



MIDTERM REVIEW

OF THE NATIONAL STRATEGIC PLAN
FOR HIV, TB AND STIs 2017 - 2022

DECEMBER 2019



REPUBLIC OF SOUTH AFRICA



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ACKNOWLEDGEMENTS

The SANAC Trust would like to thank the Institute of Health Programs and Systems (IHPS), Mid Term reference Group, and all Stakeholders who were involved in the Mid-Term Review (MTR) process. We would also like to thank the contribution of all those who devoted their time to provide information about the implementation of the NSP 2017-2022. We hope the conclusions and recommendations ensuing from the review can contribute to improve the NSP implementation and to reach its goals and targets.



The Mid-Term Review (MTR) of the NSP 2017-2022 has been prepared by a team of independent consultants from The Institute of Health Programs and Systems (IHPS). On behalf of the Health Sector, we hereby convey our gratitude to the consultants, who worked with the South African National AIDS Council (SANAC) to produce this Review.

The review has revealed to us that the current NSP has made significant inroads in terms of reducing new HIV infections compared to previous NSPs. This points to the sterling work done by drawing lessons from past NSPs to ensure that the current one is a great success. For example, at MTR point, the Gauteng province reflected a 20% decline in new HIV infections, the biggest jump recorded to date. The NSP target of reducing the number of new HIV infection to less than 100 000 by 2022 is aligned with the UNAIDS Global Coalition target of a 75% reduction from 2010 to 2020.

The country has made significant progress towards meeting the 90-90-90 targets set by UNAIDS. These targets implore countries to ensure that 90% of all people living with HIV should know their HIV status, 90% of all people with diagnosed HIV infection are on sustained treatment, and finally, 90% of all people receiving treatment should be virally suppressed. The deadline for these targets is December 2020.

Data analysis emerging from this MTR indicate that South Africa is currently sitting at 90-68-88. This means we're doing well in terms of testing people however; we aren't retaining enough of them – we need to do much more to ensure that all people living with HIV are initiated and retained on treatment. Some progress has been recorded in response to TB however,

a lot still needs to be done in terms of finding TB clients lost to follow-up as well as reducing TB related deaths.

Access to healthcare services by key and vulnerable populations through the Key Populations HIV Services mapping in all districts of the country. More work still needs to be done to have population-based data so that we can measure coverage and outcomes of Key Population services. Programme integration and stakeholder collaboration and alignment are among the key structural requirements for a successful implementation of the NSP.

Great progress in this regard, for example, AIDS Council structures have been established at levels and have opened space for full participation by civil society to lead targeted community-based interventions. Programmatic alignments include the integration of Comprehensive Sexuality Education in schools – this feeds into the on-going 'She Conquers' Campaign targeting adolescent girls and young women (AGYW) who are among the hardest hit by HIV. Through the Key Populations Regional Global Fund (GF) grant, partners have piloted human rights monitoring and response models in various communities of South Africa. This work gives effect to Goal 5 of the current NSP which is to ground our response in human rights approaches and principles.

We have seen piloting and full implementation of the Health Patient Registration System (HPRS) that allows for the unique identification of a patient across health care service points within the public sector in SA. However, there is still a need for a more streamlined data warehouse to consolidate all the data for NSP implementation for easier reporting to inform policy and programme improvement. An area of concern however, is the continued decline in donor funding towards HIV response programmes, particularly in provinces like Northern Cape where the HIV, TB and STIs burden is perceived to be relatively low. This poses significant hurdles in our quest to implement tailored and targeted HIV, TB and STIs response programmes. Sustained investment is key towards the attainment of our goal to end HIV as a public health threat.

Gratitude goes to SANAC and all stakeholders for the compilation this MTR report.

**Minister of Health
Dr. Zweli Mkhize**

PREFACE



The Mid-Term was a collaborative effort between the SANAC Secretariat, government departments, SANAC Civil Society and the numerous development partners who contributed to the process and participated in the Reference Group and the validation workshops.

The findings of the MTR are important in reviewing our progress and performance against the goals and objectives set in the NSP to help us review what is working and what has not worked in order for us to plan better before the end of the NSP.

I would like to thank all those individuals and organisations that contributed to the process especially the members of the Reference Group and all Stakeholders.

Special thanks also go to Coceka Nogoduka, Lifutso Motsieloa and Billia Luwaca from the SANAC Strategic Information Unit who managed the consultants as well as the entire process of the MTR.

**Sanac Chief Executive Officer
Dr. Sandile Buthelezi**

EXECUTIVE SUMMARY

Purpose of the NSP Mid-Term Review

The overarching goal of this midterm review (MTR) of the NSP 2017-2022 was to conduct an in-depth analysis of the NSP implementation, with a specific focus on progress made towards achieving the targets set for each of the eight goals.

The review was intended to illustrate emerging issues and opportunities, lessons learned, gaps and challenges encountered during the implementation of the first half (2017/18-2018/19) of the NSP term.

Accordingly, the MTR findings will inform targeted implementation in the second half (2019/20-2021/22) of the NSP period and guide recommendations for enhanced performance towards achievement of the targets by the end of the NSP term (2021/22).

MTR Methodology

The Institute of Health Programs and Systems (IHPS) used a highly consultative and participatory approach to the Mid-Term

Review (MTR) in which several stakeholders contributed to the NSP MTR with a central steering panel providing oversight and guidance as a multisectoral MTR Reference Group.

IHPS assembled a Team of Technical Experts (TTEs) to undertake this assignment at both National and Provincial level. In undertaking this task, the IHPS teamw engaged in an Extensive Data Collection Process that focused on both Primary and Secondary data.

The data collection was a Two-Pronged Parallel Assessment with a team of experts at National level and Provincial level who utilized the following data collection methods: Primary Data Collection (key Informant Interviews (KII), an After-Action Review (AAR) process, a Monitoring and Evaluation (M&E) Experts Workshop, Stakeholder Validation Workshops) and Secondary Data Collection (document review and epidemiological trend-analysis/review).

MTR Findings

GOAL 1

Accelerate Prevention To Reduce New HIV And TB Infections And STIS

The new HIV infections, as measured through the Thembisa model version 4.2 have shown a decline from 469000 (2007) to an estimated 231100 (2018) new infections which is a 51% reduction reported in the 2012 estimates. T

he incidence rate was 0.48% (female sex workers 8.36% and MSM 2.91%) with youth aged 15-24 years having the highest incidence rate of 0.96% (females 1.54%; male 0.42%) which was over double the overall national incidence rate of 0.44%.

If the current rate of decline is maintained in the last half of the NSP, the country is likely to not meet its goal of reducing incidence by 50% as it will only reach about 38% which will translate to 170331 new HIV infections by 2022.

This data shows that the country needs to intensify its HIV prevention interventions especially among those populations who are at more risk of contracting HIV.

A closer look into new HIV infections data shows that, the percentage change for females 25-49 years (-16%) and adults

above 50 years (both male (-15%) and female (-12%)) was relatively lower than the national percentage change of -19% between 2016 and 2018. A provincial comparison of trends of new HIV infections revealed the following:

- The current NSP is the fastest in terms of decline in new HIV infections compared to the previous two NSP periods. This could reflect gains of work that has been invested over the other two periods and intensification of interventions in the current period. As an example of this, at MTR point, the Gauteng province, with a minus 20% decline in new HIV infections, had already exceeded their percentage change for the previous two NSPs periods.
- The WC (-12%), NW (-11%) and EC (-17%) had the percentage change below the national (19%).
- All other provinces' current mid-term percentage change has shown greater potential to exceed, with a wide margin, their performance of the previous two NSP periods.

GOAL 2

Reduce Morbidity And Mortality By Providing Treatment, Care And Adherence Support For All

The HIV treatment cascade shows that the country is doing well and may have already reached the 1st 90 (PLHIV who know their status) and is closer to achieving the 3rd 90 (PLHIV virally suppressed) although this was reported based on a 50% sample of viral load done. The country remains challenged regarding the 2nd 90 i.e. 90% of PLHIV who know their status and are initiated on ART.

- South Africa is doing well as regards identifying HIV positive people and ensuring on ART are virally suppressed. Across all provinces, the key challenge remains that of initiating 90% of people who test HIV positive on ART i.e. 2nd 90, except in Limpopo where 94% has been achieved.
- Regarding the 1st 90, provinces are yet to meet the 90% targets with Limpopo, Eastern Cape and Gauteng having reached 76%, 73% and 71% respectively.
- The North West is struggling with the 2nd 90 (58%), and 3rd 90 (44%), but doing well regarding the 1st 90 (89%). There is an urgent need to support the province to understand the root causes and develop a quality improvement plan to address gaps identified.

The TB cascade reveals that in 2018, there were 301 000 TB cases. Of the new and relapse cases (56% males, 37% females and 7% children), 90% knew their HIV status and 89% had pulmonary TB. 65% of newly enrolled HIV positive patients were put on TB preventive therapy and 87% of the TB/HIV coinfected patients were on ART.

TB treatment success rate for new and relapse TB cases was 77% in 2018. Furthermore, 75% of the HIV-positive TB cases were successfully treated for TB. Despite the notable achievements in HIV and TB treatment, the following are challenges that remain:

- High TB clients lost to follow-up rate – 8% based on the 2017 cohort (ETR 2019). Increased from 6.1% (2014 cohort) to about 8% against the 2018/19 NSP target of 4.9%. The North West and Free State provinces reported high TB lost-to-follow-up and TB specific deaths rates which threaten to reverse the gains made in the fight against the HIV, TB and STIs epidemic.
- Poor performance in ART initiation undermines efforts being made in identifying PLHIV who did not know their status and threaten to reverse the gains recorded so far.
- While viral load suppression is at 88%, this achievement is based on a very small denominator (viral load done= 50%).
- Rising TB death rate - increased from 4.4% at baseline in 2016 (2014 cohort) to 6.5% in 2019 (2017 cohort), against an NSP 2018/19 NSP target of 4.65%.

GOAL 3

Reach All Key And Vulnerable Populations With Customised And Targeted Interventions

The following were key findings from the MTR:

- At all levels, HIV, TB and STIs governance structures, with representatives from key populations' organizations/networks, have been activated and are functional.
- Increased access to health services by key and vulnerable populations through KP HIV services mapping in all districts, increased coverage of CSE in schools, sex worker clinics, use of social media for accessing services by younger KPs, establishing support groups and safe spaces for KPs, providing comprehensive HIV services to inmates and implementation of PrEP demonstration projects.

Some notable challenges remain:

- The limited population-based data that are available show that testing and treatment coverage among KPs (PWID, MSM, TG and FSW) remains disproportionately low

with no key population group close to achieving 90-90-90 targets.

- Limited availability of data on KPs due to the population being hard to reach as a result of fear of stigma and discrimination.
- Law enforcement agencies' negative attitudes and practices are key barriers to scaling-up of HIV prevention and treatment efforts, leading to inducing fear of accessing harm reduction and health services among KPs.
- The KPs bemoan the limited involvement of their members both on the frontline and in the leadership of the design, implementation and evaluation of interventions that affect their lives in accessing HIV, TB and STIs services.

GOAL 4

Reach All Key And Vulnerable Populations With Customised And Targeted Interventions

The following achievements were realized:

- Stakeholder alignment of AGYW interventions under the integrated 'She Conquers' National Campaign.
- Social protection programmes reaching parents/caregivers through the Families Matter Programme, about 17,666,235 beneficiaries received social grants, all nine provincial food distribution centres (PFDCs) operational.
- The development of Scripted Lesson Plans (SLPs) for Intermediate Phase (IP) and Further Education and Training (FET) to strengthen comprehensive sexuality education.
- Scaling up of SBCC interventions under the DSD resulted in people who had high exposure to SBCC (78,7%) reported that they had taken an HIV test (SABSSM; 2019).
- From a legal perspective, 75 Regional Courts were upgraded to sexual offences courts and the conviction rate on sexual and GBV reportedly increased to 74% by the end 2017/2018.
- Inadequate funding for the coordination, monitoring and communication components of the She Conquers campaign at all levels limiting its impact.
- Recruitment of ineligible young people (older people and easily available not risky people) for the SBC programmes was a major drawback.
- A culture of silence overshadows GBV including sexual violence, which has continually resulted in underreporting of sexual offences and domestic violence.
- Limited evaluation data on the efficacy of the impact of socio-structural interventions in building or strengthening resilience among priority populations vulnerable to HIV.

Despite the successes identified under this goal, the following were identified key challenges:

GOAL 5

Ground The Response To HIV, TB And STIs In Human Rights Principles And Approaches

The following were summary of findings under this goal:

- NDOH conducted a sensitisation and training of health workers to increase their awareness and understanding of medical ethics, patient rights and needs of PLHIV.
- Through the KP REACH Regional Global Fund (GF) grant, partners have piloted human rights monitoring and response models in South Africa.
- A pilot study conducted by the Legal AID SA at four of its High Courts to determine levels of litigants' representation revealed the lack of knowledge of services that are available to clients as a major barrier to accessing such service.

GOAL 6

Promote Leadership And Shared Accountability For A Sustainable Response To HIV, TB And STIS

The following were the MTR findings under this goal:

- All AIDS Council structures have been established – one at national, nine at Provincial, fifty two at Districts and two hundred and twenty three at Local level.
- AIDS Councils have opened space for civil society to participate with full understanding of their mandate.
- SABCOHA continues to co-ordinate a private sector response to health, and more specifically the TB and AIDS epidemics.
- The development of the Accountability Framework through an Accountability Scorecard has been completed
- 46 out of 52 District AIDS Councils (DACs) have developed Multi-sectoral District Implementation Plans (MDIPs).

The following were the identified gaps and challenges:

- Due to inadequate sector representation, most AIDS Councils are generally weak and failing to implement multi-sectoral approach.
- While leadership is often strong at national level, capacity is much weaker at local levels, with Mayors and Councillors reportedly not taking full ownership and responsibility.
- Even though MDIPs exist, they are not well integrated with local development plans and budgeting processes.

GOAL 7

Mobilize Resources To Support The Achievement Of NSP Goals And Ensure A Sustainable Response

The noted challenges and gaps under this goal include:

- Declining donor funding, particularly in provinces like Northern Cape where the HIV, TB and STIs burden is estimated to be relatively low.
- Increased donor and government funding directed specifically to HIV treatment was reported to have displaced or 'crowded out' funding for other HIV non-medical programmes.
- Local municipalities are reportedly not prioritising HIV and TB funding in their budget processes.
- Local AIDS Councils reported that they, most of the times, are not allocated any funding to support the operations of their civil society at local level where adaptation to HIV, TB and STIs occur.

GOAL 8

Strengthen Strategic Information To Drive Progress Towards Achievement Of NSP Goals

The following are key SI activities that were identified by the MTR:

- The piloting and full implementation of the Health Patient Registration System (HPRS) that allows for the unique identification of a patient across health care service platforms within the public sector in SA.
- Development of nine Provincial Implementation Plans (PIPs) in all provinces and Multi-sectoral District Implementation Plans (MDIPs), except the Western Cape without MDIPs.
- Development and implementation of the M&E plan for the NSP and Provincial M&E plans.
- Regular reporting by the Provincial M&E Officers.
- SANAC met all its international obligations (GAM and NCPI reports).

The following were identified gaps and challenges:

- Lack of costed provincial M&E Plans to operationalise M&E activities.
- No standardised fully functional national data capturing system.
- Limited financial resources to absorb M&E personnel within PCA structures.
- Unavailability of certain indicators in the NSP (e.g. gender-based violence and TB).
- Absence of a 5-year NSP HIV, TB and STI research agenda.
- The unavailability of a national surveillance system to generate periodic estimates of HIV, TB and STI in the general population and in key and vulnerable populations.

Summary Of NSP Recommendations And Next Steps

GOAL 1: ACCELERATE PREVENTION TO REDUCE NEW HIV AND TB INFECTIONS AND STIS

Promote the implementation of evidence-based strategies to improve HTS yield.

Implement strategies to create demand for and expand provision of PrEP.

Address condoms supply chain management systems challenges including considerations for a decentralised procurement system.

Institutionalize the implementation of the UTT policy to ensure all HIV positive individuals are initiated on ART

Implement the national TB prevalence survey recommendation to address TB prevention and control gaps identified.

GOAL 2: REDUCE MORBIDITY AND MORTALITY BY PROVIDING TREATMENT, CARE AND ADHERENCE SUPPORT FOR ALL

Support provinces to determine the root causes for TB and HIV cascade gaps and support improvement plans, e.g. support the North West to improve performance towards achieving the 2nd and 3rd 90s whilst Northern Cape and Limpopo are supported to reach the 1st 90.

Increase demand for viral load testing at individual and community level through CBOs.

Strengthen community-based support for TB patients to reduce lost-to-follow-up and TB death rates.

Review/ revise the NSP STI indicators and targets and establish a comprehensive national STI reporting and monitoring framework to enable optimal tracking and management of the STI burden.

GOAL 3: REACH ALL KEY AND VULNERABLE POPULATIONS WITH CUSTOMISED AND TARGETED INTERVENTIONS

Improve KPs engagement, leadership and support for model design, implementation, and monitoring.

Strengthen the capacity of community health workers to implement community-level interventions and ensure appropriate linkages between community-based and health care facility-based KP services.

KPs disproportionate access to HIV services point to the need for a differentiated approach.

Review and implement the recommendations of the South African Law Reform Commission report to move forward the conversation of law reform on sex work.

GOAL 4: ADDRESS THE SOCIAL AND STRUCTURAL DRIVERS OF HIV, TB AND STIs, AND LINK THESE EFFORTS TO THE NATIONAL DEVELOPMENT PLAN (NDP)

Appoint provincial and district champions to promote collaboration in implementing the 'She Conquers' Campaign agenda.

NPOs should use the focus for impact approach to ensure that they reach the appropriate KPs to ensure impact.

Strengthen interventions that target knowledge, beliefs and attitudes of community members to eliminate the culture of silence around GBV and minimize attitudes and beliefs that promote perpetuation of GBV.

Systematic and rigorous training for law enforcement agents who specialize in gender-based violence.

Conduct an evaluation that assesses the efficacy of socio-structural interventions in building and strengthening resilience to HIV, TB and STIs at community and individual level.

GOAL 5: REDUCE MORBIDITY AND MORTALITY BY PROVIDING TREATMENT, CARE AND ADHERENCE SUPPORT FOR ALL

Develop and implement interventions that increase the visibility of human rights services across the provinces.

Educate users on how to access and use human rights services close to them .

Strengthen PCA capacity to identify high impact human rights activities.

GOAL 6: PROMOTE LEADERSHIP AND SHARED ACCOUNTABILITY FOR A SUSTAINABLE RESPONSE TO HIV, TB AND STIS

Organise a consultative meeting of Mayors, OTPs and the national level leadership to rejuvenate and strengthen political support for operationalising the AIDS Council activities at a local level.

SANAC to strengthen the capacity of PCAs, DACs and LACs to ensure effective coordination of the multi-sectoral response to HIV, TB and STI at local level, and help to address the weak relations between sectors.

Include regular reporting by political leaders to enforce compliance at the local level .

Implement a strategy to hold accountable the private sector towards achieving their NSP targets.

GOAL 7: MOBILIZE RESOURCES TO SUPPORT THE ACHIEVEMENT OF NSP GOALS AND ENSURE A SUSTAINABLE RESPONSE

SANAC to ensure a resource balance between a focus on medical and non-medical interventions.

Develop a financial model or financial sustainability framework that identifies how the HIV, TB and STIs response can be financed locally.

GOAL 8: STRENGTHEN STRATEGIC INFORMATION TO DRIVE PROGRESS TOWARDS ACHIEVEMENT OF NSP GOALS

Provide additional human resources and skills support for the development of activity-based costing of M&E plans across all provinces.

Strengthen M&E capacity by ensuring availability of data through a central repository for monitoring of the response at district and ward levels.

Prioritise the development and adoption of 5-year NSP HIV, TB and STI research agenda.

Provincial evaluations of MDIPs and development of plans of action based on identified 90-90-90 gaps.

Facilitating data sharing agreements with implementing partners to enable data collation into the SANAC data repository system.

Revise the targets for all the indicators at the provincial level as a way of strategizing towards meeting the 2022 NSP targets.

To this end, it is imperative to acknowledge the strides that have been taken to reach the goals of the NSP and the concerted efforts from the multisectoral stakeholders. It becomes critical in the next accelerated catch-up phase to engage in integrated evidence-based planning and implementation, monitoring and evaluation. South Africa is on course to reach the targets of the NSP despite the harsh realities of COVID-19 and such achievements are essential in the HIV, TB and STI response.

ABBREVIATIONS

AAR	After Action Review	NEDLAC	National Education and Development Labour Council
APN	Assisted Partner Notification	NGO	Non-Government Organisation
ART	Antiretroviral Treatment (Therapy)	NSP	National Strategic Plan
ARVs	Antiretroviral Drugs	OPEC	Operational Performance Excellence and Coordination
CDC	US Center for Disease Control and Prevention	PDoh	Provincial Department of Health
CPR	Country Portfolio Review	PEP	Post Exposure Prophylaxis
DBE	Department of Basic Education	PEPFAR	US President's Emergency Plan for AIDS Relief
DHIS	District Health Information System	PICT	Provider Initiated Counselling and Testing
DoH	Department of Health	PLHIV	People living with HIV
DPME	Department of Planning, Monitoring and Evaluation	PMTCT	Prevention of Mother to Child Transmission of HIV
DPSA	Department of Public Service and Administration	PNS	Partner Notification Services
DSD	Department of Social Development	PREP	Pre-Exposure Prophylaxis
FY	Financial Year	RMDC	Resource Mobilisation and Donor Coordination
HCT	HIV Counselling and Testing	SANAC	South African National AIDS Council
HEAIDS	Higher Education and Training HIV/AIDS Programme (now "Higher Health")	SABCOHA	South African Business Coalition on HIV/AIDS
HIV	Human Immunodeficiency Virus	SBCC	Social Behaviour Change Communication
HSRC	Human Sciences Research Council	SI	Strategic Information
HTA	High Transmission Area	SIB	Social Impact Bond
HTS	HIV Testing Services	STI	Sexually Transmitted Infection
IEC	Information, Education, Communication	TB	Tuberculosis
IHPS	Institute of Health Programs and Systems	TTEs	Team of Technical Experts
LFU	Lost to Follow Up	TORs	Terms of Reference
M&E	Monitoring and Evaluation	TTT	Technical Task Team
MDR-TB	Multi Drug resistant TB	TWG	Technical Working Group
MMC	Medical Male Circumcision	UNAIDS	United Nations Programme on HIV/AIDS
MTSF	Medium-Term Strategic Framework	US	United States
MTR	Mid-Term Review	USAID	United States Agency for International Development
NDoH	National Department of Health	WHO	World Health Organisation
NDP	National Development Plan	XDR-TB	Extensively Drug Resistant TB

CONTENTS

Acknowledgements	3
Foreword	4
Preface	5
Executive Summary	6
Abbreviations	12
Table Of Contents	13
SECTION 1: Introduction	16
Background.....	17
Purpose of the NSP Midterm Review.....	18
MTR Methodology.....	19
SECTION 2: MTR Findings	23
Goal 1: ACCELERATE PREVENTION TO REDUCE NEW HIV AND TB INFECTIONS AND STIs	25
Indicators and Results.....	26
Progress against NSP objectives.....	29
GOAL 2: REDUCE MORBIDITY AND MORTALITY BY ProVIDING TREATMENT, CARE AND ADHERENCE SUPPORT FOR ALL ...	43
Indicators and Results.....	44
Progress against Objectives.....	46
GOAL 3: REACH ALL KEY AND VULNERABLE POPULATIONS WITH CUSTOMISED AND TARGETED INTERVENTIONS	57
Indicators and results.....	61
Progress against Objectives.....	64
GOAL 4: ADDRESS THE SOCIAL AND STRUCTURAL DRIVERS OF HIV, TB AND STIs, AND LINK THESE EFFORTS TO THE NATIONAL DEVELOPMENT PLAN (NDP)	71
Indicators and results.....	72
Progress against Objectives.....	74
GOAL 5: GROUND THE RESPONSE TO HIV, TB AND STIs IN HUMAN RIGHTS PRINCIPLES AND APPROACHES	83
Indicators and results.....	84
Progress against Objectives.....	85
GOAL 6: PROMOTE LEADERSHIP AND SHARED ACCOUNTABILITY FOR A SUSTAINABLE RESPONSE TO HIV, TB AND STIS	89
Indicators and results.....	90
Progress against Objectives.....	91
GOAL 7: MOBILIZE RESOURCES TO SUPPORT THE ACHIEVEMENT OF NSP GOALS & ENSURE A SUSTAINABLE RESPONSE ..	96
Indicators and results.....	97
Progress against Objectives.....	97
GOAL 8: STRENGTHEN STRATEGIC INFORMATION TO DRIVE PROGRESS TOWARDS ACHIEVEMENT OF NSP GOALS	101
Indicators and results.....	102
Progress against objectives.....	103
Critical Enablers	111
Summary NSP MTR Findings	112
Summary NSP Recommendations and Next Steps	118
Conclusion	121
References	123

List of Tables

Table 1: Goals of the NSP 2017-2022.....	17
Table 2: Key Activities of the MTR.....	18
Table 3: Summary of the key activities (as per the TORs for this MTR).....	22
Table 4: Goal 1 Indicators – Target vs Actual.....	26
Table 5: Objectives and targets of the Cheka Impilo Campaign.....	30
Table 6: Key achievements by sub-objective 1.1.....	34
Table 7: Estimates of TB burden in 2018.....	38
Table 8: Estimated TB incidence by age and sex, 2017.....	38
Table 9: Drug-resistant TB care, 2018.....	39
Table 10: Key achievements by sub-objective 1.2.....	39
Table 11: Key STI achievements by sub-objective.....	40
Table 12: Goal 2 Indicators – Target vs Actual.....	44
Table 13: HIV Prevalence by age and sex.....	46
Table 14: HIV cascade key achievements by sub-objective.....	49
Table 15: TB key achievements by sub-objective.....	52
Table 16: Treatment success rate and cohort size.....	53
Table 17: TB mortality in 2017.....	54
Table 18: STIs key achievements by sub-objective.....	55
Table 19: Goal 3 Indicators – Target vs Actual.....	61
Table 20: Key achievements by sub-objective 3.1.....	65
Table 21: Key achievements by sub-objective 3.2.....	67
Table 22: Goal 4 Indicators – Targets vs Actual.....	72
Table 23: Key achievements by sub-objective 4.1.....	74
Table 24: Key achievements by sub-objective 4.2.....	77
Table 25: Key achievements by sub-objective 4.3.....	79
Table 26: Key achievements by sub-objective 4.4.....	80
Table 27: Key achievements by sub-objective 4.5.....	81
Table 28: Key achievements by sub-objective 4.6.....	82
Table 29: Goal 5 Indicators – Targets vs Actual.....	84
Table 30: Key achievements by sub-objective 5.1.....	85
Table 31: Key Achievements by sub-objective 5.2.....	86
Table 32: Key achievements by sub-objective 5.3.....	87
Table 33: Goal 6 Indicators – Targets vs Actual.....	90
Table 34: Key achievements by sub-objective 6.1.....	92
Table 35: Goal 6 results.....	94
Table 36: Key achievements by sub-objective 6.2.....	94
Table 37: Goal 7 Indicators – Target vs Actual.....	97
Table 38: Key achievements by sub-objective.....	98
Table 39: Goal 8 Indicators – Target vs Actual.....	102
Table 40: Key achievements by sub-objective 8.1.....	103
Table 41: Key achievements by sub-objective 8.2.....	106
Table 42: Key achievements by sub-objective 8.3.....	108
Table 43: Key achievements by sub-objective 8.4.....	110

Tables of Figures

Figure 1: Thematic analysis framework used for the MTR qualitative data analysis	23
Figure 2: Phased implementation of PrEP policy in South Africa	31
Figure 3: Total new HIV infections, 2007 to 2018	32
Figure 4: New HIV infections percentage change between 2016 and 2018 by combined sex and age	33
Figure 5: Comparing percentage change of new HIV infections by NSP period.....	33
Figure 6: Infant PCR test positivity rates at birth and at 10 weeks, 2016 – 2019	37
Figure 7: Progress towards achieving NSP annual PrEP targets	37
Figure 8: TB incidence for the period 2000 – 2018	38
Figure 9: HIV prevalence by age and sex	46
Figure 10: Progress made towards 90-90-90 targets, 2018.....	48
Figure 11: Progress towards 90-90-90 targets in 2018.....	49
Figure 12: Total remaining on ART (TROA), as at March 2019	50
Figure 14: Total AIDS Deaths for the period 2007 to 2018.....	50
Figure 15: Knowledge of status, treatment and viral suppression gaps, South Africa, 2001-2017	51
Figure 16: TB treatment success rate, 2018.....	53
Figure 17: HIV-negative tb mortality 2000 – 2018.....	54
Figure 18: Male Urethritis syndrome treated – new episode (April 2018 – March 2019)	56

SECTION 1

INTRODUCTION

Background

The National Strategic Plan for HIV, TB and STIs (NSP) 2017-2022 (“the NSP”) is the fourth plan that outlines how South Africa will respond to the epidemics of the Human Immunodeficiency Virus (HIV), Tuberculosis (TB) and Sexually Transmitted Infections (STIs) over a five-year period. It builds on the substantial progress made to date, addresses gaps identified during the past five years (2012-2016) and seeks to scale up best practices to ensure that quality and innovation underpin service provision.

The NSP outlines the strategic framework for a multi-sectoral partnership to further accelerate progress in reducing morbidity and mortality associated with HIV, TB and STIs in South Africa. Provinces developed context specific Provincial Implementation Plans (PIPs) to operationalize the broader strategic direction and approaches planned in the NSP.

The decentralisation through the PIPs allows for national strategies for HIV, TB and STIs to be tailored to the specific needs and conditions of provinces and communities. Similarly, government departments, civil society sectors and the private sector are also expected to develop their respective sectoral implementation plans including the provincial implementation plans (PIPs) and multisectoral district implementation plans (MDIPs).

The NSP is rooted in the National Development Plan (NDP) and is aligned to the Medium-Term Strategic Framework (MTSF) of government. The development of the NSP was based on a thorough review of available evidence and consultation with all SANAC stakeholders.

A multi-sectoral Steering Committee was established to guide the development of the NSP, advised by various stakeholder inputs and by sectoral and national consultations. Duly, the Plenary of the South African National AIDS Council (SANAC) and the national Cabinet endorsed the NSP.

The NSP draws on South Africa’s constitutional framework and emphasises human rights, dignity, non-racialism, non-sexism and the rule of law. Overarching guidance is obtained through alignments with international and regional obligations, commitments and targets related to HIV, TB and STIs. The NSP

steers South Africa’s HIV, TB and STIs response and progress, and allows the multi-sectoral stakeholders or partners to coordinate their efforts among themselves and with the South African Government.

At the core of the NSP 2017-2022 is the strategy to “focus for impact” using more detailed information and insights currently available to guide the national response. Based on this strategy, the NSP state that whilst comprehensive prevention and care will be provided nationwide, intensified, concentrated efforts will be made in the 27 districts that account for 82% of all people living with HIV and for most new infections. The 19 districts with the highest TB burden are also a priority of intensified and concentrated efforts.

In these high-burden districts, amplified efforts will draw on detailed, innovative data sources to identify those most at risk, with an aim to saturate high-impact prevention and treatment services and strengthen efforts to address the social and structural factors that increase vulnerability to infection. There is a significantly stronger focus on adolescent girls and young women (AGYW) and on key and vulnerable populations.

The vision, mission, and principles of the NSP 2017-2022 are as follows:

Vision

A South Africa free from the burden of HIV, TB and STIs.

Mission

South Africa on track to eliminate HIV, TB and STIs as public health threats by 2030.

Principles

- A reliance on sound evidence
- Commitment to protecting and promoting human rights
- A multi-sectoral approach
- A people-centred approach
- A response that is inclusive and participatory
- Ensuring that no one is left behind

The NSP 2017-2022 has eight goals and these are presented in table 1 below.

TABLE 1: GOALS OF THE NSP 2017-2022

GOALS OF THE NSP 2017 - 2022
1. Accelerate prevention to reduce new HIV and TB infections and STIs.
2. Reduce mortality and morbidity by providing HIV, TB and STI treatment, care and adherence support for all.
3. Reach all key and vulnerable populations with customised and targeted interventions.

GOALS OF THE NSP 2017 - 2022

4. Address the social and structural drivers of HIV, TB and STIs and link these efforts to the NDP.
5. Ground the response to HIV, TB and STIs in human rights principles and approaches.
6. Promote leadership and shared accountability for a sustainable response to HIV, TB and STIs.
7. Mobilise resources to support the achievement of NSP goals and ensure a sustainable response.
8. Strengthen strategic information to drive progress towards achievement of the NSP goals.

Purpose Of The NSP Midterm Review

The overarching goal of this midterm review (MTR) of the NSP 2017-2022 was to conduct an in-depth analysis of the NSP implementation, with a specific focus on progress made towards achieving the targets set for each of the eight goals. The review was intended to illustrate emerging issues and opportunities, lessons learned, gaps and challenges encountered during the implementation of the first half (2017/18-2018/19) of the NSP term.

Accordingly, the MTR findings will inform targeted implementation in the second half (2019/20-2021/22) of the NSP period and guide recommendations for enhanced performance towards achievement of the targets by the end of the NSP term (2021/22). As per the SANAC NSP MTR Terms of Reference (TORs), the key activities (objectives) of the MTR are presented in table 2 below.

TABLE 2: KEY ACTIVITIES OF THE MTR

KEY ACTIVITIES OF THE MTR

1. Assess the progress made in the implementation of the NSP and towards the achievements of the NSP goals, objectives, and sub-objectives
2. Identify the challenges and gaps encountered in the implementation of the NSP and recommend possible solutions
3. Assess the effectiveness of the SANAC multisectoral structures in managing the HIV response at all levels
4. Review the resources mobilised and utilised by all sectors since the inception of the NSP implementation and tentatively assess the resources committed for the remainder of the NSP implementation period, and quantify resource gaps
5. Evaluate SANAC stakeholder capabilities regarding the use of routine data including the drivers for the epidemic to improve the outcomes and response
6. Identify and illustrate relevant emerging issues or opportunities regarding HIV, TB and STIs
7. Propose appropriate and practical recommendations in terms of strategies and policies aligned to the emerging issues and/or opportunities
8. Identify lessons learned and best practices from the NSP implementation to date
9. Review impact and outcome indicator set, to create the basis for quality improvements and prioritisation in the NSP implementation
10. Propose indicator sets that are specific, measurable, achievable, reliable, and time-bound in line with set broad goals and objectives of the NSP
11. Assess strategic information (SI) gaps and challenges and propose an enabling environment for monitoring and evaluating NSP implementation progress made towards achieving set targets at the national, provincial and district levels

KEY ACTIVITIES OF THE MTR

12. Appraise the relevance of the multisectoral district implementation plans (MDIP) and PIPs operational processes in line with the NSP
13. Facilitate a national multi-stakeholder consultation to review progress made, identify gaps/challenges, and agree on a set of recommendations in line with emerging issues
14. Facilitate similar workshops for the Provincial AIDS Councils
15. Compile the final MTR report and submit it within set deadlines

MTR Methodology

The Institute of Health Programs and Systems (IHPS) used a highly consultative and participatory approach to the Mid Term Review (MTR) based on experience having conducted the previous MTR of the preceding NSP, in which several stakeholders contributed to the NSP MTR. SANAC also deemed it critical and set up a central steering panel that would provide oversight and guidance as a multisectoral MTR Reference Group.

Routine meetings and continuous engagements were conducted, and documents shared, and feedback used to guide further processes. Given the comprehensive scope of work as highlighted in Section 1 above, IHPS developed a Project Design to facilitate and guide the collection of adequate data on NSP core indicators.

Available data on the progress towards the implementation of the NSP was used to assess NSP implementation performance, and to guide and propose recommendations for the remaining term of the NSP.

IHPS assembled a Team of Technical Experts (TTEs) to undertake this assignment at both National and Provincial level. This team worked tirelessly to ensure a comprehensive assessment of all components of the MTR, including the review of Provincial PIPs, using various data collection approaches as highlighted below, consolidation of findings and presentation of results in line with the expected evaluation outcomes.

However, not all these experts attended the MTR reference group (RG) meetings. Dr TP Neluheni-Tshinaba, in her capacity as the MTR Project Manager and Technical Lead, and Mr T Macheke in his capacity as the MTR Technical Expert for Monitoring and Evaluation (M&E) attended the MTR RG meetings. The other technical experts participated in the MTR RG meetings as and when requested to do so.

The MTR Project Manager managed all communication between SANAC team, MTR RG and IHPS, via email and telephonically depending on the urgency of the matter.

In undertaking this task, the IHPS team engaged in an Extensive Data Collection Process that focused on both Primary and Secondary data. The data collection was a Two-Pronged Parallel Assessment with a team of experts at National level and Provincial level who utilized the following data collection methods:

Primary Data Collection

- i. Key Informant Interviews (KII) were conducted with lead agencies as identified in the NSP, PIPs and through SANAC secretariat and RG. This process was guided by a KII Guide (Annexure A) and was administered to identified stakeholders at all levels either on a face to face basis, telephonically or other communication channels. IHPS TTEs interviewed a total of 85 key informants at both national and provincial level as part of the MTR process, and captured all interview schedules in the KII Interview Schedule Database (Annexure B) for constant update as and when completed.
- ii. An After-Action Review (AAR) process: Each of the TTEs conducted AAR at Provincial Level with all AIDS Council stakeholders to have a thorough assessment of progress with respect to the implementation of the PIPs. TTEs conducted this review process after an in-depth assessment of the PIP achievements against set targets with the Provincial Council on AIDS (PCA) secretariat. After the KIIs and PIP assessments, the AAR was conducted for all stakeholders to collectively reflect on, : “what was supposed to happen, what actually happened and why and what will be done differently for the remainder of the PIP/NSP”. The TTEs used this process to validate provincial findings prior to inclusion in the NSP MTR report. Refer to Annexure C, for the AAR Framework Guide.
- iii. A Monitoring and Evaluation (M&E) Experts Workshop: SANAC convened an M&E experts’ workshop on the 30th October 2019 to review current indicator matrices and their relevance in the NSP, as well as propose

recommendations for the remaining duration of the current NSP with M&E representatives from the multi-sectoral stakeholders. The M&E experts reviewed the M&E framework in the NSP (NSP 2017 – 2022; Pages 80 – 99) in juxtaposition to the SANAC NSP M&E Plan. This presented an opportunity to validate and finalize data as reported per each of the key indicators. IHPS customized and used the NSP M&E Framework template during the workshop (Annexure D).

- iv. Stakeholder Validation Workshops were held with key stakeholders to solicit inputs and validate the MTR findings at National level. IHPS facilitated three sessions with (i) civil society, (ii) government departments, Non-Governmental Organizations (NGOs) and other stakeholders then finally (iii) national stakeholders to validate the MTR findings. IHPS made presentations on findings per each Goal and strategic objectives and allowed for inputs and finalization. All the IHPS technical experts were present in these validation workshops and responded to any issues as raised and captured all inputs.

Secondary Data Collection

- i. Document Review on all HIV/AIDS, TB and STI related materials of interest published between March 2017 and June 2019, including all Provincial PIPs, Annual Reports and any other work that culminated in reports within the set evaluation timeframe was conducted. SANAC shared a preliminary list of all documents with IHPS. IHPS established a Dropbox for the shared documents and this served as a Document Submission Checklist (Annexure E).
- ii. Epidemiological trend-analysis/review of key HIV, TB and STI indicators in the NSP using available data and data triangulation on all NSP indicators with data readily available and published was conducted. The epidemiologist worked closely with the SANAC Strategic Information (SI) Unit to collect data for all the indicators in the M&E Framework and used multiple sources where data was available and published.

To deliver a high-quality product, IHPS implemented the following methodology, which has four (4) critical steps:

Step 1. Inception phase

A comprehensive briefing between SANAC and IHPS served as the initial startup process. The inception phase achieved the following:

- Gaining an understanding of the process to be followed with guidance from previous work done.
- Submission of final work plan with clear roles, responsibilities and timelines for approval.
- Identifying/ confirming the MTR RG for this assignment.

- Setting clear timelines for meetings, submission of progress reports and other deliverables.

Step 2. Strategy development phase

This stage entailed the following:

- Finalization of the methodology for data collection (AARs, KIIs, provincial assessments, stakeholder validation workshops, document reviews, M&E experts' workshop).
- Mapping of relevant stakeholders and RGs/sectors in consultation with SANAC and PCA secretariats.
- Refinement and approval of the data collection tools to be used for the MTR.
- Confirming the structure of the final report.

Step 3. Implementation

The implementation stage involved data collection, data validation, data analysis and report writing. Data collection included a review of existing documents on HIV/AIDS, TB and STI published between March 2017 and June 2019, which aligned to the eight (8) goals of the NSP. These documents included reports, strategic plans, policies, the NSP, PIP progress reports and other relevant guidelines. IHPS collected primary data using the following tools:

- i. A semi-structured interview guide administered by the members of the assessment team to key informants as identified by the NSP and SANAC/PCA secretariats as leads in the NSP implementation
- ii. An AAR workshop guide developed to elicit strengths, weaknesses, opportunities and threats in the NSP and PIP implementation, which was administered during the PCA PIP review meetings, stakeholder validation workshop and the M&E technical experts' session.

These activities facilitated the identification of key gaps, disparities and opportunities for improvement. TTEs followed established data collection approaches, namely,

a. Document Review

South Africa's National Strategic Plan for HIV, TB and STIs (2017 – 2022) served as a guide for the document review framework. IHPS TTEs sourced, analyzed and shared results of all HIV/AIDS, TB and STI related policies, high-level strategic documents, strategic plans, research reports, evaluation reports and periodic performance reports as part of the MTR. This step was crucial in understanding the context, content and processes within which implementation took place. Reference documents were for the period 2017 to 2019.

TTEs analyzed data collected in line with the NSP goals and strategic objectives. The search for data was through websites including SANAC, Department of Health (DOH), research and university institutions, the United Nations Programme on

HIV/AIDS (UNAIDS), World Health Organization (WHO), the United States (US) President's Emergency Plan for AIDS Relief (PEPFAR) and other websites of interest.

IHPS TTEs gathered substantial information from research reports, policies and guidelines, peer reviewed journal articles, program reports, strategic plans, epidemiological trend reviews on HIV/AIDS, TB and STI, conference presentations and other documents of interest.

The Provincial reviews and assessments focused on the developed and adopted PIPs and included the assessment of Annual Progress reports and quarterly factsheets of the PIPs.

Findings from the document review guided the approaches to the primary data collection and some of the findings warranted further validation and clarification through interviews.

b. Programme data collection

IHPS collected and triangulated programme aggregated data on progress against set targets from standardized sources of data such as the District Health Management Information System (DHIS), the Data for Accountability, Transparency and Impact Monitoring (DATIM), Electronic TB Register (ETR), TIER. Net. IHPS also collected and triangulated aggregated data from other relevant institutions such as National Treasury, National Institute of Communicable Diseases (NICD), National Health Laboratory Services (NHLS), research and academic institutions.

c. After Action Review (AAR)

The IHPS team conducted AARs with the PCA stakeholders after the KII and the assessment of the PIP implementation with the PCA secretariat. The administration of this framework afforded the stakeholders an opportunity to reflect on progress in the implementation of their PIPs considering evidence collated, analyzed, and presented to them.

Central to the AAR framework and process was the ability to identify what has worked well (key successes), what has not worked well and why (challenges) and what should be done differently for the remainder of the PIP (opportunities for improvement).

The AAR was centrally coordinated through the PCAs and facilitated by the IHPS TTEs allocated to specific provinces. The IHPS TTEs also analyzed findings and developed abridged provincial reports which are also accessible and should be read in conjunction with this report. In addition, key findings from the provincial reports were synthesized and included in this national report so that provinces find expression in the overall consolidated report.

d. Key Informant Interviews (KIIs)

The IHPS TTEs conducted KIIs with selected key informants

as identified through support from SANAC and PCAs. IHPS developed a semi-structured interview guide to guide the conduct of KIIs with appropriate questions aligned to their key performance areas in the NSP implementation. Key informants were identified, contacted, and then interviewed using the most cost-effective means i.e. either face to face, telephonic or via email submission of questionnaires and completion thereof.

e. Review of the Governance and Institutional Arrangements

IHPSTTEs assessed governance and institutional arrangements of the PCA and the District AIDS Council to determine the functional status, representation, and participation of these structures. This informed an understanding of the extent to which these arrangements and status of each influence implementation of the PSP/NSP. IHPS TTEs reviewed SANAC functionality assessment reports for inclusion under the section on governance and institutional arrangements.

f. NSP Financial Assessment

IHPS TTEs conducted a critical analysis of the resources to implement the NSP in order to fulfil the requirements of Goal 7 (Mobilise resources and maximise efficiencies to support the achievement of NSP goals and ensure a sustainable response) of the NSP. SANAC intends to conduct an NSP spending analysis as a separate activity to establish adequacy of resources for optimal implementation of the multi-sectoral response including an intensive cost-benefit analysis.

g. Stakeholder Validation Workshops

IHPS TTEs conducted validation workshops with (i) Civil Society and (ii) all government departments and stakeholders at national level. IHPS presented findings and employed the Strengths, Weaknesses, Opportunities and Weaknesses (SWOT) analysis approach and the AAR framework facilitated by a Technical Team Expert. This fostered participation, learning, accountability, and ownership of the MTR by all SANAC stakeholders.

An expert facilitator, including the TTEs from IHPS facilitated the final national validation workshop with SANAC Plenary to allow for a focused and objective review process. Another key workshop was the National M&E Experts Workshop, convened to review current indicators, data, and their relevance in tracking NSP implementation going forward. Strategic Information (SI), M&E and Program Specialists/Managers from identified sectors participated in this session. Collectively, these review processes informed the finalization and submission of this report.

TABLE 3: SUMMARY OF THE KEY ACTIVITIES (AS PER THE TORS FOR THIS MTR) AND THE DATA SOURCES OF METHODS USED TO FULFIL THE REQUIREMENTS OF EACH ACTIVITY.

KEY ACTIVITIES		DATA SOURCES/ METHODOLOGY
1	Assess the progress made in the implementation of the NSP towards the achievements of the NSP goals and objectives	Document review of each NSP goal, AAR, inputs from interviews and stakeholder workshops as well as aggregation of data on key indicators for each NSP goal. Review of each of the NSP goals to inform the MTR by respective TTEs. Review of all PIP annual progress reports (2017/18) to ascertain progress made.
2	Identify the challenges and gaps encountered in the implementation of the NSP and recommend possible solutions	Qualitative data from document reviews, AAR, interviews, and validation meetings incorporated to supplement the aggregate data for each of the NSP indicators.
3	Assess the effectiveness of the SANAC multi-sectoral structures in managing the HIV response at all levels	
4	Identifying the challenges experienced, lessons learned and best practices during the NSP implementation	Analysis of aggregate data from various data points against set targets on core NSP indicators applicable to National and Provincial AIDS councils; including data triangulation and write up of case studies
5	Evaluate SANAC stakeholder capabilities regarding the use of routine data including the drivers of the epidemic to improve the outcomes of the response. Assess strategic information gaps and challenges and propose an enabling environment for monitoring and evaluating NSP implementation progress made towards achieving set targets at all levels Review impact and outcome indicator sets to create the basis for quality improvements and prioritisation in the NSP implementation	Convening a national M&E experts' workshop with key M&E/ program personnel to review the current indicator dataset for the NSP and relevance
6	Assess the effectiveness of SANAC multi-sectoral structures in managing the HIV response at all levels	Organisational review and KIIs to determine institutional arrangements guided by the civil society capacity and structural review
7	Appraise the relevance of the PIP operational processes in line with the NSP	All approaches as listed per objectives 1, 2, 3, 4, 5, 6, 7 and 8
8	Detecting the deficiency and propose areas for amendments/change/modification in the planned strategies for the remaining period of the NSP	Documents review of each NSP goal, inputs from interviews, AAR, and stakeholder workshops as well as aggregation of data on key indicators for each NSP goal. Review of each of the NSP goals to inform the MTR by respective TTEs

KEY ACTIVITIES		DATA SOURCES/ METHODOLOGY
9	Proposing recommendations to the strategies and policies in response to HIV, STIs and TB response at all levels	Sifting through MTR results and identifying recommendations for each goal at National and at each Province levels.
10	Facilitate a national multi-sectoral stakeholder consultation to review progress made, identify gaps/ challenges, and agree on a set of recommendations in line with emerging issues;	National Validation workshop with key stakeholders to share preliminary findings clustered per each NSP goal. This enabled further input and prioritisation.
11	Compile the final MTR report and submit it within set deadlines	Consolidation of validated results, inclusion of key provincial findings, finalisation of the report and editing, formatting, and printing.

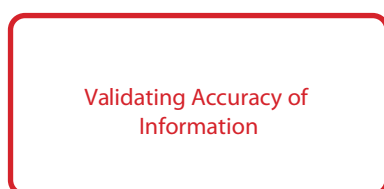
Step 4. Data Analysis and Report Writing

IHPS used both qualitative and quantitative data analysis methods to ensure the generation and presentation of quality data, which translates to good information. Good information forms the basis for evidence-based planning. IHPS used the following methods for data collection and analysis:

Qualitative Data: All interviews and stakeholder workshops were audio recorded upon informed consent and transcribed verbatim. Using thematic analysis, the TTEs coded all data generated to identify emerging themes. Figure 1 below presents the qualitative thematic analysis approach used.

Quantitative data: IHPS collected quantitative data from existing standardized data sources guided by the M&E framework in the NSP. TTEs collated, validated and analyzed the data collected. TTEs also did approximations and estimations to ascertain progress against set targets mostly in cases where available data was incomplete.

In instances where more than one data source existed, TTEs presented all figures to the validation workshops for decision making on the correct figure to be used.



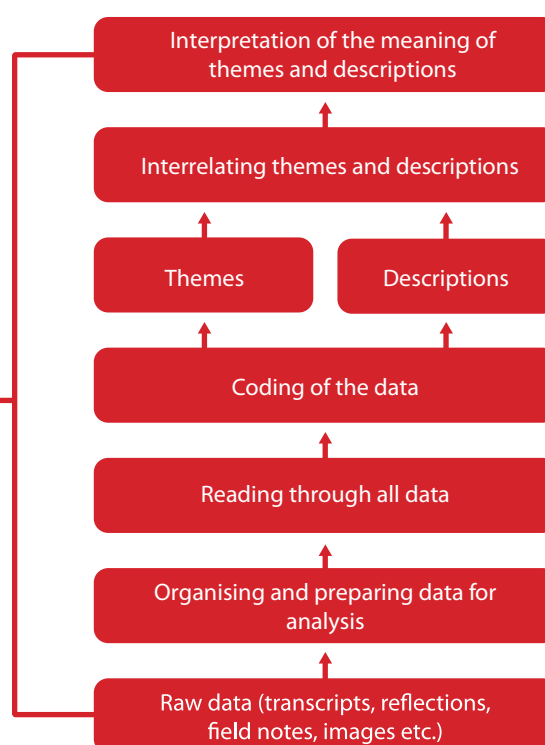
ADAPTED FROM: CRESWELL, JOHN W. RESEARCH DESIGN: QUALITATIVE, QUANTITATIVE, AND MIXED METHODS APPROACHES. 3RD EDITION. LOS ANGELES: SAGE PUBLICATIONS, INC., 2009.

Step 5: Feedback sessions to verify and interpret results

This review served as an opportunity for learning and sharing for the multi-sectoral stakeholders with vested interest in HIV, TB and STI response. SANAC convened stakeholder validation workshops to go through the findings and solicit other inputs or clarify any issues emerging from the data analysis.

PCA representatives and all key stakeholders within SANAC structures (national, provincial and district) attended these workshops. It was a platform to share findings including the specific provincial and programmatic briefs.

FIGURE 1: THEMATIC ANALYSIS FRAMEWORK USED FOR THE MTR QUALITATIVE DATA ANALYSIS



SECTION 2

MTR FINDINGS

The eight NSP goals were set, each supported by clear objectives, sub-objectives, and activities to attain them. As much as possible, this MTR report presents the progress made towards achieving the NSP goals, by sub-objective and objective based on information that was available at the time of data collection and report writing.



*"I am calling for 2000 men, as a start, to join me in getting circumcised so we can minimise the risk of HIV and STI infection."
– Kagiso Modupe, Brothers for Life Ambassador*

GOAL 1



Accelerate Prevention to Reduce New HIV and TB Infections and STIs

GOAL 1: ACCELERATE PREVENTION TO REDUCE NEW HIV AND TB INFECTIONS AND STIS

Under Goal 1 of the NSP, South Africa aims to:

- Reduce the number of new infections from 270 000 in 2016, to under 100 000 by 2022.
- Eliminate new HIV infections among children.
- Reduce TB incidence by 30%, i.e. from 834/100 000 to less than 584/100 000.

- Reduce the incidence of Treponema (T) Pallidum and Neisseria (N) Gonorrhoea by 90%.
- Virtually eliminate congenital syphilis by reducing incidence to 50 or fewer cases per 100 000 live births.
- Maintain national coverage of HPV vaccination above 90% for Grade 4 girls.

The following interventions were instrumental in meeting the targets declared above: a combination of biomedical interventions, strategies to address social and structural determinants, social and behaviour change communication, and customised HIV and TB interventions for key and vulnerable populations, supported by a rights-based approach.

Indicators and Results

TABLE 4: GOAL 1 INDICATORS – TARGET VS ACTUAL

INDICATOR	BASELINE (2016/2017)	TARGET (2018/19)	ACTUAL (2018/19)
1. Number of new infections	<p>Total: 267 000 Adults (25-49): 120 000 Adult women: 62 000 Adult men: 58 000 Youth (15-24): 107 000 Young women: 80 000 Young men: 27 000</p> <p><i>(Thembisa, 2016)</i></p>	<p>66% reduction from baseline Total: 176 220 Adults (25-49): 79 000 Adult women: 41 000 Adult men: 38 000 Youth (15-24): 71 000 Young women: 53 000 Young men: 18 000</p> <p>< 100 000 by 2022 (NSP 2017-2022)</p> <p>88 000 by 2020 (Prevention 2020 Roadmap)</p>	<p>(36% reduction from 2010/11) (9% reduction from baseline)</p> <p>Total: 249 000 Adults (25-49): 119 000 Adult men: 59 000 Adult women: 60 000 Youth: (15-24): 97 000 Young men: 23 000 Young women: 74 000 Children <15: 13 000 (mid-2017 to mid-2018)</p> <p><i>(Thembisa, 2018)</i></p>
2. MTCT rate at 10 weeks	<p>1.47 (2015/16) (NDoH APP 2017/18 – 2019/20)</p>	<p>1.26% (2019/20)</p>	<p>0.74% 50% reduction from baseline (NDoH, 2019)</p>
3. MTCT rate at 18 months	<p>4.3% (MRC SAPMTE, 2012)</p>	<p><3.2% (2019/20) 75% reduction</p>	<p>Data unavailable</p>
	<p>2.02% Spectrum, 2015</p>	<p>-</p>	<p>0.51% (Thembisa, 2018)</p>

INDICATOR	BASELINE (2016/2017)	TARGET (2018/19)	ACTUAL (2018/19)
4. Delivery in 10 -19 years in facility rate	-	-	12.9% (DHIS,2018/19)
		1.26% (2019/20)	12.7% (DHIS, 2017/18)
			<i>(Delivery in 10 - 19 years in facility rate)</i>
<i>(Up to 2016/17, the indicator reported pm was "Delivery in facility below 18 years rate")</i>	7.3% (2015/16) (NDoH APP 2017/18 – 2019/20) <i>(Delivery in facility below 18 years rate)</i>	7.2% (NDOH APP 2017/18 – 2019/20) <i>(Target based on the old indicator i.e. Delivery in facility below 18 years rate)</i>	Indicator no longer in NIDS/ DHIS Data unavailable
5. Couple year protection rate	51% (DHIS, 2015/16)	70% (2018/19)	61% (DHIS, 2018/19)
6. Number of MMC performed	Annual Total: 612 648 (NDoH Annual Report 2015/16, baseline should be cumulative from inception 2011) Cumulative: 2.4 million (as at end of 2015/16)	Targets for individual years: 2016/17: 700 000 2017/2018: 650 000 2018/2019: 600 000	Annual Actuals: 2016/17: 413 943 (59%) 2017/2018: 539 890 (83%) 2018/2019: 594 970 (99%) (DHIS, 2018/19) Cumulative: 3 948 803 (as at end 2018/19)
7. Number of people tested for HIV	11 898 308 (NDoH Annual Report 2015/16)	10 million (2018/19)	14 874 879 (2018/19) 13 875 172 (2017/18) <i>(DHIS, 2018/19)</i>
8. Number of male condoms distributed	839 532 901 (NDoH Annual Report 2015/16)	850 million (2018/19)	726 202 616 (85%) (2018/19) 693 498 769 (2017/18) (DHIS, 2018/19)
9. Number of female condoms distributed	27 005 805 (NDoH Annual Report 2015/16)	40 million (2018/19)	17 658 915 (44%) (2018/19) 21 308 215 (2017/18) (DHIS, 2018/19)

INDICATOR	BASELINE (2016/2017)	TARGET (2018/19)	ACTUAL (2018/19)
10. Number of AGYW, FSW, MSM, IDU receiving oral PrEP for the first time during the reporting period	2 003 (2016/17)	18 215 (2018/19)	21 063 (115%) (July 2019) 8 020 (2018) 3 215 (2017) (DHIS, 2018/19)
11. Number of learners reached through combination prevention interventions aimed at retention of learners in schools	85 000 (DBE Annual Report 2015/16)	86 250 (2018/19)	89 043 (DBE, Dec 2018)
12. Percentage of schools that are providing enhanced CSE	5%	30% of schools in high burden areas (2018/19)	1 716 schools (2018/19)
13. Percentage of children screened for TB symptoms	36.1% (NDoH Annual Report 2015/16)	80% (2018/19)	Not in NIDS/ DHIS
<i>TB symptom child < 5 years screened in facility rate (NIDS/ DHIS)</i>	-	-	81.7% (NIDS: TB symptom child < 5 years screened in facility rate) (DHIS, 2018/19)
14. Proportion of household contacts < 5 years started on 3HP	0% 2016 (TB Strategy 2017/21)	54% 2019 (TB Strategy 2017/21)	No data as 3HP provision has not started in SA
<i>Proportion of children (aged < 5) household contacts of bacteriologically confirmed TB cases on preventive TB</i>	-	-	59% (WHO Global TB Report, 2019)
15. Proportion of eligible PLHIV on ART started on 3HP (weekly high dose isoniazid/ rifampentine for 3 months)	0% 2016 (TB Strategy 2017/21)	54% 2019 (TB Strategy 2017/21)	No data as 3HP provision has not started in SA
<i>Proportion of HIV-positive people (newly enrolled in care) on preventive treatment</i>			65% (WHO Global TB Report, 2019)

INDICATOR	BASELINE (2016/2017)	TARGET (2018/19)	ACTUAL (2018/19)
16. Number of household contacts screened for TB	60% 2016 (TB Strategy 2017/21)	80%	Currently not in NIDS
17. New male urethritis syndrome (MUS) episodes treated rate	TBD	TBD	323 223 (successfully treated MUS, new episode) (2018/19) 327 992 (successful treated MUS, new episode) (2017/18)
18. Percentage of women accessing ANC services who were tested for syphilis	36% (for three doses) 71% (for one dose)	80% -	96.7% (Antenatal HIV prevalence sentinel survey, 2019)
<i>Syphilis in pregnant female rate</i>	-	-	0.05% (DHIS, 2018/19) 0.03% (DHIS 2017/18)
19. HPV coverage	85% (HPV 1st dose) 63.8% (HPV 2nd dose)	90% (HPV 1st dose) 90% (HPV 2nd dose)	Data not available in DHIS

Progress against NSP objectives

Objective 1.1: Reduce new HIV infections to less than 100 000 by 2022 through combination prevention interventions.

Overview and key policy issues

South Africa had an estimated 7.39 million people living with HIV (PLHIV) in 2018, equivalent to 12.9% of the population¹. At the end of FY 2018/19, there were just over 4.6 million (62% ART coverage) people on antiretroviral treatment (ART) in South Africa², making it the largest ART programme in the world.

Despite the accelerated progress and the introduction of Test and Treat All in 2016, there were approximately 249 000 new HIV infections from mid-2017 to mid-2018. This entails that programmes for preventing infection among those not infected need to be prioritised.

The programmes must be a strategic combination of evidence-based behavioural, biomedical, and structural interventions as described across the NSP 2017-2022 goals, with the critical enablers considered.

In October 2017, six months after the launch of the NSP, the Global HIV Prevention Coalition announced and stimulated commitment for reinvigorating primary prevention and galvanised planning at the national level. At the launch of the Global Prevention Coalition renewed commitments were made towards reducing new infections by 75% (from 2010 baseline) to 88 000, as per the HIV Prevention 2020 Roadmap.

Since then, the estimates have been updated and based on the most recent Thembisa estimates, the baseline number for 2010 is 416 000, and a 75% reduction should result in a target of 104 000, which is well in line with the original NSP target, i.e. less than 100 000.

¹Thembisa, 2018

²DHIS, 2018/19

HIV testing services (HTS)

The 2016 National HTS Policy currently guides the delivery of HTS in South Africa. In line with WHO guidelines, HIV testing in South Africa is done using two HIV testing technologies namely 1) *rapid HIV testing for children 18 months and older, adolescents and adults*; and 2) *polymerase chain reaction (PCR) for children younger than 18 months*. In December 2016, WHO released the Guidelines on HIV self-testing and partner notification: a supplement to the consolidated guidelines on HTS.

Accordingly, the South African Pharmacy Council (SAPC) approved over-the-counter distribution and use of HIV self-tests, to facilitate HIV self-screening or self-testing and NDoH in collaboration with implementing partners has been distributing self-testing kits since 2017.

In June 2018, the NDoH formally introduced an index-testing policy, including assisted partner notification (APN) or partner notification services (PNS).

Cheka Impilo Campaign

During the February 2018 State of the Nation Address (SONA), the President of South Africa, Mr Cyril Matamela Ramaphosa, proclaimed the Cheka Impilo Campaign, a national testing and treating campaign intended to eliminate HIV and address lifestyle diseases such as hypertension (HPT), diabetes mellitus (DM), cancers and cardiovascular diseases (CVD).

Cheka Impilo was formally launched in October 2018, and a National Community Activation was convened on the 1st December 2018 at Dobsonville Stadium. Table 5 below presents the objectives and targets of the Cheka Impilo Campaign.

TABLE 5: OBJECTIVES AND TARGETS OF THE CHEKA IMPILO CAMPAIGN

PRIMARY OBJECTIVES	SECONDARY OBJECTIVES
<ol style="list-style-type: none"> 1. Provide an enabling environment for health-seeking behaviour, i.e. screening and referrals for communicable (HIV, TB and STIs) and non-communicable diseases (NCDs), i.e. hypertension and diabetes mellitus. 2. Strengthen Test and Treat initiative and implement linkages to care, management, treatment, and support 3. Strengthen HIV prevention interventions (condom use, MMC, PMTCT, PEP, PrEP) as well as TB, STIs and NCDs. 	<ol style="list-style-type: none"> 1. Increase demand creation through community mobilisation. 2. Strengthen community testing, including HIV self-screening and other modalities. 3. Improve referrals for diagnosis and treatment. 4. Improve data collection, management and strengthen evaluation.

CHEKA IMPILO TARGETS
<ol style="list-style-type: none"> 1. Initiate two million new clients on antiretroviral treatment (ART) by 2020. 2. Fourteen million tested and screened for HIV, STIs, TB and seven million for HPT and DM. 3. Ten million of the 14 million in the 27 high burden districts. 4. Four million of the 14 million in 25 remaining districts. 5. Intensive case finding for the missing 80 000 people infected with TB and not on treatment.

Prevention of mother to child (PMTCT)

Despite the significant decline in the number of children born with HIV, mother to child transmission (MTCT) persists, especially during the postnatal breastfeeding period. To attain the elimination of MTCT, there is a need to seal all PMTCT cascade leakages. The NSP 2017-2022 calls for actions to reduce MTCT rate at 18 months to below 2%.

Universal uptake and consistent use of ART during breastfeeding as well as strong follow-up and monitoring of the mother-infant pairs through ward-based outreach teams (WBOTs) are imperative. To achieve the elimination of MTCT, South Africa set out to implement the Last Mile Plan.

This multipronged plan acknowledges the importance of delivery systems for EMTCT and prioritises five pillars, namely: (i) leadership, governance and coordination; (ii) scaling up PMTCT coverage; (iii) integrating PMTCT interventions into routine maternal and child healthcare (MCH) and primary healthcare (PHC); (iv) monitoring and evaluation; and (v) increased community awareness and involvement (NDOH, 2017).

The South African National Department of Health (NDoH) released new Guidelines for the Prevention of MTCT of Communicable Infections (HIV, Hepatitis, Listeriosis, Malaria, Syphilis and TB) in 2019. WHO calls for dual elimination of HIV and syphilis, however, South Africa aspires to eliminate all infections that are transmittable from mother to child, and these guidelines promote the prevention of such infections, early diagnosis and proper management to reduce maternal, neonatal and child morbidity and mortality. The 2019 guidelines include the introduction of dolutegravir (DTG) in pregnancy.

Male medical circumcision (MMC)

There is clear scientific evidence that MMC is a safe and highly cost-effective way to bring down one's risk of HIV. MMC reduces the risk of heterosexually acquired HIV infection in men by approximately 60% (WHO, 2012). South Africa has adopted a comprehensive approach to MMC to provide focused, age targeted MMC services in public and private with emphasis on social mobilisation, outreach, and after-hours services to expand access.

Condom distribution and use

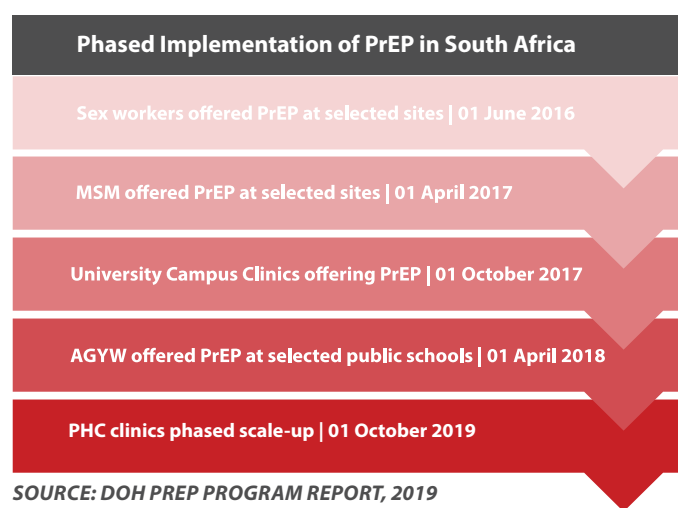
Government and private sector offer free male, and female condoms, and compatible lubricant. These are distributed via condom programmes within public and private health facilities, secondary schools (recommended), tertiary institutions and non-traditional community settings e.g. hair salons, petrol stations, spaza shops, hotels, toll plazas, truck stops, etc.

Pre-exposure prophylaxis (PrEP)

The NSP 2017-2022 stipulates the importance of offering PrEP to those most likely to benefit including adolescents, sex workers, men who have sex with men (MSM) and people who inject drugs (PWID). The NDoH approved the National PrEP policy in March 2016, and preparatory work occurred between March and May 2016.

The preparations included site readiness assessments, development of training and implementation tools, supply chain management, social mobilisation, and demand creation. Phased implementation followed the above-cited preparatory work, as reflected in figure 2 below.

FIGURE 2: PHASED IMPLEMENTATION OF PREP POLICY IN SOUTH AFRICA



SOURCE: DOH PREP PROGRAM REPORT, 2019

Adolescents and youth health

In April 2017 the National Health Council adopted the National Adolescent and Youth Health Policy 2017, which prescribes a comprehensive package of services to be offered to young people aged 10-24 years during dedicated clinic times, known as the "youth zone". To strengthen the involvement and participation of young people, the Minister appointed an Adolescent and Youth Advisory Panel (AYAP).

In Financial Year (FY) 2017/18, the NDoH supported the nine Provincial Departments of Health (PDOHs) to develop implementation plans for the Adolescent and Youth Health Policy Guidelines.

Similarly, the Department of Basic Education (DBE) has a National Policy on HIV, STIs and TB for Learners, Educators, School Support Staff and Officials in all Primary and Secondary Schools in the Basic Education Sector. In 2019, the DBE also released the Standard Operating Procedures for the Provision of Sexual and Reproductive Health, Rights and Social Services in Secondary Schools, to bolster the implementation of the DBE National Policy on HIV, STIs and TB as well as the Integrated School Health Policy and Programme (ISHP, 2012).

Key Achievements

HIV incidence

New HIV infections can be measured through direct measurement, e.g. HSRC surveys or mathematical modelling, e.g. Thembisa model.

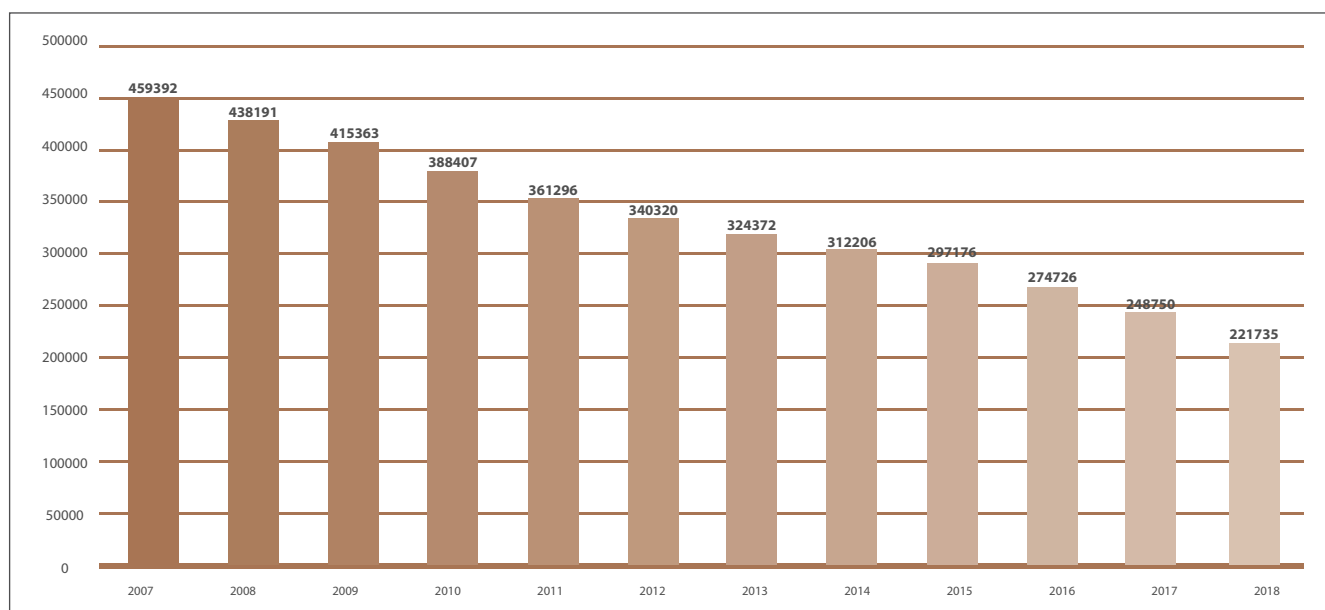
The HSRC South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2017, a cross-sectional population-based survey, found that the overall incidence was 0.48%, which translates to an estimated 231 100 new infections - a 51% decline from an estimated 469 000 new infections reported in the 2012 survey.

Youth aged 15-24 years had the highest incidence, with an estimated 88 400 new infections in 2017. Young women aged 15-24 years had an incidence of 1.51% of 66 200 new infections in 2017³.

The latest Thembisa model (Thembisa 4.2), estimates that there were 249 000 new HIV infections in South Africa over the period mid-2017 to mid-2018, a 36% reduction from the 388 000 new infections that occurred mid-2010 and mid-2011⁴.

The Thembisa model has also shown that between 2016 and 2018, there have been about 19.3% decline in the number of new HIV infections from 274726 to 221735. See figure 3 below.

FIGURE 3: TOTAL NEW HIV INFECTIONS, 2007 TO 2018



SOURCE: THEMBISA MODEL VER. 4.2, 2019

The NSP target of reducing the number of new HIV infection to less than 100 000 by 2022 is in line with the UNAIDS target of a 75% reduction from 2010 to 2020. However, given the slow pace of decline of the annual number of new infections to date, it is unlikely South Africa will be able to meet this target by 2020.

If the current rate of decline is maintained in the last half of the NSP, the country is likely not to meet its Goal of reducing incidence by 50% as it will only reach about 38% which will translate to 170331 new HIV infections by 2022.

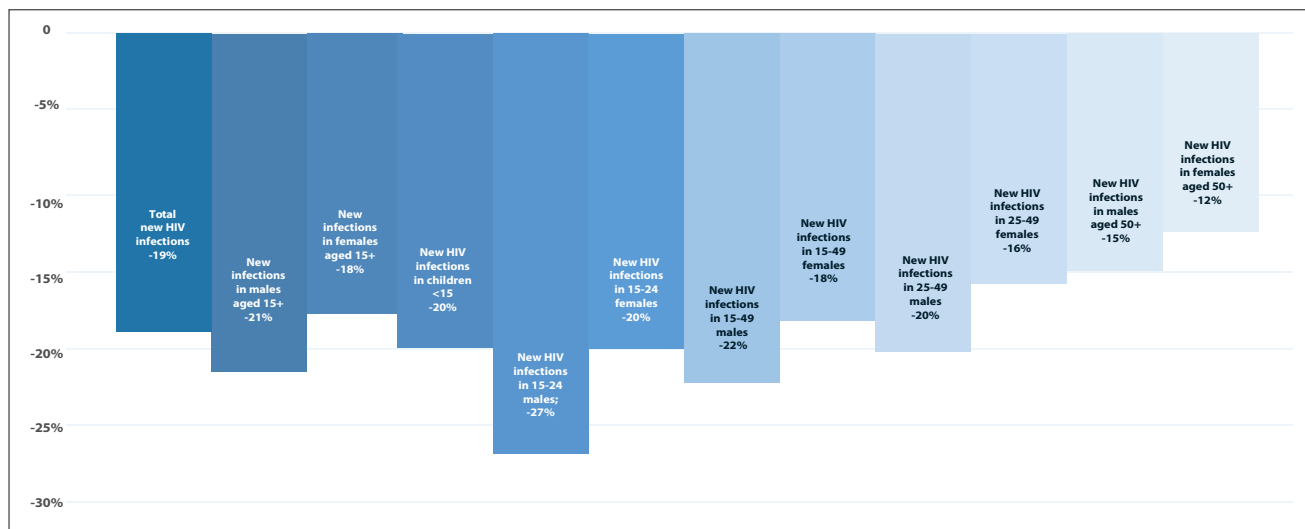
This data shows that the country needs to intensify its HIV prevention interventions, especially among those populations who are at more risk of contracting HIV.

A closer look into new HIV infections data shows that the percentage change for females 25-49 years (-16%) and adults above 50 years (both male (-15%) and female (-12%)) was relatively lower than the national percentage change of -19% between 2016 and 2018. Figure 4 below presents this data.

³ Simbayi LC, Zuma K, Zungu N, Moyo S, Marinda E, Jooste S, Mabaso M, Ramlagan S, North A, van Zyl J, Mohlabane N, Dietrich C, Naidoo I and the SABSSMV Team (2018) South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2017. Cape Town: HSRC Press

⁴ Thembisa, 2018

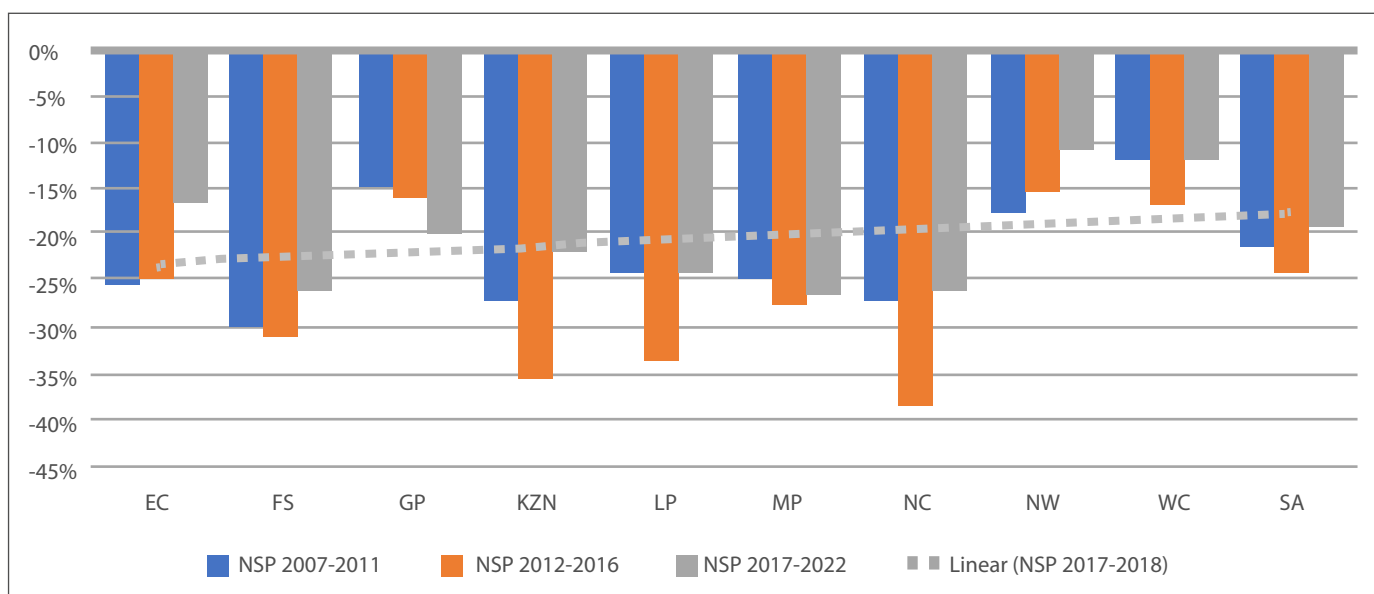
FIGURE 4: NEW HIV INFECTIONS PERCENTAGE CHANGE BETWEEN 2016 AND 2018 BY COMBINED SEX AND AGE



When looked at from a provincial contribution perspective, several observations were made which are important to summarise. A percentage change comparison of the NSP periods (2007-2011; 2012-2016; 2017-2018) was made to

investigate the trajectory of new HIV infections over a longer period. Figure 5 presents the results of the analysis.

FIGURE 5: COMPARING PERCENTAGE CHANGE OF NEW HIV INFECTIONS BY NSP PERIOD



The following observations are apparent:

- The current NSP is the fastest in terms of decline in new HIV infections compared to the previous two NSP periods. This could reflect gains of work that has been invested over the other two periods and intensification of interventions in the current period. As an example of this, at MTR point, the Gauteng province, with a minus 20% decline in new HIV infections, had already exceeded their percentage change for the previous two NSPs periods
- The WC (-12%), NW (-11%) and EC (-17%) had the

percentage change below the national (19%)

- All other provinces' current mid-term percentage change has shown a greater potential to exceed, with a wide margin, their performance of the previous two NSP periods. Again, this is evidence of the increased efforts to halt the spread of HIV in the country.

TABLE 6: KEY ACHIEVEMENTS BY SUB-OBJECTIVE

KEY ACHIEVEMENTS BY SUB-OBJECTIVE	
Sub-objective 1.1.1	Revitalise Information, Education and Communication (IEC) Programmes
	IEC campaigns were implemented, and like condom distribution, various distribution outlets were used, including public health care facilities, schools, tertiary institutions, and non-traditional community settings.
Sub-objective 1.1.2	Implement targeted biomedical prevention services tailored to setting and population
	<p>MMC Throughout the NSP 2017-2022, South Africa planned to circumcise 2.5 million men. NDoH District Health Information System (DHIS) MMC Program data shows that:</p> <p>For the period April 2017 to March 2018, 539 890 MMCs were performed across the nine provinces, with the most MMCs performed in KwaZulu-Natal (KZN) at 200 301, followed by Gauteng (GP) at 112 608.</p> <p>For the period April 2018 to March 2019, 595 006 MMCs were performed across the nine provinces – 99% of the 2018/19 NSP target; with the highest MMC numbers reported in KZN at 209 732, followed by GP at 102 325. From April to May 2019, 41 307 MMCs were performed⁵.</p> <p>Condom distribution Between April 2017 and March 2018, 693 498 769 male condoms and 21 308 215 female condoms were distributed.</p> <p>From April 2018 to March 2019, 726 202 616 male condoms were distributed - 85% of the 2018/19 NSP target; and 17 658 915 female condoms were distributed – 44% of the 2018/19 NSP target.</p> <p>Lastly, April to May 2019, 87 230 848 male condoms and 2 427 454 female condoms were distributed⁶.</p>
Sub-objective 1.1.3	Provide sensitive and age-appropriate sexual and reproductive health (SRH) services and comprehensive sexuality education
	<p>As at December 2018, the DBE had reached 89 043 learners through functional peer education programmes, exceeding the FY2018/19 target of 86 250 learners.</p> <p>Against an FY2018/19 target of 30% of schools in high burden areas, 1 716 schools were providing enhanced comprehensive sexuality education (CSE) to their learners by the end of March 2019⁷.</p>
Sub-objective 1.1.4	Provide pre-exposure prophylaxis (PrEP) to identified at-risk populations
	<p>The NDoH approved the national PrEP policy in March 2016, and phased implementation began in June 2016. A total of 12 selected facilities were offering PrEP to sex workers by the end of 2016, and 720 sex workers were initiated on PrEP. In 2017, a total of 27 facilities were offering PrEP and 3 215 sex workers and MSM were initiated on PrEP.</p> <p>By 2018, 75 facilities were offering PrEP and 8 020 sex workers; MSM, university students and AGYW were initiated on PrEP. By July 2019, 101 facilities were offering PrEP and 21 063 sex</p>

⁵ Thembisa, 2018

⁶ *ibid*

⁷ DBE Annual Report 2018/19

KEY ACHIEVEMENTS BY SUB-OBJECTIVE

	<p>workers, MSM, university students and AGYW were initiated on PrEP⁸.</p> <p>The NDoH released updated comprehensive Guidelines for the Provision of PrEP to persons at substantial risk of HIV infection in 2019. The guidelines address PrEP eligibility, identification, recruitment, provision of PrEP, patient follow-up and monitoring, discontinuation, and overall PrEP program monitoring. WHO recommendations also guide PrEP in pregnant and breastfeeding women at substantial risk of HIV infection.</p> <p>Effective 01 October 2019, PHC facilities were expected to initiate patients on PrEP, using lessons learned and best practices from the sex workers, MSM, university campus clinics and AGYW PrEP initiation implemented since June 2016.</p>
<p>Sub-objective 1.1.5</p>	<p>Provide targeted services to prevent mother-to-child transmission of HIV and syphilis in the prenatal and postnatal period</p>
	<p><i>MTCT testing of HIV</i></p> <p>The NDOH developed the Last Mile Plan to eliminate MTCT of HIV. The planned target was to reduce the number of PCR-positive babies at around ten weeks from 1 600 to less than 1 000. For the period April 2016 to March 2017, infant PCR tests at birth were done for 222 534 infants, and of these 2 140 tested positive – a positivity rate of 0.96%. For the same period, 151 246 infant PCR tests at ten weeks were done, and 2013 tested positive – a positivity rate of 1.3%.</p> <p>For the period April 2017 to March 2018, infant PCR tests at birth were done for 247 008 infants, and of these 1 637 tested positive – a positivity rate of 0.66%. For the same period, 180 790 infant PCR tests at ten weeks were done, and 1 636 tested positive – a positivity rate of 0.9%.</p> <p>For the period April 2018 to March 2019, infant PCR tests at birth were done for 258 399 infants, and of these 1517 tested positive – a positivity rate of 0.59%. For the same period, 185 318 infant PCR tests at ten weeks were done, and 1 371 tested positive – a positivity rate of 0.74% . The latter is a 50% reduction from baseline and has surpassed the 2018/19 NSP target.</p> <p>The implementation of mom-connect assisted in increasing the antenatal visit before 20 weeks rate from 65.2% to 66.3% in the 2017/18 financial year. A cumulative 1 628 207 mothers are receiving information through mom-connect, and in addition, 6 674 pregnant mothers have opted to receive information related to the prevention of mother-to-child transmission (PMTCT).¹⁰</p> <p>The DoH routinely offered index testing of family members and/ or partners including disclosure support as well as, STIs, GBV and alcohol screening and support to pregnant women living with HIV.</p> <p>96.7% of women accessing antenatal care services were tested for syphilis in 2017¹¹ - exceeding the 2018/19 NSP target of 80%.</p> <p>Based on available DHIS data, the 2018/19 syphilis in pregnant female rate was 0.05% - this is a new STI indicator in DHIS thus no baseline or NSP target.</p>

⁸ NDoH PrEP Program Report, 2019

⁹ DHIS, 2018/19

¹⁰ NDOH Annual Report, 2017/18

¹¹ Antenatal HIV prevalence sentinel survey, 2019

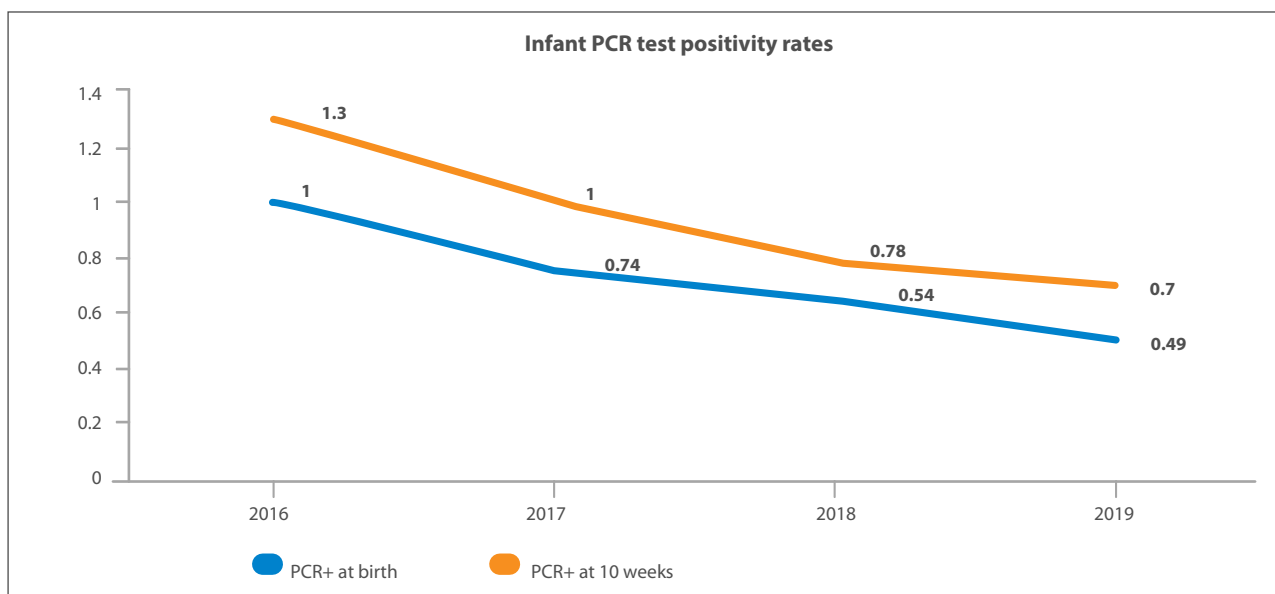
Available NDoH PMTCT program data shows that South Africa is making progress towards the elimination of MTCT at birth and at 10 weeks. The infant PCR test positivity rate at birth dropped from 1% in 2016 to 0.46% in 2019, whilst infant PCR test positivity rate at 10 weeks dropped from 1.3% in 2016 to 0.7% in 2019¹².

Figure 6 below, illustrates the infant PCR test positivity rates at birth and at 10 weeks in South Africa, for the period 2016 to 2019.

Gaps and Challenges

- Despite the high HTS uptake reported, the HTS yield remains low.
- PrEP uptake remains suboptimal – oral PrEP uptake across all PrEP implementing sites is about 29%
- Private sector reporting for indicators such as MMC performed and condom distribution not well integrated into NDoH reporting

FIGURE 6: INFANT PCR TEST POSITIVITY RATES AT BIRTH AND AT 10 WEEKS, 2016 TO 2019



SOURCE: DHIS, 2018/19

FIGURE 7: PROGRESS TOWARDS ACHIEVING NSP ANNUAL PREP TARGETS

	FY	2017/18	2018/19	2019/20
AGYW		4110	12332	24663
Progress to date		69	8122	13898
% progress to date		2%	65%	56%
MSM Target		818	1844	3383
Progress to date		1211	1511	1019
% progress to date		148%	81%	30%
SW Target		1880	3640	6280
Progress to date		2413	3944	2359
% progress to date		128%	108%	37%
PWID Target		133	400	800
Progress to date		0	0	0

SOURCE: DOH PREP PROGRAM REPORT, 2019

¹² DHIS, 2018/19

- The slow uptake of PrEP was mainly due to negative perceptions around its usage, particularly among AGYW. In the Eastern Cape, for example, it was reported that young people experienced internal stigma related to PrEP use as it is seen to imply risk sexual behaviour. Partners such as the Foundation for Professional Development (FPD) were reported to be conducting research to understand factors that may hinder or promote PrEP uptake and continued use among risk populations in the Eastern Cape.
- At the provincial level, condoms distribution seems to be affected by the inefficiencies in the supply chain management system. Some provinces reported condom stock-outs and contractual condom supply challenges, i.e. Mpumalanga, Free State, and the Eastern Cape. Female condom distribution is low - 44% of 2018/19 NSP target. The slow uptake of female condoms was reportedly due to preference for flavoured male condoms in Gauteng and the Free State.
- Despite the successes registered with the VMMC programme, the North West VMMC coverage is still low at 41% of all eligible men. In addition, the VMMC programme had difficulty integrating traditional and medical circumcision, and the North West DoH relied on the support from its development partners whose VMMC funding is declining.

Recommendations

- Promote widespread implementation or scale-up of proven strategies to improve the HTS yield i.e. Scale-up HIV self-screening,
- Bolster HIV assisted partner-notification or partner notification services implementation e.g. guidelines/SOPs.
- Implement strategies to create demand for PrEP and improve PrEP uptake among HIV negative individuals at substantial risk of HIV infection.
 - o Expand coverage to all youth at substantial risk (not AGYW only).
- Revise PrEP targets in line with the need for PrEP to achieve disease control
 - o Along with PrEP initiation, track those who remain on PrEP over time.
- Implement more targeted and focussed HIV prevention interventions, informed by AGYW and adolescent boys and young men (ABYM) incidence.
- Integrate public and private sector reporting on VMMC and condom distribution.
- Effectively address the low distribution of female condoms
 - o Pay attention to demand-supply issues.

Objective 1.2: Reduce TB incidence by at least 30%, from 834/100,000 population in 2015 to less than 584/100,000 by 2022.

Overview and key policy issues

TB is a leading cause of death in South Africa, accounting for 8.4% of natural deaths in 2015. TB incidence was 834 cases per 100 000 population in 2015, resulting in an estimated 450 000 new TB infections, 63% of which were among PLHIV¹³. Poor living conditions and late presentation to health facilities are key drivers of the TB burden.

Key achievements

The NDoH TB Control and Management sub-programme is responsible for the coordination and management of a national response to TB. This programme incorporates strategies needed to prevent, diagnose and treat both drug-sensitive TB (DS-TB) and drug-resistant TB (DR-TB) TB.

It has continued to elevate interventions that address TB and HIV service gaps in key populations, including inmates, miners and people living in informal settlements.

About R800 million received from the Global Fund was used to roll-out a comprehensive package of TB services for active case finding, with performance on TB screening exceeding targets. The quality improvement initiative for TB which commenced in 2017/18 was successfully rolled out in 10 sub-districts, with 266 facilities assisted to undertake optimised TB screening (which is expected to assist in finding missing TB patients) by the end of 2018/19¹⁴.

The drive to mobilise leaders to be involved in the response against TB using various platforms was also strengthened, with a focus on parliamentarians, provincial legislators, and religious leaders, e.g. during a successful commemoration of World TB Day.

The launch of the South African Chapter of the Global TB Caucus by the Speaker of the National Assembly is another platform for intensified mobilisation of parliamentarians and legislators¹⁵.

By the end of 2018/19, South Africa's first TB prevalence survey and the integration of TB and HIV/AIDS information systems were near completion¹⁶. Table 7 on the right shows the estimates of TB burden in 2018.

¹³ WHO Global TB Report, 2016

¹⁴ National Department of Health. Annual Report 2018/2019

¹⁵ ibid

¹⁶ ibid

TABLE 7: ESTIMATES OF TB BURDEN IN 2018

TB BURDEN IN 2018		
	Number (thousands)	Rate (per 100 000 population)
Total TB incidence	301 (215-400)	520 (373-691)
HIV-positive TB incidence	177 (127-235)	306 (219-406)
MDR/RR-TB incidence	11 (7.2-16)	19 (12-28)

SOURCE: WHO GLOBAL TB REPORT, 2019

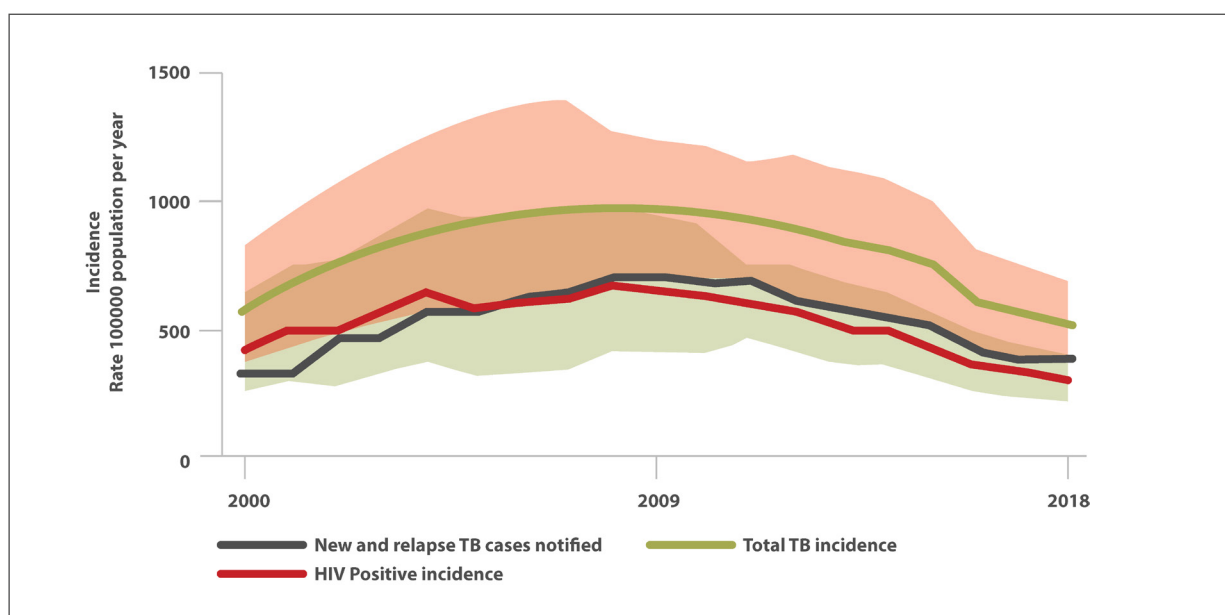
Based on the estimates presented in Table 7 above, TB incidence has dropped from 834 per 100 000 population in 2015, to 520 per 100 000 population in 2018, a significant 38% reduction in incidence¹⁷. Table 8 below shows the estimated TB incidence by age and sex in 2017.

TABLE 8: ESTIMATED TB INCIDENCE BY AGE AND SEX, 2017

TB INCIDENCE BY AGE AND SEX			
Age	0-14 years	>14 years	Total
Females	18 (17-19)	117 (95-138)	135 (108-161)
Males	20 (18-21)	167 (130-204)	187 (143-231)
Total	38 (34-42)	284 (202-366)	322 (230-428)

SOURCE: WHO GLOBAL TB REPORT, 2018

FIGURE 8: TB INCIDENCE FOR THE PERIOD 2000 – 2018



SOURCE: WHO GLOBAL TB REPORT, 2019

¹⁷ WHO Global TB Report, 2019

Based on the results in figure 8 above total TB incidence in 2018 has seemingly dropped to levels below total TB incidence reported in 2000 and has commendably surpassed the NSP target of 584/ 100 000 by 2022.

Drug-resistant TB Care

In 2018, over 90% of bacteriologically confirmed TB cases were tested for rifampicin resistance (RR) specifically, 92% of

the new cases and 94% of the previously treated cases. Table 9 below shows South Africa's drug-resistant TB care data for 2018. Laudably, the treatment gap between laboratory-confirmed XDR-TB cases and XDR-TB started on treatment has significantly dropped from 38% in 2017 to 3% in 2018¹⁸.

This can be attributed to the policy changes made and interventions implemented by the DoH.

TABLE 9: DRUG-RESISTANT TB CARE, 2018

DRUG-RESISTANT TB CARE, 2018		
Percentage (%) of bacteriologically confirmed TB cases tested for rifampicin resistance	New cases Previously treated cases	92% 94%
Laboratory-confirmed cases	MDR/RR-TB XDR-TB	13 199 553
Patients started on treatment	MDR/RR-TB XDR-TB	9 558 (72%) 539 (97%)

SOURCE: WHO GLOBAL TB REPORT, 2019

TABLE 10: KEY ACHIEVEMENTS BY SUB-OBJECTIVE

KEY ACHIEVEMENTS BY SUB-OBJECTIVE	
Sub-objective 1.2.1	Increase coverage of preventive therapy uptake
	<ul style="list-style-type: none"> In 2018, 65% of HIV positive people newly enrolled in care were on TB preventive treatment. A proportion of 59% (54-65) of children (aged below 5 years) household contacts of bacteriologically confirmed TB cases were on TB preventive treatment in 2018¹⁹.
Sub-objective 1.2.2	Promote TB infection control (TBIC)
	<ul style="list-style-type: none"> By the end of the financial year 2017/18, a total of 17 hospitals were implementing FAST – exceeding the NDoH 2017/18 target of 15 hospitals implementing FAST²⁰. For the financial year 2017/18, NDoH had a target of 3 provinces with IPT/ 3HP sentinel sites, and a total of four sentinel sites were established, with the fourth sentinel site developed in collaboration with the National Institute of Communicable Diseases (NICD)²¹.

Gaps and Challenges

- The number of household contacts screened for TB no longer in the NIDS/ DHIS thus no 2018/19 data available.
- The North West and Free State provinces reported high lost-to-follow-up and TB specific deaths rates which threaten to reverse the gains made in the fight against the HIV, TB and STIs epidemic. For example, TB treatment success rate declined from 84% to 79% in 2019 while lost to follow-up increased from 6.1% in 2018 to 8.3% in the quarter, 2019 in the Free State.
- The first National TB Prevalence Survey conducted in 2018 revealed
 - A high TB burden - higher in males than in females as well as a very high prevalence of TB among individuals aged 35 - 44 years and the elderly 65 years and older
 - The largest prevalence to notification gap was in the youth aged 15-24 years and those 65 years and older

¹⁸ ibid

¹⁹ WHO Global TB Report, 2019

²⁰ National Department of Health. Annual Report 2017/2018

²¹ ibid

- o A higher proportion of TB was detected among HIV-negative individuals, with most reporting no symptoms.
- o HIV positive participants identified as TB cases had more symptoms. Hence, they are more likely to be detected and treated in contrast to those who are HIV negative who are less likely to report symptoms and potentially contribute to ongoing transmission of TB.
- o Sub-clinical TB emerged as another area that requires further research and will be important for long term control efforts.²²
- o of poor recording and reporting.
- To address the 2018 national TB prevalence survey findings documented above, a high index of suspicion, evaluation and follow-up of TB-people presenting with TB related symptoms by health care providers is necessary to improve case detection.
 - o Intensified routine TB screening - increased vigilance in assessing TB symptoms among those who attend health facilities to promote early diagnosis.

Objective 1.3: Significantly reduce T Pallidum, gonorrhoea and chlamydia infections, virtually eliminate congenital syphilis, and maintain high coverage of HPV vaccination

Overview and key policy issues

In alignment with the WHO Global Health Sector Strategy, South Africa is implementing the National STIs Strategy. The outline of the strategy includes universal coverage for all people, especially key and vulnerable populations and focuses on key STI syndromes and aetiologies including maternal and congenital syphilis, gonococcus, chlamydia, syphilis, HSV-2, HPV.

For public health purposes, the strategy is based on standardised guidelines and treatment regimens, and the continuum of care for STIs ensure that individuals screened and diagnosed with STIs receive and finish treatment and are cured, thus safeguarding contribution to STI prevention.

Recommendations

- Reinstate or revise the indicator “number of household contacts screened for TB” in NIDS and facilitate reporting in the DHIS.
- The Limpopo province reported a consistent reduction in TB incidence for the period 2012-2017. Some interventions that were reported to have worked in the Limpopo province that can be replicated elsewhere include:
 - o Intensified Case Finding (ICF) in hard to reach areas and high transmission Areas (HTA) and door-to-door campaigns conducted collaboratively by DoH and development partners
 - o The Kick TB Campaigns were conducted at schools, ICF campaigns done at farms, correctional services and mines led by the MEC of Health (political leadership).
 - o The HIV, STI and TB program conducted IPT roadshows in all the districts in Limpopo to address the challenge

Key Achievements

TABLE 11: KEY STI ACHIEVEMENTS BY SUB-OBJECTIVE

KEY ACHIEVEMENTS BY SUB-OBJECTIVE	
Sub-objective 1.3.1	Scale-up STI prevention by providing high-quality health information and timely health services for persons at risk
	<ul style="list-style-type: none"> • During the period under review, routine STI screening and diagnosis in HIV testing and care settings, as well as partner tracing, case-finding and treatment continued. • Health care workers were trained and supported in STI data capturing and utilisation. • With support from developmental partners, adolescent and youth youth-friendly services (AYFS) were strengthened during the MTR period.
Sub-objective 1.2.2	Scale Scale-up and maintain high levels of HPV vaccination in grade 4 learners
	<ul style="list-style-type: none"> • The NSP 2017-2022 has a target of at least 90% coverage of full HPV vaccination for Grade 4 learners. In April 2014, a national school-based human papillomavirus (HPV) vaccination program was rolled out in South Africa, targeting Grade 4 girls aged ≥ 9 years. A bivalent HPV vaccine with a 2-dose (6 months apart) schedule was used. There was an overall success in key measures of coverage and safety. Over 350,000 Grade 4 girls were vaccinated in more than 16,000 public schools across South Africa, which translated to 94.6% of schools reached and 86.6% of age-eligible learners vaccinated. The target for learner

²² NDOH, 2018. The First National TB Prevalence Survey

KEY ACHIEVEMENTS BY SUB-OBJECTIVE

<p>Sub-objective 1.3.1</p>	<p>coverage was 80%, which program planners considered to be the threshold required. Learner coverage was defined as the number of Grade 4 girl learners nine years and older who were vaccinated as a percentage of the total number of age-eligible learners (Grade 4 girl learners nine years and older). 91% of schools (15,620 out of 17,175) were reached with vaccination sessions in total. Concerning learner coverage, a total of 408,273 Grade 4 girls age-eligible for vaccination were reached—received informed consent packages—during the campaign, of whom 353,564 (86.6%) were vaccinated. The eligible girls who were not vaccinated (13.4%) included girls who had not received parental consent or were absent on the vaccination day or not medically eligible for the vaccine due to ill health on the day. In terms of the proportion of Grade 4 girls who were too young to meet the eligibility criteria, based on NDoH data available through August 25, 2014, about 12% of Grade 4 girls were age-ineligible to receive the vaccine during the March 2014 campaign (range by province: 5% to 17%).²³ By the end of March 2019, 86.6% coverage of full HPV vaccination for Grade 4 learners had been achieved. The planned target was missed by 3.4%.</p> <ul style="list-style-type: none"> • Awareness-raising for HPV vaccination the strengthening of HPV curriculum in primary and high schools continued.
<p>Sub-objective 1.2.2</p>	<p>Develop and implement effective STI partner-notification strategies</p>
	<ul style="list-style-type: none"> • In June 2018, the NDOH officially introduced the index testing policy, including assisted partner notification (APN) or partner notification services (PNS). Index testing among family members has become a common practice in public health facilities.

Gaps and Challenges

- Comprehensive national STI data is limited.
 - As things stand, the new MUS episodes treated rate is not a very useful indicator since there was no baseline or NSP target set for this indicator.
 - Syphilis in pregnant female rate is a new STI indicator in DHIS thus, no baseline or NSP target to interpret results, i.e. rate of 0.05% in 2018/19.
 - There are gaps in DHIS STI surveillance and data reporting²⁴.
- The asymptomatic nature of STIs, particularly among AGYW poses a challenge.
 - Individuals with asymptomatic infections can transmit the STIs but are unlikely to get treatment.
- Latest HPV coverage data were not available on DHIS.
- Index testing among family members is a common practice; however, the implementation of STI partner-notification strategies in public health facilities remains deficient.
 - Include HPV coverage data in the DHIS.
 - There is an urgent need to consider reporting on the overall burden of STI, i.e. disaggregate by type of STI, gender, age, etc.
- To address the asymptomatic nature of STI, DoH needs to the following:
 - Introduce and scale-up better STI screening methods which go beyond symptoms screening
 - Develop a communication strategy around curable and incurable STIs - include social media to reach young people with information on types of STIs, signs and symptoms, where to get help, what treatment there is, complications of STIs, how to prevent them.
- The DoH must work closely with partner-notification experienced implementing partners to scale-up the implementation of partner-notification strategies,
 - Use lessons learnt from South Africa-based HIV partner-notification demonstration projects to inform STI partner-notification implementation in the South Africa context.
- In KZN, while overall STI cases declined, the introduction of STI screening in higher education institutions as a focused programme activity resulted in increased cases being identified and put on treatment. This activity, if scaled across other provinces, could lead to the identification of asymptomatic cases which would lead to successful treatment and reduced risk.
- To support the need for going beyond facility-based STI

Recommendations

- Improve national STI reporting and monitoring
 - Review and replace the new MUS treated episode rate with a SMART indicator.
 - Establish the 2022 target for syphilis in pregnant female rate.

²³ Delany-Moretlwe S, Kelley K, James S, et al. Human papillomavirus vaccine introduction in South Africa: implementation lessons from an evaluation of the national school-based vaccination campaign. *Glob Health Sci Pract.* 2018;6(3):425-438. <https://doi.org/10.9745/GHSP-D-18-00090>

²⁴ NDOH 2019, Report of a Joint review of South Africa's National Strategic Plan for HIV, TB and STIs 2017-2022. November 2019

programming, a study conducted in South Africa on adult gonorrhoea, chlamydia and syphilis prevalence, incidence, treatment and syndromic case reporting suggests that the lack of any decline in gonorrhoea and chlamydia prevalence highlights the need to enhance STI services beyond clinic-based syndromic case management, to reinvigorate primary STI and HIV prevention and to screen for asymptomatic infections, especially for women (Kularatne et al., 2018).



*"Strict adherence to treatment is important in order to enjoy a healthier, longer life."
– Gerry Elsdon, Global TB Champion*

GOAL 2



Reduce Morbidity and Mortality by Providing Care and Adherence Support for All

GOAL 2: REDUCE MORBIDITY AND MORTALITY BY PROVIDING TREATMENT, CARE AND ADHERENCE SUPPORT FOR ALL

During the period of the previous NSP, i.e. 2012-2016, South Africa made significant progress concerning the treatment of HIV, TB and STIs. The accomplishments include massive scale-up of ART, adoption of UTT in September 2016, nationwide implementation of the GeneXpert for TB diagnosis, development of focused TB initiatives for peri-mining communities and correctional facilities as well as the provision of concentrated care for people with drug-resistant (DR) TB.

In addition, the STI National Strategic Framework was developed.

Nonetheless, there is a need for enhanced efforts to scale up UTT fully and improve TB case finding and treatment. Children, adolescents, people with disabilities and other key and vulnerable populations still experienced barriers to ART and TB treatment.

Many PLHIV or those with TB remained unaware of their status, faced unacceptable delays between diagnosis and treatment initiation, and discontinued or in the case of TB and STIs were unable to complete their treatment. Significantly reducing the loss to follow-up for HIV and TB remains a priority.

Indicators and Results

TABLE 12: GOAL 2 INDICATORS – TARGET VS ACTUAL

INDICATOR	BASELINE (2016/2017)	TARGET (2018/19)	ACTUAL (2018/19)
1. Adult AIDS mortality	27.9% (STATS SA MYE, 2016)	TBD	22.06% (STATS SA MYE, 2018)
2. Percentage of PLHIV who know their status	Adults: 85.4% Men: 80.6% Women: 88.3% (Thembisa, 2015)	87%	90.5% (Thembisa, 2018)
3. Number of adults and children living with HIV (TROA)	3 407 336 (NDoH Annual Report 2015/16) Private sector: 287 408 (June 2015, Thembisa report)	5 363 013	Public sector 4 629 831 (86%) (2018/19) Private sector (Registered Medical AID Schemes in South Africa) 307 776 (June 2019)
4. Percentage of adults and children living with HIV is known to be on ART 12 months after starting (Retention)	78% (DHIS)	90%	63.4% (DHIS April-June 2018 cohort)
5. PLHIV viral load suppressed (VLS) rate at 12 months	85% (DHIS)	90%	89.3% (DHIS April-June 2018 cohort)

INDICATOR	BASELINE (2016/2017)	TARGET (2018/19)	ACTUAL (2018/19)
6. TB incidence	834/100 000 (WHO Global TB report, 2016)	700/100 000 16% reduction by 2019 (TB Strategy 2017/21)	520/100 000 38% reduction from baseline (WHO Global TB Report, 2019)
7. TB mortality	46/100 000 WHO Global TB report, 2016)	28% reduction (TB Strategy 2017/21)	37/100 000 (HIV-) (decreased from 39/ 100 000 in 2017) 73/100 000 (HIV+) (decreased from 99/ 100 000 in 2017) (WHO Global TB report, 2019)
8. TB death rate	4.4% (NDoH APP 2015/16)	4.65% (NDoH APP 2017/18 – 2019/20)	6.5% 2017 cohort (ETR, 2019)
9. Percentage of people/ clients started on TB treatment	92.4% (NDoH Annual Report, 2015/16)	95%	98% (DHIS, 2018/19)
<i>TB treatment coverage (notified/ estimated incidence)</i>	-	-	76% (57-119) (WHO Global TB Report, 2019)
10. TB treatment success rate	83.3% 2014 cohort 47.2% MDR-TB 2013 cohort (NDoH Annual Report, 2015/16)	86.93% 65% MDR-TB	DS-TB New and relapse cases: 77% Previously treated: 59% (2017 cohort) HIV+ TB cases: 75% (2017 cohort) MDR/RR-TB: 54% (2016 cohort) XDR-TB: 58% (2016 cohort) (WHO Global TB report, 2019)
11. TB clients lost to follow-up rate	6.1% 2014 cohort 22.3% MDR-TB 2013 cohort (NDoH Annual Report, 2015/16)	4.9% 10% MDR-TB (NDoH APP 2017/18 – 2019/20)	8.0% 2017 cohort (ETR, 2019)

INDICATOR	BASELINE (2016/2017)	TARGET (2018/19)	ACTUAL (2018/19)
12. Proportion of TB/ HIV co-infected patients on ART	87.5% (NDoH Annual Report, 2015/16)	90%	87% (WHO Global TB report, 2019)

Progress against Objectives

Objective 2.1: Implement the 90-90-90 strategy for HIV.

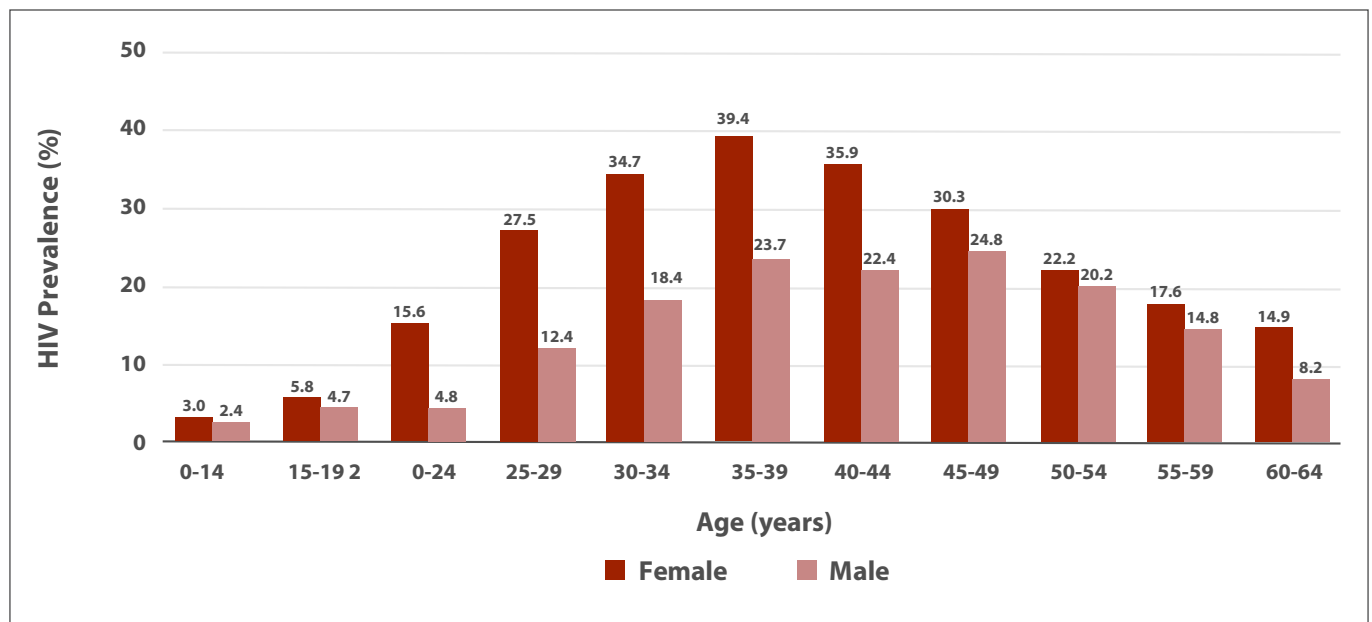
Overview and key policy issues

The Thembisa model estimates that South Africa had 7.39 million PLHIV in 2018 – equivalent to 12.9% of the population. Of these, it is estimated that 90.5% knew they were HIV-positive, 68.4% of those diagnosed were on ART, and 88.4% of those on ART were virally suppressed²⁵.

The 2017 HSRC HIV prevalence, incidence, behaviour, and communication survey estimated that there were 7.9 million PLHIV in South Africa in 2017, which is 1.6 million more than the 2012 estimate.

HIV prevalence among adults aged 15-49 years was estimated at 20.6%, with 26.3% among females and 14.8% among males²⁶. Figure 9 below depicts the HIV prevalence by age and sex (HSRC, 2018).

FIGURE 9: HIV PREVALENCE BY AGE AND SEX



SOURCE: HSRC, 2018

TABLE 13: HIV PREVALENCE BY AGE AND SEX

TOTAL		
PROVINCE	HIV+ %	95% CI
Eastern Cape	25.2	19.8 - 31.5
Free State	25.5	21.7 - 29.7

²⁵Thembisa, 2018

²⁶ Simbayi LC, Zuma K, Zungu N, Moyo S, Marinda E, Jooste S, Mabaso M, Ramlagan S, North A, van Zyl J, Mohlabane N, Dietrich C, Naidoo I and the SABSSMV Team (2018) South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2017. Cape Town: HSRC Press

TOTAL		
PROVINCE	HIV+ %	95% CI
Gauteng	17.6	14.8 - 20.7
KwaZulu-Natal	27.0	23.9 - 30.4
Limpopo	17.2	14.5 - 20.1
Mpumalanga	22.8	18.1 - 28.4
Nothern Cape	13.9	11.4 - 16.8
North West	22.7	19.6 - 26.2
Western Cape	12.6	9.7 - 16.1

SOURCE: HSRC, 2018

South Africa is committed to achieving the UNAIDS 90-90-90 targets, to contain the HIV epidemic through comprehensive HTS and the use of highly effective ART. Knowing one's HIV status is key to the realization of the national HIV prevention and treatment goals, rendering HTS the entry point to the comprehensive continuum of care.

New national and international recommendations and guidelines prompted South Africa to review its HIV Counselling and Testing (HCT) guidelines, which resulted in the 2016 National HTS Policy, which was aligned with the National Development Plan, 2030 and the UNAIDS 90-90-90 targets. In June 2018, South Africa formally introduced an index-testing policy, including APN or PNS. In addition, the South African Pharmacy Council (SAPC) approved over-the-counter distribution and use of HIV self-tests, to facilitate HIV self-screening or self-testing.

The main goal of ART is to accomplish and maintain viral suppression, which will reduce HIV-related morbidity and mortality and improve the quality of life for PLHIV. Since the introduction of ART in 2004, the National HIV Programme has made significant strides in the last two decades. Figure 11 provides a summary of the key milestones of the National ART Programme since its inception.

The 2017 HSRC HIV prevalence, incidence, behaviour, and communication survey estimated that there were 7.9 million PLHIV in South Africa in 2017, which is 1.6 million more than the 2012 estimate. HIV prevalence among adults aged 15-49 years was estimated at 20.6%, with 26.3% among females and 14.8% among males. Figure 9 below depicts the HIV

prevalence by age and sex (HSRC, 2018).

Per the 2016 WHO guidelines, South Africa introduced "Test-and-Treat-All" or UTT in September 2016, making all populations and age groups eligible for ART regardless of CD4. Similarly, the DoH introduced PrEP in 2016, as described under objective 1.1 above.

In May 2019, South Africa's NDoH published the 2019 ART Clinical Guidelines for the Management of HIV in adults, pregnancy, adolescents, children, infants, and neonates. The new guidelines include a new formulation of the fixed-dose combination (FDC) of tenofovir (TDF) 300 mg + lamivudine (3TC) 300mg + dolutegravir (DTG) 50 mg, i.e. TLD, for all eligible adults, adolescents and children over the age of 10 years and weighing 20 kg or more.

The advantages of DTG include 1) high genetic barrier to resistance, 2) minimal side effects and drug interactions, and 3) rapid viral suppression. Furthermore, DTG is well tolerated by patients and thus expected to contribute positively to adherence and retention on ART.

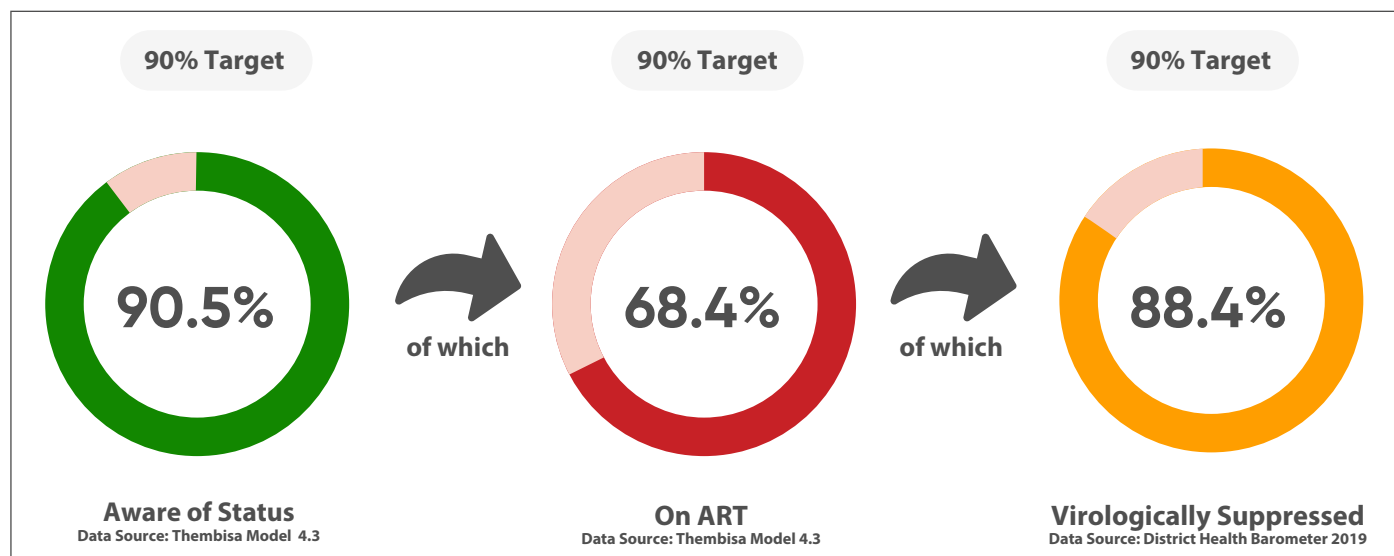
It is anticipated that these guidelines will increase access to ART services, advance the country's ability to control the epidemic, and help to achieve the 2030 Sustainable Development Goals (SDGs).

Key achievements

In 2018, South Africa had made commendable strides towards achieving the 90-90-90 targets.

Figure 12 below illustrates progress made towards attaining the 90-90-90 by the end of March 2018.

FIGURE 10: PROGRESS MADE TOWARDS 90-90-90 TARGETS, 2018



SOURCE: THEMBISA, 2018

Antenatal 90-90-90 success

Since 1990, South Africa has been implementing the national antenatal sentinel HIV prevalence survey. In 2017, the survey gathered additional data on HIV incidence, knowledge of HIV status (1st 90), ART coverage (2nd 90), viral suppression (3rd 90), syphilis screening, point-of-care HIV rapid testing and laboratory-based HIV testing.

The overall national HIV prevalence was stable at 30.7% (95% CI: 30.1% - 31.3%), a 0.1% drop from the 2015 antenatal HIV prevalence²⁷.

HIV testing uptake in the routine PMTCT HIV testing programme was over 99%, knowledge of HIV status among women attending follow-up ANC visits was 96.7%, of these 98.2% were on ART, and the ART adherence rate was 98.7%. In general, the knowledge of HIV status before the first ANC visit was low.

Nationally, 39.2% of the HIV-positive pregnant women were unaware of their HIV status prior to their first ANC visit, whilst it rose to 61.1% among adolescent women aged 15 - 19 years.

However, knowledge of HIV positive status was higher in the older age groups. 75% of women aged 35 – 49 years were aware of their HIV-positive status, and of these, 92.9% were initiated on ART prior to first ANC-visit.

To the contrary, 38.9% of pregnant women aged 15 - 19 years were aware of their HIV-positive status and of these, 86.7% were initiated on ART prior to first ANC visit. Table 13 below presents key achievements by sub-objective²⁸.

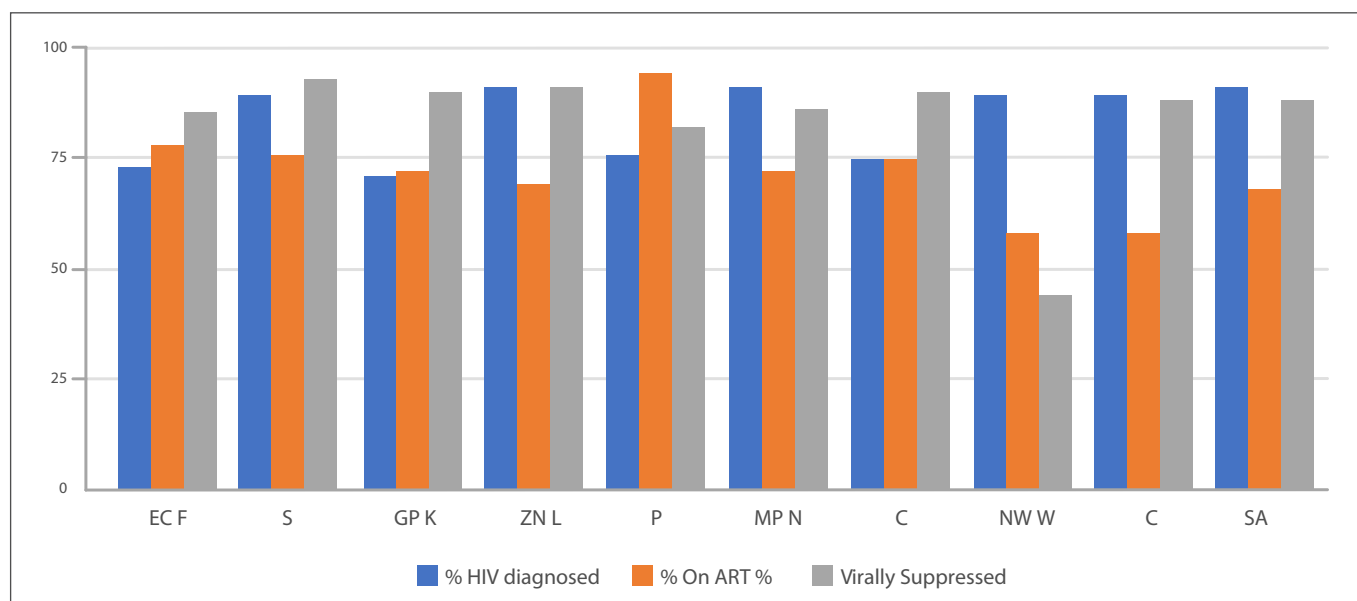
²⁷Woldesenbet, S.A., Kufa, T., Lombard, C., Manda, S., Ayalew, K., Cheyip, M., and Puren, A. (2019). The 2017 National Antenatal Sentinel HIV Survey, South Africa, National Department of Health

²⁸ibid

TABLE 14: HIV CASCADE KEY ACHIEVEMENTS BY SUB-OBJECTIVE

KEY ACHIEVEMENTS BY SUB-OBJECTIVE	
Sub-objective 2.1.1	90% of PLHIV know their HIV status
	<ul style="list-style-type: none"> For the period April 2017 to March 2018, 13 875 172 million people were tested for HIV, with Gauteng and KZN testing over 3 million people each. Against a target of 10 million for 2018/19 for the period April 2018 to March 2019, 14 874 879 HIV tests were done, an increase of 321 120 from the previous financial year. A further 2 876 343 HIV tests were done from April to May 2019²⁹. <p><i>At the midpoint of this NSP period, South Africa had 90.5% of PLHIV knowing their HIV status in 2018³⁰.</i></p>
Sub-objective 1.2.2	90% of all people diagnosed with HIV infection receive sustained antiretroviral therapy (ART)
	<ul style="list-style-type: none"> By the end of FY 2017/18, 4 196 302 PLHIV were retained on treatment (TROA) At the end of March 2019, 4 629 831 PLHIV remained on ART. This is an increase of 433 529 (10%) from the previous year. Between April and May 2019, an additional 64 013 remained on ART, bringing the total of the number of people on ART to 4 693 844³¹. <p><i>In 2018, South Africa had 68.4% of people diagnosed with HIV who were on ART.³²</i></p>
Sub-objective 2.1.3	90% of all people receiving ART are virally suppressed
	<ul style="list-style-type: none"> South Africa had made significant progress towards achieving the 90-90-90 targets, particularly the third 90. According to the 2018 Thembisa model, South Africa had 88% of people on ART, virally suppressed in 2018. Figure 13, shows the progress made towards the 90-90-90 targets (disaggregated by province), with 88% of PLHIV on ART virally suppressed.

FIGURE 11: PROGRESS TOWARDS 90-90-90 TARGETS IN 2018



SOURCE: THEMBISA, 2018

²⁹DHIS, 2018/19

³⁰Thembisa, 2018

³¹DHIS, 2018/19

³²Thembisa model, 2018

Progress against Objectives

Data from Figure 13 above communicates several key messages outlined below:

- Overall, South Africa is doing well as regards identifying HIV positive people and ensuring that those on ART are virally suppressed. Across all provinces, the key challenge remains that of initiating 90% of people who test HIV positive on ART, i.e. 2nd 90, except in Limpopo where 94% had been achieved.
- Regarding the 1st 90, provinces are yet to meet the 90% targets with Limpopo, Eastern Cape and Gauteng having

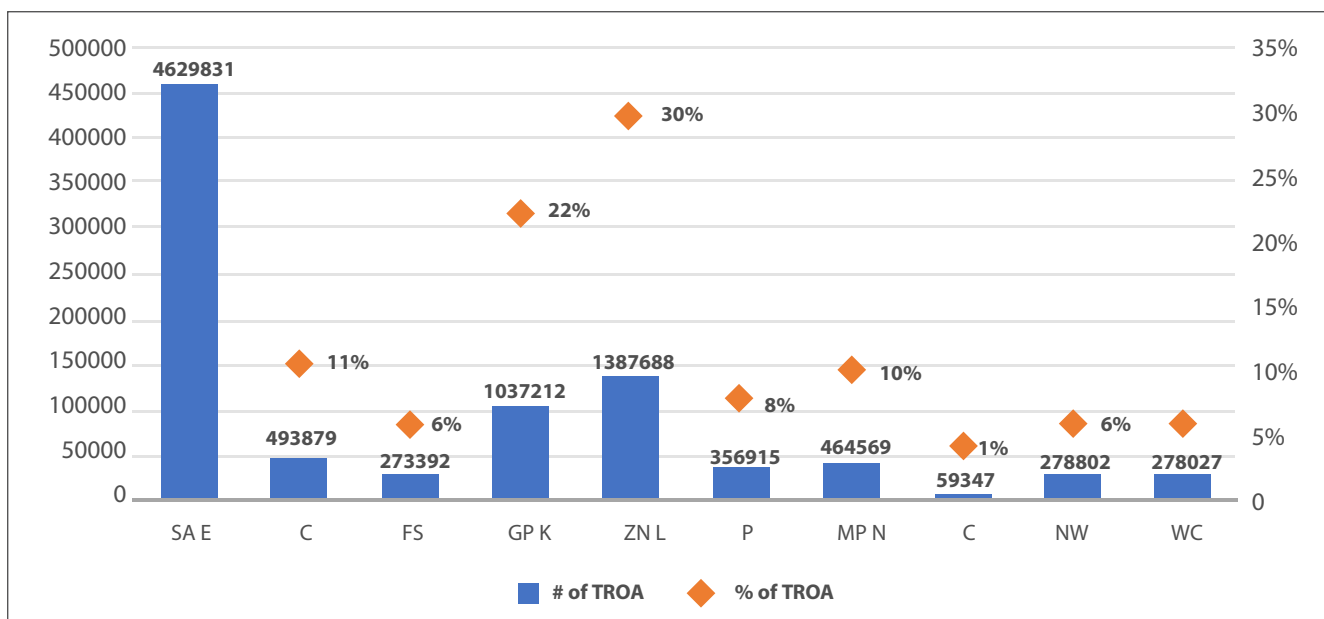
reached 76%, 73% and 71% respectively.

- The North West was struggling with the 2nd 90 (58%), and 3rd 90 (44%), but doing well regarding the 1st 90 (89%). There is an urgent need to support the province to understand the root causes and develop a quality improvement plan to address the gaps identified.

ART

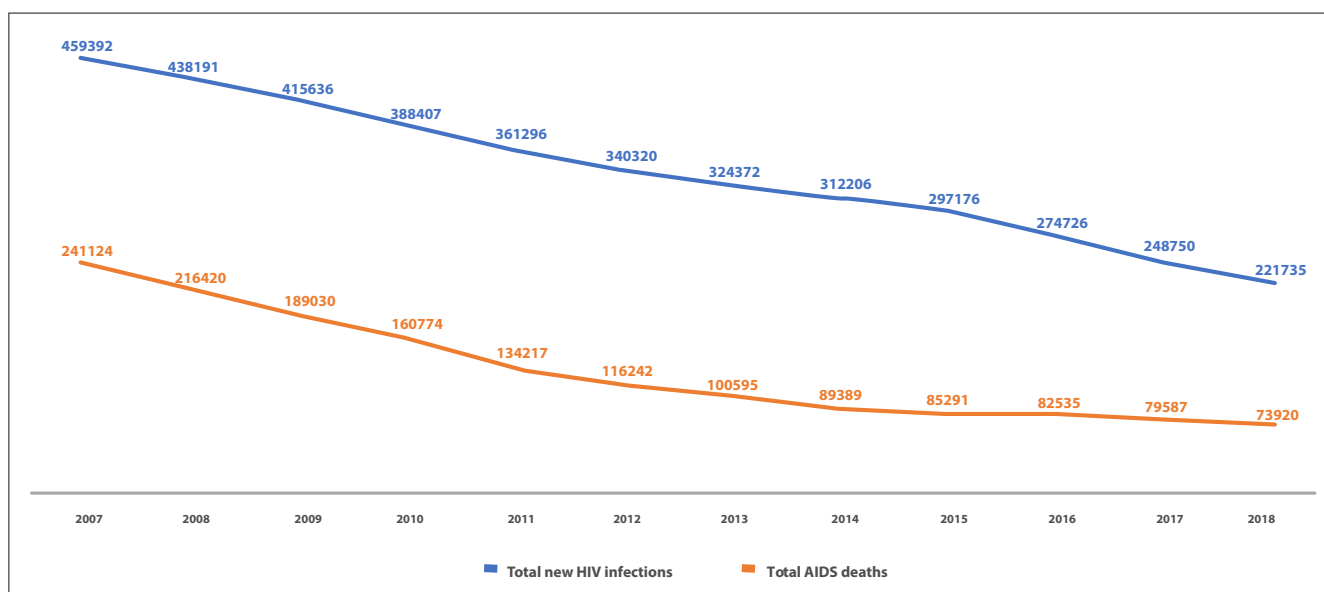
As illustrated in figure 14 below, 4 629 831 million PLHIV remained on ART by the end of March 2019. By December 2018, 303 851 remained on ART in the private sector, specifically from Council of Medical aid Schemes.

FIGURE 12: TOTAL REMAINING ON ART (TROA), AS AT MARCH 2019



SOURCE: DHIS, 2018/19

FIGURE 13: TOTAL AIDS DEATHS FOR THE PERIOD 2007 TO 2018



SOURCE: THEMBSA, 2018

Figure 15 above shows substantial declines in AIDS mortality. The annual number of AIDS deaths in South Africa has declined from about 241124 in 2007/08 to about 74 000 in 2018/19, a decline of 69%. Even though females have a higher HIV prevalence than their male counterparts, males are progressively carrying the burden of AIDS mortality. Over the 2017 to 2018 period, females accounted for 62% of new HIV infections in adults, but males accounted for 52% of adult AIDS deaths.

This difference can partly be attributed to the differences in uptake of HTS and ART uptake amongst males and females. In 2018, the Thembisa model estimates that the fraction of HIV-positive adults who were on ART was 64% in females compared to 58% in males.

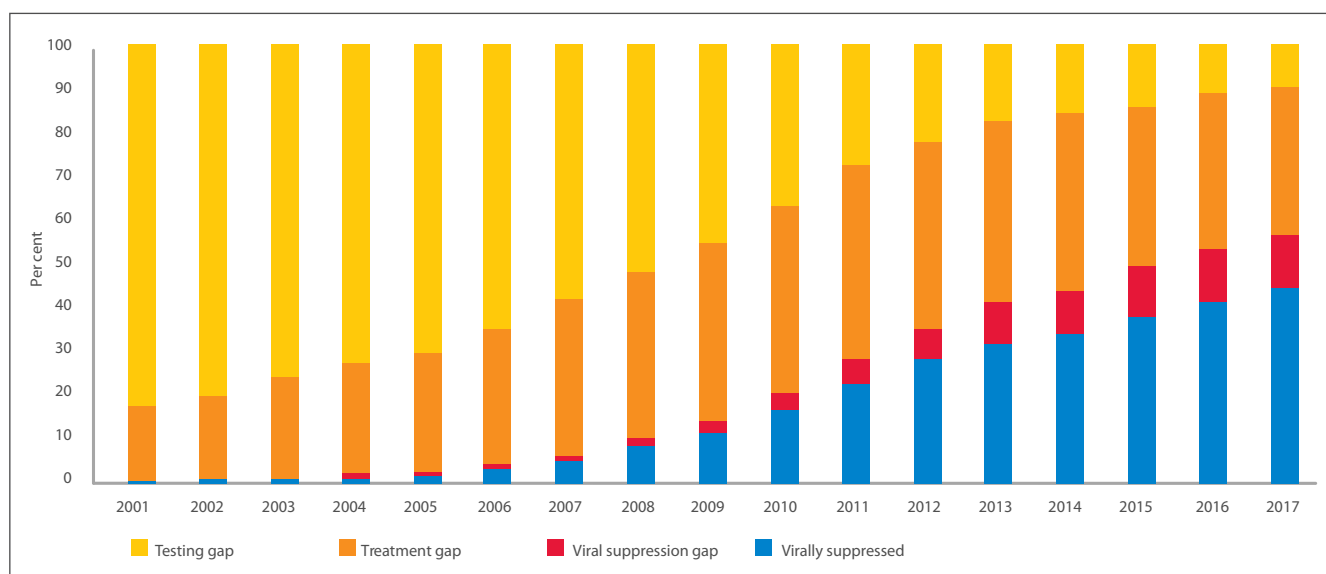
In addition, the presentation and understanding of HIV deaths need to be understood together with the number of new HIV infections. This helps with reviewing the country's progress towards epidemic control (defined by the program to be reached when the total number of new HIV infections falls below the total number of deaths from all causes among people with HIV) (PEPFAR, 2020). Figure 3 above shows that the number of new HIV infections have significantly dropped starting around 2014 and has continued that trajectory to 2018.

At the same point in time, the number of AIDS deaths started stabilising. This trend shows that there are still challenges of a high number of new HIV infections. However, the country is on a path to epidemic control which can be made possible to be reached by 2022 if the recommendations to strengthen various aspects of the HIV response as made in this report are implemented.

Gaps and Challenges

- The need for ART increases for as long as new HIV infections persist.
- Progress towards the 90-90-90 targets is not adequate:
 - Progress towards the 2nd 90 is slow 68.4% - and this demands that non-biomedical barriers to ART be considered.
 - Regarding the 3rd 90, viral load done (VLD) is about 50%; thus, viral load suppression (VLS) of 88.4% is misleading/ unrepresentative.
- Ensuring all PLHIV are on ART and those on ART remain in care over time are constant challenges.
 - Against the NSP target of 90%, only 63.4% of PLHIV are known to be on ART 12 months after starting (retention).
 - Delayed ART initiation following testing reduces the effectiveness of ART in reducing transmission.
- The UNAIDS 2018 report reveals a growing viral suppression gap in South Africa, see Figure 16 below. The figure also shows a growing challenge with the 2nd 90, which agrees with the Thembisa model estimates.
- Longitudinal follow-up of patients through the care cascade remains a challenge, in the absence of a fully implemented universal master patient index that can track patient movement between health facilities, providers and districts.

FIGURE 14: KNOWLEDGE OF STATUS, TREATMENT AND VIRAL SUPPRESSION GAPS, SOUTH AFRICA, 2001-2017



SOURCE: UNAIDS, 2018

Recommendations

- There is a need for evidence-based, focused, and targeted combination prevention interventions to drastically reduce new HIV infections and thus mitigate the new need for ART.
- Promote and enable widespread implementation of UTT and tested patient retention strategies to ensure all PLHIV are initiated on ART and unremittingly retained in care.
 - Address non-biomedical barriers to accessing ART
- Implement proven strategies to reduce the widening viral suppression gap.
- Accelerate the implementation of a universal unique patient identifier to improve the tracking of patients through the continuum of care.
- Commission and investigate the challenges encountered by provinces in terms of the 2nd 90. This is particularly related to all provinces except for Limpopo. The Limpopo province can be included from the perspective of learning best practices and lessons they have considering that they have surpassed the 90% target
- The North West province requires support in terms of understanding factors that are contributing to the suboptimal performance towards achieving the 2nd and 3rd 90s despite a good performance towards reaching the 1st 90.

- If HIV positive people identified are not initiated on ART, and those on ART are not virally suppressed, the onward transmission of HIV infections persist.

Objective 2.2: Implement the 90-90-90 strategy for TB

Overview and key policy issues

TB is a public health and development challenge for South Africa as it is for the world. The WHO post-2015 End TB Strategy serves as a blueprint for countries to reduce TB incidence by 80%, TB deaths by 90% and eliminate catastrophic costs for TB-affected households by 2030. Subsequently, South Africa committed to implementing the 90-90-90 strategy for TB by:

1. Finding 90% of all TB cases and placing them on appropriate treatment,
2. Finding at least 90% of all TB cases in key populations (the most vulnerable incl. PLHIV with low CD4 counts, underserved, at-risk) and placing them on appropriate treatment,
3. Successfully treating at least 90% of those diagnosed with DS-TB and 79% of those with DR-TB.

TABLE 15: TB CASCADE KEY ACHIEVEMENTS BY SUB-OBJECTIVE

KEY ACHIEVEMENTS BY SUB-OBJECTIVE	
Sub-objective 2.2.1	Find 90% of all TB cases and place them on appropriate treatment.
	<ul style="list-style-type: none"> • In South Africa, there were 301 000 TB cases in 2018. Of the new and relapse cases (56% males, 37% females and 7% children), 90% knew their HIV status and 89% had pulmonary TB. • 92% of the new bacteriologically confirmed TB cases, and 94% of the previously treated bacteriologically confirmed TB cases were tested for rifampicin resistance (RR). • In 2018, there were 13 199 MDR/RR-TB, and 553 XDR-TB laboratory-confirmed cases³³.
Sub-objective 2.2.2	Find at least 90% of all TB cases in key populations (the most vulnerable incl. PLHIV with low CD4 counts, underserved, at-risk) and place them on an appropriate treatment
	<ul style="list-style-type: none"> • In 2018, 65% of newly enrolled HIV positive patients have put on TB preventive therapy, and 87% of the TB/HIV coinfecting patients were on ART³⁴.
Sub-objective 2.1.3	Successfully treat at least 90% of those diagnosed with DS-TB and 79% of those with DR-TB
	<ul style="list-style-type: none"> • TB treatment success rate for new and relapse TB cases was 77% in 2018. Furthermore, 75% of the HIV-positive TB cases were successfully treated for TB³⁵. • For the financial year 2017/18, the target for MDR-TB treatment initiation sites with clinical audits conducted was 18, and 22 MDR-TB treatment initiation sites had clinical audits undertaken by the end of FY 2017/18³⁶. • See table 15 below, for more detail on treatment success attained in 2018.

³³WHO Global TB Report, 2019

³⁴ibid

³⁵ibid

³⁶NDoH Annual Report, 2017/18

The NSP demands the successful treatment of at least 90% of those diagnosed with DS-TB and 79% of those with DR-TB.

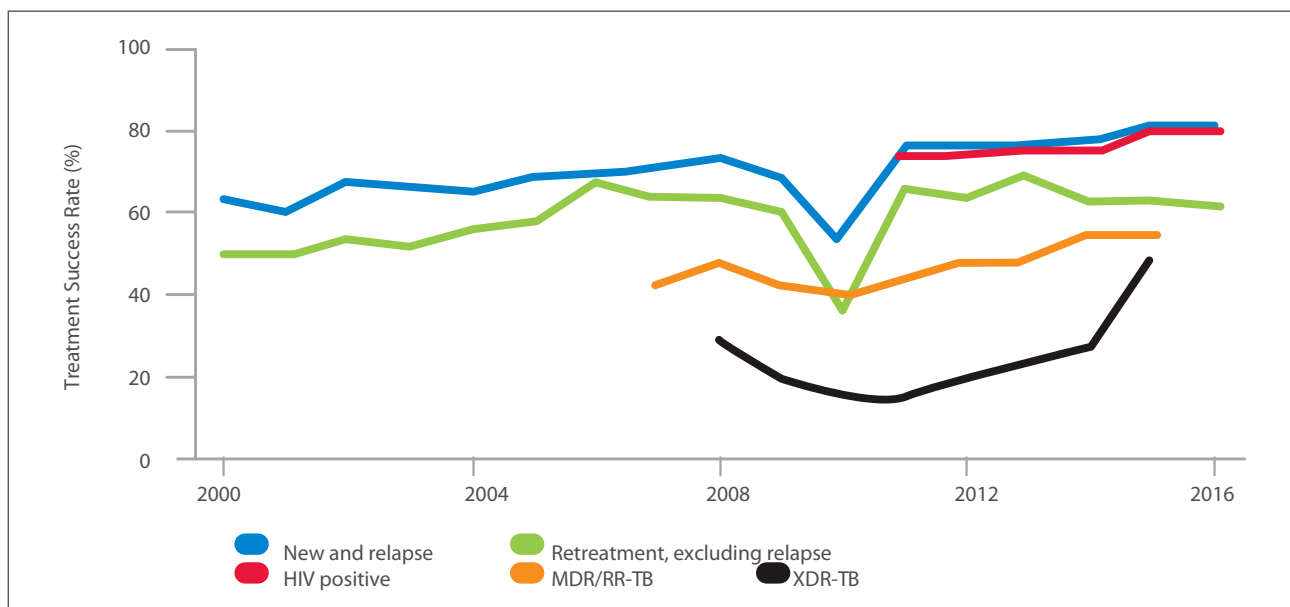
Table 15 and figure 17 illustrates TB treatment success achieved in 2018.

TABLE 16: TREATMENT SUCCESS RATE AND COHORT SIZE

TREATMENT SUCCESS RATE AND COHORT SIZE		
	Success	Cohort
New and relapse cases registered in 2017	77%	240 332
Previously treated cases, excluding relapse, registered in 2017	59%%	6 508
HIV-positive TB cases registered in 2017	75%	134 672
MDR/RR-TB cases started on second-line treatment in 2016	54%	11 159
XDR-TB cases started on second-line treatment in 2016	58%	601

SOURCE: WHO GLOBAL TB REPORT, 2019

FIGURE 15: TB TREATMENT SUCCESS RATE, 2018



SOURCE: WHO GLOBAL TB REPORT, 2019

Lastly, the elimination of injectables in the treatment of DR-TB, which, because of toxicity, were responsible for side effects such as hearing loss, was a significant milestone in DR-TB treatment evolution in South Africa³⁷.

TB population was double the mortality among the HIV- TB population³⁸. Table 17 below shows TB mortality in actual numbers and rates in 2018.

TB Mortality

In 2018, a total of 63 000 TB deaths were reported, and 42 000 of them were among PLHIV. Mortality among HIV-positive

³⁷National Department of Health. Annual Report 2018/2019

³⁸WHO Global TB Report, 2019

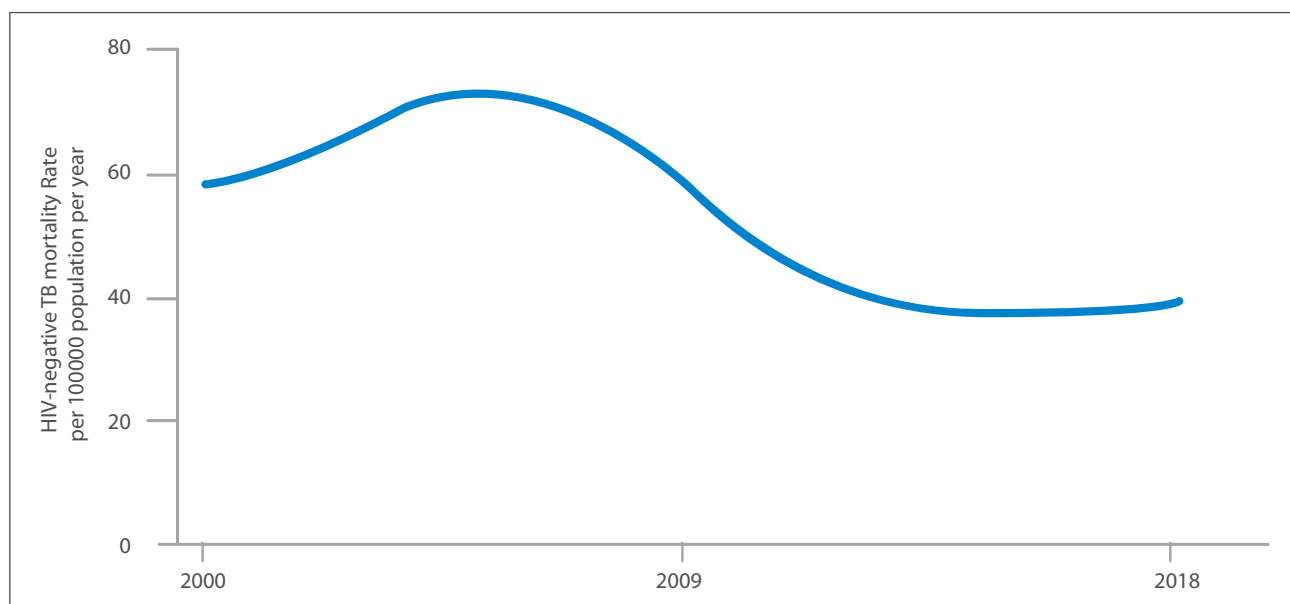
TABLE 17: TB MORTALITY IN 2017

TB BURDEN IN 2018		
	Number (thousands)	Rate (per 100 000 population)
HIV-negative TB mortality	21 (20-23)	37 (35-39)
HIV-positive mortality	42 (30-57)	73 (51-99)

SOURCE: WHO GLOBAL TB REPORT, 2019

Figure 18 shows HIV-negative TB mortality rate trends for the period 2000 – 2018. In the last few years, HIV-negative TB mortality rate has seemingly stabilized at around 37 per 100 000 population.

FIGURE 16: HIV-NEGATIVE TB MORTALITY 2000 – 2018



SOURCE: WHO GLOBAL TB REPORT, 2019

Gaps and Challenges

- Treating all TB cases remains a challenge – there are many undetected cases as well as asymptomatic TB.
- There was a 28% treatment gap between laboratory-confirmed MDR/RR-TB cases and the MDR/RR-TB patients started on treatment in 2018 – albeit an 8% improvement from the 36% reported in 2017.
- High TB clients lost to follow-up rate – 8% based on the 2017 cohort (ETR 2019).
 - o Increased from 6.1% (2014 cohort) against the 2018/19 NSP target of 4.9%.
- Rising TB death rate - increased from 4.4% at baseline in

2016 (2014 cohort) to 6.5% in 2019 (2017 cohort), against an NSP 2018/19 NSP target of 4.65%.

Recommendations

- Improve TB treatment by implementing strategies to reduce the number of undetected TB cases and improve case-finding of asymptomatic TB.
- DoH must work closely with NHLS to implement strategies to close the gap between laboratory-confirmed MDR/RR-TB cases and the MDR/RR-TB patients started on treatment.
- Implement proven strategies to reduce TB client loss to

³³ WHO Global TB Report, 2019
³⁴ ibid
³⁵ ibid
³⁶ NDoH Annual Report, 2017/18

- follow-up.
- Implement interventions and latest treatment regimens to reduce TB death rate, more so among PLHIV.

For public health purposes, the strategy is based on standardised guidelines and treatment regimens, and the continuum of care for STIs ensures that individuals screened and diagnosed with STIs receive and finish treatment and are cured, thus safeguarding contribution to STI prevention.

Objective 2.3: Improve STI detection, diagnosis, and treatment.

Overview and key policy issues

In alignment with the WHO Global Health Sector Strategy, South Africa is implementing the National STIs Strategy. The outline of the strategy includes universal coverage for all people. This outline covers key and vulnerable populations. Furthermore it focuses on key STI syndromes and aetiologies including maternal and congenital syphilis, gonococcus, chlamydia, syphilis, HSV-2, HPV.

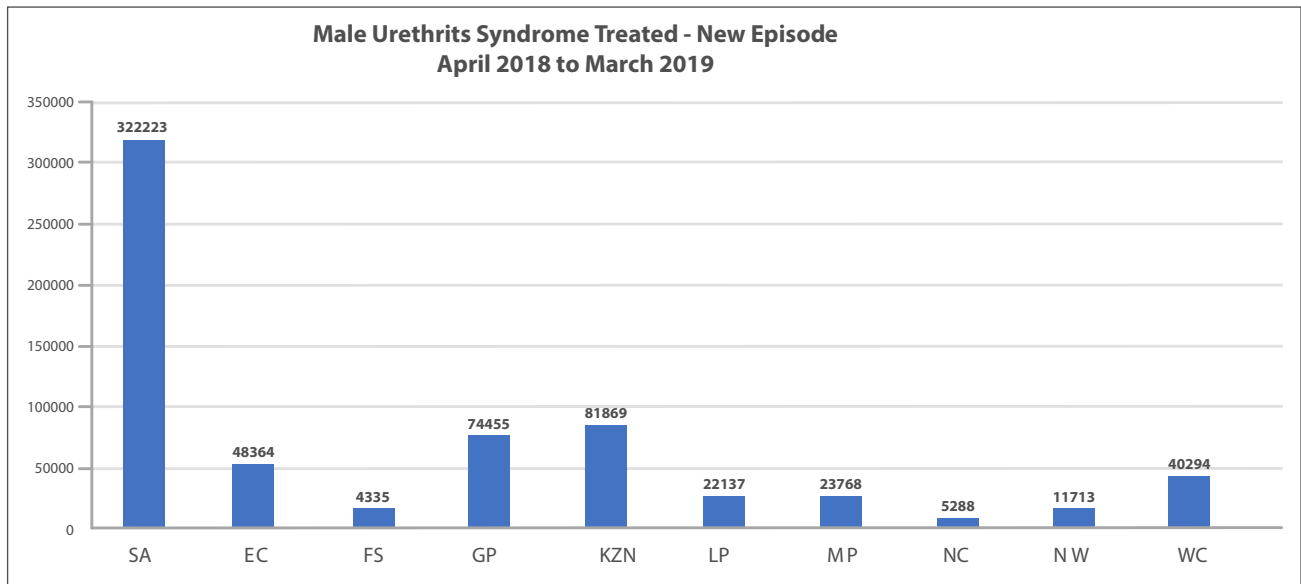
Key Achievements

TABLE 18: STIS KEY ACHIEVEMENTS BY SUB-OBJECTIVE

KEY ACHIEVEMENTS BY SUB-OBJECTIVE	
Sub-objective 2.3.1	Increase detection and treatment of asymptomatic STIs by 50%
	<ul style="list-style-type: none"> The DoH routinely screens for STIs all clients visiting health facilities, including all pregnant women at each ANC visit. The 2017 antenatal HIV prevalence sentinel survey reported a national maternal syphilis screening coverage of 96.7% at the national level, excluding 14.1% of participants, for whom this information was missing³⁹.
Sub-objective 2.3.2	Increase the detection and treatment of STIs
	<ul style="list-style-type: none"> Successful treatment of 327 992 male urethritis syndrome (MUS) new episode cases occurred between April 2017 and March 2018. For the period April 2018 to March 2019, 323 223 MUS new episode cases were successfully treated. For the period April to May 2019, a further 52 846 MUS new cases were successfully treated⁴⁰. Based on the NDOH DHIS STI program data presented above, the number of MUS new episode cases successfully treated dropped by 4 769 from March 2018 to March 2019. Figure 19 below shows the MUS new episode cases successfully treated across all nine provinces.

SOURCE: WHO GLOBAL TB REPORT, 2019

FIGURE 19: HIV-NEGATIVE TB MORTALITY 2000 – 2018



SOURCE: WHO GLOBAL TB REPORT, 2019

As shown in Figure 19 above, GP and KZN treated 81 869 and 74 455 cases of male urethritis syndrome treated (new episode) respectively, whilst NC treated the lowest caseload of 5 288 in this reporting period.

Gaps and Challenges

- No baseline and NSP target for the male MUS (new episodes) treated rate
 - o Current indicator is not very useful for STI reporting

and monitoring.

- Comprehensive national STI data not readily available.

Recommendations

- Improve national STI reporting and monitoring and ensure availability of comprehensive national STI data.
 - o Review current STI indicators and introduce SMART STI indicators where applicable.

3



"Addressing the unique and specific challenges faced by key and vulnerable populations is important in curbing the spread of HIV, TB and STIs."

– Nelson Medeiros, Step-Up Project Co-ordinator and former drug user

GOAL 3



Reach All Key and Vulnerable Populations with Customised and Targeted Interventions

GOAL 3: REACH ALL KEY AND VULNERABLE POPULATIONS WITH CUSTOMISED AND TARGETED INTERVENTIONS

Overview and key policy issues

Under Goal 3, the NSP reflects a commitment to ensure that nobody is left behind. The NSP defines key populations (KPs) as populations who are at higher risk for HIV irrespective of the epidemic type or local context and who face social and legal challenges that increase their vulnerability. These include sex workers (SW), men who have sex with men (MSM), transgender (TG) people, people who inject drugs (PWID), and people in prison and other closed settings. In addition to experiencing elevated HIV risk and burden and facing legal and social issues, these populations historically have not received adequate priority in response to the HIV epidemic.

The South African Bill of Rights, Section 27, states that everyone has the right to access healthcare services and that no one may be refused services or treatment, or provided with inferior care, because of gender or sexual minority status. However, MSM, SWs and PWIDs still report frequent exclusion from society and high levels of stigma and discrimination in the healthcare setting.

As part of the national response to HIV, STIs and TB, SANAC launched a National Plan focusing specifically on Lesbian, Gay, Bisexual, TG and Intersex (LGBTI) people in 2017, as an augmentation of the NSP HIV, TB and STIs 2017 – 2022. The plan aims to reduce new HIV infections by 63%, TB infections by 30% and increase the detection of STIs by 70% over five years.

Due to the increased vulnerability of SW in South Africa, the National Sex Worker HIV Plan 2016-2019 (NSWP) was developed to guide quality service delivery to reach 70 000 sex workers over three years use a peer educator-led approach.

The NSWP sets out targets to ensure that at least 95% of sex workers use condoms with their clients and partners, that violence against sex workers falls by 50%, and that the global targets of 90-90-90 are met for sex workers.

The South African HIV epidemic is diverse, and within the generalised national epidemic, there are several concentrated sub-epidemics namely,

Sex workers (SW)

Nationally, the SW population size is estimated at 237 717, with an HIV prevalence of 57.7%, although this varies between

areas (71.8% in Johannesburg, 53.5% in Durban and 39.7% in Cape Town) . SWs carry the highest HIV burden of all key populations in SA. Local research studies suggest that the HIV prevalence among female sex workers (FSW) ranges from 40% to 88%. However, national cascades are not available for male or transgender sex workers, during the reporting period. Global Fund grant program data shows an HIV positivity rate of 21.45% and 27.73%, respectively.

Male and transgender sex workers in South Africa are more likely than FSW to have unprotected sex (2.9 times and 2.4 times, respectively). Linked to this, male (59.7%) and transgender (66.1%) sex workers are also more likely than FSW (40%) to report alcohol use during sex2.

Men who have sex with men (MSM)

South Africa has an estimated 1 095 527 MSM, with an estimated overall HIV prevalence of 31%. This varies geographically, but studies reveal that HIV prevalence among MSM has risen by more than 10% in Johannesburg, Cape Town and Durban since 2008 , which is fuelled by high levels of alcohol and substance abuse .

People who inject drugs (PWID)

While data among PWID is limited, population size is estimated to be 75 701, with gender-disaggregated size estimates of 42 755 for men, and 32 946 for women, with an overall HIV prevalence of 17%. However, PWID only accounts for 1.3% of new HIV infections in South Africa.

Women who have sex with women (WSW)

Currently, in SA, there is very limited information available on HIV prevalence amongst lesbian and transgender populations, and there is a shortage of prevalence data for intersex persons. During the MTR, estimates of HIV prevalence amongst WSW were between 8% and 13%. Studies also reveal that nearly 50% of WSW also have consensual heterosexual sex, and 19% engage in transactional sex3.

Transgender (TG)

It is estimated that by 2015, there were 139 666 transgender people, with disaggregation of 72156 transgender women, and 67510 transgender men, with an HIV prevalence of between 9 -19.4% 3 HIV prevalence amongst TGW in South Africa remains undocumented.

A transgender Integrated Biological and Behavioural Survey (IBBS) completed in 2018, the BotsheloBaTrans study , that was implemented in three cities, found HIV prevalence amongst TGW to be 45.5% in Cape Town [Western Cape], 63.4% in Johannesburg [Gauteng], and 46.1% in Buffalo City [Eastern Cape]).

These findings were confirmed by the results of the HPTN 075 study that found HIV incidence to be high among participants

recruited in Cape Town, with the presence of a rectal sexually transmitted infection (STI) at enrolment being the key risk factor for HIV seroconversion .

Inmates/Prisoners

For prisoners, the Department of Correctional Services (DCS) reported a population of approximately 160 000 inmates housed in 247 correction centres, with an HIV prevalence of 15% in 2016 (latest available data during the MTR) . The DCS extrapolated these rates from programme data and not an HIV prevalence survey.

There is no representative data regarding TB prevalence in South African prisons . A 2014 study from a large Johannesburg-area prison found a 3.5% prevalence of laboratory-confirmed undiagnosed TB, and 44.1% of those prisoners were also HIV-positive.

Key Populations for TB

As outlined in the NSP, the Key Populations for TB include; People living with HIV, Household contacts of TB patients, Health care workers, Inmates, Pregnant women, Children < 5 years old, and Mine Workers and people in peru-mining communities. South Africa has also committed to the Global Plan to End TB 2016 – 2020. As set out by the Stop TB Partnership, this involves implementing the 90-90-90 strategy for TB.

According to Kootbodien et al. (2018), substantial differences in TB mortality across occupation groups are noted, which may reflect differences in socioeconomic levels, HIV-burden, other risk factors for TB, and occupational exposure .

Although over the past few years, the TB incidence rate has fallen by approximately 7% per year , it was observed that elevated odds of TB mortality among agricultural workers (skilled workers as well as labourers) compared to business and administration professionals remain increasing.

Farmworkers in South Africa are often migrant or seasonal workers who live in rural communities and experience difficulties in accessing health care services . A two- to three-fold increased TB mortality risk was observed among health professionals, health associate professionals, and personal care workers compared . Moreover, gold miners exposed to silica dust with or without a diagnosis of silicosis also have an increased risk of TB. Workers in the building and construction industry are also exposed to high levels of silica dust and are at increased risk of TB

Children including Orphans and Vulnerable Children (OVC)
The South African National HIV Survey reported that orphans in the survey were 3.5 times more likely than non-orphans to be HIV positive, with double orphans being 6.9 times more likely than non-orphans to be HIV positive. This difference

in HIV prevalence between orphans and non-orphans was particularly significant in the younger age group (0 – 14 years) but was not significant in the older age groups (15 – 18 years).

This disparity in HIV prevalence rates for OVC suggests the need for interventions to address this . Findings from another study also confirm that some sub-groups of orphaned youth are at increased risk of substance use, and families and communities may be influential in moderating this risky behaviour .

In response to the vulnerability of OVC, the South African government has developed and implemented a series of laws, policies, strategic plans and programmes to appropriately address the needs of OVCs and strengthen the capacity of families and communities to care for OVCs. The national Department of Social Development (DSD) published the policy framework for Orphans and other Vulnerable Children affected by HIV/AIDS (OCVAHA) in 2006.

It emphasises the importance of developing comprehensive and integrated strategic responses for orphans and other vulnerable children at the programmatic level. OVC programs aim to improve the children's resilience to meet their basic needs for health, safety, stability, and schooling through the provision of services, such as case management, psychosocial support, early childhood development, and household economic strengthening.

Mobile Populations and People Living Informal Settlements
In South Africa, HIV is increasingly associated with urban areas—particularly informal urban areas where HIV prevalence is double that of formal urban areas; 25.6% compared to 13.9% for adults aged 15–49 years – a reminder that cities are not homogeneous spaces. They are complex, encompass vastly different health and demographic profiles within their boundaries, and are often undergoing rapid change.

In response to high HIV prevalence in most South African cities, the South African Local Government Association (SALGA) together with the SANAC, UNAIDS and the International Association of Providers of AIDS Care (IAPAC) initiated the Paris Declaration on Fast Track Cities initiative, that seeks to fast track the attainment the UNAIDS 90-90-90 targets in cities by 2020.

Mayors and councillors from 19 municipalities (i.e. Buffalo City, Cape Town, Ekurhuleni, eThekweni, Johannesburg, Mangaung, Nelson Mandela Bay, Tshwane, eMalahleni, Emfuleni, Kimberley, Mafikeng, Mbombela, Mogale, Msundunzi, Polokwane, Rustenburg, Ulundi and uMhlathuze) have committed to implementing multi-sectoral municipal plans to reach the 90-90-90 Fast-Track targets for HIV and TB.

These 19 municipalities together represent half of South

Africa's population, half of all new HIV infections in South Africa and the majority of PLHIV in need of HIV treatment. If these municipalities implement the Fast-Track approach, it is feasible that South Africa could meet the global target of ending AIDS as a public health threat by 2030 .

Adolescent Girls and Young Women (AGYW)

Among the populations listed above, AGYW is the most critical to South Africa's epidemic. Estimates indicate that a third of all new HIV infections in the country occur in AGYW aged 15-24 years, contributing 1674 new infections each week. The Thembisa Model 4.2 suggests that HIV incidence among AGYW peaks at age 19 years old, at 2.74%.

However, the age and gender disparity in new infections are greatest amongst 17- year-olds. These estimates show that girls are more likely to acquire HIV-8.7 times; than their male counterparts are.

The HERStory Study reported that 12.4% of AGYW were HIV positive, and this varied by district from 3% in Cape Town to 17% in Zululand. Among AGYW aged 15 to 19 years, the prevalence of HIV was 7%, significantly lower than the prevalence among AGYW aged 20 to 24 years, which was 20%. The annual HIV incidence for participating AGYW aged 15 to 24 years was estimated to be 1.45%. Among adolescent girls aged 15 to 19 years, the incidence was 1.14%, while among young women aged 20 to 24 years, it was significantly higher at 1.93%. Among AGYW with laboratory-confirmed HIV positive status, 39% did not know their status, 51% were exposed to ART.

Of the AGYW, 11% have reported they had been diagnosed with an STI in the year before the survey. Among AGYW who had reached an age at which they could potentially have completed high school and attained Grade 12 (20 to 24 years),

only 63% reported that they had completed Grade 12.

Although to date, there have been few population estimates of the burden of STIs among adolescent girls and young women and no studies among men , STI prevalence among young women aged 15–24 years remains higher than among older women, with an estimated range of 18.5% prevalence of chlamydia, 5.2% gonorrhoea, 2.6% trichomonas, 69.3% had evidence of abnormal vaginal flora (33.7% BV and 35.6% intermediate flora), and 17.6% were diagnosed with a candida infection .

To address these challenges, South Africa has launched the She Conquers campaign , consisting of biomedical, socio-behavioural, and structural interventions targeted at AGYW age 15-24 years and their male partners. The campaign serves as an organizing framework to ensure alignment of AGYW activities, including planned interventions under Global Fund and PEPFAR, and alignment to the NSP HIV, TB and STIs 2017-2022.

To equip children and young people with the knowledge, skills, attitudes and values, DBE has rolled-out the provision of Comprehensive Sexuality Education (CSE) in schools in the curriculum through scripted lesson plans (SLPs), and through several co-curricular programmes, that include; Keeping Girls in Schools; Breaking the Silence; Determined, Resilient, Empowered, Aids-Free, Mentored and Safe (DREAMS)

Goal 3 Indicators and Results

TABLE 19: GOAL 3 INDICATORS – TARGET VS ACTUAL

INDICATOR	BASELINE (2016/2017)	TARGET (2018/19)	ACTUAL (2018/19)
1. Number of key population surveillance activities conducted	FSW IBBS 2014 MSM IBBS 2015/16	SW IBBS 2017 MSM IBBS 2017 PWID IBBS 2017 Inmates IBBS 2017	1. SW IBBS 2017/18 2. TGIBBS 2018 3. PWID IBBS 2017/18
2. HIV prevalence among specific key and vulnerable populations	<p>MSM (HSRC Marang Men's Study) Total: 28% Johannesburg: 26.8% Cape Town: 22.3% Durban: 48.2%</p> <p>FSW (IBBS, 2014) JNB - 72.0% CPT - 40.0% DUR - 55%</p> <p>MSM (IBBS 2015/16) JNB - 43.4% MAF - 18.2% BLO - 18.1% CPT - 26.7% POL - 22.3%</p> <p>(IBBS Clinical results, 2015) PWID 14% (RAR study) Inmates 23% (NSP) People with disabilities 17% (NSP)</p>	TBD	<p>TG (IBBS, 2018) JNB = 63.4 % CPT = 45.5 % BCM = 46.1%</p> <p>PWID (IBBS, 2016/17) PTA: 38% CPT: 7% DUR: 27%</p> <p>FSW (IBBS, 2018/19) Study results under review by CDC</p> <p>INMATES (IBBS, 2019) Study underway by Aurum Institute, DCS and CDC</p> <p>MSM: (IBBS 2018) 31%</p>
3. Percentage of specific key populations who correctly identify risks of HIV, STI and TB transmission and how to prevent them and reject major misconceptions about HIV	<p>FSW (IBBS, 2015) JNB: 32.8% CPT: 19.6% DUR: 4.6%</p> <p>MSM (HSRC Marang Study 2015) JNB: 48.7% CPT: 40.0% DUR: 42.3%</p>	TBD	<p>The most recent FSW (BBS, 2017/18) did not know questions from FSW.</p> <p>MSM: report for the MSM BBS conducted by the Aurum Institute and completed in 2019 was not yet approved by CDC. CDC did not yet approve the report for the MSM BBS conducted by the Aurum Institute and completed in 2019 during the time of the MTR.</p>
4. Percentage of specific key and vulnerable populations reporting using a condom	<p>FSW (IBBS, 2015) Johannesburg: 76.4% Cape Town: 89.4% Durban: 84.5%</p>	TBD	<p>FSW (BBS, 2017/18)- Condom use with the last three paying clients. Johannesburg: 68.9% Cape Town: 76.3% Durban: 81.7%</p>

⁶⁷The Aurum Institute, Anova Health Institute & UCSF (2019). The Second South African Health Monitoring Survey (SAHMS2). Results Summary Sheet: A Biological and Behavioural Survey Among Female Sex Workers, South Africa 2017–2018. Johannesburg; The Aurum Institute.

INDICATOR	BASELINE (2016/2017)	TARGET (2018/19)	ACTUAL (2018/19)
	<p>MSM - condom use during last anal intercourse</p> <p>JNB - 85.7%</p> <p>MAF - 83.4%</p> <p>BLO - 88.5%</p> <p>CPT - 63.6%</p> <p>POL - 69.1%</p> <p>PWID - 38.9% (HSRC 2012) (Data for inmates not collected for this indicator)</p>		<p>MSM: CDC did not yet approve the report for the MSM BBS conducted by the Aurum Institute and completed in 2019 during the time of the MTR.</p>
5. HIV prevalence among specific key and vulnerable populations	<p>PWID (RAR, 2013) Reported having HIV test in last 12 months and know result: Gauteng: 49% (n=150); KZN 54% (n=150); WC: 61% (n=150)</p> <p>FSW: (IBBS, 2015) JNB = 73.8% CPT = 56.7% DUR = 77.0%</p> <p>MSM: (IBBS 2015/16) JNB - 55.7% MAF - 29.35% BLO - 31.82% CPT - 50.34% POL - 24.71%</p> <p>INMATES DCS = 100%</p>	TBD	<p>TG (IBBS, 2018) JNB = 63.4 % CPT = 45.5 % BCM = 46.1%</p> <p>PWID (IBBS, 2016/17) PTA: 38% CPT: 7% DUR: 27%</p> <p>FSW (IBBS, 2018)⁶⁸ 82%</p> <p>MSM: (IBBS 2018)⁶⁹ 41%</p>
6. Percentage of specific key and vulnerable populations living with HIV receiving ART (2nd 90)	<p>FSW (IBBS, 2015) Johannesburg: 19.1% Cape Town: 25.6% Durban: 27.7%</p> <p>MSM: (IBBS 2015/16) JNB - 43.04% MAF - 29.35% BLO - 36.36% CPT - 40.00% POL - 22.35%</p> <p>INMATES DCS = 98%</p>	TBD	<p>FSW (IBBS, 2018)²⁷ 48%</p> <p>MSM (IBBS, 2018)²⁸ 28.1%</p>
7. Percentage of specific key and vulnerable populations living with HIV who have suppressed viral loads (3rd 90)	<p>FSW: Not VL tests conducted</p>	TBD	<p>FSW (IBBS,2018)²⁷ Data not available</p> <p>MSM (IBBS, 2018 28) 26.5%</p>

⁶⁸ Schwartz S, Lambert A, Phaswana-Mafuya N, Kose Z, Mclngana M, Holland C, et al. Engagement in the HIV care cascade and barriers to antiretroviral therapy uptake among female sex workers in Port Elizabeth, South Africa: findings from a respondent-driven sampling study. Sex Transm Infect. 2017;93(4):290-6.

⁶⁹<https://www.state.gov/wp-content/uploads/2019/08/2018-PEPFAR-Strategy-Progress-Report.pdf>

INDICATOR	BASELINE (2016/2017)	TARGET (2018/19)	ACTUAL (2018/19)
	<p>MSM: (IBBS 2015/16) JNB-57.81% MAF-33.70% BLO-38.64% CPT-39.31% POL-32.94%</p> <p>INMATES END JUNE 2016 = 81% (≤ 1000) End June 2016 = 63% (≤ than 40)</p>		<p>MSM (IBBS, 2018 28) 26.5%</p>
8. Percentage of specific key and vulnerable populations with access to the core package of HIV, TB and STI services	TBD	<p>46.7% (70,000/150,000)</p> <p>INMATES DCS = 87.7%</p>	<p>Inmates: ART 99% (27335/27751) ART implementation Universal Test and Treat (UTT) Guidelines and support from partners (Aurum, TB/ HIV Care & Right to Care. Inmates: TB new pulmonary cure rate of offenders: 89% (568/641)-Target achieved due to support from Global Fund Partners. Inmates: Therapeutic diets prescribed for inmates: 7% (10836/162875)</p>
9. Percentage of inmates screened for TB at different time points	<p>2014/15 On entry: 92.8% Biannually: 64.9% Exit: 91.08% (NSP Enhance progress report)</p>	90%	<p>90%, with case finding of 3.5% of the incarcerated population having undiagnosed, smear-positive TB</p>
10. Percentage of controlled mines providing routine TB screening at least once a year	83%	80%	<p>96.2% (474 429/493 054) miners screened for TB in 850 mines in the country, as follows: 140 Coal Mines with 97 594 miners screened 96.5%; 169 Diamond mines with 17 245 miners screened 92.4%; 55 Gold mines with 107 768 miners screened 92.8%; 77 Platinum mines with 169 683 miners screened</p>

⁷⁰Department of Correctional Services Vote No. 8 Annual Report 2018/2019 Financial Year, RP 303/2019; ISBN:978-0-621-47807-5

⁷¹Telisinghe L, Fielding KL, Malden JL, Hanifa Y, Churchyard GJ, Grant AD, Charalambous S., 2014. High tuberculosis prevalence in a South African prison: the need for routine tuberculosis screening. PLoS One 9: e87262

INDICATOR	BASELINE (2016/2017)	TARGET (2018/19)	ACTUAL (2018/19)
			98.9%, and 409 Other Commodities mines with 100 683 miners screened 95.8%. ⁷²
11. Percentage of people who inject drugs receiving opioid substitution therapy (OST)	40 –To be established in 2017 in 3 cities for PWID	70 0.4%	4% ⁷³
12. Percentage of specific key populations who ever experienced human rights violations	SW Police violence: 55% Client violence: 57% (SWEAT, 2013)	50 % reduction	SW: Self-reported physical assault in the past 12 months: Cape Town: 25.3% Durban: 28.0% Johannesburg: 22.0% ⁷⁴

Progress against Objectives

Objective 3.1: Increase engagement, collaboration and advocacy of key and vulnerable populations in the development and implementation of social and health support activities.

Overview and key policy issues

Under Goal 3 the NSP reflects a commitment to ensure that nobody is left behind. While working to reach the national prevention and treatment targets, intensified efforts will support peer-led and community-based services tailored to meet the needs of specific populations, initiatives to empower key and vulnerable populations, and actions to build the capacity of service providers to meet the needs of key and vulnerable populations.

Integral to this strategy is guidance for building the capacity of service providers, implementing and expanding community and peer-led programming, and creating enabling environments so that hard to reach groups advocate for their health and human rights and increase uptake of life-saving services.

The goal of this objective is to develop the roles of key and vulnerable populations and communities, community organisation and networks, and public or private sector actors

that work in partnership with civil society at the community level, in the design, delivery, monitoring and evaluations of HIV, TB and STIs services and activities aimed at improving health outcomes.

⁷² Mine Health and Safety inspectorate Annual Report, 2018/19; Department of Mineral Resources, Republic of South Africa.

⁷³ Scheibe A et al. *Still left behind: Using programmatic data to assess harm reduction service coverage and HIV treatment cascades for people who inject drugs in five South African cities* 10th International AIDS Society Conference on HIV Science (IAS 2019), Mexico City, session, MOAC0103, 2019.

⁷⁴ The Aurum Institute, Anova Health Institute & UCSF (2019). The Second South African Health Monitoring Survey (SAHMS2), Results Summary Sheet: A Biological and Behavioural Survey Among Female Sex Workers, South Africa 2017–2018. Johannesburg; The Aurum Institute.

Key Achievements

TABLE 20: KEY ACHIEVEMENTS BY SUB-OBJECTIVE

KEY ACHIEVEMENTS BY SUB-OBJECTIVE	
Sub-objective 3.1.1	All national and provincial AIDS Councils will include at least one representative from a key and vulnerable population group
	<ul style="list-style-type: none"> At national, provincial and district levels, governance structures, with representatives from key populations' organizations/networks, have been activated. Civil Society coordination structures at national, provincial and district levels have been institutionalised, to monitor HIV policies, performance, quality of services, barriers to accessing services and inequalities related to key population services and programs (including human rights violations, gender inequalities, stigma and discrimination, and community monitoring of HIV and TB treatment stock-outs) All KPs programs, (as funded by government and donors) have the presence of peer educators, promoters, counsellors and supporters to facilitate engagements with KPs and build trust that encourages the uptake of HIV services and retention in care. All provinces have fast-tracked the implementation of the "Integrated Key Populations Sensitivity Training Programme for Healthcare Workers in South Africa".
Sub-objective 2.3.2	Support key and vulnerable populations social capital by encouraging community networks that include advocacy agendas for equal health and human rights
	<ul style="list-style-type: none"> A significant number of NDoH, PEPFAR and GF funded community-based organisations (CBOs) that are led or work closely with KPs Expansion of Sisonke National SW Movement base to four provinces, in pursuit of HIV and TB competent SW communities Support groups and safe spaces were established by all KP programs supporting MSM, TGW, AGYW and SW, to build collective action and empowerment for HIV prevention Treatment, adherence, and support groups for PLHIV established to improve psychological outcomes, social support / social integration and HIV-related stigma. Community dialogues were promoted and implemented within communities and with law enforcement agents, to promote inclusivity and to reduce stigma and discrimination against KPs
Sub-objective 3.1.3	All key and vulnerable population programmes should adopt a peer educator-led approach to implementation
	<ul style="list-style-type: none"> Peer-led interventions have become a standard approach in all KPs programs. Many NDoH, PEPFAR and GF funded peer educators have been recruited for KPs program Many DSD, PEPFAR and GF funded community care workers have been recruited to implement OVC programs

Other key achievements include:

- Development of the National Sex Worker Plan 2019 – 2022
- Review of the She conquers Campaign 2016 – 2019, with a view of developing a new AGYW campaign that is aligned to the current NSP
- First Transgender Integrated Biological and Behavioural Survey conducted in 2018.
- Under the leadership of SANAC, there is improved KP coordination and collaboration.
- Provincial Councils on AIDS (PCAs) are formally established and have contributed to the strengthening of the HIV response for KPs
- PrEP implementation for KPs has progressed through the provision of diverse models of delivery.
- Implementation of the "National Operational Guidelines for HIV, STI and TB Programmes for Key Populations in South Africa" has improved.
- South African PrEP demonstration projects have indicated that PrEP is feasible to implement in integrated

reproductive health service delivery models to reach AGYW.

- School-based sexual and reproductive health programmes are widely accepted as an approach to reducing high-risk sexual behaviour among adolescents
- In the North West province, in terms of access to treatment and care, all (100%) inmates who tested for HIV during the year (2017/2018), received their results and knew their status. This was due to due diligence in following the guidelines of the HIV Test and Treat guidelines. Additionally, 99% of the HIV positive inmates were receiving antiretroviral treatment.

Gaps and Challenges

- Progress towards 90-90-90 targets for KPs remains hindered by persistent barriers, such as stigma (including self-stigma), discrimination, and punitive legal and policy environments.
- Program implementation faces ever-present data challenges since
 - o KPs often do not self-disclose their current or former status as key population members.
 - o KP are included as members of the “general population” and their contribution to HIV transmission underreported and unrecognized.
 - o Scarcity of data on vulnerable populations, e.g. people with disabilities (PWD), OVC, etc.
 - o DoH DHIS and HTA program data not disaggregated by KP group.
- The limited population-based data that are available show that testing and treatment coverage among KPs remains disproportionately low with no key population group close to achieving 90-90-90 targets
- The suboptimal alignment of surveillance and programmatic data, as well as routinely collected medical records to facilitate the reporting of the 90-90-90 indicators for HIV among KPs, remains a challenge.
- Substance use is increasing among youth in South Africa, and most likely contributing to the transmission of HIV.
- Limited knowledge of available HIV services remains a critical gap that needs to be addressed, particularly in the most rural of provinces. For example, the Eastern Cape Provincial Risk Profiling Report revealed that there is no stakeholder knowledge of PrEP across four high burden areas, i.e. two in Buffalo City (Gompo C and Sweetwaters CHC’s), one in the Nyandeni LM (Makhotyane CHC) and one in the King Sabata Dalindyebo LM (Ngangelizwe CHC). In Buffalo City, participants reported that PrEP is sometimes cited at community events and had no further PrEP knowledge or insights.

Recommendations

- To improve access to KP HIV services, new approaches are urgently needed that involve KP leaders to serve as

a bridge between communities and traditional service delivery platforms

- For any KP HIV service delivery model to succeed, KP constituency engagement and support for model design, implementation, and monitoring is essential.
- Given the reported prevalence of alcohol and drug use among key populations and the negative impact of alcohol on sexual decision making and condom negotiation skills (WHO, 2011a), the addition of alcohol and substance abuse harm reduction outreach/programs would benefit key populations.

Objective 3.2: To provide an enabling environment to increase access to health services by key and vulnerable populations.

After decades of programming to improve HIV, TB and STIs for key and vulnerable populations, it has become increasingly clear that strengthening access to, and the quality of, services does not, alone, suffice to improve health outcomes. The HIV, TB and STIs health services for key and vulnerable populations is strongly influenced by a range of social, cultural, political, and economic factors and inequalities.

These factors increase key and vulnerable populations’ vulnerability to HIV risks and pose barriers to their access to HIV information and services. Addressing these underlying determinants by working with various individuals and organizations that have a relationship with key populations and an interest in what happens to them, is essential for KPs to realize their HIV and human rights.

To achieve this objective, the NSP has implemented the key elements for creating enabling environments for access to health services for key and vulnerable populations. The application of an ecological framework enhanced the organization of the key elements of enabling environments for HIV services.

Strategies implemented at the individual level, and seem promising are those that empower KPs, build their individual assets, and create safe spaces. Strategies implemented at the relationship level and seem promising include efforts to build appropriate social-emotional assets and communication as well as peer support networks. At the community level, strategies to engage and promote the development of informed, capable and coordinated communities, CBOs, groups, networks and structures to play a critical role in the key and vulnerable populations AIDS response have been implemented.

Overview and key policy issues

The current differentiated models of care for key and vulnerable populations will include providing fixed and mobile clinics and community peer-led outreach programs. Services

to prevent HIV transmission in high-risk populations include health information products, HIV testing and counselling, distribution of male and female condoms, and oral PrEP. HIV positive clients receive ART and adherence support. The clinics also provide primary health care, family planning, TB screening, and treatment for STIs. Clinics serving the key and vulnerable populations aim to provide hormones for gender transitioning.

The current HIV response KPs programs aim to reduce HIV incidence and mitigate the impact of HIV among KPs in South Africa by utilizing a client-centred differentiated service delivery model that provides a comprehensive package of services and interventions for KPs, ranging from hotspot-based coverage within geographic locations to virtual online to offline approaches. These programs aim to fill critical gaps, reduce bottlenecks, and eliminate barriers across HIV prevention, care, treatment, and support cascade. Supporting cascades entails the following: identifying, reaching with prevention services and commodities, linking to HIV and STI testing and counselling, wrapping-around services referrals, peer outreach and navigation activities for improved linkages, retention and adherence to ART to reach the 90-90-90 goals by 2030 among KPs.

The implementation approach has been to build the capacity of local community based KP organizations to deliver HIV services tailored to the needs of KPs. There is evidence of significant progress made to date; however, there is need to support approaches that are systematic, coordinated, data-

driven, and community-led that will significantly stem new infections, mitigate the impact of HIV and address structural barriers, including stigma and discrimination remains.

Key Achievements

1. Increased coverage for the provision of Comprehensive Sexuality Education (CSE) in schools through the curriculum and co-curriculum programs
2. Improved implementation of the She Conquers Campaign
3. Improved coordination of the AGYW activities through the National Technical Working Group for AGYW
4. Launch of the National Sanitary Dignity Implementation Framework by the Department of Women Sanitary Dignity Programme that aims to provide norms and standards concerning the provision of free sanitary products to indigent women and girls in quintiles 1-3 schools
5. Implementation of the HASH study: Bio-behavioural and structural factors driving HIV/AIDS, STIs and Hepatitis (HASH) risk in correctional facilities in South Africa, a collaboration between the Aurum Institute and the Department of Correctional Services, that aims to conduct a situational analysis of the individual, social and structural factors driving HIV/AIDS, STI & hepatitis B&C (HASH) risk in incarcerated inmates. The study is anticipated to take approximately 9 months in 2019.
6. Sex worker clinics have been established in provinces such as the Western Cape to provide confidential, friendly services to that population

TABLE 21: KEY ACHIEVEMENTS BY SUB-OBJECTIVE

KEY ACHIEVEMENTS BY SUB-OBJECTIVE	
Sub-objective 3.2.1	Enable increased access to health services through differentiated service delivery approaches that are tailored for the populations served
	<ul style="list-style-type: none"> • Global Fund used various differentiated service delivery approaches to reach over 99,563 MSM with HIV prevention programs – defined package of services for the period April 2017 to March 2019. During the same period, 56,879 MSM received an HIV test and know their results, and 1,373 tested HIV positive, i.e. 2.4% positivity rate. • For the period April 2018 to March 2019, 1,275 Transgender (TG) people received an HIV test and knew their results, and 65 tested HIV positive, i.e. 5% positivity rate. • By the end of the financial year 2017/18, the NDoH HTA programme achieved 77% of the number of HTA intervention sites annual target, and 100% of the number of peer educators receiving stipends. By the end of the financial year 2018/19, the NDoH HTA programme achieved 73% of the number of HTA intervention sites annual target, and 87% of the number of peer educators receiving stipends. • Differentiated service delivery approaches included mobile services to strategic locations, e.g. hotspots and dedicated service delivery at fixed sites in strategic locations. • Eighty-nine thousand learners in Grades 7 – 9 from 1,572 schools in FS, GP, KZN, MPU, and WC provinces were reached with Sexuality Education Scripted Lesson Plans (SLPs).

KEY ACHIEVEMENTS BY SUB-OBJECTIVE

Sub-objective 3.2.2	Enable increased access to tailored health information and social and behaviour change communication interventions
	<ul style="list-style-type: none"> • KP HIV services mapping has been conducted for each district outlining information on where to access what packages of services • Younger KPs primarily access sexual health information through social media, such as instant messenger apps (e.g., WhatsApp). Apps and web-based material (such as information, podcasts, and video content) • KP ambassadors and other peers play a large role in Social Behaviour Change Communication (SBCC) via in-person communication, social media, websites, and online posts. • Mass media campaigns, educating partners and parents, and school and community meetings have been useful at improving awareness and acceptance of KPs • KPs community dialogues such as the following. <ul style="list-style-type: none"> o The “WeTheBrave.co.za” MSM campaign addresses both HIV prevention and treatment issues in an affirming, non-judgemental and sex-positive way, which is entertaining and engaging. o Health4Women was a campaign dedicated to promoting access to relevant, competent, and unprejudiced health services to women who have sex with women (WSW). o Boatmate Project for MSM and TG. o The SWEAT project that provides safe space for sex workers’ dialogues. • Decriminalisation of key populations is the central aim of the KPs HIV effective human rights-based response. This has been called upon in the launch conducted during the MTR <i>“National Implementation Plan for a Comprehensive Response to Human Rights-related barriers to HIV and TB services and gender inequality in South Africa”</i> • All KP programs create demand and expand access to high-quality HIV services to KPs using peer education, community mobilization, Social and Behaviour Change Communication and Rights-Based Approaches • KP HIV services programs have set up many non-traditional condom outlets and have widely distributed lubricants as appropriate.
Sub-objective 3.2.3	Expand provision of rehabilitation, comprehensive psychosocial support and mental health services for people living with and affected by HIV and TB
	<ul style="list-style-type: none"> • Thousands of peer educators are supporting the implementation of the psychosocial service package. This includes supporting and counselling KPs experiencing stigma and discrimination, those experiencing violence and those using substances, as well as referring them to professional services where required • All KPs HIV program include collective identity mobilisation and community empowerment programs, to improve the well-being of the KPs participating in the programs • The provision of linkage to mental health services to improve coping skills, self-efficacy, and self-esteem.
Sub-objective 3.2.4	Further, train and sensitise health care professionals in the identification and delivery of appropriate services for key and vulnerable populations
	<ul style="list-style-type: none"> • MSM and SWs Peer Educators had improved skills and knowledge through their work, sharing from other peers, mentorship, and training, and some in pursuit of formal basic education • All KP programs implement Training and Leadership Development for Peer Educators and Peer Mentors activities, to equip peer educators and mentors with the right information and skills they need to aid them in their jobs. • The ‘Integrated Key Populations Sensitivity Training Programme for Healthcare Workers in South Africa’ has been implemented, aimed at improving access to appropriate and non-judgemental health services for ‘key populations’

KEY ACHIEVEMENTS BY SUB-OBJECTIVE	
Sub-objective 3.2.5	Integrate right-based components in all health and social programmes to holistically serve KP and VP clients and patients
	<ul style="list-style-type: none"> • Rights-based interventions have begun reducing the levels of stigma and discrimination against key populations • National discussions around law reform for; sex work by South African Law Reform Commission and drug use by Central Drug Authority, have presented opportunities to remove some of these barriers • Many police have been trained in the Diversity, Dignity and Policing program, which is a sensitisation training aiming to help police officers challenge stereotypes, biases, and misinformation they might have about KPs

Other key achievements include:

- Mapping of existing HIV and health services for KPs successfully conducted.
- Development of the “*National Implementation Plan for a Comprehensive Response to Human Rights-related barriers to HIV and TB services and Gender Inequality in South Africa*” - includes actively measuring and addressing stigma and discrimination to ensure access to HIV and other services for KPs.
- Capacity strengthening of KP-led organization programmes sustained.
- In KZN, a newsletter called ‘*Izwi Lethu*’ was launched to capture personal insights and lived experiences of sex workers. This was coupled with activities to sensitize communities regarding realities of sex work and promoting the decriminalisation sex work
- Furthermore, the LGBTIQ sectors were formed at every level of the AIDS Council including the formation of the KZN Task Team on hate crimes working in collaboration with the Department of Justice and Constitutional Development (DOJ/CD)

Gaps and Challenges

- Police’s negative attitudes and practices are key barriers to scaling up HIV prevention and treatment efforts, leading to inducing fear of accessing harm reduction and health services among KPs.
- Funding for human rights and legal reform programmes is limited, despite several international commitments that put human rights at the heart of an effective KPs HIV response.
- KP HIV differentiated models of care are highly dependent on external donor declining resources and engagement, which is a threat to sustainability.
- Dearth of mass dissemination campaigns focused on sexual orientation and gender identity.

- There is insufficient and slow progress in reducing new HIV infections among young people.

Recommendations

- Review and implement the recommendations of the South African Law Reform Commission report to move forward the conversation of law reform on sex work.
- Support the scaling up of programs to reduce human rights-related barriers to HIV and TB services.
- Support the development of an HIV plan for PWID. The National Drug Master Plan 2013-2017 acknowledges the link between drug and alcohol use and HIV. However, it does not mention the human rights of drug users or address issues of stigma and discrimination.
- Support the development of a National HIV Plan for Correctional Services to address HIV and AIDS in prisons.
- Strengthen the capacity of community health workers to implement community-level interventions and ensure appropriate linkages between communities and formal health systems.
- While PrEP demonstration projects indicate that women with behavioural risks and high rates of sexually transmitted diseases are initiating PrEP; effective strategies to support AGYW’s adherence and persistence with PrEP are needed.
- The lack of decline in gonorrhoea and chlamydia prevalence, highlights the need to enhance STI services beyond clinic-based syndromic case management. This will involve reinvigorating primary STI and HIV prevention and, especially for women, to screen for asymptomatic infections.
- Increase coverage on the provision of CSE in schools.

4



"My goal as a young woman is to encourage positive change within my society through specific programmes which are interlinked with the NSP in decreasing the number of new HIV infections among adolescent girls and young women across South Africa."

– Koketso Rathumbu, She Conquers

GOAL 4



**Address the Social and Structural Drivers of HIV,
TB and STIs and Link These Efforts to the National
Development Plan (NDP)**

GOAL 4: ADDRESS THE SOCIAL AND STRUCTURAL DRIVERS OF HIV, TB AND STIS, AND LINK THESE EFFORTS TO THE NATIONAL DEVELOPMENT PLAN (NDP)

Goal 4 of the NSP provides the strategic direction to attain a balanced response to the HIV, TB and STI epidemics by addressing social and structural drivers over and above the provision of biomedical services. The successes of the biomedical interventions are far outweighed by the social and structural drivers of the epidemic such as poverty, inequality, inequities, gender-based violence (GBV) and many other social issues that confront people living in South Africa.

The proposed “multi-department, multi-sectoral approach” seeks to reduce vulnerability, enhancing sustainability and linking the response to HIV, TB and STIs to the broader development agenda. This will be achieved through:

- Expansion of SBCC campaigns and programmes that build the resilience of individuals, parents, and families.
- Reduce poverty and vulnerability through scaled-up social protection.
- Scale-up access to food and security.
- Expand a comprehensive package of interventions through the “She Conquers campaign”
- Change gender norms and prevent and address gender-based violence.
- Better define and scale-up harm reduction services.
- Implement environmental interventions for TB control.

The recently published South Africa National HIV Prevalence, Incidence, Behaviour and Communication Survey (2017) notes

the changes in behavioural determinants of HIV as highlighted in the NSP 2017 - 2022. The results from the survey specific to the behavioural determinants of HIV highlight the following:

- Sexual Debut - General increase in the proportion of people aged under 15 years who had an early sexual debut from 8,5% in 2008 to 13,6% in 2017 with early sexual debut more pronounced in males than their sexual counterparts.
- Age-Disparate sexual relationships – there is a marked upward trend in females who have age-disparate sexual relationships in the aged group 15 – 19 years from 18,5% in 2005 to 35,8% in 2017. This means many girls have sexual relationships with partners five years older, thereby confirming the “bless and blesser” phenomenon.
- Multiple Sexual Partners (MSP) – the sexually active people aged 15 years and older who have had more than one partner in the last 12 months, is higher in males as compared to women, and this is also attributed to males being more likely to report MSP. However, there is a general decrease in self-reported MSP in males and a general increase in MSP among females aged 15 – 49 years.
- Condom use – reported condom use at last sexual encounter was generally higher among males than females across all age groups with a peak in 2008 and a relative increase in 2017 which can be attributed to improved social behaviour change strategies.
- iv. Social and behavioural change communication (SBCC) programmes on HIV – there is an increase in the access to various types of media (83, 9% watched television, 66,6% listened to the radio and 59,7% accessed social media at least once per week). Consequently, there has been an increase in SBCC exposure with 16, 8% reporting high exposure to SBCC programmes and 46, 6% reporting low to medium exposure, respectively.

Goal 4 Indicators and Results

TABLE 22: GOAL 4 INDICATORS – TARGETS VS ACTUAL

INDICATOR	BASELINE (2016/2017)	TARGET (2018/19)	ACTUAL (2018/19)
1. Percentage of beneficiaries receiving Social Behaviour change programmes	To be established in 2017 HSRC Survey	TBD	16,8% - High Exposure 46,6% - Low to Moderate Exposure
2. Number of children accessing services through drop-in centres	152 531 (DSD NFD report 2015/16)	188 309	227 970
3. Number of beneficiaries receiving DSD Social Behaviour Change programmes	47 135	600 000	546 631

INDICATOR	BASELINE (2016/2017)	TARGET (2018/19)	ACTUAL (2018/19)
4. Proportion of ever married or partnered girls or young women aged 15-24 who experienced physical or sexual violence from a male intimate partner in the past twelve months	Ages 15-19: 7.7% Ages 20-24: 7.3% (HSRC 2012)	7.3% 6.9%	HSRC Study
5. Number of beneficiaries receiving social grants	17 453 848	17 523 737	17 733 651
6. Number of people accessing food through community nutrition and development centres (CNDC)	142 266	177 825	375 060
7. Number of people reached through substance abuse prevention programmes	1 565 541	2 795 608	1 036 042 (DSD) DHET/HEADS
8. Percentage of learners from ordinary public schools that attend no-fee schools	78%	80% (2017/18)	79% ⁷⁵
9. Percentage of TB affected families facing catastrophic costs due to TB	To be determined in 2017/18	TBD	No data as the program is yet to be implemented in SA NDOH
10. Proportion of health facilities accessible to people with physical disabilities	1 313 (37% percent) of 3 583 PHC facilities have access for people with disabilities (DPME June 2016)	80% of all health facilities meet the 5 compulsory criteria of accessibility by 2019 (NDOH APP 2016/17)	Data on this indicator emanates from the Operation Phakisa and ideal clinic realization maintenance initiative. One of the criteria for an ideal clinic is good infrastructure with access for people in wheelchairs. At the end of 2017/18 1507 (42.1%) Primary Health facilities qualified as ideal clinics.

⁷⁵Department of Basic Education, Annual Report 2017/2018.

⁷⁶Department of Health Annual Performance Plan 2019/20-2021/22

Progress Against Objectives

Objective 4.1: Implement social and behaviour change programmes to address key drivers of the epidemic and build social cohesion.

Overview and key policy issues

Objective 4.1 outlines social behaviour change (SBC) programmes that aim to change the attitudes, perceptions and beliefs of individuals, communities and families to reduce new HIV and TB infections and improve access to treatment, care and support for those living with HIV and or TB. Sexual contact is the main mode of HIV transmission in South Africa⁷⁷. Socio-economic and structural factors predispose key and vulnerable populations to engage in unsafe sexual practices which increase the risk of HIV infection.

These structural factors include concurrent and multiple sexual partnerships⁷⁸, early sexual debut among young people⁷⁹, inadequate access to quality education, age-disparate intergenerational sexual partnership between older men and young women⁸⁰, poverty, gender-based violence, alcohol and drug abuse and inequality. Additionally, some of these factors hinder health-seeking behaviours and treatment adherence.

Young people (15-24) with a very special focus on adolescent girls and young women (AGYW) and their sexual partners who are aged between 23 and 35 years, sex workers, men who have sex with men (MSM) have been identified as some of the key

populations to be targeted by the social behaviour change programmes.

The socio-ecological model is being used to understand the complex socio-economic factors influencing risky behaviour at the individual, interpersonal (social networks), community and societal level^{81,82}. The model also guides the implementation of SBC interventions implemented by the Department of Social Development and other key implementers.

SBC programmes being implemented focus on, among others, mobilization and capacity building of individuals, families and communities; advocacy; early childhood development; parental/caregiver support; prevention of violence and abuse; sustaining health-promoting behaviour; and facilitating the deconstruction of gender norms and roles which perpetuate violence against especially females.

Another lead agency is the Department of Education implementing life-skills based HIV education through programmes such as the Keeping Girls in School Programme, Soul Buddyz Club and Teen Parenting among others, in collaboration with civil society organizations.

The 'She Conquers' Campaign implemented from 2016 until 2019, was a three-year national campaign that integrated interventions to address socio-structural drivers among AGYW and their male sexual partners with biomedical interventions implemented by the key government departments and civil society organizations.

Key Achievements

TABLE 23: KEY ACHIEVEMENTS BY SUB-OBJECTIVE

KEY ACHIEVEMENTS BY SUB-OBJECTIVE	
Sub-objective 4.1.1	Reduce risky behaviour through the implementation of programmes that build the resilience of individuals, parents and families
	<ul style="list-style-type: none"> Increase in SBCC exposure and reach coupled with positive behavioural outcomes – people who had high exposure to SBCC (78, 7%) reported that they had taken an HIV test (SABSSM; 2019). Key government departments and civil society organizations agreed to align AGYW interventions under the 'She Conquers' National Campaign⁸³. The campaign integrated pre-existing programmes such as Keeping Girls in School, DREAMS, B-Wise, YOLO and ZAZI, among others. Over 560 000 adolescent girls received life skills and sexual education by 31 December 2017 through the 'She Conquers' National Campaign⁸⁴

⁷⁷Johnson L. THEMBSA version 4.2: A model for evaluating the impact of HIV/AIDS in South Africa. Centre for Infectious Disease Epidemiology and Research, University of Cape Town; 2018. Available: https://thembsa.org/content/downloadPage/Thembsa4_2. Accessed 10 October 2019.

⁷⁸Halperin, D & Epstein H. 2007. Why is HIV prevalence so severe in southern Africa? The role of multiple concurrent partnerships and lack of male circumcision: Implications for AIDS prevention. *S Afr J HIV Med* ;8(1):19–25.

⁷⁹Zuma, K., Setswe, G., Ketye, T., Mzolo, T., Reale, T & Mbelle, N. 2010. Age at sexual debut: a determinant of multiple partnership among South African youth. *African Journal of Reproductive Health*.

⁸⁰Leclerc-Mdlala, S. 2008. Age-disparate and intergenerational sex in southern Africa: the dynamics of hyper vulnerability. *AIDS*.

⁸¹Edberg, M., Shaikh, H., Rimal, R. N., Rassool, R., & Mthembu, M. 2017. Development of a communication strategy to reduce violence against children in South Africa: A social-ecological approach. *The African Journal of Information and Communication*, 20, 49-76. <https://doi.org/10.23962/10539/23576>.

⁸²Max, J. L., Sedivy, V., & Garrido, M. 2015. Increasing our impact by using a social-ecological approach. Washington, DC: Administration on Children, Youth and Families, Family and Youth Services Bureau.

KEY ACHIEVEMENTS BY SUB-OBJECTIVE

	<ul style="list-style-type: none"> Scaling up of You Only Live Once (YOLO), Families Matters Programme, Community Capacity Enhancement (CCE), Men Championing Change (MCC) and Ke Moja as key SBC interventions under the DSD. Sixty-eight thousand two hundred two young people reached through the YOLO programme in 2017/2018
Sub-objective 3.2.1	Comprehensive age age-specific and appropriate support for learners and out-of-school youth
	<ul style="list-style-type: none"> The DBE launched the National Policy on HIV, STIs and TB in 2018⁸⁵. The development of Scripted Lesson Plans (SLPs) for Intermediate Phase (IP) and Further Education and Training (FET) to strengthen comprehensive sexuality education. A total of 216 623 learner workbooks and 3 585 teacher guides were printed and distributed to 1 186 schools in the eight (8) activity districts in Gauteng, Mpumalanga, the Free State, the Western Cape, and KwaZulu-Natal for Grades 7 - 9 in 2017/2018. 54 draft SLPs for Grades 4 - 6 and 10 - 12 were reviewed by the DBE Curriculum Working Group to assess the alignment to the International Technical Guidance on Sexuality Education, Life Orientation textbooks writing process and LO CAPS⁸⁶. About 19 738 educators from HIV and TB high burden districts received training on the implementation of sexual reproductive health (SRH) and TB programmes during 2017/2018⁸⁷. The hosting of advocacy and social mobilization events with learners, educators and school community members to review and change societal norms and values on SRH and TB also occurred. Activities included a focus on key risk behaviours such as alcohol and drug use, learner pregnancy, inter-generational and transactional sex amongst girls⁸⁸.
Sub-objective 4.1.3	Strengthen the capacity of families and communities
	<ul style="list-style-type: none"> About 746 individuals from NPOs went through capacity building for the Community Capacity Enhancement and Families Matters Programme⁸⁹. About 3 938 parents/caregivers reached through the Families Matter Programme in 2017/2018 and trained 746 implementers in all province⁹⁰.

Gaps and Challenges

- There was limited consistency in attending DSD behaviour change sessions, especially by parents/caregivers and males. Parents and or caregivers and males are difficult to recruit, or they do not attend the minimum number of contact sessions required because of work commitments during the week.
- There are limited M&E plans, which clearly outlines outcomes, indicators, targets, data collection and analysis at key departmental levels and especially NPOs. There is very limited capacity to conduct evaluations
- for programme improvement and evidence during the implementation of the SBC programmes.
- Recruitment of ineligible young people for the SBC programmes. These are either young people who are not in the risky category or beyond the age limit or of consistently the same age group or those who are easily available for the facilitators.
- 'She Conquers' Campaign - there was inadequate funding for the coordination, monitoring and communication components of the She Conquers campaign at both the national and sub-national level, and therefore the success of the campaign was not fully realised.

⁸³Subedar, H., Chaka, T., Dladla, S., Hagerman, E., Jenkins, S., Matchimane, G., Mangold, K., Msimanga, B., Pooe, R., Schultz, L. & Pillay, P. 2018. Tackling HIV by empowering adolescent girls and young women: a multisectoral government led campaign in South Africa. *BMJ*. 363.

⁸⁴ibid

⁸⁵Department of Basic Education. Annual Report 2017/2018.

⁸⁶ibid

⁸⁷ibid

⁸⁸ibid

⁸⁹South African National AIDS Council. National Strategic Plan on HIV, TB and STIs Annual Progress Report. 2017/2018.

⁹⁰ibid

⁹¹Subedar, H., Chaka, T., Dladla, S., Hagerman, E., Jenkins, S., Matchimane, G., Mangold, K., Msimanga, B., Pooe, R., Schultz, L. & Pillay, P. 2018. Tackling HIV by empowering adolescent girls and young women: a multisectoral government led campaign in South Africa. *BMJ*. 363.

- The priority given to “She Conquers” national campaign differed at provincial and district level . Though the campaign had high level buy-in from political leadership and government departments, it was less consistent at provincial and district level. Additionally, commitment to push the ‘She Conquers’ agenda differed according to the commitment of local staff tasked.
- Though the ‘She Conquers’ National Campaign’ target population was AGYW aged 15-24 years, the design of the campaign also acknowledged the need to reach boys, older men and women. Critiques criticized the campaign for its excessive focus on the AGYW and leaving out the other target populations.

Recommendations

- Formulate innovative ways to improve participation in SBC programmes by caregivers or parents, e.g. conducting SBC sessions over the weekend.
- Development of M&E plans and building capacity among NPOs on M&E to report optimally.
- Migrate paper-based data collection systems to mobile data collection to ease the burden of paperwork.
- NPOs should use the focus for impact approach to ensure that they reach the appropriate KPs to ensure impact.
- There is a need to appoint champions at provincial and district level to promote continued stakeholder buy-in and promote collaboration in implementing the ‘She Conquers’ campaign agenda. Strengthening of coordination using champions would also result in stronger resource mobilization to fund and sustain the campaign.
- DSD should massively scale up their compendium of SBC programmes. The current reach is not adequate compared to the population in need of these interventions.

Objective 4.2: Increase access to and provision of services for all survivors of sexual and gender-based violence in the 27 priority districts

Overview and key policy issues

Gender-based violence (GBV) is a complex, multifaceted and multi-layered phenomenon which manifests itself in many forms including physical, sexual and psychosocial abuse. GBV, especially sexual violence, makes it harder for women and girls to prevent HIV or access care, support, and treatment services.

It is rooted in the gendered power inequalities and South Africa, women and girls disproportionately bear the largest burden and effects of gender-based violence since these

gendered power inequities are usually in favour of males .

GBV is a result of the complex interaction between individual, interpersonal (social networks), community, social, cultural and environmental factors. Policies are in place to ensure sustained impact for interventions targeting each of these levels.

Africa has comprehensive policies, laws and national strategies, which strive for gender equality and curb gender-based violence whilst promoting sexual and reproductive health rights.

The two most prominent laws relating to violence against women and young girls are the Domestic Violence Act No 116 of 1998 (DVA) and the Criminal Law (Sexual Offences and Related Matters Act No 32 of 2007 (SOA).

This objective seeks to increase access and provision of services for all survivors of sexual and gender-based violence. The key leading departments include the DSD with its Victim Empowerment Programme and Draft White Paper on Families in South Africa, the DOH, the Department of Justice and Constitutional Development, the South African Police Services (SAPS), National Prosecuting Agency (NPA) and the Ministry for Women, Youth and Persons with Disabilities. Civil society organizations support government departments in implementing the GBV response.

²²ibid

²³<https://www.soulcity.org.za/campaigns/gbv/resources/understanding-gender-policy-and-gender-based-violence-in-south-africa-a-literature-review>

Key Achievements

TABLE 24: KEY ACHIEVEMENTS BY SUB-OBJECTIVE

KEY ACHIEVEMENTS BY SUB-OBJECTIVE	
Sub-objective 4.2.1	Increase access to the provision of services for all survivors of sexual and gender-based violence
	<ul style="list-style-type: none"> • Fifty-five Thuthuzela Care Centres were operational by the end of the 2018/2019 financial year in the country. • Two hundred seventy-nine public healthcare facilities provided comprehensive services including Clinical Forensic Medicine in 2017/2018 and plan to extend services to community health centres during 2018/2019⁹⁴. • 75 Regional Courts were upgraded to sexual offences court to ensure improvement in the prosecution and adjudication of sexual offences and to prevent the secondary victimization experienced by survivors when they engage with the criminal justice system⁹⁵. • Conviction rate on sexual and gender-based violence reportedly increased to 74% by the end of 2017/2018⁹⁶. • Successful implementation of Public Awareness Campaigns according to the 365 National Action Plan of no violence against women and children. The campaigns included 'radio interviews/discussions, focusing inter alia on the following topics: <ul style="list-style-type: none"> • The essence of gender-based violence, TCC-services, the influence of drugs and alcohol at schools, child pornography, reporting of GBV-matters, LGBTI-cases, sexual violence/abuse at schools and tertiary institutions, importance of forensic medical examinations and post-trauma consequences of GBV, ukuthwala-practices, the existence of sexual harassment and what it entails, human trafficking specifically for sexual exploitation, etc.'⁹⁷. • The NPA collaborated with other stakeholders and held 48 training sessions attended by 1060 delegates on Domestic Violence, Sexual Offences and on TCC services at the sites among others⁹⁸.
Sub-objective 4.2.2	Provide support for survivors of sexual assault
	<ul style="list-style-type: none"> • Psychosocial support provided through the Thuthuzela Care centresCentres. • Social services provided through the Victim Empowerment Programme by the Department of Social Development. • More than 90 000 AGYW had received post violence care by 31 December 2017⁹⁹ under the 'She Conquers' National Campaign • The Western Cape province reported that SWEAT operates a 24-hour national helpline to assist sex workers and increase access to services for survivors of sexual assault and gender-based violence (GBV)

Gaps and Challenges

- A culture of silence overshadows GBV, including sexual violence, which has continually resulted in underreporting of sexual offences and domestic violence. This makes it very difficult to estimate the extent and prevalence of the offences. The culture of silence also hinders access to appropriate care, treatment and support for the survivors. Additionally, the NPA reported that about 35% of sexual offences were withdrawn before prosecution.
- There is limited evidence and evaluations to demonstrate

the impact of GBV work.

- Reports indicate that the public lacks comprehensive awareness of the relevant laws and policies, which negatively affect the public's ability to exercise their rights for their protection and access to appropriate services.
- Identification of systematic weaknesses in the implementation, and provision of services under the Domestic Violence Act (DVA) by the South African Police Services by civil society as a major challenge. This includes poor compliance to the DVA, which results in the provision of limited and inadequate services for survivors of GBV

⁹⁴National Department of Health. Annual Report 2017/2018.

⁹⁵Department of Justice and Constitutional Development. Annual Report 2017/2018.

⁹⁶National Prosecuting Authority. Annual Report 2017/2018.

⁹⁷ibid

⁹⁸ibid

⁹⁹Subedar, H., Chaka, T., Dladla, S., Hagerman, E., Jenkins, S., Matchimane, G., Mangold, K., Msimanga, B., Poore, R., Schultz, L. & Pillay, P. 2018. Tackling HIV by empowering adolescent girls and young women: a multisectoral government led campaign in South Africa. *BMJ*. 363.

at some police stations, which in some cases results in secondary victimization. Lack of trained staff and poor data management and monitoring of GBV cases are some of the challenges experienced.

- The Eastern Cape province reported that there were no official indicators in the NSP against which to report GBV statistics

Recommendations

- Strengthen interventions that target knowledge, beliefs and attitudes of community members to eliminate the culture of silence around GBV and minimize attitudes and beliefs that promote the perpetuation of GBV.
- Strengthen monitoring and evaluation initiatives in all key stakeholders responding to GBV. Also, there is a need to develop an integrated information system between key stakeholders such as the DOH, SAPS and the courts to ensure appropriate provision of services and also to measure the effectiveness of services provided. This will also promote transparency and accountability.
- Systematic and rigorous training for law enforcement agents who specialize in gender-based violence. The capacity building initiatives should target change in cultural beliefs of officers who sometimes get influence from the culture of silence which characterize the society they are also coming from. Existing policies, guidelines and laws need to be revised thereafter the enforcement of a system to ensure compliance to these policies, guidelines and laws like DVA.
- There should be alignment between the NSP, the emergency plan and National Strategic Plan for GBV once they are approved.
- Promote the integration of GBV programs including the linkages between the TCCs and the Victim Empowerment Program.
- Provide for indicators and targets against which provinces can report on sexual assault and GBV in the NSP M&E framework.

Objective 4.3: Scale-up access to social protection for people at risk of and those living with HIV and TB in priority districts.

Overview and key policy issues

The country faces the triple challenge of poverty, unemployment and inequality. According to the Living Conditions Survey (LCS), more than one out of every five adults (25.2%) were living below the food poverty line in 2015, while a third (33.8%) were living below the lower-bound poverty line and approximately half (40%) were living below the upper-bound poverty line in South Africa¹⁰⁰.

It also reports that females are more likely to be living in poverty when compared to males. This is due to gender inequalities, higher unemployment rate and lower literacy and education rates among the females. This has resulted in females, especially young and adolescent girls engaging in risky sexual behaviour for economic benefits.

According to the Child Gauge Report (2015), over half (54%) of children (under 17 years of age) lived below the poverty line with 31% living in a household with an unemployed adult. This compromises the educational, nutritional and access to health care services of children. Hence, the NSP advocates for the strengthening of various social protection programmes that aim at alleviating poverty and inequality within the key and vulnerable populations living with HIV and TB.

Social grants disbursed through the South African Social Security Agency (SASSA), and aimed at preventing poverty, serve as one of the largest social protection programmes in South Africa. The DSD provides social grants to people living with disabilities, poor children and foster children. It is noted that about 17 million beneficiaries received social grants as part of the social protection programme rolled in the country.

About 282 134 individuals also received poverty reduction initiatives through the community nutrition and development centres run by the Department of Social Development (South Africa Social Service Annual Report; 2018).

¹⁰⁰ Statistics South Africa 2019, Sustainable Development Goals: Country Report 2019

Key Achievements

TABLE 25: KEY ACHIEVEMENTS BY SUB-OBJECTIVE

KEY ACHIEVEMENTS BY SUB-OBJECTIVE	
Sub-objective 4.3.1	Ensure that all HIV- and TB-infected persons who are eligible have access to social grants
	<ul style="list-style-type: none"> DSD provided child support grants to 34.3% of households with children¹⁰¹. Improving collaboration between key government departments is enabling easier enrolment and verification of eligible persons to access social grants. 17,666,235 Seventeen million six hundred sixty-six thousand two hundred thirty-five beneficiaries reported to have having received social grants at the end of September 2018¹⁰².
Sub-objective 4.3.2	Scale Scale-up access to food security and nutritional support
	<ul style="list-style-type: none"> Nine provincial food distribution centres (PFDCs) by the Department of Social Development guided by the National Food and Nutrition Plan¹⁰³. Two hundred eighty-two thousand one hundred thirty-four poor and vulnerable people received food through the community nutrition distribution centres (CNDCs)¹⁰⁴. 221 CNDCs enabled implementation of 4 130 development activities encompassing skills training programmes facilitating support to 191 cooperatives and 100 Small and Medium and Micro-Sized Enterprises (SMMEs) through food purchases to the value of approximately R16 million .

Gaps and Challenges

- Prevalence of fraud through ghost beneficiaries.
- Reports indicate that rural beneficiaries spend a significant amount of social grant on travel and fees in areas where pay points are not easily accessible. Additionally, beneficiaries were reportedly spending time in long queues collecting the grants.
- Recipients misuse social grants including alcohol and drug abuse

Recommendations

- Fast track procurement of biometric enrolment systems to minimize ghost beneficiaries.
- Education of social grant beneficiaries on money management.

Objective 4.4: Implement and scale up a package of harm reduction interventions for alcohol and substance use in all districts

Overview and key policy issues

Alcohol and substance abuse are one of the key drivers of HIV, TB and STIs. Impaired judgement can lead to risky

sexual behaviour and or sharing of contaminated injections, increasing the risk of HIV infection and transmission. The South Africa Demographic Survey, 2016, clearly identifies alcohol and substance abuse as risk factors influencing GBV against women.

According to the South Africa Demographic Survey, 2016, alcohol use is high among South African men with 28% reporting risky drinking involving drinking five or more standard measures of alcohol on a single occasion within the last 30 days, compared to 5% of women reporting the same.

There is a growing trend in other substance abuse though data is not yet available on the extent of the challenge. However, reports indicate that there are high levels of inhalant use, nyaope, cannabis (dagga), methamphetamine (tik), methaqualone (mandrax/Quaalude) and over the counter and prescription medicines.

The Department of Social Development is the lead government department responsible for the National Drug Master Plan, which is the national blueprint in the implementation of a comprehensive approach to the rehabilitation and harm reduction.

The SBCC campaigns support the efforts that include

¹⁰¹South African Social Services. Annual Report. 2017/2018.

¹⁰² ibid

¹⁰³South African National AIDS Council. National Strategic Plan on HIV, TB and STIs Annual Progress Report. 2017/2018.

¹⁰⁴Ibid

¹⁰⁵ibid

information about the harmful effects of alcohol and drug use. Anticipated deliverables include the targeted provision of condoms and other biomedical prevention commodities and, as appropriate, testing, screening, vaccination and

treatment for HIV, TB, STIs and hepatitis B and C. Linkage to services will include adherence and psychosocial support and rehabilitation services.

Key Achievements

TABLE 26: KEY ACHIEVEMENTS BY SUB-OBJECTIVE

KEY ACHIEVEMENTS BY SUB-OBJECTIVE	
Sub-objective 4.4.1	Scale-up access and provision of in- and out-patient rehabilitation services for all who use alcohol and drugs
	<ul style="list-style-type: none"> NPOs trained on implementation of Ke Moja Programme. Three national anti-substance abuse awareness campaigns conducted in 2018/2019¹⁰⁶. Campaigns conducted at institutions of higher learning including TVET colleges and high schools. Multiple donor-driven rehabilitation programs being implemented in different communities.

Gaps and Challenges

- Patient management and tracking are problematic.
- Limited human resources and skills to implement a substance abuse programme.
- Limited or no treatment services in some provinces. Reports indicate that Northern Cape province does not have services, whilst the North West, Limpopo and Mpumalanga only have one residential treatment centre¹⁰⁷.
- Policy confusion around harm reduction, with law enforcement criminalizing users and addicts and thereby working against the public health approach of restorative justice¹⁰⁸.
- Limited coordination between key departments such as Social Development, Education, SAPS and Health.

Recommendations

- There is an urgent need for capacity building for the available human resource as well as increase the number of specialists and centres for treatment care and support.
- Social Development, Education, SAPS, Health and other key stakeholders need to develop multi sectoral guidelines that promote integrated services for prevention, diagnosis, referrals, treatment, care and support.
- There is a need to review and harmonize substance abuse-related legislation to close the legislative and policy gaps

and inconsistencies, which cause confusion between patients and law enforcement agents.

Objective 4.5: Implement economic strengthening programmes with a focus on youth in priority focus districts

Overview and key policy issues

Economic status is one of the key structural drivers of HIV, TB and STIs¹⁰⁹. Literature reveals that poverty, unemployment, low educational and economic status negatively influence risky behaviour, which increases the chance of HIV infection.

For example, studies have shown that poverty and unemployment can negatively affect HIV risk by reducing negotiating power within sexual relationships¹¹⁰, increase reliance on transitional sex and sex work¹¹¹ and limiting access to HIV prevention knowledge and services¹¹². There are possibilities of hindrances in accessing HIV testing services, routine treatment care, support and nutrition when one is poor among those who are living with HIV¹¹³.

Economic strengthening programmes form part of the comprehensive package of services offered to key and vulnerable populations. Key campaigns such as the "She Conquers" and Determined, Resilient, Empowered, AIDS-free, Mentored and Safe (DREAMS) offer economic strengthening

¹⁰⁶ Department of Planning, Monitoring and Evaluation, 2017. Implementation Evaluation of the National Drug Master Plan

¹⁰⁷ <http://www.hsrc.ac.za/en/review/hsrc-review-april-to-june-2015/substance-abuse-critical-need-for-usable-researchRecommendations>.

¹⁰⁸ Department of Planning, Monitoring and Evaluation, 2017. Implementation Evaluation of the National Drug Master Plan.

¹⁰⁹ Gupta, G. R., Parkhurst, J. O., Ogden, J. A., Aggleton, P., & Mahal, A. 2008. Structural approaches to HIV prevention. *The Lancet*, 372(9640), 764–775.

¹¹⁰ Eaton, L., Flisher, A. J., & Aarø, L. E. 2003. *Unsafe sexual behaviour in South African youth. Social Science and Medicine*, 56(1), 149–165. doi: 10.1016/S0277-9536(02)00017-5

¹¹¹ Seeley, J., Watts, C. H., Kippax, S., Russell, S., Heise, L., & Whiteside, A. 2012. *Addressing the structural drivers of HIV: A luxury or necessity for programmes? Journal of the International AIDS Society*, 15(Suppl. 1), 1–4.

¹¹² Hargreaves, J. R., Bonell, C. P., Boler, T., Boccia, D., Birdthistle, I., Fletcher, A., ... Glynn, J. R. 2008. Systematic review exploring time trends in the association between educational attainment and risk of HIV infection in sub-Saharan Africa. *AIDS*, 22(3), 403–414.

¹¹³ Weiser, S. D., Wolfe, W., Bangsberg, D. R., Thior, I., Gilbert, P., Makhema, J., ... Essex, M. 2003. Barriers to antiretroviral adherence for patients living with HIV infection and AIDS in Botswana. *Journal of Acquired Immune Deficiency Syndromes*, 34(3), 281–288.

programmes to adolescent girls and young women.

Social grants and other forms of social assistance, bursaries and funding to increase access to post-school education, and increase post-schooling options including employment, mentorship and internships for youth are some of the economic strengthening activities conducted.

The national government also roles out the Expanded Public Works Programme (EPWP) which supports government policy priorities of decent work and sustainable livelihoods, education, health, rural development, food security and land reform (EPWP, 2017).

The programme seeks to provide poverty and income relief through temporary work for the unemployed to carry out socially useful activities. The programme also offers training and enterprise development support to those it employs.

According to the National Department of Education, more than 79% of schools benefited from 'No Fees Programme' which is a marginal increase from the 2016/2017 baseline value of 78%. This is reported to help about 7, 9 million learners. The 'No Fees Programme' seeks to eliminate barriers to schooling, which is mostly experienced by poor households¹¹⁴.

Key Achievements

TABLE 27: KEY ACHIEVEMENTS BY SUB-OBJECTIVE

KEY ACHIEVEMENTS BY SUB-OBJECTIVE	
Sub-objective 4.5.1	Economically empower targeted groups of young people by increasing the availability of economic opportunities
	<ul style="list-style-type: none"> • More than 19 000 adolescent girls and young women reportedly attended economic strengthening programmes from 1 July 2016-31 December 2017 through the She Conquers Campaign. • Financial capabilities training, employability and entrepreneurship training, and support to students in grades 11 & 12 to pursue tertiary education by several funded NGOs. • Combination of social protection, access to free education, adequate supervision from parents and guardians, and adolescent-sensitive clinic care. • Social assistance through grants has successfully reduced extreme poverty according to Statistics South Africa.

Gaps and Challenges

- Limited evidence and evaluation available to show progress and impact of economic strengthening programmes targeting young people.

Recommendations

- There is a need to promote documentation and evaluations of economic opportunities for young people.
- Working closely with organizations such as the National Youth Development Agency (NYDA), promote and strengthen well-designed vocational/entrepreneurial training and savings interventions could bolster HIV prevention efforts for female sex workers.

Objective 4.6: Address the physical building structural impediments for optimal prevention and treatment of HIV, TB and STIs

Overview and key policy issues

Overcrowding, indoor air pollution, poor ventilation and poor infection control in health facilities contribute to TB transmission. Households where someone has infectious TB, health and correctional facilities, mines (especially with silica exposure), public transport and congregate settings such as schools, are potential TB transmission 'hotspots'.

Smoking, including secondary exposure to tobacco smoke, also increases the risk of TB infection, disease and recurrence. Several studies point to poor TB infection control practices at the PHC level. Additionally, poor facility infrastructure, coupled with poor maintenance, as well as a lack of material and human resources, negatively affect TB control efforts.

¹¹⁴ Department of Basic Education, Annual Report 2017/2018.

Key Achievements

TABLE 28: KEY ACHIEVEMENTS BY SUB-OBJECTIVE

KEY ACHIEVEMENTS BY SUB-OBJECTIVE	
Sub-objective 4.6.1	Improve ventilation and indoor air quality in congregate settings
	<ul style="list-style-type: none"> The proportion of public health care clinics considered as having ideal status improved from 9% in 2015/2016 to 43,5% in 2017/2018 (District Health Barometer 2017/2018). The development of a Blueprint for newly built PHC facilities to ensure minimal or no congestion at PHC facilities.
Sub-objective 4.6.2	Develop advocacy campaigns for health promotion specific to TB control
	<ul style="list-style-type: none"> Yearly World TB Day campaigns form part of yearly annual advocacy campaigns. On-going integration of TB in HIV programs including advocacy and social mobilisation
Sub-objective 4.6.3	Improve structural accommodation for people with disabilities
	<ul style="list-style-type: none"> The Department of Health is currently ensuring that all healthcare facilities are accessible to people with disabilities. By the end of 2017/18, 1 507 facilities out of 3 583 facilities have successfully been renovated.¹¹⁵

Gaps and Challenges

- Poor infrastructure, with non-functioning windows, lack of air-conditioning, and lack of separate waiting rooms for TB patients and general patients are some of the challenges experienced.
- A gap in the finalization and implementation of the policy for housing for people living with disabilities¹¹⁶.

- Strengthen coordination between DoH facilities management unit and the Department of Public Works to ensure health facilities meet the structural requirements for people with disabilities.

Recommendations

- Facilities that obtained Ideal Clinic status during peer reviews need consistent monitoring to ensure they maintain the Ideal Clinic status going forward. Support must be provided to facilities that have regressed¹¹⁷.

¹¹⁵ Department of Basic Education, Annual Report 2017/2018

¹¹⁶ South Africa Human Rights Commission: Research Policy Brief, 2016/2017

¹¹⁷ District Health Barometer 2017/2018



*"Grounding HIV response efforts in human rights principles will enable us to address challenges associated with stigma, discrimination and exclusion."
– Judge Edwin Cameron, Human Rights Activist*

GOAL 5



Ground the Response to HIV, TB and STIs in Human Rights Principles and Approaches

GOAL 5: GROUND THE RESPONSE TO HIV, TB AND STIS IN HUMAN RIGHTS PRINCIPLES AND APPROACHES

At the time of costing the NSP, there was no baseline assessment or plan for human rights-related barriers to HIV. The resource needs estimates for the NSP considered a limited suite of activities including provision for a district-level stigma reduction campaign, training of health care workers and law enforcement agents and the implementation of a human rights reporting mechanism.

A recent cost of a more comprehensive plan to address human rights-related barriers to HIV and TB as part of a baseline assessment of barriers in South Africa estimated the annual cost at \$8.2 million pa over the 5 years (internal draft, June 2018).

PEPFAR does not ring-fence expenditure for human rights-related barriers, but program directors estimated that \$1.3 million of key and vulnerable population programs towards stigma reduction programming is needed.

Although several government programs aim to respond to human rights-related barriers to services, such as the DSD HIV/AIDS sub-program and DBEs HIV and Life Skills conditional grant, there is no financial and non-financial tracking of performance in the area.

The funding landscape analysis has estimated that existing NDOH Medium Term Expenditure Framework (MTEF) provisions for NGO transfers for SBCC activities will include an increasing amount for activities that address human rights-related barriers to HIV and TB services. In ensuring prioritisation of human rights and gender approaches in the provision of HIV, TB and STI response, SA developed and is finalising

South Africa's National Human Rights Plan for three (3) years. This comprehensive plan is aligned to the NSP priorities and seeks to build on the identified responses, including other multisectoral responses and campaigns thereof.

Goal 5 Indicators and Results

TABLE 29: GOAL 5 INDICATORS – TARGETS VS ACTUAL

INDICATOR	BASELINE (2016/2017)	TARGET (2018/19)	ACTUAL (2018/19)
1. Percentage of people living with HIV who report stigma and discrimination	35.5% External Stigma among PLHIV 43% Internal Stigma among PLHIV 36.3% TB related Stigma 21.7% of PLHIV experiencing discrimination (Stigma Index, 2015)	No funding for the survey to determine targets	To be conducted in 2021
2. Percentage of population expressing accepting attitudes towards People Living with HIV and/or TB	To be established in 2017 HSRC SABSSM V survey		85,8% - 91,7% SABSSM (2019)

Progress against objectives

Objective 5.1: Reduce stigma and discrimination among people living with HIV or TB by half by 2022

Overview and key policy issues

Stigma and discrimination programmes aim to reduce inequalities that affect people living with HIV, TB and vulnerable and key populations, to promote universal health coverage.

An effective stigma and discrimination campaign will include awareness and education to promote non-stigmatising messages towards all affected populations to the general population and within sectors such as workplaces and schools; engagement with and sensitisation of political, religious and

community leaders as well as peer mobilisation, advocacy and support to overcome self-stigma. It should include a strengthened understanding of and focus on self-stigma, based on the findings of the Stigma Index study.

Anti-stigma and discrimination campaigns should also address discrimination on various grounds, including discrimination experienced by people who use drugs, sex workers and LGBTI populations. It should furthermore include a focus on reducing stigma and discrimination experienced by vulnerable populations, such as people with disabilities.

The involvement of communities and community leaders (including traditional and religious leaders) and the involvement of anti-stigma ‘champions’ is vital to the success of campaigns.

Key Achievements

TABLE 30: KEY ACHIEVEMENTS BY SUB-OBJECTIVE

KEY ACHIEVEMENTS BY SUB-OBJECTIVE	
Sub-objective 5.1.1	Revitalise community-based support groups to deal with internalised stigma
	<ul style="list-style-type: none"> Community and facility-based support groups established and supported by the various organisation including PLHIV NAPWA implementing a DOH supported program on support groups and promoting adherence and nutritional support
Sub-Objective 5.1.2	Reduce stigma through community education
	<p><i>GF funded implementers</i></p> <ul style="list-style-type: none"> Conducted community sensitization campaigns to address stigma and discrimination experienced by key and vulnerable populations Mobilized community members and Key and Vulnerable Populations (KVPs) to participate in community anti-stigma campaigns Developed and conducted education and awareness on Stigma through a door to door Conducted TB awareness campaigns and facilitated referrals for community members Developed and distributed IEC materials on stigma Documented and produced reports on human rights violations - evidence from local level REACT users.

Objective 5.2: Facilitate access to justice and redress for people living with, and vulnerable to, HIV and TB

Overview and Key Policy Issues

It is imperative that the documentation of human rights violations does not occur as an isolated activity but is part of a continuum of human rights support, which starts with educating communities about their human rights, and results

inappropriate action to support the complainant, which can include a range of support activities, including the provision of information and advice, psychosocial support, support to lay a charge, referral to a paralegal or lawyer, referral for health or social services, or a combination of thereof.

Critical is to promote the role of legal support services for all people, including key and vulnerable populations. Some of the interventions central to achieving this include providing

legal outreach services through peer outreach educators who work as human rights defenders at the community level.

Organisations are working on setting up human rights case management and referrals systems to facilitate reporting cases to first-line responders who amongst others include paralegals from Legal Aid South Africa (LASA), Community Advice Offices, and human rights sub-recipients, including NAPWA, SWEAT and TB HIV Care.

Key Achievements

TABLE 31: KEY ACHIEVEMENTS BY SUB-OBJECTIVE

KEY ACHIEVEMENTS BY SUB-OBJECTIVE	
Sub-Objective 5.2.1	Improve legal literacy about human rights and laws relevant to HIV and TB
	<ul style="list-style-type: none"> Standardised legal literacy materials for key populations, PLHIV and people with TB have been developed especially on the GF funded programs. Existing civic outreach programs have been strengthened and scaled-up to increase the capacity of community-led “Know Your Rights” campaigns for PLHIV, TB and KPs. A Human Rights toolkit has been developed with a chapter dedicated to legal literacy. Other interventions have been implemented to promote an environment that enables and protects human and legal rights and prevents stigma and discrimination.
Sub-Objective 5.2.2	Make HIV- and TB-related legal services available and accessible
	<ul style="list-style-type: none"> During period 2017-2018 Legal AID South Africa implemented programs focussed on the following objectives: <ul style="list-style-type: none"> Empowered clients and communities making informed choices about their legal rights and responsibilities. All poor and vulnerable persons able to access quality legal services to protect and defend their rights. An accessible, fair, efficient, independent and effective justice system serving all in South Africa, contributing to building safer communities. Delivering on our constitutional and statutory mandate in an independent, accountable and sustainable manner. Legal AID national footprint remained unchanged at 64 Legal AID SA Local Offices and 64 Satellite Offices, supported by six provincial offices and one national office. <ul style="list-style-type: none"> Continuous review of the footprint to ensure that Legal AID offices are located so that they provide easy access to their clients and are conveniently located close to the courts and other public amenities, such as public transport nodes. Extensive work is done to secure suitable accommodation for Legal Aid offices by continuously monitoring lease agreements, renovating some of the premises, and by purchasing some of the premises to guarantee the security of their tenure. Between August 2017 and October 2017, Legal AID SA conducted a pilot study at four of its High Courts using a paralegal and a legal practitioner to determine how many litigants are unrepresented in their matters before the High Court. The study revealed the following: 85% of litigants appearing in these four High Courts did not apply for legal aid and that 72% of the litigants that did not apply for legal aid did not know about Legal Aid SA and the services we render.

KEY ACHIEVEMENTS BY SUB-OBJECTIVE

	<ul style="list-style-type: none"> • 69% of the litigants had matters for which legal aid could possibly have been granted, if they met our criteria in terms of means and merit. • Where a Paralegal and legal practitioner were available at the High Court, more clients were assisted with legal representation as opposed to where only a paralegal was available. • Many litigants that have matters in the High Courts are not aware that they can apply for legal aid and that if they applied, a significant number of unrepresented litigants could possibly have qualified for legal aid to protect their rights. • Matters litigated in the High Courts are generally more serious matters, which affect significantly on the life of clients and therefore proceeding in these types of matters as unrepresented is certainly prejudicial to clients. • Legal Aid South Africa has very limited capacity available to attend to these matters in the High Courts and with further constraints on available resources; Legal AID will have to review our policy to re-prioritise the available resources to ensure access to legal aid services at High Courts.
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Objective 5.3: Promote an environment that enables and protects human and legal rights and prevents stigma and discrimination

Overview and key policy issues

Interventions are to implement programs to raise awareness and reduce stigma and discrimination experienced by key and vulnerable populations for HIV and TB at all levels, including communities.

Interventions to reduce stigma and discrimination towards sex workers and PWID specifically, as well as legal literacy and access to justice interventions, are integrated into programs implemented by multiple implementers. Critical is to focus on advocacy for an enabling political, policy and legal environment.

Key Achievements

TABLE 32: KEY ACHIEVEMENTS BY SUB-OBJECTIVE

KEY ACHIEVEMENTS BY SUB-OBJECTIVE	
Sub-Objective 5.3.1	Implement a Human Rights Accountability Scorecard
	<ul style="list-style-type: none"> • Through the KP REACH Regional Global Fund (GF) grant, partners have piloted human rights monitoring and response models in South Africa. From December 2016 to May 2017, Partners documented 305 cases, with 420 key populations individually affected. Of these cases, partners responded to only 56% of the cases. Lessons from the GF grant show that where strong and systematic referral systems exist, response rates are higher. • The Human Rights Baseline Assessment confirms that access to legal support for PLHIV and KPs needs strengthening, to ensure timely responses for documented infringements.
Sub-Objective 5.3.2	Monitor implementation of laws, regulations and policies relating to HIV and TB, and identify areas for reform
	<ul style="list-style-type: none"> • Several organisations are contracted to provide sensitisation and training for law enforcement agents in the South African Police Services. These include police officers and metro officers.

KEY ACHIEVEMENTS BY SUB-OBJECTIVE

Sub-Objective 5.3.3	Sensitise law makers and law enforcement agents
	<ul style="list-style-type: none"> • A 2018 human rights baseline assessment found that KPs report stigmatizing and discriminatory behaviour from HCWs as a key barrier to accessing services, especially for PWID and transgender people. • Violence against other KPs is also widespread. Studies indicate that 50.9% of sex workers in Johannesburg and 47.3% in Cape Town experienced physical assaults in 2017, more than half of MSM in Pretoria had verbal insults directed at them for being gay, and more than one in five report police discrimination. Harm Reduction International (2016: Page 134) • Studies indicate that in 2017, there were 683 human rights violations against PWID, more than half, related to the destruction or confiscation of injecting equipment. • Rights-based interventions have begun reducing the levels of stigma and discrimination against KPs and recent national discussions around law reform for sex work and drug use present opportunities to remove some of these barriers. • During the time of the MTR of the NSP, 173 police have been trained on the Diversity, Dignity and Policing program
Sub-Objective 5.3.4	Train health care providers on human rights and medical ethics related to HIV
	<ul style="list-style-type: none"> • National Action Plan for health and human rights training based on a review of training curricula for all health and social services professions, focused on issues relating to HIV, TB, young people and all KPs. • Research The research found that HCWs lacked relevant knowledge and competencies to manage specific health needs and vulnerabilities of KPs, and KPs reported experiences of stigmatization, guilt, and a loss of dignity because of the discrimination from HCWs. • Evidence The evidence further suggests service uptake by KPs will improve if HCWs are sensitized and trained to provide non-discriminatory and non-judgmental services. • NDOH conducted a sensitisation and training of health workers, to increase their awareness and understanding of medical ethics, patient rights and needs of people living with HIV, TB and all vulnerable and key populations as well as their own rights, as health workers, to work in a safe and protective environment.



"A strong and multisectoral leadership approach is important in realizing the goals of the NSP."

– Steve Letsike, SANAC Vice Chair / CSF Chair

GOAL 6



Promote Leadership and Shared Accountability for a Sustainable Response to HIV, TB and STIs

GOAL 6: PROMOTE LEADERSHIP AND SHARED ACCOUNTABILITY FOR A SUSTAINABLE RESPONSE TO HIV, TB AND STIS

In March 2017, SANAC launched the fourth generation of a 5-year National Strategic Plan (NSP) 2017 - 2022 to address HIV, TB and STIs. As with previous iterations, the NSP calls for multi-sectoral action and mandates AIDS councils at different levels to coordinate its implementation.

SANAC has strived for the effective coordination of the South African AIDS responses through strong leadership from inside and outside government, at national and local levels. SANAC designed governance and oversight structures to promote accountability, the achievement of results, and synergies between HIV and broader health efforts. Inclusion of vulnerable populations and effective partnerships between government and civil society has been crucial.

Overview and key policy issues

Unlike any other state entities, SANAC is an advisory, oversight and coordination body that brings with it a novel mode of democratic co-governance. Established by Cabinet primarily “to advise the government on the development and implementation of appropriate HIV and AIDS policies and programmes,” SANAC brings together representatives and

experts from government and civil society (which includes business and labour). Its key committees draw members from across departments and sectors, with each one led jointly by a government and civil society representative.

The guiding framework to support implementation and set out expected roles and responsibilities of the AIDS Councils are as follows:

- The “South African National AIDS Council Procedural Guidelines” captures both composition and roles & responsibilities of the national structures of SANAC.
- The “Making the Multi-sectoral HIV and AIDS response work in South Africa: A South African National AIDS Council Strategy”; is a strategy that was developed to bring about a multi-sectoral response to the HIV, TB and STIs response in South Africa. The strategy was developed against the background that AIDS Councils and their secretariats at various levels are key players in such efforts. The strategy aims at strengthening the capacity of sub-national AIDS Council structures and improving their functionality to ensure their concrete contribution towards achieving South Africa’s national HIV and AIDS and broader development goals as well as international commitments.
- The “Quality assurance resource book for Local AIDS Councils: Resource Book” is intended to assist members of the AIDS Councils responsible for providing oversight and coordination for the local epidemic responses by guiding and enhancing the capacities of secretariats and members of the AIDS councils.

Goal 6 Indicators and Results

TABLE 33: GOAL 6 INDICATORS – TARGETS VS ACTUAL

INDICATOR	BASELINE (2016/2017)	TARGET (2018/19)	ACTUAL (2018/19)
1. SANAC Accountability performance score	Baseline to be established in 2017	TBD	SANAC Accountability performance score card developed, but not implemented
2. PCA and District AIDS Councils Accountability performance score: (5-year PIP aligned to the NSP, relevant PIP; representation)	Baseline to be established in 2017	TBD	Not Achieved. The Accountability framework only finalized and approved in 2019 and has not been implemented yet.

INDICATOR	BASELINE (2016/2017)	TARGET (2018/19)	ACTUAL (2018/19)
3. Number of PCA Secretariats that are allocated sufficient enough funds to coordinate the PIP	33%	60%	66% GF allocated funds for PCA support to PIP development, costing, coordination, and evaluation
4. Number of Premiers and Mayors who Chair AIDS Councils	55%	100%	Number of Premiers who Chair Provincial AIDS Councils = 6 (except for WC, GP and NW) Number of Mayors who Chair District AIDS Councils = 32
5. Percentage of SANAC sectors with implementation plans that align with the NSP and contribute to the PIPs	Baseline to be established in 2017	100%	No sectoral plans have been updated yet but SANAC secretariat working closely with CSF to ensure this is done as part of the accountability framework

Progress Against Objectives

Objective 6.1: Strengthen AIDS Councils to provide effective coordination and leadership of all stakeholders for shared accountability in the implementation of the NSP

Overview and key policy issues

South Africa has successfully demonstrated its political commitment in response to HIV, TB and STI in a holistic manner through the development of appropriate policies and programs including the multi-sectoral National Strategic Plan (NSP) for HIV, TB and STIs currently 2017 – 2022.

Hence, sustained political, civil society and private sector leadership commitment at all levels, i.e. national, provincial, district, local and community is essential to ensure an effective, targeted and focused multi-sectoral response.

The NSP proposes that to attain the goals as set out, mutual accountability, leadership and good governance should be key at various levels as they form the basis of ensuring this level of accountability, as required by Goal 6 of the NSP.

Consequently, the SANAC Trust developed a comprehensive Accountability Framework (AF) and Score Card that outlines the roles and responsibilities and strategy for gathering information, measuring and reporting on the identified

Accountability Framework indicators.

Because civil society is widely recognised as playing a significant role in strengthening the multi-sectoral HIV response, the SANAC Civil Society Forum has added value of civil society organisations (CSOs) in extending HIV prevention, treatment, care, support and impact mitigation services in response to the NSP targets, leading to the development of the SANAC CSF Strategy 2017-2022, with a theme: “Our Communities Matter.”

Key Achievements

TABLE 34: KEY ACHIEVEMENTS BY SUB-OBJECTIVE

KEY ACHIEVEMENTS BY SUB-OBJECTIVE	
Sub-Objective 6.1.1	Formally establish the structures of AIDS Councils at national, provincial, district and local level
	<ul style="list-style-type: none"> All structures of AIDS Councils have been established – 1 x national, 9 x Provincial, 52 x Districts and 223 Local level. While the structure and composition of metro and local AIDS councils vary across the country according to the local context, the terms of reference are the same, derived from the mandate of SANAC. There is a need for additional work in making AIDS Councils responsible for the multi-sectoral response.
Sub-Objective 6.1.2	Ensure representation of all stakeholders in decision-making structures at all levels
	<ul style="list-style-type: none"> Representation and participation involve a broad array of stakeholders from multiple sectors, but because membership is voluntary, there is a lack of sustained commitment Civil society is the most represented sector across all AIDS Councils, with limited participation from government departments and a notable absence of the private sector AIDS Councils have opened space for civil society to participate, and played a crucial role in convincing the sector to get involved, and ensured that they understood their mandate and contribution in the response to HIV
Sub-Objective 6.1.3	Strengthen the role of the private sector and labour in AIDS Councils
	<ul style="list-style-type: none"> Private Sector Engagement Strategy has been developed SABCOHA continues to co-ordinate a private sector response to Health, and more specifically, the TB and AIDS epidemics. SABCOHA is a member-based organisation, including service providers who have joined forces in the private sector initiative to combat Health and AIDS. SANAC has a data data-sharing agreement with the Council for Medical Schemes (CMS), and the CMS submits data from all registered schemes on a semi-annual basis. The data is reported globally to fulfil the country's commitments to the UNAIDS 2016 Commitments to end AIDS by 2030.
Sub-Objective 6.1.4	Ensure a central role for Civil Society and community groups
	<ul style="list-style-type: none"> The SANAC Civil Society Forum (CSF) consisting of 18 sectors, elected leaders for the duration of the implementation of the NSP for HIV, TB and STIs (2017-2022). The goal of the CSF is to represent the views of civil society sectors in the policy deliberations within the SANAC Plenary and committees as well as to advocate for the policy and programme proposals of civil society for consideration by government and the private sector. National CSF held a Lekgotla on the 29 – 30 August 2019, where National Sector Leaders together and Provincial CSF Chairpersons debate on progress on the HIV, TB and STIs, strengthening the Civil Society Coordination and Governance In August 2019, the SANAC CSF conducted a <i>“Transformation Survey of Civil Society Organisations in South Africa”</i> that seeks to inform on the current state of funding transformation of the non-profit sector in South Africa.
Sub-Objective 6.1.5	Monitor annually the implementation of the accountability framework the implementation of the accountability framework annually through an Accountability Scorecard
	<ul style="list-style-type: none"> The development of the Accountability Framework and an Accountability Scorecard has been completed. The Scorecard is to be implemented at National and Provincial levels.

Other key achievements include:

- The development of the NSP Accountability Framework and scorecard completed and awaiting implementation
- All nine (9) PCAs have developed Provincial Implementation Plans
- 46 out of 52 District AIDS Councils (DACs) have developed Multi-sectoral District Implementation Plans (MDIPs)
- The development of procedural guidelines for the AIDS Councils Secretariat at provincial, district, local and ward level.

Gaps and Challenges

- The functionality of National, Provincial and District AIDS Councils' roles and functions in the effective implementation of a multi-sectoral approach in combating HIV, TB and STIs vary by province. The main challenges to the functionality of AIDS Councils include sub-optimal political leadership and support,
 - o In the Northern Cape, it was reported that although there is political leadership at Provincial level, additional buy-in needs to be obtained from various political leaders at district levels, as it was reported that no Mayors had shown willingness to participate in District AIDS structures
 - o In Limpopo, the province was supposed to have held 104 Technical Committee and AIDS Council meetings during 2018, however, they held only 46 technical committee meetings and 41 AIDS Council meetings.
 - o In the Eastern Cape, it was reported that only 25% of the Mayor's chair AIDS Councils
- Most AIDS Councils are at different levels of functionality most are generally weak and failing to implement a multi-sectoral approach. Membership is voluntary; thus, there is a lack of sustained commitment, and there is inadequate sector representation.
- Even though MDIPs exist, they are not well integrated with local development plans and budgeting processes.
 - o In the Eastern Cape, only 23% of the PAC sectors had implementation plans that align with the NSP and contribute to the PIPs

Recommendations

- Ensure an enabling environment for effective implementation of multi-sectoral approach through political leadership, support and resourcing of the HIV, TB and STIs response.
- Facilitate the implementation of the Accountability Framework and scorecard by Provincial and District Councils on AIDS
- Implement the Private Sector Strategy so that the private sector be held accountable for achieving targets in the

NSP, though reaching small and medium enterprises

- SANAC should facilitate the process of building the capacity of PCAs, DACs and LACs to ensure effective coordination of the multi-sectoral response to HIV, TB and STI at the local level, and help to address the weak relations between sectors.

Objective 6.2: Improve collaboration and cooperation between government, civil society, development partners and the private sector

To ensure effective HIV, TB and STIs responses, SANAC promotes a strong partnership between local governments and civil society, with the full involvement of people living with HIV, women and key populations. As the service delivery arm of the state, local governments ha

ve ensured the integration of HIV, TB and STIs response into local development plans and coordinate community-level processes, to ensure coordination of the implementation of HIV, TB and STI activities.

Civil society organizations (CSOs) have been at the forefront of responding to HIV in South Africa from the early days of the epidemic. The leadership by people living with HIV, including those affected by HIV has been instrumental in driving comprehensive responses to the epidemic at national and local levels.

During the implementation of the NSP (2017-2022) CSOs remained at the forefront of prevention, care and support programmes, particularly among women and the most vulnerable and hard-to-reach populations.

Implementation efforts are also supported by the various development partners including PEPFAR, GF and many others as part of the Health Partners Forum, and the private sector also plays a central role in strategic Public-Private Partnerships. SABCOHA represents the private sector in SANAC and continues to work closely with private sector businesses to contribute to the multisectoral response.

Goal 6 Indicators and Results

TABLE 35: GOAL 6 RESULTS

INDICATOR	BASELINE (2016/2017)	TARGET (2018/19)	ACTUAL (2018/19)
1. Percentage of SANAC sectors with implementation plans that align with the NSP and contribute to the PIPs	Baseline to be established in 2017	100%	Civil Society Forum Implementation Plan

Key Achievements

TABLE 36: KEY ACHIEVEMENTS BY SUB-OBJECTIVE

KEY ACHIEVEMENTS BY SUB-OBJECTIVE	
Sub-Objective 6.2.1	Ensure that the plans of government and the non-government sector are aligned with the NSP
	<ul style="list-style-type: none"> DPSA, representing 156 national and provincial government departments, has an Employee Strategic Health and Wellness Framework for the public Public Service, which is aligned with the NSP, i.e. all objectives in the framework are derived from the NSP, for government departments to implement NSP activities in the workplace. Twenty-one national government departments that are part of the SANAC Inter Ministerial Committee (IMC), have plans that are aligned to the NSP and this is coordinated through the Presidency.
Sub-Objective 6.2.2	Strengthen collaboration between and co-ordination of government departments
	<ul style="list-style-type: none"> Contribution of the IMC government departments described above to the national response is coordinated through the Government Technical Task Team (GTTT), led by the Presidency. It is through the GTTT that these government departments strengthen their collaboration and coordination in response to HIV, TB and STI in accordance with per the NSP.
Sub-Objective 6.2.3	Establish/strengthen regional collaboration
	<ul style="list-style-type: none"> SANAC participates in the different regional structures including the SADC, GF and other international coordinating mechanisms

Other key achievements include:

- Municipal governments have led the mobilisation and coordination of more inclusive and tailored local responses to HIV, TB and STIs. As the level of government closest to communities, some local governments have significantly improved the response to the HIV epidemic.
- The Global Fund Country Coordinating Mechanism that is composed of all key stakeholders in the country's response to HIV and Tuberculosis has been established to oversee the implementation progress.
- All AIDS Councils have provided a platform to facilitate collaboration between sectors, to improve synergies, reduce fragmentation of action, and decrease duplication of HIV programmes and interventions aimed towards meeting the goals of the NSP
- PEPFAR Partnership Framework Implementation Plan Management Committee was formed to ensure that leadership at both the donor agency and the government worked together to create a new governance structure for transition planning and coordination.

Gaps and Challenges

- While leadership is often strong at the national level, capacity is much weaker at local levels, with Mayors and Councillors not taking full ownership and responsibility. the PCAs reported this challenge
- The lack of representation of some sectors in DACs and LACs contradicts the purpose for the establishment of AIDS Councils, resulting in poor coordination and omission of the work of stakeholders from multiple sectors.
 - o As a result of poor coordination, reporting to the AIDS Councils is compromised. For example, in the Limpopo province, during the period under review, Mopani and Sekhukhune Districts did not receive any report from the developmental partners operating in their respective districts.
- The informal structure of AIDS Councils, based on volunteers and with continuously changing membership, does not allow for undertaking a complex and continuous task of coordination. Volunteerism can be associated with a lack of accountability, lack of ownership, low morale, and lack of commitment.

Recommendations

- Develop punitive measures to enforce compliance for political leaders at the local level to chair AIDS Councils
- There is a need to expand efforts to improve political commitment and support on the HIV response
- Mobilise resources needed by the AIDS Councils for effective coordination of a multi-sectoral response to HIV, TB and STIs.
- Review and revise the PEPFAR Partnership Framework Implementation Plan.



"We need to spend now to save later in order to achieve our targets."

– Maurice Radebe, Sasol

GOAL 7



Mobilise Resources and Maximise Efficiencies to Support the Achievement of NSP Goals and Ensure a Sustainable Response

GOAL 7: MOBILIZE RESOURCES TO SUPPORT THE ACHIEVEMENT OF NSP GOALS AND ENSURE A SUSTAINABLE RESPONSE

Goal 7 Indicators and Results

TABLE 37: GOAL 7 INDICATORS – TARGET VS ACTUAL

INDICATOR	BASELINE (2016/2017)	TARGET (2018/19)	ACTUAL (2018/19)
1. Total expenditure on HIV, TB and STIs	R28.7 billion	110%	R28.8 billion (Global AIDS Monitoring Report, 2018)
2. Percentage of the budget from sources other than government	25.9% (2016/17)	20%	23-25% (Global AIDS Monitoring Report, 2018)

Progress against objectives

Objective 7.1: Improve efficiency and mobilise enough resources to achieve the goals, objectives and targets of the NSP.

Overview and key policy issues

The NSP recommends various interventions for improving efficiency and mobilising adequate resources to achieve its goals, objectives, and targets. The interventions include 1) costing of NSP implementation plans, 2) innovative funding mechanisms, 3) technical efficiency to generate cost savings and 4) location targeting.

The government's increasing financial commitment to HIV and TB against the backdrop of declining economic conditions has been noted over the years. The consolidated health allocations have increased to R205 billion in 2018/19 whilst HIV and TB spending increased drastically from R18.3 billion in 2017/18 to R20.7 billion in 2018/19, recording a real annual growth rate of 7%.

Although the HIV and TB budget allocation is expected to grow in the future, there remains the challenge for the government to reduce new HIV infections which continue to put pressure on the government's overall HIV and TB response and financing.

Within the SAG HIV & TB response, the NDoH is the largest spender on HIV services, primarily via the HIV/TB Conditional Grant mechanism (ZAR20.5 billion in 2018/19), followed by

the Department of Social Development (ZAR1.8 billion for 2018/19). An additional ZAR1.9 billion has been allocated in 2017/18, and 2018/19 to support the implementation of the HIV, and TB Investment Case and the NSP, including the continued expansion of ART to PLHIV.

Key Achievements

TABLE 38: KEY ACHIEVEMENTS BY SUB-OBJECTIVE

SUB-OBJECTIVE 7.1.1	MAXIMISE THE FUNDS AVAILABLE FOR IMPLEMENTATION OF NSP AND THE IMPACT OF THESE RESULTS
Intervention: Costing of NSP implementation plans	
Approach	Progress To Date
<ul style="list-style-type: none"> Accurately cost all implementation plans to support budgeting and resource mobilisation efforts 	<ul style="list-style-type: none"> Through the Financial Capacity Building for Provinces (FINCAP) project, accurate costing of implementation plans was improved through capacity building and technical support to HIV, STI and TB (HAST) programmes and finance managers in provincial departments of health. This resulted in improved budget planning, costing, and expenditure tracking and reporting on HIV and TB in the health sector. The National AIDS Spending Assessment 2016/17 is the most recent analysis of HIV/AIDS expenditure in South Africa broken down by program classifications.
Intervention: Costing of NSP implementation plans	
Approach	Progress to date
<ul style="list-style-type: none"> Design, implement and evaluate new and innovative funding mechanisms 	<ul style="list-style-type: none"> The design of the first Social Impact Bond (SIB) in the health sector in South Africa has been completed. Led by the South African Medical Research Council (SAMRC), the AGYW SIB will explore an innovative financing mechanism to attract investors to social programmes traditionally funded by governments.
<ul style="list-style-type: none"> Prioritise mobilisation of previously untapped sources of funding (such as private investors) and co-investment in shared outcomes (development synergies). 	<ul style="list-style-type: none"> The 2016 National AIDS Spending Assessment (NASA) reported other external sources (bilateral, multilaterals, and foundations) accounting for about 3% of HIV response funding. Private companies and insurance contributed to around 8%. During the mid-term review period, no NASA was conducted.
<ul style="list-style-type: none"> Leverage new funding to enhance efficiency and impact 	<ul style="list-style-type: none"> The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) has committed to South Africa an amount of \$369m for the period 2019 – 2022 The PEPFAR COP 2019 implementation total was USD 752 million. PEPFAR continues to support HIV & TB responses in SA The Bill and Melinda Gates Foundation continues to invest in important formative research that informs PEPFAR investments.

SUB-OBJECTIVE 7.1.1		MAXIMISE THE FUNDS AVAILABLE FOR IMPLEMENTATION OF NSP AND THE IMPACT OF THESE RESULTS	
Intervention: Technical efficiency to generate cost savings			
Approach		Progress To Date	
<ul style="list-style-type: none"> Achieve higher technical efficiencies in service delivery and health and other systems 		<ul style="list-style-type: none"> The implementation of the latest HIV & TB Investment Case has shown that the most cost-effective set of interventions can still massively affect outcomes such as mortality and HIV incidence. As recommended, the Government has started spending more on the most cost-effective interventions, to ensure the impact over the next 20 years will be greater, which will result in improved outcomes along with reductions in total spending in the long run. The PEPFAR SA's National Sustainability Profile was completed in November 2019 using the Sustainability Index and Dashboard (SID) 4.0 and the results indicate improved sustainability and continuity of the national HIV & TB programs. 	
Intervention: Location targeting			
Approach		Progress to date	
<ul style="list-style-type: none"> Improve the precision of spatial targets for investments 		<ul style="list-style-type: none"> Using the Thembisa Model and the Districts Estimates to improve the precision of HIV spatial targets for investments, the results indicate differences in the scale-up of HIV testing and ART access by provincial and district, which is partly explained by differences in budget allocations. 	

Gaps and Challenges

- South Africa has experienced a constrained fiscal environment in recent years, i.e. considerable deficits and a growing debt-to-GDP ratio; however, financial commitment to HIV programs remains.
- Future HIV and TB treatment costs are projected to rise and consume an increasing share of the health budget - a steadily increasing investment in HIV programs is required to reach 90-90-90 targets.
- Health / social / community systems receiving funds must have the capacity to absorb the inflow of resources and safeguard effective and efficient spending.
- Due to South Africa's high HIV burden and the already large and growing number of patients on treatment, HIV costs are expected to increase over the next decade, primarily driven by costs of ARVs and ART service delivery.
- Although the continued rollout of Tenofovir/Lamivudine/ Dolutegravir fixed-dose combination (TLD) is expected to offset the increasing costs of HIV treatment, the increased donor and government funding directed specifically to HIV treatment has displaced or 'crowded out' funding for other HIV programmes.
- As South Africa grapples with competing priorities, e.g.

NHI, long-term costs and financing of HIV and TB programs become challenging, economic evaluations become imperative for priority setting and decision-making.

- There is a downward trend in overall donor funding for HIV and TB.
- Even though 40% - 50% of all new HIV infections among adults occur among key populations and their partners, just 2% of all HIV funding, and around 9% of resources allocated specifically for prevention, are spent on these groups.

Recommendations

Considering the productivity gains attained through reduced HIV, and AIDS mortality and morbidity, the private/ business sector should increase their contributions over the next 5 to 10 years to sustain these successes.

There is a need for innovative financing to augment existing domestic and international financing for HIV and TB. SAG and international partners should pay more attention to the technical and allocative efficiency regarding the use of the available resources.

- Savings can be utilized to reduce funding gaps and improve the impact.

- Conduct the next National AIDS Spending Assessments (NASA) for consolidated spending on HIV and TB.
- Update the HIV and TB Investment Case.
- Develop an investment case for non-biomedical programmes.
- Strengthen relevant coordinating structures i.e.
 - o Resource Mobilization Committee
 - o Costing Technical Task Team
 - o HIV and TB Investment Case Steering Committee
- Strengthen the participation of all relevant stakeholders on the PEPFAR PFIP, the GFATM CCM and Oversight Committee to increase efficiencies and proactive reprogramming
- SA must engage in critical conversations as regards:
 - o Increasing the efficiencies of treatment and other HIV services.
 - o How HIV/AIDS programming fits into the NHI agenda.
 - o How SAG and development partners can optimally manage the phasing-out/ transitioning of external funding and technical support.
- Ensure the sustainability of investments and their impact on the HIV and TB response in SA

8



"Continuous research and data analysis forms the operational backbone of the "focus for impact" approach to NSP implementation."

– Dr. Mookho Malahleha, Researcher

GOAL 8



**Strengthen Strategic Information to Drive Progress
Towards Achievement of NSP Goals**

GOAL 8: STRENGTHEN STRATEGIC INFORMATION TO DRIVE PROGRESS TOWARDS ACHIEVEMENT OF NSP GOALS

Goal 8 Indicators and Results

TABLE 39: GOAL 8 INDICATORS – TARGET VS ACTUAL

INDICATOR	BASELINE (2016/2017)	TARGET (2018/19)	ACTUAL (2018/19)
1. NSP Five-year costed National M&E Plan	n/a	NSP Five-year costed National M&E Plan	Approved but not costed
2. Functional National Enterprise Information System (EIS)	None	EIS system which houses real-time data on NSP indicators	Focus for Impact Platform partially functioning
3. Percentage of core NSP and PIP indicators reported	None	80%	55% out of a target of 80% (NSP Annual Progress Report 2017-2018)
4. Number of NSP Mid-term and End-term Evaluation conducted		Annual NSP report NSP Mid-term report 9 PIP Mid-term Reports	In-Progress (NSP MTR)
5. Number of provinces and districts with Annual HIV, TB and STI profiles/ implementation plans /quarterly reports/ annual	N/A	9 Nine provincial profiles 52 district profiles	4 Quarterly Factsheets per Province. A total of 8 quarters for this period of the MTR, i.e. October to December 2017; January to March 2018; April to June 2018; July to September 2018; October to December 2018 & January to March 2019. 8 Annual Progress Reports for the period of April 2017 to March 2018
6. Adoption of 5-year NSP HIV, TB and STI Research Agenda	None	5-year NSP HIV, TB and STI Research Agenda	SANAC is working to establish and coordinate a research repository working closely with research institutions

Progress Against Objectives

Objective 8.1: Optimise routinely collected strategic health information for data utilisation in decision-making

Overview and key policy issues

South Africa has demonstrated commendable political commitment to ensuring that PLHIV has access to life-saving antiretroviral treatment and lives a prolonged healthy life. This is evident through the treatment policy changes in the past decade.

The President Emergency Plan for AIDS Relief (PEPFAR's) Country Operational Plan (COP) 2018/2019 Strategic Direction Summary also supports the treatment policy changes and the Universal Test and Treat (UTT) Policy was effective during the mid-term review of the NSP 2017-2022.

Drawing from the eighth goal of the NSP, there is an emphasis on strengthening strategic information to drive progress

towards achievements of the NSP Goals. Strategic information entails that health information systems call for data-driven action.

South Africa as a country is investing funds in ensuring implementation of a robust case-based surveillance system to be used routinely within the public health care setting, the implementation of a unique patient identifier across multiple sites as part of minimising duplication and double-counting through the Health Patient Registration Systems (HPRS) and also the integration of existing data systems using the centralised Health Information Exchange (HIE) platforms.

On the other hand, SANAC seeks to set up an Enterprise Information System (EIS)/ Situation Room that will allow reporting of real-time data for analysis and use from all stakeholders on the multisectoral response.

Key Achievements

TABLE 40: KEY ACHIEVEMENTS BY SUB-OBJECTIVE

KEY ACHIEVEMENTS BY SUB-OBJECTIVE	
Sub-objective 8.1.1	Implement master patient index for use in all service delivery settings
	<ul style="list-style-type: none"> NDOH has piloted and now fully implemented the Health Patient Registration System (HPRS) that allows for the unique identification of a patient across health care service platforms within the public sector in SA.
Sub-objective 8.1.2	Link clinical laboratory and pharmacy data
	<ul style="list-style-type: none"> Some data sets have been merged between the clinical laboratory and pharmacy data using various systems. The Health Patient Registration System provides a Patient Registry and Master Patient Index using the South African identification number and other forms of legal identification. At the end of March 2018, a total of 2 968 Primary Health Care facilities were using the system and more than 20 million people had been registered on the system, compared with 1 849 PHC facilities and 6.3 million registered at the end of March 2017.¹¹⁸
Sub-objective 8.1.3	Establish Health Information Exchanges for real-time data availability
	<ul style="list-style-type: none"> Pilot projects on the HIE were implemented in Free State, and Western Cape provinces and these have generated important evidence for expansion. The Western Cape Provincial Health Data Centre (PHDC) consolidates person-level clinical data across government services, leveraging sustained investments in inpatient registration systems, a unique identifier, and maturation of administrative and clinical digital health systems. The PHDC is housed entirely within the government. Data are processed from a range of source systems, usually daily, through distinct harmonisation and curation, beneficitation, and reporting

¹¹⁸ National Department of Health Annual Report 2017/18

KEY ACHIEVEMENTS BY SUB-OBJECTIVE

	<p>processes. Linkage is predominantly through the unique identifier which doubles as a pervasive folder number, augmented by other identifiers.</p> <ul style="list-style-type: none"> • Further data processing includes triangulation of multiple data sources for enumerating health conditions, with the assignment of certainty levels for each enumeration. Outputs include patient-specific email alerts, a web-based consolidated patient clinical viewing platform, filterable line-listings of patients with specific conditions and associated characteristics and outcomes, management reports and dashboards, and data releases in response to operational and research data requests. In the past decade, 8 million unique people are recorded as having sought healthcare in the provincial public sector health services, with current utilisation at 15 million attendances or admissions a year. Cross-sectional enumeration of health conditions includes over 430 000 people with HIV, 500 000 with hypertension, 235 000 with diabetes. Annually 110 000 pregnancies and 54 000 patients with tuberculosis are enumerated. Over 50 data requests are processed each year for internal and external requesters in accordance with per data request and release governance processes. The single consolidated environment for person-level health data in the Western Cape has created new opportunities for supporting patient care, while improving the governance around access to and release of sensitive patient data.¹¹⁹
Sub-objective 8.1.4	Increase data utilisation
	<ul style="list-style-type: none"> • SANAC is setting up a Situation Room to allow for data accessibility, analysis and use using the existing FFI platform. Strides have been taken to ensure finalisation and implementation thereof.

Gaps and Challenges

- There have been delays in the setting up of a unique patient identifier that has resulted in duplication of services and double counting
- Implementation of the master patient index varies across Provinces based on the availability of resources and willingness amongst data management personnel at the facility level
- The setting up of a data repository at SANAC has taken long to be finalised, and as such, there is no real-time data to track implementation of the NSP

Recommendations

- Ensure roll-out and compulsory implementation of HPRS in all health facilities
- Fast-track finalisation and implementation of the data repository at SANAC

Objective 8.2: Rigorously monitor and evaluate the implementation and outcomes of the NSP

Overview and key policy issues

The NSP for HIV, TB and STIs is in line with the South African

National Development Plan (NDP) 2030. Some of the objectives of NDP under the thematic area "Health for All" are as follows:

- Increase the average male and female life expectancy at birth to 70 years
- Progressively improve TB prevention and cure
- Reduce maternal, infant and child mortality
- Deploy primary healthcare teams to provide care to families and communities
- Ensure access to an equal standard of care, regardless of income
- Prevent and reduce the disease burden and promote health
- Prevent and control epidemic burdens through deterring and treating HIV/AIDS, new epidemics and alcohol abuse
- Improve the allocation of resources and the availability of health personnel in the public sector
- Improve the quality of care, operational efficiency, health worker morale and leadership and innovation.

The above-cited objectives set the precedence for rigorous monitoring and evaluation of the implementation and outcomes of the NS for HIV, TB and STIs 2017-2022.

¹¹⁹ Boulle, A et. al. / International Journal of Population Data Science (2019)

Key achievements

Human Resources

To fulfil the requirements of rigorously monitoring and evaluating implementation and outcomes of the NSP, SANAC recruited a Strategic Information (SI) Executive Manager who oversees the running of the strategic information unit across all SANAC structures (National, Provincial, District and Local).

The structure of the SI Unit is such that operations are coordinated at a national level through a staff complement of three personnel as well as provincially through M&E Officers seconded to each of the nine Provincial Councils on AIDS (PCAs) and housed in either the Premier's Offices or the Provincial Departments of Health offices. The roles of the PCAs are as follows: Oversee the country's response to HIV, TB and STIs:

- Foster dialogue between government, civil society and all other stakeholders
- Advise government on HIV and AIDS, TB and STIs policy and strategy
- Strengthen the governance, leadership and management of the response at all levels
- Strengthen the multi-sectoral response to HIV, TB and STIs
- Mobilize resources to finance the response
- Monitoring of progress against NSP targets
- Create and strengthen partnerships for an expanded national response

Development of the fourth generation plans for HIV, TB and STIs

The SI Unit actively participated in the development of the fourth generation of NSP for HIV, TB and STIs 2017-2022, which is under review, using a consultative process. Subsequently, the SI Unit developed nine Provincial Implementation Plans (PIPs) and Multi-sectoral District Implementation Plans (MDIPs), in each of the provinces except the Western Cape, using the same consultative process. The Western Cape Province does not have MDIPs because there are no District AIDS Councils (DACs) in the province.

Development of the M&E Plans for the NSP and the PIPs

The SI Unit developed the M&E plan for the NSP for HIV, TB and STIs using a consultative process. The SANAC Board of Trustees, together with SANAC stakeholders, approved the M&E plan. Implementation of the M&E plan was in progress during the MTR process.

The SI Unit needs to facilitate the costing of the M&E plan to enhance effective implementation. Similarly, seconded Provincial M&E Officers from nine provinces developed M&E Plans for the PIPs. The M&E plans for the PIPs are waiting for approval and costing. Additionally, the SI Unit participated

in the development of the Implementation Plan and M&E Framework for the Comprehensive Sexuality Education (CSE) pilot project implemented in Mpumalanga Province from October to December 2018. The CSE Project was for reporting to the East Southern Africa (ESA) commitments.

Data collection, collation, analysis and reporting

The SI Unit is responsible for the collection, collation, analysis and reporting of data in line with the progress of the implementation of the NSP against set targets. The SI Unit collects secondary data from multi-sectoral implementers responding to the epidemic. The SI Unit reported data at national, regional and global levels. Reported data included data from the private sector (registered medical schemes).

The Provincial M&E Officers compiled Quarterly Factsheets per each of the eight provinces for the periods: April to June 2018, July to September 2018, October to December 2018 & January to March 2019. There were no Quarterly Factsheets for Gauteng Province due to staff shortages. The seconded M&E Officers also compiled eight Annual Progress Reports (2017/2018) for the PIPs for HIV, TB and STIs 2017-2022. Similarly, there was no Annual Progress Report for Gauteng Province.

Monitoring and evaluation system for the NSP for HIV, TB and STIs 2017-2022

The Global Fund, together with the SI Unit, developed the Focus for Impact (FFI) platform, which incorporates geospatial maps and analytics to monitor and depict the progress of the NSP against set targets. The functionality of FFI works beyond just projecting geospatial information as it can also perform analytics.

During the period of the MTR, the SI Unit was in the process of redefining the FFI into a Situation Room. The Situation Room is an interactive software platform which enables government and other authorities to use the HIV data sets effectively (e.g. epidemiological, service delivery, logistic information, community data) in real-time for decision-making.

TABLE 41: KEY ACHIEVEMENTS BY SUB-OBJECTIVE

KEY ACHIEVEMENTS BY SUB-OBJECTIVE	
Sub-Objective 8.2.1	Strengthen and promote multi-sectoral ownership and accountability of NSP and PIP M&E systems
	<ul style="list-style-type: none"> • The SI Unit managed to coordinate the use of a core set of multi-sectoral indicators for the M&E plans, as evidenced by the compilation of Annual Progress Reports and Quarterly Factsheets for the NSP and the PIPs, Global AIDS Monitoring and Regional Reporting. • Development of the FFI Platform, which served as the EIS for the NSP and redefining the FFI into a Situation Room, as described above.
Sub-Objective 8.2.2	Strengthen M&E capacity to effectively use available data to monitor NSP and PIP performance and HIV, TB and STI at all levels
	<p><i>Conduct M&E assessments at the provincial level</i></p> <ul style="list-style-type: none"> • The SI Unit coordinated the Community Based Information System (CBIS) preliminary assessment with JSI/Palladium and Mpumalanga AIDS council, during the period April to June 2018. • The aim of the joint JSI/Palladium and SANAC venture was to understand the data systems that exist at the different levels and the designing of the systems. • The assessment also sought to understand the comprehensive management of data at the different levels, and whether weather data collected and reported on informs information management. <p><i>Strengthen skilled M&E human resources through training and coaching</i></p> <ul style="list-style-type: none"> • The SI Unit organised a capacity enhancement workshop from 16-20 October 2017. • The overall goal of the workshop was to strengthen the proficiency in analysing, reporting and data interpretation, including peer-to-peer learning. The objectives of the workshop were as follows: <ul style="list-style-type: none"> o To discuss and create a platform for peer-to-peer learning and sharing o To discuss issues relating to reporting requirements and expectations o To share private sector data; to enhance data analysis skills, including data use and demand o To train M&E Unit personnel on Focus for Impact for improved reporting and to review data quality issues concepts and principles. • Two SI Unit personnel attended a UNAIDS workshop on data use to improve KP programming on 13-17 November 2017. The workshop focused on the following topics: <ul style="list-style-type: none"> o Programmatic mapping for key populations o Population size estimates for key populations: Direct estimates versus extrapolation. o Target setting for key populations o Performance monitoring using a routine monitoring system o Performance monitoring using survey-based data sources • All SI Unit members attended a report-writing workshop from 5 to 9 March 2018. <p><i>Reinforce data use to monitor programme performance</i></p> <ul style="list-style-type: none"> • The SI Unit compiled quarterly factsheets to monitor the performance of the NSPs against set targets.

KEY ACHIEVEMENTS BY SUB-OBJECTIVE

Sub-Objective 8.2.3	Ensure harmonised, timely and comprehensive routine systems to provide quality health data at national, provincial and district levels and across sectors
	<p><i>Determine baseline values of key NSP indicators at national, provincial and district levels</i></p> <ul style="list-style-type: none"> The SI Unit took the lead in providing technical assistance to determine baseline values of key indicators in the NSP, PIPs and MDIPs. <p><i>Institutionalise routine M&E supervision and data quality audits</i></p> <ul style="list-style-type: none"> The SI Unit convened meetings with PACs and DACs to provide feedback on data quality issues. <p><i>Promote the use of strategic information to inform policy and programming</i></p> <ul style="list-style-type: none"> The SI Unit reported HIV, TB and STIs data at national, regional (Southern Africa Development Community [SADC]) and global (UNAIDS Global Monitoring [GAM]) levels to inform policy and programming.
Sub-Objective 8.2.4	Disseminate timely, relevant HIV, TB and STI information to the public
	<p><i>Ensure timely dissemination of accurate progress reports</i></p> <ul style="list-style-type: none"> The SI Unit compiled quarterly factsheets to track the progress of the implementation of the NSP for HIV, TB and STIs 2017-2022, as of the period October to December 2017.
Sub-Objective 8.2.5	Generate and disseminate NSP Monitoring and Evaluation Reports
	<p><i>Timely review of PIP and NSP implementation for multi-sectoral stakeholder review</i></p> <ul style="list-style-type: none"> The SI Unit facilitated the timely mid-term review of the NSP, including conducting focus group discussions and interviews at provincial levels.

Gaps and challenges

This NSP MTR revealed the following gaps and challenges:

- Lack of costed M&E Plans which should have been done to allow for adequate funding of the SI unit for NSP M&E activities
- Timely access to data for monitoring the progress of the NSP
- No standardised fully functional national data capturing system
- Delays in the finalisation and formation of the National and Provincial Technical Task Teams (TTTs) to coordinate the M&E Plans
- Lack of a coordinated platform for reporting key populations data
- Alignment of the terminology of NSP indicators with department indicators

Recommendations

Based on the above-cited gaps and challenges to rigorously monitor and evaluate the implementation and outcomes of

the NSP, the SI Unit can consider implementing the following recommendations:

- Expediting the costing of the M&E Plans to ensure effective implementation at all levels.
- Facilitating data sharing agreements with implementing partners to enable the extraction, transforming and loading of data from the implementing partners' existing M&E systems into the SANAC data repository system. This will ensure timely analysis and reporting of the progress of the NSP to inform policy and programming.
- Mapping implementing partners at all levels to improve linkage to services and minimise duplication of efforts.
- Expediting the establishment of National and Provincial Technical Task Teams (TTTs) to coordinate the M&E Plans.
- Expediting a collaborative platform for reporting key populations data to depict performance against set targets.
- Conducting an indicator mapping initiative to align NSP terminology of indicators with department indicators

Objective 8.3: Further develop the national surveillance system to generate periodic estimates of HIV, TB and STI in the general population and in key and vulnerable populations

Overview and key policy issues

Global Agenda 2030, also known as Sustainable Development Goals (SDGs) aim at transforming the world positively. All United Nations Member States adopted the SDGs in 2015. SDG 3 focuses on ensuring healthy lives and promoting well-being at all ages, as follows: by 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.

SDGs also prioritise data, monitoring and accountability as follows:

- Enhance capacity-building support to developing countries, including for least developed countries and Small Island developing States by 2020.
- Significantly increase the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographic location and other characteristics relevant in national contexts, by 2020.
- Build on existing initiatives to develop measurements of

progress on sustainable development that complement gross domestic product, and support statistical capacity-building in developing countries, by 2030

The focus of the SDGs aligns with the NSP for HIV, TB and STIs 2017-2022 in terms of data, monitoring and accountability to end the AIDS epidemic by 2030

Key achievements

The SI Unit convened several meetings for the approval and dissemination of integrated bio-behavioural survey results and population size estimates for key populations (SW, MSM, PWID and TG). The Center for Disease Control and Prevention (CDC) funded the surveys, and the University of San Francisco-California (UCSF) conducted the studies.

SANAC and implementing partners, including the National DOH, approved the population size estimates, including HIV prevention and HIV treatment cascades for the KPs.

The SI Unit also participated in the development of the NSWP for HIV, TB and STI 2019-2022. The NSWP includes core indicators to monitor Sex Worker Programmes and to guide national surveillance on sex worker programmes.

TABLE 42: KEY ACHIEVEMENTS BY SUB-OBJECTIVE

KEY ACHIEVEMENTS BY SUB-OBJECTIVE	
Sub-Objective 8.3.1	Institutionalise HIV, TB and STI surveillance within the Department of Health
	<ul style="list-style-type: none"> • No key achievements noted since the SI unit did not have a research agenda
Sub-Objective 8.3.2	Conduct routine HIV, TB and STI surveillance activities
	<p><i>Determine the surveys on health and social systems quality to undertake regularly to inform policy and practice</i></p> <ul style="list-style-type: none"> • HIV epidemic drivers in South Africa: A model-based evaluation of factors accounting for inter-provincial differences in HIV prevalence and incidence trends, (Johnson LF, Dorrington RE, Moolla H. HIV epidemic drivers in South Africa: A model-based evaluation of factors accounting for inter-provincial differences in HIV prevalence and incidence trends. S Afr J HIV Med. 2017) • The Fifth South African National HIV prevalence, incidence, behaviour and communication survey, 2017 (SABSSM V), HSRC
Sub-Objective 8.3.3	Conduct routine HIV, TB and STI surveillance activities among key and vulnerable populations
	<p><i>Conduct Integrated bio-behavioural surveillance and population size estimation, with separate studies for SWs, MSM, PWID, transgender and other vulnerable populations</i></p> <ul style="list-style-type: none"> • The Center for Disease Control and Prevention (CDC) funded the surveys, and the University of San Francisco-California (UCSF) conducted the studies.

KEY ACHIEVEMENTS BY SUB-OBJECTIVE	
Sub-Objective 8.3.4	Implement facility and laboratory-based surveillance
Sub-Objective 8.3.5	<p><i>Prioritise the sentinel surveillance activities</i></p> <ul style="list-style-type: none"> Laboratory-Based Hepatitis C surveillance for South Africa, 2017, Morubula Manamela, 1 Nishi Prabdial-Sing, 1, 3 Melinda Suchard1, 2 1. Centre for Vaccines & Immunology, NICD 2. Chemical Pathology, School of Pathology, Faculty of Health Sciences, University of the Witwatersrand 3. Division of Virology and Communicable Diseases Surveillance, School of Pathology, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa, Volume 17, Issue 1
Sub-Objective 8.3.6	Implement non-routine surveillance activities and surveys
	<p><i>Patient care and patient satisfaction surveys</i></p> <ul style="list-style-type: none"> Evaluating patient satisfaction with primary care consultations in the Helderberg sub-district of South Africa. Stellenbosch University https://scholar.sun.ac.za

Gaps and challenges

The following gaps and challenges were evident under sub-objective 8.3 of the NSP for HIV, TB and STIs 2017-2022:

- Absence of a 5-year NSP HIV, TB and STI research agenda - The major challenge faced by the SI Unit was the non-development of the national surveillance system to generate periodic estimates of HIV, TB and STI in the general population and in key and vulnerable populations.
- Lack of coordination of surveillance activities among research institutions and other relevant stakeholders.
- Lack of synthesised data from multiple surveillance data sources
- Lack of a coordinated surveillance system to identify and fill gaps in surveillance

Recommendations

The SI Unit needs to consider the following recommendations to ensure an effective national surveillance system to generate periodic estimates of HIV, TB and STI in the general population and key and vulnerable populations:

- Prioritise the development and adoption of 5-year NSP HIV, TB and STI research agenda
- Coordinate the strengthening of capacity for surveillance among partners
- Conduct periodic reviews of surveillance activities to identify and fill gaps
- Reinforce the coordination of surveillance with research institutions and other stakeholders
- Synthesise data from multiple surveillance sources

- Establish a research TTT to coordinate all surveillance activities.

Objective 8.4: Strengthen strategic research activities to create validated evidence for innovation, improved efficiency and enhanced impact

Overview and key policy issues

Key policy issues for strengthening strategic information to drive progress towards the achievement of NSP goals are aligned with national priorities, including regional and global commitments as explained in the objectives above.

Key achievements

SANAC shared key populations HIV prevention and treatment cascades, including reporting key populations size estimates on the Global AIDS online monitoring tool.

TABLE 43: KEY ACHIEVEMENTS BY SUB-OBJECTIVE

KEY ACHIEVEMENTS BY SUB-OBJECTIVE	
Sub-Objective 8.4.1	Develop a coordinated research agenda for the NSP
	<p><i>Share research evidence and emerging best practice to strengthen policy and practice</i></p> <ul style="list-style-type: none"> • SI Unit shared KPs surveillance results with relevant stakeholders and reported key population size estimates on the GAM as well as regionally on the prevention scorecard. • SI Unit also coordinated the collection of responses for the National Commitments and Policy Instrument (NCPI) from the national authorities and the civil society and reported the responses on the GAM, including the NCPI narrative report. • The NCPI aims to measure progress in developing and implementing policies, strategies and laws related to the HIV response.

Gaps and challenges

- The MTR of the NSP for HIV, TB and STIs noted the following gaps and challenges in line with strengthening strategic research activities to create validated evidence for innovation, improved efficiency and enhanced impact:
- Lack of coordination by surveying existing research projects and then identifying and prioritising research gaps and plan how to fill them
- Lack of coordination in strengthening local research capacity and further creating an enabling environment to conduct research in South Africa

Recommendations

- The SI Unit needs to consider the following recommendations to strengthen strategic research activities to create validated evidence for innovation, improved efficiency and enhanced impact:
- Prioritise the development of a coordinated of 5-year NSP HIV, TB and STI research agenda
- Establish a research TTT to coordinate all surveillance activities.
- Facilitate the creation of an enabling environment to conduct research in South Africa
- Coordinate the strengthening of local research capacity
- Collating researches in the country and get a database for SA on HIV, TB and STI research

CRITICAL ENABLERS

INDICATOR	BASELINE (2016/2017)	TARGET (2018/19)	ACTUAL (2018/19)
1. Percentage of individuals who correctly identify risks of HIV, STI and TB transmission and how to prevent them and reject major misconceptions about HIV, STI and TB	26,8% (HSRC 2012)	TBD	36,3% (HSRC 2019)
2. Percentage of men and women aged 15 years and older who report condom use at last sexual intercourse with the most recent sexual partner	Total: 36,2% Males 38,6% Females 33,6% Youth 15-24: 58,4% (HSRC 2012)	TBD	Total: 38,9% Males 41,3% Females 36,2% Youth 15- 24: 58,8% (HSRC 2019)
3. Percentage of women and men aged 15-24 years who had sexual intercourse with more than one partner in the last 12 months	12,6% (HSRC 2012)	12,6%	17,4% Males 25,5% Females 9% (HSRC 2019)
4. Percentage of people reached by prevention communication at least twice a year	82% (NCS)	TBD	
5. Percentage of organisation with HIV, TB and STI workplace policies and programs	Government Departments: 68% of 161 (2016/17) (DPSA EHW Report) 30%	90% (20% increase in departments with annual operational plans) 45%	

SUMMARY

NSP MTR FINDINGS

National Strategic Plan for HIV, TB and STIs (NSP) 2017-2022 Mid Term Review (MTR) was an in-depth analysis of the NSP implementation, with the aim to illustrate progress made towards reaching the NSP targets across the 8 NSP goals. The review, which was conducted in 2019, focused on the first half of the NSP term (2017 to 2019) and documented emerging issues and opportunities, lessons learnt, gaps and challenges encountered. The MTR findings will:

- Inform targeted implementation of the NSP for the remaining period ending March 2022.
- Provide recommendations for enhanced performance towards achievement of the NSP targets by the end of the NSP term.

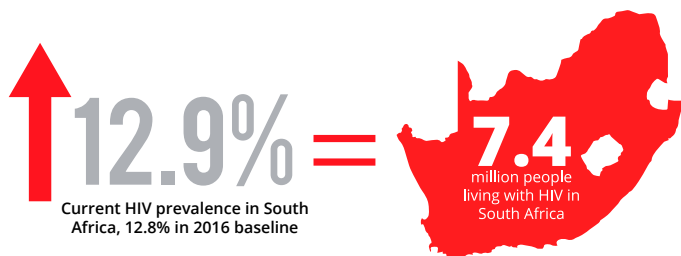
The review synthesised evidence from primary data, collected through key informant interviews at national and provincial levels, and desk review of secondary data from diverse sources. SANAC MTR Reference Group, Strategic Information Technical Task Team, Civil Society, and other stakeholders were instrumental to ensuring high-quality review and validation of findings.

The MTR included findings at national, provincial and district levels. More details about the NSP 2017-2022 MTR can be found in the full MTR report.

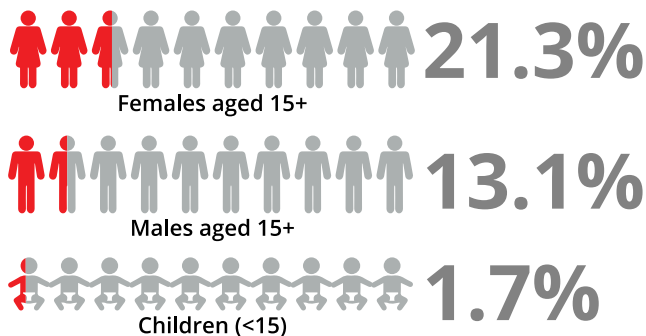
indicators to monitor Sex Worker Programmes and to guide national surveillance on sex worker programmes.

STATUS OF THE EPIDEMIC IN SOUTH AFRICA

HIV PREVALENCE 2018

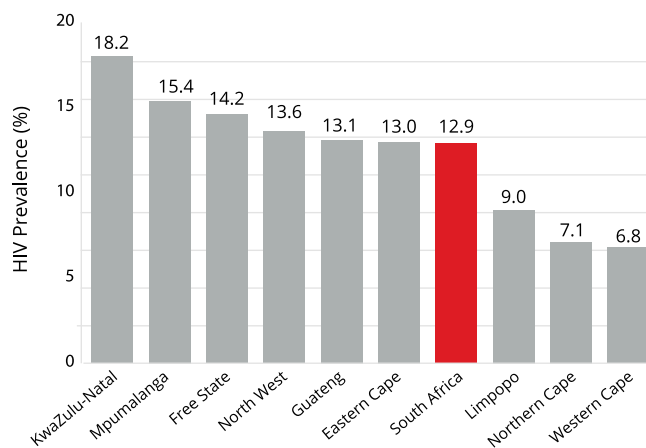


HIV PREVALENCE BY SEX AND AGE



Source: Thembisa, 2018¹

HIV PREVALENCE BY PROVINCE



Source: Thembisa, 2018¹

Data from cross-sectional surveys and estimation models show that the prevalence of HIV in South Africa has continued to increase in the past decade to the current year. The current prevalence of 12.9% for the general population translates to 7.4 million people living with HIV (PLHIV) in South Africa.

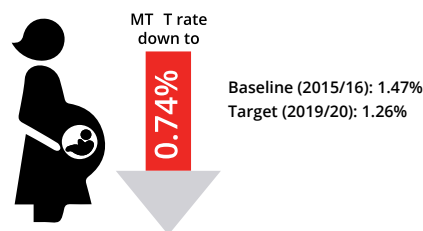
This increase can be attributed to the country's HIV treatment programme which has expanded over the years and translated to decreased HIV-related deaths and increased life expectancy. There is significant variation in the overall HIV prevalence by province, ranging from 6.8% in Western Cape Province to 18.2% in KwaZulu-Natal Province.

Six provinces have HIV prevalence higher than the country's overall level of 12.9%. The HIV prevalence remains significantly higher among females.

PROGRESS MADE TOWARDS NSP GOALS

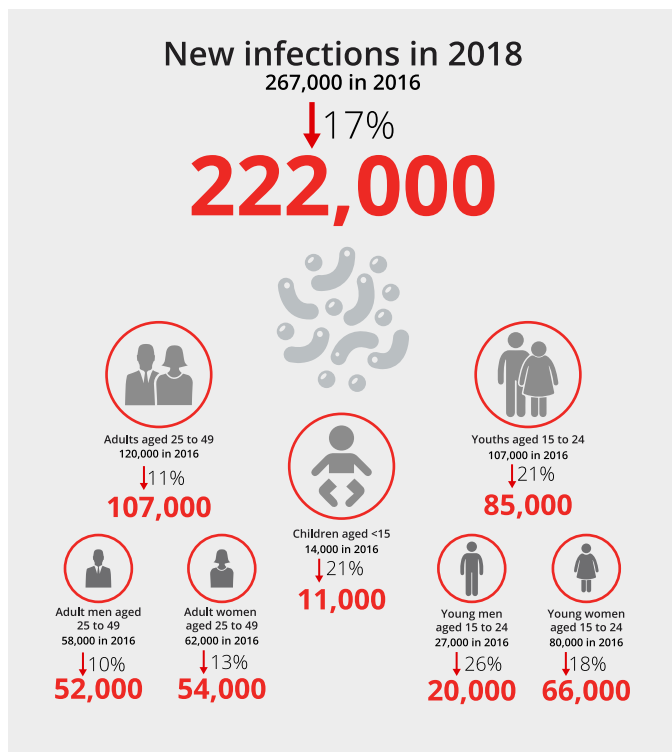
GOAL 1: ACCELERATE PREVENTION TO REDUCE NEW HIV AND TB INFECTIONS AND NEW STIS

MOTHER-TO-CHILD TRANSMISSION (MTCT) RATE AT 10 WEEKS



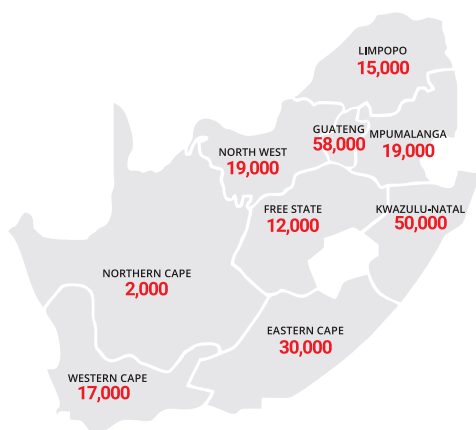
Source: NDoH^{2,3}

NEW HIV INFECTIONS: TOTAL; BY SEX AND AGE



Source: Thembisa, 2018¹

NEW HIV INFECTIONS BY PROVINCE

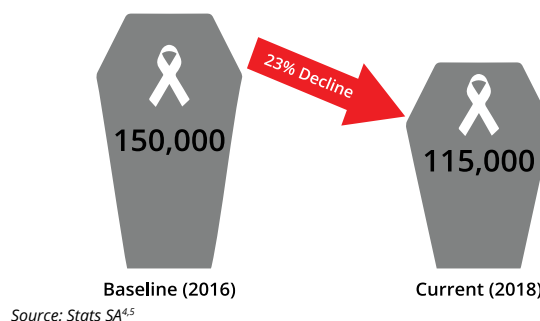


PREVENTION PROGRAMMES

INDICATOR	TARGET	2018/19
Number of MMC performed	600,000	594 970 (99%)
Number of people tested for HIV	10 million	14.8 million (148%)
Number of male condoms distributed	850 million	726 million (85%)
Number of female condoms distributed	40 million	17.7 million (44%)
Number of AGYW, FSW, MSM, IDU receiving oral PrEP for the first time during the reporting period	18,215	21,063 (115%)
Percentage of women accessing ANC services who were tested for syphilis	80%	96.7%
Number of learners reached through combination prevention interventions aimed at retention of learners in schools	86,250	89,043

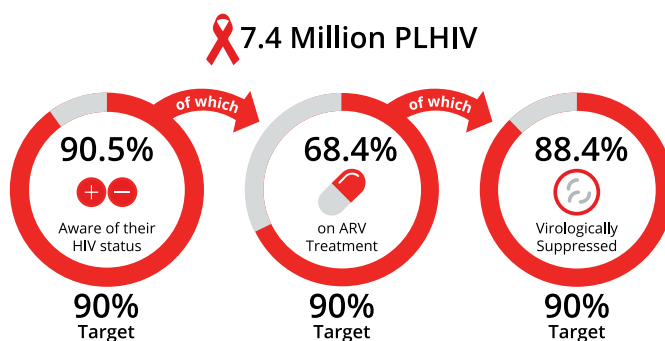
GOAL 2: REDUCE MORBIDITY AND MORTALITY BY PROVIDING TREATMENT, CARE AND ADHERENCE SUPPORT FOR ALL

AIDS-RELATED DEATHS

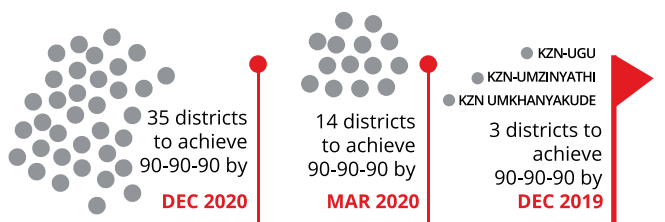


Source: Stats SA^{4,5}

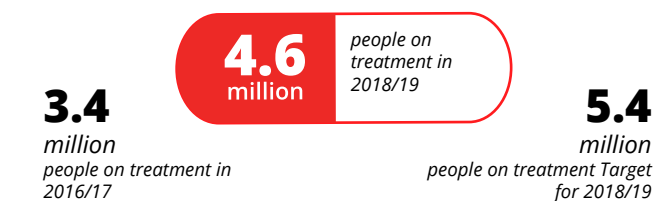
PROGRESS TOWARDS 90-90-90



FRONT-RUNNER DISTRICTS TOWARDS 90-90-90



PLHIV ON ANTIRETROVIRAL TREATMENT



Source: Thembisa, 2018¹

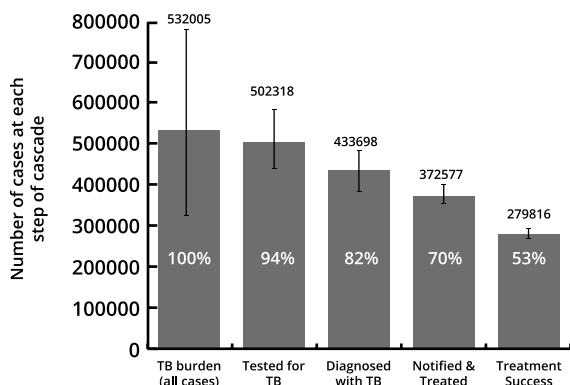
The good news is that the number of new infections is declining overall and in all subgroups. However, the rate of decline has not been sufficient to meet set targets. Also, MTCT rate at 10 weeks is now much below 1%, at 0.74%. Female condom distribution is suboptimal - 44% of NSP target. Although the 2018/19 target set for PrEP has been exceeded, the target is low and PrEP uptake remains suboptimal – oral PrEP uptake across all PrEP implementing sites is about 29%.

TB PERFORMANCE

Indicator	Baseline 2016/2017	Target 2018/19	Actual 2018/19
TB incidence	834/100 000 (7)	700/100 000 16% reduction by 2019	520/100 000 38% reduction from baseline (8)
TB mortality	46/100 000 (7)	28% reduction	37/100 000 (HIV-) 73/100 000 (HIV+) (8)
TB death rate	4.4%	4.65%	6.5% (6)
Proportion of TB/ HIV co-infected patients on ART	87.5% (2)	90%	87% (8)

Source: NDoH; ETR, 2019; Global TB reports^{7,8}

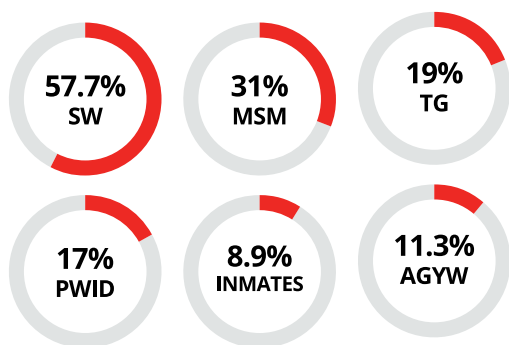
TB 90-90-90



Source: Naidoo et al, 2017⁹

GOAL 3: REACH ALL KEY AND VULNERABLE POPULATIONS WITH CUSTOMISED AND TARGETED INTERVENTIONS

HIV PREVALENCE AMONG SPECIFIC KEY POPULATIONS



OTHER INDICATORS AMONG SPECIFIC KEY POPULATIONS

Indicator	WM	SM	INMATES
Condom use	86.1% (11)	97.9%	
1st 90	82% (10)	41% (10)	90% (11)
2nd 90	48% (10)	28.1% (10)	98.8% (11)
3rd 90	No Data	26.5% (10)	No Data

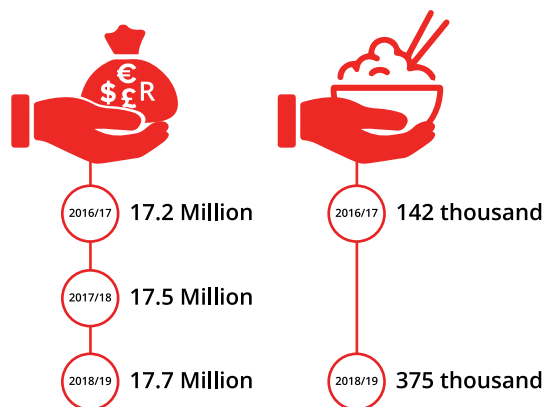
Source: IBBS, 2018¹⁰; GAM, 2018¹¹

HIV key populations in South Africa are far from achieving the 90-90-90 target. Progress towards 90-90-90 targets for key populations remains hindered by persistent barriers, such as

stigma (including self-stigma), discrimination, and punitive legal and policy environments. The scarcity of data on key populations remains a big hurdle in turning the tide on the HIV epidemic in key populations.

GOAL 4: ADDRESS THE SOCIAL AND STRUCTURAL DRIVERS OF HIV, TB AND STIS, AND LINK THESE EFFORTS TO THE NATIONAL DEVELOPMENT PLAN (NDP)

NUMBER OF BENEFICIARIES RECEIVING SOCIAL GRANTS 2016/17 - 2018/19 AND NUMBER OF PEOPLE ACCESSING FOOD THROUGH COMMUNITY NUTRITION AND DEVELOPMENT CENTRES (BASELINE AND 2018/19)

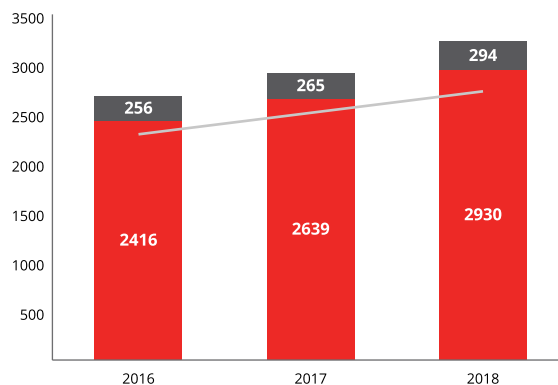


Number of beneficiaries receiving social grants

Number of people accessing food

Source: SASSA^{12,13}; DSD^{14,15}

TRENDS IN THE NUMBER OF FEMICIDES IN SOUTH AFRICA, 2016 TO 2018



Number of femicides in girls (Less than 18 years)
Number of femicides in Women (18 years and above)
Trendline of femicides in Women (18 years and above)

Source: GAM, 2018¹¹

PERCENTAGE OF BENEFICIARIES RECEIVING SOCIAL BEHAVIOUR CHANGE PROGRAMMES

16.8%
High exposure

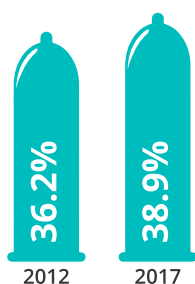


46.6%
Low to moderate exposure

The progress seen in biomedical interventions is yet to be seen in the social and structural drivers of HIV, STIs and TB in South Africa. Age-disparate sexual relationships showed upward trend in females aged 15 – 19 years from 18.5% in 2005 to 35.8% in 2017. There were also increases in GBV and IPV especially amongst females as compared to their male counterparts. The percentage of beneficiaries receiving social and behavioural change communication (SBCC) interventions remains low, as is the participation of parents/care givers in SBCC targeted interventions.

CRITICAL ENABLERS

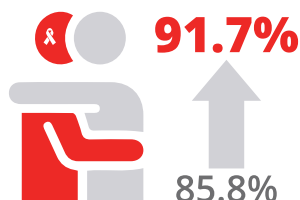
PERCENTAGE OF MEN AND WOMEN AGED 15 YEARS AND OLDER WHO REPORT CONDOM USE AT LAST SEXUAL INTERCOURSE WITH MOST RECENT SEXUAL PARTNER



Source: SABSSM IV & V^{16,17}

GOAL 5: GROUND THE RESPONSE TO HIV, TB AND STIS IN HUMAN RIGHTS PRINCIPLES AND APPROACHES

PERCENTAGE OF POPULATION EXPRESSING ACCEPTING ATTITUDES TOWARDS PEOPLE LIVING WITH HIV AND/OR TB



Source: SABSSM V¹⁷

GOAL 6: PROMOTE LEADERSHIP AND SHARED ACCOUNTABILITY FOR A SUSTAINABLE RESPONSE TO HIV, TB AND STIS

SANAC ACCOUNTABILITY PERFORMANCE SCORE



SANAC Accountability Framework and Scorecard developed in 2018/19 - Yet to be implemented

NUMBER OF PREMIERS AND MAYORS WHO CHAIR AIDS COUNCILS



PREMIERS
67%
PCAs
Target: 100%

MAYORS
62%
DACs
Target: 100%

GOAL 7: MOBILISE RESOURCES AND MAXIMIZES EFFICIENCIES TO SUPPORT THE ACHIEVEMENT OF NSP GOALS AND ENSURE A SUSTAINABLE RESPONSE

TOTAL EXPENDITURE ON HIV, TB AND STIS



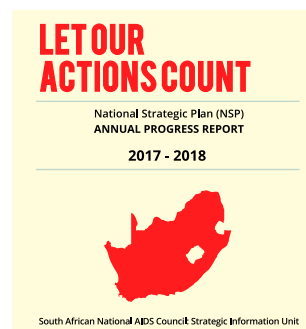
R28.8
billion
HIV expenditure
in 2018

TOTAL BUDGET FROM SOURCES OTHER THAN THE GOVERNMENT



GOAL 8: STRENGTHEN STRATEGIC INFORMATION TO DRIVE PROGRESS TOWARDS ACHIEVEMENT OF THE NSP GOALS

NUMBER OF PROVINCES AND DISTRICTS WITH ANNUAL HIV, TB AND STI PROFILES/IMPLEMENTATION PLANS /QUARTERLY REPORTS/ANNUAL



GOAL 5

PLHIV still experience stigma and discrimination including during the reporting of violations. The poor and vulnerable persons still struggle to access quality legal services to protect and defend their rights.

GOAL 6

PCA/DAC functionality levels vary across all SANAC sub-national structures. Although the lack of representation of some sectors in DACs and LACs contradicts the purpose for the establishment of AIDS Councils. Furthermore, voluntary membership thus lack of sustained commitment leading to inadequate sector representation. The absence of clear budget allocations for most PCAs thereby compromising the sustainability of PCAs e.g. M&E post not funded.

GOAL 7

South Africa funds three quarters of total HIV expenditure.

And there has been a doubling of annual TB expenditure, with a goal of reducing TB deaths by 87% over 20 years. It is commendable that SA appears to be achieving allocative efficiency at national level i.e. spending on mostly priority interventions with proven cost-effectiveness. The downward trend in overall donor funding for HIV and TB is a concern.

GOAL 8

SANAC developed the M&E Plan for the NSP and compiled Annual Progress Reports for the NSP and the Provincial Implementation Plans (PIPs).

SUMMARY

NSP RECOMMENDATIONS AND NEXT STEPS

This MTR report has documented the achievements that have been realised during the first half of the implementation of the NSP (2017-2022). Some challenges have been noted regarding the achievement of the NSP targets nationally and in different provinces.

This section provides some recommendations that should be considered towards achieving the goals and objectives of the NSP and their associated targets. Considerations are also made in terms of the necessary steps for the implementation of the NSP activities in the rest of the period.

The presentation of the recommendations is by the eight goals of the NSP.

Goal 1: ACCELERATE PREVENTION TO REDUCE NEW HIV AND TB INFECTIONS AND STIS

- Promote the implementation of evidence-based strategies to improve HTS yield, e.g. assisted partner notification services in all public health facilities.
- Implement strategies to create demand for and expand the provision of PrEP to improve PrEP uptake among HIV negative individuals at substantial risk of HIV infection. Expand coverage to all youth at substantial risk (not AGYW only)
- Address the challenges encountered with condoms supply chain management systems, including considerations for a decentralised procurement system.
- Integrate public and private sector reporting on VMMC and condom distribution.
- Institutionalize the implementation of the UTT policy to ensure all HIV positive individuals are initiated on ART, remain on treatment, and are virally suppressed to prevent onward HIV transmission.
- Reinstate or revise the indicator “number of household contacts screened for TB” in the National Indicator Dataset (NIDS) and facilitate reporting in the DHIS.
- Implement the national TB prevalence survey recommendation to address TB prevention and control gaps identified.

GOAL 2: REDUCE MORBIDITY AND MORTALITY BY PROVIDING TREATMENT, CARE AND ADHERENCE SUPPORT FOR ALL

- Support provinces to determine the root causes of their respective challenges in initiating individuals who test HIV positive patients on ART, and ensure provinces have the resources to address the gaps or areas of improvement identified.
- Facilitate the use of data to inform province-specific technical support required and support provinces to develop and implement individualised improvement

plans. For example, support the North West to improve performance towards achieving the 2nd and 3rd 90s whilst Northern Cape, and Limpopo are supported to reach the 1st 90.

- Increase demand for viral load testing at the individual and community level by supporting CBOs to educate people about the importance of viral suppression in the prevention of onward HIV transmission.
- To improve TB treatment coverage, augment intensive case finding for the missing TB cases as well as asymptomatic TB cases.
- Strengthen community-based support for TB patients to reduce lost-to-follow-up and TB death rates as observed in provinces like North West.
- Review/ revise the NSP STI indicators and targets and establish a comprehensive national STI reporting and monitoring framework to enable optimal tracking and management of the STI burden.

GOAL 3: REACH ALL KEY AND VULNERABLE POPULATIONS WITH CUSTOMISED AND TARGETED INTERVENTIONS

- For any KP HIV service delivery model to succeed, KP constituency engagement, leadership and support for model design, implementation, and monitoring is essential
- Strengthen the capacity of community health workers to implement community-level interventions and ensure appropriate linkages between community-based and health care facility-based KP services.
- There is a need to develop a differentiated approach to supporting KP access to HIV, TB and STI services. This should be based on identified gaps as the data shows disproportionate access to testing, treatment, and viral load services by different types of KPs
- Review and implement the recommendations of the South African Law Reform Commission report to move forward the conversation of law reform on sex work.

GOAL 4: ADDRESS THE SOCIAL AND STRUCTURAL DRIVERS OF HIV, TB AND STIs, AND LINK THESE EFFORTS TO THE NATIONAL DEVELOPMENT PLAN (NDP)

- There is a need to appoint champions at provincial and district level to promote continued stakeholder buy-in and promote collaboration in implementing the ‘She Conquers’ campaign agenda
- Strengthening of coordination using champions would also result in stronger resource mobilization to fund and sustain the campaign
- NPOs should use the focus for impact approach to ensure that they reach the appropriate KPs to ensure impact
- Strengthen interventions that target knowledge, beliefs

and attitudes of community members to eliminate the culture of silence around GBV and minimize attitudes and beliefs that promote the perpetuation of GBV

- Systematic and rigorous training for law enforcement agents who specialize in gender-based violence. The capacity building initiatives should target change in cultural beliefs of officers who sometimes get influence from the culture of silence which characterize the society they are also coming from
- Conduct an evaluation that assesses the efficacy of socio-structural interventions in building and strengthening resilience to HIV, TB and STIs at community and individual level. Such an evaluation should be able to identify key intervention pathways using a population and geographic focus for impact approach

GOAL 5: GROUND THE RESPONSE TO HIV, TB AND STIs IN HUMAN RIGHTS PRINCIPLES AND APPROACHES

- Develop and implement interventions that increase the visibility of human rights services across the provinces
- Educate users on the available human rights services close to them and how they can access and use them. This may include standard operating procedures for handling issues such as stigma and discrimination in health facilities
- Strengthen the capacity of PCA to be able to identify human rights activities that directly impact of access to, uptake and utilisation of HIV, TB and STI services

GOAL 6: PROMOTE LEADERSHIP AND SHARED ACCOUNTABILITY FOR A SUSTAINABLE RESPONSE TO HIV, TB AND STIS

- Organise a consultative meeting of Mayors, OTPs and the national level leadership to rejuvenate and strengthen political support for operationalising the AIDS Council activities at a local level
- SANAC should facilitate the process of building the capacity of PCAs, DACs and LACs to ensure effective coordination of the multi-sectoral response to HIV, TB and STI at the local level, and help to address the weak relations between sectors
- Include regular reporting by political leaders on specific key performance areas such as chairing council meetings to enforce compliance for political leadership at the local level
- Implement the Private Sector Strategy so that the private sector can be held accountable for achieving targets in the NSP, through reaching small and medium enterprises

GOAL 7: MOBILIZE RESOURCES TO SUPPORT THE ACHIEVEMENT OF NSP GOALS AND ENSURE A SUSTAINABLE RESPONSE

- As the country moves towards total epidemic control, the

remaining challenge will require investment into the socio-structural aspects of HIV, TB and STI programming. SANAC and its stakeholders need to ensure a balance between a focus on medical and non-medical interventions in terms of resource allocation.

- Develop a financial model or financial sustainability framework that identifies how the HIV, TB and STIs response can be financed locally. This is particularly in the context of declining donor funding and for provinces such as the Northern Cape where donors are moving out quicker, citing relatively low HIV burden. Such provinces can be used as test cases for the piloting of the financing model.

GOAL 8: STRENGTHEN STRATEGIC INFORMATION TO DRIVE PROGRESS TOWARDS ACHIEVEMENT OF NSP GOALS

- Provide additional human resources and skills support for the development of activity-based costing of M&E plans across all provinces
- Strengthen M&E capacity by ensuring the availability of data through a central repository for monitoring of the response at district and ward levels
- Prioritise the development and adoption of 5-year NSP HIV, TB and STI research agenda
- Provincial evaluations of MDIPs and development of plans of action based on identified 90-90-90 gaps. This will also feed into ideas for the next NSP starting from information gathered at the district level
- Facilitating data sharing agreements with implementing partners to enable the extraction, transforming, and loading of data from the implementing partners' existing M&E systems into the SANAC data repository system
- Develop and operationalise a central data repository with interoperability capacity with other already existing systems to regularly monitor the response at a lower level
- Revise the targets for all the indicators at the provincial level as a way of strategizing towards meeting the 2022 NSP targets.

CONCLUSION

The overarching goal of this midterm review (MTR) of the NSP 2017-2022 was to conduct an in-depth analysis of the NSP implementation, with a specific focus on progress made towards achieving the targets set for each of the eight goals. The review was intended to illustrate emerging issues and opportunities, lessons learned, gaps and challenges encountered during the implementation of the first half (2017/18-2018/19) of the NSP term.

A mixed-methods approach was used to collect both quantitative and qualitative data using document reviews, key informant interviews, secondary data analysis and consultative and validation meetings with stakeholders.

The findings of the MTR reaffirm the political and organisational commitment that South Africa has towards ending the HIV, TB and STIs epidemics by 2030. Many achievements were observed across the eight goals of the NSP and the objectives of this MTR. Equally, gaps and challenges were also observed that will require to be addressed during the second part of the current NSP to achieve the targets.

Important to note is the fact that while the number of new HIV infections has been declining with the current NSP period recording the fastest decline in percentage change terms if the current trend continues, the country will only be able to achieve 38% of incidence reduction against a target of 50%. This would mean that the country may still be experiencing about 170 000 new infections as opposed to targeted 100000 and less.

Data has shown that while the country is doing well in terms of identifying the positives, initiating them on treatment has remained a challenge. There is a need to investigate the challenges being encountered with this part of the response and develop appropriate interventions. It is important to note the provincial differentials in performance across the HIV and TB 90-90-90 targets.

This will need to be taken into consideration in the development of an action plan that can help the country to cover the gaps in achieving its targets towards epidemic control. Strengthening strategic information capacity, including the development and operationalisation of a research plan, will be important in the development of evidence-based interventions that can increase the impact potential towards closing the gap on targets.

The MTR also found that across all the provinces, the organisational strength lay mostly at the provincial level. The structures were found to be less and less functional at the district, local and ward level. This was mainly attributed to a lack of political commitment to lead the response by the leadership at that level.

As the response to HIV, TB and STIs happen at the lowest level of the public health system. The local level leadership is uniquely placed to champion the response at that level. It is therefore crucial that SANAC devise ways to strengthen the leadership of all stakeholders to effectively take charge and turn the situation around at community level.

As the country forges ahead with fast-tracking the achievement of the new UNAIDS 95-95-95 targets towards total control of the epidemic by 2030, the reality of the need to financially support the response from local resources is becoming apparent in the context of declining donor funding. This raises the need for the country to start developing financially sustainable models of financing the response.

The development and implementation of the model would benefit from the experiences of provinces such as the Northern Cape. They are already feeling the brunt of donor withdrawals based on having a relatively low burden. Some early experiences, lessons learned, and best practices will become handy in further refining the model based on the experiences of such provinces.

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