

Draft Zero for Consultation

**National Strategic Plan for HIV and AIDS,
STIs and TB, 2012-2016**

5 August 2011

EXPLANATORY NOTE

This Draft Zero of the new National Strategic Plan for HIV and AIDS, STIs and TB has been drafted based on inputs from a variety of sectors and provinces. It is important to note though that several government departments and SANAC sectors are still in an internal consultation phase, and have yet to make their initial inputs.

All stakeholders in SANAC and beyond are encouraged to contribute to this NSP by providing specific feedback, comment, and suggestions. This can be sent to the SANAC Secretariat via an email address that has been established for this purpose, namely NewNSPComments@gmail.com.

Comments and inputs (including suggested text) must be submitted by 7 September 2011.

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ACRONYMS AND ABBREVIATIONS

Draft zero note: *Please note that this is not yet complete.*

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal care
ART	Antiretroviral Therapy
ASSA	Actuarial Society of South Africa
ARV	Antiretroviral
ASSA	Actuarial Society of South Africa
AU	African Union
BCC	Behavioural Change Communication
CBO	Community-Based Organisation
DCS	Department of Correctional Services
DAC	District AIDS Council
DHIS	District Health and Information System
DHS	Demographic and Health Survey
DOBE	Department of Basic Education
DOH	Department of Health
DOTS	Directly Observed Therapy Short Course
DPSA	Department of Public Service and Administration
DSD	Department of Social Development
EC	Eastern Cape Province
EID	Early Infant Diagnosis
FS	Free State Province
GBV	Gender-based violence
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria

GP	Gauteng Province
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
IDU	Injecting Drug Use/User
KYE	Know Your Epidemic
KYR	Know Your Response
KZN	KwaZulu-Natal Province
LP	Limpopo Province
M&E	Monitoring and Evaluation
MARP	Most-At-Risk Population
MMC	Medical Male Circumcision
MCP	Multiple or Concurrent Partner
MDG	Millennium Development Goal
MP	Mpumalanga Province
MRC	Medical Research Council
MSM	Men having Sex with Men
MTCT	Mother-to-Child Transmission
MTR	Mid-Term Review
NC	Northern Cape Province
NEPAD	New Partnership for Africa's Development
NGO	Non-Governmental Organisation
NSP	National Strategic Plan for HIV and AIDS, STIs and TB
NW	North West Province
PAC	Provincial AIDS Council
PEP	Post-Exposure Prophylaxis

PLHIV	Persons Living with HIV
PIC	Programme Implementation Committee of SANAC
PICT	Provider Initiated Counselling and Testing
PMTCT	Prevention of Mother to Child HIV Transmission
PrEP	Pre-Exposure Prophylaxis
PSIP	Provincial Strategic Implementation Plan
OVC	Orphans and Vulnerable Children
SACEMA	South African Centre for Epidemiological Modelling and Analysis
SADC	Southern African Development Community
SAHRC	South African Human Rights Commission
SANAC	South Africa National AIDS Council
SANBS	South African National Blood Service
SCC	Social Change Communication
STI	Sexually Transmitted Infection
SW	Sex Worker
SWEAT	Sex Workers Education and Advocacy Taskforce
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
WC	Western Cape Province
WHO	World Health Organization

CHAPTER 1 – EXECUTIVE SUMMARY

Draft Zero note: *This is only to be written once the NSP is finalized.*

CHAPTER 2 – INTRODUCTION

The HIV and AIDS, STI and TB (HAST) National Strategic Plan (NSP) 2012-2016 is the culmination of extensive review of documentation, consultation and deliberation with a wide range of stakeholders. These processes were key to determine the strategic priorities in dealing with the dual epidemics of HIV and TB in South Africa.

The South African National AIDS Council (SANAC), and more specifically its Programme Implementation Committee (PIC), has led this process. The PIC and the Plenary Committee of SANAC has provided the overall guidance and framework for the NSP. One of the key decisions included the development of a single integrated strategy for HIV, STIs and TB for 2012-2016. This is primarily due to the high co-infection rate between HIV and TB, as well as HIV and STIs.

Under the leadership of the PIC, a small team was constituted to develop Draft Zero of the NSP 2012-2016. This draft will be used during August/September 2011 to consult with provinces, SANAC sectors, government departments and society in general to guide the development of the final NSP to be released on World AIDS Day 1 December 2011.

Draft Zero was developed using inputs from various SANAC sectors, solicited via a short template for contributions addressing: (a) the programmatic pillars of the NSP, (b) the five-year objectives, and (c) proposed indicators and five-year targets. Inputs were received from SANAC sectors and technical task teams, government departments, and development partners.

To start the NSP development process, a two-day think-tank meeting was held in April 2011. Various technical experts from government departments, non-governmental organisations (NGOs) and development partners met to craft an outline for the new NSP. These deliberations were informed by international and local evidence and guidance and by the findings of the mid-term review of the NSP 2007-2011.

The PIC and Plenary meetings discussed a long term vision for the country with respect to the twin epidemics and adopted as a twenty year vision the three zeros that have also been advocated for by UNAIDS. These are: zero new infections from HIV, zero deaths associated with HIV and AIDS and zero discrimination. Given the high co-infection rates, the vision for South Africa will also apply to TB.

The various consultations that preceded this draft agreed on a range of principles that should guide the development and finalisation of the NSP as well as the provincial strategic implementation plans and the implementation plans of all SANAC sectors. The NSP 2012-2016 will be:

- Long-term focused and vision led – all initiatives should be clearly linkable to the vision of the NSP and must be able to demonstrate how they are contributing to the achievement of that vision;
- Innovative – without diminishing the importance of evidence-based initiatives, innovation should also be encouraged to find new ways of facing significant challenges;
- Simplicity – the content must be kept simple and easy for people to engage.

- High impact and scalability – in line with international trends, preference should be given in planning to a small number of high value, high impact and scalable initiatives rather than a “shopping list” of smaller diffused initiatives. This guiding principle includes cost-effectiveness within planning processes and enables the delivery of a good return on investment;
- Results and evidence based – wherever possible initiatives should be based upon clear evidence and driven by the achievement of well formulated clear results. In some instances where there is a lack of good evidence a clear motivation should be given to support the prioritisation of the intervention e.g. rights-based arguments;
- Monitored continually;
- Sustainable – the interventions must make a sustainable difference that outlasts the lifespan of the NSP itself is critical;
- Feasible – goals set should be aspirational, but achievable and feasible;
- Flexible – an amount of flexibility needs to be built into the strategic framework to ensure that changes can be made quickly and effectively when evidence demands;
- Aligned – the goals and interventions must be aligned with the government’s Negotiated Service Delivery Agreements (NSDA) and provincial strategic plans (PSPs);
- Accountability – higher levels of accountability are essential at all levels within the planning and delivery system;
- Community empowerment and people centred – initiatives should be based on engagement with the people directly affected and should enable the participation of such affected people in the formulation and execution of initiatives;
- Inclusive and seeking leadership from people with HIV;
- Monitoring, protecting and promoting human rights in all the interventions that it proposes;
- Developmental approach – HIV and TB cannot be delinked from broader development goals;
- Multi-sectoral – it is only through combining the resources of all sectors of society that the NSP goals and objectives can be achieved;
- Partnership – the NSP must promote true partnerships and country ownership through empowerment, communication and coordination.

For the next five years, the following four pillars will form the basis of our collective response that will in turn provide the impetus towards achievement of our 20-year vision:

- Universal testing for HIV and screening for TB – the primary objectives being to ensure that all citizens know their HIV and TB status, and to prevent new HIV and TB infections;
- Health and wellness – the primary objective being to ensure access to quality treatment, care and support services for those with HIV and/or TB and to develop programmes to focus on wellness;
- Safety and dignity – the primary objective being addressing issues of stigma, unfair discrimination, human rights, and gender inequality
- Changing social norms and values – the primary objective being to address societal behaviours that are fuelling the twin epidemics of HIV and TB

The following chapters provide more detail on how we will achieve these goals over the 2012-2016 period. This NSP provides strategic direction and proposes several “game changers” to scale up the response to HIV and TB. In summary these game changers can be categorised as: those that increase coverage; those that improve quality; new

combinations of interventions that take into account the specific nature of the epidemics in different provinces and within different provinces and those interventions that are novel. These include:

- Scaling up and improving the quality of key prevention and treatment programmes, including male and female condom distribution (including for key populations), MMC, prevention of mother to child transmission, and ART;
- Combination prevention interventions that are targeted depending on epidemiology;
- Introducing new prevention interventions rapidly as informed by evidence, e.g. microbicides, and pre-exposure prophylaxis for key populations; and
- Protecting children and reducing their HIV and TB vulnerability, including keeping girls in school for as long as possible.

This strategic document is intended for use by all sectors of society and all three spheres of government (and all government departments) to develop detailed strategic implementation plans that will reflect their specific contributions to the achievement of the National Strategic Plan. Provincial strategic implementation plans (PSIPs) should be based on the National Strategic Plan and provide strategic direction at a provincial level, with specific provincial-level interventions, that take local conditions into account and with targets.

A key issue to address in this plan is the strengthening of implementation and governance structures. It has been agreed that SANAC is an institution inclusive of Provincial AIDS Councils and District AIDS Councils, and that better systems for communication, coordination and standardisation are required. In this regard measurable objectives will be set for the development and strengthening of these structures and this is seen as a vital part of the NSP, which must also be monitored.

The various members of SANAC – government, business, labour and civil society – along with other stakeholders, are committed to working together to achieve the aims of the NSP 2012-2016 over the next five years, and in so doing ensuring that progress is made towards realising the 20-year vision set out above.

CHAPTER 3 – PROGRESS OF THE NSP 2007-2011

Draft Zero note: Provincial and sector reviews are currently taking place and results will be incorporated into the relevant sections of this chapter, as will additional comments from all reviewers.

3.1 Overview of the NSP 2007-2011

The primary goals of the NSP 2007-2011 were to:

- Reduce the number of new HIV infections by 50%
- Reduce the impact of HIV on individuals, families, communities and society by expanding access to appropriate treatment, care and support to 80% of all people diagnosed with HIV

Interventions needed to reach the NSP goals were structured under the following four pillars:

- Prevention
- Treatment, care and mitigation
- Human and legal rights
- Monitoring, research and surveillance

Priority intervention areas were defined under each of the pillars, and these will be discussed under their relevant sections.

3.2 Review of the 2007-2011 NSP Progress

The review of the progress towards achieving the NSP goals was conducted using a multi-pronged approach. All provinces carried out extensive, multi-sectoral reviews that fed in to both the national report as well as providing province-specific progress reports.

Government departments also held extensive consultations. The results of these fora were synthesized with a national desk review that included findings from key documents, publications, and data sets.

Pillar 1: Prevention

A primary aim of the NSP was to ensure that the large majority of South Africans who were HIV negative remained HIV negative. The goal set out was to reduce the number of new HIV infections by 50%, with a particular emphasis on reducing new infections in the 15-24 year old age group.

According to the measure used in the NSP 2007-2011, HIV incidence in 2007 was estimated at 1.3%. To reach the target, the HIV incidence in 2011 would have to be reduced to 0.65%. Whilst this target has not been reached the, epidemiology section (see chapter 4) shows that progress has been made in reducing new infant and adult infections.

Coverage of **HIV counselling and testing** (HCT) increased substantially from 2005-2009. In 2008/09, 96% of public health facilities in the country offered voluntary HIV counselling

and testing (VCT)¹ against a target of 100%, and 24.7% of adults had been tested and received their results in the past 12 months against a target of 11%.²

In April 2010, South Africa launched a national HCT campaign with the goal of promoting HIV counselling and testing and urging all South Africans to know their HIV status, and to be screened for TB. With a target of testing 15 million people by June 2011, this was the largest testing campaign ever undertaken. By June 2011, an estimated 14.8 million counselling sessions, and 13 million tests for HIV were conducted³. Approximately 7.7 million people were symptomatically screened for TB. In addition, South Africa is currently scaling-up its provider initiated counselling and testing (PICT) model to extend access to HCT at health facilities.

As a result of new evidence showing that the risk of HIV transmission in circumcised men is significantly reduced, in 2010, South Africa instituted an aggressive rollout of a national **medical male circumcision** (MMC) programme. The goal was to reach 80% of men aged 15-49 (approximately 4.3 million men) by 2015. As of June 2011, 237 812 medical male circumcisions had been conducted.

There were a number of large-scale, national **mass media** campaigns. Exposure to South Africa's HIV prevention communication through media campaigns is high, with 80% of those surveyed knowing at least one of the initiatives⁴, in particular among the 15-24 year old age group.

In 2009, 100% of schools provided **life skills**-based HIV education within the last academic year,⁵ however the full impact of this programme needs further investigation as there are a number of challenges that have been highlighted in the implementation of the programme (such as how seriously it is taken by both learners and educators).

The distribution of **male condoms** increased from 308.5 million in 2007, to 495 million in 2010 (a 60% increase). However, what this translates to an individual level is still very low: 14.5 per adult male per year (15-49) in 2010 against 12.7 per adult male in 2008.⁶ The number of **female** condoms distributed free has increased from 3.6 million in 2007 to 5 million in 2010 (a 39% increase).

Condom use in South Africa has continued to increase. The percentage of people who reported using a condom in the most recent sexual encounter increased from 35% (2005) to 62% (2008) with the highest rates amongst younger age groups.⁷

First-line management of **sexually transmitted infections** (STI) is currently conducted at 85% of public health facilities. While STI partner notification is reported at 100%, the partner tracing rate was estimated at only 21.9% in 2010 and has remained at this low rate since 2008. The prevalence of syphilis amongst pregnant women has declined from

¹ The previous primary model for HIV counselling and testing

² Cite MTR

³ Department of Health programme data, 2011. Please note that June 2011 data is not yet complete

⁴ loveLife (2009). A gauge of HIV prevention in South Africa, 2009.

⁵ EMIS: School Realities 2008 and 2009, NDOE

⁶ NDOH programme data

⁷ NDOH M&E

11.2% in 1997 to 1.9% in 2009⁸ likely as a result of syndromic STI management. There were no cases of congenital syphilis reported.

Since 2008, South Africa has rapidly scaled up its **prevention of mother to child HIV transmission** (PMTCT) programmes. By 2010, PMTCT was offered at 98% of health facilities with virtual universal coverage of mothers booking and delivering in health facilities. South Africa has achieved global success in its PMTCT programme and against the NSP target set of less than 5% transmission rate. In 2010, early transmission from mother to child was found to be 3.5 percent in South Africa, and only 1.1 percent of 4- to 8-week-old infants in the country were infected with HIV.⁹

Blood and blood product safety continues to achieve 100% targets for blood being screened in a quality assured manner. HIV transmission through blood has been virtually eliminated and the safety of blood products in South Africa is on par with international standards (UNGASS report, 2010).

Pillar 2: Treatment, Care and Mitigation

The second aim of NSP 2007-2011 was to reduce the impact of HIV on individuals, families, communities and society by expanding access to appropriate treatment, care and support to 80% of all HIV-positive people and their families by 2011.

The achievements of the HIV counselling and testing response have been detailed in the prevention section.

Rollout of **antiretroviral therapy** continues to be successful, with 1.4 million persons started on antiretroviral therapy as at the end of June 2011. Treatment initiation rates have reached 30,000 per month.¹⁰ A revision of the treatment guidelines in 2009 has increased the threshold for ART treatment in pregnant women and patients co-infected with TB and HIV or with AIDS defining illnesses, to CD4 count 350, and to initiate all HIV positive infants regardless of CD4 level.

Expanded access to treatment through primary health care and nurse-initiated antiretroviral therapy has been expanded throughout the country. “Task-shifting” from doctor to nurse and from pharmacist to pharmacy-assistant or technician has been implemented. This is especially important in the face of a public sector shortage of skilled and trained health workers, which impacts on the ability to expand access to prevention, care and treatment services.

Overall mortality rates from HIV have demonstrated a gradual reduction, reflecting the increase in treatment access (Table 4). Because AIDS is not a notifiable disease, the table below reflects projections from two sources: Spectrum, a UNAIDS model, and ASSA, the Actuarial Society of South Africa.

⁸ UNGASS Universal Access

⁹ Cite MRC study

¹⁰ Cite

Table 4: South Africa projected AIDS related deaths¹¹

	2008		2009		2010
	<i>Spectrum</i>	<i>ASSA</i>	<i>Spectrum</i>	<i>ASSA</i>	<i>ASSA</i>
Total annual AIDS deaths	330,000	235,000	314,000	200,000	188,828
Adult AIDS deaths (15+)	297,000	208,000	284,000	179,000	167,894
AIDS Deaths (0-14)	33,000	27,000	30,000	21,000	20,934

Pillar 3: Monitoring, Research and Surveillance

The 2007-2011 NSP had an unwieldy number of indicators that were undifferentiated between those that relate to outcome from those related to process. The NSP targets were not clearly defined and monitoring and evaluation systems were not well coordinated. Throughout the system, monitoring evaluation (M&E) and analysis capacity is lacking, reducing the reliability of data used for budget and planning processes.

There continue to be challenges with ART M&E and in 2010/11 a revised policy and implementation strategy to simplify, standardise and rationalise the reporting of patients receiving ART was adopted. This new system (with 3 tiers) is currently being rolled out.

In the past five years, South Africa has been host to a number of prevention trials. These include:

- A randomised controlled trial assessing the effectiveness of male circumcision in preventing HIV infection. The result showed an effectiveness of about 60%.
- The iPrEx Study had a site in Cape Town and found oral pre-exposure prophylaxis (PrEP) reduced HIV infection risk by 44% in men having sex with men (MSM).
- The CAPRISA¹² 004 study conducted in KwaZulu-Natal found topical a ARV containing vaginal microbicides reduced HIV infection risk by 39% in women. The FACTS¹³ 001 trial recently launched at nine sites in South Africa aims to confirm the results of CAPRISA 004.
- The HPTN¹⁴ 052 study had two sites in South Africa and demonstrated that early treatment at CD4 counts of between 350-500 reduced morbidity and mortality in the infected individual and reduced transmission to the uninfected partner by 96%.

Pillar 4: Human and Legal Rights

South Africa has a very progressive constitution, as well as laws and other regulations that provide for the security of human rights and protects individuals against discrimination. These specifically include provisions for vulnerable populations such as women, young people, MSM, prison inmates and migrant populations. However, implementation of some of these policies has been poor, and policies do remain that promote stigmatization and

¹¹ National ANC Sentinel HIV and Syphilis Prevalence Report. National Department of Health, 2010, p56

¹² Centre for the AIDS Programme of Research in South Africa

¹³ Follow-on Africa Consortium for Tenofovir Studies

¹⁴ HIV Prevention Trials Network

discrimination, such as the continued criminalisation of sex work which creates barriers for HIV prevention and treatment.

The NSP explicitly provided for the promotion and protection of human rights and attempts to create benchmarks for compliance with human rights standards and the reduction of stigma. However, there was no clear implementation plan for this component and an absence of dedicated funding for this area meant implementation and monitoring was compromised.

3.3 Highlighted Challenges of the NSP 2007-2011

Despite the many successes, there have been some key challenges which needs attention in the new NSP:

- Despite the renewed political commitment, there has been little progress in restructuring SANAC and establishment of SANAC as a legal entity so that it could access and distribute funding to sectors;
- AIDS councils at provincial and district levels are not all functioning optimally, and coordination between the public sector, private sector and non-government sectors needs to be strengthened;
- Coordination between the national strategy and implementation at provincial, district, ward and facility level needs to be strengthened;
- The absence of national or provincial implementation plans linked to the NSP weakened the ability to monitor and evaluate implementation;
- TB and STI integration were not well defined in the 2007-2011 NSP and insufficient progress has been made in TB integration;
- Most reporting against the NSP targets was dominated by the health sector, and this masked the tremendous amount of activity by other government departments and sectors of SANAC;
- No clear strategy on removing punitive legislation and human rights barriers (especially in relation to sex work);
- There was no clearly defined M&E framework or costing of the research, monitoring and evaluation component in the 2007-2011 NSP.

The NSP 2012-2016 builds on the successes of the previous NSP, but also aims to address some of the challenges.

CHAPTER 4 – THE SOUTH AFRICAN HIV AND TB EPIDEMICS – WHAT DO WE KNOW?

In order to update and consolidate the evidence base for South Africa's response to the HIV and TB epidemics over the next five years, a review of existing data on the epidemiology of HIV, STIs and TB as well as their related social determinants is critical. The "Know your HIV Epidemic (KYE)" and "Know your HIV Response (KYR)" reports were commissioned by SANAC in 2010 and provide a comprehensive review of South Africa's response. This chapter summarises the epidemiology of HIV based on the 2011 KYE report, unless otherwise referenced.

The primary objectives of the KYE review were to:

- Describe the level of heterogeneity of the South African epidemic and provide information on any sub-epidemics which can be identified within the national epidemic;
- Identify populations at greatest risk of HIV infection based on an analysis of the distribution of new infections;
- Establish the factors driving the epidemic through an analysis of provincial behavioural, socio-economic, biological and demographic data; and
- Provide an epidemiological evidence base for the formulation of evidence-informed, better-targeted and more effective prevention strategies.

The assessment was conducted through a desk review of existing published and unpublished literature. In particular data were drawn from the population-based HIV sexual behaviour data from 2002, 2005 and 2008 conducted by the Human Sciences Research Council (HSRC)¹⁵, and national communication surveys conducted by Health and Development Africa¹⁶.

4.1 Levels and Trends in HIV Prevalence

South Africa has a population of approximately 50.6 million people (0.7% of the world's population)¹⁷. Of these, STATSSA estimates that 5.38 million people live with HIV (17% of global burden) in 2011. HIV prevalence for the adult population (15-29 years) is estimated at 16.6%, and the overall population prevalence rate is 10.6%.

The disease has impacted significantly on life expectancy – which is currently 54.9 years for men and 59.1 years for women according to the 2011 STATSSA estimates. Though still low, this is an increase over the 2007 rates at the start of the previous NSP (50.9 years for men, and 54.9 years for women). This increase in life expectancy is mainly due to the impact of antiretroviral therapy.¹⁸

¹⁵ South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2002, 2005 and 2008

¹⁶ Second National HIV Communication Survey (NCS 2009)

¹⁷ Mid-year population estimates, 2011. StatsSA, July 2011

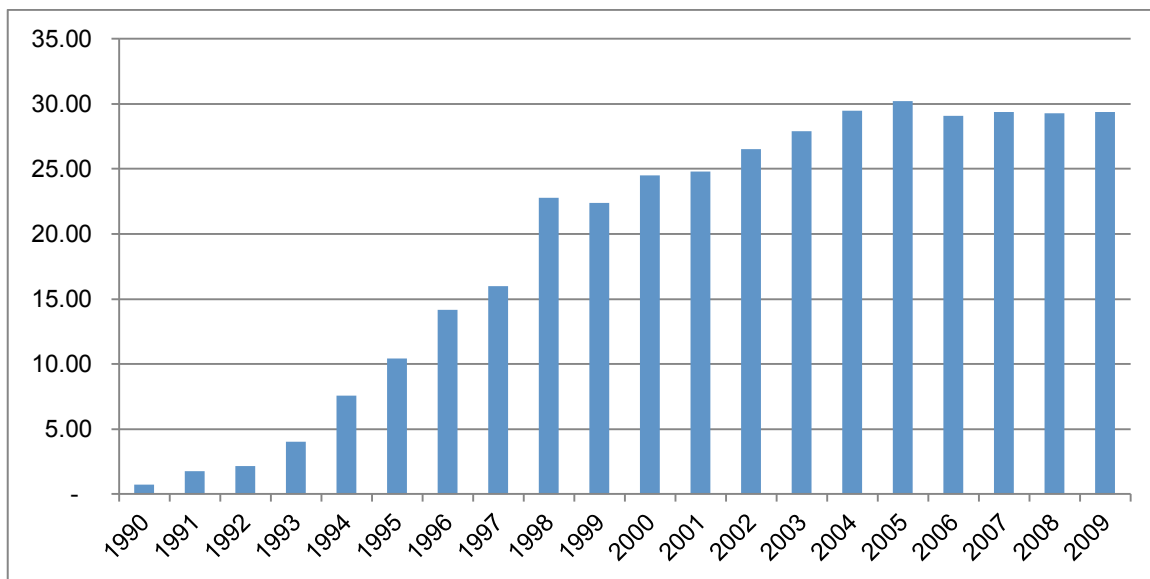
¹⁸ Mid-year population estimates, 2011. StatsSA, July 2011

Similarly, STATSSA reported improvements in infant mortality and under 5 mortality rates. The infant mortality rate has improved from 45.1/1000 live births in 2007 to 37.9/1000 in 2011. Similarly, under 5 mortality has decreased from 67.8/1000 to 54.3/1000¹⁹.

South Africa has systematically monitored the HIV epidemic for 18 years through the annual antenatal HIV and Syphilis Survey conducted by the National Department of Health. These surveys measure HIV prevalence data for a representative sample of pregnant women attending public sector antenatal clinics. Significant improvements in the methodology have been made over time and from 2006 the number of sentinel sites was increased from 400 to 1,400 with a doubling of the sample size of this survey from 16,500 to 33,000. This change means that the more recent estimates are likely to be more reliable.

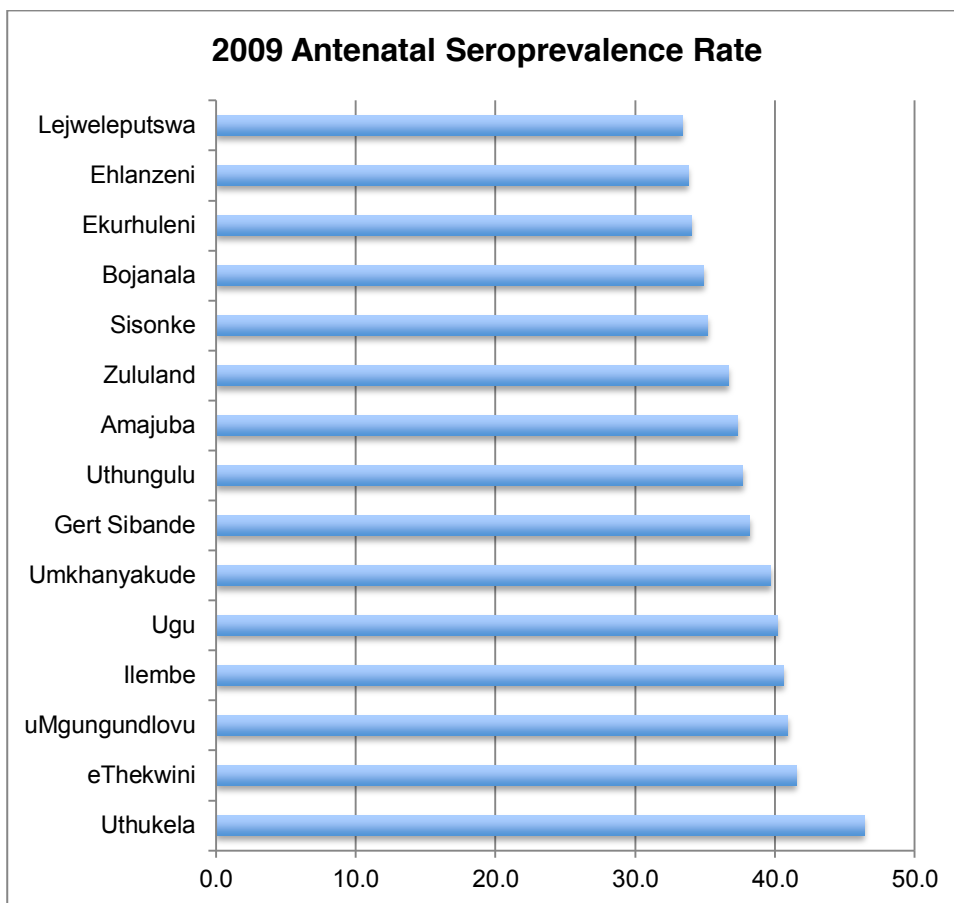
Based on current incidence rate estimates, the HIV epidemic is continuing. Data from the antenatal survey suggest that HIV prevalence has plateaued, albeit at a high level of nearly 30%. This national figure masks provincial and district level differences with some districts at above 40% in KwaZulu-Natal (Uthukela, eThekweni, Ilembe and uMgungundlovu) to several districts below 10% in the Northern Cape (e.g. Namaqua) and Western Cape (e.g. West Coast). It should be noted that high prevalence in the context of significant access to ARVs represents longer life expectancy and not necessarily increased incidence.

Graph 1: Antenatal seroprevalence rates, 1990-2009



¹⁹ Mid-year population estimates, 2011. StatsSA, July 2011

Graph 2: 2009 Antenatal Seroprevalence Rates in 15 Districts with Highest Rates



The HSRC conducted national household-based population surveys in 2002, 2005, and 2008²⁰. These surveys suggest that:

- In adults aged 15-49 years, the three national surveys in 2002, 2005, 2008 estimated HIV prevalence at 15.6%, 16.2% and 16.9% respectively; and
- The national prevalence (all survey respondents aged 2 years and older) in 2002, 2005, and 2008 was 11.4%, 10.8% and 10.9% respectively.

4.2 Trends in HIV Transmission

The Know Your Epidemic (KYE) report highlights the areas where the epidemic seems to be concentrated, and some of the major risk factors for HIV infection. Amongst others, these are:

- HIV prevalence is significantly higher in the African black population than in the other race groups;
- Adult women aged 15 years and above are significantly more likely to be HIV positive than men of the same age;
- Young women between the ages of 20 and 24 are four times more likely than males of same age to have HIV. The difference is even higher in teenage girls;

²⁰ South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2002, 2005 and 2008

- On average young females are infected about 5 years earlier than males;
- The estimated number of people living with HIV shows considerable clustering in the eastern parts of the country, with the majority of adult people living with HIV (54%) located in Gauteng and KwaZulu-Natal (KZN);
- High levels of localised HIV transmission is found in areas close to national roads and highways;
- Levels of HIV in informal settlements in urban areas are high, and highest where these informal, high-density settlements are located near national roads. Conversely, more inaccessible rural areas had the lowest prevalence, though this is increasing;
- The type of residential area is also associated with the likelihood of being HIV infected, with urban informal areas linked to highest HIV prevalence compared to urban formal, and rural informal areas. Trends indicate a slight decline of 3% in urban formal areas in contrast to an increase of over 5% in rural areas;
- Men and women with tertiary education are significantly less likely to be HIV positive than those with no school education;
- Low socio-economic status is associated with HIV infection. More importantly those who work in the informal sector have overall the highest HIV prevalence with almost a third of the African informal workers being HIV positive. Among women, those with less disposable income have a higher risk of being HIV positive;
- Men who reported having been circumcised *before* their first sexual encounter were significantly less likely to be HIV positive. Traditional circumcision, when performed after sexual debut, is less protective.²¹

National and provincial strategic implementation plans need to take these issues into account when planning interventions.

Although surveys show that HIV prevalence has plateaued, what is often not considered is that the national ART programme, by increasing life expectancy, also impacts on HIV prevalence levels, adding close to 2% to HIV prevalence through people living longer. However, the rate of new infections continues to outstrip current prevention efforts threefold, and the absolute number of people living with HIV increases at a rate of approximately 100,000 new infections per year.²²

A successful intervention impacting on HIV among children is the national prevention of mother-to-child HIV transmission (PMTCT) programme. Due to the improved coverage of PMTCT, the number of infants born HIV positive has decreased by 50% between 2004 and 2010 according to a recent Medical Research Council (MRC)²³ study.

4.3 Estimation of HIV Incidence

South Africa has considerable experience in the use of a variety of methods to estimate HIV incidence, the rate at which new infections occur. HIV incidence is a key prevention impact indicator. However, there are methodological challenges with HIV incidence measurement and efforts are being made to strengthen our ability to accurately measure incidence.

²¹ Know Your Epidemic report, 2011

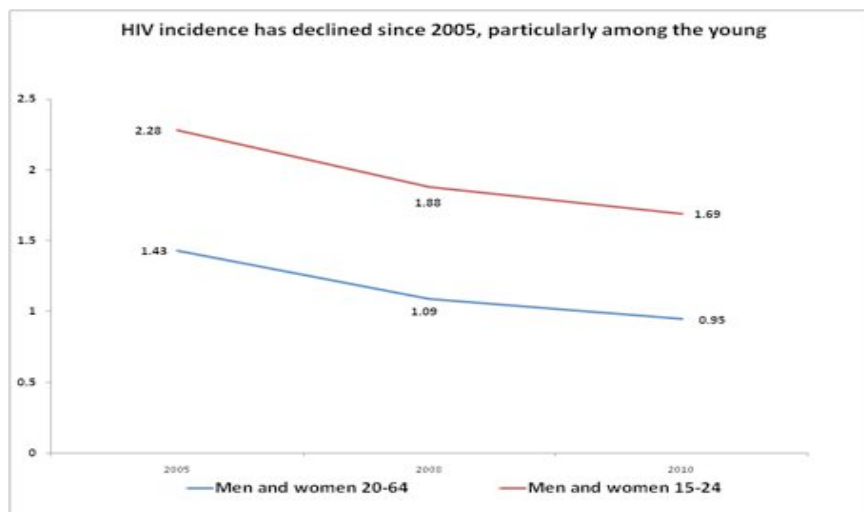
²² Mid-year population estimates, 2011. StatsSA, July 2011

²³ Presented at the SA AIDS Conference June 2011, but not yet published

In summary, the different methods to estimate HIV incidence suggest annual incidence of 2.0-2.4% in the first half of the decade starting in 2000 and about 1.2-1.7% in the second half of the last decade. UNAIDS estimated incidence in South Africa at 1.49% in 2009, with the 2011 StatsSA estimate being 1.38%. The KYE report indicates that one incidence estimation method suggested that HIV incidence may have declined by 60% in young women aged 15-24 between the inter-survey periods 2002/05 and 2005/8.

There is evidence that HIV incidence has been declining over the last decade, particularly in the younger age groups, which had an estimated incidence rate of 2.28 in 2005, and 1.69 in 2010 (ASSA 2008, Figure 1). It has been reported that between the 2002-2005 and 2005-2008 period there was a decline in HIV incidence, but this was only statistically significant for women aged 15 to 24 years, among whom a 60% reduction in incidence from 5.5 to 2.2/100 PY²⁴ was estimated.²⁵ In 2011 there was agreement on a step-wise methodology to use to project incidence using the ASSA model.

Figure 1: HIV incidence among men and women aged 20-64 and 15-24 years (ASSA 2008)



Estimates of HIV incidence in young people aged 15-20 suggest that although those in their teens prevented infections more effectively in 2008 than in 2002, they still acquire new HIV infections rapidly as they enter into their twenties.

From studies conducted in KZN by the Africa Centre, the lifetime risk for HIV infection at age 55 is estimated at 78% for males, and 75% for females. Thus, though women may be infected at a younger age, lifetime risk is not very different.

Compared to other countries in Sub-Saharan Africa, HIV incidence in South Africa is exceptionally high (see below), though lower than in three neighbouring countries (Botswana, Swaziland and Lesotho).

²⁴ /100PY refers to 100 person years of follow up. In other words, if 100 people were followed for 1 year, then this number of people (in this case 2.2) would become infected with HIV.

²⁵ Rehle 2010

Table 1: 2009 UNAIDS Estimates of HIV Incidence²⁶

Country	Incidence Rate (2009)
Rwanda	0.18%
Angola	0.21%
Namibia	0.43%
Kenya	0.53%
Uganda	0.74%
Zimbabwe	0.84%
Malawi	0.95%
Mozambique	1.19%
South Africa	1.49%
Botswana	1.56%
Lesotho	2.58%
Swaziland	2.66%

4.4 Modes of HIV Transmission

The South African epidemic is clearly driven by heterosexual transmission, which is typical for a generalised and hyper-endemic epidemic. However, in recent years there have been various efforts to understand the epidemic in sub-populations.

In terms of same-sex transmission, data from the Eastern Cape show that men who have sex with men (MSM) were 3.6 times more likely to be HIV positive than men in the general population. HIV prevalence in eight studies among MSM conducted between 2005 and 2010 ranges from 10.4% to 43.6%.²⁷ In addition, 3.2% of men self-reported same sex behaviour (roughly 750,000 South Africans), and about 10% of these were living with HIV according to the most recent national HIV survey (Shisana 2009). The South African Centre for Epidemiological Modelling and Analysis (SACEMA) estimates that 9.2% of new HIV infections are related to MSM – a clear indication for the need to focus on this key population.

SACEMA also estimates that 19.8% of all new HIV infections are related to sex work. HIV prevalence estimates among sex workers in varying locales in South Africa range from 34-69% (Leggett 2008, Parry 2008, Van Loggerenberg 2008, Dunkle 2005, Williams 2003, Rees 2000)

Table 2: Percent of new infections attributed to sex workers, injecting drug users, MSM and their sex partners, South African Centre for Epidemiological Modelling and Analysis

	Percent of new HIV infections, group only	Percent of new infections, group and their partners/clients
SW	5.5%	19.8%
IDU	1.1%	1.3%
MSM	7.9%	9.2%
Total	14.5%	30.3%

²⁶ UNAIDS HIV Epidemic Update, 2010

²⁷ Burrell, Mark, Grant, Wood and Bekker. 2010. Sexual risk behaviours and HIV-1 prevalence among urban men who have sex with men in Cape Town, South Africa, and Rispel, L. & Metcalf, C. (2009) Are South African HIV policies and programmes meeting the needs of same-sex practising individuals?

An issue that has not been fully understood before is the link between mental health and HIV. A recent report from the University of Cape Town shows that the prevalence of mental illness (especially depression and anxiety) among people living with HIV in South Africa is 43.7%. This is significantly higher than the rate of 16.5% in the general population. This highlights the need for greater psychosocial and other community support programmes. The link between mental health and HIV is especially high amongst pregnant HIV-infected women (from studies in two provinces rates of depression during pregnancy were between 39 and 41%).²⁸

There are an estimated 10,000-50,000 injecting drug users in South Africa. In the 2008 household survey, there was a 11% HIV prevalence among people who inject drugs. Research from the Medical Research Council (Parry 2008) show that 86% of South Africans who inject drugs share injection equipment, not only syringes but also other drug paraphernalia needed for preparing the drug for injection, and 65% practice unsafe sex. There is a large and growing problem with crack cocaine, especially among the youth and sex workers, thus highlighting the need to consider scaling up substance abuse reduction programmes and needle exchange programmes.

Another major risk factor is substance abuse, especially alcohol. A recent report by the UN Development Program (UNDP) and the Sex Workers Education and Advocacy Taskforce (SWEAT) showed the strong link between alcohol and unprotected sex – mainly as a result of the disinhibition as a result of alcohol and drug abuse. A 2011 report from the MRC indicates that, based on 20 studies in Africa, people who drink alcohol are 57% more likely to be HIV infected, with this likelihood increasing to 104% among those who abuse alcohol. Alcohol abuse is also associated with decreased condom use, and an increase in multiple (and concurrent) sexual partners.

Data on the role of medical injections and infection control in health care settings are limited. In a study conducted by the HSRC infants who had received an injection in the last year prior to the survey were slightly more likely to be HIV positive.

HIV transmission through blood transfusion is practically zero due to the quality of our blood services and does not require new action, but demonstrates the importance of maintaining the high standards of screening currently in place.

An important factor in transmission is early sexual debut among young people, particularly among girls from poor households, and age-disparate sexual relationships among young girls and older men.²⁹ Community poverty rates were associated with early sexual debut and higher levels of unprotected sex. School attendance as well as completing schooling is a significant factor protecting girls from early sexual debut before 17, from HIV infection as well as teenage pregnancy. Data from the Centre for the AIDS Programme of Research in South Africa (CAPRISA) shows that among school children in grades 9 and 10 in Vulindlela, KwaZulu-Natal prevalence rates among girls aged 17-18 is 7.9%, compared to 1.2% among boys of the same age group. The same rate for boys at age 15-16 is 1.4%, compared to girls at 3.6%.

Additional factors that increase the risk of HIV acquisition include:

²⁸ Centre for Public Mental Health Perinatal Mental Health Project, University of Cape Town, 2011

²⁹ Pettifor, Rees et. al. 2005. Young people's sexual health in South Africa: HIV prevalence and sexual behaviors from a nationally representative household survey

- Multiple sexual partners – in the past conventional wisdom stated that HIV transmission was driven by multiple concurrent partnerships. Based on data presented in 2011 by the Africa Centre from research conducted over 5 years in rural KwaZulu-Natal, the biggest contributor to the risk of HIV appears not to be concurrency, but the absolute number of sexual partners in a lifetime³⁰;
- Unprotected receptive anal sex in MSMs – this carries 20 times the HIV risk compared to unprotected vaginal sex;
- Transactional sex – this is increasingly being viewed as a common practice in South Africa. A study in Soweto found that 20% of women reported having engaged in transactional sex;
- Gender-based violence – the link between gender-based violence and HIV infection is well documented. This is especially true for young women. In South Africa, according to a 2011 report by the Desmond Tutu HIV Foundation³¹, an estimated one third of young girls indicate that their first sexual experience was forced, and nearly 75% have had at least one non-consensual sexual encounter;
- Mobility and migration – there are high levels of migrancy in Southern Africa (~2.2 million in 2010), with South Africa being the primary destination for migrants. Within the country there is also significant mobility and migration, including mine workers, and seasonal farm workers; and
- The migrant labour system, low marriage rates across all populations, and unstable long-term relationships.

4.5 Sexually Transmitted Infections

An often-overlooked component of the NSP is that of sexually transmitted infections (STIs). In South Africa, more than 1.5 million patients with symptomatic STIs were reported to have been treated at PHC facilities in 2009. Other health service providers, mainly in the private sector, are estimated to have treated another 1.5 million patients with symptomatic STIs in that year. Further studies indicate that up to 50% of all STIs can be asymptomatic.

In addition to this direct burden, the presence of STIs increase the risk of HIV transmission in sero-discordant couples. Prevention and early treatment of STIs is therefore a high public health priority in South Africa, and should continue to be in the NSP 2012-2016.

4.6 Prevalence and Incidence of Tuberculosis in South Africa

Draft Zero Note: *Significant additional information is needed in this section around TB epidemiology, risk factors etc.*

South Africa is facing one of the worst dual epidemics of HIV and TB in the world. The HIV burden is linked to the world's second highest per capita incidence of tuberculosis (971 per 100,000 population)³². TB is the most common opportunistic infection in people living with HIV and the major cause of mortality. Additionally, TB results in more rapid progression of HIV disease.

In people with normal immune systems the lifetime risk of progressing from latent TB

³⁰ Tanser, Bärnighausen et al, 2011

³¹ Andrew Scheibe, Benjamin Brown, Zoe Duby, Linda-Gail Bekker, 2011

³² World TB report. 2010

infection to active TB disease is 10%. HIV, by weakening the immune system, increases a person's risk of progressing from latent TB infection to active TB disease to 10% per year. In the 1980s the TB incidence was relatively stable. Between 1989 and 2009, the antenatal HIV prevalence increased from less than 1% to 30% and the TB incidence increased more than fourfold from 187/100,000 to 971/100,000. Rising HIV prevalence has also resulted in a growing percentage of TB cases occurring in women. From 1995 to 2004, the HIV antenatal prevalence rose from 10% to 30% and the proportion of new TB cases who were women increased from 35% to 44%.

The World Health Organisation (WHO) estimated that there were 490,000 TB cases in South Africa, 60% of whom were co-infected with HIV. Importantly, this means that 40% of TB patients are not HIV-infected, and thus ensuring prevention services for TB patients is critical to maintain that HIV negative status. Of all new cases of TB in 2009, 15% were children under the age of 15.³³

TB screening among HIV infected persons was approximately 57% in 2010, representing a significant increase from 2009 and the case detection rate remains stable at an estimated 6.8% (DHIS). There was a very low rate (around 4%) of isoniazid preventive therapy (IPT) but this has started with increase during 2010/11. Among known HIV-positive TB patients, 75% received cotrimoxazole preventive therapy and 31% received antiretroviral treatment (ART) in 2010.³⁴

There is late initiation of ART in TB patients, contributing to mortality. ART services have been centralized compared to TB services that are at primary health care level, making the treatment of TB patients co-infected with HIV and in need of ART difficult. However, in 2010 an aggressive effort was launched by the Department of Health to decentralise ART initiation to primary health care level. Even where ART has been decentralised, services still remain largely inadequately integrated.

Table 4: TB incidence and prevalence data, with and without HIV, 2009³⁵

Estimates of burden	Number (thousands)	Rate (per 100,000 pop)
Mortality (excluding HIV)	26 (14-42)	52 (29-85)
Prevalence (including HIV)	400 (180-650)	808 (362-1288)
Incidence (including HIV)	490 (400-590)	971 (791-1169)
Incidence (HIV positive)	280 (230-340)	563 (461-675)
Case detection, all forms (%)	74 (61-91)	

Note that ranges indicate uncertainty intervals

National targets for TB control include a 85% cure rate. Although TB cure rates are increasing in South Africa, they remain far below target. According to the National TB Programme 2010 data, among 139,458 new smear-positive patients registered for TB treatment in 2009, 70.3% were cured, 6.1% completed treatment, 1.7% failed, 7.1% died, 7.0% defaulted, 4.8% were transferred out and 2.6% were not evaluated³⁶. The new smear-negative/extra-pulmonary TB successful treatment rate was 68% and the

³³ World TB Report, 2010

³⁴ Department of Health TB programme data, 2011

³⁵ World TB Report 2010

³⁶ Department of Health TB programme data, 2011

retreatment successful treatment rate was 64% (2008 data)³⁷.

The Starting ART at 3 Points in TB (SAPIT) trial in KwaZulu-Natal showed that early initiation of ART in TB patients results in a 56% decrease in mortality. Cotrimoxazole preventive therapy has been shown to decrease hospitalisations and mortality in HIV-infected TB patients by 50%.

It is estimated that 1.8% of new TB cases and 6.7% of retreatment TB cases are multi-drug resistant (MDR) which means that the cases are resistant to isoniazid and rifampicin. South Africa has the fourth highest number of MDR-TB cases (9,600 cases in 2009) in the world with an emerging problem of extensively-drug resistant TB (XDR-TB). Many diagnosed patients do not start on MDR treatment because they die or move before they are informed of their diagnosis (in 2009 only 46% of MDR-TB cases started treatment). MDR-TB services remain centralised in most of South Africa. Based on promising results from pilots in Khayelitsha and Tugela Ferry that have decentralised MDRTB treatment to the clinic and community levels a national plan to both deinstitutionalise and decentralise MDR-TB has been developed.

4.7 Conclusion

South Africa has over 5.3 million people living with HIV, which means that one in six South Africans is HIV positive. TB incidence is 971/100,000, meaning that almost 1% of the South Africa population develops TB disease each year. The rate of new infections of HIV and TB are not declining significantly. There are thus major challenges that need to be addressed collectively by South Africans to improve prevention efforts to stem the tide of new infections, and to ensure appropriate care and treatment for those already infected.

³⁷ World TB report, 2010

CHAPTER 5 – INTERNATIONAL AND REGIONAL OBLIGATIONS

The NSP 2012-2016 must be aligned and consistent with national, international and regional obligations and commitments. Hence these obligations are included in the NSP for easy reference. These international and regional obligations include the following:

- The Constitution
- Universal Access targets;
- Millennium Development Goals;
- UNGASS Political Declaration, June 2011;
- UNAIDS 2011-2015 strategy;
- WHO Health Strategy for HIV and AIDS 2011-2015
- The Stop TB Strategy and the Stop TB Partnership's Global Plan to Stop TB 2006-2015
- Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV 2010-14
- African Union commitments; and
- Southern African Development Community commitments.
- International human rights agreements that South Africa has ratified;
- International trade agreements

5.1 Universal Access and Millennium Development Goals

The United Nations endorsed the concept of universal access (UA) to HIV prevention, treatment and care and support in 2005. The purpose of universal access is to contribute to the achievement of national targets in areas such as antiretroviral therapy, prevention of mother to child transmission, prevention programmes for key populations and HIV counselling and testing. The UA builds on the 2001 United Nations General Assembly Special Session on HIV and AIDS (UNGASS) Declaration of Commitment. In 2006, at the second United Nations General Assembly High Level Meeting on HIV and AIDS, countries agreed to work towards the goal of "UA to comprehensive prevention programs, treatment, care and support" by 2010. These global commitments complement the United Nations Millennium Development Goals, which established targets to reduce child mortality, improve maternal health and combat HIV, malaria and other major diseases by 2015.

In 2006 governments made a historic commitment at the United Nations to dramatically scale up the AIDS response. UNAIDS called for a review of universal access in 2010, building on the data received from countries through the UNGASS reporting framework. A number of barriers to expanding HIV programming were identified including poor supply systems and financial mechanisms, weak health systems, low levels of human resources, high levels of stigma and discrimination, gender inequality and marginalization of key populations at higher risk. Countries committed to tackling these obstacles and set national targets for universal access. The achievement of Universal Access and MDGs continue to guide and inspire global efforts, to overcome obstacles to equitable services, to drive the prevention revolution, and to call for appropriate investments in AIDS responses.

5.2 Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV

The global commitments to mitigate the impact of HIV to date were reviewed in June 2011 at the United Nations General Assembly. The UNGASS Political Declaration of June 2011 calls on all UN Member States to redouble their efforts to achieve universal access to HIV prevention, treatment, care and support by 2015 as a critical step towards ending the global AIDS epidemic.

The Declaration also noted the need to expand efforts to combat TB by improving TB screening, prevention, access to diagnosis and to treatment of both drug susceptible and drug resistant TB and access to antiretroviral therapy. The Declaration also calls on member states to implement integrated TB and HIV services in line with the Global Plan to Stop TB, 2011-2015.

A pledge to eliminate gender inequality, gender-based abuse and violence, and to increase the capacity of women and adolescent girls to protect themselves from HIV infection was also made. The Declaration recognizes that access to sexual and reproductive health has been and continues to be essential to the AIDS response and that governments have the responsibility of providing public health services focused on the needs of families, particularly women and children. Member states also agreed to review laws and policies that adversely impact on the successful, effective and equitable delivery of HIV prevention, treatment, care and support programmes to people living with and affected by HIV.

With nearly 7,000 new HIV infections each day globally (more than 1,000 of those in South Africa alone), the Political Declaration reaffirms that preventing HIV must be the cornerstone of national, regional and international responses to the AIDS epidemic. It calls for expanding access to essential HIV prevention commodities, particularly male and female condoms and sterile injecting equipment, intensifying national HIV testing campaigns; it urges countries to deploy new bio-medical interventions as soon as they are validated including earlier access to treatment as prevention. The declaration calls for: Leadership to uniting to end the HIV epidemic; Strengthening prevention by expanding coverage, diversify approaches and intensify efforts to end new HIV infections; Treatment, care and support: Eliminating AIDS-related illness and death; Advancing human rights to reduce stigma, discrimination and violence related to HIV; Resource mobilisation for the AIDS response; Strengthening health systems and integrating HIV into broader health and development; and Positioning research and development as the key to preventing and treating HIV.

UNGASS Political Declaration Targets for 2015

- ❖ Reduce by 50% the sexual transmission of HIV—including among key populations, such as young people, men who have sex with men, in the context of sex work; and prevent all new HIV infections as a result of injecting drug use;
- ❖ Eliminate HIV transmission from mother to child;
- ❖ Reduce by 50% tuberculosis deaths in people living with HIV;
- ❖ Ensure HIV treatment for 13 million people;
- ❖ Reduce by 50% the number of countries with HIV-related restrictions on entry, stay and residence; and
- ❖ Ensure equal access to education for children orphaned and made vulnerable by AIDS.

Given the importance of these commitments, UNAIDS has called on the General Assembly to reiterate and extend the commitment to universal access and to report back on progress in June 2016 on the targets.

5.3 UNAIDS 2011-2015 Strategy

The UNAIDS 2011-2015 strategy is more “focused, strategic, flexible, responsive, efficient and accountable” to achieve the overall global commitment of Universal Access to HIV treatment, prevention, care and support. The strategy advocates a more collaborative and constructive approach to build a more multi-sectoral AIDS response, and to use scaled up AIDS services as an entry point to achieving better health outcomes across the MDGs. This Strategy paves the way to transform the global response and outlines the role of UNAIDS:

- It sends out a new and ambitious rallying cry to achieve the UNAIDS long-term vision of the Three Zeros – Zero discrimination. Zero new HIV infections. Zero AIDS-related deaths.
- It focuses the AIDS agenda on three strategic directions. These are revolutionising HIV prevention; catalysing the next generation of treatment, care and support; and advancing human rights and gender equality for the HIV response.
- It sets a bold and transformative agenda to maximize efficiencies and focus to deliver results.
- Supports development of new tools and enables their timely and effective use.

The strategy links with and draws from various frameworks and mechanisms that have been developed to strengthen national AIDS responses and others designed to coordinate and focus the support of the UN to those responses. The UNAIDS Outcome Framework and the campaign to ‘Know Your Epidemic, Know Your Response,’ advocates a more prioritized response based on better evidence. The Three Ones and the Division of Labour among the various UN agencies are tools to help countries advance principles of country ownership and aid effectiveness. The United Nations Office on Drugs and Crime (UNODC) is mandated to assist member states to provide people who use drugs, prisoners and people vulnerable to human trafficking with evidence-informed comprehensive HIV prevention, treatment and care services.

5.4 WHO Health Strategy on HIV and AIDS 2011-2015

The strategy was launched in 2010 and guides the health sector’s response to HIV. The Strategy is fully aligned to the goals of the UNAIDS strategy and proposes four strategic directions:

- Optimise HIV prevention, treatment and care outcomes: Revolutionize HIV prevention; Eliminate new HIV infections in children; Catalyse the next phase of treatment, care and support; Provide comprehensive and integrated services for key populations.
- Leverage broader health outcomes through HIV responses: Strengthen links between HIV programmes and other health programmes
- Build stronger and sustainable systems: Strengthen the six building blocks of the health system

- Reduce vulnerabilities and remove structural barriers to accessing services: Promote gender equality and remove harmful gender norms; Advance human rights and promote health equity; Ensure health in all policies, laws and regulations.

The strategy promotes expanded integration between HIV and tuberculosis services. Key actions include producing clinical guidelines and supporting implementation of operational tools for tuberculosis prevention and treatment within HIV health services, including application of “the Three I’s (Intensive case finding; isoniazid therapy and infection control);” Promoting co-packaging, co-formulation and use of isoniazid/cotrimoxazole combinations; Prevention of tuberculosis in people living with HIV; and Leading the development of a robust research agenda on HIV-TB co-infection, including improved surveillance of HIV and tuberculosis and supporting joint reviews of HIV/tuberculosis planning and programmes.

WHO Health Strategy on HIV: 2015 Targets

- ❖ **Reduce new infections:** reduce by 50% the percentage of young people aged 15–24 years who are infected (compared with a 2009 baseline)
- ❖ **Eliminate new HIV infections in children:** reduce new HIV infections in children by 90% (compared with a 2009 baseline)
- ❖ **Reduce HIV-related mortality:** reduce HIV-related deaths by 25% (compared with a 2009 baseline)
- ❖ **Reduce tuberculosis-related mortality:** reduce tuberculosis deaths by 50% (compared with a 2004 baseline).

5.5 Global Plan to Stop TB Strategy

The long-term TB Strategy was launched in 2006 to ensure equitable access to quality care for all TB patients – infectious and non-infectious, adults and children, with and without HIV, with and without drug-resistant TB and through public or private health care providers. The Stop TB agenda was recommended for integration into national strategies to reduce poverty and advance development. The six components of the strategy are: i) To pursue high-quality DOTS expansion and enhancement; ii) Address TB/HIV and MDR-TB and other special challenges; iii) Contribute to health system strengthening; iv) Engage all care providers; v) Empower people with TB, and communities; and vi) Enable and promote research.

WHO has published an interim policy on collaborative activities between TB and HIV control programmes with recommendations in three broad categories: establishing the mechanisms for collaboration, reducing the burden of TB in people living with HIV (PLHIV), and reducing the burden of HIV in patients with TB. These activities should be included in national TB control plans. The four activities involved in mechanisms for collaboration are:

- Creation of a joint national TB and HIV coordinating body that includes TB and HIV patient support groups;
- Development and implementation of a joint national plan;
- HIV surveillance among TB patients, irrespective of HIV prevalence rates; and
- A system of monitoring and evaluation. For monitoring and evaluation, a core set of indicators should be agreed upon, based on WHO guidelines for monitoring and evaluation of collaborative TB/HIV activities.

The three activities to reduce the burden of TB in PLHIV are: i) intensified TB case-finding in all HIV/AIDS programme outlets and among high-risk populations, with a referral system between HIV and TB services; ii) provision of isoniazid preventive therapy as part of the package of care for PLWHA when active TB is excluded; and iii) ensuring that infection control is in place in health care and congregate settings.

The five activities to reduce the burden of HIV in TB patients are: i) HIV testing and counselling for all TB patients when HIV prevalence among TB patients exceeds 5%; ii) provision of HIV prevention services (including harm reduction measures when injecting drug use is a problem); iii) provision of cotrimoxazole preventive therapy to TB patients with HIV infection; iv) provision of antiretroviral therapy to TB patients with HIV infection; and v) provision of care and support services to TB patients with HIV infection.

WHO's Stop TB Strategy, 2006-2015, Targets

- ❖ By 2015: reduce by 50% the number of people/100 000 who have TB relative to 1990
- ❖ By 2015: reduce number of new TB cases per 100 000
- ❖ By 2015: reduce by 50% number of deaths from TB per 100 000 relative to 1990.
- ❖ By 2050: Eliminate TB as a public health problem to less than 1 case per million population

5.6 Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV 2010-2014

This agenda was launched at the 54th UN meeting on the Commission on the Status of Women, held in New York in March 2010, which was developed to address gender inequalities and human rights violations that continue to put women and girls at risk of HIV infection. The Global Task Force on Women, Girls, Gender Equality and HIV launched the agenda following wide consultation. The five-year action plan was launched at a high-level panel during the Commission and calls on the UN system to support governments, civil society and development partners in reinforcing country actions to put women and girls at the centre of the AIDS response, ensuring that their rights are protected.

The agenda supports the implementation of the UNAIDS action framework and focuses on: understanding and responding to particular effects of HIV on women and girls; translating political commitments into scaled-up action to address the needs of women and girls in the context of HIV; and creating an enabling environment for the fulfilment of the human rights of women and girls and their empowerment in the context of HIV. It reflects a human rights-based approach that includes the participation of men and boys, partnerships, leadership, multi-sectorality and accountability. The strategies in the Agenda are recommended for incorporation into NSPs to facilitate integrated implementation and monitoring.

Actions for Accelerated Agenda for Women, Girls and HIV

- ❖ Improving data collection and analysis to better understand how the epidemic affects women and girls.
- ❖ Reinforce the End Violence against Women campaign through the AIDS response.
- ❖ Ensure that violence against women is integrated into HIV prevention, treatment, care and support programmes.
- ❖ Analyse the impact of socio-cultural and economic factors that prevent women and girls from protecting themselves against HIV.
- ❖ Support women's groups and networks of women living with HIV to map commitments made by governments on women and HIV.
- ❖ Scale up engagement of men's and boys' organizations to support the rights of women and girls.

5.7 African Union (AU)

Ten years ago African Heads of State and Government adopted the New Partnership for Africa's Development (NEPAD), an African Union strategic framework for pan-African socio-economic development, a vision and a policy framework for Africa in the twenty-first century. NEPAD was a radically new intervention, spearheaded by African leaders, to address critical challenges facing the continent: poverty, development and Africa's marginalisation internationally. This focuses on saving lives and empowering women at the continental level and to eradicate poverty for sustainable socioeconomic growth and development.

The African Union Abuja Declaration on HIV/AIDS, TB and other related infections declared these diseases as state of emergency in the African Continent and called on the state parties to strengthen ongoing successful interventions and to develop new and more appropriate policies, practical strategies and effective implementation mechanisms and concrete monitoring structures at the regional, national and continental levels; African Union African Health Strategy (2007-2015). The African Union Ministers of Health approved this Strategic Framework during the Third (3rd) Ordinary Session of the African Union Conference of Ministers of Health (CAMH3) in April 2007. The goal of the strategy is to contribute to Africa's socio-economic development by improving the health of its people and by ensuring access to essential health care for all Africans, especially the poor and the marginalised, by 2015. It further pays special attention to post-conflict countries and those caring for the refugees and internally displaced persons.

5.8 Southern African Development Community (SADC)

SADC adopted a health protocol in 1999. The protocol declares that in order to deal effectively with the HIV, AIDS and STI epidemic in the region and the interaction of these with other diseases, member countries shall harmonise policies aimed at disease prevention and control, including cooperation and identification of mechanisms to reduce the transmission of STIs and HIV infection; Develop approaches for the prevention and management of HIV, AIDS and STIs to be implemented in a coherent, comparable, harmonised and standardised manner; Develop regional policies and plans that recognise the intersectoral impact of HIV, AIDS and STIs, and the need for an intersectoral approach to these diseases; Cooperate in harmonising protocols of HIV and STI; Surveillance systems in order to facilitate collation of information which has a regional impact; Regional

advocacy efforts to increase commitment to the expanded response to HIV and STIs and sharing of information; and Provide high-risk and trans-border populations with preventative and basic curative services for HIV and STIs.

With respect to TB control the protocol urges member states to develop strategies to control the spread of TB in the region, to harmonise TB control activities and HIV and AIDS programmes and to ensure the efficient supply and delivery of drugs.

SADC policy frameworks, declarations and legislative frameworks to guide a coherent regional response include:

- The SADC Declaration on HIV/AIDS, 2003 (referred to as Maseru Declaration). This states that halting and rolling back HIV infection constitutes a top priority on the SADC agenda. Article 3c of the Declaration makes reference to the needs of people living close to national borders;
- SADC Ministers of Health approved the Surveillance Framework for HIV & AIDS, TB and Malaria in November 2009. The objectives of the Framework are to co-ordinate regional efforts on epidemic preparedness, mapping, prevention, control and where possible, the eradication of communicable and non-communicable diseases;
- SADC Ministers of Health approved the SADC TB Strategic Framework (2007-2015) in 2007. The plan acknowledges that mobile populations present particular challenges in harmonising treatment regimes, monitoring treatment and cross-border management of TB patients. The plan includes a strong priority on harmonisation of cross-border health policies, guidelines and strategies, including cross border diagnosis and treatment of all forms of TB to ensure harmonised management of TB patients in the region;
- SADC has further developed a harmonised Surveillance Framework for TB and it was approved by SADC Ministers of Health in November 2009;
- SADC Human Resource for Health Strategic Framework (2006-2019). This strategic framework was approved by SADC Ministers of Health in April 2006 and SADC commissioned a policy document in June 2006 that addresses human resources for health challenges in SADC. One of the issues that were highlighted was that SADC region has to develop mechanisms to address the migration of its health professionals to deal with its shortages. It further states that the Ministries of Health should interact with other countries through various government-to-government agreements, and multilateral organisation-sponsored protocols like the Commonwealth Ethical Recruitment Protocol;
- SADC Policy Framework on Population Mobility and Communicable Diseases .This strategic framework was approved by SADC Ministers of Health in November 2009 and provides guidance on the protection of the health of cross-border mobile population with regards to communicable diseases as people move across the borders. Specifically it calls for the following: regional harmonisation and coordination; equitable access to health services by cross-border populations; coordinated regional public health surveillance and epidemic preparedness, information, education and health promotion for mobile populations; operational research and strategic information; and legal, regulatory and administrative reforms;
- SADC Strategic Framework and Plan of Action (2008-2015): Comprehensive Care and Support for Orphans and Other Vulnerable Children and Youth (OVCY) in SADC. This strategic framework was approved by SADC Ministers of Health in November 2009 and ensures that the rights and basic needs of all children and youth in the SADC region are fully met. The framework includes a strong priority on

harmonisation of cross-border health policies and strategies on OVCY across all SADC member states to ensure comparability and consistency in addressing the vulnerabilities of children and youth (“whole child development” approach). The Framework further calls for SADC member states to adopt and implement policies and programmes to protect mobile children and youth so as to combat trafficking of children and youth and for the protection of refugees, unaccompanied and unregistered cross border mobile children.

5.9 Maputo Plan of Action 2006

Ministers agreed to adopt a plan, which will help African nations reduce poverty levels with an uncompromising evidence, based approach to achieving the Millennium Development Goals to reduce maternal mortality, combat HIV and AIDS and reduce infant and child mortality. The plan’s main focus is the integration of sexual and reproductive health services (SRH) into primary healthcare; its implementation will improve reproductive health conditions for millions of women across the continent.

5.10 Conclusions

South Africa is a member state of the United Nations, African Union, SADC and other regional and global partnerships that have committed to and are obliged to deliver on the stated targets. It is critical that South Africa aligns its national response to the global HIV, TB and STI strategies and targets, given that it has one fifth of the world’s population of people living with HIV and a high TB-HIV co-infection.

CHAPTER 6 – DEVELOPMENT PLANNING AND HIV, AIDS, STIs AND TB – UNDERSTANDING THE CONTEXT

Draft zero note: *This chapter will be revised during the consultation phase to include more information on the national planning framework and how it relates to HIV and TB (still in development). Additional edits will reflect on the impact of HIV and TB on the economy.*

Three decades into the response to HIV, South Africa is still grappling with addressing the complex challenges posed by the epidemic. The HIV epidemic reversed some of the gains in the TB control programme and a dual epidemic of TB-HIV and the growing number of drug resistant TB patients. In addition, the social determinants and drivers of the epidemic are reflective of the issues that confront the new democracy. All sectors of society are faced with the mammoth task of addressing the legacy of the previous dispensation such as poverty, inequities, socio-economic disparities and all this in the context of a global recession and unstable market forces.

The need to respond to HIV has been a priority for almost three decades. Over time, various conceptual shifts have occurred and have influenced the characteristics of the response. Initially, the primary interventions were driven through mass information, communication campaigns followed by a narrow biomedical focus. This was soon followed by a focus on behavioural aspects including cultural issues that were identified as risks for HIV acquisition. Interventions shifted to behavioural change with a strong focus on placing the onus on individuals to adopt healthy practices supported by available biomedical interventions. Recognition of the limitations of the biomedical and anthropological/behavioural paradigms emerged when the concept of the social determinants of ill health became better understood, leading to the established and accepted paradigm of conceptualizing HIV as also a development issue. Such a concept recognizes the socio-economic context in which the epidemic occurs and the inter-relatedness of HIV with other development concerns such as poverty, inequity, lack of access to basic amenities, lack of social cohesion and many other aspects.

Appreciating that economic growth and stability, eradication of poverty, the building of a developmental state and nation building require long-term planning, coupled with the knowledge that HIV is a chronic, lifelong condition requiring lifelong interventions, a strategic approach to the development of a national plan for HIV, AIDS and TB invariably requires a broad understanding of national planning frameworks and priorities. Moreover, the magnitude of the South African epidemic and the size of the associated burden of disease, may undermine some of the objectives that are articulated in the national planning frameworks. Conversely some of the national planning frameworks present unique opportunities to address the social drivers of the epidemic thus lessening the burden on the overstretched health systems and making it possible for the state to achieve its development goals.

The Medium Term Strategic Framework (MTSF), which guides government's programme of action in the electoral mandate period 2009-2014, builds on successes of the past 15 years of democracy. It is a statement of intent, identifying development challenges facing South Africa and outlining the medium term interventions towards improving the lives of South Africans. Some of the objectives outlined in the MTSF include;

- Halving poverty and unemployment by 2014 – both factors are significant drivers of the HIV and TB epidemics. An Anti-Poverty Strategy is already being implemented. The challenge is to strategically integrate this with efforts in the NSP;
- Improve the nation's health profile – a key objective of the NSP 2012-2016
- Improve the safety of citizens. The government Social Cluster is currently developing a strategy on Social Cohesion and Social Capital and these can inform the NSP, especially pillars 3 and 4;
- Build a nation free of all forms of racism, sexism, tribalism and xenophobia – a principle that is enshrined in the Constitution of the country.

Strengthening Accountability

Poor accountability has been identified as one of the key aspects that undermine government's performance and service delivery. To address this, an outcomes-based approach to delivery has been instituted. This approach finds expression in the Negotiated Service Delivery Agreements signed by all Ministries with the President. In addition inter-Ministerial Service Delivery memoranda of understanding have been agreed to improve better planning, collaboration and mutual accountability across departments and across all spheres of government. This new development will strengthen the HIV and TB response in a number of significant ways by ensuring that ministries are accountable on an annual basis to key sets of deliverables.

The development of the NSP 2012-2016 must be underpinned by an understanding of these broader high-level planning frameworks to enable rational and appropriate evidence-informed strategies to be prioritized during planning. In the final instance, the NSP 2012-2016 cannot be a plan to cure all of the country's ills; it must, however, articulate interventions that will move the country closer to both the short-term five year vision and the longer term 20 year vision; this will naturally find expression in South Africa's vision 2025 as defined in the national plan under development by the National Planning Commission.

CHAPTER 7 – STRATEGIC PILLARS OF THE NSP 2012-2016

7.1 NSP Principles

As noted in the introductory chapter, a range of principles has been agreed upon to guide the finalisation and implementation of the NSP and implementation plans. These principles should in particular guide the finalisation and implementation of interventions listed under each of the four pillars that is discussed in this chapter.

7.2 Key Populations

As was seen in the chapter on epidemiology of HIV and TB, even though South Africa has a generalised HIV epidemic, there are still higher levels of infection and transmission within certain geographic areas, as well as among some key populations. For these reasons, despite certain general interventions (e.g. communication), key populations should be targeted for prevention, care and treatment interventions – and this should be included specifically in provincial strategic implementation plans. These key populations include:

- Young girls – preventing early sexual debut;
- Infants and children under the age of 15 – early treatment;
- Sex workers (SWs) and their clients – prevention interventions (e.g. condoms, HCT, early treatment and TB screening);
- Men having Sex with Men (MSM) – condoms, potentially pre-exposure prophylaxis, behaviour change, early treatment;
- Mobile and migrants populations (e.g. truck drivers, mine workers, construction workers, seasonal farm workers) – prevention, HCT and TB screening, early treatment;
- The clientele of taverns and shebeens – prevention, male condoms;
- Inmates of correctional facilities – condoms, HIV and TB diagnosis and treatment;
- People living in unstable communities, for example informal settlements – prevention and treatment
- Men between ages 12-49 (the inclusion of young men is to offer MMC before sexual debut to offer optimal protection) – medical male circumcision, condoms, prevention messaging, HCT and TB screening
- Sero-discordant couples – early ART for the HIV-infected partner
- HIV-infected pregnant women – PMTCT, ongoing ART
- TB-HIV co-infected patients – treatment for TB and ART

Within each pillar these key populations will need to be targeted with different, but specific interventions, to achieve maximum impact.

7.3 Goals of the NSP

The following goals have been proposed for NSP 2012-2016:

- Reduce the rate of new HIV infections by 50% by 2016
- Reduce new HIV infections in children by 90% by 2016
- Reduce HIV associated maternal mortality by 50% by 2016

- Improve life expectancy by 5 years for men and women by 2016
- Ensure access to appropriate treatment, care and support to 90% of all HIV-positive people and their families by 2016
- Ensure early diagnosis and early treatment for TB, STIs and HIV
- Reduce new TB infections to 2010 levels by 2016
- Reduce new drug resistant TB infections by 50% by 2016
- Expand access to TB treatment (including treatment for drug resistant TB)
- Reduce mortality related to HIV and TB by 25% and 50% respectively
- Reduce mother to children transmission of HIV to less than 2% by 2016
- Reduce the psychosocial impact of HIV and TB on individuals, families and community
- End all unlawful discrimination related to HIV and TB status and measurably reduce stigma
- Increase the TB cure rate to 85% by 2016

These goals will be consolidated during the consultation phase, including setting measurable targets.

Based on the data from evidence, and the goals of the NSP, there are several key interventions proposed in the NSP 2012-2016:

- HIV testing and TB screening for all South Africans (12 and older) on an annual basis for those with unknown status, or previously tested HIV negative (improved case finding)
- Early diagnosis of HIV and TB
- Early treatment for HIV and TB
- Taking biomedical and behavioural prevention interventions to scale
- Reducing vulnerability to HIV and TB infection

These goals and key interventions are further broken down into a number of objectives under the 4 pillars.

7.4 NSP Pillars

Pillar 1: Universal HIV testing and TB screening

To achieve the long-term goal of zero new TB and HIV infections, a reshaping of the response that recognises the financial constraints and will at the same time generate greater impact is needed. The prevention strategy thus needs an approach that:

- Reflects combinations that are targeted in terms of the specifics of the epidemics
- Scales up what we know that works, and
- Focuses efforts on where they are needed the most

Some of the key strategic enablers to achieve the above are:

- Up-to-date information on the magnitude, severity and impact of the epidemics, including hotspots for HIV and TB transmission;
- Creating demand for services through community empowerment;
- Simple, easy to digest information to which individuals can relate and internalize to drive action and own their response;

- Investing in strategies and technologies that will result in greatest returns on investments (value for money).

Pillar 2: Sustain health and wellness

The primary focus for this pillar is to provide HIV and TB care and treatment services, as well as psychosocial support services to ensure wellness. The objectives of this pillar speak to the long-term goal of zero deaths.

Some of the key strategic enablers for this pillar are:

- Investing in a simplified treatment, care and support delivery model that will also scale up access (e.g. nurse initiation of treatment for HIV and TB);
- Investing in innovative delivery models that will reduce cost (for both provider and patient) e.g. integration of home/community-based services into primary health care (PHC) services and promotion of more public-private partnerships;
- Strengthening community systems – empowering communities to act, demand services and own the results;
- Adopting models of care based on other chronic disease models (e.g. cancer society, diabetic association) to transmit knowledge and foster greater personal responsibility for individual health

Pillar 3: Increase safety and reduce vulnerability

As seen in the chapter on epidemiology, there are several factors that impact on safety and vulnerability to HIV and TB infection. These mainly relate to stigma reduction, gender equity, gender violence, alcohol and drug abuse, and discrimination.

Strategic enablers to address these include:

- Review of laws, policies and programmes that promote gender inequity and address gender violence;
- Building the capacity of service providers to deal effectively with these issues;
- Equipping service providers, law enforcement officers, social workers, and teachers with the relevant skills, and creating the necessary environment within the service delivery area and the community to enforce these laws and policies (e.g. creation of crisis unit for rape victims at municipal level);
- Fostering dialogue at regional level to address cross-border issues (e.g. refugee status, rights of migrants etc.)

Pillar 4: Changing societal norms and values

Ultimately the transmission of both HIV and TB will require major changes to cultural and societal norms and values.

- Shifting norms around masculinity, gender violence, multiple concurrent partnerships, age mixing, alcohol, stigma and other social drivers of risk behaviours are also crucial to successful primary prevention. These determine both the motivation for uptake of services as well as for behaviour change related to these interventions. These strategies will combine mass media, new technologies (cell phone, web; social networking) with social mobilisation in communities, facilities, the workplace, schools and tertiary institutions.

The success of the NSP 2012-2016 will require doing some things better, doing more of others, and in some cases doing new things. To frame the 4 pillars of the NSP, the following “game changers” are identified that should guide the response to HIV, STIs and TB.

7.5 Pillar 1: Universal HIV Testing and TB Screening – “Know Your Status”

The primary focus on Pillar 1 is on reducing the number of new TB and HIV infections

This pillar focuses on prevention activities to reduce new infections (primary prevention), but includes prevention activities for those already infected (secondary prevention).

The objectives for Pillar 1 are:

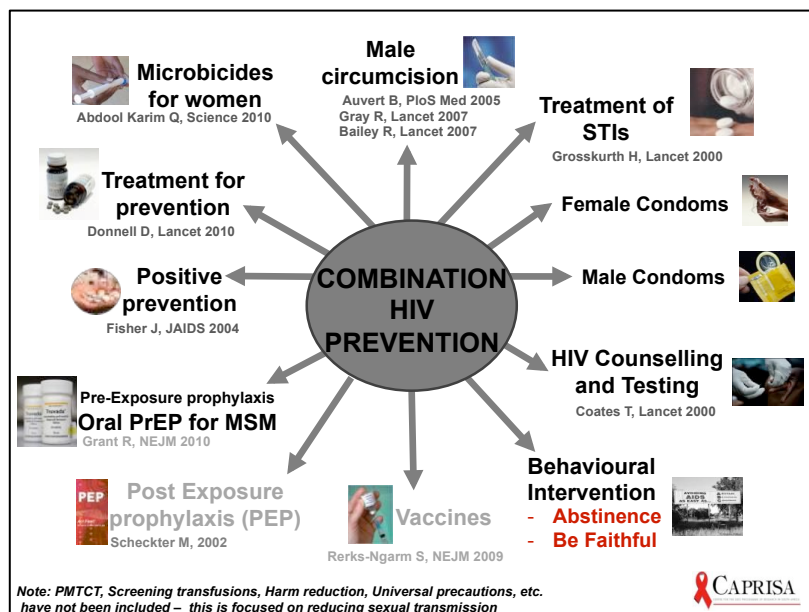
- Prevent new HIV infections (including vertical transmission)
- Ensure universal knowledge of HIV and TB status
- Prevent TB infection

7.5.1 Prevent New HIV Infections

The primary strategies to prevent new HIV infections relate to preventing sexual transmission, and vertical transmission. Both strategies require comprehensive combination prevention services.

In recent years there has been international recognition for the concept of combination prevention – understanding that no single intervention will by itself address HIV and TB infection at a population level. Combination prevention includes easily accessible and available male and female condoms in sufficient quantities to enable consistent use (in multiple settings – including health facilities, malls, taxi ranks, shebeens, prisons and sex worker settings); medical male circumcision for men on demand; and PMTCT; treatment for STIs and regular testing and counselling. Based on recent research findings, combination prevention now includes pre-exposure prophylaxis, microbicides, and using antiretroviral treatment as prevention.

The graph below (from CAPRISA) indicates the various components of combination prevention, as well as some of the most influential studies demonstrating the evidence for its efficacy.



Due to many studies conducted and published in recent years, many of those in South Africa, there is a clear evidence base for the effectiveness of prevention interventions (see below):

<u>Intervention</u>	<u>Efficacy</u>
Circumcision	54%
Pre-Exposure Prophylaxis for MSM	42%
STI treatment (ulcerative STIs)	42%
Microbicide (Tenofovir gel)	39%
HIV vaccine	31%

However, it is also clear that to date, none of these biomedical interventions alone will prevent new HIV transmissions, but that indeed a combination of several biomedical and behavioural interventions are needed. For instance, for every five medical male circumcisions, one HIV infection is prevented in the next 10 years.

Combination prevention interventions work best if they are targeted at the most appropriate key populations. Key examples would be:

- For females: Condoms, pap smears for female sex workers, complete package of reproductive health services, post-exposure prophylaxis, HCT, TB screening
- For adult men: condoms, medical male circumcision, HCT, TB screening
- For MSM: peer education, appropriate messaging, condoms, STI management, pre-exposure prophylaxis, HCT, TB screening
- For young men prior to sexual debut: medical male circumcision, prevention messaging (including sexual and reproductive health), TB screening
- For newborn males, offering medical male circumcision as part of the PMTCT package
- For prisoners: condoms, STI management, HCT, TB screening
- For migrant populations: HCT, condoms, appropriate messaging in relevant languages (including information about sexual and reproductive health)

In terms of vertical transmission, earlier chapters highlighted the success of the PMTCT programme. By adopting improved regimens, and starting antiretroviral treatment earlier for pregnant women, the NSP aims to achieve less than 2% transmission by 2016.

STI management is an important entry point for HIV counselling and testing. Screening for acute STIs in certain situations (e.g. urethral discharge in men) and enhancing uptake of HIV testing could improve case detection.

7.5.2 Ensure Universal Knowledge of HIV and TB Status

The primary vehicle to achieve this goal is universal HIV testing and TB screening. The very successful 2010-2011 HCT campaign and ART expansion programme has shown that it is possible to dramatically increase the number of people screened and tested through a focused national campaign with a clear target at national, provincial, district and facility level. In the past HCT was viewed primarily as the entry point into care and treatment. There has since been recognition that HCT has an important preventive component. It is only through knowing one's HIV or TB status that appropriate interventions and services can be accessed.

Universal HIV testing and TB screening means testing and screening every South African 12 years and older (sexually active, with previous HIV negative test, or of unknown status) on an annual basis. TB screening should be offered to all, irrespective of HIV status. This can be achieved by providing the services at multiple points including homes (by community health workers), in workplaces, in schools and tertiary institutions, at grant distribution points, in health services (through provider-initiated counselling and testing), at correctional services and through mobile services in communities (e.g. sporting events, taxi ranks, and malls).

HIV testing will be encouraged for all sexually active individuals on a regular basis for those who previously tested negative, are of unknown status, or engaged in risky behaviours. TB symptomatic screening will be conducted routinely in health and community settings to improve case finding, and by ensuring earlier care and treatment, improve mortality and morbidity. Those that have indications for TB disease should be referred for clinical TB testing, and followed up to ensure diagnosis and treatment.

The full package of screening, to be available in all clinical settings, will include HIV counselling and testing (including risk reduction counselling), TB symptomatic screening, screening for diabetes, blood pressure and anaemia. A mental health screening tool for those who test HIV positive is added in the NSP 2012-2016 to deal with the mental health and HIV link. In community and workplace settings, which may not have the necessary equipment and supplies to provide the full package, a minimum package will be provided consisting of HIV counselling and testing, TB symptomatic screening, and mental health screening.

Symptomatic TB screening for all patients accessing health services and rapid linkage to clinical TB screening is an important tool in meeting the first I of the WHO Three I's: intensified case finding.

7.5.3 Prevention TB infection

The WHO recommends the 3I's of TB control:

- Intensified case finding
- Infection control, and
- Isoniazid preventive therapy (IPT)

In South Africa, two more I's are added:

- Integration of HIV and TB services
- Initiation of early treatment

The first strategy of HIV testing and TB screening addresses most of the intensified case finding issues. It is important though that there is effective referral and follow-up from symptomatic to clinical screening. Screening and testing is especially important in congregant settings, including mines and prisons.

Infection control in the NSP refers to general infection control measures (e.g. hand washing, safe disposal of medical waste, injection safety), but also specific measures at facility and community level to prevent the spread of TB. Each health facility providing HIV and TB care must be assessed annually against a set of quality standards for infection control. This also requires each health facility to have an infection control plan, and an infection control officer. TB infection control requires administrative, environmental and personal respiratory infection interventions.

Administrative controls: Smear positive TB cases are the most infectious of TB patients. Usually, these persons present many times to health care facilities before being diagnosed with TB. Hence, health services must screen all clients entering the facility (cough screening). Patients coughing must be provided with masks or tissues, and also triaged to reduce their waiting time and thus exposure to other patients.

Environmental controls: This includes providing external access to consulting rooms, ventilating waiting and consulting rooms by opening windows, and providing external sheltered waiting areas where possible.

Personal protection: ensuring that staff and patients know their HIV status (as HIV increases a person's risk for TB infection and disease), that staff use N95 respirators, and that HIV-infected staff without active TB take isoniazid preventive therapy.

Isoniazid preventive therapy is addressed more comprehensively in Pillar 2, since it is essentially a treatment of latent infection rather than a true prevention of new infection.

The last strategy for preventing TB infection relates to children. TB vaccination should be done routinely for all infants in South Africa at birth including HIV-exposed infants. BCG vaccination protects children against serious forms of childhood TB such as TB meningitis but does not confer protection against TB to adults.

Summary

The key theme for these objectives and interventions is integration. This means ensuring that screening covers more than just HIV and TB, but also mental and other non-

communicable diseases. Screening and testing will also take place in a multitude of settings. Another key principle of Pillar 1 is to ensure that interventions are focused and targeted – in terms of scope, location and target groups.

Finally, to achieve the goals and objectives for Pillar 1 will be:

- Adequate skills for providers (including community health workers) to screen for HIV, TB, blood pressure, anaemia, diabetes, and mental health (as appropriate to the setting);
- Specific targets (per province, district, and even sector) for screening and testing within all settings;
- A clear monitoring and evaluation framework. This would include a single national patient identified to allow for improved monitoring and evaluation, seamless transfer of patient information, improved referral and tracking, decreased duplication of laboratory and radiological investigations, and harmonization of information systems – which also requires rationalisation of disease-specific registers to the single register;
- Targeted, evidence-based communication and social mobilisation strategies to create demand and effective use of HIV services as well as to ensure accurate use of prevention strategies (e.g. how to use condoms correctly and the importance of consistent use; what constitutes safe circumcision etc.), and their limitations (such as concepts of partial risk reduction etc.). This would include education on rights and responsibilities;
- Strengthening life skills education at schools that promote information to sexual and reproductive health, contraception and referral to services.

Pillar 1: Objectives and Interventions

Draft zero note: Please note that the indicators, targets and costing will depend on the negotiated interventions contained in the final NSP (for all pillars). As such as these sections will only be completed after the August consultation phase. However, inputs should be provided during the consultation phase on the measures of success (indicators) and numeric targets

Objective	Intervention	Measure of Success	Target					Costing and Source
			2012	2013	2014	2015	2016	
Prevent new infections in adults through comprehensive combination prevention	Provide male and female condoms using both health facilities, and non-traditional outlets (e.g. airports, malls, shebeens, schools, and tertiary institutions)							
	Provide medical male circumcision to men aged 15-49 to reduce the risk of acquiring HIV infection							
	Roll out microbicides when available							
	Prevent unintended pregnancies, especially among young girls through comprehensive sexual and reproductive health information and education in schools (as part of school health programmes)							
	Strengthen life skills education to focus on delaying onset of sexual debut in girls, and encouraging them to remain in school by innovation including making the social grant for children contingent on them staying in school							
Prevent new HIV infections in children	Promote awareness of and access to safe neonatal circumcision							
	Screen children for TB at postnatal, routine child health visits, and as part of immunisation services (EPI)							
	Implement integrated school health programmes with a prevention focus (including reproductive health, HCT and TB screening), and appropriate referrals for psychosocial support							
	Strengthen prevention campaigns and services targeting sexually active adolescents, including provide adolescent-friendly services at health facilities							

Draft Zero for Consultation – NSP 2012-2016

Objective	Intervention	Measure of Success	Target					Costing and Source
			2012	2013	2014	2015	2016	
Focus on injecting drug users	Provide appropriate harm reduction services for injecting drug users							
Use ARVs for prevention	Start all survivors of sexual violence on post-exposure prophylaxis (PEP) within 72 hours of presentation to police or a healthcare facility, with special attention for children and adolescents							
	Prioritise ART in discordant couples to prevent HIV infection in the HIV-negative partner							
	Provide pre-exposure prophylaxis to high-risk priority groups (to be determined, but including women who want conceive with an HIV infected partner)							
Prevent vertical transmission of HIV	Implement the full PMTCT package in all antenatal care (ANC) facilities							
	Provide lifelong ART to all HIV-infected pregnant women in their first pregnancy, irrespective of CD4 status.							
	Test all pregnant women of unknown HIV status at their first antenatal clinic visit. Those who test HIV-negative should test again at 32 weeks and, if still negative they should test again post-delivery							
Manage STIs	Provide routine STI screening and quality syndromic management of STIs according to national guidelines in all health facilities (including private sector)							
	Strengthen STI control through appropriate early antimicrobial prescribing and effective partner notification							
	Private pharmacies to refer all clients purchasing STI medications to a health facility for comprehensive management							
Ensure knowledge of HIV and TB status through universal HIV	Implement provider initiated HIV counselling and testing (PICT) and TB symptomatic screening in all entry points of health care (all health facilities ³⁸) (full package)							

³⁸ This includes clinics (including mobile clinics), community health centres, and hospitals, including specialized health facilities (e.g. TB hospitals, mental health facilities), in the public, private and NGO sector

Draft Zero for Consultation – NSP 2012-2016

Objective	Intervention	Measure of Success	Target					Costing and Source
			2012	2013	2014	2015	2016	
testing and TB screening	Provide HIV testing and TB screening in non-health settings (e.g. tertiary institutions, workplaces, homes, prisons, farms, private pharmacies, taxi ranks, malls, government departments) using community healthcare workers, peer educators, and community outreach workers (minimum package)							
	Target most-at-risk populations (e.g. discordant couples, prisoners, MSM, contacts of TB patients, STI patients, adolescents) with HCT and TB symptomatic screening							
	Screen all mothers and infants of unknown status attending EPI clinics for HIV and TB							
	Test all HIV-exposed babies for HIV at 6 weeks (PCR testing). This includes all abandoned babies							
	Enhanced diagnosis of acute (incident) HIV infections in TB and/or STI patients							
	Enhanced screening and treatment of partners of HIV/TB/STI index cases (HIV, TB, STI) for the same conditions							
Use innovation to improve screening, testing and referral	Implement innovative technologies for HCT, TB and STI screening (including oral tests, GeneXpert for TB diagnosis)							
	Implement point-of-care technologies and assays (including CD4) after establishing their sensitivity and specificity in the field to facilitate linkages from prevention to care and treatment							
Social mobilisation for HIV testing and TB screening	Use targeted communication and social marketing strategies (including social media such as Mxit) to increase uptake of HCT and TB screening							
	Use targeted communication and social mobilisation to increase knowledge on HIV, STIs and TB, and the links between these							
Improve monitoring and evaluation	Introduce an electronic HCT register to facilitate better tracking of regular testing (includes using a unique identifier)							

Draft Zero for Consultation – NSP 2012-2016

Objective	Intervention	Measure of Success	Target					Costing and Source
			2012	2013	2014	2015	2016	
Improve capacity	Ensure adequate capacity building in HCT, TB and mental health screening for health workers (professional and community health workers)							
Strengthen TB prevention practices in congregant settings, including health facilities	Ensure all facilities providing HIV and TB care implement infection control measures (e.g. injection safety, safe disposal of medical waste, open windows, hand washing, administrative, environmental and personal respiratory protection controls)							
	Ensure all new health facilities are built to optimise linear flow ventilation for TB control							
Isoniazid preventive therapy (IPT)	Provide IPT for all HIV infected individuals without active TB							
	Provide IPT to all HIV-infected individuals living with someone with TB (contact tracing and prophylaxis)							
Active TB case finding	Implement active TB and HIV case finding, including active TB contact tracing							

7.6 Pillar 2: Sustain Health and Wellness

The primary focus of pillar 2 is significant reduction in deaths and disability as a result of HIV and TB infection.

Objectives:

The five-year objectives for pillar 2 are to:

- Reduce disability and death resulting from HIV and TB
- Ensure universal access to treatment, care and support;
- Ensure that people infected with HIV, TB and STIs remain within the health care system, are adherent to treatment and maintain optimal health; and
- Ensure that systems and services remain responsive to the needs of people infected with HIV, TB and STIs.

The core strategies for this pillar relate to improved diagnosis of HIV, TB and STI, improved access to speedy, appropriate and user-friendly treatments and retention into treatment and care. Central to sustaining health and wellness is to continue and accelerate health system strengthening through a variety of key interventions with cognisance of the different needs of health service users.

Promoting shared responsibility for health and wellness (which includes personal responsibility) requires targeted interventions. However, wellness is not just a concept of access to diagnostic and curative services. Across government departments and society at large a radical shift is required where health and wellness (and especially health promotion) are integrated into broader social development and the capacity building of individuals and communities.

The Department of Health has the responsibility for the delivery and oversight of health promotion, diagnostic services, treatment and for ensuring adherence support. Whilst massive advances have been made over the last 20 years in increasing access to quality health care services, increasing demand created by the dual epidemics of HIV and TB has outpaced supply. A radical expansion of primary health care is being implemented through the re-engineering of primary health care with a special emphasis on community-based services. Community-based services have a critical role to play in expanding the quality and reach of health and wellness services – proactively taking programmes and services to people has been demonstrated to increase service uptake. The massive increase in HIV prevention, care and treatment services in the last five years, mainly through international funding to community-based organisations and NGOs, has ensured major scale up.

However, community services, whilst critically important, will not provide a panacea that addresses all of the shortcomings within the health care system. Further health systems strengthening and support is required. Central to this is to ensure that people are screened, receive results promptly, are referred appropriately, are treated correctly and quickly and receive consistent care and follow-up.

Better recording, monitoring and evaluation systems are required at community, facility, municipal, district, province and national levels. Equally at these levels specific research is required to understand the population and sub-populations dynamics in order to tailor health and wellness interventions appropriately. Monitoring, evaluation and research are

covered by a separate chapter within this NSP, however, key interventions in support of this are identified below.

The primary strategies and interventions for pillar 2 are:

7.6.1 Expand Access to Quality Care and Treatment for HIV, TB and STIs

Early treatment for HIV, TB and STIs

As discussed in chapters 3 and 4, there have been major research findings in the last 18 months showing the benefits of early treatment for HIV and TB. Early treatment decreases mortality and morbidity, and the gains we have seen in life expectancy during the previous NSP can be improved by starting treatment even earlier. To this end the government has already indicated a shift to starting all people on ART at a CD4 count of 350 or below, and increasingly there are calls to expand this to 500 and below. Key for this intervention to be successful is improved case finding and earlier diagnosis (discussed in pillar 1).

Treatment for STIs, especially genital warts, syphilis and herpes, is another important intervention. The NSP 2012-2016 includes efforts to build the capacity of nurses to provide cryotherapy, especially for co-infected patients.

Improve quality of services

In the previous NSP there was a significant focus on expanding access to HIV care and treatment services. That focus is retained in the NSP 2012-2016, but based on the experience of the last five years, there is also a strong shift to improvement of the quality of services. This includes using more efficient tracking and referral systems, as well as better drug combinations to ensure improved care and treatment outcomes.

National standards will be developed or updated for the following areas:

- Early diagnosis of people with HIV (including infant diagnosis) and TB;
- Clinical care and management of people with TB and HIV including pain management;
- Wellness programmes, social care and support services for people with HIV, TB and chronic conditions including mental health and disability;
- Sexual and reproductive healthcare for people with HIV and TB;
- HIV and pregnancy;
- Care for vulnerable populations such as adolescents and older persons with HIV;
- Respite, rehabilitative, palliative, and end of life care for adults and children with HIV, TB and chronic conditions;
- Palliative care training for health professionals in health facilities and community services.

Lastly, a standing clinical guidelines committee comprised of relevant experts should periodically review clinical HIV and TB guidelines to ensure the latest evidence informs clinical care interventions.

Improve monitoring and evaluation

As already alluded to in pillar 1, improving monitoring and evaluation systems are critical to ensuring adequate tracking and referral of people in need of HIV and TB care and

treatment. This would require national patient identifiers and a patient master index, integrated registers, and specific targets at provincial, district and facility level for treatment (HIV and TB). [As some of these issues have been covered in pillar 1, they are not repeated here.]

The government started the rollout of a tiered monitoring and evaluation system³⁹ for ART in 2011, and this is to be fully implemented by 2013/14.

7.6.2 Ensure Care and Treatment for Children

As indicated previously, evidence has shown that vertical transmission of HIV can be virtually eliminated. However, children are subject to a myriad of other risks including sexual abuse and early sexual debut. Prevention of infection is possible and so too is providing treatment, care and support both to the child, their families and communities, but special attention is required. Children infected with HIV and TB are often undiagnosed and receive limited access to services, and are exposed to stigma and discrimination. Furthermore, many children who may not be infected themselves live in families and communities where HIV, TB and STI prevalence may be high. This not just exposes them to increased risk of infection but to additional emotional and socio-economic risks.

Addressing these issues will require early diagnosis, referral, and treatment for children, especially for orphaned and other vulnerable children. This includes a greater focus on school health services, and life skills education.

7.6.3 Provide HIV and TB Care and Treatment in Non-Medical Settings

HIV and TB diagnosis, care and treatment should not be limited to medical settings, but instead should be available in a wide variety of community settings. Including tertiary institutions, prisons, and NGO-funded facilities.

Workplaces are an important setting for HIV and TB diagnosis, care and treatment – or referral for care and treatment. With 11 million people in the workplace, this is a key entry point for health and wellness programmes. Chronic illnesses affect productivity, profitability and the welfare of employees and their families.

7.6.4 Provide Appropriate Support for People Living with HIV and/or TB

The links between good nutrition and maintaining health and wellness are well established. Food insecurity may lead to increased risk taking and contributes to poor adherence to treatment and more rapid health deterioration. Good nutrition maintains the immune system, helps to prevent opportunistic infections and supports optimal quality (averting some symptoms of disease) of life.⁴⁰

7.6.5 TB Management and Treatment

TB is the leading cause of death for people living with HIV. In recent years South Africa has seen a rise in drug resistant TB. This requires aggressive TB diagnosis, treatment

³⁹ Tier 1 is a standardised paper-based system, tier 2 an e-register (an electronic, non-networked version of tier 1), and tier 3 is fully networked

⁴⁰ Castleman et. al. 2004

and ongoing management to ensure adherence to treatment. This includes contact tracing of all known TB patients to rapidly diagnose and treatment those.

Pillar 2: Objectives, and Interventions

Objective	Intervention	Measure of Success	Target					Costing and Source
			2012	2013	2014	2015	2016	
Expand access to quality care and treatment for HIV and TB	Provide access to ART at all PHC facilities for eligible patients (CD4 <350 or WHO stage 3 or 4)							
Ensure care and treatment for children	Test all HIV-exposed infants for HIV at 6 weeks, and immediately start any infant testing positive on ART							
	Target pre-adolescent and adolescent children accessing health care for HIV and TB diagnosis and treatment, as well as sexual and reproductive health							
	Ensure user-friendly treatment dosages for children							
	Address educational, developmental and vocational needs of children and adolescents who acquired HIV in infancy							
	Ensure access to nutritional support for children to reduce vulnerability							
	Implement integrated wellness education as part of life skills education in schools							
Start treatment for HIV, STIs and TB early	Ensure early case detection for both HIV and TB, including contact tracing, particularly of children							
	Provide cotrimoxazole prophylaxis for all patients living with HIV and TB							
	Ensure treatment for congenital syphilis as part of PMTCT services							
	Cervical cancer screening and treatment of genital herpes (HPV2) infection with acyclovir							
	Ensure treatment (by nurses) for genital warts with cryotherapy							
	Use innovative technologies (including point of care TB and HIV diagnostics) to diagnose TB,							

Draft Zero for Consultation – NSP 2012-2016

Objective	Intervention	Measure of Success	Target					Costing and Source
			2012	2013	2014	2015	2016	
	STIs and HIV early, and referral to appropriate management, especially in antenatal care settings							
	Use cell-phone based communication to increase tracking, retention in care, adherence and psychosocial care for HIV, TB and STI							
	Expand TB molecular testing at 80% of public sector facilities for intensified case findings for TB by 2016							
	Ensure all health facilities provide nurse-initiated and managed ART (NIMART)							
	Ensure professional health workers have appropriate ART, TB and MDR TB diagnosis and management skills							
	Promote facility-based and community adherence strategies to ensure patients remain on TB and ART treatment							
Improve quality standards for care and treatment	Set, monitor and maintain quality standards for HIV, TB and STI care and treatment services, including quality standards for community-based care and support							
	Simplify treatment regimens, including the use of fixed-dose combinations (FDCs) for TB and HIV where available							
	Implement tracing systems to ensure diagnosed with HIV but not yet on treatment are enrolled in appropriate care programmes (e.g. wellness programmes)							
	Enhance referral services to ensure patients with complex presentations, experiencing complex toxicity or multi-drug resistance, are able to have clear referral pathways and access to expanded ART / treatment choices							
	Establish a clinical guidelines committee to ensure periodic review of clinical protocols							

Draft Zero for Consultation – NSP 2012-2016

Objective	Intervention	Measure of Success	Target					Costing and Source
			2012	2013	2014	2015	2016	
Improve monitoring and evaluation	Set targets at province, district and facility level for HIV, STI and TB treatment							
	Ensure rollout of the tiered monitoring and evaluation system for ART							
	Support reporting of sector-specific programmes through a national routine information system							
Ensure care and treatment for children	Test all HIV-exposed infants for HIV at 6 weeks, and immediately start any infant testing positive on ART							
	Target pre-adolescent and adolescent children accessing health care for HIV and TB diagnosis and treatment, as well as sexual and reproductive health							
	Ensure user-friendly treatment dosages for children							
	Address educational, developmental and vocational needs of children and adolescents who acquired HIV in infancy							
	Ensure access to nutritional support for children to reduce vulnerability							
	Implement integrated wellness education as part of life skills education in schools							
Provide HIV and TB diagnosis, care and treatment in non-medical settings	Provide HIV and TB diagnosis and care, and referral for treatment if not possible onsite, in: <ul style="list-style-type: none"> • Tertiary institutions • Prisons • Workplaces • NGO-funded facilities 							
Ensure appropriate	Ensure vulnerable children access school nutrition programmes							

Draft Zero for Consultation – NSP 2012-2016

Objective	Intervention	Measure of Success	Target					Costing and Source
			2012	2013	2014	2015	2016	
nutrition interventions	Encourage home / community food productions							
Strengthen mental health services	Develop policies and protocols within health and social development policies to integrate mental health care into HIV and TB and STI, treatment, care and support							
Increase human resource capacity	Reopen government nursing colleges to address human resource shortages							
	Train professional and lay health workers in appropriate HIV and TB diagnosis, treatment and care							
	Train providers of key services in HIV and TB prevention, treatment and care (e.g. in schools, workplaces, prisons)							
Provide appropriate TB treatment (including preventive therapy)	Provide isoniazid preventive therapy (IPT) for HIV-infected individuals who do not have active TB, including children under 5 from household contacts of index cases							
	Start all TB co-infected patients on ART, irrespective of CD4 count							
	Provide IPT for high-risk groups (e.g. healthcare workers, people with diabetes)							
Ensure treatment for MDR-TB	Provide access to long-term clinical care for patients with treatment failure, and drug resistant TB							

7.7 Pillar 3: Increase safety and reduce vulnerability

As seen in the chapter on epidemiology, there are several factors that impact on safety and vulnerability to HIV and TB infection. These mainly relate to stigma, gender equity and gender violence, and discrimination.

There are many levels and manifestations of vulnerability.

Vulnerability at the personal level is heightened during times of transition in a person's life, such as through the death of a parent. As such an important focus for pillar 3 is reducing the number of children orphaned and made vulnerable. This can be achieved by some of the interventions listed in pillar 1 and 2 (e.g. treatment for infected parents), but also through interventions the increase support for children.

In addition South Africa has high levels of endemic vulnerability as a legacy of the migrant labour system and the other effects of apartheid. While the NSP cannot, and should not, address all of these vulnerabilities, it does need to focus on the "hotspots" of vulnerability. As seen in earlier chapters, there are geographic vulnerabilities in terms of both HIV and TB (e.g. informal settlements, close to major transport routes), but also among key populations.

Vulnerability is also related to issues of legality, e.g. sex workers, or poor implementation of laws and/or policies, thus necessitating legal reform, such as decriminalisation of sex work, or better implementation of laws and policies, including access to justice.

Vulnerability is also based on economic disempowerment. This requires the NSP to be firmly anchored in the broader development efforts of government, including expanding access to education, reducing poverty, improving job creation and local and foreign investments.

Objectives

- Build the capacity of communities to reduce their vulnerability to HIV and TB, through exercising their rights;
- Build the capacity of policy makers, governance structures and other duty bearers of human rights to effectively implement laws and policies that promote human rights;
- Reduce the vulnerability of children to HIV, TB and STI infection, with a particular focus on orphaned and vulnerable children;
- Support the consistent implementation of legislation that protects and promotes the human rights of people living with and affected by HIV and TB (including rights of workers to a safe working environment and social benefits);
- Expand and ensure equity in coverage of health and social protection services for those that require assistance, including access to social grants;
- Ensure that health and social services are responsive to the needs of people living with or affected by HIV or TB, including orphans and vulnerable children, people with disabilities, elderly, adolescents, sex workers, drug users, and other marginalised groups;
- Address workplace/environmental vulnerabilities to HIV, STI and TB transmission, such as mines and prisons;
- Reduce stigma through social change communication and mobilisation;

- Remove structural and functional barriers to services for migrants and refugees with health care needs.

Strategic enablers include:

- Updated laws, policies and programmes that promote a human rights culture, gender equity and address gender violence;
- Service providers law enforcement officers, social workers, and teachers capacitated and equipped to deal effectively with these issues;
- Train all government and civil society actors on the South African human rights framework and how access to justice can be improved; this includes education of police officers on dealing with victims of sexual assault, and LGBTI issues so that rights abuses can be reported and acted on with dignity and diligence;
- Enabling environments for service delivery area at facility and the community to enforce these laws and policies (e.g. Thuthuzela Treatment Centres or similar rape crisis centres at municipal level);
- Regional agreements that address cross-border issues (e.g. refugee status, rights of migrants etc.)

Building on the provisions of the Constitution and the human rights culture that it requires, it is important that the goals, objectives and activities contained in the NSP embodies a human rights culture. The focus of human rights work should be on protecting the safety and dignity of people with HIV and TB and on people from socially and legally marginalised groups (thereby bringing about vulnerability reduction). This focus is aimed at catalysing a specific, measureable and ongoing set of actions to address rights violations that exacerbate or occur because of stigma and discrimination.

The realisation of the objectives of the last NSP in relation to vulnerability reduction for sex workers need to be pursued both in terms of legislation and in relation to health and safety services.

These actions are set out below:

- Establish a coordinated and sustained effort to educate people on their rights to privacy, dignity and non-discrimination in relation to HIV infection, and access to health care services – including through communication campaigns and community dialogues;
 - Target specific sectors for education about the human rights of others, including health care workers, social workers, traditional leaders, religious leaders and magistrates;
 - Develop programmes and plans at provincial level that specifically and directly reach out to vulnerable groups to inform them on rights of access to prevention and treatment services (specifically MSM, prisoners, sex workers and undocumented migrants) and to equality before the law and protection against unfair discrimination;
 - Establish campaigns and communication activities to end gender-based violence;
- Ensure a comprehensive and functional monitoring system to document human rights abuses (including undermining the rights to privacy and dignity and that actions that constitute unfair discrimination) directly related to HIV and TB (through

the South African Human Rights Commission (SAHRC) and other Chapter 9 institutions);

- Audit and create capacity in legal services to take up HIV and TB related discrimination cases;
- Establish baseline information about the incidence of teenage pregnancy together with information about any support for teenage mothers and their children, and monitored and reported on annually;
- Strengthen monitoring of abuse of girls – and determinants of abuse including on the basis of tradition and custom;
- Develop provincial and local plans that address elimination of discrimination including access to employment, education, financial services and social protection and health services gender-based violence; these plans must respond to the specific needs of the sectors – so in relation to employment, for example, it's not much about the law but rather its implementation; but in relation to financial services, it is about the law and practices that should be prohibited – and should include the provision of information and community-based advice for PLHIV and their dependents;
 - Develop a funding plan for statutory bodies (such as Legal Aid South Africa and SAHRC) and other organisations to provide and ensure services to promote and protect human rights and address discrimination;
- Identify or create regional fora to develop and oversee the development of regional or sub-regional agreements that address upholding the human rights including access to health, legal and social protection for migrants;
- Expand programmes of grandmother support for orphaned and vulnerable children by supporting children, assisting them to access social security, ensuring they remain in schools, and aiding household food security;
- Implementing programmes to reduce school dropout, including motivational and career guidance programmes for young people, encouraging parental involvement in education, and aggressive follow-up of all children who drop out;
- Implement a national campaign on disclosure (of HIV, TB and STIs) and reduce stigma attached to these health issues;
- Reduce availability and access to alcohol (e.g. closing times, strict penalties for selling to children, increasing taxes on alcohol).

Based on the experience of the present NSP there is a specific need to:

- Ensure that human rights interventions are costed, budgeted for and allocated to responsible government departments;
- The SAHRC and other Chapter 9 institutions need to assist in the process of monitoring implementation by the parties to the NSP;
- Identify a specific institution to take overall responsibility for reporting on the implementation of the human rights pillar (most appropriately could be SAHRC) and the organisational and financial support that must be provided to this institution to enable this. In addition, determine responsibility for certain categories of human rights related interventions (such as Department of Health and its Office of Health Standards Compliance in relation to human rights interventions in clinics);
- Define the responsibilities of the Department of Justice and Constitutional Development, Department of Women, Children and Persons with Disabilities, Department of Social Development, the Department of International Relations, the Planning Commission – and possibly other departments – and the SAHRC. Have mechanisms agreed upon to ensure that the relevant Departments acknowledge, accept and assign these responsibilities;

- Define the objectives of the human rights pillar so that they can be measured and monitored. For example, setting clear targets for the monitoring sites mentioned above;
- Examine the legal framework to identify laws or policies that increase vulnerability and amend them within a defined period. The NSP should define a process for doing this and assigning overall responsibility – perhaps to the South African Law Commission.

Pillar 3: Objectives and Interventions

Objective	Intervention	Measure of Success	Target					Costing and Source
			2012	2013	2014	2015	2016	
Build the capacity of communities to reduce their vulnerability to HIV and TB, through exercising their rights	Community dialogues, social mobilisation & communication campaigns and activities							
Reduce the number of children orphaned by HIV	Ensure early treatment of infected parents							
	Expand programmes aimed at developing networks of grandmother support to reduce vulnerability							
	Implement programmes aimed at reducing school dropout, including follow-up of all children who drop out of school							
Build the capacity of policy makers, governance structures and other duty bearers of human rights to effectively implement laws and policies that promote human rights	Develop and train policy makers and other key duty bearers on rights & HIV and TB related discrimination							
	Train service providers of the human rights framework and how access to justice can be improved, including educating police officers on dealing with victims of sexual assault, and LGBTI issues							
Reduce vulnerability to gender-based violence	Scale up prevention interventions to reduce gender-based violence and comprehensive services for survivors of sexual assault							
Strengthen services to rape survivors	Increase number of health facilities with services for rape survivors							
Expand and ensure equity in access to health and social services especially for HIV and TB	Expand access points for social services (e.g. registrations of births, deaths, identity documents)							
Strengthen services to rape survivors	Increase number of health facilities with services for rape survivors							
Reduce levels of stigma and discrimination	Implement the national stigma reduction framework							
	Implement a national campaign on disclosure (for							

Objective	Intervention	Measure of Success	Target					Costing and Source
			2012	2013	2014	2015	2016	
	HIV, TB and STIs)							
	Train service providers (including health workers) on the stigma reduction framework							
Migration policies for HIV and TB developed and implemented	Develop appropriate policies for migrant populations and access to services							
Support consistent implementation of legislation to protect human rights	Strengthen capacity of Chapter 9 institutions (e.g. SAHRC) to monitor and uphold relevant legislation and policies							
	Establish community dialogues and communication initiatives to educate communities on their rights to privacy, dignity and non-discrimination in the context of HIV and TB							
Address workplace / congregant vulnerabilities to HIV, STI and TB transmission	Ensure policies and practices that address vulnerability, including mines and prisons. Phase out hostel systems in mines to improve social cohesion. (Other interventions, e.g. infection control, communication and social mobilization, and prevention and treatment services covered in pillars 1 and 2)							
Address alcohol access and availability	Implement measures to reduce access to alcohol, especially children, such as strict penalties for selling to children, amending hours of purchase, and higher taxes on alcohol							

7.8 Pillar 4: Changing Societal Norms and Values

The underpinnings of the HIV and TB epidemics are deeply rooted in social, cultural, gender and economic contexts. This applies equally to HIV and TB prevention, TB and HIV treatment, as well as in the realisation of rights and the exercise of obligations. In order to impact significantly on HIV and TB prevention and treatment and to attain the full realisation of human rights in relation to these epidemics there needs to be meaningful involvement of individuals and communities.

The Know your Epidemic chapter points to a number of ways in which social norms and values have created the conditions for the twin epidemics to grow exponentially. TB has long been described as a disease of poverty, but it is also the result of policies that create unhealthy environments such as overcrowding and poor working conditions. Equally, HIV transmission has also been fuelled by migrant labour practices, concurrent and multiple partners, lack of social cohesion and lack of early access to a comprehensive package of prevention and treatment interventions.

Changing social norms and values therefore will require that government policies (social and economic policies) as well as community and family values change and that this change be sustained over a long period. Social mobilisation is one strategy that can be used to mobilise the population, communities and families to secure the changes needed to halt the spread of these diseases.

In seeking to change societal norms and values, a multi-sectoral approach must be used. According to UNAIDS⁴¹ the following should form part of a comprehensive approach: addressing structural and social factors that drive the epidemic; influencing social norms that impact on behaviour and incidence; transform educational responses; and improving understanding of the transformative nature of education. The education sector therefore has a critical role to play in shaping societal norms and values and teachers are both vectors of social norms and change agents. But the education sector cannot change society on its own. Other social processes and actors are needed to complement the work of this sector, including faith-based organisations, and social associations (e.g. sport). Men and boys as partners need to be mobilised to understand the importance of gender equality (including the need to change norms related to male masculinity), communities must understand the importance of keeping girls in school, the increase in risky behaviour with alcohol and substance abuse.

Behaviour change is a complex phenomenon, and is the product of an interplay of individual, social and structural factors. Social change efforts thus needs to be able to address all these factors, while at the same time focusing on the real, not perceived, needs of communities and individuals. This approach calls for the strong involvement of social scientists in the design of appropriate interventions.

The objectives and strategies for this pillar need to address the level of risk tolerance in society. Risk tolerance can be driven by lack of social cohesion and perceptions of lack of choice, and a vision for the future. Social change communication should thus address some of these issues too. Because these issues are complex, there are no simple solutions to these problems, and many of the intervention, though posed within the five-

⁴¹ <http://uneddoc.unesco.org/images/0018/001888/1888943.pdf>

year timeframe of the NSP, will require much longer timeframes for meaningful implementation and impact.

Objectives of pillar 4

- Facilitate the a culture of participation of all citizens, including children and people with disabilities in social dialogue, decision making, needs assessment and monitoring of service delivery;
- Mobilise society at all levels to be tolerant and respectful towards each other, to reduce stigma and discrimination;
- Leadership at all levels of society to publicly promote the core values of the South African Constitution and speak out against stigma, discrimination and related behaviours to create a more equal society;
- Develop a national strategy that address the norms and values related to sexual behaviour, including number of sexual partners, age of sexual debut, sexual violence, amongst others;
- Implement a national campaign focusing on gender roles, harmful practices, positive sexual behaviours, and encouraging access to prevention and treatment services (especially for men);
- Develop and implement strategies that will reduce the abuse of alcohol and promote a healthy life style.

For such change to be effective, it needs the input and active participation of leaders at all levels of society, including young people. The investment in peer education needs to be taken beyond the relatively limited settings where it has been applied. Many of these peer educators have been developed through the school system – these skills need to be applied at a community level to drive this social change. This builds on existing initiatives such as the Expanded Public Works Programme and various other initiatives to find meaningful employment for young people.

This calls for a concerted effort to have national efforts, translated to the local level, for driving awareness of HIV, TB and STIs, including social and behaviour change. These efforts need to be at the type of scale and reach to have meaningful impact.

Strategic enablers for effective social mobilisation for change includes:

- Political, social and cultural leadership – leaders need to model social norms and values that are expected of the general population;
- Structural realignment for equity – policies and legislation to create a more equal society;
- Critical debate and discussion – enabling people to critically reflect on personal and social barriers to change;
- Vision and Hope: the creation of compelling visions, which are usually hopeful and filled with a sense that ‘there is a better way, and this way is accessible to me/us’;
- Practising behaviours: experiential opportunities for new behaviours to be ‘practiced’ and be reinforced and supported. This often has to extend *beyond* a training intervention;
- Reframing of identity, and creating communities of practice: opportunities for, and the validation of, a *reframing of identity*, both on an individual and collective level;

- Collective action – actively identifying with change and shifting social norms in the process.

Realising one's rights is often a process that involves learning what these rights are, demanding those rights and advocacy for the rights for oneself and others. Rights are very broad and include the right to services, protection, treatment, condoms, non-discrimination, equal opportunity, education and to live free from violence and abuse. People need to know their rights (media) and organise around the attainment of those rights. Advocacy also uses media and social mobilisation as well as lobbying to achieve these ends.

Going beyond the traditional approaches of IEC (information, communication and education), which focuses on expert driven, top down approaches that target individuals alone, social and behaviour change (SBCC) is a set of tools to address HIV and TB in the context of these social, cultural, gender and economic issues and includes transformative processes to shift social realities and norms. A shifting of these norms creates a more enabling environment for individuals to make healthier (including sexual and reproductive) choices.

The tools of SBCC are media (mass and local), social mobilisation (with meaningful community participation) and advocacy for and by affected people. Together, these tools are mutually reinforcing and form part of a comprehensive communication response. Mass media informs, creates awareness and catalyses transformative processes that are reinforced and deepened through interpersonal and community interactions that bring about lasting sustained social change.

This pillar also needs to address some of the risk factors identified in earlier chapters, e.g. alcohol use.

Pillar 4: Objectives and Interventions

Objective	Intervention	Measure of Success	Target					Costing and Source
			2012	2013	2014	2015	2016	
Facilitate a culture of participation of all citizens, including children and people with disabilities in social dialogue, decision making, needs assessment and monitoring of service delivery	Institutionalise the use of community dialogues for collective discussion on HIV, TB and STIs (all aspects)							
Develop a national strategy that address the norms and values related to sexual behaviour, including number of sexual partners, age of sexual debut, sexual violence, amongst others	Strengthen social and school-based programmes targeting girls and boys with information on vulnerability, behaviour change (e.g. age disparities, concurrency of sexual partners), sexuality							
	Implement programmes targeting male masculinity to change sexual behaviour of boys and men							
Communication for social change	Implement national programmes for social change communication to drive information of HIV, STI and TB risk, and social change required to reduce risk and vulnerability							
	Implement a national campaign focused on gender roles, harmful practices, positive sexual behaviours, and encouraging access to prevention and treatment services (especially for men)							
Develop and implement strategies that will reduce the abuse of alcohol and promote a healthy life style	Institute community-based programmes targeting parents and other adults focusing on reducing hazardous drinking and sexual violence							
	Implement legislation and social mobilisation programmes to reduce harmful alcohol use							

CHAPTER 8 – STRATEGIC ENABLERS

Draft zero note: *There is significant overlap with other chapters. This may need to move into those chapters (e.g. governance), or as a section before the discussion of the 4 pillars.*

Strategic enablers are factors that are critical to the successful implementation of the NSP 2012-2016. They are systems or structures at all levels, which, if absent or inadequately addressed, will impact on the achievement of the goals and objectives of the NSP.

There are several strategic enablers that have been identified for the successful implementation of the NSP, and these are described here in more detail.

8.1 Governance

Governance refers to the organisational arrangement and infrastructure required to inspire, guide and monitor the implementation of the NSP for both TB and HIV at all levels. The NSP *must* be led and managed by an effective coordination agency that provides the necessary strategic and operational direction support to provinces, sectors and communities in the implementation of the NSP (see the governance chapter).

To address this several actions are required:

Leadership: The national HIV and TB response requires effective leadership at all levels to mitigate the impact of the both diseases. The leadership of the response should be placed within the highest authority. To date SANAC, through its participating sectors, has led the coordination and implementation of the NSP, but concerns have been expressed about its role. This NSP seeks to address these leadership issues and provide the platform for accountability and enabling the work of provinces, sectors and communities. In addition to this central body, leadership is needed at decentralised levels to formulate concrete responses within this NSP. The provincial strategic plans clearly articulate how provincial and district AIDS councils will be strengthened during the NSP period to meet this mandate.

Coordinating structure: The coordinating structures at national, provincial and district level need to be adequately staffed with the appropriate skills to lead the response. The composition of the structures should be defined by what is needed to drive the strategy. The roles, responsibilities and functions of these bodies need to be clearly defined and have a clear mandate to inspire and lead the response at all levels and to hold the respective institutions and civil society organizations responsible for their portion of the response. This would require the development of a framework for coordination. There has been a serious effort since 2009 to establish the AIDS councils at all levels to function more effectively. At the national level a SANAC Secretariat was established to provide professional support to the SANAC sectors. However, as discussed in the chapter on governance, there are many operational challenges that remain, and must be addressed in this NSP timeframe to ensure effective coordination. With the integration of HIV and TB in the NSP 2012-2016, this also requires a review of the composition and functioning of these structures to ensure the multi-sectoral response.

Accountability framework: An accountability framework that would provide the legal mandate to the coordinating structures at national, provincial and district level to interact with all government structures and civil society within their locality to account for resources, and results in accordance with the plans at that level. To this end it is recommended that SANAC will be accountable to a parliamentary oversight committee. The same accountability framework will be applied at the provincial level to ensure that provincial and district AIDS councils meet this requirement. This implies that each sector has a clear plan for its role in the response to HIV and TB.

Effective representation of sectors: sector representation on the national, provincial and district structures must be fit for purpose. They must have clearly defined roles and responsibilities which are clearly delineated from their roles and responsibilities as implementers; the sectors must be adequately resourced and governance documents be developed that will define the election of representatives to represent sectors at each level, term limits of representation mechanisms for feedback.

Provision of resources: An adequately resourced strategic plan is key to achieving the desired results. Resource mobilization is required from national and international partners. The creation of innovative financing mechanisms (including consideration of ring-fenced taxes raised on carbonated drinks with a high sugar content) that is centred within the government agenda for action and the broader developmental goals is critical to mitigate the impact of both HIV and TB at micro (household) and macro (economic) level. Economic governance is tied with accountability for and effective use of the resources. Mainstreaming HIV and TB into the NSDAs of all government departments will ensure fiscal response to the epidemics. A key difference of the NSP 2012-2016 is that it is costed. This allows for precise resource planning at the government level in terms of its contribution to the realisation of the NSP. By also identifying the sources of funding within government for interventions, there is a clear guide for development partners (local, regional and international) to identify the gaps in resource allocation. A major issue that is not yet addressed through this NSP is the synchronisation of the NSP with the governmental planning and budgeting cycles, but this should not be an obstacle for civil society, business and development partners.

8.2 Organisational Effectiveness

Development and implementation of effective systems for management, implementation, monitoring and evaluation of the response on a regular basis is imperative. Actions required to ensure organizational effectiveness are as follows:

Country ownership: To ensure country ownership of a multi-sectoral response by government and civil society there needs to be a renewed commitment to one national response that is led by the South African Government and incorporating the HIV and TB response into all key national strategies and budgets. Through the consultation phase for the NSP, SANAC seeks to ensure buy-in from all sectors of society to the objectives and targets to address HIV, STIs and TB.

Capacity development: Ensuring the right skills in the right places, together with the right skills mix for the job is important. A developmental approach to training that will lead to an adequate skills mix to achieve the desired results is necessary. AIDS and TB competency across all sectors is needed to ensure mainstreaming of HIV and TB. Based on the framework for primary healthcare re-engineering, and the deployment of a large cadre of community health workers to provide preventive, curative and psychosocial

services at a community level, the NSP dictates the capacity building of especially community health workers to ensure they have the necessary skills. Each province has a Regional Training Centre whose responsibility is the in-service training of both professional and lay persons. These centres need to be strengthened and adequately resourced to manage and coordinate in-service training and mentoring of clinical staff within the provinces and progressively provide capacity building for non-health workers addressing HIV and TB (e.g. social workers).

Developmental approach: A developmental approach to HIV and TB programming that is linked to achieving the MDGs is important. The restructuring of the primary health care service platform has to be taken into consideration to ensure that HIV and TB services are fully integrated at all levels of responsibility and implementation, and that these programmes are included in the integrated development plans. This is addressed in more details in the development framework chapter.

Community systems strengthening: To obtain the desired impact at a household and community level, community action plans are necessary. These actions plans must be fully integrated and linked to the current service platform. It must form part of the broader development plans and adequately resourced. The government primary healthcare strategy is the vehicle that will drive this community systems strengthening.

8.3 Research and Innovation

Relevant research provides information and the impetus for innovation within the implementation of the NSP. This must be a constant focus across the strategic priorities and should be coordinated and managed from the SANAC structures, including the technical task teams, and should include:

- A national agenda for HIV and TB research (multi-sectoral)
- Efforts to encourage innovation
- Concrete plans to improve capacity for research
- Budget for research

8.4 Effective Communication

The ability to communicate effectively with and between stakeholders and mobilise community engagement in the implementation of the new NSP is a foundation for success. A comprehensive communication and social mobilisation strategy is needed to ensure buy-in and action at all levels. This includes community mobilisation and sensitisation on the goals and objectives of the NSP. This should be expanded to provincial and district level in coordination with the national structure.

Each of the NSP pillars will require major communication efforts at all levels. This will require renewed national campaign efforts – the recent HCT campaign has shown the benefit of consistent, clear messaging to drive results. In addition, these communication efforts must encompass all the various platforms for communication, including traditional media (television, radio), but also social media platforms (FaceBook, Twitter, Mxit).

The communication strategy needs to be informed by realities on the ground to ensure that the drivers (including structural and social drivers) of the epidemic are adequately addressed. The provision of services at all levels is not enough for an effective response. A concerted effort that permeates all levels for the mobilisation of communities to access

services and to contribute to the provision of prevention, treatment, care and support services needs to be the focus of the response.

The NSP advocates for a strategy to mobilise communities to access services and contribute to the provision of prevention, treatment, care and support for both TB and HIV. To this end each priority area must have a multi-sectoral communications strategy and plan in which the following issues should be carefully considered:

- Health communication – enabling communication around health issues;
- Behaviour change communication strategy to ensure behavioural changes rather than simply knowledge creation – making sure that communication is carefully crafted to enable changes in behaviour rather than simply a transfer of information;
- Communications outcomes need to be clearly defined and measurable so that the communication achieves the desired goals;
- Targeted communication interventions so that awareness is transferred into knowledge;
- Communications strategies should involve communications professionals wherever feasible

An allied enabler to communication is the ability to mobilise individuals and communities to both initiate and support interventions that achieve the strategic objectives of the NSP.

Social mobilisation is seen as a part of communication and covers the following:

- "Know your service rights" campaign – this involves, inter alia, empowering people to know what demands they can make with regard to the strategic priorities; and
- Social marketing initiatives aimed at creating and generating demand for the services offered through interventions operating within the NSP.

8.5 Monitoring and Evaluation

All activities and initiatives arising from the NSP must be subjected to rigorous monitoring and evaluation to ensure effectiveness, accountability and mutual learning.

Programme and organisational activities and interventions at all levels need to submit to monitoring and evaluation in order to ensure that objectives are achieved. This needs to be a separate structure within the framework that must provide both the guidelines and capability for M&E. The M&E framework must be developed in conjunction with the national, provincial and district plans.

Budgets need to be secured for M&E and it needs to monitor both the interventions happening at provincial, sectoral and local levels as well as the overall management and implementation of the NSP.

Based again on the recent successes from the HCT campaign, the NSP sets clear national targets, and defines a set of indicators to measure progress. These national targets must be translated into provincial, district, and in the case of health, facility-level targets. Robust monitoring and evaluation implementation plans are needed for government departments and civil society sectors at all levels (SANAC, provincial and district AIDS councils) to monitor the response, and the contribution of all sectors towards the response.

CHAPTER 9 – MONITORING AND EVALUATION

Draft Zero Note: *The SANAC Technical Task Team on Research, Monitoring and Evaluation will be developing the M&E framework and plan for the NSP during August and September. The indicator framework will only be finalised once the NSP objectives and interventions are finalised after the August consultation phase.*

9.1 Introduction

One of the key challenges experienced during the implementation of NSP 2007-2011 was the lack of a robust monitoring and evaluation strategy. The implementation plan for the NSP was drafted after the finalisation of the NSP and sectors and provinces did not have well drafted and nationally coordinated plans. This meant that the contributions of sectors to the NSP could not be easily monitored.

Two external reviews of the implementation of the NSP were conducted. A mid-term review was conducted in 2009/10 and provincial reviews conducted in 2011. These reviews were meant to strengthen implementation as well as to provide the baselines for the NSP 2012-2016.

In April 2008, UNAIDS produced global guidelines for a functional M&E system for national HIV responses. The guidelines highlight 12 key components that have to be present for an effective functioning of the system. The components are:

a) People, Partnerships and Planning

1. Organisational structures with M&E functions
2. Human resource capacity for M&E
3. Partnerships to plan, coordinate and manage the M&E system
4. National multi-sectoral M&E plan
5. Annual costed national HIV M&E workplan
6. Advocacy, communications and culture for M&E

b) Collecting, verifying and analysing data

7. Routine programme monitoring
8. Surveys and surveillance
9. National and sub-national databases
10. Supportive supervision and data auditing
11. Evaluation and research

c) Using data for decision-making

12. Data dissemination and use

For the NSP 2012-2016, the above guidance will be extended to also monitor progress with respect to STI and TB in addition to HIV.

9.2 Proposed Monitoring and Evaluation Architecture

The architecture of the M&E framework should consider the following:

Monitoring framework:

- Shared understanding of the goals of the national response and of each individual sector;
- Fully costed annual workplan highlighting sector-specific operational budgets;
 - Annual workshop to account for the roles and responsibilities of stakeholders in the implementation and funding of the NSP;
 - Commitment to capacity development, skills transfer and sustainability of the plans;
- Integration of routine and programmatic monitoring;
- Development of data quality standards for internal routine and programmatic monitoring (e.g. by using the Global Fund Routine Data Quality Audit Methodology);
- Development of data quality audit methodology for external routine and programmatic monitoring (e.g. the Global Fund Routine Data Quality Audit Methodology);
- Programme/sector-specific standard operating procedures or implementation plans to support data management for routine and programmatic data collection and reporting. This includes:
 - Standardisation of systems for sector-wide implementation;
 - Development of indicator protocol reference sheets for programme monitoring;
 - Alignment of indicators to national indicator data sets;
 - Development of a minimum data set for NSP reporting;
 - Data recording, capture, entry, verification and reporting;
 - Data use guidelines that includes the development of information products that will be produced periodically to inform programme and policy decisions;
- A capacity building plan to support:
 - Design and/or adoption of a 5-day monitoring and evaluation course to enhance routine and sector/programme reporting;
 - Mentoring and technical assistance to support sectors;
 - Training and technical assistance tracking;
- Design or enhance an existing ICT strategy for the NSP and SANAC. Efforts should be aimed at supporting country ownership of national information systems whilst promoting the use of other technologies such as mobile technology and social media to promote health and wellness outcomes, taking into consideration:
 - Workplan and timelines for implementation;
 - Government ownership;
 - Data and infrastructure management;
 - Organisational development and change management support for strategic information; and
 - Proposals on how local partners and stakeholders will be engaged, resources leveraged, and plans for sustainability.

Evaluation framework (*under development*)

- Process and output evaluation methodology for sector-specific programmes to be designed and implemented routinely

- Evaluation of current data exchange standards for sector-specific interventions. Sector-specific information systems must adhere to recognised exchange standards and adhere to reporting into a national routine system;
- Skills audit or evaluation in preparation for sector-specific support.

9.3 Proposals to Monitor the Implementation of NSP 2012-2016

Draft zero note: *This chapter is not complete.*

During 2012 an Electronic NSP Information Management System (e-NSPIMS) will be established. The e-NSPIMS will be a web-based and GIS enabled system. The enterprise and information technology of the e-NSP IMS will be based on the new NSP and its information needs. The e-NSPIMS is an overlay information management system designed to extract available data and information from several different existing systems to monitor the epidemic, monitor and evaluate the implementation of the key NSP game changers, and provide information on strategic indicators that SANAC sectors will use for NSP response coordination, policy decision and its resources allocation. The content of the e-NSPIMS will be determined by the strategic information and indicators that SANAC needs.

The structure of the e-NSPIMS will be designed in such a way that it interfaces with existing routine information systems, periodic surveillance systems, programme specific databases and evaluation studies across all sectors of SANAC. All existing routine information and periodic surveillance systems identified as primary sources for NSP indicators should be enhanced with necessary software to ensure that required data will be pushed to the e-NSPIMS. The agreed upon data dictionary, data exchange standards and protocols and data access policy are necessary for the e-NSPIMS.

By the beginning of 2013 the Electronic NSP Information Management System must be fully functional to:

- Generate regular statistical updates on quarterly and annual bases for use at district, provincial and national levels;
- Provide the data to assist SANAC to generate a 2014 midterm statistical report;
- Assist with reports required for regional (e.g. SADC), continental and international (UNGASS, Universal Access, ILO, etc.) reporting;

The SANAC Secretariat will administer the e-NSPIMS. For the e-NSPIMS to be functional and maintained, it required highly skilled, full-time IT and M&E officers. Additionally, local versions of the e-NSPIMS will be administered at Provincial and District AIDS council levels.

Community-level monitoring mechanisms must be implemented as part of the new NSP. Mobile monitoring tools will be designed to monitor activities at community level. This data will also contribute to provincial and national data.

As indicated above, an important component will be annual reporting by all sectors against a minimum set of interventions and indicators.

9.4 NSP Evaluation

Two NSP evaluations will be conducted in 2014 (midterm) and 2016 (end term review). As part of the NSP evaluation of the epidemics the Know Your Epidemic and Know Your Response analyses will be done at district level using nationally determined methodology in 2015.

Sector and programme specific evaluations will be conducted using both quantitative and qualitative approaches.

CHAPTER 10 – RESEARCH

Draft Zero Note: *The Research, Monitoring and Evaluation technical task team of SANAC has not been able to meet formally to draft inputs into this chapter. However some members were consulted and produced inputs and additional research activities were added by the drafters, especially with regard to pillar 4. Further meetings will be held in August to consolidate these inputs, and thus this chapter is not yet complete.*

10.1 Introduction

Whilst South African TB and HIV researchers are recognised as being world class, much of the research agenda has been shaped by the external funding and research agencies, and has had a largely biomedical focus. Less funding has been accessed for South African investigator driven studies and for research outside the medical field. This has resulted in a lack of prioritisation in the overall national research agenda. To correct the above, it is crucial that the NSP, 2012-2016 determines a national research process and multi-sectoral research agenda and is able to mobilise the funding required to implement the research agenda. Government, business, labour and civil society have a shared responsibility to both determine the research agenda and to fund it.

Provision in the research agenda must be made for various types of research, including basic research, applied research as well as implementation or operational (health systems) research. This will also require that research capacity is developed. Research and development must also focus on skill and technology transfer in the areas of diagnostics and drug and vaccine development.

Some ideas for research are provided below in line with the four pillars for further consultation.

10.2 Proposed Research Agenda for NSP 2012-2016

The research recommendations provided below are an **initial** reflection on research questions and priorities. These will be supplemented by the SANAC technical task team for Research, Monitoring and Evaluation, and will be supplemented with priorities from the Essential National Health Priorities summit held in late July. Some of the priorities identified at that summit include prevention, optimizing treatment, improving adherence, more efficient diagnostics, and measuring impact. This applies equally to HIV and TB.

Pillar 1: Universal Testing for HIV and Screening for TB – “Know Your Status”

There is some overlap between the research priorities for pillar 1 and 3, as some of these issues touch on essential vulnerabilities. However, in order to not duplicate activities, these are retained in pillar 1. These bullet points also indicate in places where an activity is considered research, or an evaluation activity.

- Evaluation of the current HIV prevention strategies and programmes (evaluation)
- Operational research/evaluation on HCT and TB screening, including task shifting
- Follow-up research/evaluation on pre-ART for PLHIV
- Research/evaluation on HCT in different settings (health facility, home-based care, self-testing, etc.)

- Optimization of PrEP and microbicides for HIV prevention (operational research)
- Repeat CAPRISA 004 through South African Follow-on Africa Consortium for Tenofovir Studies (FACTS) (clinical trial)
- Understanding mechanism of protection of microbicides (pre-exposure prophylaxis and post-exposure prophylaxis) (basic science)
- Microbicide product development (basic science)
- Understanding the role of host genetics in South African populations in terms of susceptibility to HIV infection and disease progression (basic science)
- Development of locally relevant and effective vaccines against HIV (basic science)
- TB vaccine research (basic science)
- Follow-up of national or professional cohorts (e.g. SANDF, miners, health workers, educators, etc.) to complement data generated from repeated HIV and TB general population surveys (surveillance)
- Develop agreed methodology to estimate HIV incidence (surveillance)
- Evaluation of communication interventions (behavioural trials/evaluation)
- Evaluation of behaviour change interventions (behavioural trials/evaluation)
- Operational research on medical male circumcision including behavioural disinhibition
- Operational research on ART for prevention including PrEP and for discordant couples
- Research on cost-effectiveness of ART for prevention

Pillar 2: Sustain Health and Wellness

The priorities listed here are mainly focused on the treatment aspect of health and wellness, and in August the SANAC technical task team on Research, Monitoring and Evaluation will add priorities linked to care and support issues.

- Operational research/evaluation on ART rollout – with a focus on clinical outcomes and quality assessment
- Operational research/M&E on combined ART and TB treatment including DOTS
- Research/evaluation on stigma reduction
- Feasibility study to advise on efficacy of test and treat strategy (operations research)
- Establishment of a national ART and TB treatment cohort to review (monitoring and evaluation)⁴²:
 - Adherence
 - Mortality
 - Morbidity
 - Resistance
- Pharmacovigilance (monitoring and evaluation)

Pillar 3: Safety and Reducing Vulnerability

- Assessment of the impact of multi-component HIV (combination) prevention interventions including behaviour change, structural interventions, gender-based violence and communication components
- Defining most-at-risk-populations (MARPS) or key populations for South Africa (surveillance/monitoring and evaluation)

⁴² This could be through the establishment of a new cohort, or participating in an international cohort such as leDEA (International Epidemiologic Databases to Evaluate AIDS)

- Evaluate structural interventions (behavioural trials/monitoring and evaluation)
 - Conditional cash transfer
 - Alcohol interventions including legislation on advertising
 - Keeping children in school

Pillar 4: Changing Social Norms and Values

- Research key protective social norms and values
- Evaluate strategies to implement/facilitate protective social norms and values
- Research key norms and values that facilitate the perpetuation of HIV transmission
- Design, implement and evaluate key strategies to mitigate norms and values that facilitate perpetuation of HIV transmission, including stigma mitigation (this is also applicable to TB)

CHAPTER 11 – GOVERNANCE AND MANAGEMENT

Draft zero note: *As the SANAC restructuring processes, including the relation to provincial and district AIDS councils, it not yet complete, this chapter is still under development.*

11.1 Background and History

In early 2007 the South African National AIDS Council (SANAC) was reconstituted under the direction of then Deputy President Phumzile Mlambo-Ngcuka to strengthen it's functioning and facilitate the introduction and implementation of the National Strategic Plan on HIV/AIDS and STIs (2007 – 2011). SANAC was re-constituted as a partnership of government and civil society, with representatives of government ministers as well as leaders of business, labour and civil society. It would be advisory and responsible for oversight, management and coordination of a multi-sectoral HIV response (with the TB response added in 2011).

SANAC became a five-tier structure made up of:

- The National Plenary
-
- The Programme Implementation Committee (PIC)
- The Resource Mobilisation Committee (RMC)
- Technical Task Teams (TTT)

Plenary now consists of most government ministries and 19 civil society sectors, namely: business; children; disability; faith-based organisations; health professionals; health-related academic and research organisations; higher education; labour; law and human rights; LGBTI; men; non-governmental organisations and community-based organisations; organisations representing people living with HIV; sex workers; sports and entertainment; traditional healers; traditional leaders; women; and youth. These sectors are represented on Plenary and the PIC, and on a separate body, the Sector Leaders' Forum.

The RMC is tasked with securing and managing funding for SANAC, in particular accessing Global Fund grants, and the PIC is tasked to review the implementation of programmes and strategies of the NSP and make recommendations to Plenary.

The implementing structure of SANAC is PIC which makes recommendations and guidelines on new innovations and which is responsible for monitoring existing programmes. The PIC reports to the SANAC plenary. In addition there are five Technical Task Teams (TTTs), which report to PIC based on the priority areas of the NSP. These are:

- Research, Monitoring and Surveillance
- Prevention
- Human Rights and Access to Justice
- Treatment, Care and Support
- Communications

The objectives of SANAC according to the Procedural Guidelines, agreed by Plenary in 2008 are:

- Advising government on HIV and STI policy and strategy, and related matters;
- Providing leadership and creating and strengthening partnerships for an expanded national response to HIV in South Africa;
- Receiving and disseminating information on sectoral interventions in respect of HIV and considering challenges; and
- Overseeing continual monitoring and evaluation of all aspects of the NSP.

In 2010 and 2011 steps were taken to revive the National AIDS Trust (NAT) in order to have a legally recognised institution for the receipt and disbursement of funds and for the employment of the secretariat that is required for the operation and campaigns of SANAC.

Whilst SANAC is perceived to be somewhat representative its effectiveness has been challenged.

It is clear from the short analysis of the current governance and management structures that for the new NSP to be successfully implemented, a revised governance and management structure is needed.

11.2 Proposed Principles for a New Governance Structure

The following principles are proposed for the establishment of new governance and management structures:

- That government has primary responsibility for the success or failure of the national response to HIV, STIs and TB, and that SANAC's mission must reflect this;
- That SANAC must have a proper and appropriate legal foundation;
- That SANAC describes the whole architecture of the response to HIV and TB and therefore includes PACs and DACs;
- That the building of SANAC structures must be seen as part of the NSP and be measurable and that the SANAC Trust must have overall responsibility for monitoring their development;
- That there must be a budgetary plan to establish and sustain these structures;
- That SANAC must be truly representative;
- Part of the plan of SANAC must be to mobilise and organise crucial sectors that are not currently organised;
- That thought needs to be given to SANAC and the NSP's relation to other development plans (and vice versa) rather than the NSP seeking to reinvent or usurp these plans.

11.3 Proposed Process to Restructure and Strengthen SANAC Governance Structures

A small task team, mandated by the SANAC Chairperson and Deputy Chairperson, will be established to develop a proposal to restructure SANAC which will be presented to plenary for consideration as it considers the draft NSP. The restructuring of SANAC, including provincial AIDS councils and district AIDS councils should be part of the process of finalising the NSP given that new expectations and deliverables (together with experiences in implementing the current NSP) should guide the structure of SANAC at all levels.

It is suggested that the principles mentioned above should form the basis of the terms of reference of the proposed task team and that in parallel with the consultative process and development of the contents of the NSP (especially pillars 1-4) the structure of SANAC be consulted and finalised.

CHAPTER 12 – FINANCING THE NSP 2012-2016

12.1 Introduction

One of the challenges in implementing the NSP 2007-2011 has been the lack of a coherent financing plan. The current NSP has never been fully costed and sectors have been largely dependent on their own resources to fund their activities. The lack of a costed financing plan has also meant that it was difficult to hold sectors (in particular government, business and labour) accountable to provision of funding. Determining the financial implication and the availability of funding required for the implementation of the NSP is critical for government, development partners and civil society organisations and sectors (which are largely dependent on donor funds and funding from government to meet, consult and implement sector-specific activities).

It is therefore imperative that the NSP 2012-2016 is costed at all levels (national, provincial, district and local) and that its activities are fully funded. It is also critical that the activities of the SANAC Secretariat are fully funded to ensure that support is provided, that activities are monitored and that all stakeholders are held accountable. Ultimately financing the NSP activities will need to bring together the resources of government, business, civil society and development partners.

12.2 Establishment and Terms of Reference of Costing Task Team

The SANAC secretariat and the National Department of Health are jointly coordinating the development of draft zero of the NSP 2012-2016. It has been broadly recognised that one of the weaknesses of the current NSP is the lack of a detailed implementation plan specifying the resource requirements, both financial and human resources.

In order to provide a more informed costing for the implementation of the NSP 2012-2016, a focussed costing working group is established. This working group is expected to provide guidance to the NSP costing process that will arise from the NSP and provide guidance to the provinces that will be required to produce their own fully costed operational plans.

Working group

It is proposed that the national working group is made up of representatives from the following organisations:

- National Department of Health
- National Treasury
- National Planning Commission
- Specialist external consultants
- A legal/constitutional expert
- A member of civil society with knowledge of finance and budgeting issues

The aims of and objectives of the working group will be to:

- Review past NSP costing initiatives/existing costing of key interventions;

- Develop an appropriate costing structure and model for future NSP implementation activities;
- Develop a national government NSP implementation budget;
- Support the development of the Provincial NSP implementation budgets;
- Compile an overarching NSP implementation budget (i.e. considering existing funding sources and estimated expenditure) and identify the funding sources; and
- Identify funding shortfalls for NSP activities.
- Propose innovative financing strategies to ensure that the NSP is fully funded

National and Provincial costing support consultants

The proposed terms of reference for the costing consultant/s are provided below.

Key proposed activities:

- Coordinate the costing of the NSP 2012-2016 and all implementation activities (national and provincial), including the M&E framework;
- Develop appropriate and comprehensive costing frameworks to achieve the prior requirement above;
- Deliver the specific outputs as per the working group terms of reference;
- Determine the overall funding envelope required to implement the NSP, including identification of potential funding gaps;
- Provide recommendations on funding alternatives and models (e.g. taxation on carbonated soft drinks).

It is anticipated that this work will commence in August 2011, and be finalised by December 2011.

Expected outputs:

- Detailed national and provincial estimates by activity for the implementation of the NSP;
- Annual funding flow timeline, considering both phased introduction of specific activities included in the NSP, and the reorganisation of current activities in line with the new NSP; and
- Annual planning tool to assess budget allocations, expenditure and achievement against targets and revised budget allocation.