PEOPLE’S COP 23
SOUTH AFRICA
COMMUNITY PRIORITY RECOMMENDATIONS
FOR PEPFAR SOUTH AFRICA IN COP 2023
DEVELOPING THE PEOPLE’S COP

This year’s “People’s COP” has been developed using data collected through Ritshidze, a community-led monitoring programme in South Africa. In addition to Ritshidze data, the People’s COP has been further shaped through consultation with people living with HIV, key populations, and other activists and organisations working at the forefront of South Africa’s HIV and TB response.

Ritshidze data in this report were collected between October and December 2022:

+ Interviews took place with 394 Facility Managers
+ Observations took place at 400 public health facilities
+ Interviews took place with 22,413 public healthcare users
+ 12,128 (54%) identified as people living with HIV
+ 14,339 (64%) identified as women
+ 4,179 (19%) were under 25 years of age
+ All data are available at: http://data.ritshidze.org.za/

Further data collection took place to specifically understand the needs and experiences of key populations in South Africa. A total of 9,137 key population members were surveyed including 2,349 gay, bisexual, and other men who have sex with men (GBMSM), 3,353 people who use drugs, 2,290 sex workers, and 1,145 trans* people. The key population data collection took place between July and September 2022 across 21 PEPFAR supported districts in seven provinces. Key populations who took part were identified through snowball sampling where initial participants were asked to refer those they know, who in turn refer those they know, to participate in the survey.

The full report on key populations is available at: https://ritshidze.org.za/category/resources/
COMMUNITY PRIORITY INTERVENTIONS FOR COP23

PILLAR 1: HEALTH EQUITY FOR PRIORITY POPULATIONS

1. PEPFAR must improve public clinics for key populations!

**COP23 TARGET**

1. Expand the Centre of Excellence model to ensure that at least 2 public health facilities per population per district serve as key population designated service delivery centres.
   - A minimum package of services (as outlined) should be made available at these facilities. *Easy referral and adequate resources (including transport/money for transport) must be provided for people to take up these services.*
   - **PEPFAR must support these facilities with additional staff and resources to provide comprehensive health services to the specific key population being served.**

2. Ensure that HIV prevention tools including lubricants, external and internal condoms, PrEP, and PEP are made easily available at all public health facilities.
   - Make available condoms and lubricants in a range of spaces across the facility (i.e., waiting areas, toilets, gate, pharmacy, consultation rooms, quiet areas out of site) so people can freely and easily collect them.
   - Ensure that PrEP is offered to everyone, including key populations who are not living with HIV/test negative for HIV, with information shared on its benefits.
   - Ensure no staff members ever tell key populations to use vaseline or other oil based lubricants instead of water or silicone based lubes.

The majority of key populations interviewed by Ritshidze said they use a public health facility to access health services (86% of GBMSM, 85% of people who use drugs, 76% of sex workers, and 75% of trans* people). Given that public health facilities are the entry point for many key populations into the health system, it is critical to ensure a friendly, respectful, safe, and confidential environment for all, with services that cater to key population specific needs.

Yet despite sensitisation training and retraining efforts, disrespect, ill-treatment, and dehumanisation of key populations remain a widespread challenge. Key populations who are treated badly, humiliated, fear their safety, or even refused entry, will inevitably not come back to the facility.

Ritshidze data reveal that staff at public health facilities were less friendly and professional to key populations compared to drop-in centres and mobile clinics (see Figure 1). This is consistent across all key population groups. Clinical staff were again this year the most commonly reported as being unfriendly and unprofessional by all key population groups followed by security staff (see Figure 2). Overall people who use drugs faced the most unfriendly services across key population groups.

“The clinic staff should not discriminate against us because sometimes we come dirty… we need medical attention too, we are all the same. Then the guys would know that a clinic is a safe space for them. Most guys die on the road while there is a clinic next to them because they know they will not get help.”

**Figure 1:** Proportion of key populations reporting staff are always friendly and professional by key population group and facility type

<table>
<thead>
<tr>
<th>Facility</th>
<th>Drop-in centre</th>
<th>Mobile clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>GBMSM</td>
<td>483 (37%)</td>
<td>116 (91%)</td>
</tr>
<tr>
<td>People who use drugs</td>
<td>506 (24%)</td>
<td>38 (50%)</td>
</tr>
<tr>
<td>Sex workers</td>
<td>525 (46%)</td>
<td>72 (77%)</td>
</tr>
<tr>
<td>Trans* people</td>
<td>218 (41%)</td>
<td>70 (88%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Facility</th>
<th>Drop-in centre</th>
<th>Mobile clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>GBMSM</td>
<td>53 (57%)</td>
<td>116 (91%)</td>
</tr>
<tr>
<td>People who use drugs</td>
<td>38 (50%)</td>
<td>49 (83%)</td>
</tr>
<tr>
<td>Sex workers</td>
<td>72 (77%)</td>
<td>364 (74%)</td>
</tr>
<tr>
<td>Trans* people</td>
<td>70 (88%)</td>
<td>62 (62%)</td>
</tr>
</tbody>
</table>
Which staff are unfriendly and unprofessional (July to September 2022)

<table>
<thead>
<tr>
<th>Staff Type</th>
<th>% (n) of respondents reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>GBMSM</td>
<td>268 (34%)</td>
</tr>
<tr>
<td>People who use drugs</td>
<td>638 (44%)</td>
</tr>
<tr>
<td>Sex workers</td>
<td>185 (33%)</td>
</tr>
<tr>
<td>Trans* people</td>
<td>120 (41%)</td>
</tr>
</tbody>
</table>

The majority of key populations interviewed did not feel safe or comfortable at the facility (Figures 3 and 4). In order for key populations to access health services and in particular key population specific services, spaces are needed that feel private enough to disclose you are a member of a key population group without fear of judgement, abuse, harassment, or even arrest.

Figure 3: Proportion of key populations reporting they feel very safe when accessing health services, by key population group

% (n) of respondents reporting they feel very safe where they access services (July to September 2022)

<table>
<thead>
<tr>
<th>Key Population</th>
<th>% (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GBMSM</td>
<td>183 (14%)</td>
</tr>
<tr>
<td>People who use drugs</td>
<td>208 (10%)</td>
</tr>
<tr>
<td>Sex workers</td>
<td>221 (19%)</td>
</tr>
<tr>
<td>Trans* people</td>
<td>74 (14%)</td>
</tr>
</tbody>
</table>

Disgraceful privacy violations continue to occur that destroy people’s right to privacy and make clinics feel unsafe and uncomfortable to be in (Table 1). This year 42% of GBMSM, 45% of people who use drugs, 38% of sex workers, and 35% of trans* people did not think privacy is well respected at clinics.
“Whenever I go to the facility it is only that sister that gives me a bad attitude. She will always embarrass me and treat me like an animal. Which is why I stopped going to that clinic and taking my medication.”

Table 1: Privacy concerns at health facilities by key population group

<table>
<thead>
<tr>
<th>Respondents who think privacy is not well respected at facilities, % (n)</th>
<th>Most common privacy violations</th>
</tr>
</thead>
<tbody>
<tr>
<td>GBMSM</td>
<td>Disclosure of HIV status (54%, 298), disclosure that respondent is GBMSM (44%, 242), healthcare workers call other staff into the consultation room to share medical issues (31%, 173)</td>
</tr>
<tr>
<td>People who use drugs</td>
<td>Disclosure that the respondent is a person who uses drugs (69%, 656), disclosure of HIV status (42%, 397), healthcare workers call other staff into the consultation room to share medical issues (27%, 258)</td>
</tr>
<tr>
<td>Sex workers</td>
<td>Disclosure respondent is a sex worker (53%, 229), disclosure of HIV status (44%, 191),</td>
</tr>
<tr>
<td>Trans* people</td>
<td>Disclosure respondent is trans* (45%, 84), patients are consulted in the same room together (33%, 61), disclosure of HIV status (33%, 61)</td>
</tr>
</tbody>
</table>

Shockingly, significant numbers of key populations reported being refused access to services in the last year because of being someone who uses drugs, is a sex worker, or is a part of the LGBTQIA+ community — including 5% of GBMSM, 19% of people who use drugs, 12% of sex workers, and 9% of trans* people (Figure 5). This is absolutely unacceptable and goes against Section 27 of the Constitution.

“Anytime I go there, the security would chase me away, saying that I need to go take a bath because I stink. They are rude towards us drug users.”

“The nurses and security guards discriminate against us, they see us as thieves because we use drugs and make accusations... Sometimes they chase you out of the facility and you end up not getting the services we need.”

“Once the nurses realise that you are sex worker, they treat you very badly, they are very judgmental towards us and sometimes deny us services.”

Where the attitudes of clinic staff have become unbearable, some people have stopped going to the facility altogether, including for HIV, TB and STI testing and treatment. Overall 12% (1,135) of key populations we interviewed were not receiving services anywhere. The most common reasons given for not going to the facility include: a lack of friendly services, lack of privacy, and a lack of safety — as well as a fear people would find out they are someone who uses drugs, a sex worker, or part of the LGBTQIA+ community (Table 2).

Table 2: Top reasons for key population members not accessing health services by key population group

<table>
<thead>
<tr>
<th>Top reasons KPs don't access services at the public health facility</th>
<th>GBMSM</th>
<th>People Who Use Drugs</th>
<th>Sex Workers</th>
<th>Trans* People</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff are not friendly (59%, 609), privacy is not respected (47%, 466), don't feel safe (27%, 280)</td>
<td>Staff are not friendly (50%, 620), privacy is not respected (35%, 434), don't feel safe (23%, 288)</td>
<td>Staff are not friendly (58%, 671), privacy is not respected (41%, 475), staff refused to provide services (22%, 256)</td>
<td>Staff are not friendly (50%, 307), privacy is not respected (35%, 223), don't feel safe (23%, 142)</td>
<td></td>
</tr>
<tr>
<td>Health services are not private (53%, 311), staff are not friendly (45%, 99), don't feel safe (26%, 58)</td>
<td>Staff are not friendly (50%, 311), services are not private (38%, 236), do not feel safe (25%, 158)</td>
<td>Staff are not friendly (53%, 112), privacy is not respected (47%, 99), fear people would find out they are a sex worker (30%, 64), don't feel safe (30%, 64)</td>
<td>Staff are not friendly (49%, 47), privacy is not respected (44%, 42), fear people would find out they are trans (27%, 26), don't feel safe (27%, 26)</td>
<td></td>
</tr>
</tbody>
</table>

Figure 5: Percentage of key populations refused access to health services because they are a KP by key population group

| % (n) of respondents who had been refused access to services at the facility because they are a KP (July to September 2022) |
|---|---|---|---|
| GBMSM | 68 (5%) |
| People who use drugs | 388 (19%) |
| Sex workers | 137 (12%) |
| Trans* people | 48 (9%) |
Compared to public health facilities, drop-in centres and mobile clinics generally performed better from the perspective of all key population groups in terms of service acceptability and service availability (Figure 1). Most key populations we interviewed are not using either a drop-in centre or mobile clinic to access services but public health facilities. In fact, Ritshidze data show that a very high proportion of key populations are not even aware of any drop-in centres — including 79% of GBMSM, 75% of people who use drugs, 74% of sex workers, and 71% of trans* people.

Ritshidze data show that key populations do not all live in certain “hotspots” or “high transmission areas”. We support drop-in centres and advocate for them to be scaled up, however they are not a panacea to the challenge of improving services for key populations. Public health facilities must also be drastically improved to ensure key populations can access the services they need in a friendly, safe and welcoming way.

Last year, we interviewed nearly six thousand key population members, and this year over nine thousand members of key populations — 92% of who had not done the Ritshidze survey last year. The robust sample of key populations continue to raise issues around inadequate access to specialised services, again showing that more facilities must be specialised to meet the needs of key populations in South Africa.

Given the disproportionate burden of HIV and violence that key populations face, as well as the additional health needs, it is critical that key populations can access specific services to meet specific needs. Yet where key populations do continue to suffer the daily indignities of using the public health system, specific services remain unavailable for the most part.

Lubricants, for example, are only freely available in 27% of facilities monitored (Figure 6). “We don’t get lubricants there. They have condoms but the staff will always complain about us taking too much” “they deny us the amount of lubricants we need. There’s hardly any lubricant, they always say they’ve run out of stock”, “If you ask for condoms, they will laugh at you, ask many questions like what are you going to do with it, how much are you going to use” explained some of the sex workers we interviewed.

| Are condoms & lubricant available at the facility (October to November 2022) |
|----------------------------------|-----------------|-----------------|-----------------|-----------------|
| Facilities observed: 396 |
| **Lubricant** | 106 (27%) |
| **Lubricant (but only upon request)** | 79 (20%) |
| **External condoms** | 321 (81%) |
| **External condoms (but only upon request)** | 31 (8%) |
| **Internal condoms** | 256 (65%) |

Table 3: Knowledge and availability of lubricant from health facilities among key population members

<table>
<thead>
<tr>
<th>% aware they should be able to get lubricant (lube) at all public health facilities</th>
<th>GBMSM</th>
<th>People who use drugs</th>
<th>Sex workers</th>
<th>Trans* people</th>
</tr>
</thead>
<tbody>
<tr>
<td>GBMSM</td>
<td>54%</td>
<td>29%</td>
<td>58%</td>
<td>63%</td>
</tr>
<tr>
<td>People who use drugs</td>
<td>29%</td>
<td>40%</td>
<td>58%</td>
<td>63%</td>
</tr>
<tr>
<td>Sex workers</td>
<td>58%</td>
<td>53%</td>
<td>56%</td>
<td>64%</td>
</tr>
<tr>
<td>Trans* people</td>
<td>63%</td>
<td>59%</td>
<td>64%</td>
<td>59%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Among those seeking lube, % always able to get it</th>
<th>GBMSM</th>
<th>People who use drugs</th>
<th>Sex workers</th>
<th>Trans* people</th>
</tr>
</thead>
<tbody>
<tr>
<td>GBMSM</td>
<td>45%</td>
<td>40%</td>
<td>53%</td>
<td>59%</td>
</tr>
<tr>
<td>People who use drugs</td>
<td>40%</td>
<td>40%</td>
<td>53%</td>
<td>59%</td>
</tr>
<tr>
<td>Sex workers</td>
<td>53%</td>
<td>53%</td>
<td>56%</td>
<td>64%</td>
</tr>
<tr>
<td>Trans* people</td>
<td>59%</td>
<td>59%</td>
<td>64%</td>
<td>59%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>% reporting staff are always respectful when asked for lube</th>
<th>GBMSM</th>
<th>People who use drugs</th>
<th>Sex workers</th>
<th>Trans* people</th>
</tr>
</thead>
<tbody>
<tr>
<td>GBMSM</td>
<td>50%</td>
<td>40%</td>
<td>56%</td>
<td>64%</td>
</tr>
<tr>
<td>People who use drugs</td>
<td>40%</td>
<td>40%</td>
<td>56%</td>
<td>64%</td>
</tr>
<tr>
<td>Sex workers</td>
<td>56%</td>
<td>56%</td>
<td>56%</td>
<td>64%</td>
</tr>
<tr>
<td>Trans* people</td>
<td>64%</td>
<td>64%</td>
<td>64%</td>
<td>64%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Among those able to get lube, % always able to get enough</th>
<th>GBMSM</th>
<th>People who use drugs</th>
<th>Sex workers</th>
<th>Trans* people</th>
</tr>
</thead>
<tbody>
<tr>
<td>GBMSM</td>
<td>48%</td>
<td>31%</td>
<td>48%</td>
<td>59%</td>
</tr>
<tr>
<td>People who use drugs</td>
<td>31%</td>
<td>40%</td>
<td>48%</td>
<td>59%</td>
</tr>
<tr>
<td>Sex workers</td>
<td>48%</td>
<td>48%</td>
<td>48%</td>
<td>59%</td>
</tr>
<tr>
<td>Trans* people</td>
<td>59%</td>
<td>59%</td>
<td>59%</td>
<td>59%</td>
</tr>
</tbody>
</table>
In addition only between 15% and 28% of eligible key populations had ever been offered PrEP (Table 4), despite it being widely available in facilities monitored by Ritshidze. 

"No, they don’t tell us about PrEP, this is the first time I am hearing about it. And from how you have explained it, this is what a sex worker should be on because of the risk of our job."

Widespread access to harm reduction services (like methadone and unused needles) or gender affirming care (including hormones) remain outside the reach of most of the people they are meant to serve (Figure 8).

Those who have tried to access harm reduction services are often left without services, or any information on where they could get them. Only 6% of people who use drugs were offered information about where they could get new needles, only 11% were given information on where to get methadone, and only 8% given information about drug dependence support. Service accessibility must be improved to ensure that people who use drugs needs are met and no additional barriers are created to being able to take drugs safely, or be supported to stop.

“I wish there was a drop-in centre for drug users like me in this area as when you go to the clinics, they treat you like a thief. I need to be able to get new needles and methadone from the clinic but they don’t take you seriously.”

Table 4: Knowledge, uptake and satisfaction of PrEP services among key population members

<table>
<thead>
<tr>
<th></th>
<th>GBMSM</th>
<th>People who use drugs</th>
<th>Sex workers</th>
<th>Trans* people</th>
</tr>
</thead>
<tbody>
<tr>
<td>% heard of PrEP</td>
<td>73%</td>
<td>40%</td>
<td>71%</td>
<td>75%</td>
</tr>
<tr>
<td>Among those not living with HIV, % ever offered PrEP</td>
<td>28%</td>
<td>15%</td>
<td>28%</td>
<td>27%</td>
</tr>
<tr>
<td>Among those offered PrEP, % who ever received it</td>
<td>72%</td>
<td>40%</td>
<td>74%</td>
<td>65%</td>
</tr>
<tr>
<td>Among those offered PrEP, % who did not want it</td>
<td>21%</td>
<td>37%</td>
<td>17%</td>
<td>27%</td>
</tr>
<tr>
<td>% very satisfied with PrEP services</td>
<td>32%</td>
<td>17%</td>
<td>52%</td>
<td>40%</td>
</tr>
</tbody>
</table>

Figure 7: Proportion of key population members offered PrEP by key population type

<table>
<thead>
<tr>
<th></th>
<th>GBMSM</th>
<th>People who use drugs</th>
<th>Sex workers</th>
<th>Trans* people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who is offered PrEP at the facility? (October to November 2022)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility Staff Surveyed: 376</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GBMSM</td>
<td>156 (41%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People who use drugs</td>
<td>127 (34%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex workers</td>
<td>157 (42%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trans* people</td>
<td>106 (28%)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 8: Access to harm reduction services and information on harm reduction services

Access to new needles at facilities (July to September 2022)

| % who wanted to access needles where they get health services in the last year | 410 (21%) |
| % given information any information about where they could access needles | 124 (6%) |

Access to methadone at facilities (July to September 2022)

| % who wanted to access methadone in the last year | 509 (26%) |
| % given information on where they could access methadone in the last year | 220 (11%) |

Access to drug dependence support at facilities (July to September 2022)

| % wanted to access drug dependence support in the last year | 580 (29%) |
| Among those who wanted drug dependence support, % able to access it | 85 (8%) |
The availability of gender affirming services for those who need them is critically important. In addition to the psychological impact of gender dysphoria, in the context of South Africa, a country rife with transphobia and attacks on trans* individuals, access to hormone therapy could mean life or death.

The majority of trans* people of those we spoke to, 63%, wanted access to hormone therapy at public health facilities (Figure 9). However, gender affirming care is mostly only available in big cities. Trans* people who do not live near these cities must travel long distances to get these services. This keeps it out of reach for those without access to transport money and places to stay.

“They do not offer hormones or even refer us to where we can get it.”

![Figure 9: Access to hormone therapy and information around hormone therapy among trans* people](image)

<table>
<thead>
<tr>
<th>Access to hormones at facilities (July to September 2022)</th>
<th>% of trans* respondents who would have liked to access hormones where they get health services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amont those who asked health providers where they could access hormones, % provided with no information</td>
<td>222 (43%)</td>
</tr>
<tr>
<td>Among those who asked health providers where they could access hormones, % told hormones were available there</td>
<td>90 (17%)</td>
</tr>
<tr>
<td>Among those who asked health providers where they could access hormones, % told they could pay to be referred to another doctor</td>
<td>186 (36%)</td>
</tr>
</tbody>
</table>

Table 5: Access to contraceptive care among key populations

<table>
<thead>
<tr>
<th>% able to get the contraception they wanted</th>
<th>People who use drugs</th>
<th>Sex workers</th>
<th>Trans* people</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of trans* respondents who would have liked to access hormones where they get health services</td>
<td>64% (568)</td>
<td>75% (623)</td>
<td>72% (226)</td>
</tr>
<tr>
<td>Among those who asked health providers where they could access hormones, % provided with no information</td>
<td>325 (63%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Among those who asked health providers where they could access hormones, % told hormones were available there</td>
<td>22 (4%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Among those who asked health providers where they could access hormones, % told they could pay to be referred to another doctor</td>
<td>90 (17%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Among those who asked health providers where they could access hormones, % referred to another facility</td>
<td>186 (36%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Key populations are at times refused access to contraceptives specifically because they are a member of a key population group (Table 5). South Africa faces a well documented epidemic of gender based violence including homophobic and transphobic attacks on LGBTQIA+ community members (Table 6). Sex workers also face extreme levels of violence and forced sex at the hands of clients, partners, and even police. It is critical that key populations who face sexual violence feel safe enough to access the necessary services at the clinic such as HIV testing & PEP, STI treatment, emergency contraceptive, 88 forms, rape kits, counselling, and referral to domestic violence shelters. However, the majority of key populations interviewed did not think staff were well trained to care for those who have experienced violence.

Not everyone who wanted to access STI treatment was able to at the facility (Table 7). Too often we hear reports of key populations being discriminated against or staff acting in a hostile manner to those trying to access these services.

Table 6: Training, access and comfortability around services for those who experience violence by a sexual partner, by key population group

<table>
<thead>
<tr>
<th>% who feel staff are well trained to care for those who experience violence from a sexual partner</th>
<th>GBMSM</th>
<th>Sex workers</th>
<th>Trans* people</th>
</tr>
</thead>
<tbody>
<tr>
<td>% who feel staff are well trained to care for those who experience violence from a sexual partner</td>
<td>35% (459)</td>
<td>41% (457)</td>
<td>46% (238)</td>
</tr>
<tr>
<td>% who would feel comfortable seeking care if they experienced violence from a sexual partner</td>
<td>55% (713)</td>
<td>57% (638)</td>
<td>57% (298)</td>
</tr>
<tr>
<td>Among those who needed them, % reporting staff were always respectful when seeking post-violence services</td>
<td>83% (167)</td>
<td>61% (114)</td>
<td>85% (94)</td>
</tr>
<tr>
<td>Among those who needed them, % reporting they were able to access post-violence services</td>
<td>83% (167)</td>
<td>71% (132)</td>
<td>94% (103)</td>
</tr>
<tr>
<td>Among those unable to access all the post-violence services they needed, top missing services</td>
<td>Counselling (54%, 19), HIV test (18%, 6), PEP (18%, 6)</td>
<td>Counselling (51%, 22), HIV test (23%, 10), STI test (23%, 10)</td>
<td>Counselling (80%, 4), referral to domestic violence shelter (40%, 2)</td>
</tr>
</tbody>
</table>
Table 7: Access to respectful STI testing and treatment by key population group

<table>
<thead>
<tr>
<th></th>
<th>GBMSM</th>
<th>Sex workers</th>
<th>Trans* people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Among those seeking STI testing, % always able to access it</td>
<td>75% (294)</td>
<td>70% (313)</td>
<td>80% (153)</td>
</tr>
<tr>
<td>% of staff always respectful when asking for STI testing</td>
<td>70% (275)</td>
<td>65% (292)</td>
<td>79% (151)</td>
</tr>
<tr>
<td>Among those needing STI treatment, % able to access it</td>
<td>80% (292)</td>
<td>72% (302)</td>
<td>80% (143)</td>
</tr>
</tbody>
</table>

A minimum package of key population specific services should be made available at at least two public health facilities, per key populations group, per district — to meet the specific needs of key populations at public health facilities. Where key populations need specialised care from a drop-in centre, or public health facility providing specialised care, easy referral and adequate resources (including transport or transport costs) should be provided to ensure uptake of those services. In the table below we outline the minimum package of key population specific services that should be made available.

It is critical that key populations who face sexual violence feel safe enough to access the necessary services at the clinic such as HIV testing & PEP, STI treatment, emergency contraceptive, J88 forms, rape kits, counselling, and referral to domestic violence shelters.
GAY, BISEXUAL, AND OTHER MEN WHO HAVE SEX WITH MEN
+ GBMSM outreach services
+ Pre-Exposure Prophylaxis (PrEP) including MMD and community refill collection
+ Post-Exposure Prophylaxis (PEP)
+ Lubricant
+ External condoms
+ GBMSM friendly HIV testing and counselling
+ GBMSM friendly HIV care and treatment
+ GBMSM focused Repeat Prescription Collection Strategies (RPCs) including access to facility pick-up points (fast lane), GBMSM adherence clubs and GBMSM friendly external pick-up points including at drop-in centres
+ HIV support groups including PrEP/ART refill collection
+ Psycho-social support
+ Mental health services
+ Information packages for sexual health services
+ GBMSM friendly STI prevention, testing & treatment
+ GBMSM friendly Hepatitis C (HCV) screening, diagnosis, and treatment
+ Treatment or support services for GBMSM who use drugs

PEOPLE WHO USE DRUGS
+ Outreach services for people who use drugs
+ On site or referral to drug dependence initiation and treatment (e.g. methadone)
+ On site or referral to drug dependence counselling and support
+ Resources to take up referred services (e.g. taxi fare)
+ Risk reduction information
+ Wound and abscess care
+ Unused needles, syringes, or other injecting equipment
+ Overdose management and treatment (e.g. naloxone)
+ Vaccination, diagnosis, and treatment of viral hepatitis (including HBV, HCV)
+ Pre-Exposure Prophylaxis (PrEP) including MMD and community refill collection
+ Post-Exposure Prophylaxis (PEP)
+ Lubricant
+ External condoms
+ Internal condoms
+ Non barrier contraception (including the pill, IUD, implant, injection)
+ Gender-based violence services on site or by referral
+ PWUD friendly HIV testing and counselling
+ HIV care and treatment
+ PWUD focused Repeat Prescription Collection Strategies (RPCs) including access to facility pick-up points (fast lane), PWUD adherence clubs and PWUD friendly external pick-up points including at drop-in centres
+ HIV support groups including PrEP/ART refill collection
+ Drug dependence support groups
+ Psycho-social support
+ Mental health services
+ Information packages for sexual and reproductive health services
+ PWUD friendly STI prevention, testing & treatment
+ Hepatitis C (HCV) screening, diagnosis and treatment
+ Cervical cancer screening

SEX WORKERS
+ Sex worker outreach services
+ Pre-Exposure Prophylaxis (PrEP) including MMD and community refill collection
+ Post-Exposure Prophylaxis (PEP)
+ Lubricant
+ External condoms
+ Internal condoms
+ Sex worker friendly HIV testing and counselling
+ HIV care and treatment
+ Sex worker focused Repeat Prescription Collection Strategies (RPCs) including access to facility pick-up points (fast lane), sex worker adherence clubs and sex worker friendly external pick-up points including at drop-in centres
+ HIV support groups including PrEP/ART refill collection
+ Psycho-social support
+ Mental health services
+ Non barrier contraception (including the pill, IUD, implant, injection)
+ Information packages for sexual and reproductive health services
+ Gender-based violence services on site or by referral
+ Sex worker friendly STI prevention, testing & treatment
+ Cervical cancer screening
+ Treatment or support services for sex workers who use drugs

TRANS* PEOPLE
+ Transgender outreach services
+ Pre-Exposure Prophylaxis (PrEP) including MMD and community refill collection
+ Post-Exposure Prophylaxis (PEP)
+ Lubricant
+ External condoms
+ Internal condoms
+ Trans friendly HIV testing and counselling
+ HIV care and treatment
+ Trans* focused Repeat Prescription Collection Strategies (RPCs) including access to facility pick-up points (fast lane), Trans* adherence clubs and Trans* friendly external pick-up points including at drop-in centres
+ HIV support groups including PrEP/ART refill collection
+ Psycho-social support
+ Mental health services
+ Hormone therapy
+ Non barrier contraception (including the pill, IUD, implant, injection)
+ Information packages for sexual and reproductive health services
+ Gender-based violence services on site or by referral
+ Trans friendly STI prevention, testing & treatment
+ Cervical cancer screening
+ Hepatitis C (HCV) screening, diagnosis and treatment
+ Treatment or support services for transgender people who use drugs

ALL KPs
+ Peer educators/navigators at the facility level
PILLAR 2: PUBLIC HEALTH SYSTEMS & SECURITY

2. IPs must implement the latest version of the National Adherence SOPs with fidelity!

COP23 TARGET

1. PEPFAR must monitor and hold accountable implementing partners to implement the latest version of the National Adherence SOPs with fidelity including:
   - Ensuring every person starting ART is provided with good quality fast track initiation counselling session 1 at ART start and session 2 after 1 month on ART
   - Taking first viral load as early as possible to ensure providing earlier adherence intervention support and earlier access to longer treatment supply at more convenient locations
   - Actioning an elevated VL without delay including funding and setting up effective abnormal result recall systems and providing quality enhanced adherence counselling when appropriate
   - Actioning a suppressed VL without delay focusing on immediate assessment, offer and enrolment into the Repeat Prescription Collection strategy of choice the month after VL taken
   - Ensuring facility pick-up points are a one-stop very quick ART collection-only visit in under 30 minutes. No need to go to the registry, collect folders, see clinician etc.
   - Ensuring quality adherence clubs are implemented including group facilitation component
   - Increase the number and type of external pick-up points to ensure urban, peri-urban and rural clinics have external pick-up points.
   - Ensure people going back to clinics for their RPCs rescript, receive the rescript on the same day if clinically well to ensure no unnecessary additional facility visits with effective recall system to action any abnormal results or elevated viral load.
   - All facilities implement 2023 re-engagement algorithm including appropriately differentiating services for returning patients

Multi-month dispensing and repeat prescription collection strategies (RPCs) can simplify and adapt HIV services across the cascade, in ways that both serve the needs of people living with HIV better and reduce unnecessary burdens on the health system. The revised National Adherence Guidelines Standard Operating Procedures (SOPs) agree that time constraints represent a challenge to many people living with HIV and that efforts should be made to support people living with HIV with suppressed viral loads to receive extended refills and/or enrollment in RPCs — including for children and adolescents.

However, Ritshidze data reveal huge gaps in the implementation of these guidelines. While there has been a major improvement in increasing the duration of ART refills, the majority of people living with HIV still receive two months or less supply (Figure 10). In addition, according to the national health department, the number of active PLHIV receiving a three month supply has decreased from 860,000 to 460,000 (Figure 11).

Figure 10: Duration of ART refill received
While 56% of Ritshidze respondents still received refills of less than 3 months, only 20% of PLHIV in other PEPFAR supported countries had refills of less than three months (Figure 12). Between October and December 2021 in 21 PEPFAR supported countries (excluding South Africa), 44% of people living with HIV received 3-5 month ART refill and 36% received 6 months supply. Further, access to extended treatment refills is also happening for children and adolescents in other PEPFAR supported countries (Figure 13). In the last quarter of 2021, 13% of people on ART less than 15 years of age received a 6-month ART refill (n=68,000) and 47% of people on ART less than 15 years of age received a 3-5 month ART refill (n=252,000). South Africa is far behind most countries in terms of maximum duration of ART — both for adults and children/adolescents.
We need effective recall systems set up at facilities to ensure people in Repeat Prescription Collection Strategies with an elevated viral load are recalled for clinical management and adherence support.

While there has been an increase in people using facility or external pick-up points (PuPs) too many people still collect at standard medicine dispensing. Of PLHIV interviewed by Ritshidze, 35% collected at standard medicine dispensing, with 23% using an external pick-up point, 38% collecting at a facility pick-up point, and 4% using an adherence club (figure 14).

In order to be effective, RPCs should make ARV collection quicker, easier and more satisfactory for people living with HIV — yet at times facility PuPs force people to collect files, take vitals, and see a clinician, making these faster options, not so fast. There also needs to be enough PuPs to decant people into especially linked to peri-urban and rural clinics. 39% of PLHIV still said that they would like to collect ARVs closer to their home if it were possible (Figure 15). A diversity of external PuP providers is needed beyond private pharmacy networks largely only available in urban areas. To service rural areas — small CBOs and early childhood development centres should be considered.

Once enrolled in RPCs, every effort should be made to keep people continually active in their chosen RPCs with facility required rescripting at the scheduled clinical review dates. Reassessment should take place at each clinical consultation to understand if people living with HIV are satisfied with their RPCs. People living with HIV who are not satisfied should be offered a different option that better meets their needs.

People in RPCs are stable and virally suppressed: this means it does not make sense to bring everyone back to review their viral load result before rescripting. However there are a small minority that will experience an elevated viral load. These people cannot wait for their elevated viral load to be actioned in 6-months time at their next clinical review. We need effective recall systems set up at facilities to ensure people in RPCs with an elevated viral load are recalled for clinical management and adherence support.
In terms of adherence clubs, these options have been devastated since the onset of COVID-19. Most clubs have been suspended, or reduced to being just a PuP. We maintain that functional adherence clubs play an important role in supporting on-going treatment literacy and peer support to help people living with HIV stay on treatment. PEPFAR must fund adherence club facilitators to actually allow for the restarting of clubs. The People’s COP has been calling for the widespread implementation of adherence clubs, for people who want to join them, every year since COP18.

Once on treatment, it is important to recognise that people living with HIV live dynamic lives, may miss appointments, and may even miss taking some pills. When they do, the public health system should meet them with support when they return to the clinic. But often, when people living with HIV return to the clinic they are treated badly. This poor treatment and unwelcoming environment is a significant reason for people living with HIV and key populations to disengage from care.

After a late appointment, silent transfer, or treatment interruption, people living with HIV must be supported to re-engage in care. The revised National Adherence Guidelines describe how staff should be friendly and welcoming and acknowledge the challenge for life-long adherence. To sustain re-engagement it is essential to reduce or remove health system barriers to being retained in care.

A differentiated service approach is required for people living with HIV who re-engage in care. Some will require intensive clinical management including advanced HIV screening and management. Some will require psychosocial support in the form of quality counselling and group support options. The majority need it to be made easier to collect treatment. These people should be offered MMD and should be assessed and offered access to RPCs as quickly as possible.

Implementing 2023 re-engagement clinical and adherence guidelines are vital to supporting improved long-term adherence and retention as well as providing appropriate clinical and psychosocial support to people living with HIV. In addition, according to the South African National Welcome Back Campaign Strategy and the national Adherence Guidelines, people cannot be sent to the back of the queue or made to wait until the end of the day to be seen. A returning patient should either be seen in a separate stream or take up the next queue space.

Yet Ritshidze data reveal that out of 22,319 respondents, only 66% of people thought that the staff were always friendly and professional. Only 22 out of 396 facilities had no reports of poor staff attitude. Out of the 4,245 people living with HIV who had missed appointments, 39% said that staff were welcoming when they came to collect ARVs if they had previously missed a visit. However, 22% said that staff send you to the back of the queue the next time you come in and 18% said that staff shouted at them. It is important to note that Ritshidze interviews take place at the facility, therefore this data does not capture the experiences of people living with HIV who have already disengaged from care and are not at the facility.

Further improvements are required to ensure all public healthcare users, including people living with HIV and key populations, are treated with dignity, respect, and compassion at all times. When people living with HIV disengage from treatment for any reason clinicians need to be sensitised and attempt to expect and normalise treatment interruption, this way the narrative between people living with HIV and clinician will be less punitive and more supportive.

Transfer letters are also not required in the guiding principles of the Re-engagement SOP which states: “If a patient comes from a different facility (transfers in) DO NOT require the patient to provide transfer documents or delay restarting treatment as per procedure in 2019 ART Clinical Guideline”. While most facilities did not have reports of transfer letters being a challenge, 491 people interviewed by Ritshidze in Q1 reported having been denied access to services in the last 3 months for not having a transfer letter. Again it is important to note that Ritshidze interviews take place at the facility, therefore people who have already disengaged from care due to challenges accessing a transfer letter would not be at the facility to interview.

Psychosocial support is another critical element to ensure long-term retention. Yet, Ritshidze data show that 25% of people living with HIV interviewed do know that psycho-social support is available. Further, a full package of psycho-social services are not yet available at every clinic (Figure 16).

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A full package of services should include: provision of individualised quality assured counselling to patients; peer-led patient navigators acting as a bridge between clinicians and patients; mapped networks of referral services; optional support groups, and food parcels. As part of psycho-social support, support groups should also be linked to each public health facility that are critical to provide counselling and support services to people prior to testing, post testing, pre-treatment, and those struggling on treatment or re-engaging in care after a treatment interruption.

Treatment literacy also improves ART continuity as people understand the importance of starting and remaining on treatment effectively. Of the over 11,000 people living with HIV surveyed, 92% had received a viral load test in the last year and only 86% reported that they knew their viral load. Further, there are significant gaps in knowledge and treatment literacy with only 86% agreeing with the statement; “having an undetectable viral load means the treatment is working well” and 75% agreeing with the statement “having an undetectable viral load means a person is not infectious.” Only 86% of those surveyed said a healthcare worker had explained the results of their viral load test.

Figure 16: The types of psycho-social support that people living with HIV know are available within public health facilities

<table>
<thead>
<tr>
<th>What psycho-social support is available (October to December 2022) PLHIV Surveyed: 8 961</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individualised counselling for any person living with HIV (no matter how long they have been on treatment)</td>
</tr>
<tr>
<td>HIV pre-test counselling</td>
</tr>
<tr>
<td>HIV post-test counselling</td>
</tr>
<tr>
<td>Peer led patient navigators</td>
</tr>
<tr>
<td>Referrals to social worker and other services</td>
</tr>
<tr>
<td>Referral to optional support groups</td>
</tr>
<tr>
<td>Food parcels</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Don’t know</td>
</tr>
</tbody>
</table>
PILLAR 2: PUBLIC HEALTH SYSTEMS & SECURITY

3. IPs must improve identification & management of people with advanced HIV disease (AHD) — stop the unnecessary deaths!

COP23 TARGET

1. PEPFAR to prioritise implementing partners’ facilitation of improved identification and management of people with advanced HIV disease (AHD) — stop the unnecessary deaths!
   » Ensure a CD4 count for every person newly diagnosed with HIV or returning to care sick or after interrupting ART for more than 3 months
   » Ensure provision of all WHO recommended AHD screening including TB LAM
   » Prioritise, fund and set up effective recall systems at health facilities to actively contact people to come in for clinical management — CD4<200 or any AHD screening identifies opportunistic infection for action (GeneXpert or CrAg positive)
   » Train and mentor provision of quality clinical management of AHD at hospitals and clinics
   » Prioritise, fund and facilitate set up of post-hospital discharge support package of care including case management, family/home support orientation, navigation to referral clinic, orientation of referral clinic
   » Clinics to actively manage, monitor and prioritise for increased support (including active tracing where necessary) people identified with AHD for at least 3 months after identification and starting management

South Africa still has a larger number of people presenting with advanced HIV disease (AHD) despite the scale-up of access to antiretroviral therapy. A large proportion of people who die from AIDS sought care at our public health facilities — either at hospitals or at clinics. Many remain hidden deaths with no-one accountable. If a person dies from AIDS post-hospital discharge before arrival at the referral clinic or the person disengages from care at a clinic and then dies — who accounts for the death?

Just starting people on ART will not eliminate opportunistic infections and Advanced HIV Disease (AHD). Instead AHD care needs to be enhanced at facility level. People living with HIV struggling with care are often very sick and management of those needs must be better integrated through point of care technology when needed and proper triage and immediate care plus referrals. Improved referral pathways between primary healthcare facilities and secondary and tertiary hospitals is critical to ensuring better outcomes.

An important systematic review in 2022² highlighted the high number of re-admissions and deaths post hospital discharge — with many of the cohorts contributing to this data coming from South Africa. We must do more to ensure people are closely supported in our communities and within the health system when discharged from hospital.

There should also be an increase in active linkage support for people living with HIV with AHD started/restarted on ART in hospitals by inclusion in individual case management/accompaniment to the clinic to reduce morbidity and mortality. Family orientation before hospital discharge and phone and/or home visit clinical check-in follow-up at 2 weeks, 6 weeks, and 10 weeks for individuals started or restarted on ART with AHD should also take place.

While South Africa has adopted a number of medical interventions to address AHD such as CrAg screening as well as some urine-LAM testing and roll out of TPT, more can be done to diagnose and treat the people who present with AHD, half of whom are missed with clinical staging/symptom screening alone as they enter care or re-engage. In addition, implementing effective recall systems at health facilities is critical — failure to immediately action a positive CrAg or GeneXpert cannot continue.

4. **PEPFAR must fund sufficient staffing in our clinics!**

**COP23 TARGET**

1. PEPFAR should support GoSA in filling all vacancies at PEPFAR Operation Phuthuma Support (POPS) facilities in the short term.
2. At all POPS sites with total average waiting time after the facility opens of >3 hours the DSP must immediately do an assessment and develop a specific plan for each facility that will bring the waiting time below 2 hours.
3. PEPFAR should fund adequate numbers of adherence club facilitators to allow for the restart of adherence clubs.

Improving the state of health services provided at our clinics — so that all people living with HIV and key populations can access friendly, welcoming, and quality services and we reach the UNAIDS 95-95-95 — depends mainly on having enough qualified and committed staff in place.

Yet of 21,701 public healthcare users, only 40% said there was always enough staff to meet the needs of public healthcare users (Figure 17). Of 383 Managers 78% reported there was not enough clinical and/or non-clinical staff at the facility.

Of facilities reporting shortages, 42% of Facility Managers attributed shortages to there not being enough positions in the organogram to do all the work, while 44% highlighted one or more unfilled vacancies. According to Facility Managers, the most commonly understaffed cadres were professional nurses, enrolled nurses, enrolled nurse assistants, and data capturers (Figure 18). The most common vacancies were among professional nurses, enrolled nurses, and cleaners (Figure 19).

More than half (54%) of facilities specifically wanted additional human resource support from PEPFAR district support partners. However, PEPFAR’s funding for critical HR posts has only reduced in recent years. There is still a way to go to fill the human resource gap that undermines the HIV and TB response.

One impact of staff shortages is long waiting times. Some public healthcare users still spend hours at each visit to the facility. The average waiting time was over 3 hours at 284 facilities monitored, over 4 hours at 136 of those, over 5 hours at 45 of those, and over 6 hours at 13 of those. This is a very long time to spend at a facility in which people are usually only seen for a very short consultation — and this is a major source of dissatisfaction for those who experience the long waits. For people living with HIV either collecting refills through standard dispensing or at facility pick-up points, or returning to the facility for a rescript, spending an extended time at a facility increases the risk of that person interrupting treatment and/or disengaging from care.

Of the more than 12,000 public healthcare users surveyed, 56% still think the waiting times at the facility are long — with 47% blaming staff shortages, 40% staff not working/working slowly, and 34% blaming disorganised filing systems (Figure 20). In fact, filing systems were observed to be in a good condition in only 66% of sites monitored (Figure 21). Messy and disorganised filing systems increase delays and increase the burden on already overstretched healthcare workers.
The most commonly understaffed cadres are professional nurses, enrolled nurses, enrolled nurse assistants, and data capturer.

The most common vacancies are among professional nurses, enrolled nurses, and cleaners.
5. Fully fund Ritshidze for 2 years!

COP23 TARGET
1. Commit USD 7 million for Ritshidze (run by the PLHIV Sector) in FY24 & FY25 to continue community-led monitoring of 400 high burden sites and drop-in centres across South Africa including to collect data (in the facility and community), generate solutions and engage with duty bearers to see swift corrective action.

Through Ritshidze, communities have been able to speak candidly and with evidence to not only PEPFAR agencies but the entire health system. Ritshidze has already been integrated into the government structures aiming to resolve challenges that mean we are missing the 95-95-95 targets as a country through Operation Phuthuma, and the data is being used by PEPFAR agency teams, health departments at various levels, and other role players aiming to fix the HIV and TB response in the country. It is apparent too that the success at implementing this programme influenced PEPFAR’s global guidance to require community-led monitoring in all supported countries as a tool to ensure quality services for people living with HIV and key populations.

PEPFAR SA should continue to fund Ritshidze through UNAIDS to ensure that people living with HIV have the ability to monitor the quality of service provision and escalate performance problems — an indispensable strategy for enabling South Africa to meet the 95-95-95 targets. Through Ritshidze we will continue to engage with duty bearers on community data and community-generated solutions, to offer insights and strategies to address the ever prevalent ART continuity challenges we face.

IN COP21
+ We interviewed 65,906 public healthcare users, 41,877 people living with HIV, and 13,659 young people (under the age 25). The team also interviewed 1,193 Facility Managers and conducted 1,617 observations. Data collection took place across 34 districts in 8 provinces.
+ A total of 9,137 surveys were taken, combining 2,349 gay, bisexual, and other men who have sex with men (GBMSM), 3,353 people who use drugs, 2,290 sex workers, and 1,145 trans* people. Data collection took place across 21 districts in 7 provinces.
+ Further stockouts monitoring took place in an additional 57 sites in 4 districts in the North West by TAC, Stop Stockouts Project, and Ritshidze.
+ Issued 1,410 facility reports that analyse data from an individual facility, 29 district reports were generated in each quarter that aggregate and analyse data from a district, and 7 provincial reports were generated in each quarter that aggregate and analyse data from a province.
+ 1,225 solutions documents were generated to be taken in conjunction with individual facility reports to feedback meetings with facility staff.
+ Quarterly meetings took place with facility staff, district, and provincial health teams on the evidence gathered and the recommended solutions. 1,213 facility meetings took place with facility staff in COP21.
+ 6 State of Health reports produced providing detailed analysis of provincial data (including disaggregation by district and site) and recommended solutions.
+ 6 community meetings held with national, provincial and district duty bearers in which we present data from Ritshidze that highlights problems at our local clinics and offer solutions to fix the challenges found. PLHIV, KPs and other healthcare users in the province have the opportunity to talk directly to those in power.
+ The State of Healthcare for Key Populations report and People’s COP produced provided detailed analysis of national issues affecting KPs and PLHIV and engagement with Operation Phuthuma including quarterly presentations on Ritshidze findings.
PRIORITY RECOMMENDATIONS

COP23 SDS

1. Key populations

“Improving the quality of ART services will be prioritized to improve retention in care. ART sites identified to have quality of care concerns (e.g., long wait times, confidentiality and privacy challenges, poor staff attitude) through Ritshidze (a community-led monitoring (CLM) program) will be followed-up in collaboration with the DoH to identify specific challenges and implement tailored interventions.” — SDS page 19

“NDoH and PEPFAR SA will provide a list of facilities that have been trained by DSPs, DoH, or the regional training centers. The CLM partner will conduct assessments of the number of health staff that were trained, and the effect on services to key populations.” — SDS page 32

“Upon receiving any report, PEPFAR SA will follow up and take action within three months. In addition, we will encourage DoH to develop and circulate an official circular reminding staff to provide respectful services.” — SDS page 32

“Harm reduction services are available at PEPFAR SA sites.” — SDS page 33

“PEPFAR SA will work closely with GoSA to urgently investigate any reports of poor staff attitude, privacy violations, verbal or physical abuse/harassment and/or of services being restricted or refused, and disciplinary action will be taken where appropriate. Further, PEPFAR will investigate any reports in PEPFAR funded KP sites. For sites reported on, a response will be issued within 3 months with actions that have been taken.” — SDS page 37

“KP individuals will continue to be involved in sensitization training. Post sensitization training, PEPFAR will work together with GoSA and with Ritshidze to assess the quality of KP service provision at site level (to show the success of the sensitization program).” — SDS page 37

“Post sensitization training, PEPFAR will work together with GoSA and with Ritshidze to assess the quality of KP service provision at site level (to show the success of the sensitization program).” — SDS page 37

“Additionally, PEPFAR SA is supporting an overhaul of the National Department of Health’s Key Populations Program (Formerly the High Transmission Area Program). The new program is embodied in the Key Populations Health Implementation Plan and translated into practice through the KP Centers of Excellence (Gauteng, KwaZulu/NCoEs). To date, six facilities in three provinces (Natal, and Mpuumalanga) have been identified and training has begun. The program is a highly collaborative activity, involving DSPs, KP IPs, Civil Society, and the Provincial and District DoHs. PEPFAR SA will establish two KP CoEs per province in COP21, and then continue to disseminate lessons learned and establish additional CoEs in COP22. Finally, we will continue to fund community led monitoring for PEPFAR SA funded KP sites and NDoH facilities in COP22.” — SDS page 37

“PEPFAR partners can work with facility managers and NDoH to address reports of poor staff attitude by staff and to ensure that disciplinary action is taken where appropriate. DSPs in PEPFAR supported sites will be made aware of the Department of Health’s directives regarding transfer letters.” — SDS page 47

“PEPFAR funded KP sites, as with public health facilities, will continue to ensure availability of internal and external condoms and compatible lubricants.” — SDS page 52

“Peer-led outreach and mobilization is the cornerstone of the KP program, supporting targeted strategic communication and demand creation, and dedicated KP mobile and DICAs. […] Where possible, KP will be employed as counselors at PEPFAR-supported sites to improve psycho-social support and counseling for KP. In COP22 KP focused RPCs will be scaled up including access to KP-focused adherence clubs and KP friendly external pick-up points including at drop-in centers.” — SDS page 57

In COP23, PEPFAR will work with GoSA to expand the Centre of Excellence model to ensure that at least 2 public health facilities per population per district serve as key population designated service delivery centres. A minimum package of services (as outlined in the People’s COP23) will be made available at these facilities — including harm reduction services (including methadone, new needles) and gender affirming care services (including hormones). Easy referral and adequate resources (including transport/ money for transport) will be provided for people to take up these services. PEPFAR will support these facilities with additional staff and resources to provide comprehensive health services to the specific key population being served. PEPFAR will support widespread communication of these services among KP communities to ensure uptake.

In COP23 PEPFAR will ensure that HIV prevention tools including lubricants, external and internal condoms, PrEP, and PEP are made easily available at all public health facilities and drop-in centres. To ensure better accessibility, PEPFAR will ensure that IPs make available condoms and lubricants in a range of spaces across the facility (i.e. waiting areas, toilets, gate, pharmacy, consultation rooms, quiet areas out of site) so people can freely and easily collect them.

PEPFAR will ensure that PrEP is offered to everyone including key populations who are not living with HIV/ test negative for HIV with information shared on its benefits. PEPFAR will also ensure that no IP staff members ever tell key populations to use vaseline or other oil based lubricants instead of water or silicone based lubes.

COP23 Target: Expand the Centre of Excellence model to ensure that at least 2 public health facilities per population per district serve as key population designated service delivery centres.

COP22, COP23

In COP23, PEPFAR will work with GoSA to expand the Centre of Excellence model to ensure that at least 2 public health facilities per population per district serve as key population designated service delivery centres. A minimum package of services (as outlined in the People’s COP23) should be made available at these facilities — including harm reduction services (methadone, new needles) and gender affirming care services (hormones). Easy referral and adequate resources (including transport/ money for transport) must be provided for people to take up these services. PEPFAR must support these facilities with additional staff and resources to provide comprehensive health services to the specific key population being served.

COP23 Target: Ensure that HIV prevention tools including lubricants, external and internal condoms, PrEP, and PEP are made easily available at all public health facilities and drop-in centres.

COP22, COP23

In COP23, PEPFAR will work with GoSA to expand the Centre of Excellence model to ensure that at least 2 public health facilities per population per district serve as key population designated service delivery centres. A minimum package of services (as outlined in the People’s COP23) should be made available at these facilities — including harm reduction services (methadone, new needles) and gender affirming care services (hormones). Easy referral and adequate resources (including transport/ money for transport) must be provided for people to take up these services. PEPFAR must support these facilities with additional staff and resources to provide comprehensive health services to the specific key population being served.

COP23 Target: Ensure that HIV prevention tools including lubricants, external and internal condoms, PrEP, and PEP are made easily available at all public health facilities and drop-in centres.

COP22, COP23

Partially — in SDS language, but Ritshidze data reveals lack of implementation
In addition to comprehensive HIV services, sites provide STI screening and treatment, TB screening and referral, PrEP (including MMD refill and community collection), PEP, and other primary health services, including sexual and reproductive health, condom compatible lubricants and both male and female condoms that are easily available (not only upon request or in public spaces that make it difficult to pick them up), psychosocial support, mental health services, and gender based violence services on site or by referral. Where possible, KP will be employed as counselors at PEPFAR-supported sites to improve psycho-social support and counseling for KP. In COP22 KP focused RPCs will be scaled up including access to KP-focused adherence clubs and KP friendly external pick-up points including at drop-in centers. — SDS page 57

"Gender affirming healthcare including Hormone replacement therapy (HRT) is an essential service for transgender people within the context of HIV epidemic control [...]. PEPFAR SA will purchase a buffer stock of HRT drugs and employ additional medical personnel to increase the uptake of HRT and support continuation on ART and PrEP. PEPFAR will ensure that there is easy referral and resources (planned patient transport/resources for transport) provided to ensure that transgender people are better able to uptake these services." — SDS page 58

<table>
<thead>
<tr>
<th>COP22 SDS</th>
<th>LANGUAGE TO INCLUDE IN COP23 SDS</th>
<th>COP23 TARGETS</th>
<th>WHEN DID WE ASK FOR IT?</th>
<th>DO WE HAVE IT?</th>
</tr>
</thead>
<tbody>
<tr>
<td>In COP23 PEPFAR will work with GoSA to ensure all public facilities, drop-in centres, mobile clinics, and other sites of service delivery always provide friendly, respectful, and confidential services to all key populations including: 1) Urgently investigating all reports of poor staff attitude, privacy violations, verbal or physical abuse/harassment, reports of services being refused/denied and ensure consequence management where necessary at PEPFAR supported public facilities, drop-in centres, and mobile clinics; 2) providing a full list of facilities by end March 2023 where District Support Partners (DSPs) have trained and sensitised staff on key populations, including how many clinic staff (including security guards) have been trained per site; 3) working with GoSA to ensure that all clinical and non-clinical staff (including security guards and security guard companies) are (re-)sensitised on provision of key population friendly services. Key populations will be involved in the implementation of these training modules. Post sensitisation training, PEPFAR will work with GoSA to complete follow-up assessments to check the quality of key population service provision at site level (to show the success of the sensitisation programme). PEPFAR will fund Key Population Peer Navigators at all PEPFAR supported sites &amp; especially at KP designated sites.</td>
<td>COP23 Target: Ensure all public facilities, drop-in centres, mobile clinics, and other sites of service delivery always provide friendly, respectful, and confidential services to all key populations. + Urgently investigate all reports of poor staff attitude, privacy violations, verbal or physical abuse/harassment, reports of services being refused/denied and ensure consequence management where necessary at PEPFAR supported public facilities, drop-in centres, and mobile clinics. Ritshidze will provide a breakdown of sites implicated. + Provide a full list of facilities by end March 2023 where District Support Partners (DSPs) have trained and sensitised staff on key populations, including how many clinic staff (including security guards) have been trained per site. + Work with the Department of Health to ensure that all clinical and non-clinical staff (including security guards and security guard companies) are sensitised on provision of key population friendly services before the end of COP22. Key populations must be involved in the implementation of these training modules. Post sensitisation training, work with the Department of Health to complete follow-up assessments to check the quality of key population service provision at site level (to show the success of the sensitisation programme). + Fund Key Population Peer Navigators at all PEPFAR supported sites &amp; especially at KP designated sites.</td>
<td>While partially in SDS language, KPs still treated extremely poorly at facilities</td>
<td></td>
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</tbody>
</table>
2. ART continuity

“In COP 22, the PEPFAR SA team in collaboration with NDoH will endeavor to provide a minimum of 3-month ART refills to stable PLHIV and offered RPCs with the aim to increase the total proportion of eligible patients decanted to 85% with the majority (70%) decanted to external pick-up points or community-based adherence clubs. PLHIV will be provided with options to choose the modality that suits their individual needs and preferences.” — SDS page 19

“An additional COP22 priority will be expanding external pick-up points and restarting facility- and community-based adherence clubs, PEPFAR SA in collaboration with GoSA will work to engage PLHIV in the facilitation of the clubs.” — SDS page 19

“PEPFAR will support training on the welcoming environment and will advocate for staff accountability in the training to provide a friendly and welcoming environment for all public healthcare users whether accessing HIV prevention, PLHIV accessing ART, PLHIV returning to care after a treatment interruption, or key populations. Where PLHIV may have had a treatment interruption or have missed an appointment, staff will treat those returning respectfully and with compassion. Overall accountability will be with the Facility Manager if no improvements are made. Working with GoSA, PEPFAR SA will strive that no PLHIV is sent to the back of the queue if they miss an appointment. PEPFAR partners can work with facility managers and NDoH to address reports of poor staff attitude by staff and to ensure that disciplinary action is taken where appropriate. DSPs in PEPFAR supported sites will be made aware of the Department of Health’s directives regarding transfer letters.” — SDS page 47

“Working with GoSA, PEPFAR SA will strive that no PLHIV is sent to the back of the queue if they miss an appointment.” — SDS page 47

“DSPs in PEPFAR supported sites will be made aware of the Department of Health’s directives regarding transfer letters.” — SDS page 47

“In COP22, PEPFAR SA will provide a package of psychosocial support at all PEPFAR SA supported sites that includes provision of individualized counseling to patients. Where possible, peer-led case managers and support groups will further act as a bridge between clinicians and clients. Mapped networks of referral services, optional support groups linked to 100% of PEPFAR SA-supported sites, and other psychosocial support services will be offered. Any person living with HIV can access these services at any time, with an enhanced focus provided for patients who are new on treatment, recently experienced a treatment interruption, or have an unsuppressed viral load.” — SDS page 47

In COP23 PEPFAR will monitor and hold accountable implementing partners to implement the latest version National Adherence SOPs with fidelity including:

- Ensuring every person starting ART is provided with good quality fast track initiation counselling session 1 at ART start and session 2 after 1 month on ART.
- Taking first viral load as early as possible to ensure providing earlier adherence intervention support and earlier access to longer treatment supply at more convenient locations.
- Actioning an elevated VL without delay including funding and setting up effective abnormal result recall systems and providing quality enhanced adherence counselling when appropriate.
- Actioning a suppressed VL without delay focusing on immediate assessment, offer and enrolment into the Repeat Prescription Collection strategy of choice the month after VL taken.
- Ensuring facility pick-up points are a one-stop very quick ART collection-only visit in under 30 minutes. No need to go to the registry, collect folders, see clinician etc.
- Ensuring quality adherence clubs are implemented including group facilitation component.
- Increase the number and type of external pick-up points to ensure urban, peri-urban and rural clinics have external pick-up points.
- Ensure people going back to clinics for their RPCs rescript, receive the rescript on the same day if clinically well to ensure no unnecessary additional facility visits with effective recall system to action any abnormal results or elevated viral load.
- All facilities implement 2023 re-engagement algorithm including appropriately differentiating services for returning patients.

COP23 Target: PEPFAR must monitor and hold accountable implementing partners to implement the latest version National Adherence SOPs with fidelity including:

- Ensuring every person starting ART is provided with good quality fast track initiation counselling session 1 at ART start and session 2 after 1 month on ART.
- Taking first viral load as early as possible to ensure providing earlier adherence intervention support and earlier access to longer treatment supply at more convenient locations.
- Actioning an elevated VL without delay including funding and setting up effective abnormal result recall systems and providing quality enhanced adherence counselling when appropriate.
- Actioning a suppressed VL without delay focusing on immediate assessment, offer and enrolment into the Repeat Prescription Collection strategy of choice the month after VL taken.
- Ensuring facility pick-up points are a one-stop very quick ART collection-only visit in under 30 minutes. No need to go to the registry, collect folders, see clinician etc.
- Ensuring quality adherence clubs are implemented including group facilitation component.
- Increase the number and type of external pick-up points to ensure urban, peri-urban and rural clinics have external pick-up points.
- Ensure people going back to clinics for their RPCs rescript, receive the rescript on the same day if clinically well to ensure no unnecessary additional facility visits with effective recall system to action any abnormal results or elevated viral load.
- All facilities implement 2023 re-engagement algorithm including appropriately differentiating services for returning patients.

COP22, COP23

No
<table>
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<tr>
<td>In COP23, PEPFAR will work with GoSA to extend and implement ARV refills to 3 and then 6 month supply for all eligible PLHIV. In COP23, PEPFAR will fund Adherence Club facilitators at all PEPFAR supported sites and ensure that adherence clubs are restarted at facilities and in the community in their group format in order to provide peer support, treatment literacy etc. Ensure that more Adherence Club Facilitators are PLHIV. In COP23, PEPFAR will work with GoSA to ensure that all staff at PEPFAR supported sites are held accountable to provide a friendly and welcoming environment for all public healthcare users, including PLHIV returning to care after a treatment interruption. + Any reports of poor staff attitude will be urgently investigated and disciplinary action taken where appropriate. + PEPFAR will work with GoSA to ensure that no PLHIV is sent to the back of the queue if they miss an appointment. + PEPFAR will work with GoSA to Investigate any reports of immediate treatment continuation or restart being delayed by requirement of a transfer letter. In COP23, PEPFAR will fund a package of psychosocial support to be available at 100% of PEPFAR supported sites that includes provision of individualised counselling to patients; peer-led patient navigators acting as a bridge between clinicians and patients; mapped networks of referral services; optional support groups linked to sites, and food parcels. All PLHIV are able to access this psychosocial support at any time, if wanted.</td>
<td>COP20, COP21, COP22, COP23</td>
<td>Partially — in SDS language, partially implemented</td>
<td></td>
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<tr>
<td>COP20, COP21, COP22, COP23</td>
<td>COP18, COP19, COP20, COP21, COP22, COP23</td>
<td></td>
<td></td>
<td>Partially — in SDS language but needs implementing</td>
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<tr>
<td>COP19, COP20, COP21, COP22, COP23</td>
<td>COP17, COP18, COP19, COP20, COP21, COP22, COP23</td>
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</table>

**COP20, COP21, COP22, COP23**

**COP23 Targets**

**Work with GoSA to extend and implement ARV refills to 3 and then 6 month supply for all eligible PLHIV.**

**COP23 Targets**

**Fund Adherence Club facilitators at all PEPFAR supported sites and ensure that adherence clubs are restarted at facilities and in the community in their group format in order to provide peer support, treatment literacy etc. Ensure that more Adherence Club Facilitators are PLHIV.**

**COP23 Targets**

**Work with GoSA to ensure that all staff at PEPFAR supported sites are held accountable to provide a friendly and welcoming environment for all public healthcare users, including PLHIV returning to care after a treatment interruption.**

+ Any reports of poor staff attitude should be urgently investigated and disciplinary action taken where appropriate.
+ Ensure that no PLHIV is sent to the back of the queue or made to wait until the end of the day to be seen. A returning patient should either be seen in a separate stream or take up the next queue space.
+ Investigate any reports of immediate treatment continuation or restart being delayed by requirement of a transfer letter.

**COP23 Targets**

**A package of psychosocial support should be available at 100% of PEPFAR supported sites that includes provision of individualised counselling to patients; peer-led patient navigators acting as a bridge between clinicians and patients; mapped networks of referral services; optional support groups linked to sites, and food parcels. All PLHIV are able to access this psychosocial support at any time, if wanted.**

**COP23 Targets**

**PEPFAR should fund an expansion of PLHIV KP led treatment literacy efforts across all provinces, through training, education and localised social mobilisation campaigns.**
**PEOPLE’S COP23 – COMMUNITY PRIORITIES – SOUTH AFRICA**

3. Advanced HIV

“PEPFAR SA will continue to engage the GoSA on future provision and/or scale-up of point of care CD4 testing among PLHIV in PEPFAR-supported sites and appropriate timely management. PEPFAR SA will continue to support the GoSA to correctly implement guidelines for AHD including appropriate management of PLHIV with cryptococcal meningitis in PEPFAR-supported health facilities.” — SDS page 24

“Together with other partners, PEPFAR SA is supporting the NDoH to develop a national Monitoring, Evaluation and Reporting Plan (MERP) for AHD. On completion and endorsement by NDoH, this framework will support reporting and monitoring of AHD including cryptococcal meningitis. This will, for example, provide national data on the number of patients with AHD, the number of cryptococcal antigen tests (CrAg) conducted and number of positive cryptococcal antigen tests (CrAg).” — SDS page 24

In COP23, PEPFAR will prioritise implementing partners’ facilitation of improved identification and management of people with advanced HIV disease (AHD). This will include:

- Ensuring a CD4 count for every person newly diagnosed with HIV or returning to care sick or after interrupting ART for more than 3 months.
- Ensuring provision of all who recommended and screening including为一体的.
- Prioritising, funding and setting up effective recall systems at health facilities to actively contact people to come in for clinical management — CD4<200 or any AHD screening identifies opportunistic infection for action (GeneXpert or CrAg positive).
- Training and mentoring provision of quality clinical management of AHD at hospitals and clinics.
- Prioritising, funding, and facilitating set up of post-hospital discharge support package of care including case management, family/home support orientation, navigation to referral clinic, orientation of referral clinic.
- Ensuring clinicians actively manage, monitor and prioritise for increased support (including active tracing where necessary) people identified with AHD for at least 3 months after identification and starting management.
- PEPFAR SA will ensure the provision of flucytosine for inpatient and outpatient facilities for follow-up oral treatment together with fluconazole in order to reduce overall mortality.
- PEPFAR SA will work with GoSA to ensure clear quantification and monitoring of cryptococcal meningitis (CM) including annually how many PLHIV: 1) develop CM; 2) receive optimal treatment for CM; 3) survive CM; 4) die of CM; 5) receive preventive treatment for CM; 6) receive a CD4 test; 7) CRAG gets lumbar puncture (LP); and 8) LP negative getting fluconazole prophylaxis.

PEPFAR to prioritise implementing partners’ facilitation of improved identification and management of people with advanced HIV disease (AHD) — stop the unnecessary deaths!

**COP23 Target:** Ensure a CD4 count for every person newly diagnosed with HIV or returning to care sick or after interrupting ART for more than 3 months.

**COP23 Target:** Ensure provision of all WHO recommended AHD screening including TB Lum.

**COP23 Target:** Prioritise, fund and set up effective recall systems at health facilities to actively contact people to come in for clinical management — CD4<200 or any AHD screening identifies opportunistic infection for action (GeneXpert or CrAg positive).

**COP23 Target:** Train and mentor provision of quality clinical management of AHD at hospitals and clinics.

**COP23 Target:** Prioritise, fund and facilitate set up of post-hospital discharge support package of care including case management, family/home support orientation, navigation to referral clinic, orientation of referral clinic.

**COP23 Target:** Clinics to actively manage, monitor and prioritise for increased support (including active tracing where necessary) people identified with AHD for at least 3 months after identification and starting management.

**COP23 Target:** PEPFAR SA should ensure the provision of flucytosine for inpatient and outpatient facilities for follow-up oral treatment together with fluconazole in order to reduce overall mortality.

**COP23 Target:** PEPFAR and GoSA should ensure clear quantification and monitoring of cryptococcal meningitis (CM) including annually how many PLHIV: 1) develop CM; 2) receive optimal treatment for CM; 3) survive CM; 4) die of CM; 5) receive preventive treatment for CM; 6) receive a CD4 test; 7) CRAG gets lumbar puncture (LP); and 8) LP negative getting fluconazole prophylaxis.
4. Staffing

“DSP should work with facility and district to develop a plan to reduce total average waiting time at POPS sites that have been flagged as having longer waiting times than average. PEPFAR is committed to ensuring efficient and respectful service delivery, such as addressing factors that create long waiting times and barriers to receiving services.” — SDS page 19

“PEPFAR SA will continue to collaborate with GoSA to identify strategies to address vacancies at POPS facilities in the short term.” — SDS page 19

“Extended hours for clients who are working or at school (including early morning from 5am, evening to 7pm, and weekend hours) will be expanded for drug pick-up.” — SDS page 20

PEPFAR SA will support GoSA in filling all vacancies at PEPFAR Operation Phuthuma Support (POPS) facilities in the short-term. At all POPS sites with total average waiting time after the facility opens of >3 hours the DSP will immediately (in COP22) do an assessment and develop a specific plan for each facility that will bring the waiting time below 2 hours.

PEPFAR’s additive HRH investment will allow for all PEPFAR supported sites to extend opening hours to 5:00-19:00 on weekdays and 8:00-16:00 on Saturdays as per the NDoH circular issued in May 2019 in response to the retention crisis.

PEPFAR will fund adequate numbers of adherence club facilitators to allow for the restart of adherence clubs.

COP23 Target: PEPFAR should support GoSA in filling all vacancies at PEPFAR Operation Phuthuma Support (POPS) facilities in the short term.

COP23 Target: At all POPS sites with total average waiting time after the facility opens of >3 hours the DSP must immediately do an assessment and develop a specific plan for each facility that will bring the waiting time below 2 hours.

COP23 Target: Additional staffing for all PEPFAR supported sites to extend opening hours to 05:00-19:00 on weekdays and 08:00-16:00 on Saturdays.

COP23 Target: PEPFAR should fund adequate numbers of adherence club facilitators to allow for the restart of adherence clubs.

COP22, COP23 No

COP22, COP23 Partially in SDS language

COP20, COP21, COP22, COP23 In part (extension but no staffing to support it)

COP20, COP22, COP23 No

5. Ritshidze

“PEPFAR SA will continue to support Ritshidze, a community-led monitoring (CLM) system developed by organizations representing people living with HIV, to improve the quality of HIV and TB services provided in the public health sector” — SDS page 69

In COP23, PEPFAR SA will continue to support the NDoH endorsed community-led monitoring programme — Ritshidze. PEPFAR will commit USD 7 million for Ritshidze (run by the PLHIV Sector) in FY24 and FY25 to scale-up community-led monitoring across South Africa including to collect data (in the facility and community), analyse data, generate solutions and engage with duty bearers to ensure swift corrective action. Community-led monitoring will contribute to South Africa’s HIV/AIDS and TB responses by holding authorities accountable for providing high-quality HIV and TB care and support.

COP23 Target: Commit USD 7 million for Ritshidze (run by the PLHIV Sector) in FY24 & FY25 to continue community-led monitoring of 400 high burden sites and drop-in centres across South Africa including to collect data (in the facility and community), generate solutions and engage with duty bearers to see swift corrective action.

COP19, COP20, COP21, COP22, COP23 In part — not fully funded
### 6. Index testing

“Screening and monitoring instances of intimate partner violence (IPV) is a key component of the index testing modality. All implementing partners will fully comply with the government SOP in screening all clients for risk of violence before contacting partners. No contacts who have ever been violent or are at risk of being violent will ever be contacted in order to protect the individual and other partners the contact may have that are unknown.” — SDS page 43

“In addition, healthcare providers will follow up with index clients after a reasonable period (1-2 months) to assess whether there were any adverse events including but not limited to violence, dissolution of the relationship, economic harms, unauthorized disclosure of the client’s HIV status, loss of housing, or other harms raised by the client as a result of their participation in index testing services. In cases of violence, clients will be referred to the nearest GBV support services. If no GBV services are available either at the facility or by referral, index testing will not be (re) implemented. All referrals will be actively tracked to ensure individuals who wish to access them do and referral sites have adequate capacity to provide services to the individual. All adverse events are monitored through a proactive adverse event monitoring system capable of identifying and providing services to individuals harmed by index testing. All adverse events identified will be documented and reported to the DSPs, agencies, and PEPFAR SA who will report these to Civil Society and the DoH. PEPFAR SA will ensure that all referral options listed for adverse events will be of the highest quality, with proven track records. Index testing will not continue at the facility for any population where an IP cannot meet these criteria.” — SDS page 43

“Index testing will always be voluntary as per the government SOP and human rights requirements. Monthly analyses comparing site level acceptance rates and partner elicited acceptance rates against the average will be conducted to identify sites where coercion may be happening.” — SDS page 43

“Index testing will not continue at the facility for any population where an IP cannot meet these criteria.” — SDS page 43

“PEPFAR will report to CSOs the results of the REDCap assessments and the specific remediation steps have been taken. REDCap tool results will be shared for all facilities.” — SDS page 44

“All adverse events are monitored through a proactive adverse event monitoring system capable of identifying and providing services to individuals harmed by index testing. All adverse events identified will be documented and reported to the DSPs, agencies, and PEPFAR SA who will report these to Civil Society and the DoH.” — SDS page 43

“All sites implementing PEPFAR supported index testing will report on: a) The number and proportion of index clients who have been screened for IPV; b) The number and proportion of index clients that have screened positive for IPV; c) Number of sites, timeframe for implementation, any preliminary results; d) Results from first wave of 1-2 month delayed healthcare provider follow-ups with index clients on adverse events; e) Plan for implementation of PEPFAR’s GBV Quality Assurance Tool: Number of sites, timeframe for implementation, any preliminary results; f) Status of referral network for GBV services; g) Plan for mechanism on reporting data to CSOs on all elements documented in the SDS.” — SDS page 44

### 7. PrEP

“PrEP refills will be extended to 3-month supply for individuals using PrEP for more than 3 months and RPCs for PrEP will be implemented to simplify service delivery including community collection of PrEP refills.” — SDS page 57

“PrEP is actively offered to everyone who is eligible and wants it.” — SDS page 58

In COP23, PrEP will be actively offered to everyone who is eligible and wants it. PrEP refills will be extended to 3-month supply for individuals using PrEP for more than 3 months and RPCs for PrEP will be implemented to simplify service delivery including community collection of PrEP refills.

### COP23 Targets

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<thead>
<tr>
<th>COP20, COP21, COP22, COP23</th>
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<tr>
<td>Yes in SDS</td>
<td>Yes in SDS</td>
<td>Yes in SDS</td>
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</table>
## 8. TB

To address these gaps and improve the quality of TB case finding, PEPFAR SA will focus on addressing operational issues to ensure consistent implementation of key interventions with fidelity. The following evidence-based interventions will be scaled up:

1. Targeted Universal Testing for TB (TUTT) for PLHIV, (2) strengthen the implementation of GeneXpert algorithm for PLHIV starting on ART, (3) support the routine use of digital chest x-rays in addition to symptomatic screening for PLHIV, (4) create awareness and monitor use of the self-screening app, and (5) continue supporting the use of TBLipoarabinomannan Assay (LAM) in primary health care clinics and community health centers.

We will further leverage community based Integrated Service Delivery Models to fully integrate TB/HIV services. Specific interventions to improve TB case finding among children will include refresher training for clinicians in health facilities on identification of TB in children with a medical doctor and chest x-ray.” — SDS page 22-23

### COP22 SDS

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<tr>
<td>COP23 Target: 100% of PLHIV, including CLHIV, are screened for TB and COVID-19 upon presentation to care at every clinical encounter.</td>
<td>COP19, COP20, COP21, COP22, COP23</td>
<td>Partially in SDS</td>
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<td>COP23 Target: 100% of PLHIV, including CLHIV, who present to care with signs and symptoms of TB or advanced HIV disease in inpatient and outpatient settings promptly receive both urine-LAM and rapid molecular testing (including the use of stool samples among CLHIV).</td>
<td>COP19, COP20, COP21, COP22, COP23</td>
<td>No</td>
</tr>
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<td>COP23 Target: 100% of PLHIV, including CLHIV, with positive urine-LAM results immediately initiate TB treatment, while awaiting confirmatory rapid molecular test results.</td>
<td>COP19, COP20, COP21, COP22, COP23</td>
<td>No</td>
</tr>
<tr>
<td>COP23 Target: 100% of PLHIV, including CLHIV, who are co-infected with TB receive confirmatory rapid molecular test results in less than 48 hours and initiate TB treatment in less than five days after first presenting to care.</td>
<td>COP19, COP20, COP21, COP22, COP23</td>
<td>No</td>
</tr>
<tr>
<td>COP23 Target: 100% of healthcare workers at PEPFAR-supported sites are trained to perform TB screening, urine-LAM, and rapid molecular testing among PLHIV in accordance with WHO recommendations and algorithms.</td>
<td>COP19, COP20, COP21, COP22, COP23</td>
<td>No</td>
</tr>
<tr>
<td>COP23 Target: Procurement quantities of commodities required for urine-LAM and rapid molecular testing each exceed 160,000, the estimated number of PLHIV, including CLHIV, expected to present to care at PEPFAR-supported sites with advanced HIV disease or TB signs and symptoms in COP23.</td>
<td>COP19, COP20, COP21, COP22, COP23</td>
<td>No</td>
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</table>

### COP23 Targets

In COP22, 100% of PLHIV, including CLHIV, will be screened for TB and COVID-19 upon presentation to care at every clinical encounter. All PLHIV who present to care with signs and symptoms of TB or advanced HIV disease in inpatient and outpatient settings receive both urine-LAM and rapid molecular testing (including the use of stool samples among CLHIV) upon their first presentation to care. All PLHIV with positive urine-LAM results immediately initiate TB treatment, while awaiting confirmatory rapid molecular test results. All healthcare workers at PEPFAR-supported sites will be trained to perform TB screening, urine-LAM, and rapid molecular testing among PLHIV in accordance with WHO recommendations and appropriate approach for sputum scarce symptom positive but rapid molecular negative patients. All PLHIV who are co-infected with TB will receive confirmatory diagnostic test results and be linked to TB treatment in less than five days after their first presentation to care. COP22 will procure quantities of commodities required for urine-LAM and rapid molecular testing to each exceed 160,000, the estimated number of PLHIV expected to present to care at PEPFAR-supported sites with advanced HIV disease or TB signs and symptoms in COP22. PEPFAR SA will support C-TBP to expedite the adoption of LTBI Guidelines. All PEPFAR-supported districts will expedite the introduction of short-course single-dose and FDC 3HP therapies.

### COP23 Targets

In COP23, 100% of PLHIV, including CLHIV, will be screened for TB and COVID-19 upon presentation to care at every clinical encounter. We will further leverage community based Integrated Service Delivery Models to fully integrate TB/HIV services. Specific interventions to improve TB case finding among children will include refresher training for clinicians in health facilities on identification of TB in children with a medical doctor and chest x-ray.” — SDS page 22-23

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### COP23 Targets

In COP23, 100% of PLHIV, including CLHIV, will be screened for TB and COVID-19 upon presentation to care at every clinical encounter. All PLHIV who present to care with signs and symptoms of TB or advanced HIV disease in inpatient and outpatient settings promptly receive both urine-LAM and rapid molecular testing (including the use of stool samples among CLHIV). All eligible PLHIV and all eligible contacts of a person with pulmonary TB, including children and adolescents, should be traced and initiated on TPT, even without having any symptoms.” — SDS page 24
<table>
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<th>COP22 SDS</th>
<th>LANGUAGE TO INCLUDE IN COP23 SDS</th>
<th>COP23 TARGETS</th>
<th>WHEN DID WE ASK FOR IT?</th>
<th>DO WE HAVE IT?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementing partners will be expected to scale up TPT to reach 2,121,100 PLHIV including children and adolescents (80% of those eligible already on ART plus 95% of those newly initiated) be initiated and complete TPT within COP22, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient. Of these, at least 26% (549,720) should receive 3HP in line with GoSA commitments at UN HLM on TB. TPT will be incorporated within RPCs. All eligible PLHIV and all eligible contacts of a person with pulmonary TB, including children and adolescents, should be traced and initiated on TPT. All people considered for TPT should undergo clinical evaluation (symptom check and physical examination) and be tested with GeneXpert (Xpert), even without having any symptoms.</td>
<td><strong>COP23 Target:</strong> TPT must be incorporated within RPCs, with 3 months supply. <strong>COP23 Target:</strong> 2,121,100 PLHIV including children and adolescents (80% of those eligible already on ART plus 95% of those newly initiated) be initiated and complete TPT within COP23, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient. Of these, at least 26% (549,720) should receive 3HP in line with GoSA commitments at UN HLM on TB. TPT will be incorporated within RPCs.</td>
<td>COP20, COP21, COP22, COP23</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

9. Men

“PEPFAR SA will continue efforts for decongesting centers by decanting stable clients, extending hours of operation, and providing population-specific services such as Men’s Corner, men-friendly service days, or youth-friendly services after school hours.” — SDS page 47

In COP23, HRH programming will add at least one counsellor who are men to each PEPFAR supported site, additive to existing HRH complements, to support greater uptake of services by men. These counsellors and nurses will at a minimum engage in at least one male clinic day (ensuring staff who are men are on duty) per week or Men’s Corners integrated into service delivery to provide services specific to the needs of men. **COP23 Target:** All PEPFAR supported sites have at least one male nurse and one male counsellor in place leading to a greater uptake of services by men. **COP23 Target:** All PEPFAR supported sites have at least one male clinic day (ensuring male staff are on duty) per week or Men’s Corners integrated into service delivery to provide services specific to the needs of men. **Trans* women will never be forced to use these modalities.**

| COP20, COP21, COP22, COP23 | COP20, COP21, COP22, COP23 | Partially in SDS language (not witnessed implemented in Ritshidze data) | No |

PEOPLE’S COP23 – COMMUNITY PRIORITIES – SOUTH AFRICA