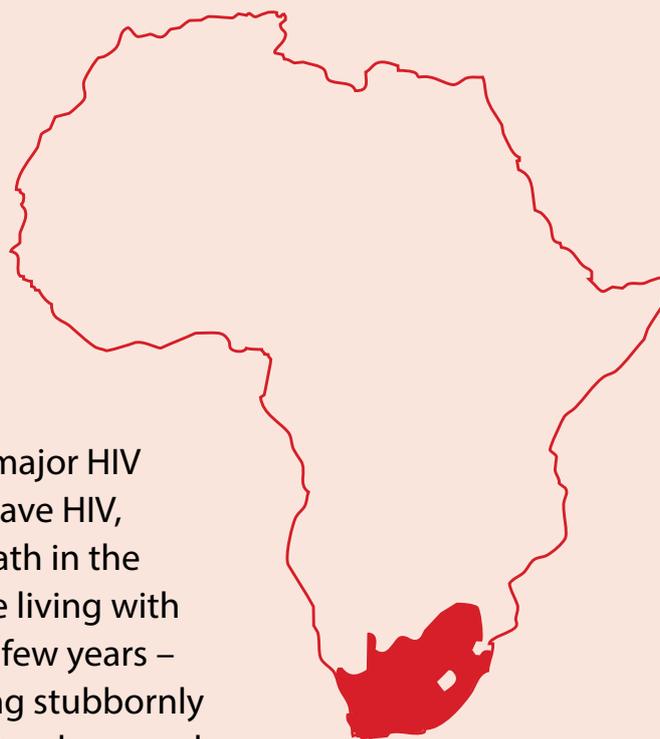


# THE PEOPLE'S COOP

COMMUNITY PRIORITIES

PEPFAR COUNTRY OPERATIONAL PLAN 2018





In 2018, South Africa continues to face major HIV and TB epidemics – 7.1 million people have HIV, and TB remains our leading cause of death in the country. The absolute number of people living with HIV is set to continue rising for the next few years – with the rate of new infections remaining stubbornly high – 270,000 in 2016. Even at current levels around three million people in South Africa who could benefit from treatment are not on treatment. There are rising rates of drug resistant TB in the country – the WHO estimates 19,000 cases in 2016 up from 7,350 in 2007 – and there are high burdens of other sexually transmitted infections. This is in conjunction with an epidemic of sexual violence across the country.

At the same time, the South African public healthcare system is in crisis. This is a crisis characterised by widespread understaffing and shortages of health workers, stockouts of medicines and other essential medical supplies, poor TB infection control measures, and long waiting times – underpinned by maladministration and mismanagement. Given ongoing political uncertainty, a stagnating economy and a shrinking health budget in real terms, this crisis seems likely to continue. It is within this context that we prepare for the PEPFAR Country Operational Plan 2018 (COP18).

PEPFAR funding constitutes roughly a quarter of all financing for HIV in South Africa and increased investment is planned for 2018. It is critical for people living with HIV and communities affected by HIV that this funding is used optimally and with the most possible impact. As such PEPFAR must critically re-think and re-prioritise where this funding is spent in order to ensure the greatest impact. We call on COP18 to:

1. **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. As seen in a recent study of facilities, an insufficient portion of funding is reaching the front-lines given the size of PEPFAR funding.
2. **Ensure better and stronger linkages between prevention, treatment, care and support services** by funding through the South African public health sector on which most people living with HIV rely – not through service provision NGOs who often work in silos and are not properly linked with frontline public health services;
3. **Fund game-changing and evidence based interventions that will shift the tide in the HIV response** including providing far more HIV and TB outreach services at a community level, and, providing commodities and resources for young people, especially young women and girls, to protect themselves from acquiring HIV. These critical interventions have been identified after provincial consultation and will be outlined fully below.

# PRIORITY INTERVENTIONS FOR COP 2018



## 1. Increase funding to HIV & TB services that reach people at both the clinic and the community level through a. CHWs, b. nurses, c. 100% support groups/adherence clubs/and fast track models of community based ART collection, d. self-testing & testing in hard to reach communities.

### a. Fund a bold, strategic expansion of community healthcare workers (CHWs) specialising in HIV and TB support at a community level.

CHWs have long been recognised to be an important part of a primary healthcare system. They have the potential to bring the community closer to health services, and health services closer to the community. Disease prevention, health promotion, and linkage to care are at the core of CHW programmes the world over. The efficacy of CHWs depends on the effectiveness of the healthcare system as a whole. They are not a panacea for a weak system and cannot replace facility-based healthcare services. What they can do is offer certain services to otherwise underserved communities, and provide preventative and health promotion services that are not otherwise adequately available within the health system. Evidence suggests that CHWs can bridge the gap between the community and the healthcare system and can facilitate patient re-entry into healthcare services after a negative experience.

CHWs can also reduce the burden on already overstretched primary healthcare services by providing services outside the facility setting that traditionally happen at a clinic level. This includes providing treatment literacy, counselling and support services, providing HIV testing and offering information to help reduce risky behaviour, providing alternate ART collection methods including direct delivery to people's homes or via adherence clubs, providing prevention information and even distributing condoms. This reduces the burden on clinic staff that often leads to other problems that worsen the HIV and TB response. For instance, one of the major causes of facility level medicine stockouts and shortages which directly impacts treatment adherence, is that overstretched clinic staff sometimes fail to order medicine stock in a timely manner given that they prioritise attending to endless long queues of patients who require care. Additionally, TAC research in over 200 facilities shows very poor levels of TB infection control at a primary healthcare level. Alleviating the burden on clinics through the CHW programme would provide time to, for example, screen patients for TB and to provide tissues and masks to those coughing.

COP18 must fund a bold expansion of CHWs in partnership with the South African Department of Health who are able to carry out all functions of this cadre (across all health areas) with a specialty focus in HIV and TB prevention, treatment, care and support. The CHWs should be split into facility and community based teams who should offer a selection of the following services:

In facility CHWs:

- + Understand HIV and TB fully to offer up to date prevention and treatment literacy information – and offer HIV and TB education in facilities;
- + Promote HIV testing at a facility level and offer information to help reduce risky sexual behaviour;
- + Provide linkages for those using the facility to counselling and support services;
- + Provide lay counselling and adherence support services, including through facilitating support groups and facility based adherence clubs;
- + Provide basic mental health assessments in particular for people living with HIV facing treatment fatigue, depression and other mental health challenges;



A community health worker in KwaZulu-Natal province in South Africa prepares to wash an elderly patient. She uses bread bags to cover her hands as she has no gloves.

- + Ensure people who access HIV treatment keep taking it and notifying community based CHWs about ART defaulters to support tracing efforts;
- + Providing community based CHWs with information about those enrolled on TB treatment at the facility in order to assist contact tracing of those with TB.

In community CHWs:

- + 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 facilitating community based adherence clubs;
- + Provide treatment home delivery, delivery to adherence clubs, and other fast track models of treatment collection and care to people on ARVs in order to relieve the burden on facilities and to increase adherence levels;
- + Provide basic mental health assessments 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.

These interventions are the core business of CHWs. We will not be able to see an end to AIDS without them and thus the development of a strong CHW cadre should be seen as a fundamental component of the HIV response. In addition to these components, CHWs must be able to provide other health services to people living with HIV who are affected with other health problems, conditions and/or diseases. The facility based and community based CHWs must work together with clear and open lines of communication to ensure that there is proper referral, enrolment on ART, linkage to care, and higher retention rates. This should lead public health users from a community level into the facility and back to the community from testing to treatment to adherence. This model is critical to the success and impact of this cadre in the HIV and TB response. PEPFAR data shows that while more people living with HIV overall have learned their status and enrolled on ART, linkage and retention rates have not increased significantly in recent years—remaining around 80%. The result is a “net” new on treatment far below targets. The PEPFAR-funded CHWs would provide better linkage to care at a community level to address this issue.

To be effective, PEPFAR-funded CHWs must be linked to a specific facility in order to establish relationships with the people living with HIV and TB that they support. This must replace the system of having “roving teams”

servicing multiple facilities. Critically however this should not mean that they all remain in the facility. In community CHWs must provide services at a community level.

The PEPFAR-funded CHWs must be well trained and capacitated, with appropriate supervision structures, and have access to all relevant tools of trade, in order to ensure they are able to carry out their duties effectively. They should have a standardised salary above the living wage.

In terms of the number of community based CHWs to be employed, UNAIDS Executive Director Michel Sidibé publicly announced that South Africa needs 200,000. The Brazilian best practice puts a ratio of 1 CHW to 600 people in the population (1:600) – this amounts to 97,825 in total in South Africa. Based on these figures it is clear that there is a major gap in the number of CHWs in the country to effectively respond to HIV, TB and non-communicable diseases. While this entire burden should not fall on PEPFAR alone, PEPFAR should fund at least 10 community based CHWs at each of the biggest health facilities supported in the districts. There are 750 sites with more than 1,500 people on ART – assuming a focus on these sites alone, this would be 7,500 CHWs directly funded by PEPFAR through the public health system.

***COP18 must fund 7,500 new in community CHWs to move towards aligning with the government’s Investment Case. This funding should directly employ CHWs through public entities, not through NGOs, in order to ensure best linkage to care. There must be a clear plan in place for the South African government to take over financing this work in the future. These additional CHWs could prioritise the highest volume sites and both PEPFAR and the government must ensure a standardised salary.***



**Pilani Clinic in rural Eastern Cape has had to deal with up to 1,800 patients per month – while only having one registered nurse and one assistant working from a “rondawel” that serves as office, consultation room and medicines stock room.**

**b. Fund public sector nurses and pharmacy technicians on the frontline of the HIV and TB response and healthcare delivery.**

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 – including nurses and pharmacy technicians. 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 a surge in the number of nurses and pharmacists working in the frontline of healthcare delivery. COP18 must clearly identify how many health workers are being funded by PEPFAR, at what level, and in what districts.

*COP18 must fund 3,000 nurses and pharmacy technicians (to support fast track refills) through the public health sector to work on the frontline of the HIV and TB response. These nurses and pharmacy technicians should be prioritised in PEPFAR sites with the highest human resource shortages and prioritizing larger sites. The nurses and pharmacy technicians should be fully integrated into the facility and relieve the burden on existing staff.*

**c. Ensure 100% of PEPFAR clinics have functional group models of care including both support groups and adherence clubs at both facility and community level, as well as fast track models of care such as home delivery and community-based ART collection by end of COP18.**

The Thembisa model projects that South Africa is on course to reach the first 90 (90% of people with HIV know their status) by 2020. Further they found that for the purposes of reducing new HIV infections the “most important epidemiological parameter to target will be the infectiousness of patients receiving ART”. They explained that this will mean “promoting adherence interventions such as adherence clubs, patient supporters, and SMS contact”. In other words, the most important intervention for reducing new infections is helping people already on treatment to stay on treatment and become and remain virally suppressed.



**People wait in line in a hospital in the Free State, South Africa. Community programmes are essential for effective ART treatment.**

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. There continues to be a high number of people lost to follow up. Even within the PLHIV community and TAC’s own membership of mainly people living with HIV, 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 and mental health services to prevent this “pill fatigue” from taking place. Support groups must be linked to adherence clubs to allow PEPFAR-funded CHWs to ensure that based on adherence levels and how well people are doing on treatment, people can progress to an adherence club or a fast track model of care, or if necessary be returned to a support group and counselling.

Adherence clubs are a way for people living with HIV and adhering properly to treatment, to collect their ARVs outside of their local clinic. Instead they join an adherence club where they can collect their medication and join discussions about issues of treatment adherence. 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. MSF and TAC piloted our adherence clubs in clinics and communities across Khayelitsha in the Western Cape in 2007. 514 patients were enrolled in clubs while 2288 patients remained on the current system. The outcomes after 40 months showed that 97.14% of patients enrolled in clubs adhered to treatment, while a lower rate of 87.18% of those attending clinics adhered. Since then the programme has been expanded to over 55 clubs across Khayelitsha.

The model has been so successful that in 2012 the Western Cape Provincial Health Department decided to take over the

management of the clubs. Following several visits by the department to learn about the management of the clubs and negotiations regarding the further employment of club counsellors, the adherence clubs were officially handed over to the department in early 2013. With the clubs in clinics now 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.

While we know PEPFAR has funded adherence clubs, COP18 must ensure all clubs are fully functional. A functional adherence club must include the following features:

- + Adherence clubs are group clinic visits run by CHWs;
- + The meetings take place either in a clinic or 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 the club facilitator;
- + Members should collect two-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 30 people living with HIV who meet every two months and are reminded of their appointment by SMS the day before;
- + Blood tests will occur every 12 months with a nurse 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.

For people who are stable on ART, there should be an option to utilise a fast track model of treatment collection at a community level.

***By the end of COP18, PEPFAR must fill the human resources and other gaps to ensure 100% of PEPFAR sites have functioning models of care including both in facility and in community adherence clubs and support groups – as well as fast track ART collection for those stable on treatment. These must be managed by the PEPFAR-funded CHWs, managed through Provincial Health Departments – that would reduce the burden on clinics and provide better access to treatment and linkage to care. Through CHWs described above, a work-flow based on national adherence guidance must ensure that people struggling to adhere are referred back to counselling and support groups, and that those adhering well are able to engage with peers in support groups to encourage adherence. Convenient fast track ART collection methods must also be provided at the community level. PEPFAR supported CHWs play a critical role in ensuring the functionality of both group and fast track models of***

***care including the facilitation of adherence groups— increasingly moving out of the clinic and into community. In addition, COP18 must fund the establishment of differentiated models of care (group and fast track) including adherence clubs, in harder to reach areas where data shows adherence is a particular challenge as per the model developed by TAC and MSF in Khayelitsha.***

**d. Fund procurement of HIV self-testing kits for use by CHWs in order to expand HIV testing services into marginalised communities and amongst key populations.**

There is still a long way to go before we close the tap on new HIV infections. There continue to be a substantial number of HIV infections in South Africa every year – 270,000 in 2016. While substantial reductions seem likely (Thembisa model outputs published in 2016 projected around 170 000 by 2022), getting as low as 100 000 requires aggressive use of all available interventions.

There was great hope that the Treatment as Prevention trial would show that providing more people with treatment earlier will reduce the rate of new infections in a community. Unfortunately, this important trial failed to show a significant reduction in new infections in communities with early treatment. The problem appears to be getting enough people tested and initiating treatment.

In South Africa, while 4.1 million people are documented to be taking treatment, more than 3 million people are still unable to access treatment, many of whom are unaware of their HIV positive status. This is particularly true for marginalised people who face various barriers to accessing HIV testing services and for men who do not interact with the healthcare system. The widespread distribution of HIV self-testing kits amongst these groups, as well as finger prick tests carried out by CHWs, will support in making testing easier to access and reduce the rates of late diagnosis and unknown status. The availability of self-testing kits could increase the numbers of marginalised people getting tested – who then go on to seek further treatment and care at a clinic level. In order to be successful this must be interlinked with the PEPFAR-funded CHW programme. CHWs should have access to HIV self-testing kits, as well as finger prick tests, in order to do outreach within hard to reach communities. Those who test positive should be referred by the CHW into the public healthcare system for further tests. The HIV self-test kits



are not a substitute for interaction within the healthcare system.

COP18 must support an expanded commitment from COP17 into HIV testing in marginalised and key populations who are not up-taking these services. This must include the “missing men” who do not uptake services and HIV testing at the clinic.

*COP18 must ensure that PEPFAR-funded CHWs do outreach in hard to reach communities in order to provide access to HIV self-test kits, finger prick tests, comprehensive HIV education and awareness, treatment and prevention literacy, counselling and support, and critically referral and*

*transfer to public health facilities for secondary tests and interaction with HIV and broader sexual health treatment, care and support moving forward. We reiterate that this programme should be run through primary health services to ensure proper and adequate linkage to care. These CHWs must be clear on issues facing key populations and not perpetuate stigma and discrimination at a community level. Sufficient numbers of HIV self-test kits and finger prick tests must be funded by PEPFAR in order to carry out this outreach work. This will increase the number of people living with HIV who know their status – and subsequently ensure more people living with HIV are able to access treatment.*

## 2. Provide HIV prevention commodities and resources for young people, especially young women and girls, to protect themselves

### a. Ensure all young people have access to HIV and STI testing, sexual health services & discreet access to condoms in schools.

Every week in South Africa more than 2,000 young girls get HIV – that is over 285 every day and 100,000 of the 270,000 new infections every year. Rates of teenage pregnancy remain high with one third of teenage girls getting pregnant before the age of 20. Whether older people like it or not, the fact is that many young people – including learners at schools – are sexually active. While comprehensive sexuality education is critically important, it is only half the battle. South Africa responded to its HIV epidemic with a rapid expansion of



Teenagers in South Africa need access to contraception and discreet sexual health testing.

its condom distribution programme. However, condoms, especially female condoms, remain out of reach to youth.

A Department of Basic Education policy released last year seeks to address these issues and allows for the distribution of condoms in the schools, albeit under a confusing description that it should be “discreet” and “dependent only on age of consent, inquiry or need.” However, this policy is not being progressively rolled out. We know already that in some clinics, healthcare professionals do not provide young people with HIV tests or contraceptives and that condoms are not truly available in many schools. To be truly effective male and female condoms should be easily available to all – meaning for example availability in toilets at schools.

Comprehensive annual sexual and reproductive health services should be made available in schools, during which learners can test for HIV, get screened for TB and STIs, take a pregnancy test, access to PrEP, access and to get referral to family planning, VMMC, TOP, or other health services (e.g. to care for sexual violence). There should be an HIV focal point in all schools—life orientation educator or learner support agent or school nurse, that can provide referral and support on a year-round basis to learners.

*COP18 should make an explicit testing plan for young people, in particular young women and girls, that includes a much more robust direct-service strategy of reaching into the communities. This should include funding the distribution of male and female condoms at all schools in the 27 priority districts and support annual comprehensive sexual and reproductive health services for young people. Especially in the DREAMS districts, PEPFAR should be working with DBE to roll out commodities and empowerment programmes far more aggressively than is currently happening.*

**b. Ensure access to PrEP for young people in South Africa by moving from demonstration to scale up.**

Preventing HIV infection in adolescent girls and young women could change the course of the epidemic in Africa, and reverse the current poor global progress in HIV prevention. Oral tenofovir, alone or in combination with emtricitabine (PrEP), is the only woman-initiated prevention technology that does not require partner knowledge or co-operation. We cannot afford not to make this prevention option available to young women.

However, PrEP is not yet widely accessible in the public sector in South Africa. It is only accessible through demonstration sites, clinical research institutes, and the private sector (although not included in all medical schemes). It is only provided to people who self-identify as being at substantial risk of acquiring HIV, and as of yet the demonstration sites have seen a very low uptake by key populations.

The alarming pregnancy rates in higher education institutions indicates low use of condoms and other family planning methods. Providing PrEP to only a select group of people is not getting us anywhere. The country continues to see rising HIV infections among young women aged between 15 and 24 years. The scale up of PrEP amongst young women and girls inside and outside of formal education is one way to move in the right direction. This should go hand in hand with the interventions outlined above (promotion of HIV testing by PEPFAR-funded CHWs, the provision of HIV self-testing kits for usage by key populations and men who do not access health services, and access to condoms in schools).

Researchers can show that about 24% of young women under 25 years of age do not know their HIV status; and about 60% are acquiring HIV from male partners who are on average eight or more years older than them, i.e. in the 25 to 40 age group. The majority of men of 25 to 40 years old are unaware of their HIV status and have high viral loads, suggesting recently acquired infection and hence higher transmission rates.

Young men are acquiring HIV from already infected women 25 to 35 years of age; on average, the age difference in these cases is about a year. About 40% of men 25 to 40

years old are having sex with women younger than 25 and women older than 25 concurrently, thus perpetuating these cycles of transmission. Preventing HIV infection in young women under 25 years therefore will require a multi-pronged approach that includes providing Sexual and Reproductive Health Rights services to young women; finding the missing men (who do not access health services); and treatment of women older than 25.

***COP18 should support large scale PrEP distribution targeting young people in each of the 27 districts where PEPFAR has focused. PEPFAR should commit to supporting both the commodities and the programming needed to provide PrEP for all young people who want it (whether at university, college, school or not in education) as well as other people at risk of HIV acquisition. This must include community education efforts through the PEPFAR-funded CHWs - with emphasis on safe, easy access that accommodates the unique needs and vulnerabilities of these target populations.***



# SPECIFIC LANGUAGE REQUESTED IN COP18

PRIORITY INTERVENTIONS	COP17 & DATA	LANGUAGE TO INCLUDE IN COP18	TARGET
<b>1. Increase funding to services that reach people at both the clinic and the community level</b>			
<p><b>a. Fund a bold, strategic expansion of community healthcare workers (CHWs) specialising in HIV and TB support at a community level.</b></p>	<p>“In COP17 PEPFAR partners will address some of the health system barriers (e.g. HRH) by deploying temporary lay counsellors, clinicians, and community workers to improve retesting of HIV-negative pregnant/breastfeeding women, male partner testing, QA of HIV rapid testing, TB screening, increased access to EID testing at birth, adherence, VL monitoring, retention, and linkages to family planning services. In COP17 PEPFAR will continue to support ward-based outreach teams (WBOTs) and other community workers (e.g., through the Mentor Mother program) to improve adolescent services and ANC booking before 20 weeks gestation through awareness raising and demand creation.” (p46)</p> <p>“In COP17 PEPFAR will support CBO’s, Ward Based Outreach Teams (WBOTS), community health workers (CHW), and (for KPs) peer navigators to serve as community linkage officers to assure PLHIV newly diagnosed in the community are successfully referred to the nearest facility, where the facility linkage and retention officers will ensure enrollment in care and treatment.” (p49)</p> <p>From Jan 28 Presentation: “Strengthen management of Community Health Workers... Ensure adequate CHWs to support ART scale-up... Support implementation of national CHW policies.</p> <p><b>No clear information: How many HCW does PEPFAR currently support? Where are they based? What % are formally paid?</b></p>	<p>In the COP18 Surge, PEPFAR will partner directly with government to fund a cadre of CHWs 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 an average of 10 CHWs in each of the facilities with more than 1,500 patients—totally 7,500—to saturate communities with CHWs and address under-performance. PEPFAR-funded CHWs should be split into facility and community based teams who should offer a selection of the following services:</p> <p>In facility:</p> <ul style="list-style-type: none"> <li>• Understand HIV and TB fully to offer up to date prevention and treatment literacy information – and offer HIV and TB education in facilities;</li> <li>• Promote HIV testing at a facility level and offer information to help reduce risky sexual behaviour;</li> <li>• Provide linkages for those using the facility to counselling and support services;</li> <li>• Provide lay counselling and adherence support services, including through facilitating support groups and facility based adherence clubs;</li> <li>• Provide basic mental health assessments in particular for people living with HIV facing treatment fatigue, depression and other mental health challenges;</li> <li>• Ensure people who access HIV treatment keep taking it and notifying community based CHWs about ART defaulters to support tracing efforts;</li> <li>• Providing community based CHWs with information about those enrolled on TB treatment at the facility in order to assist contact tracing of those with TB.</li> </ul> <p>In community:</p> <ul style="list-style-type: none"> <li>• Understand HIV and TB fully to offer up to date prevention and treatment literacy information;</li> <li>• Promote HIV testing at a facility level and offer information to help reduce risky sexual behaviour;</li> <li>• 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;</li> <li>• Provide lay counselling and adherence support services, including through home visits and through facilitating community based adherence clubs;</li> <li>• Provide treatment home delivery, delivery to adherence clubs, and other fast track models of treatment collection and care to people on ARVs in order to relieve the burden on facilities and to increase adherence levels;</li> <li>• Provide basic mental health assessments in particular for people living with HIV facing treatment fatigue, depression and other mental health challenges;</li> <li>• Ensure people who access HIV treatment keep taking it and engage in defaulter tracing;</li> <li>• Trace people with TB or who are close to people with TB and ensure that they have access to, and take, treatment effectively.</li> </ul>	<p>Target: 7,500 additional community health workers in COP18.</p>

PRIORITY INTERVENTIONS	COP17 & DATA	LANGUAGE TO INCLUDE IN COP18	TARGET
<p><b>b. Fund public sector nurses and pharmacy technicians on the frontline of the HIV and TB response and healthcare delivery.</b></p>	<p>Currently PEPFAR supports several thousand front-line health workers—about 30% seconded to clinics and the rest in “roving teams”</p> <p>PEPFAR will also support NDoH and PDoHs through technical assistance and placing human resources through roving mentoring teams that provide part-time support to multiple facilities, short-term human resources staff support or “surge” teams that assist for 3-6 months to strengthen a key cascade component(s) while implementing system improvements to allow facilities to continue to sustain improved performance, and secondments of PEPFAR-funded staff to a specific facility for up to 12 months. Facility-based staff support may include, lay counsellors, linkage officers, peer navigators, nurses and doctors in high- volume clinics with low performance to improve service delivery for HIV-infected patients (p54).</p>	<p>In COP18, PEPFAR will fund the deployment of 3,000 additional staff including nurses and pharmacy technicians (to support fast-track refills) directly through a partnership with NDOH. These staff will be fully based in facilities, but spent 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>Target: 3,000 nurses and pharmacy Technicians in COP18.</p>
<p><b>c. Ensure 100% of PEPFAR clinics have functional group models of care including both support groups and adherence clubs at both facility and community level, as well as fast track models of care such as home delivery and community-based ART collection by end of COP18.</b></p>	<p>In COP17 PEPFAR SA inputs will focus on:</p> <p>Reaching more than 2 million people with new and efficient service delivery models (e.g., Adherence Clubs, Centralized Chronic Medicine Dispensing and Distribution) (p5)</p> <p>In COP17 PEPFAR will ... promote a choice of ART delivery options such as facility-based fast track and community- led models of ART provision, including community adherence groups (CAGs), community-led adherence clubs, and community drug delivery through the CCMDD where feasible (p55)</p> <p>5.1.2 Operationalize Adherence Guidelines SOPs for fast track ART initiation across all districts. Determine the workload, supply, demand role profiles &amp; competencies of relevant HCWs for Adherence Clubs. Training of health care workers on the National Adherence Guidelines. (p93)</p> <p>Mentor mothers and teen support groups (p61)</p> <p><b>Support seems to largely be in the form of TA and Training. No clear indicators of how many sites will establish clubs and how many HCW will be paid by PEPFAR to do so.</b></p>	<p>By the end of FY2018 (COP17) PEPFAR will undertake an inventory of which of its supported facilities has adherence clubs and support groups in operation.</p> <p>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. PEPFAR will identify the communities and populations in each district most affected by adherence challenges and set up community-based adherence groups that include ART services in clinics in each of the 27 districts. Where PLHIV are adhering fast track models of care and collection of ART in the community will be made available.</p> <p>PEPFAR will support the clinical and community health worker staffing needed to establish and maintain these programs for at least 3 years.</p>	<p>Target: 100% of PEPFAR sites will have an adherence club model for ART delivery as well as support groups running by end of COP18 and will report portion of patients in adherence groups. Each district will have identified communities for targeted group and fast track models of care based on adherence levels. For PLHIV stable on ART: Implement at least one fast track individual ART refill collection system and at least one group simplified model of care in every clinic/clinic’s feeder community. For PLHIV who face adherence challenges: Implement/ orientate clinics to put in place treatment interrupter return friendly approach and immediately restart PLHIV presenting to clinic after a treatment interruption.</p>

PRIORITY INTERVENTIONS	COP17 & DATA	LANGUAGE TO INCLUDE IN COP18	TARGET
<p><b>d. Fund procurement of HIV self-testing kits for use by CHWs in order to expand HIV testing services into marginalised communities and amongst key populations.</b></p>	<p>“PEPFAR will work with the GoSA to aggressively scale-up community and facility testing in support of the first 90 with a strong emphasis on measures to improve linkage to treatment in alignment with UTT. Community testing will focus on the highest-yield modalities, specifically index case testing, as well as community outreach testing targeting hard-to-reach high-risk populations who do not utilize facility-based services, and an emphasis on men, as described in detail in Section 4.5 below. In COP17 PEPFAR will work with the GoSA to support HIV testing for 10,885,120 people in facility and community settings (inclusive of testing in other settings such as VMMC), with a goal to identify 1,027,472 PLHIV who will be linked to treatment. KP implementing partners will employ social network strategies, peer mobilization, and mapping to increase uptake and yield of hard-to-reach populations. High-risk HIV-negative individuals are urged to test regularly through risk reduction counselling and through peer networks.” (p33)</p>	<p>PEPFAR will support an aggressive self-testing effort in COP18, backed by community health workers in priority districts. Partners will focus on Key Populations and those like young people and men who are not well reached by facility-based testing efforts.</p>	<p>Target: 10% of new positive targets will be sought through self-testing modalities.</p>

**2. Provide HIV prevention commodities and resources for young people, especially young women and girls, to protect themselves**

<p><b>a. Ensure all young people have access to HIV and STI testing, sexual health services &amp; discreet access to condoms in schools.</b></p>	<p>In COP17 PEPFAR will support the GoSA in the implementation of the National Department of Basic Education’s (DBE) HIV, TB and STIs policy. The policy covers prevention, care and support within the school context. PEPFAR will work with DBE and other departments and partners to operationalize the policy initially in the DREAMS districts...</p> <p>PEPFAR prevention interventions will complement She Conquers, including HIV testing for 322,083 AGYW in focused sub-districts. (p25)</p> <p>In COP17 priority prevention will scale up the evidence-based, structured behavioral interventions for HIV prevention and demand creation for the uptake of testing services focused on vulnerable populations (i.e., adolescent girls in school. (p43)</p> <p>Through DREAMS, PEPFAR SA will expand the supply of female condoms, and emphasize the importance of dual protection with condoms and comprehensive sexual reproductive health (p43)</p> <p>Condom Budget COP17: \$39,595,579</p>	<p>In each of the DREAMS districts PEPFAR with the Department of Health will partner with NDBE to fully and progressively implement the new policy including funding the distribution of male and female condoms in all schools in the 27 districts. In DREAMS districts, PEPFAR will also support scaling up of comprehensive reproductive health services for all including salary support to youth counsellors and young male and female nurses in order to expand the youth-friendly service models in the public sector both in and out of school settings.</p>	<p>Target: By the end of COP18 all schools in the 27 districts will be actively distributing male and female condoms to students, and offer annual HIV testing and SRH services in schools.</p>
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PRIORITY INTERVENTIONS	COP17 & DATA	LANGUAGE TO INCLUDE IN COP18	TARGET
<p><b>b. Ensure access to PrEP for young people in South Africa by moving from demonstration to scale up.</b></p>	<p>“In COP17 PEPFAR will work with the GoSA to expand PrEP services to include AGYW and MSM. In COP16 PrEP focus is on FSW as a component of DREAMS-funded interventions. In COP17, DREAMS/AGYW-focused funding will maintain 3,000 FSWs on PrEP who were initiated in COP15/ FY16 and COP16/FY17 in the five target districts. In COP17/FY18 DREAMS/AGYW-focused funding will expand PrEP to 3,735 AGYW in the four DREAMS districts. In COP17 funds will also be used to support PrEP for 8,599 MSM and FSWs and 2,231 AGYW. PEPFAR COP17 support for PrEP for AGYW in select districts will be in collaboration with NDoH as part of learning sites to inform future program expansion. (p 43)</p> <p>PEPFAR SA continues to address the four systems barriers identified in COP16: (1) Limited surveillance of KPs; (2) Limited exchange of routinely collected information between the public sector and organizations serving KPs; (3) KPs experience stigma and discrimination when accessing services at public health facilities; and (4) Limited systems in place for PEP and PrEP provision. Activity changes include: collecting and utilizing more routine data for size estimates, mapping, and cascade analysis; expanding PrEP eligibility to MSM and AGYW; purchasing of PrEP drugs and labs; and implementing demand creation activities for PrEP, particularly for FSWs and MSM. Demand creation will be done through peer education and support. (p65-6)</p>	<p>PEPFAR will work with the Government of South Africa to move from COP17 activities focused on demonstration to bringing PrEP to scale—expanding from a handful of districts to support PrEP in all 27 PEPFAR districts with a continued focus on AGYW, MSM, and FSW.</p>	<p>Target: Increase the PrEP target (in addition to government targets) to include 3,500 people in all 27 PEPFAR districts at a total of 94,500 people on PrEP.</p>