SOUTH AFRICAN NATIONAL AIDS COUNCIL

ENHANCED

PROGRESS REPORT

NATIONAL STRATEGIC PLAN ON HIV, STIS AND TB (2012-2016)

SOUTH AFRICAN NATIONAL AIDS COUNCIL
ENHANCED PROGRESS REPORT OF THE SOUTH AFRICAN NATIONAL STRATEGIC PLAN ON HIV, STIs AND TB: 2012-2016

MARCH 2016

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CONDUCTED BY
Institute of Health Programs and Systems (IHPS) and Anansi Health Consulting

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ACKNOWLEDGEMENTS
Thanks to Fareed Abdullah, Matseliso Pule and Lifuto Motsieloa of the SANAC Secretariat for the support in the implementation of this review.
FOREWORD

The Enhanced Progress Report (EPR) of the NSP is a very important process to objectively gauge the country’s progress to achieve the goals that we set out in the National Strategic Plan (NSP) launched by President Jacob Zuma and then Deputy President Kgalema Motlanthe on 1 December 2011, World AIDS Day.

The report shows that South Africa has achieved its targets for antiretroviral treatment and for the prevention of mother-to-child treatment. We can all be very proud of these achievements. More than 3 million people are on antiretroviral treatment, of which the majority are in the public sector and are on the new one-pill-once-a-day combination. This makes our treatment programme the largest in the world. Of the 15 million people on treatment globally, more than 20% live in South Africa so our contribution to the global target has been substantial. We must acknowledge however, that this level of effort and investment in the treatment programme is necessary precisely because of the large number of people who are HIV+ in our country as well as the evidence that putting people on treatment saves lives and prevents new infections.

The report shows that the mother-to-child HIV transmission rate is now 1.5% at 6 weeks post-partum against the target set in the NSP of less than 2%. With no programme in place more than 70 000 babies were born HIV+, however, today the number is less than 7 000. I would like to see this rate go down even further so that elimination of transmission can be considered possible as is the case in Cuba for example.

With respect to prevention, the incidence of HIV has declined by about 20% since its peak in 2003 and 2004. Whilst much has been done, we have not reached our NSP target of a 50% reduction in 5 years. Many considered this target to be too ambitious when we set the target, though all agreed that ambitious targets for prevention are essential for the control of the epidemic.

We welcome the decision of UNAIDS and the global HIV community to add ambitious treatment targets referred to as the 90-90-90 targets which were announced in Melbourne in 2014 and adopted by the National Department of Health in 2015. We have developed detailed district implementation plans to ensure that we reach these targets, along with similar targets for TB, by 2020.

One of our priorities for the next few years is to accelerate our progress towards reaching our TB targets. Although there have been reductions in incidence in mortality from its peak in 2013, much more needs to be done to bring the TB epidemic under control. The ambitious plans announced by Deputy President Cyril Ramaphosa on World TB Day in March 2015 must be vigorously implemented. We need to give TB and indeed sexually transmitted diseases the same attention that we give to HIV.

In the course of addressing the HIV and TB epidemics we must enhance our focus on the human and legal rights of people infected and affected by HIV and TB. I am pleased that the EPR reports on the measurement of stigma for both HIV and TB and records that steps are being taken to address stigma and discrimination and to provide legal and other support for those who are subject to discrimination.

I would like to thank the EPR Steering Committee and the SANAC Secretariat for producing this important review.

DR AARON MOTSOALEDI, MP
MINISTER OF HEALTH
PREFACE

The Enhanced Progress Report was a collaborative effort between the SANAC Secretariat, the National Department of Health and other government departments, SANAC civil society and the numerous development partners who contributed to the process and participated in the Steering Committee and the validation workshops.

The findings of the report are essential in gauging our progress and performance against the goals and objectives set in the National Strategic Plan (NSP) and will go a long way to inform the priorities and targets set for the next NSP.

The review was funded by the SANAC Trust with contributions from the WHO and the Gates Foundation. Numerous other partners contributed expertise and time to the EPR.

I would like to thank all those individuals and organisations that contributed to the process especially the members of the Steering Committee. Special thanks go to Dr Nono Simelela from the Office of the Deputy President and Dr Yogan Pillay from the National Department of Health for their guidance and support of the review process.

Special thanks also go to Matseliso Pule and Lifutso Motsieloa from the SANAC M&E Unit who managed the consultants as well as the entire process of the EPR.

CHIEF EXECUTIVE OFFICER: DR. FAREED ABDULLAH

CHAIR OF THE MTR STEERING COMMITTEE
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<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>ANC</td>
<td>Antenatal Care</td>
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<tr>
<td>ART</td>
<td>Antiretroviral Treatment (Therapy)</td>
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<td>ARVs</td>
<td>Antiretroviral Drugs</td>
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<td>CSTL</td>
<td>Care and Support for Teaching and Learning</td>
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<td>DBE</td>
<td>Department of Basic Education</td>
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<td>DHIS</td>
<td>District Health Information System</td>
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<td>Department of Health</td>
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<td>DOJCD</td>
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<td>DPME</td>
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<td>Department of Public Service and Administration DR-TB</td>
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<td>ERP</td>
<td>Enhanced Progress Report</td>
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<td>ESA</td>
<td>Eastern and Southern Africa</td>
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<td>EPWP</td>
<td>Expanded Public Works Programme</td>
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<td>FSW</td>
<td>Female Sex Workers</td>
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<td>GBV</td>
<td>Gender-Based Violence</td>
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<td>GFATM</td>
<td>The Global Fund to fight Tuberculosis and Malaria</td>
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<td>GIZ</td>
<td>Die Deutsghe Gesellschft fur Internationale Zusammenarveit</td>
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<td>HCT</td>
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<td>HEAIDS</td>
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<td>HIV</td>
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<td>HTA</td>
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<td>Injecting Drug Users</td>
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<td>Multi Drug resistant TB</td>
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<td>MMC</td>
<td>Medical Male Circumcision</td>
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<td>MSM</td>
<td>Men who have sex with men</td>
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<td>MTSF</td>
<td>Medium Term Strategic Framework MTR Mid-Term Review</td>
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<td>MUS</td>
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<td>National AIDS Spending Assessment</td>
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<td>National Education and Development Labour Council</td>
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<td>Non-Government Organisation</td>
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<td>National Strategic Plan</td>
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<td>Definition</td>
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<td>Orphans and Vulnerable Children and Youth</td>
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<td>PEPFAR</td>
<td>President's Emergency Fund for AIDS Relief</td>
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<td>PICT</td>
<td>Provider Initiated Counselling and Testing</td>
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<td>PLWHA</td>
<td>People living with HIV</td>
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<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission of HIV</td>
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<td>PrEP</td>
<td>Pre Exposure Prophylaxis</td>
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<td>PWID</td>
<td>People who inject drugs</td>
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<td>South African National AIDS Council</td>
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<td>South African Police Services</td>
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<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<td>TVET</td>
<td>Technical and Vocational Education and Training</td>
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<td>UCSFS</td>
<td>University of California, San Francisco</td>
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<td>UNAIDS</td>
<td>United Nations Programme on HIV and AIDS</td>
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<td>UNGASS</td>
<td>United Nations General Assembly Special Session on HIV &amp; AIDS</td>
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<tr>
<td>VAW</td>
<td>Violence Against Women</td>
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<td>VMMC</td>
<td>Voluntary Medical Male Circumcision</td>
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<td>WBOTS</td>
<td>Ward-Based Outreach Teams</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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<tr>
<td>XDR TB</td>
<td>Extensively Drug Resistant TB</td>
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SECTION 1: Introduction

1.1. BACKGROUND

South Africa’s National Strategic Plan (NSP) 2012-2016, is the third plan outlining how the country will respond to the epidemics of the human immunodeficiency virus (HIV), sexually transmitted infections (STIs) and tuberculosis (TB) over a five-year period. The NSP builds on previous plans and achievements, focussing on improving and scaling up service delivery and implementing proven interventions.

The NSP guides and informs the development of national, provincial, district and community-level implementation and is also used by the South African National AIDS Council as a framework for coordinating and monitoring implementation by sectors, provinces, districts and municipalities. The NSP guides South Africa’s response and progress, allowing all partners to coordinate their efforts among themselves and with the South African Government.

The NSP draws on South Africa’s constitutional framework and emphasises human rights, dignity, non-racialism, non-sexism and the rule of law. It is aligned with the National Development Plan (NDP) and the Medium Term Strategic Framework (MTSF) of government. Overarching guidance is obtained through alignments with international and regional obligations, commitments and targets related to HIV, STIs and TB.

The NSP 2012-2016 draws on the vision of the Joint United Nations Programme on HIV and AIDS (UNAIDS) of zero new HIV infections, zero new infections due to vertical transmission, zero preventable deaths associated with HIV, and zero discrimination associated with HIV. It is also in line with World Health Organisation’s (WHO) goals for reducing TB incidence and mortality. The broad goals of the NSP are:

- 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 the implementation of the NSP
- Reducing self-reported stigma related to HIV and TB by at least 50%

This comprehensive report aims to provide the country and especially SANAC and its stakeholders in government, civil society and the private sector with a landscape view of the country’s progress against these five broad goals.
The NSP is organised into four Strategic Objectives that guide the 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 GOAL AND OBJECTIVES OF THE REVIEW

The Overall Goal of the Review of the NSP 2012-2016 is to conduct an in-depth analysis of the NSP implementation with a focus on achievements, challenges and emerging issues. The report findings are intended to provide guidance and recommendations for the remaining term of the NSP, and help to inform the process of developing the forthcoming 2017 NSP.

Objectives are to:

- Assess progress made in achieving the NSP goals and strategies
- Identify challenges experienced in implementing this NSP, following the strategic direction to scale-up the response to HIV, TB and STIs
- Assess the relevance and achievements of the focus on HIV, STIs and TB in relation to increased coverage, improved quality, adaptation and combination of strategies to take into account epidemic dynamics and application of innovations
- Identify challenges experienced, lessons learned and best practices of the NSP implementation to date
- Review progress of NSP implementation against the strategic objectives, indicators and priorities
- Review indicators, as well as objectives with no indicators, and the systems in place to collect and analyse data to measure these indicators
- Make recommendations for the remainder of the current NSP period and next NSP

1.3 METHODOLOGY

Inception processes for the review were initiated in April 2015 and included an agreement on the technical approach and timelines for the review. An EPR Steering Committee was established to provide oversight and guidance to the review process including approval of the technical approach, EPR review documents, data collection tools, concept notes for workshops and the approval of draft and final reports. Below is a list of Steering Committee members:
Table 1: Steering Committee Members

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<th>Bernd Appelt (GIZ)</th>
<th>Nancy Knight (Centers for Disease Control and Prevention)</th>
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<td>Celicia Serenata (CHAI)</td>
<td>Nono Simelela (Presidency)</td>
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<td>Erasmus Morah (UNAIDS)</td>
<td>Roxanna Rustomjee (Office of TB: MRC)</td>
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<td>Fareed Abdullah (SANAC) (Chair)</td>
<td>Steve Letsike (Civil Society Forum)</td>
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<tr>
<td>7</td>
<td>Fikile Ndlovu (KZN AIDS Council)</td>
<td>Vuyisa Dayile (Eastern Cape AIDS Council)</td>
</tr>
<tr>
<td>8</td>
<td>Gavin Churchyard (Aurum Institute)</td>
<td>Vuyiseka Dubula (Sonke Gender Justice)</td>
</tr>
<tr>
<td>9</td>
<td>Khangelani Zuma (HSRC)</td>
<td>Yogan Pillay (NDOH)</td>
</tr>
<tr>
<td>10</td>
<td>Lebo Ramafoko (Soul City)</td>
<td></td>
</tr>
</tbody>
</table>

The NSP review team conducted data collection and analysis as follows:

- Key documents, research reports and quantitative data were collated and shared electronically
- Additional data were compiled through key informant interviews at national and provincial levels, as well as conducting EPR review workshops. Data collection was informed by interview and workshop guides. Key informant data collection included face-to-face, telephonic and electronic methods
- Provincial workshops were conducted in all nine provinces
- Documents, reports and quantitative data were analysed through a desk review. Interview and workshop data were compiled into narrative reports for analysis
- Government departments and other sectors were requested to share their progress reports and relevant information on the implementation of the NSP was extracted to ensure inclusiveness of all departments.
- Weekly feedback sessions were conducted between the EPR review team and the SANAC Secretariat
- The steering committee met five times to review the methodology and the findings

The draft findings of the review were further informed by an M&E Experts Workshop which was held to review current indicator matrices and their relevance to the NSP, and to propose recommendations for the remainder of the current NSP period as well as the next NSP. Two Stakeholder Validation and Consensus Workshops were also conducted to solicit inputs and validate results at national level.

An excerpt of the current detailed EPR was compiled and published separately to serve as a summary EPR.

**SECTION 2: FINDINGS**

The five goals of the NSP are:

- 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%
- Table 2 outlines key NSP indicators and progress towards targets from baseline.

Table 2: NSP key indicators, baseline to 2014/15

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline</th>
<th>Target for 2017</th>
<th>FY 2014/15 Status</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV prevalence among women and men aged 15-24</td>
<td>8.7% (HSRC, 2008)²</td>
<td>4.35% (50% reduction)</td>
<td>7.1% [95% CI: 6.2-8.1] (HSRC, 2012)²</td>
<td>18% decline from 2008 to 2012; required reduction will not be reached if this trend continues through the period of the NSP</td>
</tr>
<tr>
<td>HIV prevalence in key populations</td>
<td>Survey was planned for 2012</td>
<td>50% reduction</td>
<td>MSM: 22% in Cape Town; 48% in Durban (SANAC/DOH/PEPFAR/UCSF, 2015)³ FSW: 39.7% in Cape Town 53.5% in Durban 71.8% in Johannesburg (SAHMS, 2015)³</td>
<td>Size estimation done in 2013 for sex workers estimates 153 000 sex workers in South Africa. Prevalence studies conducted for sex workers and MSM in 2013 and 2014 respectively. This is the current prevalence status only for MSM and FSW available data, there was no baseline set in 2012</td>
</tr>
<tr>
<td>Indicator</td>
<td>Baseline</td>
<td>Target for 2017</td>
<td>FY 2014/15 Status</td>
<td>Comment</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------</td>
<td>-------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| **HIV Incidence**             | 0.94% for adults (ASSA, 2012)<sup>5</sup> **Corrected** 1.79% (THEMBISA 2008) | 0.47% (<150 000 new infections, 50% reduction) | **Ages 15–49 years**  
1.47 CI (1.23–1.72)
Male 1.10% CI (0.84–1.36);  
Females 1.88% CI (1.48–2.28)  
**Ages 15–24 years**  
1.77 CI (1.56–1.98)
Male 0.82% (0.70–0.94)  
Females 2.83 CI (2.38–3.29) (THEMBISA Model 2012) | 18% decline based on updated and corrected baseline data. HIV incidence remains above the desired target for the adult population |
| TB incidence                  | 981/100 000 (WHO 2010)<sup>6</sup> | 491/100 000 (50% reduction)         | 834/100 000 (WHO, 2015)<sup>7</sup> | Annual TB incidence declined by 15% but remains well above set target for 2016                                                   |
| TB mortality                   | 50/100 000 85 000 TB deaths among PLHIV (WHO 2010) | 25/100 000 42 500 TB deaths among PLHIV (50% reduction) | 44/100 000 TB mortality in PLHIV - 134/100 000 72 000 TB deaths among PLHIV (WHO, 2015)<sup>8</sup> | TB mortality rate decreased from 50 to 44 per 100 000 in the HIV negative population. TB mortality in PLHIV decreased from 168 to 134 per 100 000 from 2012 to 2014. There is a decline compared to the baseline but the target of a 50% reduction has not been reached |
| HIV mortality                  | 3.4% (Stats SA, 2011)<sup>9</sup> | (50% reduction)                     | 5.1% (Stats SA; 2013) | According to UNAIDS (2013), HIV mortality has declined. This is a major achievement due to improved reporting.                |
| MTCT rate <br>(6 weeks and 18 months) | 3.6% for six weeks (MRC, 2010)<sup>10</sup> | <2% (6 weeks) <5% (18 months) | 1.5% (6 weeks) (DOH Annual Report, 2014/15)Less than 5% (18 months) MRC, 2015 | Target exceeded for MTCT at 6 weeks. Target met for MTCT at 18 months (at follow up)                                                  |
### Indicator

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline</th>
<th>Target for 2017</th>
<th>FY 2014/15 Status</th>
<th>Comment</th>
</tr>
</thead>
</table>
| Stigma index                      | No baseline data             | First National Stigma Index conducted in 2014 and will be used as the baseline | 35.5% external stigma among PLHIV  
43% internal stigma among PLHIV  
36.3% TB related stigma  
(Stigma Index; 2015)  
1                                                                 | The 2014 National Stigma Index marks the baseline                                                |
| Patients alive and on treatment   | No cohort data available     | 12 months – 94%  
24 months – 88%  
36 months – 82%  
48 months – 76%  
60 months – 70%  
75.0%  
52.3%  
(DOH; 2015)  
1                                                                 | 12 months  
75.0%  
60 months – 52.3%  
(DOH; 2015)  
2                                                                 | Retention on ART is below target for each cohort due to absence of a unique identifier - high chances of under-reporting. In addition unrecorded viral loads done lead to under-reporting |

### 2.1 GOAL 1: REDUCING NEW HIV INFECTIONS

Goal 1: Reducing new HIV infections by at least 50% using combination prevention approaches

<table>
<thead>
<tr>
<th>Goal 1</th>
<th>On track to target?</th>
<th>Sexual Transmission (15-49 years) has declined but the target has not been achieved</th>
<th>PMTCT (at 6 weeks) target reached. This is a major achievement</th>
</tr>
</thead>
</table>

### HIV INCIDENCE

There are various measures of HIV incidence in South Africa including estimates made by the Human Sciences Research Council (HSRC), the UNAIDS Spectrum Model and the THEMBISA model. HIV incidence for all ages using the Spectrum Model is estimated to have been 500 000 (95% CI: 450 000-540 000) in 2004; 430 000 (95% CI: 380 000-480 000) in 2009, and 330 000 (95% CI: 290 000-390 000) in 2014 (Figure 1). For persons 15 years and older, incidence is estimated to have been 330 000 (95% CI: 280,000-380,000) in 2014, indicating a decrease of 17.5% from 410 000 (95% CI: 350,000-450,000) in 2011. The model also indicates that 6.8 million South Africans were living with HIV in 2014. The HSRC study found HIV incidence in 2012 to be 0.71 (95% CI: 0.57-0.85) for males aged two years and older, and 1.46 (95% CI: 1.18-1.84) for females in the same age range. The highest HIV incidence overall was found for females aged 15-24 at 2.54 (95% CI: 2.04-3.04).
The THEMISA model was used to determine trends in HIV incidence over the past three decades (Figure 2a). HIV incidence among youth and adults aged 15-49 peaked in the late 1990s with steady declines occurring through to 2011. Figure 2b shows the provincial breakdown of incidence for 2011/12, with incidence being highest in KwaZulu-Natal, Mpumalanga and North West Province. Lower incidence provinces were Western Cape and Northern Cape.
Currently, South Africa’s new HIV infections are more than a quarter of the world’s new HIV infections. As such, efforts to address the persistent sexual transmission of HIV need to be intensified through evidence-based combination prevention interventions.

**HIV PREVALENCE**

HIV prevalence among girls and young women aged 15-24 in national surveys has consistently been found to be many times higher in comparison to boys and young men in the same age group, contributing over 30% towards new infections. In 2012, for example, HIV prevalence among males was 2.9% (95% CI: 2.1–3.9) and nearly four times higher among females at 11.4% (95% CI: 9.8–13.2). Figure 3 illustrates HIV prevalence by age group and sex in 2012, with female prevalence consistently being higher than male prevalence, although confidence intervals overlap for the 0-14 year age group, the 30-39 year age group and for persons 40 years and older.
According to the 2013 National Antenatal Sentinel HIV Prevalence Survey, the overall HIV prevalence amongst pregnant women who presented for their first antenatal care visit at public health facilities was 29.7% in 2013, an increase of 0.2% from 29.5% reported in 2012. Mother to Child Transmission (MTCT) has markedly improved over the recent period, with the NSP 2012-2016 target for vertical transmission at six weeks already reached. There has been a marked decline from >3.5% in 2010 to the targeted <2% being achieved by end of 2014 (See Figure 9).

### 2.2 GOAL 2: INITIATING ELIGIBLE PATIENTS ON ART

Goal 2: Initiating at least 80% of eligible patients on ART, with 70% alive and on treatment five years after initiation

<table>
<thead>
<tr>
<th>Goal 2</th>
<th>On track to target?</th>
<th>ART Initiation target has been reached. This is a major achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Survival on treatment low. Target not reached (difficult to estimate due to lack of unique identifier)</td>
</tr>
</tbody>
</table>

By the end of 2014/2015, South Africa had 3 078 570 persons living with HIV (PLHIV) on ART. The rate of loss to follow up (LTFU) was 27% at 12 months on ART and the viral load done among active patients on ART was 59.6% in 2014. It is estimated that life expectancy improved from 42.6 years in 2004 to 52.5 years in 2013. The number of PLHIV receiving ART in South Africa rose from 616 337 in 2009 to 3 078 570 in 2014 respectively (See Figure 17).

South Africa has one of the largest HIV-treatment programmes’ globally, and this is commensurate with the high burden of HIV and AIDS in the country. Over the past five years – 2010-2014, the annual target of initiating 500 000 PLHIV on ART has consistently been exceeded. South Africa has also contributed about 20% towards the global target of PLHIV on ART.

In 2014, AIDS related deaths were estimated at 140 000 for all ages, with 130 000 (93%) being among PLHIV aged 15 years and older. There has been a progressive drop in the AIDS deaths for all ages, and this is attributable to increased access to ART. AIDS deaths have declined from 320 000 in 2010 to 140 000 in 2014 (See Figure 28).
2.3 GOAL 3: REDUCING NEW TB INFECTIONS AND TB DEATHS

Goal 3: Reducing the number of new TB infections, as well as the number of TB deaths by 50%

<table>
<thead>
<tr>
<th>Goal 3</th>
<th>On track to target?</th>
<th>New TB infections and TB death rates beginning to decline but targets not reached</th>
<th>Beginning to decline but target not reached</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

In 2014/15, there were an estimated 270 000 (240 000-310 000) new TB infections that occurred among PLHIV out of a total of 450 000 (400 000-510 000) new TB infections. This translates into an overall incidence of 834 (737-936) cases per 100 000 in 2014. A total of 318 193 TB cases were notified in 2014. The number of multidrug resistant (MDR) TB cases have doubled from 7 350 cases in 2007 to 14 161 in 2012. Furthermore, about 4 700 (3 700-5 900) new MDR-TB and 1 500 (1 200-1 800) retreatment MDR-TB were estimated among notified pulmonary TB cases in 2014. TB is the principal cause of death for PLHIV in South Africa, with an estimated 72 000 (58 000-89 000) TB-related deaths occurring among PLHIV in 2013 – a rate of 134 (107-164) per 100 000 population. The TB case fatality rate was 8.4% in 2013. South Africa has over 300 GeneXpert machines deployed countrywide and over 2.1 million GeneXpert tests have been conducted, considerably exceeding the 2013/14 target of 800 000.

Globally, South Africa had the third highest TB burden after China and India for the period 2009-2012. After the TB programme data review in 2013, the country ranked six after India, China, Nigeria, Pakistan and Indonesia. South Africa’s TB epidemic is linked to HIV prevalence, with a co-infection rate of more than 60%. There has, however, been a gradual decline in TB incidence from 2008 to 2013 (See Figure 15).

Treatment outcomes for new smear-positive pulmonary TB (PTB) are encouraging, with the cure rate improving from 57.6% in 2005 to 75.8% in 2012. The treatment success rate for all TB forms has also increased from 60.9% in 2004 to 76.1% in 2012. There was a gradual increase of registered TB cases from 2005, peaking at 406 082 in 2009, and then declining to 328 896 cases in 2013 (See Table 16).

In general, the TB mortality rate has varied over time. However, TB mortality (excluding HIV+ TB) appears to have stabilised over the recent period (2010-2013) – See Figure 29. In 2013, an estimated 24 000 (22 000-26 000) cases, at a rate of 44 (41-48) per 100 000 persons were reported. The 2016 NSP TB mortality rate target is 25/100 000 – a 50% reduction from baseline.

2.4 GOAL 4: PROTECTION AND PROMOTION OF LEGAL RIGHTS

Goal 4: Ensuring an enabling and accessible legal framework that protects and promotes human rights in order to support implementation of the NSP

<table>
<thead>
<tr>
<th>Goal 4</th>
<th>On track to target?</th>
<th>Good progress made towards target (Please note that there was no baseline data for Goal 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

According to the 2013 HIV and TB review, South Africa’s interventions and policies respect human rights in their conceptualisation and implementation. It was found that HIV Counselling and Testing (HCT) was taking place with informed consent, PLHIV eligible for ART were referred appropriately, patients with drug-resistant TB were managed as per guidelines, women were not denied their sexual and reproductive health, and rape survivors were provided with appropriate Post-Exposure Prophylaxis (PEP) services.

Health care guidelines and policies follow a rights-based approach, and there are examples of provision for rights-based responses such as prevention of stigma and discrimination campaigns, provision of human rights training and improving enforcement of rights in programmatic responses for vulnerable and key populations. There is also a strong commitment to addressing Gender-Based Violence (GBV) and ensuring women and girls have access to health and legal services following sexual violence. SANAC has made...
progress in setting up systems to ensure effective monitoring of human rights abuses and increasing access to justice.

The South African Human Rights Commission (SAHRC) upgraded the Flow-centric data system and training of legal officers and data capturers to improve the effectiveness of complaints handling and achieved case finalisation for 93% of the 9,217 cases received. However, the data does not disaggregate HIV or TB-related complaints. The SAHRC plans to focus attention on improving its reach and accessibility to marginalised communities through convening human rights clinics in rural and peri-urban areas.


2.5 GOAL 5: REDUCING STIGMA AND DISCRIMINATION

Goal 5: Reducing self-reported stigma and discrimination related to HIV and TB by 50%

<table>
<thead>
<tr>
<th>Goal 5</th>
<th>On track to target?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Good progress made towards target though unanticipated high internalised (self) stigma was discovered in the survey</td>
</tr>
<tr>
<td></td>
<td>(Please note that there was no baseline data for Goal 5)</td>
</tr>
</tbody>
</table>

National population-based surveys have shown low levels of stigma-related attitudes among the general population. For example, the National Communication Survey found that 87% of respondents would remain friends with a person who was known to be HIV positive, while 16% said they would be embarrassed being seen with a person known to have HIV.

The perspectives of PLHIV were explored through a national Stigma Index Survey carried out in 2014 which found that 36% of PLHIV had experienced some form of external stigma and discrimination and 43% some form of internal stigma respectively. Experiences of most formats of external stigma were low. For example, 90% of PLHIV reported that they had not been excluded from social events, 92% reported never having been excluded from family activities and 96% had not been excluded from religious activities. Some experiences of social exclusion were attributed to reasons not related to HIV status. Having been gossiped about was more common, with 24% reporting this experience a few times or often in the past 12 months, while discrimination a few times or often in the past 12 months was reported by 14%. Experiences of frequent verbal harassment were reported by 10%. In relation to health services, 72% of PLHIV indicated that their HIV status was not disclosed without their consent by a health care professional, 24% were unsure and 4% believed that their status had been disclosed previously without their consent. There were some concerns that medical records were not kept confidentially. Internalised stigma, which relates to perceptions of self-esteem and self-worth, included feelings of guilt (29%), shame (28%), and self-blame (30%), with feeling suicidal being reported by 11%.

Figure 4 illustrates experiences of some form of external stigma in the past 12 months by province, with Free State and KwaZulu-Natal being highest and Limpopo and North West being lowest.
Figure 4: Experiences of some form of external stigma in the past 12 months by province

TB-related stigma and discrimination was more common among PLHIV with TB than HIV-related stigma, with experiences in the past 12 months including being gossiped about (41%) and being teased, insulted or sworn at (36%).

3. PROGRESS AGAINST STRATEGIC OBJECTIVES

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

SUB-OBJECTIVE 1: OVERVIEW

Strategic Objective (SO) 1 addresses a range of underlying factors that influence the extent of new infections and negative impacts of HIV, STIs and TB. The objective builds on the foundation of a broad rights-based framework set out in the South African Constitution, and sets out to mobilise elements of the Medium Term Strategic Framework 2009-2014, with a focus on addressing social and structural factors underpinning the HIV and TB epidemics.

The NSP sets out to address SO 1 through the following eight sub-objecitives:

1. Mainstreaming gender- and rights-based dimensions of HIV and TB into the core mandates of all government departments and all SANAC sectors
2. Addressing social, economic and behavioural drivers of HIV, STIs and TB
3. Implementing interventions to address gender inequities and gender-based violence as drivers of HIV and STIs
4. Mitigating the impact of HIV and TB on orphans, vulnerable children and youth
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
6. Reducing HIV and TB-related stigma and discrimination
7. Strengthening community systems
8. Supporting efforts aimed at poverty alleviation and enhancing food-security programmes
This Strategic Objective is aligned with global recognition that while much of the response to HIV has focused on addressing individual risk behaviours, less attention has been given to addressing vulnerabilities emanating from social and structural factors that sustain the epidemic. In addressing these factors, the NSP is reliant on response driven through multiple government departments in combination with sectoral partnerships and response located within civil society. Some aspects of the response to this SO are directly and tangibly addressed through instrumental processes – for example, mainstreaming HIV and TB into government policies, sector strategies, implementing programmes to address gender inequality and GBV, mitigating impacts of HIV on orphans and vulnerable children, strengthening community systems linked to health, retaining young people in schools and conducting poverty relief programmes. Other aspects require leadership and transformative processes linked to social norms and values to strengthen the foundation of the response as a whole.

**MAINSTREAMING**

In the context of the NSP, mainstreaming refers to the process of where development actors address the causes and effects of HIV & AIDS in a sustainable manner, within their comparative advantage (mandates) and for the benefit of their internal stakeholders and clients (e.g. employees) and external stakeholders and clients (e.g. the public). This entails fundamentally managing HIV & AIDS as a development issue that requires sustainable interventions that address structural drivers of the epidemic. It takes HIV & AIDS into consideration as a cross-cutting issue within policy and practice at different levels of implementation. HIV and TB mainstreaming thus takes underlying causes, effects and impacts into consideration.

The NSP highlights the importance of mainstreaming HIV and TB and its gender- and rights-based dimensions into policies and plans across the spectrum of government departments and SANAC sectors at all levels. In essence, mainstreaming sets out to ensure that these related concerns are expressly highlighted and analysed, and then linked to strategic priorities and actions. Analysis of the outcomes of such mainstreaming thus requires two questions to be addressed: 1) Have HIV and TB, including their gender and rights dimensions been mainstreamed into the core mandates? 2) Have the identified issues and principles been translated into operational plans?

The NSP specifically notes that the Department of Public Service and Administration (DPSA) should conclude guidelines to ensure that the government departments know how to apply mainstreaming principles and practices for HIV and TB into their operational plans. The DPSA developed and released these guidelines in 2012. This includes determining how HIV and TB affect given departments, ministries clusters or sectors in relation to the evolving epidemic, and how actions (or inaction) may influence the trajectory of these epidemics. This includes internal and external domains – i.e. in relation to human resource and management on the one hand, and in relation to influencing the prevention of new infections and mitigation of impacts of HIV infection. Mainstreaming thus includes identifying measures and actions that address the potential impacts and risks of HIV and TB.

The NSP views the HIV and TB epidemic as concerns that have the potential to undermine South Africa’s development agenda as a result of contributing markedly to the country’s overall burden of disease. HIV is the leading factor contributing to years of life lost due to premature death in South Africa, followed by diarrheal diseases and interpersonal violence.

South Africa’s Bill of Rights commits to rights and freedoms that seek to address and overcome historical inequalities including racism, patriarchy, poverty, inequality and unemployment. Institutions such as the Commission for Gender Equality focuses on legislation, monitoring and rights while gender mainstreaming has been given attention in various government policies, including, for example, the Public Service Commission’s guidance on gender mainstreaming.

While the extent of HIV and TB mainstreaming within government core mandates and operational plans can be assessed, the extent to which SANAC sectors have integrated this mandate is relative to the availability of formal policies, guidelines and sector reports. Assessing the extent to which mainstreaming has influenced operational planning requires access to detailed plans.

The suggested means of measuring progress in relation to mainstreaming is determining the proportion of government departments and sectors with operational plans that have mainstreamed HIV,TB and related gender and rights-based dimensions.
UNDERLYING DRIVERS

The NSP acknowledges that living circumstances have a strong bearing on vulnerability to HIV and TB, and national surveys on HIV prevalence have repeatedly highlighted the disproportional distribution of HIV by geographic locale with formal rural areas and informal urban areas being most affected.

The NSP makes reference to a mapping exercise and situational assessment of informal settlements to address housing and service upgrades, while government departments including the Department of Basic Education (DBE), Department of Health (DOH), and Department of Social Development (DSD) are tasked with ensuring equitable delivery of services to these areas.

To address high HIV prevalence and incidence in rural areas, the NSP outlines the planned development of a comprehensive strategy to address diverse challenges, support governance and to improve access to health services.

Concern is raised regarding substance abuse, and the NSP highlights the leadership undertaken through the Inter-Ministerial Committee (IMC) on substance abuse to address policy and programmatic matters pertaining to alcohol, illicit drugs and tobacco. The focus of the IMC includes addressing legislative matters, strengthening substance abuse education – particularly in schools, and addressing the intersection between gender and substance abuse.

Attention is given to mobility and migration including internal migration between rural and urban settings and cross-border migration. It is highlighted that female migrants overall, as well as transport workers and migrant labourers are especially vulnerable. Apart from HIV prevention, it is recognised that effective systems for managing antiretroviral treatment (ART) among mobile populations within the health system needs to be addressed.

It is anticipated in the NSP that this sub-objective be assessed through determining the proportion of municipalities with at least one informal settlement where HIV, STIs and TB services are implemented. Additionally, delivery rates for women and children under the age of 18 are suggested as a means to determine the extent of condom and other contraceptive use and sexual debut.

GENDER INEQUALITY AND GENDER-BASED VIOLENCE

The NSP recognises the links between HIV and GBV including in relation to prevention, treatment, care and support. Emphasis is placed on rights related to gender equality and the need for transformation in the spheres of economic and social development. Given the high levels of GBV – particularly GBV directed towards girls and women, it is noted that SANAC and the (then) Department of Women, Children and People with Disabilities (DWCPD) should develop a comprehensive approach to GBV prevention including both primary and secondary prevention and communication to address values perpetuating GBV. Some of the responsibilities of the DWCPD have now shifted to the DSD, with a gender focus being more directly addressed through the new Department of Women (DOW).

It is intended that this sub-objective be assessed through determining the number of women and children reporting GBV to the police each year, as well as the proportion of women reporting having experienced physical or sexual violence in the past year.

ORPHERANS, VULNERABLE CHILDREN AND YOUTH

It is recognised that HIV contributes to orphaning as well as to vulnerability of children and youth when it occurs in household settings. HIV impacts on care arrangements of children, and vulnerabilities intersect with increased risk of HIV acquisition. The NSP proposes scaling up initiatives at community level to reduce vulnerabilities and impacts related to HIV and TB and to protect the rights of orphans and vulnerable children, including children in youth headed households. Emphasis is placed on addressing mental health needs. There is no suggested approach in the NSP for measuring this sub-objective.
KEEPING YOUNG PEOPLE IN SCHOOL AND SUPPORTING POST-SCHOOL OPPORTUNITIES

The NSP recognises that education is protective in relation to HIV vulnerability, with school attendance being linked to lower HIV prevalence levels. Maintaining school attendance and mitigating against dropout are seen as a critical intervention, particularly among girls. Parent-child communication is also emphasised. To mitigate post-school vulnerabilities, it is recommended that mentoring, training and employment for school-leavers be prioritised. Opportunities to be fostered include targeted programmes for vulnerable youth, such as, the Expanded Public Works Programme (EPWP), and programmes addressing vulnerability of young people attending institutions of higher learning, through the Department of Higher Education and Training (DHET).

It is intended that this sub-objective be measured by determining school attendance among orphans and non-orphans aged 10-14.

REDUCING STIGMA AND DISCRIMINATION

The NSP highlights the need for attention to be given to addressing stigma and discrimination linked to HIV and TB, which are seen as including dimensions related to sexuality and gender identity. The need for a programmatic approach to stigma elimination is highlighted that includes the involvement of people living with HIV. Reference is made to a Stigma Mitigation Framework to be monitored through a Stigma Index, with links and oversight provided by departments in the Security Cluster in conjunction with the SAHRC.

There is no suggested approach in the NSP for measuring progress of this sub-objective.

STRENGTHENING COMMUNITY SYSTEMS

Community systems refer to capacities, referral networks, co-ordination and feedback systems related to services. The approach advocated by the NSP is the implementation of strategies to support municipalities and local communities to engage with and address challenges, and to strengthen systems including through support by integrated development plans.

Community networking can potentially be improved through sectors that draw together subpopulations within communities to foster linkages to programmes – for example, the potential to support networking and referral through faith based organisations.

There is no suggested approach in the NSP for measuring progress of the sub-objective.

POVERTY ALLEVIATION AND ENHANCING FOOD-SECURITY PROGRAMMES

Given that poverty underpins and contributes to vulnerability to HIV and TB, as well as contributing to poor overall health and limiting the effectiveness of treatment, food security for all is prioritised in the NSP. Reference is made to the integration of an anti-poverty strategy implemented through various government departments to ensure vulnerable households are identified and supported.

SUB-OBJECTIVE 1: INDICATORS AND RESULTS

Table 3 outlines the indicators and results for SO1 utilising categories defined in the NSP. For the most part, neither baseline nor mid-term data is available. The specific results are discussed further below.
### Table 3: Indicators and results for SO1

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline</th>
<th>Target 2016</th>
<th>FY 2014/15 Status</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage (%) of government departments and sectors with operational plans with HIV, TB and related gender and rights-based dimension integrated</td>
<td>20% (31) of Departmental Plans were approved by DPSA (DPSA Annual Report 2012/13)</td>
<td>100% of government departments</td>
<td>&gt;90% (115 ) government departments have an HIV&amp;AIDS and TB management Policy based on the DPSA’s HIV&amp;AIDS Policy for the Public Service 2009, and are implementing this through Department Specific Operational Plans</td>
<td>Significant progress made towards achieving the target at 70% increase from baseline</td>
</tr>
<tr>
<td>Percentage municipalities with at least one informal settlement where targeted comprehensive HIV, STI and TB services are implemented</td>
<td>No baseline</td>
<td>100%</td>
<td>Data not available</td>
<td>Indicator monitoring and reporting is not possible</td>
</tr>
<tr>
<td>Current school attendance among orphans and among non-orphans aged 10-14 (UNGASS 12; MDG Indicator)</td>
<td>98% (2008 SABSSM Survey)</td>
<td>100%</td>
<td>99%</td>
<td>1% increase from baseline 2008 and 1% to achieve set target (100%)</td>
</tr>
<tr>
<td>Delivery rates for women under 18-NIDS</td>
<td>To be determined in 2012 *7.7% in 2012</td>
<td>To be determined in 2012</td>
<td>7.4% (DHIS DOH Data; 2014/15)</td>
<td>Target not set but there is a slight decline from baseline</td>
</tr>
<tr>
<td>HIV and TB spend</td>
<td>9.7 Billion (NASA 2010)</td>
<td>32 Billion</td>
<td>R23 Billion (SANAC; 2014)</td>
<td>Significant progress towards set target</td>
</tr>
<tr>
<td>Indicator</td>
<td>Baseline</td>
<td>Target 2016</td>
<td>FY 2014/15 Status</td>
<td>Comment</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>----------------------</td>
<td>-----------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Number of women and children reporting gender-based violence to the police in the last year</strong></td>
<td>To be determined in 2012</td>
<td>Target not set</td>
<td>42 050 cases were reported between January and March 2013. Of these, 5 134 perpetrators were found “guilty” and 2 372 of the reported cases struck off the roll, and 7 321 withdrawn (Source; Report to SANAC Lekgotla June 2015)</td>
<td>There is need to aggregate the data from DOJCD, the NPA (Thuthuzela Centres), the SAPS through the relevant clusters</td>
</tr>
<tr>
<td><strong>Proportion of women who have experienced physical or sexual violence in the last year</strong></td>
<td>To be determined in 2012</td>
<td>Target not set</td>
<td>National data not available</td>
<td>Recent surveys place emphasis on ‘ever’ experiences of VAW, which does not allow contemporary trends to be measured. Only Violence Against Women is measured, rather than the broader concept of GBV which includes bi-directional violence, and gender violence affecting children, vulnerable and key populations and men</td>
</tr>
</tbody>
</table>

**SUB-OBJECTIVE 1: MAINSTREAMING GENDER- AND RIGHTS-BASED DIMENSIONS OF HIV AND TB INTO THE CORE MANDATES OF ALL GOVERNMENT DEPARTMENTS AND ALL SANAC SECTORS**

Mainstreaming of gender- and rights-based dimensions of HIV and TB into core mandates of government departments and SANAC sectors require an evidenced commitment at the level of legislation, regulations, policy and operational levels of the departments. Furthermore, government departments are required to demonstrate commitment at the level of strategic planning where HIV&AIDS issues are to be identified as strategic issues to be addressed during the Medium Term Expenditure Framework (MTEF) period by the department concerned. Departments are required to ensure that there is commitment by producing a specific HIV&AIDS Mainstreamed Policy and carrying out strategic policy and sector guidance on an annual basis. Each accounting officer is required to approve the Department Specific HIV&AIDS Mainstreamed Operational Plan and co-sign the “8 Principles of Commitment to HIV&AIDS Mainstreaming” with the Minister of Public Service and Administration.

Within government, the HIV&AIDS policy is determined, analysed and coordinated from the Presidency. The Policy position of the fifth administration was led by the President of the Republic in the National Council of Provinces, and the Presidential Coordination Council. The Deputy President is the Chairperson of SANAC and leads the National multi-sectoral response by government, business, labour and civil society. The Deputy President also chairs the Inter-Ministerial Committee on HIV&AIDS.

Linkages between departments and the regions are evident. For example, the policy on HIV&AIDS and TB Management is analysed
and coordinated between the Department of Health, Mineral Resources, Labour and their counterparts in Lesotho, Swaziland and Mozambique in the implementation of the SADC Protocol on Management of HIV&AIDS and TB in the mines and their social and economic implications. The Office of the Deputy President leads on this policy analysis and coordination work.

Another example of policy analysis and coordination is in the area of gender-based violence and HIV&AIDS. The Deputy President chairs both the councils on HIV&AIDS and Gender Based Violence. Common policy issues are flagged and analysed centrally by the Office of the Deputy President. The most recent policy work is the use of the Integrated Service Delivery Model in ensuring implementation of the HIV&AIDS response to the lowest level of the ward, local, district municipality and the highest levels of accountability to the Ward Councillor, Local Municipal Mayor and District/Metro Mayor. The approach is coordinated through the Presidential Coordination Committee in partnership with provincial Premiers.

The DPSA is the lead department that ensures HIV&AIDS mainstreaming in each department, with accountability falling to the Director General (DG) or Head of Department (HOD) as an accounting officer. The DPSA has regulated HIV&AIDS mainstreaming, and provides guidance towards the HIV&AIDS and TB management policy for the Public Service. The DPSA has also ensured that the Guidelines on Gender Sensitive Rights-Based HIV&AIDS mainstreaming in the Public Service is approved at the Governance and Administration (G&A) Cluster and this was officially launched by the Minister for Public Service and Administration. Accountability on HIV&AIDS Mainstreaming is addressed through the Management Assessment Performance Tool (MPAT), which has one of its standards on HIV/AIDS mainstreaming.

The DPSA is also linked to international structures and processes with respect to HIV&AIDS mainstreaming. The Department is the focal point on HIV&AIDS mainstreaming at SADC, and the Minister for Public Service and Administration is the focal point at the Africa Union and reports as part of the Africa Peer Review Mechanism (APRM) on the governance of HIV&AIDS as a cross cutting issue.

The DOH provides technical leadership on HIV&AIDS to all departments. DOH sits in the Technical Committees of the Mine Health and Safety Council on an advisory capacity; is part of the government delegations at the National Education and Development Labour Council (NEDLAC) on HIV&AIDS issues and is the lead department on measuring the developmental indicators related to the Millennium Development Goals (MDGs) in partnership with Statistics South Africa (Stats SA.)

SANAC coordinates government, civil society, business and labour in the implementation of the NSP, monitoring progress on the NSP and providing policy advice to government through evidence generated through its Technical Task Teams. These task teams comprise experts from government and civil society, business and labour. SANAC also represents South Africa at the forum for the National AIDS Councils at SADC and regularly develops national High Level reports to the United Nations before it is presented to Cabinet.

The DPSA draws on the Southern African Development Community (SADC) core mainstreaming indicators within the public sector, including: 1) Proportion of budgets allocated to HIV; 2) Proportional disbursement related to gender and human rights dimensions; 3) Allocation of at least 2% of budgets to HIV; 4) Legal frameworks that address the rights of key populations, training of personnel within the legal system on HIV and proportion of rights-related cases of PLHIV that are resolved in courts; 5) Mainstreaming of HIV into the development of national infrastructure projects; 6) Mainstreaming of HIV into rural and urban development, and 7) Mainstreaming of HIV into public sector workplace programmes.

To support the mainstreaming of HIV and TB, the DPSA includes emphasis on four domains of response: 1) Reducing the number of new infections and reducing the impact on employees, families and communities; 2) Reducing the burden of disease and enhancing productivity in the Public Service; 3) Involving key populations in the response and addressing stigma, discrimination, rights and inequality; 4) Introducing evidence-based practices to support organisational wellness. To support the mainstreaming in government departments, the DPSA has developed dummy operational plans that prioritise the objectives of the NSP 2012-2016, including emphasis on prioritising District, Local and Ward AIDS Councils (DACs, LACs and WACs) and alignment with the NSPs.
four strategic objectives. The approach includes:

- Validating operational plans by Heads of Portfolio and conducting capacity development workshops
- Developing project plans to support mainstreaming policy, programme and project implementation
- Developing an employee housing scheme
- Conducting capacity development on gender sensitive, rights-based HIV mainstreaming

The DPSA’s Annual Report 2012/13 indicates that 45 government departments (28%) submitted draft operational plans incorporating HIV and TB mainstreaming, and set a target of 40% for 2012/13. Ultimately 20% of plans were approved in 2012/13.

With HIV&AIDS and TB Management Policy in the Public Service, most have mainstreamed key components related to HIV and TB, and as indicated in the DPSA’s 2014/15 Annual Report, 115 government departments (>90%) have all four of the following policies (Wellness Management Policy; Health and Productivity Management Policy; HIV & TB Management Policy and Safety, Health, Environment, Risk and Quality – SHERQ – Policy). It is noted in the 2014/15 Annual Report that “HIV external mainstreaming is inadequately responded to in some departments whilst the health and productivity management tools are inadequate.”

Apart from the DPSA’s extensive support and guidance to departmental mainstreaming, guidance is provided by the DOH Prevention Strategy 2013-2016 which incorporates combination prevention. This approach ensures that the HIV&AIDS mandate of the DOH is integrated with that of other departments where appropriate. Most government departments include dedicated HIV budgets and co-ordination is cascaded at national, provincial and local level. The Office of the Deputy President analyses and coordinates this integration work, especially where it is funded by the United States President’s Emergency Plan for AIDS Relief (PEPFAR.)

Table 3 outlines the progress made by selected government departments in relation to HIV and TB mainstreaming, including addressing gender and rights-based dimensions. 41

Table 4: Selected HIV, TB and gender mainstreaming activities and outputs of government departments

<table>
<thead>
<tr>
<th>Department</th>
<th>Activities and outputs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Service and Administration</td>
<td>Gender Sensitive Rights-Based HIV&amp;AIDS Mainstreaming Guidelines for the Public Service 2012 including capacity development and methodology for implementation</td>
</tr>
<tr>
<td></td>
<td>Readiness assessment tools for HIV&amp;AIDS and TB Management Policy implementation developed</td>
</tr>
<tr>
<td></td>
<td>Generic Implementation Guides, “Dummy Operational Plans” as implementation support tools developed</td>
</tr>
<tr>
<td></td>
<td>Government Sector HIV&amp;AIDS M&amp;E Framework linked with operational plans include SADC M&amp;E indicators</td>
</tr>
<tr>
<td></td>
<td>Indicators to guide adverse HIV-related impact linked to development priorities</td>
</tr>
<tr>
<td></td>
<td>(14 Outcomes developed by DPME)</td>
</tr>
<tr>
<td></td>
<td>Tools for District Level Epidemic Response and Co-ordination Framework for Local Government and accountability links with AIDS Councils</td>
</tr>
<tr>
<td></td>
<td>Mainstreaming indicators include proportion of government department operational plans and utilisation of HIV services in the workplace by public sector personnel</td>
</tr>
<tr>
<td>Human Development Cluster</td>
<td>Development of the national and provincial implementation plans for the integrated strategy on HIV, STIs and TB in schools (aligned with the NSP 2012 – 2016); revision of the National policy on HIV for the schooling system; development of peer educator and peer mentor manuals and supporting training on peer education guidelines in 10 districts through the Life Skills Programme; as a way of mainstreaming HIV &amp; AIDS and TB and its gender and rights-based dimensions into the core of all government departments and all SANAC sectors. Implementation of the following interventions to address gender inequities and gender-based violence as drivers of HIV and STIs: Girls and Boys Education Movement (GEM/BEM) and the Development of National Policy Framework on Gender. Mitigating the impact of HIV and TB on orphans, vulnerable children and youth by conducting training on the regional Care and Support for Teaching and Learning CSTL SA Monitoring Evaluation and Reporting (MER) Framework and CSTL handbook and implementing the CSTL Programme in 35 pilot schools per province in accordance with the SADC Regional Programme and identifying and referring learners for basic services through integrated service delivery days. Reducing the vulnerability of young people to HIV infection by retaining them in schools, as well as providing post-school education and work opportunities through the following: exempting deserving learners from paying school fees and monitoring and strengthening the management and implementation of the National School Nutrition Programme in provinces, districts and schools. Reducing HIV and TB related stigma and discrimination by ensuring the following: facilitating linkages between schools and police stations and establishing safe school committees; conducting training workshops on the prevention and management of bullying in schools; and developing of the National School Safety Framework. Making accessible a package of sexual and reproductive health (SRH) services by ensuring the implementation of the Integrated School Health Programme (ISHP). Implementing a comprehensive national social and behavioural change communication strategy with particular focus on key populations through ensuring the following: strengthening of the Life Skills Programme and aligning to the NSP and the DBE Integrated Strategy On HIV, STIs and TB, 2012-2016; procuring Learning and Teaching Support Material (LTSM) to support the implementation of the HIV and AIDS Life Skills Education Programme; developing life skills and sexual and reproductive health scripted lesson plans together with scripted lesson plans on sexuality education in support of CAPS for Grades 7-9; implementing peer education programmes on sexual and reproductive health; implementing advocacy and behaviour change communication activities and monitoring and supporting implementation of the Life Skills Programme in line with the NSP’s human rights agenda. (Details of the NSP core indicators reported by the DBE in three successive years; that is, 2012-2013; 2013-2014 and 2014-2015 are tabulated in table 1 in the annexure section. It should be noted that there were no set targets for each of the indicators tracked for the following sub-objectives: 1.1; 1.3; 1.4; 1.5; 1.6; 2.2 and 2.4.)</td>
</tr>
<tr>
<td>Basic Education</td>
<td>Development of the national and provincial implementation plans for the integrated strategy on HIV, STIs and TB in schools (aligned with the NSP 2012 – 2016); revision of the National policy on HIV for the schooling system; development of peer educator and peer mentor manuals and supporting training on peer education guidelines in 10 districts through the Life Skills Programme; as a way of mainstreaming HIV &amp; AIDS and TB and its gender and rights-based dimensions into the core of all government departments and all SANAC sectors. Implementation of the following interventions to address gender inequities and gender-based violence as drivers of HIV and STIs: Girls and Boys Education Movement (GEM/BEM) and the Development of National Policy Framework on Gender. Mitigating the impact of HIV and TB on orphans, vulnerable children and youth by conducting training on the regional Care and Support for Teaching and Learning CSTL SA Monitoring Evaluation and Reporting (MER) Framework and CSTL handbook and implementing the CSTL Programme in 35 pilot schools per province in accordance with the SADC Regional Programme and identifying and referring learners for basic services through integrated service delivery days. Reducing the vulnerability of young people to HIV infection by retaining them in schools, as well as providing post-school education and work opportunities through the following: exempting deserving learners from paying school fees and monitoring and strengthening the management and implementation of the National School Nutrition Programme in provinces, districts and schools. Reducing HIV and TB related stigma and discrimination by ensuring the following: facilitating linkages between schools and police stations and establishing safe school committees; conducting training workshops on the prevention and management of bullying in schools; and developing of the National School Safety Framework. Making accessible a package of sexual and reproductive health (SRH) services by ensuring the implementation of the Integrated School Health Programme (ISHP). Implementing a comprehensive national social and behavioural change communication strategy with particular focus on key populations through ensuring the following: strengthening of the Life Skills Programme and aligning to the NSP and the DBE Integrated Strategy On HIV, STIs and TB, 2012-2016; procuring Learning and Teaching Support Material (LTSM) to support the implementation of the HIV and AIDS Life Skills Education Programme; developing life skills and sexual and reproductive health scripted lesson plans together with scripted lesson plans on sexuality education in support of CAPS for Grades 7-9; implementing peer education programmes on sexual and reproductive health; implementing advocacy and behaviour change communication activities and monitoring and supporting implementation of the Life Skills Programme in line with the NSP’s human rights agenda. (Details of the NSP core indicators reported by the DBE in three successive years; that is, 2012-2013; 2013-2014 and 2014-2015 are tabulated in table 1 in the annexure section. It should be noted that there were no set targets for each of the indicators tracked for the following sub-objectives: 1.1; 1.3; 1.4; 1.5; 1.6; 2.2 and 2.4.)</td>
</tr>
</tbody>
</table>
### Human Development Cluster

#### Health

Improvements in life expectancy, infant mortality, U5MR
Infant mortality dropped from 58 to 34 deaths per 1 000 live births between 2002 and 2014
Health diplomacy and leadership
Measurement and Implementation Sciences addressed
Implementation of largest ART programme globally
ART programme for public service personnel

#### Human Settlements

- Over this period, the number of households living in formal dwellings increased from approximately 8 million to 12.4 million

#### Department of Energy

- The share of households with basic access to electricity increased from 77% to 86%.

#### Department of Mineral Resources

- Mining licences are predetermined by among others, the HIV&AIDS policy and programme
- SADC Protocol on HIV&AIDS and TB in the mines implemented with Lesotho, Swaziland and Mozambique

#### Arts and Culture

Developed and implemented HIV communication framework
HIV included in South African films

#### Department Higher Education and Training (DHET) - HEAIDS

The model of practice designed to meet HIV prevention, care and treatment needs as well as some broader primary health needs of various sections of the student population. At the centre of the model is First Things First (FTF) programme which focuses on prevention and early detection of a range of health conditions and health risks through incorporating the following programmes: HIV and AIDS Curriculum; Men's health empowerment; women's health empowerment; LGBTI programme; Alcohol and drug abuse prevention programme and future beats youth development programme. The FTF enables HET to make specific contributions to the UNAIDS target of ensuring that 90% of PLHIV know their status, 90% of these receive antiretroviral treatment.

The FTF approach delivered upward trends in the number of students and staff members testing for HIV testing and undergoing screening for TB and STIs as follows: HIV testing in 2013, 2014 and 2015; numbers tested respectively: 41 373; 97 174 and 174 026; TB screening 2013, 2014, 2015; numbers screened respectively: 41 373; 90 567 and 163 303 while the STI screening for 2013, 2014, and 2015 were: 41 373; 76 690 and 154 626 respectively.

Condom distribution: The establishment of the partnership between the DOH and HET to introduce the first colored and scented government-sponsored condoms resulting in the distribution of 20 million male condoms; 42 000 female condoms and 450 000 tubes of lubricant in 2015.
<table>
<thead>
<tr>
<th>Human Development Cluster</th>
<th></th>
</tr>
</thead>
</table>
| **Department Higher Education and Training (DHET) - HEAIDS** | Peer education training: Regarded as one of more successful forms of behaviour change communication and covers key information sensitization issues as outlined in the FTF programmes. The number of peer educators trained in universities in the years 2013, 2014 and 2014 were: 331; 669 and 1546, respectively; while Technical and Vocational Education and Training (TVET) Colleges trained 1 493 and 3 349 peer educators in 2014 and 2015 respectively.  
HIV Curriculum development: The National Skills Fund made a substantial three-year grant through HET to 20 universities and TVET colleges sub-sector as a whole to take HIV curriculum forward. By 2015, no fewer than 402 members of academic staff, drawn from a wide range of disciplines in several different faculties of universities had attended specialized workshops on developing and/or delivering content on HIV within the formal learning programme.  
Capacity development: A total of 122 campus and community radio station journalists benefitted from a series of orientation workshops held in 2015. Capacity development was conducted through the Future Beats Youth Development programme which encourages journalists to capitalize on the interactive nature of radio to facilitate dialogue on campus on important social issues related to HIV. The combined number of audience reached by the programme grew from an estimated 270,000 listeners to an estimated 770,000 listeners after the addition of five new stations in 2015. (The above cited activities and outcomes were as a result of direct grants awarded to the universities. Refer to annexure 3 for a detailed breakdown of the funding).  
Full report on the programme can be accessed on (www.heaids.org.za). |
| **Labour** | Implementation of the International Labour Organisation’s Convention 200 of 2010 Technical Assistance Guidelines on HIV for all employers |
### Human Development Cluster

#### Department of Science and Technology (DST)

Supporting health research for the development of tools aimed at the prevention; treatment and diagnosis of HIV and TB through the following mechanisms:

- **a)** The establishment of the Strategic Health Innovation Partnerships (SHIP), managed by the Medical Research Council (MRC), as a flagship initiative of the DST to harness the capacity and strengths of local universities, science councils and the private sector and through collaborative efforts to facilitate product research and development in the field of health; with a focus on the development of novel or improving existing drugs, vaccines and other biologicals, diagnostics and medical devices for priority diseases in South Africa, especially HIV and TB. Some of the highlights include the following: the development of Seq2Res HIV drug resistance test to facilitate the implementation of high-throughput, cost-effective HIV resistance genotyping in South Africa and other resource-limited settings; the discovery of how a KwaZulu-Natal woman’s body responded to her HIV infection by making potent antibodies that are able to kill multiple strains of HIV from across the world (CAP256).

- **b)** DST provided funding (R70 million over 4 years) to support a clinical trial to confirm the safety and effectiveness of 1% tenofovir gel (FACTS 001); following the release of the results of CAPRISA 004 clinical in 2010; which showed that 1% tenofovir gel reduced the risk of HIV infection in women by 39% when compared with a placebo.

- **c)** DST also provided funding to CAPRISA for two studies that were deemed critical for the overall development and subsequent roll-out of tenofovir gel.

- **d)** The application of mathematical methods to a wide range of problems with the aim of providing evidence to better understand the HIV and TB co-epidemics; through the efforts of SACEMA work on public health research.

- **e)** The implementation of the SACEMA project on HIV Epidemiological Modelling for HIV & AIDS Policy project; managed by DST with financial support to the value of 3 million Canadian dollars over 5 years from the Canadian International Development Agency (CIDA).

**TB Research Investments:** The TB programme’s focus was on building additional biology capacity for the drug discovery programme, developing a pipeline of locally developed diagnostics, and in supporting research in TB vaccines to identify correlates of risk and protection of vaccines. The specific aims of the TB programme was to: develop new drugs and/or improve existing drugs; develop new vaccines and/or generate new knowledge that directly impacts vaccine development; develop new immunological approaches to primary and secondary disease prevention; and develop new diagnostics and/or improve existing diagnostics. (Funding provided by DST in the three successive years are tabulated in annexure 2.

### Sport and Recreation

- **Sports and Recreation Plan 2012**
- **Sports linked to HIV Counselling and Testing**
- **HIV communication at sports events**
### Economic Sector And Employment Cluster

**Economic Cluster Departments**

- Mainstreaming HIV into Environmental Impact Assessments (EIAs), including training
- Mainstreaming and SADC Protocol on HIV and TB for mining sector
- Economic empowerment and vulnerability reduction on transport corridors
- Departments of Trade and Industry and Health negotiation on ART and TB drug pricing
- Code of conduct for hospitality, travel and tourism industry

### Justice, Crime Prevention And Security Cluster

**Justice, Crime Prevention and Security Cluster Departments**

- Sexual offences legislation includes expanded definition of sexual violence
- Sexual violence and family courts supported through infrastructure development
- Thuthuzela Centers support direct from Treasury
- Law Reform Commission addressing legality of commercial sex work
- Inclusion of sex work sector in SANAC
- Ukuthwala dismissed as argument from non-consensual sex
- Security Council Resolution on HIV in military/uniformed service signed
- Progressive ART policy implemented by military health services

### Addressing Social and Structural Barriers

- Preventing new HIV, STI and TB infections by improving the accessibility of HCT, TB and STI services to more employees within the department; conducting awareness raising sessions for employees with a focus on behaviour change and promotion of healthy life styles, including male circumcision and other related issues and conducting awareness raising sessions in 3 regions on the intersection between sexual offences and HIV, STIs and TB. A total of 828 participants (2012/2013=480; 2013/2014=180 and 2014/2015=168) received training on the Integrated Training Programme on the Criminal Law (Sexual Offences and Related Matters)-Amendment ACT 32 of 2007 (the SORMAA); Victim Empowerment Programme and Policy; Victims Charter and aspects of the National Policy Framework on Sexual Offences. The integrated training programme was developed in conjunction with the Department of Social Development (DSD) and other role-player departments. The training included education on Post Exposure Prophylaxis (PEP) and compulsory application of HIV Testing of the alleged perpetrator, i.e. Chapter 5 of the SORMAA.
- A total of 17,033 employees were reached through a variety of awareness raising interventions in each financial year as follows: 2012/13: 2335 employees; 2013/14: 7704 employees; 2014/15: 7104 employees; while regional awareness interventions were as follows: 2012/13: six regions; 2013/14: eight regions; 2014/15: nine regions.
### Justice, Crime Prevention And Security Cluster

**Department of Justice and Constitutional Development (DoJ&CD)**

Sustaining health and wellness by strengthening the promotion of EHWP and its support services highlighting the HIV, TB and STI services. A total of 22 000 wellness wallet cards were nationally distributed to officials between 2012 and 2015.

Ensuring protection of human rights and increasing access to justice by amending section 1 of PEPUDA to include HIV and AIDS as one of the grounds of discrimination; strengthening Public Services Institutions to deal with LGBTI issues including discrimination and Hate Crimes and building the capacity of CSOs to deal with LGBTI issues regarding discrimination and Hate Crimes. The **Judicial Matters Amendment Bill of 2016 was published for comments to ensure inclusiveness of HIV/AIDS status to the definition of ‘Prohibited Grounds’ of discrimination; a guide for service providers, including 50 000 documents entitled “Working with diverse communities-Understanding sexual orientation, gender identity and expression were developed and published and a national workshop to sensitize civil society organizations on criminal justice system was conducted with Provincial Task Team members.**

**Department of Correctional Services**

Maintained an upward trend on the number of inmates on ART as follows: 2013/14: 15 417 inmates on ART and 2014/15: 17 526 inmates on ART. Maintained an upward trend for inmates tested for HIV as follows: 2013/14: 107 415 and 2014/15: 177 172.

Consistently screened inmates for TB as follows: **on admission:** in 2013/14 323 175/355 122 (91%); 2014/15: 34 894/375/658 (92.89%); Bi-annually: in 2013/14: 99 630/650 111 (15.32%) and in 2014/15: 223 198/343 611 (64.96%) and **on release:** in 2013/14: 134 060/162 777 (82.32%); in 2014/15: 176 157/193 408 (91.08%).

Maintained a positive TB cure rate of offenders as follows: 2013/14: 1709/2 057 (83.08%); in 2014/15: 1 216/1 417 (85.82%).

Maintained an upward distribution of condoms as follows: in 2013/14: 1 377 875 condoms were distributed; while in 2014/15 1 710 146 condoms were distributed.

### Social Protection And Community Development Cluster

**Social Protection and Community Development Cluster Departments**

Extensive support to orphans and vulnerable children
Social grants system reduces HIV vulnerability
HIV strategy for the construction sector

**Department of Labour**

Occupationally acquired HIV is compensable for health workers and there are regulations and guidelines to this effect
Occupationally acquired TB is compensable for health workers

**National Treasury**

The Financial Services Board has revised exclusions for HIV&AIDS coverage by Medical AID Schemes. Increased life expectancy was one of determinants for this increased medical benefit

**DPSA**

Government Medical AID Schemes for government employees is subsidised for every workers who cannot afford a medical Scheme (Level 1-5)
Through GEMS, the 90% ARV target is about to be attained at 86% as at June 2015
The draft M&E Framework for the Government Sector HIV, STI and TB response 2012-2016 aligns with the Millennium Development Goals, United Nations and African Union declarations on AIDS and SADC guidance. Nationally, the framework is linked to the National Development Plan (Vision 2030), the Medium Term Strategic Framework (2009-2014), and guidelines for HIV and TB mainstreaming. The approach addresses 12 outcomes linked respectively to basic education, health, safety and security, employment and economic growth, skills, infrastructure, rural development, human settlements, local government, environment, international relations and public service.

Regarding the response by SANAC’s 17 sectors, Table 5 summarises the extent of plans in relation to gender and HIV and TB rights of eight of the sectors that are available on the SANAC portal. The status of the response by the remaining nine sectors is unclear. The available plans describe general guidance, while in some cases there are detailed action plans. There is no linked information regarding implementation.

A gender equality assessment by the Health Economics and AIDS Research Division (HEARD) of Provincial Strategic and Operational Plans for HIV, STIs and TB, highlighted the need for clearer provision for the meaningful involvement of women, improvements to gender equality for service access, strengthened responses to GBV, and improvements in accountability systems.42

<table>
<thead>
<tr>
<th>Sector</th>
<th>Plan</th>
<th>Gender, HIV and TB mainstreaming</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td>Yezingane Network Sector Implementation Plan</td>
<td>Planned programmes focus on HIV, STIs and TB Gender rights linkages implicit</td>
</tr>
<tr>
<td>Men</td>
<td>Sector Plan GBV prevention mobilisation</td>
<td>Explicit focus on gender and rights. Implicit links to TB. GBV prevention activities conducted through Brothers for Life</td>
</tr>
<tr>
<td>Sex worker</td>
<td>Sector guidelines; Sex Worker Strategy</td>
<td>Addresses HIV and TB through life skills and related aspects. Developed rights-based strategic plan in 2013</td>
</tr>
<tr>
<td>Sports, arts and culture</td>
<td>Sector guidelines</td>
<td>Awareness focused through sector activities Gender not explicitly addressed</td>
</tr>
<tr>
<td>LGBTI</td>
<td>Sector guidelines; Health Care Manual</td>
<td>Explicit focus on gender and rights. Implicit links to TB. Developed health care manual for care providers/MSM and drug users</td>
</tr>
<tr>
<td>NGO</td>
<td>Sector guidelines</td>
<td>Aligned with HIV and TB goals, with reference to rights</td>
</tr>
<tr>
<td>Youth</td>
<td>Sector guidelines</td>
<td>Overall focus includes access to services and resources, addressing substance abuse, and rights including gender</td>
</tr>
<tr>
<td>Women</td>
<td>Sector guidelines 2013-2016 Sector Plan</td>
<td>Aligned with HIV and TB goals, with reference to rights. 2013 to 2016 Sector Plan provides detailed guidance and outlines various programmes, including rights focus throughout</td>
</tr>
</tbody>
</table>

**PROVINCIAL AIDS COUNCILS**

A number of provinces indicated successes in adopting a multi-sectoral approach, with a successful layering of leadership of multi-sectoral integration being observed in KwaZulu-Natal. In the North West Province it was noted that active partnerships with men’s initiatives such as Sonke Gender Justice, Brothers for Life, the Provincial Men’s Imbizo, and district and local men’s clubs enhanced social and structural approaches and addressed stigma and discrimination. Mpumalanga representatives pointed to the need to allocate budgets to AIDS Councils in combination with validation of the role of these structures in providing oversight and supporting harmonisation of programmes. The province was, however, able to build on the foundation of long-term partnerships, which strengthened multi-sectoral responses. It remained that there was a need to improve collaboration and coordination between the DSD and the DOH in the province, while there was a need to bolster the integration of civil society in response.
Eastern Cape participants highlighted the importance of a civil society forum, although participation was inconsistent and was, to some extent attributable to lack of financial support to attend meetings. A ward-based approach, including Ward AIDS Councils was also useful for coordinating community health workers.

A key issue in the Free State was the determination of leadership and location of the Provincial AIDS Council, which had been resolved through an agreement that the provincial DOH would lead, and that the Council would be located in the Office of the Premier. There has been an uneven response and coordination of District and Local AIDS Councils, and the absence of mayoral interest and participation were identified as a critical barrier. A key outcome was the integration of workplace programmes that included HIV. A linked response was achieved through key partners such as the South African Business Coalition on HIV and AIDS (SABCOHA), Soul City, LoveLife and others.

In the Northern Cape it was noted that a multi-sectoral response had not been sufficiently established, and leadership was mainly driven through the provincial DOH. A ‘war room’ approach had however proven useful as this brought together key stakeholders at ward level, with linkages being made between services such as HCT and primary health care (PHC). It was noted that most Local AIDS Councils (LACs) were not fully functional. Conditional grants were intended to support sectoral activities, yet these were not being adequately monitored.

In KwaZulu-Natal it was noted that districts focused on a multi-sectoral response, including mainstreaming HIV, TB and gender, while political ‘buy-in and support’ was described as ‘second to none’, with active involvement and leadership at all levels (e.g. Premier, Department Heads, Mayors and Councillors) as well as links to the private sector. Operation Sukuma Sakhe (OSS) had improved community leadership and supported accountability in service delivery, and mobile clinics had been expanded to reach under-serviced communities. Implementation of the Isibindi model of care bolstered support to orphans and vulnerable children and youth (OVCY). It was noted by North West Province participants that unregistered early childhood development (ECD) centres posed a threat to safety of children.

The Eastern Cape highlighted the integration of HIV and TB in workplace programmes. There were, however, HIV coordinators in only four of six districts, and less than one in five of the 45 municipalities had HIV coordinators.

In Mpumalanga, it was said that the AIDS Councils had not sufficiently been drawn into the response and that there was not adequate attention given to monitoring and evaluation. Partnerships with Civil Society Organisations (CSOs) had occurred, and these strengthened the response at provincial and sub-provincial levels, but were not adequately resourced. Key departments such as the DOH and DSD had not adequately linked with AIDS Councils, with the consequence that coordination was disrupted and parallel monitoring and reporting had occurred. District level response was uneven, with some districts being over-resourced while others were deprived of essential services. In KwaZulu-Natal, it was observed that multi-sectoral approaches were not ‘well embraced’ at community level. In the North West Province it was said that a lack of resources led to high transmission areas not being adequately reached, and caregivers tended to move to ‘greener pastures’ where they were more likely to secure an income.

A national stakeholder observed that there was a need to ‘reprioritise the multi-sectoral response’. Sectoral representatives noted that apart from HIV, TB and gender, there were other cross-cutting issues — with disability specifically being mentioned: “Disability is not regarded as an integral area of focus in programmes”, and further noting — “All sectors should have an inclusive disability component in their programmes as a prequalification for funding and programme implementation.”

**SUB-OBJECTIVE 2: ADDRESSING SOCIAL, ECONOMIC AND BEHAVIOURAL DRIVERS OF HIV, STI S AND TB**

The 2012 HSRC survey illustrates the links between HIV prevalence, race and locality type with HIV prevalence being overall highest among black Africans at 20.8% in formal rural areas, 20.4% in informal urban areas, 15.0% in formal urban areas and 13.4% in informal rural areas. HIV incidence among the population as a whole aged two years and older is highest in informal urban areas at 2.46%, followed by formal urban areas (1.06%), informal rural areas (0.87%) and rural formal areas (0.84%).
SANAC established a Social and Structural Drivers Technical Task Team to analyse structural factors and develop a framework to understand social change. The Task Team placed emphasis on addressing substance abuse, mental health and behaviour, poverty and sustainable livelihood, migration and mobility, gender and sexuality (masculinity), and gender-based violence (GBV) – although the extent of progress is unclear.

National stakeholders were of the view that SO1 needed to be ‘tightened up’. Furthermore, the health system was said to have a top-down orientation and it was observed that: “the districts are compliance driven rather than reactive. There is no innovation or creativity and there is often a slow reaction to things happening on the ground.” A further observation was that a focus on community participation and empowerment was lacking: “Currently people don’t feel empowered. They are waiting for government to come up with all the solutions… We need for a community strengthening model versus the hospital based care model in South Africa.”

Provincial representatives observed that addressing social, structural and behavioural drivers of HIV was crucial to prevention, yet there was little adequate consensus on the best approaches to ensure impact. Furthermore, while combination prevention was globally recognised, it remained that the means to address prevention were contested between the biomedical and community sectors.

The Department of Basic Education’s (DBE’s) draft policy takes the needs of economically disadvantaged children into account including those residing in informal settlements, and the DSD includes reach into informal settings to support OVC as well as various other grants programmes that benefit families. It is unclear whether the envisaged mapping of informal settlements has taken place.

Abuse of alcohol and illicit drugs are acknowledged as severe problems in South Africa. The 2012 HSRC survey identified alcohol and drug users as being more vulnerable to HIV than the general population with HIV prevalence levels of 14.3% among high-risk drinkers aged 15 and older, and 12.7% among recreational drug users. Alcohol abuse is also linked to risky sexual behaviours. A province-level study in KwaZulu-Natal and Western Cape in 2010 found that 76% of community members agreed that ‘abuse of alcohol causes violence in my community’, and 68% agreed that ‘abuse of drugs causes violence in my community’. One in 10 had been a victim of a violent crime where a gun or knife had been used, with 56% of persons affected by violence noting that the perpetrator was under the influence of violence, and 21% noting that they were under the influence of alcohol at the time of the assault.

There is some national data available on the extent of alcohol consumption – for example, the 2012 National Communication Survey indicates that 25% of men and 12% of women drink almost every week or more frequently. A detailed understanding of patterns of consumption including provincial and locality type breakdowns is, however, not available. There is some additional data available on alcohol and drug use through the South African Community Epidemiology Network on Drug Use (SACENDU) via sentinel surveillance of admissions to specialist alcohol and drug treatment centres – although only a small number of alcohol and drug abusers are admitted to such centres (there were 9 068 patients in the first half of 2014). While small-scale studies provide insights into the extent of illicit drug abuse in some communities, a national level understanding is not readily determined. It is recognised that abuse of methamphetamine (tik) and mixed drugs such as ‘nyaope’ and ‘whoonga’ is increasing and it is critical that these trends be monitored to support prevention and mitigation.

There are various policy and strategic initiatives to address substance abuse including the ‘Anti-Substance Abuse Programme of Action 2011-2016’ and the ‘National Drug Master Plan 2013-2017’. The extent of alcohol abuse and increasing intensity of illicit drug abuse are well-recognised in these plans, as are links to HIV and TB. Emphasis is given to adopting a multifaceted ecological
approach. The Inter-Ministerial Committee on Substance Abuse has developed an ‘Anti-Substance Abuse Programme of Action’, with recent activities linked to the Draft Control of Marketing of Alcohol Beverages Bill, which restricts alcohol distribution.

The Eastern Cape has given close attention to substance abuse through campaigns driven by multiple departments including the DOH, DOE, DOT, DSD and sectoral partners such as the South Africa National Council on Alcohol and Drug Abuse (SANCA), the Eastern Cape Liquor Board and South African Breweries. Campaigns have also targeted high transmission areas such as taverns and truck stops. It was noted that organisations like Soul City and LoveLife had programmes addressing substance abuse in schools and were also working with the Teens Against Alcohol and Drugs (TADA) programme. Liquor sales remained high in the province and it was said that reducing alcohol consumption required behaviour change and therefore having ad-hoc campaigns within communities without follow up, could not be expected to yield positive results. Participants in Gauteng were concerned with the growing abuse of nyaope and whoonga.

Regarding mobility and migration, SANAC has established a national forum on migrant and mobile populations, as well as a technical working group. Links are maintained with the Department of Transport (DOT) to address HIV, TB and related vulnerabilities in the sector and a ‘size estimation study’ is planned to understand the extent of migrant and mobile populations.

While delivery rates for women and children under the age of 18 is suggested as a means to determine the extent of condom and other contraceptive use and sexual debut, this data is not readily available. It should also be noted that the suggested indicator is not suitable for measuring these complex phenomena.

The NSP suggests determining the proportion of municipalities with at least one informal settlement where HIV, STIs and TB services are implemented, the source of data to measure progress for this sub-objective is lacking. Provincial respondents noted that departments such as Home Affairs, Health, and the Police Services, DSD, DOE and the South Africa Social Security Agency (SASSA) needed to work collaboratively to address HIV and AIDS in informal settlements. It is unclear whether prioritising a response in only one informal settlement per municipality would produce the necessary impacts on HIV and TB prevention and mitigation.

**SUB-OBJECTIVE 3: IMPLEMENTING INTERVENTIONS TO ADDRESS GENDER INEQUITIES AND GENDER-BASED VIOLENCE AS DRIVERS OF HIV AND STIS**

GBV contributes to HIV and STI vulnerability through disempowerment and the links between these phenomena are multifaceted. Causal pathways include direct and indirect mechanisms. For example, violence in intimate partner relationships limits capacity to determine sexual choices, including safer sex; physical trauma during sex increases the likelihood of HIV transmission; and revealing one’s HIV positive HIV status may result in violence.

In most literature, research and policy work, GBV is conflated with violence against women (VAW) by male perpetrators. This emphasis fails to address the importance of understanding the dimensions of GBV as it apply to victimisation and perpetration in both directions. Victimisation across age ranges, inter-generational victimisation and victimisation in relation to marginalisation and disempowerment are also largely overlooked – for example, GBV that is linked to race, sexuality, economic status, disability, refugee status, incarceration, and in relation to sex work – among other factors.

There is limited contemporary data on trends of VAW/GBV in South Africa. Some detailed baseline information is however information available on VAW, including intimate partner violence (IPV) and sexual abuse through four province-based studies conducted by GenderLinks. Primary emphasis is given in these studies to documenting ‘ever/lifetime’ experiences of GBV, which is of limited value for tracking changes in GBV. While rape is also measured, the definition utilised is broader than statutory definitions of rape and the data therefore needs to be disaggregated to be useful for monitoring purposes. Indicators for intimate partner violence towards women in the previous 12 months are disaggregated, and this allows for trends to be identified through repeat surveys. IPV in this instance is defined as including emotional, economic, physical and sexual IPV.
Table 7 indicates high levels of IPV directed towards women, with levels in Gauteng and KwaZulu-Natal being around double those reported in Limpopo and the Western Cape.

Table 7: Violence against women aged 18 and older by province, 2011

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Gauteng</th>
<th>KZN</th>
<th>Limpopo</th>
<th>WC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical IPV in the past 12 months</td>
<td>13%</td>
<td>11%</td>
<td>6%</td>
<td>6%</td>
</tr>
<tr>
<td>Sexual IPV in the past 12 months</td>
<td>-</td>
<td>4%</td>
<td>3%</td>
<td>4%</td>
</tr>
</tbody>
</table>

A two-province study conducted in 2010 found that both women and men perpetrated and were victims of physical violence by a partner, with victimisation in the past month being twice as high among women in comparison to men (6% vs. 3%). Men were more likely to have experienced any form of violence by any perpetrator than women (44% vs. 38%). Perpetrators of VAW included male strangers (32%), male household members (24%) and male visitors (14%). Perpetrators of violence against men included male strangers (54%), male household members (13%), male visitors (11%) and female household members (6%).

Childhood physical and sexual abuse has long-term negative psychosocial impacts and has a bearing on HIV vulnerability in later life, affecting future experiences of violence including victimisation and perpetration, and affecting both sexes. Table 8 shows that males tend to experience higher levels of physical and sexual violence in childhood in comparison to females. Given the high levels of experience of both phenomena, it may be possible to conduct secondary analysis to differentiate formats of abuse and age ranges of persons affected.

Table 8: Childhood abuse, women and men 18 and older by province, 2011

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Gauteng</th>
<th>KZN</th>
<th>Limpopo</th>
<th>WC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical abuse in childhood (males)</td>
<td>88</td>
<td>77</td>
<td>90</td>
<td>80</td>
</tr>
<tr>
<td>Physical abuse in childhood (females)</td>
<td>74</td>
<td>72</td>
<td>77</td>
<td>49</td>
</tr>
<tr>
<td>Sexual abuse in childhood (males)</td>
<td>25</td>
<td>18</td>
<td>19</td>
<td>22</td>
</tr>
<tr>
<td>Sexual abuse in childhood (females)</td>
<td>20</td>
<td>14</td>
<td>18</td>
<td>18</td>
</tr>
</tbody>
</table>

The commitment made in the NSP for developing a comprehensive approach to GBV prevention through SANAC, in conjunction with the then DWCPD was not produced. A programme of action has, however, been developed through the DSD to address VAW. The plan does not include GBV victimisation of both sexes for adults, and does not address gendered vulnerabilities of vulnerable and key populations. While the focus on violence against children includes boys and girls, the dimensions of such violence are not extensively detailed. Nonetheless, the programme of action includes reflection on approaches such as scaled up advocacy, community-based programmes and the need for a related strategic plan.

The coordinated work of the Justice and Peace Cluster of government departments has expanded legislation in relation to GBV – e.g. the criminalisation of corrective rape, forced marriage (Ukuthwala) and a comprehensive review of sexual offences legislation. A report by KPMG on the economic impacts of GBV calculates the economic costs in support of policy mechanisms and advocacy, which are the role of SANAC. The expenditure impacts of GBV were estimated to be between R28.4 billion and R42.4 billion annually (0.9%-1.3% of GDP).

Sexual offences in South Africa include references to offences ranging from sex work to severe sexual assaults and rape. Police statistics for 2013/14, which combines data for sexual offences, indicates that 62,649 cases were recorded in 2013/14, which represents a decline in comparison to data from the previous 5-year period. Rape cases decreased by 3%, as follows: from 47,588 in 2008/09, to 46,253 in 2013/14. Overall monitoring of GBV and domestic violence in South Africa is noted to be sub-optimal,
and there is a need to improve collation and reporting of data collected by the South African Police Services, the Department of Justice and Constitutional Development, and the National Prosecuting Authority (NPA).58

Resources and partnerships directed towards addressing gender vulnerabilities in relation to HIV include support to the Zazi Campaign and Rise Clubs, through Soul City, through PEPFAR and Global Fund. SANAC’s men’s sector is also active in the Brother’s for Life Campaign. It is not clear whether core common indicators and systems for measuring the effects of these campaigns in relation to gender equality and GBV outcomes have been established.

In KwaZulu-Natal, gender forums were launched to increase focus on gender equality and GBV, while mainstreaming of gender, HIV and TB remained a focus of all departments in sector planning. Gender equality and GBV response in the Eastern Cape was largely led by women’s organisations, with men’s organisations said to be lagging behind.

Considerable resources have been directed towards the National Prosecuting Authority’s Thuthuzela Care Centres (TCCs) and Domestic Violence Courts which received US$6 824 129 through a Global Fund for HIV, TB and Malaria (GFATM) grant for 2013-2016. There are currently 44 TCC’s with 30 402 matters being handled in 2014/15. A total of 6 845 sexual offence cases were assessed, 47% of which were referred for prosecution, and which secured a 68% conviction rate – with achievements being in line with targets. Additional resources have also been allocated by government to the TCCs under the NPA.

The NSP refers to assessing this sub-objective through determining the number of women and children reporting GBV to the police each year, as well as the proportion of women reporting having experienced physical or sexual violence in the past year. The lack of disaggregation in these statistics limits potential for understanding trends, while it should also be noted that the extent of reporting is not necessarily correlated with incidence.

SUB-OBJECTIVE 4: MITIGATING THE IMPACT OF HIV AND TB ON ORPHANS, VULNERABLE CHILDREN AND YOUTH

In 2012, there were around 25 million children and youth living in South Africa.59 Among these, around 18 million were children aged 0-17, the majority of whom live in poverty.60 Maternal, paternal and double orphans comprised 19% of children in this age group – most of whom are in the care of a family. Less than 1% of children live in child-headed households. Apart from orphaning and poverty, vulnerability of children and youth includes other factors – for example, disability, living with HIV, living in households affected by illness, being exposed to physical or sexual abuse in family and community settings, being exposed to alcohol or drugs, being LGBTI, or being exposed to exploitation. A grant of US$3 946 325 has been allocated through the GFATM towards programmes for men who have sex with men in higher education institutions for the 2013-2016 period.

South Africa has a well-established infrastructure of social grants provision through the DSD, and in 2012 more than 10 million children were supported by grants including 10 927 7231 supported by Child Support Grants, 536 747 supported by Foster Child Grants and 114 993 supported by Care Dependency Grants. Social protection through grants, among other initiatives in South Africa, has been noted to improve the wellbeing of children and families and has also been associated with lower HIV-related risk behaviours among orphans and vulnerable adolescents.61 A review by the Children’s Institute of budgets allocated through DSD found that initiatives such as the Isibindi Project were relevant and valued, as were fund transfers to NGOs and links to the EPWP.62 However, it was noted that resources were unevenly distributed and this limited their impact.

In Gauteng, ward door-to-door educators assisted in identifying poor households and facilitating service linkages. To address OVC, the Eastern Cape developed a core services package and established an OVC forum to assist with coordination – in particular, to prevent duplication of support.

A grant of US$2 179 349 has been allocated to the DSD for data capture, and US$17 442 626 for indirect support to OVC services through the GFATM for the 2013-2016 period.
SUB-OBJECTIVE 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

Concerns have been raised in the literature regarding the links between barriers to schooling, early school leaving and HIV vulnerability – particularly for girls and young women in Southern Africa. South Africa has very high levels of school attendance, with 97.4% of children aged 7-17 attending school in 2012, with attendance increasing over the past decade. There is also gender-parity in school attendance. The DBE reported that 60% of school learners were exempted from paying school fees, and that 9.2 million primary and secondary school learners were reached through the National School Nutrition programme. The Integrated School Health programme implemented by the DOH and DSD has reached 630 777 learners, while 340 871 female learners were vaccinated for HPV by June 2015.

School-based life skills delivery has already reached the targeted 280 000 learners, with 277 623 learners having been reached by March 2015. The target of 19 000 educators trained in Life Orientation was close to being reached by March 2015 (18 888), while 84 053 learners were reached through peer education by March 2015, exceeding the target of 83 570. Over 40 000 learners were also reached by ‘kick TB’ activations in mining areas. Distribution of Learning and Teaching Support Materials (LTSM) have exceeded targets (673 647 vs 500 000) and two thirds of the targeted 17 300 first aid kits have been distributed. HIV&AIDS supervisory visits to schools are also on target.

The gender parity index (GPI) is 1.06 at secondary school level, with more girls than boys likely to attend school, increasing to 1.13 for the last three years of schooling. Levels of early school leaving among girls in the later stages of schooling are much the same as that of boys. Reasons for drop-out among both sexes include financial factors, disaffection, failure, illness or disability. A small minority of all girls who drop out do so because of pregnancy (10%). A grant of US$3 282 082 has been allocated through the GFATM for a teachers’ survey and programmes to keep girls in school. The Draft DBE HIV, STIs and TB Strategy 2015 complements school attendance with a strengthened focus on addressing HIV prevention and mitigation in schools. The social grants system of the DSD, in combination with the DBE’s special programme for OVCs, ensures that access to schooling by OVC is sustained.

While OVC are defined as children 0-17, there is recognition that focus should extend to youth, and this is being addressed, for example, by the DSD through the expanded concept of orphans and vulnerable children and youth. Youth unemployment in South Africa is very high post-school, with a rate of 53.6% being noted by the World Bank in 2013. The recent Draft National Youth Policy 2014, takes into account the vulnerability of young people to HIV, and seeks to consolidate and mainstream youth development throughout government policies, programmes and the national budget. The draft policy is linked to the National Development Plan among other economic development policies. Challenges underpinning slow progress to date include lack of co-ordination, duplication, fragmentation and poor capacity within the National Youth Development Agency (NYDA). Measures to be undertaken include Youth Brigades, increasing youth targets in EPWP programmes, inclusion in community work, boosting internships, youth enterprise creation, rural development, and improving capacities within the education system. Strategies to include and address HIV are well detailed, including a strong focus on supporting adolescent sexual and reproductive health and rights. Collaboration between schools and organisations such as Soul City and LoveLife, in conjunction with the EPWP had improved links to post-school employment.

The Higher Education and Training HIV/AIDS Programme has provided long-term guidance to HIV-related strategies in universities and Technical and Vocational Education and Training (TVET) colleges in South Africa. A baseline HIV and socio-behavioural survey was conducted in universities in 2009, and has been utilised to guide strategy, although trends have not been determined through follow up surveillance. A more recent study has established HIV-related behavioural patterns in TVETs, although it did not survey HIV prevalence. Nonetheless, baseline data is now established to guide strategy and inform trends.
In Gauteng, transactional sex was seen as a key driver of HIV, while links to inter-generational sex were seen to be driving the problem in KwaZulu-Natal. In Limpopo, it was suggested that there was a need to resuscitate the ‘moral regeneration movement’, and number of other provinces emphasised the need to improve recreational facilities and initiatives for youth. A system of grants for business start-ups by women had been increased through the Eastern Cape Development Corporation.

In the Eastern Cape, bursaries had been used to support schooling, improving opportunities for poorer learners and improving learner retention – although it was noted that monitoring of such initiatives was necessary. In Gauteng, it was highlighted that more young women were passing matric and entering tertiary education, while in Limpopo, success had been seen with the ‘take a girl child to work’ campaign.

In the Free State it was noted that sexual abuse was rife and was not being addressed as a product of secrecy and cultural factors.

**SUB-OBJECTIVE 6: REDUCING HIV- AND TB-RELATED STIGMA AND DISCRIMINATION**

Various national population-based surveys conducted over the past decade have demonstrated low levels of stigmatising attitudes towards PLHIV among the South African population.\textsuperscript{69} Stigma and discrimination are, however, complex phenomena, extending to internalised stigma as well as experiences of discrimination that are not readily identified in surveys of the general population.

A Stigma Index Survey was commissioned by SANAC’s PLHIV sector through the Human Rights Technical Task Team, drawing on a sample of more than 10,000 participants living with HIV. The study found high levels of internalised stigma (43%), and a concern was raised that more marginalised PLHIV may be more severely affected. A minority of PLHIV experienced social exclusion from family, religious, educational and workplace activities. The overwhelming majority of PLHIV did not experience discrimination in relation to work, education or health service provision. Fear of some form of discrimination remained present among around a quarter of respondents. Levels of disclosure of HIV status among PLHIV were high with 90% sharing their status with partners, 85% sharing their status with other family members and 66% sharing their status with friends and neighbours. Most reported that responses by family members and health care workers to disclosure were supportive. It was noted that internalised stigma should be addressed through expanding support systems to PLHIV.

Stigma related to TB was also explored in the study, with gossip, insults and teasing being reported as negative outcomes by more than a third of PLHIV respondents. In the Free State, it was observed that external stigma was not a problem, but internal stigma needed to be addressed.

**SUB-OBJECTIVE 7: STRENGTHENING COMMUNITY SYSTEMS**

The municipal, district and local government infrastructures are intended to provide support to community systems strengthening – in particular, through District and Local AIDS Councils as well as municipal Integrated Development Plans (IDPs). These structures aim to provide coherent strategies for action, as well as building linkages between non-governmental and community-based organisations, religious organisations, schools and the private sector. At municipal level, linkages can be supported through local government and higher level leadership within civil society and the private sector, with attention being given to access and utilisation of referral and support systems.

In KZN, Operation Sukuma Sakhe (OSS) has been implemented as a vehicle and conduit for the implementation and monitoring of the NSP/PSP activities. It is a comprehensive infrastructure for health service delivery and poverty reduction. In essence, the approach involves call for the province, as a collective, to address the social determinants of health following a multi-sectoral approach. The main challenge with the full implementation of OSS and the realisation of its benefits is non-attendance of meetings (war rooms) by key stakeholders, which limits the multi-sectoral and holistic nature of service delivery that is expected of such a structure. (See Appendix 1).
SUB-OBJECTIVE 8: SUPPORTING EFFORTS AIMED AT POVERTY ALLEVIATION AND ENHANCING FOOD-SECURITY PROGRAMMES

Food security refers to the ability of a country to ensure adequate food and nutrition for its population as well as the capacity of individuals to access adequate food on a daily basis.

South Africa ranks 46th out of 109 countries in the 2014 Global Food Security Index, and is also ranked as an upper middle income country. Nonetheless an Oxfam report on ‘hidden hunger’ highlights that one in four people in South Africa experience hunger on a regular basis. A review of food security in South Africa highlights that an important contribution has been made to employment through the EPWP programme, but notes that the programme contributes to reduction of unemployment, but does not solve structural unemployment. Food security of children is addressed through the National School Nutrition Programme which includes a feeding scheme, food gardens at schools and provides employment to food handlers. Recommendations of the review include expanding policy, including developing a ‘Food Security Bill’ and improving monitoring and evaluation.

The National Development Plan 2030 emphasises food security in relation to rights of the population, as well as potential for South Africa to produce food surpluses. The Department of Agriculture’s (DOAs) 2013 National Policy on Food and Nutrition Security commits to a focus on adequate availability of food, utilisation and safety of food and stable food supply. Regarding contemporary food security, around one in five households (22%) had inadequate access to food in South Africa in 2012, with higher levels being noted in some provinces. Subsistence agriculture provides a means to improve household access to food, and 18% of households are engaged in farming or have backyard gardens. Most of these households (77%) do, however, attempt to access additional food sources.

In KwaZulu-Natal it was noted that OSS had enabled the successful implementation of support to SO1 in the province. This was attributed to expanding employment opportunities through the EPWP, providing services through Thusong Multipurpose Centres, expanding HCT, STI and TB screening through mobile units in high transmission areas (including a focus on delivering PHC services to truck drivers and their sexual partners), adopting a multi-sectoral approach to district-level response (including a focus on gender and GBV prevention). Limpopo participants also identified extensive successes in job creation through EPWP programmes, micro-enterprise initiatives and training offered through the Department of Economic Development, Environment and Tourism.

In the North West Province it was noted that initiatives such as AgriAIDS were effective in bringing health care services to farm communities, and mobile clinics improved reach to key populations. An analysis of food security in South Africa highlights the need to provide support to subsistence farmers and improve utilisation of agricultural land.

SUB-OBJECTIVE 1: KEY ACHIEVEMENTS, GAPS AND CHALLENGES

The reviewers feel that this Strategic Objective is very broad, and is not always focused on the HIV and TB epidemics. The country continues to address various social ills, such as, substance abuse and gender-based violence, but the Strategic Objective needs to address these issues as they pertain to HIV and TB, and this is not clearly spelt out in the NSP.

The following observations are made:

- **Sub-objective 1:** While the extent of gender- and rights-based dimensions of HIV and TB were not evaluated in detail, there is clear evidence of extensive internal mainstreaming following the guidance of the DPSA. There are also examples of close mainstreaming to be found in the emerging HIV-related policies and plans of some departments, for example, the prevention strategy of the DOH, the draft policy of the DBE, and the draft policy on youth. While gender and rights-based mainstreaming in relation to HIV and TB is evident or implicit in guiding frameworks in a number of SANAC sectors, comprehensive data was only available for some sectors. It is also unclear as to whether the guiding frameworks have been translated into effective programmes. A number of provinces noted that they continued to grapple with ‘silo’ approaches through government
departments, which constrains both mainstreaming and multi-sectoral response.

- **Sub-objective 2:** Regarding addressing social and economic drivers, repeat HSRC surveys have illustrated the higher prevalence of HIV in informal settings, as well as effects on various populations and sub-populations in South Africa. SANAC has established a technical task team to focus on this area of intervention, although the extent of progress could not be determined. The DBE and DSD do have programmes addressing impoverished settings, and it would be useful to reference clear indicators for understanding this response. The analysis of response in rural settings illustrates gaps in key areas of response – in particular, skills and efficiencies of personnel, and the need to improve resource equity. Regarding alcohol and drug abuse, the national master plan provides relevant guidance, and the Inter-Ministerial Committee on Substance Abuse supports leadership in this area. Given that the surveillance conducted by SACENDU only addresses substance abuse in relation to treatment, it is crucial to expand surveillance systems. National surveillance of consumption and abuse of alcohol and illicit drugs should be established to support setting targets and understanding trends – in particular, in relation to potential burgeoning abuse of methamphetamine (tik) and mixed drugs. Although the links between substance abuse and violence including sexual violence are well-evidenced, there appears to be an absence of strategic leadership to address these issues. While increasing regulation of alcohol is an important step, sound strategies are needed to address abuse of illicit drugs and related negative social consequences of such abuse. Regarding mobility and migration, SANAC has established a forum and technical task team, and a ‘size estimation’ study on migrancy has been planned, although the extent of progress could not be determined.

- **Sub-objective 3:** Regarding gender equality, South Africa’s overarching policy environment is exemplary globally, and gender equality is considered in a broad spectrum of government policies and strategies. The response to gender equality and GBV is integrated into a number of strategic policies. While some baseline data is available that can be utilised to inform trends if repeat studies are conducted, it is necessary to clarify indicators for measuring GBV and related phenomena. This includes focusing on contemporary or recent occurrence (i.e. past year) rather than ‘ever’ (which cannot inform trends), avoiding conflation of measures into overly broad indicators, and ensuring a gender-equal approach to enquiry that includes disaggregation on various strata of vulnerability including age groups, race, sexuality, disability, economic and other formats of marginalisation. The recent findings indicating high levels of physical and sexual abuse in childhood suggest that this focal issue has been given poor attention to date, yet is strongly linked to a range of vulnerabilities and causal and consequential pathways related to HIV. Social and public health constructs and indicators are not adequately aligned with statutory definitions, and this inhibits the development of effective and measurable strategies. South African police statistics provide some insight into the extent of sexual offences in the country, although the absence of disaggregated data limits potential for interpretation and trend analysis. Attention is given to gender rights and GBV prevention through various campaigns, although it would be useful to understand the extent of commonalities between outcome and change goals, and mechanisms suitable for monitoring change against common core indicators. TCCs provide coverage in geographic sub-areas and have a sound monitoring and target approach, with targets being met – although low-cost integrated approaches should be developed for the many areas where TCCs do not exist. In KwaZulu-Natal it was noted that rural community values were not readily transformed with respect to gender and there was improper practice of ‘ukuthwala’, while in rural and urban settings, patterns of disparate older partners and transactional sex undermined HIV prevention.

- **Sub-objective 4:** The social grants system has been in place for a considerable period of time for children aged 0-17, leading to positive outcomes including those related to HIV vulnerability. It is less clear whether benefits extend sufficiently to reducing vulnerabilities of young people aged 18-24 who are not directly reached by such social support systems. While emphasis is given to orphaning, it is relevant to consider the extent to which other categories of child and youth vulnerabilities are addressed, and whether support systems are sufficiently sensitive to preventing physical and sexual abuse, or minimising the effects of exposure to alcohol or drug use. The resources earmarked for monitoring and indirect support have potential to sharpen understanding of trends in this area of response. The emerging focus on MSM can be expected to improve prospects for HIV prevention in this long-marginalised sub-population, with a focus on young MSM being aligned with this strategic objective.
• **Sub-objective 5:** School retention is overall high with minimal school drop-out and the data illustrate that gender balance is maintained in relation to school access. The grant focused on keeping girls in school and has potential to be focused on specific aspects of HIV, TB and gender vulnerability. The draft DBE strategy provides an opportunity to refocus previous initiatives, and the resources allocated to a Teacher’s Survey will further inform implementation. The Draft National Youth Policy addresses the urgent economic needs of youth post-school and outlines a range of strategies, while also taking a critical assessment of deficiencies in response over the past decade and can be seen as complementing the work of the DSD and DBE. Baseline HIV data, in combination with socio-behavioural data have been utilised to inform strategic programmes in universities, with more recent data being available to complement strategies at TVETs.

• **Sub-objective 6:** Overall low levels of external stigma, in combination with low levels of discrimination in service provision – in particular – health services, is promising and illustrates the effects of broad rights-based strategies. PLHIV do, however, continue to experience internalised stigma and may need support in relation to disclosure.

• **Sub-objective 7:** While strengthening of community systems is a relevant consideration for the NSP, there is an absence of guidance on how systems strengthening and change should be monitored.

• **Sub-objective 8:** South Africa has a strong commitment to food security at country level, and to ensuring food supply to households, and baseline data provides an opportunity to determine opportunities for accelerated goals. Adequate prioritisation has been given by the DOA to food security at national and household level and monitoring of trends will inform progress. Links to ART programmes and adherence are not clarified.

**SUB-OBJECTIVE 1: RECOMMENDATIONS**

An overall recommendation is to reduce and sharpen the sub-objectives within SO 1. Structured as present, the sub-objectives are not readily monitored and it is clear that progress within the timeframe of the NSP will not be easily assessed. There is insufficient prioritisation given to the specific links between this SO and HIV prevention targets and goals.

Mainstreaming is a key strategic intervention. The monitoring and evaluation of mainstreaming is guided by SADC, and is clearly articulated in the Government Sector HIV&AIDS Monitoring and Evaluation Framework. This Framework has been shared and discussed within government departments, SANAC and the Department of Planning, Monitoring and Evaluation. Finalisation of this process is a crucial aspect of NSP implementation, given that the indicators link to international obligations to report on HIV&AIDS mainstreaming.

It should also be taken into account that the premise of this SO is to address the social and structural drivers that underpin behavioural risks. While strong emphasis is placed on structural drivers, social drivers – specifically attitudes and norms that underpin behaviour and advocacy to promote these – are not included as clearly articulated goals or indicators. It is also specifically necessary to understand the relation between social and structural drivers and the HIV, TB and gender vulnerabilities of HIV-vulnerable sub-populations. It is recommended that analysis be conducted towards consensus on key indicators for social drivers that should ultimately fall within this SO. These should be linked with the behavioural outcomes outlined in other SOs. It would specifically be useful to clarify the key indicators in relation to whether baseline data exists and/or would be in place for the forthcoming NSP.

It is recommended that a consensus workshop be held to determine prioritisation of social and structural drivers for the forthcoming period, and to identify lead entities for the same.

The following further recommendations are made:

• **Sub-objective I: Government Departments:** The translation of mainstreaming into active strategies to address most vulnerable populations should be intensified. For example, the need to focus on prevention of HIV among girls and young women as well as approaches towards maximising support to PLHIV, families living in poverty, and other vulnerable and marginalised sub-populations. The balance between internal and external mainstreaming should be intensified in particular, and
the Government Sector HIV&AIDS M&E Framework should be institutionalised to monitor progress. External mainstreaming of the Economic Cluster of Government departments should be improved. The current guidelines from DPSA support increased capacity to implement at the lowest municipal levels of the ward, local, district/metro municipalities and increase accountability to the highest level. Accountability frameworks for national and provincial departments should be shared with Department of Cooperative Governance and Traditional Affairs (COGTA) and the South African Local Government Association (SALGA) to ensure seamless accountability for implementation in all three spheres of government, using the Inter-Governmental Relations Framework and enabling Public Administration and Municipal Systems legislation. The Governance Model of involvement of Mayors and accountability to Mayors for municipal and cities response must be improved. Support for ART and TB treatment should be included both at the workplace and through public services. Strategies addressing the need for increased social security for people ageing with HIV&AIDS should be developed and implemented. **SANAC sectors:** All SANAC sectors should have a presence on the SANAC website that includes a clearly articulated framework and plan. This should include goals and outcome indicators that incorporate gender- and rights-based dimensions of HIV and TB. Given that the sectors are HIV-focused, the outcome indicator would then be ‘Proportion of SANAC sectors with a framework or strategy that incorporates gender- and rights-based dimensions of HIV and TB linked to core mandates’, with 100% of sectors as a goal.

- **Sub-objective 2:** Although the links between informal residential settings and HIV have long been established, there does not appear to have been sufficient nor accelerated attention given to strategies that specifically target these communities. Given that disproportional impacts remain, there is a need for a clearly articulated strategic plan based on the general health impact assessment, and HIV specific Impact Assessments addressing the implications of HIV and AIDS for human settlements in general. Abuse of alcohol and illicit drugs exacerbate gender rights, and TB and HIV vulnerabilities and there is potential for some redress through the national master plan. However, a comprehensive strategy linked to HIV would intensify the response. Priority should also be given to improving surveillance to ensure that clear goals can be established and trends monitored. While the suggested indicator – ‘proportion of municipalities with at least one informal settlement where HIV, STIs and TB services are implemented’, it needs to be clarified how such data would be gathered. Furthermore, success depends on implementation in 100% of informal rural and urban areas, and the goal should be revised beyond just one settlement per municipality. Other useful indicators would be tracking HIV prevalence and declines at district level among 15-24 year olds using a population-based survey and antenatal data. A national surveillance system for tracking alcohol and illicit drug abuse is required as a matter of urgency. The design of such a survey would need to accommodate indicators that take household and social data into account – for example, reporting alcohol or drug abuse in households and in immediate neighbourhood, as well as understanding of the links and harms associated with the same. A consensus meeting on indicators and methods should precede the survey. The need to support emerging emphasis on ART scale-up should also be addressed.

- **Sub-objective 3:** The response to GBV in South Africa is limited by a lack of adequate surveillance, including appropriate measures and indicators to monitor this phenomenon – in particular, acknowledging that both sexes are victims/perpetrators of GBV, and that gendered violence affects marginalised groups, such as, persons with disability, sex workers, LGBTI, incarcerated persons and refugees. A consensus workshop on measurement and surveillance is recommended in conjunction with planning for repeat surveillance to guide goals and monitor trends. This should include indicators for measuring the impact of campaigns and should at least have been achieved by 2016. Community mobilisation in response to GBV is well-established as a means to intensify prevention, and it is recommended that resources be directed towards grassroots mobilisation to complement mass media initiatives – for example, the Prevention in Action programme conducted in KwaZulu-Natal and Western Cape,75 the work of Brother’s for Life77 and other men-focused initiatives, and club-oriented activities such as being implemented by Soul City.76 A focus on childhood physical and sexual abuse is crucial, and priorities in general should be linked to contexts and settings where HIV incidence and GBV are most closely connected. The Government Sector M&E Framework includes indicators that need to be validated to inform planning for the remainder of the NSP. These and the responsible departments include: 1) The number of TCCs (DOJ/CD/NP); 2) Number of victim friendly facilities at police stations for sexual offences and trafficking of humans (SAPS); 3) Number of victims who attend parole hearings (DOJ/CD).

- **Sub-objective 4:** Given the high unemployment among youth in conjunction with high HIV incidence among youth and links to poverty, inequality and unemployment, social support systems should continue to be focused on employment creation and household support. Expanding focus from children aged 0-17 to youth aged 18-24 will require analysis of care, a composite index of all ranked protective public services received at a local level and residential arrangements of vulnerable youth in the latter age group. The need for spatial epidemiological assessments is thus necessary. All categories of vulnerable children and...
youth should be addressed. Research findings highlight that particular attention should be given to physical and sexual abuse in childhood, as well as vulnerabilities linked to alcohol and illicit drugs.

- **Sub-objective 5:** Attention given to keeping girls in school should clarify the extent of school-leaving, given that there is gender parity in school-leaving for learners up to age 17. Reasons for school-leaving, poor attendance or performance should be closely analysed, and potentials to support early school leavers of both sexes, and youth out-of-school in general should be explored. Given the overlap with sub-objective 4, these two sub-objectives could be integrated.

- **Sub-objective 6:** External stigmatisation and discrimination directed towards PLHIV, while not extensive, requires that all incidents of discrimination be addressed through legal and other channels. Stigma related to TB should be categorically addressed. Internalised HIV stigma and discrimination is severe and support systems should be expanded, including interpersonal approaches such as support groups and counselling, coaching, as well as networks and meaningful participation of PLHIV into various systems within the HIV and TB response. There is overlap between this sub-objective and SO4, which addresses rights. While the focus of this sub-objective is PLHIV, it should be recognised that HIV and TB stigmatisation and discrimination directed towards other vulnerable sub-populations is of equal importance and should be addressed (e.g. LGBTI, persons with disability, sex workers, prisoners, displaced persons). The SADC HIV&AIDS Mainstreaming guidance informs relevant indicators for monitoring response – including relevant departments. Examples include: 1) Existence of national legal frameworks protecting the rights of key populations to access services without stigma and discrimination (DOJ/CD); 2) Proportion of justice system personnel (Judges, Magistrates, Prosecutors, Police and Prisons Officers), trained in managing issues relate to gender, human rights and HIV & AIDS (DOJ/CD/SAPS/DCS); and 3) Proportion of cases of rights violations among PLHIV and key populations that have been resolved during the last 12 months (DOJ/CD/NPA/MOH/DSD/SAPS).

- **Sub-objective 7:** Community systems strengthening would be improved through clear guidance on best practices, with additional support needed to clarify how to monitor this aspect in relation to change goals. Lessons from the provinces should be further consolidated towards a national strategy. SANAC has potential to play a lead role in strengthening local governance structures including through clarifying accountabilities. The successes of the ‘war room’ approach, including its devolution to ward level, provide an example of an approach that can be scaled up throughout the country.

- **Sub-objective 8:** This is complex sub-objective that currently does not clarify explicit links to HIV. While the bulk of this objective is addressed through other developmental and poverty support plans, there is an overlap with sub-objectives 4 and 5, which address OVC and youth. In the context of emerging intensified ART programming, the links between poverty, inequality, unemployment, access to food, access to transport and capacity to adhere to ART should be clarified. Similarly, there are links between TB and poverty to be addressed. This sub-objective should be revised to address these links, with suitable HIV and TB specific indicators being identified.

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

In alignment with the NSP goals to ‘reduce new HIV infections by at least 50% using combination prevention approaches’, and to ‘reduce the number of new TB infections and deaths by 50%’, SO2 addresses key strategies for preventing sexual and vertical transmission of HIV and STIs, and preventing and mitigating TB. It is necessary that the combination prevention approaches applied should integrate biomedical, behavioural, social and structural interventions that will have the maximum impact on lowering the spread and diminishing susceptibility and vulnerability to HIV, STIs and TB. Furthermore, assorted prevention interventions and combinations are necessary to support a focus on key populations with a view to achieving the long-term vision of zero new HIV and TB infections.

The NSP sets out to address SO2 through the following seven sub-objectives:

1. Maximise 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
2. Ensure access to a package of sexual and reproductive health (SRH) services
3. Prevent 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

4. Implement a comprehensive national social and behavioural change communication strategy with a focus on key populations

5. Prepare for the potential implementation of future innovative, scientifically proven HIV, STI and TB prevention strategies

6. Prevent TB infection and disease

7. Address sexual abuse and improve services for survivors of sexual assault

**STRATEGIC OBJECTIVE 2: KEY POLICY ISSUES**

Mitigating the impacts of new HIV infections starts with HIV case identification or diagnosis through HCT. This is preceded by provision of prevention resources such as male and female condoms (with emphasis on dual protection and the provision of both male and female condoms), prevention of mother to child transmission, male medical circumcision, management of STIs, and post-exposure prophylaxis for eligible HIV negative individuals. Contraception provision is also relevant.

South Africa has comprehensive national HCT guidelines that are regularly updated in line with the latest available scientific evidence and national HIV and AIDS policy. Nationwide, HIV prevention services that are readily available and public health facilities include HCT services and access to prevention resources.

South Africa’s National TB Control Programme has a vision of ‘A South Africa free of TB’ and follows a mission to ‘prevent TB and to ensure that those who do contract TB have easy access to effective, efficient and high quality diagnosis, treatment and care that reduces suffering’. The National TB plan was updated in 2013 and new national TB management guidelines were published in 2014. With HIV and TB driving morbidity and mortality in South Africa, the 2014 TB guidelines place emphasis on: 1) Reducing transmission of infection; 2) Diagnosing drug-sensitive/susceptible (DS) and drug resistant (DR) TB early; 3) Initiating treatment in all patients diagnosed with TB early; 4) Retaining patients in treatment and care until completion of treatment; 5) Preventing TB in PLHIV by initiating all eligible HIV positive individuals on ART and isoniazid preventive therapy (IPT). Furthermore, there are other plans and supporting guidelines for the management of DR-TB as well as the decentralisation and deinstitutionalisation of DR-TB services.

In December 2014, the PMTCT guidelines were revised in accordance with international good practice. The updated guidelines include: 1) Initiation of lifelong ART for pregnant women regardless of CD4 count or clinical stage as well as polymerase chain reaction (PCR) testing for all HIV exposed neonates/infants. In addition, HCT is offered to all pregnant and breastfeeding mothers with unknown HIV status or those who tested HIV negative in the preceding three months. Pregnant women who test negative included in the PMTCT programme are offered routine HIV testing throughout their pregnancy, labour and breastfeeding stages. The guidelines also recommend integration of TB and syphilis screening and treatment. This also contributes to the elimination of neonatal syphilis.

To tackle the existing HIV, STI and TB prevention needs and gaps in services, research, and support for key populations, the DOH developed an Operational Framework for Key Populations HIV, STIs and TB Programmes in South Africa in 2012. The Framework was intended to assist health planners to develop, plan, implement, monitor and evaluate programmes in order to achieve the targets for key populations as set out in this NSP. A gap analysis survey conducted by the Desmond Tutu HIV Foundation in 2011 provided an overview of the current situation in relation to key populations, including issues influencing their susceptibility to HIV.
### Strategic Objective 2: Indicator Matrix with Results

Table 9 outlines the indicators and results for SO2 utilising categories defined in the NSP. In some instances baseline or mid-term data is not available. The specific results are discussed further below.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline</th>
<th>Target 2016</th>
<th>FY 2014/15 Achieved</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number (and percentage) of men and women 15–49 counselled and tested for HIV</strong></td>
<td>13 million (HCT Review Report); 62% ever tested, 37% tested in the past 12 months (2008 NCS)</td>
<td>30 million; 80% of adults tested</td>
<td>9 556 097 including ANC (DOH Annual Report 2014/15)</td>
<td>95% of the NDOH 2014/15 target of 10 000 000 achieved. This number excludes private sector and non-DHIS HCT data. This target was probably ambitious, and South Africa has the one of the largest HIV testing programmes in the world.</td>
</tr>
<tr>
<td><strong>Number and percentage of people screened for TB</strong></td>
<td>8 million (2011 HCT Review)</td>
<td>30 million</td>
<td>This indicator is currently not included in the NIDS, thus no DHIS indicator. However, this is under consideration</td>
<td>It is estimated that 12–15% of PHC attendees have TB symptoms requiring investigation. With an estimated health facility headcount of 105 998 580 in 2013, almost 16 million should have been tested for TB. This suggests that in addition to health facility based TB screening, community-based screening is necessary. As part of Global Fund TB screening programme, 70 425 inmates were tested using GeneXpert and 252 843 community members in the six targeted peri-mining communities were screened for TB. Nationally, 88% of TB miners were found to routinely screening miners for TB.</td>
</tr>
<tr>
<td>Indicator</td>
<td>Baseline</td>
<td>Target 2016</td>
<td>FY 2014/15 Achieved</td>
<td>Comment</td>
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<tr>
<td>Number of newly diagnosed HIV positive people started on IPT for latent TB infection</td>
<td>53% (NDOH HCT Review 2011)</td>
<td>85% of people newly enrolled in HIV care</td>
<td>551 787 in 2014 (WHO TB report: 2015)</td>
<td>This result is above the national 2013/14 target of 450 000 new HIV positive patients initiated on IPT. South Africa contributes about 40% of global provision of IPT. Denominator data not available to calculate percentage</td>
</tr>
<tr>
<td>Percentage men and women aged 15–24 reporting the use of a condom with their sexual partner at last sex</td>
<td>40% (for all sexually active respondents) 63.75% (16–24 years) 69% (16–19 years) 58.5% (20–24 years)] (NCS 2009)</td>
<td>100%</td>
<td>47% (for all sexually active respondents) 62.25% (16–24 years) 64.5% (16–19 years) 60% (20–24 years)] (NCS 2012)</td>
<td>Only NCS 2009 results were used at baseline and for consistency only NCS 2012 results were reported for the EPR. HSRC survey 2012 does not provide condom use with their sexual partner at last sex for this age category</td>
</tr>
<tr>
<td>Percentage young women and men aged 15–24 who had sexual intercourse before age 15 (age at sexual debut)</td>
<td>10% (HSRC 2008)</td>
<td>&lt;5% (50% reduction)</td>
<td>10.7% (HSRC 2012)</td>
<td>0.7% increase from the baseline, thus early debut increasing</td>
</tr>
<tr>
<td>Percentage women and men aged 15–49 years who have had sexual intercourse with more than one partner in the last 12 months</td>
<td>7% (HSRC 2008)</td>
<td>&lt;5% (28.5% reduction)</td>
<td>12.6% (HSRC 2012)</td>
<td>80% increase from the baseline. Trends of this indicator are in the reverse direction</td>
</tr>
<tr>
<td>Indicator</td>
<td>Baseline</td>
<td>Target 2016</td>
<td>FY 2014/15 Achieved</td>
<td>Comment</td>
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<td>-----------------------------------------------</td>
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<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Female condom distribution</td>
<td>5.1 million (2010/11)</td>
<td>25 million (400% increase)</td>
<td>20 700 161 (DOH 2014/15)</td>
<td>83% of 2016 NSP target and this is a significant improvement from baseline</td>
</tr>
<tr>
<td>Number of men medically circumcised</td>
<td>143 000 (2010/11)</td>
<td>1 600 000</td>
<td>508 404 (DOH Annual Report 2014/15)MMC Trends: 2012/13 – 422 262 2013/14 – 331 668</td>
<td>51% of the 2014/15 NDOH target of 1 000 000 achieved. More than 1.2 million circumcisions performed over the last three years and over 3 million circumcisions have been done over the last five years.</td>
</tr>
<tr>
<td>Number of people reached by prevention communication at least twice a year</td>
<td>90% (NCS 2009)</td>
<td>99% (NCS 2012)</td>
<td>82% (NCS 2012)</td>
<td>This is 17% below the 2016 target. However, for the period of this NSP, the NCS 2012 data should be used as baseline not NCS 2009</td>
</tr>
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</table>

**SUB-OBJECTIVE 1: HIV AND TB SCREENING AND ENROLMENT INTO CARE**

Knowing one’s HIV status through regular HCT is regarded as an important entry point to a comprehensive package of care for HIV prevention, care and treatment. HCT services are readily available and accessible in all South African public health facilities and population-level HIV testing is among the highest levels globally. The 2012 National Communication Survey (NCS) reported that 10.7 million people – had tested for HIV in the past 12 months. This was comparable to the routine HCT campaign testing data which showed that 10 700 276 people were tested during this period. As per Table 10 below, more than 17.6 million people had ever tested for HIV by end of 2012.

Table 10: Number and percentage of persons aged 16-55 tested for HIV in 2009 and 2012

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
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<th>2012</th>
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<tbody>
<tr>
<td></td>
<td>n</td>
<td>Weighted number</td>
<td>Weighted percentage</td>
<td>n</td>
<td>Weighted number</td>
<td>Weighted percentage</td>
</tr>
<tr>
<td>Ever tested for HIV</td>
<td>5 214</td>
<td>14 947 451</td>
<td>54.7</td>
<td>6 444</td>
<td>17 632 568</td>
<td>65.0</td>
</tr>
<tr>
<td>Tested for HIV in the past 12 months</td>
<td>3 169</td>
<td>8 849 625</td>
<td>32.3</td>
<td>3 994</td>
<td>10 707 127</td>
<td>38.1</td>
</tr>
</tbody>
</table>
Table 11 shows HCT programme data, indicating a total of 8,772,423 people were tested in 2011/12. In 2012/13, 18 million people were targeted for testing (a 100% increase from 2011/12) and ultimately 8,978,177 people were tested (49.8% increase from 2011/12) by the end of 2012/13.

Table 11: Number of HIV tested clients, 2011/12 to 2014/15

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Number of HIV test clients aged 15-49 years</td>
<td>8,772,423</td>
<td>18,000,000</td>
<td>8,978,177 (all ages)</td>
<td>13,000,000</td>
<td>6,688,950 excl.ANC (15-49 years)</td>
<td>9,713,179 incl.ANC</td>
<td>10,000,000</td>
</tr>
</tbody>
</table>

* The above data excludes private sector and non-DHIS HCT data

To further augment HCT uptake, South Africa developed a revitalisation strategy in 2012/13. The strategy was centred on three goals: 1) Ensuring that HIV-positive individuals are linked to care; 2) Ensuring that patients are provided with behavioural change counselling; 3) Ensuring that patients are screened for TB and non-communicable diseases. The Deputy President and the Minister of Health re-launched the revitalised HCT campaign in December 2013, targeting several sectors, namely, the private sector, farms and higher education to increase HCT coverage.

In 2013/14, a total of 6,688,950 people aged 15-49 years were tested for HIV, 51% lower than the 2013/14 target of 13,000,000. The latter target was set with the assumption that the 2010 HCT campaign testing rate would be maintained. All ages were included – not only the 15-49 age group reported above. In 2014/15, 95% (9,556,097) of the 2014/15 HCT target was achieved. Since the launch of the national HCT campaign in April 2010, over 35 million South Africans have been tested. Social mobilisation and communication campaigns to further enhance awareness and education on HIV and AIDS and STIs, as well as generate demand for the services continue.

In all provinces, programmes such as the ‘First things First’ campaign has encouraged young people in all public institutions of higher learning to regularly test for HIV and know their status. Other initiatives and campaigns like ‘My Life My Future’ and ‘Zazi’ have also helped promote TB screening and HIV testing to ensure early diagnosis and enrolment into care. KZN HCT targets were consistently reached and this is credited to 1) The large numbers of trained peer educators who conduct social mobilisation; 2) The integrated ‘Hiola Manje’ community awareness campaigns; 3) Intensified wellness programmes; and, 4) Constant monitoring of HCT activities through nerve centres.

Relative to HCT, TB screening remains suboptimal and this is mainly due to poor integration of HIV/AIDS/STI/TB (HAST) services at health facilities.

Limpopo province reported the Government Employees Medical Scheme (GEMS) health screenings which include HCT and TB screening as one of their key achievements for the period under review. In an effort to increase TB case finding, the North West province has implemented the annual screening of miners and peri-mining communities. Nonetheless, provincial HCT uptake remains suboptimal and this is ascribed to the inadequate implementation of provider initiated counselling and testing and partly due to weak HCT data management. HCT service delivery to farm workers also remains poor.

In the private/business sector, through combined efforts coordinated by South Africa Business Coalition on Health and AIDS (SABCOHA), from 2012 to 2015 a total of 96,489 males and female aged 15 to 49 years were tested for HIV. Refer to Appendix 4 for a list of the respective private sector organizations working with SABCOHA.
Table 12: Private/Business Sector HCT Data by age category (15-49 years)

<table>
<thead>
<tr>
<th>Year</th>
<th>Tested for HIV</th>
<th>TB Screened</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>37 913</td>
<td>22 382</td>
</tr>
<tr>
<td>2013</td>
<td>15 305</td>
<td>15 281</td>
</tr>
<tr>
<td>2014</td>
<td>10 155</td>
<td>9 409</td>
</tr>
<tr>
<td>2015</td>
<td>33 116</td>
<td>28 499</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>96 489</strong></td>
<td><strong>75 571</strong></td>
</tr>
</tbody>
</table>

**SUB-OBJECTIVE 2: ENSURE ACCESS TO A PACKAGE OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES**

**SEXUALLY TRANSMITTED INFECTIONS (STIs)**

Universally, STIs remain a sexual and reproductive health challenge and are associated with increased acquisition of HIV. The risk of acquiring HIV infection in an individual with a STI is increased by threefold or more (WHO 2013). The control of STIs can be measured by reduced incidence, but the NSP has no indicators or targets for STIs. To tackle the burden of STIs, South Africa adopted the syndromic approach as the preferred method for the control and management of STIs in 1996.

For programme monitoring, the DOH STI programme adopted the following indicators namely, 1) Incidence of STI treated new episode with a target of 35%, and 2) Male Urethritis Syndrome (MUS) rate with a target of 25%. These STI indicators are reported through the District Health Information System (DHIS) however, there are data quality challenges across provinces. The reporting on these indicators is currently limited to public health facilities.
**STI TREATED NEW EPISODE INCIDENCE**

The national STI programmatic data shows a steady decline in STI incidence since 2012, as shown in Figure 5 below.

Figure 5: National Incidence of STI treated new episode for the period 2012/13 to 2014/15

At provincial level, KZN had the highest incidence and above the national target of 35%, for the NSP period under review. Similarly, the EC STI incidence remains above 35%, as depicted in Figure 6 below.

Figure 6: STI Treated New Episode Incidence by Province, 2012/13 to 2014/15
It is important to note that the STI incidence indicator is also linked to various factors, namely, condom distribution, medical male circumcision performed, HIV incidence and other prevention strategies in place.

MALE URETHRITIS SYNDROME

Male Urethritis Syndrome is recognised as the STI syndrome that most accurately represents newly acquired STIs. Majority of the MUS (70%) are attributed to acute gonorrhoea while about 20-25% cases are due to chlamydial infection. In light of the low male attendance at public sector STI clinics, the measuring of the MUS rate i.e. number of MUS treated new episodes divided by the number of STI syndromes-treated, has been deemed less useful as it can be affected by the proportion of men attending clinical services over time. Thus, increased advocacy for the collection of MUS incidence is required. Monitoring of MUS incidence is vital as it assures there is a male-based denominator. Moreover, it is an indicator of sexual behaviour which can make the monitoring and evaluation of public health prevention strategies like 1) Reducing high-risk sexual behaviour and 2) Increasing condom use, possible. MUS incidence as an annualised percentage is the number of MUS treated new episodes divided by the male population aged 15 years and older.

Figure 7: National MUS Rate

As per Figure 7 above, the national MUS rates show a gradual increase over the period 2012/13 to 2014/15. Figure 8 shows the MUS rates by province, with the 2012/13 data for MP, NW, and WC not reported.
In collaboration with National Institute of Communicable Diseases (NICD) and the International Training and Education Centre for Health (I-TECH), the DOH STI Prevention Unit is implementing activities aimed at strengthening the STI programme, namely, 1) The development of STI training guidelines; 2) National STI clinical sentinel surveillance (CSS); 3) Review of the STI treatment protocol to address needs/gaps identified e.g. multi-drug resistant STI; and, 4) National STI services evaluation.

**MEDICAL MALE CIRCUMCISION (MMC)**

According to the United Nations (UN) investment framework, at least five million circumcisions should be conducted in South Africa for the approach to significantly contribute to incidence reduction. Since its inception in 2010, the national MMC programme has reached over 1 million male medical circumcisions among men aged 15-49 years. In 2012/13, 422,262 circumcisions were performed, reaching 86% of the target of 600,000 set for that year. In 2013/14, a total of 331,668 circumcisions were performed, achieving 55% of the 2013/14 target of 600,000. In 2014/15, 508,404 were done, thus 51% of the 2014/15 target of 1 million was achieved. These numbers exclude private sector MMC numbers. It is important to note that more than 1.2 million circumcisions were performed over the last three years. Consequently, about 3 million circumcisions performed in the last five years.

The 2012 HSRC survey showed that self-reported circumcision among youth and men aged 15 years and older has risen from 2008 to 2012, although medical circumcisions were overall low. Of the 47% of males who reported having been circumcised, considerably more than half (26%) were traditional circumcisions. A low MMC uptake was also reported in the 2013 Joint HIV, TB and PMTCT Review and provinces where traditional circumcision is practiced like the Eastern Cape, Mpumalanga and Limpopo, MMC levels were noted to be low.

A shortage of doctors inhibits the delivery of MMC services, and the DOH is exploring task-shifting to enable nurses to conduct MMC to increase coverage. Additionally, the viability of introducing non-surgical invasive medical devices (e.g. PrePex) is also being investigated to increase MMC coverage. The DOH also plans to integrate MMC into the HCT campaigns, in conjunction with an intensified social mobilisation and communication plan to increase demand for MMC services.

To help address cultural barriers to MMC in KZN, His Majesty, King Zwelithini has openly endorsed MMC. Such backing is
particularly relevant in KZN rural communities where male circumcision was not traditionally practised.

CONDOM DISTRIBUTION

DHS data shows that male condom distribution dropped from the 2010 baseline of 492 million to 230 011 696 in 2011 (53% below baseline), 251 419 268 in 2012 (49% below baseline), 352 065 256 in 2013 (29% below baseline), 506 431 299 in 2014 (51% of 2016 NSP target) and 723 799 877 in 2015 (72% of 2016 NSP target). The NSP has a target of 1 billion male condoms by 2016 for male condom distribution, a 51% increase from the 2010 baseline. It is important to note that the investment case suggests a target of 800 000, based on estimated national sexual acts.

Table 13: Male and Female Condom Distribution, 2010-2014 (in millions)

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>2010 (Baseline)</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016 NSP Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of male condoms distributed</td>
<td>492 000 000</td>
<td>230 011 096 (53% &lt; baseline)</td>
<td>251 419 268 (49% &lt; baseline)</td>
<td>352 065 256 (29% &lt; baseline)</td>
<td>506 431 299 (51% of 2016 NSP target)</td>
<td>723 799 877 (72% of 2016 NSP target)</td>
<td>1 billion (51% from baseline)</td>
</tr>
<tr>
<td>Number of female condoms distributed</td>
<td>5 100 000</td>
<td>4 325 196 (16% &lt; baseline)</td>
<td>4 309 146 (16% &lt; baseline)</td>
<td>7 686 231 (51% &gt; baseline)</td>
<td>13 254 328 (53% of 2016 NSP target)</td>
<td>20 700 161 (83% of 2016 NSP target)</td>
<td>25 000 000 (400% from baseline)</td>
</tr>
</tbody>
</table>

Female condom distribution dropped from the 2010 baseline of 5 100 000, declining by 16% in 2011 (4 325 196) and 2012 (4 309 146). In 2013, female condom distribution rose by 51% from baseline to 7 686 231 and to 13 254 328 in 2014 with a drastic increase to 20 700 161 in 2015, an 83% increase from the NSP target of 2016. The NSP has a target of distributing 25 million female condoms by 2016 – a 400% increase from baseline.

CONDOM USE

Findings on last sex condom use differ in national surveys. The 2012 NCS found that condom use at last sex among respondents who had sex in the past year was 47% – a slight increase from 40% in the survey conducted in 2009. For the age group 16-24 years, condom use dropped slightly from 63.75% in 2009 to 62.25% in 2012. It was also found that 76% of respondents used a condom at last sex with a casual partner, 65% used a condom at last sex with a main or regular partner, and 28% used a condom at last sex with their spouse or live-in partner. In contrast, the 2012 HSRC survey found condom use at last sex was 36%, a decrease from the 45% found in 2008. Condom use at last sex was found to have decreased among all age groups and both sexes, except among females aged 50 years and older.

From the provincial reviews, poor female condom utilisation was mentioned as a key challenge in Limpopo.

EARLY SEXUAL DEBUT

The 2012 HSRC survey found that the proportion of young people engaging in sex before the age of 15 years was 10.7% among youth aged 15-24, a 0.7% increase from the 2008 baseline. The 2012 NCS found that 20% of youth aged 16-24 who had ever had sex stated that they were 15 years or less when they first had sex.
MULTIPLE SEXUAL PARTNERS

The 2012 HSRC survey found that 12.6% of respondents had more than one sexual partner in the past 12 months – with higher levels being found among 15-24 year olds (22.4%). Since the first survey in 2002, trend analyses show a steady increase in the rates of multiple partnerships from 11.5% to 18.3% between 2002 and 2012 respectively. More males reported the practice in comparison to females (20.1% vs. 4.6%). In the 15-24 year age group, 23.0% of males reported having had multiple partners in the past year in 2002 in comparison to 37.5% in 2012. The range was 6-8% for young females.

In the 2012 NCS, it was found that only 40.7% of respondents mentioned faithfulness as a means to prevent HIV, while only 23.5% mentioned partner reduction. Although overall low, these proportions have been increasing since 2006 when responses were 26% and 6.7% respectively.

From the provincial reviews, Eastern Cape is the province with the highest rates of multiple and concurrent partners, early sexual debut and intergenerational sex. The EC programmes aimed at addressing these behavioural drivers, namely, dialogues, learner support programme and integrated school health programme (ISHP) are either unsuccessful or yet to be proven effective.

SUB-OBJECTIVE 3: REDUCING MTCT TO 2% AT SIX WEEKS AFTER BIRTH AND LESS THAN 5% AT 18 MONTHS BY 2016

Since the launch of the PMTCT programme in 2000, South Africa has shown commitment to eradicating vertical transmission of HIV by continuously adjusting its PMTCT policy, based on the latest available scientific evidence and international best practices. In March 2013, the PMTCT guidelines were revised to include the administration of a fixed-dose combination (FDC) regardless of CD4 count or clinical stage, during pregnancy and breastfeeding. Most recently, the PMTCT guidelines were revised in December 2014, to include lifelong ART for all HIV positive pregnant women and mothers and birth PCR for their HIV exposed infants.

SIX WEEKS MTCT

The 2012/13 MRC evaluation of the national PMTCT programme effectiveness addressed the elimination of mother to child transmission (eMTCT). The evaluation found that the HIV transmission to infants at six weeks postpartum dropped from 3.5% in 2010 to 2.7% in 2011/12, decreasing further to 2.6% in 2012/13. This translates to a decline from 117,319 infants with HIV post-partum to 10,168 by eight weeks, assuming 1,214,485 million live births per year, 32.2% infant HIV exposures and 30% MTCT by eight weeks postpartum without any PMTCT intervention (91% reduction). The introduction of FDCs for all HIV positive women regardless of CD4 count in 2013 resulted in further improvements in MTCT. Based on DHIS data, 77% of HIV positive pregnant women attending ANC have been initiated on FDCs since April 2013. According to the 2014/15 DOH Annual Report, MTCT has declined from 2% in 2013/14 to 1.5% in 2014/15, thereby reaching the 2016 NSP target.
Table 14: MTCT HIV transmission to infants at six-weeks by MRC, NHLS and guidelines in effect

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Six-weeks (MRC)</strong></td>
<td>3.5%</td>
<td>2.7%</td>
<td>2.6%</td>
<td>-</td>
<td>-</td>
<td>&lt; 2%</td>
</tr>
<tr>
<td><strong>Six-weeks (NHLS)</strong></td>
<td>4.3%</td>
<td>2.8%</td>
<td>2.4% (2012)</td>
<td>2.0 (2013)</td>
<td>1.8 (2014)</td>
<td>&lt; 2%</td>
</tr>
<tr>
<td><strong>PMTCT Guidelines</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2008 guidelines (Option A)</td>
<td>2010 guidelines (Option A)</td>
<td>2013 guidelines (Option B)</td>
<td>2013 guidelines (Option B)</td>
<td>2015 guidelines (Option B+)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Although the most recent surveys have measured the six weeks HIV transmission, there has been an observation that infant nevirapine prophylaxis compromises the sensitivity of the polymerase chain reaction (PCR) used for HIV testing in HIV-exposed infants. Consequently, the six-week HIV transmission level could be obscured, as nevirapine is routinely given to infants for HIV prophylaxis.

Figure 9 shows the changes in early infant diagnosis using National Health Laboratory Services (NHLS) and Medical Research Council (MRC) MTCT data, with 350 000 PCR tests having been conducted by 2012. The 2012 NHLS data shows that 73% of the estimated 270 000 HIV-exposed infants needing early infant diagnosis were tested. Early vertical transmission levels fell to 2.4% as a result of the programme. Based on the NHLS calendar year 2014 Early Infant Diagnosis (EID) data, 228 891 (84%) of the estimated 271 068 HIV-exposed infants were tested and early vertical transmission was measured at 1.8%. The NHLS data offers timely and inexpensive monitoring of the PMTCT programme.

Figure 9: Six-weeks MTCT rates: NHLS vs. MRC data, 2010-2014

A target of 100% was set for both ART and prophylaxis in the Annual Performance Plan (APP) for 2011/12. The 2013 Joint HIV, TB and PMTCT Review showed that 64.1% of antenatal clients were initiated on ART in 2010/11, rising to 75.4% in 2011/12. The District Health Barometer 2011/12 indicates that ART coverage for babies under 18 months was 54.4% nationally, suggesting a slight improvement from 52.7% in 2010/11 against a target of 100%. The 2012/13 MRC PMTCT evaluation concluded that maternal access to ART increased from 33% in 2010 to 55% in 2012/13. With the MRC survey perinatal MTCT of 2.6% in 2012/13, an estimated 107 100 infants were saved from perinatal HIV.
Based on the DOH programmatic data in Table 17 below, accessing antenatal care before 20 weeks of pregnancy continues to be a challenge, but there has been a gradual improvement since the 44% reported in 2012/13. In 2013/14, it was found to be 50%, against a national target of 60% and 53.9% in 2014/15, against national target of 65%. This can be attributed to various factors including the use of private health facilities – data is not captured onto the District Health Information System (DHIS), as well as the lack of knowledge about the rationale for early booking and sociocultural issues. As shown in Table 17 below, the antenatal clinic (ANC) initiated Highly Active ART (HAART) rate dropped from 81.6% in 2012/13 to 77.5% in 2013/14, and rose to 91.2% in 2014/15. The decline in 2013/14 is ascribed to data capturing challenges experienced after the introduction of FDCs and these were subsequently addressed as reflected in the 2014/15 results. The mother postnatal visit within six-day rate has progressively risen and is expected to improve as the ward-based outreach teams (WBOTs) coverage increases. The infant first PCR positive within two months rate has improved considerably from 2.5% in 2012/13 to 1.5% in 2014/15, thereby reaching the 2016 NSP target of below 2%.

Table 17: National PMTCT Cascade, 2014/15

<table>
<thead>
<tr>
<th>Performance Indicators</th>
<th>Achieved 2012/13</th>
<th>Target 2013/14</th>
<th>Achieved 2013/14</th>
<th>Target 2014/15</th>
<th>Achieved 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC 1st visit &lt; 20 weeks rate</td>
<td>44%</td>
<td>60%</td>
<td>50%</td>
<td>65%</td>
<td>53.9%</td>
</tr>
<tr>
<td>ANC initiated on ART rate</td>
<td>81.6%</td>
<td>90%</td>
<td>77.5%</td>
<td>93%</td>
<td>91.2%</td>
</tr>
<tr>
<td>Mother postnatal visit within 6 days rate</td>
<td>65.2%</td>
<td>79%</td>
<td>73%</td>
<td>80%</td>
<td>74.3%</td>
</tr>
<tr>
<td>Infant 1st PCR Positive within 2 months rate</td>
<td>2.5%</td>
<td>2.5%</td>
<td>2%</td>
<td>1.8%</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

**SUB-OBJECTIVE 4: IMPLEMENTING A COMPREHENSIVE NATIONAL SOCIAL AND BEHAVIOURAL CHANGE COMMUNICATION (SBCC) STRATEGY WITH A FOCUS ON KEY POPULATIONS**

A comprehensive national Social and Behaviour Change (SBCC) strategy in the NSP 2012-2016 aims to increase the demand and uptake of services, to promote healthy behaviours, and to address norms and behaviours that put people at risk for HIV, STIs and TB. As such, the communication should be focused on the general population as well as most at-risk sub-populations.

In South Africa, communication on HIV, STI and TB is conveyed in all South African languages through interpersonal, mass media and a range of formalised health communication programmes (HCPs). These HCPs include partnerships between the South African Government (SAG) including SANAC, international donors, mass media institutions such as the South African Broadcasting Corporation (SABC), NGOs and the private sector.

According to the 2012 National Communication Survey (NCS), 82% of the South Africans aged 16-55 years were reached by one or more HCPs. The exposure to HCPs was found to be highest in sections of the populations at highest risk of HIV infection including young Africans living in urban informal areas. The 2012 NCS also reported that exposure to higher numbers of HCPs increased the likelihood of greater knowledge, more appropriate attitudes and safer sexual behaviours among respondents. Largely, HCPs have demonstrated success in building HIV-related knowledge, forming appropriate attitudes and beliefs, and modifying behaviour patterns. The 2012 NCS showed that majority of South Africans aged 16-55 years were well informed about HIV and were taking appropriate steps to address it.

Figure 10 shows the reach of HCPs by province in 2009 and 2012. Reach of HCPs declined overall from 90% in 2009 to 82% in 2012.
KEY POPULATIONS

In South Africa, key populations include men who have sex with men (MSM), transgender persons, sex workers, prison populations, specific migrant groups and injecting drug users (IDU). Several studies have revealed that reducing HIV incidence among key populations has a positive impact on HIV incidence at population level. In South Africa, about 19.8% of all new HIV infections are related to sex work and 9.2% are related to MSM.\(^{51}\)

NATIONAL HIGH TRANSMISSION AREA PROGRAMME

DOH has a High Transmission Area (HTA) programme aimed at reducing the incidence of HIV/STI/TB among key populations, and decelerating HIV transmission into the general population. HTAs are defined as geographical and socio-demographic areas where there are high likelihood multiple concurrent sexual partnerships (MCP) occurring and individuals are most likely to be exposed or to transmit HIV – thus the interventions are targeting key populations (KPs). Within the HTAs, there are hotspots which are defined as areas where there is a concentration of people, bars, restaurants and entertainment halls where MCP is likely. Some hotspots may not contain an HTA intervention but likely have members’ characterised as key populations.

The DOH HTA model is divided into clinical and non-clinical sites and these are differentiated by environment type of services being rendered. The clinical services are either fixed or mobile. The minimum package of services rendered at clinical sites includes: 1) HCT and ART; 2) STI screening diagnosis and treatment; 3) TB screening, diagnosis and treatment; 4) Sexual and reproductive health including family planning (FP); 5) Treatment for minor ailments seen at primary health care facilities, and 5) Condom and condom-compatible lubricant distribution.

The non-clinical sites are led by peer educators who offer the following services: 1) Sexual and reproductive health screening, 2) Risk reduction counselling and skills building, 3) Education and awareness around HIV, STI and TB, 4) Distribution, demonstration, and promotion of condoms and condom compatible lubricants, 5) Promotion of the utilisation of HIV, STI, TB screening and treatment services.
KEY ACHIEVEMENTS

In collaboration with the University of Southern California (UCSF) and FHI-360, the DOH HTA programme developed a web-based tool to map the HTA sites and hot spots countrywide. In addition, a clear definition of a standard HTA site has been established and there were 2,252 HTA intervention sites established across all nine provinces by end of 2014/15 financial year; see Table 16.

Table 16: Number of HTA sites by province

<table>
<thead>
<tr>
<th>Province</th>
<th>2013/14 Baseline</th>
<th>2014/15 Target</th>
<th>Actual No. of HTA sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>EC</td>
<td>50</td>
<td>70</td>
<td>348</td>
</tr>
<tr>
<td>FS</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>GP</td>
<td>327</td>
<td>327</td>
<td>915</td>
</tr>
<tr>
<td>KZN</td>
<td>92</td>
<td>107</td>
<td>124</td>
</tr>
<tr>
<td>LP</td>
<td>326</td>
<td>350</td>
<td>409</td>
</tr>
<tr>
<td>MP</td>
<td>73</td>
<td>78</td>
<td>80</td>
</tr>
<tr>
<td>NC</td>
<td>6</td>
<td>21</td>
<td>18</td>
</tr>
<tr>
<td>NW</td>
<td>4</td>
<td>75</td>
<td>150</td>
</tr>
<tr>
<td>WC</td>
<td>100</td>
<td>110</td>
<td>108</td>
</tr>
<tr>
<td>National</td>
<td>1,078</td>
<td>1,238</td>
<td>2,252</td>
</tr>
</tbody>
</table>

Several activities have been implemented to address the HIV, STI and TB prevention, care and treatment needs of KPs, namely: 1) Development of the KP Framework; 2) Development of the KP implementation plan; 3) Mapping of the HTAs; 4) Development of the integrated KP training manual for health care providers; 5) Development of the HTA guidelines; 6) Development of the implementation plan for the HTA guideline; 7) Reviewing of the HCT policy in order to include KPs; and, 8) Reviewing of the STI training guideline to include KPs. Table 17 shows the HTA programme performance for the period 2013/14 to 2014/15.

Table 17: HTA results for the period 2013/14 to 2014/15.

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>2013/14 Baseline</th>
<th>2014/15 Target</th>
<th>2014/15 Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of HTA intervention sites</td>
<td>1 078</td>
<td>1 238</td>
<td>2 252</td>
</tr>
<tr>
<td>Number of male condoms distributed at HTA intervention sites (included in the national condom distribution data above)</td>
<td>75,305,948</td>
<td>21,007,670</td>
<td>122,073,071</td>
</tr>
<tr>
<td>Number of female condoms distributed at HTA intervention sites (included in the national condom distribution data above)</td>
<td>1,934,855</td>
<td>588,461</td>
<td>3,685,788</td>
</tr>
<tr>
<td>Trained peer educators who are operating and were receiving stipends</td>
<td>2,724</td>
<td>-</td>
<td>2,430</td>
</tr>
<tr>
<td>Total number of clients seen at the HTA sites</td>
<td>2,196,760</td>
<td>1,859,919</td>
<td>4,263,529</td>
</tr>
<tr>
<td>Total number of truck drivers seen at HTA sites</td>
<td>134,249</td>
<td>15,968</td>
<td>78,652</td>
</tr>
<tr>
<td>Total number of sex workers seen at HTA sites</td>
<td>136,064</td>
<td>15,966</td>
<td>74,623</td>
</tr>
<tr>
<td>Total number of MSM seen at the HTA sites</td>
<td>73,958</td>
<td>22,327</td>
<td>16,739</td>
</tr>
</tbody>
</table>

Considering the number of HTAs in Mpumalanga, the province has prioritised these HTAs and various departments (i.e. Transport,
Social Development, Health and CSOs) to collaborate on HIV and TB awareness activities. Mpumalanga has also noted that policies which aim to cater to the needs of migrants and farm workers are not visible and thus the need to ensure policies are reviewed and implemented as appropriate.

In the NC, the establishment of PHC facilities in HTAs and hot spots as well as the distribution of condoms at garages, taverns, hotels, youth centres and churches have made services more widely available, including HCT and integrated TB/HIV services. The NC intensified focus on key populations like MSM, Sex Workers and others were applauded and the lessons learnt/best practices, including capacity building among health care workers, will help advice future national KP programme expansion plans.

**NATIONAL SEX WORKERS PROGRAMMES**

With financial assistance from the GFATM, a National Sex Worker Programme Evaluation was conducted by SANAC, in collaboration with National AIDS Convention of South Africa (NACOSA) and the Sex Worker Evaluation and Advocacy Taskforce (SWEAT) in 2012/13. In alignment with the Global AIDS Response Progress Report (GARPR) indicators for knowledge and behaviour, the evaluation showed that 60% of female sex workers (FSW) were reached with HIV prevention programmes, 81% reported using condoms with their most recent client, 88% had undertaken an HIV test in the last 12 months and knew their results, and 59.6% were PLHIV.

From July 2013 to February 2014, SANAC in collaboration with DOH, US President’s Emergency Fund for AIDS Relief (PEPFAR), the United State Centers for Disease Control and Prevention (CDC), the University of California, San Francisco (UCSF), Anova Health Institute (Anova) and Wits Reproductive Health and HIV Institute (WRHI) conducted a health monitoring survey with FSW. Findings show relatively high HIV awareness and care seeking, with variations in uptake of ART by province (Figure 11).

**Figure 11: Selected Continuum of Care Indicators for HIV-Positive FSW in Johannesburg, Cape Town and Durban, 2013-14**

The findings suggest that the majority of FSW are able to access and have used available HCT services. However, a substantial proportion of FSW may exist outside of the FSW programme networks. The survey found that HIV prevalence among FSWs was 39.7% in Cape Town, 53.5% in Durban, and 71.8% in Johannesburg. It was further found that about 80% of FSW in the age group 30-34 years in Johannesburg and Durban were living with HIV. High prevalence of syphilis was also found in the survey – 4.6% in Durban, 16.2% in Johannesburg and 19.9% in Cape Town. Syphilis prevalence is considerably higher than FSW in other countries.
– for example, syphilis prevalence was 0.9% and 1.2% in Nairobi and Swaziland respectively. Other psychosocial health problems, substance and alcohol use, physical and sexual assault were found to be endemic to the female sex worker population.

**MEN WHO HAVE SEX WITH MEN**

SANAC has been working with DOH and development partners to plan expand and integrate the prevention, care and treatment programming for MSM into the public health service delivery system through GFATM HIV programming. In December 2013, the UCSF in partnership with DOH, SANAC, PEPFAR through CDC in South Africa, MSM programme and research stakeholders, initiated a MSM data triangulation and synthesis exercise to better understand the status of and response to HIV among MSM. Over a fourteen-month period, more than 300 research reports and programme data generated in South Africa between 2008 and 2013 were reviewed. It was found that South Africa has a concentrated HIV epidemic among MSM that does not appear to be stabilising. HIV prevalence was found to be between 1.89 and 4.65 times higher among MSM than non-MSM of the same age, with the exception of Ehlanzeni District were the HIV prevalence in MSM and non-MSM of the same age was similar. Recent MSM surveys indicate high HIV prevalence among MSM, ranging from 22% in Cape Town to 48% in Durban. Lastly, the HIV prevalence among MSM in Johannesburg, Cape Town and Durban was found to have increased by more than 10% from 2008 to 2013.

**Figure 12: HIV prevalence among MSM compared to males in the general population (aged 15 years and older), 2013**

The Mpumalanga provincial review found that in collaboration with PEPFAR implementing partners and other development partners, Mpumalanga has been able to 1) Strengthen HIV, TB and STI management within correctional facilities, and 2) Disseminate sex workers prevention packages through the Sex Workers Peer Education Programme. However, collaboration between the Departments of Health and Correctional Services needs to be strengthened to improve access to comprehensive HIV, STI and TB service within correctional facilities.
SUB-OBJECTIVE 5: PREPARE 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

ORAL PRE-EXPOSURE PROPHYLAXIS

Scientific studies of daily oral PrEP by HIV uninfected individuals, mainly a combination of TDF/FTC, have demonstrated evidence of effectiveness with sero-discordant heterosexual couples, men and transgender women who have sex with men, high risk heterosexual couples and people who inject drugs. Consequently, WHO’s recommendations promote the use of oral PrEP in demonstration projects for sero-discordant couples and men and transgender women who have sex with men. PrEP is not currently integrated in South Africa. According to the new treatment guidelines, the HIV positive partner in a sero-discordant couple is prioritised for ART initiation irrespective of CD4 count.

MICROBICIDES

Microbicides are compounds that can be applied inside the vagina or rectum to protect against STIs, including HIV. According to the recent large-scale study conducted by the Follow-on African Consortium for Tenofovir Studies (FACTS), a tenofovir-based vaginal gel was found to be ineffective. The FACTS findings contradict the results of a comparable Center for the AIDS Programme of Research in South Africa (CAPRISA) study published in 2010. The FACTS results correspond to those of the Vaginal and Oral Interventions to Control the Epidemic (VOICE) trial released in 2013. Studies on microbicides are continuing in South Africa and elsewhere.

TB VACCINES

The only existing TB vaccine, Bacille Calmette Guerin (BCG), is not reliable in preventing pulmonary TB. South Africa is actively involved in the global pursuit for a new, effective and affordable TB vaccine to protect people against TB and lead to TB eradication. Research is being conducted through the South African TB Vaccine Initiative (SATVI) and other local institutions. It is hoped that a new TB vaccine may be available by 2020.

SUB-OBJECTIVE 6: PREVENTING TB INFECTION AND TB DISEASE

In 2014, there were an estimated 270 000 (240 000-310 000) new TB infections that occurred among PLHIV out of a total of 450 000 (400 000-510 000) new TB infections. Additionally, a total of 318 193 TB cases were notified in 2014. The number of multidrug resistant TB cases have doubled from 7 350 cases in 2007 to 14 161 in 2012. In 2014, approximately 4 700 (3 700-5 900) new MDR-TB cases and 1 500 (1 200-1 800) retreatment MDR-TB cases were estimated among notified pulmonary TB cases. TB is the principal cause of death for PLHIV in South Africa, with an estimated 72 000 (58 000-89 000) TB-related deaths occurring among PLHIV in 2014 – a rate of 134 (107-164) per 100 000 population. The TB case fatality rate was 8.4% in 2013. South Africa has over 300 GeneXpert machines deployed countrywide and over 2.1 million GeneXpert tests have been conducted, considerably exceeding the target of 800 000.

Globally, South Africa had the third highest TB burden after China and India for the 2009-2012 period. After the TB programme data review in 2013, the country ranked six after India, China, Nigeria, Pakistan and Indonesia. South Africa’s TB epidemic is linked to HIV prevalence, with a co-infection rate of more than 60%. Figure 13 shows a gradual decline in TB incidence from 2008 to 2013.
Treatment outcomes for new smear-positive pulmonary TB (PTB) are encouraging, with the cure rate improving from 57.6% in 2005 to 75.8% in 2012. The treatment success rate for all TB forms has also increased from 60.9% in 2004 to 76.1% in 2012. Trends of TB cases over time are shown in Figure 14. There was a gradual increase of registered TB cases from 2005, peaking at 406,082 in 2009, and then declining to 328,896 cases in 2013.

TB treatment is readily available in South Africa and treatment success rate among new smear-positive pulmonary TB (PTB) patients has continued to improve from 75.9% in 2013/14 to 82.5% in 2014/15, exceeding the national 2014/15 target of 82%. Concerted provincial efforts to retain patients in care, strengthen treatment adherence and trace patients lost to follow up has resulted in the TB defaulter rate for new pulmonary TB patients improving from 6.2% in 2013/14 to 5.7% in 2014/15 (Table 18).
Table 18: New PTB Cure and Defaulter Rates 2012/13 to 2014/15

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Achieved 2012/13</th>
<th>Target 2013/14</th>
<th>Achieved 2013/14</th>
<th>Target 2014/15</th>
<th>Achieved 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB new client treatment success rate</td>
<td>73.8%</td>
<td>85%</td>
<td>75.9%</td>
<td>82%</td>
<td>82.5%</td>
</tr>
<tr>
<td>TB defaulter rate (new pulmonary TB)</td>
<td>6.1%</td>
<td>&lt; 5%</td>
<td>6.2%</td>
<td>6%</td>
<td>5.7%</td>
</tr>
</tbody>
</table>

As with HIV, an effective TB prevention response requires a combination of structural, social, behavioural and biomedical approaches.

**INTENSIFIED TB CASE FINDING**

According to the 2013 DOH Annual TB Report, South Africa had a total of 328 896 DS-TB registered cases and a national TB case rate of 621/100 000 population (517). About 90% of the registered cases were new, while 10% were retreatment. A large proportion of the new cases (87%) were PTB and 13% extra-pulmonary TB (ETB) compared to 95% PTB and 5% ETB in the retreatment cases.

Figure 15: TB case rate/ 100,000 population, by province

The majority (73.4%) of the 328 896 registered cases in 2013 came from four of the nine provinces namely, KwaZulu-Natal (29.3%), Eastern Cape (15.7%), Gauteng Province (15%) and Western Cape (13.3%). KwaZulu-Natal had the highest number of cases at 96 413 (29.3%) and Northern Cape had the lowest at 8 461 (2.6%) (Figure 16).
Proportions of TB in children vary by province (Table 19). Out of 328 896 TB cases registered in 2013, 37 198 (11.3%) were among children and 12 256 (3.7%) among late adolescents – totalling 49 454 (15%) of all TB cases, with 51% of cases among females and 49% among males. Data for 2013 is 7.3% (3 877) lower than the 2012 childhood TB cohort of 53 331. The Western Cape had the highest percentage of children recorded with DS-TB at 13.3% while Mpumalanga had the lowest at 7.9%.

<table>
<thead>
<tr>
<th>Province</th>
<th>Adult</th>
<th>Children</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Cape</td>
<td>47 026</td>
<td>4 757</td>
<td>51 783</td>
</tr>
<tr>
<td>Free State</td>
<td>17 740</td>
<td>2 197</td>
<td>19 937</td>
</tr>
<tr>
<td>Gauteng</td>
<td>44 312</td>
<td>5 176</td>
<td>49 488</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>84 002</td>
<td>12 411</td>
<td>96 413</td>
</tr>
<tr>
<td>Limpopo</td>
<td>17 449</td>
<td>2 064</td>
<td>19 513</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>17 750</td>
<td>1 513</td>
<td>19 513</td>
</tr>
<tr>
<td>North West</td>
<td>17 929</td>
<td>2 272</td>
<td>20 201</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>7 497</td>
<td>964</td>
<td>8 461</td>
</tr>
<tr>
<td>Western Cape</td>
<td>37 993</td>
<td>5 844</td>
<td>43 837</td>
</tr>
<tr>
<td>South Africa</td>
<td>291 698</td>
<td>37 198</td>
<td>328 896</td>
</tr>
</tbody>
</table>

The 2015 WHO Global TB Report revealed that a total of 318 193 TB cases were notified in 2014, with 306 166 of them being new and relapses. Of the 306 166 new and relapse cases, 31 977 (10%) were cases aged under 15 years, with a male to female ratio of 1:3.

South Africa has had a two-fold rise (to 1.26 million) in the number of PLHIV screened for TB between 2010 and 2011. The 2015 WHO Global TB report indicates that a total of 1 148 477 PLHIV were screened for TB in 2014. As part of the Global Fund-
funded TB screening programme, 70 425 inmates were tested for TB using GeneXpert and 252 843 people in six targeted per-
mining communities were screened for TB and 222 113 were counselled and tested for HIV in 2014/15. In addition, about 88% of
mines in South Africa routinely screen miners for TB.

Table 20 shows that the TB client tested rate for HIV rose from 85.3% in 2012/13 to 88.7% in 2013/14. However, this was lower
than the 2013/14 national target which was set at 94%. This underachievement can be attributed to ETR.net recording problems
and gaps in routinely offering HCT to TB patients. It is important to note that this indicator was excluded in the 2014/15 DOH
Annual Report but according to the 2015 WHO Global TB report, 93% of notified TB cases in 2014 had a known HIV status.

Table 20: TB client tested for HIV rate 2012/13 to 2013/14

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Achieved 2012/13</th>
<th>Target 2013/14</th>
<th>Achieved 2013/14</th>
<th>Target 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB client tested for HIV rate</td>
<td>85.3%</td>
<td>94%</td>
<td>88.7%</td>
<td>93% (WHO, 2015)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Not reported in the DOH Annual Report 2014/15</td>
</tr>
</tbody>
</table>

In an effort to tackle the limitations related to detecting TB in PLHIV, South Africa launched a national plan for phased implementation
of the GeneXpert MTB/RIF assay to substitute microscopy as the first diagnostic method. GeneXpert has doubled the number
of laboratory-confirmed TB cases compared to smear microscopy. Additionally, it has also detected 7% rifampicin resistance,
affording clinicians the opportunity to adapt treatment regimens to the needs of individual patients.

The 2013 Joint HIV, TB and PMTCT Review also advocated for the routine TB screening – especially for pregnant women, young
children and health workers – and targeting ‘most at risk groups’ particularly vulnerable to TB and HIV, including children and
people living in mining communities. From the provincial review, the NW has observed low rates of TB screening in children under
five years and this is partly attributed to the lack of confidence among health care workers to screen and diagnose TB in children.

TB INFECTION CONTROL

Inadequate implementation of TB Infection control persists in South Africa, regardless of the clear and comprehensive national
policy and guidelines. This can be attributed to a number of factors including: 1) Limited use and availability of N95 masks; 2)
Limited infrastructure for proper infection control practices; 3) Lack of facility infection control plans, facility risk assessments,
related quality assurance, and monitoring checklists for inadequate airborne infection control.

The 2013 Joint HIV, TB and PMTCT Review found that infection control practices varied between and within provinces, ranging
from ineffective triaging of potentially infectious TB cases to poor ventilation of waiting areas and consultation rooms. The
utilisation and maintenance of ultraviolet (UV) light also differs considerably, including the reliance on non-serviced/non-functional
UV lights. The review recommended that respiratory infection control be prioritised in prisons, mines, single-sex hostels, long-
distance public transport, schools, homeless shelters and repatriation centres.

The promotion of cough hygiene is key to attaining improved respiratory infection control in the community. Emphasis on TB and
respiratory infection control is a necessity in households, schools, healthcare facilities, prisons and other settings where people
congregate. As part of quality improvement planning, all health facilities providing HIV and TB care must have an infection control
plan and officer.

ISONIAZID PREVENTIVE THERAPY (IPT)

IPT reduces the incidence of TB in PLHIV. Even though ART decreases the chance of acquiring TB disease, TB incidence is 10 times
higher in PLHIV than in the general population and IPT is therefore important. Preventing TB among eligible individuals can be
achieved with daily IPT. Those eligible include adults and children living with HIV and all children under five years of age in close contact with an infectious case of TB. IPT is inexpensive and simple to use. In accordance with the national guidelines, all patients enrolled in HIV care in South Africa should be screened for TB at each visit, and those without active TB should receive at least six months of IPT. South Africa experienced a nearly threefold increase in the number of PLHIV receiving IPT between 2010 and 2011 – from 146 000 to 373 000. Recent IPT trends are shown in Table 21 below. The 2015 WHO Global TB report revealed that a total of 551 787 PLHIV were provided with IPT in 2014.

Table 21: Number of new HIV-positive clients initiated on IPT 2012/13 to 2013/14

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Achieved 2012/13</th>
<th>Target 2013/14</th>
<th>Achieved 2013/14</th>
<th>Target Achieved 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of new HIV-positive clients initiated on IPT</td>
<td>373 074</td>
<td>450 000</td>
<td>337 237</td>
<td>551 787 (WHO, 2015)</td>
</tr>
</tbody>
</table>

As a result of ongoing training, mentoring and coaching, more clinicians are adopting national IPT protocols and South Africa is presently the largest provider of this prophylactic regimen in the world.

TB IMMUNISATION

The South African Expanded Programme on Immunisation (EPI) schedule advocates the use BCG vaccine for TB prevention. National guidelines encourage BCG vaccination for all eligible infants at birth and the vaccination schedule is unchanged for HIV-exposed children. If a child is asymptomatic at birth, BCG is administered irrespective of HIV status. It is important to know that immunocompromised infants including those living with HIV are at risk of vaccine related adverse events, namely, including local BCG disease, regional disease, and distant disease and disseminated disease.

PREVENTING DR-TB

South Africa’s TB problem is complicated by the elevated caseload of DR-TB. With the introduction of GeneXpert MTB/RIF in the public sector, there has been an increase in the number DR-TB cases identified. The NHLS cumulatively diagnosed 69 460 MDR-TB cases and 6 242 extensively drug-resistant (XDR)-TB cases from 2004 to 2012. However, only a cumulative total of 10 095 (14.5%) MDR-TB patients were started on treatment from 2007 to 2012, with KwaZulu-Natal, the Eastern Cape, Gauteng and the Western Cape accounting for 80% of the MDR-TB cases. Out of the 6 242 XDR-TB cases, only 713 (11.4%) patients were cumulatively started on treatment from 2007 to 2012.

According to the NHLS data, 4% of all TB is MDR-TB. In 2012, a total of 14 161 laboratory-diagnosed of MDR-TB and 701 XDR-TB were recorded among notified pulmonary TB cases. However, only 5 890 (41.6%) were started on treatment. Among MDR-TB patients started on treatment in 2009, 42% had a successful outcome and 18% died, with poorer outcomes in XDR-TB. The gap in treatment coverage for detected cases of MDR-TB continues to widen. DS-TB and DR-TB are key public health problems in South Africa, thus the DOH is scaling up evidence-based strategies to close the obvious gap between patients diagnosed with DR-TB and those treated. In 2012/13, the number of confirmed MDR-TB clients initiated on treatment was added to the National Indicator Dataset (NIDS). A total of 7 218 clients were initiated on MDR-TB treatment, 4% higher than the 2013/14 target of 6 900. The increase in MDR-TB case identification can be credited to the availability and accessibility of GeneXpert and targeted campaigns in high-risk populations.

National TB programme data shows a steady decline in the number of all TB cases from 389 974 in 2011 to 349 582 in 2012, and
to 328 896 in 2013. A surge in the number of MDR-TB cases was reported from 10 085 in 2011 to 14 161 in 2012. In 2013, 10 719 MDR-TB patients were registered for treatment from January to December 2013. About 67.3% of these patients were laboratory confirmed and registered for treatment, 61.7% were living with HIV and 78.5% of the MDR-TB PLHIV came from the Gauteng Province. Of the 2013 MDR-TB cohort living with HIV, 88.4% were on ART, with Limpopo reporting 99% ART coverage for its patients.

Regarding the XDR-TB 2013 cohort, it was composed of 743 patients, with 586 (78.9%) laboratory confirmed. About 64.9% of the XDR-TB cohort was living with HIV and 92.7% of them were on ART. It is important to note that about 19% of XDR-TB patients were new, indicating a very high primary XDR-TB infection rate. The Western Cape had the highest percentage (40%) of patients that had XDR-TB the first time they were infected with TB while KwaZulu-Natal had the lowest percentage at 3%. The remaining 81% is a mix of patients that were lost to follow up and those who failed treatment.

The number of districts with a decentralised MDR unit was also added to the NIDS in 2012/13. A total of 26 out of 52 districts had a decentralised MDR unit in 2013/14, 42% lower than the 2013/14 target of 45 districts. Two key factors retarded the decentralisation rate – the change in policy from dedicated MDR-TB to integrated TB/HIV-MDR-TB teams and insufficient provincial budgets for essential infrastructural renovations. Explicit methods to prevent the development and transmission of DR-TB include enhancements in DS-TB identification and cure, and early detection and effective treatment of all DR-TB cases. It is expected that the ongoing decentralisation of MDR-TB management will reduce the MDR-TB diagnosis/treatment gap. Constant supply and adherence to quality assured first- and second-line therapies (including FDCs), is critical for effective DR-TB management.

From the provincial review, the NW reported that the decentralisation of MDR-TB management has improved access to MDR-TB services that were previously confined to central and referral hospitals.
CO-INVESTMENT IN SUPPORT OF THE SOUTH AFRICAN GOVERNMENT (SAG) BY IMPLEMENTING PARTNERS

Developmental partners such as PEPFAR and the Global Fund have made substantial contributions in support of the South African HIV & AIDS response. PEPFAR contributed the following achievements in 2015: provision of life-saving antiretroviral treatment for more than 2.9 million people; provision of voluntary medical male circumcision for HIV prevention for 472,047 men; conducting HIV testing and counselling for more than 9.8 million people; providing care and support for 408,969 orphans and vulnerable children affected by HIV and AIDS and providing antiretroviral medications for 226,369 pregnant women living with HIV, to reduce the risk of mother-to-child transmission.

Global Fund reached out to the following key populations tabulated in table 6 below.

Table 6: Global Fund Indicators on key populations

<table>
<thead>
<tr>
<th>Global Fund Indicators on Key populations</th>
<th>2013 to Dec 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of individuals of low socio-economic status that received an HIV test and knows their results.</td>
<td>180,654</td>
</tr>
<tr>
<td>Number of MSM/LGBTI reached with HIV prevention combination package</td>
<td>13,876</td>
</tr>
<tr>
<td>Number of MSM/LGBTI that received an HIV test and know their results.</td>
<td>77,142</td>
</tr>
<tr>
<td>Number of Prisoners that received an HIV test and know their results.</td>
<td>162,556</td>
</tr>
<tr>
<td>Number of inmates tested using the Xpert MTB/RIF</td>
<td>56,118</td>
</tr>
<tr>
<td>Number of men who underwent Voluntary Medical Male Circumcision (VMMC)</td>
<td>56,874</td>
</tr>
<tr>
<td>Number of ART patients undergoing antiretroviral (ARV) drug resistance testing.</td>
<td>5,596</td>
</tr>
<tr>
<td>Number of ART patients receiving Adherence support</td>
<td>103,098</td>
</tr>
<tr>
<td>Number &amp; Percentage of Sex workers who received an HIV test and know their test results</td>
<td>34,638</td>
</tr>
</tbody>
</table>

SUB-OBJECTIVE 7: ADDRESSING SEXUAL ABUSE AND IMPROVING SERVICES FOR SURVIVORS OF SEXUAL ASSAULT

To support and strengthen the management of sexual assault cases and adequately address sexual violence, the National Prosecution Authority’s Sexual Offences and Community Affairs Unit (SOCA) heads the implementation of the Thuthuzela Project, a partnership between various departments and donors. The project was conceptualised as a response to the critical need for an integrated strategy for prevention, response and support for sexual assault victims by healthcare providers. Nationally, the Thuthuzela Care Centres (TCCs) provide all-inclusive support to survivors of gender-based violence including PEP. TCCs are a prototype of good practice for addressing the links between sexual assault and HIV. The implementation of the TCCs has highlighted challenges related to institutional and human capacity and the full impact of the TCCs is yet to be measured.

From the provincial review findings, the EC described an increase in the number of sexual assault cases and sexual violent crimes reported, and this could be attributed to the increase in education and awareness raising campaigns driven by the Women’s Sector. Sexual assault case reporting remains a challenge with inconsistencies between cases reported to the South African Police Services (SAPS) and those reported at health facilities. Moreover, there is a discrepancy between the reported sexual assault cases at health facilities and the post exposure prophylaxis uptake.
STRATEGIC OBJECTIVE 2: GAPS AND CHALLENGES

The following gaps and challenges are identified:

HCT
• Implementation of provider initiated counselling and testing is sub-optimal
• There are no national HCT indicators for children >18 months and <15 years in the National Indicator Dataset

STIS
• The NSP has no indicators or targets for STIs
• There is a lack of a national STI clinical sentinel surveillance
• There are provincial inconsistencies regarding reporting on national STI indicators and reporting is currently limited to public health facilities
• Barriers to the implementation of the STI protocol, or syndromic management guidelines have been observed, leading to the National Evaluation of STI study

MMC
• The number of MMCs completed is still too low to influence the rate of new infections at population level
• The inadequate engagement and coordination with traditional circumcision practitioners inhibits the effectiveness of traditional circumcision

CONDOM DISTRIBUTION AND USE
• Declines in condom use at last sex – in particular among youth – constrains effective HIV prevention
• Condom distribution has remained below target for a number of years

EARLY SEXUAL DEBUT
• Early sexual debut has not been adequately addressed

MULTIPLE SEXUAL PARTNERSHIPS
• The prevalence of multiple sexual partnerships has not been adequately addressed

MTCT
• Accessing antenatal care before 20 weeks of pregnancy continues to be a challenge across all provinces
• According to the 2013 Joint HIV, TB and PMTCT Review, several gaps in the PMTCT cascade remain a challenge. Early ANC booking by pregnant women and re-testing of HIV-negative pregnant women at 32 weeks and three monthly thereafter, as per national guidelines remain suboptimal. Post-partum follow up of mother–infant pairs is still insufficient and therefore a small number of HIV-exposed infants are tested for HIV at 18 months
• Re-testing of pregnant women is suboptimal – the 2012/13 MRC SAPMTCTE found that among self-reported HIV negative mothers, only 22% had their last test at or after 32 weeks pregnancy and 2.6% [95% CI: 2.1-3.0%] of women who thought they were HIV negative gave birth to HIV-exposed infants. Additionally, the 2012/13 MRC PMTCT survey concluded that the health systems limitations to reducing perinatal MTCT to <2% include 1) <100% Coverage of late testing among HIV negative
women, 2) Undiagnosed HIV acquisition during pregnancy, and 3) <100% Coverage of PMTCT interventions

NATIONAL SBCC STRATEGY

- The NCS 2012 reported a decline in the reach of HCPs from 90% in 2009 to 82% in 2012 among the general population
- Most at risk populations like sex workers and MSM are not adequately addressed through HCPs

PREVENTING DS-TB AND DR-TB

- Loss to follow up due to patient migration remains a challenge
- There is poor implementation of TB infection control, even though there are clear and comprehensive national policy and guidelines
- While incident cases have reduced for DS-TB, there is still concern that drug resistant TB is increasing in the country since 2006, more so among new patients that never had TB before
- The DR-TB gap between patients diagnosed and patients treated has not been adequately addressed

KEY POPULATION PROGRAMMING

- Patients seen at the HTA service points were not disaggregated until two years ago, and HTA indicators are still not disaggregated by gender
- Not all health care workers have been reached with sensitisation training on KPs

STRATEGIC OBJECTIVE 2: RECOMMENDATIONS

The following recommendations are made:

HCT

- Consistently implement PICT with a focus on vulnerable and key populations. These include sex workers, MSM and prisoners, but also children over 18 months. These efforts should be monitored appropriately
- Implement and expand alternative testing strategies for HIV, including community and home-based, to reach populations that are more difficult to access
- Create organisational units to streamline partners’ HCT data into the DHIS
- Sensitise and train traditional leaders to promote and strengthen linkages and referrals following community and facility-based HCT (and TB screening)

STIS

- Prioritise the approval and implementation of STI training guidelines
- Include the MUS incidence indicator in the next cycle of NIDS
- Clinical sentinel surveillance should be revitalised, and treatment of STIs in key populations prioritised
- Address provincial reporting inconsistencies to improve the quality of STI data used to inform decision making processes and
policy interventions

- Utilise the results of the 2014/15 National Evaluation of STIs to improve the quality of STI services rendered
- Prioritise the diagnosis and management of STIs in key populations
- Establish an STI technical working group that includes experts from various specialities

BEHAVIOURAL DRIVERS

- Behaviour change happens over a period of time and as such behavioural drivers such as multiple sexual partners, sexual debut and condom use require proven long-term sustainable interventions to yield desired results. There is need to design programmes targeted at specific populations at risk e.g. young women and girls as regards the practice of inter-generational and transactional sex

CONDOM DISTRIBUTION

- Ensure sufficient condoms and lubricants are widely available, especially to vulnerable populations
- Implement and expand male and female condom social marketing, especially as regards dual utility

VMMC

- Intensify safe MMC and focus in high incidence districts. Improve demand creation at a community level targeting men aged 14–35 years for maximum impact
- Make MMC services accessible and available to children and adolescents
- Engage traditional leaders on the integration of medical circumcisions into traditional practices to augment the effectiveness of MMC

PMTCT

- All health care providers should routinely ask about HIV status and treatment at every patient contact, to avoid missed opportunities
- Implement efforts to re-test HIV negative mothers every three months during pregnancy and lactation should be implemented as per national guidelines, to eliminate postnatal MTCT
- Intensify implementation of PMTCT Option B plus
- Infant HIV-free survival can be improved by strengthening routine maternal and child primary interventions, including IMCI and EPI

NATIONAL SBCC STRATEGY

- Need a government-led and coordinated national SBCC programme to address various aspects of HIV and TB
- HCPs should focus on key areas of intervention in support of the NSP – notably, following clear strategies for addressing key aspects of prevention and treatment that are linked to gap areas where intensified communication is necessary
- Strategies to reach key populations as well as marginalised groups, such as persons with disabilities should be prioritised.

TB

- Promote community-based TB screening and reporting thereof
- Actively track TB contacts, especially children
- Intensify TB screening within correctional facilities for inmates, people working in correctional facilities, people awaiting trial
and people who leave prison facilities

**KEY POPULATION PROGRAMMING**

- Focus on saturation of high HIV incidence/prevalence districts and communities, with an appropriate package of interventions. Hot spots in these communities need to be mapped.
- Review and evaluate key populations programme to determine progress so far, and revise and strengthen where appropriate.
- Identify and implement effective HIV prevention and treatment programming.
- Scale-up combination prevention and treatment programmes and interventions to intensify testing; promote biomedical prevention technologies and early treatment and conduct research on linkages and retention in care.
- Address psychosocial co-morbidities in the context of HIV prevention and treatment.
- Promote reforms to provide an enabling legal and human rights environment to address HIV among FSW, IDUs, etc.
- Ensure optimal coverage of key population programmes and strengthen the monitoring and evaluation of these programmes.
- Strengthen the national HTA programme in line with the National Framework for HIV, STI and TB programmes for key populations.
- Consider new interventions for key populations e.g. Prep, ensure 80% coverage and strengthen the monitoring and evaluation of these programmes.

**FOCUS ON HIGH BURDEN DISTRICTS**

- Focus on saturation of high HIV incidence/prevalence districts and communities, with an appropriate package of interventions including PEP.

4.3 **STRATEGIC OBJECTIVE 3: SUSTAINING HEALTH AND WELLNESS:**

**STRATEGIC OBJECTIVE 3: OVERVIEW**

In support of the second and third goals of the NSP – namely, initiating at least 80% of eligible patients on ART, with 70% alive and on treatment five years after initiation, and reducing the number of new TB infections and deaths by 50%; the NSP sets out to address SO3 through the following three sub-objectives:

1. Reducing disability and death resulting from HIV, STI’s and TB through universal access to HIV and TB screening, diagnosis, care and treatment.
2. Ensuring that people living with HIV, STI’s and TB remain within the healthcare system, are adherent to treatment, and that they maintain optimal health and wellness.
3. Ensure that systems and services remain responsive to the needs of people living with HIV and TB.

Sub-objective 1 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.

The means to achieve Sub-objective 2 includes the establishment of ward-based PHC teams and regular communication, using all appropriate media.

Sub-objective 3 includes integrating HIV and TB care with an efficient chronic care delivery system; expanding operating hours of
service delivery points; ensuring continuum of care across service delivery points; strengthening quality standards; and adequate monitoring of drug resistance.

**STRATEGIC OBJECTIVE 3: KEY POLICY ISSUES**

Since inception of the national HIV and AIDS programme, South Africa has demonstrated commitment to sustaining the health and wellness of children, adolescents and adults living with HIV by keeping up with new policy developments, based on the latest available local and international scientific evidence. South Africa subscribes to the ‘2011 UN Political Declaration on HIV and AIDS: Intensifying our Efforts to Eliminate HIV and AIDS’. To strengthen its national efforts to scale up HIV treatment beyond 2015, South Africa has also endorsed the UNAIDS 90-90-90 targets to be achieved by 2020 (i.e. 90% of people living with HIV knowing their HIV status, 90% of people living with HIV who know their status on ART, and 90% of people on treatment having suppressed viral loads).

In December 2014, South Africa revised the national HIV and AIDS management guidelines – last updated in March 2013 – in line with international good practice. The key changes include: 1) CD4 threshold for ART initiation increased from 350 to 500; 2) Viral load monitoring prioritisation; 3) Lifelong HAART for pregnant women; 4) Birth PCR.

**STRATEGIC OBJECTIVE 3: INDICATORS AND RESULTS**

Table 22 outlines the indicators and results for SO3, using the categories defined in the NSP.

Table 22: Indicators and results for SO3

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline</th>
<th>Target 2016</th>
<th>FY 2014/15 Achieved</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion (%) of people per year becoming eligible who receive ART</td>
<td>58% (ART cohort and ASSA)</td>
<td>80%</td>
<td>73% (Adults) 75% (Children) (Spectrum 2014)</td>
<td>More than 90% achievement towards target</td>
</tr>
<tr>
<td>TB case registration rate</td>
<td>708/100 000 (National TB Programme)</td>
<td>50% Reduction 354/100 000</td>
<td>621/100 000 (DOH Annual TB Report, 2013)</td>
<td>Slow progress towards 2016 NSP target</td>
</tr>
<tr>
<td>TB case detection rate</td>
<td>72% (WHO, 2010)</td>
<td>&gt;85%</td>
<td>68% (WHO Global TB Report 2015)</td>
<td>A decline from set baseline, unlikely to meet set target for 2017</td>
</tr>
<tr>
<td>Percentage smear positive TB cases that are successfully treated</td>
<td>73% smear positive (Quarterly cohort analysis)</td>
<td>&gt;85%</td>
<td>80.7% (DOH Annual TB Report, 2013)</td>
<td>Gradual improvement towards the 2016 and international target</td>
</tr>
<tr>
<td>TB case fatality rate (CFR)</td>
<td>7.1% (National TB reports)</td>
<td>50% reduction</td>
<td>8.4% (DOH Annual TB Report, 2013)</td>
<td>Slow progress towards 2016 NSP target</td>
</tr>
<tr>
<td>CFR HIV-positive = CFR HIV-negative</td>
<td>54% (WHO, 2010)</td>
<td>90%</td>
<td>Data not available</td>
<td>The baseline and target ratios were derived by HIV- CFR/HIV+ CFR whereas it should be HIV+ CFR/HIV- CFR i.e. baseline is 200% and the target is 100%</td>
</tr>
</tbody>
</table>
STRATEGIC OBJECTIVE 3: KEY ACHIEVEMENTS

REDUCING DISABILITY AND DEATH RESULTING FROM HIV AND TB

South Africa has been an exceptional model of HIV and AIDS political leadership and civil society engagement. Since 2009, a number of progressive policy choices have been implemented. The country launched a large-scale HCT campaign in 2010. By end of 2012, over 17.6 million people had ever tested for HIV. The 2012 HSRC survey estimated that 31.2% (i.e. 2 002 000) of 6 422 000 PLHIV in 2012 were on ART. The exposure to ART among PLHIV rose from 16.6% in the 2008 survey to 31.2% in 2012. Furthermore, the 2013 Joint HIV, TB and PMTCT Review established that over a period of four years (2009-2012), there was a four-fold increase in the number of people on ART.

Table 23: New Clients started on ART 2012/13 to 2014/15

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Target 2012/13</th>
<th>Achieved 2012/13</th>
<th>Target 2013/14</th>
<th>Achieved 2013/14</th>
<th>Target + Achieved 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of new clients put on ART</td>
<td>500 000</td>
<td>612 118</td>
<td>500 000</td>
<td>662 312</td>
<td>683 680 (NDOH Annual Report 2014/15)</td>
</tr>
</tbody>
</table>

As shown in Table 23, South Africa surpassed its 2012/13 goal of initiating 500 000 new patients on ART. A total of 612 118 new patients were started on ART in 2012/13. An annual target of 500 000 new patients started on ART was also set for the financial year 2013/14. With support from development partners including PEPFAR and the GFATM, a total of 662 312 new patients were initiated on ART by end of 2013/14. By the end of 2014/15, a total of 683 680 patients were initiated on ART and overall, South Africa had 3 103 902 PLHIV remaining on ART.

SOUTH AFRICAN NATIONAL AIDS COUNCIL | ENHANCED PROGRESS REPORT (EPR)
According to the DOH 2014 programmatic data used in the Spectrum HIV/AIDS Estimates (shown in Figure 17), South Africa had a total of 3,078,570 PLHIV of all ages receiving ART by end of 2014 – equivalent to 47% ART coverage at an estimated total PLHIV population of 6,600,000. Clearly, South Africa has exceeded its NSP 2015/16 target of three million patients on ART.

Figure 18 below illustrates the number of people receiving ART by province, as at end March 2015.

Data from the NDOH ART Cohort Data, produced through the 3-Tiered ART Monitoring Strategy includes data for 1,687,883 adults enrolments for the calendar years 2004 to December 2014. This data includes the proportion of adults started on ART with a baseline CD4 <100 and demonstrates that the proportion of patients enrolled with a low CD4 has declined from 41.5% to 18.5% from 2004 to 2014, see Figure 19 below.
Baseline CD4 data contained within the DHIS includes CD4 count stratum below 350 cells/µl from the data exported from TIER. Net, but not the total number of baseline CD4 counts done, thus missing the baseline data for some patients who started ART at higher CD4 counts. The result is an under reporting of the total CD4 count done. To adjust for this, the total patients started (TOT) is used as an alternate denominator.

**Figure 19: Proportion of adults starting ART with baseline CD4 <100. Adults started ART per year**

These results are supported further when reviewed against data produced through the IeDEA-SA collaboration. This data presents the median CD4 at ART start using data from selected facilities. Data from these sites demonstrates the increase in median CD4 for adults enrolled on ART over time from 2001–2015.

South Africa’s accomplishments towards achieving its target for PLHIV on ART can be attributed to the implementation of Nurse-Initiated Management of ART (NIMART), which led to the scale-up and decentralisation of the ART programme. NIMART was formally adopted as national policy in 2010 and consequently, nurses began to initiate eligible PLHIV on ART at primary health care level. This imperative policy decision rendered ART services readily accessible and available to those in need. With the capacity building support from development partners and private sector, the DOH witnessed an increase in the number of NIMART-trained nurses, from 10 000 in 2011/12 to 23 000 at the end of 2012/13.14 Moreover, the 2013 Joint HIV, TB and PMTCT review recommended that South Africa ensures all nurses be trained to initiate patients on ART, in order to reach the NSP goal of 80% of those eligible on ART and 70% alive and on treatment five years after ART initiation. Two additional key policy changes contributed to the improved ART coverage: 1) The change in eligibility criteria for ART initiation from 200 to 350 in 2013, (and from 350 to 500 in 2014/15); 2) The introduction of FDCs in the public sector.
Figure 20: Evolution of ART eligibility criteria and baseline CD4 counts in adults ART in selected facilities in the public sector sites as part of the IeDEA-SA collaboration 2004-2015.

TB/HIV INTEGRATION

As per South Africa’s national treatment guidelines, TB HIV co-infected patients are offered lifelong ART. Accordingly, the TB/HIV co-infected client initiated on ART rate was added to the National Indicator Dataset in 2012/13. Figure 21 illustrates the TB registrations plotted against the estimated ART coverage in South Africa from 2005 to 2013.

Figure 21: TB cases plotted against ART coverage estimates from 2005-2013.
Apparently, the decrease in TB cases is related to the increased ART coverage, which almost certainly is shielding PLHIV from having episodes of TB.

Table 24: TB/HIV co-infected client initiated on ART rate 2012/13 to 2014/15

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Achieved 2012/13</th>
<th>Target 2013/14</th>
<th>Achieved 2013/14</th>
<th>Target 2014/15</th>
<th>Achieved 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB/HIV co-infected client initiated on ART rate</td>
<td>New indicator</td>
<td>85%</td>
<td>31.2%</td>
<td>64%</td>
<td>73.7%</td>
</tr>
</tbody>
</table>

As shown in Table 24, the TB/HIV co-infected clients initiated on ART rate has improved significantly from a baseline of 31.2% achieved in 2013/14 to 73.7% in 2014/15. This commendable achievement can be ascribed to the ongoing training of clinicians on TB/HIV co-infection and enhanced implementation of the TB/HIV guidelines. According to the 2015 WHO Global TB Report, 79% of HIV positive TB patients were on ART in 2014.

Figure 22 shows the trends in TB/HIV activities data for cohorts 2010-2012. The TB and HIV integration appears to be advancing desirably and it seems adequate awareness has been raised to enable further collaborative activities between TB and HIV. Initiatives implemented to ensure patients know their status have resulted in a steady increase in the percentage of TB patients with known HIV status. Fewer PLHIV diagnosed with TB have been detected, corroborating the impact of ART on the number of new TB cases.

To augment the initiation of TB/HIV co-infected patients on ART, South Africa continue to: 1) Train and mentor clinicians on the management of TB/HIV co-infected patients; 2) Strengthen intra-facility linkages to reduce the loss of patient between services within the facility; and 3) Reinforce the integration of TB and HIV services and implementation of the TB/HIV guidelines.

The 2013 UNAIDS Regional Report shows that declines in AIDS-related deaths were most visible in countries with huge HIV epidemics and intensified ART provision such as South Africa. The report established that 780 000 lives were saved by the South African ART programme 2003 and 2012. Similarly, it is estimated that 2.2 million lives will have been saved by 2016. In countries like South Africa where a significant percentage of PLHIV are receiving ART, considerable decline in TB incidences have also been
realised as a result of improved ART coverage. The intensified ART rollout has been associated with a 33% and 24% decrease in TB incidence in Malawi and South Africa, respectively.\(^{154}\)

**ENSURING THAT PEOPLE LIVING WITH HIV, STIS AND/OR TB REMAIN WITHIN THE HEALTHCARE SYSTEM**

Retaining PLHIV in care continues to be a challenge, particularly during the pre-ART period. The 2013 Joint HIV, TB and PMTCT Review found that at 36 months after patients are started on ART, 40% are lost to follow up (LFTU). This is attributed to the deficiencies in the linkages to care and patient tracking systems. The deployment of the PHC reengineering WBOTS introduced in 2011, aims to strengthen patient outreach, defaulter tracing, facility-to-community linkages and referral systems, and thus improve patient retention in care for pre-ART and ART patients. Accordingly, provinces have had to scale up the establishment of WBOTs at district level to improve the local WBOTs coverage. However, due to institutional and human resource constraints, the establishment of WBOTs has been slow. For example, less than 50% of the over 500 local wards in the Gauteng Province had well established WBOTs by end of 2014. Figure 23 shows the adults lost to follow up at 3, 6, and 12-months for patients started on ART from January to December 2013, by province – with a national average of 27% LFTU among patients who completed 12 months of ART.

Figure 23: Adult lost to follow up at 3, 6, and 12 months, full calendar year 2013, by province\(^{155}\)

![Figure 23: Adult lost to follow up at 3, 6, and 12 months, full calendar year 2013, by province](image)

The DOH data complete to 120 months in Figure 24 indicates that retention in care is declining from 78.9% in clients at six months ART to 48.3% in clients at 60 months ART respectively.

The suboptimal retention rates observed can be attributed to the poorly coordinated, inefficient and ineffective linkages and/or referral systems being implemented within or between communities, health facilities, districts and provinces. This can also be attributed to weak in-facility data management and poor adherence to the ART data management SOP (referred to as the ART M&E SOP). This tool is crucial to outline the key roles and functions for effective maintenance of the data management systems and strengthens patient tracing activities using the management reports. It is important to note that due to the design of the data
system, patients who were once reported as LFTU who return to care are retrospectively updated. This retrospectively returns the patients to care and hence results in the ‘flattening out’ of the retention in care percentage as shown in figure 24 below. This cannot be controlled through aggregate data - this phenomenon is further described by Johnson et al (Johnson et al., 2014). It is also understood that strengthened patient management and referral systems will result in improved retention and decrease the variability in these figures, if patients are effectively managed.

The imminent expanded implementation of TIER.Net, which in addition to ART data, will comprise HCT, pre-ART and TB programme data, will assist to strengthen patient-level surveillance. It is critical that the SOP is reviewed by all key stakeholders, including clinicians, facility managers, programme managers and health information managers to understand the key and respective roles they play in ART M&E. This will be increasingly important as the TB data capture shifts from paper-based management at the facility to digitised data management at the facility level. This integrated data capture aims to strengthen integrated patient management and also strengthen the integrated data management. Consequently, improved patient tracking and enhanced linkages and retention in care can be expected to be accomplished.

In 2013, South Africa revised its treatment guidelines thereby introducing a phased substitution of multiple drug regimens with Fixed Dose Combination (FDC) ART. FDCs alleviate the burden of drug intake from triple-drugs, three times per day to just one tablet per day. Furthermore, FDCs are known to improve treatment uptake and adherence. Since the introduction of FDCs for all patients in September 2013, about 900 000 of the 2.5 million patients remaining on ART were on FDCs by the end of 2013/14.156

Figure 24: Retention in care – Calendar year started ART 2004 – 2013 157

To further augment treatment adherence, South Africa adopted the implementation of Adherence Clubs. An Adherence Club consists of a group of up to 30 clients who are stable on ART. Led by a lay counsellor or CBO lay personnel, the groups meet in the health facility or community every two to three months for about one hour. At each club session, members engage in group support and educational activities, are assessed clinically and are issued with two to three months pre-dispensed, pre-packed...
medication. Periodic clinical monitoring and related blood tests are done at the health facility. Club members are referred to the clinicians for one-on-one consultations, as necessary. If all is in order, club members’ prescriptions get re-filled at the health facility every six months. However, poor documentation of clinical data in the clinical records has been observed, leading to suboptimal data quality. It is imperative that the clinical documentation is strengthened in this regard. Adherence Clubs provide peer support and increase patient participation and empowerment. From the provincial review, Mpumalanga has been able to implement Adherence Clubs with positive results, in collaboration with PEPFAR implementing partners and other development partners.

In accordance with WHO guidelines, South Africa monitors individuals receiving ART to ensure successful treatment, detect adherence problems and establish whether and which ART regimens should be switched, in the event of treatment failure. All patients on ART are offered the WHO recommended standard for monitoring the response to ART – viral load testing. The 2015 national ART guidelines provide comprehensive guidance regarding viral load monitoring for first line regimens in patients with viral load below 400 copies/ml, 400-1 000 copies/ml and above 1 000 copies/ml. The standardised first and second line regimens are based on efficacy, safety and tolerability and there is a third Line Review Committee that has been set up to coordinate the management of patients failing the second line regimen.

Viral load suppression (VLS) is reported as the total number of captured viral loads <400 copies/ml. All viral loads captured (VLD) serve as the denominator. Based on DOH programme data, Figure 25 illustrates that of active patients on ART in 2014, 59.6% had a viral load done at 96 months in 2014, and 81.0% of the patients were virally suppressed.

**Figure 25: VLD and VLS for active patients on ART in calendar year 2014 vs. data reported in the previous report (April – March 2013/14)**

![VLD and VLS graph](image)

Figure 26 shows that of the patients who started ART in 2013 and completed 12 months of ART, 46.8% of them had a viral load done and 82.5% of them were virally suppressed.
Figure 26: Adult viral load done and viral load suppressed at 12 months on ART, by year started ART

From the provincial review, Limpopo highlighted poor adherence to ART due to the use of alternative or traditional medicines. Limpopo also described an emerging trend of patients dropping out of the ART programme when they achieve viral suppression.

To enhance patient retention and treatment adherence, the DOH continues to strengthen the clinical mentorship programme and the monitoring of ART clinical outcomes using the TIER.Net system at facility level. In addition, the cascade approach will be utilised, populations at risk mapped and targeted to make sure they are monitored and supported throughout the continuum of care, including screening, counselling, diagnosis, treatment, retention in care and outcomes. By the end of 2014, the DOH was in the process of finalising the National Adherence Guidelines for Chronic Diseases (HIV / TB and NCDs) for implementation in 2014/15. This comprehensive two-part document provides a strategic overview and an implementation guide and has been developed with support from development partners.

The 2013 Joint HIV, TB and PMTCT Review emphasised the necessity to bolster the monitoring and evaluation of the HIV, TB and PMTCT programme through the application of a unique patient identifier that can track patients electronically across South Africa, thus ensuring sustainable PLHIV retention in care and optimal health.

In KZN, the implementation of the Three Tiered ART Monitoring Strategy is believed to have enhanced the province’s ability to track defaulters and retaining people on ART. In addition, the use of community care-givers has helped strengthen community linkages and referrals, resulting in improved linkage and retention in care. The integrated approach to service provision through OSS has also helped in terms of improving service delivery to populations in need. Nonetheless, the monitoring and evaluation of OSS and other ward-based strictures remain unstandardised and some of the war rooms are not fully functional. Similar to KZN, the NC mentioned the use of the Three-Tier ART Monitoring Strategy to improve defaulter tracing and patient follow up as one of its key achievements. The Tier.net missed appointment reports accompanied by the availability of WBOTs is reported to have increased the number of people retained on ART in NC. The active involvement of NGOs and other community level stakeholders has also helped strengthen linkages and referrals between health facilities and community-based services – resulting in improved treatment adherence and patient outcomes.
ENSURING THAT SYSTEMS AND SERVICES REMAIN RESPONSIVE TO THE NEEDS OF PLHIV

During the period under review, South Africa focused on improving HIV and TB integration by implementing various activities, including the first ever integrated Joint Health Review of the national HIV, TB and PMTCT programme in October 2013. This review provided a well-defined picture of the current status of the three programmes and related systems – and the development of National Adherence Guidelines for Chronic Diseases – including HIV, TB, and non-communicable diseases (NCD) – in 2014. The guidelines specify realistic measures for making sure people living with HIV, TB, NCD and other chronic conditions adhere to their chronic treatments and are retained in care.

Through the financial assistance from the GFATM, efforts to strengthen HIV and TB services for mining communities, inmates within correctional services facilities and for the decentralisation of MDR-TB treatment were also intensified, during the period under review. Additionally, the GFATM is supporting the DOH HIV drug resistance surveillance and the central chronic medicine distribution and dispensing programme. The integration of TB and HIV services is intended to ensure that the health systems and services remain responsive to the needs of people living with HIV and TB and ensure a continuum of care across service delivery points.

TB TREATMENT SUCCESS RATE

South Africa’s TB treatment success rate for all forms of TB was 76.1% in 2012.161 This is higher than the 75.4% recorded in 2011 and 70.8% in 2010 (Table 25). For the 2012 cohort, loss to follow up rate of 6.6% and death rate of 8.4% were reported.

Table 25: Treatment success rate for all TB cases for treatment cohort of 2012162

<table>
<thead>
<tr>
<th>Province</th>
<th>All TB Cases No</th>
<th>Rx Success No</th>
<th>Rx Success %</th>
<th>LFTU %</th>
<th>Died %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Cape</td>
<td>56 343</td>
<td>40 509</td>
<td>71.9</td>
<td>8.6</td>
<td>10.8</td>
</tr>
<tr>
<td>Free State</td>
<td>20 280</td>
<td>14 838</td>
<td>73.2</td>
<td>5.9</td>
<td>12.6</td>
</tr>
<tr>
<td>Gauteng</td>
<td>54 941</td>
<td>44 930</td>
<td>81.8</td>
<td>5.6</td>
<td>6.9</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>103 986</td>
<td>81 488</td>
<td>78.4</td>
<td>5.3</td>
<td>7.0</td>
</tr>
<tr>
<td>Limpopo</td>
<td>18 188</td>
<td>11 734</td>
<td>64.5</td>
<td>5.1</td>
<td>13.4</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>21 819</td>
<td>16 224</td>
<td>74.4</td>
<td>5.6</td>
<td>8.3</td>
</tr>
<tr>
<td>North West</td>
<td>24 018</td>
<td>15 955</td>
<td>66.4</td>
<td>7.6</td>
<td>11.8</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>8 666</td>
<td>6 418</td>
<td>74.1</td>
<td>7.7</td>
<td>10.3</td>
</tr>
<tr>
<td>Western Cape</td>
<td>46 029</td>
<td>37 528</td>
<td>81.5</td>
<td>9.1</td>
<td>4.3</td>
</tr>
<tr>
<td>South Africa</td>
<td>354 27</td>
<td>269 624</td>
<td>76.1</td>
<td>6.6</td>
<td>8.4</td>
</tr>
</tbody>
</table>

Available national TB programme data shows that treatment outcomes for new smear positive (SS+) PTB are improving. Trends of the national TB programme performance are shown in Figure 27. A treatment success rate of 80.8% was recorded in 2012 – a steady increase from 77.1% in 2009 to 78.9% in 2010, to 79.8% in 2011.163 According to the 2014/15 DOH Annual Report, the TB treatment success rate for new clients further improved to 82.5% in 2014/15. Although this improvement is encouraging, the national treatment success rate is still below the NSP target of >85% by 2016 - which is also equivalent to the global TB treatment success rate.
Figure 27: Trends of TB programme performance, 2004-2012

a) Treatment success rates among new SS+ patients, 2004-2012

b) Cure rates among new SS+ patients, 2004-2012
As shown in Figure 27, the national TB treatment cure rate has improved from 50.8% in 2004 to 75.8% in 2012 and similarly the treatment success rate has risen from 65.5% in 2004 to almost 80.8% in 2012. During the same period, the defaulter rate dropped from 10.3% in 2004 to 6.2% in 2012, although this is still below the national 2013/14 target of <5%. Table 26 shows that treatment outcomes for new smear-positive TB also vary by province.

### Table 26: Treatment Outcomes for new SS+ TB cases starting treatment in 2012

<table>
<thead>
<tr>
<th>Province</th>
<th>New SS+ No</th>
<th>Cured No</th>
<th>Cured %</th>
<th>Success No</th>
<th>Success %</th>
<th>LTFU No</th>
<th>LTFU %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Cape</td>
<td>20 935</td>
<td>13 774</td>
<td>65.8</td>
<td>16 072</td>
<td>76.8</td>
<td>1 775</td>
<td>8.5</td>
</tr>
<tr>
<td>Free State</td>
<td>9 061</td>
<td>6 658</td>
<td>73.5</td>
<td>7 201</td>
<td>79.5</td>
<td>505</td>
<td>5.6</td>
</tr>
<tr>
<td>Gauteng</td>
<td>20 371</td>
<td>16 900</td>
<td>83.0</td>
<td>17 036</td>
<td>83.6</td>
<td>1 074</td>
<td>5.3</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>30 257</td>
<td>24 098</td>
<td>79.6</td>
<td>25 179</td>
<td>83.2</td>
<td>1 494</td>
<td>4.9</td>
</tr>
<tr>
<td>Limpopo</td>
<td>7 263</td>
<td>5 408</td>
<td>74.5</td>
<td>5 536</td>
<td>76.2</td>
<td>351</td>
<td>4.8</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>8 255</td>
<td>6 343</td>
<td>76.8</td>
<td>6 598</td>
<td>79.9</td>
<td>443</td>
<td>5.4</td>
</tr>
<tr>
<td>North West</td>
<td>8 342</td>
<td>5 506</td>
<td>66.0</td>
<td>6 242</td>
<td>74.8</td>
<td>622</td>
<td>7.6</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>3 780</td>
<td>2 591</td>
<td>68.5</td>
<td>3 11</td>
<td>79.7</td>
<td>265</td>
<td>7.0</td>
</tr>
<tr>
<td>Western Cape</td>
<td>14 038</td>
<td>11 407</td>
<td>81.3</td>
<td>11 879</td>
<td>84.6</td>
<td>1 103</td>
<td>7.9</td>
</tr>
<tr>
<td>South Africa</td>
<td>122 302</td>
<td>92 685</td>
<td>75.8</td>
<td>98 754</td>
<td>80.7</td>
<td>7 632</td>
<td>6.2</td>
</tr>
</tbody>
</table>

In 2012, Gauteng had the highest cure rate at 83% while Western Cape had the highest treatment success rate at 84.6%. On the other hand, Eastern Cape had the lowest cure rate at 65.8% and North West had the lowest treatment success rate at 74.8%. Western Cape, Gauteng and KZN have treatment success rates above 80%.

The national DR-TB treatment outcomes are not very encouraging. For the 2011 MDR-TB cohort of about 6 523 patients, the treatment success rate was 44.8% despite the fact that there were over four times as many sites offering treatment for MDR-TB.
as there were in 2009. The MDR-TB death rate was 17.7% in 2011. For the 2011 XDR-TB cohort of 754 patients, the treatment success rate was 20.8% and mortality rate was 40.3%. It is obvious that efforts to find more DR-TB cases and initiate them on treatment are intensifying, but remain suboptimal.

MORTALITY IN SOUTH AFRICA

Mean life expectancy in South Africa has increased from a low of 42.6 years to above 50 years in 2011 (Figure 28).

Figure 28: Median age at death, South Africa, 1997-2013

According to the 2014 Spectrum Estimates, AIDS related deaths were estimated at 140 000 for all ages in 2014, with 130 000 (93%) being among persons 15 years and older. These estimates show a progressive drop in the AIDS deaths for all ages – from 320 000 in 2010 to 140 000 in 2014. This gradual drop in AIDS deaths shown in Figure 29 is commendable and can be attributed to South Africa’s large-scale national ART programme.
The TB mortality rate has varied over time. Figure 30 below shows that the TB mortality (excluding HIV+TB) appears to be stabilising in the last few years (2010-2014); in 2014, an estimated 24 000 (22 000-26 000) cases, at a rate of 44 (41-48) per 100 000 population was reported.\textsuperscript{171} With a 2016 mortality rate target of 25/100 000 (i.e. 50% reduction from baseline), South Africa is not on track for reaching the target.

Figure 30: TB mortality rate (per 100 000 population – excluding HIV+TB), South Africa, 1990-2014\textsuperscript{172}

In 2013, a total of 458 933 deaths were registered at the Department of Home Affairs (DHA) and communicated to Statistics South Africa (Stats SA). About 77 822 (17%) of these deaths were among the youth and young adults aged 14-35 years. At 14.1%, TB was the foremost cause of death among South African youth in 2013, followed by HIV and other viral diseases (Table 27).\textsuperscript{173}
Table 27: Distribution of the 10 leading causes of death among youth, South Africa, 2013

<table>
<thead>
<tr>
<th>Causes of death (Based on ICD-10)</th>
<th>Rank</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuberculosis</td>
<td>1</td>
<td>10 962</td>
<td>14.1</td>
</tr>
<tr>
<td>Human immunodeficiency virus (HIV) disease</td>
<td>2</td>
<td>7 890</td>
<td>10.1</td>
</tr>
<tr>
<td>Other viral diseases</td>
<td>3</td>
<td>4 400</td>
<td>5.7</td>
</tr>
<tr>
<td>Influenza and pneumonia</td>
<td>4</td>
<td>3 603</td>
<td>4.6</td>
</tr>
<tr>
<td>Certain disorder involving the immune mechanism</td>
<td>5</td>
<td>2 351</td>
<td>3.0</td>
</tr>
<tr>
<td>Intestinal infectious diseases</td>
<td>6</td>
<td>2 030</td>
<td>2.6</td>
</tr>
<tr>
<td>Other forms of heart disease</td>
<td>7</td>
<td>1 448</td>
<td>1.9</td>
</tr>
<tr>
<td>Inflammatory disease of the central nervous system</td>
<td>8</td>
<td>1 374</td>
<td>1.8</td>
</tr>
<tr>
<td>Protozoal diseases</td>
<td>9</td>
<td>916</td>
<td>1.2</td>
</tr>
<tr>
<td>Other acute lower respiratory infections</td>
<td>10</td>
<td>797</td>
<td>1.0</td>
</tr>
<tr>
<td>Other natural causes</td>
<td></td>
<td>20 167</td>
<td>25.9</td>
</tr>
<tr>
<td>Non-natural causes</td>
<td></td>
<td>21 884</td>
<td>28.1</td>
</tr>
<tr>
<td>All deaths</td>
<td></td>
<td>77 822</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Except for the Western Cape and Northern Cape, where HIV was at the forefront, TB was the leading cause of death in seven of the nine provinces in South Africa. As regards racial variations, TB was ranked first among Black and Indian youth, second among Coloureds and seventh among Whites. The principal cause of death for Whites was ischaemic heart diseases while for Coloureds, HIV was at the top. Furthermore, the first six causes of death are the same for both males and females.

STRATEGIC OBJECTIVE 3: GAPS AND CHALLENGES

The following gaps and challenges are identified:

- The initiation of ART among children and adolescents is still inadequate (Joint HIV, TB and PMTCT Review Report, 2014)
- TB diagnosis and management in children remains suboptimal
- Psychosocial support and disclosure in children and adolescents, including effective transition from childhood management to adult management remains challenging across provinces
- Retention of PLHIV in care remains challenging with a 27% LFTU at 12 months on ART, and even more so in the pre-ART phase. Stigma and discrimination are believed to also impact negatively on efforts to retain people on ART
- The establishment of WBOTs has been slow in the provinces - WBOTs coverage is suboptimal
- Viral load done for patients active on ART is suboptimal at 59.6% for calendar year 2014 (at 96 months), against the national target of 80%
- The use of a standardised national unique patient identifier that can trace patients electronically across the country is long overdue
- Poor DR-TB treatment outcomes i.e. MDR-TB treatment success rate of 44.8% and death rate of 17.7% while XDR-TB...
success rate was 20.8% and mortality rate was 40.3% in 2011

**STRATEGIC OBJECTIVE 3: RECOMMENDATIONS**

The following recommendations are made:

- Coordinate and collect data from non-DOH ART programme i.e. private sector
- Add the following HIV indicators: Percentage of HIV positive people tested; percentage of people who test positive who are enrolled into care (especially among key populations like sex workers); percentage of people on treatment who are virally suppressed
- Implement the planned TB prevalence survey
- Improve detection and management of TB in children
  - Active case finding, diagnosis, treatment and management
  - Use schools to raise TB literacy as well as TB screening and contact tracing
  - Building capacity amongst health care workers to diagnose and manage TB in children
- Identify and target community sites for TB programme implementation
- Prioritise initiation of ART, psychosocial support and disclosure in children and adolescents
- Evidence-based strategies to improve retention in care and adherence to treatment should be prioritised for scale up and financial resources allocated accordingly – in line with the National Adherence Guidelines for Chronic Diseases (HIV, TB and NCDs)
- There is need to improve viral load monitoring and the reporting thereof
- Psychosocial support needed to improve adherence to treatment, retention in care as well as reduce stigma (especially internalised stigma) and discrimination should be made available to all PLHIV and TB patients
- The existing deficiencies in the linkages to care and patient tracking systems need to be adequately addressed, including the following:
  - Optimal application of TIER.Net to include HCT, pre-ART, ART and TB programme data
  - The use of a standard national unique patient identifier
- To further strengthen ART initiation in TB patients, 1) The ongoing training of clinicians on TB/HIV coinfection and the implementation of TB/HIV guidelines should continue and, 2) Referrals and linkages between services within the facility should be strengthened to ensure patients are not lost to follow up
- Creative ways should be explored to improve DR-TB treatment outcomes, including closing the diagnosis vs. treatment gap.
- Support the introduction of new drugs like Bedaquiline
- Establish resources (financial, human and technological) required to meet the new HIV and TB targets
- For the next NSP, it is important to review the indicators for this Strategic Objective and:
  - Streamline the indicators and identify those that are collectable
  - Include other important factors which impact on the 90:90:90 targets, like resources available for these programmes
4.4 STRATEGIC OBJECTIVE 4: ENSURING PROTECTION OF HUMAN RIGHTS AND IMPROVING ACCESS TO JUSTICE:

STRATEGIC OBJECTIVE 4: OVERVIEW

The NSP 2012-2016 is based on an understanding that protecting the rights of people affected by HIV, STIs and TB is not only in keeping with the Constitutional values of the country, but is also integral to promoting an effective national response. As a result, it recognises the need to address the impact of stigma, discrimination and human rights violations on access to services for HIV, STIs and TB in South Africa. 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.

The NSP furthermore recognises that it cannot, during its five-year timeframe, address all legal and human rights interventions that may be required. Instead, it focuses on selected achievable, measurable and mutually reinforcing objectives and interventions, and prioritises the access needs of particularly vulnerable populations (such as women) and key populations at higher risk of HIV exposure.

The NSP prioritises the following sub-objectives:

1. 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.
2. Reducing HIV and TB discrimination, especially in the workplace.
3. Reducing unfair discrimination in access to social services.

The NSP notes that while responsibility for implementation of many of these sub-objectives rests with the relevant national government departments, SANAC has a key role to play in providing technical support, coordination, monitoring and evaluation. SANAC seeks to harness the human and institutional resources of existing constitutional and statutory structures and CSOs to advance the NSP’s human rights agenda and to create a coordinated framework for monitoring human rights abuses and ensuring access to justice for rights violations.

STRATEGIC OBJECTIVE 4: KEY POLICY ISSUES

South Africa’s response to HIV, STIs and TB recognises the centrality of constitutional values and human rights, such as, the right to equality, dignity, life, freedom and security of the person, privacy and access to health care. It recognises that the South African legal framework for respecting, protecting, promoting and fulfilling rights in the context of HIV, STIs and TB is largely in place. However, it notes that stigma, discrimination and human rights violations still require addressing, especially in the case of particular populations at higher risk.

The following priorities are identified:

• Conduct a review and assessment of remaining laws and policies that may impact negatively on the response to HIV, STIs and TB in an attempt to address any barriers and shortcomings that may undermine the rights of individuals
• Ensure that the provision of services for HIV, STIs and TB is done in a manner that upholds the dignity of individuals, especially those living with HIV and who have TB infection
• Address the support of women and young girls’ sexual and reproductive health and rights, including the right to access comprehensive services and the right to reproduce
• Continue deliberations on the decriminalisation of sex work
• Address the importance of collaborative, national campaigns to address unfair discrimination in the workplace, public amenities
and communities in general

- Address the need for strengthening workplace responses to HIV and TB in all sectors of the economy, especially the vulnerable sectors such as domestic and farm workers

**STRATEGIC OBJECTIVE 4: INDICATORS AND RESULTS**

The NSP does not have core indicators or targets for SO4, nor for its sub-objectives. There is, however, inclusion of an impact indicator in the NSP measuring trends in stigma and discrimination through a Stigma Index. It should be highlighted that the Stigma Index draws only on the perspectives of PLHIV, and the Enhanced Progress Report proposes complementing this understanding with national survey data that illustrates the extent of stigmatising attitudes held by the population as a whole. Table 28 outlines the NSP’s proposed Stigma Index indicator as well as the other potential indicators for SO4, along with most recent survey findings.

**Table 28: Indicators and results for sub-objective 4**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline</th>
<th>Target 2016</th>
<th>FY 2014/15 Achieved</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of persons aged 15 years and older willing to care for a family member with AIDS</td>
<td>92% (HSRC, 2012)</td>
<td>-</td>
<td>-</td>
<td>Targets to be determined</td>
</tr>
<tr>
<td>Proportion of persons aged 15 years and older agreeing that a teacher has HIV but is not sick, he or she should be allowed to continue to teach</td>
<td>83% (HSRC, 2012)</td>
<td>-</td>
<td>-</td>
<td>Targets to be determined</td>
</tr>
<tr>
<td>Proportion of persons aged 15 years and older agreeing that if they knew that a shopkeeper or food seller had HIV, they would buy food from them</td>
<td>79% (HSRC, 2012)</td>
<td>-</td>
<td>-</td>
<td>Targets to be determined</td>
</tr>
<tr>
<td>Proportion of persons aged 15 years and older agreeing that they would be embarrassed to be seen with someone who everyone knows has HIV</td>
<td>17% (NCS, 2009)</td>
<td>-</td>
<td>16% (NCS, 2012)</td>
<td>Targets to be determined</td>
</tr>
<tr>
<td>Proportion of PLHIV excluded from social gatherings</td>
<td>-</td>
<td>-</td>
<td>10% (Stigma Index, 2014)</td>
<td>Targets to be determined</td>
</tr>
</tbody>
</table>
### STRATEGIC OBJECTIVE 4: KEY ACHIEVEMENTS, GAPS AND CHALLENGES

The Enhanced Progress Report found limited progress in achievements towards SO4, although there were significant achievements made in terms of selected sub-objectives. This was confirmed by a number of provinces, including the Eastern Cape, KwaZulu-Natal, Free State, Northern Cape and North West Province, who acknowledged limits to overall progress and the failure to undertake significant sub-objectives (e.g. auditing laws and policies for human rights violations) as well as the limited response in the absence of a comprehensive plan with monitoring indicators.

### SUB-OBJECTIVE 1: ENSURING RIGHTS ARE NOT VIOLATED WHEN INTERVENTIONS ARE IMPLEMENTED AND ESTABLISHING MECHANISMS FOR MONITORING ABUSES AND EXERCISING RIGHTS

Auditing interventions to identify potential for human rights abuses

This sub-objective requires implementing parties to ensure that all NSP interventions take reasonable measures to guard against rights violations. It requires that all government departments and private and community-level entities with responsibility for coordinating, conceptualising and/or implementing interventions and related policies must conduct an audit to assess whether any such intervention or policy may result in a violation of human rights when, or as a result of being implemented.

Since the NSP’s inception in 2012, there is no documented evidence of all relevant institutions and organisations having conducted a systematic audit of laws, policies and programmatic interventions nor of SANAC having coordinated or monitored such an audit. However, there are a number of important pieces of research that have contributed towards identifying human rights violations across the country and the laws, policies, programmes and practices that contribute towards these violations.
In general, it appears that there is a largely protective legal framework in place and findings of rights-based protection in access to health care. However, the Enhanced Progress Report found (confirmed by respondents in KwaZulu-Natal, the Western Cape and North West Province) that stigma, including internal stigma, discrimination and gender inequality was still high and that access to human rights, although existing on paper, was not a lived reality. For example:

- 7% of female PLHIV reported coerced or forced sterilisation in health care settings, and high levels of discrimination are experienced by women living with HIV and sex workers in their interactions with health care workers.
- Section 27 has consistently drawn attention to the human rights violations against patients with MDR and XDR-TB held in appalling ‘prison-like’ conditions in facilities.
- Violations of the rights of sex workers by law enforcement officials continues to take place and the continued criminalisation of sex work is a concern.
- The SAHRC notes ongoing, systemic unfair discrimination against sexual minorities, persistent criminal hate speech and acts against African LGBTI and poor levels of awareness, even at the level of the judiciary.

### EXAMPLES OF RESEARCH ON HIV-RELATED HUMAN RIGHTS VIOLATIONS

Findings from the HIV and TB Review (2013) provides evidence that a number of existing interventions and policies do, in fact, respect human rights in their conceptualisation and implementation. The review highlights that, in general, human rights are respected with regard to access to health care services. For example, informed consent was provided prior to HCT, ART eligible clients are referred appropriately, patients with drug-resistant TB are managed as per the guidelines, women are not denied their sexual and reproductive health and rape survivors are provided with appropriate PEP services.

SANAC in partnership with the National Association of People Living with HIV/AIDS (NAPWA), Positive Women’s Network (PWN), the Treatment Action Campaign (TAC), HSRC and UNAIDS conducted the National People Living with HIV Stigma Index Study in 2013/14. Respondents in Gauteng noted the Stigma Index Study as an achievement in providing further information on human rights violations in the country. The findings of this study found instances of discrimination (e.g. coercive treatment in access to sexual and reproductive health services) but also noted that in many instances, PLHIV reported that their rights were not violated (e.g. in access to health care services more generally). The findings will also help to direct institutions and organisations in their assessment of the possibility for human rights violations in their HIV and TB-related interventions and policies.

A collaborative project between the Women’s Legal Centre, Sisonke and the Sex Worker Education and Advocacy Task Force (SWEAT) documented human rights violations by police officers against sex workers in 2012, and findings have been used to inform sex worker programming.

A report by the PWN on gender equality, harmful gender norms and GBV and the critical policy, legal and structural gaps have been useful in identifying priority interventions.

There are also indications that government departments as well as private and community-level entities have developed standard operating procedures (SOPs), guidelines, policies and programmes to guide interventions such as HIV testing, provision of ART and TB treatment, the provision of PEP to rape survivors, the provision of services to sex workers and the management of HIV in prisons, and the like. Most of these include provision for protection of the rights of affected populations, including key populations at higher risk of HIV exposure. This tends to indicate that sectors are operating in terms of an understanding of human rights violations and how to respond appropriately.

Despite the absence of a formal and coordinated audit of all laws, policies, programmes and practices, it appears that there is a good understanding of where and how human rights violations are taking place and which populations are most affected. Respondents in key informant interviews, provincial visits and at the provincial workshops noted the following gaps and priorities, however:
The need to conduct an audit into selected issues – examples provided were HIV and TB-related human rights violations in the workplace and human rights violations in HIV counselling and testing

The need to focus on specific sectors whose needs are not being reached – examples provided were sex workers, LGBTI populations (the Free State noted that they receive inadequate support and the importance of addressing cultural barriers and supporting, organising and networking in this sector) and people with disabilities (the disability sector noted a general lack of integration of disability-related rights)

The Civil Society Priorities Charter, developed by all sectors of SANAC as well as the Secretariats and Civil Society co-chairs of each PC, has furthermore recommended the development of an early warning system to highlight punitive laws, policies, programmes and practices in order to address them and hold government accountable.

GUARDING AGAINST RIGHTS VIOLATIONS AS PART OF POLICY DEVELOPMENT AND PROGRAMME PLANNING

This focal area is extremely broad and does not include core programmes and indicators, making it difficult to measure the response. The Law and Human Rights Technical Task Team of SANAC has itself acknowledged this and noted the need to review SO4 and focus on between five and 10 key issues. However, each sector of SANAC has developed individual strategic plans that include specific activities directed towards the achievement of SO4, amongst others.

The 2014 NSP Progress Report has however noted various achievements in this respect. The report notes, for instance, that there are various rights-based health care guidelines and policies in existence as has been mentioned above. Reference is also made to an assessment of human rights for all governmental HIV and TB-related plans.

EXAMPLES OF SOME OF THE NEWLY DEVELOPED RIGHTS-BASED POLICIES AND GUIDELINES REVIEWED FOR THE MTR INCLUDE, AMONG OTHERS:

- The SANAC (2012) Key Populations Policy Brief, which guides rights-based programming for key populations such as MSM, sex workers, prisoners, migrants, transgender people and people who use drugs
- The DOH 2013 Guidelines for the Management of TB, HIV and STIs in correctional centres which include a detailed focus on the rights of prisoners in the context of HIV and TB, including the right to voluntary testing and treatment and protection from isolation and segregation
- The DOH 2013 National Complaints Management Protocol for the Public Health Sector of South Africa which strives to strengthen and uphold a patient’s right to complain about health rights violations
- The DOH 2014 National Tuberculosis Management Guidelines which recognises the rights of all patients, note the impact of stigma on treatment adherence and encourage health care providers to adopt rights-based attitudes, provide counselling and support for treatment adherence and encourage voluntary treatment
- The DOH 2015 National Consolidated ART Guidelines which include the promotion of human rights and health equity as a guiding principle, provides for voluntary HIV testing with informed consent and protect women’s and children’s health rights, among other aspects
- The DBE 2015 Draft National Policy on HIV and TB which integrates rights-based guiding principles, such as, the rights to access to education; counselling; treatment; care and support; information; equity and protection from discrimination; fair labour practices; gender equality; privacy and confidentiality; reasonable accommodation; safety, security and health
- The DOL 2012 Revised Code of Practice on HIV and AIDS and the World of Work which is aligned with the ILO recommendation concerning HIV and AIDS and the World of Work No. 200 of 210

There are further examples of provision for rights-based responses, such as, stigma, discrimination campaigns, human rights training and improving enforcement of rights in programmatic responses for vulnerable and key populations. This includes a strong
focus on:

- Addressing GBV and ensuring women and girls’ access to health and legal services following sexual violence, including through the review of the Sexual Offences Act
- On-going research and documentation of the forced sterilisation of women with HIV by civil society as well as continued and ongoing work towards the decriminalisation of sex work through the work of the South African Law Reform Commission reporting to the Ministry of Justice, the Commission for Gender Equality as well as through the work of civil society

**EXAMPLES OF HIV AND HUMAN RIGHTS-BASED PROGRAMMATIC INTERVENTIONS INCLUDE:**

- The ZAZI campaign under the leadership of the SANAC Women’s Sector and Department of Women, Children and People with Disabilities, with support from the USAID/Johns Hopkins Health and Education South Africa (JHHESA) and PEPFAR addresses GBV including sexual violence
- A behaviour change communication campaign led by Soul City and aimed primarily at young women aged 15-24, includes addressing stigma, discrimination and gender equality issues
- Campaigns against GBV in partnership with the SANAC Men’s sector, the PEPFAR-funded Brothers for Life campaign and the national previous DWCPD
- The Thuthuzela Project which aims to support increased access to justice for sexual assault. Training of health care providers and law enforcement officials is taking place in relation to the rights of rape survivors to PEP and access to justice
- The human rights components of the National Sex Worker Programme, which includes training for and working with health care workers and police to reduce rights violations as well as working towards the decriminalisation of sex work, to challenge legal barriers to the provision of health services to sex workers. (A process is underway to extend the national strategy to men who have sex with men and people who inject drugs)
- The DOH National STI Care and Treatment Course for Health Care Workers includes training on health rights issues for key populations such as sex workers, MSM and prisoners and information on health services for survivors of sexual and gender-based violence
- The DOH 2013 Guidelines for the Management of TB, HIV and STIs in prisons include a concrete programme of action for responding to stigma, discrimination and human rights violations in prisons, in accordance with the NSP

Several provinces confirmed the existence of rights-based policies and programmes that included and prioritised key populations. Gauteng noted the legal and policy protection for PLHIV, children, OVC, women, people with disabilities and LGBTI both at national level and, in the case of PLHIV, children and women reflected in departmental policies and guidelines. They furthermore noted the inclusion of key populations, such as sex workers, migrants, miners and transport workers, LGBTI including MSM, prisoners and unemployed youth in HIV and TB programmatic responses. Limpopo, North West Province and Northern Cape respondents also noted the increased inclusion of people living with HIV and key populations such as sex workers and LGBTI populations in programmatic responses, through close partnerships with relevant CSOs. The North West Province also established PHCs and mobile facilities at truck stops and farms to reach truck drivers and farm workers.

However, limitations were noted in KwaZulu-Natal and the North West Province, where respondents felt that sectors had not succeeded in mainstreaming a human rights approach into their programming. In Mpumalanga, respondents felt that key rights-based policies were in place, but were not adequately implemented.

The lack of a co-ordinated, concrete plan with prioritised interventions, targets and indicators for all sectors and key populations has been said to be a major gap in the current response. For instance, a report by the PWN specifically notes the failure to develop an effective accountability framework, strategies and implementation plans for gender transformative approaches as a
However, an important achievement is that there are individual sectoral plans developed by SANAC sectors. These may help with monitoring and evaluating progress in terms of this sub-objective, and M&E in terms of these individual sectoral plans should take place.

**USING EXISTING BODIES TO MONITOR HUMAN RIGHTS ABUSES AND INCREASE ACCESS TO JUSTICE AND INTERVENTION, AND BUILDING CAPACITY WITHIN PUBLIC INSTITUTIONS AND CIVIL SOCIETY TO INCREASE ACCESS TO JUSTICE AND REDRESS**

The NSP notes that using existing bodies to monitor human rights abuses increases access to justice. SANAC, SAHRC and other relevant institutions are entities in a position to 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 for those whose rights have been violated.

The NSP further indicates that the SAHRC should assume responsibility for bringing together CSOs to develop a plan of action to build the capacity of community-based organisations to assist their members to understand and claim their rights. 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.

At national level, SANAC has made recent progress in setting up systems to ensure effective monitoring of human rights abuses and increasing access to justice.

According to the SAHRC Annual Report 2014, the SAHRC upgraded the flow centric data system and training of legal officers and data capturers, to improve the effectiveness of complaints handling and achieved case finalisation for 93% of the 9 217 cases received. Complaints trend analysis conducted in terms of rights violated does not provide information relating to HIV or TB-related complaints. Currently, the SAHRC plans to focus attention on improving its reach and accessibility to marginalised communities through convening human rights clinics in rural and peri-urban areas. The SAHRC has also reported on health and equality rights issues. The SAHRC’s Economic and Social Rights Report [Section 184(3)] notes that various programmes have been introduced to promote the health of vulnerable populations and clinic access has improved. However, it notes that concerns relating to access to health including increased maternal mortality, poor access to community health centres, especially in rural areas, lack of medicines and qualified doctors for primary health care and the poor quality of health services. The SAHRC (2012) Equality Report and the Equality Roundtable Dialogue Report also notes ongoing concerns regarding the rights of LGBTI populations, persons with disabilities and the achievement of gender equality.

Legal Aid South Africa continues to provide legal aid in civil and criminal matters to poor and vulnerable persons, with a strong focus on children. According to Legal Aid SA’s assistance was provided in relation to 776 301 criminal, civil, legal and advice matters during 2013/2014 through their 64 Justice Centres and 64 satellite offices across South Africa. Legal Aid SA’s pro bono agreements with all provincial law societies enable them to link clients with private attorneys providing pro bono legal services, increasing coverage of civil matters. Unfortunately, the report does not provide information relating to HIV and TB cases.

However, more recently and following discussions and consultations with various civil society organisations including Section 27, the private law firm Webber Wentzel, the International Labour Organisation (ILO) and Legal Aid South Africa, a partnership between Legal Aid SA and SANAC was launched in 2015 to promote access to justice to people living with HIV and TB, among others, in South Africa. The programme provides legal advice through the Legal Advice Line and related services through the Legal Aid Clinics, to reduce HIV and TB-related stigma and discrimination. It also includes a strong component to monitor all complaints received as well as referrals made to access justice for HIV and TB-related complaints.
The Department of Justice has conducted a review of the Sexual Offences Courts for purposes of strengthening access to justice for sexual offences and has developed a new model for the courts across the country. The Thuthuzela model, which includes over 50 centres across the country, has referred a number of sexual offence complaints for prosecution, but there is a need to analyse the low conviction rates and withdrawal of sexual offences.

A UNAIDS review of Stigma Index studies conducted across Southern and East Africa showed that undertaking the Stigma Index studies served to empower and build the capacity of PLHIV support networks, helping them to support their membership in understanding and claiming their rights. The national Stigma Index study involved the efforts of large numbers of people living with HIV and their support networks, potentially building capacity in this regard.

At provincial level, progress was noted in the Eastern Cape and North West Province. The Eastern Cape has developed and distributed a provincial complaints form to be submitted to the Eastern Cape AIDS Council (ECAC) on all HIV and TB-related human rights violations and in the North West Province, the establishment and monitoring of a Patient’s Rights Charter, a complaints directorate and accompanying monitoring and evaluation (M&E) tool were noted as an achievement.

Increasing access to justice for gender-based violence emerged as the most significant achievement in the provinces with respect to this sub-objective. Limpopo and the Northern Cape noted the commitments made to strengthening redress for gender-based violence by the Department of Justice; the increased access to TCCs in the case of sexual violence as an achievement, as well as the establishment of community policing and community safety forums in all regions. Mpumalanga also noted the achievements in strengthening gender-based violence initiatives and the achievements made by the provincial rape survivor programme. Broader access to justice was noted in Gauteng and KwaZulu-Natal. In Gauteng, respondents noted that there is access to legal services through social workers and legal CSOs. KwaZulu-Natal noted that the introduction of the Legal Aid SA model to provide legal advice and support for HIV and TB-related complaints would be a major achievement.

Regarding gaps and challenges, current reports from the SAHRC do not allow for monitoring of HIV and TB-related complaints, although the recently launched Legal Aid SA programme does include monitoring, as mentioned above. There is also limited information on what efforts, if any, have been made to develop a coordinated plan to build the capacity of community-based organisations to understand and claim their rights, and provinces such as the Northern Cape noted these challenges in the limited community policing forums, the limited knowledge and information (including in vernacular) of how to access justice and the delays in access to justice. The Civil Society Priorities Charter has noted the need for ongoing information and education to communities on claiming access to justice for human rights.

Finally, the NSP requires that the SANAC Secretariat ensure that reports are tabled at SANAC every six months to monitor the extent to which the rights of people in the context of HIV and TB are being violated and redressed. It is unclear whether such reporting has taken place.

**SUB-OBJECTIVE 2: REDUCING HIV AND TB DISCRIMINATION IN THE WORKPLACE**

Sub-objective 2 relates to HIV in the workplace. Apart from the activities listed below, the Department of Labour has recently revised the Code of Practice on HIV and AIDS and the World of Work, in alignment with the ILO Recommendation No. 200 of 210, both of which have been officially approved by Parliament.

**DEVELOPING AND IMPLEMENTING A NATIONAL CAMPAIGN AGAINST UNFAIR DISCRIMINATION**

The NSP aims to conduct a national multimedia campaign against unfair discrimination, to be developed and implemented by organised labour, business and government, with the assistance of the SANAC Secretariat, and under the auspices of the National
SANAC has launched a national communication campaign to address stigma and discrimination in response to the findings of the Stigma Index Study. This should include issues relating to the working environment. However, a workplace-specific stigma and discrimination campaign, as envisaged by this sub-objective, has yet to be developed. Respondents generally felt that workplace initiatives are not well coordinated or monitored and there is no well-coordinated M&E plan to determine if HIV and TB discrimination in the workplace is decreasing. SABCOHA has developed a tool for monitoring and evaluating private sector responses to HIV and TB in the workplace, but not all companies are using the tool.

While no reference was made to a national campaign against unfair discrimination, provincial initiatives in the working environment are ongoing and merit mention. The Eastern Cape reported ongoing and increased HIV workplace and employee wellness programmes in the automotive, SMME industry and government sector with the assistance of organisations like NGOs. In addition, there is a regular meeting of the Employee Assistance Workplace Forum in the Office of the Premier that co-ordinates Employee Assistance Programmes (EAPs) across various government departments and includes HIV and TB issues on every agenda. In Limpopo and the North West Provinces, respondents noted the development of a rights-based HIV and AIDS workplace policy as an achievement.

**EMPOWERING EMPLOYEES IN SMALL AND INFORMAL WORKPLACES**

The NSP aims to develop a plan to build the capacity of organisations working with small and informal workplaces (including domestic and farm workers) on employment law, to be developed by CSOs working on access to justice, under the leadership of the Department of Labour (DOL), SAHRC and SANAC. Such a plan should involve materials development and training on HIV and employment law, and be sensitive to local needs. From available reports, it does not appear that the plan has been developed. However, SABCOHA has signed a Pledge of Partnership with government to commit to achieving the NSP goals, and reports having reached more than 500 informal economy operators in selected areas with high prevalence of HIV, such as Gauteng. The Eastern Cape noted increased HIV workplace programmes in the SMME industry.

**SUB-OBJECTIVE 3: REDUCING DISCRIMINATION IN ACCESS TO SERVICES**

This sub-objective seeks to achieve broader public health goals by ensuring that no person is denied access to services on an arbitrary basis, through services being provided in a manner that fails to address or understand a person’s specific needs or through staff attitudes that discourage people from accessing social services.

**ENSURING THAT OVERSIGHT BODIES RECEIVE AND ADDRESS COMPLAINTS**

The NSP requires SANAC to support professional oversight bodies – for example, the Health Professions Council of South Africa (HPCSA), the South African Nursing Council (SANC), the Pharmacy Council of South Africa (PCSA), the South African Council for Social Service Professions (SACSSP), and the South African Council for Educators (SACE) – to develop a coordinated four-year plan and accountability frameworks (including regular reporting) to collectively receive and address complaints of unfair discrimination in the provision of HIV and TB services to affected populations.

Regarding gaps and challenges, the HPC has developed a plan; however, it appears that there is a lack of sufficient dedicated funding for professional oversight bodies to deliver optimally on their mandate, including regular reporting to SANAC.

**PROVIDING TRAINING TO PREVENT UNFAIR DISCRIMINATION**

The NSP aims to provide human rights training through all public and private bodies providing training in HIV, STIs and TB, to prevent unfair discrimination by social service providers. This intervention is to be led by the Department of Higher Education and Training (DHET) 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.

The Higher Education and Training HIV/AIDS Programme (HEAIDS) has been funded to equip academic staff at public universities and TVETs with the skills to integrate and address HIV and AIDS issues in their curricula. HEAIDS will create a pool of experts in the area of HIV curriculum development and be in a position to train other academics in integrating HIV content into the curriculum across different disciplines, including human rights components of responses. In addition, a partnership with the Networking HIV/AIDS Community of South Africa (NACOSA) will develop programmes to address the needs of LGBTI students and staff at higher education institutions. It is, however, unclear whether the HEAIDS programme is sufficient to address the training needs across the country. For instance, gaps identified by the PWN emphasises the further need for training of health care workers on the specific sexual and reproductive health and rights of women and girls. The Civil Society Priorities Charter has emphasised the need for ongoing training on HIV and human rights for all communities, to increase awareness of rights and access to justice.

**STRATEGIC OBJECTIVE 4: RECOMMENDATIONS**

Overall, the need for funding for achieving the specific sub-objectives for SO4 as well as for mainstreaming human rights across all sectors was identified as critical.

In addition, the following recommendations are made:

**SUB-OBJECTIVE 1:**

- Conduct further investigations into selected HIV and TB-related human rights violations and develop an early warning system to highlight punitive laws, policies, programmes and practices in order to address them and hold the relevant institutions accountable
- Scale up services and develop and implement policies to reform the legal framework for sex work
- Develop a concrete law and human rights charter and plan for the remainder of the NSP and for beyond 2016, with prioritised human rights interventions, targets and indicators for priority sectors and key populations
- Continue to mainstream rights-based approaches to HIV and TB into all relevant SOPs, guidelines,
- Strengthen the monitoring and reporting of human rights violations and access to justice through various strategies including:
  - Scaling up the Legal Aid Clinics to improve access to legal representation and the courts
  - Developing a coordinated plan to build the capacity of community-based organisations and service providers to increase access to justice
  - Strengthening community policing forums
  - Developing strategies to analyse low conviction rates and increase conviction rates for perpetrators of sexual assault
  - Ensuring a focus on vulnerable and key populations, e.g. sex workers, LGBTI populations, people with disabilities
  - Continue to monitor HIV and TB-related human rights violations and responses through Legal Aid South Africa
- Develop a centralised mechanism, through SANAC, for tracking all sectoral plans and human rights indicators to ensure ongoing M&E of human rights violations and responses in terms of SO4, at national level

**SUB-OBJECTIVE 2**

- Support NEDLAC to develop the envisaged HIV and TB stigma and discrimination reduction communication campaign
- Ensure that the planned national communication campaign to address stigma and discrimination by SANAC receives adequate
funding and includes the participation of and prioritisation of vulnerable and key populations, including workplace-related stigma and discrimination reduction interventions

- Support the Department of Labour’s development of a plan to build the capacity of organisations working with small and informal workplaces on HIV and employment law

**SUB-OBJECTIVE 3**

- Provide coordination support to professional oversight bodies to deliver on their proposed activities towards reducing stigma and discrimination in the health care profession
- Ensure ongoing M&E of the HEAIDS programme, ensuring inclusion of human rights issues, and priority areas of focus in line with information on human rights violations and related targets in South Africa. Monitoring and evaluation of the HEAIDS programme will support the identification of concrete and prioritised training interventions, targets and indicators for the 2017 NSP

5. MONITORING AND EVALUATION

The complexity of the HIV/AIDS response necessitates that multi-sectoral interventions incorporate a comprehensive and functional M&E system. Four NSP indicator matrices were developed for overall impact and strategic objectives 1, 2 and 3. The indicators are designed to measure progress towards the implementation of the NSP, mainly focusing on outcomes and the impact of the multi-sectoral HIV response interventions. Based on the latest available baseline data as at 2012, the NSP set ambitious targets which are to be achieved by end March 2017, which is the end date of this NSP. During the EPR process, an M&E technical experts’ workshop was held to review the current state of M&E and indicators that are being reported on. This session yielded inputs to the monitoring and evaluation function of the multi-sectoral HIV response.

**KEY ACHIEVEMENTS**

As outlined within the NSP, the responsibility to monitor and evaluate the implementation of the NSP lies within the SANAC Secretariat. During the second quarter of 2013/14 the secretariat established an M&E unit. The unit is staffed by an M&E manager at the SANAC head office and nine M&E officers based in each of the nine Provincial Aids Councils (PACs). In addition, UNAIDS and CDC provides ongoing technical support and the USAID funded Futures Group Sexual HIV Prevention Programme (SHIPP) has seconded a Senior M&E expert to the Secretariat.

SANAC led the development of an M&E framework for the NSP in order to address good M&E principles and as part of adopting the ‘three ones’ approach. The M&E framework takes into account existing M&E systems being implemented within government departments and sectors, and gives direction as well as synergising all existing sectoral M&E systems. The framework is currently being reviewed.

The Secretariat produced its first report on progress against the goals, objectives and targets set in the NSP 2012-2016 in 2014. The report covered the first year of the current NSP implementation, progress made in each of the NSP’s four strategic objectives and recommendations to remedy challenges as presented in the report. In fulfilling the recommendation of the NSP (2007-2011) the Enhanced Progress Report covering the progress of the implementation of the NSP will be published. Secondly, the SANAC secretariat embarked on an M&E assessment of all the nine Provincial AIDS Councils and the results of this activity are being used to guide support to these structures respectively. The Secretariat also managed to undertake an annual review of Provincial Strategic Plans guided by the set indicators in the NSP and reports have been published accordingly.

**CHALLENGES**

One of the main challenges identified in the 2012 NSP progress report was weaknesses in the M&E system regarding core indicators selected for monitoring progress, indicator definitions, targets set and the baseline results/values used in the NSP.
Consequently, the review of the current NSP indicators was included in the EPR terms of reference. The review of the NSP indicators was carried out in a workshop attended by M&E experts from government sectors, bilateral agencies, sectors and PACs. Further consultations were conducted with parties who were not able to attend the workshop. The main objective of the workshop was to review the NSP indicators and targets and make practical recommendations for the remaining period of the NSP and beyond. The review addressed the following questions:

- Which indicators are performing well as measures of the performance of the NSP?
- Which indicators are not performing well as measures of the performance of the NSP?
- Where are the gaps i.e. where there are no indicators to measure key programmatic outputs/outcomes?
- Are the current NSP targets still aligned with national/international targets?
- What are the strengths and weaknesses of current data collection and interpretation systems?
- What recommendations can be made to strengthen the M&E of the NSP: 1) For the current NSP; 2) For the next NSP?

The review indicated that progress towards achieving the following sub-objectives was not adequately measured by the listed NSP indicators, with some of the sub-objectives having no valid and reliable indicators to measure achievements, assess performance or reflect changes that are linked to achieving the strategic objectives or sub-objectives.

There is need for coordinated mechanisms to be built into the routine programming to generate data or information on a continuous basis to provide evidence for programme planning and decisions-making, hence, the need for an updated M&E system. The system must outline routine reporting of priority data or information, observe and track progress. In addition, the system must outline the periodic, rigorous review of information to satisfy the NSP research agenda. The SANAC Secretariat will complete the review of the current M&E framework and pilot additional recommended indicator enhancements or changes before the development of the next NSP.

**RECOMMENDATIONS**

- Adapt the NSP indicators to adequately measure the strategic objectives/sub-objectives to understand the epidemic and the extent of change resulting from the interventions
- Prioritise the piloting of suggested indicator enhancements. Indicators must be piloted between the EPR release and the development of the next NSP. The process will then lead to the indicator matrices adequately measuring the SOs and impact in the next NSP. The targets review will be done in consultation with the departments to ensure reasonable targets for the end of the NSP implementation period
- Finalise and operationalise the revised multi-sectoral NSP M&E framework
- SANAC to develop a data repository mechanism and coordinate reporting on the NSP
- Develop targets for children in the NSP
- Review all indicators and ensure they are SMART
- The next NSP targets should be aligned to the 90:90:90 and fast track targets, as well as integrate with the National Development Plan
- Future evaluations of the NSP to be in line with the existing government Evaluation Framework developed by DPME
6. NSP GOVERNANCE AND INSTITUTIONAL ARRANGEMENTS

SANAC represents all the national and provincial government departments, provincial, district and local AIDS councils, NGOs, civil society organisations, trade unions, private sector bodies and faith-based organisations that are working to address HIV and TB. SANAC structures also include the country’s top researchers and experts on HIV, STIs and TB, as well as international development partners. The current signed off structure of SANAC is shown in Figure 31.

Figure 31: SANAC Structure, 2012

SANAC STRUCTURES

SANAC has structures at national and provincial levels and their overview and roles and responsibilities are summarised below:

THE PLENARY

The Plenary provides leadership for the overall South African response to HIV, TB and STIs and is chaired by the Deputy President of the Republic of South Africa. As an Extended Plenary it includes: nine provincial Premiers; the Chairs and Co-chairs of the technical committees; and three development partners and provides the highest level of participation from government, civil society and other sectors. The Plenary is advisory in nature with its main purpose being to develop consensus in respect of overall policy, and provide guidance for the high level strategy to address the country’s response to tackling HIV, TB and STIs. It approves and makes recommendations to the cabinet on overall policy and national strategic interventions necessary to tackle HIV, TB and STIs. The Plenary is responsible for leadership and is the location where high level strategy and policy for the country is collectively deliberated and determined.

INTER-MINISTERIAL COMMITTEE (IMC)

The SANAC IMC is made up of the 22 government ministers and is chaired by the Deputy President of South Africa. The IMC’s roles and responsibilities include: to consider and recommend to Cabinet the proposed NSP agreed by Plenary every five years;
to present any major policy changes that have been agreed by Plenary to government; to provide leadership and guidance for the HIV and TB response within government; to guide and approve the coordination within government relating to HIV and TB; and to review and recommend the allocation of resources made available to HIV, TB, and STIs within government. It is responsible for deliberating the government view in preparation for the Plenary.

**NSP FINANCING COMMITTEE (NFC)**

The NSP Financing Committee (NFC) is a structure of SANAC that provides comprehensive national oversight of all financing arrangements relating to the NSP implementation. This includes the oversight of funding for the NSP, including shortfall analysis, evaluation of funding opportunities, including large-scale development partner initiatives and alignment to NSP aims and objectives. The NFC makes recommendations pertaining to NSP funding and identifies interventions to assist in the allocation of sufficient funding for the national response to the HIV, STIs, and TB.

**THE PROGRAMME REVIEW COMMITTEE (PRC)**

The PRC brings together all of the key national stakeholders involved in HIV, STIs, and TB programme implementation in South Africa. The PRC is the delegated authority to address technological advances in the course of implementation of the current NSP. This includes providing technical expertise to the review (including reports from government, civil society, business and labour) of the programmatic activities of the NSP implementation; identifying and addressing technical issues and risks to the effective implementation of the NSP; and to provide technical support during the mid-term and end-of-term review of the implementation of the NSP. The PRC recommends agenda items for the Plenary.

**SECTOR LEADERS FORUM**

The SLF is an ad-hoc committee that meets at the request of the Deputy President for additional consultations when the need arises. It consists of the Deputy President (chair) and other Ministers as needed, the Deputy Chair of SANAC and the 18 civil society sector leaders.

**THE CIVIL SOCIETY FORUM (CSF)**

The Civil Society Forum (CSF) brings together all sectors in order to strengthen sector participation and share resources and information at the national level. The ultimate goal of the CSF is to represent the views of civil society sectors in the policy deliberations within the SANAC Plenary. It also has the role to advocate for the policy proposals of civil society for consideration by government. The Civil Society Forum allows for ‘streamlining’ the sectors and for greater accountability among the sectors. The SANAC Secretariat provides financial and logistical support to the Civil Society Forum as appropriate and in keeping with available funds.

**THE GLOBAL FUND COUNTRY COORDINATING COMMITTEE (CCM)**

The Global Fund (GF) Country Coordinating Committee (CCM) is a specific committee set up, as per GF requirements, to ensure that South Africa can submit proposals and receive funds from the Global Fund. It functions according to a detailed governance manual that is required to meet the Global Funds prescripts in the way it is governed. It is chaired by the Chief Executive Officer (CEO) of SANAC who must report regularly to the SANAC Trust on all matters related to the CCM. The GF CCM is, hence, the decision making body for all matters relating to Global Fund grants in South Africa and has to continue to meet the prescribed eligibility requirements as set out by the Global Fund. The CCM also reports in to the NSP Financing Committee which, as stated above, is chaired by the Minister of Health.
THE SANAC TRUST

The SANAC Trust is the legal basis for the existence of SANAC and the Secretariat. The Trust is registered as a Trust with the Master of the North Gauteng High Court and operates in terms of the Trust Property Control Act and the SANAC Trust Deed. Trustees are appointed by the Deputy President of the Republic of South Africa. The Trust receives funds from the government of South Africa and is also able to raise funds from donors and the private sector. The Trust is responsible for approving the Secretariat budget and for auditing all expenditure at the Secretariat. Since the Trust became operational on 1 April 2012, it has had consecutive unqualified audit reports for the last three financial years. Prior to that, the Trust was not transacting off the Trust account and financial statements had not been presented for independent audit.

THE SECRETARIAT

The Secretariat is mandated to offer coordination of implementation of the NSP, monitoring and evaluation, resource mobilisation and donor coordination for the overall implementation of the National Strategic Plan. It also provides support and capacity building to government departments, provincial aids councils, the private sector and civil society organisations. The Secretariat ensures that all the SANAC structures meet regularly and fulfil their roles and responsibilities as laid out in the governance arrangements and the draft procedural guidelines. The Secretariat carries out its administrative, logistical and technical functions as directed by the Annual Performance Plan in support of the NSP as approved by the Board of Trustees. The Secretariat facilitates and oversees the implementation of the NSP.

THE TECHNICAL TASK TEAMS

The TTTs are composed of country experts in the key areas of the NSP and guides the SANAC Secretariat through the latest evidence and international best practices to inform the Secretariat’s approach to the implementation of the NSP. The TTTs provide an opportunity to build on the latest strategies, review empirical data to inform key programmes and policy decisions, and provides guidance on resource mobilisation and allocation to NSP programmes. The number of the TTTs (currently four) must be in line with the strategic objectives of the active NSP. The Technical Task Teams provide expert advice to the SANAC Secretariat on various technical aspects as required. They provide an overview of and analyse reports and or research that has been carried out nationally and/or internationally to enable SANAC to be a thought leader on HIV, STI and TB in the country and to support implementation of the NSP. In close collaboration with the SANAC M&E unit, the TTTs document emerging trends and good implementation practices and make recommendations to the Secretariat for consideration by the broader SANAC structures.

SUB-NATIONAL STRUCTURES (PCAS, DACS, LACS)

There are three structures to support SANAC initiatives at a provincial, district and local level as follows: Provincial Level: The Provincial AIDS Council (PCA) has representatives from government, civil society, labour and business at the provincial level; District Level: The District AIDS Council (DAC) has representatives from government, civil society, labour, and business at the district level; Local Level: The Local AIDS Council (LAC) has representative from government, civil society, labour, and business at the local level. The roles and responsibilities include: acting as advisory structure to the Executive Committee of the Provincial Legislature, district municipalities and advice to local municipalities; development of the Multisector Provincial Strategic Plan received from districts and local AIDS councils; coordination of the various sectors (government, civil society, business and development partners); and monitoring and evaluation of the provincial and local response.

KEY ACHIEVEMENTS

SANAC and its structures have made marked achievements in the foregoing period. These are summarised below:

• SANAC has come to be highly regarded as an effective mechanism for bringing government, provinces, the private sector and civil society together to tackle a problem as complex as HIV and is considered a best practice for the HIV response internationally and for other complex issues locally. SANAC received praise from the President in his State of the Nation
address

- Through its Plenary, SANAC has managed to deliver on its mandate to have visible political commitment from the government through the Deputy President (its chair) and other leadership involved. The Plenary has met regularly, which is an achievement for such a large national structure, and has provided leadership to the previous and current NSPs. The ability of the Plenary to obtain approval from the National Cabinet for the National Strategic Plan is recognised as a great achievement in the global HIV community.

- Through the IMC, the NSP has been monitored and supported by multiple ministries including Health, Basic Education, Higher Education, Social Development, Justice and Correctional Services, Cooperative Governance and Traditional Affairs, Science and Technology, Women and Public Service and Administration at Minister or Deputy Minister Level. The NFC has not been able to deliver on its mandate as it has only met once since it was established.

- The PRC has been effective. It is well attended by experts and key stakeholders and has processed numerous policy improvements for the National Strategic Plan, and monitored progress reports on the implementation of the NSP, such as, the NSP Annual Progress Report and the mid-term evaluation of the NSP. The PRC functions on a much more professional level compared to its predecessor (the PIC) that operated more like a ‘mini Plenary.’ The GF CCM has been able to maximise the funds raised from the GF from about US$ 20 million per year four years ago to more than US$ 100 million per year currently. Following a critical report by the Global Fund’s Inspector General in 2011, the CCM has been rebuilt and all weaknesses have been addressed. This was confirmed by the smooth passage of the South Africa CCM through the last governance assessment conducted by an international team appointed by the Global Fund. The CCM has submitted two proposals to the Global Fund over the last three years. The first was approved to the value of US$307 million, and the second (to the value of US$380 million) is awaiting approval by the Global Fund. The CCM will have effectively raised over R8 billion for the South African AIDS Response over a five and a half year period. This is a remarkable achievement. The GF CCM has recently undergone a full eligibility performance assessment and developed a performance improvement plan to ensure ongoing improvement. SANAC’s current performance was considered to be strong enough for South Africa to meet all the GF eligibility requirements and to be allowed to submit a concept note to the Global Fund. The GF CCM and the Secretariat continue to work on the improvement of their core documents to ensure the highest standard of governance, oversight and communication.

- SANAC has played an important role in ensuring appropriate participation by civil society through the Civil Society Forum. CSF meetings were held at least once per quarter. The CSF has brought together various civil society sectors (some with numerous affiliated NGOs) to discuss and to strategically position the work of civil society. The CSF has meaningfully engaged with all SANAC processes and ensures active participation in the SANAC Plenary, the committees of SANAC and events held by SANAC, such as, World AIDS Day. The CSF has resolved to strengthen its advocacy role within SANAC. SANAC has also identified sectors that need empowerment and support, with the PLHIV and labour sectors being designated for mandatory inclusion in the sectors and for plenary representation. The CSF met three times in the past year: The CSF drafted a CSF HCT Campaign, the CSF Strategy and Sector Plans. Individual sectors have been active with campaigns such as ‘Not in my Name’ (Men’s Sector), First Things First (Higher Education), PLHIV Stigma Index (PLHIV Sector), ‘A re dlale safe’ (SAC Sector), ‘PMTCT’ (Children’s Sector) and Decriminalisation of Sex Work (SW Sector).

- The SANAC Trust has established high standards of governance and integrity in the management and work of the Secretariat and its support for the implementation of the NSP and its support to SANAC structures. The Trust provided oversight, leadership and direction to the Secretariat, and has helped establish committees to help the Secretariat in achieving its mandate.

- The Secretariat has fully established itself as an independent institution under the governance of the Trust. It has its own administration, financial management and audit, human resources and fundraising functions. The Secretariat has the human capacity to fulfil its functions linked to NSP coordination and support to implementation of programmes for prevention; young women and key populations; monitoring and evaluation; donor coordination; government and civil society support; support to provincial, district and local aids councils; campaigns; human rights and corporative services. In the ten years since its establishment in 2002 to 2011, the Secretariat failed to transact in its own name and relied heavily on financial and administrative support from the DOH and development partners. The Secretariat recently relocated to Hatfield thereby
completing its goal of establishing itself as an independent institution

- SANAC has had some notable key achievements through its TTTs. The TTTs produced the Stigma Index report, the Young Women Strategy and the Evidence for Social Behaviour Change Communication reports. There were no indicators for stigma until end of 2014, but through the work of the TTT, there is a stigma index that has created a baseline for measuring stigma in South Africa. The TTTs have also provided formal reports to the respective bodies that have requested their technical input.

- The Provincial AIDS Councils are now functional in all provinces. The SANAC Secretariat has worked to bring coherence to the work of the PACs through joint planning in the HOS meetings held quarterly. The Secretariat has provided specific financial and technical support to strengthen the North West, Limpopo and Mpumalanga PCAs. KZN, the Eastern Cape, the Western Cape, the Northern Cape and Gauteng PCAs continue to function well with good infrastructure and resources from the provincial governments. The district, metro and local aids councils have only partial success, with a large proportion at the local level not functioning adequately.

**ABILITY TO DELIVER ON MANDATES**

Previous reviews have found SANAC to be not ‘fit for purpose’. Therefore, the review also focused on assessing whether the structures are capable to deliver on their mandate, and the following emerged:

- SANAC has generally been able to deliver on its mandate, though most of its structures still need strengthening. The high political commitment with the Deputy President and other structures involved have strengthened the Plenary.

- The IMC is chaired by the Deputy President of South Africa and thus has close links to the Plenary which is also chaired by the Deputy President. There is direct input from Ministers/Deputy Ministers on issues such as policies, programmes and resource allocation but there is an increased demand for a wider range of political leaders to attend the IMC.

- The NFC has representation from civil society, Deputy Ministers of government departments including Finance and is led by the Health Minister – hence, bringing together key stakeholders of the SANAC. It does have the ability to deliver on its mandate, provided regular meetings are sustained. The Secretariat supporting the structure would also need to be strengthened.

- SANAC has been able to successfully bring together technical experts to provide input and direction to its programmes and projects.

- The GF CCM is able to deliver on its mandate, as it has shown by applying for and receiving funding from the GF and by ensuring these are spent appropriately by the Principal Recipients. The most recent evaluation has shown that the Secretariat supporting the GF CCM needs to be strengthened. The active participation of members has been its key strength as the GF CCM has had regular meetings and was able to submit a concept note that was approved by all sectors. The GF CCM has also been well supported by a Secretariat structure that has been able to provide all the technical support required to inform decision making by the Oversight Committee and the full GF CCM.

- The SANAC Trust has been legally established which gives it the legal basis to provide oversight over the Secretariat according to the current guidelines and governance framework. The role of the Trustees in SANAC is becoming more important as SANAC migrates from policy dialogue to ensuring the implementation of the NSP.

- The governance and accountability framework has clarified the accountability of SANAC structures, up to the Deputy President as the chair of SANAC. There is an urgent need to finalise the procedural guidelines and this will provide the opportunity to further refine the way in which the SANAC structures become more ‘fit for purpose’.

- SANAC has been able to bring together representatives from all sectors including government, civil society, business and labour into most of its structures.

- The SANAC Secretariat has increasingly delivered on its mandate to fulfil its function as described in the NSP. The Secretariat has been significantly strengthened over the past few years. Now the Secretariat has its own budget and has increased its staff complement, with its own policies, procedures and guidelines and governance documents. The corporatisation of the Secretariat remains on track. The governance structure is in place with the Trust providing oversight over the Secretariat as
per the current guidelines and governance framework

• The TTTs have some of the structures that can be deemed ‘fit for purpose’. They have been able to include appropriate experts across disciplines, and thus are strong technically. Additionally, the TTTs have also been responsive to relevant issues and have included relevant groups in the deliberations. An example is the Legal and Human Rights TTT, which has people living with HIV, and who were part of the team working on the Stigma Index. The TTTs have also been able to work remotely which has been cost effective as it reduces travelling and workshop costs. The Treatment, Care and Support TTT has not met for more than two years and the Secretariat is in the process of merging the two Prevention Related TTTs.

• The Sub-national Structures (PCAs, DACs, and LACs) have proven the weakest of the SANAC structures, though there are a few exceptions that have done well. The ability of the provincial structures to deliver on their mandate is limited mainly because of poor resourcing and poor support and commitment by the provincial and local political leadership.

**GAPS AND CHALLENGES**

The review revealed the following set of general gaps and challenges in SANAC which are summarised by structure to highlight the location of the gaps:

• **Plenary:** The Plenary’s decision making functionality needs strengthening. Often the plenary meetings have been used to deliberate on issues rather than make resolutions, which is what the structure is mandated to do. There was no Extended Plenary and the result of that is that the Premiers might not have had direct engagement with SANAC Plenary and this might explain the apparent Premiers offices’ apathy in some provinces, with the resultant underachievement of some provincial and local structures.

• **Inter-Ministerial Committee (IMC):** The term of office for SANAC IMC members are linked to the incumbent of the position and this potentially can result in loss of departmental political momentum and memory when new ministers are appointed or reposted. But there are many other competing political agendas to the HIV and TB response. Due to the nature of the epidemic it tends to be more health dominated rather than inter-ministerial in nature and the IMC is not well represented by the other IMC members.

• **NSP Financing Committee (NFC):** The Health Minister has a busy portfolio and has not had the time to convene regular meetings. This is a similar structure to the Inter-Ministerial Committee, and as such represents duplication.

• **Programme Review Committee (PRC):** The PRC should be given more authority to make recommendations to the Plenary. The strength of the PRC needs to be reflected in the Plenary meeting by ensuring that the Plenary agenda is discussed and agreed in the PRC meeting. The co-chair of the PRC needs to be a leading expert in the field of HIV prevention and treatment and the latest HIV research findings.

• **Civil Society Forum (CSF):** Despite its notable successes, the CSF has demonstrated lack of communication between the national and district levels of the civil society structures. There has been a tendency to focus on structural and political issues relevant to the sector which has resulted in unnecessary tension. The forum has brought too many resolutions and prioritisation is needed in the face of limited resources and other sectors competing needs. Additionally, some of the subsectors within civil society are much weaker because or as a result of the leadership not being actively involved. Elected members are employed in full time jobs which make coordination and communicating on a regular basis resource intensive. Within civil society, there are better resourced sectors, with their own Secretariats in place, who are better able to deliver on their mandate, and poorly resourced sectors which are able to deliver only on parts. The CSF should focus on its advocacy agenda.

• **Country Coordinating Committee (CCM):** The communication, and the recording there-of, between civil society sector representatives on the GF CCM and their constituents needs to be strengthened for greater accountability. The Chairperson must ensure regular reporting on the activities of the CCM to the SANAC Trust.

• **The Trust:** The Trust members sometimes have more than one role in the SANAC environment and this creates some conflict of interest which potentially clouds decisions on some issues of interest to the members.

• **The Secretariat:** The Secretariat has suffered from a lack of core funding. The Secretariat role is complicated by the fact
that generally there is no legal relationship between national and provincial offices and structures, thus, complicating the coordination and M & E coordination functions of the Secretariat. From a governance perspective, more clarity between accountability, and roles and responsibilities of the Office of the DP, NDOH and the Secretariat is needed.

- **Technical Task Teams:** Though generally effective, the TTTs have a problem of overlap and lack of clarity in some TTTs. e.g. the Prevention and Social Structures issues have experienced contentions between the respective support departments viz. Department of Health and the Department of Social Development. The Treatment, Care and Support TTT has not met. The Secretariat must revive the existence of this TTT.

- **Provincial Structures (PCAs, DACs, and LACs):** The successes with the strengthening of the PCAs should be rolled out to the Metro, DCAs and the LACs. Guidelines, toolkit development and training for DACs and LACs must be urgently implemented and the PCAs should be supported to strengthen these structures.

### Table 29: Performance of the SANAC structures

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<td>Inter-Ministerial Committee (IMC)</td>
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<td>NSP Financing Committee (NFC)</td>
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<td>Programme Review Committee (PRC)</td>
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<td>Sector Leaders Forum</td>
<td>I</td>
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<tr>
<td>Civil Society Forum (CSF)</td>
<td>I</td>
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<tr>
<td>Global Fund Country Coordinating Committee (CCM)</td>
<td>I</td>
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<tr>
<td>The Trust</td>
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<td>The Secretariat</td>
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<tr>
<td>The Technical Task Teams</td>
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<tr>
<td>Provincial Structures (PCAs)</td>
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<tr>
<td>DACs, LACs</td>
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</table>

**RECOMMENDATIONS**

To deepen the culture of transparent, participatory decision-making, the following recommendations are made to address the gaps and weakness in the governance structures and processes:

**STRENGTHEN THE SANAC STRUCTURES**

- **Plenary:** The Plenary should have a strict agenda to be followed. The plenary should prioritise approval of resolutions rather than repeat discussions and debates that have already taken place at lower levels. The PRC should summarise the debates and highlight issues for approval.

- **Inter-Ministerial Committee (IMC):** There should be role clarification between the IMC and the Plenary with clarity on which structure has greater authority. Traditionally, the IMC meet to prepare for the Plenary but legally, it has more authority than the Plenary. Consideration should be given to reducing the number of Ministries represented on the IMC to include only Health, Science and Technology, Social Development, Basic Education, Higher Education, Justice and Correctional Services, DPSA, Women and Cooperative Governance and Traditional Affairs.

- **National Finance Committee (NFC):** If the NFC is not meeting regularly, then SANAC should look at expanding the structure and Secretariat of the Inter-Ministerial Committee to be able to take over the work of the NSP NFC to avoid
duplication of work and dissolve the NSP FC, if it is superfluous.

- **Civil Society Forum (CSF):** The CSF watchdog and advocacy role needs to be strengthened and strong links should be developed between national, provinces and districts. Initiatives are required to capacitate and support the CSF to meet its mandate. The tension and sense of mistrust experienced between CSF and the Secretariat needs to be addressed. The CSF would be able to deliver on its mandate fully if there is better communication, coordination and resources (both technical and financial).

- **Country Coordinating Committee (CCM):** The Global Fund requires that civil society representation includes the representation of appropriate key populations and that this representation is rotated on a set basis. This would ensure continuing contribution of new ideas and should be considered as a standard for other SANAC structures. Sex workers and young women should be represented on the CCM.

- **The Trust:** The inconsistency in the interpretation of the role of the Trust, the object of the Deed, the mandate of SANAC and the functions of the Secretariat should be speedily clarified. Multiple roles within the SANAC environment should be aligned as to reduce conflicts of interest and the resultant tardy decision-making on some issues.

- **Secretariat:** There should be role clarification between the Secretariat and all structures within the SANAC environment to avoid unnecessary overreaching by other structures outside the responsibility and accountability framework. Rather than grant funds from Health and Social Services being the only source, the funding of SANAC Secretariat should be reviewed and strengthened and could include suggestions such as having other sectors also contribute to its funding e.g. the Presidency, Science and Technology, Social Development and Justice and Correctional Services.

- **Technical Task Teams:** Implement the decisions of the Lekgotla, including the merging of the Prevention and Social Drivers TTTs. The SANAC Procedural Guidelines must also expressly outline that the technical teams are accountable to the Secretariat and its CEO and thus the Trust.

- **Provincial Structures (PCAs, DACs, LACs):** Use the extended plenary to impress on the Offices of the Premiers the imperative to take leadership, ownership and accountability of the implementation of NSP in their respective provinces and regions. The SANAC Procedural Guidelines must also expressly outline the responsibilities and accountability of the provincial and local structures and this must be additive to the national framework.

**STRENGTHEN THE PROCEDURAL GUIDELINES**

- The current procedural guidelines do represent significant improvements on the previous ones and are more aligned with the current SANAC structures; but they can be further strengthened to cover expressly the accountabilities of the structures and also cover all SANAC structures.

- The Plenary should adopt the Procedural Guidelines as a priority for the next meeting as this will solidify the SANAC governance framework and structures.

**STRENGTHEN THE GOVERNANCE AND ACCOUNTABILITY FRAMEWORK**

- Although SANAC has an existing Governance and Accountability framework, this needs review and strengthening. SANAC is advised to continue to strengthen accountability using international best practice, focusing on accountability by answering the following questions: What have all stakeholders agreed that needs to be done and by whom? Are all stakeholders doing what they agreed to do? How well are stakeholders doing what they agreed to do?

- There is a need to clarify roles and responsibilities between the Secretariat and the Office of the Deputy President on the one hand and the Secretariat and the National Department of Health on the other. It is suggested that representatives from these bodies engage in a facilitated process to clarify roles and accountabilities.

**STRENGTHEN THE NATIONAL STRATEGIC PLANNING**

- The vehicle for expressing the above recommendations should be the National Strategic Plan which should provide direction
to all sectors.

- The next NSP should specify the institutional and organisational roles and frameworks through which this national consensus will be managed and implemented.
- It must also specify the outcomes and outputs for which various implementers are to be accountable, and the monitoring indicators through which such programme accountability can be established.

### 7. OVERALL CONCLUSION

South Africa has indeed achieved a great deal during the course of this NSP. The country has reduced mother to child transmission of HIV to very low levels, at least during pregnancy and delivery. Millions of lives have been saved as a result of the widespread expansion of the ART programme, with over 3 million people now on treatment. Some of the country’s TB indicators are improving, with treatment success among new TB cases getting close to the international benchmark of 85%.

Despite these successes, significant challenges remain. HIV incidence remains stubbornly high, especially among young women. While there is a renewed focus on key populations, coverage of these populations with HIV programmes remains too low. Retention of people in the ART programme remains below target, and too many people are being lost to follow up. In terms of the TB programme, ensuring TB completion remains a priority, especially given the country’s burden of MDR and XDR TB. More should be done to diagnose and treat TB in children.

South Africa could also be doing more to have good, reliable data to inform programme planning and implementation. M&E and surveillance need to be given greater priority, based on up to date indicators and targets. Resource mobilisation efforts will need to be increased to find the additional funding needed to scale up treatment and to address prevention efforts as described by the Investment Case.

### 8. OVERALL RECOMMENDATIONS

**NSP Implementation**

The implementation of the NSP in South Africa takes place in the context of a huge TB and HIV burden in the country, coupled with ever changing and ambitious international and local targets for the prevention and treatment of these diseases. Furthermore, the cost of HIV and TB prevention and treatment will continue to rise, thus calling for innovative and sustainable financing. On the other hand, the massive ART enrolment of over 3 million people by December 2014 in South Africa means that HIV is fast becoming another chronic disease, and is no longer inevitably fatal. Consequently, for all the reasons mentioned above, the HIV and TB response in South Africa needs to be:

- Prioritised towards highest risk, highest burden populations
- Focused towards interventions with the most likely chance of having an impact on reducing new infections
- Integrated with existing health and other programmes and services, given that the best chance of success in the long run is combined and integrated programming
- Innovative, which means finding and evaluating the effectiveness of new tools in the fight against these infections, and also new methods for delivering these tools, and improving programme effectiveness
- Well monitored, so that programme improvements and quality standards are maintained Implemented in consultation and support of both government and non-governmental organisations to facilitate community-based implementation.

In conclusion, below are the overall EPR recommendations:
PREVENTION

• Develop a comprehensive, multisector strategy for prevention with specific programme interventions, targets and time frames that are aligned to the goal of an AIDS-free generation as stated in the National Development Plan.

• A specific national multisector programme and campaign targeting new infections in young women needs to be urgently launched. While the DREAMS programme has been launched in South Africa, it is limited in terms of the number of districts in which it is being implemented. It could be prioritised and expanded to additional districts.

• Due to the constraints in funding and the need to expand both prevention and treatment, appropriate geographic targeting is necessary to achieve the biggest impact. Improving programme efficiency should also be a priority.

• Develop a simple uniform approach to social and structural drivers through community-based interventions such as Operation Sukuma Sakhe. Local and District AIDS Councils need to be developed and rolled out nationally, especially in high burden areas.

• Implement a national social and behaviour change campaign (SBCC) focussing on multiple partnerships, consistent condom use (dual protection), delaying sexual debut, adolescent and male testing needs to be driven by SANAC in partnership with government departments, civil society and the private sector.

MULTI-SECTORAL RESPONSE

• The DSD needs to greatly increase its provision of psychosocial services for key populations, OVC, the disabled and services that address high levels of internalised stigma in PLHIV.

• The DBE should finalise and implement its new HIV and TB policy and ensure monitoring of the proposed interventions, especially HCT, supply and promotion of condoms, reducing teenage pregnancies and supporting girls to remain in school. The sexuality education programme needs to be assessed and strengthened to provide compulsory, comprehensive sexuality education (CSE) in line with the ESA Declaration on CSE.

TREATMENT, CARE AND SUPPORT

• PMTCT has been the single biggest achievement in the last decade. Recommend additional efforts to reducing HIV transmission in the postnatal period and increasing access to paediatric and adolescent ART and retention in care for these groups.

• Develop a comprehensive set of paediatric indicators and targets for HIV and TB in children and adolescents.

• Develop demonstration projects for universal test and offer to treat and PrEP based on the recent guidelines by the World Health Organisation.

• Improve the coverage for viral load monitoring and the proportion of patients virally suppressed on treatment.

• The NSP needs urgent alignment with the 90-90-90 strategy announced by the Minister of Health in his budget speech earlier this year.

• A national unique patient identifier is essential and will strengthen patient-level surveillance.

TB

• A significant effort focussed on increased TB case findings and higher cure rates is needed to achieve better TB outcomes.

• The NSP should specifically document the impact of interventions focussed on TB key populations such as
mine workers and prison inmates and priority programmes such as DR-TB and paediatric TB

- **Data management systems to track improvements** need to be strengthened

**OTHER**

- Prepare a **costing and financing gap analysis** and plan based on the:
  - Findings of the **Investment Case**
  - The **additional costs of factoring in the prevention strategy**
  - The **latest estimates of HIV and TB revenues** from domestic, international and private sector funding sources

- Develop new indicator matrix for the monitoring and evaluation of the next NSP **institutional arrangements governing the AIDS, TB and STIs response need to be streamlined and simplified** - with a view to deepening the role of government departments, civil society, the private sector and local aids councils in the response
### APPENDIX 1: COMMUNICATE THE FINDINGS OF THE EPR TO ALL RELEVANT STAKEHOLDERS AND THE PUBLIC.

#### CASE STUDIES

<table>
<thead>
<tr>
<th>Topic</th>
<th>Good Practice</th>
<th>Challenges with Implementation</th>
<th>Innovation</th>
<th>Impact</th>
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<tbody>
<tr>
<td>Operation Sukhuma Sakhe (OSS) acting as a catalyst to promote the mainstreaming and integration of HIV, TB and STI multi-sectoral response amongst government departments and civil society at the local level using the war room approach SO1</td>
<td>In KZN, OSS has been implemented as a vehicle and conduit for the implementation and monitoring of the NSP/PSP activities. It is a comprehensive infrastructure for health service delivery and poverty reduction. It is a call for the province as a collective in its multi-sectoral nature to address the social determinants of health</td>
<td>The main challenge with the full implementation of OSS and the realisation of its benefits is none attendance at meetings (war rooms) by critical stakeholders in the multi-sectoral response. This limits the multi-sectoral and holistic nature of service delivery that is expected of such a structure</td>
<td>The innovation of OSS is that it brings different sectors together in one forum at the lowest level possible to discuss issues affecting specific communities using a war room approach. Action plans are drawn with a specific responsible LEAD being identified. It allows for reviews of action plans, gaps in service delivery and how those can be addressed. This approach is unique to the province and is being adopted in various forms by other provinces as a best practice. It fosters accountability of various agents of service delivery</td>
<td>People feel empowered to find their own solutions to challenges. OSS increases ownership and responsibility of not only the government, business and civil society but also the communities themselves. Increasingly, more people are enrolled on ARVs as a result of the approach used by the province to implement the NSP. The province has also noted a reduction in mother to child transmission at six weeks in line with a drop in the same at national level. The war room sessions have enhanced political leadership, buy-in and accountability</td>
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<td>Topic</td>
<td>Good Practice</td>
<td>Challenges with Implementation</td>
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<td>Optimising the provision of targeted health services in high transmission/high yield areas through the use of mobile health services</td>
<td>The good practice for the KZN Province involved the approach of taking health and HIV/TB services closer to the people through targeted service delivery at high transmission areas (HTAs) like the truck routes, hot spots for KP and taxi ranks. The focus of service provision has been mainly on providing a comprehensive package of services using the primary health care approach and not only providing HIV/TB services</td>
<td>The main challenge in the implementation of this innovative approach is mainly the availability of mobile clinics (units). The mobile units are very limited and cannot reach out to all the HTAs in an effective manner. Because the population is highly mobile, it is difficult for the programme to track viral load and retention of such individuals in care and support, unless they are attached to a fixed health care facility or some community-based programme of care and support.</td>
<td>The innovation and uniqueness of this approach is that it is a new approach that targets service delivery to mobile and vulnerable populations that would not otherwise have time or consider visiting a fixed health care facility if they still consider themselves healthy. The comprehensive nature of the health services provided through the mobile clinics is highly responsive to the needs of the community (health promotion and prevention)</td>
<td>There has been an increased number of key populations testing for HIV/TB which results in more people knowing their status and enrolling early in care and support for the greatest impact</td>
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<tr>
<td>Topic</td>
<td>Good Practice</td>
<td>Challenges with Implementation</td>
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<tr>
<td>Establishing a Civil Society Secretariat as a means to creating an effective PSP governance structure - <em>Governance and Civil Society arrangements</em></td>
<td>The Northern Cape Province has a fully-fledged Civil Society Leadership at provincial level which has a CSO Secretariat at district and provincial levels that coordinates and drives the agenda of CSO</td>
<td>Civil society representation at national level needs to be improved in order for the voice of that sector to be improved. The business sector also needs to participate and provide support in this forum</td>
<td>The existence of a CSO Secretariat is unique to the province. Civil society organisations provide a lot of support to not only service delivery but also holding government responsible and accountable to their mandate of service delivery. A strong CSO helps ensure service delivery happens in the spirit and approach of human rights and access to justice by the citizenry</td>
<td>Improved political buy-in and accountability in the multi-sectoral response. The implementation of the NSP, while delayed in the province, has been given impetus by this approach</td>
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<tr>
<td>Political leadership – MEC’s as ambassadors championing and leading key provincial HIV, TB and STI interventions <em>Governance and Civil Society arrangements</em></td>
<td>The Northern Cape Province has a unique best practice of having members of the Executive Council being ambassadors in championing different programmes, for example, the MEC of Social Development being an ambassador for TB</td>
<td>The MEC’s are not always available when needed</td>
<td>The innovativeness of this approach lies in the fact that leadership takes responsibility for the outcomes of such a programme and provide support to ensure its success. This approach also ensures that information, education and communication on specific national programmes are channelled through a single source and reaches out to everybody consistently and without distortions</td>
<td>Improved political buy-in and support by political heads improves service delivery and improved outcomes at individual, community and systemic levels</td>
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<tr>
<td>Topic</td>
<td>Good Practice</td>
<td>Challenges with Implementation</td>
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<tr>
<td>Mainstreaming HIV, TB and STI in Integrated Development Plans and building capacity to monitor implementation <strong>SO1</strong></td>
<td>SALGA in Bojanala district in the North West Province incorporates HIV/TB in the IDP and trains local staff within municipalities. This is part of strengthening mainstreaming HIV, TB and STI in IDPs</td>
<td>Poor reporting from all the sectors has hampered efforts to monitor integration of HIV/TB amongst different sectors</td>
<td>The incorporation of HIV/TB programming in the Integrated Development Plans of the South Africa Local Government Agency (SALGA) in Bojanala district is highly innovative and unique to the province. While it is expected of all provinces and districts to mainstream HIV/TB programming, this is the main weakness in most districts and the Bojanala case is therefore unique. The incorporation of HIV/TB in programming and the training of all staff is evidence of a commitment towards improved service delivery</td>
<td>The effect of the successful mainstreaming of HIV/TB programming in the district planning is that sectors become responsive, develop plans to effectively implement activities and are responsible for accounting on the progress realised to the betterment and improvement of service delivery</td>
</tr>
<tr>
<td>Implementing a Workplace Wellness Management Programme in commercial agriculture <strong>SO1</strong></td>
<td>The Eastern Cape Provincial AIDS Council together with AIDC is promoting health service provision in commercial agriculture in Sarah Baartman District</td>
<td>Absence of health and wellbeing service provision in the agriculture sector</td>
<td>The Eastern Cape AIDS Council working closely with GIZ and AIDC EC are implementing health and wellbeing activities in the commercial agriculture sector</td>
<td>There is notable uptake of HCT within these sectors and buy-in from wellness managers and farm owners. A study will be conducted to ascertain impact</td>
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<tr>
<td>Door-to-door HIV education programmes coupled with referrals to services</td>
<td>In Gauteng Province, the AIDS Council Secretariats manage the ward programmes with high involvement of ward councillors through door-to-door education programmes</td>
<td>The escalating new HIV infections in Gauteng Province among key populations is a challenge for the multi-sectoral response. Lack of resources including transport, materials and adequate human resources hamper the reach through door-to-door</td>
<td>A coordinated approach focussing on youth, young women and men in high risk wards is implemented through a door-to-door mechanism working closely with AIDS Council Secretariats, government departments and civil society sectors. Ward educators provide peer based education as appropriate</td>
<td>The programme reached 8 215 508 people cumulatively with 3 618 112 in 2012/13 and 8 850 804 people with 4 001 219 visits in 2013/14 respectively. Ward educators provided interactive education, condoms and educational materials in households, bars, hostels and on the streets. A total of 256 993 referrals were made to relevant services for health care, social services and poverty relief in 2013/14</td>
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### Table 30: NSP Core Indicators to be reported by the Department of Basic Education

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<td></td>
<td></td>
<td>Target</td>
<td>Reach</td>
<td>Target</td>
<td>Reach</td>
</tr>
<tr>
<td><strong>1.1</strong></td>
<td>Number of female learners who fell pregnant during the previous trimester</td>
<td>Progress in implementing more customised interventions aiming at reducing HIV infection in young people</td>
<td>Open</td>
<td>30 005</td>
<td>Open</td>
</tr>
<tr>
<td><strong>1.1</strong></td>
<td>Percentage of schools that are providing life skills-based HIV and AIDS education during the reporting period</td>
<td>Progress in implementing a life skills-based HIV and AIDS education</td>
<td>All</td>
<td>100%</td>
<td>All</td>
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<td></td>
<td>Current school attendance among orphans 10-14 (as percentage of total orphans of school age group)</td>
<td>The proportion of orphans aged 10-14 that attend school</td>
<td>339 858</td>
<td>333 797</td>
<td>623 7832</td>
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<td>Current school attendance among non-orphans 10-14 (as percentage of total orphans of school age group)</td>
<td>The proportion of non-orphans aged 10-14 that attend school</td>
<td>5 191 315</td>
<td>5 136 0093</td>
<td>5 191 315</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5 136 0093</td>
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<td></td>
<td>Number of learners attending no fee schools</td>
<td>Learners who are exempted from paying fees</td>
<td>60% of 12 68 069</td>
<td>8 517 300</td>
<td>60% of 12 468 069</td>
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<td></td>
<td>Approved revised National policy on HIV, STIs and TB for the schooling system</td>
<td>Progress in mainstreaming HIV &amp; AIDS and TB and its gender-based dimensions into the core of the Department of Basic Education</td>
<td>DBE Integrated Strategy, 2012-2016</td>
<td>Draft Zero of the DBE Draft National Policy on HIV, STIs and TB</td>
<td>Revised Draft 4 of the DBE Draft National Policy on HIV, STIs and TB</td>
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<td></td>
<td>Approved peer educator and peer mentor manuals</td>
<td>Approved peer educator and peer mentor manuals reviewed by DBE</td>
<td>Draft peer educator and peer mentor manuals reviewed by DBE</td>
<td>Review of the peer educator and peer mentor manuals with Life Skills provincial and district officials</td>
<td>Training of provincial and district Life Skills officials on the use of the peer educator and peer mentor manuals</td>
</tr>
<tr>
<td>Sub-Objective 1.3 Implement interventions to address gender inequities and gender-based violence as drivers of HIV and STIs</td>
<td>Number of schools participating in the speak out against abuse, advocacy campaigning utilising the handbook for learners on how to prevent sexual abuse in public schools</td>
<td>Progress in implementing speak out against abuse campaigns</td>
<td>200²</td>
<td>197</td>
<td>200</td>
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<tr>
<td><strong>Sub-Objective 1.4</strong> Adapt the regional CSTL MER Framework for SA context</td>
<td>Approved CSTL MER Framework</td>
<td>Progress in developing systems to mitigate the impact of HIV and TB on orphans, vulnerable children and youth</td>
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<td></td>
<td>Number of OVCs reached through the integrated service delivery days</td>
<td>Number of OVCs receiving basic service through the integrated service delivery days</td>
<td>147 315</td>
<td>155 534</td>
<td>163 047</td>
</tr>
<tr>
<td></td>
<td>Number of learners that are provided with meals in quintile 1-3 primary and secondary schools</td>
<td>Learners who receive meals as a mechanism to keep them in school</td>
<td>9 027 419</td>
<td>9 159 773</td>
<td>8 700 000</td>
</tr>
<tr>
<td></td>
<td>Number of public ordinary schools that are linked to police stations to strengthen school safety</td>
<td>Schools that offer programmes that address stigma and discrimination</td>
<td>1 962</td>
<td>1 785</td>
<td>1 4387</td>
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<td></td>
<td>Training of School Based Support Teams on the use of the CSTL Guidelines and tools</td>
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<tr>
<td><strong>Sub-Objective 2.2</strong></td>
<td>Make accessible a package of sexual and reproductive health (SRH) services</td>
<td>Number of learners receiving school health services</td>
<td>1 196 368</td>
<td>652 258</td>
<td></td>
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<tr>
<td></td>
<td>Learners that are receiving school health services</td>
<td>750 000</td>
<td>749 537</td>
<td>510 000</td>
<td>630 777</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 196 368</td>
<td>652 258</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sub-Objective 2.4</strong></td>
<td>Implement a comprehensive national social and behavioural change communication strategy with particular focus on key populations</td>
<td>Number of educators trained to implement sexual and reproductive health (SRH) programmes for learners</td>
<td>17 900</td>
<td>17 087</td>
<td>18 755</td>
</tr>
<tr>
<td></td>
<td>Educators that are trained to implement SRH programmes</td>
<td>18 500</td>
<td>19 000</td>
<td>18 950</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 201 500</td>
<td>1 763 037</td>
<td>519 613</td>
<td>500 000</td>
</tr>
<tr>
<td></td>
<td>The number of LTSM on sexual and reproductive health delivered to schools.</td>
<td>Sets of LTSM on SRH delivered to schools</td>
<td>1 201 500</td>
<td>1 763 037</td>
<td>519 613</td>
</tr>
<tr>
<td></td>
<td>Learners trained on peer education programmes</td>
<td>450 000</td>
<td>500 000</td>
<td>673 647</td>
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<td></td>
<td></td>
<td>39 200</td>
<td>81 387</td>
<td>83 570</td>
<td>84 053</td>
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<tr>
<td></td>
<td>Number of learners, educators and school communities reached through advocacy and behaviour change communication</td>
<td>410 000</td>
<td>344 854</td>
<td>530 000</td>
<td>428 998</td>
</tr>
<tr>
<td></td>
<td>Learners, educators and school communities reached</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Monitor and support implementation of the Life Skills Programme in line with the NSP's human rights agenda</td>
<td>9 400</td>
<td>6 958</td>
<td>12 800</td>
<td>12 310</td>
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<tr>
<td></td>
<td>Implementation of the Life Skills Programme monitored</td>
<td></td>
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Appendix 3

**Funding provided by the Department of Science and Technology during the reporting period**

<table>
<thead>
<tr>
<th>Financial Year</th>
<th>HIV/AIDS</th>
<th>TB</th>
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<tbody>
<tr>
<td>2012/13</td>
<td>R31 367 379</td>
<td>R10 000 000</td>
</tr>
<tr>
<td>2013/14</td>
<td>R35 126 379</td>
<td>R12 000 000</td>
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<tr>
<td>2014/15</td>
<td>R22 596 000</td>
<td>R15 000 000</td>
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</table>

Appendix 4:
Higher Education and Training HIV/AIDS Programme direct grants to universities

<table>
<thead>
<tr>
<th>Sources of income</th>
<th>Percentage allocations</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Treasury</td>
<td>22%</td>
</tr>
<tr>
<td>National Skills Fund for Curriculum Development</td>
<td>38%</td>
</tr>
<tr>
<td>Membership contribution from public universities and colleges</td>
<td>3%</td>
</tr>
<tr>
<td>The Global Fund direct grant</td>
<td>35%</td>
</tr>
<tr>
<td>GIZ Funding</td>
<td>2%</td>
</tr>
</tbody>
</table>

Specific allocations to universities from Global Fund direct grant

**Granted R200 000:** University of Cape Town; University of KwaZulu-Natal; University of Western Cape; University of Venda and University of Zululand.

**Granted: R350 000:** Cape Peninsula University of Technology; Central University of Technology and Walter Sisulu University.

**Granted: R400 000:** Durban University of Technology; Mangosuthu University of Technology; Nelson Mandela Metropolitan University; North West University; Rhodes University; Stellenbosch University; Tshwane University of South Africa; University of Fort Hare; University of Johannesburg; University of Limpopo; University of Pretoria; University of South Africa; University of Free State; University of Witwatersrand and Vaal University of Technology.
APPENDIX 5:

LIST OF SABCOHA MEMBERS

African Rainbow Minerals
Anglo American South Africa Limited
Anglo American Kumba Iron Ore
Anglo Platinum t/a Rustenburg Platinum Mines
AngloGold Ashanti Ltd
Bidvest Group Limited
BMW (South Africa) (Pty) Ltd
De Beers Consolidated Mines
Ford Motor Company South Africa
General Motors SA
Investec Bank Limited
Metropolitan Bank Limited
Metropolitan Holdings Ltd
Nampak Products Ltd
Nedbank Group
Rand Water
SABMiller pic
Sappi
Sasol Limited
Shell SA Refining (Pty) Ltd
Standard Bank Group
Total South Africa (Pty) Ltd
Woolworths
Volkswagen of South Africa
Webber Wentzel
ABSA
Aid for AIDS
Aveng Group
Coega Development Corporation
EOH Abantu (Pty) Ltd t/a EOH Health
Hernic Ferrochrome (Pty) Ltd
Illovo Sugar Limited
Kaefer Thermal Contracting Services
LifeAssist-a division of Trauma-Assist (Pty) Ltd
Lonmin Platinum
Road Accident Fund
Toyota SA
Umgeni Water
Unilever SA
Small & Medium Enterprises
AIDC Eastern Cape
Asherson Import Export t/a Kendo International
Atomo Diagnostic (Pty) Ltd
Aurum Institutes, The
Bankmed
Epicentre
Education, Training and Counselling (ETC)
HSEC Strategic Solutions
ICAS Southern Africa t/a HealthInsite (Pty) Ltd
Imbizo Health
Innovative Health Care Solutions (Pty) Ltd
JS Training Consultants
Judith Bester
Kaelo Consulting (PTY) Ltd
Lifeworks (Pty) Ltd
Litabe Moitheri Charity
Master Builders KwaZulu-Natal
MDG Health Solutions (Pty) Ltd
Medipost Pharmacy
Medwork t/a Geneeskundige Fabricage (pty) Ltd
MJ Lebeko
Natasha Mulundu
Oxygen for Life SA t/a The CellFood® Company
Resolution Health Medical Scheme
Silverton Engineering (Pty) Ltd
South African Sugar Associates t/a (SASA)
Swedish Workforce HIV/AIDS Program (SWHAP)
Tshakule Service Providers
Tshepiso
UCL Company Limited
Unique Health
Workforce Healthcare (Pty) Ltd
# ENDNOTES AND REFERENCES

<table>
<thead>
<tr>
<th>Endnote</th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
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<td>2</td>
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<td>4</td>
<td>SAHMS-FSW Survey 2013-14</td>
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<td>5</td>
<td>ASSA, 2012</td>
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<td>6</td>
<td>WHO 2010</td>
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<td>7</td>
<td>WHO Global TB Report 2015</td>
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<td>8</td>
<td>WHO Global TB Report 2015</td>
</tr>
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<td>9</td>
<td>Stats SA 2011</td>
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<td>10</td>
<td>MRC, 2010</td>
</tr>
<tr>
<td>11</td>
<td>Stigma Index, 2015</td>
</tr>
<tr>
<td>12</td>
<td>Consolidated National report covering monthly and quarterly ART data to end March 2014. Patients without visit information for 3 months past their next appointment are defaulted to being lost</td>
</tr>
<tr>
<td>13</td>
<td>Spectrum, 2014</td>
</tr>
<tr>
<td>15</td>
<td>Spectrum Model, 2014</td>
</tr>
<tr>
<td>16</td>
<td>Summary of preliminary results from Thembisa Provincial Models; 2015</td>
</tr>
<tr>
<td>18</td>
<td>More recent data are available (UNAIDS, 2016) but this report has March 2015 as a cut-off date.</td>
</tr>
<tr>
<td>19</td>
<td>Spectrum HIV/AIDS Estimates, 2014</td>
</tr>
<tr>
<td>20</td>
<td>WHO Global TB Report, 2015</td>
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<tr>
<td>21</td>
<td>WHO Global TB Report, 2015</td>
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<tr>
<td>22</td>
<td>WHO Global Report, 2015</td>
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<tr>
<td>23</td>
<td>DOH Annual TB Report, 2013</td>
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<td>24</td>
<td>WHO Global Report, 2015</td>
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<tr>
<td>25</td>
<td>WHO Global Report, 2015</td>
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<td>26</td>
<td>DOH TB Report, 2013</td>
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<tr>
<td>27</td>
<td>DOH Report; 2012/13</td>
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<td>28</td>
<td>DOH Annual Report, 2013/14</td>
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<td>29</td>
<td>DOH Annual TB Report, 2013</td>
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<td>30</td>
<td>DOH Annual Report, 2013</td>
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<td>31</td>
<td>DOH Annual TB Report, 2013</td>
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<tr>
<td>32</td>
<td>WHO Global TB Report, 2015</td>
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<tr>
<td>33</td>
<td>Citation 2013 HIV and TB review</td>
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<tr>
<td>34</td>
<td>Johannesburg; SAHRC</td>
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<td>35</td>
<td>Johannesburg; SAHRC</td>
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<tr>
<td>36</td>
<td>Johnson et al., 2013</td>
</tr>
<tr>
<td>37</td>
<td>Stigma Index</td>
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<tr>
<td>41</td>
<td>Presentation to SANAC Plenary on Public Sector Response to HIV/AIDS, DPsA</td>
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</table>
See DHIS, 2013

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MRC SAPMCTE 2012/13 and NHLS 2014

According to manual calculations using the Health Data Advisory and Co-ordination Committee (HDACC) method

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110 WHO Global Report, 2015
111 WHO Global Report, 2015
112 DOH TB Report; 2013
113 DOH Report; 2012/13
114 DOH Annual Report, 2013/14
115 WHO Global TB Report, 2015
116 DOH Annual TB Report, 2013
117 DOH Annual TB Report, 2013
118 DOH Annual TB Report, 2013
119 DOH Annual TB Report, 2013
120 DOH Annual TB Report, 2013
121 DOH Annual Report, 2014/15
122 DOH Annual Report, 2014/15
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124 DOH Annual TB Report, 2013
125 Source: DOH Annual TB Report, 2013
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139 DOH Annual Report, 2013/14
140 UNAIDS Regional Report 2013, Getting to Zero: HIV in Eastern and Southern Africa
141 Source: DOH Annual Report, 2014/15
142 DOH Annual Report, 2013/14
143 DOH Annual Report, 2014/15
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147 DOH Annual Report. 2012/13
149 DOH Annual TB Report, 2013
150 DOH Annual Report, 2014/15
151 DOH Annual Report, 2014/15
152 DOH Annual TB Report, 2013
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155 DOH 2014
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