RITSHIDZE

SAVING OUR LIVES

NORTH WEST STATE OF HEALTH

JULY 2023

3RD EDITION

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DEVELOPING THE REPORT

This is the third edition of the North West State of Health report; the first was published in June 2021[1] and the second in July 2022[2]. Like the earlier editions, the third edition of the North West State of Health report outlines key challenges people living with HIV, key populations, and other public healthcare users face in the province.

The report focuses on the following critical themes: stockouts and shortages of medicines; staffing; waiting times; ART collection; ART continuity; treatment and viral load literacy; accessibility and friendliness of health services for key populations; the implementation of index testing to find people living with HIV; infrastructure and clinic conditions; and TB infection control.

The report has been developed using data from Ritshidze — a community-led monitoring system developed by organisations representing people living with HIV, including the Treatment Action Campaign (TAC), the National Association of People Living with HIV (NAPWA), Positive Action Campaign, Positive Women's Network (PWN), and the South African Network of Religious Leaders Living with and affected by HIV/AIDS (SANERELA+).

Community-led monitoring is a systematic collection of data at the site of service delivery by community members that is compiled, analysed and then used by community organisations to generate solutions to problems found during data collection. In Ritshidze, people living with HIV and key populations are empowered to monitor services provided at clinics, identify challenges, generate solutions that respond to the evidence collected, and make sure the solutions are implemented by duty bearers.

Ritshidze monitoring takes place on a quarterly basis at more than 400 clinics and community healthcare centres across 29 districts in 8 provinces in South Africa — including 28 facilities across North West: 10 in Bojanala Platinum, 8 in Dr Kenneth Kaunda, and 10 in Ngaka Modiri Molema. Additional quantitative and qualitative data is collected within the community specific to the quality and friendliness of health services provided for people who use drugs, sex workers, and the LGBTQIA+ community.

We collect data through observations, as well as through interviews with healthcare users (public healthcare users, people living with HIV, 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: www.ritshidze.org.za

ABOUT THE DATA IN THIS REPORT

Data in this report were collected between April 2023 and May 2023 (Q3 2023 — marked as "2023") (Figure 1).

- Interviews took place with 18 Facility Managers
- Observations took place at 18 facilities
- Interviews took place with 1,072 public healthcare users
- 49% (527) identified as people living with HIV
- 14% (153) identified as young people under 25 years of age

Data in this report are compared to data compiled in the first and second editions of the North West State of Health report to understand progress. These data were collected between April to May 2021 (Q3 2021 — marked as "2021") and April to May 2022 (Q3 2022 — marked as "2022"). Increased numbers of survey participants of public healthcare users and people living with HIV cautions against over-interpretation of the direct comparison to prior year results.

All data are available at: http://data.ritshidze.org.za/

In keeping with previous reports, additional quantitative data related to stockouts and shortages of medicines and other health products were collected between May and June 2023. Data collection took place at 72 sites across four districts: 17 sites in Bojanala Platinum, 18 sites in Dr Kenneth Kaunda, 16 sites in Dr Ruth Segomotsi Mompati, and 21 sites in Ngaka Modiri Molema. Data were collected by talking to Facility Managers and pharmacists or pharmacist assistants, where available. All data are available at https://bit.ly/NWStockoutsData2023.

1. 1st edition North West State of Health report, June 2021. Available at: https://ritshidze.org.za/wp-content/uploads/2021/06/Ritshidze-North-West-State-of-Health-2021.pdf
2. 2nd edition North West State of health report, July 2022. Available at: https://ritshidze.org.za/wp-content/uploads/2022/07/Ritshidze-State-of-Health-North-West-2022.pdf

GRACE MOKHOMO CHC

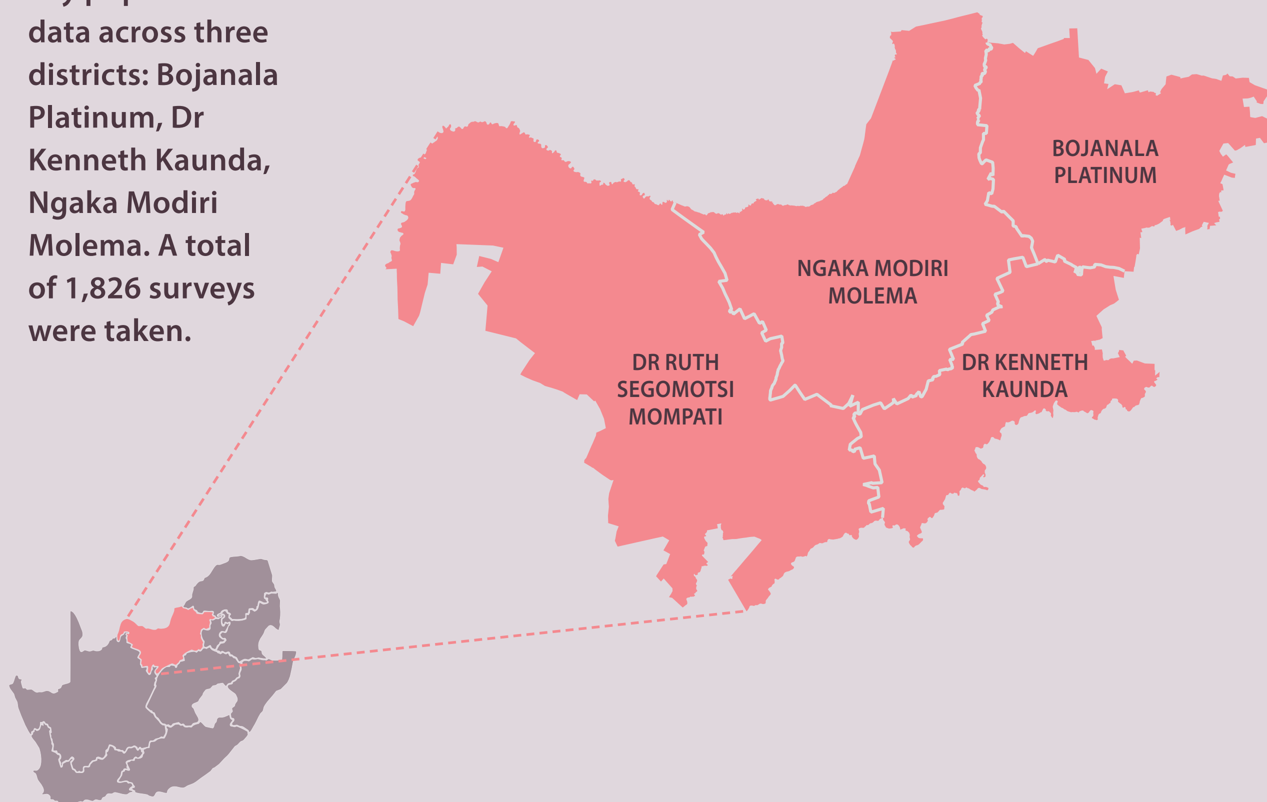
Batho Pele Call Centre

Figure 1: Facilities included in monitoring April to June 2023

District	Facility	PEPFAR agency	District support partner (DSP)	CLM
Bojanala Platinum	Bafokeng CHC	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Bapong CHC	CDC	The Aurum Institute	Ritshidze
	Boitekong Clinic	CDC	The Aurum Institute	Ritshidze
	Chaneng Clinic	CDC	The Aurum Institute	Ritshidze
	Hebron Clinic	CDC	The Aurum Institute	Ritshidze
	Jericho Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Job Shimankana Tabane Provincial Hospital	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Kgabalatsane Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Koedoesrand Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Lefatlheng Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Letlhabile CHC	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Luka Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Madibeng Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Maubane Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidz
	Mathibestad Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Mogwase CHC	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Majakaneng Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Monakato Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Mothotlung Clinic	n/a	n/a	TAC, SSP, Ritshidze
	Oukasie Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Rabokala Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Sunrise Park Clinic	n/a	n/a	TAC, SSP, Ritshidze
	Tlhabane CHC	CDC	The Aurum Institute	TAC, SSP, Ritshidze
Dr Kenneth Kaunda	Alabama Clinic	CDC	The Aurum Institute	Ritshidze
	Empilisweni Clinic	CDC	The Aurum Institute	Ritshidze
	Potchefstroom Gateway Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Grace Mokhomo CHC	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	JB Marks New Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Jouberton CHC	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Kanana Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidz
	Kgakala Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidz
	Kgotso Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Khuma Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Klerksdorp-Tshepong Tertiary Hospital	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Majara Sephapo Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Mohadin Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Orkney Town Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Park Street Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Potchefstroom Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Potchefstroom Hospital	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Promosa CHC	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Stilfontein Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Tshepong Hospital	CDC	n/a	TAC, SSP, Ritshidze
	Tsholofelo Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Tswelelang 1 Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze

District	Facility	PEPFAR agency	District support partner (DSP)	CLM
Dr Ruth Segomotsi Mompati	Amalia Clinic	n/a	n/a	TAC, SSP, Ritshidze
	Ipelegeng Clinic	n/a	n/a	TAC, SSP, Ritshidze
	Khudutlou Clinic	n/a	n/a	TAC, SSP, Ritshidze
	Kokomeng Clinic	n/a	n/a	TAC, SSP, Ritshidze
	Kudunkgwane Clinic	n/a	n/a	TAC, SSP, Ritshidze
	Mammutla Clinic	n/a	n/a	TAC, SSP, Ritshidze
	Mamusa CHC	n/a	n/a	TAC, SSP, Ritshidze
	Phaposane Clinic	n/a	n/a	TAC, SSP, Ritshidze
	Stella CHC	n/a	n/a	TAC, SSP, Ritshidze
	Tlapeng Clinic	n/a	n/a	TAC, SSP, Ritshidze
	Tlapeng Ganyesa Clinic	n/a	n/a	TAC, SSP, Ritshidze
	Tseoge Clinic	n/a	n/a	TAC, SSP, Ritshidze
	Vryburg Hospital	n/a	n/a	TAC, SSP, Ritshidze
Ngaka Modiri Molema	Agisanang Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Bodibe 1 Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Boikhutso Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Dalareyville CHC	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Dinokana Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Dithakong (Mahikeng) Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Itsoseng Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Gopane Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Lehurutshe Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Lekoko CHC	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Lobatla Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Lokaleng Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Lonely Park Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Mareetsane Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Miga Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Montshioa Stadt CHC	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Montshioa Town Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Motlhabeng Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Ramatlabama CHC	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Rapulana Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Setlopo Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Tsetse Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Unit 9 CHC	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Weltevrede Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Zeerust Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Tsetse Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Unit 9 CHC	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Weltevrede Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze
	Zeerust Clinic	CDC	The Aurum Institute	TAC, SSP, Ritshidze

Ritshidze collected key populations data across three districts: Bojanala Platinum, Dr Kenneth Kaunda, Ngaka Modiri Molema. A total of 1,826 surveys were taken.



Additional quantitative data related to key populations were collected between August and October 2022. Data collection took place across three districts: Bojanala Platinum, Dr Kenneth Kaunda, Ngaka Modiri Molema. A total of 1,826 surveys were taken, combining 558 gay, bisexual, and other men who have sex with men (GBMSM), 537 people who use drugs, 488 sex workers, and 243 trans* people.

Figure 2: Surveys by district and key population group

Districts	PEPFAR KP drop-in centre	Global Fund KP services	Number of Surveys by KP Group			
			GBMSM	People who use drugs	Sex workers	Trans* people
Bojanala	/	MSM services, Sex worker services	162	123	182	54
Dr Kenneth Kaunda	Female Sex Worker site	/	208	181	203	54
Ngaka Modiri Molema	/	Sex worker services	188	233	103	135

Ritshidze is not a research project. We are not testing hypotheses. Community-led monitoring is more akin to independent M&E than research. Limitations include:

+ Generalisability — Results are from the facilities monitored and may not be generalisable to other facilities in the district or province.
+ Facility heterogeneity — Facility results even at the district level are heterogeneous. Challenges and successes should be approached as facility specific unless results consistently identify poor performance and policy level issues.
+ A non-representative sampling of public healthcare users — Public healthcare users identified and interviewed at the facility are not necessarily representative of individuals who may have stopped accessing services at a facility. As such further qualitative data is collected in the community to capture the experiences of people who may have already disengaged from care.

INTRODUCTION

In the third edition of the Ritshidze State of Health report in the North West, it is clear that major problems linger in the public healthcare system. While there have been some improvements, the province lags behind many others across too many indicators.

The stockout crisis still persists in the province. This year there were 404 reports of different medicines, contraceptives and vaccines being out of stock in total across 72 facilities — compared to 398 reports across 57 facilities in 2022, and 895 reports across 56 facilities in 2021. In relation to stockouts, the North West scored significantly worse than all other provinces monitored by Ritshidze.

81% of facilities explain that they borrow from other facilities when they face a stockout, creating a cycle of shortages — and 49% of sites complained about unreliable transportation meaning stocks do not arrive. Other issues include stocks arriving that are close to expiration, and loadshedding spoiling vaccines that require refrigeration. Generators at each facility could resolve these challenges, yet only 38% of facilities have a generator that is working and has fuel.

While waiting times have reduced over the last year, on average people still spend 4:14 hours waiting in the facility — and the average waiting time was over 3 hours at 16 facilities monitored, over 4 hours at 8 of those, and over 5 hours at 4 of those. This is a very long time to spend at a facility in which people are usually only seen for a very short consultation. 92% of people interviewed thought waiting times are long — a major source of dissatisfaction.

71% of people interviewed blamed the long waiting times on staff shortages — and only 15% said there was always enough staff to meet the needs of public healthcare users. Concerns of staff shortages were echoed by facilities, with 83% of Facility Managers stating that there are too few staff to meet patients' needs. Without qualified and committed staff in place, we cannot hope to improve the state of our clinics.

56% of facilities specifically wanted additional clinical staff from PEPFAR district support partner in the province — The Aurum Institute. Further, 17% wanted Aurum to provide more linkage officers, 11% wanted more community healthcare workers, 11% wanted peer navigators, and 22% wanted social workers. However, PEPFAR's funding for critical HR posts has only reduced in recent years.

One clear way to reduce waiting times is to reduce the burden on facilities, by giving people living with HIV longer supplies of treatment. However, only 21% of people living with HIV interviewed receive a 3 month refill. Progress towards multi-month dispensing remains very low compared to other provinces and other PEPFAR supported countries where around 80% of people get a 3 to 6 month supply. Of additional concern are reports from the national health department that the number of active people receiving a three month supply has actually decreased from 33,964 to 16,936 in the province.

Another strategy to ease congestion is to allow people living with HIV to collect their treatment at pick-up points either at the facility or externally in the community. These options should make it quicker and easier to collect ARVs. Yet 59% of people using facility pick-up points told us that they must still collect files, take vitals, and see a clinician before getting their parcel — adding unnecessary delays. While it should take less than 30 minutes to collect your parcel and go, 34% of people interviewed said it takes up to an hour, 18% said it takes up to 2 hours, and 33% said it takes more than 2 hours.

Of those still using the facility, 50% said they had never even been offered one of these options — and 61% of people living with HIV interviewed still wish they could collect their ARVs closer to home. There needs to be enough pick-up points to decant people into especially linked to peri-urban and rural clinics.

Once on treatment, people living with HIV need to understand the benefits of taking their pills every day. Yet, there remain significant gaps in knowledge and treatment literacy. Only 77% of people understood that having an undetectable viral load means treatment is working well — and only 62% understood that having an undetectable viral load means a person cannot transmit HIV.

It remains a priority to urgently improve staff attitudes to ensure friendly and welcoming services for all people living with HIV and key populations, including those returning to care after a treatment interruption. Instead, too often, people are made to feel unwelcome or even bullied and ill-treated by clinic staff, including security guards. Only 49% of public healthcare users thought that clinic staff were always friendly and professional. 29% of people living with HIV who return to the clinic said they are sent to the back of the queue.

Worse, only 34% of gay, bisexual, and other men who have sex with men said staff are always friendly, only 22% of people who use drugs, only 45% of sex workers, and only 30% of trans* people — and the majority of key populations interviewed did not feel safe or comfortable at the facility, and many reported major privacy violations.

People living with HIV and key populations who are treated badly, humiliated, or refused access to services will inevitably stop going to the facility altogether, including for HIV, TB and STI testing and treatment. It is critical that the department investigate these reports and hold staff accountable to providing friendly, respectful, and safe services.

It remains a priority to urgently improve staff attitudes to ensure friendly and welcoming services for all people living with HIV and key populations, including those returning to care after a treatment interruption.

This dysfunctional within the public healthcare system remains key to why people stop taking their ARV treatment or don't access the HIV prevention they need in the first place — and can be seen in the province's progress towards the UNAIDS 95-95-95 targets where 93% of people living with HIV know their status, only 70% of those people are on ARVs, out of which 84% are virally suppressed[3]. This translates to just 69% of all people living with HIV receiving ARVs in the province and only 58% of all people living with HIV being virally suppressed.

The Department of Health as well as PEPFAR District Support Partner (The Aurum Institute) must address the challenges identified, and use the solutions recommended, if we are to get more people accessing the HIV and TB prevention and treatment they need — and encourage those who have interrupted treatment or disengaged from care to restart.

3. National Department of Health. Presentation made at Operation Phuthuma "DHIS". September 2022

RITSHIDZE
SAVING OUR LIVES

JULY 2023

RECOMMENDED SOLUTIONS

This table reflects the recommendations in this report. Some are priorities that were included in the 1st and 2nd Editions of the State of Health report but have not yet been implemented. Ritshidze requests a written response on each of the recommendations by the North West Department of Health and the Aurum Institute by 20 August 2023.

Priority recommendations	What years did we ask for it?	Do we have it?
1. Stockouts & shortages of medicines		
NORTH WEST DEPARTMENT OF HEALTH		
1. Ensure that **pharmacist assistants who had their contracts discontinued in March 2021 are reinstated** by September 2023, fully recognising that they are the first to notice when stock is running out. This would also relieve pressure on professional nurses and other cadres to focus on their core mandates.	2022, 2023	No
2. Complete the **decentralisation of the provincial medicines depot** through the establishment of the Rustenburg and Potchefstroom depots to ease the burden on the Mafikeng depot by June 2023.	2022, 2023	No
3. **Address the disparities in transportation of medicines to facility level** that negatively affects some sub districts through a review of its SMME partnerships by October 2023.	2022, 2023	No
2. Staffing		
NORTH WEST DEPARTMENT OF HEALTH		
1. **Produce an annual report on the number of healthcare workers per cadre employed** in each district: include the numbers of people and size of areas covered by these healthcare workers, year-on-year comparisons (from at least 2021), the vacancies, and the cost of these posts to the government	2022, 2023	No
2. **Fill all vacancies** in 2023/24 financial year	2021, 2022, 2023	No
PEPFAR		
1. Support GoSA in **filling all vacancies** at PEPFAR Operation Phuthuma Support (POPS) facilities in the short term	COP22, COP23	No
2. **Provide additional staffing** for all PEPFAR supported sites to extend opening hours to 5am to 7pm on weekdays	COP20, COP21, COP22, COP23	In part
3. **Fund adequate numbers of adherence club facilitators** to allow for the restart of adherence clubs	COP23	No
3. Waiting times		
NORTH WEST DEPARTMENT OF HEALTH		
1. **Extend facility opening times** as per the 2019 NDoH circular	2021, 2022, 2023	No
2. **Utilise appointment days and times** to ease congestion	2022, 2023	In part
3. **Ensure filing systems are maintained in an organised manner** to reduce lost files	2021, 2022, 2023	In part
4. **Open clinic grounds by 5am** so that people can wait safely in the mornings	2022, 2023	No
5. Ensure **files are not required for facility pick-up points** (people living with HIV go directly to the pick-up point to collect their ART refill)	2022, 2023	In part
6. Get **more people living with HIV into external pick-up points** to reduce congestion	2022, 2023	In part
THE AURUM INSTITUTE		
1. **Immediately do an assessment at all POPS (PEPFAR Operation Phuthuma Support) sites with waiting time over 3 hours** and develop a specific plan for each facility that will bring the waiting time below 2 hours	2023	No
2. Support the facility to **organise and maintain an organised filing system**	2022, 2023	In part
3. Ensure **files are not required for facility pick-up points** (people living with HIV go directly to the pick-up point to collect their ART refill)	2022, 2023	In part
4. Get **more people living with HIV into external pick-up points** to reduce congestion	2022, 2023	In part

Priority recommendations	What years did we ask for it?	Do we have it?
4. ART collection		
NORTH WEST DEPARTMENT OF HEALTH		
1. **Extend and implement ARV refills** (to 3 months by end September 2023 and 6 months by end September 2024)	2021, 2022, 2023	In part
2. Ensure **all people living with HIV are offered a range of repeat prescription collection strategy (RPCs) options** and those enrolled in RPCs are active	2022, 2023	In part
3. Ensure that **reassessment of RPC options takes place** at each clinical consultation to ensure people living with HIV remain satisfied with their RPC	2023	No
4. Ensure all facilities implement the 2023 Adherence Guidelines Standard Operating Procedures (SOPs) with fidelity including: a. Ensuring **facility pick-up points are a one-stop very quick ART collection-only visit in under 30 minutes**. No need to go to the registry, collect folders, see clinician etc. b. Ensuring reestablishment/implementation of **quality adherence clubs** including group facilitation component c. **Increasing the number and type of external pick-up points** to ensure urban, peri-urban and rural clinics have external pick-up points d. Ensuring people going back to clinics for their RPCs rescript, **receive the rescript on the same day** if clinically well to ensure no unnecessary additional facility visits with effective recall system to action any abnormal results or elevated viral load.	2022, 2023	In part
THE AURUM INSTITUTE		
1. Implement the 2023 Adherence Guidelines Standard Operating Procedures (SOPs) with fidelity including: a. Ensuring **facility pick-up points are a one-stop very quick ART collection-only visit in under 30 minutes**. No need to go to the registry, collect folders, see clinician etc. b. Ensuring reestablishment/implementation of **quality adherence clubs** including group facilitation component c. **Increasing the number and type of external pick-up points** to ensure urban, peri-urban and rural clinics have external pick-up points d. Ensuring people going back to clinics for their RPCs rescript, **receive the rescript on the same day** if clinically well to ensure no unnecessary additional facility visits with effective recall system to action any abnormal results or elevated viral load.	2022, 2023	In part
PEPFAR		
1. Monitor and hold accountable DSPs to implement 2023 Adherence Guidelines Standard Operating Procedures (SOPs) with fidelity	2022, 2023	No
5. ART continuity		
NORTH WEST DEPARTMENT OF HEALTH		
1. Ensure DOH staff **acknowledge that it is normal to miss appointments and/or have treatment interruptions** — PLHIV returning to care after a late/missed scheduled visit, silent transfer from another facility or treatment interruption should be welcomed	2022, 2023	In part
2. Ensure DOH staff **treat people in a dignified and friendly manner** and investigate any reports of poor attitudes raised by Ritshidze and take disciplinary action where appropriate	2021, 2022, 2023	In part
3. Send communication to all sites highlighting that **no PLHIV should be sent to the back of the queue if they miss an appointment** as per the Welcome Back Campaign strategy that says people returning to care should be triaged.	2021, 2022, 2023	In part
4. **Transfer letters must not be required for ARV continuation or restart**. Any reports where treatment is delayed by healthcare workers requiring a transfer letter should be urgently investigated and disciplinary action taken where appropriate.	2022, 2023	No
5. Implement the 2023 Adherence Guidelines Standard Operating Procedures (SOPs) with fidelity including: a. Ensuring every person starting ART is provided with good quality fast track initiation counselling **session 1** at ART start **and session 2** after 1 month on ART b. Taking **first viral load as early as possible** to ensure providing earlier adherence intervention support and earlier access to longer treatment supply at more convenient locations c. **Actioning an elevated VL** without delay including funding and setting up effective abnormal result recall systems and providing quality enhanced adherence counselling when appropriate d. **Actioning a suppressed VL** without delay focusing on immediate assessment, offer and enrolment into the Repeat Prescription Collection strategy of choice the month after VL taken e. All facilities **implement 2023 re-engagement algorithm** including appropriately differentiating services for returning PLHIV	2022, 2023	No
THE AURUM INSTITUTE		
1. Ensure DSP staff **acknowledge that it is normal to miss appointments and/or have treatment interruptions** — PLHIV returning to care after a late/missed scheduled visit, silent transfer from another facility or treatment interruption should be welcomed	2022, 2023	In part
2. Ensure DSP staff **treat people in a dignified and friendly manner** and investigate any reports of poor attitudes raised by Ritshidze and take disciplinary action where appropriate	2021, 2022, 2023	In part

<table>
<tr><th>Priority recommendations</th><th>What years did we ask for it?</th><th>Do we have it?</th></tr>
<tr><td>3. Implement the 2023 Adherence Guidelines Standard Operating Procedures (SOPs) with fidelity including:
a. Ensuring every person starting ART is provided with good quality fast track initiation counselling session 1 at ART start and session 2 after 1 month on ART
b. Taking first viral load as early as possible to ensure providing earlier adherence intervention support and earlier access to longer treatment supply at more convenient locations
c. Actioning an elevated VL without delay including funding and setting up effective abnormal result recall systems and providing quality enhanced adherence counselling when appropriate
d. Actioning a suppressed VL without delay focusing on immediate assessment, offer and enrolment into the Repeat Prescription Collection strategy of choice the month after VL taken
e. All facilities implement 2023 re-engagement algorithm including appropriately differentiating services for returning PLHIV</td><td>2022, 2023</td><td>No</td></tr>
<tr><td>4. Support with training and mentoring of DOH staff at facility level on the revised 2023 re-engagement clinical and adherence guidelines SOPs</td><td>2023</td><td>No</td></tr>
<tr><td colspan="3">6. Treatment and viral load literacy</td></tr>
<tr><td>NORTH WEST DEPARTMENT OF HEALTH
1. Ensure all DOH staff provide accurate and easily understandable information on treatment literacy and adherence, and the importance of an undetectable viral load through consultations, counselling, and outreach</td><td>2021, 2022, 2023</td><td>In part</td></tr>
<tr><td>2. Ensure that treatment literacy information is provided at health talks each day at the clinic</td><td>2021, 2022, 2023</td><td>In part</td></tr>
<tr><td>3. Ensure that DOH staff explain viral load test results to all PLHIV properly in a timely manner</td><td>2021, 2022, 2023</td><td>In part</td></tr>
<tr><td>THE AURUM INSTITUTE
1. Ensure all DSP staff provide accurate and easily understandable information on treatment literacy and adherence, and the importance of an undetectable viral load through consultations, counselling, and outreach</td><td>2021, 2022, 2023</td><td>In part</td></tr>
<tr><td>2. Ensure that DSP staff explain viral load test results to all PLHIV properly in a timely manner</td><td>2021, 2022, 2023</td><td>In part</td></tr>
<tr><td>PEPFAR
1. Fund an expansion of PLHIV + KP led treatment literacy efforts across all provinces, through training, education and localised social mobilisation campaigns</td><td>2019, 2020, 2021, 2022, 2023</td><td>No</td></tr>
<tr><td colspan="3">7. Key populations</td></tr>
<tr><td>NORTH WEST DEPARTMENT OF HEALTH
1. Ensure that all clinical and non-clinical staff (including security guards) across public health facilities are sensitised on provision of KP friendly services to ensure a welcoming and safe environment for all KPs at all times. KPs must be involved in the implementation of these training modules</td><td>2021, 2022, 2023</td><td>No</td></tr>
<tr><td>2. Any reports of poor staff attitude, privacy violations, verbal or physical abuse/harassment and/or of services being restricted or refused should be urgently investigated</td><td>2022, 2023</td><td>No</td></tr>
<tr><td>3. Expand the Centre of Excellence model to ensure that at least 2 public health facilities per population per district serve as key population designated service delivery centres.
a. A minimum package of services (as outlined in Figure 71) should be made available at these facilities.
b. Easy referral and adequate resources (including transport/money for transport) must be provided for people to take up these services.</td><td>2022, 2023</td><td>In part</td></tr>
<tr><td>4. Ensure that HIV prevention tools including lubricants, external and internal condoms, PrEP, and PEP are made easily available at <u>all</u> public health facilities.
a. Make available external and internal condoms as well as lubricants in a range of spaces across the facility (i.e., waiting areas, toilets, gate, pharmacy, consultation rooms, quiet areas out of site) so people can freely and easily collect them
b. Ensure that PrEP is offered to everyone, including key populations who are not living with HIV/test negative for HIV, with information shared on its benefits
c. Ensure no staff members ever tell key populations to use vaseline or other oil based lubricants instead of water or silicone based lubes</td><td>2022, 2023</td><td>In part</td></tr>
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1. Expand the Centre of Excellence model to ensure that at least 2 public health facilities per population per district serve as key population designated service delivery centres.
a. A minimum package of services (as outlined in Figure 71) should be made available at these facilities.
b. Easy referral and adequate resources (including transport/money for transport) must be provided for people to take up these services
c. PEPFAR must support these facilities with additional staff and resources to provide comprehensive health services to the specific key population being served</td><td>2022, 2023</td><td>In part</td></tr>
<tr><td>2. Ensure that HIV prevention tools including lubricants, external and internal condoms, PrEP, and PEP are made easily available at <u>all</u> public health facilities.
a. Make available condoms and lubricants in a range of spaces across the facility (i.e., waiting areas, toilets, gate, pharmacy, consultation rooms, quiet areas out of site) so people can freely and easily collect them
b. Ensure that PrEP is offered to everyone, including key populations who are not living with HIV/test negative for HIV, with information shared on its benefits
c. Ensure no staff members ever tell key populations to use vaseline or other oil based lubricants instead of water or silicone based lubes</td><td>2022, 2023</td><td>In part</td></tr>
</table>

Priority recommendations	What years did we ask for it?	Do we have it?
8. Index testing		
NORTH WEST DEPARTMENT OF HEALTH		
1. Follow all protocols outlined in the National Department of Health guidelines on index testing including that: a. Index testing is always voluntary b. All healthcare providers **ask if the individual's partners have ever been violent** and record the answer to this question, before contacting the sexual partners c. **No contacts who have ever been violent or are at risk of being violent are ever be contacted** d. **Adequate IPV services available** at the facility or by referral e. **Referrals are actively tracked** to ensure individuals access them and referral sites have adequate capacity to provide services to the individual f. **All adverse events are monitored** through a proactive adverse event monitoring system capable of identifying and providing services to individuals harmed by index testing. Comment boxes and other passive systems are necessary but inadequate. g. After contacting the contacts, **healthcare providers must follow-up with the individual after a reasonable period (1-2 months) to assess whether there were any adverse events** — including but not limited to violence, disclosure of HIV status, dissolution of the relationship, loss of housing, or loss of financial support — and refer them to the IPV centre or other support services if the answer is yes. Data on such occurrences must be shared.	2021, 2022, 2023	In part
2. There should be an **investigation into all sites carrying out index testing**, especially those not monitored by Ritshidze, urgently to assess the implementation of index testing. The findings of this investigation should be shared transparently.	2023	No
3. **Index testing must be suspended in poorly performing sites** until it can be carried out safely and with consent.	2022, 2023	No
THE AURUM INSTITUTE		
1. Follow all protocols outlined in the National Department of Health guidelines on index testing including that: a. Index testing is always voluntary b. All healthcare providers **ask if the individual's partners have ever been violent** and record the answer to this question, before contacting the sexual partners c. **No contacts who have ever been violent or are at risk of being violent are ever be contacted** d. **Adequate IPV services available** at the facility or by referral e. **Referrals are actively tracked** to ensure individuals access them and referral sites have adequate capacity to provide services to the individual f. **All adverse events are monitored** through a proactive adverse event monitoring system capable of identifying and providing services to individuals harmed by index testing. Comment boxes and other passive systems are necessary but inadequate g. After contacting the contacts, **healthcare providers must follow-up with the individual after a reasonable period (1-2 months) to assess whether there were any adverse events** — including but not limited to violence, disclosure of HIV status, dissolution of the relationship, loss of housing, or loss of financial support — and refer them to the IPV centre or other support services if the answer is yes. Data on such occurrences must be shared.services if the answer is yes. Data on such occurrences must be shared.	2021, 2022, 2023	In part
2. There should be an **investigation into all DSP staff carrying out index testing**, especially those not monitored by Ritshidze, urgently to assess the implementation of index testing. The findings of this investigation should be shared transparently.	2023	No
3. **Index testing must be suspended in poorly performing sites** until it can be carried out safely and with consent.	2022, 2023	No
PEPFAR		
1. PEPFAR must follow-through on commitments in COP22, including all monitoring and reporting elements. PEPFAR must share: a. Adverse Event Monitoring Tools of each DSP; b. Data from monthly analyses site level acceptance rates analyses (Oct-Jan); c. Results of REDCap assessments; d. Data on numbers of index clients screened for IPV and those screened positive; e. Planning Meeting Reporting/Presentation Expectations: f. Report on all adverse events (number, type of adverse event, and resolution); g. Results from first wave of 1-2 month delayed healthcare provider follow-ups with index clients on adverse events; h. Plan for implementation of PEPFAR's GBV Quality Assurance Tool: Number of sites, timeframe for implementation, any preliminary results; i. Status of referral network for GBV services; j. Plan for mechanism on reporting data to CSOs on all elements documented in the SDS.	2023	No

Priority recommendations	What years did we ask for it?	Do we have it?
9. Infrastructure and clinic conditions		
NORTH WEST DEPARTMENT OF HEALTH 1. Ensure that all public health facilities have a **functional generator with sufficient fuel** so that health services and administrative work can continue during loadshedding.	2023	In part
2. Ensure that **all public healthcare users are consulted, tested, and/or counselled in private rooms.**	2022, 2023	In part
3. Carry out an **audit of all facilities to assess infrastructural challenges**. After which the Department should develop a plan in order to renovate buildings and ensure adequate space to provide efficient, private, and safe healthcare services. The Department must publish the audit results.	2023	No
4. In the interim, **provide temporary structures** and ensure that **more PLHIV are being decanted out of the facility** and **receiving longer ART refills**, to reduce the burden on overcrowded clinics.	2023	No
5. Ensure that **all facilities are maintained to the highest standards of cleanliness** including through implementing regular cleaning rotas.	2023	In part
6. Ensure clinics have resources to **provide soap and toilet paper in all toilets.**	2023	In part
10. TB infection control		
NORTH WEST DEPARTMENT OF HEALTH 1. **Issue communication to all facilities** stating that: a. All windows must be kept open b. TB infection control posters must be displayed in visible places in the waiting area c. Public healthcare users must be screened for TB symptoms upon arrival d. People coughing or with TB symptoms must be seen first to reduce the risk of transmission e. People coughing or with TB symptoms must be provided with masks f. People who are coughing must be separated from those who are not while wai ting	2021, 2023	No
2. **Carry out a full audit of all public health facilities in the province to assess TB infection control**, based upon WHO guidelines. After which the Department should develop a plan based upon the infrastructural, human resource, or behavioural challenges found in order to improve TB infection control. The Department must publish the audit results.	2021, 2023	No

MEDICAL STORE
NO
UNAUTHORIZED
ENTRY
#eLABS FOR ALL

avacare
5 ML SYRINGE
BRUFEN
Lacson
Epilim CR 500

THIS UP
FHC Blue Sky
Durban-South Africa
Aldo-Unión
Adcock Ingram

1. Shortages and stockouts of medicines

2021	2022	2023
895 reports of stockouts and/or shortages	**398** reports of stockouts and/or shortages	**404** reports of stockouts and/or shortages
115 facilities had shortages of HIV medicines	**43** reports of shortages of HIV medicines	**68** reports of shortages of HIV medicines
28 facilities of shortages of TB medicines	**15** reports of shortages of TB medicines	**57** reports of shortages of TB medicines
80 reports of shortages of contraceptives	**97** reports of shortages of contraceptives	**41** reports of shortages of contraceptives

RECOMMENDATIONS

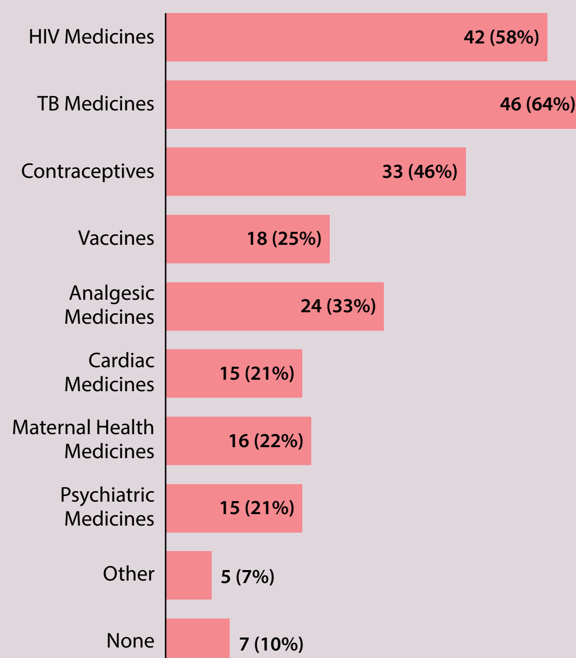
NORTH WEST DEPARTMENT OF HEALTH

1. Ensure that **pharmacist assistants who had their contracts discontinued in March 2021 are reinstated** by September 2023, fully recognising that they are the first to notice when stock is running out. This would also relieve pressure on professional nurses and other cadres to focus on their core mandates.
2. Complete the **decentralisation of the provincial medicines depot** through the establishment of the Rustenburg and Potchefstroom depots to ease the burden on the Mafikeng depot by June 2023.
3. **Address the disparities in transportation of medicines to facility level** that negatively affects some sub districts through a review of its SMME partnerships by October 2023.

Stockouts and shortages of medicines and medical tools cause disruption, confusion, cost, and can detrimentally affect treatment adherence. Again this year, a further extensive community-led monitoring effort took place at 72 facilities by the Treatment Action Campaign (TAC), Stop Stockouts Project (SSP) and Ritshidze.

This year there were 404 reports of different medicines, contraceptives, vaccines, and dry stock being out of stock in total across the 72 facilities (Figure 3, Figure 4) — compared to 398 reports across 57 facilities in 2022, and 895 reports across 56 facilities in 2021. The worst hit district this year was again Ngaka Modiri Molema (Figure 5), followed by Dr Ruth Segomotsi Mompati (Figure 6), Bojanala Platinum (Figure 7), then Dr Kenneth Kaunda (Figure 8).

Figure 3: Facility reports of stockouts/shortages of medicines and medical products across the North West (May to June 2023)
Facility Staff Surveyed: 72



> **Stockouts and shortages of medicines and medical tools cause disruption, confusion, cost, and can detrimentally affect treatment adherence.**

Figure 4: Number of facilities monitored with number of reports of stockouts (May to June 2023)

	Facilities monitored	Reports of stockouts
Bojanala Platinum	17	96
Dr Kenneth Kaunda	18	59
Dr Ruth Segomotsi Mompati	16	102
Ngaka Modiri Molema	21	147
Total	**72**	**404**

Figure 5: Facility reports of stockouts/shortages of medicines and medical products in Bojanala Platinum (May to June 2023)
Facility Staff Surveyed: 17

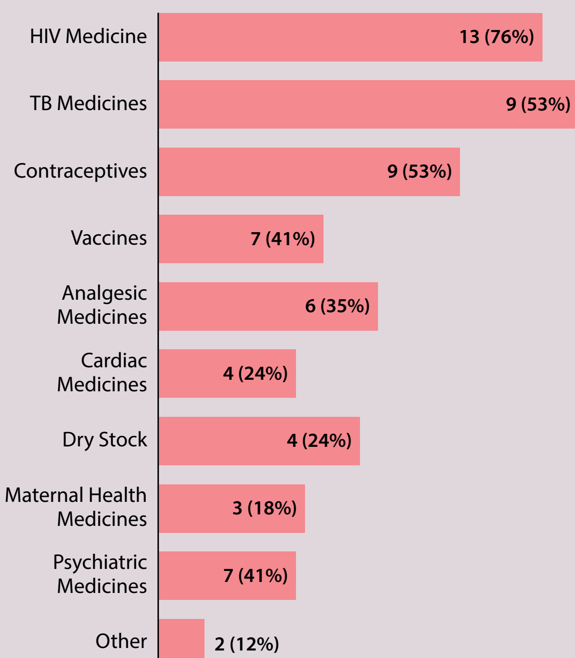


Figure 6: Facility reports of stockouts/shortages of medicines and medical products in Dr Kenneth Kaunda (May to June 2023)
Facility Staff Surveyed: 18

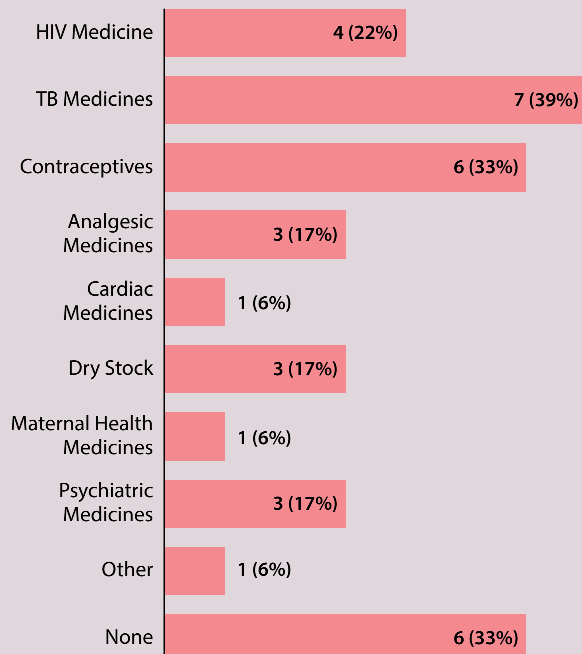
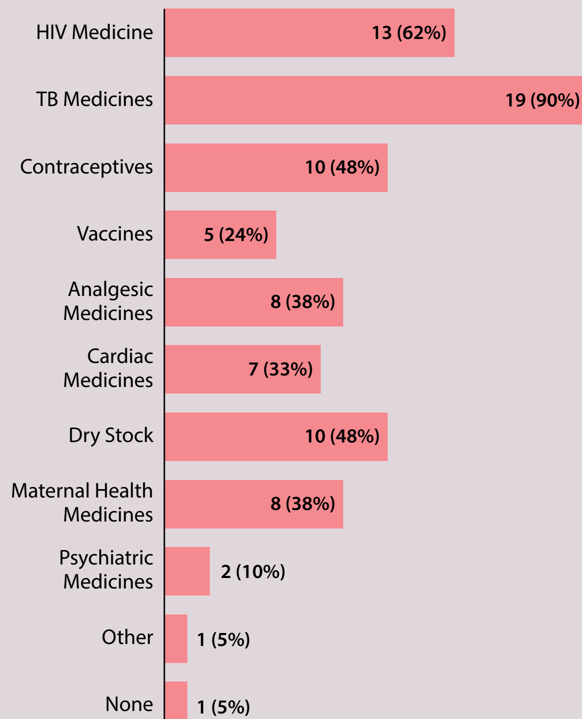


Figure 7: Facility reports of stockouts/shortages of medicines and medical products in Ngaka Modiri Molema (May to June 2023)
Facility Staff Surveyed: 21



Similarly to last year, while protocol dictates that either pharmacists or professional nurses should be responsible for stock (receiving orders, updating the stock visibility system), enrolled nurses, enrolled nurse assistants, facility managers and even a cleaner acted in that capacity in some sites (Figure 9). This year only 17% of facilities had a pharmacist and only 28% had a pharmacist assistant — adding to the workload of already overburdened nurses in sites without.

The stockouts and/or shortages were reported: 42 HIV medicines (Figure 10), 46 TB medicines (Figure 11), 33 contraceptives (Figure 12), 18 vaccines (Figure 13), 24 analgesic medicines (Figure 14), 15 cardiac medicines (Figure 15), 22 dry stock (Figure 16), 16 maternal health medicines (Figure 17), and 15 psychiatric medicines (Figure 18).

This year only 17% of facilities had a pharmacist and only 28% had a pharmacist assistant — adding to the workload of already overburdened nurses in sites without.

Figure 8: Facility reports of stockouts/shortages of medicines and medical products in Dr Ruth Segomotsi Mompati (May to June 2023)
Facility Staff Surveyed: 16

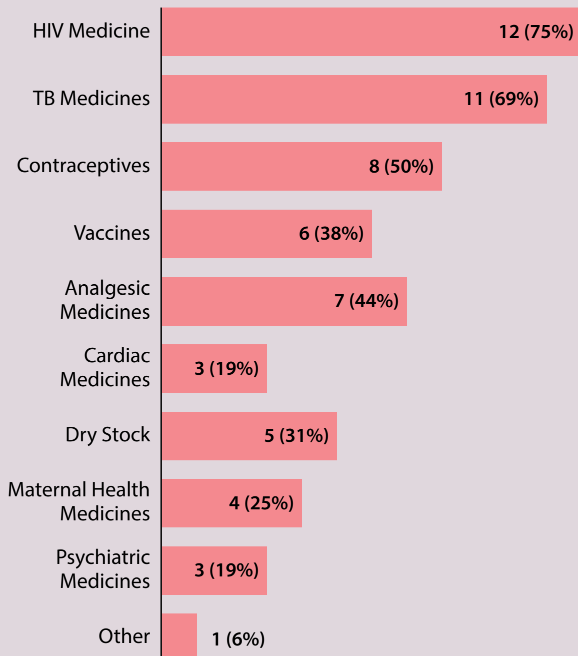


Figure 9: Who is responsible for managing stock at the facility? (May to June 2023)
Facility Staff Surveyed: 72

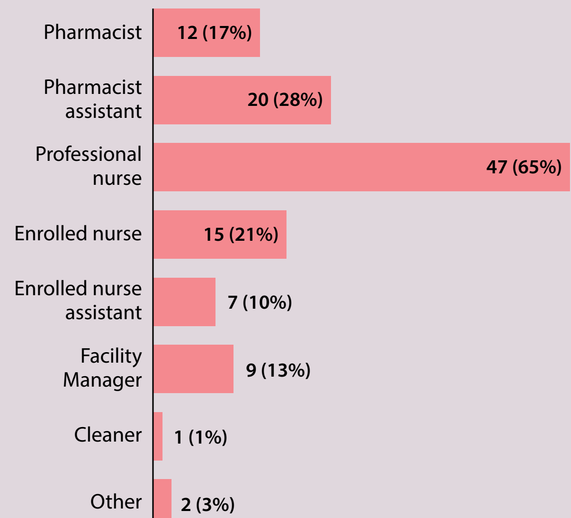


Figure 10: Which HIV medicines experienced a shortage or stockout? (Among facilities reporting a HIV medicine stockout) (May to June 2023)
Facility Staff Surveyed: 42

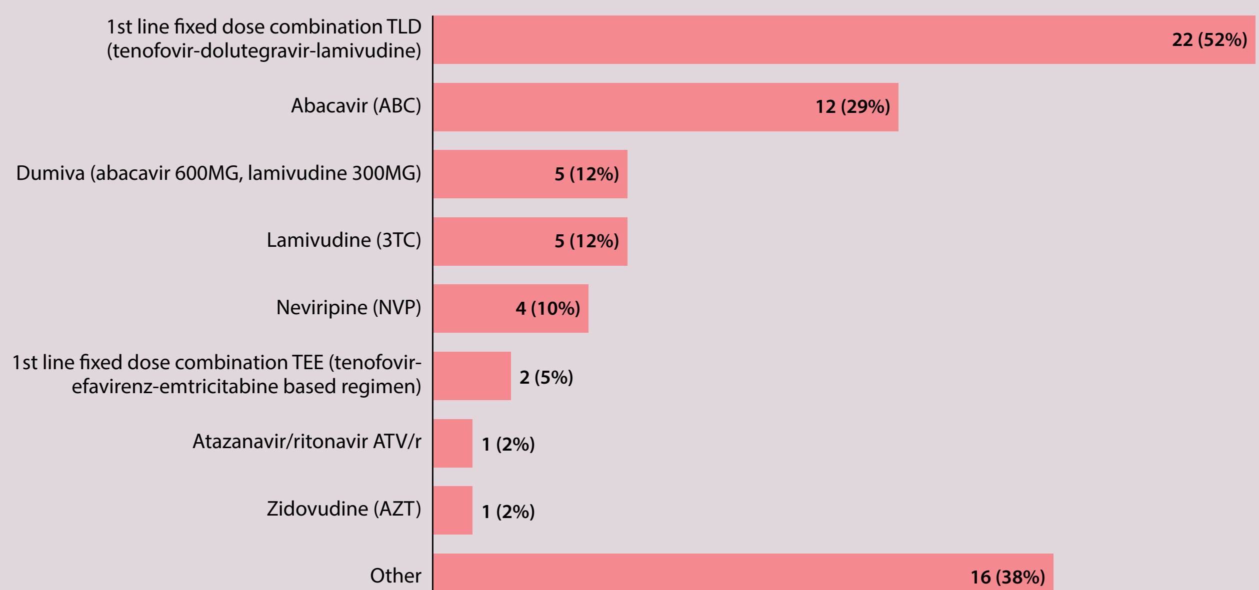


Figure 11: Which TB medicines experienced a shortage or stockout? (Among facilities reporting a TB medicine stockout) (May to June 2023)
Facility Staff Surveyed: 41

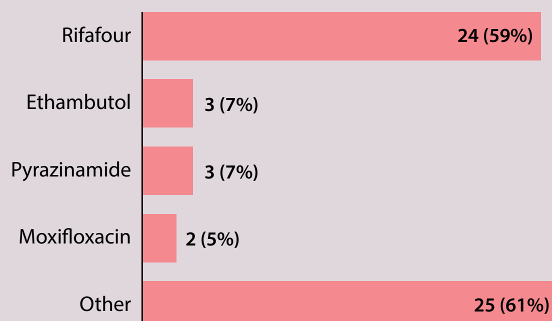


Figure 12: Which contraception experienced a shortage or stockout? (Among facilities reporting a contraception stockout) (May to June 2023)
Facility Staff Surveyed: 31

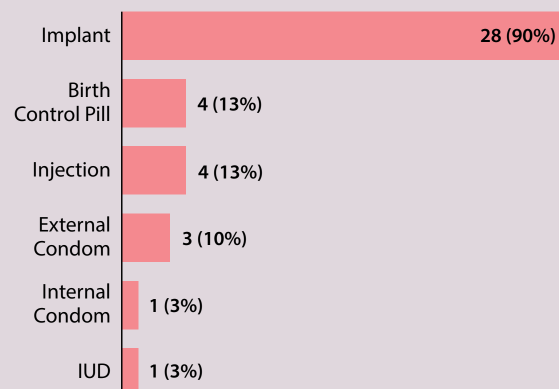


Figure 13: Which vaccines experienced a shortage or stockout? (Among facilities reporting vaccine stockouts) (May to June 2023)
Facility Staff Surveyed: 16

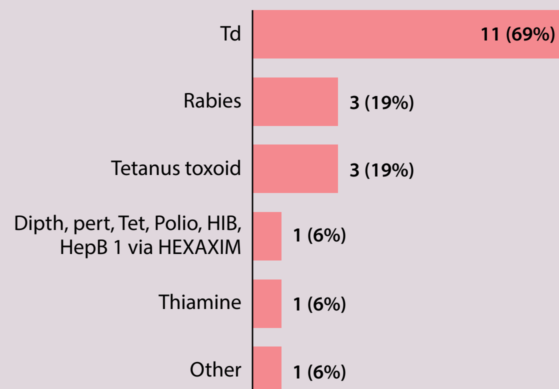


Figure 14: Which analgesics experienced a shortage or stockout? (Among facilities reporting analgesic stockouts) (May to June 2023)
Facility Staff Surveyed: 21

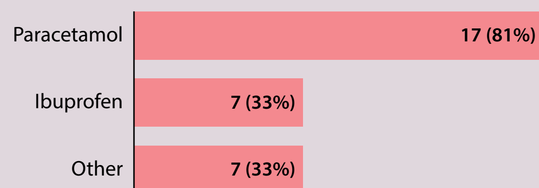


Figure 15: Which cardiac medicines experienced a shortage or stockout? (Among facilities reporting cardiac medicine stockouts) (May to June 2023)
Facility Staff Surveyed: 15

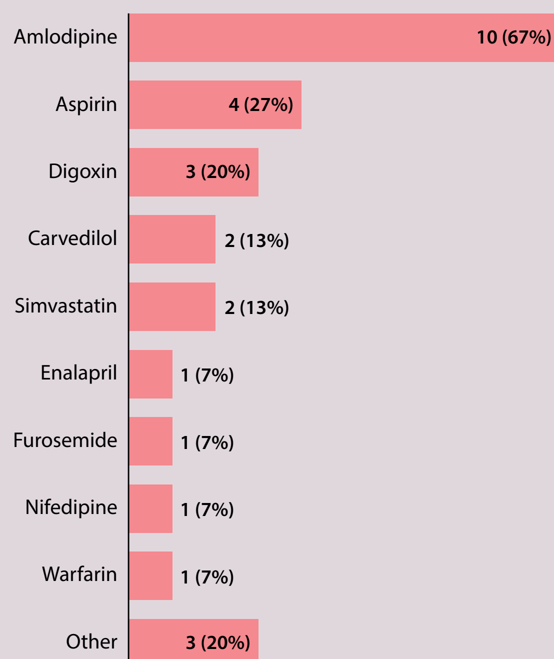


Figure 16: Which dry stock experienced a shortage or stockout? (Among facilities reporting dry stock stockouts) (May to June 2023)
Facility Staff Surveyed: 72

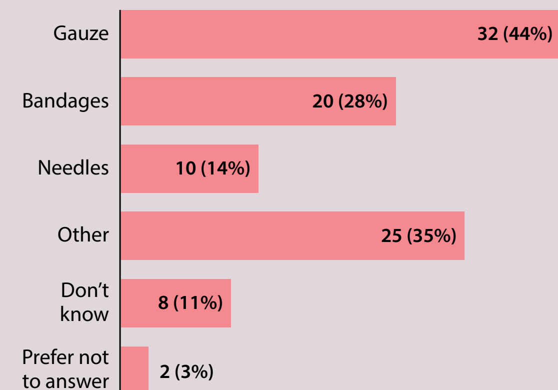


Figure 17: Which maternal medicines experienced a shortage or stockout? (Among facilities reporting maternal medicine stockouts) (May to June 2023)
Facility Staff Surveyed: 14

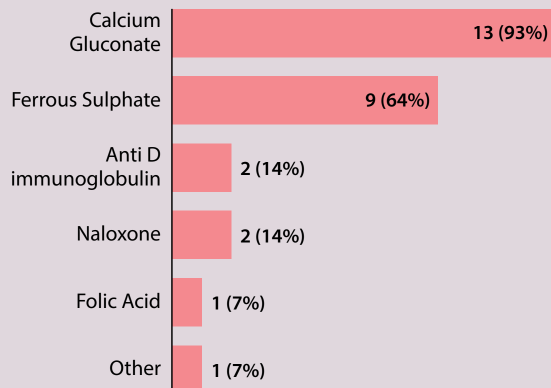
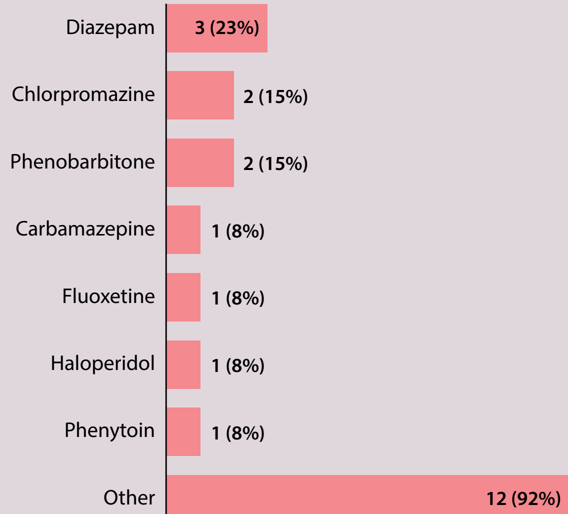


Figure 18: Which psychiatric medicines experienced a shortage or stockout? (Among facilities reporting psychiatric medicine stockouts) (May to June 2023)
Facility Staff Surveyed: 13



CHALLENGES REVEALED DURING THE DATA COLLECTION INCLUDE

+ Short-dated stock from medical stores (stock arriving with a date that is close to expiring, 14-30 days).
+ Always receiving less stock than what has been ordered, e.g. (facility places an order of 30 boxes of ARVs and they receive only 5-15 boxes, even if they double their order they never have enough to last until the next order).
+ 81% of facilities (58 sites) have a borrowing protocol where they borrow stock from each other when facing a shortage or stockout. When their order arrives they will have to return back what they borrowed. This creates a cycle of shortages occurring more quickly, leading to more total stockouts, and then facilities borrow again.
+ 49% of facilities (35 sites) don't get their stock on time because of the unreliability of transport. At times facilities end up collecting medication directly.
+ Only 3% of facilities (2 sites) had enough space to store medication. District medical stores also struggle with space because they don't have their own premises, instead sharing space with district hospitals.
+ Only 20 sites (both Ritshidze and additional sites monitored here) have a functional generator. Vaccines and other medication that needs fridges are affected by loadshedding, especially when power takes a longer time to return.

2. Staffing

2021	2022	2023
0% of Facility Managers say their facilities have enough staff	**15%** of Facility Managers say their facilities have enough staff	**6%** of Facility Managers say their facilities have enough staff
32% of public healthcare users say there are always enough staff at facilities	**11%** of public healthcare users say there are always enough staff at facilities	**15%** of public healthcare users say there are always enough staff at facilities
61 vacancies unfilled across 3 facilities	**39** vacancies unfilled across 3 facilities	**110** vacancies unfilled across 10 facilities

RECOMMENDATIONS

NORTH WEST DEPARTMENT OF HEALTH

1. **Produce an annual report on the number of healthcare workers per cadre employed in each district: include the numbers of people and size of areas covered by these healthcare workers, year-on-year comparisons (from at least 2021), the vacancies, and the cost of these posts to the government**
2. **Fill all vacancies in 2023/24 financial year**

RECOMMENDATIONS

PEPFAR

1. **Support GoSA in filling all vacancies at** PEPFAR Operation Phuthuma Support (**POPS) facilities in the short term**
2. **Provide additional staffing** for all PEPFAR supported sites to extend opening hours to 5am to 7pm on weekdays
3. **Fund adequate numbers of adherence club facilitators to allow for the restart of adherence clubs**

Improving the state of health services provided at our clinics — so that all people living with HIV and key populations can access friendly, welcoming, and quality services — depends mainly on having enough qualified and committed staff in place.

Yet, while up from 11% last year, this year of 1,072 public healthcare users, only 15% said there was always enough staff to meet the needs of public healthcare users (Figure 19), with the best and worst performing sites outlined (Figure 20 and Figure 21). Of 18 Managers, 83% reported there was not enough clinical and/or non-clinical staff at the facility (Figure 22), just down from 85% last year. Bojanala performed worst, with 100% of Facility Managers (6 sites) reporting too few staff in place, compared to 83% in Dr Kenneth Kaunda (5 sites) and 67% in Ngaka Modiri Molema (4 sites).

Figure 19: Are there enough staff at the facility? (April to May 2023)
Patients Surveyed: 1 072

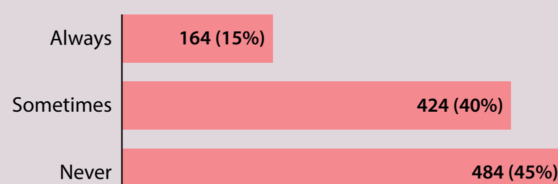


Figure 20: Best performing facilities for "Are there enough staff at the facility?" (April to May 2023)

District	Facility	Surveys Completed	Always	Sometimes	Never	Score
Dr Kenneth Kaunda	Park Street Clinic	59	39	20	0	**1.66**
	Jouberton CHC	51	19	31	1	**1.35**
	Grace Mokgomo CHC	56	19	37	0	**1.34**
	Majara Sephapho Clinic	61	21	40	0	**1.34**

> **Improving the state of health services provided at our clinics — so that all people living with HIV and key populations can access friendly, welcoming, and quality services — depends mainly on having enough qualified and committed staff in place.**

Figure 21: Worst performing facilities for "Are there enough staff at the facility?" (April to May 2023)

District	Facility	Surveys Completed	Always	Sometimes	Never	Score
Ngaka Modiri Molema	Itsoseng Clinic	75	0	0	75	**0**
	Lonely Park Clinic	75	0	0	75	**0**
	Montshioa Stadt CHC	76	0	0	76	**0**
	Ramatlabama CHC	25	0	0	25	**0**
	Unit 9 CHC	75	0	2	73	**0.03**
	Miga Clinic	25	0	2	23	**0.08**
Bojanala Platinum	Letlhabile CHC	55	0	15	40	**0.27**

Figure 22: Facility Manager: does the facility have enough staff? (April to May 2023)
Facility Staff Surveyed: 18

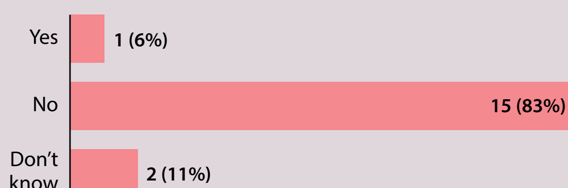
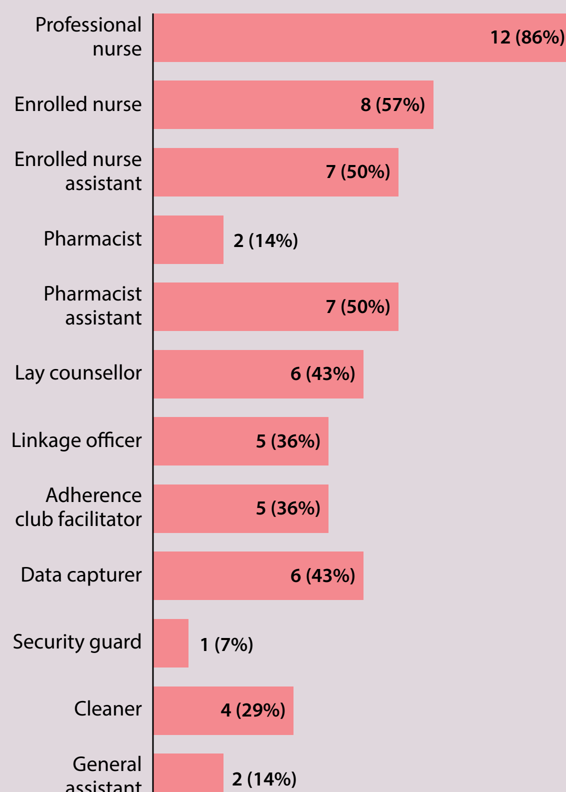


Figure 23: Which cadres are understaffed? (April to May 2023)
Facility Staff Surveyed: 14



Of facilities reporting shortages, 43% of Facility Managers attributed shortages to there not being enough positions in the organogram to do all the work 43% highlighted one or more unfilled vacancies. According to Facility Managers, the most commonly understaffed cadres were professional nurses, enrolled nurses, enrolled nurse assistants, pharmacist assistants, and data capturers (Figure 23). The most common vacancies were among data capturers, enrolled nurses, and pharmacist assistants (Figure 24).

56% of facilities specifically wanted additional clinical staff from PEPFAR district support partner in the province — The Aurum Institute. Further, 17% wanted Aurum to provide more linkage officers, 11% wanted more community healthcare workers, 11% wanted peer navigators, and 22% wanted social workers. However, PEPFAR's funding for critical HR posts has only reduced in recent years.

A gap still remains in the North West between the staffing needed to ensure high quality services and the staff present each day at site level. There is still a way to go to fill the human resource gap that undermines the HIV and TB response.

Figure 24: Total number of vacancies per healthcare cadre

	April to May 2022 (Q3 2022)	July to August 2022 (Q4 2022)	October to November 2022 (Q1 2023)	January to February 2023 (Q2 2023)	April to May 2023 (Q3 2023)
# Facilities monitored with vacancies	3	2	3	1	10
Doctor	0	0	2	0	0
Professional nurse	16	14	10	0	61
Enrolled nurse	6	4	4	0	6
Enrolled nurse assistant	8	3	0	0	23
Pharmacist	1	0	1	0	0
Pharmacist assistant	1	0	1	0	4
Lay counsellor	0	0	2	4	6
Linkage officer	0	0	4	0	0
Data capturer	3	0	2	0	4
Cleaner	4	2	8	0	6
Security guard	0	0	0	0	0
Total	39	23	34	4	110

3. Waiting times

2021	2022	2023
5:13 hours was the average reported waiting time by patients (including time before the facility opened)	**4:26** hours was the average reported waiting time by patients (including time before the facility opened)	**4:14** hours was the average reported waiting time by patients (including time before the facility opened)
5:09 hours was the average reported waiting time by patients after the facility opened	**4:08** hours was the average reported waiting time by patients after the facility opened	**4:00** hours was the average reported waiting time by patients after the facility opened
4:48am was the average earliest arrival time	**5:54am** was the average earliest arrival time	**5:29am** was the average earliest arrival time
71% of public healthcare users felt "unsafe" or "very unsafe" waiting for facility to open	**9%** of public healthcare users felt "unsafe" or "very unsafe" waiting for facility to open	**22%** of public healthcare users felt "unsafe" or "very unsafe" waiting for facility to open
2 of 14 facilities had a filing system observed in bad condition	**2 of 12** facilities had a filing system observed in bad condition	**6 of 18** facilities had a filing system observed in bad condition
	91% of public healthcare users think waiting times are long	**92%** of public healthcare users think waiting times are long

RECOMMENDATIONS

NORTH WEST DEPARTMENT OF HEALTH

1. **Extend facility opening times** as per the 2019 NDoH circular
2. **Utilise appointment days and times** to ease congestion
3. **Ensure filing systems are maintained in an organised manner** to reduce lost files
4. **Open clinic grounds by 5am** so that people can wait safely in the mornings
5. Ensure **files are not required for facility pick-up points** (people living with HIV go directly to the pick-up point to collect their ART refill)
6. Get **more people living with HIV into external pick-up points** to reduce congestion

RECOMMENDATIONS

THE AURUM INSTITUTE

1. **Immediately do an assessment at all POPS (PEPFAR Operation Phuthuma Support) sites with waiting time over 3 hours** and develop a specific plan for each facility that will bring the waiting time below 2 hours
2. Support the facility to **organise and maintain an organised filing system**
3. Ensure **files are not required for facility pick-up points** (people living with HIV go directly to the pick-up point to collect their ART refill)
4. Get **more people living with HIV into external pick-up points** to reduce congestion

Average waiting times have reduced in the last year in facilities monitored in the North West, down to an average of 4:14 hours waiting in the facility (including time before the facility opens), and 4 hours waiting after the facility opens. There is some variation across districts with Ngaka Modiri Molema performing best in the province (Figure 25). Two facilities monitored now have average waiting times of under three hours (Figure 26).

However, some public healthcare users still spend hours at each visit to the facility. The average waiting time was over 3 hours at 16 facilities monitored, over 4 hours at 8 of those, and over 5 hours at 4 of those (Figure 27). This is a very long time to spend at a facility in which people are usually only seen for a very short consultation — and this is a major source of dissatisfaction for those who experience long waits. 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.

> **Messy and disorganised filing systems increase delays and increase the burden on already overstretched healthcare workers.**

Figure 25: Average Facility Waiting Time by District (April to May 2023)

District	Number of Facilities Assessed	Time Patients Spend at the Facility?	Time Spent In the Facility after Opening?
Ngaka Modiri Molema	6	3:21	3:11
Dr Kenneth Kaunda	6	3:36	3:13
Bojanala Platinum	6	5:34	5:24

Figure 26: Facilities with waiting times under 3 hours (April to May 2023)

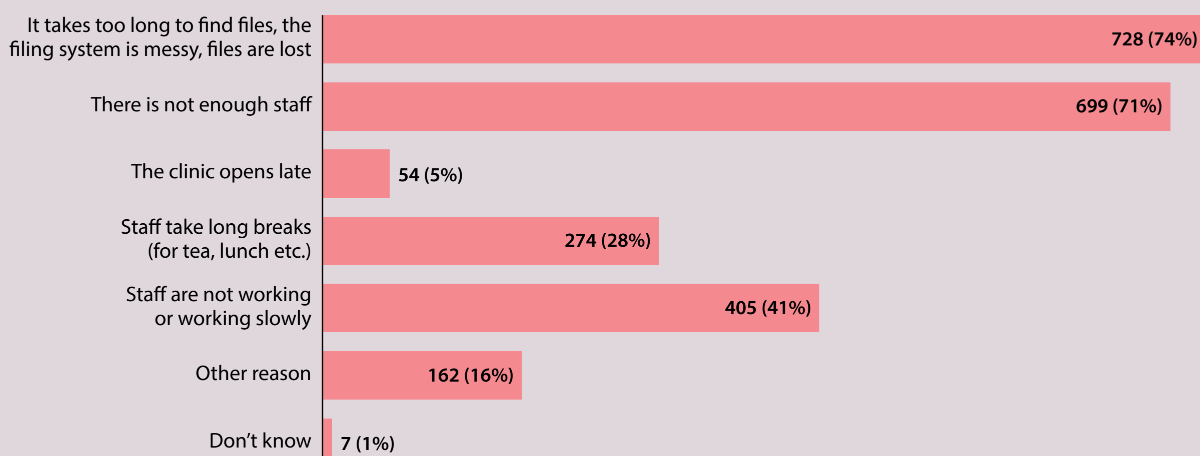
District	Facility	Surveys Completed	Time patients spend at the facility
Ngaka Modiri Molema	Itsoseng Clinic	75	2:43
Ngaka Modiri Molema	Montshioa Stadt CHC	76	2:50

Of 1,071 public healthcare users surveyed, 92% think the waiting times at the facility are long, down from 91% last year, varying across districts (Figure 25) — with 71% blaming staff shortages, 41% blaming staff not working/working slowly, and 74% blaming disorganised filing systems (Figure 28). In fact, filing systems were observed to be in good condition in only 33% of sites monitored, mostly due to filing rooms being too small to maintain (Figure 29, Figure 30). Messy and disorganised filing systems increase delays and increase the burden on already overstretched healthcare workers.

Figure 27: Facilities with waiting times over 4 hours (April to May 2023)

District	Facility	Surveys Completed	Time patients spend at the facility
Bojanala Platinum	Boitekong Clinic	74	6:39
Bojanala Platinum	Tlhabane CHC	77	6:06
Bojanala Platinum	Letlhabile CHC	54	5:48
Bojanala Platinum	Mogwase CHC	52	5:28
Bojanala Platinum	Bafokeng CHC	75	4:55
Dr Kenneth Kaunda	Jouberton CHC	51	4:16
Dr Kenneth Kaunda	Grace Mokgomo CHC	56	4:05
Bojanala Platinum	Bapong CHC	54	4:04

Figure 28: Why do you think the waiting time is long at this facility? (April to May 2023)
Patients Surveyed: 988



The average earliest arrival time has improved (from 5:54am last year to 5:26am this year), however, some people still begin queuing early in the morning, in an attempt to get seen more quickly. 14 facilities still have an average arrival time of before 6am (Figure 31). Of 517 people who arrived before the facility opened, 22% reported feeling unsafe/very unsafe while waiting for the facility to be open (up from 9% last year) (Figure 32).

While a circular was issued in May 2019 by the National Department of Health calling on facilities to open by 5am on weekdays, none of those monitored even open before 7am. Commonly, Facility Managers tell us that they are unable to extend opening hours due to insufficient staffing to cover this time. Yet of 1,065 public healthcare users, 70% think that extended hours would improve access to services.

Figure 29: What is in bad condition in the filing system? (April to May 2023)
Observations completed: 6

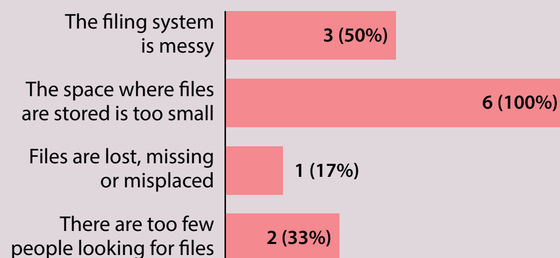


Figure 31: Average arrival time before 6am (April to May 2023)

District	Number of Facilities Assessed	Total number of surveys	Earliest patient arrival time?
Bojanala Platinum	Tlhabane CHC	77	4:39
Dr Kenneth Kaunda	Grace Mokgomo CHC	56	4:53
Bojanala Platinum	Letlhabile CHC	55	5:03
Dr Kenneth Kaunda	Alabama Clinic	54	5:06
Dr Kenneth Kaunda	Majara Sephapho Clinic	61	5:07
Dr Kenneth Kaunda	Park Street Clinic	59	5:08
Dr Kenneth Kaunda	Jouberton CHC	51	5:15
Bojanala Platinum	Boitekong Clinic	75	5:19
Bojanala Platinum	Bafokeng CHC	75	5:30
Bojanala Platinum	Bapong CHC	55	5:37
Dr Kenneth Kaunda	Tsholofelo Clinic	51	5:37
Ngaka Modiri Molema	Unit 9 CHC	75	5:39
Bojanala Platinum	Mogwase CHC	52	5:57
Ngaka Modiri Molema	Montshioa Stadt CHC	76	5:59

Figure 30: What is observed in bad condition in filing systems (April to May 2023)

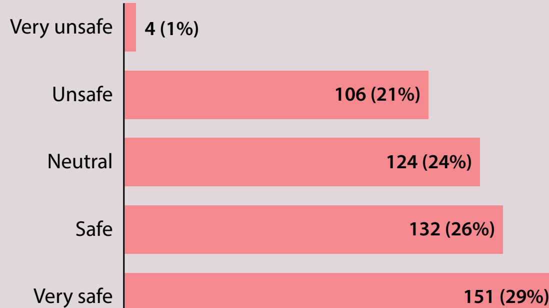
District	Facility	The filing system is messy	The space where files are stored is too small	Files are lost, missing or misplaced	There are too few people looking for files
Bojanala Platinum	Boitekong Clinic	Yes	Yes		
Bojanala Platinum	Letlhabile CHC	Yes	Yes		
Dr Kenneth Kaunda	Alabama Clinic		Yes		Yes
Dr Kenneth Kaunda	Majara Sephapho Clinic		Yes		
Dr Kenneth Kaunda	Tsholofelo Clinic		Yes		
Ngaka Modiri Molema	Ramatlabama CHC	Yes	Yes	Yes	Yes

F29-69
H90-19

TUESDAY.
WENSDAY
THURSDA

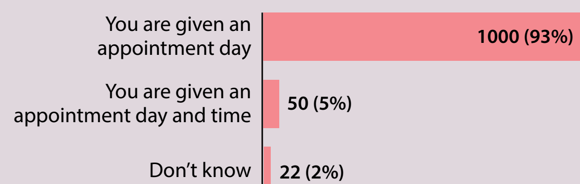
"When you are at the clinic you have to wait and they take long just to find your file. Then you have to go and queue again to see the nurse or maybe the doctor. It can be over two hours waiting and it's very painful for me"

Figure 32: How safe is the facility to wait before it opens? (April to May 2023)
Patients Surveyed: 517



While 98% of public healthcare users were aware of a clinic appointment system, only 5% report getting both a date and time, and 93% reporting just getting a date (Figure 33). This again means people arrive early in a cluster in order to get seen and clinics are empty by the afternoon. Appointments could be spaced out throughout the day to ease congestion.

Figure 33: Which of the following best describes the appointment system? (April to May 2023)
Patients Surveyed: 1 072



COMMUNITY STORY

At 34 years old Dineo* has to rely on his mother to help him wash. This has been the case since a botched surgical procedure at Tshepong Hospital in the North West province left him with bleeding abscesses that don't heal properly, he says.

That was in 2016 and since then Dineo says he has to make regular visits to the Majara Sephago Clinic in Rustenburg to clean the sores. It's absolute agony, he says.

"I have to walk very slowly to get to the clinic and it's very painful for me," he says of the two sores on his buttocks. The sores bleed and cause him pain when he moves or even when he sits down. Because of this he hardly leaves his home any more, he says, apart from for his clinic visits.

"When you are at the clinic you have to wait and they take long just to find your file. Then you have to go and queue again to see the nurse or maybe the doctor. It can be over two hours waiting and it's very painful for me," he says.

He has been able to pick up his ARVs at a pharmacy at a local mall though, which he says is a relief, because he doesn't have to be in the clinic system for this. Dineo still wants a solution to getting proper treatment for the sores. The clinic has given him referral letters to go to Tshepong Hospital but he refuses to return to the facility.

"Tshepong is where this happened to me. They did that operation in 2016 and they cut me with something like a razor and now I bleed and I have this pain with these sores that don't come right," he says.

Dineo says he wishes that the clinic understood that he has lost trust and confidence in Tshepong Hospital and that they find a different solution for him.

"I am too young to stay at home; I can't help my family; I can't get a grant even — I just do nothing now and I just need them to help," he says.

** Name changed to protect identity*

***Since finding out about Dineo's situation Ritshidze members have intervened to try to get Dineo into a different facility that can help treat his sores properly.*

4. ART collection

2021	2022	2023
13% of PLHIV received one month or less supply of ARVs	**5%** of PLHIV received one month or less supply of ARVs	**4%** of PLHIV received one month or less supply of ARVs
60% of PLHIV received two months supply of ARVs	**77%** of PLHIV received two months supply of ARVs	**74%** of PLHIV received two months supply of ARVs
27% of PLHIV received three or six months supply of ARVs	**17%** of PLHIV received three or six months supply of ARVs	**21%** of PLHIV received three or six months supply of ARVs
59% of PLHIV would like to collect ARVs closer to their home	**68%** of PLHIV would like to collect ARVs closer to their home	**61%** of PLHIV would like to collect ARVs closer to their home

RECOMMENDATIONS

NORTH WEST DEPARTMENT OF HEALTH

1. **Extend and implement ARV refills** (to 3 months by end October 2023 and 6 months by end September 2024)
2. Ensure **all people living with HIV are offered a range of repeat prescription collection strategy (RPCs) options** and those enrolled in RPCs are active
3. Ensure that **reassessment of RPC options takes place** at each clinical consultation to ensure people living with HIV remain satisfied with their RPC
4. Ensure all facilities implement the 2023 Adherence Guidelines Standard Operating Procedures (SOPs) with fidelity including:
    a. Ensuring **facility pick-up points are a one-stop very quick ART collection-only visit in under 30 minutes.** No need to go to the registry, collect folders, see clinician etc.
    b. Ensuring reestablishment/implementation of **quality adherence clubs** including group facilitation component
    c. **Increasing the number and type of external pick-up points** to ensure urban, peri-urban and rural clinics have external pick-up points
    d. Ensuring people going back to clinics for their RPCs rescript, **receive the rescript on the same day** if clinically well to ensure no unnecessary additional facility visits with effective recall system to action any abnormal results or elevated viral load.

RECOMMENDATIONS

THE AURUM INSTITUTE

1. Implement the 2023 Adherence Guidelines Standard Operating Procedures (SOPs) with fidelity including:
    a. Ensuring **facility pick-up points are a one-stop very quick ART collection-only visit in under 30 minutes.** No need to go to the registry, collect folders, see clinician etc.
    b. Ensuring reestablishment/implementation of **quality adherence clubs** including group facilitation component
    c. **Increasing the number and type of external pick-up points** to ensure urban, peri-urban and rural clinics have external pick-up points
    d. Ensuring people going back to clinics for their RPCs rescript, **receive the rescript on the same day** if clinically well to ensure no unnecessary additional facility visits with effective recall system to action any abnormal results or elevated viral load.

RECOMMENDATIONS

PEPFAR

1. Monitor and hold accountable DSPs to implement 2023 Adherence Guidelines Standard Operating Procedures (SOPs) with fidelity

Multi-month dispensing and repeat prescription collection strategies (RPCs) can simplify and adapt HIV services across the cascade, in ways that both serve the needs of people living with HIV better and reduce unnecessary burdens on the health system. The revised 2023 National Adherence Guidelines Standard Operating Procedures (SOPs) agree that time constraints represent a challenge to many people living with HIV and that efforts should be made to support people living with HIV with suppressed viral loads to receive extended refills and/or enrollment in RPCs — including for children and adolescents.

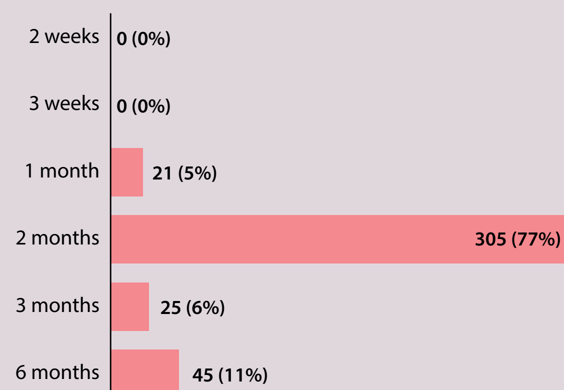
Ritshidze data reveal a little improvement in increasing the duration of ART refills, with the majority of people living with HIV (74%) interviewed by Ritshidze still receiving two months

supply (Figure 34). Only 21% of people received a 3 or 6 month supply. This is compared to 64% in Mpumalanga, the best performing province monitored by Ritshidze. Progress towards multi-month dispensing (MMD) in the North West remains very low compared to 21 other PEPFAR supported countries, where 80% of people living with HIV received 3-6 month ART refill between October and December 2021 (Figure 35). Additionally, according to the national health department, the number of active people living with HIV receiving a three month supply has decreased from 33,964 to 16,936 in the North West (Figure 36).

Figure 34: Duration of ART refill received in 2022 and 2023
Data across time periods: ARV refill length has improved since last year

APRIL TO MAY 2022

Length of HIV medicine refill
PLHIV Surveyed: 396



APRIL TO MAY 2023

Length of HIV medicine refill
PLHIV Surveyed: 527

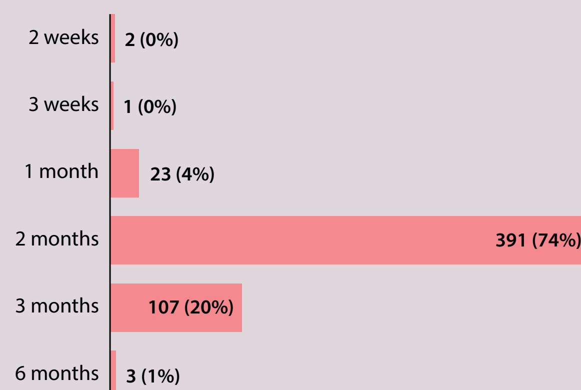
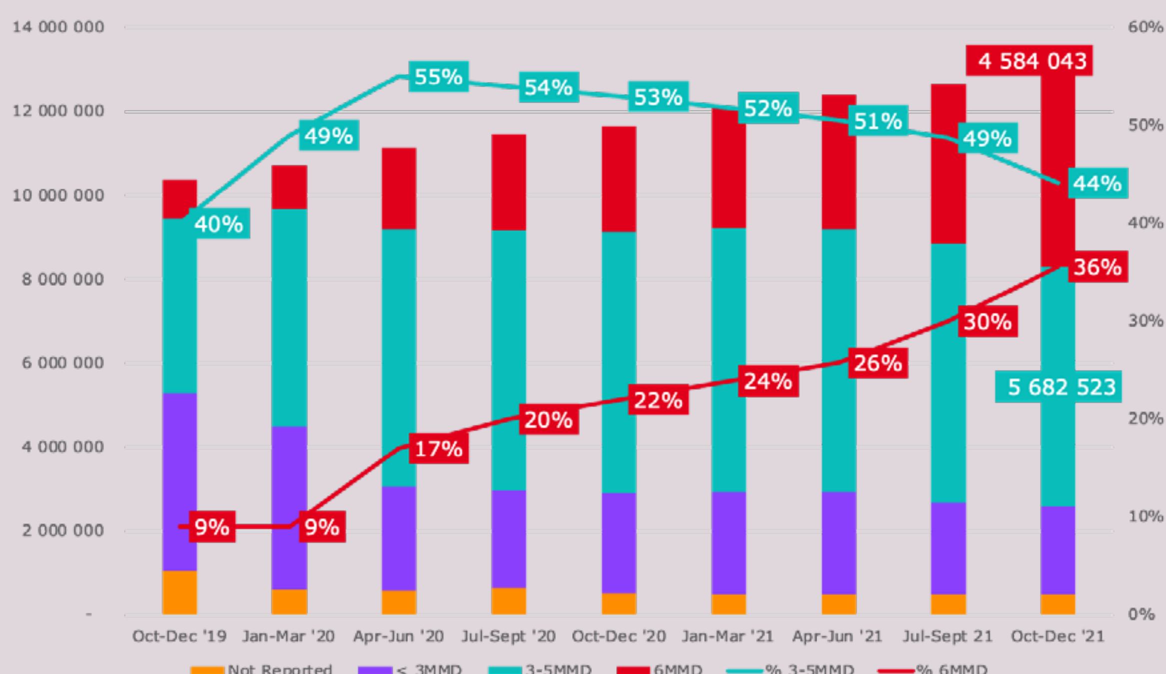
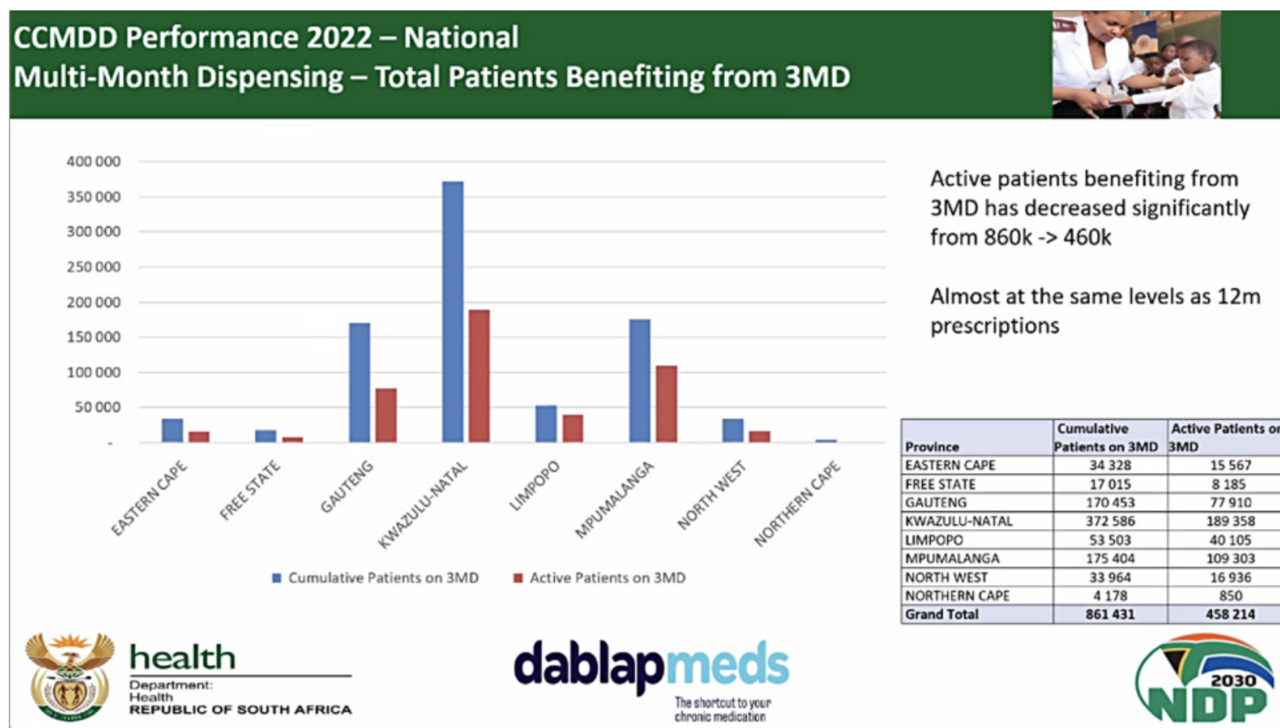


Figure 35: Number and proportion of all people on ART on MMD in 21 PEPFAR supported countries, (Oct 2019-Dec 2021)



From Bailey L, AIDS 2022 DSD pre-conference

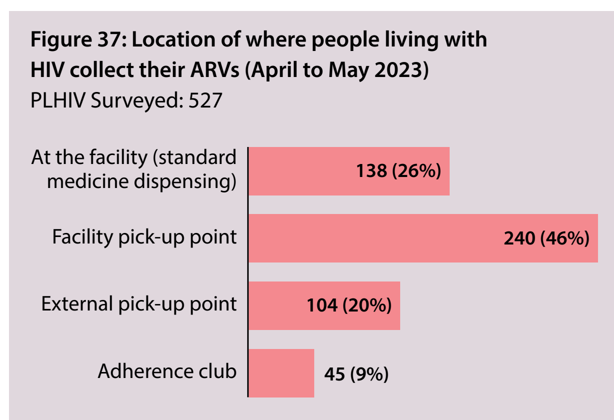
Figure 36: National CCMDD data on the number of PLHIV on 3MMD by province



Province	Cumulative Patients on 3MD	Active Patients on 3MD
EASTERN CAPE	34 328	15 567
FREE STATE	17 015	8 185
GAUTENG	170 453	77 910
KWAZULU-NATAL	372 586	189 358
LIMPOPO	53 503	40 105
MPUMALANGA	175 404	109 303
NORTH WEST	33 964	16 936
NORTHERN CAPE	4 178	850
Grand Total	861 431	458 214

There has been an increase in people using facility or external pick-up points (PuPs), although more than a quarter of people still collect at standard medicine dispensing. Of people living with HIV interviewed by Ritshidze, 26% collected at standard medicine dispensing, with 46% collecting at a facility pick-up point, 20% using an external pick-up point, and 9% using an adherence club (Figure 37).

Figure 37: Location of where people living with HIV collect their ARVs (April to May 2023)
PLHIV Surveyed: 527



Importantly, in order to be effective, repeat prescription collection strategies (RPCs) should make ARV collection quicker, easier and more satisfactory for people living with HIV — yet this is too often not happening. 39% of facilities monitored said that people using facility PuPs must collect files, take vitals, and see a clinician before getting their parcel. 59% of people living with HIV also affirmed this problem that adds to delays at the facility. While it should take less than 30 minutes to collect your parcel and go, 34% of people interviewed said it takes up to an hour, 18% said it takes up to 2 hours, and 33% said it takes more than 2 hours.

For those using standard medicine dispensing, 50% said they have not been offered the option to use RPCs (Figure 38). Further 61% of all people living with HIV interviewed said that they would like to collect ARVs closer to their home if it were possible (Figure 39). There needs to be enough PuPs to decant people into especially linked to peri-urban and rural clinics. A diversity of external PuP providers is needed beyond private pharmacy networks largely only available in urban areas. To service rural areas — small CBOs and early childhood development centres should be considered.

Figure 38: 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 May 2023)
PLHIV Surveyed: 138

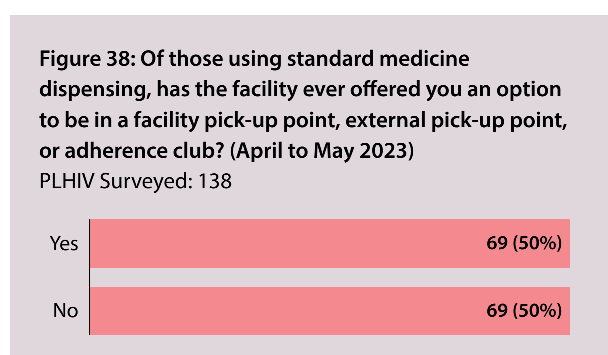
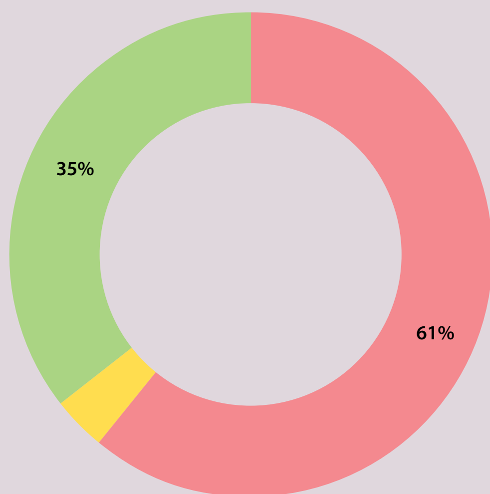


Figure 39: Would PLHIV like to collect ARVs closer to home? (April to May 2023)
PLHIV Surveyed: 527



Once enrolled in RPCs, every effort should be made to keep people continually active with facility required rescripting at the scheduled clinical review dates. Reassessment should take place at each clinical consultation to understand if people living with HIV are satisfied with their RPCs. People living with HIV who are not satisfied should be offered a different option that better meets their needs.

The majority of people in RPCs are stable and virally suppressed: this means it does not make sense to bring everyone back to review their viral load result before rescripting. However, there is a small minority that will experience an elevated viral load. These people cannot wait for their elevated viral load to be actioned in 6-months time at their next clinical review. Positively 89% of Facility Managers report effective recall systems, however, 11% do not have effective recall systems to ensure people in RPCs with an elevated viral load are recalled for clinical management and adherence support.

In terms of adherence clubs, these options have been devastated since the onset of COVID-19. Most clubs have been suspended, or reduced to being just a PuP. We maintain that functional adherence clubs play an important role in supporting ongoing treatment literacy and peer support to help people living with HIV stay on treatment.

COMMUNITY STORY

Quick and fast service may seem like the obvious solution to long queues at clinics but for Peter* this is only a good thing if it doesn't mean shortcuts.

Peter has been using the facilities at Boitekong Community Health Centre in Rustenburg for the past year to pick up his ARVs. Speaking through a translator, he says he has no complaints about the speed of the pick-up points at the clinic but says there is still a need for people to have somewhere to turn to get medical attention and information when they need it.

"You don't wait long there, so I really can't complain about waiting times. I came to Boitekong when the NPO where I was diagnosed and initiated on treatment closed down. Everything I learnt about HIV and my health I got from that side in 2005 already. There they take your vitals, ask you how your life is and what you are feeling — not like in a government clinic," he says.

Peter's concern is that the pick-up point model at Boitekong doesn't account for answering questions or offering support when people need it. He last had blood drawn in March and says he wasn't given his results, not even over three months later.

"I assume that I am stable and that my viral load is suppressed because they did offer to decant me when I asked about getting more information and support. But I prefer coming here still because it's close to my house," he says.

Peter also notes that the clinic's community health workers (CHWs) do not carry out their role of talking to patients, assisting them with information and support and helping to navigate them to the right channels of care.

"They sometimes take vitals, that is more the nurses' job, or work with registration but they should be talking to patients to understand the needs and concerns," he says.

Because of this Peter has become involved with a patient support group at the clinic. He and the other volunteers started discussions with the clinic and the district to find proper structures through which to advance their work but he says communications have hit a dead-end.

He adds: "We are doing this because we know that people don't always want something like an adherence club if they feel they are stable and they don't have time for a club. But there must be somewhere they can go, even if it's by referral, where they can ask their questions and understand what is going on in their bodies. Patients need to know what is going on inside their bodies, not just that they must stay on their treatment," he says.

** Name changed to protect identity*

5. ART continuity

2021

60% say staff are always friendly and professional

16% say they are welcomed back if they miss an appointment

78% feel that facilities keep their HIV status private and confidential

2022

58% say staff are always friendly and professional

8% say they are welcomed back if they miss an appointment

73% feel that facilities keep their HIV status private and confidential

29 people had been refused access to services for not having a transfer letter

19 people had been refused access to services for not having an ID

2023

49% say staff are always friendly and professional

23% say they are welcomed back if they miss an appointment

71% feel that facilities keep their HIV status private and confidential

37 people had been refused access to services for not having a transfer letter

18 people had been refused access to services for not having an ID

RECOMMENDATIONS

NORTH WEST DEPARTMENT OF HEALTH

1. Ensure DOH staff **acknowledge that it is normal to miss appointments and/or have treatment interruptions** — PLHIV returning to care after a late/ missed scheduled visit, silent transfer from another facility or treatment interruption should be welcomed
2. Ensure DOH staff **treat people in a dignified and friendly manner** and investigate any reports of poor attitudes raised by Ritshidze and take disciplinary action where appropriate
3. Send communication to all sites highlighting that **no PLHIV should be sent to the back of the queue if they miss an appointment** as per the Welcome Back Campaign strategy that says people returning to care should be triaged.
4. **Transfer letters must not be required for ARV continuation or restart.** Any reports where treatment is delayed by healthcare workers requiring a transfer letter should be urgently investigated and disciplinary action taken where appropriate.
5. Implement the 2023 Adherence Guidelines Standard Operating Procedures (SOPs) with fidelity including:
   a. Ensuring every person starting ART is provided with good quality fast track initiation counselling **session 1** at ART start **and session 2** after 1 month on ARTTaking **first viral load as early as possible** to ensure providing earlier adherence intervention support and earlier access to longer treatment supply at more convenient locations
   b. Actioning an elevated VL without delay including funding and setting up effective abnormal result recall systems and providing quality enhanced adherence counselling when appropriate
   c. Actioning a suppressed VL without delay focusing on immediate assessment, offer and enrolment into the Repeat Prescription Collection strategy of choice the month after VL taken
   d. All facilities implement 2023 re-engagement algorithm including appropriately differentiating services for returning PLHIV

RECOMMENDATIONS

THE AURUM INSTITUTE

1. Ensure DSP staff **acknowledge that it is normal to miss appointments and/or have treatment interruptions** — PLHIV returning to care after a late/ missed scheduled visit, silent transfer from another facility or treatment interruption should be welcomed
2. Ensure DSP staff **treat people in a dignified and friendly manner** and investigate any reports of poor attitudes raised by Ritshidze and take disciplinary action where appropriate
3. Implement the 2023 Adherence Guidelines Standard Operating Procedures (SOPs) with fidelity including:
   a. Ensuring every person starting ART is provided with good quality fast track initiation counselling **session 1** at ART start **and session 2** after 1 month on ART
   b. Taking **first viral load as early as possible** to ensure providing earlier adherence intervention support and earlier access to longer treatment supply at more convenient locations
   c. **Actioning an elevated VL** without delay including funding and setting up effective abnormal result recall systems and providing quality enhanced adherence counselling when appropriate

- d. **Actioning a suppressed VL** without delay **focusing on immediate assessment, offer and enrolment into the Repeat Prescription Collection strategy of choice the month after VL taken**
- e. **All facilities implement 2023 re-engagement algorithm** including appropriately **differentiating services for returning PLHIV**

4. **Support with training and mentoring of DOH staff at facility level on the revised 2023 re-engagement clinical and adherence guidelines SOPs**

Once on treatment, it is important to recognise that people living with HIV live dynamic lives, may miss appointments, and may even miss taking some pills. When they do, the public health system should meet them with support when they return to the clinic. But often, when people living with HIV return to the clinic they are treated badly. This poor treatment and unwelcoming environment is a significant reason for people living with HIV and key populations to disengage from care.

After a late appointment, silent transfer, or treatment interruption, people living with HIV must be supported to re-engage in care. The 2023 National Adherence Guidelines describe how staff should be friendly and welcoming and acknowledge the challenge for life-long adherence. To sustain re-engagement it is essential to reduce or remove health system barriers to being retained in care.

A differentiated service approach is required for people living with HIV who re-engage in care. Some will require intensive clinical management including advanced HIV screening and management. Some will require psychosocial support in the form of quality counselling and group support options. The majority need it to be made easier to collect treatment. These people should be offered MMD and should be assessed and offered access to RPCs as quickly as possible. Implementing 2023 re-engagement clinical and adherence guidelines are vital to supporting improved long-term adherence and retention as well as providing appropriate clinical and psychosocial support to people living with HIV. However, 63% of facilities report that PEPFAR partners have not yet supported in training/mentoring on the changes in the new 2023 adherence SOPs.

Ritshidze data reveal that out of 1,072 respondents, only 49% of people thought that the staff were always friendly and professional. However, 51% of people thought staff were only sometimes or never friendly. This has worsened over the last year (Figure 40). The best and worst performing facilities are outlined in the tables (Figure 41 and Figure 42).

Further improvements are required to ensure all public healthcare users, including people living with HIV and key populations, are treated with dignity, respect, and compassion at all times.

Figure 40: Staff attitudes over time (higher scores are better)

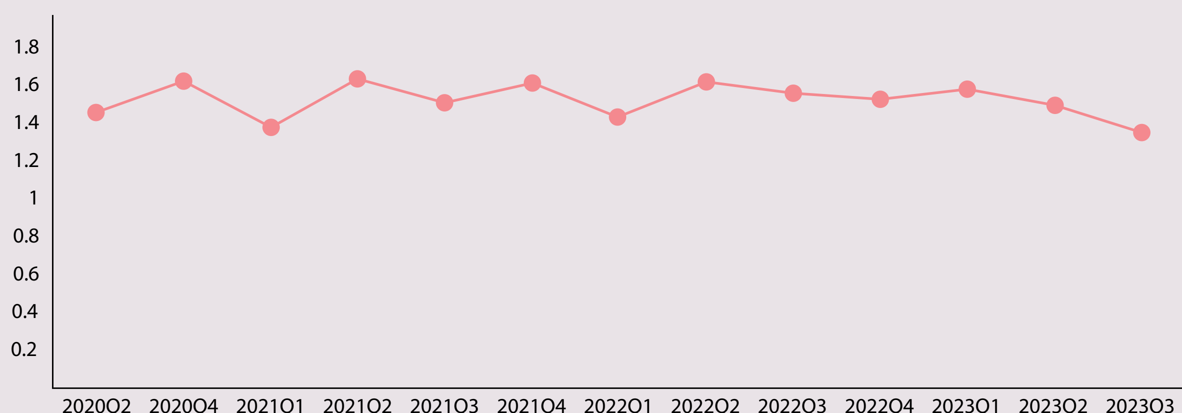


Figure 41: Best performing facilities on staff attitudes (April to May 2023)

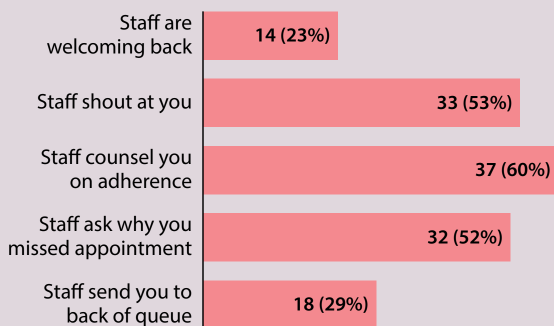
District	Facility	Surveys Completed	Yes	Sometimes	No	Score
Ngaka Modiri Molema	Lonely Park Clinic	75	75	0	0	2
Ngaka Modiri Molema	Ramatlabama CHC	25	25	0	0	2
Ngaka Modiri Molema	Itsoseng Clinic	75	74	0	1	1.97
Ngaka Modiri Molema	Montshioa Stadt CHC	76	65	9	2	1.83
Ngaka Modiri Molema	Unit 9 CHC	75	59	14	2	1.76
Dr Kenneth Kaunda	Park Street Clinic	59	44	15	0	1.75

Figure 42: Worst performing facilities on staff attitudes (April to May 2023)

District	Facility	Surveys Completed	Yes	Sometimes	No	Don't know	Score
Bojanala Platinum	Letlhabile CHC	55	3	8	44	0	0.25
Bojanala Platinum	Boitekong Clinic	75	4	35	36	0	0.57
Dr Kenneth Kaunda	Tsholofelo Clinic	51	7	19	24	1	0.66
Dr Kenneth Kaunda	Alabama Clinic	54	10	20	24	0	0.74
Bojanala Platinum	Tlhabane CHC	77	22	35	20	0	1.03
Bojanala Platinum	Bapong CHC	55	14	33	8	0	1.11
Dr Kenneth Kaunda	Majara Sephapho Clinic	61	14	47	0	0	1.23
Bojanala Platinum	Bafokeng CHC	75	23	50	2	0	1.28
Ngaka Modiri Molema	Miga Clinic	25	14	4	7	0	1.28
Dr Kenneth Kaunda	Grace Mokgomo CHC	56	19	34	3	0	1.29

Out of the 62 people living with HIV who had missed appointments, 23% said that staff were welcoming when they came to collect ARVs if they had previously missed a visit (Figure 43), similar to last year. However, 29% said that staff still send you to the back of the queue the next time you come in — yet according to the South African National Welcome Back Campaign Strategy and the national adherence guidelines, people should not be sent to the back of the queue or made to wait until the end of the day to be seen. A returning patient should either be seen in a separate stream or take up the next queue space.

Figure 43: How are PLHIV treated if they miss appointments (April to May 2023)
PLHIV Surveyed: 62



** It is important to note that Ritshidze interviews take place at the facility, therefore this data does not capture the experiences of people living with HIV who have already disengaged from care and are not at the facility.*

Further improvements are required to ensure all public healthcare users, including people living with HIV and key populations, are treated with dignity, respect, and compassion at all times. When people living with HIV disengage from treatment for any reason clinicians need to be sensitised and attempt to expect and normalise treatment interruption, this way the narrative between people living with HIV and clinician will be less punitive and more supportive.

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 day of presentation... while referral letters are helpful, a patient cannot be required to leave the facility without treatment". While most facilities did not have reports of transfer letters being a challenge, alarmingly 82 people reported having been denied access to services in the last year for not having a transfer letter (Figure 44). Further, 80 people reported having been denied access to services across the last year for not having an identity document (Figure 45). These reports must be urgently investigated.

Figure 44: People refused access to services without a transfer letter

District	Facility	Q4 2022	Q1 2022	Q2 2023	Q3 2023
Bojanala Platinum	Hebron Clinic	1	Not monitored	Not monitored	Not monitored
Bojanala Platinum	Letlhabile CHC	36			
Bojanala Platinum	Mogwase CHC	1			
Bojanala Platinum	Tlhabane CHC	4			4
Ngaka Modiri Molema	Montshioa Stadt CHC	1			
Ngaka Modiri Molema	Unit 9 CHC		2		
Dr Kenneth Kaunda	Alabama Clinic	Not monitored	Not monitored	Not monitored	4
Dr Kenneth Kaunda	Grace Mokgomo CHC				1
Dr Kenneth Kaunda	Jouberton CHC				5
Dr Kenneth Kaunda	Majara Sephapho Clinic	Not monitored	Not monitored	Not monitored	2
Dr Kenneth Kaunda	Tsholofelo Clinic	Not monitored	Not monitored	Not monitored	21

Psychosocial support is another critical element to ensure long-term retention. Ritshidze data show that only 87% of people living with HIV interviewed do know that psycho-social support is available.

Figure 45: People refused access to services without an identity document

District	Facility	Q4 2022	Q1 2022	Q2 2023	Q3 2023
Bojanala Platinum	Boitekong Clinic				4
Bojanala Platinum	Hebron Clinic	3	Not monitored	Not monitored	Not monitored
Bojanala Platinum	Letlhabile CHC	39			
Bojanala Platinum	Mogwase CHC	1			
Bojanala Platinum	Tlhabane CHC				5
Dr Kenneth Kaunda	Alabama Clinic	Not monitored	Not monitored	Not monitored	1
Dr Kenneth Kaunda	Grace Mokgomo CHC				1
Dr Kenneth Kaunda	Jouberton CHC				5
Dr Kenneth Kaunda	Park Street Clinic				1
Dr Kenneth Kaunda	Tsholofelo Clinic	Not monitored	Not monitored	Not monitored	1
Ngaka Modiri Molema	Montshioa Town Clinic	15	1		

** Again it is important to note that Ritshidze interviews take place at the facility, therefore people who have already disengaged from care due to challenges accessing a transfer letter or those without IDs, would not be at the facility to interview.*

Psychosocial support is another critical element to ensure long-term retention. Ritshidze data show that only 87% of people living with HIV interviewed do know that psycho-social support is available. Further, a full package of psycho-social services are not yet available at every clinic (Figure 46).

A full package of services should include: provision of individualised quality assured counselling to patients; peer-led patient navigators acting as a bridge between clinicians and patients; mapped networks of referral services; optional support groups, and food parcels (Figure 47). As part of psycho-social support, support groups should also be linked to each public health facility that are critical to provide counselling and support services to people prior to testing, post testing, pre-treatment, and those struggling on treatment or re-engaging in care after a treatment interruption.

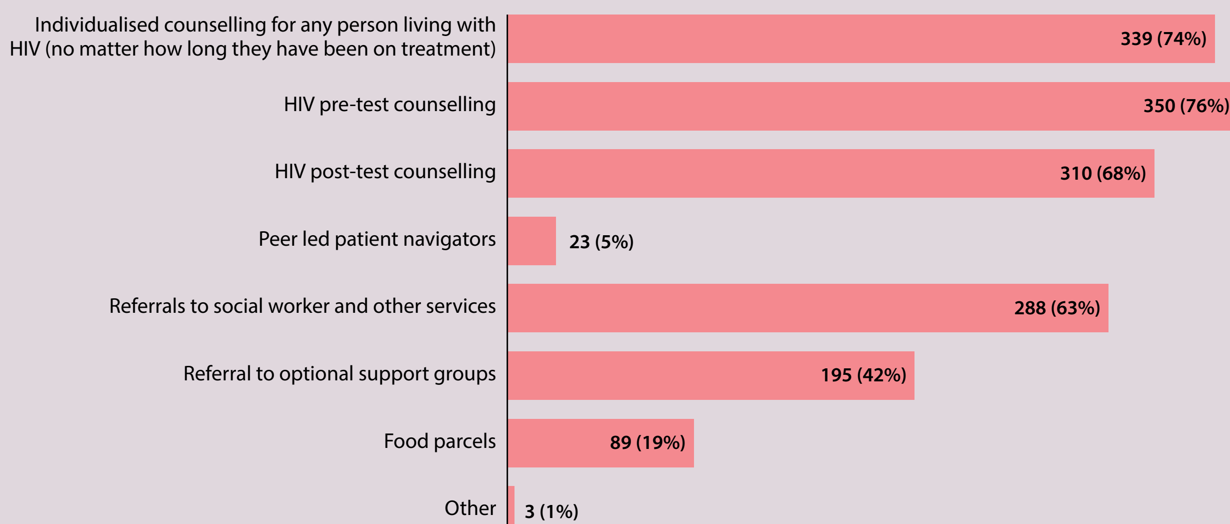


Figure 46: The types of psycho-social support that people living with HIV know are available (April to May 2023)
PLHIV Surveyed: 459

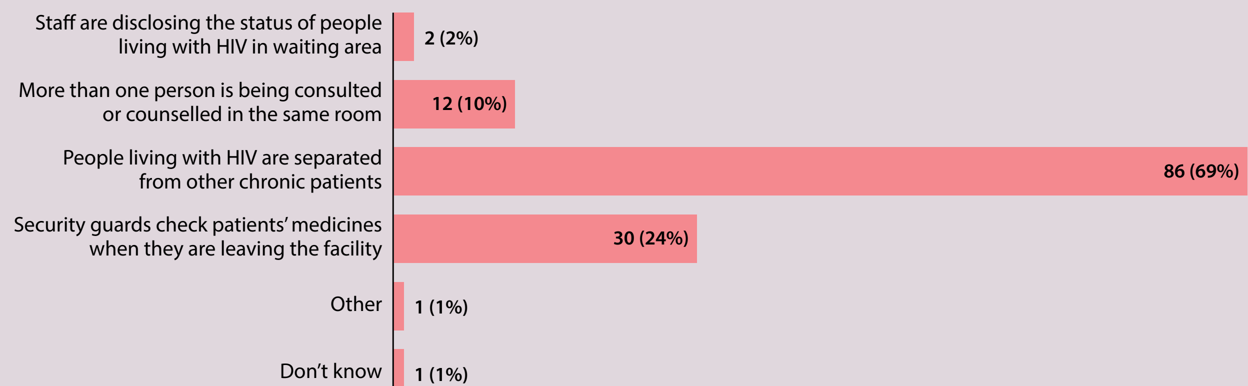
Figure 47: The types of psycho-social support that people living with HIV know are available per district (April to May 2023)

District	Number of facilities assessed	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 social worker and other services	Referral to optional support groups	Food parcels
Bojanala Platinum	4	122	28	122	120	15	28	27	9
Dr Kenneth Kaunda	6	187	167	183	164	5	114	123	3
Ngaka Modiri Molema	6	150	144	45	26	3	146	45	77

Another reason people stop going to the clinic is where privacy violations occur. Of 526 people living with HIV interviewed, only 71% feel that facilities keep their HIV status private and confidential, down from 73% last year.

More must be done to ensure that everyone can access private and confidential healthcare. People living with HIV being separated from other chronic patients was the main reason people felt privacy was being violated (Figure 48).

Figure 48: Reasons why people living with HIV felt privacy is being violated (April to May 2023)
PLHIV Surveyed: 125



6. Treatment + Viral Load Literacy

2021

99% of PLHIV had a viral load test in the last year

93% PLHIV said that a healthcare provider had explained the results

97% agreed that having an undetectable viral load means treatment is working well

75% agreed that having an undetectable viral load means a person is not infectious

2022

98% of PLHIV had a viral load test in the last year

100% of PLHIV said that a healthcare provider had explained the results

73% agreed that having an undetectable viral load means treatment is working well

75% agreed that having an undetectable viral load means a person is not infectious

2023

98% of PLHIV had a viral load test in the last year

85% of PLHIV said that a healthcare provider had explained the results

77% agreed that having an undetectable viral load means treatment is working well

62% agreed that having an undetectable viral load means a person is not infectious

RECOMMENDATION

NORTH WEST DEPARTMENT OF HEALTH

1. Ensure all DOH staff **provide accurate and easily understandable information on treatment literacy and adherence**, and the importance of an undetectable viral load through consultations, counselling, and outreach
2. Ensure that **treatment literacy information is provided at health talks** each day at the clinic
3. Ensure that DOH staff **explain viral load test results to all PLHIV properly** in a timely manner

RECOMMENDATIONS

THE AURUM INSTITUTE

1. Ensure all DSP staff **provide accurate and easily understandable information on treatment literacy and adherence**, and the importance of an undetectable viral load through consultations, counselling, and outreach
2. Ensure that DSP staff **explain viral load test results to all PLHIV properly** in a timely manner

RECOMMENDATIONS

PEPFAR

1. Fund an **expansion of PLHIV + KP led treatment literacy efforts** across all provinces, through training, education and localised social mobilisation campaigns

Treatment literacy also improves ART continuity as people understand the importance of starting and remaining on treatment effectively. Of the 527 people living with HIV surveyed, 98% had received a viral load test in the last year, yet only 90% reported that they knew their viral load. Only 77% agreed with the statement; "having an undetectable viral load means the treatment is working well" (Figure 49) — just up from 73% last year — and only 62% agreed with the statement "having an undetectable viral load means a person cannot transmit HIV" — down from 75% last year (Figure 50). There remain significant gaps in knowledge and treatment literacy.

Figure 49: Treatment Literacy: Do PLHIV understand viral load and their health? (April to May 2023)
PLHIV Surveyed: 526

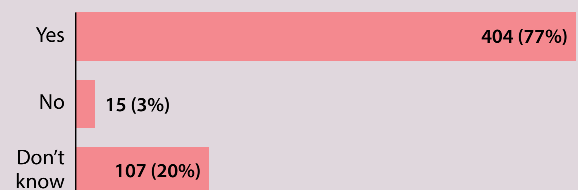
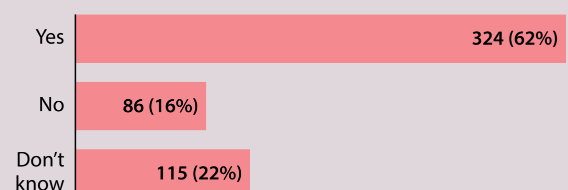


Figure 50: Treatment Literacy: Do PLHIV understand viral load and transmission? (April to May 2023)
PLHIV Surveyed: 525



> **It is critical that healthcare workers explain people's viral load test results in a timely manner.**

Only 85% of those surveyed said a healthcare worker had explained the results of their viral load test. It is critical that healthcare workers explain people's viral load test results in a timely manner and ensure that the message that an undetectable viral load is beneficial for your own health and prevents transmission (U=U) is better communicated. The tables show the best (Figure 51 and Figure 52) and worst (Figure 53 and Figure 54) performing sites on these indicators. By district, Ngaka Modiri Molema performed best, with all sites getting perfect scores in both indicators. Most sites in Dr Kennth Kaunda got perfect scores in understanding treatment is working well, but most were in the worst performing in understanding U=U. Sites in Bojanala Platinum performed badly across both indicators.

Figure 51: Facilities with perfect scores on people living with HIV understanding that an undetectable viral load is beneficial for their own health (April to May 2023)

District	Facility	Surveys collected	Yes	No	Don't know	Score
Dr Kenneth Kaunda	Jouberton CHC	25	25	0	0	100%
	Majara Sephapho Clinic	36	36	0	0	100%
	Park Street Clinic	25	25	0	0	100%
	Tsholofelo Clinic	25	25	0	0	100%
Ngaka Modiri Molema	Itsoseng Clinic	25	25	0	0	100%
	Lonely Park Clinic	25	25	0	0	100%
	Miga Clinic	25	25	0	0	100%
	Montshioa Stadt CHC	25	25	0	0	100%
	Ramatlabama CHC	25	25	0	0	100%
	Unit 9 CHC	25	25	0	0	100%

Figure 52: Facilities with perfect scores on people living with HIV understanding that an undetectable viral load means a person cannot transmit HIV (April to May 2023)

District	Facility	Surveys Completed	Yes	No	Don't know	Perfect score
Ngaka Modiri Molema	Itsoseng Clinic	25	25	0	0	100%
	Lonely Park Clinic	25	25	0	0	100%
	Miga Clinic	25	25	0	0	100%
	Montshioa Stadt CHC	25	25	0	0	100%
	Ramatlabama CHC	25	25	0	0	100%
	Unit 9 CHC	25	25	0	0	100%

Figure 53: Facilities with worst scores on people living with HIV understanding that an undetectable viral load is beneficial for their own health (April to May 2023)

District	Facility	Surveys Completed	Yes	No	Don't know	Score
Bojanala Platinum	Letlhabile CHC	30	1	6	23	3%
	Bapong CHC	28	2	1	25	7%
	Boitekong Clinic	20	4	1	15	20%
	Tlhabane CHC	51	24	6	21	47%
	Mogwase CHC	27	14	0	13	52%
	Bafokeng CHC	32	23	0	9	72%

Figure 54: Facilities with worst scores on people living with HIV understanding that an undetectable viral load means a person cannot transmit HIV (April to May 2023)

District	Facility	Surveys Completed	Yes	No	Don't know	Score
Bojanala Platinum	Letlhabile CHC	29	1	6	22	3%
Bojanala Platinum	Bapong CHC	28	2	1	25	7%
Bojanala Platinum	Boitekong Clinic	20	3	0	17	15%
Dr Kenneth Kaunda	Grace Mokgomo CHC	34	13	21	0	38%
Bojanala Platinum	Tlhabane CHC	51	21	5	25	41%
Dr Kenneth Kaunda	Tsholofelo Clinic	25	12	12	1	48%
Dr Kenneth Kaunda	Alabama Clinic	43	22	19	2	51%
Bojanala Platinum	Mogwase CHC	27	14	0	13	52%
Dr Kenneth Kaunda	Jouberton CHC	25	16	9	0	64%
Dr Kenneth Kaunda	Park Street Clinic	25	17	8	0	68%
Bojanala Platinum	Bafokeng CHC	32	22	0	10	69%

7. Key Populations

Only 30% of trans* people say that clinic staff are always friendly and professional

Only 15% of gay, bisexual, or another man who has sex with men (GBMSM) feel very safe at the facility

Only 6% of people who use drugs feel very comfortable at the facility

14% refused access to health services because they are a sex worker

42% of sex workers say that privacy is not well respected at the facility

Only 25% of facilities monitored had lubricants available

Only 7% of people who use drugs given information about accessing methadone at facilities

Only 17% of sex workers report being offered PrEP at the facility

58% of trans* people want hormone therapy to be available at facilities

Only 37% of sex workers would feel comfortable accessing post-violence services at the facility

RECOMMENDATIONS

NORTH WEST DEPARTMENT OF HEALTH

1. **Ensure that all clinical and non-clinical staff (including security guards) across public health facilities are sensitised on provision of KP friendly services** to ensure a welcoming and safe environment for all KPs at all times. KPs must be involved in the implementation of these training modules
2. **Any reports of poor staff attitude, privacy violations, verbal or physical abuse/harassment and/or of services being restricted or refused should be urgently investigated**
3. **Expand the Centre of Excellence model to ensure that at least 2 public health facilities *per population* per district serve as key population designated service delivery centres.**
   a. A minimum package of services (as outlined in Figure 71) should be made available at these facilities.
   b. Easy referral and adequate resources (including transport/money for transport) must be provided for people to take up these services.
4. **Ensure that HIV prevention tools including lubricants, external and internal condoms, PrEP, and PEP are made easily available at all public health facilities.**
   a. Make available external and internal condoms as well as lubricants in a range of spaces across the facility (i.e., waiting areas, toilets, gate, pharmacy, consultation rooms, quiet areas out of site) so people can freely and easily collect them
   b. Ensure that PrEP is offered to everyone, including key populations who are not living with HIV/test negative for HIV, with information shared on its benefits
   c. Ensure no staff members ever tell key populations to use vaseline or other oil based lubricants instead of water or silicone based lubes

RECOMMENDATIONS

PEPFAR

1. **Expand the Centre of Excellence model to ensure that at least 2 public health facilities *per population* per district serve as key population designated service delivery centres.**
   a. A minimum package of services (as outlined in Figure 71) should be made available at these facilities.
   b. Easy referral and adequate resources (including transport/money for transport) must be provided for people to take up these services
   c. PEPFAR must support these facilities with additional staff and resources to provide comprehensive health services to the specific key population being served
2. **Ensure that HIV prevention tools including lubricants, external and internal condoms, PrEP, and PEP are made easily available at all public health facilities.**
   a. Make available condoms and lubricants in a range of spaces across the facility (i.e., waiting areas, toilets, gate, pharmacy, consultation rooms, quiet areas out of site) so people can freely and easily collect them
   b. Ensure that PrEP is offered to everyone, including key populations who are not living with HIV/test negative for HIV, with information shared on its benefits
   c. Ensure no staff members ever tell key populations to use vaseline or other oil based lubricants instead of water or silicone based lubes

Public health facilities are the entry point for many key populations into the health system, therefore it is critical to ensure a friendly, respectful, safe, and confidential environment for all, with services that cater to key population specific needs. Yet despite sensitisation training and retraining efforts, disrespect, ill-treatment, and dehumanisation of key populations remain a widespread challenge. Key populations who are treated badly, humiliated, fear their safety, or even refused entry, will inevitably not come back to the facility.

Ritshidze data reveal that staff at public health facilities were less friendly and professional to key populations compared to drop-in centres and mobile clinics (Figure 55). This is consistent across all key population groups. Clinical staff were again this year the most commonly reported as being unfriendly and unprofessional by all key population groups followed by security staff (Figure 56). Overall people who use drugs faced the most unfriendly services across key population groups.

> ***"The way I see it, some of the LGBTQI community members do not feel comfortable at the facility. They would prefer to be attended to by someone who is also part of the LGBTQI community. If one of us is in the clinic, more people would feel more comfortable to come there. Our community clinics don't have queer staff members which makes it not a safe space for us"*** *— a gay person using Boitekong Clinic (Bojanala Platinum), interviewed in May 2023*

> ***"I was raped and went to the clinic, they said to me that they don't believe me, that we gays like to sleep around. I was showing them all the bruises, cuts, and I was bleeding. I asked them if this is how I should look if it was consensual sex. One of them said just give him antibiotics so he can just go as we are not buying anything he is saying. It was on a Wednesday afternoon, I had to heal on my own, even my family did not believe me, the people at the clinic did not believe me, who then do I go to?"*** *— a trans woman using Boitekong Clinic (Bojanala Platinum), interviewed in June 2023*

> ***"I went to Marikana Clinic to test for HIV and the test came back positive. I was judged by the nurses saying things like "vele HIV ke ya di Gay", meaning obvious HIV is for the gays. I tried to get a transfer so I can get my ARVs in another clinic but I was denied that letter. Now I am always stressed when it is time to go to the clinic again for a checkup"*** *— a gay man using Marikana Clinic (Bojanala Platinum), interviewed in April 2023*

> ***"When I went to the clinic, the sister that was attending to me was like "ausi or abuti what are you here for?" And when she goes back to the room, that's when you become their topic, that there is a gay guy that looks like a woman and they'd make you feel uncomfortable because you can see that everyone just wants to see the gay that looks like a woman. So when I have to go to the clinic I always have doubts because they always make me feel uncomfortable"*** *— a trans woman using Tlhabane CHC (Bojanala Platinum), interviewed in June 2023*

> ***"The services at the clinic are not that bad but the staff are quick to judge you which makes me feel uncomfortable. I cannot tell the nurses about personal things, I just ask general questions, it is only when I get to the doctor that I can disclose what exactly is wrong with me"*** *— a gay man, using Unit 9 Clinic (Ngaka Modiri Molema), interviewed in June 2023*

> ***"I once visited Motlhabeng Clinic where I usually go to because I had a pimple on my butt thinking it was anal warts. I was judged and asked if I don't use lubricants during intercourse"*** *— a gay man, using Motlhabeng Clinic (Ngaka Modiri Molema), interviewed in June 2023*

Figure 55: Percentage of key populations reporting staff are always friendly and professional (July to September 2022)

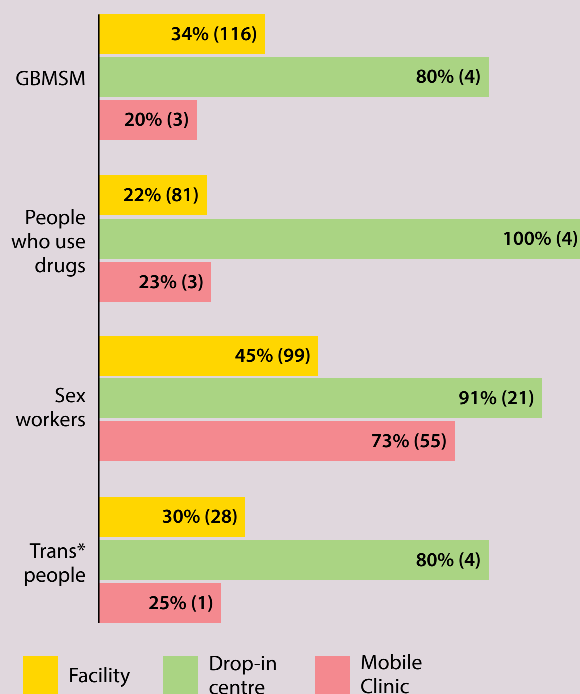
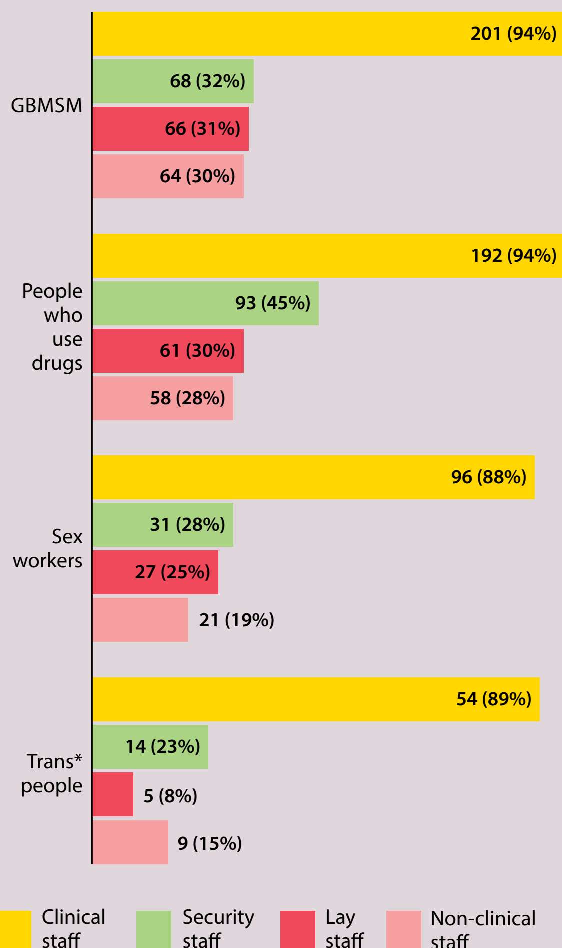


Figure 56: Percentage of staff that are unfriendly and unprofessional by key population group and staff type (July to September 2022)



The majority of key populations interviewed did not feel safe or comfortable at the facility (Figures 57 and 58). In order for key populations to access health services and in particular key population specific services, spaces are needed that feel private enough to disclose you are a member of a key population group without fear of judgement, abuse, harassment, or even arrest.

Figure 57: Percentage of key populations reporting they feel very safe accessing services at the facility (July to September 2022)

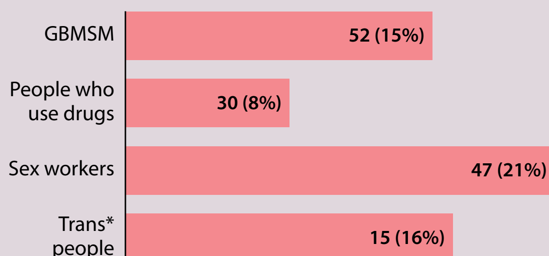
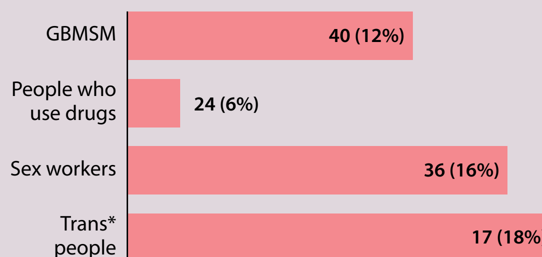


Figure 58: Percentage of key populations reporting they feel very comfortable accessing services at the facility (July to September 2022)



Disgraceful privacy violations continue to occur that destroy people's right to privacy and make clinics feel unsafe and uncomfortable to be in (Figure 59). This year 43% of GBMSM, 38% of people who use drugs, 42% of sex workers, and 48% of trans* people did not think privacy is well respected at clinics.

> ***"They will also scream that people that are living with HIV should come to this queue. That makes me very uncomfortable because I did not disclose my status to my family yet, and there are some people that know me at the clinic so they now know about my status"*** *— a trans woman, using Jouberton CHC (Dr Kenneth Kaunda), interviewed in May 2023*

> ***"The experience is not good, LGBTQI people require privacy and that is not there at the clinic. They disclose people's HIV status. The last time I went there, while I was taking my vitals, they were talking about some other guy and just left his file where I could see"*** *— a gay man using Grace Mokhomo CHC (Dr Kenneth Kaunda), interviewed in May 2023*

> ***"There is no privacy at all. The last time I was there, I was taking bloods, there were like 3 or 4 nurses in the room. It was uncomfortable to have so many people present because I felt they would all be curious to want to see the test results, they would want to find out what is wrong with this trans* person. Even when you are consulting, a nurse can just barge in to ask for something. It is just uncomfortable"*** *— a trans woman using Tlhabane CHC (Bojanala Platinum), interviewed in June 2023*

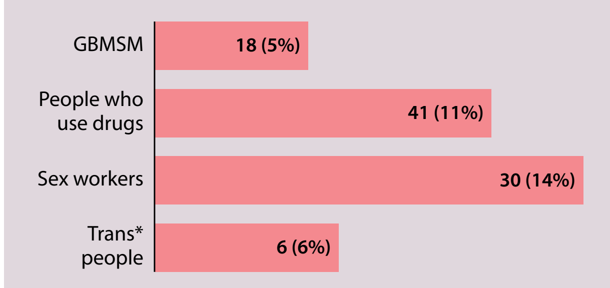
> ***"The other time while I was there, my testicles were sore but I could not mention that because there were alot of people in the consulting room. It was only when I got to the doctor that I was able to tell him about the symptoms and he prescribed medication for it"*** *— a trans woman using Tlhabane CHC (Bojanala Platinum), interviewed in June 2023*

Figure 59: Percentage of key populations reporting they feel privacy is not well respected at facilities (July to September 2022)

	Respondents who think privacy is not well respected at facilities, % (n)	Most common privacy violations
GBMSM	43% (145)	Disclosure of HIV status (52%), disclosure that respondent is GBMSM (48%), healthcare workers call other staff into the consultation room to share medical issues (46%), patients are consulted in the same room together (32%)
People who use drugs	38% (141)	Disclosure that the respondent is a person who uses drugs (73%), disclosure of HIV status (45%), healthcare workers call other staff into the consultation room to share medical issues (31%), patients are consulted in the same room together (31%), security checks medicines as people leave facility (21%)
Sex workers	42% (92)	Disclosure of HIV status (58%), disclosure respondent is a sex worker (51%), patients are consulted in the same room together (23%), healthcare workers call other staff into the consultation room to share medical issues (20%), staff enter the room during your consultation without knocking (20%)
Trans* people	48% (45)	Disclosure respondent is trans* (53%), disclosure of HIV status (42%), patients are consulted in the same room together (20%), staff enter the room during your consultation (18%), healthcare workers call other staff into the consultation room to share medical issues (15%)

Shockingly, significant numbers of key populations reported being refused access to services in the last year because of being someone who uses drugs, is a sex worker, or is a part of the LGBTQIA+ community — including 5% of GBMSM, 11% of people who use drugs, 14% of sex workers, and 6% of trans* people (Figure 60). This is absolutely unacceptable and goes against Section 27 of the Constitution.

Figure 60: Percentage of key populations who had been refused access to services at the facility because they are a KP (July to September 2022)



Where the attitudes of clinic staff have become unbearable, some people have stopped going to the facility altogether, including for HIV, TB and STI testing and treatment. Overall 10% of GBMSM, 17% of people who use drugs, 11% of sex workers, and 5% of trans* people we interviewed in the province were not receiving services anywhere. The most common reasons given for not going to the facility include: a lack of friendly services, lack of privacy, and a lack of safety — as well as a fear people would find out they are someone who uses drugs, a sex worker, or part of the LGBTQIA+ community.

Compared to public health facilities, drop-in centres and mobile clinics generally performed better from the perspective of all key population groups in terms of service acceptability and service availability. However, most key populations we interviewed are not using either a drop-in centre or mobile clinic to access services but public health facilities. In fact, Ritshidze data show that a very high proportion of key populations are not even aware of any drop-in centres — including 83% of GBMSM, 62% of people who use drugs, 72% of sex workers, and 64% of trans* people.

Ritshidze data show that key populations do not all live in certain "hotspots" or "high transmission areas". We support drop-in centres but they are not a panacea to the challenge of improving services for key populations. Public health facilities must also be drastically improved to ensure key populations can access the services they need in a friendly, safe, and welcoming way.

Additionally, given the disproportionate burden of HIV and violence that key populations face, as well as the additional health needs, it is critical that key populations can access specific services to meet specific needs. Yet where key populations do continue to suffer the daily indignities of using the public health system, specific services remain unavailable for the most part.

Lubricants, for example, are only freely available in 25% of the 67 facilities monitored (Figure 61) and in those sites too often the lubricants are put in spaces where staff and community members can see as you collect them (Figure 62).

"After we tested negative for HIV, this other nurse came with like 6 packets of condoms each and said I hope you use these forever. And we were surprised, why would she be giving us such a number, she said I know how you guys are. She said the government doesn't provide them with lubricants so they don't have it" *— a trans woman using Boitekong CHC (Bojanala Platinum), interviewed in June 2023*

"You normally do not find lubricants at the clinic but you will find condoms. They will tell you lubes are out of stock" *— a gay man using Karlien Park Clinic (Bojanala Platinum), interviewed in May 2023*

"There are no services for LGBTQI people. You can only see the MAX condoms there but you cannot get lubricants. If you want to get lubes, you have to go to the NGOs, which is very far. And most of us cannot afford to go there" *— a trans woman using Tlhabane CHC (Bojanala Platinum), interviewed in June 2023*

"You will always have to ask for condoms and lubricants, and most of the time they will tell you that it is out of stock" *— a gay man using Grace Mokhomo Clinic (Dr Kenneth Kaunda), interviewed in May 2023*

"The clinic staff are not friendly, I never see condoms or lubricants in the clinic, and I am too embarrassed to ask for it" *— a gay man using Tigane CHC (Dr Kenneth Kaunda), June 2023*

Figure 61: Are condoms and lubricant available at the facilities? (April to May 2023)
Observations completed: 67

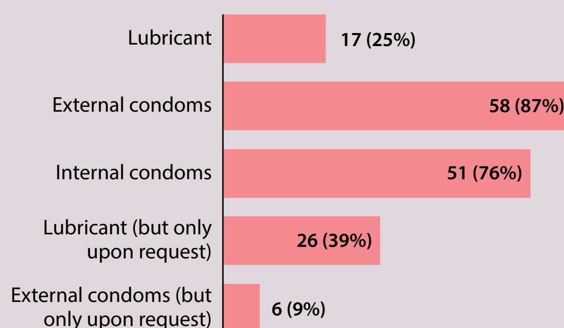
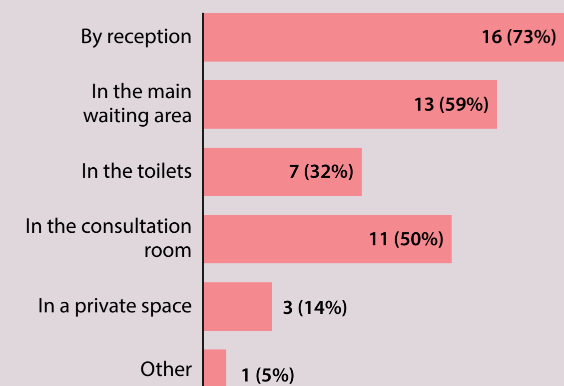


Figure 62: Where lubricants are located at facilities (April to May 2023)
Observations completed: 22



Service accessibility must be improved to ensure that people who use drugs needs are met and no additional barriers are created to being able to take drugs safely, or be supported to stop.

Figure 63: Lubricant access at facilities (July to September 2022)

	GBMSM	People who use drugs	Sex workers	Trans* people
% aware they should be able to get lubricant (lube) at all public health facilities	35% (120)	16% (50)	58% (127)	38% (35)
% tried to access lube	30% (103)	10% (32)	43% (94)	23% (21)
Among those seeking lube, % always able to get it	44% (45)	31% (10)	38% (36)	43% (9)
% reporting staff are always respectful when asked for lube	41% (43)	19% (6)	49% (46)	33% (7)
Among those able to get lube, % always able to get enough	56% (42)	29% (6)	43% (34)	46% (6)

Not all facilities prioritise offering key populations PrEP (Figure 64) and far fewer report being actively offered it (Figure 65), despite it being widely available in facilities monitored by Ritshidze.

"When I go to the clinic with my friends for an HIV test, you hear the things that the staff says. They say it right in front of you. They would say "we would not be surprised if you guys test positive for HIV because we know all gays love to sleep with different men. And when the tests come back negative, we get told that we must take care of ourselves because it is only a matter of time before we get HIV. They don't tell you about PrEP at the clinic, but only from places like LifeLine" *— a trans woman using Boitekong Clinic (Bojanala Platinum), interviewed in June 2023*

"I have done an HIV test there before, but because the staff are from my area, she did not talk at all. It was a quiet moment. She just showed me the results. They did not offer me PrEP" *— a trans woman using Tlhabane CHC (Bojanala Platinum), interviewed in June 2023*

Figure 64: Does the facility prioritise offering PrEP to any of the following populations? (April to May 2023)
Facility Staff Surveyed: 76

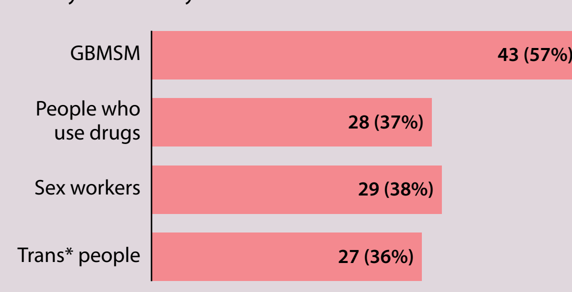


Figure 65: PrEP access at facilities (July to September 2022)

	GBMSM	People who use drugs	Sex workers	Trans* people
% heard of PrEP	55% (188)	25% (78)	65% (144)	64% (59)
Among those not living with HIV, % ever offered PrEP	28% (8)	5% (20)	17% (38)	11% (10)
Among those offered PrEP, % who ever received it	89% (25)	9% (7)	84% (32)	55% (6)
% very satisfied with PrEP services	28% (7)	43% (3)	34% (11)	33% (2)

Widespread access to harm reduction services (like methadone and unused needles) or gender affirming care (including hormones) remain outside the reach of most of the people they are meant to serve.

Those who have tried to access harm reduction services are often left without services, or any information on where they could get them. Only 5% of people who use drugs were offered information about where they could get new needles, only 7% were given information on where to get methadone, and only 2% able to access drug dependence support (Figure 66). Service accessibility must be improved to ensure that people who use drugs needs are met and no additional barriers are created to being able to take drugs safely, or be supported to stop.

The availability of gender affirming services for those who need them is critically important. Yet only 33% of trans* people say facility staff are respectful of their gender identity — 74% said that healthcare providers use their wrong names and 52% said they use their wrong pronouns.

Figure 66: Access to methadone at facilities (July to September 2022)

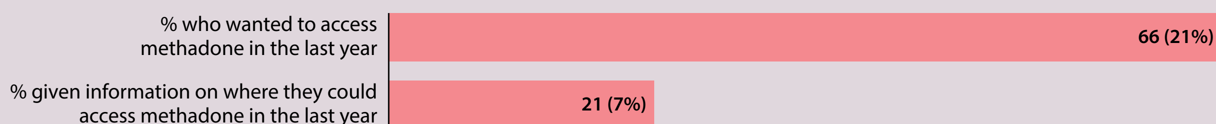


Figure 66: Access to new needles at facilities (July to September 2022)

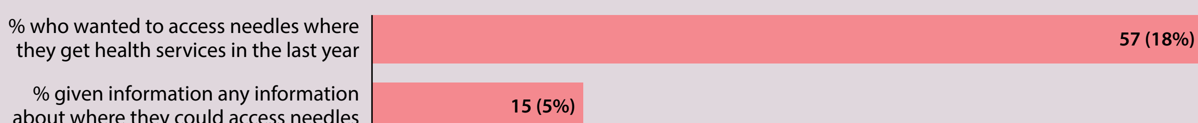


Figure 66: Access to drug dependence support at facilities (July to September 2022)

"There are a lot of challenges. Sometimes they would not ask me how I identify, they would just scream my surname and ask "are you a man or a woman. They do not respect your pronouns or use the name that you want" *— a trans woman, using Jouberton CHC (Dr Kenneth Kaunda), interviewed in May 2023*

"I try not to use the toilets at the clinics because of the experience I had, they told me that you are not a woman, you are a man so you must use the male toilet. Since then, I will go to my friend's place near the clinic to use the toilet" *— a trans woman, using Jouberton CHC (Dr Kenneth Kaunda), interviewed in May 2023*

"Going to the clinic, the experience is always bad. Recently, I was referred to as a man by the receptionist even when I was wearing a dress and had make-up on. And everyone was laughing, it was like he just wanted to make fun of me" *— a trans woman using Boitekong Clinic (Bojanala Platinum), interviewed in June 2023*

"They misgender me and never want to call me by my preferred name" *— a trans woman using Tlhabane CHC (Bojanala), interviewed in June 2023*

"The problem is when you get there as a trans* person, they do not have someone who is part of the LGBTQI community that you can be comfortable with. Their problem is that they do not know how to talk to us (trans* people), they are unsure if they should be addressed as men or women. They would say things like "you look like a girl but your ID says male", that is one of our general issues" *— a trans woman using Tlhabane CHC (Bojanala Platinum), interviewed in June 2023*

"I think the staff need more education. I am not comfortable with the way they address me. They refer to me as "he" when I prefer to be called "she". And because you are in need of assistance, you just keep quiet and do not want to speak. You just take the abuse so you can be helped" *— a trans woman, using Jouberton CHC (Dr Kenneth Kaunda), interviewed in May 2023*

In addition to the psychological impact of gender dysphoria, in the context of South Africa, a country rife with transphobia and attacks on trans* individuals, access to hormone therapy could mean life or death. The majority of trans* people we spoke to, 58%, wanted access to hormone therapy at public health facilities (Figure 67). However, gender affirming care is mostly only available in big cities. Trans* people who do not live near these cities must travel long distances to get these services. This keeps it out of reach for those without access to transport money and places to stay.

Key populations are at times refused access to contraceptives specifically because they are a member of a key population group (Figure 68).

> ***"I went to the clinic to ask for hormones as it was out of stock where I usually got them from. The nurse was shocked, she did not know what hormones were but she asked me to come to see the doctor the next day. The doctor too was unable to help me but tried to check with another doctor from JST Hospital but that one too did not know about hormones. It seems most healthcare practitioners in government facilities do not know much about trans* people or the LGBTQIA community as a whole"*** *— a trans woman using Tlhabane CHC (Bojanala Platinum), interviewed in June 2023*

> ***"I asked the nurse if she knew about hormone replacement, and she replied: "you think you are better, for that you must go to a private hospital". I was just asking where I can get hormones from. She said this is a public clinic, they don't offer such. I just cut the conversation and left. She was rude and did not provide any information"*** *— a trans woman, using Jouberton CHC (Dr Kenneth Kaunda), interviewed in May 2023*

Figure 67: Access to hormones at facilities (July to September 2022)

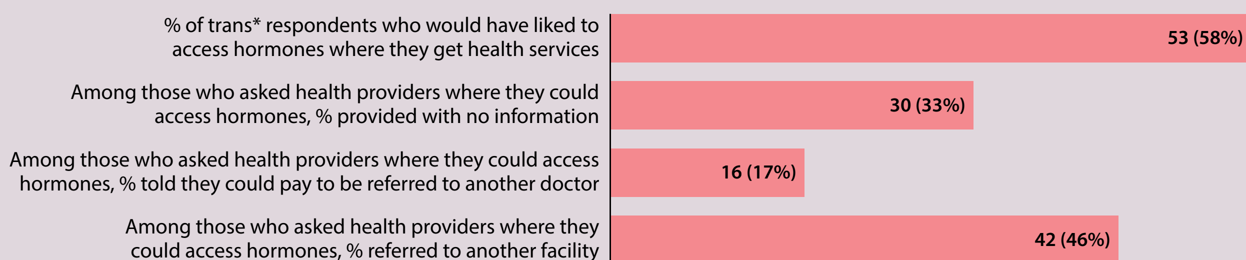


Figure 68: Contraceptive access at facilities (July to September 2022)

	People who use drugs	Sex workers	Trans* people
% able to get the contraception they wanted	66% (85)	62% (78)	66% (19)
Top reasons they were unable to get the contraception they wanted	First choice was not available (29%), were told there was a stockout (21%), were told they couldn't have it because they use drugs (21%), were told they had to come back (3%), were told they were too young (3%)	Were told they could not have it because they are a sex worker (35%), first choice was not available (35%), were told they had to come back (30%), were told there was a stockout (16%), were told there were no pregnancy tests (3%)	Were told they had to come back (43%), were denied because they are trans* (43%)

South Africa faces a well documented epidemic of gender based violence including homophobic and transphobic attacks on LGBTQIA+ community members (Figure 69). Sex workers also face extreme levels of violence and forced sex at the hands of clients, partners, and even police. It is critical that key populations who face sexual violence feel safe enough to access the necessary services at the clinic such as HIV testing & PEP, STI treatment, emergency contraceptive, J88 forms, rape kits, counselling, and referral to domestic violence shelters. However, the majority of key populations interviewed did not think staff were well trained to care for those who have experienced violence.

Figure 69: Sexual violence services at facilities (July to September 2022)

	GBMSM	Sex workers	Trans* people
% who feel staff are well trained to care for those who experience violence from a sexual partner	24% (81)	39% (85)	22% (20)
% who would feel comfortable seeking care if they experienced violence from a sexual partner	33% (112)	60% (131)	37% (34)
Among those who needed them, % reporting staff were always respectful when seeking post-violence services	66% (19)	61% (25)	67% (2)
Among those who needed them, % reporting they were able to access post-violence services	72% (21)	73% (30)	67% (2)

Not everyone who wanted to access STI treatment was able to at the facility (Figure 70). Too often we hear reports of key populations being discriminated against or staff acting in a hostile manner to those trying to access these services.

A minimum package of key population specific services (Figure 71) should be made available at at least two public health facilities, per key populations group, per district — to meet the specific needs of key populations at public health facilities. One site per district as planned remains inadequate in districts that are often vast. Additionally, where key populations need specialised care from a drop-in centre, or public health facility providing specialised care, easy referral and adequate resources (including transport or transport costs) should be provided to ensure uptake of those services.

Figure 70: STI service access at facilities (July to September 2022)

	GBMSM	Sex workers	Trans* people
Among those seeking STI testing, % always able to access it	66% (47)	69% (48)	65% (11)
% of staff always respectful when asking for STI testing	62% (44)	71% (50)	71% (12)
Among those needing STI treatment, % able to access it	79% (44)	75% (48)	62% (8)

FIGURE 71: 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
+ Psycho-social support
+ Mental health services
+ Information packages for sexual health services
+ GBMSM friendly STI prevention, testing & treatment
+ GBMSM friendly Hepatitis C (HCV) screening, diagnosis and treatment
+ Treatment or support services for GBMSM who use drugs

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)
+ Risk reduction information
+ Wound and abscess care
+ Unused needles, syringes, or other injecting equipment
+ Overdose management and treatment (e.g. naloxone)
+ Vaccination, diagnosis, and treatment of viral hepatitis (including HBV, HCV)
+ Pre-Exposure Prophylaxis (PrEP) including MMD and community refill collection
+ Post-Exposure Prophylaxis (PEP)
+ Lubricant
+ External condoms
+ Internal condoms
+ 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 groups
+ Psycho-social support
+ Mental health services
+ Information packages for sexual and reproductive health services
+ PWUD friendly STI prevention, testing & treatment
+ Hepatitis C (HCV) screening, diagnosis and treatment
+ Cervical cancer screening

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
+ 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
+ Psycho-social support
+ Mental health services
+ Non barrier contraception (including the pill, IUD, implant, injection)
+ Information packages for sexual and reproductive health services
+ Gender-based violence services on site or by referral
+ Sex worker friendly STI prevention, testing & treatment
+ Cervical cancer screening
+ Treatment or support services for sex workers who use drugs

TRANS* PEOPLE

+ Transgender outreach services
+ Pre-Exposure Prophylaxis (PrEP) including MMD and community refill collection
+ Post-Exposure Prophylaxis (PEP)
+ Lubricant
+ External condoms
+ Internal condoms
+ 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
+ Psycho-social support
+ Mental health services
+ Hormone therapy
+ Non barrier contraception (including the pill, IUD, implant, injection)
+ Information packages for sexual and reproductive health services
+ Gender-based violence services on site or by referral
+ Trans friendly STI prevention, testing & treatment
+ Cervical cancer screening
+ Hepatitis C (HCV) screening, diagnosis and treatment
+ Treatment or support services for transgender people who use drugs

ALL KPS

+ Peer educators/navigators at the facility level

A minimum package of key population specific services (Figure 71) should be made available at at least two public health facilities, per key populations group, per district — to meet the specific needs of key populations at public health facilities.

COMMUNITY STORY

"If I had to choose I would choose to be straight," says a frustrated Omphemetse*. She's a lesbian and proud of who she is, but she also feels beat down and sick and tired of the treatment she and her wife receive at Lonely Park Clinic in Mafikeng.

Omphemetse says the latest incident of discrimination took place early this year. Her wife, identified here as Cee*, went to the clinic for a pap smear. Omphemetse says Cee was told she would only be treated if she took a pregnancy test and an HIV test.

"She told the nurses she's a married lesbian woman. She knows who she is and doesn't want to do the tests. They refused to treat her, saying the two tests are clinic protocol. In the end, Cee had to do the tests, she had no choice. And then at the end of it all the nurses told her they couldn't do a pap smear because they didn't have the materials," she says.

Omphemetse says: "We are treated unfairly at Lonely Park. I have been at the clinic when all they want is to do is make a spectacle of you if you are gay or lesbian. They will even ask 'how do you do it' — about my sex life — I couldn't believe it."

She says there is no privacy at the clinic and nurses are offensive and have left her and wife feeling humiliated.

"Everything is wrong at that clinic — from the reception to being in the consulting room. They will take a whole hour just to find your file because they are chatting and joking instead of doing their jobs. In the consultation there isn't just one nurse attending to you because the nurse will keep calling over other nurses. Sometimes they are on their phones even there in the consultation room," says Omphemetse.

One time Omphemetse, in retaliation she says, pulled out her own phone and started taking photos and recording the nurses. This led to an argument and she demanded the right to lay a formal complaint.

"The head nurse, instead of listening to me, ended up also arguing with me. I wrote that complaint, I even wanted a clinic stamp on it but nothing came of that," she says.

Omphemetse says she no longer wants to keep quiet about the discrimination and the unprofessional service at Lonely Park Clinic. She says the government must train nurses better but there must also be improved channels for complaints to be dealt with properly and for there to be resolution to complaints.

"These things must go to a higher level because these nurses can't be allowed to carry on this way. Even now when I am sick I can't go to that clinic — I would rather suffer in my house than to go there — this is not right at all," she says.

** Name changed to protect identity*

COMMUNITY STORY

One nurse can make all the difference to improve public healthcare users' experience. Botho* cannot speak highly enough of a particular nurse at Ramatlabama Clinic in Mafikeng.

She doesn't know the man's name even but she says that in the three years that he's started working at the clinic, the mood and atmosphere at the clinic has changed for the better. Patients seem to be happier when he is on duty, she says.

"I can't even say what it is that he is doing but I think it's because he talks to people, he treats the patients nicely and he has patience with us," she says.

Botho has used Ramatlabama Clinic for the past eight years but was first diagnosed with HIV in 2010. She says people always used to complain about the bad service and the bad attitude at the clinic until this nurse arrived.

The nurse is an openly gay man, Botho says. It's only a significant point because his presence makes the LGBTQIA+ community feel more welcome in the clinic. It has been a call by the LGBTQIA+ community to have more people from the LGBTQIA+ community employed in public service — from nurses, social services to policing and the judiciary. It's a way to ensure that there is more presence, inclusion, diversity, tolerance and understanding.

"He treats everyone with a smile and with a good, professional attitude and that's all that every patient wants," Botho says.

** Name changed to protect identity*

8. Index Testing

2021

91% of PLHIV were told they were allowed to refuse to give the names of their sexual partners for index testing

82% of PLHIV reported that they were asked about the risk of violence from their partner

92% of facilities always screen PLHIV for intimate partner violence

45% of facilities trace all contacts regardless of reports of violence reported violence

2022

62% of PLHIV were told they were allowed to refuse to give the names of their sexual partners for index testing

65% of PLHIV reported that they were asked about the risk of violence from their partner

85% of facilities always screen PLHIV for intimate partner violence

45% of facilities trace all contacts regardless of reports of violence reported violence

2023

72% of PLHIV were told they were allowed to refuse to give the names of their sexual partners for index testing

73% of PLHIV reported that they were asked about the risk of violence from their partner

81% of facilities always screen PLHIV for intimate partner violence

29% of facilities trace all contacts regardless of reports of violence reported violence

RECOMMENDATIONS

NORTH WEST DEPARTMENT OF HEALTH

1. Follow all protocols outlined in the National Department of Health guidelines on index testing including that:
   a. Index testing is always voluntary
   b. All healthcare providers **ask if the individual's partners have ever been violent** and record the answer to this question, before contacting the sexual partners
   c. **No contacts who have ever been violent or are at risk of being violent are ever be contacted**
   d. **Adequate IPV services available** at the facility or by referral
   e. **Referrals are actively tracked** to ensure individuals access them and referral sites have adequate capacity to provide services to the individual
   f. **All adverse events are monitored** through a proactive adverse event monitoring system capable of identifying and providing services to individuals harmed by index testing. Comment boxes and other passive systems are necessary but inadequate.
   g. After contacting the contacts, **healthcare providers must follow-up with the individual after a reasonable period (1-2 months) to assess whether there were any adverse events** — including but not limited to violence, disclosure of HIV status, dissolution of the relationship, loss of housing, or loss of financial support — and refer them to the IPV centre or other support services if the answer is yes. Data on such occurrences must be shared.
2. There should be an **investigation into all sites carrying out index testing**, especially those not monitored by Ritshidze, urgently to assess the implementation of index testing. The findings of this investigation should be shared transparently.
3. Index testing must be suspended in poorly performing sites until it can be carried out safely and with consent.

RECOMMENDATIONS

THE AURUM INSTITUTE

1. Follow all protocols outlined in the National Department of Health guidelines on index testing including that:
   a. **Index testing is always voluntary**
   b. All healthcare providers **ask if the individual's partners have ever been violent** and record the answer to this question, before contacting the sexual partners
   c. **No contacts who have ever been violent or are at risk of being violent are ever be contacted**
   d. **Adequate IPV services available** at the facility or by referral
   e. **Referrals are actively tracked** to ensure individuals access them and referral sites have adequate capacity to provide services to the individual
   f. **All adverse events are monitored** through a proactive adverse event monitoring system capable of identifying and providing services to individuals harmed by index

testing. Comment boxes and other passive systems are necessary but inadequate

g. After contacting the contacts, **healthcare providers must follow-up with the individual after a reasonable period (1-2 months) to assess whether there were any adverse events** — including but not limited to violence, disclosure of HIV status, dissolution of the relationship, loss of housing, or loss of financial support — and refer them to the IPV centre or other support services if the answer is yes. Data on such occurrences must be shared.services if the answer is yes. Data on such occurrences must be shared.

2. There should be an **investigation into all DSP staff carrying out index testing**, especially those not monitored by Ritshidze, urgently to assess the implementation of index testing. The findings of this investigation should be shared transparently.
3. **Index testing must be suspended in poorly performing sites** until it can be carried out safely and with consent.

RECOMMENDATIONS

PEPFAR

1. PEPFAR must follow-through on commitments in COP22, including all monitoring and reporting elements. PEPFAR must share:
   a. Adverse Event Monitoring Tools of each DSP;
   b. Data from monthly analyses site level acceptance rates analyses (Oct-Jan);
   c. Results of REDCap assessments;
   d. Data on numbers of index clients screened for IPV and those screened positive;
   e. Planning Meeting Reporting/ Presentation Expectations:
   f. Report on all adverse events (number, type of adverse event, and resolution);
   g. Results from first wave of 1-2 month delayed healthcare provider follow-ups with index clients on adverse events;
   h. Plan for implementation of PEPFAR's GBV Quality Assurance Tool: Number of sites, timeframe for implementation, any preliminary results;
   i. Status of referral network for GBV services;
   j. Plan for mechanism on reporting data to CSOs on all elements documented in the SDS.

89% of facilities monitored by Ritshidze engage in index testing and of 527 people living with HIV interviewed, 44% said a healthcare worker had asked them for the names and contact information of their partners to test them for HIV. While index testing has the ability to help identify individuals who may have been exposed to HIV earlier, it must be implemented in ways that do not cause harm to individuals, or undermine their rights to consent, privacy, safety and confidentiality.

Yet in terms of consent, only 72% reported that they were allowed to refuse to give the names of their partners — and nearly a quarter of sites had 0% of respondents saying they could refuse (Figure 72). Index testing must always be completely voluntary. This is possible, as seen at the 8 facilities where 100% of people reported that they were told they could refuse (Figure 73).

Figure 72: Worst performing sites on PLHIV who reported they were told they could refuse to engage in index testing (April to May 2023)

District	Facility	Surveys Completed	Yes	No	Score
Bojanala Platinum	Bapong CHC	25	0	25	0%
	Letlhabile CHC	31	0	31	0%
Dr Kenneth Kaunda	Grace Mokgomo CHC	1	0	1	0%
	Tsholofelo Clinic	1	0	1	0%

Figure 73: Facilities where 100% of people living with HIV report being told they can refuse index testing

- Boitekong Clinic
- Itsoseng Clinic
- Jouberton CHC
- Lonely Park Clinic
- Miga Clinic
- Mogwase CHC
- Ramatlabama CHC
- Unit 9 CHC

81% of facilities say they screen for intimate partner violence (IPV) as part of their index testing protocol — down from 85% last year. However, while up from 65% last year, of 527 people living with HIV, still only 73% reported that they were asked about the risk of violence from their partners. Some sites had minimal or no people reporting they were asked about risk of violence (Figure 74).

There must always be an IPV screen to protect people's safety who undergo index testing. This is possible, as seen at 9 facilities where 100% of people reported that they did an IPV screen (Figure 75).

Figure 74: Worst performing sites on PLHIV who reported they were asked about risk of violence from their partner(s) (April to May 2023)

District	Facility	Surveys Completed	Yes	No	Score
Bojanala Platinum	Letlhabile CHC	31	1	30	3%
	Bapong CHC	25	0	25	0%
Dr Kenneth Kaunda	Grace Mokgomo CHC	1	0	1	0%

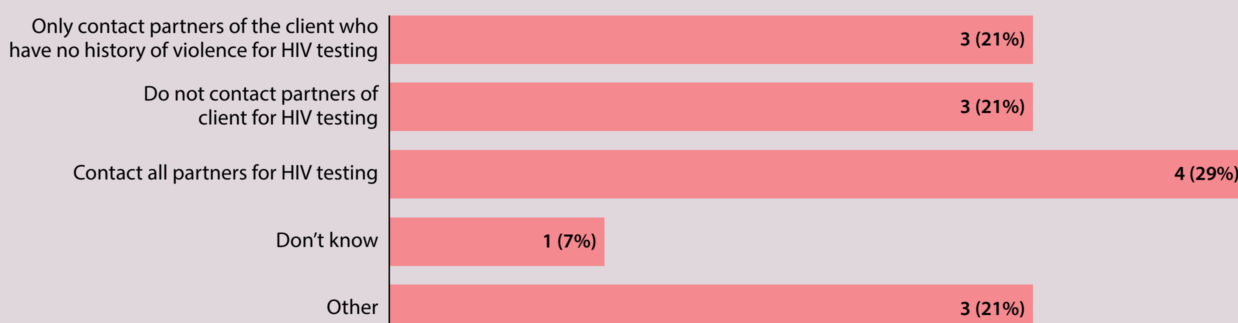
Figure 75: Facilities where 100% of people living with HIV report an IPV screen

- Boitekong Clinic
- Itsoseng Clinic
- Lonely Park Clinic
- Miga Clinic
- Mogwase CHC
- Montshioa Stadt CHC
- Ramatlabama CHC
- Tsholofelo Clinic
- Unit 9 CHC

While there has been improvement, worryingly still 29% of those that do screen, report that the practice is still to contact all the partners of people living with HIV regardless of reported violence (Figure 76). This is a major concern and violation of people's safety and privacy. There is no point to the IPV screen if contacts are just notified of their exposure anyway.

Figure 76: In case of violence from a sexual partner, what do you do with the contact information of the sexual partner? (April to May 2023)

Facility Staff Surveyed: 14



The majority of sites said that if people living with HIV screen positive for IPV they offer them services either on site or by referral (Figure 77). However, all facilities should be able to provide on site or referred services for IPV. Screening for IPV at the 2 sites without adequate IPV services to respond to an individuals 'positive' screen is dangerous and unethical. Referrals must be actively tracked to ensure individuals access them and referral sites have adequate capacity to provide services to the individual.

Figure 77: In case of violence from a sexual partner, what additional services do you provide? (April to May 2023)
Facility Staff Surveyed: 14

9. Infrastructure and clinic conditions

2021

29% of facilities in bad condition

86% of facilities needed some additional space

71% of facilities did not have enough room in the waiting area

50% of facility toilets in bad condition

18% of public healthcare users reported that facilities are "dirty" or "very dirty"

2022

50% of facilities in bad condition

92% of facilities needed some additional space

83% of facilities did not have enough room in the waiting area

50% of facility toilets in bad condition

5% of public healthcare users reported that facilities are "dirty" or "very dirty"

2023

50% of facilities in bad condition

89% of facilities needed some additional space

67% of facilities did not have enough room in the waiting area

78% of facility toilets in bad condition

21% of public healthcare users reported that facilities are "dirty" or "very dirty"

61% of facilities have a functional generator

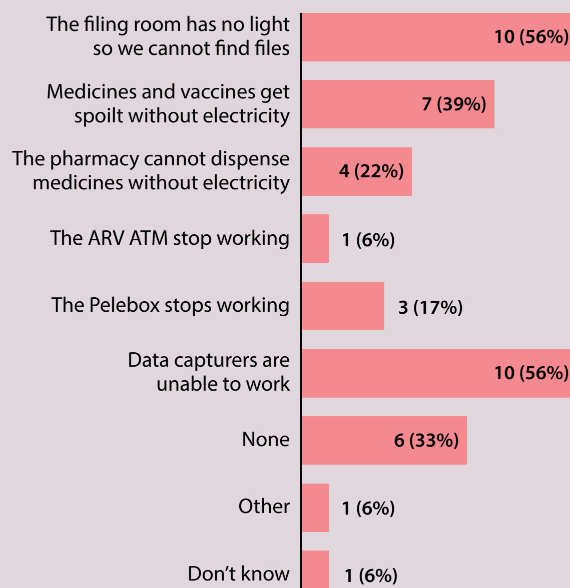
RECOMMENDATIONS

NORTH WEST DEPARTMENT OF HEALTH

1. Ensure that all public health facilities have a **functional generator with sufficient fuel** so that health services and administrative work can continue during loadshedding
2. Ensure that **all public healthcare users are consulted, tested, and/ or counselled in private rooms**
3. Carry out an **audit of all facilities to assess infrastructural challenges.** After which the Department should develop a plan in order to renovate buildings and ensure adequate space to provide efficient, private, and safe healthcare services. The Department must publish the audit results
4. In the interim, **provide temporary structures** and ensure that **more PLHIV are being decanted out of the facility** and **receiving longer ART refills,** to reduce the burden on overcrowded clinics
5. Ensure that **all facilities are maintained to the highest standards of cleanliness** including through implementing regular cleaning rotas
6. Ensure clinics have resources to **provide soap and toilet paper in all toilets**

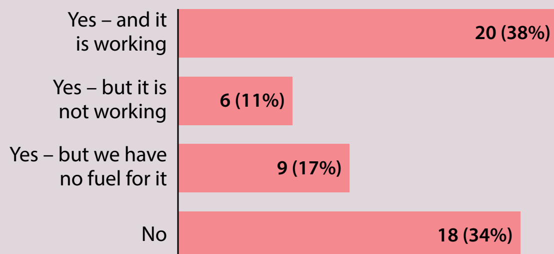
The country's loadshedding crisis negatively impacts the provision of healthcare in our clinics and can often lead to people waiting much longer to collect medicines or consult with a clinician. In the North West the most common challenges include delays in finding files when filing rooms are in darkness, increasing overall waiting times, as well as data capturers not being able to capture information, creating a backlog and impacting follow up with people who have missed appointments and recall systems (Figure 78). Generators at each facility could resolve these challenges, yet only 38% of facilities have a generator that is working and has fuel (Figure 79).

Figure 78: What challenges does the facility face because of loadshedding? (April to May 2023)
Facility Staff Surveyed: 18



The country's loadshedding crisis negatively impacts the provision of healthcare in our clinics and can often lead to people waiting much longer to collect medicines or consult with a clinician.

Figure 79: Is there a generator at the facility? (April to May 2023)
Facility Staff Surveyed: 53

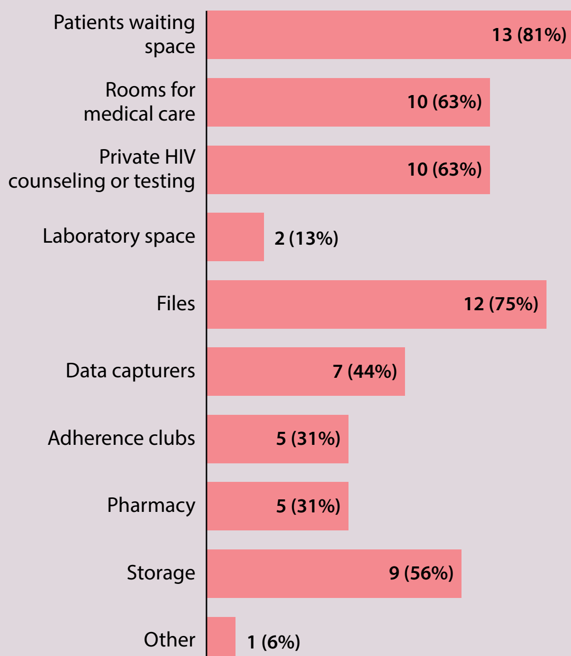


Only 50% of facilities monitored in the North West are in good condition. Of the 50% in bad condition, the most common reason is that the buildings are in need of renovation and that there are broken or cracked roofs, walls, or floors (Figure 80).

89% of facilities reported needing more space, down from 92% last year — with waiting space, filing space, rooms for medical care, rooms for private HIV testing and counselling, and storage given as the most common things facilities needed extra space for (Figure 81). Limited waiting room can force people to queue outside, increase congestion, and have a negative impact on TB infection control. Lack of space for filing leads to messy filing systems, delays in finding files and/or lost files. Lack of space for medical care and private HIV counselling and testing can result in privacy violations as people are consulted, tested, or counselled in the same room as someone else — leading to some people not wanting to test, or for those living with HIV to interrupt treatment or disengage from care.

Figure 80: What is in a bad condition in the facility (April to May 2023)

District	Facility	No light / or lights	Broken furniture	Broken or cracked roof, walls or floor	No running water	Broken windows or doors	Old building needs renovation
Bojanala Platinum	Boitekong Clinic		1		1	1	1
	Letlhabile CHC					1	
	Mogwase CHC			1			1
Dr Kenneth Kaunda	Alabama Clinic			1			1
	Jouberton CHC	1	1	1		1	1
	Park Street Clinic			1			1
	Tsholofelo Clinic	1	1	1	1	1	1
Ngaka Modiri Molema	Montshioa Stadt CHC			1			
	Unit 9 CHC	1	1			1	



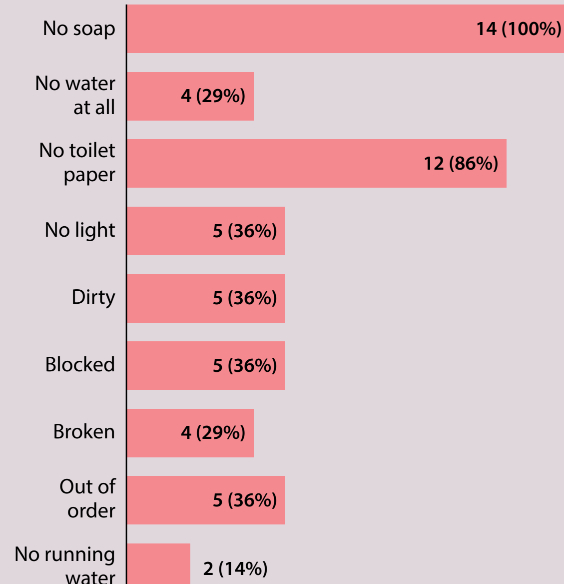


Figure 82: Best performing sites on clinic cleanliness (April to May 2023)

District	Facility	Surveys completed	Very Dirty	Dirty	Neutral	Clean	Very Clean	Score
Ngaka Modiri Molema	Lonely Park Clinic	75	0	0	0	0	75	5
	Miga Clinic	25	0	0	0	0	25	5
	Ramatlabama CHC	25	0	0	0	0	25	5
	Unit 9 CHC	75	0	0	0	0	75	5
	Itsoseng Clinic	75	0	0	0	1	74	4.99
	Montshioa Stadt CHC	76	0	0	4	3	69	4.86
Bojanala Platinum	Bafokeng CHC	75	0	0	1	32	42	4.55
	Mogwase CHC	52	0	0	0	37	15	4.29

Figure 83: Worst performing sites on clinic cleanliness (April to May 2023)

District	Facility	Surveys completed	Very Dirty	Dirty	Neutral	Clean	Very Clean	Score
Bojanala Platinum	Boitekong Clinic	75	32	38	5	0	0	1.64
	Tlhabane CHC	77	17	38	17	4	1	2.14
	Letlhabile CHC	55	7	37	11	0	0	2.07
Dr Kenneth Kaunda	Alabama Clinic	54	2	14	35	3	0	2.72

On overall cleanliness, 60% of public healthcare users reported that facilities were very clean/clean. However, 21% reported that facilities were very dirty/dirty. The best (Figure 82) and worst (Figure 83) performing sites are shown in the tables.

78% of Ritshidze observations found that toilets were in bad condition — with no soap, no toilet paper, no light, as well as blocked, broken or dirty toilets given as the most common reasons (Figure 84).

DIESEL GENERATOR SET

BIO-HAZARDOUS WASTE

Toilet Paper
is available
please ask
the staff in the reception area
if there is no toilet paper
in the bathroom

10. TB infection control

2021	2022	2023	
0 facilities were awarded green status	**0** facilities were awarded green status	**0** facilities were awarded green status	*GREEN* *checking all six measures on the TB infection control scorecard*
7 facilities scored yellow status	**5** facilities scored yellow status	**9** facilities scored yellow status	*Yellow* *following about half of the best practice measures*
7 facilities scored red status	**7** facilities scored red status	**9** facilities scored red status	*RED* *failing altogether at meeting the best practices to stop the spread of TB*

RECOMMENDATIONS

NORTH WEST DEPARTMENT OF HEALTH

1. **Issue communication to all facilities** stating that:
   a. All windows must be kept open
   b. TB infection control posters must be displayed in visible places in the waiting area
   c. Public healthcare users must be screened for TB symptoms upon arrival
   d. People coughing or with TB symptoms must be seen first to reduce the risk of transmission
   e. People coughing or with TB symptoms must be provided with masks
   f. People who are coughing must be separated from those who are not while waiting
2. **Carry out a full audit of all public health facilities in the province to assess TB infection control**, based upon WHO guidelines. After which the Department should develop a plan based upon the infrastructural, human resource, or behavioural challenges found in order to improve TB infection control. The Department must publish the audit results.

In South Africa around 300,000 people develop tuberculosis every year and about 56,000 people die. Yet TB infection control in our public health facilities remains inadequate. By following a simple checklist of good practice — including key measures that were successfully implemented during COVID-19 — facilities can be safer for public healthcare users and staff.

With the checklist in mind, Ritshidze has developed a scorecard and a traffic light system to rate clinics on how good their TB infection control is. Clinics that adhere to

How do we know if our clinics have good TB infection control?

- Is there enough room in the waiting area?
- Are you seen within 1 hour 15 minutes of arriving at the facility?
- Are the windows open?
- Are people in the facility waiting area asked if they have TB symptoms?
- Are people who cough a lot or who may have TB given tissues or TB masks?
- Are people who are coughing separated from those who are not?
- Are there posters telling you to cover your mouth when coughing or sneezing?

SCORING SYSTEM:

- RED 3+ questions answered "no"
- YELLOW 1-2 questions answered "no"
- GREEN 0 questions answered "no"

all the measures are given a green light, those that are on the right track but still off target get a yellow light and a red light is given to those that are way off the mark on ticking the checklist for the six measures.

In April and May 2023, 0 facilities were awarded green status for checking all six measures on the scorecard. Ritshidze scored 9 clinics yellow status; this translates to 50% of the facilities being monitored following about half of the best practice measures for infection control. It leaves the other 50% of facilities surveyed failing altogether at meeting these six basic best practices to stop the spread of TB (Figure 85).

By indicator:

+ Only 33% of facilities had enough room in the waiting area
+ 100% of facilities had the windows open
+ 83% of facilities had TB infection control posters
+ Of 1,072 responses, only 52% say staff always ask people in the waiting areas if they have TB symptoms
+ Of 1,072 responses, only 47% say people coughing in waiting areas are always moved to a separate room
+ Of 1,072 responses, only 44% say people who are coughing in the waiting room are given a mask

Our clinics are failing to prevent TB infection!

*Data collected in the North West in April & May 2023

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Figure 85: TB Infection Control (April to May 2023)

District	Facility	Enough room in the waiting area?	Were the facility windows open?	Are there posters telling patient to cover mouth when coughing/sneezing?	Are people who are coughing in a separate room?	Time spent in the facility after opening	Are people being asked for TB symptoms?	Score
Bojanala Platinum	Bafokeng CHC	100%	100%	100%	0%	04:55	0%	RED
	Bapong CHC	0%	100%	0%	0%	04:04	0%	RED
	Boitekong Clinic	0%	100%	100%	0%	05:50	1%	RED
	Letlhabile CHC	0%	100%	0%	0%	05:48	0%	RED
	Mogwase CHC	100%	100%	100%	2%	05:28	2%	RED
	Tlhabane CHC	100%	100%	100%	13%	06:06	13%	RED
Dr Kenneth Kaunda	Alabama Clinic	0%	100%	100%	24%	02:41	32%	RED
	Grace Mokgomo CHC	100%	100%	0%	45%	03:54	54%	RED
	Jouberton CHC	100%	100%	100%	46%	04:06	73%	YELLOW
	Majara Sephapho Clinic	100%	100%	100%	58%	02:53	83%	YELLOW
	Park Street Clinic	0%	100%	100%	73%	03:07	83%	YELLOW
	Tsholofelo Clinic	0%	100%	100%	18%	02:41	25%	RED
Ngaka Modiri Molema	Itsoseng Clinic	0%	100%	100%	100%	02:28	100%	YELLOW
	Lonely Park Clinic	0%	100%	100%	100%	03:11	100%	YELLOW
	Miga Clinic	0%	100%	100%	100%	03:18	100%	YELLOW
	Montshioa Stadt CHC	0%	100%	100%	100%	02:50	99%	YELLOW
	Ramatlabama CHC	0%	100%	100%	100%	03:57	100%	YELLOW
	Unit 9 CHC	0%	100%	100%	100%	03:56	100%	YELLOW

NOTES

LEBOX
OPEN
PELEBOX IS UNDER 24 HOUR VIDEO SURVEILLANCE
pele box
health
Bojanala Platinum District Municipality
PEPFAR
CDC
THE AURUM INSTITUTE

RITSHIDZE
SAVING OUR LIVES
ritshidze.org.za

TAC
TREATMENT ACTION CAMPAIGN

SANERELA+

POSITIVE
-WOMEN'S NETWORK-
FOR WOMEN LIVING WITH HIV/AIDS

POSITIVE · ACTION · CAMPAIGN

NAPWA
SOUTH AFRICA

HEALTH GAP
GLOBAL ACCESS PROJECT

amfAR
MAKING AIDS HISTORY

O'NEILL
INSTITUTE
FOR NATIONAL & GLOBAL HEALTH LAW
GEORGETOWN LAW