Review

Health and related indicators: a mental health focus

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Aim

South Africa faces a complex and intersecting burden of communicable, non-communicable, maternal, child, injury, and mental health conditions, all within a context of profound socio-economic and environmental inequities. This paper consolidates recent nationally representative and routine data to characterise population health status, service performance, mental health data assets, and cross-cutting system gaps. It places a strengthened emphasis on mental health surveillance and its integration into broader health system monitoring.

Method

The most recent publicly available national surveys, routine health information, modelled estimates, administrative financing and human resource datasets, mental health policy indicator frameworks, and longitudinal cohort platforms were synthesised. The strengths and limitations of indicators, as well as equity patterns across provinces and priority populations, were also appraised.

Results

Mental health data assets are expanding, with improvements in the routine indicator set and the inclusion of mental health metrics in longitudinal cohorts. However, significant gaps remain in community-level data capture, disaggregation by age, gender, and geography, standardisation of indicators, and governance structures. These limitations hinder the full integration of mental health into national health surveillance. Service performance data reveal uneven access to mental health services, workforce shortages in specialised cadres, and limited financing. Provincial disparities in mental health infrastructure and reporting exacerbate inequities in care and outcomes.

Conclusion

Accelerating progress requires integrated, equity-orientated strategies: strengthening mental health information governance; closing gaps in the HIV/TB care cascade; improving the quality of maternal, newborn and child preventive services; rebalancing workforce and financing allocations; and addressing upstream socio-environmental determinants.

Introduction

South Africa's health landscape is shaped by entrenched socio-economic and environmental disparities, including elevated exposure to climate risks, persistent multidimensional poverty, and high unemployment.[1] These factors intensify differential exposure and vulnerability to disease across provinces. South Africa also ranks among the top 25 countries globally for disability-adjusted life-years (DALYs) lost to mental disorders, with depression and anxiety alone accounting for an estimated 2.5 % of total years lived with disability.[2]

The country continues to bear the world's largest national HIV burden. While diagnostic coverage is high, persistent gaps in treatment access and viral suppression, particularly among children, adolescents and key populations, underscore the need for targeted interventions.[3] Tuberculosis (TB), including drug-resistant strains with modest treatment success rates, further compounds the epidemiological burden at the HIV and TB syndemic interface.[4] Co-morbid depression and anxiety reduce antiretroviral adherence by up to 35%, amplifying morbidity and onward transmission risk.[5]

Maternal and neonatal health indicators reveal preventable mortality despite high institutional delivery rates and increasing caesarean section prevalence. This suggests that quality of care and emergency response capacity remain critical challenges. Declines in childhood immunisation coverage and under-five mortality rates that exceed Sustainable Development Goal (SDG) thresholds point to weaknesses in primary prevention systems. Concurrently, high levels of tobacco and alcohol use perpetuate avoidable burdens of chronic disease and injury.[6,7] Emerging evidence links perinatal depression with suboptimal breastfeeding and immunisation uptake, underscoring the need for integrated maternal mental health services.[8]

Within this broader context, mental health has gained increasing policy and programmatic attention.[9] Advances include the expansion of routine mental health indicators, the establishment of policy frameworks with defined targets, and the growth of longitudinal cohort platforms that enhance surveillance capacity. However, critical limitations persist. These include the limited integration of community-based and informal care data, insufficient disaggregation for equity-focused analyses, and inconsistent measurement standards. These gaps constrain the utility of available data for comprehensive planning, monitoring and evaluation. Productivity losses linked to untreated common mental disorders are estimated at 4–5% of South Africa's gross domestic product (GDP), making mental health investment not only a rights imperative but also an economic priority.[10]

Health system performance and capacity constraints also affect the accessibility and quality of mental health services. These include uneven utilisation of primary health care (PHC), disparities in workload and bed occupancy, maldistribution of clinical and specialised human resources, and persistent financing inequities. Recent flood-related displacement in KwaZulu-Natal doubled the prevalence of post-traumatic stress symptoms among affected adolescents, highlighting how climate shocks magnify mental health needs.[11]

With a particular focus on mental health, this paper:

1. consolidates the most recent multisource indicators across key health domains, with an enhanced focus on mental health;
2. critically appraises the national health data architecture, including routine systems, longitudinal cohorts and administrative sources, highlighting strengths and limitations that affect interpretability and policy relevance; and
3. identifies cross-cutting challenges related to equity, quality and governance that should inform integrated policy development and resource allocation strategies in pursuit of universal health coverage and the Sustainable Development Goals (SDGs) for 2030.

Data sources

Box 1 lists the key new or updated international and national sources consulted for this analysis. Specific references and the current indicator definitions are provided in the data tables.

Mental health indicators

The availability of mental health indicator datasets in South Africa, as outlined in Table 1, provides a foundational basis for monitoring and evaluating mental health trends and service delivery across the country. These datasets — derived from global and local sources such as the GBD, the WHO's Mental Health Atlas, the DHIS, Stats SA, and surveys such as the South African National and Nutrition Examination Survey (SANHANES) and South African National HIV Prevalence, Incidence, Behaviour and Communication Survey (SABSSM) VI — offer valuable insights into the burden of mental illness, service utilisation, and treatment coverage.

One of the key strengths of these datasets lies in their routine collection and national coverage, which allows for longitudinal tracking of mental health indicators at national and sub-national levels. This is particularly important for identifying regional disparities and informing targeted interventions. The inclusion of indicators such as the number of mental health admissions, outpatient visits, and availability of mental health professionals provides a comprehensive view of the mental health system's capacity and performance. However, outcome-orientated metrics such as 30-day re-admission, relapse and remission rates remain largely absent. Incorporating such measures would allow for assessment of service effectiveness and progress towards recovery-focused care.

Several limitations constrain the utility of these datasets. Firstly, the reliance on administrative data may lead to under-reporting or misclassification, especially in under-resourced settings where data-quality assurance mechanisms are weak. Secondly, the indicators often focus on service outputs rather than outcomes, limiting the ability to assess the effectiveness of mental health interventions. Additionally, the absence of disaggregated data by age, gender and socio-economic status hampers equity analyses. A further blind spot is the near-total exclusion of community-based, informal and digital mental health services, despite evidence that they comprise up to 40% of first-contact care in rural districts.[9]

Despite the growing recognition of mental health as a public health priority, there remains a significant gap in the literature and policy discourse regarding the role and extent of private-sector service provision in South Africa. Much of the existing analysis tends to focus predominantly on public-sector challenges, thereby overlooking the contributions, limitations and regulatory complexities of private mental health care. This lack of comprehensive coverage obscures a full understanding of the mental health landscape, particularly in terms of access, equity and quality of care across socio-economic groups.

Box 1. Sources used for this paper

International	South African
• Institute for Health Metrics (IHME)[2] • Global Cancer Observatory (GLOBOCAN)[12] • World Health Organization (WHO) Global Tuberculosis Report 2024[13] • International Diabetes Federation (IDF) Diabetes Atlas 2025[14] • WHO Immunization update 2025[15] • WHO Mental Health Atlas 2020[16] • State of Global Air 2024[17] • State of the World's Children 2024[18] • Tobacco Atlas[6] • Joint United Nations Programme on HIV/AIDS (UNAIDS) data 2024[19] • United Nations Development Programme (UNDP) Human Development Report 2023/24[1] • WHO African Region Health Expenditure Atlas 2023[20] • WHO Global Health Observatory[21] • WHO World Health Statistics 2025[7] • WHO World Malaria Report 2024[22]	• Council for Medical Schemes (CMS) Industry Report 2023[23] • Health Professionals Council of South Africa (HPCSA) Statistics[24] • National Cancer Registry[25] • National Treasury Health Expenditure data[26] • National Institute for Communicable Diseases (NICD) Surveillance Reports[27] • Personnel Administration System (PERSAL)[28] • Road Traffic Management Corporation (RTMC) Road Fatalities 2024[29] • Saving Mothers 2023[30] • South African Community Epidemiology Network on Drug Use (SACENDU)[31] • Statistics South Africa (Stats SA) General Household Survey (GHS) 2024[32] • Stats SA Labour Force Surveys up to the 4th quarter of 2024[33] • Stats SA Mid-year Population Estimates 2024[34] • Stats SA Mortality and Causes of Death 2021[35] • Stats SA Recorded Live Births 2023[36] • The 2022 Antenatal HIV Sentinel Survey[37] • Thembisa v4.7 HIV and AIDS model[38] • District Health Information System (DHIS)[39]

Future iterations should routinely integrate Council for Medical Schemes (CMS) claims data and large-insurer electronic records to create a full system view.

Another critical gap is the limited integration of community-based and informal mental health services into the national reporting systems. Given the significant role of Traditional Health Practitioners and Community Health Workers in mental health care, their exclusion from official statistics presents an incomplete picture of service provision. Furthermore, the datasets do not adequately capture the social determinants of mental health, such as poverty, violence and substance abuse, which are essential for a holistic understanding of mental health trends.

To enhance the relevance and impact of mental health indicators, there is a need for improved data governance, including standardised definitions, regular audits, and capacity-building for data collection and analysis. Integrating mental health indicators into broader health and development monitoring frameworks, such as the SDGs, could also elevate their policy visibility and resource prioritisation.

Longitudinal datasets supporting mental health monitoring

The availability of longitudinal mental health datasets (Table 2) in South Africa represents a significant advancement in the monitoring and evaluation of mental health outcomes. These datasets, such as Birth-to-Forty (Bt40), Dikgale, Mamabolo and Mothiba (DIMAMO) health and demographic surveillance systems (HDSS), and the Drakenstein Child Health Survey (DCHS), provide valuable insight into the temporal dynamics of mental health conditions across diverse populations. Their longitudinal nature allows for the tracking of mental health trajectories, identification of risk and protective factors, and evaluation of interventions over time.

A key strength of these datasets lies in their diversity of target populations, ranging from children and adolescents to older adults, and their inclusion of both urban and rural settings. This heterogeneity enhances the generalisability of findings and supports the development of context-specific mental health policies. Moreover, the integration of mental health indicators into broader health and demographic surveillance systems, such as South African Population Research Infrastructure Network (SAPRIN) and Health and Ageing in Africa: A Longitudinal Study of an INDEPTH Community in South Africa (HAALSi), facilitates a more holistic understanding of mental health within the broader determinants of health framework.

However, several limitations must be acknowledged. Firstly, there is variability in the consistency and depth of mental health measures across studies, with some relying on self-reported symptoms and others using validated diagnostic tools. Secondly, access to data remains uneven, with some datasets being publicly available and others requiring direct contact with principal investigators, potentially limiting their utility for broader research and policy development. Thirdly, while many studies are ongoing, others have ceased data collection, raising concerns about sustainability and long-term impact.

The implications of these datasets for mental health policy and planning are profound. They offer a founda-

Table 1. Global and local mental health data sources

Domain	Most recent source (year)	What you get
Population burden and epidemiology	IHME GBD results tool (2024 release)	DALYs, years of lived with disability (YLDs), prevalence and incidence for every mental-disorder category, 1990–2024
	Stats SA: Mortality and Causes of Death series (latest: deaths registered 2021, issued 2024)	Suicide and other mental-disorder International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) codes by age, sex, province
	SABSSM VI National HIV Survey (fieldwork 2022, report 2024)	K-10 psychological-distress scale and socio-demographics for 27 000 adults
	SANHANES II (2023)	Depressive-symptom prevalence, comorbidity with NCDs, health-behaviour correlates
	National Planning Commission: Situational Analysis of Mental Health in SA (May 2024)	Synthesises DHIS 2017–2023 caseload trends, facility audits and province comparisons
Service coverage and quality	DHIS Standardised Mental Health Indicator Set (five routine indicators)	PHC caseload, new-treatment rate, separation rate, involuntary admissions, child/adolescent attempted suicide rate
	CMS Industry Report (private sector), 2023	Admissions for mental health institutions, mental health coverage, claims by workforce type
Mental-health workforce and beds	WHO Mental Health Atlas – SA country profile (2020 edition, still the latest)	Psychiatrists, psychologists, psychiatric nurses per 100 000; in-patient-bed ratios; legislation status
	HPCSA Annual Report 2023/24	Registered practitioners by speciality and province (psychiatry, psychology, counselling)
Budget and expenditure	National Department of Health (NDoH) Annual Report 2023/24 + Provincial BAS datasets	Programme 2 sub-programme: Mental Health spend; performance targets
Policy indicators and targets	National Mental Health Policy Framework and Strategic Plan 2023–2030	30 headline indicators with 2020 baseline and 2030 targets; specifies DHIS and human resources (HR) data flows
Help-seeking and sentiment	UNICEF U-Report Youth Mental Health poll (2023/24)	Perceived need for support, barriers, preferred channels (≈28 000 SA respondents)
Civil society service statistics	South African Depression and Anxiety Group (SADAG) / South African Federation for Mental Health (SAFMH) helpline data (2023/24)	Call volumes by age, gender, issue; regional heat-maps

tion for evidence-based decision-making, enable the identification of emerging trends, and support the evaluation of mental health interventions. To maximise their impact, efforts should be made to harmonise data-collection methodologies, ensure open access where feasible, and promote the integration of mental health indicators into national health information systems. Additionally, aligning indicator metadata with the WHO Indicator Metadata Registry List will facilitate international comparability.[21]

In conclusion, the landscape of mental health data in South Africa has evolved significantly, offering a diverse array of sources that collectively enhance understanding of mental health needs, service delivery, and population-level trends. Routine indicator datasets, such as those from the DHIS and national surveys, provide essential insights into system performance and access to care, while longitudinal cohort studies offer depth and nuance in understanding mental health trajectories over time. However, both types of data systems face challenges related to completeness, standardisation, and accessibility. Addressing these limitations through improved data governance, integration across platforms, and investment in sustainable data infrastructure is critical. Doing so will not only strengthen the evidence base for mental health policy and planning, but will also ensure that mental health is adequately prioritised within South Africa's broader health and development agenda.

Demographic trends

On a global level, demographic transitions are reshaping health systems and policy priorities. Many countries are experiencing declining fertility rates, increasing life ex-

Table 2. Summary of longitudinal datasets

Study name	Institution, country	Years active	Target group	Mental health disorder
Bt40	University of Witwatersrand (WITS), South Africa	1990—ongoing	Mothers and children (birth to 40 years)	Depression, major depressive disorder (MDD), behavioural disorders, unspecified disruptive, impulse control, and conduct disorder
DIMAMO HDSS	South African Medical Research Council (SAMRC) and University of Limpopo, South Africa	1996—ongoing	adult residents (15 years and older)	Anxiety, depression, general anxiety disorder (GAD), MDD
DCHS	University of Cape Town (UCT), South Africa	2012—ongoing	Pregnant women and children	Depression, post-traumatic stress disorder (PTSD), distress
Evidence for Better Lives Study (EBLS)	University of Cambridge	2019—ongoing	Pregnant women, fathers	Psychological distress
Global Flourishing Study (GFS)	Center for Open Science, Gallup, Harvard, United States of America (USA)	2022—ongoing	Varied[1]	Anxiety, depression
HAALSi	SAMRC and WITS, South Africa	2014—ongoing	Adults ≥40 years	Depression, PTSD, well-being
WHO Study on Global AGEing and Adult Health (SAGE)	WHO: China, Ghana, India, Mexico, Russian Federation and South Africa	2002—ongoing	Adults ≥18 years	Depression, well-being
Vukuzazi	Africa Health Research Institute (AHRI), South Africa	2018—ongoing	Adults ≥15 years	Alcohol use disorder (AUD), anxiety, depression, distress, well-being
Transfer Project	UNICEF, Food and Agriculture Organization of the United Nations (FAO), University of North Carolina, Italy and USA	2008—ongoing	Varied[1]	Depression, distress, well-being
SAPRIN	SAMRC, South Africa	2016—ongoing	Varied[1]	Depression, MDD, anxiety
Siyakhula Cohort	AHRI, South Africa	2012—ongoing	Children 7–11 years	Attention Deficit/Hyperactivity Disorder (ADHD), anxiety, depression AUD, antisocial behaviour, GAD, substance-related and addictive disorder
Prospective Urban and Rural Epidemiological Study (PURE)	Public Health Research Institute, McMaster University, Canada	2001—ongoing	Varied[1]	Depression, MDD
National Income Dynamics Study (NIDS)	UCT, and the Department of Planning, Monitoring and Evaluation (DPME), South Africa	2008—stopped	Varied[1]	Depression, MDD
Migration Health Follow-up Study	Mpumalanga Province and Brown University, South	2018—ongoing	Adults 18–40	Depression, MDD

Study name	Institution, country	Years active	Target group	Mental health disorder
(MHFUS)	Africa and USA		years	
International Epidemiologic Databases to Evaluate AIDS — Southern Africa (IeDEA-SA)	UCT and University of Bern, South Africa and Switzerland	2006–ongoing	Varied[1]	Anxiety, depression, PTSD, suicide

[1]Age group or sex not outlined

pectancy and ageing populations, which are trends that mirror South Africa's shift from a youthful to a more mature population structure.[40] These shifts are already changing the mental health profile where, for example, dementia prevalence is projected to double by 2040, while depression among older adults is rising in tandem with multimorbidity.[41]

According to the United Nations' World Population Prospects (2024),[42] the global fertility rate has dropped to 2.3 children per woman, with significant regional variation. High-income countries often report rates below replacement level, while parts of sub-Saharan Africa still experience higher fertility.

Urbanisation

Urbanisation continues to accelerate worldwide, with over 56% of the global population now residing in urban areas. This trend places immense pressure on urban infrastructure, housing and health services, particularly in rapidly growing cities across Asia and Africa.[43] South Africa's concentration of population in Gauteng and KwaZulu-Natal reflects this global urban shift. Rapid urban growth is associated with increased exposure to crime, social isolation and 'eco-anxiety', which are all recognised drivers of common mental disorders in young adults.[44]

Ageing index

Ageing populations, especially in Europe, East Asia, and parts of Latin America, are driving demand for chronic disease management, geriatric care, and long-term health financing strategies. The global ageing index is rising, with countries like Japan and Italy already facing ratios above 50.[42] South Africa's ageing index of 33.5 suggests that it is entering this phase, necessitating proactive planning for age-appropriate services. Provincially, the Western Cape (33.1) and Gauteng (26.8) reflect more advanced demographic transitions compared to provinces like KwaZulu-Natal and Limpopo (both 18.8). This shift has implications for the burden of non-communicable diseases and the design of age-appropriate health services. Integrating geriatric psychiatry and caregiver-support indicators into routine surveillance would provide an early warning of service gaps.[45]

Population and births

The 2024 mid-year population estimates from Statistics South Africa[34] reveal a national population of just over 63 million, with Gauteng (25.3%) and KwaZulu-Natal (19.5%) together accounting for nearly 45% of the total. Mental health-related disability benefits already cluster in these two provinces, highlighting the importance of co-locating psychosocial services within existing urban PHC networks. This concentration underscores the continued urbanisation trend and the associated pressure on infrastructure and health services in these provinces.

Live birth registrations in 2023 totalled 932 138, with the highest numbers recorded in Gauteng (219 023) and KwaZulu-Natal (205 831), aligning with their population shares. However, the total fertility rate has declined to 2.4 children per woman,[34] indicating a continued demographic transition. This is also reflected in Figure 1 which shows that between 2004 and 2024, South Africa's population pyramid transitioned from a youthful, broad-based structure to a more column-like shape, reflecting declining birth rates, a growing working-age population, and an increasingly ageing society. The crude death rate is estimated at 8.7 per 1 000 population, although provincial disaggregation is lacking, which limits more granular mortality analysis.

Population density figures highlight stark contrasts where Gauteng's density of 876.4 people/km² far exceeds the national average of 51.6, while the Northern Cape remains sparsely populated at just 3.7 people/km² (Table 3). High-density informal settlements report up to threefold higher rates of depression and alcohol-use disorders than rural areas.[46] These disparities have direct implications for service delivery models, with rural provinces requiring logistical and infrastructural approaches that differ from those needed in urban centres.

Uninsured population estimates

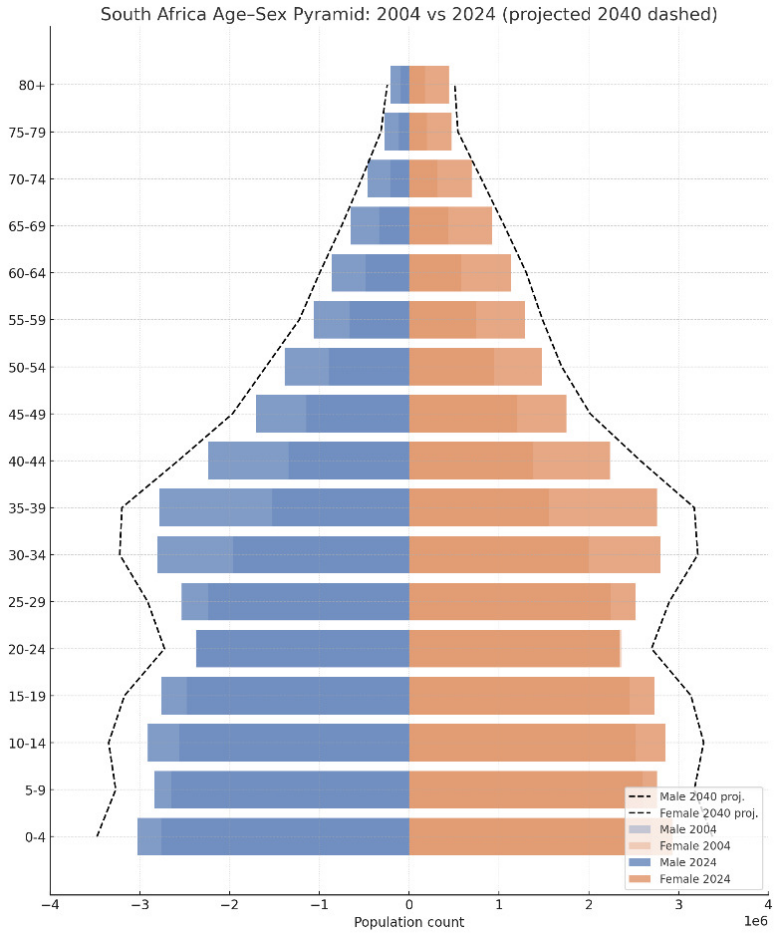
The reliance on public health systems is a common feature in many low- and middle-income countries. With 85% of South Africans being dependent on public health services, the challenge of equitable resource allocation is shared globally.[32] Incorporating a short validated mental health screening tool (e.g. PHQ-9, GAD-7) into the next General Household Survey (GHS) would enable province-level prevalence estimates for the first time.

Table 3. Demographic indicators by province

Indicator	Period	Sex|Age|Series|Cat	SA	EC	FS	GP	KZN	LP	MP	NC	NW	WC	Ref
Ageing index	2024	both sexes mid-year	33.5	27.6	25.1	26.8	18.8	18.8	20.3	25.4	21.3	33.1	a
Crude death rate (deaths per 1 000 population)	2024	both sexes mid-year	8.7										a
Live birth occurrences registered	2023	vital registration total	932 138	101 901	44 552	219 023	205 831	114 688	74 967	24 490	55 520	91 146	b
Population	2024	both sexes mid-year	63 015 904										a
		female mid-year	32 129 704										a
		male mid-year	30 886 200										a
Population % by province	2024	both sexes mid-year	100	11.4	4.8	25.3	19.5	10.2	8.0	2.2	6.6	12.0	a
Population density (per km2)	2024	mid-year	51.5	42.5	23.4	876.4	130.5	50.9	66.1	3.7	39.6	58.4	a
Public sector dependent (uninsured) population	2023	both sexes all ages GHS	52 491 846	5 895 776	2 624 569	12 916 030	10 716 242	5 640 806	4 424 424	1 107 729	3 690 519	5 475 946	a
	2024	both sexes all ages GHS	53 369 336	5 856 558	2 648 787	13 099 118	10 740 162	5 609 642	4 424 424	1 099 882	3 681 986	5 498 056	a
Total fertility rate	2022-2024	female mid-year	2.4										a

Sources:
a: StatsSA MYE 2024[34]
b: StatsSA Recorded Live Births 2023[36]
Indicator [units]: Definition
• Ageing index [Number]: Ratio of the number of people 65+ to the number under 15 years, i.e. a value of 16 means that there are 16 people aged 65 and older for every 100 under 15 years of age. Calculated as ([65+/0—14]*100).
• Crude death rate [per 1 000 population]: Number of deaths in a year per 1 000 population.
• Live birth occurrences registered [Number]: The number of live birth occurrences registered.
• Population [Number]: Total number of people. Projected population figures are based on various projection models attempting to quantify the expected effects of HIV and AIDS on population growth.
• Population % by province [Percentage]: Proportion of South African population in each province (calculated from population per province and population for the whole of South Africa).
• Population density [people per km^2]: The number of people per square kilometre.
• Public sector-dependent (uninsured) population [Number]: This is an adjustment of the total population to the number assumed to be dependent on services in the public health sector based on medical scheme (health insurance) coverage. It is calculated by subtracting the number of people with medical scheme cover (determined from medical scheme membership reports, or surveys indicating percentage of population on medical schemes) from the total population.
• Total fertility rate [Number]: The average number of children that a woman gives birth to in her lifetime, assuming that the prevailing rates remain unchanged.

Figure 1. South Africa age-sex pyramid: 2004 vs 2024 (projected 2040 dashed)



Source: StatsSA Mid-year Estimates (MYE), 2024[34]; United Nations Department of Economic and Social Affairs (UN DESA), 2024[42]

As the estimated uninsured populations per province and district are important denominators for a wide range of indicators, the estimates of the uninsured population in South Africa down to district level has been updated (Table 4). The proportion of uninsured to insured individuals has not shifted significantly in recent years, as high costs continue to pose a barrier to private medical aid. Nevertheless, regular updates to these estimates are essential to ensure continued relevance and accuracy in health system planning and decision-making.

Methodology

To estimate the uninsured population per district, estimates of medical scheme coverage at that level were first determined. The GHS captures medical scheme coverage; however, it is statistically representative at the provincial level. The Census, on the other hand, provides detailed population data at the district level but does not record medical scheme coverage. Applying the average provincial medical scheme coverage from the GHS to all districts in the Census would not accurately reflect district-level demographics, as key factors influencing coverage (such as income or educational level) can vary greatly between districts, even within the same province.

To create a representative estimate, a small area estimation model was built to estimate medical scheme coverage within districts in provinces. The model was trained on the GHS 2024[32] using key variables to predict medical scheme coverage. The relationships between these variables were then used to predict coverage probabilities for households in the Census 2022 microdata. This approach enabled more granular and realistic estimates at the district level, overcoming the limitations of both datasets when used in isolation. A more detailed methodology is available on request.

Results

The small area estimation model produced detailed estimates of medical scheme coverage across South African districts. The key findings showed that medical scheme coverage rates differ between districts within provinces, as expected. These results highlight the socio-economic and demographic differences that cannot be captured by high-level provincial averages alone. The updated estimates indicate that approximately 84.3% of the population remains uninsured nationally, with higher uninsured proportions being concentrated in rural and lower-income districts.

Table 4. Uninsured population estimates, 2024

Province	District municipality name	District municipality code	Calculated coverage %	Uninsured population %	2022 estimates (Population source: Census 2022)			2024 estimates (Population source: GHS 2024 Mid-year)		
					2022 population	Covered	Not covered	2024 population	Covered	Not covered
Eastern Cape	Buffalo City	BUF	20.9%	79.1%	975 255	203 828	771 427	967 961	202 304	765 657
Western Cape	Cape Town	CPT	27.8%	72.2%	4 772 846	1 326 851	3 445 995	4 856 044	1 349 980	3 506 064
Western Cape	West Coast	DC1	18.5%	81.5%	497 394	91 819	405 575	506 064	93 419	412 645
Eastern Cape	Sarah Baartman	DC10	10.3%	89.7%	533 253	54 925	478 328	529 265	54 514	474 751
Eastern Cape	Amathole	DC12	5.8%	94.2%	871 601	50 553	821 048	865 082	50 175	814 907
Eastern Cape	Chris Hani	DC13	5.4%	94.6%	828 387	44 733	783 654	822 192	44 398	777 794
Eastern Cape	Joe Gqabi	DC14	5.5%	94.5%	393 048	21 618	371 430	390 108	21 456	368 652
Eastern Cape	OR Tambo	DC15	4.7%	95.3%	1 501 702	70 580	1 431 122	1 490 570	70 057	1 420 513
Free State	Xhariep	DC16	12.5%	87.5%	131 901	16 488	115 413	135 444	16 931	118 513
Free State	Lejweleputswa	DC18	14.0%	86.0%	679 746	95 164	584 582	698 007	97 721	600 286
Free State	Thabo Mofutsanyane	DC19	11.2%	88.8%	831 421	93 119	738 302	853 758	95 621	758 137
Western Cape	Cape Winelands	DC2	18.7%	81.3%	862 703	161 498	701 205	877 741	164 313	713 428
Free State	Fezile Dabi	DC20	15.2%	84.8%	509 912	77 507	432 405	523 611	79 589	444 022
KwaZulu-Natal	Ugu	DC21	7.1%	92.9%	773 402	54 834	718 568	766 480	54 343	712 137
KwaZulu-Natal	uMgungundlovu	DC22	7.9%	92.1%	1 235 715	98 116	1 137 599	1 224 655	97 238	1 127 417
KwaZulu-	uThukela	DC23	6.2%	93.8%	789 092	48 608	740 484	782 030	48 173	733 857

Province	District municipality name	District municipality code	Calculated coverage %	Uninsured population %	2022 estimates (Population source: Census 2022)			2024 estimates (Population source: GHS 2024 Mid-year)		
Natal										
KwaZulu-Natal	uMzinyathi	DC24	5.2%	94.8%	649 261	34 021	615 240	643 450	33 717	609 733
KwaZulu-Natal	Amajuba	DC25	7.2%	92.8%	687 408	49 356	638 052	681 256	48 914	632 342
KwaZulu-Natal	Zululand	DC26	5.2%	94.8%	942 794	48 742	894 052	934 356	48 306	886 050
KwaZulu-Natal	uMkhanyakude	DC27	4.7%	95.3%	738 437	35 002	703 435	731 828	34 689	697 139
KwaZulu-Natal	King Cetshwayo	DC28	6.7%	93.3%	1 021 344	68 839	952 505	1 012 203	68 222	943 981
KwaZulu-Natal	iLembe	DC29	6.5%	93.5%	782 661	50 951	731 710	775 656	50 495	725 161
Western Cape	Overberg	DC3	19.8%	80.2%	359 446	71 314	288 132	365 712	72 557	293 155
Mpumalanga	Gert Sibande	DC30	10.5%	89.5%	1 283 459	135 277	1 148 182	1 262 083	133 024	1 129 059
Mpumalanga	Nkangala	DC31	10.6%	89.4%	1 588 684	168 718	1 419 966	1 562 224	165 908	1 396 316
Mpumalanga	Ehlanzeni	DC32	9.8%	90.2%	2 270 897	221 640	2 049 257	2 233 355	217 975	2 015 380
Limpopo	Mopani	DC33	7.9%	92.1%	1 372 873	108 869	1 264 004	1 337 338	106 051	1 231 287
Limpopo	Vhembe	DC34	8.0%	92.0%	1 653 022	132 076	1 520 946	1 610 290	128 662	1 481 628
Limpopo	Capricorn	DC35	9.1%	90.9%	1 447 103	132 121	1 314 982	1 409 649	128 701	1 280 945
Limpopo	Waterberg	DC36	9.7%	90.4%	762 862	73 616	689 246	743 116	71 711	671 405
North West	Bojanala	DC37	14.9%	85.1%	1 624 144	242 485	1 381 659	1 774 192	264 887	1 509 305
North West	NM Molema	DC38	11.3%	88.7%	937 723	106 338	831 385	1 024 175	116 141	908 034
North West	Dr RS Mompati	DC39	9.5%	90.5%	508 192	48 126	460 066	555 044	52 563	502 481
Western Cape	Garden Route	DC4	20.8%	79.2%	838 457	174 315	664 142	853 072	177 354	675 718
North West	Dr K Kaunda	DC40	14.0%	86.0%	734 203	102 862	631 341	801 892	112 345	689 547
Gauteng	Sedibeng	DC42	18.7%	81.3%	1 190 688	222 540	968 148	1 256 328	234 808	1 021 520

Province	District municipality name	District municipality code	Calculated coverage %	Uninsured population %	2022 estimates (Population source: Census 2022)			2024 estimates (Population source: GHS 2024 Mid-year)		
KwaZulu-Natal	Harry Gwala	DC43	5.2%	94.8%	563 893	29 548	534 345	558 846	29 284	529 562
Eastern Cape	Alfred Nzo	DC44	4.3%	95.7%	936 462	40 268	896 194	926 458	39 967	889 491
North West	John Taolo Gaetsewe	DC45	14.6%	85.4%	272 454	39 887	232 567	275 869	40 387	235 482
Limpopo	Sekhukhune	DC47	7.8%	92.2%	1 336 805	103 870	1 232 935	1 302 203	101 181	1 201 022
Gauteng	West Rand	DC48	21.7%	78.3%	998 466	216 867	781 599	1 053 510	228 822	824 688
Western Cape	Central Karoo	DC5	14.7%	85.3%	102 173	14 999	87 174	103 954	15 260	88 694
Northern Cape	Namakwa	DC6	15.8%	84.3%	148 935	23 457	125 478	150 802	23 751	127 051
Northern Cape	Pixley ka Seme	DC7	14.1%	85.9%	216 589	30 582	186 007	219 304	30 966	188 338
Northern Cape	Z F Mgcawu	DC8	15.8%	84.2%	283 624	44 813	238 811	287 179	45 374	241 805
Northern Cape	Frances Baard	DC9	15.7%	84.3%	434 343	68 192	366 151	439 788	69 047	370 741
Gauteng	Ekurhuleni	EKU	22.4%	77.6%	4 066 691	910 939	3 155 752	4 290 880	961 157	3 329 723
KwaZulu-Natal	eThekwini	ETH	21.0%	79.0%	4 239 901	889 107	3 350 794	4 201 953	881 150	3 320 803
Gauteng	Johannesburg	JHB	19.8%	80.2%	4 803 262	951 046	3 852 216	5 068 057	1 003 475	4 064 582
Free State	Mangaung	MAN	18.7%	81.3%	811 431	151 738	659 693	833 230	155 814	677 416
Eastern Cape	Nelson Mandela Bay	NMA	21.3%	78.7%	1 190 496	253 576	936 920	1 181 593	251 679	929 914
Gauteng	Tshwane	TSH	30.0%	70.0%	4 040 315	1 212 095	2 828 220	4 263 050	1 278 915	2 984 135
South Africa			15.7%	84.3%	62 026 876	9 718 433	52 308 443	63 015 904	9 963 491	53 052 413

Socio-economic and environmental risk factors

Across the globe, socio-economic and environmental determinants are increasingly recognised as critical drivers of health outcomes. Crucially, they also explain an estimated 30–40% of the variance in common mental disorder prevalence, underscoring why mental health cannot be separated from broader development agendas.[47] The WHO and United Nations Development Programme (UNDP) have consistently highlighted how poverty, lack of access to quality education, unemployment, inadequate housing, and harmful environmental exposures shape population health and contribute to widening health inequities.

Air pollution

Air pollution is now the second-largest leading risk factor for premature death world. The impact of particulate matter ($PM_{2.5}$) on global life expectancy is comparable to that of smoking, more than four times that of high alcohol use, more than five times that of transport injuries like car crashes, and more than six times that of HIV/AIDS.[48] According to the 2024 State of Global Air Report, 99% of the world's population lives in places with unhealthy levels of $PM_{2.5}$ pollution, and air pollution from $PM_{2.5}$ and ozone was estimated to contribute to 8.1 million deaths worldwide.[48] Urban centres in South and East Asia, parts of Africa, and Latin America face particularly high $PM_{2.5}$ levels, mirroring the challenges seen in South Africa's industrial provinces like Gauteng and Mpumalanga. Long-term exposure to $PM_{2.5}$ is also linked to higher odds of depression (OR 1.11 per 10 µg/m³) and cognitive decline,[49] making clean-air policy a mental health as well as a cardiovascular imperative. In 2022, Gauteng recorded the highest $PM_{2.5}$ levels at 43.14 µg/m³, followed by Free State (26.08) and Mpumalanga (22.76), all well above the WHO guideline of 5 µg/m³.[17] Western Cape, by contrast, reported the lowest level at 4.3 µg/m³, reflecting regional disparities in environmental exposure.

Poverty

Multidimensional poverty remains a global concern, especially in low- and middle-income countries. In South Africa, adults living in the bottom income quintile face twice the prevalence of psychological distress compared with the top quintile.[50] While global extreme poverty has declined, over 1.1 billion people still experience multidimensional poverty, with the largest burdens occurring in sub-Saharan Africa and South Asia. Like South Africa, many countries face overlapping deprivations in health, education and living standards, which compound vulnerability to disease and limit access to care.[1] South Africa's Human Development Index (HDI) stands at 0.7, placing it 105th globally which is indicative of moderate development but persistent inequality. While only 0.9% of the population is classified as being in severe multidimensional poverty, 12.2% are considered as being vulnerable to it.[1] The largest contributor to deprivation is standard of living (47.4%), followed by health (39.5%) and education (13.1%). These figures highlight the interlinked nature of poverty and health, where inadequate housing, poor nutrition, and limited access to services compound health risks. Notably, 3% of adults aged 20 years and older have no formal schooling, with the highest rates recorded in Limpopo (5.7%) and Mpumalanga (5.5%).[32]

Unemployment

Unemployment and under-employment are global challenges, especially among youth, which in South Africa exceeds 45%.[33] The International Labour Organization (ILO) reports that youth unemployment rates are three times higher than adult rates globally, with significant implications for mental health, social cohesion, and long-term economic stability.[51] The official unemployment rate remains high at 32.9%, with Eastern Cape (39.3%), North West (40.4%), and Free State (37.9%) facing the highest rates. Western Cape, at 19.6%, is the only province below 20%, reflecting stronger labour market absorption.[33]

Climate change

Climate change amplifies existing vulnerabilities. The April 2022 floods in KwaZulu-Natal doubled probable post-traumatic stress symptoms among displaced adolescents,[11] illustrating how extreme weather fuels mental health crises. Rising temperatures, extreme weather events and environmental degradation disproportionately affect low-income populations and exacerbate health risks. Countries worldwide are increasingly adopting a 'Health in All Policies' approach to address these interconnected challenges through multisectoral collaboration.[52]

Housing and basic services

Housing and basic service access indicators further illustrate inequality. Nationally, 84.1% of households live in formal dwellings, but informal housing remains prevalent in provinces like Western Cape (18.6%) and North West (17.2%). Access to piped water is high nationally (87.7%) but drops to 62.9% in Limpopo and 69.9% in Eastern Cape. Similarly, access to improved sanitation is lowest in Limpopo (62.2%) and Mpumalanga (66.6%), compared to 97.1% in Western Cape.[32]

These socio-economic and environmental indicators, as illustrated in Table 5, underscore the need for a multisectoral approach to health. Health system interventions alone are insufficient. Progress towards universal health coverage and improved population well-being will require co-ordinated action across housing, education, employment, sanitation, and environmental regulation. Embedding health equity into all policies and strengthening interdepartmental collaboration are essential to mit-

igate the health impacts of socio-economic and environmental risk factors.[52]

HIV

Although significant progress has been made in prevention, diagnosis and treatment, HIV remains a major public health challenge. According to UNAIDS,[19] approximately 39 million people are living with HIV worldwide, with sub-Saharan Africa accounting for nearly two-thirds of the global burden. South Africa continues to have the highest national prevalence, but similar patterns are observed in countries like Nigeria, Mozambique, and Kenya.[19]

The global push toward the UNAIDS 95-95-95 targets for epidemic control has seen uneven progress. While many high-income countries have achieved or are close to achieving these targets, several low- and middle-income countries still face gaps, particularly in treatment access and viral suppression among adolescents and key populations. These gaps are likely to worsen due to the cuts in US funding for HIV programmes, which have already led to declines in testing and treatment in several countries. The results from a recent modelling exercise show that longer-term reductions in donor funding could lead to an additional 10.8 million HIV infections and 2.9 million deaths by 2030, over and above what would have occurred with the support of HIV programmes remaining in place.[53]

According to Thembisa v4.7,[38] KwaZulu-Natal (1.95 million) and Gauteng (1.86 million) account for nearly half of all people living with HIV (PLHIV) in South Africa, underscoring the need for sustained, province-specific responses. The South African National AIDS Council's (SANAC) National Strategic Plan (NSP) 2023–2028[3] outlines ambitious targets for HIV and TB to help South Africa eliminate these diseases as public health threats by 2030.

Encouragingly, the first 95 target, which is knowledge of HIV status, has been largely achieved, with 95% of PLHIV being aware of their status.[19] However, gaps remain in treatment and viral suppression, particularly among adolescents and key populations.

HIV prevalence

HIV prevalence among antenatal clients aged 15–49 remains high at 21.5% in 2024, with the highest rates shown in KwaZulu-Natal (27.3%) and Mpumalanga (28.1%).[38] These figures reinforce the need for integrated sexual and reproductive health services and continued investment in prevention of mother-to-child transmission (PMTCT) programmes.

The data also highlight the disproportionate burden among key populations, where HIV prevalence is estimated at 62.3% among sex workers, 58.0% among transgender people, and 29.7% among men who have sex with men.[19] This calls for targeted, rights-based interventions and the removal of structural barriers to care — even more so as key populations are being disproportionately affected by the US funding cuts which specifically prevent any funding in HIV programmes being allocated to support them.

Antiretroviral therapy coverage

In response to the global funding cuts, South Africa launched the Close the Gap campaign in February 2025 which aims to enrol an additional 1.1 million PLHIV on life-saving treatment by the end of 2025.[53] According to the 2024 DHIS data, antiretroviral therapy (ART) coverage (the second 95) stands at 77.1% nationally, but is notably lower among children aged 0–14 (60.6%) and youth aged 15–24 (54.3%). Provinces such as Limpopo (65.1%) and Mpumalanga (73.4%) fall below the national average, while KwaZulu-Natal leads with 86.6% coverage.[39] Among key populations, ART coverage is highest among female sex workers (74.5%) and lowest among men who have sex with men (63.7%), reflecting persistent barriers to access and stigma.[19]

Viral suppression

As illustrated by Figure 2, viral load suppression (the third 95) remains below target at 66.8% nationally, with even lower rates among children (41.2%) and men aged 15 and older (61.3%). Western Cape (54.4%) and KwaZulu-Natal (78.8%) show the widest provincial variation, highlighting the importance of differentiated care models and adherence support.[54]

HIV and mental health integration

Mental health integration into HIV care is gaining traction worldwide. The bidirectional relationship between HIV and mental health, whereby depression, anxiety and trauma affect ART adherence and outcomes, is increasingly recognised. Countries like Brazil and Thailand have begun to embed psychosocial support into HIV programmes, aligning with South Africa's strategic emphasis on integrated care.[55] The 2023–2028 NSP[3] explicitly elevates mental health within Goal 1, Objective 1.7 "Integrate and standardise delivery and access to mental health services", recognising the bidirectional links between HIV, TB, sexual and gender-based violence (SGBV), human rights violations, inequalities, and mental health. By foregrounding integration, the NSP positions routine HIV/TB platforms as entry-points for early identification of depression, anxiety and trauma, and for referral pathways that include psychosocial support, law and policy reform, redress mechanisms, dignified survivor-centred services, and sensitised health facilities and personnel. This strategic emphasis strengthens the rationale for embedding mental health screening and support within adherence clubs, adolescent/youth models, PMTCT, and key population programmes to accelerate progress towards achieving the second and third 95s (Table 7).[3]

Table 5. Socio-economic and environmental risk indicators by province

Indicator	Period	Sex|Age|Series|Cat	SA	EC	FS	GP	KZN	LP	MP	NC	NW	WC	Ref
Air pollution level in cities (particulate matter [PM])	2022	AQLI $PM_{2.5}$	23.3	11.9	26.1	43.1	20.2	14.3	22.8	13.6	29.6	4.3	a
Education as a contributor of deprivation in dimension to overall multidimensional poverty	2023/24	both sexes all ages UNDP	13.1										b
Education level: percentage of population with no schooling	2024	both sexes 20+ years GHS	3.0	3.7	2.7	1.1	3.8	5.7	5.5	3.7	5.2	0.9	c
Formal dwellings	2024	both sexes all ages GHS	84.1	77.0	84.0	82.3	84.5	95.3	90.6	85.2	82.7	80.8	c
Health as a contributor of deprivation in dimension to overall multidimensional poverty	2023/24	both sexes all ages UNDP	39.5										b
Percentage of female-headed households	2024	female GHS	42.4	48.8	43.2	37.3	46.8	46.5	46.7	45.8	38.8	39.7	c
		female GHS Rural	47.1										c
		female GHS Urban	40.4										c
Percentage of households by type of housing	2024	both sexes GHS Formal	84.1	77.0	84.0	82.3	84.5	95.3	90.6	85.2	82.7	80.8	c
		both sexes GHS Informal	11.7	4.6	14.9	17.2	4.9	2.5	6.7	14.1	17.2	18.6	c
		both sexes GHS Other	0.3	0.6	0.0	0.5	0.3	0.1	0.0	0.3	0.0	0.4	c
		both sexes GHS Traditional	3.9	17.7	1.1	0.1	10.3	2.2	2.7	0.4	0.1	0.2	c
Percentage of households using electricity for cooking	2024	both sexes GHS	90.2	93.4	92.8	83.2	93.5	96.6	89.4	90.9	90.1	96.0	c
Percentage of households with access to improved sanitation	2024	both sexes GHS Formal	83.1	89.9	86.4	91.3	77.8	62.2	66.6	84.3	72.7	97.1	c
Percentage of households with access to piped water	2024	both sexes GHS	87.7	69.9	94.8	98.0	82.9	62.9	87.5	95.1	86.0	99.0	c
Percentage of households with no	2024	both sexes GHS	0.7	2.4	0.9	0.1	0.6	0.6	1.2	3.6	1.3	0.0	c

Indicator	Period	Sex|Age|Series|Cat	SA	EC	FS	GP	KZN	LP	MP	NC	NW	WC	Ref
toilet / bucket toilet		Formal											
Percentage of households with refuse removal	2024	both sexes GHS Communal refuse dump	6.2	4.2	5.6		4.7	8.0	3.9	3.0	8.0	7.1	c
		both sexes GHS Dump or leave rubbish anywhere	1.8										c
		both sexes GHS Other	0.3	2.6	4.4	2.1	1.1	2.3	2.0	7.3		0.3	c
		both sexes GHS Own refuse dump	28.1	49.8	16.3		44.3	64.5	49.0	23.9	5.7	1.0	c
		both sexes GHS Removed at least once per week	61.3	43.4	73.7		49.9	25.3	45.1	65.8	84.3	91.5	c
		both sexes GHS Removed less than once per week	2.3										c
Percentage of households with telephone (telephone in dwelling or cell-phone)	2024	both sexes GHS	3.9	7.3	8.9	1.9	2.6	2.0		8.6	5.9	4.2	c
		both sexes GHS Cell and landline	3.3	1.4	3.1	1.7	3.7	3.0		1.5	1.7	5.1	c
		both sexes GHS Only cell	92.8	91.3	87.9	96.4	93.6	94.9		90.0	92.3	90.7	c
		both sexes GHS Only landline	0.1	0.1	0.1	0.0	0.1	0.1		0.0	0.1	0.1	c
Population in severe multidimensional poverty	2023/24	both sexes all ages UNDP	0.9										b
Population vulnerable to multidimensional poverty	2023/24	both sexes all ages UNDP	12.2										b
Standard of living as a contributor of deprivation in dimension to overall multidimensional poverty	2023/24	both sexes all ages UNDP	47.4										b
Unemployment rate (official	2024	both sexes 15-64	32.9	39.3	37.9	34.7	32.3	33.3	35.4	29.5	40.4	19.6	d

Indicator	Period	Sex|Age|Series|Cat	SA	EC	FS	GP	KZN	LP	MP	NC	NW	WC	Ref
definition)	Q4	years LFS											

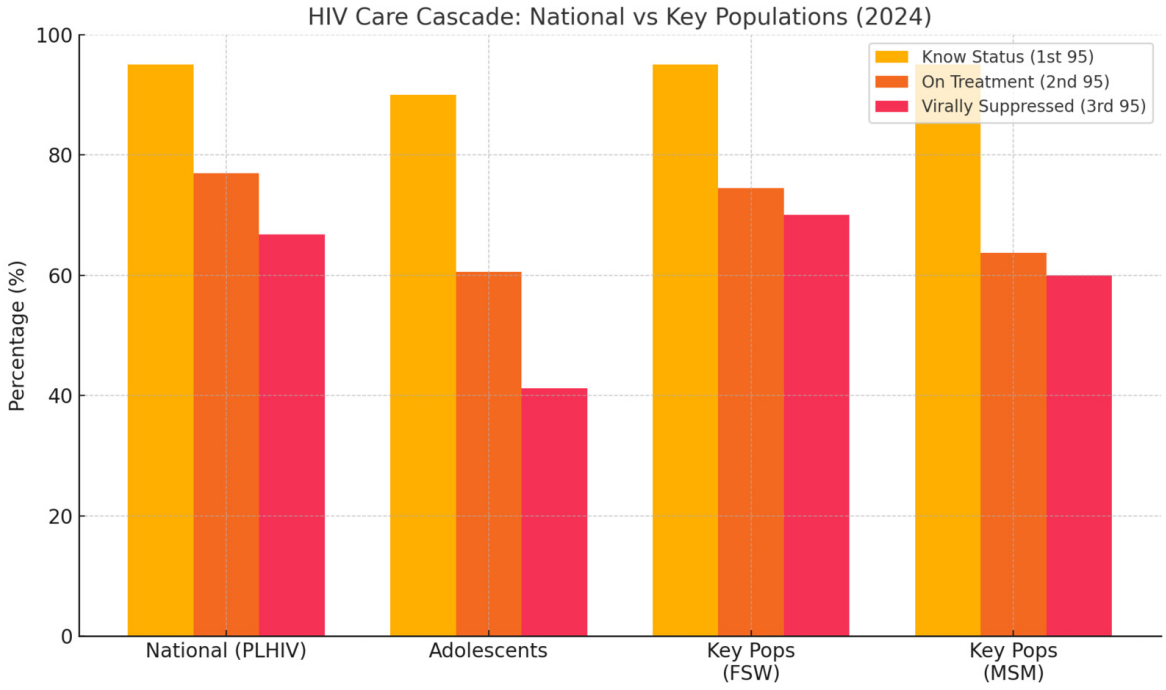
Sources:
a: AQLI 2024[17]
b: HDR 2023/2[41]
c: StatsSA GHS 2024[32]
d: Labour Force Survey Q4 2024[33]
Indicator [units]: Definition
• Air pollution level in cities (particulate matter [PM]) [ug/m3]: Annual mean concentration of particulate matter of less than 2.5 microns of diameter ($PM_{2.5}$) [ug/m3] (or of less than 10 microns [PM_{10}] if $PM_{2.5}$ is not available) in cities.
• Education level: percentage of population with no schooling [Percentage]: Percentage of people in a given age group who have received a particular level of education. Data are presented for the percentage of population aged 20 years and older with no schooling. In some cases, the indicator is presented for a different age category, depending on what is available in the source.
• Education as a contributor of deprivation in dimension to overall multidimensional poverty [Percentage]: The proportion of the MPI (poverty burden) attributable to education-related deprivations.
• Formal dwellings [Percentage]: Percentage of households living in formal dwellings.
• Health as a contributor of deprivation in dimension to overall multidimensional poverty [Percentage]: The percentage share of overall multidimensional poverty that is attributable to deprivations in the health dimension (nutrition and child mortality).
• Percentage of female-headed households [Percentage]: Percentage of female-headed households.
• Percentage of households by type of housing [Percentage]: Percentage of households that are categorised as formal, informal, traditional or other.
• Percentage of households using electricity for cooking [Percentage]: Percentage of households using electricity as their main energy source for cooking.
• Percentage of households with access to improved sanitation [Percentage]: Percentage of households using improved sanitation facilities (including flush to piped sewer system, flush to septic tank, flush/pour flush to pit, flush/pour flush to elsewhere).
• Percentage of households with access to piped water [Percentage]: Includes households with piped water in dwelling, piped water inside yard, or piped water on a community stand (<200m away or further).
• Percentage of households with no toilet / bucket toilet [Percentage]: Percentage of households that have no toilet, or were using a bucket toilet.
• Percentage of households with refuse removal [Percentage]: Percentage of households that have refuse removal by the local authority at least once a week.
• Percentage of households with telephone (telephone in dwelling or cell phone) [Percentage]: Percentage of households with a telephone in the dwelling or a cellular telephone.
• Population in severe multidimensional poverty [Percentage]: The proportion of people who are multidimensionally poor and deprived in at least half of the weighted indicators.
• Population vulnerable to multidimensional poverty [Percentage]: The proportion of people who are not yet multidimensionally poor but are deprived in 20–33% of the weighted indicators, and are thus at risk of falling into multidimensional poverty.
• Standard of living as a contributor of deprivation in dimension to overall multidimensional poverty [Percentage]: The percentage share of overall multidimensional poverty that is attributable to deprivations in the standard of living dimension (e.g. housing, assets, electricity, water, sanitation, and cooking fuel).
• Unemployment rate (official definition) [Percentage]: The official definition of the unemployed is that they are those people within the economically active population (aged 15—65) who:
(a) did not have a job or business during the seven days prior to the interview,
(b) want to work and are available to work within two weeks of the interview, and
(c) have taken active steps to look for work or to start some form of self-employment in the four weeks prior to the interview.

Table 6. HIV 2028 targets summary

Target area	Baseline value (year)	2028 goal
New HIV infections	198 311 (2021)	↓ to 81 467 annually
Mother-to-child transmission	0.91% (2021/22) at 10 weeks, 2.9% at 18 months	↓ to 0.46% at 10 weeks, 1.4% at 18 months
Treatment cascade (95-95-95)	94.2% know status (2022) → 75% on ART (2022) → 92% virally suppressed (2022)	96.5% know status → 95% on ART → 97% virally suppressed
AIDS-related deaths	71 663 (2021)	↓ to 52 580 annually
Key populations HIV prevalence	• FSW: 57.9% (2022), • MSM: 29.9% (2022), • PWID: 21% (2017), • TG: 51.9% (2021), • Inmates: 17.5% (2021)	↓ across all groups • FSW: 48.5% • MSM: 26.1% • PWID: 16% • TG: 45% • Inmates: 17.5%
PHC client treated for mental disorders	69 139 (2021/22)	256 708

Source: SANAC HIV, TB; STI NSP, 2025[3]
FSW = female sex worker; MSM = men who have sex with men; PWID = people who inject drugs; TG = transgender

Figure 2. HIV care cascade: national vs key populations, 2024



Source: DHIS[39]; UNAIDS, 2024[19]

Tuberculosis

Tuberculosis remains one of the top infectious disease killers, with an estimated 10.6 million people falling ill and 1.3 million deaths in 2023, according to the WHO Global TB Report.[13] The burden is disproportionately concentrated in low- and middle-income countries, with India, Indonesia, China, the Philippines, Pakistan, Nigeria, and Bangladesh accounting for two-thirds of global cases. Drug-resistant TB poses a growing threat worldwide, with nearly half a million cases of rifampicin-resistant TB reported annually. Treatment success rates for multidrug-resistant TB (MDR-TB) remain below 60% globally, mirroring challenges seen in South Africa.[13]

Integration of TB and HIV services is a global priority, especially in high-burden regions. Innovations such as shorter treatment regimens, digital adherence technologies, and community-based care models are being scaled up to improve outcomes. Similar to the national Close the Gap campaign for HIV epidemic control, the End TB

Table 7. HIV indicators by province

Indicator	Period	Sex|Age|Series|Cat	SA	EC	FS	GP	KZN	LP	MP	NC	NW	WC	Ref
Total living with HIV	2024 Q1	both sexes all ages NDoH-Thembisa	7 850 921	881 854	429 252	1 909 663	1 979 164	717 039	754 588	105 977	542 361	531 023	a
People living with HIV (PLHIV)	2023	both sexes 0—14 years Global report	160 000										b
		both sexes all ages Global report	7 700 000										b
		female 15 years and older Global report	4 900 000										b
		male 15 years and older Global report	2 600 000										b
	2024	both sexes all ages Thembisa 4.7	7 881 970	885 252	408 309	1 861 750	1 946 960	722 302	807 350	103 883	494 362	558 817	c
HIV prevalence (age 15—49)	2023	both sexes 15—19 years Global report	17.1										b
HIV prevalence (total population)	2023	both sexes all ages Global report Prisoners	7.0										b
		both sexes all ages Global report Sex workers	62.3										b
		both sexes all ages Global report Transgender people	58.0										b
		male all ages Global report Men who have sex with men	29.7										b
Percentage of people living with HIV (PLHIV) who know their status (1st 95)	2023	both sexes 0—14 years Global report	87.0										b
		both sexes all ages Global report	95.0										b
		female 15 years and older Global report	96.0										b
		male 15 years and older Global report	94.0										b
Number of patients receiving ART	2024	both sexes all ages Thembisa 4.7	6 076 240	646 495	334 960	1 377 300	1 686 160	470 411	626 080	76 154	386 137	365 441	c

Indicator	Period	Sex|Age|Series|Cat	SA	EC	FS	GP	KZN	LP	MP	NC	NW	WC	Ref
Antiretroviral coverage (2nd 95)	2024	both sexes 0–4 years Thembisa 4.7	60.6	59.9	51.9	42.8	55.6	46.9	49.8	69.0	55.3	67.0	c
		both sexes 15–24 years Thembisa 4.7	54.3	46.4	62.5	52.5	67.8	42.6	56.7	46.8	57.7	38.9	c
		both sexes all ages Thembisa 4.7	77.1	73.1	82.0	74.0	86.6	65.1	77.6	73.4	78.1	65.4	c
		both sexes all ages Thembisa 4.7 Female sex worker clients	71.3	66.4	78.5	70.0	84.1	55.9	72.9	66.7	72.2	59.3	c
		both sexes all ages Thembisa 4.7 Men who have sex with men	63.7	59.8	67.7	63.6	78.0	48.3	64.4	58.3	64.4	51.2	c
		female 15 years and older Thembisa 4.7	80.4	76.3	84.9	76.9	89.1	69.5	80.9	76.8	81.8	68.2	c
		female 15–24 years Thembisa 4.7	53.8	45.7	60.8	51.0	66.6	42.2	55.9	46.3	57.4	38.0	c
		female all ages Thembisa 4.7 Female sex workers	74.5	70.5	80.1	70.7	86.0	63.1	76.9	71.5	76.5	60.7	c
		male 15 years and older Thembisa 4.7	71.6	67.0	78.6	70.5	84.0	56.7	73.1	66.9	72.7	59.6	c
		males 15–24 years Thembisa 4.7	55.5	48.3	65.9	56.0	70.4	43.4	58.6	48.0	58.5	41.2	c
HIV viral load suppression (3rd 95)	2023	both sexes 0–14 years Global report	47.0										b
		both sexes 0–14 years Thembisa 4.7 <400 copies/ml	41.2	39.5	38.7	31.3	42.7	29.3	33.2	45.1	36.5	54.4	c
		both sexes all ages Global report	71.0										b
		both sexes all ages Thembisa 4.7 <400 copies/ml	66.8	63.2	73.9	65.8	78.8	55.6	66.6	63.5	67.8	61.8	c
		female 15 years and older Global report	75.0										b
		female 15 years and older Thembisa 4.7 <400	70.4	66.9	77.4	69.1	82.0	60.2	70.5	67.4	72.1	64.9	c

Indicator	Period	Sex|Age|Series|Cat	SA	EC	FS	GP	KZN	LP	MP	NC	NW	WC	Ref
		copies/ml											
		male 15 years and older Thembisa 4.7 <400 copes/ml	61.3	56.8	69.9	62.0	75.6	47.2	61.5	56.9	61.9	56.3	c
		males 15 years and older Global report	64.0										b
HIV prevalence among antenatal clients	2023	15—49 years Thembisa 4.7	22.4	24.5	24.0	21.8	28.7	17.2	29.0	13.2	22.4	13.9	c
	2024	15—49 years Thembisa 4.7	21.5	23.8	23.0	21.0	27.3	16.7	28.1	12.8	21.5	13.4	c
HIV testing coverage	2023	both sexes 15+ years Thembisa 4.7	83.4	82.2	81.4	85.5	87.3	79.8	84.6	79.2	85.5	83.6	c
Male circumcision (% of men who are circumcised)	2023	15—49 years Thembisa 4.7	64.1	80.1	66.4	73.5	58.0	92.4	79.5	39.8	55.9	44.9	c
	2024	15—49 years Thembisa 4.7	65.6	80.4	67.6	75.1	50.4	92.7	81.1	41.7	57.6	45.6	c

Sources:
a: DHIS[39]
b: UNAIDS 2024[19]
c: Thembisa v4.7[38]

Indicator [units]: Definition

• Antiretroviral coverage (2nd 95) [Percentage]: The number of patients receiving ART, divided by the number needing treatment. The denominator has changed over time, due to changes in treatment guidelines affecting the criteria for treatment eligibility. The latest definition is that all HIV-infected patients should be on ART. This indicator is also one of the UNAIDS 95-95-95 global targets for epidemic control.
• HIV prevalence (age 15—49) [Percentage]: Percentage of population (age 15—49) estimated to be HIV-positive.
• HIV prevalence (total population) [Percentage]: Percentage of population estimated to be HIV-positive.
• HIV prevalence among antenatal clients [Percentage]: Percentage of women surveyed testing positive for HIV.
• HIV testing coverage [Percentage]: Percentage of target population who have been tested for HIV.
• HIV viral load suppression (3rd 95) [Percentage]: Percentage of people on ART who are virologically suppressed (VL level <= 1 000 copies/mL). This indicator is also one of the UNAIDS 95-95-95 global targets for epidemic control.
• Male circumcision (% of men who are circumcised) [Percentage]: The percentage of men (15—59 years, unless otherwise specified) who have been circumcised.
• Number of patients receiving ART [Number]: Number of patients receiving ART.
• People living with HIV (PLHIV) [Number]: The number of people who are HIV-positive.
• Percentage of people living with HIV (PLHIV) who know their status (1st 95) [Percentage]: Percentage of people living with HIV who know their HIV status. This indicator is also one of the UNAIDS 95-95-95 global targets for epidemic control.
• Total living with HIV [Number]: The estimated number of people who are HIV-positive.

Table 8. TB 2028 targets summary

Target area	Baseline (year)	2028 goal
TB case detection	58% (2020)	↑ to 95%
TB incidence	304 000 (2021)	215 000
TB treatment success	DS-TB: 78% (2020) and MDR/XDR-TB: 66% (2019)	↑ to 90% for DS-TB and 75% MDR-/XDR-TB
TB preventive therapy (TPT)	63%	80% coverage with shorter regimens
TB mortality	56 000 (2021)	Significant reduction (modelled)
TB screening and diagnosis		Scale up digital chest X-rays, urine LAM, and universal screening

Source: SANAC HIV, TB & STI NSP, 2025[3]
DS-TB = drug-susceptible tuberculosis; MDR/XDR-TB = multi-drug resistant / extensively drug-resistant tuberculosis

campaign in South Africa is a national effort to reduce TB incidence and mortality by 2035. The campaign's initial phase focuses on expanding TB testing to reach 5 million people by 2025/26, with the goal of diagnosing 250 000 new TB cases. This effort is part of a broader strategy to eliminate TB as a public health threat in South Africa. Achieving the End TB targets will require sustained investment, political commitment, and multisectoral action to address the social determinants of TB, including poverty, malnutrition, and housing conditions.[56]

TB incidence

With an estimated incidence rate of 427 per 100 000 population in 2023,[13] South Africa remains among the top 10 countries with the highest burden of TB, accounting for two-thirds of all TB infections globally.[3] Among PLHIV, the incidence is particularly high at 230 per 100 000, reflecting the persistent syndemic relationship between TB and HIV. Similar to HIV, the SANAC NSP 2023–2028 outlines South Africa's targets for TB for 2028, which are outlined in Table 8. The targets include increasing the TB case detection rate to 95% from 77% in 2022,[57] indicating that nearly a quarter of cases may remain undiagnosed or unreported. In addition to this, the NSP seeks to increase TB treatment success across all forms of TB to 95% by 2028.[3]

Drug-resistant TB

Drug-resistant TB continues to pose a significant threat. In 2022, 7 109 MDR-TB patients were recorded in the national cohort, with KwaZulu-Natal (1 736) and Eastern Cape (1 610) reporting the highest numbers.[58] Treatment outcomes remain suboptimal: the national MDR-TB treatment success rate was 62.4%, with Western Cape trailing at just 52.5%. Loss to follow-up rates were also high, particularly in Western Cape (24.2%) and Gauteng (20.6%), suggesting systemic challenges in patient retention and adherence support.

Extensively drug-resistant TB (XDR-TB) outcomes are even more concerning. The national XDR-TB treatment success rate was only 51.0%, with mortality rates reaching 34.8% in Mpumalanga and 34.3% in Northern Cape. These figures highlight the urgent need for improved diagnostics, second-line treatment access, and patient-centred care models.

HIV and TB co-infection

The intersection of TB and HIV remains a critical concern. In 2022, 54% of TB incident cases were co-infected with HIV in South Africa, and the TB mortality rate among PLHIV was 49 per 100 000 in 2023.[13] While the overall TB mortality rate has declined to 90 per 100 000, the mortality rate in South Africa remains among the highest globally. Notably, the mortality rate excluding HIV has plateaued at 39 per 100 000, indicating that broader TB control efforts must be intensified beyond the HIV-positive population. Interestingly, the 2021 StatsSA Causes of Death report showed that TB went from being ranked as the second-highest cause of death in 2019 (accounting for 5.5% of deaths) to the seventh-highest cause of death in 2021 (accounting for 2.9% of deaths).[35]

Efforts to address the social determinants of TB must also extend to the psychological and emotional well-being of patients. Depression, anxiety and stress not only reflect social disadvantage but also pose direct barriers to achieving the End TB targets, as demonstrated by a global review and meta-analysis. The review, which included a pooled estimate of 8 086 TB patients, reported a prevalence of 32.5% for anxiety, 32.9% for comorbid depression, and 52.7% for stress with the highest prevalence reported in the African region.[35] More locally, a qualitative study based in Khayelitsha, Cape Town, found that patients living with HIV-associated TB scored higher in themes related to physical, social, and mental health aspects of health-related quality of life (HRQoL) assessments. In particular, concerns and coping within the mental health domain emerged as dominant themes.[59]

While individual studies have explored the psychological impact of HIV and TB separately,[60,61] there is a notable lack of nationally representative evidence focusing specifically on the psychosocial experiences of those co-infected with HIV and TB. This represents a critical research gap, particularly in high-burden settings like South Africa, where understanding and addressing the compounded mental health challenges of co-infection could significantly improve care outcomes. Taken together, these global and local findings underscore the need to integrate psychosocial support into TB and HIV programmes as a core component of achieving the End TB targets.

These indicators underscore the need for a re-invigorated TB response that integrates prevention, early detection and treatment adherence, while ensuring alignment with HIV care services for individuals with HIV/TB co-infection. Strengthening community-based care, expanding access to newer TB regimens, and addressing social determinants such as poverty and malnutrition will be essential to achieving the End TB targets (Table 8).[62]

Maternal and reproductive health

Maternal mortality ratio

According to WHO, the global maternal mortality ratio declined by over 40% between 2000 and 2023, but progress has stalled in many low- and middle-income countries. Sub-Saharan Africa continues to account for approximately 70% of global maternal deaths, with leading causes including haemorrhage, hypertensive disorders, and sepsis.[64]

The institutional maternal mortality ratio (iMMR) was 111.7 per 100 000 live births in 2023 in South Africa, with the highest provincial ratios found in North West (156.5), Free State (139.5), and Eastern Cape (140.4).[30] These figures contrast with the WHO national estimate of 118 per 100 000, highlighting discrepancies between facility-based and modelled estimates. Routine DHIS data show a similar picture, with an overall facility ratio of 101 and the same provinces at the extremes. More than half of these deaths are still judged as preventable, underscoring ongoing gaps in the timeous management of haemorrhage, hypertension and infection.[30]

Access to skilled birth attendance

Although access to skilled birth attendance has improved — reaching 87% in 2024 — the quality of care and emergency obstetric services remains uneven. Caesarean section rates are rising worldwide, with some countries exceeding the WHO-recommended threshold of 10–15%, raising concerns about over-medicalisation.[65] In contrast, many low-resource settings still face barriers to timely surgical intervention. Nationally, the institutional delivery rate stands at 78.4%, with Limpopo (90.3%) and Free State (85.5%) outperforming the national average, while Northern Cape (69.4%) and Eastern Cape (71.2%) lag behind.[39] Caesarean section rates remain high at 32.4% nationally, with KwaZulu-Natal reporting the highest rate at 38.9%, raising questions about clinical appropriateness and access to emergency obstetric care.[39]

Contraception

Access to modern contraception has expanded globally, yet unmet need remains high in parts of South Asia and sub-Saharan Africa. The global health community increasingly emphasises respectful maternity care, adolescent-friendly services, and integration of sexual and reproductive health with HIV and mental health services.[66] These global trends offer important lessons and benchmarks for South Africa's ongoing efforts to improve maternal and reproductive health outcomes.

Teenage pregnancy

High adolescent fertility rates remain a concern in many regions, particularly in West and Central Africa, where rates exceed 100 births per 1 000 girls aged 15–19 years.[64] In South Africa, teenage pregnancy remains a significant concern, where over 122 000 facility-based deliveries were recorded among girls aged 10–19 years. KwaZulu-Natal (31 088) and Gauteng (19 836) accounted for the highest numbers. Statistics South Africa's Vital Registration Register mirrors the magnitude of the problem, logging just over 100 000 live births to 15–19-year-olds in 2023.[36] The facility delivery rate for this age group is 14.1%, peaking at 18.0% in Eastern Cape.[39] Condom use among young women aged 15–24 has declined to 26.2% nationally, according to THEMBISA 4.7,[38] suggesting a worrying trend in sexual risk behaviour. The trend threatens to undermine gains in HIV prevention and heightens the risk of unintended and unsupported pregnancy.

Neonatal deaths

Neonatal outcomes have barely shifted. The facility-based neonatal mortality rate stands at 9.9 deaths per 1 000 live births, down slightly from recent years but stubbornly high in Free State and Northern Cape and at its lowest in Western Cape. While the WHO estimates are not disaggregated provincially, neonatal mortality remains high at 11.6 per 1 000 live births,[67] underscoring the need for improved perinatal care, as this rate has increased from 2021.

Termination of pregnancies

The data also show that 137 331 terminations of pregnancy (ToPs) were performed in 2023, with Gauteng (35 363) and Western Cape (20 624) leading in service provision.[39] This reflects both access and demand, but also points to the need for strengthened contraceptive services and post-abortion care.

These indicators reveal a health system that is succeeding at bringing more women into care earlier, but

Table 9. TB indicators by province

Indicator	Period	Sex|Age|Series|Cat	SA	EC	FS	GP	KZN	LP	MP	NC	NW	WC	Ref
All MDR-TB patients in cohort	2022	both sexes all ages EDRWeb	7109	1610	267	810	1736	226	363	315	348	1434	a
Case detection rate (all forms)	2022	both sexes Global TB (2023)	77										b
HIV prevalence in TB incident cases	2022	both sexes Global TB	54										b
Incidence of TB (all types) (per 100000)	2023	both sexes all ages Global TB	427										c
		both sexes all ages Global TB PLHIV	230										c
Reported cases of MDR-TB	2022	WHO	7590										b
TB MDR client death rate	2022	both sexes all ages EDRWeb	15.6	17.4	21.3	12.8	13.8	19.0	16.8	15.6	18.4	14.6	a
TB MDR client loss to follow-up rate	2022	both sexes all ages EDRWeb	17.5	17.7	12.7	20.6	15.3	8.8	9.6	16.8	11.5	24.2	a
TB MDR treatment success rate	2022	both sexes all ages EDRWeb	62.4	61.2	62.2	64.4	68.5	63.3	66.7	64.8	67.0	52.5	a
TB XDR client death rate	2022	both sexes all ages EDRWeb	20.1	21.2	28.1	22.2	14.2	21.4	34.8	34.3	15.0	15.6	a
TB XDR client loss to follow-up rate	2022	both sexes all ages EDRWeb	16.2	12.9	9.4	18.1	16.8	7.1	4.3	11.4	10.0	25.0	a
TB XDR treatment success rate	2022	both sexes all ages EDRWeb	51	55.4	46.9	47.2	52.2	50.0	56.5	54.3	65.0	42.8	a
Tuberculosis death rate per 100000 (in HIV-positive people)	2023	both sexes Global TB	49										c
Tuberculosis mortality rate per 100000	2022	both sexes all ages Global TB	90										b
Tuberculosis mortality rate per 100000 (excluding HIV)	2022	Global TB	39										b
	2023	both sexes Global TB	39										c

Sources:
a: EDRWeb[63]
b: Global TB database[57]
c: Global TB 2024[13]
Indicator [units]: Definition
• Case detection rate (all forms) [Percentage]: Proportion of incident cases of TB (all types) that were notified. For a given country, it is calculated as the number of notified cases of TB in one year divided by the number of estimated incident cases of TB in the same year, and expressed as a percentage.
• HIV prevalence in TB incident cases [Percentage]: Percentage of new TB cases that are HIV-positive.
• Incidence of TB (all types) [per 100000 population]: Estimated number of cases of tuberculosis (all types) per 100000 population (for the year).
• Reported cases of MDR-TB [Number]: Number of laboratory-diagnosed cases of MDR-TB. MDR-TB is defined as resistance to rifampicin and isoniazid, with or without resistance to other first-line anti-TB drugs.
• TB MDR client death rate [Percentage]: The percentage of TB clients (MDR-TB) who died.
• TB MDR client loss to follow-up rate [Percentage]: The percentage of TB clients (MDR-TB) who are lost to follow-up.
• TB MDR treatment success rate [Percentage]: The percentage of TB clients (MDR-TB) cured plus those who completed treatment.
• TB XDR client death rate [Percentage]: The percentage of TB clients (XDR-TB) who died.
• TB XDR client loss to follow-up rate [Percentage]: The percentage of TB clients (XDR-TB) who are lost to follow-up.
• TB XDR treatment success rate [Percentage]: XDR-TB clients who successfully complete treatment as a proportion of XDR-TB clients started on treatment.
• Tuberculosis death rate per 100000 (in HIV-positive people) [per 100000 population]: Number of deaths due to TB in HIV-positive people per 100000 population.
• Tuberculosis mortality rate per 100000 [per 100000 population]: Number of deaths due to tuberculosis (all types) reported per 100000 population (for the year).

has yet to translate such access into faster reductions in maternal and newborn deaths. Closing the provincial equity gaps, re-energising HIV and pregnancy-prevention efforts among adolescents, and sharpening the quality of intrapartum and emergency obstetric care will be critical if South Africa is to restart progress towards achievement of the SDG targets for 2030.

Perinatal mental health challenges and economic considerations

A review informed by a significant proportion of South African studies suggests that women in Africa experience a range of perinatal mental disorders, including depression and psychosis, often linked to socio-economic and poverty-related factors operating at multiple levels.[68] However, evidence on the health and social impacts of these conditions, the availability of context-specific interventions, and patterns of mental healthcare use remains limited.[68] In quantifying the economic toll, models suggest that perinatal depression and anxiety in South Africa account for a lifetime cost of USD 2.8 billion per annual birth cohort — a figure that rises when post-traumatic stress disorder is included.[69] Despite progress in mental health policies and interventions, there remains a significant gap in economic investment to meet perinatal mental health needs, which in itself is a barrier to meeting these needs (Table 9).

Child health

Child health has seen significant improvements over the past decades, yet disparities remain stark across regions. According to UNICEF and WHO, global under-five mortality has declined by over 50% since 1990, but sub-Saharan Africa still accounts for more than half of all under-five deaths. Immunisation coverage has plateaued in many countries, with the COVID-19 pandemic causing setbacks in routine vaccinations. In 2023, an estimated 25 million children missed out on essential vaccines worldwide.[15]

Malnutrition continues to be a leading cause of child morbidity and mortality, with 148 million children under five being affected by stunting and 45 million by wasting. Conversely, childhood obesity is rising, particularly in middle-income countries, posing new challenges for health systems. Mental health and developmental delays are also gaining attention, with global initiatives calling for integrated early childhood development programmes. These global trends underscore the need for resilient PHC systems, equitable access to services, and targeted interventions to address both infectious and non-communicable threats to child health.[18]

Immunisation

Child health outcomes in South Africa continue to reflect both progress and persistent gaps in service coverage and equity. Immunisation coverage has declined across several key vaccines: BCG coverage dropped from 79% in 2023 to 74% in 2024, and DTP3 coverage also stands at 74% from 79% in those same years.[15] Measles coverage shows slightly better performance in 2024, with 81% for the first dose and 82% for the second dose, yet still falls short of the 95% target required for herd immunity.

The pneumococcal conjugate vaccine (PCV) third-dose coverage also declined slightly from 83% in 2023 to 81% in 2024, mirroring the trend seen in other immunisation indicators. This decline may reflect broader systemic issues in routine child health services, including supply-chain constraints and workforce shortages, challenges in vaccine uptake (possibly linked to service disruptions), vaccine hesitancy, and access barriers.[70]

Child mortality

Under-five mortality remains a pressing concern. According to the UNICEF State of the World's Children Report, the 2023 estimate for South Africa was 34.7 deaths per 1 000 live births, with boys (37.2) experiencing higher mortality than girls (31.9).[18] The 2024 mid-year estimate[34] shows a modest improvement to 28.6, but this still exceeds the SDG target of 25 per 1 000. Similarly, child mortality in the 1–4-year age group was 10.4 per 1 000 in 2023, again with higher rates among boys (11.1) than girls (9.8).[21]

Orphanhood

Orphanhood data from the 2024 GHS[32] reveals concerning levels of parental orphanhood among children under 18 years. Nationally, 7.6% of children are paternal orphans, with Free State (10.7%) and Northern Cape (9.3%) reporting the highest rates. Maternal orphanhood is lower at 2.7% nationally, but still significant, particularly in Western Cape (4.3%). These figures underscore the need for strengthened social protection and psychosocial support for vulnerable children.

Collectively, these findings underscore the need to reinvigorate primary health care and immunisation outreach, especially in under-served areas, by bolstering health information systems, optimising vaccine delivery, and tackling the social determinants that shape child health.[70]

Balancing challenges and resilience in orphaned adolescents

Addressing the mental health challenges of orphaned and vulnerable children is critical, yet nationally representative data remain scarce. Evidence from a study conducted in the City of Tshwane shows a 21% prevalence of depressive symptoms among orphaned adolescents in township secondary schools.[71] Further research on maternally orphaned adolescents reveals maladaptive behaviours, including suicidal thoughts, poor self-perception, silence, psychological distress, risky behaviours, and social withdrawal.[72] In contrast, a more recent study by the same authors identifies protective behaviours among some orphans, such as resilience fostered through par-

Table 10. Maternal and reproductive indicators by province

Indicator	Period	Sex|Age|Series|Cat	SA	EC	FS	GP	KZN	LP	MP	NC	NW	WC	Ref
Condom use at last sex	2023	female 15–24 years THEMBISA 4.7	26.2	24.2	26.1	29.5	31.0	22.5	30.4	26.2	26.7	33.6	a
		female 25–49 years THEMBISA 4.7	29.2	25.5	26.2	24.7	31.9	22.9	30.1	23.3	26.0	25.3	a
Delivery 10–14 years in facility	2023/24	female 10–14 years DHIS	2716	395	106	430	610	375	293	70	151	286	b
Delivery 10–19 years in facility	2023/24	female 10–19 years DHIS	122302	16222	5501	19836	31088	16637	11827	3608	7676	9907	b
Delivery 15–19 years in facility	2023	female 15–19 years vital registration	100095										c
	2023/24	female 15–19 years DHIS	119586	15827	5395	19406	30478	16262	11534	3538	7525	9621	b
Delivery in 10–19 years in facility rate	2023/24	female DHIS	14.1	18.0	13.3	9.9	16.6	15.0	16.6	17.2	14.0	11.0	b
Delivery by Caesarean section rate	2023	female NCCEMD	32.2	33.7	34.8	32.9	38.4	26.9	24.2	25.3	26.9	32.9	d
	2023/24	female DHIS	32.4	33.9	34.1	33.2	38.9	26.7	24.3	26.6	26.7	33.0	b
Delivery in facility – total	2023/24	DHIS	866582	89881	41392	200367	186725	111151	71388	21027	54739	89912	b
Delivery in facility rate	2023/24	female DHIS	78.4	71.2	85.5	76.8	78.9	90.3	78.3	81.5	69.4	78.4	b
Live birth in facility	2023/24	both sexes DHIS	861717	89137	41100	199342	184881	110790	71140	21793	54068	89466	b
Maternal death in facility	2023/24	female DHIS	915	131	47	223	173	121	83	28	64	45	b
Maternal mortality in facility ratio	2023/24	female DHIS	100.6	136.2	104.8	107.3	89.2	104.7	109.4	115.8	110.2	48.3	b
Maternal mortality ratio (MMR)	2023	female WHO	118.0										e
Maternal mortality ratio in facility / institutional (iMMR)	2022	female NCCEMD	109.9	128.9	116.2	121.7	87.8	114.7	137.4	117.4	116.8	70.8	d
	2023	female NCCEMD	111.7	140.4	139.5	107.6	88.1	120.2	138.3	134.6	156.5	71.8	d
Neonatal mortality rate (NMR) (deaths <28 days old per 1 000 live births)	2022	both sexes WHO	11.6										f
Number of maternal deaths	2022	female NCCEMD	1062	133	55	266	189	143	113	26	70	67	d

Indicator	Period	Sex|Age|Series|Cat	SA	EC	FS	GP	KZN	LP	MP	NC	NW	WC	Ref
	2023	female NCCEMD	987	129	60	217	169	136	101	35	75	65	d
		female WHO	1 400										e
Teenage pregnancy	2024	female 14—19 years GHS	3.8										g
ToPs (terminations of pregnancy)	2023/24	DHIS	137 331	15 566	7 041	35 363	23 470	14 072	9 408	1 871	9 916	20 624	b

Sources:
a: Thembisa v4.7[38]
b: DHIS[39]
c: StatsSA Recorded Live Births 2023[36]
d: Saving Mothers 2023[30]
e: WHO MMR 2025[64]
f: Global Health Observatory[21]
g: StatsSA GHS 2024[32]
Indicator [units]: Definition
• Condom use at last sex [Percentage]: Percentage of those who reported ever having had sex, who used a condom the last time they had sex. Note that the precise definition of this indicator varies between surveys.
• Delivery 10—14 years in facility [Number]: Delivery where the mother is 10—14 years old. These deliveries are done in facilities under the supervision of trained medical/nursing staff.
• Delivery 15—19 years in facility [Number]: Delivery where the mother is 15—19 years old. These deliveries are done in facilities under the supervision of trained medical/nursing staff.
• Delivery 10—19 years in facility [Number]: Delivery where the mother is 10—19 years old. These deliveries are done in facilities under the supervision of trained medical/nursing staff.
• Delivery by Caesarean section rate [Percentage]: Delivery by Caesarean section as a proportion of total deliveries in health facilities.
• Delivery in 10—19 years in facility rate [Percentage]: Deliveries to women younger than 20 years as a proportion of total deliveries in health facilities.
• Delivery in facility — total [Number]: Any delivery taking place in a health facility under the supervision of trained medical/nursing staff.
• Delivery in facility rate [Percentage]: Deliveries in health facilities as a proportion of expected deliveries in the population. Expected deliveries are estimated as population under 1 year multiplied by 1.025 to compensate for still births and infant mortality.
• Live birth in facility [Number]: Live birth resulting from a delivery in a facility.
• Maternal death in facility [Number]: Maternal death is death occurring during pregnancy, childbirth or puerperium within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy and the cause of death (obstetric and non-obstetric).
• Maternal mortality in facility ratio [per 100 000 live births]: Women who die as a result of childbearing, during pregnancy or within 42 days of delivery or termination of pregnancy, per 100 000 live births, and where the death occurs in a health facility.
• Maternal mortality ratio (MMR) [per 100 000 live births]: The number of women who die as a result of childbearing, during the pregnancy or within 42 days of delivery or termination of pregnancy in one year, per 100 000 live births during that year.
• Maternal mortality ratio in facility / institutional (iMMR) [per 100 000 live births]: The number of women who die as a result of childbearing, during the pregnancy or within 42 days of delivery or termination of pregnancy in one year, per 100 000 live births during that year. Refers only to institutional / facility-based deaths, not representing the entire population. Note that the WHO Core List definition is per 100 000 deliveries (not live births) — number of maternal deaths among 100 000 deliveries in health facilities/institutions. For the estimates from NCCEMD: The confidential enquiry into maternal deaths system is not set up to determine the maternal mortality ratio (MMR) for a country. Live birth data were obtained from the DHIS. It must be noted that the confidential enquiry system is not designed for calculating ratios and rates. It is dependent on reporting; the more complete the reporting, the more accurate the estimates of the MMR.
• Neonatal mortality rate (NMR) (deaths <28 days old per 1 000 live births) [per 1 000 live births]: Number of deaths within the first 28 days of life, in a year, per 1 000 live births during that year. Also called Neonatal Death Rate (NDR).
• Number of maternal deaths [Number]: The number of women who die as a result of childbearing, during the pregnancy or within 42 days of delivery or termination of pregnancy in one year. In the International Statistical Classification of Diseases and Related Health Problems, 10th Revision, 1992 (ICD-10), WHO defines maternal death as: The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. For countries using ICD-10 coding for registered deaths, all deaths coded to the maternal chapter (O codes) and A34 (maternal tetanus) were counted as maternal deaths. Note that the system of Confidential Enquiries into Maternal Deaths (NCCEMD) captures only institutional deaths, and thus is known to miss deaths occurring at home. The confidential enquiry system is ideally suited to identifying the most common causes of death and ranking the causes of death according to priority.
• Teenage pregnancy [Percentage]: Percentage of women aged 15—19 who are mothers or who have ever been pregnant.
• ToPs (terminations of pregnancy) [Number]: The number of terminations of pregnancy.

ticipation in meaningful daily activities.[73] Taken together, these findings point to both significant vulnerabilities and notable strengths among orphaned adolescents, underscoring the urgent need for nationally representative studies to inform targeted mental health interventions more effectively (Table 10).

Non-communicable diseases

The global rise of non-communicable diseases (NCDs), driven by ageing populations, urbanisation, unhealthy diets, physical inactivity, tobacco use, and harmful alcohol consumption is the leading cause of death, accounting for over 70% of all deaths worldwide. Cardiovascular diseases, cancers, chronic respiratory diseases, and diabetes are the most prevalent, with low- and middle-income countries bearing over 85% of premature deaths. The mortality rate from major NCDs among adults aged 30–70 years is 22.7%,[7] reflecting the cumulative impact of late diagnosis, poor treatment adherence, and limited access to quality chronic care.[74]

Mental health

Mental health, which is often under-recognised, is increasingly prioritised in global health agendas, with the WHO Comprehensive Mental Health Action Plan 2013–2030 calling for universal access to mental health care. Suicide mortality remains high globally at 22.3 per 100 000, highlighting the intersection of mental health and broader NCD burdens.[75]

South Africa's NCD burden mirrors these global trends, and the country's efforts to integrate mental health and chronic disease management align with international best practices. Figure 3 illustrates that the highest burden of mental disorders in South Africa are depression and anxiety[2] based on global modelling estimates; however, local mental health indicators show concerning gaps. The new treatment rate for mental disorders is negligible in most provinces, and the mental health separation rate varies widely, from 0.9 in Northern Cape to 18.0 in Gauteng, suggesting uneven access to inpatient mental health services. This is particularly concerning given that the Northern Cape recorded the highest rate of suicide at 6.6% in the StatsSA Causes of Death report.[35]

Cancer

According to GLOBOCAN,[12] in South Africa, the age-standardised cancer incidence rate is 203.4 per 100 000 population, with prostate (62.0), breast (47.8), and cervical cancer (33.2) being among the most common. Notably, male cancer incidence (232.4) exceeds that of females (190.4), reflecting gendered risk exposures and screening disparities. National Cancer Registry (NCR) data for 2023 show lower incidence rates, which is likely to be due to under-reporting or differences in case capture, underscoring the need for improved cancer surveillance, as discussed in Ndlovu, et al. (2024).[76]

Diabetes and hypertension

Diabetes prevalence among adults aged 20–79 years is estimated at 7.2%,[14] with detection and treatment rates remaining low. In 2023/24, only 87 792 new diabetes clients aged 45 years and older were recorded, and detection rates for adults aged 18 years and older remain below 0.6% in most provinces.[39] Hypertension detection is slightly better, with 113 340 new cases among 18–44-year-olds and 168 956 among those aged 45 years and older, but detection rates still hover below 1% in most provinces. These trends suggest substantial underdiagnosis and missed opportunities for early intervention within routine systems in the public health sector. Strengthening surveillance, improving access to essential medicines, and addressing social determinants are critical components of the global response to NCDs (Table 11).

Nutrition

On a global and local level, nutrition is recognised as a cornerstone of health across the life course. The WHO reports that while global stunting rates among children under five have declined, over 148 million children remain stunted, with the highest burden being in South Asia and sub-Saharan Africa. Simultaneously, childhood overweight and obesity are rising rapidly, particularly in middle-income countries, reflecting a global nutrition transition marked by increased consumption of ultra-processed foods and sedentary lifestyles.[78]

Exclusive breastfeeding

Exclusive breastfeeding rates vary widely, with global averages at 48%, far below the 70% target set by the WHO. Micronutrient deficiencies, including iron, vitamin A and iodine, continue to affect billions, particularly women and children. In response, countries are adopting multisectoral strategies that integrate nutrition into health, education, and agriculture policies. Global initiatives such as the Scaling Up Nutrition (SUN) movement and the UN Decade of Action on Nutrition are driving co-ordinated action. South Africa's dual burden of under-nutrition and obesity mirrors global trends, underscoring the need for comprehensive, equity-focused nutrition policies. Locally, exclusive breastfeeding rates remain suboptimal, with only 43.3% of infants being exclusively breastfed at the time of the third hexavalent vaccine dose in 2023/24. Provincial disparities are stark, where KwaZulu-Natal leads at 55.6%, while Limpopo (32.1%) and Mpumalanga (34.1%) fall well below the national average.[39] These figures highlight missed opportunities for early-life nutrition and immune protection.

Table 11. Child health indicators by province

Indicator	Period	Sex|Age|Series|Cat	SA	EC	FS	GP	KZN	LP	MP	NC	NW	WC	Ref
BCG coverage	2023	both sexes WHO/ UNICEF	79.0										a
	2024	both sexes WHO/ UNICEF	74.0										a
Child mortality (deaths between 1 and 4 years per 1 000 live births)	2023	both sexes WHO	10.4										b
		female WHO	9.8										b
		male WHO	11.1										b
DTP3 coverage	2024	both sexes WHO/ UNICEF	74.0										a
Measles 1st dose under 1 year coverage	2023	both sexes WHO/ UNICEF	83.0										a
	2024	both sexes WHO/ UNICEF	81.0										a
Measles 2nd dose coverage	2024	both sexes WHO/ UNICEF	82.0										a
Orphanhood	2024	both sexes <18 years GHS double	1.5	1.7	1.8	1.0	1.8	1.9	1.7	1.8	2.5	0.9	c
		both sexes <18 years GHS maternal	2.7	3.0	2.6	2.6	3.0	2.1	2.5	3.3	4.3	1.3	c
		both sexes <18 years GHS paternal	7.6	7.6	10.7	6.5	8.6	6.3	9.3	7.5	8.1	5.9	c
PCV 3rd dose coverage	2023	both sexes WHO/ UNICEF	83.0										a
	2024	both sexes WHO/ UNICEF	81.0										a
Under 5 mortality rate (deaths under 5 years per 1 000 live births)	2023	both sexes WHO/ UNICEF	34.7										d
		female WHO/UNICEF	31.9										d
		male WHO/UNICEF	37.2										d

Indicator	Period	Sex|Age|Series|Cat	SA	EC	FS	GP	KZN	LP	MP	NC	NW	WC	Ref
	2024	both sexes mid-year	28.6										e

Sources:
a: Immunization 2024[15]
b: Global Health Observatory[21]
c: StatsSA GHS 2024[32]
d: State of the World's Children 2024[18]
e: StatsSA MYE 2024[34]
Indicator [units]: Definition
• BCG coverage [Percentage]: The proportion of expected live born babies who received BCG under 1 year of age (note: usually given immediately after birth).
• Child mortality (deaths between 1 and4 years per 1 000 live births) [per 1 000 live births]: The number of children aged 12 months to 5 years (i.e. to the end of the 4th year) who die in a year, per 1 000 live births.
• DTP3 coverage [Percentage]: The proportion of children who received their third DTP doses (normally at 14 weeks).
• Measles 1st dose under 1 year coverage [Percentage]: Children under 1 year who received measles 1st dose, as a proportion of population under 1 year.
• Measles 2nd dose coverage [Percentage]: Children 1 year (12 months) who received measles 2nd dose, as a proportion of the 1 year population.
• Orphanhood [Percentage]: Proportion of children under 18 years whose biological mother, biological father or both parents have died.
• PCV 3rd-dose coverage [Percentage]: Children under 1 year who received PCV 3rd dose, normally at 9 months as a proportion of population under 1 year.
• Under 5 mortality rate (deaths under 5 years per 1 000 live births) [per 1 000 live births]: The number of children under 5 years who die in a year, per 1 000 live births during the year. It is a combination of the infant mortality rate, plus the age 1–4 mortality rate.

Table 12. NCD indicators by province

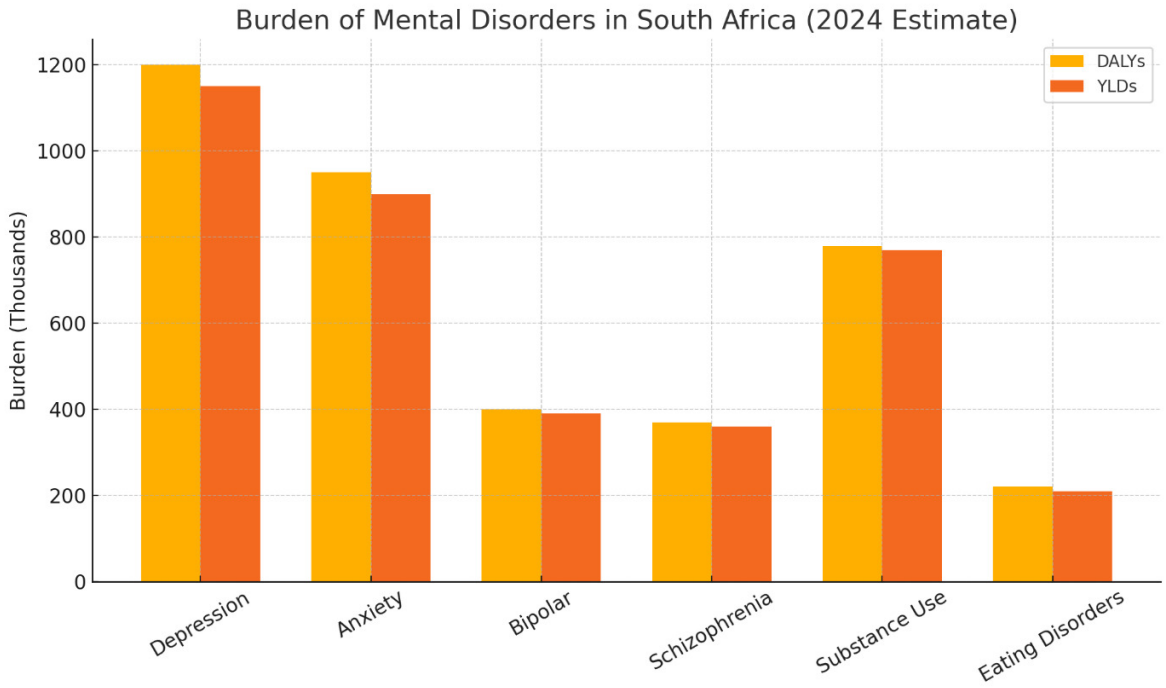
Indicator	Period	Sex|Age|Series|Cat	SA	EC	FS	GP	KZN	LP	MP	NC	NW	WC	Ref
Cancer incidence rate, by type of cancer (per 100 000 population)	2022	both sexes age-standardised GLOBOCAN all cancers	203.4										a
		both sexes age-standardised GLOBOCAN bladder	4.1										a
		both sexes age-standardised GLOBOCAN colorectal	13.5										a
		female age-standardised GLOBOCAN all cancers	190.4										a
		female age-standardised GLOBOCAN bladder	1.7										a
		female age-standardised GLOBOCAN breast	47.8										a
		female age-standardised GLOBOCAN cervix	33.2										a
		female age-standardised GLOBOCAN colorectal	11.3										a
		female age-standardised GLOBOCAN ovary	5.1										a
		male age-standardised GLOBOCAN all cancers	232.4										a
		male age-standardised GLOBOCAN bladder	7.8										a
		male age-standardised GLOBOCAN colorectal	17.0										a
		male age-standardised GLOBOCAN prostate	62.0										a
	2023	female age-standardised NCR all cancers	108.9										b
		female age-standardised NCR bladder	0.9										b
		female age-standardised NCR breast	32.9										b

Indicator	Period	Sex|Age|Series|Cat	SA	EC	FS	GP	KZN	LP	MP	NC	NW	WC	Ref
		female age-standardised NCR cervix	23.0										b
		female age-standardised NCR colorectal	6.5										b
		female age-standardised NCR lung	2.8										b
		female age-standardised NCR ovary	1.8										b
		male age-standardised NCR all cancers	119.0										b
		male age-standardised NCR bladder	4.0										b
		male age-standardised NCR breast	0.9										b
		male age-standardised NCR colorectal	10.2										b
		male age-standardised NCR lung	6.5										b
		male age-standardised NCR prostate	47.0										b
Diabetes client treatment new 45 years and older	2023/24	DHIS	87 792	9 881	3 330	22 318	20 518	8 308	11 035	1 931	5 105	5 366	c
Diabetes new client 18 years and older detection rate	2023/24	DHIS	0.4	0.4	0.3	0.3	0.4	0.5	0.6	0.4	0.3	0.2	c
Diabetes prevalence	2024	both sexes 20–79 years Diabetes Atlas age-standardised	7.2										d
Hypertension client treatment new 18–44 years	2023/24	DHIS	113 340	11 887	7 859	28 500	21 745	10 190	10 001	4 402	8 230	10 526	c
Hypertension client treatment new 45 years and older	2023/24	DHIS	168 956	22 125	9 413	38 940	36 962	17 182	18 516	3 755	11 154	10 909	c
Mental Health Quotient	2023	both sexes all ages MHQ	52.3										e
		female all ages MHQ	45.8										e
		male all ages MHQ	59.2										e
Mental health separation rate	2023/	DHIS	3.9	2.7	18.0	2.5	2.6	2.6	2.5	0.9	1.6	4.3	c

Indicator	Period	Sex|Age|Series|Cat	SA	EC	FS	GP	KZN	LP	MP	NC	NW	WC	Ref
	24												
Mortality between 30 and 70 years from cardiovascular. cancer. diabetes or chronic respiratory disease	2021	both sexes 30-70 years WHO	22.7										f
Suicide mortality rate (per 100 000 population)	2021	both sexes WHO	22.3										f

Sources:
a: GLOBOCAN[12]
b: NCR[25]
c: DHIS[39]
d: IDF Diabetes Atlas 2025[14]
e: MHQ 2024[77]
f: World Health Statistics 2025[7]
Indicator [units]: Definition
• Cancer incidence rate, by type of cancer [per 100 000 population]: Number of new cancers of a specific site/type occurring per 100 000 population. Numerator: Number of new cancer cases diagnosed in a specific year. This may include multiple primary cancers occurring in one patient. The primary site reported is the site of origin and not the metastatic site. In general, the incidence rate would not include recurrences. Denominator: The at-risk population for the given category of cancer. The population used depends on the rate to be calculated. For cancer sites that occur only in one sex, the sex-specific population (e.g. females for cervical cancer) is used.
• Diabetes client treatment new 18—44 years [Number]: Newly diagnosed clients 18—44 years with a fasting blood glucose of >7mmol/L or random blood glucose >11.1mol/L.
• Diabetes client treatment new 45 years and older [Number]: Newly diagnosed clients 45 years and older with a fasting blood glucose of >7mmol/L or random blood glucose >11.1mol/L.
• Diabetes prevalence [Percentage]: Percentage of people with diabetes. WHO Core indicator is: Age-standardised prevalence of raised blood glucose/diabetes among persons aged 18+ years or on medication for raised blood glucose. Defined as: fasting plasma glucose value >= 7.0 mmol/L (126 mg/dL) or on medication for raised blood glucose among adults aged 18+ years.
• Hypertension client treatment new 18—44 years [Number]: Total number of new hypertension clients aged 18—44 years put on treatment.
• Hypertension client treatment new 45 years and older [Number]: Total number of new hypertension clients 45 years and older put on treatment.
• Mental health separation rate [Percentage]: Proportion of clients admitted for mental health problems. In-patient separations is the total of in-patient discharges, in-patient deaths and in-patient transfers out.
• Mental Health Quotient (MHQ) [Percentage]: The MHQ provides an aggregate metric of well-being. An aggregate mental well-being score based on these aspects (the MHQ) positions individuals on a spectrum from Distressed to Thriving. The positive range of the scale represents the spectrum of normal functioning, and is a 200-point scale calibrated to a mean of 100 based on pre-pandemic responses in 2019, similar to the IQ scale. The negative range of the scale represents mental well-being scores associated with a negative impact on the ability to function, and is associated with clinical-level risks and challenges.
• Mortality between 30 and 70 years from cardiovascular, cancer, diabetes or chronic respiratory disease [Percentage]: Unconditional probability of dying between exact ages 30 and 70 from any of cardiovascular disease, cancer, diabetes, or chronic respiratory disease. Deaths from these four causes will be based on the following ICD codes: I00–I99, COO–C97, E10–E14 and J30–J98. According to WHO Core Indicators: Modelling, using multiple inputs, is often used if no complete and accurate data are available. Age standardisation is done for comparability over time and between populations.
• Suicide mortality rate [per 100 000 population]: Suicide rate per 100 000 population in a specified period (age-standardised).

Figure 3. Burden of mental disorders in South Africa, 2024



Source: IHME, 2024[2]

Obesity

Childhood and adolescent obesity and overweight rates are rising in South Africa. Among children aged 5–9 years, 6.9% are obese and 19.5% are overweight, while among adolescents aged 10–19, 7.2% are obese and 21.8% are overweight.[78] Gender disparities are notable, where 9.6% of adolescent girls are obese compared to 4.9% of boys, and 29.4% of girls are overweight compared to 14.4% of boys. These trends reflect dietary shifts, sedentary lifestyles, and socio-environmental influences, and signal future increases in diabetes, cardiovascular disease, and other NCDs.[79]

Among adults, the situation is even more concerning. Over half (55%) of adults aged 18 and older are overweight, with 30.8% classified as obese. The gender gap is pronounced, with 71.3% of women being overweight or obese compared to 37.2% of men in South Africa. Conversely, underweight remains a concern for 5.2% of adults, particularly among men (8.2%), reflecting a dual burden of malnutrition.[7] Stunting among children under five remains high at 24.4%, indicating chronic under-nutrition and its long-term developmental consequences.[80]

Micronutrients

Micronutrient deficiencies also persist. Vitamin A supplementation coverage for children aged 12–59 months was 69.5% nationally in 2023/24, with wide provincial variation from 85.7% in KwaZulu-Natal to just 47.9% in Northern Cape.[39] These gaps suggest uneven implementation of child health programmes and highlight the need for strengthened outreach and supply-chain management.

There is a need for a comprehensive, life-course approach that includes promoting breastfeeding, improving school-based nutrition and physical activity programmes, scaling up community-based screening and counselling, and addressing the social determinants of health that drive poor nutrition and lifestyle risk factors. Without decisive action, the rising tide of NCDs threatens to overwhelm the health system and reverse gains in life expectancy and quality of life.[81]

Nutrition and mental health

Recent South African studies reveal a strong link between malnutrition and mental health in children and adolescents. Food insecurity remains a major issue, with children in food-insecure households having over 60% higher odds of anxiety and depression compared to those in food-secure homes.[82,83] Under-nutrition marked by stunting and micronutrient deficiencies adversely affects cognitive development and school readiness, especially in female-headed or informal households where food insecurity is more prevalent.[84] Concurrently, rising adolescent overweight and obesity were found to be linked to increased depression and low self-esteem, particularly among girls.[85] This dual burden of malnutrition highlights the need for integrated policies addressing both nutrition and mental health to improve children's lifelong well-being (Table 12).

Table 13. Nutrition indicators by province

Indicator	Period	Sex|Age|Series|Cat	SA	EC	FS	GP	KZN	LP	MP	NC	NW	WC	Ref
Infant exclusively breastfed at DTaP-IPV-Hib-HBV 3rd dose rate	2023/24	both sexes DHIS	43.3	39.6	44.1	47.3	55.6	32.1	34.1	50.9	32.7	38.7	a
Infant exclusively breastfed at DTaP-IPV-Hib-HBV (Hexavalent) 3rd dose	2023/24	both sexes DHIS	385 579	37 290	16 697	97 979	106 155	36 224	25 444	10 790	18 655	36 345	a
Obesity	2022	both sexes 5–9 years WHO crude estimates	6.9										b
		both sexes 5–19 years WHO crude estimates	7.1										b
		both sexes 10–19 years WHO crude estimates	7.2										b
		female 5–9 years WHO crude estimates	8.0										b
		female 5–19 years WHO crude estimates	9.0										b
		female 10–19 years WHO crude estimates	9.6										b
		male 5–9 years WHO crude estimates	5.8										b
		male 5–19 years WHO crude estimates	5.2										b
		male 10–19 years WHO crude estimates	4.9										b
Overweight	2022	both sexes 5–9 years WHO crude estimates	19.5										b
		both sexes 5–19 years WHO crude estimates	21.0										b
		both sexes 10–19 years WHO crude estimates	21.8										b
		both sexes 18 years and older WHO age-standardised	55.0										b
		female 5–9 years WHO crude estimates	21.7										b

Indicator	Period	Sex|Age|Series|Cat	SA	EC	FS	GP	KZN	LP	MP	NC	NW	WC	Ref
		female 5—19 years WHO crude estimates	26.7										b
		female 10—19 years WHO crude estimates	29.4										b
		female 18 years and older WHO age-standardised	71.3										b
		male 5—9 years WHO crude estimates	17.3										b
		male 5—19 years WHO crude estimates	15.4										b
		male 10—19 years WHO crude estimates	14.4										b
		male 18 years and older WHO age-standardised	37.2										b
	2024	both sexes <5 years WHO	12.8										c
Percentage of adults overweight or obese	2022	both sexes 18 years and older WHO age-standardised	30.8										b
		female 18 years and older WHO age-standardised	45.8										b
		male 18 years and older WHO age-standardised	13.9										b
Stunting	2024	both sexes <5 years WHO	24.4										c
Underweight	2022	both sexes 18 years and older WHO age-standardised	5.2										b
		female 18 years and older WHO age-standardised	2.5										b
		male 18 years and older WHO age-standardised	8.2										b
Vitamin A dose 12—59 months	2023/	both sexes DHIS	4 705 259	551 250	206 531	1 010 538	1 065 793	494 782	505 950	82 013	356 460	431 942	a

Indicator	Period	Sex|Age|Series|Cat	SA	EC	FS	GP	KZN	LP	MP	NC	NW	WC	Ref
	24												
Vitamin A dose 12—59 months coverage	2023/24	both sexes DHIS	69.5	76.1	58.9	64.9	85.7	55.4	81.2	47.9	72.3	50.4	a

Sources:
a: DHIS[39]
b: Global Health Observatory[21]
c: World Health Statistics 2025[7]
Indicator [units]: Definition
• Infant exclusively breastfed at DTaP-IPV-Hib-HBV 3rd dose rate [Percentage]: Infants exclusively breastfed at 14 weeks as a proportion of the DTaP-IPV-Hib-HBV 3rd dose vaccination. Take note that DTaP-IPV-Hib-HBV 3rd dose (Hexavalent) was implemented in 2015 to include the HepB dose.
• Infant exclusively breastfed at DTaP-IPV-Hib-HBV (Hexavalent) 3rd dose [Number]: Infant reported to be exclusively breastfed at DTaP-IPV-HepB-Hib (Hexavalent) 3rd dose immunisation (preferably 14 weeks after birth).
• Obesity [Percentage]: Percentage of people with a body mass index (BMI) (body mass in kg divided by the square of the height in m) equal to or more than 30kg/m2.
• Overweight [Percentage]: Children: Proportion of children with weight for height over 2 standard deviations from the norm (reference population median). Adults: Percentage of people with body mass index (BMI) of 25-29.9 kg/m2. BMI is weight in kg divided by the square of height in m. WHO Core Indicators for children under 5 years of age and adults (aged 18+ years). Rates in adults to be age-standardised. In adolescents, the definitions of overweight and obesity vary by age and gender. The prevalence of overweight is defined as the percentage of adolescents with sex-specific BMI-for-age above +1 SD from the WHO 2007 growth reference median, and the prevalence of obesity as the percentage of adolescents with sex-specific BMI-for-age above +2 SD from the WHO 2007 growth reference median.
• Percentage of adults overweight or obese [Percentage]: Percentage of adults (15+ years) who are either overweight or obese according to standard BMI cut-offs.
• Stunting [Percentage]: Proportion of children with height for age under 2 standard deviations from the norm (reference population median).
• Underweight [Percentage]: Children: Proportion of children with weight for age under 2 standard deviations from the norm (reference population median). Adults: Percentage of people with body mass index (BMI) <18.5 kg/m2. BMI is weight in kg divided by the square of height in m.
• Vitamin A dose 12—59 months [Number]: Vitamin A dose given to a child, preferably every six months from the age of 12 to 59 months.
• Vitamin A dose 12—59 months coverage [Percentage]: Proportion of children aged 12—59 months who received vitamin A 200 000 units, preferably every six months. The denominator is therefore the target population 1—4 years multiplied by 2.

Injuries and risk behaviours

Injuries and risk behaviours remain leading contributors to premature mortality and disability. The global estimates state that over 1.3 million people die annually from road traffic injuries, with low- and middle-income countries accounting for more than 90% of these deaths. Homicide rates are highest in Latin America and parts of sub-Saharan Africa, reflecting the intersection of socioeconomic inequality, urban violence, and weak law enforcement. Substance use, particularly alcohol and tobacco, continues to drive a significant share of the global disease burden.[86] The Global Burden of Disease Study attributes over 7 million deaths annually to tobacco use, and 3 million to harmful alcohol consumption. Among adolescents, early initiation of smoking, alcohol and drug use is a growing concern worldwide, with rising trends in e-cigarette use and synthetic drugs. Countries such as Iceland[87] and Australia[88] have implemented successful school- and community-based prevention programmes, offering models for reducing youth risk behaviours. Globally, there is increasing recognition of the need for integrated, multisectoral strategies that combine public health, education, law enforcement, and social services to address the root causes of injuries and risk behaviours.

Interpersonal violence and road traffic fatalities

The data reflected in Table 13 highlight the persistent burden of violence, road traffic injuries, and substance use. The national homicide mortality rate remains alarmingly high at 33.8 per 100 000 population,[67] positioning South Africa among the countries with the highest levels of interpersonal violence globally. Road traffic fatalities also remain a major concern, with 10 339 deaths recorded in 2024 which was an increase from 10 180 in 2023, despite a slight decline in the rate per 100 000 population from 19.4 to 19.3.[29] Provinces such as Gauteng (2 218 deaths) and KwaZulu-Natal (2 069) continue to bear the brunt of road-related mortality, reflecting both high vehicle density and systemic road safety challenges.

Substance abuse

Substance use data from SACENDU Phase 54[31] further underscore the scale of the problem. In the first half of 2024 alone, Gauteng recorded 4 782 admissions for alcohol and drug abuse, followed by the Western Cape (1 727) and KwaZulu-Natal (872). Among individuals under 19, cannabis dominates as the primary drug of abuse, accounting for up to 84% of cases in some provinces, while alcohol, mandrax and methamphetamine also feature prominently.[31] These patterns point to the urgent need for targeted prevention and treatment strategies, particularly for adolescents.

Prevalence of smoking and alcohol consumption

Tobacco use remains widespread, with 20.2% of individuals aged 15 and older in South Africa reporting smoking in 2022.[6] The gender disparity is stark: 35.1% of adult males smoke compared to just 6.5% of females. Alarmingly, smoking prevalence among South African children aged 10–14 years is also high at 21.3% for boys and 17.7% for girls, suggesting early initiation and inadequate enforcement of tobacco control measures.

Alcohol consumption per capita among those aged 15 years and older stands at 7.8 litres annually,[7] reinforcing South Africa's classification as a high-consumption country.[89] This, combined with the high rates of alcohol-related admissions and road fatalities, signals the need for stronger policy interventions, including regulation, taxation, and public education.

Infectious diseases

Despite advances in prevention, surveillance, diagnostics, treatment and control, infectious diseases continue to pose significant public health challenges. The resurgence of diseases like cholera and measles in various regions underscores the fragility of health systems and the importance of sustained immunisation and water sanitation efforts.[90] The WHO estimates that over 1.3 billion people remain at risk of neglected tropical diseases, with climate change and urbanisation contributing to the spread of vector-borne illnesses such as malaria and dengue. Cross-border mobility and global trade have also heightened the risk of rapid disease transmission, necessitating stronger international collaboration and early warning systems.[91]

Disease outbreaks like cholera, measles and malaria can have significant psychosocial impacts on individuals and communities, including increased anxiety, grief and stigma, which can disrupt social structures and mental well-being. Furthermore, healthcare workers face unique challenges and potential psychological distress during outbreaks, highlighting the need for comprehensive mental health support.[92]

Cholera

Despite significant progress in disease surveillance and control, South Africa continues to face recurrent outbreaks and persistent burdens from key infectious diseases. Cholera re-emerged as a public health concern in 2023, with 1 395 reported cases and a case fatality rate of 3.4% which is well above the WHO threshold of 1%.[93] The 47 reported deaths underscore gaps in water, sanitation and rapid response systems, particularly in vulnerable communities.

Table 14. Risk and injuries indicators by province

Indicator	Period	Sex|Age|Series|Cat	SA	EC	FS	GP	KZN	LP	MP	NC	NW	WC	Ref
Mortality rate attributed to unintentional poisoning (per 100 000 population)	2021	both sexes WHO	1.7										a
Mortality rate due to homicides (per 100 000 population)	2021	both sexes WHO	33.8										a
Road accident fatalities	2023	both sexes RTMC	10 180	1 132	539	2 313	1 985	1 089	955	301	641	1 225	b
	2024	both sexes RTMC	10 339	1 202	596	2 218	2 069	1 060	963	281	769	1 181	b
Road accident fatalities per 100 000 population	2021	both sexes WHO	24.5										a
	2023	both sexes RTMC	19.4										b
	2024	both sexes RTMC	19.3										b
Number of admissions for alcohol and other drug abuse	Jan—Jun 2024	both sexes all ages SACENDU		261		4 782	872					1 727	c
Prevalence of smoking	2022	both sexes 10—14 years Tobacco Atlas	19.5										d
		both sexes 15 years and older Tobacco Atlas	20.2										d
		female 10—14 years Tobacco Atlas	17.7										d
		female 15 years and older Tobacco Atlas	6.5										d
		male 10—14 years Tobacco Atlas	21.3										d
		male 15 years and older Tobacco Atlas	35.1										d
Primary drug of abuse as % of all drugs of abuse	Jan—Jun 2024	both sexes <19 years SACENDU alcohol		2		2	12					12	c
		both sexes <19 years SACENDU cannabis		76		84	75					69	c

Indicator	Period	Sex|Age|Series|Cat	SA	EC	FS	GP	KZN	LP	MP	NC	NW	WC	Ref
		both sexes <19 years SACENDU cocaine		9		1	1					4	c
		both sexes <19 years SACENDU heroin		0		0	1					0	c
		both sexes <19 years SACENDU mandrax		8		6	1					8	c
		both sexes <19 years SACENDU methamphethamine		6		1	0					1	c
		both sexes all ages SACENDU alcohol		14		20	37					21	c
		both sexes all ages SACENDU cannabis		29		29	31					21	c
		both sexes all ages SACENDU cocaine		6		2	12					5	c
		both sexes all ages SACENDU heroin		1		19	11					9	c
		both sexes all ages SACENDU mandrax		3		4	1					8	c
		both sexes all ages SACENDU methamphethamine		12		24	2					34	c
Total alcohol per capita (age 15+ years) consumption (litres per year)	2022	both sexes WHO	7.8										a

Sources:
a: World Health Statistics 2025[7]
b: RTMC 2024[29]
c: SACENDU Phase 54[31]
d: Tobacco Atlas 202[56]

Indicator [units]: Definition

• Mortality rate attributed to unintentional poisoning (per 100 000 population) [Rate]: Number of deaths from unintentional poisonings (by age and sex), for the year indicated.
• Mortality rate due to homicides (per 100 000 population) [Rate]: A homicide is the killing of a person by another with intent to cause death or serious injury. Infanticide should be included. Cases where the perpetrator was merely reckless or negligent should be excluded.
• Number of admissions for alcohol and other drug abuse [Number]: Number of patients admitted for treatment by treatment centres who are part of the SACENDU Project sentinel surveillance system.

• Prevalence of smoking [Percentage]: Proportion of the population who currently smoke.
This indicator is also known as 'Current smokers (%)'. Note that the indicator may be given just for cigarettes or for other tobacco products. The WHO Core indicator is 'Age-standardised prevalence of current tobacco use among persons aged 18+ years' and is defined as: Age-standardised prevalence of current tobacco use among persons aged 18+ years.
• Primary drug of abuse as % of all drugs of abuse [Percentage]: Percentage breakdown of the primary drug of abuse reported by patients admitted to treatment centres that are part of the SACENDU sentinel surveillance system.
• Road accident fatalities [Number]: Estimated number of deaths due to road traffic fatal injury in the specified year.
• Road accident fatalities per 100 000 population [Rate]: Estimated road traffic fatal injury deaths per 100 000 population.
• Total alcohol per capita (age 15+ years) consumption (litres per year) [litres per year]: Total alcohol per capita is the total amount (sum of recorded alcohol per capita three-year average and unrecorded alcohol per capita) of alcohol consumed per adult (15+ years) in a calendar year, in litres of pure alcohol.

Measles

Measles outbreaks also persisted, with 1 029 laboratory-confirmed cases in 2023 and 833 in 2024.[94] Gauteng and Mpumalanga reported the highest case counts, suggesting gaps in immunisation coverage and outbreak containment. The increase in cases in provinces like KwaZulu-Natal and Western Cape between 2023 and 2024 signals the need for intensified catch-up campaigns and improved vaccine confidence.

Malaria

Malaria remains endemic in several provinces, with 4 384 cases reported by the NICD in 2023,[27] and a higher estimate of 5 291 cases from WHO sources.[22] The rise in malaria cases in Botswana, Eswatini and South Africa is likely to be driven by several factors, such as difficulties in maintaining high coverage of vector control measures, increased cross-border movement (particularly between Mozambique and Eswatini and South Africa for economic reasons), and weaknesses in surveillance systems. Other contributing factors include the influence of climate change disasters on malaria transmission patterns, under-reporting, and delays in case detection, investigation and response in 2022.[22] Limpopo (2 137 cases) and Mpumalanga (635) continue to bear the brunt of transmission, while Gauteng (830) and KwaZulu-Natal (332) reflect increasing urban and peri-urban exposure. The 113 malaria-related deaths in 2023 highlight the need for sustained vector control, early diagnosis, and treatment access, especially in border regions and mobile populations.[22]

These trends reflect the ongoing vulnerability of South Africa's population to preventable infectious diseases. Strengthening early warning systems, improving outbreak preparedness, and ensuring equitable access to vaccines and treatment are critical. Moreover, integrating infectious disease surveillance with broader health system strengthening, particularly in PHC and community outreach, will be essential to mitigate future outbreaks and reduce mortality.[95]

Outbreaks and the mental health system gap

Infectious disease outbreaks such as cholera, measles and malaria not only cause physical harm but also trigger significant psychological and social impacts including heightened anxiety, fear and stress, as seen during and after COVID-19.[96,97] These effects are intensified by South Africa's under-resourced mental health system where nationally, about 5% of the health budget goes to mental health and only ~25% of people who need care receive it,[98,99] despite policy commitments in the National Mental Health Policy Framework and Strategic Plan 2023–2030 (NMHPFSP).[9] High burdens of depression, anxiety and psychological distress among people living with HIV compound vulnerability during outbreaks (Table 14).[100]

Health facilities

Health facility performance is a critical determinant of health system effectiveness. Countries with well-distributed and adequately resourced health infrastructure tend to achieve better health outcomes.[101] The WHO recommends optimal bed occupancy rates range between 75% and 85%, balancing efficiency with surge capacity. Many high-income countries maintain average lengths of stay that are shorter than six days through efficient care co-ordination and post-discharge support. In contrast, low- and middle-income countries often face challenges such as under-utilisation in rural areas and overcrowding in urban centres.[102]

Globally, nurse workloads and facility standards are key indicators of service quality, with the WHO advocating for workload-sensitive staffing models and universal adoption of quality improvement frameworks. South Africa's performance reflects global strengths, such as high medicine availability, as well as challenges, including regional disparities in infrastructure and staffing. Lessons from countries that have successfully decentralised services and invested in PHC revitalisation may offer valuable insights for strengthening South Africa's health facility performance.

Psychiatric health facilities

South Africa's mental healthcare system leans heavily on specialised psychiatric hospitals for in-patient care, with a smaller proportion of services offered at general hospitals.[98] The NMPHFSP does, however, outline plans to downscale specialist mental healthcare facilities and upscale community-based care facilities, in line with WHO recommendations.[103]

Figure 4 shows the distribution of the 23 specialised psychiatric hospitals within the public sector in South Africa. The distribution of psychiatric facilities across the country reveals a concentration in urban and peri-urban areas, with notable clusters in provinces such as Gauteng, KwaZulu-Natal, and the Western Cape. These provinces host multiple specialised psychiatric hospitals, reflecting their higher population densities and more developed healthcare infrastructure. In contrast, provinces like Mpumalanga have no facilities, which may indicate limited access to specialised mental health services in more rural or sparsely populated regions. This uneven distribution underscores the need for strategic planning to improve equitable access to psychiatric care across all provinces, particularly in under-served areas.

Average length of stay

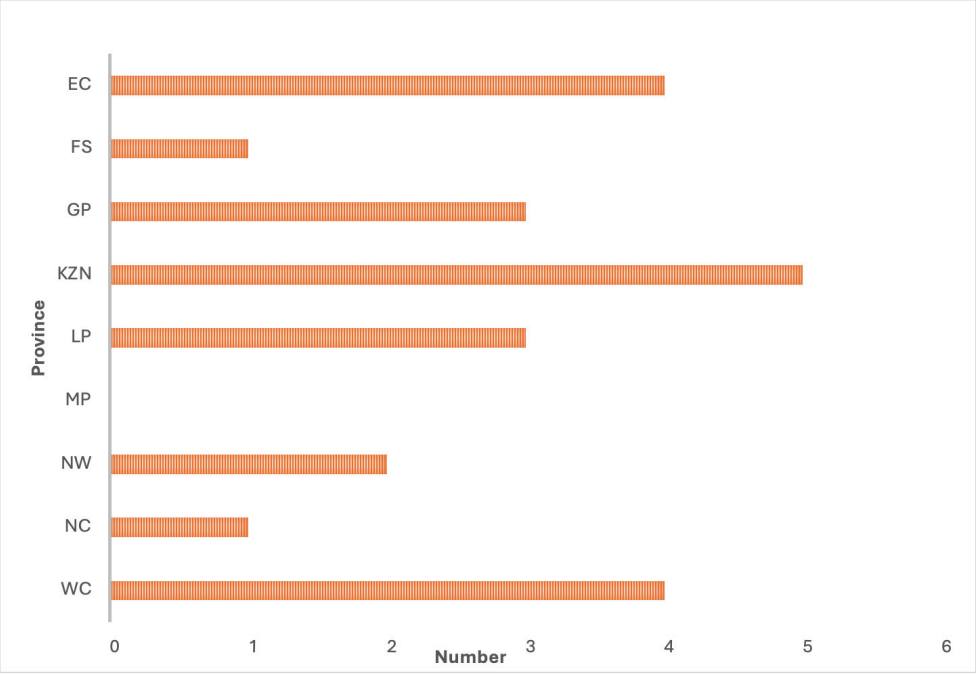
The performance of South Africa's health service infrastructure, as reflected in Table 15, reveals a system under pressure but showing signs of resilience and responsiveness. The national average length of stay (ALOS) across all hospitals was 6.4 days, with Gauteng (7.5) and Eastern Cape (7.0) reporting the longest stays which po-

Table 15. Infectious disease indicators by province

Indicator	Period	Sex|Age|Series|Cat	SA	EC	FS	GP	KZN	LP	MP	NC	NW	WC	Ref
Case fatality rate: cholera	2023/24	WHO	3.4										a
Reported cases of cholera	2023/24	WHO	1 395										a
Reported cases of cholera (per 100 000)	2023/24	WHO	2.5										a
Reported cases of malaria	2023	both sexes all ages NICD	4 384	50	70	830	332	2 137	635	18	118	194	b
		both sexes all ages WHO	5 291										c
Reported cases of measles	2023	NICD lab-diagnosed	1 029	8	34	284	33	435	40	19	113	63	d
	2024	NICD lab-diagnosed	833	52	48	311	114	25	53	43	127	60	d
Reported deaths from cholera	2023/24	WHO	47										a
Reported deaths from malaria	2023	both sexes all ages WHO	113										c

Sources:
a: Global Cholera Dashboard[93]
b: NICD NMC 2024[27]
c: World Malaria 2024[22]
d: NICD Dashboard[94]
Indicator [units]: Definition
• Case fatality rate: cholera [Percentage]: Number of deaths divided by the number of cases expressed as a percentage.
• Reported cases of cholera [per 100 000 population]: The number of cases of cholera reported to the National Department of Health per 100 000 population (for the relevant year). Also known as incidence of cholera or 'Attack rate'.
• Reported cases of cholera [Number]: The number of cases of cholera reported to the National Department of Health. Since case-reporting of notifiable diseases has been incomplete and delayed for several years, the number of laboratory-confirmed cases from NHLS has been included where available, although these would be expected to include only a subset of the total number of notified cases.
• Reported cases of malaria [Number]: The number of cases of malaria reported to the National Department of Health.
• Reported cases of measles [Number]: The number of cases of measles reported to the National Department of Health per year.
• Reported deaths from cholera [Number]: The number of deaths from cholera reported to the National Department of Health.
• Reported deaths from malaria [Number]: The number of deaths from malaria reported to the National Department of Health or recorded in vital registration (ICD-10 codes B50-B54).

Figure 4. Specialist psychiatric hospitals by province, 2024



Source: DHIS[39]

tentially reflects higher patient acuity or delayed discharges. In district hospitals, the ALOS was shorter at 4.5 days, with Free State (3.4) and Northern Cape (3.4) at the lower end, suggesting more efficient throughput or lower case complexity.[39]

The ALOS in specialised psychiatric hospitals across South Africa reflects considerable variation (Figure 5), highlighting differences in provincial mental health service delivery. While the national average is just under 183 days, some provinces, particularly the Free State and Limpopo, show markedly longer hospital stays, suggesting a predominance of long-term admissions or systemic factors affecting discharge. In contrast, provinces such as the Western Cape and Northern Cape report much shorter stays, possibly due to more community-based care options or higher patient turnover. These variations may be influenced by differences in bed availability, referral pathways, and the extent of mental health integration into primary and community care services. Addressing these disparities is important for ensuring equitable, efficient, and patient-centred psychiatric care nationwide.[103]

Bed utilisation

Bed utilisation rates offer further insight into system capacity. The national in-patient bed utilisation rate as recorded in the public health routine system was 69.4%, with Western Cape (86.7%) and Gauteng (78.7%) operating near or above optimal thresholds, while Eastern Cape (59.1%) and KwaZulu-Natal (62.2%) reported under-utilisation. District hospital bed utilisation was lower at 61.4% nationally, with Western Cape again leading at 86.9%.[39] These figures suggest regional imbalances in demand and capacity, with implications for referral patterns and resource allocation.

Primary Health Care utilisation

Primary Health Care indicators show mixed performance. The PHC utilisation rate was 1.7 visits per person per year nationally, below the recommended benchmark of 3.0. Utilisation was highest in Eastern Cape (2.1) and Limpopo (2.0), and lowest in Gauteng (1.2), suggesting access barriers or service delivery gaps in urban areas. Among children under five, the utilisation rate was higher at 3.0, with Limpopo (3.7) and Western Cape (3.2) performing well.

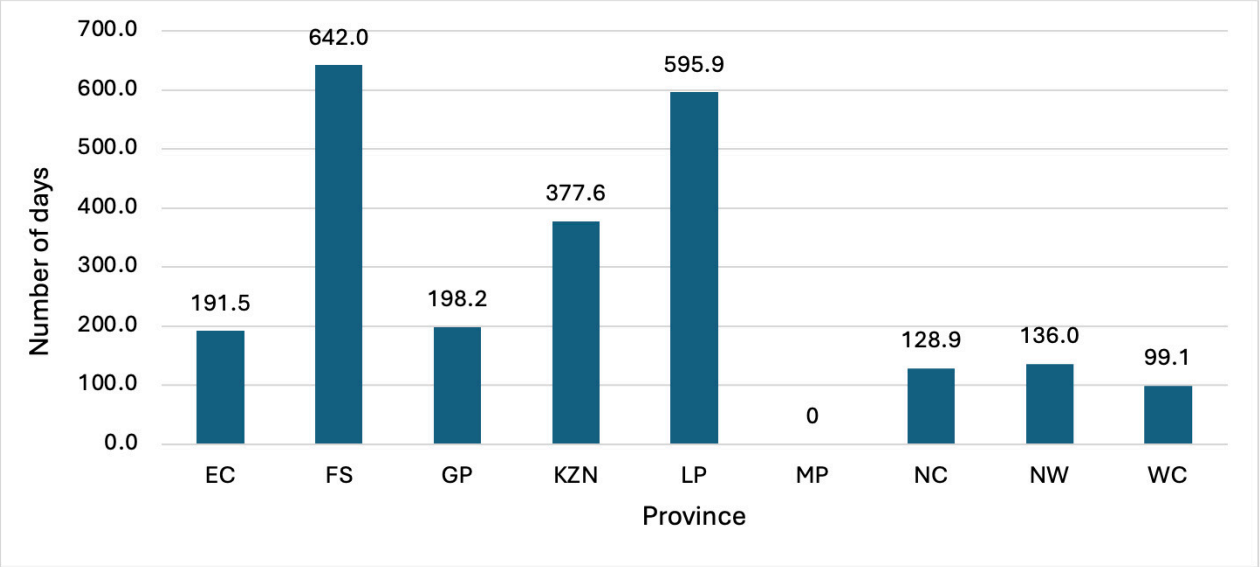
In-patient mortality

In-patient mortality remains a concern, with a national crude death rate of 4.7%. Eastern Cape (6.3%) and Gauteng (5.4%) reported the highest rates, while Western Cape had the lowest at 3.4%. The total number of in-patient deaths exceeded 165 000, with district hospitals accounting for nearly 44% of these. Notably, national central hospitals in Gauteng and Western Cape reported high mortality volumes, reflecting their role in managing complex cases.

Professional Nurse workloads

The PHC Professional Nurse workload averaged 23.3 patients per day, with the highest burdens in Eastern Cape (27.3) and KwaZulu-Natal (26.9), raising concerns about

Figure 5. Average length of stay: specialised psychiatric hospitals in public sector



Source: DHIS[39]

staff burnout and quality of care. Encouragingly, 78% of clinics nationally met the Ideal Clinic standards, with KwaZulu-Natal, North West, and Western Cape achieving 97% compliance. However, Limpopo (42%) and Northern Cape (35%) lag significantly, highlighting the need for targeted quality improvement initiatives.

Availability of medicines

Medicine availability remains strong, with 89% of Ideal Clinics reporting 90% tracer medicine availability. This is a positive sign of supply-chain stability, although continued vigilance is needed to prevent stock-outs, particularly in rural provinces.

Overall, the health service indicators reflect a health system that is functional but uneven. Addressing disparities in infrastructure, staffing and service quality will be essential to achieving equitable access and improving health outcomes across provinces.

Health personnel

The health workforce crisis remains a major barrier to achieving universal health coverage where there is a projected shortfall of 10 million health workers by 2030, primarily in low- and lower-middle-income countries.[104] Many nations face similar challenges to South Africa, including maldistribution of health professionals, urban—rural disparities, and shortages in specialised cadres such as mental health professionals. High-income countries often rely on international recruitment to fill gaps, which can exacerbate workforce shortages in source countries. Task-shifting and Community Health Worker programmes have been adopted globally to address these gaps, with countries like Ethiopia, Brazil, and India demonstrating scalable models.[105]

Strengthening health workforce information systems, improving retention strategies, and aligning training with population health needs are global priorities echoed in the WHO Global Strategy on Human Resources for Health.[106] A closer look at South Africa's human resources for health reveals a system marked by both progress and persistent inequities. Rather than a uniform distribution, the data show significant provincial disparities in the availability of key health professionals. For example, the national average of medical practitioners in the public sector stands at 35.6 per 100 000 population, but this ranges from 28.0 in Free State to 40.7 in Northern Cape.[28]

Human resources for mental health

South Africa faces a persistent and inequitable shortage of human resources for mental health across disciplines and levels of care. There is a severe shortage of trained mental healthcare providers, with considerable variation between provinces (Figure 6).[107] Psychologists, for instance, are available at just 1.5 per 100 000 nationally in the public sector, with even lower densities in provinces such as the Free State (0.9) and Mpumalanga (0.9), reflecting critical shortages in specialised and allied health professions.[107] The WHO Mental Health Atlas estimates for South Africa are only 1.59 psychiatrists, 15.36 psychologists and 86.23 social workers per 100 000 overall, with just 0.11 child and adolescent psychiatrists per 100 000.[16] These figures mask deep public–private and urban–rural disparities: approximately 80% of psychiatrists work in the private health sector, and the vast majority are based in urban areas in just two provinces: Gauteng and the Western Cape.[108] In the public sector,

Table 16. Health services indicators by province

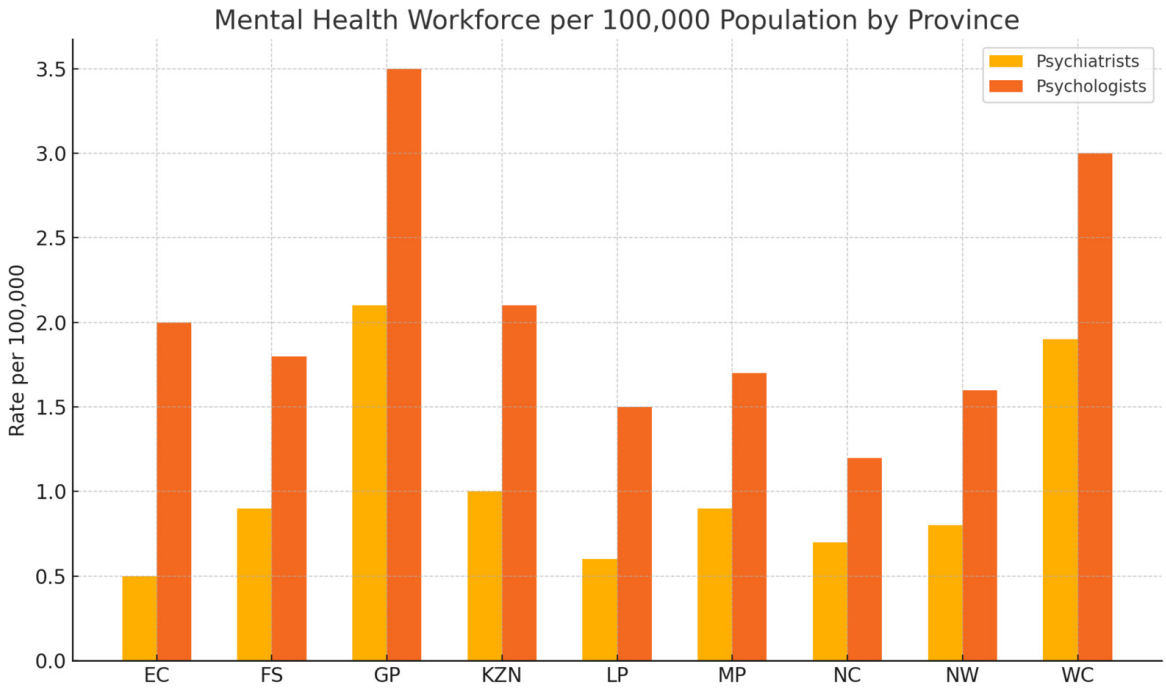
Indicator	Period	Sex|Age|Series|Cat	SA	EC	FS	GP	KZ	LP	MP	NC	NW	WC	Ref
Average length of stay — total	2023/24	DHIS	6.4	7.0	5.8	7.5	6.9	5.7	4.8	5.7	6.2	5.7	a
Average length of stay (district hospitals)	2023/24	DHIS	4.5	4.9	3.4	5.1	5.3	4.4	4.5	3.4	4.5	3.6	a
Birth registration coverage	2023	both sexes Live births of current registration	80.7										b
Complaints resolution rate	2023/24	DHIS	92.8	93.0	89.1	93.6	93.5	94.6	88.5	82.3	95.4		a
Complaints resolution rate within 25 working days	2023/24	DHIS	95.9	97.5	93.5	95.2	95.3	98.9	98.4	85.8	97.0		a
In-patient bed utilisation rate — total	2023/24	DHIS	69.4	59.1	62.4	78.7	62.2	69.8	64.2	61.5	73.7	86.7	a
In-patient bed utilisation rate (district hospitals)	2023/24	DHIS	61.4	48.8	51.4	72.8	55.2	68.7	61.5	52.8	66.2	86.9	a
In-patient crude death rate	2023/24	both sexes DHIS	4.7	6.3	4.2	5.4	4.7	4.6	4.4	5.2	4.7	3.4	a
In-patient deaths — total	2023/24	both sexes DHIS	165341	25430	10649	37229	32543	16321	10292	3907	9182	19788	a
		DHIS District Hospital	72529	13519	4718	6588	15893	10035	6271	1599	3397	10509	a
		DHIS National Central Hospital	21264	1415	699	13144	684	0	0	0	0	5322	a
		DHIS PHC/CHC	580	0	0	37	69	0	0	451	0	23	a
		DHIS Provincial Tertiary Hospital	22194	4174	1086	4782	3289	2423	2071	1184	3034	151	a
		DHIS Regional Hospital	45902	5748	2914	12613	12392	3845	1939	655	2731	3065	a
International Health Regulations (IHR) core capacity	2024	WHO	63.0										c

Indicator	Period	Sex|Age|Series|Cat	SA	EC	FS	GP	KZ	LP	MP	NC	NW	WC	Ref
index													
Number of beds	Mar 2024	DHIS District Hospital	31360	6118	1674	2596	8731	4240	2900	577	1240	3284	a
		DHIS public sector	85119	13111	4822	17873	20506	7853	4721	1636	4480	10117	a
Number of health facilities	Mar 2024	DHIS CHC/CDC	359	43	10	42	23	26	58	33	48	76	a
		DHIS Clinic	3150	735	210	332	597	451	241	130	269	185	a
		DHIS District Hospital	253	65	25	12	42	30	23	11	12	33	a
		DHIS Military Hospital	3		1	1						1	a
		DHIS National Central Hospital	9	1	1	4	1					2	a
		DHIS Provincial Tertiary Hospital	18	3	1	3	3	2	2	1	2	1	a
		DHIS Regional Hospital	48	5	4	9	13	5	3	1	3	5	a
		DHIS Specialised Psychiatric Hospital	23	4	1	3	5	3		1	2	4	a
		DHIS Specialised TB Hospital	25	10			3	1	4	1		6	a
OHH headcount under 5 years coverage	2023/24	DHIS	117	85	95	99	160	116	114	98	110	126	a
Patient Day Equivalent	2023/24	DHIS	30808628	3871881	1881297	7264514	6695183	2863895	1803704	613994	1598498	4215662	a
		DHIS District Hospital	4041	4079	3139	4345	4051	3798	4974	7281	4641	3043	a
Percentage Ideal Clinics	2023/24	IC status	78	63	91	96	97	42	97	35	97	87	d
Percentage Ideal Clinics with 90% of tracer medicines available	2023/24	IC	89	91	88	90	97	87	87	85	89	90	d
PHC headcount total	2023/24	both sexes all ages DHIS	104773184	13943191	5206919	5206919	19293430	24040578	12462544	8167138	2683013	7117778	a
PHC Professional	2023/	DHIS	23.3	27.3	24.9	23.7	26.9	19.0	26.2	18.7	17.5	21.0	a

Indicator	Period	Sex|Age|Series|Cat	SA	EC	FS	GP	KZ	LP	MP	NC	NW	WC	Ref
Nurse clinical work load	24												
PHC utilisation rate	2023/24	DHIS	1.7	2.1	1.8	1.2	2.0	2.0	1.7	2.0	1.7	1.6	a
PHC utilisation rate under 5 years	2023/24	DHIS	3.0	3.1	3.0	2.4	3.1	3.7	3.1	3.1	2.8	3.2	a

Sources:
a: National Treasury[26]
b: Medical Schemes 2023[23]
c: World Health Statistics 2025[7]
Indicator [units]: Definition
• Average length of stay — total [Days]: The average number of days that an admitted patient spends in hospital before separation.
• Average length of stay (district hospitals) [Days]: The average number of days that an admitted patient spends in hospital before separation.
• Birth registration coverage [Percentage]: Percentage of births that are registered within one month of age in a civil registration system.
• Complaints resolution rate [Percentage]: Complaints resolved as a proportion of complaints received.
• Complaints resolution rate within 25 working days [Percentage]: Complaints resolved within 25 working days as a proportion of all complaints resolved.
• In-patient bed utilisation rate — total [Percentage]: A measure of the average number of beds that are occupied — expressed as the proportion of all available bed days, which is calculated as the number of actual beds multiplied by the average number of days in a month (30.42).
• In-patient bed utilisation rate (district hospitals) [Percentage]: A measure of the average number of beds that are occupied — expressed as the proportion of all available bed days, which is calculated as the number of actual beds multiplied by the average number of days in a month (30.42).
• In-patient crude death rate [Percentage]: Proportion of admitted clients/separations who died during hospital stay. In-patient separations is calculated as the total of day clients, in-patient discharges, in-patient deaths, and in-patient transfers out.
• In-patient deaths — total [Number]: An in-patient death is a death recorded against an admitted in-patient, including the death of a patient admitted earlier on the same day. The total is specialities plus all others that do not appear on the identified specialities.
• International Health Regulations (IHR) core capacity index [Percentage]: Percentage of attributes of 13 core capacities that have been attained at a specific point in time. The 13 core capacities are: (1) National legislation, policy and financing; (2) Co-ordination and National Focal Point communications; (3) Surveillance; (4) Response; (5) Preparedness; (6) Risk communication; (7) Human resources; (8) Laboratory; (9) Points of entry; (10) Zoonotic events; (11) Food safety; (12) Chemical events; (13) Radio-nuclear emergencies.
• Number of beds [Number]: The total number of beds in a health facility.
• Number of health facilities [Number]: The total number of health facilities.
• OHH headcount under 5 years coverage [Percentage]: Children 5 years and older in the population who received care during Ward-based Outreach Team visits.
• Patient Day Equivalent [Number]: The sum of in-patient days total x 1, Day patient total x 0.5, and OPD/Emergency total headcount x 0.3333333.
• Percentage Ideal Clinics [Percentage]: Percentage of fixed PHC facilities assessed on the Ideal Clinic dashboard that achieved Ideal Clinic status (silver, gold, platinum or diamond status).
• Percentage Ideal Clinics with 90% of tracer medicines available [Percentage]: Percentage of Ideal Clinics with 90% of the tracer medicines available.
• PHC headcount total [Number]: All individual clients attending Primary Health Care services at a facility.
• PHC Professional Nurse clinical work load [Clients per nurse per day]: The average number of clients seen per Professional Nurse per Professional Nurse clinical work day.
• PHC utilisation rate [Average number of visits per person]: The average number of PHC visits per person per year in the population.
• PHC utilisation rate under 5 years [Average number of visits per person under 5 years]: The average number of PHC visits per year per person under 5 years of age in the population.

Figure 6. Mental health workforce per 100 000 population by province



Source: PERSAL[28]

which serves most of the population, psychiatrist density is only 0.38 per 100 000 compared to 4.98 per 100 000 in the private sector.[109] The NMHPFSP acknowledges "major shortfalls in human resources" and reports densities among the uninsured population of just 0.31 psychiatrists and 0.97 psychologists per 100 000.[9] These shortages contribute to hospital-centric models of care, limited community-based services, and significant service bottlenecks, with the most pronounced deficits to be found in rural areas and in child and adolescent mental health. Addressing these gaps requires accelerated workforce expansion, strategic redistribution, and supported task-sharing to extend equitable mental health coverage nationwide.

To address the shortage of specialist mental healthcare providers, South Africa has adopted task-sharing models in line with WHO recommendations. Task-sharing refers to the structured redistribution of responsibilities traditionally performed by specialist mental health professionals, such as psychiatrists and psychologists, to non-specialist health workers. This approach aims to expand access to mental health services, particularly in resource-constrained settings like South Africa.[107]

Nurses

Nursing remains the backbone of the health system, with Professional Nurses at 141.3 per 100 000 nationally. However, the distribution again varies widely from 91.8 in Western Cape to 187.5 in Eastern Cape. The density of Enrolled Nurses and Nursing Assistants also reflects this imbalance, with Limpopo and Eastern Cape reporting the highest ratios. There is a need for targeted workforce planning and retention strategies, particularly in underserved provinces.

Medical doctors

The gap between registered and employed professionals is another concern. For example, while 53 408 medical practitioners are registered with the Health Professions Council of South Africa (HPCSA)[24] (as of October 2024), only 16 493 are employed in the public sector. This suggests that a significant proportion of the workforce is either in the private sector or not actively practising, raising questions about workforce absorption and distribution.

To address these challenges, South Africa must strengthen its Human Resources for Health (HRH) strategy through improved forecasting, equitable deployment, and incentives for rural service. The 2030 National Human Resources for Health Strategy outlines many of these priorities, but implementation remains uneven. Without a concerted effort to align workforce supply with population health needs, the goal of universal health coverage will remain out of reach.

Health financing

Many low- and middle-income countries continue to struggle with inadequate public health spending, high out-of-pocket expenditures, and limited financial risk protection. While South Africa has met the Abuja target of allocating at least 15% of government expenditure to health, most African countries fall short, with the regional average hovering around 9%. Globally, the average gov-

Table 17. Number of health personnel practising in the public sector by province

Indicator	Period	Sex|Age|Series|Cat	SA	EC	FS	GP	KZN	LP	MP	NC	NW	WC	Ref
Number of clinical associates registered	2024 Oct	both sexes HPCSA	1 266										a
Number of CS clinical psychologists	2024 Mar	both sexes public sector	66	4	3	33	8	3	3	1	3	8	b
Number of CS dentists	2024 Mar	both sexes public sector	223	17	29	46	43	21	16	13	22	16	b
Number of CS dieticians	2024 Mar	both sexes public sector	213	18	20	60	37	13	19	13	27	6	b
Number of CS doctors	2024 Mar	both sexes public sector	2 457	276	112	473	321	343	325	88	260	259	b
Number of CS environmental health practitioners	2024 Mar	both sexes public sector	179	4	16	34	5	42	24	14	40		b
Number of CS nurses	2024 Mar	both sexes public sector	2 449	300	195	577	284	192	255	59	238	349	b
Number of CS occupational therapists	2024 Mar	both sexes public sector	336	62	27	90	66	13	26	21	16	15	b
Number of CS optometrists	2024 Mar	both sexes public sector	184	6	6	54		104	7	2	4	1	b
Number of CS pharmacists	2024	both sexes SAPC	959	139	22	219	203	136	66	16	59	99	c
	2024 Mar	both sexes public sector	734	67	45	163	152	82	54	45	74	52	b
Number of CS physiotherapists	2024 Mar	both sexes public sector	431	69	30	102	74	16	31	27	53	29	b
Number of CS radiographers	2024 Mar	both sexes public sector	396	34	13	104	83	30	36	10	49	37	b
Number of CS speech therapists	2024 Mar	both sexes public sector	271	31	10	68	86	11	19	13	25	8	b
Number of dental practitioners	2024 Mar	both sexes public sector	945	146	43	215	113	148	74	28	50	128	b
Number of dental practitioners registered	2024 Oct	both sexes HPCSA	6 756										a
Number of dental specialists	2024 Mar	both sexes public sector	127		2	91	1	4	1			28	b
Number of dental therapists	2024	both sexes public	342	17	1	42	100	121	22	26	12	1	b

Indicator	Period	Sex|Age|Series|Cat	SA	EC	FS	GP	KZN	LP	MP	NC	NW	WC	Ref
	Mar	sector											
Number of dental therapists registered	2024 Oct	both sexes HPCSA	928										a
Number of enrolled nurses	2024 Mar	both sexes public sector	27570	3225	1054	6667	9226	2642	835	198	976	2747	b
Number of environmental health practitioners	2024 Mar	both sexes public sector	444	19	87	133	79	33	47	13	33		b
Number of environmental health practitioners registered	2024 Oct	both sexes HPCSA	4107										a
Number of medical practitioners	2024 Mar	both sexes public sector	16493	1939	600	4128	3869	1438	1008	374	1079	2058	b
Number of medical practitioners (including specialists) registered	2024 Oct	both sexes HPCSA	53408										a
Number of medical researchers	2024 Mar	both sexes public sector	34	4		19	4	2		1	1	3	b
Number of medical specialists	2024 Mar	both sexes public sector	4529	177	326	1763	813	77	62	40	162	1109	b
Number of nursing assistants	2024 Mar	both sexes public sector	33221	5222	2091	6441	5438	4324	2011	785	2692	4217	b
Number of occupational therapists	2024 Mar	both sexes public sector	1041	110	47	266	143	189	54	25	40	167	b
Number of occupational therapists registered	2024 Oct	both sexes HPCSA	6233										a
Number of optometrists and opticians	2024 Mar	both sexes public sector	65				65						b
Number of pharmacists	2024 Mar	both sexes public sector	5714	938	386	1180	856	608	370	107	258	1011	b
Number of pharmacists registered	2024	both sexes SAPC	17929	2008	612	6116	2860	869	905	270	1198	3057	c
Number of physiotherapists	2024 Mar	both sexes public sector	1127	134	47	193	265	150	78	33	76	151	b
Number of physiotherapists registered	2024 Oct	both sexes HPCSA	8783										a
Number of professional nurses	2024 Mar	both sexes public sector	72845	11047	2334	15271	17838	8308	6507	1445	4945	5150	b
Number of psychologists	2024	both sexes public	732	72	21	215	101	124	34	14	42	109	b

Indicator	Period	Sex|Age|Series|Cat	SA	EC	FS	GP	KZN	LP	MP	NC	NW	WC	Ref
	Mar	sector											
Number of psychologists registered	2024 Oct	both sexes HPCSA	9 511										a
Number of radiographers	2024 Mar	both sexes public sector	2 888	367	146	846	593	213	114	71	115	423	b
Number of radiographers registered	2024 Oct	both sexes HPCSA	8 892										a
Number of speech therapists and audiologists	2024 Mar	both sexes public sector	580	61	12	143	144	52	44	17	31	76	b
Number of student nurses	2024 Mar	both sexes public sector	497			38	329		126		4		b

Sources:
a: HPCSA[24]
b: PERSAL[28]

Table 18. Health personnel per 100 000 uninsured population by province

Indicator	Period	Sex|Age|Series|Cat	SA	EC	FS	GP	KZN	LP	MP	NC	NW	WC	Ref
Density of dentistry personnel (per 100 000 population)	2023	both sexes WHO	0.2										a
Density of midwifery personnel (per 100 000 population)	2022	both sexes WHO	63.9										a
Density of pharmaceutical personnel (per 100 000 population)	2022	both sexes WHO	2.7										a
Dental practitioners per 100 000 population	2024 Mar	both sexes public sector	2.2	2.7	2.8	2.0	1.5	2.9	2.1	3.6	1.9	2.4	b
Dental specialists per 100 000 population	2024 Mar	both sexes public sector	0.2		0.1	0.7	0.0	0.1	0.0			0.5	b
Dental therapists per 100 000 population	2024 Mar	both sexes public sector	0.6	0.3	0.0	0.3	1.0	2.1	0.5	2.3	0.3	0.0	b
Enrolled nurses per 100 000 population	2024 Mar	both sexes public sector	51.7	53.3	41.4	51.8	87.2	45.9	19.3	17.4	25.4	45.9	b
Environmental health practitioners per 100 000 population	2024 Mar	both sexes public sector	1.2	0.4	4.0	1.3	0.8	1.3	1.6	2.4	1.9		b
Medical practitioners per 100 000 population	2022	both sexes WHO	7.9										a
	2024 Mar	both sexes public sector	35.6	36.6	28.0	35.7	39.6	30.9	30.8	40.7	34.9	38.7	b
Medical specialists per 100 000 population	2024 Mar	both sexes public sector	8.5	2.9	12.8	13.7	7.7	1.3	1.4	3.5	4.2	18.5	b
Nursing assistants per 100 000 population	2024 Mar	both sexes public sector	62	86	82	50	51	75	47	69	70	70	b
Occupational therapists per 100 000 population	2024 Mar	both sexes public sector	3	3	3	3	2	4	2	4	2	3	b
Pharmacists per 100 000 population	2024 Mar	both sexes public sector	12	17	17	10	10	12	10	13	9	18	b
Physiotherapists per 100 000 population	2024 Mar	both sexes public sector	3	3	3	2	3	3	3	5	3	3	b
Professional nurses per 100 000 population	2024 Mar	both sexes public sector	141	188	99	123	171	148	156	132	135	92	b
Psychologists per 100 000 population	2024 Mar	both sexes public sector	2	1	1	2	1	2	1	1	1	2	b
Radiographers per 100 000 population	2024 Mar	both sexes public sector	6	7	6	7	6	4	4	7	4	8	b
Speech therapists and audiologists per 100 000 population	2024 Mar	both sexes public sector	2	2	1	2	2	1	2	3	2	1	b

Sources:
a: World Health Statistics 2025[7]
b: PERSAL[28]

ernment health expenditure as a share of GDP is 6.6%, with high-income countries spending over 8% and low-income countries often below 2%. Out-of-pocket spending remains a major barrier to access in many regions, accounting for over 40% of total health expenditure in some countries, leading to catastrophic health costs and impoverishment.[20]

Mental health programme expenditure

Mental healthcare spending in South Africa is estimated to account for 5% of the total public health budget. However, six out of nine provinces allocate less than this benchmark.[98,103] In South Africa, mental healthcare services are predominantly concentrated at the top of the healthcare system, mainly within secondary hospitals and specialist facilities.[107] An estimated 86% of the mental health budget is reportedly spent on in-patient care, with nearly half of that going to tertiary hospitals.[98] This leaves significantly fewer resources available at other levels of care, especially within community-based services — thus going against the WHO's optimal mix of services pyramid, which recommends integrating mental health into primary health care and limiting the number of psychiatric hospitals or specialist services providing long-term chronic care.[107]

An analysis of provincial health budget allocations to mental health care showed that Gauteng (6.2%), KwaZulu-Natal (5.0%), and the Western Cape (7.5%) allocate a higher-than-average share, indicating stronger prioritisation of mental health. In contrast, provinces such as the Eastern Cape (2.8%), Limpopo (2.6%), and the North West (3.1%) dedicate a smaller proportion of their budgets to this area.[109] In their analysis of health expenditure on mental health programmes across provinces, Docrat, et al. (2019)[109] highlighted that PHC receives the lowest contribution from the total mental health budget, followed by district hospitals. The PHC expenditure also includes the costs of medication for people living with severe mental health conditions who are discharged from hospitals and community health centres.[107]

Key recommendations for improving mental health financing emphasise optimising the use of existing resources. This includes aligning human resource allocations and budgets with actual service demands; restructuring hospital platforms to support shorter in-patient stays and expanded out-patient care; and redirecting funds to fully operationalise under-utilised facilities rather than investing in new infrastructure.[98]

Health programmes expenditure

The percentage of expenditure per programme by province, as illustrated in Figure 7, shows that District Health Services saw increased prioritisation in provinces such as KwaZulu-Natal and the Eastern Cape, suggesting an emphasis on PHC and community-level service delivery. Although there was a slight decline, Central Hospital Services expenditure has dominated in provinces like Free State, Mpumalanga and Limpopo, indicating continued reliance on tertiary care infrastructure in these regions. Overall, Health Facilities Management, Health Sciences and Training, and Emergency Health Services remained relatively stable across provinces, showing consistent investment in infrastructure, workforce development, and emergency response.

Medical scheme coverage

Medical scheme coverage remains highly unequal. Nationally, only 14.7% of the population is covered by medical schemes, with Gauteng (39%) and Western Cape (15%) far exceeding provinces like Northern Cape (2%) and Free State (5%). This entrenches a two-tiered health system, where access to private care is concentrated among wealthier, urban populations. The pensioner ratio within medical schemes, which is 9.4% overall and 11.4% among females, also highlights the ageing of the insured population, with implications for scheme sustainability and benefit design.[23]

Expenditure per patient day equivalent

There are still persistent disparities in health spending across provinces and between insured and uninsured populations, as shown in Table 18. Nationally, the average expenditure per patient day equivalent (PDE) in district hospitals was R3 754, with Gauteng (R4 493) and North West (R4 683) spending significantly above the national average, while Free State (R3 049) and Western Cape (R3 193) reported the lowest.[26] These differences may reflect variations in input costs, service delivery models, and efficiency, but also raise concerns about equity and resource allocation.

District Health Services expenditure

Per capita expenditure on District Health Services for the uninsured population averaged R2 355 nationally, with Limpopo (R2 788) and KwaZulu-Natal (R2 644) at the higher end, and Gauteng (R1 834) at the lowest despite its large uninsured population.[26] This suggests a potential mismatch between population need and financial allocation. Similarly, PHC expenditure per capita ranged from R1 305 in Limpopo to R1 676 in KwaZulu-Natal, while PHC expenditure per headcount was highest in Gauteng (R882.6) and lowest in Limpopo (R599.6), indicating differences in service utilisation and cost structures.

Official development assistance

South Africa received just USD1.50 per capita in official development assistance (ODA) for medical research and basic health in 2022, underscoring the need for greater domestic investment in health system strengthening. While ODA plays a supplementary role, reliance on external funding is not sustainable for core service delivery.[7]

There is an urgent need for more equitable and efficient health financing. The National Health Insurance (NHI) policy aims to address these disparities, but its suc-

Table 19. Health financing indicators by province

Indicator	Period	Sex|Age|Series|Cat	SA	EC	FS	GP	KZN	LP	MP	NC	NW	WC	Ref
Expenditure per patient day equivalent (district hospitals)	2023/24	BAS real 2023/24 prices	3754	3913	3049	4493	3853	3596	3655	3469	4683	3193	a
Medical scheme beneficiaries	2023	both sexes all ages med schemes	9127453	668146	414470	3529855	1302597	498749	578240	192648	499642	1411888	b
		female all ages med schemes	4908106										b
		male all ages med schemes	4219347										b
Medical scheme coverage	2023	both sexes all ages med schemes	14.7	7.0	5.0	39.0	14.0	5.0	6.0	2.0	5.0	15.0	b
		female all ages med schemes	54.0										b
		male all ages med schemes	46.0										b
Pensioner ratio	2023	both sexes all ages med schemes	9.4										b
		female all ages med schemes	11.4										b
		male all ages med schemes	8.9										b
Provincial & LG District Health Services expenditure per capita (uninsured)	2023/24	BAS real 2023/24 prices	2355	2608	2305	1834	2644	2788	2529	2647	2086	2283	a
Provincial & LG PHC expenditure per capita (uninsured)	2023/24	BAS real 2023/24 prices	1448	1440	1563	1352	1676	1305	1378	1630	1370	1415	a
Provincial & LG PHC expenditure per PHC headcount	2023/24	BAS real 2023/24 prices	724.4	625.7	758.0	882.6	729.2	599.6	719.5	683.1	726.2	701.1	a
Total net official development assistance to medical research and basic health sectors per capita (US$) by recipient country	2022	WHO	1.5										c

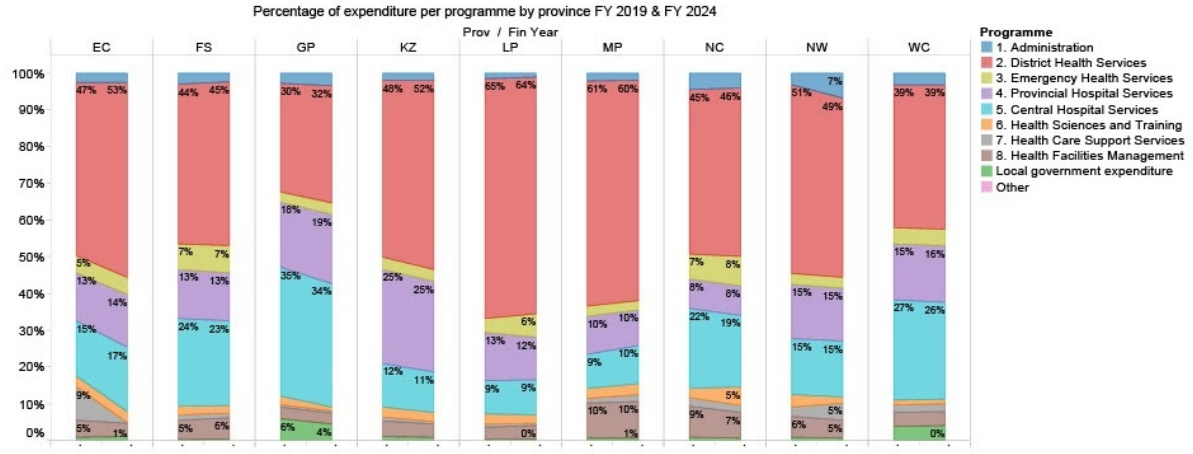
Sources:
a: National Treasury[26]
b: Medical Schemes 2023[23]
c: World Health Statistics 2025[7]
Indicator [units]: Definition

• Expenditure per patient day equivalent (district hospitals) [Rand (real prices)]: Average cost per patient per day seen in a hospital (expressed as Rand per patient day equivalent).
• Medical scheme beneficiaries [Number]: Number of medical scheme beneficiaries, as reported by the Medical Schemes Council.
• Medical scheme coverage [Percentage]: Proportion of population covered by medical schemes
• Pensioner ratio [Percentage]: Proportion of members of medical schemes who are 65 years or older, in registered medical schemes.
• Provincial & LG District Health Services expenditure per capita (uninsured) [Rand (real prices)]: Provincial expenditure on District Health Services (all sub-programmes except 2.8 Coroner services) plus net local government expenditure on PHC per uninsured population.
• Provincial & LG PHC expenditure per capita (uninsured) [Rand (real prices)]: Provincial expenditure on sub-programmes of DHS (2.2 — 2.7) plus net local government expenditure on PHC per uninsured population.
• Provincial & LG PHC expenditure per PHC headcount [Rand (real prices)]: Provincial expenditure on sub-programmes of DHS (2.2 — 2.7) plus net local government expenditure on PHC divided by PHC headcount from DHIS.
• Total net official development assistance to medical research and basic health sectors per capita (US$) by recipient country [Percentage]: Gross ODA disbursements from all donors to those sectors, divided by recipient population.

Table 20. Trends in overall provincial health expenditure by programme, nominal prices (Rand million, nominal prices), 2013/14 – 2023/24

	Financial Year										
Programme	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
1. Administration	3 578	3 599	4 313	4 462	4 690	5 129	5 368	8 799	7 596	7 273	7 207
2. District Health Services	57 991	64 181	69 854	76 540	83 671	90 978	98 688	109 448	115 084	116 406	118 957
3. Emergency Health Services	5 352	5 556	6 025	6 435	7 380	7 671	8 394	8 660	8 791	9 817	10 464
4. Provincial Hospital Services	26 420	28 694	29 576	29 675	32 262	34 275	36 609	37 623	39 134	40 607	43 442
5. Central Hospital Services	23 559	25 804	29 529	33 736	37 437	41 120	44 608	47 516	47 227	50 010	51 560
6. Health Sciences and Training	4 039	4 248	4 529	5 107	4 916	5 037	5 115	4 796	4 792	5 270	5 314
7. Health Care Support Services	1 877	1 322	2 834	1 796	1 806	4 661	2 301	3 469	3 073	2 936	3 072
8. Health Facilities Management	7 895	7 491	8 514	8 316	8 651	9 014	9 844	11 526	10 433	10 236	10 574
Local government expenditure	2 869	3 389	3 730	4 103	4 199	4 858	4 828	5 392	5 158	5 140	5 285
Other	0	0	0	0	0	0	0	-14	0	0	0
Grand Total	133 581	144 283	158 903	170 171	185 013	202 744	215 755	237 229	241 273	247 697	255 877

Figure 7. Percentage of expenditure per programme by province, 2018/19 compared to 2023/24



Source: BAS (National Treasury)[26]

cess will depend on robust fiscal planning, improved public financial management, and transparent allocation mechanisms. Strengthening provincial budgeting processes and aligning expenditure with population health needs are essential steps towards universal health coverage.[110] Furthermore, in alignment with the recommendations of the National Mental Health Investment Case,[111] it is essential to establish dedicated mental health directorates in all nine provinces. Building capacity to effectively plan, manage and evaluate integrated mental health services is also critical to strengthening the system and ensuring sustainable delivery.

Conclusion and recommendations

Globally, the integration of mental health into broader health and development agendas is gaining momentum. Countries are increasingly recognising the importance of mental health data governance, standardised indicators, and community-based care models. The WHO Mental Health Atlas and the SDGs have catalysed efforts to embed mental health metrics into national surveillance systems. However, challenges persist worldwide, including fragmented data systems, under-reporting, and limited disaggregation by key equity dimensions.

Lessons from countries that have successfully harmonised mental health indicators and strengthened data infrastructure such as Chile,[112] Thailand[113] and the United Kingdom (NHS Mental Health datasets) offer valuable insights for South Africa. A global shift towards open data access, cross-sectoral collaboration, and investment in digital health platforms underscores the need for South Africa to align its mental health surveillance strategies with international best practices to ensure policy relevance and equitable service delivery.

In the context of mental health, the expansion of routine indicators, policy frameworks, and longitudinal cohort resources presents a significant opportunity for enhanced analysis and system insight. However, fragmented data governance, incomplete inclusion of community and informal care data, and limited disaggregation continue to hinder the generation of actionable evidence. Addressing these challenges will require the adoption of harmonised indicator standards, improved data quality assurance mechanisms, integration of mental health metrics into broader health and development monitoring systems, and greater transparency and accessibility to support effective policy translation.

The current distribution of mental health expenditure in South Africa reflects a system heavily skewed towards specialist and in-patient care, with limited investment in community and PHC services. This imbalance not only undermines equitable access to mental health care, but also diverges from global best practices advocating for integrated, community-based mental health care.

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Table 21. Provincial expenditure by programme per province (Rand million), 2023/24

	Financial Year 2024								
Programme	EC	FS	GP	KZN	LP	MP	NC	NW	WC
1. Administration	759	317	2 170	1 014	284	339	264	1 081	981
2. District Health Services	15 618	5 820	20 529	27 511	15 873	10 672	2 942	7 827	12 165
3. Emergency Health Services	1 360	977	2 065	1 692	1 577	474	522	447	1 350
4. Provincial Hospital Services	4 253	1 712	12 030	13 188	2 902	1 710	520	2 326	4 801
5. Central Hospital Services	5 133	2 988	21 549	5 925	2 302	1 842	1 249	2 422	8 150
6. Health Sciences and Training	872	280	700	1 341	598	515	321	269	419
7. Health Care Support Services	113	165	439	356	165	361	126	729	619
8. Health Facilities Management	1 018	759	1 832	1 908	888	1 754	453	793	1 169
Local government expenditure	327	52	2 883	438	91	117	34	96	1 249
Grand Total	29 454	13 070	64 196	53 371	24 680	17 783	6 432	15 989	30 902

Table 22. District Health Service expenditure by province (Rand million), 2023/24

	Financial year 2024								
	2. District Health Services								
Subprogramme	EC	FS	GP	KZ	LP	MP	NC	NW	WC
2.1 District Management	1 036	146	1 393	372	592	647	376	860	452
2.2 Community Health Clinics	3 284	1 067	2 757	5 645	3 737	1 929	635	1 344	1 741
2.3 Community Health Centres	1 541	178	2 417	2 297	648	1 199	451	1 471	2 919
2.4 Community-based Services	790	711	3 055	1 070	666	20	-	4	477
2.5 Other Community Services	55	0		1 878	469	-	149	519	-
2.6 HIV/AIDS	2 697	1 922	5 853	6 172	1 858	2 603	561	1 735	1 857
2.7 Nutrition	30	17	64	32	5	9	3	1	71
2.8 Coroner Services	143	51	302	300	-	-	-	50	-
2.9 District Hospitals	6 042	1 728	4 688	9 746	7 899	4 265	768	1 844	4 648
Grand Total	15 618	5 820	20 529	27 511	15 873	10 672	2 942	7 827	12 165

Abbreviations

Abbreviation	description
AIDS	acquired immunodeficiency syndrome
ALOS	average length of stay
AQLI	air quality life index
ART	antiretroviral therapy
BCG	Bacillus Calmette-Guérin
Bt40	Birth–to–Forty
CMS	Council for Medical Schemes
DALYs	disability-adjusted life-years
DCHS	Drakenstein Child Health Study
DHIS	District Health Information System
DIMAMO	Dikgale, Mamabolo and Mothiba
DS-TB	drug-sensitive tuberculosis
FSW	female sex worker
GAD	generalised anxiety disorder
GBD	global burden of disease
GDP	gross domestic product
GHS	General Household Survey
GLOBOCAN	Global Cancer Observatory
HDI	Human Development Index
HAALSi	Health and Ageing in Africa: A Longitudinal Study of an INDEPTH Community in South Africa
HDR	Human Development Report
HDSS	health and demographic surveillance systems
HIV	human immunodeficiency virus
HPCSA	Health Professions Council of South Africa
HRH	human resources for health
IDF	International Diabetes Federation
MDD	major depressive disorder
MDR-TB	multi-drug resistant tuberculosis
MHQ	mental health quotient
MSM	men who have sex with men
MYE	mid-year estimates
NCD	non-communicable disease
NCR	National Cancer Registry
NHI	National Health Insurance
NICD	National Institute for Communicable Diseases
NMHPFSP	National Mental Health Policy Framework and Strategic Plan
NSP	National Strategic Plan
ODA	official development assistance
PCV	pneumococcal conjugate vaccine
PERSAL	Personnel and Salary System
PHC	primary health care

Abbreviation	description
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
PTSD	post-traumatic stress disorder
PWID	people who inject drugs
RTMC	Road Traffic Management Corporation
SA	South Africa
SABSSM	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey
SACENDU	South African Community Epidemiology Network on Drug Use
SADAG	South African Depression and Anxiety Group
SAFMH	South African Federation for Mental Health
SANAC	South African National AIDS Council
SANHANES	South African National Health and Nutrition Examination Survey
SAPRIN	South African Population Research Infrastructure Network
SDGs	Sustainable Development Goals
SGBV	sexual and gender-based violence
STI	sexually transmitted infection
SUN	Scaling Up Nutrition
TB	tuberculosis
TG	trans-gender
ToP	termination of pregnancy
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WHO	World Health Organization
XDR-TB	extensively drug-resistant tuberculosis

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