National Strategic Plan

on HIV, STIs and TB

2012 – 2016

REPUBLIC OF SOUTH AFRICA

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SANAC 2011
www.sanac.org.za

National Strategic Plan

on HIV, STIs and TB

2012 – 2016

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ACRONYMS AND ABBREVIATIONS

AEF	Aid Effectiveness Framework
AIDS	Acquired immunodeficiency syndrome
APT	Annual Planning Tool
ART	Antiretroviral therapy
ARV	Antiretroviral
BCG	Bacille Calmette-Guérin
CEDAW	Convention to End Discrimination Against Women
CFR	Case Fatality Rate
CSO	Civil society organisation
DBE	Department of Basic Education
DCOGTA	Department of Cooperative Governance and Traditional Affairs
DCS	Department of Correctional Service
DHET	Department of Higher Education and Training
DHIS	District Health Information System
DOH	Department of Health
DOJ&CD	Department of Justice and Constitutional Development
DPSA	Department of Public Service and Administration
DSD	Department of Social Development
DTI	Department of Trade and Industry
DWCPD	Department of Women, Children and People with Disabilities
EPI	Expanded Programme on Immunisation
ETR.NET	Electronic TB register
GBV	Gender-based violence
HCT	HIV counselling and testing
HIV	Human immunodeficiency virus
HPV	Human papilloma virus
HSV	Herpes simplex virus
ILO	International Labour Organisation
IPT	Isoniazid preventive therapy
KYE	Know your epidemic
KYR	Know your response
M&E	Monitoring and evaluation
MCC	Medicines Control Council
MCWH	Maternal, child and women's health
MDG	Millennium Development Goal
MDR-TB	Multidrug-resistant tuberculosis
MMC	Medical male circumcision
MSM	Men who have sex with men
MTCT	Medium-Term Strategic Framework

MMC	Mother to child transmission
NASA	National Aids Spending Assessment
NCS	National communication survey
NEDLAC	National Economic Development and Labour Council
NIDS	National Indicator Data Set
NSDA	National Service Delivery Agreement
NSP	National Strategic Plan for HIV, STIs and TB
OVC	Orphans and vulnerable children
PCR	Polymerase Chain Reaction
PEP	Post-exposure prophylaxis
PHC	Primary health care
PLHIV	Persons living with HIV
PIC	Programme Implementation Committee of SANAC
PICT	Provider-initiated counselling and testing
PMTCT	Prevention of mother to child transmission of HIV
PrEP	Pre-exposure prophylaxis
SABSSM	South Africa's Population-Based HIV/AIDS Behavioural Risks, Sero-Status, and Mass Media Impact Survey
SACEMA	South African Centre for Epidemiological Modelling and Analysis
SAHRC	South African Human Rights Commission
SALGA	South African Local Government Association
SANAC	South African National AIDS Council
SAPS	South African Police Service
SBCC	Social and behaviour change communication
SES	Socio-economic status
SIGI	Social Institution and Gender Index
SMS	Short Messaging System
SO	Strategic objective
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
SW	Sex Worker
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNICEF	United Nations Children's Fund
WHA	World Health Assembly
WHO	World Health Organization
XDR-TB	Extensively drug-resistant tuberculosis

GLOSSARY OF TERMS[1]

Age-disparate relationships: This refers to relationships in which the age gap between sexual partners is five years or more. The terms 'intergenerational relationships' and 'cross-generation relationships' generally refer to those with a 10-year or greater age disparity between sexual partners.

BCG vaccination: Vaccination with a strain of tubercle bacillus that has lost the power to cause TB.

Behaviour change communication (BCC): Behaviour change communication promotes tailored messages, personal risk assessment, greater dialogue and an increased sense of ownership.

Combination HIV prevention: The combination prevention approach seeks to achieve maximum impact on HIV prevention by combining behavioural, biomedical and structural strategies that are human rights-based and evidence-informed, in the context of a well-researched and understood local epidemic.

Community systems strengthening: This refers to initiatives that contribute to the development and/or strengthening of community-based organisations in order to increase knowledge of and access to improved health service delivery.

Cryptococcal infection: A disease caused by a yeast-like fungus, which attacks the lung. It may spread to the brain, causing meningitis; this may occur as an opportunistic infection in those suffering from AIDS.

Extensively drug-resistant tuberculosis (XDR-TB): In addition to resistance to isoniazid and rifampicin, XDR-TB is also resistant to fluoroquinolones and at least one injectable second-line drug.

Extrapulmonary TB: TB disease in any part of the body other than the lungs, for example, the kidneys or lymph nodes.

Gender equality: Gender equality between men and women means that all human beings, both men and women, are free to develop their personal abilities and make choices without the limitations set by stereotypes, rigid gender roles and prejudices. Gender equality means that the different behaviours, aspirations and needs of women and men are considered, valued and favoured equally. It signifies that there is no discrimination on the grounds of a person's gender in the allocation of resources or benefits, or in access to services.

Health system: A health system consists of all organisations and individuals whose actions are intended to promote, restore or maintain health. A health system involves a broad range of institutions and individuals; their actions help to ensure the efficient and effective delivery and use of products and information for the prevention, treatment, care, and support of people in need of these services.

Human papilloma virus (HPV): a virus that causes warts, including genital warts.

Key populations at higher risk of HIV exposure: Refers to those most likely to be exposed to HIV or to transmit it – their engagement is critical to a successful HIV response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender persons, people who inject drugs, sex workers and their clients, and seronegative partners in serodiscordant couples are at higher risk of exposure to HIV than other people. There is a strong link between various kinds of mobility and heightened risk of HIV exposure, depending on the reason for mobility and the extent to which people are outside their social context and norms.

Men who have sex with men (MSM): The term 'men who have sex with men' describes males who have sex with males, regardless of whether or not they have sex with women or have a personal or social gay or bisexual identity. This description includes men who self-identify as heterosexual but have sex with other men.

Mobile workers/population: This term refers to individuals who may cross borders or move within their own country on a frequent and short-term basis for a variety of work-related reasons, without changing

1 UNAIDS Terminology Guidelines, October 2011.

place of habitual primary residence or home base. Mobile workers are usually in regular or constant transit, sometimes in (regular) circulatory patterns and often spanning two or more countries, away from their habitual or established place of residence for varying periods of time.

Morbidity: The state of being ill or having a disease.

Mortality: An individual's death or decease; loss of life.

Multidrug-resistant tuberculosis (MDR-TB): MDR-TB is a specific form of drug-resistant tuberculosis, due to a bacillus that is resistant to at least isoniazid and rifampicin, the two most powerful anti-tuberculosis drugs.

Post-exposure prophylaxis (PEP): PEP refers to antiretroviral medicines that are taken after exposure or possible exposure to HIV. The exposure may be occupational, as in a needle stick injury, or non-occupational, as in unprotected sex with a person living with HIV.

Pre-exposure prophylaxis (PrEP): PrEP refers to antiretroviral medicines prescribed before exposure or possible exposure to HIV. PrEP strategies under evaluation increasingly involve the addition of a post-exposure dosage.

'Positive health, dignity, and prevention': Previously referred to as 'positive prevention', it encompasses strategies to protect sexual and reproductive health and delay HIV disease progression. It includes individual health promotion, access to HIV and sexual and reproductive health services, community participation, advocacy and policy change.

Prevention of mother-to-child transmission (PMTCT): PMTCT refers to a four-pronged strategy to prevent new HIV infections in children and keep mothers alive and families healthy. The four prongs are: halving HIV incidence in women; reducing the unmet need for family planning; providing antiretroviral prophylaxis to prevent HIV transmission during pregnancy, labour and delivery, and breastfeeding; and providing care, treatment and support for mothers and their families. Some countries prefer to use the term 'vertical transmission' to acknowledge the role of the father/male sexual partner in transmitting HIV to the woman and to encourage male involvement in HIV prevention.

Serodiscordant: Serodiscordant is a term used to describe a couple in which one partner is HIV positive and the other is HIV negative.

Seronegative: Seronegative refers to the absence of the specific antibodies that were being tested for.

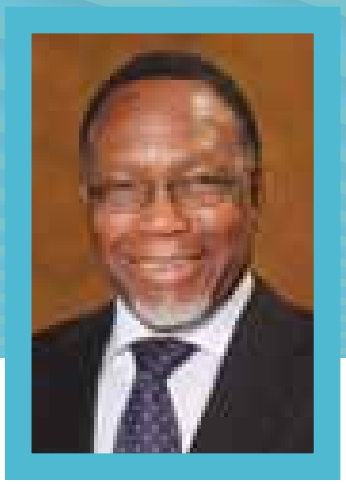
Sexual and reproductive health services: This includes services for family planning; infertility services; prevention of unsafe abortion and post-abortion care; diagnosis and treatment of sexually transmitted infections, including HIV infection, reproductive tract infections, cervical cancer and other gynaecological morbidities; and the promotion of sexual health, including sexuality counselling.

Sexually transmitted infection (STI): STIs are spread by the transfer of organisms from person to person during sexual contact. In addition to the traditional STIs (syphilis and gonorrhoea), the spectrum of STIs also includes: HIV, which causes AIDS; chlamydia trachomatis; human papilloma virus (HPV), which can cause cervical, penile or anal cancer; genital herpes; and cancroid. More than 20 disease-causing organisms and syndromes are now recognised as belonging in this category.

Transgender persons: Transgender persons express a gender identity that is different from their birth sex.

Vertical transmission: Transmission of an infection such as HIV from mother to foetus via the placental circulation.

Women who have sex with women (WSW): It includes not only women who self-identify as lesbian or homosexual and have sex only with other women, but also bisexual women and those who self-identify as heterosexual but who have sex with other women.



PREFACE TO THE NATIONAL STRATEGIC PLAN ON HIV, STIs AND TB 2012 – 2016

DEPUTY PRESIDENT KGALEMA MOTLANTHE

CHAIRPERSON, SOUTH AFRICAN NATIONAL AIDS COUNCIL (SANAC)

The publication of the National Strategic Plan on HIV, Sexually Transmitted Infections (STIs) and Tuberculosis (TB) 2012 – 2016 marks a milestone in our nation's response to the dual epidemics of HIV and TB.

This five-year strategy reflects the progress we have made in achieving a clearer understanding of the challenges posed by these epidemics and the increasing unity of purpose among all the stakeholders, who are driven by a shared vision to attain the highest impact of our policies towards our long-term vision of zero new HIV and TB infections.

Working together, over the past few years we have been able to register some marked progress in a number of critical areas in our response, such as a significant reduction in the vertical transmission of HIV and expanding access to a comprehensive package of HIV, STI and TB services.

For its part, government has expanded its menu of options across the continuum of care from prevention, treatment, care, support and addressing the social drivers of ill health, as well as locating the strategy into the broader development agenda of government.

Our antiretroviral treatment (ART) expansion programme has resulted in an increase in ART facilities countrywide to about 2 552 currently and more people accessing treatment. Our continuous efforts to strengthen our prevention strategies and our programme of medical male circumcision is increasingly bearing fruit in terms of uptake of the programme.

To date, more than 250 000 men have undergone medical male circumcision nationally and we encourage more men to use this service as part of a comprehensive package of prevention. It is also good to note that there is an increase in the number of both male and female condoms being distributed nationally.

The response of South Africans to the call to action through our theme *I am Responsible. We are Responsible, South Africa is Taking Responsibility* has been positive; reaffirming the fact that we are indeed united in our efforts to reduce new infections and to create an environment that is enabling for all.

Fundamentally, we must endeavour to change the perception of our response as an emergency that needs to be controlled and managed to positioning this response as an investment in the health of our people and our new democracy.

Poverty is one of the major contributors to poor health through food insecurity, which in turn is linked to HIV and TB acquisition and poor treatment adherence, so government and its partners will make every effort to ensure food security for all.

Government has already launched an integrated anti-poverty strategy that involves various government departments, which have specific responsibilities to ensure that vulnerable households are identified and supported. Child-headed and youth-headed households are also prioritised to ensure that needs, such as food, shelter and access to health and social services, are fast-tracked.

More importantly, the millennium development goals provide the common global vision to carry out those dedicated actions that will ensure that we meet those and other goals aimed at improving our response mechanisms.

With the present National Strategic Plan for 2012 – 2016, I am confident that we are ready to build on the above achievements. Once again, our strength lies in our unity.

In the next five years our key strategic objectives include:

- addressing social and structural barriers that increase vulnerability to HIV, STI and TB infection
- preventing new HIV, TB and STI infections
- sustaining health and wellness
- increasing the protection of human rights and improving access to justice.

Let us once again join hands as we deepen and strengthen our response and seek innovative ways to sustain our interventions over the short, medium and long term.

Let us also bear in mind that all our efforts contribute to the global vision of an AIDS-free world. This vision is attainable; let us continue to strive towards it! ■

ACKNOWLEDGEMENTS

The implementation of the National Strategic Plan (NSP) on HIV, STIs and TB 2012 – 2016 will be as strong and successful as the partnership that is built around it. Every sector of society, every organisation and every individual has a role to play in its implementation.

In this regard, the process of writing this NSP bodes well for the future and we would like to acknowledge and thank all of those involved in the consultation, research, writing and production of this visionary and life-saving policy. In particular we thank:

- the SANAC sectors, task teams and individuals who contributed more than 100 written submissions
- those who sent in their suggestions and ideas by SMS and other forms of media
- the office bearers of SANAC, particularly the Programme Implementation Committee, and staff of the Department of Health, who guided the process and kept it on track
- staff from other government departments who contributed key insights and ideas
- the Office of the Deputy President and Chairperson of SANAC
- the staff of SANAC, who organised numerous meetings and consultations
- the writing team, who listened carefully to numerous suggestions, guiding the NSP through three drafts
- the international development partner community, including the United Nations agencies, who provided funds and technical expertise to support the consultations and writing process
- provincial AIDS councils who – for the first time – were fully part of the writing process and who have committed to developing provincial strategic implementation plans in line with the NSP.

MARK HEYWOOD
SANAC DEPUTY CHAIRPERSON

1
EXECUTIVE SUMMARY

1.1 INTRODUCTION

The National Strategic Plan (NSP) on HIV, Sexually Transmitted Infections (STIs) and Tuberculosis (TB) (2012 – 2016) NSP is the strategic guide for the national response to HIV, STIs and TB for the next five years. The plan addresses the drivers of the HIV and TB epidemics and builds on the achievements of the previous NSPs to achieve its goals. Interventions that have worked well will be scaled up and the quality of service delivery will be improved, while at the same time proven new interventions will be implemented. Because it is intended to respond to the changes in the HIV and TB epidemics, the NSP will be reviewed periodically for relevance and effectiveness and, when necessary, adjustments will be made.

The NSP aims to inform national, provincial, district and community-level stakeholders on *strategic directions* to be taken into consideration when developing implementation plans. It will also be used by SANAC as the framework to coordinate and monitor implementation by sectors, provinces, districts and municipalities. International development partners will use the NSP to support the country in its efforts to turn the tide with respect to the twin epidemics of HIV and TB.

The NSP is located within the constitutional framework of South Africa and strives towards its ideals of human dignity, non-racialism, non-sexism and the rule of law. The NSP is aligned with the broader development plans of government. These include the Medium-Term Strategic Framework (MTSF) and Programme of Action, which commit to ensuring *A long and healthy life for all South Africans*. The National Planning Commission (NPC) is currently developing a government framework for addressing major developmental challenges, which will both inform the implementation of the NSP and be strengthened by it.

The NSP is aligned with international and regional obligations, commitments and targets related to HIV, STIs and TB.

VISION AND GOALS

The NSP is driven by a long-term vision for the country with respect to the HIV and TB epidemics. It has adapted, as a 20-year vision, the three zeros advocated by the Joint United Nations Programme on HIV and AIDS (UNAIDS). The vision for South Africa is:

- zero new HIV and TB infections
- zero new infections due to vertical transmission
- zero preventable deaths associated with HIV and TB
- zero discrimination associated with HIV and TB.

In line with this 20-year vision, the NSP has the following broad goals:

- reducing new HIV infections by at least 50%, using combination prevention approaches
- initiating at least 80% of eligible patients on antiretroviral treatment (ART), with 70% alive and on treatment five years after initiation
- reducing the number of new TB infections and deaths from TB by 50%
- ensuring an enabling and accessible legal framework that protects and promotes human rights in order to support implementation of the NSP
- reducing self-reported stigma related to HIV and TB by at least 50%.

STRATEGIC OBJECTIVES

The plan has four strategic objectives, which will form the basis of the HIV, STI and TB response. These are:

1. Addressing social and structural barriers to HIV, STI and TB prevention, care and impact
2. Preventing new HIV, STI and TB infections
3. Sustaining health and wellness
4. Increasing the protection of human rights and improving access to justice.

1.2 STRATEGIC OBJECTIVES OF THE NSP 2012 – 2016

THE EPIDEMIOLOGY OF HIV, STIS AND TB

South Africa has a generalised HIV epidemic, which has stabilised over the past four years at a national antenatal prevalence of around 30%. South Africa currently ranks the third highest in the world in terms of the TB burden, with an incidence that has increased by 400% over the past 15 years. There is a wide variation in HIV and TB prevalence across age, race, gender, socio-economic status and geographical location. Whereas STIs such as syphilis have decreased in most provinces over the past 10 years, the prevalence of herpes simplex, which is a co-factor in the acquisition of HIV, is still high in many sectors of the population.

The NSP's goals and strategic objectives are guided by evidence from various reports, including the *Know Your Epidemic* (KYE) report, a situation analysis of TB in the country and other epidemiological studies. These studies identified key populations that are most likely to be exposed to or to transmit HIV and/or TB. For HIV, key populations include young women between the ages of 15 and 24 years; people living close to national roads and in informal settlements; young people not attending school and girls who drop out of school before matriculating; people from low socio-economic groups; uncircumcised men; people with disabilities and mental disorders; sex workers and their clients; people who abuse alcohol and illegal substances; men who have sex with men and transgender individuals.

It is estimated that 80% of the South African population is infected with the TB bacillus; however, not everyone who is infected will progress to active TB disease.[2] Certain populations are at higher risk of TB infection and re-infection, including: healthcare workers; miners; prisoners; prison officers and household contacts of confirmed TB patients. In addition, certain groups are particularly vulnerable to progressing from TB infection to TB disease. These include children; people living with HIV; diabetics; smokers; alcohol and substance users; people who are malnourished or have silicosis; mobile, migrant and refugee populations; and people living and working in poorly ventilated environments. These groups are considered key populations for TB.

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

STRATEGIC ENABLER: COMMUNICATION

Key strategic enablers that underpin the entire NSP, which will determine the success of its implementation, include governance and institutional arrangements; effective communication; monitoring and evaluation (M&E); and research. Effective communication is critical to the successful implementation of the NSP. Social and behavioural change communication is also critical to changing risk behaviour and the social conditions that drive the HIV and TB epidemics, while at the same time supporting a demand for prevention, care and support, and treatment services. A challenge for communication in a hyperendemic country is to reach key populations while still ensuring that the general population is well informed and able to prevent and mitigate the effects of HIV, STIs and TB.

Each of the NSP strategic objectives will require major communication efforts at all levels of implementation.

2 Not all individuals infected with TB will develop active TB (also called TB disease). The risk of developing active TB for HIV-negative individuals is 10% over their lifetime, whereas PLHIV with TB infection have a 10% annual risk of TB disease.

STRATEGIC OBJECTIVE 1:
ADDRESSING SOCIAL AND STRUCTURAL DRIVERS OF HIV, STI AND TB PREVENTION, CARE AND IMPACT

Strategic Objective 1 (SO 1) is focused specifically on addressing the structural, social, economic and behavioural factors that drive the HIV and TB epidemics. The sub-objectives are:

- mainstreaming HIV and TB and its gender- and rights-based dimensions into the core mandates of all government departments[3] and all other sectors of the South African National AIDS Council (SANAC)
- addressing social, cultural, economic and behavioural drivers of HIV, STIs and TB, including the challenges posed by socialisation practices; living in informal settlements, as well as rural and hard-to-reach areas; migration and mobility; and alcohol and substance abuse
- implementing interventions to address gender norms and gender-based violence
- mitigating the impact of HIV, STIs and TB on orphans, vulnerable children and youths
- reducing the vulnerability of young people to HIV infection by retaining them in schools, and increasing access to post-school education and work opportunities
- reducing HIV- and TB-related stigma and discrimination
- strengthening community systems to expand access to services
- supporting efforts aimed at poverty alleviation and enhancing food-security programmes.

STRATEGIC OBJECTIVE 2:
PREVENTING NEW HIV, STI AND TB INFECTIONS

Strategic Objective 2 (SO 2) is focused on primary strategies to prevent sexual and vertical transmission of HIV and STIs, and to prevent TB infection and disease, using a combination of prevention approaches.

Combination prevention is a mix of biomedical, behavioural, social and structural interventions that will have the greatest impact on reducing transmission and mitigating susceptibility and vulnerability to HIV, STIs and TB. Different combinations of interventions will be designed for the different key populations.

The following sub-objectives are included for HIV, STI and TB prevention:

- Maximising opportunities for testing and screening to ensure that everyone in South Africa is tested for HIV and screened for TB at least annually, and appropriately enrolled in wellness and treatment, care and support programmes.
- Increasing access to a package of sexual and reproductive health (SRH) services, including those for people living with HIV and young people, and conducting prevention activities in non-traditional outlets[4]. The package includes medical male circumcision (for adults and neonates), an emphasis on dual protection, the provision of both male and female condoms, the termination of pregnancy and the provision of contraception.
- Reducing transmission of HIV from mother to child to less than 2% at six weeks after birth and less than 5% at 18 months of age by 2016. This includes strengthening the management, leadership and coordination of the prevention of mother to child HIV transmission (PMTCT) programme and ensuring its integration with maternal- and child health programmes. TB screening will be integrated into the PMTCT programme. In addition, screening and treatment of syphilis will be strengthened to eliminate neonatal syphilis.

3 The Department of Public Service and Administration is finalising the '*Guidelines on gender-sensitive and rights-based HIV mainstreaming into public service and administration 2012 – 2016*', which will serve as the guide for all government departments.

4 The provision of traditional circumcision should also include a comprehensive package of sexual and reproductive health services.

- Implementing a comprehensive national social and behavioural change communication strategy with a focus on key populations. This aims to increase the demand and uptake of services, promote healthy behaviours, and address norms and behaviours that put people at risk for HIV, STIs and TB.
- Preparing for the potential implementation of future innovative, scientifically proven HIV, STI and TB prevention strategies, such as pre-exposure prophylaxis (PrEP), new TB vaccines and microbicides.
- Preventing TB infection and disease through intensified TB case finding, TB infection control, workplace/occupational health policies on TB and HIV, isoniazid preventive therapy (IPT), immunisation, prevention of multidrug-resistant TB (MDR-TB), and reducing TB-related stigma, alcohol consumption and smoking.
- Addressing sexual abuse and improving services for survivors of sexual assault.

STRATEGIC OBJECTIVE 3:
SUSTAINING HEALTH AND WELLNESS

The primary focus of Strategic Objective 3 (SO 3) is to achieve significant reduction in deaths and disability as a result of HIV and TB. This will be accomplished by universal access to affordable and good quality diagnosis, treatment and care.

The sub-objectives of SO 3 are:

- Reducing disability and death resulting from HIV and TB. This includes annual testing/screening for HIV and TB, particularly for key populations; improved contact tracing; early diagnosis and rapid enrolment into treatment; increased access to high-quality drugs; improved access to treatment for children, adolescents and youth; early initiation of all HIV-positive TB patients on ART; strengthened implementation of a patient-centred pre-ART package; early referral of all patients with complications; appropriate screening and treatment for cryptococcal infection; and strengthened screening and treatment of pregnant women for syphilis.
- Ensuring that people living with HIV and TB remain within the healthcare system, are adherent to treatment and maintain optimal health. The means to achieve this include the establishment of ward-based public healthcare (PHC) teams and regular communication using all appropriate media.
- Ensuring that systems and services remain responsive to the needs of people living with HIV and TB. This includes integrating HIV and TB care with an efficient chronic-care delivery system; expanding of operating hours of service delivery points; ensuring a continuum of care across service delivery points; strengthening quality standards; and adequate monitoring of drug resistance.

STRATEGIC OBJECTIVE 4:
ENSURING PROTECTION OF HUMAN RIGHTS AND IMPROVING ACCESS TO JUSTICE

South Africa's response to HIV, STIs and TB is based on the understanding that the public interest is best served when the rights of those living with HIV, STIs and/or TB are respected, protected and promoted. The NSP 2012 – 2016 recognises the need to continuously assess barriers to access to services and instances of stigma and discrimination and provides the framework for addressing such issues.

It aims to ensure that rights are not violated when interventions are implemented, and that discrimination on the basis of HIV and TB is not only reduced, but ultimately eliminated.

It has the following sub-objectives:

- ensuring that rights are not violated when the interventions under the other three strategic objectives are implemented, and that functioning mechanisms for monitoring abuses and vindicating rights are established

- reducing HIV and TB discrimination, especially in the workplace
- reducing unfair discrimination in access to social services.

Targeted interventions, which are identified in respect of each of these sub-objectives, may have to be implemented in different spheres or levels. In respect of government entities, this may be at the national, provincial and/or local sphere of government. In respect of civil society, business, private sector and non-governmental sectors, this may be at a sectoral, organisational and/or community level.

1.3 GOVERNANCE AND INSTITUTIONAL ARRANGEMENTS

NSP implementation will be coordinated through revised governance structures and strengthened secretariat services. The aim is to have a broad, appropriate and consistent representation through amended structures with increased accountability and responsibility at all levels of implementation and coordination. A review team convened by the Deputy President will make recommendations on future governance and institutional arrangements in February 2012.

The guiding principles that will underpin the revised structures will include:

- access to relevant information
- "bottom-up" governance
- accountability and responsibility
- reporting
- transparency
- meaningful involvement of people living with HIV and TB.

To support the implementation of the revised governance and institutional arrangements, comprehensive policies and guidelines will be established and rolled out, with training being given at all levels. A capacity-strengthening strategy will also be put in place to ensure that the required skills at all levels of coordination are in place.

1.4 MONITORING AND EVALUATION

The NSP highlights the key aspects towards building and operationalising of a comprehensive M&E system for monitoring the NSP. A detailed M&E framework for monitoring the NSP will be developed by SANAC by 1 April 2012 and made available on the SANAC website *www.sanac.org.za*.

The framework takes into account existing M&E systems being implemented by different stakeholders, as well as planning and monitoring frameworks and policies in government.

The M&E framework seeks to:

- monitoring the HIV and TB epidemics, as well as STIs, focusing on incidence, prevalence, morbidity and mortality
- building an M&E system for the NSP that strengthens existing systems, and incorporates systems for community-based monitoring and reporting
- monitoring implementation of the NSP and report periodically on its implementation
- developing and implement an evaluation agenda for the NSP.

A strengthened M&E Unit within the SANAC Secretariat will be responsible for implementing the M&E framework at national level. The M&E units in the provincial AIDS councils and sectors will assume the same responsibility at provincial and sectoral levels to ensure continuous feedback of relevant and accurate information.

CORE INDICATORS

The overall impact of the NSP implementation will be measured through the following impact indicators:

- percentage of young women and men aged 15–24 years who are HIV-positive
- percentage of key populations who are HIV-positive
- number and percentage of HIV-exposed infants testing HIV-positive at six weeks and 18 months post-partum
- prevalence and incidence of TB
- percentage of adult mortality due to HIV and TB
- trends of stigma
- retention on ART.

MIDTERM AND END-OF-TERM EVALUATIONS

Midterm and end-of-term evaluations of the NSP will be conducted. The midterm evaluation will focus on achievements, challenges, emerging issues and recommendations for the remaining term of the NSP, and will take place in 2014. In addition, an end-of-term evaluation will be conducted. Independent researchers will conduct both evaluations.

1.5 RESEARCH

The main goal of research on HIV, STIs and TB in South Africa is to provide scientific evidence to guide and enhance the country's response.

The NSP provides an overall approach to the research agenda, rather than listing individual research topics. Four main streams of research are presented as the basis for generating the knowledge needed to support the goals of the NSP. These are:

- surveillance and vital statistics
- health systems and operations research
- research for innovation
- policy, and social and public health research.

South African research on HIV, STIs and TB is widely recognised as being world-class; however, much of the current research done by South African researchers is determined by the agendas of international donor agencies that provide the bulk of research funding. Therefore a new approach and the following four steps are proposed:

- researchers and policy-makers must commit jointly to an evidence-based approach and a common understanding of the country's HIV, STI and TB response
- regular interaction must occur between researchers, policy-makers and the leaders of public-health programmes to ensure that the HIV, STI and TB policies and programmes take account of the latest science
- a national research agenda needs to be developed on the basis of detailed knowledge of the burden of disease
- local funding of HIV, STI and TB research must increase substantially.

1.6 COSTING AND FINANCING THE NSP 2012 – 2016

The NSP has been designed to indicate broad goals and objectives for the country's response to HIV, STIs and TB. Because the NSP is strategic in nature, costing at this stage can provide only an estimate of the likely magnitude of the costs.

An updated and adjusted version of the Resource Needs Model from the 'AIDS 2031' costing, and the National ART Cost Model and National TB Cost Model have been used to provide broad estimates of the cost of the NSP. These models allowed for costing interventions in SO 1, 2 and 3. Primary costing was needed for the new interventions in SO 4. There were some interventions and strategies for which no costing was possible at this stage. However, the costing summary does cover all known key cost drivers of the NSP.

The table below provides a summary of the total costs over the five years.

TABLE 1: *SUMMARY OF TOTAL COSTS OF THE NSP OVER THE FIVE YEARS*

ANNUAL COSTS BY STRATEGIC OBJECTIVE IN R'BILLION					
Period	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**
Strategic Objective 1	1 227,41	1 400,02	1 574,88	1 750,31	1 929,56
Strategic Objective 2	4 131,16	5 550,40	6 519,20	7 953,18	9 352,78
Strategic Objective 3	13 336,73	16 455,42	18 515,30	19 951,94	20 946,09
Strategic Objective 4	32,46	25,93	19,08	19,08	19,08
TOTAL	**18 727,76**	**23 431,77**	**26 628,46**	**29 674,50**	**32 247,50**

Once the provinces have developed measurable implementation plans, the costing of these plans will be undertaken and completed by March 2012. A results-based costing tool will link the resource needs estimates to their intended outputs and results. This will enable the provinces to track their expenditure and ultimately to ensure that their spending achieves their overall goals. SANAC will also have an over-arching tool to track implementation and expenditure.

SUSTAINABLE FINANCING OF THE NSP

While the NSP is not a strategy of the health department, the majority of the directly attributable costs are incurred within the health sector. While donor funding will be important for many of the interventions outlined by the NSP, domestic funding for health services will be key to long-term sustainability. In this regard, the national commitment to increasing public funding of health services and the radical reforms envisaged by National Health Insurance are intended to improve equity in access to quality healthcare. ■

2
INTRODUCTION

The NSP 2012 – 2016 is the culmination of extensive consultation and deliberation over several months with a wide range of stakeholders. This involved a review of achievements against the goals and objectives in the previous NSP (2007 – 2011) using reports and other documentation. These processes were key to determining the strategic priorities and the appropriate way forward in dealing with the dual epidemics of HIV and TB in South Africa.

SANAC provided the overall guidance and framework for the NSP. The Programme Implementation Committee and the Plenary Committee of SANAC played an important role in this process. One of the key decisions is the development of a single integrated strategy for HIV, STIs and TB for 2012 – 2016. This is due primarily to the high HIV and TB co-infection rate.

The NSP 2012 – 2016 will provide strategic guidance for HIV, STI and TB activities for the next five years. It focuses on the drivers of the HIV and TB epidemics to achieve the goals defined below. It builds on the achievements of the previous NSPs, scaling up what has been done well, and improving the quality of services, while at the same time integrating new and proven strategies. As such, it does not repeat many of the interventions that are now considered to be part of the routine package of services for HIV and TB prevention, care and treatment (e.g. home-based care and support groups). The NSP is intended to respond to the rapid changes in the epidemics and will therefore be reviewed regularly for relevance and effectiveness. It is located within the broader development plan of government.

The NSP is a multi-sectoral, overarching guide that will inform national, provincial, municipal and community-level stakeholders about the *strategic directions* to be considered when developing implementation plans. It will also be used by SANAC as the framework for coordinating and monitoring the implementation of the plan. Every national and provincial government department, municipality and sector will develop implementation plans by March 2012, in line with the NSP.

Past successes that guide this NSP include:

- the renewed engagement and high-level political leadership spearheading the HIV response, as well as the growing cooperation between government and its partners
- the strong policies that were developed and implemented to deal with the HIV and TB epidemics
- the scaling up and strengthening of the programme to prevent PMTCT of HIV, which resulted in the reduction in HIV-transmission at six weeks post-birth
- the increase in the number of people testing for HIV
- the initiation of 1,4 million[5] people on ART since the programme began in December 2003
- the introduction and scaling up of medical male circumcision services as part of male sexual and reproductive health
- the rapid scaling up of accelerated TB and MDR-TB diagnosis, improving TB case detection, and good adherence to TB treatment and ART
- improving TB cure rates and a decreasing defaulter rate
- the commitment to focus on the drivers of the HIV and TB epidemics and measures to address the social determinants of health
- the large number of eligible orphans and vulnerable children, among others, who have access to social security services
- the increase in the number of learners who have access to education, particularly girls
- the provision of HIV life-skills education in all schools and grades, as a compulsory part of the education curricula
- the reduction in prices for key commodities, including antiretroviral drugs (ARVs) and TB drugs, which enabled the further expansion of access to treatment.

5 By 1 April 2011.

This NSP will also address some of the challenges identified in the previous NSP, such as:

- inadequate coordination of the public, private and non-government sector responses
- the weak governance and coordination structures of SANAC (from ward to national level)
- the lack of robust monitoring and evaluation of the NSP
- the failure to ensure a truly multi-sectoral and integrated response
- a weak focus on human rights and justice
- the lack of a comprehensive and integrated approach to HIV and TB prevention.

2.1 NSP VISION

The NSP 2012 – 2016 is driven by a long-term vision for the country with respect to the HIV and TB epidemics. It has adapted the three zeros advocated by UNAIDS to suit the local context. The South African vision is:

- zero new HIV and TB infections
- zero new infections due to vertical transmission
- zero preventable deaths associated with HIV and TB
- zero discrimination associated with HIV, STIs and TB.

2.2 NSP GOALS

In line with this 20-year vision, the NSP has the following broad goals:

- reducing new HIV infections by at least 50% using combination prevention approaches
- initiating at least 80% of eligible patients on ART, with 70% alive and on treatment five years after initiation
- reducing the number of new TB infections, as well as the number of TB deaths by 50%
- ensuring an enabling and accessible legal framework that protects and promotes human rights in order to support implementation of the NSP
- reducing self-reported stigma and discrimination related to HIV and TB by 50%.

2.3 NSP PRINCIPLES

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

- **Long-term focused and vision led** – All initiatives should be clearly linked to the vision of the NSP and must be able to demonstrate how they contribute to the achievement of that vision.
- **High impact and scalable** – Preference should be given in planning and implementation to high-value, high-impact and scalable initiatives.
- **Evidence-based** – Initiatives should be based upon evidence and implementation should focus on the achievement of well-formulated objectives and targets. In instances in which there is a lack of good evidence, a clear motivation should be given to supporting the prioritisation of the intervention, e.g. rights-based arguments.
- **Flexible** – The NSP needs to be flexible to ensure that changes can be made quickly when evidence or contexts demand flexibility.

- **Multi-sectoral** – It is only through combining the resources of all sectors of society that the NSP goals and objectives can be achieved, especially at local level where a community-centred integrated approach is critical.
- **Partnership and country ownership** – The NSP must promote true partnerships at all levels and country ownership through empowerment, communication and coordination.
- **Rights-based** – The NSP must be rooted firmly in the protection and promotion of human and legal rights, including prioritising gender equality and gender rights.

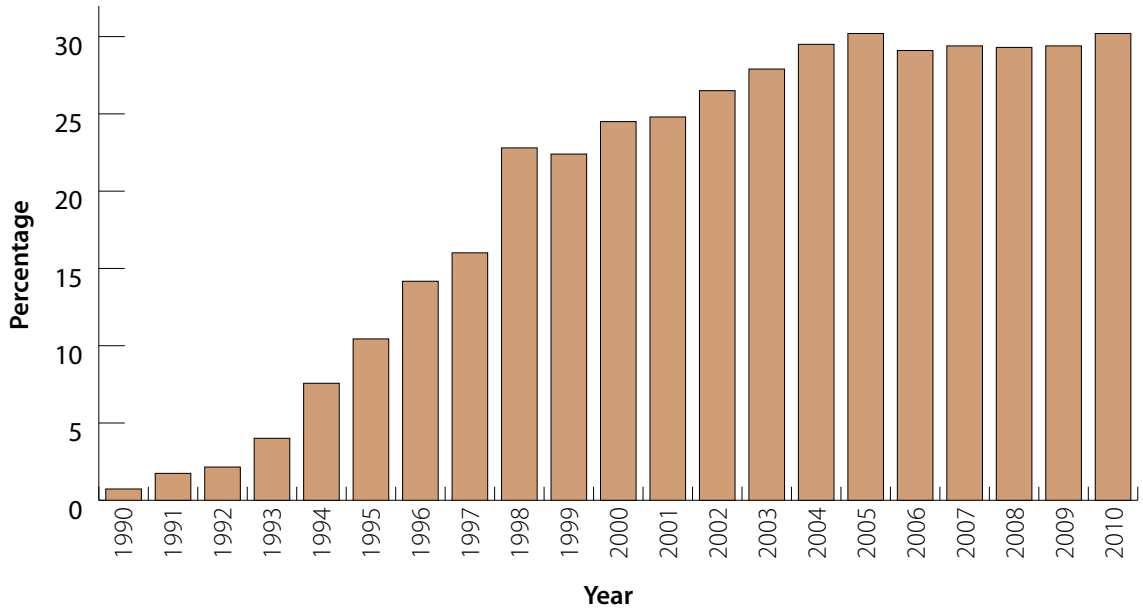
2.4 EPIDEMIOLOGY OF HIV AND TB

2.4.1 THE HIV EPIDEMIC

An understanding of the HIV epidemic and its key drivers is fundamental in guiding the NSP. The HIV interventions proposed in this NSP are guided by the findings of the KYE report[6] and other analyses, which identified the key determinants of the HIV epidemic in South Africa. These include behavioural, social and biological factors – as well as underlying structural and societal factors, such as poverty, gender inequalities, human rights abuse and migrant labour.

A review of the evidence shows that the HIV prevalence in pregnant women attending public sector clinics is stabilising, albeit at a very high level of around 30% (see Figure 1). However, there is marked heterogeneity in HIV prevalence by key epidemiological variables, such as age, race, gender, geographical location and socio-economic status, which reflect differentials in exposure to risk of infection.

FIGURE 1: *ANTENATAL HIV SEROPREVALENCE RATES, 1990 – 2010*



South Africa has a generalised HIV epidemic driven largely by sexual transmission. Using the Spectrum model, the 2009 HIV prevalence in the adult population (aged 15–49) was estimated to be 17,8%. An estimated 5,63 million adults and children were living with HIV in 2009. Of these, 5,3 million were adults aged 15 years and older, 3,3 million were females and 334 000 were children.[7]

The following box highlights key determinants of the HIV epidemic in South Africa based on the report and other analyses, and highlights actions that will mitigate the impact of the epidemic.

6 '*Know your Epidemic*' Synthesis Report, 2011.

7 Department of Health, 2010. National Antenatal Sentinet HIV and Syphilis Prevalence Survey in South Africa, 2009.

RECOMMENDED ACTION ON BEHAVIOURAL AND SOCIAL DETERMINANTS

Sexual debut – Tailored prevention interventions for the youth to facilitate the delay of sexual debut and sustain protective behaviours.

Multiple sexual partners – Multi-level interventions that focus on sexual, social, cultural and gender norms and values.

Condom use – Increase consistent use, especially among key populations, including those involved in sex work.

Age-disparate sexual (intergenerational) relationships – Target prevention strategies at those men and women who have partners much younger/older than themselves, given that significant age discrepancy increases HIV-exposure risk compared to people who reported partners of similar age.

Alcohol and substance abuse – Interventions to decrease alcohol abuse and other substance abuse, including illegal substances.

Prevention knowledge and risk perception – Prevention strategies for people who expose themselves to the risk of HIV infection, including education and addressing perceptions of personal risk.

BIOLOGICAL DETERMINANTS

Mother-to-child transmission – Strengthen the implementation of the four prongs of the PMTCT programme.

Medical male circumcision – Continue with large-scale rollout of a national medical male circumcision programme as part of a package of sexual and reproductive health services, which includes gender sensitisation.

Other sexually transmitted infections – Prevention and early treatment of STIs.

Treatment as prevention – Initiating all eligible people living with HIV to treatment according to national guidelines to improve their health outcomes and to reduce transmission.

STRUCTURAL DETERMINANTS

Mobility and migration – The risk of HIV infection is higher among individuals who either have personal migration experience or have sexual partners who are migrants and, therefore, appropriately targeted interventions are required.

Gender roles and norms – Challenge the gender roles, norms and inequalities that increase women's vulnerability to HIV and compromise men's and women's health; address the position of women in society, particularly their economic standing; and engage with men on changing socialisation practices.

Sexual abuse and intimate partner violence – Implement interventions to prevent gender-based violence, as well as intimate partner violence, and educate men about women's rights.

While the rates of syphilis have decreased in most provinces over the past 10 years, the prevalence of the herpes simplex virus (HSV), which is a co-factor in the acquisition of HIV, is still high. Early infection with HSV in young women results in cancer of the cervix in the longer term. Trichomonas vaginalis and bacterial vaginosis, both of which are associated with HIV, are common infections in women.

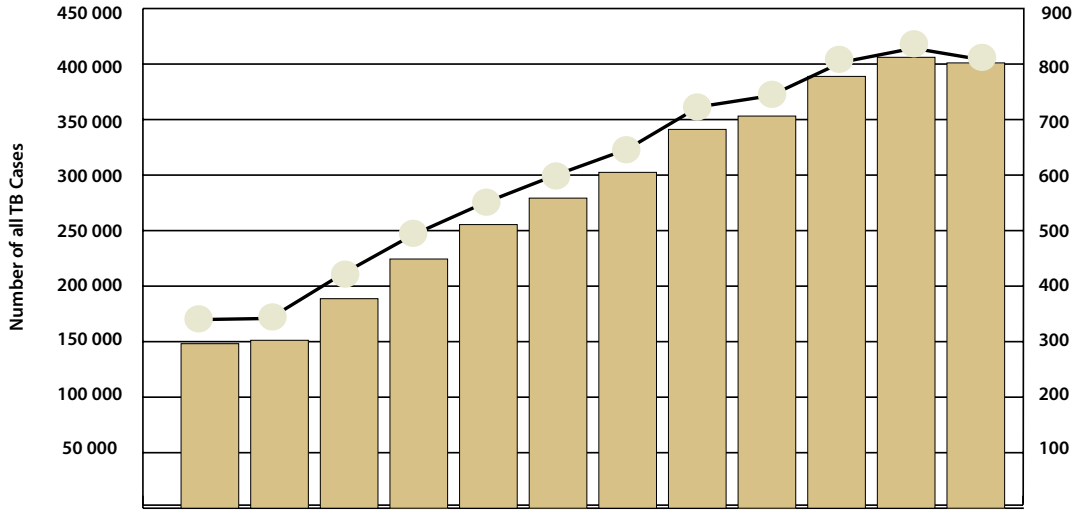
2.4.2 THE TB EPIDEMIC

According to World Health Organization (WHO) estimates[8], South Africa ranks the third highest in the world in terms of TB burden (0,4–0,59 million), after India (2,0–2,5 million) and China (0,9–1,2 million). HIV is fuelling the TB epidemic with more than 70% of TB patients also living with HIV.

Approximately 1% of the South African population develops TB disease every year. The number of cases detected for all forms of TB has steadily increased from 148 164 in 2004 to 401 048 in 2010 (Figure 2). The number of new smear-positive cases has remained stable during the same period. The highest prevalence of latent TB infection, estimated at 88%, occurred among people in age group 30–39 years in township situations and informal settlements. This underscores the fact that TB is a disease of poverty. Township and informal settlement conditions are characterised by overcrowding and low socio-economic status, all of which provide fertile ground for TB infection and disease.

The TB epidemic is further compounded by MDR-TB, with almost 7 386 laboratory confirmed MDR-TB cases and 741 confirmed cases of extensively drug-resistant TB (XDR-TB) in 2010.

FIGURE 2: *NUMBER OF CASES NOTIFIED AND THE INCIDENCE RATE OF ALL TB CASES, 1999 – 2010*



	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Cases	148,16	151,23	188,69	224,42	255,42	279,26	302,46	341,16	353,87	388,88	406,08	401,04
Incidence Rate	344,1	346,2	423,5	493,7	550,1	599,4	645,1	719,9	739,5	798,7	823,4	802,2

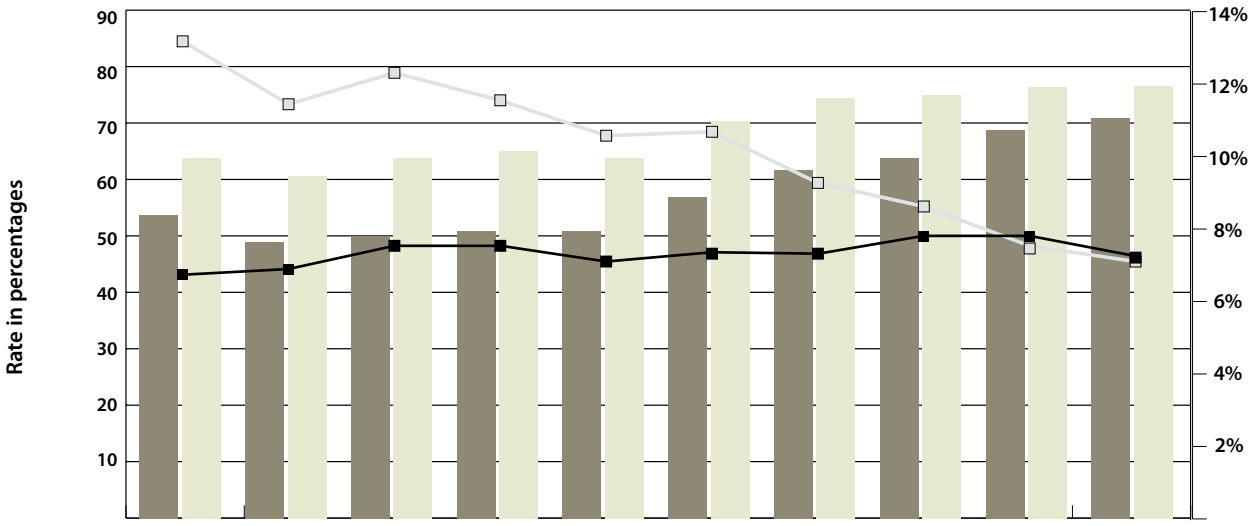
TB screening among people living with HIV is around 80%. Of those who screened negative for TB, 38% were initiated on IPT.[9] However, late initiation of ART in TB patients has contributed to high levels of mortality.

Among the important outcomes, the TB cure rate has been improving over the years from 54% in 2000 to 71,1% in 2009 (Figure 3). The corresponding treatment success rate of new infectious TB cases was 77,1% in 2009. This is still below the global target of >85%.

8 2011. WHO Report. Global Tuberculosis Control.

9 2011 NDOH Programme Data.

FIGURE 3: *TREATMENT OUTCOMES OF NEW TB CASES 2000 – 2009*



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Cure rate	53,8%	49,7%	50%	50,9%	50,8%	57,6%	62,9%	64%	67.5%	71,1%
Success rate	63%	60.5%	63%	65,5%	62,9%	70,8%	73,8%	73,9%	76,4%	77,1%
Mortality rate	6,5%	6,7%	7,5%	7,5%	7,1%	7,3%	7,3%	7,8%	7,8%	7,2%
Defaulter rate	12,7%	11,1%	11,9%	11,2%	10,3%	10,4%	9,1%	8,5%	7,5%	7,1%

2.5 KEY POPULATIONS FOR THE HIV AND TB RESPONSE

The term 'key populations' refers to those most likely to be exposed to, or to transmit, HIV and/or TB. As a result, their engagement is critical to a successful HIV and TB response. Key populations include those who lack access to services, and for whom the risk of HIV infection and TB infection is also driven by inadequate protection of human rights, and by prejudice.

Even though South Africa has a generalised HIV epidemic, with some of the highest rates of TB infection and disease burden in the world, there are still higher levels of infection and transmission within certain geographic areas, as well as among some key populations. Although the NSP promotes a broad framework for addressing HIV, STIs and TB at a general population level, it also identifies key populations that should be targeted for specific prevention, care, treatment and support interventions based on risk and need.

The identification of key populations for targeted interventions should be included in all implementation plans.

The KYE report highlights the areas where the epidemic seems to be concentrated, and some of the major risk factors for HIV infection – this shows a definite overlap with the global list of key populations. In the context of the NSP, key populations that are at higher risk for HIV infection include:

- **Young women between the ages of 15 and 24** years are four times more likely to have HIV than males of the same age. (This risk is especially high among pregnant women between 15 and 24 years, and survivors of physical and/or intimate partner violence.) On average, young females become HIV-positive about five years earlier than males.
- **People living or working along national roads and highways.**
- **People living in informal settlements** in urban areas have the highest prevalence of the four residential types.[10]

10 Urban formal, urban informal, rural formal, and rural informal.

- **Migrant populations.** The conditions associated with migration increases the risk of acquiring HIV. Approximately 3% of people living in South Africa are estimated to be cross-border migrants.
- **Young people who are not attending school.** Completing secondary schooling is protective against HIV, especially for young girls. In addition, men and women with tertiary education are significantly less likely to be HIV-positive than those without tertiary education.
- **People with the lowest socio-economic status** are associated with HIV infection. Those **who work in the informal sector** have the highest HIV prevalence, with almost a third of African informal workers being HIV-positive. Among women, those with less disposable income have a higher risk of being HIV-positive.
- **Uncircumcised men.** Men who reported having been circumcised were significantly less likely to be HIV-positive. The protective factor of circumcision is higher for those circumcised *before* their first sexual encounter.
- **People with disabilities** have higher rates of HIV. Attention should be paid to the different types of disability, as the vulnerabilities of different groups and the associated interventions required will vary.
- **Men who have sex with men (MSM)** are at higher risk of acquiring HIV than heterosexual males of the same age, with older men (>30 years) having the highest prevalence.[11] [12] It is estimated that 9,2% of new HIV infections are related to MSM.[13]
- **Sex workers and their clients** have a high HIV prevalence, with estimates among sex workers varying from 34–69%.[14] It is estimated that 19.8% of all new HIV infections are related to sex work.
- **People who use illegal substances, especially those who inject drugs** are at higher risk of acquiring and transmitting HIV. There is a large and growing problem with crack cocaine and tik, especially among young people and sex workers, highlighting the need to consider scaling-up programmes to reduce substance abuse, and harm reduction programmes. Research shows that of injecting drug users, 65% practise unsafe sex.[15]
- **Alcohol abuse** is a major risk factor for HIV acquisition and transmission. Heavy drinking is associated with decreased condom use, and an increase in multiple and concurrent sexual partners. Data from several studies[16] indicate that people who drink alcohol are more likely to be HIV-positive. This figure is higher among heavy drinkers. It is also a major impediment to treatment adherence. Strategies should address male gender norms that equate alcohol use with masculinity.
- **Transgender persons** are at higher risk of being HIV-positive. Owing to lack of knowledge and understanding of this community, and because of stigma, this population is often at risk for sexual abuse and marginalised from accessing prevention, care and treatment services.
- **Orphans and other vulnerable children and youth** are another key population for whom specific interventions will be implemented as primary prevention for HIV, as well as to mitigate impact and to break the cycle of ongoing vulnerability and infection.

There are also substantial geographic differences in HIV incidence, and thus local KYE assessments are needed to ensure appropriate targeting of transmission hotspots and key populations, and must form part of provincial and sector plans.

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

12 Shisana, O, 2009.

13 Welte, A, 2010 (22 March 2010).

14 Leggett, T, 2008; Parry, C, 2008; Van Loggerenberg, F, 2008; Dunkle, KL, 2005; Williams, ML, 2003; Rees, H, 2000.

15 Parry, C, 2008; Medical Research Council.

16 Kiene, SM, 2006; Fisher, LB 2007; Baliunas, DO & Rehm, J, 2009; Shuper, 2009; Townsend, 2010; Friedman, 2006.

Up to 80% of the South African population is infected with the TB bacillus[17], but certain populations are at higher risk of TB infection. These high-risk groups include health care workers, mine workers, prisoners, prison officers and household contacts of confirmed TB cases. In addition, certain groups have a greater chance of progressing from TB infection to TB disease. These include children, people living with HIV, diabetics, smokers, people with silicosis, alcohol and substance abusers and people who are malnourished. However, little research has been done to quantify the contribution of the various risk factors to the TB burden in South Africa in the same way as the KYE studies have done for HIV. This will be addressed in this NSP (i.e., a KYE for TB).

Similar to HIV, certain groups are considered key populations for TB. Taking the risk of TB infection, the risk of progression from infection to TB disease and poor access to services into account, the following groups should be prioritised for TB services:

- **household contacts** of confirmed TB cases, including infants and young children
- **healthcare workers, mine workers, correctional services staff and inmates**
- **children and adults living with HIV**
- **diabetics and people who are malnourished**
- **smokers, drug users and alcohol abusers**
- **mobile, migrant and refugee populations**
- people living and working in **poorly ventilated** and **overcrowded** environments, including those who live in informal settlements.

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

2.6 NSP STRATEGIC OBJECTIVES

The following four strategic objectives will form the basis of the collective South African HIV, STI and TB response that will in turn provide the impetus for achieving the 20-year vision:

- addressing social and structural barriers to HIV and TB prevention, care and treatment – the primary objective is to address societal norms and behaviours through structural interventions to reduce vulnerability to and to mitigate the impacts of HIV and TB
- preventing new HIV, STI and TB Infections – the primary objective is to ensure a multi-pronged approach to HIV, STI and TB prevention which includes all biomedical, behavioural, social and structural approaches in order to reduce new HIV, STI and TB infections
- sustaining health and wellness – the primary objective is to ensure access to quality treatment, care and support services for those with HIV, STIs and/or TB and to develop programmes to focus on wellness, inclusive of both physical and mental health
- ensuring protection of human rights and increase access to justice – the primary objective is to address issues of stigma, discrimination, human rights violations and gender inequality.

The following chapters provide more detail on how these objectives will be achieved. This NSP provides strategic direction to scale-up the response to HIV and TB. In summary, these responses can be categorised as: those that ***increase coverage***; those that ***improve quality***; ***new combinations*** of interventions which take into account the specific nature of the epidemics in different provinces and within different municipalities; and those interventions that are ***novel***.

17 Latent infection. Not everyone infected with the TB bacillus will develop TB disease.

2.7 NSP AND NATIONAL, REGIONAL AND INTERNATIONAL OBLIGATIONS

The NSP 2012 – 2016 aims to align and be consistent with national, regional and international obligations, commitments and targets, which include:

- the Constitution of South Africa
- universal access to comprehensive prevention programmes, treatment, care and support
- the Millennium Declaration and the millennium development goals (MDGs)
- United Nations (UN) General Assembly Special Session (UNGASS) Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS, June 2011
- UNAIDS 2011 – 2015 Strategy: Getting to Zero
- WHO Health Strategy for HIV and AIDS 2011 – 2015
- World Health Assembly (WHA) Resolutions on TB Control (WHA 60.19; WHA 58.14. and WHA 62.15)
- the Stop TB Strategy and the Stop TB Partnership's Global Plan to Stop TB 2006 – 2015
- Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV 2010 – 2014
- African Union commitments
- Southern African Development Community commitments
- international human rights agreements that South Africa has ratified
- international trade agreements
- International Labour Organisation (ILO) Recommendation on HIV and AIDS and the World of Work, 2010
- Joint WHO-ILO-UNAIDS policy guidelines on Improving Health Workers' Access to HIV and TB Prevention, Treatment, Care and Support Services
- International Conference on Population and Development, 1994
- Convention to End Discrimination Against Women (CEDAW)
- Beijing Platform of Action
- UN Convention on Persons with Disabilities.

2.8 NSP IMPLEMENTATION

The NSP will guide all stakeholders in the development of implementation plans that will reflect their specific contributions to the achievement of the NSP. These plans will be costed and resources mobilised to support its implementation.

A national framework will provide guidance to all sectors and provinces to develop and cost implementation plans. ■

3 GOVERNMENT'S DEVELOPMENT AGENDA AND HIV, STIs AND TB

The need to respond to HIV has been a priority for almost three decades. Over time, various conceptual shifts have influenced the characteristics of the response. Initially, the primary interventions were driven through mass information and communication campaigns, backed up by a narrow biomedical focus. This was soon followed by a focus on behavioural aspects, including cultural issues that were identified as risks for HIV acquisition, such as gender norms and resultant gender inequalities. Interventions shifted to behavioural change, with a strong focus on placing the onus on individuals to adopt healthy practices supported by available biomedical interventions.

Recognition of the limitations of the biomedical and behavioural paradigms emerged when the concept of the social determinants of ill health became better understood, leading to the established and accepted paradigm of also conceptualising HIV and TB as a development challenge. Such a developmental concept recognises the socio-economic context in which these epidemics occur and the inter-relatedness of HIV and TB with other development concerns, such as gender inequality, poverty, unemployment, inequity, lack of access to basic services and lack of social cohesion.

Almost from the beginning, HIV has also been understood as a human rights issue – the denial of human rights increases the risk of HIV infection, and HIV infection increases the risk of human rights violations. It is for this reason that a human-rights approach has been a core principle of the response to HIV.

A strategic approach to the development of the NSP requires a broad understanding of national planning frameworks and priorities. This is because there is a dynamic relationship between the HIV and TB epidemics and development issues. One the one hand, HIV is a chronic, lifelong condition requiring lifelong interventions and, on the other hand, the magnitude of the South African HIV and TB epidemics and the cost of the associated burden of disease may undermine some of the objectives that are articulated in the various national planning frameworks. Moreover, some of the national planning frameworks present unique opportunities to address the social drivers of the epidemic, thus decreasing the burden on the overstretched health system and making it possible for the state to achieve its development goals.

DEVELOPMENT AND THE CONSTITUTIONAL FRAMEWORK

The founding provisions of the Constitution provide the framework within which the NSP is located, namely:

- human dignity, the achievement of equality and the advancement of human rights and freedoms
- non-racialism and non-sexism
- supremacy of the Constitution and the rule of law.

Considered in its broadest terms, the Constitution lays down a set of ideals towards which the NSP must strive, such as the commitment to healing the divisions of the past and to improve the quality of life of all those who live in South Africa.

The cooperative nature of the three spheres of government (national, provincial and local), as espoused by the Constitution, has a critical bearing on the NSP. The Intergovernmental Relations (IGR) Framework Act 2005 (Act 13 of 2005) aims to facilitate such cooperation. Since HIV and TB have an impact across all three spheres of government, the implementation of the NSP will take place within the IGR framework.

At a macro level, the 2009 – 2014 MTSF sets out the strategic mandate of government. The MTSF identifies strategic priorities and targets that serve as the basis for determining government's implementation plans for the period to 2014. The 12 key targets are:

1. Quality basic education.
2. A long and healthy life for all South Africans.
3. All people in South Africa are and feel safe.
4. Decent employment through inclusive economic growth.
5. A skilled and capable workforce to support an inclusive growth path.

6. An efficient, competitive and responsive economic infrastructure network.
7. Vibrant, equitable, sustainable rural communities contributing towards food security for all.
8. Sustainable human settlements and improved quality of household life.
9. Responsive, accountable, effective and efficient local government system.
10. Protect and enhance our environmental assets and natural resources.
11. Create a better South Africa, a better Africa and a better world.
12. An efficient, effective and development-oriented public service and an empowered, fair and inclusive citizenship.

These outcomes have, in turn, been translated into national service delivery agreements (NSDAs) that commit to specific outputs and have been signed by all ministers. The NSP goals, vision and targets are aligned with the NSDAs of all government departments. In turn, some outputs of the non-health NSDAs will address structural determinants of the epidemics.

The four outputs that relate to Outcome 2 (long and healthy life) and are primarily in the health NSDA, but also signed by all relevant national ministers, as well as the MECs for health, are:

- increasing life expectancy
- decreasing maternal and child mortality
- combating HIV and AIDS, and reducing the burden of disease from TB
- strengthening health system effectiveness.

NSP implementation will directly support the third output, and indirectly support the others.

In addition, the NPC is currently developing a broad government framework for addressing the major developmental challenges in South Africa, which include:

- high rates of unemployment
- poor quality education
- high rates of domestic and sexual violence
- poorly located and inadequate infrastructure
- weak economic growth
- spatial challenges marginalising the poor
- high burden of disease
- uneven public service delivery
- corruption and its impact on service delivery
- a lack of social cohesion.

At the international level, the MDGs have specific targets that all countries are striving to achieve by 2015. By situating the response to HIV, STIs and TB within the broader development agenda and integrating the human rights and gender dimensions, countries are in a better position to accelerate progress across an array of MDGs.

For South Africa in particular, HIV has undoubtedly undermined and reversed many gains that were made in the reduction of infant and maternal mortality, therefore investing strategically to address HIV and TB and the other MDGs will maximise the developmental agenda of government.

The implementation of the NSP is underpinned by and aligned with an understanding of these broader, high-level planning frameworks, which will enable rational and appropriate, evidence-informed strategies to be prioritised during planning. In each of these strategic priorities, government departments will take greater cognisance of how their plans can mitigate the HIV and TB epidemics, with regular reporting to SANAC. An appreciation of the above will enable the NSP to focus strategically on interventions that will move the country closer to the achievement of both the five-year and the 20-year vision.

Apart from the direct commitment to reversing the HIV and TB epidemics, the following are examples of the government-led initiatives that will contribute to the achievement of the NSP goals:

- in the context of HIV, STIs and TB, where access to services has been a critical challenge, the re-engineering of PHC services developed by the Department of Health has the potential to address many of the prevention, health promotion, treatment and care issues
- given the centrality of education as a protective factor against HIV risk, the Department of Basic Education will strengthen interventions to reduce dropout rates and increase school completion rates
- given the relationship between gender inequality, gender-based violence and vulnerability to HIV, the Department of Women, Children and People with Disabilities has made commitments to address the intersection of gender-based violence and HIV
- to deal more comprehensively with the issue of orphans and vulnerable children the Department of Social Development will strengthen its programmes targeting this group, with interventions, such as promoting the concept of family and encouraging South Africans to adopt orphaned children, which will provide a nurturing environment to enable the development of full human capital
- inmates and staff of correctional facilities are at higher risk for both HIV and TB; and the Department of Correctional Services will implement a number of interventions to decrease the transmission of HIV and TB in correctional facilities
- human settlements, especially informal settlements, will also be targeted as part of government's development programme, with an accelerated building programme to provide formal housing.

4
STRATEGIC OBJECTIVES OF THE NSP 2012 – 2016

4.1 INTRODUCTION

As noted in Chapter 2, a number of principles have been adopted to guide the finalisation and implementation of the NSP, as well as the development and implementation of sector and provincial operational plans. These principles, together with the consultation process described earlier and other reports and studies, have culminated in the development of four strategic objectives for the NSP.

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

- Strategic Objective 1: Addressing social and structural drivers of HIV and TB prevention, care and impact.
- Strategic Objective 2: Preventing new HIV, STI and TB infections.
- Strategic Objective 3: Sustaining health and wellness.
- Strategic Objective 4: Ensuring protection of human rights and improving access to justice.

4.2 STRATEGIC OBJECTIVE 1: ADDRESSING SOCIAL AND STRUCTURAL DRIVERS OF HIV AND TB PREVENTION, CARE AND IMPACT

The impact of infection and disease on people living with HIV and TB, as well as their families and communities, is profound. Social and structural approaches address the social, economic, political, cultural and environmental factors that lead to increased vulnerability.

Some of the structural approaches seek to address deeply entrenched and long-established cultural, socio-economic and behavioural factors, such as economic inequality, gender inequality, marginalisation and lack of access to basic services, which are difficult to resolve in the short term. For this reason, they commonly require long-term strategies and interventions that are largely addressed by national socio-economic and development strategies and policies, including those referred to in Chapter 3. In addition to including measures in the NSP to address these structural factors, it is also important to mainstream HIV and TB management into the core strategies of government departments, the private sector and civil society in order to ensure a comprehensive and sustainable approach to the HIV and TB epidemics.

Specific interventions to mitigate the impact of these epidemics are critical to support affected communities and to break down the vicious cycle of ongoing vulnerability and infection from generation to generation.

Strategic Objective 1 (SO 1) will focus on key structural factors that need to change over the next five years. These deal with the factors that facilitate the spread and impact of HIV and TB, as well as those that are protective and should be harnessed and promoted.

Sub-Objective 1.1:
Mainstreaming HIV and TB and its gender- and rights-based dimensions into the core mandates of all government departments[18] and all SANAC sectors

Government, in its entirety, has the responsibility of defining the development agenda of the country and for ensuring the achievement of the nation's development goals and objectives. Given the profound impact of HIV and TB, and the huge burden of disease attributable to these epidemics, every government department (at national, provincial and municipal level) has a critical role to play in addressing the social, economic and structural factors driving these diseases.

18 Using the DPSA guidelines for mainstreaming, to be finalised in 2011.

Sub-Objective 1.2:
Addressing social, economic and behavioural drivers of HIV, STIs and TB

Informal settlements

The poor living conditions in informal settlements provide fertile ground for HIV, STI and TB transmission, as well as the spread of many other communicable diseases, especially among children – mainly as a result of the lack of proper building materials, the lack of access to basic services, such as sewerage, electricity and running water, and the lack of food security.

The Department of Human Settlements has conducted a mapping exercise of all informal settlements and compiled a brief situational analysis report that documents the key challenges in these settlements. Improved access to basic services is one of the key outputs of this process, as is a plan to upgrade units of accommodation. To complement this, the departments of basic education, health, and social development must ensure that social services such as education, health and social security are available.

Rural and hard-to-reach areas (including farms)

According to the KYE report, HIV prevalence is increasing rapidly in rural formal settlements. A big challenge in rural areas is access to appropriate services. A large proportion of the rural population has no sustainable livelihood, which contributes to deprivation and ill health.

Government will develop and implement a comprehensive strategy to address the social, economic, infrastructural and governance challenges that have been identified in rural areas. Access to health services, including HIV and TB interventions, has also been prioritised.

Migration and mobility

Cross-border mobility and internal migration between rural areas and urban areas is associated with an increased risk of HIV acquisition. Cross-border issues can be addressed through protecting the rights of migrants in accordance with the Constitution, and the implementation of regional agreements and strategies, such as referral systems and the harmonisation of treatment protocols. Female migrants, truck drivers, migrant labourers and mine workers are particularly vulnerable to HIV and TB transmission. A comprehensive package of services is urgently needed for these key populations.[19] There is a need to implement a unique identifier to ensure a continuum of care for migrant populations, both between rural and urban areas and provinces within South Africa, and between countries in the region.

Alcohol and substance use

Recognising the impact of alcohol and substance abuse, government has established an Inter-Ministerial Committee on Substance Abuse to review research findings and develop appropriate policies and programmes to address these issues. These may include increasing taxation, limiting access to alcohol sales and advertising, advertising health messages (such as on cigarette packages), and strengthening alcohol- and substance abuse education in schools and tertiary institutions. These strategies must also address the gender norms that equate alcohol consumption with masculinity.

Sub-Objective 1.3:
Implementing interventions to address gender inequities and gender-based violence as drivers of HIV and STIs

Girls and women are particularly vulnerable to HIV infection because of their biological vulnerability and gender norms, roles and practices. Acknowledging the fact that gender inequality hinders social and economic development, the achievement of gender equality remains one of the critical components of the transformation agenda. South Africa is grappling with high levels of violence against women, with sexual assault and intimate partner violence contributing to increased risks for HIV infection.[20] The departments in the social and security clusters of government at national and provincial levels, SANAC and the Department of Women, Children and People with Disabilities must develop a comprehensive

19 This includes specific efforts to reach former mine workers who are no longer employed due to their health status.

20 Jewkes R, Dunkle K, Nduna M & Shai N. 2010. Intimate partner violence, relationship gender power inequity, and incidence of HIV infection in young women in South Africa: A cohort study. *The Lancet*, 367:41–48.

approach to reduce gender-based violence in society, which will include both primary and secondary prevention, and scaling-up social change communication programmes dealing with gender stereotypes and harmful norms.

Sub-Objective 1.4:
Mitigating the impact of HIV and TB on orphans, vulnerable children and youths

The numbers of orphans and children made vulnerable by HIV has increased over the years. The Department of Social Development has been leading activities to protect the rights of orphans, vulnerable children and youths, and to reduce their vulnerability and the impact of HIV and TB. There is a need to scale up these interventions and strengthen initiatives at community level to protect the rights of orphans and, in particular, child– and youth-headed households. Mental health services must also be part of the package of services provided to support orphans and vulnerable children.

Sub-Objective 1.5:
Reducing the vulnerability of young people to HIV infection by retaining them in schools, as well as providing post-school education and work opportunities

Education has been identified as a protective factor against HIV infection. School-going children and young people are less likely to become HIV-positive than those who do not attend school, even if HIV is not included in the curriculum.[21] Ensuring school completion, as well as facilitating re-entry into the school system after dropping out, for whatever reason, is a critical intervention to ensure that learners acquire knowledge and skills to improve employment opportunities, and life skills to negotiate a safe transition into adulthood.

Education reduces the vulnerability of girls, and each year of schooling offers greater protective benefits. Educating parents and caregivers to encourage intergenerational conversations with young people on sex and sexuality will be prioritised. This includes education for learners and parents on gender norms and transformation.

Youth-specific interventions are also critical once learners transition out of school. Evidence has shown that HIV infection levels increase exponentially among school leavers who do not have employment, mentoring or further training opportunities. This essentially means a loss in the investment made during the school-going years. It is thus crucial to implement targeted programmes (e.g. through the Expanded Public Works Programme) for these young people who are at risk of harmful lifestyles that will increase the likelihood of HIV infection, including alcohol and substance abuse. Such programmes must also extend to young people attending institutions of higher learning and should be led by the Department of Higher Education and Training.

Sub-Objective 1.6:
Reducing HIV- and TB-related stigma and discrimination

TB and HIV infection both generate significant stigma due a variety of factors, such as lack of understanding of the illness, inadequate access to knowledge, fear, prejudice and socially sensitive issues, such as sexuality and gender identity.

A clear programme of action that covers both innovative and established methods of stigma elimination is essential. The greater involvement of people living with HIV and TB is key in such programmes to empower and educate communities and individuals. A Stigma Mitigation Framework will be implemented and efforts to reduce stigma will be monitored by a Stigma Index. The departments in the security cluster must play a role in monitoring the impact of stigma, together with the South African Human Rights Commission (SAHRC).

21 Department of Basic Education Draft Integrated Strategy on HIV and AIDS, 2012 – 2016.

Sub-Objective 1.7:
Strengthening community systems

Strengthening the capacity of community systems to expand access to services is key and requires a systematic and comprehensive strategy to address capacity, referral networks, coordination and feedback mechanisms. All provinces should implement strategies to support municipalities and local communities to address challenges and strengthen community systems. These should be reflected in the integrated development plans.

Some sectors, for example the faith-based sector, have an extensive network of institutions and individuals in communities, from densely populated cities to the most remote rural areas in South Africa. This network is coupled with infrastructure, e.g. places of worship, halls, schools and hospitals, which can be used to enhance existing programmes and create new programmes and services; and to act as points of service delivery, information centres and points of referral to services.

Sub-Objective 1.8:
Supporting efforts aimed at poverty alleviation and enhancing food-security programmes

Poverty is one of the major contributors to poor health through food insecurity, which in turn is linked to HIV and TB acquisition and poor treatment adherence, so every effort must be made by government and its partners to ensure food security for all. Government has launched an integrated anti-poverty strategy that involves various government departments, which have specific responsibilities to ensure that vulnerable households are identified and supported. Child- and youth-headed households are also prioritised to ensure that their needs, such as food, shelter and access to health and social services, are fast-tracked.

TABLE 2: *STRATEGIC OBJECTIVE 1: CORE INDICATORS*

Measuring the implementation and outcome of SO 1 ***at the national level*** will be done through a few core indicators. Departmental, provincial and sectoral implementation/operational plans will contain more detailed interventions, indicators and targets. Annual reports will detail progress against all interventions.

Where available, the baseline value is 2009/2010 data – as 2011 data is mostly not available. Where baselines do not currently exist, it will be the task of the SANAC M&E Unit to determine them. The 2016 target is not a cumulative target, but the target for 2016 only.

INDICATOR	WHAT THE INDICATOR MEASURES	NUMERATOR	DENOMINATOR	BASELINE VALUES	TARGET 2016	DATA SOURCE	FREQUENCY	DISAGGREGATION
% government departments and sectors with operational plans with HIV, TB and related gender- and rights-based dimensions integrated	The extent to which HIV and TB is integrated into the broader development agenda of government and civil society	Number of annual performance plans where HIV and TB are integrated	Number of annual performance plans developed	To be obtained in 2012	100% of government departments		Annually	
100% of sectors	DPSA, SANAC sector reports	Annual					Annually	Province
% municipalities with at least one informal settlement where targeted comprehensive HIV, STI and TB services are implemented	The extent to which social and structural factors that influence HIV and TB transmission in informal settlements are addressed	Number of municipalities implementing comprehensive HIV, STI and TB services in informal settlements	Number of municipalities	To be obtained in 2012	100%	DCOGTA	Quarterly	Province, gender, age,
Current school attendance among orphans and among non-orphans aged 10-14 (UNGASS 12; MDG indicator)	Progress towards preventing relative disadvantage in school attendance among orphans versus non-orphans	a) Number of children who have lost both parents and who attend school b) Number of children both of whose parents are alive, who are living with at least one parent and who attend school	a) Number of children who have lost both parents b) Number of children both of whose parents are alive who are living with at least one parent	98% (2008 SABSSM survey)	100%	Population-based survey (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)	Every two years	National, provincial
Delivery rates for women under 18 – NIDS	Condom and other contraception use plus, sexual debut	DHIS	DHIS	To be determined in 2012	To be determined in 2012	DHIS	Annually	National, provincial
HIV and TB spend	Spend as a proportion of need	Actual spend	Planned spend	NASA 2010		SANAC resource tracking tool	Annually	National, provincial
Number of women and children reporting gender-based violence (GBV) to the police in the last year	Progress in mobilisation of society to promote gender and sexual equality and address gender-based violence	Count	Count	To be determined in 2012		SAPS Progress report	Annually	Age, national, province
Proportion of women who have experienced physical or sexual violence in the last year	Progress in mobilisation of society to address gender and sexual equality and address gender-based violence	Number of women who reported physical or sexual violence in the past 12 months	All women	To be determined in 2012		Survey	Every three years	Age, national, provincial

4.3 STRATEGIC OBJECTIVE 2: PREVENTING NEW HIV, STI AND TB INFECTIONS

Targeted, evidence-based combination prevention interventions are needed to achieve the long-term goal of zero new HIV and TB infections. Focusing prevention efforts in high-transmission areas and on key populations is likely to have the greatest impact, while simultaneously sustaining and expanding efforts in the general population.

Combination prevention interventions recognise that no single prevention intervention can adequately address the HIV and TB epidemics, but must consider the combination of structural, biomedical and behavioural approaches, which together are likely to have the greatest impact on reducing the likelihood of transmission and mitigating individuals' susceptibility and vulnerability to acquiring new infection.

A package of combination prevention may include male and female condoms; medical male circumcision; HIV counselling and testing (HCT); TB screening and preventive therapy; social and behaviour change communication promoting health-seeking behaviour, changing socialisation practices and interventions to eliminate gender-based violence; increasing access to sexual and reproductive health services; providing post-exposure prophylaxis (PEP); peer education; and PMTCT services.

Structural interventions
The NSP cannot achieve its prevention objectives unless key high-risk determinants of HIV, STIs and TB are addressed. Some of these have been addressed in SO 1. Others, while important, are beyond the direct remit of the NSP but are part of government's broad developmental agenda.

Social interventions
Social interventions include efforts to change cultural and social norms that increase vulnerability to HIV and STIs and to reinforce those norms and behaviours that are protective. Some social norms (most notably gender norms) are drivers of behaviours that place individuals at increased risk of HIV acquisition, such as multiple partnerships, intimate partner violence and alcohol abuse. Social norms may also promote discrimination against members of the community with certain diseases (e.g. TB or HIV) and against those with different sexual orientations (e.g. men who have sex with men and women who have sex with women) and may result in reluctance to attend health services for fear of discrimination. Similarly, norms that condone gender violence will make it difficult for abused women to seek redress. Social interventions also include interventions that promote positive social cohesion and enhance community involvement. Strategies to address these issues are dealt with in SO 1 and SO 4.

Behavioural interventions
Behavioural interventions include a range of activities designed to encourage people to change behaviours that increase the risk of HIV and TB infection and increase protective behaviours. Key activities include: delaying sexual debut; reducing multiple and concurrent sexual partnerships and challenging gender norms that drive this; cough hygiene; reducing alcohol consumption; reducing cigarette smoking (for TB); promoting correct and consistent use of male and female condoms, and increasing the population's knowledge of their HIV, STI and TB status.

Biomedical interventions
Biomedical interventions for prevention include medical male circumcision; male and female condoms; PMTCT; PEP for occupational injuries and rape survivors; safe blood services; TB vaccination; and IPT. Based on recent research findings, biomedical prevention should now also include 'treatment as prevention' for both HIV and other STIs, as well as for TB. Recent data on microbicides and PrEP with antiretrovirals has shown that they can prevent HIV infection. Policy decisions on the use of microbicides and PrEP should follow studies to establish their safety and efficacy when delivered at the population level, guidance from UNAIDS or WHO, and their registration with the Medicines Control Council (MCC) for this use.

Combination prevention efforts must also consider the needs of people living with HIV and their role in prevention of new HIV infections, and must be guided by a human rights framework that promotes health, empowerment and dignity.

The following sub-objectives are included for HIV, STI and TB prevention:

- ensuring everyone in South Africa tests voluntarily for HIV and is screened for TB annually, and subsequently enrols in relevant wellness and treatment, care and support programmes
- making accessible a package of sexual and reproductive health services to prevent HIV and STIs, with an emphasis on key populations, including the strengthening of the syndromic management of STIs in both the public and private health sectors
- preventing transmission of HIV from mother to child to reduce MTCT to less than 2% at six weeks post-birth and to less than 5% at 18 months of age by 2016
- implementing a national social and behavioural change communication programme with a focus on key populations to shift social norms (especially those related to gender), attitudes, promote healthy behaviours, and increase the demand and uptake of services
- preparing for the potential implementation of innovative biomedical prevention strategies such as microbicides, PrEP and treatment as prevention
- preventing new TB infection and disease through IPT, infection control, early identification and treatment of TB and an improved TB cure rate.

Sub-Objective 2.1:
Maximising opportunities to ensure everyone in South Africa tests voluntarily for HIV and is screened for TB at least annually, and is subsequently enrolled in relevant wellness and treatment, care and support programmes

Universal access to HIV counselling and testing and TB screening, as an entry point for diagnosis and HIV and TB treatment, care and support is a key intervention required to achieve the goals of the NSP. Special attention will be required to ensure that people from key populations know their HIV and TB status. This is to ensure early access to treatment and to reduce transmission.

Knowing one's HIV or TB status is critical to gain access to effective prevention interventions for those testing negative. Data from the 2010 – 2011 national HCT campaign indicates that men represented only 30% of those who tested. Efforts must be made to increase men's health-seeking behaviour, including participation in HCT.

With well-linked services, HCT will assist in getting people living with HIV onto treatment speedily, in line with national policy guidelines. HCT for discordant couples is particularly important in this regard. A prevention package that includes SRH education needs to be included for those who test negative, as well as those who test positive.

The full package of screening, to be available in all clinical settings, will include: HCT; TB symptomatic screening, linked to TB testing for those with symptoms; as well as screening for diabetes, blood pressure, anaemia, mental illness and alcohol abuse, with referral to psychological and social support. STI management is an important entry point for HCT. Screening for acute STIs in certain situations (e.g. urethral discharge in men) and enhancing the uptake of HIV testing will improve case detection.

Screening for domestic violence and child abuse should also be part of the package of health and social services. Counselling and mental health services should be available in all health and social services facilities given the impact of testing positive and its implications, such as being on chronic medication for the length of one's life.

Testing and screening services must take place at multiple settings to reach all populations, including homes (by trained community health workers), workplaces, schools[22] and tertiary institutions, social grant distribution points, and correctional facilities. HCT services must also be made available through mobile services in communities (e.g. sporting events, taxi ranks and malls) and for sex workers and their clients at sex work venues and locations. In these non-clinical settings, the package of services may be less comprehensive than the full package described above, but appropriate referrals and follow-up must be done.

22 Testing in schools is not current DBE policy, but this will be explored for implementation within the NSP timeframe.

Provider-initiated counselling and testing (PICT) should be offered to all clients accessing healthcare services. The possibility of introducing home-based CD4 testing combined with HCT should be explored.

Sub-Objective 2.2:
Making accessible a package of sexual and reproductive health services

Integrating HIV and STI prevention into a sexual and reproductive health framework is core to the success of the NSP. Interventions include:

- The delivery of an integrated package of SRH services as part of the PHC approach within the district health system, with a focus on key populations. The package should include fertility-management services (including termination of pregnancy services, contraception counselling and dual-contraceptive method use). This is essential to reducing unintended pregnancies (especially teenage pregnancy) and improving the planning for safe and desired pregnancies. The range of contraceptive methods available to all women should be increased. Appropriate contraception should be offered to all HIV-positive women and men at every opportunity, and contraceptive services should be integrated into ART services.
- Maximised coverage of male and female condoms through distribution in health facilities and non-traditional outlets, including correctional facilities, mines, airports, malls, shebeens, hotels and schools[23] as part of a broader health package, and tertiary institutions, sex work venues/locations and clubs.
- Improved coverage of medical male circumcision as an essential part of a male SRH package[24].
- National guidelines for the safe practice of circumcision must be developed and implemented, and its use monitored.
- Surveillance of STIs in key populations, including young women, must be increased and appropriate interventions developed in response to this, including resistance monitoring.
- Strengthening antenatal clinic screening for syphilis to eliminate congenital syphilis.

Special attention must be given to the issue of teenage pregnancy (planned and unplanned) with pregnancy-prevention education provided to young men and young women. Thirty-nine per cent of 15- to 19-year-old girls in South Africa have been pregnant at least once and 49% of adolescent mothers are pregnant again within the subsequent 24 months. One in five pregnant adolescents is HIV-positive. In addition, the annual risk of TB infection in this age group is high, and TB incidence peaks in adolescents and youths.

Comprehensive education on sexuality, reproductive health and reproductive rights, inclusive of life skills education, will be provided in all schools through the curriculum and co-curricular activities, to build skills, increase knowledge and shift attitudes, change harmful social norms and risky behaviour, and promote human rights values. The departments of basic education, health and social development must ensure that an integrated school health programme is implemented that includes a package of sexual and reproductive health and rights services, sexuality and TB education appropriate to each school phase. This package must be available in all schools, including private and special schools. A similar package of services must be implemented in institutions of higher learning.

23 Condoms in schools is not current DBE policy, but this will be explored during the NSP timeframe.

24 The provision of traditional circumcision should also include a comprehensive package of sexual and reproductive health services

Sub-Objective 2.3:
Preventing transmission of HIV to reduce mother-to-child transmission to at least 2% at six weeks and to less than 5% at 18 months by 2016[25]

The Action Framework for No Child Born with HIV by 2015 and Improving the Health and Wellbeing of Mothers, Partners and Babies in South Africa will be finalised and adopted and its implementation monitored. The action framework provides a roadmap for the elimination of HIV transmission and includes four prongs, namely:

1. Primary prevention of HIV among young women, with specific interventions targeting women who test negative and specific positive prevention interventions.
2. Prevention of unintended pregnancies for teenagers and HIV-positive women. This involves engaging women and men, and ensuring that PMTCT is integrated into sexual and reproductive health and fertility management services, and that functional linkages are established to routinely address reproductive health needs of both HIV-negative and HIV-positive women (also addressed in Sub-Objective 2.2).
3. Prevention of HIV transmission from HIV-positive women to their infants through better implementation of national guidelines on ART for pregnant women and ongoing infant feeding counselling and support with a focus on exclusive breastfeeding.
4. Provision of appropriate treatment, care and support to HIV-positive mothers, their infants and family with a focus on establishing appropriate mechanisms for referral and linkages with long-term HIV-care services (including ART, cotrimoxazole prophylaxis, TB screening and treatment, diagnosis of HIV infection in infants) and other child survival services to ensure a continuum of care for women and children.

The PMTCT programme must be strengthened with respect to both coverage and quality through inter alia: the engagement of fathers; the integration of PMTCT into PHC services through enhancement of referral services and the increase of linkages allowing for a continuum of care, inclusive of contraception; good-quality antenatal care (including HIV testing before 14 weeks and at 32 weeks gestation); improved maternity delivery services and postnatal care, with PCR testing for all exposed infants at six weeks, and immediate initiation on ART if positive, as well as HIV rapid antibody testing at 18 months, ART initiation in line with current guidelines and emerging evidence; and strengthened infant feeding practices with support for exclusive breastfeeding for at least the first six months. Improved training and integration of community health workers with facilities will further enhance the effective postnatal follow-up for mothers and infants.

Finally, making appropriate resources available to ensure ongoing monitoring of PMTCT programme operations and outcomes, including postnatal transmission, must be prioritised.

Sub-Objective 2.4:
Implementing a comprehensive national social and behavioural change communication strategy with a particular focus on key populations

A comprehensive national social and behavioural change communication strategy must serve to increase demand and uptake of services, to promote positive norms and behaviours and to challenge those that place people at risk (including norms that discourage men from accessing HIV, STI and TB services, contribute to violence against women, multiple partnerships and those that encourage alcohol consumption). These norms are also addressed in SO 1. Sexuality and reproductive health and rights education, as well as TB symptom recognition, cough hygiene and how to access services, form an important component of a comprehensive communication strategy. The strategy must aim to shift attitudes and behaviours related to the reduction of HIV and STI transmission. It must focus on consistent and correct condom usage; ensuring that sex is always consensual; that women can negotiate condom use; delaying sexual debut and the reduction of age mixing; and reducing multiple and concurrent partners. The strategy must also focus on all aspects of the advocacy, communication and social mobilisation related

25 These targets conform to the international targets for PMTCT, but during the midterm evaluation consideration will be given to reducing the 18-month target.

to TB infection and disease. This strategy must take into consideration the special communication needs of people with disabilities, and also target traditional circumcision.

Sub-Objective 2.5:
Preparing for the potential implementation of future innovative, scientifically proven HIV, STI and TB prevention strategies

The prevention strategies in the NSP are based on current knowledge. However, the need to prepare for the use of alternative new combination prevention efforts that may emerge in future is acknowledged.

Innovative technologies under investigation that could prevent the spread of new HIV infections include microbicides, PrEP, new vaccines (including an HIV vaccine and a TB vaccine), PEP beyond sexual assault and occupational exposure (after unprotected sex); as well as treatment as prevention.

In recent studies, PrEP using ARVs (microbicides) has been shown to be modestly effective against HIV acquisition. However, antiretrovirals have not yet been licensed for PrEP, and international guidelines on their use have not yet been issued. Further work needs to be done on strategies and the feasibility of implementing these prevention strategies as proposed below:

- the provision of oral PrEP for MSM
- the provision of oral PrEP for key populations who would benefit, such as discordant couples
- the provision of microbicides (topical PrEP) to women at risk (of HIV and HSV-2) in the general population
- the provision of PEP in circumstances other than occupational exposure and post-sexual assault
- using ART as prevention
- new TB vaccines.

Sub-Objective 2.6:
Preventing TB infection and disease

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

Intensified TB case finding
This will be achieved through annual TB symptom screening and testing (for those with a positive symptom screen) through testing campaigns (see Sub-Objective 2.1). These will take place in community campaigns, schools, universities, workplaces, the military, places of worship, taxi ranks and shebeens; with focused screening of all health facility attendees and at-risk populations (TB-exposed infants and children, people living with HIV, contacts of people with sensitive and drug-resistant TB, pregnant women, healthcare workers, mine workers, prisoners and prison staff).

TB screening must be linked seamlessly to accessible TB diagnosis for all identified with TB symptoms, and effective treatment for all found to have drug-sensitive and -resistant TB disease. Interventions that focus on prompt diagnosis and treatment for smear-negative TB and extra-pulmonary TB are particularly important for people living with HIV.

TB infection control
Instilling a culture of cough hygiene is essential to achieving better respiratory infection control in the community. A greater emphasis on TB and respiratory infection control is needed in households, schools, health care facilities, prisons, and other congregate settings to ensure a safe environment. TB infection control requires a combination of administrative, environmental and personal respiratory infection interventions. This should be delivered in the context of broader infection control standards, e.g. hand washing. All health facilities providing HIV and TB care must be assessed annually for infection control against a set of quality standards. This also requires each health facility to have an infection control plan and officer.

Respiratory infection control should also be prioritised in prisons, high-risk industries (mines, textiles, construction, agriculture), single-sex hostels, long-distance public transport (such as taxis, buses and trains), schools (including preschool facilities), homeless shelters and repatriation centres. Infection control should be considered to be a component of health impact assessment for all new government and private-sector projects and programmes, in particular in developing minimum standards for buildings that take into consideration airborne infection control. Annual risk assessments should be carried out and 90% of high-risk institutions (health facilities, schools, prisons and mines) should achieve a basic infection control standard.

Workplace/occupational health policies on TB and HIV
All high-risk workplaces should have clear management policies on confidentiality, discrimination, routine medical screening and testing of employees, respiratory infection control, treatment, sick leave, psychosocial support, and job modification/alternative placement, where necessary. All workplace wellness programmes should address HIV, STIs and TB in an integrated manner and aligned with national standards.[26]

Isoniazid preventive therapy
The implementation, monitoring and evaluation of IPT must be scaled up for adults and children living with HIV (with clear recommendations for ages 5–15 years), asymptomatic child contacts of people with infectious TB and mine workers.

Immunisation
Hundred per cent BCG vaccination for all eligible infants at birth should be facilitated and ensured.

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

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

Reduce TB-related stigma, malnutrition, alcohol consumption and smoking
Interventions reducing stigma are important to facilitate health-seeking behaviour and treatment adherence. Malnutrition, diabetes, smoking and alcohol consumption are significant risk factors for TB infection. Interventions to address these issues include supporting food security, reducing obesity, social and behaviour change communication, enforcing legislation aimed at regulating the use of cigarettes and the development of legislation to regulate the availability of alcohol (dealt with under SO 1).

26 Specifically the South African HIV National Standard for Workplace Programmes, SANS 16001, as per the South African Bureau of Standards.

Sub-Objective 2.7:
Addressing sexual abuse and improve services for survivors of sexual assault

As stated earlier, sexual abuse is a driver of HIV transmission. A comprehensive package of services is needed to prevent sexual abuse, and to provide comprehensive post-sexual assault care, including PEP, medical care, counselling, access to justice, and protection services for rape survivors. Current systems for the provision of PEP, for adults and children, need to be significantly scaled up and improved, especially in rural areas. PEP must be available at all healthcare sites for survivors of sexual violence and health workers must be trained to explain and administer PEP – with a target of PEP provision to 100% of eligible children and adults. Clear process guidelines must be made available at all relevant service points detailing immediate steps to be taken when an adult or child presents with suspected sexual abuse.

Campaigns targeting adults and children are needed to raise awareness of sexual abuse and exploitation, educate communities about their obligations and procedures for reporting and the importance of immediate reporting in order to ensure access to services, to gather the necessary forensic evidence, and to address the stigma associated with sexual abuse, which may prevent disclosure and hence inhibit access to services.

TABLE 3: *STRATEGIC OBJECTIVE 2: CORE INDICATORS*

Measuring the implementation and outcome of SO 2 at the national level will be done through a few core indicators. Departmental, provincial and sectoral implementation/operational plans will contain more detailed interventions, indicators and targets. Annual reports will detail progress against all interventions. *Note that some indicators are contained in the core impact indicators listed in chapter 6.*

Where available, the baseline value is 2009/10 data – as 2011 data is mostly not available. Where baselines do not currently exist, it will be the task of the SANAC M&E Unit to determine these. The 2016 target is not cumulative, but the target for 2016 only.

There are no lead agencies indicated here, as HIV, STI and TB prevention is the responsibility of all SANAC sectors (government, civil society, private sector) and development partners.

INDICATOR	WHAT THE INDICATOR MEASURES	NUMERATOR	DENOMINATOR	BASELINE VALUES	TARGET 2016	DATA SOURCE	FREQUENCY	DISAGGREGATION
Number (and percentage) of men and women 15–49 counselled and tested for HIV	Reach of the HCT programme	Number of people who have been tested for HIV	Total number of people in the population	13 million (HCT Review Report); 62% ever tested, 37% tested in the past 12 months (2008 NCS)	30 million; 80% of adults tested	DHIS, mobile HCT reporting system	Quarterly	Province, gender, age
Number and percentage of people screened for TB	Population coverage of TB screening	Number of people screened for TB	Total population	Eight million (2011 HCT Review)	30 million	National reports	Annually	Province, gender, age, HIV status
Number of newly diagnosed HIV-positive clients who are given IPT for latent TB infection	PLHIV initiated on IPT for latent TB	Number of people newly enrolled in HIV care who start IPT (are given at least one dose of IPT)	Number of people newly enrolled in HIV care	53% (2011 HCT Review)	85% of people newly enrolled in HIV care	National reports	Annually	Province, gender, age
% men and women aged 15–24 reporting the use of a condom with their sexual partner at last sex	Success of prevention programmes in achieving a high number of protected sex acts	Number of young women and men reporting condom use at last sex	Total number of young men and women surveyed	40% (NCS 2008)	100%	Household or other surveys	Every 2–3 years	Province, gender, age
% young women and men aged 15–24 who had sexual intercourse before age 15 (age at sexual debut)	Preventing young people engaging in sexual activities	Number of young women and men reporting their first sexual act below the age of 15	Total number of young men and women surveyed	10% (UNGASS Report 2010)	<5%	Household or other surveys	Every 2–3 years	Province, gender, age
% women and men aged15–49 years who have had sexual intercourse with more than one partner in the last 12 months	Measure of multiple partners	Number of women and men reporting more than one sexual partner in the last month	Total number of young men and women surveyed	7% (UNGASS Report 2010)	<5%	Household or other surveys	Every 2–3 years	Province, gender, age
Male condom distribution	Reach of condom distribution programme	Number of male condoms distributed	N/A	492 million (2010/11)	One billion	Stock records from hospitals, clinics, workplace etc.	Quarterly	Province, private/public sector
Female condom distribution	Reach of condom distribution programme	Number of female condoms distributed	N/A	5,1 million (2010/11)	25 million	Stock records from hospitals, clinics, workplace etc.	Quarterly	Province, private/public sector
Number of men medically circumcised	Reach of male circumcision programmes	Number of men medically circumcised	N/A	143 000 (2010/11)	1 600 000	Records from health services	Quarterly	Province, age, location
Number of people reached by prevention communication at least twice a year	Reach of communications	Number of people who recall being reached by two or more communications about HIV prevention	Total population	To be determined in 2012	99%	National Communication Survey	Every three years (2012; 2015)	Age, gender, location, province

4.4 STRATEGIC OBJECTIVE 3: SUSTAINING HEALTH AND WELLNESS

The primary focus of Strategic Objective 3 (SO 3) is a significant reduction in deaths and disability as a result of HIV and TB infection through universal access to accessible, affordable and good quality diagnosis, treatment and care.

The sub-objectives for SO 3 are:

- reducing disability and death resulting from HIV and TB through universal access to HIV and TB screening, diagnosis, care and treatment
- ensuring that people living with HIV, STIs and/or TB remain within the healthcare system, are adherent to treatment and maintain optimal health
- ensuring that systems and services remain responsive to the needs of people living with HIV, STI and/or TB disease.

The core strategies for this strategic objective relate to early and improved diagnosis of HIV, STIs and TB, improved access to speedy, appropriate and user-friendly treatment services (including rehabilitation) and retention in treatment and care. A radical expansion of PHC is being implemented through the re-engineering of PHC with a special emphasis on community-based services. Community-based services have a critical role to play in expanding the quality and reach of health and wellness services and, if implemented appropriately, will address many of the concerns regarding the last NSP, in terms of programme reach, early diagnosis, follow-up, support to adherence and retention in care.

Sub-Objective 3.1:
Reducing disability and death resulting from HIV, STIs and TB through universal access to HIV and TB screening, diagnosis, care and treatment

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

Intervention 3.1.1:
Ensuring every person is tested annually for HIV and screened for TB[27]
As per Sub-Objective 2.1, all screening should be done with adequate counselling, including being conscious of persons with communication disabilities. Screening must be linked to follow-up clinical and laboratory investigations for those with TB symptoms and access to appropriate treatment must be ensured.

Intervention 3.1.2:
Implementing targeted programmes of HIV, STI and TB screening and support for key populations
The KYE report provides good evidence for special attention to be given to populations at risk for HIV infection that require specific efforts to screen, diagnose and provide treatment services. This includes:

- Sex workers: Treatment programmes targeting HIV, STIs and TB as part of a broader health and prevention package should be developed where there are large concentrations of brothel- and street-based sex workers. An enabling legal framework, healthcare worker sensitisation and sex-worker involvement is imperative for the effectiveness of this intervention.
- Men who have sex with men: Concerted efforts are needed to reach this target group with appropriate screening, diagnosis and treatment.
- Drug and heavy alcohol users: Illegal drug users suffer from similar legal and stigma issues as sex workers; use of drugs and alcohol also impedes adherence and may enhance side-effects of medication. Drug and alcohol screening in all high-risk patients should be routine and interventions to address the abuse should be implemented. Treatment and referral interventions should be more accessible.

27 This intervention is critical for the separate success of both SO 2 and SO 3, and hence is repeated in each section.

- Correctional and detention facilities: These facilities have high rates of TB and high rates of HIV. The Department of Correctional Services must ensure the provision of appropriate prevention and treatment services, including HIV, STI and TB screening, prompt treatment of all inmates and correctional services staff, ensuring a continuum of care through proper referrals, and the enforcement of laws and policies to prevent sexual violence in prison settings, including the use of newly developed screening guidelines to identify inmates who are vulnerable to sexual violence.
- Workplaces: The private sector, all employers and labour unions should ensure that all formal sector and informal sector employees are tested and screened annually and have equitable access to prevention, treatment and wellness services. Special attention should be given to high-risk workplaces and trades (e.g. mines and truck drivers).
- People with disabilities: Screening and testing programmes that focus on this group must use tailored interventions according to specific needs of people with disabilities. Physical access to facilities and accessible communication are imperative and must be designed and implemented in partnership with organisations that focus on the needs of people with disabilities.

Intervention 3.1.3:
Improving HIV, STI and TB contact tracing to facilitate early diagnosis, using the PHC approach

All health workers will be expected to facilitate contact screening for HIV, STIs and TB in a confidential and sensitive manner. Testing and screening services should be accompanied by educational and awareness programmes. In addition, outreach programmes should be used to also screen for other chronic diseases, i.e. diabetes and hypertension.

Contact tracing, especially of children of TB patients, should be a prime function of the envisaged ward-based PHC outreach teams as well as school health services and should strengthen referral and community follow-up to ensure rapid treatment initiation, increase adherence and eliminate loss to follow-up.

Intervention 3.1.4:
Ensuring access to affordable, high-quality drugs to treat HIV, STIs and TB

Ensure adequate supply of affordable ARV and STI and TB drugs through pooled procurement, negotiated price reductions, improved regulatory approval and better supply chain management. In addition, access to age-appropriate paediatric formulations for HIV and TB must be assured. Common drug combinations should be available as fixed-dose combinations to reduce the pill burden, improve adherence, reduce dosage mis-prescribing, and reduce the dispensing load of pharmacies. New drugs for drug-resistant TB need to be made available to patients with complicated drug-resistant TB. Expanded access to opportunistic infection medication should be made available at PHC level.

Intervention 3.1.5:
Ensuring the earliest possible enrolment for and universal access to appropriate treatment for HIV and TB, after screening and diagnosis

There is strong evidence that ART for people living with HIV can reduce the risk of sexual transmission of HIV to an HIV-negative partner. The treatment of HIV is now recognised as a critical HIV and TB prevention intervention. ART can reduce a person's risk of TB, thus early ART for all eligible people living with HIV will have a significant impact on TB incidence and will reduce mortality in HIV-positive TB patients. The NSP goal is to ensure 80% of eligible clients are initiated on ART, and that 70% of those initiated on ART are alive and on treatment at the end of five years.

Following national guidelines, every effort should be made to ensure eligible clients are enrolled as soon as possible. To this end, all primary care, antenatal, TB and mobile outreach health facilities must become fully functional nurse-initiated ART and MDR-TB initiation sites for adults, children and pregnant women.

Loss to follow-up, especially if referral is required, is high within the health system. Better links are needed between HIV and TB screening sites and strengthened clinical and laboratory services, with test results being available much more quickly. These and new diagnostic technologies, particularly point-of-care technologies appropriate for low-resource environments, should be evaluated and validated to improve turnaround times. In addition, new technologies for the diagnosis of extra-pulmonary and smear-negative TB should be explored for early introduction.

STI syndromic management guidelines must be followed in both the private and public health sectors.

Referral services to ensure that patients with complicated disease or experiencing complex toxicity or multi-drug resistance must have clear, rapid referral pathways. Access to expanded ART and TB treatment choices must also be developed and implemented urgently. Drug resistance threatens the adequate provision of STI care, and can spread rapidly. Surveillance efforts by the National Institute of Communicable Diseases should be actively supported and treatment guidelines adjusted accordingly.

A communication strategy must be developed and implemented, which includes daily adherence reminders, using messaging systems and creative use of media to describe the benefits, and side effects of medication for HIV, STIs, TB, and other chronic diseases. The national broadcaster should provide the space and resources free of charge as part of their contribution to mitigating these epidemics.

Intervention 3.1.6:

Ensuring treatment of children, adolescents and youth

Child mortality is a proxy indicator of failing health systems and should trigger urgent action to prevent unnecessary morbidity and mortality. The following interventions are key:

- strengthening health services to offer child- and adolescent-friendly HIV and TB service packages, including adherence support programmes
- routine HIV testing and PCR screening, with adequate counselling
- ART initiation for all infants under 24 months who test positive for HIV
- a strengthened and standardised TB diagnostic approach for children
- proper recording and reporting of all paediatric cases of HIV and TB
- specific child indicators to be prioritised in the M&E system, with effective management interventions if targets are not reached – these include 90% of children initiated and maintained on ART and/or TB treatment; and milestone screening and interventions for early identification of nutrition and HIV-related stunting
- strengthening early birth registration and certification to improve the availability and accuracy of morbidity and mortality data.

Intervention 3.1.7:

Initiating all HIV-positive TB patients on lifelong ART, irrespective of CD4 count

In line with WHO recommendations, all HIV-positive TB patients should, with immediate effect, be initiated on ART, irrespective of CD4 count. The same intervention should be considered for pregnant women as evidence becomes available. Until such time, the current guideline of initiating pregnant women on ART at or below CD4 350 will apply, and every effort must be made to initiate pregnant HIV-positive women on ART as early as possible. This intervention recognises the high mortality associated with HIV and TB co-infection, as well as the benefits for maternal health and PMTCT of having HIV-positive women on treatment.

Intervention 3.1.8:

Implementing a patient-centred pre-ART package for PLHIV not requiring ART

The loss to follow-up of people living with HIV with high CD4 counts and not in immediate need of ART is high. This results in many patients returning late to care, when they are ill and past the point at which they should have started ART for maximum benefit. This is especially true of men who under-use health services. Pre-ART packages should be designed around what patients value, rather than simply what health providers believe they need. Positive health, dignity and prevention[28] interventions, including safe sex, fertility, IPT and health advice, must be considered within the package of care.

Intervention 3.1.9:

Ensuring all people living with HIV with low CD4 counts (<100) are screened for cryptococcal infection and given appropriate treatment

Cryptococcal infection, which is the second most common serious opportunistic infection after TB, produces much morbidity and mortality. It is complex and expensive to treat, and occurs generally at CD4 counts of less than 100 cells/ul. Screening on all samples where the CD4 count is less than 100 for

28 What used to be referred to as Prevention with Positives.

cryptococcal infection must be routine and reported along with the CD4 count. Treatment guidelines should be reviewed regularly.

Intervention 3.1.10:
Preventing, screening and treatment for cervical cancer
The human papilloma virus (HPV) vaccine has been shown to prevent the precursors of cervical cancer. The HPV vaccine will have the added benefit of preventing genital warts, which cause significant morbidity, especially among people living with HIV.

Cervical cancer screening is an important intervention for HIV-positive women, through annual pap smears. Once diagnosed, every effort must be made to ensure early treatment of cervical cancer.

Sub-Objective 3.2:
Ensuring that people living with HIV, STIs and TB remain within the healthcare system, are adherent to treatment and maintain optimal health and wellness

Intervention 3.2.1:
Strengthen primary healthcare, with a focus on the provision of medication at PHC facilities and support at the household level
Household contact is a major part of the work of the ward-based PHC outreach teams in the new PHC re-engineering programme. Currently, medication is delivered by healthcare facilities or by couriers (in the private sector). In the case of the former, a huge burden is placed on employed and rural people with chronic illnesses who may not have access to health facilities during working hours. This intervention is critical to decentralised community-based programmes.

The PHC system should be re-engineered to facilitate the following:

- delivery of routine chronic medication, including repeat antiretrovirals and TB medication for stable patients, through community models of care
- active screening for medication side-effects, with appropriate referral for side-effects or specific needs, including palliative care
- routine screening for food insecurity with appropriate referrals
- adherence checking and basic mental health screening (including for gender-based violence and drug and alcohol abuse), with appropriate referral to relevant treatment and support programmes
- TB infection control assessments, with the provision of information on control strategies
- collection of TB sputum samples for testing, as well as timely treatment of positive cases
- strengthening the integration and provision of mental health and wellness services within maternal- and childcare programmes, school-based support programmes, and treatment programmes for adults and children.

Intervention 3.2.2:

Developing a single patient identifier in the health sector

Currently, the country lacks the ability to track usage patterns of individual patients within the healthcare system, including movements between the private and public sectors. In addition, poor record keeping and communication lead to increased costs, delays in diagnosis and treatment, with unnecessary repetition and loss of laboratory, radiological and clinical records. A single patient identifier is the basis for addressing this, especially as electronic and Internet systems become more available in all facilities.

Sub-Objective 3.3:
Ensuring that systems and services remain responsive to the needs of people living with HIV, STIs, and TB

Specific interventions are required to make health services more responsive, including:

- The integration of HIV and TB care with an efficient chronic-care delivery system: Clinics should offer an integrated chronic-care package that emphasises rapid transit through the system for stable patients with chronic illnesses. The Department of Health and other care providers (private sector, mining industry, military and correctional services) must fully implement the guidelines for TB and HIV integration with due care being paid to limiting cross infection. In addition, the Department of Health must reorganise the delivery of services for people with chronic illnesses, including mental-health conditions, to ensure greater efficiency and effectiveness of the service and to reduce the burden on patients.
- Access to services on weekends/out of hours: Most PHC facilities operate on a five-day, 08h00–16h00 basis. This makes these services inaccessible to many people who require PHC services out of hours, including the employed, those at school or tertiary institutions, and those who travel long distances to seek care, particularly people living in rural areas. Re-examining delivery models and hours for clinical services will allow for improved access to treatment, and better use of scarce healthcare resources. This also applies to most other social services required by people with chronic illnesses.
- A single registry at primary care level: The plethora of and the vertical nature of reporting requirements and formats have hampered progress on tracking programme outputs and outcomes. All efforts should be made to decrease the recording and reporting burden on health personnel without the loss of health information that is critical to the management of the patient and of the health service.

TABLE 4: *STRATEGIC OBJECTIVE 3: CORE INDICATORS*

Measuring the implementation and outcome of SO 3 ***at the national level*** will be done through a few core indicators. Departmental, provincial and sectoral implementation/operational plans will contain more detailed interventions, indicators and targets. Annual reports will detail progress against all interventions. *Note that some indicators are contained in the core impact indicators listed in chapter 6.*

Where available, the baseline value is 2009/10 data – as 2011 data is mostly not available. Where baselines do not currently exist, it will be the task of the SANAC M&E Unit to determine these. The 2016 target is not cumulative, but the target for 2016 only.

INDICATOR	WHAT THE INDICATOR MEASURES	NUMERATOR	DENOMINATOR	BASELINE VALUES	TARGET 2016	DATA SOURCE	FREQUENCY	DISAGGREGATION
% people per year becoming eligible who receive ART	Coverage of the ART programme	Number of people initiated on ART according to national guidelines	Estimated number of people in need of ART	58%	80%	Numerator from ART cohort records; denominator from Spectrum or ASSA models	Quarterly	Age, gender, province, location, 1st line vs. 2nd line
TB case registration rate	Number of TB cases detected and started on treatment	Number of new and relapse cases of TB (all forms) registered (placed in the TB register and started on treatment) to the National TB Programme	Total population/ 100 000	708/100 000	354/100 000	National TB Control Programme	Annually	Age, gender, province
TB case detection rate	An indication of the proportion of all incident TB cases that are diagnosed, reported and started on treatment	Number of new and relapse TB cases that were diagnosed and notified to National TB Programme	Estimated incident cases of TB	72% (2010, WHO)	>85%	National reports and WHO estimates	Annually	Gender, province
% smear positive TB cases that are successfully treated	Successful smear positive TB treatment	Number of smear positive TB cases cured or completed treatment	Total number of smear positive TB cases registered in the cohort	73% smear positive	>85%	Quarterly cohort analysis	Quarterly	Province, gender, age, HIV status
TB case fatality rate (CFR)	The proportion of notified TB patients who die while on treatment	Number of notified TB cases who die during treatment	Total number of notified TB cases	7,1%	50% reduction	National TB reports	Annually	Province, gender, age, HIV status
CFR HIV-positive = CFR HIV-negative	National TB programme reports	Annually	Province, gender, age, HIV status	54% (2010 WHO)	90%	Electronic TB Register, DHIS	Annually	Province, gender, age
Number and percentage of registered TB patients who tested for HIV	Uptake of HIV testing by TB patients	Total number of patients registered over a given period, who are tested for HIV during their TB treatment	Total number of TB patients registered over the same given time period	54% (2010 WHO)	90%	Electronic TB Register, DHIS	Annually	Province, gender, age
Number of all newly registered TB patients who are , expressed as a proportion of all newly registered TB patients	Information about the epidemics of both TB and HIV. It gives an indication of the degree of overlap in the epidemics and the contribution that HIV is making to the TB epidemic in any given setting	Total number of newly registered TB patients who are HIV-positive, over a given period	Total number of newly registered TB patients who were tested for HIV and included in the surveillance	60% (WHO)	-	Electronic TB Register, DHIS	Annually	Province, gender, age

4.5 STRATEGIC OBJECTIVE 4: ENSURING PROTECTION OF HUMAN RIGHTS AND IMPROVING ACCESS TO JUSTICE

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

The NSP takes as a starting point the constitutional recognition that access to healthcare and other social services – which includes reproductive healthcare – is itself a right enshrined in the Constitution. In this regard, each strategic objective – where appropriate – addresses the specific access needs of particular groups and key populations, including, but not limited to, women (pregnant, with child-bearing potential or post-menopausal), men, adolescents, children and people with disabilities. Ensuring access to social services requires that interventions be planned and implemented in a manner that recognises the specific needs of these groups and the social, cultural, legal, economic and other possible barriers to accessing services.

While the focus of this strategic objective is forward-looking, largely containing a set of interventions to be implemented over the course of the NSP, considerations of human rights and access to justice are ever-present. Recognising that the legal framework for respecting, protecting, promoting and fulfilling rights in the context of HIV and TB is largely in place, SANAC must give special attention to groups that are at higher risk. SANAC will work with all institutions to address human rights and any form of discrimination with respect to HIV, STI and TB.

The NSP 2007 – 2011 also addressed issues related to law, human rights and access to justice. However, reviews of the NSP 2007 – 2011 noted several challenges in the implementation of specific activities related to human rights. In addition, the 2009 NSP Midterm Review recognised that ongoing campaigns to educate citizens on human rights and discrimination are required.

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

In an attempt to address any barriers and shortcomings – legal, social or economic – that may exist and therefore could undermine the rights of individuals, reviews and assessments of laws and policies that may impact negatively on the response to HIV and TB will be conducted expeditiously. In addition, audits of interventions related to HIV, STIs and TB by all stakeholders should be undertaken, using tools adopted by SANAC, to ensure that they comply with human rights. The results of such reviews and audits will inform the course of action to be recommended to all stakeholders and be forwarded to Cabinet for consideration.

It is crucial to ensure that wherever service provision occurs, this must be done in a manner that upholds the dignity of individuals especially those living with HIV and who have TB infection. Women and young girls must also be supported and enabled to access a comprehensive package of services including sexual and reproductive health services. Where such services are not available, referral mechanisms must be put in place to facilitate access within a reasonable timeframe and limited costs to those seeking care.

Decriminalisation of sex work is a matter that has been a subject of debate and society should continue to deliberate on the matter until it is finally resolved.

Women living with HIV in particular have fertility desires which must be protected, respected and addressed. Curricula for training healthcare providers in these areas must be prioritised; such curricula should include a module on human rights.

Unfair discrimination on the basis of HIV and/or TB status has been identified as an area which requires a comprehensive approach by all stakeholders. Organised labour, business and government, with support from the SANAC structures, should assume responsibility for conceptualising, developing and supporting the implementation of national campaigns to address unfair discrimination in the workplace, public amenities and communities in general. Such a campaign should also include information on how HIV and TB infection occurs, how these can be treated and the impact of unfair discrimination on individuals, groups, families and society at large.

As far as the workplace is involved, every effort must be made by employers, both public and private, to ensure that HIV and TB transmission in the workplace is mitigated, and that appropriate treatment, care and support is provided to those affected. Specific strategies to ensure that prevention and treatment campaigns are inclusive in all sectors of the economy, especially the vulnerable sectors such as domestic and farm workers.

Addressing the dual epidemics in the workplace is an economic imperative in that it results in reduction in absenteeism due to ill health and creates an enabling environment for employee well-being and productivity. Evidence has shown that enterprises that proactively implement prevention, support and treatment programmes are able to mitigate the impact of various forms of illnesses, be they acute or chronic.

In summary, the NSP 2012 – 2016 recognises the need to continuously assess barriers to access to services and instances of stigma and discrimination and provides the framework for addressing such issues.

This strategic objective recognises that the NSP, insofar as it seeks to play a central role in protecting human rights and promoting access to justice in the context of the response to HIV and TB, cannot address the sum total of all legal and human rights interventions required; instead, it is focused on a sufficient number of achievable, measurable and mutually reinforcing objectives and interventions relevant to dealing with the objectives of the NSP.

It has the following sub-objectives:

- ensuring that rights are not violated when the interventions under the other three strategic objectives are implemented, and that functioning mechanisms for monitoring abuses and vindicating rights are established
- reducing HIV and TB discrimination, especially in the workplace
- reducing unfair discrimination in access to social services.

Targeted interventions, which are identified in respect of each of these sub-objectives, may have to be implemented in different spheres or levels. In respect of government entities, this may be at the national, provincial and/or local sphere of government. In respect of civil society, business, private sector and non-governmental sectors, this may be at a sectoral, organisational and/or community level.

Sub-Objective 4.1: Ensuring rights are not violated when interventions are implemented and establishing mechanisms for monitoring abuses and exercising rights

This sub-objective seeks to ensure that implementing parties – when they conceptualise and plan the interventions recommended in the NSP – take reasonable measures to guard against rights violations. In addition, it seeks to harness the human and institutional resources of existing constitutional and statutory structures and civil society organisations to advance the NSP's human rights agenda. Further, it seeks to create a coordinated framework for (1) monitoring human rights abuses that have the potential to undermine the interventions set out in the NSP, and (2) ensuring that rights – where violated – may be vindicated efficiently and effectively.

While responsibility for implementation of this sub-objective rests with the relevant national government departments, SANAC has a key role to play in providing technical support and coordination.

Intervention 4.1.1:

Auditing interventions to identify potential for human rights abuses

All government departments and private and community-level entities with responsibility for coordinating, conceptualising and/or implementing interventions and related policies must assess whether any such intervention or policy may result in a violation of human rights when, or as a result of being, implemented. For example, such a violation could occur when:

- HIV testing is conducted without proper informed consent, or is required before other services, such as treatment for STIs, are provided
- those eligible for ART are not referred to appropriate facilities
- patients with drug-resistant TB are detained under 'prison-like' conditions
- social and behaviour change communication interventions attribute blame for the spread of HIV and TB infection to key populations (those at higher risk), as perpetrators rather than victims of their circumstances
- women living with HIV are denied their sexual and reproductive health rights, especially the desire to have children
- health workers insisting that rape survivors lay a charge at a police station by rape survivors before they are provided with PEP services.

Intervention 4.1.2:

Guarding against rights violations as part of policy development and programme planning

Each government department, and private and civil society entity with responsibility for coordinating, conceptualising and/or implementing interventions and related policies must take reasonable measures to guard against the potential rights violations identified. Using some of the examples cited above, such steps could include:

- taking action against health workers who demand that patients test for HIV, against their will, before providing services which ordinarily do not require an HIV diagnosis
- developing and implementing a national policy that permits the detention of patients with drug-resistant TB only when necessary and under conditions consistent with international good practice
- training healthcare providers and other relevant public servants on the requirements of the Criminal Laws (Sexual Offences and Related Matters) Amendment Act, 2007 (Act 32 of 2007), relating to the laying of charges and access to PEP services.

Intervention 4.1.3:

Using existing bodies to monitor human rights abuses and increase access to justice

SANAC, SAHRC and other relevant institutions established in terms of the Constitution responsible for protecting and upholding the rights of individuals must monitor human rights abuses involving those living with HIV and TB or who are at the greatest risk of infection, as well as the appropriate referral to legal service providers of those whose rights have been violated. It is important to note that rights may be violated in the public sector, the private sector and within communities.

While all rights violated should be addressed, particular attention should be drawn to two areas: first, unfair discrimination on the basis of HIV and/or TB status in areas such as workplaces, housing, education and access to basic services; and second, the violation of women's sexual and reproductive health rights.

The SANAC Secretariat, working with relevant institutions, must ensure that the following are achieved:

- a coordinated and effective system for receiving and processing complaints is in place
- the necessary human and financial resources for dealing appropriately with such complaints are available
- reports are tabled at SANAC at least every six months on (1) the steps necessary to ensure that the SAHRC and Legal Aid South Africa are able to discharge their statutory mandates, and (2) the nature of, and extent to which the right to be free from unfair discrimination, and/or the sexual and reproductive health rights of women are being violated.

Intervention 4.1.4:

Building capacity within public institutions and civil society to increase access to justice and redress

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

Sub-Objective 4.2: Reducing HIV and TB discrimination in the workplace

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

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

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

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

Intervention 4.2.1:

Developing and implementing a national campaign against unfair discrimination

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

Intervention 4.2.2:

Empowering employees in small and informal workplaces

Civil society organisations working on access to justice, under the leadership of the Department of Labour, SAHRC and SANAC, should conceptualise, develop, resource and implement a plan to build the capacity of organisations working with and/or representing employees in small and informal workplaces. These include domestic workers and farm workers. Such a plan should involve materials development and training on HIV and employment law, and be sensitive to local needs.

Sub-Objective 4.3: Reducing unfair discrimination in access to services

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

In addition to respecting and protecting people's rights to have access to services, this sub-objective seeks to facilitate the achievement of broader public health goals by ensuring that no person eligible for the identified services is denied access on an arbitrary basis. Denial of access may take place in a number of ways, including by way of services being provided in a manner that fails to address or understand a person's specific needs. This may include staff attitudes that discourage people from accessing social services. The following examples are instructive:

- information that is provided only in written form may limit the ability of the visually impaired to provide informed consent
- understanding the difference between transgender persons and gay men, who are often collectively considered to be men who have sex with men, is essential for the provision of appropriate HIV-counselling services
- judgemental attitudes of health staff towards young people who attempt to access SRH services
- failing to recognise the reason for non-adherence, such as excessive use of alcohol or depression, may undermine access to ART or TB treatment.

Intervention 4.3.1:
Ensuring that oversight bodies receive and address complaints

The statutory mandates of professional oversight bodies – for example, the Health Professions Council of South Africa, the South African Nursing Council, the South African Pharmacy Council, the South African Council for Social Service Professions and the South African Council for Educators – are sufficiently broad to receive and address complaints of unfair discrimination.

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

Intervention 4.3.2:
Providing training to prevent unfair discrimination

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

In particular, this intervention seeks to ensure that all public and private bodies providing training in HIV, STIs and/or TB include modules dealing with unfair discrimination, including a focus on the needs of people with disabilities. The Department of Higher Education and Training will lead it, in collaboration with the departments of basic education, health and social development, other relevant government departments, professional associations, trade unions and national non-profit bodies that develop professional practice guidelines, and professional associations.

4.6 STRATEGIC ENABLER – EFFECTIVE COMMUNICATION

Strategic enablers are factors that are critical to the successful implementation of the NSP. They are systems or structures at all levels, which, if absent or inadequately addressed, will negatively affect the achievement of the goals and objectives of the NSP. Four strategic enablers have been identified as key to the success of the NSP. These are:

- effective governance and institutional arrangements
- effective communication
- regular monitoring and evaluation
- relevant and focused research.

Some of these strategic enablers (M&E and research) are addressed in separate sections of the NSP. While communication issues have been alluded to throughout the NSP, they are important enough to warrant being highlighted here.

The first type of communication that needs to be strengthened is between the national and provincial efforts and that between sectors to ensure that all efforts are coordinated and focused on achieving the goals of the NSP. A comprehensive communication strategy will be developed and implemented by SANAC to ensure that continuous two-way communication is in place.

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

Thirdly, social and behaviour change communication is critical to changing risk behaviours and the social conditions that drive the HIV and TB epidemics. This encompasses the individual, community and socio-political levels and includes advocacy, media, social/community mobilisation and campaigns.

A challenge for communication in a country with a generalised epidemic is to reach key populations while still ensuring that the general population is well informed and able to prevent and mitigate the effects of HIV and TB. Therefore all three types of communication must ensure that both key populations and the general public are targeted. The communication strategy needs to be informed by evidence and the realities on the ground to ensure that the drivers (including structural and social drivers) of the epidemic are adequately addressed.

The capacity of sectors to reach their constituencies via direct personal contact on a regular basis should be strengthened. To this end, the existing ability of some sectors, e.g. the religious sector, to mobilise and communicate with its members should be used, as they can facilitate local community-level dialogues and campaigns in the local language and address local needs.

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

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

Adequate funding to enable communication in multiple languages, including braille and sign language, as well as to ensure repeated communication to reach the necessary scale is needed to change risk behaviour and sustain healthy behaviours.



Coordination is critical to national HIV and TB communication efforts. Therefore, a specific unit within SANAC should be established to coordinate communication within and between different government departments, sectors and NGOs. ■

5
GOVERNANCE AND INSTITUTIONAL ARRANGEMENTS

5.1 INTRODUCTION

The Deputy President has convened a review team to make recommendations on future governance and institutional arrangements to coordinate the implementation of the NSP. It is anticipated that their report will be made available during February 2012 for review, whereafter implementation of their recommendations will aim to start during the financial year 2012/2013.

The review is to ensure that the future Governance and Accountability Framework is clearly informed by the new NSP and to provide SANAC with the ability to discharge its mandate of monitoring implementation, coordinating the response, mobilising resources, disseminating reports and establishing expanded partnerships for a comprehensive response.

The NSP 2012 – 2016, highlights the need to locate the HIV response within the broader development agenda of government, thus ensuring that the response is sustainable and comprehensive. To this end, the Governance and Accountability Framework will reflect this paradigm shift, while taking into consideration other relevant aspects of the new strategy. The importance of aligning the strategy with existing government frameworks has already been articulated and the new strategy will therefore inform the new approach to governance.

One of the key principles that underpinned the development of the NSP 2012 – 2016 was the bottom-up approach, which has enabled communities to participate in the development of this important strategy. This principle will also apply to the new institutional arrangements, thus empowering SANAC to discharge its mandate of monitoring the implementation of the NSP.

5.2 GUIDING PRINCIPLES

The initial guiding principles to formulating the revised structures are summarised below:

- ***Access to relevant information:*** Information and its use in effective M&E is key to SANAC being able to fulfil its coordination and monitoring mandate. Accurately recorded information must be made available 'bottom-up' from all stakeholders involved with the implementation and must adhere to standard formats. Furthermore, it must be made available and shared regularly through SANAC structures to be fully reviewed and used in implementing M&E.
- ***'Bottom-up' approach:*** Governance and reporting arrangements will start at ward level through districts and municipalities to provincial AIDS councils and finally to SANAC. There will be a clear guiding framework to support implementation and set out expected roles and responsibilities.
- ***Accountability and Responsibility:*** Accountability and responsibility for implementation and coordination activities will be strengthened at all levels with a step-up process for feedback and reporting at the next level of governance. Appropriate ownership for reporting and implementation outcomes will be established.
- ***Reporting:*** A standard framework of reporting will guide the regular monitoring and tracking of NSP implementation at all levels. Reporting will be completed at each level of implementation coordination, and verified and passed upwards through formal reporting channels to SANAC. As already indicated, governance arrangements will require direct ownership of all reports, their content and outcomes.
- ***Transparency:*** The entire NSP implementation and coordination process will be based on clear and open communication that leads to a common understanding and discussion of relevant facts. There will be no ambiguity in decision-making and there will be a common understanding of expectations and requirements among everyone involved.
- ***Meaningful involvement of people living with HIV and affected by TB:*** Governance structures will recognise the important role to be played by people living with HIV and TB and will involve them in governance structures.


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5.3 PROCESS GOING FORWARD

Once the review is complete, and consultative dialogue on the recommendations made has been finalised, it is anticipated that existing SANAC governance structures, from national down to ward level, will be restructured and the SANAC Secretariat suitably strengthened to support coordination and oversight of the implementation of NSP 2012 – 2016 and to meet the enhanced governance protocol expected of it.

Importantly, the revised arrangements will also make proposals on how membership of national committees will be approached. Given the 'bottom-up' approach, processes will require structured representation from district and provincial structures through to SANAC. In addition, a revised process will be proposed for the participation of national government and national representative bodies in SANAC structures.

To support the implementation of the revised governance and institutional arrangements, comprehensive policies and guidelines will be established and rolled out through training. A capacity-strengthening strategy will also be put in place to ensure the required skills at all levels of coordination are in place.

The current SANAC structures will continue to carry out the functions of SANAC until the new structure is in place. ■

6
MONITORING & EVALUATION

6.1 INTRODUCTION

SANAC will develop a detailed M&E framework for the NSP. The framework will take into account existing M&E systems being implemented by different stakeholders.

Realisation of the goals and strategic objectives of the NSP is the collective responsibility of all stakeholders in the country. A M&E system with a simple information management and reporting system is central to effective implementation of the NSP, by continuously holding stakeholders accountable for their contributions towards the achievement of specific deliverables.

Apart from monitoring progress in NSP implementation, the framework will provide for ongoing monitoring of the changing dynamics of the HIV and TB epidemics. The KYE reports for both HIV and TB and expenditure analyses will be repeated every two years to realign the intervention focus and the direct resource allocation.

Objectives of the M&E framework are:

1. monitoring the HIV and TB epidemics, as well as STIs, focusing on incidence, prevalence, morbidity and mortality
2. building a national M&E system to evaluate the outcomes of the NSP that strengthen existing systems (e.g. in health and other sectors), and incorporate new systems for community-based monitoring and reporting
3. monitoring the implementation of the NSP
4. developing and implementing an evaluation agenda for the NSP.



6.2 CORE INDICATORS

The overall impact of the NSP implementation will be measured through the following impact indicators:

TABLE 5: *NSP IMPACT INDICATORS*

INDICATOR	WHAT THE INDICATOR MEASURES	NUMERATOR	DENOMINATOR	BASELINE VALUES	TARGET 2016	DATA SOURCE	FREQUENCY	DISAGGREGATION
HIV prevalence among women and men aged 15–24	Monitor trends in HIV prevalence in young ages to assess progress in reducing new infections	Number of men and women testing HIV-positive	Total number of men and women tested	8,7% (HSRC 2008)	4,35% (50% reduction)	Household surveys	Every three years	Province, gender, age, SES, location
HIV prevalence in key populations	Monitor levels of infection in these groups over time	Number of key populations testing HIV-positive	Total number of people (key populations) tested	To be determined and finalised in 2012 (planned survey)	50% reduction	Specific surveys	Periodic	By key population
HIV incidence	Actual number of new HIV infections in the population	Number of new infections arising in a defined population	Total number of people in that population	Estimated incidence = 0,94% in adults in 2012 (ASSA)	0.47% (<150 000 new infections) (50% reduction)	Modelled, estimated or laboratory measures	Periodic	Province, gender, age
TB incidence	Number of new and relapse cases of TB (all forms) estimated to occur in a given year	Number of new and relapse cases of TB (all forms) estimated to occur in a given year	Total population per 100 000	981/100 000 (WHO 2010 estimate)	491/100 000 (50% reduction)	WHO estimates	Annually	HIV status
TB mortality	Success of HIV and TB programmes	The number of deaths caused by TB in HIV-negative people (TB deaths among HIV-positive people are classified as HIV deaths in ICD-10) TB deaths in PLHIV are reported separately	Total population per 100 000	50/100 000 (85 000 TB deaths in HIV-positive people – WHO 2010 estimate)	25/100 000 (42 500 TB deaths in HIV-positive people) (50% reduction)	WHO estimates	Annually	
HIV mortality	Success of HIV and TB programmes	Adult mortality attributable to HIV	Total adult mortality from all causes	43,6% (Stats SA 2011)	21,8% (50% reduction)	Stats SA	Annually	Province, gender, age
MTCT rate (six weeks and 18 months)	Success of PMTCT programme, by determining the percentage of babies born HIV-positive	Number of babies tested HIV-positive (PCR) at six weeks and 18 months	Total number of live births to HIV-positive women	MRC Study 3.6% (for six weeks, 2010)	<2% (six weeks) <5% (18 months)	PMTCT surveillance (MRC); programme data	Annually	Province
Stigma Index	Trends of stigma and discrimination experienced by those living with HIV or TB	N/A	N/A	To be determined in 2012	To be determined in 2012	Survey	Every two years	Province
Patients alive and on treatment	Retention in care	ART patients alive and on treatment at six, 12, 24, 36, 48 and 60 months	Total number of patients starting ART treatment	No cohort data currently available	12 months – 94% 24 months – 88% 36 months – 82% 48 months – 76% 60 months – 70%	ART cohort records	Quarterly	Province, gender, age

6.3 M&E COORDINATION

M&E of the multi-sectoral response will require greater coordination of all sectors (public, private, civil society and development partners) to ensure optimal use of the available resources and continuous learning through sharing of experiences. The M&E Unit in the SANAC Secretariat will be responsible for the coordination of the M&E framework of the multi-sectoral response at national level. The M&E units in the provincial AIDS councils and sectors will assume the same responsibility at provincial and sectoral levels, respectively. These coordinating structures will oversee capacity development, data quality assurance, resource mobilisation for M&E and data archiving. The coordinating mechanisms will not take direct responsibility for M&E implementation, as this is the responsibility of the implementing institutions.

6.4 BASELINE VALUES

Both the 2009 NSP Midterm Review and final review of the NSP 2007 – 2011 highlighted the absence of baseline values as a major weakness in tracking progress with implementation of the NSP. To address this problem, the M&E Unit in the SANAC Secretariat will lead a process to determine consensual baseline values for the core indicators selected at national level. Provinces and sectors will follow a similar process to establish baseline values for the indicators of choice at the respective levels, with the support of the SANAC Secretariat. Determination of baseline values at national, provincial and sectoral levels should be completed by 24 March 2012, when the national and provincial operational plans will be officially launched.

6.5 DATA FLOW

Data on selected indicators for HIV, STIs and TB will flow from ward level to district level (to district AIDS councils), provincial AIDS councils, and then to the SANAC Secretariat and M&E Unit at national level, and back to the lowest level for feedback. Whereas government and civil society sectors will be reporting within their established structures at the different levels, they will be required to feed into the AIDS council structures at the corresponding levels at the same time. This will help strengthen the multi-sectoral response at the different levels.

The SANAC Secretariat will provide quarterly progress reports on selected core indicators. These progress reports will also be shared with the institutions providing the data as feedback. The SANAC Secretariat will also manage international reporting obligations.

6.6 DATA AUDITING AND ARCHIVING

National-level monitoring of the HIV and TB response will rely on routine data on adults and children through the age spectrum from programmes, surveillance and research. Routine programme monitoring will assist with coverage (outputs) while surveillance and population surveys will generate data on outcomes (behaviour change) and impacts (incidence, prevalence). A data audit system, which will ensure that routine programme data are meeting the minimum data quality requirements, will be developed and implemented.

The SANAC Secretariat will be required to establish a database of data elements. It is recommended that data auditing of a sample of the core NSP data by the Office of the Auditor-General, the Performance M&E Unit in the Presidency and Stats SA should be done annually.

6.7 NSP REVIEWS

A midterm and end-of-term NSP evaluation will be conducted. The midterm evaluation will focus on achievements, challenges, emerging issues and recommendations for the remaining half of the NSP, and will take place in 2014. In addition to the midterm evaluation, annual programme reviews will be conducted. This will require multi-sectoral stakeholders to come together at the end of each implementation year to review progress and challenges. The final NSP evaluation will be conducted in 2016 to provide the evidence base for the next NSP. Independent evaluators will carry out the midterm and end-term evaluations. ■

7
RESEARCH

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

7.1 INTRODUCTION

South African research on HIV, STIs and TB is widely recognised as being world-class. Over the past five years, South African researchers have made several ground-breaking contributions that have had an impact on these diseases. Despite this excellent reputation, one of the major challenges has been the lack of a strong link between the research conducted in South Africa and the country's local needs. Much of the current research done by South African researchers is dictated by the agendas of international funders.[29] To correct this situation, which existed during the previous NSP 2007–2011, it is crucial that research, over the next few years includes a focus on local priorities and that local funding for research in support of the NSP is increased. The establishment of a local research agenda, linked much more closely to the country's specific needs related to HIV, STIs and TB and in line with the four strategic objectives, with the necessary funding, is an important initial step. This increased level of funding could emanate from a combination of sources, including the government, the private sector, international agencies and philanthropic organisations.

7.2 PROPOSED RESEARCH STREAMS FOR NSP 2012 – 2016

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

SURVEILLANCE AND VITAL STATISTICS

Information generated by effective surveillance systems is critical to enabling an adequate response to the HIV, STI and TB epidemics. 'Know Your Epidemic, Know Your Response' applies equally to TB and STIs as it does to HIV. South Africa needs accurate baseline local-level data that include maternal mortality, infant mortality, vertical transmission, and TB prevalence and incidence to ensure appropriate responses.

The improved registration of births and deaths (including a more robust capture of cause of disease in all cases) provides a foundation for planning and for monitoring the impact of interventions on HIV and TB mortality. For example, the total number of deaths is a critical and sensitive indicator of the success of ART programmes. Similarly, surveillance to monitor new and existing cases of HIV, new STI cases and new cases of TB in the general population and specific key populations (e.g. healthcare workers, prisoners, sex workers and their clients), as well as temporal trends in incidence and prevalence rates is essential. Such data on the occurrence of disease should incorporate data on behavioural and sociological risk factors. In the case of HIV surveillance, data can be obtained from population-based surveys, antenatal clinic sentinel site surveillance, sentinel population surveillance and targeted prevalence/incidence studies. The recording and reporting of TB cases and their outcomes through the national TB register provides data to monitor national trends, while surveys to monitor drug resistance are essential. Until a better

29 Abdool Karim, SS & Abdool Karim, Q 2010. AIDS research must link to local policy. ***Nature,*** 4(63), 733–734.

mechanism for measuring TB transmission and incidence can be detected, a sentinel surveillance system to monitor TB infection rates in cohorts of school children should be developed.

In order to achieve the above, it is critical that one of the first steps to be taken is a comprehensive review of surveillance and vital statistics systems and data and the development of a plan to strengthen surveillance and vital statistics as proposed above. Stats SA should lead this process.

HEALTH SYSTEMS AND OPERATIONS RESEARCH

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

The recent improvements and gains achieved in PMTCT have, in no small measure, been achieved through systematic studies of the shortcomings in the cascade of steps from pregnant women being tested for HIV to their newborn babies receiving antiretroviral prophylaxis. This has included understanding and removing some of the behavioural, biomedical, socio-cultural and economic barriers which prevent women from accessing and using PMTCT services. Similarly, systematic assessments of ART programmes are leading to substantially higher HIV-suppression rates, leading to lower vertical transmission and improved life expectancy.

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

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

RESEARCH FOR INNOVATION

While research can provide information that describes and analyses events and processes that currently exist, it also plays an important role in identifying future problems, questions and challenges, and developing new technologies to address these. The NSP recognises that science includes a long-term perspective, where knowledge is built through small increments, not necessarily clearly linked to one another.

The value of indigenous knowledge is acknowledged, and should also be part of the research agenda of SANAC, with particular emphasis on the use of traditional medicine for HIV and TB, and the efficacy of traditional circumcision in preventing HIV infection.

With regard to HIV, basic research on the local viruses, immune responses, diagnostics, vaccines, microbicides and antiretroviral drugs have been critical to the potential successes in HIV prevention. Innovation in antiretroviral use has seen the potential for new approaches to HIV emerge, for example the use of ARVs as PrEP. Early initiation of ART has also now been shown to be highly efficacious in HIV prevention. These prevention innovations need to continue, as does the creation of effective combinations of prevention tools, including behavioural and social/structural strategies, which can effectively stem the local epidemic. The search for a highly efficacious and safe vaccine remains a beacon in this quest.


VITAMIN B COMPLEX
STRONG TABLETS
28
USE ONLY • NOT FOR RESALE

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

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

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

POLICY, SOCIAL AND PUBLIC HEALTH RESEARCH

Decisions on services, programmes and interventions for HIV, STIs and TB usually have far-reaching implications. Biomedical information and cost-effectiveness estimates must be fed in to policy debates. In addition, South Africa's values need to be analysed, understood and factored into policy development. The NSP encourages research on HIV, STI and TB policies, their social, economic and ethical dimensions, as well as the processes of policy development and implementation. Research on the public health consequences of policy decisions such as their impact on resources available for other services can provide a broader perspective to better understand whether the NSP is contributing to the promotion of a caring society.

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

7.3 MAPPING THE WAY FORWARD

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

Firstly, researchers[30] and policy-makers must commit jointly to an evidence-based approach to the country's HIV, STI and TB response, including the development of a common understanding of the main drivers and risk factors for transmission at a local and national level. Data need to be collated and synthesised so that researchers and policy-makers can make informed decisions on priorities. A common understanding of the status, nature and future consequences of these diseases is an initial step.

30 This includes researchers from all disciplines.

Secondly, regular interaction must occur between researchers, policy-makers and the leaders of public health programmes to ensure that the HIV, STI and TB policies take account of the latest science. Communication of the research needs to be carefully planned and integrated into the research agenda.

Thirdly, a coordinated national research agenda needs to be developed on the basis of detailed knowledge of the country's epidemic, such as the recent *Know Your Epidemic and Know Your Response (KYE-KYR)* analysis. Such an agenda should not be an exhaustive list, but a set of priorities for research action that can make a real difference to the country's efforts against these diseases. The priorities should preferably be set during the first 6–12 months and then reviewed at appropriate intervals during the course of the implementation of this NSP. South African researchers will have to redirect some of their effort away from internationally contracted studies towards implementing this national agenda. To make this possible, government backing will be essential and scientific excellence must remain the benchmark.

Finally, government funding of HIV, STI and TB research must increase substantially. Today, less than 5% of all the AIDS research funding in South Africa comes from the government's three major funding sources — the Medical Research Council, South African AIDS Vaccine Initiative (SAAVI) and the newly established South African HIV/AIDS Research and Innovation Platform. This needs to increase significantly. But even if government increases its budget several-fold, international finance will still be required. The Department of Science and Technology and the Department of Health, in consultation with other relevant government departments and SANAC, need to lead the process of developing a compact for joint funding for South Africa's research priorities with the world's largest funders of research. ■

8
COSTING AND FINANCING THE NSP

8.1 INDICATIVE COSTS OF THE NSP

The NSP is designed to indicate broad goals and objectives for the country's response to HIV, STIs and TB. The plan is strategic in nature, with the detailed implementation plans being developed separately by the sectors and provinces. The costing that accompanies the NSP is, therefore, best viewed as giving an indication of the potential magnitude of the anticipated costs. Once implementation plans have been designed, they will be costed to ensure that sufficient budget is available to put these plans into operation.

A review of the high-level costing tools and cost estimates available in South Africa concluded that an updated and adjusted version of the Resource Needs Model from the 'AIDS 2031' costing,[31] the National ART Cost Model and the National TB Cost Model[32] would be used to provide the broad estimates of the costs of the NSP. These models were used to cost interventions in SO 1, SO 2 and SO 3. For SO 4, the costing team undertook primary costing of the proposed interventions.

The general approach to calculating costs is to estimate the number of people in need of an intervention from epidemiological and demographic data, together with the coverage of the service, based on the coverage targets contained in the NSP (i.e. the percentage of the need or coverage that is to be met, etc.). The unit cost of each intervention is then calculated by estimating the physical ingredients of the intervention (e.g. ARVs, diagnostic tests, health-facility consultations) and multiplying this by the cost of each component.

Overall resource needs are a function of the number of people using the intervention and the unit cost of the intervention. These are estimated on an annual basis and summed across the period to give an indication of the likely costs of implementation. Costing is undertaken for the country as a whole (government, civil society and the private sector) from a provider's perspective. This perspective focuses only on the costs incurred by the provider of a service; no costs incurred by patients (such as travelling costs to and from facilities) are considered.

Costs are expressed in 2011 prices; where necessary, inflation adjustments have been made using the Consumer Price Index. The unit costs that are used in the costing of the NSP are based on earlier work undertaken in the costing of the previous NSP,[33] the AIDS 2031 costing, and under the remit of the detailed costing processes involved in putting the National ART Cost Model and the National TB Cost Model into operation. A small number of more recent studies were also used.[34]. These unit costs are the best available estimates in the country at present. As mentioned above, primary costing was undertaken for SO 4.

For some of the proposed interventions and strategies, no costing was possible at this stage. However, the costing covers all of the interventions that are known to be the key cost drivers of the NSP. The omitted interventions include those associated with:

1. research (e.g. identify and addressing structural barriers to residents in informal settlements accessing HIV, STI and TB services)
2. programme management and governance (e.g. district AIDS councils to develop a plan for community system strengthening)
3. M&E.

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31 Guthrie, T., Ndlovu, N., Muhib, F., Hecht, R. & Case, K. 2010. The long run costs and financing of HIV/AIDS in South Africa. Centre for Economic Governance and AIDS in Africa; Results for Development.

32 Meyer-Rath, G., Brennan, A., Schnippel, K., *et al*. 2011. National ART Cost Model, South Africa/National TB Cost Model, South Africa. Health Economics and Epidemiology Research Office, Boston University/University of the Witwatersrand: Johannesburg.

33 Cleary, S., Blecher, M., Boulle, A. & Dorrington, R. 2007. The costs of the National Strategic Plan on HIV and AIDS & STIs 2007–2011.

34 Jarvis, J.N., Harrison, T.S., Lawn, S.D., Meintjes, G., Wood, R. & Cleary, S.M.2011. *Cost Effectiveness of Cryptococcal Antigen Screening as a Strategy to Prevent HIV-associated Cryptococcal Meningitis in South Africa*. In 6th IAS Conference on HIV Pathogenesis, Treatment and Prevention. Rome, Italy.

Jones, L., Akugizibwe, P., Clayton, M., Amon, J., Sabin, M., Bennett, R., Stegling, C., Baggaley, R., Kahn, J., Holmes, C., Garg, N., Makhlouf-Obermeyer, C., DeFilippo Mack, C., Williams, P., Smyth, C., Vitoria, M., Crowley, S., Williams, B., McClure, C., Granich, R. & Hirnschall, G. 2011. Costing Human Rights and Community Support Interventions as a Part of Universal Access to HIV Treatment and Care in a Southern African Setting. *Current HIV Research,* 9: 000-000.

Research costs cannot be estimated because they depend directly on the size of the proposed study. Similarly, the costs related to programme planning and governance are more appropriately estimated once national departments, provinces and districts have finalised the personnel who are required to manage the provision of these services. Finally, while appropriate costing for and budgeting of M&E is essential, there are currently no data available for these costs.

While costs for these items have not been included, international practice suggests that their approximate values would be:

- programme management and governance: 0,05%
- M&E: 0,12%.

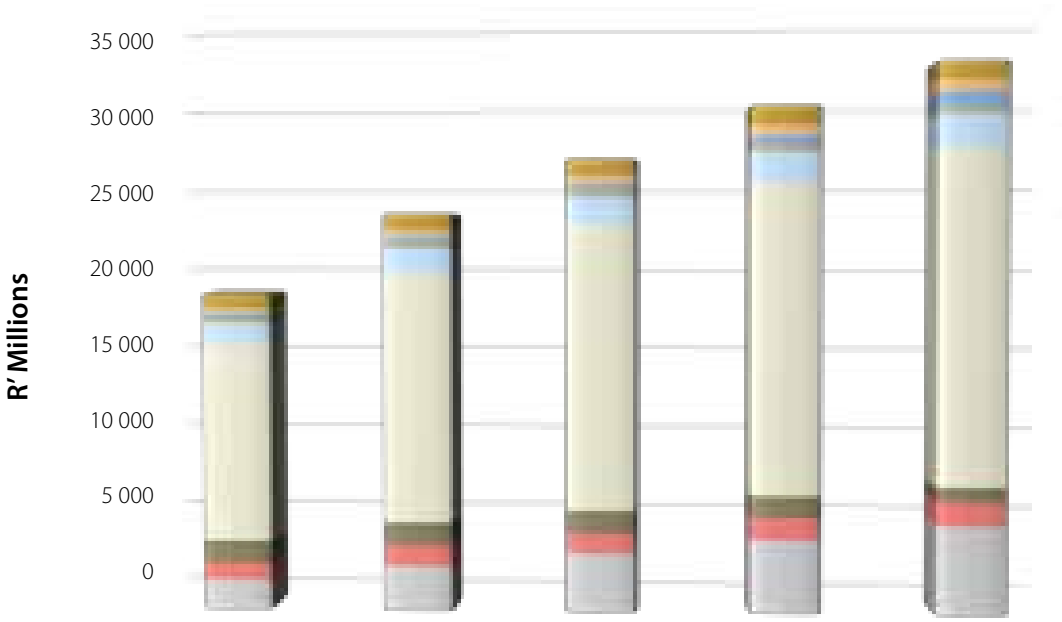
Thus, although these items have been omitted, it is clear that these values would not be of large relative magnitude and that their omission from the national costing would not unduly bias the overall estimates.

Annual total costs are summarised in Figure 4 for each NSP cost driver. Cost drivers include all of the cost categories that contribute greater than 1% to the total cost of the NSP.

The full list of interventions included for costing, together with some key assumptions, targets, annual and total costs is set out in Table 6.

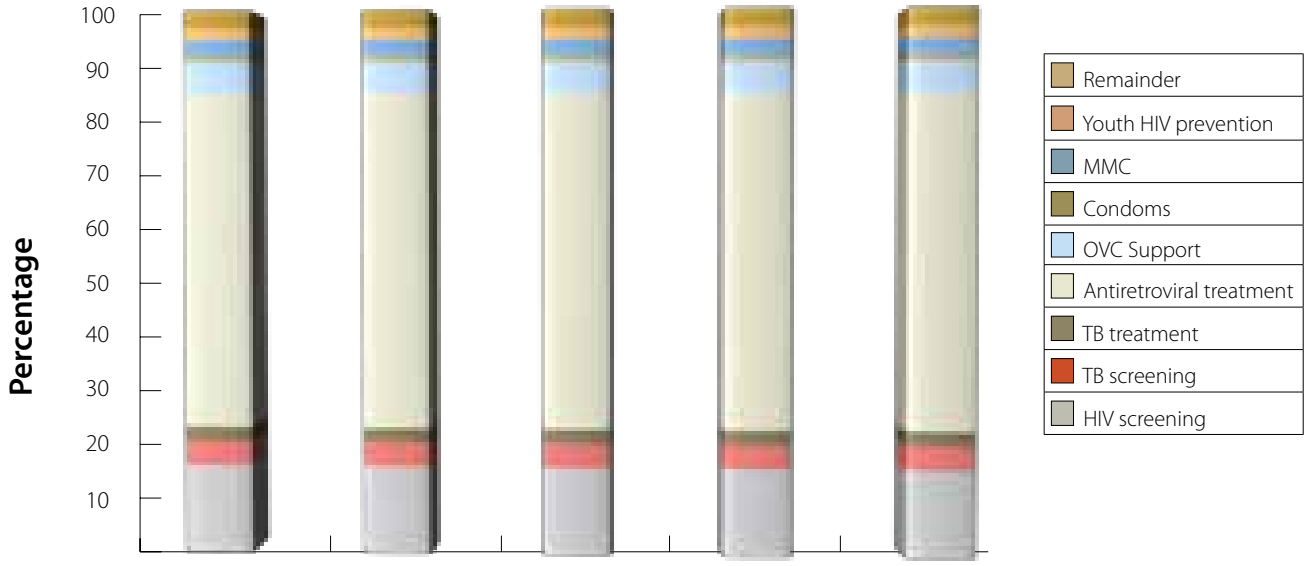
FIGURE 4: *CATEGORISED ANNUAL COSTS (ZAR MILLIONS IN 2011 PRICES)*

Annual costs summarised by key cost driver



	2012/13	2013/14	2014/15	2015/16	2016/17
Remainder	870	960	967	1061	1 070
Youth HIV prevention	323	451	529	689	756
MMC	244	293	293	488	781
Condoms	329	355	399	442	469
OVC Support	1 227	1 400	1 575	1 750	1 930
Antiretroviral treatment	11 681	14 783	16 827	18 352	19 737
TB treatment	1 329	1 337	1 356	1 253	869
TB screening	985	1 243	1 175	1 291	1 418
HIV screening	1 739	2 609	3 478	4 348	5 217

Share of costs by key cost driver



	2012/13	2013/14	2014/15	2015/16	2016/17
Annual total cost ZAR million	18 728	23 432	26 628	29 675	32 248

TABLE 6: *SUMMARY OF INTERVENTIONS AND COSTS*

INTERVENTIONS RELATED TO THE COSTING	UNIT COST	UNIT	2012/13	2013/14	2014/15	2015/16	2016/17	TOTAL COST
	R' MILLIONS (2011 PRICES)							
Scale up a comprehensive package of services that will remove structural barriers to access to HIV, STI and TB services for OVCs and their support structure	13 659	Cost OVC services	1 227	1 400	1 575	1 750	1 930	7 882
Implement PICT for HIV and screening for TB in all health facilities as well as in non-health settings; offer TB screening and HIV testing to the household contacts of all TB cases and provide IPT to all who are eligible; improve HIV, STI and TB contact tracing using PHC revitalisation; school-based screening for children with HIV, STIs and TB		**Targets**	**10 mil**	**15 mil**	**20 mil**	**25 mil**	**30 mil**	
	R173,91	Cost HIV screening	1 739	2 609	3 478	4 348	5 217	17 391
	R471 (2012) to R449 (2016)	Cost TB screening	985	1 243	1 175	1 291	1 418	6 111
Scale up implementation of IPT for all people living with HIV without active TB (preferably only those who have a positive tuberculin skin test)		**Targets**	**40%**	**60%**	**70%**	**75%**	**80%**	
	R574,17	Cost IPT	62	139	184	197	203	784
Maximise coverage of readily available and accessible male and female condoms using both health facilities and non-traditional outlets		**Targets**	**1 bil male**	**1 bil male**	**1 bil male**	**1 bil male**	**1 bil male**	
	R0,25	Costs male condoms	251	251	251	251	251	1,255
		Targets	**9 mil female**	**12 mil female**	**17 mil female**	**22 mil female**	**25 mil female**	
	R8,72	Cost female condoms	78	105	148	192	218	741
Expansion of MMC as part of male sexual and reproductive health programme		**Targets**	**500,000**	**600,000**	**600,000**	**1,000,000**	**1,600,000**	
	R488,30	Cost MMC	244	293	293	488	781	2 100
National SBCC strategy developed and implemented with specific focus on key populations to increase demand and uptake of services and promote positive norms and behaviours		**Targets**	**81%**	**85%**	**90%**	**90%**	**90%**	
	R103 million budget for current mass media programmes	Cost SBCC strategy	124	129	133	137	142	665

INTERVENTIONS RELATED TO THE COSTING	UNIT COST	UNIT	2012/13	2013/14	2014/15	2015/16	2016/17	TOTAL COST
	R' MILLIONS (2011 PRICES)							
Implement sexuality education, inclusive of life skills education, through the curriculum in all schools (in grades 1–12)		**Targets**	**60%**	**70%**	**70%**	**80%**	**85%**	
	196 million MTEF budget for life skills for primary and secondary schools	Cost sexuality and life skills education	178	215	222	263	271	1 150
Develop and implement HIV prevention strategies for further education and training colleges and institutions of higher learning, and for out-of-school youths		**Targets**	**35%**	**50%**	**60%**	**80%**	**90%**	
	R101,91	Cost per youth reached	323	451	529	689	756	2 749
Investigate the use of PEP, PrEP and microbicides to prevent the spread of new HIV infections	R241,40	Cost PEP	12	12	13	14	15	66
Finalise, adopt and implement the Action Framework for No Child Born with HIV by 2015 in South Africa; target one for PCR positivity at three months; target two for PCR positivity at 18 months		**Target 1**	**<3.5%**	**<3%**	**<2.5%**	**<2%**	**<1%**	
		Target 2	**Baseline**	**-- reduce by 1% per year --**				
	R799 (2012) to R982 (2016)	Cost PMTCT	135	104	93	84	80	496
Early ARV initiation as per national policy guidelines; ensure access to affordable, high-quality drugs to treat TB, HIV and STIs; ensure the fastest possible investigation and enrolment into appropriate treatment for HIV and TB, after screening and testing; initiate all TB patients on lifelong ART, irrespective of CD4 count; package of treatment services for HIV, STI and TB for key populations (including sex workers and their clients, truckers, prisoners, people with disabilities, migrants); integration of HIV and TB care with an efficient chronic care delivery system; clinics to provide services on weekends/out of hours	R4 889 (2012) to R5 134 (2016) (Adults) and R6 902 (2012) to R7 251 (2016) (children)	**Targets**	**61%**	**74%**	**80%**	**80%**	**80%**	
		Cost ART	11 681	14 783	16 827	18 352	19 737	81 380
Early treatment of TB and improved cure rate; Improve infection control in congregate settings; ensure access to affordable, high-quality drugs to treat TB, HIV and STIs; ensure the fastest possible investigation and enrolment into appropriate treatment for HIV and TB, after screening and testing; package of treatment services for HIV, STI and TB for key populations (including sex workers and their clients, truckers, prisoners, people with disabilities, migrants); integration of HIV and TB care with an efficient chronic care delivery system; clinics to provide services on weekends/out of hours		**Targets**	**75%**	**77%**	**80%**	**83%**	**85%**	
	R2 050 (2016) to R3 546 (2012)	Cost TB treatment	1 329	1 337	1 356	1 253	869	6 144
Ensure access to affordable, high-quality drugs to treat TB, HIV and STIs; package of treatment services for HIV, STI and TB for key populations (including sex workers and their clients, truckers, prisoners, people with disabilities, migrants)	R98,96	Cost STI treatment	212	214	216	218	220	1 078
PCR testing at EPI services		**Targets**	**90%**	**100%**	**100%**	**100%**	**100%**	
	R348,21	Cost PCR testing	68	64	55	50	47	285
Ensure all HIV-positive people with low CD4 counts (<100) are screened for cryptococcal meningitis and given appropriate treatment and rehabilitation		**Targets**	**30%**	**50%**	**60%**	**80%**	**90%**	
	R253,57	Cost screening and prophylaxis	5	13	14	17	19	68
Package of treatment services for HIV, STI and TB for key populations (including sex workers and their clients, truckers, prisoners, people with disabilities, migrants)		**Targets**	**Package implemented for each key population**	**30% of package available**	**50% of package available**	**70% of package available**	**80% of package available**	
		Cost for SWs and prisoners; others included above	41	45	48	62	55	250
Ensure protection of human rights and increased access to justice		**Targets**						
	Various	Cost of personnel and other costs	33	27	20	20	20	120

8.2 COMPARISON OF THE NSP COSTS TO ESTIMATES OF HIV- AND TB-RELATED EXPENDITURE

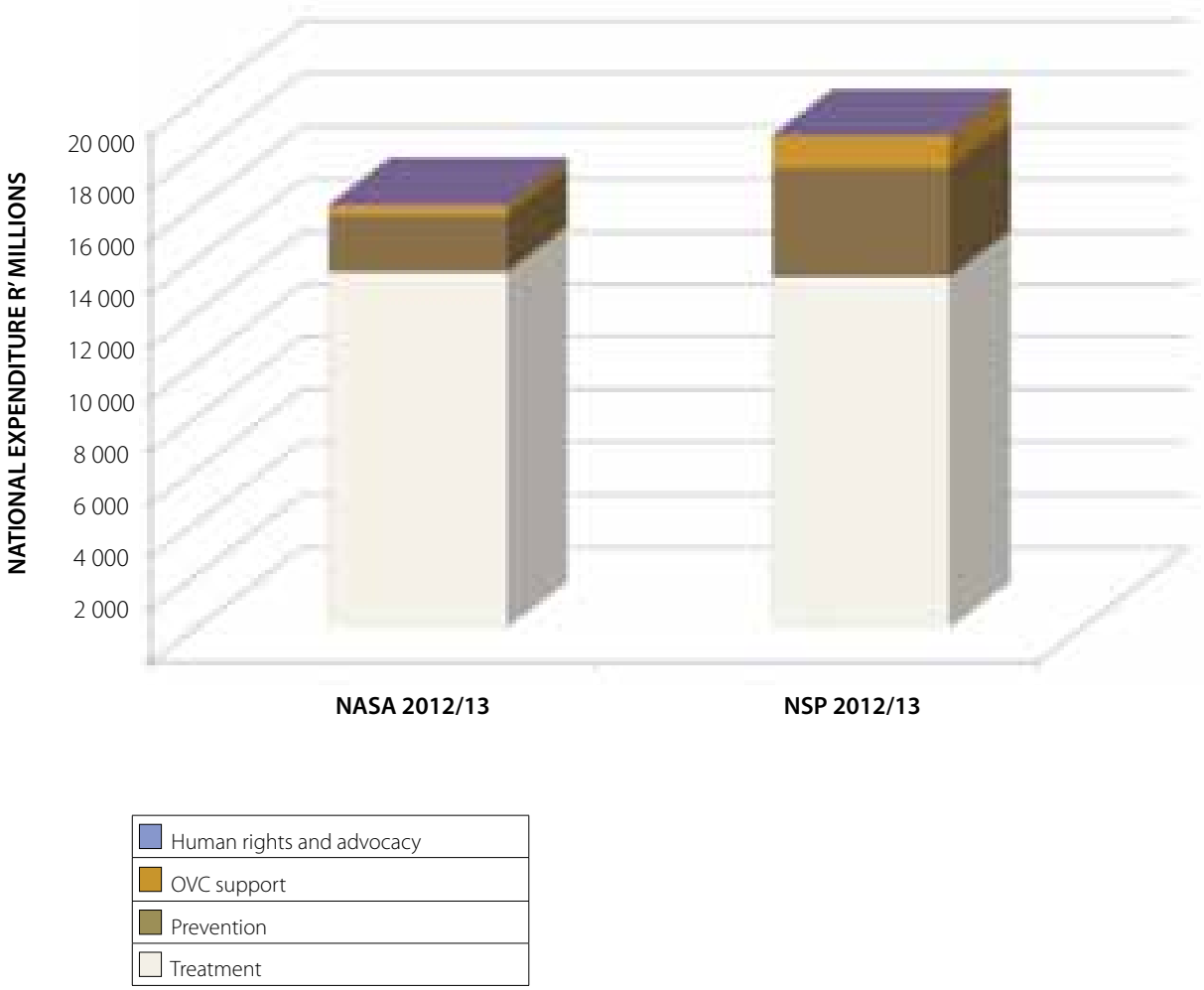
The recently concluded National AIDS Spending Assessment (NASA) provides the opportunity to compare the projected costs of the NSP to actual expenditures on HIV and TB-related interventions within South Africa, incurred by government, development partners, and the private sector. The NASA data were collected through the following methods:

- interviews and expenditure record verification
- data triangulation to ensure correct actual expenditure.

Data were then cleaned and captured in Excel, and analyses were undertaken. In addition, stakeholders were invited to provincial workshops where results were presented and an opportunity was given for comment on the accuracy of the data. Because the NASA measures actual expenditure, it should be noted that the expenditure estimates are from the 2009/10 financial year. To make the comparison more relevant, expenditure estimates were projected forward to 2012/13, based on the rate of increase in expenditure observed between 2008/09 and 2009/10 (18%). While 18% may seem high, it should be noted that this rate is considerably lower than the increase in expenditure between 2007/08 and 2008/09 (39%).

As shown in Figure 5, projected national expenditure by 2012/13 is 15% lower than the calculated costs of the NSP during 2012/13.

FIGURE 5: COMPARISON BETWEEN NASA AND NSP ESTIMATES WITHIN KEY PROGRAMMATIC AREAS



8.3 SUSTAINABLE FINANCING OF THE NSP

While the NSP is not a strategy of the Department of Health, the majority of the directly attributable costs are incurred within the sector. Sustainable financing of the NSP, therefore, includes the need to ensure sustainable financing of healthcare. South Africa's healthcare system includes both public and private financing and delivery.

Although funding for HIV-specific interventions has increased dramatically over the past few years within the public health sector, specifically linked to the HIV conditional grant, the overall resources required for the effective implementation of the NSP necessitates an increased investment.

There is growing consensus that the public health sector is inadequately resourced and there appears to be a commitment on the part of government to gradually increasing public funding of health services to closer to 5% of GDP.

While donor grants and external aid will continue to be a critical funding source for many of the interventions outlined in the NSP, international evidence suggests that domestic funding for health services is the key to long-term sustainability. In addition, while substantial donor funding is available to support the scaling up of many NSP-related interventions, this amounts to approximately only 2% of the overall resource envelope available in the public health system.

The key need, therefore, following the 'Taskforce on Innovative International Financing for Health Systems'[35] is to increase the pool of domestic resources, to reduce the fragmentation of funding flows and to focus on strengthening the health system.

It might also be relevant to consider innovative financing mechanisms, including excise taxes in tobacco, alcohol and unhealthy foods (foods high in salt and sugar), where a portion of the tax collected could be earmarked for the financing of the NSP.

- alcohol and tobacco taxes seem particularly relevant, given the identified role that their consumption plays in the transmission of HIV and TB
- AIDS levies are also a potential source of innovative funding – for example, Zimbabwe introduced such a levy on personal income tax, while Zambia introduced a levy of 1% on all gross interest earned in any savings or deposit accounts, with revenue generated earmarked for supporting these governments' efforts to increase access to HIV treatment
- other relevant financing mechanisms could include an earmarked employer's levy on the payroll, which could function similarly to the skills development levy, in the absence of employers providing workplace programmes that include treatment or medical insurance coverage.

8.4 ALIGNING AID ASSISTANCE

In January 2011, the Minister of Health launched the Aid Effectiveness Framework (AEF). The AEF seeks the alignment of development partner assistance with departmental processes, to make planning and implementation more efficient, reduce the administrative burden and minimise transaction costs, while at the same time recognising the need to strengthen the internal capacity and procedures.

The AEF will be updated annually to incorporate the needs and progress on the NSP implementation. As such, it is critical that the Annual Planning Tool to collect expenditure information according to a uniform set of reporting categories for all funding and implementing bodies in the health sector is used to track both the resources available and the spending patterns. This approach (and these tools) can be used in other sectors and government departments for resource tracking.

35 Taskforce on Innovative International Financing for Health Systems. 2009. Constraints to scaling up and costs. Working Group 1 Report.

8.5 COSTING OF THE PROVINCIAL STRATEGIC IMPLEMENTATION PLANS

While this costing of the NSP gives an indication of the potential magnitude of costs needed to achieve the NSP's goals, costing of the provincial plans and creation of provincial budgets are essential. A relatively simple costing tool will be used to cost the provincial plans.

The costing tool will link the resource needs estimates to their intended outputs and results. This will enable the provincial officials to track their expenditure according to these and, ultimately, to ensure that their spending relates to their overall goals. In addition, the cost estimates will be broken down by cost component (budgetary line items) to enable the provinces to easily identify the salary, drugs, laboratory, equipment, capital investments, communication, research, overhead costs etc. Once structured in this way, their budget estimates will be created, which will inform their application to their provincial departments (at the very beginning of the budget cycle) and subsequently to National Treasury.

The process described above will require extensive and ongoing training and technical support for provincial- and district-level programme managers and financial managers, in the application of the costing and budgeting tool, and in the tracking of expenditure. The financial management system will need to be adjusted and improved, for easier use by the programme managers, and to ensure routine and ongoing expenditure tracking (with the analysis of financial data) to inform project planning. ■

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- Afrikaans
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