THE SOUTH AFRICAN NATIONAL **WELCOME BACK CAMPAIGN** STRATEGY

OCTOBER 2021

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NATIONAL DEPARTMENT OF HEALTH

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ACRONYMS AND ABBREVIATIONS

ACSM	Advocacy, Communication and Social Mobilization
AGL	Adherence Guidelines for HIV, TB and NCDs
ANC	Antenatal Care
ART	Antiretroviral Therapy
AYFS	Adolescent Youth Friendly Services
CCMDD	Central Chronic Medicines Dispensing and Distribution
CHW	Community Health Worker
CSS	Community Systems Strengthening
DBE	Department Of Basic Education
DSD	Differentiated Service Delivery
DMoC	Differentiated Models of Care
DSP	District Support Partner
EPI	Expanded Programme for Immunisation
HAST	HIV, AIDS, & STIs
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
HSS	Health Systems Strengthening
HTA	High Transmission Areas
LTFU	Lost to Follow Up
NDOH	National Department of Health
NCDs	Non Communicable Diseases
NIMART	Nurse Initiated Management of Antiretroviral Therapy
OTL	Outreach Team Leader
OM	Operational Manager
PHC	Primary Health Care
PLHIV	Person Living with HIV
PMTCT	Prevention of Mother to Child Transmission
RPCs	Repeat Prescription Collection Strategies
SANAC	South African National AIDS Council
SDI	Same Day Initiation
SOP	Standard Operating Procedure
TRIC	Tracing and Retention in Care
uLTFU	Unconfirmed Lost to Follow Up
TLD	tenofovir disoproxil fumarate (TDF), lamivudine (3TC), and dolutegravir (DTG).
TT	Test and Treat
VMMC	Voluntary Medical Male Circumcision
WBPHCOT	Ward Based Primary Health Care Outreach Team
UNAIDS	Joint United Nations Programme on HIV and AIDS
WHO	World Health Organization

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FOREWORD

There is an increasing trend in the disengagement from HIV care services which threatens the progress towards the 90-90-90 targets. The Welcome Back Campaign seeks to support re-engagement and retention of PLHIV who were diagnosed but never initiated on ART and those who were initiated on treatment and interrupted ART or missed ART appointments.

The Welcome Back Campaign strategy compliments other NDOH policy documents that contribute to the country's HIV response. The campaign has adopted a four- pronged approach. These are the patient centred, Community Systems Strengthening (CSS), Health Systems Strengthening (HSS) and Social Behavior Change Communication (SBCC).

Effective implementation of the Welcome Back Campaign in all provinces, districts and facilities will:

- Support in achieving Goal 1 and 2 of National Strategic Plan for HIV, TB and STIs 2017–2022 of reducing morbidity and mortality by offering prevention, treatment, care and adherence support services for all
- Support the goal of the National Department of Health which seeks to ensure that morbidity and mortality is reduced by providing treatment, care, and adherence support for all
- Ensure retention of PLHIV in care
- Support the country in the achievement of the 90-90-90 commitments.

This booklet has been produced so that the targeted population as outlined in the strategy can refer to it to ensure maximum support and retention of patients re-engaging in care.

1. INTRODUCTION AND SITUATIONAL ANALYSIS

1.1 Overview of the South African HIV Epidemic

South Africa has been one of the hardest hit countries by the HIV epidemic with an estimated 7.8 million people living with HIV (UNAIDS, 2020). The high rates of new infections are also alarming. In 2020, the country had 230 000 new HIV infections and 4,60 HIV incidence per 1000 population for all ages. A total of 83 000 HIV related deaths and 1 600 000 AIDS orphans were also reported for the same year in South Africa (UNAIDS, 2020)

Despite these huge numbers, progress has been made in South Africa's response to the epidemic. The HIV treatment programme has grown from 400 000 PLHIV on ART in 2009 to 5 600 000 PLHIV on ART in 2020 (UNAIDS, 2020), making it the largest treatment programme in the whole world. The expansion of the treatment programme is also attributed to the implementation of the "test and treat" guidelines which were introduced in 2016.

In 2014, the country adopted the Joint United Nations Programme on HIV/AIDS (UNAIDS) 90-90-90 set targets (90% of people living with HIV should know their status, 90% who know their HIV status should be on ART, 90% of those on ART should be virologically suppressed). It is estimated that in 2020, out of the 7 800 000 PLHIV, 7 200 000 (92%) knew their status. Out of the 92% who knew their status, 5 600 000 (78%) were on treatment and for those diagnosed and on treatment, 5 100 000 (91%) were virologically suppressed. This equates to 72% of all PLHV in South Africa on treatment and 65% virologically suppressed (UNAIDS, 2020).

It is evident that South Africa is doing well in its testing interventions, there are however substantial gaps between the 1st 90 (those that know their HIV status) and 2nd 90 (PLHIV accessing and being retained on treatment) and the 3rd 90 (those who are virologically suppressed). This can either be because people never started taking treatment or because they started and then stopped.

These gaps have also been made worse by the Coronavirus Disease (COVID-19) and related lock-downs and socio-economic effects thereof. During the hard lockdown when movement was restricted many people were hesitant to visit health facilities in fear of contracting COVID-19. The National Department of Health (NDoH) continues to promote treatment adherence even during this period. Measures have been put in place by the NDoH to ensure that patients continue to receive their treatment while decongesting facilities and promoting decentralized services delivery closer to the people.

The identified gaps have called for South Africa to scale up its efforts to achieve the 90-90-90 targets and to do that it is critical for the country to identify the missing population in the care cascade.

The section below looks at the different groups of people who are not engaged in care and will be targeted in the Welcome Back Campaign. For purposes of the Differentiated Models of Care (DMoC) or Differentiated Service Delivery (DSD), it is critical to also consider the different population groups (age, sex, women (pregnant and/or breastfeeding), key populations and the context of those patients who are not engaged HIV care.

1.2 Patients not engaged in HIV care- who are we missing?

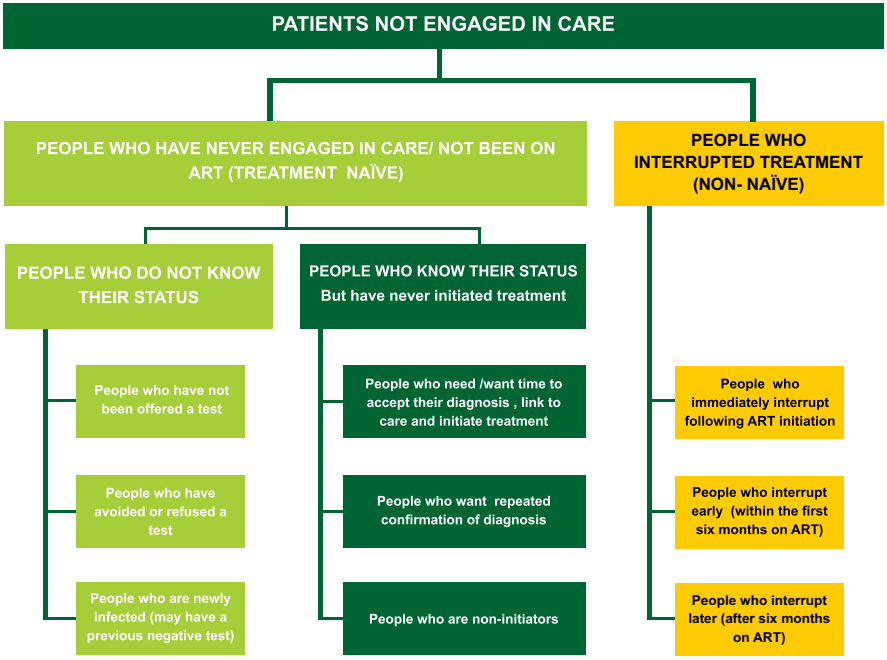


Figure 1: Diagram depicting PLHIV who are not engaged in care adapted from Grimsrud et. al (2020)

1.3 Identifying leakage in the HIV care cascade- where is the problem?

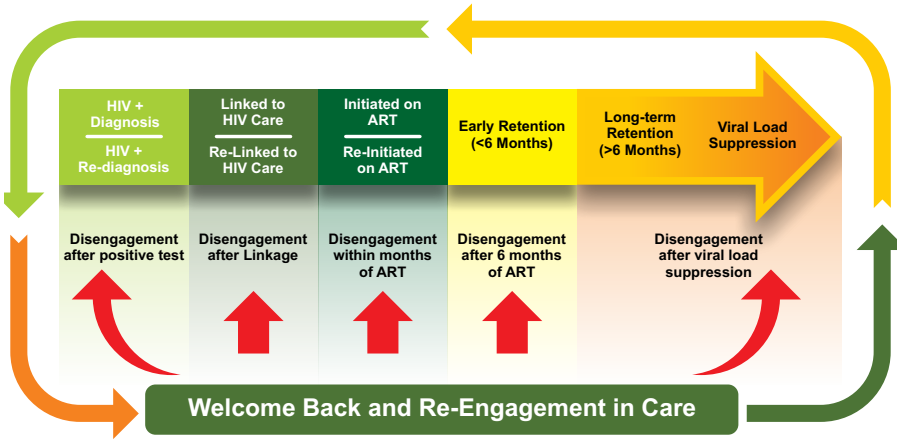


Figure 2: Diagram depicting the different stages in the HIV care cascade where patients disengage from care and the Welcome Back and Reengagement in Care Model. Adapted from Ehrenkranz et al. 2021.

It is critical to note that due to the leakage in the HIV care cascade South Africa is currently missing approximately 2 200 000 PLHIV who disengaged from care and need to be welcomed back and re-engaged in care.

1.4 Scaling up the response

The South African National Department of Health has made efforts in the past to address the quality of care provided to PLHIV. This has been through updating treatment and adherence guidelines to be in line with the latest evidence, training and mentoring health workers, providing aides for health workers, establishing support groups, adherence clubs as well as Internal and External Pick- Up Points (PuPs). However, these interventions are not sufficient as reflected in the gaps in the cascade of care.

During the State of the Nation address in February 2018, the President of South Africa, Cyril Ramaphosa made the following announcement:

“This year, we will take the next critical steps to eliminate HIV from our midst. By scaling up our testing and treating campaign, we will initiate an additional two million people on ART by December 2020. We will also need to confront lifestyle diseases such as high blood pressure, diabetes, cancers and cardiovascular diseases”.

A National Wellness Campaign known as “Cheka Impilo” was then developed with various stakeholders. The aim of the campaign is to:

1. Reinforce implementation of prevention strategies, linkages to care management, treatment, and support as well as intensifying TB case finding.
2. Encourage all South Africans to undergo health screening and testing services available at the community and facility level.

In August 2019, National Department of Health (NDoH) took a robust project management approach through the Operation Phuthuma project, prioritizing high volume facilities and employing a ten-point plan for Acceleration described below:

1. Strengthen management (including quality patient centered care).
2. Strengthen data systems; clean up data.
3. Same day initiation: follow-up first missed appointment.
4. Use unique ID (HPRN).
5. Enable all trained Nurse Initiated Management of Antiretroviral Therapy (NIMART) nurses (23 000) to initiate patients including children and adolescents.
6. Set performance targets for: NIMART nurses; lay counsellors; data clerks; Community Healthcare Workers/Ward- Based Outreach Teams (CHWs/WBOTS).
7. Strengthen Centralized Chronic Medicines Dispensing and Distribution and increase pick up points.
8. Decrease waiting times through different initiatives including improving the filing system.
9. Provide services during extended working hours.
10. Ensure accountability of action plan.

NDoH is focused on closing the treatment gap by intensifying HIV Testing Services (HTS); returning clients to care; and initiating those who have previously been diagnosed but never initiated on ART. This is in line with Goal 1 and 2 of National Strategic Plan for HIV, TB and STIs 2017–2022 and Goal 1 of the Department of Health Strategic Plan 2020–2025.

In its efforts to scale up, NDoH has introduced the Welcome Back Campaign a sub-campaign of the National Wellness campaign “Cheka Impilo” with the aim

to further support re- engagement and retention of PLHIV who were diagnosed but never initiated on ART and those who were initiated on treatment and interrupted ART or missed ART appointments.

1.5 Purpose of this strategy

The purpose of the Welcome Back Campaign strategy is to guide and support the provision of effective re-engagement in care services for patients who disengage from HIV care for various reasons.

1.5.1 Target audience for the document

- Patients.
- Healthcare workers.
- Pharmacists or pharmacy assistants.
- Non-clinicians (could include lay counsellors or equivalent).
- Community Health Workers (CHW).
- Ward Based PHC Outreach Teams (WBPHCOT) including WBPHCOT Team Leaders.
- Administrative clerks.
- Central Chronic Medicine Dispensing and Distribution program (CCMDD).
- Facility Managers.
- Program Managers.

2. WELCOME BACK CAMPAIGN

2.1 Background

There is an increasing trend in the disengagement from HIV care services which threatens the progress towards the 90-90-90 targets. Patients who do not get linked to care and those that are no longer in care have a higher chance to clinically deteriorate, develop advanced HIV disease, develop resistance to ART or even die. It is therefore important to link all diagnosed HIV positive patients and those that have dis-engaged from care to avoid more difficult and expensive care and treatment because of advanced HIV disease and resistance to ART, and also avoid unnecessary mortality. This would potentially avoid worsening individual patient outcomes in addition to burdening of the health system.

2.2 Benefits of early ART initiation, adherence and retention

ART is not only beneficial to the individual but also their partners, children, community, and the health system at large. Global guidelines recommend that all PLHIV should start ART as soon as they are diagnosed regardless of CD4 count. The 'Test and Treat All' approach has made it possible for PLHIV to access ART timeously. Studies have shown that immediate initiation on ART after a positive HIV test result could contribute to epidemic control. ART reduces vertical transmission, reduces transmission to seronegative partners, reduces opportunistic infections, reduces healthcare burden and reduces advanced HIV and HIV related morbidity and mortality.

A total of 34.9 million deaths could be averted between 1995 and 2030 if treatment scale up achieves the UNAIDS 90-90-90 targets (Forsythe et al, 2019). According to UNAIDS, 680 000 (480 000-1 million) people died from AIDS-related illnesses globally in 2020, compared to 1,9 million (1,3 million–2,7 million) people in 2004 and 1,3 million (910 000–1,9 million) people in 2010 (UNAIDS, 2020). AIDS-related deaths have been reduced by 64% since the peak in 2004 and by 47% since 2010, (UNAIDS, 2020).

According to UNAIDS, a total of 850 000 AIDS related deaths were averted in Eastern and Southern Africa in 2020 due to ART. In 2020, 350 000 deaths were averted due to ART in South Africa (UNAIDS, 2020). The number of HIV infections is expected to continue to decline as the 90-90-90 targets are achieved. New HIV infections have declined by 38% in the Eastern and Southern African region since 2010 (UNAIDS, 2020).

Optimal adherence to ART is important to achieve sustained viral suppression and to ensure treatment and prevention benefits. Retaining PLHIV in care is necessary for the achievement of optimal clinical outcomes as it allows the patient to access their medication refills on time, treatment for opportunistic infections, switching of ART regimens in cases of treatment failure, viral load suppression and monitoring of medication toxicities. Engagement in care further facilitates linkage to additional services such as psycho-social support and information. Based on the mentioned benefits of ART it is critical for the NDOH to intensify its treatment and care programme to continue to improve the health of South Africans.

2.3 Consequences of inadequate adherence and retention in HIV care

Non-adherence and dis-engagement from care puts PLHIV at risk of onward transmission, opportunistic infections, and emergence of drug resistance, which reduce drug options and ultimately increase HIV related mortality (Mwamba, 2018).

To reach National Strategic Plan for HIV, TB and STIs 2017–2022 goals, Department of Health Strategic Plan 2020 – 2025 goals and to achieve the UNAIDS 90-90-90 targets, it is critical for South Africa to ensure that PLHIV adhere and remain in care. Failure to do so has serious implications for the country's health system, health care costs, economic productivity at country level as well as mortality and morbidity rates through suboptimal viral suppression.

2.4 Barriers to antiretroviral therapy (ART) initiation, adherence and retention in care.

PLHIV face many barriers to ART initiation, adherence and retention in care. Figure 3 below shows individual, interpersonal (those influenced by the individual and other people around them such as family and friends), community (these relate to the broader social network and context) and structural related barriers these are factors within the broader environment that are beyond the control of the individual. It is critical to note that although the barriers have been classified into these four levels, they are not all independent and many of the factors identified at one level may interact with other factors within and between levels. Understanding of these different barriers assisted in the approach taken to develop interventions for the Welcome Back Campaign.

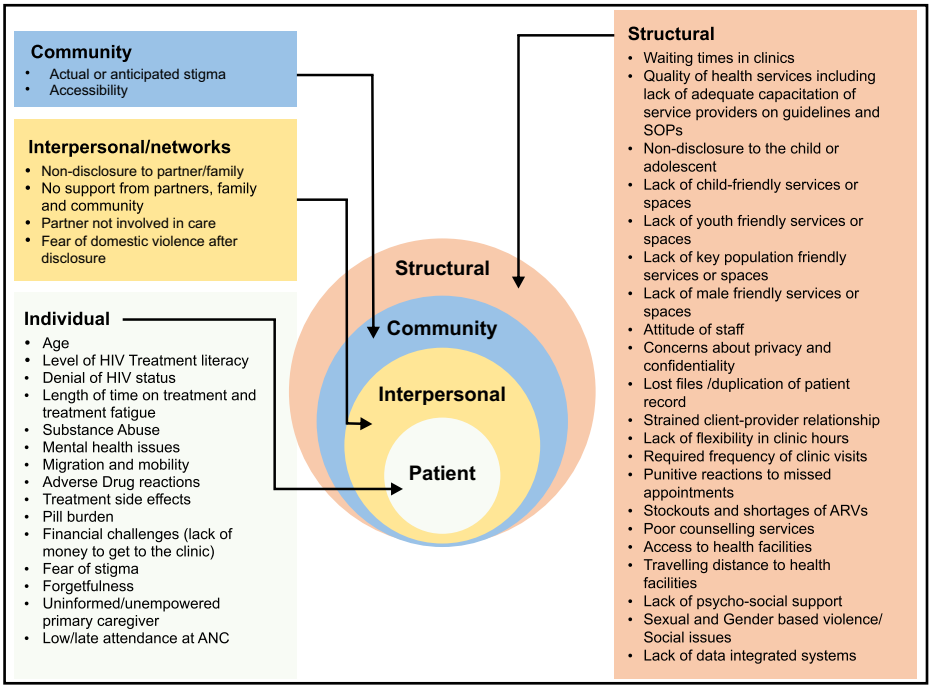


Figure 3: Barriers to ART initiation, adherence, and retention in care.

It is critical to note that over the years, the NDoH gradually increased, eligibility threshold from 200 cells/μL in 2004 to 350 cells/μL in 2010 and 500 cells/μL in January 2015. These thresholds both capped the number of persons initiating

ART and negatively affected the retention of pre-ART patients. The attrition from care after HIV diagnosis was also related to the number of assessment and counselling visits required before treatment initiation for eligible patients and the lack of systematic monitoring of and benefits for patients who were not offered ART. Additional Pre-ART determinants of losses from the HIV treatment cascade include gender, the requirement for a treatment buddy/disclosure for ART initiation, HIV stigma and the high cost of attending clinic visits. In September 2016, South Africa removed the CD4 cell count threshold for ART eligibility and adopted the WHO 2015 Universal Test and Treat (UTT) policy, making all HIV positive patients eligible for ART at diagnosis and therefore reducing barriers to ART. In September 2017, the general UTT policy was updated with a directive to initiate ART on the day of HIV diagnosis (same-day initiation), further reducing barriers to treatment.

2.5 Overview of the South African National Welcome Back Campaign Strategy

2.5.1 Aim

Guide and Support re-engagement and retention of PLHIV in care as well viral load suppression.

2.5.2 Strategic Objectives

1. To develop a welcome back brand identity and key messages for patient support.
2. To improve strategies to successfully welcome back and retain in care PLHIV who were diagnosed and are not on ART (treatment naïve patients), including children and adults.
3. To improve strategies to successfully welcome back and retain in care PLHIV (children and adults) who were initiated on treatment and return to care after a period of interrupting ART or ART appointments.
4. To improve strategies for early infant diagnosis (EID) and successfully re-engage those that dropped off the EID cascade before final determination of HIV status.
5. To develop and implement triage and flow algorithms that identify and re- engage patients with Advanced HIV Disease (AHD).
6. To optimize the clinical management of PLHIV re-engaging in care.
7. To equip and support staff to deal with interruption in treatment and efficiently and effectively manage re engagement of patients in a non-judgemental way.
8. To optimize tracking and tracing services.
9. To continue implementing patient-oriented practices to empower patients and improve retention in care.

2.6 Target Population

The campaign is targeting all PLHIV but will have a particular focus on the following population groups that have lower rates of retention in care and adherence: children below the age of 15, young people 15–24, pregnant and breastfeeding women and their partners, men in general and key and vulnerable populations.

- Children below the age of 15. It is estimated that 57% of children < 15 living with HIV and know their status are on ARVs; 65% are virologically suppressed (DHIS March 2021). Interventions will therefore be focused at Antenatal clinics i.e., Prevention of Mother to Child Transmission (PMTCT) focusing on linking mothers to care and viral load suppression, Expanded Programme for Immunization (EPI), child health clinics, In-patient wards, Ideal clinics, school health teams, Adolescent Youth Friendly Services (AYFS) facilities and communities, Early Childhood Development Forums, Child Protection Forums.
- Young people between the ages of 15–24 years. Interventions will target Adolescent Youth Friendly Services (AYFS), Youth Zones, Children's Committees, Peer Education by Department of Basic Education, Dreams Project.
- Women in antenatal and postnatal care. Interventions will therefore be focused at Antenatal clinics, post-natal clinics and Mothers to Mothers (mentor mothers projects).
- Men: only 63% of men estimated to be HIV+ and know their status are on ARVs; and 88% of men 15–44 years are virologically suppressed (DHIS March,2021). A comprehensive package of services utilizing Voluntary Medical Male Circumcision (VMCC) and Non-Communicable Diseases (NCDs) as an entry point will be defined and implemented. Interventions will therefore be focused on men's health comprehensively including partnerships with men's health organisations.
- Key and Vulnerable Populations: Interventions will target High Transmission Areas (HTA) Sites and Primary Health Care (PHC) Mobiles.

2.7 Guiding Principles

The successful implementation of this strategy depends on the incorporation of the following six guiding principles:

Guiding Principle	What It means
1. Human rights- based response.	• Need to understand that the rights of PLHIV must be protected, promoted, and respected. This includes the right to access to health care services, life, privacy and dignity.
2. Policy driven	• Strategy compliments other NDOH policy documents that contribute to the country's HIV response and supports the achievement of the 90-90-90 commitments.

Guiding Principle	What It means
2. Policy driven	• Health care workers and non-clinicians are encouraged to refer to policies which underpin the Welcome Back Campaign strategy to ensure that all necessary procedures and steps are followed to encourage linkage to care, adherence to treatment and retention in care of all PLHIV. This includes the following policies: • 2020 Adherence Guidelines for HIV, TB and NCDs Available: https://knowledgehub.org.za/elibrary/adherence-guidelines-hiv-tb-and-ncds • 2016 HIV Disclosure Guidelines for Children and Adolescent • Available: https://chivasouthafrica.org/wp-content/uploads/2020/01/1.-HIV-disclosure-guideline-for-children-and-adolescent-2016_1-1.pdf • 2019 ART Clinical Guidelines for the Management of HIV in Adults, Pregnancy, Adolescents, Children, Infants and Neonates • Available: https://knowledgehub.org.za/elibrary/2019-art-clinical-guidelines-management-hiv-adults- pregnancy-adolescents-children-infants • National Consolidated Guidelines for the Management of HIV in Adults, Adolescents, Children and Infants and Prevention of Mother-to Child Transmission • Available: https://knowledgehub.org.za/system/files/elibdownloads/2020-07/National%20Consolidated%20Guidelines%2030062020%20signed%20PRINT%20v7.pdf
3. Development of synergies and integration with other health programs	• Use opportunities to integrate Welcome Back services with other health programs promoting linkage, adherence, re-engagement and retention in care of children below 15 years, young people between the ages of 15-24 years, pregnant and breastfeeding women and men. These include but not limited to: • Antenatal Care • Expanded Programme for Immunization (EPI) • Ritshidze Community led monitoring • U = U Campaign • Mina Campaign • Coach Mpilo

Guiding Principle	What It means
4. Demand creation with active involvement of PLHIV and communities	• Create demand for treatment services for PLHIV who tested positive and were not initiated on treatment. • Create demand for return to care services for patients who were initiated on treatment but missed their appointments. • Develop messages to support all PLHIV to adhere at home, in the community and at the facility. • Develop messages and interventions which convince patients to return to care and educates them on the benefits of treatment adherence. Messages and interventions are needed to reach those who are not yet initiated and those who have missed their appointments. • Develop age-appropriate messages for children on ART, including their care givers • Develop messages for young people and caregivers to promote/ support disclosure • Use effective demand creation platforms and approaches to reach the targeted populations.
5. Data Driven	• Use available data to identify any gaps trends over time. • Use data to come up with possible innovations or solutions to close the treatment gap. • Use data for high-level decision making and policy formulation
6. Focus on Targeted populations	• Prioritize targeted populations i.e. Children below 15 years, young people between the ages of 15- 24 years, pregnant and breastfeeding women, men, key and vulnerable populations.

2.8 Approach

In welcoming clients back to care, one needs to focus on how to make the clinic and staff more patient-centered. In addition, both patient and staff needs have to be addressed to improve outcomes. Patients need to fully understand the importance of being on treatment and being virally suppressed as well as a focus on community-wide stigma mitigation programmes (Eyassu et al, 2016). Patients may be motivated by different reasons to be adherent – which implies that a one size fits all strategy may not work for all patients.

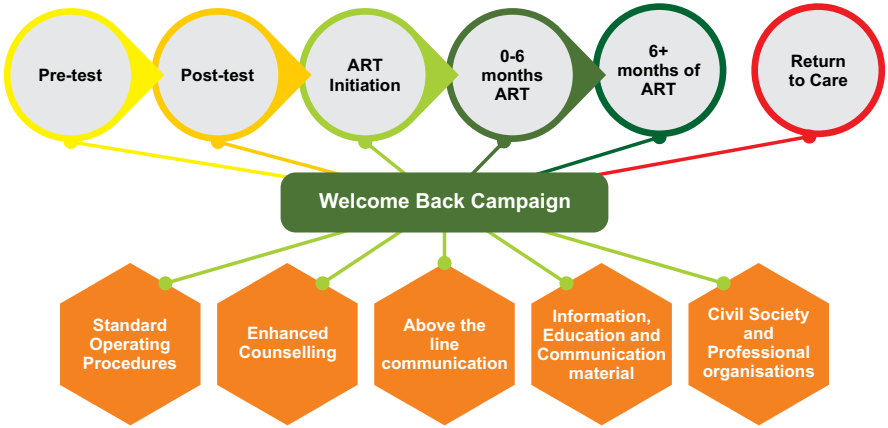
The Welcome Back Campaign will adopt a four (4) pronged approach for the development of the strategy interventions.

1. Patient-centered.
2. Community Systems Strengthening (CSS)
3. Health Systems Strengthening (HSS).
4. Social Behavior Change Communication (SBCC).

2.8.1 Patient- centered

The Welcome Back Campaign will be segmented according to the stages of treatment that a patient is in. Specific interventions will be implemented for the following stages of care:

- *Pre-diagnosis:* Services delivered and engagement during pre-test period.
- *Post-diagnosis:* Services delivered and engagement when a patient tests HIV positive.
- *ART Initiation:* Services and engagement during the patients' first consultation with a clinician for ART initiation.
- *First 6 months of ART:* Services and engagement with patients who have been on ART for less than 6 months.
- *Treatment beyond 6 months:* Services and engagement with patients who have been on ART for 6 months or more.
- *Return to Care:* Services and engagement with patients who missed an appointment and are returning to care.



For each of these stages, there will be 7 interventions. These include:

1. Standard Operating Procedures to guide the process for delivering services.
2. Enhanced Counselling provided by clinicians and non-clinicians.
3. Peer led counselling.
4. Above the line communication through radio, TV, print and social media.
5. Social Behaviour Change Communication (SBCC) which includes Information Education and Communication (IEC) materials which may be given to the client during re-engagement or via Short Message Service (SMS), and interventions given through group and one-on-one interactions.
6. Communication through civil society or professional organizations.
7. Staff training and sensitization on friendly provision of care with understanding of specific needs of sub populations (men, children, adolescents, pregnant and breastfeeding women, KPs, priority populations and those with advanced disease.

2.8.2 Community Systems Strengthening (CSS)

Community-based interventions provide a platform to offer patient support beyond a specific facility and to intervene in some of the broader social barriers to engagement in care. During the implementation of the Welcome Back Campaign, CSS will focus on mobilizing communities, PLHIV and community-based organizations and other decision makers to participate in treatment programs, including the reduction/elimination of HIV related stigma and discrimination as well as in the delivery, coordination and monitoring of activities related to the campaign.

CSS interventions will revolve around the following:

- Addressing issues of stigma and discrimination in communities.
- Strengthening stakeholder engagements and collaborations at district, provincial and national level.
- Coordination of all partners that are providing HTS in communities to ensure that they link all clients who test positive and assist with tracking and tracing interventions.
- Carrying out treatment literacy education at community level.
- Strengthen community drug distribution including multi-month dispensing of drugs at community level
- Strengthening the community-facility link.
- Strengthening community-based adherence support.
- Strengthening monitoring and reporting of all community-based organizations working on Welcome back campaign to report on their activities.
- Strengthening Child protection Forums, Early Childhood Development Forums, Children's committees/ peer education.

2.8.3 Health Systems Strengthening (HSS)

The successful implementation of the Welcome Back Campaign is to a large extent dependent on a functional health system. Out of the six health systems strengthening building blocks articulated by World Health Organization (WHO, 2007), the Welcome Back Campaign will be modelled around the following blocks (Leadership and governance, service delivery, human resources, medicines, and health information system). A functional health system results in availability of services, access and utilization.

The following interventions will be implemented to improve functioning of the health system:

- Capacitation of clinicians and non-clinicians on the following:
  - HIV prevention strategy and HTS guidelines.
  - In service training for lay counsellors to promote linkage to care, retention and re-engagement.
  - The revised Adherence guidelines.
  - Integrated Access to Care and Treatment (I-ACT).
  - to strengthen adherence support during the first 6 months of ART.
- Strengthening service delivery.
  - Ensure services are friendly, non-judgmental, private, and always confidential.
  - Use of non-judgmental welcoming attitudes and messages to motivate clients who are LTFU to return to care.
  - Improve or expand counseling services for newly diagnosed HIV-positive and other pre-ART clients to offer comprehensive psychosocial support, utilizing peer counselors or community health workers, and including adherence support.
  - Minimizing waiting times.
  - Extend working hours (from 5am to 7pm where possible) to allow for those working and in schools to attend the clinic and collect treatment.
  - Establish and maintain filing systems to reduce waiting times, prevent lost files, and ensure patient confidentiality.
  - Where patients wait in the early hours for clinics to open, efforts should be made to ensure the safety of those waiting through the placement of additional security guards and opening of waiting areas in clinic grounds.
  - Operationalize clinic appointment systems to be functional.
  - Ensure that all facilities are adequately stocked so that no PLHIV is sent home empty handed forcing them to have to return to collect refills.
  - Minimize stockouts of equipment needed for assessing clients' eligibility for ART and scale up TPT and co-trimoxazole.

- Ensure timely CD4 testing at the facility-level and in the community, if feasible.
- Employ active monitoring and tracking strategies for pre-ART clients ineligible for ART, both at the facility and in communities. Enhancing client tracking systems may include adapting registers for pre-ART clients transitioning to ART.
- Implementation of community-based HIV management interventions, e.g., mobile HIV services to mitigate client distance or transportation issues.
- Establish electronic tracking systems (ETS) for all clients in HIV care.
- Build on achievements in integration.
- Continue implementing patient-oriented practices to empower patients and improve retention in care.

Increase integration of services and availability of population specific services:

- Integration of services can motivate hard to reach clients for example men to visit facilities.
- Population specific services should be established at all sites including:
  - All sites to have at least one male nurse and one male counsellor in place leading to a greater uptake of services by men.
  - All sites have at least one male clinic day (ensuring male staff are on duty) per week or Men's Corners integrated into service delivery to provide services specific to the needs of men.
  - All sites to have key population friendly integrated services (HIV, SRHR, STIs, TB etc.)
  - Harm reduction services — including medically assisted treatment and other drug dependence treatment — are made available at health facilities and Drop in Centres.
- Demand creation for treatment services for PLHIV who tested positive and were not initiated.
- Demand creation for return to care services for patients who were initiated on treatment but missed an appointment.
  - Demand creation messaging to motivate patients to return to care.
  - Educate patients on the benefits of treatment and adherence.

- Healthcare workers—including implementing partner staff and community healthcare workers— provide accurate and easily understandable information on treatment adherence and the importance of an undetectable viral load when talking to PLHIV, through counselling, and through health talks at clinics. This ensures that viral load test results are always properly explained to all PLHIV in a timely manner.

- Implementation of Differentiated Models of Care (DMoC):
  - Demand creation for Differentiated Models of Care is also important, especially by engaging community- based organizations
  - Department of Health and supporting partners will optimize DMoC options to be more patient-centered and so better cater for patient needs and preferences.
- (DMoC) options including Internal and External Pick-Up Points (PuPs), adherence clubs, and multi month dispensing will also help reduce congestion at health facilities.
  - Decant more PLHIV to different repeat prescription collection strategies that are available.
  - Monitor the quality of repeat prescription strategies and improve where satisfaction levels are not optimal.
- Awareness raising on ART in general and the advantages on the DTG-based regimens, especially on the first line regimen containing tenofovir disoproxil fumarate (TDF), lamivudine (3TC), and dolutegravir (DTG) (TLD) and DTG-containing second line regimes.
- Tracing and recalling of PLHIV patients who tested positive and were not initiated as per test and treat guidelines as well patients who failed to return to facility within 7 calendar days of their scheduled appointments including PLHIV.
- Use of NHLS Dashboard for tracing.

Outreach services targeted to youth (at schools, youth centres, halls, community events), men (at unemployment spots, malls, taxi ranks, sporting events, near taverns) and key populations.

- Case management for patients returning to care.
- Task allocation: designate a focal person to welcome patients who are found and report back to facility.
- PLHIV returning after a treatment interruption should be triaged in separate streams instead of being sent to the back of the queue.

- Strengthen data management system.

As demand for treatment is created through the Welcome Back Campaign, it is critical that the health care system is not burdened, (DMoC) options will need to be implemented to reduce congestion at health facilities.

2.8.4 Social Behaviour Change Communication (SBCC)

Communication messages will be framed as per specific target audience including messages targeting clinicians and non-clinicians. The messages will clarify the importance of ART, adherence to treatment, Undetectable =Untransmittable (U=U) and quality healthcare. The proposed mass media platforms and channels which will be utilized are IEC, radio including Side by Side radio campaign, television, social media (Twitter, Facebook), websites, Mom Connect, Men Connect, Bwise and any other available platforms.

2.9 Standard Operating Procedures (SOPS) Guiding Implementation

The Implementation of the Welcome Back Campaign strategy should be guided by the 2020 NDoH, Adherence Guidelines for HIV, TB and STI. Health Care Workers and non-clinicians are encouraged to refer to Tracing and Recall (SOP 8), Re-engagement in Care (SOP 9) of the Adherence Guidelines as well as Central Chronic Medicine Dispensing and Distribution (CCMDD) SOP 4 to ensure that all necessary procedures and steps are followed in tracing, recalling and re-engagement of patients back to care.

SOP 8 outlines the process of tracing and recalling of patients and SOP 9 outlines the process of determining the most appropriate support for patients who re-engage in care to facilitate improved retention. The re-engagement algorithm which is part of SOP 9 outlines the process to be followed when a patient re-engages in care after 7 calendar days of missed appointment or last Repeat Collection Strategies (RPCs) collection date (Available at (https:// www. knowledge- hub.org.za/elibrary/adherence-guidelines-hiv-tb-and-ncds).

For patients under CCMDD refer to CCMDD SOP 4 which outlines the process and management of uncollected Patient Medicine Parcels including upliftment (Available at (http://health.gov.za/ccmdd-documents-resources/).

2.10 Monitoring and Evaluation

2.10.1 Documenting, monitoring and evaluation

Monitoring and Evaluation is critical component of the implementation of the Welcome Back Campaign. The implementation of the strategy will be monitored at four levels i.e. facility, district, provincial and national levels, using existing mechanisms. HIV, ART and TB patient information is captured in the integrated TB/HIV information system, TIER.Net in public health facilities across South Africa. Administrative clerks capture HIV, ART patient information directly from standard clinical stationery into TIER.Net daily. Data is then either captured monthly or imported quarterly into the routine health information system, webDHIS for reporting. To trace patients who missed appointments facilities should use TIER.Net missed appointment lists and have systems in place to trace patients who missed an appointment.

The prioritization order for tracing and recall outlined in SOP 8 should be followed. All tracing processes must be documented in patient clinical stationery and relevant monitoring systems. All data should be checked and verified before submission on DHIS. Facilities should conduct monthly clinical audits to ensure that guidelines are adhered to and that clients are receiving good quality care. Analysis of data should enable continuous quality improvement.

NDOH will conduct routine monitoring of the campaign activities to ensure that resources going into the campaign are utilized. Additionally, the NDoH will ensure that SOP 8 & 9 which guide campaign implementation are implemented with fidelity and campaign activities at all levels occur in an efficient and guided manner and expected results are achieved.

Finally, NDOH and partners will include reporting on the status of the welcome back campaign in existing meetings with Provinces. Furthermore, National, Provincial, District and local levels will use existing meetings and other opportunities, including National/Provincial engagements, Provincial/District engagements, nerve center meetings at all levels and other fora, to share progress and provide feedback on the campaign.

2.10.2 Indicators

No	Data Element/Indicator	Type of Indicator	Data Source	Frequency of reporting	Agency Responsible
1.	Number of Welcome Back messages developed and reviewed.	Process	Programme reports	Monthly	NDOH
2.	Number of people reached through Welcome Back messages including primary caregivers of children living with HIV	Process	Programme reports	Quarterly	NDoH PDoH Supporting partners
3.	Number of clinicians trained on disclosure guidelines	Process	Programme reports	Quarterly	NDoH PDoH Supporting partners
4.	Number of clinicians trained on advanced HIV management	Process	Programme reports	Quarterly	NDoH PDoH Supporting partners
5.	Number of lay counsellors trained on linkage to care	Process	Programme reports	Quarterly	NDoH PDoH Supporting partners
6.	Percentage of clinicians and non-clinicians that have been reoriented on HIV prevention strategy and HTS guidelines	Process	Programme reports	Quarterly	NDoH PDoH Supporting partners
7.	Percentage of clinicians and non-clinicians that have been reoriented on revised Adherence guidelines SOPs	Process	Programme reports	Quarterly	NDoH PDoH Supporting partners

No	Data Element/Indicator	Type of Indicator	Data Source	Frequency of reporting	Agency Responsible
8.	Number of revised I-ACT materials printed	Process	Programme reports	Periodically	NDoH PDoH Supporting partners
9.	Number of AGL SOPs distributed to provinces.	Process	Programme reports	Periodically	NDOH Supporting partners
10.	Number of clinicians and non- clinicians trained on I-ACT	Process	Programme reports	Quarterly	NDoH PDoH Supporting partners
11.	Number of AGL materials printed	Process	Programme reports	Periodically	NDOH Supporting partners
12.	Number of clinicians and non- clinicians trained on the revised AGL SOPs.	Process	Programme reports	Quarterly	NDoH PDoH Supporting partners
13.	Number of clinicians and non- clinicians trained on Advanced Clinical Care	Process	Programme reports	Quarterly	NDoH PDoH Supporting partners
14.	Number of HIV patients who missed an appointment and were traced	Process	DHIS	Monthly/ Quarterly	PDoH Supporting partners

No	Data Element/Indicator	Type of Indicator	Data Source	Frequency of reporting	Agency Responsible
15.	Number of patients traced and re-engaged in care	Process		Monthly/ Quarterly	NDoH PDoH Supporting partners
16.	Number newly diagnosed who start ART within 7 days/on the same day	Process		Quarterly	NDoH PDoH Supporting partners
17.	Total number of patients waiting on ART	Process		Monthly/ Quarterly	NDoH PDoH Supporting partners
18.	Number of new patients started on ART	Outcome	DHIS	Monthly/ Quarterly	NDoH PDoH Supporting partners
19.	Number of patients restarted on ART	Outcome		Quarterly	NDoH PDoH Supporting partners
20.	Total number of patients on ART remaining in care (TROA)	Outcome	DHIS	Monthly/ Quarterly	NDoH PDoH Supporting partners
21.	Loss to follow-up rate	Outcome	DHIS	Quarterly	NDoH PDoH Supporting partners

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