DRAFT 2

South African National Strategic Plan on HIV, TB and STIs 2017-2022

WORKING DRAFT FOR COMMENT

**** A NOTE FOR READERS****

This is a public working draft of the NSP for HIV, TB and STIs 2017-2022.
It has been developed under the guidance of the NSP Steering Committee taking into consideration
all the inputs from the sectoral and national Stakeholder Consultations.

NB: Please note that there are currently placeholders in the text for certain additions to be made. The final product will include engaging use of color, images, and user-friendly infographics.

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Introduction: South Africa's National Strategic Plan on HIV, TB and STIs 2017-2022

Comment [MI1]: REFERENCES TO BE FINALIZED

The diseases that the National Strategic Plan (NSP) for HIV, TB and STIs 2017-2022 addresses are among the most serious health and development threats that South Africa confronts. South Africa accounts for nearly one in five people living with HIV globally[1] [2]; tuberculosis (TB) is the nation's leading cause of death[3]; and 1.14 million new sexually transmitted infections (STIs) among adults aged 15 years and older were treated in the country's health facilities in 2015/16. In addition, the NSP will have an important impact on South Africa's burden of viral hepatitis, especially Hepatitis B (approximately 2.5 million chronic infections) and Hepatitis C (around 350 000 infections), both of which cause widespread liver disease and death.

Comment [MI2]: Insert citation:

NDoH. National Trends of STI 2015/16 Pretoria: National Departe\ment of Health; 2016.

The NSP outlines the strategic framework for a multi-sectoral partnership to accelerate progress in reducing the morbidity (illness) and mortality (death) associated with HIV, TB and STIs. The NSP serves as a framework to inform and guide national, provincial and local level stakeholders. At the provincial level, the NSP will be used to guide the development Provincial Implementation Plans, which will outline a blueprint for action to implement the NSP.

The NSP 2017-2022, which leverages lessons learned from public health gains made under the NSP 2012-2016, is the product of an extensive collaboration involving national, provincial and local governments; civil society; the private sector; academic experts; multilateral institutions; development partners and other stakeholders. Through the goals, objectives, targets and activities it outlines, the NSP expresses the collective vision of a nation that becomes healthier, stronger, more equitable, and better prepared to realize our goals as reflected in the National Development Plan.

1.1 Development of the NSP

Since 2000, a series of strategic plans have guided the national response to HIV, TB and STIs. The NSP 2000-2005 outlined the structures and mechanisms to support the national response[4]; the NSP 2007-2011 moved decisively to galvanize a massive expansion in the provision of antiretroviral therapy[5]; and the NSP 2012-2016 accelerated access to HIV treatment, called for the delivery of comprehensive HIV prevention services, prioritised action to ground the national response in human rights principles and ensorsed steps to address social and structural drivers of the three epidemics[6].

[Placeholder: infographic to show evolution of all NSPs, identifying unfinished business and challenges]

With the aim of building on progress achieved to date and of using the best available evidence to foster an even more effective national response, a broadly consultative, evidence-based process was undertaken to develop the fourth NSP, for 2017-2022. This process included:

- *A review of evidence:* The Secretariat of the South African National AIDS Council (SANAC), undertook a comprehensive review of progress made towards the goals and targets in the NSP 2012-2016.[7] [8] This review included an identification and analysis of progress as well as key gaps and challenges. The NSP also draws from the findings from the South African HIV and TB Investment Cases. These Investment Cases included an exhaustive review of the evidence base for HIV and TB interventions and used an

evidence-based model to project the long-term impact and costs associated with different combinations of interventions and financing scenarios.[9] Development of the NSP also took into account the latest global, regional and national evidence on effective strategies for responding to the three epidemics.

- *Steering Committee:* The Steering Committee for development of the NSP was co-chaired by Dr Nono Simelela, Office of the Deputy President, and Mabalane Mfundisi of the civil society forum. The committee included representatives of government, private sector, civil society, provinces and development partners who actively participated in leading the development of the NSP.The committee was supported by the SANAC secretariat staff.

- *Consultations:* The development of the NSP drew on extensive consultations with diverse stakeholders involved in the national response to HIV, TB and STIs. The consultation process was launched at the International AIDS Conference in Durban in July 2016. Sectoral consultations were held and in September 2016, a national multi-stakeholder consultation was held. A brief strategic overview document, "Let Our Actions Count," was launched by the Deputy President on World AIDS Day, 1 December 2016.[10] The consultation process was continued in early February 2017, and a draft NSP was produced and reviewed at a national consultation in February 2017.

- *Formal Endorsement:* The NSP has been endorsed by SANAC's Programme Review Committee, Plenary and SANAC Trust Board and by the national Cabinet.

1.2 The NSP Context: From Planning to Implementation

The NSP is informed by and situated within the broader development and human rights context. The NSP is closely aligned with the National Development Plan Vision 2030 (NDP), which acknowledges the profound effect that the HIV and TB epidemics have had in slowing national development. The NDP pledges to stop HIV infections and ensure an AIDS-free generation and to prevent TB and improve the cure rate of TB. The NSP specifically responds to the mandates in the Medium-Term Strategic Framework 2014-2019, including the call to strengthen health service delivery, increase life expectancy, reduce morbidity and mortality, enhance management of HIV and TB, and progressively improve TB prevention and cure. This includes the national "She Conquers" campaign which addresses both the HIV-specific and the social and structural challenges confronted by adolescent girls and young women. These and other crucial national and international health and social policies that underpin the NSP are listed in Box 1.

Box 1. Health and Social Policies and Strategies Encompassed in NSP 2017-2022

- NDOH Health Sector HIV Strategy (2016)
- National She Conquers Campaign for Girls and Young Women (2016-2019)
- National Sex Worker HIV Plan (2016-2019)
- National LGBTI HIV Framework (2017-2022)
- Roadmap to reducing HIV infections among PWID in South Africa (2017 and beyond)
- Framework and Strategy for Disability and Rehabilitation Services in South Africa, 2015-2020
- African Union Agenda 2063,
- Maseru Declaration 2003 (the basis for the SADC regional response to HIV)
- The Global End TB Strategy (2016-2020)
- The Global Health Sector Strategy on HIV (2016-2021)
- The Global Health Sector Strategy on Sexually Transmitted Infections (2016-2021)
- UN Political Declaration on HIV and AIDS (2016)
- UNAIDS Fast-Track strategy, Agenda 2030 (the Sustainable Development Goals)
- Eastern and Southern African Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people (2013)
- Convention on the Rights of the Child
- African Charter on the Rights and Welfare of the Child
- NDOH policy on occupational health for health care workers with respect to TB and HIV (2017)
- White Paper on the Rights of Persons with Disabilities
- Convention on the Rights of Persons with Disabilities
- Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection (2016)

Integrally linking the national response to HIV, TB and STIs with the broader development and human rights context maximizes the potential for sustainable structural change to effectively address the health and social determinants that fuel these epidemics. The integration of the response to HIV, TB and STIs within a wider social project is also consistent with the transition from the Millennium Development Goals to the Sustainable Development Goals, which emphasize the links between communicable diseases and other health and development challenges and the importance of pursuing a rights-based approach in development efforts.[18] The NSP will reinforce South Africa's efforts to combat closely related diseases such as Hepatitis B and C, as the models for HIV and TB prevention and treatment are highly relevant for Hepatitis, and screening and treatment for HIV (including the use of tenofovir-based regimens) will have a direct impact on the burden of Hepatitis B.

1.3 The NSP in Perspective: A strategic roadmap

This NSP is a high-level strategic roadmap that serves to guide a multi-stakeholder, multi-sector, accountable response to end HIV, STI and TB as public health threats in South Africa. As a strategic plan, it sets priority targets and highlights key activities, rather than providing guidance for programme implementation. Translating the NSP into measurable operational plans will be achieved through provincial and district implementation plans (PIPs and DIPs). Every sector, every government department, private stakeholders and development partners will contribute to the implementation of this NSP to ensure that its goals are achieved. Overall coordination of this response rests with the SANAC structures with the support of the SANAC secretariat.

1.4 NSP Vision

[PLACEHOLDER]

1.5 NSP Principles

The NSP for 2017-2022 is based on the same principles that have long characterised South Africa's response to HIV, TB and STIs:

- *Evidence:* The response to HIV, TB and STIs – both in its broad strategic approaches and in specific interventions and programmes – must be guided by the best available regarding how best to reduce new infections as well as morbidity and mortality associated with the three diseases, including evidence on how best to maxise the impact and efficiency of efforts.

- *Human rights:* The national response is grounded in a commitment to protect and promote the fully enjoyment of human rights by all people and communities. Not only does a human rights-based approach reflect the values of our society and the South African Constitution, but extensive experience both here and throughout the world underscores that a human rights-based approach is also the most effective way to reduce new infections, morbidity and mortality.

- *Multisectorality:* The three epidemics are not just health problems, but are driven by and have an effect on broader social and structural aspects of our country. Accordingly, all sectors of society have critical roles to play in the response to HIV, TB and STIs.

- *People-centred:* People living with HIV, TB or STIs, as well as households and communities affected by these epidemics, are the touchstone by which our action on HIV, TB and STIs must be judged. The national response is committed to adherence to the principles of the Greater Involvement of People with HIV/AIDS.

- *Inclusion and participation:* South Africa is committed to leaving no one behind in our quest to sharply lower new infections, illness and death associated with HIV, TB and STIs. Recognising the multisectoral nature of the response and the centrality of diverse people and communities, our response must be inclusive and participatory in nature. People living with and affected by the epidemics, as well as the communities in which they live and civil society more broadly, must be engaged in the development, implementation and monitoring of our efforts.

1.6 NSP Goals

In 2015, South Africa joined other members of the United Nations in endorsing the Sustainable Development Goals, which call for action to end the AIDS and TB epidemics by 2030.[18] The NSP aims to ensure an enhanced national response to HIV, TB and STIs, by sharply reducing morbidity and mortality associated with these diseases and by laying the foundation to end AIDS and TB as public health threats.

The consultative process undertaken for NSP resulted in agreement on eight strategic goals:

Goal 1: Accelerate prevention to reduce new HIV, TB and STI infections.

> By fully harnessing proven prevention strategies, sharply increasing prevention coverage and quality and targeting prevention efforts strategically to the locations and populations in greatest need, the NSP seeks to *break the cycle of transmission.* The NSP aims to reduce new HIV infections by more than 60% – from an estimated 270 000 in 2016 to below 100 000 by 2022, including elimination of mother-to-child HIV transmission and a reduction in new infections among adolescent girls and young women from 2000 each week to less than 800; to cut TB incidence by at least 30% (from 450 000 to 315 000); and to significantly lower the incidence of gonorrhoea, syphilis and chalmydia, achieve virtual elimination of congenital syphilis, and maintain high coverage of HPV vaccination in selected groups.

Goal 2: Reduce morbidity and mortality by providing treatment, care and adherence support for all.

> The NSP calls for concerted action to *achieve the 90-90-90 targets for HIV and TB by 2020 and to achieve even higher coverage by 2020.* [*] Attaining these targets will require that we need to treat at least 6.1 million people (including 175 000 children) with antiretroviral therapy, ensure that at least 5.5 million people (including 158 000 children) achieve HIV viral suppression, and attain at least a 90% treatment success rate for drug-sensitive TB and at least 70% treatment success rate for multi-drug resistant TB.

Goal 3: Reach all key and vulnerable populations with comprehensive, customised and targeted interventions.

> 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 include

[*] With respect to HIV, the 90-90-90 target, as recommended by UNAIDS, provides that by 2020:

(a) 90% of all people living with HIV will know their HIV status;
(b) 90% of all people with an HIV diagnosis receive sustained antiretroviral therapy; and
(c) 90% of all people receiving antiretroviral therapy achieve viral suppression.

The 90-90-90 target requires that 81% of all people living with HIV receive antiretroviral therapy and that 73% of all people living with HIV are virally suppressed.

As set forth in the Global Plan to End TB 2016–2020, the 90-90-90 target for TB provides that:

- 90% of all people who need TB treatment are diagnosed and receive appropriate therapy — first-line, second-line and preventive therapy, as required;
- 90% of people in key and vulnerable populations are diagnosed and receive appropriate therapy; and
- Treatment success is achieved for least 90% all people diagnosed with TB.

support for peer-led and community-based services tailored to meet the needs of specific populations, as well as initiatives to empower key and vulnerable populations. Integral to this strategy is the need to build the capacity of service providers, implement and expand community and peer-led programming, and create enabling environments so that hard-to-reach groups advocate for their health and human rights and increase uptake of life-saving services.

Goal 4: Address the social and structural drivers of HIV, TB and STI infections

The NSP calls for a *multi-department, multi-sector approach* to address the social and structural determinants that increase risk and vulnerability to HIV, TB and STIs, with particular attention to the needs of adolescent girls and young women without neglecting the general population.

Goal 5: Ground the response to HIV, TB and STIs in human rights principles and approaches.

The NSP reflects a continued and deepened commitment to *equal treatment and social justice*, including protection of human rights and increased access to justice, with the aim of achieving at least a 50% reduction in externalised and internalised stigma among people living with HIV and TB. Urgent efforts will focus on mitigating stigma and discrimination affecting key and vulnerable populations.

Goal 6: Promote leadership at all levels and shared accountability for a sustainable response to HIV, TB and STIs.

Mutual, collective accountability is fundamental to the achievement of the objectives of the NSP. To ensure leadership and accountability for results and an expanded partnership to address HIV, TB and STIs, the NSP calls for the strengthening of SANAC at all levels, improved cooperation and collaboration among government departments, deeper involvement of the private sector and organised labour and capacitation of civil society sectors and community networks.

Goal 7: Mobilise resources to support the achievement of NSP goals and ensure a sustainable response.

Meeting the challenge of fully resourcing the NSP will require maximizing funding from existing sources, improving efficiency and leveraging innovative financing mechanisms to generate new funding. Particular efforts will be made to capitalise on the growth of National Health Insurance to generate new funding for HIV, TB and STI services.

Goal 8: Strengthen strategic information and research to drive progress towards achievement of NSP goals.

The goals and targets of this NSP will only be met through the generation and use of relevant, valid, timely data and new information required to understand these epidemics, monitor progress in prevention and the uptake of services and reductions in morbidity and mortality associated with these diseases. Monitoring and evaluation of the NSP will not only include a final review of progress at the end of the NSP but also a comprehensive mid-term review of results.

Recognizing that robust, flexible and client-centred service systems are essential to reach these goals, the NSP also prioritises "cross-cutting systems enablers" to ensure successful implementation of the NSP. The enablers include health system factors and social factors:

Health system enablers:

- Effective integration of HIV, TB and STI interventions and services
- Strengthening information, procurement and supply chain systems
- Ensuring that the human resources required are sufficient in number and mix, trained and located where they are needed

Social enablers:

- Focus on social and behaviour change communication to ensure social mobilization and increasing awareness
- Build strong social systems, including strengthening families and communities, to decrease risks of transmission and to mitigate the impact of the epidemics

1.7 What is New in the NSP

In the transition from disease control to disease elimination, the NSP calls for a significant reduction in the number of new infections and mortality associated with HIV, TB and STIs, as well as major, sustained increases in service coverage. In light of these aspirations for the coming years, it is clear that *business as usual will not suffice* to achieve South Africa's ambitious goals and targets for the three epidemics.

Accordingly, the NSP 2017-2022 prioritises a substantially enhanced *focus for impact* to drastically accelerate progress. The pivotal action steps prioritised in the NSP constitute important new features or areas of emphasis, including the following:

- *Prioritising prevention.* The NSP provides for a substantial intensification of strategic, evidence-based efforts to prevent new HIV, TB and STI infections. The NSP calls for the combination of behaviour change and action to address social and structural drivers of these epidemics, biomedical HIV prevention (including pre-exposure antiretroviral prophylaxis, or PrEP), airborne infection prevention and control, treatment-associated viral suppression, successful treatment of drug-sensitive TB and prevention of person-to-person transmission of TB.

- *Accelerating implementation of test-and-treat.* The NSP reaffirms South Africa's recent adoption of the "treat-all" approach for HIV recommended by the World Health Organization (WHO), as well as the 90-90-90 focus, which calls for concerted, prioritised efforts to accelerate testing, linkage to care testing and treatment for all who need them. With regard to treat-and-treat for HIV, antiretroviral therapy should be offered and initiated as soon as possible after HIV diagnosis, as soon as a patient is medically and emotionally ready.

- *An intensified focus on spatial location.* This NSP reflects a much more refined and sophisticated analysis of micro-locations with high burdens of HIV, TB and/or STIs , such as specific areas in metros, districts with peri-mining areas, truck routes, and health care and correctional facilities. While the NSP aims to guide, strengthen and accelerate action across the country, especially intensive efforts will be made in high-burden areas to achieve high prevention and treatment coverage and address social and structural drivers of the epidemics. Intensifying action in the settings where most new infections

occur will accelerate progress towards the NSP's ambitious goals and objectives and also identify best practices that can be applied in other settings as well.

- *An intensified focus on populations disproportionally affected.* The NSP calls for the improved targeting of efforts and the development of tailored services and interventions for groups that are disproportionately affected by HIV, TB and STIs but are often at risk of being left behind. The NSP seeks to leverage the substantially greater knowledge that has been accumulated since 2012 regarding the size and distribution of key and vulnerable populations, effective ways to strengthen HIV prevention and treatment, and strategies to align responses with human rights principles.

- *A substantially stronger focus on adolescent girls and young women.* Within the increased focus on key and vulnerable populations, the NSP endorses transformed and much stronger efforts at national, provincial and local levels to reduce new HIV infections and improve HIV outcomes for adolescent girls and young women. This will include the rapid and thorough nationwide expansion of the She Conquers campaign, multi-faceted efforts to prevent and address gender-based violence, improved efforts to retain girls in school, and scaled-up initiatives to change gender norms, with a focus on adolescent boys and young men in particular.

- *Prioritizing service quality.* In addition to increasing service coverage, the NSP recognizes the equally urgent need to improve the quality and sustainability of services. The 90-90-90 targets for both HIV and TB by 2020 (and the even more ambitious 95-95-95 targets for the post-2020 period) stress the importance of ensuring that treatment services achieve their desired health outcomes. In addition to guaranteeing the uninterrupted availability of the highest quality of essential medicines and other health commodities, the NSP focuses on enabling access to comprehensive, holistic services, including psychosocial counselling and mental health, alcohol and substance use services where indicated. A particular aim of the NSP is to substantially reduce loss to follow-up in HIV and TB treatment services. Similarly, the NSP's focus on critical enablers seeks to strengthen and sustain service systems in order to deliver services that are optimally accessible and of good quality.

- *Implementation of differentiated care.* The NSP recognises the need for the adoption of differentiated care, which is defined by WHO as a client-centred approach to care that simplifies and adapts HIV and TB services across the service cascade. This differentiation could improve outcomes reduce costs, minimise inconvenience and potential loss to follow up, and improve the quality of care through the efficient use of available health facility and community resources.

- *Addressing co-morbidities of HIV,* especially hepatitis B and C, which are widely prevalent in South Africa. Surveys suggest rates of hepatitis B infection (over 14%) among pregnant women living with HIV in KwaZulu-Natal, and among men who have sex with men and sex workers. incorporating hepatitis screening, diagnosis, and counselling in HIV services, and linking infected persons to highly effective and inexpensive new treatments (including with tenofovir and entecavir for those with chronic hepatitis B infection), South Africa will address a major epidemic resulting in a heavy burden of illness and premature death due to preventable liver disease, including cirrhosis and cancer.

- *Understanding and responding to sexual networks.* The NSP responds to the expanded understanding of how sexual networks, such as the sexual partnering between women and men of similar ages (and some older men), contribute to new HIV infections among adolescent girls and young women. The interventions in the NSP seek to break the cycle of transmission through focused behavioural, biomedical and social and structural interventions that simultaneously provide clients with the information and services to address the social and structural factors that increase their vulnerability.

- *A strengthened multi-sectoral response.* The NSP envisages a major strengthening of multi-sectoral cooperation and collaboration to address the social and structural determinants of HIV, TB and STIs. Government departments must work together and not in silos. Provincial, district and municipal AIDS councils will be strengthened and be more representative of members of key and vulnerable population groups and representatives of the private sector and organised labour. The interventions by government and all civil society groups must be integrated at all levels of implementation of the NSP.

- *An expanded approach to costing and financing the response.* Recognising limitations in domestic fiscal space and declining external assistance, the NSP prioritises efforts to identify and leverage new sources of funding for health services, including National Health Insurance, and to ensure greater efficiency in the use of resources. Financial management of the response to HIV, TB and STIs will improve, and there will be greater attention paid towards maximising efficiencies.

- *Strengthening strategic information.* Strategic information will be used to identify where the NSP is on track and what improvements and new knowledge are needed. The rollout of the use of a unique identifier throughout the health and social systems will facilitate better co-ordination across services, improve our ability to track patient cohorts and enable the system to better support people with the three diseases. To ensure more reliable monitoring of service utilization and programme outcomes, the NSP prioritises the implementation of a national unique identifier to effectively track the progress, uptake and linkage of services at the individual level. The NSP includes specific mandates for strengthening surveillance and surveys and for improving the use of strategic data for decision-making. In addition to the ultimate targets for 2022, the NSP also outlines interim targets for monitoring and evaluation, permitting on-going assessment of whether the country is on track to reach its goals. Well-designed implementation research will identify optimal ways of delivering services and programmes, and the country's enormous expertise in scientific research will be fully leveraged to accelerate the development of new prevention and treatment technologies and approaches to implementation.

At the launch of the NSP, important policy issues remain incompletely addressed, including those relating to national drug policy, sex workers and transgender people. Although the outcome of these policy questions remains uncertain, the NSP includes a commitment over the five-year duration of this plan to enhance the provision of harm reduction services for people who use drugs as well as the provision of comprehensive prevention and treatment services for sex workers. As this NSP extends over five years, both the policy framework and the broader social environment are likely to undergo continual changes, necessitating the adapation of approaches to ensure progress towards the targets and indicators outlined in this plan.

The goals of the NSP build on and implicitly reference the numerous national guidelines that have been developed for prevention, treatment, care, support and impact mitigation for HIV, TB and STIs. A driving aim of the NSP is to ensure full, scaled-up implementation of the many evidence- and human rights-based guidelines that exist to inform and strengthen the delivery of services and approaches to address the three epidemics.

2.0 The state of the epidemics in 2017

The challenges posed by the HIV, TB and STI epidemics remain enormous, but the strategic information on which to base prevention and treatment approaches has significantly increased since 2012. There is now a much more granular appreciation of the spatial dynamics of these epidemics. Reliable size estimations for some of the key and vulnerable populations are enabling more strategic public health approaches. New interventions, including pre-exposure antiretroviral prophylaxis (PrEP), have emerged in the last five years.

2.1 State of the epidemic: HIV

HIV prevalence (i.e., the proportion of people living with HIV*):* South Africa is home to the world's largest HIV epidemic.[20] An estimated 7.02 million people were living with HIV in South Africa in 2016, representing 12.7% of the national population or 19.1% of those aged 15-49.[†]

Nationally, HIV prevalence is increasing, as people living with HIV are on average living longer due to the beneficial effects of antiretroviral therapy.[1] This is reflected in increasing average life expectancy from an estimated 58.3 years in 2011 to 62.4 years in 2015.[22] HIV prevalence varies considerably by age, sex, race, locality type and geographic area.[1] Peak HIV prevalence occurs at ages 35-39 for females, while men ages 35-39 and ages 40-44 have roughly equivalent peak prevalence.[1] Among age groups, HIV prevalence is higher in females than in men in all groups except for those 60 years and older.[1] Adolescent girls and young women are much more likely to have HIV infection than boys and young men their own age (5.4% vs. 2.1% among 15-19 year-olds, and 16.8% vs. 4.4% among 20-24 year-olds).[1]

In 2012, HIV prevalence was higher among Black Africans (15.0%) than among coloureds (3.1%).[23] With respect to locality, people residing in informal settlements have the highest HIV prevalence (19.9%), followed by those living in rural informal areas (13.4%).[23] Among provinces, KwaZulu-Natal has the highest HIV prevalence (18%), followed by Mpumalanga (15%), with the Northern Cape (6.8%) and the Western Cape (6.6%) having the lowest provincial HIV prevalence.[1]

HIV prevalence among pregnant women attending antenatal clinics in the public sector has remained stable since 2004 when prevalence in this group was 29.5%, compared to 30% in 2014. There is significant variation across provinces with the Northern Cape having the lowest prevalence at 16.1% and KwaZulu-Natal having the highest at 42.4% (2014). Similarly,

[†] Unless otherwise indicated, estimates of HIV prevalence and incidence are derived from the Thembisa model.

prevalence in districts are also variable with Namaqa (Northern Cape) at 3.6% and mGungundlovu (KZN) at 47.6% (2014).

HIV incidence (i.e., the rate at which people are newly infected each year)*:* An estimated 270 000 people were newly infected in South Africa in 2016 compared to 360 000 in 2012, continuing a steady decline in new HIV infections. HIV incidence (i.e., the rate at which people are newly infected each year) is considerably higher among females than among males. Adolescent girls and young women (ages 15-24) have the highest HIV incidence pf any age or sex cohort (2.01% in 2015). The number of new HIV infections among infants has markedly declined, from 70 000 in 2004 to less than 6 000 in 2015; the mother-to-child HIV transmission rate fell by more than half from 2011 (3.6% at six weeks) to 2016 (1.5%). Although historic progress has been made in reducing new HIV infections among children, the HIV challenge among children remains pressing; there is now global agreement that it is feasible to eliminate mother-to-child HIV transmission and that focused efforts are needed towards this goal.

Comment [MI3]: Citation to be inserted:

www.statssa.gov.za/publications/P0302/P03022015.pdf;

HIV mortality: In 2016 in South Africa, 150 375 people died of AIDS-related causes in 2016, representing 27.9% of all deaths.[10] This compares to 185 558 (33%) of AIDS deaths in 2011/12.[10] Peak mortality associated with AIDS occurred in 2006 at 681 434 (47.7%). These declines in AIDS mortality primarily stem from the introduction and scale-up of antiretroviral therapy.

Key and vulnerable populations: Transmission among adolescent girls and young women is in large measure driving South Africa's HIV epidemic; about 1,750 young women 15-24 years of age are infected with HIV each week, accounting for roughly 100 000 of the 270 000 new infections in South Africa each year. HIV prevalence among the estimated 150 000 sex workers[24] ranges from 48-72%[25]. HIV prevalence is 28%[26] among the estimated 1.2 million men who have sex with men (MSM)[27]; 14%[28] among the estimated 67 000 people who inject drugs (PWID)[29]; 23% among inmates[30]; and 17% among people with disabilities.[23]

2.2 State of the epidemic: TB

TB incidence: In 2015, 454 000 new TB cases were estimated to have occurred in South Africa.[31] TB incidence in 2014 was estimated at 834 cases per 100 000 population[31], a modest decline since 2011 but short of the NSP 2012-2016 goal of decreasing TB incidence by 50%. South Africa's TB incidence is ranked the sixth highest globally.[8] Among all new and relapse TB notifications in the country in 2015, 89.7% were pulmonary TB and 94.6% new cases.[1]

Link with HIV:. People living with HIV accounted for 63% of incident TB cases in 2015.[31] National policy provides for the initiation of isoniazid preventive therapy (IPT) to all HIV-positive TB patients; South Africa has the largest national IPT programme in the world, although finding a shorter preventive regimen would bolster efforts to prevent TB among people living with HIV. There is also considerable TB transmission in South Africa that is unrelated to HIV, driven by poverty, medical conditions such as poverty, tobacco use, diabetes and silicosis, poor nutritional status, sub-optimal living conditions, overcrowding, late presentation to health facilities , and lower than acceptable treatment success rates.[31]

Multi-drug resistant TB: From 2007 to 2012, the number of multi-drug resistant TB (MDR-TB) cases doubled, from 7350 to 14 161, a result primarily associated with more rigorous case finding

using GeneXpert diagnostic technology.[32] MDR-TB accounts for 1.8% of new TB cases and 6.7% of retreatment cases.[31]

TB mortality: Deaths from TB dropped from 69 916 in 2009 (12% of all deaths) to 37 878 in 2014 (8.2% of all deaths). [31] This represents a 45% decline in five years, but TB remains the leading cause of death in South Africa[8], representing 8.4% of all deaths in 2014. Among notified TB cases receiving treatment in 2014, 6.7% died, including 22.3% of MDR-TB patients and 43.0% of patients with extreme drug resistant TB.[33] TB is more likely to be the cause of death among males (9.5% of all male deaths in 2014) than among females (7.1%), although TB is a more prominent cause of death among young females (16.8%) than among young males (11.8%).[33]

Variations in TB burden: Males tend to experience higher TB rates than females; peak TB prevalence occurs at ages 35-44 for men and for 25-34 for women.[33] TB cases are higher among children under age 5 than among children aged 5-14.[33] TB burden is elevated among people with increased TB exposure due to where they live or work and among people at greater TB risk as a result of biological or behavioural factors that compromise immune function. High-risk groups for TB include inmates[34], gold mine workers [35] and diabetics.[36] People with diabetes are three times more likely than the general population to have TB. Health care workers also experience disproportionate risks of TB, including drug-resistant TB.[37] Seven metro areas (eThekwini,Cape Town, Jphannesburg, OR Tambo, Tshwane, Neslon Mandela and Ekuhuleni) account for 40% of all TB cases in South Africa.

Comment [MI4]: Cite to NDOH TB data

2.3 State of the epidemic: STIs

STI prevalence: Compared to HIV and TB, recent data is much more limited with respect to STIs. Nevertheless, available evidence clearly demonstrates that STIs remain a serious challenge in South Africa, with a substantial portion of people with STIs having no symptoms. The prevalence of syphilis among antenatal patients fell from 11.2% in 1997 to 1.6% in 2011.[38] Prevalence of HSV-2 among antenatal patients in Gauteng, KwaZulu-Natal, Northern Cape and Western Cape was 55.8% in 2012.[39]

Variations in STI burden: Various local studies have reported that STI prevalence is especially high among young women: ranging from 17-42% for chlamydia, 71% for HPV, 6.2% for syphilis, 10.9% for gonorrhoea and 42-47% for bacterial vaginosis.[40] One third or more of MSM surveyed report STI symptoms.[41] Syphilis prevalence among sex workers was found to be 19.6% in Cape Town and 16.2% in Johannesburg in 2015.[42] With respect to syphilis prevalence among antenatal women, prevalence in 2011 was highest in Mpumalanga (4.1%) and lowest in KwaZulu-Natal (0.4%).[38] Among antenatal women nationally, HSV-2 prevalence increases with age, with highest prevalence (above 90%) among women aged 45-49.[39] Although local surveys of STI burden cannot be generalised nationally, available studies nevertheless illustrate the severity of the STI epidemic in South Africa.

2.4 The National response: Achievements on which to build

Under the NSP 2012-2016, South Africa made major strides in its response to HIV, TB and STIs:

- *Reducing new HIV infections:* The decline in the number of new HIV infections was aided by important steps taken by South Africa in 2012-2016. These include the scale-up of voluntary medical male circumcision (2.4 million procedures over the last four years),

the addition of PrEP to combination prevention services for sex workers and MSM in selected trial sites, and massive distribution of male and female condoms.[10]

- *Towards elimination of new HIV infections among infants:* The rate of mother-to-child transmission at six weeks dropped from 3.6% in 2011/12 to 1.5% in 2016, exceeding the NSP 2012-2016 target of reducing the transmission rate to below 2%.[10] The 18-month transmission rate of 4.3% in 2016 also exceeded the NSP target of below 5%.[10]

- *Orphans and vulnerable children:* School attendace among orphans is comparable to that of non-orphans, demonstrating the positive effect of the pro-poor package provided through schools. Nationally, 9.2 million learners benefit from school feeding, 78% of all learners pay no school fees and 386 448 learners benefit from scholar transport. Annually approximately 1 million learners receive health services through the Integrated School Health Programme,

- *Expanding access to testing and treatment services:* Over 10 million people were voluntarily tested for HIV in 2016. Cumulatively by 2016, 3.7 million people were intiated on HIV treatment.[10]

- *Bolstering TB diagnosis and treatment:* South Africa rolled out the Gene Xpert technology nationwide to permit quicker diagnosis of drug-sensitive TB as well as drug-resistant TB. Operational guidelines were developed and screening and treatment programmes scaled up for heavily affected populations, including people living in mining and peri-mining communities as well as inmates.

- *A commitment to human rights:* During 2012-2016, South Africa continued and deepened its commitment to an enabling legal framework that reflects a human rights-based approach to HIV, TB and STIs. The country's commitment to an inclusive response is reflected in the launch of its National Sex Worker HIV Plan.[45]

- *Mobilising resources for the response:* South Africa has sharply increased spending on HIV and TB programmes, with most of this increase driven by spending by the national government.[9] HIV allocations made by the South African government have grown from R1.2 billion in 2004/5 to R17.4 billion in 2016/17, representing a more than 14-fold growth in nominal public spending. Donor support has also played an important role in strengthening the response to the HIV and TB epidemics in particular.[9]

The many achievements that South Africa has made in its response to HIV, TB and STIs provide a robust foundation on which to accelerate progress in reducing morbidity and mortality. The NSP has been strategically formulated to build on these gains, taking into account lessons learnt, but also to address the gaps and bottlenecks that limited progress.

Comment [MI5]: Insert citation:

HIV Financing Chapter, SA Health Review 2016

3.0 Strategic approach in 2017-2022: Focus for impact

The eight goals of the NSP, described in subsequent chapters, aim to build on lessons learnt and achievements to date, close gaps that persist in the national response, and build a strong foundation to end the HIV, TB and STIs epidemics as public health threats. To implement these eight goals, the NSP serves as a call to action for a much more strategic, more focused approach that uses a more granular understanding of epidemic dynamics to maximise the impact of available resources and efforts.

How these goals are implemented will be as important as the substance of the goals themselves. To implement the goals and objectives outlined in the NSP, provincial AIDS councils will develop more detailed implementation plans.

3.1 Focus for impact

Although the NSP is national in scope, its ultimate success will depend on effective implementation at the provincial, district, municipal and local levels. From the national to the local context, three levels of focus will be needed to accelerate implementation of the NSP and optimise its impact in reducing morbidity and mortality associated with HIV, TB and STIs.

Box XX. Selecting high-burden districts: Background

The process for identifying high-burden districts for intensification of efforts dates back to September 2015, when the SANAC secretariat established the Hotspot Mapping Advisory Committee. The committee – composed of governmental and non-governmental epidemiological experts as well as international partners – was tasked with developing a transparent, multi-sectoral, locally informed and user-friendly approach to hotspot mapping.

Following deliberations, the committee developed an approach to geospatial mapping and risk profiling that allows stakeholders to obtain a more granular understanding of geospatial variations in HIV burden – an approach that was eventually expanded to TB and STIs as well. The approach aimed to answer key questions: (a) Where in a particular district area the areas with highest HIV burden? (b) Why does a specicia area have higher HIV burden (i.e., what are the contributing factors)? (c) Which multi-sectoral interventions may be deployed in the high-burden area to reduce HIV risk? This approach is now being piloted in two districts: uMgungundlovu district in KwaZulu-Natal and the Cape Winelands district in Western Cape province.

To identify the high-burden districts for prioritization at the outset of the NSP, the committee examined key epidemiological and service indicators (e.g., infant first PCR test at around 10 weeks, antenatal client first HIV positive test, HIV prevalence among testing clients aged 15-49). To complement service data, the committee consulted secondary data to identify populations at risk of or living with HIV in an area. In addition, feedback was provided at the local level through stakeholder and community workshops, which proved to be an excellent vehicle for local participatory involvement.

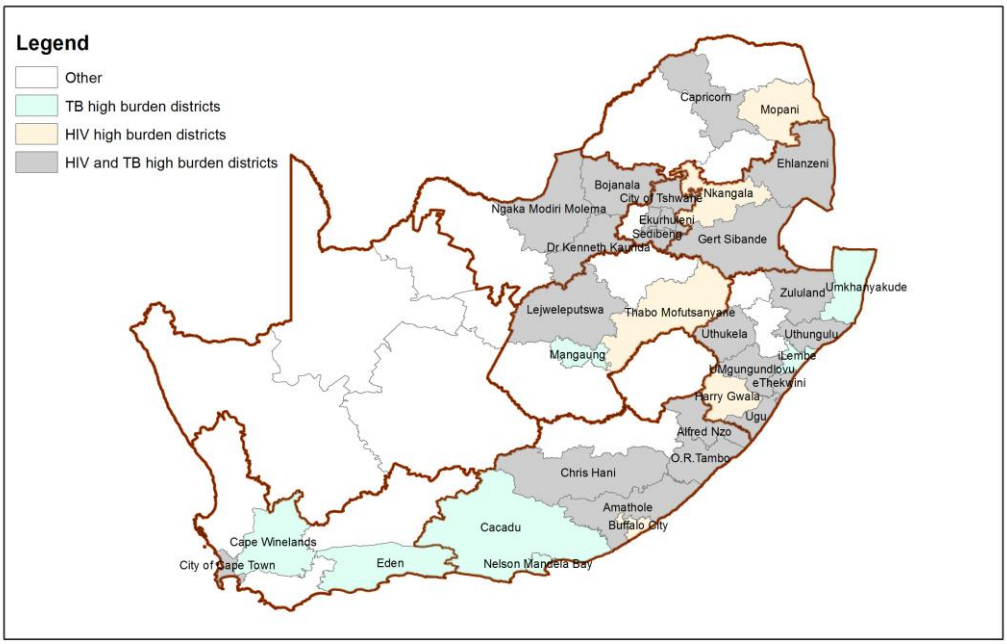
Piloting of the approach has underscored the importance of buy-in at provincial, district and ward levels; the value of using existing structures for engagement; the value of imperfect data in informing decision-making; and the need for intensified efforts to engage hard-to-reach populations.

- *Spatial location:* The NSP calls for steps to ensure the delivery of essential evidence-based services to all who need them, regardless of where they live. However, taking account the substantial geographic variation in disease burden, the NSP endorses particularly intensified action in the 27 districts (these include metros and district municipalities) that account for 82% of all people living with HIV and in a different set of 27 districts with high TB burden.[‡] In each of these high-burden areas:

[‡] The high-burden districts noted here are those that are prioritised at the outset of the NSP in 2017 based on the latest available data. The epidemiological situation with respect to HIV, TB and STIs will be assessed initially annually but more regularly as the scale up of geospatial and hotspot profiling makes more detailed localized information available

1) ambitious coverage targets will be set;
2) current and new programmes will focus strategically on those in greatest need; and
3) other strategies will be intensified to address social and structural factors that increase individual and community vulnerabilities that contribute to disease burden.

HIV and TB High Burden Districts



for decision making. As the HIV and TB epidemics continue to evolve, the specific districts prioritised in the "focus for impact" approach may change over time (as may the total number of districts targeted for intensified effort) and in fact there is a move to target specific sub-districts through the geospatial mapping and hotspot profiling real-time data tools.

Box XX. HIV and TB high-burden areas (2017)

HIV Burden Areas							
KwaZulu Natal	**Gauteng**	**Mpumalanga**	**North West**	**Western Cape**	**Northern Cape**	**Free State**	**East**
Ethekwini	City of Johannesburg	Ehlanzeni	Bojanala	City of Cape Town		Thabo Mofutsanyane	Oliv
uMgungundlovu	Ekurhuleni	Nkangala	Dr Kenneth Kaunda			Lejweleputswa	Ama
Uthungulu	City of Tshwane	Gert Sibande	Ngaka Modiri Molema				Alfr
Zululand	Sedibeng						Chri
Ugu							Buff
Uthukela							
Harry Gwala							
TB Burden Areas							
Ethekwini	City Of Johannesburg	Ehlanzeni	Bojanala	City of Cape Town		Mangaung	Oliv
Uthungulu	City Of Tshwane	Gert Sibande	Dr Kenneth Kaunda	Cape Winelands		Lejweleputswa	Chri
uMgungundlovu	Ekurhuleni		Ngaka Modiri Molema	Eden			Ama
Zululand	Sedibeng						Nels
Ugu							Alfr
iLembe							Caca
Umkhanyakude							
Uthukela							

Note: the districts shaded in yellow are common to the HIV and TB high burden district list.

- *Population:* In each of these high-burden districts and cities, programmatic efforts will be strategically targeted towards the populations where the need is greatest and where the impact of efforts will be most pronounced. Given the degree to which transmission among adolescent girls and young women is driving HIV across the country, *every* province, district and ward must take steps to intensify efforts to reduce new HIV infections and increase service access for adolescent girls and young women, including addressing the social and structural factors that increase vulnerability. Guided by local data and circumstances, provinicial and local responses should prioritise key populations (sex workers, MSM, transgender people, people who use drugs (PWUD), people living with HIV, miners, inmates, household contacts of TB index patients, health care workers, children <5 years, people living in informal settlements, pregnant women and migrants and vulnerable populations (adolescent girls and young women (ages 15-24), children and orphans and other vulnerable children, people with disabilities, other vulnerable LGBTI communities, en, diabetics, health care workers).

- *Interventions:* Enhanced focus is also needed on the combination of interventions that are prioritised for scale-up. Priority will be placed on implementing the right mix of high-value, high-impact interventions that will maximise the number of new infections and deaths that will be averted.

3.2 Strategic approach

To ensure strategic focus for impact, provinces should use a step-wise approach for implementation:

- *Use data:* Leveraging the more detailed, more granular strategic information that is now available on these epidemics, provinces will use data, including geospatial mapping, to strategically focus and intensify responses in high-burden areas. Within these high-burden areas, spatial mapping data will be used to identify "hotspots" where interventions are most needed. In each of the high-burden areas, profiling of communities must be undertaken to develop a clearer, more detailed understanding of the local contextual drivers of the epidemics, the individual and community resources and strengths, and the location of available and needed services.

- *Scale up high-impact interventions:* Focused efforts in high-burden areas should achieve saturation coverage of high-impact prevention and treatment interventions as well as multi-sector strategies to address the social and structural drivers of the epidemics. In high-burden areas, rigorous efforts will be made to expand the reach and impact of interventions through critical enablers.

- *Ensure an integrated, multi-sector response:* Strategic integration of programmes and approaches must be prioritised, from planning to service delivery. Building on the cooperation and collaboration of key departments, more focused efforts will ensure that responses at all levels are fully multi-sectoral in order to address the social and structural factors that increase vulnerability and limit service uptake.

- *Monitor results and take corrective action where needed:* From the individual service site to the district, provincial and national levels, improved data, including unique health identifiers and strengthened monitoring and evaluation, will be used to track outcomes

and improve performance over time. These data and analytics should serve as a continual "feedback loop," allowing stakeholders at all levels to address problems as they arise and identify weaknesses requiring intervention.

To operationalize this approach, provinces, led by provincial AIDS councils, will develop Provincial Implementation Plans that describe in detail how to implement the NSP in each province. These Provincial Implementation Plans will focus for impact by tailoring this Strategic Approach to the specific epidemiological patterns, needs and challenges within each province. While taking account of comprehensive services to which every community and person is entitled, regardless of location and disease burden, the Provincial Implementation Plan should elaborate how the provincial response will intensify efforts in high-burden areas. Building off the Provincial Implementation Plan, district AIDS councils should use a broadly inclusive, participatory approach to the development of local interventions with targets to guide the intensification of efforts.

Focusing for impact involves much more than merely implementing validated interventions. To make these interventions work, steps are needed to maximise the reach and impact of these approaches. In this regard, the critical enablers outlined in the NSP are essential if we hope to leverage high-impact, high-value interventions to reach the goals and objectives outlined in the NSP. In particular, social and behaviour change communication (SBCC) has a pivotal role to play in promoting safer behaviours, increasing demand for services, mobilising communities and increasing service retention and adherence.

"Focus for Impact" is a fundamentally new "way of doing business" as South Africa works to achieve a decisive transition from disease control to virtual elimination. These focus areas and strategic approaches apply across the goals outlined in this NSP.

Goal 1: Accelerate prevention to reduce new HIV, TB and STI infections

4.1 Situation analysis

Although the number of new HIV infections has declined, the pace of reduction fell short of the 50% reduction envisaged in the NSP 2012-2016.[10] Similarly, the 15% decline in TB incidence from 2011/12 to 2016 fell short of the 50% reduction target.[10] The number of new HIV, TB and STI infections remains unacceptably high.

Sharply reducing the number of new HIV infections will only be possible if the transmission-reducing effects of antiretroviral therapy and TB are combined with an equally robust reduction in risks of HIV and TB acquisition. While the share of HIV spending focused on prevention has increased[9], an increased emphasis on prevention of HIV, TB and STIs is essential if the ambitious goals of this NSP are to be achieved. It is especially critical that HIV prevention efforts are strengthened for adolescent girls and young women and other key populations, as the risk and vulnerability of these groups are driving the HIV epidemic nationally and in many localities across the country.

Similarly, more attention must be paid to infection prevention and control to ensure that the reduction in TB incidence is achieved, including increasing coverage of prophylaxis for latent TB. Equally, the consistent use of male and female condoms will play a key role in reducing STI transmission.

4.2 Strategic approach: Breaking the cycle of transmission

South Africa aims by 2022 to reduce the number of new HIV infections to under 100 000; eliminate new HIV infections among children; reduce TB incidence by 30% (from 834/100 000 to no more than 584/100 000); reduce the incidence of T.pallidum and N gonorrhoeae by 90%; and virtually eliminate congenital syphilis by reducing incidence to 50 or fewer cases per 100 000 live births; and maintain national coverage of HPV vaccination above 90% for grade 4 girls through the following steps:

- *Increase the priority placed on primary prevention:* Recognising the ambitious nature of the NSP's targets for reductions of new HIV and TB infections, the priority given to prevention efforts must increase. Effective prevention programmes will be strategic, targeting combinations of evidence-based behavioural, biomedical and structural interventions. Building a strong, sustainable prevention culture must begin early in life, underscoring the importance of school-based life skills education to increase personal and collective resilience and skills to reduce risks.

- *Use granular data for programme design and targeting:* Surveillance and other sources of data will be used to understand where new infections are occurring, who is becoming infected and by whom. This data will inform the design and delivery of prevention interventions as well as the targeting of programmes based on geography and population. For HIV prevention, this requires effective use of detailed, multi-sector mapping that is being undertaken by all provinces, as well as more granular disaggregation of data (e.g., age, race, gender, etc.). Existing data collection tools, such as Road to Health cards, must

be fully leveraged. Specific steps will taken to strengthen STI surveillance, including ensuring disaggregation of data by sex, geographic area and population.

- *Scale up high-impact prevention interventions:* A comprehensive package of high-impact, context-tailored combination prevention interventions[§] will be provided in all districts, with concerted efforts taken to target these interventions where impact will be greatest. In the currently identified 27 districts with high HIV burden, in the current 16 focus districts for TB control and in settings and populations with elevated risk of STI acquisition, intensified efforts will achieve saturation coverage with enhanced targeting of prevention efforts and provision of strategic social support. Nationally, over the duration of this NSP, we aim to medically circumcise 2.5 million men; we will offer PrEP to those who are most likely to benefit, including adolescents, sex workers, MSM and people who inject drugs; we will roll out post-exposure TB management to eligible household contacts and at least 90% of eligible people receiving antiretroviral therapy; TB infection control will be improved in facilities, households and other congregate settings; we will maintain at least 90% coverage of HPV vaccination. Post-exposure antiretroviral prophylaxis (PEP) will be made available on demand for all significant HIV exposures (including but not limited to instances of sexual violence), and communications efforts will emphasise the availability of PEP for adolescent girls and young women. Efforts will be intensified to ensure the tracing of contacts of all cases of drug-resistant TB. The NSP calls for scale-up of IPT (or newer regimes such as the isoniazid and refampatine combination) for people living with HIV, reaching 90% of people living with HIV by 2022. Particular effort will be taken to strengthen TB prevention in all health care settings, including strong, sustained enforcement of occupational health and infection control measures.

- *Renew momentum for sexual risk reduction:* Sexual risk reduction efforts appear to be faltering. According to 2012 household survey data, the percentage of young people who had their sexual debut prior to 15 years of age has increased, the number of men reporting multiple sex partners rose, and reported condom use appeared to decline.[39] To reverse these trends and restore momentum for sexual risk reduction, new investments will be made in SBCC approaches, including providing comprehensive sexuality education in all secondary schools; at least 800 million male condoms and at least 30 million female condoms each year, targeted to those most in need; developing and disseminating information, education and communications (IEC) on STI prevention and the dangers of sexual abuse and early sexual debut; and fully leveraging SBCC efforts to scale up medical male circumcision and PrEP. IEC programmes for HIV, TB and STIs will be age- and gender-appropriate, taking into account differing needs across the life cycle.

- *Make a major national push to scale up comprehensive sexuality education and sexual and reproductive health services:* The NSP envisages full implementation of the new *DBE National Policy on HIV, STIs and TB* to provide comprehensive sexuality education in all schools, using the enhanced curriculum. In high priority districts, this will be coupled with access to sexual and reproductive health and rights services, including counselling on contraception and medical male circumcision, provision of contraception

[§] As provided in the 2016 NDOH Health Sector HIV Strategy, combination prevention refers to the strategic simultaneous use of different classes of prevention interventions (biomedical, behavioural and structural) that operate on multiple levels (individual, couple, community and societal) to respond to the specific needs of particular audiences and modes of HIV transmission, and to make efficient use of resources through prioritising partnerships and engagement of affected communities.

and condoms, pregnancy testing, HIV testing services and pre-exposure antiretroviral prophylaxis (PrEP) as well as interventions to improve TB literacy and enhance uptake of TB screening and contact tracing.

- *Implement the last mile plan to achieve the elimination of mother-to-child transmission of HIV:* While the number of children born with HIV has markedly declined, mother-to-child transmission persists, especially during the breastfeeding period. To reach the elimination target, all leakages in the service cascade of prevention of mother-to-child transmission need to be closed, including greater efforts to ensure universal uptake and consistent use of antiretroviral therapy for breastfeeding women living with HIV, as well as on-going monitoring and retention in care for mother and infant. The NSP calls for actions to ensure that the rate of mother-to-child transmission of HIV be held to below 2% at 18 months. Clear protocols and related training will be in place regarding age-appropriate disclosure of status for children. All children born to women living with HIV will be vaccinated for Hepatitis B.

- *Achieve 90-90-90 by 2020 and 95-95-95 by 2025 for HIV and TB:* Although 90-90-90 is commonly referred to as a treatment target, achievement of these benchmarks is central to hopes for rapid progress in reducing new HIV infections. According to modelling by UNAIDS, attainment of 90-90-90 would account for 60% of all new infections averted through a broad, fast-tracked response to HIV.[17] To fully leverage the prevention benefits of antiretroviral therapy for both HIV and TB, the proportion of people living with HIV who know their HIV status will increase from an estimated 60% to 90%, the proportion who are receiving antiretroviral therapy will increase from 53% to at least 81%, and at least 73% of all people living with HIV will achieve viral suppression in line with the 90-90-90 benchmarks.

- *Expand prevention for co-morbidities, especially Hepatitis B.* To strengthen hepatitis B prevention at low cost, South Africa will consider implementation of the hepatitis B vaccine birth dose to prevent transmission from pregnant women to their children as well as screening pregnant women and using prophylactic tenofovir in the final trimester of pregnancy. Child-to-child transmission will also be further reduced by expanding coverage of hepatitis B vaccination within the Expanded Programme on Immunization (EPI), above the current 80% coverage level for young children.

- *Build prevention leadership and accountability for results:* From the national to the district level, clear and measurable indicators and targets will be used to measure success, ensure transparency and accountability in the response, and identify where course corrections are needed. Further strengthening of surveillance systems is needed to obtain the level of detail required for "focus for impact" programmatic targeting, design and monitoring. Strategic selection of HIV and TB prevention champions – including but not limited to political leaders, opinion makers and influential members of key and vulnerable populations – will be prioritised, especially at the district level. Political living with HIV are critical leaders and actors in HIV prevention, consistent with the goals and tenets of Positive Health, Dignity and Prevention.

GOAL 1 Accelerate prevention to reduce new HIV, TB, and STI infections					
	Objective 1.1 Reduce new HIV infections to less than 100,000 by 2022 through combination prevention interventions				
	Core Interventions	**Routine approach**	**Intensified approach**	**National Target**	**Accountable parties**
Sub-objective 1.1.1 Implement targeted combination prevention* services tailored to setting and population	-Comprehensive HIV testing services	- Routine PITC in all health facilities -Provide outreach HTS in HTAs -Ensure access to self-screening -Ensure quality testing services Moniitor positivity rate of tesetign services being offered to ensure optimal yield	-Focused PITC for AGYW and their partners -Focussed outreach HTS for KP and for AGYW -Youth-friendly SRH in schools, community settings -Promote self-screening -Explore innovative ways to improve uptake of testing	-Provide HIV testing services (HTS) to 10,000,000 people annually to ensure 90% of PLHIV know their status by 2022, with focus on high-yield settings and testing strategies. This has to be broken down per province and district according to male, female, age, key and vulnerable populations, as pe the local context.	-DOH -DBE -DCS -DSD -CBOs -NGOs -Retail pharmacies -Private employers -Private healthcare providers -Health insurance schemes -Organised labour -SANAC sectors
	-MMC services	-Provide routine MMC in public health facilities -Provide outreach MMC services in targeted areas -Ensure availability of MMC services for traditional initiation practices	-Focused MMC services in public, private facilities and using mobile and community outreach to achieve saturation -Offer alternative hours of service provision (nights, weekends)	-Provide Medical Male Circumcision (MMC) to 2,500,000 eligible men by 2022 (cumulative) Aim to reach as many 19-24 year olds first before older groups of men	
	-Condoms	-Provide male and female condoms, compatible lubricant and condom programmes in all public and private health facilities, in secondary schools, tertiary institutions, non traditional community settings	-Ensure constant condom supply in non traditional sites (e.g.,hair salons, spaza shops, informal traders, garages, hotels) and in high transmission areas (e.g., alcohol outlets, truck stops, brothels)	-Distribute 850 million male condoms and 40 million female condoms per year by 2011	

	Best Practices to Adopt: *At every service delivery opportunity, providers must encourage uptake of all combination prevention services (HTS, MMC (only males), male and female condoms, SRH services including screening for asymptomatic STIs,PrEP and PEP for eligibles, IEC) among sexually active clients, TBbscreening and provide comprehensive services where possible or at a minimum provide specific referral, linkage, and follow-up*				
	Core Interventions	**Routine approach**	**Intensified approach**	**National Target**	**Accountable parties**
Sub-objective 1.1.2 Provide sensitive and age-appropriate sexual and reproductive health services (SRH) and comprehensive sexuality education (CSE)	*Core CSE components:* -Sexuality, puberty education -Gender and empowerment -GBV -Reproduction, contraception - Alcohol and drug use prevention -decision making -Self-esteem -HIV & STIs -Referral to SRH *Core SRH components*: -SRH counselling -PMTCT - Male and female condoms and lubricant -Cervical cancer screening -PAP smears as per policy and risk profile -Access to emergency contraception Choice of termination of pregnancy -STI risk assessment and testing for asymptomatic STIs -HIV and STI counselling, screening and treatment	- Ensure HCW trained and follow NDOH Contraception and Fertility Planning Policy and Guidelines in all SRH service points -Implement core components of CSE programme and monitor to ensure fidelity and quality Ensure educators are trained in the enhanced sexuality education curriculum and the SLPs and implement CSE, with appropriate LTSM (textbooks and teaching aids)	-Implement intensified CSE curriculum with linkage to youth-friendly SRH -Provide youth and gender-friendly SRH clinics in non-healthcare settings (schools, mobile sites) -Train and support HCW to provide sensitive, non-discriminatory SRH to youth, AGYW, MSM, sex workers	-Implement CSE programmes in at least 100% of schools in 27 high burdern districts -All PHC facilities to be youth friendly in the 27 high burden distrcts by 2011	-DOH -DBE- -DHET -Independent schools -DSD -CBOs -NGOs -Private healthcare providers -Private schools -Health insurance schemes -NHLS SAQMEC and HSRC

Sub-objective 1.1.3 Provide Pre-Exposure Prophylaxis (PREP) to identified risk populations	Educate intended beneficiaries -Conduct pre-PREP screening -Provide PREP as part of a comprehensive prevention package -Provide regular follow up and adherence support	-Implement PREP per national guidelines -Conduct implementation science activities to evaluate programmatic best practices -Pilot PREP in KP groups (high risk MSM, AGYW, discordant couples and others) and conduct implementation science and demonstration projects to determine best programmatic practices	-Implement PREP using best practices and lessons learnt from demonstration projects using established SW and MSM service delivery sites -Develop comprehensive PrEP guidelines that address identification, recruitment, adherence support	Make provision for PREP to an estimated 1,385,000 persons • 200 000 women aged 20-24 years • 500 000 adolescents • 450 000 female sex workers • 175,000 MSM • 60,000 PWID	-DOH -DBE -DCS -DSD -CBOs -NGOs -Retail pharmacies -Private employers -Private healthcare providers -Health insurance schemes
	Core Interventions	**Routine approach**	**Intensified approach**	**National Target**	**Accountable parties**
Sub-objective 1.1.4 Provide targeted services to prevent MTCT of HIV and syphilis in the prenatal and postnatal period	Contraception and Fertility Planning -Early ANC attendance -HCT and syphilis testing -HIV re-testing -Implement PMTCT services including ART -Treat syphilis	-Ensure full implementation of PMTCT programme including HTS and syphilis testing throughout pregnancy and immediate initiation and consistent adherence support to appropriate ART regimens throughout ante- and post-natal periods -Include self testing for partners -Ensure access to MomConnect and other supportive programmes	-Accelerated implementation of last mile Focus on the 5 pillars: Leadership, Management and Co-ordination; Scaling up coverage and improving the quality of care; Integration of PMTCT programmes into MNCWH services, Strengthen Monitoring and Evaluation of PMTCT programmes and Increase awareness and community involvement -Intensified partner testing for pregnant women living with HIV, including disclosure support -Intensified GBV and alcohol screening and support -Innovations to ensure timely Early Infant Diagnosis and		-DOH -DSD -CBOs -NGOs -Private healthcare providers -Health insurance schemes

			birth testing and the tracking there-of (unique identifier would assist)		
	Objective 1.2: Significantly reduce T. pallidum, gonorrhoea and chlamydia infection, to achieve the virtual elimination of congenital syphilis, and maintain high coverage of HPV vaccination.				
	Core Interventions	**Routine approach**	**Intensified approach**	**National Target**	**Accountable parties**
Sub-objective 1.2.1 Scale up STI prevention for by providing high quality health information and timely health services for persons at risk	Comprehensive health information, STI education and health promotion programmes Adequate STI screening and diagnostic services, including point-of-care technology for KPs and VPs Syndromic management in all health facilities Improved surveillance of the viral and bacterial causes of STIs (gonorrhea, syphilis, and HPV), as well as microbial resistance -	-Ensure STI components of SRH and CSE programmes are fully capacitated and accurate -Train and support health workers to provide comprehensive STI screening and diagnosis, including reverse testing algorithm -Provide periodic presumptive treatment (PPT) for high risk groups including sex workers.	-Develop routine support to ensure healthcare workers include STI screening and diagnosis in all HIV testing and care settings -Active partner tracing, case finding and treatment -Conduct STI aetiological and antimicrobial resistance studies (2017) -Establish effective referral and diagnostic system for cases of suspected treatment failure and complicated STIs: include recommendations in primary healthcare and hospital-level STGs. -Train and support health workers in STI data capturing and data utilization (2017 – 2022) -Establish adolescent- and youth-friendly services -Train and support health workers in STI data capturing and data utilization (2017 – 2022)	Data available through surveillance -90% reduction of syphilis incidence -90% reduction of N gonorrhoeae incidence -50 or fewer cases of congenital syphilis per 100,000 live births -Sustain 90% national coverage and at least 80% in every district of HPV vaccination among grade 4 girls	-DOH -DBE -DCS -DSD -CBOs -NGOs -Private healthcare providers -Health insurance schemes

Sub-objective 1.2.2: Scale up and maintain high levels of HPV vaccination in 9-13 years target age group	-Continue high coverage of HPV vaccination of targeted girls in public schools including schools for people with disabilities -Encourage HPV vaccination in private schools	-Implement Awareness raising for HPV vaccination -Strengthening curriculum in primary and high school on HPV		Sustain 90% national coverage and at least 80% (of grade 4 learners in public schools) in every district of HPV vaccination	-DOH -DBE -DCS -DSD -CBOs -NGOs -Retail pharmacies -Private healthcare providers -Health insurance schemes
Sub-objective 1.2.3 Develop and implement effective STI partner-notification strategies	-Risk based screening for asymptomatic STIs -Counselling for partner treatment -Assess best method for notification (patient delivered partner medication (PDPM) and referral (PBPR)) -Active provider oriented/initiated partner notification and case finding	-Introduce Provider-oriented partner notification (2017) with a focus on key populations and AGYW and improve the use of partner notification slips. Monitor results of partner notification and explore other effective methods for partner notification through implementation research (2017/2018) Capacitate non- health workers working at community level to provide for assisted partner notification	-Introduce Provider-oriented partner notification (2017) with a focus on KPs and AGYW -Explore other effective methods for partner notification through implementation research (2017/2018	Reach 90% of partners treated by 2022 100% target for people returning the partner notification slip. Reach 90% of partners treated by 2022	-DOH -DBE -DCS -CBOs -NGOs -Private healthcare providers - Retail pharmacies
	Objective 1.3: Reduce TB incidence by at least 30%, from 834/100,000 population in 2015 to less than 584/100,000 by 2022.				
Sub-objective 1.3.1 Increase coverage of Preventive Therapy Uptake (PTU) This refers to promptly finding people who have been exposed to TB or who are at higher risk of TB (like PLHIV), accurately excluding TB disease, assessing whether the exposed	Expand implementation and demand for preventive therapy for PLHIV and household contacts of people with DS TB	Implement current guidelines for contact tracing of DS TB and Isoniazid Preventive Therapy (IPT) Include school based screening and provision of IPT Continue to support the development of new diagnostics for incipient (latent) TB	-Include Preventive Therapy Uptake as an essential component of Universal Test and Treat (UTT), intensified HIV testing measures and linkage to care. -Develop simplified screening algorithms for TB-exposed children -Implement community education and mobilization programmes to improve acceptance of contact investigations and to create awareness of the benefits of	>90% of eligible PLHIV on preventive therapy >90% of eligible children < 5 yrs household contacts on preventive therapy >90 % of all household contacts of DS TB cases on preventive therapy	DOH Provincial and District AIDS councils (PCA)

individual has been infected with TB and providing optimal treatment of incipient (latent) TB.			Preventiove therapy -Implement mHealth solutions and care facilitators to increase number of people accessing Preventive therapy -Strengthen routine M&E for contact investigations, HIV testing, TB Preventiove Therpay Update including outcomes, and pharmacovigilance -Consider preventive therapy for all high risk groups regardless of immune or infection status as new evidence becomes available		
	Scale up 3HP (weekly high-dose isoniazid/Rifapentine for 3 months) for preventive therapy uptake	3 HP is not yet routinely used but the aim is to make this routine by 2022	-Submit to MCC for RPT approval/ Negotiate a volume- based reduction in RPT price/ Include RPT in the essential medicines list (EML) -Identify domestic funds or alternate donor funding, to procure 3HP/ Obtain importation waiver to pilot 3HP -Revise South Africa guidelines to include 3HP -Generate and Disseminate lessons learnt, best practice models of delivery, results of operational, implementation, cost effectiveness and modelling studies	>90% HIV infected individuals receive 3HP >90% of household contacts> 2 years of age receive 3HP	NDOH TB Think Tank

	Preventive Therapy Uptake for contacts of patients with DR-TB	Randomised control trials are underway in South Africa	-Develop an interim policy for Preventive Therapy Uptake after exposure to drug-resistant TB based on available evidence (while waiting for RCT results) to include algorithns for adults and children.	>90% eligible DR-TB contacts receive Preventive therapy	NDOH
Sub-objective 1.3.2. Promote TB Infection control	Promote TB Infection control in health facilities Promote TB infection control in correctional facilities and detention centers	-Implement existing guidelines: ▪ Annual assessments against a set of quality standards for infection control. ▪ Finalise and implement draft NDOH guidelines for HCW ▪ TB screening at entry, biannually and at exit as per existing guidelines ▪ Isolation of symptomatic patients and TB patients	-Implement FAST: Finding cases Actively by cough surveillance and rapid molecular sputum testing, Separating safely, and Treating effectively based on rapid drug susceptibility testing -Formalise programmes for health care workers (HCW)to reduce TB risk and provide access to regular TB screening and provision of TB preventive therapy where appropriate -Record and monitor TB and DR-TB disease in HCW -Aggressive TB screening including chest x-ray and TB culture where appropriate -Institute infrastructural changes to improve ventilation	By 2022, 100% of health facilities with infection control that meets the set quality standards annually. By 2022,100% of correctional facilities and detention centres have TB infection control policies implemented	DOH Employers of health care workers Occupational Health Services Department of Public Works DCS, DHA, Department of Public Works

	Establish robust TB infection control in communities and households Fund research and development for a more effective TB vaccine		-Introduce appropriate legislation and building regulations -Develop norms and standards for housing and congregate settings including schools and public transport. -Develop guidelines for TB infection control in congregate settings and households		DOH Department of Housing Department of Transport

Table XX. General population group--specific comprehensive prevention services and interventions

Population	Services/Interventions/Approaches	Setting	Accountable parties
Children	-Child abuse screening -Age-appropriate HIV testing, treatment, adherence-support -HIV testing upon household adult or adolescent index client -TB screening -Contact tracing from adult, adolescent TB cases -Sputum induction for TB testing -Update hospital admission requirements for DR-TB treatment	Health facility-based School-based Community-based Mobile services	DOH -DBE -DSD -CBOs -NGOs -Private employers -Private healthcare providers -Health insurance schemes
PLHIV (adults, adolescents)	-TB screening, treatment, contact tracing -STI screening, treatment, contact tracing -Hearing and vision screening, referral, treatment -Partner HIV testing, disclosure support, treatment, adherence support -Hepatitis B and HPV vaccine where eligible -PMTCT and enhanced adherence support through pre and post-natal period, including breastfeeding -Mental health screening -Alcohol screening -Violence screening, including GBV -Condom promotion, provision	Health facility-based School-based Community-based Mobile services	-DOH -DBE -DCS -DSD -CBOs -NGOs -Private employers -Private healthcare providers -Health insurance schemes

	-Gender norms education -Health and health rights literacy -Economic empowerment and health promotion -School retention - Accelerated nutritional and social grant support, if indicated -Targeted demand creation -Targeted, PLHIV-friendly IEC materials and SBCC, including social media , including social media and materials for vision and hearing impairment -Service delivery points in community, non-traditional settings		
Persons with TB (adults, adolescents)	-TB contact tracing, testing, and post-exposure management -STI screening, treatment, contact tracing -HIV testing, disclosure support, treatment, adherence support -Partner HIV testing, disclosure support, treatment, adherence support -Enhanced health education in HIV/TB co-infection, reinfection -Hearing and vision screening, referral, treatment -Hepatitis B and HPV vaccine where eligible -PMTCT and enhanced adherence support through pre and post-natal period, vincluding breastfeeding, if indicated -Mental health screening -Alcohol screening -Violence screening, including GBV -Condom promotion, provision -Gender norms education -Health and health rights literacy -Economic empowerment and health promotion -School retention -Accelerated nutritional and social grant support, if indicated -Targeted, TB-friendly IEC materials and SBCC, including social media , including social media and materials for vision and hearing impairment -Service delivery and treatment delivery points in community, non-traditional settings	Clinic-based School-based Community-based Mobile services	-DOH -DBE -DCS -DSD -CBOs -NGOs -Private employers -Private healthcare providers -Health insurance schemes
Discordant couples	TB screening, treatment, contact tracing -STI screening, treatment, contact tracing --Partner HIV testing, disclosure support, treatment, adherence support -Hepatitis B and HPV vaccine where eligible -PMTCT and enhanced adherence support through pre and post-natal period, including breastfeeding if pregnant and HIV positive -Violence screening, including GBV -Condom promotion, provision -Gender norms education -Health and health rights literacy	Clinic-based Community-based Mobile services	-DOH -DCS -DSD -CBOs -NGOs -Private employers -Private healthcare providers -Health insurance schemes

	-Economic empowerment and health promotion - Accelerated nutritional and social grant support, if indicated -Targeted demand creation		

Goal 2: Reduce morbidity and mortality by providing treatment, care and adherence support to all

In 2017-2012, South Africa will build on its global leadership on treatment and care programming to achieve further, substantial reductions in morbidity and mortality associated with the three epidemics.

5.1 Situation analysis

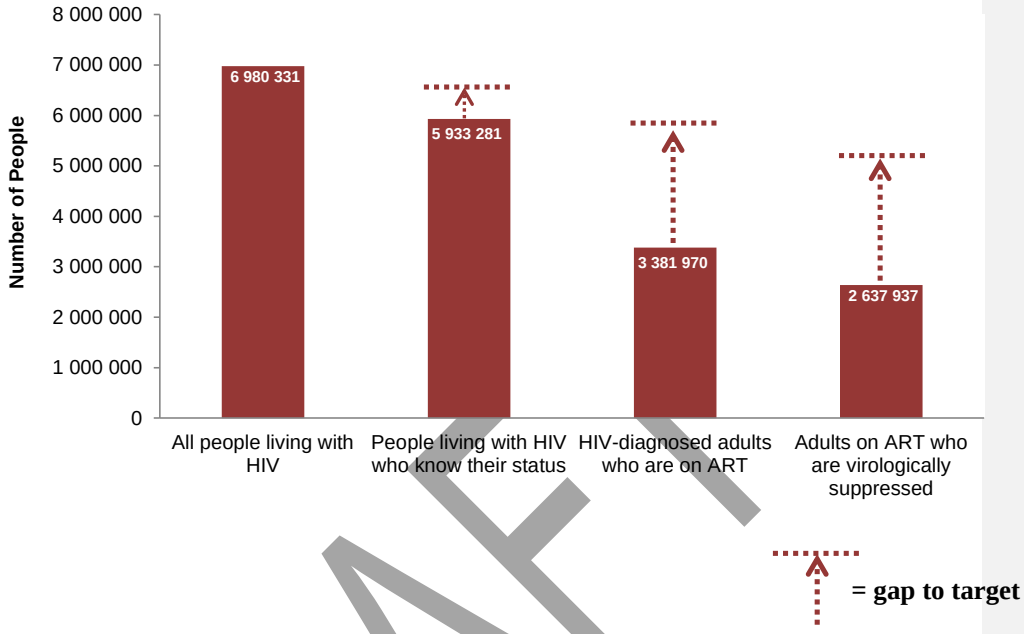
South Africa made notable advances in the treatment of HIV, TB and STIs in 2012-2016, massively scaling up antiretroviral therapy, adopting HIV Test & Treat in September 2016, scaling up the implementation of GeneXpert for TB diagnosis, and developing focused TB initiatives for peri-mining communities, correctional facilities and people with drug-resistant TB. Sustained progress was made to increase the number of people receiving antiretroviral therapy to 3.7 million by late 2016. However, much more remains to be done, especially as steps are taken to effectively implement Test & Treat. Particular barriers to antiretroviral therapy are experienced by children, adolescents, men and other key and vulnerable populations, which will need to be addressed under this NSP.

Many people living with HIV and/or TB remain unaware of their disease status, unacceptable delays persist between diagnosis and treatment initiation, and far too many people who start treatment discontinue therapy or otherwise fail to adhere to prescribed regimens. HIV and TB remain leading causes of death, including among children under five. South Africa's ability to monitor outcomes along the continuum of care is undermined by the lack of a national system that uses a unique patient identifier. Dramatically lowering rates of loss to follow-up for HIV and TB care is a critical priority for the NSP for the next five years. In addition, although existing therapies are highly effective, focused research is needed to generate shorter, more tolerable TB therapies as well as a greater array of child-appropriate antiretroviral regimens and long-acting antiretroviral regimens that can help improve treatment adherence.

The 90-90-90 targets for HIV and TB provide the cornerstone for national commitment to achieve Goal 2 and substantially contribute towards achievement of Goal 1. To reach the 90-90-90 HIV target, the number of people receiving antiretroviral therapy in South Africa will need to rise from 3.7 million to 6.1 million (including 175 000 children, with proportional representation of age and gender) and rates of viral suppression must also significantly increase. With respect to TB, the 90-90-90 target can only be attained if there are marked improvements in rates for case detection, initiation on treatment as well as treatment success rates. As this NSP covers the years 2017-2022, Goal 2 objectives and activities aim to reach the 90-90-90 target by 2020, and to begin progress towards the 2025 outcomes target of 95-95-95. This NSP primarily focuses on achievement of the 90-90-90 target but also recognizes the longer-term nature of this undertaking.

STIs persist as a major source of morbidity in South Africa, even with the improvements seen in the prevalence and incidence of some STIs. Barriers to reducing STI morbidity include inadequate diagnosis (including for STIs that are asymptomatic), inadequate cure rates and the growth of drug-resistant STIs. By 2020, 90% of HIV-positive pregnant women will be receiving effective syphilis treatment.

Figure: National HIV Care and Treatment Cascade (Thembisa Model, 2015)



5.2 Strategic Approach: Achieving 90-90-90 in all districts by 2020 and on target for 95-95-95 by 2025

The NSP aims to accelerate the decline in HIV-related mortality and to reduce TB mortality by 50%.[**] In addition to attainment of 90-90-90 for HIV and TB in children and adults, reaching these goals will require increasing STI detection and treatment by 50%; ensuring access to rehabilitation, psychosocial and mental health support for people living with HIV and TB in every district; and scaling up access to social grants, food security and nutritional support for people living with HIV and TB in need. The NSP focuses particular attention on addressing the unique challenges that children face in accessing HIV and TB diagnostic and treatment services. Realising these aims will require the robust participation of diverse actors in and out of the health system: not only the public sector, but also private providers, pharmacies and other health providers as well as diverse civil society and affected communities. Uptake and outcomes of the biomedical tools for diagnosis and treatment of HIV, TB and STIs can only be optimised if they are supported by robust SBCC efforts that build service demand, improve service retention and adherence, and empower individuals and communities to overcome impediments to service utilisation. To accomplish these aims, South Africa will take the following strategic steps:

- *Increase the proportion of people living with HIV who know their HIV status to 90%, consistent with the 90-90-90 approach:* Diverse outreach and service delivery strategies

[**] Mortality targets may be slightly adjusted once clearer baselines are established for purposes of monitoring implementation of the NSP.

are required to reach high-risk individuals and communities with testing services. HIV testing must be available not only in health facilities but also in community locations and in homes. A new national HIV testing effort, strategically focused on optimising testing yield, will be launched to decentralise testing and expand testing services delivered in and outside health facilities (e.g., workplaces, and in community settings); specific efforts will be made to close testing gaps for men, children, adolescents, young people, key and vulnerable populations and other groups that are not currently accessing HIV testing at sufficient levels; self-testing will be rolled out and actively promoted; and a major push will be made to expand birth testing, use of point-of-care early infant HIV diagnosis to increase testing among infants, and testing outreach for children up to 18 months to identify those that acquired HIV through breastfeeding. All people accessing HIV testing will have a known and recorded HIV status, and routine testing will be performed for children with HIV-positive parents. Every person that is tested for HIV must also be screened for other STIs as well as for TB.

- *Increase TB case detection from 68% to 90%, consistent with the 90-90-90 approach:* The NSP includes clear targets for expanding targeted facility-level TB screening, household contact tracing and targeted case-finding. Every person that is tested for HIV must also be screened for TB, all TB contacts must be screened for TB and all those with diabetes must be screened for TB. In addition, every patient with diabetes must be screened for TB. The NSP envisages intensified case-finding for priority populations, including household contacts of people with TB disease, health care workers and people living in informal settlements. Every child contact of an adult TB patient will be screened.

- *Strengthen screening and diagnosis of STIs:* STI screening will be integrated in health programmes across the life cycle beginning with adolescence, including the integration of STI screening for adolescents in the integrated school health programm, with appropriate referral for needed follow-up care. Steps will also be taken to improve the accessibility of STI services for men, including through mobile outreach and extended hours for STI service providers.

- *Increase antiretroviral treatment coverage from 53% to 81%, consistent with the 90-90-90 approach:* Achieving the 90-90-90 target and moving towards 95-95-95 will demand that at least 81% of people living with HIV receive antiretroviral therapy by 2020. To achieve this target, South Africa will ensure full implementation of its Test & Treat policy, focusing on rapid treatment initiation for adults and children and enabling same-day treatment initiation for those prepared to start treatment upon diagnosis. At least 90% of all antiretroviral therapy patients will receive timely and accurate viral load testing in accordance with clinical guidelines. Differentiated service delivery models for people-centered care will be developed and implemented, including the fast-tracking of health facility procedures, enabling stable patients to use alternative options for providing care and drug dispensing within and outside of health facilities. Improved tracking of mother-infant pairs will be undertaken to enable prompt initiation of antiretroviral therapy among children. The Central Chronic Disease Dispensing and Distribution Programme will be expanded, facilitating both access to essential medicines and improved efficiency.

- *Increase treatment coverage for TB and STIs:* The NSP includes ambitious targets for the scale-up of services for the treatment of TB. The 90-90-90 targets for TB will serve as the unifying focus in every district and in the currently identified 16 high-prevalence districts

in particular. In combination with intensified prevention efforts, the NSP's treatment provisions for TB aim to reach *zero TB deaths* in high-burden areas by 2022. Treatment coverage for STIs, including partner notification, will also be intensified to reach the targets set forth in the NSP.

- *Ensure that 90% of all patients receiving antiretroviral therapy are virologically suppressed:* Viral load monitoring should be a routine component of HIV treatment for every person living with HIV. According to local research, 52-75% of patients on antiretroviral therapy currently receive regular viral load tests.[47] [48] Where drug resistance has developed, viral load monitoring is equally important to ensure appropriate interventions, such as timely switching of regimens. To drive progress towards the goal of universal access to routine viral load monitoring, South Africa will educate health workers on the urgency of intervention when a patient has a detectable viral load, misses clinic appointments or is otherwise lost to follow-up. As safer, more effective antiretroviral medicines become available, such as dolutegravir for HIV, roll-out of superior regimens will be prioritised. This will include efforts to promote harmonisation of adult, adolescent and paediatric regimens where possible, as well as concerted efforts to further simplify antiretroviral regimens for childen and to ensure access to third-line paediatric regimens. Drug resistance surveillance will be improved and pharmacovigilance will be strengthened. Districts and facilities will receive clearly communicated performance indicators for 90-90-90, use results to improve programme performance and report results more frequently and in a timely manner. Clear guidelines will support community-based workers to optimise their role in health facilities and in communities and households.

- *Improve cure rates for drug-susceptible and drug-resistant TB and STIs:* In order for drug-susceptible TB cure rates to move from 83% to at least 90% and for drug-resistant TB cure rates to improve from 48% to at least 70%, South Africa will prioritise early detection, early initiation on treatment after diagnosis and appropriate treatment and the rapid introduction of new drugs, e.g. , e.g. bedaquiline (replacing injectables in the short-course treatment for MDR-TB), delamanid, pretomanid and regimes (especially novel shorter options for XDR-TB, like the Nix-TB Regimen, as they are approved. Improvements to supply chain management and training and mentorship of staff will be undertaken to expedite scale-up of short-course treatment for MDR-TB. Increased emphasis will be placed on implementation of STI syndromic management in both the public and private health sectors and the reduction of treatment failures for STIs.

- *Ensure that treatment services are of good quality and that loss to follow up is reduced:* Improvements in the quality of HIV, TB and STI services are needed to improve treatment outcomes and reduce the risk of antimicrobial resistance. As one important measure of quality, loss to follow-up, must be reduced and retention in care increased. Twelve months after initiating antiretroviral therapy, an estimated 27% of patients are no longer engaged in HIV treatment, with five-year loss to follow-up rising to almost half.[8] Nationally, treatment default rates are low drug-sensitive TB patients seen in primary health clinics, although local studies have sometimes found higher rates of loss to follow-up. [49] [50] [51] [52] [53] [54] The NSP aims to increase retention in care through a combination of approaches, including community education and awareness initiatives, patient tracking systems, routine patient education and counselling, and age-appropriate psychosocial support. Implementation of a pregnancy registry, including postnatal follow-up of infants and improved tracking of mother-infant pairs, will help guide and improve choice of regimens for both mothers and children. TB awareness and

demand-driven services will increase and new recording and monitoring tools will be rolled out to ensure that initial loss to follow-up is held below 5% for both drug-sensitive and drug-resistant TB patients. A quality improvement programme, reaching at least 90% of primary health facilities providing TB treatment, will be implemented to close gaps in the TB treatment cascade. Expanded use of unique health identifiers will also be fully leveraged to reduce loss to follow-up for TB treatment. Recognising that loss to follow-up persists as a major challenge for STI control, the NSP emphasises the engagement of individuals as early as possible, retain them in care and minimise leakages along the cascade of service continuum.

- *Prevent and/or minimize the emergence of HIV, STI and TB drug resistance:* In addition to the general improvement in the quality of services, specific efforts are needed to strengthen surveillance systems for monitoring emergence of antimicrobial resistance and taking appropriate action as early as possible. The HIV Drug Resistance strategy will be finalized and implemented during 2017/18, with the aim of improving both monitoring and prevention of drug resistance. Systems to strengthen gonococcal antimicrobial resistance will also be put in place. HIV drug resistance surveillance will be intensified, with the standardization of HIVDR testing practices and development of a national drug resistance database. TB resistance monitoring will also be strengthened. The national Antimicrobial Resistance Strategy will be fully implemented to address the emergence of resistance to HIV, STI, TB and other infections.

- *Provide holistic, integrated, people-centred care and support:* To ensure that treatments for HIV, TB and STIs are optimally effective and to maximise quality of life for people living with HIV and TB, all people living with one or more of these diseases will have access to differentiated service delivery, including facilities that are friendly for children, adolescents, young people, men and survivors of sexual assault. Services provided will be people-centred, integrated and comprehensive in scope, addressing not only HIV, TB and STIs but also non-communicable diseases and other health conditions experienced by individuals, including functional limitations or disabilities that people living with HIV and TB may increasingly experience as they age. All affected persons, including children, adolescents and survivors of sexual and gender-based violence, will have access to age-appropriate psychosocial and treatment continuation counselling and support, mental health screening and (where indicated) treatment, together with rehabilitation services for alcohol and substance abuse, including harm reduction services, and palliative care (where indicated). Particular attention will be paid to scaling up social protection programmes for vulnerable households and for orphans and vulnerable children, and to actions to strengthen the household as the central social support unit.

- *Promote innovation:* The NSP encourages the roll-out of innovative approaches to increase treatment uptake and improve treatment outcomes, such as use of self-testing technologies, male- and adolescent-friendly clinic hours, community- or home-based initiation, provision and follow-up of antiretroviral therapy as resources permit, after-hours and weekend services, contracting of general practitioners, increased use of mHealth solutions, expansion of treatment sites to include more workplaces, and presumptive STI treatment for individuals at high risk of STI acquisition. National standards will be developed and updated in line with the latest evidence to guide service delivery at decentralised sites.

Goal 2.0 Reduce morbidity and mortality by providing treatment, care and adherence support for all				
	Implement the 90-90-90 Strategy for HIV			
Objective 2.1	**Interventions**	**Approaches**	**Populations**	**Lead agencies**
Sub Objective 2.1.1: 90% of all people living with HIV know their HIV status (6.8 million people, including 363 000 children)	Scale up implementation of the single patient unique identifier, as part of the broader integrated patient registration system that will ultimately be linked to a patient electronic record.	-Phased implementation of the unique patient identifier till all health facilities have the IPRS implemented. -As the IPRS is phased in, optimise the functionality by expanding it to connect with data from other government departments e.g Home Affairs and DSD, to align packages of services. -Develop and disseminate guidelines and tools to ensure confidentiality and protection of patient data	All populations	NDOH Other government departments
	Expand HIV testing through diversifying testing approaches and services by combining provider-initiated testing, community-based testing and self-testing, promoting decentralization of services to reach underserved populations and those with high HIV burden while ensuring equity.	-National updated HIV testing campaign including decentralised testing, targets for testing outside health facilities, ensuring each child and adolescent has a recorded HIV status and testing all children whose parent/sibling is HIV positive or has died due to HIV. -Provide HIV self-screening guidelines, including partner screening for partners of pregnant women who test positive in ante-natal clinics -Evaluate and implement self-testing initiatives -Provide support to HIV testing, including self-testing including for people with disabilities. -Community health worker guidelines on role in facilities, ‘’opt-out’’ testing and linkage to care. -Assess and expand use of new laboratory techniques for point-of-care testing in non-traditional settings -Expand” All children and adolescents accessing health facilities should have a known and recorded HIV status. Every child whose parent/sibling is HIV+ or whose parent/s are deceased should be tested.	All populations	NDOH Private Sector Civil Society (all sectors to play a role)

	Strengthen the early infant diagnosis of HIV, especially at 18 months to detect transmission due to breastfeeding.	-Monitor annually the HIV testing rate at 10 weeks and 18 months to identify districts that need extra managerial support. -Optimise cohort measurement although a unique identifier would be best. -Measure through annual surveys. -Optimise the use of the Road to Health Card by ensuring the inclusion of the HIV status on each card.	Infants Pregnant and breastfeeding women	NDOH
Sub Objective 2.1.2: 90% of all people with diagnosed HIV infection receive sustained antiretroviral therapy (6.1 million people, including children)	Develop and implement national guidelines and tools on HIV Treatment for health providers and community health workers	-Update national HIV treatment and care guidelines and protocols for health providers, including information on referral pathways and monitoring and evaluation. -Simplify and improve guidelines for ART regimens to improve ART adherence particularly in children where pill burdens is high. -Develop differentiated service delivery model for patient-centered care of individuals (adults, pregnant women, adolescents, children, people with disabilities, other key and vulnerable populations, etc) at different stages of HIV disease and with different treatment needs (advance disease vs well on presentation/diagnosis, and "stable" with virological suppression vs "not stable") for the whole continuum of care, addressing when clinical reviews are done, where the patient is managed (Clinic, GP, community, etc), who manages the patient (Dr, nurse, GP, community health worker, etc) and how the patient is managed (ART initiation, refills, adherence support, psychosocial support, , referral pathways and follow-up etc.) -Guidelines for community health workers on role in community and facility HCT, linkage to care, ART initiation counselling, ART delivery and follow-up in the context of differentiated service delivery. -Updated treatment literacy materials with information that is relevant to context, age and population Provide support to health professionals to manage adverse events through an appropriately staffed help-line with immediate access to the necessary information.	General population Key and vulnerable populations including AGYW	NDOH

	Improve linkage to care to ensure quick and easy intiation on ART of all people diagnosed with HIV, when they are ready for treatment	-Fast-track implementation of national test and treat by ensuring the policy is understood and implemented at all health facilities. -Provincial, district and facility targeting and reporting for critical indicators to track performance. (e.g. % of patients initiated through non-rapid initiation (> 7 days)) -Ensure programme quality including: First ART preparation education/counselling session (provided for in national adherence guidelines) provided at site/time of HIV diagnosis and given appointment date and time for ART initiation at closest facility; Establish Peer/other appropriate navigation services within clinic – where to go to test/initiate (especially for youth who too scared to ask reception) -Expand implementation strategies to include: Establish Community-based ART (outside of clinic settings) initiation demonstration projects for well patients, including the use of GPs; Prioritise rapid and enable same day initiation; Implement extended hours services for working people, males and adolescents; Implement a facility return-friendly focus with immediate restart of treatment; Use PLHIV to encourage linkage to care within communities and in health facilities; Explore innovative ways to link people with services e.g. support PLHIV to access services through transport vouchers, use of home visits.	PLHIV	NDOH District Management Teams Civil society (PLHIV sector)
	Strengthen the monitoring system to enable better tracking of patients between services and facilities and their outcomes.	-Expand the rollout of the third phase of Tier.Net to all health facilities -Fast track the integration of Tier.Net with EDR.Net as a first step whilst the unique identifier is beign rolled out (as this will then include the integrated services)	PLHIV	NDOH

	Implement strategies to prevent and minimize HIV drug resistance and use to inform national antiretroviral policies and guidelines.	-Implementing the national HIVDR strategy for programming and monitoring -Integrating drug resistance surveillance into the overall ART programme to ensure sustainability -Standardized HIVDR testing practices (clinical and laboratory) -National Drug Resistance database for improved monitoring, evaluation and reporting -Expanded laboratory capacity for HIVDR surveillance -Build the capacity of health care providers in HIVDR management.	General population Key populations Pregnant women Children	NDOH Private Sector Academia
	Ensure uninterrupted supplies of the best possible range of antiretroviral drugs at the lowest cost, including first, second and third line drugs	-Up to date national first, 2nd line and 3rd line antiretroviral regimens based on the latest available evidence and harmonisation between different population groups. -Provision of High Quality low pill burden third line regimens for children and adolescents with HIV drug resistance. Expansion of Drug stockout early warning system	PLHIV	NDOH Civil society (PLHIV sector)
	Improve pharmacovigilance to enable increased timeous reporting of adverse events, detect trends and respond to them.	-Expansion of the National Pharmacovigilance Pan for HIV and TB to include all districts -Implement a national pregnancy registry , starting in selected sentinel sites before expanding to other sites.	All People living with HIV Pregnant women	NDOH Private sector Civil society (PLHIV sector)
Sub Objective 2.1.3: 90% of all people receiving antiretroviral therapy are virally suppressed (5.5 million people, including children)	Improve viral load monitoring through systems strengthening	-Use the District Implementation Plan process to create a system of accountability (target setting and reporting) down to the facility and staff level for achieving the 90-90-90 targets -Ongoing quality improvement to identify the gaps and challenges, including data capturing, results management, protocol being followed -Decentralised point of care viral load testing to optimise viral load testing -Improve patient information, education and communication materials, including the use of PLHIV, to create demand for timely viral load testing from the patient's side.	PLHIV	NDOH District Management Teams Civil society (PLHIV sector)

	Promote retention in care for all PLHIV on ART	-Implement differentiated ART delivery for stable patients with target of 75% of patients. For these stable patients include the following services: o A minimum of 3 months drug supply at a time. o Each health facility to offer drug collection sites outside of the health facility as well as a fast lane for drug collection at the pharmacy o Allow patient representative to collect ART refills o Lengthened prescription period to 12 months o Expand the Central Chronic Medicine Dispensing and Distribution programme to deliver drugs at many places outside of the health facilities e.g local pharmacies, stand alone Pharmacy Dispensing Units -Mhealth interventions to communicate VL results, stock outs and appointments -Develop an implement in all health facilities a "Return Friendly" plan that guides how to manage patients who have interrupted their treatment. -Expand access to palliative care, including pain relief -Track and improve the management of chronic diseases amongst PLHIV, as the population on ART ages.	PLHIV Key populations AGYW Pregnant women	NDOH Private Sector
	Improve adherence support	-Implement a comprehensive and age appropriate Psychosocial package to enhance adherence and retention and care -Promote the establishnment of peer-led differentiated support groups for new and stable patients and ensure their linkages to psychosocial support. -Develop guidelines for CBOs to direct their support of ART adherence in communities.	PLHIV Key populations AGYW Pregnant women	DSD NDOH Private Sector

Objective 2.2	**Objective: Improve STI detection, diagnosis and treatment**				
	Core Interventions	**Routine approach**	**Intensified approach**	**National Target**	**Accountable parties**
Sub Objective 2.2.1: Increase detection and treatment of asymptomatic STIs by 50% in high burden districts	Implement the updated STI guidelines that now includes a specific approach for the management of asymptomatic infections.	-Develop, test and validate the sexual history tool for different populations and different ages. -Train health care workers and community health workers on the use of the tool -This service should be integrated into existing programmatic systems – MSM male friendly clinics, ART clinics, FSW programs, ANC clinics and FPC services and through pre-exposure prophylaxis (PrEP) programmes. -The screening history tool will also be used at community level through peer outreach or Ward Based Outreach Teams who will then refer at- risk clients on for further assessment and appropriate management.	-Strengthen ACSM in high burden districts by providing targeted STIs messages all year round -Screen and test priority populations (AGYW & SW) for asymptomatic STIs .	50% increased detection and treatment of asymptomatic STIs in high burden districts cumulatively by 2022. (Year 1: get baseline ; Year 2 : 10% Year 3: 20% ;Year 4: 35% Year 5: 50%)	NDOH, NICD ,NHLS Civil society (key population sectors) District Management Teams
Sub-objective 2.3.2: Increase the detection and treatment of STIs	Appropriate syndromic management of STIs and further care of those who fail syndromic management Mobile outreach services for: men with extended hours, TVET colleges and Universities Ensure screening for STIs and linkage to services for learners as part of the	-Adapt and implement guidelines on STI and HIV screening, diagnosis and management guidelines based on national data and building on available services -Develop and implement strategies to strengthen sexual partner management, including partner notification and contact tracing especially key populations. -STI treatment in all primary health care facilities -Train and re-train HCWs on syndromic management -Advanced STI care services in secondary level hospitals and CHCs -Set up the capability for advanced STI management including appropriate sample collection and processing. -Train HCWs on advanced STI care,	-Screen for STIs symptoms all 15-49 yr coming to health facilities for consultation -Increase the proportion of 15 -49yrs screened through STIs screening tools	Baseline is 1.144 million new STIs episodes 50% increase per annum	NDOH District Management Teams DHET/HEAIDS

	integrated school health programme.	referral and appropriate specimen collection -Care for individuals with persistent and or complicated STI			
	Eliminate congenital syphilis	-Screening of all pregnant women for syphilis at first ANC visit -Treating all syphilis positive women with three doses of Benzathine penicillin -Screening for syphilis at birth: all infants born to Syphilis positive women or to women who were unbooked or untested -Linking all children diagnosed with congenital syphilis to care and ensuring they receive treatment	-Intensify notification process -Develop routine congenital syphilis monitoring -Tracing and management of confirmed syphilis clients	95% pregnant women screened for syphilis at first ANC visit 100% of pregnant women screening positive for syphilis treated with Bezathine penicilin 100% of syphilis exposed infants screened at birth 100% linkage to care all infants diagnosed with syphilis	NDOH, NICD, NHLS District Management Teams
	Strengthen private – public partnership for STI management	-Mapping key private sector stakeholders in STI research -Use framework for PPP in STI management -SAQA accredited course on Genitourinary Tract Infections -Partnership with NGOs and government to improve efficiency and quality of STI service delivery -Capacity building of private practitioners in STI management -Use service agreements and contracts with private service delivery organizations for STIs prevention, testing, treatment and management.	-Develop and conduct electronic routine training in service education on STIs guidelines -Develop a database for private practitioners & NGOs rendering STIs services	90% of private STIs researchers mapped 50% of private practitioners trained on STIs management (basic & advanced) % of Service level agreements and contracts signed with private service delivery organisations for STIs (prevention, testing , treatment & management)	NDOH District Management Teams Civil society (health profession sector) Private health service providers Medical Aid Schemes
	Promote integration of STI prevention care and treatment into HIV, TB, ANC, sexual and reproductive health	-HIV testing of all STI patients -ART for all HIV positive STI clients -Referral to MMC for all male STI clients -Screening of all MMC clients for STIs -Family planning and cervical cancer screening for all eligible female STI	-Strengthen ART initiation at STIs services	100% integrated services of STIs prevention and treatment into HIV,TB,ANC,SRH services.	NDOH District Management Teams

	services	clients -STI screening and treatment of all symptomatic / asymptomatic pregnant women			
Objective 2.3	***Implement the 90-90-90 Strategy for TB***				
	Core Interventions	**Routine approach**	**Intensified approach**	**National Target**	**Accountable parties**
Sub-objective 2.3.1 Find 90% of all TB cases and place them on appropriate treatment	Intensified facility-level TB case-finding	-Passive case-finding (test individuals presenting with symptoms of TB)	-Routine symptom screening for all adult clinic attendees -Undertake Xpert MTB/RIF test for symptomatic individuals not tested for TB in the last 3 months -Undertake culture test for HIV+, Xpert-negative cases	>90% adult attendees screened >90% of HIV+ adult attendees screened >95% symptomatic individuals tested for TB with Xpert MTB/RIF 80% HIV+, Xpert-negative cases receive culture test Household/close contacts tested per year: Year 1: 100 000 Year 2: 200 000 Year 3: 300 000 Year 4: 400 000 Year 5: 500 000 HCWs screened per year: Year 1: 1600 Year 2: 10 000 Year 3: 30 000 Year 4: 70 000 Year 5: 120 000 Residents screened per year: Year 1: 100 000 Year 2: 300 000 Year 3: 600 000 Year 4: 800 000 ▪ Year 5: 1 000 000	NDOH Private healthcare providers Health insurance schemes
	Improve laboratory diagnostics to deliver optimal DS and DR-	-Universal implementation of Xpert MTB/RIF as initial diagnostic -Improve adherence to Xpert- negative	-Prepare and train on guidelines and algorithms in advance of Xpert Ultra introduction	By 2022, 100% of staff in health facilities offering TB testing are trained in	NDOH NHLS

	TB services	algorithm -Implement robust reflex testing for tests found to be Xpert Rif resistant -Optimise implementation of existing algorithms -Develop a platform for introduction of new diagnostics	-Upgrate the laboratories to ensure sufficient second line LPA coverage to ensure optimal implementation of MDR-TB short regimen -Implement lessons learnt from Xpert rollout -All labs doing second line LPA shoud be either able to conduct phenotypic second line DST or have easy referral to a lab that does have this capability.	the use of the Xpert MTB/RIF	
Sub Objective 2.3.2: Find at least 90% of the TB cases in key populations (the most vulnerable including PLHIV with low DC4 counts, under-served, at-risk populations) and place them on appropriate treatment	Active case-finding for special populations	-Screening of household contacts under 5 years of age -TB screening in correctional facilities -TB screening in large, medium and small mines.	-Implement contact tracing for all household members of TB index cases -Implement routine screening for health care workers -Improve TB screening and testing among pregnant women to reduce congenital and perinatal TB transmission -Improve paediatric sputum induction at PHC and hospital level -Implement targeted screening in TB hotspots in informal settlements	>80% index cases have household contacts evaluated >60% health care workers screened annually 3 million individuals in informal settlements screened (cumulative)	NDOH NGOs and CBOs working in this area DBE DSD Private healthcare providers Health insurance schemes
Sub Objective 2.3.3: Treat successfully at least 90% of those diagnosed with TB (and 75% for those with DR TB)	Reduce initial loss to follow-up rates for DS and DR TB cases	-Identify and track loss to follow up from diagnosis to initiation to reduce early loss to followup. -Change the Electronic TB Register to track patients progress from the time of diagnosis rather than intiation of treatment to better track early loss to follow up. -Identify and recall patients who do not return for treatment after diagnosis. -Retrain staff and implement on-going clinical governance using QI approach -Conduct training per province and then re-enforce at a site level	-Establish initial loss to follow-up rate as a management priority -Reduce duration and number of visits from symptom onset to treatment -Improve identification and recall of cases not returning for treatment	<5% laboratory diagnosed DS and DR TB cases with initial loss to follow-up	NDoH NHLS PDOH Districts, Facilities, Development Partners
	Provide standard of care for DS-TB cases	-Initiate patients on standard TB regimens -Provide adherence support and retain patient in care for treatment duration -Bacteriologically monitor treatment outcomes	-Undertake national research priority studies: o What health facility and programme management interventions impact on treatment outcomes? o Do alternative drug dispensing strategies affect adherence and	Policy review undertaken based on research findings	NDOH

			patient outcomes? ○ What clinical management and adherence support strategies improve treatment outcomes? -Review policies through multi-sectoral TB Think Tank		
	Improve current implementation of DR-TB programme, including decentralised DR-TB care	-Implement current guidelines -Implement recommendations from WHO 2015 review Provide psycho-social support	-Revise DR-TB policy documents including clarifying the decentralisation policy that needs to specify which level of site can intiate treatment and what treatment and support, including mentorship and referral system is needed. -Revise treatment guidelines to also include: differentiated care strategies that include self administered treatment for adherent and stable DR TB patients; and the implementation of treatment interrupted interventions for those interrupting treatment; and the use of drusg for patients who do not qualify for short course regimens. -Regular revision of policy and guidelines to reflect new evidence and lessons learnt from implementation. -Improve Pharmacovigilance (PV) -Modify EDR to accommodate PV, new regimens and tracking of patients from diagnosis. Set up a regular feedback process form users of the system to developers to optimise functioning of the anhanced EDR.Net. -Conduct regular clinical audits including chart reviews to ensure adherence to guidelines -Initiate patients on appropriate treatment short-course (including bedaquiline where necessary)	800 sites by 2018 and 1000 sites by 2022, providing decrentralsied DR TB management	NDOH
	Scale up short-course MDR-TB treatment	-Provide decentralised MDR-TB care -Provide psychosocial support	-Revise MDR-TB policies and guidelines -Improve supply chain management -Train and mentor staff to provide shortened regimen	90% of Rif-Resistant cases on short course treatment 80 % of decentralised	NDOH

			-Adapt EDR to accommodate new regimens -Initiate patients on appropriate treatment short-course (including bedaquiline where necessary)	sites initiating patients on bedaquilline and other new drugs 90% of health facilities with no drug stockouts	
	Implement a quality improvement (QI) initiative to close gaps in the TB care cascade and improve programme otucomes.	-Successful national PMTCT QI programme -TB QI projects implemented by partners	-Develop DOH capacity to undertake QI (national, provincial, district and sub-district teams established; leadership and QI skills developed; tools and guidelines developed; learning networks established) -Demonstration sites for QI established -Undertake district baseline assessments and set targets -National scale-up based on successful models including nurse initiated care	90% treatment success rate for drug-sensitive TB 75% treatment success rate for multi-drug resistant TB 90% of all primary health care facilities treating TB patients implementing a QI programme	NDoH PDoH Districts Support partners
	Review and improve supply chain management	-Meet with key stakeholders from AMD (including EML), NTP as required. -Review initial anticipated demand shifts and impact on current contract commitment -Analyse provincial stock situation -Determine the mechanism for clofazimine registration and supply -Distribute stock to provincial depots			NDoH Key stake-holders Provincial TB directorate
	Continuously train staff and implement on-going clinical governance	-Convert new guidelines into training materials for all cadres of staff -Conduct training per province and then re-enforce at a site level -Conduct regular clinical audits including chart reviews to ensure adherence to guidelines			NDoH Key stake-holders

Goal 3: Reach all key and vulnerable populations with customised and targeted interventions

6.1 Situation analysis

The high-impact prevention and treatment strategies outlined in Goals 1 and 2 will only have their desired result if they reach those who need them. While South Africa has a generalized HIV epidemic and nationwide TB and STI epidemics, underscoring the critical importance of universal access to a comprehensive package of prevention and treatment services, some groups are much more heavily affected than the population as a whole. Various social and structural factors increase vulnerability to HIV, TB and STIs, and although disproportionately burdened by HIV, populations most affected by these social and structural factors frequently struggle to obtain appropriate prevention and treatment services, often due to stigma and discrimination. Individuals may belong to multiple key or vulnerable populations, often compounding personal vulnerabilities and barriers to service access. In addition, membership in a key or vulnerable population is not always static or permanent; as examples, individuals eventually age out of adolescence, while people who are migrants at one point in time may ultimately become part of a local community.

Key populations for HIV and STIs
Sex Workers
Transgender people
Men who have sex with men
People who use drugs
Inmates

Key populations for TB
People living with HIV
Household contacts of TB index patients
Health care workers
Inmates
Pregnant women
Children < 5 years
Diabetics
People living in informal settlements

Vulnerable populations for HIV and STIs
Adolescent girls and young women
Children including Orphans & vulnerable children
People living in informal settlements
Mine workers
Migrants and undocumented foreigners
People with disabilities
Other LGBTI populations

In addition to imposing disproportionate health burdens and contributing to health inequities, elevated levels of transmission among key and vulnerable populations also drives epidemics at national, provincial and district levels. For example, with an estimated 2000 adolescent girls and young women newly infected *every week*, strengthening prevention, treatment and vulnerability reduction for this group as well as other key and vulnerable populations is an urgent national priority.

Since the launch of the NSP 2012-2016, evidence has grown regarding the size and distribution of key populations and vulnerable groups as well as the patterns that increase their health risks. In recent years, South Africa has made important strides in addressing the health needs of key and vulnerable populations. The 'all of society and all of government' She Conquers campaign, the DREAMS initiative, and contributions from the Global Fund have and will continue to contribute to HIV and vulnerability reduction among adolescent girls and young women. In 2016, South Africa launched an HIV strategy for sex workers[45] and drafted the South African National LGBTI Framework for 2017-2022.[56]

Substantially stronger and more successful efforts will be needed to meet the HIV, TB and STI challenge for key and vulnerable populations. Considerable gaps remain in national efforts to meet the needs of key and vulnerable populations; as one example, people with disabilities often struggle to participate or are sometimes wholly excluded from participation in prevention programmes, development of sector frameworks and provincial AIDS council structures.

6.2 Strategic approach: Ensuring that no one is left behind

The NSP provides for equitable, meaningful access among key and vulnerable populations to the comprehensive package of services endorsed in the NSP, plus tailored interventions to address the specific needs of each key and vulnerable population. Strong, appropriately focused SBCC programmes and concerted efforts to reduce vulnerability will be required to effectively link key and vulnerable populations to the services they need. To substantially reduce new infections, morbidity and mortality associated with HIV, TB and STIs among key and vulnerable populations, South Africa will implement the following interventions in 2017-2022:

- *Strengthen strategic information for action on key and vulnerable populations:* Size estimations are not yet available for all key populations, and programme utilization data are frequently not disaggregated to identify coverage trends for specific key and vulnerable populations. To close these gaps, concerted efforts will be made to expedite development of reliable size estimations and additional mapping and qualitative information for key and vulnerable populations. Through implementation of the "focus for impact" approach, stronger efforts will be made to use this data for programme development and targeting for key and vulnerable populations. Data collection and reporting must be disaggregated, taking into account age, gender, race, disability and specific key and vulnerable population.

- *Build robust household and community capacity, engagement and inclusion:* Although South Africa's response to HIV, TB and STIs has amply demonstrated the transformative potential of community leadership and engagement on public health issues, community capacity in many key and vulnerable populations is still weak. As one example, adolescent girls and young women who wish to break free of the cycle of transmission associated with sexual network dynamics frequently lack access to peer support or advocacy that could help them do so. Inadequate community capacity and meaningful involvement of key and vulnerable populations in all levels of decision-making regarding HIV, TB and STIs diminishes the ability of these communities to play their optimal role. The NSP outlines an array of strategies and activities to build strong capacity for key and vulnerable populations and to ensure their full participation at national, provincial and district levels, including their participation in the development of health and social support activities. This includes efforts to build the social capital of key and vulnerable populations by encouraging community networks and community empowerment, and also by creating a collective identify or shared sense of belonging to a social group or network.

- *Engage communities in the development and implementation of social and health support activities:* Peer-involved and peer-led interventions will be substantially expanded; key and vulnerable population representatives will be included in all national, provincial, district and local AIDS councils and other cross-cutting working and advocacy groups; and civil society and community networks will be encouraged to support and mobilise key and vulnerable populations. Civil society and community networks will be

encouraged and capacitated to mobilise members of key and vulnerable populations to access services and reduce risks.

- *Ensure multi-sectoral engagement:* Broad-based collaboration and the engagement of multiple sectors will ensure an optimally coherent and holistic response for and by key and vulnerable populations. Specific efforts will be needed to engage a broad array of key public sectors, community-based organisations, civil society and the private sector, including for the implementation of relevant national strategies, plans and campaigns (e.g., National Sex Worker HIV Plan, National LGBTI HIV Framework, She Conquers campaign, Roadmap to reducing HIV infection among PWID in South Africa, Framework and Strategy for Disability and Rehabilitation Services in South Africa, the new National Policy for Occupational Health for Health Workers regarding TB and HIV, due for release as of the development of the NSP).

- *Tailor health and social services and the mode of delivery:* Services and information will be customised to address the unique needs of specific key and vulnerable populations, including steps to ensure that services are designed in a manner to ensure accessibility for persons with physical and mental disabilities. To close utilization gaps that remain for key and vulnerable populations, materials and training packages will promote standardised packages of health and social services for key and vulnerable populations, including programmes for health empowerment, economic empowerment, gender norms and equality, justice and universal design and accommodation for people with disabilities. Particular efforts will be made to expand access to peer-involved and/or peer-led psychosocial support, information-sharing, adherence support, risk reduction counselling, peer navigation and HIV testing services. Steps will be taken to move towards harm reduction policies and programming for people who use drugs.[††] To improve service access and continuity for migrants, health passports will be issued and emergency buffer supplies of drugs will be provided. Scale-up will aim to ensure that at least 90% of all key and vulnerable populations have access by 2022 to a comprehensive package of innovative, integrated HIV/STI prevention and treatment services, including sexual and reproductive health services. Services recommended in the National TB Guidelines will be scaled up for key and vulnerable populations. Social and behaviour change communications interventions will be implemented to build demand for HIV, TB and STI services and increase service uptake. Steps will be taken to ensure that health services include reasonable accommodation of all people with disabilities, including ensuring that information and services are accessible for hearing- and sight-impaired people, people with intellectual disabilities and other people with disabilities. Enhanced efforts will focus on the development of tailored services and interventions for people living with HIV who are older or are also experiencing other chronic diseases. To the extent resources are available, innovative methods will be used to deliver these services, including comprehensive and holistic "one stop shop" approaches, dedicated services, and alternative hours and days. Physical and virtual "safe spaces" will be created to serve as entry points for social and health services for key and vulnerable populations. Efforts must be innovative and opportunistic with respect to scaling up tailored services for key populations, fully levering venues such as colleges and universities, where a substantial share of participants belong to key and vulnerable populations.

[††] UNODC, WHO and UNAIDS have identified nine essential components of a harm reduction package, http://www.who.int/hiv/pub/idu/idu_target_setting_guide.pdf.

- *Sensitise providers to address the needs of key and vulnerable populations.* Health and social service providers should address the needs of key and vulnerable populations in an effective, non-judgmental and non-discriminatory manner. Prior negative experiences in health and social service settings often serve as powerful deterrents for key and vulnerable populations to seek services when they need them. To prepare health and social service workers to provide population-tailored, good-quality, non-discriminatory services, sensitisation training will be conducted to increase their ability to meet the needs of key and vulnerable populations. Trainings will build the core competencies of providers in a broad array of health and non-health areas. Health care managers are required to implement infection control and prevention and occupational health programmes in accordance with their legal responsibilities.

- *Eliminate stigma, discrimination and punitive laws that burden key and vulnerable populations:* Key and vulnerable populations are often highly marginalized. As a result, they sometimes lack access to information and support and may avoid seeking services due to the fear or expectation that they will not be treated well. Sex work is currently criminalized in South Africa, although proposals have been made to decriminalize it. In a national survey of South Africans, while 51% said that gay people have the same human rights as others, 72% said that same-sex sexual activity is "morally wrong."[57] The NSP calls for steps to be taken towards the decriminalisation of sex work. In addition, actions will work to eliminate the stigma experienced by people with disabilities. Under the NSP, actions will be taken to implement evidence-based anti-stigma initiatives, including broad anti-stigma communications campaigns. In addition, stronger efforts will be made to monitor service utilization patterns and to identify and rectify inequities or bottlenecks as they occur; and greater attention to implementation will help service access (e.g., for migrants, who are legally entitled to services under law but may experience stigma, diminished access or other forms of discrimination in service settings).

GOAL 4	Reach all key and vulnerable populations with customised and targeted interventions.		
Objective 4.1	**Increase engagement, collaboration and advocacy of key and vulnerable populations in the development and implementation of social and health support activities**		
	Comprehensive Approach	**Intensified Approach**	**Lead agencies**
Sub Objective 4.1.1 All national and provincial AIDS Councils will include at least one representative from a key and vulnerable population group	Inclusion of population representatives in national and provincial AIDS councils, and other cross-cutting working & advocacy groups (e.g. PLHIV, health care worker, ex-inmate, mine worker and a community member who is living with TB or has been affected by TB)	Build and sustain capacity for KP and VP representatives to undertake leadership roles	AIDS council secretariats all levels Advocacy groups Civil society (key and vulnerable population sectors)
Sub objective 4.1.2 Support key and vulnerable population social capital by encouraging community networks to create a collective identity that includes advocacy agendas for equal health and human rights	Encourage civil society and community networks to support and mobilize members of KP and VP to access services and develop and promote an advocacy agenda to realise their health and human rights	Provide meeting spaces, social marketing support, guidance, support for community groups to organise and mobilise	SANAC secretariat AIDS council secretariats all levels Advocacy groups Civil society (key and vulnerable population sectors)
Sub objective 4.1.3 All key and vulnerable population programmes should adopt a peer educator led approach to implementation	Ensure peer-involved psychosocial support, information sharing, adherence support, risk reduction counselling, peer linkage and navigation throughout delivery of health and social services, and HIV testing services to promote inclusion, appropriate tailoring	Ensure peer-led psychosocial support, information sharing, adherence support, risk reduction counselling, peer linkage and navigation throughout delivery of health and social services, and HIV testing services to promote inclusion, appropriate tailoring	All implementers AIDS councils Advocacy groups
Objective 4.2	**To provide an enabling environment to increase access to health services by key and vulnerable populations**		
	Comprehensive Approach	**Intensified Approach**	**Lead agencies**
Sub objective 4.2.1 Enable increased access to health services through differentiated service delivery approaches that are tailored for the populations served	Implement dedicated service delivery fixed sites and/or hours of operation for specific populations (e.g. youth-friendly clinics in schools, MSM-friendly clinics) Ensure alternative hours, days of operation of service delivery sites Adopt the principles of universal design and reasonable accommodation to ensure accessibility for persons with physical and mental disabilities	Implement dedicated mobile service delivery sites in strategic locations (hotspots, workplaces, truck stops, etc.) with services customized to the target populations Implement dedicated service delivery fixed sites in strategic locations, including mines and correctional services.	All implementing organizations DOH at every level DCS DBE

Sub Objective 4.2.2 Enable increased access to appropriate health information that addresses the needs of the population group (including language, accessible formats for visual/auditory impairment)	Provide sensitive health information and IEC services for the primary KP and VP populations served in the catchment area	Customise and contextualise health information and materials for the primary KP and VP populations served, including local referral information	All implementing organizations DOH at every level DBE Advocacy groups
Sub objective 4.2.3. Scale up tailored social and behaviour change communication interventions that promote the adoption of protective behaviours and uptake of health services	Ensure access to SBCC interventions tailored to the primary KP and VP populations served in the catchment area	Customise and contextualize SBCC interventions to the local context Pilot, refine, and disseminate population-sensitive social marketing, social media and other direct demand creation activities that promote the uptake of protective behaviours	SANAC Secretariat All implementing organizations
Sub objective 4.2.4 Provide psychosocial support services and safe spaces for key and vulnerable populations who experience internalized stigma	Designate physical and virtual safety areas with sensitized providers and peer navigators to facilitate entry into social and health services.	Create and promote physical and virtual safety centres, e.g. drop-in centres, youth centres, recovery houses, etc. to provide peer and psychosocial support, and serve as entry points for social and health services.	All implementing organizations DSD
Sub objective 4.2.5 Train healthcare professionals in the identification and delivery of appropriate services for key and vulnerable populations	Develop, provide materials and training of core health and psychosocial service components, including: -Customised, appropriate and sensitive health screening -Customised, appropriate violence screening, including GBV, child abuse -Customised, appropriate drug and alcohol use screening -Customised, appropriate mental health screening -Impartial and non-stigmatizing language, terminology -Thorough and sensitive contact tracing -Assurance and follow-up of all linkage and referral services, following case management principles	Institute robust staff support systems, including supervision, mentoring, support, skills review and refresher training to promote staff skills, reduce burnout, and retain employees Institute zero tolerance policies for non-adherence to competencies	All implementing organizations DOH at every level
Sub objective 4.2.6 Integrate core rights-based components in all health and social programmes to holistically serve KP and VP clients and patients	Develop, provide materials and training of core rights-based components, including: -*Human rights and constitutional protection*: recognition and literacy in basic human rights, constitutional rights, recognition of violations and actions to report -*Health empowerment*: communication, health literacy, health rights and responsibilities, guarantee of confidentiality, -*Economic empowerment:*	Pilot, evaluate, revise core programmes Develop minimum standard core competencies for all health, social, education sector service providers Institute zero tolerance policies for non-adherence to competencies	All implementing organizations DOH DSD DBE DCS

	alternative livelihood support for sex workers who choose to exit, social support and access to economic empowerment programmes for people with disabilities, access to legal support -*Gender norms and equality*¸ including GBV screening, prevention, care and support -*Justice* for persons facing stigma, discrimination, legal injustices, and access to legal support, including legal literacy and access to legal aid, - *Principles of universal design and reasonable accommodation* in to enable access of persons with disabilities		Advocacy groups Civil society (key and vulnerable population sectors)

Package of services for key and vulnerable populations

Core package of services for all key and vulnerable populations		
Service/intervention/approach, customised to the age and population served		**Lead agency**
• Service delivery in non-traditional settings, including after hours and weekend hours • Health education, customised to client needs • HIV Screening, Testing, and Treatment • STI screening, treatment • TB screening, treatment and contact tracing for DS and DR TB • Mental health screening and psychosocial support • Access to PEP and post sexual assault support • Alcohol and drug use screening • Violence screening • Condom promotion and provision • Targeted social and behaviour change communication • Core rights-based programme components: *-Human rights and constitutional protection*: *-Health empowerment*: *-Economic empowerment* *-Gender norms and equality* *-Justice* *-Principles of universal design and reasonable accommodation*		All implementing agencies All implementing agencies DoH DoH DSD, DOH, DBE DoH, NPA DSD DSD DoH DoH DSD, DoH, NGOs, SANAC Secretariat NGOs, SAPS, NPA
Population-specific additions to the core package of services		
Sex Workers	• Peer-led outreach • PrEP • Female condoms and lubricant • Intensified psychosocial support • Periodic presumptive treatment for STIs • Social mobilisation, use of formal/informal peer networks to create demand • PMTCT • Hepatitis B immunisation • Annual pap smears • CTOP [Choice of Termination of Pregnancy) • Screening and protection for the sexual exploitation of children • Community empowerment	DoH, DSD, NGOs, SANAC Secretariat DoH DoH DSD DoH NGOs DoH DoH DoH DoH DoH, DSD NGOs
Transgender Persons	• Peer-led outreach • Specialised counselling support • PrEP • Female condoms and lubricant • Rectal care and treatment	DoH, DSD, NGOs, SANAC Secretariat DSD DoH DoH DoH
Men who have sex with men	• Peer-led outreach • PrEP • Lubricant, Condom options • Hepatitis B screening and immunisation • Rectal care and treatment	DoH, DSD, NGOs, SANAC Secretariat DoH DoH DoH DoH

People who use drugs	• Peer-led outreach • Harm reduction counselling • Linkage to rehabilitation centres • Needle and syringe exchange programmes • Opioid Substitution Therapy • Accelerated nutritional and social grant support, if indicated • Hepatitis B screening and immunisation	DoH, NGOs NGOs DoH DoH NGOs DSD DoH
Inmates	• Entry, exit and biannual TB screening and offer of HIV testing • Detention and home contact tracing for persons diagnosed or exposed to TB • Support groups for inmates living with HIV and TB in prisons • Peer education and support for HIV and TB programming	DoH, DCS DoH, DCS DCS DCS
People living with HIV	• Prompt ART initiation as a component of TB prevention • Adherence and psychosocial support • Peer education and support for TB prevention and treatment • Optimal uptake of preventive therapy for TB • Infection control in facilities, communities and households • TB screening at each visit, linkages to treatment and care • HIV screening for household members, including partners and children • Cohort monitoring of HIV/TB coinfection patients • Support groups specifically addressing internalised stigma	DoH DoH DoH DoH DoH DoH DoH DoH SANAC Secretariat
Household contacts of TB index patients	• Develop simplified screening algorithms for TB-exposed children • Implement community education and mobilization programmes to improve acceptance of contact investigations and to create awareness of the benefits of preventive therapy • Strengthen routine M&E for contact investigations, HIV testing, TB preventive therapy including outcomes, and pharmacovigilance	DoH DoH, NGOs DoH
Healthcare workers	• Finalise and implement guidelines for TB in HCW • Institute regular TB screening and offer of HIV testing for all HCW • Offer Preventive therapy to all HCW who are living with HIV • Develop a recording and reporting system for TB and DR-TB in HCW • Appoint a DOH-led task force to monitor implementation and further elucidate the effort-effect ratio of screening all HCWs annually with symptom screen and CXR and to investigate the role of preventive therapy for HCWs • Implement the FAST model in facilities(finding cases actively by cough surveillance and rapid molecular sputum testing, separating safely, and treating effectively based on rapid drug susceptibility testing)	DoH DoH DoH NIOH DoH DoH

Adolescent girls and young women	• Peer-led outreach
	• Youth friendly sexual and reproductive health services in schools and community settings which include:
	  ○ PrEP (for over 18 years)
	  ○ HPV vaccine
	  ○ PMTCT
	  ○ Choice of termination of pregnancy
	  ○ Family planning services
	  ○ Male and female condom provision in school
	  ○ Sanitary towels
	• Programmes to keep girls in schools
	• Economic empowerment programmes
		NGOs, DoH, DBE, DHET, D
		DoH, DBE
		DoW
		DBE, DSD
		DHET, DoL
		DBE

	• Comprehensive sexuality and gender education	

Children and Orphans and Vulnerable children	• Health education, particular focus on sexual exploitation in the absence of primary caregivers
	• Accelerated nutritional and social grant support
	• Youth friendly sexual and reproductive health services in schools and community settings which include:
	  o HPV vaccine
	  o Contraceptives including condoms
	  o Choice of termination of pregnancy
	• Comprehensive sexuality education in residential, school and non-school and youth-friendly settings
	• Intensive psychosocial support
	• Gender norms education, including risk reduction in relation to age—disparate relationships
	• School retention
		DBE, DoH
		
		DSD
		DoH, DBE
		
		DBE, DoH, DSD
		
		DSD
		DBE
		
		DBE, DSD

People living in informal settlements	• Facilitated access and demand creation to increase community HIV, TB and STI service provision • Intensified GBV programmes and screening • Accelerated social support	DoH, DSD, NGOs DSD DSD
Mine workers	• Peer education and support for TB programming • Specialised health education regarding risk and vulnerability to TB, particularly regarding working and close contact living conditions • Routine TB screening and treatment with intensified contact tracing for work place lodging, work contacts, home lodging. • Silica-exposed mine workers to receive Preventive Treatment per guidelines • Improve linkage and access to cross-border care • Workplace HIV,TB and STI treatment services • Intensified psychosocial support • Education regarding annual benefit examinations and compensation for Occupational Lung Disease during life and post-mortem where applicable	NGOs DoH, mining houses DoH DoH Mining houses, multilateral ag DME, mining houses DSD DoH, DME, mining houses
Migrants and Undocuments foreigners	• Cross border collaboration on HIV, TB and STI policy and programming • Utilise informal networks to raise awareness about services • Intensified psychosocial support • Accelerated access to official papers to access services • Places of safety	SADC, DIRCO, Multilaterals NGOs DSD SAPS, DHA DSD
People with disabilities	• Peer-led outreach • Specialised health education regarding risk and vulnerability to HIV, STIs and TB, particularly regarding sexual exploitation • Accelerated nutritional and social grant support • Comprehensive sexuality education in disability-friendly settings • Intensive psychosocial support • Intensified TB screening, treatment and care due to increased exposure owing often to confined living conditions	NGOs DoH DSD DoH, DBE DSD DoH
Other LGBTI populations	• Peer-led outreach • Provision of appropriate condoms, lubricants, other barrier devices • Empowerment programmes including skills building, ABET, and facilitation of post school training and employment • Enhanced programmes for legal and counselling support	NGOs DoH, NGOs DHET, DSBE DoJ, NPA, private sector

Pregnant women and neonates	▪ Full access to PMTCT services ▪ Household TB and HIV screening, immediate linkage to treatment ▪ Improved mother/child pair tracing and service delivery ▪ Improve TB screening and testing among pregnant women to reduce congenital and perinatal TB transmission ▪ Improved diagnostic and treatment capacity for neonatal TB ▪ Screening and protection for the sexual exploitation of children	DoH DoH, NGOs DoH DoH DoH and research institutions DoH, DSD
Children < 5 yrs	▪ Household TB and HIV screening, immediate linkage to treatment ▪ Improved diagnostic and treatment capacity for paediatric TB ▪ Promote activism for child-friendly HIV and TB formulations and introduce as soon as they are available ▪ Improve sputum induction at PHC and hospital level ▪ Screening and protection for the sexual exploitation of children	DoH, NGOs DoH Civil Society DoH, Medical/Nursing trainin DoH, DSD

Goal 4: Address the social and structural drivers of HIV, TB and STIs, and link these efforts to the NDP

7.1 Situation analysis

The social and physical context in which the epidemics of HIV, TB and STIs are happening is continually evolving, shaping the manner in which these epidemics are unfolding. As highlighted in the NDP[58], we as a country currently confront the linked challenges of poverty, long-term unemployment and inequality. In the context of slow economic growth and financial constraints, unemployment remains high, with particularly acute and concerning levels of joblessness among young people. Under the Medium-Term Strategic Framework 2014-2019, South Africa has prioritised national action to address these inter-related challenges to national well-being.[59]

Both vulnerability to HIV, TB and STIs as well as efforts to address them do not occur in a vacuum but are heavily affected by the social and physical environment. Factors such as poverty, inequality, inadequate access to education, poor nutrition, migration, gender inequality and gender-based violence, and alcohol and substance abuse increase vulnerability to HIV, TB and STIs; deter individuals from seeking needed services early; and interfere with the ability of individuals to receive services and to adhere to prescribed regimens.[60] The physical environment – including access to safe water and sanitation; the availability of safe and secure housing with good ventilation; the number of people in the household, the spatial location and distribution of health services; and access to transportation – also has a powerful impact on the risks of disease acquisition or transmission, as well as on access to health services. This has been confirmed by the 'Know Your Epidemic' exercise conducted in 2011, which found that those most vulnerable to HIV and TB included people with low literacy, residents of informal settlements, migrants, women, people who are poor, miners and people living in peri-mining communities, inmates in correctional facilities, and the contacts of people with TB.[61]

These social and structural factors are often complex and multi-dimensional. Women, for example, constitute the majority of people who have precarious jobs with low income, and female-headed households earn significantly lower than male-headed households. While the NDP envisages a slow but steady reduction in economic inequality through 2030, there are also other forms of inequality that undermine sound responses to HIV, TB and STIs, including those relating to race, gender, geography, disability and socioeconomic status. South Africa has among the world's highest rates of consumption of alcohol, and gender-based violence may increase women's odds of acquiring HIV up to three-fold.

Unless these factors are addressed in the context of disease control, public health goals for HIV, TB and STIs will be undermined and gains achieved will not be sustainable. Addressing social and structural drivers demands not only specific action by the health sector, but even more importantly integration of health into broader development efforts. Efforts already undertaken by the national government, including social security, nutritional and food security measures, support for early childhood development, and developmental social service interventions, must be fully utilised to accelerate progress in reducing vulnerability to HIV, TB and STIs. Empowering households and parents is critical to progress in addressing social and structural drivers. Participatory research approaches that involve community members, researchers, stakeholders and policy-makers as partners can help shed light on action steps needed to reduce risks and vulnerabilities associated with social and structural factors.

Under the NSP 2012-2016, South Africa placed a particularly high priority on addressing the social and structural factors that increase risk and vulnerability among adolescent girls and young women.[6] The "She Conquers" campaign, for example, is a nationwide HIV prevention campaign that prioritises action to decrease teenage pregnancies, prevent gender-based violence, keep girls in school, and increase economic opportunities for young people, especially young women. TheYolo and Zazi programmes of DSD, the multi-partner DREAMS initiative and the young women and girls programmes funded by the Global Fund take a similar approach, nesting HIV prevention within a broader effort to address social and structural drivers of risk and vulnerability among adolescent girls and young women. The Department of Women champions the advancement of women's socioeconomic empowerment and the promotion of gender equality, coordinating, monitoring and supporting implementation of the National Gender Based Plan. The coverage of these important programmes and initiatives still needs to be expanded, the various initiatives linked at local level to achieve sufficient scale, and nurses trained to provide appropriate services for adolescent girls and young women generally and specifically for survivors of gender-based violence. The cycle of transmission that exposes each generation of girls to substantial risks of HIV transmission can only be broken if the factors that make adolescent girls and young women vulnerable, including inadequate educational and economic opportunities, gender-based violence and harmful gender norms, are adequately addressed.

Effective programmes are needed to reduce poverty, inequity, unemployment, gender inequality and gender-based violence and problems associated with alcohol and drug use. At the time the NSP was developed the Justice, Crime, Prevention and Security Cluster was reviewing the national policy framework for sexual offenses, with one of its aims strengthening the prevention of sexual violence, including through public education and communications. In addition, actions are required to enable intersectoral planning and integrated service delivery, especially at the community level, and to achieve more resilient social systems and strengthened service delivery systems. This NSP focuses on specific interventions to address social and structural drivers, with the goal of expanding these interventions for key and vulnerable populations and in priority districts.

7.2 Strategic approach: Reducing vulnerability, enhancing sustainability and linking the response to HIV, TB and STIs to the broader development agenda

To address social and structural drivers, we will pursue the following strategic approach:

- *Reduce poverty and vulnerability through scaled-up social protection:* Although South Africa has among the highest per capita gross domestic product in Africa[63], the country is also characterized by extreme income inequality. While the Expanded Public Works Programme has increased access to work opportunties, issues of structural unemployment remain a major challenge. In South Africa, the poorest 40% of the population bears 65% of the TB burden[64], and people with lower socioeconomic status also experience the greatest barriers to health care access.[64] Lower-income households are more vulnerable to economic shocks generally as well as those specifically associated with HIV, TB or other chronic diseases.[65] To reduce poverty and financial insecurity linked to HIV, TB and STIs, social protection packages will be scaled up to reduce the proportion of households experiencing catastrophic expenditure due to HIV or TB. The Social Protection Cluster will be strengthened to fast-track the roll-out of universal social protection.

- *Ensure food security:* While surveys indicate that the proportion of the South African population experiencing food insecurity has declined since 1999, the share of the population at risk of food insecurity has remained largely unchanged.[65] Poor nutrition weakens the immune system; increases the risk of TB infection, progression to disease and TB reactivation; and worsens TB outcomes.[66] [67] In addition, TB can lead to malnutrition.[67] Food insecurity is correlated with reduced reduced rates of HIV treatment adherence.[68] Taking account of the links between food insecurity and vulnerability to HIV and TB, the NSP provides for nutritional screening to be made available for all people living with HIV and/or TB, as well as access to food and nutritional support where indicated. This will include strengthening and expansion of the National School Nutrition Programme.

- *Expand economic and educational opportunities for adolescent girls:* Intensified efforts will be made to promote the economic empowerment of young people, especially adolescents girls and young women, and to expand their economic and social opportunities and reduce their potential economic dependence on men; to be optimally effective, these efforts should begin in primary school. South Africa will intensify its efforts to keep young girls in school, including fully leveraging the She Conquers campaign. South Africa aims to reduce teenage pregnancy by at least 5% per year over the next five years, through increasing contraceptive availability, training educators and capacitating peer educators, and expanding access to health care and support for teenage mothers.

- *Ensure livelihoods for young people:* Through a phased-in approach, South Africa will scale up skills training for young people, affordable microfinance, training in financial literacy and micro-enterprise, young people's access to social grants, and expanded work opportunities. These efforts will particularly focus on economic and livelihood support for young women and men.

- *Change gender norms and prevent and address gender-based violence:* Harmful gender norms increase HIV risk and vulnerability, especially for girls and women. Gender-based violence also increases HIV risk and vulnerability on many levels and in many different ways, which needs to be more clearly tracked to develop the best responses. It is estimated that 20-25% of new HIV infections in young women in South Africa are linked to gender-based violence. Due to the lack of data and a comprehensive plan to tackle gender based violence, it is not possible to gauge the degree to which interventions to address gender norms and gender-based violence were expanded under the NSP 2012-2016.

  The NSP provides for the expansion of evidence-based programmes to change gender norms, with particular attention to the involvement of boys and men and the expansion of services for survivors of gender-based violence. A comprehensive national plan on gender-based violence, including provisions for appropriate human and financial resource allocations, enhanced monitoring, implementation and accountability, is needed, both to ensure the success of investments in HIV, TB and STI prevention and treatment programmes and to address the effects of gender-based violence that extend well beyond disease control.

- *Better define and scale up harm reduction services:* Alcohol and drug abuse increases HIV, Hepatitis C and TB risk and vulnerability and can also undermine adherence to

treatment and ultimately the health of the person affected. Both the NSP and NVP envisage an expansion of harm reduction services for people who use alcohol and drugs.

- *Implement environmental interventions for TB control:* Overcrowding, indoor air pollution and poor ventilation contribute to TB transmission. Households, health facilities, correctional facilities , mines and public transport, and schools are TB transmission "hotspots." Workplaces, including those that expose workers to silicosis, may increase vulnerability to TB acquisition. Smoking, including secondary exposure to tobacco smoke, also increases the risk of TB infection, disease and recurrence. Under the NSP, a series of efforts, including community education, review of norms and standards for new housing, and enhanced monitoring, will focus on improving ventilation in housing, workplaces, schools and public transport. Architects and engineers should be consulted regarding TB infection control measures when planning new facilities to optimise air flow and environmental infection control measures.

Table 5. Goal 4.0 Social and Structural Drivers Goals, Objectives, Sub-objectives and activities

GOAL 4: Address the social and structural drivers of HIV, TB and STI infections and linking them to NDP Go				
Objective 4.1	***Implement social and behaviour change programmes to address key drivers of the epidemic and build social cohesio 27 priority districts by 2022***			
	Interventions	**Approaches**	**Populations**	**Lead agencies**
Sub-Objective 4.1.1: Reduce risky behaviour through the implementation of programmes that build resilience of individuals, parents and families	Prevention and early intervention programmes to identify risk e.g. Buddy systems Zazi, Masidlale programmes Positive parenting Early childhood development programmes to integrate prevention and early intervention measures to mitigate risks for young children from conception until they enter formal schooling. For example -Nutrition -Parent support -Early learning home and community-based and centre-based programmes	-Strengthen DSD programmes in high-burden districts and among vulnerable groups including children and OVCs. Programmes to include: -Mobilisation -Advocacy -Capacity building, including for care givers -ECD programmes -Parent support -Social security -Prevention of violence and abuse -Monitoring -Sustain positive behaviour outcomes and facilitate the deconstruction of gender norms and roles Review existing programmes and services and where gaps are identified strengthen DSD, NPO, CBO intervention	Children and OVC Parents and families of vulnerable children Out-of-school youth, AGYW 15 and 24, Adolescents living with adults with HIV/TB, Older persons, People with disabilities, People who abuse alcohol and substances, Sex workers and their clients, men and boys	DSD, NDOH, DI Society including and CBOs
Sub Objective 4.1.2: Comprehensive age-specific and appropriate support for learners and out-of-school youth.	Provision of Comprehensive Sexuality Education in schools and Higher Education Institutions (HEIs) including TVETs and colleges.. Provision of support to pregnant learners in line with DBE policy. Provision of comprehensive Care and Support for Teaching and Learning for vulnerable children through the education system (CSTL) Age-specific support for HIV positive	-Deliver CSTL and CSE through educators, peer educators and civil society including NGOs. - Ensure accessible support and education materials for PWDs	Learners and students and out of education youth, learners with disabilities and HIV positive adolescents, children and OVC	DBE DSD DHET/HEAIDS NDOH Civil Society incl NGOs and CBOs DPOs

	adolescents.			
Sub-Objective 4.1.3: Strengthen the capacity of families and communities.	Interventions to provide comprehensive support for families afflicted by HIV/TB. Provision of support for parenting and carers of people with disabilities Implement Community Capacity Enhancement and Dialogue Programmes Educational materials regarding HIV and TB	Ensure that DSD Programmes to include: -Mobilisation -Advocacy -Capacity building -Monitoring -Improve communication on issues of sex and sexuality, the prevention HIV and TB infections as well as unplanned pregnancies and teenage pregnancies. Programmes to support parental disclosure to children and adolescents	Families, primary caregivers with pre-adolescents, families and communities afflicted by HIV and TB	DSD NDOH DBE
Sub Objective 4.1.4: Integrate strategies that address HIV. TB and STIs into existing workplace policies and programmes.	All workplace health and wellness policies to be reviewed ensuring full integration.	- Facilitate and encourage the review of all workplace policies and programmes to ensure full integration of HIV, TB and STI's including for PWDs -Ensure that organised labour works with employer organisations and SABCOHA and their own structures for a combined approach.	All employers Unions Organisations of PWDs	NEDLAC SABCOHA Organised labour Other non-unioni workplaces
Sub Objective 4.1.5: Integrate strategies that address HIV, TB and STIs in the education system	Full integration into and expand school and post school Health Services and social services	Operationalise programmes	Children and youth	DBE DHET/HEAIDS NDOH DSD NGOs
Sub Objective 4.1.6 Integrate strategies that address and integrate HIV. TB and STIs into existing policies and programmes within the educational system from ECD centres up to tertiary education	Review of all educational health and wellness policies to ensure full integration into the existing Integrated School Health programme	Educators, parents, NGOs and relevant government departments to review and develop and operationalise the Integrated school, health programme	Children and Youth	DBE DOE DSD Higher Educatior
Objective 4.2	***Increase access to and provision of services for all survivors of sexual and gender based violence in the 27 priority d by 2022***			
	Interventions	**Approaches**	**Populations**	**Lead agencies**
Sub Objective 4.2.1: Increase access to provision of services for all survivors of sexual and gender-based violence	-Finalised and implemented National Gender Based Violence Plan -Support for existing and new resources	-Develop and launch a national plan that articulates a comprehensive strategy to deal with GBV including the allocation of resources and improved monitoring and evaluation of GBV	General Population Students	DOW (support to implementers) Presidency, DSD DOH Justice, Police DHET/HEAIDS

		-Provide access to mental health counselling and psychosocial support for survivors - Develop SGBV policy for HEIs, TVETs and colleges and implement SGBV peer education clubs - Tailor interventions for PWDs in all services - Build capacity and awareness of services and how to access them. - Implement database of services and professionals		Civil society sect
	Child protection systems to be strengthened to protect children against the risks of violence and provide comprehensive responses to those who are victims of violence and abuse	A child-specific national plan to prevent and address consequences of violence and abuse against children targeting families, communities and schools through parenting support, home based care and support, facility-based care and support (for example, screening for abuse in clinics), and support through the integration of care and support in the education system to prevent violence in schools and surrounding communities	Children and OVC	DSD DBE DOH Justice, Police Civil society
	Maintain the GBV Command Centre: 24hr/7days Telephonic counselling to survivors of crime and violence including Gender Based Violence Support existing and new telephonic counselling services to survivors of crime and violence including Gender Based Violence	-Ensure that the Gender Based Violence Command Centre forms part of the RESPONSE pillar 2 of the South African Integrated Programme of Action Addressing Violence Against Women and Children (2013-2018) which was approved by Cabinet in September 2013. -Strengthen and promote psychosocial wellbeing of individuals, families and communities through prevention, care, and psychosocial support services to respond to social ills. Identify gaps in existing victim empowerment programmes. Strengthen existing programme and develop new where needed	The Victim Empowerment Programme caters for the adults and the most vulnerable victims such as women, children, persons with disabilities, Older persons, LGBTI Community and People with Albinism	DSD
	Scaled-up implementation of the victim empowerment programme e.g. everyday heroes and similar	-Promote learning about VEP and illustrate how every person/citizen of this country can	General community	DSD

	programmes.	provide support to victims of crime and violence and make our communities safer and caring. -Strengthen victim empowerment programmes -Raise awareness and education for communities		
Sub Objective 4.2.2 Provide support for survivors of sexual assault.	Strengthened and scaled-up provision of services through Thuthuzela Centres and other relevant therapeutic interventions at sites in communities. This includes a minimum package of services at PHC, CHCs and TCCs	-PHCs: Min clinical package (PEP, STI prophylaxis, first aid), screening via HCT counselors, and referral networks/linkage -CHC: Forensic examination and trained (specialized) DOH psychology counsellors, in addition to clinical package; social worker referral; legal referral -TCC: Specialised unit at hospital incl. complex/ongoing support for medical/psychological, including legal case work and DSD link, etc. Centralizes cases from lower levels, but provides flying support as needed to lower levels of care if more convenient for survivorEnsure – Ensure that all services are accessible to all populations, including People with disabilities and that they have a full package with relevant services for children or linkages to - child counselling and support, referrals, psychosocial and therapeutic support, case management	Survivors of sexual and gender based violence Child abuse victims	DSD NPA DOH Justice civil society grou key population se SAPS & FCS
	Strengthened and scaled-up community based one stop Khuseleka Centres *Note: Currently the centres are in 4 Districts (one in each of the following provinces: Eastern Cape, North West, Limpopo and Gauteng)*	-Scale up the number of one stop centres that offer services from a number of departments – psychosocial, forensic clinical services, psychological, child support services, skills development and long term shelter services.	Survivors of crime and violence Victims of child abuse	DSD Police services DOH Justice
	Strengthen and scale up of community based white door shelters that must provide a minimum 72 hr package and appropriate referral to system described above.	-Provide short-term places of safety and shelter within communities	Survivors of gender based violence Victims of child abuse	DSD Police services DOH Justice
Objective 4.3	***Ensure access to rehabilitation, comprehensive psychosocial support and mental health services for people living wi affected by HIV and TB in priority districts***			

	Interventions	Approaches	Populations	Lead agencies
Sub Objective 4.3.1: Increase referral to rehabilitation, comprehensive psychosocial support and mental health services for people living with and affected by HIV and TB	In-service training for all health care workers. Improved identification and referral systems.	-Sensitise and capacitate HCWs and SCWs to screen for and refer and provide interim support for patients with mental health problems and those in need of rehabilitation services and psychosocial support	Health and social care workers (including those based in communities and work place programmes)	DOH DSD NGOs Unions DHET DBE
Sub Objective 4.3.2: Increase the provision of rehabilitation, comprehensive psychosocial support and mental health services for people living with and affected by HIV and TB	Strengthened and expanded provision of psychosocial support services in communities, schools, institutions of higher learning, health facilities	-Expand the number of social auxiliary workers available to support treatment adherence groups and see referrals from health facilities/schools/DHET - Provide guidelines on suitability of levels of levels of rehabilitation	People affected by HIV and TB	DSD
	Strengthened and scaled-up access to a comprehensive range of rehabilitation services		People affected by HIV and TB who have disabilities	DSD DOH Civil society incl NGOs
	Strengthened and scaled-up access to a comprehensive range of in- and out-patient mental health services		People affected by HIV and TB	DSD DOH
Objective 4.4	***Scale up access to social protection for people at risk of and those living with HIV and TB in priority districts***			
	Interventions	**Approaches**	**Populations**	**Lead agencies**
Sub Objective 4.4.1: Scale up access to social grants	Full access to social grants for the most vulnerable where indicated.	-Ensure access to and shorten waiting times for social grants	Children, youth, women, men, older persons and persons with disabilities	DSD Civil society incl NGOs
Sub Objective 4.4.2: Scale up access to food security	Scaled-up provision of food parcels, cooked meals and nutritional supplementation	-Ensure access to sufficient food	People at risk and those living with HIV and TB OVCs People with DR-TB	DSD NGOs SANAC sectors,
	Scaled-up availability of the social relief distress grant of 3-6 months for people living with HIV and TB	-Ensure access to sufficient food, with particular emphasis on people with DR-TB	People living with HIV and TB	DSD
	Scaled-up services to orphans and vulnerable children through the expansion of drop-in centres and the Isibindi model.	-Ensure access to sufficient food	OVC	DSD
Sub Objective 4.4.3: Scale up access to nutritional support	Strengthen and expand the coverage of the National School Nutrition Programme and and nutrition support in HEIs and TVETs	-Expand the availability of all three elements of the programme and make it available during school holidays. - Provide nutritional support services for vulnerable students	In school youth	DBE

Objective 4.5	***Implement and scale up a package of harm reduction interventions for alcohol and substance use in all districts***			
	Interventions	**Approaches**	**Populations**	**Lead agencies**
Sub-Objective 4.5.1: Improve the policy for harm reduction for substance and alcohol use and its implementation.	Revised Drug Master Plan's clear articulation of a harm reduction response with roles and responsibilities clarified	-Include clear harm reduction strategies including services for people who use drugs.	All stakeholders	DSD DOH Civil society SANAC secret
	Co-ordinated prevention and referral between communities, schools and HET facilities, health facilities and rehabilitation facilities through strengthened and expanded the provincial drug management units to.	-Improve co-ordination to facilitate identification of people who need help and easier referrals for a comprehensive response.	All stakeholders	DSD DOH DBE SANAC Secre
Sub-Objective 4.5.2: Scale up the provision of in- and out-patient rehabilitation services for all who use alcohol and drugs	Outpatient rehabilitation facilities	-Expand availability of inpatient and outpatient rehabilitation facilities -Develop adolescent friendly practices	People who use alcohol or drugs	DSD DOH DBE NGOs
	Inpatient rehabilitation facilities	-Expand availability of inpatient rehabilitation facilities	People who use alcohol or drugs	DSD DOH
Sub-Objective 4.5.2: Scale up the access to in- and out-patient rehabilitation services for all who use alcohol and drugs	Community awareness and advocacy programmes.	-Implement programmes to increase awareness of services	Primary: children, Youth in and out of school Secondary: caregivers and parents	DSD Civil society in NGOs
	In-service training for all health care workers	-Sensitise and capacitate HCWs to screen for and refer and provide interim support for people with alcohol and substance use.	All Health care workers (including those based in communities and work place programmes) People who use alcohol or drugs	DSD DOH
Objective 4.6	***Implement economic strengthening programmes with a focus on youth in priority districts***			
	Interventions	**Approaches**	**Populations**	**Lead agencies**
Sub Objective 4.6.1: Economically empower targeted groups of young people by increasing the availability of economic opportunities	Combination Socio-Economic Programmes	-Strengthen the economic capacities of vulnerable adolescents and youth infected and affected by HIV and TB. through support to access further education, training, job placements and entrepreneurial activities, including for PWDs.	Out of school and further education and job placement Youth especially OVC 15 - 18 years that are recipients of the South African Child Support Grant	DSD DPSA Private sector DHET, Civil society in NGOs
	Action by companies to create opportunities for exposure of young women to the workplace through learnership/internships and link young women trained in SABCOHA's BizAIDS training	-Companies to participate in the creation of job exposure opportunities for adolescent girls and young women	Adolescent girls and young women out of school	SABCOHA Organised labo

	programme to formal job opportunities			
	BizAIDS training to adolescent girls and young women as part of all programmes focusing on young women and adolescent girls	-Empower young women through SABCOHA's BizAIDS programme to start and improve their own business. -Encourage companies to support the programme through co-funding.	Adolescent girls and young women out of school	SABCOHA Organised labo
Objective 4.7	***Address the physical building structural impediments for optimal prevention and treatment of HIV, TB and STIs***			
	Interventions	**Approaches**	**Populations**	**Lead agencies**
Sub Objective 4.7.1: Improve ventilation and Indoor Air Quality in living and working conditions including schools, institutions of further education and public transport	Adequate ventilation and indoor air quality in congregate settings to minimise transmission of TB	-Establish multi-stakeholder task team to review relevant legislaton, regulations, norms and standards related to improving ventilation and indoor air quality for optimal TB prevention (including attention to TB prevention in correctional settings) -Develop and implement funded plan of action -Consult architects and engineers on TB environmental controls when developing new facilities -Support implementation of environmental controls in facilities, including ultraviolet germicidal disinfection and appropriate ventilation -Monitor and evaluate TB infection control and environmental control measures according to WHO guidelines	All stakeholders	DOH Environmental H DHS Transport (public private sector) Public Works CSIR DST Built Environmer Professional Asso COGTA Eskom Municipalities
	Awareness and education to promote behaviour change	-Develop and implement campaigns to raise awareness on the need for adequate ventilation and good air quality for the prevention of TB	All stakeholders	DOH SALGA COGTA PCAs
Sub Objective 4.7.2: Improve the provision of structural accommodations for people with disabilities in living and working conditions including schools, institutions of further education and public transport	-Appropriate accommodations for people with disabilities due to HIV and/or TB or side effects of treatment	-Establish a multi-stakeholder task team to review relevant legislation, regulations, norms and standards as they relate to improving the provision of structural accommodations for people with disabilities -Develop and implement a funded plan of action to address shortcomings.	HIV and TB affected people with disabilities	DOH, SANAC secretariat, Environmental H DHS, Transport (and private secto Public Works, CS Built Environmer Professional Associations, CO Eskom, Municipa

Goal 5: Ground the response to HIV, TB and STIs in human rights principles and approaches

Experience both in South Africa and around the world highlights the need to base the response to HIV, TB and STIs on human rights approaches, as stigma, discrimination, exclusion and other human rights violations serve to increase risk and vulnerability. These factors also cause profound harm to the people and communities affected by the three epidemics. The NSP builds upon and further strengthens South Africa's longstanding commitment to a human rights-based approach to the three epidemixa.

8.1 Situation analysis

South Africa's legal framework is guided by a progressive Constitution, which guarantees a broad range of civil, political, cultural and socioeconomic rights, including the rights to equality and non-discrimination, privacy, dignity, freedom and security of the person, access to health care and access to justice. A 2013 review confirmed that the national response to HIV and TB has adopted in its policy frameworks the human rights principles reflected in the national law, including a commitment to gender equality and recognition of the right to equal access to health and social services. However, effective action is often needed to ensure that the rights in legal and policy frameworks are respected in the real world.

Comment [MI6]: Citation:

South Africa National Department of Health, Joint Review of HIV, TB and PMTCT Programmes in South Africa, Main Report, April 2014 available at http://www.hst.org.za/sites/default/files/WHO-final-report-of-joint-hiv-tb-pmtct-main_April2014.pdf

During the implementation of the NSP 2012-2016, a survey to better understand stigma and discrimination was conducted – the People Living with HIV index, a national survey of more than 10 000 people living with HIV and/or TB. The survey found that 35.5% of people living with HIV reported experiencing externalised stigma, and 43% experience internalised stigma.[62] As well, 36.3% of people living with TB reported experiencing TB-related stigma.[62]

At the time this NSP was developed, the Department of Justice and Constitutional Development, in conjunction with the Justice, Crime Prevention and Security Cluster, was planning for the development of HIV-Responsive Victim Support and Empowerment Norms and Standards integrating both national and international human rights standards. This document will provide guidance to front-line workers and policy-makers on the provision of services in a manner that responds to the realities faced by people living with HIV and TB. The document is also expected to guide and support efforts to improve coordination of services for people living with HIV and TB in the criminal justice system.

The NSP recognises that there are still important gaps to close with respect to full implementation of the human rights agenda. Amongst these is the need to translate key policies into implementation, and to ensure that all people know their rights and where to seek redress when rights are violated. Stigma and in particular internalised stigma must be reduced, including stigma at the family, community, facility and societal levels. Barriers that prevent people from accessing services must be removed, in particular for women, sex workers, drug users, inmates, LGBTI persons and people with disabilities. People with HIV, STIs and TB will lead in driving the human rights and access-to-justice agenda.

8.2 Strategic approach: Protecting and promoting human rights to enable a strong, effective and equitable response

To reduce both externalised and internalised stigma by 50% and ensure that human rights principles are embedded across the response to HIV, TB and STIs, the following strategic approaches will be used:

- *Monitor and respond to human rights abuses:* Under the NSP, every district will implement a system to prevent, monitor and respond to human rights abuses and challenges and remove human rights barriers to health and social services access. The human rights sector wil be re-established within SANAC and a Human Rights Accountability Charter on HIV, TB and STIs developed. SANAC secretariat will advocate for full implementation of protective laws and policies to ensure realisation of the human rights underpinnings of the national response, meaningful and equal access to services, and protection against discrimination or other human rights abuses. Mechanisms will be in place to monitor human rights violations related to HIV, TB and STIs, and the South African Human Rights Commission and the Commission for Gender Equality will continue to refer cases of human rights violations to Equality Courts for redress and accountability. Access to legal services will also be scaled up, and investments will be made in community-centred rights and legal literacy programmes.

- *Support SBCC initiatives to reduce stigma:* The NSP calls for the development and implementation of a national multi-sector, multi-method strategy to reduce both internalised and externalised stigma. An essential role will be played by SBCC programmes that address the documented sources of stigmatizing behaviours, including ignorance about the harm of stigma, continuing irrational fears of infection and moral judgments. Community-based support groups will be revitalised to deal with internalised stigma, reduce stigma through community education and sensitize those in authority to human rights and stigma-related issues. Focused, evidence-based programmes will promote changes in gender norms that harm girls, women, men and boys, addressing the intersection of gender inequality, gender-based violence and vulnerability to HIV infection and its associated impacts.

- *Invest in training and sensitisation programmes to reduce stigma:* Programmes will inform and sensitise those who make the laws and those who enforce them about the important role of the law in the response to HIV, TB and STIs, e.g. to protect those affected by HIV against discrimination and violence and to support access to HIV prevention, treatment, care and support. In addition, human rights and ethics trainings will educate health care providers about their own human rights to health and social services (e.g., HIV prevention and treatment, universal precautions, compensation for work-related infection, access to social grants) and also reduce stigmatising attitudes in health care settings. These trainings will provide health care workers with the skills and tools necessary to ensure patients' rights to informed consent, confidentiality, treatment and non-discrimination.

Objective 5.1	***Reduce stigma and discrimination among people living with HIV or TB by half by 2022***			
	Interventions	**Approaches**	**Populations**	**Lead agencies**
Sub-Objective 5.1.1 : Revitalise community-based support groups to deal with internalised stigma	Revitalisation of community based support groups and explore merging support groups across health challenges e.g. TB and HIV group	-Develop and implement plan for revitalisation of community-based support groups -Train peer outreach workers on stigma and discrimination	PLHIV, People living with TB, all Key and vulnerable populations	Civil Society Sectors (PLHIV, People living with and affected by TB, Key and vulnerable populations) SANAC Secretariat DSD DOH
Sub-Objective 5.1.2 : Reduce stigma through community education	Social mobilisation	-Develop and implement campaigns to increase understanding of internalised stigma and TB stigma -Implement multi-sectoral, multi-level, multi-method internalised and externalised stigma programmes -Develop community-centred social mobilisation strategy - Integrate stigma into all programmes for key and vulnerable populations	Society and PLHIV, PLTB, Key and vulnerable populations	Human Sciences Research Council and other researchers SANAC Secretariat Civil society sectors especially key and vulnerable populations, human and legal rights.
Sub-Objective 5.1.3 : Sensitise those in authority to Human rights and stigma	Sensitation of service providers	-Develop and implement capacity-building on rights, stigma and appropriate service delivery approaches for PLHIV, PTB, KPs and VPs (focus on those working in government, NGOs, private sector, religious and community leaders.) -Promote and enforce "zero tolerance" policy for discrimination in health care settings	All key and vulnerable populations.	SABCOHA Labour unions Government departments including: DOH, DSD, DCS, SAPS Civil society sectors (Faith based, PLHIV, PLTB, Traditional healers and leaders, health professions, legal and human rights)
Objective 5.2	Faciliate access to justice and redress for People living with and vulnerable to HIV and TB			
	Interventions	**Approaches**	**Populations**	**Lead agencies**
Sub Objective 5.2.1: Improve legal literacy about human rights and national and local laws relevant to HIV and TB	Awareness raising campaigns Community mobilisation and education on these rights and laws Training of peer outreach workers	-Implement media awareness campaigns on rights and laws related to HIV and TB - Incorporate human rights in all programmes for KPs, VPs -Train outreach workers on human rights and legal literacy -Implement telephone hotlines to increase legal literacy and	PLHIV PLTB People vulnerable to HIV and TB KPs VPs	Civil society (PLHIV, legal and human rights sectors and all other sectors) DOJ DSD DOH

		answer questions relating to legal issues -Catalyse community mobilisation on rights -Focus the above-noted efforts on strategies regarding how to use this knowledge to improve health and justice.		
Sub Objective 5.2.2: Make HIV related legal services available and accessible	Access to legal services	-Expand access to affordable legal information and referrals - Expand access to affordable legal advice and representation -Strengthen and resource organisations on legal issues -Collaborate with South African Human Rights Commission, Commission for Gender Equality and Legal Aid South Africa to make promotional material available at public places and to ensure proper legal representation and referrals to the Equality Courts	PLHIV, PLTB People vulnerable to HIV and TB KPs VPs	Civil society (PLHIV, communities, traditional leader, legal and human rights sectors and all other sectors) DOJ NPA
Objective 5.3	Promote an environment that enables and protects human and legal rights and prevents stigma and discrimination			
	Interventions	**Approaches**	**Populations**	**Lead agencies**
Sub Objective 5.3.1: Implement a Human Rights Accountability Scorecard	Human Rights Accountability Scorecard to promote protection of human rights	- Strengthen the Human and legal rights sector of SANAC - Develop an accountability charter and framework - Develop and implement the accountability scorecard annually.	PLHIV, PLTB, Key and vulnerable populations, People vulnerable to HIV and TB	Civil society (PLHIV, legal and human rights sectors, key and vulnerable populations and all other sectors) DOJ
Sub Objective 5.3.2: Monitor and reform laws, regulations and policies relating to HIV and TB	Policy reform and implementation	-Promote enactment and implementation of laws, regulations and guidelines that prohibit discrimination and support access to HIV prevention, treatment, care and support -Audit laws and law enforcement practices to see whether they impact the response to HIV positively or negatively - Advocate for policy reform -Assess access to justice for people living with HIV and TB -Leverage platforms for engagement with decision-	PLHIV PLTB People vulnerable to HIV and TB KPs VPs	Civil society (PLHIV, legal and human rights sectors and all other sectors) DOJ NPA

		makers		
Sub Objective 5.3.3: Sensitise law makers and law enforcement agents	Sensitisation of decision makers	- Train correctional and detention centre staff regarding the prevention and health care needs and human rights of detainees and inmates living with or at risk of HIV and TB -Implement HIV in the workplace programmes for law makers and enforcers - Faciliate discussions between police, service providers and those who access services to maximise service access - Conduct information and sensitisation sessions with decision makers (parliamentarians, ministries of justice, judges, presecutors and lawyers) on the lgal and human rights aspects of HIV and TB on relevant national laws and the implications for enforcement, investigations and court proceedings. -Develop with the collaboration of parliamentarians and all organs of the state- a comprehensive campaign to promote respect for the rights of the most vulnerable especially people living with HIV and TB and KPs and VPs	PLHIV PLTB People vulnerable to HIV and TB KPs VPs	DOH DOJ SAPS, DCS NPA Lawyers Associations
Sub Objective 5.3.4: Train health care providers on human rights and medical ethics related to HIV.	Training of health care providers and their managers (in health facilities, communities, work places, schools, institutions of higher learning) Training of health care policy makers	- Focus trainings on the following objectives: ensure that health care providers know about human rights to health and to non discrimination in the context of HIV and TB;reduce stigmatising attitudes in health care settings; and provide health care providers with the skills and tools necessary to ensure patients' rights to informed consent, confidentiality, treatment and care and non-discrimination.	PLHIV, PLTB People vulnerable to HIV and TB	DOH DHET/HEAIDS DBE Civil society (legal and human rights sector, health professions sector)
Sub Objective 5.3.5: Reduce harmful gender norms and violence against	Safe school initiatives Policy reform	- Implement safe school initaitives to eliminate sexual violence and harassment at	PLHIV, PLTB People vulnerable to	DBE DOJ DOW

women and increasing their legal, social and economic empowerment in the context of HIV	SBCC approaches Community engagement	schools that threaten HIV infection - Reform domestic relations and domestic violence laws and law enforcement where these fail to adequately protect and/or create barriers to HOV prevention, treatment, care and support. - Implement programmes to reduce harmful gender norms and traditional practices that put women, girls, boys and men at risk of HIV infection - Engage religious and traditional leaders with a view to changing traditional norms and practices that put women, girls, boys and men at risk of HIV infection. -Ensure that that above-noted activities address the intersection between gender inequality, gender based violence and vulnerability to HIV infection and impact (in a way not addressed in the programmes specific for key and vulnerable populations or the social and structural drivers).	HIV and TB	SAPS Traditional leaders Civil society (faith based, traditional healers and leaders, legal and human rights sectors)

Goal 6: Promote leadership and shared accountability for a sustainable response to the HIV, TB and STI epidemics

Given the ambitious goals and objectives of the NSP, strong multisectoral leadership, building off South Afria's impressive record to date, will be needed to continue and enhance the response in the coming years and move from disease control to elimination.

9.1 Situation analysis

South Africa is a global leader in the fields of HIV and TB, with a response that is multi-sectoral, built on the synergistic collaboration of government, civil society and the private sector. Established in 2000, SANAC is the highest body advising the government on all matters relating to HIV, TB and STIs, with a mandate to provide policy advice to government decision-makers, advocate for multi-sectoral engagement, monitor implementation of the NSP, create and strengthen strategic partnerships, mobilise resources for implementation of the AIDS programme, and recommend appropriate research.

A clear legislative framework is in place to govern and promote cooperation between the three spheres of government in South Africa. However, government alone cannot meet the challenges posed by HIV, TB and STIs or fully capitalise on the historic opportunities to transition from epidemic control to elimination of these epidemics as public health threats. The NSP demands leadership from all spheres of government (national, provincial, local government) as well as communities, the private sector, organised labour, civil society, the general as well as key and vulnerable populations, academics, researchers, development partners and – most important of all – people living with HIV or infected with TB. Civil society, which is agile and rooted in the communities most vulnerable to disease acquisition, has a particularly critical role to play in ensuring a seamless continuum between social sector systems and community systems. To ensure full and expedited implementation of the NSP, all sectors will develop sector-specific implementation plans. Only a multi-faceted approach – which integrates services and unites parents, learners and educators, households and communities in a common undertaking – can address the persistently high rates of HIV, TB and STIs.

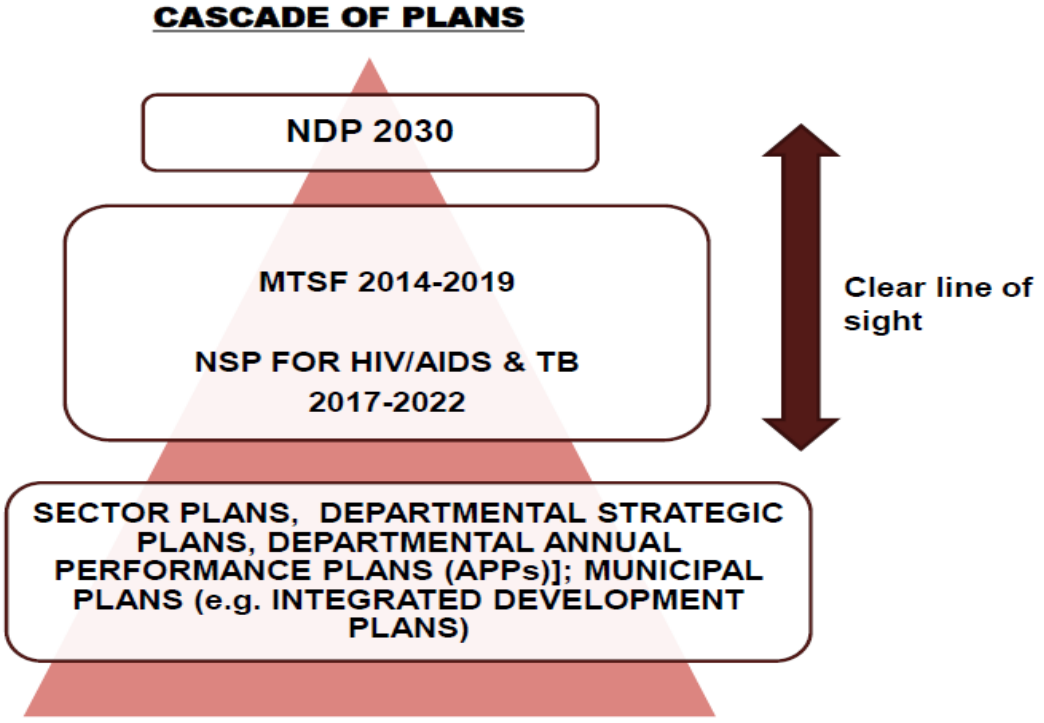
This multi-facted approach will require greater decentralision if we are to focus for impact, underscoring the NSP's emphasis on strengthening leadership at the community level, where multi- and inter-sectoral programmes are best implemented. Municipal wards or groupings of wards, constituting well-established towns, townships or villages, must be empowered to lead. Focusing for impact requires leadership with an unwavering commitment to accountability at provincial, district and local government levels. Therefore, Premiers, Members of the Executive Council (MECs) and Mayors will strengthen their HIV, TB and STI leadership and programmes.

In line with the overall approach of this plan – focusing for impact – the ability to tailor the response to specific locations and populations is critical to maximise outcomes. Districts need to be the architects of refining their own responses for implementing the NSP, with provincial and national leadership supporting this decentralised approach. Development partners must also respond to local priorities.

Partnerships to address HIV, TB and STIs need renewed attention and new ways of thinking. Particular efforts are needed to cultivate greater engagement by sectors that to date have been underutilized in the response, including the private sector, organised labour and women's organizations. The ambitious nature of the NSP also requires that the response to HIV, TB and STIs be coherent and optimally co-ordinated, monitored and evaluated, with continual feedback loops to enable change as needed.

The NSP is not a sectoral plan, but rather one that unites broadly diverse sectors in a common undertaking to address an overriding national priority. With strong support from the senior-most political leaders on down, the NSP has the potential to rally and unify the whole of government around a single purpose. It has a similar potential to mobilise all sectors of society. Achieving these ends will demand strong coordination and collaboration in order to maximize the coherence and impact of the efforts of diverse partners. In addition, it is imperative that the NSP is embedded in all plans of government (see cascade below). The NSP must be elevated to the level of the MTSF, and its indicators and targets should be incorporated into the MTSF and in the plans of diverse partners and Clusters. The NSP will be embedded in the mid-term review of government performance against the 2014-2019 electoral mandate, to be completed by July 2017, with results used to produce revised MTSF Chapters.

Figure X. Cascade of South African Sectoral, Performance, Strategic and Development Plans



Effective implementation of the NSP will require that the priorities and strategic directions outlined in this plan are reflected in the Budget. For the Budget cycle for 2018/19, the first drafts of National and Provincial APPs for 2018/19 are due for completion in July 2017. In the development and finalization of their APPs and budget bids for 2018/19 and in subsequent years, the national and

provincial spheres of government should work to mobilise resources for the implementation of the NSP 2017-2022.

9.2 Leadership and accountability: A framework for action

Genuine leadership on HIV, TB and STIs is people-centred, transparent and committed to mutual accountability for concrete results. In working to build and fast-track leadership for achievement of the ambitious goals and targets in the NSP, two key criteria must be satisfied:

- *Transparency:* All stakeholders – including people living with, affected by and vulnerable to HIV, TB and STIs – must have sufficient and equal access to relevant data. This data must include all aspects of implementation of the NSP, including but not limited to representation on AIDS councils, progress against targets set, budgeting and expenditure information and data on the community response.To make joint leadership meaningful, this data must be presented in a manner that enables all stakeholders to use it to draw conclusions. This is possible only if national, provincial and local governments commit to have a system of monitoring and evaluation based on key indicators (such as those recommended by UNAIDS), and civil society and the private sector ensure that they contribute to data collection as well, using agreed indicators and reporting tools and rigorously abiding by strict confidentiality provisions, including prohibitions on the release or sharing of patient data.

- *Dialogue on performance:* AIDS councils at all levels, with leadership and coordination and using data generated by the monitoring and evaluation system, must engage diverse stakeholders in periodic reviews of the performance of the response, permitting identification of progress against targets, as well as gaps, weaknesses and emerging trends. To ensure the broadest possible participation in this dialogue – including but not limited to women, children and people living with, affected by and vulnerable to HIV and TB – an annual scorecard will track engagement. To make this dialogue meaningful and productive, civil society and the private sector must prepare and participate fully in this information-sharing process. Civil society representatives who participate in this dialogue must share information with their constituents and partners.

Good governance and leadership includes effective planning, monitoring, reporting, acting on evidence and taking corrective action to steer performance. Vigorous implementation of this approach will be required to ensure successful delivery on the NSP.

9.3 Strategic approach: Implementing the action framework for leadership and accountability

To translate into action the framework for leadership and accountability, the following strategic steps will be taken:

- *Strengthen SANAC secretariat:* As a key element of the three-step framework for leadership and accountability, the SANAC secretariat needs sufficient capacity to oversee and shepherd the process of information-sharing, dialogue and agreement on key action steps. To ensure that SANAC is fit for purpose, the structure of SANAC will be aligned with the NSP, with appropriate membership for its component parts and a code of conduct to govern how it operates.

- *Strengthen civil society participation and leadership:* Recognising the critical importance of civil society to achievement of the goals and objectives of the NSP, steps will be taken to build on the strong history of SANAC's Civil Society Forum to further strengthen and expand civil society engagement and leadership at all levels in the response. A framework will be developed for civil society and community responses, including clear definitions of roles, scope, activities and deliverables. Sectoral leadership will be strengthened, with particular attention to the need to enhance the role of key and vulnerable populations and affected communities at the national, provincial, district and local levels.

- *Strengthen private sector engagement:* The engagement of the private sector will be enhanced to capture the most critical sectors, such as the formal and informal agricultural sector. Particular efforts will focus on increasing private sector engagement in provincial and district AIDS councils. Steps will be taken to improve collaboration with private health care providers (including general practitioners, pharmacies and traditional health practitioners), scale up workplace health and wellness programmes, expand workplace testing programmes to reach more men, and build and implement public-private partnerships to enhance implementation of all campaigns. Particular efforts will be needed to increase engagement in the informal and agricultural sectors.

- *Engage organised labour:* Organised labour needs to be better engaged and its role more sharply defined, to ensure access to workplace programmes and to monitor compliance with standards for workplace programmes, including infection prevention and control and occupational health. This process should be formalized through the National Economic Development and Labour Council (NEDLAC).

- *Improve collaboration and cooperation among national and provincial government departments:* Every department of government has a role to play in the comprehensive response to HIV and TB. To enable an optimally coherent and effective multi-sector response, all annual departmental performance plans should be aligned with the NSP. The Department of Planning, Monitoring and Evaluation should develop a joint results framework that catalyses and monitors inter-departmental collaboration towards shared outcome targets.

- *Improve collaboration and cooperation between government, civil society and private sector:* Each non-governmental sector (e.g., civil society, private sector, development partners) should develop an NSP-aligned implementation plan to feed into the Provincial Implementation Plans. All provincial, district and ward-level AIDS Councils must have representation of all key sectors, including civil society, private sector, organised labour and people living with HIV and TB.

- *Strengthen the capacity of AIDS Councils to contribute towards implementation of the NSP and achievement of its goals and objectives:* Sufficient resources should be allocated for AIDS Councils, including the SANAC secretariat, to enable them to fulfil their coordinating function. Funding also needs to be available for sector coordination. Well-governed AIDS Councils will be in place in all provinces, districts and at the ward level. Efforts will focus on broadening and optimising participation in provincial, district/municipality and ward-level AIDS councils, including all key provincial and local/municipal government departments. Particular efforts will focus on strengthening

district AIDS councils, in order to facilitate greater decentralisation. Provincial, district and ward-level AIDS councils will adopt an integrated service delivery model that addresses HIV, TB and STIs as well as social and structural drivers. Each provincial AIDS council's work should be costed and funded through the provincial government and its partners, with SANAC responsible for building the capacity of provincial AIDS councils were necessary. Particular capacity-building assistance will focus on enabling each provincial AIDS council to implement a strategic, customised focus-for-impact approach. In each province, an accountability scorecard should be used to ensure annual monitoring progress in implementing the Provisional Implementation Plan, which must specify the roles of district and ward-level AIDS Councils in implementing the plan.

- *Build local leadership:* To drive progress towards the goals and objectives of the NSP, particular efforts will focus on strengthening leadership at ward level. Steps will be taken to ensure that ward governments work together alongside civil society and the private sector to institutionalise an inter-and multi-sectoral approach. Traditional leaders will be engaged at local level, in particular to serve as champions of behaviour change and to facilitate uptake of locally tailored HIV prevention, treatment and care services.

- *Increase cross-border cooperation*: To improve responses for migrant labourers, especially with respect to TB, South Africa will continue to strengthen cross-border cooperation with neighbouring governments and other stakeholders.

GOAL 6: Mobilise leadership and co-ordination at all levels and promote shared accountability for a sustainable response to HIV, TB and				
Objective 6.1	**Strengthen the South African National AIDS Council to provide effective co-ordination and leadership of all stakeholders for shared accountability in the implementation of the NSP.**			
	Interventions	**Approaches**	**Population**	**Lead agencies**
Sub Objective 6.1.1: Develop and implement procedures for optimal implementation of NSP.	Agreed procedures to govern implementation and coordination	-Review and establish membership of SANAC structures in line with the current NSP -Review and approve Procedural Guidelines in line with restructuring -Develop and adopt a Code of -Conduct for SANAC structures -Develop a clear funded plan to strengthen the sectors of the SANAC civil society forum	All stakeholders	Plenary
	A robust, well-functioning Secretariat	-Review and improve the functioning of SANAC secretariat. -Clarify roles of leadership stakeholders to be clarified (Office Deputy President, NDOH and SANAC) -Fully fund the secretariat to enable it to fulfil its mandate.	All stakeholders	SANAC Trust Board Office of Deputy Presid
Sub-Objective 6.1.2: Monitor annually the implementation of the accountability framework through an Accountability scorecard	Accountability Framework	-Develop and implement accountability framework -Develop and implement an Accountability Scorecard tracking performance of implementation of the accountability framework at a national level.	Relevant stakeholders	Plenary
Objective 6.2	**Improve collaboration and co-operation between national government departments**			
	Interventions	**Approaches**	**Populations**	**Lead agencies**
Sub Objective 6.2.1: Ensure alignment of all government department annual performance plans with the NSP.	Fully NSP-aligned annual departmental performance plans	-Develop individual departmental 5 year implementation plan that is aligned to the NSP and its targets and shows clear areas of inter – departmental collaboration and co-operation. -Each provincial department and municipality to develop implementation plans that are aligned with the relevant provincial implementation plan.	All national government departments	DPME

		-Use implementation plans to guide the process of mainstreaming NSP directives into their annual performance plans and budgets. -Mainstream implementation plans into government strategic plans then annual performance plans and MTEF budgets and reporting frameworks. -Encourage joint planning and monitoring in high-burden districts		
Sub-Objective 6.2.2: Ensure collaboration between government departments through the use of joint results frameworks.	Joint inter-governmental results framework and progress reporting system.	-The DPME to develop a joint inter-governmental results framework and progress reporting system that directs collaboration and responsibility towards shared outcome targets. -Demonstrate in each joint results frameworks the need for co-ordination and show the performance and contribution of each government department.	All national government departments	DPME
Sub-Objective 6.2.3 Establish/ strengthen regional collaboration	Adherence to regional protocols (SADC and ESA)	Submit compliance reports to SADC	All national government departments, civil society	DPSA DPME DIRCO SADC
Objective 6.3	**Improve collaboration and co-operation between government, civil society, development partners and private sectors.**			
	Interventions	**Approaches**	**Populations**	**Lead agencies**
Sub Objective 6.3.1: Ensure alignment of plans of all non-government stakeholders with Provincial Implementation Plans.	Sectoral implementaiton plans aligned with NSP	-Each sector (civil society, private sector, development partners) to develop an implementation plan that is aligned with the NSP -Ensure that each sectoral implemenation plan contributes to the Provincial Implementation Plans.	All non-government stakeholders	SANAC Secretariat PCA Secretariat
Sub-Objective 6.3.2: Ensure representation of all stakeholders in decision making structures at provincial, district and local levels.	Broadly representative AIDS Councils	-Each Provincial, District and Local AIDS Council and Municipality (or equivalent) to ensure representation from all provincial government departments, development partners, the private sector, a	All stakeholders	SANAC Secretariat PCA Secretariat

		representative sample from the civil society sectors, representatives from people living with or affected by HIV and TB and a representative from the national government departments that only have provincial deployment (police, minerals etc.).		
	Participation of private sector on all AIDS Councils	-SABCOHA to facilitate Private Sector meetings in order to nominate representatives of the Private Sector -SABCOHA to co-ordinate the participation of representatives from the private sector at all these levels.	All industries in the Private Sector, including Informal Economy	SANAC Secretariat PCA Secretariat SABCOHA
Sub Objective 6.3.2: Strengthening the role of the private sector.	SABCOHA-led Private Sector Engagement Strategy	-Implement the Private Sector Engagement Strategy	All non-government stakeholders	SANAC Secretariat PCA Secretariat SABCOHA
Sub Objective 6.3.3: Ensure a central role for civil society and community groups	Sustainable funding for high-quality civil society and community services towards the NSP targets	-Develop a clear framework for civil society and community responses that enables sustainable funding to these groups in return for specific measured high quality services to help achieve the targets of the NSP -Enable NGOs to enter into multi-year service level agreements to provide services to priority populations (in particular) that government may not be able to reach as effectively	Civil society	SANAC Secretariat NDOH Treasury Civil Society Forum DSD DBE
	Involvement and leadership by key and vulnerable populations in the response	-Establish focal points for key and vulnerable populations in police stations, hospitals, schools, DSD community centres and faith based centres.	Key and vulnerable populations	PCAs COGTA DOH DSD DBE Police services Civil society forum
Sub Objective 6.3.4: Strengthen the co-ordination of government departments	Coordination among national government departments.	-Clarify roles and responsibilities of the different co-ordinating structures -Identify linkages between national government departments and different coordinating structures	All stakeholders	DPME, IMC, DPSA, SANAC Secretariat

		-Promote and deepen the coordination of national government departments.		
Objective 6.4	**Strengthen capacity of AIDS Councils at all levels (provincial, district and local) to develop and implement mu sectoral implementation plans for the NSP.**			
	Interventions	**Approaches**	**Populations**	**Lead agencies**
Sub-Objective 6.4.1: Formally establish the structures of AIDS council at provincial, district and local level	AIDS Council in place in all provinces, districts and local levels	-Pass a resolution to establish in each province, Provincial Councils on AIDS in the Premier's office and at the local level in the Executive Mayor's office -Develop and approve Procedural Guidelines for AIDS council structures at all levels targets. -Develop and adopt a Code of Conduct for AIDS council structures at all levels	All stakeholders	Provincial Executive Committees
Sub-Objective 6.4.2: Ensure that the AIDS council structures are adequately resourced and capacitated	Costed, well-capacitated AIDS councils	-Cost the work of each Provincial AIDS Council is costed -Fund the work of AIDS Councils through the Provincial Government budget. -Strengthen and scale up the integrated ward based structures to institutionalise an inter and multi-sectoral approach at a local level.	All stakeholders	Provincial Executive Committees SALGA SANAC Secretariat
Sun-Objective 6.4.3: Develop and then Monitor annually the implementation of the Provincial Implementation Plan using an Accountability scorecard	Provincial implementation plans	-Each Provincial AIDS Council to develop a 5 year implementation plan that is aligned to the NSP and its targets. -Each district and local AIDS Council (or its equivalent) to develop implementation plans that are aligned with the relevant provincial implementation plan.	All stakeholders	SANAC Secretariat Provincial Executive Committee SALGA COGTA
	Accountability Scorecard	-Develop and implement an Accountability Scorecard tracking performance of implementation of the accountability framework at a provincial level.	All stakeholders	Provincial Executive COGTA

Goal 7: Mobilise resources and maximise efficiencies to support the achievement of NSP goals and ensure a sustainable response

Achieving the goals and objectives of the NSP will be possible only if sufficient resources are available to implement the NSP at all levels. Given the ambitious nature of the NSP, resources for the response to HIV, TB and STIs will substantially increase in 2017-2022.

Investments in the response to HIV, TB and STIs generate enormous health and economic returns. A recent international economic analysis calculated that ending AIDS as a public health threat by 2030 would generate economic returns of approximately R8 for every R1 of additional expenditure for upper-middle income countries like South Africa. The same analysis found that every ZAR1 invested in TB programmes would generate ZAR43 in economic returns. Moreover, the South African HIV and TB Investment Cases identified strategies to maximize economic returns from investments and minimize long-term costs, including the front-loading of investments, allocating resources towards high-impact interventions, and optimising technical efficiencies.[9]

Comment [MI7]: Add citation:

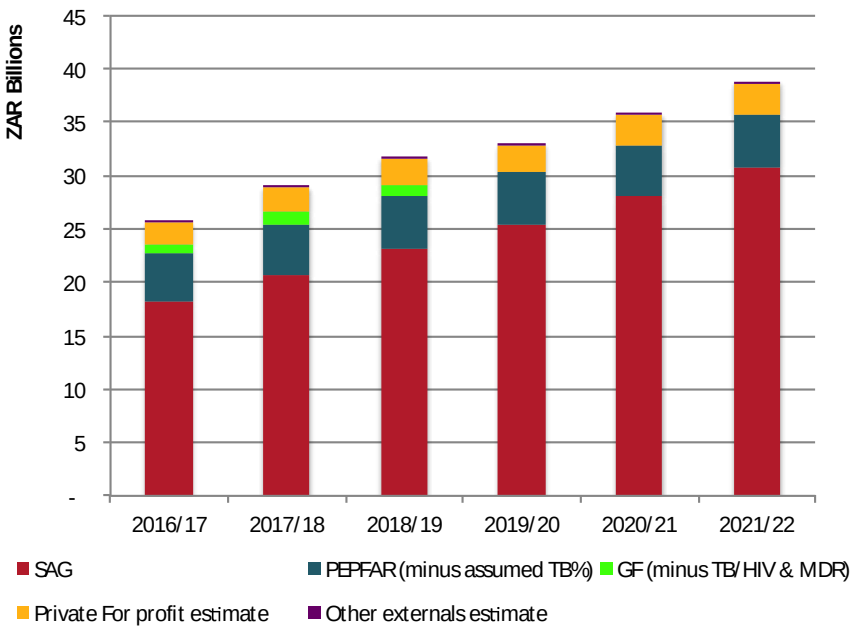
Lamontagne, E., Over, M., Stover, J., McGreevey, W & Izazola, J.A. (2016). The economic returns or ending the AIDS epidemic by 2030: a full income approach. Presented at the 9th International AIDS Economic Network pre conference Durban, 15 – 16 July 2016. Online at http://www.heard.org.za/wp-content/uploads/2016/06/iane-2016-The-economic-returns-or-ending-the-AIDS-epidemic-by-2030.pdf

10.1 Situation analysis

Total financing for HIV and TB programmes in South Africa in 2015/16 amounted to RXX and RXX, respectively. The National Department of Health continues to be the largest spender on HIV services, primarily via the conditional grant (ZAR20.5 billion in 2018/19), followed by DSD (ZAR1.8 billion for 2018/19), with an additional ZAR1.9 billion allocated in 2017/18 and 2018/19 specifically to support implementation of the HIV and TB Investment Cases and to ensure the sustained expansion of antiretroviral therapy. The United States President's Emergency Plan for AIDS Relief (PEPFAR) slightly increased its HIV allocation for South Africa in its most recent Country Operational Plan (2016), and the Global Fund to Fight AIDS, Tuberculosis and Malaria has allocated resources for HIV programming in South Africa through to 2018/19, after which the country would need to apply for renewed funding for the subsequent three-year cycle. The projected trend in total HIV financing in South Africa, including a projected continued increase in spending by the government, is illustrated in Figure XX.

FigureXX: Anticipated HIV funding from all sources

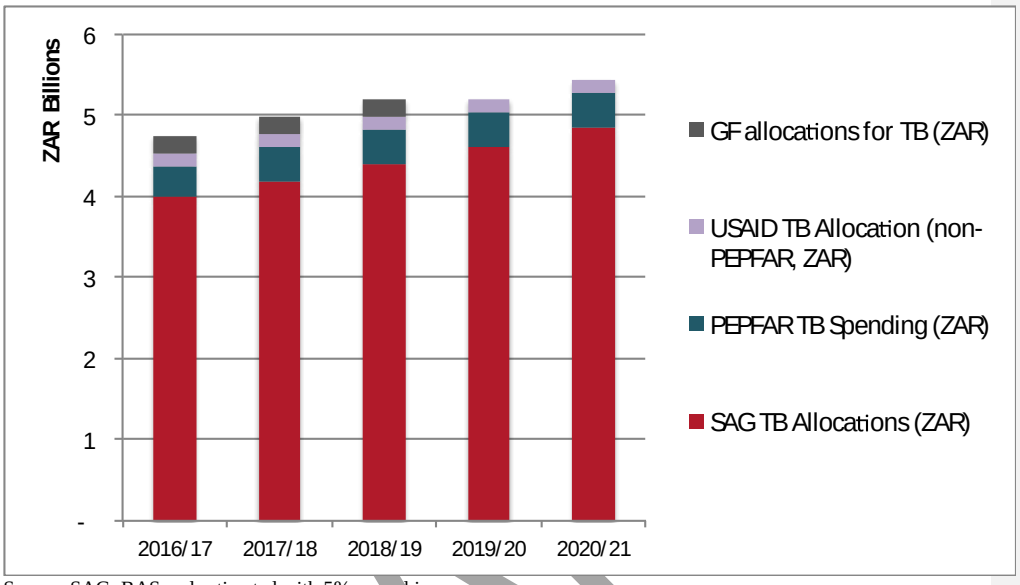
South Africa Government, Global Fund, PEFPAR, private sector and other development partners
(2015/16-2021/22) (ZAR billions)



Sources: SAG: ENE (2016/17) and estimated 10% annual growth, PEFPAR: COP 16 and assumed constant, GF: Concept Note (2016), Private sector: estimated 8.3% (NASA 2012), other development partners: estimated 3% (NASA, 2012).

The same primary HIV funders – South Africa Government, PEPFAR and Global Fund – are also the most important funders for TB activities, with South Africa again providing the overwhelming majority of TB financing. As shown in Figure YY, additional funding is anticipated for TB activities through 2022, although the pace of increase for TB financing is expected to be much more modest than for HIV.

FigureYY: Anticipated TB funding
South Africa Government, Global Fund and PEFPAR (2015/16-2021/22) (ZAR billions)



Source: SAG: BAS and estimated with 5% annual increase,
PEFPAR & USAID: COP 16, GF: Concept Note 2016.

[PLACEHOLDER: COSTING AND RESOURCE GAP ANALYSIS TO BE INSERTED FOLLOWING COSTING OF NSP]

The traditional means of mobilising resources for the response – through budgetary allocations by the national government and via international assistance – are likely on their own to be insufficient to close this resource gap. Although government funding for HIV and TB has increased, fiscal space for the mobilisation of even greater domestic resources is limited by low economic growth. PEPFAR and the Global Fund, which have historically accounted for the overwhelming majority of international assistance, have remained solid in their support for South Africa's response. However, other forms of international HIV and TB assistance to South Africa has declined in recent years, and prospects for a substantial rebound in international aid are dim. While it is currently projected that PEPFAR and Global Fund will maintain their investments a steady level of ZAR 5.7 billion and ZAR 1.4 billion, respectively, in the coming years, continuing political changes in both the U.S. and Western Europe nevertheless inject a degree of uncertainty in the stability of such funding in 2017-2022.

10.2 Strategic Approach: Mobilising sufficient resources to achieve the goals and objectives of the NSP

Meeting the challenge of fully funding the NSP will require a combination of approaches: maximising funding from existing governmental and international sources, improving the efficiency of spending (e.g., targeting for impact, spending only on evidence-based interventions, and implementing efficiencies in

implementation, such as reducing commodity costs, implementing differentiated care, decreasing loss to follow-up, etc), and leveraging innovative mechanisms to generate new sources of funding for the response to HIV, TB and STIs.

- *Optimise investments:* The health, social and economic returns on investment may be maximised by strategically selecting the optimal combination of high-value, high-impact interventions. Modelling undertaken as part of the South Africa HIV and TB Investment Case found that a scenario emphasizing achievement of 90-90-90 offered the most cost-effective approach with respect to cost per life-year saved and new infections averted.[9] However, the modelling also found that prevention efforts (specifically condoms, medical male circumcision and social and behaviour change communication) are as important as treatment, and that an approach that combines treatment and prevention is necessary to achieve the 90-90-90 targets.[9]

- *Increase efficiencies:* Using data to strategically target high-value, high-impact interventions towards spatial locations and populations where impact will be greatest will maximise the efficiency of the response to HIV, TB and STIs.[69] In addition, steps will be taken to implement strategies to achieve greater technical efficiencies, thereby improving the return on investments in HIV, TB and STIs. For example, more targeted community based testing, expanding the Central Chronic Medicine Delivery and Dispensing Programme and establishing additional adherence clubs in facilities and communities should be prioritied.

- *Frontload investments:* While front-loading investments during 2017-2022 will intensify fiscal demands in the short run, the Investment Cases found that this approach maximises the reduction of future costs.[9] Although increases in investments over the next five years will enable HIV programme costs to fall relative to baseline after 10 to 15 years, a failure to make needed increases in investment will allow costs to continue to increase as more and more people are newly infected and require treatment.[9] In addition, to reach the 90-90-90 for TB, the TB Investment Case indicates that an increase in spending on TB by ZAR 4 billion (15%) over next five years can save the national TB programme ZAR 33 billion (27%) over next 20 years.[9]

- *Roll out and fully leverage National Health Insurance:* The roll-out of national health insurance (NHI) has the potential to generate additional resources for HIV, TB and STI services outside the current sources from government and international donors. In particular, NHI enables the response to mobilise resources from the single best resourced sector – the private sector. Prospects for a meaningful roll-out of NHI in 2017-2022, however, are uncertain. To make a meaningful contribution towards closing the resource gap for the response to HIV, TB and STIs, accelerating the roll-out of NHI, especially in high-burden districts may be needed.

- *Increase multi-sector engagement to address social and structural determinants:* The NSP prioritises interventions to address the social and structural determinants of HIV, TB and STIs. Government departments other than health are typically responsible for financing and administering approaches that focus on structural issues (e.g., housing, education, poverty reduction, food and nutrition, employment, access to justice), although there is a risk that these approaches may be insufficiently prioritised or inadequately HIV and TB-sensitive if they are planned and implemented in isolation. Focused efforts are needed to enable and deepen integration of social and structural interventions into combination prevention packages. This approach has the dual benefit of enhancing the effectiveness of the response and diminishing pressures on the health sector to fund many aspects of the NSP. To enable the resourcing and scale-up of social and structural interventions, evidence-based budget bids or business cases should be developed,

compellingly demonstrating how these approaches will improve HIV and TB outcomes while also advancing broader development aims outlined in the NDP.

- *Identify and leverage innovative financing mechanisms:* South Africa will aggressively explore innovative options to generate new funding sources for the response. Options include:
  - *Government co-investment*, whereby multiple departments agree to co-finance priority interventions, an approach that is particularly well-suited to structural interventions, which have broader, cross-cutting benefits.
  - *Partner co-investment*, whereby the government joins with development partners, the private sector and others to co-finance efforts to achieve specific programme outcomes.
  - *Social impact bonds*, a contracting and financing mechanism whereby socially motivated investors pay for social services upfront and are repaid by outcomes funders (such as government department or development partner) only if pre-agreed outcome targets are achieved.

- *Improve financial information systems and management:* Fully resourcing the NSP and maintaining strong oversight during its implementation will demand rigorous financial management, which in turn depends on key action steps:
  - A modern management information system is needed, with advanced analytical and reporting capabilities (financial and non financial data, human resources etc).
  - Budgeting as well as financial and non-financial reporting frameworks should consolidate HIV and TB across departments and development partners.
  - Annual expenditure reviews should be conducted, consolidating data on expenditure by the South Africa Government, the U.S. Government, the Global Fund and other partners. Improving the financial information systems mentioned above will enhance the government's ability to collate and review all expenditures and to track expenditures against programme outcomes to identify potential technical inefficiencies.
  - The mapping and reporting of all HIV, TB and STI expenditures should simplified, standardised and routinized through mandatory reporting of all actors in the HIV and TB responses. This will greatly enhance the co-ordination of efforts and would reduce duplicative or fragmentation.

Objective 7.1	**Improve efficiency and mobilise sufficient resources to achieve the goals, objective and targets of the NSP.**			
	Interventions	**Approaches**	**Populations**	**Lead agencies**
Sub-Objective 7.1.1: Maximise the funds available for implementation of the NSP and the impact of these funds.	Costing of implementation plans	-Accurately cost all implementation plans to support budgeting and resource mobilisation efforts	All stakeholders	SANAC structures Government departmen SABCOHA PCAs
	Innovative funding mechanisms	- Design and implement new and innovative funding mechanisms . - Prioritise mobilisation of previously inaccessible sources of funding (such as private investors) and co-investment in shared outcomes (development synergies).		SANAC Secretariat National Treasury Provincial Treasuries Municipalities

		-Leverage new funding to enhance efficiency and impact		
	Technical efficiencies to generate cost savings	-Achieve higher technical efficiencies in service delivery and health and other systems	All stakeholders	SANAC structures All government departm
	Location targeting	- Improve the precision of spatial targets of investments		SANAC structures All government departm
	Increased corporate social investment	-SABCOHA to lead the scale up of the SABCOHA Community Fund existing to increase the allocation of corporate social investment funds to PDPs in support of PIP implementation. -Implement the SANAC Private sector strategy - Include SABCOHA to work at provincial levelt with different businesses, from large to medium-sized businesses.	Multinational and Local Businesses	SANAC Secretariat PCA Secretariat
Sub-Objective 7.1.2: Improve allocations based on emerging evidence and modelling work	Optimally strategic allocations	-Develop broad investment cases for better alignment with NDP. -Develop evidence-based budget bids or business cases for priority structural interventions -Maximise allocative efficiency in HIV and TB budgets.	All stakeholders	All government departm in consultation with stakeholders

Goal 8: Strengthen strategic information to drive progress towards achievement of NSP goals

Strategic information is a fundamental pillar of the NSP. The availability and use of data is pivotal to the "focus for impact" approach, including the development of optimally tailored and targeted plans at the provincial, district and local levels; the selection of combination interventions; the way in which interventions are implemented and delivered; the monitoring and evaluation of outcomes; the mid-term adjustments required to address problems as they emerge; understanding the South African context; and ensuring that the response is on track to achieve the NSP's goals, objectives and targets.

11.1 Situation analysis

For the purposes of the NSP, "strategic information" includes three key components.

1. *Routine information systems* enable on-going, regular programmatic data to be produced at disaggregated levels of service delivery, providing key insights regarding service utilization, gaps and outcomes.
2. Data from *surveillance, surveys qnd sentinel site monitoring* enable stakeholders to understand their epidemics, including the burden and distribution of disease, the populations and spatial locations most affected, and the factors that increase risk and vulnerability. Surveillance and surveys enables the evaluation of interventions. This data also enables stakeholders to target and tailor programmes most effectively and to allocate finite resources in a manner to maximise progress towards the NSP's goals, objectives and targets.
3. *Research* encompasses well-designed studies that build the evidence base for action to address HIV, TB and STIs. The research agenda includes the development of new or improved prevention, treatment and diagnostic tools and interventions, as well as new learning on optimal multidisciplinary strategies to implement or deliver validated interventions.

Monitoring and evaluation ascertains the degree to which progress is being made towards the NSP's goals, objectives and targets, using standardised indicators and comparing outcomes with quantified baselines. Monitoring and evaluation enables stakeholders to obtain an on-going assessment of progress at national, provincial and local levels; to identify problems or bottlenecks in a timely manner; and to determine whether adjustments or new approaches are needed. Some monitoring and evaluation is dependent on data obtained from routine data collection, surveillance, surveys and research.

The strategic information measures of the NSP build on data-related achievements to date, including mechanisms and systems developed to monitor the NSP 2012-2016 as well as South Africa's sophisticated health information systems, routinized monitoring and evaluation activities, rigorous epidemiological and programmatic research, highly capable research institutions and universities, and ground-breaking clinical trials. Recent, ongoing and planned strategic information activities are highlighted in Box X:

Box X: Highlighted Strategic Information activities spanning NSP 2012-2016 and NSP 2017-2022

- 2012 and 2016 national HIV prevalence, incidence, behavior, and communication surveys (SABSSM IV and V)
- Demographic Health Survey (2016)
- District Implementation Plan monitoring and bottle neck analyses
- Key populations size estimation, mapping and IBBS activities for sex workers, MSM, PWID (2015-2017)
- KZN HIV Incidence Provincial Surveillance System (HIPSS 2015-2019)
- Assessment of the utility of PMTCT program data (DHIS) for HIV sentinel surveillance among pregnant women
- HIV drug resistance & Pharmacovigilance surveillance
- Strengthening existing data collection of HIV cause-specific mortality (vital registration system)
- Impact evaluation of DREAMS iniatiave (2017-2020)
- Impact evaluation of AGYW iniatiaves (2017-2020)
- Evaluation and improvement of Tier.net modules, integration of data systens to conduct case-based HIV surveillance (2017-2020)
- NDOH Health Coordination Committee

11.2 Strategic approach

While capitalising on the important resources that South Africa already possesses, the NSP also aims to address some of the weaknesses identified in current strategic information systems. These include inadequate or poorly defined and harmonised indicators, including with respect to specific populations; unclear indicator baselines and performance targets; weak accountability for reporting; insufficient human resources and coordination mechanisms and systems to ensure routine data collection at all levels and from all sectors, including private sector and civil society; insufficient financial resources for monitoring and evaluation activities at all levels; and limited indicators for the measurement and assessment of structural aspects of the response. Lastly, an overarching coordinating body to oversee the development,

implementation, and utilisation of data from monitoring and evaluation systems, surveys and surveillance, and research studies is currently lacking. A crucial outcome of this NSP is the reinvoragation of committed, capacitated and multi-sectoral technical working groups in these areas, under the guidance of SANAC secretariat, to determine and prioritise vital strategic information needs.

11.2.1. Routine information systems

Monitoring the HIV, TB and STI response relies on the routine collection and reporting of programmatic data on adults and children, as well as regarding key and vulnerable populations. Routine programme monitoring helps quantify service coverage coverage (outputs and outcomes), while surveillance and population surveys (discussed below) generate data on outcomes (behaviour change) and impacts (incidence, prevalence). A data audit system, which will ensure that routine programme data are meeting the minimum data quality requirements, will be developed and implemented. The Office of the Auditor-General, the Performance M&E unit in the Presidency and STATS SA are encouraged to conduct a data auditing of a sample of core NSP and PIP data each year.

Data on the core NSP and PIP indicators for HIV, STIs and TB will flow from the ward level to district level (to district AIDS councils), to provincial AIDS councils, and then to the SANAC secretariat at national level, and will be returned back to the lowest level for feedback. While government and civil society sectors will report within their established structures at the different levels, they will also be required to feed into the AIDS council structures at the corresponding levels at the same time. This will help strengthen the multi-sectoral response at the different levels.

To enable the collection and optimise the use of routine health information, a system of unique health identifiers will be implemented. Specific measures will be taken to strengthen STI surveillance.

	Objective 8.1 Optimize routinely collected strategic health information			
Sub-Objective 8.1.1 Optimize systems for data utilization	Implement unique health ID	Facility specific ID	-Adapt current systems to accommodate Health Patient Registration Number (HPRN) -Undertake public awareness campaign on use of unique health ID and data confidentiality -Provide infrastructure (including IT) changes required to implement HPRN -Establish network connectivity at health facilities -Scale-up unique ID nationally to health facilities	100% health facilities utilising HPRN
	Link clinical, laboratory and pharmacy data	Stand-alone laboratory, ETR, EDR and Tier.net systems	-Audit existing systems for compliance to National Health Normative Standards Framework (HNSF) for interoperability in eHealth, the Protection of Personal Information Act and other legal prescripts -Develop inter-operability framework -Implement software changes to enable system linkages	Linked data system fully operational
	Establish health information (HIE)		-Establish HIE infrastructure in provinces -Develop dashboards and reporting systems at	-9 provincial HIE established

	exchanges for real-time data availability		each level (from facility to national), including for TB and HIV care cascades -Generate routine exception reports for action on patients failing to receive appropriate services	-Routine quarterly and annual TB & HIV care cascades generated
	Increase data utilisations		-Develop computer and data analysis skills at all levels of health system -Develop data science capacity in National and Provincial DOH -Provide automated quarterly facility cascade reports to District Implementation Teams -Produce national/provincial annual reports	-National and Provincial - Annual TB Reports produced

11.2.2. Surveillance and surveys

A particular aim of the NSP is to strengthen surveillance and surveys to enhance monitoring of outcomes across the cascade or continuum of services for HIV, TB and STIs. Monitoring of the HIV and TB cascades typically draws from clinic-based care and treatment monitoring data and helps identify gaps and inform programme improvements. However, neither the District Health Information System (DHIS) nor regular surveys capture cascade data on key and vulnerable populations, as these groups often experience barriers to accessing services in the public clinics where data is collected. As a result, surveillance and surveys need to be complemented by additional research and data collection strategies to better understand population sizes, programme utilisation and service gaps experienced by key and vulnerable populations. These complementary research efforts should integrate internationally validated scales for substance use and mental health disorders to shed light on the impact of these issues on outcomes among key and vulnerable populations across the treatment cascade.

Under the NSP, particular efforts will be made to strengthen STI surveillance as well as surveillance for key and vulnerable populations. In addition to strengthening routine surveillance, steps will be taken to determine the appropriate timing of surveillance studies, improve the collection of disaggregated data (by age, sex, race and disability), undertake focused research on priority populations, develop prevention cascades and dashboards to measure progress, and monitor outcomes along the HIV and TB treatment cascades. Areas of immediate need include enhanced drug resistance surveillance, which is vital in light of the massive anticipated uptake of antiretroviral therapy under the Test and Treat approach, the expanded use of PrEP, the increase in person-to-person transmission of drug-resistant TB and sub-optimal district-level understanding of STI-related microbial susceptitibility. Monitoring the clinical and epidemiologic trends in drug reactions through pharmacovigilance is also crucial, particularly in light of the increasing use of multi-line drug regimens and the growth in drug resistance. Further implementation of the unique identifier has great potential to improve the reliability and comprehensiveness of health data, reduce fragmentation (such as the use of multiple data collection systems for STI services), and increase care continuity and therapeutic follow-through (e.g., ensuring viral load suppression).

Comment [MI8]: TB Proof recommends addition of the following indicators:

- *Numbers and rates of HCWs diagnosed with TB*
- *Compliance by health facilities with National Core Standards in respect of infection prevention and control and occupational health.*

Objective 8.2: Optimise use of surveillance surveys

Sub-Objective 8.2.1: Improve surveillance and vital statistics, particularly for STIs and priority populations		Routine data collection for surveillance improved: ▪ Appropriate timing of surveillance studies determined ▪ Disaggregated data for accurate epidemiological information collected ▪ PSE and IBBS on all priority populations that are disproportionately affected by HIV, TB and STIs performed ▪ Prevention cascades and prevention dashboards to measure our progress and successes ▪ Treatment cascades of HIV and TB services are monitored ▪ Special surveys identified ▪ Vital statistics data integrated into health systems data	▪ STATSSA

11.2.3. Research

Focused research studies help develop new prevention and treatment technologies and strategies and answer key strategic questions that may not always be fully answered by surveillance and surveys, such as optimal ways to deliver evidence-based interventions and improved understanding of the South African context. In 2013, the South Africa Medical Research Council (SAMRC) and the Department of Science and Technology (DST) formed the Strategic Health Innovation Partnership (SHIP) unit to collaboratively support the development of home-grown innovation, with the goal of developing new diagnostic tools, drugs, vaccines and medical devices to address priority health issues in South Africa and all of Africa. Think tanks for HIV, TB and STIs also represent vital assets in driving innovation in addressing these three epidemics.

Numerous international donors provide additional funding for research and innovation, both for specific research programmes and to support targeted HIV, TB and STI research networks. An important consideration for the research and innovation agenda will be to develop strategic partnerships with the international funding bodies and product development partnerships (PDPs), with the purpose of leveraging expertise and facilitating further investment into HIV, TB and STI research and development in South Africa.

The NSP will strengthen strategic research activities to create validated evidence for innovation, improved efficiency and enhanced impact:

- *Develop, fully resource and implement a coordinated research agenda for the NSP:* South Africa will fully maximise its substantial research expertise by enhancing coordination, knowledge sharing, planning and implementation of all research efforts. This will aid in identifying gaps, mobilising resources for priority research proejcts and implementing research across South Africa. Research technical working groups, convened by SANAC secretariat, will help build relationships and support coordination among diverse stakeholders in the research arena, including encouraging and facilitating multi-disciplinary research. SANAC secretariat and NDOH will collaborate in convening discussions with key research institutions on the development of a coordinated national research plan. Specific efforts will be made to ensure rapid and widespread dissemination of research findings, and research efforts will adhere to best practices for community engagement and participation in research.

- *Enable research:* Steps will be taken to increase local research capacity, including the creation of fellowships for tertiary education students. Coordinated efforts will ensure the sharing of researchers for identified surveillance studies.

- *Fill critical research gaps:* Focused activities will help generate new knowledge to strengthen the national response and accelerate progress towards the goals, objectives and targets of the NSP. Particular efforts will focus on social and anthropological research to develop interventions to address social and structural factors, including establishment of an inter-disciplinary Social Science Think Tank at the Human Sciences Research Council; prioritising research on anti-stigma interventions; catalysing customised strategies for adolescent girls, young women and key and vulnerable populations; and validating additional social and behaviour change communication campaigns. Other areas of research consideration include traditional and alternative medicine, basic and clinical sciences, health systems and implementation research, and policy and public health research. Integrated bioheavioural surveys will be supported to generate size estimates and other strategic information for key populations, including MSM, PWID, sex workers and transgender people. SANAC secretariat will encourage efforts to develop new biomedical breakthroughs, including but not limited to vaccines; cures for HIV, TB and STIs; new microbicides; shorter, simpler and safer treatment options for the three diseases, including a particular emphasis on treatment options for TB and DR-TB; child-friendly TB medicines, with a focus on easy-to-take fixed dose combinations; strategic information to strengthen PrEP roll-out; optimising evaluations of models of differentiated care; and effective strategies to increase treatment retention and adherence.

- *Support implementation research:* The NSP seeks to catalyse implementation research for real-time learning and programme improvements, including through coordinated impact evaluations on implementation of best practices. The SANAC secretariat-led implementation research advisory committee recently developed a prioritised list of important implementation research questions. Implementation research priorities include studies on optimal strategies for linkage of people living with HIV to rehabilitation services and ensuring access to services for HIV, TB and STIs for people with disabilities.

- *Support research on the safety and efficacy of traditional and complementary medicines:* The NSP calls for a national strategy to foster the appropriate integration, regulation, availability and supervision of traditional and complementary medicine. Consistent with WHO guidance, this research strategy will build the knowledge base for formulating national policy regarding traditional and complementary medicine; enable evidence-based regulation to improve the safety, quality and effectiveness of traditional and complementary medicine; and ensure access to validated traditional and complementary medical interventions.

- *Support research to develop best practice models:* The NSP prioritises identification and dissemination of best practices, with the aim of continually improving the quality and impact of services for the three epidemics. Research will be supported to develop best practice models for community care support. In addition, experience from the intensified approaches undertaken in high-burden districts, particularly to address social and structural drivers, will be documented to inform efforts in other parts of the country. The NSP prioritises steps to ensure that communities are consulted, engaged, and fully

informed of research on HIV, TB and STIs, consistent with international guidelines on Good Participatory Practice in research. These steps will ensure the establishment of effective partnerships among research stakeholders, increase research transparency, and enhance the relevance and impact of research efforts.

Together, these enhanced research activities under the NSP seek to generate and informed an ongoing and evolving learning agenda to support achievement of the goals, objectives and indicators of the NSP. Continuing analysis of results from monitoring and evaluation of progress towards NSP targets and indicators will help identify knowledge gaps and inform the development of new research questions and projects, including special surveys and implementation research studies where indicated.

Sub-Objectives	2022 Target	Indicators	Responsible
Objective 8.3 - Coordinate research in South Africa to ensure that NSP 2017-2022 is guided by evidence and emerging best practice			
Sub-Objective 8.3.1 Build better relationships between scientists and clinicians, and between clinician researchers and policy-makers	Functional SANAC Research TWG established by August 2017	Newly elect Research Sector TWG committee Hold quarterly meetings Agree to budget for SANAC Research sector TWG	SANAC Research sector TWG including DoH; HSRC; SAMRC
Sub-Objective 8.3.2 Improve and streamline regulatory procedures including Ethics approval, pharmacovigilance and regulatory processes	Open 2-way communication between the TWG, researchers, academic institutions and SAG departments: national, provincial and local levels including policy makers	Support multidisciplinary research	All think tanks
Sub-Objective 8.3.3 Improve coordination of policies and operational plans of various stakeholders		Develop national policies and plans for research Sample sharing policy across research sites	SANAC Research sector TWG
Sub-Objective 8.3.4 Monitor and evaluate the health research enterprise		Develop implementation plan for national research agenda for HIV, TB and STIs	SANAC Research sector TWG
Sub-Objective 8.3.5 Share research findings with policymakers		Ensure swift adoption of best cost effective practices	DoH DST
Objective 8.4 - Develop a national research agenda to underpin the NSP			
Sub-Objective 8.4.1 Review existing research landscape	National multi-sectoral research agenda developed by December 2017	Survey existing research projects conducted Identify research gaps	SANAC Research sector TWG
Sub-Objective 8.4.2 Conduct social and anthropological science to develop additional social solutions for HIV, TB and STI prevention		Establish inter-disciplinary Social Science Think Tank Identify research to: ▪ unpack social and structural drivers and barriers to accessing health services in the South African context identified ▪ understand social, behavioural and structural barriers to adherence ▪ on reducing stigma and discrimination and how to reduce it ▪ understand the context and response to human rights violations ▪ learn from indigenous and traditional	HSRC Social science think tank

Sub-Objectives	2022 Target	Indicators	Responsible
		medicines ▪ improve and design evidence-informed SBCC campaigns and new harm reduction strategies to protect specifically key and priority populations	
Sub-Objective 8.4.3 Support research for innovation in biomedical breakthroughs		Identify research priorities for: ▪ the development of vaccines and cures for TB, HIV and STIs that are effective for all ages, that can prevent all forms of TB including MDR- and XDR-TB, and can be used in HIV-positive populations. ▪ new microbicides and the optimal drug formulations for different target groups including more effective treatment for both TB infection and disease of both DR-TB and drug sensitive TB ▪ research and costing for the roll out of optimised first line HIV treatment regimens ▪ New diagnostic tests for TB to detect extra-pulmonary TB, additional drug resistance, latent TB, and risk of progression ▪ diagnostics for STI to screen at least 95% of pregnant women for syphilis and test 90% for HIV, to ensure 95% of HIV positive pregnant women receive effective treatment, and new mult-disease point of care technology. ▪ mobilisation of research resources for novel shorter, simpler and safer treatment options for HIV, TB and STIs ▪ fast-track research into new drugs and especially new regimens that can be used to treat all forms of active and latent TB infection ▪ development and roll out child-friendly TB medicine ▪ additional research on PrEP for girls and young women ▪ individual risk profiling to roll out PrEP to all individual at substantial risk, including, transgender people, MSM, PWID, discordant couples, people with repeated STIs ▪ to address issues around security of supply of key drugs and vaccines, it is imperative to have cGMP manufacturing capability for drugs as well as biologics (including vaccines). The Biovac institute has a critical role to play in the establishment of cGMP manufacturing capabilities for vaccines, while the country needs to support efforts to localise the manufacture of APIs for key ARVs	SANAC Research sector TWG All research institutions

Sub-Objective 8.4.4 Conduct ongoing Implementation research for real-time learning and programme improvements		Identify priority Implementation research questions for HIV, TB and STI for inclusion in national research agenda	SANAC Research sector TWG

Objective 8.5 - Ensure that the national research agenda is costed and funded			
Sub-Objective 8.5.1 Calculate total cost for short- and medium term research priorities	100% of critical research questions are funded	Support modelling to identify most cost effective approaches done	SANAC
Sub-Objective 8.5.2 Lobby for increased local Government funding for research (currently <1% GDP)	TBD	Engage Treasury; DST; NRF; MRC; HSRC in budget discussions	SANAC
Sub-Objective 8.5.3 Encourage international funders to align with research funding priorities and plans	TBD	Involve development partners in design of national research agenda	SANAC Research sector TWG Development partners
Sub-Objective 8.5.4 Incentivise the private healthcare industry to spend 2% of turnover on R&D	TBD	Engage pharmaceutical industry / private hospitals / medical schemes Identify and implement best practice occupational health for HIV and TB screening and treatment developed Engage commodity/consumable suppliers Implement mandatory proportion of Corporate Social Responsibility budget for research	▪ SANAC
Aim 8.6 - Strengthen systems for adequate research capacity and an enabling environment to conduct research in South Africa			
Sub-Objective 8.6.1 Build capacity of local researchers	xxx research organisations to produce xxx new SA Masters and xxx PhD graduates xxx fellowships created xxx peers and community members developed as research assistants and research field workers	Establish need for qualified researchers at Masters and PhD levels Review current researcher output Establish number of learnerships/ fellowships for Masters and PhD students Establish number institutions providing technical and managerial support services to their current and developing researchers Share cadre of researchers among identified surveillance studies	SANAC Research sector TWG
Sub-Objective 8.6.2 Develop implementation plan for central knowledge hub	Central knowledge hub for research established by April 2018	Strengthen HRDS or new central hub for registration of all research created Develop national MIS including unique identifier	DST DoH
Sub-Objective 8.6.3 Streamline processes for an enabling environment for research	Regulatory systems can cope with research environment	Streamline ehhics approval and regulatory processes Strengthen pharmacovigilence Streamline regulatory processes, as evidence becomes available, e.g. MCC Adhere to Good Community Participatory Guidelines to engage communities in research and disseminate research findings Disseminate plans for research proposals Perform impact evaluations on implemented best practices	SANAC Research sector TWG

11.2.4. Monitoring and evaluation

To promote accountability and transparency and to drive progress towards the goals and objectives of the NSP, a detailed monitoring and evaluation plan has been developed. The plan advocates a "whole of government" and "whole of society" approach for tracking progress with the implementation of the NSP 2017-2022, in a comprehensive and inclusive manner.

The plan recognises and aligns with the leadership of the Department of Planning, Monitoring and Evaluation (DPME), housed in the Presidency, which oversees implementation of the Government–wide M&E framework (GWME). The plan for monitoring and evaluation takes into account existing monitoring and evaluation-implemented by different stakeholders, and is based on principles, practices and standards for performance management and reporting on public programmes, including the policy framework for the Government-wide Monitoring and Evaluation System (GWMES); the National Treasury framework for Programme Performance Information; the Statistics South Africa (Stats SA), South African Statistical Quality Assurance Framework (SASQAF); and the DPME National Evaluation Policy Framework.

Core indicators, baselines and targets for HIV, TB and STIs are drawn from existing policy and planning documents, including the NDP, MTSF, and relevant HIV-, TB- and STI-related strategies and plans and cascades. National and Provincial government departments, local government structures (metropolitan, district, and local municipalities) will reflect the relevant core NSP indicators and targets in their relevant Annual Performance Plans (APP) and Integrated Development Plans.

To close identified gaps in the monitoring and evaluation system for HIV, TB and STIs and to generate the information needed for effective monitoring and evaluation of the NSP, we will implement the following strategic approach:

- *Strengthen and promote multi-sectoral ownership and accountability of the NSP monitoring and evaluation system:* As monitoring and evaluation relies on multiple systems and data sources, which are supported and maintained by various stakeholders, greater coordination of efforts will be essential among implementing agencies in key sectors (public, private, civil society and development partners) to optimize available resources and ensure continuous learning through sharing of experiences. In support of greater multi-stakeholder ownership, accountability and responsiveness, SANAC secretariat will develop a national five-year costed monitoring and evaluation plan and framework to accompany the NSP. This plan will detail and define core indicators, data sources, data collection tools, data flow mechanisms, reporting timelines as well as roles and responsibilities of all stakeholders.

  The SANAC secretariat will coordinate the plan at the national level, with provincial AIDS councils and sectors assuming similar responsibilities at provincial and sectoral levels. These co-ordinating structures will oversee capacity development, data quality assurance, resource mobilisation for monitoring and evaluation and data archiving. Implementing institutions will be responsible for the actual implementation of monitoring and evaluation activities.

  An *Enterprise Information System (EIS)* that collates data from different sources and sectors will be built and dashboards developed with flexible and predefined templates to

facilitate standardised reporting, data interpretation and gap analysis. Monitoring and evaluation of the NSP will draw on key systems already in place, such as District Health Information System (DHIS), the Learner Unit Record Information and Tracking System (LURITS), Education Management Information Systems (EMIS) and the Social Pensions system (SOCPEN).

- *Strengthen capacity to use available data effectively to monitor NSP performance.* An overriding aim of the monitoring and evaluation plan is to improve aid to stakeholders to use their data to adapt and improve their programmes. Under the monitoring and evaluation plan, steps will be taken to mentor, guide and strengthen various stakeholders to improve data quality and use for decision-making in order to foster a culture of "data-driven action" at all levels of the response. All sectors and localities will be supported to track progress, measure results and interrogate their data to adapt, improve programs and strengthen the response on a continuous basis.

- *Conduct independent reviews of progress:* Independent evaluators will conduct robust and inclusive *mid-term, end-term and programme evaluations* of the NSP and PIPs. The mid-term review, scheduled for 2019, will assess the relevance, effectiveness, and efficiency of the NSP. This review will allow for adjustments in programming and resource allocation for the second half of the NSP and also provide an opportunity for stakeholders to revise NSP and PIP targets as necessary. A final review will be conducted at the end of the term to evaluate the full five-year period of the NSP and will focus on the extent to which the NSP impact and outcome sub-objectives have been achieved. This evaluation is scheduled for 2022, and findings will inform the development of the next NSP. Following each of the annual, mid-term and end term reviews, the SANAC secretariat will oversee feedback at all levels, and provide guidance and support for the use of data for program strengthening.

- *Disseminate the latest strategic information to the public:* Information generated through the monitoring and evaluation systems of government and its partners will periodically be translated into accessible, digestible and user-friendly formats on which ordinary citizens can rely to make decisions about their lives. Young people, in particular, are keen consumers of such information, especially through rapidly evolving and improving electronic information tools. This phenomonen is illustrated by the Be-WISE programme of the health sector, which has been accessed by over 800 000 users in its first year of existence. These efforts will position government programmes as providers of choice with respect to information on HIV, TB and STIs, in order to enable the public to rely on sound and validated evidence rather than folklore or myths in their personal decision-making.

A core set of indicators (Annex XX) will be used to monitor, track and evaluate the outputs, outcomes, and impact of the NSP, and to inform decision-making at national and sub-national levels. The core indicators measure the performance of NSP against the plans' goals, objectives and sub-objectives. Through development of specific implementation plans, provinces and other stakeholders may identify additional indicators to meet their information requirements.

Objective 8.7: Rigorously monitor and evaluate implementation and outcomes of the NSP			
	Recommended Actions	**Expected Results**	**Responsibility**

Sub-Objective 8.7.1 Strengthen and promote multi-sectoral ownership and accountability of the NSP and PIP M&E system.	Coordinate a multi-sectoral approach including use of one M&E PLan and reporting on a core set of NSP indicators by all stakeholders. Establish a National multi-sectoral M&E Technical Task Team to coordinate and maintain partnerships among stakeholders involved in NSP M&E plan including the Government-led M&E working group and STATS SA. Develop a well-defined and managed national Enterprise Information System (EIS) that collates and provides comprehensive information package on key NSP Indicators for decision making.	Five-year costed National M&E Plan which includes the specific activities of all relevant stakeholders and identified sources of funding. Functional National multi-sectoral M&E Technical Task Team. Well-defined and managed national Enterprise Information System (EIS).	SANAC PCAs National & Provincial agencies Implementing partners
Sub-Objective 8.7.2 Strengthen M&E capacity to effectively use available data to monitor NSP and PIP performance and HIV, TB and STI epidemics at all levels.	Conduct M&E capacity assessments at national, provincial and district levels, and strengthen skilled M&E human resources Train, coach and mentor key personnel at national, provincial, and district level on data analysis and use to improve utilization of data. Collect comprehensive information on NSP progress Use program data to evaluate implementation of the NSP, between formal reviews.	Assessments of the 12-components of the Provincial M&E systems. All district and provincial AIDS councils have at least 1 specialized M&E specialist to support NSP M&E Community based routine. monitoring system strengthened All AIDS councils produce annual provincial and HIV, TB and STIs district profiles. National and provincial annual programme reports, midterm and end-term evaluation reports, and global reports implemented and disseminated in timely manner.	SANAC PCAs National & Provincial agencies Implementing partners
Sub-Objective 8.7.3 Ensure harmonised, timely and comprehensive routine systems to provide quality HIV, TB and STI data at national, provincial and district levels and across	Determine baseline values at national, provincial and sectoral levels Conduct non-health routine M&E supervision, and periodic data quality audit verification. Harmonise and create linkages between the Enterprise Information System (EIS) and other health, education and social sector Information systems Promote data demand and use of HIV, TB and STI strategic information to inform policy and programming.	Availability of indicator baseline values at the different levels to track progress in the implementation of the NSP and PIPs. 90% of NSP and PIP core indicators reported. Availability of comprehensive HIV, TB and STI data to assess performance towards attainment of NSP and PIP goals and objectives.	SANAC PCAs National & Provincial agencies Implementing partners

sectors.			
Sub-Objective 8.7.4 Disseminate the latest, cutting edge information to the public, to enable people to make informed decisions about their lives	Establish strong relations with the Health Promotion, Communication and Primary Health Care (community-based services) Units in all national and provincial governments department and municipalities Ensure that timely, relevant and appropriate information is disseminated by these units to the public, in an accessbile manner, but based on scientific rigour Support Health Promotion, Communication and Primary Health Care (community-based services) Units in all national and provincial governments to use media platforms popular amongst youth, learners, students, out of school youth and key populations to disseminate information	Availability reliable, evidence-based "facts and figures" about HIV/AIDS, STIs and TB to the public Self-reported improvement in the knowledge, attitudes and behaviour of youth, learners, students, out of school youth and key populations, reported through national surveys and snap surveys conducted through different media platforms	SANAC National government departments Provincial government departments Municipalities AIDS Councils

Table xx: NSP Monitoring and Evaluation Reports (to be disseminated by SANAC secretariat and provincial and district AIDS councils)

M&E Reports	Frequency	Purpose/Focus of the Report	Responsible
Annual NSP and Provincial HIV, TB and STI Programme reports	Annually	Programme reviews will be conducted annually, and will be informed by quarterly performance reports. Multi-sectoral stakeholders will come together at the end of each implementation year to establish the effectiveness and efficiency of the HIV, TB and STI programmes.	**Lead:** SANAC Secretariat National entities[‡‡] Provincial entities[§§] Local entities[***]
NSP and PIP Mid-term Evaluation Reports	2019	The mid-term review of the NSP and PIPs will focus on achievements, challenges, emerging issues and recommendations for the remaining half of the NSP and PIPs. This evaluation will assess the relevance, effectiveness, and efficiency of the NSP and PIPs. A detailed evaluation protocol will be developed to ascertain the achievements against what was planned and will be informed by the departmental, provincial and local Annual performance reports.. Findings of this evaluation will inform the review of the NSP and PIPs	**Lead:** SANAC Secretariat Independent evaluators National entities Provincial entities Local entities
NSP and PIP End-Term Evaluation	2022	The end-term evaluation will be undertaken in 2022 in all 9 provinces and at national level to provide the evidence base for the next NSP.	**Lead:** SANAC Secretariat Independent

[‡‡] National (Presidency, Ministries, Departments, Public Entities) Provincial (Office of the Premier, MECs, Depts, Public Entities)
[§§] Provincial (Office of the Premier, MECs, Depts, Public Entities)
[***] Local (Metros, District Municipalities, Local Municipalities, public entities) – high-burden districts]

reports			evaluator National entities Provincial entities Local entities
Provincial and District HIV, TB and STI Profiles	Annually	In order to effectively support the implementation of successful programmes that are evidence based and take into account local heterogeneity, the PCA will support the development of annual profiles of the status of the HIV, TB and STIs epidemic and response in all 9 provinces and 52 districts.	**Lead:** PCAs and DACs Provincial entities Local entities
Global and Regional AIDS , TB and STI Monitoring	Annually	SANAC Secretariat in consultation with the relevant departments and development partners will manage HIV, TB and STI international reporting obligations.	**Lead:** SANAC Secretariat National entities
Evaluation reports	Every 2 years	Apart from monitoring progress in NSP implementation, the M&E Plan will provide for special evaluations such as the Know-Your-Epidemic/Response, and Expenditure analyses.	**Lead:** Relevant agency

Critical enablers to maximise the reach and impact of South Africa's response to HIV, TB and STIs

For the achievement of the eight NSP goals, systems must be strengthened to ensure delivery of services. Programmes need to be both effective and optimally efficient, taking into account the finite nature of available resources. Critical enablers strengthen and configure systems to meet the challenges outlined in the eight goals, helping maximise the reach and impact of programmes.

The enablers described in this chapter are not merely ancillary to essential services but critical to the success of service delivery. In furtherance of the NSP, Provincial Implementation Plans should specifically describe concrete actions to implement these enablers in order to ensure that the vision, goals and objectives of the NSP are realized.

Critical enablers fall into two categories: health system enablers and social enablers.

12.1 Health system enablers

12.1.1 Health system enabler 1: Effectively integrate HIV, TB and STI interventions and services

Service integration is a critical aspect of health and social system strengthening in all cases, but it especially important where resources are limited. Offering services and information in an integrated manner is more efficient from a systematic standpoint and more friendly to consumers of health and social services, as integrated systems require fewer clinic visits and also help diminish stigma. Service integration has been shown to generate concrete health benefits; for example, early antiretroviral therapy initiation among people co-infected with HIV and either hepatitis B or C virus can generate approximately 10% greater health benefits per year on treatment. Service integration can be further enhanced through implementation of the Integrated Chronic Disease Management model through the Ideal Clinic programme at the primary health care level.

While service integration is a broader imperative, it is especially critical in the case of HIV and TB, given the high levels of HIV/TB co-infection. South Africa has had some important successes in integrating HIV and TB services. The proportion of TB patients who know their HIV status rose from 25.9% in 2007 to 89.9% in 2013. There are signs that service integration may be contributing to public health gains, as the proportion of TB patients who are also HIV-positive fell from 69.6% in 2009 to 63.3% in 2013. Building on these advances, further steps are needed to ensure integration of HIV, STI and TB into all prevention and treatment programmes, enabling entry points to address all three diseases at point of care.

In addition to needed service integration in health care settings, additional efforts are required to ensure thorough integration of health and non-health sectors in order to achieve the goals and targets of the NSP. Health care settings should ensure appropriate referral and linkage of patients to enabling social services, and policy-makers in other sectors should also aim to ensure that their programmes are optimally HIV-sensitive. For example, in the case of food and nutrition programmes, prioritising services to children and households orphaned or made vulnerable by

Comment [MI9]: Insert citation:

Martin, N. K., Devine, A., Eaton, J. W., Miners, A., Hallett, T. B., Foster, G. R., ... & Vickerman, P. (2014). Modeling the impact of early antiretroviral therapy for adults coinfected with HIV and hepatitis B or C in South Africa.*AIDS*, *28*, S35-S46.

Comment [MI10]: Insert citation:

Standards and Benchmarks Assessment for TB Surveillance in South Africa. February 2015. A report commissioned by the National Department of Health (NDoH) in South Africa with the support of the World Health Organization (WHO) in preparation for development of the National Strategic Plan and the Global Fund concept note (23-27 February 2015).

HIV and/or TB offers a path towards simultaneously reducing hunger and accelerating implementation of the NSP.

12.1.2 Health system enabler 2: Strengthen procurement, supply chain and information systems

Strong procurement and supply chain management systems are fundamental components of health system strengthening. To achieve the ambitious goals and objectives of the NSP, ready, uninterrupted access to essential prevention, diagnostic and treatment commodities will be critical. While South Africa's procurement and supply chain system has largely functioned well in response to HIV, TB and STIs, the gaps that have sometimes occurred have undermined effective use of essential health commodities as well as adherence to prescribed prevention and treatment regimens.

In 2017-2022, South Africa will take additional steps to strengthen procurement, supply chain and information systems and ensure quality throughout. The country will further strengthen its stock monitoring system at national and local levels, supported by a rapid response system for shortages, to ensure consistent and adequate supplies of medicines, testing kits, TB personal protective equipment, and female and male condoms as well as lubricants at all service delivery sites. Steps will be taken to strengthen and enhance the accountability of efforts to reduce the occurrence of medicines stock-outs, including improved case and stock management at health facilities, an early warning system that identifies impending shortages, a distribution plan to respond in a timely manner to impending shortages, roll-out to all communities of a direct distribution system for medicines for chronic diseases (including HIV and TB) delivered in venues outside of health facilities, and improved, transparent information systems that identify the causes of stockouts. In addition to the Central Chronic Medicine Dispending and Distribution Programme, other approaches will be implemented to provide antiretroviral and TB medicines and other health supplies in venues other than health facilities, bringing HIV and TB treatment as well as services for other chronic diseases closer to where people live and work.

Continued efforts will work towards optimizing access to drugs that people living with HIV, TB and STIs need, at the lowest possible prices. Towards this end, South Africa will further improve the capacity of the Medicine Control Council/SAHPRA to rapidly review and approve generic versions of medicines and new combinations and medicines that become available. Further vigilance will be needed to ensure that South Africa benefits from the most favourable prices possible for medicines, diagnostics and other health commodities.

12.1.3 Health system enabler 3: Ensure that there are sufficient, appropriately trained human resources where they are needed

HIV, TB and STI prevention, treatment and care is labour intensive and requires diverse cadres of human resources from multiple sectors. Workers in both public and private sectors have roles to play, ranging from professionals to volunteers and from disease specialists to generalists whose work touches on all three diseases. Given the ambitious nature of the NSP's service targets and the imperative of expanding efforts to address social and structural drivers, human resource needs under the NSP will undoubtedly grow and further diversity. This is true not only for health and social service systems generally, but for the sub-systems (e.g.,mental health services) that will be needed to effectively implement the NSP. Only a robust, resilient system of human resources – one that prepares every worker to serve in a caring, people-centred and competent manner – will

ensure that human resources are sufficient and that all actors are working in harmony to achieve the goals and objectives of the NSP. In particular, efforts to expand human resources for the HIV, TB and STI response should be intensified in high-burden districts and cities and for key and vulnerable populations.

The NSP requires an increase in the number of primary health care nurses who have the needed skills to administer antiretroviral therapy, manage drug-resistant TB, and address STIs beyond syndromic management, as well as a sufficient number of doctors to support and mentor nurses and pharmacists to ensure the prescription and dispensing of antiretroviral medicines and other health commodities. Health care workers must be trained and proficient in occupational health and infection control standards and practices, and health and social care workers will also benefit from trainings and technical support on working with key and vulnerable populations. Community health workers need to be formalized as a cadre, appropriately trained and supported, and fully integrated into the health system. The need for expanded human resources is pertinent not only to the public sector but also in the private sector, including but not limited to incorporating HIV, TB and STIs in the training of wellness coordinators.

Under the NSP, South Africa will invest greater resources and efforts in the training and mobilization of peer educators and support personnel. Peer workers have an especially vital role to play in contributing to the response for young people and for other key and vulnerable populations. To play their optimal role, peer workers require training, support and supervision, and stipends or other compensation.

12.2 Social enablers

12.2.1 Social enabler 1: Focus on social and behaviour change communication (SBCC) to ensure social mobilisation and increasing awareness

Effective communication is a central element and determining enabler of each and every aspect of the NSP. Social and behaviour change communication (SBCC) helps individuals at risk of HIV reduce HIV risk behaviours, builds demand for services, and assists people to remain engaged in HIV services and to adhere to prescribed prevention and treatment regimens. According to a recent analysis by the World Bank and other partners, changes in sexual behaviours played a decisive role in the substantial declines in HIV incidence that reversed in the AIDS epidemic in many African countries.

SBCC is an especially important component of an effective response to HIV, TB and STIs at this stage of the national response, when growing evidence suggests that young people are less informed about HIV than in the past and often less likely to take steps to reduce sexual risks. Results from three national surveys indicate that fewer South Africans are reached by SBCC programmes, with the proportion of people reporting having been reached by SBCC interventions falling from 92.5% in 2006 to 82% in 2012.

To be effective, SBCC approaches must be of high quality, reach high coverage (at least 80% of the target population) and include measures to reinforce messages through multiple channels. Effective SBCC is characterized by strong stakeholder participation, capacity building for programmes, geospatial mapping to inform targeting, risk profiling of communities and the tailoring of national campaigns to local communities. SBCC programmes should be theory-based,

Comment [MI11]: Citation to add:

Evalutating the evidence for historical interventions having reduced HIV incidence: A retrospective programmatic mapping analysis, 2016, Washington DC: World Bank et al.

Comment [MI12]: Citations needed.

client/community-centred, participatory, oriented around the benefits of key behaviours and linked to services. SBCC programmes should use multiple channels (e.g., advocacy, mass media, etc.); be scaleable, sustainable, results-oriented and cost-effective; and recognize that social and behaviour change is seldom a linear process.

To support full implementation of the NSP, an evidence-informed national SBCC strategy should be developed and steps should be taken to align existing SBCC initiatives with the goals and objectives of the NSP. This new SBCC strategies should support a national 360˚ communication campaign to support achievement of the NSP. Steps should be taken to increase the capacity of the national government to lead and support this national SBCC campaign and to build the capacity of key stakeholders to enable them to leverage the campaign for advocacy. Planning for the campaign should be inclusive, involving members of the targeted audience, skilled communicators, content experts (programme managers and coordinators) and researchers, and informed by focus groups and other research efforts. Toll-free lines operated by the government should be made accessible to people using mobile phones in order to increase the reach and impact of the SBCC campaign.

To implement a stronger, sustained SBCC effort to support achievement of the NSP goals and objectives, SANAC will review existing SBCC interventions (e.g., She Conquers, GBV campaigns, etc.) and develop a baseline to aid in measuring the campaign's impact. The national government will coordinate the national campaign and prescribed sustained SBCC interventions in support of the NSP. As the campaign will aim to increase use of key commodities (e.g., male and female condoms, test kits, etc.), the national government must ensure a robust, continuous and reliable supply of commodities at the local level. The national government will oversee capacity-building activities to enable communities to fully leverage the SBCC campaign and to address the drivers of the HIV, TB and STI epidemics.

In support of the SBCC aims of the NSP, provincial and district AIDS councils will engage opinion leaders and influential individuals in local communities to support the campaign. Provincial and local leaders should ensure an enabling environment to support local actors in leveraging the campaign for advocacy. Community-based coordinating structures, such as the War Rooms established under Operation Sukuma Sakhe in KwaZulu-Natal, should be established in each community, with particular attention to high-burden districts. Community health care workers and care givers should be trained to undertake household wellness assessments and to make referrals to integrated HIV/TB/STI/SRHR and GBV services.

12.2.2 Social enabler 2: Build strong social systems, including strengthening families and communities, to decrease risks of transmission and to mitigate the impact of the epidemics

The NSP recognizes that social systems are vital to supporting and enabling the prevention and treatment goals of the NSP. In particular, these social systems are pivotal to the NSP's ambitions for key and vulnerable populations, for addressing social and structural drivers, and for promoting and protecting human rights. Under the NSP, concerted efforts will be made to empower and strengthen households and parents as key actors in achievement of NSP targets and indicators. The Department of Social Development will play the lead role in building strong social support systems, supported by other government departments, SANAC secretariat, civil society (including faith-based and traditional leaders), and private sector wellness programmes. Integration and coordination with diverse sectors will be central to hopes of fully leveraging

stronger social systems to accelerate progress towards the goals, objectives and targets of the NSP.

Under the NSP, community-based responses will be strengthened through the implementation of a core package of multi-sectoral services to address the social, physical, educational and emotional needs of children and families. In all prevention and early intervention programmes, the role of parents and caregivers will be addressed. Safe spaces will be provides for families or individuals who experience or are at risk of gender-based violence, including linkages to appropriate social behaviour change programmes.

Community engagement, dialogue and direct support will be prioritised to permit the most pressing needs of communities to be identified and addressed. Targeted risk assessments and measures to ensure early detection, treatment and adherence support will focus on reducing the vulnerability of children and families, with particular attention to adolescent girls and young women. Children, families and caregivers will be referred to screening for HIV, TB and STIs, and psychosocial support services will enable the uptake of testing. Existing platforms and institutions, such as Sisonke, will be fully leveraged to build strong, durable social systems for sex workers and other key and vulnerable populations.

The capacity, competencies and capabilities of government, civil society and NGO and CBO service providers will be increased to support the roll-out of quality HIV, TB and STI interventions and services. At the local level, improved community coordination forums and networks will strengthen integration, coordination and collaboration between health and social service providers.

Conclusion: Focusing for impact

[PLACEHOLDER]

In recent decades, South Africa has experienced the devastating effects of HIV and TB. As a result of these epidemics, national life expectancy plummeted, millions of children lost one or both parents, households and communities were riven, and local economies suffered. Persistently high levels of STIs further added to the country's health burden.

At the dawn of this new NSP, however, there is renewed hope and optimism in the national response to HIV, TB and STIs. People from all walks of life have joined together to respond to these epidemics, national investments in prevention and treatment programmes have dramatically increased, and the array of prevention and treatment tools continues to expand. Indeed, it is now apparent that we have everything we need to lay the foundation to end HIV, TB and STIs as public health threats in our country.

However, there is another side to the extraordinary hope and optimism generated by the unprecedented national mobilisation, the many scientific breakthroughs and the innovations in the pipeline. These include the establishment of the state-owned company, company Ketlaphela ,to build South Africa's capacity to manufacture active pharmaceutical ingredients for key HIV medicines and other drugs.This initiative will create jobs, transfer technology, reduce the country's technology balance of payment in pharmaceuticals, and improve the delivery of high quality medicines for the treatment of high burden diseases such as cancer, tuberculosis and HIV.

Modelling indicates that a failure to build on gains to date and to front-load investments in the response will allow these epidemics to rebound. If we fail to act – if we do not seize the historic opportunities we have – the human and financial costs of HIV, TB and STIs will grow much worse in the coming years.

The "focus for impact" approach outlined in this NSP offers a roadmap for fully leveraging scientific advances and for averting the inevitable costs of complacency. Through smarter action, especially at the local level, and with greater engagement of affected communities and all sectors, we can by 2030 ensure that our country will be free of HIV and TB. The "focus for impact" approach will only be possible with renewed commitment, sufficient resources and an inclusive, data-centred approach.

"A new world will be won not by those who stand at a distance with their arms folded, but by those who are in the arena," President Nelson Mandela said. With such bountiful health and economic benefits within our grasp, our challenge now is to enter the arena and work together towards a South Africa that is healthier and better prepared to thrive in future decades.

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