Impact, Adaptation and Opportunity

SOUTH AFRICA'S HEALTH SYSTEM POST-PEPFAR

March 2026

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catalysts for social justice

CENTRE FOR CHILD LAW

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Contents

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TAC TREATMENT ACTION CAMPAIGN

RudASA

RHAP Rural Health Advocacy Project

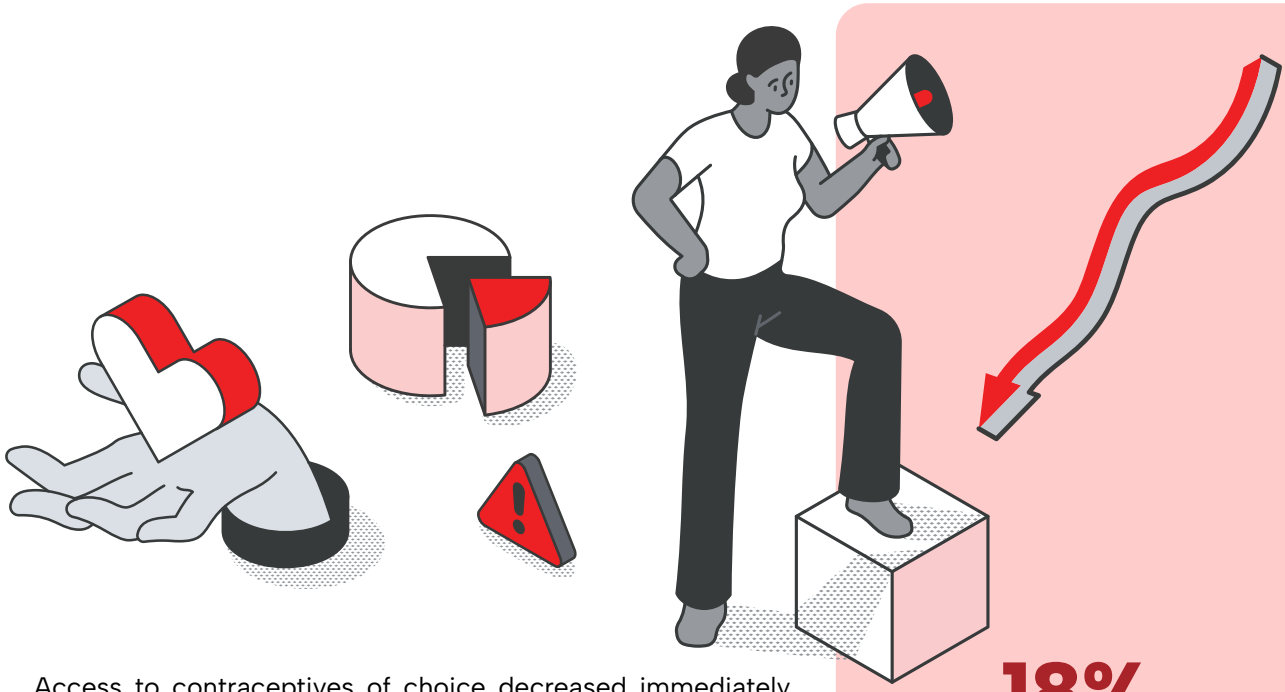
MEDECINS SANS FRONTIERES DOCTORS WITHOUT BORDERS

Introduction

In January 2025, US President Donald Trump issued an executive order freezing foreign aid, which was followed by stop-work orders halting US funding for HIV across the world. With 18% of South Africa's HIV programme funded through PEPFAR, the potential impact on the health system and those who depend on it was significant.

Having monitored medicines availability over the past 13 years, the Stop Stockouts Project was anxious to establish the impact on the health system and public health users in the months immediately following the PEPFAR withdrawal. Using a mixed-method approach, this report draws on Ritshidze's open-source national datasets (considering comparative quantitative data collected over eighteen months from 1 January 2024 to 31 June 2025) and from Key Informant Interviews conducted between 15 November 2025 and 20 March 2026. While we examine and situate the impact of PEPFAR's withdrawal on South Africa's national HIV programme and public health system, the quantitative data is drawn from three high-HIV prevalence former PEPFAR-priority districts in KwaZulu-Natal: eThekwini, uMgungundlovu, and King Cetshwayo. While eThekwini and uMgungundlovu remain priority districts, PEPFAR support has been withdrawn from King Cetshwayo following the PEPFAR crisis. The subject of this report and the origins of our dataset present peculiar circumstances. Crucially, Ritshidze has been funded by the CDC and USAID. Ritshidze lost funding at the time of the freeze and withdrawal, so the dataset, its limitations, and the challenges the community-led monitoring programme faces are part of this report's narrative.

The report finds that HIV testing has been affected due to staff shortages following the PEPFAR withdrawal.



Access to contraceptives of choice decreased immediately (although not significantly) following the PEPFAR withdrawal in each of the districts examined. While in-facility and external pick-up points to collect ART are widely used and appreciated for their time-saving potential, there has been a notable reassignment of facility staff to facilitate pick-up points due to the absence of PEPFAR-funded staff. Significant proportions of public healthcare users reported longer ART collection times following PEPFAR disruptions and withdrawal in King Cetshwayo. Perhaps the most significant impact has been on ART refill length. While each of the districts had been achieving higher percentages of people living with HIV receiving two- or three-month refills before the PEPFAR disruptions, after the disruptions, these gains were reversed.

The report's findings illustrate not just a negative impact but also adaptation. Department of Health ("DoH") staff members stepped in to fill gaps left by PEPFAR. The data do not indicate that people living with HIV were turned away from receiving their medication after PEPFAR-funded programmes were closed. Instead, health service users redirected to Department of Health-operated facilities and shorter refills were given to accommodate additional users. While far from optimal outcomes, this ability to adapt is notable and welcome. This however put additional burden back onto people living with HIV to attend the clinic more frequently, and onto clinic staff at more over congested sites.

Finally, the report points to opportunities to build on strengths, including the further resourcing and streamlining of pick-up points, better integration of the HIV programme into primary health care services, and the resourcing and continued support for community-led monitoring to uncover what is really happening in the health system and contribute to its improvement.

18%

of South Africa's HIV programme was PEPFAR-funded at the time of the cuts.

US$8 billion

in total PEPFAR support to South Africa over the programme's lifetime.

43%

of patients in King Cetshwayo reported it took longer to collect ARVs after January 2025.

25-45%

of facilities reported fewer staff available for HIV testing.

PEPFAR's Beginning and its end in South Africa

The President's Emergency Plan for AIDS Relief program (PEPFAR) was established by the United States (U.S.) Congress in 2003 to respond to the urgent growth of the HIV/AIDS epidemic. PEPFAR focused on 50 countries with high-burden HIV positive populations, notably in Asia, sub-Saharan Africa, and the Caribbean (Verryn, 2025). The program has spanned providing lifesaving antiretroviral drugs and treatment (ART), expanding HIV testing and prevention, supporting orphans and vulnerable populations impacted by the epidemic, and strengthening national health systems to sustain long-term HIV response (Ibid).

As the country with the largest HIV burden globally, South Africa has been one of the largest recipients of PEPFAR support (Verryn, 2025). Over the course of the two-decade-long U.S. program's existence, South Africa has received an estimated USD $8 billion in total (UNAIDS, 2023). Recent annual support has amounted to between $400 – $500 million (Verryn, 2025). The program launched in South Africa in 2004, to support ART through partnerships with Non- Governmental Organisations (NGOs) working as Implementing Partners (IPs). PEPFAR funding allowed the South African government to fund a comprehensive free HIV treatment programme within its public health system (UNAIDS, 2023). In 2010, the emergency response phase wound down, and PEPFAR's focus in South Africa shifted to funding clinicians, healthcare workers and infrastructure, which expanded existing HIV service delivery throughout the country (Verryn, 2025).

South Africa, the country with the largest HIV burden globally, has received an estimated USD $8 billion from PEPFAR over two decades.

However, strong signalling that the political and financial consensus of U.S. and European donor governments on HIV, was weakening was noticeable from 2018 (Directors, PLWHIV NGO, interview, 14 January 2026). In 2020, the Global Fund began to struggle in comparison to GAVI, the vaccine alliance, which was resourced quickly. Since 2021, major HIV-related agreements were no longer passed by consensus, but by vote. In January 2025, the U.S. President issued an executive order calling for a 90-day freeze on foreign aid, after which stop-work orders were issued halting HIV service delivery through CDC and USAIAD. A limited waiver was issued in February 2025 allowing for some services to resume under CDC. Soon after, the U.S. government dismantled its overseas agency, USAID.

Still, the changes in 2025 impacting national health systems, the populations that rely on them, and employees across continents were blunt and swift. By September, the America First Global Health Strategy was launched, replacing these developmental mechanisms and many of their approaches. Some describe the new strategy as reframing global health "as an explicit political strategy to pursue American national advantage, rather than a public-health first technical issue" (2025, Fos Feminista). This new approach, "preserves U.S. priorities that don't conflict with populist and anti-rights perspectives While the strategy emphasises infectious diseases including HIV and TB, it pointedly omits women's health, including

maternal and reproductive health. This selective approach underscores the [U.S.] administration's intent to reshape global health priorities around ideology and domestic political alignment rather than evidence-based need or global equity" (2025, Fos Feminista).

Public framing has been that HIV is a manageable condition; and people living with HIV (PLHIV) can live full lives. The framing after the U.S. funding freezes and cuts has been reversing this narrative overnight. The years spent innovating treatment and making it accessible, building evidence showing HIV is a manageable condition, and getting the public to believe and experience this reality is being undone (Directors, PLWHIV INGO, interview, 14 Jan. 2026).

At the time of the cuts, PEPFAR funded approximately 18% of South Africa's HIV/AIDS programme (US Department of State, 2022). PEPFAR did not fund ART and HIV diagnostics. The South African government self-funds the medicines and commodities aspect of the nation's HIV/AIDS program (Ibid). Rather, the bulk of U.S. financing – at the time of the withdrawal – supported high-level technical assistance through staff tasked with supply chain monitoring, and forecasting; various forms of expert data collection and logistics; along with front line clinical and administrative staffing at site level and in community outreach, external pick-up points (places for ART collection), and key populations programming (UNAIDS, 2023). Key population programming was largely covered by U.S. funding.

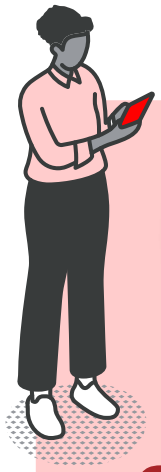
The South African HIV programme's relative stability comes from years of strong civil society advocacy that pushed full government ownership and integration of HIV prevention and services early on (Directors, PLHIV INGO, interview, 14 January 2026). The strength and stability of the programme have, in turn, been monitored in recent years by community-led monitoring through Ritshidze, which was itself supported by U.S. government funding, now withdrawn.

The Stop Stockouts Project

The Stop Stockouts Project (SSP) commissioned this research. SSP is a consortium of five civil society organisations: Doctors without Borders (MSF), Rural Doctors Association of South Africa (RuDASA), Rural Health Advocacy Project (RHAP), SECTION27 and the Treatment Action Campaign (TAC). SSP monitors and reports on public primary healthcare facilities across the country.

SSP has positively improved service delivery and addressed shortages and stockouts of medicine and vaccines. Since its inception in 2013, the project's evidence-based agility has allowed it to respond to real-time population health needs. It has successfully used evidence gathering, analysis, and advocacy to meet urgent health needs reported to its hotline and by community partners. Initially, SSP investigated the availability of a wide range of medicines, especially ART. Whilst improvements in the ART supply chain and government response to ART stock shortages became effective, reports showed contraceptives were increasingly inaccessible due to stockouts. Instead of focusing on a wide range of medicines, between 2018 and 2022 SSP shifted focus to the availability of contraceptives. By 2024, access to contraceptives stabilised, albeit not fully reflective of the range of contraceptives set out in the national family planning program method mix. In 2025, when PEPFAR and USAID funding froze and was withdrawn, SSP again shifted focus, this time to assess the immediate impact of PEPFAR withdrawal on South Africa's health system.

Ritshidze



RITSHIDZE
SAVING OUR LIVES

8 years

of clinic monitoring & advocacy for HIV services

Before 2025

- Quarterly cycle
- 80 monitors
- 450–560 clinics

After 2025

- Twice-yearly cycle
- 20 monitors
- 400 clinics

Ritshidze is the largest community-led monitoring programme in the world, led by TAC. Ritshidze was developed and designed in response to the crisis in our clinics. Ritshidze gives communities the tools and techniques to monitor the quality of health services provided at clinics — including HIV and TB services, and services for members of key populations — and escalate challenges to duty bearers. For the last seven years on a quarterly cycle Ritshidze has been systematically collecting data at more than 450 clinics (up to 560 during 2024), across 25 districts, in eight provinces. However, following the U.S. government funding cuts, Ritshidze lost its main source of funding. While previously there were 140+ staff in place, with 80 community monitors collecting data, now there are just 20 monitors continuing with this work. Ritshidze is currently monitoring 400 facilities, but now on a six-month cycle, to understand the challenges public healthcare users – including people living with HIV and members of key populations – face at clinics.

Open-source quantitative data, collected by Ritshidze, is used by SSP for its research. Ritshidze's data provides public healthcare user and staff perspectives, as well as observational data. Ritshidze holds a Memorandum of Understanding with the National Department of Health to engage in community-led monitoring, as well as authorisation from provincial and district health departments to allow access into sites.

This study aimed to assess the impact of PEPFAR withdrawal in South Africa's health system and to determine whether, and how, the health system adapted to this abrupt change to ensure continued access to healthcare services. The objectives were to determine the trends in the:

1. availability and accessibility of HIV testing and ART to assess the extent to which HIV services were disrupted, and
2. availability and accessibility of contraceptives to determine whether PEPFAR disruptions impacted other healthcare services. Although contraceptives were supported by PEPFAR, we assessed this because this has been a particularly weak area for the health system.

KwaZulu-Natal (KZN) was the focus of this report for several reasons. First, the province is generally considered to be the epicentre of South Africa's HIV epidemic (National Department of Health, 2025). As a result, seven of the 27 HIV high-burden districts supported by PEPFAR were in KZN. Secondly, over the years that SSP has focused on the availability and accessibility of contraceptives, KZN consistently ranked in the top three provinces reporting the highest percentage of contraceptive stockouts. As one informant put it:

> "KZN has the highest burden of HIV. If KZN succeeds, the whole country benefits"
> **Senior Executive of the South African National Aids Council (SANAC), 20 March 2026.**

Methodology

This report is based on two data sets. The first consists of specific indicators to assess the state of HIV testing services, and to determine the availability and accessibility of ART and contraception pre-and post PEPFAR withdrawal. This quantitative assessment relies on data collected by Ritshidze through public healthcare user and facility manager surveys.

Data was collected from three high HIV-prevalence PEPFAR-funded districts in KZN, eThekwini, uMgungundlovu, and King Cetshwayo between 1 January 2024 and 30 June 2025. The quantitative data provides a comparative element because it includes data collected *before and after* PEPFAR disruptions. The data covers four thematic areas: PEPFAR awareness and perceptions; HIV testing; ART and contraception.

2 data sets

3 districts

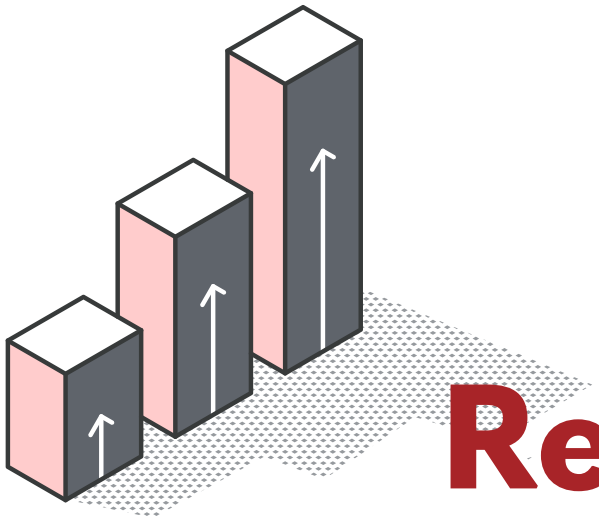
18 voices

The second data set (qualitative) consists of Key Informant Interviews with informants recruited from civil society, the National Department of Health, and the KZN Provincial Department of Health. These three sectors are structurally involved in the HIV programme. They also have each been impacted by the funding loss, relative to their differing roles in the programme. Inviting a variety of actors from each sector was attempted to ensure a diversity of vantage points amongst Key Informants. For example, those working at the national level are responsible for ensuring oversight and success of the HIV programme, while some recruited from civil society were PEPFAR Implementing Partners, and some are community and sector leaders (PLHIV, key populations). Those invited from the provincial level are tasked with day-to-day operations, task shifting, and prioritising services. Key Informant Interviews were analysed through narrative thematic analysis.

Table 1. Sample Size: Qualitative data – Semi-structured Key Informant Interviews

Key Informants Sector	Invited	No. KII	Of which, no. Directors / Managers
Civil Society	8	6	4
National Health Dept.	5	2	2
Provincial Health Dept.	5	1	-
Total	**18**	**9**	**6**

A mixed-method approach was adopted to provide both a broad scope of service delivery information and to contextualise this data by engaging duty-bearers responsible for the delivery of these services.



Results

This chapter presents the findings from our analysis. Each section draws on quantitative data from patient and facility manager surveys and from the qualitative data. The flow of the chapter tells the story of funding and mitigation awareness, staffing and service impacts (HIV testing and contraceptives), and supply chain adaptations (ART collection and refills). Focusing on data across the three districts with the highest HIV burden in South Africa: eThekwini, uMgungundlovu, and King Cetshwayo.

The first section elaborates on awareness of PEPFAR, including the main support it provided, reflections on current challenges, and the impact of withdrawal. The second section engages findings on staffing and service availability. The subsequent sections detail access to ARVs, mitigation efforts, and their sustainability. Together, these findings provide a foundation for understanding how patients and facilities, particularly in KZN, experienced disruptions and adaptations to ART access, staffing, waiting times, differentiated service delivery models, and other critical health services.

I. PEPFAR Awareness & Perceived Impact

This section examines the perceptions and awareness of U.S. funding, identifying what aspects of the HIV programme it supported, and how it did so. We also capture stakeholders' feelings, knowledge, and perceptions about the withdrawal almost one year later. The section begins with Key Informant reflections and then draws on patient and facility manager surveys conducted in April to June 2025. The patient survey assessed awareness and perceptions of PEPFAR, USAID, and the CDC, while the facility manager survey examined the operational status of PEPFAR IP following the January 2025 withdrawal. These indicators provide both patient-level awareness and facility-level system perspectives, allowing assessment of how visible the withdrawal was to service users and providers.

Key Informants agreed that US funding of the HIV programme, at the time of withdrawal, primarily supported three key areas: technical assistance, key populations and community engagement.

1. Technical Assistance

At the National Department of Health level, U.S. funding supported staffing, including analytical expertise in supply chain, logistics, and efficiency, and specialists in contracting, supplier performance management, and monthly forecasting for ARV procurement. At the Provincial Department of Health Level, U.S. funding supported staffing, including analytical experts deployed to support the supply chain (procurement and contracting of ART); data capturers; clinic clerks; and nurses and other clinical staff.

The impact on employees from the loss of technical assistance and staffing support was noted by Key Informants:

> "Look at us [employees] holistically. We've got psychological, emotional, physical, and spiritual needs. So, it's really impacted us. We are colleagues. We [KZN Department of Health staff] have been having people that are seconded here by our partners. Now they are losing, losing jobs, young people too. We are comparing, looking at facilities which one doesn't have this, which one has that. I don't know how they are going to cope. That's the saddest, retrenchment because the level of unemployment is so high. And now this is going to add to unemployment and then again deepened poverty" **Programme Supervisor, eThekwini District, KZN Dept. of Health, 19 November 2025.**

Key Informants highlighted that the South African government has been able to mitigate some of the challenges. Significantly, the Department of Health has been able to recruit thirteen of the USAID funded supply chain experts through one-year contracts. This was enabled by the experts' willingness to take pay cuts, and the National Treasury's release of emergency funding through Section 16 of the Public Finance Management Act. A Key Informant noted:

> "Differentiated salaries are a downside of donor-funded support. Salaries were often not aligned with government scales. When people came onto our contracts, there is a reduction. There were also inequities where people doing the same work were paid very differently under the donor model, which doesn't happen in government. In government, the job determines the salary, not the individual. This causes obstacles to integration, and staff sustainability and retention." **Interview, Deputy Director General, National Dept. of Health, 9 December 2025.**

2. Key Populations

U.S. funding supported external drop-in centres providing services for members of key populations (e.g. POP INN, HARMless, Engage Men's Health and Wits Reproductive Health Institute Sex worker and trans health centres), which provided comprehensive services for members of key populations including gender affirming and harm reduction to complement the HIV package; and sexual and reproductive health rights (SRHR) education.

A Key Informant noted the importance of such services because health systems are still places of stigma and discrimination:

"Overnight, 3,000+ trans women have been left without care."
Director, National LGBTQI+ NGO, 19 January 2026.

> "Key populations face double stigmas, related to sexual orientation or gender identity, or the criminalisation of sex work. There have been cases of sex workers and other key populations are denied access to treatment because of the closure of friendly facilities." **Regional Coordinator, NGO, 13 January 2025.**

Key populations specific services in large part originated 15–20 years ago as an approach to engage gay, bisexual and other men who have sex with men (GBMSM) in testing and treatment. Around six years ago, grants were made available to expand this approach in South Africa. The idea is that by offering gender affirming care and harm reduction services as a part of the ART care package, trans and queer people, sex workers and people who use drugs may be more likely to engage in HIV services. In this way, tailored external clinical services expanded across the country. Since the withdrawal of support, these services have largely not been provided. For instance, an NGO that was sub-granted to support Transgender and LGBTQ+ key populations explained:

> "[The withdrawal] has been devastating… Overnight, 3,000+ trans women have been left without care. That facilities under the auspices of [the implementing partner] closed without planning. We, civil society, are really scrambling to look at how to integrate individuals back into the public healthcare system because that became the contingency option. Up until today, not everybody has been integrated. There hasn't been a great deal of capacity –because of the defunding of institutions – to focus on integration." **Director, National LGBTQI+ NGO, 19 January 2026.**

Sex workers' access to services were significantly affected:

> "The ART programme in South Africa, and across the region is based on access to treatment, prevention and care. Since the stop work orders sex workers have been reported to default on treatment. A lot of sex worker organizations have closed and members that were employed as peer educators, advocators, programmes officers or project leads have lost employment and opportunities. This is because of the closure of sex work helping clinics, mobile clinics. Government and clinics are still full of stigma and discrimination. For example, we have had communications about people having to align to one of two genders in order to gain access". Other vulnerable populations, such as adolescent girls and young women, have also been affected. An informant noted that "five young women leading the country's Adolescent and Young People (AYP) programme were funded through the CDC and lost their jobs." **Senior Executive, SANAC, 20 March 2026.**

3. Community Engagement, Education & Infrastructure

U.S. funding supported multi-sectoral Provincial Technical Officers (PTO) working with adolescent girls to coordinate peer SRHR education and engagement in response structures in high-burden provinces as part of the Adolescent and Young People (AYP) programme.

At the Provincial and District level, U.S. funding supported implementing partner mobile clinics, outreach & HIV testing programmes.

> "The South African National AIDS Council reports having a shortfall of R40 million for its Annual Performance Plan. This is the portion PEPFAR historically would cover, adjusted for inflation for 2026." **Senior Executive, SANAC, 20 March 2026.**

"The cuts have set us back"

Key Informants from all three sectors and levels of service explained that while the South African government makes the decisions and overwhelmingly independently funds the HIV programme, all of these systems, staff, and programmes have been destabilised, threatened, or closed by the withdrawal of U.S. government support.

One Key Informant encapsulated the impact on the communities the HIV Programme serves:

> "The cuts have set us back. They send a message that people's lives do not matter. If the U.S. truly cared, we would have been provided a better transition plan and early warning which would have ensured protection for monitoring of services for people living with HIV and members of key populations." **Ritshidze Manager, 9 February 2025.**

"The cuts have set us back. They send a message that people's lives do not matter."

Ritshidze Manager, 9 February 2025.

The funding withdrawal provides an opportunity for reflection and changes to systems that no longer work. One Key Informant noted:

> "When someone walks into a facility, they bring their whole self. We created parallel systems for HIV for good reasons at the time, but over the years they became inequitable and unsustainable. They have their own infrastructure, their own systems, their own schedules. Meanwhile, the main system serves everything else: women, children, diabetes, hypertension, cancer etc. The main system is overwhelmed. PLWHIV are ageing, with multiple conditions. Yet their services are still organised around one disease. That does not make sense anymore. This is why civil society broadly argues for integrated primary patient-centred care." **Directors, PLHIV INGO, interview, 14 January 2026.**

Patient Awareness of PEPFAR (Apr–Jun 2025)

Table 2: Have you heard of PEPFAR, USAID, or CDC?

District	Surveys Completed	Yes (%)	No (%)	Don't know (%)
eThekwini	1,184	33%	28%	36%
uMgungundlovu	1,033	26%	71%	4%
King Cetshwayo	983	53%	40%	4%

Table 2 shows that awareness of PEPFAR, USAID, and CDC varies across districts. King Cetshwayo shows the highest levels of awareness, while uMgungundlovu shows the lowest, with most respondents reporting that they have not heard of these agencies. eThekwini shows a more mixed distribution across response categories. These patterns reflect differences in familiarity with funding agencies rather than direct interaction with services that are provided under implementing partner brands.

Patient Awareness of PEPFAR Withdrawal (Apr–Jun 2025)

Table 3: Have you heard about the United States pausing or possibly stopping support for HIV and other health services in South Africa?

District	Surveys Completed	Yes (%)	No (%)	Don't know (%)
eThekwini	1,184	28	30	36
uMgungundlovu	1,033	47	49	3
King Cetshwayo	983	54	38	3

Table 3 shows that awareness of the withdrawal of US support varies across districts. King Cetshwayo shows the highest awareness, followed by uMgungundlovu, while eThekwini shows lower awareness and a higher proportion of uncertainty. This suggests that knowledge of funding changes was uneven among patients.

Facility Manager Awareness of the Status of PEPFAR Implementing Partners (Apr–Jun 2025)

Table 4: Is the PEPFAR implementing partner working as usual?

District	Facilities Surveyed	Yes	Reduced capacity	No longer working	Never present	Don't know
eThekwini	20	16 (80%)	3 (15%)	0	0	1 (5%)
uMgungundlovu	20	13 (65%)	5 (25%)	1 (5%)	0	0
King Cetshwayo	20	19 (95%)	1 (5%)	0	0	0

Table 4 shows that facility manager responses indicate that most PEPFAR implementing partners were still operating during Apr–Jun 2025, although some were functioning at reduced capacity, particularly in uMgungundlovu and eThekwini. Reports of complete withdrawal were limited. These findings suggest partial continuity of services, with variation in operational capacity across districts.

The reduced capacity of implementing partners was a source of strain for Department of Health officials and staff. One Key Informant noted:

> "There are partners that cover all the facilities in the district, but suddenly, now they need to cut down to 70 facilities. Now we need to look around and say which partners are remaining. We are really comparing, looking at facilities which one doesn't have this, which one has that. I don't know how they are going to cope." **Programme Supervisor, eThekwini District, KZN Dept. of Health, 19 November 2025.**

II. HIV Testing

HIV testing is crucial for the diagnosis of new infections and monitoring of treatment. PEPFAR disruption therefore, triggered concerns about the continuity of care and the threat of reversing gains. This section examines responses from public health care users and from facility managers to assess the availability, continuity, and quality of HIV testing services post PEPFAR withdrawal.

A community leader in KZN explained the landscape of HIV testing during the post-PEPFAR period, noting that the demand for testing in South Africa, while decreased, is still high due to:

> "the government invest[ing] our money to ensure that the Closing 1.2. Million HIV Treatment Gap testing program designed in 2024 is sustained." **Lead, Community Programmes, KZN, NGO, 18 February 2026.**

"Right now, we have lost about 30 to 35% of our testing capabilities, because that was a huge part played by PEPFAR Implementing Partners."

Lead, Community Programmes, KZN NGO, 18 February 2026.

HIV Testing Offered on Day of Visit (Apr–Jun 2025)

Table 5: Were you offered HIV testing today (including a HIV self-test)?

District	Number of people surveyed	Offered Yes	No	I tested in 2024 so I did not need a test offered to me
eThekwini	22	12 (55%)	7 (32%)	3 (14%)
uMgungundlovu	359	128 (36%)	217 (60%)	14 (4%)
King Cetshwayo	332	71 (21%)	184 (55%)	77 (23%)

Note: Scores represent the proportion of respondents who reported being offered an HIV test on the day of the visit.

Table 5 shows that the proportion of patients offered an HIV test on the day of their visit varied markedly by district. eThekwini had the highest offer rate (55%), followed by uMgungundlovu (36%) and King Cetshwayo (21%). Despite these differences, the overall offer rates were low across all three districts, indicating missed opportunities for provider-initiated testing during routine facility visits. The pattern is consistent with the staffing shortages reported by Facility Managers, particularly in uMgungundlovu and King Cetshwayo, where reduced human resources likely limited the ability to offer testing opportunistically. The relatively higher offer rate in eThekwini may reflect better preservation of testing capacity in that district, though it still falls short of routine testing coverage.

Reported Impact on HIV Testing Services (Apr–Jun 2025)

Table 7: Have there been any disruptions to HIV testing services in 2025?

District	Surveyed completed (n)	No Staff to test	Fewer Staff to test	No
eThekwini	20	1 (5%)	4 (20%)	15 (75%)
uMgungundlovu	20	2 (10%)	7 (35%)	11 (55%)
King Cetshwayo	20	2 (10%)	2 (10%)	16 (80%)

Table 7 shows that across the three districts, the main challenges were related to staffing: 20% facilities in eThekwini, 35% in uMgungundlovu, and 10% in King Cetshwayo indicated having fewer staff to provide HIV testing. uMgungundlovu had the highest proportion of facilities 35% reporting fewer staff, which needs review by the district health department. 10% of the facilities in both uMgungundlovu and King Cetshwayo reported having no staff at all for HIV testing. Overall, the majority of facilities in each district reported that services were not affected (75%, 55%, and 80%, for eThekwini, uMgungundlovu and King Cetshwayo respectively).

Service Areas Impacted by Reduced HIV Testing Capacity (Apr–Jun 2025)

Table 8: Where have HIV testing services been affected?

District	eThekwini	uMgungundlovu	King Cetshwayo
Surveys completed (n)	*5*	*9*	*4*
Outpatients (OPD)	1 (20%)	1 (11%)	0
HIV Services	3 (60%)	4 (44%)	3 (75%)
TB Services	2 (40%)	1 (11%)	1 (25%)
Family Planning	2 (40%)	2 (22%)	1 (25%)
Antenatal (ANC) or Postnatal/(PNC(	2 (40%)	3 (33%)	2 (50%)
Mother and Child Health (MCH)	2 (40%)	4 (44%)	1 (25%)
Youth Zones	2 (40%)	4 (44%)	1 (25%)
Men's Corners	1 (20%)	3 (33%)	1 (25%)
Index Testing	2 (40%)	4 (44%)	1 (25%)
Self-Testing	1 (20%)	2 (22%)	1 (25%)
Tents	0	2 (222%)	0
Outreach in the community	3 (60%)	4 (44%)	3 (75%)
STI Services	2 (40%)	2 (22%)	2 (50%)
Other	0	1 (11%)	1 (25%)

Note: Facilities could report multiple service areas; numbers represent counts of facilities that reported disruptions in each area.

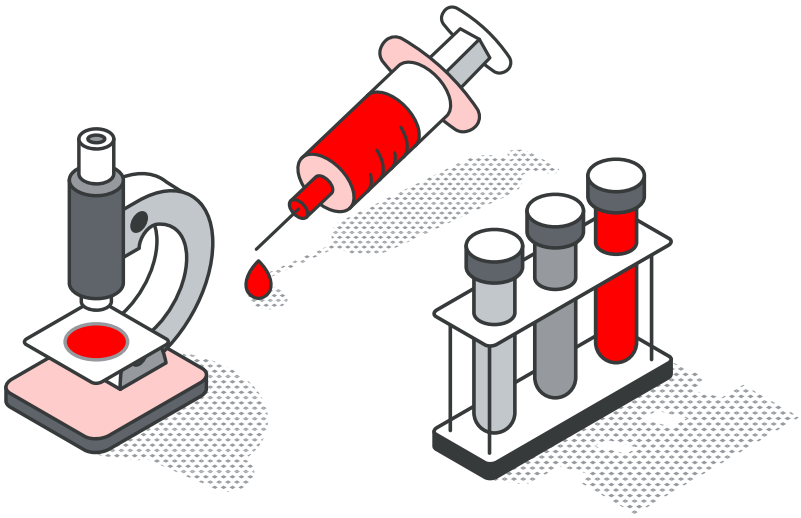
Table 8 shows that disruptions to HIV testing were reported across a wide range of service areas, from core clinical departments to specialised outreach programmes. In eThekwini, 60% of the facilities that reported disruptions most frequently cited HIV services and outreach services. In uMgungundlovu, where staffing shortages were most pronounced, the affected facilities reported disruptions across nearly all service areas 75% of the facilities surveyed in King Cetshwayo reported impacts to HIV services and outreach. The wide distribution of affected service points suggests that HIV testing responsibilities are embedded across routine clinical and community activities, meaning that staffing cuts have knock-on effects throughout the facility. uMgungundlovu's broader spread of affected areas aligns with its higher reported staff shortages.

Key Informants reflected on the gaps created by the PEPFAR disruptions, noting:

> "Right now, we have lost about 30 to 35% of our testing capabilities, because that was a huge part played by PEPFAR Implementing Partners. The rest, 50% is still maintained by the State. Most Overseas development aids were funding the mobile testing clinics while working with the State. PEPFAR provided us an opportunity, to go where people are and test them and offer them these services. I would say when we went to the community to test, almost 75 to 80% of people will always agree then only that 20 or 25% wouldn't. Right now we still have Global Fund, it is not as substantial as it used to be because of the funding cuts 25% of testing is coming from their support. Still a lot of testing is happening, not in the aggressive way which we used to it's a very conscious kind of decision and very, very personal to a certain degree." **Lead, Community Programmes, KZN, NGO, 18 February 2026.**

In eThekwini District, according to a HIV Programme Supervisor:

> "HIV testing is continuing. We're still doing testing, and outreach because even under HAST, we've got one person who's responsible for activation. We still have partners that are not PEPFAR funded. Some partners have been recently finalized. The partners that are remaining behind, they still go out and do the testing. We have got mobile services as well. They've integrated HIV testing into… facility contraceptives [clinics]. Facilities are still there standing and most of those activities are Department of Health activities, you know, and we never relied, that much [on implementing partners] for medications and biomedicals, we never relied that much on partners, even the partners, some of them are getting some biomedicals from our facilities. They come and present and we would link them." **Programme Supervisor, eThekwini District, KZN Dept. of Health, 19 November 2025.**



III. Contraceptive Access

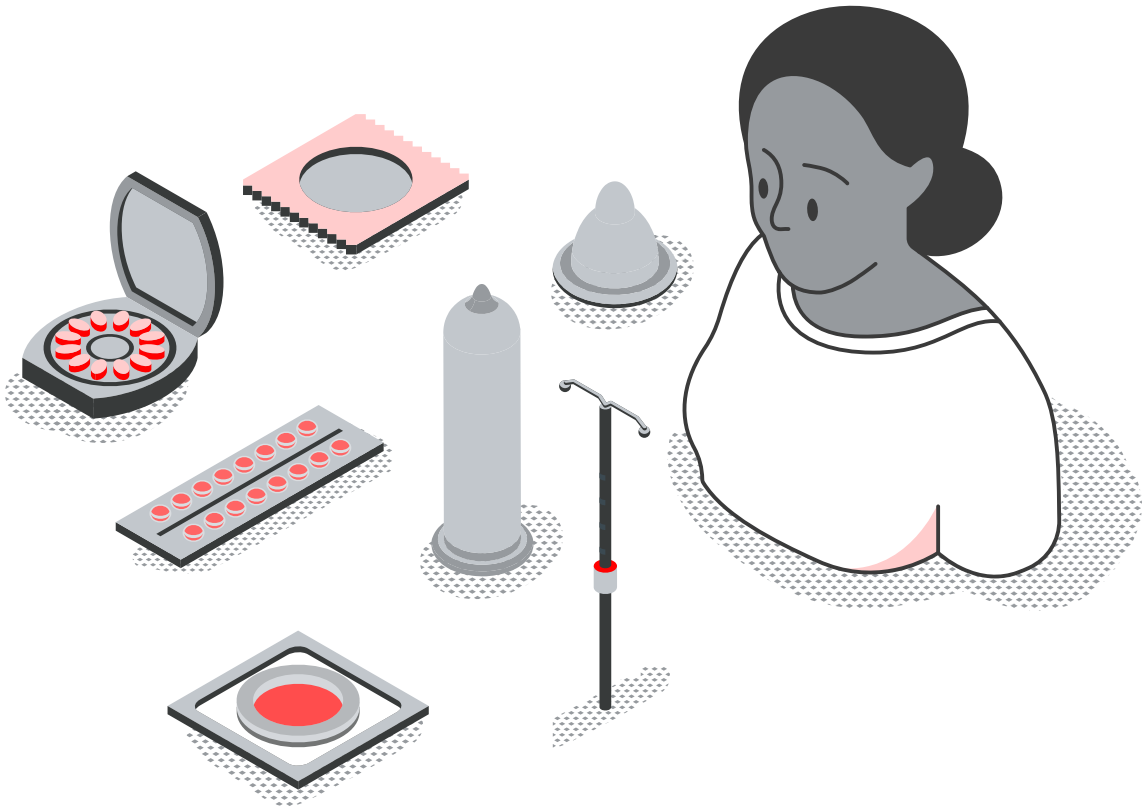
This section examines the availability and accessibility of contraceptive access across eThekwini, uMgungundlovu, and King Cetshwayo from January 2024 to June 2025, using data collected from both healthcare users and health facility managers.

Ability to Obtain Desired Contraceptives (Jan–Mar 2024 to Apr–Jun 2025)

Table 9: Were you able to get the contraceptives you wanted?

District	Period	Number of surveys (n)	Yes	No
eThekwini	Jan–Mar 2024	1993	1 989 (99,7%)	4 (0.3%)
	Apr–Jun 2024	1815	1 800 (99.2%)	15 (0.8%)
	Jul–Sep 2024	1827	1 821 (99.7%)	6 (0.3%)
	Oct–Dec 2024	1565	1 561 (99.7%)	4 (0.3%)
	Jan–Mar 2025	1720	1 716 (99.7%)	4 (0.3%)
	Apr–Jun 2025	357	348 (97.5%)	9 (2.5%)
uMgungundlovu	Jan–Mar 2024	480	480 (100%)	0
	Apr–Jun 2024	592	592 (100%)	0
	Jul–Sep 2024	598	598 (100%)	0
	Oct–Dec 2024	558	558 (100%)	0
	Jan–Mar 2025	575	574 (99.8%)	1 (0.2%)
	Apr–Jun 2025	464	452 (97.4%)	12 (2.6%)
King Cetshwayo	Jan–Mar 2024	380	380 (100%)	0
	Apr–Jun 2024	389	389 (100%)	0
	Jul–Sep 2024	355	355 (100%)	0
	Oct–Dec 2024	401	401 (100%)	0
	Jan–Mar 2025	356	376 (100%)	0
	Apr–Jun 2025	560	532 (95%)	28 (5%)

Table 9 shows that throughout 2024, almost all respondents in all three districts reported being able to obtain the contraceptive method they wanted. In eThekwini, the number of respondents reporting inability to get the contraceptives they wanted remained very low (below 1% per quarter). However, in the post-PEPFAR withdrawal period (Apr–Jun 2025), the proportion of respondents unable to obtain their desired contraceptive increased in all districts (2.5%, 2.6%, and 5% in eThekwini, uMgungundlovu, and King Cetshwayo respectively). The emergence of reported access barriers across all three districts in the same quarter suggests a potential deterioration in contraceptive availability following the PEPFAR withdrawal.



Types of Contraceptives Which Respondents Tried to Access at Facilities (Apr–June 2025)

Table 10: Which contraceptives have you tried to access at this facility?

District	eThekwini	uMgungundlovu	King Cetshwayo
Number of surveys (n)	*1184*	*1033*	*983*
External Condoms	185 (16%)	212 (21%)	374 (38%)
Internal Condoms	169 (14%)	17 (2%)	343 (35%)
Birth control pill	28 (2%)	10 (1%)	337 (34%)
Injection	96 (8%)	188 (18%)	416 (42%)
Implant	83 (7%)	44 (4%)	312 (32%)
IUD	27 (2%)	7 (0.7%)	252 (26%)
None	742 (63%)	538 (52%)	344 (35%)
Other	9 (0.7%)	6 (0.5%)	30 (3%)
Don't know	3 (0.2%)	3 (0.3%)	16 (1.6%)

Table 10 shows the responses from public health care users who were asked the type of contraceptives they tried to access from a facility. In eThekwini, the external and internal condoms were the most sought contraceptives but 63% of the participants responded that they had not tried to access any contraceptives from the facility. Similarly, 52% of the participants in uMgungundlovu did not seek any contraceptives and the external condom was the most sought contraceptive. The injection was the most sought contraceptive in King Cetshwayo district.

Reasons for Non-access (2024 Combined vs. Apr–Jun 2025)

Table 11: Why were you unable to get the contraceptives you wanted?

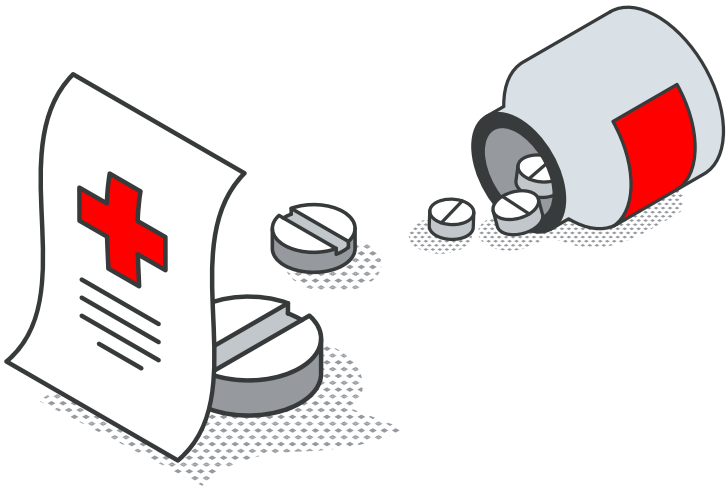
Reason	2024 (Full Year)*	Jan–Mar 2025	Apr–Jun 2025
I was told my first choice was not available	6	0	24
I was told to come back	0	0	13
Stockout / shortage	12	1	7
Stigma-related reasons*	1	1	2
Other / don't know	8	3	4

**Data is aggregated from eThekwini, uMgungundlovu, and King Cetshwayo*

Table 11 shows that in Apr–Jun 2025, the number of patients reporting that their first-choice contraceptive was unavailable increased sharply to 24, and 13 were told to come back later, both substantially higher than in any previous period. Stockout or shortage was cited by 7 respondents in Apr–Jun 2025, a similar level to the peak in 2024, but now occurring alongside other supply-related reasons. Stigma-related reasons were reported by a small number of respondents (1–2 per period). The increase in reports of first-choice unavailability and being told to come back suggests that barriers to contraceptive access became more pronounced in the post withdrawal period, consistent with the decline in ability to obtain contraceptives observed in Table 10.

A community leader noted the compounded impact of PEPFAR withdrawal, particularly on young girls, reporting that:

> "Community Engagement, Education technical assistance programmes were funded to strengthen adolescents and young girls sexual and reproductive health (SRH) knowledge and access to services. Though SRH services are there, albeit some are offered in the private sector for fees, these services are not easy to come by. This human rights education, provided by IP has been affected by the cuts. This program was in place for quite some time. It had a good impact, we hadn't had cases of abandoned newborns then. We are seeing that regression and going back into the old ways again." **Lead, Community Programmes, KZN, NGO, 18 February 2026.**



IV. ARV Collection

This section examines the organisation and management of ART collection systems, including facility pick-up points (e.g., CCMDD parcel collection rooms, fast lanes, Pelebox etc), external pickup points (e.g., independent pharmacies, Post Offices, Sha'p Left containers, mobile vans etc), and adherence clubs. Data are drawn from facility manager and patient surveys conducted in April–June 2025 and, where available, from earlier quarters to show trends.

"PEPFAR supported strategic positions that matter to make the system work."

Lead, Community Programmes, KZN NGO, 18 February 2026.

Patient ARV Collection Points

Table 12: Where did you collect your ARVs today?

District	Quarter	Number of surveys	Facility PUP	External PUP	Adherence Club	Standard Dispensing
eThekwini	Jan–Mar 2025	2016	434 (22%)	858 (43%)	13 (0,6%)	707 (35%)
	Apr–Jun 2025	521	176 (34%)	182 (35%)	2 (0.3%)	158 (30%)
uMgungundlovu	Jan–Mar 2025	342	141 (41%)	51 (15%)	9 (3%)	141 (41%)
	Apr–Jun 2025	562	282 (51%)	179 (32%)	2 (0.3%)	98 (17%)
King Cetshwayo	Jan–Mar 2025	307	130 (42%)	151 (49%)	9 (3%)	17 (6%)
	Apr–Jun 2025	503	331 (66%)	150 (30%)	5 (0.9%)	16 (3%)

**Respondents could select more than one collection point. "Standard dispensing" means collecting medication at the facility without using a differentiated model. Adherence club numbers should be interpreted with caution as many clubs were disbanded during the COVID-19 pandemic and not re-established.*

Table 12 shows that external and facility pickup points are widely used across all districts. In eThekwini, external pickup points were more commonly used than facility pickup points in the first two quarters of 2025. Standard facility dispensing remains common in eThekwini and uMgungundlovu, suggesting that many patients are either not offered or not eligible for differentiated collection models.

"The waiting time is now back to 5 to 6 hours from 3 hours with the availability of PEPFAR employees."

Lead, Community Programmes, KZN NGO, 18 February 2026.

Patients Who Had to Visit Additional Service Points Before Collecting ARVs at Facility Pick-Up Points

Table 13: When using a facility pick-up point, do you have to go to any other service point other than parcel collection e.g. registry or folder collection?

District	Quarter	Surveys	Yes (%)	No	Don't Know
eThekwini	Apr–Jun 2025	176	153 (87%)	9 (5%)	10 (8%)
uMgungundlovu	Apr–Jun 2025	282	81 (29%)	195 (69%)	2 (0.7%)
King Cetshwayo	Apr–Jun 2025	331	162 (49%)	139 (42%)	14 (4%)

Table 13 shows that a large proportion of patients in eThekwini and King Cetshwayo districts using facility pick-up points still needed to visit additional service points before collecting their medication. Requiring patients to move through multiple points contradicts national guidelines for fast, one-stop ART collection and adds to congestion and waiting times.

One of the challenges in the public health care system relates to long waiting times. A Key Informant highlighted how PEPFAR had assisted in mitigating this, saying:

> "Some programs were funded by the Global Fund. Then the key populations, they created key points, for collection of treatment, all those needed to be rerouted back into Department of Health. After the closure of the of the support of those key points, some were closed altogether and some were rerouted back into nearest clinics. The reason why we did not want people to go to those Health facilities was because people wait a very long time just to collect the treatment]." **Lead, Community Programmes, KZN, NGO, 18 February 2026.**

Do Facility Pick-Up Points Save Time? (Apr–Jun 2025)

Table 14: Does the facility pick-up point make it quicker to collect your ARVs than waiting at the facility?

District	Yes (%)
eThekwini	86%
uMgungundlovu	95%
King Cetshwayo	91%

Do External Pick-Up Points Save Time? (Apr–Jun 2025)

Table 15: Does the external pick-up point make it quicker to collect your ARVs than waiting at the facility?

District	Yes (%)
eThekwini	97%
uMgungundlovu	99%
King Cetshwayo	100%

Tables 14 and 15 show that, despite the inefficiencies, patients overwhelmingly report that both facility and external pick-up points make ARV collection faster than waiting in standard queues. Perceived time savings are particularly high for external pick-up points.

Satisfaction With Facility Pick-Up Points (Apr–Jun 2025)

Table 16 shows that satisfaction with facility pick-up points is high, especially in uMgungundlovu and King Cetshwayo. This suggests that patients value these services even when they are not fully streamlined, and that further improvements could enhance satisfaction further.

Table 16: Overall, how satisfied are you with the facility pick-up point where you collected your ARVs today? *(1 = Very unsatisfied, 5 = Very satisfied)*

District	Mean Score (1 = Very Unsatisfied, 5 = Very Satisfied)
eThekwini	3.48
uMgungundlovu	4.68
King Cetshwayo	4.21

Patients Reporting Longer ARV Collection Time After January 2025 (Apr–Jun 2025)

Table 17 shows that a substantial minority of patients reported that it took longer to collect their ARVs after January 2025. This was most pronounced in King Cetshwayo (43%), followed by eThekwini (38%) and uMgungundlovu (30%). These findings align with evidence of staff reallocation and inefficiencies at facility pick-up points, suggesting that the PEPFAR disruptions contributed to increased delays for a notable share of patients.

Table 17: Today, did it take longer to collect your parcel than before the end of January?

District	Yes (%)
eThekwini	38%
uMgungundlovu	30%
King Cetshwayo	43%

Key Informants' observations with relation to the waiting times corroborated the quantitative findings, with one informant stating:

> "PEPFAR supported strategic positions that matter to make the system work. Like your data capturers, clinic clerks, nursing staff. This has weakened the system by the pulling out of the funds, the crucial positions were affected. Actually some of them were closed, some staff just left. The different employees that were funded by PEPFAR made a huge difference in the system. The waiting time is now back to 5 to 6 hours from 3 hours with the availability of PEPFAR employees." **Lead, Community Programmes, KZN, NGO, 18 February 2026.**

"The waiting time is now back to 5 to 6 hours from 3 hours with the availability of PEPFAR employees."

Lead, Community Programmes, KZN NGO, 18 February 2026.

Types Of Facility-Based Pick-Up Points Available (Apr–Jun 2025)

Table 18: What are the types of availability of pick-up points?

District	Facilities	CCMDD Parcel Room	Pelebox	Fast Lane	Sha'p Left
eThekwini	15	10 (67%)	6 (40%)	5 (33%)	2 (13%)
uMgungundlovu	19	13 (68%)	3 (16%)	6 (32%)	3 (16%)
King Cetshwayo	15	12 (80%)	0	6 (40%)	0

Note: Facilities could report more than one type of pick-up point.

Table 18 shows that facility-based pick-up points, especially CCMDD parcel rooms, are widely available. Fast lanes exist in about one-third of facilities, while Pelebox and Sha'p Left are less common. More importantly than a range of options, is that all facilities have at least one facility pick-up point available to decant people to – yet 18% of facilities monitored in the province in this reporting period had no facility pick-up points available.

Staff Responsible for Running Facility Pick-Up Points? (Apr–Jun 2025)

Table 19: Who is currently running the facility pick-up points (e.g., CCMDD parcel room, fast lane, Pelebox, Sha'p Left) at this facility?

District	Facilities	DOH Staff	CHWs	PEPFAR IP Staff	CBO Staff
eThekwini	15	8 (53%)	2 (13%)	4 (26%)	1 (7%)
uMgungundlovu	19	13 (68%)	6 (32%)	7 (37%)	1 (5%)
King Cetshwayo	15	14 (93%)	5 (33%)	1 (7%)	0

Table 19 shows that facility pick-up points are predominantly run by Department of Health (DOH) staff. Community health workers (CHWs) are involved in many facilities, especially in uMgungundlovu and King Cetshwayo. PEPFAR implementing partner (IP) staff remain present in some facilities, particularly in eThekwini and uMgungundlovu, reflecting the continuation of CDC-funded programmes during this period.

Department of Health Staff Reassigned from Other Duties to Run Facility Pick-Up Points (Apr–Jun 2025)

Table 20: Have Department of Health staff been reassigned from other duties to run the facility-based pick-up point (e.g., CCMDD parcel room, fast lane, Pelebox)?

District	Facilities Assessed	Yes	No
eThekwini	8	2 (25%)	6 (75%)
uMgungundlovu	13	4 (31%)	9 (69%)
King Cetshwayo	14	1 (7%)	13 (93%)

Department of Health Staff Reassigned to Run External Pick-Up Points (Apr–Jun 2025)

Table 21: Have Department of Health (DOH) staff been reassigned from other duties to run external pick-up points (e.g., community pharmacies, post offices, Sha'p Left containers, mobile vans)?

District	Facilities Assessed	Yes	No
eThekwini	8	3 (38%)	5 (62%)
uMgungundlovu	12	4 (25%)	8 (75%)
King Cetshwayo	11	3 (27%)	8 (73%)

Tables 20 and 21 show that a small but notable number of facilities reported redirecting Department of Health staff from other duties to sustain both facility and external pick-up points. This was most common in eThekwini and uMgungundlovu. Such reassignments indicate operational strain, particularly where PEPFAR-funded staff previously supported these services and may contribute to longer queues elsewhere in the facility.

Availability of Facility Pick-Up Points (Apr–Jun 2025)

Table 22: Is there a facility-based pick-up point (e.g., CCMDD parcel room, fast lane, Pelebox, Sha'p Left) available at this facility for patients to collect ARVs without seeing a clinician?

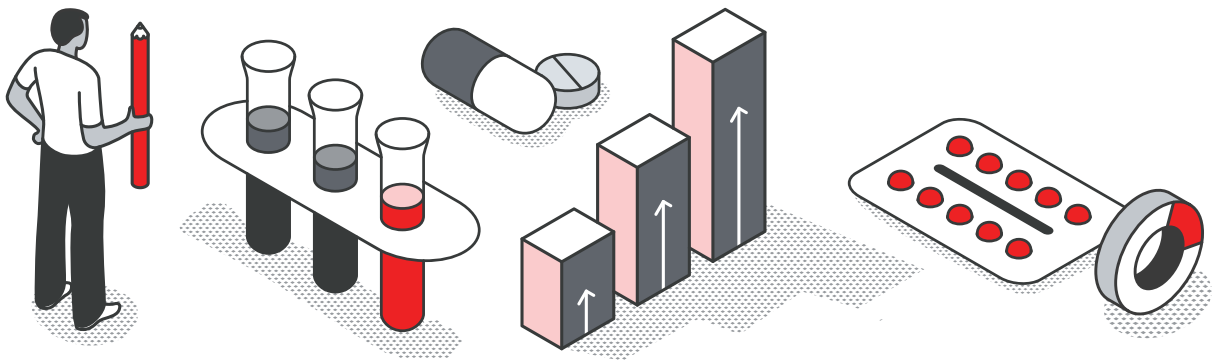
District	Facilities	Yes (%)
eThekwini	20	15 (75%)
uMgungundlovu	20	19 (95%)
King Cetshwayo	20	15 (75%)

Availability of External Pick-Up Points (Apr–Jun 2025)

Table 23: Are external pick-up points (e.g., community pharmacies, post offices, Sha'p Left containers, mobile vans) available for patients in the area served by this facility?

District	Facilities	Yes (%)
eThekwini	20	20 (100%)
uMgungundlovu	20	20 (100%)
King Cetshwayo	20	20 (100%)

Tables 22 and 23 show that most facilities have at least one facility pick-up point, with availability highest in uMgungundlovu. All facilities in all three districts reported having external pick-up points available nearby. This strong foundation of differentiated collection options is an important asset, though availability alone does not guarantee efficient functioning.



V. ARV Refills

This section examines whether people's ARV' refill lengths changed following the PEPFAR disruptions. Data is drawn from patient surveys (refill length on last visit and refill length received on the day of visit) and Facility Manager surveys (standard refill length and whether it changed). Together, they show how dispensing practices shifted in the first quarter after the funding disruption.

Patient-reported ARV Refill Length (2024–2025)

Table 24: How long is your ARV medicine refill?

District	Quarter	Surveys	1 month	2 months	3 months	6 months	Don't know
eThekwini	Oct–Dec 2023	1 875	187 (10%)	502 (27%)	1 038 (56%)	119 (6%)	29
	Jan–Mar 2024	1 769	169 (10%)	428 (24%)	1 051 (60%)	110 (6%)	11
	Apr–Jun 2024	1 894	136 (7%)	245 (13%)	1 364 (72%)	139 (7%)	10
	Jul–Sept 2024	1 889	147 (8%)	333 (18%)	1 305 (70%)	81 (4%)	23
	Oct–Dec 2024	2 016	105 (5%)	240 (12%)	1 589 (79%)	8 (0.4%)	74
	Jan–Mar 2025	526	169 (32%)	24 (5%)	301 (57%)	24 (5%)	8
uMgungundlovu	Oct–Dec 2023	362	7 (2%)	114 (32%)	231 (64%)	9 (3%)	1
	Jan–Mar 2024	388	10 (3%)	82 (21%)	295 (76%)	1 (0.3%)	0
	Apr–Jun 2024	376	8 (2%)	90 (24%)	276 (74%)	1 (0.3%)	1
	Jul–Sept 2024	338	7 (2%)	56 (17%)	274 (82%)	0	1
	Oct–Dec 2024	342	10 (3%)	54 (16%)	278 (81%)	0	0
	Jan–Mar 2025	562	20 (4%)	95 (17%)	442 (79%)	1 (0.2%)	4
King Cetshwayo	Oct–Dec 2023	312	0	3 (1%)	309 (99%)	0	0
	Jan–Mar 2024	312	0	15 (5%)	244 (80%)	53 (17%)	0
	Apr–Jun 2024	314	0	21 (7%)	88 (30%)	204 (68%)	1
	Jul–Sept 2024	307	1 (0.3%)	20 (7%)	235 (83%)	22 (8%)	29
	Oct–Dec 2024	307	0	7 (2%)	299 (98%)	0	1
	Jan–Mar 2025	505	40 (8%)	76 (15%)	372 (74%)	0	17

Note: Percentages are based on total respondents who reported a specific refill length; "don't know" responses are shown separately. Data for 2025 are from April–June.

Table 24 shows that before the PEPFAR disruptions, three-month refills were the dominant model across all districts.

Table 24 shows that before the PEPFAR disruptions, three-month refills were the dominant model across all districts. In eThekwini and King Cetshwayo, three-month dispensing fluctuated across the reporting period, whilst in uMgungundlovu, three-month refills remained consistently high (around 76–82%) across all quarters. Six-month dispensing remained limited outside of King Cetshwayo which was found to be an outlier.

Refill Length Received on Day of Survey (Apr–Jun 2025)

Table 25: How many months of ARVs did you receive today?

District	Surveys	1 month	2 months	3 months	6 months	Don't know
eThekwini	1 061	479 (45%)	90 (8%)	473 (45%)	10 (1%)	9
uMgungundlovu	568	18 (3%)	66 (12%)	456 (80%)	19 (3%)	9
King Cetshwayo	758	71 (9%)	363 (48%)	324 (43%)	0	0

**This question was asked when patients were exiting the facility, and reflects the supply received on that day.*

Table 25 shows that the exit data provide a more direct view of dispensing practices following PEPFAR disruptions. In eThekwini, only 45% of patients received a three-month supply, while an equal proportion received a one-month supply – a marked departure from earlier quarters. In King Cetshwayo, two-month refills were most common (48%), followed by three-month (43%). uMgungundlovu maintained a strong three-month dispensing pattern (80%). These findings confirm that the shift toward shorter refills observed in patient reports was already being implemented at the facility level in eThekwini and King Cetshwayo.

Facility Manager Reported Standard Refill Length (2024–2025)

Table 26: What is the standard ARV refill length at the facility?

District	Quarter	Facilities	1 month	2 months	3 months	6 months	Other
eThekwini	Apr–Jun 2024	63	0	2 (3%)	41 (65%)	15 (24%)	5 (8%)
	Jul–Sept 2024	65	0	1 (2%)	39 (60%)	24 (37%)	1 (2%)
	Oct–Dec 2025	65	1 (2%)	0	51 (78%)	12 (18%)	2 (3%)
	Jan– Mar 2025	20	0	1 (5%)	14 (70%)	3 (15%)	2 (10%)
uMgungundlovu	Apr–Jun 2024	14	0	0	6 (43%)	8 (57%)	0
	Jul–Sept 2024	13	0	0	13 (100%)	0	0
	Oct–Dec 2025	14	1 (7%)	0	12 (86%)	1 (7%)	0
	Jan– Mar 2025	20	1 (5%)	1 (5%_	16 (80%)	0	2 (10%)
King Cetshwayo	Apr–Jun 2024	11	0	1 (9%)	3 (27%)	6 (55%)	1 (6%)
	Jul–Sept 2024	11	0	0	10 (91%)	1 (9%)	0
	Oct–Dec 2025	11	0	0	10 (91%)	1 (9%)	0
	Jan– Mar 2025	20	0	1 (5%)	17 (85%)	1 (5%)	1 (5%)

Table 26 shows that before the PEPFAR withdrawal, three-month refills were the dominant mode across all three districts, in line with National Guidelines. However, following the PEPFAR disruptions, both three-month refills showed decreases. In all three districts, there was a slight increase in two-months refills, suggesting that while the standard remained three-months, actual dispensing was shortened for some patients.

VI. Mitigation & Sustainability

Results from this study highlighted several shifts in the delivery of health care service and the experiences of both public health care users and health care providers. These changes necessitated some actions to mitigate harm to health care users and to ensure the sustainability of the HIV programme and the public health system broadly. This section focuses on the actions taken to address the gaps left by the vacuum of U.S. support. It highlights the similarities across sectors and discusses Key Informants reflections on the direction and assessment of the sustainability of interventions.

From civil society, provincial, and national government positions, Key Informants shared a realisation and position of self-reliance.

> "We have, in a very uncomfortable way, slowly begun to learn the importance of integration of services and programming with local governments and health systems. Because I think in all this work that we've been doing with support from the U.S., we at some point say to ourselves we were not integrating with local authorities. For instance, almost 80% of the local health systems that acknowledge sex work haven't acknowledged the HIV and other services sex workers require." **Regional Coordinator, NGO, 13 January 2025.**

> "[The abrupt withdrawal of U.S. funding] is also teaching us as the Department of Health we should not rely on partners." **Programme Supervisor, eThekwini District, KZN Dept. of Health, 19 November 2025.**

> "Going forward, we don't want to return to that dependency, but we can still acknowledge the value it had at the time. We were never dependent on external partners to make decisions. We use technical advice where needed, but the Department of Health always makes the final call. That's why we were able to continue functioning while other institutions may struggle without technical support." **Deputy Director General, National Dept. of Health, 9 December 2025.**

> "Long standing civil society networks led by PLWHIV, made it very clear their minimum standards for integrating HIV into broader health systems. Drawing on the example of the aging population of PLWHIV in Africa, and the complexity of services we need, we demonstrated health care for PLWHIV needs to be holistic. Over time, donor funding had created parallel public health systems. Those systems were very well resourced, especially for HIV, but they weakened government accountability. When donors pulled back, those systems collapsed because they were never fully owned by governments. So for us, this moment was an opportunity. An opportunity to deconstruct the over reliance on donor funding that had created an unsustainable system. Fighting donors would not save treatment. Working with governments might." **Directors, PLHIV INGO, interview, 14 January 2026.**

At the national level the mitigation and sustainability intervention began as early as 2021, and its finalisation is almost complete in early 2026. A participant explained as follows:

> "We saw funds being redirected to COVID, and that showed us the risk. So we started developing a national sustainability framework. We didn't want a fragmented approach, so we created a framework to guide provinces. Provinces then developed their own plans involving stakeholders—civil society, private sector, and government. We started in 2021. There was little global guidance at the time, so we researched other countries and did consultations. The initial framework was 2021–2023, but we had to revise it to align with the new National Strategic Plan on HIV. Now we have a 2023–2028 framework. We've completed plans in eight out of nine provinces. …We are consolidating it into a national transition plan with support from UNAIDS. Now we have a 2023-2028 framework in the finalisation stage. There are big undertakings in terms of transitioning, and without Cabinet approval, it means the role players needed may not be secured. So it's taking time, but we are making sure we do it properly aligned to global guidance on how countries should transition from donor funding to country-led sustainability." **Senior Executive, SANAC, 20 March 2026.**

Discussion

The PEPFAR program was established by the US Congress in 2003 to respond to the urgent growth of the HIV/AIDS epidemic. PEPFAR focused on 50 countries with high-burden HIV+ populations, notably in Asia, sub-Saharan Africa, and the Caribbean. The program has spanned providing lifesaving ART, expanding HIV testing and prevention, supporting orphans and vulnerable populations impacted by the epidemic, and strengthening national health systems to sustain long-term HIV response.

South Africa has been one of the largest recipients of PEPFAR support. This has resulted in the program's early prioritisation of high-burden settings, and South Africa remaining the country with the most PLWHIV, globally. The programme launched in South Africa in 2004 to support ART through partnerships with U.S. Implementing Partners and NGOs. This response was one of the catalysts for the South African government to develop a comprehensive free HIV treatment program within its public health system. In 2010, PEPFAR's emergency response phase wound down. This meant the programme shifted focus to funding healthcare staffing and infrastructure, which expanded South Africa's existing HIV service delivery.

Over the course of the two-decade-long U.S. program's existence, South Africa has received an estimated USD $8 billion in total (UNAIDS, 2023). Recent annual support has amounted to between $400 - 500 million (Verryn, 2025). At the end of January 2025, the incoming Donald Trump administration abruptly froze this global epidemic prevention, treatment, and staffing support.

Indicators of both adaptability in the system, and reduced system slack.

Given this volatile and sudden disruption to financial and technical support, many experts warned of excess death, increases in HIV transmission, and health system collapse if the freeze persisted (Adeyinka et al., 2025; Grimsrud Wilkinson and Raphael., 2025; Stover et al., 2025; Egga et al., 2025). Predictions included supply-chain breakdowns, ART interruptions, suspended prevention services (condom distribution, PrEP, etc), workforce layoffs, and large numbers of excess deaths and paediatric infections (Adeyinka et al., 2025). In the first months after the halt of U.S. funding, scholars concluded the freeze exposed dependency risks and threats to HIV and TB epidemic control (Egga et al., 2025). Many called for mitigation, domestic financing scale-up, investment in resilience, and retention of health workforces (Adeyinka et al., 2025; Egga et al., 2025; Stover et al., 2025). These recommendations affirmed earlier assessments examining the sustainability of HIV programs in Southern and Eastern Africa (Neel et al., 2024). Some highlighted the need for urgent coordinated action to mobilise funds by national governments, donors, and civil society (Grimsrud Wilkinson and Raphael, 2025).

These predictions have seemed accurate given the existing earlier HIV program assessments (Hwang et al., 2019; Neel et al., 2024). Studies examining stock-outs across South Africa in 2019 (conducted by the Stop Stockouts Project) noted shortfalls of ARV and TB medicines were widespread in the public health system (Hwang et al., 2019; SSP 2019). Hwang and colleagues highlighted substantial variability between provinces and durations of stockouts. Oberth and their colleagues (2025) found staff confusion, disrupted ART refills, reduced key population services, and loss of data clerks as a result of the funding cuts. The significant losses in open-source community-led data we report here affirms the fears noted in the prediction impact literature (Adeyinka et al., 2025; Grimsrud Wilkinson and Raphael, 2025; Stover et al., 2025; Egga et al., 2025). This report clearly demonstrates the impact on evidence posed by this significant loss, in particular to Ritshidze in our case.

In South Africa, and in particular in KZN, recent research has shown that adequate medicine availability is poor and is associated with staffing, especially the presence/experience of Pharmacist Assistants (Buthelezi, 2023). Annual data on primary healthcare facilities in KZN from 2024 noted 438 unfilled vacancies across 83 health facilities (Ritshidze, 2024). Despite this, the same assessment found 18% of Facility Managers interviewed said their facilities had adequate staffing. When compared to the 2023 annual assessment, 10% less Facility Managers reported having enough staff (in 2023, 28% of Facility Managers interviewed reported having adequate staffing) (Ibid; Ritshidze, 2023). This is suspected to have worsened with the loss of PEPFAR IP staff. This study affirms the compounding of previously noted weakened human resource capacity, by reporting loss off, US funded, critical staff.

Our findings from the three high-burden districts, eThekwini, uMgungundlovu, and King Cetshwayo, provide a detailed picture of how the health system responded in the early months after the loss of U.S. funding. The results reveal a mixed picture: while ART services remained largely functional, underlying strains in staffing and supply chains became evident, with notable variations across districts in KZN.

Awareness and Perceptions of PEPFAR

Patient awareness of PEPFAR, USAID, and CDC was uneven, with only about one-third of respondents in eThekwini and one-quarter in uMgungundlovu reporting familiarity, compared to over half of respondents in King Cetshwayo. Perceptions of PEPFAR's value also varied: most patients in uMgungundlovu and King Cetshwayo viewed the programme positively, while a substantial proportion in eThekwini expressed negative views. This variation may reflect differences in the visibility of PEPFAR-supported services or in how the withdrawal was conducted and communicated. The majority of KIIs noted wanting to have self-reliance. Awareness of the funding withdrawal itself was highest in King Cetshwayo (54%) and lowest in eThekwini (28%), suggesting that knowledge of the policy change did not spread uniformly.

Staffing Disruptions and Service Impacts

Facility Manager's reporting shows most PEPFAR Implementing Partners continued to operate in April–June 2025, but with notable reductions in capacity, particularly in uMgungundlovu and eThekwini, where 4–5 facilities reported reduced capacity, and two facilities (one each in uMgungundlovu and King Cetshwayo) reported that IP staff were no longer working. Staff shortages were also the main driver of HIV testing disruptions, with 25–45% of facilities reporting fewer staff available for testing. No facility reported a shortage of test kits, confirming that human resources, not supplies, were the binding constraint.

These staffing pressures had cascading effects. In uMgungundlovu, where staff shortages were most pronounced, HIV testing disruptions were reported across the widest range of service areas – including outpatient departments, mother and child health, youth zones, and outreach – indicating retrenchment of IP staff across primary care services. Consequently, staffing cuts in PEPFAR-supported roles created knock-on effects throughout facilities. The patient survey corroborated this: HIV testing offer rates were low in all three districts, especially in uMgungundlovu (37%) and King Cetshwayo (28%), suggesting missed opportunities for provider-initiated testing.

Contraceptive Access and Supply

Contraceptive access showed the clearest signs of emerging strain. While nearly all patients reported being able to obtain their desired method throughout 2024, in April–June 2025 the number of patients unable to do so increased across all three districts, most sharply in King Cetshwayo (28 patients, compared to zero in all previous quarters) and uMgungundlovu (12 patients). The reasons shifted: 24 patients reported that their first-choice method was unavailable (up from 6 in all of 2024), and 13 were told to come back later. Stockouts were reported by facilities, most notably in King Cetshwayo, where six facilities reported stockouts of pills, injections, or implants in the same quarter. The coincidence of patient-reported barriers and facility-reported stockouts suggests that contraceptive supply chains began to show pressure. This could undermine interventions to actualise contraceptive method mix in South Africa (Furey and Fiander, 2019). Adding to this concern, is that lack of available contraceptive method availability undermines sexual reproductive health rights (Senderowicz, 2019; Senderowicz, 2020).

ARV Collection Systems

Despite these strains, ART collection systems demonstrated notable resilience. All facilities had external pickup points available, and most had facility pickup points. These decanting models were highly valued by patients: over 85% of patients using facility pickup points and over 97% using external pick-up points reported that they saved time compared to standard dispensing. Satisfaction was similarly high, especially in uMgungundlovu and King Cetshwayo.

However, the efficiency of the facility pick-up points was compromised. In eThekwini, 87% of patients using facility pickup points were still required to visit additional service points (registry, vitals) before collecting their ARVs. In King Cetshwayo, nearly half faced the same extra steps. Only uMgungundlovu approached the intended one-stop model, with 71% of patients collecting without additional steps. This inefficiency contradicts national differentiated service delivery guidelines and contributes to congestion and staff workload.

To sustain these pick-up points, facilities had to reassign Department of Health staff from other duties, reported by a small but notable number of facilities, particularly in eThekwini and uMgungundlovu. Such internal redistribution of labour may explain why ART services remained functional, but it also signals that facilities were absorbing the loss of PEPFAR staff by stretching existing human resources.

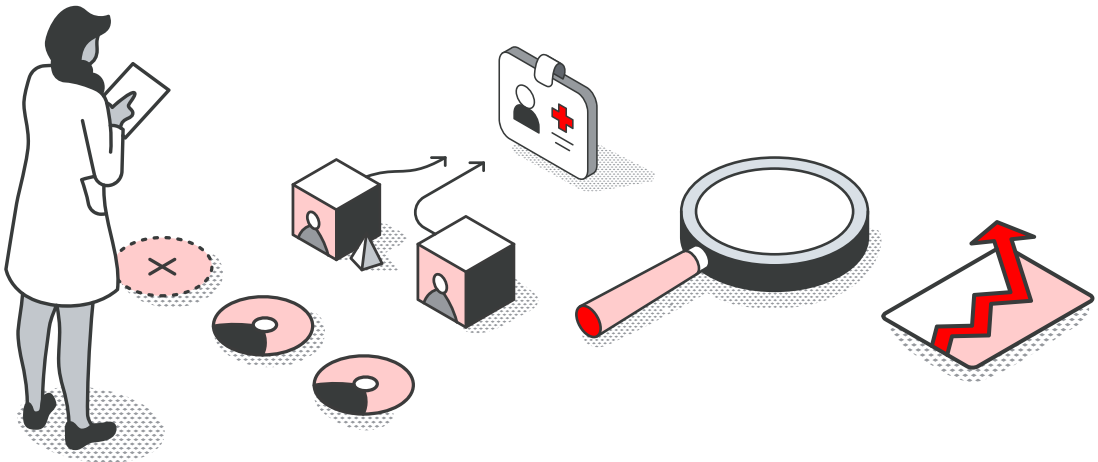
ARV Refill Lengths

Refill practices also showed district-specific adaptations. Before the PEPFAR disruptions, three-month refills were the dominant model across all districts. In April–June 2025, eThekwini saw a sharp shift: the proportion of patients receiving one-month refills jumped from 5% in Oct-Dec 2024 to 32% in Jan-Mar 2025, while three-month refills fell from 79% to 57%. Exit data confirmed that only 45% of patients received a three-month supply on the day of visit, while 45% received only one month. These patterns suggest that some districts responded to the PEPFAR disruptions by shortening dispensing intervals, perhaps to manage uncertainty in supply or to free up staff time, while others maintained longer dispensing. This is particularly concerning given the increased burden on people living with HIV and on clinic staff with more frequent visits.

A critical finding is, at the national level Treasury was able to fund the absorption of key supply chain technical experts, which has been an adaptation colleagues have advocated for (Grimsrud A, Wilkinson L, Raphael, 2025). Our findings align with earlier warnings that the PEPFAR withdrawal would strain health systems through staffing losses and supply disruptions (Egga et al., 2025; Oberth et al., 2025). They also echo the Ritshidze assessments that staffing inadequacy in KZN pre-dated the PEPFAR crisis, with only 18% of facilities reporting adequate staff in 2024. The redistribution of Department of Health staff to sustain facility and external pick-up points is a direct manifestation of this preexisting fragility.

The variation across districts is striking. uMgungundlovu appeared to maintain more stable HIV testing and contraceptive access, and its facility pickup points functioned more efficiently, suggesting that district level preparedness or pre-existing differentiated models of care influenced the impact. In contrast, eThekwini and King Cetshwayo experienced more pronounced disruptions in testing, contraceptive availability, and refill lengths. This heterogeneity underscores that the consequences of the disruptions were not uniform and that local capacity and systems mattered.

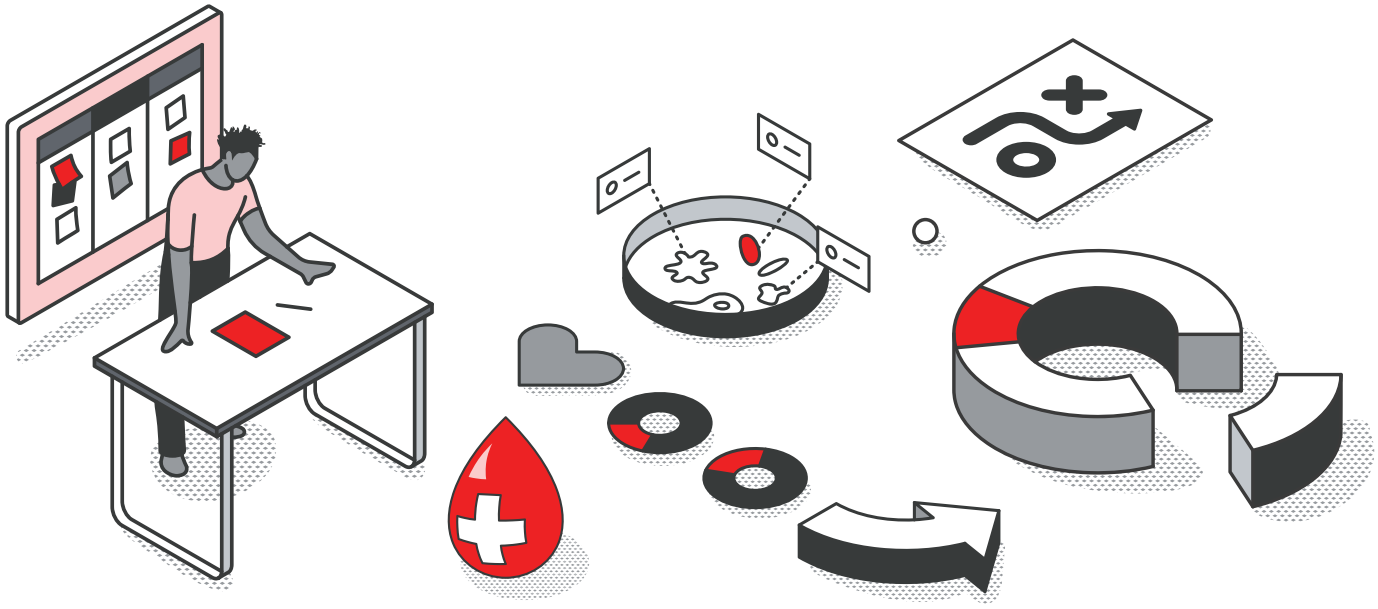
Notably, while ART services continued, the signs of strain, staff reassignments, longer delays, more requirements at the facility, shorter refills – are indicators of both adaptability in the system, and reduced system slack. The decline in HIV testing offer rates and the emergence of contraceptive access barriers suggest that non-ART services were more vulnerable, possibly because they relied more heavily on PEPFAR funded staff or because they were deprioritised when resources became tight.



Limitations

Quantitative monitoring was reduced as a result of USAID and CDC cuts in funding to Ritshidze. As a result, monitoring and collection were not conducted from July–September 2025, and when it was collected, coverage was reduced to three districts in KZN, with 20 sites per district. The quantitative analysis, therefore, focuses on eThekwini, uMgungundlovu, and King Cetshwayo, where data remained available for the indicators included in this report.

Monitoring in the other districts was discontinued, rather than being incomplete or delayed. These constraints limit the generalisability of findings to all districts in KZN. However, the three districts examined remain important high- burden settings and provide- useful insight into health system pressures following the PEPFAR funding disruptions. Monitors, while navigating these tremendous institutional changes, developed new survey tools, aimed at enabling the monitoring to provide information on the immediate impact to the national HIV programme. These tools, administered in April - June 2025, reported in our results section, created context specific indicators. A downside to the newer indicators is that they cannot be compared to prior datasets, while many of the indicators remained in place and could be compared to past data sets to understand the shifts in quality of service delivery following PEPFAR disruptions. While the Key Informants Interviews provide a diversity of vantage points, participation is lacking at the provincial level. This limitation is seen in the lack of detail about the day-to-day operations, task shifting, and prioritising services at the district level.



Recommendations

To sustain and expand the national HIV programme and meet the rights of everyone to prevent and treat the epidemic, we recommend that the government:

Strengthen human resources by expediting recruitment to fill funded vacancies in the most affected districts (including uMgungundlovu and eThekwini) and developing a rapid redeployment plan to shift staff from lower burden to high burden facilities where PEPFAR funded positions were lost. Reestablish mentorship and supervision for newly deployed staff, particularly in HIV testing, contraceptive services, and ART services, to implement National Guidelines with fidelity, and maintain quality.

Optimise differentiated models of care by conducting rapid operational assessments at facilities where large proportions of facility pick-up points users still visit additional service points before collecting ARVs (eThekwini, King Cetshwayo) to eliminate unnecessary steps. Expand the use of external pickup points, which are uniformly perceived as timesaving, and align facility pickup point protocols with national one stop collection guidelines.

Restore HIV testing by integrating testing into routine entry points (OPD, TB, ANC, STI services) and retraining staff on targeted provider-initiated testing, particularly in districts with the lowest offer rates. Use community health workers and mobile services to reach populations not accessing facilities.

Secure contraceptive supply chains by strengthening stock management for the most affected methods (pills, injections, implants) and establishing buffer stocks in districts where stockouts were reported (King Cetshwayo). Train staff to offer alternative methods when first choices are unavailable and to communicate clearly about when stock will be restored.

Target district specific support by conducting rapid reviews in eThekwini and King Cetshwayo to understand why HIV testing offer rates were lower, contraceptive access more strained, and facility pickup points less efficient. Share best practices from uMgungundlovu – where services remained more stable – through peer learning and allocate resources accordingly.

Monitor refill lengths to prevent further erosion, ensuring that 6-month supply is offered to everyone eligible in all facilities in the province, and that everyone else who is not sick is provided with a 3-month supply. Review facility level reasons for shortening refills (e.g., stock concerns, staffing, policy confusion) and urgently address root causes.

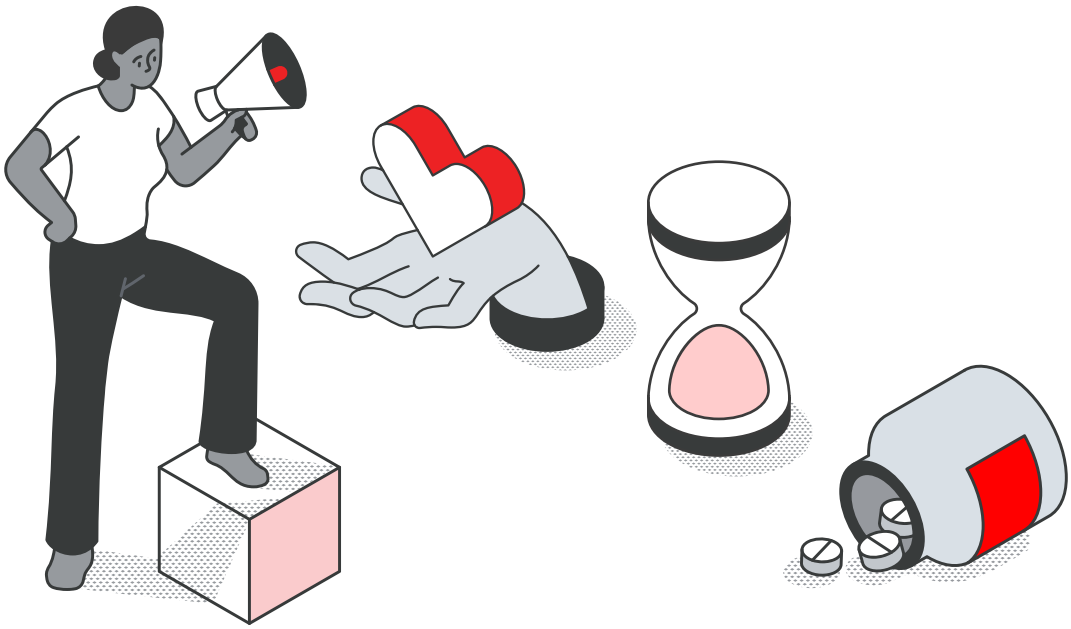
Strengthen data systems by restoring quarterly facility manager surveys in all seven Ritshidze monitored districts and integrating key indicators (staff presence, stockouts, patient flow efficiency) into routine health information systems to enable early detection of pressure points.

Conclusion

Findings show successful mitigation, in the immediate term at all levels of the HIV programme, of the forecasted worst outcomes of substantial U.S. funding disruptions. Access and engagement of adolescent girls and young women, and members of key populations are the first casualties, of the weakening of the health system. Human resources, and Sexual & Reproductive Health education and access to services are the second.

Facilities across the three PEPFAR-funded districts in KZN, eThekwini, uMgungundlovu, and King Cetshwayo, adapted to the disruption through internal redistribution of labour and continued use of differentiated models of care, rather than through strengthened capacity. While ART services remained functional, HIV testing rates dropped, and contraceptive access again showed signs of erosion. Staffing shortages were the primary driver, with facilities redirecting Department of Health staff to sustain pickup points and manage workload.

The uneven district experiences highlight that local resilience factors, such as efficiencies in differentiated models of care and existing staffing buffers, mediated the impact. However, the emergence of shorter ART refill intervals, increased patient access requirements, and patient reported barriers to contraceptives signal that the system is operating with less slack. Without renewed investment in human resources, commodities, and integrated service support, these pressures may worsen, particularly for services that were already under resourced before the U.S. funding disruptions. Sustained monitoring and targeted support to the most affected districts will be essential to prevent further deterioration.



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Annexure A

Analysed Quantitative Survey Questions

This annexure presents the full list of Ritshidze quantitative survey questions and indicators that were included in the analysis. Questions were selected based on their relevance to service access, health system functioning, and patient experience before and after the withdrawal of PEPFAR-supported human resources. The table is organised by the thematic areas as they appear in the results section.

Thematic Area	Indicator Theme	Survey Question	Survey Type	Quarter(s) Used
I. PEPFAR Awareness & Perceptions	Awareness	Are you aware that PEPFAR previously supported services at this facility?	Patient	Apr–Jun 2025
	Awareness	Have you heard of PEPFAR, USAID or CDC?	Patient	Apr–Jun 2025
	Perception	On a scale of 1 to 5, do you think PEPFAR has been good for South Africa? (1 = VERY BAD, 5 = VERY GOOD)	Patient	Apr–Jun 2025
	Awareness of withdrawal	Have you heard about the United States pausing and possibly stopping support for HIV and other health services in South Africa?	Patient	Apr–Jun 2025
	Staffing impact	How were staff shortages today compared to before the end of January?	Manager	Apr–Jun 2025
II. HIV Testing	Testing availability	Were you offered HIV testing today (including a HIV self-test)?	Patient	Apr–Jun 2025
	Staff availability	Are staff available to provide HIV testing?	Manager	Apr–Jun 2025
	Service disruption	Have HIV testing services been affected by the PEPFAR withdrawal?	Manager	Apr–Jun 2025
	Disruption details	Have there been any disruptions to HIV testing services in 2025?	Manager	Apr–Jun 2025
	Locations affected	Where have HIV testing services been affected? (multiple service areas)	Manager	Apr–Jun 2025
	Testing history	How long has it been since you were diagnosed with HIV?	Patient	All
	Retesting	Since you were first diagnosed with HIV, have you ever tested for HIV again?	Patient	All

Thematic Area	Indicator Theme	Survey Question	Survey Type	Quarter(s) Used
III. Contraceptive Access	Method access	Which contraceptives have you tried to access at this facility?	Patient	All
	Method availability	Were you able to get the contraceptives you wanted?	Patient	All
	Reasons for non-access	Why were you unable to get the contraceptives you wanted?	Patient	All
	Stockouts (patient)	In the last three months have you or anyone you know left the facility without the medicines, vaccines, tests, or contraceptives that you needed because of a stockout and/or short supply?	Patient	All
	Stockouts (patient)	Which medicines had a stockout and/or shortage? Please select all that apply.	Patient	All
	Stockouts (patient)	If you know, please specify which contraceptives experienced a stockout and/or shortage.	Patient	All
	Return visits	(coded as "I was told to come back" in reasons for non-access)	Patient	All
	Method mix	What contraceptive options are available at the facility? Select all that apply.	Manager	2025
	Condom access	Are external condoms available at the facility?	Manager	2025
	Condom access	Are internal condoms available at the facility?	Manager	2025
	Condom access	Are lubricants available at the facility?	Manager	2025
	Staff restrictions	(coded as stigma-related reasons in reasons for non-access)	Patient	All
	Facility readiness	Do you have staff trained and available on site for implant insertion & removal?	Manager	2025
	Facility readiness	Do you have staff trained and available on site for IUD insertion & removal?	Manager	2025
	Stockouts (facility)	Which contraceptive methods were out of stock?	Manager	2025

Thematic Area	Indicator Theme	Survey Question	Survey Type	Quarter(s) Used
IV. ARV Collection	Collection model	Where do you collect your ARVs?	Patient	All
	Differentiated care	Are there external pick-up points available near the facility that you can decant stable PLHIV to for ARV collection?	Manager	All
	Pick-up point type	Are there facility pick-up points at the facility that you can decant stable PLHIV to for ARV collection?	Manager	All
	Pick-up staffing	Who is currently running the facility pick-up points? Please select all that apply.	Manager	Apr–Jun 2025
	Pick-up staffing	Who is currently running the external pick-up points? Please select all that apply.	Manager	Apr–Jun 2025
	Model stability	Has your ARV collection point changed since the end of January 2025?	Patient	Apr–Jun 2025
	Additional steps	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)?	Patient	All
	Adherence clubs	How many adherence clubs does the facility have?	Manager	All
	Facility congestion	Does the facility pick-up point make it quicker to collect your ARVs than waiting at the facility?	Patient	All
	External efficiency	Does the external pick-up point make it quicker to collect your ARVs than waiting at the facility?	Patient	All
	Preference	If you could collect your ARVs closer to home, would you like to?	Patient	Apr–Jun 2025
	Satisfaction	On a scale of 1 to 5, how satisfied are you with the facility pick-up point you use? (1 = VERY UNSATISFIED, 5 = VERY SATISFIED)	Patient	Apr–Jun 2025
	Satisfaction	On a scale of 1 to 5, how satisfied are you with the external pick-up point you use? (1 = VERY UNSATISFIED, 5 = VERY SATISFIED)	Patient	Apr–Jun 2025
	Perceived delays	Did it take longer to collect your ARVs after January 2025?	Patient	Apr–Jun 2025

Thematic Area	Indicator Theme	Survey Question	Survey Type	Quarter(s) Used
V. ARV Refills	Timing of last refill	Choose the time frame when you last collected your refill?	Patient	Apr–Jun 2025
	Refill length	How long was your last ARV refill?	Patient	All
	Refill length (exit)	At today's visit, how long were you given HIV medicine for?	Patient	Apr–Jun 2025
	Regimen change	Have you changed your ARV treatment or dosage?	Patient	Apr–Jun 2025
	Regimen change details	If you know, what did your ARV treatment change to?	Patient	Apr–Jun 2025
	Standard refill length	What is the standard for ARV refills at this facility for all clients?	Manager	All
	Change in standard	Has the standard for ARV refills at this facility changed since the end of January 2025?	Manager	Apr–Jun 2025
	Pre-withdrawal standard	What was the standard for ARV refills at this facility before the end of January 2025?	Manager	Apr–Jun 2025
	Reasons for shorter dispensing	Why are you only giving out 1MMD or 2MMD as standard to all clients?	Manager	All
	6-month dispensing	Are you giving stable PLHIV 12-month scripts for ARVs?	Manager	Q1 2024 only (discontinued)
	Stockouts (patient)	In the last three months have you or anyone you know left the facility without the medicines, vaccines, tests, or contraceptives that you needed because of a stockout and/or short supply?	Patient	All
	Stockouts (patient)	Which medicines had a stockout and/or shortage? Please select all that apply.	Patient	All
	Stockouts (patient)	If you know, please specify the HIV medicine that experienced a stockout and/or shortage.	Patient	All
	Stockouts (patient)	If you know, please specify the HIV medicine that experienced a stockout and/or shortage.	Patient	All

Note: "All" quarters refer to available data from January 2024 through April–June 2025. Some indicators were only asked in specific quarters; where data were not collected, the cell is marked with the relevant quarter(s). Some answered 2025 Q4 questions are 0 (No value, which are not included in the analysis, where there is no comparison).

Notes

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