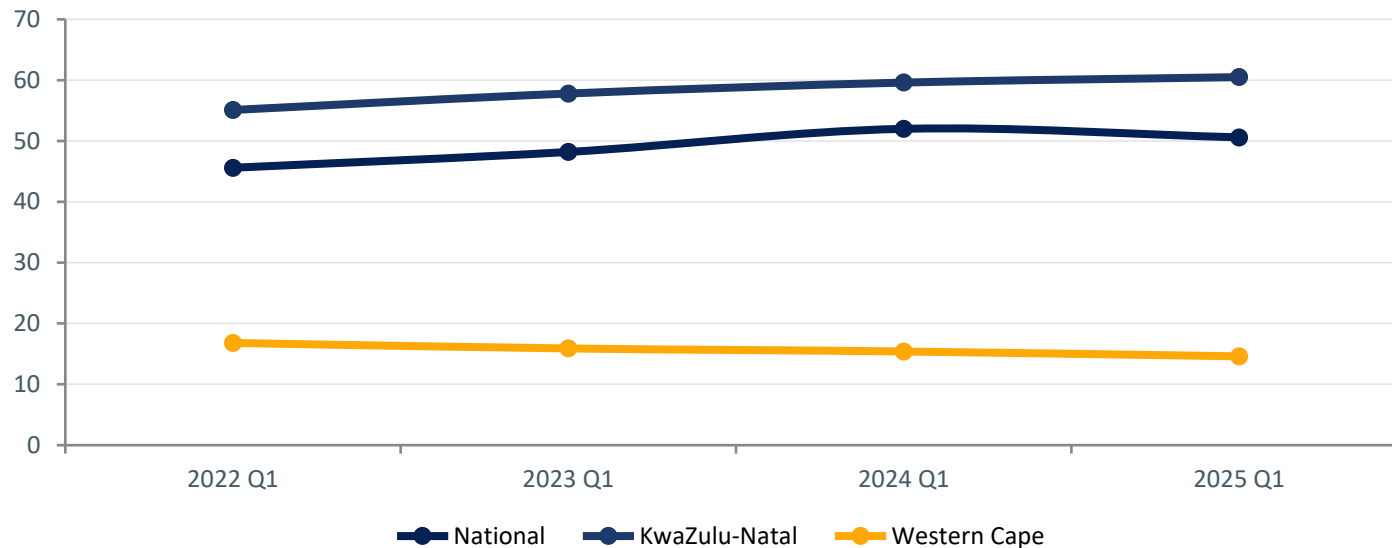
50.6 %



Antiretroviral effective coverage

KZ 60.5% highest · WC 14.6% lowest

Antiretroviral effective coverage: the HIV equity story



Three things to notice

1. Treatment works: 92.4% suppression among those on ART is clinical excellence.
2. The bottleneck is retention: only 69.7% of those ever initiated remain on treatment.
3. Paediatric VLS sits at 73.5%: children are the gap in an otherwise strong programme.

03


SECTION 3

Non-communicable diseases

Cervical cancer screening and mental health: where PHC meets prevention


A preventable cancer and a 40% screening floor

40.0 %




National screening coverage
WHO target: 70% · No province meets it

7 of 9



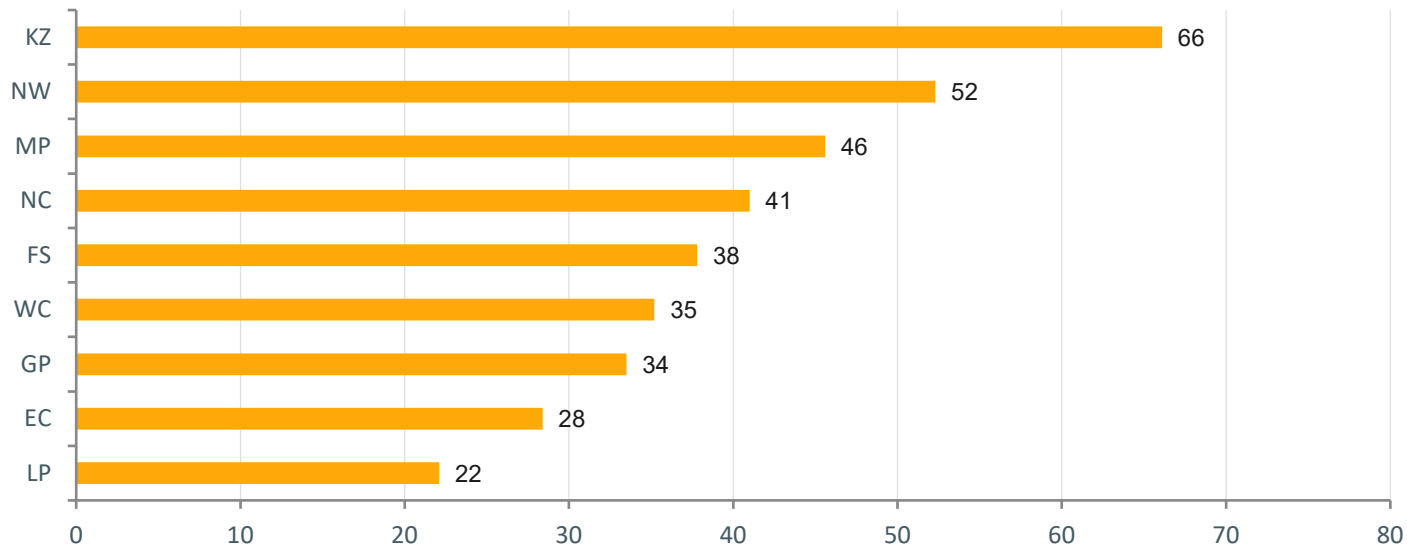
Provinces declining
Between 2023/24 and 2024/25 · NW and MP the exceptions

6.2x



District variation
uMkhanyakude (KZ) 97.2% · Vhembe (LP) 15.7%

Cervical cancer screening coverage by province (%) — WHO target 70%



The bright spots

North West lifted coverage by 31 percentage points in one year: the largest single-year improvement in the edition.

KZ holds 8 of the 10 best-performing districts.

These are proof that system-led improvement is possible.

The question is why it hasn't happened everywhere.

A gap between PHC treatment and involuntary admission

43 333



New PHC clients treated for mental health

Declining since pre-COVID peak · data quality concerns

56 474



Mental health involuntary admissions

Up from 33 351 in 2016/17 = a 69% increase

7 of 9



Provinces: more admissions than PHC treatments

System is admitting more than it is catching early

What the mental health data is telling us

The ratio is wrong

Several provinces show implausibly low PHC treatment numbers against high involuntary admissions → a sign that the system is catching people only at crisis, not before.

Concentration is extreme

Cape Town alone accounts for 83.6% of WC's involuntary admissions (12 739 cases). Frances Baard accounts for 79.8% of Northern Cape's.

Data quality is a priority

Lejweleputswa reports 1 new PHC client treated; Free State province reports 122 in total. These numbers need verification before policy response.

04

SECTION 4

Service capacity, access, and the workforce

Ideal Clinics, inpatient management, finance, HRH, and surgical care



Ideal Clinic status edging up - inpatient capacity under-utilised

80 %



Ideal Clinic status nationally

↑ from 78% · 34/52 districts above national average

61.0 %



District hospital bed utilisation

Below 70% recommended minimum for 5 years

8×



Gap in Ideal Clinic performance

Best district >80% · Frances Baard (NC) just 10%

Ideal Clinic: where the concentration lies

Top performers

- uThukela (KZ)
- King Cetshwayo (KZ)
- uMzinyathi (KZ)
- iLembe (KZ)
- Dr Kenneth Kaunda (NW)

Most concerning

- Frances Baard (NC): 10%
- Namakwa (NC): 28%
- John Taolo Gaetsewe (NC): 33%
- Z F Mgcawu (NC): 33%
- West Coast (WC): 41%

Inpatient management → efficiency under pressure

OPD new client not referred **57.5%**

District hospitals absorbing PHC-level work

Avg. length of stay **4.6 days**

Stable · 2.5 (Namakwa) – 6.3 (Ekurhuleni)

Expenditure per PDE **R3 710**

NW R5 008 highest · FS R2 543 lowest

Inpatient crude death rate **4.7%**

EC 6.1% highest · WC 3.4% lowest

PHC expenditure under steady budget pressure

R657 – R961



PHC expenditure per headcount (province range)

Limpopo lowest · Gauteng highest → a 46% gap

47 %



Share of DHS spending on district hospitals

The single largest driver of district expenditure

1/3 +



Share of PHC spending on HIV/AIDS

Largest single driver of PHC expenditure

What the financial data signals

PHC is taking a disproportionate hit

PHC per capita expenditure has declined since 2021/22 and is declining faster than district health services overall. Budget pressures are landing where they shouldn't.

Allocative equity is improving...maybe

Variation in PHC per capita spend is narrowing at both provincial and district level. Whether this is equity gains or just tighter budgets across the board is unclear.

Gauteng's outlier costs are structural

GP sits at R961 per headcount, which is the highest in the country, largely because patients bypass clinics for hospitals. A demand-side issue, not a supply-side one.

A workforce showing its age

141.3



Professional nurses per 100 000 uninsured

EC 173.0 highest · WC 103.6 lowest · 4.8× district gap

33.2



Medical practitioners per 100 000 uninsured

HRH 2030 target: 37.9 · Only NC meets it (40.2)

9.3×



Medical practitioner district gap

Dr Kenneth Kaunda 69.5 · Pixley Ka Seme 7.5

The workforce warning the DHB is issuing

An ageing nursing workforce, a thin mid-career layer, and too few early-career entrants in public sector

Ageing

Rapid growth in nurses approaching retirement across every province.

Missing middle

Mid-career professional nurses declining — the most productive cohort.

Weak inflow

Severely limited entry of early-career nurses into the public sector.

Gender concentration

85% female, 15% male — a 1:6 ratio with its own workforce planning implications.

A chapter that says: we do not yet measure what we should



1/3

of the global burden of disease could be addressed by surgical care.

5 billion people globally lack access to safe surgery. Most live in low- and middle-income countries.

Where South Africa stands

- 1 WHO mandate**

District hospitals should provide essential and emergency surgical care (EESC) which is a core UHC commitment.
- 2 Current reality**

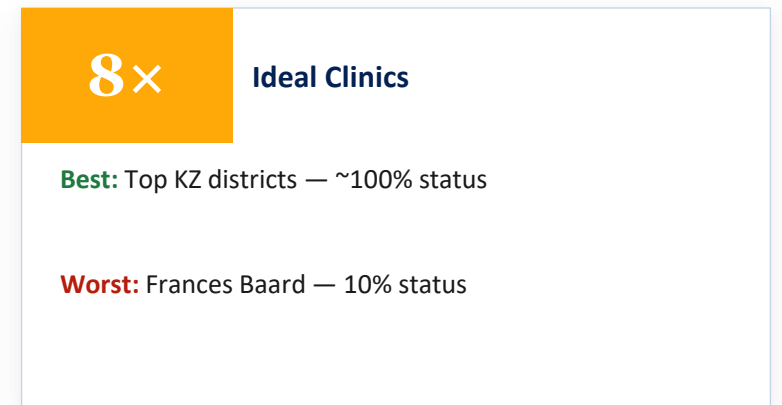
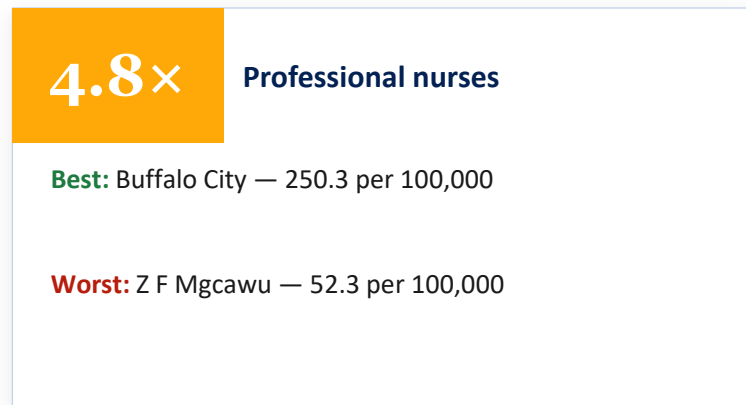
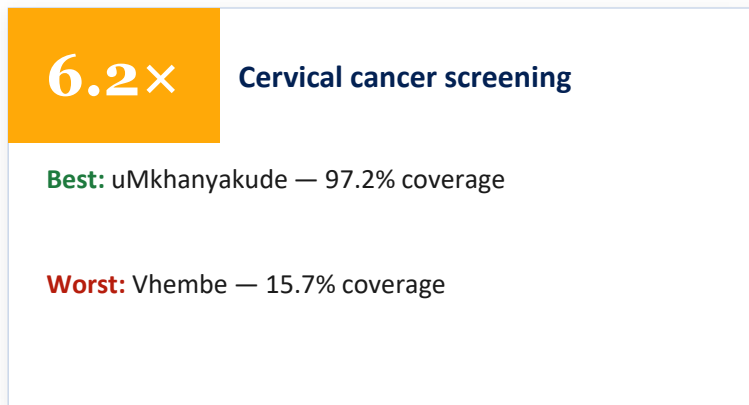
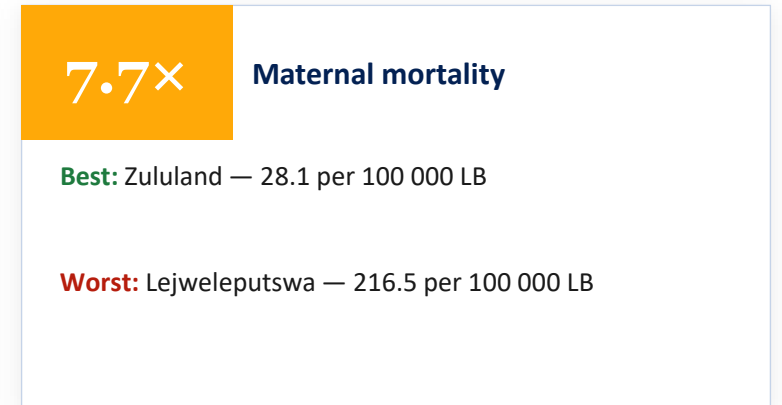
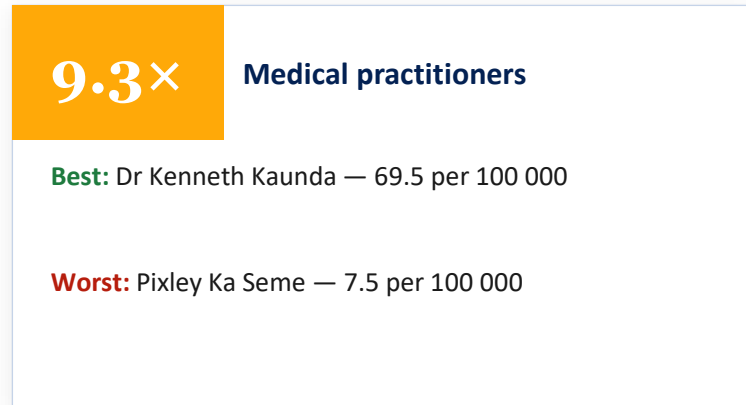
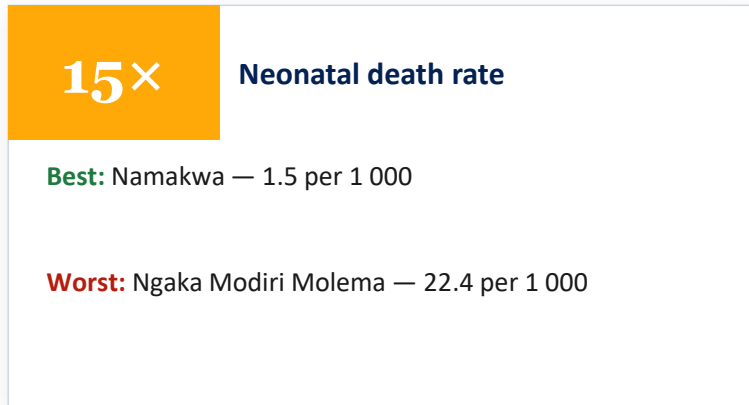
District hospital surgical capacity in SA is limited. Investment in SAO (surgical, anaesthetic, obstetric) staff has historically been thin.
- 3 What we measure**

Caesarean section is currently the only routinely-reported indicator of district hospital surgical activity.
- 4 What this chapter is asking for**

Routine national surgical indicators because without them we cannot identify service gaps or design policies to close them.

The equity story – district variation in one country

National averages conceal more than they reveal.



Five things to take from this year's DHB

01

There is progress and this should be celebrated

Early ANC booking, TB case finding, adult viral suppression, Ideal Clinic status are all moving in the right direction.

02

There are four signals that should not be ignored

Maternal mortality increased. Immunisation has gone down. Cervical cancer screening at 40%. An ageing nursing workforce.

03

Averages hide the truth

The variation within South Africa is often greater than the variation between South Africa and its peers. District is the unit of change.

04

Data quality still needs work

Mental health, some expenditure indicators, and outlier district values are flags for routine data system strengthening.

05

This is a UHC/NHI readiness report

Quality, equity, workforce, efficiency which are the four pillars of UHC are exactly what the DHB measures district by district.

THANK YOU



This edition is the work of 42 authors

across government, research institutions, universities, and multilateral partners.

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- Roma Ramphal
- Sindisiwe Ngobese
- Thobelani Majola
- Zinhle Mtwane
- Danita Hingston
- Gilbert Tshitaudzi
- Jonatan Daven
- Livhuwani Mashamba
- Mathilda Ntloana
- Naomi Massyn
- Norbert Ndjeka
- Sadiyya Sheik
- Tamlyn MacQuene
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NOW LIVE

Let's explore your district.

The DHB interactive dashboard – live

<https://dhb.hst.org.za/>

What we'll do together

- Navigate any indicator at national, provincial, district level
- Compare districts side-by-side
- Drill into trends over time
- Download the data behind every number

BEFORE WE GO LIVE

A two-minute tour of the dashboard

A short video overview, then we go live.



dhb.hst.org.za · approx. 2 minutes

DHB Publication and Dashboard Survey

We are continuously striving to improve so please complete this short survey so we can get your feedback.

Scan the QR Code OR Follow this link:

<https://redcap.hst.org.za/redcap/surveys/?s=9PTPFLAPHJT4W9L3>

