PEOPLE'S COP20 SOUTH AFRICA

COMMUNITY PRIORITY RECOMMENDATIONS

PEPFAR COUNTRY OPERATIONAL PLAN 2020

SANEREL A+

SOUTH AFRICAN NATIONAL AIDS COUNCIL
OUR ACTIONS COUNT
SANAC CIVIL SOCIETY FORUM

RITSHIDZE
SAVING OUR LIVES

MEDECINS SANS FRONTIERES

POSITIVE ACTION CAMPAIGN

+SECTION27
catalysts for social justice

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

HEALTH GAP
GLOBAL ACCESS PROJECT

TAC
TREATMENT ACTION CAMPAIGN

NAPWA
SOUTH AFRICA

TB PROOF?

INTRODUCTION

South Africa has 7.7 million people living with HIV (PLHIV), more than any other country, as well as one of the world's highest HIV prevalence rates.[1] Yet we remain dangerously off-track to meet the 90-90-90 targets and incidence rates are far too high—particularly amongst young people.

Of particular concern has been the insufficient pace of scale up of antiretroviral treatment and insufficient quality of programmes, leading to high rates of loss-to-follow-up. South Africa has relatively high rates of knowledge of HIV status—yet amongst those who know their status, fewer are on effective treatment and have successfully suppressed the virus in South Africa than in neighboring countries that have seen more rapid progress. The progress on the UNAIDS 90-90-90 targets by 2018, as estimated by Thembisa 4.2, has been 91%-68%-88%, translating into 62% and 55% of people living with HIV receiving ART and being virally suppressed, respectively.[2]

First, too many individuals are lost to follow-up before they initiate ART. For example, the 2019 PEPFAR Country Operational Plan (COP) reported that in the previous year, only 80% of individuals who tested positive initiated treatment.[3] For some key populations, that number was far lower—e.g. 56% for MSM and 19% for people who inject drugs.[4] Additionally, South Africa has led the world in scaling-up TB preventative therapy (TPT). However, there is still a long way to go until we reach the 90% target—in FY19, only 193,536 people completed a course of TPT (against a target of 578,149). Meanwhile, 759,506 were initiated on ART meaning only 25.6% coverage of people newly initiating ART.

Once PLHIV do initiate on treatment, there are severe retention problems. PEPFAR's 2019 data shows that while 759,506 people were initiated on treatment during the year, NET_NEW increased by only 353,605 by the end of Q4. In addition, only 55% of all PLHIV are virally suppressed. 2019 has seen some improvements, but not nearly enough to reach 90-90-90.

PEPFAR SA is also projecting a major increase in the number of PLHIV on treatment in FY20, needing a NET_NEW of 296,000 per quarter in FY20 to reach their COP19 targets—despite a NET_NEW of just 353,605 for COP18 for all four quarters. To support this target PEPFAR would need to be initiating almost the annual achievement each quarter (to account for people disengaging from care). This will not be possible without something truly transformative happening in the underlying programming, but what that is has not been identified.

A major reason for the failures in reaching 90-90-90 is the poor quality of HIV services available in the public sector. Poor HIV outcomes can be directly linked back to gaps in service delivery and poor quality public health services. In May 2019 the National Department of Health announced a slate of policy changes in a circular distributed to all Siyenza sites to remove barriers to care and support accountability of health workers—however the reality is that this directive has not been enacted by all sites, noted also in the planning letter: *"Despite extensive collaboration with and Circular dissemination by the GoSA, bottlenecks and inadequate policy implementation for optimal client-centered services persist at the provincial, district and site levels."*

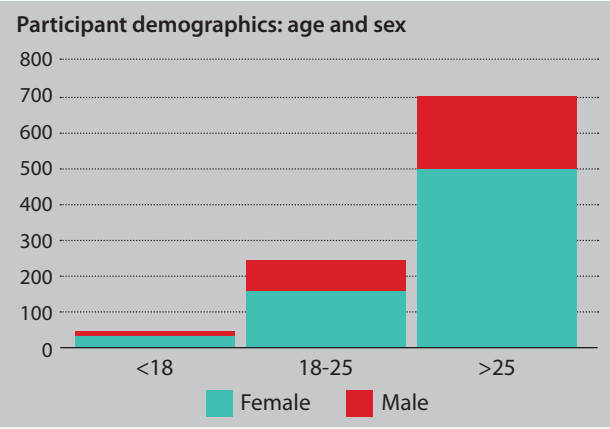
With the establishment of Ritshidze—a community-led monitoring system developed by organisations representing people living with HIV including the Treatment Action Campaign (TAC), the National Association of People Living with HIV (NAPWA), Positive Action Campaign, Positive Women's Network (PWN) and the South African Network of Religious Leaders Living with and affected by HIV/AIDS (SANERELA+)—we have begun to more systematically document the failures in quality HIV service delivery as well as gaps in terms of implementation of the circular.

1. UNAIDS, 2019, South Africa Country Fact Sheet, https://www.unaids.org/sites/default/files/media_asset/2019-UNAIDS-data_en.pdf; Our World In Data, 2017, https://ourworldindata.org/hiv-aids
2. UNAIDS Data 2019, p. 26, https://www.unaids.org/sites/default/files/media_asset/2019-UNAIDS-data_en.pdf.
3. PEPFAR COP 19 SDS, Table 2.1.2.
4. PEPFAR COP 19 SDS, Table 2.1.2.

This year's People's COP has been developed using data collected across two time periods: August and September 2019 (COP18 Q4) with the main focus on data collected in November and December 2019 (COP19 Q1).

The demographics of healthcare users surveyed in November and December include:

+ 639/1016 (63%) of people surveyed were living with HIV
+ 681/1016 (67%) of people surveyed identified as female
+ The majority were over 25 years old (69%)



While most data will be disaggregated throughout the community priorities outlined below, in terms of general clinic conditions during Q1 monitoring we found the following: About half (56%) of the clinic observations reported that there were enough seats for the people waiting. The majority of patients thought that facilities were relatively clean, with about 50% of patients indicating that the facilities were clean or very clean. Overall, 10% of patients reported that clinics were *"very dirty"*. The majority of data collectors found that the facility buildings were in good condition (69%), however toilets were frequently reported to be out of order, dirty, or lacking basic supplies with 67% of observations saying that the toilets were not in good condition. These 24 facilities were found to be in poor condition (both building and toilets in poor condition):

Alexandra CHC	Itireleng CHC	Ramokonopi CHC
Bethal Town Clinic	Lethabong Clinic	Sinqobile Clinic
Bophelong CDC (Emfuleni)	Lillian Mambakazi CHC	Soshanguve 2 Clinic
Chiawelo CHC	Lillian Ngoyi CHC	Soshanguve Block X Clinic.
Daveyton Main CDC	Mofolo CHC	Thoko Mngoma Clinic
Empilisweni CDC	Nyanga CDC	Thussiville (MN Cindi) Clinic
Emthonjeni Clinic (Msukaligwa)	Orange Farm Ext 7 Clinic	Yeoville Clinic
Guguletu CHC	Orlando Prov Clinic	Zone 17 Clinic

There was a pharmacist actively giving out medicine in 72% of facilities monitored and there was a health marshal helping patients to get to where they needed to go in 47%. Further data and observations will be documented throughout the People's COP.

In addition to monitoring data, the People's COP has been further shaped following consultation with people living with HIV, key populations, community based organisations (CBOs), Non-Governmental Organisations (NGOs), and Faith Based organisations (FBOs)—all stakeholders with collective experience at the forefront of South Africa's HIV and TB response.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PHILANI CLINIC
WORKING HOURS
MONDAY-FRIDAY :- 07:45 TO 16:30
WEDNESDAYS - STAFF MEETING
07:45 TO 08:30

COMMUNITY PRIORITIES INTERVENTIONS FOR COP20

PRIORITY	WHAT YEARS DID WE ASK FOR IT?	DO WE HAVE IT?
1. Increase the budget for the overall PEPFAR programme by US$200 million to match last year's overall budget that included surge funding.	COP20	No
2. Implement and maintain the promises made in COP18 to fund 20,000 supplemental frontline staff and 8 000 community healthcare workers in order to reduce waiting times and ensure better re-engagement in care.	COP18, COP19, COP20	No
3a. Roll out multi-month dispensing including six month supply.	COP20	No
3b. Establish and scale up facility and community adherence clubs at all PEPFAR supported sites to ensure at least 20% of eligible PLHIV are decanted into them (with the other eligible PLHIV decanted into CCMDD, fast lane, and other models).	COP17, COP18, COP19, COP20	In part
3c. Establish and scale up functional support groups at 100% of PEPFAR supported sites.	COP18, COP19, COP20	No
3d. Establish a sustainable and comprehensive approach to provide medical and psychosocial support that can be individualised according to distinctive needs of the disengaged individuals.	COP19, COP20	No
4. Put in place measures to ensure that index testing does not lead to intimate partner or other violence, or forced disclosure of PLHIV's status'.	COP20	No
5. Fund a widespread expansion of high-quality treatment literacy information.	COP17, COP19, COP20	No
6. Ensure that PLHIV are able to make an informed decision to start/ transition to a dolutegravir based regimen, and that PLHIV on DTG are tracked for weight gain and moved back if needed.	COP20	No
7. Scale up optimised HIV treatment for infants and ensure access to differentiated service delivery models for mothers and babies with HIV.	COP20	Waiting on registration
8a. Ensure "GREEN" TB infection control at all PEPFAR supported sites.	COP19, COP20	No
8b. Ensure universal TB screening, improve rates of TB testing, and ensure contact tracing amongst PLHIV with TB.	COP19, COP20	In part
8c. Support scale up of TB preventive therapy (TPT) amongst PLHIV.	COP19, COP20	In part
9. Support a bio-behavioural survey and a size estimate study for key populations to improve service delivery.	COP20	No
10. Ensure that men are able to access male friendly services e.g. male outreach initiation and management, male after hours clinics, and community testing.	COP20	In part
11. Ensure that interventions targeting young people reduce HIV incidence and provide adequate care and support to ensure long term treatment retention through youth friendly services and youth clubs.	COP18, COP19, COP20	In part
12a. Fund a community-led capacity building programme to strengthen and ensure the functionality of clinic committees across South Africa.	COP17, COP20	No
12b. Ensure accountability in HIV and TB service delivery by maintaining funding for Ritshidze in COP20.	COP19, COP20	YES!
12c. Eradicate barriers to accessing HIV, TB and STI medicines — caused by stockouts and/or shortages of medicines — at 100% of PEPFAR sites in COP20 by funding the Stop Stockouts Project.	COP19, COP20	No

1. Increase the budget for the overall PEPFAR programme by US$200 million to match last year's overall budget that included surge funding.

In COP19, the PEPFAR SA programme benefited from a $200 million surge fund that greatly catalysed the country's capacity to focus on game-changing strategies that improved the overall quality of the response. Those funds allowed the country to scale up interventions that they would have otherwise not been able to afford and that were directly targeted at escalating the successes of the programme. In COP20, PEPFAR SA needs to be able to maintain those gains and in the case where the viability of a strategy has been exhausted, reprogramme to new strategies.

According to the planning letter in COP20, PEPFAR SA will be receiving a relative funding cut of $207,000,000 (from up to USD 730,000,000 down to USD 523,440,000) based on the end of the surge funding. The planning letter states: *"With the end of the two-year surge of the additional $500 million USD through COP 18 and 19, we must ensure appropriate transition to the GoSA and adequate USG support to maintain those on treatment."*

Surge capacity as envisioned is critical to the success of the response in South Africa. However there also remains questions about the degree of the implementation of this plan. COP20 should provide an account of the resources that were spent as part of surge funds and the gaps that would be left if funds were decreased.

COP20 must increase the proposed budget for the overall PEPFAR programme by US$ 200 million to match last year's overall budget to ensure the maintenance of current success and to improve the quality of service delivery and retention rates more broadly.

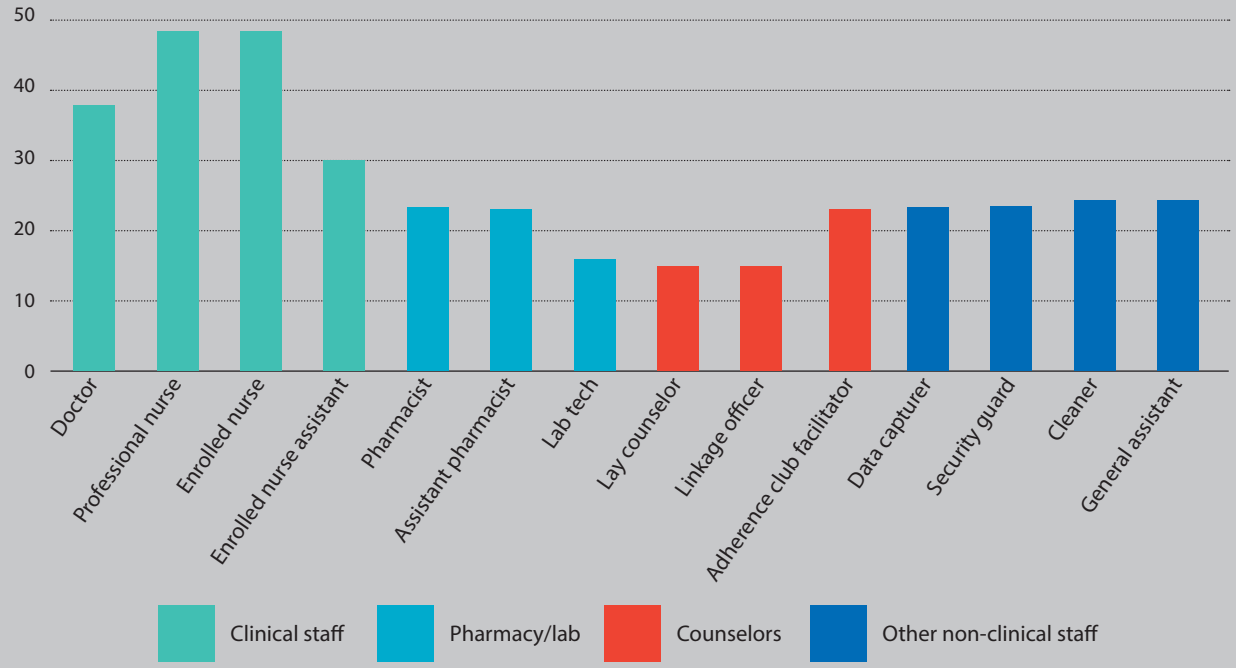
2. Implement and maintain the promises made in COP18 to fund 20,000 supplemental frontline staff and 8,000 community healthcare workers in order to reduce waiting times and ensure better re-engagement in care.

Despite commitments made by PEPFAR SA in COP18 to hire in facilities *"20,000 supplemental health workers from nine cadres"* including *"over 12,000 clinical and clinical support staff, complemented by management and lay staff"* — Q3 data shows that only 11,936 people were hired with (what looks like) just over 2,000 of those being clinical and clinical support staff. In addition, there was a commitment to hire *"over 8,000 CHWs and Outreach Team Leads to supplement NDoH investments"* — yet in Q3 only 5,356 CHWs and OTLs had been hired. Further there was a commitment to *"capacitate over 25,000 CHWs to provide quality services that increase treatment uptake, adherence and retention among PLHIV"* — yet in Q3 only 7,752 CHWs and OTLs had been trained. This begs the question, what was the surge funding spent on?

Monitoring at Ritshidze pilot sites in COP18 Q4 showed that 89.4% of the healthcare workers interviewed reported that there are not enough staff to meet the needs of patients. According to 987 patients, interviewed, on average, only 24.6% thought there was always enough staff to meet patients' needs across the sites. This varied across districts with 44.2% in the City of Tshwane, 74% in Sedibeng, and only 35% in eThekwini.

During November and December 2019 (COP19 Q1) Ritshidze monitoring 91% of facility managers reported that there was not enough clinical and non-clinical staff at the facility. The most commonly reported understaffed cadre was clinical staff including professional nurses (73%), enrolled nurses (73%), and doctors (57%).

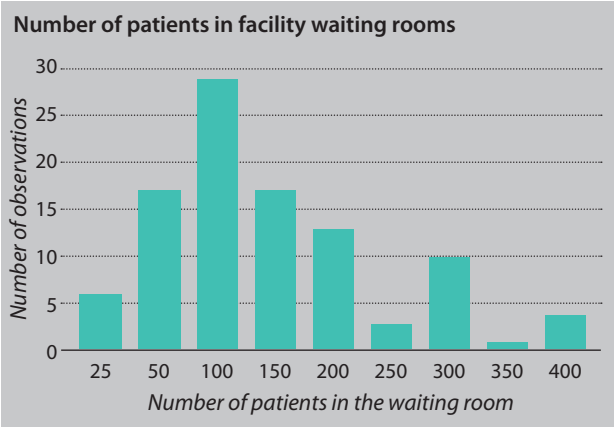
Facility manager reports of under-staffing by cadre



According to patients, on average 24% thought there were always enough staff to meet patients' need across the sites. This varied significantly across districts. In the City of Cape Town Metropolitan Municipality only 3% of patients said that there was always enough staff compared to Sedibeng District Municipality where 47% of patients thought there was enough staff.

One major result of human resource shortages is long waiting times. It is well known that each time someone is asked to spend an extended time at a health centre, simply to collect ART refills, there is an increased risk of losing that person from care. Long waiting times also affect the quality of services provided as healthcare providers have little time to provide adequate information or care to patients.

In Q1, 111 observation surveys were carried in Ritshidze. Most commonly, around 100 patients were recorded waiting for services. However, 4 observations recorded 350-400 patients waiting to be seen. These observations were at: Empilisweni CDC, Holy Cross Gateway Clinic, Dan Kubheka Clinic and St Elizabeth's Gateway Clinic.



Overall, 334 (38%) of patients said that clinics are not open enough hours and the **average wait time across clinics was 5.24 hours**.

Clinics with >50% of patients reporting that the clinic is not open for enough hours and there is never enough staff.

	Patients who think the clinic is not open for enough hours, (%)	Patients who think there is never enough staff, (%)	Average wait times (hours)	Average patient arrival time (earliest time)
Dan Kubheka Clinic	67%	50%	9.00	5:50 (5:00)
Ermelo Clinic	63%	56%	4.56	7:50 (6:00)
Flagstaff Clinic	100%	50%	6.50	8:00 (7:00)
Germiston City Clinic	65%	55%	6.22	7:30 (5:30)
Lethabong Clinic	71%	71%	8.03	6:26 (6:06)
Mary Moodley Memorial CDC	60%	67%	7.13	6:12 (5:00)
Michael Maponya Prov Clinic	59%	56%	3.90	7:29 (6:00)
Orange Farm Ext 7 Clinic	64%	55%	5.98	8:38 (5:00)
Stanza Bopape II Clinic	78%	67%	8.57	5:33 (3:00)
Tembisa Health Clinic	56%	56%	7.46	6:42 (5:00)
Tladi Prov Clinic	83%	94%	5.08	6:10 (5:00)
Town 2 CDC	100%	100%	6.69	7:49 (5:30)
Tshepisong Clinic	76%	59%	5.63	8:12 (5:00)
Weltevreden Valley Clinic	71%	64%	4.85	7:58 (6:00)

Long waiting times also mean that healthcare users arrive at the facility early in order to try to beat the queues and be seen during the day. There was an average arrival morning time of approximately 7:20am across the sites, with the earliest reported arrival time being 3:00am at four clinics: Stanza Bopape CHC (City of Tshwane), Stanza Bopape II Clinic (City of Tshwane), Sebei Motsoeneng Clinic (Sedibeng), and Itireleng CHC (City of Johannesburg). Overall, 25% of patients reported that they feel "very unsafe" when waiting for the clinic to open. Several clinics had 100% of respondents say that they felt very unsafe while waiting, including Embalenhle CHC (Gert Sibande), Inzame Zabantu CDC (City of Cape Town), Mary Moodley Memorial CDC (Ekurhuleni), and Weltevreden Valley Clinic (City of Cape Town). People should not be put in danger or unsafe conditions whilst waiting for healthcare.

The challenge of long waiting times is compounded in certain facilities where Ritshidze monitoring shows staff opening clinics late, taking excessive breaks, and/or closing early. There were also frequent complaints of staff being slow, relaxed or reluctant to work. Some complained of nurses being disinterested in patients and spending too much time playing on their phones or gossiping. For example:

+ At **Goodwins Clinic (eThekwini)** community members told us that 'people arrive at 5am or 6am. The gate opens at 6.30am. Staff are meant to start working at 7am — but only start at 9am. The healthcare workers take a break at 10am. Back at 11am. Then lunch at 12pm. Back at 1pm. Then stop taking patients at 2pm.'
+ At **Umzomuhle Clinic (eThekwini)** according to patients the staff don't have enough time for patients, take long breaks, and whilst the opening hours on the board say 7am, the reality is that doors open at 7.30am or 8am. It is not safe to wait outside due to robberies, yet people wait from 4am. Whilst monitoring we witnessed all staff taking a long break at the same time, leaving patients waiting.
+ At **Chesterville Clinic (eThekwini)** the staff at the clinic are reportedly late to arrive. This leads to long waiting times. Whilst the clinic is meant to open by 8am, they would still be cleaning until 10am, which is when the first patient would be seen. Some nurses would be doing nothing. *"They need to clean at night, not the morning. If they can take just 10 minutes per patient... you can arrive by 7am, but up until 5pm we are still there. Staff take tea breaks at the same time and lunches, so the facility stops. By 2pm they chase patients away saying [they are] cleaning. Worse, on pay day they don't have time for people at all".*
+ At **Soshanguve Block TT Clinic (City of Tshwane)** people arrive at 4am, when it is unsafe to do so. Staff are apparently rushed, due to being overburdened, where they see patients and dispense medicines. On one day of monitoring, the nurses had knocked off duty in the middle of the day. Further, people complain of a lack of privacy at the facility.
+ At **Soshanguve Block JJ Clinic (City of Tshwane)** people reportedly arrive at 3am and are not attended to for many hours. The clinic opens at 7am but no one is seen until 9am. Patients reported people being robbed waiting for the facility to open.
+ At **Stanza Bopape CHC (City of Tshwane)** there are very long waiting times. Reportedly the staff work slowly — and some fail to wear uniforms or name tags so there is no ability for patients to complain. Patients report waiting for more than 4 hours simply to get their files. Most people told us they wait the whole day at this facility to be seen. There were reports of patients being robbed waiting for the facility to open.
+ At **Diepkloof Prov Clinic (City of Johannesburg)** one person living with HIV told us *"staff work slowly and do personal business like playing with their phones instead of attending patients"*.

Further, whilst a National Department of Health (NDoH) circular issued in May 2019 states that *"Every effort must be made to extend opening hours of facilities to attract patients, e.g., those not working, who cannot attend during normal opening times. Facilities must be open from 5:00 -19:00, as well as 8:00-16:00 on Saturdays. Patients should also be able to use these extended opening times to pick up their medication from internal pick up points"* — not all facilities have implemented this directive.

Patients at only 7 non-24-hour sites monitored reported opening times from 6am Monday to Friday and 8am Saturday (Alexandra 8th Avenue Clinic (City of Johannesburg), Alexandra CHC (City of Johannesburg), Daveyton Main CDC (Ekurhuleni), Mary Moodley Memorial CDC (Ekurhuleni), Mofolo CHC (City of Johannesburg), Soshanguve 2 Clinic (City of Tshwane), Soshanguve Block TT Clinic (City of Tshwane), **at all other sites monitored opening hours have not been extended as per the circular**. In addition at some facilities, such as Umzomuhle (Umlazi H), PLHIV are still being turned away without receiving ART based on the fact that a PLHIV arrives outside of the designated collection day — "they told me to come back on Wednesday".

At many facilities, poor filing systems and/or lost files or cards were also observed or reported on by healthcare users. Messy and disorganised filing systems increase the delays to healthcare users being attended to, and increase the burden on already overstretched healthcare workers. Lost files can cause huge inconvenience to healthcare users. Many patients complained about the filing systems of clinics being a mess, with their files often missing or taking forever to find. This was one of the primary reasons that they thought the waits were so long. This despite directive in the May 2019 NDoH circular stating: *"a functional filing system must be in place and maintained to ensure that files can be open and retrieved in the shortest possible time to reduce patient waiting times."* One patient at Diepkloof Prov Clinic told us: *"The filing system is the worst of its kind, if they don't lose files they give you duplicates every time you visit".*

Patients using Sebei Motsoeneng Clinic (Sedibeng) complained about cards being lost due to the negligence of clinic administrators. *"This affects us a lot as we are forced to bring our medication containers and packets when we go to the clinic so that if our cards are not found the Sisters will be able to see as to which medication we are taking."* Sisters at the clinic confirmed this challenge stating that the issue is created due to a lack of space and filling cabinets to store the cards. At times patient files are even left unattended in open areas of the clinic where anyone can access them for instance this was found at Stanza Bopape CHC (City of Tshwane), Soshanguve CHC (City of Tshwane), Mpola Clinic (eThekwini), and Umlazi D Clinic (eThekwini).

In terms of Community Healthcare Workers (CHWs) — the vast majority of facility managers (90%) report that there are CHW based at their facilities. These facilities had on average 24 CHWs based at the facility (range 3-80). These CHWs are mostly supervised by the Department of Health (48/60, 80%), with 5 Facility Managers (8%) reporting that the CHWs were supervised by PEPFAR implementing partners. Most facilities had 2 CHW supervisors (range 1-6). The majority of Facility Managers (82%) said that CHWs at their facility do not have access to transport to work in the field. Of those that did report that there is transportation for CHWs (n=9), 6 Facility Managers considered this transportation reliable. **This means that across 66 facilities where we have good data, only 6 (<10%) report having CHWs based at the facility who have reliable transportation to the field.**

+ In Eshowe, MSF provided HIV testing and linkage to care through community-based support (through patient supporters and community health workers), resulting in Eshowe being able successfully to achieve the 90-90-90 targets (95-95-95) a year ahead of the UNAIDS deadline. Critical to this was the ability to use mobile sites and community-based support on farms and in deep rural communities. Although over time the HIVyield of the CHW testing programme decreased, early on it was very high. The CHW also helped to "normalise" HIV testing and treatment as they became a fixture of normal community health services. Finally, when a HIVcase was detected, they were able to follow up to try to ensure that the individual had been linked to HIV treatment services.

Separately, in the peri-urban township of Khayelitsha in Cape Town, MSF has demonstrated the capacity to manage patients in the community with an Outreach Initiation Management (OIM) approach, using a mobile van as an outreach of a primary care facility to provide HIV services (counseling and testing, ART initiation and management of ART and differentiated service delivery through clubs and quick pick up options). Other services included, NCD management, family planning as well as STI screening and management. Comprehensive service delivery is helpful to reduce the stigma associated with attending an 'HIV facility' and increases the headcount, with most patients attending for minor medical issues. Nearly all the attending patients are opportunistically tested for HIV, providing a convenient platform to find those who had never tested before (1% of those tested) or who had not tested in over a year (12% of those tested) — people who had not been reached by standard services.

OIM hads initiated 325 people on ART since Q2 2017, with 71% initiated same day, 79% within a week and 88% of those testing positive initiating within 3 months. The 12 month retention in care (RIC) for the first year averages 66%; this is lower than facility-initiated patients but compares favorably to RIC for people tested in the community and linking into facilities. After prioritising youth after 3pm, their proportion rose from 22% in 2017 to 48% by the end of 2019. Despite the availability of DoH services in peri-urban Khayelitsha, the convenience of a community-based model like OIM is an enabling factor in accessing care, particularly for those individuals that struggle to access services in the existing health system. That said, it takes time for a community to trust new services and for mobilisation to gain momentum: after 2 years in the community, 47% of patients surveyed said they first heard of OIM through word-of-mouth. Mobilisation is resource intensive but finding patients that do not access facilities may require a thorough approach, including door-to-door, radio and social media campaigns those ones appearing to have a potential big impact.

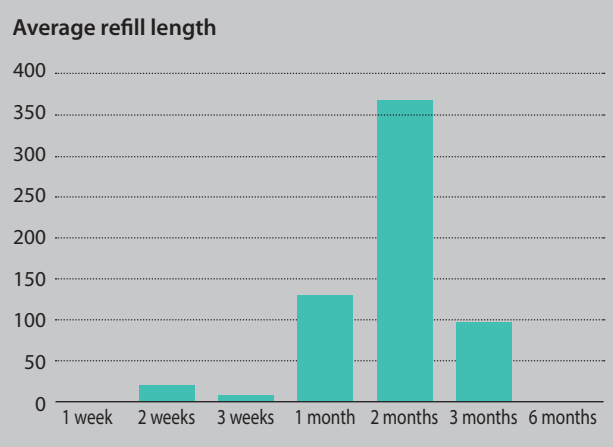
COP20 must implement and maintain the promises made in COP18 to fund 20,000 supplemental frontline staff 8,000 community healthcare workers in order to reduce the burden on facilities including to reduce waiting times.

3. Improve retention in care and number of PLHIV re-engaged in care by implementing 6 month refills, establishing and scaling up adherence clubs, support groups and MSF's "welcome services".

Ritshidze data collected through focus groups and door to door engagement in communities revealed a number of reasons why PLHIV were stopping ARVs or even dying:

+ *"I'm a traditional health practitioner living with HIV. I am worried about my patients not wanting to attend the clinic to access ARVs because the staff disclose people's HIV statuses."*
+ *"I have been living with HIV for 16 years and have stopped my ARVs because of the bad and extremely slow service from the clinic. I went back on treatment but struggle to access other healthcare services because for any illness I have I am told to take ARVs and am not allowed the opportunity for consultation."*
+ *"I have defaulted from ARV treatment because I moved and the clinic denied me a referral letter and my new clinic is denying me services because I do not have a referral letter."*
+ *"I came to the clinic this year around February because I had defaulted, I had no problem if a sister had talked to me in a polite manner instead she decided to humiliate me, reminding that I'm a useless person with no future, and she also reminded of how I have shingles because of stupidness. I got hurt in a way where I stopped coming to the clinic."*
+ *"I lost my sister-in-law to TB in November 2019 — but the clinic had taken numerous TB tests that were either not returned, or came back TB negative. My sister-in-law was referred to the hospital late and ended up dying in the facility that was meant to keep her alive and healthy as a person living with HIV."*
+ *"In September I went to the clinic and the queues were very long and there was very bad staff attitude. I ended up not taking my ARVs for about two months. It ended very bad because I got very sick my viral load was affected and CD4 count was affected. I borrowed some medication from my neighbours. My wife went to clinic for me because I was very sick. When she got there she was told to go to the end of the line, but at least she came with the ART."*
+ *"I stopped taking ART and was scared to go to the clinic. By the time I decided to go back, they gave me a very hard time to re initiate. So I continued defaulting until I went to another clinic and was helped."*
+ *"I started ART in 2018 but I stopped taking my treatment in November 2019 because of the long queues. I live near the clinic but I have to queue at 6am then leave at 4pm. As I was supposed to go back to the facility on the 8th January 2020, I did not go back to collect. I'm now very sick and I have lost weight."*
+ *"It was March 2019 when I started collecting my ARVs at the clinic. When I went to the facility collect my medication in the following months, I had to stand in the queue from 6am in the morning. When I went in, they told me they lost my file, they gave me few ARV pills to come back the following week I did that for 4 weeks. The facility does not have a health promoter that teaches us about HIV. I stopped taking my ARVs 6 months ago because of being ill treated at this facility, I don't even wish to go back to the facility."*
+ *"In October 2019 I went to the clinic to collect my ARVs and I had missed my appointment date by just 1 day. When I arrived in the clinic it was around 6am and I went to the administrator to check my file. When he looked at my file, he noticed that I missed my appointment date and he started shouting at me. He didn't even give me the chance to explain why I missed my appointment and he went on, yelling about me being lazy and not caring about my life and that attracted attention from other patients who were waiting for their file and I felt so humiliated and it got to a point where I thought its best if I leave without taking the medication. From there I never went back to the facility."*
+ *"I defaulted for 2 months and I got very sick, then a sister advised me to register as a sex worker so that I can have an access to ARVs at an outreach clinic. Even though I am not a sex worker, I did that in January 2020, just so I can be back on treatment."*
+ *"I am HIV positive. When I collect my medication I am always early, as I normally arrive early before the clinic opens. We wait outside until the security opens the gate. After the security guards open the gates, we go inside to get our cards for retrieval of files. While we are waiting outside under the tree until the admin worker calls our names one by one while waiting under the tree. All community members who pass by the clinic already know our status as its everyday thing and they have to stay out as their clinic is small. Some of my friends have asked for transfers and others have stopped coming to take their treatment due to waiting outside for their meds."*

Yet the planning letter makes the assumption that since the "Siyenza" project took place, the retention crisis has been averted stating: *"The significant client retention issue that existed at end of FY18 was resolved in FY19, though retention continues to be a problem".* Further the planning letters go on to state that *"While linkage and retention improved in FY19… the program only reached 81% of COP18 TX_CURR target in the 27 districts. ART initiation and retention, especially for men and adolescents lags behind."* The reality is though that the retention crisis is far from over — and many people who would like to collect ARVs through differentiated methods and/or closer to home do not.



In Q1 monitoring, Ritshidze found that the majority of Facility Managers report that there is a fast track available for stable patients (89%) and that there are CCMDD pickup locations at the facility (44%), nearby in the community (35%) or both (17%).

Of PLHIV surveyed at facilities, the majority (70%) are collecting ARVs through the facility, although 14% of participants collected their ARVs through Central Chronic Medication Dispensing and Distribution (CCMDD) and 12% through an adherence club. It is notable that most patients reported receiving 2 month ART refills still despite the SDS stating *"beginning in COP19, patients will be able to receive three months of medications",* and worrying **some PLHIV reported refills of only 1 month, or even 3, 2, or 1 weeks**.

The SDS states that *"a total of 1.47 million patients receive two months of medications through adherence clubs and*

centralized chronic medicines dispensing and distribution (CCMDD) models; beginning in COP19, patients will be able to receive three months of medications and will have access to additional medical collection options such as lockers." (SDS p8) 1.47 million patients accounts for just under 20% of PLHIV in South Africa, leaving 80% of PLHIV continuing to collect their ART refills in overburdened public health facilities. With 55% of PLHIV virally suppressed and potentially eligible for CCMDD or differentiated service delivery model collection, the number decanted is not enough to release the burden on struggling and under-staffed public health facilities.

3a. Roll out multi-month dispensing including six month supply

Related to the broader call for novel ways to decant PLHIV from facilities while retaining patients in care, we welcome the push towards multi-month dispensing advocated for by PEPFAR in the Planning Letter. We support the proposed pilot that PEPFAR will be conducting, involving rollout of 6-month supply of treatment in PEPFAR-supported districts. MSF has implemented a randomised controlled trial to compare extending multi-month ART refill intervals from two to six months among existing adherence club patients (Lebelo et al., 2019; Wilkinson et al., 2016). Preliminary results show non-inferiority in terms of 12-month retention (97% compared to 98%) and VL suppression (98% compared to 97%).

Pursuant to this study, MSF also conducted a descriptive qualitative study including in-depth interviews with patients, healthcare workers and key informants to understand the acceptability of 6-month refills in the SA health system. The findings of the study indicated that patients, healthcare workers and key informants found six-month refills within adherence clubs acceptable and beneficial. Patients found six-month refills increased convenience and reduced unintended disclosure. Contrary to key informant concerns about patients' responsibility to manage larger quantities of ART, patients receiving six-month refills were highly motivated and did not face challenges transporting, storing or adhering to their treatment. Six-month refills were felt to increase the health system's efficiency and free healthcare worker time for other tasks (admin and patient care), but there were concerns from the procurement department about whether the existing drug supply system could adapt to six-month ART refills at scale. Stepwise, slow expansion could avoid overstressing supply and allow time for the health system to adapt, permitting six-month ART refills to enhance various current differentiated service delivery options, such as the club model, to be more efficient and patient-centred within current health system constraints.

COP20 must roll out multi-month dispensing including 6 month supply to all stable patients (i.e. >6 months on treatment and more than a month without adverse effects), whether within a differentiated model of care (e.g. adherence club) or not, across South Africa.

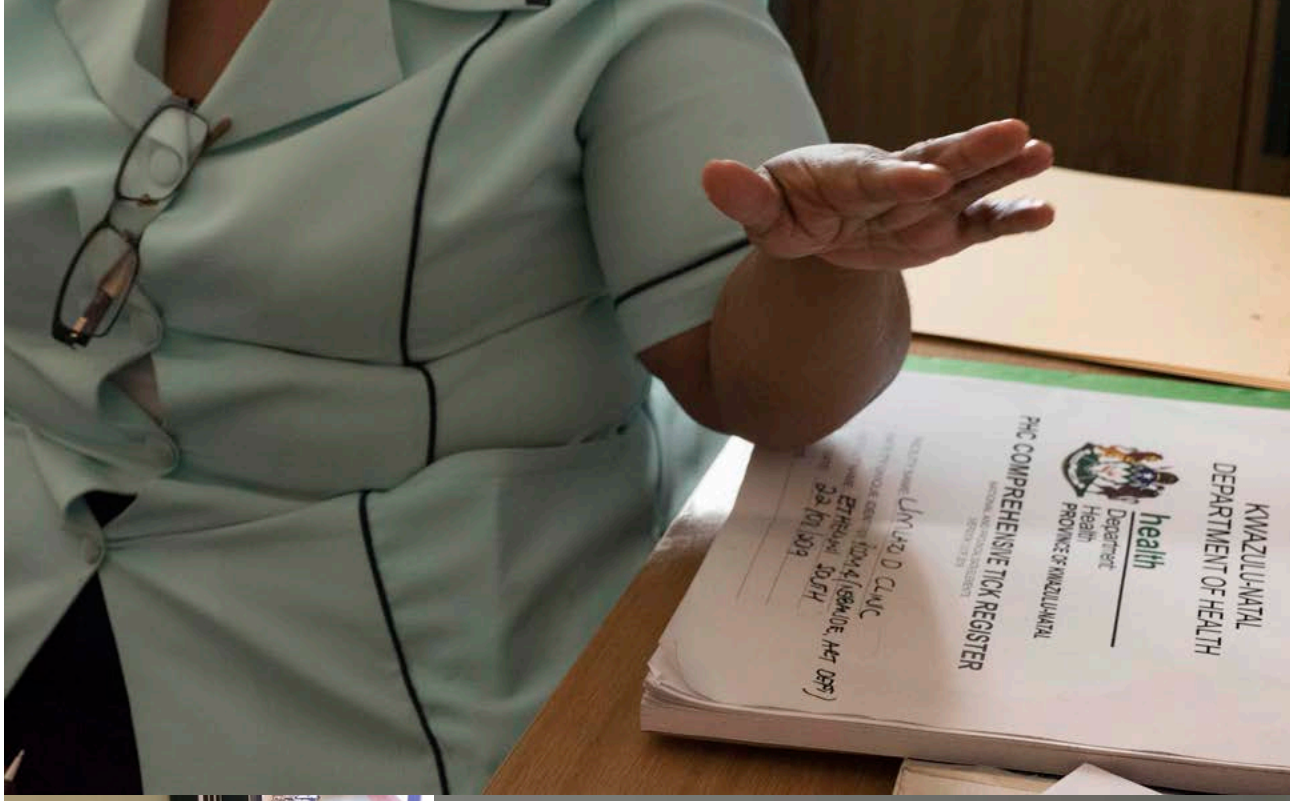
3b. Establish and scale up facility and community adherence clubs at all PEPFAR supported sites to ensure at least 20% of eligible PLHIV are decanted into them (with other eligible PLHIV decanted into CCMDD, fast lane and other models).

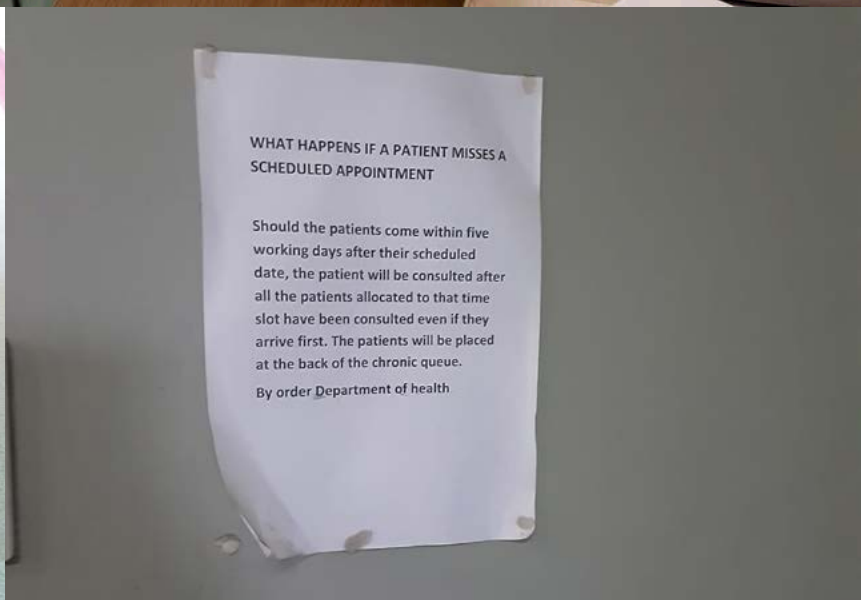
One method recommended by community to improve retention, has been the establishment of functional adherence clubs across the country. In COP18 the People's COP recommended a target that: *"In COP18, every PEPFAR-supported site will aim to have both group and fast track models of care in place. This will include group models of adherence clubs with integrated ART delivery as well as support groups up and running at both facility and community level. Each facility will have a target for the portion of PLHIV engaged in adherence clubs"* and PEPFAR SA committed to *"jointly developing 40 SOPs to cover identified priority interventions across the HIV care cascade [that are] designed to improve quality and efficiencies across community and facility sites, and to ensure that key interventions are delivered with fidelity and scaled optimally to address the identified barriers to performance. Examples of priority interventions include extended clinic hours, intensified case finding, self screening, same-day ART initiation, adherence clubs and support groups."*

However, at the COP planning meetings in Johannesburg in March 2019, it became clear that these had not been scaled appropriately. In the City of Tshwane at Stanza Bopape CHC it was found for instance that there was 1 Adherence Club facilitator for nearly 11,000 PLHIV collecting ARVs at the site. With this knowledge, in COP19 the People's COP again recommended **functional** adherence clubs as a means of improving retention requesting the following language: *"At start COP19, 100% of PEPFAR sites will have a functional adherence club model for ART delivery as well as support groups, and will report portion of patients in adherence groups"* and PEPFAR SA committed to *"reducing treatment disengagement from care by improving patient experience during clinic visits through a range of interventions, including [amongst other listed items]: increasing access to facility and community Adherence Clubs"* (SDS p29). Further to *"identify the populations in each district most affected by adherence challenges and will increase support for them via community- based adherence clubs."* (SDS p29).

Yet, in February 2020, adherence clubs remain at times either dysfunctional, under-staffed, and/or with fewer PLHIV than are thought actually decanted into them. During August and September 2019 (COP18 Q4) across 23 pilot sites in the City of Tshwane (Gauteng), Sedibeng (Gauteng) and eThekwini (KwaZulu-Natal) data collected showed limited progress in the COP18 cycle. Of the 23 sites surveyed — with a total of 195,737 people on ART — there were a total of 198 clubs reported, with 5 sites not having any clubs at all, managed by only 50 adherence club facilitators, and a total of 2,466 PLHIV decanted. This means only 1.26% of the PLHIV population is collecting ART via an adherence club at these sites and that the adherence clubs are under-subscribed at only 12 people per club on average. At some clinics patients told us that they had *"never heard of an adherence club"*. Worryingly, adherence club figures given by facility managers, adherence club facilitators and patients did not tally in a number of facilities.

During Q1 Ritshidze monitoring, data in our sample of PLHIV showed the minority (37.4%) of participants were aware of an adherence club at the facility or in the community where they could meet with other people living with HIV and pick up their medicines. However, of the patients who were accessing an adherence club, they generally reported positive experiences with 88.2% of patients saying that their club made it quicker to pick up their medication, 85.7% saying that their club provided information about HIV and adherence, and 81% saying that they got peer support from their club. Most PLHIV who were surveyed (71%) said that they would like to collect ARVs closer to their home if it were possible.





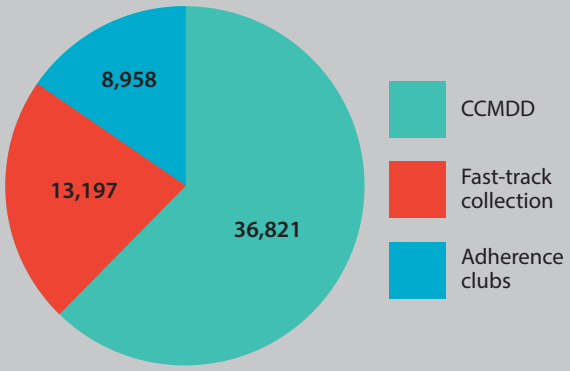
Overall Ritshidze data collected from Facility Managers at facilities monitored in November and December 2019 found that 58,967 patients across had been reported to have been decanted to CCMDD, fast track collection or adherence club collection in the past two months. This is 17% (58,967/353,303) of people accessing treatment across all facilities monitored. Of those decanted, the majority were decanted to CCMDD (36,821, 62%).

When monitoring teams surveyed Adherence Club Facilitators, 70% report having at least one adherence club at the facility and 54% report at least one club operating in the community. 29/35 adherence clubs (83%) meet more than once every two months.

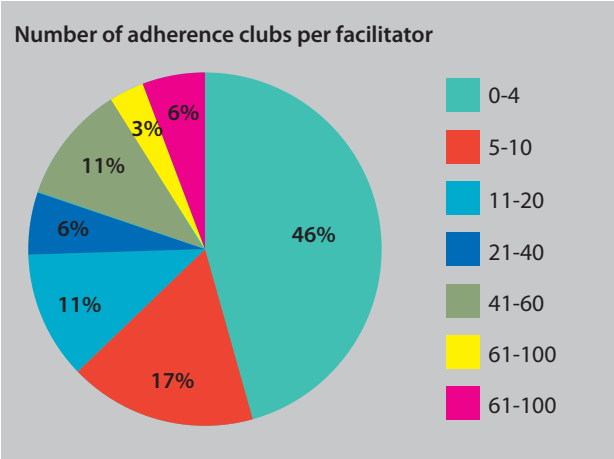
Summary statistics on adherence clubs:

+ Number of reported adherence clubs located at the facility ranges from 0 to 384 at Zola CHC (City of Johannesburg). The median number of adherence clubs per facility was 6. There were six clinics that reported 0 adherence clubs at the facility: Ramokonopi CHC (Ekurhuleni), Dawn Park Clinic (Ekurhuleni), Palmridge Clinic (Ekurhuleni), Goba Clinic (Ekurhuleni), Diepkloof Prov Clinic (City of Johannesburg), Mandela Sisulu Clinic (City of Johannesburg).

Number of patients decanted in the past 2 months by type



+ Number of reported adherence clubs located in the community ranges from 0 to 1,064 (at Zola CHC). The average number of adherence clubs in the community was 48, and the median number was 3. Twelve facilities reported having no community adherence clubs: Orlando Prov Clinic (City of Johannesburg),



Tshepisong Clinic (City of Johannesburg), Lillian Ngoyi CHC (City of Johannesburg), Midvaal CDC (Sedibeng), Mandela Sisulu Clinic (City of Johannesburg), Ethandakukhanya Clinic (Gert Sibande), Lillian Mambakazi CHC (Gert Sibande), Amsterdam CHC (Gert Sibande), Mary Moodley Memorial CDC (Ekurhuleni), Senaoane Clinic (City of Johannesburg), Lenasia Clinic (Ekurhuleni), Malvern Clinic (City of Johannesburg).

Most commonly, facilities reported having one adherence club facilitator (32%), or two facilitators (22%). However, one adherence club facilitator was often responsible for overseeing more than 40 adherence clubs (20% of facilities), and **over 100 adherence clubs** in 6% of facilities.

A FUNCTIONAL ADHERENCE CLUB

+ Adherence clubs are run by an adherence club facilitator who understands treatment adherence information and who is trained to identify people with psycho-social and other mental health challenges who need referral for further support;
+ Community-based clubs can be run by community based organisations in conjunction with facilities, where a visiting clinician joins the club sessions to dispense medicines and provide a clinical check-up;
+ The meetings take place either at the facility or in a venue in the community where participants discuss issues concerning them and their group members;
+ Members should have a basic clinical check-up, conducted by a visiting clinician;
+ Members are stable patients who should collect three to six months' supply of ARVs;
+ To qualify for the adherence club, patients must be stable (have been on the same ART regimen for over a year; have adhered to ART for 18 months or more; have an undetectable viral load as shown by the latest two consecutive tests; have no history of defaulting or missing appointments in the last 12 months; and have no medical conditions that require regular clinical care);
+ One club consists of a maximum of 30 people living with HIV who meet every three to six months and are reminded of their appointment by SMS the day before;
+ Blood tests will occur every 12 months with a clinician visiting;
+ TB symptom screening will occur at each session and TPT collection will be available through clubs;
+ In contrast to clinic visits which can take hours or even a full day, adherence club members must be in and out of their club visit in between one and two hours.
+ Clubs are not simply a collection point, they must include discussion on issues of treatment literacy and adherence information which members have to attend;
+ Some clubs should be specific to target populations based on gender, age of if part of a key population; such as male clubs, youth clubs, KP clubs etc.
+ All club members should understand what is the function of the club and why they have been decanted to the model.

Patient reports matched adherence club facilitator reports concerning what topics are more commonly discussed at adherence clubs, including side effects of medications (92% of clubs), why patients should adhere (90% of clubs), and discussing different medicine options such as new drugs (55% of clubs). Patients at the following clinics reported that adherence clubs provided information about all three topic areas: Boipatong CHC (Sedibeng), Bophelong CDC (Ekurhuleni), Levai Mbatha CHC (Sedibeng), Malvern Clinic (City of Johannesburg), Mary Moodley Memorial CDC (Ekurhuleni), Midvaal CDC (Sedibeng), Orange Farm Ext 7 Clinic (City of Johannesburg), Ramokonopi CHC (Ekurhuleni), Sebei Motsoeneng Clinic (Sedibeng), Yeoville Clinic (City of Johannesburg), and Zone 17 Clinic (Sedibeng).

However, community monitors also report challenges in the overall functionality of adherence clubs for instance at Emthonjeni Clinic (Gert Sibande) where it is reported that adherence clubs are simply pick up points, *"even clients do not know about adherence clubs"*. Or Empilisweni CDC (Ekurhuleni) where *"they have no space for adherence clubs, patients are being mixed together with the chronic patients"*. Or Esselen Clinic (City of Johannesburg) where *"patients are transferred to adherence clubs at the community, but when patients arrive there is no treatment for them as they are not captured in the system. So patients end up going back to the facility and getting their treatment there"*.

COP20 must establish and scale up facility and community based adherence clubs at 100% of PEPFAR supported sites as committed to in COP18 and COP19. Of eligible patients (approximately 4,235,000 PLHIV — 55% of 7.7 million — who are virally suppressed) at least 20% should be voluntarily decanted to join a club (with other eligible PLHIV decanted into CCMDD, fast lane and other models).

3c. Establish and scale up functional support groups at 100% of PEPFAR supported sites.

As requested in previous People's COPs — support groups linked to each public health facility 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. There continues to be a high number of people lost to follow up. There have been a number of losses in the past few years of people becoming treatment fatigued, stopping ARVs, and passing away. Much more needs to be done to provide counselling, psycho-social support and other mental health services to prevent this "pill fatigue" from taking place. There should be a minimum of one support group linked to each PEPFAR supported facility that people newly initiated on treatment, people re-engaging in care, and people struggling on treatment can be linked to.

COP20 must fill the human resource and other gaps to ensure the establishment and scale up support groups at all PEPFAR supported sites run either by community based HIV organisations or healthcare providers.

3d. Establish a sustainable and comprehensive approach to provide medical and psychosocial support that can be individualised according to distinctive needs of the disengaged individuals.

In COP19 the People's COP requested a pilot of an MSF model of "Welcome Services" combining recommendations around patient identification, medical package of care, and psycho-social package of support — with one focus area being *"in helping change staff attitudes to patients upon return after interruption".* Continuing in COP19, PEPFAR SA and the DoH committed to *"ensure "Welcome Back Services" are maximizing opportunities to re-engage people who have interrupted treatment into care to achieve stable outcomes".* However the realisation of robust and effective "Welcome Services" has yet to be seen.

Firstly — the DOH "Welcome Back Campaign" is not what was outlined in the People's COP19. The focus has almost solely been placed on staff attitude, which whilst critical to fix, is not the only aspect of "Welcome Services" which need to be targeted to PLHIV with low CD4 counts and presenting with AIDS. In order to fully implement effective "Welcome Services" we need a full package of services as outlined below.

MSF'S WELCOME SERVICES

MSF, together with the Department of Health in the Western Cape, has established "Welcome Services" at Michael Mpongwana Clinic in Khayelitsha. The following are the components of this approach, operated by the provincial health department:

+ Identifying patients (counsellors to trace patients; digital single patient viewer' to track movement of patients through health system);
+ Medical package of care (provide point of care diagnostic tools to allow CD4 detection allowing patients to be assigned to care depending on whether their CD4 count is above or below 200 cells/ul; provide TB LAM and Gene Xpert testing among PLHIV (1) with TB signs and symptoms, (2) who are seriously ill, or (3) have advanced HIV disease (AIDS); incorporate evaluation for eligibility to receive a course of TB preventive therapy);
+ Psychosocial package of support (training in helping change staff attitudes to patients upon return after interruption, provide individualised counseling to patients, peer-led patient navigators acting as a bridge between clinicians and patients, mapped networks of referral services, and optional support groups.

WHAT THE "WELCOME SERVICE" ADDS:

+ **Foundational/system changes:**
  - » Support linkage/referral along continuum of care/ referral along continuum of care: PHC Hospital;
  - » System to identify and follow up patients to target support (triage/prep room clinicians, M&E reports);
  - » Support staff resilience and welcoming attitude (HCW engagement package);
  - » Create enabling environment: easier to see difficult patients (merge with risk-of-treatment-failure, clinical/ counseling tools, training);

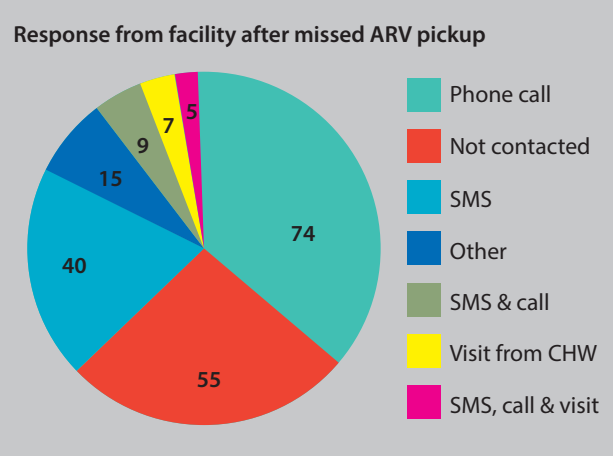
+ **Practical support additions:**
  - » Medical:
    - › Getting patients onto effective regimen ASAP to improve VL suppression:
      - · Rapid restart, rapid switch to second line treatment;
      - · Risk of treatment failure merge i.e. triaging to determine treatment failure;
    - › Emphasis on managing advanced HIV:
      - · Improving rates of TPT and Bactrim prescription; improve mix of OI's CD4 at restart;
      - · Continuum of care PHC Hospital (provision of clinical training; stationery)
  - » Psychosocial:
    - › Improve retention in care with counseling tools to effectively address gaps in support;
      - · Treatment literacy, return to care
      - · Managing barriers to treatment;
      - · Support referrals for mental health/substance use disorder
      - · Provision of counseling tools; training;
    - › Provide individual support to patients that need it through patient navigators (TAC volunteers):
      - · Facilitate patient journey;
      - · Appointment reminders

The Welcome Back Campaign is a positive step towards filling gaps in care for patients that are struggling with engagement in the current system. The focus on tracing and monitoring of these tracing systems is welcomed. The emphasis on enhanced adherence counselling (EAC) and patient education is important, however there is no counselling content in the national adherence guidelines that supports staff to give tailored sessions to those that are returning to care or who have advanced HIV. MSF has content on these topics and would be willing to share it (MSF has already trained the Western Cape PDC trainers in its use).

The WBC is also supportive of the use of motivational interviewing and a 'Welcome Approach', but does not give further tools or instruction on how to implement this. We feel strongly that healthcare cannot merely adopt 'customer service' techniques and apply them to the healthcare worker-patient relationship, as the power dynamics and objectives of the clinic visit are very different from sales. Thus we have developed a three-session package to support staff's welcoming attitudes and build resilience to help them be more supportive of difficult patients. As part of this we feel the language used regarding patients who are struggling with ART needs to change, including replacing the word 'default' with 'disengage', including in all guidance on the topic, in order to reduce the stigma associated with these 'bad patients' who are labelled as such for life after any episode of poor adherence. Again, MSF is willing to share the three 'Healthcare Worker Engagement' sessions.

The WBC should incorporate a more cyclical view of engagement (account for the 'churning' seen when looking at large datasets) rather than the traditional, linear 90-90-90 perspective, and should include all patients who struggle with ART (those who have a high VL due to non-adherence, those who intermittently engage with the system and those who have completely disengaged and are returning to restart ART) into one differentiated model for struggling patients. Advanced HIV (AIDS) is an ongoing challenge especially in those patients disengaging from care. Advanced HIV care needs to be enhanced at primary healthcare (PHC) facilities (training and mentoring) and referral pathways between secondary and tertiary hospital with PHC and communities must be improved to ensure good outcomes. Patients struggling with care often means very sick patients and management of those needs must be better integrated through POC technology when needed and proper triage and immediate care plus referrals. Access to better regimens that are affordable is also urgently needed. Clear examples being flucytosine not yet registered in South Africa and liposomal amphotericine B (LAmB) which is very expensive and only used with there is renal impairment instead of using it as first line treatment.

A second challenge is reports that people who miss appointments are not contacted. Whilst the majority of patients (51%) we talked to said that they had never missed a facility visit to collect their ARVs (so they did not know what would happen if they did) — we see that for some PLHIV, they are not contacted at all. See the details below for those that had missed a visit:



According to Q1 data capturer surveys completed by Ritshidze, the number of PLHIV accessing services or lost to follow up at the facilities in each district are as follows:

District	# of adults accessing ARVs	# of children accessing ARVs	# confirmed LTFU in two months	# unconfirmed LTFU in two months
City of Cape Town	8,923	41	0	146
City of Johannesburg	136,830	5,067	67,322	880
City of Tshwane	5,238	65	24	6
Ehlanzeni District	875	65	--	17
Ekurhuleni	123,666	2,365	1,433	6,131
Gert Sibande	26,471	558	5,349	518
King Cetshwayo	9,131	227	49	34
Oliver Tambo	10,914	321	481	147
Sedibeng	31,255	734	3,436	618
Total	**353,303**	**9,443**	**78,094**	**8,497**

On average facilities reported tracing and bringing back 553 PLHIV into care in the past two months via community health workers (range 0 to 10,668). However, reports from Facility Managers at facilities report the following challenges: the most common barrier reported was that patients give the wrong information for follow-up. However, Facility Managers also report lack of equipment for linkage officers or lack of transportation for CHWs as challenges.

What are the major challenges for linkage officers to finding people who are lost to follow up?	(%)
Patients give wrong phone numbers or addresses	(88%)
Not enough linkage officers	(26%)
Not enough phones	(21%)
What are the major challenges to bringing patients back into care?	
Patients give wrong number or addresses	(92%)
No transport	(33%)
Not enough phones	(26%)
Safety issues	(24%)
Not enough CHWs	(10%)

Thirdly, staff attitude remains a major barrier — reports of staff reactions to patients who missed a facility visit for ARV collection were often unwelcoming, unempathetic, or at worst objective human rights violations. Across clinics only 47% of patients thought that the staff were friendly and professional. About a fourth (24%) of patients said that staff were welcoming when they came to collect ARVs even if they had previously missed a visit. However, 25% said that if you miss an ARV pick-up you are sent to the back of the queue next time you come in.

At Meadowlands Zone 2 Provincial Clinic (City of Johannesburg) a poster was found on the wall stating that *"What happens if a patient misses a scheduled appointment. Should the patients come within five working days after their scheduled date, the patient will be consulted after all the patients allocated to that time slot have been consulted even if they arrive first. The patients will be placed at the back of the chronic queue. By order Department of health".*

At Lusikisiki Village Clinic (OR Tambo) a policy was found that stated: *"Should they come within five working days after their scheduled date, they will be consulted after all the patients allocated to that time slot have been consulted, even if they arrive first."*

At Itireleng CHC (City of Johannesburg) most patients reported that after a missed visit you are served last: *"They make you wait until they finish all other patients [before you get your medications]. Even If you arrive at 5am you end up leaving at 2"* — PLHIV at Itireleng CHC (City of Johannesburg)

Another 15% of patients reported that when you return to the clinic you are reprimanded for missing a visit. This compares to only 9% of patients who report that staff will provide counseling on adherence if you return to the clinic. At Daveyton Main CDC (Ekurhuleni), multiple respondents reported that the staff *"will shout at you in front of everyone"* if you come back in after missing an appointment. In the worst cases, some respondents reported that when they missed an appointment they were told that they could no longer get ARVs from that clinic:

"They told me that they will cancel me from accessing my ARVs from the facility for 2 months or refer me to Piet Retief clinic" — PLHIV at Amsterdam CHC (Gert Sibande)

The SDS states that *"Siyenza works with facility staff and managers to ensure that PLHIV are linked to care, PLHIV who miss appointments are traced immediately and returned to care, and PLHIV who have dropped out of care are identified and welcomed back"* (SDS p10) — yet the reality is that this is not happening in all Siyenza sites as monitored by Ritshidze. PEPFAR's new definition of lost to follow up (28 days instead of 90 days) means that the numbers of people needed to be followed up will greatly increase and the programme needs to ensure that all sites are implementing the "Welcome Services" needed to increase retention outcomes.

Another factor contributing to unwelcoming services is that there have been 31 reports of confidentiality or privacy concerns across clinics (30% of observations). Most commonly, 45% data collectors reported that PLHIV were being separated from other chronic patients in the waiting rooms, and 42% reported that more than one person was being consulted or counselled in the same room or with the door open. Data collectors observed the presence of a locked complaint box in the majority of clinics (73%).

Some clinics reported having too little space and needing to consult PLHIV in the same room, at times with a cupboard separating the room in half, but still being able to hear everything, as is the case in Midvaal CHC (Sedibeng) for instance.

COP20 should implement "Welcome Services" as per the MSF model (that is more extensive than the DOH Welcome Back Campaign) that aims to ensure people who have interrupted treatment are re-engaged into care to achieve stable outcomes and, where necessary, are quickly switched to appropriate regimens of care (i.e. 2nd line or 3rd line treatment).

4. Put in place measures to ensure that index testing does not lead to intimate partner or other violence, or forced disclosure of PLHIV's status'

The SDS states that *"the NDoH index testing guidance includes specific procedures to ensure consent, protect confidentiality and prevent harm related to intimate partner violence, informed by broad consultations. PEPFAR and NDoH are working together to ensure structures are in place to support consent, disclosure to spouse and sexual partners, and to manage risks and incidence of intimate partner violence related to HIV disclosure."*

Almost every facility reports engaging in index testing (97%). Of these, 70% of Facility Managers say that they screen clients for intimate partner violence (IPV) as part of their index testing protocol. However, the majority of Facility Managers (53%) who do screen for IPV still contact all the partners of clients regardless of reported violence. This is a major concern and violation of people's safety and privacy. Only 14% said that they either don't trace any contacts or don't trace the contacts for which there was reported violence for HIV testing. The majority of Facility Managers (79%) also said that if a client screened positive for violence that they offered then IPV services on site (43%) or referred for services (35%). Importantly, screening for IPV without adequate IPV services to respond to a client's 'positive' screen is dangerous and unethical.

If a client has experienced violence from one or more of their sexual partners what do you do with the contact information of their sexual partners?	(%)
Do not contact partners of client for HIV testing	(4%)
Only contact partners of the client who have no history of violence for HIV testing	(10%)
Contact all partners for HIV testing	(53%)
Don't know	(8%)
Other	(24%)

Based on Q3 data there are Index Acceptance rates of 60% (community) and 50% (facility) are important to monitor. There should not be a dramatic increase in those rates as it would suggest healthcare providers are not letting people "opt-out" easily.

However, Ritshidze monitoring from Q1 shows that amongst PLHIV, (59%) said that a healthcare worker had ever asked them for the names and contact information of their sexual partners so that they may be able to test them for HIV. Of these, 378 participants who remembered ever having been asked for the contacts of their sexual partners, **23% reported that they did not think they were allowed to "say no"** or refuse to give the names of their sexual partners.

Individual site reports revealed worrying practices. For example at Stanza Bopape CHC (City of Tshwane) or Emthonjeni Clinic (Gert Sibande) where PLHIV reported being forced to provide the contacts of children — even if born prior to HIV infection — in order to test for HIV thus forcibly having their statuses disclosed to their children.

COP20 must not contain any targets that a percentage of people newly diagnosed with HIV must come from index testing. COP20 must additionally ensure that before contacting the sexual partners of PLHIV, all healthcare providers ask if their client's partners have ever been violent and avoid contacting them if so in order to protect their client — and after contacting the client the healthcare providers must also check with the patient if they faced any violence due to contacting and refer them to the IPV centre if the answer is yes. Prior to (re-)implementing index testing in any facility, there must be adequate IPV services available for PLHIV at the facility or by referral and all patients who are screened should be offered this information. PEPFAR must ensure that index testing is always voluntary, for both sexual contacts and children, where clients are not required to give the names of their sexual partners or children if they don't want to. All PLHIV must understand that this is voluntary. Additionally, an adverse event monitoring system must be established that's capable of identifying and providing services to individuals harmed by index testing. If these demands are not or cannot be met by an implementing partner, index testing must not continue at the facility for any population.

5. Fund a widespread expansion of high-quality treatment literacy information

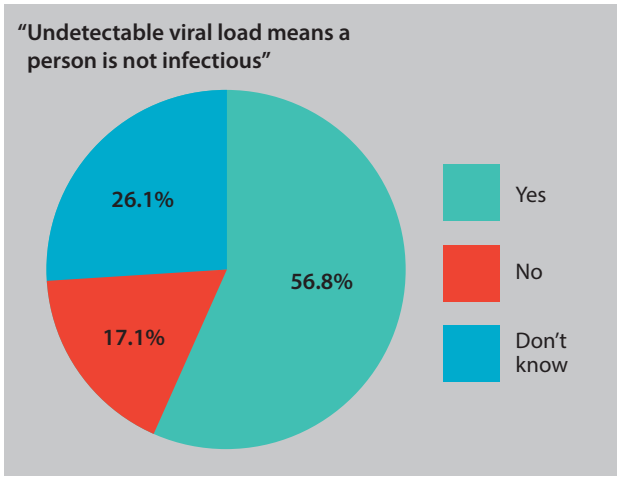
Since 2016, we have been calling for funding for prevention and treatment literacy. Last year we called for COP19 to "provide the financial and other resources necessary to ensure a major upscale of treatment literacy in the country. This should include a community lead component: material development and dissemination to 100% of PEPFAR sites, training of trainers & subsequent trainings, social mobilisation campaigns at community level. Additionally, there will be a health worker lead component ensuring that community and facility-based health workers understand HIV and TB fully to offer up to date prevention and treatment literacy information."

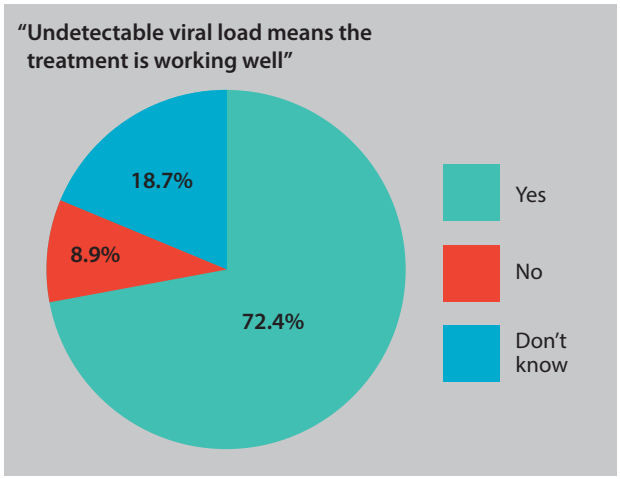
The SDS made vague commitments that *"During the second half of COP18 and during COP19, PEPFAR SA will focus on preventing disengagement from care by (amongst other things) improving health and treatment literacy"* (SDS p28). Further that *"Treatment literacy will needed to inform PLHIV of the risks and benefits of switching to TLD versus TLE400. PEPFAR SA will support PLHIV and community led treatment literacy interventions which will include trainings and health promotional campaigns"* (SDS p8). However a number of questions remain for how and when this will be implemented.

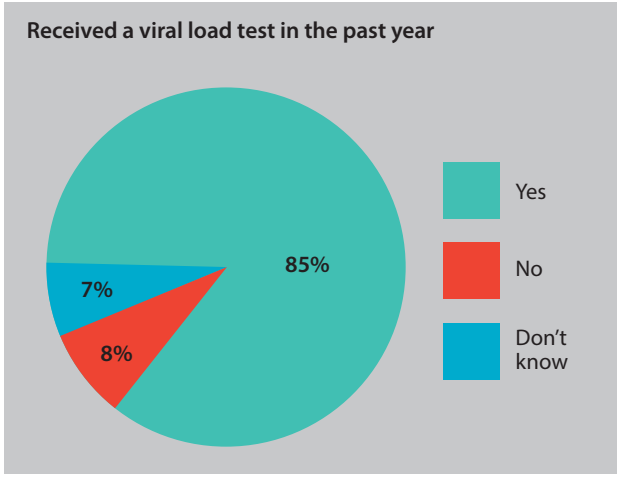
Firstly, no PLHIV Sector or Key Populations Sector organisations have been approached to date to implement community-led treatment literacy interventions. Who is PEPFAR engaging to implement this work, at what scale ,and in what timeframe?

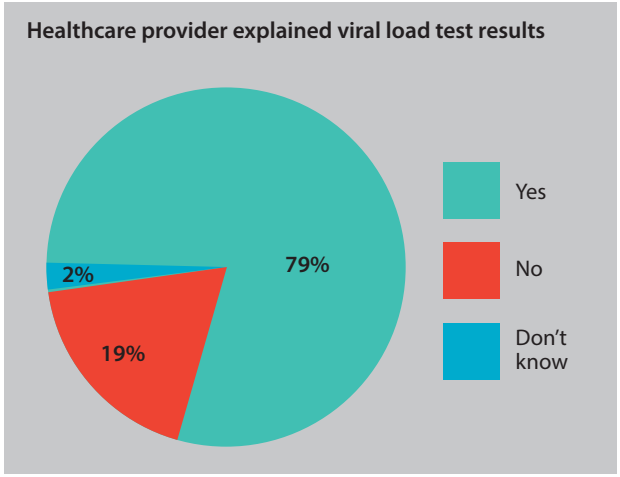
Secondly, monitoring through Ritshidze shows a number of concerns in regard to both PLHIV and healthcare worker treatment and prevention literacy levels. For example, healthcare workers at several sites during the design phase did not understand the difference between PrEP and PEP — with PrEP often cited as prescribed for a "burst condom".

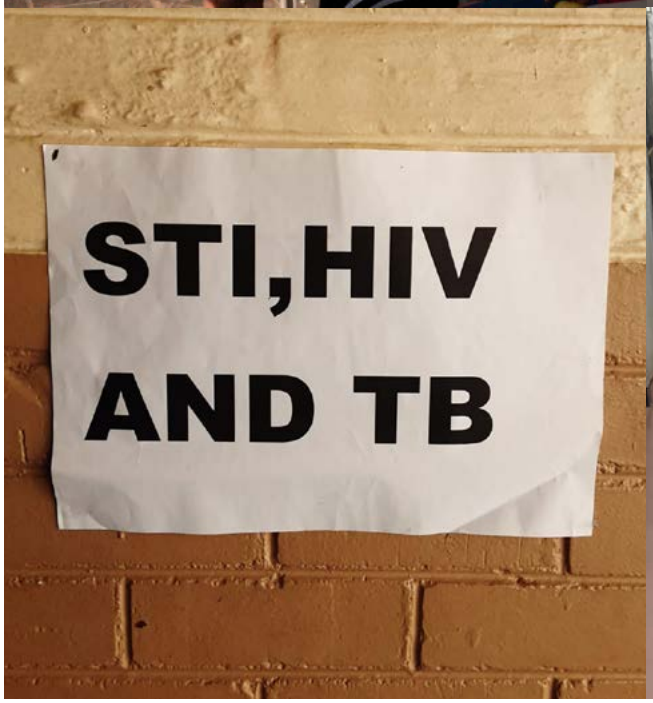
Further, there were gaps in knowledge amongst PLHIV about what an undetectable viral load test means. Whilst 71% of participants living with HIV reported that they know their viral load, in our sample only 51% agreed with both of these statements; *"having and undetectable viral load means the treatment is working well"* and *"having an undetectable viral load means a person is not infectious."* 85% of participants had gotten a VL test in the past year and of those, only 79% said that a healthcare provider had explained the results.











COP20 must financially and otherwise support efforts to design and implement a widespread quality community-led treatment literacy programme that complements and supports the provider initiated counselling services by funding at least 5 community, PLHIV, and KP lead organisations in South Africa to:

a. *Design and develop accurate, informative, accessible and easily understandable prevention and treatment literacy materials related to the science of HIV/TB and related medicines, treatment adherence, the importance of early treatment initiation, treatment adherence to achieve an undetectable viral load, and mental health issues — PEPFAR should then ensure the dissemination of these materials to all PEPFAR supported health facilities;*
b. *Implement a country-wide training of trainers programme to develop a cadre of PLHIV treatment literacy trainers to improve treatment literacy levels in the general population and amongst key and marginalised populations through trainings in the community as well as through localised social mobilisation campaigns at a community level in all PEPFAR supported districts;*
c. *Disseminate all materials to PEPFAR supported sites and amongst support groups and adherence clubs to reduce information gaps and ensure PLHIV are able to access the most up to date, accurate and relevant treatment literacy information especially with regard treatment regimen changes and the importance of maintaining an undetectable viral;*
d. *Run subsequent trainings and health talks at facility level to provide information to patients waiting for services as well as healthcare providers.*

PEPFAR SA must also ensure the inclusion of prevention and treatment literacy topics in the training and scope of work of all government funded CHWs and all PEPFAR funded health workers doing tracing of people with HIV and TB in the community and adherence club facilitators.

6. Ensure that PLHIV are able to make an informed decision to start/ transition to a dolutegravir based regimen, and that PLHIV on DTG are tracked for weight gain and moved back if needed.

Dolutegravir offers many important clinical benefits to PLHIV, notably that it is highly effective, well-tolerated, has a high barrier to resistance, has fewer interactions with other medicines (although some exist) — and compared to efavirenz, is easier to take and has the capacity to be produced more affordably. However, evidence from new studies shows first-line DTG is associated with rises in body weight (mean change in weight at 96 weeks >5kg) for PLHIV on TAF/FTC+DTG, worse for women (mean change in weight at 96 weeks >10kg).

Further it is associated with clinical obesity in men and women (ADVANCE and NAMSAL), and increased trunk and limb fat (ADVANCE). Further, rises in body weight on TAF/FTC+DTG are progressive and do not plateau to 96 weeks in women (ADVANCE).

While longer term follow-up and re-analysis of other studies is required to evaluate the consequences of weight gain and clinical obesity — in the interim PEPFAR SA should ensure that within its programme, PLHIV are able to choose whether to start/or continue on an efavirenz based regimen or start/ switch to a dolutegravir based regimen. Health workers must be trained on the need to allow PLHIV to make an informed choice for TLD initiation / transition. Further, PEPFAR must institute tracking of weight gain amongst PLHIV taking DTG and respond accordingly, including by returning people back to an efavirenz based regimen where necessary.

Q1 monitoring shows that the majority of Facility Managers report that their staff have been trained on TLD transition (77%) and about half (41%) of Facility Managers reported that DTG was available at their facility at the time of the survey. Of these, 23 (85%) report that patients are given a choice between a dolutegravir or efavirenz based HIV regimen when initiating treatment. Facility Managers in all of the clinics offering DTG reported that they 'always' or 'most of the time' provide people with information about the pros and cons of choosing efavirenz based regimens versus dolutegravir based regimens when they are initiating.

The majority of Facility Managers (81%) report that women who are on or are switching to a DTG-based regimen are offered contraception, 3 said 'no' and 2 reported that they 'didn't know'. **Of those clinics that reported offering contraceptives to women on or switching to a DTG based regimen, (77%) were also facing a contraceptive stockout or shortage in the last two months.**

COP20 must ensure that PLHIV are able to choose whether to start/or continue on an efavirenz based regimen or start/switch to a dolutegravir based regimen. Health workers must be trained on the need to allow PLHIV to make an informed choice for TLD initiation / transition. PEPFAR must institute tracking of weight gain amongst PLHIV taking DTG and respond accordingly, including by returning people back to an efavirenz based regimen where necessary.

7. Scale up optimised HIV treatment for infants and ensure access to differentiated service delivery models for mothers and babies with HIV.

It is estimated that 1.8 million children are living with HIV, of whom almost 90% live in sub-Saharan Africa. Only an estimated 54% of these children have access to HIV treatment and over 300 children still die from the disease every day. Inappropriate, suboptimal treatment options have contributed to low treatment coverage.

WHO recommends use of DTG based regimens for infants and children who meet the dosing criteria (>20kg) phasing out use of Nevirapine based regimen for neonates and paediatrics. Currently the LPV/r-based regimens remain the optimal first line agents for infants and young children < 20 kg until DTG based regimens are readily accessible for them. We note that challenges of tolerability and acceptability have impaired adherence to the current syrup used which has negatively affected adherence to treatment. Additionally the need for refrigeration has led to wastage and stockouts of medicine. New paediatric formulation which will address these challenges and ensure optimised treatment for paediatric and children for whom approved DTG dosing is still unavailable. i.e those <20kg are expected in the year including the 4 in 1 granules (contain ritonavir, lopinavir, abacavir and lamivudine) and DTG 10mg. We recommend in COP20 that in all infants and children are phased out of nevirapine and switched to DTG based regimens. Children <20kg should be initiated/switched on Lpv/r-based regimens in the most friendly formulations, like LPV/r pellets or 4-in-1 as soon as it is available. Treatment literacy for mothers of children living with HIV to improve case finding, treatment adherence and retention to care.

In addition there should also be Postnatal Clubs (PNC) where mothers living with HIV and their HIV exposed infants are offered peer-led psychosocial group support for the mother, clinical one-stop shop and early childhood development activities.

MSF piloted this activity in Khayelitsha and compared it to historical controls. The data showed that the intervention led to VL completion for the mothers being statistically higher for PNC compared to controls (RR1,5 for 0-12 months and 2.6 for 12-18 month VL completion). Through qualitative study, patients also indicated a high level of satisfaction with the model. The PNC model allows integration of healthcare for the mother and infant pair and can be placed outside of the health facilities as space is a common challenge presented in an overburdened health systems. Community venues are currently being used for Community Postnatal Clubs and adaptation of the clubs to offer PrEP to breastfeeding women will be implemented soon allowing HIV negative women to have access to improved healthcare systems.

COP20 must ensure rapid transition from nevirapine based regimen to DTG based regimen for all infants and children living with HIV within dosing criteria of >20kgs. LPV/r based regimens must be made available for infants and children <20kgs using available syrup whilst making the pellets/granules available for paediatrics who are struggling with taking the syrup. Health workers must be trained on the need to support treatment literacy for mothers of children living with HIV to improve case finding, treatment adherence and retention to care.

8. Reduce TB mortality (the leading cause of death amongst PLHIV) by upscaling interventions aimed at preventing and diagnosing active TB cases.

8a. Ensure "GREEN" TB infection control at all PEPFAR supported sites.

Various TB infection control measures can be taken to reduce the risk of TB transmission at clinics. The following questions in Ritshidze monitoring relate to TB infection control:

1. **Is there enough room in the waiting area? (Observation survey)**
2. **Are you seen within 30 minutes of arriving at the facility? (Patient survey)**
3. **Are the windows open? (Observation survey)**
4. **Are there posters telling you to cover your mouth when coughing or sneezing? (Observation survey)**
5. **Are people in the facility waiting area asked if they have TB symptoms? (Patient survey)**
6. **Are people who are coughing separated from those who are not? (Patient survey)**
7. **Are people who cough a lot or who may have TB given tissues or TB masks? (Patient survey)**

Based on the answers to these seven questions facilities are ranked RED (3+ questions answered "no"), ORANGE (1-2 questions answered "no"), or GREEN (0 questions answered "no"). Out of 73 facilities with full results for all TB infection control indicators, **69 were in a RED state, 4 in an ORANGE state and 0 in a GREEN state**.

By indicator our data shows that the majority of patients still report that facilities are not taking the appropriate measures to minimize the risk of TB spread in waiting rooms: 46% of patients report that staff do not ask people in the waiting areas if they have TB symptoms (i.e. coughing, fever, recent weight loss); 53.4% of patients report that coughing patients in waiting areas are not separate from other people; 56.7% report that coughing patients are not given masks or tissues while they wait; and on a slightly more positive note, across clinics there were observations of visible TB infection control posters in 74% of clinics and the majority (80%) of the clinics had their windows open. However much more needs to be done to ensure that all facilities are at a GREEN TB infection control level.

8b. Ensure universal TB screening, improve rates of TB testing, and ensure contact tracing amongst PLHIV with TB.

One key driver of excess morbidity and mortality amongst PLHIV are symptoms of TB or other risk factors that are overlooked by clinics and healthcare workers. Monitoring by Ritshidze in COP19 Q1 revealed that a majority 79% Facility Managers reported no TB LAM testing being available. In contrast, but still with room for improvement, Facility Managers reported GeneXpert testing as being available in a majority of clinics, either onsite (42%) or offsite (41%).

To improve rates of TB detection amongst PLHIV in the PEPFAR programme in South Africa in COP20, clinics, hospitals and other PEPFAR sites should universally screen PLHIV for TB symptoms and other risk factors upon their presentation to care, and ensure both urine-LAM and Xpert MTB/RIF Ultra testing for those with TB signs and symptoms or who are seriously ill. Whenever an individual is believed to be at risk of or is diagnosed with TB, PEPFAR South Africa should ensure contact tracing is conducted amongst their household and other close contacts.

In COP19, PEPFAR South Africa committed to *"make urine mycobacterial lipoarabinomannan (LAM) available to patients hospitalized with advanced HIV disease."* In COP20, South Africa should expand this commitment to include PLHIV in outpatient settings, as well as all PLHIV with TB signs and symptoms or who are seriously ill, in accordance with the latest WHO recommendations and PEPFAR COP20 Guidance.

Additionally, in COP20, PEPFAR South Africa should commit to positioning GeneXpert testing platforms as close as possible to the point of care (not only in laboratories), in order to ensure that rapid Xpert MTB/RIF Ultra testing is readily available for use in combination with urine-LAM testing wherever PLHIV present to care. Where sample transport is required for Xpert MTB/RIF Ultra testing, PEPFAR should aspire to turnaround results and link people to appropriate treatment in less than five days. In COP20, PEPFAR South Africa should support training for healthcare workers on TB symptom screening, and sample collection and preparation for urine-LAM and Xpert MTB/RIF Ultra testing as close to the point of care as possible, including for children. Where TB tests are inconclusive but risk factors and likelihood of TB are high, especially amongst children, PEPFAR South Africa should support clinical/empirical TB diagnosis and treatment initiation.

To ensure TB symptom screening, and urine-LAM and Xpert MTB/RIF Ultra testing are being implemented in all settings where PLHIV present to care in COP20, PEPFAR South Africa should set ambitious targets for TB screening and testing among PLHIV, and allocate sufficient budget to support the procurement of commodities required for urine-LAM (e.g., TB LAM Ag urine assays, urine cups, pipettes, pipette tips, timers) and Xpert MTB/RIF Ultra testing in quantities that at minimum match the number of people projected to present to PEPFAR-supported sites with advanced HIV disease, plus the number of PLHIV projected to present to care with signs and symptoms of TB. If a more sensitive urine-LAM assay becomes available and receives WHO endorsement during COP20, PEPFAR South Africa should support its use. In the meantime, PEPFAR South Africa should plan to procure the already available and WHO-recommended Abbott Determine TB LAM Ag test.

	Enough room (y/n)	Open Windows (y/n)	TB poster (y/n)	% of patients reporting waiting <30 mins*	% of patients reporting being asked if they have TB symptoms	% of patients reporting that coughing patients are separated	% of patients reporting that people are given masks in the waiting room	Clinic rating
Alexandra 8th Avenue Clinic				0%	0%	9%	27%	
Alexandra CHC				0%	13%	7%	13%	
Amsterdam CHC				7%	0%	13%	0%	
Andries Raditsela Clinic				0%	0%	0%	0%	
Bellavista Clinic				0%	33%	38%	38%	
Bethal Town Clinic				0%	31%	31%	19%	
Boipatong CHC				5%	100%	53%	0%	
Bophelong CDC (Emfuleni)				0%	100%	53%	13%	
Buffelspruit CHC				20%	0%	0%	0%	
Chiawelo CHC				0%	31%	38%	35%	
Dan Kubheka Clinic				0%	0%	0%	0%	
Daveyton Main CDC				0%	0%	0%	0%	
Diepkloof Prov Clinic				4%	7%	46%	39%	
Empilisweni CDC				0%	50%	0%	0%	
Emthonjeni Clinic (Msukaligwa)				11%	37%	37%	26%	
Erin Clinic				8%	46%	31%	46%	
Ermelo Clinic				6%	13%	13%	13%	
Esangweni CHC				0%	33%	33%	33%	
Ethandakukhanya Clinic				7%	43%	29%	36%	
FF Ribeiro Clinic				0%	0%	0%	0%	
First Avenue Clinic				7%	14%	14%	14%	
Freedom Park Clinic				0%	100%	0%	0%	
Germiston City Clinic				0%	10%	5%	10%	
Giyani CHC				0%	33%	67%	0%	
Goba Clinic				0%	31%	31%	23%	
gp 17 Esselen Street Clinic				0%	0%	0%	0%	
Holy Cross Gateway Clinic				0%	100%	0%	0%	
Inzame Zabantu CDC				0%	71%	0%	86%	
Itireleng CHC				0%	12%	28%	20%	
Kemston Clinic				0%	31%	38%	38%	
Lenasia Clinic				0%	20%	20%	20%	
Lethabong Clinic				0%	14%	14%	14%	
Levai Mbatha CHC				6%	69%	44%	31%	
Lillian Mambakazi CHC				8%	25%	33%	17%	
Lillian Ngoyi CHC				0%	28%	67%	50%	
Lusikisiki Village Clinic (Qaukeni)				0%	0%	0%	0%	
Malvern Clinic				6%	38%	38%	19%	
Mandela Sisulu Clinic				7%	47%	13%	7%	
Market Avenue Clinic				0%	94%	56%	6%	
Mary Moodley Memorial CDC				0%	40%	40%	27%	
Michael Maponya Prov Clinic				10%	9%	25%	25%	
Midvaal CDC				0%	33%	20%	27%	
Mofolo CHC				0%	24%	24%	18%	
Mthatha Gateway Clinic				0%	0%	0%	0%	
Nhlazatshe Clinic				0%	0%	11%	22%	
Orange Farm Ext 7 Clinic				0%	0%	6%	0%	
Orlando Prov Clinic				0%	0%	3%	0%	
Palmridge Clinic				0%	63%	88%	88%	
Phillip Moyo CHC				6%	24%	29%	12%	
Ramokonopi CHC				9%	18%	27%	18%	
Sead Clinic				0%	15%	25%	25%	
Sebei Motsoeneng Clinic				7%	87%	53%	33%	
Secunda Clinic				0%	25%	0%	0%	
Senaoane Clinic				8%	31%	23%	0%	
Sinqobile Clinic				0%	25%	13%	6%	
Soshanguve 2 Clinic				7%	43%	21%	7%	
Soshanguve Block TT Clinic				4%	22%	57%	26%	
Soshanguve Block X Clinic.				0%	40%	40%	40%	
Stanza Bopape CHC				0%	0%	0%	0%	
Stanza Bopape II Clinic				0%	0%	0%	0%	
Tembisa Health Clinic				0%	13%	19%	13%	
Thoko Mngoma Clinic				0%	0%	0%	13%	
Thussiville (MN Cindi) Clinic				0%	67%	33%	33%	
Tladi Prov Clinic				0%	6%	61%	61%	
Town 2 CDC				0%	0%	0%	100%	
Tsakane Clinic				0%	21%	11%	0%	
Tshepisong Clinic				0%	72%	45%	17%	
Weltevreden Valley Clinic				0%	93%	100%	100%	
Winnie Mandela Clinic				0%	50%	0%	50%	
Yeoville Clinic				6%	56%	25%	6%	
Zola CHC				0%	12%	32%	28%	
Zone 17 Clinic				0%	100%	87%	0%	

***assumes total clinic time <1hour 10 mins**

8c. Support scale up of TB preventive therapy (TPT) among PLHIV

In COP19, South Africa committed to *"scaling up TB preventive therapy [INH] to include those currently on treatment who have not previously received TPT in addition to those newly initiating treatment."* Yet in FY19, just 193,536 people completed a course of TPT, representing 33% of the 578,149 PLHIV on ART expected to complete a course of TPT, and 25.6% of the 759,506 people newly initiated on ART in FY19.

To harmonise what is happening on the ground with expectations laid out in South Africa's COP20 planning letter, which recommends that at minimum, all eligible PLHIV, including children, be offered TPT by the end of COP20 (FY21), South Africa will need to dramatically scale up its support for TPT among PLHIV. TPT scale up should be linked to TLD transition and incorporated within differentiated models of HIV service delivery.

For PLHIV already on ART, the DOLPHIN-1 study completed in 2019 demonstrated that 3HP can safely be given to PLHIV on TLD without compromising viral suppression. For PLHIV starting ART, PEPFAR notes that based on SPRING-1 trial data *"it seems reasonable to start 3HP and TLD simultaneously in treatment naïve patients…"* In PLHIV on ART switched from efavirenz to TLD, 3HP can be started 2–4 weeks after making the TLD switch. Training, adherence support, pharmacovigilance, adverse event monitoring, and reporting systems associated with TLD transition should incorporate 3HP.

Children, including those identified by contact investigations, should be offered TPT with the regimen determined after considering HIV status, ARV regimen, pill burden and the availability of child-friendly formulations. Per the PEPFAR COP20 Guidance: for HIV-negative children, the preferred TPT regimen is 3HR; for HIV-positive children, the preferred regimen is 6H until 3HP becomes available in child-friendly dosages and formulations (expected after COP20). 3HR may also be considered for any children with HIV on efavirenz-based ART.

South Africa's COP20 planning letter acknowledges the availability of updated TPT guidelines, revised to incorporate 3HP and other rifamycin-based, short-course therapies for TB prevention, and the anticipated availability of 3HP in South Africa starting in April 2020. Of note, the price of 3HP has recently been reduced from $45 to $15 per patient course. Of the 600,000 patient-courses committed as part of this deal negotiated between Sanofi, Unitaid, and Global Fund, the GoSA is slated to receive 300,000 patient courses of 3HP. In addition, a second supplier of 3HP (Macleods) is expected to enter the market in COP20. Macleods is offering a fixed-dose combination of 3HP that will reduce the pill burden of the regimen, improving acceptability and promoting treatment completion. As such, in COP20, South Africa should set a target specifying the number of PLHIV to be initiated on 3HP (i.e., 40% of the overall TPT target for COP20) and allocate its budget for FY21 accordingly. It should take advantage of both Sanofi and Macleods 3HP products.

COP20 must invest in TB service delivery including (1) improving infection control in PEPFAR funded sites; (2) ensuring TB symptom screening, and urine-LAM and Xpert MTB/RIF Ultra testing are being implemented in all settings where PLHIV present for care, including outpatient settings; and (3) supporting universal access to TPT for all eligible PLHIV (those currently on treatment who have not previously received TPT in addition to those newly initiating treatment) and household contacts of PLHIV with TB disease, including children. The preferred TPT regimen for adults should be 3HP, pending availability of rifapentine.

9. Improve the quality of services offered to key populations and review implementing partners not reaching targets

Only about 70% of key populations targeted by PEPFAR in SA were reached with prevention services. Most of the district level results show an even worse picture with 13 of the targeted districts achieving less that 50% of their targets. Monitoring of PEPFAR sites revealed that whilst health workers responded affirmatively to providing services for key populations when asked generally, the implementing sites did not provide comprehensive key population services when probed further.

Whilst a smaller number than the general population, the HIV prevalence among sex workers is estimated at 54%, HIV prevalence among men who have sex with men (MSM) in South Africa is estimated at 30%, HIV prevalence among transgender women who is 46% and an estimated 14% of people who use drugs in South Africa are living with HIV.

COP20 must improve the quality of service delivery among key populations by ensuring that partners reach key populations with comprehensive services and review districts and implementers struggling to meet key population targets for site improvement and monitoring.

10. Ensure that men are able to access male friendly services e.g. male outreach initiation and management, male after hours clinics, and community testing.

Men represent about 37% of PLHIV but accounted for 52% of AIDS deaths amongst adults in 2017. This may be because male HIV diagnosis and ART coverage is much lower compared to women in South Africa. In Khayelitsha just 30% of those on ART are men and in Eshowe MSF/DOH data for 2017 showed that only 27% of patients on ART are men.

The table below shows the results of the 90-90-90 estimates following the MSF population survey conducted in Eshowe and Mbongolwane areas in 2013 and 2018, showing poorer outcomes across the cascade for men[5]. This is not unique to South Africa. Research in many African settings has shown that HIV-positive men are less likely to initiate ART, and those who do are more likely to present to clinics later, more ill and have poorer retention and worse clinical outcomes. UNAIDS 2018 global AIDS monitoring estimated that there was lower coverage of ART amongst men in Eastern and Southern Africa at 56% compared to women at 72%). Explanations put forward for men's low attendance and poor outcomes include notions of masculinity that are at odds with illness and 'good patient' behaviour, public health systems that are historically built around maternal and child health and systematic under-funding of men's services compared to women's.

90-90-90 ESTIMATES AMONGST ADULTS AGED 15-59 YEARS, STRATIFIED BY GENDER

Year	Women			Men		
	1st 90	*2nd 90*	*3rd 90*	*1st 90*	*2nd 90*	*3rd 90*
2013	79.0	70.5	93.4	68.3	67.9	91.1
2018	91.9	95.5	95	82.5	86.4	92.3

About 30% of HIV transmission occurs among stable partners and the HIV positive partner amongst sero-discordant couples is more commonly male than female. This, coupled with growing evidence that ART reduces HIV mortality and morbidity more so if treatment is started early and

potential benefits of viral suppression in reducing transmission make men a critical target population to reduce HIV incidence and mortality. The recently launched MenStar coalition also identifies men's HIV diagnosis and treatment as a key to breaking the cycle of transmission which when dealt with could ultimately end the AIDS epidemic as a public health problem by 2030. Targeting specific populations that are most likely to transmit the virus like men and adolescents for ART treatment and care could have important outcomes in preventing transmission to other populations.

MSF pursued a range of interventions aimed at tackling this challenge, of engaging men in HIV care[6]. The results document the following interventions:

+ **Male vertical clinics** — male only clinics operated by male only staff that offer adaptable services in order to increase voluntary medical male circumcision (VMMC), testing, ART initiation, retention in care, TB screening and early diagnosis, and STI management in sexually active men. These were run in conjunction with South Africa's NDoH.
+ **Outreach initiation and management** — using a mobile outreach service which served as an extension of the existing healthcare system to provide a broad range of services accessible to the community in order to encourage access and uptake of basic services such as HIV testing, family planning, STI screening and ART initiation and management closer to the community.
+ **Male after hours clinic** — male-only clinic, with male only staff and differentiated service delivery models, that offered more flexible opening hours (16h00 to 19h00 one day a week) within a conventional provincial CHC.
+ **High transmission areas** — MSF's High Transmission Areas (HTA) programme was specifically designed to provide HIV/TB screening and management related medical services to farm workers who are mostly men and young students in college.
+ **Community testing events** — in Eshowe, this included testing at fixed sites in the community and door-to-door community testing: community health workers go door to door, providing a package of care, including but not limited to health education, HIV testing and counseling, condom distribution, voluntary medical male circumcision (VMMC) recruitment, STI screening and TB screening. Fixed sites were set up within the community, providing a similar package of care. Community testing reaches out to people who would not come to a clinic. In Khayelitsha, this includes HIV testing together with screening of hypertension, diabetes and weight at community social events such as taverns, taxi ranks, soccer tournaments, shopping malls, unemployment spots (places where people wait to be picked up for piece work).

MSF studied the impact of these activities across the clinical cascade for men including finding and testing men; starting

5. Mbongolwane and Eshowe HIV impact in population survey (2nd survey, 2018) https://www.msf.org.za/system/tdf/publications/eshowe_hiv_survey_2018.pdf?file=1&type=node&id=15355&force=
6. All references for this section taken from the MSF report, HIV Care for Men: Lessons learnt from Médecins Sans Frontières Experiences in Rural and peri-urban South Africa. Accessible here: https://samumsf.org/sites/default/files/2019-07/HIV%20Care%20for%20Men.pdf

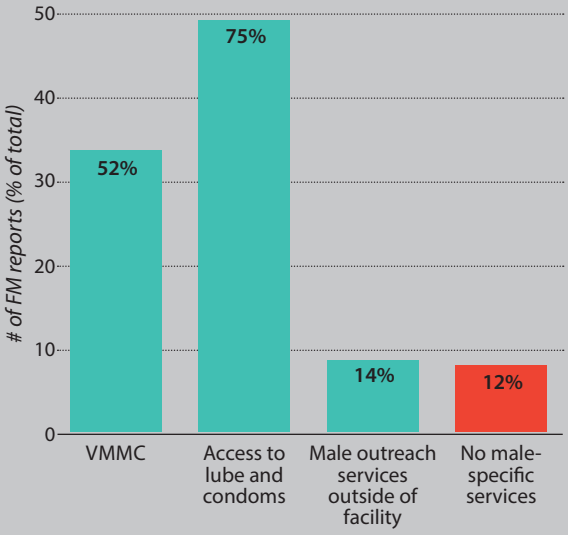
men on treatment; and keeping men in care. Key lessons from MSF's experience thus far include the following:

+ We can reach more men by adapting HIV services that are tailored to their social and medical needs;
+ One strategy to reaching HIV positive men earlier and in a healthier state required stepping out of the facility and offering testing in the community;
+ Such approaches included targeting hotspots (including at traditional health practitioners), providing mobile clinics, establishing fixed community sites, testing at education institutions, at home, and offering oral self-testing. However, due to the known difficulty in demonstrating linkage to care, our data provides stronger evidence for testing and linkage at male-friendly services;
+ A large proportion of men attending male clinics came for STI screening and management. This provided an entry point into health services that led to HIV testing and ART initiation of younger, healthier men. Differentiated models of care should therefore take into account clients' ages and needs and offer relevant packages of care;
+ Extended hours integrated into a conventional clinic or community healthcare centre appears to be a feasible adaptation to achieve better linkage and retention to care outcomes compared with male only vertical clinics;
+ Male patients report increased satisfaction because of peer (male to male) support through male only staff, which enhances empathy and understanding.

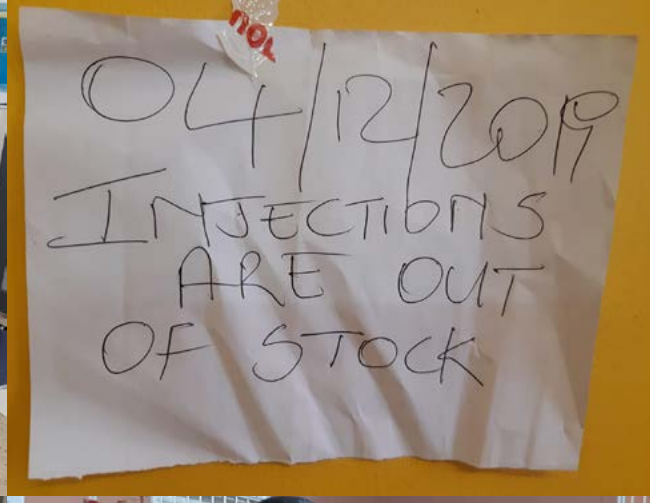
COP19 states that *"NDoH and PEPFAR SA are committed to reducing treatment disengagement from care by improving patient experience during clinic visits through a range of interventions, including:..... providing population-specific services like Men's Corner or youth-friendly services after school hours".*

Through Ritshidze Q1 monitoring the most commonly reported service for men by Facility Managers was providing access to condoms and lube (75%), followed by VMMC (52%). Facility Managers at 7 clinics reported providing VMMC, access to lube and condoms, and do male-specific outreach services including Palmridge Clinic (Ekurhuleni), Alexandra CHC (Ekurhuleni), Zola CHC (Ekurhuleni), Bophelong CDC (Sedibeng), Boipatong CHC (Sedibeng), Chiawelo CHC (Ekurhuleni), and St Elizabeth's Gateway Clinic (Oliver Tambo).

Facility manager reports of male-specific services offered



COP20 must explore a range of approaches to urgently bring more men into HIV care — with attention to cost-effectiveness and to ensuring successful retention in care. HRH programming must also be more attentive to ensuring a larger number of male counselors and male nurses as a way to urgently increase the number of men on treatment and who are virally suppressed.



11. Ensure that interventions targeting young people reduce HIV incidence and provide adequate care and support to ensure long term treatment retention through youth friendly services and youth clubs.

Retention amongst adolescent girls and young women (AGYW) is mentioned as a key remaining retention challenge in the country. In the People's COP19, we recommended that PEPFAR should address this challenge by:

+ Ensuring that all clinical and non-clinical staff at all PEPFAR sites are sensitised to provide youth friendly services; from doctors, to nurses, to security guards;
+ Ensuring that there is no regression on the available forms of contraceptives and treatment as prevention tools that are already available to the youth; and
+ Saturating PEPFAR districts with closed membership youth clubs, at 100% PEPFAR sites, for young people living with HIV that integrate psychosocial support, HIV clinical management (including ART initiation), SRHR education and ART refills.

The SDS committed: *"Similarly, to close the treatment gap for youth in general and AGYW in particular, PEPFAR SA will work with facility, community, faith-based and traditional structures. PEPFAR SA will support the GoSA to expand adolescent and youth friendly services in facilities and communities, after-school hours, school health services, self-screening, youth connectors, youth care clubs, and mHealth (including social media)".*

Through Ritshidze Q1 monitoring we have found that almost all Facility Managers report that their facility offers at least one youth friendly service — 3 clinics — Germiston City Clinic (Ekurhuleni), Rabie Ridge Clinic (Ekurhuleni), and Diepkloof Prov Clinic (City of Johannesburg) — reported no youth friendly services. The most common youth friendly services reported by Facility Managers were youth friendly HIV testing and counseling (63%), followed by youth friendly STI and treatment services (56%), and information packages for adolescent sexual and reproductive health services (54%). By Facility Manager report the clinics offering the most youth friendly services were Itireleng CHC (City of Johannesburg), King Dinuzulu Clinic (eThekwini), Lillian Ngoyi CHC (City of Johannesburg), Malvern Clinic (City of Johannesburg), and Michael Maponya Prov Clinic (City of Johannesburg). These clinics report providing youth outreach services, youth friendly HIV testing and counseling, PrEP, information packages for adolescents, STI testing and treatment, youth happy hours, and youth champions. There are still gaps in the availability of youth happy hours and champions with only 35% offering these services.

COP20 must ensure sensitisation of all clinical and non-clinical staff in all PEPFAR sites to provide youth friendly services. COP20 must establish and saturate PEPFAR districts with closed membership youth clubs, at 100% PEPFAR sites, for young people living with HIV that integrate psychosocial support, HIV clinical management (including ART initiation), SRHR education and ART refills.

12. Ensure better quality HIV and TB service delivery by strengthening clinic committees and ensuring continued funding for community-led monitoring through Ritshidze and the Stop Stockouts Project.

12a. Fund a community-led capacity building programme to strengthen and ensure the functionality of clinic committees across South Africa.

In South Africa, governance structures in the form of clinic committees are intended to ensure community participation at a local and district level. They are provided for in South African law and are key to ensuring accountability and a successful AIDS and TB response. They are the forums through which pubic healthcare users are meant to engage and take ownership over the health system, raise concerns and ensure accountability at local, district, and provincial levels. They should input and feedback into the planning, delivery and organisation of health services and play an oversight role in the development and implementation of health policies and provision of equitable health services. The committees are made up of a combination of community and civil society representatives and health professionals of each area. They allow community concerns to be elevated through the structures from local to district to provincial and finally to national level.

Section 42 of the National Health Act 61 of 2003 requires provinces to provide for clinic committees and ensure their functioning. However, to our knowledge no provinces have such legislation and it cannot be claimed that clinic committees function effectively in any province. Too many lack a clear understanding of their role and responsibility and no financial resources are allocated to improve this situation.

COP20 should emphasise the need for provinces to comply with the National Health Act and provide support for the development and functioning of clinic committees; provide resources to HIV-led organisations to ensure a wide-scale capacity building programme to ensure functionality of clinic committees; and emphasise the need for linkage between clinic committees and ward, local, and district AIDS councils, given that the implementation of HIV policy occurs at a clinic level.

12b. Ensure accountability in HIV and TB service delivery by maintaining funding for Ritshidze in COP20.

Until now, district and local governments have faced only limited accountability for the public health services they provide. This lack of accountability itself is a major barrier to improving the quality of care. But it is compounded by the fact that the people who are most motivated to demand accountability are not being empowered to do so. PLHIV-led advocacy organisations, through Ritshidze, have a critical role to play in identifying local-level problems and solutions. As stated in the People's COP19, *"as public healthcare users, and people living with HIV, we are the people who need the public health system to work, so we are the first to notice when it does not."* Before now, community members lacked the opportunity and resources to monitor facilities, document the barriers to care, and share their findings. Conversely, provincial and national officials who are empowered to hold the district and local governments accountable are not receiving the information from the communities that they need in order to do so.

Community-led monitoring will contribute to South Africa's HIV/AIDS and TB responses by empowering PLHIV to monitor facilities and hold authorities accountable for providing high-quality HIV and TB care and support. During August and September of 2019, the PLHIV Sector together with support from Health GAP, amfAR and the O'Neill Institute, piloted a set of tools and strategies for systematising community monitoring at 23 clinics in Gauteng and KwaZulu-Natal. In this process we have shown it is possible to systematically collect information and translate that into informed community accountability efforts. Following this effort, the tools and strategies were revised based on learning from the pilot phase.

Known as Ritshidze—meaning "Saving our lives" in TshiVenda—the project started to be brought to full scale in October 2019. When at scale, it will take place across 27 districts, in 8 provinces in South Africa, to be expanded to 400 facilities by the end of the project. Facilities chosen cover nearly half of all people living with HIV on treatment in the country, with a focus on sites with large treatment cohorts and where data shows poor linkage and retention rates.

45 community monitors and 20 district organisers have been hired to carry out facility and community monitoring on the ground. Using tablets and the CommCare app, they will carry out surveys on a bi-monthly basis to capture data. Using data collected, fieldworkers will analyse the findings in order to outline the state of the facility, capturing challenges and evidence-based solutions for addressing them. The findings of monitoring efforts reflecting the "state of the facility" will form the basis of regular engagement with facility staff, clinic committees, and implementing partners in order to raise challenges, identify solutions for facility staff and implementing partners to undertake, and to then monitor the implementation of these solutions. Where challenges cannot be addressed at a facility level, or there is failure to address concerns, or resistance from facilities to make progress, fieldworkers will escalate the issues either through additional advocacy or to decision makers at higher levels. In the coming weeks, all data collected will be available on a public data dashboard searchable by province, district or site, as well as by thematic area.

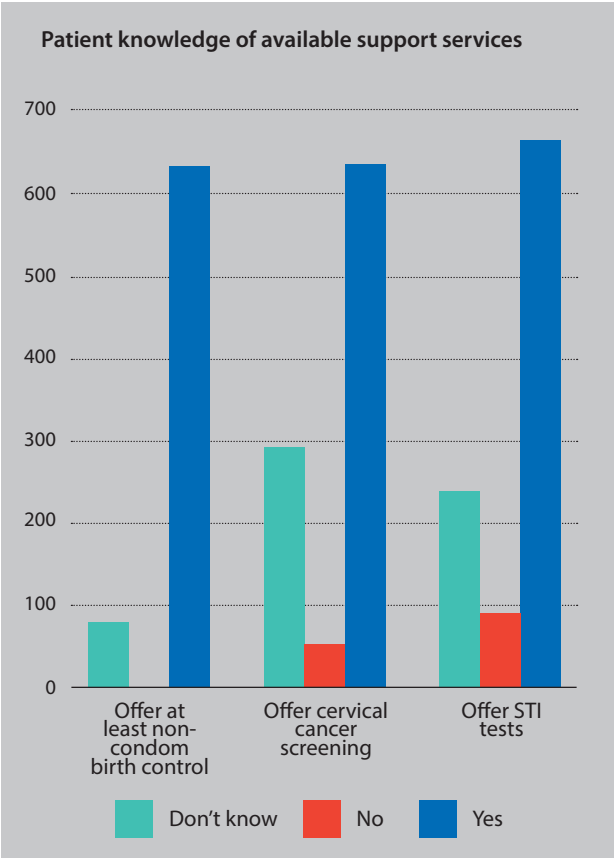
Huge progress has been made in testing and validating a number of monitoring tools and the CommCare app, recruiting and capaciting the team, procuring and capacitating people to use the equipment, liaising with government at national, provincial and district level to ensure access to sites (ongoing), and building the data systems including the online data dashboard. Data capture has begun at many sites, the analysis of which has formed the People's COP for 2020. PEPFAR SA should continue to fund this project through UNAIDS going forward to ensure that PLHIV have the ability to monitor the quality of service provision and escalate performance problems — an indispensable strategy for enabling South Africa to meet the 90-90-90 targets.

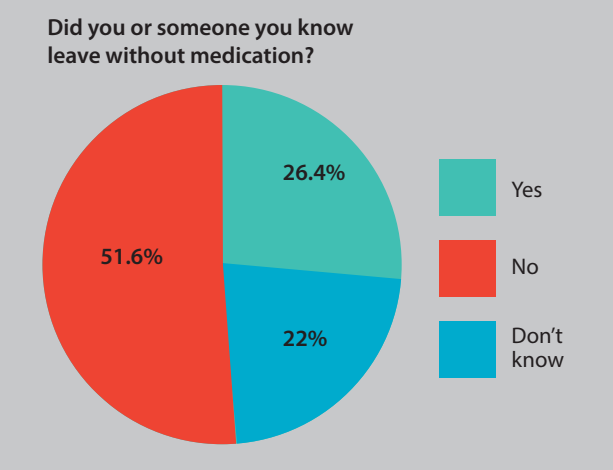
COP20 should maintain USD 2 million funding for the Ritshidze project (run by the PLHIV Sector) to continue monitoring 400 high burden sites across South Africa.

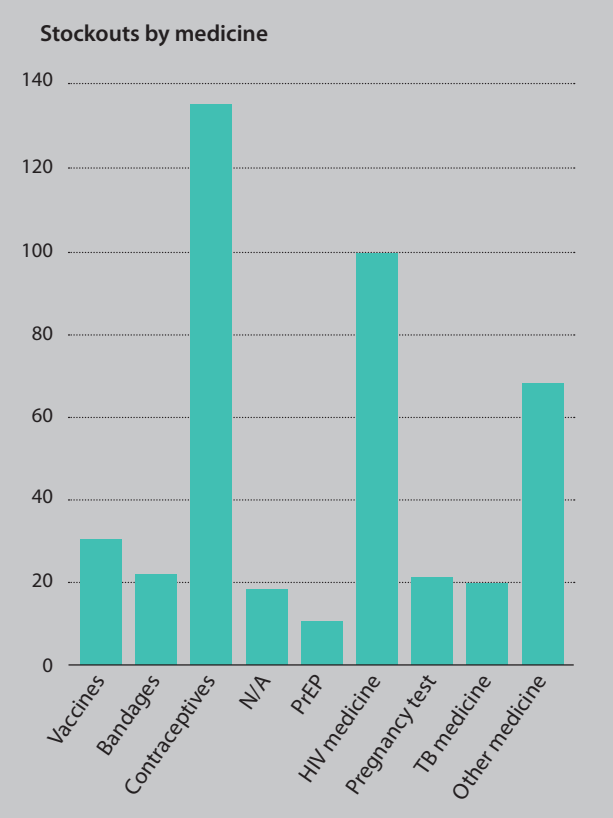
12c. Eradicate barriers to accessing HIV, TB and STI medicines — caused by stockouts and/or shortages of medicines — at 100% of PEPFAR sites in COP20 by funding the Stop Stockouts Project.

Stockouts and shortages of ARVs, TB medicines and contraceptives cause disruption, confusion, and cost to people, and in extreme cases detrimentally affect adherence and lead to disengagement from care. In COP19, we asked PEPFAR to *"support the health worker staffing, transportation, and other needs to ensure that facilities in the 27 PEPFAR supported districts are adequately stocked and that supply chain monitoring tools (such as the stock visibility system) allow for public monitoring and problem identification in a transparent, expeditious manner."* However, there was only vague commitment in the SDS to rectify stockouts and shortages of medicines — and community-led monitoring through Ritshidze in Q1 reveals ongoing shortages and stockouts of medicines.

The majority of patients reported that clinics did offer at least one non-condom form of birth control (bc), however, contraception stockouts were the most common category of medication shortages, followed by HIV medication.

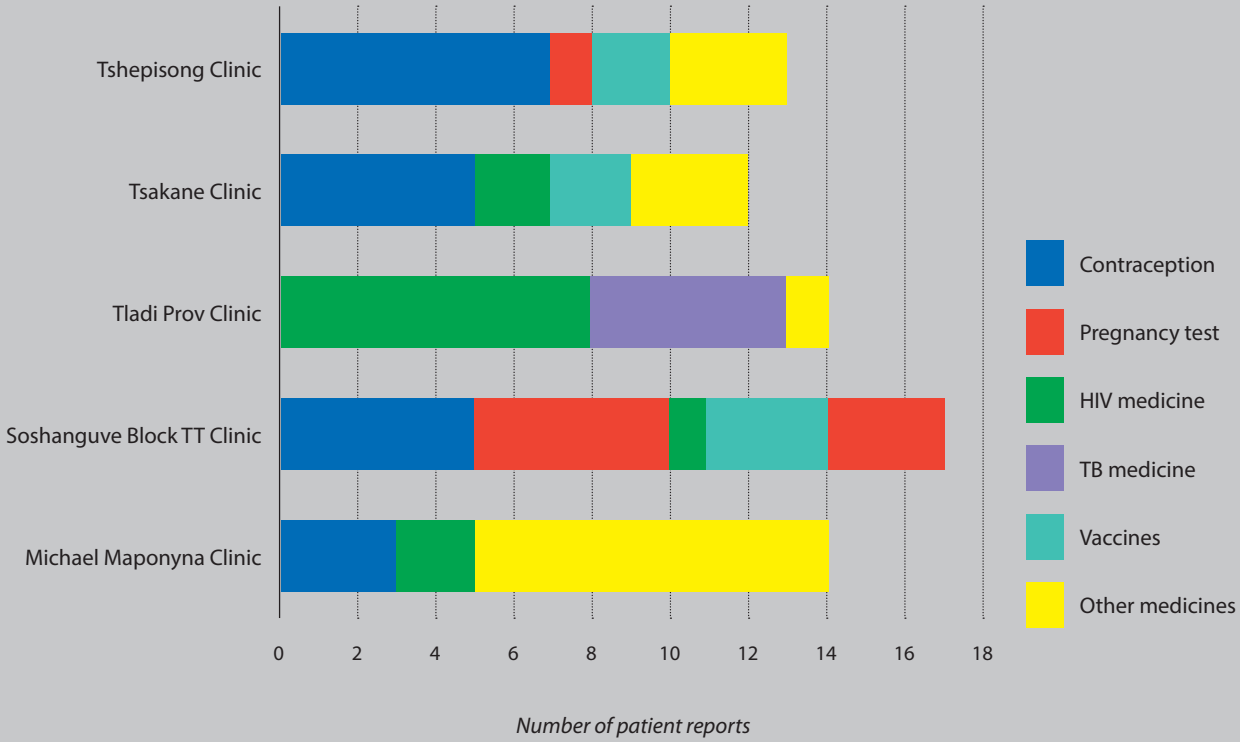






Across clinics, 26% of people left, or knew someone who left, a clinic without the medication that they needed. There were 135 patient reports of contraception stockouts and 99 reports of HIV medicine stockouts in addition to vaccines, pregnancy tests, TB medicines, and PrEP. The most common "other medicines" which experienced a stockout were: medication for hypertension or high blood pressure, cough or flu medications, and painkillers. The most common HIV medication stockouts were for Dumiva and Fixed-Dose Combination Antiretrovirals.

Clinics with the most stockouts by type:



The most common category of stockout by Facility Managers was in contraceptive commodities, with (50%) reporting experiencing a stockout or shortage of contraceptives in the past two months, this was followed by reports of stockouts or shortages to HIV medications (29%). Zola CHC (City of Johannesburg) reported stockouts in all commodity categories. Half of the reported HIV medicine stockouts were for Dumiva (53%). Other common stock outs for HIV medicines included Lamivudine (26%), and 1st line fixed dose combination (FDC) — also known as Atripla, Tribuss, Atrioza or Adumen (21%). The most common contraceptive commodity to have a shortage or a stockout was for the injection (60%), followed by the pill/oral contraception (24%), and the implant (9%).

Worsening the situation, in January and February 2020 ARVs worth over a million rands have been stolen from several facilities in the Free State province — allegedly by healthcare workers. The Treatment Action Campaign and Positive Action Campaign publicly called out these ARV thefts, that put people's ability to access a steady supply of ARVs at risk. PEPFAR must re-orient supply chain support to address these challenges. Whilst significant money is being spent on supporting the supply chain at a facility level, focus also needs to be put on securing supply to ensure that ARV thefts cannot take place, thus ensuring that PEPFAR supported districts are adequately stocked. In addition supply chain monitoring tools (such as the stock visibility system) must be strengthened to allow for public monitoring and problem identification in a transparent, expeditious manner.

COP20 must fund the Stop Stockouts Project to run workshops to educate community members about stockouts/shortages of medicines and empower them to take action to report these challenges through the Stop Stockouts Project hotline. COP20 must also ensure that PEPFAR supported districts are adequately stocked by supporting the supply chain at a facility level including securing supply to ensure that ARV thefts cannot take place.

** This year's People's COP has been developed using data collected across two time periods: 23 sites in August and September 2019 (COP18 Q4) and more than 100 sites in November and December 2019 (COP19 Q1). In the latter period data has been collected using various types of surveys including: 111 Observation Surveys; 1016 patient/PLHIV surveys; 41 Adherence Club Facilitator surveys; 69 Facility Manager surveys; and 75 Data Capturer surveys.*

SPECIFIC LANGUAGE REQUESTED IN COP20

PRIORITY INTERVENTIONS • PRIORITY INTERVENTIONS • PRIORITY INTERVENTIONS • PRIORITY INTERVENTIONS

COP19 & DATA	LANGUAGE TO INCLUDE IN COP20	TARGET
1. Increase the budget for the overall PEPFAR programme by US$200 million to match last year's overall budget that included surge funding.		
"Approve the South Africa Country Operational Plan (COP) 2019 with a total budget of $752,896,249 including all initiatives and applied pipeline" (Approval Memo pg 1) "Systems support activities strengthen components of the health system that are critical to the successful implementation of HIV prevention, care, and treatment health services. This is both the focus of COP19 and Surge funding." (SDS pg 44) "The Treatment Surge will accelerate roll-out of South Africa's HPRS, including unique patient identifiers, and establish provincial Information Hubs to integrate TIER.Net with other key databases using the unique identifier." (SDS pg 73)	In COP20, PEPFAR will maintain COP19 funding levels to South Africa. This will ensure gains made during the surge including support to the health system such as hiring of health workers will be maintained to improve the quality of service delivery. PEPFAR will work with the GoSA to ensure a transition plan that ensures quality service delivery is maintained.	**Target:** Maintain COP20 funding at USD 752,896,249
2. Implement and maintain the promises made in COP18 to fund 20,000 supplemental frontline staff and 8 000 community healthcare workers in order to reduce waiting times and ensure better re-engagement in care.		
"Four elements were identified with vulnerabilities to sustainability: [amongst other listed items] human resources for health (HRH). [...] In terms of HRH, the substantial improvements made to leverage the strategic value of the Ward Based Primary Health Care Outreach Team program (Community Health Workers), including setting performance targets, is expected to lead to important gains in ART patient linkage and retention, all improving sustainability of the national HIV program by optimizing the value of these important community resources." "PEPFAR SA will substantially increase its facility- and community-level human resource investments to enable increased HIV testing, same-day initiation, extended service hours, patient navigation, active linkage, "case management" of newly initiated patients, adherence and retention tracking and tracing, and differentiated care." (SDS p30) "NDoH and PEPFAR SA are committed to reducing treatment disengagement from care by improving patient experience during clinic visits through a range of interventions, including: [amongst other listed items] expanding hours of operation" (SDS p28) "PEPFAR SA and DoH will ensure "Welcome Back Services" are maximizing opportunities to re-engage people who have interrupted treatment into care to achieve stable outcomes, all NIMART-trained nurses are initiating PLHIV on ART, lay counselors and data capturers are performing against targets, and filing systems are strengthened to improve data quality and the patient experience by reducing waiting times." (SDS p36)	In COP20, PEPFAR will continue to fund the deployment of 20,000 supplementary staff including nurses and pharmacy technicians directly through a partnership with NDOH. These staff will be fully based in facilities, but spend a portion of their time outside of peak need times supporting community-based ART programming and adherence clubs in the community to help expand initiation and follow ups outside of over-crowded clinics. The staff will be prioritized for larger clinics, with significant HRH shortages. Additionally, in COP20 PEPFAR will continue to partner directly with government to fund 8,000 CHWS and OTLs in line with the government's CHW Policy. All PEPFAR sites will be linked with a cadre of community health workers supported by PEPFAR through the public sector. These CHWs will be formally paid, trained, capacitated, and equipped with communications and transportation needed to be effective. PEPFAR will also fund a cadre of supervisors of the CHWs at ratios based on best practices. In addition to government workers, PEPFAR will fund 8,000 CHWs—to saturate communities and address under-performance.	**Target:** Maintain funding for 20,000 frontline staff and 8,000 CHWs and OTLs.

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COP19 & DATA	LANGUAGE TO INCLUDE IN COP20	TARGET
3a. Roll out multi-month dispensing including six month supply		
"A total of 1.47 million patients receive two months of medications through adherence clubs and centralized chronic medicines dispensing and distribution (CCMDD) models; beginning in COP19, patients will be able to receive three months of medications and will have access to additional medical collection options such as lockers." (SDS pg 8) "In COP19 PEPFAR SA will invest nearly $26 million for the procurement of ARVs, PrEP, and TPT (including INH). This investment includes support for multi-month ART scripting and private sector expansion (procuring ARVs for private sector clinicians initiating HIV treatment for targeted priority populations)." (SDS pg 35) PEPFAR and partners will work with NDoH to provide evidence for the benefit of extended refill length, including 6- months' supply for stable patients through CCMDD, Adherence Clubs or through Fast Track ART collection. PEPFAR will support any transition to 6-month scripting through development and implementation of operational plans. (SDS pg 67)	In COP20, PEPFAR SA will support GoSA to roll out multi-month dispensing including 6 month supply to all stable patients (i.e. >6 months on treatment and more than a month without adverse effects), whether within a differentiated model of care (e.g. adherence club) or not, across South Africa.	**Target:** By end COP20, all stable PLHIV are able to collect a 6 month supply of ARVs.
3b. Establish and scale up facility and community adherence clubs at all PEPFAR supported sites to ensure at least 20% of eligible PLHIV are decanted into them (with the other eligible PLHIV decanted into CCMDD, fast lane, and other models).		
"A total of 1.47 million patients receive two months of medications through adherence clubs and centralized chronic medicines dispensing and distribution (CCMDD) models; beginning in COP19, patients will be able to receive three months of medications and will have access to additional medical collection options such as lockers." (SDS p8) "NDoH and PEPFAR SA are committed to reducing treatment disengagement from care by improving patient experience during clinic visits through a range of interventions, including [amongst other listed items]: increasing access to facility and community Adherence Clubs" (SDS p28) "In COP19, PEPFAR SA and Implementing Partners will identify the populations in each district most affected by adherence challenges and will increase support for them via community- based adherence clubs. Relevant community PLHIV organizations will be linked with community adherence clubs to support this work." (SDS p29)	By start COP20, all PEPFAR sites will have functional facility and community based adherence clubs that at least 20% of eligible PLHIV will be decanted into. PEPFAR will continue to support the clinical and staffing needed to establish and maintain these clubs for at least 3 years.	**Target:** At start COP20, 100% of PEPFAR sites will have functional adherence clubs for ART delivery and will report 20% of eligible PLHIV in them.
3c. Establish and scale up functional support groups at 100% of PEPFAR supported sites.		
No mention.	COP20 must fill the human resource and other gaps to ensure the establishment and scale up of support groups linked to all PEPFAR supported sites, run by community based HIV organisations, where newly diagnosed PLHIV, PLHIV returning to care, or others struggling with adherence can be referred to for peer support.	**Target:** At start COP20, 100% of PEPFAR sites will have at least one functional support group attached to the site and will link newly diagnosed PLHIV, PLHIV re-engaging in care and PLHIV with adherence challenges to the groups.

COP19 & DATA	LANGUAGE TO INCLUDE IN COP20	TARGET
3d. Establish a sustainable and comprehensive approach to provide medical and psychosocial support that can be individualised according to distinctive needs of the disengaged individuals.		
"Specifically, PEPFAR SA and DoH will ensure "Welcome Back Services" are maximizing opportunities to re-engage people who have interrupted treatment into care to achieve stable outcomes, all NIMART-trained nurses are initiating PLHIV onto ART, lay counselors and data capturers are performing against targets, and filing systems are strengthened to improve data quality and the patient experience by reducing waiting times." (SDS p36)	COP19 will scale "Welcome Services" as per the MSF model to ensure people who have interrupted treatment are re-engaged into care to achieve stable outcomes and, where necessary, are quickly switched to appropriate regimens of care (i.e. 2nd line or 3rd line treatment). The components of the "Welcome Services" will include: • Identifying patients (counsellors to trace patients; digital 'single patient viewer' to track movement of patients through health system); • Medical package of care (provide point of care diagnostic tools to allow CD4 detection allowing patients to be assigned to care depending on whether their CD4 count is above or below 200 cells/ul); and provide TB LAM and Gene Xpert testing among PLHIV (1) with TB signs and symptoms, (2) who are seriously ill, or (3) have advanced HIV disease (AIDS); incorporate evaluation for eligibility to receive a course of TB preventive therapy); • Psychosocial package of support (training in helping change staff attitudes to patients upon return after interruption, provide individualised counseling to patients, peer-led patient navigators acting as a bridge between clinicians and patients, mapped networks of referral services, and optional support groups.)	**Target:** <90% of enrolled patients return for follow up visit to clinic and are appropriately linked to care.
4. Put in place measures to ensure that index testing does not lead to intimate partner or other violence, or forced disclosure of PLHIV's status'.		
"The NDoH index testing guidance includes specific procedures to ensure consent, protect confidentiality and prevent harm related to intimate partner violence, informed by broad consultations. PEPFAR and NDoH are working together to ensure structures are in place to support consent, disclosure to spouse and sexual partners, and to manage risks and incidence of intimate partner violence related to HIV disclosure." (SDS p10/11)	PEPFAR SA will not enforce ANY targets that a percentage of people newly diagnosed with HIV must come from index testing for the remainder of COP19 and COP20. PEPFAR SA will ensure that before contacting the sexual partners of any PLHIV, all healthcare providers should ask if their client's partners have ever been violent and avoid contacting them if so in order to protect their client. After contacting partners, healthcare providers will follow up to check if any PLHIV faced violence due to the contacting and refer them to the IPV centre if the answer is yes. Prior to (re-) implementing index testing in any facility, there must be adequate IPV services available for PLHIV at the facility or by referral and all patients who are screened should be offered this information. PEPFAR SA will ensure that all implementing partners fully understand that index testing is always voluntary, for both sexual contacts and children, where clients are not required to give the names of their sexual partners or children if they don't want to. Clients must be directly advised that there is no obligation to participate in index testing and that it is only a service offered should the client wish to access it. All PLHIV must understand that this is voluntary. No incentives for participating in index testing may be offered or provided. Additionally, an adverse event monitoring system will be established that is capable of identifying and providing services to individuals harmed by index testing. If these demands are not or cannot be met by an implementing partner, index testing must not continue at the facility for any population.	**Target:** No index testing targets enforced in COP20 or the remainder of COP19. **Target:** All IPs fully understand that index testing is ALWAYS voluntary. **Target:** No contacts of PLHIV who have been violent should EVER be contacted. **Target:** Any PLHIV who faced violence following contacting MUST be referred to IPV services — and any adverse events will be monitored through a newly established tracking system.

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COP19 & DATA	LANGUAGE TO INCLUDE IN COP20	TARGET
5. Fund a widespread expansion of high-quality treatment literacy information.		
"Treatment literacy will needed to inform PLHIV of the risks and benefits of switching to TLD versus TLE400. PEPFAR SA will support PLHIV and community led treatment literacy interventions which will include trainings and health promotional campaigns." (SDS pg 8) During the second half of COP18 and during COP19, PEPFAR SA will focus on preventing disengagement from care by better understanding the individual characteristics and reasons for loss to follow-up, improving health and treatment literacy, eliminating drug stock-outs and providing enhanced-support SMS reminders. SDS pg 28)	COP20 will fund an aggressive expansion of treatment literacy across all PEPFAR supported districts run by, and for, communities living with HIV and key populations. This will include both a community lead component including: material development and dissemination to 100% of PEPFAR sites, training of trainers & subsequent trainings, social mobilisation campaigns at community level, as well as a healthcare worker component ensuring that community and facility-based health workers understand HIV and TB fully to offer up to date prevention and treatment literacy information – and offer HIV and TB education in facilities, adherence clubs and beyond. PEPFAR will fund at least 5 community lead PLHIV organisations to engage with the general population and 5 key populations lead organisations (including MSM, sex workers, transgender people, and people who use drugs) to target those groups more specifically.	**Target:** People friendly treatment literacy materials, developed with PLHIV and KPs, are available and community based organisations deliver treatment literacy services through support groups, adherence clubs, health talks, and localised social mobilisation campaigns.
6. Ensure that PLHIV are able to make an informed decision to start/transition to a dolutegravir based regimen, and that PLHIV on DTG are tracked for weight gain and moved back if needed.		
"Within PEPFAR supported districts overall viral load (VL) suppression was reported at 91% by the end of Fiscal Year 2018 (FY18), and we fully expect the program to achieve at least 80% VL suppression across all populations/genders by the end of COP19. The upcoming roll-out of Tenofovir/Lamivudine/ Dolutegravir fixed-dose combination (TLD) beginning August 2019 and continuing into COP19 is expected to provide an additional boost to both ART coverage and VL suppression rates." (SDS p5) "The majority of patients are expected to transition to TLD by January 2020. PEPFAR has initiated discussions with NDoH regarding the potential to decant stable patients on TLD to CCMDD after a single suppressed VL." (SDS p68)	PEPFAR SA will ensure that all PLHIV are able to choose whether to start/or continue on an efavirenz based regimen or start/switch to a dolutegravir based regimen. Health workers will be trained to provide adequate information to allow PLHIV to make an informed choice for TLD initiation / transition. COP20 will institute tracking of weight gain amongst PLHIV taking DTG and respond accordingly, including by returning people back to an efavirenz based regimen where necessary.	**Target:** All PLHIV are informed and able to access a 1st line ARV regimen suitable for their needs.
7. Scale up optimised HIV treatment for infants and ensure access to differentiated service delivery models for mothers and babies with HIV.		
"ART coverage among children is estimated to be 55% (Table 2.1.2)." (SDS pg 7) "Major programmatic and system gaps or barriers to achieving epidemic control remain. Patients continue to start treatment too late and too sick; there are approximately 40,000 untreated HIVchildren with advanced disease, and an estimated 16% of HIV-infected adults have a CD4 count less than 200." (SDS pg 10) "Similar to adults, case finding and clinical management remain the principal gaps in the clinical cascade for children." (SDS pg 30) "Nevirapine has been removed for all patients except for children <4 weeks as Raltegravir is not yet registered for neonates in South Africa. The revised treatment guidelines provide Dolutegravir to pediatric patients from 20kg in combination with Abacavir and Lamivudine." (SDS pg 73)	COP20 will ensure rapid transition from nevirapine based regimen to DTG based regimen for all infants and children living with HIV within dosing criteria of >20kgs. LPV/r based regimens must be made available for infants and children <20kgs using available syrup whilst making the pellets available for paediatrics who are struggling with taking the syrup. COP20 will ensure that healthcare workers will be trained on the need to support treatment literacy for mothers of children living with HIV to improve case finding, treatment adherence and retention to care. COP20 will support the establishment of Postnatal Clubs (PNC) at all facilities where mothers with babies living with HIV present.	**Target:** All children living with HIV will be transitioned off nevirapine based regimens. Children living with HIV >20kgs access DTG. Children living with HIV <20kgs should access LPV/r pellets or the 4 in 1 as soon as it is available. **Target:** All health workers are trained on treatment literacy support for mothers with babies living with HIV. **Target:** Postnatal clubs established at all facilities where mothers with babies living with HIV present.

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COP19 & DATA	LANGUAGE TO INCLUDE IN COP20	TARGET
8a. Ensure "GREEN" TB infection control at all PEPFAR supported sites.		
"PEPFAR SA COP19 investments will also improve infection prevention and control practices, strengthen service delivery integration and ensure robust TB/HIV data reporting (e.g., EDRWeb)." (SDS pg 30)	PEPFAR SA will work with GoSA to audit all PEPFAR supported facilities to establish the levels of TB infection control in place. Together of GoSA, PEPFAR will ensure that: • All windows are kept open; • TB infection control posters to be displayed in visible places in the waiting area; • Patients to be screened for TB symptoms upon arrival; • People coughing or with TB symptoms to be seen first to reduce the risk of transmission; • People who are coughing to be separated from those who are not while waiting; and • People who cough a lot or who may have TB to be given tissues or TB masks.	**Target:** 100% of PEPFAR supported facilities will have good TB infection control measures in place, as found with spot checks, by end COP20. **Target:** N-95 respirators are provided for all health and community workers that consult with TB patients; and all health workers will be screened for TB in COP20.
8b. Ensure universal TB screening, improve rates of TB testing, and ensure contact tracing amongst PLHIV with TB.		
"In COP19, PEPFAR SA will support the GoSA to scale up TB prevention and treatment among PLHIV. Priorities include expanded implementation of universal TB screening at all PEPFAR- supported facilities, increased HIV testing among individuals with presumptive TB, ensuring rapid ART initiation for TB/HIV co-infected individuals, scaling up TB preventive therapy [INH]] to include those currently on treatment who have not previously received TPT in addition to those newly initiating treatment, and support NDoH efforts to make urine mycobacterial lipoarabinomannan (LAM) available to patients hospitalized with advanced HIV disease. PEPFAR SA COP19 investments will also improve infection prevention and control practices, strengthen service delivery integration and ensure robust TB/HIV data reporting (e.g., EDRWeb)." (SDS p68) According to PEPFAR data, the # of registered new and relapsed TB cases with documented HIV status increased from 139,230 in 2018 to 161,427 in 2019, surpassing the 2019 target of 145,007 by 11%.	In COP2020 PEPFAR will measure impact on TB-related morbidity and mortality among PLHIV by tracking progress in terms of scaling up implementation of TB symptom screening and contact tracing; urine-LAM and Xpert MTB/RIF Ultra testing;, and TPT among PLHIV who have not yet received a course of TPT or are newly enrolled in care, and in which active TB disease has been ruled out. Key to supporting these scaled up efforts aimed at reducing TB morbidity and mortality among PEPFAR clients are: healthcare working training initiatives (on TB symptom screening and contact tracing, and to support sample collection and preparation as close to the point of care as possible); budget to support healthcare worker training, contact tracing, and procurement of key commodities, including those required for urine-LAM and Xpert MTB/RIF Ultra testing and TPT; and the establishment of links between TPT scale up and TLD transition, and DSD models of HIV service delivery.	**Target:** TB symptom screening conducted at 100% of PEPFAR supported facilities. Target:100% of people presenting to care with TB symptoms, serious illness or advanced HIV receive urine-LAM and Xpert MTB/RIF Ultra testing for TB. **Target:** 80,000 registered cases of new and relapsed TB diagnoses among PLHIV **Target:** 100% of people living with HIV diagnosed with active TB disease (TX_TB) receive household contact investigation of family and close contacts. **Target:** 80% of Xpert MTB/RIF Ultra results turned-around in less than 5 days.
8c. Support scale up of TB preventive therapy (TPT) among PLHIV		
"In COP19 PEPFAR SA will support NDoH to increase TPT coverage among patients newly and previously initiated on ART. A total of 836,401 (85%) patients on ART receiving TPT are expected to complete the course from the 984,001 initiated on TPT. This is in line with the COP19 TB_PREV target in the planning letter." (SDS p70)	PEPFAR will continue to work closely with the GoSA to scale-up rifapentine-based TPT and transition the TPT program from IPT to 3HP, pending adequate supply and drug availability. Major concerns cited in COP19 about 3HP (price/ affordability and compatibility with TLD) have now been resolved. 3HP scale-up will be linked to TLD transition and offered to both ARV-naive and ARV-experienced people initiating TLD. TPT will be incorporated into DSD models of HIV care.	**Target:** All children identified through household contact investigation (TX_TB x 2) screened for TB, and either initiate TB treatment or TPT. **Target:** 800,000 PLHIV initiate and complete TPT within COP20. Of these, 40% receive 3HP.

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COP19 & DATA	LANGUAGE TO INCLUDE IN COP20	TARGET
9. Support a bio-behavioural survey and a size estimate study for key populations to improve service delivery.		
"To maximize prevention impact in COP19, the PEPFAR SA prevention program will continue to ensure that HIV prevention resources are focused on priority populations and in geographic areas at elevated risk. In COP19 priority combination evidence-based prevention investments continue to be promoted for AGYW, OVC, key populations and men (15-34 years), and will include increased use of peer-led prevention approaches to reach priority populations." (SDS p31) "PEPFAR SA continues to strengthen its key population prevention, care and treatment investments targeted to female sex workers, men who have sex with men, transgender women, people who inject drugs, and incarcerated individuals, aligned with strong country strategic plans, and informed by the most recent population size estimations and bio-behavioral data. [...] The core of the COP19 program focuses on peer-led outreach and mobilization, targeted strategic communication and demand creation, and key population-friendly mobile and drop-in centers providing HIV, STI, and TB screening, testing and treatment services, and PrEP. Additional emphasis will be placed on case identification to increase HTS yield through social networking strategies such as the Enhanced Peer Outreach Approach. This core package is complemented by interventions focused on stigma reduction, community mobilization, and use of strategic information for program management. Resources from the PEPFAR Key Populations Implementation Fund will be leveraged on COP19 investments and will include innovations to improve yield, linkages and retention across the prevention, care and treatment cascades." (SDS p33)	PEPFAR will support an IBBS and a size estimate study amongst key populations to measure prevalence, numbers and risk behaviours to provide quality targeted services for key populations.	**Target:** A country wide bio-behavioural study and size estimate is funded.
10. Ensure that men are able to access male friendly services e.g. male outreach initiation and management, male after hours clinics, and community testing.		
"Community testing in COP19 will primarily be focused on index testing and enhanced case-finding among men, which is expected to result in increased yield and more efficient testing in COP19." (SDS pg28) "PEPFAR SA will continue to engage religious and traditional leaders to empower them to create demand for HIV services among men and adolescents in the 14 highest burden districts.'(SDS pg 28) "NDoH and PEPFAR SA are committed to reducing treatment disengagement from care by improving patient experience during clinic visits through a range of interventions, including:providing population-specific services like Men's Corner or youth-friendly services after school hours." (SDS pg. 28)	COP20 will explore a range of approaches to urgently bring more men into HIV care — with attention to cost-effectiveness and to ensuring successful retention in care. These approaches will include, at a minimum, male after hour clinics in PEPFAR supported facilities and community testing models. HRH programming will also be more attentive to ensuring a larger number of male counselors and male nurses as a way to urgently increase the number of men on treatment and who are virally suppressed.	**Target:** 100% of PEPFAR supported sites to have a range of approaches to urgently bring more men into HIV care by the start of COP20. The gap in HRH support through the surge is in part filled by hiring male healthcare workers including counsellors and nurses.

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COP19 & DATA	LANGUAGE TO INCLUDE IN COP20	TARGET
11. Ensure that interventions targeting young people reduce HIV incidence and provide adequate care and support to ensure long term treatment retention through youth friendly services and youth clubs.		
"Similarly, to close the treatment gap for youth in general and AGYW in particular, PEPFAR SA will work with facility, community, faith-based and traditional structures. PEPFAR SA will support the GoSA to expand adolescent and youth friendly services in facilities and communities, after-school hours, school health services, self-screening, youth connectors, youth care clubs, and mHealth (including social media)" (SDS p29) "Adolescent case finding is optimized through youth friendly services and "Youth Zones" in facilities, through after-school hours, school health services, and mHealth (including social media)". (SDS p74)	COP20 will ensure that all clinical and non-clinical staff in PEPFAR sites are sensitised to provide youth friendly services. PEPFAR will develop closed membership youth clubs for young people living with HIV that integrate psychosocial support, HIV clinical management (including ART initiation), family planning and ART refills.	**Target:** 100% of PEPFAR sites receive sensitisation training to provide youth friendly services. By end COP19 there are no reports of youth "unfriendly" services, as reported by PLHIV led PEPFAR site monitoring. 100% of sites will establish closed membership youth clubs to support adherence and retention of young people in the area – where young people are collecting ART.
12a. Fund a community-led capacity building programme to strengthen and ensure the functionality of clinic committees across South Africa.		
No mention.	In COP20, PEPFAR SA will provide resources to ensure a wide-scale capacity building programme led by community and PLHIV groups to ensure functionality of clinic committees. Additionally it is critical that there is improved linkage between clinic committees and ward, local, and district AIDS councils, given that the implementation of HIV policy occurs at a clinic level.	**Target:** By end COP20, 100% of clinic committees at PEPFAR supported sites will have received capacity building by community groups to increase functionality.
12b. Ensure accountability in HIV and TB service delivery by maintaining funding for Ritshidze in COP20.		
"The COP19 plan incorporates recommendations from The People's COP, such as: [amongst other listed items] (5) partnering with civil society organizations for facility accountability" (SDS p24) "In COP19, PEPFAR SA will fund a coordinated community monitoring system lead by PLHIV and KP organizations to monitor the state of service provision at PEPFAR supported sites and escalate issues including (but not limited to): poor performance, poor quality of services, poor health worker attitudes, health and rights violations, and stockouts/ shortages of diagnostics and treatment. Widespread or repeating issues will be discussed at Community Advisory Group in order to attempt to generate systemic solutions." (SDS p37)	COP20 will maintain funding of USD 2 million for the PLHIV Sector lead Ritshidze project to continue monitoring 400 sites across the high burden districts in South Africa.	**Target:** Issues affecting HIV and TB service delivery at site level are rapidly addressed by PEPFAR and implementing partners through an accelerated response mechanism.

PRIORITY INTERVENTIONS

COP19 & DATA	LANGUAGE TO INCLUDE IN COP20	TARGET
12c. Eradicate barriers to accessing HIV, TB and STI medicines — caused by stockouts and/or shortages of medicines — at 100% of PEPFAR sites in COP20 by funding the Stop Stockouts Project.		
"During the second half of COP18 and during COP19, PEPFAR SA will focus on preventing disengagement from care by better understanding the individual characteristics and reasons for loss to follow-up, improving health and treatment literacy, eliminating drug stock-outs and providing enhanced-support SMS reminders." (SDS p28)	COP20 will fund the Stop Stockouts Project to run workshops to educate community members about stockouts/shortages of medicines and empower them to take action to report these challenges through the Stop Stockouts Project hotline. COP20 will ensure that PEPFAR supported districts are adequately stocked by supporting the supply chain at a facility level including securing supply to ensure that ARV thefts cannot take place. In addition supply chain monitoring tools (such as the stock visibility system) must be strengthened to allow for public monitoring and problem identification in a transparent, expeditious manner.	**Target:** Stockouts and shortages of medicines at PEPFAR supporting sites are reported through the Stop Stockouts Project hotline.


Mpola


Welcome to Springs Clinic
OPEN HOURS Monday to Friday 08:00 - 16:30 Tel: (011)
Management and Control of Tuberculosis (TB) Management of Acute and Chronic Diseases
Management of Sexually Transmitted Infections (STI) Management of HIV/AIDS and ARV's
Child Health and Immunization, Monitoring of Child Development and Screening (IMCI)
Cancer Screening, Cervical Cancer Screening (PAP SMEAR) Prostate Cancer
Screening Female Reproductive Health Ante-Natal Care (ANC) and Post Natal Care (PNC)
HIV Counseling and Testing (HTC) Primary Mental Health and Health Promotion
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THIS FACILITY IS TO BE USED AT OWN RISK AND THE EKURHULENI METROPOLITAN MUNICIPALITY SHALL NOT BE HELD LIABLE FOR ANY INJURY OR DEATHS SUFFERED DURING THE VISIT OR FOR ANY LOSS OR DAMAGE TO POSSESSIONS.
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CLINIC


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PRIMARY HEALTH CARE CENTRE
CLINIC/UMTHOLAMPILO
SIYAKWAMUKELA


MOFOLO CHC
07H00 - 16H00
SERVICES RENDERED
- CURATIVE SERVICES
- X-RAY SERVICES
- PHARMACY
- SOCIAL WORKER
- MENTAL HEALTH
- ORAL HEALTH
- V.C.T.
- CHILD ABUSE
- HEALTH PROMOTION
- YOUTH FRIENDLY
- PHYSIOTHERAPY
- MOU
- ANTE-NATAL CARE
- LABOUR WARD (24 HRS)
- POST NATAL CARE


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• Curative
• Growth monitoring
• Immunisations
• Vitamin A & D
• Deworming
Sexual and reproductive health
• Family planning
• Pap smears
• Sexually transmitted infections
BANC (basic antenatal care)
Tuberculosis management & testing
ART (antiretroviral treatment)
HIV testing and care
Working hours: 07:30 -16:30
Tel: 021 444 6096/7
Ambulance No.:
021 937 0500
021 480 7700


Lusikisiki
Village Clinic
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His Excellency,
Mr. Matamela Cyril Ramaphosa.
President of the Republic of South Africa.
On 17 September 2019


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ALL VEHICLES ON [redacted] PREMISES ARE
DRIVEN AND PARKED AT OWNERS OWN RISK
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OPERATIONAL MANAGER