

SCIENTIFIC REPORTS AND GUIDELINES

South African Renal Registry Annual Report 2024

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ABSTRACT

This is the thirteenth consecutive annual report of the South African Renal Registry since its re-establishment and launch, beginning with the December 2012 data on kidney replacement therapy (KRT) in South Africa. The December 2024 data presented here show the number of patients on treatment to be 9 093, compared with 8 881 in 2023.

There were 1 091 patients who started KRT in 2024, an incidence of 17.3 per million population (pmp). Most of these patients (87.7%) were treated in private centres; the increased private-sector share reflects lagging reporting of new public-sector patients rather than a real shift in provision. In December 2024, the total number of patients receiving chronic dialysis or living with a functioning kidney transplant stood at 9 093, an overall prevalence of 144 pmp. The prevalence was 754 pmp in the private healthcare sector. In the public sector, the overall prevalence was 41 pmp, with the Western Cape being the province with the highest public-sector prevalence (166 pmp) and Mpumalanga the province with the lowest (1 pmp).

Keywords: renal registry; South Africa; haemodialysis; peritoneal dialysis; transplantation.

INTRODUCTION

The South African Renal Registry (SARR) collects, analyses and publishes information on kidney replacement therapy (KRT) for patients with kidney failure in South Africa. The registry, a project of the South African Nephrology Society, was re-established almost two decades after the last report of the previous registry, the South African Dialysis and Transplant Registry [1]. This is the thirteenth consecutive annual report, which summarises the data on record as at December 2024. The December 2024 data show the number of patients on KRT to be 9 093, compared with 8 881 in 2023.

METHODS

Registry platform

Our data-capture platform was developed using the WEBDEV programming environment (www.windev.com) and resides on a secure, dedicated server (Windows

Server 2019) at a South African internet hosting company. The infrastructure runs Windows Internet Information Services (IIS) and uses the client/server version of HFSQL (formerly Hyperfile SQL) as its relational database management system. Data capturers interface with the central database via user-friendly web pages from any device with internet access. The platform employs end-to-end encryption and full backups are made daily.

To confirm vital status, we cross-check the identity numbers of our patients with the Department of Home Affairs database of births and deaths, which is accessible via the South African Medical Research Council.

The technology platform of the SARR also serves as the backbone of the African Renal Registry. Botswana, Burundi, Ghana, Kenya, Nigeria and Zambia have joined the African Renal Registry and have used our platform [2,3].

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Definitions

Kidney failure and start date of KRT. Kidney failure refers to advanced, irreversible kidney disease which requires the initiation of KRT. The start date is that of first haemodialysis (HD), the date of the first peritoneal dialysis (PD) flushes or exchanges, or that of pre-emptive transplantation (where there is no prior dialysis). For patients who are initially thought to have acute kidney injury (AKI) but who do not recover function and continue KRT, the start date is that of the first dialysis, even though the diagnosis at that time was AKI and not kidney failure.

Initial KRT modality. This is the intended first modality and should normally be the modality being used on day 91 of KRT. This means that someone who presents late and who is started on urgent HD but is soon established on PD, will have PD recorded as the initial modality.

Changes in the responsible treating unit. This refers to a change in the dialysis unit, PD follow-up unit/clinic or transplant follow-up unit/centre/practice. A transfer entry in the registry is required to record this. This is not done for short-term transfers when the intention is that the patient will return to the “home” unit, for example, for holiday dialysis, temporary transfer to a unit with isolation facilities, etc.

Primary kidney disease. Responsible nephrologists/physicians should assist their data-capturers to ensure that this critical information is accurate. We are using the diagnostic codes of the European Renal Association registry [4]. If there is uncertainty about the diagnosis, as is often the case with patients who present late, then it should be recorded as “**chronic kidney disease (CKD) – aetiology uncertain/unknown**”. In patients who present with kidney failure, small kidneys and hypertension, there should not be an automatic default to labelling such patients as having “chronic glomerulonephritis” or “hypertensive kidney disease”.

Chronic hypertensive nephropathy or malignant hypertensive nephropathy. This should be selected as the primary kidney disease only if there is no reason to suspect that the hypertension is secondary to pre-existing kidney disease. We suggest that the following criteria be met: hypertension known to precede kidney dysfunction, left ventricular hypertrophy, proteinuria <2 g/day, and no evidence of other kidney diseases [5,6].

Lost to follow-up. The SARR assumes that a functioning transplant is maintained unless there is evidence of a “transplant failure” or death. Patients are considered lost to follow-up one year after a “transplant failure” entry if no further entries are recorded. A dialysis modality is assumed to continue for one year from the date of the last registry

entry or laboratory result, in the absence of evidence of death; thereafter, the patient is considered lost to follow-up. Confirmation of vital status through the Department of Home Affairs linkage constitutes evidence of life for this purpose. The two-year allowance applied for the 2023 report, to accommodate delays in data submission, has not been applied for 2024.

Recovered kidney function. Patients on chronic HD/PD who recover kidney function and so do not require dialysis are no longer counted as prevalent; their records are retained in the registry. The period of dialysis-free recovery must persist for at least 90 days; if the period of recovery is less than 90 days and dialysis is restarted, there is no end of treatment entry and dialysis is considered to have been continuous. If the period of recovery exceeds 90 days and the patient restarts KRT, a new registration is created and the two periods are recorded as separate treatment episodes. The earlier period is not regarded as permanent kidney failure; it is treated as acute kidney injury from which the patient recovered. For analyses of incident patients, the later period is the incident event, and where a patient has more than two episodes the most recent is the incident event. Earlier episodes are retained to permit study of recovery of kidney function after starting KRT. Because an episode is reclassified only once a later episode is recorded, incidence for a given year may decrease if recomputed from a later data extract; incidence figures are therefore reported as at the stated extract date.

Prevalent cohort adjustment

The 2024 data extract was taken 18 months after the report date. The lost-to-follow-up thresholds now match the stated methodology. The approach for the 2023 report used a two-year threshold, with a 10% attrition rate applied to patients on dialysis. This was informed by our study on one-year patient survival [7]. For this 2024 report, the prevalent cohort comprises all patients recorded as receiving KRT on 31 December 2024, less all deaths and treatment withdrawals occurring before that date, and minus patients on dialysis with no evidence of life within the preceding year.

Ethical approval

The SARR runs this longitudinal study with ethical approval from the Health Research Ethics Committee of Stellenbosch University (reference no. N11/01/028). This approval is renewed annually upon submission of a progress report. A waiver of individual informed consent has been granted, and the approval covers countrywide data collection on adults and children, in the public and private sectors, and the accessing of various data sources to improve the accuracy and completeness of data. These include records

available through doctors' practices, from dialysis and transplant centres, provider companies and medical aid funds. Ethical approval has also been granted for the use of the expanded SARR platform for the African Renal Registry.

Use of artificial intelligence

Claude Opus 4.8 (Anthropic, accessed August 2026) was used to support data preparation. All analyses were performed using the registry's established Stata (Stata 16, StataCorp, Texas) pipeline, and AI-assisted outputs were reviewed and verified as accurate by the authors.

RESULTS

South Africa in 2024

Figure 1 illustrates the provinces and major cities of South Africa. According to the Statistics South Africa (Stats SA) 2024 mid-year population estimates [8], the population of South Africa had grown to 63.02 million people. There was

a slight female predominance (51.0%) and Black/African citizens constituted 81.7% of the population (Table 1). About 27.5% of the population was younger than 15 years of age and approximately 9.7% was aged 60 or older. The province of Gauteng was home to 25.3% of the population, followed by KwaZulu-Natal with 19.5% (Table 2). Migration continues to have a major impact on the age structure and distribution of provincial populations, with Gauteng and the Western Cape experiencing the largest net inflows of migrants.

South Africa is classified as an upper-middle-income country by the World Bank, with a gross national income per capita for 2024 by the Atlas method (current US\$) of \$6 110 and by the purchasing power parity (PPP) method (current international US\$) of \$15 170 [9]. Most of the population (85.5%) rely on the public healthcare sector for services, with only a small proportion (14.5%) having medical insurance and accessing private-sector health care [10].



Figure 1. Provinces and major cities of South Africa.

Table 1. Population data by ethnic group.

Population group	Million	%
Black	51.51	81.7
Coloured (mixed ancestry)	5.34	8.5
Indian/Asian	1.63	2.6
White	4.54	7.2
Total	63.02	100

Table 2. Population data by province.

Province	Million	%
Eastern Cape (EC)	7.18	11.39
Free State (FS)	3.04	4.83
Gauteng (GT)	15.93	25.28
KwaZulu-Natal (KZN)	12.31	19.54
Limpopo (LP)	6.40	10.16
Mpumalanga (MP)	5.06	8.03
North West (NW)	4.16	6.59
Northern Cape (NC)	1.37	2.18
Western Cape (WC)	7.56	12.00
Total	63.02	100

Treatment centres for dialysis and transplantation

The number of centres contributing data was 296; of these, 266 (89.9%) are privately owned (Table 3 and Appendix 1). Life Healthcare acquired and progressively integrated much of the southern African dialysis operations of Fresenius Medical Care (FMC) during 2024. Some of these centres were rebranded as Life Renal Dialysis, as confirmed by Life Healthcare. All remaining FMC centres

are reported under their legacy names. Several provinces have increased access for their public-sector patients by utilising spare capacity at private haemodialysis centres on a fee-per-treatment basis. There are also a few privately run centres on the premises of government hospitals, which serve public-sector patients.

Table 3. Number of treatment centres by province and sector.

Sector	EC	FS	GT	KZN	LP	MP	NW	NC	WC	All
Public	4	7	6	4	1	0	2	1	5	30
Private	20	14	86	65	16	10	16	5	34	266
Total	24	21	92	69	17	10	18	6	39	296

Prevalence and incidence of kidney replacement therapy

The total number of patients on KRT on 31 December 2024 was 9 093. This is a prevalence of 144 per million population (pmp). Gauteng remains the province with the highest numbers of patients on KRT, followed by the Western Cape and KwaZulu-Natal, whereas the province with the highest prevalence was the Western Cape (282 pmp), followed by the Free State and Gauteng (Figure 2). Patient numbers by province were: Gauteng 2 673, Western Cape 2 130, KwaZulu-Natal 1 708, Eastern Cape 958, Free State 597, Limpopo 374, North West 267, Northern Cape 205 and Mpumalanga 181 (Figure 2).

Survival and inclusion in the prevalent cohort are often confirmed through linkage of the patient ID number to the national Home Affairs mortality dataset. Overall, 1 084 of the 9 093 prevalent patients (11.9%) had no national ID number recorded. Absence of a valid ID number was markedly higher in the public sector (39.9%) than the private sector (3.1%). Among public-sector patients this

ranged from 72.9% in Gauteng, 65.7% in the Northern Cape and 43.1% in KwaZulu-Natal to 20.4% in the Eastern Cape (North West, Limpopo and Mpumalanga each have fewer than 30 public-sector patients). By modality, ID numbers were most often absent in transplant recipients (39.7% overall; 53.9% in the public sector), followed by peritoneal dialysis (20.3%) and haemodialysis (3.3%).

There were 1 091 patients who started KRT in 2024, an incidence of 17.3 pmp. Most of these patients (957 patients, 87.7%) were treated in private centres. The low public-sector count reflects delayed reporting of new patients rather than a real change in provision. Their median age was 54.9 years (40.2 years in the public sector and 56.8 years in the private sector). Diabetic nephropathy was recorded as the cause of kidney failure in 123 (11.3%) of these incident patients and the initial KRT modality was haemodialysis in 89.0%.

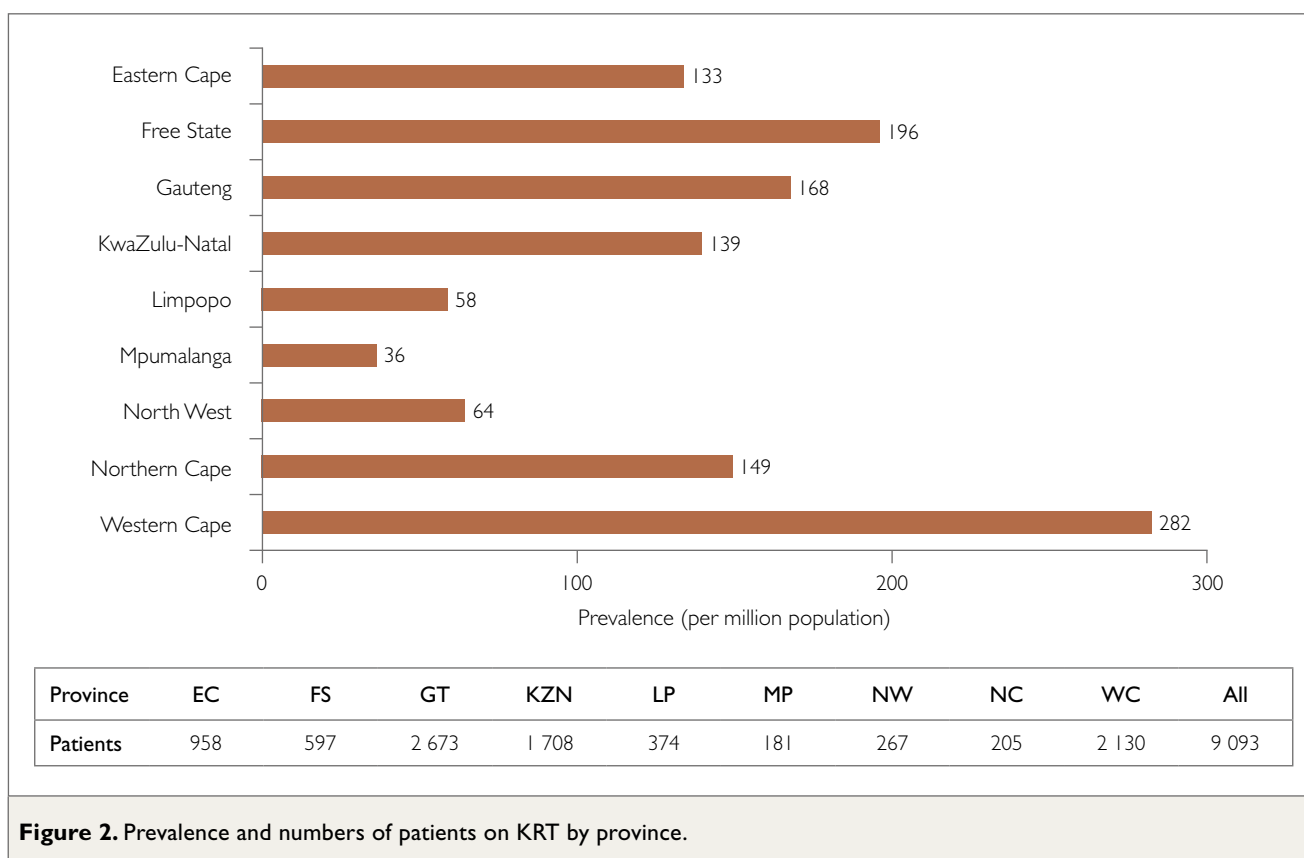


Figure 2. Prevalence and numbers of patients on KRT by province.

The number of patients treated in the public sector decreased slightly from 2 308 in 2023 to 2 183 in 2024, resulting in a prevalence of 41 pmp (Table 4). In the private sector, the number of patients rose from 6 573 to 6 910, yielding a prevalence of 754 pmp. The figures for patients and prevalences by province and healthcare sector are depicted in Table 5 and Figure 3. Denominators for prevalence calculations are derived from Stats SA 2024 mid-year population estimates [8] and the Council for Medical Schemes Annual Report [10].

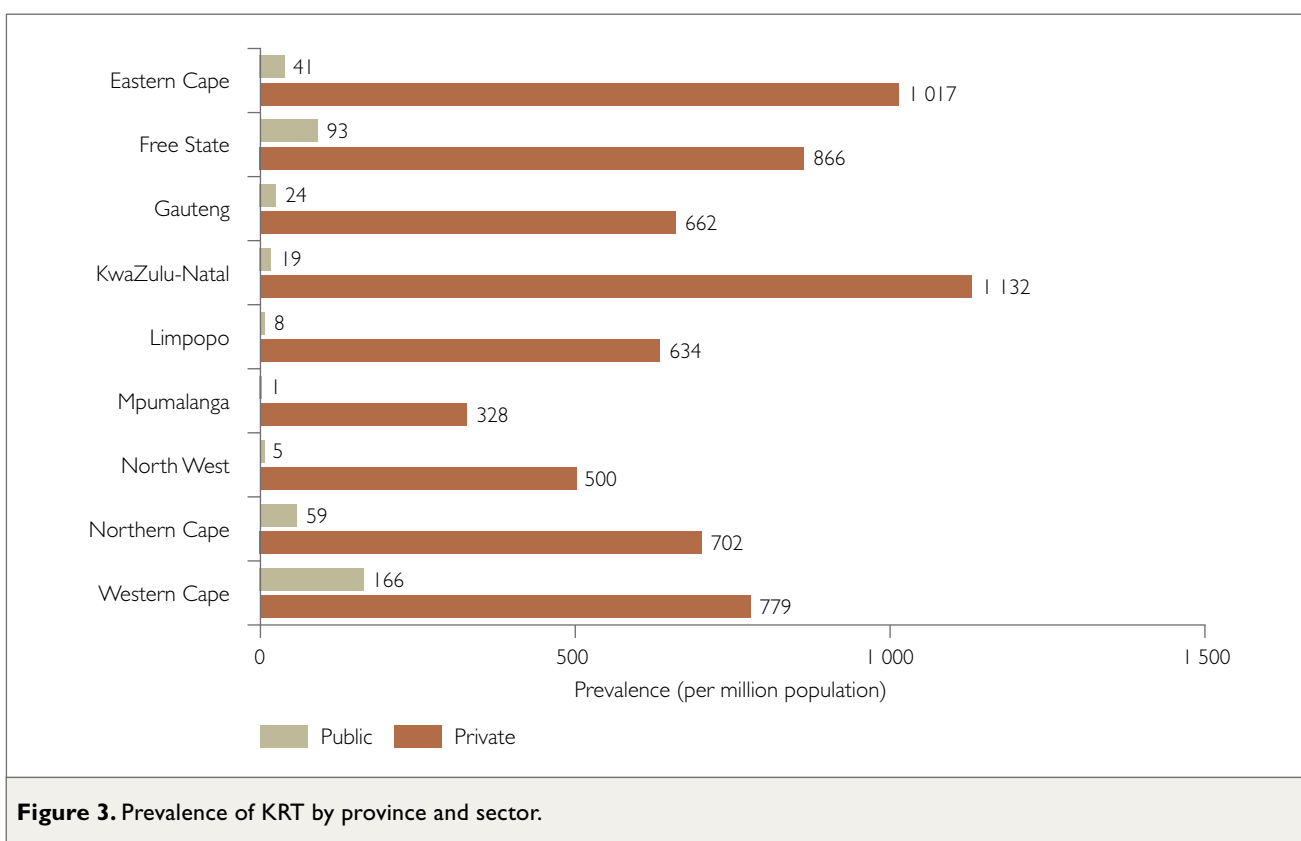
Table 4. KRT prevalence by healthcare sector.

	Public	Private
Population in millions	53.85	9.16*
Patients on treatment	2 183	6 910
Treatment rate (pmp)	41	754

*Data supplied by the Council for Medical Schemes

Table 5. Numbers of patients by province and sector.

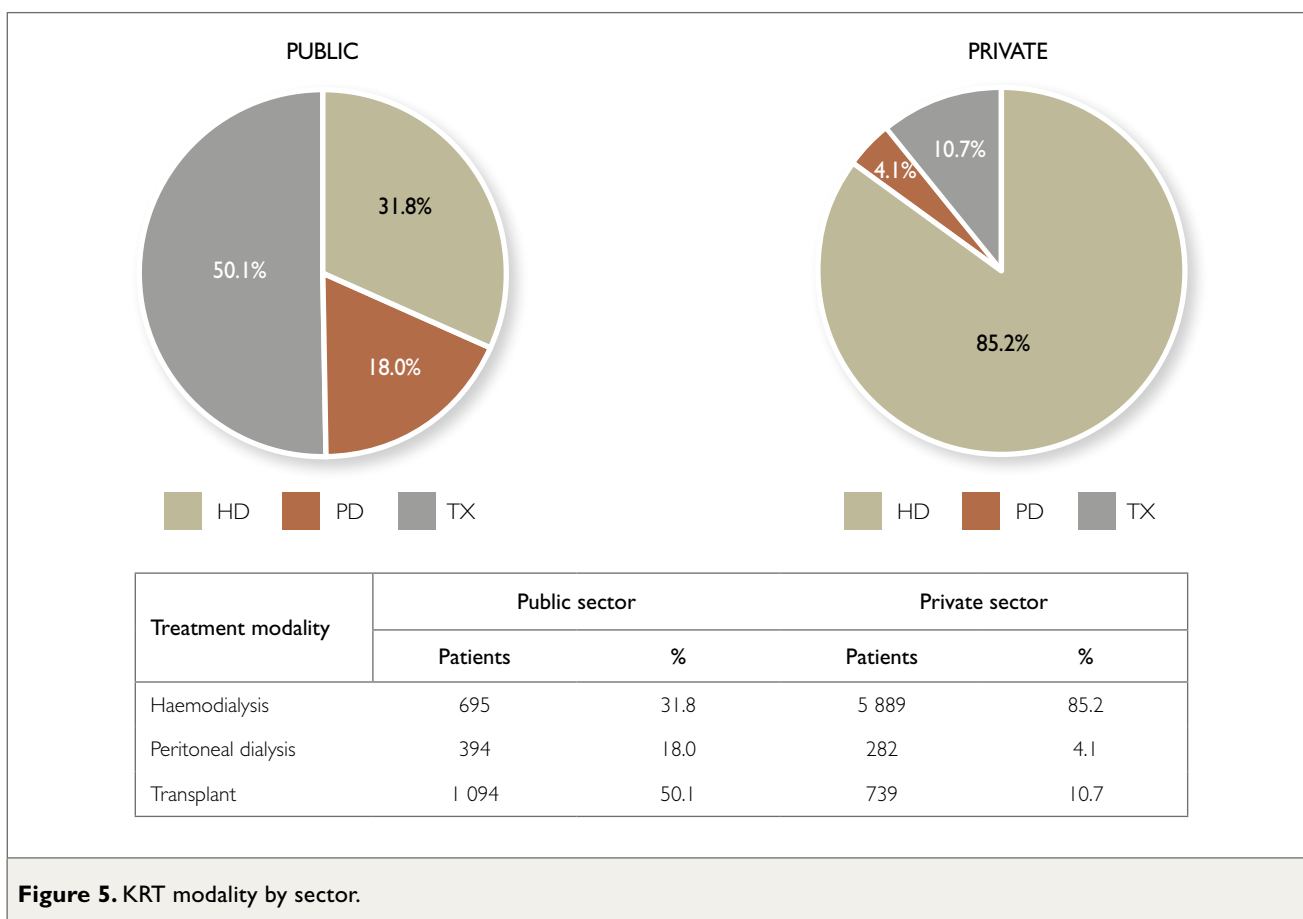
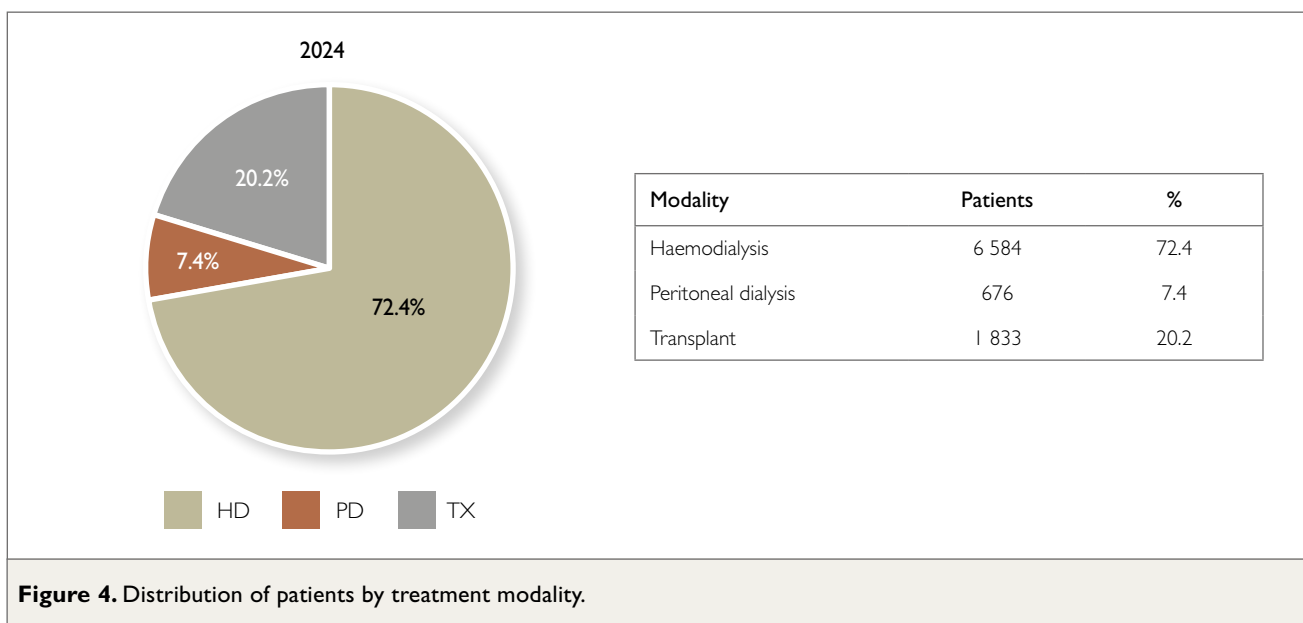
Sector	EC	FS	GT	KZN	LP	MP	NW	NC	WC	All
Public	269	244	295	211	50	4	18	70	1 022	2 183
Private	689	353	2 378	1 497	324	177	249	135	1 108	6 910
Total	958	597	2 673	1 708	374	181	267	205	2 130	9 093



Treatment modality and KRT vintage

In December 2024, 20.2% of patients on KRT had a functioning kidney transplant. Among those on dialysis, 90.7% were on HD and 9.3% were on PD. Most of the patients with kidney transplants or who were on PD were being managed in the public sector; the private sector had much lower proportions of patients on these KRT modalities (Figures 4 and 5).

Overall, the median KRT vintage was 6.4 years [interquartile range (IQR) 2.3–11.2 years]. The median vintage was 5.0 years (IQR 1.9–9.2 years) for patients on haemodialysis, 3.6 years (IQR 1.6–7.8 years) for patients on peritoneal dialysis and 13.1 years (IQR 9.0–17.1 years) for transplant recipients.



Demographic and clinical data

The median age of the patients on KRT was 54.1 years (IQR 43.3–63.8 years) and 58.4% were male. Because of the rationing and selection criteria applied in public sector hospitals, patients treated there were much younger than those in the private sector (median age 45.2 years versus

56.7 years). Just more than half of the patients (52.4%) were Black. However, the prevalence was still lowest in Blacks (92 pmp) and highest in Indians/Asians (635 pmp) (Figure 6).

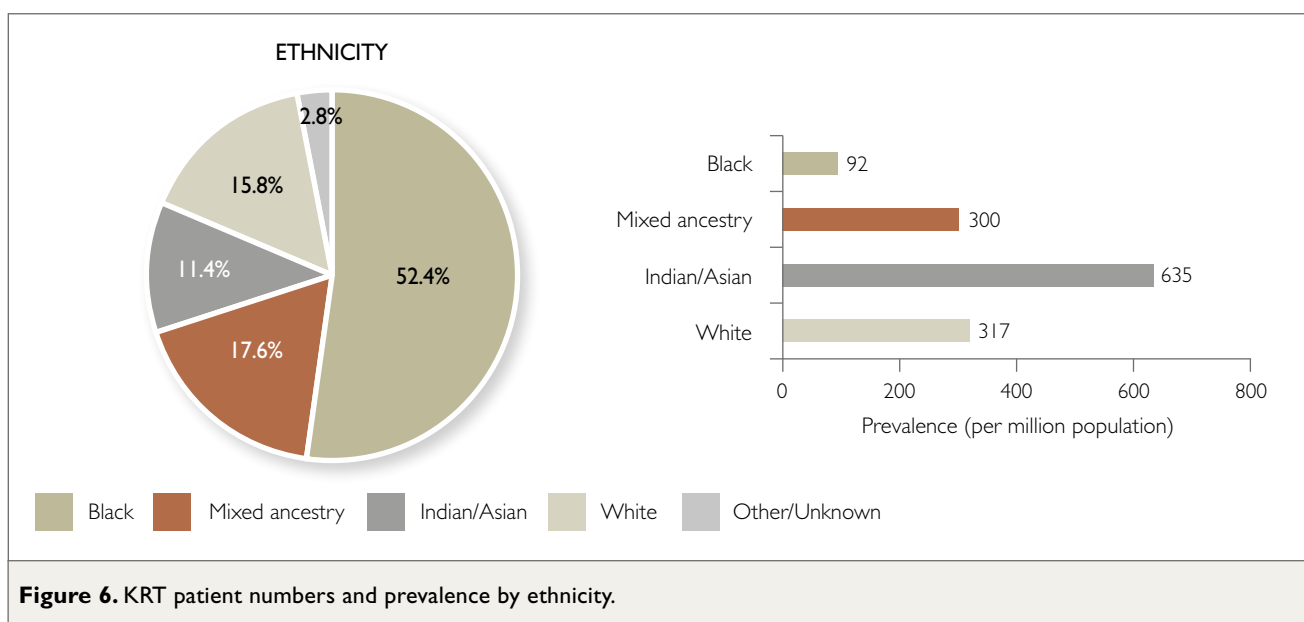


Figure 6. KRT patient numbers and prevalence by ethnicity.

The most common primary kidney disease recorded was hypertensive kidney disease, followed by CKD/kidney failure of unknown cause and diabetic nephropathy (Table 6).

Table 6. Most commonly reported causes of kidney failure.

	% of total
Hypertensive kidney disease	42.4
Cause unknown	29.6
Diabetic nephropathy	11.6
Glomerular disease	9.6
Cystic kidney disease	2.6
Obstruction and reflux	1.5

Of the 8 284 patients with data on their status, 36.3% had diabetes, with a greater proportion in the private sector compared to the public sector (43.5% versus 13.6%). The seropositive rate for hepatitis B virus was 2.0%, for hepatitis C virus 0.5% and for HIV 12.5%.

DISCUSSION

The number of patients on KRT in South Africa increased to 9 093 in December 2024 compared with 8 881 in December 2023, resulting in a prevalence of 144 pmp for 2024.

The disparity in access to KRT across healthcare sectors remains clear, with the prevalence of KRT in the public sector (41 pmp) roughly one-eighteenth of that in the private sector. Prevalent public-sector numbers fell from 2 308 to 2 183. The Western Cape continues to have the highest public-sector prevalence (166 pmp), whereas Mpumalanga has the lowest (1 pmp).

Incidence has been broadly stable. On the current database extract, 1 091 patients started KRT in 2024 (17.3 pmp), against counts of 1 082 in 2022 and 1 042 in 2023; the lower figures published previously for those years (822 and 627) were undercounts at the time. The 2024 private share of incident patients (87.7%) is temporarily above the usual 80–82% because new public-sector patients are reported with greater delay.

The concentration of missing ID numbers in the public sector means that vital status could not be verified by linkage for roughly two in five public-sector patients, against fewer than one in thirty in the private sector. This limitation

is most acute for transplant recipients, over half of whom lacked an ID in the public sector. Prevalence and survival estimates should therefore be regarded as carrying greater uncertainty for public-sector statistics.

CONCLUSIONS

In December 2024, the number of patients receiving KRT in South Africa had modestly increased, at 9 093 (144 pmp). The marked disparity in access between the private and public sectors persists. The corresponding incidences have been broadly stable; the low recorded public-sector incidence for 2024 largely reflects delayed reporting. Continued attention to the completeness and timeliness of data submission, particularly from the public sector, remains a priority.

Acknowledgements

The SARR is an initiative of the South African Nephrology Society (<http://www.sa-renalsociety.org/>) and is chaired by Razeen Davids and Julian Jacobs. The SARR has been incorporated as a non-profit company (company registration no. 2018/401217/08, NPO no. 212-901) with Julian Jacobs, Razeen Davids and Sajith Sebastian as directors. The founding document is available from the South African Nephrology Society.

We thank the doctors, nurses, technologists, support staff and management of participating treatment centres for contributing to the 2024 data collection. These centres are listed in Appendix I. We also thank the sponsors listed below, especially the National Department of Health, for their financial and logistical support:

- National Department of Health
- Aspen Pharmacare
- Astellas Pharma
- Sandoz South Africa
- Stellenbosch University.

Supplementary materials

The figures in this report are available as PowerPoint slides via the supplementary materials on the *African Journal of Nephrology* website.

Usage of this report

Extracts from this report, and figures from the accompanying PowerPoint slides, may be freely used and reproduced without requesting permission, provided the source is acknowledged. Suggested citation: Jardine T, Marais N, Sebastian S, Chothia M-Y, Stead PA, Jacobs JC, Davids MR. South African Renal Registry Annual Report 2024. *African Journal of Nephrology*. 2026; 29(1):89-101.

Use of AI in manuscript preparation

Claude Opus 4.8 (Anthropic, accessed August 2026) was used to update the 2024 figures from the registry's Stata analysis output, to revise the wording of the Results and Discussion, and to prepare the accompanying population-denominator and KRT rate tables. All AI-assisted content was reviewed and verified against the underlying registry data and analysis by the authors, who take full responsibility for the accuracy and integrity of the manuscript.

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APPENDIX I: PARTICIPATING TREATMENT CENTRES

EASTERN CAPE		
Public	Private	Private
Dora Nginza Hospital	B. Braun Avitum Mthatha	NRC Kwadwesi
Frere Hospital	Life East London Private Hospital	NRC Mdantsane
Livingstone Hospital	Life Mercantile Hospital	NRC Mthatha
Nelson Mandela Academic Hospital	Life Renal Dialysis Jeffreys Bay	NRC Port Elizabeth
	Life Renal Dialysis Port Elizabeth	NRC Port Elizabeth PD
	NRC Alice	NRC Queenstown
	NRC Butterworth	NRC Uitenhage
	NRC East London	Regional Renal Services Matatiele
	NRC East London PD	Regional Renal Services Mount Frere
	NRC King Williamstown	Regional Renal Services Mthatha
FREE STATE		
Public	Private	Private
Boitumelo Regional Hospital (Kroonstad)	B. Braun Avitum Bethlehem (Hoogland)	Life Rosepark Hospital
Bongani Regional Hospital (Welkom)	B. Braun Avitum Bloemfontein	Mediclinic Bloemfontein Renal Services
Dihlabeng Regional Hospital (Bethlehem)	B. Braun Avitum Harrismith	Netcare Transplant Centre Universitas
Mofumahadi Manapo Mopeli Hospital (Qua Qua)	B. Braun Avitum Welkom	NRC Bloemfontein
Pelononi Regional Hospital	Bophelong Busamed Harrismith Hospital	NRC Bloemfontein PD
Universitas Academic Hospital	Life Renal Dialysis Bloemfontein	NRC Kroonstad
Universitas Paeds	Life Renal Dialysis Sasolburg	NRC Pelonomi
GAUTENG		
Public	Private	Private
Charlotte Maxeke Johannesburg Academic Hospital	Arcadia Kidney and Dialysis Centre (FMC)	Life Renal Dialysis Atteridgeville
Charlotte Maxeke Johannesburg Academic Hospital Paediatric Unit	B. Braun Avitum Emfuleni (Vanderbijlpark)	Life Renal Dialysis Groenkloof
	B. Braun Avitum Kloof (Pretoria)	Life Renal Dialysis Kempton Park
Chris Hani Baragwanath Hospital	B. Braun Avitum Lakeview (Benoni)	Life Renal Dialysis Lenasia
Dr George Mukhari Hospital	B. Braun Avitum Pretoria (Urology Hospital)	Life Renal Dialysis Midstream
Helen Joseph Hospital	B. Braun Avitum Vereeniging	Life Renal Dialysis Morningside
Steve Biko Academic Hospital	B. Braun Melrose	Life Renal Dialysis Pretoria
	BRC Braamfischer	Life Renal Dialysis Randfontein
	BRC Modderfontein	Life Renal Dialysis Vaal
	Carletonville Kidney and Dialysis Centre (FMC)	Life Renal Dialysis Westrand
	Edison Hammanskraal Centre	Life Renal Dialysis Wits (Donald Gordon)
	Edison Mamelodi Centre	Life Robinson Private Hospital
	Izinso Dialysis Busamed	Life Springs Parkland Hospital
	Izinso Dialysis Centre Eersterust	Life The Glynnwood Hospital
	Izinso Dialysis Garankuwa	Life Wilgeheuwel Hospital
	Izinso Dialysis Kempton Park	LRC Lenasia
	Izinso Dialysis Soshanguve (Pretoria)	Mabika Renal Solutions
	Izinso Dialysis Soweto	Morningside Children's Kidney Treatment Centre (FMC)
	Izinso Pretoria West	Morula Kidney and Dialysis Centre (FMC)
	Lesedi Kidney and Dialysis Centre (FMC)	Naledi Kidney and Dialysis Centre (FMC)
	Life Bedford Gardens Hospital	Nephromed Kidney Centre Kwa-Thema
	Life Brenthurst Hospital	Netcare Transplant Centre Garden City Hospital
	Life Carstenhof Hospital	Netcare Transplant Centre Jakaranda Hospital
	Life Fourways Hospital	Netcare Transplant Centre Milpark Hospital
	Life Groenkloof Hospital	

Abbreviations: BRC, Busamed Renal Care; FMC, Fresenius Medical Care; LRC, Lenmed Renal Centre; MRC, Melomed Renal Care; NRC, National Renal Care; RCH, Renal Care Holdings.

APPENDIX I: PARTICIPATING TREATMENT CENTRES continued

GAUTENG cont.		
Public	Private	Private
	NRC Akasia	NRC Rynfield
	NRC Alberton	NRC Sebokeng
	NRC Arcadia	NRC Sedibeng
	NRC Johannesburg PD	NRC Springs N17
	NRC KidneyKidz	NRC Sunninghill
	NRC Krugersdorp	NRC Sunward Park
	NRC Linksfield	NRC Waterfall
	NRC Lyttleton	Ramdial Renal Services
	NRC Mayfair	Randfontein Private Hospital Dialysis Unit
	NRC Midvaal	RCH Randfontein
	NRC Montana	RCH Zamokuhle (Thembisa)
	NRC Mulbarton	Renalworx Dialysis Centre Wilgers
	NRC Olivedale	Tshepo-Themba Kidney and Dialysis Centre (FMC)
	NRC Parktown West	Tshwane Kidney and Dialysis Centre (FMC)
	NRC Pinehaven	Vosloorus Kidney and Dialysis Centre (Clinix)
	NRC Pretoria East	Waverley Kidney and Dialysis Centre (FMC)
	NRC Pretoria North	Westrand Dialysis Randfontein
	NRC Pretoria PD	Wits Donald Gordon Medical Centre Transplant Division
	NRC Raslouw	
KWAZULU-NATAL		
Public	Private	Private
Addington Hospital	B. Braun Avitum Dundee	Life Renal Dialysis Umhlanga
Greys Hospital	B. Braun Avitum Durban North	Life Renal Dialysis Vryheid
Inkosi Albert Luthuli Hospital	B. Braun Avitum Durdoc	Life Westville Hospital
St Aidan's Hospital	B. Braun Avitum Ethekwini	Merediac Durban (Durdoc)
	B. Braun Avitum Howick	Mount Edgecombe DCG
	B. Braun Avitum Newcastle	Netcare Transplant Centre St Augustine's Hospital
	B. Braun Avitum Pietermaritzburg	NRC Athlone
	B. Braun Avitum Scottburgh	NRC Ballito
	B. Braun Avitum Vryheid	NRC Berea
	BRC Gateway	NRC Chatsworth
	BRC Hillcrest	NRC Durban PD
	Coastal Nephrology Centre Ulundi	NRC Gateway
	Dr Parag and Raghubir Kidney Care Centre	NRC Hillcrest
	Kidney Care Estcourt	NRC Ladysmith
	Kwazulu Dialysis Randles Renal Unit (Sparks)	NRC Margate
	Kwazulu Dialysis Umlazi Megacity Renal Unit	NRC Pietermaritzburg CBD
	Life Chatsmed Hospital	NRC Pietermaritzburg PD
	Life Empangeni Hospital	NRC Pinetown
	Life Entabeni Hospital	NRC Richards Bay
	Life Hilton Hospital	NRC Umhlanga
	Life Mount Edgecombe Hospital	Pinetown Kidney and Dialysis Centre (FMC)
	Life Renal Dialysis Chatsworth	Port Shepstone Kidney and Dialysis Centre (FMC)
	Life Renal Dialysis Durban	Q Kidney Care
	Life Renal Dialysis Empangeni	RCH Ethekwini
	Life Renal Dialysis Ethekwini	RCH Ladysmith
	Life Renal Dialysis Hibiscus	RCH Shifa
	Life Renal Dialysis Kokstad	Regional Renal Services Harding
	Life Renal Dialysis Newcastle	Regional Renal Services Ixopo
	Life Renal Dialysis Richards Bay	

Abbreviations: BRC, Busamed Renal Care; FMC, Fresenius Medical Care; LRC, Lenmed Renal Centre; MRC, Melomed Renal Care; NRC, National Renal Care; RCH, Renal Care Holdings.

APPENDIX I: PARTICIPATING TREATMENT CENTRES continued

KWAZULU-NATAL cont.		
Public	Private	Private
	Renal Care Team Durdoc	Stanger Kidney and Dialysis Centre (FMC)
	Renal Care Team Kwamashu	Ultra Kidney Care Isipingo
	Renal Care Team Ladysmith	Verulam Dialysis Centre
	Renal Care Team Pinetown	Victoria Kidney and Dialysis Centre (FMC)
LIMPOPO		
Public	Private	Private
Pietersberg Hospital	B. Braun Avitum Louis Trichardt	Nephromed Polokwane
	B. Braun Avitum Mokopane	Nephromed Thohoyandou
	B. Braun Avitum Polokwane	NRC Polokwane
	B. Braun Avitum Tzaneen	NRC Thabazimbi
	Chantel van Rooyen Bela-Bela	NRC Venda
	Edison Giyani Centre	Polokwane Kidney and Dialysis Centre (FMC)
	Edison Thohoyandou Centre	Thohoyandou Kidney and Dialysis Centre (FMC)
	Nephromed Kidney Centre Elim	Van der Walt Renal Care Groblersdal
MPUMALANGA		
Public	Private	Private
	B. Braun Avitum Ermelo	Life Midmed Hospital
	B. Braun Avitum Nelspruit	Life Renal Dialysis Emalaheni (Witbank)
	B. Braun Avitum Trichardt	Middelburg Kidney and Dialysis Centre (FMC)
	B. Braun Avitum Witbank	NRC Nelspruit
	Highveld Nephrology Centre Bethal	White River Dialysis
NORTH WEST		
Public	Private	Private
Job Shimankana Tabane Hospital	B. Braun Avitum Vryburg	Mafikeng Kidney and Dialysis Centre (FMC)
Klerksdorp Hospital	Izinso Dialysis Mafikeng	Nephromed Kidney Centre Rustenburg
	Life Klerksdorp Dialysis	North West Dialysis Klerksdorp
	Life Lichtenburg Dialysis	North West Dialysis Lichtenburg
	Life Renal Dialysis Brits	NRC Lonmin
	Life Renal Dialysis Potchefstroom	NRC Rustenburg
	Living Waters Dialysis Klerksdorp	Rustenburg Kidney and Dialysis Centre (FMC)
	Living Waters Dialysis Taung	Zeerust Renal Unit
NORTHERN CAPE		
Public	Private	Private
Kimberley State Hospital	B. Braun Avitum Kimberley	North West Dialysis Hartswater
	B. Braun Avitum Upington	RCH Kimberley
	Mediclinic Gariep Renal Services	
Abbreviations: BRC, Busamed Renal Care; FMC, Fresenius Medical Care; LRC, Lenmed Renal Centre; MRC, Melomed Renal Care; NRC, National Renal Care; RCH, Renal Care Holdings.		

APPENDIX I: PARTICIPATING TREATMENT CENTRES continued

WESTERN CAPE		
Public	Private	Private
George Hospital	B. Braun Avitum Cape Gate	Netcare Transplant Centre Christiaan Barnard Memorial Hospital
Groote Schuur Hospital	B. Braun Avitum Mossel Bay	
Red Cross War Memorial Children's Hospital	B. Braun Avitum Oudtshoorn	NRC Blaauwberg
Tygerberg Hospital	B. Braun Avitum Worcester	NRC Cape Town CBD
Worcester Hospital	Khayelitsha Kidney and Dialysis Centre (FMC)	NRC Cape Town PD
	Life Renal Dialysis Athlone	NRC Eersterivier
	Life Renal Dialysis Cape Town	NRC George
	Life Renal Dialysis George	NRC Goodwood
	Life Renal Dialysis Hermanus	NRC Kuilsriver
	Life Renal Dialysis Panorama	NRC Paarl
	Life Renal Dialysis Winelands	NRC Plumstead
	Life Renal Dialysis Worcester	NRC Vredenburg
	Life Vincent Pallotti Hospital	Paardevelei Kidney and Dialysis Centre (FMC)
	MRC Bellville	Rondebosch Dialysis Centre
	MRC Gatesville	Stellenbosch Kidney and Dialysis Centre (FMC)
	MRC Gatesville PD	UCT Kidney and Dialysis Centre (FMC)
	MRC Mitchells Plain	UCT Private Academic Hospital
	MRC Tokai	

Abbreviations: BRC, Busamed Renal Care; FMC, Fresenius Medical Care; LRC, Lenmed Renal Centre; MRC, Melomed Renal Care; NRC, National Renal Care; RCH, Renal Care Holdings.

APPENDIX I: PARTICIPATING TRANSPLANT CENTRES

FREE STATE	
Public	Private
	Universitas Private Hospital
GAUTENG	
Public	Private
Charlotte Maxeke Johannesburg Academic Hospital	Netcare Garden City Hospital
Steve Biko Academic Hospital	Netcare Jakaranda Hospital
	Netcare Milpark Hospital
	Wits Donald Gordon Medical Centre
KWAZULU-NATAL	
Public	Private
Inkosi Albert Luthuli Hospital	Life Entabeni Hospital
	Netcare St Augustine's Hospital
WESTERN CAPE	
Public	Private
Groote Schuur Hospital	Netcare Christiaan Barnard Memorial Hospital
Red Cross War Memorial Children's Hospital	UCT Private Academic Hospital
Tygerberg Hospital	

