RITSHIDZE
SAVING OUR LIVES

ACTIVIST GUIDE

COMMUNITY-LED CLINIC MONITORING IN SOUTH AFRICA

RITSHIDZE
SAVING OUR LIVES

INTRODUCTION

The objective of the Ritshidze project is to improve the quality of HIV and TB service delivery for people living with HIV in South Africa—by empowering people living with HIV to monitor services provided at PEPFAR-supported clinics, identify challenges, generate solutions that respond to the evidence collected, and make sure the solutions are implemented.

PEPFAR is the second largest funder of the HIV response in South Africa—amounting to nearly ZAR 10 billion (USD 523,440,000) in 2020. Much of this funding is spent at public sector clinics across the 27 highest burden districts in the country. Yet, until now there has been limited accountability of how this money is actually spent. With under a year left to achieve the UNAIDS 90-90-90 goals and progress toward epidemic control, the stakes are higher than ever to make sure that this funding is put to the best possible use, in accordance with community needs.

Community-led clinic monitoring is one way to hold PEPFAR accountable to ensure this—and improve overall HIV and TB service delivery. Meaning "Saving our Lives" in Tshivenda, Ritshidze will highlight challenges where HIV and TB services are actually delivered—at public clinics and community healthcare centres—in order to hold decision makers like PEPFAR and the Department of Health accountable to fixing them.


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GATEWAY CLINIC
UMLAZI D
CLINIC / UMTHOLAMPILO
health
Department:
Health
PROVINCE OF KWAZULU-NATAL
WELCOME / SIY
OPERATING HOURS
24 HOURS
Dukuza
UMTHOLAMPILO
OLIVIERSHOEK
CLINIC/KLINIEK
WELCOME TO HAZYVIEW CLINIC
PRIMARY HEALTH CARE
health
MPUMALANGA PROVINCE
REPUBLIC OF SOUTH AFRICA
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MOLETSI
PERSKEBULT CLINIC
FELO GA BOTSOGO GA
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SERVICES OFFERED:
HEALTH PROMOTION
SEXUALLY TRANSMITTED DISEASES;
TB SERVICES; TREATMENT (D.O.T.) DOCTOR; X-RAYS
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IMMUNISATIONS:
FAMILY PLANNING
CHILD HEALTH SERVICE
MON FRI
08H00-16H30
TEL: 852-1055
Protects You & Your Family Against Germs
Dettol
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WHO WE ARE

The Ritshidze project is being implemented by organisations representing people living with HIV—including the Treatment Action Campaign (TAC), the National Association of People Living with HIV (NAPWA), Positive Action Campaign, Positive Women's Network (PWN) and the South African Network of Religious Leaders Living with and affected by HIV/AIDS (SANERELA+)—in alliance with Health Global Access Project (Health GAP), the Foundation for AIDS Research (amfAR), and Georgetown University's O'Neill Institute for National and Global Health Law.

Together, we are working towards improving the quality of HIV and TB services provided in the public health sector through our community-led clinic monitoring system which is being rolled out in hundreds of primary healthcare facilities across the country.

The Ritshidze project is supported by the Centers for Disease Control (CDC), USAID, and UNAIDS to engage in community-led monitoring in South Africa.

WHERE WE WORK

At its peak, Ritshidze monitoring will take place at 400 clinics and community healthcare centres across 27 districts in 8 provinces in South Africa. Facilities chosen cover nearly half of all people living with HIV on treatment in the country, with a focus on sites with large treatment cohorts and where data shows poor linkage and retention rates.

Two thirds of the sites are in the epicentres of South Africa's epidemic in Gauteng and KwaZulu-Natal. Many of the sites where the work will focus are in major urban areas where overcrowded, high-burden public health facilities are the norm—including many sites with more than 5,000 people on HIV treatment and some with over 20,000 in a single site. Mpumalanga, Eastern Cape, and Western Cape are home to most of the other sites where we will focus. These areas have also been chosen based on high treatment numbers and low performance, with a small handful of sites in Free State, Limpopo and North West provinces that are particularly in need of attention as they fail to provide the HIV, TB and other health services people need, even in these lower burden provinces.

PROVINCE AND DISTRICT		SITE NAME	IMPLEMENTING PARTNER	INTENSITY (HIGH / MEDIUM / LOW)
EASTERN CAPE PROVINCE	Alfred Nzo District Municipality	Amadiba Clinic	Maternal, Adolscent and Child Health (MatCH)	
		Imizizi Clinic	Maternal, Adolscent and Child Health (MatCH)	
		Isikelo Clinic	Maternal, Adolscent and Child Health (MatCH)	
		Maluti CHC	Maternal, Adolscent and Child Health (MatCH)	
		Matatiele Community Clinic	Maternal, Adolscent and Child Health (MatCH)	
		Mount Ayliff Gateway Clinic	Maternal, Adolscent and Child Health (MatCH)	
		Mount Frere Gateway Clinic	Maternal, Adolscent and Child Health (MatCH)	
		St Patrick's Gateway Clinic	Maternal, Adolscent and Child Health (MatCH)	
		Tabankulu CHC	Maternal, Adolscent and Child Health (MatCH)	
	Amathole District Municipality	Butterworth Gateway Clinic	TB/HIV Care	
		Idutywa Village CHC	TB/HIV Care	
		Nozuko Clinic	TB/HIV Care	
		Nqamakwe CHC	TB/HIV Care	
		Willowvale CHC	TB/HIV Care	
		Xhora CHC	TB/HIV Care	

PROVINCE AND DISTRICT		SITE NAME	IMPLEMENTING PARTNER	INTENSITY (HIGH / MEDIUM / LOW)
EASTERN CAPE PROVINCE	Buffalo City Metropolitan Municipality	Central Clinic (East London)	Kheth'Impilo	
		Duncan Village CHC	Kheth'Impilo	
		Empilweni Gompo CHC	Kheth'Impilo	
		Fezeka NU 3 Clinic	Kheth'Impilo	
		Gompo C Jabavu Clinic	Kheth'Impilo	
		Greenfields Clinic	Kheth'Impilo	
		Grey Gateway Clinic	Kheth'Impilo	
		Luyolo NU 9 Clinic	Kheth'Impilo	
		Nontyatyambo CHC	Kheth'Impilo	
		Philani NU 1 Clinic	Kheth'Impilo	
		Zanempilo Clinic (East London)	Kheth'Impilo	
	Chris Hani District Municipality	Ngcobo CHC	TB/HIV Care	
		Nomzamo CHC	TB/HIV Care	
		Philani Clinic (Queenstown)	TB/HIV Care	
		Tembelihle Clinic	TB/HIV Care	
	Nelson Mandela Metropolitan Municipality	Gustaye L'Amour Clinic	n/a	
		Letitia Bam Clinic	n/a	
		Motherwell CHC	n/a	
		Nomangesi Jayiya Clinic	n/a	
		Rosedale Clinic	n/a	
		Soweto Clinic	n/a	
	Oliver Tambo District Municipality	Civic Centre Clinic (Mthatha)	TB/HIV Care	
		Flagstaff Clinic	TB/HIV Care	
		Holy Cross Gateway Clinic	TB/HIV Care	
		Lusikisiki Village Clinic (Qaukeni)	TB/HIV Care	
		Mhlakulo CHC	TB/HIV Care	
		Mqanduli CHC	TB/HIV Care	
		Mthatha Gateway Clinic	TB/HIV Care	
		Ngangelizwe CHC	TB/HIV Care	
		Ntapane Clinic	TB/HIV Care	
		Port St Johns CHC	TB/HIV Care	
		Qumbu CHC	TB/HIV Care	
		St Elizabeth's Gateway Clinic	TB/HIV Care	
		Stanford Terrace Clinic	TB/HIV Care	
		Tsolo Clinic	TB/HIV Care	

PROVINCE AND DISTRICT		SITE NAME	IMPLEMENTING PARTNER	INTENSITY (HIGH / MEDIUM / LOW)
FREE STATE PROVINCE	Lejweleputswa District Municipality	Albert Luthuli Memorial Clinic	Wits Reproductive Health& HIV Institute	
		Hani Park Clinic	Wits Reproductive Health& HIV Institute	
		Hoopstad Clinic	Wits Reproductive Health& HIV Institute	
		Kgotsong (Bothaville) Clinic	Wits Reproductive Health& HIV Institute	
		Matjhabeng Clinic	Wits Reproductive Health& HIV Institute	
		OR Tambo Clinic	Wits Reproductive Health& HIV Institute	
		Phahameng (Bultfontein) Clinic	Wits Reproductive Health& HIV Institute	
		Phomolong (Hennenman) Clinic	Wits Reproductive Health& HIV Institute	
		Thabong Clinic	Wits Reproductive Health& HIV Institute	
		Tshepong (Welkom) Clinic	Wits Reproductive Health& HIV Institute	
		Welkom Clinic	Wits Reproductive Health& HIV Institute	
	Manguang District Municipality	Bloemspruit Clinic	n/a	
		Chris de Wert (Gabriel Dichabe) Clinic	n/a	
		Freedom Square Clinic	n/a	
		Kagisanong Clinic	n/a	
		MUCPP CHC	n/a	
	Thabo Mofutsanyane District Municipality	Bohlokong Clinic	Right To Care, South Africa	
		Boiketlo Clinic	Right To Care, South Africa	
		Harrismith Clinic	Right To Care, South Africa	
		Mphohadi Clinic	Right To Care, South Africa	
		Namahali Clinic	Right To Care, South Africa	
		Phuthaditjhaba Clinic	Right To Care, South Africa	
		Reitumetse Clinic	Right To Care, South Africa	
		Thusa Bophelo Clinic	Right To Care, South Africa	
GAUTENG PROVINCE	City of Johannesburg Metropolitan Municipality	17 Esselen Street Clinic	Anova Health Institute	
		4th Avenue Clinic	Anova Health Institute	
		Alexandra 8th Avenue Clinic	Anova Health Institute	
		Alexandra CHC	Anova Health Institute	
		Alexandra East Bank Clinic	Anova Health Institute	
		Barney Molokoane Clinic	Anova Health Institute	
		Bellavista Clinic	Anova Health Institute	
		Chiawelo CHC	Anova Health Institute	
		Cosmo City Clinic	Anova Health Institute	
		Diepkloof Prov Clinic	Anova Health Institute	
		Diepsloot South Clinic	Anova Health Institute	
		Discoverers CHC	Anova Health Institute	
		Eyethu Yarona Clinic	Anova Health Institute	
		Freedom Park Clinic	Anova Health Institute	
		Hikhensile Clinic	Anova Health Institute	
		Hillbrow CHC	Anova Health Institute	
		Imbalenhle Clinic	Anova Health Institute	
		Itireleng CHC	Anova Health Institute	
		Jabavu (Vusabantu) Clinic	Anova Health Institute	
		Lenasia Clinic	Anova Health Institute	

PROVINCE AND DISTRICT		SITE NAME	IMPLEMENTING PARTNER	INTENSITY (HIGH / MEDIUM / LOW)
GAUTENG PROVINCE	City of Johannesburg Metropolitan Municipality	Lenasia South CHC	Anova Health Institute	
		Lillian Ngoyi CHC	Anova Health Institute	
		Malvern Clinic	Anova Health Institute	
		Mandela Sisulu Clinic	Anova Health Institute	
		Mayibuye Clinic	Anova Health Institute	
		Meadowlands Zone 2 Prov Clinic	Anova Health Institute	
		Michael Maponya Prov Clinic	Anova Health Institute	
		Mofolo CHC	Anova Health Institute	
		Mpumelelo Clinic	Anova Health Institute	
		OR Tambo CHC	Anova Health Institute	
		Orange Farm Ext 7 Clinic	Anova Health Institute	
		Orlando Prov Clinic	Anova Health Institute	
		Princess Clinic	Anova Health Institute	
		Protea Glen Clinic	Anova Health Institute	
		Rabie Ridge Clinic	Anova Health Institute	
		Randburg Clinic	Anova Health Institute	
		Rex Street Clinic	Anova Health Institute	
		Senaoane Clinic	Anova Health Institute	
		Sinqobile Clinic	Anova Health Institute	
		Stretford CHC	Anova Health Institute	
		Thoko Mngoma Clinic	Anova Health Institute	
		Tladi Prov Clinic	Anova Health Institute	
		Tshepisong Clinic	Anova Health Institute	
		Vlakfontein Clinic	Anova Health Institute	
		Witkoppen Clinic	Anova Health Institute	
		Yeoville Clinic	Anova Health Institute	
		Zandspruit Clinic	Anova Health Institute	
		Zola CHC	Anova Health Institute	
		Zondi Clinic	Anova Health Institute	
	City of Tshwane Metropolitan Municipality	Boekenhout Clinic	Wits Reproductive Health& HIV Institute	
		Boikhutsong Clinic	Wits Reproductive Health& HIV Institute	
		Dark City CHC	Wits Reproductive Health& HIV Institute	
		FF Ribeiro Clinic	Wits Reproductive Health& HIV Institute	
		Hercules Clinic	Wits Reproductive Health& HIV Institute	
		Jubilee Gateway Clinic	Wits Reproductive Health& HIV Institute	
		Kgabo CHC	Wits Reproductive Health& HIV Institute	
		KT Motubatse Clinic	Wits Reproductive Health& HIV Institute	
		Laudium CHC	Wits Reproductive Health& HIV Institute	
		Lyttelton Clinic	Wits Reproductive Health& HIV Institute	
		Maria Rantho Clinic	Wits Reproductive Health& HIV Institute	
		Phedisong 1 Clinic	Wits Reproductive Health& HIV Institute	
		Phedisong 4 CHC	Wits Reproductive Health& HIV Institute	
		Phomolong Clinic	Wits Reproductive Health& HIV Institute	
		Sedilega Clinic	Wits Reproductive Health& HIV Institute	

PROVINCE AND DISTRICT		SITE NAME	IMPLEMENTING PARTNER	INTENSITY (HIGH / MEDIUM / LOW)
GAUTENG PROVINCE	City of Tshwane Metropolitan Municipality	Skinner Street Clinic	Wits Reproductive Health& HIV Institute	
		Soshanguve 2 Clinic	Wits Reproductive Health& HIV Institute	
		Soshanguve Block JJ Clinic	Wits Reproductive Health& HIV Institute	
		Soshanguve Block TT Clinic	Wits Reproductive Health& HIV Institute	
		Soshanguve Block X Clinic	Wits Reproductive Health& HIV Institute	
		Stanza Bopape CHC	Wits Reproductive Health& HIV Institute	
		Stanza Bopape II Clinic	Wits Reproductive Health& HIV Institute	
		Temba CHC	Wits Reproductive Health& HIV Institute	
		Tlamelong Clinic	Wits Reproductive Health& HIV Institute	
	Ekurhuleni Metropolitan Municipality	Andries Raditsela Clinic	Aurum Health Research	
		Barcelona Clinic	Aurum Health Research	
		Boksburg Civic Centre Clinic	Aurum Health Research	
		Boksburg North Clinic	Aurum Health Research	
		Crystal Park Clinic	Aurum Health Research	
		Dan Kubheka Clinic	Aurum Health Research	
		Daveyton East Clinic	Aurum Health Research	
		Daveyton Main CDC	Aurum Health Research	
		Dawn Park Clinic	Aurum Health Research	
		Dresser Clinic	Aurum Health Research	
		Endayeni Clinic	Aurum Health Research	
		Erin Clinic	Aurum Health Research	
		Esangweni CHC	Aurum Health Research	
		First Avenue Clinic	Aurum Health Research	
		Germiston City Clinic	Aurum Health Research	
		Goba Clinic	Aurum Health Research	
		Itireleng (Region B) Clinic	Aurum Health Research	
		Jabulane Dumane CHC	Aurum Health Research	
		Katlehong North Clinic	Aurum Health Research	
		Kempton Park Civic Centre Clinic	Aurum Health Research	
		Kemston Clinic	Aurum Health Research	
		Khumalo Clinic	Aurum Health Research	
		Kwa-Thema CHC	Aurum Health Research	
		Leondale Clinic	Aurum Health Research	
		Lethabong Clinic	Aurum Health Research	
		Mary Moodley Memorial CDC	Aurum Health Research	
		Nokuthela Ngwenya CHC	Aurum Health Research	
		Olifantsfontein Clinic	Aurum Health Research	
		Palmridge Clinic	Aurum Health Research	
		Phenduka Clinic	Aurum Health Research	
		Phillip Moyo CHC	Aurum Health Research	
		Phola Park CHC	Aurum Health Research	
		Ramokonopi CHC	Aurum Health Research	
		Spartan Clinic	Aurum Health Research	
		Tembisa Health Clinic	Aurum Health Research	

PROVINCE AND DISTRICT		SITE NAME	IMPLEMENTING PARTNER	INTENSITY (HIGH / MEDIUM / LOW)
GAUTENG PROVINCE	Ekurhuleni Metropolitan Municipality	Tembisa Main Clinic	Aurum Health Research	
		Tsakane Clinic	Aurum Health Research	
		Vosloorus Poly Clinic	Aurum Health Research	
		Winnie Mandela Clinic	Aurum Health Research	
	Sedibeng District Municipality	Boipatong CHC	Anova Health Institute	
		Bophelong CDC (Emfuleni)	Anova Health Institute	
		Empilisweni CDC	Anova Health Institute	
		Levai Mbatha CHC	Anova Health Institute	
		Market Avenue Clinic	Anova Health Institute	
		Midvaal CDC	Anova Health Institute	
		Sebei Motsoeneng Clinic	Anova Health Institute	
		Zone 17 Clinic	Anova Health Institute	
KWAZULU-NATAL PROVINCE	eThekwini Metropolitan Municipality	Addington Gateway Clinic	Health Systems Trust	
		Amanzimtoti Clinic	Health Systems Trust	
		Amaoti Clinic	Health Systems Trust	
		Athlone Park Hall Clinic	Health Systems Trust	
		Besters Clinic	Health Systems Trust	
		Bluff Clinic	Health Systems Trust	
		Caneside Clinic	Health Systems Trust	
		Cato Manor CHC	Health Systems Trust	
		Chatsworth Township Centre Clinic	Health Systems Trust	
		Chesterville Clinic	Health Systems Trust	
		Clare Estate Clinic	Health Systems Trust	
		Ekuphileni (Umlazi L) Clinic	Health Systems Trust	
		Folweni Clinic	Health Systems Trust	
		Glen Earle Clinic	Health Systems Trust	
		Goodwins Clinic	Health Systems Trust	
		Halley Stott Clinic	Health Systems Trust	
		Hambanathi Clinic	Health Systems Trust	
		Hlengisizwe CHC	Health Systems Trust	
		Illovu Clinic	Health Systems Trust	
		Inanda C CHC	Health Systems Trust	
		Inanda Seminary Clinic	Health Systems Trust	
		Isipingo Clinic	Health Systems Trust	
		Kingsburgh Clinic	Health Systems Trust	
		Klaarwater Clinic	Health Systems Trust	
		KwaMakhutha Clinic	Health Systems Trust	
		KwaMashu B Clinic	Health Systems Trust	
		KwaMashu Poly CHC	Health Systems Trust	
		KwaNdengezi Clinic	Health Systems Trust	
		Lamontville Clinic	Health Systems Trust	
		Lindelani Clinic	Health Systems Trust	
		Luganda Clinic	Health Systems Trust	
		Molweni Clinic	Health Systems Trust	

PROVINCE AND DISTRICT		SITE NAME	IMPLEMENTING PARTNER	INTENSITY (HIGH / MEDIUM / LOW)
KWAZULU-NATAL PROVINCE	eThekwini Metropolitan Municipality	Mpola Clinic	Health Systems Trust	
		Mpumalanga Clinic	Health Systems Trust	
		Nagina Clinic	Health Systems Trust	
		New Germany Clinic	Health Systems Trust	
		Newlands West Clinic	Health Systems Trust	
		Newtown A CHC	Health Systems Trust	
		Nsimbini Clinic	Health Systems Trust	
		Ntuzuma Clinic	Health Systems Trust	
		Osizweni (Umlazi Q) Clinic	Health Systems Trust	
		Ottawa Clinic	Health Systems Trust	
		Overport Clinic	Health Systems Trust	
		Phoenix CHC	Health Systems Trust	
		Pinetown Clinic	Health Systems Trust	
		Prince Mshiyeni Gateway Clinic	Health Systems Trust	
		Qadi Clinic	Health Systems Trust	
		Queensburgh Clinic	Health Systems Trust	
		Redcliffe Clinic	Health Systems Trust	
		Redhill Clinic	Health Systems Trust	
		Reservoir Hills Clinic	Health Systems Trust	
		Savannah Park Clinic	Health Systems Trust	
		Shallcross Clinic	Health Systems Trust	
		Sivananda Clinic	Health Systems Trust	
		Sydenham Heights Clinic	Health Systems Trust	
		Tongaat CHC	Health Systems Trust	
		Tshelimnyama Clinic	Health Systems Trust	
		Umbumbulu Clinic	Health Systems Trust	
		Umlazi D Clinic	Health Systems Trust	
		Umlazi G Clinic	Health Systems Trust	
		Umlazi K Clinic	Health Systems Trust	
		Umlazi N Clinic	Health Systems Trust	
		Umlazi U21 Clinic	Health Systems Trust	
		Umzomuhle (Umlazi H) Clinic	Health Systems Trust	
		Verulam Clinic	Health Systems Trust	
		Waterloo Clinic	Health Systems Trust	
		Westville Clinic	Health Systems Trust	
		Wyebank Clinic	Health Systems Trust	
	Harry Gwala District Municipality	East Griqualand and Usher Memorial Hospital	Maternal, Adolscent and Child Health (MatCH)	
		Ixopo Clinic	Maternal, Adolscent and Child Health (MatCH)	
		Kokstad Clinic	Maternal, Adolscent and Child Health (MatCH)	
		Pholela CHC	Maternal, Adolscent and Child Health (MatCH)	
		Rietvlei Gateway Clinic	Maternal, Adolscent and Child Health (MatCH)	

PROVINCE AND DISTRICT		SITE NAME	IMPLEMENTING PARTNER	INTENSITY (HIGH / MEDIUM / LOW)
KWAZULU-NATAL PROVINCE	King Cetshwayo District Municipality	Empangeni Clinic	Broadreach	
		Eshowe Gateway Clinic	Broadreach	
		Khandisa Clinic	Broadreach	
		King Dinuzulu Clinic	Broadreach	
		KwaMbonambi Clinic (Sappi Clinic)	Broadreach	
		Ndlangubo Clinic	Broadreach	
		Ngwelezana Clinic	Broadreach	
		Nseleni CHC	Broadreach	
		Phaphamani Clinic	Broadreach	
		Richards Bay Clinic	Broadreach	
		Thokozani Clinic	Broadreach	
		Umbonambi Clinic	Broadreach	
	Ugu District Municipality	Gamalakhe CHC	Broadreach	
		Gcilima Clinic	Broadreach	
		Izingolweni Clinic	Broadreach	
		KwaMbunde Clinic	Broadreach	
		Marburg Clinic	Broadreach	
		Margate Clinic	Broadreach	
		Port Edward Clinic	Broadreach	
		Port Shepstone Clinic	Broadreach	
		Southport Clinic	Broadreach	
		Turton CHC	Broadreach	
		Umzinto Clinic	Broadreach	
	uMgungundlovu District Municipality	Azalea Clinic	Health Systems Trust	
		Caluza Clinic	Health Systems Trust	
		Howick Clinic	Health Systems Trust	
		Impilwenhle Clinic	Health Systems Trust	
		Mafakathini Clinic	Health Systems Trust	
		Mooi River Clinic	Health Systems Trust	
		Mpophomeni Clinic	Health Systems Trust	
		Mpumuza Clinic	Health Systems Trust	
		Ndaleni Clinic	Health Systems Trust	
		Pata Clinic	Health Systems Trust	
		Richmond Clinic	Health Systems Trust	
		Sinathing Clinic	Health Systems Trust	
		Songonzima Clinic	Health Systems Trust	
		Taylors Halt Clinic	Health Systems Trust	
		Willowfountain Clinic	Health Systems Trust	

PROVINCE AND DISTRICT		SITE NAME	IMPLEMENTING PARTNER	INTENSITY (HIGH / MEDIUM / LOW)
KWAZULU-NATAL PROVINCE	Uthukela District Municipality	Acaciavale Clinic	Health Systems Trust	
		AE Haviland Memorial Clinic	Health Systems Trust	
		Amazizi Clinic	Health Systems Trust	
		Bergville Clinic	Health Systems Trust	
		Driefontein Clinic	Health Systems Trust	
		Dukuza Clinic	Health Systems Trust	
		Ekuvukeni Clinic	Health Systems Trust	
		Emmaus Gateway Clinic	Health Systems Trust	
		Injisuthi Clinic	Health Systems Trust	
		Ncibidwane Clinic	Health Systems Trust	
		Oliviershoek Clinic	Health Systems Trust	
		Steadville Clinic	Health Systems Trust	
		Walton Clinic	Health Systems Trust	
		Watersmeet Clinic	Health Systems Trust	
		Wembezi Clinic	Health Systems Trust	
	Zululand District Municipality	Bhekuzulu Clinic	Health Systems Trust	
		eDumbe CHC	Health Systems Trust	
		Hlobane Clinic	Health Systems Trust	
		Mason Street Clinic	Health Systems Trust	
		Mdumezulu Clinic	Health Systems Trust	
		Ncotshane Clinic	Health Systems Trust	
		Pongola Clinic	Health Systems Trust	
		Queen Nolonolo Clinic	Health Systems Trust	
		Ulundi A Clinic	Health Systems Trust	
LIMPOPO PROVINCE	Capricorn District Municipality	Buitestraat Clinic	Anova Health Institute	
		Nobody Clinic	Anova Health Institute	
		Perskebult Clinic	Anova Health Institute	
		Rethabile CHC	Anova Health Institute	
		Seshego IV Clinic	Anova Health Institute	
	Mopani District Municipality	Carlotta Clinic	Anova Health Institute	
		Giyani CHC	Anova Health Institute	
		Grace Mugodeni CHC	Anova Health Institute	
		Motupa Clinic	Anova Health Institute	
		Tzaneen Clinic	Anova Health Institute	
	Vhembe District Municipality	Dzwerani Clinic	n/a	
		Margareta Clinic	n/a	
		Muledane Clinic	n/a	
		Shayandima Clinic	n/a	
		Thohoyandou Clinic	n/a	
		Tshisaulu Clinic	n/a	
		Tswinga Clinic	n/a	

PROVINCE AND DISTRICT		SITE NAME	IMPLEMENTING PARTNER	INTENSITY (HIGH / MEDIUM / LOW)
MPUMALANGA PROVINCE	Ehlanzeni District Municipality	Agincourt CHC	Right To Care, South Africa	
		Bhuga CHC	Right To Care, South Africa	
		Buffelspruit CHC	Right To Care, South Africa	
		Cottondale Clinic	Right To Care, South Africa	
		Eziweni Clinic	Right To Care, South Africa	
		Gutshwa Clinic	Right To Care, South Africa	
		Hazyview Clinic	Right To Care, South Africa	
		Kabokweni CHC	Right To Care, South Africa	
		Kanyamazane CHC	Right To Care, South Africa	
	Ehlanzeni District Municipality	Langloop CHC	Right To Care, South Africa	
		Lillydale Clinic	Right To Care, South Africa	
		Mangweni CHC	Right To Care, South Africa	
		Manzini Clinic	Right To Care, South Africa	
		Msogwaba Clinic	Right To Care, South Africa	
		Mthimba Clinic	Right To Care, South Africa	
		Naas CHC	Right To Care, South Africa	
		Nelspruit CHC	Right To Care, South Africa	
		Nkwalini Clinic	Right To Care, South Africa	
		Phola-Nzikasi CHC	Right To Care, South Africa	
		Tonga Block C Clinic	Right To Care, South Africa	
		White River Clinic	Right To Care, South Africa	
	Gert Sibande District Municipality	Amsterdam CHC	Broadreach	
		Bethal Town Clinic	Broadreach	
		Embalenhle CHC	Broadreach	
		Emthonjeni Clinic (Msukaligwa)	Broadreach	
		Ermelo Clinic	Broadreach	
		Ethandakukhanya Clinic	Broadreach	
		Langverwacht Ext 14 Clinic	Broadreach	
		Lebohang CHC	Broadreach	
		Lillian Mambakazi CHC	Broadreach	
		Mkhondo Town Clinic	Broadreach	
		Nhlazatshe 6 Clinic	Broadreach	
		Nhlazatshe Clinic	Broadreach	
		Paulina Morapeli CHC	Broadreach	
		Piet Retief Clinic	Broadreach	
		Sead Clinic	Broadreach	
		Secunda Clinic	Broadreach	
		Thussiville (MN Cindi) Clinic	Broadreach	
		Winifred Maboa CHC	Broadreach	
	Nkangala District Municipality	Beatty Clinic	Broadreach	
		Empumelelweni CHC	Broadreach	
		Siphosesimbi CHC	Broadreach	
		Thembalethu CHC	Broadreach	

PROVINCE AND DISTRICT		SITE NAME	IMPLEMENTING PARTNER	INTENSITY (HIGH / MEDIUM / LOW)
NORTH WEST PROVINCE	Bojanala Platinum District Municipality	Bafokeng CHC	Aurum Health Research	
		Bapong CHC	Aurum Health Research	
		Boitekong Clinic	Aurum Health Research	
		Hebron Clinic	Aurum Health Research	
		Letlhabile CHC	Aurum Health Research	
		Mogwase CHC	Aurum Health Research	
		Tlhabane CHC	Aurum Health Research	
	Dr Kenneth Kaunda District Municipality	Grace Mokgomo CHC	Aurum Health Research	
		Jouberton CHC	Aurum Health Research	
		Park Street Clinic	Aurum Health Research	
		Potchefstroom Clinic	Aurum Health Research	
	Ngaka Modiri Molema District Municipality	Lonely Park Clinic	Aurum Health Research	
		Montshioa Stadt CHC	Aurum Health Research	
		Unit 9 CHC	Aurum Health Research	
WESTERN CAPE PROVINCE	City of Cape Town Metropolitan Municipality	Albow Gardens CDC	Anova Health Institute	
		Bloekombos Clinic	Anova Health Institute	
		Crossroads CDC	Anova Health Institute	
		Delft CHC	Anova Health Institute	
		Delft South Clinic	Anova Health Institute	
		District Six CDC	Anova Health Institute	
		Dr Ivan Toms CDC	Anova Health Institute	
		Du Noon CHC	Anova Health Institute	
		Guguletu CHC	Anova Health Institute	
		Hout Bay Main Road Clinic	Anova Health Institute	
		Inzame Zabantu CDC	Anova Health Institute	
		Khayelitsha (Site B) CHC	Anova Health Institute	
		Kraaifontein CHC	Anova Health Institute	
		Kuyasa CDC	Anova Health Institute	
		Langa Clinic	Anova Health Institute	
		Matthew Goniwe CDC	Anova Health Institute	
		Mfuleni CDC	Anova Health Institute	
		Michael Mapongwana CDC	Anova Health Institute	
		Mitchells Plain CHC	Anova Health Institute	
		Mzamomhle Clinic	Anova Health Institute	
		Nolungile CDC	Anova Health Institute	
		Nyanga CDC	Anova Health Institute	
		Town 2 CDC	Anova Health Institute	
		Wallacedene Clinic	Anova Health Institute	
		Weltevreden Valley Clinic	Anova Health Institute	

RITSHIDZE
SAVING OUR LIVES

OUR PRINCIPLES

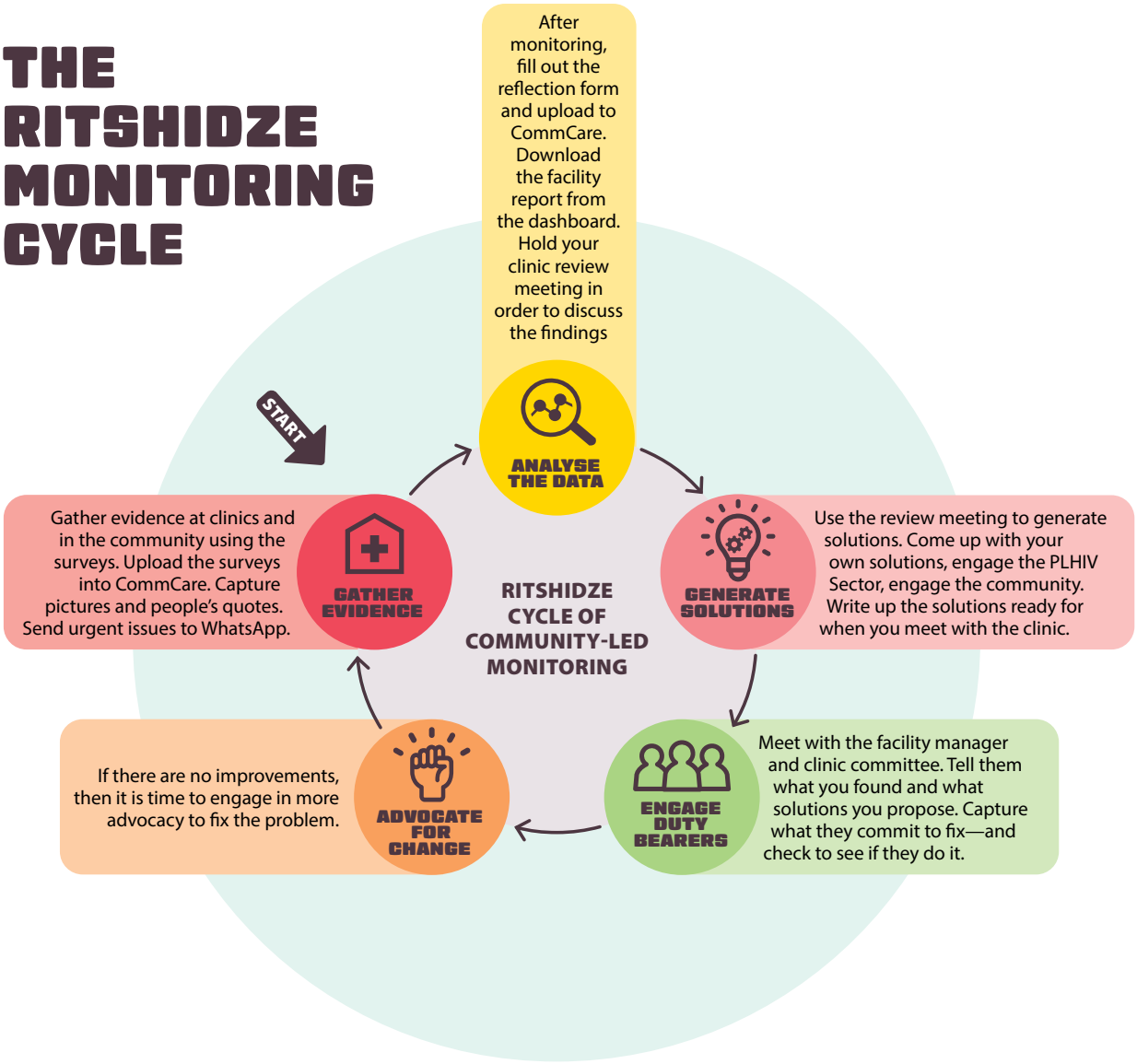
The Ritshidze project recognises, respects and embraces diversity. We actively fight for the rights of people living with HIV, womxn, queer people, transgender people, young people, sex workers, people who use drugs, migrants, and other marginalised populations. We actively fight and will not tolerate any acts of racism, patriarchy, homophobia, transphobia or any other stigma or discrimination.

THE PURPOSE OF THIS GUIDE

This guidebook provides step-by-step instructions on how to conduct community-led clinic monitoring in South Africa. It has been developed for the Ritshidze team and PLHIV Sector organisation members by Health GAP and the Treatment Action Campaign with support from amfAR and Georgetown University's O'Neill Institute for National and Global Health Law.

The guidebook provides you with everything you need to know to effectively implement the project. You'll learn the basics about HIV in South Africa and the role of the PEPFAR programme; how to collect and capture evidence, how to analyse the findings and come up with solutions to benefit communities, and how to engage duty bearers and advocate for change.

THE RITSHIDZE MONITORING CYCLE



THE RITSHIDZE CYCLE CHECKLIST*

GATHER EVIDENCE

- [ ] The observation survey is completed
- [ ] Patient surveys have been completed with 15 people living with HIV reached
- [ ] The Facility Manager survey is completed
- [ ] Adherence club members surveys have been completed where possible
- [ ] The Adherence Club Facilitator survey is completed
- [ ] The Medicines survey is completed
- [ ] Pictures have been taken at the clinic
- [ ] All surveys have been uploaded into CommCare
- [ ] Pictures have been sent to the correct WhatsApp channel with clear updates
- [ ] Issues requiring rapid response have been communicated to the correct WhatsApp channel
- [ ] Is this a high or medium intensity site? If so do community monitoring to find individual testimonies through door to door or an informal focus group (*if you run out of activities later in the month, do more community monitoring*)

ANALYSE THE DATA

- [ ] The reflection form has been filled on CommCare
- [ ] Facility report has been downloaded from the data dashboard
- [ ] Clinic review meeting held with PLHIV Sector members, Community Monitor, District Organiser, and Project Officer responsible for that clinic
- [ ] Clinic review meeting template completed.

GENERATE SOLUTIONS

- [ ] Do you need to find other solutions? If so reach out to the wider PLHIV Sector, other Ritshidze staff, the community, healthcare providers for more ideas
- [ ] Is there a branch attached to the clinic? If so engage the branch on the data report and potential solutions. Do they agree? Do they have more inputs?
- [ ] Is this a high intensity site? Do you need to organise a community dialogue to generate solutions?
- [ ] Write up the solutions using the clinic review meeting template
- [ ] Present the solutions to the members, Community Monitor, District Organiser, and Project Officer responsible for that clinic
- [ ] Once agreed, and signed off by the Project Officer, the District Organiser must submit to CommCare

ENGAGE DUTY BEARERS

- [ ] Download the State of the Clinic report from CommCare (facility report + recommended solutions report)
- [ ] Request a meeting with the Facility Manager and Clinic Committee Chairperson
- [ ] Hold a pre-meeting with the team who will attend the meeting to outline roles (who will discuss which finding and solutions; who will note all the commitments etc.)
- [ ] Present the State of the Clinic report
- [ ] Capture what they commit to fix—upload the commitments to CommCare
- [ ] Monitor to see if they do it (ongoing)

ADVOCATE FOR CHANGE

- [ ] Are there no improvements? It is time to engage in more advocacy to fix the problem.
- [ ] Engage the national project team & PLHIV Sector
- [ ] Develop a campaign strategy
- [ ] Implement the campaign

** See last page in the ADVOCATE FOR CHANGE section for a version that will photocopy well.*

LEARN THE BASICS

SOUTH AFRICA'S HIV RESPONSE

THE U.S. PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF (PEPFAR) SUPPORT TO SOUTH AFRICA'S HIV RESPONSE

PURPOSE AND IMPORTANCE OF COMMUNITY-LED MONITORING

SOUTH AFRICA'S HIV RESPONSE

Over the past decade, South Africa's HIV response has come a long way—from the dark days of AIDS denialism under then President Thabo Mbeki, to the establishment of the world's largest treatment programme. However, this achievement only reflects half of the story. The full picture of South Africa also reveals that more than 2.7 million people living with HIV are still not on lifesaving antiretroviral treatment. Despite the implementation of the "test and treat" policy in the country in 2016, the reality is that many people living with HIV are not on treatment—either never having known their HIV status, or more worryingly having started on treatment and then stopped. Compared to other countries in the region who are on track to reach epidemic control like Malawi, Zimbabwe, and Botswana, South Africa is lagging far behind.

Arguably the biggest challenge facing South Africa's HIV response today is how to support many more people living with HIV to start and, importantly, stay on treatment. Doing this in the context of a dysfunctional healthcare system will not be easy, but cannot be shied away from.

Fact-finding missions and facility monitoring exercises conducted by TAC, Health GAP, and other groups consistently reveal a litany of problems. Often people start queueing outside clinic gates as early as 4am, only to wait all day, and in some cases never be seen. They get to the clinic, only to be sent home empty handed without the medicines they need. Nurses are overworked and under-resourced. They shout at people. Doctors are scarce. People wait in overcrowded waiting rooms—or sit outside without shade or seats, even the elderly or sick. When they eventually get seen, in some clinics there is no privacy and other people can see or hear their consultations. Buildings are old and falling apart, with dirty or pit latrine toilets. Equipment is missing or broken. Files take hours to find or go missing altogether. People get TB because the windows are closed and no-one gives out masks to those coughing. The clinic committees that people rely on to solve these problems either don't exist, or don't know what they should do. Our clinics are in crisis.

These are the typical and frequent types of complaints we receive from people with HIV who are trying to get HIV treatment and care through the South African public health system. These problems reveal a crisis that needs to be urgently addressed.

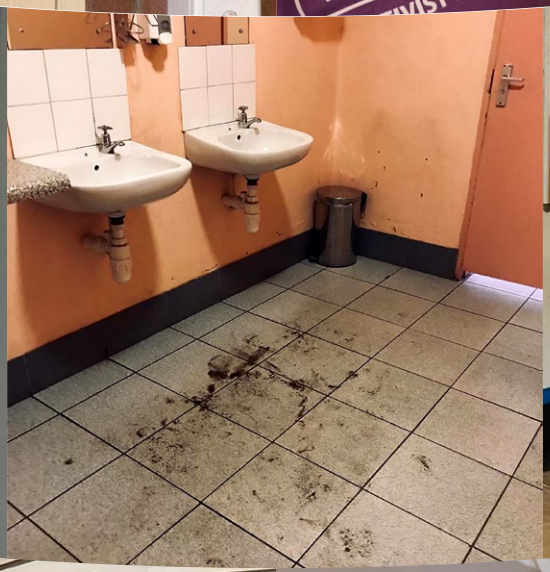
COMMON COMPLAINTS

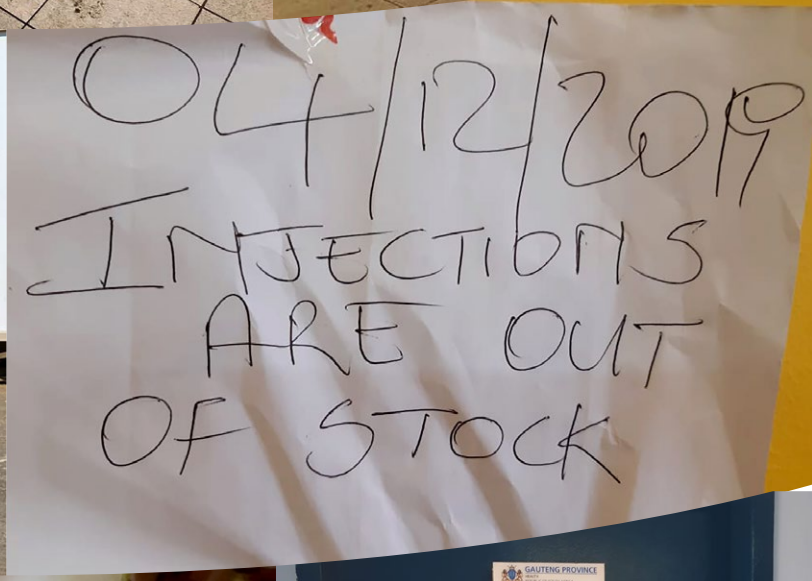
+ **Shortages** of medical (doctors, nurses, pharmacists etc.) and non-medical staff (cleaners, security etc.)
+ **Poor staff attitudes** with patients reporting being treated badly, shouted at, humiliated.
+ **Long waiting** times with people forced to queue in the early hours before the clinic opens.
+ **Messy and dysfunctional filing** systems that increase waiting times—or where patients are not provided with the right services or medicines due to incorrect files.
+ **People living with HIV** being shouted at, sent to the back of the queue, or mistreated if they miss an appointment, or when re-engaging in care.
+ **Stockouts & shortages** of diagnostic tests, medicines, contraceptives, vaccines and other medical supplies.
+ **Medical equipment** that is old, broken, or missing.
+ People living with HIV are forced to wait long hours to collect **ARV refills** at the facility—even in the fast lane.
+ **Adherence clubs** for people living with HIV that are not available or not functional.
+ **Lack of psycho-social support** or access to mental healthcare for people living with HIV who are struggling to adhere to medicines.
+ **Poor TB infection control** at the clinic—for example closed windows, people not screened for TB upon arrival, people coughing are not seen first or separated from those who are not provided with a tissue or mask.
+ **Clinic infrastructure** that is old, small, broken, putting patient safety at risk, or otherwise not meeting the needs of patients.
+ **The privacy of people living with HIV** and other patients is not respected as people are consulted in the same room, or people's HIV status is forcibly disclosed in one way or another.
+ **Test results** take too long to return, or never come back.
+ The facility is **dirty**.
+ Small facilities mean there is **overcrowding**.

WHAT HAPPENS IF A PATIENT MISSES A SCHEDULED APPOINTMENT

Should the patients come within five working days after their scheduled date, the patient will be consulted after all the patients allocated to that time slot have been consulted even if they arrive first. The patients will be placed at the back of the chronic queue.

By order Department of health





TAC and other HIV activists in South Africa have been calling on the government for years to do more, and faster, to address the crisis in the healthcare system that is undermining the HIV and TB response—calling on them to roll out innovative models of care and help failing clinics to improve.

On some fronts the government is moving—in 2019 the Department of Health announced a slate of policy changes in a circular distributed to all PEPFAR priority sites to remove barriers to care and support accountability of health workers. In addition they launched Operation Phuthuma—driving key interventions to accelerate towards 90-90-90 by December 2020. The challenge now is to ensure that those policies and interventions are enacted at the district and facility levels.

Table 1: National Department of Health circular, May 2019

CHALLENGE	HOW THE MAY 2019 CIRCULAR IS ATTEMPTING TO ADDRESS THE CHALLENGE
When PLHIV miss an appointment or return to care after stopping treatment they are often shouted out, reprimanded, and/or sent to the back of the queue. This means often PLHIV are afraid to return to care.	*"1. Ensure a patient centred approach is implemented in all facilities including a welcome back campaign for defaulting patients — this approach should ensure confidentiality and respectful care."*
Human resource shortages are a major issue in South Africa. Ensuring access to quality healthcare services and ensuring everyone living with HIV and TB gets access to treatment and care depends largely on having enough qualified and committed staff. These shortages lead to long waiting times, poor quality service provision (such as rushed counselling), stockouts (due to staff being too busy to place orders), and overall increased pressure on the few staff in place. However, instead of adding to the overall staff complement and reducing burden on the clinic, often the supplemental staff funded through the PEPFAR programme end up replacing existing staff. In reality this means that while PEPFAR is funding human resources, people at clinics do not feel the benefit.	*"2. Ensure that PEPFAR- funded staff are not "replacement staff" — they should be additive to government staff. The following minimum services must be performed: one patient initiated a day by NIMART nurses; 12 HIV tests a day by HIV counsellors; 100 files a day captured by data capturers; community healthcare workers through Ward Based Outreach Teams (WBOTs) track and trace at least 3 defaulting patients a week."*
At many facilities, poor filing systems and/or lost files or cards were also observed or reported on by healthcare users. Messy and disorganised filing systems increase the delays to healthcare users being attended to, and increase the burden on already overstretched healthcare workers. Lost files can cause huge inconvenience to healthcare users. Many patients complained about the filing systems of clinics being a mess, with their files often missing or taking forever to find. This was one of the primary reasons that they thought the waiting times were so long.	*"3. Improve the implementation of the data system by ensuring the necessary administrative staff are in place; that there is a functional filing system in place and maintained to reduce patient waiting times; and fully implementing the HPRS unique identifier, and use this to order laboratory tests and track and trace defaulters."*
The Centralised Chronic Medicines Dispensing and Distribution (CCMDD) system is meant to be a much simpler and quicker system to collect HIV treatment (and other chronic medication) than waiting in long clinic queues. When functioning effectively, CCMDD should not only provide patients with an easier way to pick up medicines, but should also relieve the burden on health facilities that are already stretched to capacity by reducing the numbers of patients coming to the clinic.	*"4. Thousands of possible external pick up points have been mapped to support the Centralised Chronic Medicines Dispensing and Distribution (CCMDD) system. PEPFAR-supported District Support Partners (DSPs) will assist to register at least one additional external pick up point around prioritised sites."*
It is well known that each time someone is asked to spend an extended time at a health centre, simply to collect ART refills, there is an increased risk of losing that person from care. Yet at many clinics across the country, PLHIV and other patients Face long queues each time they go to the facility. To beat the queues and ensure they are seen, often healthcare users arrive at the facility early—leading to safety issues as they wait outside locked clinic gates in the early hours. In addition, often community members, more especially men, complain that they are unable to access the clinic between 8am and 4pm because of work commitments.	*"5. Extend opening hours to attract patients e.g. those working, who cannot attend during normal opening times. Facilities must be open from 5.00 — 19.00, as well as 8.00 — 16.00 on Saturdays. Patients should also be able to use these extended hours to pick up their medication from internal pick up points."*
The reality is that our clinics are failing to provide the healthcare needed across the country. Ensuring that duty bearers act to respond to challenges at clinic level is key to ensuring accountability and a successful HIV/AIDS and TB response.	*"6. Heads of Health must receive progress reports against the performance of prioritised high-volume facilities and report to MECs [of health] weekly. Facilities that are not on track should be visited by a senior official and report back to MECs. MECs should recognise facilities that reach their targets."*

How much of this is actually being implemented at site level? Your monitoring will reveal the answer to this question.

THE U.S. PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF (PEPFAR) SUPPORT TO SOUTH AFRICA'S HIV RESPONSE

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) is the largest source of funding for the HIV response globally (second largest in South Africa), with most funding focused in Sub-Saharan Africa, Haiti, and in smaller regional programmes in Asia, the Caribbean, and Latin America. As of 2019, this programme was supporting access to HIV treatment for 18 million people.

PEPFAR serves as the umbrella and coordinator for all U.S. government agencies providing funding for the AIDS response. Funding is spent through the U.S. Centers for Disease Control (CDC), United States Agency for International Development (USAID), Health Resources and Services Administration (HRSA), the Departments of Defense, Commerce and Labour, and the Peace Corps. These agencies are the ones that write the contracts and manage the programmes—so HIV programmes funded by CDC or USAID are part of PEPFAR.

WHO GETS PEPFAR FUNDING?

PEPFAR funding goes to 'implementing partners' (IP) that are most often large, non-governmental organisations (NGOs) as well as government agencies in the implementing country. Implementing partners are then responsible for running HIV programmes and sometimes provide funding to other organisations as sub-contractors ("subs") including smaller, local organisations to implement programmes.

WHO ARE THE IMPLEMENTING PARTNERS IN SOUTH AFRICA?

THE AURUM INSTITUTE

Kheth'Impilo — Choose Life for an AIDS Free Generation

ANOVA HEALTH INSTITUTE

HEALTH SYSTEMS TRUST

TBHIVCARE

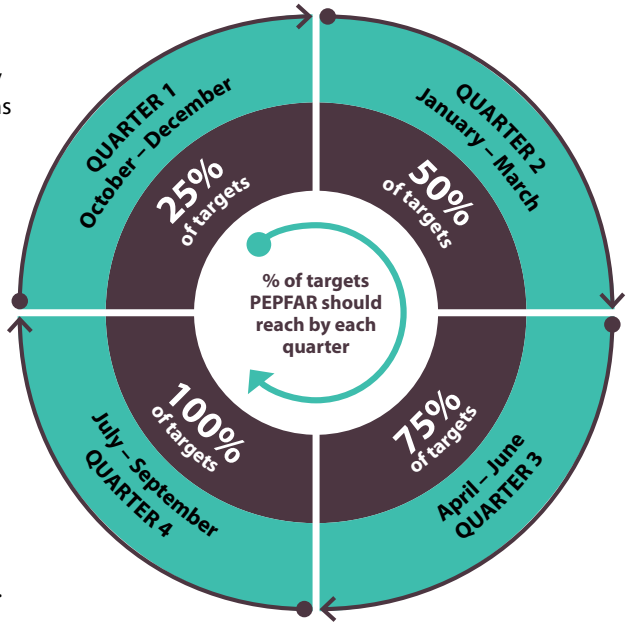
MatCH — Maternal, Adolescent & Child Health Institute

BroadReach healthcare

University of the Witwatersrand WITS RHI

WHAT IS THE COUNTRY OPERATIONAL PLAN?

The Country Operational Plan (COP) is a plan created jointly by several U.S. government agencies that outlines how the billions of dollars in HIV funding from the U.S. government will be allocated. The COP also spells out programmatic priorities and targets in South Africa. The COP consists of a detailed budget and target report, and a narrative account of PEPFAR's plans, known as a Strategic Direction Summary (SDS). The SDS outlines the main goals and targets PEPFAR aims to achieve in South Africa, which populations and geographic areas PEPFAR will prioritise, what strategies and interventions PEPFAR and its implementers are planning to use to achieve their goals and targets, and how they will monitor progress. The SDS also contains details about who is funding what in the AIDS response in the country, and about the state of the epidemic and response in the country as a whole, amongst other important pieces of information.



The COP starts on 1st October each year, in line with the U.S. government financial year—and ends on 30th September. It is split into four quarters—that match the Ritshidze monitoring quarters. PEPFAR also publishes its own data corresponding to each quarter that we can review and assess their performance against. All the COPs and other key PEPFAR documents are available here: https://www.state.gov/where-we-work-pepfar/

HOW DO WE INFLUENCE THE DEVELOPMENT OF THE COP?

For years the COP process was closed—a confidential U.S.-government-only set of discussions that excluded affected communities. Health GAP, amfAR and a coalition of activists in the U.S. and East and Southern Africa fought to open the process, beginning in 2013. We continue to insist that the inputs from people most affected by HIV should weigh more heavily than those from bureaucrats. Currently, members of civil society are able to take part in COP planning and monitoring in most countries through quarterly meetings organised by PEPFAR country teams.

But a seat at the table does not necessarily translate into meaningful input into PEPFAR programme planning. Only where activists have proactively used these opportunities to hold PEPFAR accountable—pushing the programme to deliver on the transparency and access it has promised—has 'engagement' resulted in impact.

THE "PEOPLE'S COP"

The "People's COP"—established in South Africa and now used in multiple other countries—is a tactic used to influence the development of the COP. Using data collected from clinics and other health facilities, a comprehensive document is developed that outlines community's recommendations to PEPFAR. In past years, the recommendations have been launched in high profile community events attended by people living with HIV, alongside U.S. Global AIDS Coordinator Ambassador Deborah Birx and the leadership of each of the U.S. agencies involved in PEPFAR in South Africa. The events—held in 2018, 2019, and 2020—pushed the voices of people living with HIV, young women, key populations, and health workers into the PEPFAR discussions that too often focus on numbers and targets instead of people and lives.

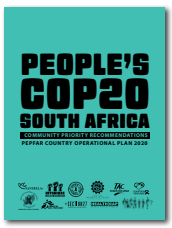
In 2019, the "People's COP" recommended that community-led monitoring be funded by PEPFAR. This is where the Ritshidze project came from. In 2020, data collected in the project was used to outline the recommendations to PEPFAR against clear evidence from the ground. Twelve recommendations were outlined, most having been asked for in previous years, but not yet implemented properly or at all (see Table 2).

> ***The People's COP is fantastic – it's a clear best practice. It makes specific recommendations that we can really act on. I've asked the team to go point by point and be clear on what we are going to do on each point. We wish all countries had this.***
>
> **U.S. Global AIDS Coordinator Ambassador Deborah Birx**

Table 2: Community Priorities Interventions for COP20

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

The People's COPs are critical reading for Ritshidze project staff members. You can access them here:



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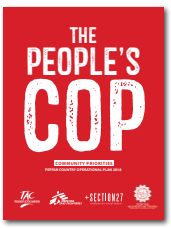


bit.ly/SAPeoplesCOP18

HOW WELL IS PEPFAR DOING IN SOUTH AFRICA?

Local monitoring of PEPFAR-supported sites often paints a bleak picture of dysfunction and wasted resources. Even PEPFAR's own data shows that there has been poor performance by the implementing partners (IPs) and for the amount of money being invested, too little impact has been shown. PEPFAR and their IPs must be held to account to do better—failing partners should be swapped for those who can deliver.

Of particular concern has been the insufficient pace of scale up of antiretroviral treatment and insufficient quality of programmes, leading to high rates of loss-to-follow-up. South Africa has relatively high rates of knowledge of HIV status—yet amongst those who know their status, fewer are on effective treatment and have successfully suppressed the virus in South Africa than in neighboring countries that have seen more rapid progress.

First, too many individuals are lost to follow-up before they initiate ART. For example, the 2019 COP reported that in the previous year, only 80% of individuals who tested positive initiated treatment. For some key populations, that number was far lower—e.g. 56% for men who have sex with men and 19% for people who use drugs.

Once people living with HIV do initiate treatment, there are severe retention problems—for example according to PEPFAR's data—while 759,506 people started treatment in 2019, the total number of people taking treatment across the country by the end of the year had only increased by 353,605. This means that 405,901 people had been lost to follow up, stopped adhering to treatment, or died during the year.

Further, only 55% of all PLHIV are virally suppressed. 2019 has seen some improvements, but not nearly enough to reach 90-90-90.

A major reason for the failures in reaching 90-90-90 is the poor quality of HIV services available in the public sector. Poor HIV outcomes can be directly linked back to gaps in service delivery and poor quality public health services.

In February 2019, as a response to this poor performance and threats of funding cuts, PEPFAR and its agencies announced a new rapid plan to improve service delivery. Through this emergency approach, progress was made and PEPFAR and their IPs managed to meet their targets in re-engaging people in care and testing new people living with HIV. This intensive strategy has since been renamed the "Siyenza" project. The Siyenza project is taking place at more than 400 PEPFAR-supported sites across South Africa—these are the sites we are monitoring in Ritshidze.

WHAT IS COMMUNITY-LED MONITORING?

Community-led clinic monitoring is a systematic collection of data at the site of service delivery by community members that is compiled, analysed and then used by community organisations to generate solutions to problems found during data collection.

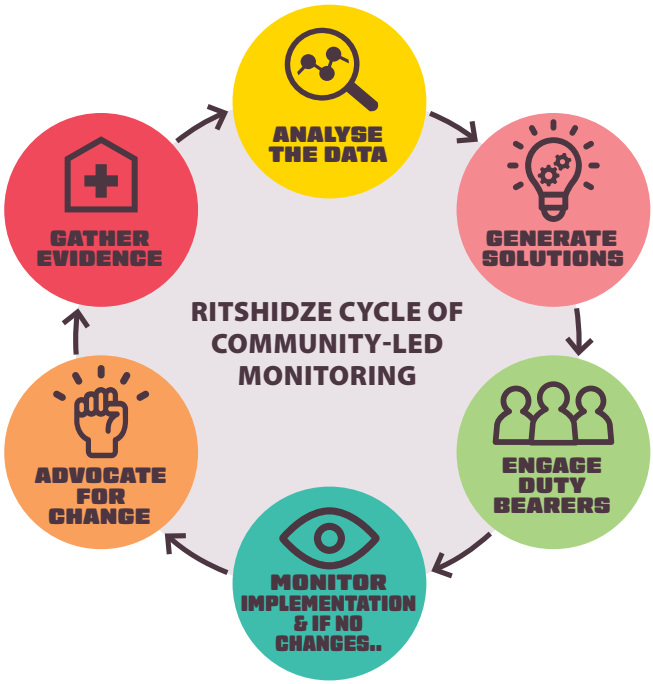
Giving communities the ability to monitor the quality of service provision and highlight performance problems is an indispensable strategy for improving PEPFAR performance and enabling South Africa to meet the UNAIDS 90-90-90 targets.

PURPOSE AND IMPORTANCE OF COMMUNITY-LED MONITORING

Until now, district and local governments have faced only limited accountability for the public health services they provide. This lack of accountability itself is a major barrier to improving the quality of care. But it is compounded by the fact that the people who are most motivated to demand accountability are not being empowered to do so. Conversely, provincial and national officials who are empowered to hold the district and local governments accountable are not receiving the information from the communities that they need in order to do so.

In this project, people living with HIV are empowered to monitor services provided at PEPFAR-supported clinics, identify challenges, generate solutions that respond to the evidence collected, and make sure the solutions are implemented by duty bearers.

Community-led data collection that leads to the generation of evidence based-solutions can bring about meaningful changes to a community—not least the enhanced capacity of community members to continue to engage in future evidence-based monitoring and advocacy.



GATHER EVIDENCE

WHAT EVIDENCE WILL WE GATHER?

WHERE WILL WE GATHER EVIDENCE?

WHO WILL GATHER EVIDENCE?

WHEN WILL WE GATHER EVIDENCE?

HOW WILL WE GATHER EVIDENCE?

GETTING INFORMED CONSENT

GATHERING EVIDENCE IN CLINICS AND OTHER HEALTHCARE FACILITIES

GATHERING EVIDENCE IN THE COMMUNITY

USING TECHNOLOGY TO CAPTURE DATA

WHAT EVIDENCE WILL WE GATHER?

Ritshidze will collect both qualitative and quantitative data in clinics and the community through the use of a standardised set of monitoring tools, in order to systematically gather evidence for analysis and potential action. The questions help to identify the main challenges that healthcare users find at the clinic and the underlying reasons for them—for example, identifying that waiting times are long because of shortages of staff and a messy filing system, or that people are not accessing the HIV or TB services they need because they are scared of being treated badly or shouted at by staff members. Across the surveys the questions attempt to identify all the main challenges regularly reported at clinics. The table shows a sample of questions from the Ritshidze tools.

MAIN CHALLENGES	TYPES OF QUESTIONS
Facility Hours and Waiting Times	• How long do you wait at the clinic? • Are the queues considered as long? • Why are the queues long? • How early do people arrive in the mornings? • Is it safe to wait outside the clinic gates before the clinic opens? • What time does the clinic usually stop seeing patients?
Facility Staff	• Are there enough staff at the clinic? • Which cadres are vacant or understaffed? • Are the staff friendly and professional? • How do the challenges impact on your accessing services?
Clinic Conditions and Patient Safety	• Is the clinic in good or bad condition? • Are the toilets in good condition? • How clean is the clinic? • Is the filing system in an orderly manner? • Is there enough space at the facility? • What additional space is needed?
Access to Medicines and Shortages/Stockouts	• Do you know about any stockouts or shortages of medicines or medical supplies? • Have patients left the clinic without the medicines they needed? • If there was a shortage, were people given alternatives or short supplies?
ARV Collection and Access	• Where do you collect ARVs? • What length of ARV refill are you given? • What happens if you miss a clinic visit to collect ARVs? • Would you like to collect ARVs closer to home? • Are you scared of being reprimanded if you miss a visit? • If someone stopped taking treatment do you think it is a welcoming environment to return to care?
Adherence Clubs	• Are there adherence clubs at the clinic or in the community? • Are they functional? • Do they make it quicker to collect ARV refills? • Do they provide information on the importance of treatment adherence? • How often do they meet? • How long do meetings last?


PATIENT SURVEY
SORRY
TOILET
OUT OF SERVICE
FIX OUR CLINICS
SAVE OUR LIVES
#CLINICSinCRISIS
RECEPTION
ATTENTION SPRAY YOUR HANDS
RITSHIDZE
SAVING OUR LIVES
FIX OUR CLINICS
SAVE OUR LIVES
#CLINICSinCRISIS
HIV
PLEASE MEC SAVE OUR LIVES!!!

QUALITATIVE VS QUANTITATIVE DATA

Quantitative data can be counted, measured, and expressed using numbers

e.g. 100 people have been lost to follow up in the last 3 months.

Qualitative data is descriptive.

e.g. People are being lost to follow up because the staff have a bad attitude at the clinic, meaning people do not want to go there.

MAIN CHALLENGES	TYPES OF QUESTIONS
Access to Viral Load Testing / Information	• Do you know your viral load? • When was the last time you had a viral load test? • Did a healthcare worker explain the result of your viral load test? • Do you see any benefits to having a VL test?
Confidentiality and Privacy	• Has a healthcare worker ever asked you for the names and contacts of your partners or children to test for HIV? • Did they tell you that you could refuse to give those contacts? • Did you have any concerns about this? How were you treated during this process?
Psycho-Social Support for PLHIV	• Were you offered HIV counselling and support? • What HIV counselling and support services or other mental healthcare services are you able to access?
TB infection control	• Do people have enough room to wait? • Are the windows open? • Are people asked if they have TB symptoms? • Are people separated or seen first if they are coughing, or given a mask or tissue? • Are there posters telling people to cover their mouths when coughing or sneezing?
Young people	• Are there youth friendly services at this clinic? • What services do young people who are having sex receive? • Do you think this facility does a good job serving youth? • Do you need parent permission for any services? • Are there outreach services in schools and the community for young people?
Key populations	• Is the clinic sensitised to cater to men who have sex with men, transgender people, people who use drugs and/or sex workers? • Do you think this facility does a good job serving gay, bisexual, or other men who have sex with men? • What services are transgender people offered and receive? • What sort of attitude do service providers have towards sex workers? • Do you think this facility does a good job serving people who use drugs? List reasons why and why not. • Do you feel like this facility respects your privacy? • Are there outreach services in the community for key populations?

The tools try to cover these types of issues and will help us to more systematically understand the challenges people living with HIV and TB are facing when accessing healthcare services. This in turn will help us to generate evidence-based solutions that could improve the overall impact of the PEPFAR programme.

WHAT HAPPENS IF THE FACILITY MANAGER OR IMPLEMENTING PARTNER WON'T LET ME START MONITORING?

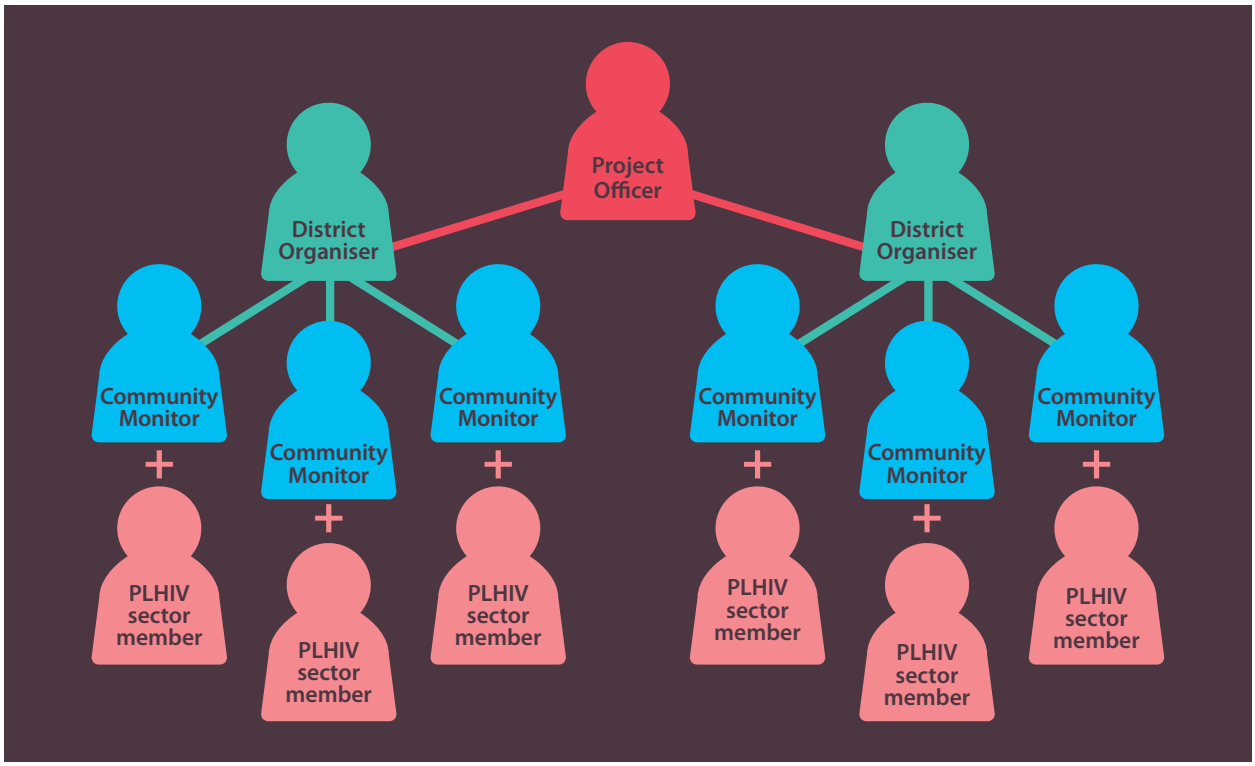
The Ritshidze project has been granted permission to monitor all these clinics by National, Provincial and District health departments—and by USAID and CDC. This agreement is outlined in a Memorandum of Understanding (MoU) between the PLHIV Sector and the National Department of Health, and reiterated in a number of authorization letters from provincial, district and municipal health teams. Ask your District Organiser and Project Officer for a copy of the MoU and the relevant authorization letters that can be taken with you to the clinic as you introduce yourself.

If you experience any challenges from either Department of Health staff or implementing partners in allowing you to monitor, immediately reach out to your District Organiser and Project Officer to help escalate the issue to the relevant authorities in order to rectify the situation.

WHERE WILL WE GATHER EVIDENCE?

At its peak we will be gathering evidence at 400 clinics and community healthcare centres across 27 districts in 8 provinces in South Africa. Facilities chosen cover nearly half of all people living with HIV on treatment in the country, with a focus on sites with large treatment cohorts and where data shows poor linkage and retention rates.

The tools will gather data at two levels—at the clinic as well as in the community. This is necessary to capture the experience and insights both of those accessing public healthcare services in these facilities and of those who are *not* currently interacting with the facility, both of whom have critical information about what is and is not working. The "facility-based" monitoring will capture observations as well as the perspectives of both healthcare users and healthcare providers. In the "community-based" monitoring component, we will gather information directly from community members through the use of door to door engagement, individual interviews, and informal focus groups.



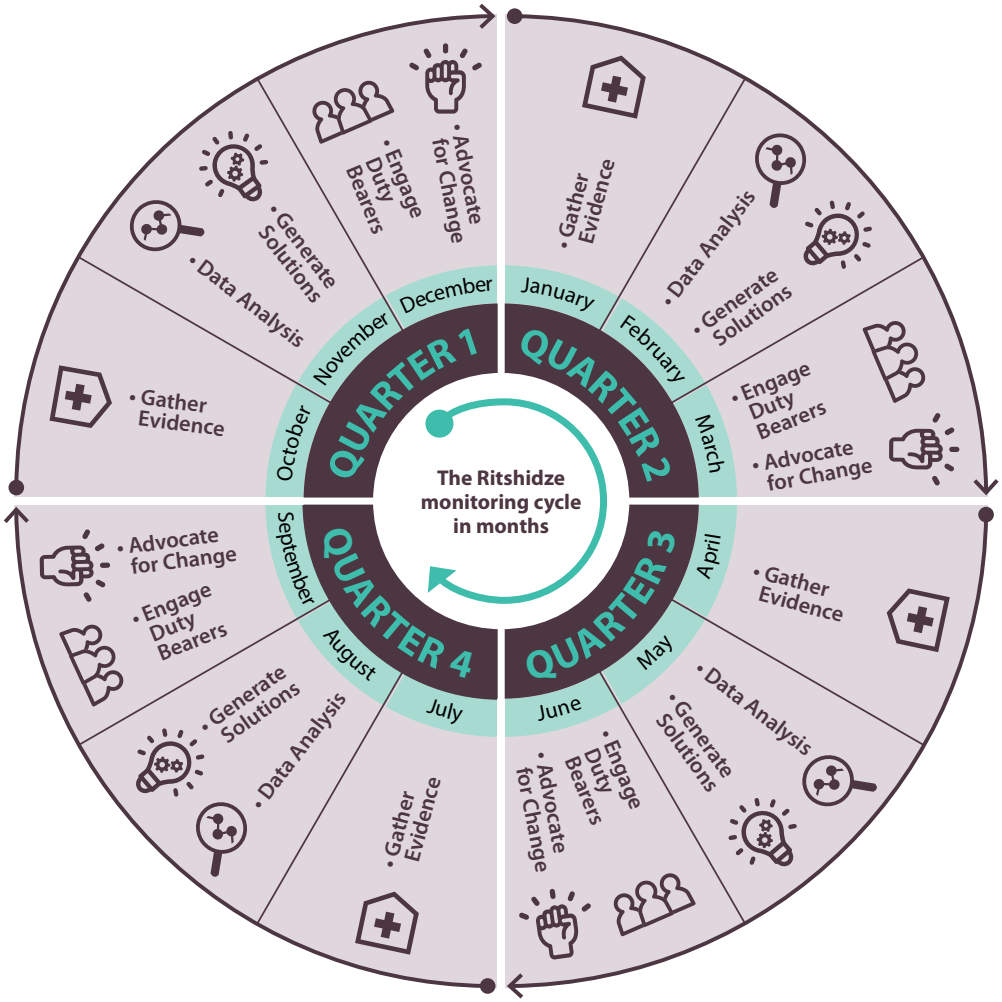
WHO WILL GATHER EVIDENCE?

The 80 teams collecting data will be made up of Ritshidze staff members with support from members from the PLHIV Sector organisations. Each *Ritshidze Community Monitor* has been assigned a set of between 4 to 8 clinics in a particular district that they will work in, depending on distance. Community Monitors are supported by *Ritshidze District Organisers* who oversee and verify their work. At a national level *Ritshidze Project Officers* oversee the functioning of the entire data collection effort.

Community Monitors should never collect data alone. Working as a small team or in a pair will mean that another person is able to verify the data collected. It also makes the data collection easier and means you have another person to reflect with on the challenges found. Where there are members of the organisations on the ground, you will work with them. Where there are no members on the ground, you will work with another staff member.

Before you start work at a facility, you will need to check with your District Organiser to find out who you will be working with. Once you know, follow the steps in the table below.

	THERE ARE MEMBERS *I am working with members*	THERE ARE NO MEMBERS *I am working with another staff member*
 **IN SERVICE TRAINING**	**Yes** — first engage the allocated members in an in service training on the project. Ask your District Organiser for the template presentation you can use for this training.	Not required.
 **DATA COLLECTION**	**Yes** — the members who have been chosen to support you at the facility should join you on the chosen day to collect data using the surveys. You may need to provide transport money for this person to get to the clinic.	**Yes** — you should agree to the date of data collection at the facility during quarterly planning.
 **DATA ANALYSIS**	**Yes** — once you have downloaded the data report you should discuss the findings together with the members in your clinic review meeting.	**Yes** — once you have downloaded the data report you should discuss the findings together in your clinic review meeting.
 **GENERATING SOLUTIONS**	**Yes** — you should generate solutions together for the State of the Clinic report and then feedback to the rest of the branch (where one exists) together. You should get the opinions of the branch and see if there are different or additional solutions. If necessary, you should organise a community dialogue together with the members to gather community-led solutions.	**Yes** — you should generate solutions together for the State of Clinic report.
 **ENGAGING DUTY BEARERS**	**Yes** — you should organise to meet with the Facility Manager and the Clinic Committee together with the member(s) supporting. You will feedback the findings and solutions generated based on your earlier discussions written down in a "State of the Clinic" report.	**Yes** — you should organise to meet with the Facility Manager and the Clinic Committee together. You will feedback the findings and solutions generated based on your earlier discussions written down in a "State of the Clinic" report.
 **ADVOCATING FOR CHANGE**	**Yes** — where the clinic does not fix the challenges, together with the branch you will engage in advocacy to fix the problem.	**Yes** — where the clinic does not fix the challenges, together with the staff member, you will engage in advocacy to fix the problem.



WHEN WILL WE GATHER EVIDENCE?

We are working on a quarterly cycle. This means that you will need to complete each aspect of the Ritshidze cycle four times a year—every three months.

+ **In the first month** of the quarter you will gather evidence. You should expect to spend around two or three days at each clinic. All evidence should be uploaded to CommCare either the same day or day after monitoring (in sites where there are safety issues with carrying a tablet). In 80 selected clinics, you will also gather evidence in the community.
+ **In the second month** of the quarter you will do data analysis and solution generation including having clinic and/or district review meetings. By the end of the month you will have a State of the Clinic report and/or State of the district report.
+ **In the third month** of the quarter you will engage duty bearers on the findings and solutions on the State of Clinic and/or State of the District reports.

You will complete a plan every quarter in line with this timeline that will need to be approved by the national project team before you start your activities.

MY TABLET IS NOT WORKING — WHAT SHOULD I DO?

If you have any problems with your tablet, computer or other equipment please contact the IT team so they can fix it. You can send requests for help via email to helpit@tac.org.za or call or WhatsApp 087 802 7881.

HOW WILL WE GATHER EVIDENCE?

The methods used to collect data will be through observations, interviews and group discussions which will be guided by different surveys designed for specific types of individuals. These surveys contain the key questions that are relevant for each type of person interviewed.

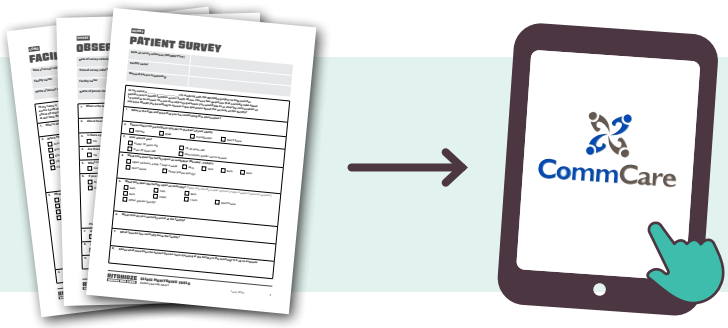
Data will be captured in two ways: either using an online survey through an app called "CommCare", or using a paper survey and filling it in by hand.

1. **Collect using the online surveys:** All Ritshidze Community Monitors will be provided with a tablet with access and logins to the CommCare app. This is where all the Ritshidze surveys can be found. Where possible and safe to do so, you should use the tablet at the clinic or in the community to directly capture data into the surveys.

2. **Collect using the paper surveys:** For clinics or communities where it is not safe to carry a tablet, and for members of the PLHIV Sector supporting you, there are paper surveys. These surveys should be filled out by hand. All paper surveys should be collected at the end of the monitoring activity by the Community Monitor and uploaded into the online CommCare app.

REMEMBER

If you collect data using paper surveys, make sure everything is uploaded into CommCare afterwards.



DATA COLLECTION VERIFICATION & STORAGE

It is critical that data collected in the project is captured accurately, effectively and stored safely—and people's private information is not disclosed without consent. Members supporting data collection are required to provide all paper surveys to the Community Monitor after each activity. After Community Monitors receive paper surveys, they should be verified to check all the information is in order—accurate, clear and easily understandable, and complete with all questions answered. After the Community Monitor captures the paper tools into CommCare—a password protected online system—paper surveys should then be destroyed.

wOnline surveys are then verified by the system itself. CommCare is designed to help you upload everything correctly into the system, without missing any data. For example, you will not be able to submit a survey that is incomplete. If you have not added an answer to a question, you will not be able to move on to the next question. This helps us to not submit partially completed surveys, or accidentally miss an answer. There are options like *"none of the above"*, *"don't know"* or *"prefer not to answer"* for when someone does not know the answer. Once the submitted, CommCare will help us identify any anomaly or information outside the overall pattern that may need to be verified.

GETTING INFORMED CONSENT

You should never force someone or otherwise coerce them to share information in a survey, meeting or testimony.

WHAT IS INFORMED CONSENT?

Informed consent refers to giving people all the information they need to decide if they want to answer your questions or not ***before*** you interview them. This means that they will need to know:

1. Who you are and why you want to talk to them
2. What kinds of information you want and what you will do with it
3. That participating is completely voluntary and they can skip or refuse to answer any questions
4. That we will never share their name or personal information unless they give us permission to do so

WHY IS IT IMPORTANT?

It is very important to get informed consent from people you will be interviewing because under no circumstances do we want people to feel forced or that they must answer our questions. Informed consent is critical in building trust between you and the person you are interviewing.

SAMPLE SCRIPTS FOR YOU TO USE

We have written a few example scripts that you can use to get informed consent from the patients and facility staff that you will be interviewing. Once you get more comfortable, you don't have to read the script word for word, however, you must still cover the major points above.

Informed consent script — patient surveys
Hi my name is _____, I'm working with the Ritshidze project to help monitor patient care in health facilities across South Africa [OR STATE NAME OF PROVINCE OR DISTRICT]. The purpose of the Ritshidze project is to find out if patients face any challenges in accessing health services so that we can raise these challenges with duty bearers and hold them accountable to fix them. I have a few questions that normally take about 10 minutes to answer. You can also skip any questions or stop the conversation at any time. Would you be willing to answer a few questions about the services at this facility?

Informed consent script — facility manager surveys
Hi my name is _____, I'm working with the Ritshidze project to help monitor patient care in health facilities across South Africa [OR STATE NAME OF PROVINCE OR DISTRICT]. The purpose of the Ritshidze project is to find out if patients face any challenges in accessing health services so that we can raise these challenges with you and other duty bearers in order to fix them. I have a few questions that normally take about 30 minutes to answer. You can also skip any questions or stop the conversation at any time. Would you be willing to answer a few questions about the services at this facility?

Informed consent script — individual testimony

In general, we will not be asking for people to give their names, except for the individual testimony form. The informed consent process is a little longer for this form because we want people to understand that they can (but do not have to) give their name and they can change their mind about sharing their story publically at any time. Script below:

Hi, my name is _____, I am working with the Ritshidze project to help monitor patient care in health facilities across South Africa. The purpose of the Ritshidze project is to find out if patients face any challenges in accessing health services so that we can raise these challenges with duty bearers and hold them accountable to fix them. Today we are talking to community members to collect people's stories about their experiences accessing health services [OR STATE NAME OF PROVINCE OR DISTRICT]. These stories would be used to highlight specific issues patients have had while accessing health services in South Africa. We hope that by bringing people's stories to the attention of the public we can improve the quality of services for patients.

You can give us permission to share your story and name publicly. If you choose to share your story with us publicly the risk is that people would know your story. Or alternatively we can hide your identity and your story will remain completely anonymous. The benefit to providing your experience either publicly or anonymously would be that you could help us to improve the quality of healthcare services for yourself and other people.

If you do give us permission to use your name we ask that you sign in the correct box below as an acknowledgment of informed consent.

If you do not give us permission to use your name with your story we will not share your name and we ask that you sign in the correct box below as an acknowledgment of informed consent.

Even after signing, you can change your mind about sharing your story at any time. Please let us know if you do change your mind, or if you have any questions at any time by calling or sending a WhatsApp message or Please Call Me to: 067 428 2075 (Sinazo) or 066 161 1073 (Bellinda).

Are you happy for us to discuss your experience now for about 10 to 20 minutes? We may also want to follow up with you to get more details, to see if you would like to engage in Ritshidze advocacy going forward, or to feedback to you what has happened after engaging duty bearers. Are you happy for someone to get in touch with you to follow up?

Ask the individual to sign this consent form if they agree to have their story shared. There is a box to sign to give permissions to use their story, with and without their names.

GATHERING EVIDENCE IN CLINICS AND OTHER HEALTHCARE FACILITIES

INITIAL CONTACT WITH THE CLINIC

It is important that the facility manager understands the details of the project and the importance of working together. You need to try to build a good working relationship between the data collection team and the clinic. To do this you will need to introduce yourself properly before you start monitoring and get agreement to proceed.

1. Before you go to the clinic you should familiarise yourself with this guidebook which has all the information you need to discuss the purpose and details of Ritshidze.
2. Next you should write to or call the clinic to set up a meeting with the Facility Manager to introduce the project.
3. In the meeting you should describe the background of the project, the quarterly monitoring cycle, and the specific surveys you will take. You should explain that we have permission from the national, provincial and district health departments and show the Facility Manager the MoU and any authorization letters. You should also explain that you will be feeding back findings and potential solutions on a quarterly basis at a time to be arranged and convenient for the Facility Manager.
4. If you have any challenges accessing the clinic don't panic. Send a message to the Ritshidze WhatsApp group to get advice on how to proceed.

WHAT TO TAKE ON YOUR FIRST VISIT?

+ Your Ritshidze identification badge
+ The facility monitoring tools
+ A register (to be completed by all monitors and the Facility Manager)
+ The MoU between PLHIV Sector & National Department of Health
+ Any authorization letters from the Provincial and District Department of Health or the municipality (you can ask your District Organiser for these materials)
+ Don't forget to wear your Ritshidze t-shirt or hoody!

SAMPLE INTRODUCTION MEETING REQUEST LETTER TO FACILITY MANAGER

To: Sister Moletsane, Facility Manager
Per email: facilitymanager@gmail.com
Phone number: 012 345 6789
1st October 2020

Dear Sister Moletsane,

I am writing to you from the Ritshidze project. Ritshidze — meaning "Saving our Lives" in Tshivenda — is a project of the PLHIV Sector made up of the National Association of People Living with HIV (NAPWA), Positive Action Campaign, Positive Women's Network, the South African Network of Religious Leaders Living with HIV (SANERELA+), and the Treatment Action Campaign (TAC). Through this project, that has been endorsed by the Department of Health at national and provincial levels, we are monitoring the state of HIV and TB services being delivered at over 400 clinics across the country.

Our aim is to work together with facilities in order to identify challenges in service delivery that are poorly impacting upon HIV and TB linkage to care and retention rates, and continuing to contribute to new infections. We aim to meet with you to discuss the findings on a quarterly basis and put forward proposed solutions that could be implemented not only by the Department of Health staff, but also the PEPFAR implementing partner at the facility, and/or the clinic committee, to improve services. We hope to partner with you to try to make the facility better. In addition to suggesting our solutions, we hope to hear from you about what you think could improve the facility too and how we can help. In addition to trying to improve services at a local level, we also use the data we gather to influence PEPFAR's annual plans at a national level to ensure that their money is put to best possible use, and ensure that the implementing partners are doing their jobs well.

I am therefore writing to you to request a meeting to further discuss this project and to begin the project with an initial survey. I anticipate this taking around 30 minutes. In addition to speaking to you as the Facility Manager, we would also like to talk with patients accessing services, any adherence club facilitators, and the pharmacist or other person dispensing medicines. Please let me know if you have any further questions that I would be happy to answer.

I look forward to your positive response to set a date for this initial meeting.

Kind regards
Zandile Matsolo
Community Monitor
Ritshidze — a project of the PLHIV Sector
zandile@tac.org.za
012 345 6789

INTRODUCING YOURSELF TO THE FACILITY MANAGER AND OTHER STAFF IN THE CLINIC

"Hi, my name is _____ and I am working with the Ritshidze project. Ritshidze is a project being led by five organisations including: the National Association of People Living with HIV (NAPWA), Positive Action Campaign, Positive Women's Network, the South African Network of Religious Leaders Living with HIV (SANERELA+), and the Treatment Action Campaign (TAC). We are working together on a community-led clinic monitoring project called Ritshidze. Through this project, that has been endorsed by the National Department of Health, we are monitoring the state of HIV and TB services being delivered at over 400 PEPFAR supported clinics across the country. We want to work with facilities in order to identify challenges and put forward solutions that can be implemented by the Department of Health staff, the PEPFAR implementing partner at the facility, or the clinic committee, to improve services. We hope to partner with you to try to make the facility better. In addition to suggesting our solutions, we hope to hear from you about what you think could improve the facility too and how we can help. We also use the data we gather to influence PEPFAR's annual plans at a national level to ensure that their money is put to best possible use, and ensure that the implementing partners do their jobs well.

The monitoring takes place every quarter. For each visit we'd like to ask you some questions as the facility manager that takes between 15 - 45 minutes. In addition other comrades will engage with patients around the clinic, and carry out observation. We'd also like to speak to the data capturer and adherence club facilitator in order to find out some figures around HIV and TB treatment uptake at the clinic and details about adherence clubs, if there are any. Afterwards we will set up a meeting with you in order to discuss the findings and our proposed solutions. We aim to find a time that is convenient for you to monitor and feedback our findings, as we don't want to detract from the important work of providing care to patients. We are here to help and try to work together to fix the challenges that mean people do not access the services they need."

FACILITY MONITORING TOOLS

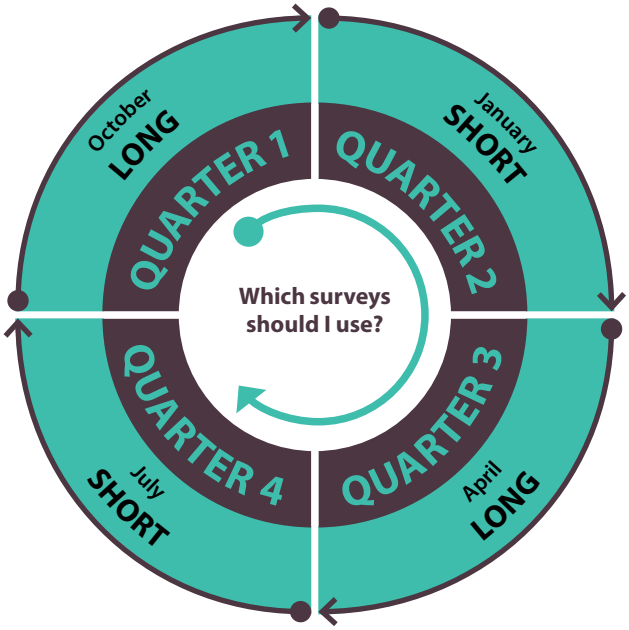
The facility-based tools are divided into different surveys, to be collected through either observations, or talking to healthcare providers or healthcare users. We will outline each in more detail below. It is critical that activists engaging in data collection are very familiar with the tools and understand each of the questions before going to the clinic. A technical guide to the tools as well as the paper based surveys can be found in the TOOLS section of this guidebook.

1. **Observational survey:** Through the observational survey we get a sense of the functionality of the clinic based on the number of people waiting, the size, space, condition and cleanliness of the facility, and whether required procedures and information is visibly on display.
2. **Patient survey:** Through the patient survey we learn about the patient perspective in terms of the length of waiting times, the safety of queueing in the early hours, if there are enough staff at the facility and whether they are friendly and professional, if anyone has left the clinic empty handed recently, and whether there are adequate TB infection control measures in place. After the general questions, there is the following question in the patient survey: *"The next set of questions are for people living with HIV specifically. If that applies to you, can I continue with these questions?"* If yes, move onto the PLHIV section. For those patients who are also willing to answer questions for people living with HIV, we continue on to find out about the functionality and availability of differentiated service delivery options like adherence clubs and external pick up points, whether clinic staff "welcome back" people who have missed appointments or treat them poorly, the accessibility of psycho-social support options, and the level of understanding of the importance of viral load testing.
3. **Adherence Club Member survey:** Through the adherence club member survey we talk to PLHIV who are adherence club members to understand how functional the clubs really are. Do the clubs make it quicker to collect ARVs? Do they get peer support in the clubs? Is there information on the importance of adhering to treatment properly at club meetings? When do they meet and how long do the meetings last?
4. **Facility Manager survey:** Through the Facility Manager survey, we gather information from the perspective of a healthcare provider about the size and adequacy of the staff complement, the role of the PEPFAR implementing partner, infrastructural and space challenges,, potential barriers to quality HIV linkage and retention, accessibility of TB services, and programmes that target key populations, youth and men.
5. **Adherence Club Facilitator survey:** Through the adherence club facilitator survey we deep dive into the specifics of adherence clubs from the perspective of the facilitators to understand if clubs are actually functional: including uncovering the number of clubs, ratio of facilitators and nurses to PLHIV decanted, and topics covered.
6. **Medicines survey:** Through the medicines survey we find out the frequency and type of stockouts/shortages of medicines at the clinic.

DIFFERENT VERSIONS OF THE SURVEYS

Each survey outlined above has two versions—a long and a short version.

+ **LONG:** A longer version that includes all the questions to be taken on the first round of monitoring and then every 6 months after that. The long surveys include questions about less frequently changing information that does not need to be asked on every visit e.g. about the size of the infrastructure and the staff complement. The longer Facility Manager survey can take between 30 — 45 minutes.
+ **SHORT:** A shorter version that includes a subset of questions to be taken in the alternating 3 months. The short surveys are much shorter and quicker to carry out. They include information that can change regularly e.g. about medicine stockouts, cleanliness and staff attitude. The shorter Facility Manager survey can take between 10 — 15 minutes.



WHICH PATIENTS SHOULD YOU INTERVIEW AT THE CLINIC?

Each quarter the monitoring team should aim to collect at least 15 patient surveys that result in data from people living with HIV being collected. You should speak to patients of different genders and ages. You should speak to patients in all areas of the clinic including the waiting area and the chronic queues. Not everyone will be living with HIV in the clinic, and, some people living with HIV will not want to disclose their status to you by agreeing to answer the HIV section.

This means you may interview several patients who say no, when you ask *"The next set of questions are for people living with HIV specifically. If that applies to you, can I continue with these questions?"* If yes, move onto the PLHIV section. The team of monitors should keep collecting patient surveys until you reach 15 people living with HIV. If the clinic is very small and there are not enough patients to interview, continue until you run out of people and explain in the Reflection Form.

CHECKLIST FOR PREPARING FOR YOUR VISIT TO THE CLINIC

- ☑ Go through the monitoring tools and **make sure you understand all the questions**. If you get stuck, ask another Community Monitor, your District Organiser, or a Project Officer for help. Prior preparation is critical. You need to be familiar with the surveys and questions, to allow for an easier flow of discussion.
- ☑ Work out who will be in your data collection team to monitor the clinic. Ask your District Organiser who you should be working with from a **local branch or members of a PLHIV Sector organisation**. If there are no members and you are working with a staff member, coordinate with them.
- ☑ If you have been given the names of members to work with, go and meet with them. Introduce yourself and the project. **Train them on introducing themselves, informed consent, and the monitoring tools,** so that they understand all the questions too, as well as the role of monitoring and the objectives of the project.
- ☑ Make sure you have **printed enough surveys and a register** for the data collection team. Take extra pens and paper with you. You will need something to lean on to take the paper surveys.
- ☑ Is it safe to take your tablet to the clinic? If so make sure your **tablet is fully charged** to upload the surveys to CommCare at the end of the day.
- ☑ Leave enough time to monitor well. Consider spending **a day or two at the facility** in order to get all the information you need.
- ☑ **Book an appointment** with the Facility Manager ahead of your visit. The questions for the Facility Manager take about 30-45 minutes in the LONG survey, and 10-15 minutes in the SHORT survey.

CHECKLIST FOR DURING YOUR VISIT TO CLINICS

- [x] Make sure to **introduce your team** to the Facility Manager before you start monitoring on each visit.
- [x] **Allocate roles** for each visit. Who will speak to the Facility Manager? Who will interview patients? Who will do the observation survey? Who will speak to the pharmacist? Who will find the adherence club facilitator?
- [x] During your meeting with the Facility Manager, make sure to put your phone on silent and **do not answer calls.** Have a **register ready** for the Facility Manager to sign, the data collection team can fill it out before getting in the meeting to take up less time of the Facility Manager and save time for the questions.
- [x] **Collect data through pictures** of what is happening at the facility, especially of clinic signs, long queues, poor filing systems, dirty facilities, or other poor service you want to highlight. There is more information on what pictures to collect, what makes a good picture, and how to submit your pictures later in the guidebook.
- [x] After you finish all the surveys and before you leave the facility—meet with the data collection team in order to check all the surveys were completed properly and to **consolidate what you have learnt**. You should use this time to fill the reflection form, discussed later in the guidebook. If it is safe to carry your tablet to the facility, and you do not have to travel a long distance home, try to upload all the paper forms online on your tablet before you leave that day.
- [x] Make sure that everyone involved in doing the monitoring **signs a register**, including the Facility Manager. You will need this for finance and verification purposes.
- [x] **Develop a database of key contacts** of the facility and implementing partner staff at the facility including: the Facility Manager, the adherence club facilitator, the pharmacist, and the chairperson of the clinic committee.

GATHERING EVIDENCE THROUGH PICTURES

Photographs are very important as we collect data at facilities. A photograph can tell a thousand words and provide very powerful evidence. Below we outline what type of pictures you should try to capture during facility monitoring—and how you should share these with the team.

WHAT MAKES A GOOD PHOTOGRAPH

- [x] The photo should **tell a story** without needing a long caption i.e. *a long queue at the door of the clinic, people standing without a seat, a big pile of patients files in the hallway, toilets that have out of order signs, or are extremely dirty and unusable.*
- [x] The photo should make you **feel** something—are you outraged or angry looking at it?
- [x] Try to take a **variety** of different shots of a single situation to tell the full story—*e.g. wide-angle shots of the whole scene, shots from up high, down low, zoomed-in details… all these combined tell the full story.*
- [x] The photo should be **well lit**—we should be able to clearly see what is happening
- [x] The photo should **not be blurry**—you should wipe your camera lens every day to make sure it is clean before taking pictures and hold the camera still.
- [x] The view of what you are taking a photo of should **not be blocked**—make sure your finger is not over the lens and someone is not standing in the way (where possible)
- [x] You should take **lots of pictures**—invest in learning what works and what does not!

DOS AND DON'TS OF WHAT PICTURES TO TAKE AT THE CLINIC

DO TRY AND GET:

1. Do get a picture of the facility name

2. Do get shots of signs outside the clinic

3. Do get shots of people waiting in the queues

4. Do get photos of other areas of the facility

5. Do get pictures of the filing system

6. Do get photos of the dysfunction, dirty facilities, and things that are broken or in bad condition

7. Do get photos of data collectors doing observations or interviewing patients—ask first!

8. Do get photos of closures or physical distancing measures due to COVID-19

9. Do get photos of meetings—ask first!

DON'T GET:

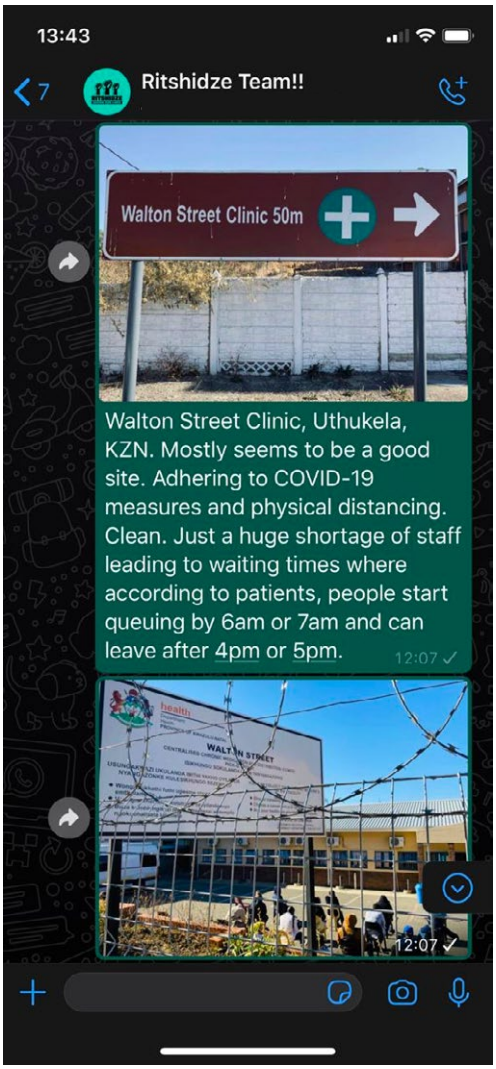
1. Don't get blurry pictures

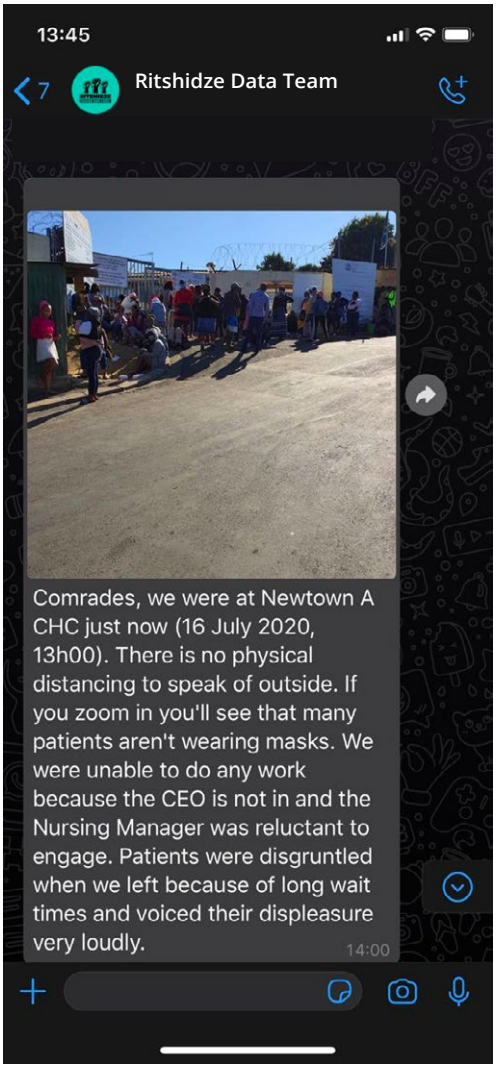
2. Don't take pictures of signs too close

3. Don't take pictures too far away or with objects in the way or staff members posing
(You can take pictures with data collectors in too! These are nice to have. Just make sure to also collect the picture without anyone in for use in other types of communications.)

SUBMITTING YOUR PHOTOS

When submitting your photos please make sure you include a description of what is in the picture, the date it was taken, as well as the clinic name, district and province. If you have collected ten powerful photographs that show different types of problems—for example: the toilet out of order, a broken window, security turning people away, a long queue, the dirty floor, etc—please share all of them. Please make sure to label them all individually. It is important to provide these details in order for us to file them appropriately. Please follow the chart to determine where to share your photos.





ARE THERE PATIENTS IN YOUR PHOTO?	
YES	**NO**
Submit to the data team via WhatsApp on 067 428 2075. We will blur out people's faces so they cannot be identified—and then share them with the Ritshidze WhatsApp group with your update. After you have shared the pictures to the data team and you have received a notification that your picture has been successfully received—delete the photo off your device.	Submit to the Ritshidze WhatsApp group.

PLHIV SECTOR

Before you start work at a facility, you will need to check with your District Organiser to find out whether your site is high, medium or low intensity—and whether there is a branch who has already adopted your facility, or if there is a member close by you will be working in a pair with.

GATHERING EVIDENCE IN THE COMMUNITY

In order to deep dive into the challenges people experience, at certain sites we will also gather evidence in the community. Through this we will capture the experiences and insights of both of those accessing public healthcare services in specific facilities and of those who are not currently interacting with any facility, both of whom have critical information about what is and is not working. In the "community-based" monitoring component, we will gather information directly from community members through the use of door to door engagement and informal focus groups that will focus on specific themes and geography. The community monitoring tools allow us to gather evidence that we do not find in the facility monitoring tools. Information gathered in the community often provides deeper insights as community members are able to speak more freely outside of the facility, and away from the watchful eyes of healthcare providers.

Of the 400 clinics* we are monitoring, there are different levels of intensity—high, medium and low—that outlines how much community monitoring will happen.

LEVEL	# OF SITES	COMMUNITY MONITORING
HIGH INTENSITY	80	In the high intensity sites there will be ***at least three community monitoring activities per month*** carried out by a PLHIV Sector branch together with the Community Monitor. This will mainly be door to door but also include individual interviews and/or informal focus groups. The main purpose is to find additional evidence and to collect recent testimonies from people in the community. All high intensity sites have an existing PLHIV Sector branch working locally. There should be no community monitoring activities organised by the Community Monitor alone—the branch should be working hand in hand with you.
MEDIUM INTENSITY	60	In the medium intensity sites there will be ***four community monitoring activities per year***. These sites have been selected because they are high burden sites with low retention of people living with HIV, based on PEPFAR's own data. This means they are important to monitor. Mostly there are no PLHIV Sector branches local to these sites. Community Monitors can bring members from other areas to support, or focus on organising a focus group which requires less person-power on the ground than a door to door.
LOW INTENSITY	260	In the low intensity sites ***no community monitoring*** will take place, only facility monitoring.

**See the full list of facilities along with intensity grading in the INTRODUCTION section.*

COMMUNITY BASED MONITORING TOOLS

There are three types of community based tools (available in the TOOLS section in full):

1. **Individual testimonies:** This tool should be used if someone you are talking to has a specific personal story about the impact of bad healthcare services. Only fill out the individual testimony tool after you know this to be true. Individual testimonies should not have taken place too long ago—as a general rule only capture testimonies that have taken place preferably in the last six months, or at most in the last year.
2. **Door to door survey:** This survey is similar to patient surveys captured at the facility, however they include more qualitative data collection. We will learn about the patient perspective in terms of the length of waiting times, the safety of waiting outside the facility in early hours, staff shortages and staff attitudes, stockouts and shortages of medicines and health technologies, the functionality and availability of differentiated service delivery options like adherence clubs and external pick up points, whether clinic staff "welcome back" people who have missed appointments or treat them poorly, the accessibility of psycho-social support options, and the level of understanding of the importance of viral load testing. Importantly, during this data collection method, we will be able to engage directly with some people who do not go to the clinic, and get a clearer understanding as to why.
3. **Focus group discussions**: These discussions cover broad categories of topics, but are not exhaustive and will allow for open ended responses and evolving conversations. The topics are aligned to key audiences including: public healthcare users, people living with HIV, people with TB, adherence club members, adolescent girls and young women, young people, men, sex workers, men who have sex with men, transgender people and people who use drugs. The focus group discussions allow us to collect information that cannot be collected through clinic surveys. There is much more qualitative data that will tell us in more detail what the challenges are and potential solutions. Consult your District Organiser and Project Officer before organising a focus group.

INDIVIDUAL TESTIMONIES

Individual testimonies detail a specific person's story about the impact of bad healthcare services on them. This could be a specific story about any kind of poor quality service e.g. their experience of being treated poorly by clinic staff or how they experienced a stockout of their HIV treatment. This survey can be carried out during door to door, at the facility or at community events if a community member has a specific story or testimony they want to give.

Individual testimonies are very important—they provide insights and details not provided through facility monitoring. They allow us to raise the voices of community members struggling to access healthcare services and involve them closely in trying to fix the challenges. Working together with community members strengthens our engagement with duty bearers and further efforts to advocate for change. Decision makers can not ignore that the problems highlighted in the data collection are negatively affecting people's lives.

Individual testimonies are integral to organise impactful public hearings and other types of advocacy (outlined in more detail in the ENGAGE DUTY BEARERS & ADVOCATE FOR CHANGE sections). You can explain to people giving testimonies the possible ways we may raise their story outlined below.

HOW COMMUNITY MEMBERS CAN SHARE THEIR STORIES

Different ways we recommend to community members on how we can raise their stories and how they think the problem can be fixed

1. You could remain completely **anonymous**, and we include your experience in a report that we use to put pressure on duty bearers to fix the challenges.
2. You could join us **in person or virtually** to raise your challenges and proposed solutions in a meeting with duty bearers.
3. You could tell your story at a **public hearing** in front of key decision makers. You do not need to tell them your name.
4. You could share your experience in a **short video** that we publish online and share on social media like facebook and twitter.
5. You could tell your story to a **newspaper** with our support.

AN EXAMPLE OF HOW WE RAISE PEOPLE'S VOICES

The People's COP meeting with Ambassador Birx

In order to present the findings of the first quarter of data collection for Ritshidze and the solutions outlined in the "People's COP"—a public hearing was held to allow community members struggling to access HIV and TB services to raise their concerns and challenges directly to U.S Ambassador Deborah Birx, head of the PEPFAR programme.

This high-profile event was attended by around 100 people including people living with HIV, healthcare workers, young people, sex workers, men who have sex with men, people with TB, and other community members—as well as the leadership of each of the U.S. agencies involved in PEPFAR, the National Department of Health and UNAIDS.

We presented the key challenges we had found during data collection alongside each of our proposed solutions. We had powerpoint slides that showed the analysis of the data, people's quotes, and pictures.

For each challenge we had 4 or 5 people ready and waiting to tell their own personal story. We had collected these stories through door to doors across the country. It was difficult for the duty bearers to ignore the impact of these challenges on people's lives as they came directly from the people experiencing them. By holding a meeting the day before to verify all the stories, we were able to organise people so that their testimonies were impactful and clear. We knew what everyone was going to say.

In addition, we printed some of the photos collected during the data collection on big boards in order to showcase the dysfunction at clinics. We put these up across the room so no-one could miss them. The event pushed the voices of grassroots people living with HIV, young women, and communities of key populations into PEPFAR discussions that too often focus on numbers and targets instead of people and lives.

AN EXAMPLE OF HOW WE RAISE PEOPLE'S VOICES

Meet Thakane

Thakane is living with her only son in Welkom, South Africa. One day when she arrived at the clinic, she was told that her usual HIV medicines were out of stock. Instead she was given alternatives that were difficult to take and gave her many side effects.

It shouldn't be this difficult to get the treatment you need to survive. Yet, the reality is, Thakane is not alone. All over South Africa, clinics are facing shortages and stockouts of HIV and other medicines that put people's health and lives at risk. It doesn't have to be this way.

After more than six months without her medicines, activists from TAC who were monitoring the facility found out and intervened on behalf of Thakane. The activists didn't take no for an answer. The authorities had no choice but to listen and they found the medicines Thakane needed the very next day.

You can watch Thakane's story here: https://healthgap.org/meet-thakane/

Make sure that you explain that we will only raise people's stories with the consent of the individual involved—and this can either be publicly or anonymously. The individual testimony tool provides space for individuals to sign to confirm if they want to raise their story publicly (with their name on) or anonymously (without their name or face being exposed). Those who provide a testimony can change their mind at any time. You must get the consent form signed after capturing the story and give them the information slip to allow them to get in touch if they change their mind.

Make sure that you explain that we will only raise people's stories with the consent and involvement of the individual involved.

INFORMED CONSENT SCRIPT

Hi, my name is _____, I am working with the Ritshidze project to help monitor patient care in health facilities across South Africa. The purpose of the Ritshidze project is to find out if patients face any challenges in accessing health services so that we can raise these challenges with duty bearers and hold them accountable to fix them. Today we are talking to community members to collect people's stories about their experiences accessing health services [OR STATE NAME OF PROVINCE OR DISTRICT]. These stories would be used to highlight specific issues patients have had while accessing health services in South Africa. We hope that by bringing people's stories to the attention of the public we can improve the quality of services for patients.

You can give us permission to share your story and name publicly. If you choose to share your story with us publicly the risk is that people would know your story. Or alternatively we can hide your identity and your story will remain completely anonymous. The benefit to providing your experience either publicly or anonymously would be that you could help us to improve the quality of healthcare services for yourself and other people.

If you do give us permission to use your name we ask that you sign in the correct box below as an acknowledgment of informed consent.

If you do not give us permission to use your name with your story we will not share your name and we ask that you sign in the correct box below as an acknowledgment of informed consent.

Even after signing, you can change your mind about sharing your story at any time. Please let us know if you do change your mind, or if you have any questions at any time by calling or sending a WhatsApp message or Please Call Me to: 067 428 2075 (Sinazo) or 066 161 1073 (Bellinda).

Are you happy for us to discuss your experience now for about 10 to 20 minutes? We may also want to follow up with you to get more details, to see if you would like to engage in Ritshidze advocacy going forward, or to feedback to you what has happened after engaging duty bearers. Are you happy for someone to get in touch with you to follow up?

Ask the individual to sign this consent form if they agree to have their story shared. There is a box to sign to give permissions to use their story, with and without their names.

So what should you capture in the testimony? The testimony should have happened recently—within the last year. Try to find out when a problem occurred before noting down the story. It is difficult for us to advocate for challenges that happened a long time ago. When talking to the individual, find out as much detail as possible using "what, when, who, where, why, how" questions as outlined below. If there is something that seems unclear, or you do not understand, ask more questions to get the full story. Imagine you were reading the story in the newspaper, would it make sense to you? You can capture the story in any language you want to.

WHAT SHOULD YOU ASK WHEN CAPTURING AN INDIVIDUAL TESTIMONY?

WHAT happened?

+ What was the problem?
+ What was the individual trying to get help for at the clinic?
+ What happened instead?

WHEN did it happen?

+ What month(s) did it happen?
+ Did it all happen on the same day?
+ Did the person go back to the clinic several times?

WHO did it happen to?

+ Who was affected?
+ Is it the person you are talking to, or a family member?
+ Who else was involved?

WHERE did it happen?

+ Which clinic?
+ Did the individual go to more than one clinic?
+ Did the individual then go to a hospital?
+ Where did the individual eventually get help?

WHY did it happen?

+ Why did the individual not get the care or treatment they needed?

HOW did things unfold?

+ How was the person impacted?
+ Has there been any long term impact?
+ How did this experience make the person feel?

Use the individual testimony tool (in the TOOLS section) to collect stories. Make sure to print lots of forms to distribute to branch members before a door to door, focus group or facility monitoring in order to ensure you are able to collect any stories that may be raised. People may want to give their testimony privately, so wait until the end of a focus group, for instance, to take the full story when you can talk to them alone.

After you capture the form, work with your District Organiser or Project Officer to translate it into English. It must then be uploaded to CommCare as a photo (as a proof of consent) and as the written up version of the text. It is very important to keep the original paper copy safe and to submit it to your District Organiser at the next monthly reporting session. It will then be given to a Project Officer and stored in a locked space in the head office.

In order to raise people's stories we will need to get back in touch with the individual, and may need to ask more questions. Even if a person wants to remain anonymous, ask if you can have their contact information which will only be used internally for the data collectors to follow-up with other questions.

CAPTURING QUOTES

It is also useful to capture **things that people say (i.e. quotes**,) even if they do not have a full testimony. Always have a book so that you can write down what people say when you hear it. These can be submitted in CommCare in your reflection form and to the data team via WhatsApp on 067 428 2075. Don't forget to tell us the date you heard the quote, and which clinic the person is talking about (including which district and province it is in). You can follow some of the examples below:

"We must arrive at the clinic as early as 4am and wait many hours to collect medicines. The clinic is under-staffed and the nurses are sometimes rude and treat us badly." — 17/6/2020, Zone 20 Clinic, Sedibeng, Gauteng

"I was struggling to adhere and didn't know where to turn for help, so I stopped taking my HIV medicines. Now I'm too scared to go back to the clinic to ask to start treatment again because I know I'll be shouted at by the nurses." — 20/09/2019, Soshanguve Block EE, City of Tshwane, Gauteng

"Sometimes there aren't enough HIV medicines at the clinic. They can give you a few pills and ask you to come back, give you a bottle to share with someone, or even switch you to an alternative. The disruptions and side effects make it hard to adhere." — 25/05/2020, Umlazi X Clinic, eThekwini, KZN

"DOOR TO DOOR" ENGAGEMENT

"Door to door" engagement is when we work as a team to literally go from "door to door" in the community, speaking to people about what challenges they are facing in terms of healthcare and access to HIV and TB services. It helps us to find out more about what the services are like. Often people feel more open to talk about these issues in their own homes, away from the facility setting.

Getting your introduction right influences what information you will gather during the "door to door". For example, if you arrive at a house and ask if the person has experienced any challenges such as stockouts, likely the person will only tell you if they have faced a stockout, and not think anything else is relevant. The door to door survey helps us to introduce ourselves in such a way that we can gather evidence of <u>any</u> challenges. It is important that everyone understands the survey and what we want to find out before doing a "door to door".

Before doing a "door to door: you should ensure that you conduct an ***in service training*** for the branch you are working with. This should include information on the project, what evidence you are hoping to collect during the activity, and how to use the tools including getting consent. There are two monitoring tools to use for data collection during "door to door" engagement: The door to door survey and the individual testimony tool. The in-service training should be held a few days before the "door to door". You should also use the training to plan together where in the community you are going to target. Try to make the training practical—including practicing introducing yourself and practicing using the tools.

It is essential to cover the following in the training:

1. An overview on the Ritshidze project
2. The aims of this activity—what evidence are you trying to collect and why
3. How to introduce yourself
4. How to use the individual testimony tool (including getting consent)
5. How to use the "door to door" survey
6. How to note down all the issues you hear during the activity including quotes.

Ask your Project Officer for the template presentation to use

INFORMAL FOCUS GROUPS

A focus group is a method of engaging specific groups of people in a planned or thematic discussion. In Ritshidze we want to engage the following groups of people:

+ People living with HIV
+ People newly diagnosed with HIV
+ People using adherence clubs or other differentiated service delivery models
+ People struggling to adherence to HIV treatment
+ People with TB
+ Young people
+ Adolescent girls and young women
+ Men
+ Sex workers
+ Men who have sex with men
+ Transgender people
+ People who use drugs

We want to target these specific people to find out in more detail what challenges they face at the clinic, or what are the reasons they do not go to the clinic at all. For example, what do men find challenging about accessing HIV services at Welkom Clinic? Or are services at Inanda CHC friendly to transgender people, or sex workers. By finding out the specifics we will be able to advocate for very clear changes that will help these individuals in the future. For example we may find out that we need to ask for all staff members to be trained on how to treat transgender people and what specific health needs they may have. Or we may find out that more men would be willing to go to the clinic if there were extended opening hours, or a male nurse on duty.

You can use the focus group questions (in the TOOLS Section) as a guide for what to ask in a focus group. These meetings will vary in terms of size and audience depending on which set of questions you are trying to answer. If you want to find out more about challenges affecting youth, you should only invite young people to the meeting and use the youth section of focus group questions. If you want to find out more about challenges affecting sex workers, you should only invite sex workers to the meeting and use the sex workers section of the focus group questions.

ESSENTIAL TIPS FOR ORGANISING A FOCUS GROUP

+ **Invite the right people:** Make sure to invite specific people who are able to answer the set of questions you will be asking for example: people living with HIV, adherence club members, people with TB, sex workers, men who have sex with men, people who use drugs, transgender people, young people, adolescent girls and young women, or men. The people should all use the same clinic. This is mandatory because all the information will be submitted in CommCare afterwards under one site.
+ **Don't invite too many people**: Maximum 8 people are perfect for this kind of meeting. If you invite a larger group it will become too difficult to facilitate and get meaningful inputs from everyone. Some people may not want to share their experiences in a larger group. If more people want to come, hold two meetings instead.
+ **Preparation is everything:** Go through the focus group questions and identify which you will use. Is there anything missing you'd like to raise in addition? Do you understand all the questions to be able to explain to participants if they ask? Print a few copies of the questions for the facilitation team to be using.
+ **Assign roles:** At minimum you will need three people to engage in this activity, one person to facilitate, one person to take notes and manage the audio recording, and one person to deal with logistics (*such as food arrangements and distributing transport money*).
+ **Put chairs in a circle:** This should be an inclusive discussion that everyone can join in. Instead of a school room style set up, put chairs in a circle instead.
+ **Start the meeting promptly**: Arrive early to the venue. Start the meeting on time. A late start wastes everyone's time and may mean you will be rushed in getting answers to the questions as the discussion gets going. If for any reason you are delayed, be sure to let the participants know.
+ **Turn your phone off or on silent**: Make sure you turn your phone off and put your tablet on silent mode. Do not check your phone during the meeting so that you are not distracted.
+ **Allow enough time for the meeting**: Make sure to plan enough time for your meeting to take place, allow two hours for a proper discussion. Make sure that the people attending know how long it will take beforehand.
+ **Review the purpose & agenda**: Before you start the discussion, introduce the Ritshidze project and outline the purpose of the focus group and how it will run. Don't forget to encourage people to provide lots of information. Explain that everyone should speak through the facilitator by raising their hand, and that only one person should speak at a time.
+ **Be flexible**: Occasionally issues come up that are important and can alter the discussion. Allow the discussion to continue if useful information is being provided.
+ **Thank people**: Take a moment to thank everyone present for attending the focus group and making it a success, and thank those who helped to organise the meeting.
+ **Record the discussion**: Community Monitors should record the focus group discussion on your tablet. This will help us keep a record of what was discussed and create a transcript. Make sure your tablet is fully charged, and ask permission from the focus group attendees before recording. You can let attendees know ahead of time that you will be recording the discussion so they understand. The recording will be for internal use only and not be given to anyone outside the project.
+ **Get stories:** If people in the focus group seem to have an individual testimony, ask to sit with them afterwards or at a later time to capture their full story. Use the individual testimony tool for this. Make sure you print enough individual testimony forms for use at the focus group. Ensure all stories are uploaded in CommCare after the focus group.
+ **Write a transcript:** Listen back to the recording to write down a transcript of everything that people said. A transcript is a "word for word" account of the discussion. You'll need to listen to the recording several times to capture everything. Listen back to it when you finish to make sure it is all captured. Your District Organiser can assist in translating this into English. This should be typed up and submitted in CommCare in the "Community Monitoring" folder. After you have successfully uploaded the transcript, you must delete the recording from your device. Don't forget to also upload any stories you collect. You should try to do this within a few days of the focus group.

USING TECHNOLOGY TO CAPTURE DATA

In order to streamline the monitoring process we will be using technology to gather evidence. The system—"CommCare"—will allow you to capture the survey responses into the tablet that you have been provided with. At the end of each facility monitoring, all information collected on paper surveys must be uploaded into CommCare. For clinics where there may be a safety concern with bringing a tablet to the facility, or for community monitoring information that may be substantial in volume, the information can be uploaded to CommCare the following day. By uploading information in a timely manner, it will allow the national project team to track site visits and analyse findings quicker.

SET UP AND INSTALLATION

Step 1: Download

Download the "CommCare" app from the Google **Play Store** onto your tablet or phone. You will need to be connected to Wifi or have your mobile data switched on to do this. Once you find it press **Install.** If there is not enough space to download the app please delete some of your other apps or pictures to make room.

Step 2: Finish installing

Please allow Commcare to access your location and photos. You will then be prompted to either enter an installation code or scan a barcode. Please select **Enter a Code** to finish installing the app and load all of the forms. Ask a Project Officer for the latest app code.

Step 3: Set up your tablet

Please set your tablet to the following settings:

a. Go to **Settings**, then click **Display**, then find **Sleep**, and set to **5 minutes**. This will make it so your screen does not go black until after 5 minutes of inactivity.

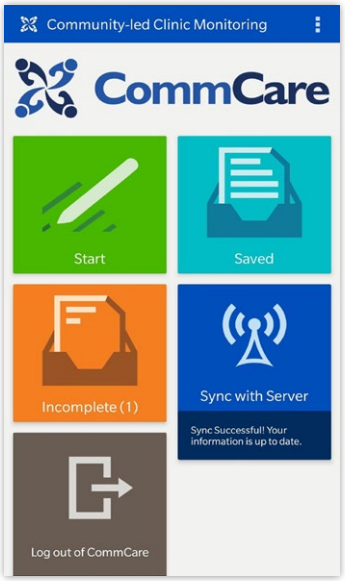
b. Go to **Settings**, then to **Secure Lock Settings**, and set to **5 minutes**. This will make it some your tablet will not lock for 5 minutes.

Step 4: Log in

You will have been given a permanent login username and password for data collection

COLLECTING DATA

Once you are logged in to CommCare you will see several menu options:



START MENU For collecting all data. Here you will find all the forms you need to complete including for observation, patients, facility managers, adherence club facilitator, data capturer, individual testimony, door to door, and focus groups.

SAVED MENU This is where all of your completed forms will be stored on your device. In this folder you can filter to look at the forms you have completed and sent, completed and have not been sent yet, and are incomplete.

INCOMPLETE MENU This is where all of the forms that you started but did not finish will be stored until you can go back and finish them.

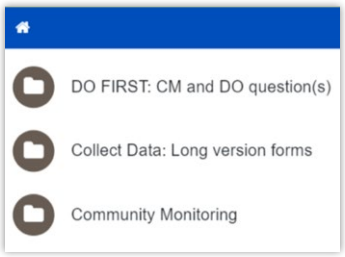
SYNC WITH SERVER MENU You will click this menu in order to upload all of your data to the main server for safe-keeping after data collection.

LOG OUT MENU *(grey menu at the bottom):* This is where you will log out.

To collect data click the **Green Start Menu.**

When you click the start menu you will see several options depending on what round of data collection the project is in. Data will be collected 4 times a year: Twice a year we will be using "Long-versions" of the forms and twice a year we will be using the "Short-versions" of the forms. You will only have access to the correct forms if you update your app before data collection and so you **MUST UPDATE** your app before every round of data collection.

During data collection periods when you will be using the "Long-version" forms you will see:

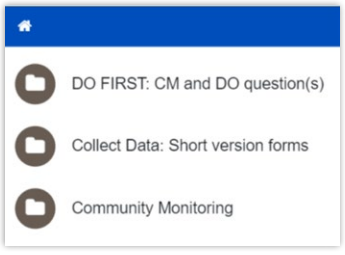


DO FIRST: CM/DO question(s): This folder contains a short survey (1 or 2 questions) that you should answer once before you begin data collection for the quarter.

Collect Data: Long version form: This folder contains the LONG version facility monitoring tools that will need to be completed for every facility every 6 months.

Community monitoring: This folder contains all the community monitoring tools including the individual testimony form, the door to door survey, and the focus group form.

During data collection periods when you will be using the "Short version" forms you will see:



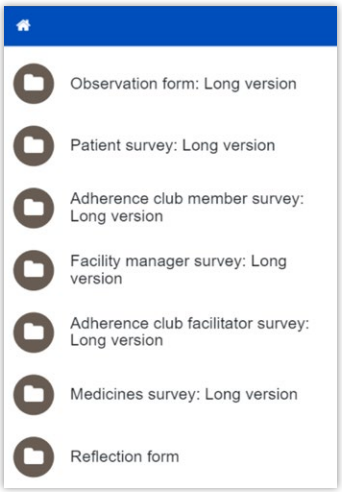
DO FIRST: CM/DO question(s): This folder contains a short survey (1 or 2 questions) that you should answer once before you begin data collection for the quarter.

Collect Data: Short version forms: This folder contains the SHORT version (version 2) facility monitoring tools that will need to be completed for every facility in the alternating 3 months (*between the 6 month data collection periods*).

Community monitoring: This folder contains all the community monitoring tools including the individual testimony form, the door to door survey, and the focus group form.

Click through each of the folders and look at the forms. Some details about the forms are provided below. You will find the same forms in the **LONG version** and the **SHORT version** data collection folders. But the forms will have slightly different questions depending on which round of data collection you are engaged in.

In the **LONG version** and **SHORT version** folders you will find:



An **observation form** that you will fill out when you arrive at the facility. You will answer these questions by walking around and observing what is happening at the facility.

A **patient survey** that you will fill out by talking to patients who are in the waiting areas.

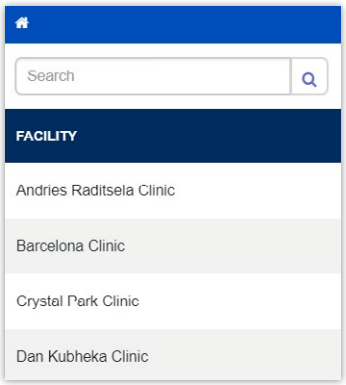
An **adherence club member** survey that you will fill out by talking to people living with HIV who are members of adherence clubs.

A **facility manager** survey that you will fill out by talking to the facility manager.

An **adherence club facilitator** survey that you will fill out by either talking to an adherence club facilitator or to the facility manager depending on who can answer your questions.

A **medicines survey** that you will fill out by either talking to the pharmacist, assistant pharmacist, or facility manager depending on who is available at the clinic to answer your questions.

A **reflection form** that you will fill out once at the end of the day after you have completed all other parts of data collection. This form will ask you to reflect on the most important things that you learnt during the day. (*We will discuss this form more in the ANAYLSE THE DATA section*).

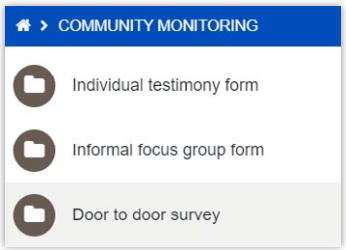


Every form that you click on will be linked to the **facility that you are working in**. When you click on a form you will be asked to verify for which facility the form applies. Find the facility name on the list provided and click on it. You will then be prompted to start filling out the questions for that facility. At the end of data collection you should press submit and then your form will automatically be saved as data under that facility.

For example, if you are conducting an observation for Barcelona Clinic you will first click Observation form and then select Barcelona Clinic as shown on the screen to the left:

If you cannot see your facilities or have the wrong facilities please contact commcare@tac.org.za

In the community monitoring folder you will find the following forms:



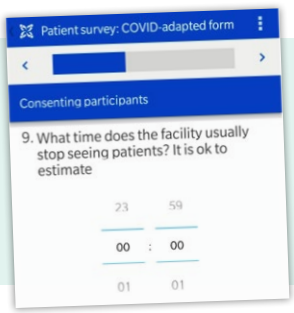
Individual testimonies: This form is where you will upload individual testimonies. You will be asked to upload photos of the actual individual testimonial form too.

Informal focus groups: This form is where you will upload your transcripts from focus groups and individual interviews.

Door to doors: This survey is to upload information captured using the door to door survey.

Again, every form that you click on will be linked to the facility that you are working in. When you click on a form you will be asked to verify for which facility the form applies. Find the facility name on the list provided and click on it. You will then be prompted to start filling out the questions for that facility. At the end of data collection your form will automatically be saved as data under that facility.

At different times we may also develop admin surveys for internal use that help us document things like access challenges at the clinics, and the contact details of facility managers, pharmacists, and adherence club facilitators. You can complete these surveys when informed to do so by the national project team.

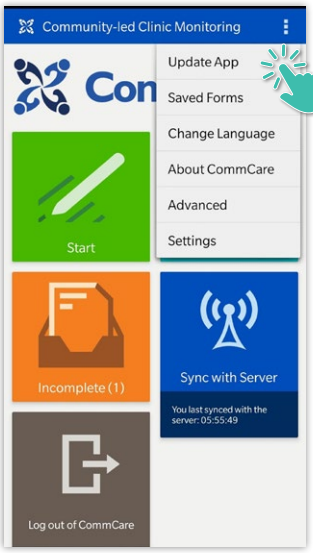


HOW DO I ANSWER QUESTIONS WITH TIMES IN IF THE PATIENT DOES NOT KNOW THE ANSWER?

For some of the questions in CommCare, the answer is a time. For this answer you will not be able to move if the answer is "don't know" or "prefer not to answer" without selecting a time. Please select the time 00.00 if this is the case and move forwards.

00:00 if the answer is "I don't know"

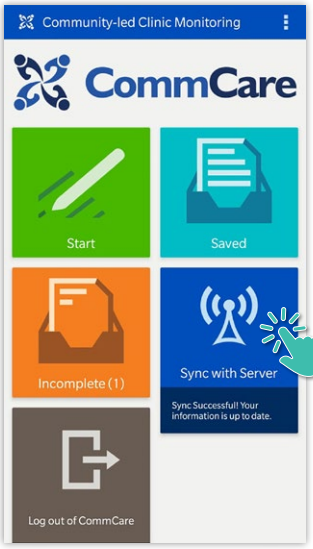
UPDATING COMMCARE



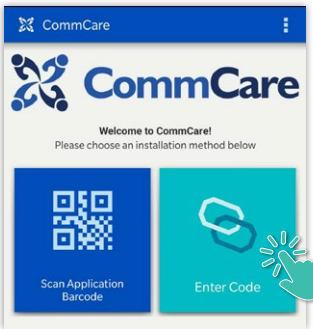
At certain times during data collection you may be asked to update the app so that you have access to all of the newest information and updated surveys.

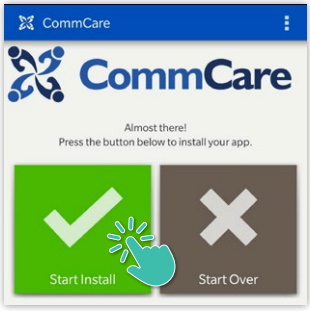
To do this click the three vertical dots at the top of the app and select **Update App.**

The programme will automatically search and upload the newest version. When the download is complete, select the green update button to complete the upgrade process and log you out of the app. Once the app is updated, you will see a message that reads *"App update was successful"* and you can log in again to start using the new app version.



After that you will need to "**Sync with the server**" by pressing the dark blue button on the homepage.





If you are still experiencing problems accessing the latest version you should uninstall and reinstall the whole app from on your tablet or phone. **Only do this if you have been unable to update the app using the instructions above.** The following steps must be followed:

1. Delete the app from the table or cellphone.
2. Open the Google Play Store (the Android App Store) on your device.
3. Search for CommCare
4. Install CommCare—make sure that automatic updates are enabled for the device
5. Once open CommCare on the phone, as you can see below, you can either click on Scan Application Barcode or Enter Code.
6. Type in the latest app code **(ask a Project Officer for the latest code)** into the box and click on "Start Install." Depending upon the size of the application, it could take several minutes for the installation to complete.
7. Log in on the mobile device with the Mobile Worker username and password created on
8. If CM/DO does not have a mobile user account, please create a new CommCare mobile worker in the project.

If you are still experiencing problems accessing the latest CommCare version, please contact commcare@tac.org.za

TOP TIPS FOR TRACKING PROGRESS

You will be able to track progress on all the sites you are monitoring by logging in to the data dashboard. This will show exactly what surveys have been uploaded at each site you are monitoring. You can use this to ensure data collection teams have captured and uploaded everything that is required each quarter. You will only be able to see the sites that you can see on CommCare when uploading surveys. More details on how to use this system can be found in the ANALYSE THE DATA section of the Guidebook.

OTHER PROBLEMS YOU MIGHT EXPERIENCE	
I received an error message	You might see the following message on your phone screen: *"A serious problem occurred while CommCare was trying to download an update (or install your app): CommCare couldn't find the resource with id: commcare-application-profile : Part of your app is not valid."* This message, which can show up upon installation, is often due to a bad internet connection. Try again with better internet access in order to complete the set up. It can also mean you have entered the incorrect login details. Try again making sure that you have entered the correct username and password.
Commcare won't start at all?	If a red X appears on your CommCare icon, the programme may need to be re-installed. Please follow the steps above on how to reinstall.
Can't move forward once you log into the application?	If your screen remains frozen while 'attempting to contact the server' there may be a problem with connectivity. Try again with better internet access.
My application is forcing me to quit, what can I do?	If you are getting an error message, please read the message carefully, try to remember the message or take a screenshot. Contact commcare@tac.org.za and share the image for further assistance.
Help! I made a mistake. I submitted the wrong information to a facility, or submitted information to the wrong facility. What should I do?	Data entry errors can happen. If you have submitted information that you know is incorrect by mistake to a facility, or you have submitted information meant for one facility to the wrong site, make sure you immediately write down all the details of the mistake including the facilities involved, question/information that was wrongly submitted, the survey it came from (e.g. observation, patient etc.) the correct information, and the time and date that this occurred. Contact commcare@tac.org.za with all the details as soon as possible for the error to be logged and fixed.

ANALYSE THE DATA

LOOKING AT THE DATA

REFLECTING AS A TEAM

THE DATA DASHBOARD

INTERNAL CLINIC REVIEW MEETINGS

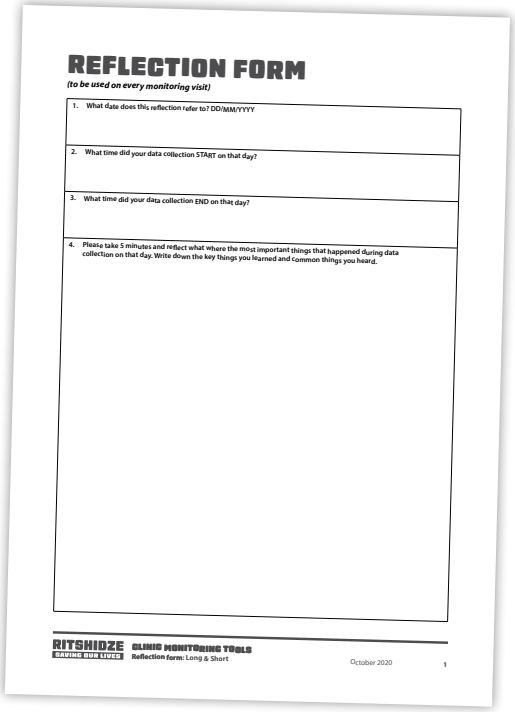
LOOKING AT THE DATA

The next step after collecting data and inputting it into CommCare is to analyse it. Data analysis is the process of looking at the raw data in order to discover trends or discrepancies—and any explanations for these—in order to inform our key findings, final conclusions and any recommendations. The raw data that you have gathered can be used to determine what the biggest challenges are at the facility, what needs fixing most urgently, or if there are any successes.

Looking at the data not just for one facility, but across facilities that are being monitored can be done to assess how a facility is doing in comparison to other facilities. Demonstrating—through data—that a facility is below average can be used to motivate facility managers to make changes.

REFLECTING AS A TEAM: THE REFLECTION FORM

The reflection form is the first tool to begin the process of data analysis after you have gathered evidence at the clinic or in the community. You should complete this form before you leave the facility, or immediately after the community monitoring activity, with inputs from everyone who took part. The reflection form helps us to get a sense of the most important things that happened during monitoring. It is a place to write down the things you want to be fresh in your mind when you get to reviewing the data later in the cycle. You will upload the form to CommCare after it is completed.



REFLECTION FORM

(to be used on every monitoring visit)

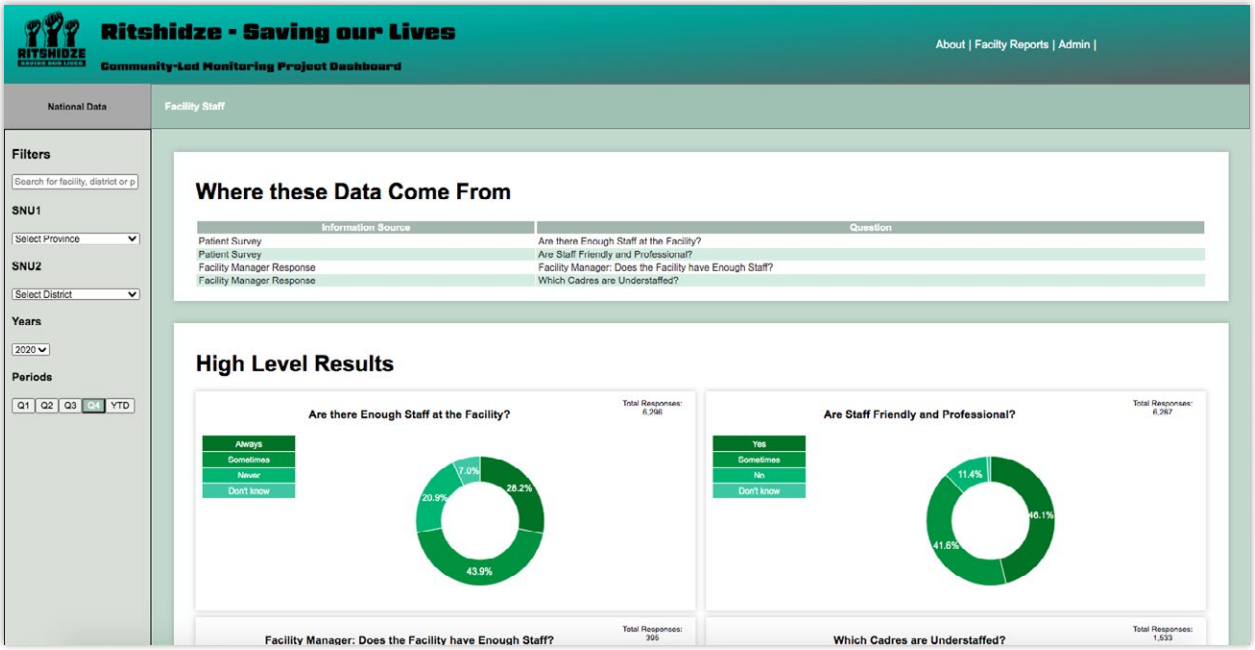
1. What date does this reflection refer to? DD/MM/YYYY
2. What time did your data collection START on that day?
3. What time did your data collection END on that day?
4. Please take 5 minutes and reflect what where the most important things that happened during data collection on that day. Write down the key things you learned and common things you heard.

RITSHIDZE SAVING OUR LIVES CLINIC MONITORING TOOLS
Reflection form: Long & Short
October 2020 1

TRY TO REFLECT ON:

1. **The evidence you gathered at the facility**
   + What are the most important things that you found out during data collection?
   + What are the common things that you heard?
   + What did you see?
   + What were the key challenges?
   + Were there any successes where the clinic is functioning well?
   + Was there anything that needed a rapid response?
   + Were there any problems at the facility that didn't get asked about in the surveys?
2. **Lessons learnt from the monitoring process**
   + Did you have any challenges accessing the facility? How open were they to you?
   + Was it easy to find people to interview?
   + What worked well in the data collection process?
   + Could anything be better about the data collection process?


TREATMENT ROOMS
IQUMBI LONYANGO
FIX OUR CLINICS
SAVE OUR LIVES
#CLINICSINCRISIS
FIX OUR CLINICS
SAVE OUR LIVES
#CLINICSINCRISIS

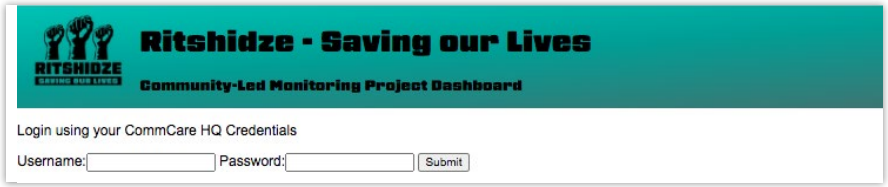


THE DATA DASHBOARD

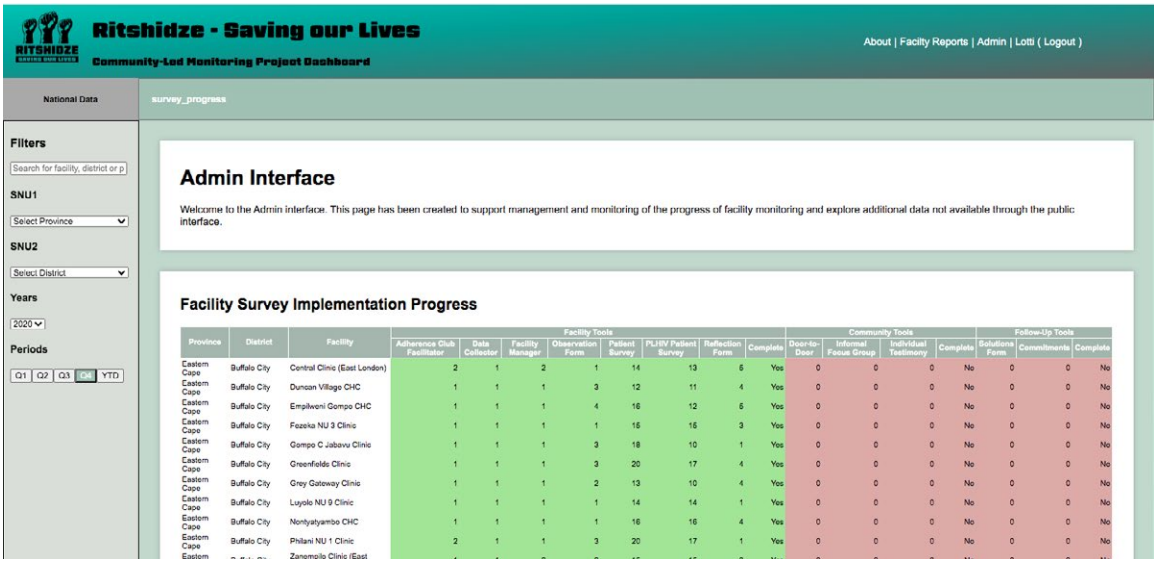
After submitting to CommCare the data will be analysed and appear on the Ritshidze data dashboard. The dashboard takes the data from CommCare and presents it using charts and graphs to make it easy to see changes over time and how the current monitoring effort compares to prior quarters. The dashboard puts critical aspects of the data collection together that contextualises the concerns with an individual facility, but also at the district, provincial and national level. This is the first place to look at the data, which are updated regularly as new data are submitted. The data dashboard is available at data.ritshidze.org.za.

WHO CAN SEE THE DATA DASHBOARD?

The data dashboard is a public resource to be used not only by the Ritshidze staff and members of the PLHIV Sector organisations, but also by duty bearers from National, Provincial and District health departments and PEPFAR agencies (CDC and USAID). It will also be available to activists and the public. Make sure that the data collection team you are working with knows about the dashboard if they are able to access it directly — otherwise make sure you feedback the data analysis to them in your meetings.



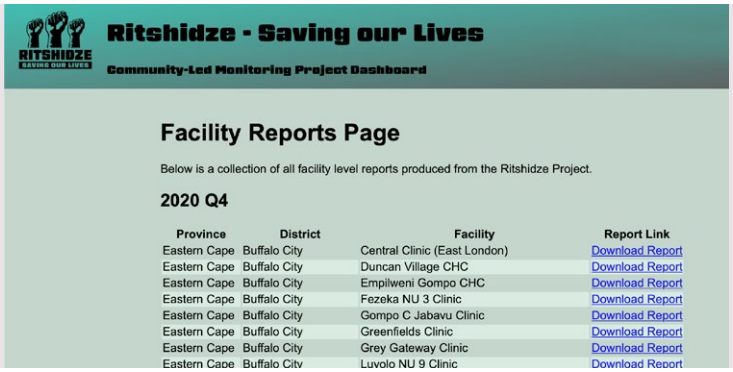
All Ritshidze staff members will be able to login to the dashboard which opens up extra features that the public will not be able to see. This includes the admin interface, where you will be able to track what facility and community monitoring surveys have been uploaded to CommCare for each clinic you monitor, and if the "recommended solutions" and "facility manager commitments" have been uploaded to CommCare (more to come on these in the GENERATE SOLUTIONS and ENGAGE DUTY BEARERS sections respectively).



HOW ARE THE DATA PRESENTED?

Once all the data is uploaded in CommCare, a facility report is generated. These reports are organised into different categories that help us to understand how well the clinic is doing overall. These categories include:

1. Facility Hours and Waiting Times
2. Facility Staff
3. Clinic Conditions and Patient Safety
4. Access to Medicines and Shortages/Stockouts
5. ARV Collection and Access
6. Adherence Clubs
7. Access to Viral Load Testing / Information
8. Confidentiality and Privacy
9. Psycho-Social Support for PLHIV
10. PrEP and DTG-Related Contraceptive Access
11. COVID-19 Disruptions
12. TB Infection Control



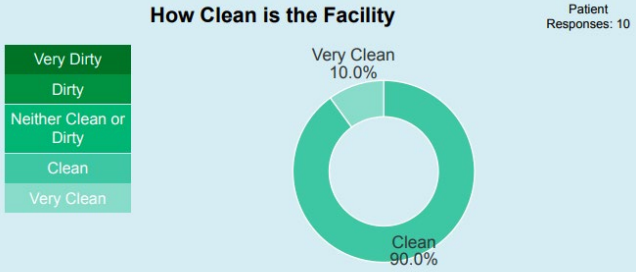
In order to download the Facility report you need to click on the "Reports" page in the top right corner of the dashboard — and then choose the report from the correct facility in the list.

The clinic data reports are 6 pages long and combine data from across the facility based monitoring surveys. At the top of every page you will see the name of the facility, the year, and the quarter (Q1, Q2, Q3, Q4) when we monitored it.

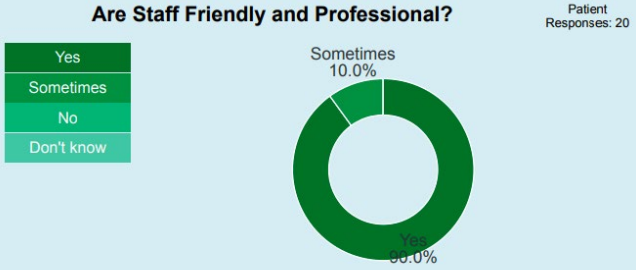
Under each category, data are presented in different ways, including pie charts, bar charts, checkboxes, and single answers like "Yes" or "No", numbers, or times. Let's review each of them individually.

1. PIE CHARTS

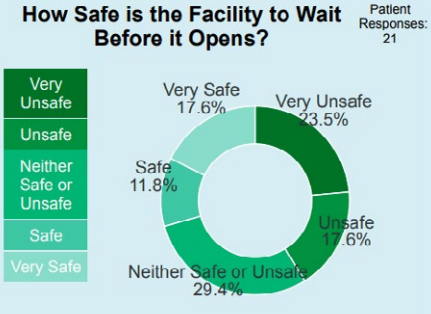
A pie chart is a graph in which a circle is divided into sections. Each section represents a portion of the whole pie. These sections are expressed as percentages (%). Next to every pie chart there is a key explaining what each percentage means. Here are some examples of pie charts you will find:



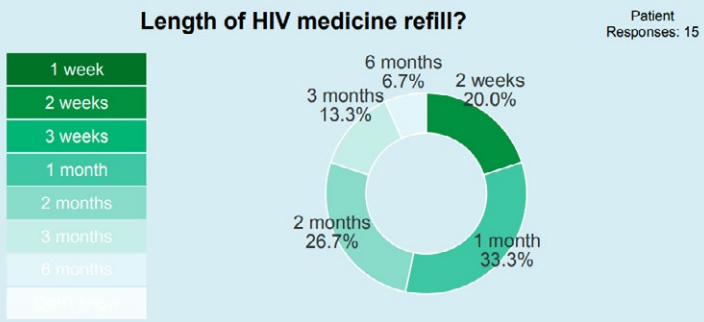
This pie chart answers the question — "How Clean is the Facility". This question comes from the patient survey. As shown in the number of "Patient Responses" in the top right corner — 10 patients responded to this question at this clinic. The key on the left side tells us the possible answers that can be given by patients to this question — Very Dirty, Dirty, Neither Clean or Dirty, Clean, Very Clean. In this case 10% of the patients said the clinic is "Very Clean" and 90% of patients said the clinic is "Clean". When we add that up it equals 100% of the patients.



This pie chart answers the question — "Are Staff Friendly and Professional". This question comes from the patient survey. As shown in the number of "Patient Responses" in the top right corner — 20 patients responded to this question at this clinic. The key on the left side tells us the possible answers that can be given by patients to this question — Yes, Sometimes, No, Don't Know. In this case 10% of the patients said "Sometimes" and 90% of patients said "Yes". When we add that up it equals 100% of the patients.



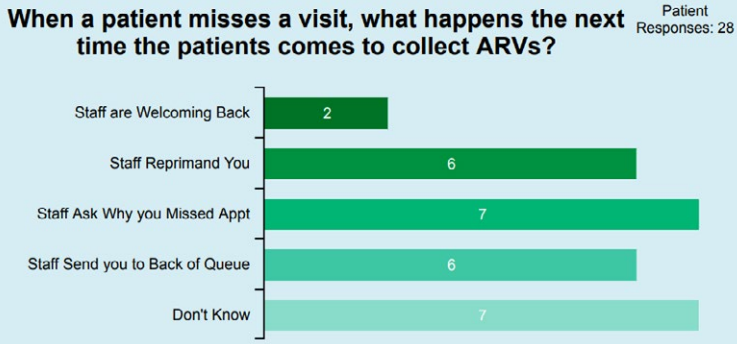
This pie chart answers the question — "How Safe is the Facility to Wait Before it Opens?". This question comes from the patient survey. As shown in the number of "Patient Responses" in the top right corner — 21 patients responded to this question at this clinic. The key on the left side tells us the possible answers that can be given by patients to this question — Very Unsafe, Unsafe, Neither Safe or Unsafe, Safe, Very Safe. In this case 23.5% of the patients said "Unsafe", 17.6% of the patients said "Unsafe", 29.4% of the patients said "Neither Safe or Unsafe", 11.8% of the patients said "Safe" and 17.6% of patients said "Very Safe". When we add that up it equals 100% of the patients.



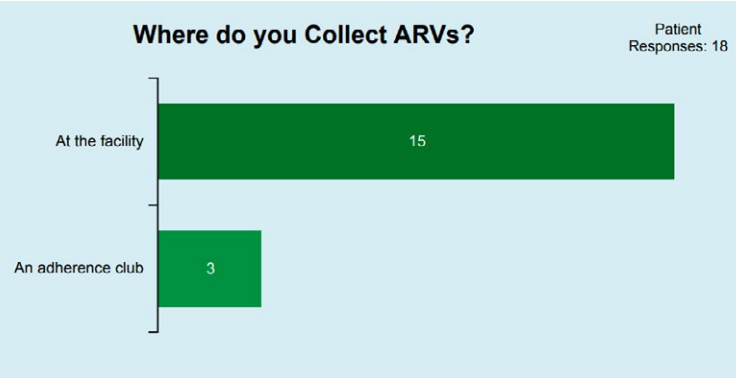
This pie chart answers the question — "Length of HIV medicine refill?". This question comes from the patient survey in the PLHIV section. As shown in the number of "Patient Responses" in the top right corner — 15 patients responded to this question at this clinic. The key on the left side tells us the possible answers that can be given by patients to this question — 1 week, 2 weeks, 3 weeks, 1 month, 2 months, 3 months, 6 months. In this case 20% of the patients said "2 weeks", 33.3% of the patients said "1 month", 26.7% of the patients said "2 months", 13.3% of the patients said "3 months" and 6.7% of patients said "6 months". When we add that up it equals 100% of the patients.

2. BAR CHARTS

A bar chart is a diagram in which the number of responses are represented by the height or length of lines or rectangles. In contrast to pie charts, bar charts show the number of answers rather than percentages. The longer or higher the line is = greater number of responses. The shorter or lower the line is = less number of responses. Find below some examples of bar charts you will find:



This example answers the question — "When a patient misses a visit, what happens the next time the patient comes to collect ARVs?". This question comes from the patient survey in the PLHIV section. As shown in the number of "Patient Responses" in the top right corner — 28 patients responded to this question at this clinic. The bar chart shows us the options patients chose to answer this question: 2 PLHIV say that staff welcome them back, 6 PLHIV say staff reprimand you, 7 PLHIV say staff ask why you missed the appointment, 6 PLHIV say staff send you to the back of the queue, and 7 PLHIV did not know.



This example answers the question — "Where do you Collect ARVs?". This question comes from the patient survey in the PLHIV section. As shown in the number of "Patient Responses" in the top right corner — 18 patients responded to this question at this clinic. The bar chart shows us the options patients chose to answer this question: 15 PLHIV say they collect ARVs at the facility, and 3 PLHIV say they collect ARVs at an adherence club.

3. CHECKBOXES

Checkboxes show the options that were selected by the patients or facility managers, or different observations made by the data collectors. If you selected "yes" to a particular option on the survey, it will be shown by a tick in the box to the left of the answer choice. In contrast, if there is no tick in the box it means nobody selected that option. Checkboxes do not show the number of answers or any percentages.

Facility Manager: Have you had any of the following issues at your clinic because of the COVID-19 crisis?

☑ The clinic has been completely closed for a period of time	☐ We have more restricted hours of operation than usual	☑ We are experiencing more stockouts or shortages of medicines that usual
☐ We are experiencing more shortages of personal protective equipment for staff than usual	☑ We have higher patient wait times that usual	☑ We are operating with fewer staff than usual
☐ We can serve less patients than usual	☐ We can only serve patients at the gate—patients do not enter the facility	☐ Other
☐ None of the above		

This example answers the question — "Have you had any of the following issues at your clinic because of the COVID-19 crisis?". This question comes from the Facility Manager survey. The check boxes show us the options the Facility Manager chose to answer this question: The clinic has been completely closed for a period of time, we have higher patient wait times than usual, we are experiencing more stockouts and shortages of medicines than usual, and we are operating with fewer staff than usual.

Which Cadres are Understaffed?

☑ Doctor	☑ Professional nurse	☑ Enrolled nurse
☐ Enrolled nurse assistant	☐ Pharmacist	☑ Assistant pharmacist
☐ Lab technician	☐ Lay counselors	☐ Linkage officers
☑ Adherence club facilitators	☐ Data capturer	☐ Security guard
☐ Cleaner	☐ General assistant	☐ Don't know
☐ Prefer not to answer		

This example answers the question — "Which cadres are Understaffed?". This question comes from the Facility Manager survey. The check boxes show us the options the Facility Manager chose that are understaffed: Doctor, Professional nurse, Enrolled nurse, Assistant pharmacist, and Adherence Club facilitators.

What patients are offered PrEP? Select all that apply

☑ Adolescent girls/young women	☑ All women	☑ Men who have sex with men
☑ Sex workers	☑ People who inject drugs	☑ Anyone who is sexually active
☐ Other	☐ Don't know	☐ Prefer not to answer

This example answers the question — "What patients are offered PrEP? Select all that apply". This question comes from the Facility Manager survey. The check boxes show us the types of patients the Facility Manager chose who are offered PrEP: Adolescent girls/young women, all women, men who have sex with men, sex workers, people who inject drugs, and anyone who is sexually active.

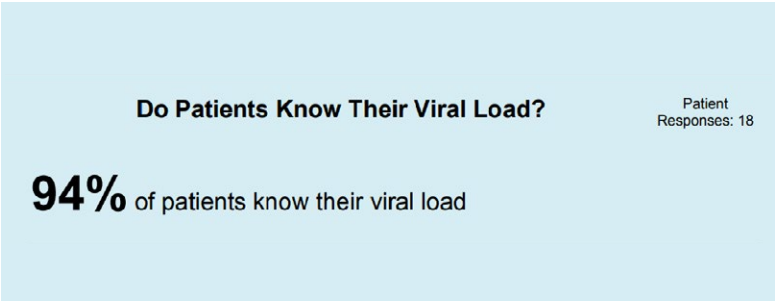
4. SINGLE ANSWERS

Results are also displayed with single answers. In many cases the answers may be "Yes" or "No" answers to a question. In some it can be "Good" or "Bad". In others, it can be an average time, a percentage, or even a number.

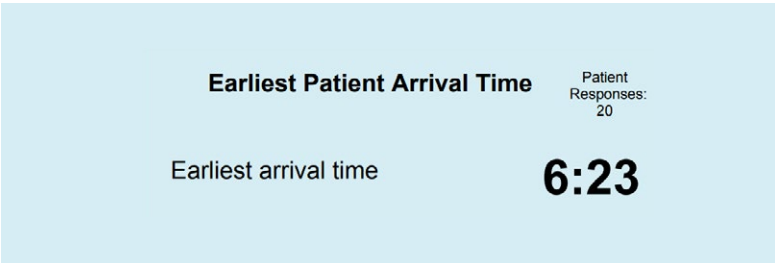
Are Women Who are On or Switching to Dolutegravir-Based Regimens Offered Contraception? Facility Responses:1

Yes

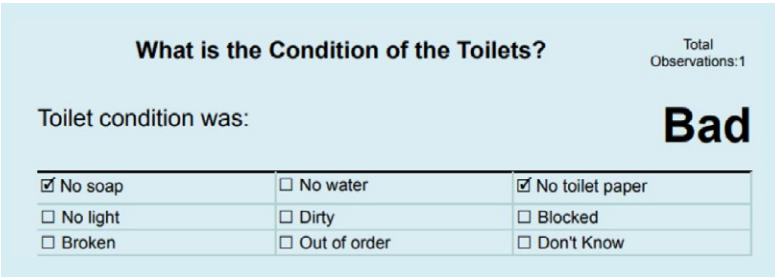
This single answer answers the question — "Are Women Who are On or Switching to Dolutegravir-Based Regimens Offered Contraception?" This question comes from the Facility Manager survey. It shows us that the Facility Manager answered Yes.



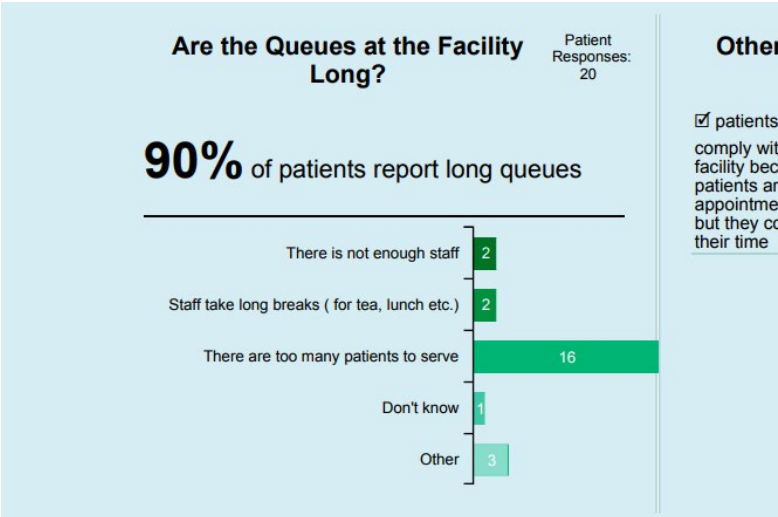
This single answer answers the question — "Do Patients Know Their Viral Load?" This question comes from the patient survey in the PLHIV section. As shown in the number of "Patient Responses" in the top right corner — 18 patients responded to this question at this clinic. It shows us that 94% of the patients who responded said that they did know their viral load.



This single answer answers the question — "What time does the earliest person arrive at the facility?" This question comes from the patient survey. As shown in the number of "Patient Responses" in the top right corner — 20 patients responded to this question at this clinic. It shows us that the average earliest arrival time is 6.23am.



This single answer answers the question — "What is the Condition of the Toilets?" This question comes from the observation survey. It shows us that the condition of the toilets is Bad. The checkboxes then tell us why we said the condition of the toilet was bad — because there was no soap and no toilet paper available.



This example combines single answers, a bar chart, and a checkbox. It answers the question — "Are Queues at the Facility Long". This question comes from the patient survey. As shown in the number of "Patient Responses" in the top right corner — 20 patients responded to this question at this clinic.

The single answer shows us that 90% of patients report long queues.

The bar chart shows us the reasons patients gave for why they thought the queues were long. 2 patients think there is not enough staff, 2 patients think that staff take long breaks, 16 patients think there are too many patients to serve, 1 patient did not know, and 3 patients offered other possible reasons.

The "other" free responses are shown on the right in the checkboxes. If you remember back to data collection — you will remember that if a patient chooses the option "other" that you can type in a response. Whatever you type in that box on CommCare will appear exactly the same on the Facility report.

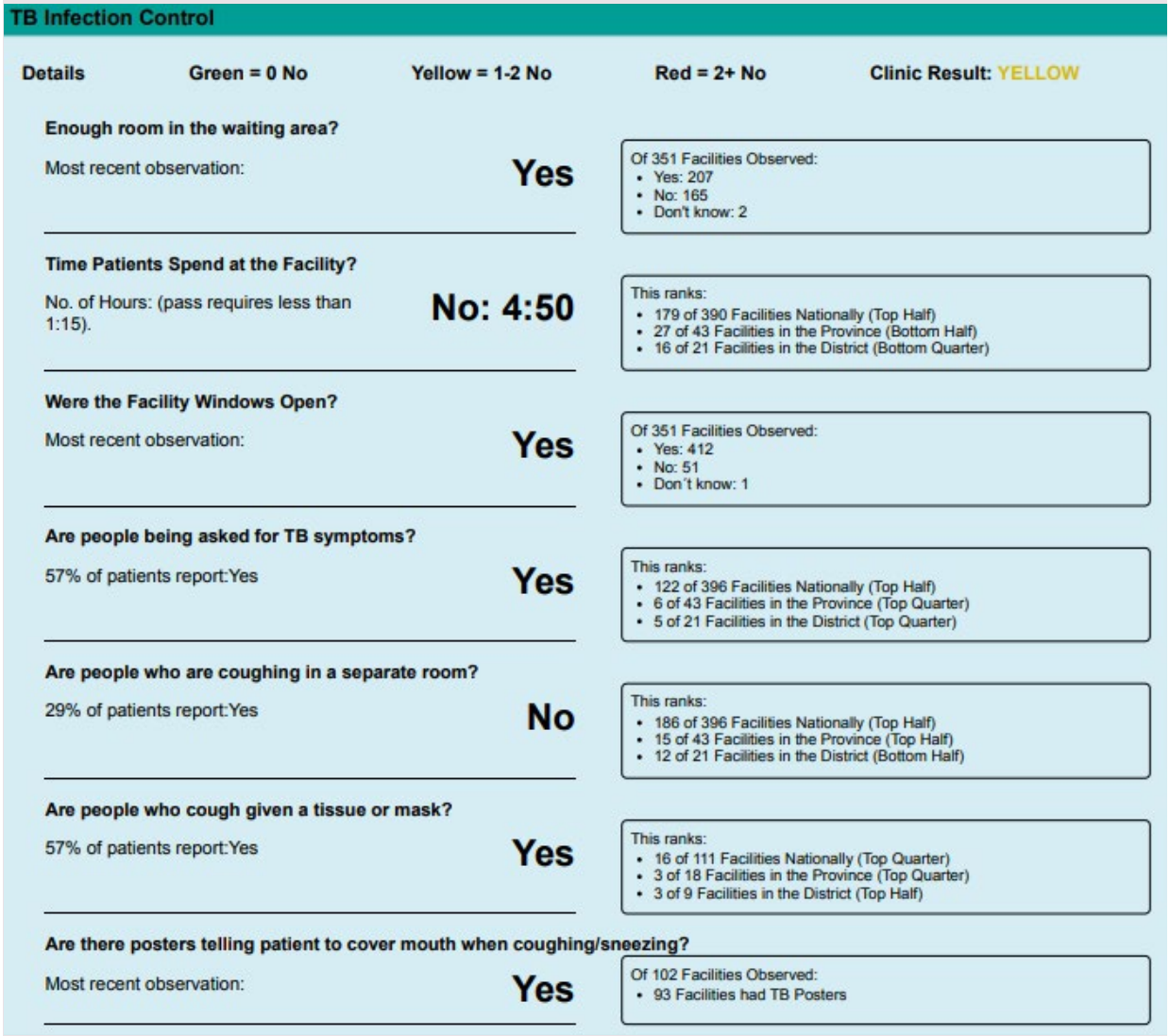
5. THE TB INFECTION CONTROL SURVEY

Finally you will find data presented as a TB infection control survey in the Facility report. The following questions in Ritshidze monitoring relate to TB infection control:

+ Is there enough room in the waiting area? (Observation survey)
+ Is the time spent at the facility under 1 hour 15 minutes? (Patient survey)
+ Are people in the facility waiting area asked if they have TB symptoms? (Patient survey)
+ Are the windows open? (Observation survey)
+ Are people who are coughing separated from those who are not? (Patient survey)
+ Are people who cough a lot or who may have TB given tissues or TB masks? (Patient survey)
+ Are there posters telling you to cover your mouth when coughing or sneezing? (Observation survey)

These are all measures that can be taken to reduce the risk of TB transmission at clinics.

Based on the answers to these seven questions facilities are ranked RED (3+ questions answered "no"), YELLOW (1-2 questions answered "no"), or GREEN (0 questions answered "no"). The TB infection control survey results are auto-generated in your Facility report.



For each of the patient survey questions — if more than 50% of the patients respond yes, the clinic gets a "Yes" score. If less than 50% of patients answer yes, the clinic gets a "No" score.

For the time spent at the clinic — if the average time at the clinic is less than 1 hour 15 minutes, the clinic gets a "Yes" score. If more than1 hour 15 minutes, the clinic gets a "No" score.

Does the Adherence Club provide information about the importance of taking your HIV medicine?

No Data for this Indicator

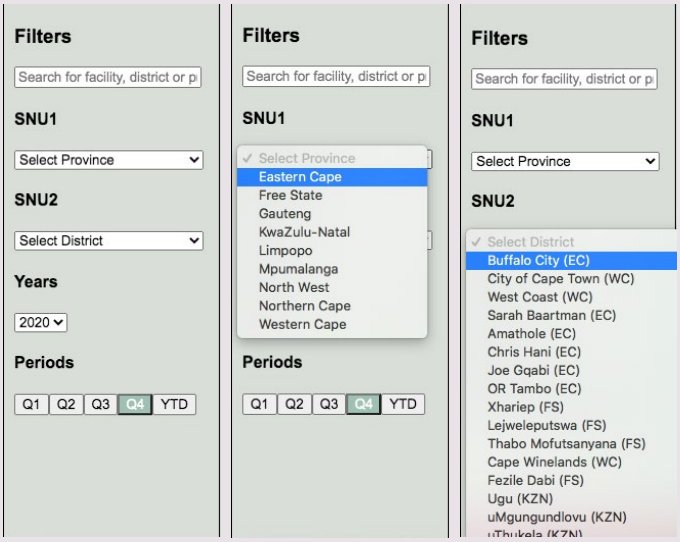
WHAT IF THERE ARE NO DATA?

When a facility does not have information for a particular question, the report will display a NA which means "not applicable", or it will say No Data for this Indicator. This means that in the surveys you have submitted, this question has not been answered.

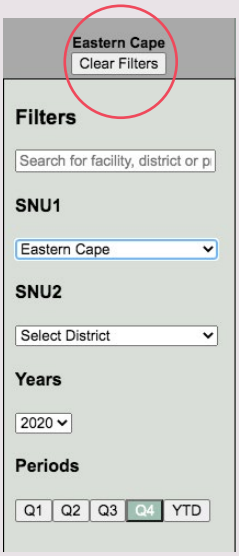
HOW ELSE IS THE DATA PRESENTED ON THE DASHBOARD?

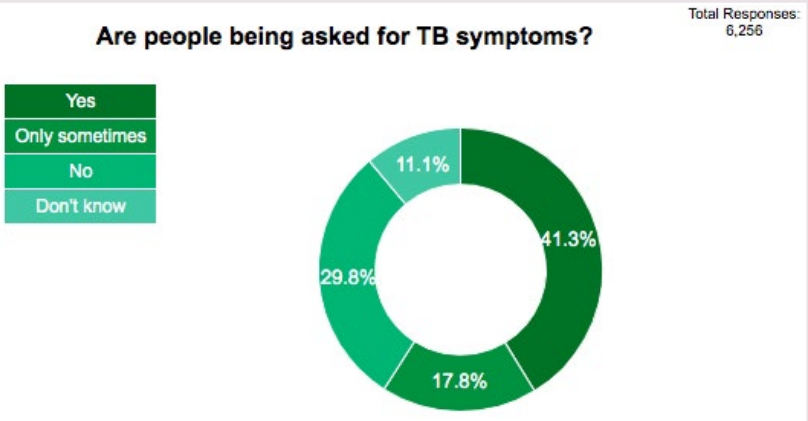
In comparison to the Facility reports, that only look at the data from an individual clinic — you can also look at the online dashboard in order to see data from an individual clinic or clinics across particular districts, provinces or nationally — or see data from different quarters (time periods). The dashboard contains all the same types of charts and graphs as in the Facility reports.

In order to filter by clinic, district and province, or by different monitoring quarters, you can select options in the sidebar.

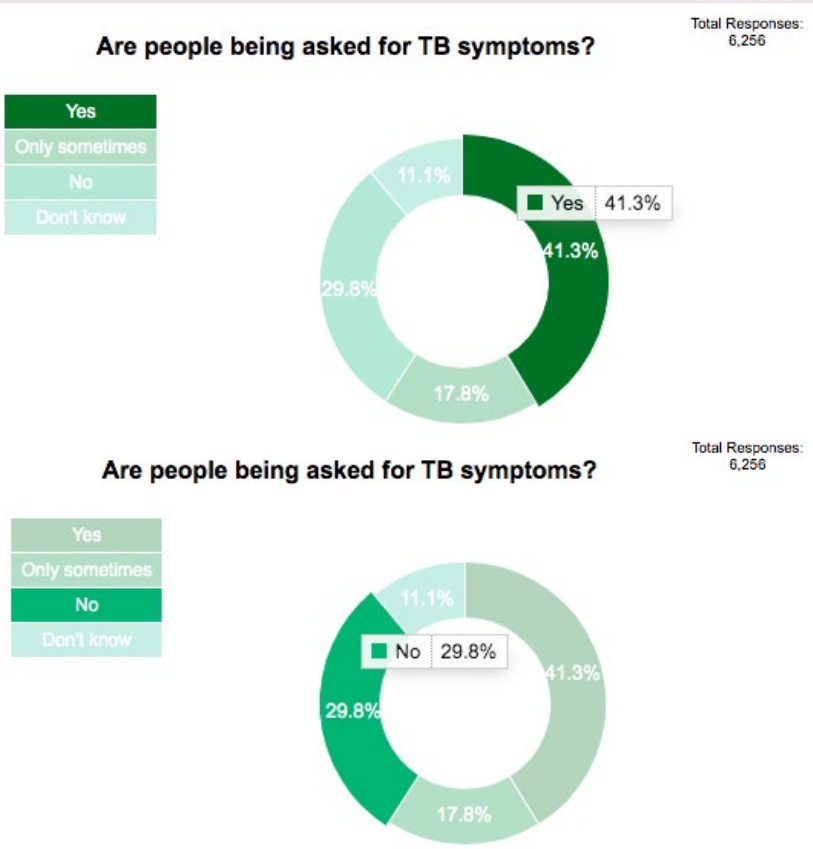


To reset the dashboard after filtering click "Clear Filters" at the top.

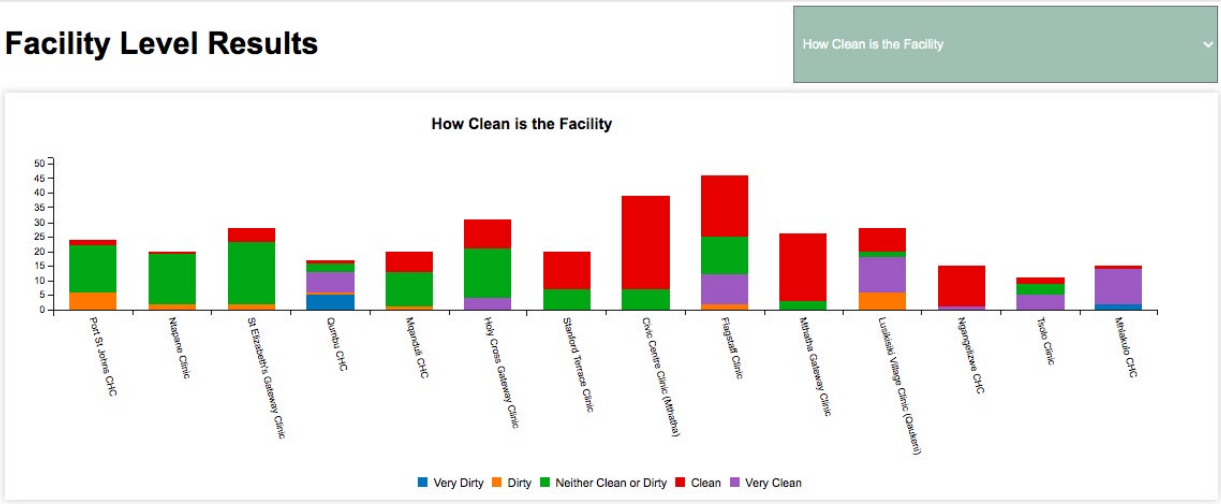




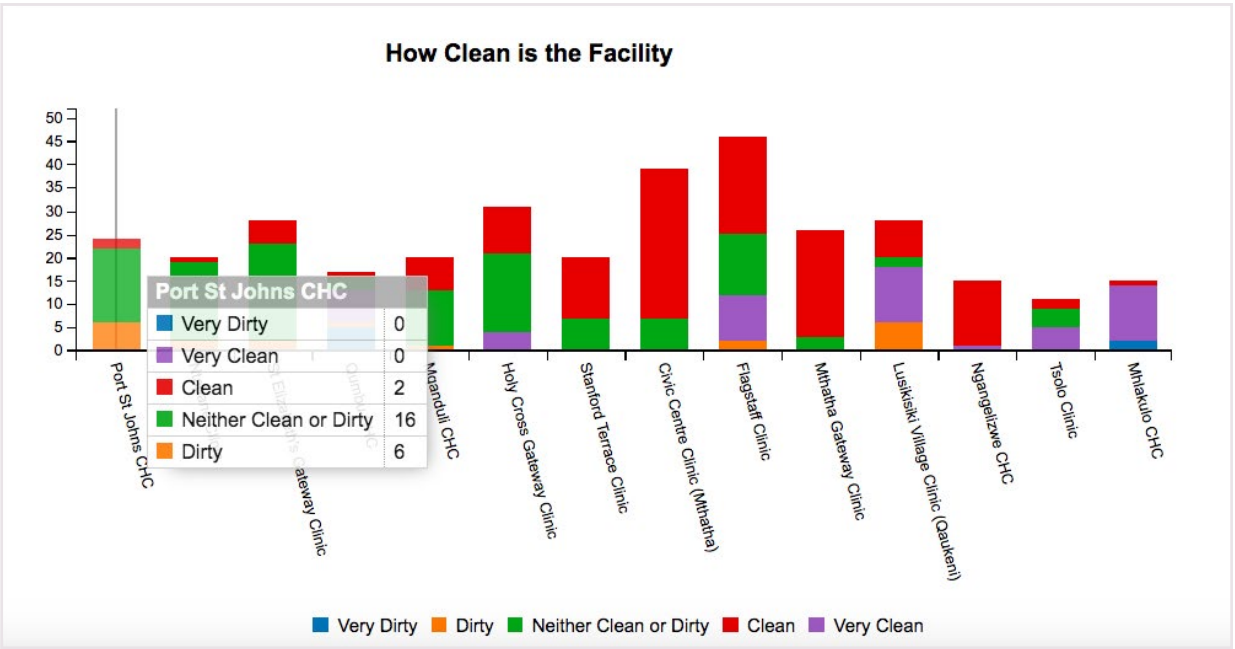
The data shown on the dashboard will depend on how you filter. Here the data is showing the national view of all the clinics we have monitored.



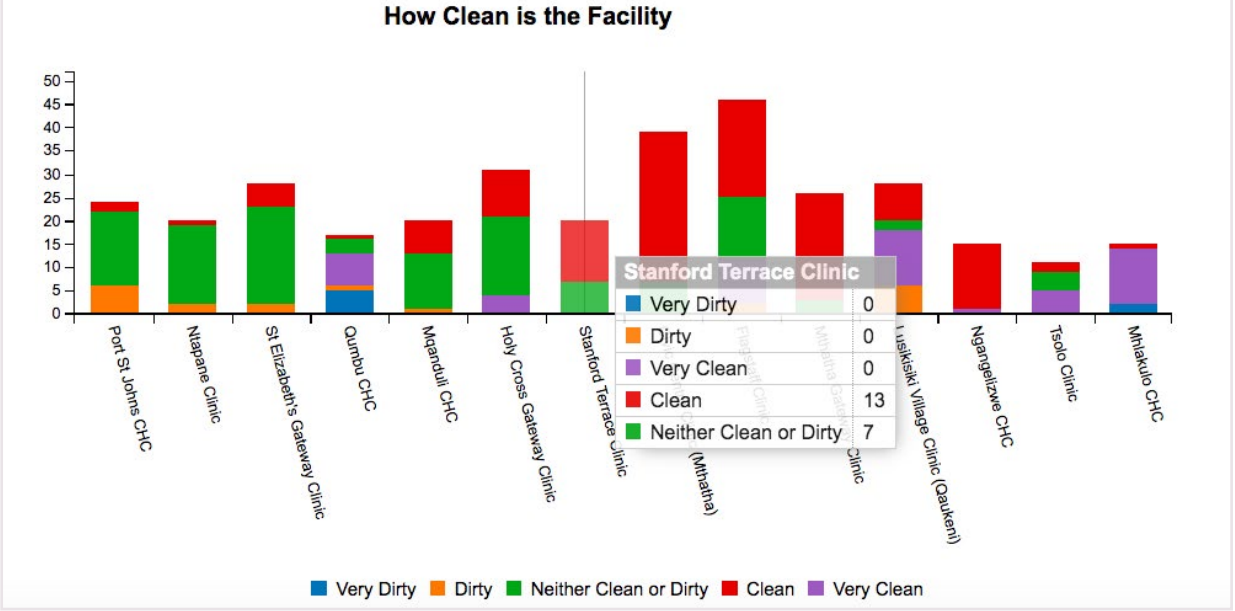
This pie chart answers the question — "Are people being asked for TB symptoms". This question comes from the patient survey. As shown in the number of "Patient Responses" in the top right corner — 6,256 patients responded to this question nationally in all the facilities we monitored.
The key on the left side tells us the possible answers that can be given by patients to this question — Yes, Only sometimes, No, Don't Know. In this case 41.3% of the patients said "Yes" the clinic asks if people have TB symptoms, 17.8% of the patients said "Only sometimes" does the clinic ask if people have TB symptoms, 29.8% of the patients said "No" the clinic does not ask if people have TB symptoms, and 11.1% of patients said they "Don't know". When we add that up it equals 100% of the patients. When you are on the dashboard and you hover your mouse over a portion of the pie chart, it will tell you the answer with the percentage of responses.



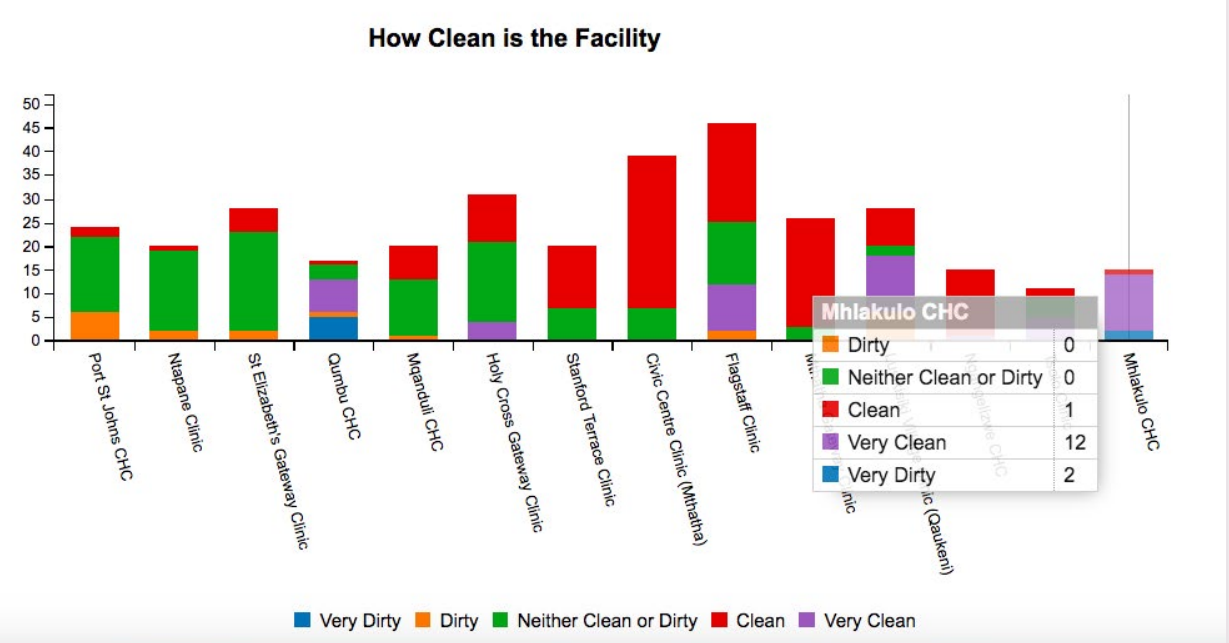
This example is comparing the results of all the clinics in OR Tambo district in Eastern Cape. It answers the question — "How Clean is the Facility?". This comes from the patient survey. The height of the bar shows the number of patients who responded to the question. The colours inside the bar show the different answers. The key at the bottom tells us the possible answers that can be given by patients to this question — Very Dirty, Dirty, Neither Clean or Dirty, Clean, Very Clean. When you are on the dashboard and you hover your mouse over a single bar, it will tell you the breakdown of patient responses for that clinic. With all these types of bar charts on the dashboard, the clinic that performed the worst is on the left, and they improve as we move to the right.



Port St. Johns CHC performs the worst in the district — where 2 of the patients said the clinic is "Clean", 16 of the patients said the clinic is "Neither Clean or Dirty" and 6 of patients said the clinic is "Clean".

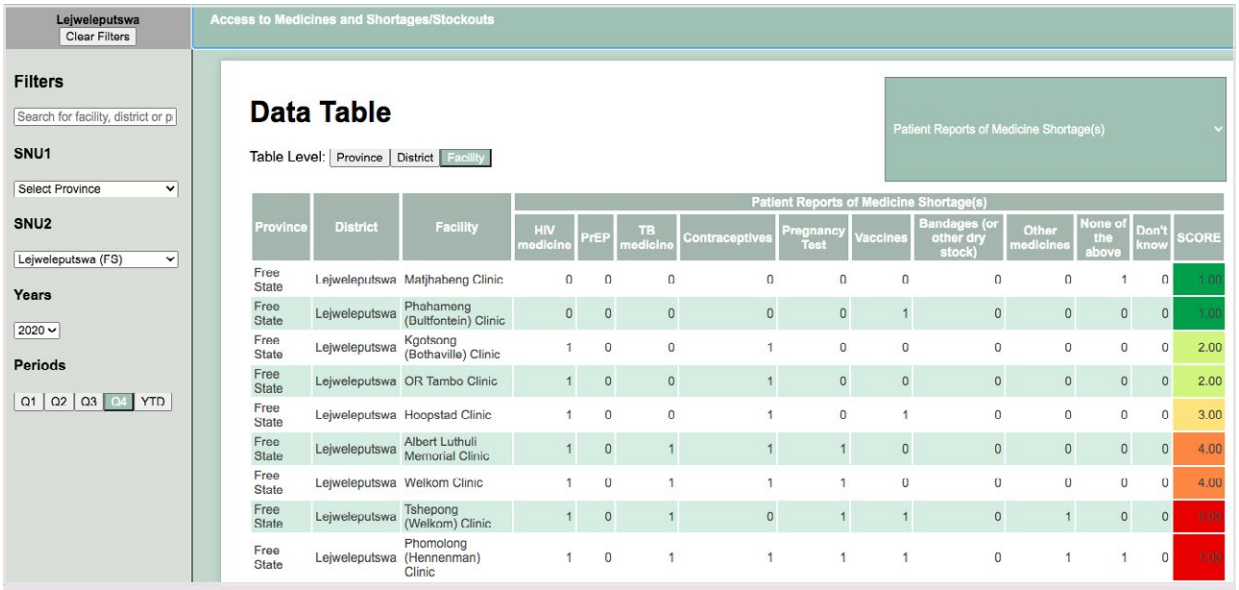


Stanford Terrace Clinic performs in the middle in the district — where 13 of the patients said the clinic is "Clean", and 7 of the patients said the clinic is "Neither Clean or Dirty".



And Mhlakulo CHC performs the worst in the district — where 1 of the patients said the clinic is "Clean", 12 of the patients said the clinic is "Very Clean" and 2 of patients said the clinic is "Very DIrty".

Note that if you filter this bar chart for a smaller district or province where we monitor less than 100 clinics, you will see all the clinics on the bar chart. If you filter this bar chart for a larger province where we monitor more than 100 clinics, or nationally, you will only see the worst 100 clinics on the bar chart.



Province	District	Facility	Patient Reports of Medicine Shortage(s)									
			HIV medicine	PrEP	TB medicine	Contraceptives	Pregnancy Test	Vaccines	Bandages (or other dry stock)	Other medicines	None of the above	Don't know	SCORE
Free State	Lejweleputswa	Matjhabeng Clinic	0	0	0	0	0	0	0	0	1	0	1.00
Free State	Lejweleputswa	Phahameng (Bultfontein) Clinic	0	0	0	0	0	1	0	0	0	0	1.00
Free State	Lejweleputswa	Kgotsong (Bothaville) Clinic	1	0	0	1	0	0	0	0	0	0	2.00
Free State	Lejweleputswa	OR Tambo Clinic	1	0	0	1	0	0	0	0	0	0	2.00
Free State	Lejweleputswa	Hoopstad Clinic	1	0	0	1	0	1	0	0	0	0	3.00
Free State	Lejweleputswa	Albert Luthuli Memorial Clinic	1	0	1	1	1	0	0	0	0	0	4.00
Free State	Lejweleputswa	Welkom Clinic	1	0	1	1	1	0	0	0	0	0	4.00
Free State	Lejweleputswa	Tshepong (Welkom) Clinic	1	0	1	0	1	1	0	1	0	0	5.00
Free State	Lejweleputswa	Phomolong (Hennenman) Clinic	1	0	1	1	1	1	0	1	1	0	7.00

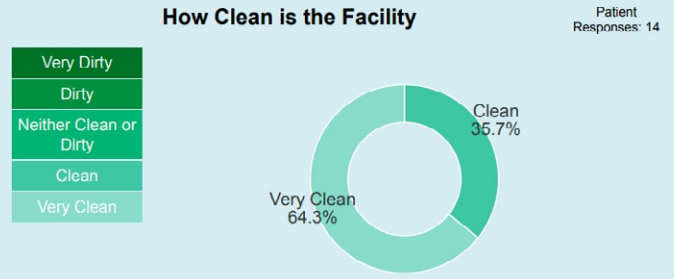
This example is using a data table to compare the results of all the clinics in Lejweleputswa district in Free State. It answers the question — "Have there been any stockouts or shortages of medicines?". This comes from the patient survey. The data table shows us the province, the district and the name of the clinic. It further tells us the different types of stockouts or shortages that patients can report in the surveys including: HIV medicine, PrEP, TB medicine, Contraceptives, Pregnancy Test, Vaccines, Bandages (or other dry stock), Other medicines, None of the above, or Don't know. Finally it shows the score of the clinic.

If one or more patients have reported a stockout of an HIV medicine for example, there will be a 1 showing. If no patients have reported a stockout of an HIV medicine, there will be a 0 showing. In this case at Matjhabeng Clinic and Phahameng Clinic, 0 patients reported HIV medicine stockouts.

In contrast at OR Tambo Clinic, Hoopstad Clinic, Albert Luthuli Memorial Clinic, Welkom Clinic, Tshepong Clinic, and Phomolong Clinic — 1 or more patients did report HIV medicine stockouts.

HOW TO INTERPRET THE DATA?

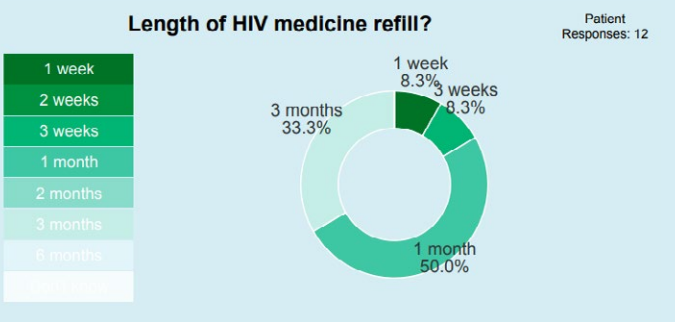
In some cases it will be easy to interpret the data to see if the clinic is doing well or badly on that question.



For example here it is clear that all the patients who responded thought that the clinic is either "Very Clean" or "Clean" which is positive.

However sometimes you may get mixed responses. For example here we have a range of answers.

In your teams you should think about why this is. Why do people have different opinions? Does age or gender play a role in influencing people's responses? Does the time of the day they come to the clinic affect how they experience services? Do most people think one thing, and very few people think the opposite? Do we have too few patient responses to get a clear picture? Do we need to try to collect more data on this, by interviewing more people? Does data collected in the other surveys agree with this data or say something different? In some instances some people may be getting a good service, whilst others do not.



For example here, some people are getting 3 months of ARVs and others are getting 1 week, 3 weeks, or 1 month. National guidelines say that everyone should get at least 2 months supply, so we know that this is not good, even though some people are getting longer 3 month refills.

We now have to think why is this the case? Was there a shortage of certain types of ARVs that affected some people? Were they newly initiated on ARVs and had to come back quicker? Were there other reasons? Or was it just luck or bad luck of the person collecting? This will help guide the solutions we may wish to generate (more on this in the GENERATE SOLUTIONS section).

RANKING AND SCORING THE CLINICS

In order to help you see how well the clinic is doing, you'll see in the facility report that the clinic is compared to other clinics we are monitoring across the district, the province and nationally. It is given a "rank".

To think about the rank, let's imagine a race with 100 runners. The winner of the race finishes in 1st place, the person is ranked at number 1. The person who comes last finishes the race in 100th place, the person is ranked at number 100.

If there are 50 runners in the race, the winner of the race still finishes in 1st place, the person is ranked at number 1. But this time the person in last place finishes in 50th place, the person would be ranked at number 50.

If there are 400 runners in the race, the winner of the race still finishes in 1st place, the person is ranked at number 1. But this time the person in last place finishes in 400th place, the person would be ranked at number 400.

It is just the same in our clinic ranking system. In the clinic data reports it will look like this:

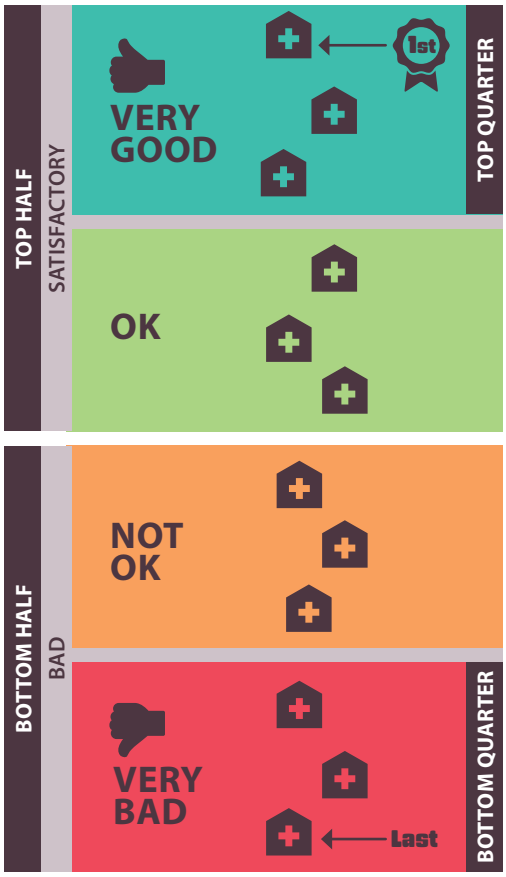
This ranks:

+ 1 of 400 facilities Nationally (Top Quarter)
+ 1 of 75 facilities in the Province (Top Quarter)
+ 1 of 10 facilities in the District (Top Quarter)

The first number is the position the clinic we are looking at comes. In this case the clinic is in 1st place nationally, 1st place in the province and 1st place in the district.

The second number is the number of other clinics we are comparing it with. In this case, 400 clinics were monitored nationally, 75 clinics were monitored across the province, and 10 clinics were monitored across the district.

In this case the clinic is doing the best nationally, in the province and in the district. It is in the top quarter for each.



Let's take another example:

This ranks:

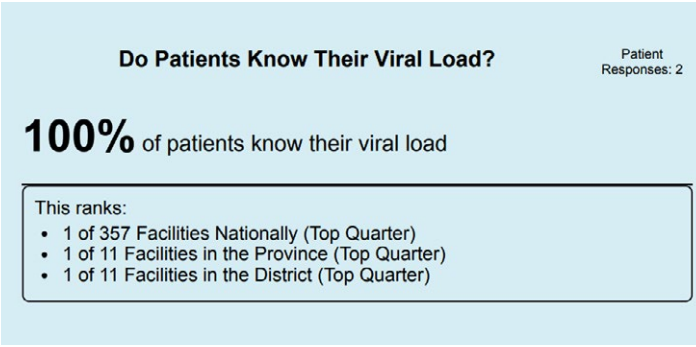
+ 400 of 400 facilities Nationally (Bottom Quarter)
+ 75 of 75 facilities in the Province (Bottom Quarter)
+ 10 of 10 facilities in the District (Bottom Quarter)

In this case the clinic is in 400th place nationally, 75th place in the province and 10th place in the district — it is doing the worst nationally, in the province and in the district. It is in the bottom quarter for each.

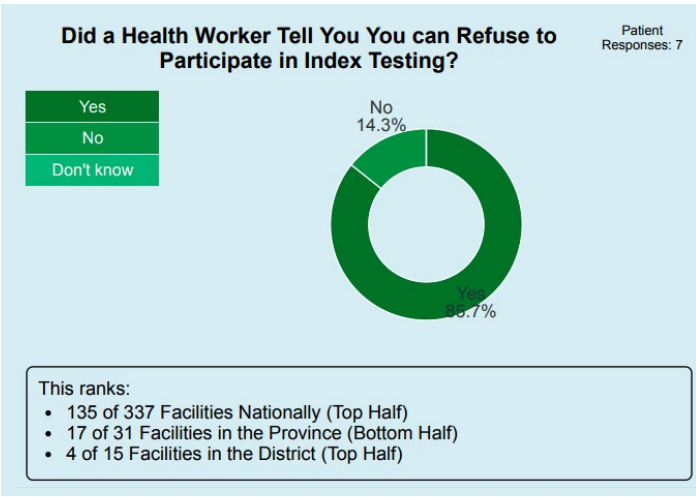
TOP QUARTER	VERY GOOD	If the clinic is ranked in the Top Quarter it is amongst the top 25% of clinics monitored that are the best performing.
TOP HALF	SATISFACTORY	Clinics that are amongst the top 25% to 50% of clinics monitored will be ranked in the Top Half. This is satisfactory but likely still needs improvement.
BOTTOM HALF	BAD	Clinics that are amongst the bottom 50% to 75% of clinics monitored will be ranked in the Bottom Half. Improvement is needed.
BOTTOM QUARTER	VERY BAD	If the clinic is ranked in the Bottom Quarter it is amongst the bottom 75% to 100% of clinics monitored that are the worst performing. A lot of improvement is needed.

Note: depending on the data, there could be many clinics that score the same, i.e. they are tied in 1st position. For example if multiple clinics have 100% of patients knowing their viral load, they will be tied in 1st position.

Here are some real examples:

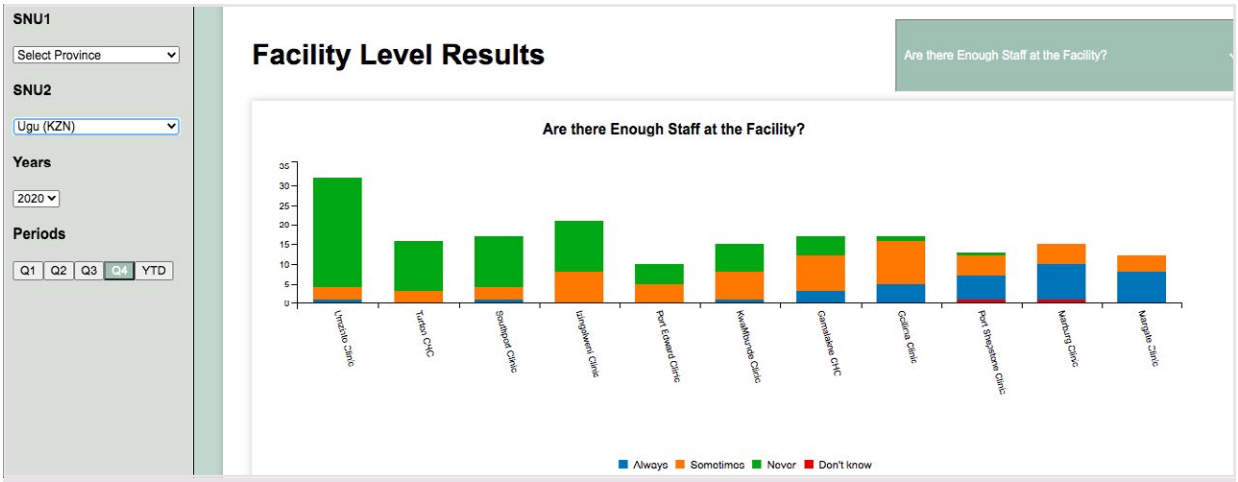


This single answer answers the question — "Do Patients Know Their Viral Load?" This question comes from the patient survey in the PLHIV section. As shown in the number of "Patient Responses" in the top right corner — 2 patients responded to this question at this clinic. It shows us that 100% of the patients who responded said that they did know their viral load. This ranks the facility 1st nationally (Top Quarter), 1st in the province (Top Quarter), and 1st in the district (Top Quarter).

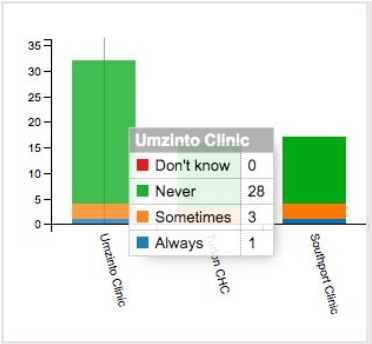


This pie chart answers the question — "Did a Health Worker Tell You You Can Refuse to Participate in Index Testing?". This question comes from the patient survey. As shown in the number of "Patient Responses" in the top right corner — 7 patients responded to this question at this clinic. The key on the left side tells us the possible answers that can be given by patients to this question — Yes, No, Don't Know. In this case 14.3% of the patients said "No" and 85.7% of patients said "Yes". This ranks the facility 135th nationally (Top Half), 17th in the province (Bottom Half), and 4th in the district (Top Half).

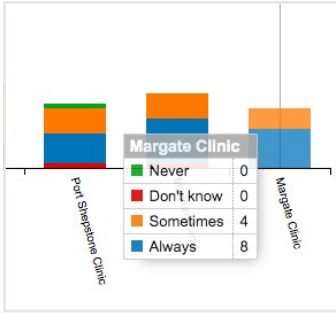
The dashboard also scores the clinics based on performance. On the dashboard the scores are presented in two ways. First you can look at the bar chart, filtering by district or province to see how a facility scores. The worst performing clinic will always be on the left side, getting better as we move to the right:



This example is comparing the results of all the clinics in Ugu district in KwaZulu-Natal. It answers the question — ***"Are there Enough Staff at the Facility?"***. This comes from the patient survey. The height of the bar shows the number of patients who responded to the question. The colours inside the bar show the different answers. The key at the bottom tells us the possible answers that can be given by patients to this question — Always, Sometimes, Never, and Don't Know.



Here the worst performing clinic is Umzinto Clinic where 28 patients said "**Never**", 3 patients said "**Sometimes**" and only 1 patient said "**Always**".



The best performing clinic is Margate Clinic where 4 patients said "**Sometimes**" and 8 patients said "**Always**".

The last way that clinics are scored is in the Data Table. The Data Table gives a number score for each question. The colour coding also helps to highlight how good the number is and how well the clinic is doing. You can think of it like a traffic light — DARK GREEN is the best, YELLOW is in the middle, and RED is the worst.

Data Table

Table Level: Province | District | Facility

Are there Enough Staff at the Facility?

Province	District	Facility	Are there Enough Staff at the Facility?				
			Always	Sometimes	Never	Don't know	SCORE
Western Cape	City of Cape Town	Langa Clinic	7	5	1	1	1.46
Western Cape	City of Cape Town	Khayelitsha (Site B) CHC	4	6	0	0	1.40
Western Cape	City of Cape Town	Delft CHC	5	5	2	0	1.25
Western Cape	City of Cape Town	Kuyasa CDC	2	8	0	0	1.20
Western Cape	City of Cape Town	Kraaifontein CHC	2	12	0	0	1.14
Western Cape	City of Cape Town	Bloekombos Clinic	2	14	1	0	1.06
Western Cape	City of Cape Town	Nolungile CDC	1	8	1	1	1.00
Western Cape	City of Cape Town	District Six CDC	0	12	0	0	1.00
Western Cape	City of Cape Town	Mitchells Plain CHC	0	10	0	0	1.00
Western Cape	City of Cape Town	Inzame Zabantu CDC	0	12	0	3	1.00
Western Cape	City of Cape Town	Wallacedene Clinic	3	13	4	0	0.95
Western Cape	City of Cape Town	Dr Ivan Toms CDC	2	6	3	0	0.91
Western Cape	City of Cape Town	Matthew Goniwe CDC	0	9	1	0	0.90
Western Cape	City of Cape Town	Weltevreden Valley Clinic	0	9	1	0	0.90
Western Cape	City of Cape Town	Hout Bay Main Road Clinic	3	8	5	0	0.88
Western Cape	City of Cape Town	Michael Mapongwana CDC	0	11	2	0	0.85
Western Cape	City of Cape Town	Town 2 CDC	1	8	3	0	0.83
Western Cape	City of Cape Town	Mzamomhle Clinic	0	10	2	0	0.83
Western Cape	City of Cape Town	Crossroads CDC	0	8	2	0	0.80
Western Cape	City of Cape Town	Nyanga CDC	0	11	3	1	0.79
Western Cape	City of Cape Town	Du Noon CHC	2	4	5	0	0.73
Western Cape	City of Cape Town	Delft South Clinic	0	7	3	0	0.70
Western Cape	City of Cape Town	Mfuleni CDC	1	8	14	0	0.63
Western Cape	City of Cape Town	Albow Gardens CDC	0	6	13	0	0.57
Western Cape	City of Cape Town	Guguletu CHC	0	1	9	0	0.50

INTERNAL CLINIC REVIEW MEETINGS

After monitoring takes place, data collection teams should hold an internal *clinic review meeting*. Make sure that for each site being discussed you include the Community Monitor, all the PLHIV Sector members supporting, District Organiser, and Project Officer in these meetings. The review meeting should take place in the second month of the monitoring cycle. The purpose of the meeting is to analyse and understand what you have learnt throughout the data collection—what are the biggest challenges? Were there any successes? What was promised to be fixed, but remains unresolved? This will help you to understand what are the key findings that you want to raise in your next meeting with the facility staff.

Before your clinic review meeting you should make sure to have at hand:

1. The data report for the clinic (*downloaded from the dashboard in paper copy. Consider also emailing this to the data collection team to look at ahead to prepare for the meeting*)
2. The reflection form from the last facility monitoring visit
3. Any previous state of the clinic reports
4. Any previous actions and commitments made by the clinic staff or clinic committee at the facility manager and/or clinic committee meetings.

When the meeting takes place, use the following questions to help prompt your discussion.

+ Which of the areas seem to be major problems of the clinic from the data report?
+ How do these compare to your notes in the reflection form?
+ How do these compare to the last time you monitored?
+ How does this clinic compare to the other clinics you're monitoring?
+ Which areas seem to be getting better? Are they getting better fast enough?
+ Which issues are getting worse? Do you know why?
+ What problems seem new from this round of monitoring—these are especially important to pay attention to.
+ Which problems have you already discussed with the facility manager?
+ What solutions were proposed? Does it seem like those solutions were implemented?
+ If they were implemented but things did not get better, why not?
+ What are the top issues that are <u>still a problem</u> you think you should bring up with the facility manager?
+ Are there any <u>new</u> problems to bring up with the facility manager?
+ What is the facility doing well? Are there findings where the patients gave positive feedback?

By the end of the discussion you should have identified the following:

+ What are the top issues (4 or 5) that you think you should bring up with the facility manager?
+ Which problems do you think need to be referred to national staff to be addressed at the district, provincial, or national level because it doesn't seem like they can or will be solved at the clinic?

You will use the list of top issues as the start point for discussions on solution generation in the next section. Make sure to take detailed notes of the discussion using the clinic review meeting template (available in the appendix).

GENERATE SOLUTIONS

MOVING FROM PROBLEMS TO SOLUTIONS

COMING UP WITH YOUR OWN SOLUTIONS

WORKING WITH THE COMMUNITY TO IDENTIFY SOLUTIONS

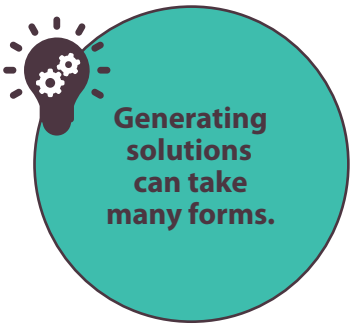
SOLUTIONS BEYOND THE IMMEDIATE CLINIC

PROBLEMS THAT NEED URGENT SOLUTIONS

POTENTIAL SOLUTIONS TO SOME COMMON PROBLEMS

SO YOU HAVE YOUR SOLUTIONS, WHAT NEXT?

MOVING FROM PROBLEMS TO SOLUTIONS



The next stage is to generate solutions to the top problems you have outlined. Here are some key questions to guide your thinking:

+ What are the most important actions that could be taken to improve this facility, according to patients and staff?
+ What can be fixed in the short term? Medium term? Long term?
+ What is the role of the community in helping to resolve issues?
+ Who are the key individuals who can best address the problems? Are they at the facility level? District, provincial, or national level?

While a problem may be detected at the facility-level, sometimes the solution could be at the facility level, or at the district, provincial or national level? Do we need PEPFAR to fix it? In other words, some problems are more systemic, which is why this project includes advocacy and engagement at the district, provincial, national and international (global donors) levels as well (we'll speak more about navigating this later).

Generating solutions can take many forms. You can think of them in three main groups:

1. Monitoring team generated solutions (including you, your team, the members you are working with)
2. Community generated solutions
3. Solutions beyond the immediate clinic

Let's take them one by one.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Suggestions / Imibono
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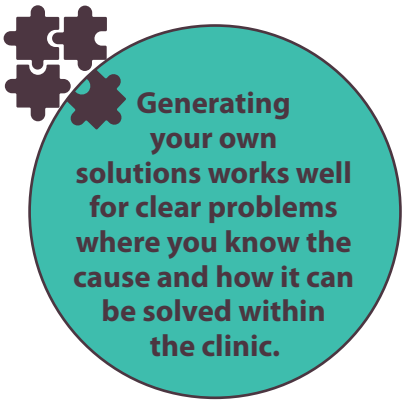


COMING UP WITH YOUR OWN SOLUTIONS

Most often you'll start by generating some of your own solutions. This works well for clear problems where you know what the cause is and where it can be solved within the clinic. Use the second part of your clinic review meeting to discuss ideas for possible solutions and document them on the clinic review meeting template (available in the appendix).

There are a number of ways to find more solutions:

+ If there is a branch locally, talk to them about the top problems found and what they think could be the solution to each.
+ Talk to patients or community leaders one-on-one about the problems and see what they suggest.
+ Talk to clinic staff while you're there about what they think the solutions are. Maybe go back to the clinic another day to sit down with the staff or the patients at the clinic to ask what could be most helpful.
+ Ask staff at the clinics where things seem to be going well for ideas to help your other clinics.
+ Describe the problem to other Community Monitors—see if they have ideas about how that's being addressed where they are.
+ Reach out to the Project Officers to get their ideas.
+ Ask implementing partners who are funded to support the clinics for their ideas and insights.

WORKING WITH THE COMMUNITY TO IDENTIFY SOLUTIONS

Solutions may not always be easily identified at the individual or facility level—it is then often most appropriate to turn to the community to help generate solutions. A community dialogue is a strategy that can be used to generate solutions that are community-based and owned. A community dialogue is a large meeting of community members that meets together to agree on the problems to tackle, identify solutions to address the problems, come up with a plan on how the solutions will be implemented, including what challenges may arise along the way.

You can hold a community dialogue where you invite people who you think have experienced the problem (is it a problem about the general clinic? PLHIV? Women? LGBTQIA people?) or who might have good ideas (leaders in the community, local partner groups). This is a good tool when the solutions are not obvious or when you've tried the obvious solutions and they aren't working. Community dialogues are also often useful for identifying people who want to offer individual testimonies which can be a very powerful advocacy tool.

In Ritshidze we will be organising community dialogues in high intensity sites only. Agree in the clinic review meeting if you think we need to organise a community dialogue.

ESSENTIAL TIPS FOR PLANNING A COMMUNITY DIALOGUE TO GENERATE SOLUTIONS

1. **Get buy in:** It is important to do an analysis of the community to understand who the stakeholders are locally. Who are our allies? Who are our targets? Who influences who? We need to ensure buy in from leaders and those with influence in the community to ensure the dialogue is successful. Ensure that you also have an analysis of the political atmosphere within the area in which you want to have a dialogue.
2. **Location, location, location:** Find an appropriate venue for the number of people you are inviting. Avoid having these events at places where participants may be distracted (such as malls and open grounds). Figure out if you will need a PA system. Set up the room school room style.
3. **The budget & logistics**: You will need to develop a budget breakdown that includes the cost of the venue, chairs (if needed), PA system, transport of community members, refreshments for community members, social mobilisation activity costs and anything else. The District Organiser should lead this and make sure the budget and plan is reviewed and approved by the national team before starting.
4. **Who to invite**: About 80 to 100 people is ideal for a community dialogue. Reach out to people who are directly affected by the issue or problem you want to solve. Invite people who you think have experienced the problem (is it a problem about the general clinic? PLHIV? Women? LGBT people?) or who might have good ideas (leaders in the community, local partner groups). You will likely be trying to generate solutions at a particular clinic, so make sure the attendees use that facility. Try to avoid generalisation by targeting relevant people to join the dialogue. For instance if you do door to door to mobilise people for the dialogue, and people say they have no issues needing to be solved, then do not invite them to the event. Only invite those with ideas for solutions who will contribute to the discussion. Also make sure that the majority of participants will be community members, not all PLHIV Sector branch members. The facilitator will need to be prepared to ensure that as many voices are heard as possible—and make sure it is not only the loudest voices in the room dominating the conversation. As well as inviting community members, a dialogue could also include stakeholders such as traditional leaders, clinic committee members, ward councilors, and ward committee members. Just note that community members may speak less freely if the targets of your campaign are present, such as facility staff.
5. **Social mobilisation & build up activities**: Ahead of your dialogue you will need to do social mobilisation to ensure that community members know about the dialogue and what it is for. This will help you ensure there is good attendance from the right people. You could develop some posters and flyers ahead of time to use while on door to door activities in order to engage people. Make sure to encourage those with stories, complaints, and importantly possible solutions to attend.
6. **Assign roles**: Assign roles ahead of the dialogue—you will need people for registration, a good facilitator, at least two people taking notes and others taking detailed personal testimonies, someone taking pictures, a timekeeper, and someone to be in charge of logistics like getting food and water. Facilitators should be able to cater for local languages and local protocols. You should engage with local PLHIV Sector branches to fill some of these roles.
7. **Develop the agenda**: The agenda should be centered around the key challenges that have been found during facility & community monitoring that you want to generate solutions for. For instance this could be things like bad staff attitudes, long waiting times, stockouts, poor treatment of sex workers, or discrimination against men who have sex with men at the clinic. There should be a balance to ensure that there is enough time allocated per issue to allow community members to voice their concerns and provide possible solutions, while not letting the discussion drag out too long that causes people to lose interest and enthusiasm.
8. **Take notes**: Take notes as to what is discussed, potential solutions identified, and any commitments made. Make sure you note down key challenges, complaints, people's stories, potential solutions, and what the community resolves to do about it. Type this up after and share this with your District Organiser (*see the box on how to take good notes*).
9. **Collect stories**: Often at dialogues, community members recount personal stories of how the public health system has failed them. Put a system in place to capture these personal testimonies using the individual testimony tool. As people with stories are identified during the dialogue, you could ask them to go and talk to one or two people sitting outside, or at the back, to give more detail and fill the individual testimony tool.
10. **Take pictures**: Make sure to assign someone to take pictures during the dialogue. Send pictures to ritshidze-comms@tac.org.za after the event.
11. **Write up**: It is always important to ensure that there is post dialogue evaluation and write up of the entire event. Include the key discussion points under each of the issues outlined in the agenda, possible solutions generated, as well as any other resolutions taken.
12. **Feedback**: After you engage with duty bearers on the complaints raised by the community members, as well as their possible solutions generated, it is important to feedback to them on progress. Regular feedback is important for a meaningful community engagement approach—it ensures that members of the community do not feel ignored or simply used.

SOLUTIONS BEYOND THE IMMEDIATE CLINIC

Often the issue cannot be tackled in the community alone and has to be solved by the district, province, or national government or by donors such as PEPFAR. For example a province wide stockout of a medicine, or an implementing partner NGO pulling out of all sites. With these kinds of problems, identify some solutions in the clinic review meeting.

PROBLEMS THAT NEED URGENT SOLUTIONS

Sometimes you will encounter a problem that requires immediate action to protect someone's health and life.

Examples of this could include:

+ A stockout of lifesaving medicines (like HIV or TB treatment) with no alternative
+ A person with an emergency health need not being treated
+ People's rights being violated, such as HV status' being disclosed, that need addressing then and there
+ A clinic that is physically unsafe for people to be in (e.g. roof falling in)

IN THIS CASE YOU SHOULD ASK:

1. Can the facility manager fix the situation?

IF NO: then you and your District Organiser should consider what can be done. Contacting district, provincial, or national government duty bearers or the PEPFAR teams may be necessary to resolve the situation. If so, consult quickly with Project Officers to make a plan—also share a WhatsApp message outlining the challenge to the Ritshidze group (*see the box for what should be included*).

IF YES THEN ASK:

2. Is the facility manager or other managers aware of the situation?

IF NO: consider bringing the situation to their attention.

IF YES: If the facility management is aware, but has not resolved the situation consult with your District Organiser and make a plan about how you can help resolve the situation. If needed consider also consulting quickly with Project Officers.

REPORTING STOCKOUTS AND SHORTAGES OF MEDICINES

Whether someone is a patient, friend, or a healthcare worker and knows about medicine stockouts or shortages, they should let the Stop Stock Outs Project know. The Stop Stock Outs Project (SSP) monitors the availability of ARVs, TB treatment, routine childhood vaccines and other essential medicines in South Africa. If you are told about a stockout or shortage of any of these medicines during facility monitoring, then you need to report it. You should also explain to community members how they can report stockouts in the future if you are not there.

To report medicine stockouts and shortages:

Send a Please Call Me, SMS, or Phone 084 855 7867

Email: report@stockouts.org

SENDING CHALLENGES TO THE WHATSAPP GROUP

Here are some examples of how to write your update to send to the Ritshidze WhatsApp group when you encounter a problem that requires immediate action beyond the immediate clinic (i.e. from the National Department of Health or PEPFAR teams):

"*Today (20/72020) at Lethabong Clinic (Lejweleputswa, Free State) we found that staff from the implementing partner (ADD NAME) were shouting at chronic patients and publicly announcing people's HIV status in the clinic. PLHIV left the clinic without their medicines because they did not want their status revealed."*

"Today (4/6/2020) at Lomdzala Clinic (Gert Sibande, Mpumalanga), we observed the implementing partner staff (ADD NAME) telling patients in the waiting area that if they did not want to test for HIV they would not get medical attention nor treatment. In our attempt to question this she was very rude and we reported to the facility manager who raised that she is tired, she has reported this and nothing was done about it, thus the matter escalated to the district DOH and right to care."

POTENTIAL SOLUTIONS TO SOME COMMON PROBLEMS

Here are some possible solutions to some common problems that you may draw from when coming up with your own solutions. These solutions come from government World Health Organization (WHO) and PEPFAR policies and best practice guidelines—as well as from community-led solution generation to date. Depending on the problem, the possible solutions are aimed at different duty bearers who have the power to fix them including the clinic staff, district, provincial or national health teams, or even PEPFAR or their implementing partners. These are not the only possible solutions—you may need to add other solutions generated by the branch or community, or you may need to amend these based on the context at your clinic.

#	FINDING	POSSIBLE SOLUTIONS AT FACILITY AND DISTRICT LEVEL
1	**FACILITY HOURS AND WAITING TIMES**	**CLINIC LEVEL** *(Where issues of clinics that have not extended hours)* a. According to a National Department of Health circular issued in May 2019 all PEPFAR Siyenza designated sites were requested to extend opening hours to attract patients e.g. those working, who cannot attend during normal opening times. Facilities must be open from 5.00 — 19.00, as well as 8.00 — 16.00 on Saturdays. Patients should also be able to use these extended hours to pick up their medication from internal pick up points. However, Ritshidze monitoring shows that this facility has not extended its opening times as per the circular. Hours should be extended urgently, or reasons why this cannot occur should be outlined in order for us to escalate the issue to district and provincial health department level. *(Where issues of bad filing systems)* b. Ritshidze monitoring shows that the filing system at the facility is not kept in an orderly manner and contributes to long queues. Files must be kept in an orderly manner to reduce the number of lost files, and to ensure that the time it takes patients to access files and therefore overall waiting times can be reduced. According to a National Department of Health circular issued in May 2019 all PEPFAR Siyenza designated sites were requested to ensure a functional filing system is in place that is maintained to reduce patient waiting times, and that the unique identifier is fully implemented. *(Where issues of staff taking long, or many breaks)* c. Ritshidze data shows that staff taking long/many breaks is contributing to long queues in the facility. Staff breaks should be regulated to agreed frequency and time periods. Further they should not all happen at the same time. This should be addressed and managed by the Facility Manager. *(Where issues of long queues)* d. According to National Core Standards "waiting times and queues must be managed to improve patient satisfaction and care, and serious patients are attended to first" however Ritshidze data shows excessive waiting times at this facility. Further National Core Standards say that "procedures must be followed to manage queues and minimise waiting times" and that "waiting times are monitored and improvement plans are implemented." The Facility Manager should develop and share an improvement plan in order to shorten the length of queues. Ritshidze staff will provide feedback on the reasons given by patients for long queues that may assist the improvement plan. OR ADD YOUR OWN BASED ON CONTEXT

#	FINDING	POSSIBLE SOLUTIONS AT FACILITY AND DISTRICT LEVEL
2	FACILITY STAFF	**CLINIC LEVEL** *(Where issues of not enough staff)* a. There is a need for additional clinical and/or non-clinical staff members [ADD RELEVANT CADRES] to ensure a better service at the facility. This will be escalated to district & provincial health department level. b. According to National Core Standards "Staff must treat patients with care and respect, with consideration for patient privacy and choice." Ritshidze monitoring shows that there are many patients who consider the staff to not always be friendly and professional as expected. Any allegations made with regard to bad staff attitude must be investigated by the Facility Manager in a timely manner, with disciplinary action taken where appropriate. c. Ritshidze monitoring shows that the complaints box is [ADD AS APPROPRIATE]. According to National Core Standards "Patient satisfaction surveys and patient complaints must be used to improve service quality" and "Patients who wish to complain about poor service must be helped to do so and their concerns must be properly addressed". Further according to the National Policy to Manage Complaints, Compliments & Suggestions (2016)—Information about how and where to complain must be well publicised to patients, their families and supporting persons. It must be made as easy as possible for users to lodge a complaint at the point of service. A complaints box must be in place that is visible for patients to use. The complaints box must be locked and the clinic committee should hold the key. The clinic committee should regularly review the contents of the box and deal with challenges accordingly. People should be allowed to anonymously add complaints to the box that do not require direct follow up. **DISTRICT LEVEL** a. All community healthcare workers must be provided with appropriate and adequate training, equipment, PPE, transport and supervision they need to be employed in an effective and dignified manner as per the Ward Based Primary Healthcare Outreach Team (WBPHOT) strategy and COVID-19 prevention measures. b. Often staff do not treat people properly due to stress, exhaustion, and burn out as a result of the malfunction in the health system including lack of time. Better staff support systems should be outlined clearly and put in place by the District Department of Health in order to ensure staff wellness and support. OR ADD YOUR OWN BASED ON CONTEXT

#	FINDING	POSSIBLE SOLUTIONS AT FACILITY AND DISTRICT LEVEL
3	**CLINIC CONDITIONS AND PATIENT SAFETY**	**CLINIC LEVEL** *(Where clinic in bad condition)* a. According to National Core Standards "Patients must be satisfied with the cleanliness and hygiene of the facility and with their accommodation." With this in mind the facility must be cleaned daily and kept clean throughout the day to provide an adequate environment to both staff and healthcare users. *(Where toilet in bad condition)* b. According to National Core Standards "Patients must be satisfied with the cleanliness and hygiene of the facility and with their accommodation." With this in mind the toilets must be cleaned regularly and there must be soap, water, toilet paper, and light available to provide an adequate environment to both staff and healthcare users. *(Where Facility Manager need for additional space)* c. Ritshidze monitoring show a lack of [ADD AS APPROPRIATE]. In order to address this challenge, with your recommendations on how to fix the problem, we will escalate this issue to district and provincial health department level. *(Where issues of lack of shelter)* d. Ritshidze monitoring show a lack of shelter, where patients are forced to wait outside in the heat or cold. In the short term the facility needs a shelter outside to accommodate people waiting in all weather conditions to provide an adequate environment to healthcare users. For the longer term, with your recommendations on how to fix the problem, we will escalate this issue to district and provincial health department level. *(Where unsafe to wait in the early hours)* e. Ritshidze monitoring shows that patients arrive as early as [ADD TIME]. Further [ADD %] of patients think that it is unsafe or very unsafe to wait at that time. The Facility Manager should ensure that security guards should open gates by [ADD RECOMMENDED TIME] to allow patients who arrive early to be safe as they wait for the clinic to open. [ADD ANY OTHER POTENTIAL SOLUTIONS] *(Where no or not enough security)* f. An adequate number of security guards should be hired to ensure patient safety in the early hours and during the working day. OR ADD YOUR OWN BASED ON CONTEXT **DISTRICT LEVEL** a. There should be inclusion of site visits to the facility to ensure the facility maintains cleanliness. A clear budget needs to be identified and put in place for additional cleaners where required. b. An audit should take place of [ADD FACILITY NAME] after which a costed turnaround plan needs to be developed to ensure adequate and functional equipment and to improve the state of the infrastructure. A clear budget needs to be put in place for structural repairs, renovations, broken and/or missing equipment. c. The Department needs to ensure there is adequate funding and personnel to ensure that health facilities are maintained, fitted with appropriate technology (medical equipment, ICT equipment, phones, access to internet) in order to address the compromised ability of facilities to provide an adequate environment to both staff and healthcare users. OR ADD YOUR OWN BASED ON CONTEXT

#	FINDING	POSSIBLE SOLUTIONS AT FACILITY AND DISTRICT LEVEL
4	**ACCESS TO MEDICINES AND SHORTAGES/ STOCKOUTS**	**CLINIC LEVEL** a. According to National Core Standards "Stock levels and storage of medicines and medical supplies must be managed appropriately". However, Ritshidze monitoring shows stockouts reported by patients and healthcare workers [DELETE AS APPROPRIATE]. Where unavoidable stockouts arise (e.g. global shortage), patients who are put on alternative medicines should be informed adequately on: why, the expected timeline, and the potential side effects of the alternative medicines. No patient should leave the facility empty handed. b. According to National Core Standards "Stock levels and storage of medicines and medical supplies must be managed appropriately". However, Ritshidze monitoring shows stockouts reported by patients and healthcare workers [DELETE AS APPROPRIATE]. Where unavoidable stockouts arise (e.g. global shortage), these should be escalated by the facility to the relevant management teams ASAP to avoid prolonging the situation and to ensure that no patient goes home empty handed. c. Ritshidze observations show that there was no pharmacist dispensing medicines on the day we monitored [DELETE AS APPROPRIATE]. As such we recommend that there should be a pharmacist, actively dispensing medicines and ensuring that the pharmacy is fully stocked at all times. If this cannot be achieved at clinic level, this recommendation will be escalated to district and provincial health department levels. OR ADD YOUR OWN BASED ON CONTEXT
5	**ARV COLLECTION AND ACCESS**	**CLINIC LEVEL** *(Where PLHIV report being unable to collect ARVs)* a. According to a National Department of Health circular issued in May 2019, all PEPFAR Siyenza sites should aim to extend opening hours to attract patients e.g. those working, who cannot attend during normal opening times. Facilities must be open from 5.00 — 19.00, as well as 8.00 — 16.00 on Saturdays including for medicine collection. In this regard, the pharmacy/dispensary should be open every day for collection of medicines. No person living with HIV or TB should be returned home empty handed based on what day they attend the clinic. *(Where PLHIV face bad treatment when re-engaging in care)* b. According to the National Patients' Rights Charter, every patient has the right to: "Friendly health care providers." However, Ritshidze monitoring shows that some patients report that staff at the facility have bad attitudes which impact on people's ability to access healthcare. This is especially true for people living with HIV who may have missed appointments or stopped taking treatment. Often, they are fearful to return as they know they will be shouted at. For PLHIV who face adherence challenges the clinic must put in place "Welcome Services" as per the MSF model (that can be provided) with a friendly approach and immediately restart PLHIV presenting to a clinic after a treatment interruption back on ARVs. PLHIV who return to care must not be shouted at or otherwise treated badly or "punished" for disengaging from care. OR ADD YOUR OWN BASED ON CONTEXT

#	FINDING	POSSIBLE SOLUTIONS AT FACILITY AND DISTRICT LEVEL
6	ADHERENCE CLUBS	**CLINIC LEVEL** *(Where there are no adherence clubs, or where they are dysfunctional)* a. The facility must have functional adherence clubs for people living with HIV to be recruited to. However, Ritshidze data shows that there are no clubs/the clubs are not functional [DELETE AS APPROPRIATE]. A functional adherence club must include the following features: • Adherence clubs meetings take place either in a clinic or a venue in the community where participants discuss issues concerning them and their group members; • Members should have a basic clinical check-up, conducted by the club facilitator; • Members should receive treatment literacy and adherence information at every club visit including but not limited to information on why they should adhere to medicines, side effects of medicines, and new treatment regimens. • Members should collect at least two-months' supply of ARVs; • Members should receive peer support from other members living with HIV in the club; • To qualify for the adherence club, patients must be stable (have been on the same ART regimen for over a year; have adhered to ART for 12 months or more; have an undetectable viral load as shown by the latest two consecutive tests; have no history of defaulting or missing appointments in the last 12 months; and have no medical conditions that require regular clinical care); • One club consists of 30 people living with HIV who meet every two months and are reminded of their appointment by SMS the day before; • Blood tests will occur every 12 months with a nurse clinician visiting; • In contrast to clinic visits which can take hours or even a full day, adherence club members must be in and out of their club visit between one and two hours. *(Where clubs do not provide good treatment literacy)* b. Ritshidze data collection shows that many PLHIV report not getting good information at the adherence club [DELETE AS APPROPRIATE]. Further our data shows that many people do not understand that an undetectable viral load means that you are healthy and cannot transmit HIV [DELETE AS APPROPRIATE]. This means we need better treatment literacy information at the facility in general and in adherence clubs. The adherence club facilitators should be trained on treatment literacy and basic mental health in order to provide adequate and ongoing learning on HIV and treatment. *(Where there is an insufficient number of adherence club facilitators)* c. Ritshidze data shows that there are many clubs being managed by an inadequate number of facilitators. The clinic should have an enough adherence club facilitators to ensure adequate time for managing, running and doing the admin associated with club management as well as to ensure time for learning on training materials for treatment literacy modules. The PEPFAR implementing partner should ensure adequate staffing to fulfil this mandate. OR ADD YOUR OWN BASED ON CONTEXT

#	FINDING	POSSIBLE SOLUTIONS AT FACILITY AND DISTRICT LEVEL
7	**ACCESS TO VIRAL LOAD TESTING / INFORMATION**	**CLINIC LEVEL** *(Where PLHIV are not getting a viral load test)* a. Ritshidze data shows that not all PLHIV are getting viral load tests at the facility. All PLHIV must receive a viral load test at 6 months after initiation and annually after that. *(Where PLHIV are not being given information on their viral load test results or do not understand results)* b. Ritshidze data shows that PLHIV are not being provided with the results of their viral load tests/do not understand the results of their viral load tests [DELETE AS APPROPRIATE]. All PLHIV must be educated on the importance of viral load (including the long-term positive health impact of an undetectable viral load and the prevention of transmission to other people). This should be provided by clinicians to PLHIV individually, through health talks by healthcare workers, and in adherence clubs. In addition, the PLHIV Sector organisations can support longer term HIV treatment adherence and retention in care through carrying out health talks on treatment literacy & adherence at the facility. OR ADD YOUR OWN BASED ON CONTEXT
8	**CONFIDENTIALITY AND PRIVACY**	**CLINIC LEVEL** *(Where people's HIV status' are being disclosed)* a. According to National Core Standards "Staff must treat patients with care and respect, with consideration for patient privacy and choice." No person living with HIV should have their status disclosed without their consent. Any staff member who discloses a person's HIV status without consent should be subject to disciplinary action [EDIT BASED ON CONTEXT OF HOW HIV STATUSES ARE BEING DISCLOSED IN ORDER TO ADDRESS ROOT CAUSE]. *(Where there is insufficient space at the clinic so more than one person is being seen in one room)* b. Ritshidze monitoring shows that there is insufficient space at the facility to provide private care to PLHIV. Where infrastructural issues mean that patient privacy is not being as people are being counselled, tested and treated for HIV and other conditions in the same room; in the short term the clinic must find space to confidentially see patients and let us know how this will be solved in the short term [ADD SPECIFIC SOLUTION TO SPACE CHALLENGE IF ABLE]. This issue will be escalated to district and provincial level to propose a recommendation for additional infrastructure based on the report of the Facility Manager. *(Where files are stored in a space accessible to patients)* c. According to the National Patients' Rights Charter, every patient has the right to: "Confidentiality and privacy concerning health care issues and treatment." Files must be kept in a space that is not accessible by patients to ensure that patient confidentiality is respected. *(Where people are not told they can refuse to participate in index testing)* d. Ritshidze monitoring shows that many PLHIV report not knowing that they could say no to giving the names and contacts of sexual partners and children through index testing. When healthcare providers alert someone that they may have been exposed to HIV by one of their sexual partners, there is always a risk of violence. This is why before contacting the sexual partners of PLHIV all healthcare providers should ask if their individual's partners have ever been violent and avoid contacting them if so in order to protect the individual. The clinic should ensure these questions are asked and if there are any positive responses that could indicate the potential for violence, that the partner is not contacted. Index testing must be entirely voluntary, where patients can choose to not disclose their partners names for any reason. *(Where patients are forced to take an HIV test in order to access other health services)* e. Ritshidze monitoring shows that some patients say that they must take an HIV test in order to access other services. No one should be forced to take an HIV test to qualify for access to contraceptives or other treatment or health care. OR ADD YOUR OWN BASED ON CONTEXT

#	FINDING	POSSIBLE SOLUTIONS AT FACILITY AND DISTRICT LEVEL
9	**PSYCHO-SOCIAL SUPPORT FOR PLHIV**	**CLINIC LEVEL** *(Where there is not adequate pre and post HIV test counselling)* a. Pre and post HIV test counselling must take place for each person who tests. This must ensure adequate explanation of the tests, what it means to be HIV positive, and for post-test counselling, include treatment literacy and adherence information. *(Where there is not adequate and ongoing HIV counselling for PLHIV who are on treatment)* b. People living with HIV should be able to access counselling services at any time after they have initiated treatment in order to support them in treatment adherence and living with HIV. HIV counselling should be made available to every person living with HIV, no matter how long they have been diagnosed with HIV and on treatment. *(Where there is not adequate HIV counselling for PLHIV who are on treatment in adherence clubs)* c. The adherence club facilitators should be trained on basic mental health in order to assess and refer club members for further psycho-social support where necessary. OR ADD YOUR OWN BASED ON CONTEXT
10	**PREP AND DTG-RELATED CONTRACEPTIVE ACCESS**	**CLINIC LEVEL** *(Where PrEP is not accessible to all)* a. Ritshidze monitoring reveals that PrEP is only accessible to a subset of people/ not available at the clinic [DELETE AS APPROPRIATE]. PrEP should be made available to anyone who is sexually active as a method of preventing HIV infection. Health talks should take place that explain what PrEP is and who it is for (i.e. everyone who is sexually active). Specific groups such as adolescent girls and young women, men who have sex with men, sex workers, people who use drugs, and women, should be particularly targeted for PrEP initiation. *(Where PLHIV are not being provided with information about transitioning to DTG)* b. All PLHIV should be counselled on the pros and cons with first line HIV treatment and make an informed decision between an efavirenz and a dolutegravir based regimen. However, Ritshidze monitoring shows that not everyone being transitioned is being provided with this information. This must be rectified going forward. *(Where women are not offered contraception if on DTG)* c. Women of reproductive age currently taking dolutegravir (DTG) should be offered access to contraception of their choice however Ritshidze monitoring shows this is not happening. Going forward this must be the case for all women of reproductive age. However, no-one should be forced to take contraception before accessing dolutegravir (DTG). OR ADD YOUR OWN BASED ON CONTEXT

#	FINDING	POSSIBLE SOLUTIONS AT FACILITY AND DISTRICT LEVEL
11	**COVID-19 DISRUPTIONS**	**CLINIC LEVEL** *(Where no physical distancing)* a. Ritshidze monitoring showed that there is inadequate physical distancing inside/outside the gates of the facility [DELETE AS APPROPRIATE]. Staff must ensure that all patients are encouraged to carry out physical distancing (of more than 1.5 metres) in order to avoid COVID-19 transmission. This applies to both inside and outside the clinic grounds. *(Where no access to sanitizer)* b. Ritshidze monitoring showed that there is no access to sanitizer upon entry to this facility. Everyone entering the facility must be provided with access to sanitizer in order to avoid transmission of COVID-19. This must be rectified to ensure adequate provision. If this is a supply issue it will be escalated to district and provincial health department level. *(Where not enough PPE for staff)* c. All staff (including CHWs) should have adequate access to personal protective equipment, yet Ritshidze monitoring showed challenges with this. PPE includes but is not limited to N95 masks and hand sanitizer. This must be rectified to ensure adequate provision. If this is a supply issue it will be escalated to district and provincial health department level. OR ADD YOUR OWN BASED ON CONTEXT
12	**TB INFECTION CONTROL**	**CLINIC LEVEL** a. There must be a full audit of the facility to assess the state of TB infection control measures in place based upon WHO guidelines. Results of the audit should be shared with the PLHIV Sector and Clinic Committee and a plan to address the challenges put in place. *(Where there is not enough room in the waiting area)* b. Ritshidze monitoring shows a lack of room in the waiting area. In order to address this challenge, with your recommendations on how to fix the problem, we will escalate this issue to district and provincial health department level. *(Where people are at the facility for more than 1 hour 15 minutes)* c. According to National Core Standards "waiting times and queues must be managed to improve patient satisfaction and care, and serious patients are attended to first" however Ritshidze data shows excessive waiting times at this facility that could contribute to TB infection. The Facility Manager should develop and share an improvement plan in order to improve the length of queues. Ritshidze staff will provide feedback on the reasons given by patients for long queues that may assist the improvement plan. *(Where windows are closed)* d. All windows must be kept open to ensure better ventilation and reduce the risk of TB infection. *(Where patients are not screened for TB symptoms)* e. Patients must be screened for TB symptoms upon arrival. The facility should consider screening people for TB symptoms at the same time as screening for COVID-19 symptoms. *(Where patients who are coughing are not separated)* f. People who are coughing must be separated from those who are not while waiting. Further, people coughing or with TB symptoms must be seen first to reduce the risk of transmission to others in the facility. *(Where patients who are coughing are not given tissues or masks)* g. People who cough a lot or who may have TB must be given tissues or TB masks. *(Where no/or inadequate posters)* h. Large TB infection control posters must be visibly on display in all waiting areas. These should also be in local languages. DELETE BASED ON CONTEXT

#	FINDING	POSSIBLE SOLUTIONS AT FACILITY AND DISTRICT LEVEL
13	YOUTH	**CLINIC LEVEL** *(Where there are no youth specific services)* a. The clinic should ensure that the following youth services are offered at the site (DELETE AS APPROPRIATE) • Youth outreach services • Access to HIV testing & counselling • Access to PrEP • Access to contraceptives • Information packages for adolescent SRH services • STI screening & treatment • Youth happy hour • Youth champions *(If young people are being turned away without access to SRHR and/or HIV services)* b. No young person should be turned away without being able to access contraceptives, HIV testing and treatment, and/or other sexual and reproductive health and rights (SRHR) and health services. *(Where the clinic is not friendly to young people)* c. All staff should be sensitized to the needs of young people and ensure a youth friendly service. OR ADD YOUR OWN BASED ON CONTEXT
14	KEY POPULATIONS	**CLINIC LEVEL** *(Where key populations do not want to access services at the clinic)* a. Key population specific days at the clinic should be considered to help increase the numbers of key populations accessing services. *(Where the clinic does not friendly to key populations)* b. The clinic should consider training health workers of service provision for key population and its importance including sensitizing staff on key population friendly service provision and the different health needs of these groups (including sex workers, transgender people, men who have sex with men, and people who use drugs). c. The clinic should consider hiring staff members that identify as members of different key population groups to increase friendly services that are offered amongst peers. *(Where the clinic does not offer key population specific services)* d. The clinic should consider introducing services that are attractive to key populations e.g. outreach services, introduction of PrEP at the facility, and having access to condoms and lubricants. OR ADD YOUR OWN BASED ON CONTEXT
15	MEN	**CLINIC LEVEL** *(Where the clinic does not provide male specific services)* a. The clinic should ensure that the following services are offered at the site (DELETE AS APPROPRIATE) • Voluntary male medical circumcision • Access to condoms & lubricant • Services for men who have sex with men • Male outreach services (outside facility setting) b. Men living with HIV should be recruited into men only adherence clubs. *(Where men are not accessing services as the clinic is only open for limited hours)* c. Flexible service delivery e.g. extended hours and weekend service should be offered for men who are working during the week and are unable to visit the facility. OR ADD YOUR OWN BASED ON CONTEXT

SO YOU HAVE YOUR SOLUTIONS, WHAT NEXT?

After you have identified your solutions— through the monitoring team, the branch, and at times the community—you need to write those final solutions up in the clinic review meeting template.

The Community Monitor should do the first draft in the clinic review meeting template and send this to the District Organiser for review. You will see that the template shows you sections based upon the clinic data report. Only fill out the sections where you have a solution—you can leave the other sections empty.

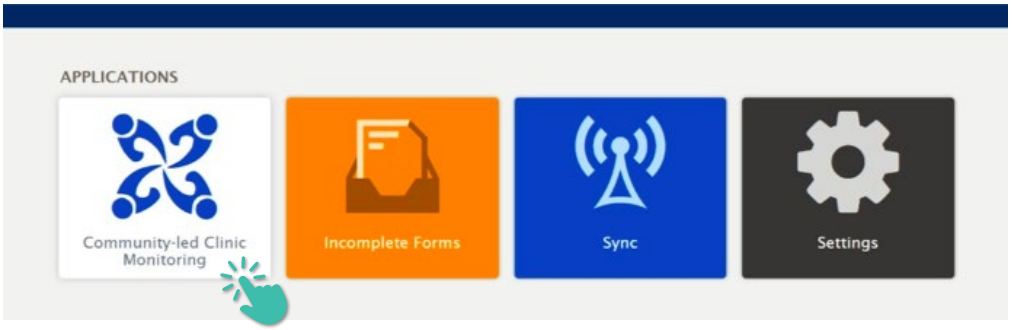
After reviewing, the District Organiser will then send to the Project Officer to review and sign off. Once these have been reviewed and signed off by the Project Officer, the final version will be returned to the District Organiser in order to upload into CommCare.

Make sure that you include everything you want into the template as you will not be able to add solutions after submitting to CommCare.

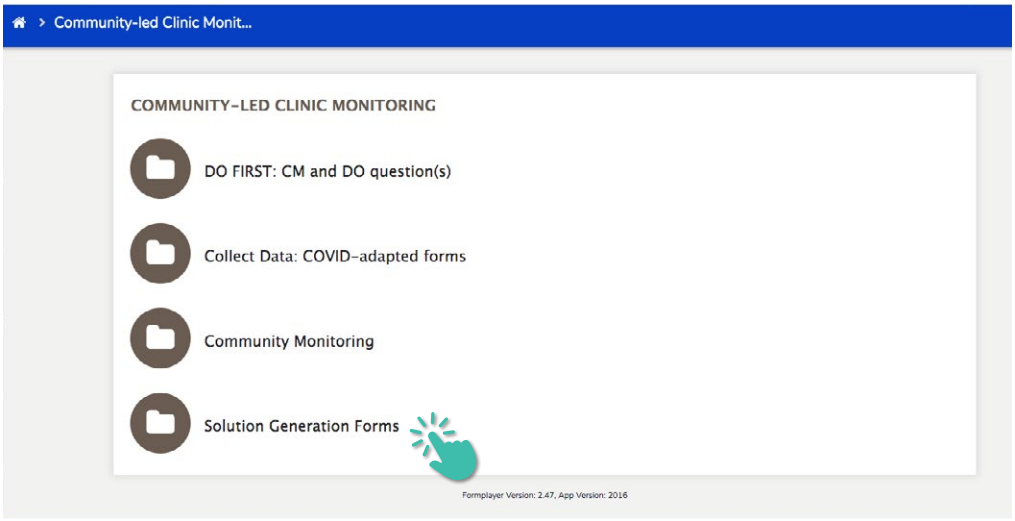
HOW TO UPLOAD TO THE COMMCARE WEBSITE

STEP 1: District Organisers can login to CommCare on your computers at bit.ly/RitshidzeCommcare using your normal login details.

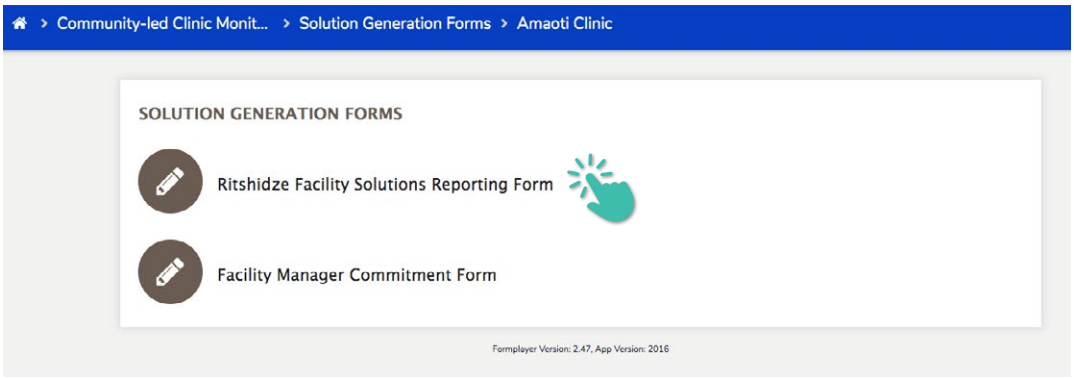
STEP 2: Choose the "Community-led Clinic Monitoring" button.



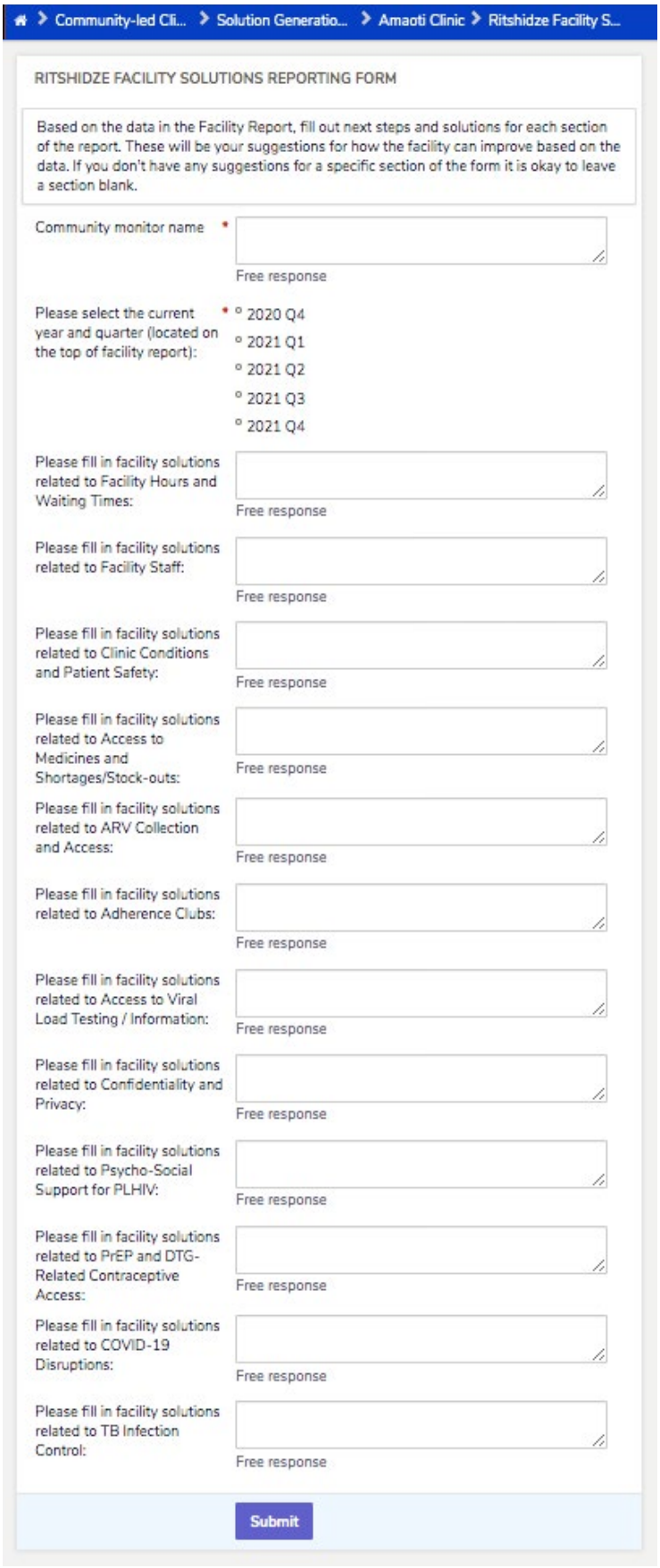
STEP 3: Next choose the "Solution Generation Forms" folder at the bottom of the screen and then go to the clinic you want to add solutions for.



STEP 4: Next choose "Ritshidze Facility Solutions Reporting Form".



STEP 5: Follow the steps in the form. You will need to choose the correct quarter (this is written in the Facility report at the top).



STEP 6: You can then copy and paste the solutions from the clinic review meeting template into CommCare. Only fill the sections that have a recommended solution, leave the sections blank if there is no solution. To do this:

1. Highlight the text you want to copy.
2. Copy by pressing Command + C
3. Put the cursor where you want to place the text, and Paste by pressing Command + V.

STEP 7: Press submit and the solutions will be saved on CommCare.

ENGAGE DUTY BEARERS

ENGAGING OFFICIALS AT CLINICS AND OTHER HEALTHCARE FACILITIES

ENGAGING OFFICIALS AT DISTRICT, PROVINCIAL AND NATIONAL LEVELS

ENGAGING OFFICIALS AT CLINICS AND OTHER HEALTHCARE FACILITIES

At this stage it is time for you to start engaging officials at the clinic on what you have found. When doing this is it important that you have documentation that outlines the analysis of data collected (the facility report), as well as the solutions generated to fix them (the solutions report).

You should never just arrive at a feedback meeting in the clinic without anything written down. This documentation must form the basis of your engagement with officials at clinics—it is called your "State of the Clinic report".

HOW TO CREATE THE STATE OF THE CLINIC REPORT

Step 1: Take your downloaded Facility report from the "Reports" page of the dashboard

Step 2: Take your downloaded solutions report from the "Reports" page of the dashboard (you will need to be logged in to see the solutions).

Step 3: Print then staple them together for a complete State of the Clinic report. Take copies for everyone who will be in the meeting. When you request the meeting to feedback on the reports, you should also share soft copies with the Facility Manager ahead of time.

This is what a state of the clinic report will look like:

Hikhensile Clinic Monitoring Report

Gauteng - City of Johannesburg: 2020 Q4

Facility Hours and Waiting Times

Facility is Open 24 Hours

No

Open Time M-F:	7:00
Open Time Sat:	7:00
Average stop time:	15:54

NDoH May 2019 Circular: "Facilities must be open from 5.00 - 19.00, as well as 8.00 - 16.00 on Saturdays."

Time Patients Spend at the Facility?

Patient Responses: 14

No. of Hours: **6:42**

This ranks:
- 348 of 398 Facilities Nationally (Bottom Quarter)
- 104 of 118 Facilities in the Province (Bottom Quarter)
- 41 of 47 Facilities in the District (Bottom Quarter)

Earliest Patient Arrival Time

Patient Responses: 15

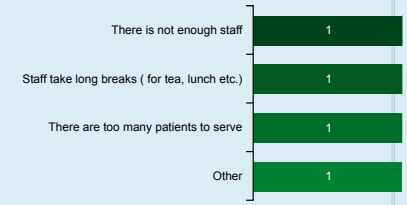
Earliest arrival time **5:01**

This ranks:
- 329 of 398 Facilities Nationally (Bottom Quarter)
- 98 of 118 Facilities in the Province (Bottom Quarter)
- 40 of 47 Facilities in the District (Bottom Quarter)

Are the Queues at the Facility Long?

Patient Responses: 15

93% of patients report long queues

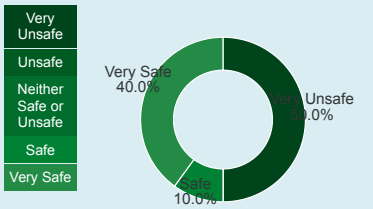


Other Reasons given for Long Queues

No Data for this Indicator

How Safe is the Facility to Wait Before it Opens?

Patient Responses: 10

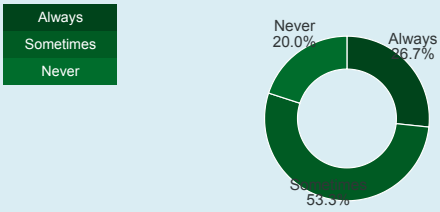


This ranks:
- 206 of 353 Facilities Nationally (Bottom Half)
- 65 of 112 Facilities in the Province (Bottom Half)
- 25 of 46 Facilities in the District (Bottom Half)

Facility Staff

Are there Enough Staff at the Facility?

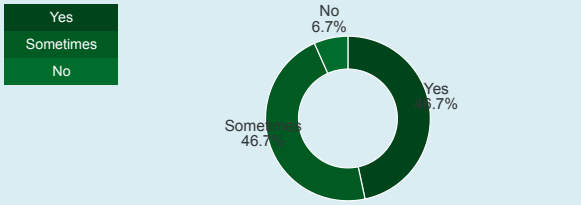
Patient Responses: 15



This ranks:
- 198 of 404 Facilities Nationally (Top Half)
- 59 of 118 Facilities in the Province (Bottom Half)
- 24 of 47 Facilities in the District (Bottom Half)

Are Staff Friendly and Professional?

Patient Responses: 15



Facility Manager: Does the Facility have Enough Staff?

Facility Responses:1

Yes

Which Cadres are Understaffed?

No Data for this Indicator

Hikhensile Clinic Solutions & Commitments

Gauteng - City of Johannesburg: 2020 Q4

Facility Hours and Waiting Times

Proposed Solutions	Facility Commitments
• Patients should be offered treatment in the quickest possible time • The national target of not more than 3 hours for time spent in the facility reception and waiting areas should be visibly displayed • Patients should be informed intermittently of any delays promptly or as often as possible and mitigating measures that are being instituted • Waiting time must be monitored six monthly • If the facility's average time spend in the facility exceeds three hours, establish which service areas are causing the bottle-neck • Staff breaks should be regulated to agreed time periods and not all happen at the same time. This should be addressed and managed by the Facility Manager	

Clinic Conditions and Patient Safety

Proposed Solutions	Facility Commitments
• Security guards should ensure that gates open by 5am to allow patients who arrive early to be safe since the earliest arrival time is 4:56 am • An adequate number of security guards should be hired to ensure patient safety in the early hours and during the working day	

Access to Medicines and Shortages/Stockouts

Proposed Solutions	Facility Commitments
• There should be a pharmacist, actively dispensing medicines and ensuring that the pharmacy is fully stocked. • Where unavoidable stockouts arise (e.g. global shortage), patients who are put on alternative medicines should be informed adequately on: why, the expected timeline, and the potential side effects of the alternative medicines.	

TB Infection Control

Proposed Solutions	Facility Commitments
There must be a full audit of the facility to assess the state of TB infection control measures in place based upon WHO guidelines. Results of the audit should be shared with the PLHIV Sector and Clinic Committee and a plan to address the challenges put in place. b. Large TB infection control posters must be visibly on display in all waiting areas. These should also be in local languages. c. All windows must be kept open. d. Patients must be screened for TB symptoms upon arrival. e. People coughing or with TB symptoms must be seen first to reduce the risk of transmission to others in the facility. f. People who are coughing must be separated from those who are not while waiting. g. People who cough a lot or who may have TB must be given tissues or TB masks.	


ITSHIDZ
PEOPLE'S
COP19
SOUTH AFRICA
COMMUNITY PRIORITIES
OPERATIONAL PLAN 2019
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POSITIVE
PATENT LAWS
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MEETING WITH OFFICIALS AT THE CLINIC

The next step is to set up a meeting with the Facility Manager and the Clinic Committee to go through the State of the Clinic report in detail. It is important that where you have been working with a PLHIV Sector branch or member, you must prepare together and include them in the meeting.

During the meeting you will go through the State of the Clinic report in detail. For each challenge highlighted and solution recommended, make sure you get a commitment from the officials as to what they actually commit to do. Make sure that they understand that our solutions are just recommendations. Take detailed notes of the meeting including all commitments made. Type this up after the meeting and send a copy to everyone who attended the meeting as well as to your District Organiser. This is very important so that in the next round of monitoring you can monitor to see if they are doing what they committed to. At your next meeting you should also check from the problems that have already been identified, which have been resolved and which ones have not yet been addressed and why?

WHAT SHOULD YOU DO IF YOU FEEL YOUR MEETING ISN'T GOING ANYWHERE?

1. Take some deep breaths.
2. Stay calm and patient.
3. Try to keep the meeting focused on the topic.
4. Rephrase what has been said or the reasons for the problems described.
5. Rephrase the solutions.
6. If the problem cannot be solved at a clinic level, continue to ask what concrete action is possible for the official to do to get to the solution (*e.g. call someone higher up, agree to a follow up meeting, send an email or message to someone with influence etc.*)

Always make sure to leave with some concrete commitments from either side and make sure that all of these commitments are not on you!

ENGAGING CLINIC COMMITTEES

When engaging with the clinic staff, it is important to also engage with the clinic committee. Clinic committees are governance structures that are intended to ensure community participation at a local level. They are key to ensuring accountability and a successful AIDS and TB response.

Through clinic committees, public healthcare users are meant to engage and take ownership over the health system, raise concerns and ensure accountability at local levels. The committees should be made up of a combination of community representatives and health professionals of each area and meet regularly. They should input and feedback into the planning, delivery and organisation of health services and play an oversight role in the development and implementation of health policies and provision of equitable health services. However often clinic committees are not functioning effectively.

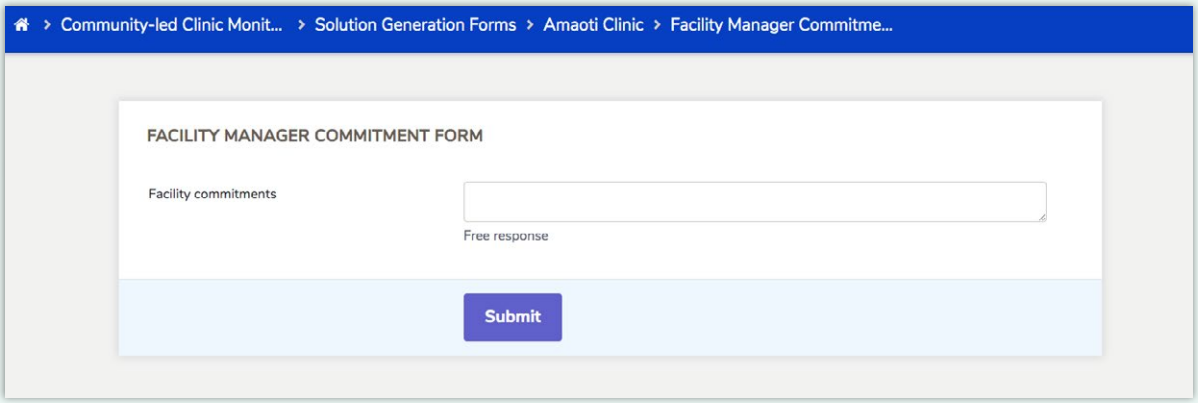
While clinic committees are required by law—Section 42 of the National Health Act 61 of 2003 requires provinces to provide for clinic committees and ensure their functioning—it cannot be claimed that clinic committees function effectively in any province. Too many lack a clear understanding of their role and responsibility and no financial resources are allocated to improve this situation.

Make sure you find out who the members of the clinic committee are, including the chairperson. Set up a meeting with them. Introduce the project and its objectives in your first meeting. Find out what challenges are impacting upon the functioning of the clinic committee. Try and establish a partnership to work towards addressing these challenges. Make sure the clinic committee knows their purpose, roles and responsibilities. Include the chairperson on meeting with the facility manager to feedback the findings of the community data collected at the facility as well as the proposed solutions. Ensure the clinic committee intervenes where required in addressing the challenges.

HOW TO TAKE GOOD NOTES IN MEETINGS

Note taking is a critical part of the job of everyone in the Ritshidze team. Without comprehensive notes and reports from each meeting and activity, you will be unable to inform your advocacy with the latest developments. Here are some top tips to help you take better notes to capture commitments and to ensure accountability :

1. **Prepare your tools**: Have you got a notebook and pens?
2. **Determine important content**: Notes do not need to be word for word. Listen carefully and determine the important content to note down including key developments, actions, and commitments.
3. **Minimise distractions**: Turn your phone off and make sure other logistical responsibilities have been delegated to another team member so that you can concentrate on what is being said.
4. **Write in the language you are comfortable**: You can always translate to English later for the final record.
5. **Reflect and review:** After the event, reflect on the meeting with the other PLHIV Sector branch members who were supporting you—review and edit your notes together and include any reflections. Do this in a timely manner before you forget what was said. Preferably the same day.
6. **Share**: Make sure that you add the commitments made into the solutions template and that the District Organiser has the final version to upload to CommCare in the "Facility Manager Commitment Form" found in the "Solution Generation Forms" folder. This is essential to ensure we maintain a paper trail.



Don't forget that taking notes is a skill you can learn. You'll get better with practice!

ENGAGING OFFICIALS AT DISTRICT, PROVINCIAL AND NATIONAL LEVELS

Where challenges cannot be addressed at a clinic level, or there is resistance from clinics to fix them, we need to escalate the issues to decision makers at district, provincial or even national level. In all these levels of engagement it is critical to work hand in hand with PLHIV Sector leaders.

The first stage is district level. When doing this it is important that you have documentation that outlines the analysis of key challenges found through all the facility and community monitoring in the district, as well as the solutions generated for the district as a whole. It is critical to have clear demands to hold the officials to account on. You should never just arrive at a meeting with district health officials without anything prepared. This documentation must form the basis of your engagement with officials—it is called your "State of the District report". It is always more impactful to use evidence and data to make your point, than speaking generally about problems.

HOW TO CREATE THE STATE OF THE DISTRICT REPORTS

The State of the District report should be created by the District Organiser(s) with inputs from the PLHIV Sector leadership. If there is more than one District Organiser in the district, you must work together to compile the report. If you are working alone in the district, you can ask a Project Officer to assist.

Step 1: Download the data report for the district from the "Reports" page of the dashboard.

Step 2: Gather all the State of Clinic reports from the clinics in the district—as well as any notes, commitments and reflections from meetings with the clinic staff and clinic committees. *Is there resistance from the clinic to fix the challenges? Where are the bottlenecks? Which issues need to be escalated?*

Step 2: Gather all the notes from each of the clinic review meetings held with Community Monitors—in particular look at which problems you thought needed to be addressed at the district level because it didn't seem like they can or will be solved at the clinic.

Step 3: Hold a ***district review meeting*** with all the **District Organisers** from that district, the Project Officer, and district level PLHIV Sector leaders to discuss all the clinics in the district—*what are the district wide trends in terms of human resources, clinic conditions, stockouts and shortages of medicines, HIV adherence, or TB infection control? What can only be fixed at the district level? What are the challenges that need to be escalated? What solutions were generated for the district level? What are the most urgent things to raise? What should be raised at a provincial or national level instead?*

Step 4: Decide together the 5 or 6 major challenges as discussed in your district review meeting together with the solutions generated for each (*decide which District Organiser will take a lead on this—make sure everyone reviews the draft document*). Use the district review meeting template to outline this (available in the appendix).

Step 5: Present the data report and draft solutions to the provincial PLHIV Sector leaders at the monthly provincial meeting. Allow time to discuss the report and see if there are any additions or changes. Make sure to make any changes to the report following this meeting. Write up the final solutions in the template and upload to CommCare in the "Solution Generation Forms" folder.

Step 6: Print the district data report and the district solutions then staple them together for a complete State of the District report. Take enough copies for everyone who will be in the meeting. You should also share electronic PDF copies to the district health team ahead of time.

RITSHIDZE PROVINCIAL GOVERNANCE MEETINGS

In each province every quarter there will be a governance meeting that discusses the data analysis, the generated solutions, and the plans to engage duty bearers in the province and relevant districts. The meetings are important to allow for joint discussion and planning—and to ensure that the project is supporting the broader work of the PLHIV Sector organisations and we are not working in parallel. Included in these meetings will be **provincial PLHIV Sector leaders** (as chosen by the organisations), a **national PLHIV Sector leader**, all **Ritshidze District Organisers** from the province, and a **Project Officer**. Clear notes should be captured and shared with all attendees for each meeting. Use the provincial governance meeting template to capture notes (available in the appendix).

MEETING WITH DISTRICT HEALTH OFFICIALS

The next step is to set up a meeting with the district health team to go through the State of the District report in detail. It is ideal to meet with the district health teams on a quarterly basis to raise these issues that must be addressed at a district level. This could include issues such as staff shortages or infrastructural issues that cannot be addressed at a clinic level, or could include issues that have failed to be addressed by the clinic staff in a reasonable way.

First agree on the team who will meet with the district health officials—*this should include Ritshidze District Organisers as well as provincial PLHIV Sector leaders. In high burden districts, include a Project Officer too.* Agree who will present what is in the State of the District report. Consider making a powerpoint presentation of the report to be able to clearly present the data, the findings and the proposed solutions as you engage officials.

For each challenge highlighted and solution recommended, make sure you get a commitment from the officials as to what they actually commit to do. Take detailed notes of the meeting including all commitments made. Type this up after the meeting and send a copy to everyone who attended the meeting as well as to your Project Officer, and all the Community Monitors in the district. This is very important so that in the next round of monitoring they can monitor the implementation of these solutions, to check if they are doing what they committed to. At your next meeting you should also check from the problems that have already been identified, which have been resolved and which ones have not yet been addressed and why?

PROVINCIAL AND NATIONAL LEVEL

Engagement with duty bearers at provincial and national level will be led by the Project Officers together with the PLHIV Sector national and provincial leadership, and support from activists from Health GAP, amfAR, and O'Neill Institute. Where necessary this team will consult with District Organisers and Community Monitors.

HOLDING AIDS COUNCILS ACCOUNTABLE

South Africa has a National AIDS Council (SANAC), provincial AIDS councils, district AIDS councils, and ward AIDS councils. These AIDS councils give civil society a way to have a say in South Africa's AIDS response. However, often AIDS councils are dormant or dysfunctional. The PLHIV Sector works at all levels to ensure that AIDS Councils are functional and responsive to the realities we face in our communities. Ritshidze data should be used to support this effort.

AIDS Councils can play a critical role in getting business, labour, civil society and various government departments to work together in the fight against HIV and TB. It is through these consultative structures that the vision set out in South Africa's National Strategic Plan for HIV, TB and STIs 2017 – 2022 is to be turned into real and tangible change in our communities. The Council should meet every quarter to discuss the AIDS response in the district. However, just having meetings is not good enough, people have to make sure that these meetings are used to catalyse a more effective response to the HIV and TB epidemics in their districts or provinces.

In order to do this, every quarter District Organisers should work with the PLHIV Sector in the district to organise district PLHIV Sector meetings ahead of AIDS Council meetings. These should include PLHIV sector organisations that are part of AIDS councils—as well as any other community and district based organisations working on HIV in the area.

Use these meetings to present the State of the District report, hear back from other organisations as to further challenges they have identified, and then develop a joint plan to address these challenges through engagement in AIDS councils. PLHIV Sector representatives who participate in AIDS Councils should use the State of the District report, as well as other issues raised in our meeting, to raise challenges in the AIDS Councils and hold them accountable for fixing challenges.

PUBLIC HEARINGS & OTHER ACCOUNTABILITY MEETINGS

One powerful method to engage duty bearers is through the use of a public hearing. Public hearings act as platforms for individuals to challenge and mobilise against systemic oppression and marginalisation in the health system. Public hearings allow community members to make their voices heard, to call for their rights to be realised and their dignity to be restored. They have the ability to both disseminate evidence collected whilst also raising the voices of people affected individually.

A public hearing is different from a community dialogue. A community dialogue is a method of generating solutions where targeted community members affected by a specific issue are brought together to help generate solutions. At a community dialogue you will likely not know what inputs people have to make ahead of time.

In contrast, a public hearing is a method of engaging duty bearers to try to actually implement already identified solutions. You will know exactly what all the community members are going to say as it will align with the evidence and solutions you will be presenting (*all the community members will have previously filled out an individual testimony tool*). In Ritshidze, public hearings will mostly take place at a district, provincial and national level.

STEPS TO ORGANISE AN IMPACTFUL PUBLIC HEARING

STEP 1: A public hearing is a method of presenting the evidence and proposed solutions identified in a report—such as the State of District report, the State of Province report, or the People's COP—together with people's stories. The report and the stories must be aligned. This means that if the evidence is showing a challenge with long waiting times, then we will hear stories related to long waiting times. In contrast if stockouts are not a challenge in the report, we will not hear from a person who is facing a stockout.

STEP 2: Once you have developed your report, you can then try to find stories that align to those challenges. First the national or technical support team can check all the individual testimonies that have been submitted to CommCare to see which stories align with the issues you want to raise at the hearing. If there are not enough testimonies, or not enough people willing to join the event and speak out, further door to doors may need to happen to find people with stories. You need around 20 or 30 people able to testify—depending on the length of the public hearing.

STEP 3: Next you will need to ensure that all the other people needed at the event are invited: this could include health officials at the district, provincial and/or national levels, facility managers, clinic committees, PEPFAR teams including representatives CDC, USAID and/or implementing partners, UNAIDS, other community or civil society groups, and any other relevant stakeholders. Discuss who to invite with the national team beforehand. Make sure to send invitations on Ritshidze letterhead.

STEP 4: Once you have the right people lined up to be in the room, you can start building the agenda and presentation. The agenda should run through the challenges in your corresponding report including outlining the data analysis, highlighting people's stories, and offering the proposed solutions—see an example on the right.

Make sure you assign roles for who will be the chairperson, who will present the data, who will facilitate the testimonies, and who will outline the solutions.
You will need a powerpoint presentation that includes the data and solutions—the national and technical support teams will be able to assist.

AGENDA

Introduction *(overview of Ritshidze & how we collect data)*

Challenge 1
+ Data collected
+ Stories
+ Solution

Challenge 2
+ Data collected
+ Stories
+ Solution

Challenge 3
+ Data collected
+ Stories
+ Solution

Challenge 4
+ Data collected
+ Stories
+ Solution

Response from key duty bearer

Closing

STEP 5: Think about how the room will look and if you can add to the advocacy impact. Consider printing large pictures showing the challenges you will be highlighting, for example clinic photos collected whilst monitoring that show long queues, dirty facilities, or messy filing systems. You can display these throughout the room so that no one can escape the reality people face in clinics. Make sure to also display a Ritshidze banner and that all the presenters are wearing Ritshidze t-shirts—this is important not only to show who we are but also for any photographs of the event for use on social media and in future online and other communications tools.

STEP 6: The day before the public hearing you should bring all the community members who will testify together. Outline what will happen the following day. Make sure you know who will say what and make sure they know when in the agenda they will be called on.

CASE STUDY

THE "PEOPLE'S COP" COMMUNITY MEETINGS

One example of a public hearing is the People's COP meetings held for the last three years to influence U.S Ambassador Deborah Birx, PEPFAR Coordinator ahead of the annual planning process.

As an example in March 2020, in order to present the findings of the first quarter of data collection for Ritshidze and the solutions outlined in the "People's COP"—a public hearing was held to allow community members struggling to access HIV and TB services to raise their concerns and challenges directly to the Ambassador and PEPFAR teams.

This high-profile event was attended by around 100 people including people living with HIV, healthcare workers, men, young people, sex workers, men who have sex with men, people with TB, and other community members—as well as the leadership of each of the U.S. agencies involved in PEPFAR, the National Department of Health and UNAIDS.

We presented the key challenges we had found during data collection alongside each of our proposed solutions. We had powerpoint slides that showed the analysis of the data, people's quotes, and pictures.

For each challenge we had 4 or 5 people ready and waiting to tell their own personal story. We had collected these stories through door to doors across the country. It was difficult for the duty bearers to ignore the impact of these challenges on people's lives as they came directly from the people experiencing them. By holding a meeting the day before to verify all the stories, we were able to organise people so that their interventions were impactful and to the point. We knew what everyone was going to say.

In addition we printed some of the photos collected during the data collection on big boards in order to showcase the dysfunction at clinics. We put these up across the room so no-one could miss them. The event pushed the voices of grassroots people living with HIV, young women, and communities of key populations into PEPFAR discussions that too often focus on numbers and targets instead of people and lives.

CASE STUDY

THE PEOPLE'S COMMISSION OF INQUIRY INTO THE FREE STATE HEALTH SYSTEM

The People's Commission of Inquiry into the Free State Health System was held in 2015 and provided a platform to hear the voices of those accessing public healthcare services in the province.

It aimed to make an independent assessment of the realities of healthcare delivery in the Free State from the ground, across a broad cross section of those accessing or working within the public health sector in the province. Through a structured, transparent and inclusive process it aimed to shine a light on people's lived experiences and show—in their own words—how they were experiencing the Free State public healthcare system.

The process began in May 2015 with a month of community dialogues in the province organised by TAC. TAC reached 600 people, in 15 communities, across three of the five districts in the Free State. They collected people's experiences of using the healthcare system, organised them as testimonies, and then invited people to testify at a public commission of inquiry that would be overseen by three independent commissioners. It was apparent from the outcome of the community dialogues that a full inquiry into the state of health services in the province was necessary.

Many of those reached by the TAC arrived to give their testimonies at this public platform. Many more submitted written testimonies to be analysed by the commissioners. In addition, civil society, activists and healthcare professionals spoke or made submissions to the commissioners. The Free State Department of Health was also invited to testify and to make submissions. The inquiry was live streamed to enable those who were not able to attend to follow the process and listen to the testimonies.

ADVOCATE FOR CHANGE

WHEN IS IT TIME TO ADVOCATE FOR CHANGE?

DEVELOPING A CAMPAIGN STRATEGY

RITSHIDZE
SAVING OUR LIVES

WHEN IS IT TIME TO ADVOCATE FOR CHANGE?

So you've gathered evidence, analysed the data and diagnosed the problems, generated solutions, and you have politely engaged clinic and health officials through meetings and public hearings—yet nothing has changed. People are still struggling to access quality HIV and TB services. People continue to wait in long queues. The clinic is still dirty. So what should happen next?

Now it is time to develop a campaign strategy to address the challenges. Importantly, it will be branch members and leaders from the PLHIV Sector who will take a lead in advocating for change together with support from team members at TAC and Health GAP.


STOP
THE FREE STATE
HEALTH
CRISIS


SHIDZE


HIV
PLEASE MEC SAVE
OUR LIVES!!!!


HIV
HIV
HIV


ACTIVE ACTIVIS
OF
M-DR & X-DR
TREATMENT

DEVELOPING A CAMPAIGN STRATEGY

First of all you need to develop a campaign strategy—below is a suggested campaign planning structure you can use. If your campaign plan answers the questions in each section, you should be well on your way to a strong and well thought out plan.

STEP 1: STATE YOUR PROBLEM AND GOAL

The first step is to outline what is the problem you are trying to solve and what is the change you want to see (solution). These questions will already be answered in the State of the Clinic or State of District reports.

STEP 2: IDENTIFY YOUR TARGETS

Next you need to identify who you will target with your campaign.

Who are your primary targets?

+ Who has the power to give you what you want?
+ What power do you have over them?

Who are your secondary targets?

+ Who has power over the people with the power to give you what you want?
+ What power do you have over them?
+ Who can influence your targets? (This could be the media, other officials, the public, specific individuals etc.)

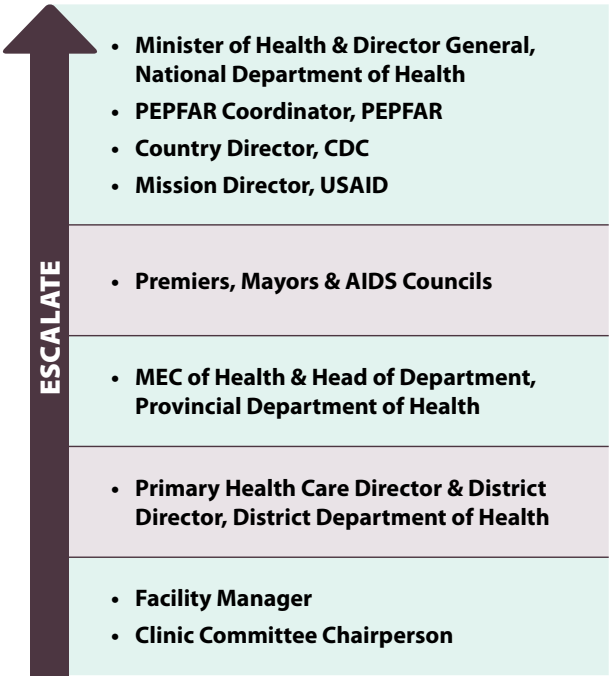


Figure 1: Targets, showing the line of escalation.

STEP 3: IDENTIFY YOUR ALLIES AND OPPONENTS

Next you should identify who are your allies and opponents. Follow the questions below to help determine this:

Who are your allies?

+ Who cares about this issue enough to join in or help the organisation?
+ Whose problem is it?
+ Who else needs to be made aware of our campaign?
+ What do they gain if you achieve the goal?
+ What risks would they be taking to join you?
+ What power do they have over the target?
+ Into what groups are they organised?

Who are your opponents?

+ What will your victory cost them?
+ What will they do/spend to oppose you?
+ How strong are they?
+ How are they organised?

There are many tactics you can use! The more creative the better to get the attention of the media.

STEP 4: DETERMINE YOUR TACTICS

What are you actually going to do to achieve your objective? What can you highlight to either encourage the duty bearer to take action, or to expose the problem and push it into public view?

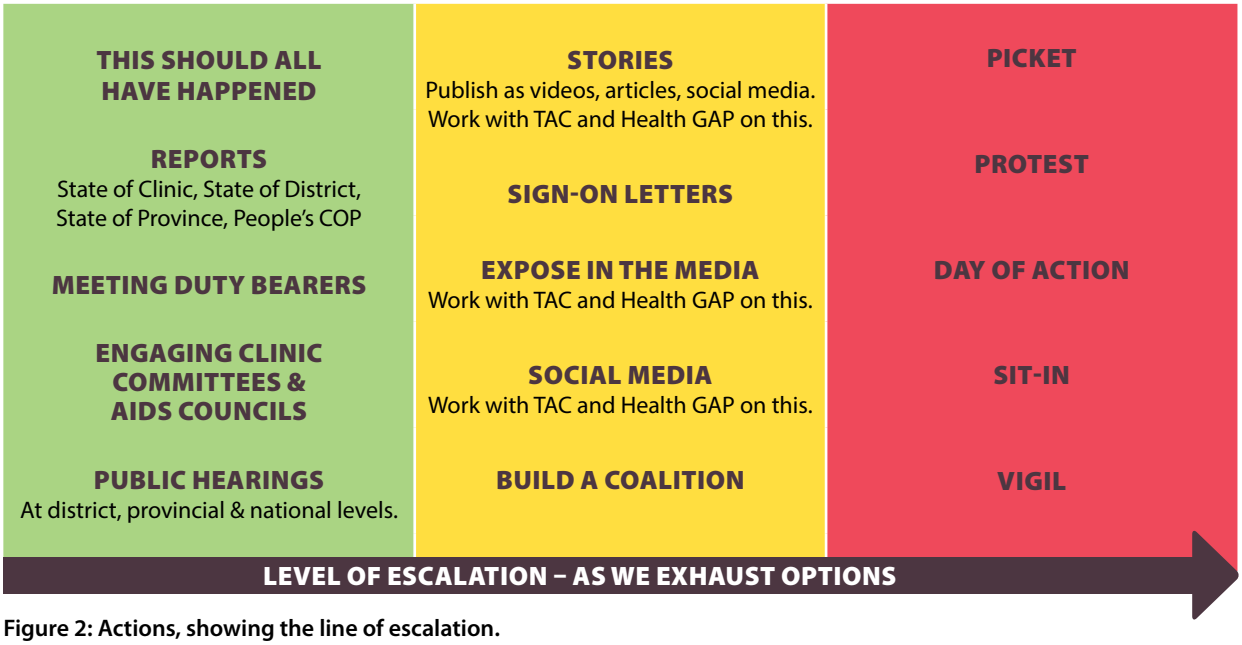


Figure 2: Actions, showing the line of escalation.

STEP 5: DEVELOP AN ACTION PLAN

You've chosen your tactics, when is the best time to use them? Who will do which tactic? What is the best way to make your tactics have the maximum impact? Make sure you engage national project staff as well as TAC and Health GAP on your plans for their support.

THE RITSHIDZE CYCLE CHECKLIST

GATHER EVIDENCE

- [ ] The observation survey is completed
- [ ] Patient surveys have been completed with 15 people living with HIV reached
- [ ] The Facility Manager survey is completed
- [ ] Adherence club members surveys have been completed where possible
- [ ] The Adherence Club Facilitator survey is completed
- [ ] The Medicines survey is completed
- [ ] Pictures have been taken at the clinic
- [ ] All surveys have been uploaded into CommCare
- [ ] Pictures have been sent to the correct WhatsApp channel with clear updates
- [ ] Issues requiring rapid response have been communicated to the correct WhatsApp channel
- [ ] Is this a high or medium intensity site? If so do community monitoring to find individual testimonies through door to door or an informal focus group (*if you run out of activities later in the month, do more community monitoring*)

ANALYSE THE DATA

- [ ] The reflection form has been filled on CommCare
- [ ] Facility report has been downloaded from the data dashboard
- [ ] Clinic review meeting held with PLHIV Sector members, Community Monitor, District Organiser, and Project Officer responsible for that clinic
- [ ] Clinic review meeting template completed.

GENERATE SOLUTIONS

- [ ] Do you need to find other solutions? If so reach out to the wider PLHIV Sector, other Ritshidze staff, the community, healthcare providers for more ideas
- [ ] Is there a branch attached to the clinic? If so engage the branch on the data report and potential solutions. Do they agree? Do they have more inputs?
- [ ] Is this a high intensity site? Do you need to organise a community dialogue to generate solutions?
- [ ] Write up the solutions using the clinic review meeting template
- [ ] Present the solutions to the members, Community Monitor, District Organiser, and Project Officer responsible for that clinic
- [ ] Once agreed, and signed off by the Project Officer, the District Organiser must submit to CommCare

ENGAGE DUTY BEARERS

- [ ] Download the State of the Clinic report from CommCare (facility report + recommended solutions report)
- [ ] Request a meeting with the Facility Manager and Clinic Committee Chairperson
- [ ] Hold a pre-meeting with the team who will attend the meeting to outline roles (who will discuss which finding and solutions; who will note all the commitments etc.)
- [ ] Present the State of the Clinic report
- [ ] Capture what they commit to fix—upload the commitments to CommCare
- [ ] Monitor to see if they do it (ongoing)

ADVOCATE FOR CHANGE

- [ ] Are there no improvements? It is time to engage in more advocacy to fix the problem.
- [ ] Engage the national project team & PLHIV Sector
- [ ] Develop a campaign strategy
- [ ] Implement the campaign


TAC
TREATMENT ACTION CAMPAIGN


SANERELA+


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


POSITIVE ACTION CAMPAIGN


NAPWA
SOUTH AFRICA


HEALTH GAP
GLOBAL ACCESS PROJECT


amfAR
MAKING AIDS HISTORY


O'NEILL
INSTITUTE
FOR NATIONAL & GLOBAL HEALTH LAW
GEORGETOWN LAW