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REVISED ADHERENCE GUIDELINES SOPs ORIENTATION REPORT

Care and Support Directorate: National Department of Health

September 2020

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1. Introduction

The National Department of Health, HIV/AIDS and STIs cluster, conducted orientation sessions on the revised Adherence Guidelines Standard Operating Procedures (AGL –SOPs) to the provincial managers, PEPFAR staff and PEPFAR funded agencies. These sessions were conducted virtually on the 18th – 20th, 30th and 31st August 1st- 3rd and 16th September 2020, respectively. The provincial sessions were conducted through the Knowledge Hub; the audience for these sessions were provincial, district and sub-district programme managers, regional training centre managers, clinicians, and the district support partner. The audience for PEPFAR funded agencies included the provincial point of contacts, programme/project managers, HIV specialists and clinicians.

The purpose of the orientation sessions was to strengthen interventions on the delivery of differentiated care services to patients across the care cascade.

The objectives of the sessions were to:

- Provide briefing on Human Rights in the Covid-19 era.
- Orientate managers on the revised Adherence Guideline SOPs which enhances the DMoC strategies
- Provide updates on ART including Paeds
- Provide updates on TPT and decanting
- Provide briefing on NDoH Response to Mitigate Covid-19 Impact
- Provide updates on AHD/ACC
- Give an overview on the Welcome Back Strategies and Behavioural Change Strategies
- Research, Pilot (Home Deliveries) Monitoring, Evaluation and Reporting
- Roles and Responsibilities at all Levels on the implementation of Differentiated Models of Care
- Discuss plans on cascading orientation of AGL – SOPs from province to Facility

2. Aim of the report

- To provide the background and rationale of the orientation sessions, outline key focus areas discussed during these sessions fostering an integrated approach of HIV, TB and NCDs Care and Treatment.
- To outline the questions and answers (Q&A) raised during the sessions, which informs the level of technical support whilst implementation is optimized thereof.
- To share a comprehensive and integrated slide deck attached in Annexure 1.

3. Background and Rationale

The revised Adherence Guidelines (AGL) Standard Operating Procedures (SOPs) endorsed in March 2020, provides a minimum package of interventions to enable delivery of differentiated care services to patients across the care cascade, while recognizing the importance of integrated chronic care service provision. These interventions also provide guidance on facility decongestion through decanting stable patients to Repeat Prescription Collection Strategies (RPCs). Differentiated care therefore aims to strengthen linkage, adherence and retention in care using a patient centred approach throughout the care cascade.

South Africa continues to face a quadruple burden of diseases both communicable and non – communicable. South Africa is committed to attaining the UNAIDS 90-90-90 targets to control the HIV epidemic. The 'Test and Treat All' approach has made it possible for people living with HIV (PLHIV) to access ART timeously with the goal to attain and maintain viral suppression, prevent new HIV infections, decrease morbidity and mortality, and to improve quality of life for clients. In South Africa, around 7.5 million people are living with HIV (PLHIV), with 6,6 million knowing their status (1st 90) and 5 million on ART (2nd 90) and 3.3 virally suppressed (3rd 90) (DHIS 2020). To attain the 2nd 90, 6 million PLHIV should be on ART and to attain the 3rd 90, 5 million PLHIV on ART should be virally suppressed.

Nonetheless, adherence to treatment remains a challenge and poses a strain on health care services, which presents challenges of maintaining high quality public services. The issuing of new ART clinical guidelines, NCDs and TB treatment goals, warranted the revision of adherence guidelines, to ensure alignment with such goals; thus, AGL – SOPs 2020 were developed. Effective implementation of the minimum package of interventions to support linkage to care, adherence to treatment and retention in care is essential in alleviating the strain in health facilities. Stable clients on chronic treatment are therefore decanted to the Differentiated Models of Care that ensures limited visits to healthcare facilities.

The Covid-19 pandemic, however, has created challenges globally including for people living with HIV, TB and NCDs. Healthcare facilities have observed a decline in health clinical visits/consultations, which has an impact on the quality of care, treatment, and support. Accessing medical refills is also compromised, due to patients' anxiety that they may be at increased risk of Covid-19 infection. Thus, enrolling stable clients on Differentiated Models of Care is of utmost importance and of greater benefit even in the Covid-19 era.

The minimum package of interventions are standard operating procedures that also guide implementation of priorities in the National Department of Health Covid-19 response which are:

1. Accelerate decanting to external pick up points (PUPs)
    a. Decanting all eligible clients who are currently not decanted
    b. Transferring clients from in-facility to external pick up points and/or temporarily from larger group pick up points to external pick up points
2. Implement multi-month dispensing for all chronic patients
3. Rapidly scale up TLD among all eligible ART clients

In light of this overview, the National Department of Health conducted orientation sessions on the revised Adherence Guidelines SOPs (minimum package of interventions to support linkage to care, adherence and retention in care) to provincial and district programme managers, regional training centre managers, clinicians and support partners (PEPFAR agencies). Post these sessions, the Directorate received positive comments for successfully facilitating the sessions and applauded for the comprehensive & integrated approach taken.

Table 1 below, provides a summary of participants' attendance per session. Although the provinces were clustered according to the scheduled dates. Some of the officials though, opted to attend according to their convenient dates. However, only one session for PEPFAR agencies was held.

Table 1: Number of Participants Per Session

Date	Province	Number of participants
18 August 2020	FS, GP	103
19 August 2020	KZN	70
20 August 2020	NC, NW, WC	61
31 August 2020	PEPFAR	175
1 September 2020	FS, GP	70
2 September 2020	KZN	63
3 September 2020	NC, NW	80
16 September 2020	MP	74

Figure 1 indicates all the Adherence Guidelines materials that have been updated, to align with the revised Adherence Guidelines SOPs. These materials have been uploaded on the Knowledge Hub, the NDoH and South African HIV Clinicians Society websites respectively:

1. Adherence Guidelines Standard Operating Procedures
2. Diagram: Integrated management of Patients with Chronic Conditions
3. Patient adherence plan
4. Adherence Flip Chart
5. Slide Deck on the Orientation Sessions

***Figure 1**: Updated Adherence Guideline Materials*

These are the Links:

Knowledge Hub:
https://protect-za.mimecast.com/s/UDGBC98BOqSkXpwWFo1BDx?domain=knowledgehub.org.za
National Department of Health:
http://www.health.gov.za/index.php/component/phocadownload/category/672
South African HIV Clinicians Society
https://sahivsoc.org/SubHeader?slug=ndoh-and-who-guidelines
Drobox for Video and Audio
PEPFAR Session:
https://www.dropbox.com/s/mhrd41dpa6sdu77/AGL-SOPs%20VIDEO%2031%20August%202020.mp4?dl=0 **Provincial Session:**
https://www.dropbox.com/s/4zof9sqlrkis20w/AGL%20-

4. Orientation Session Agenda

A team of programme managers and technical advisors from NDoH HIV/AIDS&STIs cluster, care, and treatment directorate, led by Ms Mokgadi Phokojoe facilitated each of the key agenda items (Table 2 and 3).

This section will, however, provide an overview of the revised AGL-SOPs, outlining the key revisions made as well as the minimum package of interventions. It will further outline monitoring, evaluation and reporting of DMoC interventions as well as Home Delivery of Medicine as an extension of DMoC. Nonetheless, this section will still provide an overview of each of the key agenda items. Detailed content presented is in the attached comprehensive orientation slide deck (Annexure 2).

Table 2: Agenda (Province)

Chairperson: M Phokojoe **Co-chairs:** M Manganye, L Diseko, L Seshoka and K Vilakazi-Nhlapo **Scribers:** T Nyawasha, M Kgokolo, M Mkhize, M Pilusa, L Maku	
Agenda Item	**Facilitator**
1. Welcome and Introductions 2. Purpose of the Meeting 3. House Keeping	Ms M Phokojoe Ms M Tlaka
4. Briefing on Human rights in the Covid-19 era	Ms T Msila
5. Revised AGL SOPs	Dr M Manganye, D Gavhi, L Malala, M Mkhize, M Pilusa, T Nyawasha
6. NDOH Response to Children	Ms L Maku
7. Clinical Governance and Patient Drug Regimen Switching	Ms L Diseko
8. TPT and decanting	Dr K Vilakazi – Nhlapo, Ms N Zondo
9. Strategies to Manage Advanced HIV Disease	Ms L Seshoka
10. Research, Pilot (Home Deliveries) Monitoring, Evaluation and Reporting	Dr M Manganye
11. Roles and Responsibilities at all Levels	Dr M Manganye
12. Wrap - Up and Announcements (Including Provincial Plans)	Ms L Seshoka

Table 3: Agenda (PEPFAR)

Date: 31st August 2020 Time: 14:00-16:30

Agenda Item	Presenter
1. Logistical arrangements 2. Welcome 3. Introductions	Monica Patton, CDC Melissa Briggs-Hagen, CDC David Makapela, CDC & Mokgadi Phokojoe, NDOH
4. Introductions	
5. Purpose	CDC
6. Minimum Package of Interventions to Support Linkage to care, Adherence and Retention in Care	Ms M Phokojoe, Ms L Malala Mr D Gavhi
7. NDOH Response to Children	Ms L Maku
8. Clinical Governance and Patient Drug Regimen Switching	Ms L Diseko
9. TPT and decanting	Dr K Vilakazi - Nhlapo
10. NDoH Response to Mitigate Covid-19 Impact	Ms L Seshoka
11. Strategies to Manage Advanced HIV Disease	Ms L Seshoka
12. Welcome Back Strategies and Behavioural Change Strategies	Ms T Nywasha J Rathauser
13. Research, Pilot (Home Deliveries) Monitoring, Evaluation and Reporting	Dr M Manganye
14. Roles and Responsibilities at all Levels	Dr M Manganye
15. Q&A	CDC
16. Wrap up and closure	David Makapela & Melissa Briggs, CDC

5. Welcome and Purpose

In the provincial sessions, Ms Mokgadi Phokojoe officially welcomed all in attendance from each of the respective provinces (Table 1). She outlined the purpose and objectives of the orientation session as indicated in the introductory section. Emphasis was on strengthening effective differentiated service delivery amidst the Covid-19 dynamics. Also emphasised was the issue of integration, hence the orientation session comprised of integrated agenda items, all included in one comprehensive slide-deck.

PEPFAR Session: Dr Melissa Briggs-Hagen welcomed the NDoH team, speakers and all in attendance, acknowledging the importance of adherence guidelines, which is critical to enhance implementation thereof, and to emphasise the importance of decanting of stable clients as a measure to decongest facilities. She applauded NDoH for revising the guidelines and for planning on the orientation sessions to ensure maximum support in implementation.

Ms Mokgadi Phokojoe, providing an overview on the progress to 90-90-90, acknowledged the country's progress with regard to the 1st and 3rd 90, wherein 91% (6,7million) know their status, and 88% (3,2 million) of those on ART, are virally suppressed. However, 2nd 90 remains a concern, with 5million PLHIV on treatment (73%) and a variance of 1million; thus, warranting the necessity of the minimum package of interventions to support linkage to care, adherence, and retention in care.

6. Briefing on Human rights in the Covid-19 era

This presentation acknowledged that that Covid-19 has had negative impact in the health care system and that there is need to mitigate covid -19 impact and protect programme gains. Ms T Msila provided a briefing with emphasis on reminding the health care workers, and programme managers of patient rights.

7. Revised AGL SOPs

This section outlines the key revisions made and provides an overview of the minimum package of interventions to support linkage to care, adherence, and retention in care. These interventions emanate from the Care flow diagram (figure 2). The facilitators were Dr M Manganye, Mr D Gavhi, Ms L Malala, Ms M Mkhize, Ms M Pilusa, Ms L Maku and Ms T Nyawasha presented this section.

Key Revisions

- Decanting of stable patients no longer at 12 months but at 6 months
- Decanting Criteria:
    - HIV: VL < 50 copies/ml and no longer 400copies/ml
    - Diabetes: HbA1c<7% for Diabetes
- **RPCs modalities:**
    - Facility Pick – up point (Fac – PUP) and no longer SFLA
    - CCMDD no longer a modality, but a medicine distribution system
- Criteria for return to regular care added in all the RPCs
- Criteria for children and adolescent included
- New SOPs added:
    - Drug switching
    - Re-engagement
- **Terminology:**
    - TRIC now called Tracing and Recall.
    - Referring to a patient as a defaulter has been discouraged; instead, this is a patient who missed and appoint

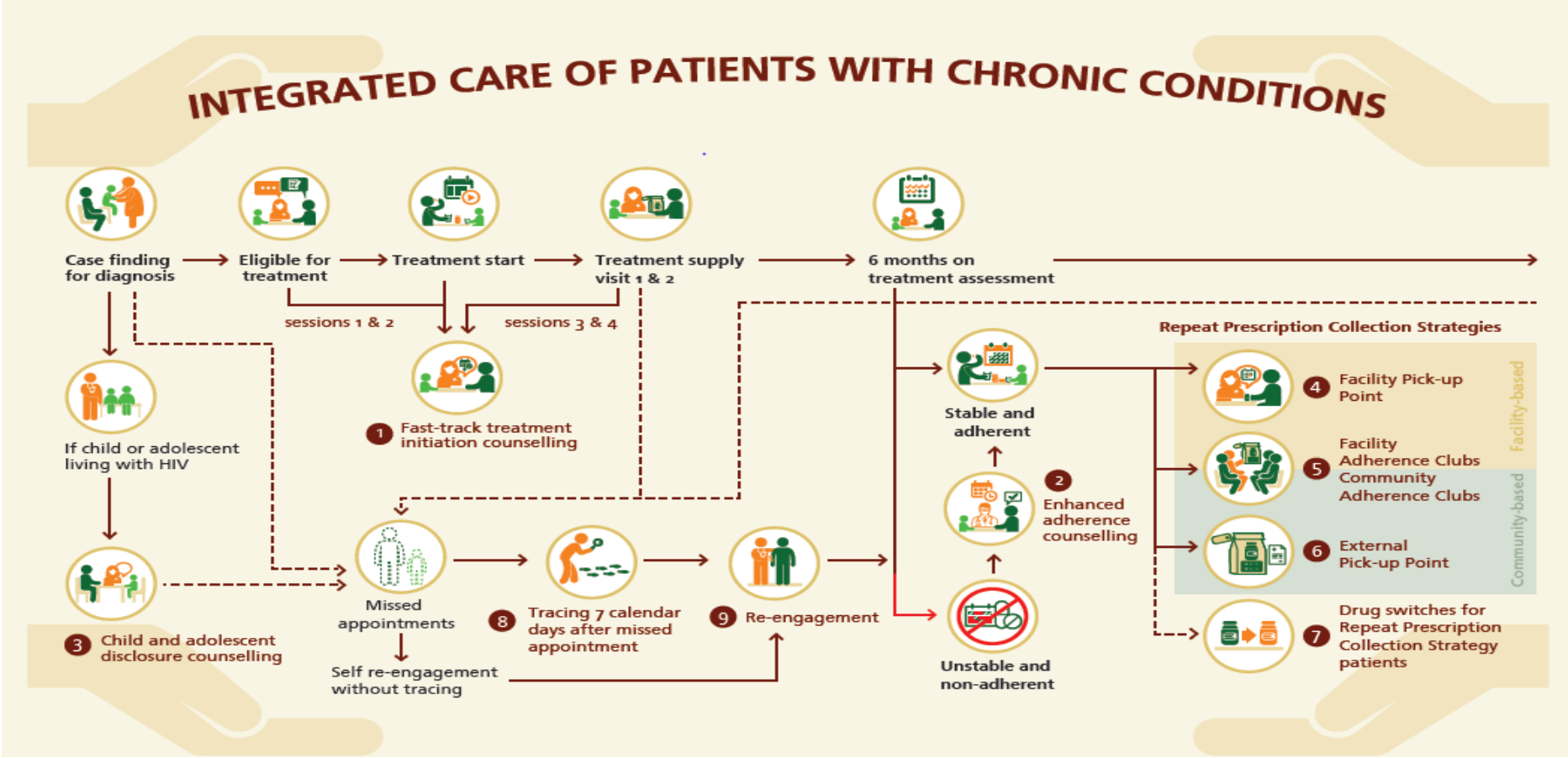

***Figure 2**: Care flow Diagram (Integrated Care of Patients with Chronic Conditions)*

8. Overview of Key Interventions

Table 3: Key Interventions

Intervention	SOP #	SOP label	Summary	
Standardised Education Sessions and Counselling approach for: ○ Treatment Initiation ○ Patients struggling with adherence (while in care or when re-engaging in care) ○ Supporting child and adolescent disclosure	**SOP 1**	Fast Track Initiation and Counselling (FTIC)	○ Client-centered focus (assist the client to make their adherence plan which should be kept in the patient's folder) ○ Speed up treatment initiation without compromising adherence ○ Add focus on explaining the service delivery options on treatment pathway ahead – if assessment normal at 6 months patient opts for easier collection options ○ Added Adherence step 11, which emphasizes treatment pathway ahead.	
	SOP 2	Enhanced Adherence Counselling (EAC)	○ Aligns with new ART clinical guidelines: Clients with VL>50 copies/ml can be referred for EAC by clinician after assessing possible adherence issue after A - E clinician's assessment (Page 39 ART Consolidated Guidelines)	
	SOP 3	Child and Adolescent Disclosure Counselling (CADC)	○ Emphasis on clinician's facilitation of disclosure with the child and caregiver.	
Differentiated Models of care (DMoC) for stable patients on treatment ○ Repeat Prescription Collection strategies (RPCs) after 6 months on treatment: ○ SOP4-6 (Patients decanted at 6months) ○ Switching first line regiments for stable patients utilizing RPCs – SOP7	**SOP 4**	Facility Pick – up Point (FAC-PUP)	**Eligibility criteria: Adults** ○ Above 18 years ○ On treatment for at least 6 months ○ Most recent assessment results normal: ○ Most recent viral load (VL) taken in past 6months < 50 copies/ml for HIV ○ Most recent HbA1c taken in past 6 months ≤ 7% for Diabetes ○ 2 consecutive BP < 140/90 for Hypertension	**For Children and Adolescents** ○ 5-18 years ○ On ART for at least 6 months with no regimen or dosage change in the last 3 months ○ Most recent VL taken in past 6 months < 50 copies/ml ○ Care givers counselled on disclosure process ○ Patient (>12 years/caregiver if patient<12 years) voluntarily opts for the RPCs option
	SOP 5	Adherence Club (AC)		
	SOP 6	External Pick – up Point (EX – PUP)		

Intervention	SOP #	SOP label	Summary
Differentiated Models of care (DMoC) for stable patients on treatment ○ Repeat Prescription Collection strategies (RPCs) after 6 months on treatment: ○ SOP4-6 (Patients decanted at 6months) ○ Switching first line regiments for stable patients utilizing RPCs – SOP7	**SOP7**	Switching first line regiment for stable patients utilizing RPCs (DRUG SWITCH)	○ NEW SOP – supporting access for stable clients in RPCs to new regimens while remaining in their RPCs ○ Overview of the Drug Switching procedure: ○ Review the patient's recent viral load result (not older than 6 months) ○ Assess the stability of the patient: ▪ Either VL<50 copies/ml **OR** ▪ Second VL assessment between 50-1000 copies/ml ▪ Remember the A - E Assessment ○ Existing patients on RPCs can be switched if: ○ Their VL has been taken in the last 6 months and is less than 50c/mL or, ○ Two consecutive VL done in the last 6 months (within 3 months of each other), are both between 50 – 999c/mL (provided the client has had an assessment of causes (A-E assessment) and gone through enhanced adherence counselling) And, ○ On medication for NCDs that do not have a known drug interaction
Patient tracing and re-engagement	**SOP8**	Tracing and Recall (TRACING)	○ Discourages use of the term defaulter, rather 'clients who missed an appointment. ○ This SOP serves for clients who failed to return to the facility within the 7 days of their scheduled appointment. ○ It outlines the tracing and recall prioritization
	SOP9	Re-engagement in care (RE – ENGAGEMENT)	○ NEW SOP – supports re-engagement after tracing or self-re-engagement

9. NDOH Response to Children

Ms L Maku provided updates on the departments' response to children, raised a concern regarding progress on the 90-90-90 targets for children wherein the programme underperformed in all the 90s. She highlighted a need to address this through focused interventions. Across all provinces, the knowledge of HIV status in children is very low, whilst ART Coverage in most districts remains below 60%.

10. Clinical Governance and Patient Drug Regimen Switching

The purpose of this section was to provide updates on ART, presented by Ms L Diseko who provided a summary on the following:

I. 1st line regimens following population groups:

A summary on the 1st line regimens for the following population groups was provided:

- Neonates (AZT, 3TC, and NVP), infants (ABC, 3TC, LPV/r), children (ABC, 3TC, and DTG), adolescents and adults 35kg TDF, 3TC, and DTG (TLD).
- Introduction of DTG on children, adolescents, and adults

Also emphasized were the important principles on VL monitoring:

- The threshold for defining VL suppression is VL < 50 c/ml.
- The threshold for defining failure is a VL > 1000 c/ml
- The principle is that we never want to change one drug in a failing regimen (i.e., VL > 1000).

II. Re-initiating treatment interrupters

The importance of history taking and assessment for re-initiating ART in treatment interrupters was as emphasised. A thorough history should be taken and should include the following:

- Which drugs the client was taking, and for how long.
- The reasons for stopping ART.
- side-effects; and
- Any information on VL measurements whilst on ART

III. Dual Treatment for HIV and Active TB

It is important to note that TB/HIV co-infection affects ART drug selection; the following should therefore be taken into consideration:

- Adult clients who are not yet on ART when TB treatment is initiated should initiate ART with an EFV-containing regimen.
- Adults who are already on an EFV-containing regimen when TB treatment is initiated should continue the EFV-containing regimen whilst also taking TB treatment. Continue until 2 weeks after TB treatment is completed.
- Clients who are already on a DTG-containing regimen when TB treatment is initiated should remain on DTG and boost the DTG dose to 50mg bd until 2 weeks after TB treatment is completed.

IV. PMTCT

Ms M Ntloana highlighted that the new PMTCT guidelines provide guidance on both safe conception (should a woman desire to be pregnant) and contraception. Emphasis on the integration of family planning services in the era of DTG was made. In addition, clinicians are encouraged to talk about the risk and benefits of DTG during antenatal talk; with emphasis that, should the client test positive and pregnant, emphasis on family planning and contraceptives for future should be considered. It was also emphasised that TLD is a choice for females of childbearing age as well as importance of fertility, sterilisation, family planning

In addition, emphasis regarding the importance of stock levels of contraception was made. Clinicians are also reminded of the use of electronic gatekeeping codes- for VL specimen for pregnant women to prevent VL rejection

11. TPT updates

Dr K Vilakazi - Nhlapo gave updates on TPT and emphasised that there are only 2 possible outcomes to TB screening. Either you are a TB suspect and you get investigated, or you are an "IPT suspect" and you get "investigated" i.e. other contraindications to IPT must be excluded so that the patient can start IPT. Other contra indications are liver disease, alcohol abuse, TB Rx NOT successfully completed, about to start ART, or previously had IPT.

If someone screens negative for TB, we expect them to start IPT, unless their clinical factors that impede treatment initiation. Guidance regarding TPT and children, adolescent and adults was provided. Also included is the decanting and adherence to treatment guidance.

I. **Screening for children is as follows**:
   - Asking about TB contacts
   - Contact with a TB infected person within the last 12 months
   - Asking about TB symptoms: Cough / fever / loss of weight / night sweats
   - If positive TB contact and no active disease offer TPT for 6 months
   - In all children <5 years
   - In all HIV-positive children up to 15 years

II. **Summary of the Differences in TPT for Adults and Children**
   - A child with a positive TB contact may be eligible for TPT, if less than 5 years old or HIV positive; INH for 6 months; TPT with every new exposure to TB
   - Any HIV positive adult may be eligible for TPT, regardless of presence of known TB contact or not; INH for 12 months; Usually only given once per lifetime

12. NDoH Response to Mitigate Covid-19 Impact

Ms L Seshoka provided an overview of the NDoH response to mitigate covid-19 impact. NDoH response takes note of the facility decongestion strategies; thus, encouraging decanting of all stable clients to the RPCs, especially decanting them to Ex – PUPs. Emphasised as well is the provision of 3 months' supply to all the chronic patients, including those who just started with their chronic treatment.

13. Advanced HIV disease/Clinical Care

Ms L Seshoka, highlighted on the WHO definition of Advanced HIV disease (AHD): wherein for adults and adolescents, and children ≥5 years old, advanced HIV disease is defined as the presence of a CD4 cell count <200cells/ mm3 or a WHO clinical stage 2, 3 or 4. Of importance to note is that all children < 5 years old with HIV infection are considered as having advanced HIV disease.

People with advanced HIV disease are at high risk of death, even after starting ART. This risk increases with decreasing CD4 cell count. The most common causes of death are tuberculosis (TB), severe bacterial infections, and cryptococcal meningitis.

In addition, WHO has recommended a package of care for AHD patients. The rationale for this package is to reduce morbidity and mortality to patients with Advanced HIV disease. It is further offered to all people presenting with advanced HIV disease even when re-engaging in after a period of ART interruption. The package should include the following:

- Screening,
- Treatment and prophylaxis for major opportunistic infections,
- Rapid initiation of ART and
- Intensified treatment adherence support,

14. Welcome Back Strategies and Behavioural Change

Ms T Nyawasha gave an overview of the Welcome Back Campaign (WBC) strategy, which aims at Retaining HIV, TB & NCD clients in care, with the objective to welcome back at least 27% (1.074. 979) HIV clients who were diagnosed with HIV and are not on ART by March 2021. The populations that the campaign is targeting are young people (15-24 years), women and men.

Further to note is the four prongs of the WBC, which are the Client, Community Systems Strengthening, Health Systems Strengthening and Social Behavioural Change Communication. Highlighting on the communication progress, Ms Nyawasha gave a brief on the MINA campaign, which is focusing on Men's health and for launch in September 2020.

On the behavioural change strategies, John Rathauser did a presentation on the Keheala behavioural model. The model extends the reach of the healthcare system to directly empower patients with reminders, information, motivation, and support, across basic feature phones or smartphones. The model also helps patients to adhere to treatment, thus, it improves treatment outcomes, reduces cost, and increases healthcare system resiliency.

Of importance to note is that, in a randomized controlled trial to demonstrate the value of behavioural nudges across basic feature phones in Kenya, 96% treatment success rate was achieved, translating to 68% reduction in the unsuccessful health outcomes-death, failed treatment and loss to follow-up.

It was further indicated that considering these results, the model was scaled up to support 18,000 patients across 8 countries and 900 facilities in Kenya. Thus, the Kenyan Ministry of Health achieved a 300% ROI on the Keheala project. In addition, each healthcare worker saved an average of 6 hours per week by using Keheala.

15. Monitoring, Evaluation and Reporting

Giving the highlights on the key DMoC data elements for 2nd and 3rd 90, in his presentation, Dr M Manganye, indicated that these key elements are sourced from TIER.Net and DHIS.

The following are the Key DMoC monitoring / data elements:

- Coverage – RPCs (Fac-PuP, AC, Ex-PuP)
- Total number of patients on ART (TROA
- Number of patients virally suppressed
- Number of ART Pickups
- Number of Clinical Visits

Further highlights included the **DMoC register,** which has been revised to align with the RPCs on the revised AGL – SOPs.

Emphasis on monitoring of blood requested was done, and that once they are received, clinicians should act on them – e.g. high VL or failure, HIV resistant testing – attend to abnormal results.

In addition, emphasis on the Integration of services and harmonizing of M&E systems at all levels was made; i.e. monitoring linkage, adherence and retention in care along the continuum of care

I. Home Medicine Delivery

Dr M Manganye presented on this section, indicating the essence of how the medicine value chain plays a critical role in overall health system efficiency. Further to note is that treatment services or programmes cannot be effective without medicines; thus, patients need to have a consistent supply of the right medicines at the right time, in the right amount at the right place.

It is on this basis that the CCMDD programme provides opportunities for patients with chronic diseases to collect their medicines from a convenient pickup point of their choice. This presentation was therefore based on the CCMDD SOP 22 on home deliveries, which provides guidance on home deliveries of patient's medicines, an expansion of DMoC. This initiation seeks to improve adherence and retention in care.

Home Medicine Delivery is not yet NDOH policy; however, pilots are underway. The pilot will assist to generate evidence which will inform policy in the future. Emphasis was made on the Home Delivery Service Pick-up Point (HDSPuP) consignment, that it must be marked clearly as HDS PuP Patient Medicine Parcel (PMP) to avoid confusion with facility PMPs. Home Medicine Delivery has been rolled out in Mpumalanga province; piloting was done by Right to Care at Ehlanzeni District. Arum is also piloting this at Gauteng province- Ekurhuleni District.

16. Questions and Answers (Q&A)

This section will tabulate all the discussions according to the Key Agenda Items as presented by Ms L Diseko, Ms L Seshoka, Dr K Vilakazi-Nhlapo, and Ms M Ntloana, including the facilitators mentioned in section 1.3. All the Questions and Answers have been classified according to the Thematic Areas that follows the structure of the Agenda Items.

Thematic Area	Questions	Answers
	Revised AGL SOPs	
SOP1: Fast Tracking Initiation and Counselling (FTIC)	1. Does the Adherence plan cover consent to be traced? If there is no adherence plan in a patient record may you trace them	○ The Adherence plan step 4 asks the patient to indicate the preferred method of follow-up. We encourage that every patient folder should have the adherence plan so that it will be easier to follow. And note that in the revised SOPs emphasis is made that the plan should remain in the patient folder, patient should not go home with the plan
	Differentiated Models of Care (DMoC) – Repeat Collection Strategies	
Repeat Collection Strategies:	2. Which RPC strategies are they able to use? Do we wait for full disclosure or not before decanting?	○ It is encouraged that the child should be decanted together with the caregiver, clinicians will facilitate disclosure (but the clinician should not disclose to the child). This means that the child can be decanted with the caregiver before disclosure. Lastly a child will be able to choose modalities of care after full disclosure (>12 years)",
	3. Are we enrolling under 5 years on CCMDD but at the same time adjust dose according weight which is correct?	○ Its only children 5 years and above
	4. Children 5yrs and older decanted after 6 months- is dosage adjustment no more applicable, weight issues	○ The child who meet criteria (have not changed dosage for past 3months)
	5. Whilst acknowledging the presentation, there is a request to integrate CCMDD SOPs with AGL SOPs given that CCMDD SOPs and AGL SOP 8 here and SOP 8 on CCMDD talking differently	○ Revision of the SOPs was a consultative process which also included CCMDD unit, request for integration noted

Thematic Area	Questions	Answers
Repeat Collection Strategies (RPCs)	6. Can patients that have a Viral Load that is between 50 -100 copies in the last 6 months be decanted or not, otherwise clinically stable	○ You have to do a thorough assessment of the cause of an elevated VL if there are challenges you implement interventions and provide EAC and repeat VL in 3month (ART consolidated guideline page 40)
	7. What happens to clients that are on RPC with VL 50- 400	○ You do not have to remove them from the RPCs; you manage them according to the management indicated in the ART Guidelines page 40. Also refer to SOP 2 (EAC) which also provide guidance
	8. How far apart must the 2 BP monitoring be done after patient is stable for 6 months	○ Patients who are already decanted are only subjected to two clinical visit (scripting and clinical assessment) and BP will be monitored during those visits. refer to SOP 4, 5 and 6."
	9. For 3-month dispensing, the understanding was that it was initially just for TLD because there were TEE shortages. Once there is enough of both drugs in country, will 3-month dispensing be allowed for all 1st line ARVs and for IPT as well?	○ The ideal and preferable dispensing is 3 months; however 2 months dispensing continues until pharmaceutical contracts ends. 3 months dispensing is also promoted due to Covid-19 challenges. Service providers are aware that this is NDoH stance. This is happening in most of districts
SOP 4: Facility Pick – up Point (FAC-PUP)	10. Regarding facility pick up point, are we not missing the opportunity of screening these patients for TB?	○ This goes with all decanted patients picking up medicine externally, the goal is to decongest the facility. We need to intensify health education and advise them to report to clinician if they feel sick
	11. If adherence club takes place in or outside the facility it might not be enough to decant patient remember we will not be able to distinguish it from Facility pick up points. Can you emphasize this further?	○ The revised AGL SOPs emphasise that Facility Pick -up point is only one pick up point. This means that the client who are going to pick medication in the facility will be reported as FAC -PUP only. Once the patients meet as a group in the AC then they can be reported as AC patients and this should be indicated as such in the register. AC will only attend the club and collect medication at FAC – PUP

Thematic Area	Questions	Answers
SOP5: Adherence Clubs (AC)	12. If CCMD formulary has more than 10 conditions, why is AGL still talking about HIV, DM, BP, & TB only? can we request that AGL rather refers to all NCDs	○ AGL is for HIV, TB and NCDs. It is difficult to set criteria for other NCDs like mental health and epilepsy. But if you can refer to annexure II of the AGL SOP you will realise that assessment referred to is a mental health assessment. Other NCDs are widely covered in the AGL training manual
	13. Can patients to AC now be decanted without looking at the ART start date (Cohorts),	○ Cohorting still continuing, as it assists us to manage blood collection
	14. If adherence clubs are used as a PUP and not in a group. Does this mean we can cohort them geographically and not on ART start date	○ Patients collecting from community designated venue but do not belong in AC are just like patients collecting from private pharmacy. There is no need to cohort per start date.
	15. How do we capture clients, that collect their medication (ART) from community outreach point which is not adherence club nor Ex-PuP	○ Patients will be registered with CCMDD community designated community venue (Not AC)
	16. How safe are AC in this era of Covid 19?	○ The patients cannot meet as groups in the Covid 19 era. They can only collect their medicine packs as individuals from their AC.
	17. During Siyenza virtual calls, Mpumalanga DoH reps mentioned permanent move away from Adherence Clubs. Is this an NDoH position? The presenter alluded to a temporary suspension due to Covid-19	○ NDoH still in support of Adherence Clubs, they have been found to play an important role in patient retention in care, hence this remains in the SOPs as one of the modalities; Thus a temporary suspension due to Covid-19.

Thematic Area	Questions	Answers
SOP 6: External Pick –up Point (EX-PUP)	18. Do we have a proportion of clients who can be allowed to use facility PUP in the context of COVID where clients are discouraged to visit facilities?	○ This question also applies to facility adherence clubs if they are still allowed, ○ This is based on the facilities' line list. We are not prescriptive on this, hence facilities' discretion
SOP 7: Drug Switch	19. What does switching with VL<1000 from TEE to TLD mean; what is the rationale behind that?	○ The guideline is very clear on how and when to switch patients from TEE to TLD, patient with a persistent low VL between 50-999 which is less that 1000 (<1000) can be switched after following all steps are taken to rule out RX failure, so that the patient can benefit from the high viral suppression and resistance barrier of TLD.
	20. On the issue of <50 copies VL suppression while decanted and on other non - DTG regimen are we waiting for less <50 copies for switching to DTG even if the client is less than 400 copies?	Existing patients on RPCs can be switched if: ○ Their VL has been taken in the last 6 months and is less than 50c/mL or, ○ Two consecutive VL done in the last 6 months (within 3 months of each other), are both between 50 – 999c/mL (provided the client has had an assessment of causes (ABCDE) and gone through enhanced adherence counselling) And, ○ On medication for NCDs that do not have a known drug interaction
Tracing &Recall and Re-engagement		
SOP 8: Tracing and Recall	21. According to the old AGL guidelines, one of the tools required for Tracing of patients who missed their appointments was a Standardised Tracing Register which we never received. Will there be one with the revised guidelines	○ Tracing is now competency of COS (WBPHCOT) they have developed a standardized tool for tracing
	22. Kindly confirm if patients are returned to clinic care after 7 or 14 days of failing to collect their PMPs at the collection points? Factoring Covid-19	○ The patients are returned to clinic care after 7 days of failing to collect their treatment in all the RPCs, however due to Covid-19 grace period of 14 days is given

Thematic Area	Questions	Answers
SOP 9: Re-engagement	23. Clarity regarding criteria for Return to Care for VL (50-1000 copies/m/). Page 74 of the SOP states that they can remain in the External pick-up point but page 75 states that they must be de-registered if they meet the criteria for return to care	○ In this case you have to do thorough assessment of the cause of an elevated VL as outlined on page 40 (ART consolidated guideline) and repeat VL in 3 month if still elevated you can return the patient to care
	24. (Follow-up to question #18): The two statements seem contradictory; it would have been better if VL (50-1000) was removed from a criterion for Return to Care.	○ A client who is not continuously suppressing they must be deregistered from RPCs after not responding to interventions (A-E assessment)
	25. ART refers to defaulters as treatment interrupters and we changing to patient missed appointment?	○ A patient can miss an appointment with or without interrupting treatment. Each case should be treated individually during intervention.7-day intervention is still early and aim to promote adherence and prevent Rx interruption
	26. With regard to the clients traced back to care, how to manage them in terms of ART if they got lost up taking TEE, and when they come back only to find that the TEE is currently out of stock. last VL in the file > 1000 copies/ml	○ If TEE is out of stock, give TEN (i.e. replace Efavirenz with NVP) and take viral load after 3 months. Please also refer to page 26 of the National HIV Consolidated guidelines
SOP 9: Re-engagement	27. Re-engagement instead of re-initiation?	○ Re-engagement. The term re-engagement is used because patients who are traced and re-recalled are re-engaged to the mainstream for differentiated interventions such as EAC, Re-initiation, bloods etc. ○ According to the clinician assessment: • Patient did not interrupt treatment, treatment will be continued • Interrupted treatment (further assessment and management according to the ART guidelines)

NDOH Response to Children		
Thematic Area	Questions	Answers
NDOH Response to Children	28. SyNCH is not allowing children to be captured if they are decanted	○ This will be taken up with CCMDD and provide feedback
	29. Please advise on children 5 -18 yrs. Which RPC strategies are they able to use? Do we wait for full disclosure or not before decanting?	○ It is encouraged that the child should be decanted together with the caregiver, clinicians will facilitate disclosure (but the clinician should not disclose to the child). This means that the child can be decanted with the caregiver before disclosure. Lastly a child will be able to choose modalities of care after full disclosure (>12 yrs)
	30. Children 5yrs and older decanted after 6 months- is dosage adjustment no more applicable, weight issues	○ The child who meet criteria (have not changed dosage for past 3months)
	31. This matrix is not aligned to the Kidz Alive age segregation, which addresses peads issues. I am under the impression that it should be up to 15 years.	○ The Paediatric CCMT age segregation ends at under 15 years. Hence the programme is in Child, Youth and School Health Cluster; the Youth and School Health will be monitoring 15 years and above.
	32. How is PCR going to be digitised? By ensuring that all PCR hard copy are digitally recorded in Tier.net	○ To make the soft copy of Positive PCR results available on Tier.net
	33. Where can we get updated Paediatric guideline on DTG for <20kg?	○ The information is in the Consolidated AR Guideline that was recently distributed to the provinces/facilities ○ The Paeds Guidelines is in the ART consolidated guidelines, distributed in the provinces and districts in August 2020
	34. Please explain again the index case of children.	○ Biological children to adults who tested positive or enrolled on ART programme.

Thematic Area	Questions	Answers
NDOH Response to Children	35. Last year during the master trainers of TLD/PMTCT guidelines, KZN team requested that National explore reducing VL to <50copies/ml to define Low Risk and High-Risk babies - any updates on that point.	○ This is not incorporated as yet. A request has been made for data from the Provinces on the Infants who converted with the maternal VL of less than 1000, to be able to gather evidence, there hasn't been a response thus far; once available, this will be updated.
	36. Children on RPC, weight should be taking only twice a year for dose adjustments	○ The SOPs apply when all is normal for children our guiding growth will be the WHO growth chart, it can give you the child's estimated weight gain in 6 months. Then health worker will have a clear idea when should return for dose adjustment."
	37. At 5yrs kids still have weight changes, this was not explained on what we should do then? Please explain clearly - Do we put them on RPC/ CCMDD and only weigh them twice a year? We must be clear on how we relay this message to clinicians at ground	○ The dosage is still dependent on the child's weight ○ We put them on RPC and weight them twice a year, ideally; but your WHO growth chart can estimate that the child will pick up in the next 5 months. The clinician then will give a return date based on child expected weight gain, for returning for dose adjustment. The following considerations were considered: ○ Children older than 5 years old grow slower than we think. ○ The dosing chart also has quite broad dosing weight bands for children >10kg. ○ Lastly, our SA dosing chart errs on using the higher range of the dose per weight band, so even if a child exceeds their weight band in 6 months, it is unlikely that they will be significantly under dosed
	38. So, it is acceptable that they get weighed 6 monthly during their clinical visits, if they qualify for 6 monthly scripting	○ The 6-month scripting is still in pilot study stage and children are not included. Which means even during roll out children will be excluded. However, they can be catered for in the 2- and 3-month treatment supply.

Thematic Area	Questions	Answers
NDOH Response to Children	39. Clarity on the RPCs regarding to linking the child with the care giver: If they are on RPC and decant children over 5-18 and kids from 12 can choose which PUP, they want to collect	○ The current SOPs will cover children between the ages 5 to 18 years as they were not covered by the previous SOP. ○ The idea is, if the caregiver is on RPCs we need to pair the child with the caregiver so that we limit the visits. ○ Also note that for a child to be decanted there should not have been any dosage change in the last 3month to ensure that they are stable in terms of weight gain. ○ However, clinician will weigh and adjust dosage on their clinical visits and assessment. ○ Lastly, when they are above 12years they can opt not to be paired with caregiver and choose modality of their choice.
	40. How can we improve collaboration between NGOs working with OVCs and vulnerable children and health facilities and DSPs to improve uptake of HTS and treatment for HIV exposed/ HIV positive children?	○ Working with the local clinic is key improving services for OVC. Both sides must make an effort to work together. E.g., one official from NGO can be in the clinic committee. ○ working on referral pathways between the OVC partners and health facilities with support of the DSP can also close the gap ○
Clinical Governance and Patient Drug Regimen Switching		
Clinical Governance and Patient Drug Regimen Switching	41. What does switching with VL<1000 from TEE to TLD mean; what is the rationale behind that?	○ The guideline is very clear on how and when to switch patients from TEE to TLD, patient with a persistent low VL between 50-999 which is less that 1000 (<1000) can be switched after following all steps are taken to rule out RX failure, so that the patient can benefit from the high viral suppression and resistance barrier of TLD.

Thematic Area	Questions	Answers
Clinical Governance and Patient Drug Regimen Switching	42. On the issue of <50 copies VL suppression while decanted and on other non - DTG regimen are we waiting for less <50 copies for switching to DTG even if the client is less than 400 copies?	Existing patients on RPCs can be switched if: ○ Their VL has been taken in the last 6 months and is less than 50c/mL or, ○ Two consecutive VL done in the last 6 months (within 3 months of each other), are both between 50 – 999c/mL (provided the client has had an assessment of causes (ABCDE) and gone through enhanced adherence counselling) And, ○ On medication for NCDs that do not have a known drug interaction
	43. TLD stock out a concern	Affordable medicine working on the matter
	44. Is laboratory gate keeping applicable to VL monitoring > 50 of non PMTCT clients...if so, is there a specific code,	○ Electronic gate keeping is for any viral load taken at facility for a pregnant or breast- feeding women only. It does not have anything to do with the values of the VL. The code is recorded on the provided place in the lab form when you send the blood to the lab.
	45. Where on the specimen form should you put the code C#PMTCT?	○ Some specimen forms have the codes and you just tick, but if there is none just add/write it below the sticker used for labelling. Please also communicate with your respective lab to process these specimens."
	46. Is there any data regarding the side effects of TLD that can be shared with us?	○ The available data was Botswana study, which WHO used it to recommend DTG. We refer to also WHO website for more information"
	47. There are some 2019/2020 updates from the Tsepamo trial on DTG and NTD risk. When will the Department issue guidance in that regard?	○ The Tsepamo trial updates have been noted, but this study was not yet peer reviewed and published. It might be used to inform policy once peer reviewed and published.

TPT and decanting		
Thematic Area	Questions	Answers
TPT and decanting	48. How many times are we supposed to reinitiate TPT on patients who interrupted treatment? **Scenario 1**: Client completed 6 or more of IPT according to previous guidelines **Scenario 2**: client is currently in the process of completing 36 months of TPT due to a positive TST **Scenario 3**: Missed opportunity and at<3 month	○ Don't repeat TPT ○ Continue and complete 36 months ○ Discuss with the client the reasons for defaulting, counsel on adhering to the treatment and the benefits of TPT. Screen again as per TPT algorithm and initiate again on TPT if eligible"
	49. What is the best practice regarding decanting ART patients within the first 6months on Rx who are also receiving TPT, because TPT is not on the CCMDD drug list?	○ TPT multi script should be aligned to ART multi script (2 or 3 months). TPT is allowed for stable patients on RHPC, All provinces should have INH on the CCMDD list. Please indicate which province you are so we can assist.
	50. Summary on TPT eligibility among children excluded children who are 5-15 years. Does this amend the criteria stipulated on the TPT recent circular?	○ Children older than 5 years and those less than 15 who are Living with HIV are given TPT for 6 months, repeated every time they are exposed to a TB case"
	51. How soon after completion of TB treatment can TPT be started	○ TPT can be started as soon as possible after successful completion of TB treatment, there are no set time lines
	52. Why is there no TPT for HIV-negative children older than 5?	○ Studies showed no benefit
	53. What are NDOH strategies to strengthen recording and reporting of TPT outcomes?	○ Aligning TPT to ART appointments; addition of TPT completion indicators in our information systems; Consider shorter duration of TPT(still under review by TB Think Tank, and will depend on approval by NHC-National Health Council),etc.

Thematic Area	Questions	Answers
TPT and Decanting	54. IPT given to Former TB patient provided treatment was completed, is this regardless of the time/ period when TB treatment was completed?	○ There are no set time lines. If there is documented proof that the patient has completed TB treatment, and screen negative for TB with no contra indications TPT can be started anytime if TB treatment was successfully completed in the last 6-12 months, "Refer to ART consolidated guidelines page 50: PLHIV Eligibility Criteria: Adult > 15 years, known-pregnant, Children (HH contacts of TB client), Pregnant women CD4 < 350, completed TB treatment successfully, on PLHIV: Child contacts of TB confirmed < 5years"
	55. Children initiated on TPT are only exposed who had exposure to TB active pts irrespective of HIV POs	○ This statement is true, also note that the irrelevant HIV status applies to children <5, for children >5 but <15, they are offered TPT only if they are HIV positive and are household contacts of a TB patient
	56. Enrolment clients on RPC strategy for patients on TPT will only be after 12 months of completing IPT despite the 6months VL of < 50	○ Patients on TPT& ART for 6 months with a VL<50 copies/ml can be enrolled on the RPCS
	57. Exclusion criteria for TPT is excessive alcohol use. How do we ascertain or calculate excessive alcohol consumption? Consumption of large amounts of alcohol.	○ Consumption of large amounts of alcohol ○ Units of alcohol = volume in ml X ETOH%/1000 ○ 28 units per week in men ○ >21 units per week in women
	58. Please be aware that in the Free State we still don't have IPT on CCMDD. We last heard that some districts had made a submission for it to be included but we were still awaiting the province to take it with the service provider	○ This matter will be taken up with CCMDD

Thematic Area	Questions	Answers
TPT and Decanting	59. Is it possible to get alerts on patients with a CD4 of less than 200 to ensure that all patients are screened for TB using ULAM?	○ ULAM is a point of Care test, it can be done immediately on eligible patients.
	60. Why should pregnant women with CD4> 350 NOT GIVEN TPT?	○ TB Maternal mortality is high in Africa, hence Pregnant Women with a low CD4<350 are offered TPT as the benefits outweigh the risks(A study done in 3 African countries showed that PW offered INH during pregnancy had adverse pregnancy outcomes-prematurity, Low Birth Weight, etc.)"
	61. Former TB patients for TPT? Is there a set timeframe post successful treatment?	○ There are no set time lines, as long as there is documented successful completion of TB treatment, no signs or symptoms of active TB, no contraindications"
	62. Some patients were missed and have never been on TPT. Can MM prescription be given to someone who is initiated when already on Repeat prescription stream for ART already? - might improve completion rates	○ If patient stable on ART and is eligible for TPT after screening, yes they can be initiated on TPT during RPCS
Strategies to Manage Advanced HIV Disease		
Strategies to Manage Advanced HIV Disease	63. How are provinces and districts monitoring the management of Crag positive patients	○ Clinicians (Doctors & Nurses) must follow up the CD4 count taken to see if is below 100copies, to follow on the CrAg results as it is done automatically, and act on it. We also use Lab report for collation per province
	64. NW happy to hear that the Advanced HIV disease training is on the way; which will be of great aid to clinically manage patients better. The province also planning to establish centre of excellence for HIV & TB Clinical care	○ Comment well received

Research, Pilot (Home Deliveries) Monitoring, Evaluation and Reporting		
Thematic Area	**Questions**	**Answers**
Research, Pilot (Home Deliveries)	65. Will the pilot results of DMOCR in Ehlanzeni be shared, we are currently contracted Community Base organisation to support Adherence clubs in Zululand, uThukela, uMgungundlovu and eThekwini	○ They will be shared, and the project will be scaled up too if found to be effective
	66. Mpumalanga already rolled out bicycle home deliveries of patient medicine parcels	○ Comment Noted
Monitoring, Evaluation and Reporting	67. Thanks for the intense update on all SOPs. Please let us not forget the issue of viral load monitoring according to COHORT when we do 12 months scripting	○ Comment acknowledged and noted
	68. In ACs do we still have standard visits that will be captured into the Clubs register by the Club Facilitator or do patients just pick up their medications?	○ We have also reviewed the AC register and it is now DMoC Register which will cater for Facility pick-up point and AC. the space is provided to indicate either: community AC, Facility AC or FAC pick Point"
	69. Is there any review on the Adherence Club registers to accommodate the 3months dispensing cycle?	○ We have also reviewed the AC register and it is now DMoC Register which will cater for Facility pick-up point and AC. the space is provided to indicate either: community AC, Facility AC or FAC-PUP"
	70. When is the new DMoC register will officially enrolled, the one that has 02- and 03-months prescription	○ It is readily available catering for up to three month we will upload in the knowledge HUB after finishing it.
	71. Does Tier.net accommodate capturing of patients on the different RPC strategies?	○ The updated version includes capturing of RPCs

Thematic Area	Questions	Answers
Monitoring, Evaluation and Reporting	72. What is the purpose of the DMoC register when these patients are captured on tier?	○ They update the register so that they capture on tier.net. e.g. Adherence Club bulk capturing is done from the register
	73. How are we strengthening the Tier system nationally so we are able to track our client who might access services in other provinces?	○ Tier is still a stand - alone database, unable to see if patient is taking treatment in other province, we need to strengthen our referral or transfer out system and request feedback
	74. How do we capture re-engagement on tier because there is no re-engagement, we only have new or re-start?	○ We will only change the outcome to indicate that the patient is back in care
	75. What if patient has interrupted treatment? Wording for clinicians and data capturer will create confusion.	○ We will have to use the existing wording on tier (further consultation will still be done)
Roles and Responsibilities at all Levels		
Access of AGL materials	○ All AGL materials have been uploaded on the Knowledge Hub and NDoH websites: ○ **KnowledgeHub**: https://www.knowledgehub.org.za/elibrary/adherence-guidelines-hiv-tb-and-ncds-standard-operating-procedures-2020 ○ **National Department of Health**: http://www.health.gov.za/index.php/component/phocadownload/category/672 ○ **South African HIV Clinicians Society:** https://sahivsoc.org/SubHeader?slug=ndoh-and-who-guidelines	
Printing	○ First print run of the AGL SOPs is underway, and distribution will be done by the 31st October	
Training on SOPs	76. As the Free State, we have already started training on the changes on the new AGL guidelines. So far, we have trained 200 people in the province. We have worked with RTC to compile the training slides	○ Comment noted, a request to share the slides developed by Free State (which were developed with RTC) – this will be helpful in ensuring standardized training slides
	77. Request for a template for the training plans	○ Provinces are advised to submit plans on their existing training templates at least seven working days after National orientations.
Human Resource	78. For EAC2 and CADC3 we desperately need the presence of Social workers! Can our Department please investigate appointing this category of Health Workers?	○ This matter needs to need to be taken up with individual provincial office. NDoH cannot as we cannot give a directive to provinces what to do but can only advice (delete the latter)
	79. Adherence counselling is very important. Can we be assisted with Adherence counsellors, it can help a lot.	○ Escalate to provincial principals

17. Wrap - Up and Announcements

Ms Mokgadi Phokojoe officially closed the sessions, thanking all participation in attendance. A request was made for provinces to submit their training plans regarding cascading the orientation on the revised AGL –SOPs. Provinces to send their training plans by 7 days post training.

18. Acknowledgements

This process, since inception, has been under the leadership of Ms Mokgadi Phokojoe, the Director Care and Support Directorate in the HIV/AIDS, STI &TB Cluster NDoH. The following teams are acknowledged and appreciated:

The steering committee: M Phokojoe, M Manganye and L Malala

Facilitators: Dr M Manganye, Dr K Vilakazi Nhlapo, Ms L Seshoka, Ms L Diseko, Ms T Msila; D Gavhi, Ms L Malala, Ms T Nyawasha, Ms M Pilusa, Ms M Mkhize and Ms L Maku

Scribers: T Nyawasha, M Mkhize, M Kgokolo, L Maku and M Pilusa

Knowledge Hub Team: Ms M Tlaka and Ms M Msila

CDC: Mr D Makapela

19. Annexures

i. Revised Adherence Guidelines Orientation Slide Deck
ii. Attendee Registration
iii. HOD Letters