RITSHIDZE

SAVING OUR LIVES

EASTERN CAPE STATE OF HEALTH

How the PEPFAR disruptions have impacted public health services

OCTOBER 2025

5TH EDITION



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TRIGGER WARNING

This report contains testimonies from community members of the challenges they have faced while trying to use the public healthcare system, including prejudice, discrimination, and abuse for some people living with HIV, people who use drugs, sex workers, and LGBTQIA+ community members. These stories are upsetting.

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ABOUT THE DATA



This is the 5th edition of the Eastern Cape State of Health report, developed using Ritshidze data.

Data collection periods and locations

Facility level data: Collected between April 2025 and June 2025 at 40 public health facilities in two districts: Buffalo City (20 sites) and OR Tambo (20 sites) (Appendix 1). Surveys were carried out with 40 Facility Managers, 2,107 public healthcare users, and 1,150 people living with HIV.

Key Population service data: Data regarding the quality of services for people who use drugs, sex workers, and queer and trans people was collected in the community between July 2024 and September 2024 in four districts: Amathole, Buffalo City, Nelson Mandela Bay, and OR Tambo. A total of 3,149 surveys were carried out in the province including 2,196 people using public health facilities: 542 gay, bisexual, and other men who have sex with men (GBMSM), 834 people who use drugs, 605 sex workers, and 215 trans people (Appendix 2). Others were using drop-in centres or mobile services provided by NGOs, private doctors, or had stopped getting health services altogether. The focus for this report is on the quality of services at public health facilities. This has been expanded upon with data from in-depth interviews carried out in July and August 2025.

Data comparisons

Data in this report are compared to data in prior reporting periods. Changes in the number of clinics being assessed and the overall number of survey participants – as well as the removal of sites in Alfred Nzo and Chris Hani previously monitored – cautions against over-interpretation of the direct comparison to prior quarter results. All data are available at: http://data.ritshidze.org.za/.



4TH EDITION
September 2024



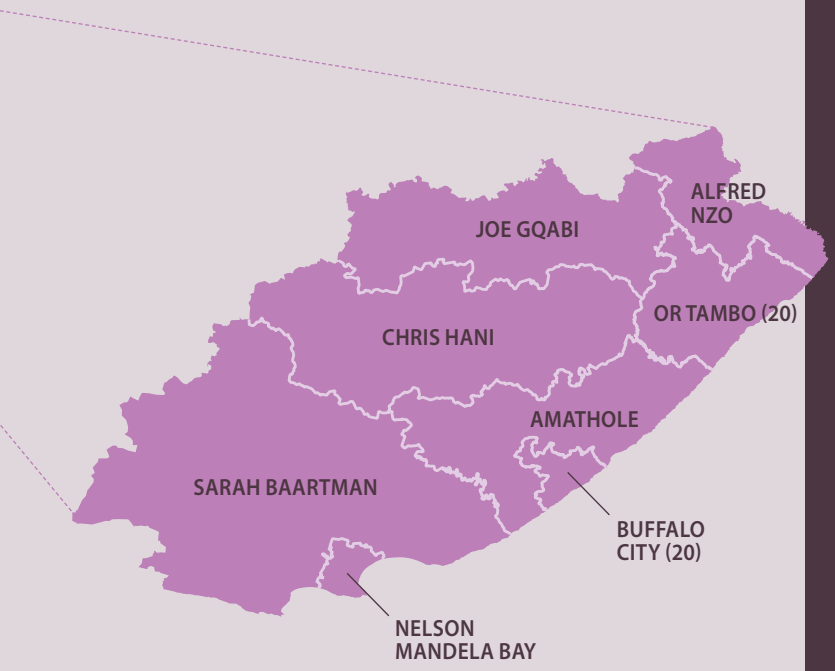
3RD EDITION
September 2023



2ND EDITION
October 2022



1ST EDITION
September 2021



Limitations of the Ritshidze data

Ritshidze is not a research project. We are not testing hypotheses. Community-led monitoring is more akin to independent monitoring, evaluation, and advocacy than research. Limitations of the Ritshidze data include:

+ **Generalisability** – Results are from the facilities monitored and may not be generalisable to other facilities in the district, province, or country.
+ **Facility heterogeneity** – Facility results, even at the district level, are heterogeneous. Challenges and successes should be approached as facility-specific unless they consistently identify poor performance and policy level issues.
+ **A non-representative sampling of public healthcare users** – Public healthcare users identified and surveyed at the facility are not necessarily representative of all individuals in the catchment area of the health facility. For example, the sample excludes by definition those who may have stopped accessing services at a facility. To address this, further qualitative data is collected in the community to capture the experiences of people who may not currently be in care.

WHO IS RITSHIDZE?

Ritshidze is a community-led monitoring (CLM) system implemented by the Treatment Action Campaign (TAC). Through Ritshidze, community members systematically collect data at clinics and in the community that are analysed, and then used to generate solutions to problems that are put to duty bearers for action. Community-led monitoring is an indispensable strategy for improving the state of our public healthcare system, and getting more people on ARVs.

How does Ritshidze collect data?

Ritshidze collects both quantitative and qualitative data through observations, as well as through the implementation of standardised surveys and in depth interviews with healthcare users (public healthcare users, people living with HIV, members of key populations) and healthcare providers (Facility Managers, pharmacists/ pharmacist assistants). All Ritshidze's data collection tools, our data dashboard, and all raw data are available through our website.

What changes have been made in where Ritshidze collects data following the PEPFAR disruptions?

Prior to the end of January 2025, Ritshidze data was collected across sites in four PEPFAR priority districts in the Eastern Cape: Alfred Nzo, Buffalo City, Chris Hani, and OR Tambo. Following cuts in funding, Ritshidze monitoring has continued in Buffalo City and OR Tambo only. PEPFAR implementing partners are still active in both districts. Ritshidze data will be able to document any changes in the quality of service provision following the PEPFAR disruptions.

What changes were made to data collection to determine the impact of PEPFAR funding cuts on HIV services?

A new tool was developed in this reporting period to survey patients as they exit the clinic. This was to gather evidence to the state of service provision that day – to better understand the impact of the PEPFAR disruptions on clinics.

INTRODUCTION

> ***"Sometimes I don't even want to go to the clinic because of the long waiting hours and other difficulties we face. We arrive early in the morning. Even when it's still dark, just to queue. And we end up leaving very late. That's one of the reasons people stop using the clinics".***

Long waiting times continue to frustrate public healthcare users who waste long hours in queues for check-ups, and even just to collect medication. *"On my last visit, I waited for close to seven hours,"* one public healthcare user told us. The Eastern Cape had the second longest waiting times out of all six provinces monitored by Ritshidze.

48% of people said the waiting times at the facility are long. This rose to 73% in Buffalo City. One person living with HIV explained: *"when you have a clinic appointment, you have to tell yourself that you're going to spend your whole day at the facility. It's very painful. Sometimes I tell myself that I am not going because of all the challenges".* While PEPFAR support is still active in both districts we are monitoring in the province, 24% of people said that waiting times were longer than usual after the PEPFAR disruptions (34% in Buffalo City).

While 76% of people blamed staff shortages, 25% blamed staff not working or working slowly. As one person described: *"there are enough nurses.. but they don't work effectively. They spend time talking.. instead of assisting patients.. Some even go shopping while we are there, hungry and without money for food".* Waiting times cannot be ignored as the Department of Health aims to get 1.1 million more people on (or back on) HIV treatment by the end of 2025.

Long waiting times are among a number of issues outlined in the 5th edition of the Ritshidze State of Health report for the Eastern Cape. Between April and June 2025, the Treatment Action Campaign (TAC) through Ritshidze carried out 4,215 surveys with public healthcare users, and spoke to facility staff to assess 40 facilities in 2 districts in the Eastern Cape. The data reveal the challenges arising in our clinics following the PEPFAR disruptions earlier in the year.

Critical staff shortages continue to drive long waiting times. *"The main problem is the shortage of staff.. which is why we often end up waiting for long hours to be assisted… it is very frustrating,"* one person explained to us. In Buffalo City – where PEPFAR support was temporarily suspended but then re-instated – 80% of Facility Managers reported the PEPFAR partner working at reduced capacity, and 100% said there were not enough staff at their clinics. 28% of public healthcare users in the district agreed there were never enough staff, and 23% thought staff shortages had worsened since January 2025. One community member described how *"the nurses at the clinic are very slow… this is painful. I often leave the facility feeling frustrated because when I leave late, I still need to get a sick note to give to my employer, even though I arrived at the clinic early."*

Paper filing systems in disarray are another cause of the delays. While the condition of the filing systems has been improving in OR Tambo, this still needs attention with 25% still reported to be in a bad condition. In contrast, Buffalo City's filing systems are reported to be in a disastrous state with 80% reported to be in a bad condition – a worrying 43% increase from January 2025. *"We usually get our files quickly, but sometimes there are unexplained delays. You can queue and move along with the line, but when it's your turn, they keep looking for your file,"* one person explained. Buffalo City had the second most reports of filing systems being in a bad condition out of all districts monitored by Ritshidze.

Given that PEPFAR partners have often supported the maintenance of clinic filing systems and funded data capturers, it is sensible to think this is correlated with the PEPFAR implementing partner working at a reduced capacity, as reported by 80% of facilities in Buffalo City. One person living with HIV described how: *"our files often go missing. They will tell you that they can't find your file. Then you have to wait for them to create a temporary file, which also takes time"*. 36% of people surveyed said that the delays were longer after the PEPFAR disruptions because of filing systems being messier and files being lost. Only 14% of people said it took under 30 minutes to find their file in Buffalo City – 25% less than in January 2025 – while 29% said it took over an hour.

One easy solution to reduce congestion and overall delays is to get people out of the clinic who do not need ongoing clinical care. In January 2025, the Eastern Cape was among the provinces making the slowest progress in giving out longer ARV supplies – with Alfred Nzo only giving 39% of people surveyed a 3 month supply or longer. Positively, the facilities in the province surveyed by Ritshidze managed to increase the amount of people getting a 3 month supply or longer to 88%, becoming the best performing province monitored out of all six by Ritshidze. However due to funding cuts, Ritshidze was unable to monitor either Alfred Nzo or Chris Hani – and we do not know if these districts have improved or not.

Conversely, progress in decanting people to pick-up points in the community has deteriorated. One person living with HIV who has returned to the clinic described the ease at the pick-up point: *"I used to collect my treatment at Clicks, and that system was very helpful. You would get there, press "collect" on the machine, sit down, and then they'd call you to collect your treatment. The process was very quick"*. However, in this reporting period 57% of people surveyed in the Eastern Cape said they had to collect their ARVs at the facility after consultation and rescript with a clinician. The Eastern Cape was the worst performing province on this. OR Tambo performed worst out of all 16 districts monitored by Ritshidze, with 25% fewer people using external pick-up points after the PEPFAR disruptions. This while 65% of people said they would like to collect ARVs closer to their home if it were possible.

One-stop facility pick-up points continued to operate inefficiently in the Eastern Cape, requiring 42% of people living with HIV surveyed in the province to go to other service points before collecting their parcel. *"There is no sense of urgency… when you go to collect your treatment, you will still leave at 4pm when they are about to close. Ideally, your treatment should already be packed so you can just collect it and leave,"* one person living with HIV told us.

While it should take less than 30 minutes to collect your parcel, only 48% of people said it did, down from 77% in January 2025. 15% of people surveyed in OR Tambo and 29% of people in Buffalo City said it took longer to collect their parcel than before the PEPFAR disruptions. One person living with HIV explained: *"we wait for long hours.. even if we are just here to collect treatment. There has never been a day at this facility when I could just collect my treatment and leave. This is frustrating because I have temporary jobs that I need to attend to as well"*. It is extremely inefficient to increase workload for staff at a time when staff shortages are a crisis.

Changing between clinics remains difficult in the Eastern Cape. 26 people told us they or someone they knew had been denied services without a transfer letter in the last 3 months, all in Buffalo City – something that is not required by national ART guidelines to start or restart your ARVs. On top of that 56 people told us they or someone they knew had been denied services without an ID – accounting for 19% of the 291 people who reported this across all six provinces monitored by Ritshidze. 18% of people who use drugs surveyed across the province had been denied access to services because they did not have an ID.

Members of key populations had also been refused access to health services. *"Some staff members at the clinic are very homophobic. When they see someone is part of the LGBTIQ community, they sometimes refuse to assist them,"* one member of the LGBTQIA+ community told us. 12% of gay, bisexual, and other men who have sex with men (GBMSM), 15% of trans people, 19% of people who use drugs, and 21% of sex workers we surveyed had been denied services in the last year, and 9% of people who use drugs had been denied their ARVs.

The report also finds that health workers continue to treat members of key populations poorly – let alone be sensitive to or knowledgeable of the health services they need. As one gay man explained: *"when I disclose that I'm gay or that I have sex with men to a healthcare worker, they sometimes shout or make inappropriate remarks, such as, "anal sex is painful; how do you do it?"*. Only 28% of trans people, 21% of GBMSM, 17% of sex workers, and 15% of people who use drugs surveyed thought staff were always friendly. People in the Eastern Cape reported some of the worst attitudes towards members of key populations out of all six provinces monitored by Ritshidze.

Another challenge in the report is an ingrained culture of punishing those who are late for appointments. One person living with HIV explained: *"If you've missed your appointment at the clinic, they don't help you at all. If you decide to stay, they might help you collect your treatment, but after seven hours, when everyone else has been assisted"*.

Health workers must recognise that people living with HIV might miss appointments and may even miss taking some pills. That is normal. When they return to the clinic they should be met with support and encouragement, not punishment. Yet in Buffalo City, 60% of those who had been late for/ missed appointments said staff shouted at them, and 22% were sent to the back of the queue. *"Some nurses shout at you if you've missed your appointment date. They even tell you they will assist you last, even if you were next in line. So you're forced to go to the back of the queue. This is very stressful, but I wait patiently because I need my ARVs,"* another person living with HIV told us. The guidelines specifically state that no punitive actions are allowed. Instead the majority of people re-engaging in care need it to be made easier to collect treatment. Yet of people surveyed across the province, 0% said staff asked how they could help make it easier in the future.

HIV prevention has also been impacted. Only 75% of sites monitored in OR Tambo had external condoms available – this is unacceptable as the provision of condoms is known to be the cheapest and most cost effective HIV prevention intervention. Only 48% of sites had lubricant available. One gay man living with HIV describes the pain in asking for lubricants: *"At the drop-in centre, we used to get lubricant freely. But at the facility, you have to ask because it is not displayed. This makes me feel ashamed. The last time I asked, the staff said.. they don't think they're meant for people like us. Since then, I've stopped asking for them"*.

51% of PrEP users said it took longer than usual to collect PrEP, and 5% had to return because of the queues. In OR Tambo less than half of facilities were even prioritising offering PrEP to members of key populations. PEP has been routinely denied to members of key populations – of those who tried to access PEP, only 56% of trans people, 34% of sex workers, and 19% of GBMSM said they were always able to get PEP in the last year. Further, sterile needles and syringes remain out of reach for people who inject drugs, with clinics either providing no information or referring people to private pharmacies to buy needles themselves, or to hospitals that do not provide them. Just 7% of people who use drugs said they were given any information about where to get these commodities.

43% of trans people wanted to access hormones at the facility in the last year – however hormonal care remains unavailable in primary health facilities. Following the closure of two PEPFAR funded drop-in centres for trans women in the Eastern Cape, this situation is only going to worsen.

What is clear is that government cannot get everyone on HIV treatment while denying people health services, or by making conditions intolerable. The failures in the health system are key reasons why people struggle to stay on ARVs, or access HIV prevention. Without making changes, the government will continue to lose people at unacceptable rates. This year's report continues to call for urgent action to improve health services – that have only deteriorated following the PEPFAR disruptions in the Eastern Cape.

KEY FINDINGS

Staffing

Since Ritshidze monitoring began, the Eastern Cape has repeatedly been the province where facilities report the worst staff shortages. This reporting period is no different. 93% of facilities said there are too few staff – including 100% of sites in Buffalo City. Most blamed unfilled vacancies, and not enough open positions on the organogram in the first place. But others blamed PEPFAR implementing partner staff working at a reduced capacity. While PEPFAR implementers are still active in both Buffalo City and OR Tambo, 80% of sites monitored in Buffalo City said they were working at a reduced capacity – only adding to the pressures on already overburdened staff. 23% of public healthcare users reported that staff shortages were worse in Buffalo City since the PEPFAR disruptions. Evidence on human resources shortages must be used to inform plans for use of the additional funds provided by Treasury.

Waiting Times

Long Waiting Times

The Eastern Cape had the second longest waiting times out of all provinces monitored by Ritshidze at 3:25 hours (after the Free State) – with Buffalo City at 3:40 hours. Long waiting times continue to frustrate public healthcare users who waste long hours in queues for check-ups and even just to collect medication. 48% of people said the waiting times at the facility are long – and 69% of those people blamed too few staff for the delays. 15% of people in OR Tambo and 34% in Buffalo City said waiting times were longer than usual in this reporting period. Waiting times cannot be ignored as the Department of Health aims to get 1.1 million more people on HIV treatment – including those who have disengaged because of conditions at the clinic.

Delays in Finding Files

While the condition of the filing systems has been improving in OR Tambo, this still needs attention with 25% still reported to be in a bad condition. In contrast, Buffalo City's filing systems are reported to be in a disastrous state with 80% reported to be in a bad condition. Buffalo City had the second most reports of filing systems being in a bad condition out of all districts monitored by Ritshidze. Messy and disorganised filing systems result in people waiting longer to receive their file – increasing overall waiting times. 33% of people surveyed across the province said the reason they thought waiting times were long was because of disorganised filing systems – and when leaving the facility that day, 36% of people surveyed said that the delays were longer compared to the end of January 2025 because of filing systems being messier and files being lost.

HIV Testing

No HIV testing means it is not possible to identify people who are living with HIV who need to start or restart treatment – or identify people for prevention services. Yet only 46% of people not on ART reported being offered HIV tests at a health facility visit in this reporting period. 35% of sites in Buffalo City reported that there were fewer staff to provide HIV testing following the PEPFAR disruptions – the majority of which correlate with the sites reporting that the PEPFAR implementing partner is working at a reduced capacity. Missing an easy opportunity to test people who are coming to our health facilities either sick, with an STI, or for either family planning or ante/post-natal services which may indicate unprotected sex.

ART Collection

6MMD

In the Eastern Cape there has been very limited implementation of 6 month supply (6MMD) despite Minister of Health commitments to the Treatment Action Campaign (TAC), and the Director-General's circular requiring urgent implementation in February 2025. Recent plans to start implementing on 1 August 2025 in only 10 facilities in the province from now until end March 2026 is inequitable and far too slow. Phase 1 and 2 implementation from now until end March 2026 must include a minimum of 50% of all Eastern Cape facilities – with full roll out during the last phase.

3MMD

In January 2025, the Eastern Cape was among the provinces making the slowest progress on 3MMD – with 71% of people getting a 3 month supply or longer of ARVs. Below the 90% we would expect to see by now. This was largely driven by very poor implementation in Alfred Nzo with only 39% of people living with HIV surveyed reporting getting a 3 month or longer supply. The Eastern Cape improved overall in this reporting period to 88% with OR Tambo making the biggest improvement. However due to funding cuts, Ritshidze was unable to monitor either Alfred Nzo or Chris Hani – who were previously among the worst performing of all districts monitored by Ritshidze in January 2025. We do not know if these districts have improved or not. The Provincial Department of Health must urgently ensure that the progress seen in Buffalo City and OR Tambo is mirrored in all districts across the province.

Pick-Up Points: 57% of people still collect from the facility after consultation and rescript with a clinician – including 43% in Buffalo City and 68% in OR Tambo. In OR Tambo, 25% fewer people reported using external pick-up points, while 11% more people reported using facility pick-up points, and 14% more people reported collecting through standard medicine

dispensing. The Eastern Cape was the worst performing province at decanting people living with HIV to pick-up points to make ARV collection easier – and OR Tambo the worst performing district. In OR Tambo, 65% of all people living with HIV surveyed said that they would like to collect ARVs closer to their home if it were possible – the third highest proportion of reports across all districts monitored by Ritshidze.

Delays in Pick-Up Points

One-stop facility pick-up points continued to operate inefficiently, requiring 42% of people living with HIV to go to other service points before collecting their parcel. While it should take less than 30 minutes to collect your parcel, only 48% of people said it did, down from 77% in January 2025. 15% of people surveyed in OR Tambo and 29% of people in Buffalo City said it took longer to collect their parcel than before the PEPFAR disruptions. It is extremely inefficient to increase workload for staff at a time when staff shortages are a crisis. Resolving such inefficiencies require urgent focused facility management.

Parcels Sent Back Before Mandated 28 Days

There is an unnecessary increased burden for people and the health system by parcels at pick-up points not being available for collection for the mandated 28 days. 83% of facilities in the province said that parcels only wait for 0-7 days, and 8% more for 8-14 days. These people all unnecessarily then need to return to the facilities and see clinicians to get new prescriptions, adding to the burden on people living with HIV and facilities.

Compassionate Care and Support

General Patients

Clinic staff being unfriendly is a common reason for people disengaging from care or interrupting treatment. While people reporting that staff are always friendly has improved from 58% in January 2025 to 67% in the Eastern Cape in this reporting period – this varied considerably across districts. While 82% of people reported staff were always friendly in OR Tambo, only 51% did in Buffalo City. Further in January 2025 only 57% did in Chris Hani and just 39% in Alfred Nzo. Given monitoring is no longer taking place in these two districts, Ritshidze cannot know if any improvement has taken place in these districts. The Provincial Department of Health should take steps to ensure staff friendliness in all facilities across the province. Without addressing this – including ensuring adequate staffing and longer ARV refills (3MMD to 6MMD) to reduce the stress for those working in facilities – the government will continue to lose people from care at unacceptable rates and will never create the welcoming, safe and non-judgemental environment needed to encourage people back into care who have interrupted treatment.

People Living with HIV Re-engaging In Care

Healthcare workers must expect treatment interruptions – it is normal! To support long term retention people re-engaging should be supported, not punished. Yet after being late for an appointment only a handful of people said staff asked how they could help make it easier in the future, and no-one said staff offered them a longer ART refill, or that staff told them about pick-up points to make ARV collection easier. The majority of people re-engaging in care need it to be made easier to collect treatment – this is a key element of the differentiated service approach in the ART guidelines. Conversely people did experience punitive actions by staff, mostly in Buffalo City where 60% said staff shouted at them on return – Buffalo City accounted for 16% of the 392 people who reported being shouted at across all districts monitored by Ritshidze. 22% said they were sent to the back of the queue to wait until all other patients had been seen first as punishment – accounting for 33% of the 579 people who reported being made to wait across all districts monitored by Ritshidze. The guidelines also specifically state that no punitive actions are allowed.

Challenges with Transferring Between Clinic

It is imperative people can move between health facilities without barriers that can cause prolonged treatment interruptions. Yet 26 people reported having been denied services because they did not have a transfer letter in the last 3 months in the Eastern Cape – all in Buffalo City. This accounts for 26% of all reports across all districts monitored by Ritshidze. Transfer letters are not mandatory and people transferring without such documents should be immediately formally transferred and provided with a full supply of ART. However some sites said they provide only a buffer stock of ARVs until transfer documentation is collected, often from health facilities far away. People who are unable to collect these transfer documents, are very likely not to return and stop treatment.

Poor Treatment of People who Use Drugs, Sex Workers, and the LGBTQIA+ Community

Only 28% of trans people surveyed reported that facility staff were always friendly, 21% of GBMSM, 17% of sex workers, and 15% of people who use drugs – compared to 63% of public healthcare users in the same reporting period. People in the Eastern Cape reported some of the worst attitudes towards members of key populations across all provinces monitored by Ritshidze. Further 12% of GBMSM, 15% of trans people, 19% of people who use drugs, and 21% of sex workers surveyed in the Eastern Cape had been denied services in the last year, and 9% of people who use drugs had been denied their ARVs. To address unfriendliness, lack of confidentiality, and routine denial of services, Centres of Excellence (CoEs) need additional staffing to instil culture change within the facility. At least 2 CoEs per district per population group must be established.

Identity Documents/Migrants

Section 27 of the South African Constitution affords everyone the right to have access to health care services, yet 56 people told us they or someone they knew had been denied services without an ID – accounting for 19% of the 291 people who reported this across all provinces monitored by Ritshidze. Further 18% of people who use drugs surveyed across the province had been denied access to services because they did not have an ID including 25% in OR Tambo, and 35% in Nelson Mandela Bay.

Clinical ART Managament Services

Viral load

Most facilities reported that viral load testing services have not been affected by the PEPFAR disruptions – and 95% of people living with HIV reported a healthcare worker explaining the results of their viral load test to them. This correlates with overall treatment literacy levels in the province.

Routine Clinical Consultations

8% of sites in the Eastern Cape reported there were fewer staff to conduct routine clinical consultations since January 2025 and 3% of sites said there were no staff.

Calling a Person Back to the Facility Early to Manage an Abnormal Test Result

All sites reported challenges with recalling people with elevated viral loads or other abnormal blood results – with 95% of sites blaming people providing incorrect phone numbers. Facility management must assess the specific drivers of an ineffective recall system in their facility and implement interventions to improve effectiveness urgently.

Psychosocial Support

Awareness of psychosocial support services remains high among people living with HIV at 94%, however the package of psychosocial services remains inadequate. While 98% of people in OR Tambo reported that individualised counselling was available for any person living with HIV – only 45% in Buffalo City did. This points to the PEFPAR disruptions in Buffalo City reducing the number of counsellors available for critical HIV testing and adherence counselling. Other elements of psychosocial support remain unavailable – 0% of people reported being able to access food parcels.

Advanced HIV (AHD)

55% of facilities said they needed support to monitor people with advanced HIV for the first three months after diagnosis.

HIV Prevention

Condoms and Lubricant

Only 88% of sites had external condoms available (only 75% in OR Tambo) and only 63% had internal condoms. 12% of facilities (25% in OR Tambo) not providing external condoms is unacceptable as the provision of condoms is known to be the cheapest and most cost effective HIV prevention intervention. Only 48% of sites had lubricant available – with most failing to put this in private areas of the clinic where people can take it without feeling uncomfortable. These commodities are the basics of the HIV response and should be easily available to take without question or judgement at all sites.

PrEP

While only 11% of sites reported challenges with PrEP services following the PEPFAR disruptions – of PrEP users surveyed, 51% said it took longer than usual to collect PrEP, and 5% had to return because of the queues. Fast track systems are urgently required to reduce workload on overstretched staff and ensure people do not discontinue PrEP. Unnecessary discontinuations put people vulnerable to HIV acquisition at risk, and waste intensive work done to find, test, and start people benefitting from PrEP.

PEP

PEP is a critical minimum package HIV prevention tool. Yet awareness of PEP is low in the Eastern Cape among members of key populations. Further it has been routinely denied to people – only 56% of trans people, 34% of sex workers, and 19% of GBMSM said they were always able to get PEP in the last year. Knowledge of PEP and easily accessible PEP in communities must be prioritised.

Needles and Syringes

47% of facilities said they provide information about needle safety and where to get sterile needles – 80% in Buffalo City, and 11% in OR Tambo. However only 7% of people who use drugs surveyed in 2024 were actually given information on where to get sterile needles from. This was not surveyed in 2025 yet, but is unlikely to have improved.

Opioid Substitution Therapy (OST)

Only 16% of people were given information about where they could get methadone from clinic staff. The 21% of sites that said they refer people, referred them to hospitals – where methadone is only available for withdrawal management on a short term basis – or to buy methadone themselves at a pharmacy or go to private rehabs – putting it out of reach of most people with little or no income. Ultimately,



even clinics that do want to provide information and care have nowhere to refer people onwards. National guidelines and policies must be amended to ensure that OST is made available in clinics, starting with the Centres of Excellence.

Other Important Services

Naloxone for Opioid Overdose Reversal

Only 20% of people who use drugs had heard of naloxone to reverse overdoses – despite being a life saving treatment it remains nurse initiated and unavailable in the community where it is most needed.

Psychosocial Support for People who Use Drugs

Only 22% of people who use drugs were able to get psychosocial support. Most sites did not know where to refer people.

Hepatitis C (HCV) Services

HCV prevalence is estimated to be at 83% among people who inject drugs in South Africa – yet only 10% of people who use drugs even knew what hepatitis C was. Only 3% said a healthcare worker in the public health system had talked to them about screening – and only 3% surveyed had been screened.

Gender Affirming Care for Trans and Gender Diverse People

43% of trans people wanted to access hormones at the facility in the last year – yet hormonal care is not available in primary health facilities currently. While 30% of sites said they provide trans people with information on hormonal care – 44% of trans people we surveyed were confronted with a staff member that did not know anything about hormones or where to get them. Following the closure of two PEPFAR funded drop-in centres for trans women in the Eastern Cape, this situation is only going to worsen. A change in national policy is critical to ensure that hormones could be prescribed by doctors at primary level, just like they are by private GPs. This would expand access to many more trans and gender diverse people in need.

Services for Cisgender Men

64% of sites in the district did not have any interventions for cisgender men to improve uptake of services – despite being shown to improve uptake of services. 54% of sites reported these service delivery models stopping after the PEPFAR disruptions.

RECOMMENDATIONS

Staffing

Having enough committed and qualified staff in place remains integral to ensuring that all people living with HIV, members of key populations, and other public healthcare users can access friendly, welcoming, and quality services.

Evidence on human resources shortages must be used to inform plans for use of the additional funds provided by Treasury. Counsellors are critical and must be prioritised. In addition, Centres of Excellence (COEs) for members of key populations need additional staffing so that they can function effectively and to support and instil culture change within the facility.

National Department of Health

Provincial Department of Health

Waiting times

The knock on effect of the staffing crisis, unnecessarily frequent clinic appointments or medicine collections, and reduction of community-based key population services, is that people wait for longer to receive services or receive a reduced quality of services. Waiting times cannot be ignored as the Department of Health aims to get 1.1 million more people on HIV treatment – including those who have disengaged because of conditions at the clinic.

The Department of Health should urgently intervene in the Eastern Cape where waiting times – the second longest out of all provinces monitored by Ritshidze – continue to frustrate public healthcare users. Further an urgent strategy to improve the disastrous state of filing systems in Buffalo City must be implemented. Substantial numbers of people reported waiting times increasing due to messy and disorganised filing systems, and files going missing.

The Department of Health should maximise strategies such as decanting clinically stable people to pick-up points and facility provided 6 month supply (6MMD), with everyone else who is not sick getting 3MMD, maintaining organised filing systems, and using appointment times to space out appointments throughout the day to ease congestion at clinics.

Provincial Department of Health

District Department of Health

HIV Testing

The Department of Health must recognise that reductions in HIV testing are a crisis. This is not only community-based testing, but even missing offering HIV testing to people coming to our facilities! The Department of Health must recognise that HIV testing is the door to HIV treatment and prevention services. Without HIV testing, people living with HIV not diagnosed or linked to treatment will not be able to access treatment, nor will people who need PEP/PrEP be able to be offered these prevention services. **Counsellors at public health facilities are essential to ensure HIV testing is offered and provided at facilities. All facilities must offer every person who comes to a health facility an HIV test if they have not tested in the last year.**

Provincial Department of Health

District Department of Health

ART Collection

Multi-month dispensing

In line with the Minister of Health commitments to the Treatment Action Campaign (TAC), and the Director-General's circular requiring urgent implementation in February 2025 – **all provinces must urgently start rolling out 6MMD. Rollout must meet the 30% commitment made by the Minister of Health – estimated to be at least 750,000 people by the end of March 2026 (a 9 month extension on commitment made) – with a minimum of 50% of facilities in the province in the first two phases, with full roll out during the last phase.**

At the same time, all public health facilities must immediately adhere to National ART Guidelines and ensure everyone who is not sick is getting a 3 month supply of ARVs. This includes all stable people living with HIV – whether collecting ARVs from the clinic, or at a facility or external pick-up point, or adherence club. As well as all other people living with HIV who have been on ART for 4 months who struggle to come to the clinic more regularly, including people: re-engaging in care, those travelling, postnatally, those with an elevated viral load after a session of adherence counselling, and children under 5 years old.

The Department of Health must investigate progress on provision of 3MMD in all districts across the Eastern Cape. This is to ensure that progress seen in Buffalo City and OR Tambo is mirrored in

National Department of Health (6MMD)

Provincial Department of Health (6MMD, 3MMD)

District Department of Health (3MMD)

all districts, especially in Alfred Nzo, the district that was falling far behind when last monitored.

District Departments of Health must better support stock management to ensure that there are enough ARVs at clinics to give out a 3 month supply to everyone, and a 6 month supply to those eligible.

Pick-Up Points

As the worst performing province in decanting people to pick-up points, the Department of Health must investigate why people are not being offered pick-up point options in the Eastern Cape, especially Buffalo City.

There needs to be enough pick-up points to decant people into – especially linked to peri-urban and rural clinics. **A diversity of external pick-up point providers is needed beyond private pharmacy networks largely only available in urban areas, and beyond services provided by PEPFAR partners that have been disrupted in multiple districts. To service rural areas – small CBOs, traditional houses, and early childhood development centres should be considered with a viable CCMDD funding model as service providers for small numbers of people living with HIV.**

The Department of Health should urgently investigate why parcel collection times have increased across the Eastern Cape since January 2025, both in Buffalo City and OR Tambo.

Facility pick-up points are meant to act as a one-stop very quick ART collection only allowing people living with HIV to easily and quickly collect their pills. **National ART guidelines say this should take less than 30 minutes. Facility pick-up point users must not be sent to the registry, to collect folders, to take vitals, or to see a clinician. It is extremely inefficient to increase workload for staff at a time where staff shortages are a crisis. Resolving such inefficiencies require urgent focused facility management.**

National Department of Health

National Treasury

Provincial Department of Health

District Department of Health

Parcels Sent Back Before Mandated 28 Days

Parcels must wait for 28 days before being returned to the facility. Returning parcels before this creates an unnecessary increased burden for people and the health system by parcels at pick-up points not being available for collection for the mandated 28 days. These people all then need to return unnecessarily to facilities and see clinicians to get new prescriptions, adding to the burden on people living with HIV, and therefore increasing treatment interruptions and disengagements. It also adds to the burden on facilities, and this unplanned treatment supply from facility pharmacies also increases stockout risks.

Provincial Department of Health

District Department of Health

12 Month Scripts

The Minister of Health together with the South African Health Products Regulatory Authority (SAHPRA) must enable 12 month prescriptions for stable people living with HIV and/or controlled non-communicable diseases (NCDs). This will be key to further reduce the burden of unnecessary visits to clinics and will also be critical to retain the benefit of pick-up points as 6 month supply is rolled out. Allowing stable people living with HIV to receive a 12 month script will ensure they visit the clinic just once annually for rescript and viral load testing, and collect either 3 or 6 month parcels at a pick-up point. This can be done by:

+ **Based on funding disruptions, issuing an emergency exemption from 6-month scripting** as was done during the Covid-19 pandemic. During this period evidence shows that viral load suppression was equivalent to 6 month scripting.
+ **In parallel, accelerating an amendment to the Medicines Act to enable 12 month prescriptions longer term.**

Minister of Health

South African Health Products Regulatory Authority (SAHPRA)

Compassionate Care

The Department of Health must ensure staff friendliness in all facilities across the province. Measures should be taken to ensure sufficient staffing and vacancies to be filled, to reduce the burden on staff. Further measures to reduce stress should be maximised such as providing a 6 month supply of ARVs, resolving inefficiencies around facility pick-up points, and decanting people to external pick-up points. Without addressing this the government will continue to lose people from care at unacceptable rates and will never create the welcoming, safe and non-judgemental environment needed to encourage people back into care who have interrupted treatment. **The Department of Health should urgently investigate the particularly poor staff attitudes reported in Buffalo City.**

Provincial Department of Health

District Department of Health

People living with HIV re-engaging	
Treatment interruptions must be expected and normalised, without penalty. People who have come back despite being late or missing an appointment have made it easier for the health system – it is not necessary to track and trace them and encourage them back into care. To support long term retention people re-engaging should be supported, not punished. **The majority of people re-engaging in care need it to be made easier to collect treatment less frequently to help solve their challenges – they should be provided with a 3 month supply on the day of return and assessed for (re)enrollment in pick-up points as quickly as possible. This is a key element of the differentiated service approach in the ART guidelines. The guidelines also specifically state that no punitive actions are allowed. The Department of Health should investigate the high number of reports of punitive action in Buffalo City especially. The Department of Health must ensure that all facilities adhere to the guidelines with fidelity.**	Provincial Department of Health District Department of Health
Challenges with Transferring Between Clinics	
Transfer letters are not required by ART guidelines to start or restart your ARVs. Providing a buffer stock is also not good enough – it simply means more unnecessary trips back to the clinic for the person transferring, and a higher likelihood of the person interrupting treatment or disengaging from care. **The Guidelines on managing clinic transfers must be immediately re-iterated and implemented at all health facilities: continuing a person's ARV treatment on the day of arrival without short supply or requiring anyone to collect transfer documentation before or after being enrolled in the new clinic. The Department of Health should investigate the high number of reports of people being denied services without a transfer letter in Buffalo City especially.**	Provincial Department of Health District Department of Health
Poor Treatment of People who Use Drugs, Sex Workers, and the LGBTQIA+ Community	
A culture change needs to be instilled to address unfriendliness, violations of confidentiality, and routine denial of services towards people who use drugs, sex workers, and the LGBTQIA+ community. **Facilities must offer friendly, welcoming, and confidential services to ensure members of key populations feel safe and comfortable to access health services in public health facilities.** **People who use drugs, sex workers, and the LGBTQIA+ community should never be denied access to health services, including ARVs.** **All facility staff (including clinical staff, non-clinical staff, lay staff, and security guards) who ill treat people, violate people's privacy, verbally or physically abuse or harass people, or deny people services including life saving ARVs must be held accountable and face consequences.** In addition, **all facilities must provide gender affirming services for trans and gender diverse people including using trans people's correct name and pronouns; allowing trans people to use their preferred bathroom and/or providing a gender neutral toilet; and removing coloured folders that mark people's (perceived) gender.** Ritshidze receives countless reports of people who use drugs being denied health services because they have not had access to ablution facilities. No-one should ever be turned away for this. **Facilities should assess how they can provide people with a form of private ablution facilities on site, even at a basic level, especially at Centres of Excellence (CoEs).**	National Department of Health Provincial Department of Health District Department of Health
Identity Documents/Migrants	
Section 27 of the South African Constitution affords everyone the right to have access to health care services, including reproductive services – including migrants, stateless persons and transient populations. Further, in 2023 the Gauteng High Court upheld the right of all pregnant and lactating women, and children under 6, irrespective of nationality and documentation status, to access free health services at all public health establishments, including hospitals. Migrants, asylum seekers, stateless people, and **people without identity documents or proof of address should not be denied health services. The Department of Health should investigate the high number of reports of people being denied services without an identity document across multiple districts in the Eastern Cape.**	National Department of Health Provincial Department of Health District Department of Health

Clinical ART Management Services

Viral load

Viral load testing services are a critical component of the HIV response. **The Department of Health must ensure that viral load testing is maintained following the PEPFAR disruptions.**

In addition, all facilities must explain the results of people's viral load tests and help them understand the importance of taking treatment effectively.

Provincial Department of Health

District Department of Health

Routine Clinical Consultations

The Department of Health must ensure that routine clinical consultations are adequately maintained following the PEPFAR disruptions.

Provincial Department of Health

District Department of Health

Calling a Person Back to the Facility Early to Manage an Abnormal Test Result

Facility management must assess the specific drivers of an ineffective recall system in their facility and implement interventions to improve effectiveness urgently. People with abnormal test results need to be recalled to ensure they do not become sick or get worse. Differentiated care means actioning people who require more clinical attention instead of wasting time on people who are stable on treatment and doing well.

Clinics must regularly and clearly inform people about the reason for providing a phone number that works and update their phone numbers at every visit. By better informing people so they understand the importance of providing a functional phone number through health talks, posters, and direct engagement, and ensuring people know that no private information will be disclosed over the phone, people will be much more likely to provide correct numbers in the first place and update them as they change.

Provincial Department of Health

District Department of Health

Psychosocial Support

Psychosocial support services are a critical component of the HIV response. **The Department of Health must ensure that psychosocial support services are maintained following the PEPFAR disruptions. Further, the Department of Health must ensure that people are aware of what services are actually available and how to access them.**

Further, facilities must provide a full package of psychosocial support services including: individualised quality counselling at any time including before and after an HIV test, before ART initiation, at re-engagement or struggling with adherence, and for disclosure support; peer-led patient navigators acting as a bridge between clinicians and patients; referral to social workers, mental health services, and other services; optional support groups and adherence clubs linked to each facility; and food parcels.

The Department of Health must urgently investigate the limited reports of individualised counselling being available in Buffalo City.

Provincial Department of Health

District Department of Health

Advanced HIV (AHD):

National Advanced HIV (AHD) Guidelines must be finalised with a properly costed and funded budget. Training must be provided on these guidelines to clinicians in facilities with full implementation by no later than January 2026. Facilities must be supported to closely monitor and manage people with AHD for their first 3 months of treatment to reduce disengagements due to poor health and deaths during this critical time.

National Department of Health

HIV Prevention

Condoms & Lubricant

The provision of condoms is known to be the cheapest and most cost effective HIV prevention intervention. Additionally, lubricants must be made available at all sites as part of the HIV prevention package. **The Department of Health must urgently investigate and address the major gaps in provision of external condoms, internal condoms, and lubricants at sites in the Eastern Cape, especially OR Tambo. External condoms, internal condoms, and lubricants must be made available at all facilities in a range of spaces across the facility (including in the toilets, at the gate, in quiet areas out of sight) so people can freely and easily collect them without fear or judgement.**

Provincial Department of Health

District Department of Health

PrEP

Oral PrEP is a critical minimum package HIV prevention tool that must be available at all public health facilities. Fast track systems are urgently required to reduce workload on overstretched staff and ensure people do not discontinue PrEP. Unnecessary discontinuations put people vulnerable to HIV acquisition at risk, and waste intensive work done to find, test, and start people benefitting from PrEP. **The Department of Health must urgently investigate delays in PrEP collection as reported across sites monitored in the Eastern Cape.**

PrEP should be actively offered to members of key populations, pregnant and breastfeeding women, and adolescent girls and young women. People must be made aware of its benefits in order to make an informed decision about starting. Ensuring a safe environment is particularly important, so that people feel comfortable to disclose if they are a member of a key population and subsequently request or be offered PrEP services. **PrEP posters should be distributed and put up in all facilities informing people about PrEP, and information about PrEP provided in daily health talks.**

Provincial Department of Health

District Department of Health

PEP

PEP is a critical minimum package HIV prevention tool that must be available at all public health facilities. Anyone requesting PEP following a condom break, condomless sex, or sharing a needle should be provided with PEP without judgement. **PEP should urgently be made available through community service delivery models, especially for members of key populations.**

Provincial Department of Health

District Department of Health

Key Populations

Services specific to the needs of people who use drugs, sex workers, and LGBTQIA+ communities must be made available in public health facilities, beginning with the expansion of the Centres of Excellence (COE) model. **At least two COEs per district, per population group must be established (this means up to 8 sites per district). They must offer the clinical services, expertise, transport, and referral pathways that members of key populations need. The sites must not be exclusive to one population group, but are selected according to their geographic accessibility to the target population, and must have additional concentrated expertise, training, and recruitment strategies, based on the population group the site is most likely to be working with.**

A minimum package of services (as outlined in Appendix 3) must be made available at facilities serving as Centres of Excellence so that they can provide comprehensive health services to people who use drugs, sex workers, and LGBTQIA+ communities. Where people live too far away still to access services, resources (taxi fare, planned patient transport) must be made available so that people can actually get to them.

National Department of Health

Provincial Department of Health

Harm Reduction

The National Department of Health's guidelines and policies must be amended to allow for the roll out of harm reduction services at public health facilities in South Africa – including but not limited to provision of sterile needles/syringes, safe disposal of injecting equipment, methadone, naloxone, and psychosocial support. National Department of Health guidelines and policies should be amended to ensure that naloxone is not only nurse initiated but can be initiated by community members themselves.

National Department of Health

People who use drugs must be able to access these life saving harm reduction tools closer to where they stay – including in public health facilities and correctional service facilities. Harm reduction services must also be made available to sex workers and LGBTQIA+ community members who use drugs.

The Department of Health must urgently start providing sterile needles/syringes, safe disposal of injecting equipment, methadone, naloxone, and psychosocial support in public health facilities, beginning with the expansion of Centres of Excellence (COEs). The Department of Health should social contract this work to organisations competent in providing these services already.

Ritshidze, the South African Network of People Who Use Drugs (SANPUD), and TAC request an urgent meeting with relevant teams in the National Department of Health to discuss recommendations around harm reduction in more detail.

Other Important Services

Gender Affirming Care for Trans and Gender Diverse People

Clinicians must understand the health needs of trans and gender diverse people and be able to offer appropriate services e.g. appropriate sexual and reproductive health services, or cancer screening. These services must be provided in a caring, respectful, and compassionate manner.

National Department of Health

National Department of Health guidelines and policies must be amended to ensure that trans people are able to access hormonal care from doctors in public health facilities, just like they are by private GPs. At a minimum, all Centres of Excellence (CoEs) must be able to provide hormonal care and have access to medical support networks, mentorship, and tele-support to assist in consultations on the use of hormone therapy for trans people.

On 20 May 2024, Ritshidze, Gender Dynamix, and TAC requested a meeting with relevant teams in the National Department of Health to discuss recommendations around gender affirming care in more detail. To date this meeting has not taken place. We urgently request for the National Department of Health to provide a date for this meeting to take place.

Services for Cisgender Men

Men's Corners and other service delivery points for cisgender men must be maintained following the PEPFAR disruptions.

Provincial Department of Health

No trans women should be ever made to use service points for cisgender men. Forcing trans women to use spaces for cisgender men is not gender affirming care – it is reckless, dangerous, and unconstitutional.

District Department of Health



PRIORITY 1

STAFFING

KEY FINDINGS

Since Ritshidze monitoring began, the Eastern Cape has repeatedly been the province where facilities report the worst staff shortages. This reporting period is no different. 93% of facilities said there are too few staff – including 100% of sites in Buffalo City. Most blamed unfilled vacancies, and not enough open positions on the organogram in the first place. But others blamed PEPFAR implementing partner staff working at a reduced capacity. While PEPFAR implementers are still active in both Buffalo City and OR Tambo, 80% of sites monitored in Buffalo City said they were working at a reduced capacity – only adding to the pressures on already overburdened staff. 23% of public healthcare users reported that staff shortages were worse in Buffalo City since the PEPFAR disruptions. Evidence on human resources shortages must be used to inform plans for use of the additional funds provided by Treasury.

RECOMMENDATION

National Department of Health & Provincial Department of Health

Having enough committed and qualified staff in place remains integral to ensuring that all people living with HIV, members of key populations, and other public healthcare users can access friendly, welcoming, and quality services. **Evidence on human resources shortages must be used to inform plans for use of the additional funds provided by Treasury. Counsellors are critical and must be prioritised. In addition, Centres of Excellence (COEs) for members of key populations need additional staffing so that they can function effectively and to support and instil culture change within the facility.**

The shortage of healthcare workers in our clinics is a longstanding crisis. Ritshidze data has documented this for several years – both from the perspectives of people using the facility and staff members directly. Since Ritshidze monitoring began, the Eastern Cape has repeatedly been the province reporting the worst staff shortages. These shortages lead to longer waiting times and increased congestion, rushed clinical consultations, and increased pressure on the few staff in place. While PEPFAR implementers are still active in both Buffalo City and OR Tambo, 80% of sites monitored in Buffalo City (40% of sites monitored in the province overall) said that PEPFAR implementing partner staff were working at a reduced capacity (Figure 1, Figure 2) – only adding to these pressures.

Having enough committed and qualified staff in place remains integral to ensuring that all people living with HIV, members of key populations, and other public healthcare users can access friendly, welcoming, and quality services. Yet the reality is that a major gap still remains between the staffing needed to ensure high quality services and the staff present each day at site level.

> ***"The main problem** is the shortage of staff at Nobuhle Clinic. When I was there the pharmacist was absent, so the nurse assisting us had to keep leaving to dispense medicines at the pharmacy. Staff members are often absent, which is why we often end up waiting for long hours to be assisted. Nurses also work very slowly. Sometimes only one nurse will be productive. When you ask why, they'll say, "You can see that I'm the only one working, running up and down this facility." This is very frustrating"* – *a public healthcare user, Nobuhle Clinic, Buffalo City, August 2025*

Figure 1: Eastern Cape: Is the PEPFAR implementing partner working as usual? (April to May 2025)
Facility staff surveyed: 40



Figure 2: Buffalo City: Is the PEPFAR implementing partner working as usual? (April to May 2025)

Facility staff surveyed: 20

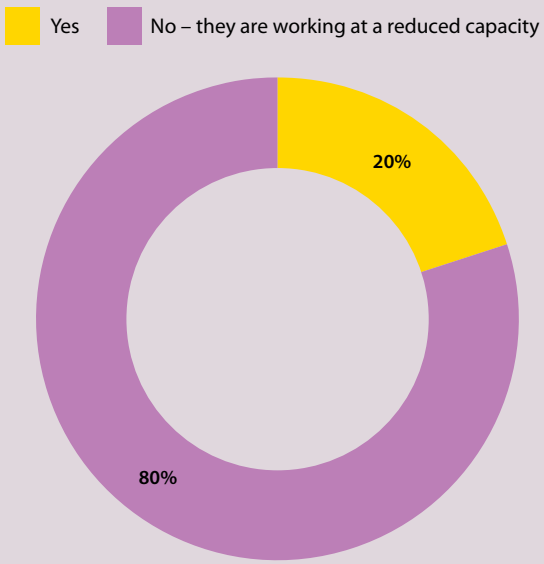
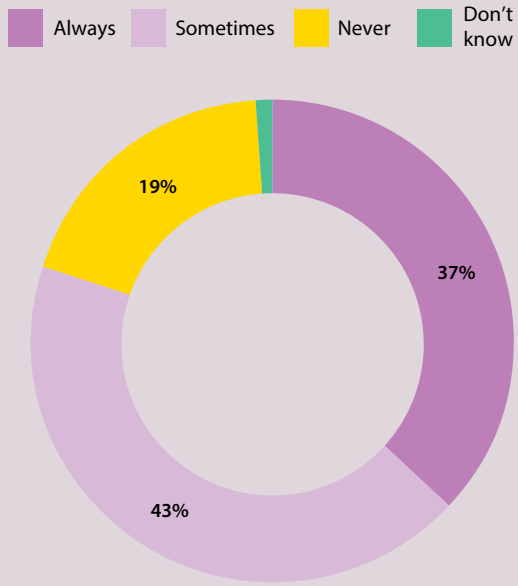


Figure 3: When you come to the facility are there enough staff to meet the needs of patients? (April to June 2025)

Patients surveyed: 2 105



On top of that, the improvement of services for members of key populations requires the addition of staff and expertise at key clinics that would become specialised sites of service delivery in every district – labelled as Centres of Excellence (CoEs). This is especially critical with the closure of some drop-in centres and disruption of PEPFAR services for members of key populations since January 2025 across the country. CoEs are public health facilities that are identified as places members of key populations can go to access services. Additional staffing is critical at these sites not only to provide the expertise and specialised clinical services required, but also to instill culture change and improve attitudes towards people who use drugs, sex workers, and the LGBTQIA+ community. The openly hostile treatment of members of key populations is prevalent and has been well documented in past Ritshidze reports, and later in this report.

PUBLIC HEALTHCARE USER PERSPECTIVE

Of 2,105 public healthcare users surveyed in the province, only 37% said there were always enough staff members, 43% said there were only sometimes enough staff, and 19% said there were never enough staff (Figure 3). Across districts 65% said there were always enough staff in OR Tambo, compared to just 9% in Buffalo City (Figure 4). Conversely, 11% said there were never enough staff in OR Tambo, compared to 28% in Buffalo City. A full site breakdown is available in appendix 4. 18% of people surveyed when leaving the facility in the province reported staff shortages were worse compared to before the end of January – 11% in OR Tambo and 23% in Buffalo City.

"The nurses at Ndende Clinic are very slow. The only nurse who works quickly is the one assisting sick patients. The others don't work efficiently. One nurse in particular is very slow. We wait for her, and while we are queuing, other people just enter the consultation room ahead of us. This is painful. I often leave the facility feeling frustrated because when I leave late, I still need to get a sick note to give to my employer, even though I arrived at the clinic early" *– a public healthcare user, Gompo A Ndende Clinic, Buffalo City, August 2025*

"Tshangana Clinic is failing the community at large. Many people complain of poor service. In fact, two people have passed away there. When the clinic was questioned about why they didn't attend to one of the patients who died, they responded that there were no nurses on duty. When help was called, nothing was done. The same staff members are still working there" *– a public healthcare user, Tshangana Clinic, Nelson Mandela Bay, August 2025*

Figure 4: When you come to the facility are there enough staff to meet the needs of patients? (April to June 2025)

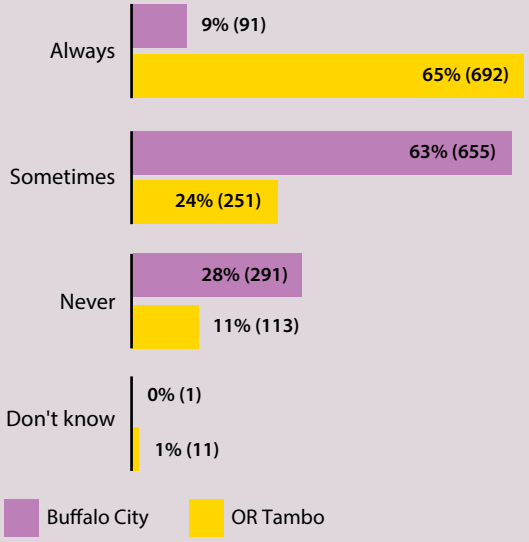
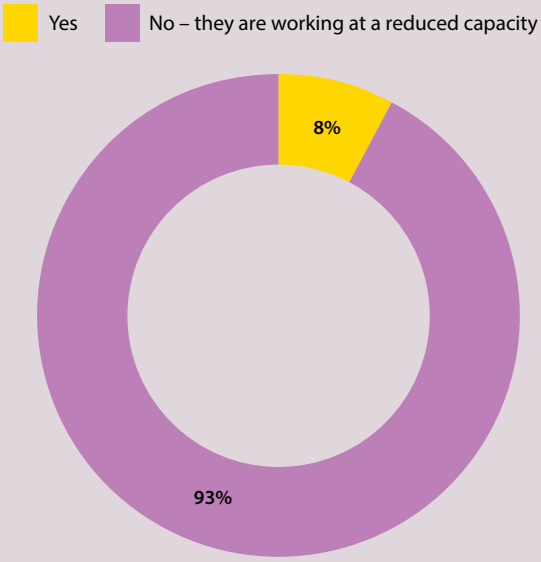


Figure 5: Facility Manager: does the facility have enough clinical and/or non-clinical staff? (April to June 2025)

Facility staff surveyed: 40

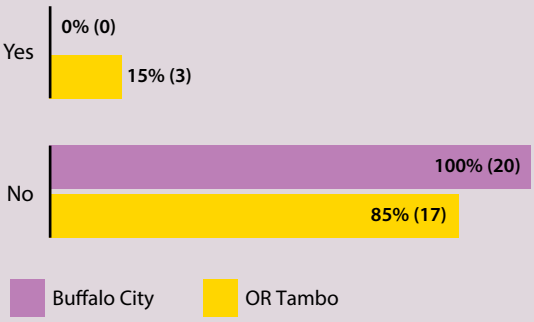


FACILITY PERSPECTIVE

Of 40 Facility Managers surveyed, 93% reported that there were not enough clinical and/or non-clinical staff in place (Figure 5) – 85% in OR Tambo, and 100% in Buffalo City (Figure 6). Facilities in the Eastern Cape had the highest proportion of reports of staff shortages out of all provinces monitored by Ritshidze, with Buffalo City performing worst out of all districts. 11% blamed the staff from the PEPFAR implementing partner no longer working or working at a reduced capacity at the facility – while 57% blamed existing unfilled vacancies and 22% blamed there not enough positions (Figure 7). Nursing cadres, pharmacist assistants, cleaners, general assistants, and data capturers were the most commonly understaffed (Figure 8). There were 144 vacancies across 28 facilities (Table 1). Nursing cadres and pharmacist assistants had the most unfilled vacant posts.

Of 40 Facility Managers, 28% did not think that staff had the resources and support to do their jobs well – 20% in OR Tambo, and 35% in Buffalo City. Common missing resources included medical equipment and tools, adequate human resources, IT and administrative equipment, phones, electricity, as well as adequate space in the facility to function effectively.

Figure 6: Facility Manager: does the facility have enough clinical and/or non-clinical staff? (April to June 2025)



***"I use NU 8 Clinic,** and nothing is going right there. They need to hire more staff. When you are at the clinic you wait for the longest time. You end up wanting to leave without getting help"* – *a public healthcare user, NU 8 Clinic, Nelson Mandela Bay, August 2025*



Figure 7: Facility Manager: Why do you think that there are not enough clinical and/or non-clinical staff (April to June 2025)

Facility staff surveyed: 37

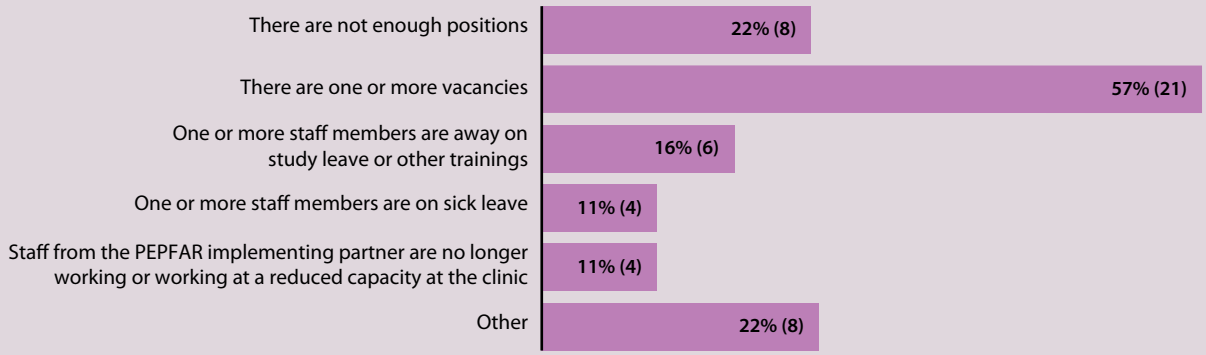


Figure 8: Which cadres are understaffed? (April to June 2025)

Facility staff surveyed: 37

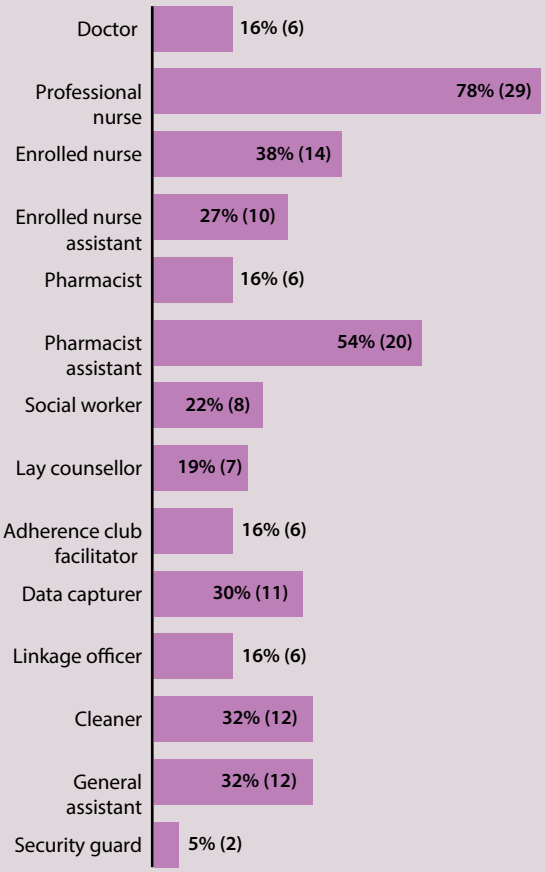


Table 1: Total number of vacancies per healthcare cadre (April to June 2025)

	Buffalo City	OR Tambo
Facilities assessed	16	12
Doctor	1	1
Professional nurse	38	15
Enrolled nurse	12	3
Enrolled nurse assistant	11	7
Pharmacist	-	1
Pharmacist assistant	15	3
Lay counsellor	7	6
Linkage officer	1	4
Data capturer	4	5
Cleaner	5	5
Total	94	50

The shortage of healthcare workers in our clinics is a longstanding crisis. Ritshidze data has documented this for several years – both from the perspectives of people using the facility and staff members directly.

PRIORITY 2

WAITING TIMES

KEY FINDINGS

The Eastern Cape had the second longest waiting times out of all provinces monitored by Ritshidze at 3:25 hours (after the Free State) – with Buffalo City at 3:40 hours. Long waiting times continue to frustrate public healthcare users who waste long hours in queues for check-ups and even just to collect medication. 48% of people said the waiting times at the facility are long – and 69% of those people blamed too few staff for the delays. 15% of people in OR Tambo and 34% in Buffalo City said waiting times were longer than usual in this reporting period. Waiting times cannot be ignored as the Department of Health aims to get 1.1 million more people on HIV treatment – including those who have disengaged because of conditions at the clinic.

RECOMMENDATION

Provincial Department of Health
District Department of Health

The knock on effect of the staffing crisis, unnecessarily frequent clinic appointments or medicine collections, and reduction of community-based key population services, is that people wait for longer to receive services or receive a reduced quality of services. Waiting times cannot be ignored as the Department of Health aims to get 1.1 million more people on HIV treatment – including those who have disengaged because of conditions at the clinic.

The Department of Health should urgently intervene in the Eastern Cape where waiting times – the second longest out of all provinces monitored by Ritshidze – continue to frustrate public healthcare users. Further an urgent strategy to improve the disastrous state of filing systems in Buffalo City must be implemented. Substantial numbers of people reported waiting times increasing due to messy and disorganised filing systems, and files going missing.

The Department of Health should maximise strategies such as decanting clinically stable people to pick-up points and facility provided 6 month supply (6MMD), with everyone else who is not sick getting 3MMD, maintaining organised filing systems, and using appointment times to space out appointments throughout the day to ease congestion at clinics.

The knock on effect of the staffing crisis, unnecessarily frequent clinic appointments or medicine collections, and reduction of community-based key population services, is that people wait for longer to receive services or receive a reduced quality of services.

For the Eastern Cape, the average waiting time across facilities monitored was 3:25 hours (Table 2). This compares to 2:28 hours in KwaZulu-Natal (the province with the shortest reported waiting times). The Eastern Cape had the second longest waiting times out of all provinces monitored by Ritshidze, after the Free State. There has been a slight improvement from an average of 3:38 hours in January 2025[1]. Across districts the average waiting time widens to 3:40 hours in Buffalo City (up from 3:28 hours in January 2025), and 3:10 hours in OR Tambo (down from 3:52 in January 2025). Facility level data reveals further gaps with average waiting times ranging from 2:17 hours to an extended wait of 4:47 hours. A full site breakdown is in appendix 5.

***"Sometimes I don't** even want to go to the clinic because of the long waiting hours and other difficulties we face. We arrive early in the morning. Even when it's still dark, just to queue. And we end up leaving very late. That's one of the reasons people stop using the clinics. If the clinic staff worked faster to provide services, things would be so much better"* – *a public healthcare user, Empilweni Gompo CHC, Buffalo City, September 2025*

1. We note that monitoring has stopped in two districts in the Eastern Cape since January 2025: Alfred Nzo (where average waiting times were 3:55 hours in January 2025) and Chris Hani (where average waiting times were 3:08 hours in January 2025).

Table 2: Average facility waiting time (April to June 2025)

District	Number of Facilities Assessed	Average time patients spent at the facility (including time before the facility opens)	Average time patients spent at the facility after opening
Buffalo City	20	03:40	03:14
OR Tambo	20	03:10	03:07
Eastern Cape	40	03:25	03:10

> ***"On my last** visit, I waited for more than five hours. Actually close to seven hours"** – a public healthcare user, Flagstaff Clinic, OR Tambo, September 2025*

48% of public healthcare surveyed in the Eastern Cape thought that waiting times were long (Figure 9) – 23% in OR Tambo, and 73% in Buffalo City (Figure 10). Buffalo City was in the bottom four districts with the highest proportion of reports of waiting times being long across all facilities monitored by Ritshidze, after all the Free State districts. 76% of people surveyed thought waiting times were long due to staff shortages, 33% thought it was because it took a long time to find files, and 25% thought it was due to staff not working or working slowly (Figure 11).

Figure 9: Do you think the waiting time is long at this facility? (April to June 2025)

Patients surveyed: 2 102

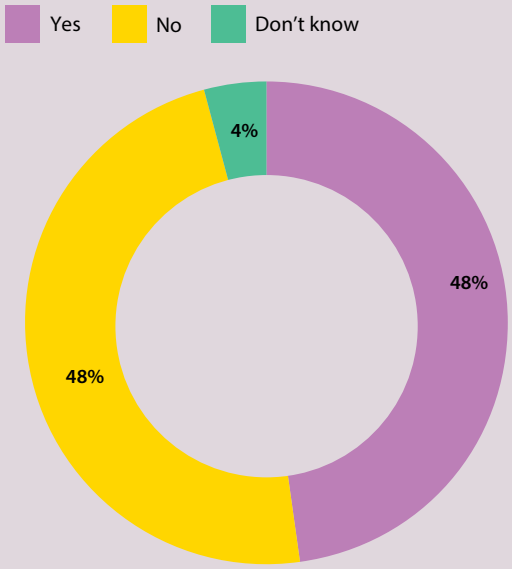


Figure 10: Do you think the waiting time is long at this facility? (April to June 2025)

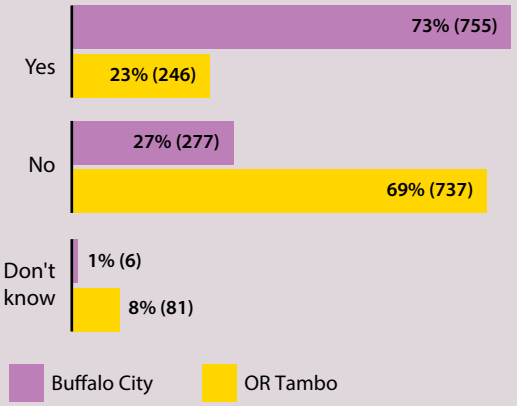
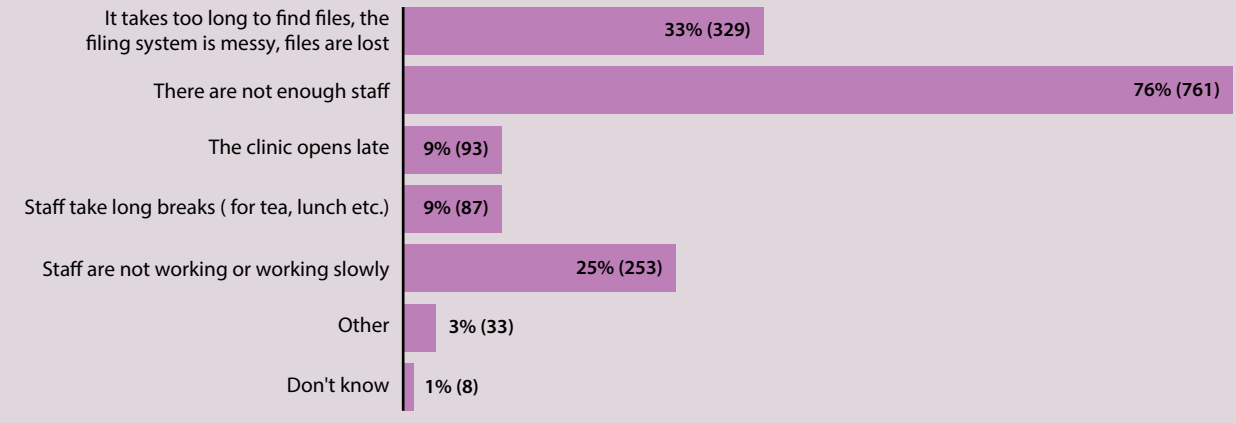


Figure 11: Why do you think the waiting time is long at this facility? (April to June 2025)

Patients surveyed: 1 001



***"There are enough** nurses at Empilweni CHC, but they don't work effectively. They spend time talking among themselves instead of assisting patients. When they go on tea breaks, they return as late as 11:30am, while we sit waiting. Some even go shopping while we are there, hungry and without money for food"* – *a person living with HIV, Empilweni Gompo CHC, Buffalo City, September 2025*

***"When you have** a clinic appointment, you have to tell yourself that you're going to spend your whole day at the facility. It's very painful. Sometimes I tell myself that I am not going because of all the challenges. But at the end of the day, I go because my health is important, and I want to live for the sake of my children"* – *a public healthcare user, Empilweni Gompo CHC, Buffalo City, September 2025*

When leaving the clinic that day, 24% of people surveyed across the province reported experiencing a longer waiting time than usual – 15% in OR Tambo, and 34% in Buffalo City. Delays were increased across the clinic including waiting to be seen by a clinician (48%), waiting for files (34%), waiting to register (33%), waiting to collect medicines (22%), waiting to enter the facility (18%), and waiting for vitals to be checked (16%) (Figure 12). A full site breakdown is in appendix 6. 69% of people surveyed thought waiting times were longer than usual because there were less staff than usual – 68% in Buffalo City and 70% in OR Tambo (Figure 13). 36% thought it was due to filing systems being messier and files being lost – 30% in OR Tambo and 39% in Buffalo City (Figure 14). A full site breakdown is in appendix 7.

Figure 12: Where were the delays longer than usual? (April to June 2025)

Patients surveyed: 513

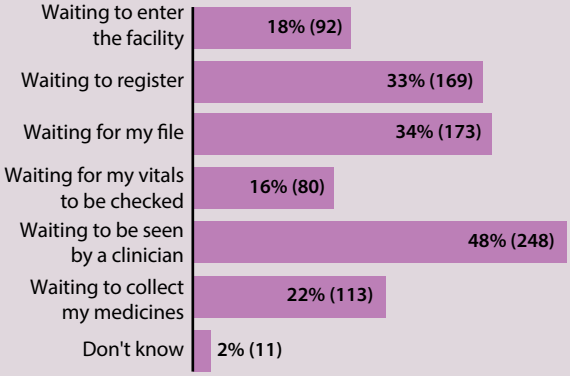
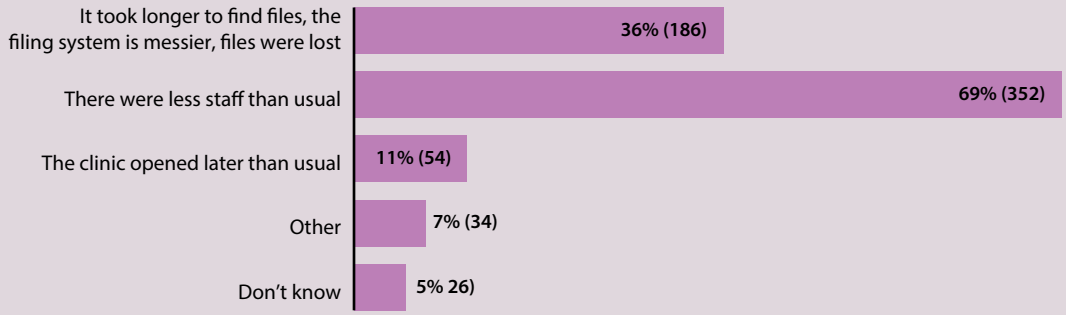


Figure 13: Why do you think the delays were longer than usual? (April to June 2025)

Patients surveyed: 934



***"I use Nobuhle** Clinic for healthcare services. We arrive early in the morning while sick, and we have to wait outside the clinic. There is no waiting area with chairs or shelter at Nobuhle Clinic. You arrive at 7am, queue outside in the cold, and wait until they open the gates at 8am. Sometimes it's very cold, and other times the sun is hot, but you still have to wait outside until the clinic opens"* – *a public healthcare user, Nobuhle Clinic, Buffalo City, August 2025*

***"We queue and** wait outside. Some patients arrive as early as 3am or 4am. There is no shelter. It's dark and cold, and we wait until they open the gates at 8am. We even asked a member of the clinic committee why there's no shelter for us. It doesn't sit well with me because we have to wait outside in the cold, despite coming so early in the morning"* – *a public healthcare user, Gompo A Ndende Clinic, Buffalo City, August 2025*

DELAYS IN COLLECTING FILES

KEY FINDINGS

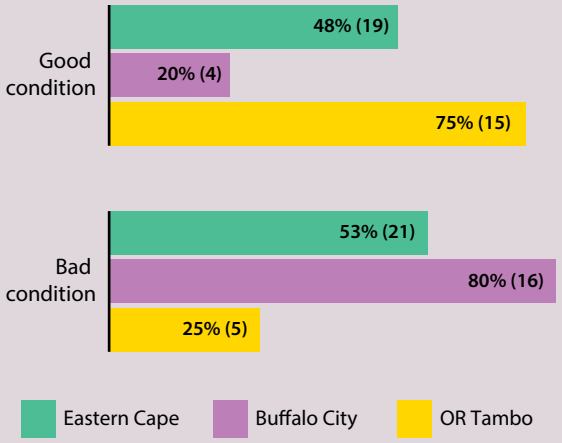
While the condition of the filing systems has been improving in OR Tambo, this still needs attention with 25% still reported to be in a bad condition. In contrast, Buffalo City's filing systems are reported to be in a disastrous state with 80% reported to be in a bad condition. Buffalo City had the second most reports of filing systems being in a bad condition out of all districts monitored by Ritshidze. Messy and disorganised filing systems result in people waiting longer to receive their file – increasing overall waiting times. 33% of people surveyed across the province said the reason they thought waiting times were long was because of disorganised filing systems – and when leaving the facility that day, 36% of people surveyed said that the delays were longer compared to the end of January 2025 because of filing systems being messier and files being lost.

Delays can be worsened by disorganised paper filing systems. This can be the result of overburdened staff working in a rushed manner, no dedicated filing room staff, or of small filing rooms without the space needed to organise properly. However the disorganisation is created, the result is that staff struggle to locate people's medical files, or lose them – and a person's entire medical history – altogether.

Filing systems were observed to be in a bad condition in 53% of sites monitored in the Eastern Cape (Figure 14) – worsening from 48% in January 2025. However this differs greatly between districts. In OR Tambo significant improvement has been made with 67% of filing systems observed in a bad condition in January 2025 compared to just 25% of filing systems in this reporting period (42% reduction). In Buffalo City filing systems observed to be in a bad condition have increased from 37% of sites in January 2025 to 80% in this reporting period (43% increase). Buffalo City had the second most reports of filing systems being in a bad condition out of all districts monitored by Ritshidze. Given that PEPFAR partners have often supported the maintenance of clinic filing systems, it is sensible to think that the increase in filing systems in a bad condition in Buffalo City is correlated with the PEPFAR implementing partner working at a reduced capacity, as reported by 80% of facilities in the district.

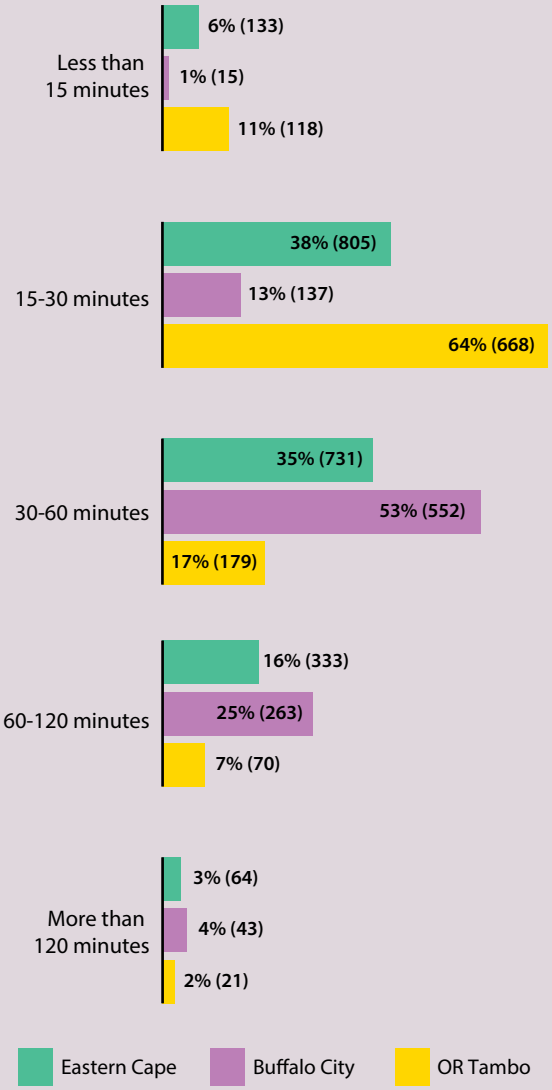
***"We usually get** our files quickly, but sometimes there are unexplained delays. You can queue and move along with the line, but when it's your turn, they keep looking for your file until you reach the consultation room. This becomes a challenge"* – *a public healthcare user, Gompo A Ndende Clinic, Buffalo City, August 2025*

Figure 14: What is the condition of the filing system (April to June 2025)



***"I collect treatment** for HIV and diabetes. One of the biggest problems is that our files often go missing. They will tell you that they can't find your file. Then you have to wait for them to create a temporary file, which also takes time. It happened to me. My file was reported missing, and while they were creating a temporary file, they gave me a piece of paper to write down my blood pressure readings"* – *person living with HIV, Empilweni Gompo CHC, Buffalo City, September 2025*

Figure 15: How long until you received your file (April to June 2025)



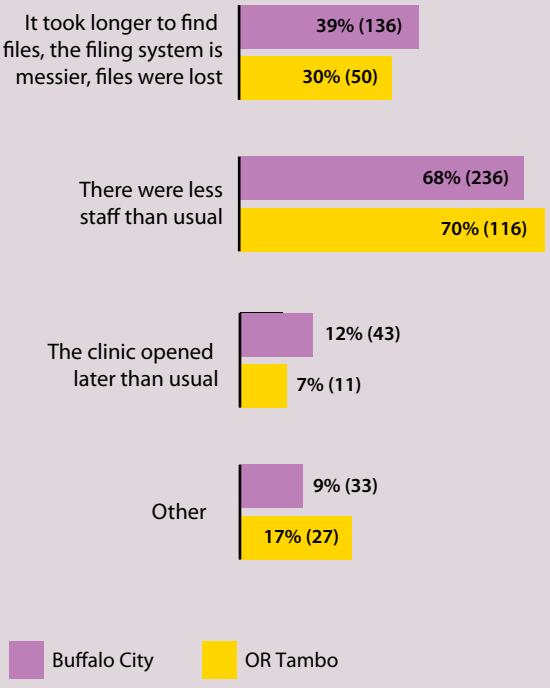
Across sites in the province, 6% of people said it took under 15 minutes to get their file, 38% said it took 15–30 minutes, 35% said it took 30–60 minutes, 16% said it took 1–2 hours, and 3% said it took over 2 hours (Figure 15). This has worsened from January 2025 when 21% said it took under 15 minutes. The 19% who said it took over an hour compares to just 3% who said it took over one hour in KwaZulu-Natal, the best performing province.

However there are major differences across districts. While 74% of people reported it taking under 30 minutes to receive their file in OR Tambo (12% more than in January 2025), only 14% did in Buffalo City (25% less than in January 2025). Conversely, while just 9% of people said it took over an hour to receive their file in OR Tambo, 29% did in Buffalo City.

33% of people surveyed said the reason they thought waiting times were long was because of disorganised filing systems – 17% in OR Tambo, and 38% in Buffalo City. When leaving the facility that day, 36% of people surveyed said that the delays were longer compared to the end of January 2025 because of filing systems being messier and files being lost – including 30% in OR Tambo, and 39% in Buffalo City (Figure 16).

Waiting for many hours at the clinic remains an exhausting and frustrating reality for many many people in the province. The longer waits are a major source of dissatisfaction and are a reason why people feel anxious about going to the clinic, or stop going altogether. For people living with HIV, either collecting refills through standard dispensing or at facility pick-up points, or returning to the facility for a rescript, spending an extended time at a facility increases the risk of that person interrupting treatment and/or disengaging from care. Further, for people who use drugs, sex workers, and the LGBTQIA+ community who often face discrimination and hostility at the clinic, the shorter the time spent in such an unsafe or uncomfortable environment the better. Data from 2024 show that 11% of trans people, 13% of gay, bisexual, and other men who have sex with men (GBMSM), 16% of people who use drugs, and 27% of sex workers surveyed who no longer use public health facilities blamed the long waits. While Ritshidze does not have equivalent data for other populations who have discontinued care in public clinics, it is sensible to believe that many of the people who drop out of care do so as a result of the long waiting times in the province. Waiting times cannot be ignored as the Department of Health aims to get 1.1 million more people on HIV treatment – including those who have disengaged because of conditions at the clinic.

Figure 16: Why do you think the delays were longer than usual? (April to June 2025)



PRIORITY 3

HIV TESTING

KEY FINDINGS

No HIV testing means it is not possible to identify people who are living with HIV who need to start or restart treatment – or identify people for prevention services. Yet only 46% of people not on ART reported being offered HIV tests at a health facility visit in this reporting period. 35% of sites in Buffalo City reported that there were fewer staff to provide HIV testing following the PEPFAR disruptions – the majority of which correlate with the sites reporting that the PEPFAR implementing partner is working at a reduced capacity. Missing an easy opportunity to test people who are coming to our health facilities either sick, with an STI, or for either family planning or ante/post-natal services which may indicate unprotected sex.

RECOMMENDATION

Provincial Department of Health
District Department of Health

The Department of Health must recognise that reductions in HIV testing are a crisis. This is not only community-based testing, but even missing offering HIV testing to people coming to our facilities! The Department of Health must recognise that HIV testing is the door to HIV treatment and prevention services. Without HIV testing, people living with HIV not diagnosed or linked to treatment will not be able to access treatment, nor will people who need PEP/PrEP be able to be offered these prevention services. **Counsellors at public health facilities are essential to ensure HIV testing is offered and provided at facilities. All facilities must offer every person who comes to a health facility an HIV test if they have not tested in the last year.**

HIV testing is a critical entry point for all HIV treatment and prevention services. No HIV testing means it is not possible to identify people who are living with HIV who need to start treatment, or who interrupted treatment and need to restart. It also means it is not possible to identify people who are vulnerable to acquiring HIV for prevention services including, PrEP, PEP, and harm reduction services (outlined in more detail later in this report). However, 18% of sites reported that there were fewer staff to provide HIV testing following the PEPFAR disruptions (Figure 17). While no sites in OR Tambo reported that HIV testing services had been affected, 35% of sites in Buffalo City did (Figure 18). This mostly correlates with the sites reporting that the PEPFAR implementing partner is working at a reduced capacity. Only 46% of people not on ART surveyed in the Eastern Cape reported being offered HIV tests in April to June 2025 (Figure 19) – 55% in Buffalo City, and 37% in OR Tambo (Figure 20). HIV testing services were most affected in family planning (71%) and Youth Zones (57%), followed by HIV services (43%), index testing services (43%), HIV self-testing (43%), and outreach in the community (43%) (Figure 21).

Figure 17: Eastern Cape: Have HIV testing services been affected by the PEPFAR withdrawal? (April to June 2025)

Facility staff surveyed: 40



Figure 18: Buffalo City: Have HIV testing services been affected by the PEPFAR withdrawal? (April to June 2025)

Facility staff surveyed: 20





Figure 19: Were you offered HIV testing today? (April to June 2025)

Patients surveyed: 420

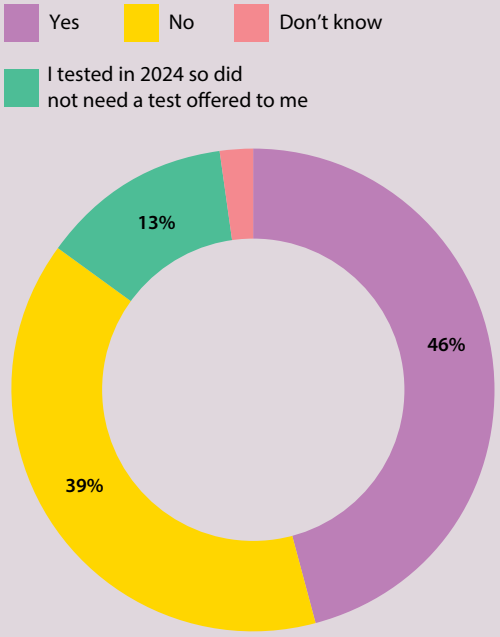
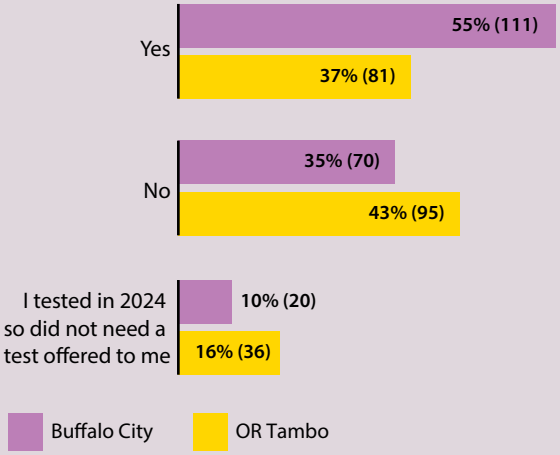


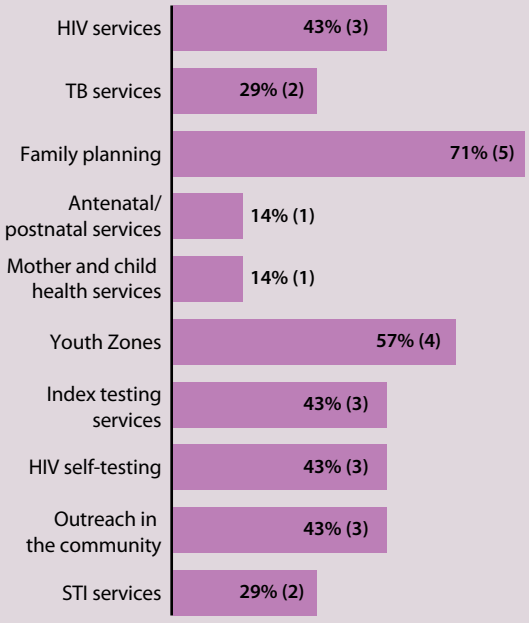
Figure 20: Were you offered HIV testing today? (April to June 2025)



HIV testing is a critical entry point for all HIV treatment and prevention services. No HIV testing means it is not possible to identify people who are living with HIV who need to start treatment, or who interrupted treatment and need to restart.

Figure 21: Where have HIV testing services been affected? (April to June 2025)

Facility staff surveyed: 7



PRIORITY 4

ART COLLECTION

KEY FINDINGS

Ensuring that ARV collection is easier and quicker for people living with HIV is another critical way to get 1.1 million people on treatment by the end of 2025 – including the many many people who have started on treatment and then stopped. The burden of going to the clinic including taxi fares, having to take time off from work or childcare, or miss out on piece job opportunities, the long waiting times, the lack of compassion and care, and the dysfunction in the health system are all core reasons why people living with HIV may interrupt treatment, or disengage from care altogether. This situation is made even worse for people living with HIV who also use drugs, do sex work, and/or who are a member of the LGBTQIA+ community who can face intense hostility at the clinic that can make it intolerable to go.

LONGER ARV REFILLS

RECOMMENDATION

National Department of Health (6MMD)
Provincial Department of Health (6MMD, 3MMD)
District Department of Health (3MMD)

In line with the Minister of Health commitments to the Treatment Action Campaign (TAC), and the Director-General's circular requiring urgent implementation in February 2025 – **all provinces must urgently start rolling out 6MMD. Rollout must meet the 30% commitment made by the Minister of Health – estimated to be at least 750,000 people by the end of March 2026 (a 9 month extension on commitment made) – with a minimum of 50% of facilities in the province in the first two phases, with full roll out during the last phase.**

At the same time, **all public health facilities must immediately adhere to National ART Guidelines and ensure everyone who is not sick is getting a 3 month supply of ARVs**. This includes all stable people living with HIV – whether collecting ARVs from the clinic, or at a facility or external pick-up point, or adherence club. As well as all other people living with HIV who have been on ART for 4 months who struggle to come to the clinic more regularly, including people: re-engaging in care, those travelling, postnatally, those with an elevated viral load after a session of adherence counselling, and children under 5 years old.

The Department of Health must investigate progress on provision of 3MMD in <u>all</u> districts across the Eastern Cape. This is to ensure that progress seen in Buffalo City and OR Tambo is mirrored in <u>all</u> districts across the province, especially in Alfred Nzo, the district that was falling far behind when last monitored.

District Departments of Health must better support stock management to ensure that there are enough ARVs at clinics to give out a 3 month supply to everyone, and a 6 month supply to those eligible.

One solution to reduce this burden is simply for people living with HIV to go to the clinic less often. A longer supply of ARVs would mean fewer trips back to the clinic just to collect medicines. This is proven to make it easier to stay on treatment in the long term by reducing the cost of getting to the clinic and the hours spent waiting every year. Importantly it would also reduce congestion and overall waiting times for everyone using the clinic, and reduce the burden on already overstretched healthcare workers.

> ***"If I could** get a 6 month supply of ARVs that would be very helpful. It would reduce the number of patients going to the clinic, because there are always many people there for different healthcare services. Just like the 3 month supply reduced the number of patients visiting frequently, a 6 month supply would have an even better impact. No-one would be given a 6 month supply and not take their medication – it benefits our health. People living with HIV would continue taking their treatment and it would also give us time to focus on other things, knowing we have our medication at home"** *– a person living with HIV, Nobuhle Clinic, Buffalo City, August 2025*

***"I recently started** collecting my HIV treatment from this clinic. I used to collect it at Wits RHI, but when the organisation closed permanently, I had to move here to continue my treatment. When I arrived, my blood was drawn, and I was given a 2 month supply of treatment. If I could receive a 6 month supply instead it would really help. It's tiring to go to the clinic often and it causes me to miss work"* – *a gay man living with HIV, Thembisa Clinic, August 2025*

6 MONTH SUPPLY

KEY FINDINGS

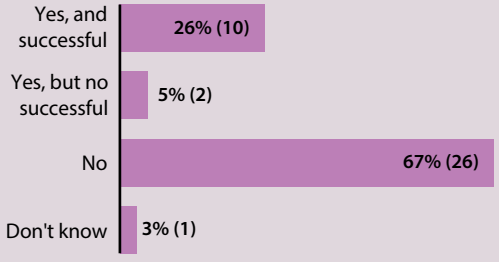
In the Eastern Cape there has been very limited implementation of 6 month supply (6MMD) despite Minister of Health commitments to the Treatment Action Campaign (TAC), and the Director-General's circular requiring urgent implementation in February 2025. Recent plans to start implementing on 1 August 2025 in only 10 facilities in the province from now until end March 2026 is inequitable and far too slow. Phase 1 and 2 implementation from now until end March 2026 must include a minimum of 50% of all Eastern Cape facilities – with full roll out during the last phase.

South Africa's national ART guidelines say that most people should get a 3 month supply of ARVs. They were revised in 2023 based on strong evidence showing longer ARV supplies support long term retention. In December 2024, commitments were made by the Deputy President and Minister of Health to extend this to 6 month supply – with 30% of eligible people receiving 6 month supply by July 2025. Since 2021, the World Health Organisation (WHO) has recommended that preferably people doing well on treatment should be getting a 6 month supply of ARVs. This would mean going to your clinic just twice a year for clinical review, rescript, and collecting your next 6 month supply of pills. This is an extremely simple intervention with big gains for people living with HIV, and an already overburdened and understaffed public health system.

The National Department of Health has delayed rollout to finally begin 1 August 2025, with a very slow phased roll out limited to a maximum of ten facilities per province in the first two phases. While 31% of Facility Managers in the Eastern Cape reported attempting to procure increased ART stock to enable 6 months supply – as set out by the Director-General of Health in the PEPFAR disruptions emergency circular in February 2025 – 5% had been unsuccessful with orders not fulfilled (Figure 22) and had been initially forbidden by the National Department of Health from implementing 6 month supply despite the circular. While phased roll out can ensure any early problems are quickly addressed, phases are not pilots. Phased roll out must consider equity of access and critical importance of reducing unnecessary visits to an overburdened and understaffed health system. It must meet the 30% commitment made by the Minister of Health – estimated to be at least 750,000 people by the end of March 2026 (a 9 month extension on commitment made) – with a minimum of 50% of facilities in the province in the first two phases from now until end March 2026, with full roll out during the last phase.

Figure 22: Has your facility attempted to increase its ART stock orders to enable 6MMD? (April to June 2025)

Facility staff surveyed: 39



3 MONTH SUPPLY

KEY FINDINGS

In January 2025, the Eastern Cape was among the provinces making the slowest progress on 3MMD – with 71% of people getting a 3 month supply or longer of ARVs. Below the 90% we would expect to see by now. This was largely driven by very poor implementation in Alfred Nzo with only 39% of people living with HIV surveyed reporting getting a 3 month or longer supply. The Eastern Cape improved overall in this reporting period to 88% with OR Tambo making the biggest improvement. However due to funding cuts, Ritshidze was unable to monitor either Alfred Nzo or Chris Hani – who were previously among the worst performing of all districts monitored by Ritshidze in January 2025. We do not know if these districts have improved or not. The Provincial Department of Health must urgently ensure that the progress seen in Buffalo City and OR Tambo is mirrored in all districts across the province.

Figure 23: At your <u>last</u> ARV refill, how long were you given HIV medicine for? (January 2025)

PLHIV Surveyed: 1 483

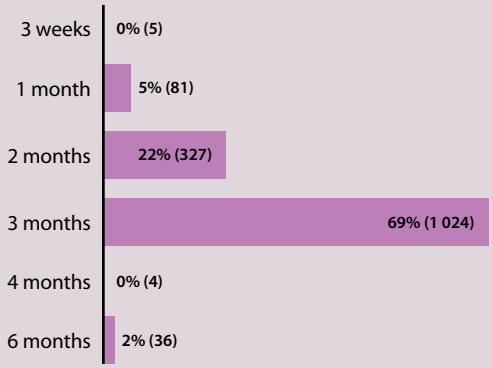
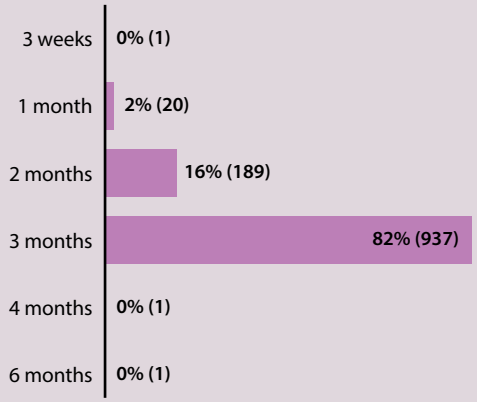


Figure 24: At your last ARV refill, how long were you given HIV medicine for? (April to June 2025)

PLHIV Surveyed: 1 149



In January 2025, the Eastern Cape was among the provinces progressing slowest in providing people a 3 month supply or longer of ARVs as required in ART guidelines – with 71% of people living with HIV surveyed reporting getting a 3 month supply or longer (Figure 23). Positively in this reporting period, this increased to 82% of people living with HIV surveyed reporting getting a 3 month supply or longer on their last refill (Figure 24) – 72% of which were after January 2025.

When reporting what length of refill people surveyed got on the day of monitoring, this increased to 88% of people who reported getting a 3 month supply or longer that day (Figure 26)[2] – while still below the 90% we expect to see by now – the Eastern Cape was the best performing province on this indicator. Positively 93% of facilities reported that the standard of care is to give most people a 3 month supply, and 8% said the standard is to give most people a 6 month supply.

However, while it appears that progress has been made, Ritshidze monitoring is no longer taking place in Alfred Nzo and Chris Hani districts, where progress on 3 month supply had been poor[3]. The Provincial Department of Health must ensure that the provision of longer refills is taking place across all districts in the province.

Across districts, in January 2025, 96% of people living with HIV surveyed reported getting a 3 month supply or longer in Buffalo City, followed by 70% in OR Tambo, 67% in Chris Hani, and 39% in Alfred Nzo. In this reporting period, when asked about their last ARV refill – 77% of

Figure 25: At your ARV refill today, how long were you given HIV medicine for? (April to June 2025)

PLHIV Surveyed: 1 347

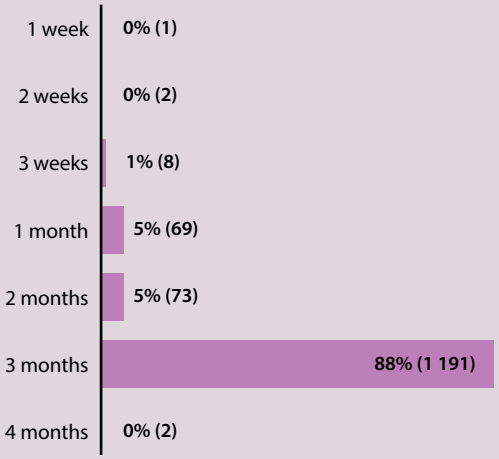
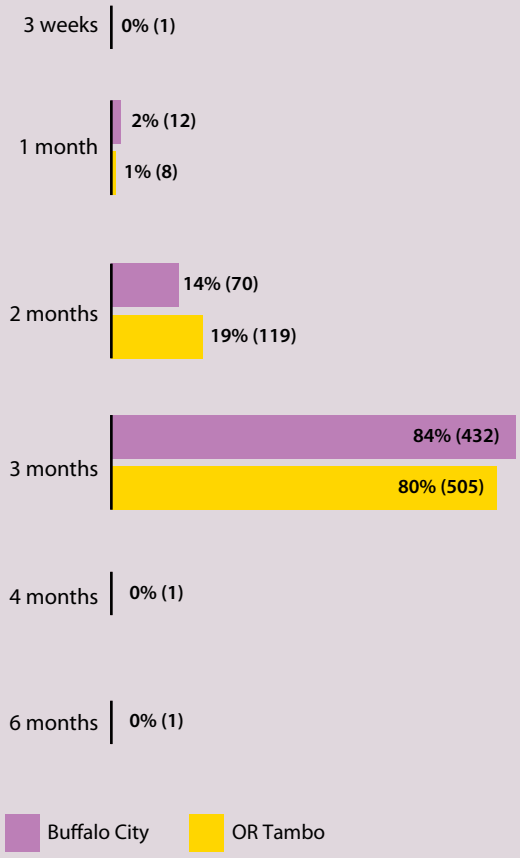


Figure 26: At your last ARV refill, how long were you given HIV medicine for? (April to June 2025)



2. ARV refill length data is calculated from two surveys. In the patient survey we ask "At your last ARV refill, how long were you given HIV medicine for?". This survey is conducted while people are waiting for services, most commonly before the person has actually received services or collected their parcel. Following the PEPFAR disruptions an additional patient exit survey was created to assess the state of services that day. In the patient exit survey we ask "At your ARV refill today, how long were you given HIV medicine for?". This survey is conducted while people are leaving, after they have received services and collected their parcels. This is to help us collect more up to date information to better understand changes since January 2025.
3. Changes in the number of clinics being assessed and the overall number of survey participants – as well as the removal of sites in Alfred Nzo and Chris Hani previously monitored – cautions against over-interpretation of the direct comparison to prior quarter results.

Figure 27: At your ARV refill today, how long were you given HIV medicine for? (April to June 2025)

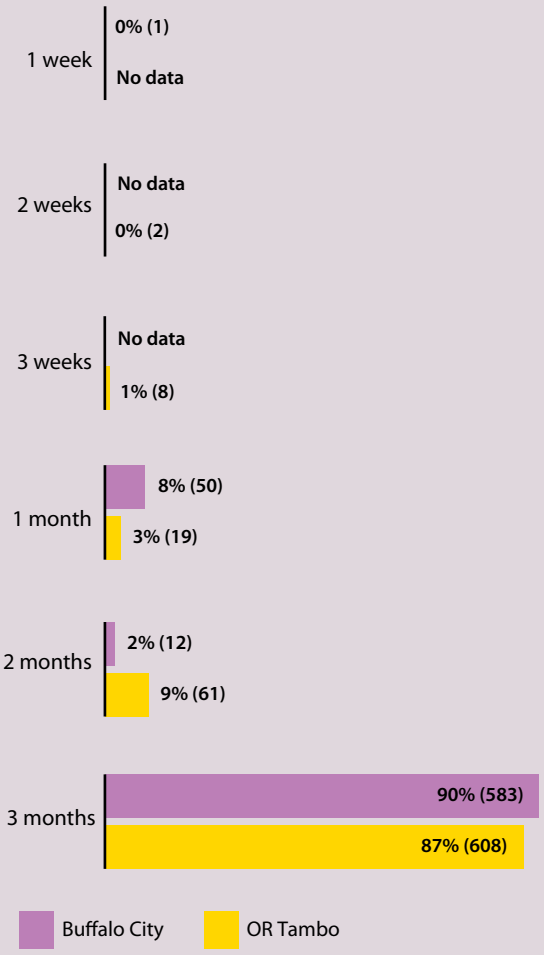
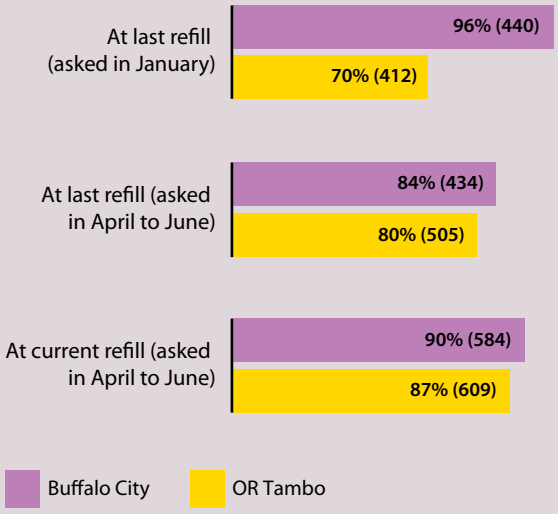


Figure 28: Number of people reporting 3-6 month supply (January to June 2025)



which were after January 2025 in OR Tambo, and 65% in Buffalo City – those getting a 3 month supply or longer had increased to 80% in OR Tambo (10% increase) and dropped to 84% in Buffalo City (8% reduction) (Figure 26).

When reporting what length of refill people surveyed got on the day of monitoring – while still lower than January 2025, Buffalo City increased back to 90% (6% increase), while OR Tambo increased to 87% (7% increase) (Figure 27). This compares to 98% in Capricorn (Limpopo), the best performing district. Changes in people reporting getting a 3 to 6 month supply are summarised in Figure 28. Full site breakdowns are in appendix 8 and 9.

PICK-UP POINTS

KEY FINDINGS

57% of people still collect from the facility after consultation and rescript with a clinician – including 43% in Buffalo City and 68% in OR Tambo. In OR Tambo, 25% fewer people reported using external pick-up points, while 11% more people reported using facility pick-up points, and 14% more people reported collecting through standard medicine dispensing. The Eastern Cape was the worst performing province at decanting people living with HIV to pick-up points to make ARV collection easier – and OR Tambo the worst performing district. In OR Tambo, 65% of all people living with HIV surveyed said that they would like to collect ARVs closer to their home if it were possible – the third highest proportion of reports across all districts monitored by Ritshidze.

RECOMMENDATION

National Department of Health
National Treasury
Provincial Department of Health
District Department of Health

As the worst performing province in decanting people to pick-up points, the Department of Health must investigate why people are not being offered pick-up point options in the Eastern Cape, especially Buffalo City.

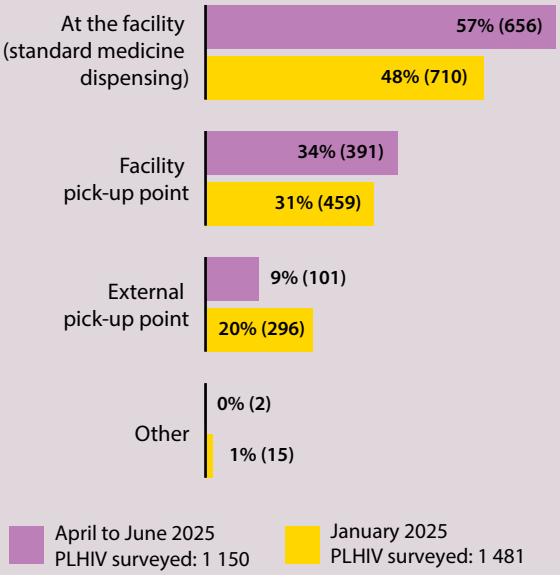
There needs to be enough pick-up points to decant people into – especially linked to peri-urban and rural clinics. **A diversity of external pick-up point providers is needed beyond private pharmacy networks largely only available in urban areas, and beyond services provided by PEPFAR partners that have been disrupted in multiple districts. To service rural areas – small CBOs, traditional houses, and early childhood development centres should be considered with a viable CCMDD funding model as service providers for small numbers of people living with HIV.**

> ***"I used to** collect my treatment at Clicks, and that system was very helpful. You would get there, press "collect" on the machine, sit down, and then they'd call you to collect your treatment. The process was very quick. Unfortunately, I fell sick and had to return to Empilweni CHC to continue collecting my treatment"** – person living with HIV, Empilweni Gompo CHC, Buffalo City, September 2025*

Another solution to make ART collection easier and quicker is the use of pick-up points, either at the facility or in the community. Instead of waiting in long clinic queues, people can instead go to the pick-up point simply to pick up their parcels. External pick-up points located even closer to where people live or work can make it even easier. Known as repeat prescription collection strategies in South Africa – pick-up points reduce the overall time it takes to collect medication. They also reduce congestion and overall waiting times for everyone using the clinic, and reduce the burden on already overstretched healthcare workers.

In this reporting period, 34% of people living with HIV surveyed reported collecting their ARVs at a facility pick-up point, and 9% at an external pick-up point (Figure 29). 57% of people were collecting through standard facility medicine dispensing after a consultation and rescript with a clinician. This compares to 31% of people reporting collecting their ARVs at a facility pick-up point (3% increase), 20% at an external pick-up point (11% reduction), and 48% through standard facility medicine dispensing (9% increase) in January 2025. The Eastern Cape was the worst performing province at decanting people living with HIV to easier collection models across this reporting period and in January 2025.

Figure 29: Location of where people living with HIV collect their ARVs



This varied considerably across districts:

+ In Alfred Nzo: in January 2025, 35% were using a facility pick-up point, 20% were using an external pick-up point, and 44% reported collecting through standard facility medicine dispensing in the district. Alfred Nzo was in the bottom five worst performing districts monitored by Ritshidze in January 2025. This district is not currently monitored by Ritshidze following funding cuts.
+ In Buffalo City: more people (41%) were using a facility pick-up point in this reporting period (5% increase from 36% in January 2025), and more people (16%) were using an external pick-up point (5% increase from 11% in January 2025). However, while a 10% improvement from 53% in January 2025, still 43% reported collecting through standard facility medicine dispensing in the district. Buffalo City was in the bottom four worst performing districts monitored by Ritshidze in this reporting period, and the bottom two in January 2025.
+ In Chris Hani: in January 2025, 60% were using a facility pick-up point, 19% were using an external pick-up point, and 18% reported collecting through standard facility medicine dispensing in the district. This district is not currently monitored by Ritshidze following funding cuts.
+ In OR Tambo: while more people (29%) were using a facility pick-up point in this reporting period (11% increase from 18% in January 2025), far less (3%) were still using an external pick-up point (25% drop from 28% in January 2025). Worse, more people (68%) reported collecting through standard facility medicine dispensing in the district, a 14% increase from 54% in January 2025. OR Tambo was the worst performing district monitored by Ritshidze in both January 2025 and this reporting period.

A full site breakdown is in appendix 10.

> ***"Collecting HIV treatment** at Booysens Park Clinic was very challenging. At first, we used to get our treatment in the consultation rooms, then it changed to a nurse prescribing it, and you have to collect it from the pharmacy. When you get there, there's a waiting area where everyone is looking at you. You feel ashamed and try to hide the medication. Sometimes the staff will ask loudly – "how many pills did you get last month?" – and everyone in the room can hear. I would answer quietly, "2 months' worth" but other patients would still overhear, which made me very uncomfortable and discouraged me from returning to the clinic"** – a gay man living with HIV, Booysens Park Clinic, Nelson Mandela Bay, August 2025*

> ***"There is no** sense of urgency at Ndende Clinic. When you go to collect your treatment, you will still leave at 4pm when they are about to close. Ideally, your treatment should already be packed so you can just collect it and leave"* – *a person living with HIV, Gompo A Ndende Clinic, Buffalo City, August 2025*

For the 48% of people collecting through standard facility medicine dispensing after a consultation and rescript with a clinician – 32% said they have not been offered the option to use a pick-up point or club (Figure 30). This varied across districts. In OR Tambo, 9% of those collecting at the facility said they have not been offered the option to use a pick-up point or club (Figure 31). OR Tambo was in the top three best performing districts after Vhembe (Limpopo) and Capricorn (Limpopo). However delayed enrollment in pick-up points was highest in Buffalo City, where 78% of those collecting at the facility said they have not been offered the option to use a pick-up point or club. Buffalo City was in the bottom four worst performing districts out of all those monitored by Ritshidze on offering people pick-up point options.

On top of this, 39% of all people living with HIV surveyed said that they would like to collect ARVs closer to their home if it were possible (Figure 32). Across districts the third highest proportion of people who would like to collect ARVs closer to home was 65% in OR Tambo (Figure 33). Conversely, Buffalo City had the second fewest proportion of reports (7%) of people wanting to collect closer to home out of all districts monitored by Ritshidze, after Thabo Mofutsanyana (Free State). Full site breakdowns are available in appendix 11 and 12.

Figure 30: Of those using standard medicine dispensing, has the facility ever offered you an option to be in a facility pick-up point, external pick-up point, or adherence club? (April to June 2025)

PLHIV surveyed: 656

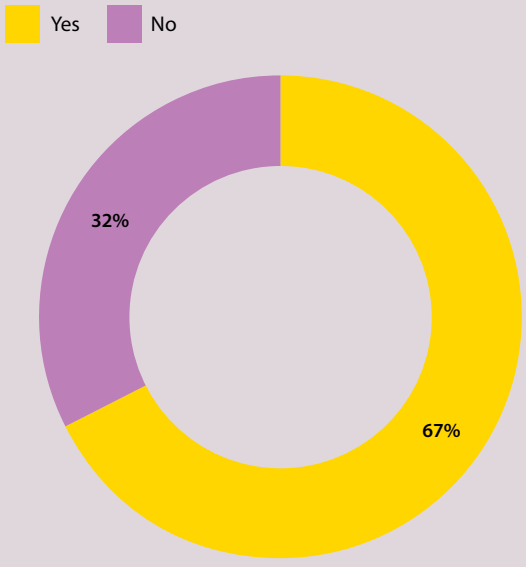


Figure 31: Of those using standard medicine dispensing, has the facility ever offered you an option to be in a facility pick-up point, external pick-up point, or adherence club? (April to June 2025)

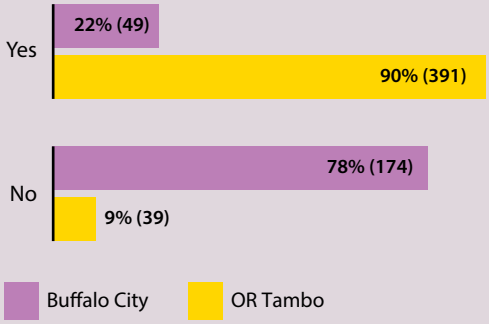
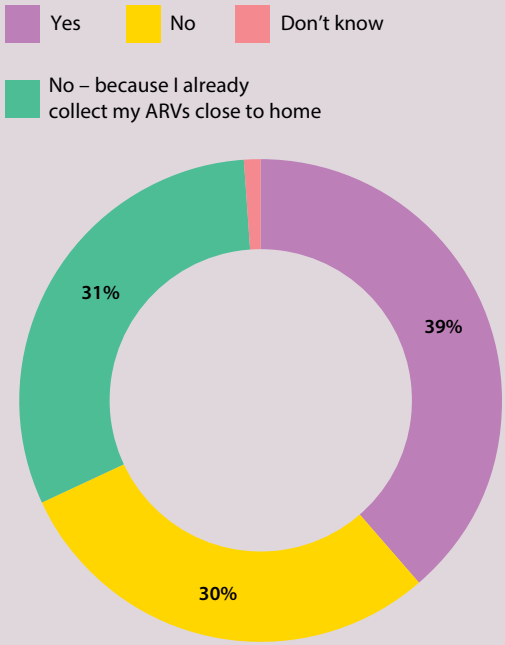


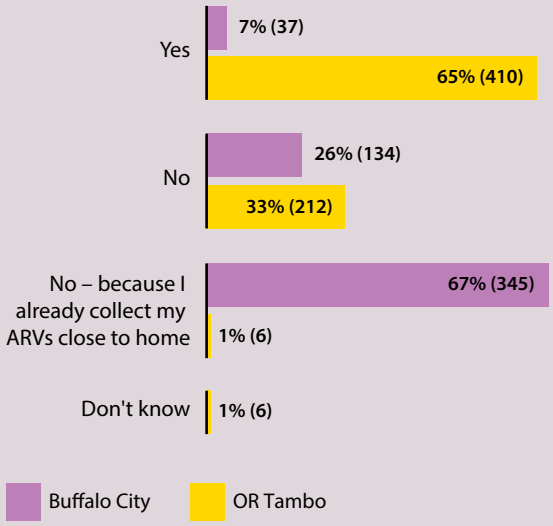
Figure 32: Would PLHIV like to collect ARVs closer to home? (April to June 2025))

PLHIV surveyed: 1 150



There needs to be enough pick-up points to decant people into – especially linked to peri-urban and rural clinics. A diversity of external pick-up point providers is needed beyond private pharmacy networks largely only available in urban areas, and beyond services provided by PEPFAR partners that have been disrupted in multiple districts. To service rural areas – small CBOs, traditional houses, and early childhood development centres should be considered with a viable CCMDD funding model as service providers for small numbers of people living with HIV.

Figure 33: Would PLHIV like to collect ARVs closer to home? (April to June 2025)



DELAYS IN PICK-UP POINTS

KEY FINDINGS

One-stop facility pick-up points continued to operate inefficiently, requiring 42% of people living with HIV to go to other service points before collecting their parcel. While it should take less than 30 minutes to collect your parcel, only 48% of people said it did, down from 77% in January 2025. 15% of people surveyed in OR Tambo and 29% of people in Buffalo City said it took longer to collect their parcel than before the PEPFAR disruptions. It is extremely inefficient to increase workload for staff at a time when staff shortages are a crisis. Resolving such inefficiencies require urgent focused facility management.

***"We wait for** long hours at Ndende Clinic, sometimes until 4pm. Even if we are just here to collect treatment. There has never been a day at this facility when I could just collect my treatment and leave. This is frustrating because I have temporary jobs that I need to attend to as well. Sometimes, I ask someone to queue for me around 3am or 4am. But even if I make that effort, I still end up leaving the clinic when the staff are about to close. Being early does not help"* – *a person living with HIV, Gompo A Ndende Clinic, Buffalo City, August 2025*

RECOMMENDATION

Provincial Department of Health
District Department of Health

The Department of Health should urgently investigate why parcel collection times have increased across the Eastern Cape since January 2025, both in Buffalo City and OR Tambo.

Facility pick-up points are meant to act as a one-stop very quick ART collection only allowing people living with HIV to easily and quickly collect their pills. **National ART guidelines say this should take less than 30 minutes. Facility pick-up point users must not be sent to the registry, to collect folders, to take vitals, or to see a clinician. It is extremely inefficient to increase workload for staff at a time where staff shortages are a crisis. Resolving such inefficiencies require urgent focused facility management.**

Facility pick-up points are meant to act as a one-stop very quick ART collection only allowing people living with HIV to easily and quickly collect their pills. National ART guidelines say this should take less than 30 minutes. There is no need to go to the registry, collect folders, take vitals, or see a clinician. Yet 17% of facilities told Ritshidze that people living with HIV must go somewhere other than the pick-up point before collecting their parcel (Figure 34) – 5% in Buffalo City, and 31% in OR Tambo. In addition many more people living with HIV reported this challenge that adds to delays. 42% of people living with HIV surveyed said they do have to go to other service points before collecting their parcel (Figure 35) – 39% in Buffalo City, and 46% in OR Tambo (Figure 36).

Figure 34: Do PLHIV have to go anywhere other than the pick-up point when they come to collect their parcel e.g. registry or vitals etc. (April to June 2025)

Facility staff surveyed: 35

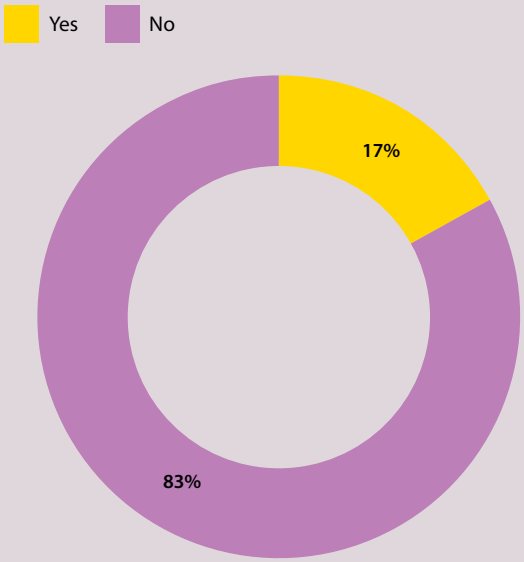


Figure 35: When using the facility pick-up point, do you have to go to any other service point other than parcel collection (for example registry or folder collection)? (April to June 2025)

PLHIV surveyed: 391

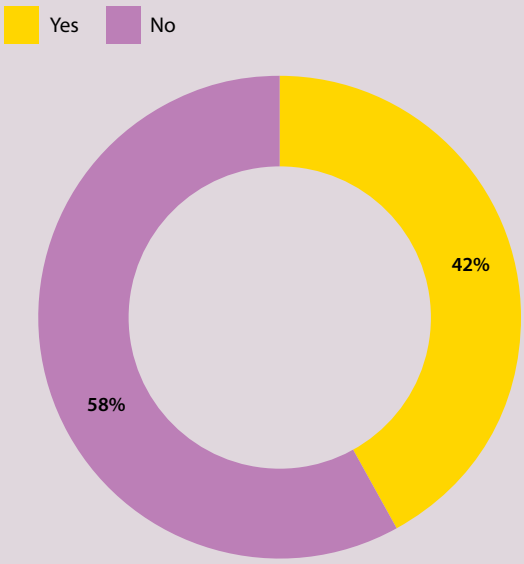


Figure 36: When using the facility pick-up point, do you have to go to any other service point other than parcel collection (for example registry or folder collection)? (April to June 2025)

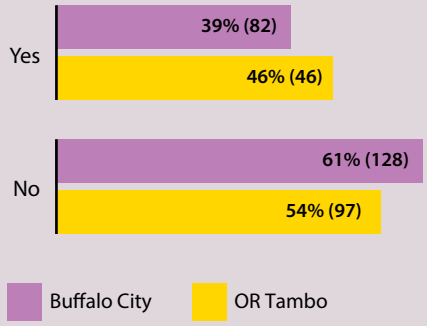


Figure 37: Today did it take longer to collect your parcel than before the end of January? (April to June 2025)

PLHIV surveyed: 1 349

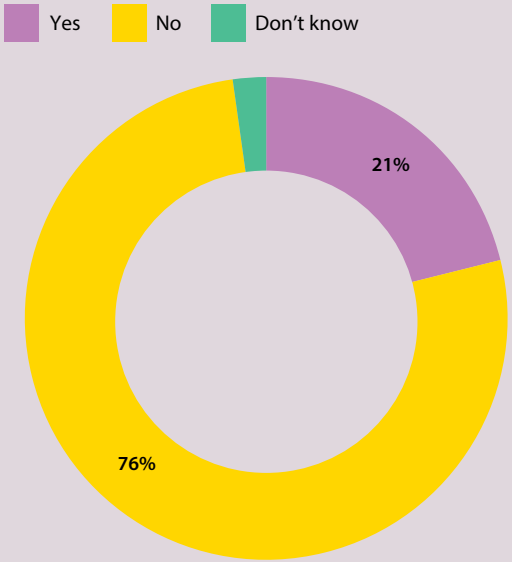
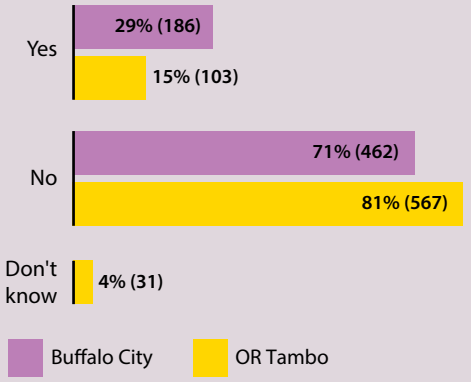


Figure 38: Today did it take longer to collect your parcel than before the end of January? (April to June 2025)



Only 48% of people said normally it took under 30 minutes to collect their parcel, as prescribed by national guidelines – 64% in OR Tambo, and 34% in Buffalo City. This has worsened dramatically overall in the province – and in Buffalo City in particular – since the PEPFAR disruptions in January 2025, and the removal of sites in Chris Hani and Alfred Nzo.

In January 2025 71% of people reported parcel collection taking under 30 minutes – 99% in Chris Hani, 77% in Buffalo City, 64% in OR Tambo, and 42% in Alfred Nzo. While leaving the clinic on the day of monitoring, 21% of people surveyed said it took longer to collect their parcel than before end of January 2025 (Figure 37) – 15% in OR Tambo, and 29% in Buffalo City (Figure 38).

PARCELS SENT BACK BEFORE GUIDELINE MANDATED 28 DAYS

KEY FINDINGS

There is an unnecessary increased burden for people and the health system by parcels at pick-up points not being available for collection for the mandated 28 days. 83% of facilities in the province said that parcels only wait for 0-7 days, and 8% more for 8-14 days. These people all unnecessarily then need to return to the facilities and see clinicians to get new prescriptions, adding to the burden on people living with HIV and facilities.



RECOMMENDATION

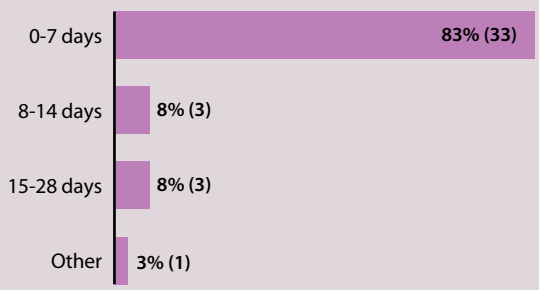
Provincial Department of Health
District Department of Health

Parcels must wait for 28 days before being returned to the facility. Returning parcels before this creates an unnecessary increased burden for people and the health system by parcels at pick-up points not being available for collection for the mandated 28 days. These people all then need to return unnecessarily to facilities and see clinicians to get new prescriptions, adding to the burden on people living with HIV, and therefore increasing treatment interruptions and disengagements. It also adds to the burden on facilities, and this unplanned treatment supply from facility pharmacies also increases stockout risks.

According to the guidelines, you are late for an appointment if you return within 28 days of your appointment date, and you have missed an appointment if you return after 28 days have passed. Your parcel should wait for you at your pick-up point for 28 days before being returned to the facility – however 83% of facilities in the province said that parcels only wait for 0-7 days, and 8% more for 8-14 days (Figure 39). There was limited variation across districts and neither district was following the guidelines on this measure.

Figure 39: How many days do parcels wait for people to collect them from facility pick-up points, external pick-up points, and/or adherence clubs? (April to June 2025)

Facility staff surveyed: 40



12 MONTH SCRIPTS

RECOMMENDATION

Minister of Health
South African Health Products Regulatory Authority (SAHPRA)

The Minister of Health together with the South African Health Products Regulatory Authority (SAHPRA) must enable 12 month prescriptions for stable people living with HIV and/or controlled non-communicable diseases (NCDs). This will be key to further reduce the burden of unnecessary visits to clinics and will also be critical to retain the benefit of pick-up points as 6 month supply is rolled out. Allowing stable people living with HIV to receive a 12 month script will ensure they visit the clinic just once annually for rescript and viral load testing, and collect either 3 or 6 month parcels at a pick-up point**. This can be done by:**

+ **Based on funding disruptions, issuing an emergency exemption from 6-month scripting** as was done during the Covid-19 pandemic. During this period evidence shows that viral load suppression was equivalent to 6 month scripting.
+ **In parallel, accelerating an amendment to the Medicines Act to enable 12 month prescriptions longer term.**

It is critical that the Minister of Health together with the South African Health Products Regulatory Authority (SAHPRA) exempt stable people living with HIV from 6 month scripting – as required in the Medicines Act. This is essential to retain the benefit of pick-up points as 6 month supply is rolled out. Allowing stable people living with HIV to receive a 12 month script will ensure they visit the clinic just once annually for rescript and viral load testing, and collect their other 6 month parcel at a pick-up point. This would make ARV collection even easier and quicker, supporting long term retention. During the Covid-19 pandemic this measure was implemented: scripts were automatically renewed at 6 months, essentially providing a 12 month script. During this period evidence shows that viral load suppression was equivalent to 6 month scripting. The Minister of Health should review this request in Parliament during the Medicines Act Review processes starting in 2025.

PRIORITY 5

COMPASSIONATE CARE & SUPPORT

KEY FINDINGS

Clinic staff being unfriendly is a common reason for people disengaging from care or interrupting treatment. While people reporting that staff are always friendly has improved from 58% in January 2025 to 67% in the Eastern Cape in this reporting period – this varied considerably across districts. While 82% of people reported staff were always friendly in OR Tambo, only 51% did in Buffalo City. Further in January 2025 only 57% did in Chris Hani and just 39% in Alfred Nzo. Given monitoring is no longer taking place in these two districts, Ritshidze cannot know if any improvement has taken place in these districts. The Provincial Department of Health should take steps to ensure staff friendliness in all facilities across the province. Without addressing this – including ensuring adequate staffing and longer ARV refills (3MMD to 6MMD) to reduce the stress for those working in facilities – the government will continue to lose people from care at unacceptable rates and will never create the welcoming, safe and non-judgemental environment needed to encourage people back into care who have interrupted treatment.

RECOMMENDATION

Provincial Department of Health
District Department of Health

The Department of Health must ensure staff friendliness in all facilities across the Eastern Cape. Measures should be taken to ensure sufficient staffing and vacancies to be filled, to reduce the burden on staff. Further measures to reduce stress should be maximised such as providing a 6 month supply of ARVs, resolving inefficiencies around facility pick-up points, and decanting people to external pick-up points. Without addressing this the government will continue to lose people from care at unacceptable rates and will never create the welcoming, safe and non-judgemental environment needed to encourage people back into care who have interrupted treatment. **The Department of Health should urgently investigate the particularly poor staff attitudes reported in Buffalo City.**

All public healthcare users – including people living with HIV and members of key populations – should be treated with dignity, respect, and compassion. Data collected in the Eastern Cape in this reporting period shows an increase in people surveyed reporting that staff are always friendly from 58% in January 2025 to 67% (Figure 40)[4]. 30% of people thought staff were only sometimes friendly, and 3% thought they were never friendly in this reporting period. However this varied considerably across districts.

In January 2025, 76% of people reported staff were always friendly in OR Tambo, compared to 57% in Chris Hani, 49% in Buffalo City, and 39% in Alfred Nzo. This increased to 82% in OR Tambo (6% increase) and just 51% in Buffalo City (2% increase) since January 2025 (Figure 41). This compares to 93% of people thinking staff are always friendly in Vhembe (Limpopo), the best performing district. A full site breakdown is in appendix 13.

Further, 20% more people surveyed reported feeling comfortable/very comfortable to use the facility, up from 57% in January 2025 to 77% in this reporting period (Figure 42). By comfortable we mean that a person would feel at ease among other patients and with the clinic staff, and believe they will be treated well.

***"At the clinic** not all the staff are friendly. The staff first look at you to determine if they can be rude to you or not"* – *a public healthcare user, NU 8 Clinic, Nelson Mandela Bay, August 2025*

4. Given that our surveys take place at the facility, those who have already interrupted treatment or disengaged from care after facing unfriendly or uncomfortable services would not be there to survey. As such this challenge may be more widespread than the data suggests.

***"I feel that** there are enough staff, they just don't want to do their job. Not all the staff are the same, not all of the staff are rude, and not all of them are friendly. Sometimes they say they can't find my file, and I must use my card instead" – a PrEP user, Flagstaff Clinic, OR Tambo, September 2025*

How comfortable people felt varied across districts. In OR Tambo this increased from 62% in January 2025 to 89% in this reporting period (27% increase) (Figure 43). In Buffalo City, while this increased from 58% in January 2025 to 66% in this reporting period (8% increase), the district remains among the five worst performing districts monitored by Ritshidze on comfortability. A full site breakdown is in appendix 14.

Figure 41: Are the facility staff friendly? (April to June 2025)

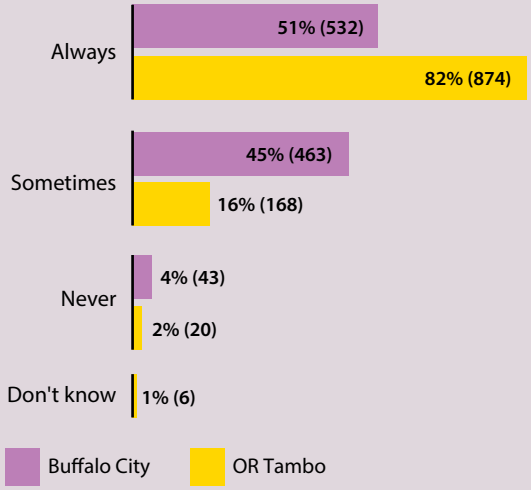


Figure 40: Are the facility staff friendly? (April to June 2025)

Patients surveyed: 2 106

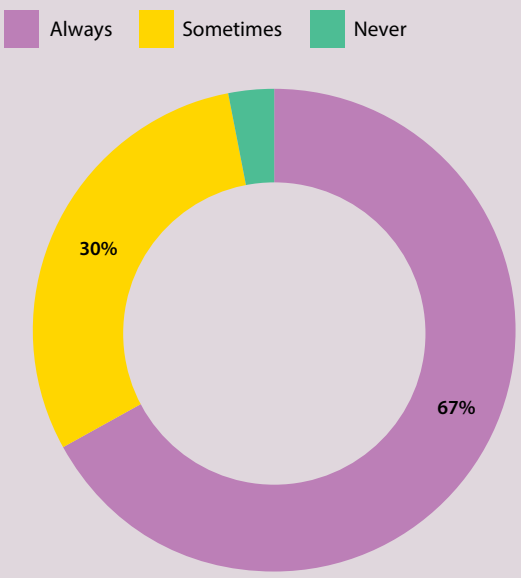
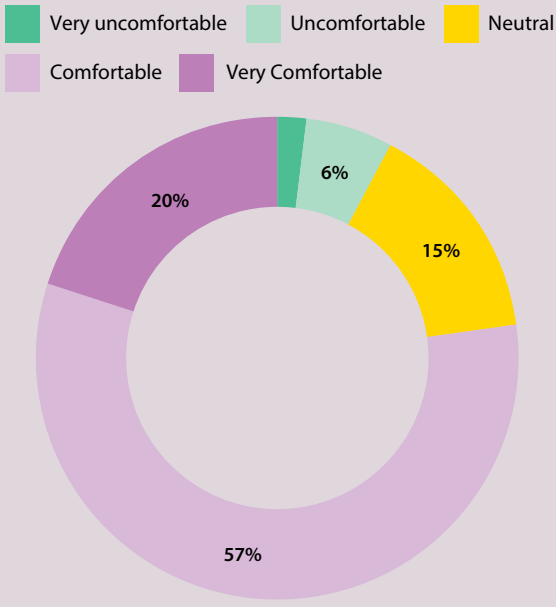


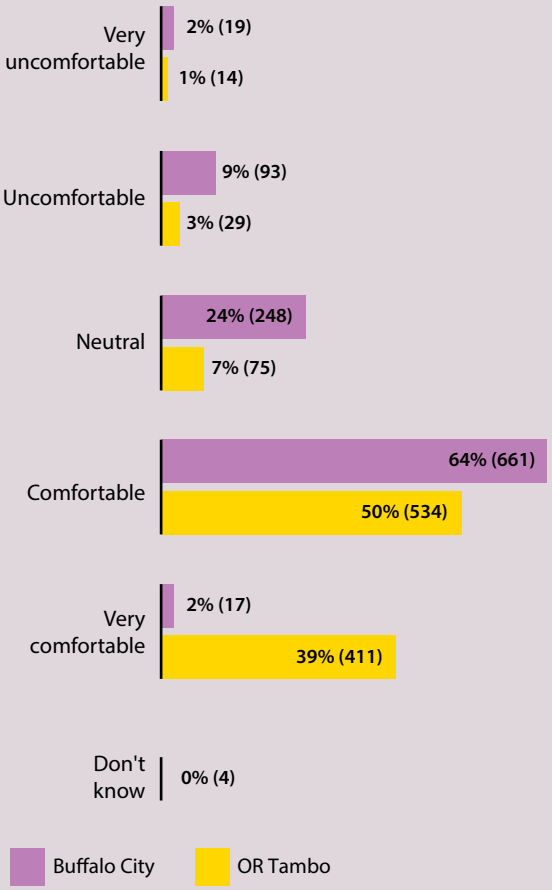
Figure 42: On a scale of 1-5, how comfortable do you feel at the facility? (April to June 2025)

Patients Surveyed: 2 105



***"I work at** an old age home, and we take our patients to different clinics. At Luyolo Clinic, the staff are not friendly at all. They don't know how to treat people properly. I accompanied a patient there, and it was clear the staff members were the kind who shout at and humiliate patients in front of others. There was a staff member… who was very rude. When I arrived with an elderly patient, she started shouting, saying "why do you keep bringing people like this? What must we do with them, because you can see they are dying?" Everyone was looking at us and it was humiliating"* – *a public healthcare user, Thembisa Clinic, August 2025*

Figure 43: On a scale of 1-5, how comfortable do you feel at the facility? (April to June 2025)



PEOPLE LIVING WITH HIV RE-ENGAGING IN CARE

KEY FINDINGS

Healthcare workers must expect treatment interruptions – it is normal! To support long term retention people re-engaging should be supported, not punished. Yet after being late for an appointment only a handful of people said staff asked how they could help make it easier in the future, and no-one said staff offered them a longer ART refill, or that staff told them about pick-up points to make ARV collection easier. The majority of people re-engaging in care need it to be made easier to collect treatment – this is a key element of the differentiated service approach in the ART guidelines. Conversely people did experience punitive actions by staff, mostly in Buffalo City where 60% said staff shouted at them on return – Buffalo City accounted for 16% of the 392 people who reported being shouted at across all districts monitored by Ritshidze. 22% said they were sent to the back of the queue to wait until all other patients had been seen first as punishment – accounting for 33% of the 579 people who reported being made to wait across all districts monitored by Ritshidze. The guidelines also specifically state that no punitive actions are allowed.

RECOMMENDATION

Provincial Department of Health
District Department of Health

Treatment interruptions must be expected and normalised, without penalty. People who have come back despite being late or missing an appointment have made it easier for the health system – it is not necessary to track and trace them and encourage them back into care. To support long term retention people re-engaging should be supported, not punished. **The majority of people re-engaging in care need it to be made easier to collect treatment less frequently to help solve their challenges – they should be provided with a 3 month supply on the day of return and assessed for (re)enrollment in pick-up points as quickly as possible. This is a key element of the differentiated service approach in the ART guidelines. The guidelines also specifically state that no punitive actions are allowed. The Department of Health should investigate the high number of reports of punitive action in Buffalo City especially. The Department of Health must ensure that all facilities adhere to the guidelines with fidelity.**

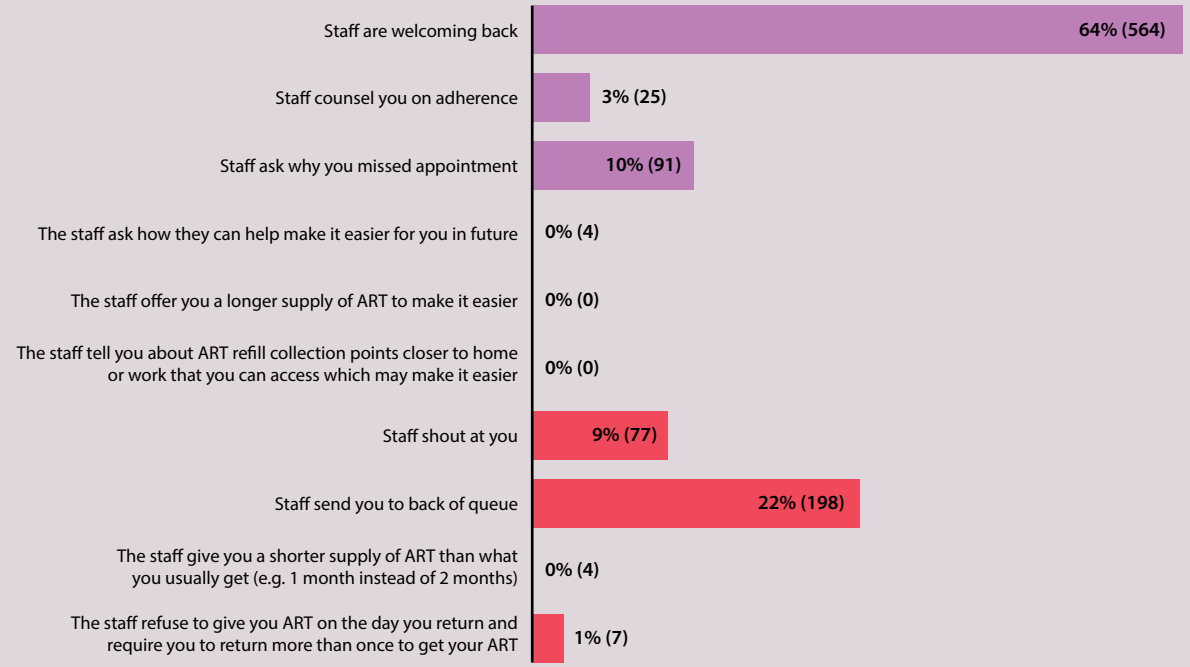
Once on treatment, it is important to recognise that people living with HIV live dynamic lives and it is normal to be late for or even miss appointments, and even miss taking some pills. When they return to the clinic, the public health system should meet them with support. The 2023 ART Guidelines describe how staff should be friendly and welcoming, and acknowledge the challenge for life-long adherence – as well as the importance of providing longer ART supply preferably from a pick-up point if the person returning is clinically well. However, often when people re-engage, instead of being asked how treatment collection could be made easier, they are shouted at and met with punishment.

If service delivery is not improved for those re-engaging, it will only continue to delay people's return to the clinic and

***"When I don't** have money for transport on my appointment date, I miss my appointment. When I finally go after getting money, the nurse tells me I will be the last patient to be assisted"* – *a person living with HIV, Empilweni Gompo CHC, Buffalo City, September 2025*

Figure 45: What happens if you are late for or miss an appointment (April to June 2025)

PLHIV surveyed: 882



increase the likelihood that people will return with advanced HIV. To address this, clinicians must be sensitised and attempt to expect and normalise treatment interruptions. This way the narrative between people living with HIV and clinician will be less punitive and more supportive. This is especially important given that more people are re-engaging currently than starting treatment for the first time.

Of those who had been late for/or missed an appointment, 64% said that on return staff welcomed them back (Figure 45). Yet – despite being mandated by national ART guidelines – other supportive measures were incredibly limited. Only 3% of people said staff counselled them on adherence, only a handful of people said staff asked how they could help make it easier in the future, and no-one said staff offered them a longer ART refill, or that staff told them about ART refill collection points closer to home or work that you can access which may make it easier. The majority of people re-engaging in care need it to be made easier to collect treatment and should be offered longer ARV supplies and assessed for (re)enrollment in pick-up points as quickly as possible. **This is a key element of the differentiated service approach in the ART guidelines – yet this is something the Eastern Cape is failing on.**

Conversely people did experience punitive actions by staff[5]. 9% said staff shouted at them on return – the Eastern Cape accounted for 20% of the 392 people who reported being shouted at across all provinces monitored by Ritshidze[6]. 22% said they were sent to the back of the queue to wait until all other patients had been seen first as punishment[7] – the Eastern Cape accounted for 34% of the 579 people who reported being made to wait across all provinces monitored by Ritshidze[8]. **The guidelines specifically state that no punitive actions are allowed.**

> ***"If you've missed your appointment at the clinic, they don't help you at all. If you decide to stay, they might help you collect your treatment, but after seven hours, when everyone else has been assisted"*** *– a person living with HIV, Flagstaff Clinic, OR Tambo, September 2025*

5. Again given that our surveys take place at the facility, those who have already interrupted treatment or disengaged from care after facing punitive measures would not be there to survey. As such this challenge may be more widespread than the data suggests.
6. This excludes Mangaung (Free State) where there were a very large number of people reporting being shouted at, skewing the data set.
7. The guiding principles of the re-engagement SOP state: *"Returning or re-engaging patients should not be made to wait until last to see any service provider but should join the patient queue on the same basis as all other patients. No punitive actions may be taken by facility staff"*. People should not be sent to the back of the queue or made to wait until the end of the day to be seen. People should join the queue as normal on arrival at the facility, irrespective of whether on time or late for their appointment. They should simply take up the next queue space.
8. This excludes Mangaung (Free State) where there were a very large number of people reporting being sent to the back of the queue, skewing the data set.

> ***"Sometimes I find** a friendly nurse, but other times I deal with unfriendly ones. By unfriendly, I mean that some nurses shout at you if you've missed your appointment date. They even tell you they will assist you last, even if you were next in line, so you're forced to go to the back of the queue. This is very stressful, but I wait patiently because I need my medication"*
> *– a person living with HIV, Empilweni Gompo CHC, Buffalo City, September 2025*

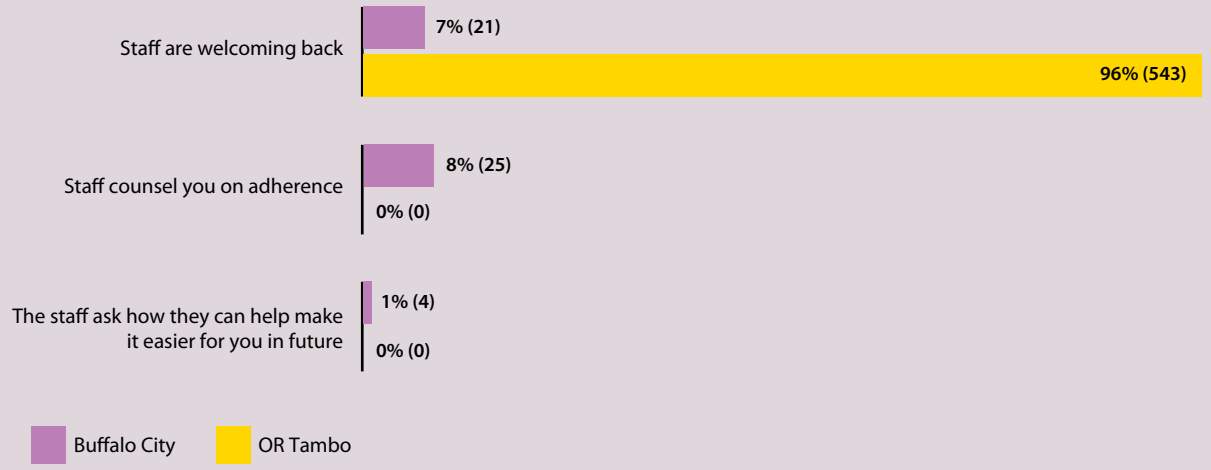
This varied considerably across districts – of those who had been late for/or missed an appointment – 96% of people were welcomed back in OR Tambo and just 7% in Buffalo City (Figure 46). Again, other supportive measures were incredibly limited across both districts: only 1% of people said staff asked how they could help make it easier in the future in Buffalo City, and no-one in OR Tambo. No-one in either district reported being offered a longer ARV refill or pick-up point option. All facilities must follow requirements outlined in ART guidelines to ensure those re-engaging are supported and offered longer refills and pick-up point options to make ARV collection easier.

While there were limited reports of punitive action in OR Tambo, 20% said staff shouted at them on return in Buffalo City – accounting for 16% of the 392 people who reported being shouted at across all districts monitored[9] (Figure 43). Buffalo City had the third highest number of reports of people being shouted at across all districts monitored, following Mangaung and uMgungundlovu. 60% said they were sent to the back of the queue to wait until all other patients had been seen first in Buffalo City – accounting for 33% of the 547 people who reported being sent to the back of the queue across all districts monitored[10]. A handful of people were even given a shorter supply or refused ART as punishment in both districts. A full site breakdown is in appendix 15.

Late and missed appointments must be normalised, without penalty. People who have come back despite being late or missing an appointment have made it easier for the health system – it is not necessary to track and trace them and encourage them back into care. The person has stepped back into the facility, so that experience should be as supportive as possible.

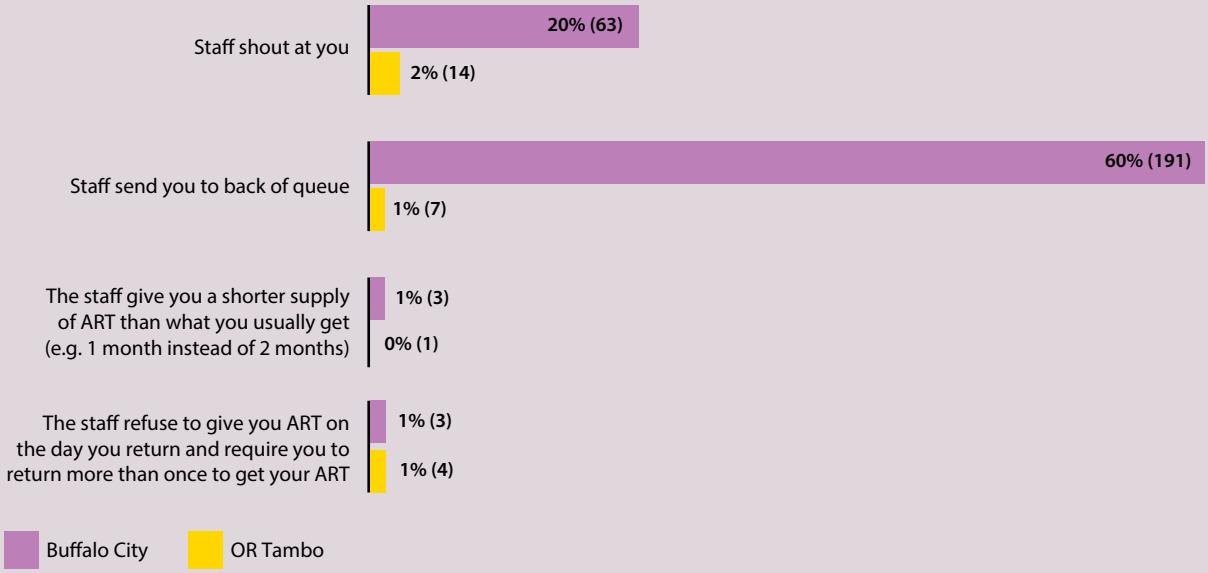
> ***"When you miss** an appointment, they shout at you"* *– a person living with HIV, NU 8 Clinic, Nelson Mandela Bay, August 2025*

Figure 46: SUPPORTIVE: What happens if you are late for or miss an appointment (April to June 2025)



9. This excludes Mangaung (Free State) where there were a very large number of people reporting being shouted at, skewing the data set.
10. This excludes Mangaung (Free State) where there were a very large number of people reporting being sent to the back of the queue, skewing the data set.

Figure 47: PUNITIVE: What happens if you are late for or miss an appointment (April to June 2025)



CHALLENGES TRANSFERRING BETWEEN CLINICS

KEY FINDINGS

It is imperative people can move between health facilities without barriers that can cause prolonged treatment interruptions. Yet 26 people reported having been denied services because they did not have a transfer letter in the last 3 months in the Eastern Cape – all in Buffalo City. This accounts for 26% of all reports across all districts monitored by Ritshidze. Transfer letters are not mandatory and people transferring without such documents should be immediately formally transferred and provided with a full supply of ART. However some sites said they provide only a buffer stock of ARVs until transfer documentation is collected, often from health facilities far away. People who are unable to collect these transfer documents, are very likely not to return and stop treatment.

RECOMMENDATION

Provincial Department of Health
District Department of Health

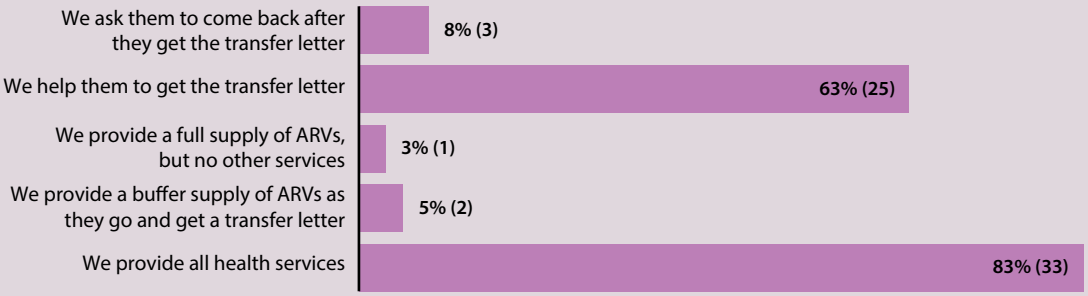
Transfer letters are not required by ART guidelines to start or restart your ARVs. Providing a buffer stock is also not good enough – it simply means more unnecessary trips back to the clinic for the person transferring, and a higher likelihood of the person interrupting treatment or disengaging from care. **The Guidelines on managing clinic transfers must be immediately re-iterated and implemented at all health facilities: continuing a person's ARV treatment on the day of arrival without short supply or requiring anyone to collect transfer documentation before or after being enrolled in the new clinic. The Department of Health should investigate the high number of reports of people being denied services without a transfer letter in Buffalo City especially.**

It is imperative that people can move between facilities without barriers that can cause prolonged treatment interruptions. 63% of facilities did say they help people to get a transfer letter if patients come to the facility without one (Figure 48). 83% of sites said that they provide all health services to people without a transfer letter, and 3% said they provide a full supply of ARVs. However, 5% said they only provide a buffer supply of ARVs, and the remainder did not provide any ARVs. Of the two facilities that provide a buffer stock, 1 provided just 1 month supply. Transfer letters are not required by ART guidelines to start or restart your ARVs[11]. While transfer letters can be helpful – they shouldn't be used as a barrier to getting ARVs, especially as often people struggle to get a referral from their previous facility, or do not have the time or money to travel back to their previous facility. Providing a buffer stock just means more unnecessary trips back to the clinic for the person transferring, and a higher likelihood of the person interrupting treatment or disengaging from care.

11. Transfer letters are also not required in the guiding principles of the re-engagement SOP which states: *"If a patient comes from a different facility, it is critical that the patient be provided with treatment on the day of presentation to limit any further treatment interruption... while referral letters are helpful, a patient cannot be required to leave the facility without treatment to first obtain a referral/transfer letter".*

Figure 48: What happens if a new patient comes to the clinic without a transfer letter? (April to June 2025)

Patients surveyed: 40



***"I started using** Luyolo Clinic after Engage Men's Health closed. They closed immediately without giving us transfer letters to take to other clinics. Not having my transfer letter became a challenge because there was no-one to contact from the organisation after they shut down. I went to Luyolo Clinic and explained my situation. The nurses drew my blood and gave me a 1 month supply of ARVs. During my next appointment, they gave me a 3 month supply instead of one month. They also told me that from my next collection date, I would be collecting my treatment from Clicks"* – *a gay man living with HIV, Luyolo Clinic, Buffalo City, August 2025*

Despite most facilities saying they support people to get transfer letters and provide services, concerningly 26 people told us they or someone they knew had been denied services without a transfer letter in this reporting period – accounting for 26% of the reports of people being denied services without a transfer letter across all provinces monitored[12]. As most people would have not needed a transfer letter, and the fact that those who had been denied services would not be at the clinic to survey, this could point to an even larger challenge with regard to transferring among clinics. All reports came from Buffalo City. Buffalo City was the third worst performing district out of all those monitored by Ritshidze, following Manguang (Free State) and Lejweleputswa (Free State). A full site breakdown is in appendix 16.

Additionally, during the PEPFAR disruptions, some mobile services and drop-in centres for members of key populations were disrupted or shut altogether. This forced people to return to the clinic. While PEPFAR partners attempted to ensure people received communication and referrals, Ritshidze received reports of people not being provided with transfer letters in the rush and confusion of the stop work orders.

The Guidelines on managing clinic transfers must be immediately re-iterated and implemented at all health facilities: continuing a person's ARV treatment on the day of arrival without short supply or requiring anyone to collect transfer documentation before or after being enrolled in the new clinic. Especially now that some services have closed with no possibility of collecting transfer documentation.

POOR TREATMENT OF PEOPLE WHO USE DRUGS, SEX WORKERS, AND THE LGBTQIA+ COMMUNITY

KEY FINDINGS

Only 28% of trans people surveyed reported that facility staff were always friendly, 21% of GBMSM, 17% of sex workers, and 15% of people who use drugs – compared to 63% of public healthcare users in the same reporting period. People in the Eastern Cape reported some of the worst attitudes towards members of key populations across all provinces monitored by Ritshidze. Further 12% of GBMSM, 15% of trans people, 19% of people who use drugs, and 21% of sex workers surveyed in the Eastern Cape had been denied services in the last year, and 9% of people who use drugs had been denied their ARVs. To address unfriendliness, lack of confidentiality, and routine denial of services, Centres of Excellence (CoEs) need additional staffing to instil culture change within the facility. At least 2 CoEs per district per population group must be established.

12. This excludes Mangaung (Free State) where there were a very large number of people reporting being denied services without a transfer letter, skewing the data set.

RECOMMENDATION

National Department of Health
Provincial Department of Health
District Department of Health

A culture change needs to be instilled to address unfriendliness, violations of confidentiality, and routine denial of services towards people who use drugs, sex workers, and the LGBTQIA+ community. **Facilities must offer friendly, welcoming, and confidential services to ensure members of key populations feel safe and comfortable to access health services in public health facilities. People who use drugs, sex workers, and the LGBTQIA+ community should never be denied access to health services, including ARVs.**

All facility staff (including clinical staff, non-clinical staff, lay staff, and security guards) who ill treat people, violate people's privacy, verbally or physically abuse or harass people, or deny people services including life saving ARVs must be held accountable and face consequences.

In addition, **all facilities must provide gender affirming services for trans and gender diverse people including using trans people's correct name and pronouns; allowing trans people to use their preferred bathroom and/or providing a gender neutral toilet; and removing coloured folders that mark people's (perceived) gender.**

Ritshidze receives countless reports of people who use drugs being denied health services because they have not had access to ablution facilities. No-one should ever be turned away for this. **Facilities should assess how they can provide people with a form of private ablution facilities on site, even at a basic level, especially at Centres of Excellence (CoEs).**

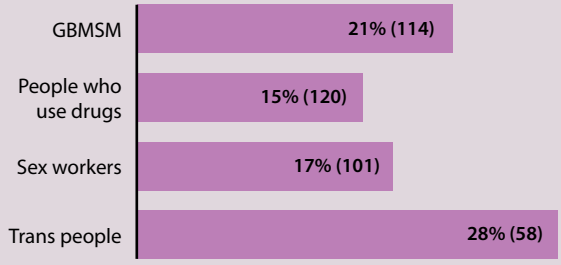
> ***"When I disclose that I'm gay or that I have sex with men to a healthcare worker, they sometimes shout or make inappropriate remarks, such as, "anal sex is painful; how do you do it?"*** *– a gay man living with HIV, Booysens Park Clinic, Nelson Mandela Bay, August 2025*

Commonly people who use drugs, sex workers and the LGBTQIA+ community face particularly uncaring, uncompassionate, and sometimes cruel treatment at clinics. This makes it even more difficult to access health services including HIV testing/prevention services, or ART collection for members of key populations living with HIV. Without making services friendlier and safer for people who use drugs, sex workers and the LGBTQIA+ community, the Department of Health will never get everyone on ARVs and address the retention crisis, or prevent more people getting HIV.

Data collected in the community in 2024 in the Eastern Cape shows that only 28% of trans people surveyed reported that facility staff were always friendly, 21% of gay, bisexual, and other men who have sex with men (GBMSM), 17% of sex workers, and 15% of people who use drugs (Figure 49). The Eastern Cape scored worst on staff friendliness towards sex workers and trans people, and second worst on staff friendliness towards GBMSM and people who use drugs. While this cannot be directly compared to data collected through our general facility monitoring (that takes place in the facility setting among all public healthcare users), it points to worse attitudes towards members of key populations compared to the 63% of public healthcare users who said staff were friendly in the province in the same reporting period (July to September 2024).

> ***"Before using Engage Men's Health, I was a patient at Nontyatyambo Clinic, but I faced challenges there too. The waiting times were extremely long. Even if you arrived early in the morning, you would leave late in the afternoon, sometimes without getting the medication or services you needed. It was exhausting. Privacy and confidentiality were also not respected. A nurse would shout in the waiting area, saying, "those who came for treatment collection, this side; those who are sick, that side." That immediately disclosed my HIV status to everyone, which was very painful. That experience pushed me to switch to Engage Men's Health, where I felt safer and respected. When Engage Men's Health closed, I was afraid to use clinics again because of those bad past experiences and the challenges we often face"*** *– a gay man living with HIV, Luyolo Clinic, Buffalo City, August 2025*

Figure 49: Members of key populations reporting that facility staff are always friendly (July to September 2024)



> ***"I previously used** Booysens Park Clinic. I changed clinics because I experienced stigma there. Things have been much better since the switch, even though Despatch Clinic is not close to where I live. At Booysens Park Clinic, there was no confidentiality. For example, a cleaner would say things like, "You didn't show up last month for your appointment," in front of others. Some nurses who live in the community know about my personal life outside the clinic and sometimes bring up things I do and talk about them while I'm at the facility"*
> *– a gay man living with HIV, Booysens Park Clinic, Nelson Mandela Bay, August 2025*

Figure 50: Members of key populations reporting that facility staff are always friendly (July to September 2024)

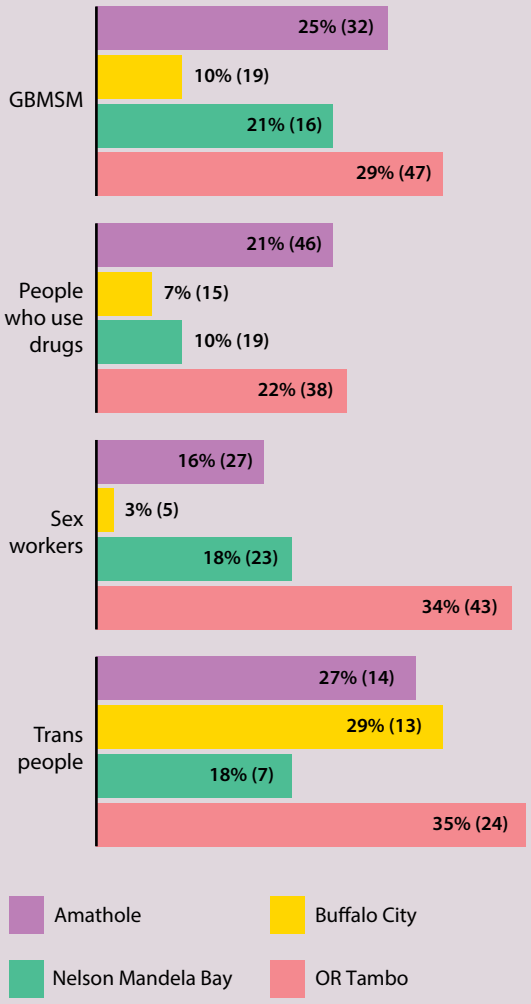
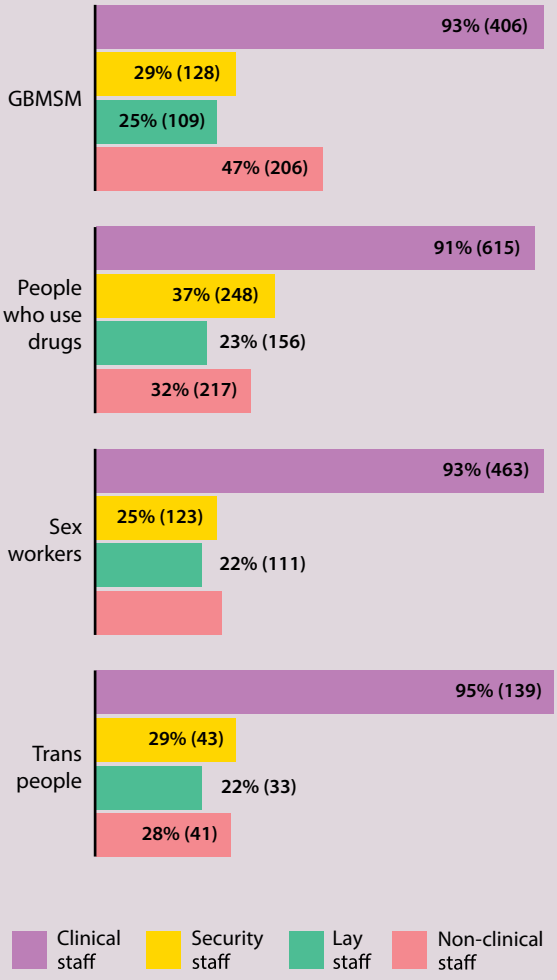


Figure 51: Which staff are not always friendly? (July to September 2024)



There was some variation across districts. Only 29% of GBMSM surveyed reported that staff were always friendly in OR Tambo, followed by 25% in Amathole, 21% in Nelson Mandela Bay, and just 10% in Buffalo City (Figure 50). Only 22% of people who use drugs surveyed reported that staff were always friendly in OR Tambo, followed by 21% in Amathole, 10% in Nelson Mandela Bay, and just 7% in Buffalo City. Only 34% of sex workers surveyed reported that staff were always friendly in OR Tambo, followed by 18% in Nelson Mandela Bay, 16% in Amathole, and just 3% in Buffalo City. Only 35% of trans people surveyed reported that staff were always friendly in OR Tambo, followed by 29% in Buffalo City, 27% in Amathole, and 18% in Nelson Mandela Bay. Overall Buffalo City performed worst, however no district treated members of key populations well.

Most typically clinical staff (doctors, nurses etc) were reported as being unfriendly, followed by security staff (who are meant to protect and keep people safe) and non-clinical staff (cleaners, admin staff, file clerks etc) (Figure 51).

Disgraceful confidentiality violations remain common. 58% of trans people, 72% of GBMSM, 74% of people who

use drugs, and 74% of sex workers did not think privacy was respected (Figure 52). This includes disclosure of people's HIV status, sexuality, gender, or that they use drugs or do sex work, security guards checking people's medicines, and staff entering consultation rooms mid consultation (Figure 53, 54, 55, 56). This is another factor that results in people not feeling truly safe and comfortable when trying to access healthcare at the facility.

While we cannot make any direct comparisons, it is important to note that among people living with HIV surveyed at the facility, only 2% thought their HIV status was not kept confidential in the province in the same reporting period[13].

Figure 52: Members of key populations reporting that privacy is not well respected at facilities (July to September 2024)

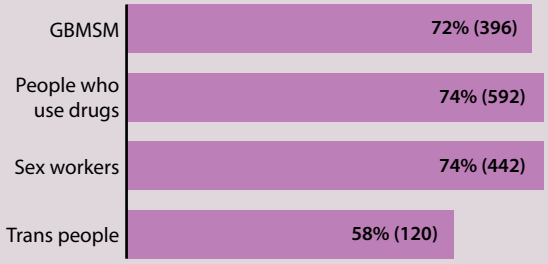


Figure 53: Most common privacy violations faced by GBMSM (July to September 2024)

GBMSM surveyed: 396

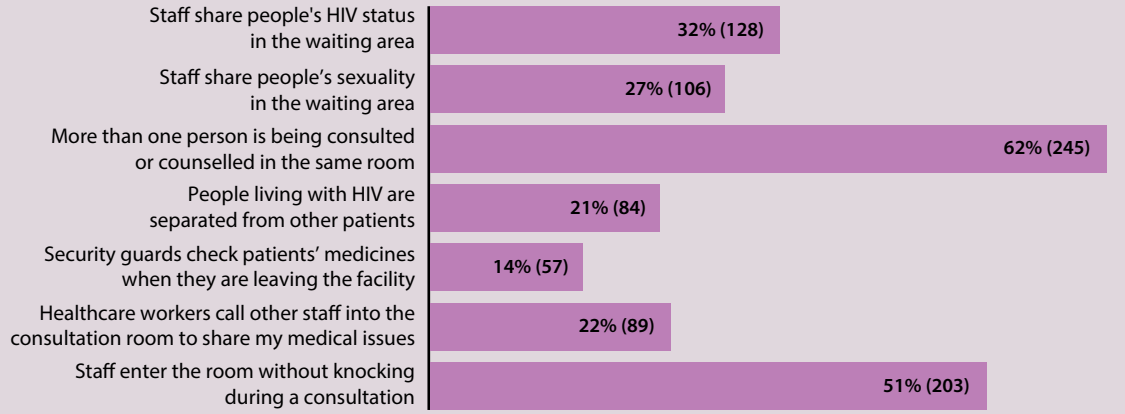
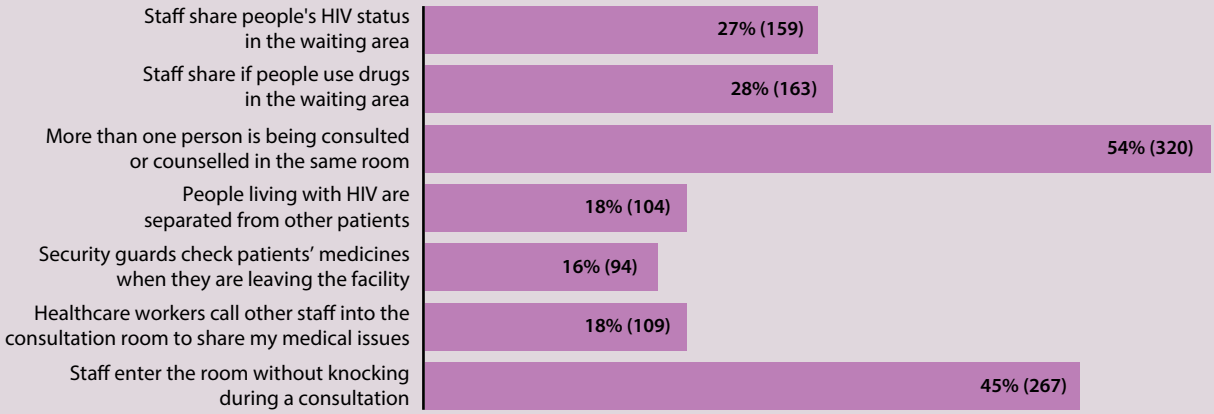


Figure 54: Most common privacy violations faced by people who use drugs (July to September 2024)

People who use drugs surveyed: 592



13. Note that there is a potentially meaningful difference in how this question is asked in our general facility monitoring survey and the KP surveys. In the general population survey, the question is phrased as "Do you think that this facility keeps people's HIV status confidential and private?" with answer choices as "Yes", "No", "Don't Know" and "Prefer not to answer". In the KP survey, our question was phrased as "Do you think that this facility respects people's confidentiality and privacy?" with answer choices "Yes", "No", "Don't Know", and "Prefer not to answer".

Figure 55: Most common privacy violations faced by sex workers (July to September 2024)

Sex workers surveyed: 441

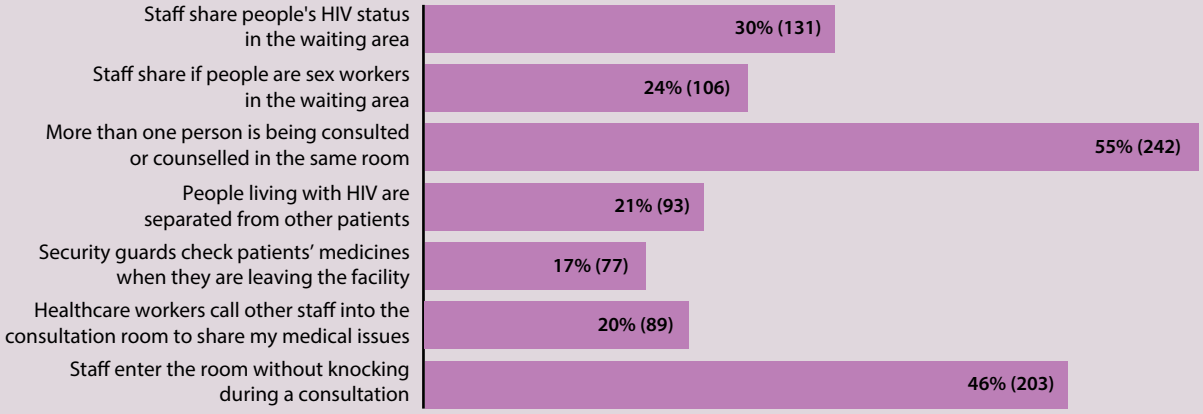
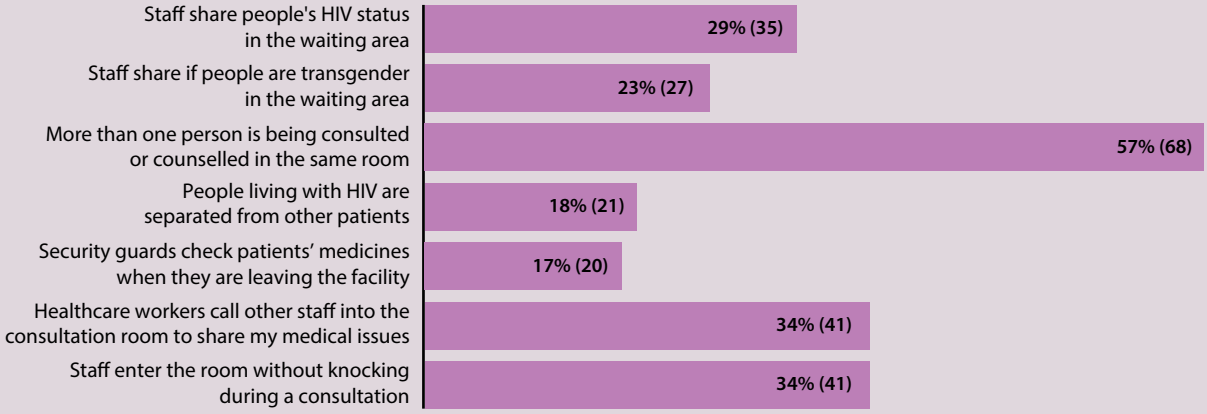


Figure 56: Most common privacy violations faced by trans people (July to September 2024)

Trans people surveyed: 120



For trans and gender diverse people there is a further level of disrespect. Public health facilities should provide gender affirming care to ensure that trans and gender diverse people feel comfortable and affirmed in their gender identity and gender expression.

However, only 26% of trans people surveyed said that staff were always respectful. 60% said staff were only sometimes respectful, and 14% said they were never respectful (Figure 57). 59% of those who said staff were only sometimes/never respectful blamed facility staff not using their preferred name and 71% blamed them using the wrong pronouns (Figure 58). Other people also complained about: staff being rude because they are trans (22%); being asked questions about being trans not related to the services they needed (21%); not being able to use their preferred toilet (20%); the folders being colour coded by perceived gender and staff giving them the wrong colour (14%); staff revealing they were trans to other staff for no reason (8%); or being refused services because they said I was the "wrong" gender (7%).

All of this adds the discomfort, lack of safety, and gender dysphoria trans and gender diverse people may feel while at the facility – and can lead to people not accessing HIV prevention services, or disengaging from care and stopping their ARVs.

Figure 57: Are the staff respectful of your gender identity, for example using your preferred name and using your correct gender? (July to September 2023)

Trans people surveyed: 228

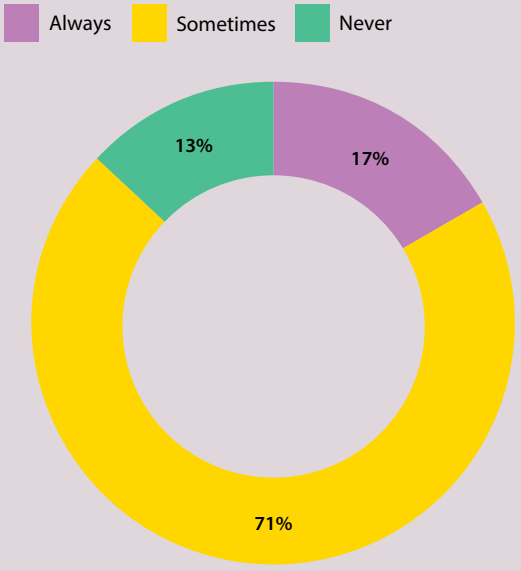
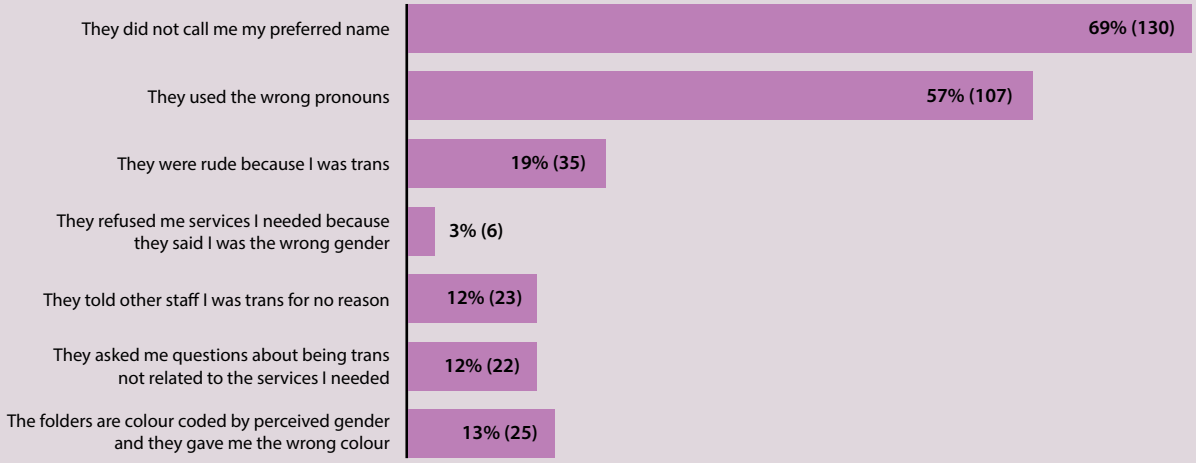




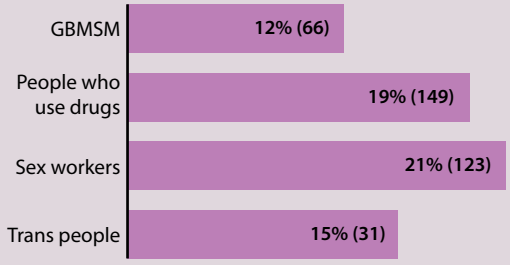
Figure 58: How were staff disrespectful? (July to September 2024)
Trans people surveyed: 189



Members of key populations are also routinely denied access to services. Being denied services is a humiliating, painful, and unjust experience to go through – and a violation of the Constitutional right to health, equality, and human dignity. While some people may suffer the indignity of trying to get services another time, others can be pushed out of care altogether.

Data from 2024 show that 12% of GBMSM, 15% of trans people, 19% of people who use drugs, and 21% of sex workers surveyed in the Eastern Cape had been denied services in the last year (Figure 59). No district performed well for any population group – but the worst performers include: 39% of GBMSM being denied services in Nelson Mandela Bay; 35% of people who drugs being denied services in Nelson Mandela Bay, 21% in OR Tambo, and 13% in Buffalo City; 54% of sex workers being denied services in Nelson Mandela Bay, 17% in OR Tambo, and 11% in Buffalo City; and 33% of trans people being denied services in Nelson Mandela Bay, 13% in Buffalo City, and 13% in OR Tambo (Figure 60).

Figure 59: People who had been refused access to services at the facility in the last year because they are a member of a key population (July to September 2024)



***"Some staff members** at the clinic are very homophobic. When they see someone is part of the LGBTIQ community, they sometimes refuse to assist them" – a gay man, Tshangana Clinic, Nelson Mandela Bay, August 2025*

Figure 60: People who had been refused access to services at the facility in the last year because they are a member of a key population (July to September 2024)

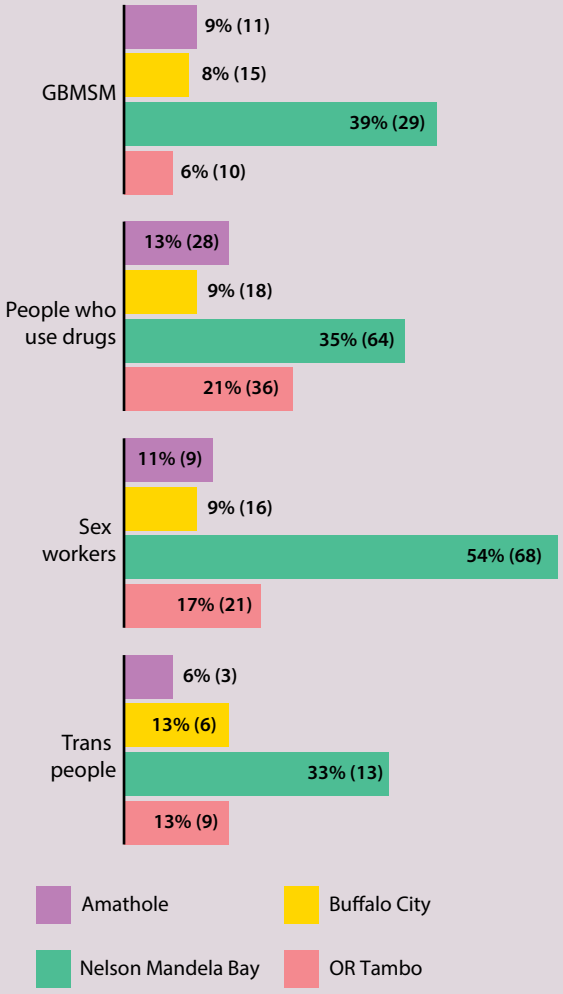
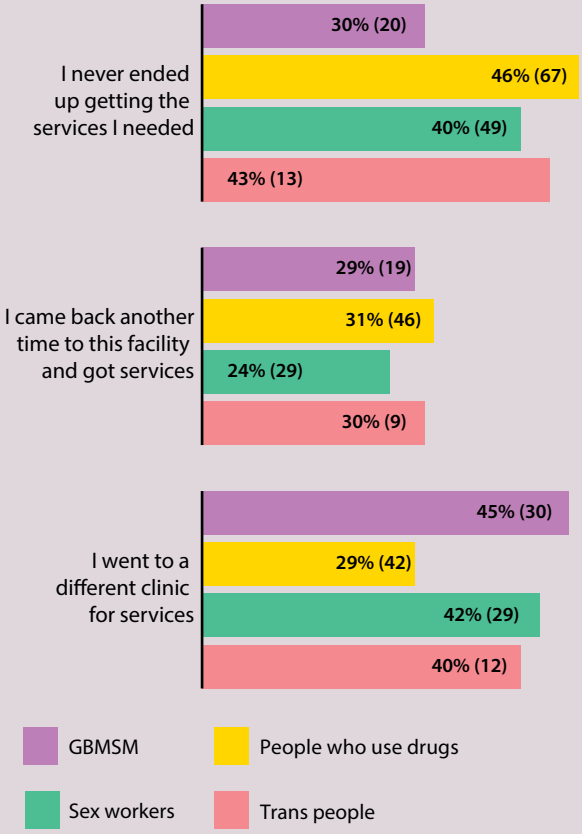


Figure 61: What happened after you were refused access to services at the facility? (July to September 2024)



Some people surveyed suffered the indignity of returning to the clinic another time to get services – including 24% of sex workers, 29% of GBMSM, 30% of trans people, and 31% of people who use drugs surveyed who had been denied services (Figure 61). However others never got the services they needed – including 30% of GBMSM, 40% of sex workers, 43% of trans people, and 46% of people who use drugs surveyed who had been denied services.

9% of people who use drugs surveyed across the province also reported having been denied access to their HIV treatment in the last year (Figure 62) – 6% in Buffalo City, 7% in Amathole, 10% in OR Tambo, and 11% in Nelson Mandela Bay (Figure 63). 46% of those were told they could not have their ARVs because they would smoke them, and 28% were told they could not have their ARVs because they use drugs (Figure 64). A result of longstanding and unfounded myths around the addition of ARVs to heroin based substances (such as nyaope). Denying people their life saving ARVs puts them at risk of getting advanced HIV, multiple other illnesses, and even dying. It also further increases HIV transmission.

Figure 62: Of people living with HIV, in the last year have you been refused access to ARVs at this facility because you are a person who uses drugs? (July to September 2024)

People who use drugs surveyed: 600

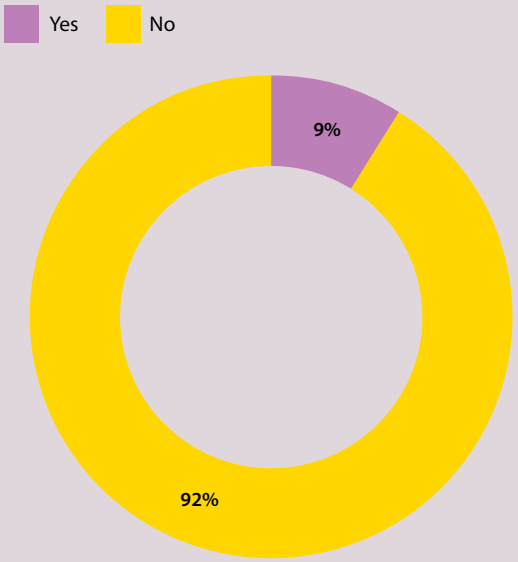
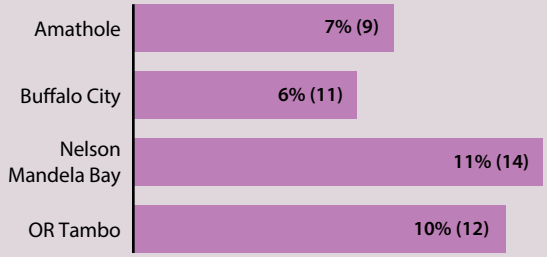
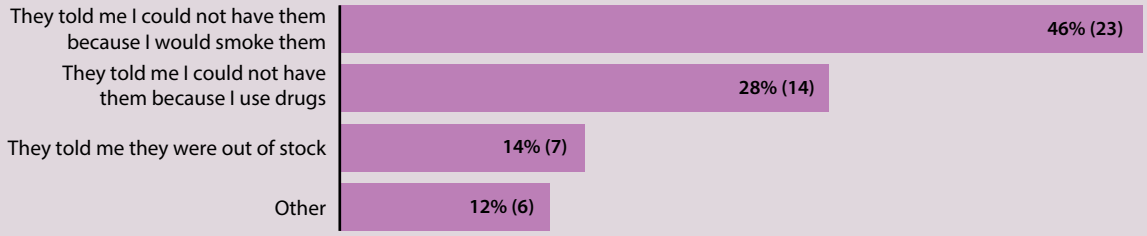


Figure 63: People living with HIV who have you been refused access to ARVs at the facility in the last year because they use drugs (July to September 2024)



"I'm not the only gay person who has had problems at Booysens Park Clinic. Two of my friends, who are also gay, stopped collecting their HIV treatment there and are planning to get it from the Despatch Clinic as well" *– a gay man living with HIV, Booysens Park Clinic, Nelson Mandela Bay, August 2025*

Figure 64: Why were you refused ARVs? (July to September 2024)
People who use drugs surveyed: 50



In addition to ARVs, people surveyed also reported being denied other key services specifically because they are a member of a key population. PEP had been denied for a variety of reasons, but 8% of people surveyed had been told they could not get PEP at the facility specifically because they are GBMSM, and 11% because they are a sex worker. 20% of people surveyed had been told they could not get STI services at the facility because they are a sex worker, and 35% because they are trans. Contraceptives were also denied with 10% of people surveyed being denied contraceptives because they are a sex worker, 15% because they are trans, and 20% because they use drugs.

These are core issues why people stop going to the facility and are scared to return, or are unable to return because they are refused services entirely. This is critical to address across all facilities – and particularly in sites being classified as Centres of Excellence (CoEs). CoEs are public health facilities that are identified by the Department of Health and PEPFAR as places members of key populations can go to access services. However, after several years of implementation, at the end of 2024 only 3 CoEs had been "completed" across just OR Tambo in the Eastern Cape. In addition to being slow progress, being "completed" simply means that a training has taken place at the site. No additional staffing, expertise, or clinical services have been added to make this a place for members of key populations to come. To address unfriendliness, lack of confidentiality, and routine denial of services, CoEs need additional staffing to instil culture change within the facility. At least 2 CoEs per district per population group must be established.

IDENTITY DOCUMENTS (IDs)/MIGRANTS

KEY FINDINGS

Section 27 of the South African Constitution affords everyone the right to have access to health care services, yet 56 people told us they or someone they knew had been denied services without an ID – accounting for 19% of the 291 people who reported this across all provinces monitored by Ritshidze. Further 18% of people who use drugs surveyed across the province had been denied access to services because they did not have an ID including 25% in OR Tambo, and 35% in Nelson Mandela Bay.

RECOMMENDATION

National Department of Health
Provincial Department of Health
District Department of Health

Section 27 of the South African Constitution affords everyone the right to have access to health care services, including reproductive services – including migrants, stateless persons and transient populations. Further, in 2023 the Gauteng High Court upheld the right of all pregnant and lactating women,

and children under 6, irrespective of nationality and documentation status, to access free health services at all public health establishments, including hospitals. Migrants, asylum seekers, stateless people, and **people without identity documents or proof of address should not be denied health services**. **The Department of Health should investigate the high number of reports of people being denied services without an identity document across multiple districts in the Eastern Cape.**

Additionally people can be denied services without an ID or because they are not a South African citizen. 56 people told us they or someone they knew had been denied services without an ID in this reporting period in the Eastern Cape – accounting for 19% of the 291 people who reported this across all provinces monitored by Ritshidze[14]. This includes 42 people in Buffalo City (accounting for 14% of the 291 people who reported this), and 14 people in OR Tambo (accounting for 5% of the 291 people who reported this)[15]. A full site breakdown is in appendix 16. Further data from 2024 show that 18% of people who use drugs surveyed across the province had been denied access to services because they did not have an ID (Figure 65) – 5% in Buffalo City, 12% in Amathole, 25% in OR Tambo, and 35% Nelson Mandela Bay (Figure 66).

Section 27 of the South African Constitution affords everyone the right to have access to health care services, including reproductive services – including migrants, stateless persons and transient populations.

Further, in 2023 the Gauteng High Court upheld the right of all pregnant and lactating women, and children under 6, irrespective of nationality and documentation status, to access free health services at all public health establishments, including hospitals.

While the South African public health system is under strain, scapegoating migrants diverts attention away from the real challenges – decreasing budgets and lack of investment, the withdrawal of PEPFAR resources, overworked healthcare workers, mismanagement, corruption – that have plagued the public health system[16]. Denying migrants health services does not alleviate this crisis. Furthermore, an estimated 12% of people born in South Africa do not have identity documentation[17]. It is critical that migrants, asylum seekers, stateless people, and people without identity documents or proof of address are not denied health services in our clinics.

Figure 65: In the last year, have you been refused access to services at this facility because you did not have an ID? (July to September 2024)

People who use drugs surveyed: 799

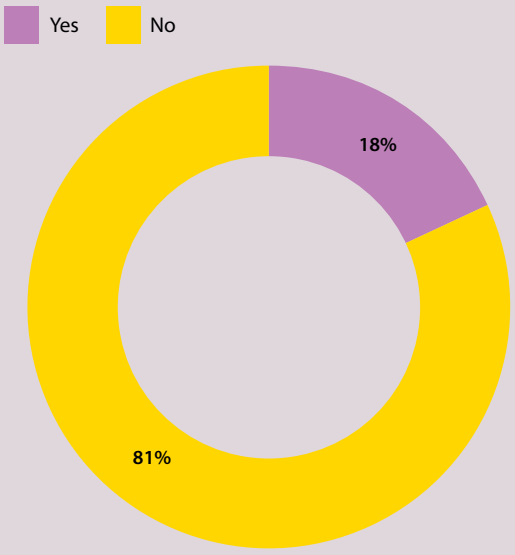
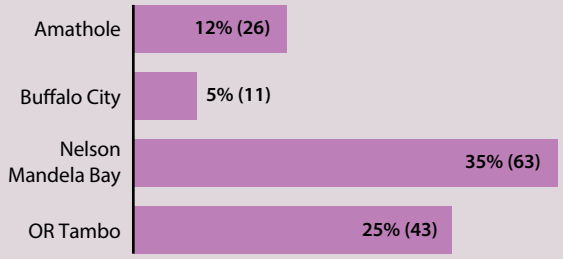


Figure 66: In the last year, have you been refused access to services at this facility because you did not have an ID? (July to September 2024)



Section 27 of the South African Constitution affords everyone the right to have access to health care services, including reproductive services – including migrants, stateless persons and transient populations.

14. This excludes Mangaung (Free State) where there were a very large number of people reporting being denied services without an ID, skewing the data set.
15. Given that our surveys take place at the facility, those who have already interrupted treatment or disengaged from care after facing challenges getting services without an ID or for not being South African would not be there to survey. As such this challenge may be more widespread than the data suggests.
16. Understanding Migration in South Africa. Lawyers for Human Rights, SECTION27, Kopanang Africa, Scalabrini Centre of Cape Town, Treatment Action Campaign (TAC), Consortium for Refugees and Migrants in South Africa (CoRMSA). Available at: https://kaax.org.za/wp-content/uploads/2025/04/Migration-and-Healthcare-in-South-Africa.pdf
17. Stats SA (2022). Census 2022. Statistical release P0305. Statistics South Africa.

PRIORITY 6

CLINICAL ART MANAGEMENT SERVICES

Figure 67: Have viral load testing services been affected by the PEPFAR withdrawal? (April to June 2025)

Facility staff surveyed: 40

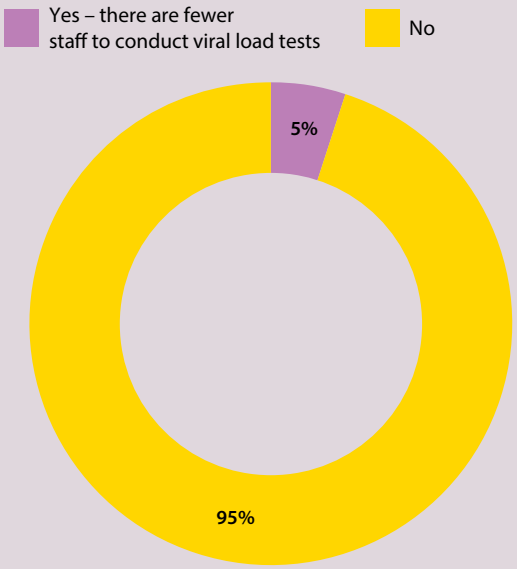
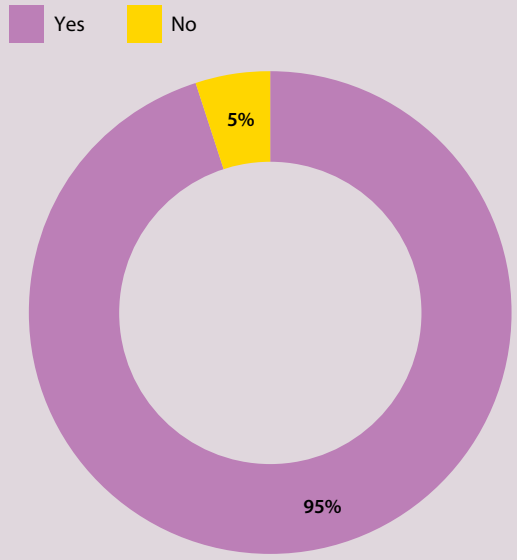


Figure 68: Did a healthcare provider explain what the results of this test means to you? (April to June 2025)

PLHIV surveyed: 1 118



VIRAL LOAD

KEY FINDINGS

Most facilities reported that viral load testing services have not been affected by the PEPFAR disruptions – and 95% of people living with HIV reported a healthcare worker explaining the results of their viral load test to them. This correlates with overall treatment literacy levels in the province.

RECOMMENDATION

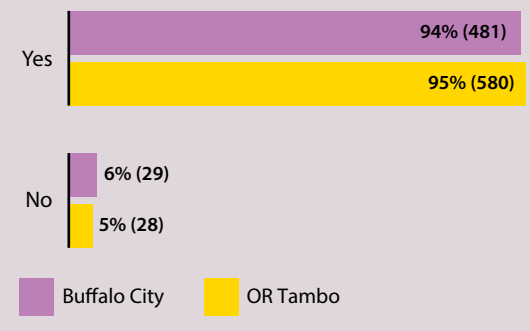
Provincial Department of Health
District Department of Health

Viral load testing services are a critical component of the HIV response. **The Department of Health must ensure that viral load testing is maintained following the PEPFAR disruptions.**

In addition, all facilities must explain the results of people's viral load tests and help them understand the importance of taking treatment effectively.

Viral load testing services are a critical component of the HIV response. The majority of sites monitored did not report challenges since the PEPFAR disruptions (Figure 67). Positively 95% of people reported a healthcare worker explaining the results of their viral load test (Figure 68) – 94% in Buffalo City (down from 99% in January 2025), and 95% in OR Tambo (up from 83% in January 2025) (Figure 69). The Eastern Cape was the second best performing province at providing explanations for viral load test results.

Figure 69: Did a healthcare provider explain what the results of this test means to you? (April to June 2025)



The proportion of people reporting that healthcare workers explained their test results to them also correlates with overall treatment literacy. Treatment literacy educates and empowers ordinary people in South Africa to understand how HIV works in the body, how they can be treated, and how transmission can be prevented. It helps people understand the importance of taking treatment as prescribed. In this reporting period 97% of people surveyed agreed that having an undetectable viral load means treatment is working well (Figure 70) – and 97% agreed that having an undetectable viral load means a person cannot transmit HIV (Figure 71). This is up from 90% and 88% in January 2025 respectively. The Eastern Cape is the best performing province with regard to treatment literacy.

Both Buffalo City and OR Tambo performed well, improving from January 2025. Facility level results range from 100% down to 85% on both indicators. Full site breakdowns are in appendix 17 and 18. Chris Hani also performed well in January 2025 with 97% of people surveyed agreed that having an undetectable viral load means treatment is working well – and 91% agreed that having an undetectable viral load means a person cannot transmit HIV. Conversely, people in Alfred Nzo surveyed had far lower levels of treatment literacy: only 68% of people surveyed agreed that having an undetectable viral load means treatment is working well – and only 65% agreed that having an undetectable viral load means a person cannot transmit HIV.

The Department of Health must ensure that all facilities explain the results of people's viral load tests and help them understand the importance of taking treatment effectively.

***"When they draw** blood, they don't usually explain the results to me… sometimes they will remind me about drawing blood at my next appointment, but other times they just give me another date without explaining anything. It's important to know whether your treatment is working. But most of the time, the staff don't explain my viral load. This is very wrong because it's important for me to know my viral load levels. I keep taking my treatment without knowing my viral load, and this makes me feel uninformed about my health"* – *a person living with HIV, Nobuhle Clinic, Buffalo City, August 2025*

Figure 70: Do you agree with the following statement: an undetectable viral load means the treatment is working well (April to June 2025)

PLHIV surveyed: 1 149



Figure 71: Do you agree with the following statement: an undetectable viral load means a person cannot transmit HIV (April to June 2025)

PLHIV surveyed: 1 148



Figure 72: Do you agree with the following statement: an undetectable viral load means the treatment is working well (April to June 2025)

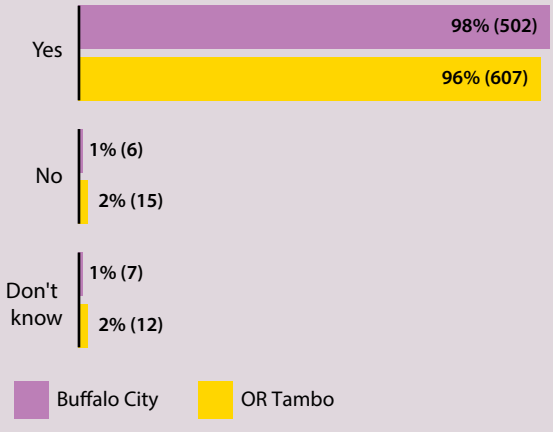
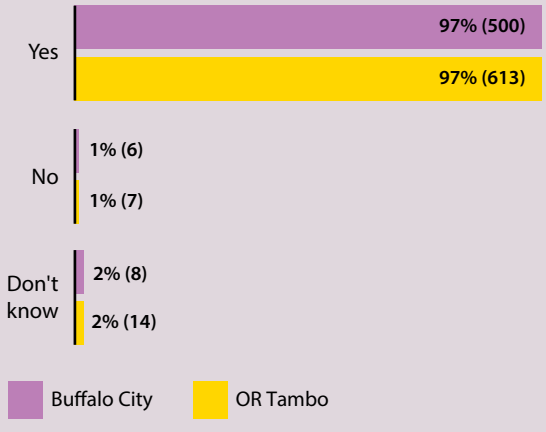


Figure 73: Do you agree with the following statement: an undetectable viral load means a person cannot transmit HIV (April to June 2025)



> ***"Another challenge is** that they don't explain my results to me, despite me continuously taking the treatment. I expected them to explain because I've been feeling weak since December 2024 until now. But they just look at the computer, tell me my blood results are back and say nothing else"** – a person living with HIV, Empilweni Gompo CHC, Buffalo City, September 2025*

> ***"When they take** our blood for tests, they never explain our results and it is not fair"** – a public healthcare user, NU 8 Clinic, Nelson Mandela Bay, August 2025*

ROUTINE CLINICAL CONSULTATIONS

KEY FINDINGS

8% of sites in the Eastern Cape reported there were fewer staff to conduct routine clinical consultations since January 2025 and 3% of sites said there were no staff.

RECOMMENDATION

Provincial Department of Health
District Department of Health

The Department of Health must ensure that routine clinical consultations are adequately maintained following the PEPFAR disruptions.

Routine clinical consultations have been mildly impacted by the PEPFAR disruptions. 8% of sites in the Eastern Cape reported there were fewer staff to conduct routine clinical consultations and 3% said there were no staff since January 2025 (Figure 74). Both districts reported routine clinical consultations being affected (Figure 75).

Figure 74: Have routine HIV clinical consultations been affected by the PEPFAR withdrawal? (April to June 2025)

Facility staff surveyed: 40

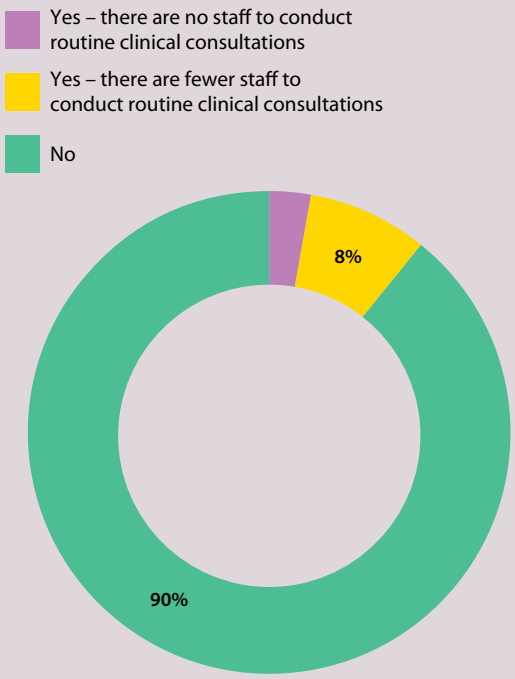
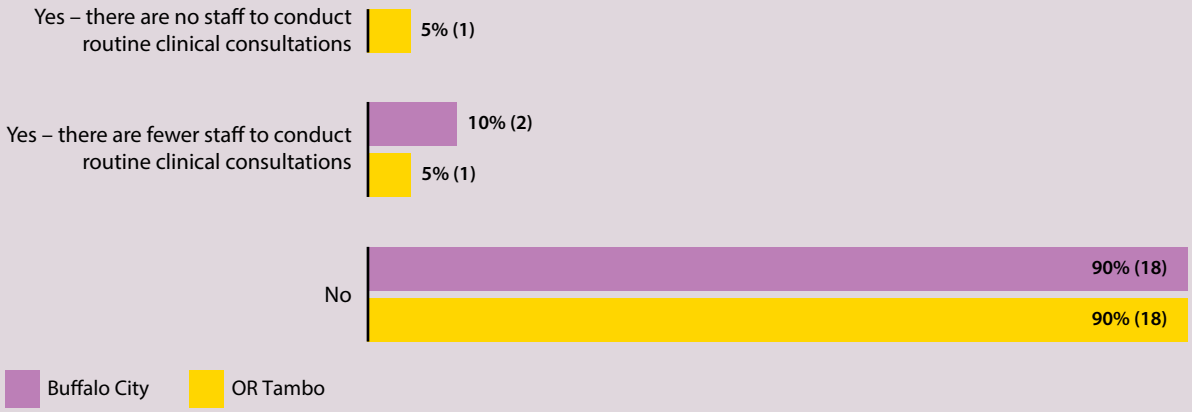


Figure 75: Have routine HIV clinical consultations been affected by the PEPFAR withdrawal? (April to June 2025)



CALLING A PERSON BACK TO THE FACILITY EARLY TO MANAGE AN ABNORMAL BLOOD RESULT

KEY FINDINGS

All sites reported challenges with recalling people with elevated viral loads or other abnormal blood results – with 95% of sites blaming people providing incorrect phone numbers. Facility management must assess the specific drivers of an ineffective recall system in their facility and implement interventions to improve effectiveness urgently.

RECOMMENDATION

Provincial Department of Health
District Department of Health

Facility management must assess the specific drivers of an ineffective recall system in their facility and implement interventions to improve effectiveness urgently. People with abnormal test results need to be recalled to ensure they do not become sick or get worse. Differentiated care means actioning people who require more clinical attention instead of wasting time on people who are stable on treatment and doing well.

Clinics must regularly and clearly inform people about the reason for providing a phone number that works and update their phone numbers at every visit. By better informing people so they understand the importance of providing a functional phone number through health talks, posters, and direct engagement, and ensuring people know that no private information will be disclosed over the phone, people will be much more likely to provide correct numbers in the first place and update them as they change.

While the majority of people in pick-up points are stable/virally suppressed and do not need to be brought back in to review their viral load before rescripting – the minority who do have an elevated viral load or other abnormal result cannot wait for it to be actioned in 6-months time at their next clinical review. Effective recall systems are critical to bring these people back to the clinic.

While 96% of facilities reported having effective recall systems – all sites still report challenges recalling people including: having incorrect phone numbers on file (95%), patients delaying coming in after contact (83%), delays from the lab (28%), not enough staff managing recalls (18%), and no airtime or dedicated phone line to recall people (10%) (Figure 76). A full site breakdown is in appendix 19.

It is unsurprising that people delay coming to the clinic after contact given people's fears of facing punishment when they re-engage in care. Or for people who use drugs, sex workers, and queer and trans people to delay coming in on the basis of past hostility and ill treatment. It is critical that clinicians are supportive to those re-engaging, not punitive.

Facilities must offer friendly and welcoming services, so that people are able to easily return to the clinic. A culture change needs to be instilled towards people living with HIV who have interrupted treatment or disengaged from care, and towards members of key populations.

Further to support rapid recall systems, facilities must ask public healthcare users for updated phone numbers on every clinic visit. While 95% of facilities say they do ask on every visit – still 95% report having incorrect phone numbers on file, leading to challenges in recall.

By better informing people so they understand the importance of providing a functional phone number through health talks, posters, and direct engagement, and ensuring people know that no private information will be disclosed over the phone, people will be much more likely to provide correct numbers in the first place and update them as they change.

Helping people understand the importance of taking their treatment as prescribed to increase overall treatment literacy levels is also critical to ensure that people do not delay returning to the clinic after being recalled.

Figure 76: What difficulties are you having to recall people with abnormal results? (April to June 2025)
Facility staff surveyed: 40

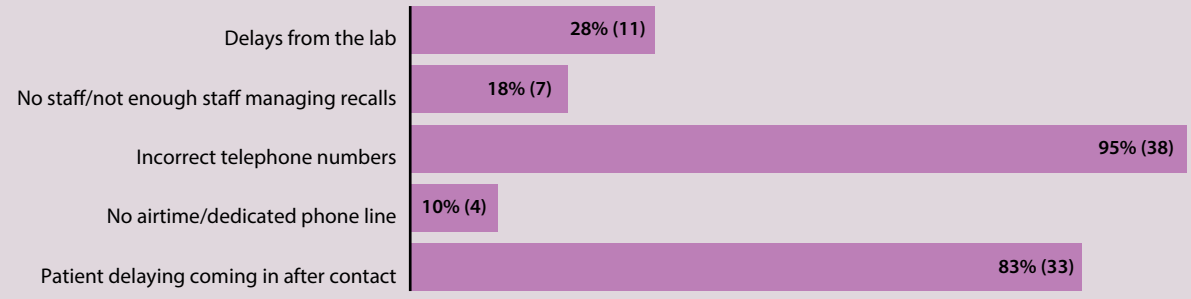


Figure 77: Have psychosocial support services been affected by the PEPFAR withdrawal? (April to June 2025)

Facility staff surveyed: 39



PSYCHOSOCIAL SUPPORT

KEY FINDINGS

Awareness of psychosocial support services remains high among people living with HIV at 94%, however the package of psychosocial services remains inadequate. While 98% of people in OR Tambo reported that individualised counselling was available for any person living with HIV – only 45% in Buffalo City did. This points to the PEFPAR disruptions in Buffalo City reducing the number of counsellors available for critical HIV testing and adherence counselling. Other elements of psychosocial support remain unavailable – 0% of people reported being able to access food parcels.

RECOMMENDATION

Provincial Department of Health
District Department of Health

Psychosocial support services are a critical component of the HIV response. **The Department of Health must ensure that psychosocial support services are maintained following the PEPFAR disruptions. Further, the Department of Health must ensure that people are aware of what services are actually available and how to access them.**

Further, facilities must provide a full package of psychosocial support services including: individualised quality counselling at any time including before and after an HIV test, before ART initiation, at re-engagement or struggling with adherence, and for disclosure support; peer-led patient navigators acting as a bridge between clinicians and patients; referral to social workers, mental health services, and other services; optional support groups and adherence clubs linked to each facility; and food parcels.

The Department of Health must urgently investigate the limited reports of individualised counselling being available in Buffalo City.

Psychosocial support for people living with HIV – including for some people re-engaging in care – is critical to ensure long term retention. This is a key element of the differentiated service approach in the ART guidelines. The majority of sites did not report that psychosocial support services had been affected by the PEPFAR disruptions (Figure 77) – however the 8% that did were all in Buffalo City.

Further, awareness of psychosocial support services among people living with HIV increased from 91% in January 2025 up to 94% in this reporting period (Figure 78). Across districts 98% said that psychosocial support was available in OR Tambo (3% increase from 95% in January 2025). In correlation with the PEPFAR disruptions, there was a 9% reduction in those knowing psychosocial support was available in Buffalo City (from 99% in January 2025 to 90% in this reporting period). Also in January 2025, 100% of people said psychosocial support was available in Chris Hani, while just 65% did in Alfred Nzo. Again the Provincial Department of Health should look into sites outside of Ritshidze monitoring to assess awareness of psychosocial support services. A full site breakdown is in appendix 20.

While awareness of psychosocial support services was for the most part high, the package of psychosocial services remains inadequate. A full package of services should include: individualised quality counselling at any time including before and after an HIV test, before ART initiation, at re-engagement or struggling with adherence, and for disclosure support; peer-led patient navigators acting as a bridge between clinicians and patients; referral to social workers, mental health services, and other services; and optional support groups and adherence clubs linked to each facility. Poverty can also make it hard to stay on treatment. Food parcels are also a key component of psychosocial support.

However, only 75% of people reported that individualised counselling was available for any person living with HIV no matter how long they have been on treatment (Figure 79) – 98% in OR Tambo, yet only 45% in Buffalo City. Additionally only 2% of people reported referrals to social workers were provided, only 2% respondent reported referrals to support groups, and only 1% reported peer-led navigators on site. Only 2 people reported being able to access food parcels, even though 28% of sites said that food parcels were provided for people with HIV and TB (Figure 80) – 55% in OR Tambo, and no sites at all in Buffalo City. A full site breakdown is in appendix 21.

Figure 78: Is psychosocial support available for people living with HIV here?



Figure 79: The types of psychosocial support that people living with HIV know are available (April to June 2025)
PLHIV surveyed: 1 084

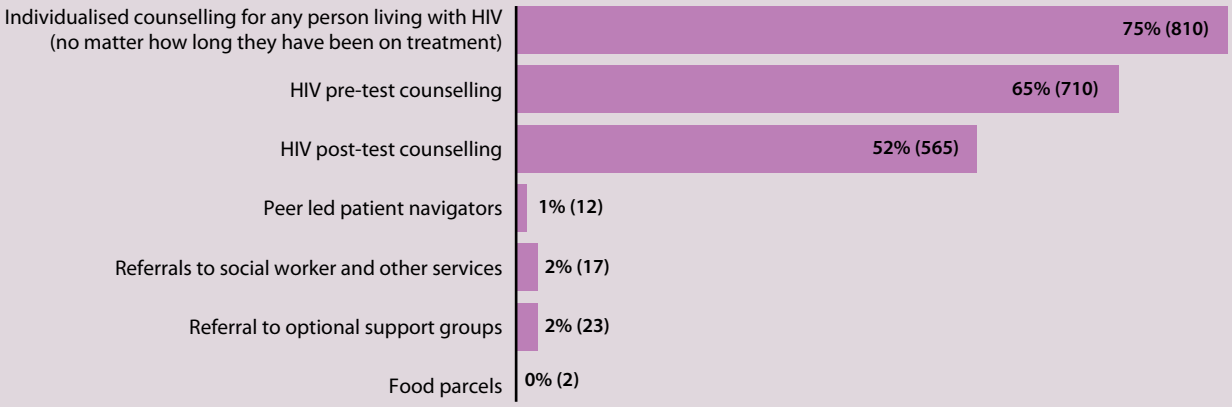


Figure 80: Are food parcels provided at this facility for people living with HIV and/or TB? (April to June 2025)
Facility staff surveyed: 40

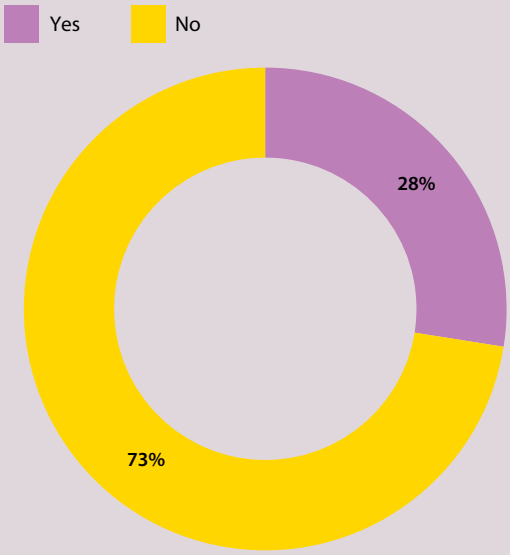
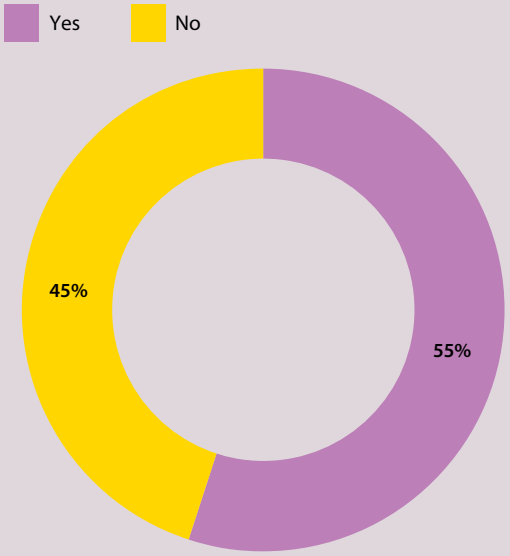


Figure 81: Does your facility need support to monitor people with advanced HIV (AHD) for the first 3 months after being diagnosed with AHD? (April to June 2025)
Facility staff surveyed: 40



ADVANCED HIV

KEY FINDINGS

55% of facilities said they needed support to monitor people with advanced HIV for the first three months after diagnosis.

RECOMMENDATION

National Department of Health

National Advanced HIV (AHD) Guidelines must be finalised with a properly costed and funded budget. Training must be provided on these guidelines to clinicians in facilities with full implementation by no later than January 2026. Facilities must be supported to closely monitor and manage people with AHD for their first 3 months of treatment to reduce disengagements due to poor health and deaths during this critical time.

Some people – including people starting treatment late or some of those re-engaging in care after a lengthy treatment interruption – will require intensive clinical management including advanced HIV screening and management. This is a key element of the differentiated service approach in the ART guidelines. Yet 55% of facilities said they needed support to monitor people with advanced HIV for the first three months after diagnosis – including checking they are coming to their appointments, that their blood results are actioned, and that they are on appropriate prophylaxis (Figure 81) – 50% in Buffalo City, and 60% in OR Tambo. A full site breakdown is in appendix 22.

PRIORITY 7

HIV PREVENTION

CONDOMS AND LUBE

KEY FINDINGS

Only 88% of sites had external condoms available (only 75% in OR Tambo) and only 63% had internal condoms. 12% of facilities (25% in OR Tambo) not providing external condoms is unacceptable as the provision of condoms is known to be the cheapest and most cost effective HIV prevention intervention. Only 48% of sites had lubricant available – with most failing to put this in private areas of the clinic where people can take it without feeling uncomfortable. These commodities are the basics of the HIV response and should be easily available to take without question or judgement at all sites.

RECOMMENDATION

Provincial Department of Health
District Department of Health

The provision of condoms is known to be the cheapest and most cost effective HIV prevention intervention. Additionally, lubricants must be made available at all sites as part of the HIV prevention package. **The Department of Health must urgently investigate and address the major gaps in provision of external condoms, internal condoms, and lubricants at sites in the Eastern Cape, especially OR Tambo. External condoms, internal condoms, and lubricants must be made available at all facilities in a range of spaces across the facility (including in the toilets, at the gate, in quiet areas out of sight) so people can freely and easily collect them without fear or judgement.**

Basic HIV prevention tools are not always easily available at the facility. In this reporting period only 88% of sites had external condoms available, and only 63% had internal condoms (Figure 82). Notably only 75% of sites had external condoms available in OR Tambo which was the worst performing district monitored by Ritshidze on this indicator, alongside Ehlanzeni (Mpumalanga) (Figure 83). Further, only 65% of sites in Buffalo City, and 60% of sites in OR Tambo had internal condoms available. A full site breakdown is in appendix 23.

Lubricant is a critical component of safer sex that can reduce the risk of vaginal or anal tears, and can prevent condoms from tearing. 80% of sites said they do provide lubricant for HIV prevention purposes (Figure 84) – 95% in Buffalo City and 65% in OR Tambo. Yet only 48% actually had lubricant available for people to take – 60% in Buffalo City (up from 53% in January 2025) and just 35% in OR Tambo (down from 67% in January 2025). Of the sites that did provide lubricant, 63% put them in the main waiting area, and 11% put those by the reception (Figure 85). 26% only had them available in the consultation room where you must ask for them. Only 26% were in a private space and 5% in the toilets. Not only can it be uncomfortable to take condoms and lubricant in front of people in the waiting area or the receptionist, it can also be unsafe or lead to further hostility, particularly for members of key populations.

Figure 82: Are condoms and lubricant available at facilities? (April to June 2025)

Observations completed: 40

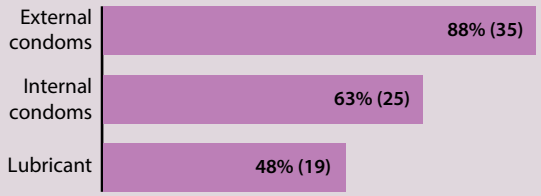
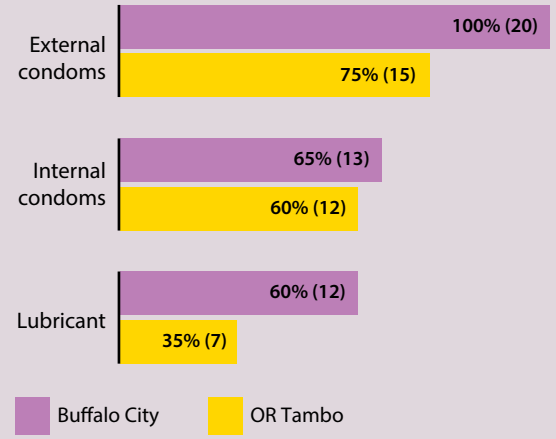


Figure 83: Condom and lubricant availability across districts



"Whenever I ask for lubricant, the staff question me, asking why I take so much. This causes people to stare at me which is very embarrassing" *– a gay man, Tshangana Clinic, Nelson Mandela Bay, August 2025*


RITSHIDZE
SAVING OUR LIVES


BIO HAZARDOUS
max
EASTERN CAPE




max


MAINTAIN HAND HYGIENE
Wash your hands regularly with soap and water or use an alcohol-based sanitizer.
1.5M
ALWAYS MAINTAIN SOCIAL DISTANCING
Maintain a 1.5 meter distance between yourself and others and practice non-touch greetings.
AVOID TOUCHING EYES, NOSE AND MOUTH
ALWAYS WEAR A MASK IN PUBLIC SPACES
CONDOMAN CONDOTAINER

Figure 84: Does this facility provide lubricant for HIV prevention? (April to June 2025)

Facility staff surveyed: 40

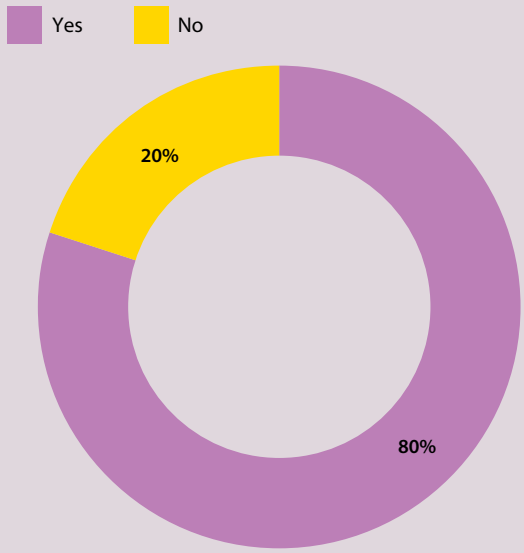


Figure 85: Where available, where lubricants are located at facilities (April to June 2025)

Observations completed: 19

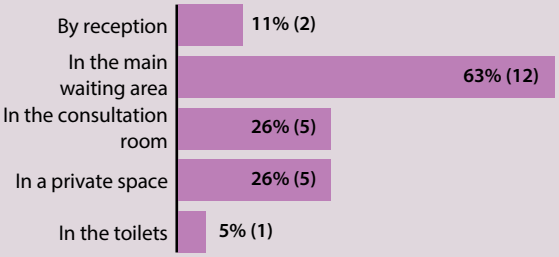
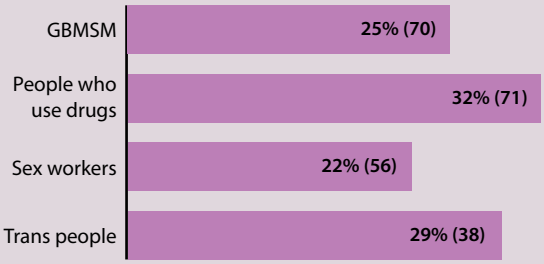


Figure 86: Members of key populations who have tried to access lube reporting they can always get lube at facilities (July to September 2024)



While some progress has been made, still only 32% of people who use drugs (15% in 2023), 29% of trans people (25% in 2023), 25% of GBMSM (19% in 2023), and 22% of sex workers (28% in 2023) reported being always able to access lubricant at the facility (Figure 86). Further, only 32% of people who use drugs, 27% of trans people, 20% of GBMSM, and 20% of sex workers who tried to get lubricant said they could always get enough. Only 36% of trans people, 33% of people who use drugs, 30% of sex workers, and 28% of GBMSM said that staff were always respectful to them when they asked for lubricant. Further 66% of people who use drugs, 62% of sex workers, 54% of GBMSM, and 46% of trans people said they were always or sometimes questioned for why they wanted lubricant. Additional factors that put people off asking in the first place. For those who were unable to access lubricant, 88% reported staff said there was a stockout and 10% said they never offer lubricant.

PRE EXPOSURE PROPHYLAXIS (PrEP)

KEY FINDINGS

While only 11% of sites reported challenges with PrEP services following the PEPFAR disruptions – of PrEP users surveyed, 51% said it took longer than usual to collect PrEP, and 5% had to return because of the queues. Fast track systems are urgently required to reduce workload on overstretched staff and ensure people do not discontinue PrEP. Unnecessary discontinuations put people vulnerable to HIV acquisition at risk, and waste intensive work done to find, test, and start people benefitting from PrEP.

RECOMMENDATION

Provincial Department of Health
District Department of Health

Oral PrEP is a critical minimum package HIV prevention tool that must be available at all public health facilities. Fast track systems are urgently required to reduce workload on overstretched staff and ensure people do not discontinue PrEP. Unnecessary discontinuations put people vulnerable to HIV acquisition at risk, and waste intensive work done to find, test, and start people benefitting from PrEP. **The Department of Health must urgently investigate delays in PrEP collection as reported across sites monitored in the Eastern Cape.**

PrEP should be actively offered to members of key populations, pregnant and breastfeeding women, and adolescent girls and young women. People must be made aware of its benefits in order to make an informed decision about starting. Ensuring a safe environment is particularly important, so that people feel comfortable to disclose if they are a member of a key population and subsequently request or be offered PrEP services. **PrEP posters should be distributed and put up in all facilities informing people about PrEP, and information about PrEP provided in daily health talks.**

Positively oral PrEP is available at all facilities monitored by Ritshidze in the Eastern Cape. However, of members of key populations surveyed in the community in 2024, PrEP awareness varied. While 90% of trans people had heard of PrEP and knew what it was, only 76% of GBMSM, 66% of sex workers, and 47% of people who use drugs had (Figure 87).

There are also gaps on who facilities are prioritising to offer PrEP: just 78% of sites say they prioritise offering PrEP to GBMSM, 73% to people who use drugs, 73% to sex workers, 73% to HIV negative people in sero-discordant couples, and 70% to trans people (Figure 88). This is mainly due to major gaps in OR Tambo where only 55% of sites say they prioritise offering PrEP to GBMSM, 50% to HIV negative people in sero-discordant couples, 45% to people who use drugs, 45% to sex workers, and 40% to trans people (Figure 89).

Reports of people actually being offered PrEP in 2024 were low and varied widely. While better than 2023, still only 53% of trans people (up from 19% in 2023), 44% of GBMSM (up from 38% in 2023), 35% of sex workers (up from 20% in 2023), and 23% of people who use drugs (up from 14% in 2023) reported being offered PrEP (Figure 90).

Figure 87: Members of key populations reporting they have heard of PrEP and know what it is (July to September 2024)

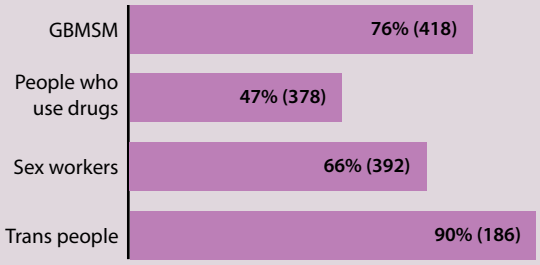


Figure 88: Does the facility prioritise offering PrEP to any of the following populations? (April to June 2025)

Facility staff surveyed: 40

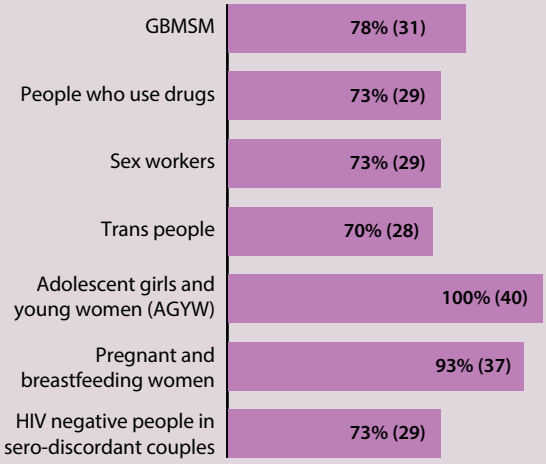
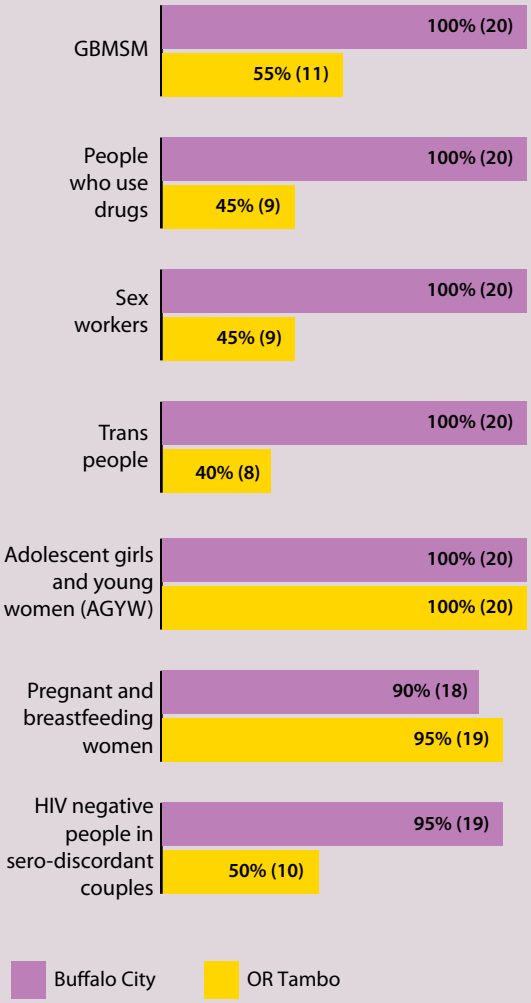


Figure 89: Does the facility prioritise offering PrEP to any of the following populations? (April to June 2025)



It is important that PrEP is actively offered to members of key populations, and that people are actually made aware of its benefits in order to make an informed decision about starting. Ensuring a safe environment is particularly important, so that people feel comfortable to disclose this and subsequently request or be offered PrEP services. This shows the critical role that Centres of Excellence (CoEs) could play in providing a safe space for members of key populations to disclose this, allowing for more people to be actively offered PrEP. Only 11% of sites reported challenges with PrEP services following the PEPFAR disruptions (Figure 91) – however of people who use PrEP surveyed, 51% said it took longer than usual to collect PrEP, and 5% had to return because of the queues (Figure 92).

> **It is important that PrEP is actively offered to members of key populations, and that people are actually made aware of its benefits in order to make an informed decision about starting.**

Figure 90: Members of key populations not living with HIV reporting they have ever been offered PrEP at facilities (July to September 2024)

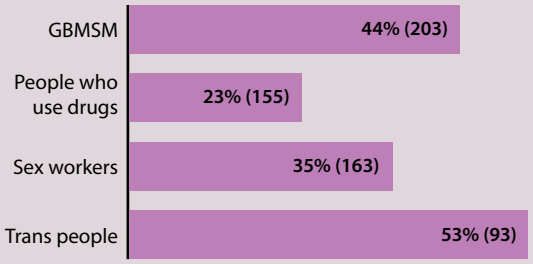


Figure 91: Have PrEP services been affected by the PEPFAR withdrawal? (April to June 2025)
Facility staff surveyed: 40

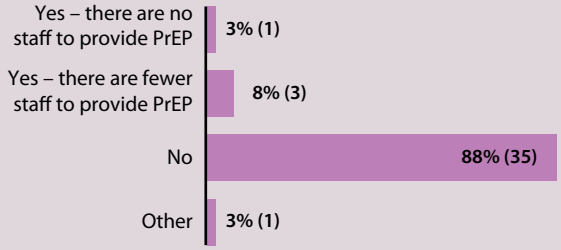
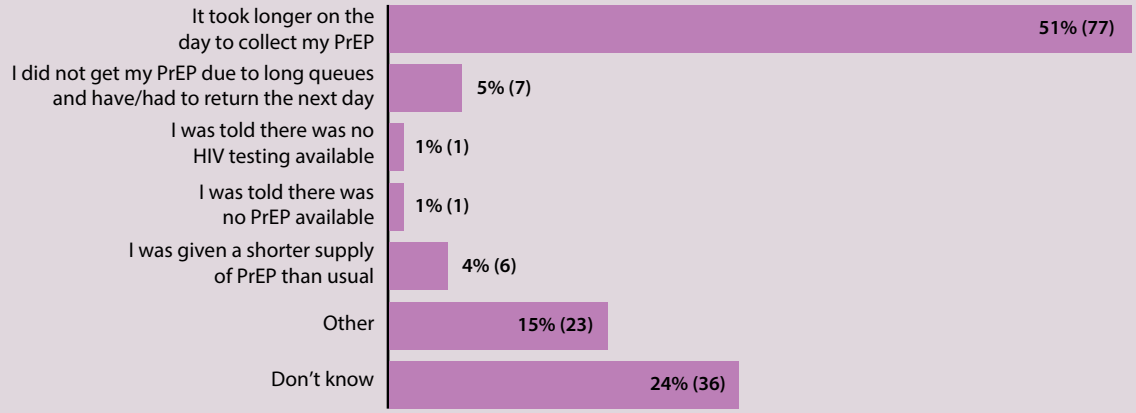


Figure 92: Since the end of January, what challenges have you faced collecting your PrEP? (April to June 2025)
PrEP users surveyed: 150



POST EXPOSURE PROPHYLAXIS (PEP)

KEY FINDINGS

PEP is a critical minimum package HIV prevention tool. Yet awareness of PEP is low in the Eastern Cape among members of key populations. Further it has been routinely denied to people – only 56% of trans people, 34% of sex workers, and 19% of GBMSM said they were always able to get PEP in the last year. Knowledge of PEP and easily accessible PEP in communities must be prioritised.

RECOMMENDATION

Provincial Department of Health
District Department of Health

PEP is a critical minimum package HIV prevention tool that must be available at <u>all</u> public health facilities. Anyone requesting PEP following a condom break, condomless sex, or sharing a needle should be provided with PEP without judgement. **PEP should urgently be made available through community service delivery models, especially for members of key populations.**

PEP is a critical minimum package HIV prevention tool and is available at 100% of sites monitored by Ritshidze. However, while 100% of facilities said people who have had a condom burst or unprotected sex are eligible for PEP, only 74% said people who have shared a needle are eligible (Figure 93).

Among members of key populations surveyed in 2024, PEP awareness was low: only 59% of trans people, 41% of sex workers, and 39% of GBMSM were aware of PEP and knew what it was (Figure 94). PEP availability was also low across population groups: only 56% of trans people, 34% of sex workers, and 19% of GBMSM said they were always able to get PEP in the last year (Figure 95). For those unable to access PEP, 47% were told the facility never offers it, 28% were told it was out of stock, 16% were told they were not eligible, 11% said they were asked too many questions about why they needed it, 11% were told it was not for sex workers, and 8% were told it was not for GBMSM.

Figure 93: Who is eligible for PEP? (April to June 2025)

Facility staff surveyed: 39



Figure 94: Members of key populations reporting they have heard of PEP and know what it is (July to September 2024)

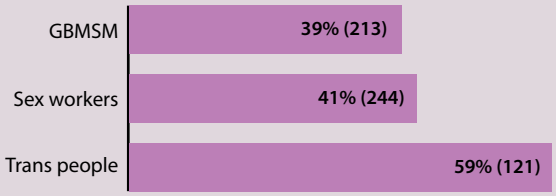
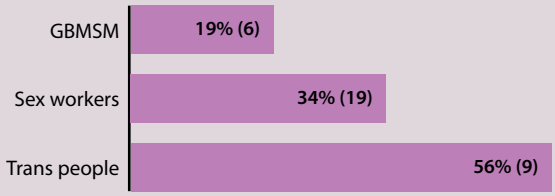


Figure 95: Members of key populations who wanted PEP reporting they could always access it at facilities (July to September 2024)



HARM REDUCTION

RECOMMENDATION

National Department of Health

The National Department of Health's guidelines and policies must be amended to allow for the roll out of harm reduction services at public health facilities in South Africa – including but not limited to provision of sterile needles/syringes, safe disposal of injecting equipment, methadone, naloxone, and psychosocial support. National Department of Health guidelines and policies should be amended to ensure that naloxone is not only nurse initiated but can be initiated by community members themselves.

People who use drugs must be able to access these life saving harm reduction tools closer to where they stay – including in public health facilities and correctional service facilities. Harm reduction services must also be made available to sex workers and LGBTQIA+ community members who use drugs.

The Department of Health must urgently start providing sterile needles/syringes, safe disposal of injecting equipment, methadone, naloxone, and psychosocial support in public health facilities, beginning with the expansion of Centres of Excellence (COEs). The Department of Health should social contract this work to organisations competent in providing these services already.

Ritshidze, the South African Network of People Who Use Drugs (SANPUD), and TAC request an urgent meeting with relevant teams in the National Department of Health to discuss recommendations around harm reduction in more detail.

Harm reduction services are life saving – including information on safer drug use, sterile needles and syringes, safe disposal of used injecting equipment, naloxone, opioid substitution therapy (OST), and psychosocial support. People who use and inject drugs should be supported and welcomed in our clinics – and have access to the information, prevention tools, and the help they need. However, harm reduction services are almost entirely unavailable in public health facilities – and currently the national government does not fund any harm reduction services or commodities in South Africa. Most harm reduction services have been funded via PEPFAR or the Global Fund, with the only domestic funding from the City of Tshwane[18].

The Department of Health's guidelines and policies must be amended to allow for the roll out of harm reduction services at public health facilities in South Africa. Further the Department of Health must urgently

18. South African Network of People Who Use Drugs (SANPUD) and Harm Reduction International Briefing Note on Impact of US Funding Cuts on Harm Reduction in South Africa. Available at: https://hri.global/publications/impact-of-the-us-funding-cuts-on-harm-reduction/

start providing sterile needles/syringes, safe disposal of injecting equipment, methadone or other OST, naloxone, and psychosocial support in public health facilities, beginning with the expansion of COEs. The Department of Health should social contract this work to organisations competent in providing these services already.

NEEDLES AND SYRINGES

KEY FINDINGS

47% of facilities said they provide information about needle safety and where to get sterile needles – just 11% in OR Tambo. However only 7% of people who use drugs surveyed in 2024 were actually given information on where to get sterile needles from. This was not surveyed in 2025 yet, but is unlikely to have improved.

Ensuring access to sterile needles & syringes and providing a safe place to dispose of used ones, is a key component of harm reduction. Using a sterile, sharp, new needle every time reduces the risk of getting HIV and hepatitis C (HCV). It also reduces the risk of skin damage and wounds that can get infected, or even endocarditis that can be fatal. Needle and syringe programmes for all who need them are life saving. They also reduce syringe litter in public places. The UN recommends the distribution of 200 needles per person per year for HIV prevention and 300 for HCV prevention, yet in South Africa only 36 needles per person are distributed according to UNAIDS[19] – and many people cannot access these commodities at all.

In this reporting period, 47% of facilities said they provide information about needle safety and where to get sterile needles (Figure 96) – 80% in Buffalo City, and just 11% in OR Tambo. However most facilities either referred people to private pharmacies to buy needles themselves, or to hospitals that do not provide them. Others had nowhere to refer them. Only 7% of people who use drugs surveyed in 2024 were actually given information on where to get sterile needles from (Figure 97) – let alone the actual commodities.

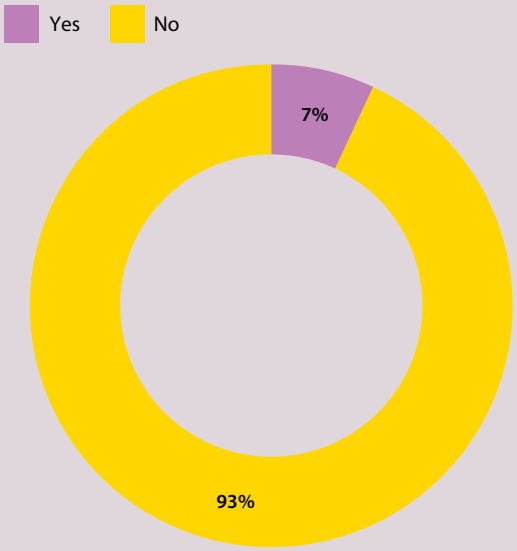
Figure 96: Do you provide people who inject drugs with information about needle safety and where to get new needles? (April to June 2025)

Facility staff surveyed: 38



Figure 97: Did the facility give you any information about where you could get new/unused needles? (July to September 2024)

People using drugs surveyed: 836



OPIOID SUBSTITUTION THERAPY (OST)

KEY FINDINGS

Only 16% of people were given information about where they could get methadone from clinic staff. The 21% of sites that said they refer people, referred them to hospitals – where methadone is only available for withdrawal management on a short term basis – or to buy methadone themselves at a pharmacy or go to private rehabs – putting it out of reach of most people with little or no income. Ultimately, even clinics that do want to provide information and care have nowhere to refer people onwards. National guidelines and policies must be amended to ensure that OST is made available in clinics, starting with the Centres of Excellence.

Opioid substitution therapy (such as methadone) can be a life changing medication for people using heroin or other opioids, reducing the risk of getting HIV and hepatitis C. Unfortunately, it is extremely expensive and unattainable for most people who need it. Especially for people who are in rural areas, and for people with little or no income.

In this reporting period only 3% of sites said they provide information about methadone and where people can get it (Figure 98). Yet of those who knew what methadone was, only 21% of people said that they were even given any information about where they could get it in 2024 (Figure 99), while 18% would have wanted access to it at the facility

19. UNAIDS: Available at: https://www.unaids.org/en/regionscountries/countries/southafrica



in the last year (Figure 100). The only site that said they refer people for services, referred them to a private rehab – putting it out of reach of most people with little or no income. Ultimately, even clinics that do want to provide information and care have nowhere to refer people onwards.

It is unrealistic to think that people will be able to afford to see a private doctor and pay for a prescription, or that people will be able to afford to attend one of the few drop-in centres or harm reduction centres in other provinces across the country on a daily basis. National guidelines and policies must be amended to ensure that OST is made available, closer to where people actually stay in order to be useful. Methadone programmes should be made available in public health facilities, beginning with the expansion of Centres of Excellence (COEs). The Department of Health should social contract this work to organisations competent in providing these services already. By making methadone available in primary health facilities, it can support people who may never have an opportunity otherwise.

Figure 98: Do you provide people who use opioids with information about methadone and where to get it? (April to June 2025)

Facility staff surveyed: 34

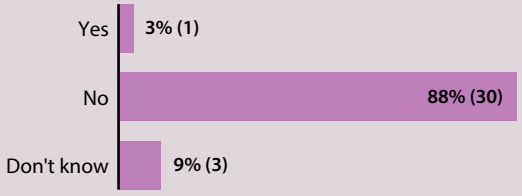


Figure 99: Has the facility given you any information about where you could get methadone in the last year? (July to September 2024)

People using drugs surveyed: 102

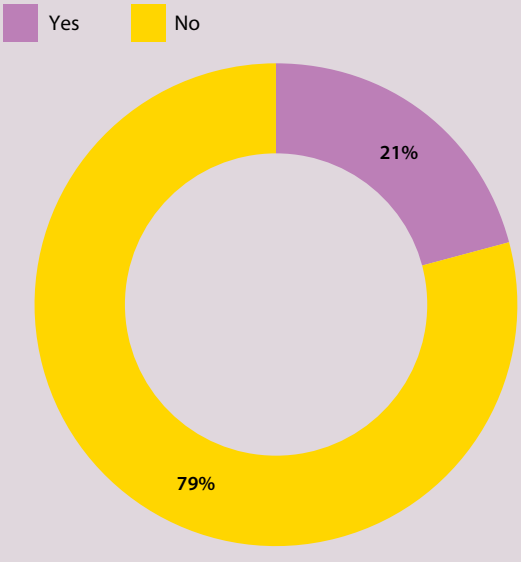
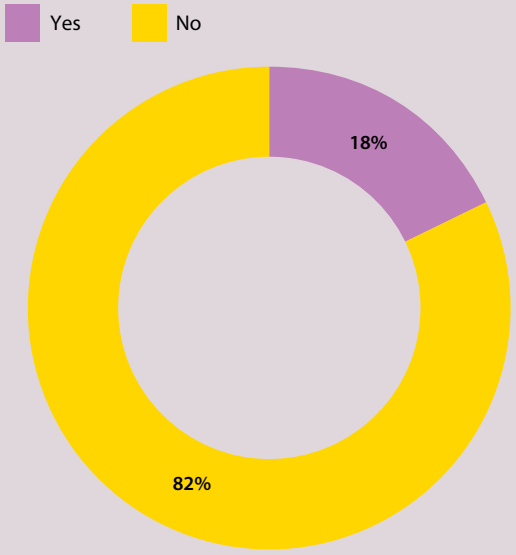


Figure 100: Have you wanted to access methadone at the facility in the last year? (July to September 2024)

People using drugs surveyed: 102



National guidelines and policies must be amended to ensure that OST is made available, closer to where people actually stay in order to be useful. Methadone programmes should be made available in public health facilities, beginning with the expansion of Centres of Excellence (COEs).

PRIORITY 8

OTHER SERVICES

NALOXONE FOR OPIOID OVERDOSE REVERSAL

KEY FINDINGS

Only 7% of people who use drugs had heard of naloxone to reverse overdoses – despite being a life saving treatment it remains nurse initiated and unavailable in the community where it is most needed.

Naloxone is a life saving opioid overdose reversal treatment yet only 7% of people who use drugs surveyed had heard of it and knew what it was (Figure 101). Of those who knew what it was, 15% wanted access to it in the last year (Figure 102). However today it remains a nurse-initiated only treatment. To be effective, naloxone needs to be carried by people in the community, and available for peers and partners to initiate if needed in a timely manner. National Department of Health guidelines and policies should be amended to ensure that naloxone is not only nurse initiated, but can be initiated by community members themselves.

Figure 101: Have you heard of naloxone? (July to September 2024)

People using drugs surveyed: 837

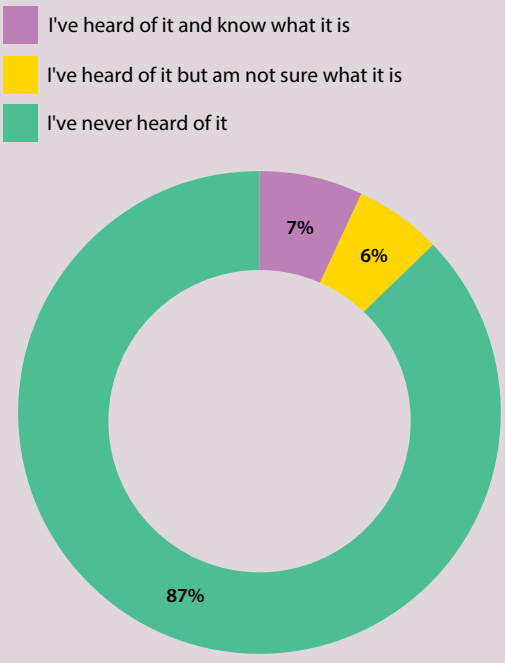
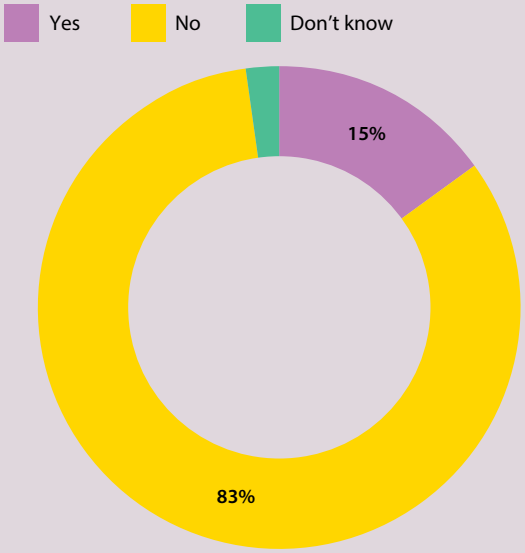


Figure 102: Of those who knew what naloxone was, have you wanted to access naloxone at the facility in the last year? (July to September 2024)

People using drugs surveyed: 59



PSYCHOSOCIAL SUPPORT FOR PEOPLE WHO USE DRUGS

KEY FINDINGS

Only 22% of people who use drugs were able to get psychosocial support. Most sites did not know where to refer people.

Psychosocial support for people who use drugs also needs to be made available. Of 799 people who use drugs surveyed in 2024, 10% wanted drug dependence support in the last year (Figure 103). However, only 22% of those people were actually able to access any drug dependence support (Figure 104). 54% were told it was not offered at the facility, 41% did not feel comfortable asking for it, and 8% were told they were ineligible (Figure 105). In this reporting period, 10% of sites said they offer drug dependence support at the facility, and 43% of sites said they referred people for drug dependence support services elsewhere (Figure 106) – however most said they referred people to hospitals, where again ongoing psychosocial support services are not available for people who use drugs.

Figure 103: Have you wanted to access drug dependence support at the facility in the last year? (July to September 2024)

People using drugs surveyed: 838

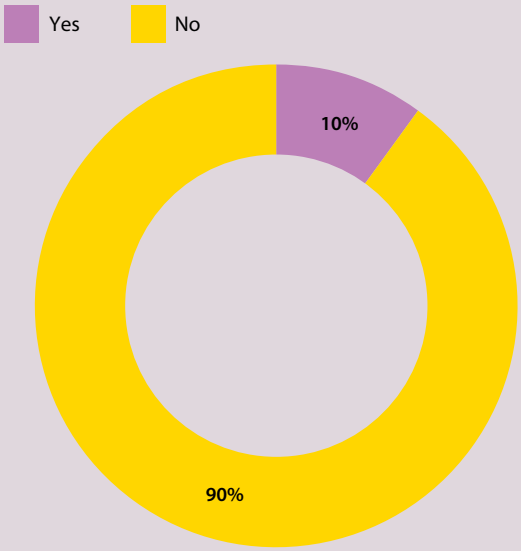
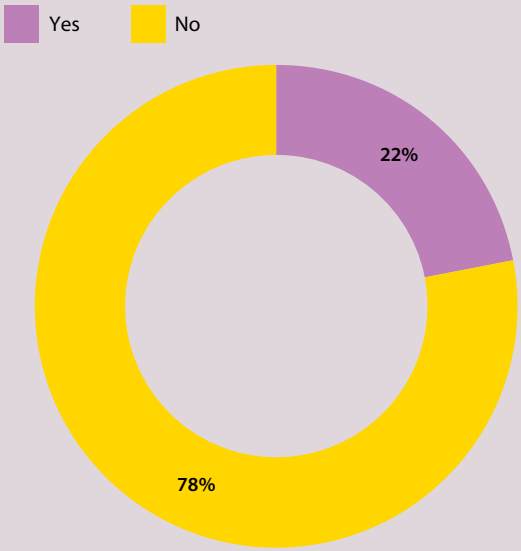


Figure 104: Were you able to access drug dependence support? (July to September 2024)

People using drugs surveyed: 85



Only 10% of people who use drugs surveyed in 2024 in the Eastern Cape even knew what hepatitis C was.

Figure 105: Why were you unable to access drug dependence support at the facility? (July to September 2024)

People using drugs surveyed: 63

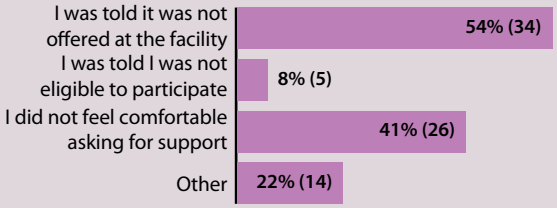
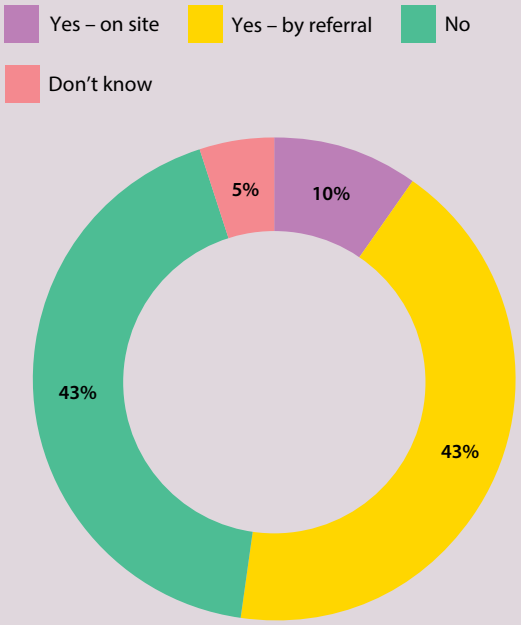


Figure 106: Do you provide drug dependence support? (April to June 2025)

Facility staff surveyed: 40



HEPATITIS C (HCV) SERVICES

KEY FINDINGS

HCV prevalence is estimated to be at 83% among people who inject drugs in South Africa – yet only 10% of people who use drugs even knew what hepatitis C was. Only 3% said a healthcare worker in the public health system had talked to them about screening – and only 3% surveyed had been screened.

While HIV testing and prevention is commonly available in clinics – although not without major gaps and additional challenges for members of key populations especially people who use drugs as outlined in the learnings in this report – access to hepatitis C testing and treatment is not. Only 10% of people who use drugs surveyed in 2024 in the Eastern Cape even knew what hepatitis C was (Figure 106).

Further, only 3% said a healthcare worker in the public health system had talked to them about screening (Figure 107), and only 3% surveyed had been screened (Figure 108). Yet prevalence of hepatitis C among people who inject drugs is estimated to be 83% in South Africa (compared with 0.47% among the general population).

Figure 107: Have you heard of Hepatitis C? (July to September 2024)

People using drugs surveyed: 838

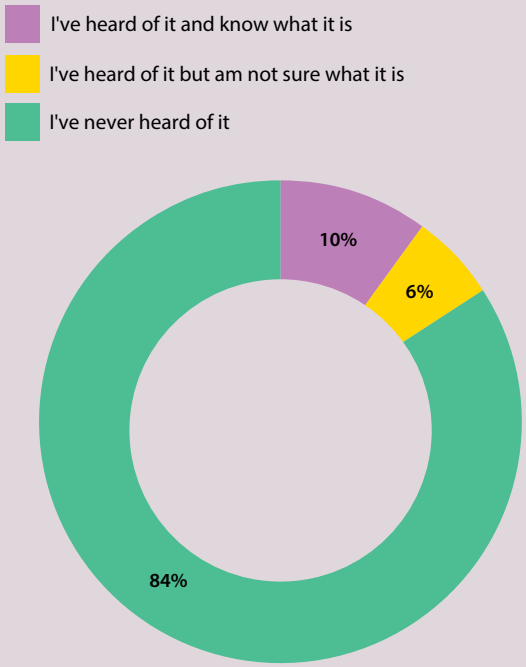


Figure 108: Has a health worker at this facility talked to you about screening for Hepatitis C in the last year? (July to September 2024)

People using drugs surveyed: 838

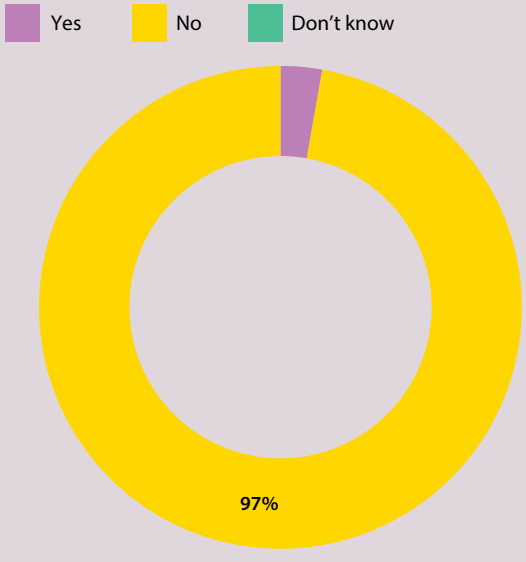
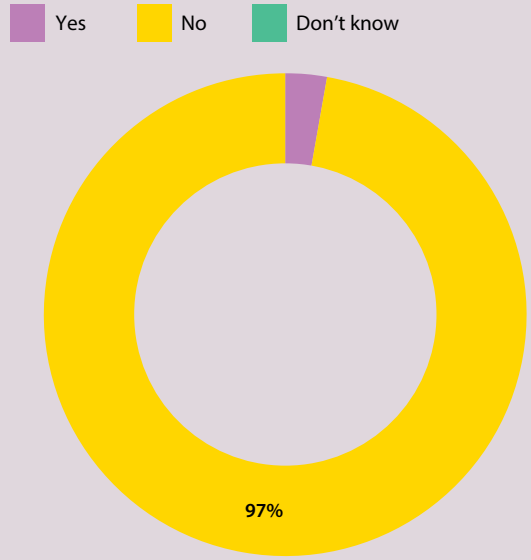


Figure 109: Have you been screened for Hepatitis C at this facility in the last year? (July to September 2024)

People using drugs surveyed: 838



GENDER AFFIRMING CARE FOR TRANS AND GENDER DIVERSE PEOPLE

KEY FINDINGS

43% of trans people wanted to access hormones at the facility in the last year – yet hormonal care is not available in primary health facilities currently. While 30% of sites said they provide trans people with information on hormonal care – 44% of trans people we surveyed were confronted with a staff member that did not know anything about hormones or where to get them. Following the closure of two PEPFAR funded drop-in centres for trans women in the Eastern Cape, this situation is only going to worsen. A change in national policy is critical to ensure that hormones could be prescribed by doctors at primary level, just like they are by private GPs. This would expand access to many more trans and gender diverse people in need.

RECOMMENDATION

National Department of Health

Clinicians must understand the health needs of trans and gender diverse people and be able to offer appropriate services e.g. appropriate sexual and reproductive health services, or cancer screening.
These services must be provided in a caring,



respectful, and compassionate manner.

National Department of Health guidelines and policies must be amended to ensure that trans people are able to access hormonal care from doctors in public health facilities, just like they are by private GPs. At a minimum, all Centres of Excellence (CoEs) must be able to provide hormonal care and have access to medical support networks, mentorship, and tele-support to assist in consultations on the use of hormone therapy for trans people.

On 20 May 2024, Ritshidze, Gender Dynamix, and TAC requested a meeting with relevant teams in the National Department of Health to discuss recommendations around gender affirming care in more detail. To date this meeting has not taken place. We urgently request for the National Department of Health to provide a date for this meeting to take place.

To provide gender affirming healthcare means that public health facilities should respect trans and gender diverse people and ensure they feel comfortable and affirmed in their gender identity and gender expression. Clinicians at public health facilities must be trained to better understand the health needs of trans and gender diverse people and be able to offer appropriate services. For example, offering trans women prostate cancer screening and voluntary medical male circumcision, and offering trans men reproductive services, contraceptives, and cervical cancer screening. These services must be provided in a caring, respectful, and compassionate manner.

In addition to the standard primary health package, trans and other gender diverse people may also want information and access to hormonal care. Gender dysphoria can be extremely distressing, and can lead to broader mental health issues. Rates of suicide are also extremely high. This is also in the context of living in a country rife with transphobia and attacks on trans people. Hormonal care is life saving care. Yet hormonal care is not available in primary health facilities, despite the need and demand. Even information provision is limited.

70% of trans people surveyed in 2024 in the Eastern Cape knew what hormone therapy was (Figure 109) and 43% would have wanted to access hormones at the facility in the last year (Figure 110). Yet only 30% of sites said they even provide trans people with information on hormonal care (Figure 111). Of those who had asked for hormones at the facility, while 55% of trans people surveyed said that they were referred to another facility, 44% were confronted with a staff member that did not know anything about hormones or where to get them (Figure 112).

When trans people are able to get a referral for hormonal care, often this means travelling long distances to a few hospitals in larger cities in the country. For those without the money to travel, or at the end of long waiting lists, it means hormonal care remains out of reach. Only worsening the situation, the four USAID funded drop-in centres for trans people closed down in January 2025 – including one in Buffalo City and one in Nelson Mandela Bay – further reducing access to hormonal care.

A change in national policy is critical to ensure that hormones could be prescribed by doctors at primary level, just like they are by private GPs. This would expand access to many more trans and gender diverse people in need. At a minimum, all Centres of Excellence must be able to provide hormonal care and have access to medical support networks, mentorship, and tele-support to assist in consultations on the use of hormone therapy for trans people.

Figure 110: Have you ever heard of hormone therapy? (July to September 2024)

Trans people surveyed: 206

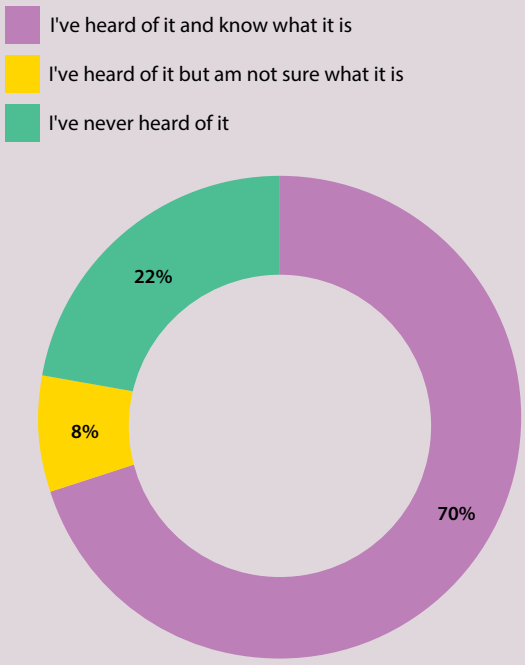


Figure 111: If available, would you have wanted to access hormone therapy at this facility in the last year? (July to September 2024)

Trans people surveyed: 206

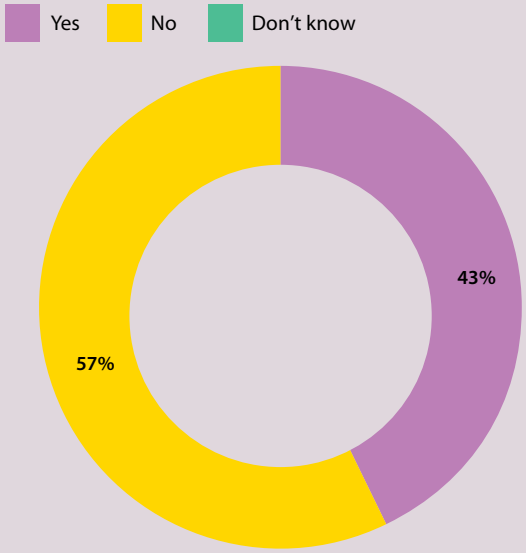


Figure 112: Do you provide trans people with information about hormone therapy and where to get it? (April to June 2025)

Facility staff surveyed: 37

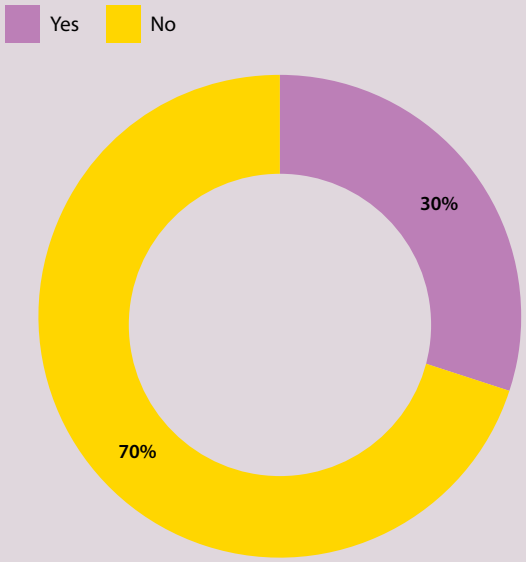


Figure 113: Were facility staff able to tell you where you could get access to hormone therapy? (July to September 2024)

Trans people surveyed: 62



SERVICES TARGETING CISGENDER MEN

KEY FINDINGS

64% of sites in the district did <u>not</u> have any interventions for cisgender men – despite being shown to improve uptake of services. 54% of sites reported these service delivery models stopping after the PEPFAR disruptions.

> ***"I especially liked** the male nurse who assisted me during my last visit. I believe that when you are at the clinic you should feel free and comfortable, not like you are at a police station"* – *a public healthcare user, Nobuhle Clinic, Buffalo City, August 2025*

RECOMMENDATION

Provincial Department of Health
District Department of Health

Men's Corners and other service delivery points for cisgender men must be maintained following the PEPFAR disruptions.

<u>No trans women</u> should be ever made to use service points for cisgender men. Forcing trans women to use spaces for cisgender men is <u>not</u> gender affirming care – it is reckless, dangerous, and unconstitutional.

Men's Corner's and men-only hours at clinics were established to encourage cisgender men to go to the facility, with positive impact. However, prior to February 2025, only 33% of facilities reported having a Men's Corner (Figure 113) – 32% in Buffalo City, and 35% in OR Tambo (Figure 114). No facilities reported

having men only clinic hours, and 64% of sites in the province did not have any interventions for cisgender men to improve uptake of services, even in PEPFAR supported facilities. Since January 2025, 54% of these services have stopped running (Figure 115) – 50% in Buffalo City, and 57% in OR Tambo (Figure 116).

Figure 114: Prior to February 2025, was there a "Men's Corner" or other specific service delivery option for men at this facility? (April to June 2025)

Facility staff surveyed: 39

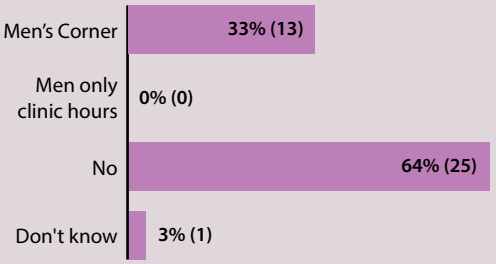


Figure 115: Prior to February 2025, was there a "Men's Corner" or other specific service delivery option for men at this facility? (April to June 2025)

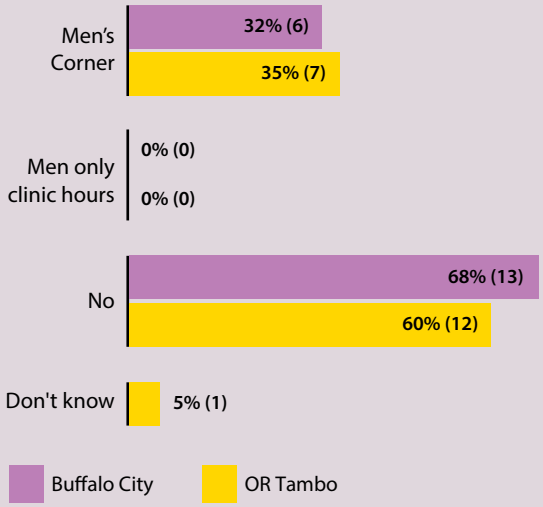


Figure 116: Is the "Men's Corner" or other specific service delivery option for men still running since the PEPFAR withdrawal? (April to June 2025)

Facility staff surveyed: 13



Figure 117: Is the "Men's Corner" or other specific service delivery option for men still running since the PEPFAR withdrawal? (April to June 2025)

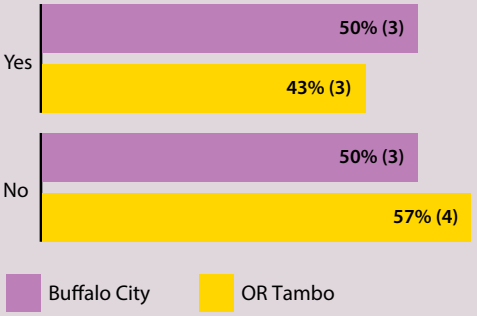
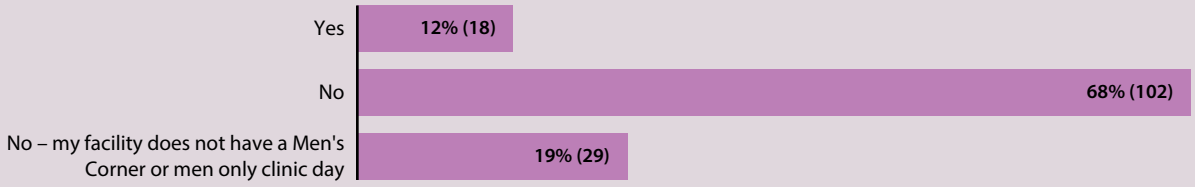


Figure 118: Have you ever been told to use a Men's Corner or men only clinic day? (July to September 2024)

Trans women surveyed: 149



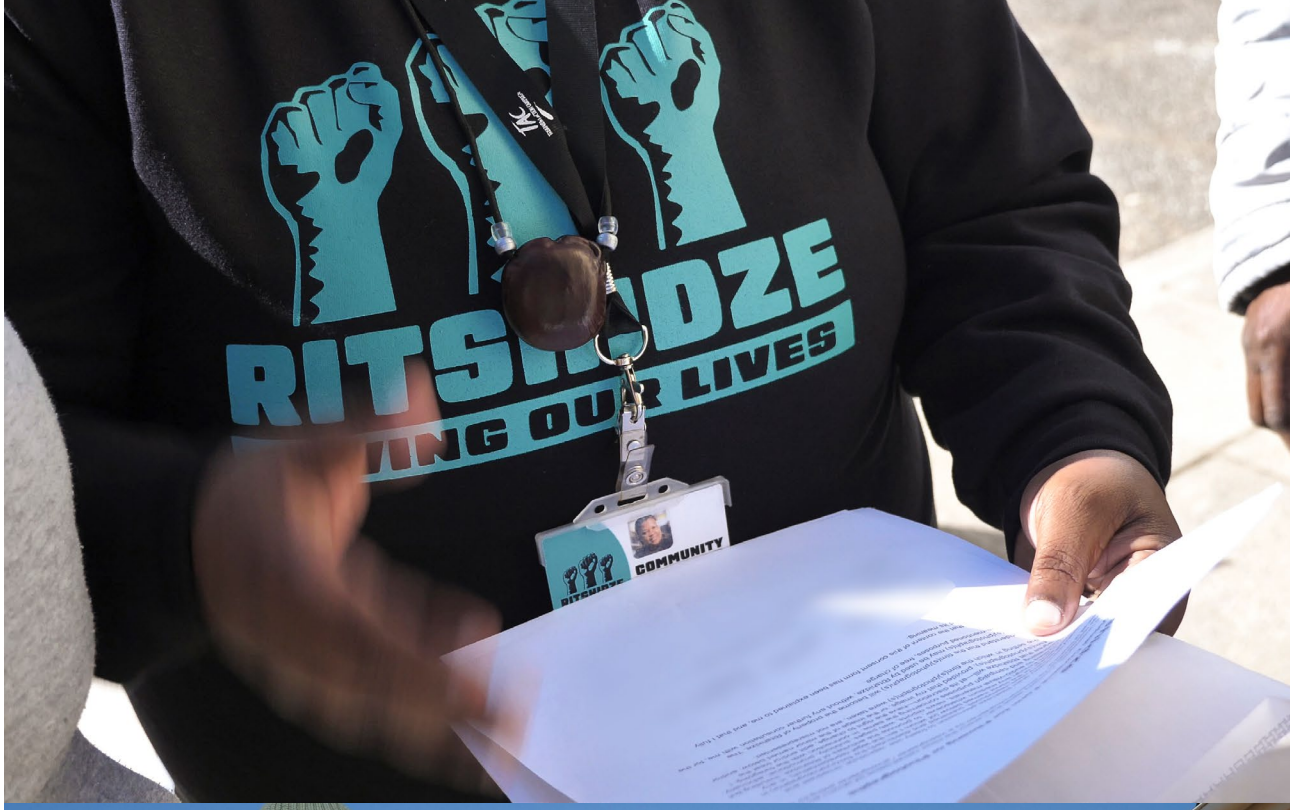
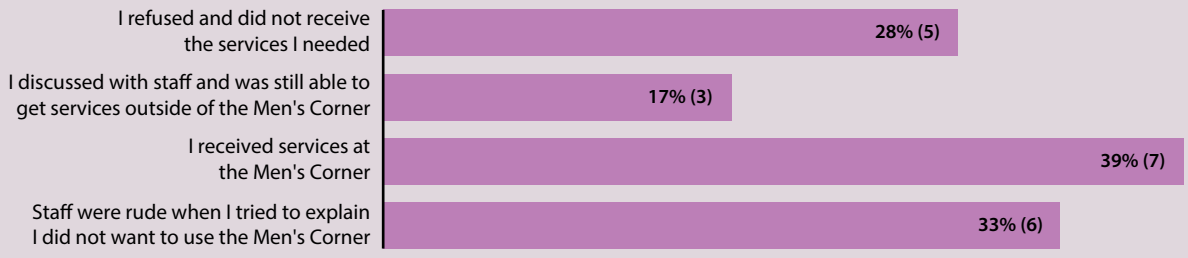




Figure 119: What happened when you were told to use the Men's Corner? (July to September 2024)

Trans women surveyed: 18



APPENDICES

Appendix 1: Facilities included in monitoring (April to June 2025)

District	Facility	PEPFAR agency	District support partner (DSP)	Type of monitoring
Alfred Nzo	Amadiba Clinic	USAID	MatCH	Existing Ritshidze Site
	Imizizi Clinic	USAID	MatCH	Existing Ritshidze Site
	Isikelo Clinic	USAID	MatCH	Existing Ritshidze Site
	Maluti CHC	USAID	MatCH	Existing Ritshidze Site
	Matatiele Community Clinic	USAID	MatCH	Existing Ritshidze Site
	Mount Ayliff Gateway Clinic	USAID	MatCH	Existing Ritshidze Site
	Mount Frere Gateway Clinic	USAID	MatCH	Existing Ritshidze Site
	St Patrick's Gateway Clinic	USAID	MatCH	Existing Ritshidze Site
	Tabankulu CHC	USAID	MatCH	Existing Ritshidze Site
Buffalo City	Alphendale Clinic	n/a	n/a	Ritshidze HIV Prevention Survey
	Aspiranza Clinic	n/a	n/a	Ritshidze HIV Prevention Survey
	Beacon Bay Clinic	n/a	n/a	Ritshidze HIV Prevention Survey
	Berlin Clinic	USAID	MatCH	Existing Ritshidze Site
	Bisho Gateway Clinic	n/a	n/a	Ritshidze HIV Prevention Survey
	Braelyn Clinic	USAID	MatCH	Existing Ritshidze Site
	Braelyn Ext 10	n/a	n/a	Ritshidze HIV Prevention Survey
	Cambridge Clinic	n/a	n/a	Ritshidze HIV Prevention Survey
	Central Clinic (East London)	USAID	MatCH	Existing Ritshidze Site
	Chris Hani Clinic	n/a	n/a	Ritshidze HIV Prevention Survey
	Dimbaza CHC	USAID	MatCH	Ritshidze HIV Prevention Survey
	Duncan Village CHC	USAID	MatCH	Existing Ritshidze Site
	Empilweni Gompo CHC	USAID	MatCH	Existing Ritshidze Site
	Fezeka NU 3 Clinic	USAID	MatCH	Existing Ritshidze Site
	Ford Grey Clinic	n/a	n/a	Ritshidze HIV Prevention Survey
	Frere Gateway	n/a	n/a	Ritshidze HIV Prevention Survey
	Ginsberg Clinic	n/a	n/a	Ritshidze HIV Prevention Survey
	Gompo A Clinic Ndende	n/a	n/a	Ritshidze HIV Prevention Survey
	Gompo B Clinic Jwayi	n/a	n/a	Ritshidze HIV Prevention Survey
	Gompo C Jabavu Clinic	USAID	MatCH	Existing Ritshidze Site
	Greenfields Clinic	USAID	MatCH	Existing Ritshidze Site
	Grey Gateway Clinic	n/a	n/a	Ritshidze HIV Prevention Survey
	Ilitha Clinic	n/a	n/a	Ritshidze HIV Prevention Survey
	John Dube Clinic	n/a	n/a	Ritshidze HIV Prevention Survey
	Luyolo NU 9 Clinic	USAID	MatCH	Existing Ritshidze Site
	Masakhane clinic	n/a	n/a	Ritshidze HIV Prevention Survey
	Masiphile Clinic	USAID	MatCH	Existing Ritshidze Site
	Mncotsho Clinic	n/a	n/a	Ritshidze HIV Prevention Survey
	Moore Street Clinic	n/a	n/a	Ritshidze HIV Prevention Survey
	Mount Coke Clinic	n/a	n/a	Ritshidze HIV Prevention Survey

District	Facility	PEPFAR agency	District support partner (DSP)	Type of monitoring
Buffalo City	Ncera Clinic	n/a	n/a	Ritshidze HIV Prevention Survey
	Ndevana Clinic	n/a	n/a	Ritshidze HIV Prevention Survey
	Needscamp Clinic	n/a	n/a	Ritshidze HIV Prevention Survey
	Newlands Clinic	n/a	n/a	Ritshidze HIV Prevention Survey
	Nontyatyambo CHC	USAID	MatCH	Existing Ritshidze Site
	NU 16 Clinic	n/a	n/a	Ritshidze HIV Prevention Survey
	Tembisa NU7 Clinic	USAID	MatCH	Existing Ritshidze Site
	Peffesville Clinic	n/a	n/a	Ritshidze HIV Prevention Survey
	Phakamisa Clinic	n/a	n/a	Ritshidze HIV Prevention Survey
	Philani NU 1 Clinic	USAID	MatCH	Existing Ritshidze Site
	Potsdam Clinic	USAID	MatCH	Existing Ritshidze Site
	Qurhu Clinic	n/a	n/a	Ritshidze HIV Prevention Survey
	Schornville clinic	n/a	n/a	Ritshidze HIV Prevention Survey
	Sizimisele N.U 17 Clinic	USAID	MatCH	Existing Ritshidze Site
	Sweetwaters Clinic	n/a	n/a	Ritshidze HIV Prevention Survey
	Tshabo Clinic	USAID	MatCH	Existing Ritshidze Site
	Zanempilo Clinic (East London)	USAID	MatCH	Existing Ritshidze Site
	Zingisa NU5 Clinic	USAID	MatCH	Existing Ritshidze Site
	Zwelitsha Zone 5 Clinic	n/a	n/a	Ritshidze HIV Prevention Survey
Chris Hani	Ezibeleni Clinic	CDC	TB HIV Care	Existing Ritshidze Site
	Lesseyton Clinic	CDC	TB HIV Care	Existing Ritshidze Site
	Linge Clinic	CDC	TB HIV Care	Existing Ritshidze Site
	Nomzamo CHC	CDC	TB HIV Care	Existing Ritshidze Site
	Philani Clinic (Queenstown)	CDC	TB HIV Care	Existing Ritshidze Site
	Sada Clinic	CDC	TB HIV Care	Existing Ritshidze Site
OR Tambo	Bala Clinic	CDC	TB HIV Care	Existing Ritshidze Site
	Civic Centre Clinic (Mthatha)	CDC	TB HIV Care	Existing Ritshidze Site
	Ezingcuka Clinic	CDC	TB HIV Care	Existing Ritshidze Site
	Flagstaff Clinic	CDC	TB HIV Care	Existing Ritshidze Site
	Holy Cross Gateway Clinic	CDC	TB HIV Care	Existing Ritshidze Site
	Lusikisiki Village Clinic (Qaukeni)	CDC	TB HIV Care	Existing Ritshidze Site
	Mahlungulu Clinic (Mhlontlo)	CDC	TB HIV Care	Existing Ritshidze Site
	Mdeni Clinic	CDC	TB HIV Care	Existing Ritshidze Site
	Mhlakulo CHC	CDC	TB HIV Care	Existing Ritshidze Site
	Mqanduli CHC	CDC	TB HIV Care	Existing Ritshidze Site
	Mthatha Gateway Clinic	CDC	TB HIV Care	Existing Ritshidze Site
	Ngangelizwe CHC	CDC	TB HIV Care	Existing Ritshidze Site
	Nkozo Clinic	CDC	TB HIV Care	Existing Ritshidze Site
	Ntapane Clinic	CDC	TB HIV Care	Existing Ritshidze Site
	Ntshele Clinic	CDC	TB HIV Care	Existing Ritshidze Site
	Palmerton Clinic	CDC	TB HIV Care	Existing Ritshidze Site
	Qumbu CHC	CDC	TB HIV Care	Existing Ritshidze Site
	St Elizabeth's Gateway Clinic	CDC	TB HIV Care	Existing Ritshidze Site
	St Lucy's Gateway Clinic	CDC	TB HIV Care	Existing Ritshidze Site
	Stanford Terrace Clinic	CDC	TB HIV Care	Existing Ritshidze Site
	Tsolo Clinic	CDC	TB HIV Care	Existing Ritshidze Site

Appendix 2: KP surveys by district and key population group

District	Where people surveyed go for health services	GBMSM	People who use drugs	Sex workers	Trans people
Amathole	Public health facility	129	239	175	54
	Drop-in centre	-	-	-	1
	Mobile clinic	-	5	3	1
	Private doctor	2	11	3	-
	I do not get health services	13	42	27	7
	District Total	144	297	208	63
Buffalo City	Public health facility	180	238	176	52
	Drop-in centre	16	4	2	93
	Mobile clinic	12	2	-	11
	Private doctor	1	-	1	1
	I do not get health services	5	3	4	-
	District Total	214	247	183	157
Nelson Mandela Bay	Public health facility	67	182	127	39
	Drop-in centre	24	11	23	33
	Mobile clinic	85	121	109	30
	I do not get health services	1	16	9	2
	District Total	177	330	268	104
OR Tambo	Public health facility	166	175	127	70
	Mobile clinic	15	9	11	9
	Private doctor	29	2	6	49
	I do not get health services	23	47	2	17
	District Total	233	233	146	145
	Provincial Total	**768**	**1,107**	**805**	**469**

Appendix 3: Minimum Package of KP Specific Service Provision:

GAY, BISEXUAL, AND OTHER MEN WHO HAVE SEX WITH MEN

+ GBMSM outreach services
+ Pre-Exposure Prophylaxis (PrEP) including MMD and community refill collection
+ Post-Exposure Prophylaxis (PEP)
+ Lubricant
+ External condoms
+ GBMSM friendly HIV testing and counselling
+ GBMSM friendly HIV care and treatment
+ GBMSM focused Repeat Prescription Collection Strategies (RPCs) including access to facility pick-up points (fast lane), GBMSM adherence clubs and GBMSM friendly external pick-up points including at drop-in centres
+ HIV support groups including PrEP/ART refill collection
+ Psychosocial support
+ Mental health services
+ Sexual health services
+ Information packages for sexual health services
+ GBMSM friendly STI prevention, screening & treatment
+ GBMSM friendly hepatitis B (HBV) vaccination, screening, diagnosis and treatment
+ GBMSM friendly hepatitis C (HCV) screening, diagnosis and treatment
+ GBMSM friendly prostate cancer screening
+ Harm reduction services for GBMSM who use drugs
+ Post violence services including rapid HIV testing, PEP, STI treatment, emergency contraceptive, completion of J88 forms, rape kits, counselling, and referral to domestic violence shelters.

PEOPLE WHO USE DRUGS

+ Outreach services for people who use drugs
+ On site or referral to drug dependence initiation and treatment (e.g. methadone)
+ On site or referral to drug-dependence counselling and support
+ Resources to take up referred services (e.g. taxi fare, planned patient transport)
+ Risk reduction information
+ Wound and abscess care
+ Sterile needles, syringes, or other injecting equipment
+ Safe disposal of used needles, syringes,

or other injecting equipment
+ Overdose management and treatment (e.g. naloxone)
+ Pre-Exposure Prophylaxis (PrEP) including MMD and community refill collection
+ Post-Exposure Prophylaxis (PEP)
+ Lubricant
+ External condoms
+ Internal condoms
+ Sexual and reproductive health services
+ Information packages for sexual and reproductive health services
+ Non barrier contraception (including the pill, IUD, implant, injection)
+ Gender-based violence services on site or by referral
+ PWUD friendly HIV testing and counselling
+ PWUD friendly HIV care and treatment
+ PWUD focused Repeat Prescription Collection Strategies (RPCs) including access to facility pick-up points (fast lane), PWUD adherence clubs and PWUD friendly external pick-up points including at drop-in centres
+ HIV support groups including PrEP/ART refill collection
+ Drug dependence support
+ Psychosocial support
+ Mental health services
+ PWUD friendly STI prevention, screening & treatment
+ PWUD friendly hepatitis B (HBV) vaccination, screening, diagnosis and treatment
+ PWUD friendly hepatitis C (HCV) screening, diagnosis and treatment
+ PWUD friendly cervical cancer screening
+ PWUD friendly prostate cancer screening
+ Post violence services including rapid HIV testing, PEP, STI treatment, emergency contraceptive, completion of J88 forms, rape kits, counselling, and referral to domestic violence shelters.

SEX WORKERS

+ Sex worker outreach services
+ Pre-Exposure Prophylaxis (PrEP) including MMD and community refill collection
+ Post-Exposure Prophylaxis (PEP)
+ Lubricant
+ External condoms
+ Internal condoms
+ Sexual and reproductive health services
+ Information packages for sexual and reproductive health services
+ Non barrier contraception (including the pill, IUD, implant, injection)
+ Sex worker friendly HIV testing and counselling
+ Sex worker friendly HIV care and treatment
+ Sex worker focused Repeat Prescription Collection Strategies (RPCs) including access to facility pick-up points (fast lane), sex worker adherence clubs and sex worker friendly external pick-up points including at drop-in centres
+ HIV support groups including PrEP/ART refill collection
+ Psychosocial support
+ Mental health services
+ Gender-based violence services on site or by referral
+ Sex worker friendly STI prevention, screening & treatment
+ Sex worker friendly cervical cancer screening
+ Sex worker friendly prostate cancer screening
+ Sex worker friendly hepatitis B (HBV) vaccination, screening, diagnosis and treatment
+ Sex worker friendly hepatitis C (HCV) screening, diagnosis and treatment
+ Harm reduction services for sex workers who use drugs
+ Post violence services including rapid HIV testing, PEP, STI treatment, emergency contraceptive, completion of J88 forms, rape kits, counselling, and referral to domestic violence shelters.

TRANS PEOPLE

+ Transgender outreach services
+ Pre-Exposure Prophylaxis (PrEP) including MMD and community refill collection
+ Post-Exposure Prophylaxis (PEP)
+ Lubricant
+ External condoms
+ Internal condoms
+ Sexual and reproductive health services
+ Non barrier contraception (including the pill, IUD, implant, injection)
+ Information packages for sexual and reproductive health services
+ Trans friendly HIV testing and counselling
+ Trans friendly HIV care and treatment
+ Trans focused Repeat Prescription Collection Strategies (RPCs) including access to facility pick-up points (fast lane), Trans adherence clubs and Trans friendly external pick-up points including at drop-in centres
+ HIV support groups including PrEP/ART refill collection
+ Psychosocial support
+ Mental health services
+ Hormone therapy
+ Gender-based violence services on site or by referral
+ Trans friendly STI prevention, screening & treatment
+ Trans friendly cervical cancer screening
+ Trans friendly prostate cancer screening
+ Trans friendly hepatitis B (HBV) vaccination, screening, diagnosis and treatment
+ Trans friendly hepatitis C (HCV) screening, diagnosis and treatment
+ Harm reduction services for transgender people who use drugs
+ Post violence services including rapid HIV testing, PEP, STI treatment, emergency contraceptive, completion of J88 forms, rape kits, counselling, and referral to domestic violence shelters.

ALL

+ Peer educators/navigators at the facility level

Appendix 4: When you come to the facility are there enough staff to meet the needs of patients? (April to June 2025)

District	Facility	Surveys completed	Always	Sometimes	Never	Don't know	Score
OR Tambo	Nkozo Clinic	58	53	1	1	3	1.95
OR Tambo	Holy Cross Gateway Clinic	51	48	1	1	1	1.94
OR Tambo	Bala Clinic	50	46	1	3	0	1.86
OR Tambo	Qaukeni Clinic	50	39	6	3	1	1.75
OR Tambo	St Elizabeth's Gateway Clinic	60	49	7	4	0	1.75
OR Tambo	Bodweni Clinic	51	41	6	4	0	1.73
OR Tambo	Goso Forest Clinic	54	40	13	1	0	1.72
OR Tambo	Port St Johns CHC	52	37	14	1	0	1.69
OR Tambo	Flagstaff Clinic	56	37	16	1	2	1.67
OR Tambo	KTC Clinic	54	35	16	2	1	1.62
OR Tambo	Lusikisiki Village Clinic (Qaukeni)	54	36	13	4	1	1.6
OR Tambo	Khanyayo (Holy Cross) Clinic	52	33	11	8	0	1.48
OR Tambo	Mbadango Clinic	53	25	26	1	1	1.46
OR Tambo	Xurana Clinic	53	33	9	11	0	1.42
OR Tambo	Palmerton Clinic	51	34	3	14	0	1.39
OR Tambo	Ntafufu Clinic	57	22	30	5	0	1.3
OR Tambo	Mantlaneni Clinic	52	22	22	8	0	1.27
OR Tambo	Mpoza Clinic	54	29	10	15	0	1.26
Buffalo City	Duncan Village CHC	53	14	32	7	0	1.13
OR Tambo	Xopozo Clinic	52	21	14	17	0	1.08
Buffalo City	Empilweni Gompo CHC	52	6	43	3	0	1.06
OR Tambo	Mfundisweni Clinic	54	12	32	9	1	1.06
Buffalo City	Zingisa NU 5 Clinic	52	5	43	4	0	1.02
Buffalo City	Zanempilo Clinic (East London)	53	1	46	6	0	0.91
Buffalo City	Chris Hani Clinic	54	1	46	7	0	0.89
Buffalo City	NU7 Thembisa Clinic	58	9	33	15	1	0.89
Buffalo City	Nontyatyambo CHC	52	3	40	9	0	0.88
Buffalo City	Gompo C Jabavu Clinic	48	4	33	11	0	0.85
Buffalo City	Central Clinic (East London)	51	4	35	12	0	0.84
Buffalo City	Luyolo NU 9 Clinic	58	6	36	16	0	0.83
Buffalo City	Fezeka NU 3 Clinic	55	0	45	10	0	0.82
Buffalo City	Gompo B Jwayi Clinic	50	10	21	19	0	0.82
Buffalo City	Greenfields Clinic	50	4	31	15	0	0.78
Buffalo City	Siyaphilisa NU 13 Clinic	50	5	27	18	0	0.74
Buffalo City	Philani NU 1 Clinic	46	1	30	15	0	0.7
Buffalo City	Braelyn Ext 10 Clinic	44	2	25	17	0	0.66
Buffalo City	John Dube Clinic	51	6	20	25	0	0.63
Buffalo City	NU 8 Clinic	53	6	21	26	0	0.62
Buffalo City	Gompo A Ndende Clinic	51	3	23	25	0	0.57
Buffalo City	Aspiranza Clinic	57	1	25	31	0	0.47

Appendix 5: Average waiting time by facility (April to June 2025)

District	Facility	Surveys Completed	Time patients spent at the facility (including time before the facility opens)	Average time patients spent at the facility after opening
OR Tambo	Bodweni Clinic	50	02:17	02:17
OR Tambo	Xurana Clinic	53	02:17	02:17
Buffalo City	Zanempilo Clinic (East London)	53	02:25	02:12
Buffalo City	Zingisa NU 5 Clinic	52	02:25	02:18
Buffalo City	Fezeka NU 3 Clinic	55	02:29	02:12
OR Tambo	Nkozo Clinic	57	02:29	02:29
OR Tambo	Mfundisweni Clinic	54	02:39	01:40
OR Tambo	KTC Clinic	54	02:39	02:38
Buffalo City	Chris Hani Clinic	54	02:48	02:27
OR Tambo	Mbadango Clinic	53	02:48	02:48
OR Tambo	Palmerton Clinic	51	02:51	02:49
OR Tambo	Mpoza Clinic	54	02:53	02:51
OR Tambo	Goso Forest Clinic	54	02:53	02:53
Buffalo City	Braelyn Ext 10 Clinic	44	03:00	02:29
Buffalo City	Empilweni Gompo CHC	52	03:02	03:02
OR Tambo	Xopozo Clinic	51	03:05	03:03
Buffalo City	Central Clinic (East London)	51	03:08	02:43
Buffalo City	Siyaphilisa NU 13 Clinic	49	03:10	02:40
OR Tambo	Port St Johns CHC	52	03:13	03:13
OR Tambo	Khanyayo (Holy Cross) Clinic	52	03:14	03:14
OR Tambo	Bala Clinic	50	03:18	03:16
OR Tambo	Qaukeni Clinic	50	03:20	03:19
OR Tambo	Lusikisiki Village Clinic (Qaukeni)	54	03:22	03:19
OR Tambo	St Elizabeth's Gateway Clinic	60	03:33	03:30
OR Tambo	Ntafufu Clinic	57	03:38	03:24
Buffalo City	Greenfields Clinic	50	03:42	03:16
Buffalo City	Gompo C Jabavu Clinic	48	03:48	03:26
OR Tambo	Mantlaneni Clinic	50	03:49	03:47
Buffalo City	Luyolo NU 9 Clinic	58	03:55	03:21
Buffalo City	Nontyatyambo CHC	52	03:55	03:44
Buffalo City	John Dube Clinic	50	03:56	03:24
Buffalo City	NU 8 Clinic	53	04:16	04:02
Buffalo City	Philani NU 1 Clinic	46	04:17	03:24
Buffalo City	Duncan Village CHC	53	04:24	03:39
OR Tambo	Holy Cross Gateway Clinic	51	04:27	04:26
Buffalo City	Gompo B Jwayi Clinic	50	04:29	04:29
Buffalo City	NU7 Thembisa Clinic	58	04:36	03:57
Buffalo City	Aspiranza Clinic	57	04:37	04:06
OR Tambo	Flagstaff Clinic	56	04:42	04:41
Buffalo City	Gompo A Ndende Clinic	51	04:47	03:41

Appendix 6: Where were the delays longer than usual? (April to June 2025)

District	Facility	Surveys completed	Waiting to enter the facility	Waiting to register	Waiting for my file	Waiting for my vitals to be checked	Waiting to be seen by a clinician	Waiting to collect my medicines
Buffalo City	Aspiranza Clinic	19	0	0	2	0	12	9
	Braelyn Ext 10 Clinic	14	1	2	5	2	9	4
	Central Clinic (East London)	26	2	3	6	1	25	1
	Chris Hani Clinic	17	0	2	12	1	16	3
	Duncan Village CHC	16	0	7	8	7	4	3
	Empilweni Gompo CHC	28	14	6	23	3	3	17
	Fezeka NU 3 Clinic	23	6	1	6	0	21	11
	Gompo A Ndende Clinic	39	21	32	12	10	14	3
	Gompo C Jabavu Clinic	26	0	8	5	2	14	4
	Greenfields Clinic	22	0	6	3	1	10	6
	John Dube Clinic	1	0	0	0	0	1	0
	Luyolo NU 9 Clinic	16	0	2	8	1	10	6
	Nontyatyambo CHC	25	0	2	12	1	10	10
	NU 8 Clinic	8	0	0	0	0	8	0
	NU7 Thembisa Clinic	5	0	1	3	0	3	1
	Philani NU 1 Clinic	34	13	30	11	5	7	8
	Siyaphilisa NU 13 Clinic	1	0	0	0	0	1	0
	Zanempilo Clinic (East London)	20	0	0	9	0	16	8
	Zingisa NU 5 Clinic	9	0	0	3	0	6	2
OR Tambo	Bala Clinic	47	1	13	11	11	33	2
	Flagstaff Clinic	9	0	5	1	0	0	2
	Goso Forest Clinic	1	0	0	1	0	0	0
	Holy Cross Gateway Clinic	10	0	6	4	4	4	0
	Khanyayo (Holy Cross) Clinic	5	0	0	0	0	0	0
	Lusikisiki Village Clinic (Qaukeni)	46	10	20	8	23	13	12
	Mantlaneni Clinic	2	0	1	1	1	0	0
	Mfundisweni Clinic	1	1	0	1	0	0	0
	Nkozo Clinic	2	0	0	1	2	1	1
	Ntafufu Clinic	25	23	18	14	5	0	0
	Port St Johns CHC	1	0	0	0	0	0	0
	St Elizabeth's Gateway Clinic	3	0	0	0	0	1	0
	Xopozo Clinic	13	0	4	3	0	6	0

Appendix 7: Why do you think the delays were longer than usual? (April to June 2025)

District	Facility	Surveys completed	It took longer to find files, the filing system is messier, files were lost	There were less staff than usual	The clinic opened later than usual	Other	Don't know
Buffalo City	Aspiranza Clinic	19	1	18	0	1	0
	Braelyn Ext 10 Clinic	14	3	14	0	0	0
	Central Clinic (East London)	26	1	26	1	0	0
	Chris Hani Clinic	17	11	16	0	0	0
	Duncan Village CHC	16	11	8	0	1	0
	Empilweni Gompo CHC	28	25	2	2	6	0
	Fezeka NU 3 Clinic	23	3	7	14	2	0
	Gompo A Ndende Clinic	39	13	39	2	2	0
	Gompo C Jabavu Clinic	26	9	15	0	4	0
	Greenfields Clinic	22	5	17	0	1	0
	John Dube Clinic	1	0	1	0	0	0
	Luyolo NU 9 Clinic	16	8	6	0	5	0
	Nontyatyambo CHC	25	12	16	1	2	0
	NU 8 Clinic	8	2	1	0	6	0
	NU7 Thembisa Clinic	5	2	4	1	0	0
	Philani NU 1 Clinic	34	20	20	22	0	0
	Siyaphilisa NU 13 Clinic	1	0	1	0	0	0
	Zanempilo Clinic (East London)	20	8	20	0	0	0
	Zingisa NU 5 Clinic	9	2	5	0	3	0
OR Tambo	Bala Clinic	47	9	46	1	0	0
	Flagstaff Clinic	9	4	4	0	0	1
	Goso Forest Clinic	1	1	1	0	0	0
	Holy Cross Gateway Clinic	10	1	9	1	1	0
	Khanyayo (Holy Cross) Clinic	5	0	0	0	0	5
	Lusikisiki Village Clinic (Qaukeni)	46	10	25	1	0	17
	Mantlaneni Clinic	2	0	2	0	0	0
	Mfundisweni Clinic	1	1	1	1	0	0
	Nkozo Clinic	2	1	1	0	0	0
	Ntafufu Clinic	25	22	14	7	0	0
	Port St Johns CHC	1	0	0	0	0	1
	St Elizabeth's Gateway Clinic	3	1	1	0	0	1
	Xopozo Clinic	13	0	12	0	0	1

Appendix 8: At your last ARV refill, how long were you given HIV medicine for? (April to June 2025)

District	Facility	Surveys completed	3 weeks	1 month	2 months	3 months	4 months	6 months	Score
Buffalo City	Gompo B Jwayi Clinic	25	0	0	0	25	0	0	3
OR Tambo	Bala Clinic	31	0	0	0	31	0	0	3
OR Tambo	Khanyayo (Holy Cross) Clinic	31	0	0	0	31	0	0	3
OR Tambo	Mantlaneni Clinic	25	0	0	0	25	0	0	3
OR Tambo	Mpoza Clinic	25	0	0	0	25	0	0	3
OR Tambo	Xopozo Clinic	33	0	0	0	33	0	0	3
OR Tambo	Mbadango Clinic	29	0	0	1	28	0	0	2.97
OR Tambo	Mfundisweni Clinic	25	0	0	1	24	0	0	2.96
OR Tambo	Qaukeni Clinic	28	0	0	1	27	0	0	2.96
OR Tambo	Port St Johns CHC	27	0	1	0	26	0	0	2.93
Buffalo City	Aspiranza Clinic	26	0	0	2	24	0	0	2.92
Buffalo City	Chris Hani Clinic	25	0	0	2	23	0	0	2.92
OR Tambo	Bodweni Clinic	37	1	0	1	35	0	0	2.91
Buffalo City	Empilweni Gompo CHC	28	0	0	3	25	0	0	2.89
OR Tambo	KTC Clinic	27	0	0	3	24	0	0	2.89
Buffalo City	Greenfields Clinic	25	0	2	2	20	0	1	2.88
Buffalo City	John Dube Clinic	26	0	0	3	22	1	0	2.88
OR Tambo	Ntafufu Clinic	33	0	1	2	30	0	0	2.88
Buffalo City	Central Clinic (East London)	26	0	1	2	23	0	0	2.85
Buffalo City	Fezeka NU 3 Clinic	27	0	2	0	25	0	0	2.85
Buffalo City	Luyolo NU 9 Clinic	27	0	1	2	24	0	0	2.85
OR Tambo	Xurana Clinic	26	0	0	4	22	0	0	2.85
Buffalo City	Nontyatyambo CHC	25	0	0	4	21	0	0	2.84
Buffalo City	Zingisa NU 5 Clinic	25	0	1	2	22	0	0	2.84
Buffalo City	NU 8 Clinic	24	0	1	2	21	0	0	2.83
OR Tambo	Flagstaff Clinic	37	0	1	5	31	0	0	2.81
OR Tambo	Goso Forest Clinic	25	0	0	5	20	0	0	2.8
Buffalo City	Duncan Village CHC	28	0	0	6	22	0	0	2.79
Buffalo City	NU7 Thembisa Clinic	27	0	0	6	21	0	0	2.78
Buffalo City	Gompo C Jabavu Clinic	26	0	1	4	21	0	0	2.77
Buffalo City	Braelyn Ext 10 Clinic	25	0	1	4	20	0	0	2.76
Buffalo City	Philani NU 1 Clinic	25	0	0	6	19	0	0	2.76
Buffalo City	Gompo A Ndende Clinic	25	0	0	7	18	0	0	2.72
Buffalo City	Zanempilo Clinic (East London)	25	0	2	4	19	0	0	2.68
Buffalo City	Siyaphilisa NU 13 Clinic	26	0	0	9	17	0	0	2.65
OR Tambo	Nkozo Clinic	31	0	1	9	21	0	0	2.65
OR Tambo	Palmerton Clinic	24	0	0	9	15	0	0	2.63
OR Tambo	St Elizabeth's Gateway Clinic	54	0	0	20	34	0	0	2.63
OR Tambo	Lusikisiki Village Clinic (Qaukeni)	43	0	2	21	20	0	0	2.42
OR Tambo	Holy Cross Gateway Clinic	43	0	2	37	3	0	0	2.02

Appendix 9: At your ARV refill today, how long were you given HIV medicine for? (April to June 2025)

District	Facility	Surveys completed	1 week	2 weeks	3 weeks	1 month	2 months	3 months	4 months	6 months	Score
Buffalo City	Central Clinic (East London)	36	0	0	0	0	0	36	0	0	3
Buffalo City	Gompo B Jwayi Clinic	34	0	0	0	0	0	34	0	0	3
Buffalo City	NU7 Thembisa Clinic	40	0	0	0	0	0	40	0	0	3
Buffalo City	Philani NU 1 Clinic	22	0	0	0	0	0	22	0	0	3
OR Tambo	Bala Clinic	48	0	0	0	0	0	48	0	0	3
OR Tambo	Mbadango Clinic	49	0	0	0	0	0	49	0	0	3
OR Tambo	Mpoza Clinic	28	0	0	0	0	0	28	0	0	3
Buffalo City	Nontyatyambo CHC	40	0	0	0	0	1	39	0	0	2.98
Buffalo City	Braelyn Ext 10 Clinic	35	0	0	0	0	1	34	0	0	2.97
OR Tambo	Xopozo Clinic	46	0	0	0	1	0	45	0	0	2.96
OR Tambo	Xurana Clinic	63	0	0	0	0	4	59	0	0	2.94
Buffalo City	Empilweni Gompo CHC	31	0	0	0	1	0	27	0	0	2.93
Buffalo City	John Dube Clinic	27	0	0	0	1	0	25	1	0	2.93
Buffalo City	NU 8 Clinic	38	0	0	0	1	1	36	0	0	2.92
Buffalo City	Zanempilo Clinic (East London)	38	0	0	0	1	1	36	0	0	2.92
OR Tambo	Bodweni Clinic	47	0	0	0	1	2	44	0	0	2.91
Buffalo City	Aspiranza Clinic	32	0	0	0	1	1	28	0	0	2.9
Buffalo City	Duncan Village CHC	30	0	0	0	0	3	27	0	0	2.9
Buffalo City	Siyaphilisa NU 13 Clinic	31	0	0	0	1	1	29	0	0	2.9
OR Tambo	Goso Forest Clinic	43	0	0	1	0	2	40	0	0	2.9
OR Tambo	KTC Clinic	46	0	0	0	0	5	41	0	0	2.89
OR Tambo	St Elizabeth's Gateway Clinic	24	0	0	0	0	3	21	0	0	2.88
OR Tambo	Qaukeni Clinic	31	0	0	0	1	3	27	0	0	2.84
Buffalo City	Gompo A Ndende Clinic	24	0	0	0	2	0	22	0	0	2.83
OR Tambo	Lusikisiki Village Clinic (Qaukeni)	37	0	0	0	2	3	30	1	0	2.81
OR Tambo	Ntafufu Clinic	36	0	0	1	1	3	31	0	0	2.8
Buffalo City	Luyolo NU 9 Clinic	29	0	0	0	3	0	26	0	0	2.79
OR Tambo	Mantlaneni Clinic	33	0	0	0	2	3	28	0	0	2.79
Buffalo City	Greenfields Clinic	29	1	0	0	2	0	26	0	0	2.77
Buffalo City	Gompo C Jabavu Clinic	28	0	0	0	3	1	24	0	0	2.75
OR Tambo	Nkozo Clinic	35	0	0	0	1	7	27	0	0	2.74
Buffalo City	Zingisa NU 5 Clinic	37	0	0	0	5	1	31	0	0	2.7
OR Tambo	Khanyayo (Holy Cross) Clinic	27	0	2	1	0	2	22	0	0	2.66
OR Tambo	Holy Cross Gateway Clinic	21	0	0	1	1	3	15	0	0	2.64
OR Tambo	Port St Johns CHC	30	0	0	0	1	9	20	0	0	2.63
OR Tambo	Mfundisweni Clinic	40	0	0	2	5	6	27	0	0	2.49
Buffalo City	Fezeka NU 3 Clinic	33	0	0	0	8	1	24	0	0	2.48
OR Tambo	Flagstaff Clinic	14	0	0	2	3	3	6	0	0	2.04
OR Tambo	Palmerton Clinic	3	0	0	0	0	3	0	0	0	2
Buffalo City	Chris Hani Clinic	38	0	0	0	21	0	17	0	0	1.89

Appendix 10: Location of where people living with HIV collect their ARVs (April to June 2025)

District	Facility	Surveys completed	At the facility (standard medicine dispensing)	Facility pick-up point	External pick-up point	Adherence club	Score
Buffalo City	Aspiranza Clinic	26	17	6	0	3	0.88
Buffalo City	John Dube Clinic	26	16	4	0	6	0.77
Buffalo City	Gompo A Ndende Clinic	25	17	2	0	6	0.76
OR Tambo	Mfundisweni Clinic	25	19	0	0	6	0.76
Buffalo City	NU7 Thembisa Clinic	27	10	10	0	7	0.74
Buffalo City	Central Clinic (East London)	26	12	7	0	7	0.73
Buffalo City	Philani NU 1 Clinic	25	10	6	1	8	0.68
Buffalo City	Braelyn Ext 10 Clinic	25	14	2	0	9	0.64
Buffalo City	Duncan Village CHC	28	18	0	0	10	0.64
Buffalo City	Gompo B Jwayi Clinic	25	13	3	0	9	0.64
OR Tambo	Ntafufu Clinic	33	20	0	0	13	0.61
Buffalo City	Luyolo NU 9 Clinic	27	12	4	0	11	0.59
Buffalo City	Fezeka NU 3 Clinic	27	8	7	0	12	0.56
Buffalo City	Nontyatyambo CHC	25	7	7	0	11	0.56
Buffalo City	Zingisa NU 5 Clinic	25	8	5	0	12	0.52
OR Tambo	Port St Johns CHC	27	14	0	0	13	0.52
OR Tambo	Flagstaff Clinic	37	16	3	0	18	0.51
Buffalo City	Gompo C Jabavu Clinic	26	10	3	0	13	0.5
Buffalo City	Siyaphilisa NU 13 Clinic	26	12	1	0	13	0.5
OR Tambo	Goso Forest Clinic	25	11	1	0	13	0.48
OR Tambo	Khanyayo (Holy Cross) Clinic	31	15	0	0	16	0.48
Buffalo City	Greenfields Clinic	25	7	3	0	15	0.4
OR Tambo	Mantlaneni Clinic	25	10	0	0	15	0.4
OR Tambo	St Elizabeth's Gateway Clinic	54	16	5	0	33	0.39
OR Tambo	Mbadango Clinic	29	11	0	0	18	0.38
OR Tambo	Bodweni Clinic	37	13	0	0	24	0.35
OR Tambo	Lusikisiki Village Clinic (Qaukeni)	43	4	11	0	28	0.35
Buffalo City	NU 8 Clinic	24	6	2	0	16	0.33
Buffalo City	Zanempilo Clinic (East London)	25	5	3	0	17	0.32
OR Tambo	Qaukeni Clinic	28	9	0	0	19	0.32
Buffalo City	Empilweni Gompo CHC	28	2	5	1	20	0.29
OR Tambo	Palmerton Clinic	24	7	0	0	17	0.29
Buffalo City	Chris Hani Clinic	25	6	1	0	18	0.28
OR Tambo	Xopozo Clinic	33	6	0	0	27	0.18
OR Tambo	KTC Clinic	27	4	0	0	23	0.15
OR Tambo	Mpoza Clinic	25	2	0	0	23	0.08
OR Tambo	Nkozo Clinic	31	2	0	0	29	0.06
OR Tambo	Holy Cross Gateway Clinic	43	2	0	0	41	0.05
OR Tambo	Bala Clinic	31	0	0	0	31	0
OR Tambo	Xurana Clinic	26	0	0	0	26	0

Appendix 11: Of those using standard medicine dispensing, has the facility ever offered you an option to be in a facility pick-up point, external pick-up point, or adherence club? (April to June 2025)

District	Facility	Surveys completed	Yes	No	Don't know	Score
OR Tambo	Flagstaff Clinic	18	18	0	0	100%
OR Tambo	Mfundisweni Clinic	6	6	0	0	100%
OR Tambo	Mpoza Clinic	23	22	0	1	100%
OR Tambo	Palmerton Clinic	17	17	0	0	100%
OR Tambo	Port St Johns CHC	13	13	0	0	100%
OR Tambo	Qaukeni Clinic	19	19	0	0	100%
OR Tambo	Holy Cross Gateway Clinic	41	40	1	0	98%
OR Tambo	Bodweni Clinic	24	23	1	0	96%
OR Tambo	Xurana Clinic	26	25	1	0	96%
OR Tambo	Bala Clinic	31	29	2	0	94%
OR Tambo	Lusikisiki Village Clinic (Qaukeni)	28	26	2	0	93%
OR Tambo	KTC Clinic	23	21	2	0	91%
OR Tambo	St Elizabeth's Gateway Clinic	33	29	3	1	91%
OR Tambo	Nkozo Clinic	29	26	3	0	90%
OR Tambo	Mbadango Clinic	18	16	2	0	89%
OR Tambo	Mantlaneni Clinic	15	12	2	1	86%
OR Tambo	Goso Forest Clinic	13	10	3	0	77%
OR Tambo	Ntafufu Clinic	13	10	3	0	77%
OR Tambo	Khanyayo (Holy Cross) Clinic	16	12	4	0	75%
Buffalo City	John Dube Clinic	6	4	2	0	67%
OR Tambo	Xopozo Clinic	27	17	10	0	63%
Buffalo City	Luyolo NU 9 Clinic	11	6	5	0	55%
Buffalo City	Gompo B Jwayi Clinic	9	4	5	0	44%
Buffalo City	NU7 Thembisa Clinic	7	3	4	0	43%
Buffalo City	Braelyn Ext 10 Clinic	9	3	6	0	33%
Buffalo City	Gompo A Ndende Clinic	6	2	4	0	33%
Buffalo City	Gompo C Jabavu Clinic	13	4	9	0	31%
Buffalo City	Siyaphilisa NU 13 Clinic	13	4	9	0	31%
Buffalo City	Central Clinic (East London)	7	2	5	0	29%
Buffalo City	Greenfields Clinic	15	4	11	0	27%
Buffalo City	NU 8 Clinic	16	4	12	0	25%
Buffalo City	Duncan Village CHC	10	2	8	0	20%
Buffalo City	Philani NU 1 Clinic	8	1	7	0	13%
Buffalo City	Zanempilo Clinic (East London)	17	2	15	0	12%
Buffalo City	Nontyatyambo CHC	11	1	10	0	9%
Buffalo City	Zingisa NU 5 Clinic	12	1	11	0	8%
Buffalo City	Chris Hani Clinic	18	1	17	0	6%
Buffalo City	Empilweni Gompo CHC	20	1	19	0	5%
Buffalo City	Aspiranza Clinic	3	0	3	0	0%
Buffalo City	Fezeka NU 3 Clinic	12	0	12	0	0%

Appendix 12: Would PLHIV like to collect ARVs closer to home? (April to June 2025)

District	Facility	Surveys completed	Yes	No	Don't know	No - because I already collect my ARVs close to home	Score
Buffalo City	Chris Hani Clinic	25	0	0	0	25	0%
	Duncan Village CHC	28	0	19	0	9	0%
	Gompo A Ndende Clinic	25	0	3	0	22	0%
	Gompo B Jwayi Clinic	25	0	11	0	14	0%
	John Dube Clinic	26	0	12	0	14	0%
	NU 8 Clinic	24	0	8	0	16	0%
	Siyaphilisa NU 13 Clinic	26	0	13	0	13	0%
	Aspiranza Clinic	26	1	10	0	15	4%
	Braelyn Ext 10 Clinic	25	1	3	0	21	4%
	Gompo C Jabavu Clinic	26	1	3	0	22	4%
	Nontyatyambo CHC	25	1	6	0	18	4%
	Philani NU 1 Clinic	25	1	8	0	16	4%
	Central Clinic (East London)	26	2	11	0	13	8%
	Zanempilo Clinic (East London)	25	2	3	0	20	8%
	NU7 Thembisa Clinic	27	3	10	0	14	11%
	Zingisa NU 5 Clinic	25	4	3	0	18	16%
	Empilweni Gompo CHC	28	5	2	0	21	18%
	Fezeka NU 3 Clinic	27	5	5	0	17	19%
	Greenfields Clinic	25	5	2	0	18	20%
	Luyolo NU 9 Clinic	27	6	2	0	19	22%
OR Tambo	Xurana Clinic	26	6	19	1	0	24%
	KTC Clinic	27	10	14	0	3	37%
	Qaukeni Clinic	28	12	13	0	3	43%
	Mantlaneni Clinic	25	11	14	0	0	44%
	Mpoza Clinic	25	11	14	0	0	44%
	Goso Forest Clinic	25	13	12	0	0	52%
	Khanyayo (Holy Cross) Clinic	31	16	15	0	0	52%
	Nkozo Clinic	31	19	12	0	0	61%
	Palmerton Clinic	24	15	9	0	0	63%
	Bodweni Clinic	37	25	12	0	0	68%
	Mbadango Clinic	29	20	9	0	0	69%
	Lusikisiki Village Clinic (Qaukeni)	43	30	12	1	0	71%
	Port St Johns CHC	27	19	7	1	0	73%
	Ntafufu Clinic	33	23	8	2	0	74%
	St Elizabeth's Gateway Clinic	54	39	14	1	0	74%
	Xopozo Clinic	33	25	8	0	0	76%
	Bala Clinic	31	24	7	0	0	77%
	Mfundisweni Clinic	25	20	5	0	0	80%
	Flagstaff Clinic	37	32	5	0	0	86%
	Holy Cross Gateway Clinic	43	40	3	0	0	93%

Appendix 13: Are the facility staff friendly? (April to June 2025)

District	Facility	Surveys completed	Always	Sometimes	Never	Don't know	Score
OR Tambo	Bodweni Clinic	51	50	1	0	0	1.98
OR Tambo	Nkozo Clinic	58	57	0	1	0	1.97
OR Tambo	St Elizabeth's Gateway Clinic	60	58	2	0	0	1.97
OR Tambo	Bala Clinic	50	48	2	0	0	1.96
OR Tambo	Holy Cross Gateway Clinic	51	49	2	0	0	1.96
OR Tambo	Qaukeni Clinic	50	46	4	0	0	1.92
OR Tambo	Mpoza Clinic	54	49	4	1	0	1.89
OR Tambo	Goso Forest Clinic	54	46	8	0	0	1.85
OR Tambo	Xopozo Clinic	52	44	8	0	0	1.85
Buffalo City	Zingisa NU 5 Clinic	52	43	9	0	0	1.83
Buffalo City	Gompo B Jwayi Clinic	50	40	10	0	0	1.8
OR Tambo	Mbadango Clinic	53	41	10	0	2	1.8
OR Tambo	Port St Johns CHC	52	42	9	1	0	1.79
OR Tambo	Xurana Clinic	53	45	5	3	0	1.79
OR Tambo	Flagstaff Clinic	56	42	12	0	2	1.78
OR Tambo	KTC Clinic	54	45	6	3	0	1.78
Buffalo City	Empilweni Gompo CHC	52	38	14	0	0	1.73
OR Tambo	Khanyayo (Holy Cross) Clinic	52	39	12	1	0	1.73
Buffalo City	NU 8 Clinic	53	38	14	1	0	1.7
Buffalo City	Zanempilo Clinic (East London)	53	37	16	0	0	1.7
OR Tambo	Lusikisiki Village Clinic (Qaukeni)	54	37	17	0	0	1.69
Buffalo City	Nontyatyambo CHC	52	36	14	2	0	1.65
OR Tambo	Palmerton Clinic	51	36	12	3	0	1.65
OR Tambo	Mfundisweni Clinic	54	37	14	3	0	1.63
Buffalo City	Central Clinic (East London)	51	31	19	1	0	1.59
Buffalo City	Greenfields Clinic	50	29	21	0	0	1.58
OR Tambo	Ntafufu Clinic	57	34	20	2	1	1.57
Buffalo City	Fezeka NU 3 Clinic	55	32	22	1	0	1.56
Buffalo City	John Dube Clinic	51	30	18	3	0	1.53
OR Tambo	Mantlaneni Clinic	52	29	20	2	1	1.53
Buffalo City	Duncan Village CHC	53	25	27	1	0	1.45
Buffalo City	Braelyn Ext 10 Clinic	44	20	23	1	0	1.43
Buffalo City	Gompo C Jabavu Clinic	48	20	28	0	0	1.42
Buffalo City	Chris Hani Clinic	54	23	30	1	0	1.41
Buffalo City	Luyolo NU 9 Clinic	58	29	24	5	0	1.41
Buffalo City	Siyaphilisa NU 13 Clinic	50	17	30	3	0	1.28
Buffalo City	Phillani NU 1 Clinic	46	13	32	1	0	1.26
Buffalo City	NU7 Thembisa Clinic	58	17	32	9	0	1.14
Buffalo City	Gompo A Ndende Clinic	51	5	42	4	0	1.02
Buffalo City	Aspiranza Clinic	57	9	38	10	0	0.98

Appendix 14: On a scale of 1-5, how comfortable do you feel using the facility? (April to June 2025)

District	Facility	Surveys completed	Very uncomfortable	Uncomfortable	Neutral	Comfortable	Very comfortable	Score
OR Tambo	KTC Clinic	54	0	0	6	15	32	4.49
OR Tambo	Bodweni Clinic	51	0	0	2	24	25	4.45
OR Tambo	Goso Forest Clinic	54	0	0	2	26	26	4.44
OR Tambo	Port St Johns CHC	52	0	0	3	23	26	4.44
OR Tambo	Qaukeni Clinic	50	0	1	2	21	26	4.44
OR Tambo	Khanyayo (Holy Cross) Clinic	52	0	0	7	16	29	4.42
OR Tambo	Xurana Clinic	53	2	0	0	23	26	4.39
OR Tambo	Palmerton Clinic	51	0	0	3	30	18	4.29
OR Tambo	Lusikisiki Village Clinic (Qaukeni)	54	0	0	0	40	14	4.26
OR Tambo	Mantlaneni Clinic	52	0	2	2	29	19	4.25
OR Tambo	Xopozo Clinic	52	0	1	5	28	18	4.21
OR Tambo	Nkozo Clinic	58	2	0	1	38	17	4.17
OR Tambo	St Elizabeth's Gateway Clinic	60	3	3	3	23	28	4.17
OR Tambo	Holy Cross Gateway Clinic	51	2	1	2	29	17	4.14
OR Tambo	Mpoza Clinic	54	1	11	1	10	30	4.08
OR Tambo	Mbadango Clinic	53	0	0	11	27	14	4.06
OR Tambo	Ntafufu Clinic	57	1	1	5	37	13	4.05
OR Tambo	Bala Clinic	50	0	3	5	29	13	4.04
Buffalo City	Gompo B Jwayi Clinic	50	2	1	2	39	6	3.92
OR Tambo	Flagstaff Clinic	56	3	3	5	30	15	3.91
Buffalo City	Empilweni Gompo CHC	52	0	0	6	46	0	3.88
Buffalo City	Zingisa NU 5 Clinic	52	0	0	8	42	2	3.88
Buffalo City	NU 8 Clinic	53	0	3	4	45	1	3.83
OR Tambo	Mfundisweni Clinic	54	0	3	10	36	5	3.8
Buffalo City	Zanempilo Clinic (East London)	53	0	1	10	41	1	3.79
Buffalo City	Fezeka NU 3 Clinic	55	0	1	12	42	0	3.75
Buffalo City	Nontyatyambo CHC	52	0	0	14	37	1	3.75
Buffalo City	Duncan Village CHC	53	2	3	10	33	5	3.68
Buffalo City	Central Clinic (East London)	51	1	1	12	37	0	3.67
Buffalo City	John Dube Clinic	51	1	5	7	38	0	3.61
Buffalo City	Aspiranza Clinic	57	1	5	12	39	0	3.56
Buffalo City	Luyolo NU 9 Clinic	58	0	6	16	36	0	3.52
Buffalo City	Braelyn Ext 10 Clinic	44	3	2	10	28	1	3.5
Buffalo City	Greenfields Clinic	50	0	5	15	30	0	3.5
Buffalo City	Gompo C Jabavu Clinic	48	0	8	12	28	0	3.42
Buffalo City	NU7 Thembisa Clinic	58	1	11	18	28	0	3.26
Buffalo City	Siyaphilisa NU 13 Clinic	50	4	6	18	22	0	3.16
Buffalo City	Philani NU 1 Clinic	46	0	11	17	18	0	3.15
Buffalo City	Chris Hani Clinic	54	1	6	33	14	0	3.11
Buffalo City	Gompo A Ndende Clinic	51	3	18	12	18	0	2.88

Appendix 15: What happens if you are late for or miss an appointment (April to June 2025)

District	Facility	Surveys completed	Staff are welcoming back	Staff counsel you on adherence	Staff ask why you missed appointment	The staff ask how they can help make it easier for you in future	The staff offer you a longer supply of ART to make it easier	The staff tell you about ART refill collection points closer to home or work that you can access which may make it easier	The staff shout at you for being late/ missing the appointment date	Staff send you to back of queue	The staff give you a shorter supply of ART than what you usually get (e.g. 1 month instead of 2 months)	The staff refuse to give you ART on the day you return and require you to return more than once to get your ART
Buffalo City	Aspiranza Clinic	26	0	0	3	0	0	0	1	5	1	0
	Braelyn Ext 10 Clinic	25	2	0	0	0	0	0	0	9	1	0
	Central Clinic (East London)	26	0	1	3	0	0	0	7	14	0	0
	Chris Hani Clinic	25	0	0	3	0	0	0	3	13	0	0
	Duncan Village CHC	28	7	0	11	1	0	0	9	0	0	0
	Empilweni Gompo CHC	28	0	5	1	0	0	0	0	10	1	0
	Fezeka NU 3 Clinic	27	0	2	0	0	0	0	3	9	0	1
Buffalo City	Gompo A Ndende Clinic	25	0	0	4	0	0	0	8	17	0	0
	Gompo B Jwayi Clinic	25	2	0	5	2	0	0	4	16	0	0
	Gompo C Jabavu Clinic	26	0	2	1	0	0	0	1	14	0	0
	Greenfields Clinic	25	2	3	4	0	0	0	3	7	0	2
	John Dube Clinic	26	0	0	1	0	0	0	0	11	0	0
	Luyolo NU 9 Clinic	27	2	1	7	0	0	0	2	6	0	0
	Nontyatyambo CHC	25	1	5	6	1	0	0	0	1	0	0
	NU 8 Clinic	24	0	1	3	0	0	0	6	10	0	0
	NU7 Thembisa Clinic	27	0	0	6	0	0	0	8	14	0	0
	Philani NU 1 Clinic	25	5	2	6	0	0	0	1	6	0	0
	Siyaphilisa NU 13 Clinic	26	0	0	7	0	0	0	6	4	0	0
	Zanempilo Clinic (East London)	25	0	3	1	0	0	0	0	13	0	0
	Zingisa NU 5 Clinic	25	0	0	1	0	0	0	1	12	0	0
OR Tambo	Bala Clinic	31	29	0	1	0	0	0	4	0	0	0
	Bodweni Clinic	37	36	0	0	0	0	0	0	0	0	0
	Flagstaff Clinic	37	29	0	1	0	0	0	3	1	0	0
	Goso Forest Clinic	25	22	0	0	0	0	0	0	0	0	0
	Holy Cross Gateway Clinic	43	26	0	2	0	0	0	0	1	1	1
	Khanyayo (Holy Cross) Clinic	31	30	0	0	0	0	0	0	0	0	0
	KTC Clinic	27	26	0	0	0	0	0	0	0	0	0
	Lusikisiki Village Clinic (Qaukeni)	43	36	0	0	0	0	0	2	0	0	0
	Mantlaneni Clinic	25	24	0	0	0	0	0	1	0	0	0
	Mbadango Clinic	29	28	0	1	0	0	0	0	0	0	0

District	Facility	Surveys completed	Staff are welcoming back	Staff counsel you on adherence	Staff ask why you missed appointment	The staff ask how they can help make it easier for you in future	The staff offer you a longer supply of ART to make it easier	The staff tell you about ART refill collection points closer to home or work that you can access which may make it easier	The staff shout at you for being late/ missing the appointment date	Staff send you to back of queue	The staff give you a shorter supply of ART than what you usually get (e.g. 1 month instead of 2 months)	The staff refuse to give you ART on the day you return and require you to return more than once to get your ART
OR Tambo	Mfundisweni Clinic	25	22	0	1	0	0	0	0	2	0	2
	Mpoza Clinic	25	22	0	2	0	0	0	0	0	0	0
	Nkozo Clinic	31	30	0	1	0	0	0	0	0	0	0
	Ntafufu Clinic	33	25	0	0	0	0	0	1	2	0	0
	Palmerton Clinic	24	23	0	5	0	0	0	0	0	0	0
	Port St Johns CHC	27	23	0	0	0	0	0	0	0	0	1
	Qaukeni Clinic	28	28	0	4	0	0	0	0	0	0	0
	St Elizabeth's Gateway Clinic	54	39	0	0	0	0	0	0	1	0	0
	Xopozo Clinic	33	21	0	0	0	0	0	3	0	0	0
	Xurana Clinic	26	24	0	0	0	0	0	0	0	0	0

Appendix 16: In the last 3 months, have you been refused access to services at this facility because you did not have an ID or transfer letter, or because you are not South African? (April to June 2025)

District	Facility	Surveys completed	Been refused access to services in the facility for not having an identity document	Been refused access to services without a transfer letter from another clinic	Been refused access for not being South African
Buffalo City	Braelyn Ext 10 Clinic	9	9	0	0
	Chris Hani Clinic	1	0	1	0
	Duncan Village CHC	5	3	1	1
	Fezeka NU 3 Clinic	3	3	0	0
	Gompo A Ndende Clinic	7	4	3	0
	Gompo B Jwayi Clinic	3	1	2	0
	Gompo C Jabavu Clinic	12	11	0	0
	Greenfields Clinic	2	2	0	0
	John Dube Clinic	3	0	3	0
	Luyolo NU 9 Clinic	2	0	2	0
	Nontyatyambo CHC	4	0	4	0

District	Facility	Surveys completed	Been refused access to services in the facility for not having an identity document	Been refused access to services without a transfer letter from another clinic	Been refused access for not being South African
Buffalo City	NU 8 Clinic	3	0	3	0
	NU7 Thembisa Clinic	13	8	5	0
	Phlani NU 1 Clinic	4	0	3	1
	Siyaphilisa NU 13 Clinic	1	1	0	0
	Zanempilo Clinic (East London)	2	0	2	0
OR Tambo	Bala Clinic	2	2	0	0
	Bodweni Clinic	1	1	0	0
	Goso Forest Clinic	1	1	0	0
	Khanyayo (Holy Cross) Clinic	3	3	0	0
	KTC Clinic	1	1	0	0
	Lusikisiki Village Clinic (Qaukeni)	2	2	0	0
	Mantlaneni Clinic	1	1	0	0
	Mfundisweni Clinic	3	2	0	0
	Port St Johns CHC	1	1	0	0
	Xopozo Clinic	1	0	0	1

Appendix 17: Do you agree with the following statement: an undetectable viral load means the treatment is working well (April to June 2025)

District	Facility	Surveys completed	Yes	No	Don't know	Score
Buffalo City	Central Clinic (East London)	26	26	0	0	100%
Buffalo City	Chris Hani Clinic	25	25	0	0	100%
Buffalo City	Duncan Village CHC	28	28	0	0	100%
Buffalo City	Empilweni Gompo CHC	28	28	0	0	100%
Buffalo City	Gompo A Ndende Clinic	25	24	0	0	100%
Buffalo City	Gompo B Jwayi Clinic	25	25	0	0	100%
Buffalo City	Gompo C Jabavu Clinic	26	26	0	0	100%
Buffalo City	John Dube Clinic	26	26	0	0	100%
Buffalo City	Nontyatyambo CHC	25	25	0	0	100%
Buffalo City	Siyaphilisa NU 13 Clinic	26	26	0	0	100%
Buffalo City	Zingisa NU 5 Clinic	25	25	0	0	100%
OR Tambo	Bala Clinic	31	31	0	0	100%
OR Tambo	Flagstaff Clinic	37	37	0	0	100%
OR Tambo	Goso Forest Clinic	25	25	0	0	100%
OR Tambo	Khanyayo (Holy Cross) Clinic	31	31	0	0	100%
OR Tambo	Mantlaneni Clinic	25	25	0	0	100%
OR Tambo	Mpoza Clinic	25	25	0	0	100%
OR Tambo	Nkozo Clinic	31	31	0	0	100%
OR Tambo	Port St Johns CHC	27	27	0	0	100%
OR Tambo	Xopozo Clinic	33	33	0	0	100%
OR Tambo	Xurana Clinic	26	26	0	0	100%

District	Facility	Surveys completed	Yes	No	Don't know	Score
OR Tambo	Holy Cross Gateway Clinic	43	42	1	0	98%
OR Tambo	Bodweni Clinic	37	36	1	0	97%
OR Tambo	Mbadango Clinic	29	28	1	0	97%
Buffalo City	Aspiranza Clinic	26	25	0	1	96%
Buffalo City	Braelyn Ext 10 Clinic	25	24	1	0	96%
Buffalo City	Fezeka NU 3 Clinic	27	26	0	1	96%
Buffalo City	Luyolo NU 9 Clinic	27	26	1	0	96%
Buffalo City	Philani NU 1 Clinic	25	24	1	0	96%
Buffalo City	Zanempilo Clinic (East London)	25	24	1	0	96%
OR Tambo	Mfundisweni Clinic	25	24	0	1	96%
OR Tambo	Palmerton Clinic	24	23	1	0	96%
Buffalo City	NU7 Thembisa Clinic	27	25	1	1	93%
OR Tambo	KTC Clinic	27	25	1	1	93%
Buffalo City	Greenfields Clinic	25	23	0	2	92%
OR Tambo	Qaukeni Clinic	28	25	2	1	89%
OR Tambo	St Elizabeth's Gateway Clinic	54	48	2	4	89%
Buffalo City	NU 8 Clinic	24	21	1	2	88%
OR Tambo	Lusikisiki Village Clinic (Qaukeni)	43	37	2	4	86%
OR Tambo	Ntafufu Clinic	33	28	4	1	85%

Appendix 18: Do you agree with the following statement: an undetectable viral load means a person cannot transmit HIV (April to June 2025)

District	Facility	Surveys completed	Yes	No	Don't know	Score
Buffalo City	Central Clinic (East London)	26	26	0	0	100%
Buffalo City	Chris Hani Clinic	25	25	0	0	100%
Buffalo City	Duncan Village CHC	28	28	0	0	100%
Buffalo City	Empilweni Gompo CHC	28	28	0	0	100%
Buffalo City	Gompo A Ndende Clinic	25	24	0	0	100%
Buffalo City	Gompo B Jwayi Clinic	25	25	0	0	100%
Buffalo City	Gompo C Jabavu Clinic	26	26	0	0	100%
Buffalo City	John Dube Clinic	26	26	0	0	100%
Buffalo City	Nontyatyambo CHC	25	25	0	0	100%
Buffalo City	Siyaphilisa NU 13 Clinic	26	26	0	0	100%
Buffalo City	Zingisa NU 5 Clinic	25	25	0	0	100%
OR Tambo	Bala Clinic	31	31	0	0	100%
OR Tambo	Bodweni Clinic	37	37	0	0	100%
OR Tambo	Flagstaff Clinic	37	37	0	0	100%
OR Tambo	Goso Forest Clinic	25	25	0	0	100%
OR Tambo	Khanyayo (Holy Cross) Clinic	31	31	0	0	100%
OR Tambo	KTC Clinic	27	27	0	0	100%
OR Tambo	Mantlaneni Clinic	25	25	0	0	100%
OR Tambo	Mbadango Clinic	29	29	0	0	100%
OR Tambo	Mpoza Clinic	25	25	0	0	100%

District	Facility	Surveys completed	Yes	No	Don't know	Score
OR Tambo	Nkozo Clinic	31	31	0	0	100%
OR Tambo	Palmerton Clinic	24	24	0	0	100%
OR Tambo	Port St Johns CHC	27	27	0	0	100%
OR Tambo	Xopozo Clinic	33	33	0	0	100%
OR Tambo	Xurana Clinic	26	26	0	0	100%
OR Tambo	Holy Cross Gateway Clinic	43	42	1	0	98%
Buffalo City	Aspiranza Clinic	26	25	0	1	96%
Buffalo City	Braelyn Ext 10 Clinic	25	24	1	0	96%
Buffalo City	Luyolo NU 9 Clinic	27	25	1	0	96%
Buffalo City	Phillani NU 1 Clinic	25	24	1	0	96%
Buffalo City	Zanempilo Clinic (East London)	25	24	1	0	96%
OR Tambo	Mfundisweni Clinic	25	24	0	1	96%
Buffalo City	Fezeka NU 3 Clinic	27	25	0	2	93%
Buffalo City	NU7 Thembisa Clinic	27	25	1	1	93%
Buffalo City	Greenfields Clinic	25	23	0	2	92%
OR Tambo	Qaukeni Clinic	28	25	2	1	89%
OR Tambo	St Elizabeth's Gateway Clinic	54	48	1	5	89%
Buffalo City	NU 8 Clinic	24	21	1	2	88%
OR Tambo	Lusikisiki Village Clinic (Qaukeni)	43	38	0	5	88%
OR Tambo	Ntafufu Clinic	33	28	3	2	85%

Appendix 19: What difficulties are you having to recall people with abnormal results? (April to June 2025)

District	Facility	Delays from the lab	No staff/ not enough staff managing recalls	Incorrect telephone numbers	No airtime/ dedicated phone line	Patient delaying coming in after contact
Buffalo City	Aspiranza Clinic			Yes		Yes
Buffalo City	Braelyn Ext 10 Clinic			Yes		Yes
Buffalo City	Central Clinic (East London)			Yes		Yes
Buffalo City	Chris Hani Clinic		Yes	Yes		Yes
Buffalo City	Duncan Village CHC			Yes		Yes
Buffalo City	Empilweni Gompo CHC			Yes		Yes
Buffalo City	Fezeka NU 3 Clinic			Yes		Yes
Buffalo City	Gompo A Ndende Clinic			Yes		Yes
Buffalo City	Gompo B Jwayi Clinic			Yes		Yes
Buffalo City	Gompo C Jabavu Clinic			Yes		Yes
Buffalo City	Greenfields Clinic			Yes		Yes
Buffalo City	John Dube Clinic		Yes	Yes		Yes
Buffalo City	Luyolo NU 9 Clinic	Yes		Yes		Yes
Buffalo City	Nontyatyambo CHC			Yes		Yes
Buffalo City	NU 8 Clinic			Yes		Yes
Buffalo City	NU7 Thembisa Clinic			Yes		Yes
Buffalo City	Phillani NU 1 Clinic			Yes		Yes

District	Facility	Delays from the lab	No staff/ not enough staff managing recalls	Incorrect telephone numbers	No airtime/ dedicated phone line	Patient delaying coming in after contact
Buffalo City	Siyaphilisa NU 13 Clinic	Yes		Yes		Yes
Buffalo City	Zanempilo Clinic (East London)	Yes		Yes		Yes
Buffalo City	Zingisa NU 5 Clinic	Yes		Yes		Yes
OR Tambo	Bala Clinic		Yes	Yes		
OR Tambo	Bodweni Clinic	Yes	Yes	Yes	Yes	Yes
OR Tambo	Flagstaff Clinic			Yes		Yes
OR Tambo	Goso Forest Clinic			Yes	Yes	Yes
OR Tambo	Holy Cross Gateway Clinic			Yes		Yes
OR Tambo	Khanyayo (Holy Cross) Clinic			Yes	Yes	
OR Tambo	KTC Clinic			Yes		
OR Tambo	Lusikisiki Village Clinic (Qaukeni)			Yes		Yes
OR Tambo	Mantlaneni Clinic	Yes	Yes	Yes	Yes	Yes
OR Tambo	Mbadango Clinic	Yes	Yes			Yes
OR Tambo	Mfundisweni Clinic	Yes		Yes		
OR Tambo	Mpoza Clinic	Yes		Yes		Yes
OR Tambo	Nkozo Clinic	Yes	Yes	Yes		
OR Tambo	Ntafufu Clinic			Yes		Yes
OR Tambo	Palmerton Clinic			Yes		Yes
OR Tambo	Port St Johns CHC			Yes		
OR Tambo	Qaukeni Clinic			Yes		Yes
OR Tambo	St Elizabeth's Gateway Clinic			Yes		Yes

Appendix 20: Is psychosocial support available for people living with HIV here? (April to June 2025)

District	Facility	Surveys completed	Yes	No	Don't know	Score
Buffalo City	Chris Hani Clinic	25	25	0	0	100%
Buffalo City	Empilweni Gompo CHC	28	28	0	0	100%
Buffalo City	Fezeka NU 3 Clinic	27	27	0	0	100%
Buffalo City	Gompo C Jabavu Clinic	26	26	0	0	100%
Buffalo City	Luyolo NU 9 Clinic	27	27	0	0	100%
Buffalo City	Nontyatyambo CHC	25	25	0	0	100%
Buffalo City	Philani NU 1 Clinic	25	24	0	0	100%
OR Tambo	Bala Clinic	31	31	0	0	100%
OR Tambo	Bodweni Clinic	37	37	0	0	100%
OR Tambo	Flagstaff Clinic	37	37	0	0	100%
OR Tambo	Holy Cross Gateway Clinic	43	42	0	1	100%
OR Tambo	Lusikisiki Village Clinic (Qaukeni)	43	42	0	1	100%
OR Tambo	Mbadango Clinic	29	29	0	0	100%
OR Tambo	Mpoza Clinic	25	25	0	0	100%
OR Tambo	Nkozo Clinic	31	31	0	0	100%
OR Tambo	Palmerton Clinic	24	24	0	0	100%

District	Facility	Surveys completed	Yes	No	Don't know	Score
OR Tambo	Qaukeni Clinic	28	27	0	1	100%
OR Tambo	St Elizabeth's Gateway Clinic	54	54	0	0	100%
OR Tambo	Xopozo Clinic	33	33	0	0	100%
OR Tambo	Xurana Clinic	26	26	0	0	100%
OR Tambo	Khanyayo (Holy Cross) Clinic	31	30	1	0	97%
OR Tambo	Ntafufu Clinic	33	32	1	0	97%
Buffalo City	Aspiranza Clinic	26	25	1	0	96%
OR Tambo	Goso Forest Clinic	25	23	1	1	96%
OR Tambo	KTC Clinic	27	26	1	0	96%
OR Tambo	Mantlaneni Clinic	25	24	1	0	96%
OR Tambo	Port St Johns CHC	27	26	1	0	96%
Buffalo City	Gompo B Jwayi Clinic	25	23	2	0	92%
Buffalo City	John Dube Clinic	26	24	2	0	92%
Buffalo City	Central Clinic (East London)	26	22	3	1	88%
Buffalo City	NU 8 Clinic	24	21	3	0	88%
Buffalo City	Siyaphilisa NU 13 Clinic	26	23	3	0	88%
OR Tambo	Mfundisweni Clinic	25	22	3	0	88%
Buffalo City	NU7 Thembisa Clinic	27	23	4	0	85%
Buffalo City	Braelyn Ext 10 Clinic	25	21	4	0	84%
Buffalo City	Gompo A Ndende Clinic	25	21	4	0	84%
Buffalo City	Zanempilo Clinic (East London)	25	20	5	0	80%
Buffalo City	Zingisa NU 5 Clinic	25	20	5	0	80%
Buffalo City	Greenfields Clinic	25	18	7	0	72%
Buffalo City	Duncan Village CHC	28	20	8	0	71%

Appendix 21: The types of psychosocial support that people living with HIV know are available (April to June 2025)

District	Facility	Surveys completed	Individualised counselling for any person living with HIV (no matter how long they have been on treatment)	HIV pre-test counselling	HIV post-test counselling	Peer led patient navigators	Referrals to a social worker and other services	Referral to optional support groups	Food parcels
Buffalo City	Aspiranza Clinic	25	12	19	18	0	1	3	0
	Braelyn Ext 10 Clinic	21	13	21	21	0	0	0	0
	Central Clinic (East London)	22	8	22	21	0	0	2	0
	Chris Hani Clinic	25	2	24	25	1	0	4	0
	Duncan Village CHC	20	15	18	18	0	0	0	0
	Empilweni Gompo CHC	28	8	28	28	0	0	0	0

District	Facility	Surveys completed	Individualised counselling for any person living with HIV (no matter how long they have been on treatment)	HIV pre-test counselling	HIV post-test counselling	Peer led patient navigators	Referrals to a social worker and other services	Referral to optional support groups	Food parcels
Buffalo City	Fezeka NU 3 Clinic	27	7	26	26	0	0	0	0
	Gompo A Ndende Clinic	21	13	19	19	0	0	0	0
	Gompo B Jwayi Clinic	23	9	16	14	1	6	3	0
	Gompo C Jabavu Clinic	26	15	24	24	0	0	0	0
	Greenfields Clinic	18	7	17	17	0	0	0	0
	John Dube Clinic	24	12	19	19	0	0	0	0
	Luyolo NU 9 Clinic	27	12	27	27	0	1	0	0
	Nontyatyambo CHC	25	10	25	25	0	0	0	0
	NU 8 Clinic	21	10	13	12	1	1	4	0
	NU7 Thembisa Clinic	23	13	17	17	1	0	0	0
	Philani NU 1 Clinic	24	15	24	24	0	0	0	0
	Siyaphilisa NU 13 Clinic	23	11	21	21	0	0	0	0
	Zanempilo Clinic (East London)	20	7	19	19	0	0	0	0
	Zingisa NU 5 Clinic	20	3	19	20	0	0	0	0
OR Tambo	Bala Clinic	31	31	9	3	0	0	0	0
	Bodweni Clinic	37	36	14	3	0	0	0	0
	Flagstaff Clinic	37	35	32	17	1	0	1	0
	Goso Forest Clinic	23	23	3	1	0	0	0	0
	Holy Cross Gateway Clinic	42	42	36	30	1	0	0	0
	Khanyayo (Holy Cross) Clinic	30	30	3	1	0	0	0	0
	KTC Clinic	26	26	10	3	0	0	0	2
	Lusikisiki Village Clinic (Qaukeni)	42	42	28	21	1	1	0	0
	Mantlaneni Clinic	24	24	7	5	0	0	0	0
	Mbadango Clinic	29	27	9	3	0	1	0	0
	Mfundisweni Clinic	22	22	2	0	0	0	0	0
	Mpoza Clinic	25	25	16	5	0	0	0	0
	Nkozo Clinic	31	31	15	6	0	0	0	0
	Ntafufu Clinic	32	32	7	7	1	1	0	0
	Palmerton Clinic	24	24	16	2	0	0	0	0
	Port St Johns CHC	26	26	4	1	0	0	0	0
	Qaukeni Clinic	27	27	17	6	1	0	0	0
	St Elizabeth's Gateway Clinic	54	54	42	28	3	3	0	0
	Xopozo Clinic	33	25	6	3	0	2	6	0
	Xurana Clinic	26	26	16	5	0	0	0	0

Appendix 22: Does your facility need support to monitor people with advanced HIV (AHD) for the first 3 months after being diagnosed with AHD? (April to June 2025)

District	Facility	Surveys completed	Yes	No	Score
Buffalo City	Aspiranza Clinic	1	1	0	100%
Buffalo City	Chris Hani Clinic	1	1	0	100%
Buffalo City	Duncan Village CHC	1	1	0	100%
Buffalo City	Fezeka NU 3 Clinic	1	1	0	100%
Buffalo City	Gompo B Jwayi Clinic	1	1	0	100%
Buffalo City	Gompo C Jabavu Clinic	1	1	0	100%
Buffalo City	Greenfields Clinic	1	1	0	100%
Buffalo City	Luyolo NU 9 Clinic	1	1	0	100%
Buffalo City	NU 8 Clinic	1	1	0	100%
Buffalo City	Philani NU 1 Clinic	1	1	0	100%
OR Tambo	Bala Clinic	1	1	0	100%
OR Tambo	Bodweni Clinic	1	1	0	100%
OR Tambo	Flagstaff Clinic	1	1	0	100%
OR Tambo	Goso Forest Clinic	1	1	0	100%
OR Tambo	Holy Cross Gateway Clinic	1	1	0	100%
OR Tambo	KTC Clinic	1	1	0	100%
OR Tambo	Mantlaneni Clinic	1	1	0	100%
OR Tambo	Mbadango Clinic	1	1	0	100%
OR Tambo	Mpoza Clinic	1	1	0	100%
OR Tambo	Nkozo Clinic	1	1	0	100%
OR Tambo	Xopozo Clinic	1	1	0	100%
OR Tambo	Xurana Clinic	1	1	0	100%
Buffalo City	Braelyn Ext 10 Clinic	1	0	1	0%
Buffalo City	Central Clinic (East London)	1	0	1	0%
Buffalo City	Empilweni Gompo CHC	1	0	1	0%
Buffalo City	Gompo A Ndende Clinic	1	0	1	0%
Buffalo City	John Dube Clinic	1	0	1	0%
Buffalo City	Nontyatyambo CHC	1	0	1	0%
Buffalo City	NU7 Thembisa Clinic	1	0	1	0%
Buffalo City	Siyaphilisa NU 13 Clinic	1	0	1	0%
Buffalo City	Zanempilo Clinic (East London)	1	0	1	0%
Buffalo City	Zingisa NU 5 Clinic	1	0	1	0%
OR Tambo	Khanyayo (Holy Cross) Clinic	1	0	1	0%
OR Tambo	Lusikisiki Village Clinic (Qaukeni)	1	0	1	0%
OR Tambo	Mfundisweni Clinic	1	0	1	0%
OR Tambo	Ntafufu Clinic	1	0	1	0%
OR Tambo	Palmerton Clinic	1	0	1	0%
OR Tambo	Port St Johns CHC	1	0	1	0%
OR Tambo	Qaukeni Clinic	1	0	1	0%
OR Tambo	St Elizabeth's Gateway Clinic	1	0	1	0%

Appendix 23: Are condoms and lubricants available at the facility? (April to June 2025)

District	Facility	External condoms	Internal condoms	Lubricant
Buffalo City	Aspiranza Clinic	Yes	Yes	Yes
	Braelyn Ext 10 Clinic	Yes	Yes	Yes
	Central Clinic (East London)	Yes	No	No
	Chris Hani Clinic	Yes	Yes	Yes
	Duncan Village CHC	Yes	Yes	Yes
	Empilweni Gompo CHC	Yes	Yes	Yes
	Fezeka NU 3 Clinic	Yes	No	No
	Gompo A Ndende Clinic	Yes	No	Yes
	Gompo B Jwayi Clinic	Yes	No	Yes
	Gompo C Jabavu Clinic	Yes	Yes	Yes
	Greenfields Clinic	Yes	Yes	Yes
	John Dube Clinic	Yes	Yes	Yes
	Luyolo NU 9 Clinic	Yes	No	No
	Nontyatyambo CHC	Yes	No	No
	NU 8 Clinic	Yes	No	No
	NU7 Thembisa Clinic	Yes	Yes	No
	Philani NU 1 Clinic	Yes	Yes	No
	Siyaphilisa NU 13 Clinic	Yes	Yes	Yes
	Zanempilo Clinic (East London)	Yes	Yes	Yes
	Zingisa NU 5 Clinic	Yes	Yes	No
OR Tambo	Bala Clinic	No	No	No
	Bodweni Clinic	Yes	Yes	No
	Flagstaff Clinic	Yes	Yes	No
	Goso Forest Clinic	Yes	Yes	No
	Holy Cross Gateway Clinic	No	No	No
	Khanyayo (Holy Cross) Clinic	Yes	Yes	No
	KTC Clinic	Yes	No	No
	Lusikisiki Village Clinic (Qaukeni)	Yes	Yes	Yes
	Mantlaneni Clinic	No	No	No
	Mbadango Clinic	Yes	Yes	No
	Mfundisweni Clinic	Yes	Yes	No
	Mpoza Clinic	Yes	No	Yes
	Nkozo Clinic	Yes	Yes	Yes
	Ntafufu Clinic	No	No	Yes
	Palmerton Clinic	Yes	Yes	Yes
	Port St Johns CHC	Yes	Yes	Yes
	Qaukeni Clinic	Yes	No	No
	St Elizabeth's Gateway Clinic	No	No	No
	Xopozo Clinic	Yes	Yes	Yes
	Xurana Clinic	Yes	Yes	No

NOTES

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