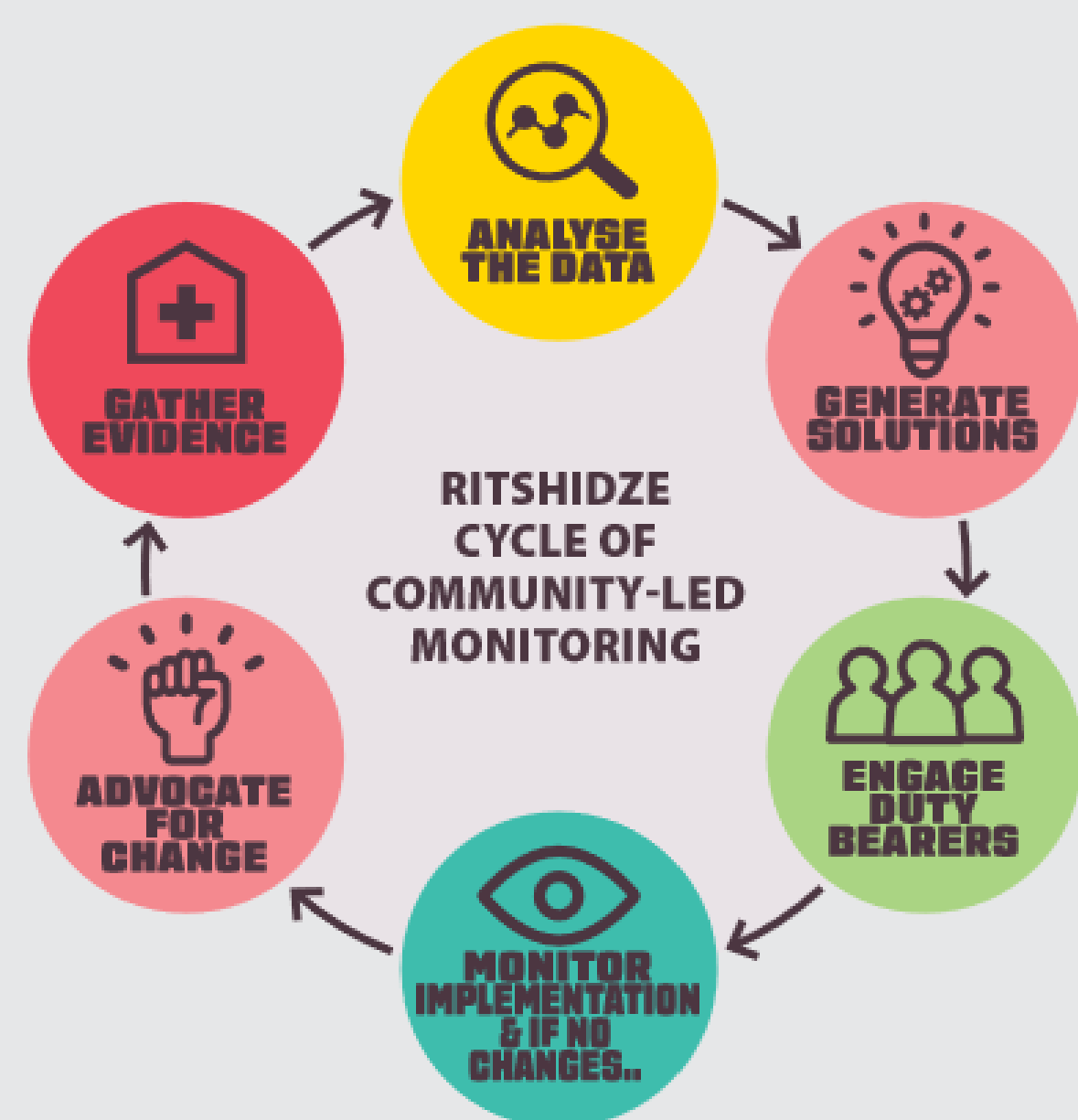


Background

Community-led monitoring (CLM), where civil society collects data on services for people living with HIV to advocate for improved services, is an emerging and powerful approach to improving quality healthcare.

“Ritshidze” — meaning “Saving Our Lives” in TshiVenda — has been developed by people living with HIV and activists to hold the South African government and aid agencies accountable to improve overall HIV and TB service delivery.



In 2019, the Ritshidze CLM programme was launched in South Africa to monitor HIV, TB and other health service delivery to advocate for improved primary healthcare services for all people in the country.



In the CLM programme, **trained and paid community monitors gather data in facilities** and surrounding communities on metrics related to healthcare accessibility and quality. These include measures of staffing and staff attitudes, wait times and appointment systems, stockouts and shortages, availability of adherence clubs, clinic infrastructure, treatment literacy, privacy and confidentiality, and access to medicines.

After data are gathered, service users, community members, and **advocates analyse the data and develop solutions to the gaps identified**. These findings and advocacy messages are disseminated at routine community accountability meetings and the Ritshidze team conducts data-informed advocacy at the facility, district, provincial, national, and international levels.

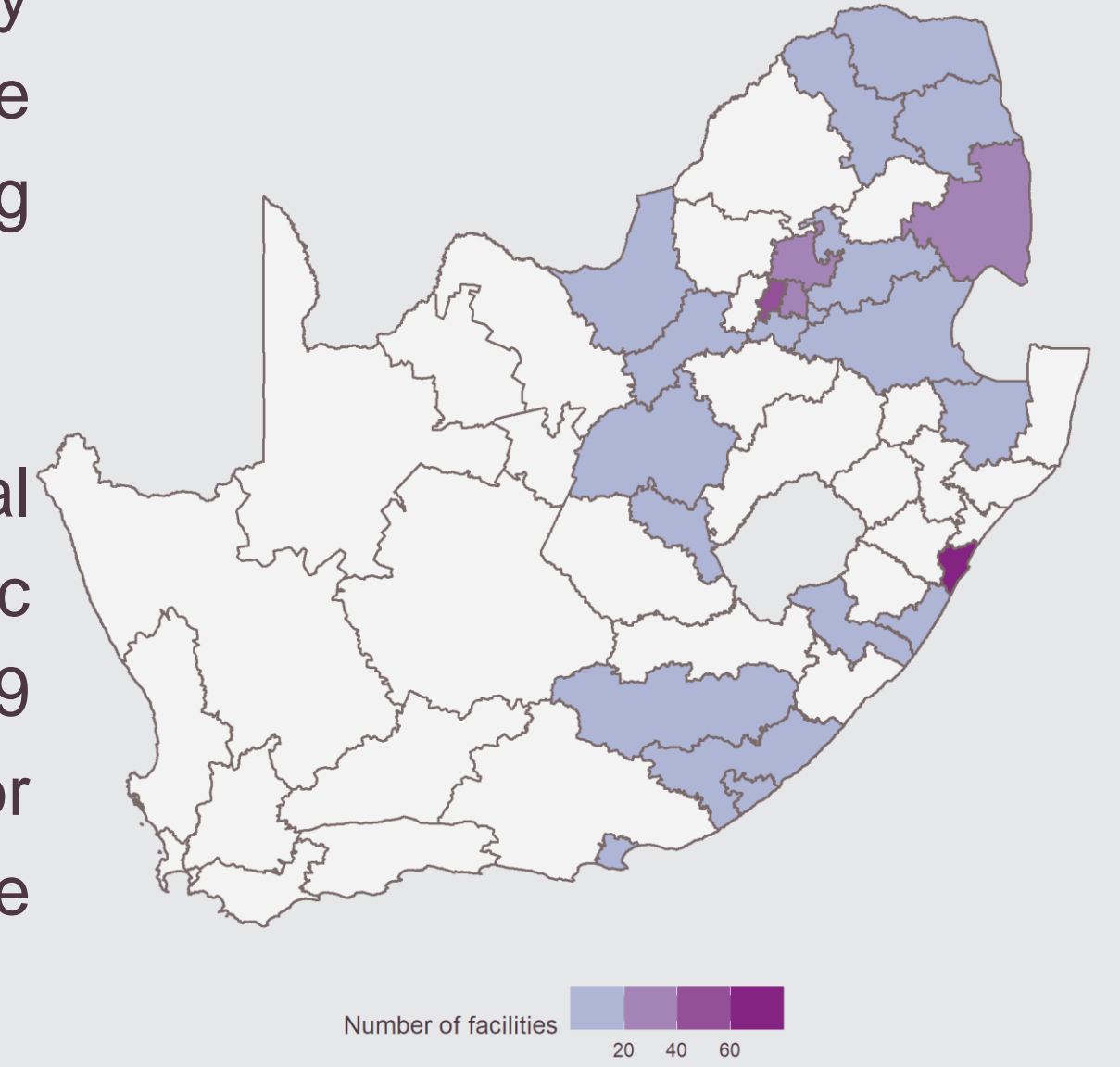
As the programme enters its third year, this analysis compared CLM measures of service delivery after year 1 and year 2 of the programme to evaluate longitudinal trends in measures gathered by Ritshidze.

Methods

Between July 2019 and September 2021, **data were collected from 433 public health facilities in 30 health districts**. Survey data taken from observation, patient and facility managers were gathered electronically by community monitors using the CommCare application. **A total of 109 unique indicators were included in the analysis**, after removing free text questions and those asked in fewer than three quarters.

The indicators were **grouped into 14 priority areas**: access to medicines, access to viral load testing and information, accountability, antiretroviral (ART) collection and access, clinic conditions, confidentiality and privacy, contraceptive services and access, COVID-19 disruption, facility hours and wait times, facility staff, psycho-social support, services for specific populations, TB infection control, and TB services. Longitudinal trends were calculated by the average of the quarter-by-quarter percentage change in each metric.

Figure 1. Facilities monitored by Ritshidze, by district



Results

The final sample included 81,397 respondents to the patient survey, 3,725 observation surveys, and 2,392 facility manager surveys.

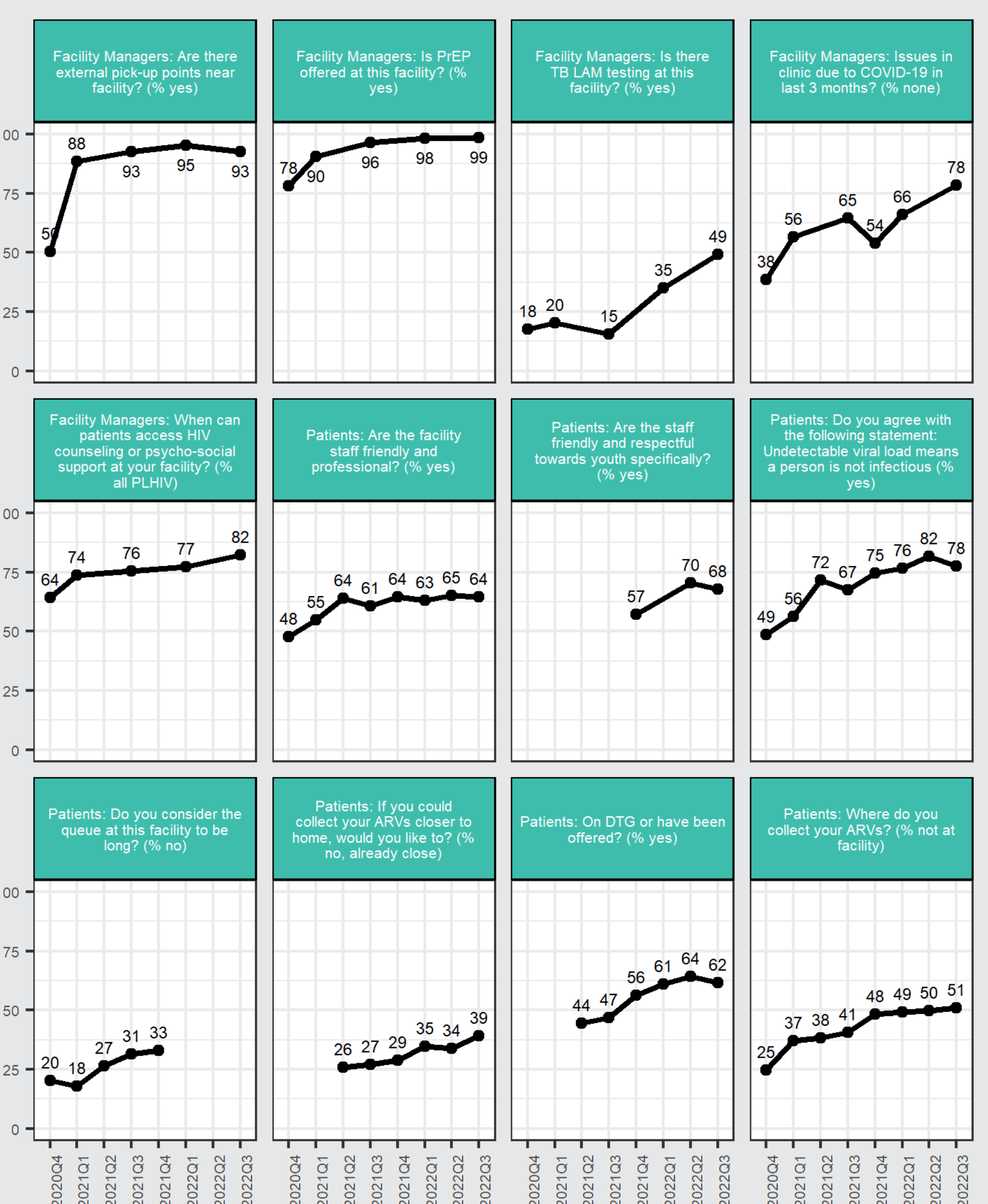
Overall, the majority of Ritshidze indicators improved between 2020 Q4 and 2022 Q3 (Fig. 3). Out of 109 indicators, **80 (73%) indicators improved nationally on a quarterly basis**, on average.

By category, the most consistent improvements were observed in metrics of **access to viral load testing and treatment literacy, confidentiality and privacy, and COVID-19**, for which all related indicators improved in this period (Fig. 4). **More than 80% of indicators of access to medicines and TB infection control improved** on a quarterly basis.

Other categories of indicators showed more mixed results, with fewer than two-thirds of indicators related to accountability, ARV collection and access, clinic conditions, contraceptive access, facility staffing, TB service provision, and services for specific populations improving each quarter.

By magnitude of change, **large improvements were observed in the availability of external pick-up points near facilities** (increasing from 50% to 93%, representing an average of 6.1 percentage points per quarter), COVID-19 disruption in clinics (5.7 quarterly p.p. increase in facility managers reporting no COVID-19-related issues, from 38% to 78%), access to TB testing (4.5 p.p. increase in clinic availability of TB-LAM, from 18% to 49%), disruptions in healthcare access due to COVID-19 (4.5 p.p. increase in those reporting no challenges, from 55% to 87%) and awareness of U=U (4.1 p.p. increase, from 49% to 78%).

Figure 1. Trends in selected indicators, 2020 Q4 to 2022 Q3.



Conclusions

Results from the Ritshidze CLM programme show early promise and suggest that CLM's can positively contribute to improving the quality, accessibility, and acceptability of HIV, TB and other health services. The programmatic areas that experienced the largest increases during this period were generally consistent with areas where the Ritshidze intervention could plausibly create impact in this period. For instance, facility staffing and clinic infrastructure require multi-year interventions to solicit funding to create measurable change. By contrast, Ritshidze advocacy is likely an important driver of the improvements in measures of treatment literacy, access to medicines, ARV access, and TB and COVID infection control observed during this period.

Acknowledgements

Ritshidze partner organisations include 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+)—in alliance with Health Global Access Project (Health GAP), the Foundation for AIDS Research (amfAR), and Georgetown University's O'Neill Institute for National and Global Health Law. Ritshidze is supported by UNAIDS, PEPFAR, USAID, and CDC. The financial contributions of UNAIDS (and any other agencies as directed by UNAIDS) towards Ritshidze is gratefully acknowledged. However, its content and ideas expressed therein do not necessarily reflect the views and opinions of UNAIDS or engage the responsibility of UNAIDS. Ritshidze is supported by a Cooperative Agreement from the CDC and USAID. Its content are solely the responsibility of the authors and do not necessarily represent the official views of the CDC, USAID, DHHS, or the U.S. Government.