

# DRAFT 1.1

## 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 for comment. 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.

**All stakeholders are invited to submit comments to [nsp@sanac.org.za](mailto:nsp@sanac.org.za)**

*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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DRAFT

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

The National Strategic Plan for HIV, TB and STIs 2017-2022 (NSP) outlines the strategic framework for a multi-sector 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 Provincial Implementation Plans, which will outline a blueprint for action at provincial, district, municipal and local levels to operationalize the strategic directions outlined the NSP. The diseases that the NSP 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; TB is the nation's leading cause of death; and 1.4 million new STIs are treated annually in the country's health facilities.

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 our collective vision of a nation that is healthier, stronger, more equitable, and better prepared to realize our goals as reflected in our National Development Plan.

### 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; the NSP 2007-2011 moved decisively to galvanize a massive expansion in the provision of antiretroviral therapy; and the NSP 2012-2016 accelerated access to HIV treatment, called for the delivery of comprehensive HIV prevention services, a prioritized action to ground the national response in human rights principles as well as to address the social and structural drivers.

[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:

- *A review of evidence:* The South African National AIDS Council (SANAC), the National Department of Health (NDOH) and other stakeholders undertook a comprehensive review of progress made towards the goals and targets in the NSP 2012-2016. This review included an identification and analysis of progress as well as key gaps and challenges. The latest, fourth NSP also draws from the findings from the South African HIV and TB Investment Cases, which 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.
- *Steering Committee:* [PLACEHOLDER]
- *Technical Working Groups:* XX multi-stakeholder working groups were convened to analyse in granular detail the current situation, gaps and optimally promising ways forward in core work

areas (e.g., prevention and treatment of HIV, TB and STIs, social and structural drivers, human rights and stigma, key populations, financing and, monitoring and evaluation).

- *Consultations:* The development of the NSP 2017-2022 drew on extensive consultations with diverse stakeholders in the national response to HIV, TB and STIs, undertaken under the umbrella of SANAC. The consultation process was launched at the International AIDS Conference in Durban in July 2016, with three ministers and four deputy ministers in attendance. 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. The consultation process was then continued to produce a final draft document, reviewed at a national consultation in February 2017.
- *Formal Endorsement:* The NSP 2017-2022 has been endorsed by SANAC’s Programme Review Committee, Plenary and SANAC Trust Board and by the national Cabinet.

### From Planning to Implementation: The NSP Context

The NSP is informed by and situated within the broader development context. The NSP is closely aligned with the National Development Plan Vision 2030 (NDP), which acknowledges the profound effect that HIV has had in slowing national development and 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 set forth 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. The NSP builds on innovative programmes and initiatives of recent years that have worked to synergize the AIDS response with the broader development agenda, such as the national She Conquers campaign which address both the HIV-specific as well as social and structural challenges confronted by young women and girls. These and other crucial national and international health and social policies that underpin NSP 2017-2022 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 (year)
- [PLACEHOLDER: MORE TO BE ADDED]

The NSP also aligns with regional and global frameworks. These include the African Union Agenda 2063, the 2003 Maseru Declaration (the basis for 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), the 2016 UN Political Declaration on HIV and AIDS, the UNAIDS Fast-Track strategy, Agenda 2030 (the SDGs), and the 2013 Eastern and Southern African Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people.

Integrally linking the national response to HIV, TB and STIs with the broader development 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 (SDGs), which emphasize the links between communicable diseases and other health and development challenges. The NSP is fully aligned with the 2016 Declaration of Commitment on HIV and AIDS that emerged from the High Level Meeting on Ending AIDS at the United Nations General Assembly.

### The NSP 2017-2022 in Perspective

This National Strategic Plan 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, and not an operational guideline, it sets priority targets and highlights key activities, rather than programme implementation guidance. Thus, translating the NSP into measurable operational plans will be required by provincial and district implementation plans (PIPs and DIPs), civil society, and private sectors. Every sector, government department, private stakeholder and development partner will need to contribute if the goals and objectives of this NSP are to be achieved. Overall coordination of this response rests with the SANAC Plenary with the support of the SANAC secretariat.

## NSP Goals 2017-2022

In 2015, South Africa joined other countries in endorsing the Sustainable Development Goals, which call for action to end the AIDS and TB epidemics by 2030. The NSP 2017-2022 aims to ensure an enhanced national response to HIV, TB and STIs, by sharply reducing new infections, 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 2017-2022 resulted in agreement on seven 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 targeting prevention efforts strategically to the locations and populations in greatest need, the NSP seeks to *break the cycle of transmission*. The fourth NSP seeks to reduce new HIV infections by more than 60% – from 270 000 in 2016 to below 100 000 by 2022; to cut TB incidence by at least 30%; and to significantly lower the incidence of gonorrhoea, syphilis and chlamydia, achieve virtual elimination of congenital syphilis, and maintain high coverage of HPV vaccination.

*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* (see Goal 2, Chapter 5). Attaining these targets will reach 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 65% 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 support peer-led and community-based services tailored to meet the needs of specific populations, initiatives to empower key and vulnerable populations, and actions to build the capacity of service providers to meet the needs of key and vulnerable populations. Integral to this strategy is guidance 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, including human rights*

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 both to the needs of adolescent girls and young women without neglecting the general population. The NSP reflects a continued and deepened commitment to *equal treatment and social justice*, including protection of human rights, 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.

*Goal 5: Promote leadership at all levels and shared accountability for a sustainable response to HIV, TB and STIs.*

*Mutual accountability* is a fundamental to the achievement of the objectives of the NSP 2017-2022. 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 capacitation of civil society sectors and community networks.

*Goal 6: Mobilise resources to support the achievement of NSP goals and ensure a sustainable response.*

Meeting the challenge of fully funding the NSP will require a maximizing funding from existing sources, improving spending efficiency of and leveraging innovative mechanisms to generate new funding sources.

*Goal 7: Strengthen strategic information 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 data needed to monitor and investigate the burden of disease, uptake of services, and effective approaches to prevent and reduce morbidity and mortality.



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.

*Enablers:*

- Effective integration of HIV, TB and STI interventions and services
- Building strong social systems, including strengthening families and communities, to decrease risks of transmission and to mitigate the impact of the epidemics
- Strengthening information, procurement and supply chain systems
- Ensuring that the human resources required are sufficient, trained and located where they are needed
- Focusing on social and behaviour change communication to ensure social mobilization and increasing awareness.

## What is New in the NSP 2017-2022

In the transition from disease control to disease elimination, the NSP 2017-2022 calls for a marked reduction of new infections and mortality associated with HIV, TB and STIs, as well as sharp, sustained increases in service coverage. In light of these elevated 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 enhances focus for impact to drastically speed progress on HIV, TB and STIs. These pivotal action steps prioritised in the NSP 2017-2022 constitute important new features or areas of emphasis compared to the NSP 2012-2016:

- *Prioritising HIV prevention.* The NSP provides for a substantial intensification of strategic, evidence-based efforts to prevent new HIV infections. The NSP calls for the combination of treatment-associated viral suppression, biomedical HIV prevention (including pre-exposure antiretroviral prophylaxis, or PrEP), behaviour change and action to address social and structural drivers of the epidemic.
- *Accelerating implementation of universal test-and-treat.* The fourth NSP reaffirms South Africa’s recent adoption of the “treat-all” approach for HIV recommended by the World Health Organization, as well as the 90-90-90 and STIs, and calls for concerted, prioritised efforts to accelerate testing, linkage to care testing and treatment for all who need them. With regard to universal treat-and-treat for HIV, ART should be initiated as soon as possible after HIV diagnosis, as soon as a patient is medically and emotionally able.
- *An intensified focus on location.* This NSP reflects a much more refined and sophisticated analysis of locations with high burdens of HIV, STIs and/or TB, such as metros, districts with peri-mining areas and truck routes. While the NSP aims to guide, strengthen and accelerate action across the country, especially intensive efforts will be made in high-burden jurisdictions 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 disproportionately affected.* The NSP also 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 calls a transformed and substantially intensified 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, 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 2017-2022 recognizes the equally urgent priority to improve the quality and sustainability of services. The 90-90-90 targets for both HIV and TB stress the importance of ensuring that treatment services achieve their desired health outcomes. In addition to ensuring the ready available and 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 fourth 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 recognizes 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 services across the cascade to reflect the preferences and expectations of various groups of people living with HIV (PLHIV). This means that patients who enrol into care with advanced disease will require a different level of care than those who enrol while still clinically and/or immunologically well. Furthermore, stable patients with good adherence and durable virological suppression will require less intensive follow-up and monitoring than those not stable on treatment, who will need more intensive care, support and follow-up. Differentiated care will therefore address the whole continuum of care for the patient, including *when* clinical reviews are conducted, *where* the patient is managed (clinic, community, etc.), *who* manages the patient (type of provider) and *how* the patient is managed (ART initiation, refills, adherence support, psychosocial support, etc). This differentiation could improve outcomes through the efficient use of available health facility and community resources and reduced costs, reduced inconvenience and potential loss to follow up, and improvement in quality of care.
- *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 and young women. The NSP seeks 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 vulnerability.

- *A strengthened multi-sectoral response.* The NSP envisages a major strengthening of multi-sector cooperation and collaboration to address the social and structural determinants of HIV, TB and STIs. Government departments must implement together and not in silos. Decentralised staff of national departments must become part of provincial, district and municipal AIDS councils, as must members of key population groups and representatives of the private sector and organised labour.
- *An expanded approach to costing and financing the response.* Recognizing limitations in domestic fiscal space and declining external assistance, the NSP prioritises efforts to identify and leverage new sources of funding, 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 the efficiency of and the health, social and economic returns on financial investments.
- *Strengthening strategic information.* Strategic information will identify where the NSP is on track and what improvements and new knowledge are needed. 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 ambitious 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.

## The state of the epidemics in 2017

Since 2012 there has been a significant increase in the country's understanding of its HIV, TB and STI epidemics. There is now a much more granular understanding 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; and critical new interventions, including PrEP, have emerged in the last five years. The public health and development challenges posed by these three diseases remain enormous, but the strategic information on which to base prevention and treatment approaches is more solid than ever.

### State of the epidemic: HIV

*HIV prevalence:* South Africa is home to the world's largest HIV epidemic. 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.

HIV prevalence (i.e., the proportion of people living with HIV) among pregnant women has remained stable since 2004. [INSERT MORE SPECIFIC DATA ON ANC PREVALENCE – ASSISTANCE NEEDED]

Nationally, HIV prevalence is increasing, as people living with HIV are on average living longer due to the beneficial effects of antiretroviral therapy. This is reflected in increasing average life expectancy from an estimated 58.3 years in 2011 to 62.4 years in 2015. HIV prevalence varies considerably by age, sex, race, locality type and province. Peak HIV prevalence occurs at ages 35-39 for females and at 35-44 for men. Among age groups, HIV prevalence is higher in females than in men in all groups except for those 60 years and older. 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).

In 2012, HIV prevalence was higher among Black Africans (15.0%) than among coloureds (3.1%). With respect to locality, people residing in informal areas have the highest HIV prevalence (19.9%), followed by those living in rural informal areas (13.4%). 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.

*HIV incidence:* An estimated 270 000 people were newly infected in South Africa in 2016, continuing a slow but 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. Young women (ages 15-24) have the highest HIV incidence any age or sex cohort (2.01% in 2015). New HIV infections among infants has markedly declined, from 70 000 in 2003 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; for every child initiated on antiretroviral therapy, there are approximately 1.4 children newly infected with HIV.

*HIV mortality:* An estimated 150 3759 South Africans died of AIDS-related causes in 2016, representing 27.9% of all deaths. This compares to 225 901 (37.6%) of AIDS deaths in 2011. Peak mortality associated with AIDS occurred in South Africa 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 2,000 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 ranges from 48-72%, compared to 14.4% among adult women overall. HIV prevalence is 28% among the estimated 1.2 million men who have sex with men (MSM); 14% among the estimated 67 000 people who inject drugs (PWID); 23% among inmates; and 17% among people with disabilities.

## State of the epidemic: TB

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

*Link with HIV:* People living with HIV accounted for 63% of incident TB cases in 2015. However, there is considerable TB transmission in South Africa that is unrelated to HIV, driven by poverty, medical conditions such as 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.

*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 of more rigorous case finding using GeneXpert diagnostic technology. MDR-TB accounts for 1.8% of new TB cases and 6.7% of retreatment cases.

*TB mortality:* In 2016, 73 000 TB-related deaths occurred. TB is the leading cause of death in South Africa, representing 8.4% of all deaths in 2014. TB mortality is slowly declining, although at a rate that is too slow. 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. 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 among young people, TB is a more prominent cause of death among young females (16.8%) than among young males (11.8%).

*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. TB cases are higher among children under age 5 than among children ages 5-14. TB burden is elevated among people with increased TB exposure due to where they live or work, to those with limited access to TB services, and to people at greater TB risk as a result of biological or behavioural factors that compromise immune function. High-risk groups for TB include inmates (2.1% prevalence), gold mine workers (3 000-7 000 per 100 000) and diabetics (2 760 per 100 000). 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. Among provinces, KwaZulu-Natal has the highest number of TB cases and the Northern Cape the lowest. Eight cities account for 40% of all TB cases in South Africa.

## 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 proportion of people ages 15-49 who have been treated for an STI has slowly declined, falling from 34% in 2012/13 to 31% in 2014, although this does not necessarily mean that actual STI incidence has declined as well. The prevalence of syphilis among antenatal patients fell from 11.2% in 1997 to 1.6% in 2011. Prevalence of HSV-2 among antenatal patients in Gauteng, KwaZulu-Natal, Northern Cape and Western Cape was 55.8% in 2012.

*Variations in STI burden:* STI prevalence is especially high among young women: 17-42% for chlamydia, 71% for HPV, 6.2% for syphilis, 10.9% for gonorrhoea and 42-47% for bacterial vaginosis. More than one third of MSM report STI symptoms. Syphilis prevalence among sex workers was found to be 19.6% in Cape Town and 16.2% in Johannesburg. With respect to syphilis prevalence among antenatal women, prevalence in 2011 was highest in Mpumalanga (4.1%) and lowest in KwaZulu-Natal (0.4%). Among antenatal women nationally, HSV-2 prevalence increases with age, with highest prevalence among women aged 45-49.

*Link with HIV:* STI control represents an important public health priority in its own right, but also because it is so closely linked to HIV, as untreated STIs substantially increase the risk of HIV transmission and acquisition.

## 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 number of new HIV infections among people aged 15-49 fell from 410 000 in 2011 to 270 000 in 2016, a 34% decline. Prevention efforts in 2012-2016 were bolstered by 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 sites, and massive distribution of male and female condoms.
- *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 target of reducing the transmission rate to below 2%. The 18-month transmission rate of 4.3% in 2016 also exceeded the NSP target of below 5%. However, critical gaps remain in diagnosing children, especially older children, and linking children living with HIV with treatment services.
- [Placeholder from DBE (OVC) and DBE/DOH (ISHP)]
- *Expanding access to testing and treatment services:* 10 million people were voluntarily tested for HIV in 2016. South Africa has the largest antiretroviral treatment programme in the world, with 3.7 million people receiving HIV treatment in 2016. South Africa has formally adopted a test-and-treat approach to antiretroviral therapy.

- *Bolstering TB diagnosis and treatment:* South Africa rolled out the Gene Expert technology to permit quicker diagnosis of TB. The TB treatment success rate improved from 78% in 2014 to 83% in 2016. 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.
- *Increasing life expectancy:* Due in large measure to improvements in HIV and TB treatment outcomes, life expectancy in South Africa continues to recover, increasing from 58.3 years in 2011 to 62.4 years in 2016.
- *A commitment to human rights:* In 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 its launch of its National Sex Worker HIV Plan.
- *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. Donor support has also played an important role in strengthening the response to the HIV and TB epidemics in particular.

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 2017-2022 has been strategically formulated to build on these gains, taking into account lessons learnt, but also to address the gaps and bottlenecks that slow progress. Towards the vision of a South Africa free of the burden of HIV, TB and STIs, the NSP prioritises further increasing service coverage (both in facilities and in the community), better service integration, decentralisation, accountability and ownership of the national response to these diseases. The NSP also aims to empower people, address social and structural drivers and galvanize innovative financing strategies to ensure that this ambitious national framework is fully funded and effectively implemented.



## Strategic approach in 2017-2022: Focus for impact

The five goals of the NSP, described in subsequent chapters, aim to build on lessons learnt and achievements to date, to close gaps that persist in the national response, and build a strong foundation to end the HIV, TB and STIs epidemics. To implement these five 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.

### 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.

- *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 of the substantial geographic variation in disease burden, the NSP calls for particularly intensified action in the 27 districts that account for 82% of all people living with HIV and in 16 municipalities with high TB burden. . In each of these high-burden areas: 1) ambitious coverage targets will be used; 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.
- *Population:* In each of these high-burden districts and cities, programmatic efforts will be 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 girls and young women is driving HIV across the country, every province, district and locality must take steps to intensify efforts to reduce new HIV infections and increase service access for girls and young women. Guided by local data and circumstances, responses should prioritise key populations (sex workers, MSM, transgender people, people who inject drugs (PWID), people living with HIV, miners and migrants) and vulnerable populations (girls and young women (ages 15-24), orphans and other vulnerable children, people with disabilities, other vulnerable LGBTI communities, people living in informal settlements, pregnant women, diabetics, health care workers).
- *Interventions:* Enhanced strategic focus is also needed on the combination of interventions that are prioritised for scale-up. More strategic efforts will be required to implement the right mix of high-value, high-impact interventions that will maximise the number of new infections and deaths averted.



## 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 should use data, including geospatial mapping, to strategically focus and intensify responses in high-burden districts and cities. Within these high-burden districts and cities, spatial mapping data should be used to identify “hotspots” where interventions are most needed. In each of the high-burden districts, profiling of communities must be undertaken to develop a more granular understanding of the local contextual drivers of the epidemics, the individual and community resources and strengths, and the location of available and needed key services for future planning.
- *Scale up high-impact interventions:* Focused efforts in high-burden districts and cities 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 should 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 are needed to ensure that responses at all levels are fully multi-sectoral in order to address the social and structural factor that increase vulnerability and block service uptake.
- *Monitor for results:* From the individual service site to the district, provincial and national level, improved data, including unique health identifiers and strengthened monitoring and evaluation, should be used to track outcomes and improve performance over time. This strategic data, which should take into account government departments, the private sector, civil society and development partners, 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 are developing Provincial Implementation Plans that describe in detail how to implement the NSP across the country. These Provincial Implementation Plans will focus for impact by tailoring this Strategic Approach to the specific epidemiological patterns, needs and challenges in specific provinces and districts and municipalities. While taking account of comprehensive core 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 districts and cities. Building off the Provincial Implementation Plan, high-burden districts and cities should use a broadly inclusive, participatory approach to the development of local targets to guide the intensification of efforts.

“Focus for Impact” is a fundamentally new “way of doing business” as South Africa works to achieve a decisive transition from disease control to 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.

### 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. Similarly, the 15% decline in TB incidence from 2011/12 to 2016 fell short of the 50% reduction target. The number of new HIV, TB and STI infections remains unacceptably high – 270 000 new HIV infections in 2016, more than 450 000 new TB cases in 2015, and 1.4 million STIs treated annually in health facilities.

Sharply reducing the number of new HIV infections will only be possible if the transmission-reducing effects of antiretroviral therapy are combined with an equally robust reduction in risks of HIV acquisition. While the share of HIV spending focused on prevention has increased (reaching 19%), an increased emphasis on prevention 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 in these groups are driving the HIV epidemic nationally and in many localities across the country.

### Strategic approach: Breaking the cycle of transmission

South Africa aims by 2022 to reduce the number of new HIV infections to under 100 000; achieve elimination of new HIV infections among children; reduce TB incidence by 30%; significantly reduce gonorrhoea, syphilis and chlamydia infection, including a 90% reduction in incidence of *T. Pallidum* and gonorrhoea; achieve the virtual elimination of congenital syphilis by reducing incidence to 50 or fewer cases per 100 000 live births; and maintain national coverage of HPV vaccination above 90% through the following steps:

- *Increase the priority placed on primary HIV prevention:* Recognizing 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, effectively targeting combination of evidence-based behavioural, biomedical and structural interventions.
- *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 in all provinces.
- *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 27 districts with high HIV burden, in the 16 focus districts for TB control and in settings and populations with elevated risk of STI acquisition, intensified efforts will be undertaken to achieve saturation coverage with enhanced targeting of prevention efforts and provision of strategic social support. Nationally, we aim to medically circumcise 2.5 million men; we will offer PrEP to 1.4 million people (including 200 000 young women ages 20-24, 500 000 adolescents of both sexes, 450 000

sex workers, 175 000 MSM and 60 000 people who inject drugs; we will roll out post-exposure TB management to at least 90% of 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; and we will effectively use STI partner notification strategies.

- *Renew momentum for sexual risk reduction:* Sexual risk reduction efforts appear to be faltering. According to household survey data, the percentage of young people who had their sexual debut prior to 15 has increased, the number of men reporting multiple sex partners rose, and reported condom use declined. To reverse these trends and restore momentum for sexual risk reduction, new investments will be made in behavioural approaches, including providing comprehensive sexuality education in at least 50% in secondary schools, distributing 3 billion male condoms and 33 million female condoms in 2017-2022, and developing and disseminating information, education and communications on STI prevention.
- *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. Congenital syphilis also remains far from elimination. 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 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.
- *Achieve 90-90-90 through full implementation of Universal Test and Treat:* 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. 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 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. (See Goal 2, Chapter 5.)
- *Rigorously monitor prevention programmes and outcomes:* 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. Although progress has been made in developing a more granular understanding of HIV epidemic dynamics (including the spatial distribution of new infections, the dynamics of sexual networks and the size of key and vulnerable populations), further strengthening of surveillance systems is needed to obtain the level of detail required for “focus for impact” programmatic targeting, design and monitoring. Particular efforts are needed to strengthen STI surveillance, including steps to ensure that data is disaggregated by sex, geographic area and population. At all levels, but especially at the district level, performance and outcome data will be used to improve and adapt programmes on an on-going basis.

- *Build leadership and accountability for HIV and TB prevention:* Strategic selection of HIV and TB prevention champions – including but not limited to political leaders, opinion makers and influential members of priority populations – will be prioritized, especially at the district level.

[INSERT PREVENTION INDICATORS]

DRAFT

Table I Goal 1.0 Prevention Goals, Objectives, Sub-objectives and activities

GOAL 1.0 Accelerate prevention to reduce new HIV, TB, and STI infections					
	Objective 1.1 Reduce new HIV infections to less than 100,000 per year by 2022 through combination prevention interventions				
	Core Interventions	Routine approach	Intensified approach	National Target	Accountable parties
Sub-objective 1.1A  Revitalize Information Education Communication (IEC) programmes in school, health, workplace and community settings	-Comprehensive sexuality education -Health empowerment: communication, health literacy, health rights and responsibilities, guarantee of confidentiality, -Economic empowerment: -Gender norms and equality, including GBV prevention, care and support -Justice for persons facing stigma, discrimination, legal injustices, and access to legal support -Principles of universal design and reasonable accommodation in to enable access of persons with disabilities	-Provide IEC materials and messages through interpersonal communication, printed materials, mass media	-Target IEC approaches by risk profile -Strategically implement IEC campaigns to support health and social service campaigns	[PLACEHOLDER]	-DOH -DBE -DSD -CBOs -NGOs -Private healthcare providers -Private schools -Health insurance schemes

	Core Interventions	Routine approach	Intensified approach	National Target	Accountable parties
<b>Sub-objective 1.1B</b>  Provide sensitive and age-appropriate sexual and reproductive health services (SRH) and comprehensive sexuality education (CSE)	<i>Core CSE components:</i> -Sexuality, puberty education -Gender and empowerment -GBV -Reproduction, contraception -HIV & STIs -Referral to SRH -Condoms and lubricant  <i>Core SRH components:</i> -SRH counselling -PMTCT -Cervical cancer screening -Annual PAP smears -Access to emergency contraception -Choice of termination of pregnancy -Male & female condoms and lubricant -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 DBE staff are trained in the updated content and approach to SRH in schools	-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 90% of schools in 27 high burden districts	-DOH -DBE -DSD -CBOs -NGOs -Private healthcare providers -Private schools -Health insurance schemes

	Core Interventions	Routine approach	Intensified approach	National Target	Accountable parties
Sub-objective 1.1C  Implement targeted combination prevention* services tailored to setting and population	-Comprehensive HIV testing services	- Routine PITC in all health facilities -Provide outreach VCT in HTAs -Ensure access to self-screening	-Focussed PITC for AGYW and partners -Focussed outreach VCT for KP and -Youth-friendly SRH in schools, community settings -Promote self-screening	-Provide HIV testing services (HTS) to 18,000,00 people annually to ensure 90% of PLHIV know their status by 2022	-DOH -DBE -DCS -DSD -CBOs -NGOs -Retail pharmacies -Private employers -Private healthcare providers -Health insurance schemes
	-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	-Focussed 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	
	-Condoms	-Provide condoms and condom programmes in all public and private health facilities, in secondary schools, tertiary institutions, community settings	-Ensure constant condom supply in high transmission areas, including alcohol outlets, truck stops, brothels	-Distribute 3 billion male and 33 million female condoms by 2022	
	<b>Best Practices to Adopt:</b>  - At every service delivery opportunity, providers must encourage uptake of all 3 services (HTS, MMC, condoms) among sexually active clients, 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 1.1D  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 Provide PREP to SW -Pilot PREP in key population groups (high risk MSM, AGYW, 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	Provide PREP to 1,385,000 persons <ul style="list-style-type: none"> <li>• 200,000 women aged 20-24 years</li> <li>• 500 000 adolescents</li> <li>• 450 000 female sex workers</li> <li>• 175,000 MSM</li> <li>• 60,000 PWID</li> </ul>	-DOH -DBE -DCS -DSD -CBOs -NGOs -Retail pharmacies -Private employers -Private healthcare providers -Health insurance schemes
Sub-objective 1.1E  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 -Ensure access to MomConnect and other supportive programmes	-Accelerated implementation of last mile plans -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		-DOH -DSD -CBOs -NGOs -Private healthcare providers -Health insurance schemes



Objective 1.2: Significantly reduce gonorrhoea, syphilis, 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 1.2A  Scale up STI prevention for by providing high quality health information and timely health services for persons at risk	<ul style="list-style-type: none"> <li>-Comprehensive health information, STI education and health promotion programmes</li> <li>-Adequate STI screening and diagnostic services, including point-of-care technology</li> </ul>	<ul style="list-style-type: none"> <li>-Ensure STI components of SRH and CSE programmes are fully capacitated and accurate</li> <li>-Train and support health workers to provide comprehensive STI screening and diagnosis, including reverse testing algorithm</li> <li>-Provide periodic presumptive treatment (PPT) of gonorrhea, chlamydia, ulcerative cancrroid quarterly for sex workers</li> </ul>	<ul style="list-style-type: none"> <li>-Develop routine support to ensure healthcare workers include STI screening and diagnosis in all HIV testing and care settings</li> <li>-Conduct etiological and antimicrobial surveys (2017)</li> <li>-Train and support health workers in STI data capturing and data utilization (2017 – 2022)</li> </ul>	<ul style="list-style-type: none"> <li>-90% reduction of T. pallidum incidence</li> <li>-90% reduction of N gonorrhoeae incidence</li> <li>-50 or fewer cases of congenital syphilis per 100,000 live births</li> <li>-Sustain 90% national coverage and at least 80% in every district of HPV vaccination</li> </ul>	<ul style="list-style-type: none"> <li>-DOH</li> <li>-DBE</li> <li>-DCS</li> <li>-DSD</li> <li>-CBOs</li> <li>-NGOs</li> <li>-Private healthcare providers</li> <li>-Health insurance schemes</li> </ul>
Sub-objective 1.2B  Scale up and maintain high levels of HPV vaccination in XXX target age groups	<ul style="list-style-type: none"> <li>-Continue high coverage of HPV vaccination of targeted girls in public schools</li> <li>-Encourage HPV vaccination in private schools</li> </ul>	<ul style="list-style-type: none"> <li>-Implement Awareness raising for HPV vaccination</li> <li>-Strengthening curriculum in primary and high school on HPV</li> </ul>	[PLACEHOLDER]	[PLACEHOLDER]	<ul style="list-style-type: none"> <li>-DOH</li> <li>-DBE</li> <li>-DCS</li> <li>-DSD</li> <li>-CBOs</li> <li>-NGOs</li> <li>-Retail pharmacies</li> <li>-Private healthcare providers</li> <li>-Health insurance schemes</li> </ul>

Sub-objective 1.2C  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) )	-Introduce Provider-oriented partner notification ( 2017) -Explore other effective methods for partner notification through implementation research ( 2017/2018)	[PLACEHOLDER]	[PLACEHOLDER]	-DOH -DBE -DCS -CBOs -NGOs -Private healthcare providers -
<b>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.</b>					
	<b>Core Interventions</b>	<b>Routine approach</b>	<b>Intensified approach</b>	<b>National Target</b>	<b>Accountable parties</b>
Sub-objective 1.3A  Active TB case finding: Increase TB screening among adult clinic attendees, including PLHIV and persons presenting with TB symptoms	-Offer TB screening to all new and returning adult clinic attendees	-Conduct TB information sessions in the waiting areas - Offer TB screening to all newly diagnosed and stable HIV-positive persons - Train clinic staff on the TB screening and diagnostic algorithm -Train clinic staff on TB screening and sputum collection procedures -Refer all those self-presenting with TB symptoms for sputum collection; capture in the TB Suspect Register	-Train and monitor ward based outreach teams (WBOT) in household contact tracing -Develop and implement infection control guidelines for household and congregate settings	[PLACEHOLDER]	-DOH -DCS -CBOs -NGOs

	Core Interventions	Routine approach	Intensified approach	National Target	Accountable parties
Sub-objective 1.3B  Improve and implement active case finding through contact tracing of persons with undiagnosed TB*	Improve case finding among household contacts of TB clients, inmates, healthcare workers and persons in informal settlements	<u>Year 1: Pilot 2 processes to determine model for implementation</u> and compare the processes in 2 high-burden provinces <u>Year 2: Implementation of contact tracing</u> Define intervention with national SOPs and guidelines Staggered implementation across districts Implement monitoring and evaluation Policy for TB and HIV screening in HCWs must be finalized Evaluate processes to encouraging screening and tests needed to identify TB, evaluate the use of screening and treatment for LTBI	-Improve contact tracing in cells when TB case identified -Improve communication with district system for tracing back to homes  -Implement and monitor programmes for TB screening of HCW, miners, and residents of informal settlements, including with evaluation of TB yield efficiency  -Investigate cost-benefit of annual TB screening of HCW, and role of preventive therapy in HCW	Household/close contacts 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: <u>Year 1:</u> 1600 <u>Year 2:</u> 10 000 <u>Year 3:</u> 30 000 <u>Year 4:</u> 70 000 <u>Year 5:</u> 120 000  Residents screened per year: <u>Year 1:</u> 100 000 <u>Year 2:</u> 300 000 <u>Year 3:</u> 600 000 <u>Year 4:</u> 800 000 <u>Year 5:</u> 1 000 000	-DOH -DBE -DCS -DMR -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 1.3C  Improve case finding for neonatal and paediatric TB		<ul style="list-style-type: none"> <li>-Routinely screen all adults &amp; adolescents diagnosed with TB at all visits for infant and child contacts</li> <li>- Develop and pilot simplified screening algorithms in TB-exposed children</li> <li>-Enhance TB screening and testing among pregnant women to reduce congenital and perinatal TB transmission</li> <li>- Improve uptake of pediatric sputum induction at PHC and hospital level</li> </ul>	[PLACEHOLDER]	[PLACEHOLDER]	<ul style="list-style-type: none"> <li>-DOH</li> <li>-DBE</li> <li>-DSD</li> <li>-CBOs</li> <li>-NGOs</li> <li>-Private healthcare providers</li> <li>-Health insurance schemes</li> </ul>
Sub-objective 1.3D Increase national coverage of Xpert MTB/RIF as the first-line diagnostic tool for TB cases		<ul style="list-style-type: none"> <li>Train clinic staff on Xpert</li> <li>Train clinic staff on NHLS requisition procedures</li> </ul>	[PLACEHOLDER]	[PLACEHOLDER]	<ul style="list-style-type: none"> <li>-DOH</li> <li>-DCS</li> <li>-Private healthcare providers</li> <li>-Health insurance schemes</li> </ul>

Table II Goal 1.0 General population group-specific comprehensive services and interventions

Population	Services/Interventions/Approaches	Setting	Accountable parties
Children	<ul style="list-style-type: none"> <li>-Child abuse screening</li> <li>-Age-appropriate HIV testing, treatment, adherence-support</li> <li>-HIV testing upon household adult, adolescent, and/or child index client</li> <li>-TB screening</li> <li>-Contact tracing from adult, adolescent, and/or child cases</li> <li>-Sputum induction for TB testing</li> <li>-Update hospital admission requirements for DR-TB treatment</li> </ul>	<ul style="list-style-type: none"> <li>Clinic-based</li> <li>School-based</li> <li>Community-based</li> <li>Mobile services</li> </ul>	<ul style="list-style-type: none"> <li>DOH</li> <li>-DBE</li> <li>-DSD</li> <li>-CBOs</li> <li>-NGOs</li> <li>-Private employers</li> <li>-Private healthcare providers</li> <li>-Health insurance schemes</li> </ul>
Youth	<ul style="list-style-type: none"> <li>-Age-appropriate HIV testing, treatment, adherence-support</li> <li>-HIV testing upon household adult, adolescent, and/or child index client</li> <li>- Family, partner HIV testing, disclosure support, treatment, adherence support</li> <li>-TB screening</li> <li>-Contact tracing from adult, adolescent and/or child index TB cases</li> <li>-Alcohol and drug use screening</li> <li>-Violence screening, including GBV</li> <li>-Condom promotion, provision</li> <li>-Gender norms education</li> <li>-Health and health rights literacy</li> <li>-Economic empowerment</li> <li>-School retention</li> <li>- Accelerated nutritional and social grant support, if indicated</li> <li>-Targeted demand creation</li> <li>-Targeted, youth-friendly IEC materials and SBCC, including social media , including social media</li> <li>-Service delivery points in community, non-traditional settings</li> </ul>		

PLHIV (adults, adolescents)	<ul style="list-style-type: none"> <li>-TB screening, treatment, adult, adolescent, and/or child contact tracing</li> <li>-STI screening, treatment, adult, adolescent, and/or child contact tracing</li> <li>-Hearing and vision screening, referral, treatment</li> <li>-Partner HIV testing, disclosure support, treatment, adherence support</li> <li>-Hepatitis B and HPV vaccine where eligible</li> <li>-PMTCT and enhanced adherence support through pre and post-natal period, including breastfeeding</li> <li>-Mental health screening</li> <li>-Alcohol and drug use screening</li> <li>-Violence screening, including GBV</li> <li>-Condom promotion, provision</li> <li>-Gender norms education</li> <li>-Health and health rights literacy</li> <li>-Economic empowerment</li> <li>-School retention</li> <li>- Accelerated nutritional and social grant support, if indicated</li> <li>-Targeted demand creation</li> <li>-Targeted, PLHIV-friendly IEC materials and SBCC, including social media , including social media and materials for vision and hearing impairment</li> <li>-Service delivery points in community, non-traditional settings</li> </ul>	Clinic-based School-based Community-based Mobile services	<ul style="list-style-type: none"> <li>-DOH</li> <li>-DBE</li> <li>-DCS</li> <li>-DSD</li> <li>-CBOs</li> <li>-NGOs</li> <li>-Private employers</li> <li>-Private healthcare providers</li> <li>-Health insurance schemes</li> </ul>
Persons with TB (adults, adolescents)	<ul style="list-style-type: none"> <li>-TB adult, adolescent, and/or child contact tracing, testing, and post-exposure management</li> <li>-STI screening, treatment, contact tracing</li> <li>-HIV testing, disclosure support, treatment, adherence support</li> <li>-Partner HIV testing, disclosure support, treatment, adherence support</li> <li>-Enhanced health education in HIV/TB co-infection, reinfection</li> <li>-Hearing and vision screening, referral, treatment</li> <li>-Hepatitis B and HPV vaccine where eligible</li> <li>-PMTCT and enhanced adherence support through pre and post-natal period, including breastfeeding, if indicated</li> <li>-Mental health screening</li> <li>-Alcohol and drug use screening</li> </ul>	Clinic-based School-based Community-based Mobile services	<ul style="list-style-type: none"> <li>-DOH</li> <li>-DBE</li> <li>-DCS</li> <li>-DSD</li> <li>-CBOs</li> <li>-NGOs</li> <li>-Private employers</li> <li>-Private healthcare providers</li> <li>-Health insurance schemes</li> </ul>

	<ul style="list-style-type: none"><li>-Violence screening, including GBV</li><li>-Condom promotion, provision</li><li>-Gender norms education</li><li>-Health and health rights literacy</li><li>-Economic empowerment</li><li>-School retention</li><li>-Accelerated nutritional and social grant support, if indicated</li><li>-Targeted, TB-friendly IEC materials and SBCC, including social media , including social media and materials for vision and hearing impairment</li><li>-Service delivery and treatment delivery points in community, non-traditional settings</li></ul>		
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## Goal 2: Reduce morbidity and mortality by providing treatment, care and adherence support for all.

### Situation analysis

South Africa made substantial advances in the treatment of HIV, TB and STIs in 2012-2016, massively scaling up antiretroviral therapy, adopting Universal HIV Test & Treat in 2016, universally implementing the Xpert MTF/RIF for TB diagnosis, and developing focused TB initiatives for peri-mining communities, correctional facilities and people with drug-resistant TB. However, much more remains to be done. Substantial progress was made to increase the number of people on ART to 3.x million by the late 2016, reaching most people who met the CD4 500 eligibility criteria for starting ART at that time. Then, in September 2016, South Africa took the massive leap of instituting the “Universal Test and Treat” policy, removing CD4 count as an eligibility criterion, and enabling ART initiation for essentially anyone stable who tested HIV. Thus, the target for ART nearly doubled in late 2016. Particular barriers to ART uptake have been experienced by adolescents, children, adolescent girls and young women, and other key and vulnerable populations, a factor which will also need to be addressed under the new policy.

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 treatment or otherwise fail to adhere to prescribed regimens. Due in large part to these gaps, the reduction in HIV-related mortality of 33% from 2011/12 to 2016 was well below the 50% target in the NSP 2012-2016. 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.

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 in 2017-2022.\* 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 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

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\*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.

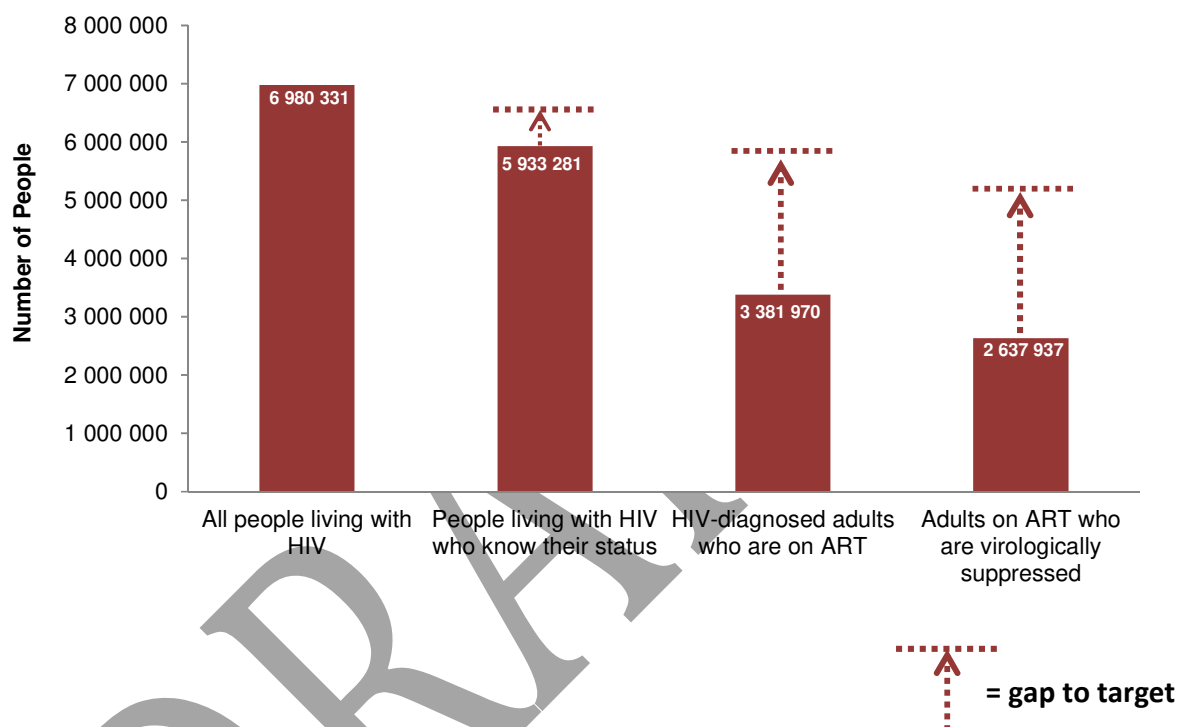
As set forth in the Global Plan to End TB 2016–2020, the 90-90-90 target for TB provides that:

- 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.



success rates. This NSP spans the period 2017-2022. Achieving 90-90-90 for HIV is a global target for 2020, with 95-95-95 the target for 2025. This means that by 2022 we should be beyond 90-90-90, which this plan recognises, but it rallies around the 90-90-90 focus so as not to add a confusing midway number into the Plan.

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



#### 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%. Reaching these goals will require attainment of 90-90-90 for HIV and TB; 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 in every district. 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 from 60% to 90%, consistent with the 90-90-90 approach:* Diverse outreach and service delivery strategies 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 accessible community locations and in homes. A new national HIV testing campaign will be launched to decentralise testing and expand testing delivered in and outside health facilities (e.g., workplaces, and in community settings); specific efforts will be made to

close testing gaps for men, younger people, key populations and other groups that are not currently accessing HIV testing at sufficient levels; self-screening will be rolled out and actively promoted; and a major push will be made to expand birth testing as well as the use of point-of-care early infant HIV diagnosis to increase testing among infants. Every person that is tested for HIV must also be screened for TB.

- *Increase TB case detection from 68% to 90%, consistent with the 90-90-90 approach:* The TB case detection is currently estimated at 68%, a particular concern as evidence indicates that most transmission (75-95%) occurs prior to diagnosis and initiation of therapy and are person-to-person. Efforts will be intensified with respect to targeted facility-level screening, household contact tracing and targeted case-finding. Every patient with TB must be tested for HIV. As well every patient with diabetes must be screened for TB.
- *Strengthen diagnosis of STIs:* Many STIs are asymptomatic and therefore difficult to diagnose. Due to diagnostic gaps, many STIs go undiagnosed. To increase STI diagnosis, mapping of key and vulnerable populations will be used to inform service targeting, existing programmes will be leveraged more strategically to identify asymptomatic patients, point-of-care testing will be expanded, and health workers will be trained to identify STIs in extra-genital sites.
- *Increase antiretroviral treatment coverage from 53% to 81%, consistent with the 90-90-90 approach:* Achieving the 90-90-90 target will demand that at least 81% of people living with HIV receive antiretroviral therapy. To achieve this target, South Africa will ensure full implementation of its Universal 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. 90% of all antiretroviral therapy patients will receive timely and accurate viral load testing as per clinical guidelines. To support this, the differentiated service delivery model for patient-centered care will be developed and implemented. Differentiated care will include the fast-tracking of health facility procedures and enable stable patients to use alternative options for providing care and drug dispensing within and outside of health facilities. The Central Chronic Disease Dispensing and Distribution Programme will be expanded, facilitating both access and improved efficiency to essential medicine.
- *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 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 municipalities by 2022. Treatment coverage for STIs, including partner notification, will also be intensified.
- *Ensure that 90% of all patients on antiretroviral therapy are virologically suppressed:* Viral load monitoring should be a routine component of HIV treatment for every person living with HIV. Studies indicate that currently between 52-75% of patients on antiretroviral therapy receive regular viral load tests. 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. 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 optimize their role in both facility and in communities and households.

- Improve cure rates for drug-resistant TB and STI:* In order for drug resistant TB cure rates to improve from 48% to at least 70%, South Africa will prioritise early detection and appropriate treatment and the rapid introduction of new drugs, e.g. delamanid, and regimes as they are approved. Increased emphasis will be placed on implementation of STI syndromic management and the reduction of treatment failures for STIs.
- Ensure that treatment services are of good quality and reduce loss to follow up:* There is need to improve the quality of services for in order to improve HIV, STI and TB treatment outcomes and reduce the risk of antimicrobial resistance. In addition to other dimensions of quality addressed in other sections, there will be need to reduce loss to follow-up and increase retention in care. Twelve months after initiating antiretroviral therapy, 27% of patients are no longer engaged in HIV treatment, with five-year loss to follow-up rising to almost half. Among drug-sensitive TB patients seen in primary health clinics, between 16% and 25% are reported lost to follow-up, with rates as high as 68% seen in one Johannesburg hospital. Prior to initiating TB treatment, rates of lost to follow-up as high as 63% have been reported. The NSP aims to increase retention in care through a combination of approaches, including community education and awareness initiatives, patient tracking systems, and routine patient education and counselling. Implementation of a pregnancy registry, including postnatal follow-up of infants, 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 cases
- Prevent and/or minimize the emergence of HIV, STI and TB drug resistance:* In addition to the general improvement in the quality of services, there is need to strengthen surveillance systems for monitoring emergence of antimicrobial resistance and taking appropriate action as early as possible. The NSP proposes the finalization and implementation of the HIV Drug Resistance strategy. Systems to strengthen Gonococcal antimicrobial resistance should also be put in place as there is already significant resistance to antibiotics in current use. HIV drug resistance surveillance should also be intensified, with the standardization of HIVDR testing practices and development of a national drug resistance database. TB resistance monitoring should also be intensified. Consideration should also be made for the development and implementation of a

national Antimicrobial Resistance Strategy that would address the emergence of resistance to HIV, STI, TB and other infections.

- *Provide holistic, patient-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 should have access to differentiated service delivery. Further, all persons should have access to psychosocial counselling and support, and, where indicated, mental health screening and treatment, and rehabilitation services for alcohol and substance use issues, including harm reduction services. 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 family 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-screening technologies, male- and adolescent-friendly clinic hours, community- or home-based initiation of antiretroviral therapy as resources permit, after-hours and Saturday services, 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 to guide service delivery at decentralised sites.

[INSERT TREATMENT INDICATORS]

Table III. Goal 2.0 Treatment Goals, Objectives, Sub-objectives and activities

Goal 2.0 Reduce morbidity and mortality by providing treatment, care and adherence support for all				
Objective 2.1	Implement the 90-90-90 Strategy for HIV			
	Interventions	Approaches	Populations	Lead agencies
Sub Objective 2.1.A: 90% of all people living with HIV know their HIV status (6.8 million people, including 195,000 children)	Scale up implementation of the single patient unique identifier, starting with NHLS facilities and gradually expanding to all health facilities as well other government departments and donor funded programmes.	<ul style="list-style-type: none"> <li>Phased implementation of the unique patient identifier</li> <li>Develop and disseminate guidelines and tools to ensure confidentiality and protection of patient data</li> </ul>	All populations	NDOH
	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.	<ul style="list-style-type: none"> <li>National new HIV testing campaign including decentralised testing and targets outside health facilities</li> <li>Provide HIV self-testing guidelines</li> <li>Evaluate and implement self-testing initiatives</li> <li>Community health worker guidelines on role in facilities, “opt-out” testing and linkage to care.</li> </ul>	All populations High burden districts	NDOH Private Sector Civil Society
	Expand coverage of early infant diagnosis	<ul style="list-style-type: none"> <li>Assess and expand use of new laboratory techniques for point-of-care in non-traditional settings</li> </ul>	Infants Pregnant and breastfeeding women	NDOH

Sub Objective 2.1.B: 90% of all people with diagnosed HIV infection receive sustained antiretroviral therapy (6.1 million people, including 175,000 children)	Develop and implement national guidance and tools on HIV Treatment for health providers and community health workers	<ul style="list-style-type: none"> <li>Update national HIV treatment and care guidelines and protocols for health providers</li> <li>Develop differentiated service delivery model for patient-centered care of individuals (adults, pregnant women, adolescents, children, key 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, etc)</li> <li>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.</li> <li>Updated treatment literacy materials.</li> </ul>	General population  Key populations  AGYW	NDOH
	Accelerate ART initiation and retention in care for all PLHIV in a way that ensures equity	<ul style="list-style-type: none"> <li>Fast-track implementation of national test and treat</li> <li>Provincial, district and facility targeting and reporting for critical indicators to track performance.</li> <li>Integration and linkages with other health areas to achieve equity to reach adolescents, young women, men, key populations.</li> </ul>	General population  Key populations  AGYW	NDOH  Private Sector

		<ul style="list-style-type: none"><li>▪ Capacitate health providers to deal with detectable viral load or a “lost patient” is an emergency.</li><li>▪ Improved tracking and reporting of all patients on treatment.</li></ul> Up to date national first and 2 <sup>nd</sup> line antiretroviral regimens based on the latest available evidence and harmonisation between different population groups.	Pregnant women	
	Implement a national pregnancy registry , starting in selected sentinel sites before expanding to other sites	<ul style="list-style-type: none"><li>▪ Selected sentinel registry sites.</li></ul> Expand to more sites across the country based on lessons learnt	Pregnant women  Infants	NDOH
	Implement strategies to prevent and minimize HIV drug resistance and use to inform national antiretroviral policies and guidelines.	<ul style="list-style-type: none"><li>▪ Implementing the national HIVDR strategy for programming and monitoring</li><li>▪ Integrating drug resistance surveillance into the overall ART programme to ensure sustainability</li><li>▪ Standardized HIVDR testing practices (clinical and laboratory)</li><li>▪ National Drug Resistance database for improved monitoring, evaluation and reporting</li><li>▪ Expanded laboratory capacity for HIVDR surveillance</li></ul> Capacity of health providers in HIVDR	General population  Key populations  Pregnant women  Children	NDOH  Private Sector  Academia
	Sub Objective 2.1.C: 90% of all people receiving antiretroviral therapy are virally	Accelerate ART initiation and retention in care for all PLHIV in a way that ensures equity	<ul style="list-style-type: none"><li>▪ Fast-track implementation of national test and treat</li><li>▪ Provincial, district and facility targeting and reporting for critical indicators to track performance.</li></ul>	General population  Key populations

suppressed (5.5 million people, including 158,000 children)		<ul style="list-style-type: none"> <li>Integration and linkages with other health areas to achieve equity to reach adolescents, young women, men, key populations.</li> <li>Capacitate health providers to deal with detectable viral load or a “lost patient” is an emergency.</li> <li>Improved tracking and reporting of all patients on treatment.</li> </ul> <p>Up to date national first and 2<sup>nd</sup> line antiretroviral regimens based on the latest available evidence and harmonisation between different population groups.</p>	AGYW  Pregnant women	
	Improve pharmacovigilance to enable increased timeous reporting of adverse events, detect trends and respond to them and provide support to health professionals to manage adverse events through an appropriately staffed help-line.		All People living with HIV	NDOH Private sector Civil society



Objective 2.2	Implement the 90-90-90 Strategy for TB			
	Interventions	Approaches	Populations	Lead agencies
Objective 2.2.A: Test 90% of all people with TB (408 600)	Upgrade laboratory diagnostic services (second line LPA)	<ul style="list-style-type: none"> <li>Ensure proficiency in laboratories selected for testing</li> <li>Develop laboratory costing and finalized tariff</li> <li>Load test method on LIS and standard comments</li> <li>Load consumables on Oracle and procure reagents for testing</li> <li>Procure reagents for testing</li> <li>Train initiation sites and labs receiving on-test requisition</li> <li>Review implementation every 6 months</li> </ul>	PLHIV	NDoH/ NICD CHAI
	Increased national coverage of Xpert MTB/RIF as the first-line diagnostic tool for TB cases	<ul style="list-style-type: none"> <li>Train clinic staff on Xpert</li> <li>Train clinic staff on NHLS requisition procedures</li> </ul>		NDoH PDoH Districts
Sub Objective 2.2.B: Treat at least 90% of those diagnosed with TB	Scale up appropriate Short Course treatments: Establish and appoint Steering Committee for introduction of the 9-month regimen	<ul style="list-style-type: none"> <li>Appoint relevant individuals, secretariat</li> <li>Schedule and organize quarterly meetings, teleconferences every 2 weeks (bi-monthly), ad hoc meetings as needed</li> </ul>		NDoH
	Revise the normative and regulatory documents	<ul style="list-style-type: none"> <li>Revise MDR-TB policy documents in South Africa</li> <li>Revise treatment guideline</li> <li>Link the new MDR guidelines to the EML process</li> </ul>		NDoH/RTC NHLS WHO FHI URC Aurum

		<ul style="list-style-type: none"> <li>Revise the diagnostic algorithms for second line testing</li> </ul>		Clinton Health Access Initiative Other partners
	Review supply chain management	<ul style="list-style-type: none"> <li>Meet with key stakeholders from AMD (including EML), NTP as required</li> <li>Review initial anticipated demand shifts and impact on current contract commitment</li> <li>Analyse provincial stock situation</li> <li>Determine the mechanism for clofazimine registration and supply</li> <li>Distribute stock to provincial depots</li> </ul>		NDoH Key stakeholders Provincial TB directorate
	Retrain staff and implement on-going clinical governance	<ul style="list-style-type: none"> <li>Convert new guidelines into training materials for all cadres of staff</li> <li>Conduct training per province and then re-enforce at a site level</li> <li>Conduct regular clinical audits including chart reviews to ensure adherence to guidelines</li> </ul>		NDoH Key stakeholders
	Provide enhancements to the EDR to accommodate a number of different regimen lengths	<ul style="list-style-type: none"> <li>Re-define how outcomes are measured, based on the treatment guidelines</li> <li>Change categorization and expand drugs to be entered</li> <li>Update date capture and clinical training to ensure adequate capture of outcome</li> </ul>		NDoH RIMES Wamtech

	Implement short course treatment of DR-TB	<ul style="list-style-type: none"> <li>▪ Implement real-time monitoring of appropriate patient selection for short-course via EDR</li> <li>▪ Actively monitor outcomes: death and loss to follow up</li> <li>▪ Implement measurement of culture conversion at 4 months</li> </ul>		NDoH
	Implement bedaquiline short course	<ul style="list-style-type: none"> <li>▪ Develop operational research protocol for the modified bedaquiline short course</li> <li>▪ Selection of initial sites for bedaquiline short course</li> <li>▪ Implement operational research protocol for the modified bedaquiline short course</li> </ul>		NDoH Partners
Sub Objective 2.2.C: Ensure a 90% treatment success rate for drug-sensitive (and at least a 65% treatment success rate for multi-drug resistant TB).	Reduce loss to follow-up rates established as management priority	<ul style="list-style-type: none"> <li>▪ Undertake district baseline assessments and set targets</li> <li>▪ Implement electronic system for routine monitoring / reporting on loss to follow-up at facilities</li> <li>▪ Implement quality improvement approach to reduce loss to follow-up</li> </ul>		NDoH PDoH Districts Support partners
	Reduce duration and number of visits from symptom onset to treatment initiation	Undertake community awareness campaigns on early health seeking for TB		NDoH NDoH NHLS PDoH Districts, Facilities, Partners

	Improve identification and recall of cases not returning for treatment	<ul style="list-style-type: none"> <li>Establish use of unique ID (national ID/HPRN)</li> <li>Implement interactive web-based system for action on positive DS-TB and DR-TB results</li> </ul>		NDoH - HIER Unit, NHLS PDoH Districts Facilities/ Facility managers
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<b>Objective 3.3: Improve STI detection, diagnosis and treatment</b>				
	<b>Interventions</b>	<b>Approaches</b>	<b>Populations</b>	<b>Lead Agencies</b>
Sub-objective 3.3.A: Increase detection and treatment of asymptomatic STIs by 50% in high burden districts	Update the STI guidelines to include specific approach for the management of asymptomatic infections..	<ul style="list-style-type: none"> <li>The starting point is to take a concise STI (sexual) history to assess the client's risk and so perform aetiological testing.</li> <li>This service should be integrated onto existing programmatic systems – MSM male friendly clinics, ART clinics, FSW programs, ANC clinics and FPC services and through pre-exposure prophylaxis (PrEP) programmes.</li> <li>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.</li> <li></li> </ul>		

<b>Objective 3.3: Improve STI detection, diagnosis and treatment</b>				
	<b>Interventions</b>	<b>Approaches</b>	<b>Populations</b>	<b>Lead Agencies</b>
Sub-objective 3.3.B: Increase the detection and treatment of STIs	Appropriate syndromic management of STI s and and further care of those who fail syndromic management	<ul style="list-style-type: none"> <li>Adapt and implement guidelines on STI and HIV screening, diagnosis and management guidelines based on national data and building on available services</li> <li>Develop and implement strategies to strengthen sexual partner management, including partner notification and contact tracing especially most at risk populations.</li> <li>STI treatment in all primary health care facilities</li> <li>Train and re-train HCWs on syndromic management</li> <li>Advanced STI care services in secondary level hospitals and CHCs</li> <li>Train HCWs on advanced STI care, referral and appropriate specimen collection</li> <li>Care for individuals with persistent and or complicated STI</li> </ul>		
	Eliminate congenital syphilis and neonatal conjunctivitis	<ul style="list-style-type: none"> <li>Screening all pregnant women for syphilis at first ANC visit</li> <li>Treating all syphilis positive women with three doses of Benzathine penicillin</li> </ul>		

<b>Objective 3.3: Improve STI detection, diagnosis and treatment</b>				
	<b>Interventions</b>	<b>Approaches</b>	<b>Populations</b>	<b>Lead Agencies</b>
		<ul style="list-style-type: none"> <li>Screening for syphilis at birth all infants born to Syphilis positive women or to women who were unbooked or untested</li> <li>Linking all children diagnosed with congenital syphilis to care and receive treatment</li> </ul>		
	Strengthen private – public partnership for STI management	<ul style="list-style-type: none"> <li>Mapping key private sector stakeholders in STI research</li> <li>Use framework for PPP in STI management</li> <li>SAQA accredited course on Genitourinary</li> <li>Partnership with NGOs and government to improve efficiency and quality of STI service delivery</li> <li>Capacity building of private practitioners in STI management</li> <li>Use service agreements and contracts with private service delivery organizations for STIs prevention, testing, treatment and management.</li> </ul>		
	Promote integration of STI prevention care and treatment into HIV, TB, ANC, sexual and reproductive health services	<ul style="list-style-type: none"> <li>HIV testing of all STI patients</li> <li>ART for all HIV positive STI clients</li> <li>Referral to MMC for all male STI clients</li> <li>Screening of all MMC clients for STIs</li> </ul>		

<b>Objective 3.3: Improve STI detection, diagnosis and treatment</b>				
	<b>Interventions</b>	<b>Approaches</b>	<b>Populations</b>	<b>Lead Agencies</b>
		<ul style="list-style-type: none"> <li>Family planning and cervical cancer screening for all eligible female STI clients</li> <li>STI screening and treatment of all symptomatic / asymptomatic pregnant women</li> </ul>		
	Collaborate with relevant organization to ensure delivery of targeted response and professional development (continuous education)	<ul style="list-style-type: none"> <li>Capacity building of health workers in STI management.</li> </ul>		
	Conduct operational research to strengthen the diagnosis, care and treatment of STIs	<ul style="list-style-type: none"> <li>Literature reviews of published and unpublished STI</li> <li>Operational research prioritisation</li> </ul>		

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

#### 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 often struggle to obtain appropriate prevention and treatment services, often due to stigma and discrimination. 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.

#### **Key populations**

People living with HIV  
Migrants  
Sex Workers  
Transgender people  
Men who have sex with men  
Inmates  
People who inject drugs  
LGBTI

#### **Vulnerable populations**

Adolescent girls and young women  
Orphans and vulnerable children  
People living in informal settlements  
Miners  
People with disabilities

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. With almost 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.

In recent years, South Africa has made important strides in addressing the health needs of key and vulnerable populations. Through the government's High Transmission Areas (HTA) programme, the number of service sites for key and vulnerable populations doubled from 2013/14 to 2014/15. In part as a result of the government's She Conquers campaign, the multi-partner DREAMS initiative, and contributions from the Global Fund to support risk mitigation in this group, HIV and vulnerability reduction approaches for adolescent girls and young women have been expanded. In 2016, South Africa launched an HIV strategy for sex workers and drafted the South African National LGBTI Framework for 2017-2022.

However, substantially stronger and more successful efforts will be needed to meet the HIV, TB and STI challenge for key and vulnerable populations. Among young people aged 15-24, HIV prevalence fell by only 10% from 2012 to 2016, well short of the targeted 50% reduction. HIV prevalence remains substantially elevated among female sex workers, MSM and other high-



burden populations. Likewise, TB continues to exact a disproportionately heavy burden on the populations most vulnerable to TB acquisition and disease progression.

### Strategic approach: Ensuring that nobody is left behind

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 develop reliable size estimations and additional mapping 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.
- *Build robust 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 weak and underdeveloped. 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. The lack of robust community capacity and the thorough 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. 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 identity 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 and local AIDS councils and other cross-cutting working and advocacy groups; and civil society and community networks will be encouraged to support and mobilize 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-sector 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 plans and strategies (e.g., National Sex Worker HIV Plan, National LGBTI HIV Framework, She Conquers, Roadmap to reducing HIV infection among PWID in South Africa, Framework and Strategy for Disability and Rehabilitation Services in South Africa).

- *Tailor health and ancillary 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 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.
- *Scale up tailored health services for key and vulnerable populations:* As the number of service sites for key and vulnerable populations has increased, the number of individuals reached by HIV, TB and STI services has risen as well. To close utilization gaps for key and vulnerable populations, materials and training packages will promote standardized 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. Scale-up will aim to ensure that at least 90% of all key and vulnerable populations have access by 2022 to a package of innovative, integrated, core 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.
- *Sensitise providers to address the needs of key and vulnerable populations.* Health and social service providers are often not able to 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.
- *Eliminate stigma, discrimination and punitive laws that burden key and vulnerable populations:* Key and vulnerable populations are often highly marginalized. As a result, they often lack access to needed 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.” The NSP calls for steps to decriminalise sex work. Under the NSP, steps are needed to implement evidence-based anti-stigma initiatives, including broad anti-stigma communications campaigns. In addition, stronger efforts are needed to monitor service utilization patterns and to identify and rectify inequities or bottlenecks as they occur; greater attention to implementation, for example, could help service access for migrants, who are legally entitled to services under law but may experience stigma, diminished access or other forms of discrimination in service settings.

[INSERT INDICATORS FOR KEY AND VULNERABLE POPULATIONS]

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Table IV. Goal 3.0 Key and vulnerable population-specific comprehensive services and interventions

Population	Services/Interventions/Approaches	Setting	Accountable parties
AGYW	<ul style="list-style-type: none"> <li>-Youth-friendly SRH including HPV vaccines, contraception, emergency contraception, safe termination of pregnancy</li> <li>-Comprehensive sexuality education in school and non-school, youth-friendly settings</li> <li>-STI screening, treatment, contact tracing</li> <li>-TB screening, treatment, contact tracing</li> <li>-HIV testing, treatment, adherence support</li> <li>-Mental health screening</li> <li>-Alcohol and drug use screening</li> <li>-Violence screening, including GBV</li> <li>-Condom promotion, provision</li> <li>-Gender norms education, including risk reduction in relation to age-disparate relationships</li> <li>-Health and health rights literacy</li> <li>-Economic empowerment</li> <li>-School retention</li> <li>-Access to PEP and sexual assault support</li> <li>-Targeted demand creation</li> <li>-Targeted, youth-friendly IEC materials and SBCC, including social media and materials for vision and hearing impairment</li> <li>-Service delivery points in community, non-traditional settings</li> </ul>	School-based Community-based Clinic-based	<ul style="list-style-type: none"> <li>-DOH</li> <li>-DBE</li> <li>-DCS</li> <li>-DSD</li> <li>-CBOs</li> <li>-NGOs</li> <li>-Retail pharmacies</li> <li>-Private employers</li> <li>-Private healthcare providers</li> <li>-Health insurance schemes</li> </ul>

Sex Workers	<ul style="list-style-type: none"> <li>-Facilitated access to community HIV, STI, TB service provision</li> <li>-Access to non-discriminatory, rights-based service delivery</li> <li>-Specialised health education regarding risk and vulnerability to HIV, STI, TB,</li> <li>-Utilisation of informal networks to raise awareness about services</li> <li>-SW-friendly SRH including HPV vaccines, contraception, emergency contraception, safe termination of pregnancy</li> <li>-Peer-led service delivery</li> <li>-STI screening, treatment, contact tracing</li> <li>-TB screening, treatment, contact tracing</li> <li>-HIV testing, treatment, adherence support</li> <li>-Hepatitis A and B screening, vaccination</li> <li>-Intensified psychosocial support</li> <li>-Mental health screening</li> <li>-Alcohol and drug use screening</li> <li>-Violence screening, including GBV</li> <li>-Condom &amp; lubricant promotion, provision</li> <li>-Gender norms education, including risk reduction in relation to age-disparate relationships</li> <li>-Health and health rights literacy</li> <li>-Economic empowerment</li> <li>-Access to PEP and sexual assault support</li> <li>-Targeted demand creation</li> <li>-Targeted, SW-friendly IEC materials and SBCC, including social media</li> <li>-Service delivery points in community, non-traditional settings</li> </ul>	Community-based Clinic-based	<ul style="list-style-type: none"> <li>-DOH</li> <li>-SAPS</li> <li>-DSD</li> <li>-CBOs</li> <li>-NGOs</li> </ul>
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MSM	<ul style="list-style-type: none"> <li>-Facilitated access to community HIV, STI, TB service provision</li> <li>-Access to non-discriminatory, rights-based service delivery</li> <li>-Specialised health education regarding risk and vulnerability to HIV, STI, TB,</li> <li>-Utilisation of informal networks to raise awareness about services</li> <li>-Peer-led service delivery</li> <li>-TB screening, treatment, contact tracing</li> <li>-HIV testing, treatment, adherence support</li> <li>-MSM-specific STI screening, treatment</li> <li>-Hepatitis A and B screening, vaccination</li> <li>-Alcohol and drug use screening</li> <li>-Condom &amp; lubricant promotion, provision</li> <li>-Health and health rights literacy</li> <li>-Legal resources</li> <li>-Stigma reduction</li> <li>-Targeted demand creation</li> <li>-Targeted, MSM-friendly IEC materials and SBCC, including social media</li> <li>-Service delivery points in community, non-traditional settings</li> </ul>	Community-based Clinic-based Mobile services	<ul style="list-style-type: none"> <li>-DOH</li> <li>-DCS</li> <li>-DSD</li> <li>-CBOs</li> <li>-NGOs</li> <li>-Private employers</li> <li>-Private healthcare providers</li> <li>-Health insurance schemes</li> </ul>
Inmates	<ul style="list-style-type: none"> <li>-Peer-led service delivery when possible</li> <li>-STI screening, treatment, contact tracing</li> <li>-TB screening, treatment, contact tracing</li> <li>-HIV testing, treatment, adherence support</li> <li>-Alcohol and drug use screening</li> <li>-Condom &amp; lubricant promotion, provision</li> <li>-WSW, MSM-specific STI screening, treatment</li> <li>-Legal resources</li> <li>-Cell and home contact tracing for persons diagnosed or exposed to TB, upon incarceration and upon release</li> <li>-Targeted, inmate-friendly IEC materials and SBCC, including social media and materials for vision and hearing impairment</li> </ul>	DCS clinic-based Community-based upon release	<ul style="list-style-type: none"> <li>-DOH</li> <li>-DCS</li> <li>-DSD</li> <li>-CBOs</li> <li>-NGOs</li> </ul>

PWID	<ul style="list-style-type: none"> <li>-Facilitated access to community HIV, STI, TB service provision</li> <li>-Access to non-discriminatory, rights-based service delivery</li> <li>-Specialised health education regarding risk and vulnerability to HIV, STI, TB</li> <li>-Utilisation of informal networks to raise awareness about services</li> <li>-Peer-led service delivery</li> <li>-Harm reduction counseling, health education regarding transmission risks through needle sharing and risky sexual behaviour, transactional sex</li> <li>-Linkage to drug abuse rehabilitation services</li> <li>-TB contact tracing, testing, and post-exposure management</li> <li>-STI screening, treatment, contact tracing</li> <li>-HIV testing, disclosure support, treatment, adherence support</li> <li>-Partner HIV testing, disclosure support, treatment, adherence support</li> <li>-Enhanced health education in HIV/TB co-infection, reinfection</li> <li>-Hepatitis A and B screening, vaccination</li> <li>-PMTCT and enhanced adherence support through pre and post-natal period, including breastfeeding, if indicated</li> <li>-Mental health screening</li> <li>-Alcohol screening</li> <li>-Violence screening, including GBV</li> <li>-Condom promotion, provision</li> <li>-Gender norms education</li> <li>-Health and health rights literacy</li> <li>-Economic empowerment</li> <li>-Accelerated nutritional and social grant support, if indicated</li> <li>-Targeted, PWID-friendly IEC materials and SBCC, including social media</li> <li>-Service delivery and treatment delivery points in community, non-traditional settings</li> </ul>	Community-based Clinic-based	<ul style="list-style-type: none"> <li>-DOH</li> <li>-DCS</li> <li>-DSD</li> <li>-CBOs</li> <li>-NGOs</li> </ul>
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Transgender	<ul style="list-style-type: none"> <li>-Facilitated access to community HIV, STI, TB service provision</li> <li>-Access to non-discriminatory, rights-based service delivery</li> <li>-Specialised health education regarding risk and vulnerability to HIV, STI, TB,</li> <li>-Utilisation of informal networks to raise awareness about services</li> <li>-Peer-led service delivery</li> <li>-STI screening, treatment, contact tracing</li> <li>-TB screening, treatment, contact tracing</li> <li>-HIV testing, treatment, adherence support</li> <li>-Hepatitis A and B screening, vaccination</li> <li>-TG-specific STI screening, treatment</li> <li>-Alcohol and drug use screening</li> <li>-Condom &amp; lubricant promotion, provision</li> <li>-Health and health rights literacy</li> <li>-Legal resources</li> <li>-Stigma reduction</li> <li>-Access to PEP</li> <li>-Targeted demand creation</li> <li>-Targeted, TG-friendly IEC materials and SBCC, including social media</li> <li>-Service delivery points in community, non-traditional settings</li> </ul>	School-based Community-based Clinic-based	<ul style="list-style-type: none"> <li>-DOH</li> <li>-DBE</li> <li>-DSD</li> <li>-CBOs</li> <li>-NGOs</li> <li>-Retail pharmacies</li> <li>-Private employers</li> <li>-Private healthcare providers</li> <li>-Health insurance schemes</li> </ul>
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OVC	<ul style="list-style-type: none"> <li>-Health education regarding risk and vulnerability to HIV, STI, TB, particularly regarding sexual exploitation in the absence of primary caregivers</li> <li>-Accelerated nutritional and social grant support</li> <li>-Youth-friendly SRH including HPV vaccines, contraception, emergency contraception, safe termination of pregnancy</li> <li>-Comprehensive sexuality education in residential, school and non-school, youth-friendly settings</li> <li>-STI screening, treatment, contact tracing</li> <li>-TB screening, treatment, contact tracing</li> <li>-HIV testing, treatment, adherence support</li> <li>-Intensive psychosocial support</li> <li>-Mental health screening</li> <li>-Alcohol screening</li> <li>-Violence screening, including GBV</li> <li>-Condom promotion, provision</li> <li>-Gender norms education, including risk reduction in relation to age-disparate relationships</li> <li>-Health and health rights literacy</li> <li>-Economic empowerment</li> <li>-School retention</li> <li>-Access to PEP and sexual assault support</li> <li>-Targeted, youth-friendly IEC materials and SBCC, including social media and materials for vision and hearing impairment</li> <li>-Service delivery points in community, non-traditional settings</li> </ul>	School-based Community-based Clinic-based	<ul style="list-style-type: none"> <li>-DOH</li> <li>-DBE</li> <li>-DSD</li> <li>-CBOs</li> <li>-NGOs</li> </ul>
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Miners	<ul style="list-style-type: none"> <li>-Access to culturally competent, non-discriminatory, rights-based service delivery in workplace and community settings</li> <li>-Specialised health education regarding risk and vulnerability to HIV &amp; STI, particularly regarding sexual risk behaviour</li> <li>--Specialised health education regarding risk and vulnerability to TB, particularly regarding close contact living and working conditions</li> <li>-Utilisation of informal networks to raise awareness about services</li> <li>-Utilisation of formal workplace, labour networks to raise awareness about services</li> <li>-STI screening, treatment, with sexual partner contact tracing</li> <li>-TB screening, treatment, with intensified contact tracing for workplace lodging, work contacts, home lodging; inclusive of child, adolescent, adult contacts</li> <li>-HIV testing, treatment, adherence support; including workplace treatment services</li> <li>-Intensified psychosocial support</li> <li>-Violence screening, including GBV</li> <li>-Condom promotion, provision</li> <li>-Health and health rights literacy</li> <li>-Economic empowerment</li> <li>-Access to PEP and sexual assault support</li> <li>-Targeted, migrant-friendly IEC materials and SBCC, including social media and translations into common non-South African languages</li> <li>-Service delivery points in community, non-traditional settings</li> </ul>		
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Persons with disabilities	<ul style="list-style-type: none"> <li>-Peer-led service delivery when possible</li> <li>-Accessible prevention, care, treatment services that accommodate persons with physical, visual, hearing impairment</li> <li>-Specialised health education regarding risk and vulnerability to HIV, STI, TB, particularly regarding sexual exploitation</li> <li>-STI screening, treatment, contact tracing</li> <li>-TB screening, treatment, contact tracing</li> <li>-HIV testing, treatment, adherence support</li> <li>-Accelerated nutritional and social grant support</li> <li>-Comprehensive sexuality education in disability-friendly settings</li> <li>-Intensive psychosocial support</li> <li>-Mental health screening</li> <li>-Alcohol screening</li> <li>-Violence screening, including GBV</li> <li>-Condom promotion, provision</li> <li>-Health and health rights literacy</li> <li>-Economic empowerment</li> <li>-Access to PEP and sexual assault support</li> <li>-Targeted, disability-friendly IEC materials and SBCC, including social media and materials for vision and hearing impairment</li> <li>-Service delivery points in community, non-traditional settings</li> </ul>	School-based Community-based Clinic-based	<ul style="list-style-type: none"> <li>-DOH</li> <li>-DBE</li> <li>-DSD</li> <li>-CBOs</li> <li>-NGOs</li> <li>-Retail pharmacies</li> <li>-Private employers</li> <li>-Private healthcare providers</li> <li>-Health insurance schemes</li> </ul>
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Migrants	<ul style="list-style-type: none"> <li>-Access to culturally competent, non-discriminatory, rights-based service delivery</li> <li>-Specialised health education regarding risk and vulnerability to HIV, STI, TB, particularly regarding sexual exploitation</li> <li>-Utilisation of informal networks to raise awareness about services</li> <li>-STI screening, treatment, contact tracing</li> <li>-TB screening, treatment, contact tracing</li> <li>-HIV testing, treatment, adherence support</li> <li>-Intensified psychosocial support</li> <li>-Violence screening, including GBV</li> <li>-Condom promotion, provision</li> <li>-Health and health rights literacy</li> <li>-Economic empowerment</li> <li>-Access to PEP and sexual assault support</li> <li>-Targeted, migrant-friendly IEC materials and SBCC, including social media and translations into common non-South African languages</li> <li>-Service delivery points in community, non-traditional settings</li> </ul>	School-based Community-based Clinic-based	<ul style="list-style-type: none"> <li>-DOH</li> <li>-DBE</li> <li>-DSD</li> <li>-CBOs</li> <li>-NGOs</li> <li>-Retail pharmacies</li> <li>-Private employers</li> <li>-Private healthcare providers</li> <li>-Health insurance schemes</li> </ul>
Mobile populations	<ul style="list-style-type: none"> <li>-Facilitated access to community HIV, STI, TB service provision, assurance of service delivery on weekends, evenings</li> <li>-Access to non-discriminatory, rights-based service delivery</li> <li>-Specialised health education regarding risk and vulnerability to HIV, STI, TB,</li> <li>-Utilisation of informal networks to raise awareness about services</li> <li>-STI screening, treatment, contact tracing</li> <li>-TB screening, treatment, contact tracing</li> <li>-HIV testing, treatment, adherence support</li> <li>-Intensified psychosocial support</li> <li>-Violence screening, including GBV</li> <li>-Condom promotion, provision</li> <li>-Health and health rights literacy</li> <li>-Access to PEP and sexual assault support</li> <li>-Targeted, IEC materials and SBCC, including social media</li> <li>-Service delivery points in community, non-traditional settings</li> </ul>	Community-based Clinic-based	<ul style="list-style-type: none"> <li>-DOH</li> <li>-DSD</li> <li>-CBOs</li> <li>-NGOs</li> <li>-Retail pharmacies</li> <li>-Private employers</li> <li>-Private healthcare providers</li> <li>-Health insurance schemes</li> </ul>

Persons living in informal settlements	<ul style="list-style-type: none"> <li>-Facilitated access to community HIV, STI, TB service provision</li> <li>-Access to non-discriminatory, rights-based service delivery</li> <li>-Specialised health education regarding risk and vulnerability to HIV, STI, TB,</li> <li>-Utilisation of informal networks to raise awareness about services</li> <li>-STI screening, treatment, contact tracing</li> <li>-TB screening, treatment, intensified contact tracing</li> <li>-HIV testing, treatment, adherence support</li> <li>-Intensified psychosocial support</li> <li>-Violence screening, including GBV</li> <li>-Condom promotion, provision</li> <li>-Health and health rights literacy</li> <li>-Access to PEP and sexual assault support</li> <li>-Targeted, IEC materials and SBCC, including social media</li> <li>-Service delivery points in community, non-traditional settings</li> </ul>	School-based Community-based Clinic-based	<ul style="list-style-type: none"> <li>-DOH</li> <li>-DBE</li> <li>-DSD</li> <li>-CBOs</li> <li>-NGOs</li> </ul>
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## **Goal 4: Address the social and structural drivers of HIV, TB and STIs, including human rights, and link these efforts to the NDP deliverables**

### **Context**

The social and physical context in which the epidemics of HIV, TB and STIs are happening is continually evolving. As highlighted in the NDP, we currently confront the linked challenges of poverty, inequality and unemployment. 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.

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, inadequate access to education, poor nutrition, migration, gender inequality and gender-based violence, and alcohol and substance use and abuse increase vulnerability to HIV, TB and STIs; deter individuals from seeking needed services; and interfere with the ability of individuals receiving services and to adhere to prescribed regimens. The physical environment – including access to safe water and sanitation; the availability of safe and secure housing; the concentration of housing; conditions within the home; the 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 essential health services. This has been confirmed by our Know Your Epidemic exercise in 2011, which found that those most vulnerable to HIV or 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. These economic and social factors are at the heart of the extreme vulnerability to HIV, TB and STI's confronted by adolescent girls and young women.

An effective, sustainable response to HIV, TB and STIs requires concerted efforts to address the social and structural elements that fuel these epidemics. Unless these factors are addressed in the context of disease control, public health goals 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. Only a well-coordinated multi-sectoral response can effectively address the social and structural factors that increase vulnerability.

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. 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. However, the coverage of these programmes still needs to be expanded.

However, much more work is needed to address the social and structural factors that increase risk and vulnerability. Effective programmes are needed to reduce poverty, inequity, unemployment, gender inequality and gender-based violence and alcohol and drug abuse. Actions are needed 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.

In this NSP, the aim is to focus on specific interventions and then ensure expansion for key and vulnerable populations and in priority districts.

Especially urgent, intensive and sustained efforts are required to reduce the vulnerability of adolescent girls and young women. 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.

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. 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.

During the NSP 2012-2016, an important new vehicle for better understanding stigma and discrimination was used – the People Living with HIV index, a national survey of more than 10 000 people living with HIV and/or TB.

However, stigma and discrimination continue to represent major barriers to the achievement of national HIV and TB goals. In 2014, 35.5% of people living with HIV reported experiencing externalised stigma, and 43% experience internalised stigma. Likewise, 36.3% of people living with TB reported experiencing TB-related stigma.

While valuing the progress made in the last NSP, this NSP recognises that there are still important gaps to close in the human rights agenda. Amongst these is a focus on bridging some policy to implementation gaps, ensuring that all people know their rights and where get to justice if these are violated. Stigma and in particular internalized 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, prisoners, LGBTI persons and people with a disability. People with HIV, STIs and TB should lead in driving the human rights and access to justice agenda.

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

- *Reduce poverty and vulnerability through scaled-up social protection:* Although South Africa has among the highest per capita GDP in Africa, the country is also characterized by extreme income inequality. While the Expanded Public Works Programme has helped ease unemployment, issues of structural unemployment remain largely unaddressed. In South Africa, the poorest 40% of the population bears 65% of the TB burden, and people with lower socioeconomic status also experience the greatest barriers to health care access. Lower-income households are more vulnerable to economic shocks associated with HIV, TB or other chronic diseases. 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 should 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. Poor nutrition weakens the immune system; increases the risk of TB infection, progression to disease and TB reactivation; and worsens TB outcomes. In addition, TB can lead to malnutrition. Food insecurity is correlated with reduced rates of HIV treatment adherence. 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 educational opportunities for adolescent girls:* 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 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, and young people's access to social grants. 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 women and girls. 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, for example, 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 difficult to baseline data, 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 victims of gender based violence. However, a, should be scaled up. A national plan on gender-based violence which is a broader than HIV, TB and STIs – including provisions for appropriate human and financial resource allocations, enhanced monitoring, implementation and accountability – is needed, otherwise the effect on HIV risk and vulnerability cannot be optimally addressed and the pressure on provision of services for victims of gender based violence will continue to grow. The absence of a national plan to address gender based violence is a risk to the success of and investment in HIV, TB and STI prevention and treatment programmes.

- *Better define and then Scale up harm reduction services to deal with alcohol and drug abuse:* Alcohol and drug abuse lead to an increased HIV and TB risk and vulnerability as well as affecting adherence to treatment and ultimately the health of the person affected. This is a major concern and a major problem across the country with specific areas being dealt with in the NSP and others in the NDP.
- *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. A Human Rights Accountability Charter on HIV, TB and STIs should be developed, and a dedicated human rights sector established within SANAC. Mechanisms should be in place to monitor human rights violations related to HIV, TB and STIs, and to refer cases of human rights violations to Equality Courts for redress and accountability. Access to legal services should be scaled up.
- *Reduce stigma:* The NSP calls for a 50% reduction in both externalised and internalised stigma, through the development and implementation of national multi-sector, multi-method strategy to reduce both internalised and externalised stigma. Specific efforts will be undertaken to reduce internalised stigma, alleviate TB stigma, ensure the confidentiality of medical records and strengthen workplace anti-stigma and discrimination efforts. To reduce internal stigma, empowerment, community mobilisation and counselling interventions will be supported. Intensified efforts will work to increase social support for people living with HIV and/or TB, through peer support, adherence clubs and access to psychosocial counselling. With respect to external stigma, there is a growing evidence base on strategies to change stigmatizing attitudes in communities and among health care providers and the general population. Community groups will be revitalised and capacitated to help lead anti-stigma efforts, and advocacy campaigns and social transformation intervention will be supported.
- *Environmental interventions for TB control:* Overcrowding, indoor air pollution and poor ventilation contribute to TB transmission. Households, health facilities, prisons, mines and transport settings, in particular, are TB transmission “hotspots.” Workplaces,

including those that expose workers to silicosis of high silica dust level, 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.

- *Steps to ensure access for people with disabilities:* Where needed, structural changes should be made to buildings to accommodate the increase in people with disabilities due to the impact of HIV, TB and STIs.

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

<b>GOAL 4: Address the social and structural drivers of HIV, TB and STI infections and linking them to NDP Goals.</b>				
<b>Objective 4.1</b>	<b><i>Implement social and behaviour change programmes to address key drivers of the epidemic and build social cohesion within 27 priority districts by 2022</i></b>			
	<b>Interventions</b>	<b>Approaches/ Rationale</b>	<b>Populations</b>	<b>Lead agencies</b>
Sub-Objective 4.1.1: Reduce risky behaviour through the implementation of programmes that build resilience of individuals	Prevention and Early intervention programmes to identify risk	Strengthening of DSD programmes in high burden districts and among vulnerable groups. Programmes to include: Mobilisation Advocacy Capacity Building Monitoring  DBE to plan to sustain positive behaviour outcomes and facilitate the deconstruction of gender norms and roles	OVC, 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, DBE, Civil Society including NGOs and CBOs
Sub Objective 4.1.2: Comprehensive age-specific and appropriate support for learners.	Provision of Comprehensive Sexuality Education in schools. Provision of support to pregnant learners in line with DBE policy.  Age-specific support for HIV positive adolescents.	DBE to deliver through educators, peer educators and civil society including NGOs.	Leaners and HIV positive adolescents	DBE, DSD, NDOH, Civil Society including NGOs and CBOs

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  Implement Community Capacity Enhancement Programmes	DSD Programmes to include: Mobilisation Advocacy Capacity Building Monitoring Ultimately to improve communication on issues of sex and sexuality, the prevention HIV infections as well as unplanned pregnancies and teenage pregnancies.	Families 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.	SABCOHA through BUSA, AMCHAM, Chambers of Commerce etc to facilitate and encourage the review of all workplace policies to ensure full integration of HIV, TB and STI's Organised labour to work with SABCOHA and their own structures for a combined approach.	Private sector companies	SABCOHA, Organised labour
<b>Objective 4.2</b>	<b><i>Increase access to and provision of services for all survivors of sexual and gender based violence in the 27 priority districts by 2022</i></b>			
	<b>Interventions</b>	<b>Approaches/ Rationale</b>	<b>Populations</b>	<b>Lead agencies</b>
Sub Objective 4.2.1: Increase access to provision of services for all survivors of sexual and gender based violence	Finalise and implement a National Gender Based Violence Plan	A national plan that brings together a comprehensive strategy to deal with GBV including the allocation of resources and improved monitoring and evaluation of GBV.	General Population	Department of Women, Presidency, DSD DOH Justice, Police Civil society sectors

	<p>Maintain the GBV Command Centre: 24hr/7days Telephonic counselling to victims of crime and violence including Gender Based Violence</p> <p>Tel. no: 0800 428 428 SMS line: *120*7867#</p>	<p>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.</p> <p>The project serves as a response to the Minister's call for the establishment of a national Command Centre as one of the vehicles to implement gender based violence prevention in the country.</p> <p>To strengthen and promote psychosocial wellbeing of individuals, families and communities through prevention, care, and support services to respond to social ills.</p>	<p>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</p>	DSD
	<p>Scale up the implementation of the victim empowerment programme e.g. everyday heroes and similar programmes.</p>	<p>The programme aims at promoting learning about VEP and illustrates how every person/citizen of this country can provide support to victims of crime and violence and make our communities safer and caring.</p> <p>The program raises awareness and education for communities</p>	General community	DSD

Sub Objective 4.2.2 Provide support for survivors of sexual assault.	Strengthen and scale up provision of services through Thuthuzela Centres and other relevant sites in communities.	Ensure that the full package of services, including psychosocial support and case management, is offered in at least one TCC (or equivalent package in a designated site) per district and is accessible to all populations.	Victims of sexual and gender based violence	DSD, DOH, Justice, civil society groups, key population sectors
	Strengthen and scale up community based one stop Khuseleka Centres <i>Note: Currently the centres are in 4 Districts (one in each of the following provinces: Eastern Cape, North West, Limpopo and Gauteng)</i>	One stop centres that offer services from a number of departments – psychosocial, forensic clinical services, psychological, skills development and long term shelter services.	Victims of crime and violence	DSD, Police services, DOH, Justice
	Strengthen and scale up of community based white door shelters	Provide short term places of safety and shelter within communities	Victims of gender based violence	DSD
<b>Objective 4.3</b> <i>Ensure access to rehabilitation, comprehensive psychosocial support and mental health services for people living with and affected by HIV and TB in 27 priority districts</i>				
	<b>Interventions</b>	<b>Approaches/ Rationale</b>	<b>Populations</b>	<b>Lead agencies</b>
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	Develop and implement in-service training for all health care workers.	HCWs need to be sensitised and capacitated 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 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	Strengthen and expand the 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	People affected by HIV and TB	DSD

psychosocial support and mental health services for people living with and affected by HIV and TB		groups and see referrals from health facilities/schools/DHET		
	Strengthen and scale up access to a comprehensive range of rehabilitation services		People affected by HIV and TB who have disabilities	DSD, DOH, Civil society including NGOs
	Strengthen and scale 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	<b>Scale up access to social protection for people at risk of and those living with HIV and TB in 27 priority districts</b>			
	<b>Interventions</b>	<b>Approaches/Rationale</b>	<b>Populations</b>	<b>Lead agencies</b>
Sub Objective 4.4.1: Scale up access to social grants	Ensure full access to social grants for the most vulnerable where indicated.	Access to social grants decreases HIV and TB risk	Children, youth, women, men, older persons and persons with disabilities	DSD, civil society including NGOs
Sub Objective 4.4.2: Scale up access to food security	Scale up the provision of food parcels and cooked meals	Access to sufficient food decreases HIV and TB risk and improves adherence.	People at risk and those living with HIV and TB OVCs	DSD, NGOs, SANAC sectors,
	Scale up the availability of the social distress grant of 3-6 months for people living with HIV and TB	Access to sufficient food decreases HIV and TB risk and improves adherence.	People living with HIV and TB	DSD
	Scale up services to Orphans and vulnerable children through the expansion of the Isibindi model.	Access to sufficient food decreases HIV and TB risk and improves adherence.	OVC	DSD

Sub Objective 4.4.3: Scale up access to nutritional support	Strengthen and expand the coverage of the National School Nutrition Programme	Expand the availability of all three elements of the programme and make it available during school holidays.	In school youth	DBE
Objective 4.5	<b>Implement and scale up a minimum package of harm reduction interventions for alcohol and substance use in all districts</b>			
	<b>Interventions</b>	<b>Approaches/Rationale</b>	<b>Populations</b>	<b>Lead agencies</b>
Sub-Objective 4.5.1: Improve the policy for harm reduction for substance and alcohol abuse and its implementation.	Revise the Drug Master Plan to clearly articulate a harm reduction response with roles and responsibilities clarified	There is a need to include clear harm reduction strategies including services for injection drug users.	All stakeholders	DSD, DOH, Civil society, SANAC secretariat
	Strengthen and expand the provincial drug management units to co-ordinate prevention and referral between communities, schools and HET facilities, health facilities and rehabilitation facilities.	Better co-ordination will facilitate identification of people who need help and easier referrals for a comprehensive response.	All stakeholders	DSD, DOH, DBE, SANAC Secretariat
Sub-Objective 4.5.2: Scale up the provision of in- and out-patient rehabilitation services for all who use alcohol and drugs	Expand the availability of outpatient rehabilitation facilities	Expanding availability improves access.	People with alcohol and substance abuse	DSD, DOH, DBE, NGOs
	Expand the availability of inpatient rehabilitation facilities	Expanding availability improves access.	People with alcohol and substance abuse	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	Implement community awareness and advocacy programmes.	Awareness of services will facilitate access.	Primary: children, Youth in and out of school Secondary: caregivers and parents	DSD, civil society including NGOs



	Develop and implement in-service training for all health care workers	HCWs need to be sensitised and capacitated 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 with alcohol and substance abuse	DSD, DOH
<b>Objective 4.6</b>	<b>Implement economic strengthening programmes with a focus on youth in the 27 priority districts</b>			
	<b>Interventions</b>	<b>Approaches/ Rationale</b>	<b>Populations</b>	<b>Lead agencies</b>
Sub Objective 4.6.1: Economically empower targeted groups of young people by increasing the availability of economic opportunities	Implement Combination Socio-Economic Programmes	The main aim is to strengthen the economic capacities of vulnerable adolescents and youth infected and affected by HIV/AIDS. This is done through support to access further education, training, job placements and entrepreneurial activities.	Out of school and further education Youth especially OVC 15 - 18 years that are recipients of the South African Child Support Grant	DSD, Private sector, DHET, civil society including NGOs
	Encourage 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 programme to formal job opportunities	Approach companies to participate in the creation of job exposure opportunities for young women and girls	Young women and girls out of school	SABCOHA, organised labour
	Provide BizAIDS training to young women and girls as part of all programmes focusing on young women and 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.	Young women and girls out of school	SABCOHA, organised labour

Objective 4.7	<b>Address the physical building structural impediments for optimal prevention and treatment of HIV, TB and STIs</b>			
	Interventions	Approaches/Rationale	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	Set up a multi-stakeholder task team to review relevant legislation, regulations, norms and standards related to improving ventilation and indoor air quality for optimal TB prevention -Develop and implement a funded plan of action	To drastically improve the prevention of TB, we need to ensure adequate ventilation and indoor air quality, such that transmission of TB is minimised in spaces where people congregate in significant number for long periods.	All stakeholders	DOH, SANAC secretariat, Environmental Health, DHS, Transport (public and private sector), Public Works, CSIR, DST, Built Environment Professional Associations, COGTA, Eskom, Municipalities.
	-Develop and implement campaigns to raise awareness on the need for adequate ventilation and good air quality for the prevention of TB	Awareness through education is the first step to behaviour change.	All stakeholders	SANAC secretariat, 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	-Set up a multi-stakeholder task team that will review relevant legislation, regulations, norms and standards as they relate to improving the provision of structural accommodations for people with disabilities and then develop and implement a funded plan of action to address shortcomings.	As people live longer with HIV and TB remains prevalent, the number of people with disabilities due to the disease or side effects of treatment will increase and accommodation has to be made for this.	HIV and TB affected people with disabilities	DOH, SANAC secretariat, Environmental Health, DHS, Transport (public and private sector), Public Works, CSIR, Built Environment Professional Associations, COGTA, Eskom, Municipalities. Sub

Objective 4.8	<i>Every district will implement a system to prevent, monitor and respond to human rights abuses and challenges and remove human rights barriers to accessing services.</i>			
	Interventions	Approaches/ Rationale	Populations	Lead agencies
Sub Objective 4.8.1: A Human rights and stigma programme in every district	Every district to have a plan prepared, implemented and monitored.	The plan has to track and show responses to abuses and challenges. Need to ensure HRS implementation has national coverage and reaches into all communities	Everyone with an emphasis on Key and vulnerable populations	District AIDS councils Civil Society
Sub Objective 4.8.2 All programmes for key and vulnerable populations to have a strong human rights and stigma component	Generic national support for programme design Support materials for all and for each Key and vulnerable population Training and sensitisation of all service delivery personnel	Programmes are designed to prevent, monitor and respond to human rights abuses and stigma. This design is done centrally and then adapted for local context as needed.	All and Key and vulnerable populations	SANAC secretariat, Civil Society, Health, Social Development
Sub-objective 4.8.3: Referral system in place to ensure stigma does not arise in new circumstances	Prepare a national directory of services that is readily available and easy to access. Establish a referral system to services and support groups for people living with HIV and TB.	New environments pose a risk of isolation and discrimination	Workers transferred between positions because of their HIV or TB status Former inmates Migrant workers	Lead government departments including Health, Social Development, Education, Correctional services, Labour
Sub-objective 4.8.4: Monitoring Human rights and stigma abuses and challenges to identify progress and challenges	A system in each district to monitor human rights and stigma programmes and routine services	National tracking of local implementation National development of a system that is then applied nationally.	All with an emphasis on Key and vulnerable populations	SANAC Secretariat, SA Human Rights Council, Civil Society

Objective 4.9	<i>Review legal and policy frameworks and their implementation, with a focus on drug use, mental health, domestic violence, sexual abuse of inmates and migration</i>			
	Interventions	Approaches/Rationale	Populations	Lead agencies
Sub-Objective 4.9.1: Ensure stronger legal protection for vulnerable populations	Review of all legislation that might impact on risk factors for HIV, TB or STIs and for access to services	There should be no legal impediments blocking success of the goals of the NSP	All Key and vulnerable populations Victims of Domestic violence Sex workers	Justice Law Reform Commission Human Rights Commission Civil Society
Sub-Objective 4.9.2: Review Policies on Criminalisation and Protection	Review existing policies from a public health perspective	Criminalisation is a barrier to service access and harm reduction	Sex workers Drug users	Justice Law Reform Commission
	Practice stronger protection of Key and vulnerable populations	Key and vulnerable populations need the backing of authority, including government and employers	All KP, VP	All government departments, civil society, organised labour, SABCOHA
Sub-Objective 4.9.3: Ensure confidentiality of personal records	Strengthen confidentiality of client records through controlled access to electronic records that can be tracked.	Improved confidentiality will improve access to services and decrease stigma.	All key and vulnerable populations	DSD, DOH
Sub-Objective 4.9.4 : Roll out an HIV, TB, STI Human Rights Accountability Charter	Prepare and implement a Human Rights Accountability Charter	An accountability charter sets out expectations and responsibilities.	All key and vulnerable populations	SANAC secretariat

Objective 4.10	Reduce externalised and internalised stigma among people living with HIV or TB by half			
	Interventions	Approaches/ Rationale	Populations	Lead agencies
Sub-Objective 4.10.1: Revitalise community-based support groups	Assess the situation of community-based support groups Develop and implement a plan for revitalisation Explore merging support groups across health challenges e.g. TB and HIV groups	Community based support groups offer more than adherence support. Become part of a community addressing rights and empowered	PLHIV and PTB Key and vulnerable populations	Civil Society SANAC Secretariat Health and social development
Sub-Objective 4.10.2: Reduce stigma	Develop and implement campaigns to achieve greater awareness and understanding of internalised stigma & TB stigma  National multi-sectoral, multi-level, multi-method internalised and externalised stigma programmes to be implemented	The levels of stigma, albeit reduced, remain too high.	Society and PLHIV, PLTB, Key and vulnerable populations	Human Sciences Research Council and other researchers SANAC Secretariat and all stakeholders Office of Deputy President
Sub-Objective 4.10.3: Sensitize those in authority to Human rights and stigma	Develop and implement training programmes to sensitise service providers to human rights and stigma and to change their behaviour.	Those in authority have a major impact on Human rights and stigma	Business Justice cluster Faith leaders	SABCOHA Labour inspectors Correctional services & SAPS Faith based sector

Objective 4.11	Implementing advocacy campaigns and social transformation interventions			
	Interventions	Approaches/ Rationale	Populations	Lead agencies
Sub-Objective 4.11.1: Develop and implement advocacy plans for key and vulnerable populations	Develop and implement advocacy plans for all key and vulnerable populations.	Advocacy is essential to advance the provision of services.	Key and vulnerable populations	SANAC Civil society
Sub-Objective 4.11.2: Communication materials on human rights and stigma to be widely available in key locations	Prepare and test multi-media materials Ensure sufficient availability	Vital to leverage the full scope of SBCC communications, including the potential of social media.	All especially Key and vulnerable populations	SANAC Civil society Equality courts and other public venues Social development Business
Sub-objective 4.11.3: Establish a SANAC Law and Human Rights Sector	Consult widely Prepare a proposal for the SANAC plenary Implement the final proposal	Establishment of a SANAC sector has given impetus to other facets, so Human rights and stigma would benefit similarly	Key and vulnerable populations	SANAC Civil society Legal and Human rights NGOs and researchers

## Goal 5: Promote leadership and shared accountability for a sustainable response to HIV, TB and STIs.

### Situation analysis

South Africa is a global leader in the fields of HIV and TB, with the world's largest antiretroviral treatment programme and an approach to the 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 and AIDS, 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. Given the ambitious goals and objectives of the NSP 2017-2022, this leadership will need to continue and be enhanced in the coming years.

Having achieved substantial gains in the response to HIV, TB and STIs, we can move our response to the next level and transition from disease control to elimination only if we further strengthen collaboration and effectively address the challenges we face.

In terms of government co-ordination, South Africa has a very sound legislative framework for cooperation between the three spheres of government including the following: (a) Section 41(2) of the Constitution of the country directs that an Act of Parliament must be developed to establish or provide for structures and institutions to promote and facilitate intergovernmental relations; and to provide for appropriate mechanisms and procedures to facilitate the settlement of intergovernmental disputes; (b) the Intergovernmental Relations Framework Act (No 13 of 2005) establishes a framework for the national government, provincial governments and local government to promote and facilitate intergovernmental relations, as well as to provide for mechanisms and procedures to facilitate the settlement of intergovernmental disputes and (c) the Intergovernmental Relations Framework Act (No 13 of 2005) establishes a consultative forum for the President, known as the President's Co-ordinating Council (PCC) that consists of the President; the Deputy President; the Minister in the Presidency; the Cabinet member responsible for finance; the Cabinet member responsible for the public service; the Premiers of the nine provinces; and a municipal councillor designated by the national organisation representing organised local government (SALGA). Once completed and adopted by Cabinet, the NSP 2017-2022 will be presented to both the PCC and PIF for endorsement and support.

Also, the completion of the NSP occurs when the country has already adopted the National Development Plan (NDP) 2030, which has been embraced by all political parties and most sectors of society as a lodestar for national development. With respect to addressing the structural drivers of HIV/AIDS and TB, the NDP envisions that by 2030, South Africa should have: (a) eradicated absolute poverty from 39% of people living below the poverty line of R419 (2009 prices) to zero; (b) reduced unemployment rate to 6% – by creating 11 million more jobs by 2030 and (c) significantly reduced inequality from 0.69 to 0.60 in terms of the gini coefficient - through a range of policy interventions. With respect to health outcomes, the NDP 2030 envisions that by 2030,

the country should have raised the life expectancy of its citizens to at least 70 years; produced a generation of under-20s that is largely free of HIV; and reduced the burden of disease, amongst others. The NDP 2030 is implemented through 5-year plans known as the Medium-term Strategic Framework (MTSF).

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 for these epidemics. 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 health systems and community systems. Only a multi-faceted approach – which integrates services and unites parents, teachers, families and communities in a common undertaking – can address the persistently high rates of HIV infection among adolescents and young women as well as the factors that increase their vulnerability.

This multi-faceted approach will require a move to a decentralised approach if we are to focus for impact, hence the most important level of leadership to be strengthened is at the community level. Wards or groupings of wards, constituting well-established towns, townships or villages, must be empowered to lead. To really focus for impact, we need to move even further to develop multi-government and inter-sectoral responses that gets government departments working together with the private sector, organised labour, civil society organisations and other sectors in the co-ordinated response. While conscious of the number of priority demands, focusing for impact requires leadership with an unwavering commitment to accountability mechanisms 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. For the Strategy to fully succeed it is vital for leadership to be strengthened at the community level. One of the key reasons for this devolution of leadership is because multi- and inter-sectoral behavior change and other programmes are best implemented at the local level. 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. This means that districts need to be the architects of refining their own responses for implementing the NSP, with provincial and national leadership supporting this bottom up approach. It also means ensuring that development partners respond to local priorities.

In short, the NSP demands leadership from all spheres of government (national, provincial, local government) as well as communities, the private sector, organised labour civil society, priority populations, academics, researchers, development partners, and – most important of all – people living with HIV or infected with TB. Particular attention is 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 feedback loops to enact change as it is needed .

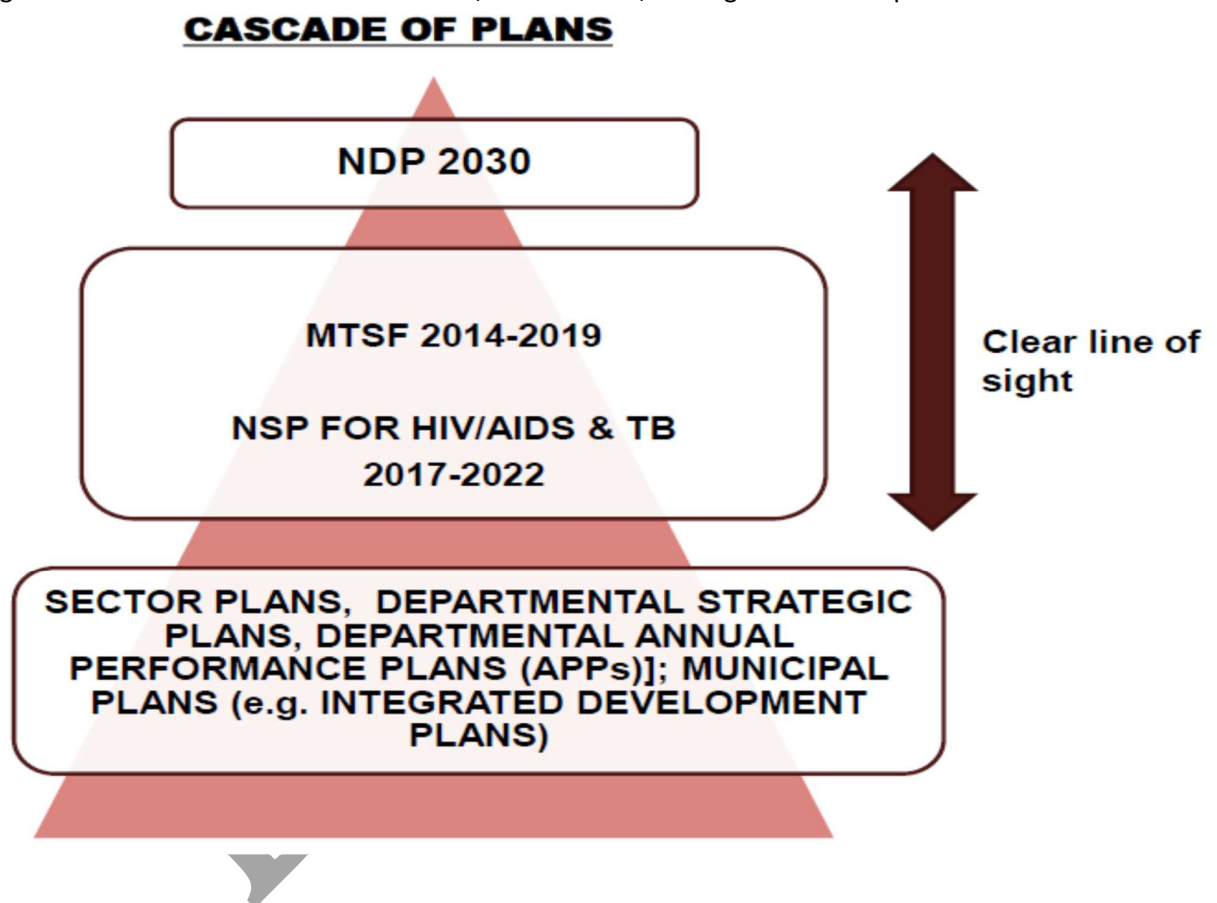
In terms of the role of government, it is imperative that the NSP 2017-2022 is embedded in all plans of government. The NSP 2017-2022 must be elevated to the level of the MTSF, and that its indicators and targets are incorporated into the MTSF. It is also important that the NSP 2017-2022 is not perceived as a sector plan, as this will fragment the support that it could receive. No matter how excellently constructed, a sectoral plan (or sector specific plan) struggles to attract multisectoral support. Accountability for implementation and results becomes diffused. However, appropriately



marketed, with good leadership from the Presidency and Cabinet 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.

This embedding of the NSP in the plans of government is shown in the cascade below. This cascade should apply to not only the plans of Departments in the Social Protection, Community and Human Development Cluster of government, but to other Clusters as well. The health of any society and its economic development are intricately linked and inseparable.

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



The NSP will then be embedded in the Midterm review of government performance against the 2014-2019 electoral mandate, that is to be completed by July 2017, and this will result in the production of revised MTSF Chapters. This will be done in consultation with key government departments and stakeholders.

The next step will be to use the NSP to influence the Budget cycle for 2018/19, as the first drafts of National and Provincial APPs for 2018/19 are due for completion in July 2017. This is of strategic importance, since the budget process of government is framed within the objectives, indicators and

targets entailed in the APPs. These annual plans are the vehicle for the resource allocation within government. It is of critical importance that in the development and finalization of their APPs and budget bids for 2018/19, the national and provincial spheres of government mobilise resources for the implementation of the NSP 2017-2022. Over the 22-years of democracy, South Africa has shown major resilience in that its AIDS-response has not been hugely dependent on external donor funding. The latter has assisted in specific programmes guided by national priorities. This resilience must be sustained over the next 5-years.

In terms of monitoring and evaluation, the Presidency and Offices of the Premiers in Provinces are custodians of planning and monitoring processes and frameworks within government. In the Presidency, this function is assigned to the Department of Planning, Monitoring and Evaluation (DPME). The political leadership and technical teams within these offices will ensure that the indicators and targets from the NSP are included in the cascade of all plans across different levels of government.

### 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, three 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 from it. 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:* Using data generated by the monitoring and evaluation system and with leadership and coordination provided by SANAC, AIDS Councils at all levels 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.

Effective planning, monitoring, reporting, acting on evidence and taking corrective action to steer performance, are part of good governance and leadership. Vigorous implementation of this approach will be required to ensure successful delivery on the NSP 2017-2022.

#### 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:* As a key element of the three-step framework for leadership and accountability, SANAC 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:* Recognizing 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 clear 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 needs to be enhanced to capture the most critical sectors such as the formal and informal agricultural sector, which employs almost 10 million people. 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 wellness programmes, expand workplace testing programmes to reach more men, and build and implement public-private partnerships to enhance implementation of all the campaigns. Particular efforts will be needed to increase private sector engagement in the informal and agricultural sectors.
- *Engage organised labour:* Organized 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. 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) will develop an NSP-aligned implementation plan to feed into the Provincial Implementation Plans. All provincial, district and local AIDS Councils must have representation of all key sectors, including civil society, private sector, organised labour and people living with HIV or TB.
- *Strengthen the capacity of AIDS Councils to contribute towards implementation of the NSP and achievement of its goals and objectives:* Well-governed AIDS Councils should 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 local AIDS councils will adopt an integrated service delivery model that address 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, with SANAC responsible for building the capacity of Provincial AIDS Councils where 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 local 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, municipal and district governments work together alongside civil society and the private sector to institutionalise an inter-and multi-sector approach.
- *Commit resources for AIDS Councils* including the SANAC secretariat to fulfil its coordinating function. There needs to be funding for sector coordination.
- *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.

[ADD INDICATORS]

Table 6. Goal 5 Leadership and Accountability Goals, Objectives, Sub-objectives and activities

<b>GOAL 5: Mobilise leadership and co-ordination at all levels and promote shared accountability for a sustainable response to HIV, TB and STIs</b>				
<b>Objective 5.1</b>	<b>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.</b>			
	<b>Interventions</b>	<b>Approaches/Rationale</b>	<b>Population</b>	<b>Lead agencies</b>
Sub Objective 5.1.1: Develop and implement procedures for optimal implementation of NSP.P	-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	An appropriate structure with clear operating procedures will enhance implementation of the NSP	All stakeholders	SANAC Secretariat
	Review and improve the functioning of SANAC secretariat.	Roles of leadership stakeholders to be clarified (Office Deputy President, NDOH and SANAC) and the secretariat fully funded for its mandate.	All stakeholders	SANAC secretariat, SANAC Trust Board, Office of Deputy President, NDOH
Sub-Objective 5.1.2: Monitor annually the implementation of the accountability framework through an Accountability scorecard	Implement the accountability framework Develop and implement an Accountability Scorecard tracking performance of implementation of the accountability framework at a national level.	Accountability is a central part of this NSP to ensure the strategy is implemented fully.	Relevant stakeholders	SANAC Secretariat

Objective 5.2	Improve collaboration and co-operation between national government departments			
	Interventions	Approaches/Rationale	Populations	Lead agencies
Sub Objective 5.2.1: Ensure alignment of all government department annual performance plans with the NSP.	Each national government department must develop a 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 must develop implementation plans that are aligned with the relevant provincial implementation plan.	The implementation plans needs to be aligned to the NSP for accountability and best results. Implementation plans will be used by departments to guide the process of mainstreaming NSP directives into their annual performance plans and budgets. These Implementation plans will be mainstreamed into government strategic plans then annual performance plans and MTEF budgets and reporting frameworks.	All national government departments	DPME SANAC Secretariat
Sub-Objective 5.2.2: Ensure collaboration between government departments through the use of joint results frameworks.	The DPME must develop a joint inter-governmental results framework and progress reporting system that directs collaboration and responsibility towards shared outcome targets.	Joint results frameworks will demonstrate the need for co-ordination and show the performance and contribution of each government department to the overall situation.	All national government departments	DPME SANAC Secretariat
Sub-Objective 5.3.1 Establish/ strengthen regional collaboration	Adhere to protocols signed at the Regional level- SADC and ESA	Enhanced co-operation will improve outcomes for all countries involved as people move between countries.	All national government departments, civil society	DPSA DPME DIRCO SADC SANAC Secretariat

Objective 5.3	Improve collaboration and co-operation between government, civil society, development partners and private sector sectors.			
	Interventions	Approaches/Rationale	Populations	Lead agencies
Sub Objective 5.3.1: Ensure alignment of plans of all non-government stakeholders with Provincial Implementation Plans.	Each sector (civil society, private sector, development partners) to develop an implementation plan that is aligned with the NSP and contributes to the Provincial Implementation Plans.	If the plans of all stakeholders are aligned with PIPs there will be greater accountability and efficiencies.	All non-government stakeholders	SANAC Secretariat PCA Secretariat
Sub-Objective 5.3.2: Ensure representation of all stakeholders in decision making structures at provincial, district and local levels.	Each Provincial, District and Local AIDs Council and Municipality (or equivalent) must have representation from all provincial government departments, development partners, the private sector, a 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.).	Representation is the first step in the development of local context specific PIPs and an important part of accountability.	All stakeholders	SANAC Secretariat PCA Secretariat
	SABCOHA to co-ordinate the participation of representatives from the private sector at all these levels.	SABCOHA to facilitate Private Sector meetings in order to nominate representatives of the Private Sector. This will enhance ownership and meaningful involvement of the Private Sector	All industries in the Private Sector, including Informal Economy	SANAC Secretariat PCA Secretariat

Sub Objective 5.3.2: Strengthening the role of the private sector.	Implement the Private Sector Engagement Strategy led by SABCOHA	Implement the Private Sector Engagement Strategy	All non-government stakeholders	SANAC Secretariat PCA Secretariat
Sub Objective 5.3.3: Ensure a central role for civil society and community groups	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	Such a framework will allow 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
	Promote greater involvement and leadership by key and vulnerable populations through the establishment of focal points 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 5.3.4: Strengthen the co-ordination of government departments	Promote and deepen the co-ordination of national government departments.	The roles and responsibilities of the different co-ordinating structures to be made clear and linkages identified.	All stakeholders	DPME, IMC, DPSA, SANAC Secretariat



Objective 5.4	Strengthen capacity of AIDS Councils at all levels (provincial, district and local) to develop and implement multi-sectoral implementation plans for the NSP.			
	Interventions	Approaches/ Rationale	Populations	Lead agencies
Sub-Objective 5.4.1: Formally establish the structures of AIDS council at provincial, district and local level	<ul style="list-style-type: none"> <li>-The Provincial Executive Committees to 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</li> <li>-Develop and approve Procedural Guidelines for AIDS council structures at all levels targets.</li> <li>-Develop and adopt a Code of Conduct for AIDS council structures at all levels</li> </ul>	To ensure accountability structures are in place to oversee the implementation plans	All stakeholders	Provincial Executive Committees
Sub-Objective 5.4.2: Ensure that the AIDS council structures are adequately resourced and capacitated	<ul style="list-style-type: none"> <li>-The work of each Provincial AIDS Council is costed and funded through the Provincial Government budget.</li> <li>-Strengthen and scale up the integrated ward based structures to institutionalise an inter and multi-sectoral approach at a local level.</li> </ul>	To enable optimal functioning, structures need to be resourced and capacitated.	All stakeholders	Provincial Executive Committees SALGA SANAC Secretariat

Sun-Objective 5.4.3: Develop and then Monitor annually the implementation of the Provincial Implementation Plan using an Accountability scorecard	Each Provincial AIDS Council must develop a 5 year implementation plan that is aligned to the NSP and its targets. Each district and local AIDS Council (or its equivalent) must develop implementation plans that are aligned with the relevant provincial implementation plan.	The provincial implementation plans are essential to take the NSP from a strategy to implementation and impact.	All stakeholders	SANAC Secretariat, Provincial Executive Committee, SALGA, COGTA
	Develop and implement an Accountability Scorecard tracking performance of implementation of the accountability framework at a provincial level.	A scorecard is a high level tool used to track performance against an accountability framework, hence operationalizing the accountability in a measurable way.	All stakeholders	Provincial Executive, COGTA
Objective 5.5	<b>Resource mobilisation</b>			
	<b>Interventions</b>	<b>Approaches/ Rationale</b>	<b>Populations</b>	<b>Lead agencies</b>
Sub-Objective 5.5.1: Maximise the funds available for implementation of the NSP and the impact of these funds.	Ensure that all implementation plans based on the NSP are accurately costed to support budgeting and resource mobilisation efforts.	Budgeting and resource mobilisation needs information on costs	All stakeholders	SANAC Secretariat SANAC structures Government departments SABCOHA PCAs
	Design and implement new and innovative funding mechanisms to deepen the traditional mix of finance for HIV and TB in South Africa.	Innovative funding mechanisms can secure access to previously inaccessible sources of funding (such as private investors) and may attract investment from non-HIV sources of public funding through co-investment		SANAC Secretariat SANAC structures

		in shared outcomes (development synergies). New funding mechanisms that enhance efficiency and impact		
	Implement strategies to achieve higher technical efficiencies in service delivery and health and other systems, thereby generating cost savings.	Efficiencies allow more to be done with the funds available and more people to benefit.	All stakeholders	SANAC Secretariat SANAC structures All government departments
	Improve the precision of where investments are spatially targeted to maximize impact and value for money.			SANAC Secretariat SANAC structures All government departments
	SABCOHA to lead the scale up of the Community Fund existing within SABCOHA to increase the allocation of corporate social investment funds to Public Private Partnerships in support of implementation of the Provincial Implementation Plans.	SANAC and PCA Private Sector Strategy/ies SABCOHA will have to work with different businesses on this one, from large to medium-sized businesses.	Multinational and Local Businesses	SANAC Secretariat PCA Secretariat

<p>Sub-Objective 5.5.2: Improve allocations based on emerging evidence and modelling work</p>	<ul style="list-style-type: none"> <li>-Develop broad investment cases for better alignment with NDP.</li> <li>-Develop evidence based budget bids or business cases for priority structural interventions that can achieve both targeted HIV outcomes and broader development outcomes elucidated in the NDP</li> <li>-Re-prioritise funding within existing government HIV and TB budgets to ensure allocative efficiency and that the most effective interventions have sufficient resources.</li> </ul>		<p>All stakeholders</p>	<p>SANAC Secretariat SANAC structures All government departments</p>
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## Goal 6: Mobilise resources to support the achievement of NSP goals and ensure a sustainable response.

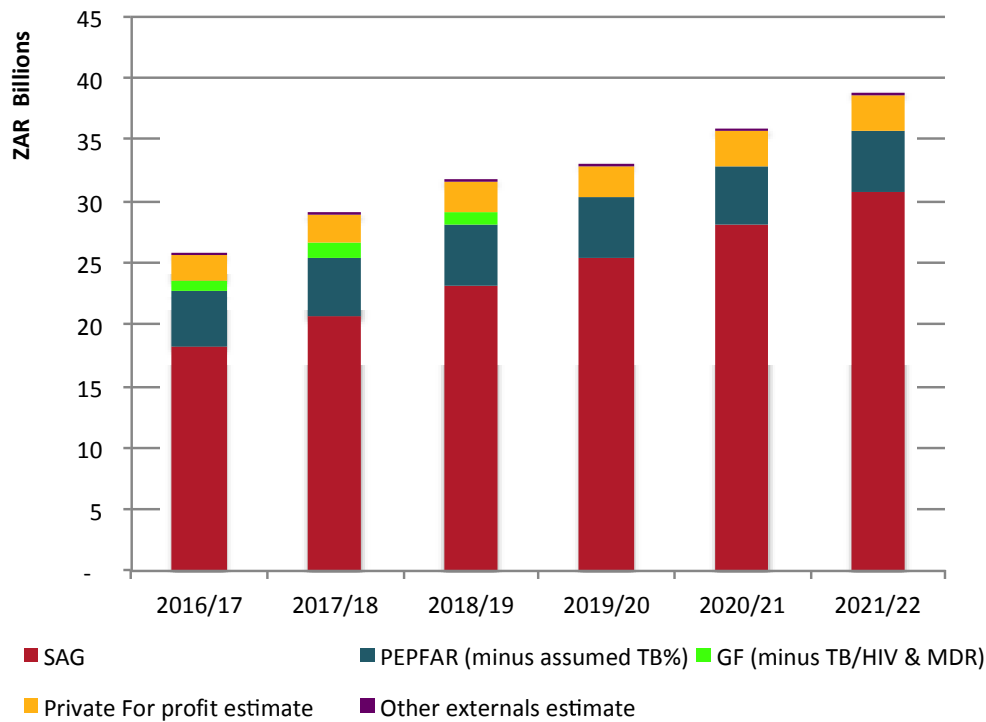
Achieving the goals and objectives of the NSP will be possible only if sufficient resources are available to implement the NSP at all levels. Given the ambitious nature of the NSP, resources for the response to HIV, TB and STIs will substantially increase in 2017-2022.

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 R1 invested in TB programmes would generate R43 in economic returns. Moreover, the South African HIV and TB Investment Case 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.

### 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 (R20.5 billion in 2018/19), followed by DSD (R1.8 billion for 2018/19). 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.

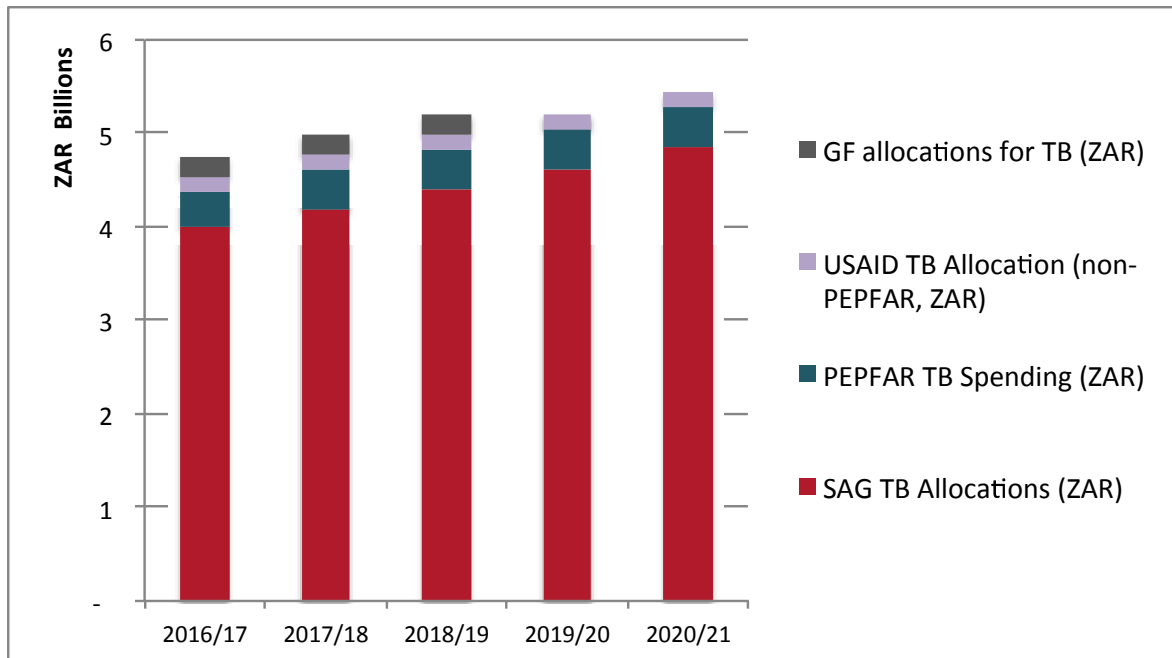
FigureXX: Anticipated HIV funding from all sources: South Africa Government, Global Fund, PEPFAR, private sector and other development partners (2015/16-2021/22) (ZAR billions)



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

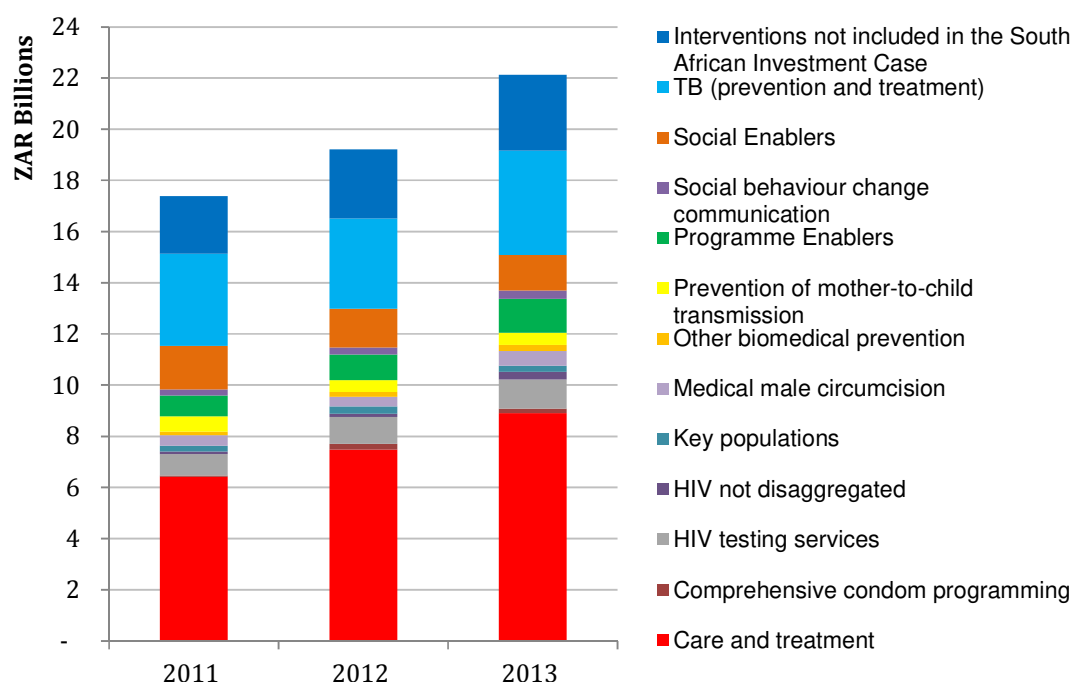
The same primary HIV funders – South Africa Government, PEPFAR and Global Fund – are also the most important funders for TB activities, with South Africa again providing the overwhelming majority of TB financing. As shown in Figure YY, additional funding is anticipated for TB activities through 2022,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

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



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

Antiretroviral treatment costs account for 40% of total HIV spending and represents the single biggest expenditure item (Figure ZZ). Allocations for HIV prevention have increased in recent years to 19% of total HIV spending, although HIV testing and counselling accounts for almost half of expenditure labelled HIV prevention. Social and programme enablers represented 17% of total HIV spending in 2013/14.



[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 the government has pledged to ramp up HIV and TB funding in order to achieve 90-90-90, fiscal space for the mobilisation of even greater domestic resources is limited by the low economic growth.. Other than PEPFAR and the Global Fund, international HIV and TB assistance to South Africa has declined, and prospects for a substantial rebound in international aid are dim. South Africa currently projects that PEPFAR and Global Fund will maintain their investments a steady level of R5.7 billion and R1.4 billion 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.

**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: maximizing funding from existing governmental and international sources, improving the efficiency of spending (e.g., targeting for impact, spending only on evidence-based interventions, 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. 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. Interventions that are currently funded but are not central to achievement of the goals and objectives of the NSP – (13% of current HIV funding was found not to support priority interventions validated by the extensive evidentiary review of the Investment Case) – should be de-prioritised, with funding reallocated to more evidence-based approaches.

- *Increase efficiencies:* Using data to strategically target high-value, high-impact interventions towards the locations and populations where impact will be greatest can maximise the efficiency of the response to HIV, TB and STIs. 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 prioritised.
- *Frontload investments:* While front-loading investments in 2017-2022 will intensify fiscal demands in the short run, the Investment Cases found that this approach maximizes the reduction of future costs. While 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 require treatment. In addition, to reach the 90-90-90 for TB, the Investment Case indicates that an increase in spending on TB by R4 billion (15%) over next five years can save the national TB programme R33 billion (27%) over next 20 years.
- *Roll out and fully leverage National Health Insurance:* The roll-out of national health insurance (NHI) has the potential to generate a new source of funding for HIV, TB and STI services outside the normal funding channels of the Department of Health conditional grants and international donors. In particular, NHI enables the response to mobilise resources from the single best-resource sector – the private sector. 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 2017-2022 prioritises interventions to address the social and structural determinants of HIV, TB and STIs. Governmental sectors 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 all 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 has 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 will demand rigorous financial management, which in turn depends on sound, reliable and timely information systems (data, financial, personnel, etc). Using the methodology of the Investment Case, annual expenditure reviews should be conducted, consolidating data on expenditure by the South Africa Government with information regarding spending by the U.S. Government, the Global Fund and other partners. Budgeting and financial reporting frameworks on HIV and TB should be consolidated across departments and development partners. Steps should be taken to improve the tracking of expenditure for HIV, TB and STIs, and the strong emphasis on programme performance monitoring for HIV and TB should be extended to STIs. In addition, the mapping and reporting of expenditure should be simplified and standardised.

[ADD INDICATORS]

## Goal 7: Strengthen strategic information to drive progress towards achievement of NSP goals.

### Situation analysis

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; and the mid-term adjustments required to address problems as they emerge and to ensure that the response is on track to achieve the NSP’s goals, objectives and targets.

For the purposes of the NSP, “strategic information” includes three key components. *Surveillance and surveys* enable stakeholders to understand their epidemics, including the burden and distribution of disease, the populations and locations most affected, and the factors that increase risk and vulnerability. This data enables stakeholders to target and tailor programmes most effectively and to allocate finite resources in manner to maximise progress towards the NSP’s goals, objectives and targets.

*Monitoring and evaluation* systems ascertain 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.

*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, as well as new learning on optimal strategies to implement or deliver validated interventions.

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 and 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. Highlighted 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
- Pre-ART surveillance (defining the program cascade from HIV testing through ART initiation)
- Maternal and Infant Mortality (MIMS) Survey
- Strengthening existing data collection of HIV cause-specific mortality (vital registration system)
- Data triangulation of clinical prevention and treatment cascades for KP (2017-2018)
- Impact evaluation of DREAMS initiative (2017-2020)
- Impact evaluation of AGYW initiatives (2017-2020)
- Evaluation and improvement of Tier.net modules, integration of data systems to conduct case-based HIV surveillance (2017-2020)

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. An important consideration for the research and innovation agenda would 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 STIs research and development in South Africa.

While leveraging these important resources, the NSP 2017-2022 also aims to address some of the weaknesses identified in strategic information systems. These include inadequate 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; limited indicators for the measurement and assessment of structural aspects of the response; and the lack of harmonised indicators and clear performance targets for specific groups, such as children and key populations. Lastly, an overarching coordinating body to oversee the development, implementation, and utilisation of data from M&E systems, surveys and surveillance, and research studies is currently lacking. The reinstitution of committed, capacitated, and multi-sectoral technical working groups in these areas, under the guidance of SANAC, to determine and prioritise vital strategic information needs is a crucial outcome of this NSP.

### Strategic approach

### Monitoring and evaluation

To strengthen monitoring and evaluation plans, systems and data for the generation of real-time data for programme improvement, the NSP will:

[PLACEHOLDER: M&E SECTION TO BE ADDED]

### Research and surveillance

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

- *Develop, fully resource and implement a coordinated research agenda for the NSP:*  
Taking into account available resources and research needs under the NSP, a national research agenda will be developed and costed. This research agenda will identify and prioritise key research questions for investigation, and allow for continuous identification of new research questions. A portion of the national health budget will be allocated to support this research agenda, and efforts will also be made to engage the pharmaceutical industry, private hospitals, the private sector and other stakeholders for funding to support these research efforts. Research technical working groups, convened by SANAC, will help build relationships and support coordination among diverse stakeholders in the research arena, including encouraging and facilitating multi-disciplinary research. Upon the adoption of the national research plan, and

implementation plan will be developed and implemented. 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 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 drivers, including establishment of an inter-disciplinary Social Science Think Tank, prioritising research on anti-stigma interventions, catalysing new strategies for adolescent girls and young women, and validating additional SBCC 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. Specific work aims 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; child-friendly TB medicines; and strategic information to strengthen PrEP roll-out.
- *Strengthen surveillance:* Particular efforts will be made to strengthen STI surveillance as well as surveillance for priority 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, 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 for enhanced drug resistance surveillance and pharmacovigilance. Surveillance of HIV drug resistance, TB drug resistance, and antimicrobial resistance for STI regimens is vital in light the anticipated massive uptake in ART with Universal Test and Treat and PrEP policies, surges in person-person transmission of drug resistant TB, and lack of district-level understanding of STI-related antimicrobial susceptibility. 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 increasing drug resistance.
- *Support implementation research:* The NSP aims to ensure implementation research for real-time learning and programme improvements, including through coordinated impact evaluations on implementation of best practices.
- *Support research on the efficacy of traditional and complementary medicines for HIV treatment and OI prophylaxis*
- *Support research to develop best practice models for community care support*

[ADD INDICATORS]

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

For the achievement of the five NSP goals for 2017-2022, systems must be strengthened to ensure delivery of services. Programmes need to be not only effective, but also optimally efficient, taking into account the finite nature of available resources. Critical enablers strengthen and configure systems to meet the challenges outlined in the five goals, and they help maximize 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.

### Enabler 1: Effectively integrate HIV, TB and STI interventions and services

[PLACEHOLDER]

### 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. The Department of Social Development will play the lead role in building strong social support systems, supported by other government departments, SANAC, 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 provided 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 HIV testing services, and psychosocial support services will enable the uptake of testing.

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 and TB 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.

### 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. 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 will demand an increase in the number of primary health care nurses that 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 as well as pharmacists to ensure the prescription and dispensing of antiretroviral medicines and other health commodities. Community health workers need to be formalized as a cadre, appropriately trained and supported, and fully integrated into the health system. Social work auxiliaries should be trained to help mitigate the epidemic's impact and address social and structural drivers. Sectoral workers, such as agricultural extension workers, should be prepared to integrate HIV and TB in their work. 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 the training of wellness coordinators should include HIV, TB and STIs.

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.

### Enabler 4: Strengthen information, procurement and supply chain systems

To achieve the ambitious goals and objectives of the NSP, ready, uninterrupted access to essential prevention, diagnostic and treatment commodities is essential. 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 supply chain information, procurement and supply chain systems and ensure quality throughout. The country will further strengthen its stock monitoring system at national and local level, supported by a rapid response system for shortages, to ensure consistent and adequate supplies of medicines, testing kits and female and male condoms as well as lubricants at health facilities and other community-based outlets. 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, and 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. In addition to the CCMDD programme, other approaches will be implemented to provide antiretroviral medicines and other health supplies in venues other than health facilities, bringing HIV treatment services 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.

#### **Enabler 5: Focusing on social and behaviour change communication (SBCC) to ensure social mobilisation and increasing awareness**

The 2017 – 2022 National Strategic Plan (NSP) recognises that without scaled up social and behaviour change communication (SBCC) none of the goals of this NSP will be realised. It is a critical enabler of success.

##### ***The potential of SBCC***

HIV, TB and STI programming involves a host of sexual and other behaviours. Factors that influence behaviour include an individual's knowledge, attitudes, emotions, access to services, risk perception, power dynamics between sexual and social partners, financial disparities, criminalization, and stigma.

SBCC aims to change the outcomes of these, influence social and cultural norms, attitudes, beliefs and practices, and provide people with skills (e.g. negotiation skills) to take action.

Research shows that effective SBCC programmes could achieve these changes if programme implementation is of high quality, that coverage of the specific audience is high (over 80%), and that messages are reinforced through multiple media channels that build upon the existing knowledge base.

SBCC encompasses an interactive process with individuals and communities to develop tailored communication strategies through a mix of programmes including advocacy, capacity building, community-level activities and community mobilisation, interpersonal communication, communication technologies and mass media. Linkage to effective services is vital and personal stories, social dramas and interactive methods are particularly impactful. An effective SBCC programme uses entertainment education approaches drawing upon the arts, culture, sports and other interactive participatory techniques that enable learning and promote buy-in. SBCC



programmes must be monitored and evaluated to measure for their impact and contribution to track their effect and strengthen programme design.

### ***The need for scaled up SBCC***

While SBCC is so vital, three national communication surveys (see below) have shown a steady decline in the investment in and the reach of SBCC interventions over the past decade, and seemingly also the impact on those they reach. Reasons cited for this decline include shifting and competing programmatic and financial priorities, declines in government and donor investments in SBCC and an increasingly fragmented communication environment with more channels, making it more difficult to engage with audiences and realise economies of scale. The three SBCC programmes analysed in the investment case combined, represented a mere 1% of total expenditure on HIV/AIDS in the period 2011-2013. This NSP will reverse this trend.

	2006	2009	2012
Percentage of population reached with SBCC interventions	92.5%	90%	82%
Number of people aged 16 – 55 years reached with SBCC interventions	27 million	24.5 million	23 million

### ***SBCC in the NSP 2017-2022***

***Five fundamental principles*** will underpin the SBCC: Stakeholder participation; Capacity building; Geospatial mapping; Risk profiling of communities; and Adaption of national campaigns to local areas.

All SBCC will be guided by the following ***minimum key elements***: Theory-based, client/community-centred, participatory, benefit-oriented, service-linked, multi-channelled, high technically quality, advocacy-related, scalable, sustainable, results-oriented and cost-effective.

***SBCC will combine a mix of programmes*** including: advocacy, capacity building, community mobilisation and mass media to reduce teen pregnancies and Sexually Transmitted Infections (STIs), new HIV or TB infections and deaths, maternal and infant morbidity and mortality and sexual and gender based violence. The programmes will recognise that social and behavioural change is seldom a linear process; that it could be influenced by competing forces on communication (health communication vs. political/commercial/peer discourses) as well as by different phases in people's lives (stable relationship vs. single/unstable relationships).

***The SBCC programmes will be enabled by a strengthened support infrastructure*** that includes:

- *Development of an evidence-informed national SBCC strategy informed by international best practices and in partnership with its beneficiaries to guide the national response: a costed*

strategy in partnership with relevant national departments, provinces, civil society and the private sector. Existing SBCC strategies will be reviewed for their alignment with the goals and objectives of the NSP 2017-2022.

- *A coordinated national 360 degree communication campaign:* will support all the goals of the NSP 2017-2022. There has been fragmentation with many small campaigns competing with each other for the same audiences, while other priority populations were omitted. Youth prevention, people living with HIV and TB and vulnerable groups have not been addressed effectively. The national 360<sup>0</sup> process will include a reflection on the major mass media and SBCC campaigns for their alignment and to identify gaps. [See Table (to be developed)]
- *Develop one national brand to unify the national response:* One overarching logo and branding plan will be developed and used to denote the national HIV/TB and STI response. This logo should be used as the primary symbol in any social and behavioural communication activities whether at national, provincial, district and within local communities.
- *Build the capacity of the SA government to lead the national SBCC response in :* Government departments should invest in developing a cadre of master trainers in applying international best practices in the management, design, implementation, monitoring and evaluation of SBCC interventions.
- *Create an enabling environment that allows people to take action through advocacy:* engage and mobilise leaders to create an enabling environment to fast track the achievement of the goals of the NSP through identifying, and addressing legislative, policy, programmatic, social, cultural and traditional norms that may act as barriers to strengthening SRHR/HIV/TB and SGBV outcomes.
- *Campaign planning and implementation will involve a diverse team:* Campaign planning and implementation must involve members of the targeted audience, skilled communicators, content experts (programme managers and coordinators) and researchers. Plans will be informed by the target audience through consultations, focus group discussions, surveys, media preferences of the audience and field-testing of messages and images. The national campaigns will be adapted by local communicators to local areas informed by local audiences, the local social and behavioural drivers, and service utilisation levels.
- *Toll free lines:* The government funds several toll-free lines, including the 24-hour AIDS Helpline, Child Line, Legal Aid Advice and the Stop SGBV Helpline that are advertised as a point of referral for services. However, these lines are only accessible if the user phones from a Telkom line. To increase access and given the coverage, calls from mobile phones calls also need to be free.
- *Institute a national SBCC coordinating mechanism to coordinate the SBCC response in line with the goals of the NSP:* establish a national SBCC task team, comprising of officials from relevant national departments, provinces, civil society, and the private sector. The purpose of the National SBCC Task Team will be to share implementation plans, agree on priorities, provide key messages for advocacy, and disseminate lessons learnt and emerging practices.

- *Increase leadership capacity for SBCC:* Political, social, private sector and civil society leaders will be identified and engaged and their capacity built to become effective SBCC advocates and champions of the goals of the NSP.

***Priority SBCC campaigns in support of the NSP goals for 2017-2022 include:***

- The She Conquers campaign for adolescent and young women and their sex partners, including DREAMS.
- National and local youth training, access to jobs and poverty alleviation.
- Substance abuse and GBV.
- For PLHIV sector and key populations, the elimination of stigma and discrimination, including a decrease in human rights violations.
- Adherence to HIV and TB treatment to achieve the 90-90-90 targets
- Public awareness of AIDS Councils (which is low and needs to be increased).

***There will be responsibility for organisation and co-ordination of SBCC will be at the national and provincial/local level***

*The National level will*

- Evaluate existing SBCC interventions and determine a baseline to measure impact
- Develop a coordinated national campaign, which supports all the NSP goals to increase national efficiency, effectiveness and cost effectiveness;
- Prescribe sustained interventions focussed on achieving the goals and objectives of the NSP 2017-2022;
- Ensure that services/commodities are available at local level to ensure that uptake and service delivery is not affected.
- Develop community capacity to address HIV, TB and STIs, its drivers and impacts

*The provincial / local level will*

- Engage people who have influence in local communities
- Create an enabling environment that allows people to take action through advocacy
- Establish community based coordinating structures, such as the War Rooms established under Operation Sukuma Sakhe in KwaZulu-Natal, in each community, with a priority focus on high prevalence districts
- Train Community Health Care Workers and Community Care Givers to undertake household health and social wellbeing assessments, with referral to integrated SRHR/HIV/TB and SGBV services.

***Research, monitoring and evaluation of SBCC will include:***

- Analysis of epidemiological data to identify populations most at risk, the behavioural, social and structural factors that place people at risk of new HIV/STIs and TB infections, and the barriers to the uptake of health and social services that can reduce these risks or reduce illness and death.
- Undertaking participatory community assessments to identify hotspots

- An analysis of the available local mediums (radio, television and social media) to base the media strategy on.
- Undertaking qualitative and quantitative research to monitor the effectiveness of mass media campaigns and to determine the extent to which different programmes reached their intended audience and their objectives and to inform the design of the next iteration of the campaign.
- Developing a set of exposure variables and mapping programme outcomes for community mobilisation and mass media interventions that can be integrated into national surveillance surveys to measure impact
- Performing impact evaluations to measure the success of the SBCC interventions.

## The way forward: Focusing for impact

In recent decades, South Africa has experienced the devastating effects of HIV and TB. National life expectancy plummeted, millions of children lost one or both parents, households and communities were riven, and local economies suffered.

In 2017, 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 soared, 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 are public health threats in our country.

However, there is another side to the extraordinary hope and optimism generated by the unprecedented national mobilisation and the many scientific breakthroughs we have seen. 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 a 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.