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

3 October 2011
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# ACRONYMS AND ABBREVIATIONS

[Please note that the list of acronyms and abbreviations will be updated once the content of the NSP is finalised]

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal care</td>
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<td>ART</td>
<td>Antiretroviral Therapy</td>
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<td>ARV</td>
<td>Antiretroviral</td>
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<td>ASSA</td>
<td>Actuarial Society of South Africa</td>
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<td>AU</td>
<td>African Union</td>
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<tr>
<td>BCC</td>
<td>Behavioural Change Communication</td>
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<td>CBO</td>
<td>Community-Based Organisation</td>
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<td>DCS</td>
<td>Department of Correctional Services</td>
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<td>DAC</td>
<td>District AIDS Council</td>
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<td>DHIS</td>
<td>District Health and Information System</td>
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<td>DHS</td>
<td>Demographic and Health Survey</td>
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<tr>
<td>DOBE</td>
<td>Department of Basic Education</td>
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<td>DOH</td>
<td>Department of Health</td>
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<tr>
<td>DOTS</td>
<td>Directly Observed Therapy Short Course</td>
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<tr>
<td>DPSA</td>
<td>Department of Public Service and Administration</td>
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<td>DSD</td>
<td>Department of Social Development</td>
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<tr>
<td>EC</td>
<td>Eastern Cape Province</td>
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<tr>
<td>EID</td>
<td>Early Infant Diagnosis</td>
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<td>FS</td>
<td>Free State Province</td>
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<tr>
<td>GBV</td>
<td>Gender-based violence</td>
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<tr>
<td>GFATM</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<td>GP</td>
<td>Gauteng Province</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>HCT</td>
<td>HIV Counselling and Testing</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HPV</td>
<td>Human Papilloma Virus</td>
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<td>HSRC</td>
<td>Human Sciences Research Council</td>
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<tr>
<td>IDU</td>
<td>Injecting Drug Use/User</td>
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<td>KYE</td>
<td>Know Your Epidemic</td>
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<td>KYR</td>
<td>Know Your Response</td>
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<td>KZN</td>
<td>KwaZulu-Natal Province</td>
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<td>LP</td>
<td>Limpopo Province</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>MMC</td>
<td>Medical Male Circumcision</td>
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<tr>
<td>MCP</td>
<td>Multiple or Concurrent Partner</td>
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<td>MCWH</td>
<td>Maternal, Child and Women’s Health</td>
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<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>MP</td>
<td>Mpumalanga Province</td>
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<tr>
<td>MRC</td>
<td>Medical Research Council</td>
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<td>MSM</td>
<td>Men having Sex with Men</td>
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<td>MTCT</td>
<td>Mother-to-Child Transmission</td>
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<td>MTR</td>
<td>Mid-Term Review</td>
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<td>NC</td>
<td>Northern Cape Province</td>
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<td>NEPAD</td>
<td>New Partnership for Africa’s Development</td>
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<td>NGO</td>
<td>Non-Governmental Organisation</td>
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<tr>
<td>NSP</td>
<td>National Strategic Plan for HIV and AIDS, STIs and TB</td>
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<td>NW</td>
<td>North West Province</td>
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<td>PAC</td>
<td>Provincial AIDS Council</td>
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<td>PEP</td>
<td>Post-Exposure Prophylaxis</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>PLHIV</td>
<td>Persons Living with HIV</td>
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<td>PIC</td>
<td>Programme Implementation Committee of SANAC</td>
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<td>PICT</td>
<td>Provider Initiated Counselling and Testing</td>
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<td>PMTCT</td>
<td>Prevention of Mother to Child HIV Transmission</td>
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<td>PrEP</td>
<td>Pre-Exposure Prophylaxis</td>
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<td>PSIP</td>
<td>Provincial Strategic Implementation Plan</td>
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<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
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<tr>
<td>SACEMA</td>
<td>South African Centre for Epidemiological Modelling and Analysis</td>
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<td>SADC</td>
<td>Southern African Development Community</td>
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<tr>
<td>SAHRC</td>
<td>South African Human Rights Commission</td>
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<td>SANAC</td>
<td>South Africa National AIDS Council</td>
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<td>SANBS</td>
<td>South African National Blood Service</td>
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<td>SCC</td>
<td>Social Change Communication</td>
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<tr>
<td>SMS</td>
<td>Short Messaging System</td>
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<td>SRHR</td>
<td>Sexual and Reproductive Health and Rights</td>
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<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>SW</td>
<td>Sex Worker</td>
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<tr>
<td>SWEAT</td>
<td>Sex Workers Education and Advocacy Taskforce</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>TOP</td>
<td>Termination of Pregnancy</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>UNGASS</td>
<td>United Nations General Assembly Special Session on HIV and AIDS</td>
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<td>WC</td>
<td>Western Cape Province</td>
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WHO  World Health Organization
CHAPTER 1 – EXECUTIVE SUMMARY
CHAPTER 2 – INTRODUCTION

The HIV, STI and TB National Strategic Plan (NSP) 2012-2016 is the culmination of extensive review of documentation, consultation and deliberation over several months 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 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.

The NSP 2012-2016 is the strategic guide for HIV, STI and TB initiatives for the next five years. It is results-based, focusing on the drivers of the epidemic to achieve the goals defined below. It builds on the achievements in the previous NSPs, scaling up what has been done well, and improving on the quality of services, while at the same time integrating new and proven strategies. The NSP is meant to respond to the changes in the epidemic and will therefore be reviewed periodically for relevance and effectiveness. It will be located within the broader development plan of government.

As a guide the NSP informs national and provincial stakeholder strategies and implementation plans. It will also be used by SANAC as the framework by which they will coordinate and monitor implementation.

Every government department, sector and provincial authority will need to develop implementation plans by March 2012.

2.1 NSP Vision

The NSP 2012-2016 is driven by 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 been advocated for by UNAIDS. These are:

- Zero new infections
- Zero deaths associated with HIV and TB, and
- Zero discrimination

2.2 NSP Goals

In line with this 20-year vision (the Three Zeros), the NSP 2012-2016 has the following broad goals, to:

- Reduce new HIV infections by at least 50% using combination prevention approaches (75% reduction in vertical transmission, 50% in high-risk group, 50% reduction in the general population);
- Initiate at least 80% of eligible patients on antiretroviral treatment (ART), with 80% alive and on treatment 5 years after initiation;
• Reduce the number of new TB case registrations by 50%;
• Reduce the number of TB deaths by 50%;
• Ensure an enabling and accessible legal framework to support implementation of the NSP;
• Reduce self-reported stigma related to HIV and TB by 50% (using the stigma index).

2.3 NSP Principles

The principles that underpin the NSP as well as the national, provincial and sectoral implementation plans are as follows:

• 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 contribute to the achievement of that vision;
• Innovative – without diminishing the importance of evidence-based initiatives, innovation should be encouraged to find new ways of dealing with 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 and implementation 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 the delivery of a good return on investment;
• Results and evidence based – initiatives should be based upon clear evidence and driven by the achievement of well-formulated clear results. In 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;
• Feasible – goals set should be achievable and feasible;
• Flexible – the strategic framework needs to be flexible to ensure that changes can be made quickly when evidence demands;
• Aligned – the goals and interventions and the government’s Negotiated Service Delivery Agreements (NSDA) and provincial strategic plans (PSPs) must be aligned;
• 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 infected and affected and should enable the participation of such affected people in the formulation and execution of initiatives;
• Inclusive and seeking leadership from people living 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.
2.4 NSP Strategic Objectives

For the next five years, the following four strategic objectives will form the basis of the collective HIV and TB response that will in turn provide the impetus towards achievement of the 20-year three zeros vision:

- Prevention of HIV, STI and TB Infections – the primary objective being to ensure a multi-pronged approach to HIV and TB prevention that includes all biomedical, behavioural, social and structural approaches in order to reduce new HIV and TB infections; and further for all citizens to know their HIV and TB status;
- Sustain 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;
- Protection of Human Rights and Promotion of Access to Justice – the primary objective being to address issues of stigma, unfair discrimination, human rights abuses, and gender inequality; and
- Social and Structural Approaches to HIV and TB Prevention, Care and Impact – the primary objective being to address societal norms and behaviours that fuel the twin epidemics of HIV and TB, and structural interventions to reduce vulnerability to HIV and TB and to mitigate the impacts thereof.

The following chapters provide more detail on how these objectives will be achieved 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 municipalities and those interventions that are novel.

2.5 NSP and International Obligations

The NSP 2012-2016 aims to align and be consistent with national, international and regional obligations, commitments and targets, including:

- The Constitution;
- Universal Access targets;
  - 80% treatment access
- Millennium Development Goals;
- UNGASS Political Declaration, June 2011, and 2015 targets;
  - Reduce by 50% the sexual transmission of HIV
  - Eliminate HIV transmission from mother to child
  - Reduce by 50% TB deaths in people living with HIV
  - Ensure equal access to education for children orphaned and made vulnerable by AIDS
- UNAIDS 2011-2015 strategy;
  - Reduce new infections by 50% the percentage of those aged 15-24 years living with HIV (compared to the 2009 baseline)
  - Reduce new HIV infections in children by 90% (compared to the 2009 baseline)
  - Reduce HIV-related deaths by 25% (compared to the 2009 baseline)
Reduce TB deaths by 50% (compared to the 2004 baseline)

The Stop TB Strategy and the Stop TB Partnership’s Global Plan to Stop TB 2006-2015;
- Reduce by 50% the number of people per 100,000 who have TB, relative to 1990
- Reduce the number of new TB cases per 100,000
- Reduce by 50% the number of deaths from TB per 100,000, relative to 1990
- Eliminate, by 2050, TB as a public health problem to less than 1 case per million population

Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV 2010-14;
- Improve 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 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’ organisations to support the rights of women and girls

African Union commitments;
Southern African Development Community commitments;
International human rights agreements that South Africa has ratified; and
International trade agreements.

2.6 NSP Implementation

Once complete, the NSP will guide all stakeholders in the development of suitably aligned implementation plans that will reflect their specific contributions to the achievement of the National Strategic Plan. These plans will be costed and financed to ensure that sufficient resources are able to support implementation.

Implementation planning (operational) will adhere to a structured framework upon finalisation of the NSP. The framework will provide guidance to all sectors in terms of structure and approaches to costing.

National government departments and provincial strategic plans will be completed and finalised for 1\textsuperscript{st} December and that costed implementation plans will be finalised in March 2012 for implementation commencing 1 April 2012.

All implementation plans must be multisectoral in their orientation and clearly demonstrate accountability and responsibility for all interventions across all stakeholders (for example, the role civil society stakeholders in the implementation of interventions in a specific province).

A fundamental requirement is to overcome the implementation coordination challenges of the previous NSP. SANAC is an institution inclusive of Provincial AIDS Councils and
District AIDS Councils. The Governance chapter outlines the proposed governance and institutional requirements to ensure coordination and monitoring of all NSP interventions.
CHAPTER 3 – PROGRESS AGAINST THE NSP 2007-2011

This chapter highlights the achievements and challenges of the NSP for HIV and AIDS and STI 2007 – 2011 (NSP HIV) and the National TB Strategic Plan (NSP TB). It is based largely on the mid-term and final review of the NSP HIV and the mid-term review of the NSP TB.

3.1 NSP HIV 2007 – 2011: Achievements and Challenges

The NSP HIV plan was based on a set of guiding principles including supportive leadership, effective communication, effective partnerships, promoting social changes and cohesion, and developing sustainable programmes and funding.

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

- Reduce the number of new HIV infections by 50%
- Reduce the impact of HIV and AIDS 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 HIV 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 the relevant sections.

Goal 1: Reduce the number of new HIV infections by 50%

Achievements

Prevention of mother to child transmission (PMTCT)

The PMTCT programme had the biggest achievements of all the prevention programmes:

- Over 90% of health facilities offer PMTCT services to pregnant women
- 98% of pregnant mothers were counselled and tested for HIV
- Uptake of HIV prophylaxis increased from 30% to 60% among antenatal clients
- The South Africa PMTCT Evaluation Study and laboratory data showed decreasing transmission trends at six weeks in infants exposed to HIV: 3.5 % nationally (MRC), and 3.5% at <2 months (NHLS).
**Life Skills Programme**

In 2009, 100% of primary schools provided life skills-based HIV education within the last academic year;\(^1\) however, there has not been a rigorous evaluation of the efficacy of these programmes.

**Mass Media Campaigns**

Significant effort went into mass media campaigns from both government and development partners. 90% of the national population was reached by communication and there is good evidence to suggest that there was a cumulative impact of these communication programmes.

**Medical Male Circumcision**

In 2010 a national rollout of medical male circumcision was initiated with over 150,000 circumcisions conducted by April 2011.

**HIV Counselling and Testing (HCT) Campaign**

A national HCT campaign was introduced in April 2010 with the intent of testing 15 million South Africans, with referrals to continued care. By June 2011 more than 13 million HIV tests had been conducted – a significant increase over previous years, when less than 3 million tests were conducted per annum (and in most years, less than 2 million). The success of the campaign can be attributed to strong political leadership, the multi-sectoral approach to the campaign – the business sector, civil society organizations and the government working together towards a common cause. There was also strong communication including social mobilisation and mass media mostly by partners, which also contributed to the success of the campaign.

**Condom Use**

Condom use in South Africa has continued to increase with the percentage reporting the use of condoms in the most recent sexual encounter increasing from 35% (2005) to 62% (2008), with the highest rates amongst younger age groups.\(^2\) Increased condom use among the youth may have contributed to the recent decline in HIV incidence in this age group. People above 50 years of age and married people are least likely to report condom use.

**Challenges**

Based on available data on HIV incidence, South Africa will not meet the target as set out in the NSP HIV of 50% reduction in new infections by December 2011 despite the steady drop in new infection rate over the years. Several reasons can be attributed to this:

- The prevention strategy in the NSP HIV was too generalised. It needed to be more focused on the key interventions that would give the biggest results e.g. focusing

\(^{1}\)EMIS: School Realities 2008 and 2009, NDOE  
\(^{2}\)NDOH M&E
interventions on populations where new infections occur the most; like MSM and SW\textsuperscript{3}.

- Follow-up of mother and baby pairs to 18 months to determine PMTCT outcomes was poorly implemented. In addition, the weak M&E system to collect data on the outcomes and support provided to these mother/baby pairs made it difficult to effectively implement interventions to reduce the risk of HIV transmission to infants.
- The lack of a national prevention strategy, coordination and government communication resulted in each intervention being implemented in isolation of each other and not presented as a combination package of interventions, which would enhance the impact.
- Inadequate role models for safe sexual behaviours.

**Goal 2: Reduce the impact of HIV and AIDS on individuals, families, communities and society by expanding access to appropriate treatment, care and support to 80% of all people diagnosed with HIV**

**Achievements**

**ART Services**

Expansion of ART services to all hospitals as well as many primary health care facilities has enabled a rapid expansion of ART services with 1.4 million persons started on ART and around 1.1 million currently on treatment\textsuperscript{4}. Nurse Initiated and Managed ART (NIMART) was launched with the HCT campaign allowing treatment initiation rates to reach 30,000 per month.

South Africa was able to secure a significant reduction in the prices of ART with the new national tender for ARVs, thus enabling increased access to ART.

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.\textsuperscript{5}

**Management and Coordination**

There is renewed engagement and high-level political leadership for the HIV response as well as growing cooperation between the Presidency, the Department of Health, NGOs and all sectors of civil society. The South Africa National AIDS Council (SANAC), established in 1997 was restructured in 2006 with the Deputy President serving as the chairperson of SANAC and a civil society member as the deputy chairperson.

All provinces have established a Provincial AIDS Council (PAC) and most districts have district AIDS councils.

\textsuperscript{3} Know Your Epidemic Report
\textsuperscript{4} End of Term Review of the NSP 2007 — 2011
\textsuperscript{5} Mid-year population estimates, 2011. StatsSA, July 2011
While SANAC has representation of 19 sectors, the same is not true for the PACs and the district AIDS councils. Representation of sectors varies at these levels making it difficult to coordinate a true multi-sectoral response.

*Research and Innovation*

There has been a proliferation of research activities for both HIV and TB, which has enabled policy makers and implementers to better define both epidemics, identify the drivers of the epidemics, intervention-specific populations, key populations and the structural determinants of the epidemics.

There have been a number of population-based research/surveys, which has been used to assess impact.

*Community Systems Strengthening*

There has been a scale up and strengthening of community systems. There has been a growth in the community caregiver programme (for both the Care and Support programme and the OVC programme). Both government and development partners increased funding for community caregivers.

*Challenges:*

- Despite the significant achievement due to the rapid scale-up of ART services, especially within primary health care services, the weak monitoring and evaluation system resulted in poor follow-up of patients on treatment. This resulted in an inability to give an accurate picture of the number of patients currently on treatment, number lost to follow-up and number died.
- TB/HIV integration activities were poorly addressed in the NSP HIV, with little effort addressed to reducing the impact of TB in people living and thus TB remains a major cause of morbidity and mortality among people living with HIV.
- There is a need to strengthen the supervisory and mentoring system for NIMART. The lack of doctors at primary health care level poses a challenge in implementing an effective mentorship programme. This is mainly done by development partners, with no long-term sustainability planning and integration into the public health system.
- Pre-service training for nurses has been slow in integrating HIV and updates on TB and STI into the pre-service training curriculum. Part of the challenge is that most nursing tutors are not updated on HIV/TB and STI. The training of health care professionals on management of HIV/TB is still largely done through in-service training (even after at least 15yrs into the epidemic), which means that nurses are constantly being taken out of service delivery for training.
- Despite the fact that a monitoring and evaluation framework was developed for the NSP HIV, the collection, collation and analysis of data has been and still is a challenge. There is still not one multi-sectoral M&E system that allows for the collection of broad-based data on NSP HIV implementation. SANAC does not have the M&E capacity to monitor the response on a national level from all sectors and therefore regular public reports on the progress of implementing the NSP HIV does not exist. The response is largely monitored through the systems of the NDOH.
- The NSP HIV has too many, non-prioritised and in some cases un-measurable indicators.
• There was no national implementation plan in place to break targets down by priority area and province.
• There is no single national research agenda addressing the issues of HIV, STIs and TB. Research is currently being conducted based on interests by individual research institutions or driven by availability of funding.
• The absence of a legal status of the SANAC Secretariat and most of the PCAs restricted their authority and therefore decision-making ability. This impacted on how well SANAC was resourced and managed.
• Both the midterm review and the end of term review of the NSP HIV highlighted the ineffectiveness of SANAC and the secretariat. Despite the restructuring of SANAC not much has changed in term of energising a nationally comprehensive response.
• There is very little data to measure progress in increasing access to justice and protection of human rights. This was due to the fact that there was no clear strategic plan or indicators for this component, which made it difficult to cost and measure.

Indirect Achievements

South Africa is among the high burden countries for both HIV and TB and therefore has received support from many development partners to curb the impact and halt the spread of the epidemics. The NSP HIV and NSP TB have been used to mobilise more resources from the Global Fund and development partners. The PEPFAR programme has provided about $2.5 billion to support both the NSP HIV and NSP TB since the start of the PEPFAR programme in 2003. The European Union Member States and other countries including individual European countries have also contributed substantial amounts of funding to support the implementation of the NSP HIV and NSP TB during that period.

Challenges

Given the weak coordination mechanisms from national to district level, development partner programmes were implemented for the most part in parallel to that of the government. The PEPFAR programme began as an emergency plan, which resulted in direct programme implementation within health facilities, and increasing the potential for duplication.

The increased resources towards the HIV programmes drew resources and in particular, critical human resources from other areas of the health care system to the HIV programme, thus further weakening an already strained health care system.

3.2 Overview of the TB National Strategic Plan

The main goal of the NSP TB 2007-2011 was to reduce the burden of TB disease in the country through early diagnosis and initiation of appropriate treatment to reduce TB mortality and prevent ongoing TB transmission.

There were seven strategic objectives under which the key activities were outlined, these are:

• To strengthen the implementation of the DOTS strategy
• To address TB and HIV, MDR and XDR-TB
• To contribute to health systems strengthening
- To work collaboratively with all care providers
- To empower people with TB as well as communities
- To coordinate and implement TB research
- To strengthen infection control

The targets to be achieved by 2011 were: to achieve a case detection rate of 70% for new smear positive TB; a cure 85% of new positive PTB cases identified and; to attain a treatment success rate for all TB cases of more than 85%.

A major review of the TB programme was conducted in July 2009 over a period of two weeks with partners from WHO, CDC, KNCV, STOP TB Partnership, The Union and PEPFAR.

Achievements:

- Demonstrable improvement in case detection (78%) of new infectious TB cases
- Significant progress by National Health Laboratory Services in most provinces on access, turnaround time and quality assurance of sputum smear microscopy, culture and drug sensitivity tests (DST), including introduction of rapid diagnosis of MDR-TB
- Generally systematic linkages between public hospitals and PHC clinics
- Drug procurement and supply chain was functioning well
- Uniform availability of electronic TB register (ETR) for susceptible TB and evolving electronic system for drug resistant TB (EDR)
- Widespread provision of CPT and increasing access to ART for all TB patients living with HIV
- Expanded M/XDR-TB management (treating >60% of estimated incident MDR-TB patients) with mostly sufficient supply of 2nd line anti-TB drugs
- Infection control measures generally well implemented in MDR-TB hospitals
- Advocacy, communication and social mobilisation (ACSM) focal point and plan in place at the national level
- Evident involvement of care providers outside the TB programme including private clinics and hospitals, NGOs, mines, other workplaces and correctional services

Challenges

- HIV mostly drove the increase in cases notified, with more than 70% of TB patients also living with HIV but less than half know their HIV status.
- TB screening for people living with HIV is around 40% with only 4% on Isoniazid preventive therapy (IPT).
- There was late initiation of ART in TB patients, resulting in high mortality. The reason for this being that ART services are centralised (hospital level) compared to TB services, which are provided at clinic level.
- The treatment success rate for new infectious TB cases is at 73% (the global target is >85%) with high death (7%) and default rate (8%) and patients not evaluated at 6%.
- Provision of community TB care and support to DOT providers is not standardised in all districts and there is insufficient training and supervision of DOT providers.
- Inadequate key human resources at various levels with variable training.
- Discrepancies between data management systems (paper based versus ETR) resulting in poor quality of data.
• Inadequate laboratory network in KwaZulu-Natal.
• The programmatic management of MDR-TB is not consistent with WHO guidelines. The deviations from the guidelines are particularly serious in the correctional facilities visited.
• Challenges in implementation of infection control measures in general hospitals, correctional centres and general health facilities.

Recommendations:

The degree of response to the TB epidemic is not yet commensurate with the size of the TB and TB/HIV epidemics, both in terms of service coverage, human and financial resources, and infrastructure required to reverse the tide of the epidemic. The following recommendations were proposed in the midterm review to address the major challenges:

• Establish and implement all possible mechanisms to intensify case finding particularly, but not solely, in high-risk groups such as people living with HIV, prisoners, miners and other risk groups. Consider major efforts to intensify use of IPT in HIV positive persons. Ensure all TB patients are tested for HIV.
• Intensify and decentralise provision of ART to match TB treatment network to ensure patients with HIV-associated TB receive it in time to impact on mortality.
• Promote implementation of patient centred approaches to TB care including sustainable expansion of community based care and strict DOT to enhance treatment adherence and reduce default.

Conclusion:

Many of the challenges in implementing the NSP HIV and NSP TB are common to both programmes and could be overcome by a more integrated approach to programming in terms of addressing the social drivers of the epidemics and the strategic enablers such as governance and accountability, engaging other sectors in the response, and monitoring and evaluation.
CHAPTER 4 – EPIDEMIOLOGY OF HIV, STIs AND TUBERCULOSIS

4.1 Introduction

Understanding of the factors that increase vulnerability to HIV, STIs and TB is critical for development of future strategies and ensuring that the responses are tailored to address them. Against this background, analytical pieces of work such as the “Know Your Epidemic” and “Know Your Response,” National Tuberculosis Programme review, among others are instrumental in guiding formulation of the National HIV/STI and TB Strategic Plan (2012-2016). This chapter presents the proximate determinants of the South African HIV epidemic and highlights the intervention-specific populations that the new strategic plan has to pay particular attention to and discusses the epidemiology of HIV, tuberculosis and HIV related TB in South Africa.

4.2 Background

A number of contextual factors underpin the dual epidemics of HIV and TB in South Africa. The country is still reeling from the impacts of a long history of apartheid characterized by inequitable distribution of available resources and racial discrimination. In addition, South Africa is an economic hub for countries south of the equator. As a result the rate of immigration is higher as people from other countries come to South Africa in search of employment opportunities and better living conditions. The country shares common borders with countries that also have generalized HIV epidemics – Botswana, Namibia, Zimbabwe, Mozambique, Swaziland and Lesotho.

4.3 Trends of HIV Prevalence

The major data sources of HIV prevalence trends in the country are the antenatal surveillance surveys by the Department of Health and the population surveys by the Human Sciences Research Council (HSRC). Antenatal surveillance surveys have been conducted annually since 1990 while three rounds of population surveys have been conducted every 3 years from 2002. Data from both sources suggest stabilization of HIV prevalence albeit at high levels. See figures 1a and 1b below.
There is marked heterogeneity in HIV prevalence by key epidemiological variables such as age, race, gender, geographical location and social economic status reflecting differentials in exposure to risk of infection. The highest prevalence of HIV infections is between ages 25-39. Black South Africans have consistently registered higher HIV prevalence rates compared to other racial groups. According to the HSRC survey of 2008, African women and men aged 20-34 and 25-49 have been classified high risk with 32.7% and 23.7% HIV prevalence respectively. HIV prevalence among females has peaked at the age of 25-29 at about 33% in all the population surveys. As shown in figure 3, HIV prevalence variation is well established and is consistently higher among women across almost all age groups. By province, HIV prevalence among pregnant women attending antenatal clinic services ranged from 39.5% in KwaZulu-Natal to 16.9% in the Western Cape in 2009 (see figure 2). These provincial averages tend to mask district variations.

The protective effect of level of education to HIV infection has been documented in several studies. A study of impacts of HIV in the private security and legal services industry found
higher HIV prevalence of 24.5% among labourers and cleaners compared to professionals, managers and directors at 5.1%. This also shows that social economic status positively correlates with vulnerability to HIV infection.

**Figure 2: HIV Prevalence by Province**

![HIV Prevalence by Province](image)

Source: ANC report 2008 (DOH, 2009)

The age and gender dimensions of the HIV epidemic are illustrated in figure 3. Over half of the infections among females happen before age 35.

**Figure 3: HIV prevalence by age and sex, South Africa, 2008**

![HIV prevalence by age and sex, South Africa, 2008](image)

Source: HSRC 2008
4.4 Key Proximate Determinants of the HIV Epidemic

The key proximate determinants of the HIV epidemic in South Africa are categorized into immediate determinants such as behavioural, social and biological factors; and underlying or structural and societal factors such as poverty, gender inequalities, human rights abuses, migrant labour, etc. From the “Know Your Epidemic” and other analyses, the following have been highlighted.

**Behavioural and Social Determinants**

**Sexual debut**

Early sexual debut is a well-documented risk factor for HIV infection among young people. Close to 10% of young people reported having had sex before the age of 15 in 2008, with higher rates in males (13.1%) compared to their female counterparts (5.9%). The trend has not changed since 2002. Sex before 15 years of age, between 2002 and 2008, increased significantly in Free State (0.9% vs. 9.6%), North West (2.5% vs. 8.5%) and Mpumalanga (4.9% vs. 15%). This calls for specifically tailored prevention interventions for the youth to facilitate delay of sexual debut and to sustain protective behaviours.

**Multiple sexual partners**

The positive correlation between multiple sexual partnerships and HIV infection is well established. According to the 2009 National Communication Survey, 16.7% of men and 2.3% of women aged 16-55 years reported two or more sexual partners. An analysis of the three HSRC population surveys also found significant gender differences with males consistently reporting 4–7 times more multiple sexual partnerships in the last 12 months compared to females. The frequency of reported multiple partners varies by race and is highest among black African men. This calls for multi-level interventions focusing on sexual, social and cultural norms and values.

**Condom use**

To effectively prevent HIV infection, consistent and correct condom use is encouraged. Over the years both male and female condom distribution free by government has increased significantly from 308.5 million to 495 million and 3.6 to 5 million respectively between 2007 and 2009. However, unmet need remains high. Overall, reported condom use significantly increased between 2002 and 2008 in South Africa. At least 70% of the respondents with multiple sexual partners reported using condoms during the last sexual encounter in all the three population surveys. However, available data show that condoms are least likely to be used consistently among married couples and sexual partners in long-term relationships.

**Age-disparate sexual (intergenerational) relationships**

An analysis of the reported age gaps between sexual partners suggests that as men get older, the age gap with their partners gets bigger. The HSRC data show that sexual relationships between young girls aged 15-19 years and older men are risky – girls reporting an age-disparate relationship were 72% more likely to be HIV infected than girls with similar-aged partners (HIV prevalence 29.5% vs. 17.2%). In summary, men and women who have partners much younger/older than themselves are more likely to be HIV-positive than people who reported partners of similar age only.
**Alcohol and substance abuse**

South African data demonstrate that alcohol consumption is associated with risky sexual behaviour. A report by UNDP and the Sex Worker Education and Advocacy Taskforce (SWEAT) showed a strong link between alcohol and unprotected sex. A 2011 report from the MRC based on 20 studies in Africa indicates that 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 positively associated with multiple sexual partners and decreased condom use. Data on IDU and abuse of other substances in South Africa are scarce. However, IDU has been documented in studies in Europe and elsewhere as a practice that predisposes individuals to high risk of HIV infection through needle exchange and engaging in risky sexual behaviours.

**Prevention knowledge and risk perception**

According to the HSRC surveys, correct knowledge on prevention of sexual transmission of HIV was lower in 2008 than in 2005 in all age and sex strata except in males aged 50 or above. Correct knowledge on prevention and the rejection of misconceptions about HIV transmission has overall decreased especially in Limpopo (14% vs. 51.3%), KwaZulu-Natal (29.5% vs. 49%), Mpumalanga (18.2% vs. 27.9%) and Eastern Cape (36% vs. 44.3%). A relatively small proportion of the South African population perceive themselves to be at any significant risk for HIV infection. As a result, people continuously expose themselves to the risk of HIV infection because of wrong perceptions.

**Transactional sex**

The exchange of cash, gifts or services for sexual intercourse is closely linked with age-disparate sex. In South African surveys, reported frequencies of transactional sex vary widely; 2-52% of females and 4-30% of males have reported transactional sex experiences. Research in a number of sub-Saharan African contexts has conclusively demonstrated that exchange of sex for material resources is common practice, and that the vast majority of women who engage in such transactions do not see themselves as sex workers.

**Biological Determinants**

**Mother to Child Transmission**

According to the Department of Health, the rate of vertical HIV transmission at six weeks post-partum decreased from 4.3% in 2009 to 3.5% in 2010. Currently, all public health care facilities in South Africa provide antenatal care and CD4 testing services out of which 65% offer ARV prophylaxis for PMTCT on site. Statistics from the HCT campaign show that out of 311,499 HIV positive pregnant women 80% received ARV drugs to reduce the risk of mother to child transmission and 87% of the infants born to women living with HIV received antiretroviral prophylaxis in 2010. With a high HIV prevalence rates among pregnant women attending antenatal clinic services, PMTCT remains a critical intervention programme. Despite the decline at 6 weeks post-partum, there is a threefold increase in HIV infection rates at 18 months, reflecting the contribution of breastfeeding.
Male Medical Circumcision

As a result of new evidence showing that the risk of HIV transmission among circumcised men is significantly reduced, in 2010 South Africa instituted an aggressive rollout of a national male medical circumcision programme. The goal is to reach 80% of all men aged 15-49 by 2015. As at June 2011, a total of 237,812 male medical circumcisions had been conducted. Traditional circumcision is prevalent as a right of passage to adulthood among several communities in South Africa such as the Xhosa in the Eastern Cape.

Other Sexually Transmitted Infections

A number of studies have found out that other sexually transmitted infections, particularly ulcerative ones, are a risk factor for both HIV transmission and acquisition. Appropriate management of other sexually transmitted infections has been adopted as an HIV prevention strategy by countries including South Africa. In 2009 approximately 1.5 million patients with symptomatic STIs were reportedly treated at public health care facilities. First line management of STIs is currently conducted at 85% of public health facilities in the country. 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. Prevention and early treatment of other STIs should be a priority in South Africa.

Structural Determinants

Mobility and Migration

The risk of HIV infection has been noted to be higher among individuals who either have personal migration experience or have sexual partners who are migrants. Since the early stages of the epidemic, infections in rural areas were traced to those who had been in urban areas and truckers who were found to be at higher risk because of their greater mobility. Apart from internal migration, South Africa is a favoured destination for migrants from neighbouring countries in the SADC region who come to work in the mines and farms as well as in search for other forms of employment and better living conditions. The vast majority of these migrants are sexually active.

Gender Roles and Norms

The HIV epidemic in sub-Saharan Africa has deeply entrenched gender dimensions as women are disproportionately affected. Traditionally, in many parts of sub-Saharan Africa, women play a subordinate role in reproductive and sexual decision-making. Culturally, gender norms render women subservient to male partners. In South Africa women bear the brunt of the epidemic, as they constitute 55% of all people living with HIV. One example is the culture of pre-arranged marriages in the Eastern Cape that is still prevalent, marrying young women to older men thereby exposing them to a higher risk of HIV infection. However, gender norms and roles are undergoing change in South Africa. To make a dent on further spread of the HIV epidemic there is need to address the standing of women in society, particularly their economic standing.

Violence and Rape

South African data suggest a positive correlation between violence and HIV infection i.e. HIV-positive women are more likely to have experienced partner physical abuse. For example, in an HIV-negative cohort of young women in Eastern Cape, relationship power
inequity and intimate partner violence significantly increased the risk of incident HIV infection. With very high rates of violence against women and rape in the country, interventions on gender-based violence and rape should be prioritized.

**Social Cohesion and Social Capital**

As urbanization levels increase the traditional social fabric that hold families and societies together is fast disintegrating. Migration to the urban centres in search of employment has seen increases in unemployment and emergence of informal settlements. Higher HIV prevalence rates in informal settlements compared to formal and rural settlements in South Africa are well documented. Unemployment and deprivation often lead to risk taking thereby increasing vulnerability to HIV infection. There is evidence of a possible link between levels of social cohesion or social capital and HIV prevalence.

### 4.5 Tuberculosis

**Introduction**

According to World Health Organization (WHO) estimates, South Africa has one of the most serious tuberculosis (TB) epidemics in the world. South Africa currently ranks the third highest in the world in terms of TB burden behind India and China with an incidence that has increased by 400% in the past 15 years, reaching 970 new infections per 100,000 population in 2009\(^6\). This increase in incidence is compounded by high levels of multidrug-resistant tuberculosis (MDR-TB), almost 7500 confirmed cases in 2009 and the emergence of extensively drug-resistant TB (XDR-TB). The HIV epidemic is currently driving the TB epidemic with more than 70% of TB patients also living with HIV (figure 4) yet hardly half of them know their HIV status. To tackle the dual epidemics the government has decided to address the challenges of HIV and TB through an integrated approach.

**Figure 4: TB incidence and HIV prevalence trend in South Africa (1991-2007)**

![TB incidence and HIV prevalence in South Africa](image)

**Source:**

\(^6\) WHO Global TB Control Report, 2010
**Epidemiology of TB**

Approximately 1% of the South African population develop TB disease every year. Case detection for all forms of TB has steadily increased from 279,260 in 2004 to 401,608 in 2010. The number of new smear positive cases has remained stable during the same period (see figure 5 below). The highest prevalence of latent TB infection, estimated at 88% occurred among people in age group 30 – 39 in township situations and informal settlements. This underscores the fact that TB is a disease of the poor. Township and informal settlement conditions are characterized by overcrowding and low social economic status. The 2007 Statistics South Africa report indicated that TB is the leading underlying cause of death (13 out of every 100 deaths) in every municipal district in South Africa.

**Figure 5: TB Case Detection Trend (2004-2010)**

![Figure 5: TB Case Detection Trend (2004-2010)](image)

Source: National TB Programme.

People in age group 30–39 experience the greatest burden of both HIV and TB. The HIV epidemic has had negative impacts on the outcome of TB case management as those co-infected with HIV experience a higher mortality both during and after treatment. Among HIV positive patients who acquire extensively drug resistant TB (XDR-TB) mortality is almost 100% despite viral suppression with antiretroviral therapy (see figure 6).
Treatment outcomes vary across provinces as shown in the figure below. In 2009 Western Cape and North West recorded the highest and lowest treatment success rates respectively.

TB screening among people living with HIV is around 40% with a very low rate about 4% of isoniazid preventive therapy (IPT). There is late initiation of ART in TB patients, contributing to mortality. Prior to 2009 ART services were centralized making the treatment of TB patients living with HIV and in need of ART difficult at primary health care level. Treatment success rate of new infectious TB cases is around 73% compared to the global target of >85%.
4.6 Conclusion

The integrated strategy should guide programmes that will address the key determinants of the dual HIV and TB epidemics. Critical is the integration of services, ensuring all HIV positive people know their TB status and vice versa. Although South Africa has the largest HIV treatment programme in the world, its sustenance will depend on efforts to prevent new infections. The response will require a holistic approach that will mainstream HIV and TB responses in the national government development agenda. Government programmes to address unemployment and poverty are central to the HIV and TB prevention and control efforts.
CHAPTER 5 – GOVERNMENT’S DEVELOPMENT AGENDA AND HIV, STIs AND TB

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 and 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 and TB as also a development issue. Such a concept recognizes the socio-economic context in which the epidemics occur and the inter-relatedness of HIV and TB 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, STIs and TB invariably requires a broad understanding of national planning frameworks and priorities. Moreover, the magnitude of the South African HIV and TB epidemics 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.

Development and the constitutional framework

The founding provisions of the Constitution provide the framework within which the NSP 2012 – 2016 firmly rests, namely:

(a) Human dignity, the achievement of equality and the advancement of human rights and freedoms;
(b) Non-racialism and non-sexism;
(c) Supremacy of the Constitution and the rule of law.

Considered in its broadest terms, the Constitution lays down a set of ideals which the NSP 2012 – 2016 must strive towards, such as to heal the divisions of the past and to improve the quality of life of all South Africans. It also establishes a set of values that must be advanced and promoted, for example, non-sexism and non-racism, the achievement of equality, and the right to human dignity and freedoms.

Since 1994, government policies and programmes have firmly endorsed the imperative of equity, quality and access. To a large degree, these imperatives guide the NSP in terms of its implementation and performance.
The cooperative nature of the three spheres of government (national, provincial, local) as espoused by the Constitution has a critical bearing on the NSP 2012 – 2016. The Intergovernmental Relations Framework Act (IGR) aims to facilitate such cooperation. Since HIV and TB have an impact on across the three spheres of government, it is expected that the development of the NSP take place within the IGR framework.

A number of consultative bodies/forums have been established in order to give effect to the cooperative governance system, described below.

**The President’s Coordinating Council (PCC)** – a consultative body to deal with cross-sectoral issues, and therefore allowing for provincial and local government to contribute to national policy and ensure a coordinated response to implementing national policies and programmes at provincial and local level. The PCC is used to consult the provincial governments and organised local government on matters relating to the implementation of national policy and legislation in provinces and municipalities; the coordination and alignment of priorities, objectives and strategies across national, provincial and local governments and on other matters of strategic importance that affect the interests of other governments.

**Minister and Members of the Executive Council (MinMECs)** – are an example of best practice emerging from the need to oversee areas of joint concurrent competency between spheres as contained in Schedule 4 of the Constitution, especially provincial and national government.

**Budget Council** – where national government and the provincial governments consult on fiscal, budgetary or financial matters affecting the provincial sphere of government.

**Local Government Budget Forum** – which serves as a body where the three spheres consult on any fiscal, budgetary or financial matter affecting local government, any proposed legislation or policy that has a financial implication for local government, or any matter concerning the financial management or the monitoring of the finances of local government.

**Premiers’ Intergovernmental Forums (PIF)** – a consultative forum for the Premier and local government in the province which discusses the implementation of national policy and legislation that affects local government and discusses new national legislative and policy initiatives that will affect local government. Similarly, the impact of new and existing provincial policy and legislation is discussed in the PIF. Matters affecting local government that arose in the President’s Coordinating Council or in a MinMEC are discussed. The coordination of planning is a key performance area for a PIF. It must discuss the coordination of provincial and municipal development planning to facilitate coherent planning in the province as a whole. It pays specific attention to the alignment of provincial and municipal strategic plans.

**District Intergovernmental Forums (DIF)** – where the municipalities can discuss the implementation of national policy and legislation that affect the district and discuss upcoming national policy and legislation that will affect the district. The DIF is an ideal forum to discuss progress with regard to service delivery in the district as well as the problems that may impede such progress. Initiatives such as shared services models could also be dealt with at DIF meetings. The DIF plays a crucial role in the coordination of planning in the district. It must discuss the coordination of district and local Integrated Development Plans (IDPs) so that coherent planning in the district is facilitated. In terms
of the law, there is a duty on all municipalities to be ready to support other municipalities in the district. The implementation of this can be discussed at the DIF.

At a macro level, the 2009 – 2014 Medium Term Strategic Framework (MTSF) sets out the strategic mandate of government. The MTSF identifies ten strategic priorities that serve as the basis for determining the government’s implementation plans for the period to 2014:

1. Speed up economic growth and transform the economy to create decent work and sustainable livelihoods
2. Massive programmes to build economic and social infrastructure
3. A comprehensive rural development strategy linked to land and agrarian reform and food security
4. Strengthen the skills and human resource base
5. Improve the health profile of society
6. Intensify the fight against crime and corruption
7. Build cohesive, caring and sustainable communities
8. Pursue regional development, African advancement and enhanced international cooperation
9. Sustainable resource management and use
10. Build a developmental state, including improving of public services and strengthening democratic institutions.

In translating the above into outcomes, twelve key targets have been identified:

1. Quality basic education
2. A long and healthy life for all South Africans
3. All people in South Africa are and feel safe
4. Decent employment through inclusive economic growth
5. Skilled and capable workforce to support an inclusive growth path
6. An efficient, competitive and responsive economic infrastructure network
7. Vibrant, equitable, sustainable rural communities contributing towards food security for all
8. Sustainable human settlements and improved quality of household life
9. Responsive, accountable, effective and efficient Local Government system
10. Protect and enhance our environmental assets and natural resources
11. Create a better South Africa, a better Africa and a better world
12. An efficient, effective and development oriented public service and an empowered, fair and inclusive citizenship

The process from priority-setting based on the MTSF through the outcomes definition with measurable outputs and key activities, has laid a firm basis for signalling the focal areas that need to be addressed by the target date of 2014.

In the context of HIV, STIs and TB, where access to services has been a critical challenge, the re-engineering of PHC framework developed by the Department of Health will address many of the access-related issues. Another area of specific focus relates to the centrality of education as a protective factor against HIV risk; in this regard the Department of Basic Education will identify and rapidly implement interventions to increase school completion rates whilst looking at ways of reducing dropout rates. The rising number of orphans presents a unique and complex challenge for South Africa. The Department of Social Development is already considering a number of options such as promoting the concept of
family, encouraging South Africans to adopt orphaned children, thus providing a nurturing environment to enable full human capital. Recognizing the unique challenges faced by the Department of Correctional Services, a number of specific strategies will be put in place to improve access to health services, address infection control, measures to separate inmates with MDR-TB to reduce TB transmission, and interventions for staff.

The implementation 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. An appreciation of the above enables the NSP to focus strategically on interventions that will move the country closer to the achievement of both the short-term five-year vision and the longer-term 20-year vision. Given the profound impact of HIV and TB on progress towards the MDGs, the NSP 2012-2016 is crucial to our vision of a healthy life for all South Africans.
CHAPTER 6 – STRATEGIC OBJECTIVES OF THE NSP 2012-2016

6.1 Introduction

As noted in chapter 2, a range of principles has been adopted to guide the finalisation and implementation of the NSP and implementation plans. These principles, together with the consultation process described earlier, have culminated in the development of four strategic objectives for the NSP 2012-2016. The evidence generated by the Know Your Epidemic (KYE) report and other epidemiological studies, and strategic enablers also guides the strategic objectives. These are described below.

6.2 Key populations in the context of a generalised HIV epidemic

The term ‘key populations’ refers to those most likely to be exposed to or to transmit HIV and/or TB – their engagement is critical to a successful HIV and TB response, i.e. they are key to the epidemic and key to the response.

Even though South Africa has a generalised HIV epidemic and among the highest rates of TB infection and disease in the world, there are still higher levels of infection and transmission within certain geographic areas, as well as among some key populations. Though the NSP promotes a broad framework for addressing HIV, STIs and TB at a general population level, it also promotes that certain sub-populations should be targeted for specific prevention, care, treatment and support interventions based on their risk behaviours and their needs. This identification of key groups for intervention should be included in all implementation plans for SANAC sectors.

Accessing services and risk of HIV transmission and TB infection is also driven by inadequate protection for human rights, and prejudice. The KYE report highlights the areas where the epidemic seems to be concentrated, and some of the major risk factors for HIV infection. In the context of the NSP, key populations that are at higher risk for HIV infection include:

- The African black population is more likely to be HIV positive than 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;
- 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 adults 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;
- 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. Data suggests 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.\(^7\)

In addition to the KYE report, other studies have also highlighted at-risk populations:

- 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 studies among MSM ranges from 10.4% to 43.6%.\(^8\) 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. 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%.\(^10\)
- There are an estimated 10,000-50,000 injecting drug users in South Africa. In the 2008 HSRC household survey, there was an 11% HIV prevalence among people who inject drugs. Research shows 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.\(^11\) 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 alcohol abuse. A recent report by the UN Development Program (UNDP) and the Sex Workers Education and Advocacy Taskforce (SWEAT) illustrated a strong link between alcohol and unprotected sex – mainly as a result of the alcohol and drug induced disinhibition. Data from 2007\(^12\) indicates that 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.

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\(^7\) Know Your Epidemic report, 2011
\(^8\) 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?
\(^9\) Shisana, 2009
\(^11\) Parry, 2008. Medical Research Council
\(^12\) Fisher, LB et. al. 2007. Predictors of Initiation of Alcohol Use Among US Adolescents. Findings From a Prospective Cohort Study
Another key population that has not been sufficiently addressed in previous strategic plans and interventions related to transgender persons. Transgender people express a gender identity that is different from their birth sex. Due to a fundamental misunderstanding of this community, this population is often at risk for sexual abuse and marginalised from accessing prevention, care and treatment services.

Up to 80% of the South African population is infected with the TB bacillus, but certain populations are at very high risk of exposure or repeated exposure to TB infection. These high-risk groups include: health care workers, miners, prisoners, prison officers and household contacts of confirmed TB cases. In addition certain groups are particularly vulnerable to progressing from TB infection to TB disease, such as infants, young children, people living with HIV, diabetics, smokers, substance users and people who are malnourished, or have silicosis. However, little research has been done to quantify the contribution of the various risk factors to the TB burden in South Africa in the same way as the KYE studies have done for HIV and this will be addressed in this NSP. In addition, and similar to HIV, certain groups are considered key populations for TB because of their poor access to services to prevent, diagnose and treat TB and require special attention to ensure better access (e.g. migrants and refugees, informal settlement dwellers). Taking risk of TB infection, risk of progression from infection to TB disease and poor access to services into account, the following groups should be prioritised for TB services:

- Household contacts of confirmed TB cases
- Health care workers, miners, prison officers and prisoners
- Children and adults living with HIV
- Infants and young children
- Diabetics, smokers, people who are malnourished, drug users and alcohol abusers
- Mobile, migrant and refugee populations
- People living in poorly ventilated and overcrowded houses
- Working age adults

Based on the above risk profiles for HIV and TB the following sectors of the population should be targeted for specific types of intervention.

- Young girls – combination prevention interventions to enable them to make safe choices, e.g. preventing early sexual debut;
- Infants and children under the age of 15 – life skills education, early treatment;
- Sex workers (SWs) and their clients – combination prevention (including condoms, HCT, early treatment and TB screening);
- Men having Sex with Men (MSM) – combination prevention (condoms, potentially pre-exposure prophylaxis, behaviour change), early treatment;
- Mobile and migrants populations (e.g. truck drivers, mine workers, construction workers, seasonal farm workers) – combination prevention (HCT and TB screening), early treatment;
- The clientele of taverns and shebeens – combination prevention (male condoms, behaviour change communication);
- Inmates of correctional facilities – combination prevention (condoms, HIV and TB diagnosis, information) and treatment;
- People living in unstable communities, for example informal settlements – combination prevention and treatment; structural interventions;
- Men between ages 12-49 (the inclusion of young men is to offer MMC before sexual debut to offer optimal protection) – combination prevention (medical male
circumcision, condoms, social change, gender equality, violence reduction programmes, prevention messaging, HCT and TB screening)

- Sero-discordant couples – early treatment
- Pregnant women living with HIV – PMTCT, ongoing ART
- TB patients living with HIV – prevention interventions, treatment for TB and ART

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

### 6.3 Strategic Enablers

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 negatively impact on the achievement of the goals and objectives of the NSP.

There are several strategic enablers that have been identified for each of the strategic objectives to positively support implementation and there are strategic enablers that underpin the entire NSP, and these are outlined in more detail in later chapters. The strategic enablers are:

- Governance and institutional arrangements
- Effective communication
- Monitoring and evaluation
- Research

As there is not a separate chapter in which details for effective communication are outlined, these are described below.

**Effective Communication**

There are 3 types of communication critical to the achievement of the NSP.

First is communication within SANAC (including provinces) and between sectors ensuring that all players coordinate efforts and focus on achieving the goals of the strategic plan. There are numerous tools to improve communication and a comprehensive strategy needs to be developed and implemented by SANAC to ensure that continuous two way communication is in place.

The second type of communication critical for implementation is that of communicating with and through the media about the NSP and its goals, principles, interventions and successes and challenges. This is to gain buy-in from people not directly involved in SANAC and to ensure the widest possible acceptance of the strategic plan, enabling the country to work together towards the goals.

Thirdly social and behaviour change communication which encompasses individual, community and socio-political levels and includes advocacy, media, social/community mobilisation and campaigns is critical to changing risk behaviours and the social conditions that drive the HIV and TB epidemics.
A challenge for communication in a hyper-endemic country is to reach key populations while still ensuring that the national population is well informed and able to prevent and mitigate the effects of HIV and TB. Therefore all three types of communications must ensure that both key populations and the nation as a whole are targeted.

Each of the NSP strategic objectives will require major communication efforts at all levels. The communication should be integrated into the interventions from the research and development phase. In addition, South Africa needs renewed national campaign efforts – the recent HCT campaign has shown the benefit of consistent, clear messaging to drive results. These communication efforts must encompass all the various platforms for communication, including traditional media (newspapers, television, radio), but also social media platforms (FaceBook, Twitter, Mxit), SMS, local community dialogues and interpersonal communication.

Provincial and local communication efforts need to be tailored to reach particular communities or groups and the most vulnerable must be reached (such as persons with disabilities, sex workers and prisoners).

The communication strategy needs to be informed by research and the realities on the ground to ensure that the drivers (including structural and social drivers) of the epidemic are adequately addressed. Communication for human rights, social drivers of the epidemic and prevention has to be mostly outside of the health services, as the majority of non-infected people live, work and play outside of the health services.

Coordination is critical to national HIV and TB communication efforts and a body within SANAC to coordinate such efforts including different government departments, sectors and NGOs should be established that reports to the PIC.

Adequate funding to enable communication in multiple languages, including Braille and signing, as well as to ensure repeated reach at scale is needed to change and sustain healthy behaviours.

6.4 NSP 2012-2016 Strategic Objectives

Following the consultative process, the NSP 2012-2016 goals are to be achieved through interventions categorised in four strategic objectives, described below.

6.5 Strategic Objective 1: Prevention of HIV, STI and TB Infections

Targeted, evidence-based combination prevention informed by epidemiological data is needed to achieve the long-term goal of zero new TB and HIV infections. Focusing prevention efforts in high transmission areas and on key interventions that are likely to have the greatest impact, whilst sustaining efforts in the general population is one of the key strategic challenges of the NSP.

The primary strategies to prevent new HIV and STI infections relate to preventing sexual transmission and vertical transmission.

Key principles for these strategies are:
Combination Prevention

Preventing HIV and STIs (and TB) requires combination prevention interventions. This approach recognises that no single intervention can address the HIV and TB epidemics at population level. Combination prevention uses a mix of biomedical, behavioural, social and structural interventions that will have the greatest impact on reducing transmission, mitigating individuals’ susceptibility and vulnerability to infection, and the infectivity and impact of the infectious agents.

**Behavioural interventions** include a range of activities designed to encourage people to reduce behaviours that increase risk of HIV and increase protective behaviours. For example, delaying sexual debut; reducing multiple and concurrent sexual partnerships; reducing alcohol consumption (for HIV, STI and TB) and reducing cigarette smoking (for TB); promoting correct and consistent use of easily accessible and available male and female condoms and increase knowledge of one’s status.

**Social interventions** include efforts to change negative cultural and social norms that increase vulnerability to HIV and STIs and to reinforce those that are protective. Harmful social norms often make it difficult for individuals to change their behaviours and perpetuate norms that may discriminate against members of the community with certain diseases like HIV and AIDS and against those with different sexual orientations like the LGBTI community. It also includes interventions that promote positive social cohesion and community involvement. Many of these norms determine both the motivation for uptake of biomedical interventions and prevention related services as well as impacting on individual behaviour. Strategies to address these issues are dealt with in SO1, 3 and 4.

**Structural interventions**: The NSP cannot achieve its prevention objectives unless key high-risk determinants of HIV, TB and STIs are addressed. This includes poverty and inequality, lack of affordable and reliable transport to and from services, access to adequate nutrition; accessibility of services to persons with disabilities, high quality education, decent housing and accommodation designed with proper ventilation. Some of these are addressed in SO 4, while others are beyond the remit of the NSP. These are discussed in the chapter on the development context.

**Biomedical interventions** for prevention include medical male circumcision for men; prevention of vertical transmission; post-exposure prophylaxis for occupational injuries and rape survivors; and IPT for TB. Based on recent research findings, biomedical prevention should now include pre-exposure prophylaxis, treatment as prevention and microbicides.

**Integration of HIV prevention into Sexual and Reproductive Health Rights (SRHR) framework**

The delivery of integrated SRHR services as part of the PHC approach within a district health system is core to the success of the NSP. Comprehensive sexual and reproductive health and rights services includes all aspects of promoting a culture of sexual and reproductive rights, and all aspects of prevention, diagnosis, treatment and care in relation to sexual and reproductive health. Services to all clients should be age appropriate and relevant, including services for marginalised or vulnerable populations, such as persons with disabilities, transgender and intersex persons, same sex practising persons, sex workers and people living with HIV, among others, and must be provided without prejudice or bias.
Contraception and fertility management services (including termination of pregnancy services) must be provided to all communities to improve planning for safe, desired pregnancies. In addition, the types of contraceptives offered to HIV positive women should be improved and all efforts must be made to minimise drug interactions that affect the effectiveness of contraceptives.

**Sub-Objective 1: Reduce new HIV and STI infections by 50% by 2016**

Key interventions focus on young girls and women aged 12 years and above; pregnant women and girls and infants in relation to vertical transmission, survivors of sexual abuse and exploitation, sex workers (male, female and transgender) and their clients, prisoners, drug users, transgender people, MSM and WSW, discordant couples, internal and cross border migrants and communities along major transport routes.

Key geographic areas include informal settlements and hotspots along major transport corridors. All health facilities must ensure that every patient is offered a HIV test and that all that accept should also be screened for TB.

Examples of this combination prevention approach are:

For sex workers: decriminalisation of sex work, the provision of male and female condoms with lubricants, access to respectful sexual and reproductive health services, post-exposure prophylaxis, HCT at sex work venues/locations, peer educators, TB screening and services sensitive to the needs of transgender sex workers.

For adult men: condoms, medical male circumcision as part of sexual and reproductive health services, HCT for HIV and STIs, TB screening, social and behaviour change communication promoting health seeking behaviour, shifting norms on gender (masculinity, identity, gender equality) and gender based violence, structural interventions to reduce availability, affordable and advertising of alcohol.

For adolescents: adolescent-friendly sexual and reproductive health services, TB screening and HCT, delivery of comprehensive post-sexual assault care to child rape survivors, integrated school health services, appropriate sexuality and reproductive health education at schools from grade R to grade 12, social and behaviour change communication interventions to promote delayed sexual debut and safer sex and increase risk perceptions, particularly around intergenerational relationships and multiple and concurrent partnerships, parenting programmes to improve communication about sexuality and reproductive health and to reduce exposure to abuse in childhood, and violent behaviour, and interventions aimed at keeping children in schools.

For MSM and WSW: peer education, access to respectful sexual and reproductive health services, condoms and lubricants, STI management, pre-exposure prophylaxis, HCT, TB screening, and social and behaviour change interventions to increase safer sex, and to decrease stigma.

For persons with disabilities: combination prevention that includes targeted and accessible information and sexuality education, access to respectful sexual and reproductive health services, HCT and TB screening, provision of condoms, and STI management, with the provision of “universal design” and “reasonable accommodation” of disability; where universal design is not feasible, in regard to all HIV services, the review of laws and programmes in regards to disability inclusiveness and interventions to increase
sensitisation around issues of persons with disability, as well as their empowerment. Due to the unique access challenges for persons with disabilities, the health sector needs to address service delivery to ensure facilities are disability-friendly, provide comprehensive HIV, STI and TB services, and ensure their communication needs are addressed.

**Sub-Objective 2: Prevent vertical transmission of HIV to reduce MTCT to less than 2% at 6 weeks and less than 5% at 18 months by 2016**

Key to achieving the targets to reduce vertical transmission will be to strengthen the management, leadership and coordination to prevent vertical transmission integrated with maternal, child and women’s health (MCWH) programmes; scaling up and improving quality of PMTCT coverage, the integration of PMTCT into PHC services through enhancement of referral services and the increase of linkages allowing for a continuum of care inclusive of contraception, good quality ANC (including HIV testing before 14 weeks and at 32 weeks), delivery services and postnatal care, and infant feeding. Skill building and integration of community health workers with facilities will further enhance effective postnatal follow up of mothers and infants. TB screening will be integrated into the programme. Policies and services must be in place for testing all pregnant women for HIV. All women resting HIV negative initially need to have repeated HIV testing at intervals throughout pregnancy and postpartum, throughout breastfeeding. Partners should be encouraged to participate in PMTCT services, which should also seek to be an entry point to testing partners, children or family members. Systems must be in place to ensure the most effective antiretroviral-based interventions (whether as prophylaxis during gestation and breastfeeding, or lifelong ART to the mother) are implemented optimally throughout pregnancy, and postpartum.

The PMTCT programme will focus on strengthening infant feeding practices, supporting mothers to feed exposed infants safely. All infants known to be HIV-exposed, as well as those of unknown exposure status should be tested at 6 weeks postpartum and breastfed infants are to be retested at regular intervals until after cessation of breastfeeding. There needs to be effective entry into and retention in long-term HIV care and treatment services for all HIV-positive mothers, as well as rapid ART initiation in all HIV positive infants/children. Ensuring counselling on and access to effective fertility management for all women of reproductive age as well as postpartum for HIV-positive mothers, is key.

Finally, making appropriate resources available to ensure ongoing surveillance of PMTCT programme operations and outcomes, including postnatal transmission is critical.

**Sub-Objective 3: Preventing TB Infection and Disease**

A combination prevention approach is also necessary for an effective response to TB. The following interventions combine behavioural, social, structural and biomedical approaches.

**Intensified TB Case Finding**

Annual TB symptom screening for every South African through mass testing campaigns (community campaigns, schools, universities, workplaces, military, churches, taxi ranks and shebeens) with focused screening of all health facility attendees and high-risk populations (people living with HIV, TB contacts, pregnant women, health care workers, miners, prisoners and prison officers).
TB screening must be seamlessly linked with accessible TB diagnosis for all identified to have TB symptoms and treatment for all found to have TB disease. Turnaround time from identifying TB symptoms to starting treatment should be less than 2 working days (5 days for MDR TB). GeneXpert and nebulizers for inducing sputum with children and immune-compromised patients in whom TB symptom screens are less effective in identifying TB disease must be available. Interventions that focus on prompt diagnoses and treatment for smear negative TB and extrapulmonary TB are particularly important for people living with HIV.

Point of care tests for TB, HIV and CD4 should be available in every health facility by 2016 (dependent on available appropriate technology).

**TB Infection Control**

Instilling a culture of cough hygiene is essential to achieve better respiratory infection control in the community. A greater emphasis on TB and respiratory infection control is needed in health care facilities and other congregate settings to ensure a safe environment. TB infection control requires a combination of administrative, environmental and personal respiratory infection interventions. This should be delivered in the context of stricter infection control standards (including hand washing, safe disposal of medical waste, injection and sharps safety). 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 officer.

Respiratory infection control should also be prioritized in prisons, high-risk industries – mines, textiles, construction, agriculture (single sex hostels), taxis, schools, and for people living with HIV. Infection control should be considered as a component of health impact assessment for all new government projects and programmes, in particular in improving housing and building standards. Annual risk assessments should be carried out and 90% of high-risk institutions (health facilities, schools, prisons, and mines) should achieve a basic infection control standard.

**Isoniazid Preventive Therapy (IPT)**

There needs to be an acceleration of implementation, monitoring and evaluation of strengthened IPT policy for adults and children living with HIV and for child contacts of TB cases and a review of the use of IPT in mines and prisons. IPT should ideally be given to people living with HIV who are tuberculin skin test (TST) positive, but TST should not be a barrier to accessing IPT.

**Immunisation**

Implement a policy of 100% BCG vaccination for all infants without HIV. BCG vaccination protects children against serious forms of childhood TB such as TB meningitis (but does not confer protection against TB to adults).

There is a need to fast track the development of new TB vaccines that are effective in children and people living with HIV through advocacy for investment, public private partnerships, accelerated and novel licensing mechanisms and rapid uptake and implementation of effective candidate TB vaccines.
Prevention of MDR TB

Specific measures to prevent further development and spread of drug resistant TB include: improvement in identifying and curing drug susceptible TB and early detection and effective treatment of all MDR TB cases (reduce time from suspicion to starting standard 2nd line treatment – 5 working days, 100% of confirmed MDR-TB cases treated as per national and international guidelines with 60% treatment completion). Ensure guaranteed supply of and adherence to quality assured first and second line therapies in fixed-dose combinations.

Reducing TB related stigma, undernourishment, alcohol consumption and smoking

Interventions reducing stigma are important to facilitate health seeking behaviour and treatment adherence. Undernourishment, diabetes, smoking and alcohol consumption are significant risk factors for TB infection. Interventions to address these issues include supporting food security, reducing obesity, social and behaviour change communication as well as legislation aimed to regulate the availability of cigarettes and alcohol.

Sub-Objective 4: Universal Screening and Testing for HIV, STIs and TB

Universal access to HIV testing and STI, TB screening seamlessly linked to TB diagnosis, and TB and HIV treatment, care and support is a key intervention required to achieve the goals of the NSP.

Universal HIV testing and TB screening refers to annual testing and screening of every South African (for HIV – 12 years and older, sexually active, with previous HIV negative test, or of unknown status). The full package of screening, to be available in all clinical settings, will include HIV counselling and testing, TB symptomatic screening (symptom screen needs to be adapted to the individual's HIV status) as well as screening for diabetes, mental health, blood pressure and anaemia, psychological and social support. Screening for domestic violence and child abuse should also be part of the PHC package and package of social services.

It is only through knowing one’s HIV or TB status that appropriate interventions and services can be accessed and positive prevention implemented. There is evidence that HCT can bring about behaviour change for those who test positive.

Testing services must also take place at multiple settings to reach all at-risk populations, including homes (by community health workers), in workplaces, in schools and tertiary institutions, social grant distribution points, correctional services and through mobile services in communities (e.g. sporting events, taxi ranks, and malls) and for sex workers at sex work venues and locations. Provider initiated counselling and testing (PICT) should be offered for all patients, including children accessing health care services, regardless of complaint.

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

Mental health services should be available in all health and social services facilities given the impact of testing positive and being on chronic medication for the length of one’s life.
Strategic Enablers

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

- Locating HIV and STI prevention within a Sexual and Reproductive Health and Rights (SRHR) framework
- Ensuring up-to-date information on the magnitude, severity and impact of the epidemics, including hotspots for HIV and TB transmission
- Building the capacity of multisectoral service providers
- Integration of TB and HIV services – All TB suspects and patients should be encouraged to test for HIV and all HIV positive TB patients started on ART.
- Targeted social and behaviour change communication to shift social and cultural norms and values that increase vulnerability to HIV, and to reinforce protective ones, to create demand and effective use of HIV, STI and TB services as well as to ensure accurate knowledge and use of prevention strategies (e.g. how to use condoms correctly and the importance of consistent use; what constitutes safe circumcision etc.). This also includes knowledge on sexual and reproductive rights and responsibilities.

Unless otherwise stated the baseline targets for these goals and objectives are 2010 figures (as 2011 data is not yet available).

These sub-objectives build on what we know, but the NSP acknowledges the need to allow scope for exploration of alternative / new combination prevention efforts that may emerge in future.
### Strategic Objective 1: Objectives and Interventions

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<th>Objective</th>
<th>Intervention</th>
<th>Indicator</th>
<th>Target</th>
<th>2012</th>
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<th>Costing and Source</th>
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<tr>
<td>Prevent new HIV and STI infections by 50% by 2016 through the provision of targeted combination prevention focussing on key biomedical, behavioural, social and structural drivers; Prioritised intervention mix based upon hotspots and district level variations</td>
<td>Increase access to contraception (including male and female condoms) and fertility management services (including TOP) to all adults and youth with the strengthening of adolescent friendly health services</td>
<td>Number of survivors of sexual assault/abuse (disaggregated to include children and LBTGI) receiving package of post assault care</td>
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<td>Expand provision of MMC from 12 years and older</td>
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<td>Ensure a comprehensive package of post sexual assault care for adults and children, including PEP to all eligible</td>
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<td>Implement key interventions for adolescents and young women, prisoners, sex workers and their clients, discordant couples, MSM, transgender people, people who use drugs (based on a harm reduction philosophy), and people with disabilities</td>
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<td>Behavioural:</td>
<td>Scale up social and behaviour change communication interventions promoting sexual and reproductive health and rights including delayed debut, safer sex and health seeking behaviours (communication to</td>
<td>Number of male and female condoms distributed</td>
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<td>Other indicators for safer sex including delayed sexual debut</td>
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<td>Implement integrated school health programmes (including SRHR and TB) with appropriate referrals for diagnosis, treatment and psychosocial support.</td>
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<td>Age appropriate Sexuality and Reproductive Health and Rights education in schools, combined with effective Life Orientation from Grade R to Matric</td>
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<td>Annual developmental screening of all children under 5 years</td>
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<td>Ensure parenting programmes to improve communication about sexuality and reproductive health and to reduce exposure to abuse in childhood, and violent behaviour</td>
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<td>Prevent vertical transmission of HIV to reduce MTCT to less than 2% at 6weeks and 4/5% at 18 months by 2016</td>
<td>Strengthen the implementation of the 4 prongs of the PMTCT programme. These are:</td>
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<td>1. Primary HIV prevention among women and girls of childbearing age</td>
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<td>Reduce TB case registration rate by 50% by 2016</td>
<td>4. Treatment, care and support for women living with HIV, their children and families (see SO2 and SO4)</td>
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<td>Reduce TB infection rates in children by 30%</td>
<td><strong>Biomedical:</strong></td>
<td>% of estimated number of people living with HIV in need on ART % of estimated number of PLHIV on IPT</td>
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|                                                                          | • Increased access to HIV testing and early initiation of ART < 350 cells/mm3  
• Provide IPT for all people living with HIV without active TB (preferably only those who have a positive tuberculin skin test.  
• Offer TB screen and HIV testing to the household contacts of all TB cases and provide IPT to all who are eligible  
• Provide BCG vaccine to all newborns that are not living with HIV, according to WHO guidelines | TB infection rate in cohorts of children measured through sentinel surveillance sites (to be established) % household contacts screened % household contacts < 5 given IPT % newborns *(without HIV infection) given BCG vaccine |                          |
<p>|                                                                          | <strong>Behavioural:</strong>                                                                                                                                                                                                                                                          |                                                                                                                                                                                                          |                          |
|                                                                          | • Communication campaigns to increase health seeking behaviour and cough hygiene                                                                                                                                                                                      |                                                                                                                                                                                                          |                          |
| Universal HIV, STI and TB screening and testing                         | Implement provider initiated HIV counselling and testing (PICT), STI and TB symptomatic screening in all entry points of public and private                                                                                                                                                         | % population screened for TB (disaggregated by high risk groups)                                                                                                                                      |                          |</p>
<table>
<thead>
<tr>
<th>Objective</th>
<th>Intervention</th>
<th>Indicator</th>
<th>Target</th>
<th>Costing and Source</th>
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<td></td>
<td>health care and in non-health settings</td>
<td>% of those with a positive TB screen who were tested for TB</td>
<td>2012</td>
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<td>% of those investigated who start TB treatment</td>
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<td>Turnaround time from identifying TB symptoms to starting TB treatment &lt;2 days (5 days for MDR TB)</td>
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6.6 Strategic Objective 2: Sustain Health and Wellness

The primary focus of strategic objective 2 is significant reduction in deaths and disability as a result of HIV, TB and STI infection through universal access to accessible, affordable and good quality diagnosis, treatment and care.

The five-year objectives for strategic objective 2 are to:

- Reduce disability and death resulting from HIV and TB
- Ensure universal access to TB diagnosis and HIV and TB treatment, care and support;
- Ensure that people living with HIV, STIs and/or TB 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 living with HIV, STI and/or TB disease.

The core strategies for this strategic objective relate to early improved diagnosis of HIV, TB and STI, improved access to speedy, appropriate and user-friendly treatments (including rehabilitation) and retention in treatment and care. 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, and if implemented appropriately, will address much of the concerns regarding the last NSP, in terms of programme reach, early diagnosis, follow-up, support to adherence and retention in care.

Sub-Objective 1: Reduce disability and death resulting from HIV, TB and STIs

Critical to this objective is early accurate diagnosis and initiation of treatment according to guidelines. There are significant prevention benefits associated with earlier treatment for HIV, TB and STIs, e.g. early treatment of HIV will reduce the risk of TB disease.

Intervention 1.1: Ensure every person is screened annually for HIV, TB and STIs

All screening should be done with adequate counselling, including being conscious of persons with communication, cognitive and physical disabilities. Screening must be closely linked to follow up clinical and laboratory investigations for those with TB symptoms and appropriate treatment. HIV staging and TB/STI resistance point-of-care diagnosis should be done where possible. All these interventions must link with Department of Health initiatives to improve quality.

For screening to be comprehensive, it should be extended to non-conventional areas and communities with high burden of disease and/or poor access to services, described below in sub-objective 2.

This intervention should be commenced as soon as possible, with the primary care revitalisation programme being central, with full coverage by 2016.

Intervention 1.2: Improve HIV, TB and STI contact tracing to facilitate early diagnosis, using primary health care revitalisation
Traditionally, TB was thought to largely transmitted in households, however data suggests that transmission takes places in most congregate settings, like prisons, health facilities, churches, shebeens, pension pay points and within public transport. Community health workers and health professionals will be expected to confidentially and sensitively facilitate contact screening for HIV, TB and STIs. Testing and screening services should be accompanied by educational and awareness programmes. In addition, outreach programmes should be used to also screen for other chronic diseases, i.e. diabetes and hypertension.

- Sexual contacts of people diagnosed with HIV and/or STIs should be followed up and screened in the household and community.
- There is evidence of TB spread within churches, and screening programmes attached to congregations could be easily implemented.
- Shebeens, taxis, public transport areas and pension points should, at minimum, be the focus of HIV, TB and STIs education programmes, but preferably where feasible with active screening programmes attached.

This intervention should be a prime function of the ward based primary care outreach teams as well as school health services and should strengthen referral and community follow up to ensure rapid treatment initiation, increase adherence, and eliminate loss to follow-up.

**Intervention 1.3: Accelerate access to accurate TB diagnosis with reduction in time from TB suspicion to starting treatment to less than two working days (≤5 working days for MDR-TB)**

This requires better links between TB screening sites and strengthened clinical and laboratory services with greater availability of GeneXpert, rapid TB culture and drug sensitivity testing, and other new diagnostic technologies and interventions to improve diagnosis of extra-pulmonary and smear-negative TB.

**Intervention 1.4: Ensure access to affordable, high-quality drugs to treat TB, HIV and STIs and their sequelae**

Ensure adequate supply of quality-assured, affordable (lowest cost) first and second line TB drugs through for example local production, pooled procurement, negotiated price reductions, improved regulatory approval and better supply chain management. In addition, access to paediatric TB formulations must be assured. Common drug combinations should be available as fixed dose combinations to reduce the pill burden and improve adherence. In addition, access to paediatric formulations and FDCs must be assured. This will enhance adherence, reduce dosage mis-prescribing, and reduce the dispensing load within pharmacies. New drugs, especially for MDR-TB and resistant HIV, must be fast-tracked through the registration and tender processes. Expanded access to opportunistic infection medication, such as gancyclovir and macrolides, needs to be made available at primary care.

**Intervention 1.5: Ensure the fastest possible enrolment into appropriate treatment for HIV and TB, after screening and diagnosis**

Loss to follow-up, especially if referral is required, is very high within the system. Better links are needed between TB screening sites and strengthened clinical and laboratory services with greater availability of GeneXpert, rapid TB culture and drug sensitivity
testing, and other new diagnostic technologies and interventions to improve diagnosis of extrapulmonary and smear-negative TB.

STIs are almost always treated immediately on diagnosis, and hence no intervention is required (except that syndromic management guidelines must be followed by health professionals in the private and public health sectors).

- All ART started within 2 weeks of staging and adherence eligibility being confirmed.
- All TB treatment to be started <48 hours after TB suspected at screening site (<5 days for MDR TB).
- All primary care, antenatal, TB and mobile outreach health facilities to become fully functional nurse-initiated ART and MDR TB initiation sites for adults, children and pregnant women.
- Unless otherwise clinically indicated all patients started on ART and MDR-TB treatment should be managed at PHC level
- Ensure 90% treatment completion for drug susceptible TB (60% for MDR TB)

Expectations should be conveyed to clinics, with management responsibility and M&E systems to track success.

*Intervention 1.6: Children/Adolescence/Youth treatment specific recommendations*

Child mortality is a good indicator of failing health systems, and should trigger urgent action to prevent unnecessary morbidity and mortality. Unfortunately, poor monitoring systems often mean this information is not available or is inaccurate. The following interventions are key:

- Notification of all paediatric cases of HIV, with an investigation and report at a sub-district level
- Specific child indicators need to be prioritised in the M&E system, with management interventions if not reached; these include 90% of children maintained on ART and/or TB treatment at primary care facilities; milestone screening and interventions will allow for early identification of HIV-related stunting
- Routine HIV testing and PCR screening, with adequate counselling
- Strengthened and standardised TB diagnostic approach in children including access to nebulisers for sputum induction and GeneXpert
- Strengthening clinics to offer child and adolescent-friendly HIV/TB services, including adherence support programmes, as part of the quality improvement initiative;

*Intervention 1.6: Initiate all TB patients and pregnant women on lifelong ART, irrespective of CD4 count*

In line with WHO recommendations all TB patients and pregnant women should, with immediate effect, be on ART irrespective of CD4 count. This intervention recognises the high mortality associated with HIV/TB co-infection, as well as the benefits for maternal health and PMTCT of having women on treatment.
Intervention 1.7: Design of a patient-centred pre-ART package for patients with HIV not requiring ART

Loss to follow-up of HIV-infected patients with high CD4 counts is very high. This results in many patients returning late to care –when they are ill. Pre-ART packages should be designed around what patient’s value, rather than simply what health providers believe they need. Positive Health Dignity and Prevention interventions, including safe sex, fertility, and health advice, must be considered within the package of care.

Intervention 1.7: Immediate up-referral for all complicated HIV, TB and STI cases

Referral services to ensure patients with difficult presentations, experiencing complex toxicity or multi-drug resistance, are able to have clear, rapid referral pathways and access to expanded ART / treatment choices must be development and implemented urgently.

Intervention 1.8: Ensure all HIV-positive people with low CD4 counts are screened for cryptococcal infection and given appropriate treatment

Cryptococcal infection which is the second commonest serious opportunistic infection after TB, produces much morbidity (including blindness and deafness) and mortality, is complex and expensive to treat, and occurs generally at CD4 counts of less than 100 cells/ul. Screening on all samples where the CD4 counts is less 100 should be routine and reported along with the CD4. Treatment should be given to all asymptomatic patients, and symptomatic patients referred for inpatient care.

Sub-Objective 2: Ensure universal access to treatment, care and support for HIV, TB and STIs

Central to this objective is recognition that services, including screening, need to move beyond conventional health care provision areas, and that certain groups require specifically tailored interventions.

Intervention 2.1: School-based screening and support for children with HIV, TB and STIs

Children bear a large burden of new cases of TB; increasingly, it is recognised that adolescents are very vulnerable to STIs, including HIV. Adolescents require special adherence and counselling support for HIV, TB and STIs, and schools remain a critical support venue. The Departments of Basic Education and Health must ensure that an integrated school health programme is fully implemented over the lifespan of this NSP. The screening package should be designed around a broader reproductive health and sexuality intervention, including fertility, circumcision, family planning, condoms, and protection from violence and substance harm. HIV positive children and adolescents often have complex disclosure and adherence issues that require specialised support. If this is not available within the school, clear referral systems must be in place. Schools focusing on children with disabilities must be prioritised, and integration of disability programmes within ordinary schools improved.

Intervention 2.2: Rural support, farm worker, informal urban and peri-urban settlements and traditional healers support through primary care revitalisation

13 What used to be referred to as Prevention with Positives
Rural and farm worker communities and those in informal settlements continue to be underserved. Long travelling distances, and the lack of health care staff, often lead to these populations being poorly served. Primary care revitalisation must be prioritised for these areas, and include access to farm workers and their families as well as those living in informal urban and peri-urban settlements. Creation of adequate and timely referral systems, with clear accountability and transport, must be the responsibility of managers of the district health system.

Where appropriate, partnering with traditional healers to create mutually respectful referral programmes should be piloted. Better referral and information systems for patients moving between cities and home rural areas, will facilitate continuity of care. Finally, communication programmes can be effective for these populations.

**Intervention 2.3: Targeted programmes of HIV, TB and STI screening and support for specific groups**

The Know-your-epidemic report provides good evidence for those at risk for HIV, and suggests communities that would benefit from focused support. In addition, there are communities that have specific needs.

- **Sex workers**: Traditionally, this group has been very difficult to reach with clinical services, due to criminalisation, high levels of police harassment, and stigma and discrimination. Treatment programmes directed at targeting HIV, TB and STIs as part of a broader mobile health and prevention package should be developed where there are large concentrations of brothel- and street-based sex workers. An enabling legal framework, health care worker sensitisation and sex worker involvement, is imperative for the effectiveness of this intervention.

- **Drug and heavy alcohol users**: Illegal drug users suffer from similar legal and stigma issues as sex workers; use of drugs and alcohol impede adherence and may enhance medication side effects. A package of interventions should be designed to address HIV, TB and STIs within this community. Drug and alcohol screening in all suspected poorly adherent patients should be routine. Treatment and referral interventions should be routinely available within primary health care clinics.

- **Prisons and detention facilities**: These facilities have high rates of TB and high rates of HIV. The Department of Correctional Services must commit to annual HIV, TB and STIs screening, and prompt treatment of all detainees and prison officers.

- **Workplaces**: Certain workplaces and working conditions lend themselves to being priority areas for improved detection and treatment, and where services should be routinely offered. These include: mining areas, where HIV, STIs and especially TB is prevalent; truckers, where access to services is sporadic; and healthcare arenas, where TB is an occupational hazard. Workplaces in general lend themselves to screening programmes for HIV, TB and STIs, and all employers and labour unions should ensure that all formal sector and informal sector employees are tested and screened annually.

- **Refugees, legal foreigners, undocumented migrants**: Health care workers must ensure that all refugees, legal foreigners and undocumented migrants are screened for TB and tested for HIV in line with Department of Health policies and guidelines. The Departments of Health, Correctional Services and Home Affairs jointly develop and implement guidelines and to implement these guidelines uniformly within the relevant facilities.

- **Persons with Disabilities**: Screening and testing programmes that focus on this group must use tailored interventions according to specific needs of persons with
disabilities. Access to health services for persons with disabilities is still often difficult and must be addressed urgently. Universal design of all facilities, and accessible communication (and where not possible, reasonable accommodation), is imperative and must be designed and implemented in partnership with organisations focusing on the needs of persons with disabilities.

*Intervention 2.4: Implement innovative technologies for HIV, TB and STIs*

Every effort must be made to ensure that innovative diagnostic technologies for HIV, TB (including drug resistant TB) and STIs are used with due regard to cost and quality of care. This includes 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, with an emphasis on tests appropriate for environments with minimal resources (such as no electricity).

*Sub-Objective 3: Ensure that people living with HIV, TB and STIs remain within the health care system, are adherent to treatment and maintain optimal health*

*Intervention 3.1: Support the primary care revitalisation expansion, with a strong focus on provision of medication and support at the household level*

Household contact is a major part of the work of the ward-based primary health care outreach teams in the new primary care revitalisation programme. Currently, medication is delivered from health care facilities or couriers (in the private sector), and in the case of the former, places huge burdens on employed and rural people with chronic conditions. This intervention is critical to decentralised community-based programmes.

The primary health care system should be re-engineered to facilitate the following:

- Delivery of routine chronic medication, including antiretrovirals and TB medication.
- Active screening for medication side effects, with appropriate referral (including palliative care)
- Adherence check and basic mental health screening, with appropriate referral (including to drug and alcohol use and other support programmes)
- Infection control checks in the case of TB
- Collection of TB sputum samples for resistance testing
- Screening of family members for HIV, TB and STIs
- Provision of all palliative care interventions, including morphine

*Intervention 3.2: Development of a single patient identifier for ALL residents in South Africa*

Currently, the country lacks the ability to track usage patterns of individual patients within the system. In addition, poor record keeping and communication leads to huge costs, delays in diagnosis and treatment, with unnecessary repetition and loss of laboratory, radiological and clinical records. Referral of patient’s between facilities is often poorly coordinated, with missing information. A single patient identifier would allow for this to start being addressed, especially as electronic and internet systems become more available in all facilities. Immediate M&E benefits would be seen, along with laboratory follow-up. The Department of Health must begin to look at implementation options, and explore confidentiality restrictions with relevant stakeholders.
Ethical, confidentiality and operational issues should be discussed with relevant groups by end of 2012, and a decision made, with implementation in 2013 if feasible.

**Intervention 3.3: Regular communication using national media**

A national communication strategy must be developed and implemented which includes daily adherence reminders, using SMSs and creative use of media, new media and networks, especially using radio and television, to describe benefits, side effects of HIV, TB, STI and other chronic diseases medication. The national broadcaster should provide the space and resources free of charge as part of their contribution to mitigating the epidemic.

**Intervention 3.4: Implementation of the HPV vaccine among girls at schools**

This intervention has an STI control component, effectively prevents cervical cancer, and may have some HIV prevention value. The HPV vaccine poses specific challenges, as it will need to be administered in pre-adolescents or adolescents, which will practically need to happen at schools to have maximum coverage as it requires multiple dosage administration. Vaccine coverage will only be achieved with cooperation with schools bodies and the Department of Education. The provision of this vaccine further allows for engagement with parent and teacher bodies on vulnerabilities regarding HIV.

**Sub-Objective 4: Ensure that systems and services remain responsive to the needs of people living with HIV, TB and STIs**

**Intervention 4.1: Integration of HIV and TB care with an efficient chronic care delivery system**

Clinics should offer an integrated chronic care package that emphasises rapid transit through the system of patients with chronic illness. The Department of Health must fully implement the guidelines for TB/HIV integration with due care being paid to limiting cross infection. In addition, the Department must reorganise the delivery of services for people with chronic illnesses to ensure greater efficiency and effectiveness of the service and to reduce the burden on patients.

**Intervention 4.2: Clinics to provide services on weekends/out of hours**

Most primary health care facilities operate on a 5-day, 8am to 4pm basis. This makes these services inaccessible to many people who require primary health care services, including the employed and those who live in rural communities who travel long distances to seek care. Relooking at clinical services required at different times will allow for broader access to treatment, and better use of scarce health care resources.

**Intervention 4.3: A single registry at primary care**

The plethora of and vertical nature of reporting requirement and formats has hampered progress on tracking the programme efforts and outcomes. Rationalization of disease-specific registers should occur, as a single register for all conditions compatible with the national health information systems.

**Intervention 4.4: Strengthen quality standards to ensure world-class treatment and care services**
The Office of Standards Compliance to be established by the Department of Health should play a major role in ensuring that the quality of care is improved. Actions to be taken to improve quality should include:

- Facility based targets, with management support and accountability, especially regarding waiting times, staff attitudes and ease of access, including for persons with disabilities
- A national anonymous reporting centre for drug stock outs, service interruptions and complaints regarding staff attitudes/ confidentiality loss, with an independent ombudsperson
- Performance improvement benchmarks for each level of the system.
- National standards for user experience – waiting times, staff attitudes, repeat visits for the same complaint.
- Regular periodic audit of compliance with national guidelines
- Periodic review of clinical protocols, with a strong emphasis on consistency and implementation feasibility, especially in rural areas
- All QI initiatives must be marketed as service interventions, not stand alone interferences from outside programmes

_Intervention 4.5: Adequate monitoring of STI drug resistance nationally_

Drug resistance threatens the adequate provision of STI care, and can spread rapidly. Surveillance efforts by NICD should be actively supported, reported back to guidelines committees, and recommendations adjusted accordingly.
### Strategic Objective 2: Objectives, and Interventions

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<tr>
<th>Objective</th>
<th>Intervention</th>
<th>Indicator</th>
<th>2012</th>
<th>2013</th>
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<th>2015</th>
<th>2016</th>
<th>Costing and Source</th>
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<tbody>
<tr>
<td>Reduce disability and death resulting from HIV, TB and STIs</td>
<td>Ensure that all residents, including hard-to-reach groups and non-South Africans, are screened annually for HIV, TB and STIs</td>
<td>% of population, including children, reached</td>
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<td>90%</td>
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<tr>
<td>Improve HIV, TB and STI contact tracing, investigation and treatment in households, workplaces, churches and selected high transmission zones, to facilitate early diagnosis, using primary health care revitalisation</td>
<td>Number of contacts screened, number of contact points accessed</td>
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<td>Ensure access to affordable, high-quality drugs to treat TB, HIV and STIs and their sequelae</td>
<td>% TB, HIV and STI drugs available in South Africa at equivalent or lower cost than global average</td>
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<td>% TB, HIV and STI drug combinations in national policy available as FDCs</td>
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<td>No. drug stockouts at national, provincial, district and facility level</td>
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<td>% TB, HIV and STI drugs recommended in national policy that are fully registered by MCC</td>
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<td>Ensure the fastest possible investigation and enrolment into</td>
<td>% of ART started within 2 weeks of HIV diagnosis</td>
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<td>appropriate treatment for HIV and TB, after screening and testing, including:</td>
<td>% TB patients started on treatment within 48 hours of suspicion (by sensitive and MDR-TB)</td>
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<td>2016</td>
<td>Costing and Source</td>
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<td></td>
<td>ART initiation within 2 weeks</td>
<td>% PHC facilities initiating ART and MDR-TB treatment</td>
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<td>TB treatment within 48 hours of identification of TB symptoms</td>
<td>% confirmed TB cases started on treatment</td>
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<td>All primary care, including ANC and TB, and mobile clinics, to start ART and MDR treatment</td>
<td>% ART managed at PHC level</td>
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<td>100% of confirmed TB cases started on treatment</td>
<td>TB treatment completion rate (by sensitive and MDR-TB)</td>
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<td>90% of all ART management to be at primary care</td>
<td>TB case fatality rate by HIV status</td>
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<td>90% TB treatment completion (60% MDR treatment completion)</td>
<td>% of TB cases that die by the end of treatment</td>
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<td>Children/Adolescence/Youth treatment specific recommendations</td>
<td>% of children started and maintained on ART/TB treatment at primary care facilities; % receiving HIV testing/PCR at EPI; % of clinics fulfilling 'child friendly' quality indicators; children screened for delayed milestones; client satisfaction questionnaires</td>
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<td>Initiate all TB patients and</td>
<td>% eligible initiated</td>
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<td>pregnant women on lifelong ART, irrespective of CD4 count</td>
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<td>Design of an incentive-based pre-ART package for patients with HIV not requiring ART</td>
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<td>% retained in care over 1 year; % receiving IPT</td>
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<td>60%</td>
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<td>Immediate up-referral for all complicated HIV, TB and STI cases</td>
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<td>Audit of referral processes at selected facilities - % with understood, easy and appropriate referral</td>
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<td>Ensure all HIV-positive with low CD4 counts are screened for cryptococcal meningitis and given appropriate treatment and rehabilitation</td>
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<td>% of eligible patients receiving fluconazole</td>
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<td>Ensure universal access to treatment, care and support for HIV, TB and STIs</td>
<td>School-based screening and support for children with HIV, TB and STIs</td>
<td>% of scholars screened annually; % of schools offering either school based adherence or appropriate referral programmes</td>
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<td>Rural support, farm worker and traditional healers support through primary care revitalisation</td>
<td>% of rural population seen annually by community health worker; audit of appropriate/ available referral</td>
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<tr>
<td></td>
<td>Targeted programmes of HIV, TB and STI screening and support for specific groups including:</td>
<td>Number of programmes, number of participants reached in each; focused client satisfaction questionnaire looking at staff attitudes, service provision, etc.</td>
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<tr>
<td></td>
<td>• Sex workers</td>
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<tr>
<td></td>
<td>• Drug and alcohol users</td>
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<tr>
<td></td>
<td>• Prisoners and detainees</td>
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<tr>
<td>Objective</td>
<td>Intervention</td>
<td>Indicator</td>
<td>2012</td>
<td>2013</td>
<td>2014</td>
<td>2015</td>
<td>2016</td>
<td>Costing and Source</td>
</tr>
<tr>
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</tbody>
</table>
| • Workplaces: mines, truckers, healthcare workers  
• Refugees, migrants etc.  
• Disabled | Implement innovative technologies for HIV, TB and STIs | Number of technologies rolled out | | | | | | |
<p>| Ensure that people living with HIV, TB and STIs remain within the health care system, are adherent to treatment and maintain optimal health | Support the primary care revitalisation expansion, with a strong focus on provision of medication and support at the household level, including rehabilitation | % of patients receiving and % of disease burden addressed through community health worker home-based care ; % of disabled receiving home based care | | | | | | |
| | Development of a single patient identifier for ALL residents in South Africa | % of residents with identifier | | | | | 90% | |
| | Regular communication using national media | % of population reached with daily messaging | | | | | | |
| | HPV vaccines in schools | % girls receiving full vaccination course | | | | | 90% | |
| Ensure that systems and services remain responsive to the needs of people living with HIV, TB and STIs | Integration of HIV and TB care with an efficient chronic care delivery system | % of clinics offering integrated chronic care | | | | | 90% | |
| | Clinics to provide services on weekends/out of hours | % of clinics offering this | | | | | 90% | |
| | Fixed dose combinations and accelerated access to appropriate HIV, TB and STI drugs, and expanded access to opportunistic treatment | Number of new FDCs and drugs offered and used | | | | | | |
| | A single registry at primary care | % of clinics implementing primary care registry | | | | | 100% | |</p>
<table>
<thead>
<tr>
<th>Objective</th>
<th>Intervention</th>
<th>Indicator</th>
<th>Target</th>
<th>Costing and Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Introduce quality standards to ensure world-class treatment and care services</td>
<td>Facility based targets; implementation of a reporting centre; establishment of benchmarks; periodic reviews</td>
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<td></td>
<td>Address core standards for health service delivery</td>
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<td></td>
<td>Adequate monitoring of STI drug resistance nationally</td>
<td>Annual reports; regular guideline assessment</td>
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6.7 Strategic Objective 3: Protection of Human Rights and Promotion of Access to Justice

Introduction

South Africa’s response to HIV, STIs and TB, which recognises the centrality of constitutional values and human rights, is based on the understanding that the public interest is best served when the rights of those living with HIV or TB – or at the greatest risk of infection – are respected, protected and promoted. Not only is this sound, globally accepted public policy, but it is also in line with the rights entrenched in Chapter 2 of the Constitution and the obligations they impose on the state regarding their progressive realisation. Amongst others, these include the rights to equality, dignity, life, freedom and security of the person and privacy.

The NSP takes as a starting point the constitutional recognition that access to health care services is itself a fundamental right, with the state taking primary responsibility for ensuring access. In this regard, each strategic objective – where appropriate – addresses the specific access needs of particular groups such as women (pregnant, with child-bearing potential or post-menopausal), men, adolescents, children, persons with disabilities, etc. Ensuring access to health care services requires that interventions be planned and implemented in a manner that understands their specific needs and the social, cultural and other barriers that may stand in their way of accessing services.

Respect for and the protection and promotion of human rights are central to all aspects of the NSP, which is why this strategic objective first considers the legal and human rights implications of interventions. It does this in two ways: first by dealing with the need to identify and address legal barriers to the implementation of such interventions, with a focus on national statutes and regulations; and second, by addressing what needs to be done – at a policy and programmatic level – to ensure that human rights are not violated when interventions are implemented.

In addition, this strategic objective considers law and human rights more broadly. It focuses on four additional sub-objectives: first, how the human and institutional resources of existing constitutional and statutory structures and civil society organisations should be harnessed to advance the NSP’s human rights agenda; second, how human rights abuses should be monitored and appropriate mechanisms accessed for redress; third, how specific aspects of unfair discrimination that undermine the country’s response to HIV and TB should be addressed; and fourth, how vulnerability to infection could be reduced through law reform.

While the focus of this strategic objective is forward looking, largely containing a set of interventions to be implemented over the course of the next few years, considerations of human rights and access to justice are ever-present. Recognising that the legal framework for respecting, protecting, promoting and fulfilling rights in the context of HIV and TB is largely in place, SANAC – in collaboration with the SA Human Rights Commission (SAHRC) – must take urgent and ongoing steps to ensure that this framework is accessed. The SANAC secretariat should work with the SAHRC to prepare a report to be tabled at SANAC detailing what steps have and are being taken in this regard.
Background

The previous NSP addressed law, human rights and access to justice in two ways: first, it set out four goals (with 13 objectives and 30 interventions) under priority area 4 dealing with human rights and access to justice; and second, it drew attention to a number of “issues of policy and regulation that require[d] attention from relevant policy makers and the legislature” in each of the four key priority areas. In respect of the former, it set out a limited number of quantitative indicators; in respect of the latter, it did not identify the relevant lead department or the timelines in terms of which the relevant policy or legislative intervention was to take place.

The Midterm Review recognised that “very little data (either quantitative or qualitative) [was found] to measure progress in … Priority Area [4] of the NSP.” In particular, it found that it was “not possible to make accurate comment on coverage, or gaps in coverage”. It shows that we do not know whether, and if so to what extent, the goals were met. In addition, the Midterm Review raised serious concerns regarding the quantitative nature of the indicators chosen in the NSP; in particular, the NSP did not seek to monitor or assess the effectiveness or impact of the goals, objectives and interventions.

Sub-Objectives

This strategic objective recognises that the NSP, insofar as it seeks to play a central role in protecting human rights and promoting access to justice in the context of the response to HIV and TB, cannot address the sum total of all legal and human rights interventions required; instead, it needs to focus on a limited number of achievable, measurable and mutually reinforcing objectives and interventions. In particular, it has the following six sub-objectives:

- To identify and address legal barriers to the implementation of all NSP interventions;
- To ensure that rights are not violated when interventions are implemented;
- To establish credible mechanisms for monitoring abuses and vindicating rights;
- To reduce HIV and TB discrimination in the workplace;
- To reduce unfair discrimination in access to health care services; and
- To reduce vulnerability to HIV and TB infection through law reform.

Targeted interventions, which are identified in respect of each of these six objectives, may have to be implemented at a range of different spheres or levels. In respect of state actors, this may be at the national, provincial and/or local sphere of government. In respect of non-state actors, this may be at a sectoral, organisational and/or community level.

Sub-Objective 1: Identify and address legal barriers to implementation of interventions

Recognising that laws have the potential to frustrate progress, this sub-objective seeks to ensure that the legislative framework does not undermine – but rather facilitates – implementation of the interventions identified in strategic objectives 1 and 2. The sub-objective is to be achieved through the following two interventions:

- Conducting an audit of primary and secondary legislation (statutes and regulations) at the national sphere of government to identify provisions that have the potential to
undermine the implementation of interventions; and
- Developing and implementing a law reform agenda and process to address the identified provisions.

While primarily responsibility for implementation of this sub-objective vests in the relevant national government departments, SANAC, and in particular its M&E unit, has a key role to play in providing technical support and coordination. More detail in this regard is provided in the M&E chapter.

**Intervention 1: Conducting an audit of primary and secondary legislation**

Each national government department with responsibility for one or more interventions must conduct an audit of their legislative frameworks that have the potential to undermine or facilitate implementation. In addition, those departments whose legislation has a direct impact on other departments’ ability to implement should also conduct similar audits. Amongst others, laws to be considered should include the following:

- Department of Home Affairs: Refugees Amendment Act 33 of 2008 (to the extent that it may unfairly and unjustifiably limit access to health care services for refugees and asylum seekers through the use of vague language that could be used to deny the provision of services identified in strategic objectives 1 and 2);
- Department of Justice and Constitutional Development: Criminal Laws (Sexual Offences and Related Matters) Amendment Act 32 of 2007 (to the extent that (a) it may unfairly and unjustifiably limit access to post-exposure prophylaxis services by requiring the use of “designated facilities” and reporting of the alleged crime), and (b) conflict with other laws such as the provisions of the Choice on Termination of Pregnancy Act 92 of 1996 that deal with informed consent and adolescent girls);
- Department of Health: National Health Act 61 of 2003 (to the extent that regulations regarding communicable diseases have yet to be finalised and brought into force, meaning that people with drug-resistant TB may still be detained unjustifiably, sometimes under inhumane conditions);
- Department of Health: Medicines and Related Substances Act 101 of 1965 (to the extent that regulations regarding complementary medicines and medical devices have yet to be finalised and brought into force, leaving the public at risk because of the availability of unregulated products on the market); and
- Department of Trade and Industry: Patents Act 57 of 1978 (to the extent that it may unconstitutionally limit access to medicines by providing patent protection in excess of what is required under international trade law and thereby preventing the market entry of generic competition necessary to bring prices down and ensure the sustainability of medicines supply).

**Intervention 2: Developing and implementing a law reform agenda and process**

Relevant national government departments should take the necessary law reform steps once the audit referred to above is completed. These include: policy development; the preparation of draft bills for submission to Cabinet or the development and finalisation of regulations (whichever is appropriate); and appropriate public consultation. In the case of statutory amendments, these processes should result in the tabling of an amendment bill in Parliament; in the case of amendments to regulations, they should result in the promulgation of amended regulations.

These law reform processes should be completed by no later than 30 June 2014, by which
time amendment bills should be tabled in Parliament. For the proposed legislative amendments that this sub-objective has already identified, the timelines should be expedited by a year. In other words, bills addressing the concerns already identified in the NSP should be tabled in Parliament by no later than the end of June 2013.

**Sub-Objective 2: Ensuring rights are not violated when interventions are implemented**

This sub-objective seeks to ensure that implementing parties – when they conceptualise and plan the interventions contemplated in strategic objectives 1 and 2 – take reasonable measures to guard against rights violations. This is to be achieved through the following two interventions:

- Auditing of interventions to identify those that raise the potential for human rights abuses; and
- Guarding against rights violations as an integral part of programme planning.

While primarily responsibility for implementation of this sub-objective vests in the relevant national government departments, SANAC, and in particular its M&E unit, has a key role to play in providing technical support and coordination. More detail in this regard is provided in the M&E chapter.

**Intervention 1: Auditing interventions to identify potential for human rights abuses**

Each government department, other organ of state or private entity with responsibility for coordinating, conceptualising and/or implementing must assess whether any intervention – when, or as a result of being, implemented – results in a violation of human rights. For example, such a violation could occur when –

- HIV testing is conducted without proper informed consent, or is required before other services, such as treatment for STIs, is provided;
- Those eligible for antiretroviral treatment are not referred to appropriate facilities;
- Patients with multi-drug resistant TB are detained under inhumane “prison-like” conditions;
- Rape survivors are required to lay a charge at a police station before being able to access PEP services; or
- Untested medical devices are used to perform procedures.

**Intervention 2: Guarding against rights violations as part of programme planning**

Once intervention 1 is completed, each government department, other organ of state or private entity with responsibility for coordinating, conceptualising and/or implementing must take reasonable measures to guard against the potential rights violations identified. Using the examples cited above, such steps could include –

- Issuing a circular to health care facilities that warns that those who require HIV testing before providing services for which an HIV diagnosis is not required will face disciplinary action;
- Developing and implementing a national policy that only permits the detention of patients with multi-drug resistant TB when necessary and under conditions consistent with international good practice;
- Training health care providers on the requirements of the Criminal Laws (Sexual
Offences and Related Matters) Amendment Act 32 of 2007 relating to the laying of charges and access to PEP services; and

- Ensuring that all tenders for medical devices exclude bidders whose products have not been registered or licensed by a stringent regulatory authority.

**Sub-Objective 3: Establish mechanisms for monitoring abuses and vindicating rights**

This sub-objective seeks to harness the human and institutional resources of existing constitutional and statutory structures and civil society organisations to advance the NSP’s human rights agenda; it also seeks to create a coordinated framework for (a) monitoring human rights abuses that have the potential to undermine the interventions set out in strategic objectives 1 and 2, and (b) ensuring that rights – where violated – may be vindicated efficiently and effectively.

This objective is to be achieved through the following two interventions:

- Using existing bodies to monitor human rights abuses and increase access to justice; and
- Building capacity within civil society to increase access to justice.

**Intervention 1: Use existing bodies to monitor human rights abuses and increase access to justice**

The M&E framework must deal appropriately with monitoring human rights abuses of those living with HIV or at the greatest risk of infection, as well as the appropriate referral to legal service providers of those whose rights have been violated. The SANAC secretariat must ensure that the following are achieved:

- A coordinated and effective system for receiving and processing complaints is in place;
- The necessary human and financial resources for dealing appropriately with such complaints are available; and
- Report at least every six months to SANAC on the steps necessary to ensure that the identified statutory and constitutional bodies are able to discharge their mandates.

**Intervention 2: Build capacity within civil society to increase access to justice**

Better use of existing pro bono departments of private law firms, law clinics and public interest law centres should be made, primarily through appropriate coordination and an effective referral system. In this regard, the SAHRC should assume responsibility for bringing together civil society organisations working on access to justice; in turn, these organisations should take joint responsibility for developing a plan of action to build the capacity of community-based organisations so that they are better placed to assist their members and communities in understanding and claiming their rights.

**Sub-Objective 4: Reduce HIV and TB discrimination in the workplace**

This sub-objective is the first of two dealing with unfair discrimination; in this case, the focus is on HIV or TB status as a basis for differential treatment and includes particular focus on HIV and TB in persons with disabilities. While there may be discrimination in all
spheres of public and private life, this objective – in line with the NSP’s commitment to the principles of simplicity, high impact and scalability – has a singular focus on the workplace. In particular, it focuses on those workplaces where unfair discrimination is most likely to remain unchecked and/or where employees are least likely to be able to access legal services.

A focus on the workplace enables the NSP to draw attention to and begin addressing concerns that are common to all types of unfair discrimination:

- An enabling legal framework, whilst essential, is not enough to ensure that unfair discrimination is eliminated;
- People need to have knowledge of and be in a position to claim their rights;
- Those who unfairly discriminate against people with HIV and/or TB often do so in ignorance of the ways in which HIV and TB are prevented, transmitted and treated; and
- Being aware of the law, those who unfairly discriminate against people with HIV and/or TB often try to find others ways in which to give effect to their prejudices.

Such a focus is also based on the recognition that the right to work is central to the ability of people with HIV and/or TB to mitigate their impact on them, on their families and on society more broadly. Given high levels of unemployment in South Africa, denying equal opportunity in employment on the basis of HIV status or TB disease may place an undue burden on the state in the provision of health care services, education, housing, social assistance and basic services, amongst others (displaced from employers).

The objective is to be achieved through the following two interventions:

- Developing and implementing a national campaign against unfair HIV and/or TB discrimination in all workplaces; and
- Empowering employees in small workplaces to claim their own rights.

**Intervention 1: National campaign against unfair discrimination**

Organised labour, business and government, with the assistance of SANAC’s communications task team and under the auspices of the National Economic Development and Labour Council (NEDLAC), should assume responsibility for conceptualising, developing, resourcing and implementing a national, multi-media campaign to address unfair discrimination in the workplace. By definition, such a campaign would have to address how HIV and TB are acquired and treated, what services are available to prevent and treat them, and why discrimination therefore cannot be justified.

**Intervention 2: Empowerment of employees in small workplaces**

Civil society organisations working on access to justice, under the leadership of the SAHRC, should conceptualise, develop, resource and implement a plan to build the capacity of organisations working with and/or representing employees in small workplaces (including domestic and farm workers). Such a plan should involve materials development and training on HIV and employment law, and be sensitive to regional variation.

**Sub-Objective 5: Reduce unfair discrimination in access to health care services**

This sub-objective is the second of two dealing with unfair discrimination; in this case, the
focus is on a range of grounds on the basis of which people may be denied access to the HIV, STI and TB services identified in the interventions set out in strategic objectives 1 and 2. Amongst others, these grounds include race, gender (including gender identity), sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language, birth, geography, nationality and socio-economic status.

In addition to respecting and protecting people’s rights to have access to health care services, this sub-objective seeks to ensure that broader public health goals are achieved by ensuring that all those who are eligible for the identified services are not denied access on an arbitrary basis.

Denial of access may take place in a number of ways, including by way of services being provided in a manner that fails to address or understand a patient’s specific needs. The following examples are instructive:

- Information that is only provided in written form may limit the ability of the visually impaired to provide informed consent;
- Understanding the difference between transgender women and gay men, who are often collectively considered as men who have sex with men, is essential for the provision of appropriate HIV counselling services; and
- Failing to recognise the reason for non-adherence, such as excessive use of alcohol or depression, may undermine access to ARV treatment.

This sub-objective is to be achieved through the following two interventions:

- Ensuring that existing oversight bodies receive and address complaints of unfair discrimination in health establishments; and
- Training health care workers to understand and address unfair discrimination in access to health care services.

**Intervention 1: Ensuring that oversight bodies receive and address complaints**

The statutory mandates of professional oversight bodies – including the Health Professions Council of South Africa (HPCSA), the South African Nursing Council (SANC) and the Office of Standards Compliance (OSC) – are sufficiently broad to receive and address complaints of unfair discrimination in health establishments. In respect of the HPCSA and SANC, these mandates have been used for some time to hold health care providers to account. The OSC is a relatively new structure.14

What may be lacking to enable them to discharge this function optimally is sufficient dedicated funding, a coordinated plan to make best use of their collective capacity and an accountability framework which includes regular reporting to SANAC. This intervention seeks to ensure that these requirements are addressed within 12 months, enabling the oversight bodies to implement a joint four-year plan (2013 – 2016) to combat unfair discrimination in the provision of health care services identified in strategic objectives 1 and 2.

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14 In terms of the draft National Health Amendment Bill, 2011 (GN 44 of 2011, *Government Gazette* No. 33962, 24 January 2011), the OSC is to become the Office of Health Standards Compliance.
Intervention 2: Training health care workers to prevent unfair discrimination

While it is important to hold health care providers to account through professional disciplinary mechanisms, it is also vital that such workers have access to dedicated human rights training programmes designed to equip them with the necessary skills to respect, protect and promote equality in the provision of health care services. This intervention is therefore aimed at all bodies that train health care providers in HIV, STI and TB care, as well as dedicated services for pregnant women and adolescents.

In particular, this intervention seeks to ensure that all public and private bodies providing training on HIV, STIs and/or TB include modules dealing with unfair discrimination, including a focus on disability and the need to make provision for reasonable accommodation. It will be led by the Department of Higher Education and Training, in collaboration with the Department of Health and national non-profit bodies that develop professional practice guidelines and professional associations to which health providers belong.

Sub-Objective 6: Reduce vulnerability to HIV and/or TB infection through criminal law reform

While the Constitution and other laws recognise a long list of prohibited grounds of unfair discrimination, which are addressed in sub-objective 5, the focus of this final sub-objective is on those identities and/or characteristics that render people particularly vulnerable to HIV and/or TB infection. In particular, this objective – which seeks to reduce vulnerability to infection through law reform – recognises that the criminal law can sometimes contradict the goals and objectives of the NSP as a whole.

This objective is to be achieved through the following two interventions:

- Conducting an audit of the criminal law to identify provisions that render people vulnerable to HIV and/or TB infection; and
- Developing and implementing a law reform agenda and process to address the identified provisions.

Intervention 1: Conducting an audit of the criminal law

The Department of Justice and Constitutional Development (DOJ&CD), working in collaboration with the SAHRC, must conduct an audit of the criminal law to identify those provisions of statutes and the common law that have the potential to render people vulnerable to HIV infection. Amongst others, laws to be considered should include those that criminalise –

- The conduct of injecting drug users and those who provide harm reduction services to them;
- The buying and selling of sex between adults;
- Exposure to HIV infection; and
- Consensual sex between children.

While primary responsibility for implementation of this sub-objective vests in the DoJ&CD and the SAHRC, SANAC – and in particular its M&E unit – has a key role to play in providing technical support. More detail in this regard is provided in the M&E chapter.
Intervention 2: Developing and implementing a law reform agenda and process

Once this audit has been completed, the Department of Justice and Constitutional Development should begin taking the necessary law reform steps: policy development; the preparation of draft bills for submission to Cabinet and appropriate public consultation (at all relevant points). These processes should result in the tabling of an amendment bill in Parliament; in the case of amendments to regulations, they should result in the promulgation of amended regulations.

These law reform processes should be completed by no later than 30 June 2014. For the proposed legislative amendments that this sub-objective has already identified, the timelines should be expedited by a year. In other words, bills addressing the concerns already identified in the NSP should be tabled in Parliament by no later than the end of June 2013.
## Strategic Objective 3: Objectives and Interventions

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<thead>
<tr>
<th>Objective</th>
<th>Intervention</th>
<th>Indicator</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>Costing and Source</th>
</tr>
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<tbody>
<tr>
<td>Identify and address legal barriers to implementation of interventions</td>
<td>Conduct an audit of primary and secondary legislation</td>
<td>Audit complete</td>
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<td></td>
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<td>Problematic laws identified</td>
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<tr>
<td></td>
<td>Develop and implement a law reform agenda and process</td>
<td>Law reform agenda developed</td>
<td>–</td>
<td>100%</td>
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<tr>
<td></td>
<td></td>
<td>Bill tabled in Parliament</td>
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<td>–</td>
<td>100%</td>
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<tr>
<td>Ensure rights are not violated when interventions are implemented</td>
<td>Audit interventions to identify potential for human rights abuses</td>
<td>Systems in place to identify rights violations</td>
<td>100%</td>
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<td>Systems in place to identify rights violations</td>
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<td>Establish mechanisms for monitoring abuses and vindicating rights</td>
<td>Use existing bodies to monitor human rights abuses and increase access to justice</td>
<td>Systems in place to identify abuses and ensure redress</td>
<td>100%</td>
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<td></td>
<td></td>
<td>Cases properly pursued</td>
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<td>100%</td>
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<td></td>
<td>Build capacity within civil society to increase access to justice</td>
<td>Plan of action developed</td>
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<td></td>
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<td>Plan of action implemented</td>
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<td>40%</td>
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<td>Reduce HIV and TB discrimination in the workplace</td>
<td>Implement a national campaign against unfair discrimination</td>
<td>Campaign conceptualised</td>
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<td></td>
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<td>Campaign implemented</td>
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<td>100%</td>
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<td>100%</td>
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<td></td>
<td>Empower employees in small workplaces</td>
<td>Plan of action developed</td>
<td>100%</td>
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<td>Plan of action implemented</td>
<td>20%</td>
<td>40%</td>
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<td>80%</td>
<td>100%</td>
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<tr>
<td>Reduce unfair discrimination in access to health care services</td>
<td>Ensure that oversight bodies receive and address complaints</td>
<td>Plan of action developed</td>
<td>100%</td>
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<td>Complaints properly pursued</td>
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<td>100%</td>
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<td>Train health care workers to prevent unfair discrimination</td>
<td>Plan of action developed</td>
<td>100%</td>
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<td></td>
<td></td>
<td>Plan of action implemented</td>
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<td>Reduce vulnerability to HIV and/or TB infection through criminal law reform</td>
<td>Conduct an audit of the criminal law</td>
<td>Audit complete</td>
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<td>Problematic laws identified</td>
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<td></td>
<td>Develop and implement a law reform agenda and process</td>
<td>Law reform agenda developed</td>
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<td>Bill(s) tabled in Parliament and/or amended regulations promulgated</td>
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6.8 Strategic Objective 4: Social and Structural Approaches to HIV and TB Prevention, Care and Impact

Introduction

The impact of infection and disease on people living with HIV, STIs and TB, as well as their families and communities is profound. Social and structural approaches address the social, economic, political, cultural and environmental factors that lead to increased vulnerability whilst reinforcing impact mitigation interventions. Interventions that change conditions beyond individual control such as the social and physical environments are termed structural interventions.

Given that some of the structural approaches seek to address deeply entrenched and long established cultural and socio-economic factors such as economic inequality, social issues such as gender inequality, marginalisation and lack of access to basic amenities, that are difficult to resolve in the short-term, they commonly require long-term strategies and interventions that are largely addressed by national socio-economic and development plans and strategies. It is thus important to mainstream HIV and TB in the core strategies of key ministries and departments in order to ensure a comprehensive and sustainable approach to the dual epidemics and their related impact.

Finally, specific interventions to mitigate the impact of the epidemics are critical in order to support affected communities and to breakdown the vicious cycle of ongoing vulnerability and infection from generation to generation.

Strategic Objective 4 will focus specifically on factors emanating from the Know Your Epidemic report, which has identified structural factors that are amenable to appropriate approaches.

Sub-Objective 1: Address the HIV and TB epidemics as a development challenge

Allocate sufficient resources to enable capacity building within the public sector. Empowering all spheres of government to mainstream HIV in their core business, will address the complex interplay of macro factors, community level and individual level factors that comprise social drivers of the dual epidemics.

The interventions must be identifiable, verifiable and measurable.

Addressing specific structural factors identified through the Know Your Epidemic analysis.

Sub-Objective 1.1: Informal Settlements

Informal settlements comprise densely populated areas where many people who have less disposable income reside. Many of these settlements have minimal infrastructure with limited access to basic services such as clean water and sanitation. Residents often come from a variety of primary homes with large numbers of undocumented migrants living in these settlements. Informal settlements provide a fertile ground for HIV, STI and TB transmission as well as spread of many other communicable diseases especially among children due to poor living conditions.

The Department of Human Settlements has conducted a mapping exercise of all informal settlements with a brief situation analysis report which states what the key challenges are
in these settlements. A plan to upgrade units of accommodation is being developed with improved access to basic services, including comprehensive primary health care services, social cohesion and recreation facilities. The implementation of this plan must be monitored by the SANAC secretariat and regular reports provided to SANAC on progress and challenges that line departments and other stakeholders may be also to assist with.

**Sub-Objective 1.2: National Roads**

Some of the key national roads have been identified as high transmission areas for HIV and the associated risks of STI and TB disease. Truck drivers have already been identified as highly vulnerable to HIV infection due to their working environment and interaction with sex workers.

The interventions will include education and an innovative communication strategy for truck drivers and sex workers. The need for the decriminalisation of sex work to, inter alia, enable specific interventions to be put in place along the national roads should be urgently explored as already noted above. Access to services such as HIV counselling and testing, treatment of STIs and TB screening, diagnosis and treatment offered to truck drivers through strategically placed mobile and/or static units where feasible and appropriate along the national roads must be urgently addressed.

**Sub-Objective 1.3: Rural Settlements**

According to the Know your Epidemic Report, HIV prevalence is increasing in rural formal settlements as well as in urban informal settlements. A big challenge for rural areas is access to appropriate services and infrastructure including housing. A large proportion of the rural population has no sustainable livelihoods, which contribute to deprivation and ill health, including TB.

Government has established an intergovernmental committee to develop and implement a comprehensive strategy to address, social, economic, infrastructure and governance challenges that have been identified in rural communities. Access to health services has also been prioritized, through the PHC re-engineering process, and will assist in ensuring that HIV and TB related interventions are in place close to these hard to reach communities. A communication strategy needs to be developed and implemented in these hard to reach populations.

**Sub-Objective 1.4: Informal Sector**

According to the KYE report, a third of people working in the informal sector are living with HIV. A number of plausible reasons for this increased vulnerability of the informal sector are poverty-related such as poor living conditions, lack of access to basic services where they reside, limited access to health services and perhaps limited time to attend health facilities due to the opportunity costs.

Reduction of vulnerability in this sector can be achieved through a multisectoral programme consisting of Local Government, provincial departments of health, the private sector and other stakeholders. There are limited formal mechanisms to address this sector due to its nature but by improving living conditions and providing economic opportunities as highlighted earlier will increase individual level competencies to cope with ill health and/or reduce vulnerability.
Sub-Objective 2.5: Mobility and Migration

Cross-border mobility and internal migration from rural areas to urban areas is associated with increased risk of HIV acquisition.

Cross-border issues can be addressed through implementation of regional policies endorsed by SADC, such as harmonisation of treatment protocols. The need for continuity of care for internal migrants has been addressed in SO2.

Sub-Objective 2.6: Alcohol and Substance Abuse

Evidence from the KYE highlights the impact of alcohol and substance abuse on HIV transmission and vulnerability to TB. Alcohol consumption and substance abuse leads to increased risk taking including unsafe sexual practices. Alcohol excess, cigarette smoking and drug use are independently linked to an increased risk of TB disease.

Recognizing the impact of alcohol and substance abuse, government has established an Inter-ministerial Committee on substance abuse to review research findings and develop appropriate policies to address substance abuse.

The decisions taken by the IMC and implemented by government and its partners will hopefully contribute significantly to the reduction of the impact of substance abuse and alcohol on society especially for young people. Although Injecting drug use has not been identified as a key driver of HIV transmission, a pro-active stance will contain the emergence of IDU challenges in the context of HIV transmission.

Regular reports on the impact of policies to curb alcohol abuse in particular must be tabled at SANAC.

Sub-Objective 2: Mitigate the impact of HIV, STIs and TB on orphans, vulnerable children and youth

The impact of the HIV epidemic over three decades has created complex social challenges that require specific interventions to address these ongoing challenges. The rising numbers of orphans and vulnerable children and youth need a comprehensive package of services to enable smooth transition to adulthood. The aim is to have each generation that becomes part of the adult cohort with comprehensive knowledge and skills, and growing up in a social environment that makes safer sex the easier choice – thus contributing to extinguishing the HIV and TB epidemics.

SANAC must ensure that all relevant role-players develop a comprehensive strategy to assist orphans and vulnerable children, building on the provision of existing services.

Sub-Objective 3: Address social and structural barriers to access to HIV, STIs and TB services to persons with disabilities

Persons living with disabilities are a largely underserved population with respect to HIV, STI and TB services. There are social and structural barriers such as lack of appropriate language and physical access, which serve as barriers to facilities, health care providers and social and behaviour change communication on HIV/STI and TB. Treatment, care and support services to persons with disabilities require additional resources and attention and are therefore sometimes overlooked.
SANAC, working with the disability sector, must develop a comprehensive package of HIV, STI and TB services that will address issues related to the prevention, diagnosis, treatment, care and support of persons with disabilities.

**Sub-Objective 4: Reduction of stigma and discrimination**

Stigma and discrimination continue to impact on access to services and limit other social opportunities for people living with HIV and those with TB. Stigma reduction interventions will target institutions, workplaces, institutions, communities and individuals.

The key intervention will be roll out the stigma mitigation framework and the Stigma Index.

**Sub-Objective 5: Community Systems Strengthening**

Communities play a critical role in establishing and strengthening networks that support healthy communities and that can strengthen service delivery. They also serve as a safety net of OVCY and have the potential to impact positively on social norms and behaviours of the communities. Appropriate and adequate resourcing of community systems is crucial in ensuring that the needs of those who are hard to reach, marginalized and poor are addressed. Community systems strengthening must ensure an effective system is in place for delivering services in a manner that complements and links with local government efforts.

SANAC needs to work with local government structures at all levels of government as well as other relevant sectors to ensure that community systems are strengthened.

**Sub-Objective 6: Empowering women and changing harmful gender practices**

Apart from their biological vulnerability, girls and women are particularly vulnerable to HIV infection and bearing a great burden of care because of gender roles and practices. In order to change this pattern, social change communication programmes dealing with gender stereotypes and harmful norms need to be scaled up addressing men, women, boys and girls.
### Strategic Objective 4: Objectives and Interventions

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<tr>
<th>Objective</th>
<th>Intervention</th>
<th>Indicator</th>
<th>2012</th>
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<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>Costing and Source</th>
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<tbody>
<tr>
<td>Address the HIV and TB epidemics as a development challenge</td>
<td>Mainstreaming of HIV and TB in the strategic plans of all government departments</td>
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<td>(Lead Agency: Planning Commission; PME; DPSA; National Treasury)</td>
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<tr>
<td>Addressing specific structural factors identified through the Know Your Epidemic analysis</td>
<td>Prioritize informal settlements by burden of HIV and TB infection for implementation of HIV, STI and TB programmes</td>
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<td>Identify and address structural barriers to access to HIV/STI and TB services to residents in informal settlements</td>
<td>Conduct an in-depth diagnosis of key challenges related to infrastructural issues, and access to basic health services, including HIV, STIs and TB</td>
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<td>(Lead Agency: Department of Human Settlements)</td>
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<td>Address vulnerability associated with truckers</td>
<td>Conduct a situational analysis of key drivers of HIV risk along key national roads</td>
<td>Situational analysis report</td>
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(Lead Agency: Department of Human Settlements)
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<tr>
<td>and use of national roads (Lead Agency: Department of Transport, Road Freight Association, Economic and Infrastructure Cluster, Department of Health)</td>
<td>Sign Memoranda of Understanding with key service providers to ensure HIV, STI and TB interventions are integrated into their service package (e.g. condoms and social change communication on HIV, STI and TB distribution to all truck drivers)</td>
<td>Number of MOUs signed with key service providers such as the Road Freight Association, Taxi Associations</td>
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<td>Ensure access to basic HIV services to truck drivers and sex workers through the establishment of static/mobile health services along key routes where appropriate (e.g. clinic offering basic health services including HIV/STI and TB screening and diagnosis to truck drivers at 1 stop shops along national routes)</td>
<td>Number of functional clinics along major routes offering HIV/STI &amp; TB services</td>
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<td>Communication strategy developed and implemented</td>
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<td>Minimize structural barriers to access to health services in rural settlements (Lead Agency: Department of Rural Development; Local Government; Department of Health)</td>
<td>Empower women in rural areas to negotiate safe sex</td>
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<td>Expand mobile and community health worker services to reach distant and hard to reach rural areas</td>
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<td>Ensure social change communication strategies to reach these hard to reach people.</td>
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<td>Remove structural barriers to access to SBCC on HIV, STI and TB and minimise risks of HIV, STI</td>
<td>Develop a policy with states that all new industrial/business development sites must include HIV, STI &amp; TB risk factors in the</td>
<td>Number of new developments conducted and environmental scan that includes HIV, STI and</td>
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<tr>
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<tr>
<td>and TB infections to people in the informal sector and industrial sites</td>
<td>environmental scan</td>
<td>TB risk factors</td>
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<td>(Lead Agency: Department of Public Works, Department of Mineral Resources, Department of Trade and Industries)</td>
<td>Develop a policy which states that all existing industrial/business sites must undertake to conduct an HIV, STI and TB risk profile by 2013</td>
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<td>(Lead Agency: Department of Public Works, Department of Mineral Resources, Department of Trade and Industries)</td>
<td>Develop a policy to incentivise businesses and mines who implement measures to minimize risk of HIV, STI and TB infection</td>
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<td>Address vulnerability associated with mobility and migration</td>
<td>Implement the SADC framework on migration and mobility</td>
<td>Progress report on the implementation of the framework</td>
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<td>(Lead Agency: DOH, DPSA, Trade &amp; Industry, Home Affairs, DIRCO, SADC Health Desk)</td>
<td>Develop a policy to address harmonisation and standardisation of treatment protocols</td>
<td>Policy document developed and shared with SADC member states</td>
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<td>Reduce alcohol and substance abuse related vulnerabilities</td>
<td>Program of action of the IMC on Alcohol and Substance abuse is implemented</td>
<td>Number of interventions that integrate HIV and TB prevention and mitigation</td>
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<tr>
<td>(Lead Agency: IMC on Alcohol and Substance abuse, Department of Trade &amp; Industry)</td>
<td>Develop a functional, integrated management system (between spheres of government, departments, facilities, civil society and community systems) to address alcohol and substance abuse</td>
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<td>Mitigate the impact of HIV, STI and TB on Orphans, Vulnerable Children and</td>
<td>Strengthen the existing OVCY policy framework to extend services to street children and youth out of school</td>
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<td>Youth (Lead Agency: DSD, DBE, DHET, DOH)</td>
<td>Ensure that all youth leaving school are knowledgeable and skilled enough to be able to prevent HIV infection</td>
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<td>Parenting/caregiver programmes to improve intergenerational communication on sexuality and reproductive health and to reduce exposure to abuse in childhood</td>
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<td>Address social and structural barriers to access to HIV, STI and TB services to people with disabilities (Lead Agency: Department of Children, Women and People with disabilities)</td>
<td>Translate all SBCC and other pertinent information on treatment, care and support on HIV/STI and TB for persons with disabilities</td>
<td>Progress report on the implementation of the framework</td>
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<td>Policy document developed and shared with SADC member states</td>
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<td></td>
<td>Minimize social and structural barriers to access to treatment, care and support services to people with disabilities. Ensure adequate communication for people with disabilities</td>
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<td>Reduce HIV and TB related stigma and discrimination (Lead Agency: SANAC; NGO Sector)</td>
<td>Roll out stigma reduction framework and stigma index</td>
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<td>Strengthen Community Systems (Lead Agency: Local Government, NGO sector)</td>
<td>Develop capacity of and adequately resource community systems to improve access to health and wellness at community level</td>
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<td>Empower women and change harmful gender practices</td>
<td>Engage communities in conversations about the role of gender stereotypes in the context of the HIV epidemic. Ensure</td>
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<td>women have access to microfinance, introduce gender education from grade R to Matric Engage with traditional leaders about cultural misconceptions Develop a gender norm index</td>
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CHAPTER 7 – MONITORING AND EVALUATION

A detailed Monitoring and Evaluation Framework for the NSP (2012-2016) will be developed by SANAC once the details of the strategic objectives are finalised. This chapter highlights the key aspects towards building and operationalisation of a single M&E system for the dual epidemics of HIV and TB in South Africa. In doing this the framework will take into account existing frameworks and policies in government.

Objectives of the M&E framework are:

1. To build a national M&E system for the HIV and TB strategic plan that strengthens existing systems (e.g. in health), and develops new systems for community-based monitoring and reporting
2. To monitor implementation of the national strategic plan
3. To develop and implement an evaluation agenda for the NSP

7.1 M&E Coordination

Monitoring and evaluation of the multi-sectoral response will require greater coordination of all sectors (public, private, civil society and development partners) to ensure optimal utilization of the available resources and continuous learning through sharing of experiences. The M&E Unit in the SANAC secretariat with technical support from the Research Monitoring and Evaluation Technical Task Team (RME TTT) will be responsible for the coordination of the monitoring and evaluation framework of the multi-sectoral response at national level. The M&E units in the Provincial Councils on AIDS and sectors will assume the same at provincial and sectoral levels (where these exist). These coordinating structures will oversee capacity development, data quality assurance, resource mobilization for M&E and data archiving. The coordinating mechanisms will not take direct responsibility for M&E implementation, as this is the responsibility of the implementing institutions. Below is the proposed outline of the coordination structure for monitoring and evaluation of the national response to HIV and TB.

7.2 Data Flow

Data on selected indicators for HIV, STIs and TB will flow from the Ward Councils on AIDS (WCAs), District Council on AIDS (DCAs), Provincial Councils on AIDS (PCAs) to SANAC Secretariat M&E Unit at national level and vice versa for feedback. While government and civil society sectors will be reporting within their established structures at the different levels, they will be encouraged to feed into the AIDS council structures at the corresponding levels at the same time. This will help strengthen the multi-sectoral responses at the different levels.

On a quarterly basis the SANAC Secretariat M&E Unit will provide a progress report on selected core indicators to the SANAC Plenary through the Programme Implementation Committee. These progress reports will also be shared with the institutions providing the data as feedback. The Unit, as required, will manage international reporting obligations.
7.3 Indicators

The SANAC Secretariat M&E Unit in collaboration with the RME TTT will harmonise and align indicators for monitoring progress at national level. This process will allow SANAC to monitor progress with the response as well as to report on progress with implementation of international declarations that South Africa has signed up to such as UNGASS. A core set of indicators (no more than 40) will be developed with which to measure progress at national level. However, the PCAs and implementing partners are encouraged to add more indicators at their levels as they see fit to facilitate programmatic monitoring and decision-making. Selection of indicators for the NSP will be guided by:

- Data availability
- Cost effectiveness
- Relevance
- Reliability
- Sensitivity and Specificity
- Measurable
- Alignment with international and regional commitments
7.4 Data Sources and Archiving

National level monitoring of the HIV and TB response will rely on routine data from programmes, surveillance and research. Routine programme monitoring will assist with coverage (outputs) while surveillance and population surveys will generate data on outcomes (behaviour change) and impacts (incidence, prevalence). By virtue of mandate of the AIDS Council, the M&E unit will focus on output, outcome and impact monitoring.

The M&E Unit will be required to establish a database of data elements for the selected indicators. In instances where data sharing is a challenge the SANAC Secretariat will have to negotiate for reasonable access to some databases.

7.5 NSP Reviews

A mid-term and end-of-NSP review will be conducted. The midterm review will focus on looking at achievements, challenges, emerging issues and recommendations for the remaining half of the NSP will take place in 2014. To decrease the resources required for the mid-term review annual programme reviews will be conducted. This will require multi-sectoral stakeholders to come together at the end of each implementation year to review progress, challenges and set priorities for the following year focusing on results and mutual accountability. The final NSP review will be conducted in 2016 to provide the evidence base for the next national strategic plan.

7.6 Evaluation

This is the least developed component of the M&E system. Through a consultative process the M&E unit will lead the process to come up with and evaluation agenda for the national HIV and TB response. Among other things the evaluation agenda will include questions around cost effectiveness of the governance structure and intervention programmes, efficacy of interventions and efficiency of delivery.

7.7 Operationalisation of the M&E Framework

From the M&E framework, an operational plan will be elaborated. The operational plan will highlight the following:

- **Data collection plan**: This will outline the frequency and timelines for data collection on selected core indicators.
- **Data sources**
- **Dissemination Plan**: The operational plan will clearly indicate the information products that will be generated and the timeframes. These could include quarterly reports, newsletters, annual M&E reports, UNGASS reports, service coverage reports, etc.
- **Capacity development** for M&E focusing on government (particularly at decentralized levels), civil society organizations, private sector and community based organizations. A generic curriculum already exists and all that is required is to domesticate it to the South African context.
- **Resources requirements** for successful implementation of the framework
- **Clear roles and responsibilities** for the different actors in the monitoring and evaluation of the national response. These have to be clearly understood to enhance accountability.
7.8 Conclusion

The Monitoring and Evaluation framework provides a solid foundation for building and operationalising one system for monitoring the implementation of the NSP for HIV, STIs and TB. To achieve this there is need for the SANAC M&E Unit to cultivate strategic partnerships with key stakeholders – government, civil society, private sector and development partners.
CHAPTER 8 – RESEARCH

The main goal of local research on HIV, STIs and TB in South Africa in the new NSP is to provide scientific evidence to guide and enhance the country’s response to the three diseases. The production of new knowledge to impact these diseases is a critical component of South Africa’s strategic plan. This includes generating behavioural, sociological, economic and biomedical information to enhance the implementation of existing interventions and programmes as well as the development of innovative new approaches for the prevention, diagnosis, treatment and care, and mitigation of the impact of HIV, STIs and TB either singly or in combination.

8.1 Introduction

South African research on HIV, STIs and TB is widely recognised as being world class. Over the past five years South African researchers have made several ground breaking contributions that have impacted all three diseases. In spite of this excellent reputation, one of the major challenges has been the lack of a strong link between the research conducted in South Africa and the country’s local needs. Most of the current research done by South African AIDS researchers is skewed towards global issues, largely dictated by their dependence on international funding. To correct this situation that existed during the last NSP (2007-2011), it is crucial that research over the next few years include a focus on both local priorities and that local funding for research in support of the NSP for the period 2012 to 2016 be enhanced. The establishment of a local research agenda linked much more closely to the country’s specific needs related to HIV, STIs and TB in line with the four strategic objectives, with the necessary funding is an important initial step. This increased level of funding could emanate from a combination of sources, including the South African government, the private sector, international agencies and philanthropy.

In essence, South Africa needs locally relevant research that can transform policy and practice to accelerate progress towards meeting targets set in the NSP and the Millennium Development Goals related to HIV, STIs and TB.

8.2 Proposed Research Streams for NSP 2012-2016

Four main streams of research are presented below as the basis for generating the knowledge needed to support the goals of the NSP. An overall approach is provided, rather than listing individual research questions or research topics. The four streams represent the continuum between policy, behavioural, sociological and non-hypothesis driven descriptive studies to long-range clinical and basic science research to inform the development of a new research agenda during 2012-2016 period. While the priorities ascribed to individual research questions may change over the next 5 years, this overarching approach provides a constant framework to locate and organise changing research priorities.

A. Surveillance and Vital Statistics

Information generated by effective surveillance systems is critical for responding adequately to the HIV, STI and TB epidemics. “Know your epidemic, know your response” applies equally to TB and STIs as it does to HIV.

The improved registration of births and deaths (including more robust capture of cause of disease in all cases), which record vital statistics, provide a foundation stone for planning and for monitoring the impact of interventions on HIV and TB mortality. For example, the total number of deaths is a critical and sensitive indicator of the success of antiretroviral treatment programmes. Similarly, surveillance to monitor new and existing cases of HIV, new STI cases and new cases of TB, in the general population and specific high-risk groups (e.g. healthcare workers, prisoners, sex workers) as well as temporal trends in these incidence and prevalence rates is essential. Such data on the occurrence of disease should incorporate, where possible, data on behavioural and sociological risk factors. In the case of HIV surveillance, data can be obtained from population-based surveys, antenatal clinic sentinel site surveillance, sentinel population surveillance and targeted prevalence/incidence studies. The recording and reporting of TB cases and their outcomes through the national TB register provides data to monitor national trends while surveys to monitor drug resistance are essential. Until a better mechanism for measuring TB transmission and incidence can be detected, a sentinel surveillance system to monitor TB infection rates in cohorts of school children should be developed.

B. Health Systems and Operations Research

Health systems and operations research assesses the efficiency and effectiveness of health systems and programmes. This type of research provides a methodological approach to generate the information needed to make the health system, health services and health programmes more efficient and effective. The former aims to improve value-for-money while the latter aims to generate improvements in health outcomes. In many cases, health systems and operations research builds on and supplements existing monitoring and evaluation efforts.

The systematic improvements and gains achieved in preventing mother-to-child transmission of HIV infection has, in no small measure, been achieved through systematic studies of the shortcomings in the cascade of steps from pregnant women being tested for HIV to their newborn babies receiving antiretroviral prophylaxis. This has included understanding and removing some of the sociocultural and economic barriers that prevent women from accessing and utilising the available PMTCT services. Similarly, systematic assessments of antiretroviral treatment programmes are leading to substantially higher HIV suppression rates.

As well, STI programmes use health systems and operations research to ensure opportunities to diagnose and treat STIs are not lost and that the 4 Cs (counselling, condoms, compliance and contact tracing) of STI programmes are effectively implemented.

It is widely recognised that TB control is dependent on detection and successful treatment completion rates. To maximise the benefit of existing and new tools and strategies on TB control, health systems and operations research is essential. Specific components of TB programmes that should be included are strategies to improve case detection and successful treatment completion rates, methods to scale up diagnostics for and access to
treatment for MDR-TB and XDR-TB, strategies to optimize implementation of isoniazid preventive therapy among ART patients, and TB infection control in health settings, communities and households, strategies to improve TB and HIV treatment integration and strategies to prevent and minimise stigma from TB.

C. Research for Innovation

While research can provide information that describes and analyses events and processes that currently exist, it has an important role in identifying future problems, questions and challenges and developing new technologies to address them. Research for innovation includes the most basic research at molecular and cellular level, to elucidating pathogenesis, to clinical manifestations, public health consequences and society level impact. Importantly, the NSP recognises that science includes a long-term perspective where knowledge is built through small increments not necessarily clearly linked with each other. However, it is this search for new knowledge at all levels from the most minute molecule to the macro-level of communities and societies that will enable South Africa to forge ahead in devising new ways to combating HIV, STIs and TB. This encompasses not only biomedical, but also behavioural, sociological and economic aspects.

With regard to HIV, fundamental research on the local viruses, immune responses, diagnostics, vaccines, microbicides and antiretroviral drugs have been critical to the recent successes in HIV prevention. Innovations in antiretroviral use have seen the creation of a completely new approach to HIV emerge since July 2010 – the use of antiretroviral drugs in topical and/or oral formulations for HIV and HSV-2 pre-exposure prophylaxis. Early initiation of antiretroviral therapy has now been shown to be highly efficacious in HIV prevention. These prevention innovations need to continue through the development of new prevention interventions and the creation of effective combinations of prevention tools, including behavioural and social/structural ones, that can effectively stem the local epidemic. The search for a highly efficacious and safe vaccine remains a beacon in this quest.

Innovations in HIV treatment such as cheap incidence assays, point-of-care CD4 count and viral load assays and long-acting drug formulations, which are less prone to poor adherence, could make useful contributions to improve patient outcomes. In this context, the search for a cure remains central. The impact of HIV on society, the economy and social development, communications, social norms and human rights require careful long-term study, while the efforts to mitigate these impacts require systematic long-term evaluation. Innovation must be linked to a thorough understanding of the local context of these epidemics and the structural constraints to HIV and TB control in South Africa.

Like HIV, the large number of people with asymptomatic STIs presents a substantial challenge in STI control. Innovations in STIs, including simpler point-of-care STI diagnostics, drug resistance assays, simpler treatment regimens could have a substantial impact by improving individual patient treatment, community-based screening and wide-scale community outreach STI control strategies.

Innovations in TB are needed to increase our understanding of the pathogenesis of TB and to fuel discovery of drugs, vaccines and diagnostics. Long-range basic and applied research is required to improve diagnostics for TB infection and disease (especially point-of-care tests), to develop improved treatment and prevention regimens using current and
new drugs, to develop novel vaccines and optimise current vaccines, and to identify and validate biomarkers that facilitate development of vaccines, diagnostics and drugs.

**D. Policy, Social and Public Health Research**

Decisions on services, programmes and interventions for HIV, STIs and TB usually have far-reaching implications, for example, on gender equity, alcohol use, and intellectual property rights. Just as biomedical information and cost-effectiveness estimates feed into policy debates, South Africa’s values, as a constitutional democracy and a society in transition, need to be analysed, understood and factored into policy development. The NSP encourages research on HIV, STI and TB policies, their social, economic and ethical dimensions, as well as the processes of policy development and implementation. Research on the public health consequences of policy decisions such as their impact on resources available for other health challenges and social development can provide a broader perspective to better understand whether the NSP is contributing to the promotion of a caring society.

Whilst there should be rapid implementation of research innovations key social, behavioural and economic considerations may also play a role in determining uptake. These need to be studied to ensure that implementation is sensitive, within reason, to community needs, preferences and perceptions. SANAC needs to ensure that new knowledge is rapidly processed and translated into policy for action. All relevant role players need to be involved in making decisions on how the new research is processed and translated, how decisions on its use are made and how these decisions are communicated to the broader public and service providers.

**8.3 Mapping the way forward**

A new approach is needed for the way HIV, STI and TB research is done in South Africa. The gap between the high quality globally focused research being conducted in South Africa and the lack of elementary information to improve the impact on these diseases needs to be addressed. The following four steps are proposed.

*First*, researchers\(^{16}\) and policy-makers must commit jointly to an evidence-based approach to the country’s HIV, STI and TB response, including the development of a common understanding of the main drivers and risk factors for transmission at a local and national level. Data need to be collated and synthesized so that researchers and policy-makers can make informed decisions on priorities. A common understanding on the status, nature and future consequences of these diseases is an initial step.

*Second*, regular interaction must occur between researchers, policy-makers and the leaders of public health programmes to ensure that the HIV, STI and TB policies take account of the latest science. SANAC is well placed to play this role though its Research and Monitoring and Evaluation (M&E) Sector and/or Research, and M&E Technical Task Team (TTT), which oversee the implementation of the national response to the HIV and TB epidemics as well as the treatment and prevention task teams. Communication of the research needs to be carefully planned and integrated into the research agenda.

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\(^{16}\) This includes researchers from all disciplines
Third, a national research agenda needs to be developed on the basis of detailed knowledge of the country’s epidemic such as the recent Know-Your-Epidemic and Know-Your Response (KYE-KYR) analysis. Such an agenda should not be an exhaustive list but a set of priorities for research action that can make a real difference to the country’s efforts against these diseases. The priorities should preferably be set during the first 6-12 months and then reviewed at appropriate intervals during the course of the implementation of this NSP from 2012 to 2016. It needs to take a long-term view — TB, STIs and HIV are likely to be around for decades to come — and should strike a balance between implementing and evaluating known effective public-health strategies one the one hand, and on the other hand, developing new technologies (e.g. behavioural programmes, microbicides, vaccines and PrEP) and new approaches (e.g. structural interventions like conditional cash transfers and legislative changes on sex work) for prevention, treatment and impact mitigation. South African researchers will have to redirect some of their effort away from internationally contracted studies towards implementing this national agenda. To make this possible, government backing will be essential and scientific excellence must remain the benchmark.

Finally, government funding of HIV, STI and TB research must increase substantially. Today, less than 5% of all the AIDS research funding in South Africa comes from the government’s three major funding sources — the Medical Research Council, South African AIDS Vaccine Initiative (SAAVI) and the newly established South African HIV/AIDS Research and Innovation Platform. This has to change. But even if the government increases its budget several-fold, international finance will still be required. The government’s Department of Science and Technology needs to lead the process of developing a compact for joint funding for South Africa’s research priorities, with the world’s largest funders of research such as the US National Institutes for Health, the President’s Emergency Plan for AIDS Relief (PEPFAR), the US Agency for International Development (USAID), the US Centres for Disease Control and Prevention (CDC), Wellcome Trust, Bill & Melinda Gates Foundation and the Howard Hughes Medical Institute.
This chapter is not yet complete – as the reference group established by the SANAC chairperson, has not yet completed its deliberations. Every effort is being made to ensure that this will be available by the time of the PIC meeting on 6 October.
CHAPTER 10 – COSTING AND FINANCING THE NSP 2012-2016

10.1 Indicative Costs of the NSP

An indicative costing of the NSP will be based on the interventions proposed within draft 1. Since a national HIV, STI and TB strategy is designed to indicate broad goals and objectives for the country’s response without detailed activities and implementation plans, any costing undertaken at this stage can only provide an estimate of the likely magnitude of the costs.

After reviewing the available high level costing tools and cost estimates already undertaken in South Africa, the costing team agreed that an updated and adjusted version of the Resource Needs Model from the “AIDS 2031” costing and the National AIDS Cost Model would be used to provide the broad estimates of the cost of the NSP.

The general approach to estimating costs is to estimate the number of people in need of an intervention from epidemiological and demographic data together with the coverage of the service based on the targets contained in the NSP (i.e. the percentage of the need that is to be met). The unit cost of each intervention is then calculated by estimating the physical ingredients of the intervention (e.g. ARVs, diagnostic tests, health facility consultations) and multiplying this by the cost of each ingredient. Overall resource needs are a function of the number of people using the intervention and the unit cost of the intervention. These will be estimated on an annual basis and will be summed across the period to give an indication of the likely costs of implementation. Costing will be undertaken for the country as a whole, from a provider’s perspective. In other words, we will only include the costs incurred by the provider of a service; no costs incurred by patients (such as travelling costs to and from facilities) will be considered. Costs will be presented in 2011 prices; where necessary, inflation adjustments will be made using the Consumer Price Index.

The AIDS 2031 model will be calibrated to the latest ASSA epidemiological indicators, the unit costs will be updated with more recent unit costs (if available), and the ART estimates will be updated with the latest estimates from the Meyer-Rath et al (2009) model.

10.2 Gap Analysis

In addition to providing estimates of costs, the chapter will undertake a gap analysis. Such an analysis compares projected costs to current expenditure. Expenditure data will be taken from the results of the National AIDS Spending Assessment (NASA) that has recently been completed by the Centre for Economic Governance and AIDS in Africa (CEGAA) (these data are currently being validated and finalised with the provinces and SANAC and will be released shortly). Because actual expenditure is measured, these data are only available for the 2007/08 to 2009/10 financial years. NASA measures all

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17 Guthrie, T., N. Ndlovu, et al. (2010). The long run costs and financing of HIV/AIDS in South Africa, Centre for Economic Governance and AIDS in Africa; Results for Development
expenditure on HIV and TB incurred by government, development partners, and the private sector.

The NASA data were collected through the following methods:

- Interviews and expenditure record verification
- Data triangulation to ensure correct actual expenditure.

Data were then cleaned and captured in excel, and analyses were undertaken. In addition, stakeholders were invited to provincial workshops where results were presented and an opportunity was given to comment on the accuracy of the data.

Expenditure will be analysed within the following categories:

- Government departments (particularly departments of health, education, and social development)
- Development partners and donors
- Non-governmental organisations
- The for profit private sector

In addition, we will be able to use these data to disaggregate expenditure by strategic objective.

10.3 Sustainable Financing

The third section of the Costing and Financing Chapter will make recommendations as to how the NSP should be financed. Given that the vast majority of the costs will be covered through government budgets, this section will also unpack any double counting between these costs and existing government initiatives (for example the National Health Insurance and the plans for Primary Health Care revitalisation).

10.4 Costing of the Provincial Strategic Implementation Plans

Once the NSP has finalised the national targets of each intervention identified as necessary to achieve the national goals, an estimation of the provincial share of each of the targets should guide the Provincial Strategic Implementation Plans (PSPs). Provinces can then develop their implementation plans, with clear interventions and targets that are SMART (specific, measurable, accurate, reliable and timely). Note that the interventions must be ‘tangible’ and operational. For example, objectives such as ‘reduce stigma’ cannot be costed without precise details of the exact programmes to achieve this, such as 3 national education campaigns rolled out per annum via TV, radio and bill boards. An intervention such as: “Build capacity within civil society to increase access to justice” will require exact details of what training or awareness raising activities will be implemented, as well as their frequency and scope/size. In other words, costing requires SMART interventions with adequate detail to allow the costing team to identify and cost the components. Only then can the costing of the provincial operational plans begin.

It is suggested that a relatively simple costing tool, preferably results-based, be designed for the provincial operational plans. This might be an adjustment of the tool applied by Strategic Development Consultants, or the UNAIDS costing and budgeting tool, or the Resource Needs Model. However, whichever tool is applied, the following will be required to populate it:
• Provincial level epidemiological and behavioural data – e.g. numbers of adults and children living with HIV, numbers in need of treatment, numbers of commercial sex workers, provincial rates of HIV transmission between different population groups, frequency of casual sexual relationships with and without condoms, age of sexual debut etc. These data are particularly difficult to obtain, as was found by the Modes of Transmission study at provincial level.

• Provincial current coverage rates for all interventions – e.g. number of school children currently reached by the life-skills programme, number of mothers receiving PMTCT, number of health workers receiving PEP, number of orphans receiving support and grants, etc.

• The provincial annual scale up targets for each year for each intervention.

The costing team should start working with provinces early in the process so as to ensure that the provincial interventions and targets can be costed, and to encourage their early collection of the above data. This process needs appropriate political buy-in given that costing and budgeting of this nature is not straightforward and new data will need to be collected. If there is appropriate buy-in, the costing team can then provide training and technical support to the provinces to enable them to populate and use the costing tool, and to develop their budgets accordingly. This will be necessary on an annual basis, prior to the commencement of the budget determination cycle.

The proposed results-based costing tool will link the resource needs estimates to their intended outputs and results which will enable the provincial officials to track their expenditure according to these and to ultimately ensure that their spending achieves their overall goals. In addition, the cost estimates must be broken down by cost component (budgetary line items) to enable the public official to easily identify the salary, drugs, laboratory, equipment, capital investments, overheads costs etc. Once structured in this way, their budget estimates can be created which will inform their application to their provincial departments (at the very beginning of the budget cycle) and subsequently to National Treasury. If this application can clearly indicate the intended results and coverage rate, the required activities, the realistic unit costs, and the budgetary item breakdown of the total for each year of the MTEF period, it will greatly enhance its chance of approval and adequate funding. At the same time, the financial management system (currently BAS) must be adjusted so as to easily track the provincial and district spending according to specified interventions, which will allow the public officials to prove their achievement of their results (or lack thereof).

The process described above will require extensive and ongoing training and technical support for provincial and district level programme managers and financial managers, in the application of the costing and budgeting tool, and in tracking of expenditure. The financial management system will need to be adjusted and improved, for easier use by the programme managers, and to ensure routine and ongoing expenditure tracking (with the analysis of financial data) to inform project planning. It is therefore imperative that this process is properly resourced in order to allow for successful implementation. The following table provides a breakdown of the likely timeframe and the required time input from consultants. The final Costing and Financing Chapter will also provide a more detailed budget for doing this work.
Table 1: Activities and timeframes for costing and budgeting at the provincial level

<table>
<thead>
<tr>
<th>Activity</th>
<th>Steps Required Prior to Commencement</th>
<th>Possible Date of Commencement</th>
<th>Timeframe Required</th>
<th>Possible Date of Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Costing the Provincial Operational Plans - 2012</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review available results-based costing and budgeting tools</td>
<td>None – can begin once costing contract is finalised</td>
<td>January 2012</td>
<td>15 days</td>
<td>End Jan 2012</td>
</tr>
<tr>
<td>Design a results-based costing and budgeting tool suitable to the Provincial needs</td>
<td>Discussion with provinces to ascertain the status of Operational plans and costing needs</td>
<td>February 2012</td>
<td>15 days</td>
<td>March</td>
</tr>
<tr>
<td>Provide training to each province in the application of the tool</td>
<td>Dates secured with PACs, PDOH, PDSD, PDOE &amp; logistics arranged by SANAC. PSPs and Operational Plans finalised</td>
<td>? April 2012</td>
<td>5 days in each province = 45 days</td>
<td>End June</td>
</tr>
<tr>
<td>Assist the provinces to populate the model with their PSP interventions and targets (assuming most done during training week)</td>
<td>Operational Plans finalised with clear SMART interventions &amp; targets</td>
<td>? April 2012</td>
<td>5 days in each province = 45 days</td>
<td>End June</td>
</tr>
<tr>
<td>Assist the provinces to populate the model with their epidemiological &amp; behavioural data (assuming most done during training week, if data available)</td>
<td>Provinces must collect their epidemiological and behavioural data PRIOR to the training week</td>
<td>? April 2012</td>
<td>5 days in each province = 45 days</td>
<td>End June</td>
</tr>
<tr>
<td>Assist the provinces to populate the model with provincial ASSA figures</td>
<td>ASSA expert to provide the provincial data</td>
<td>? April 2012</td>
<td>5 days in each province = 45 days</td>
<td>End June</td>
</tr>
<tr>
<td>Assist the provinces to populate the model with their current coverage rates for each intervention</td>
<td>Provinces must collect their current coverage rates for all interventions PRIOR to the training week</td>
<td>? April 2012</td>
<td>5 days in each province = 45 days</td>
<td>End June</td>
</tr>
<tr>
<td>Assist the provinces to populate the model with provincial specific unit costs (if any exist). Or apply the unit costs used in the national estimates.</td>
<td>Provinces must collect their unit costs for each intervention PRIOR to the training week</td>
<td>? April 2012</td>
<td>5 days in each province = 45 days</td>
<td>End June</td>
</tr>
<tr>
<td>Assist the provinces to generate first draft estimates to present to stakeholders</td>
<td>Can only be done if ALL of the above data has been provided by the provinces</td>
<td>? April 2012</td>
<td>5 days in each province = 45 days</td>
<td>End June</td>
</tr>
<tr>
<td>Activity</td>
<td>Steps Required Prior to Commencement</td>
<td>Possible Date of Commencement</td>
<td>Timeframe Required</td>
<td>Possible Date of Completion</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Assist the provinces to adjust their model accordingly and regenerate.</td>
<td>Provinces to share initial estimates with stakeholders, receive feedback</td>
<td>July 2012</td>
<td>1 month</td>
<td>August</td>
</tr>
<tr>
<td>Assist the provinces to prepare their MTEF budgets</td>
<td>Cost estimates to be converted into provincial MTEF budget estimates, if all of the above has occurred timeously</td>
<td>August 2012</td>
<td>1 month</td>
<td>Sept 2012</td>
</tr>
<tr>
<td>Annual assistance to provinces to review their expenditure, assess achievement of targets, adjust targets, rerun cost estimates, and develop their annual and MTEF budgets.</td>
<td></td>
<td></td>
<td>5 days per province, annually.</td>
<td></td>
</tr>
</tbody>
</table>