

PEOPLE'S COP19 SOUTH AFRICA

COMMUNITY PRIORITIES

PEPFAR COUNTRY OPERATIONAL PLAN 2019



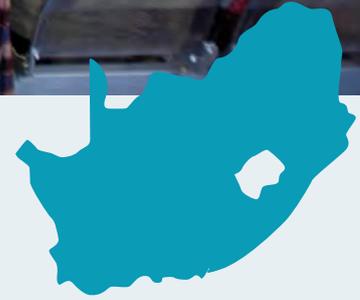
FOR WOMEN LIVING WITH HIV/AIDS



+SECTION27
catalysts for social justice



HEALTH GAP
GLOBAL ACCESS PROJECT



With only a year until 2020 – and the deadline to reach the 90-90-90 targets – South Africa is dangerously off track. Currently 7.1 million people are living with HIV in the country. New HIV infections remain high, according to the Thembisa model¹ at 275 000 in 2017, higher than the 231 000 estimated in the Human Sciences Research Council (HSRC) survey².

Either way, given the current trajectory it seems highly unlikely that South Africa will reach the target of less than 100,000 new HIV infections by 2022 as outlined by the National Strategic Plan on HIV, TB, and STIs (NSP). The Thembisa model projects that new infections will only drop to around 198 000 by 2022.

At current levels, around 2.7 million people in South Africa who could benefit from treatment are not, with only 61.9% of people diagnosed with HIV receiving antiretroviral therapy in 2017 based on Thembisa estimates³ (the HSRC survey paints a slightly rosier picture, at 71%). According to the Thembisa model projections, South Africa will only reach around 70.4% by 2020. This is a major red flag. The reality is that many people who are living with HIV are not on treatment – either never having known their HIV status, or having started on treatment then disengaged from care. Arguably the biggest challenge facing the public healthcare system today is to support many more people living with HIV to start and stay on treatment. Doing this in an often-dysfunctional healthcare system will not be easy.

WHO estimates that in South Africa alone there are 322,000 people with TB in 2017 (14,000 with drug resistant TB). The rates appear to be coming down slowly – largely as a result of ART coverage – although it is hard to state the rate of progress with any certainty. The bad news is that even in 2018, many people in South Africa with TB do not even get diagnosed.

In order to turn the tide on the national HIV and TB epidemics, we need to ensure that South Africa's PEPFAR funding is used optimally and with the most possible impact. However local monitoring of PEPFAR supported sites often paints a bleak picture of dysfunction and wasted resources. A targeted fact-finding mission was carried out in the City of Tshwane, Lejweleputswa and the North West to attempt to assess the state of a number of PEPFAR supported facilities. The results of this monitoring have been compiled into a report and also unpacked in the analysis below. As people living with and affected by HIV rooted in communities across the country, the priorities outlined in the "People's COP" reflect solutions to the realities seen every day on the ground.

We also note the impending cuts of up to 30% (USD 217 million) in COP19 that truly threaten the national HIV and TB response. We should note that for many years South Africa did not receive adequate financing for HIV and TB, with PEPFAR only increasing funding in the last few years. Further until COP18, much of this funding had been mostly dedicated to technical assistance programmes, not to services at the frontline of HIV and TB service delivery. For PEPFAR to now pull that funding before results can be seen is highly problematic.

PEPFAR must cut expensive technical assistance programmes that provide little value in the South African HIV response – and in fact sometimes hinder services as overburdened health professionals are taken away from delivering frontline services to attend numerous lengthy trainings. Instead fund game-changing and evidence-based interventions that will shift the tide in the HIV and TB response, as outlined below.

1. The Thembisa Model. Available at: <https://www.thembisa.org>

2. The South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2017. Available at: <http://www.hsrc.ac.za/en/media-briefs/hiv-aids-stis-and-tb/sabssm-launch-2018v2>

3. See note 1 above.

PRIORITY INTERVENTIONS FOR COP19

1. PEPFAR must implement and maintain the promises made in COP18 to fund 20,000 supplemental frontline staff & 8 000 community healthcare workers.

Human resource shortages are a major issue in South Africa. Ensuring access to quality healthcare services and ensuring everyone living with HIV and TB gets access to treatment and care depends largely on having enough qualified and committed staff. However, there are not enough open positions to employ the health workers we need. These shortages lead to long waiting times, longer hospital stays, higher numbers of deaths, and increased pressure on the few staff in place. One of the major causes of medicine stockouts and shortages are a result of staff being too busy to place orders in time. In order to ensure an effective HIV and TB response, we require PEPFAR to support the staffing costs of healthcare workers working in the frontline of healthcare delivery.

In light of the Government of South Africa's renewed commitment to retain the existing community healthcare workers (CHWs) outlined in the 2019 Budget Review⁴, we support that PEPFAR implement and maintain the promises made in COP18 to fund 20,000 supplemental frontline staff and 8,000 CHW's in line with the National Department of Health (NDoH) CHW programme. All frontline staff and CHW's must be practically trained in order to be able to provide a full package of services which shall, in addition to any other functions stipulated by NDoH, include the following:

- + Understand HIV and TB fully to offer up to date prevention and treatment literacy information;
- + Promote HIV testing at a facility and community level and offer information to help reduce risky sexual behaviour;
- + Promote and provide HIV self-testing kits and/or finger prick tests to marginalised and hard to reach communities not currently accessing health services through the clinic, linking those who gain positive results to facility services;
- + Provide lay counselling and adherence support services, including through home visits and through linkages with adherence clubs;
- + Provide basic mental health assessments and referrals in particular for people living with HIV facing treatment fatigue, depression and other mental health challenges;
- + Ensure people who access HIV treatment keep taking it and engage in defaulter tracing;
- + Trace people with TB or who are close to people with TB and ensure that they have access to, and take, treatment effectively;
- + Be able to identify people with advanced HIV and make urgent referrals to link those individuals into care.

We note that in order to effectively respond to HIV and TB, we must make use of suitably trained, adequately resourced and fully functional CHW's. Also, to note, the role of the Linkage Officer is not the same as a CHW based at a facility level as we have been assured. At monitored sites, the role of the Linkage Officers is to make three follow up calls to people living with HIV who miss clinic visits, after which they pass the details of the person to the WBOT team for follow up, where the teams exist.

Finally, all frontline staff, CHW's and cadres performing any of the associated functions must have the resources available in order

to engage in their functions effectively. In Tshwane, one Linkage Officer we spoke to had no access to a phone for over 2 weeks. One facility had 7 data capturers and the Linkage Officer working in limited space on two small desks. No facilities we monitored had access to internet. While this information is anecdotal, it points to dysfunction that prevents people who are lost to follow up being found and subsequently re-engaged in care.

PEPFAR must implement and maintain the promises made in COP18 to fund 20,000 supplemental frontline staff & 8 000 community healthcare workers. We support that frontline staff and community healthcare workers be trained to deliver functions that focus on HIV and TB relief whilst also providing more comprehensive community healthcare services to reduce the burden of disease.



4. Budget Review 2019, National Treasury. Available at: <http://www.treasury.gov.za/documents/national%20budget/2019/review/FullBR.pdf>

2. COP19 must radically improve retention rates through an expansion of functional facility and community-based adherence clubs, piloting “Welcome Back Services”, and financing a widespread treatment literacy program.

Currently individuals are being lost in several places in the HIV cascade including between testing HIV positive and initiating on treatment, and interrupting treatment between initiation and long-term retention.

According to PEPFAR’s 2018 data, while 743,889 people were initiated on treatment (TX_NEW) during the year, treatment rolls increased by only 383,644 (TX_NET_NEW) by end Q4. Analysis at a district level shows that most of the PEPFAR priority districts achieved less than 60% of their net new goals, some far below that figure, pointing to many diagnosis and retention challenges. Some districts even had a negative Net New number, which signals a linkage and retention crisis. Several priority districts saw 10% or more of their total people lost by end 2018 including Buffalo City (54%) Chris Hani (10%), City of Johannesburg (23%), City of Tshwane (21%), eThekweni (11%), Zululand (13%), Capricorn (28%), Mopani (15%), Nkangala (38%), Dr Kenneth Kaunda (61%). While data challenges may account for some of these figures, the picture remains bleak.

For example, in Khayelitsha, where Médecins Sans Frontières (MSF) has medical operations, a study showed that up to 25% of the HIV positive cohort cumulatively disengaged from care in the first two years of initiating ART. By 2014, close to half of those previously on ART had dropped out of care or had a substantial gap in care the preceding year. Of patients presenting to HIV services in Western Cape with a low CD4 count (<50 cells/ul) the proportion of ART-experienced patients increased from 14% in 2007 to 52% in 2017⁵.

Not only do we need to rectify this linkage and retention challenge for the health of people living with HIV, but also to close the tap on new infections. According to the Thembisa model, the most important epidemiological parameter to reduce new infections will be to target the infectiousness of people receiving ART. In other words, the most important intervention for reducing new infections is enabling people to get on treatment, stay on treatment, become and remain virally suppressed. As a further 3 million people are targeted to start treatment, effective strategies for ensuring we keep people on treatment and targeting these “losses” and ‘missed opportunities’ must be urgently implemented, addressing the underlying causes. We outline a selection of key interventions to address linkage, non-adherence and loss to follow up that should be included in the COP in 2019.

5a. Implement & maintain facility-based adherence clubs at 100% of PEPFAR supported facilities

Adherence clubs are a way for people living with HIV and adhering properly to treatment, to collect their ARVs outside of their local clinic. People living with HIV who join an adherence club can collect their medication and join discussions about issues of treatment adherence. It is an opportunity to get the much-needed treatment literacy information and support to

remain adherent to their treatment. This is a much friendlier, simpler and quicker system than waiting in long clinic queues. Not only do the clubs promote better adherence but they also relieve the burden on health facilities that are already stretched to capacity. Given the increasing uptake of HIV treatment through “test and treat” this burden will only grow.

However, in many districts across the country, adherence clubs are reportedly dysfunctional. Research carried out by SANERELA at more than 200 adherence club visits in 2018 showed that instead of being a place to learn about adherence information and get a health check by a clinician, clubs were simply an ART collection point, with little further treatment information and no mental health component. Club members often do not understand the role of clubs or why they are in them. The clubs are failing to support people in long-term adherence on medicines due to these failings. This must be urgently rectified at all sites in COP18. All facility-based adherence clubs must be made functional as per the key components outlined below.

A recent fact-finding mission in the City of Tshwane shows that some progress is being made, with a few PEPFAR sites now having functioning adherence club models theoretically in place. This was determined after adherence club facilitators (in place since December 2018) explained the model being implemented in recruitment and during club meetings. This was not however verified by observing a club meeting. However, at all sites monitored only one adherence club facilitator was operating: be it in a site servicing as many as 3652 or even 11,495 people on ART. We will not address South Africa’s major retention challenge at these ratios.

5b. Establish community-based adherence clubs linked to PEPFAR supported facilities

Building on the commitment last year, COP19 should expand this model of adherence clubs deeper into communities. This will support people living with HIV who are unable to easily access facilities, people who want to collect ART closer to home, and also support facilities with small infrastructure and no space to host clubs on site (a challenge widely reported by PLHIV sector members).

MSF and the Treatment Action Campaign (TAC) piloted adherence clubs in clinics across Khayelitsha in the Western Cape in 2007, which were subsequently taken over by the Western Cape Provincial Health Department in 2012. A study of the MSF & TAC run adherence clubs showed that of the 3,216 patients enrolled (70% of whom were women), retention

5. Kaplan SR, Oosthuizen C, Stinson K, Little F, Euvrard J, Schomaker M, et al. (2017) Contemporary disengagement from antiretroviral therapy in Khayelitsha, South Africa: A cohort study. PLoS Med 14(11): e1002407. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5675399/pdf/pmed.1002407.pdf>



was 92.5% after 12 months and 89.3% at 24 months⁶. In the 13 months prior to analysis closure, 88.1% of patients had viral load assessments and of those, viral loads ≤ 400 copies/mL were found in 97.2% (95% CI, 96.5-97.8) of patients.

With the clubs in clinics then being run by government, MSF and TAC moved the model deeper into communities, and opened clubs closer to patients' homes. Club activities are now being run from libraries, community centres and even people's houses. In short, the outcomes showed that community clubs were at least as good as facility clubs in terms of club and overall retention, and viral load outcomes.

KEY COMPONENTS OF A COMMUNITY AND FACILITY-BASED ADHERENCE CLUBS:

- + Adherence clubs are run by an adherence club facilitator who understands treatment adherence information and who is trained to identify people with 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 months and are reminded of their appointment by SMS the day before;

- + Blood tests will occur every 12 months with a clinician visiting;
- + 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 or if part of a key population; such as male clubs, youth clubs, KP clubs etc.

PEPFAR must implement and maintain facility-based adherence clubs at 100% of sites as committed to in COP18 and further set a target to establish community-based adherence clubs, based on analysis of all people on treatment in a given district, across all PEPFAR supported districts that are even more accessible for people living with HIV who are stable and choose to join a club.

5c. Pilot a scalable, sustainable and comprehensive approach to provide medical and psychosocial support that can be individualised according to distinctive needs of the disengaged individuals in the following five poorly performing sites: City of Johannesburg, City of Tshwane, eThekweni, Ekurhuleni, and the City of Cape Town – followed by wider expansion across all PEPFAR supported districts in 2020.

It is often reported to us that people who miss appointments and/or default on their treatment can be treated badly by health workers when they return into care. This fear of being reprimanded discourages people from going

6. "High rates of retention and viral suppression in the scale-up of antiretroviral therapy adherence clubs in Cape Town, South Africa". Available at: <https://onlinelibrary.wiley.com/doi/pdf/10.7448/IAS.20.5.21649>

back to the clinic to seek help and restart their treatment.

In order to address this challenge, MSF has established “Welcome Back 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);
- + **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.)

These districts have been selected based on PEPFAR’s own data that reports extremely poor retention rates in these areas, as well as the size of the populations living with HIV.

COP19 should pilot “Welcome Back Services” in the City of Johannesburg, City of Tshwane, eThekweni, Ekurhuleni, and the City of Cape Town, 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).

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

In an era of immediate treatment initiation, we need a far better approach to ensuring PLHIV starting care are well prepared for adherence from the start. Community led HIV prevention and treatment literacy (PTL), pioneered by TAC, teaches people living with HIV the science of HIV, TB, STIs and other diseases. The programme has proved to be a novel and effective public health intervention in South Africa. People living with HIV are taught about the importance of adhering to their medicines as prescribed. By becoming as informed as possible, people are empowered to take control of their own health and sex lives. Treatment literacy helps people to stay both physically and mentally healthy. It will improve linkage and retention rates as people understand the importance of starting and remaining on treatment effectively. In an era of same day initiation, we need an updated treatment literacy effort that also targets and promotes information for people are healthy and who have never been ill.

As South Africa shifts to a dolutegravir based first line regimen, and in line with new South African ARV guidelines, it will be critical to ensure people are informed on the benefits and risks associated with TLD, in order for them to make an appropriate ART choice, having regard to the relevant information. Demand creation for new medicines, and preparedness for interim side effects, is another benefit of widespread treatment literacy programmes.

While providing accurate, scientific, but easily understandable information in all South African languages, treatment literacy can support the debunking of myths that are being spread through our communities and online (of note is the misinformation too often spread within religious platforms in the country). Part of the treatment literacy expansion would address this head on.

COP19 must financially and otherwise support efforts (lead by PLHIV, lay counsellors and health workers) to improve treatment literacy levels in the country through funding:

- a) training of trainers (lead by PLHIV and key population groups) to develop a cadre of PLHIV PTL trainers to improve treatment literacy levels in the general population & amongst key populations;
- b) subsequent trainings and health talks run by PLHIV at community and facility level – and outreach to marginalised populations;
- c) the inclusion of prevention and treatment literacy topics in the training and scope of work of all government funded CHWs;
- d) the inclusion of prevention and treatment literacy topics in the training and scope of work of all PEPFAR funded health workers doing tracing of people with HIV and TB in the community and adherence club facilitators;
- e) the development (by PLHIV groups) of accurate and informative prevention and treatment literacy materials (in all South African languages) 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 etc.; and
- f) the dissemination of these materials to all PEPFAR supported health facilities and through localised social mobilisation campaigns at a community level by PLHIV groups and by CHWs, where possible, in all PEPFAR supported districts.

COP19 must provide the financial and other resources necessary to ensure a major upscale of treatment literacy in the country. This must 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. PEPFAR must 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. Efforts should not duplicate each other. 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 – and offer HIV and TB education in facilities, adherence clubs and beyond.



3. Eradicate barriers to accessing HIV, TB and STI medicines – caused by stockouts and/or shortages of medicines – at 100% of PEPFAR sites in COP19.

Stockouts and shortages of ARVs and TB medicines place people’s health and lives at risk. Monitoring at PEPFAR supported sites reveals ongoing shortages and stockouts of medicines that cause disruption, confusion, and cost to people, and in extreme cases detrimentally affect adherence and lead to disengagement from care.

The 2016 Stop Stockouts Survey, showed that one in four facilities, contacted telephonically, had recorded a shortage of ARV or TB medicines, three months prior to contact and one in ten had recorded stockouts on the day of contact⁷. While this has improved considerably, with most facilities contacted in 2017/18 mentioning less frequent stockouts, North West province faced extremely difficult challenges, with up to 42% of contacted facilities reporting wait times of up to one month to resolve stockouts⁸. In addition, recent reports from TAC branches who monitor more than 200 facilities across South Africa, show a series of ongoing complaints regarding stockouts and/or shortages of medicines at PEPFAR supported sites. People report being given a box of pills to share with another person, a few pills to last a couple of days, different substitute medicines or dosages, or even at times sent home empty handed. When community-based activists attempt to resolve these problems locally, pills are often brought in from a second facility to alleviate the burden at the first. This is not resolving the shortage or obvious gaps within the supply management but, only shifting the problem to another location. In one instance, while escalating a two-month shortage of second line ARVs to PEPFAR teams nationally, it became apparent that they were not even aware of the shortage, which we were told was a result of a lack of transportation to collect

the stocks. This while USAID and other implementing partner branded cars sat outside the facility unused. Most stockouts and shortages of medicines are simply a result of poor management or a lack of human resources to ensure a fully stocked pharmacy.

In 2016, the National Department of Health (NDoH), developed a system to monitor the availability of medicines at primary facility level. The mobile-based Stock Visibility System (‘SVS’) is meant to provide real-time information on the availability of medicines in primary health care (PHC) clinics thereby preventing stockouts or shortage of medicines at facilities when there is adequate stock in the district or province. However currently it is not being optimally utilised. PEPFAR should ensure that all their supported sites utilise and enter data into the SVS to ensure better monitoring of stock levels. PEPFAR should also support that the SVS is made public to provide for better transparency.

COP19 must 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.

7. Stop Stockouts Survey, 2016. Available at: <https://www.groundup.org.za/media/uploads/documents/StopStockoutsSurvey2016.pdf>

8. Stop Stockouts Survey, 2017. Available at: <https://sahivsoc.org/FileUpload/Stop%20Stockouts%20National%20Report%20Oct%202018.pdf>



4. Fund local level community and PLHIV led groups to monitor the state of service provision at PEPFAR supported sites & escalate issues of poor performance.

Ongoing local facility monitoring at PEPFAR supported sites highlights a range of challenges that detrimentally impact on people's ability to access HIV & TB prevention, treatment and care services. Community based and PLHIV lead advocacy organisations play a pivotal role in identifying challenges and ensuring local level accountability where the services are actually delivered. 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. COP19 must set aside resources to ensure that this monitoring and escalation of issues can be more consistently rolled out and maintained.

EFFECTIVE MONITORING OF FACILITIES WILL INCLUDE:

- + Consistent monthly or bi-monthly monitoring of selected PEPFAR supported facilities – and ad hoc fact-finding missions to assess the state of other facilities less consistently monitored and where issues arise;
- + The monitoring will be based on a set of survey questions that monitor: HIV and TB service provision at the facility, waiting times, staff attitudes, stockouts & shortages of health technologies (including diagnostics, treatments, and prevention methods), facility cleanliness and the state of infrastructure, TB infection control at the facility, as well as other key issues related to HIV and TB;
- + Monitoring results to be collated and published in a simple model for tracking;
- + Monitoring results to be linked to a model of accelerated response from PEPFAR and partners to address issues outlined;
- + Widespread and repeating issues to be presented at Community Advisory Group meetings in order to attempt to generate systemic solutions;
- + Community based and PLHIV led organisations to also be included in Site Improvement Monitoring System (SIMS) visits to ensure that assessments made are based on quality of services, not just quantity/counts of services.

Resources will be used for travel, communication and other costs to allow groups to carry out the monitoring at site level, document and upload results, and escalate any issues required.

COP19 must fund local level community and PLHIV led groups in at least 18 of PEPFAR's 27 districts to monitor the state of service provision at PEPFAR supported sites & escalate issues including (but not limited to) poor performance, poor quality of services, poor health worker attitudes, health and rights violations, and stockouts and/or shortages of diagnostics and treatment. The results of monitoring must be linked to a model of accelerated response from PEPFAR and partners to address the issues identified in order to ensure they are rapidly rectified. Widespread or repeating issues identified should be discussed at Community Advisory Group level in order to attempt to generate systemic solutions. Community based and PLHIV led organisations must also be included in PEPFAR SIMS visits to assess quality of service provision.

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

5a. Universal TB Screening at 100% of PEPFAR sites

One key driver of TB is people with TB symptoms being missed and going undiagnosed. Whilst health facilities should universally screen people in South Africa as per national guidelines, many people who could have TB are continually “missed”.

In our understanding the indicator that most closely tracks whether we are finding people with TB is the case detection rate. According to figures available from the World Health Organisation’s TB data portal South Africa’s case detection rate was 68% in 2017. But the WHO also has the case detection rate at 68% for each of the last six years – something which does not inspire much confidence in this number.

A TB infection control survey carried out by TAC in 2018 found that 57% of facilities surveyed (119 out of 207) did not screen people for TB symptoms whilst they were waiting to be seen⁹. A study carried out in the Buffalo City Metropolitan Municipality, Eastern Cape, found that of people attending the clinic with respiratory issues, only 78% of people were screened for TB, and of those attending the clinic for other reasons, only 18% of people were screened for TB¹⁰.

Recent testing campaigns in mining and other high-burden areas have been an important step in the right direction. However, indications are that we are most likely still failing to diagnose many thousands of TB cases, thus falling short of reaching 90% of people with TB and putting them on treatment.

PEPFAR sites should ensure that people are routinely and universally screened for TB symptoms upon arrival at the facility. People with symptoms should be referred for testing, and separated from other people waiting at the facility to avoid further transmission. Tissues and masks should be provided to people coughing.

GeneXpert MTB/RIF Ultra should be the initial TB test in all PLHIV and their household and other close contacts, including HIV-negative persons with TB symptoms. Training and equipment necessary to obtain specimen samples from children for Ultra testing and culture, and to support clinical TB diagnosis among the 80% of children with TB in whom microbiological confirmation cannot be achieved, should also be supported by PEPFAR. Training and tools to rule out active TB disease should be supported by PEPFAR, especially for groups in which existing TB diagnostics have limited sensitivity (PLHIV and children)– this is especially important for initiating people at risk of TB on TPT (see section 5c).

GeneXpert platforms at PEPFAR sites can be used for TB diagnosis, viral load monitoring, and early infant diagnosis. At sites where pregnant women, infants, and children present for care, it is

important for PEPFAR to ensure Ultra availability, given increased risk of TB among infants and children and the poor performance of symptom-based TB screening among pregnant women with HIV.

COP19 should fill the human and other resource gap to ensure that 100% of PEPFAR sites screen every patient for TB upon arrival at the facility. People found to have TB symptoms should immediately be separated from those without TB, and provided with tissues and/or masks to prevent the spread of TB. People with TB symptoms should receive TB testing with GeneXpert MTB/RIF Ultra those diagnosed with TB should be started on treatment; people in whom active TB is ruled out should receive TPT (see section 5c).

5b. Improved access to TB LAM testing in outpatient settings at all hospitals in PEPFAR districts

The TB LAM test is an affordable, quick and easy to use TB urine test that requires no electricity or reagents and where the results are ready in 25 minutes. Studies show that it allows earlier TB diagnosis in people with advanced HIV, and reduces TB mortality¹¹. TB LAM testing has been recommended by the WHO for use in people with advanced HIV since 2015, and Global Fund and PEPFAR funding should be used for TB LAM procurement and implementation. South Africa’s new guidelines on TB case finding recommend TB LAM testing for all people living with HIV in hospital settings and among those with CD4 counts less than 100 mm³ in primary care settings. These recommendations are a welcome advance, but require a plan for implementation.

TB LAM procurement was not included in COP18 despite being a life-saving test and an important component of care for people living with HIV. Based on available evidence, COP19 should ensure that TB LAM test is available for use in outpatient settings. PEPFAR should develop an indicator for TB LAM use to measure its implementation and impact on people living with HIV.

To note, a separate prospective observational cohort study of both ambulatory and hospitalized HIV-positive adults in Kenya indicated the utility of expanding TB-LAM testing to people with CD4<200/mm³ to increase diagnostic yield¹².

COP19 should procure and distribute LF LAM tests and related commodities (including urine cups) to all hospitals in PEPFAR supported districts together with information on use. COP19 should develop an indicator for LF LAM to measure usage.

9. “Red Alert on TB Infection Control”, March 2018. Treatment Action Campaign. Available at: <https://tac.org.za/news/red-alert-on-tb-infection-control-in-clinics/>

10. “Missed pulmonary TB screening opportunities at Primary Healthcare Facilities: An Exit Study, Eastern Cape Province, South Africa.” International Journal of Infectious Diseases. Available at: [https://www.ijidonline.com/article/S1201-9712\(16\)30092-3/fulltext](https://www.ijidonline.com/article/S1201-9712(16)30092-3/fulltext)

11. “Effect on mortality of point-of-care, urine-based lipoarabinomannan testing to guide tuberculosis treatment initiation in HIV-positive hospital inpatients: a pragmatic, parallel-group, multicountry, open-label, randomised controlled trial”. The Lancet. Available at: <http://thelancet.com/journals/lancet/article/PIIS0140-6736%2815%2901092-2/fulltext>

12. Huerga H, et al. Incremental Yield of Including Determine-TB LAM Assay in Diagnostic Algorithms for Hospitalized and Ambulatory HIV-Positive Patients in Kenya. PLoSOne. 2017 Jan 26;12(1):e0170976. doi: 10.1371/journal.pone.0170976



5c. Expand provision of TB preventive therapy (TPT) to all PLHIV newly enrolled into care, and expand provision of TPT to eligible household contacts of PLHIV with active TB, with a special emphasis on reaching young children.

TB preventive therapy (TPT) is proven to reduce morbidity and mortality among PLHIV, including PLHIV on ART. For this reason, TPT should be considered a routine and integral part of the HIV clinical care package. South Africa has led the world in scaling-up TPT through the use of isoniazid preventive therapy (IPT). In 2017, of the 958,559 PLHIV who started TPT globally, South Africa accounted for 39% of the total. In the same year, 53% of PLHIV newly enrolled into care in South Africa started TPT, as did a reported 79% of child household contacts of people with pulmonary TB.¹³ Although these figures lead the world, there is much progress still to be made in South Africa in scaling up TPT.

South Africa's 2017–2022 National Strategic Plan for HIV, TB, and STIs has set an ambitious and attainable goal of ensuring TPT uptake “for all household contacts and other vulnerable groups,” reaching 90% of PLHIV by 2022 using either IPT, or, preferentially newer regimens such as 3HP. To reach this goal:

- + All PLHIV should be screened for TB with the outcome of this screening one of two mutually exclusive clinical decisions: 1) diagnosis of active TB and initiation of TB treatment; or 2) initiation and completion of TB preventive therapy.
- + All PLHIV diagnosed with active TB should receive household contact investigation to identify TB in their families and among their close contacts, with TPT offered to household members who screen negative for TB. Household contact investigation is especially important for preventing TB in young children who living in the same household as an adult with TB.
- + PEPFAR SA should aim to put a significant proportion (suggested 20%) of PLHIV who receive TPT on 3HP. While currently more costly than IPT, the 3HP regimen is shorter, safer, easier for people to complete, and has been shown to be as effective in preventing TB as IPT. Generic producers of 3HP are expected to enter the market soon, making it important for PEPFAR SA to lay the groundwork for transitioning more PLHIV to rifapentine-based TPT as the cost of rifapentine comes down and information on the safety of its use with dolutegravir becomes available (expected March 2019). Anyone receiving IPT should receive the fixed-dose combination of isoniazid/cotrimoxazole/B6 (Q-TIB), which is available for \$1.99.
- + Children receiving TPT should receive the 3HR regimen, which is available in a child-friendly dispersible tablet. Children with HIV requiring TPT can receive 3HR if they are on efavirenz-based ART; children on nevirapine, lopinavir/ritonavir, or dolutegravir-containing regimens should receive IPT to avoid drug-drug interactions with the rifampicin in 3HR.

COP19 should expand provision of TB preventive therapy (TPT) to all PLHIV newly enrolled into care, and expand provision of TPT to eligible household contacts of PLHIV with active TB, with a special emphasis on reaching young children.

13. WHO 2018 Global TB Report. <https://apps.who.int/iris/bitstream/handle/10665/274453/9789241565646-eng.pdf?ua=1>.



6. 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.

Young people, particularly young women and girls, are disproportionately affected by the HIV epidemic, and are at high risk for infection up to three times as much as their male counterparts. According to the latest available data from HSRC, every day in South Africa more than 180 young girls get HIV – that is 66,000 of the 231,000 new infections every year¹⁴. Incidence among youth (aged 15-24) remains high, especially adolescent girls and young women (AGYW), with the lowest proportion of treatment exposure and significantly poorer retention and viral suppression outcomes than their adult counterparts. Models of care remain largely undifferentiated for this vulnerable population.

Yet despite great burden, most clinic services do not cater to the specific needs of this growing population. Youth friendly services remain the exception to the rule. Systematic review shows that 'youth friendly' healthcare is urgently needed. Factors cited as important included: clinical attitudes, quality of clinical communication skills, perceived medical competency and accessibility of services in age appropriate environments that provides continuity of care¹⁵. Reports show that adolescents seeking both contraceptives and counseling and testing for HIV in general clinic settings, are often turned away due to the personal views of health workers (that that adolescents should not be sexually active). Yet whether older people like it or not, the fact is that many young people – including learners at schools – are sexually active.

In order to redress this challenge, COP19 should ensure 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. COP19 should further ensure that there is no regression on the available forms of contraceptives and treatment as prevention tools that are already available to the youth.

COP19 must saturate PEPFAR districts with youth clubs which target losses from HIV diagnosis throughout lifelong treatment journey with a specific focus on retention after initiating ART. Closed membership groups should be established which integrate psychosocial support, HIV clinical management (including ART initiation), family planning and ART refills for approximately 20 members who include a combination of HIV positive youth ineligible for ART, youth newly initiated on ART or youth stable on ART. Groups will be led by young people with mentorship from adults/older youth. They meet monthly and discuss adherence and other topical issues. They should include diverse membership including in and out of school, key populations etc.

COP19 must ensure sensitisation of all clinical and non-clinical staff in all PEPFAR sites to provide youth friendly services. COP19 must establish 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.

14. HSRC South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2017 <http://www.hsrc.ac.za/uploads/pageContent/9234/FINAL%20Presentation%20for%202017%20July%20launch.pdf>

15. "Impact on ART initiation of point-of-care CD4 testing at HIV diagnosis among HIV-positive youth in Khayelitsha, South Africa". Available at: <https://onlinelibrary.wiley.com/doi/pdf/10.7448/IAS.16.1.18518>

SPECIFIC LANGUAGE REQUESTED IN COP19

PRIORITY INTERVENTIONS • PRIORITY INTERVENTIONS • PRIORITY INTERVENTIONS	COP18 & DATA	LANGUAGE TO INCLUDE IN COP19	TARGET
	1. PEPFAR must implement and maintain the promises made in COP18 to fund 20,000 supplemental frontline staff and 8 000 community healthcare workers.	<p>“Facility-based Health Workers: Placement of 20,000 supplemental health workers from nine cadres to provide targeted facility-based direct service delivery in existing high-volume public health facilities, to identify PLHIV, initiate and retain them on ART. These cadres will be placed based on facility-specific needs, but are expected to include over 12,000 clinical and clinical support staff, complemented by management and lay staff.” p7</p> <p>“In COP18 PEPFAR SA will support the expansion and enhancement of the NDoH CHW program. PEPFAR investments will hire over 8,000 CHWs and Outreach Team Leads to supplement NDoH investments; capacitate over 25,000 CHWs to provide quality services that increase treatment uptake, adherence and retention among PLHIV; support supervisory staff and systems that support effective CHW interventions; and support an M&E system to track quality and quantity of service provision.” p35</p>	<p>In COP19, PEPFAR will continue to fund the deployment 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.</p> <p>Additionally, in COP19 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. PEPFAR-funded CHWs should offer a selection of the following services:</p> <ul style="list-style-type: none"> • Understand HIV and TB fully to offer up to date prevention and treatment literacy information; • Promote HIV testing at a facility level and offer information to help reduce risky sexual behaviour; • Promote and provide HIV self-testing kits and/or finger prick tests to marginalised and hard to reach communities not currently accessing health services through the clinic, linking those who gain positive results to facility services; • Provide lay counselling and adherence support services, including through home visits and through linkages with adherence clubs; • Provide basic mental health assessments and referrals in particular for people living with HIV facing treatment fatigue, depression and other mental health challenges; • Ensure people who access HIV treatment keep taking it and engage in defaulter tracing; • Trace people with TB or who are close to people with TB and ensure that they have access to, and take, treatment effectively.
2a. Implement & maintain facility-based adherence clubs at 100% of PEPFAR supported facilities	<p>“PEPFAR SA and NDoH are jointly developing 40 SOPs to cover identified priority interventions across the HIV care cascade. These SOPs 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. Monthly reporting will monitor the coverage and quality of these interventions across PEPFAR-supported facilities.” p28</p>	<p>By start COP19, 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.</p> <p>PEPFAR will continue to support the clinical and staffing needed to establish and maintain these programs for at least 3 years.</p>	<p>Target: 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.</p> <p>All adherence club and support group facilitators will be trained on basic mental health in order to assess and refer club/group members for further psycho-social support where necessary.</p>

PRIORITY INTERVENTIONS - PRIORITY INTERVENTIONS - PRIORITY INTERVENTIONS - PRIORITY INTERVENTIONS	COP18 & DATA	LANGUAGE TO INCLUDE IN COP19	TARGET
	2b. Establish community-based adherence clubs linked to PEPFAR supported facilities.		
	<p>In COP19, PEPFAR will identify the communities and populations in each district most affected by adherence challenges and set up community-based adherence clubs that include ART services in each of the 27 districts.</p> <p>PEPFAR will support the clinical and community staffing needed to establish and maintain these programs for at least 3 years.</p>	<p>Target: PEPFAR will set a target (perhaps at least 10%) based on analysis for the portion of all people on treatment in a given district who are actively engaged in community-based ART programmes.</p>	
2c. Pilot a scalable, sustainable and comprehensive approach to provide medical and psychosocial support that can be individualised according to distinctive needs of the disengaged patient in the following five poorly performing sites: City of Johannesburg, City of Tshwane, eThekweni, Ekurhuleni, and the City of Cape Town – followed by wider expansion across PEPFAR districts in 2020.			
<p>No reference.</p>	<p>COP19 will pilot “Welcome Back Services” in the City of Johannesburg, City of Tshwane, eThekweni, Ekurhuleni, and the City of Cape Town, that will 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 Back Services” will include:</p> <ul style="list-style-type: none"> 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); 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.) 	<p>Target: <90% of enrolled patients return for follow up visit to clinic and are appropriately linked to care.</p>	
2d. Fund a widespread expansion of treatment literacy information.			
<p>“Support scale-up of treatment initiation, adherence, and retention through development of psychosocial, peer-to-peer tools and communication for PLHIV and health care providers.” p80</p> <p>“# PLHIV accessing high quality treatment literacy on ART initiation, adherence, disclosure, viral load suppression in different platforms % of acceptable scores on patient surveys on Health care worker attitudes towards PLHIV.” p81</p> <p>“Tools distributed to all partners; 80% of PLHIV have access to high quality treatment literacy tools on ART initiation, adherence, disclosure and VL suppression; Communications workshops for health care workers held in 27 districts.” p82</p>	<p>COP19 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.</p>	<p>Target: People friendly treatment literacy materials, developed with PLHIV and KPs, are available and community based organisations deliver treatment literacy services through support groups and localised social mobilisation campaigns.</p> <p>Community based and facility-based health workers deliver high quality treatment literacy to 80% of people living with HIV including (but limited to) through facility based health talks and adherence clubs.</p>	
3. Eradicate barriers to accessing HIV, TB and STI medicines – caused by stockouts and/or shortages – at 100% of PEPFAR sites in COP19.			
<p>“COP18 funds will support development of a central selection and contracting framework for medical supplies, and its incorporation into the NDoH’s stock Visibility and Analytics Network blueprint.” p35</p>	<p>COP19 will 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.</p>	<p>Target: Validated stock visibility system through community-led monitoring of stock levels.</p>	

PRIORITY INTERVENTIONS • PRIORITY INTERVENTIONS • PRIORITY INTERVENTIONS	COP18 & DATA	LANGUAGE TO INCLUDE IN COP19	TARGET	
	4. Fund local level community and PLHIV led groups to monitor the state of service provision at PEPFAR supported sites & escalate issues of poor performance			
	No reference.	COP19 will fund local community and PLHIV groups in at least 18 of PEPFAR's 27 districts to monitor the state of service provision at PEPFAR supported sites & 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. The results of monitoring will be linked to a model of accelerated response from PEPFAR and partners to address the issues identified in order to ensure they are rapidly rectified. Widespread or repeating issues identified will be discussed at Community Advisory Group level in order to attempt to generate systemic solutions. PEPFAR will also ensure that community based and PLHIV led organisations are included in SIMS visits to assess quality of service provision at supported sites.	Target: Issues affecting HIV and TB service delivery at site level are rapidly addressed by PEPFAR and implementing partners through an accelerated response mechanism.	
	5a. Universal TB Screening at 100% of PEPFAR sites			
<p>"In COP18, PEPFAR SA will support the GoSA to scale up TB prevention and treatment among PLHIV. Priorities include increased HIV testing among individuals with presumptive TB and expanded screening for TB among PLHIV, ensuring ART for all TB/HIV co-infected individuals, and increasing TB preventive therapy." p24</p> <p>"The core of the COP18 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." p26</p>	<p>PEPFAR SA will integrate TB screening into HIV case finding, and ensure that 100% of people presenting for care are screened for TB using the TB symptom screen and, where indicated, chest X-ray.</p> <p>PEPFAR SA will use GeneXpert MTB/RIF Ultra as the initial TB diagnostic test for all people who screen with TB symptoms, and support training and equipment necessary to obtain specimen samples for Ultra testing and culture from adults with possible extrapulmonary TB and children, and to support clinical TB diagnosis in children.</p> <p>PEPFAR SA will ensure that the outcome of TB screening results in one of two mutually exclusive decisions: 1) people diagnosed with TB should be started on treatment; 2) people in whom active TB is ruled out should receive TPT.</p>	<p>Target: 100% of people presenting for care screened for TB using TB symptom screen and, where indicated, chest X-ray.</p> <p>100% of people with TB symptoms identified during screening are tested using GeneXpert MTB/RIF Ultra, including children.</p>		
5b. Improved access to TB LAM testing for people with advanced HIV in both hospital and ambulatory settings				
<p>No reference to LAM in COP18.</p> <p>Ref: "From 2012 to 2016 the proportion of patients presenting with advanced HIV disease [in South Africa] remained relatively unchanged and ranged from 34.8% to 32.9%."16</p> <p>Ref: In the Western Cape, 51.8% of people attending HIV care with CD4<50 were ART experienced in 2016. 17</p>	<p>PEPFAR SA will make LAM testing available in all settings where PLHIV present for care, including both inpatient and outpatient settings. In inpatient, hospital settings, PEPFAR SA will use TB LAM as a screening test in all hospitalized patients with HIV. In outpatient, ambulatory settings, PEPFAR SA will provide LAM testing to all people presenting to care with clinical signs of apparent serious illness, or, if CD4 testing is available, with CD4<200..</p> <p>PEPFAR SA will support training in the use of TB LAM and ensure the procurement of required commodities (TB LAM Ag urine assays, urine cups, pipettes, pipette tips, timers) within laboratory costs. PEPFAR SA will also support sensitization of health care workers on the utility of TB LAM and its place in the TB diagnostic algorithm. Task sharing should be considered as the test is easy enough to be conducted by nurses.</p> <p>PEPFAR SA will preferentially support the use of more sensitive TB urine LAM tests, if they become available and are recommended by WHO within COP19.</p>	<p>Target: LAM testing provided to 100% of PLHIV who are hospitalized.</p> <p>LAM testing provided to all PLHIV presenting to care in outpatient settings with signs of advanced illness or with CD4<200 [i.e., 33% of TX_NEW target].</p>		

16. Carmona et al (2018). Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5850436/pdf/ciy045.pdf>
17. Osler et al (2018). Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5850025/pdf/cix1140.pdf>

PRIORITY INTERVENTIONS • PRIORITY INTERVENTIONS • PRIORITY INTERVENTIONS	COP18 & DATA	LANGUAGE TO INCLUDE IN COP19	TARGET
	<p>5c. Expand provision of TB preventive therapy (TPT) to all PLHIV newly enrolled into care, and expand provision of TPT to eligible household contacts of PLHIV with active TB, including young children and HIV-negative adults.</p>	<p>No reference to TPT in COP18 aside from the quotation from p. 24 noted in row 4a. above.</p> <p>From PEPFAR SA data:</p> <p>TB_PREV</p> <p>Target: 112,560</p> <p>Result (thru Q4): 117,644</p> <p>Only 7 districts met or exceeded their TPT targets; all were put on IPT. Districts in the cape provinces underperformed those in KZN.</p> <p>Ref. South Africa 2017–2022 National Strategic Plan for HIV, TB, and STIs: ensuring TPT uptake “for all household contacts and other vulnerable groups,” reaching 90% of PLHIV by 2022 using either IPT, or, preferentially, newer regimens such as 3HP. “3HP is not yet routinely used, but the aim is to make this routine by 2022.”</p> <p>2012 estimate by OECD is that there are an average of 2 children age 15 and under in a typical household¹⁸. Regarding HIV-positive children, an estimated 7% of child TB deaths in the WHO AFRO region among children living in the same household as an adult with TB occur in HIV-positive children¹⁹.</p>	<p>TPT for PLHIV: PEPFAR SA will support the GoSA scale-up TB preventive therapy (TPT), ensuring that all PLHIV newly enrolled into care who screen negative for active TB disease initiate and complete a course of TPT. All PLHIV in PEPFAR SA programs newly diagnosed with active TB disease receive contact investigations of their families and close contacts, with contacts offered TPT.</p> <p>PEPFAR SA will pilot the use of the short-course, rifampentine-based 3HP regimen as an alternative to isoniazid preventive therapy (IPT) for 20% of PLHIV started on TPT, pending confirmation that rifampentine is safe to use with dolutegravir. Individuals receiving IPT will receive the fixed-dose combination of isoniazid/cotrimoxazole/B6 (Q-TIB).</p> <p>TPT for children: PEPFAR SA will support contact investigations for all PLHIV diagnosed with active TB disease. Children of PLHIV with TB identified by contact investigations will be offered TPT with the regimen determined by HIV status. HIV-negative children will be offered the 3HR regimen, which is available as a child-friendly FDC. Children with HIV will be offered 3HR (if on EFV-based ART) or 6H (if on nevirapine, lopinavir-ritonavir, or dolutegravir-based ART). 6H is also available in a child-friendly dispersible tablet. (3HR = three months of daily isoniazid + rifampicin; 6H = six months of isoniazid preventive therapy).</p> <p>PEPFAR SA will integrate training on TPT initiation and adherence support into preparations to rollout dolutegravir-based ART, recognizing that TB prevention is a routine and integral part of the HIV clinical care package.</p> <p>Human Rights and Stigma: PEPFAR SA will ensure that TPT implementation respects human rights and minimizes stigma. In particular, that TPT initiation is always voluntary, introduced with full information and proper counselling on the risk/benefits, and never mandatory. Contact investigations should be designed and carried out in a way that minimizes the potential impact of stigma in the community (e.g., identifying a household as having TB or disclosing the TB or HIV status of a PLHIV without their consent).</p>
<p>6. 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.</p>	<p>“Similarly, to close the treatment gap for youth in general and AGYW in particular, PEPFAR SA will close case finding, linkage, and retention gaps by leveraging 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).” p23</p>	<p>COP19 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.</p>	<p>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.</p> <p>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.</p>

18. Becerra et al. Available at: <https://link.springer.com/article/10.1057%2Fjph.2014.35>

19. Dodd et al, 2018. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6227381/>